East Dunbartonshire
Community Health Partnership

NHS
Greater Glasgow and Clyde

East Dunbartonshire CHP

Development Plan 2013-16

INVESTING IN VOLUNTEERS™

HEALTHY WORKING LIVES

CONTENTS

SECTION 1 EARLY INTERVENTION AND PREVENTING ILL-HEALTH

Key outcomes

- improve identification and support to vulnerable children and families;
- enable disadvantaged groups to use services in a way which reflects their needs;
- increase identification of and reduce key risk factors (smoking, obesity, alcohol use);
- increase the use of anticipatory care planning;
- increase the proportion of key conditions including cancer and dementia detected at an early stage;
- enable more older people to stay healthy.

1.1 Mental Health

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Meet performance trajectory for access to psychological therapies in line with HEAT target	% waiting over 18 wks for referral to treatment for Psychological Therapies	23%	4%	0%
	% of patients who started treatments within 18wks of referral	N/A	85%	90%
Raise awareness of suicide prevention by delivering training to appropriate front line staff	Maintain level of 50% of staff trained in suicide prevention	33%	50%	50%
	Reduce suicide rate between 2002 and 2013 by 20%	9.3 (2002 baseline)	7.4	
Deliver the revised waiting targets for PCMHT of: – 28 day referral to assessment – 9 weeks referral to treatment	Reduce waiting times to PCMH: – referral to assessment	6 days	28 days	28 days

	– referral to treatment	10 weeks	9 weeks	9 weeks

1.2 Cancer

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Increase uptake of cancer screening in East Dunbartonshire through the : – dissemination Detect Cancer Early materials and information to a wide range of services in all sectors – delivery of targeted public health campaign in Hillhead community – delivery of cancer awareness training to a range of partners	Uptake of cancer screening programmes: – Bowel SIMD1 – Breast – Cervical SIMD1	 58.8% 44.2% 79.1% 82.4% 76.6%	 60% 46.2% 79.1% 82.4% 77.6%	 60% 60% 79.1% 82.4% 80%
Deliver universal and targeted smoking services with particular focus on areas of deprivation and smoking in pregnancy	Reduce smoking rates SIMD 1 Smoking in pregnancy	711 96 9.7%	1236 340 9.7%	1236 340 9.7%

1.3 Children & Maternal Health

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Develop and agree a joined up model for the delivery of services to pregnant vulnerable women through the delivery of SNIPs and the Family Health Nurse partnership	Number of first time teenage mums participating in FHN Partnership	0	4	TBC
Improve the identification and support for vulnerable children and families in line with GG&C plans by: – implementing the 30 month assessment – Auditing and reviewing invitations and attendance to child	% of children receiving 30 months assessment Percentage of CHP staff	60% 75.3%	65% 90%	80% 95%

protection case conferences	attending case conferences			
Deliver and improve uptake of universal and targeted Triple P parenting support in range of settings to support families to increase their confidence and skills in parenting.	No. of parents receiving Triple P parenting support	104	114	125
Maintain UNICEF accreditation across the CHP and support mothers to breast feed Improve infant nutrition, reducing the inequality gap and the breast feeding drop rates between HV 1st visit and 6-8wks	Breastfeeding rates at: – Birth – hospital discharge – Health Visitors first visit – 6 - 8 weeks – 6-8 weeks in deprived areas	 58.4% 46.0% 37.5% 29.1% 12.2%	 58.4% 49.0% 39.5% 30.1% 15.2%	 53.1% 41.6% 39.5% 30.1% 19.2
Address childhood obesity through the deliver of Active Choices and Aces programmes	Number of completed child healthy weight interventions over the three years ending March 2014	98	287	TBC
Improve oral health for children through: – Completion of 6-8 week assessment by HVs for dental registration	Improve dental registration 0-2yrs	44.5%	60%	60%
– Establishing systems to ensure all children will have access to a programme of care within Primary care dental services at age 0-2 years	Improve dental registration 3-5yrs	85.8%	85.8%	85.8%
– Participation in the Scottish Government Nursery Toothbrushing Programme for East Dunbartonshire nurseries	Percentage of all ED nursery children participating in toothbrushing programme	78.9%	100%	100%
– Participation in the Scottish Government school Toothbrushing Programme for East Dunbartonshire	Percentage of all ED schools participating in toothbrushing	100%	100%	100%

schools – Maintain the number of percentage of children who have no dental decay	programme Dental decay rates in P1 (%Caries free) Dental decay rates in P7	 78.9% N/A	 78.9% 60%	 78.9% 60%

1.4 Disability

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Assess and take action to increase staff knowledge regarding adult support and protection procedures,	No. of staff completed ASP training	45%	80%	90%
Monitor performance against planned number of LD health checks following the change in GP contracts. Routinely screen those with Down's syndrome for dementia	Number of health checks completed Number of those with Downs syndrome screened	25 per year 10 per year	25 per year 10 per year	25 per year 10 per year
Improve access to health improvement services for those with learning disabilities through: – Referrals to Live Active or other physical activity groups	Number of referrals to activity based / healthy lifestyle initiatives completed.	20	25	30

1.5 Drugs and Alcohol

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Delivery of ABIs by key front line staff such as GPs in line with agreed level of activity to reduce the impact of substance misuse among both adults and children. Integrate ABI work into community and health promotion events,	Number of alcohol brief interventions delivered Reduce rate of alcohol related admissions	457 3.6 (Dec 12)	649 3	649

pharmacies and wider clinical justice work	Reduce alcohol related deaths per 100,000 pop	26.1 (2011)	25	

1.6 Long Term Conditions

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Increase early intervention and prevention through – improving local access to Patient Information, health and well-being opportunities self management programmes – developing opportunities for peer support, buddying and self help. – implementing the falls policy across services	Numbers and types of staff accessing disability awareness training Number of people accessing buddy model of support through Ceartas	5 0	7 20	10 TBC

1.7 Older People

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Increase the diversity of support for patients and their carers through more effective access to voluntary sector services. This will be delivered through a single point of access to voluntary sector interventions for older people and carers through delivery of the Older People Access Line (OPAL)	Number of people contacting OPAL	0	340	TBC
Implement a structured approach to anticipatory care planning across community nursing for vulnerable older people at risk of hospital readmission	Number of older people with an anticipatory care plan	70	100	TBC

1.8 Primary Care

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Review and improve GP participation in child protection	% of child protection case conferences attended by GPs % child protection reports provided by GPs	4% 6.25%	10% 15%	10% 20%
Deliver the childhood immunisation programme, particularly improving the uptake of MMR	MMR vaccination rates at: 24 months 5 yrs	 95% 95.7%	 95% 95%	 95% 95%
Engage with GPs to implement anticipatory care programme including Keepwell	No. of practices delivering Keepwell	0	1	3
Jointly commission with EDC a Mental Health service through the voluntary sector (Carers Link) to provide support for carers of individuals with a mental health diagnosis. For all carers, including young carers, identify and improve the uptake of carer's assessments so that they are supported in maintaining their caring role.	No. of carers referred for assessment	Not known	50	TBC

1.9 Sexual Health

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Improve access for residents to local Sandyford services to improve sexual health and increase contraception uptake and reduce teenage pregnancies	LARC increased in Primary care Reduce teenage pregnancy rates per 1,000	41.2 14.8	(target TBC by Sandyford) 14.5	

Improve uptake of local condom scheme Support schools in delivering the sexual health curriculum to enable children and young people to acquire knowledge, understanding and skills about their sexuality and relationships	Number of condoms distributed % of non denominational and special schools participating in sexual health curriculum training	10,500 (Dec 12) 100%	12,000 100%	16,000 100%

Financial issues/actions to deliver corporate outcomes
– Redesigning current DN and HV workforce to realise the resource for investment in anticipatory care and on the 30 month assessment. Over next year we will measure impact of anticipatory care investment. – Shift balance of activity within PCMHCT from 1:1 interventions towards evidence based large group approaches. – Invest £59,000 Change Fund monies to develop our long term conditions infrastructure that will be mainstreamed into the Keepwell post

SECTION 2 SHIFTING THE BALANCE OF CARE

Key outcomes

- fewer people cared for in settings which are inappropriate for their needs;
- there are agreed patient pathways across the system, with roles and capacity clearly defined including new ways of working for primary and community care;
- we offer increased support for self care and self management which reduces demand for other services;
- more carers are supported to continue in their caring role;
- more people are able to die at home or in their preferred place of care**.**

2.1 Acute services

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Support people in their decision about where they wish to die, in accordance with their stated preference, as part of advance care planning and the Liverpool Care Pathway. Provide proactive support for discharge of patients for end of life care	Reduce % of total palliative care patient deaths that occur in hospital	20%	18%	15%

2.2 Mental Health

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Monitor and take appropriate action to maintain the targets for delayed discharges for adults with mental health and AWI	Delayed Discharge Adults with Mental Health			
	> 28 days	0	0	0
	< 28 days	0	0	0

Identify areas for improvement in the patient journey of adults with a mental health diagnosis to reduce bed days consumed by delayed discharge AWIs	Reduce bed days consumed by delayed discharge for AWIs to 25% of 2009/10 baseline	3,200 (2009-10)	1600	800

2.3 Disability

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Support more people with disabilities in their own home we: – Deliver an open access service for patients to the Community Rehabilitation team – Increase the number of people accessing the Community Rehabilitation service Single Point of Access and promote immediate self referral back into the service when any changes or deterioration in condition occur	Increase the number of people accessing Community Rehabilitation Services	5	10	TBC
Monitor and take appropriate action to maintain the targets for delayed discharges for adults with Learning Disabilities	Delayed Discharge Adults with LD > 28 days < 28 days	 122 (2012-13) N/K	 0 0	 0 0

2.4 Long Term Conditions

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Implement the Long Term Conditions plan to reduce the use of hospital inpatient care through a collaborative approach to the patient journey. Reduce admissions through effective care planning and management, including: – the provision of the DESMOND programme by those newly diagnosed with diabetes – the provision of podiatry reviews of patients with diabetes	Reduce long term conditions bed days rate (per 100,000 pop) Reduce the number of acute bed days consumed by each LTC: All	6696.0 9517.7	6562 9326	6302 8956

	COPD Asthma Diabetes CHD:	2004.4 204.6 304.1 4182.8	1964.3 200.6 298.0 4099.1	1885.75 192.5 286.0 3935.1
Prevent pressure ulcers through the implementation of the Tissue Viability Model and Safety Cross	Reduction in number of grade 3 & 4 pressure ulcers	6	5	3

2.5 Primary Care

Action to deliver corporate outcomes	**Performance Measure**	**Baseline 2011-12**	**Year 1 Target**	**2016 Target**
Work with pharmacies and GP practices to increase number of patients receiving electronic repeat prescription and maintain delivery of the chronic medication service	Number of GP practices participating in electronic repeat prescription transfer	5	8	17

SECTION 3 RESHAPING CARE FOR OLDER PEOPLE

Key outcomes

- clearly defined, sustainable models of care for older people;
- more services in the community to support older people at home and to provide alternatives to admission where appropriate;
- increased use of anticipatory care planning which takes account of health and care needs, and home circumstances and support;
- carers are supported in their caring role;
- improved partnership working with the third sector to support older people;
- improved experience of care for older people in all our services.

3.1 Acute services

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Monitor and improve early supported discharge through: – Increasing referrals to social work prior to fit for discharge date – Increasing proactive, supportive, pre discharge assessments to CRT – Increasing use of the Voluntary Sector to support patients and their carers.	Reduce bed days consumed by delayed discharge to 25% of 2009/10 baseline	7,359 (2009-10)	3,679	1,839
	Reduce the number of unplanned acute bed days (65 years+)	54,865	53,767.7	TBC
Identify gaps and areas for improvement and redesign opportunities by undertaking a whole systems audit of patients referred to the hospital social work team Increase the use of GP rapid rehabilitation response to prevent admission and support early discharge	Reduce number of unplanned acute bed days rate (per 1,000 pop 65 years+)	2,824	2,767	TBC
	Reduce the number of unplanned acute bed days (75 years+)	43,358	42,491	TBC
Developing and improving pathways for people admitted to EMI and acute				

	10% reduction in bed days aged 75 years and over per 1,000 pop from 2009/10 of 5,205 by 2014/15	4,866	4768	4685 (2014)
	Reduce the number of emergency admissions (per 1,000 pop 65 yrs+)	246	241.1	TBC
	Reduce emergency admissions bed days rate (per 1,000 pop pop 75years+)	4,899	4,409	TBC

3.2 Older People

Action to deliver corporate outcomes	**Performance Measure**	**Baseline 2011-12**	**Year 1 Target**	**2016 Target**
Deliver the Dementia Strategy priorities and improve early diagnosis through: – EMI service working with GPs to improve recording on QOF of people diagnosed – Providing one year post diagnosis support	People with a diagnosis of dementia on the QOF register	628	792	792
	% of newly diagnosed people with support plan	0	100%	100%
Improve the integration of adult mental health and OPMH by – increasing the referrals of those aged 65+yrs to PCMHT – rectifying the gap in provision of psychiatry for older people	Proportionate access to psychological therapies (age)	11%	13%	15%
Encourage and support practices to review patients medication and implement mindful prescribing to reduce polypharmacy, in accordance with the LES target	Number of GP practices participating in the LES	16	16	17

3.3 Primary Care

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Improve joint planning with primary care contractors through local planning groups and annual PLTs, including presentations on ACPs and LTC work, to ensure that GPs are key partners in planning the modernisation of older people services.	Number of GP practices engaging with PLT events	15	17	17
	Number of GP practices engaging with GP Forum / Locality groups	16	17	17
Work in partnership with GPs to identify vulnerable older people and plan anticipatory care with DNs and community nursing staff	Number of GP practices using SPARRA data to identify vulnerable older people	10	17	17

Financial issues/actions to deliver corporate outcomes
Evaluation of the Change Fund is now underway and will inform future spend

SECTION 4 IMPROVING QUALITY, EFFICIENCY & EFFECTIVENESS

Key outcomes

- making further reductions in avoidable harm and in hospital acquired infection;
- delivering care which is demonstrably more person centred, effective and efficient;
- patient engagement across the quality, effectiveness and efficiency programmes;
- developing the Facing the Future Together programme to support our staff to improve quality, hear and respond to patient feedback;
- improve appropriate access on a range of measures including waiting times, access to specialist care; physical access and needs responsive access.

4.1 Acute services

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Maintain direct access for referrals to diagnostics and investigations through SCI gateway referrals, particularly the recent direct access for MRI scanning for knees	SCI Gateway referrals	97%	98%	98%

4.2 Mental Health

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Use text messaging directly to patients to improve clinic attendance at OPMH and PCMHT for one to one interventions	Reduce DNAs at clinics	16%	14%	10%

4.3 Disability

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Analyse user experience data, identify and deliver actions to improve the experience of services for people with a learning disability	Number of focus groups for LD service users and carers	0	1 per annum	1 per annum

4.4 Drugs and Alcohol

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Maintain drug and alcohol waiting times to meet the 21 day target through contributing to the delivery of the actions set out in the East Dunbartonshire ADP strategy, including: – Alcohol and Drug Prevention and Education – Targeted health improvement activities; – Contributing to Over Provision Statements meetings.	90% of clients will wait no longer than 3 weeks from referral to treatment	83.2%	91.5%	91.5%
	Reduce drug related deaths (per 100,000 pop)	1.9	1.8	TBC
	Reduce alcohol related deaths (per 100,000 pop)	26.1 (2010-11)	26	TBC

4.5 Primary Care

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Implement the recommendations from the Review of District Nursing in accordance with the GG&C plan, including implementation of the iPad pilot within district nursing	Increase in direct patient facing time	0	5%	5%
Identify and support GP practices to maintain access targets through learning from models such as the Productive GP	GP 48 hour access	94%	95%	95%

	GP Advance Booking	93.5%	maintain	maintain
Support GPs to address prescribing variation through: – undertaking annual prescribing discussions – participating in medicines management LES – agreeing and support the achievement of prescribing targets	Achieve and where appropriate exceed the escitalopram target	<3%	<3%	<3%
	Achieve and where appropriate exceed the citalopram target	<65%	<65%	<65%
	Reduce cost per weighted patient	£168	£165	TBC
	% of pharmacies participating in the chronic medication service	76.5% (2012-13)	80%	100%
Support GPs to identify practice variances, gaps and potential service improvements.	Analyse PAR data and identify priority areas	N/A	Priority areas identified	TBC

Financial issues/actions to deliver corporate outcomes
– Testing ipads as part of DN review to release 1hr of nurse time – Support staff to generate and deliver ideas which make better use of resources through the Bright Ideas scheme

SECTION 5 TACKLING INEQUALITIES

Key outcomes

- we plan and deliver health services in a way which understands and responds better to individuals' wider social circumstances;
- information on how different groups access and benefit from our services is more routinely available and informs service planning;
- We narrow the health inequalities gap through clearly defined programmes of action by our services and in conjunction with our partners

5.1 Mental Health

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Implement plan to mainstream assets based approaches within service delivery models and roll out asset mapping resource for the wider community.	% of relevant staff trained in asset based assessments.	0	50% relevant staff trained	100% relevant staff trained
Commission Ceartas to improve access to advocacy with a specific focus on mental health and Low Moss prison work	Number of referrals to advocacy service	200	210	

5.2 Cancer

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Reduce equalities gap through the delivery of targeted smoking cessation services for pregnant women in SIMD 1 areas	Reduce smoking in pregnancy (SIMD)	29.8%	20%	20%

5.3 Children & Maternal Health

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target

Implement recommendations from audit of locality based Birth -5 year Drop-in Service to improve access, provision of health improvement information and quality of support for parents, with a particular focus on areas of deprivation	% return rates to service	N/A	10%	TBC
Maintain level of Healthier Wealthier Children referrals to CAB	No. of HWL referrals	21	22	22

5.4 Drugs and Alcohol

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Deliver the improvement actions in the addictions equalities plan: – Provide all information on drugs and alcohol services in an information policy format	% Information provided in an Information Policy format	N/A	100%	100%
– Record equalities dataset to assess pattern of use of services and identify gaps in relation to services demand verses projected population need	% of addictions clients with recorded Equalities data	N/A	100%	100%
	Reduce SIMD gradient for addictions	TBC	TBC	TBC

5.5 Primary Care

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target	2016 Target
Improve access to financial inclusion services, particularly for families at risk of poverty and increase additional income generated (£) as a result of financial inclusion advice received	Number of referrals to financial inclusion	90	100	100
	Additional income generated (£)	£200K	£200K	£200K
Increase access to employability services/interventions, including vocational rehabilitation for people with disability or long term ill-health.	Number of work placements for vulnerable groups	0	10	10

Deliver equality assured services through undertaking EQIAs and implementing of improvement plans.	Number of EQIAs	4	4	4
Embed routine sensitive enquiry through delivery of training to CHP front line staff and support staff to undertake routine sensitive enquiries	% of staff attended sensitive enquiry training	36%	60%	80%

5.6 Equality Outcomes

Action for delivery as part of GGC-wide approach
The CHP will undertake a number of actions relating to the equality outcomes. Measures are provided throughout the development plan to address, in particular, the following actions: – Identify and address inequalities in access to cancer screening and services, specifically bowel screening for men in SIMD 1, and access to psychological services – Deliver the relevant actions within the NHSGG&C Communication and support plan and ensure all information is compliant with the accessible Information Policy – Assess current position, develop and implement actions to reduce discrimination faced by LGBT, sensory impaired people and people with learning disabilities and implement actions to reduce discrimination including through the EQIA process – 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 promote needs led access to services. – Remove barriers to services by promoting self referral to PCMHT, SPOA to CRT, and identify barriers for disabled people by asking disability specific questions – Address the health needs of those who are homeless as agreed through the joint East Dunbartonshire Homeless Action Plan – Improve the health needs of prisoners, particularly in relation to alcohol and drug issues, and oral health needs – Extend as appropriate the use of routine sensitive enquiry to new settings and support shared GBV approach with GPs – Raise staff awareness of the needs of groups with protected characteristics through elearning modules, including equality training, and KSF discussions

Financial issues/actions to deliver corporate outcomes
– Supporting investment in recovery work with families, and employability as part of the ADP delivery strategy

SECTION 6 ORAL HEALTH

6.1 Early intervention and preventing ill health

Action to deliver corporate outcomes	Performance Measure	Baseline	Year 1 Target	2016 Target
100% of P1 & P2 schools to participate in Toothbrushing Programme	% of schools participating in toothbrushing programme	86%	100%	100%
Childsmile Nursery Fluoride Varnish Programme is provided in 20% of feeder nurseries to most deprived schools.	% children who have received FVA as a proportion of total children in participating nurseries	33%	35%	60%
Childsmile School Fluoride Varnish Programme to be provided in 20% of most deprived school population Target is % of children receiving FVA as a proportion of total P1-P4 roll in participating schools	% children who have received FVA as a proportion of total P1-P4 roll in participating schools	36%	40%	60%

6.2 Shifting the balance of care

Action to deliver corporate outcomes	Performance Measure	Baseline	Year 1 Target	2016 Target
Support all dental practices to offer Childsmile interventions and particularly provide targeted support to practices not participating, or data show low level of Childsmile activity.	% of total GDS practices delivering Childsmile Programme	73.9%	80%	100%
Plan and Implement Capital Planning Priorities: – Vale of Leven Health & Care Centre to have all 13 chairs operating effectively within budget and timeframe (4 GDP, 4 Student Outreach and 5 CSDS chairs)	Number of chairs operating effectively in VoL	0	13	13

– Successful transfer of Outreach Teaching Service from Greenock HC to VoL H&C Centre by August 2013 – Consolidation and Delivery of improved CSDS services/GDS for patients from the Maryhill, Woodside, Possilpark and Gorbals new builds	Number of outreach chairs available and in use for start of Academic term Number of chairs available for the delivery of service in new builds – Maryhill – Possilpark – Gorbals/Govanhill – Woodside	0 0 0 0 0	4 0 0 0 0	4 2 2 4 chairs (reduced to 3 – improved occupancy) 4 GDP chairs
Improve the recording of all CSDS activity through R4 and that activity data are provided to ISD via EDI by April 2013	% of GP17s completed	N/A	60%	100%
Ensure effective patient charging systems are implemented across all CSDS sites by April 2013	Number of sites operating a patient charging system	3	14	28

6.3 Reshaping care for older people

Action to deliver corporate outcomes	Relevant KPIs baseline	Baseline	Year 1 Target	2016 Target
Deliver the Caring for Smiles Oral Health Programme, to Care Homes within GG&C	Number of Care Homes receiving training	24	120	169

6.4 Improving quality, efficiency and effectiveness

Action to deliver corporate outcomes	Relevant KPIs baseline	Baseline	Year 1 Target	2016 Target
Improve Access and Engagement with GDS to support effective use of referral pathways into secondary care.	Maintain 18 week RTT	18wks	18wk s	18wks

Increase use of electronic referral by GDS	Proportion of electronic referrals received	40%	70%	100%
All GDS/CSDS services inspected with new PI document will be Glennie compliant and meet the requirements of the new practice inspection programme	% of practices that are Glennie compliant	96%	100%	100%
Complete Oral Health Clinical Services Review to involve all stakeholders through wider clinical engagement and involvement of the PFPI. This will lead to the development of an Oral Health Strategy	Completion of Oral health Strategy	N/A	Oral health strategy completed	
Trakcare implementation to improve access for staff to clinical information and the electronic transfer of activity data through R4 to PSD for CSDS	GDHS implementation to commence in May2013	N/A	All staff groups trained	Full implementation
Improve waiting times for all referred new outpatients in accordance with the local waiting time stage of treatment guarantee	All new outpatients referred seen within local waiting time stage of treatment guarantee of 10 weeks	Guarantee	10 weeks	10 weeks

6.5 Tackling inequalities

Action to deliver corporate outcomes	Relevant KPIs baseline	Baseline	Year 1 Target	2016 Target
Continue to increase the delivery of Childsmile Programmes by working with CHPs to meet the NDIP target for 5 year olds and particularly focusing activity in CHP areas where 60% target is not achieved.	% of 5 year old children with no obvious dental decay	63.2%	65%	65%
Continue to increase the delivery of Childsmile Programmes by working with CHPs to meet the NDIP target for 11 year olds and particularly focusing activity in CHP areas where 60% target is not achieved.	% of 11 year old children will have no obvious dental decay National Dental Inspection Programme	62.6%	65%	65%
Deliver priority group strategy, specifically: – Make appropriate oral hygiene aids readily available via the CSDS, Homeless Team,	Availability of oral hygiene aids to the homeless population	0	50%	100%

drop in centres and LA charity/volunteer organisations – Provide Smile4life training for staff working with people who are homeless.	%of appropriate homeless team staff trained in Smile4life homeless.	0	50%	80%
– Provide oral health awareness training for staff working with looked after and accommodated children in residential units	% of appropriate LAAC staff trained.	0	40%	70%

Financial issues/actions to deliver corporate outcomes
Development of an integrated service and financial plan for Salaried Dental Services by April 2013-02-14 See attached paper. The other financial risk for OHD is the impact of the implementation of the new PDS terms and conditions and pay package still under negotiation, to be introduced from April 2013, which will increase the pay bill for the salaried service, but should provide opportunities to facilitate ongoing service redesign.

SECTION 7 FINANCIAL PLANNING

The context for financial planning is the updated estimate of the level of financial challenge faced by the Board in 2013/14.

	Sep 2012 £m
Carry Forward from 2012/13	
Forecast recurring over-commitment	(0.0)
2013/14 Funding Uplift	
Minimum uplift	57.8
Cost Drivers	
Pay Cost Growth	(31.1)
Prescribing Cost Growth	(28.4)
Energy Cost Growth	(3.0)
Capital Charges Growth	(4.0)
Other Cost Inflation	(13.1)
	(79.6)
New Service Commitments	
Acute – existing commitments	(6.0)
NHS Partnerships – existing commitments	(2.5)
Other – existing commitments	(2.9)
Increase in general provision	(0.0)
	(11.4)
Financial Challenge	**(33.2)**

It is forecast that the CHP will achieve its financial target of operating within its allocated revenue budget of £79.3m for the financial year 2012/13.

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

Table 1 – Draft CHP Budget 2013-14

2013/14 Draft Budget	
	£m
2012/13 Current Expenditure Budget	79.3
Less: Non Recurring	?
2013/14 Base Budget	79.3
Less total Indicative Savings Targets (see note 3)	TBC

Draft 2012/13 Opening Budget	79.3

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 2.8%. 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 within partnerships. Work is underway to confirm East Dunbartonshire CHP share of the £2.4m indicative savings. The 1.7% has been applied to the recurring allocation excluding Family Health Services and Prescribing as these will be included within their overall service area.

Table 2 – Draft CHP Budget by Service Area

	Annual Budget £'000
Accommodation And Admin	708.8
Executive	368.0
Prescribing	15,781.9
Fhs	24,662.5
Addictions	841.6
Mh Adult Community Services	1,198.6
Learning Disabilities	286.3
PC & Comm Services	5,960.1
Planning & Hlth Imprv	848.7
Oral Health	18,650.7
Development Funding	231.2
Change Fund	1,273.9
Res Transfr To Local Authority	8,614.1
Total Expenditure	79,326.4

For the 2012/13 financial year the CHP faced a £0.4m savings challenge which was be delivered through a variety of approved efficiency schemes targeted at areas where service delivery would not be affected.

Although a balanced budget is forecast for 2012/13 it is important to recognise that a number of financial pressures do exist within the system which will be addressed throughout 2012/13 and these include:-

- **Prescribing Expenditure** - During 2012/13 the Board and CHP has benefited from some additional underspends due to Atorvastatin and other off patent price reductions which are greater than was anticipated in the financial plan. As a result, for the year to date overall prescribing expenditure continues to be reported as running in line with budget within Primary Care Services and current information suggests that GP Prescribing will be contained within budget for 2012/13.

- **Achievement of Savings Targets** – At this stage of the year savings targets are reported as being achieved but there is pressure within the CHP's mental health budget as a result of a budget reduction in respect of the CHP's contribution to an area wide savings target. Full achievement of the CHP and OHD savings target remains an important factor in enabling the CHP is to achieve a breakeven year end position. In achieving the local targets for 2012/13 the CHP has used its remaining flexibility from unspent funding provisions which will men that any future local savings targets would require to be funded from reductions in services although it should be noted that at this stage it has not been confirmed whether a local savings target will be applied in 2013/14.

- **Pay modernisation for salaried dentists** – Scottish Government is currently reviewing the salary structure for salaried dentists. Any proposed changes are intended to be self financing through increased use of dental therapists and other skill mix changes however until this is confirmed there is a risk that salary costs may increase beyond budgeted levels. Provision for this increase has been made in the Board's draft Financial Plan for 2013/14.

- **The potential impact of restricting future access to non cash limited funding for primary care dental services** – Under NHS funding arrangements some elements of primary care expenditure is "non cash limited" which essentially means the Board recovers the full costs of eligible expenditure directly from the Scottish Government Health Department. In recent years the levels of expenditure have increased significantly across Scotland and it appears likely that there may be some tightening of the regulations which could in turn generate a cost pressure against the unified (i.e. mainstream) budget if access to non cash limited funding is restricted. From 2013/14 the costs for Community & Salaried Dentists will become "cash limited" and the Board will be expected to manage costs within a specific funding allocation for this service.

Outlook for 2013/14

In preparing a Financial Plan for 2013/14 there are a number of factors which will need to be taken in to account and will include the following:

Efficiency Challenge – it is considered likely that there will be a requirement to release somewhere in the region of 2% of resources to be redirected to achieving significant service redesign. The CHP will continue to work both locally and system wide to ensure that service redesign is delivered to best effect for all NHSGG&C patients.

Linking Finance to workforce – the requirement to ensure that financial and workforce plans are properly linked to ensure that the impact on service quality and delivery is fully considered for both short and long term planning.

Focus on local/national priorities – this is integral to the development of plans to ensure that planned changes are directed as required. This includes for example provision of mental health services which are recognised as a priority area for action.

Equality Issues - ensuring that equality issues are considered as part of all proposed changes is included as part of the planning process in order to ensure that resource shifts impact unfairly on any particular group of our patients.

Older Peoples Change Fund – in 2012/13 the CHP received a £1.392m 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 CHP will be at the same level for 2013/14. A substantial joint planning structure with partners from East Dunbartonshire Council, the Independent and the Voluntary sector has been introduced to develop and deliver changes as detailed elsewhere within this plan.

GP Prescribing – it is recognised that pressures on the provision of medicines is going to continue throughout the coming years. The CHP will continue to ensure that there is a major focus on ensuring that resources are used to best effect whilst ensuring that there is no diminution on the quality of care provided.

Capital and Accommodation

In order to ensure maximum use of resources the CHP (and Oral Health Directorate) continues to review all accommodation, including both leased and owned properties, with a view to maximising use of available space and achieving a reduction in the use of leased properties. Work on achieving this reduction will continue throughout 2013/14 and for a number of years following.

The CHP is signed up to the principle of agile working with a view of changing the way in which office accommodation is utilised and as a consequence of this rationalised.

Outlook for 2013/14

As part of the accommodation review the CHP has reduced the number of properties occupied in recent years and will continue review its use of accommodation during 2013/14 and the following years.

Modernisation of Glasgow Dental Hospital

There is an ongoing programme of modernisation and refurbishment being undertaken within the Glasgow Dental Hospital. The building requires significant investment in order for it to continue to be fit for purpose. Proposals will require detailed analysis for precise costs and timelines however it should be possible to address the majority of the C and B category areas over a period of 2/3 years with completion of the remaining areas over 4/5 years. The programme should be clinically focussed to minimise patient impact and continue meeting waiting times guarantees. i.e. create new clinical space in advance of relocating/closing old clinical space.

Several of these projects will incorporate necessary infrastructure improvements (e.g. plumbing) however there will still be a requirement for ongoing investment in infrastructure.

	Addresses Category	Timescale (months)	Description	Cost Estimate (£1,000s)	Year (Approx)
1	B	3	Vacate offices on level 5 to level 8 and create new photography suite	100	2013/14
2	C		Relocate photography from level 4 to level 5		
3		3	Create Oral Surgery facilities in old photography space	500	
4	C		Relocate Minor Oral Surgery & Sedation (same level)		
5		3	Create Oral Surgery Treatment Area in vacated space (same level)	500	
6	C		Relocate OS treatment area (same level)		
7	C	6	Create Oral Surgery / Oral Medicine consult clinic and new reception/waiting in vacated space (same level)	1,500	2014/15
8	C		Relocate Oral Surgery / Oral Medicine Clinic from level 3 to level 4. (consolidation achieved)		
9		3	Refurbish old OM/OS clinic to offices.	100	
10	B		Relocate offices from Level 4 to old OM/OS Clinic		
11		3	Refurbish level 4 office space as Radiography	1,500	
12	B		Relocate Radiography to Level 4.		2015/16
13		3	Refurbish old radiography to offices	100	
14	B		Relocate Offices from L6 & L7		
15		6	Convert offices (including clinical tech lab) on L6 & L7 to clinical spaces	750	
16	C	6	Refurbish reception/waiting and restorative staff clinic	2,500	
17	C	6	Refurbish reception/waiting and hygiene/therapy teaching clinic	2,500	
18			Relocate some clinical activity from Main Restorative Clinic to surplus chairs		2016/17
19	B		Relocate Conservation lab to part main restorative clinic	500	
20		3	Convert old conservation lab to clinic.		
21			Relocate last of main clinic activity.		
22	C	6	Refurbish main clinic to accommodate Cons & Prosthodontic production lab.	500	
	TOTAL	**51**		11,050	

Community & Salaried Dental Services

In general terms, the majority of CSDS facilities/surgeries require basic redecoration and appropriate handwash facilities to satisfy HAI / Infection control requirements. The following programme has been developed to give sequence to site-investment, mostly prioritised in relation to date of previous modernisation / refurbishments.

Community & Salaried Dental Departments	Refurbishment Priority	Comments	Estimated Costs (£1,000s)	Year
Govan Health Centre	H	2 surgeries. Full refurbishment required. Space limited	60	2013/14
Drumchapel Health Centre	H	2 surgeries. Chairs have been replaced. Cabinetry and decoration required. Additional Storage desired.	40	
Dumbarton Health Centre	M	Part refurbished - 2012/13.	30	
Possilpark Health Centre	M	Relocating to new centre (early 2014)		
Cambuslang Clinic	M	Refurbish single surgery	30	2014/15
Easterhouse Health Centre	M	Refurbish 2 x surgeries	60	
Townhead Health Centre	M	Part refurbished / 1 chair replaced 2012	20	
Gorbals Health Centre	M	Relocating to new centre (April 2015)		
Govanhill Health Centre	M	Relocating to new centre (April 2015)		
Bridgeton Health Centre	M	4 surgeries. Chairs have been replaced. Cabinetry and decoration required.	80	2015/16
Parkhead Health Centre	M	One of 2 surgeries already refurbished 2007	20	
Port Glasgow Health Centre	M	2 x surgeries	60	
Pollok Health Centre	M	3 x surgeries	90	
Castlemilk Health Centre	L	3 x surgeries		2016/17
Emergency Dental Centre	L	8 x surgeries		
Community Centre for Health	L	2 x surgeries		
Golden Jubilee National Hospital	L	2 x surgeries		
Springburn Health Centre	L	4 x surgeries		
Kirkintilloch Health & Care Centre	L	1 x surgery		2018 and beyond
Stobhill ACH	L	3 x surgeries		
Victoria ACH	L	2 x surgeries		
Greenock Health Centre	L	8 x surgeries		

SECTION 8 EFFECTIVE ORGANISATION

8.1 FTFT:

We have developed a 'Measures of Success template' which guides FTFT under each team for the year. This approach is monitored by the Development Group, and the group produces a quarterly FTFT bulletin which celebrates staff successes and briefs staff on FTFT activity.

Our culture
- Commitment for each team to have a team development plan by March 2013 which is updated annually for each year of the plan.
- Continuing programme of senior management visibility and consultation programme annually

Our leaders
- Commitment to annual focus group to evaluate leadership development activity and challenge.
- Access to Board wide programmes and programme of reflective practice.

Our patients
- Annual sharing of clinical best practice with 'Clinical Effectiveness Showcase'
- Programme of PLT events

Our people
- Commitment to local staff awards scheme
- Commitment to follow through for gold HWL, findings from the stress and FTFT survey with staff focus groups and agreed activity
- Learning and Development activities as part of extended SMT meetings

Our resources
- Continuing programme of 'Bright Ideas' awards scheme
- Systematic learning of 'waste reduction' across CHP
- Systematic sharing of 'lessons learnt' logs from service improvement activity

Action to deliver corporate outcomes	Performance Measure	Baseline 2011-12	Year 1 Target 2013-14	2016 Target
HIT systems will be established to enable staff to fulfil their roles. We are introducing iPads to make care delivery more accessible	Number of staff using the iPad device	0	17	All DN staff
Provide a Modern Apprenticeship placements	Number of Modern Apprentice schemes offered	0	1	TBC
All staff will have annual KSF/PDP Review.	Percentage of KSF and PDP Reviews	63.75%	80%	80%
Embed a systematic approach to measuring patient experience	Percentage of patients reporting positive experience		80%	90%
Managers analyse and take action in relation sickness/absence performance in line with NHS GG &C Policies	Percentage of Sickness Absence	4.6%	4%	4%
All new staff will be provided with an induction.	Percentage of Induction completed.	N/A	100%	100%
Ensure that complaints are acknowledged, appropriately investigated and responded to within the agreed timescales	Number of complaints responded to within 20 days	91.6%	92%	95%
Maintain systematic process of reminding staff and checking that NMC registration is renewed timeously	NMC registration compliance	N/A	100%	100%
Equality e modules	20% increase in staff doing equality e-modules	102	110	123
All information will be made available in an accessible format in accordance with the Accessible Information Policy	All requests for accessible formats met	N/A	100%	100%
Compliance with the Scottish Health council PPF participation standards	Maximise % compliance	80%	90%	100%

Introduction

In October 2012 NHS Boards were advised of changes to the financial governance arrangements that will apply to the salaried General Dental Service (GDS) with effect from 1 April 2013. The funding for salaried GDS expenditure which has historically been made available on a non cash limited basis where funding is drawn down monthly from Scottish Government to meet eligible expenditure will become cash limited. Between 2005/06 and 2011/12 expenditure on salaried GDS has increased by £40m and as a result Ministers have now advised Scottish Government that this budget should become cash limited.

Proposal

With effect from 2013/14 NHS Boards will receive an earmarked annual allocation for salaried GDS services at the start of the financial year and will be required to provide the services and manage any associated financial risks within the allocated funding. This in effect transfers financial risks to NHS Boards as they will be required to manage any overspend within their overall financial allocation however at this stage it is unclear whether underspends would be retained should Boards redesign services and reduce costs. In addition, guidance will be issued to ensure consistency of treatment of eligible costs as it appears to be the case that there are currently different interpretations of what is eligible to be charged against the budget. Boards will also be required to provide an annual service plan and financial plan for salaried GDS services for discussion with Scottish Government which is an extension of the arrangements that currently apply to expenditure against the funding provided within the "Dental Bundle".

Current Expenditure within NHSGGC

Within NHSGGC the annual expenditure is proportionally less that the Board's NRAC percentage as access to mainstream GDS services is generally freely available in most parts of the Board's area compared to the position in more rural Board's where there is greater dependency on the salaried GDS service provided by the NHS.

The current costs charged to the salaried GDS funding are £5.1m as shown in the table below.

	Annual Budget £m	**WTE**
Dentist salaries	2.5	37.5
Chairside Assistant and Receptionist salaries	2.0	95.7
Total Pay Costs	**4.5**	**133.2**
Non Pay Costs	0.6	

Total Expenditure	**5.1**	

These costs represent the revenue running costs of providing the salaried GDS service across a range of community clinics and health centres as well as larger sites including Glasgow Dental Hospital and the Royal Alexandra Hospital.

Potential Risks to NHSGGC

A national working group has been set up by Scottish Government to work up how these proposals will operate in practice. To date there has been a recent letter indicating that Boards will require to submit an annual integrated service and financial plan on Salaried Dental Services which will form the basis of earmarked funding allocations for salaried GDS in 2013/2014. Informal discussions with Scottish Government Finance colleagues have indicated that there is no intention to place any Board's at financial risk at the inception of these arrangements. Through time funding may be reallocated to Board's where provision is considered to be inadequate which would involve reduction to the funding of Boards where there is overprovision of services but this would most likely be achieved in a phased manner.

Some initial risks are assessed in the table below:

Risk	**Comment/Action Required**
1. Ineligible expenditure currently being incurred.	Initial discussions with SGHD indicate that funding will initially be set at existing levels. Costs will be reviewed against criteria for eligibility when these are available.
2. Inability to expand current service to deal with any future increase in demand.	Risk would be managed in the following order: 1. Expansion to be contained within funding uplifts. 2. Use of surplus funding within the existing Dental Bundle 3. Efficiency savings from other Oral Health Budgets 4. Developmental funding in Board Financial Plan
3. Reduction in funding results in creation of a cost pressure.	Managed as in risk 2 above.

Conclusion

A process is underway to develop the integrated service and financial plan for Salaried Dental Services for NHS GG&C in time for submission to SGHD by April 2013. Detailed guidance for the development of the plan has been promised by the SGHD SLWG by the end of February.

The most significant risk to the development of the integrated service and financial plan is the historic lack of accurate clinical activity data in our CDS service. Plans are in train to record all salaried and community dental clinical activity through the R4 system and to submit data electronically to PSD for all CDS clinics from April 2013. There are however some challenges to address with our current version of R4.

At this stage the precise details of the proposals and their impact on NHSGGC are unclear. Our initial assessment is that the Board is unlikely to be exposed to a significant financial risk when these changes become effective on 1 April 2013. The position will be reviewed and updated and appropriate actions to manage risks will be identified and implemented as the position becomes clearer.

James Hobson – Head of Finance **Karen Murray – Director**

Oral Health Directorate
January 2013