East Renfrewshire Community Health & Care Partnership

CHCP Development Plan

2013 - 16

VERSION 6 – UPDATED 24.05.2013

1. EARLY INTERVENTION AND PREVENTING ILL-HEALTH

Key outcomes we need to deliver in this area during 2013-16 are:-

- 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 prolonging active life and reducing avoidable illness, particularly associated with chronic disability and dependency, and/or premature mortality

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
	High Level Actions				
1.1	Deliver local public health programmes in partnership with others - smoking, alcohol, physical activity, healthy eating with a focus on deprivation and vulnerable groups	People supported to successfully stop smoking at four weeks Number of smoker living in most deprived communities successfully supported to stop smoking	535 96	415 79	415 79
1.2	Ensure local employability outcomes for Eastwood Health and Care Centre construction	Number of work placements for vulnerable groups	To be agreed and implemented when construction scheduled 2014	TBC	TBC
1.3	Explore potential for social enterprise Training café within Eastwood Heath and Care Centre	To be developed and agreed for implementation 2015	TBC	TBC	TBC

1.4	Implementation of the 'family firm pilot' which will give 'looked after young people' access to training, employment, mentoring and job taster opportunities tailored to their individual needs.	Number of children with access to family firm opportunities (no. work placements for vulnerable groups)	0	7 (2012/13)	TBC
1.5	Improve access to financial inclusion and employability	Increase number of staff making referrals to financial inclusion and employability advice			
		Additional income (£) generated as a result of financial inclusion advice received			
1.6	Work with primary care professionals to identify carers, signpost and refer for support.				
	Adult Mental Health				
1.6	Implement redesign of Primary care mental health services and ensure equity of access	% of people waiting over 18 weeks for Referral To Treatment for Psychological Therapies from December 2014	3%	4%	0%
		% of patients who started treatments within 18 weeks of referral	80%	90%	90%
1.7	Through redesign improve PCMHT access and reduce variation in access and waiting times	Reduce PCMHT waiting times, (SIMD, age and sex).	25 days	28 days	28 days
1.8	Provide suicide prevention training for frontline staff and develop local suicide prevention action plan	Maintain 50% of designated staff groups trained in suicide prevention. (Measure is based on local staff turnover rates).	55%	50%	50%

		Reduce suicide rate between 2002 and 2013 by 20%.	9.1	7.7	7.7
	Cancer				
1.9	Promote 'early detection of cancer' screening programmes for bowel, breast and cervical cancer and prevention through public health campaigns	Increase uptake of cancer screening programmes - Bowel - SIMD 1	58.1% 41%	60% 43%	60% 45%
		Increase uptake of cancer screening programmes - Breast	77.2 (2009/10)	70%	70%
		Increase uptake of cancer screening programmes - Cervical - SIMD1	82.1% 73.5%	80% 74.5%	80% 75.5%
	Children and Maternity				
1.10	The Getting it right for every child implementation plan will further embed cultural, systems, and practice change into children and young people's services with the introduction of the named person and lead professional roles and the one child, one plan approach	Number of children with: • named, lead professional • single plan	Baseline Y1 Baseline Y1	TBC TBC	TBC TBC
1.11	We will work through an Early Years Collaborative model to share good	Infant mortality rate	TBC	TBC	15% reduction by 2015

	practice and take concerted action to shift towards early intervention, tackle inequalities and deliver positive outcomes for children	Stillbirth rate	TBC	TBC	15% reduction by 2015
		Percentage of children developmental milestones reached by 30 months	TBC	TBC	85% by 2016
		Percentage of children with developmental milestones reached by P1	TBC	TBC	90% by 2017
		At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by 12th week of gestation by March 2015	68.1%	71.4%	80.0%
		MMR up-take at 24 months	95%	95%	95%
		MMR up-take at 5 years	95.7%	97%	97%
1.12	The Healthier Wealthier Children project will deliver an income maximisation service to low income families	Referrals to financial inclusion and employability services (Maintain level of Healthier Wealthier Children referrals).	105	105	105
		Additional income generated (£s) as a result of financial inclusion advice	125,000	125,000	125,000
1.13	The Triple P Steering Group will coordinate current and future roll out and ensure programme evaluation is incorporated into the process	% of parents who report universal Triple P programme has met their child's needs	85%	90%	90%
1.14	Reduce smoking and alcohol use in pregnancy and reduce equalities gap	% of women smoking at booking	7.8%	8%	8%

	through the delivery of targeted smoking cessation services for pregnant women in SIMD 1 areas	% of women smoking at booking in SIMD % of women consuming alcohol during pregnancy	26.1% Baseline Y1	23.9% TBC	22.9% TBC
1.15	Deliver Maternal and Infant Feeding Strategy by establishing new local delivery group and action plan. and maintain UNICEF level 3 accreditation	Improve breastfeeding rates at: • Birth • Discharge • Health Visitors first visit • 6-8 weeks	65.2% 54.1% 44.5% 35.8%	67.2% 56.1% 46.5% 36.8%	67.2% 56.1% 46.5% 36.8%
1.16	Support the delivery of the ACES (Active Children Eating Smart) and Right Moves curriculum programme for children in East Renfrewshire.	To achieve agreed number of completed child healthy weight interventions over the three years ending March 2014	95	175	262
1.17	Implement Keeping Children Safe Planning Group action plan within the new Integrated Children's Services Plan 2013/16 including: • health visitor home safety checks for vulnerable families. • Promote child safety campaigns including blind cord safety	Childhood injury rates: • Crude admission rates • SIMD 1:5 ratio	6.3 (2010-11) 2.4 (2010-11)	6.1 1.8	5.9 1.7
1.18	Develop and deliver multi agency mental health improvement plan for children and young people by March 2014 including: • Communication and engagement (to increase awareness of self help				

	resources, services and anti stigma campaigns etc) • Resilience and early intervention supports in schools and communities • Distress, self-harm and suicide prevention				
1.19	Child and Adolescent Mental Health Services (CAMHS) and Speech and Language services will be integrated within the CHCP to provide a more easily accessible, localised service	Referral to treatment for CAMHS within 18 weeks.	N/A	100%	100%
1.20	Local implementation of CEL 15 - Refresh of Health for all Children (Hall 4) will take place and the new 27/30 month assessment will be introduced.	% of eligible children with reviews undertaken at 30 months.	From April 2013	75%	80%
1.21	Children/young people looked after at home will have their health assessment plan reviewed to ensure outcomes are being achieved	No of reviews undertaken	TBC	TBC	TBC
1.22	Improve the identification of young carers by developing systems to record young carers across all settings.	Number of young carers identified	25	30	30
1.23	Health Improvement team will support substitute care staff to coordinate delivery of health sessions to carers	No of substitute carers attending health sessions	Baseline Y1	TBC	TBC

1.24	Deliver Child Smile Programme to increase dental registration at age 2 and provide tooth brushing in nurseries.	At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.			
		• 3 year olds	0.44%	35%	60%
		• 4 year olds	0.48%	35%	60%
		Percentage of nurseries with toothbrushing programme	100%	100%	100%
		Percentage of nurseries with children offered toothbrushing	100%	100%	100%
		Improve dental registration rates in 0-2 year olds.	48.1%	60%	60%
		Improve dental registration rates 3-5 year olds.	84.9%	84.9%	84.9%
		Reduce dental decay rates (% children screened with no sign of decayed, filled or missing teeth):			
		P1	80%	60%	60%
		P7	70% (2010/11)	60%	60%
	Disability				
1.25	Through ASP Committee and local governance arrangements ensure adult support and protection is delivering on agreed work plan and	Percentage of reviews with service user reporting reduced risk (from April 2012)	78.6%	75%	75%

	operating effectively.				
1.26	Implement local actions from the Health Needs Assessment for learning disability described through the Board Wide LD Change Programme and Strategy				
	Drugs and Alcohol				
1.27	Implement the NHSGGC prevention and education framework, providing a range of health improvement programmes including early intervention and harm reduction.	Reduction in excessive drinking and illegal drug use.			
1.28	Implement ADP delivery plan including • joint work with public health to complete an overprovision assessment in relation licensing • review of the alcohol and drugs workplace policy in line with healthy working lives.	Alcohol-related deaths per 100,000 population	12.1	TBC	TBC
1.29	Implement Naloxone programme, review drug related death action plan and continue to participate / promote the overdose prevention campaign.	Drug-related deaths per 100,000 population	3.4	4.6	4.6
1.30	Deliver ABI screening interventions in primary care and extend to criminal justice setting in line with HEAT standard and SIGN Guideline 74.	Number of alcohol brief interventions in the 3 established settings.	469	490	490
	Long Term Conditions				
1.32	Through implementation of LTC LES	Number of anticipatory care	Baseline Y1	TBC	TBC

	focus resources in primary care on the most effective interventions for highest risk patients.	plans in place			
1.33	Implement supported self care framework linking to talking points personal outcomes				
	Older People				
1.34	Develop a range of opportunities for older people to remain active and engaged in their communities.	Number of over 50s volunteers	74	40 new volunteers	50 new volunteers
1.35	Increase delivery of early intervention for vulnerable older people through 'Wise Connections' Older Adults Mental Health service and the 'Early Intervention' Pharmacy service	Increase range of sources of referral to 'Wise Connections' • GP • Older Adults Mental Health • Other	 80 20 0	 55 20 25	 45 20 35
1.36	Implement redesigned local falls prevention programmes in light of national recommendations, including education of staff, clients and carers and development of the falls responder service through RCOP.	Increase percentage of indicators achieved on self-assessment of position against 'Up and About or Falling Short' (2012) falls prevention survey baseline.			
	Primary Care				
1.37	Implement standard reporting mechanism for GPs offering information about vulnerable children and families as part of Child Protection process.				

1.38	Phased implementation of Anticipatory Care Programme (including Keepwell).	Increase the number of practices opting to deliver Keepwell. Increased number of patients in anticipatory care programmes.	0	3	3
1.39	Work with primary care professionals to identify carers, signpost and refer to support	Practices taking-up carers' information signposting information and referrals to carers support Proportion of identified carers offered a carers assessment	TBC 96	TBC 98	TBC 100
	Sexual Health				
1.40	Review and develop local multi agency sexual health plan to reduce unintended pregnancy, including action to reduce teenage pregnancy, provision of LARC via primary care and condom distribution	% of women aged 15-49 using Long Acting Reversible Contraception (LARC) (Primary Care +NASH)	38.7	TBC	TBC
1.41	Work with education to deliver renewed SHRE in all schools	Teenage pregnancy rates (aged 16 or under)	2.7 (2008-10)	3.4	3.4
1.42	Increase HIV testing in Primary Care	HIV testing level	N/A	TBC	TBC

Financial outcomes from Corporate Plan

- A shift in spending to prevention and early intervention, including from hospital care.
- Being able to evidence that shift and its financial effectiveness.
- Focusing on interventions which are effective and reduce demand.
- Care is provided in the most appropriate place by the most appropriate professionals.

Financial detail

- Children and Adolescent Mental Health Service resources of £X will be part of aligned CHCP budget in 2013/14.
- The Early Years Change Fund for Scotland 2013/14 is comprised of existing and new resources consisting of £14.5M Scottish Government, £39M NHS, and £35M local government. East Renfrewshire's share of the Early Years Change Fund for 2013/14 is £558,000 rising to £785,000 in 2014/15.

2.SHIFTING THE BALANCE OF CARE

Key outcomes we need to deliver in this area during 2013-16 are:-

- 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.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
	Acute Services				
2.1	Provide proactive support of patients for end of life care in particular at discharge from hospital and in care home settings.	Reduced total deaths which occur in hospital (% of last six months of life spent at home or in community setting)	89.6% (2010/11)	90.3	92%
		Reduced deaths of care home residents in hospital (% of care home residents with care home as place of death)	71.9%	77%	80%
2.2	Develop local out of hours response to provide options for first line services including GPs and A & E to avoid admission to hospital.	Number of out of hours contacts Reduce ALOS on emergency admission	Baseline Y1 3.2 days	TBC 3.1 days	TBC 3.0 days

	Adult Mental Health				
2.3	Monitor and maintain delayed discharge level for adult mental health	Reduce delayed discharge for adults mental health	N/A	TBC	TBC
2.4	Improve crisis response as part of redesigned CMHT	% of people managed by a crisis team	82.5%	85%	85%
2.5	Review community MH teams to understand current activity and proposed service activity and targets including use of activity tracker in Eastwood Community Mental Health Team to inform most efficient use of specialist resources.	Reduce bed days lost to delayed discharges.	N/A	0	0
	Disability				
2.6	Monitor and maintain delayed discharge level for physical disability bed days	Physical disability bed days lost to delayed discharge.	0	0	0
2.7	Reduce In Patient Learning Disability bed days lost to delayed discharges through development of a jointly agreed discharge process which incorporates actions for delays	a) Reduction in the number of LD patients whose discharge has been delayed:	0	0	0
		b) Reduction in the number of LD bed days lost to delayed discharges	0	0	0
2.8	Produce specific and tailored information in relation to parent carers.	Tailored info produced		In place	From stock control
2.9	Recruit peer volunteers to develop	Number of peer volunteers	Baseline Y1	TBC	TBC

	practical support for carers, e.g., hospital discharge.	recruited			
	Long Term Conditions				
2.10	Through ANPs ensure earlier identification of individuals who might benefit from interventions to sustain independence and avoid or delay deterioration or exacerbation of illness	ANP Caseload	Baseline Y1	TBC	TBC
2.11	Increase effectiveness of supported self care through local implementation of evidence based practice.	Number of people with supported self care plans in place	Baseline Y1	TBC	TBC
	Primary Care				
2.12	Deliver a programme of demand reduction for acute care through anticipatory care planning, RES cluster rollout and referral pathways.	Reduce LTC bed day rates per 100,000 population • All LTCs • COPD • Asthma • Diabetes • CHD	 6373.6 1949.8 358.1 401.3 1949.8	 6362 1794 349 368 1795	 6349 1639 340 335 1640
2.13	Progress approach to improve team working between community services and GP practices through development of RES clusters, including review of practice				

	populations, by July 2013				
2.14	*Work with practices to identify and address local and system issues from the Quality and Productivity processes*	QOF report			
2.15	Review practice profiles and implement actions to address variation and issues.	• Admission rates for potentially preventable admissions • Did Not Attend rates	Baseline Y1 Baseline Y1	TBC TBC	TBC TBC
2.16	Make capacity within Eastwood Health and Care Centre for patient services which can be delivered in primary care.	No of bookable clinical rooms			
2.17	Encourage practices to opt into CMS rollout.	Increase the % of community pharmacies participating in medication service	Baseline Y1	TBC	TBC
2.18	Work with RAD to develop and promote rapid access to consultant geriatrician advice and appointments for GPs	Number of East Renfrewshire residents accessing consultant geriatrician.	Baseline Y1	TBC	TBC

Financial outcomes from Corporate Plan:

- A shift in spending from hospital to community services.
- This will require creation of levers and incentives for our existing and new Partnerships to change patterns of demand.
- We also need to reshape spending on community and primary care services, including controlling growth in prescribing, to free up resources to invest in local services.
- Prescribing budget of £13M was on balance as at time of publication.

3 RESHAPING CARE FOR OLDER PEOPLE

Key outcomes we need to deliver in this area during 2013-16 are:-

- 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.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
	Older People				
3.1	Provide support for people with dementia and their carers using the post diagnostic service model based on Alzheimer Scotland's 5 pillar model.	Maintain the proportion of people with a diagnosis of dementia on the QOF dementia register Number of people referred for post-diagnostic support % of people with post-diagnostic support for one year	524 (79%) 87 Baseline Y1	530 (80%) TBC TBC	535 (81%) TBC TBC
3.2	Ensure proportionate access to psychological therapies and crisis supports for older people	% of primary care mental health caseload aged 65+	Baseline Y1	TBC	TBC

3.3	Publish and implement Reshaping Care for Older People Partnership Joint Strategic Commissioning Plan. Including:	Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15	4820 (2009/10 baseline)	4776	4766
		Reduce the number of unplanned acute bed days (65 years+)	42,102	41,260	End target influenced by CSR
		Reduce the number of unplanned acute bed days per 1,000 population (65+)	2,700	2,646	End target influenced by CSR
		Reduce the number of unplanned acute bed days (75 years+)	33,435	32,766	End target influenced by CSR
		Reduce the number of unplanned acute bed days per 1,000 (75+)	4,494	4,404	End target influenced by CSR
		Reduce the number of emergency admissions (65+)	3,592	3,522	End target influenced by CSR
		Reduce the number of emergency admission per 1,000 population (65 years+)	229	224	End target influenced by CSR
		Reduce the number of emergency bed days (75 years+)	39,148	38,756	End target influenced by CSR
		Number of individual budgets	126	200	300
		Number of care home residents	566	538	538
3.4	Ensure older people are able to access to housing advice and support to plan for future needs.	% outcomes met ‘living where I want to live’	89.3% (2012/13)	89%	90%
3.5	Implement anticipatory care plans for those older persons at risk of hospital	Number of anticipatory plans in place	Baseline Y1	TBC	TBC

	admission.				
3.6	Wider use of community supports, housing advice and support services and telecare to support older people's needs at home.	Numbers using housing options advice Percentage of over 75s with telecare support	Baseline Y1 14%	TBC 18%	TBC 20%
3.7	Develop hospital discharge liaison work to support safe timely discharge including Senior Social Work Practitioner engagement with Mansionhouse Unit and Reablement Discharge Support Worker.	Reduce bed days consumed by delayed discharge to 50% of 2009/10 baseline followed by further reduction to 25% of baseline by 2016. Reduce bed days consumed by delayed discharge for AWI to 50% of 2009/10 baseline followed by further reduction to 25% of baseline by 2016. No people will wait more than 28 from April 2013; 14 day maximum wait from April 2015 for hospital discharge	4,093 60 3	2,415 609 0	1,207 (75% reduction indicator) 305 (75% reduction indicator) 0 0
3.8	Care Home Liaison Nurse to deliver training in care homes including Behavioural and Psychological Symptoms with Dementia, and Cognitive Stimulation Therapy in 2013.	Number of interventions % of interventions reducing psychiatric medicines % of interventions preventing unnecessary moves to hospital	20 per calendar month Baseline Y1 Baseline Y1		
3.9	Through Early Intervention Pharmacy service to proactively screen and identify people with multiple medicines (polypharmacy).	Number screened Number of interventions per person screened			

	Primary Care				
3.10	Build on established GP engagement in Reshaping Care agenda and wider engagement through Protected Learning Time opportunities in 2013.	Engagement events held			

Financial outcomes from Corporate Plan:

- Demonstrating the value for money of the change fund and other community service investments.
- Directing our resources to support primary care to do more for older people.
- Reducing spending on hospital care for older people.
- Reshaping Care for Older People total resource across sectors for 2013/14 is £71.6M comprising £48.5M of NHS, £20.9M of local authority resource alongside specific Change Fund allocation and additional demographic pressure monies of £2.1M.

4. IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS

Key outcomes we need to deliver in this area during 2013-16 are:-

- 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.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
	Acute Services				
4.1	Implement agreed referral pathways and participate in programme of effective joint working between primary and secondary care.	SCI Gateway referrals	94%	100%	100%
	Adult Mental Health				
4.2	Develop local Mental health strategy response to national mental health strategy by March 2014				
4.3	Build on local engagement in developing the Case for Change in mental health by contributing to the building and testing of new models of care and options for service delivery in Stage 2 and 3 of Clinical Services Review.				
	Children and Maternity				

4.4	Implement governance arrangements including clinical supervision and caseload management for the Care Aims Framework.				
4.5	Participate in redesign for school nursing integration into children and family teams.				
	Disability				
4.6	Improve experience of mainstream services				
4.7	Improve transition from children's to adult services Implementation of an LD Strategy that identifies clear transition pathways between children's and adult services Development of an information capturing methodology				
	Drugs and Alcohol	**PERFORMANCE MEASURE**	**BASELINE 2011-12**	**YEAR ONE TARGET 2013-14**	**2016 TARGET**
4.8	Scope and commission hidden population research in relation to understanding barriers to accessing services and identify unmet need. Identify action required to improve engagement.				
4.9	Progress implementation of service	90% of clients will wait no longer than 3 weeks from referral	86.8	91.5	91.5

	redesign providing recovery focussed care. Implement and monitor through alcohol and drug outcome data reporting.	received to an appropriate drug or alcohol treatments that supports their recovery			
4.10		Reduce alcohol emergency admissions rate	5.0	4.8	4.6
	Primary Care				
4.11	Complete and implement review of District Nursing services				
4.12	Use feedback about GP appointments to identify and address access issues with practice andencourage participation in Productive General Practice Initiative.	Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team	92.9%	95%	95%
		GP Advance Booking	92.1%	92.1%	92.1%
4.13	Use local and national prescribing indicator targets to report, benchmark and effect change in both 'practice to practice' variation within CHCP and to GGC wide comparators and Adopt facilitation and joint working models to address specific issues e.g. benzodiazepine reduction clinics	Achieve and where appropriate exceed the escitalopram target	3.35%	<3%	<3%
		Achieve and where appropriate exceed the Citalopram target	68.7%	> 65%	> 65%
4.14	Implement Guidance issued in CEL 03 (2013) via QOF and Polypharmacy	Reduce the cost per weighted patient.	£176	£167	TBC

	LES for 13/14				
4.15		Increase the % uptake of medicines management	Baseline Y1	TBC	TBC
4.16		Reduce waiting times to access termination services	Baseline Y1	TBC	TBC

Financial outcomes from Corporate Plan

- Use technology to further drive forward flexible and agile working to further reduce our office and support costs.
- Encourage and support our staff to generate and deliver ideas which make better use of resources.
- Develop our benchmarking activity to understand where there may be potential for change or improvement.
- Rationalise the number of sites which we occupy.
- Deliver a number of whole system redesigns which reduce costs and increase efficiency and effectiveness including for district nursing and mental health.
- Continue our focus to deliver effective and efficient services, based on best practice and value for money including reducing the numbers of hospital beds the use of hospital services.

5. TACKLING INEQUALITIES

Key outcomes we need to deliver in this area during 2013-16 are:-

- 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.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
	Equality Outcomes				
	Barriers to all ERCHCP services are removed for people with protected characteristics Continued implementation of Communication Support and Language Plan, Interpreting and Communication Support Policy and Accessible Information Policy.	Usage of accessible information resources. Usage of interpreting and support.	Baseline Y1 Baseline Y1	TBC TBC	TBC TBC
	Reduced discrimination is faced by Lesbian, Gay, Bisexual and Transgender people, sensory impaired people and people with learning disabilities in our services Assess current position, develop and implement actions to reduce discrimination faced by people with the above protected characteristics and establish areas of exemplary practice in services most likely to be accessed	Data recording completeness among staff	Baseline Y1	TBC	TBC

	by them.				
	Age discrimination is removed in all services. Assess current position, develop and implement actions to reduce discrimination faced by people with the above protected characteristics and establish areas of exemplary practice in services most likely to be accessed by them.	Up-take of psychological therapies among people aged 65 and over	4%	6%	8%
	The health needs of prisoners and homeless people with protected characteristics, Roma/Gypsy Traveller people and Refugees and Asylum Seekers are addressed. Contribute to review of protocols and policies with Housing to prevent homelessness and develop prevention and early intervention approach as per Local Housing Strategy (LHS). As set out in Local Housing Strategy, to work in partnership with neighbouring areas to assess current position, develop long-term solutions to the needs of Roma people across the region.	Sustained tenancies across protected characteristics. Repeat homeless presentation within 12 months by protected characteristics.	Reported through LHS performance framework		
	The health impact of both hate crime and incidence is reduced for all those with the added protection afforded by Hate Crime Legislation. Develop action plan to support staff and service users experiencing identity-based harassment. Work with East Renfrewshire Hate	Level of third party reporting.	Baseline Y1	TBC	TBC

	Crime Monitoring Group to develop multi-agency approach to hat crimes.				
	All CHCP staff have a greater awareness of the needs of groups with protected characteristics. Production and promotion of CHCP Learning and Development Plan linked to Equality and Diversity Learning and Education. Ongoing implementation of Communication Strategy.	Up-take of learning and education opportunities. Up-take of e-learning modules.	Baseline Y1 Baseline Y1	TBC TBC	TBC TBC
	East Renfrewshire CHCP has maximised the likelihood of people with protected characteristics attending appointments Assess current position and develop plans to address Did Not Attend inequality gradient by age, sex, ethnicity and deprivation. Identify barriers to attending appointments and plan to address these.	Reduce DNA differentials by protected characteristics.	See 5.9		
	Personal characteristics and circumstances which affect health are effectively addressed in health encounters through routine sensitive enquiry on social issues as part of Person Centred Care. Staff training in routine sensitive enquiry.	Number of staff trained.	Baseline Y1	TBC	TBC
	High Level Actions				
5.1	Sensitive enquiry is extended to new				

	settings and higher volume				
5.2	Consider implications of Health Needs Assessment for Prisoners for CHCP Criminal Justice Services				
5.3	Work with Housing to identify and respond to health issues of homeless people resulting from changes to welfare reform				
5.4	Work with people on DLA to understand migration to PIP				
5.5	Participate in ERC Welfare Reform Strategy Implementation				
5.6	Offer Modern Apprenticeships in NHS settings within CHCP	Number of Modern Apprenticeships in NHS services	N/A	1	TBC
5.7	Improve uptake of interpreting services within CHCP				
5.8	Access to advocacy services is improved in line with NHSGGC Advocacy Plan				
	Acute Services				
5.9	Work with Acute services to reduce DNAs	General DNA % Reduce DNA by SIMD, Age, Sex and BME gradient Narrow ratio of DNA for: SIMD1:5 Male: All	8.1% TBC TBC TBC	11.3% TBC TBC TBC	TBC TBC TBC TBC

		Female: All Age group: All	TBC	TBC	TBC
	Adult Mental Health				
5.10	Effective response to personality disorder led by mental health				
5.11	Undertake a baseline audit of current caseloads by deprivation, age and sex local mental health services.	Proportionate access to psychological therapies by SIMD, age and sex [Monitor through ratios as above]	N/A	N/A	N/A
	Cancer				
5.12	Identify and address differential access issues for cancer screening and services including welfare benefits.	Increase uptake of cancer screening programmes SIMD1 - Bowel	41%	43%	
		Increase uptake of cancer screening programmes SIMD1 - Breast			
		Increase uptake of cancer screening programmes SIMD1 - Cervical	73.5%	74.5%	
	Child and Maternity				
5.12	Improve delivery of maternity services to vulnerable women through the rollout of the Family Health Nurse partnership	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by 12th week of gestation by March 2015	68.1%	71%	80%
5.13	Improve breastfeeding rates and reduce the SIMD differential through development of peer and professional support models.	Breastfeeding rates in 15% most deprived areas	23.3%	26.3%	29.3%

5.14	Reduce smoking in pregnancy	Reduce smoking in pregnancy (SIMD	26.1%	23.9%	21.9%
	Drugs and Alcohol				
5.15	Deliver addiction equality action plan in line with the addiction EQIA. Complete further EQIA in relation to access to services.	Reduce SIMD gradient	N/A	N/A	N/A
5.16	Increase Hep B Vaccination and provide information and support for people with BBV and carers.	Increase uptake of Hepatitis B vaccination	Baseline Y1	N/A	N/A
		Reduce SIMD gradient for uptake of Hepatitis B vaccination	Baseline Y1	N/A	N/A
	Long Term Conditions				
5.17	Ensure that people identified through Keepwell and anticipatory care planning have access to local sources of financial advice	Reduce SIMD gradient	N/A	N/A	N/A
	Older People				
5.18	Undertake Equality Impact Assessment (EQIA) for Change Plan initiatives to support the delivery of the RCOP programme.				
	Primary Care				
5.19	Encourage GPs to participate in Early Years Collaborative work	Reduce SIMD gradient			
5.20	Promote shared GBV approach with				

	GPs through Protected Learning and other local communication channels.				
	Sexual Health				
5.21	Review inequalities sensitive approach with addictions services; increase number of addictions clients receiving Hep B vaccination and accessing sexual health services	Reduce SIMD gradient	N/A	N/A	N/A
5.22	Increase Hep B Vaccination and provide information and support for people with BBV and carers	Increased Hepatitis B vaccination	N/A	N/A	N/A

Financial outcomes from Corporate Plan:

- Demonstrate that we have shifted our use of resources to deliver on these inequalities outcomes.
- Considered the inequality impact in all of our financial decisions.

6. Effective Organisation

Key outcomes we need to deliver in this area during 2013-16 are:-

- All staff have the HIT systems they require to fulfil their roles including electronic referral and appointment systems
- All staff have the administrative systems and support they require to fulfil their roles
- All staff are supported to develop the skills and knowledge they require to fulfil their roles
- CHCP will have an appropriate system to ensure we act on feedback from patients;
- We reduce energy based carbon emissions, energy consumption, domestic waste to landfill and water consumption.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
6.1	Undertake Phase 2 of business support review – NHS admin staff				
6.2	Rollout agile working across CHCP	Number of staff enabled for agile working			
6.3	Implement sickness absence policies	Sickness absence rate	5.3%	4.0%	4.0%
6.4	Support staff development through e-KSF	e-KSF rate	47.03%	80%	80%
6.5	Implement new complaints policy and operational guidance	Number of complaints responded to within 20 days	87.5%	70%	70%
6.6	Share learning from complaints through regular reports to Care Governance Committee				
6.7	Ensure NMC Registration compliance	NMC Registration compliance	n/a	100%	100%
6.8	Support new CHCP with induction training.	% staff with mandatory induction training completed within the deadline	n/a	100%	100%
		% staff with standard induction training completed within the deadline	n/a	100%	100%

6.9	Reduce carbon footprint	Energy and water consumption (CO_2 tonnes)			

7. Organisational Development Priorities and Approach

The organisational development approach will consider 6 overarching areas and these are:

a) Engagement and involvement – implementing and developing the five programmes of Facing the Future Together, with a focus on team working, organisational values, improving the accessibility of Directors Brief and working with leaders to deliver change.
b) Supporting the vision and purpose of the CHCP's Transformation Programme and its associated work streams and where appropriate identifying ways to evaluate these.
c) Leadership development through national and local programmes evaluated and costed where possible.
d) Partnership and collaborative working to continue to develop and enhance integration
e) Culture review to identify local values and behaviours with a view to integrating these into the local authority's ways of working.
f) Service improvement work to support CHCP transformation programme priorities, including psychological therapies work, review of Primary Mental Health teams, RTTC, Development of Early Years, Paediatric Review

CHCP Programme for each of the five FTFT themes:

Our culture	
Expected outcome – There is a measurable change in culture reflected in the experience of staff, patients and managers	
	Activities to evidence work towards the outcome
7.1	Undertake self evaluation and team development activities with all teams within the CHCP in line with recommended approaches from GGC & East Renfrewshire Council.
7.2	Evaluate team development approach and activity
7.3	Benchmark quality of PRD, Performance Appraisal process in preparation for improvement work around the delivery of appraisals

Our leaders	
Expected outcome – Managers and leaders feel better equipped and supported, there are more consistent requirements for delivery and performance is pushed to a higher level	
	Activities to evidence work towards the outcome
7.4	Identify and communicate management and leadership development opportunities to support succession planning and leading change through service improvement.
7.5	Provide access to leadership development opportunities
7.6	Continue to update and involve all CHCP leaders in the development of the CHCP by holding 4 leadership events throughout the year

Our clients/patient's/service users	
Expected outcome – We make real changes to people's experience.	
	Activities to evidence work towards the outcome
7.7	Learn from patient centred approach through pilots
7.8	Build on co production approach with the public & community e.g. RCOP and learning from person /service user experience e.g. redesign of the rehabilitation and enablement service
7.9	Involve the public in strategy implementation through the setting up of involvement events from the transformation programme work streams e.g. self directed support
7.10	Engage PPF and staff groups in the development of the new Eastwood Health & Care Centre to enhance service delivery from a patient experience perspective

Our people:	
Expected outcome – Our workforce feels positive to be part of East Renfrewshire CHCP, staff feel listened to and valued and staff take responsibility to identify and address issues in their area of work.	
	Activities to evidence work towards the outcome
7.11	Implement staff governance action plan in conjunction with the staff partnership forum and communication group
7.12	Improve team briefing process by increasing number of staff who receive directors brief face to face
7.13	Evaluate road shows and consider actions for short and long term staff engagement including feedback from the FTFT staff survey
7.14	Develop Agile Working Group to engage with staff around flexible working

Our resources	
Expected outcome – There is a consistent focus on efficiency and effectiveness	
	Activities to evidence work towards the outcome
7.15	Continue to roll out the transformation programme which applies a quality improvement approach across the CHCP
7.16	Develop capacity in standardised improvement methods across the CHCP by providing SQA approved PDA in project management
7.17	Pilot and rollout agile working across CHCP
7.18	Develop design for Eastwood Health and Care Centre to ensure it has maximum flexibility of clinical and service delivery areas and supports agile working

8. Financial Planning

Finance and Workforce

Finance

Revenue Budget

It is projected that the CHCP will achieve its financial target of operating within its allocated revenue budget of £92.6m for the financial year 2012/13. An in year overspend on the Social Care budget is currently being managed to ensure spend is brought back in line with budget by the end of the financial year.

The revenue budget for the year 2013/14 has yet to be finalised. The following table presents an outline draft 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.

2013/14 Draft Budget			
	NHSGGC £m	**ERC £m**	**Total £m**
2012/13 Recurring Base Budget	49.4	43.0	92.4
Less: Health savings target (see note 1)	tbc	-	tbc
Less: Council savings agreed (see note 2)	-	(1.0)	(1.0)
Add: Council additional resource (see note 2)	-	1.4	1.4
Add: Change Funds (see note 3)	1.3	0.9	2.2
Draft 2013/14 Budget	**50.7**	**44.3**	**95.0**

Notes

1. 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 Renfrewshire CHCP's 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.

2. A savings package of £1.0m has been agreed by the Council for 2013-14, with much being delivered through service redesign and the CHCP's Transformation Programme. Additional recurring funding of £1.4m has been agreed to meet identified spending pressures, including demographics, care home / FPC obligations, anticipated pay uplift, and energy inflation.

3. East Renfrewshire's allocation from the Health & Social Care Change Fund is expected to be £1.3m, with an additional £0.3m coming from Local Authority contributions. The Local Authority contribution to the Early Years Change Fund of £0.6m is also included above.

For the 2012/13 financial year the CHCP faced a £1.3m savings challenge (£0.2m health and £1.1m social care) delivered through a variety of approved efficiency schemes and restructuring of services 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 require to be addressed throughout 2013/14 and these include:-

- Due to substantial product price increases the City Wide hosted Continence Service is reporting ongoing pressure (current overspend £20,000). This pressure is reducing due to lower product prices under the new contract arrangements.

- Due to cost and volume issues, the Community Equipment budget is reporting substantial pressure, currently projecting anoverspend of £120,000 within the Health budget.

- There continues to be a risk surrounding GP Prescribing and this will continue to be monitored throughout this financial year.

- Care Home nursing placements has experienced a sharp increase over the past financial year, putting significant pressure on the Social Care budget. While the Council has again allocated a significant increase in resource for older people demographic for 2013-14 (£650,000) this trend remains under close monitoring.

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

Health – 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 CHCP will continue to work both locally and system wide to ensure that service redesign is delivered to best effect for all NHSGGC patients.

Social Care – following a public consultation exercise the budget for 2013/14 has now been agreed and includes CHCP saving and efficiency plans of £1m. Much of this will be delivered through the CHCP's Transformation Programme and involves service redesign across a range of areas as preparation is made for the implementation of Self Directed Support.

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 the 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 do not impact unfairly on any particular area of our care groups.

Health & Social Care Change Fund – in 2012/13 the CHCP received a £1.3m 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 remain at the same level for 2013/14. A substantial joint planning structure with partners, the Independent and the Voluntary sector has been introduced to develop and deliver changes as detailed elsewhere within this plan. A strategic planning group, chaired by the CHCP Head of Health & Community Care, has been established to ensure that robust financial plans are developed as part of this process. Financial representation is also included in the membership of all the service planning groups.

Early Years Change Fund – in 2012/13 the CHCP was allocated £300,000 within the Social Care budget to allow local partners to deliver a shift towards preventative care. This figure will rise to £558,000 for 2013/14 and will be further supplemented by contributions from Scottish Government and Health.

GP Prescribing – it is recognised that pressures on the provision of medicines is going to continue throughout the coming years. The CHCP 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/Accommodation

In order to ensure maximum use of resources the CHCP has undertaken a complete review of all accommodation, including both leased and owned properties, with a view to maximising use of available space and achieving efficiencies across the estate.

The CHCP 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.

Barrhead Health & Care Centre - the new facility, opened during 2011/12, is a partnership venture between NHS Greater Glasgow and Clyde and East Renfrewshire Council. Uniquely the building is jointly owned by the two organisations.

Eastwood Health & Care Centre - approval has recently been received for a new Eastwood Health & Care Centre subject to the Outline Business case & Full Business case being affordable & acceptable. This will be taken forward jointly by NHS Greater Glasgow and Clyde and East Renfrewshire Council through the Hub initiative, and will provide a much needed replacement for a variety of social care and health facilities within the area.