West Dunbartonshire Community Health & Care Partnership

Strategic Plan 2014/15

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

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1. INTRODUCTION

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

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

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

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

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

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

This fourth integrated Strategic Plan sets out the key actions prioritised for delivery over the course of 2014/15. Its focus reflects the requirements and expectations of the CHCP's "corporate parents": the West Dunbartonshire Council Strategic Plan 2012-17; and the NHSGGC Corporate Plan 2013-16. As in previous years, its structure is a blend of the distinct formats preferred by each organisations, including consideration of key issues from the Chief Social Work Annual Report 2012/13; and an overview of local Clinical Governance priorities. In a similar vein, it has also incorporated consideration of key strategic risks; and integrated workforce planning priorities.

In accordance with good practice and building on the success of the previous year, the Strategic Plan incorporates the CHCP Key Performance Indicators (KPIs) for 2014/15 which also include those indicators within the local Community Planning Partnership (CPP) Single Outcomes Agreement (SOA) 2014-2017 that the CHCP has lead responsibility for. The suite of indicators included relate to a combination of routine

service activity and developmental/transformational initiatives; and delivery that is predominantly under the direct management of the CHCP as well as outcomes that are heavily influenced by the practice and contributions of other stakeholders (e.g. other council departments; other NHSGGC divisions; or NHS external contractors). It is also important to note that as in previous years, there is not a necessarily direct correlation between specific "actions for delivery" set out within the CHCP Strategic Plan and each of the indicators included, as the actions here deliberately represent high-level change commitments.

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

The Scottish Government's Public Bodies (Joint Working) (Scotland) Act sets out the arrangements for the integration of health and social care across the country. The leadership and work that staff across the CHCP have already invested ensure that the enactment of this new legislation should not pose any significant challenges for us, nor indeed require any major structural reorganisations for local services. This confidence is reflected in the fact that the NHSGGC Board (at its 17th December 2013 meeting) and the West Dunbartonshire Council (at its 18th December 2013 meeting) both agreed to transition the current Community Health and Care Partnership (CHCP) to a **shadow Health and Social Care Partnership** (HSCP) for West Dunbartonshire on 1st April 2014.

These decisions represent a commitment on the part of all involved to transitioning the current CHCP to the new HSCP in an orderly fashion that emphasises continuity – and minimises potential disruption or uncertainty - for staff and service users; and that prioritises continuous quality improvement of services for the benefit of the local communities of West Dunbartonshire.

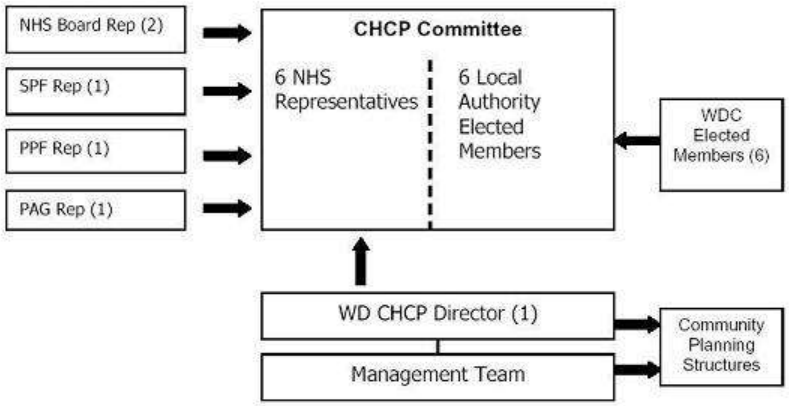
2. GOVERNANCE ARRANGEMENTS

CHCP Governance Structure

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

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

The relationships of these five elements are as illustrated below:



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

Shadow HSCP Arrangements

Through 2014/15, WDC and NHSGGC will agree the parameters for the new HSCP within an *integration* scheme that is required by the new legislation, the detail of which will include:

- The model of integration governance to be used, i.e. the form of integration authority.
- The functions and resources to be delegated.
- Strategic commissioning – inc. strategic planning, performance management and public reporting.
- Clinical and care governance.
- Workforce and staff governance.
- Professional leadership.
- Financial governance and resource management.
- Risk management.

- Relationship with NHS Acute services.
- GP and other NHS External Contractor engagement.
- Third Sector engagement.
- Community engagement.
- Locality (sub-local authority level) planning.
- Participation in local CPP and contribution to SOA.

The full Council and NHSGGC Board have both recognised that the form of integration authority expressed within the Act which most closely matches the existing arrangements for West Dunbartonshire CHCP are those referred to as the "body corporate". Consequently the HSCP will clearly be a **key constituent organ of both WDC and NHSGGC** – it will not be an independent organisation. However, it will have a different status – hence why it will be led by a Chief Officer – and so in order for it to perform effectively, the support from respective corporate centre support functions will need to evolve/adapt..

In order to enable as seamless and well-prepared transition as possible from the existing CHCP to the new HSCP, both the full Council and the NHS Board have agreed that from **1st April 2014 to 31st March 2015**:

- The CHCP will be recognised as the **shadow HSCP** for West Dunbartonshire.
- The CHCP Committee will have the additional role of operating as the **shadow Integration Joint Board** (IJB) with the current membership and standing orders.
- The shadow IJB will develop its performance scrutiny and governance roles to reflect the emerging obligations of HSCPs as defined in primary legislation and statutory guidance.
- The CHCP Director will take on the additional role as the Chief Officer (CO) designate of the shadow HSCP. Their objectives will be framed by the Chair and Vice Chair of the shadow IJB with the Health Board and Council Chief Executives; and will be a member of the Council and Health Board corporate management teams. At the point the Bill enables the establishment of the new HSCP - and subject to confirmation by the IJB - the CO designate will become the substantive CO for the new HSCP.
- The CO designate will bring forward and ensure appropriate engagement on an integration scheme for the new HSCP.
- The CO designate will lead the development of the strategic plan for the HSCP's first formal year of operation (2015/16), including joint planning for acute services.
- Financial arrangements will remain as at present but the Older People's Change Fund resources will become a core part of the shadow HSCP allocation from the NHSGGC Board.

The approval of the shadow arrangements does not equate to the approval for the activation of a formal HSCP for West Dunbartonshire by either full Council or the NHS Board – this will be further developed through 2014/15 prior to formal consideration by the Council, the NHSGGC Board and then Scottish Government. The shadow HSCP arrangements now agreed are similar to the shadow CHCP arrangements that were put in place by West Dunbartonshire Council and the NHSGGC Board in April 2010, prior to their formally agreeing and then establishing the current CHCP in October 2010.

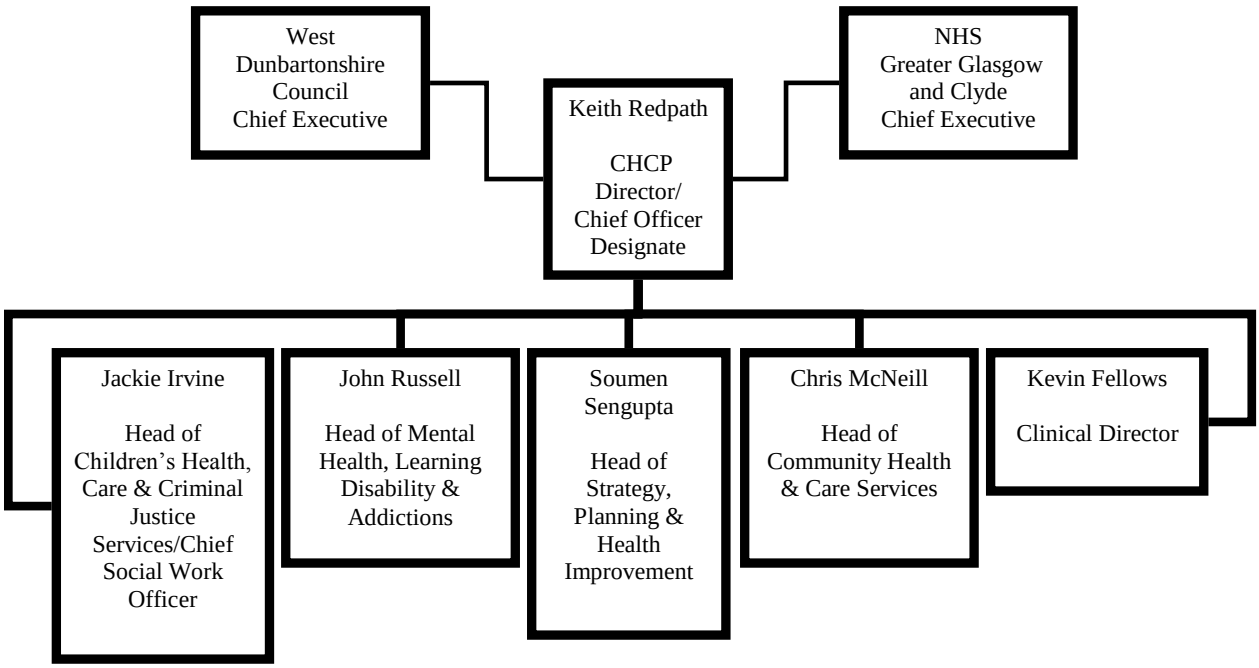
While the new HSCP will be principally constituted on the basis of the Public Bodies (Joint Working) (Scotland) Act, the local integration scheme will also take account of other recent or impending legislation to ensure that the new arrangements are as state-of-the-art as possible – these include:

- The Social Care (Self-directed support) (Scotland) Act 2013.
- The Children and Young People (Scotland) Bill (when enacted).
- The Community Empowerment and Renewal Bill (currently being consulted upon).

The integration scheme will be refined by an Equalities Impact Assessment (EIA) as per the Equalities (Scotland) Act 2010.

The integration scheme will then be presented for approval by the shadow IJB, the full Council and the NHSGGC Board prior to submitted to Scottish Ministers for approval.

Senior Management Team Structure



Clinical Governance Overview

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

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

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

Notable work undertaken has included:

- Speech & Language Therapy (SLT) Service case note audit evidenced that clinical standards are being maintained; and that there has been improved accountability through appropriate recording of how decisions related to patient care were made.
- A Community Mental Health Team (CMHT) audit of the follow-up provided to patients discharged from acute psychiatric hospital found an improvement (from 50% to 73%) of patients being followed up within 7 days.
- The introduction of an 'Ice Spy Logger' early alert mechanism for the vaccine fridge in Clydebank Health Centre substantially reduced the amount of medication wasted through refrigeration faults.
- An Optometry Medication supply audit provided evidence of the effectiveness of enabling community optometrists to supply a range of medications (both free to the patient at the point of diagnosis and delivered safely to NHS standards)
- The work of Community Nurses in West Dunbartonshire was recognised in a national report for the improvements they have made through the 'Releasing Time to Care' programme. The West Dunbartonshire community nursing team, by making changes to working practices, have revolutionised the way patients are treated and improved the training and expertise of staff. By using their standard care procedures, the team developed a range of documentation that ensured the patients' needs could be identified at a glance.

Against the backdrop of the embedding integrated managerial arrangements across health and social care services, the CHCP's approach to clinical governance demonstrates the enthusiasm of all staff striving to deliver better quality clinical care. The cohesive manner in which all services come together to do this for patients is both reassuring and refreshing in these challenging times.

Chief Social Work Officer's Overview

Social Work and Social Care Services are delivered usually, but not exclusively, to the most vulnerable in our communities and therefore have a particular contribution to make to safeguarding individuals from harm and protecting the public. These are complex issues requiring a balance to be struck between needs, risks and rights. The assessment and management of risk posed to individual children, vulnerable adults and the wider community require both clear systems to be in place to govern those responsibilities and require close collaboration with partner agencies.

The Local Government (Scotland) Act 1994 sets out the requirement that every local authority should have a professionally qualified Chief Social Work Officer (CSWO). The role of the CSWO is to provide professional governance, leadership and accountability for the delivery of Social Work and Social Care Services.

Within West Dunbartonshire CHCP, the responsibilities of the CSWO are formally discharged by the Head of Children's Health, Care & Criminal Justice Services. The annual Chief Social Work Officer's Report was submitted to West Dunbartonshire Council at its December 2013 meeting. That Annual Report highlighted a number of areas of notable work, including:

- The Child Protection Committee agreeing a three year Improvement Action Plan.
- The Adult Support & Protection Committee agreeing a three year Action Plan.
- The changes to practice and procedures led by the Criminal Justice Service in response to the most recent Multi-Agency Public Protection Arrangements (MAPPA) guidance in relation to the management of high risk offenders were completed and rolled out on schedule.
- A number of Mental Health Officers (MHOs) undertaking the accredited training on the HCR-20 Risk Assessment and Management Tool.
- The Blue Triangle Multi-Agency Review and the approval of its recommendations.
- Work to reinforce the Corporate Parenting role of the Council, with the very successful launch of the annual Care Leavers week having included a drama production from young people from Kibble Residential School; and the local launch of the Who Cares Anti-Stigma campaign and signing of the Anti-Stigma Pledge.

The CSWO Annual Report also provided assurance that within the integrated CHCP, the governance of social work has been considered and appropriate mechanisms put in place to ensure that these functions are being dealt with properly and appropriately.

Scottish Government Guidance emphasises the need for the CSWO to have access to the Council Chief Executive as required and within West Dunbartonshire this has never been a difficulty. Likewise, there is appropriate access to elected members. Within the CHCP, the role of the CSWO is clearly understood, with proper account taken of any need for specific involvement from the CSWO. The CSWO meets regularly with managers across the service to review and progress relevant areas of activity in a manner that clearly respects the CHCP's general management structure.

3. PLANNING CONTEXT

West Dunbartonshire Council

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

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

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

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

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

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

- Social Mission
- Organisational Capabilities
- Legitimacy and Support.

NHS Greater Glasgow & Clyde

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

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

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

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

West Dunbartonshire Community Planning Partnership

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

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

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

The 2014-17 WD CPP SOA focuses on the following interconnected priorities:

- Employability & Economic Growth
- Supporting Safe, Strong and Involved Communities
- Supporting Older People
- Supporting Children and Families

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

The new SOA also reflects the recognition amongst local stakeoholders of the links between the expectations on the new HSCP (as part of both the Council and NHSGGC) and the aspirations of the National Agreement on Joint Working on Community Planning and Resourcing, which further underlines the importance of these updated arrangements being appreciated as a manifestation of strategic community planning in practice (especially given that it will include all community children's health and social care services, as has successfully been the case within the existing CHCP).

4. DELIVERING OUR OUTCOMES

	EARLY INTERVENTION AND PREVENTING ILL-HEALTH		2013-14 Target	2014-15 Target
SOCIAL MISSION	**Key Actions for Delivery**	**Indicators**		
	Complete relevant actions within CPP Integrated Children's Services Plan. Further develop of CPP parenting programme. Undertaken agreed review and developmental work in support of CPP Early Year's Collaborative (EYC) programme. Embed 30 month assessment for all children, ensuring developmental needs being met as per CPP EYC programme. Embed Universal and Vulnerable pathways for all children 0-19 years. Complete local implementation of GIRFEC National Practice Model. Embed SLT framework in accordance with local structures. Redesign specialist community paediatrics. Embed local CAMHS redesign. Continue roll-out of EMIS Web across children's health services.	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	85%	90%
		Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	85%	90%
		Percentage of designated staff groups trained in suicide prevention	50%	50%
		5-year moving average suicide rate (per 100,000 population)	15	14
		Primary Care Mental Health Teams average waiting times from referral to first assessment appointment (Days)	14	14
		Percentage uptake of bowel screening	60%	60%
		Percentage of those invited attending for breast screening	71.4%	71.4%
		Percentage uptake of cervical screening by 21-60 year olds (excluding women with no cervix)	80%	80%
		Number of children completing tailored healthy weight programme	-	65
		Percentage of babies breast-feeding at 6-8 weeks	16%	16%
		Percentage smoking in pregnancy	20%	20%
		Percentage of five-year olds (P1) with no sign of dental disease	60%	60%
		Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	95%	95%
		Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	97%	97%

SOCIAL MISSION	EARLY INTERVENTION AND PREVENTING ILL-HEALTH		2013-14 Target	2014-15 Target
	Key Actions for Delivery	**Indicators**		
	Lead implementation of Child Protection Committee Improvement Action Plan with and across community planning partners. Refresh CPP Teenage Pregnancy Action Plan. Further improve access to PCMHT and reduce incidence of clients failing to attend appointments. Lead the development and implementation of the CPP ADP Delivery Plan and Annual Report. Lead CPP suicide prevention programme in line with national suicide prevention strategy 2013-16. Implement CHCP Cancer Information Action Plan. Support Alcohol Brief Interventions within different settings. Ensure delivery of nutrition and physical activity programmes for children and adults. Ensure full compliance with outcome and requirements from the Scottish Governments Redesign of the Community Justice system for the delivery of adult criminal justice services.	Percentage of child protection referrals to case conference within 21 days	95%	95%
		Percentage of children on the Child Protection Register who have a completed and up-to-date risk assessment	100%	100%
		Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	63%	66%
		Number of children with or affected by disability participating in activities	172	172
		Rate per 1,000 of children/young people aged 8-18 who are referred to the Reporter on offence-related grounds	7	6.5
		Rate per 1,000 of children/young people aged 0-18 who are referred to the Reporter on non-offence grounds	39.2	38.5
		Number of children with mental health issues (looked after away from home) provided with support	23	23
		Stillbirth rate (as indicative of women experiencing positive pregnancies which result in the birth of more healthy babies)	5.9	5
		Infant mortality rate (as indicative of women experiencing positive pregnancies which result in the birth of more healthy babies)	4.1	3
		Percentage of all children that have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review	70%	75%
		Percentage of Adult Support and Protection clients who have current risk assessments and care plan.	100%	100%
		Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	91.5%	91.5%
		Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling	98%	98%

	SHIFTING THE BALANCE OF CARE		2013-14 Target	2014-15 Target
	Key Actions for Delivery	**Indicators**		
SOCIAL MISSION	Continue to develop Anticipatory Care as a model of prevention and work with GPs to develop self care models, and preventative interventions. Continue to develop care for patients with long term conditions inc. additional nursing support to patients, GP practices and care homes. Further develop Hospital Discharge team to increase early supported discharges. Further develop use of care planning and management to reduce hospital inpatient care. Embed early referral for assessment by integrated health and social care teams. Further develop CMS with local pharmacies through local community pharmacists group. Increase range of urgent access options to advice and appointments for GPs. Work with GP practices to monitor their provision of third available appointment, planned appointments and 24 hour access.	Number of adult mental health patients waiting more than 28 days to be discharged from hospital into a more appropriate setting, once treatment is complete	0	0
		Number of adult mental health patients waiting more than 14 days to be discharged from hospital into a more appropriate setting, once treatment is complete	0	0
		Long Term Conditions - bed days per 100,000 population	10,000	10,000
		Long Term Conditions - bed days per 100,000 population Asthma	310	304
		Long Term Conditions - bed days per 100,000 population CHD	5,300	5,199
		Long Term Conditions - bed days per 100,000 population COPD	4,000	3,924
		Long Term Conditions - bed days per 100,000 population Diabetes	740	726
		Percentage of community pharmacies participating in medication service	80%	80%
		Percentage of all Looked After Children supported within the local community	88%	89%
		Gross cost of Children Looked After in residential based services per child per week	£1,805.00	£1,842.00
		Gross cost of Children Looked After in a community setting per child per week	£255.00	£260.10
		Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	85%	86%
		Percentage of Care Plans reviewed within agreed timescale	70%	72%

SOCIAL MISSION	SHIFTING THE BALANCE OF CARE		2013-14 Target	2014-15 Target
	Key Actions for Delivery	**Indicators**		
	Expand Diabetic Retinal Screening service to cope with volume of patients and ensure quality. Deliver annual cycle for Retinal Screening appointments. Deliver quality assured NHSGGC-wide eye care service through audit and review. Contribute to reduction in Ophthalmology Out Patient by continuing OCT clinics. Expand the number of fixed sites for the delivery of local eye care clinics. MSK Physiotherapy Service: • Ensure equitable waiting times across sites. • Complete roll-out of self-referral across all sites. • Improve supported self management by working with staff and by developing standardised resources and other methods to support self management. • Develop and implement physiotherapy pathways to ensure patients get the right treatment at the right time by the right person (including involving key stakeholders). • Outcome measures will be fully implemented and used to address physical activity, stress, anxiety & depression, employability, smoking, obesity and alcohol use. • Implement a single IT system across service.	Average waiting times in weeks for musculoskeletal physiotherapy services - WDCHCP	9	9
		Average waiting times in weeks for musculoskeletal physiotherapy services - NHSGGC	9	9

	RESHAPING CARE FOR OLDER PEOPLE		2013-14 Target	2014-15 Target
SOCIAL MISSION	**Key Actions for Delivery**	**Indicator**		
	Implement Year Four CPP Older People's Change Fund Commissioning Plan, including (1): • Lead local CPP Older People's Change Fund Plan Implementation Group. • Plan rapid response and alternative choices on behalf of at risk clients • Develop ACP Nursing team, linked to Out of Hours services. • Develop additional respite and rehabilitation options. • Further develop the LinkUp service to streamline referrals from and between the 3rd and Independent Sectors. • Maintain a dedicated helpline number manned by volunteers. • Increase appropriate use of Telecare and Step Up, Step Down provision. • Continue to develop appropriate medication-related education and training for CHCP Home Care staff. • Introduce Day Care Reablement and reablement in short term care home placements.	Emergency inpatient bed days rate for people aged 75 and over (per 1,000 population)	6,400	5,434
		Number of people who wait more than 28 days to be discharged from hospital into a more appropriate care setting.	0	0
		Number of acute bed days lost to delayed discharges	3819	1909
		Number of Acute bed days lost to delayed discharges for Adults with Incapacity	466	233
		Unplanned acute bed days 65+	55,000	48,643
		Unplanned acute bed days 65+ as a rate per 1,000 population	3,735	3,292
		Number of emergency admissions 65+	4,250	4,169
		Emergency admissions 65+ as a rate per 1,000 population	300	295
		Unplanned acute bed days (aged 75+)	38,600	36,477
		Average length of stay for emergency admissions	3	3
		Number of patients on dementia register	672	672
		Number of patients in anticipatory care programmes	824	865
		Percentage of identified patients dying in hospital for cancer deaths	35%	35%
		Percentage of identified patients dying in hospital for non-cancer deaths	40%	40%
		Number of bed days lost to delayed discharge elderly mental illness	530	530
		Average length of stay elderly mental illness delayed discharge	96	90
		Average length of stay adult mental health delayed discharge	35	34
		Total number of homecare hours provided as a rate per 1,000 population aged 65+	678	695
		Percentage of homecare clients aged 65+ receiving personal care	81%	82%
		Percentage of adults with assessed Care at Home needs and a reablement package who have reached their agreed personal outcomes	50%	55%
		Older Person's (Over 65) Home Care Costs per Hour	£18.05	£18.42

SOCIAL MISSION	RESHAPING CARE FOR OLDER PEOPLE		2013-14 Target	2014-15 Target
	Key Actions for Delivery	**Indicator**		
	Implementation of Year Four of CPP Older People's Change Fund Commissioning Plan, including (2): • Reduce the proportion of people within West Dunbartonshire dying in hospital. • Use Supportive and Palliative Action Register (SPAR) to aid the identification of cancer and non-cancer patients entering a palliative phase. • Deliver targeted physical activity programmes to vulnerable adults in communities outwith Leisure Settings. • Deliver a Post Diagnostic Support Service for newly diagnosed patients and their carers, with Alzheimer Scotland. Develop respite provision to include respite at home. Deliver expanded reablement support as part of Care at Home Services. Work with WDC Housing Section to develop housing with care options to meet target of increasing the number of older people with complex needs living at home or in a homely setting.	Percentage of people aged 65 and over who receive 20 or more interventions per week	44.5%	45%
		Percentage of people 65+ with intensive needs receiving care at home (Existing definition)	49%	51%
		Percentage of people 65+ admitted twice or more as an emergency who have not had an assessment	33%	32%
		Number of people aged 75+ in receipt of Telecare – Crude rate per 100,000 population	21,773	22,410
		The percentage of people receiving free personal or nursing care within 6 weeks of confirmation of 'Critical' or 'Substantial' need	100%	100%
		Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	95%	96%
		Number of people in care home placements at month end (65+)	483	468
		Number of new admissions to Care Homes (65+)	188	183
		Occupancy rate in local authority care homes (65+ only)	95%	95%
		Number of carers of people aged 65+ known to CHCP	1600	1680
		No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015	0	0

	IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS		2013-14 Target	2014-15 Target
	Key Actions for Delivery	**Performance Measure**		
LEGITIMACY AND SUPPORT	Continue to embed Releasing Time To Care and Leading Better Care. Improve children's to adults' services transition Work with GPs on Productive General Practice model. Support Scottish Patient Safety Programme in community and primary care services. Maintain routine meetings with DOME and develop local services as a partnership. Complete scheduled development and review of service specifications for procured services. Complete feasibility study and business case for new Clydebank Health & Care Centre. Complete Post-Project Evaluation of Vale Centre for Health & Care. Deliver plans for the design and location of two Older People's Residential Care Homes with Day Care facilities. Consolidate improvement in Care Inspectorate Gradings for Older People's Care Homes (older people). Consolidate improvement in Care Inspectorate Gradings for Day Care.	Percentage of patients achieved 48 hour access to appropriate GP practice team	95%	95%
		Percentage of patients advanced booking to an appropriate member of GP Practice Teams	90%	90%
		Prescribing cost per weighted patient	£152.50	£152.50
		Percentage of adults satisfied with social care or social work services	68%	69%
		Primary care phased prescribing budget allocation ('£000)	£16,789	£16,789

	Consolidate improvement in Care Inspectorate Gradings for Home Care. Consolidate improvement in Care Inspectorate Gradings for Children's Residential Care Homes. Consolidate improvement in Care Inspectorate Gradings Fostering Service. Consolidate improvement in Care Inspectorate Gradings for Adoption Service. Continue to implement findings of Blue Triangle review, including: • To develop supported accomodation within both Clydebank and Dumbarton with crisis support from All4Youth over 24 hours if required. • To develop an outreach support programme over 7 days to our most vulnerable young people. • To build on the existing Young People in Mind service and provide additional support for Residential Homes and support for young people in transition to through care. • To develop a family mediation service which supports the critical factor of family breakdown. Promote the principles of Facing the Future Together and WDC corporate transformation programmes in an integrated manner, with a focus on strengthening integrated arrangements in preparation for the new HSCP in 2015.	

SOCIAL MISSION	TACKLING INEQUALITIES		2013-14 Target	2014-15 Target
	Key Actions from Delivery	**Indicator**		
	Implement requirements of Self-Directed Support Act. Implement local Smoking Cessation Service Action Plan. Lead community planning approach to health inequalities. Address impact of welfare reform addressed where possible, ensuring access to money advice services. Continue to deliver Work Connect employability programme. Implement relevant actions generated by NHSGGC *Further Developing A Systematic Approach to Tackling Inequality* process; and that flow from *Scotland's National Action Plan for Human Rights*. Work with WDC Housing Section and third sector providers to develop appropriate supported living accommodation for those with long-term mental health needs. Work with third sector to relocate local clients with a learning disability diagnosis who are currently living in specialist care facilities out of area back within West Dunbartonshire. Support local GP Domestic Abuse Pilot. Support implementation of WDC Gaelic Language Action Plan.	Self Directed Support (SDS) spend on adults 18+ as a percentage of total social work spend on adults 18+	1.65%	1.7%
		Total number of respite weeks provided to all client groups	7647	7647
		Percentage uptake of bowel screening SIMD1	60%	60%
		Percentage of those invited attending for breast screening SIMD1	71.4%	71.4%
		Percentage uptake of cervical screening by 21-60 year olds (excluding women with no cervix) SIMD1	80%	80%
		Percentage of babies breast-feeding at 6-8 weeks from the 15% most deprived areas	16%	16%
		Percentage smoking in pregnancy - Most deprived quintile	20%	20%
		Number of successful quits, at 12 weeks post quit, in the 40% most deprived areas (SIMD 1 and 2)	-	211
		Number of unplanned admissions for people 65+ by SIMD Quintile 1	588	577
		Proportionate access to psychological therapies – Percentage waiting no longer than 18 weeks SIMD 1	85%	90%
		Proportionate access to psychological therapies – Percentage waiting no longer than 18 weeks SIMD 5	85%	90%
		Proportionate access to psychological therapies – Percentage waiting no longer than 18 weeks Male	85%	90%
		Proportionate access to psychological therapies – Percentage waiting no longer than 18 weeks Female	85%	90%
		Number of quality assured Equality Impact Assessments	8	8

	EFFECTIVE ORGANISATION		2013-14 Target	2014-15 Target
ORGANISATIONAL CAPABILITIES	**Key Actions for Delivery**	**Indicator**		
	Agree and then deliver HSCP Transition Action Plan: • Develop proposed HSCP Integration Scheme. • Development of Integration Joint Board. • Develop singular model of support for HR management, staff/practice governance and workforce development. • Develop singular model of support for management accounting and financial governance. • Develop arrangements and proposals for refreshed approach to community engagement that addresses the integration planning principles, plus the expectations of Community Empowerment & Renewal Bill connected to and supported by wider CPP arrangements. • Develop consortia model with independent sector that addresses integration planning principles, and supports local strategic commissioning process. • Develop consortia model with third sector that addresses the integration planning principles, builds community capacity, strengthens co-production and supports local strategic commissioning process. • Develop arrangements and proposals for locality planning, including supporting GP leadership.. • Develop model approach for and prepare an Equality Scheme for HSCP. • Develop first West Dunbartonshire HSCP Strategic Plan. Update integrated staff and practice governance framework., including CHCP actions in response to relevant findings of Staff Surveys. Maintain Healthy Working Lives Gold Award. Maintain NHS FPI Participation Standards.	Sickness/ absence rate amongst WD CHCP NHS employees (NHSGGC)	4%	4%
		Average number of working days lost per WD CHCP Council Employees through sickness absence	10	9
		Percentage of WD CHCP NHS staff who have an annual e-KSF review / PDP in place	80%	80%
		Percentage of WD CHCP Council staff who have an annual PDP in place	80%	90%
		Percentage of complaints received and responded to within 20 working days (NHS policy)	70%	70%
		Percentage of complaints received which were responded to within 28 days (WDC policy)	70%	70%
		NMC Registration compliance	100%	100%
		Percentage staff with mandatory induction training completed within the deadline	100%	100%

5. WORKFORCE DEVELOPMENT

As at March 2014 the CHCP workforce comprised of 2,280 Headcount staff inputting 1787.39 whole time equivalents (WTE). The table below shows the workforce broken down by employing authority and service area. Note that these figures do not include any vacant posts in the process of recruitment.

West Dunbartonshire CHCP			
WTE Staff in Post by Service & Employing Authority			
Service Description	**NHS Employees**	**Council Employees**	**Total**
Community Health & Care	**118.01**	**747.05**	**865.06**
Child Health Care & Criminal Justice	**107.47**	**246.01**	**353.47**
Mental Health, Addictions & LD	**215.72**	**141.47**	**357.18**
Strategy, Planning & Health Improvement	**16.71**	**43.87**	**60.58**
Senior Management Team	**4.50**	**1.00**	**5.50**
Hosted Services	**145.60**		**145.60**
Grand Total	**608.00**	**1179.39**	**1787.39**

Notable characteristics of the CHCP workforce include:

- It is predominantly (85%) female.
- 45% are aged over 50 years old, with the largest age band falling between 50 and 54 years of age.
- 10% are aged over 60 years old, with some staff working beyond the "historic" retiral age of 65 years; and a small number working into their 70's.
- The CHCP employs only a small number of staff under 20 years old.
- The service areas with the highest proportion of staff (albeit under 20%) approaching anticipated retiral age are Mental Health, Addictions & Learning Disability Services; and Community Health & Care Services.

Looking forward within the context of the impending new HSCP for West Dunbartonshire, key workforce development priorities are:

- Ensuring staff accreditation, disclosure and registration.
- Supporting staff personal and continuous professional development planning (PDP and CPD).
- Ensuring training needs addressed – including child protection; adult support & protection; person-centred care; are planning; and dementia care.
- Investing in leadership development and succession planning.
- Supporting flexible working opportunities and arrangements.
- Enabling the use of agile technologies by staff.
- Supporting staff health and wellbeing.
- Supporting appropriate and effective attendance management.
- Emphasising career pathways to encourage retention.
- Ensuring active development of Mental Health Officer (MHO) status.
- Fostering external capacity within the volunteer and third sector workforce to support co-production.

6. STRATEGIC RISK MANAGEMENT

The CHCP recognises that the management of strategic risk at CHCP-level will impact on both WDC's and NHSGGC's respective abilities to achieve their strategic aims and objectives. To assist the SMT to manage and monitor such risks, it maintains an integrated CHCP Strategic Risk Register that both feeds the Corporate Risk Registers of its parent organisations; and is itself supported by operational service risk registers.

Risk Scoring Matrix (Pre-Mitigation):	Likelihood = L	Severity = S	Likelihood (L) X Severity (S) = Risk Scoring Level
WDC Risk Scoring		NHSGGC Risk Scoring	Risk Level
<6 = Low		1 – 3 = Low	Green
6 – 9 = Medium		4 – 9 = Medium	Amber
> 12 = High		10 – 19 = High; 20 – 25 = Very High	Red

RISK	**Risk Exposure**						**Risk Level**	**Mitigation / Risk Controls**	**Mitigation Lead**
	WDC			**NHSGGC**					
	L	S	LxS	L	S	LxS			
Failure to moderate and contingency plan for 1: 200 (SEPA) flood risk for site of Dumbarton Health Centre.	-	-	-	4	5	20	Red	Alternative accommodation identified to relocate staff and services in event of flood. Flood protection measures identified and documented to be employed as required. CHCP contributing to NHSGGC and WDC civil and business continuity arrangements.	Head of Community Health & Care Services
Failure to deliver a sustainable solution to asbestos-related health & safety risks within fabric of Clydebank Health Centre.	-	-	-	2	5	10	Red	On-going repair and refurbishment expenditure in immediate to short-term, but increasingly constrained by limitations caused by and increasing costs associated with the asbestos in the building. Following Health & Safety Executive assessment of premises, CHCP has confirmed that optimal solution is to secure funding and approval for a replacement facility. Clydebank Health Centre replacement prioritised no. 2 on NHSGGC partnerships' property strategy; and the CHCP has undertaken preparatory work and actively participating in the NHSGGC primary care estate feasibility scoping process in anticipation of the announcement of capital funds.	Head of Community Health & Care Services; and Head of Strategy, Planning & Health Improvement
Failure to ensure that Guardianship cases are appropriately allocated to a supervising social worker for monitoring, support and review.	3	4	12	3	3	9	Red / Amber	Procedures for allocating case being reviewed and strengthened, alongside training being provided to relevant staff in accordance with former SWIA Good Practice Guidelines on Supervising and Supporting Welfare Guardians (2009). Additional investment to recruit mental health officers explicit element within the local Older People's Change Fund Plan, alongside HR activities to retain recruited staff.	Head of Mental Health, Learning Disabilities & Addictions

RISK	Risk Exposure						Risk Level	Mitigation / Risk Controls	Mitigation Lead
	WDC			NHSGGC					
	L	S	LxS	L	S	LxS			
Failure to monitor and ensure the wellbeing of people in independent or WDC residential care facilities.	3	3	9	3	3	9	Amber	Systems are in place to ensure that findings of external scrutiny (Care Inspectorate) processes are acted upon timeously. CHCP Quality Assurance team provide pro-active and constructive support to care facilities alongside leadership role of relevant CHCP operational managers. Regular reports on residential care facilities standards are provided to CHCP Committee.	Head of Community Health & Care Services; and Head of Strategy, Planning & Health Improvement
Failure to meet legislative compliance in relation to child protection.	2	4	8	1	5	5	Amber	Child Protection procedures are in place and oversee by the Child Protection Committee. Work plan developed addressing identified areas for improvement as informed by recent child protection inspection. All child protection cases are audited regularly by the Child Protection Co-ordinator.	Chief Social Work Officer
Failure to meet legislative compliance in relation to adult support and protection.	2	4	8	1	5	5	Amber	Vulnerable adult procedures are in place and overseen by the ASP Committee and MAPPA arrangements. External inspection undertaken and recommendations acted upon. Local adult support arrangements will be subject to a bi-annual review process, with improvement actions set depending on findings	Chief Social Work Officer
Failure to deliver efficiency savings targets and operate within allocated budgets.	2	3	6	2	2	4	Amber	Finance management systems in place for both NHSGGC and WDC budgets, including regular reporting to SMT and CHCP Committee. Specific attention being paid to pressures within allocated prescribing budget.	CHCP Director
Failure to identify &/or then mitigate any significant adverse effects to patients / clients - including protecting equality groups - that may arise as an unintended consequence of delivering financial targets.	2	3	6	1	4	4	Amber	EQIAs undertaken routinely in relation to substantial changes/development, and explicitly reported on in relation to relevant reporting to CHCP Committee. Financial savings proposals routinely subjected to EQIA process prior to initiatives being confirmed by SMT.	CHCP Director
Failure to mitigate risks to Diabetic Screening Service of dependence on IT systems during on-going up-dating process.	-	-	-	2	2	4	Amber	Manual systems documented for use in the event of an IT failure, their application augmented by experienced staff.	Head of Community Health & Care Services
Failure to ensure that services are delivered by appropriately qualified and / or professionally registered staff.	2	2	4	1	1	2	Green	Systems are in place to discharge this in line with NHSGGC policy and WDC requirements, and compliance with standards set by external scrutiny and registration bodies. Refresher training arranged for relevant professional staff - including care planning, chornologies, supervision and risk assessment tools.	CHCP Director; and Chief Social Work Officer

7. FINANCE

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

WDC (Social Work) Budget

- Revenue Estimates

OUTTURN 2012/2013 £000	SERVICE DESCRIPTION	REVISED EST. 2013/2014 £000	PROBABLE 2013/2014 £000	ESTIMATE 2014/2015 £000
1,387	STRATEGY AND PLANNING	1,347	1,177	1,235
3,408	RESIDENTIAL ACCOMODATION - YOUNG PEOPLE	3,261	3,368	3,227
2,257	CHILDREN'S COMMUNITY PLACEMENTS	2,194	2,550	2,423
2,374	RESIDENTIAL SCHOOLS	2,027	2,164	2,037
3,138	CHILDCARE OPS	3,314	3,323	3,609
3,519	OTHER SERVICES - YOUNG PEOPLE	3,738	3,723	4,127
11,467	RESIDENTIAL ACCOMODATION FOR ELDERLY	11,207	11,760	12,006
1,333	SHELTERED HOUSING	1,340	1,347	1,374
1,088	DAY CENTRES – ELDERLY	1,073	1,058	1,023
121	MEALS ON WHEELS	89	89	88
297	COMMUNITY ALARMS	277	289	286
2,972	COMMUNITY CARE OPS	2,954	2,875	3,190
8,563	RESIDENTIAL CARE - LEARNING DISABILITY	9,471	9,441	9,582
1,141	PHYSICAL DISABILITY	1,062	1,234	1,117
1,546	DAY CENTRES - LEARNING DISABILITY	1,536	1,564	1,615
912	OTHER SERVICES – DISABILITY	930	879	569
207	CHCP HQ	193	234	230
1,826	MENTAL HEALTH	1,820	1,807	1,889
9,094	HOMECARE	9,000	9,101	8,995
365	OTHER SPECIFIC SERVICES	367	366	366
1,127	ADDICTION SERVICES	1,344	1,262	1,240
0	CPP - CHILDREN'S SERVICES	412	412	0
293	OLDER PEOPLE'S CHANGE FUND	0	0	0
		58,956	**60,023**	**60,228**

- Capital

DESCRIPTION	*ESTIMATE 2014/2015 £000*
REPROVISION OF LEARNING DISABILITY SERVICES	516
SLIPPAGE	**516**
SPECIAL NEEDS ADAPTATIONS	655
RECURRING: OPERATIONAL REQUIREMENTS	**655**
REPLACE ELDERLY CARE HOMES AND DAY CARE CENTRES	8,910
ONE OFF PROJECTS IN TOP 50 WDC PROJECTS	**8,910**
TOTAL	**10,081**

NHSGGC Budget

- Revenue Estimates

The revenue budget for the year 2014/15 has yet to be finalised. The table presents the budget based on the existing budget rolled forward to exclude non-recurring expenditure, including assumptions of changes based on best estimates available.

The draft opening 2014/15 budget by service area is as follows in the table below.

Care Group	Annual Budget
Addictions - Community	1,833.4
Adult Community Services	9,827.4
Change Fund	11.2
Child Services - Community	1,684.3
Child Services - Specialist	1,228.5
Fhs - Gms	11,780.5
Fhs - Other	10,034.7
Fhs - Prescribing	16,442.6
Hosted Services	837.9
Learn Dis - Community	267.6
Men Health - Adult Community	3,414.3
Men Health - Adult Inpatient	0.0
Men Health - Elderly Services	2,983.4
Other Services	2,432.1
Planning & Health Improvement	872.9
Resource Transfer - Local Auth	7,518.6
Expenditure	**71,169.4**

With respect to the Older People's Change Fund, in 2013/14 the allocation to the CHCP for 2014/15 (the final year of the four year national funding) will fall to £1,209,000 (from £1,381,000 in 2013/14). As the Older People's Change Fund monies have been allocated to the NHSGGC Health Board on a non-recurring basis, this funding does not appear in the draft 2014/15 budget figure above.

- Capital

The main feature of the CHCP's NHS capital programme is pursuing the development of a new and substantive Clydebank Health & Care Centre as part of a wider regeneration strategy for the Clydebank area.