West Dunbartonshire Council

NHS Greater Glasgow and Clyde

West Dunbartonshire
Community Health & Care Partnership

West Dunbartonshire Community Health & Care Partnership

Strategic Plan 2012/13 (Draft)

TABLE OF CONTENTS

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

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

1. INTRODUCTION

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

This second integrated Strategic Plan sets out the key actions prioritised for delivery over the course of 2012/13. As previously, its focus reflects the requirements and expectations of the CHCP's "corporate parents". Its structure is a blend of the distinct formats required by both organisations. The development of this distinctive Plan has also been informed by analysis of local health and social care needs; on-going dialogue with local stakeholders; and other relevant sources of evidence - most notably the findings of the Audit Scotland Evaluation of Community Health Partnerships.

During 2011/12 NHSGGC launched its ambitious corporate change programme, *Facing the Future Together*. I view it as incumbent on myself and the Senior Management Team to make the various elements of this programme real and relevant for all CHCP staff – not least as they resonate with similar expectations within WDC of what we all accept as being the 'right things' that all good organisations should be doing. The reality is though that just too often the 'day job' and the urgency of dealing with the legitimate needs of the people who use our services and the needs of those who provide those services get prioritised over other things that do not seem to be quite so pressing. With that in mind we have committed ourselves to fostering a culture of constructive and critical self-evaluation; and have adopted the Public Service Improvement Framework (PSIF) as our over-arching organisational development approach to encouraging this with and across all of our services.

This Strategic Plan sets out an ambitious suite of actions for the year ahead. We have collectively achieved a considerable amount of progress across the breadth of our responsibilities in the previous year against a dynamic policy backdrop and done so in a financially responsible manner. We are also clearly sighted on a number of areas where we are committed to delivering improved performance, a notable example being in relation to the variable gradings awarded to some of our residential Care Homes by the Care Inspectorate. While these present challenges, I am in no doubt about the commitment and resolve of our staff to positively respond in those situations (as evidenced by the programme of improvement swiftly initiated across said Care Homes). I want to take this opportunity to recommit myself to working with all CHCP staff to ensure that we collectively do the best we can for all the people who receive services from us. I and the Senior Management Team look forward to working with you collectively and individually to deliver our shared ambitions.

Keith Redpath - Director

2. GOVERNANCE ARRANGEMENTS

West Dunbartonshire CHCP leads and manages a substantial range of services on behalf of NHSGGC and West Dunbartonshire Council. Its 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.

Its stated aims are to:

- Improve the health of the population.
- Contribute to closing the inequalities gap.
- Promote Social Welfare for the population of West Dunbartonshire.
- Share governance and accountability between NHSGGC and WDC.
- Have substantial responsibility and influence in the deployment of NHS and Council resources.
- Manage local NHS and social care service.
- Play a major role in Community Planning.
- Achieve better specialist care for its population.
- Achieve strong local accountability through the formal roles for lead councillors and the engagement and involvement of its community.
- Drive NHS and Local Authority planning processes.
- Protect and support vulnerable children and adults in the community.
- Deliver services that are of good quality and value for money.
- Make access to our services easier.
- Promote an understanding of Social Work within the wider community.
- Have a competent, confident and valued work force.

In addition to local 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.

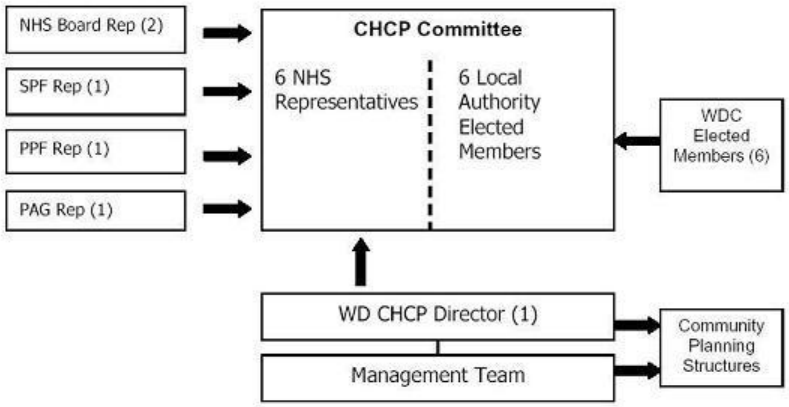
The CHCP also has a number of formal Service Level Agreements in place with the neighbouring Argyll and Bute Community Health Partnership in relation to services that have mutually agreed as being sensibly provided across the boundaries of our respective geographic boundaries (all of which are subject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

CHCP Governance Structure

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

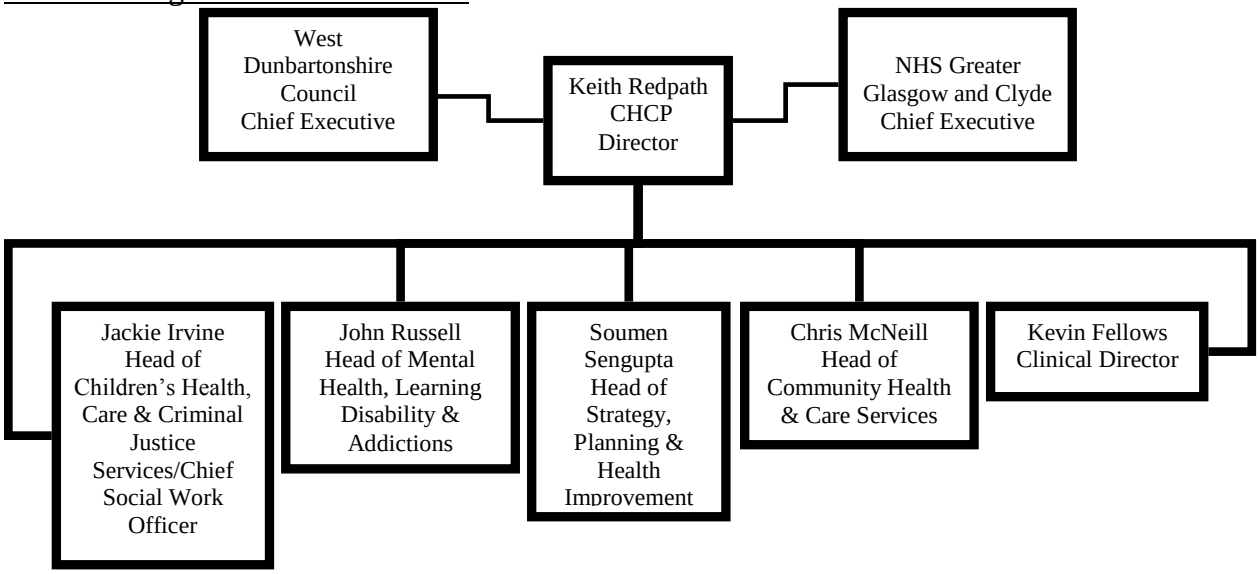
- The CHCP Committee.
- The Joint Staff Forum (JSF)
- The Public Partnership Forum (PPF)
- The Professional Advisory Group (PAG)
- The CHCP Senior Management Team (SMT)

The relationships of these five elements are as illustrated below:



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

Senior Management Team Structure



Clinical Governance Overview

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

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

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

The CHCP's Clinical Governance Workplan explicitly reflects the three 'quality ambitions' as outlined in the NHS Quality Improvement Scotland paper on developing a 'quality strategy programme in primary care', i.e. person centred, safe and effective. This is summarised in the diagram overleaf and detailed within the CHCP Clinical Governance Annual Report 2011/12. Against the backdrop of the embedding integrated managerial arrangements across health and social care services, the local CHCP's approach to clinical governance demonstrates an impressive enthusiasm of all staff striving to deliver better quality clinical care. The cohesive manner in which all services come together to do this for patients is both reassuring and refreshing in these challenging times. It is also notable that priority has also been attached to ensuring that the integrated management arrangements of the CHCP are fully used to both streamline and strengthen a number of clinical governance systems: most notably establishing a single integrated strategic risk register for the CHCP.

Looking to the year ahead, the CHCP is looking to promote the roll-out of the national patient safety programme in primary care, with two local GP practices (Dr Bell & Partners and Levenside Medical Practice) participating in the NHSGGC pilot workstream to explore different aspects of patient safety and share learning. A notable innovation has been the creation of a single CHCP strategic risk register across its health and social care responsibilities. The CHCP will also further strengthen its clinical governance arrangements in relation to and support for those NHSGGC-wide clinical services that the CHCP "hosts", namely the established Eye Care Service and the MSK Physiotherapy Service. Even though the latter is a new arrangement from the 1st April 2012, clinical governance priorities have already been established, most notably utilising standard outcome measures NHSGGC-wide to evaluate the impact of physiotherapy - pre and post intervention - on patients' pain, functions of daily life and work status. Work will also continue to further capitalise on opportunities afforded by the integrated management arrangements of the CHCP to support effective and joined-up clinical governance, including establishing a single incident reporting system across all CHCP services, with clear feedback loops to ensure lessons learned are put into everyday practice.

High Quality Health care

Key Drivers	Quality Ambitions	Priority Areas
Person-centred	Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making	1. **Complaints & Feedback-** Learning and improvement 2. **Increase PPF representation-** 3. **Communication-** Sharing learning and CG outputs 4.**People/staff governance** 5**. Better Together Survey actions**
Safe	There will be no avoidable injury or harm to people from healthcare, advice or support they receive, and an appropriate clean and safe environment will be provided for delivery of healthcare services at all times.	1. **Incident Management-** Themes, Learning and action plan 2**. Risk Register** Review and escalate Risks 3. **Health Care Associated Infection-** 4. **Health and Safety-** Safety action notices 5. **Professional registration, Clinical Support and registration**
Effective	The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated	1**.Programe of Clinic Audit** 2. **Service Evaluation Activity** 3**. Use of existing datasets for QI-** Complaints,CIR, IT systems 4. **Guidelines**- Review & implementation of Guidelines & standards 5. **Research and development**

Theme	Service	Project
1pc	CMHT	The advice clinic Audit
2pc	PCMHT	Evaluation of users views
3pc	Mental Health	Access to Psychological Services
4pc	Pharmacy	Visual Impairment Resource
5pc	Children's	Rainbow room evaluations
6pc	Health Visitors	Parents views on Parenting handbook
7pc	Health Visitors	Antenatal home visits, vulnerable mothers
8pc	DNurses	Living and dying well
9pc	COPT	Evaluation of client centred goals
10pc	Podiatry	User experience of nail surgery
	All Staff	Staff annual have individualised PDPs
1s	Pharmacy	Warfarin INR Monitoring
2s	Pharmacy	Methotrexate prescribing Audit
3s	Pharmacy	Baseline medication issues, hospital admission
4s	DNurses	COPD Management LTC
5s	Mental Health	Adult support and protection
6s	Mental Health	Complete review of clinical incident system
7s	Pharmacy	Hospital medication discharge anomalies
	All services	log of all clinical incidents on Datix
	All services	Maintenance and management of Risk Registers
	All services	Monthly incident reports
	All services	Eksf related PDP monitoring
	All clinicians	Monitor updating of annual registrations
	All clinicians	Clinical supervision
1e	HV& SN	HMIe Inspection
2e	HV	SHANARRI assessment tool
3e	SchoolNurse	Record keeping audit
4e	Podiatry	Toe Nail surgery Audit
5e	Physio COPT	Physiotherapy Tinetti interventions
6e	Mental Health	Local Autism Strategy
7e	Health Imprv.	Suicide prevention training programme
8e	**All services**	Clinical Governance related guidelines review

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 2010-2011 was submitted to West Dunbartonshire Council at its August 2011 meeting. This report explained the particular duties and responsibilities that the Council exercises through the delivery of the Social Work function and more fully how that role has been carried out, managed, evaluated and scrutinised over that period.

That report provided assurance that within the integrated CHCP, the governance of Social Work has been considered and appropriate mechanisms put in place to ensure that these functions are being dealt with properly and appropriately. Scottish Government Guidance emphasises the need for the CSWO to have access to the Council Chief Executive as required and within West Dunbartonshire this has never been a difficulty. Likewise, there is appropriate access to elected members. Within the CHCP, the role of the CSWO is clearly understood, with proper account taken of any need for specific involvement from the CSWO. In addition, 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. During a period of such marked change this has proved to be regarded as positive.

One of the issues about integration is that the focus can become the structure of that integrated arrangement rather than the encouragement of good collaborative practice between the various staff involved which puts the needs of the client at the centre. Key to this is a focus on agreed outcomes, both for the individual and the organisation, underscored by mutual respect for the role and contribution of the range of practitioners involved. The CHCP remains committed to this approach, particularly as partnership working extends far beyond the two agencies within the CHCP and good joint working needs to be in place with those other partner agencies as well. A report to the CHCP Committee in June 2011 on the Audit Scotland Review of Community Health Partnerships re-iterated the commitment of the CHCP locally to nurturing strong arrangements and avoiding the risk of strategic complacency.

Particular mention should be given to a Significant Case Review, commissioned by the Child Protection Committee (CPC), into the circumstances surrounding an incident where a young child drank methadone. There are a number of actions as a result of the findings of the review, not just for local implementation but others that been highlighted at national level. Contact was made with the team at the Scottish

Government responsible for children affected by parental substance misuse (CAPSM) to ensure that the recommendations of the Review were widely disseminated. Locally, this incident also provided an example of a care quality concern that overlapped with the interests and responsibilities of the CHCP's clinical governance arrangements, with the integrated senior management arrangements ensuring a joined-up and consistent response to the local actions identified.

The report by the Care Inspectorate on Services to Protect Children and Young People in the West Dunbartonshire area was published on 20th March 2012. CHCP health and social care services, the Police, the Children's Reporter as well as other NHS and Council Services along with voluntary organisations were all involved in the multi-agency inspection which took place during autumn 2011. The Inspection found evidence of very good practice, including that:

- Children get the right kind of help as soon as difficulties arise and for as long as it is needed.
- Services make sure children are safe and well cared for when placed with relatives or friends in an emergency.
- Staff work hard to help children remain, whenever possible, in their own families, schools and communities.
- Workers get to know children well and take their views seriously.

Child Protection Inspection Reports use a six point scale (from Unsatisfactory to Excellent), with four "reference indicators" which are reported on as follows: children are listened to and respected; children are helped to keep safe; response to immediate concerns; and meeting needs and reducing long term harm. All four of these indicators were evaluated as "Very Good", placing West Dunbartonshire amongst the highest performing areas in Scotland. Particular positive comment was made about the programme of support to Children and Families which has been a priority within the local Community Planning Partnership.

The inspectors also report on Improvements in Performance, which was graded as "Good"; and Self-Evaluation, which was graded as "Weak". There are two main action points: one relating to the work needed to improve self-evaluation; and the other to improve assessments of risks and needs and outcome-focused planning for individual children. The CPC (chaired by the CSWO) and the Chief Officers' Group (chaired by the Council Chief Executive) will be taking forward these improvement actions. This will include both Groups - as well as the Adult Support and Protection Committee – undertaking a PSIF self-evaluation with support from Quality Scotland

Looking ahead, the CHCP will be subject to a routine comprehensive inspection by the Care Inspectorate through a large portion of 2012/13. Positive and regular contact has been maintained with the Care Inspectorate Link Inspector in preparation for this important external scrutiny process. The explicit emphasis that the CHCP has placed on self-evaluation (and particularly the use of PSIF) should provide positive evidence of our ability to accurately assess the quality of our services and show how we intend to address any short-comings.

3. PERFORMANCE 2011-12: NOTABLE ACHIEVEMENTS

This Strategic Plan builds on the positive progress over the course of 2011/12. This has been routinely reported to and scrutinised by the CHCP Committee throughout the year (with the attendant details provided within the publicly available papers of that meeting), and further performance managed through the Organisational Performance Review process (see *Effective Organisation*). The considerable achievements of the CHCP and its staff over the previous year provide a robust platform for action over the coming twelve months. The following examples are of strategic note:

- Secured NHSGGC and Scottish Government approval for the construction of the new Vale Centre for Health and Care Centre.
- Completed and approved Commissioning Strategies for Adult Learning Disability Services; Alcohol and Drug Services; Older People's Services completed; and Adult Rehabilitation Services.
- Achieved UNICEF Baby Friendly Communities Stage 3 Accreditation.
- Completed and approved local CPP Parenting Strategy.
- Implemented local Year 1 Older People's Change Fund Plan.
- Completed user evaluation of Primary Care Mental Health Team (PCMHT) advice clinics – this reported positive findings.
- Completed evaluation of physiotherapy therapeutic interventions within the Community Older Peoples Team (COPT) – this reported positive findings.
- Completed and disseminated findings of Child Protection Committee Significant Case Review, surrounding an incident where a young child drank methadone.
- Introduced local Community Specialist Palliative Care Nurse Service.
- Established supportive contingency arrangements for West Dunbartonshire residents within residential care homes affected by the demise of Southern Cross.
- Delivered successful bid to establish a Family Nurse Partnership (FNP) pilot.
- Implemented new National Guidance for Child Protection and revised West of Scotland procedures.
- Implemented Adult Support and Protection (ASP) flowchart, including recommendations for the role of GPs (via locality groups).
- Completed and approved local Adoption and Permanence Service Plan.
- Completed and approved local Relationships, Sexual Health & Parenthood (RSHP) policy.
- Secured Big Lottery Funding to expand and roll out Children Affected by Domestic Abuse Recovery (CEDAR) project.
- Achieved Healthy Working Lives (HWL) Silver Award for the CHCP.
- Led West Dunbartonshire processes that delivered HWL Gold Award for the Council as a whole.
- Introduced successful community pharmacy initiative to assist visually impaired patients with safe taking of medication.
- Established single CHCP strategic risk register.
- Enhanced role of Public Partnership Forum (PPF) with a remit and sphere of interest across the CHCP's breadth of health and social care responsibilities.
- The first integrated health and social care partnership in Scotland to have applied the Public Service Improvement Framework (PSIF) at a strategic management/departmental level (supported by the Improvement Service & Quality Scotland).

4. LOCAL PLANNING CONTEXT

West Dunbartonshire lies north of the River Clyde and encompasses the urban communities of Clydebank, Dumbarton, Balloch, Alexandria and Renton. There is also a more rural area that runs south of Loch Lomond. The population of West Dunbartonshire is estimated at 90,920 (table 1). In West Dunbartonshire the trend has been for the number of deaths to be greater than the number of births; and for out-migration levels to exceed in-migration.

Table 1 (West Dunbartonshire Social and Economic Profile 2009-2010)

Age Bands	Number of Females	% Females	Number of Males	% Males	Total Persons	% Total
0-4	2,611	5.5%	2.728	6.3%	5,339	5.9%
5-9	2,352	4.9%	2,356	5.5	4,708	5.2%
10-14	2,505	5.2%	2,681	6.2%	5,186	5.7%
15-19	2,849	6.0%	3,080	7.1%	5,929	6.5%
20-24	3,100	6.5%	3,262	7.6%	6,362	7.0%
25-29	2,982	6.2%	2,928	6.8%	5,910	5.4%
30-34	2,591	5.4%	2,336	5.4%	4,927	5.4%
35-39	3,047	6.4%	2,671	6.2%	5,718	6.3%
40-44	3,752	7.9%	3,321	7.7%	7,073	7.8%
45-49	3,772	7.9%	3.375	7.8%	7,147	7.9%
50-54	3,486	7.3%	3,121	7.2%	6,607	7.3%
55-59	2,954	6.2%	2,733	6.4%	5,687	6.3%
60-64	2,864	6.0%	2,685	6.2%	5,549	6.1%
65-69	2,370	5.0%	1,892	4.4%	4,262	4.7%
70-74	2,081	4.4%	1,621	3.85	3,702	4.1%
75-79	1,897	4.0%	1,207	2.8%	3,104	3.4%
80-84	1,319	2.8%	716	1.7%	2,035	2.2%
85-89	823	1.7%	314	1.0%	1,137	1.3%
90+	403	0.8%	135	0.3%	538	0.6%
Total	**47,758**		**43,162**		**90,920**	

According to the Scottish Index of Multiple Deprivation (SIMD) 2009, West Dunbartonshire has 33 datazones in the 15% most income deprived category. Half the datazones in West Dunbartonshire are in the 30% most deprived on the overall SIMD with similar patterns showing in the income, employment, health and crime domains. The more deprived datazones in West Dunbartonshire are concentrated in the South East and the West of the area.

This Strategic Plan has benefited from up-to-date information within the *West Dunbartonshire Social and Economic Profile 2009-2010*; the *2010 Health and Wellbeing Profile for West Dunbartonshire*, the *2010 Children and Young People Health and Wellbeing Profile for West Dunbartonshire* and the *2011 Mental Health and Wellbeing Profile for West Dunbartonshire* (all produced by the Scottish Public Health Observatory), as well as the findings of the local Community Planning-sponsored *Health and Wellbeing Survey of West Dunbartonshire's 15% SIMD Areas.*

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. Recent guidance provided by the Scottish Government and COSLA entitled "Equal Communities in a Fairer Scotland: A Joint Statement" restates the underpinning principles for tackling high levels of deprivation. The Guidance seeks to connect the key aims uniting all three of the linked social policy frameworks - Achieving our Potential, Equally Well and the Early Years Framework - and the principles that underpinned Fairer Scotland Fund investment before the end of ring fencing, i.e.:

- A focus on investment and services that address the root causes of long standing concentrated multiple deprivation, not only alleviate its symptoms.
- Emphasis on making early interventions in vulnerable communities to address problems as quickly as possible.
- Encouraging effective joint working between community planning partners, including links to the third and private sectors.
- Focused action on improving employability and linking residents to employment opportunities as a key means of extending opportunity and tackling high levels of local deprivation.
- Support for community empowerment so that local communities become more resilient and deliver change themselves, and influence and inform the decisions make by community planning partners.

Single Outcome Agreements (SOA) are the means by which Community Planning Partnerships agree their strategic priorities for their local area, express those priorities as outcomes to be delivered by the partners, either individually or jointly, and show how those outcomes should contribute to the Scottish Government's relevant National Outcomes. The West Dunbartonshire SOA for 2011-14 expresses three priorities, with "health and wellbeing" explicitly addressed as a cross-cutting issue within each:

- Worklessness (tackling the work and poverty agenda)
- Early Years
- Safe, Strong and Involved Communities

Locally, the CHCP status as a joint vehicle for the planning, allocation and management of WDC and NHSGGC health and social care resources (both strategically and operationally) is recognised as a clear manifestation of community planning in practice (not least because of the community engagement mechanisms and elected member representation hardwired into its formal governance). The CPP's overall approach to population health improvement is reflective of an understanding that primary determinants of health are economic, social and environmental: i.e. its priorities on economic regeneration, education (particularly within, but not exclusive to, early years) and community safety all have a well recognised reciprocal relationship with health status (reinforced by the fact that the CHCP is represented on the thematic groups responsible for leading each of those work programmes).

Equalities, Health & Human Rights

The *Equality Act 2010* clarifies that having due regard for advancing equality involves:

- Removing or minimising disadvantages experienced by people due to their protected characteristics
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- Encouraging people with protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

The General Public Sector Equality Duty came into force on 5 April 2011, requiring public authorities in the exercise of their functions to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Scottish Ministers intend to make 'specific duties' which are intended to support the fulfillment of the general duties. Although not finalised yet, they are expected to be confirmed in 2012 and have been subject to extensive consultation with stakeholders. As of 2009, both WDC and NHSGGC have each had a single Equality Scheme. The WDC Equality Scheme 2009-12 sets out how and when the Council will meet its objectives in relation to the promotion of equal opportunities across the following protected characteristics: disability; gender reassignment; race (this includes ethnic or national origins, colour and nationality); religion or belief; sex; sexual orientation; marriage and civil partnership; and pregnancy and maternity. Similarly the NHSGGC Equality Scheme 2010-13 specifies the commitment of NHS Greater Glasgow and Clyde to meet its General and Specific Public Duties under the, Act as well as addressing socio-economic disadvantage because of the adverse consequences it has on people's health (as reinforced for the CHCP within its Scheme of Establishment).

Equalities legislation requires that new or significantly changing policies or services and financial decisions should be subject to an assessment of their impact on the wellbeing of certain groups of people. The CHCP is committed to:

- Strengthening an inequalities sensitive approach across all its operational service plans (e.g. through application of equality impact assessments).
- Continuing to develop those services that by definition have a particular focus on equalities concerns.
- The on-going development of competencies and skills on inequalities in the Continuous Professional Development of staff**.**
- The on-going development of effective and representative arrangements for community engagement.
- Maintaining a focus on equalities and inequalities issues through the CHCP's working relationships with other providers and contractors; and its active involvement in key partnerships (notably the local CPP).

The *Patient Rights (Scotland) Act 2011* supports the Scottish Government's vision for a high quality, person-centred NHS. The Act applies to every member of staff working for NHS Scotland, and for all independent contractors and their staff who provide NHS services. The Act states that everyone involved in the delivery of NHS services in Scotland, and their employers, must uphold a set of Healthcare Principles that underpin quality care and treatment. Providers of NHS services throughout the country practise these principles every day, and now the Act sets them out in law. The principles cover the following:

- Patient Focus – each patient's needs, circumstances, opinions and abilities must be taken into account when they receive healthcare. Privacy and confidentiality should be respected and patients should receive any support they need to enable them to access healthcare.
- Quality Care and Treatment – healthcare should be based on current clinical guidelines and standards and should be provided in such a way as to avoid any unnecessary harm or injury to the patient. Healthcare providers should consider the range of treatment options available to the patient.
- Patient Participation – patients should be encouraged to take part in decisions about their health and wellbeing, and given any information or support that they need. They should be encouraged to treat healthcare staff with dignity and respect.
- Communication – patients should be communicated with in a way that they can understand and healthcare staff should make sure that the patient has understood the information given.
- Patient Feedback – all staff should be able to listen and respond to feedback, comments and concerns appropriately, effectively and efficiently. They should also ensure that complaints are dealt with according to the NHS complaints procedure.
- Best Use of Resources – healthcare staff and patients should make sure that resources are used as efficiently as possible.

The Act introduces a Charter of Patient Rights and Responsibilities which will bring together a summary of the rights and responsibilities that patients have when using NHS services and outlines the new ones. The Scottish Government will consult on the content of the Charter of Patient Rights and Responsibilities and its format before it is published in autumn 2012. In addition to patient rights, the Act sets out how staff should be treated. All staff providing NHS services must:

- Be treated with dignity and respect.
- Have their views valued and opinions respected.
- Be supported by their employers to make improvements to their working practices, processes and systems where this demonstrates real benefits and positive outcomes for both staff and patients.

From the perspective of the CHCP, we see the above principles and ethos being relevant to and applicable across the breadth of our health and social care responsibilities - and so are committed to ensuring they are promoted and embraced as such for and by all our staff and those we provide services for and with.

The Scottish Government's *Self-Directed Support: A National Strategy for Scotland* (2010) defined s*elf-directed support (SDS)* as a term that describes the ways in which individuals and families can have informed choice about the way support is provided to them. It includes a range of options for exercising those choices. Through a co-production approach to agreeing individual outcomes, options are considered for ways in which available resources can be used so people can have greater levels of control over how their support needs are met, and by whom. The choice may include taking a *Direct Payment (DP),* having a direct payment managed by a third party, or directing the *Individual Budget* to arrange support from the local authority or from a commissioned provider. The choice can also be for a combination of these. The fundamental principles of SDS are choice and control. Choice is evident where people are able to choose how they live their life, where they live and what they do. People have control of their support by determining and executing the who, what, when and how of the provision. The principles of SDS are also strongly linked to those of recovery, rehabilitation and re-ablement. It is a shift to doing things with people who require support, patients and carers, rather than to them, within the framework of outcome planning and co-production. At the heart of this are good personalised and co-produced assessment, service design and care management and review. Shared messages within such approaches are:

- A change in culture of service provision from task and time approaches to better outcomes and on focussed goals.
- Doing with the service user/patient/carer rather than doing to or for.
- Maximising people's long term independence and quality of life.
- *Appropriately* minimising ongoing support - and thereby minimising the whole life cost of care.

The Scottish Government introduced its Social Care (Self-directed Support) (Scotland) Bill in February 2012, which is working its way through the legislative process. The policy objective of the Bill is to make legislative provisions relating to the arranging of care and support (community care services and children's services) in order to provide a range of choices to individuals as to how they are to be provided with their support. It would introduce the language and terminology of self-directed support into statute; and would places a duty on local authorities to offer four options to individuals who they assess as requiring care and support. It would require authorities to provide information and assistance to individuals in order that they can make an informed choice about the options available. It also provides a discretionary power to authorities in order that they can provide support to carers following a carer's assessment. It also repeals and reframes provisions relating to direct payments.

The CHCP has a well established mechanism for direct payments that has been operating within a wider context of its commitment to **personalisation**. However, the CHCP recognises that if enacted, the new legislation will require adjustments to the arrangements that are in place. Two different SDS pilots are underway locally (as highlighted under the Quality sub-section of this Strategic Plan), the outputs of which will contribute to the formulation of an up-to-date local Personalisation Strategy and attendant local SDS policy that will be first consulted upon (included being subjected to a comprehensive equality impact assessment) before then being presented to the CHCP Committee for consideration and approval (as committed to within this Strategic Plan).

5. DELIVERING OUR OUTCOMES

Outcome	Actions for 2012/13	Key Performance Indicators
Acute Services Improved secondary care Interface with primary care and partners.	Work in partnership with NHSGGC Acute Division services to improve the management of GP to hospital referrals through use of electronic referrals (SCI-Gateway). Review referral rates and share data with GPs, including review of frequent attendees. Ensure regular monitoring reports provided to the CHCP Committee, PPF and local Mental Health Forum on the arrangements for the NHSGGC Vision for the Vale.	Rates of attendance at Accident & Emergency (per 100,000). Number of people waiting more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete.
Adult Mental Health Delivery of care on a timely basis in the right settings, which focuses on recovery. Promote positive mental health.	Continue to ensure that services meet the referral to treatment target for psychological therapies. Continue to work with GPs to ensure anti-depressant prescribing in is line with good practice and explore potential alternatives. Integrate the Ardmore day hospital staff into the Older Adults Community Mental Health Team (Cairnmhor Resource Centre). Roll out Adults With Incapacity (AWI) training Scotland 2000 to acute and mental health staff. Refresh internal processes for ensuring that guardianship cases are appropriately allocated to a supervising social worker for monitoring, support and review. Refresh local Mental Health Improvement Plan to incorporate local Choose Life suicide prevention action plan. Develop self harm awareness DVD in parallel with teaching pack in partnership with PACE theatre group, Renfrewshire Council and Glasgow City CHP. Complete and agree local Mental Health Commissioning Strategy.	Mean number of weeks for referral to treatment for Psychological Therapies. Reduce the annual rate of increase of defined daily dose per capita Citalopram/Fluoxotine/Sertraline prescribing for patients aged +15 years. Reduce the annual rate of increase of defined daily dose per capita Escitalopram prescribing for patients aged +15 years. Number of adult mental health patients waiting more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete. Suicide rate.

Outcome	Actions for 2012-2013	Key Performance Indicators
Alcohol & Drugs Deliver better care through early intervention. Reduce levels of alcohol consumption. Reduce use of illegal drugs.	Continue to ensure services meet the access target for drug and alcohol services. Continue to promote alcohol brief interventions (ABI) across all services and GP practices. Continue to lead implementation of the Alcohol & Drug Partnership (ADP) Community Planning Alcohol and Drug Strategy.	Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. Number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention (in line with SIGN 74 guidelines). Rate of emergency hospital admissions for alcohol misuse for people aged 16 years and over (per 100,000 population). Deaths from drug misuse per 100,000 population.
Cancer The incidence of cancer among the population is reduced through primary prevention.	Continue implementation of CHCP Cancer Information Action Plan, including focus on improved awareness of signs and symptoms of cancer. Continue to monitor cancer screening rates at practice and SIMD level, working with locality groups and individual GP practices. Use the Supportive and Palliative Action Register (SPAR) to aid the identification of cancer (as well as non-cancer) patients entering a palliative phase.	Percentage uptake of cervical screening by 21-60 year olds (excluding women with no cervix). Percentage uptake of bowel screening. Percentage of those invited attending for breast screening.

Outcome	Actions for 2012-2013	Key Performance Indicators
Child & Maternal Health (1) There is a focus on early intervention in the lives of women children and young people. Provide opportunities to enable young people at risk to have positive chances and make positive choices in their life.	Establish authority-wide Child and Adolescent Mental Health Service. Implement Young People's Mental Health and Emotional Wellbeing Review and Improvement Group Work Plan Achieve 105 completers for Child Healthy Weight evidence-based programmes for reporting period 2012/13. Develop and implement action plan to maintain UNICEF Baby Friendly Community Stage 3 accreditation. Continue to implement requirements of CEL 15: *Refresh of Health for All Children*. Implement Releasing Time to Care across Health Visiting Service. Completion of pilot of SHANARRI based assessment tool for health visitors. Develop and plan for implementation of Early Years Change Fund, including: • Enhanced implementation of CPP Parenting Strategy. • Continue to ensure application of Getting it Right for Every Child.	Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS). Completion rates for child healthy weight intervention programme. Percentage breastfeeding at 6-8 weeks. Percentage of measles, mumps and rubella immunisation at 24 months. Percentage of measles, mumps and rubella immunisation at 5 years. Percentage of Human Papilloma Virus (HPV) vaccinations – school routine cohort S2. Percentage of Human Papilloma Virus (HPV) vaccinations – school routine cohorts S2, S4 and S5.

Outcome	Actions for 2012-2013	Key Performance Indicators
Child & Maternal Health (2) There is a focus on early intervention in the lives of women children and young people. Provide opportunities to enable young people at risk to have positive chances and make positive choices in their life.	Contribute to development of additional smoking cessation Maternity Hub. Support 100% nursery participation in the Childsmile oral health programme. Support 100% primary school participation in the Childsmile oral health programme. Continue involvement in cross-local authority Multi-Dimensional Treatment and Foster Care (MTFC) service. Continue to implement requirements of CEL 16 (2009) to ensure that Looked After Children receive the same level of primary and secondary health care as the general child population. Implement Children with Disabilities Review and Improvement Group Work Plan, including: • Improve transition arrangements for children with learning disabilities into adult services. • Develop an authority-wide service to support children and young people with complex health needs in the community (including respite). Complete and agree Children's Services Commissioning Strategy.	Percentage smoking in pregnancy. Percentage of five year olds (P1) with no sign of dental disease. Percentage of 3 and 4 year olds in each SIMD quintile to have consented to fluoride varnishing twice a year. Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care.

Outcome	Actions for 2012-2013	Key Performance Indicators
<u>Long Term Conditions & Disabilities</u> Have services which are focused on effective assessment, early intervention and maximising opportunities for recovery and enablement.	Implement integrated structure for rehabilitation and enablement services. Introduce Local Enhanced Service (LES) for general practice to identify patients-at-risk. Introduce Anticipatory Care Plan Nursing team. Continue to offer healthy eating/weight management community group programmes with targeting in deprived areas Ensure the delivery of Live Active programme, targeting deprived areas. Support local GP practices participating and delivering cardiovascular health checks. Support Community Pharmacy Chronic Medication Service. Develop and support CH(C)P-led Optometry Network. Continue to develop training and education with NHS Education Scotland for community optometrists. Continue to support improvement in Eye Care Acute-Primary Care interface, including direct referrals. Develop community optometry role in providing low vision aids. Complete Optometry Formulary development and sponsor roll out across community optometry. Continue process of up-dating IT systems that support NHSGGC Diabetic Retinal Screening Service.	Percentage of at-risk clients with anticipatory care plans. Percentage of anticipatory care plans reviewed within agreed timescale. Number of inequalities targeted cardiovascular Health Checks during 2012/13.

Outcome	Actions for 2012-2013	Key Performance Indicators
Older People Increase proportion of older people (65 years+) needing care or support who are able to sustain an independent quality of life as part of the community. People with dementia and their carers receive the treatment, care and support following diagnosis that enables them to live as well as possible. People are able to die with dignity in a place of their own choosing needs and aspirations	Continue to implement Local Older People's Change Fund Plan, including: • Improve coordination, ensuring that information is updated and shared. • Develop networked services with WDCVS to build on community capacity. • Develop a LinkUp service to streamline referrals from and between the Third and Independent Sectors. • Develop a dedicated helpline number manned by volunteers. • Develop a shared assessment process between key Third Sector delivery partners. • Procure new models of care at home. • Manage Out of Hours Nursing, Home Care, Sheltered Housing, Care Homes, and Mobile Attendants as neighbourhood-oriented and networked teams. • Continue to develop medication-related training for CHCP Home Care staff. • Introduce day care reablement and reablement in short term care home placements. • Deliver a case management service for dementia clients and their carers and who are currently not managed by traditional mental health specialist services. • Develop partnership with Alzheimer's Scotland and WDCVS to develop social supports for patients with dementia and their carers. • In partnership with NHSGGC Acute Division, increase the available palliative care beds and provide additional Community Palliative Specialist Nurse capacity. Implement improvement action plans as required for CHCP-operated residential care homes, providing regular reports to CHCP Committee. Support the development of independent sector care home provision in line with priorities within CHCP Older People's Service Commissioning Strategy. Continue to develop quality of Residential Care Home provision, including preparing formal proposals and business case for future provision.	Total number of homecare hours provided as a rate per 1,000 (65+). Percentage of homecare clients aged 65+ receiving personal care. Number of people in care home placements in the month (65+). Percentage of people 65+ admitted twice or more, as an emergency, who have not had an assessment. Emergency inpatient bed days rate for people aged 75 and over (per 1,000 population). Number of patients not in short-stay waiting more than 4 weeks for discharge to appropriate care setting. Number of patients on dementia register. Total number of patient deaths at home on the Liverpool Care Pathway.

Outcome	Actions for 2012-2013	Key Performance Indicators
<u>Primary Care</u> Develop access and engagement with services.	Continue to implement NHSGGC Primary Care Framework, including: • Establish process of monthly reports from Practitioner Services on list admission and deletions reported to Locality Groups. • Provide Locality Groups with core data set, including key targets, clinical quality indicators and population health measures. • Develop Practice Manager Group as local access group delegated to provide peer support and review approaches to access. • Utilising Local Citizens Panel and GP Patient Experience questionnaire to audit local access arrangements – results to PPF and Locality Groups. Support roll out of the Scottish Patient Safety programme to primary care. Continue to work with GPs to encourage and support appropriate formulary prescribing. Implement a single system MSK physiotherapy service across NHSGGC. Implement the key recommendations from the NHSGGC MSK physiotherapy redesign sub-group. Develop patient specific pathways for MSK physiotherapy service. Standardise demand and activity data across MSK physiotherapy service. Introduce outcome measures NHSGGC-wide to evaluate the impact of physiotherapy - pre and post intervention - on patients' pain, functions of daily life and work status. Oversee delivery of the new Vale Centre for Health and Care.	Percentage of patients achieved 48 hour access to appropriate GP practice team. Percentage of GP practices opting into Medicines Management Local Enhanced Service (LES). Average waiting times for MSK physiotherapy services.

Outcome	Actions for 2012-2013	Key Performance Indicators
Public Protection & Criminal Justice Children and vulnerable adults are protected from abuse, harm and neglect.	Implement action plan in response to Child Protection Inspection report. Continue to ensure that staff and independent contractors are appropriately trained and supported with robust systems to: identify harm; assess risk; manage risk; and work with other agencies. Continue to ensure there are clear plans in place on: Child Protection; Adult Support and Protection; MAPPA; and the Mental Health Act. Undertake Adult Support and Protection biannual self-evaluation process. Work with WDC HEED to review arrangements for Women's Aid across the area. Continue to deliver Women's Support Service. Review Criminal Justice Services for Women Offenders. Implement Criminal Justice Partnership Performance Improvement Action Plan. Review Criminal Justice Partnership Commissioning Strategy. Undertake audits of use of all risk assessment tools within criminal justice services. Lead and implement relevant actions agreed within local Violence Against Women Partnership programme of work. Extend Children Experiencing Domestic Abuse Recovery (CEDAR) project.	Percentage of children on the Child Protection Register who have a completed and up-to-date risk assessment. Percentage of children and young people who are supported at home under statutory supervision. Rate per 1,000 of children/young people aged 8-18 who are referred to the Reporter on offence-related. Percentage of Adult Support and Protection clients who have current risk assessments and care plan. Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling. Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.

Note: The actions above include key CHCP commitments within the Argyll, Bute & Dunbartonshires' Criminal Justice Partnership agreed Planning & Performance Improvement Framework.

Outcome	Actions for 2012-2013	Key Performance Indicators
Sexual Health Promote sexual wellbeing and prevent sexual ill health.	Continue to provide support for the delivery of high quality consistent sexual health and relationships education in schools. Continue to support sexual health training of staff working with Looked After and Accommodate Children (LAAC) and staff working with foster parents. Implement Family Nurse Partnership (FNP) pilot in collaboration with Glasgow City CHP. Complete analysis of local teenage pregnancy profile, and key actions for implementation (including through FNP pilot). Continue to support the delivery of NHSGGC free condom distribution service. Continue to lead local Sexual Health Strategy Group.	Reduction in teenage pregnancy rates per 1,000 girls aged 13 to 15 years.
Employability, Financial Inclusion & Responding To The Recession Improve the health of our staff. Maximise organisation's contribution to economic regeneration to reduce poverty and income inequality.	Achieve Healthy Working Lives Gold Award for the CHCP. Lead WDC Healthy Working Lives Gold Award maintenance action plan. Continue to develop opportunities for signposting from and referral to advice giving and employability services. Take on and provide support to modern apprentices. Continue to contribute to and undertaken relevant actions from within Community Planning Partnership priority work programme focused on *Work and Benefits*.	Number of patients referred for financial inclusion advice and outcomes.

Outcome	Actions for 2012-2013	Key Performance Indicators
Health Improvement Reduce prevalence of smoking.	Continue to ensure that services deliver smoking cessation targets. Continue with targeting smoking cessation delivery with focus in SIMD 1 areas in parallel with insight gathering from Equally Well Test Site e.g. social marketing approaches. Continue to implement Raising the Issue of Tobacco training plan. Implement action plan for roll out of Smoke Free Schools Award Implement training action plan for Second Hand Smoke awareness. Continue to lead on health improvement and health inequalities across and on behalf of local Community Planning Partnership.	Total number of successful quits (at one month post quit) delivered by community-based universal smoking cessation service. Total number of successful quits (at one month post quit) delivered by community-based universal smoking within specified SIMD areas of high socio-economic deprivation.
Quality (1) Care and services are provided in partnership with people, treating individuals with dignity, empathy and respect, based on their strengths, needs, experiences and preferences.	Continue to ensure that effective complaints processes are in place. Submit Initial Scrutiny Level Assessment (ISLA) material to Care Inspectorate on schedule. Complete scheduled case file audits in preparation for Care Inspectorate inspection. Develop local Personalisation Strategy and policy for self-directed support. In partnership with RNIB (Royal National Institute for Blind People) and Lomond & Argyll Advocacy Services develop Scottish-Government funded pilot on self-directed support. In partnership with In Control Scotland, develop pilot on self-directed support focused on children with learning disabilities (and their families). Continue to ensure that PPF and relevant patient / carer fora are involved across CHCP services and developments.	Percentage of complaints received and responded to within 20 working days (NHS policy). Percentage of complaints received which were responded to within 28 days (WDC policy).

Outcome	Actions for 2012-2013	Key Performance Indicators
Quality (2) Care and services are safe and effective.	Continue to ensure application of absence management requirements/policies. Continue to support staff through supervision and PDPs. Agree integrated CHCP Workforce Development Plan. Evidence routine application of appropriate recruitment and vetting procedures. Streamline and consolidate SSSC monitoring and maintance system. Continue to ensure CHCP Committee arrangements meet public accountability requirements. Implement actions agreed from CHCP corporate/strategic level PSIF. Refresh and continue programme of operational-level PSIFs. Continue to ensure CHCP meets its requirements for NHS Staff Governance Standard. Up-date and continue to maintain integrated CHCP Risk Register. Contribute to civil and business continuity arrangements both within NHSGGC and WDC. Agree and implement integrated Health & Safety Protocol. Continue to improve effective ICT systems, including mobile technology. Promote behaviours expressed by the NHSGGC Facing the Future Together programme.	Average number of working days lost per WD CHCP Council employees through sickness absence. Sickness/absence rate amongst WD CHCP NHS employees. Percentage of WD CHCP Council staff who have an annual PDP in place. Percentage of WD CHCP NHS staff who have an annual e-KSF review/PDP in place.
Sustainability Workforce is supported to act in a sustainable way.	Continue to contribute carbon management processes both within NHSGGC and WDC. Through Community Planning Partnership arrangements, continue to work with partners on a range of sustainability issues.	Levels of energy-based carbon emissions and energy consumption.

Outcome	Actions for 2012-2013	Key Performance Indicators
Tackling Inequalities Service plans resulting from new planning and policy arrangements clearly demonstrate how they will promote equality and remove discrimination.	Undertake review of social transport provision, preparing refreshed scope and eligibility criteria that ensures compliance with Equality Act 2010 for formal consideration. Continued roll out of equality impact assessment programme to cover wider range of services in line with priorities identified through the planning process. Establish partnership agreement with WD CVS to enhance CHCP engagement with representative organisations. Undertake equalities assessments of all financial plans to prevent unlawful decisions and to minimise the impact for Equality groups or those experiencing health inequalities. Continue to work with Community Planning Partnership community engagement structures to enhance diversity and representativeness of community engagement with CHCP.	Number of quality assured Equality Impacts Assessments.
Unpaid Care Carers are fully supported in their caring role.	Support carers through Carers of West Dunbartonshire and do this in partnership with West Dunbartonshire CVS. Establish a bureau model for older peoples respite services. Align the development of supported self and carer's support by sponsoring a collaborative project bringing together our investment from the Carers Information Strategy, Long Term Conditions Funding and the Change Fund. Raise awareness of CHCP staff of carers' needs, the role carers play in supporting self care particularly in areas of Diabetes, COPD, Stroke, and Dementia. Continue to work with McMillan, Carers of West Dunbartonshire to deliver training and education for patients and carers with long term conditions. Roll out of findings of Young Carer school pilot across secondary schools.	Percentage of carers who feel supported and capable to continue in their role as a carer. Total number of respite weeks provided to all client groups.

Wider Geographic Functions

- NHSGGC Community Eye Care Service

  The CHCP is responsible for supporting continuing development of community eye care services across NHSGGC, including retinal screening; community optometry networks; locally accessible services for visually impaired adults; and direct referrals from community optometrists to acute eye care services.

  Key actions for 2012-13:
  - Develop and support CH(C)P-led Optometry Network.
  - Continue to develop training and education with NHS Education Scotland for community optometrists.
  - Continue to support improvement in Eye Care Acute-Primary Care interface, including direct referrals.
  - Develop community optometry role in providing low vision aids.
  - Complete Optometry Formulary development and sponsor roll out across community optometry.
  - Continue process of up-dating IT systems that support NHSGGC Diabetic Retinal Screening Service.

- NHSGGC Musculoskeletal Physiotherapy Service

  From the 1st of April 2012, the CHCP has taken on responsibility for the management of the Musculoskeletal (MSK) Physiotherapy Service across NHSGGC. This development is part of the wider re-alignment and introduction of "hosted" arrangements for Allied Health Professional services - specifically, MSK physiotherapy, podiatry and dietetics - across NHSGGC.

  Key actions for 2012-13:
  - Implement a single system MSK physiotherapy service across NHSGGC.
  - Implement the key recommendations from the NHSGGC MSK physiotherapy redesign sub-group.
  - Develop patient specific pathways for MSK physiotherapy service.
  - Standardise demand and activity data across MSK physiotherapy service.
  - Introduce outcome measures NHSGGC-wide to evaluate the impact of physiotherapy - pre and post intervention - on patients' pain, functions of daily life and work status.

- Management of Argyll, Bute and Dunbartonshire's Criminal Justice Social Work Partnership

  Criminal Justice Social Work Services are delivered within a formal partnership arrangement between West Dunbartonshire, East Dunbartonshire and Argyll and Bute. Accountability is achieved to the member councils via a Joint Committee with delegated powers, comprising elected members from each council. Staff are employed by their host Local Authority although a number have remits which extend across authority boundaries. The overall management of the service rests with a Partnership Manager (with a single Partnership budget) – this post and responsibility are held by West Dunbartonshire CHCP.

  The Criminal Justice Social Work Partnership's Strategic Plan 2011/14 sets out five priority areas: assessment; supervision; workforce development; resource planning and commissioning; and management and performance improvement. It highlights the following strategic objectives:
  - Improved quality and consistency of criminal justice assessments.
  - Improved case/risk management.
  - Successful implementation of Community Payback Orders (CPO).
  - Improve and maintain skills/competence of staff.
  - Effective deployment of resources to meet current and projected need.

  Key actions for 2012-13:
  - Review Criminal Justice Services for Women Offenders.
  - Implement Criminal Justice Partnership Performance Improvement Action Plan.
  - Review implementation of Criminal Justice Partnership Commissioning Strategy.
  - Implement audits of use all risk assessment tools within criminal justice services.

6. EFFECTIVE ORGANISATION

Performance Management

At its inaugural meeting in October 2010 the CHCP Committee approved an action plan for the first six months of the new entity's development. This included the requirement that the "NHS and WDC look at respective performance management arrangements to identify joint performance measures and performance indicators". That requirement has guided the arrangements that are summarised below, underpinned by an understanding of the evidence-base in relation to the effective partnership delivery arrangements; and also reflections on more specific sources of learning, notably the findings of the Scottish Government's Study of CHPs (2010).

During 2011, Audit Scotland published the findings of an audit of all CHPs across Scotland to examine whether they were achieving what they were set up to deliver, including their contribution to moving care from hospital settings to the community and improving the health and quality of life of local people. The audit also attempted to assess governance and accountability arrangements, and the efficient use of resources. The report highlighted a range of key good practice principles that the CHCP Committee and Senior Management Team understand (including within the aforementioned six month action plan) and have underscored the importance of maintaining attention to as part of the continued organisational and strategic development of West Dunbartonshire CHCP. These include:

- Personal commitment from the partnership leaders and staff for the joint strategy.
- Understanding and respecting differences in organisations' cultures and practice.
- Clarity of vision and strategy.
- Clear decision-making and accountability structures and processes.
- Agreeing what success looks like and indicators for measuring progress.
- Implementing a system for managing and reporting on performance.
- Achieving efficiencies through sharing resources, including money, staff, premises and equipment.
- Accessing specific initiative funding made available for joint working between health and social care.

All of the issues highlighted within the Report are reflective of the wider theoretical evidence-base, with the substance of the Report explicitly accepting the increasingly ambitious agendas and complex environment that CH(C)Ps have to operate and lead within, including that:

- Partnership working across organisational boundaries is complex due to differences in organisational cultures, priorities, planning and performance management, decision-making, accountability and financial frameworks.
- Performance reporting arrangements can be challenging as they need to account for various national and local performance monitoring systems and targets for the NHS and councils which are not necessarily aligned.
- Governance arrangements for integrated CHCPs are generally more complex because they need to take account of different lines of accountability and the existing corporate governance arrangements for both partners.

- Health inequalities are complex, with socio-economic factors such as low income, gender, social position, ethnic origin, age and disability increasing the risks of poor health.

The Report concludes by making a number of recommendations (bullet points below) for NHS Boards and Councils, all of which have been addressed within West Dunbartonshire and continue to provide a focus for the CHCP as follows (and has been endorsed by the CHCP Committee):

- Work with Scottish Government to streamline existing partnership arrangement.

This was addressed by the establishment of the CHCP itself; and the CHCP's active engagement within the strategic arrangement for the local Community Planning Partnership.

- Put in place transparent governance and accountability arrangements.

Locally this is exampled by the Scheme of Establishment agreed for the CHCP and the recommendations agreed from the comprehensive CHCP Community Engagement Review approved during 2011/12.

- Have a clear joint strategy for delivering health and social care services.

Locally this was addressed in the priority work programme set out within the action plan for the first six months of the new CHCP's operation; and the integrated approach and actions clearly set out within the CHCP Strategic Plans for 2011/12 and now 2012/13.

- Clearly define objectives for measuring CHP performance; and implement a system for reporting performance to stakeholders.

Locally, robust examples of how this is being attended to include the development of agreed Key Performance Indicators (KPIs) reported to the CHCP Committee; and a joint Organisational Performance Review process (as described further on).

- Collect, monitor and report data on costs, staff and activity levels.

Examples of how this has been addressed would be the inclusion of staff absence indicators (for both NHSGGC and WDC employees) within the CHCP agreed KPIs; and the development of a single, integrated CHCP workforce development plan.

- Improve financial management and reporting.

This is already a robust feature of the routine reports provided to the CHCP Committee on the separate budgets devolved to the CHCP by both its parent organisations. It is important to note that the West Dunbartonshire CHCP has maintained a strong track-record in delivering financial balance and necessary efficiency savings with respect to both its NHS and WDC budgets.

- Involve GPs in planning services and work with them to address variations in their prescribing and referral practice.

This has been addressed locally by refreshing the Professional Advisory Group (PAG) arrangements and the practice-led locality groups sponsored by the CHCP (under the chair of the CHCP Clinical Director); the lead role for GPs that the CHCP has supported within condition-specific planning groups (e.g. GP chairing local diabetes group); and the strong track record of effective support provided to individual practices by the CHCP's local Prescribing Support Team. Across the NHS GGC area it is noteworthy that this CHCP has been able to demonstrate upper quartile performance in a range of prescribing management indicators.

It is important to appreciate that many of the points highlighted are generic issues of good practice, i.e. they apply irrespective of the organisational and management arrangements that are in place for the planning, management and wider co-ordination of community health and care services. The Audit Scotland report itself does acknowledge this within its text, most pointedly in stating: *partnership working depends on good local relationships, commitment and clarity of purpose, irrespective of structural arrangements*.

As agreed then, corporate CHCP performance management for 2012/13 will focus on the priority actions as described within this Strategic Plan. As for the previous year, a suite of Key Performance Indicators (KPIs) has been utilised - and are identified - across the actions set out within this Strategic Plan. They represent a combination of obligatory national indicators (both local authority and NHS) and locally determined indicators, which are reflective of the span of the CHCP's responsibilities. Two key criteria for inclusion have been the availability of robust data at a West Dunbartonshire level; and the frequency of data publication (as both are critical to enable meaningful performance management, either in-year or on an annual basis). These KPIs capture the national NHS HEAT (Health improvement, Efficiency, Access, Treatment) targets for 2012/13 that are pertinent to the CHCP; and the most recent agreed WDC Corporate Performance Indicators that have been allocated to the CHCP. They also address the requirement agreed within to Council's most recent Assurance and Improvement Plan (AIP) to sharpen local corporate health and wellbeing indicators.

Corporate performance management and scrutiny is primarily undertaken at three-levels:

- Internal performance management by the CHCP Senior Management Team (SMT) fulfilling the role of a performance scrutiny panel, with dedicated peer-review of progress as part of regular SMT meetings.

- Performance management by both "parent" organisations via the agreed joint Organisational Performance Review process for the CHCP. These sessions are co-chaired by the Chief Executives of both NHSGGC and WDC; and take place six monthly. This process includes reflections on local performance against a much wider and organic set of measures/indicators collated by the parent organisations.

- Partnership scrutiny through the formal governance structures represented by the CHCP Committee, to whom consolidated performance reports are presented for consideration by alongside papers of discrete activities, achievements and concerns (all of which are made publicly available following the meetings). The formal feedback agreed by both Chief Executives from each OPR is also reported back to the CHCP Committee alongside the consolidated report in order to further inform the Committee's deliberations and discussion.

The above is reinforced by the delivery of collective and specified actions being reflected within the individual objectives of the CHCP Director and Heads of Service. Furthermore, the work of each CHCP service area will be underpinned by individual operational service plans by which Heads of Service set out local targets, performance indicators, and activities; and can provide assurance regarding relevant contributions required for KPIs and the achievement of the actions within this CHCP Strategic Plan.

This process is inevitably subject to on-going refinement, but has certainly operated effectively to-date the satisfaction of the members of the CHCP Committee as well as both the Chief Executives of the NHSGGC and WDC.

Strategic Commissioning

The Institute of Public Care (IPC) has defined a commissioning strategy as "a formal statement of plans, for specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the NHS, the Local Authority, other public agencies or by the voluntary and private sectors". Audit Scotland have emphasised their expectation that good commissioning of these services is essential to ensure that high quality sustainable services are available to all those who need them; and that NHS boards and councils need to work together to agree strategic commissioning plans. An explicit action identified from the former Social Work Inspection Agency (SWIA) assessment undertaken of the previous Social Work and Health Department was the production and approval of a range of commissioning strategies to span the breadth of service delivery responsibilities. This is an action that the successor Care Inspectorate will be seeking evidence of material progress on during its scheduled inspection of the CHCP in 2012. As part of an explicit commitment within CHCP Strategic Plan 2011-12, the CHCP developed a schedule for the delivery of commissioning strategies across the breadth of its service delivery responsibilities. This commitment was reinforced as an objective within the most recent WDC Assurance and Improvement Plan. During 2011/12 the following commissioning strategies where presented to, considered and then approved by the CHCP Committee: Alcohol and Drug Services; Adult Rehabilitation Services; Adult Learning Disability Services; and Older People Services. In addition, a Criminal Justice Services Commissioning Strategy was presented to and approved by the Argyll, Bute and Dunbartonshires' Criminal Justice Partnership Committee. A further two are scheduled for completion during 2012/13: Adult Mental Health Services; and Children's Services.

There are four core values that have been identified to underpin all the CHCP's cyclical approach to strategic commissioning across the breadth of its service delivery responsibilities, namely: quality; fairness; sustainability; and openness. These values will be manifested through a systematic concern for the following principles ensuring:

- Optimal outcomes for individual service users.
- A client-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services.
- Effective and safe services that draw upon the best available evidence and local feedback from service users.
- Equalities-sensitive practice.
- Acceptability of service provision informed through constructive engagement with local stakeholders, including staff, community groups and elected members.
- Affordable and efficient services that continue to be reflective of the relative demands across the West Dunbartonshire population as a whole.

Audit Scotland's recent report on social care commissioning underscored the importance of and technical complexities of establishing comprehensive long-term strategic commissioning. Consequently, the high-level documents noted above are recognised as being "live" products – as per the cyclical nature of the process – that will be reviewed and formally up-dated to reflect emergent data and analysis (particularly in relation to budgeting and benchmarking) in line with the "gold standard" ambitions of all involved.

Strategic Risk Management

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

To assist the CHCP to manage and monitoring such risks, it has developed an integrated CHCP Strategic Risk Register that both feeds the Corporate Risk Registers of its parent organisations; and is itself supported by operational service risk registers. At the time of writing this Strategic Plan, the following risks have been prioritised within the CHCP Strategic Risk Register as draft subject to formal Senior Management Team agreement (listed below in no particular order):

- Failure to meet legislative compliance in relation to child protection.
- Failure to meet legislative compliance in relation to adult support & protection.
- Failure to deliver efficiency savings targets and operate within allocated budgets.
- Failure to identify and/or then mitigate any significantly adverse effects to patients/clients – including protected equality groups – that may arise as an unintended consequence of delivering financial targets.
- Failure to promote patient safety measures (including infection control standards).
- Failure to deliver new Vale Centre for Health & Care on schedule.
- Failure to moderate and contingency plan for flood risk for site of Dumbarton Health Centre (SEPA flood map identifies a 1:200 risk for this location).
- Failure to mitigate risks to NHSGGC-wide Diabetic Screening Service of heavy dependence on IT systems through on-going process of their being updated.
- Failure to ensure that guardianship cases are appropriately allocated to a supervising social worker for monitoring, support and review.
- Failure to ensure that services are delivered by appropriately qualified and/or professionally registered staff.
- Failure to monitor and ensure the wellbeing of people in independent or WDC residential care facilities.

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

Continuous Improvement

CHCP staff and services have a strong track record of working in partnership. The smooth establishment of the CHCP was itself a major expression of the positive culture of joint working that has been developed over time. Strong examples of how staff come together to debate, listen and reflect are the service planning activities that routinely take place; the willingness of service leads and managers to participate in engagement sessions with the public (e.g. the local PPF); and the strong and enthusiastic participation in multi-disciplinary Protected Learning Events. Indeed, the evaluation of our most recent whole CHCP Protected Learning Event (November 2011) evidenced that 95% of all those who participated felt that the programme met their expectations either well or very well.

The Senior Management Team is particularly committed to fostering a culture of critical self-evaluation across and within CHCP staff and services. The CHCP has adopted the Public Service Improvement Framework (PSIF) as its over-arching organisational development approach to systematically driving this forward. The CHCP is committed to working within this recognised framework for continuous improvement, having worked closely with the former Social Work Inspection Agency (now care Inspectorate) on their revised methodology for self evaluation; and spearheading work within WDC to take forward the Public Service Improvement Framework (PSIF). Both frameworks have been cross-mapped, are compatible and provide a basis for self evaluation and continuous improvement.

Self evaluation will be a key component of external scrutiny arrangements, with the CHCP scheduled for a formal inspection by the Care Inspectorate during 2013. A programme of operational-level PSIF has been undertaken through 2011/12 (e.g. adult learning disabilities service), with more scheduled for 2012/13 (e.g. child protection arrangements). Notably, the CHCP has recently completed a corporate/strategic PSIF exercise with support from the Improvement Service and Quality Scotland. The following are the (1) notable strengths, and (2) areas for improvement (AFIs) identified through the PSIF assessment that were prioritised by the SMT during a facilitated consensus session; and which have been subsequently validated by the wider staff complement that participated in the overall process.

Notable strengths:

- Good quality direct services with positive client/patient satisfaction expressed.
- Positive and productive joint working across services and staff groups.
- Robust corporate governance arrangements, with strong commitment to and platform established for further developments.
- Strong commitment to and methodical arrangements utilised to foster on-going engagement and constructive consultation with stakeholders.
- Robust track-record of and strong approach to responsible financial management.

Areas for improvement prioritised for 2012/13:

- More vigorously encourage an explicitly shared and consistent ethos of care governance across full breadth of health and social care, in a manner that strengthens and does not dilute the discharging of core responsibilities. This to

include revisiting relationships between formal meetings of SMT, Clinical Governance Group and Chief Social Work Officer's Group.

- Drive greater focus of management capacity and capability on leading and enabling staff and services, including:

  - Continue streamlining and integrating plans, policies/protocols, processes and meetings/groups.
  - Further improve access to relevant performance management information and use of IT systems.

- Consistently promote culture of and embed systematic undertaking of self-evaluation (using PSIF as over-arching construct).

- Seek further opportunities to enhance communications (internal and external), including sharing good practice and recognising achievements.

- Further develop and widen range of options for staff learning and development that are affordable, equitable and feasible, ensuring service requirements appropriately prioritised (e.g. as identified through case file audits or critical incident reviews). It was noted that this to include refresher training on care planning, reflective supervision, client risk assessment, the allocation of Welfare Guardianship (WG) Orders and use of social work case file chronologies as an evaluative tool.

It should be noted that a number of the AFIs explicitly seek to build on some of the notable strengths identified (as per the cyclical nature of total quality management). These AFIs will form the core of the CHCP's structured continuous improvement commitments as per the expectation of WDC and NHSGGC (specifically in relation to the latter's Facing the Future Together corporate change programme), and have informed the actions set within this Strategic Plan.

7. WORKFORCE DEVELOPMENT

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

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

The CHCP has been founded on a very strong local track record within West Dunbartonshire for positive joint working between health and social care staff and services. With this in mind, an integrated Workforce Plan has been prepared to ensure that the CHCP maintains a capable, competent and confident workforce working within a mutually-supportive culture and that are supported to deliver a common commitment to high quality and equitable health and care services. This is the CHCP's first integrated workforce plan, which is designed and intended to be read/used in support of this CHCP Strategic Plan; and within the context of the corporate workforce plans and priorities of NHSGGC and WDC. The intention is that it will be refined year-on-year, particularly with reference to the Commissioning Strategies that the CHCP has developed across its services.

The objectives of the (draft) Workforce Plan are:

- To ensure that CHCP service planning is informed by - and demonstrates - an understanding of the profile of the workforce that the CHCP is composed of.
- To identify key areas for workforce (and organisational) development action to enable effective delivery of CHCP service priorities (as articulated within the CHCP Strategic Plan).

The approach adopted in the preparation of this plan reflects consideration of:

- Critical workforce issues where action is needed to achieve the organisation's strategic ambitions.
- Critical cross-cutting skill and capability development areas.
- Those areas/issues where the CHCP is able to directly exercise control/influence in relation to its workforce.
- Those areas/issues where there is scope for collaborative working with other dept/divisions of NHSGGC and WDC plus other partners/stakeholders.
- Due cognisance of those issues/areas where distinct employing organisational policies or contractual arrangements need to be respected.
- The ambitious policy agenda that and challenging financial climate within which the CHCP has to deliver.

The Plan will be subject to monitoring of progress and reports on progress in relation to key actions will be provided to the CHCP Committee on a regular basis as part of the overall and routine reporting on Strategic Plan commitments. The Workforce Plan itself is subject to annual review and will therefore take account of future changes in corporate priorities and objectives; legislative and regulatory changes; and reflect ongoing changes to the profile of the CHCP workforce, their development needs and succession planning as services change in the future to meet service demand.

Key principles that have been adopted in identifying actions are:

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

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

- High quality service provision, particularly person-centred care and support.
- Staff governance.
- Staff accreditation, disclosure and registration.
- Absence management.
- Staff personal and continuous professional development planning (PDP and CPD).
- The requirements of the Equalities Act 2010.
- Self-evaluation (including application of PSIF).
- Leadership development.

From the perspective of the CHCP, the above are relevant across the breadth of health and social care staff; and thus that on-going work is best informed by an integrated approach that consolidates the common ethos and expectations of staff and practice governance. Consolidating the sound foundations of the CHCP and strengthening its integrated arrangements will require a continued focus on good quality organisational development. The CHCP will draw upon expertise and support from the organisation development functions of both WDC and NHSGGC to deliver as much joint activity as possible; ensure that the specific needs and legitimate distinctiveness of individual services, teams and staff groups (including primary care contractors) are recognised.

8. 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.

Looking forward – and within the context of Scottish Government's ambitions for pooled budgets in relation to the proposed new health and social care partnerships - the CHCP approach to strategic commissioning requires further exploration of utilisation of budgeting and benchmarking techniques, specifically the integrated resource framework (IRF) with support from Scottish Government ISD.

WDC (Social Work) Budget – Summary of Revenue Estimates

Outturn 2010/11		**Estimate 2011/2012**	**Probable 2011/2012**	**Estimate 2012/2013**
		£	**£**	**£**
7,913,560	Operations and Servicing	8,141,520	8,375,420	8,573,590
4,776,050	Residential Accommodation - Young People	5,245,900	4,955,880	5,146,310
2,000,820	Residential Schools	2,316,720	2,080,790	2,002,580
3,819,570	Other Services - Young People	3,937,640	3,838,100	3,853,090
11,427,950	Residential Accommodation - Older People	11,930,050	11,524,860	11,892,930
1,300,570	Sheltered Housing	1,395,370	1,393,180	1,394,430
1,112,270	Day Centres - Older People	1,109,330	1,121,070	1,120,910
113,440	Meals on Wheels	129,120	112,530	112,510
195,310	Community Alarms	263,260	269,320	267,290
9,058,740	Res. Accom. - Learning Disability	8,081,150	8,190,170	8,281,950
1,151,510	Res. Accom. - Physical Disability	1,151,170	1,079,290	1,026,320
1,532,180	Day Centres - Learning Disability	1,551,340	1,529,420	1,573,410
1,076,080	Other Services - Disability	983,810	844,120	862,790
2,631,520	Supplementation - Mental Health	2,675,780	1,837,120	2,112,590
8,604,710	Home Care	8,911,290	8,938,110	9,003,340
828,610	Other Specific Services	829,750	824,600	824,600
715,850	Addiction Services	753,960	1,355,660	1,265,580
(180)	CPP investment	0	0	0
58,258,560	**Total**	**59,407,160**	**58,269,640**	**59,314,220**

NHSGGC Budget

It is forecast that the CHCP will achieve its financial target of operating within its allocated NHS revenue budget of £69.5m for the financial year 2011/12. While the revenue budget for the year 2012/13 has yet to be finalised, the following table presents the budget based on the existing budget rolled forward to exclude non-recurring expenditure and include assumptions of changes based on best estimates.

2012/13 Draft Budget	
	£m
2011/12 Current Net Expenditure Budget	69.5
Less: Non Recurring	(2.9)
2011/12 Base Budget	66.6
Less total Indicative Savings Targets (see note 3)	(0.5)
Draft 2012/13 Opening Budget	**66.1**

Notes

1. The 2011 Scottish Spending Review and Draft Budget 2012-13 has indicated that the Scottish Government intends to freeze pay for staff earning over £21,000 and to increase pay by £250 per annum for those earning less. The original working assumption of a 1% increase for all staff has allowed the provision for pay uplift to be reduced from £14.1m to £4.0m. In addition, the provision for incremental pay progression has been reduced by £1m to £12m.

2. A number of factors have contributed to push forecast energy costs up by £4.4m Board-wide in 12/13. These include further increases in gas/electricity tariffs and increase in regulator imposed charges for electricity.

3. The savings strategy across Partnerships has been to look at services and through redesign at a system-wide level over a 4 year period achieve the necessary level of savings. At this stage, the details of savings are only available at a system-wide and not an individual CH(C)P level. For the purposes of this CHCP Strategic Plan, however, it has been estimated that a 3% savings target will be applied to the CHCP allocation. This percentage has been applied to the recurring allocation excluding Family Health Services, Prescribing and Resource Transfer as these will be included within their overall service area.

In preparing a financial plan for 2012/13 there are a number of factors which will need to be taken in to account and will include the following:

- It is considered likely that there will be a requirement to release somewhere in the region of 3% 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.
- The requirement to ensure that financial and workforce planning are properly linked to ensure that the impact on service quality and delivery is fully considered for both the short and long term.
- A focus on both local and national priorities 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.

- 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 group.
- 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.

WD CHCP has contributed its assigned allocation to these system-wide savings for 2012/13 as per the table below. All of these will be achieved through efficiency (with no consequent material service impact), the specific proposals having been subjected to the Equality Impact Assessment process and discussion with staff-side representatives from the local Joint Staff Forum prior to finalisation.

	Planned Savings 2012/13 £000
Addiction Services	28.0
Admin & Others	35.0
Children Services	42.0
Community Health & Care	58.0
Hosted Services (Eye Care)	12.0
Learning Disabilities Services	29.0
Mental Health Services	77.0
Planning & Health Improvement	27.0
b/f from 11/12	(46.0)
Total	**262.0**

The NHS capital planning priority for the CHCP remains the delivery of the new state-of-the-art £20.8m Vale Centre for Health and Care (as identified within the NHSGGC Capital Plan); with a key 2012/13 milestone being the commencement of construction on site in anticipation of the new facility being operation Summer 2013.