Change Plan Template

1. Name of Partnership

West Dunbartonshire Community Health and Care Partnership

2. Partner Organisations

2.1 Partners signed up to the Change Plan

The Change Plan is submitted by West Dunbartonshire Community Health and Care Partnership on behalf of

NHS Greater Glasgow and Clyde
West Dunbartonshire Council
West Dunbartonshire Council for Voluntary Service and other third sector partners
Scottish Care and partners from the private sector

2.2 Professional Engagement in the development of Plans

GP Locality Groups have been involved in developing service detail and approving the overall plan.
Joint Staff Forum – Staff side representatives are on the Change Plan Implementation Group and the plan is shared with staff side partners and their views sought.
Change Plan Implementation Group has wide representation from all stakeholders including Independent and 3rd Sector partners and approves the projects.
Health and Community Care Team meetings and uniprofessional staff groups are co-authors of the plan leading on the detailed service development work.
CHCP Professional Advisory Group have reviewed the plan and provided detailed professional advice.
Ageing Population Planning Group – an NHS GGC wide group which has strategic overview of the NHS contribution to the Change Plan.

2.3 Public engagement in the development of Plans

Organisations involved in the monitoring of 2011 Plan and signed up as partners for 2012 Plan are the Public Partnership Forum; West Dunbartonshire Council for Voluntary service; Clydebank Seniors Forum; Older People's Strategy Group; Carers of West Dunbartonshire; West Dunbartonshire Community Care Forum; Vale of Leven Seniors Forum

A six month consultation process (2011) across West Dunbartonshire was carried out to seek the views of older people, their carers and potential service users on the

future of Older People's Services, including the delivery of the Change Plan ; Consultation with volunteers and befrienders from Council for Voluntary Service (2011) to seek their views on their role as service providers to older people in line with the co-production element of the Change Plan. The views of service users included accessibility, meeting needs, being viewed as an individual and involvement in the planning and delivery of services. The outputs from the consultation will be included in our Older Peoples Commissioning Strategy.

3. Finance

3.1 Resources available to Partnerships
see Note 4

From	Amount £	Difference from 2011/12
Monies carried forward from 2011/12 allocation	80,000	N/A
Initial central allocation	1,382,000	173,000
Added by NHS Board	0	0
Added by local authority (non recurrent)	360,000	360,000
Other	0	0
TOTAL	1,822,000	533,000

3.2 Reasons for financial 'carry forward'

Delays in recruitment of Mental Health Officers, Occupational Therapists, Social Work staff have resulted in an in year underspend although there is a full year commitment in the budget.
In turn this has lead to slower than expected assessment activity with a knock on effect on placements and aids and adaptations
It is our intention to fully recruit to these posts and in addition to recruit short term additional staff to reduce assessment times and to undertake waiting list initiatives in Occupational Therapy
We will also undertake evaluations of our Anticipatory Care Plans and use additional staff to populate our e-KIS data.

3.3 Change Fund allocation by pathway

	Preventative & Anticipatory Care	Proactive Care & Support at Home	Effective Care at Time of Transition	Hospital & Care Homes	Enablers
2011/12*	125	330	264	420	70
2012/13	175	305	497	358	47
2013/14	175	488	324	348	47
2014/15	169	424	324	245	47

3.4 Total resource allocation by pathway

	Preventative & Anticipatory Care	Proactive Care & Support at Home	Effective Care at Time of Transition	Hospital & Care Homes	Enablers
2011/12*	125	330	264	420	70
2012/13	289	550	497	358	47
2013/14	175	488	324	348	47
2014/15	169	424	324	245	47

* as per 2011/12 plan

See attached a revised Change Fund Plan (Appendix 1) which reflects the new guidance. These plans bring with them recurrent liabilities which make the movement of resource within the plan difficult although they will be reflected in our Joint Commissioning Strategy for Older People.

4. Self Assessment Against 2011/12 Performance

4.1 Nationally available outcome measures and indicators

It is our intention to develop a suite of outcome indicators against the targets set in our Joint Commissioning Strategy which will include Change Plan targets. Specific Performance Indicators are aligned to the Change Plan Pathway (see appendix 2)

A1 Emergency inpatient Bed day rate >75 currently **3934**

A2a Our performance in the latter half of this year has been disappointing with on average **2** delays per census. This is mostly due to high uptake of first choice placements, and the configuration of the care home sector in West Dunbartonshire. We are working with Scottish Care to develop additional care opportunities - the first of which is due to come on stream in 2012/13 - and to make more beds available within WDC direct provision.

A2b There is marginal improvement in accumulated bed days although the measure is unclear and further guidance is welcome. The average length of stay over 6 weeks is approximately 25 days which is improved from 2009/10

A3 Prevalence rates for Diagnosis of Dementia against the notional target is **83%**

A4 The proportion of older people with complex needs living at home is **42%** and the proportion of WDC older people living at home or in adapted housing is **95.5%**

A5 88.34% (2009/10)

A6 Community Care Outcomes Framework - we currently measure against all of these targets

Carers known to CHCP	**2056**
Numbers of carers requesting assessment and receiving one	**52%**
Number of staff trained in carer assessments	
Number of short breaks for carers	
%age of carers who feel supported to continue in their role as carer	**83.1%**

4.2 Local improvement measures

B1 Approximately 1% of elderly residents in West Dunbartonshire are housebound. In 2011/12 we undertook an exercise to develop a cohort of high risk clients who would benefit from assessment and Anticipatory Care Plans. Of this cohort 100% will have plans in place that are shared with OOH services. In 2012/13 we intend to further develop this service using e-KIS which will be available to OOH staff and which will provide those staff with access to ACPs.

B2 Waiting times for OT assessment are 60 days
Average wait from assessment to completion of adaptation 3months
Note for Aids and Equipment provided by equipu the average waiting time is 48 hours

B3 1437 Clients aged 75 or over have access to telecare provision in West Dunbartonshire which represents or **21%** of all residents

B4 Data is not yet reliable for the service

B5 Respite care for older people. Our target is to provide 3238 weeks of respite provision in 2011/12. (rate per 1000 population **3.22** weeks per annum)

B6 Admitted to A&E following a fall – awaiting information from SAS

B7 Acute

B8 Average admissions 213 per annum

From Home	**35%**
From Hospital	**46%**
From intermediate care	**0%**
From emergency respite	**18%**

4.3 Partnership resources

C1 Unavailable

C2 Unavailable

C3 In development

Key Change Fund Measures

Our local plan set challenging targets in a number of key areas - these are outlined in brief below with outcome data where we have it.

Delayed Discharge

CHCP001 Reduce bed days consumed by 50% - Actual YTD 6339 Target YTD 2544. Outcomes are disappointing so far although there has been a considerable lag time to recruitment and therefore redesign

CHCP003 Reduce bed days consumed by patients with AWI - Actual YTD 946 target YTD 312. This is a much improved performance and although we will miss our stretching target we are on track to reduce the annual figure by 50%. This has been achieved with the additional resource - in particular additional SW and MHO capacity.

CHCP 005 Reduce Delayed Discharge for EMI Patients - the YTD figures and year end outturn is likely to show that bed days lost has remained at 2010/11 levels.

Care Home and Home Care Provision

CHCP 007 Provide an additional 10 care packages per year - on average we are supporting 471 care home placements per month compared to 449 in 2009/10. Although we are committed to providing a high proportion of care at home there will be an increase in the number of older people requiring residential care and many of these clients will come from the hospital sector.

Anticipatory Care

CHCP 009 Introduce Anticipatory Care case finding and plans - cohort identified and the target of providing ACPs to 100% of them will be met - additional investment will improve coordination and we will introduce from 2012/13

Out of Hours Care

CHCP 011 Integrate Out of Hours Care and provide rapid access to alternatives to admission - continues in development

End of Life Care

CHCP 010 End of Life Care - Reduce end of life care in hospitals – complete data not yet available although initial analysis indicates improvement in care at home with increased proportion (100%) of all LCP patients dying at home

NOCC-R3 Admitted >x2 without an assessment 45%

4.4 Successes and lessons learnt

We have improved our management of Adults with Incapacity and have successfully delivered earlier discharge to an appropriate setting.

The palliative care service and our partnership work with Alzheimer Scotland have also proved successful in maintaining people at home.

Reablement and pharmacy support has also shown early success.

We have successfully cut waiting times for OT assessment and adaptations.

Lessons Learnt

Implementing complex redesign has had a significantly longer lead in time than expected.
Outcome targets need to be achievable

Delays in recruitment have reduced the full year impact of our service redesigns which we now know to be integral to achieving our targets.

5. Governance

5.1 Describe your Partnership governance framework and financial framework to enable Partnership decisions if they have changed since 2011/12

Our governance framework has not changed. The Partnership Board is the CHCP Committee which approves and receives plans and reports. The Change Plan is approved and overseen by the CHCP Committee exercising its delegated function from West Dunbartonshire Council and NHS Greater Glasgow and Clyde.

We have improved and integrated our performance monitoring systems and actions. Performance reporting of targets across the CHCP has been centralised using Covalent as the reporting tool, the CHCP can provide an audit track of analysis, action and follow up. By using data from Carefirst, GPass and PIMS there is an ability to interpret and present data in actual time on service delivery in line with Performance Measures linked to the Change Plan.

The CHCP's targets, actions and outcomes as recorded within Covalent represent corporate targets from NHS Greater Glasgow and Clyde including the HEAT Targets, corporate targets from West Dunbartonshire Council including Single Outcome Agreement as well as specific targets relating directly to the Change Plan and service specific targets. Reshaping Care for Older People is represented by key core improvement measures to ensure implementation. These Core Measures are aligned with, and support the delivery of the Quality Strategy Ambitions, and form part of the Quality Measurement Framework. The ongoing work to review the Community Care Outcomes Framework ensures that the Core Measures are equally aligned and integrated by focusing ultimately on improving outcomes for clients, patients and carers.

Specific governance for the implementation of the Change Plan will continue to be monitored through the Change Plan Implementation Group which has been functioning over the past year to develop, implement and monitor performance directly relating to the Change Plan, in line with the structures above. The Change Plan Implementation Group is a partnership representing statutory, voluntary and private providers as well as community representatives.

6. Carers

6.1 Describe the range of services that improve outcomes for carers

We will publish our new Local Carers Strategy in 2012.As part of our Reshaping Care Plan we are undertaking a wide consultation with carers on their needs and views about the development of our services.

In our current service provision we are making improvements in the way we deliver services. In particular we are improving annually the rate of carers' assessments we do and in planning for care for service users.

Anticipatory Care Plans will detail what support carers and clients may need at times of crisis and transition

We continue to invest in **aids and adaptations** to support carers and clients to remain independent at home

We will improve uptake of **Respite** by expanding options and making it easier to book it at a time which suits clients and carers

We will provide additional opportunities for **Care at Home** and use **reablement** to maximise the independence of clients and to support their carers

We will provide primary care **Dementia** services and work with Alzheimer Scotland to deliver support to patients and their families at diagnosis.

We will improve our **Out of Hours** services to ensure that we can respond rapidly to the changing needs of clients or when their carers are themselves in need of help

We will ensure that clients and their carers have rapid access to **Specialist Medicine** for the Elderly Services locally

At the **end of life** we will provide additional support to patients and their carers at home.

We will ensure that we **assess patients in hospital** quickly and provide additional care on their return home or admission to respite, rehabilitation or residential settings. This will include early identification of carers and their involvement and engagement within the discharge process.

6.2 Indicate the total amount of Partnership resource allocated to support carers to enable them to continue to care

Almost all of our interventions in this plan support both carers and the cared for so a proportion of each funding stream benefits both and we have approximated the financial benefit for each. Carers of West Dunbartonshire will realign the anticipated Carers Information Strategy monies of 2012/13 to compliment and support objectives in the Change Fund plan.

Specific Budget (2012/13 Excluding the additional contribution from West Dunbartonshire Council)

	£ 000s	
Additional Respite	70	
Anticipatory Care	50	
Primary Care Dementia Service	50	
Alzheimer Scotland	25	
Palliative Care	40	
Long Term Conditions (matched to CIS)	40	
Facilitating Discharge (Carers Liaison)	40	
Care at Home	50	
Total	**365**	(26.5%)
Including additional contribution from West Dunbartonshire Council		
Alzheimer Scotland	25	
Respite	60	
Total	85	
Total	**450**	(32.6%)

7. Support Mechanisms

7.1 What support has helped you so far? What didn't?

We have received excellent support from JIT representatives
The online resources are also welcome

It is difficult to change the balance of spend before being able to undertake good analysis of what has worked at this early stage. Most of the inputs we make have significant resource costs and these commitments are delivered over longer than a 10 month period. Early notification of change would help.

There are some artefacts in expenditure which relate to where in the Reshaping Care Pathway services or projects lie eg reablement.

7.2 What support, if any, could you offer other Partnerships?

We are happy to contribute to partnership networks and would be keen to share our experiences of what works with others.

8. Joint Commissioning Strategy for Older People

In terms of your Joint Commissioning Strategy:
- what Partners will be involved in the preparation of the Strategy;
- what are the estimated total resources for the Strategy;
- what governance arrangements are you planning on implementing;
- what is the timeline involved;
- how will your Joint Commissioning Strategy link in with your Change Fund application?

What Partners will be involved in the preparation of the Strategy?

NHS Greater Glasgow and Clyde
West Dunbartonshire Council
West Dunbartonshire Community Health and Care Partnership
West Dunbartonshire Council for Voluntary Service and other third sector partners
Scottish Care and partners from the private sector

What are the estimated total resources for the Strategy?

Resources for this strategy will represent resource from Community Health and Social Work budgets from the CHCP and West Dunbartonshire Council including monies used for commissioning external services from private and voluntary sector services. We will include resources held by our commissioning partners in Housing.
The total Partnership budget is circa £65.7m (see appendix 3) plus the additional £1.38m from Change Plan 2012.

What governance arrangements are you planning on implementing?

This Commissioning Strategy represents the partnership between health and social work from NHS Greater Glasgow & Clyde and West Dunbartonshire Council and their commitment to having a commissioning process across services for older people. Effective joint commissioning is crucially important in the process of developing a whole systems approach to service delivery and improving outcomes to users and carers.

The central framework for planning and governance for the CHCP is laid out in the CHCP Strategic Plan. The Plan brings together both NHS Greater Glasgow and Clyde's and West Dunbartonshire Council's separate responsibilities for community based health and social care services within an integrated structure and sets out the key actions prioritised for delivery, reflecting corporate outcomes and financial frameworks. The structures represent governance for both NHS Greater Glasgow

and Clyde and West Dunbartonshire Council (CHCP Committee); Staff (Joint Staff Forum); service users, patients, carers and the public (Public Partnership Forum); clinicians and medical contractors (Professional Advisory Group) and CHCP managers (Senior Management Team).

The quality agenda here will be further reinforced through the CHCPs clinical governance arrangements and those of the West Dunbartonshire Chief Social Work Officers Group. Over the course of 2012 we will also develop explicit reporting relationships with our Community Planning Partners.

The CHCP's targets, actions and outcomes as recorded within Covalent represent corporate targets from NHS Greater Glasgow and Clyde including the HEAT Targets, corporate targets from West Dunbartonshire Council including Single Outcome Agreement as well as specific targets relating directly to the Change Plan and service specific targets.

Specific governance for the implementation of the Change Plan will continue to be monitored through the Change Plan Implementation Group which has been functioning over the past year to develop, implement and monitor performance directly relating to the Change Plan, in line with the structures above. The Change Plan Implementation Group is a partnership representing statutory, voluntary and private providers as well as community representatives (as laid out as key partners).

What is the timeline involved?

The Commissioning Strategy for Older People has been informed by the six month long consultation process with older people as well as the guidance from Audit Scotland (June 2011). The Commissioning Strategy will cover the timeline from 2011 – 2021.

The commissioning strategy will be completed by Spring 2012 and the detailed planning flowing from it will be completed by Autumn 2012.

How will your Joint Commissioning Strategy link in with your Change Plan?

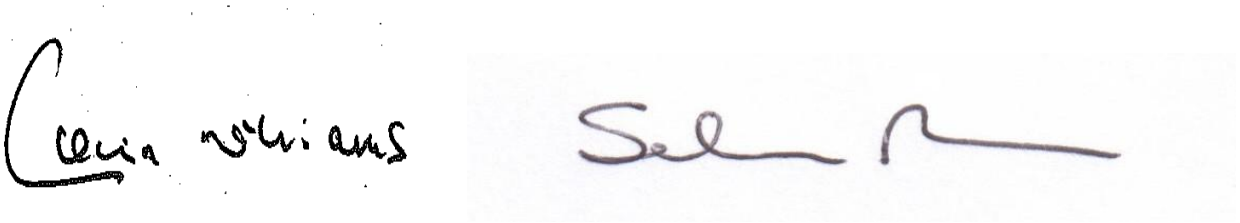
Shifting the Balance of Care is a key priority for the CHCP. It is a means of supporting people to remain in a homely setting for as long as possible, rather than within care homes or hospitals. The content of the Change Plan is evident within the CHCP Strategic Plan, reflecting the importance of this programme to so many of the existing CHCP priorities and corporate outcomes for the year ahead. There are commonalities across the Commissioning Strategy for Older People and the Change plan as well as meeting priorities within the Commissioning Strategy for Rehabilitation Services. The Commissioning Strategy and Change Plan also meet one of the commitments made in Homes Fit for the 21st Century (2011 – 2021), the Scottish Government's strategy which makes a commitment to independent living for older people and people with disabilities.

This plan has been prepared and agreed by the NHS, Council, Third Sector and Independent Sector interests.

Signed

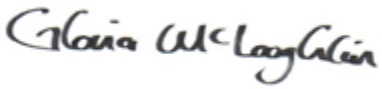
R. Calderwood
Chief Executive
NHS Board

Joyce White
Chief Executive
West Dunbartonshire Council



Colin Williams
Carers of West Dunbartonshire

Selina Ross
West Dunbartonshire CVS



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