West Dunbartonshire CHCP Year End Performance Overview 2013/14
Key Performance Indicators: Summary of Progress

Performance Indicator	2012/13	2013/14					
	Value	Value	Target	Status	Long Trend	Short Trend	Note
Rate of stillbirths per 1,000 births	5.9	5.4	5.9				Target achieved.
Rate of infant mortality per 1,000 live births	1	2.7	4.1				Target achieved.
Percentage smoking in pregnancy	16.7%	17%	20%				Target achieved.
Percentage smoking in pregnancy - Most deprived quintile	25.8%	24.5%	20%				Provisional - Data for March 2014 not yet available. Indicative target has not been achieved and performance is being reviewed.
Percentage of babies breast-feeding at 6-8 weeks	14%	17%	16%				Target achieved.
Percentage of babies breast-feeding at 6-8 weeks from the 15% most deprived areas	9.2%	9.9%	16%				Provisional - March 2014 not yet available. Indicative target has not been achieved and performance is being reviewed. It has been confirmed that local practice is in line with best practice being undertaken in other areas, and that variations likely influenced by demographic and cultural differences between communities.
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	93.2%	96.1%	95%				Target achieved.
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	96.9%	97.2%	97%				Target achieved.
Completion rates for child healthy weight intervention programme over the three years ended March 2014 (Cumulative)	304	437	315				Target achieved
Number of children with or affected by disability participating in sports and leisure activities	179	175	172				Target achieved.
Percentage of child protection referrals to case conference within 21 days	95.1%	80.2%	95%				During 2013/14 case conferences were carried out within the timescale for 77 out

Performance Indicator	2012/13	2013/14					
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							of 96 children. Indicative target has not been achieved and performance is being reviewed.
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%	100%				Target achieved.
Balance of Care for looked after children: % of children being looked after in the Community	87%	87.7%	88%				Provisional. This figure will be updated in line with the annual Looked After Children return to the Scottish Government which relates to the period 1st August 2013 to 31st July 2014.
Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	60%	44%	63%				7 of the 16 young people who left care in year entered a positive destination.
Number of children with mental health issues (looked after away from home) provided with support	30	50	23				Target achieved.
Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	6.5	6	18				Target achieved.
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	78.6%	92.8%	85%				Target achieved.
PCMHT average waiting times from referral to first assessment appointment (Days)	20	29	14				Provisional - Indicative target has not been achieved and performance is being reviewed.
Proportionate access to psychological therapies - Percentage waiting no longer than 18 weeks SIMD1	89.5%	87.2%	85%				Target achieved.
Average length of stay adult mental health	33	29	35				Target achieved.
Number of adult mental health patients waiting more than 28 days to be discharged from hospital into a more appropriate setting, once treatment is complete	0	1	0				Indicative target has not been achieved and performance is being reviewed.
Number of bed days lost to delayed discharge elderly mental illness	611	710	530				Indicative target has not been achieved and performance is being reviewed.
Percentage of designated staff groups trained in suicide prevention	100%	100%	50%				Target achieved.
Number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention	975	945	838				Target achieved.

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Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	92.3%	92.6%	91.5%				Target achieved.
Percentage uptake of bowel screening	49.5%	49.7%	60%				Provisional - Data for March 2014 not yet available. Indicative target has not been achieved and performance is being reviewed.
Percentage uptake of bowel screening Male SIMD1	39.5%	39.4%	60%				Provisional - Data for March 2014 not yet available. Indicative target has not been achieved and performance is being reviewed.
Percentage of those invited attending for breast screening	72.7%	70.9%	71.4%				Provisional - Figure for round completed May 2012.
Percentage uptake of cervical screening by 21-60 year olds (excluding women with no cervix)	77.9%	77.1%	80%				Provisional - Data for March 2014 not yet available and Quarter 3 December 2013 reported as interim figure.
Percentage uptake of cervical screening by 21-60 year olds (excluding women with no cervix) SIMD1	74.58%	74.57%	80%				Provisional - Data for March 2014 not yet available and December 2013 reported as interim annual figure.
Number of inequalities targeted cardiovascular Health Checks (Cumulative)	1,547	1,350	796				Target achieved.
Total number of successful quits (at one month post quit) delivered by community-based universal smoking cessation service	141	123	158				Indicative target has not been achieved and performance is being reviewed. It has been confirmed that local practice is in line with best practice being undertaken in other areas.
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	106	97	95				Target achieved.
Average waiting times in weeks for musculoskeletal physiotherapy services - WDCHCP	6	4	9				Target achieved.
Long Term Conditions - bed days per 100,000 population	9,293	8,200	10,000				Target achieved.
Long Term Conditions - bed days per 100,000 population COPD (crude rate)	3,439.2	3,062.9	4,000				Target achieved.
Long Term Conditions - bed days per 100,000 population	375.2	273.4	310				Target achieved.

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Asthma (crude rate)							
Long Term Conditions - bed days per 100,000 population Diabetes (crude rate)	616.6	504.8	740				Target achieved.
Long Term Conditions - bed days per 100,000 population CHD (crude rate)	4,861.6	4,359.1	5,300				Target achieved.
Number of acute bed days lost to delayed discharges	6,050	4,925	3,819				Target has not been achieved and performance is being reviewed.
Number of acute bed days lost to delayed discharges for Adults with Incapacity	1,872	1,547	466				Target has not been achieved and performance is being reviewed.
No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013	2	2	0				Target has not been achieved and performance is being reviewed.
Unplanned acute bed days 65+	51,748	45,641	55,000				Target achieved.
Unplanned acute bed days 65+ as a rate per 1,000 population	3,502	3,025	3,735				Target achieved.
Number of unplanned admissions for people 65+ from SIMD1 communities	588	588	588				Target achieved.
Unplanned acute bed days (aged 75+)	39,314	33,094	38,600				Target achieved.
Emergency inpatient bed days rate for people aged 75 and over (per 1,000 population)	5,750	4,788	6,400				Target achieved.
Number of emergency admissions 65+	4,398	3,973	4,250				Target achieved.
Emergency admissions 65+ as a rate per 1,000 population	298	263	300				Target achieved.
Average length of stay for emergency admissions 65+	3.8	3.7	3				Provisional – Indicative target has not been achieved and performance is being reviewed.
Percentage of people 65+ admitted twice or more as an emergency who have not had an assessment	34.16%	41%	33%				Indicative target has not been achieved and performance is being reviewed.
Number of patients in anticipatory care programmes	372	1,024	824				Target achieved.
Percentage of Care Plans reviewed within agreed timescale	65.73%	62.9%	70%				A staff vacancy resulted in a backlog of residential reviews late December 2013. Performance has improved during January

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							- March 2014 to 70%.
Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	77.6%	85%	85%				Target achieved.
Number of patients on dementia register	589	613	672				Figure taken from QOF report for 1st April 2014.
Number of weeks of respite provided for carers of Older People / Dementia 65+	3,057	2,610	3,057				This is a provisional figure pending the data checks for the Scottish Government's Short Breaks (Respite) Return which is due for submission July 2014.
Number of people aged 75+ in receipt of Telecare - Crude rate per 100,000 population	21,889	22,403	21,773				Target achieved.
Percentage of adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes	47%	51%	50%				Target achieved.
Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	41.6%	97.7%	95%				Target achieved.
Total number of homecare hours provided as a rate per 1,000 population aged 65+	652.9	654.9	678				This is a provisional figure and may be subject to change as part of the data check processes for the Scottish Government's Social Care Return and Statutory Performance Indicator. In line with the focus on reablement, service is being targeted towards those with high level needs to maximise any potential for improvement in levels of independence.
Percentage of homecare clients aged 65+ receiving personal care	81.6%	81.3%	81%				Target achieved.
Percentage of people aged 65 and over who receive 20 or more interventions per week	50.47%	51.3%	44.5%				Target achieved.
% of people aged 65 or over with intensive needs receiving care at home	42.52%	40.8%	49%				Provisional – Indicative target has not been achieved and performance is being reviewed.
Percentage of people receiving free personal or nursing care within 6 weeks of confirmation of 'Critical' or 'Substantial' need	98%	100%	100%				Target achieved.

Performance Indicator	2012/13	2013/14					
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Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)	35%	27%	35%				Target achieved.
Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	40%	49.6%	40%				Indicative target has not been achieved and performance is being reviewed. Of the 133 identified non cancer patient deaths during 2013/14, 66 patients died in hospital.
Percentage of patients achieved 48 hour access to appropriate GP practice team	94.1%	94.1%	95%				Provisional - 2013/14 data not yet available. 2011/12 reported as interim.
Percentage of patients advanced booking to an appropriate member of GP Practice Teams	74.6%	74.6%	90%				Provisional - Indicative target has not been achieved and performance is being reviewed.
Percentage of complaints received and responded to within 20 working days (NHS)	90%	100%	70%				Target achieved.
Percentage of complaints received which were responded to within 28 days (WDC)	62%	79%	70%				Target achieved.
Sickness/ absence rate amongst WD CHCP NHS employees (NHSGGC)	5.1%	4.6%	4%				Addressing sickness absence has been a particular priority amongst the SMT with improvements accompanying the management emphasis on staff applying the relevant policies (alongside encouraging uptake of training).
Average number of working days lost per WD CHCP Council Employees through sickness absence	17.35	16.67	10				
NMC Registration compliance	100%	100%	100%				Target achieved.
Percentage of WD CHCP Council staff who have an annual PDP in place	51%	53%	80%				PDP action plan has been developed and implemented by SMT. This emphasises the manager and individual member of staff responsibilities for undertaking PDP processes.
Percentage of WD CHCP NHS staff who have an annual e-KSF review/PDP in place	66%	68.09%	80%				
Percentage of staff with mandatory induction training completed within the deadline (NHS)	100%	100%	100%				Target achieved.
Percentage of Council-operated children's residential care homes which are graded 5 or above	50%	25%	N/A				The Strategic Plan target is for all Council-operated children's residential care homes to be graded at 5 or above by 2017. In line with the Care Inspectorate's practices, where homes have been inspected on more than 1 theme, the

Performance Indicator	2012/13	2013/14					
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							lowest grading received has been used to calculate performance against this measure. Of the 4 homes, 1 received a grade 5 as their lowest grading on inspection. This home also received a grade 6 in relation to the quality of care and support when inspected in January 2013.
Percentage of Council Home Care services which are graded 5 or above	100%	100%	N/A				The Strategic Plan target is for all Council Home Care services to be graded at 5 or above by 2017. In line with the Care Inspectorate's practices, where services have been inspected on more than 1 theme, the lowest grading received has been used to calculate performance against this measure. All 3 Home Care services (Care at Home, Community Alarms and Sheltered Housing), received a grade 5 as their lowest grading on inspection.
Percentage of Council-operated older people's residential care homes which are graded 5 or above	0%	0%	N/A				The Strategic Plan target is for all Council-operated older people's residential care homes to be graded at 5 or above by 2017. In line with the Care Inspectorate's practices, where services have been inspected on more than 1 theme, the lowest grading received has been used to calculate performance against this measure. None of the current homes received a grade 5 as their lowest grading on inspection although 1 home received a grade 5 in relation to quality of staffing. The new older people's care homes are scheduled for completion in 2015 and this will positively influence the direction of travel towards the 100% target.

WD CHCP Strategic Plan: Key Actions – Summary of Progress

2013-14 Strategic Plan Action	Outcomes Achieved / Progress to Date
Deliver and open the Vale Centre for Health & Care.	The new Vale Centre for Health & Care was formally opened by the Cabinet Secretary for Health & Wellbeing at a short ceremony on the 27th November 2013. Having already won the "best design category" at the Health Facilities Scotland Awards 2013, the Vale Centre was nominated for Scottish Civic Trust Awards 2014 (the first NHS facility to have been recognised in that scheme); and is a finalist in 2014 Scottish Design Awards.
Deliver quality assured NHS GGC-Wide Eye Care Service through audit and review.	Diabetic Retinal Screening Service continues to deliver quality assured investigations in spite of the increasing cohort of diabetic patients requiring the service. The service is continuing to experience pressures in meeting the target times for 3rd stage examinations, although for the majority of patients results are available within target.
Manage Argyll, Bute and Dunbartonshire's Criminal Justice Social Work Partnership.	The Criminal Justice Partnership continues to operate successfully in its current form. A local development session is planned for the autumn to fully consider the implications of the Scottish Governments proposals for a local criminal justice model that is more explicitly aligned to the Community Planning Partnerships in respective areas.
Implement findings of Blue Triangle review.	As reported to CHCP Committee, the comprehensive Multi-Agency Review was commissioned by the West Dunbartonshire Public Protection Officers Group found no deficit in the care in the three tragic cases; and it has been confirmed that there will be no Fatal Accident Inquiry into any of the deaths. A dedicated report on the implementation of the approved multi-agency improvement action plan has been separately prepared for the May

2013-14 Strategic Plan Action	Outcomes Achieved / Progress to Date
	2014 meeting of the Shadow Integrated Joint Board.
Implement 30 month assessment for all children and establish Health Support Team.	Implemented successfully under the stewardship of a multi-agency local implementation group. Established a Joint Support Team (JST) for Health Visitors to discuss children who required priority nursery places; speech and language input; and/or parenting programmes.
Implement Universal and Vulnerable pathways for all children 0 – 19 years.	Successfully implemented Universal and Vulnerable pathways for all children 0 – 19 years. CHCP actively contributing to developments at NHSGGC-level.
Develop local implementation plan of GIRFEC National Practice Model.	Implementation plan and work streams well established for multi-agency implementation across WD area. Community Health Team work fits into the overall plan and WD CHCP are early adopters of the National Practice Model. Training took place in January and new record and assessment materials where adopted. At an evaluation session on 26th February feedback from the early adopter sites has led to NHSGGC reconsideration of the format and detail of the assessment materials (with redesign of said materials now to follow). The CHCP Youth Mentoring Scheme is one of the first such projects in Scotland to maintain Approved Provider Status (APS) from the Mentoring and Befriending Foundation; has achieved accreditation for the third time with the Scottish Mentoring Network; and is a finalist in the 2014 Care Accolades.
Undertake agreed review and developmental work in support of CPP Early Year's Collaborative programme.	Intensive work progressing under the stewardship of local EYC Executive Group as an explicit component of CPP arrangements. Current areas of practice for testing in use of improvement methodology

2013-14 Strategic Plan Action	Outcomes Achieved / Progress to Date
	are: smoking cessation; and book knowledge and reading across a number of early years establishments. The micro-testing in nurseries is scaling up; and this will involve collaborative work and sharing of the methodology across health visiting and social work professionals who are working with the children involved. Comparative work on outcomes from the Family Nurse Partnership cohort of young mothers also being undertaken with other areas of NHSGGC.
Ensure full compliance with outcome and requirements from the Scottish Governments Redesign of the Community Justice system for the delivery of adult criminal justice services.	Given the national "hybrid" model that has emerged from the Scottish Government following national consultation, it is likely that full implementation of the new structures will not be concluded until 2016/2017. CHCP and local Criminal Justice Partnership engaged in discussions at national level regarding the role and remit of the national Criminal Justice body that is to be established. In addition, the local consideration will have to be given to the viability and potential alternative options for developing partnership-approach to criminal justice (including with respect to fit with the three Community Planning Partnerships that have to be explicitly aligned with).
Offer increased support for self-care and self-management which reduces demand on other services.	West Dunbartonshire Link Up ensures older people have access to a range of community health, social care and third sector services through a single point of access. This service was developed in response to feedback from older people and their carers; and specifically to the Reshaping Care for Older people programme. Older people, carers and local services are working jointly to help older people maintain their independence. The Link Up initiative (developed by the CHCP and WD CVS) is a finalist in the 2014 Care Accolades Awards and the 2014 Scottish Charity

2013-14 Strategic Plan Action	Outcomes Achieved / Progress to Date
	Awards. The Link Up Initiative won the Excellence in Innovation and Service Delivery category at the WDC Employee Recognition Awards 2014.
Further develop Hospital Discharge team to increase early supported discharges.	The hospital discharge team is in place and working well, with an exceptional increase in the number of patients being supported.
Work with HEED and third sector providers to identify suitable housing to develop appropriate supported living accommodation for those with long-term mental health needs.	Work is progressing well with accommodation identified. Have identified a third sector organisation to provide this service; and are currently working with Gartnavel Royal Hospital to identify suitable patients and work towards a discharge planning date.
Develop Anticipatory Care as a model of prevention and work with GPs to develop self-care models, and preventative interventions.	Have developed an Anticipatory Care Programme (ACP) which allows the identification of older people at risk; undertakes a full assessment; and puts in place a wide range of supports and plans particularly at times of crisis.
Plan rapid response and alternative choices on behalf of at risk clients.	Urgent access to Integrated teams is now well-established and available during working hours. Access to services such as respite at home or in a care home setting is available via these teams or the lead shift nurse 24/7 can be accessed by GPs and other services/teams.
Increase appropriate use of Telecare and Step Up, Step Down provision.	There continues to be a high uptake of telecare, with regular demonstrations provided for carers and staff (including GPs). Four step up / step down beds are available in local sheltered housing provision; and 1 residential rehabilitation bed is also available.
Work with WDC HEED to develop housing with care options to meet target of increasing the number of older people with complex needs living at home or in a homely setting.	Developing a detailed plan with colleagues in WDC Housing Section and Third Sector partner. This includes reviewing whether the traditional complex model of Housing with Care should be augmented with small scale very local housing developments on a hub and spoke model.

2013-14 Strategic Plan Action	Outcomes Achieved / Progress to Date
Develop respite provision to include respite at home	Successfully developed a respite booking bureau which enables service users to plan and book their own scheduled respite, alongside increasing the amount of respite provided (with improved uptake rates evidenced).
Consolidate improvement in CI Gradings for Older People's Care Homes (older people), Day Care and Home Care.	The Integrated Operational Manager for Older People Care Homes and Day Care and the Manager for Quality Assurance and Development for Older People Care Homes and Day Care ensure that Care Inspectorate recommendations are implemented. The Section Head of Quality Assurance receives regular progress reports from care home and day care management and the CHCP Committee is apprised of CI grades, recommendations and the progress of improvement actions. Care home and day care documentation (e.g. care plans and case recording) have been reviewed and improved. Care Home and Day Care managers and staff are managed and supported to implement improvements by the Integrated Operational Manager, the Manager for Quality Assurance and Development and the Head of Service assisted by specialists such as pharmacists and community nursing. Staff learning and development is being progressed. Home Care grades and improvement action implementation is monitored, tracked and reported to the CHCP Committee.
Consolidate improvement in CI Gradings for Children's Residential Care Homes.	Progress is being made on this steadily and the one unit that had grades of 3 has at their last inspection brought this up to 4's. The introduction of a Senior Residential grade across the units has enhanced the CHCP's ability to improve grades through improved working across all key Quality Indicators.
Deliver plans for the design and location of two Older People's Residential Care Homes	Design of the care home complete to RIBA Stage C: this design to be adapted for use on each of the two sites.

2013-14 Strategic Plan Action	Outcomes Achieved / Progress to Date
	Site for the Dumbarton care home has been identified and planning application will be made in summer 2014. Recommendation for the Clydebank site is being made to Shadow Integrated Joint Board at its May 2014 meeting.
Implement local Smoking Cessation Service Action Plan	Action plan implemented. Comprehensive service evaluation currently being undertaken with perspectives from clients, staff and West Dunbartonshire Citizens Panel.
Maintain Healthy Working Lives Gold Award.	Single application to Scottish Centre for HWL for joint (WDC & WDCHCP) annual assessment was successful. Annual assessment for Gold Maintenance due July 2014, with assessment actions on target completion. Integrated SMART action plan (improvement plan) implemented April 2013, on target in line with planned benchmarking via Staff Health Survey 2015.
Lead community planning approach to health inequalities.	As endorsed by the CHCP Committee, the CHCP has worked with other Council departments and secured the commitment of other Community Planning Partners to a determinants-based approach to health inequalities, with the local-term goal being to have tackled population-level health inequalities as a result of having collectively addressed its root causes – by stimulating sustainable economic growth and employment; promoting educational attainment and aspiration; and supporting community cohesion and self-confidence. This is explicitly described within the new local Single Outcome Agreement (SOA) 2014-2017, with activity evidenced within the recent SOA Annual Report.