West Dunbartonshire CHCP Performance Overview 1st April 2014 to 30th June 2015
Key Performance Indicators: Summary of Progress

15 month values/15 month targets

Performance Indicator	2013/14	April 2014 – June 2015			
	Value	Value	Target	Status	Note
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	92.6%	100%	90%		Target achieved.
Primary Care Mental Health Team average waiting times from referral to first assessment appointment (Days)	28	20	14		Target has not been achieved and performance is being reviewed
Percentage of designated staff groups trained in suicide prevention	100%	100%	50%		Target achieved.
Percentage uptake of bowel screening	51.8%	53.8%	60%		Latest data from Bowel Screening Programme April 2013 - March 2015.
Percentage uptake of cervical screening by 21-60 year olds (excluding women with no cervix)	76.5%	75.6%	80%		Latest data December 2014.
Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	44%	52%	69%		Target not achieved. There are a very small number of young people leaving care each quarter meaning that this percentage can fluctuate considerably.
Rate per 1,000 of children/young people aged 8-18 who are referred to the Reporter on offence-related grounds	4.8	4.6	6.5		Target achieved.
Rate per 1,000 of children/young people aged 0-18 who are referred to the Reporter on non-offence grounds	33.15	19.6	38.5		Target achieved.
Percentage of babies breast-feeding at 6-8 weeks	15.3%	13.9%	16%		Target has not been achieved and performance is being reviewed.
Percentage of babies breast-feeding at 6-8 weeks from the 15%	9.9%	10.5%	16%		Target has not been achieved and

Performance Indicator	2013/14	April 2014 – June 2015			
	Value	Value	Target	Status	Note
most deprived areas					performance is being reviewed.
Percentage smoking in pregnancy	19.6%	17.7%	20%		Target achieved.
Percentage smoking in pregnancy - Most deprived quintile	28%	24.9%	20%		Target has not been achieved and performance is being reviewed
Percentage of five-year olds (P1) with no sign of dental disease	58.6%	61.9%	60%		Source is the Annual National Dental Inspection Programme. It alternates between reporting on P1 and P7 children. The most recent programme took place in 2014.
Number of children with mental health issues (looked after away from home) provided with support	50	117	38		Target achieved.
Number of children with or affected by disability participating in sports and leisure activities	175	170	186		Annual target under review due to the loss of a privately-run Soft Play facility within the area and a reduction in the number of days available from Able2Sail.
Number of children completing tailored healthy weight programme	N/A	49	50		Further marketing to take place to recruit families and workshops with Health Visiting Team.
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	97.4%	96.3%	95%		Target achieved.
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	97.3%	96.4%	97%		Target achieved.
Percentage of child protection investigations to case conference within 21 days	80.2%	88.4%	95%		Reasons for the delay in case conferences include waiting on the conclusion of police investigation and the availability of team leads to chair conferences.

Performance Indicator	2013/14	April 2014 – June 2015			
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Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%	100%		Target achieved.
Percentage of Adult Support and Protection clients who have current risk assessments and care plan	100%	100%	100%		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	1	0	0		Target achieved at March 2015. Timescale reduced to 14 days from April 2015.
Number of adult mental health patients waiting more than 14 days to be discharged from hospital into a more appropriate setting, once treatment is complete	1	0	0		Target achieved.
Balance of Care for looked after children: % of children being looked after in the Community	89%	89%	89%		Target achieved.
Long Term Conditions - bed days per 100,000 population	8,630.4	9,444.4	8,465		Target has not been achieved and performance is being reviewed
Long Term Conditions - bed days per 100,000 population COPD (crude rate)	3,056.5	3,441.7	2,986		Target has not been achieved and performance is being reviewed
Long Term Conditions - bed days per 100,000 population Asthma (crude rate)	266.1	335.2	260		Target has not been achieved and performance is being reviewed
Long Term Conditions - bed days per 100,000 population Diabetes (crude rate)	713.7	711.5	701		Target has not been achieved and performance is being reviewed
Long Term Conditions - bed days per 100,000 population CHD (crude rate)	4,594.1	4,956	4,518		Target has not been achieved and performance is being reviewed
Average waiting times in weeks for musculoskeletal physiotherapy services - WDHSCP	9	15	9		Due to changes in IT system and the introduction of a national target, future reporting will be based on the percentage of patients seen within the 9 week target.

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	Value	Value	Target	Status	Note
Average waiting times in weeks for musculoskeletal physiotherapy services - NHSGGC	6	14	9		Due to changes in IT system and the introduction of a national target, future reporting will be based on the percentage of patients seen within the 9 week target.
Percentage of Care Plans reviewed within agreed timescale	62.9%	73%	72%		Target achieved.
Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	85%	87.6%	88%		Target has not been achieved and performance is being reviewed.
Total number of respite weeks provided to all client groups	6,522	8,471	8,175		Target achieved.
Percentage of community pharmacies participating in medication service	100%	100%	80%		Target achieved.
Number of patients in anticipatory care programmes	1,024	1,601	1,200		Target achieved.
Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)	27%	30.7%	30%		Target has not been achieved and performance is being reviewed.
Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	49.6%	43.9%	35%		Target has not been achieved and performance is being reviewed.
Number of acute bed days lost to delayed discharges (including AWI)	4,925	6,712	4,773		Target has not been achieved and performance is being reviewed.
Number of acute bed days lost to delayed discharges for Adults with Incapacity	1,547	2,455	583		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	0	0		Target achieved at March 2015. Timescale reduced to 14 days from April 2015.
No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015	5	0	0		Target achieved.

Performance Indicator	2013/14	April 2014 – June 2015			
	Value	Value	Target	Status	Note
Unplanned acute bed days (aged 65+)	45,641	59,130	56,026		Target not achieved.
Unplanned acute bed days (aged 65+) as a rate per 1,000 population	3,025	3,802	3,669		Target not achieved.
Unplanned acute bed days (aged 75+)	33,094	43,603	40,625		Target not achieved.
Emergency inpatient bed days rate for people aged 75 and over (per 1,000 population)	4,788	6,341	5,902		Target not achieved.
Number of emergency admissions aged 65+	3,973	5,358	4,876		Target not achieved.
Emergency admissions aged 65+ as a rate per 1,000 population	263	344	319		Target not achieved.
Number of bed days lost to delayed discharge elderly mental illness	710	648	662		Target achieved.
Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	41%	29.4%	40%		Target achieved.
Occupancy rate in local authority care homes (65+ only)	93%	93%	95%		When all cross border residents and those aged under 65 who are resident in our care homes for older people are included, occupancy is sitting on target at 95%.
Number of people aged 75+ in receipt of Telecare - Crude rate per 100,000 population	22,666	22,688	22,589		Target achieved.
Percentage of adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes	51%	56%	55%		Target achieved.
Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	98.2%	98%	97%		Target achieved.
Number of patients on dementia register	613	629	695		Figure taken from QOF report for 1st July 2015. Target has not been

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					achieved and performance is being reviewed. Estimated prevalence has been recalculated based on May 2015 CHI extract.
Total number of homecare hours provided as a rate per 1,000 population aged 65+	642.3	578.3	600		Transition to new home care scheduling system CM2000 still in progress.
Percentage of homecare clients aged 65+ receiving personal care	82.7%	93.8%	83%		
Percentage of people aged 65 and over who receive 20 or more interventions per week	51.3%	31.6%	45.5%		Transition to new home care scheduling system CM2000 still in progress. The old system recorded interventions by the type of care required and it has been anticipated that this figure will fall as the new system records each visit accurately regardless of the type of service being delivered. The target for this measure will require to be reviewed in light of this.
Percentage of people aged 65 or over with intensive needs receiving care at home	40.71%	38%	40%		Transition to new home care scheduling system CM2000 still in progress. This measure focuses on people with 10 hours or more of homecare service each week. The increased use of additional Telecare sensors as an integral component of care packages to sustain people at home contributes towards a reduction in the number of homecare hours and increased support to carers.

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Average length of stay adult mental health	28.8	26	33		Target achieved.
Number of carers of people aged 65+ known to HSCP	1,348	1,446	1,764		Data subject to validation.
Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	95%	90.3%	91.5%		Target not achieved.
Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	98%	93%	98%		Targets have not been achieved and performance is being reviewed.
Number of unplanned admissions for people 65+ from SIMD1 communities	588	633	718		Target achieved.
Number of quality assured Equality Impact Assessments	16	20	10		Target achieved.
Percentage uptake of bowel screening SIMD1	44.3%	46.1%	60%		Latest data April 2013 to March 2015.
Percentage uptake of cervical screening by 21-60 year olds (excluding women with no cervix) SIMD1	74.11%	72.4%	80%		Latest data December 2014.
Number of successful quits, at 12 weeks post quit, in the 40% most deprived areas (SIMD1 and 2)	99	109	233		West Dunbartonshire quit rates are in line with those across NHSGGC. A comprehensive local service evaluation was undertaken with findings considered and recommendations implemented.
Proportionate access to psychological therapies - Percentage waiting no longer than 18 weeks SIMD1	95%	100%	90%		Target achieved.
Proportionate access to psychological therapies - Percentage waiting no longer than 18 weeks SIMD5	93.3%	100%	90%		Target achieved.
Proportionate access to psychological therapies - Percentage waiting no longer than 18 weeks Male	91.9%	100%	90%		Target achieved.

Performance Indicator	2013/14	April 2014 – June 2015			
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Proportionate access to psychological therapies - Percentage waiting no longer than 18 weeks Female	96%	100%	90%		Target achieved.
Percentage of complaints received and responded to within 20 working days (NHS)	100%	87.5%	70%		Target achieved.
Percentage of complaints received which were responded to within 28 days (WDC)	79%	78.8%	70%		Target achieved.
NMC Registration compliance	100%	100%	100%		Target achieved.
Sickness/ absence rate amongst WD HSCP NHS employees (NHSGGC)	5%	4.92%	4%		Figure for rolling year July 2014 to June 2015.
Average number of working days lost per WD HSCP Council Employees through sickness absence	16.15	25.8	11		There has been a significant reduction in absence over a 6 month period - however this is still well in excess of the target of 2 days per quarter. A targeted approach is on-going within the department to improve attendance with a number of strategies outlined in the departmental action plan.
Percentage of WD HSCP Council staff who have an annual PDP in place	67%	88%	95%		Heads of Service receive monthly reports on out of date PDPs.
Percentage of WD HSCP NHS staff who have an annual e-KSF review/PDP in place	68.09%	61.13%	80%		Target has not been achieved and performance is being reviewed.
Percentage of staff with mandatory induction training completed within the deadline (NHS)	67%	100%	100%		Target achieved.

WD CHCP Strategic Plan 2014/15: Key Actions – Summary of Progress

Key Actions	Summary of Progress Made
Complete local implementation of Getting It Right for Every Child (GIRFEC) National Practice Model (NMP).	Responded to the guidance from Scottish Government on named person role, with intention to have all requirements late 2015. This will provide the opportunity of a shadow year in which to finalise local guidance and processes to ensure consistent and appropriate implementation of the named person (NP) role across health and education; clear information sharing processes with NP; and development of single child's plan. The local Work Plan has been shared with Scottish Government, who provided positive feedback and have no objection to the above local approach to early implementation.
Continue roll-out of EMIS Web (electronic record) across children's health services.	Local community child's health visiting teams went live with EMIS and the National Practice Model (NMP – GIRFEC) from November 2014, with the full child health family record up and running – thus enabling Speech and Language Therapy (SLT), Child and Adolescent Mental Health Services (CAMHS), Health Visiting and School Nursing to contribute to the one child's record.
Lead implementation of Child Protection Committee Improvement Action Plan with and across community planning partners.	The Child Protection Committee (CPC) updated their Improvement Action Plan in January 2015, with a further revision in May 2015 covering all improvement areas. In addition a reflective case review was undertaken of a significant child protection case for the purposes of learning – this has greatly informed the CPC Improvement Action plan going forward and has led to the identification of some local training needs. Revised and re-launched the local approach to domestic abuse screening and intervention, with key professionals from the HSCP working into the Police Concern Management Hub for this purpose. The Public Protection Chief Officers Group (PPCOG) hosted a multi-agency development event on 5th December 2014 on domestic abuse. This evaluated very positively. Have continued to refine the overall Public Protection Performance Assurance and Reporting Framework to provide clear assurance and accountability to the PPCOG.

Implement Year Four CPP Older People's Change Fund Plan.	Now providing accessible options to General Practice and operational community services for clients who require rapid response, nursing and care at home provision by providing a single point of contact. This links into the development of an Anticipatory Care Plan (ACP) nursing post linked to the Out of Hours services. Out of Hours Nursing, Home Care, Sheltered Housing, Care Homes, and Mobile Attendants now managed as a coherent network, based around neighbourhood teams to ease access and pathways for those using those local services. Established a bureau model for older people's respite services linked to Primary Care Dementia Service, Community Older People's Team, Out of Hours Services and independent sector providers. It enables direct access, improved coordination and take-up of existing respite and step up/step down opportunities. It is more flexible and responsive to people's needs and provides an out of hours service to support emergency access to respite and step up services where a client's or a carer's needs are urgent. Care at Home services are targeted towards those with high level needs in order to maintain or even improve levels of independence. Established a Home Care Reablement team, which has ensured that the focus is on better outcomes, maximising clients' long term independence and quality of life and appropriately minimises structured supports. A single point of access that allows close links with Supported Discharge Team and Community Older People's Team is in place. In addition to the Care at Home and Occupational Therapy staff, there has been recruitment of pharmacy technicians managed within the local prescribing service to provide compliance support and to liaise with community pharmacy. The West Dunbartonshire Care at Home Pharmacy Service has been recognized as a finalist at the *NHSGGC Chairman's Celebrating Success Awards*. Developed networked services with WD CVS to build on community capacity in particular befriending services, care and repair, support to carers and increasing awareness. This has also been accompanied by investments in developing community directories; and in publicising independent and 3rd sector services and groups, in partnership with Carers of West Dunbartonshire and Alzheimer Scotland.

	West Dunbartonshire Link Up, developed and delivered with West Dunbartonshire CVS and other local organisations, enables older people to access a range of community health, social work and third sector services through a single point of access. Staffed by trained volunteers, the service helps reduce stress for older people and their families by offering easy and prompt access to local services, providing information, support and direct referral opportunities to services such as befriending and assisted shopping. This service won several national awards during the year including: • Working with Local Communities category of the *2014 Care Accolades Awards*. • Self-Management Project of the Year of the *Health and Care Alliance Scotland Awards 2014*. • Gold Award for the Local Matters category of the COSLA *Excellence Awards 2015*. • Commendation at *MJ Local Government Achievement Awards 2015*. Worked in partnership with West Dunbartonshire Leisure Trust to introduce the Vitality physical activity programme – which is specifically tailored for and targeted at older people – within a variety of community facilities, including our own care homes and day care facilities. This initiative has been recognised nationally as a finalist in the *Herald Society Awards 2015*. Worked with Alzheimer Scotland to recruit a local dementia adviser, matching their contribution to provide support to patients, their carers and to health and social care staff across all care settings. The post supports early diagnosis of dementia and diagnosis in primary care and provides education and training to staff. With support from Alzheimer Scotland and WDCVS, continue to develop social supports for patients with dementia and their carers. Embedded the Supportive and Palliative Action Register (SPAR) within local Care Home documentation: the tool is used routinely in Care and Nursing homes to help to identify patients who are deteriorating. A Palliative Care Nurse is in post to support the on-going educational needs of Clinical and Non Clinical staff for people at end of life (which includes refresher sessions on SPAR and support visits to Care and Nursing Homes). Since 2008

	patients on the palliative care register dying in a homely setting has increased from 44% to 56% in 2014/15. During 2014/2015 the percentage of patients dying in hospital for non-cancer deaths reduced from 49.6% to 38% reflecting the change in the service. The local integrated palliative care programme has been recognized nationally: • As a finalist at the *Scottish Health Awards 2015*. • The winner of the best integration award at the *NHSScotland Event 2015*. • The winner of the Health & Social Care Integration category at the *Herald Society Awards 2015*.
Implement requirements of Self-Directed Support Act.	Draft Procedures updated to incorporate new duties. Policy and draft Procedures circulated to all relevant departments. SDS and Support Plan training delivered to staff in the form of formal, informal and ad-hoc sessions as required and/or requested. SDS Website is maintained and updated on a regular basis and is available via main West Dunbartonshire Council site. Carers of West Dunbartonshire offering an independent advice service.
Further improve access to Primary Care Mental Health Team (PCMHT) and reduce incidence of clients failing to attend appointments.	Developed a program of evidence based groups which have been the product of a short life working group led by both Community Mental Health and Primary Mental Health Staff working collaboratively. The Program has formally launched and incorporates a number of accessible groups which are open to all. These include Cognitive Behavioural Therapy in Action hosted by the Primary Care Mental Health Team; Emotional Skills Group hosted by the Community Mental Health Team (CMHT); and a number of Mindfulness Groups delivered by all teams. All of these groups can be accessed by all clients. In addition to this, with the clear increase in the referrals looking to access psychological therapies, resources have been reallocated from CMHT to PCMHT to meet this demand. Worked through locality groups and GPs to promote the option of clients accessing the service using self-referral; and promote third sector options for psychological therapies that GPs can access on behalf of patients.
Work with WDC Housing Section and third sector providers to develop appropriate supported living accommodation for those with long-term mental	Building works were ongoing over this period. Third sector providers agreed to become the tenants. Clients were identified by the clinical team at Gartnavel Royal Hospital, and well developed plans were put in place to discharge clients to their flats with ongoing housing

health needs.	support in the middle of 2015. The Cairnmhor and Hardgate Older Adults Community Team won the Team of the Year at the *WDC Employee Recognition Awards 2015*.
Work with third sector to relocate local clients with a learning disability diagnosis who are currently living in specialist care facilities out of area back within West Dunbartonshire.	Worked with third sector providers to relocate local clients with a learning disability diagnosis who had been living in specialist care facilities out of area (due to a previous lack of local appropriate facilities) back within West Dunbartonshire. Worked in partnership with the charity Cornerstone to develop the new purpose-built Baxter View accommodation within the area that allows a greater degree of independent living than is normally the case for people with high level needs. Baxter View was officially opened in Autumn 2014, and is operated by Cornerstone as a Centre of Excellence - the intention being that the team there will share learning and best practice with other care providers.
Target people with learning disability and sensory impairment to increase their uptake of the national screening programme and continue to target people in SIMD 1 and men.	As part of the local dissemination activity of the Scottish Government's Detecting Cancer Early Campaign, groups experiencing "inequalities" were targeted for key message. There was also ongoing engagement with the NHSGGC/ Cancer Research UK Primary Engagement Programme that encouraged GP Practices to target men and SIMD 1 population.
Embed pathways & processes for supporting patients with health conditions to engage with the employability pathway.	Processes embedded to ensure all services can engage with the local community planning partnership (CPP) employability pathway particularly through the integrated CPP Working 4 U service which delivers on work, learning and money advice support. Increased focus within addictions, mental health and learning disability services, enhanced with Work Connect Initiatives delivered in partnership with WDC HEED; plus range of employability initiatives sponsored through the MCNs (e.g. Get Back Plus programme).
Implement improvement actions to reduce discrimination faced by lesbian, gay and bi-sexual (LGB) people, transgender people, sensory impaired people and people with learning disabilities.	Range of work carried out as part of the West Dunbartonshire Equality Forum, most notably to increase awareness of the third party reporting centres in relation to hate crime. The refurbishment of Dumbarton learning disability resource centre provided an opportunity to for the centre to be a "hub" for more community healthy living activity with

	the aim of reducing stigma. The local Sensory Impairment Forum continues to work on delivering the See Hear Strategy; and the Augmented and Assistive Communication Programme.
Deliver quality assured NHSGGC-wide eye care service through audit and review.	Given the increasing cohort of diabetic patients requiring Diabetic Retinal Screening Service the service is continuing to experience pressures in meeting the target times for 3rd stage examinations. However for the majority of patients results are available within target. It has been agreed with NHSGGC Acute Services Division that Optical Coherence Tomography (OCT) examinations will be delivered to reduce the cost of waiting list initiatives and reduce waiting times to be seen.
MSK Physiotherapy Service: • Ensure equitable waiting times across sites. • Complete roll-out of self-referral across all sites. • Improve supported self-management by working with staff and by developing standardised resources and other methods to support self-management. • Develop and implement physiotherapy pathways to ensure patients get the right treatment at the right time by the right person (including involving key stakeholders) • Outcome measures will be fully implemented and used to address physical activity, stress, anxiety & depression, employability, smoking, obesity and alcohol use. • Implement a single IT system across service.	TrakCare successfully implemented in all 37 MSK Physiotherapy sites across NHSGGC. Moved to Referral Management Centre in May 2015. Completed roll-out of self-referral across all sites. Developed supported management gym rehab programmes that patients attend; and currently reviewing impact of this service. Spinal, Shoulder and Knee pathways have been piloted and feedback obtained. Now being finalised and work starting on elbow, hip and thoracic spine pathways. All staff using outcome measures for every patient. Last audit showed the significant benefit MSK physiotherapy had in reducing pain, increasing function, getting patients back to work or keeping them at work. It also showed a considerable rise in health improvement activity as a result of “raising the issue” training and focusing on specific target areas. Single IT system implemented across service.
Further develop chronic medication service (CMS) with local pharmacies through local community pharmacists group.	Utilising the elements of CMS, local community pharmacies continue to support locally identified priorities – these include both the asthma and the pain local enhanced services (LES). Learning from both of these projects has directly influenced the GGC-wide

	Respiratory LES which commenced in April 2015; and the updated Pain LES, which has been continued in West Dunbartonshire for a further year.
Work with GP practices to monitor their provision of third available appointment, planned appointments and 24 hour access.	Have continued to work with 14 of our 17 practices to record 3rd available appointment and have shown an improvement in those achieving their 3rd available appointment in 24 hours. Continuing to encourage practices to continue to work on improving access using the materials and documentation provided for the GP Contract.
Ensure full compliance with outcome and requirements from the Scottish Government's Redesign of the Community Justice system for the delivery of adult criminal justice services.	Accepted proposal is to maintain a Community Justice Partnership (CJP) across West and East Dunbartonshire and Argyll and Bute until 2017. There are several work streams underway, with the Heads of Service from each partner authority meeting regularly to manage this transition. There has also been engagement with community planning partnership members across the three authority areas and regular reporting to both the CJP Committee and the Community Planning West Dunbartonshire Management Group.
Develop proposed HSCP Integration Scheme.	At its May 2014 meeting, the then Shadow Integration Joint Board for West Dunbartonshire directed the then Interim Chief Officer to develop an integration scheme for West Dunbartonshire on behalf of both the Council and the Health Board in accordance with requirements of the legislation; and for subsequent recommendation for approval by the NHSGGC Health Board and the Council. The completed integration scheme was then presented and approved by the Health Board at its January 2015 meeting; and West Dunbartonshire Council at its February 2015 meeting. The integration scheme was then formally submitted to the Scottish Government for scrutiny and consideration (well in advance of the legislative deadline of 1st April 2015). In May 2015 date the Council and the Health Board received formal confirmation that the Scottish Government had approved the attached Integration Scheme. This enabled the establishment of the new arrangements for West Dunbartonshire on the 1st July 2015, well in advance of the legislative deadline of 1st April 2016 and most other areas of the country.