WEST DUNBARTONSHIRE JOINT FUTURE PARTNERSHIP

APPENDIX 5

West Dunbartonshire Council – NHS Greater Glasgow & Clyde – Communities Scotland

Scottish Executive September 2006

Report for year ended 31st March 2006

REPORTING TEMPLATE FOR LOCAL IMPROVEMENT TARGETS 2006 / 2007

1. National Outcome	2. Local Improvement Target 2006/ 2007	3. Proposed Performance Indicators	4. Stakeholders Involved in Setting Targets	5. Target Value 2004 / 2005 & 2005 / 2006	6. Definition of how targets will be measured	7. Monitoring Arrangements	8. Comments
OLDER PEOPLE Supporting more people at home, as an alternative to residential and nursing care.	**OP1**. Increase by 2% the number of homecare service-users aged 65+ receiving 10 to 20 client visits per week.	Total no. of homecare service-users aged 65+ receiving 10 to 20 client visits per week	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 399 Figure for last week in September 05 = 389 (2.5% decrease) Last wk in Mar 06 = 359 (overall decrease from baseline = 10%)	The targets (column 2) will be measured against the baseline figures in column 5 to determine percentage improvement Source: SE Homecare Return	Progress on target will be reported to the Joint Strategy Group on an annual basis	The reported figures are taken as a snapshot from the last week in March 2006, and indicate a decrease of 10.5% in the number of people receiving this level of service. This indicator must be viewed in the context of the following LIT (OP2), which shows a significant increase in the number of clients receiving more intensive inputs. Initial analysis suggests that continuous review to promote independence and reduce over-care means that homecare inputs are now being better targeted.

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Supporting more people at home, as an alternative to residential and nursing care.	**OP2**. Increase by 2% the number of homecare service-users aged 65+ receiving more than 20 visits per week.	Total No. of homecare service-users aged 65+ receiving more than 20 visits per week.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 278 Figure for last week in September 05 = 261 (6% decrease) Last wk in Mar 06 = 427 (overall increase from baseline = 53.5%)	The targets (column 2) will be measured against the baseline figures in column 5 to determine percentage improvement Information source: SE Homecare Return	Progress on target will be reported to the Joint Strategy Group on an annual basis	As in the previous indicator (OP1), we expect a degree of fluctuation given the snapshot nature of our reporting. We are pleased to note such a large increase in the number of people receiving this most intensive level of homecare support. However we are carefully monitoring this target to ascertain future sustainability. We are optimistic that our new service management system will enable us to provide this enhanced level of support within agreed budgets.

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Supporting more people at home, as an alternative to residential and nursing care.	**OP3**. Increase by 2% the number of homecare service-users aged 65+ receiving weekend homecare service	Total No. of homecare service users aged 65+ receiving weekend service	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 763 Figure for last week in September 05 = 763 (no change) Last wk in Mar 06 = 782 (2.5% increase)	Information source: SE Homecare Return	Progress on target will be reported to the Joint Strategy Group on an annual basis	The number of clients receiving weekend service has increased by 0.5%. The service works in partnership with families and carers to ensure clients are supported. The figure also does not reflect the turnover of clients who require extended cover for a short period to regain a level of independence. (We do have unmet need for weekend cover, but this has not prevented discharge from hospital, nor has it necessitated a hospital admission).

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Supporting more people at home, as an alternative to residential and nursing care.	**OP4**. Increase by 2% the number of homecare service users aged 65+ receiving evening service	Total No. of homecare service-users aged 65+ receiving evening service	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 206 Last wk in Mar 06 = 485 (135% increase)	Information source: Business Objects Report	Progress on target will be reported to the Joint Strategy Group on an annual basis	Report for this indicator was previously based on H1 definitions of evening service (7pm – 10pm). This excluded our early evening services which are now included in this target return.
Supporting more people at home, as an alternative to residential and nursing care.	**OP5**. Increase by 2% the number of homecare service-users aged 65+ receiving overnight service	Total No. of homecare service-users aged 65+ receiving overnight service	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 218 Last wk in Mar 06 = 203 (7% decrease)	Information source: Business Objects Report	Progress on target will be reported to the Joint Strategy Group on an annual basis	This figure has fallen as a result of the recording system for tuck-in service, which was historically recorded as a night service, but has now been classified as late evening if delivered before 10pm.

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Supporting more people at home, as an alternative to residential and nursing care.	**OP6**. Sustain smart technology packs for up to 100 people.	Number of individuals aged 65+ supported by smart technology.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	2004 / 05 Pilot – 10 individuals March 2006 = 100 people in sheltered housing have had smart technology installed.	Information Source: Business Objects Report	Progress on target will be reported to the Joint Strategy Group on an annual basis	Installation programme in Sheltered Housing commenced in November 2005. We have exceeded our 2005/06 target and will closely monitor the effectiveness before committing to further installations.
SINGLE SHARED ASSESSMENT (OLDER PEOPLE) Ensuring people receive an improved quality of care through faster access to services and better quality services.	**OP7**. The number of working days between referral and assessment commencement should not exceed 5	Average number of days between referral and assessment commencement.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 7 days Apr 05 – Mar 06 = 3.26 Target achieved	Information Source: Report from CareFirst via Business Objects	Progress on target will be reported to the Joint Strategy Group on an annual basis	We believe that our improvement in this target indicates a better service for older people in West Dunbartonshire.

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Ensuring people receive an improved quality of care through faster access to services and better quality services.	**OP8**. The number of working days between start of assessments to first service start should not exceed 30.	Average number of days between start of assessments and the first part of a care package to be delivered.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 32 days Apr 05 – Mar 06 Elderly Median = 21 Dementia Median = 30 Target achieved	Information Source: Scottish Executive JPIAF Return – Table 2 Will be a statutory performance indicator 05/06	Progress on target will be reported to the Joint Strategy Group on an annual basis	Recording Processes will improve with the implementation of Care Assess.
Ensuring people receive an improved quality of care through faster access to services and better quality services.	**OP9**. Number of working days between start of assessments and completion should not exceed 28.	Average No. days between start of and completion of assessment.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 29 days Apr 05 – Mar 06 = 24 days Target achieved	Information Source: Report from CareFirst via Business Objects on completed SSA's.	Progress on target will be reported to the Joint Strategy Group on an annual basis	We believe that our improvement in this target indicates a better service for older people in West Dunbartonshire.

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Ensuring people receive an improved quality of care through faster access to services and better quality services.	**OP10** Increase the number of people aged 65+ who receive SSA by 20%	No. of people aged 65+ having single shared assessments completed	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05: Frail Elderly = 1681 Dementia = 149 Total = 1830 Apr 05 – Mar 06 Frail Elderly = 1385 Dementia = 109 Total = 1,494	Information Source: Scottish Executive JPIAF Return	Progress on target will be reported to the Joint Strategy Group on an annual basis	Note – The definitions for this are different than those used for JPIAF 6 as they exclude on-going service users and this Local Improvement Target does not.
Ensuring people receive an improved quality of care through faster access to services and better quality services.	**OP11**. Increase the number of SSA completed by Health and Housing by 50%	No. of single shared assessments for 65+ completed	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004 / 05 Health = 256 Housing = 2 April to September 2005 Health = 88 Housing = 0 2005 / 06 Health = 168 Housing = 1	Information Source: SSA database	Progress on target will be reported to the Joint Strategy Group on an annual basis	The decrease in the number of SSAs completed by health workers appears to be a reflection in the overall decrease in the number of SSAs. We would however have expected to see more housing SSAs given the low baseline figures. This issue is currently under investigation.

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Ensuring people receive an improved quality of care through faster access to services and better quality services.	**OP12**. Increase the number of people aged 65+ receiving a care management service by 2%	Number of people aged 65+ receiving care management service.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline: Cases open during last week in March 2006 = 1,229	Information Source: CareFirst Report based on Client Manager	Progress on target will be reported to the Joint Strategy Group on an annual basis	Local systems have now been developed to enable us to report on this indicator.

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DELAYED DISCHARGE Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD1**. Reduce delayed discharges over 6 weeks by 50%, in line with the national target set by the Scottish Executive.	Number of delayed discharges over 6 weeks	• NHS Greater Glasgow & Clyde • West Dunbartonshire Council • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline as at as at 15/04/05 = 43 At 15.04.06 = 25 46.5% decrease)	Quarterly National Census	Progress on target will be reported to the Joint Strategy Group on a quarterly basis.	Delayed discharges remain a serious issue in West Dunbartonshire, and we are committed to the new targets set by the Scottish Executive. This report covers all delayed discharges in all settings, and no age split is available, therefore figures cover all ages. A more detailed breakdown reflecting the new targets will be provided at the October 2006 interim report.

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Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD2**. Reduce delayed discharges in short stay beds by 50%, in line with the national target set by the Scottish Executive.	Number of delayed discharges in short stay beds	• NHS Greater Glasgow & Clyde • West Dunbartonshire Council • Communities Scotland • Community Care Planning & Implementation Partnership	15th April 2006: number = 18	Quarterly National Census	Progress on target will be reported to the Joint Strategy Group on a quarterly basis.	

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Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD3**. Increase the number of people aged 65+ supported by Rapid Response Services by 2%.	Number of clients supported by Rapid Response Services.	• NHS Greater Glasgow & Clyde • West Dunbartonshire Council • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 1025 Baseline 2005 / 06 Apr – Mar = 904 (12% decrease)	SEHD monthly monitoring returns	Progress on target will be reported to the Joint Strategy Group on a quarterly basis.	No split available by age group so figures cover all age ranges. There appears to be a decrease in the number of people supported by Rapid Response services. Local analysis indicates that that while operating under 2 NHS systems, different methods of Data Collection and interpretation have been used. We therefore believe that the 4/5 figure was on over-estimate as it includes a significant element of double counting. Under the new CHP arrangements we have harmonised the two systems and believe that the 5/6 figure provides a more accurate baseline to determine performance against LITs.

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Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD3**. Increase the number of people aged 65+ supported by Rapid Response Services by 2%.	Number of clients supported by Rapid Response Services – under definition of 2 hour service	• NHS Greater Glasgow & Clyde • West Dunbartonshire Council • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2005/06 = 438	SEHD monthly monitoring returns	Progress on target will be reported to the Joint Strategy Group on a quarterly basis.	No split available by age group so figures cover all age ranges. This is a new LIT to measure and record Rapid Response services within a timeframe of 2 hours. This has been developed in response to local concerns regarding the increase in the number of unplanned admissions.

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Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD4**. Reduce the number of people aged 65 - 74 with 2 or more emergency in-patient admissions in a year by 5%.	Number of people aged 65 - 74 with 2 or more emergency in-patient admissions	• NHS GG & C • WDC • Communities Scotland	Baseline 2004/05 = 277 2005/06 = 253* *This is an estimate based on 12 months data to 31.12.05. Estimate indicates a 9% reduction	Information from NHS Greater Glasgow & Clyde	Progress on target will be reported to the Joint Strategy Group on an annual basis	Whilst it appears that DD4&5 will be on target, DD6 through to 9 appear to be highlighting increases in unplanned admissions. This is despite high levels of Home Care input and more streamlined delivery of Rapid Response services. We have therefore engaged the support of the Joint Improvement Team to help us understand the key risk factors and development of an Action Plan to address these issues. Our joint Capacity Plan reinforces our commitment to review services, Over the next year a key priority for the WDCHP will be to establish a range of mechanisms and forums to ensure joint plans and priorities are agreed with the Rehabilitation and Assessment Directorate and Acute Operating Divisions. We will foster a partnership approach at all levels of secondary and specialist care to ensure there are efficient care pathways between secondary, primary and community care services, which will prevent both delayed discharges occurring and repeated admissions to hospital wards.

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Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD5**. Reduce the number of people aged 75 - 84 with 2 or more emergency in-patient admissions in a year by 5%.	Number of people aged 75 - 84 with 2 or more emergency in-patient admissions.	• NHS GG & C • WDC • Communities Scotland	Baseline 2004/05 = 350 2005/06 = 324* * This is an estimate based on 12 months data to 31.12.05. Estimate indicates 7% reduction.	Information from NHS Greater Glasgow & Clyde	Progress on target will be reported to the Joint Strategy Group on an annual basis	Estimated figures based on 12 months data to 31.12.05. The 7% reduction indicated is subject to verification once year-end data is available.
Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD6**. Reduce the number of people aged 85+ with 2 or more emergency in-patient admissions in a year by 5%.	Number of people aged 85+ with 2 or more emergency in-patient admissions.	• NHS GG & C • WDC • Communities Scotland	Baseline 2004/05 = 134 2005/06 = 146* *This is an estimate based on 12 months data to 31.12.05. Estimate indicates a 9% increase	Information from NHS Greater Glasgow & Clyde	Progress on target will be reported to the Joint Strategy Group on an annual basis	Estimated figures based on 12 months data to 31.12.05. The 9% increase indicated is subject to verification once year-end data is available.

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Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD7**. To reduce the number of people aged 65 – 74 admitted to hospital as an urgent or emergency admission by 5%	Number of people aged 65 – 74 who are subject to urgent or emergency admissions.	• NHS GG & C • WDC • Communities Scotland	Baseline 2004/05 = 810 2005/06 = 955* *This is an estimate based on 12 months data to 31.12.05. Estimate indicates an 18% increase	Information from NHS Greater Glasgow & Clyde	Progress on target will be reported to the Joint Strategy Group on an annual basis	Estimated figures based on 12 months data to 31.12.05. The 18% increase indicated is subject to verification once year-end data is available

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Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD8**. To reduce the number of people aged 75 – 84 admitted to hospital as an urgent or emergency admission by 5%	Number of people aged 75 – 84 who are subject to urgent or emergency admissions.	• NHS GG & C • WDC • Communities Scotland	Baseline 2004/05 = 905 2005/06 = 1,024* *This is an estimate based on 12 months data to 31.12.05. Estimate indicates a 13% increase	Information from NHS Greater Glasgow & Clyde	Progress on target will be reported to the Joint Strategy Group on an annual basis	Estimated figures based on 12 months data to 31.12.05. The 13% increase indicated is subject to verification once year-end data is available

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Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD9**. To reduce the number of people aged 85 + admitted to hospital as an urgent or emergency admission by 5%	Number of people aged 85+ who are subject to urgent or emergency admissions.	• NHS GG & C • WDC • Communities Scotland	Baseline 2004/05 = 422 2005/06 = 527 * *This is an estimate based on 12 months data to 31.12.05. Estimate indicates a 25% increase	Information from NHS Greater Glasgow & Clyde	Progress on target will be reported to the Joint Strategy Group on an annual basis	Estimated figures based on 12 months data to 31.12.05. The 25% increase indicated is subject to verification once year-end data is available
Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD10**. To increase the number of clients benefiting from early / supported discharge by 2%	Number of clients benefiting from Early / Supported Discharge	• NHS GG & C • WDC • Communities Scotland	Baseline 2004/05 = 315 2005 / 06 = 343 (8.9% increase)	Information from NHS Greater Glasgow & Clyde	Progress on target will be reported to the Joint Strategy Group on an annual basis	We believe that our improved performance in this indicator has contributed to our reduction in the number of delayed discharges.

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Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD11**. Reduce the number of people aged 65 – 74 who are re-admitted within 7 days of discharge by 2%	Number of people aged 65 - 74 who were re-admitted within 7 days of discharge	• NHS GG & C • WDC • Communities Scotland	Baseline 2004/05 = 106* 2005/06 = 121* *This is an estimate based on 12 months data to 31.12.05. Estimate indicates an 14.1% increase	Information from NHS Greater Glasgow & Clyde	Progress on target will be reported to the Joint Strategy Group on an annual basis	Estimated figures based on 12 months data to 31.12.05. The 14.1% increase indicated is subject to verification once year-end data is available.
Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD12**. Reduce the number of people aged 75 – 84 who are re-admitted within 7 days of discharge by 2%	Number of people aged 75 - 84 who were re-admitted within 7 days of discharge	• NHS GG & C • WDC • Communities Scotland	Baseline 2004/05 = 131 2005/06 = 131 * *This is an estimate based on 12 months data to 31.12.05.	Information from NHS Greater Glasgow & Clyde	Progress on target will be reported to the Joint Strategy Group on an annual basis	Estimated figures based on 12 months data to 31.12.05. This is subject to verification once year-end data is available.

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Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.	**DD13**. Reduce the number of people aged 85+ who are re-admitted within 7 days of discharge by 2%	Number of people aged 85+ who were re-admitted within 7 days of discharge	• NHS GG & C • WDC • Communities Scotland	Baseline 2004/05 = 42 2005/06 = 66 * This is an estimate based on 12 months data to 31.12.05. Estimate indicates an 57% increase	Information from NHS Greater Glasgow & Clyde	Progress on target will be reported to the Joint Strategy Group on an annual basis	Estimated figures based on 12 months data to 31.12.05. The 57% increase indicated is subject to verification once year-end data is available.
CARERS Better involvement and support of carers	**C1**. Increase the number of people receiving a short break by 2%.	Number of people who received a short break	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 61 2005/06 = 64 (increase = 5%)	Information Source: Scottish Executive JIPAF Return	Progress on target will be reported to the Joint Strategy Group on an annual basis	This service has been tailor made around the needs of the carer. The Carers themselves were fully involved in designing and commissioning this service.

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Better involvement and support of carers	**C2**. Sustain residential respite at current levels	Residential respite nights	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 3,648 2005/06 = 4304 (18% increase)	Information Source: Statutory Performance Indicator PI (Number of people receiving respite care)	Progress on target will be reported to the Joint Strategy Group on an annual basis	This is mainly due to respite beds in units closed for upgrading coming back into use.
Better involvement and support of carers	**C3**. Sustain Respite at home at current levels	Respite at home	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 12,096 2005/06 = 18,959 (recorded in hours) (57% increase)	Information Source: Statutory Performance Indicator PI (Number of people receiving respite care)	Progress on target will be reported to the Joint Strategy Group on an annual basis	The level of respite at home increased due to the development of the MacMillan Carers Service and the ongoing development of the Carer's Short Break Service.

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Better involvement and support of carers	**C4**. Sustain Respite at day services at current levels	Respite at day services	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 62,759 2005/06 = 66,509 (recorded in hours)	Information Source: Statutory Performance Indicator PI (Number of people receiving respite care)	Progress on target will be reported to the Joint Strategy Group on an annual basis	The level of respite at Day Services increased due to the development of MacMillan Carers Service.
Better involvement and support of carers	**C5**. Increase the number of carers' assessments to 60	Number of carers who received a Carers Support Plan	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Communities Scotland • Community Care Planning & Implementation Partnership	Baseline 2004/05 = 36 2005/06 = 23 (36% decrease)	Information Source: Scottish Executive JIPAF Return Carers Assessments table	Progress on target will be reported to the Joint Strategy Group on an annual basis	Operational staff have reported that carers remain reluctant to complete a support plan, either under the self-assessment model or with a worker helping. We are keen to know if other partnerships are experiencing this difficulty, and to learn from any successful areas.

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LEARNING DISABILITY Everyone with a learning disability who wants to, should be able to have a 'personal life plan'. Reference: The Same as You? 2000 WDC PIP Agreement 2004 – 2007	**LD1**. Total number of clients with Personal Life Plan to increase by 10%	Total number of clients being offered a PCP	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline 2005/2006 = 194	The targets will be measured against the baseline figures in column 5 to determine % improvement	Half yearly through JPIAF	
Develop a range of employment opportunities for people with learning disabilities. Reference: The Same as You? 2000 WDC PIP Agreement 2004 - 2007	**LD2**. To increase the total number of people in paid employment by 5	Total number of people in paid employment	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline 2005/2006 = 19	The targets will be measured against the baseline figures in column 5 to determine % improvement	Half Yearly Through JPIAF	

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With partners implement a programme of Health Checks for people with a learning disability who wish one. Reference: The Same as You? 2000 WDC PIP Agreement 2004 - 2007	**LD3**. To increase the total number of people with a learning disability who are being offered a health check by 10%	Total number of people being offered a health check	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline 2005/2006 =119	The targets will be measured against the baseline figures in column 5 to determine % improvement	Half yearly through JPIAF	
The development and implementation of Health Logs Reference: The Same as You? 2000 WDC PIP Agreement 2004 - 2007	**LD4**. To increase the number of health logs being used by 8	Total number of Health Logs being used	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline 2005/2006 = 25	The targets will be measured against the baseline figures in column 5 to determine % improvement	Half yearly through JPIAF	
Ensuring people receive an improved	**LD5**. Increase number of staff	Total number of staff being	• West Dunbartonshire	Baseline 2005/2006 = 79	The targets will be measured	Quarterly through the quarterly	

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quality of care through better trained staff. Access for staff to level one of Inclusive (Total) communication training to assist in their contact with people with a learning disability. Reference: The Same as You? 2000 WDC PIP Agreement 2004 - 2007	being trained to level one of Inclusive (Total) communication training to assist in their contact with people with a learning disability by 35.	trained in level 1 Inclusive (Total) Communication	Council • NHS Greater Glasgow & Clyde		against the baseline figures in column 5 to determine improvement	performance report Annual reporting to SE and HISJP	
Ensuring people receive an improved quality of care through faster access to services and better quality services.	**LD6**. Specialist Single Shared Assessment to be implemented across LD Services	Number of SSAs completed.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline to be established during 2006 / 2007	The targets will be measured against the baseline figures in column 5 to determine % improvement	Quarterly through the quarterly performance report	

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ADDICTIONS Ensuring people receive an improved quality of care through faster access to services and better quality services.	**A1**. Increase Number of individuals accessing addiction services by 5% per annum	New clients accessing addiction services	• WDC • WDCHP	Baseline to be established during 2006 / 2007	The targets (column 2) will be measured against the baseline figures in column 5 to determine level of improvement.	Quarterly Performance Reports	
Ensuring people receive an improved quality of care through faster access to services and better quality services.	**A2**. Reduce waiting times between referral to service and first appointment – 90% of clients seen within 14 days	Days between referral and first appointment	• WDC • WDCHP	Baseline July – September 2005 = 58% of individuals offered first appointment within 14 days of referral	The targets (column 2) will be measured against the baseline figures in column 5 to determine level of improvement.	Quarterly / Waiting Times Figures	Same targets across partner agencies

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Ensuring people receive an improved quality of care through faster access to services and better quality services.	**A3**. Improve access to integrated addiction services through increasing the number of Single Shared Assessments, by 10 in year one and subsequently by 20% per annum	Number of Addiction SSA'S completed	• WDC • WDCHP	Baseline 2004/05 = 2 20% per annum 2005/06 = 12 2006/07 = 14 2007/08 = 17	The targets (column 2) will be measured against the baseline figures in column 5 to determine level of improvement.	Quarterly / Scottish Executive Returns	Same % increase across partner agencies. Baseline to be established during 2006 / 07
Improve range of service choice for individuals	**A4.** Focus groups and client surveys to be used to test perceptions of clients and range of service choice relative to client need	Completed Surveys and reports on outcome to HISJP.	• WDC • WDCHP	To be set following first results of Focus Groups and Surveys		Reports to November 06 and February 07 HISJP	

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MENTAL HEALTH Ensuring people receive an improved quality of care through faster access to services and better quality services.	**MH1**. The number of working days between referral and assessment commencement should not exceed 20.	Average number of days between referral and assessment commencement.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline will be developed during 2006 / 07	Information Source: Report from CareFirst via Business Objects Number of new referrals and number with 1st appointment within 14 days of referral.	Progress on target will be reported to the Joint Strategy Group on an annual basis	Develop report that will capture required information.
Ensuring people receive an improved quality of care through faster access to services and better quality services.	**MH2**. Increase the number of MH Specialist SSA's by 20%	Number of MH SSSAs completed	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline: 2004/05 =9 2005/06 =29 (222% increase) Target for 2006/07 = 35	Information Source: Report from CareFirst via Business Objects	Report to WD MH Planning Group	

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Ensuring people receive an improved quality of care through faster access to services and better quality services.	**MH3**. Increase the number of Carer's Support Plans by 100%	Number of Carer's Support Plans completed	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline 04/05 = 2 05/06 = 0 Target for 2006/07 = 4	Information Source: Report from CareFirst via Business Objects	Report to WD MH Planning Group	We note that we have not completed any Carer's Support Plans in respect of Mental Health Services, but would stress that these have been offered as a matter of course to every identified carer. We plan to further develop our systems to record the number of assessments offered, refused & accepted.
Promote consumer involvement in the planning & delivery of services	**MH4**. Train 12 consumers in committee skills	No of consumers trained.	• WDC • NHSGG&C • MHF • LAAS	New development – therefore no current baseline.	Completion of training	Report to WD MH Planning Group	Build on joint approach to consumer perspective monitoring, evaluation & consultation

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ACQUIRED BRAIN INJURY Supporting more people at home to live full and independent lives.	**ABI1.** Establish baseline of the number of people receiving service provision for Acquired Brain Injury	Number of individuals accessing the service for the first time.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Momentum • Community Care Planning & Implementation Partnership	A baseline will be developed during 2006/07	Once baseline is established, the targets (column 2) will be measured against the baseline figures in column 5 to determine level of improvement.	Report to WD ABI Planning Group	Acquired Brain Injury clients may be recorded within a variety of Community Care Group classifications (e.g. Physical Disability; Mental Health), therefore our information system cannot readily report the current baseline. We are working to try to develop a baseline measure that can be reported more easily.

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Ensuring people receive an improved quality of care through faster access to services and better quality services.	**ABI2.** Develop Specialist ABI SSA.	Specialist SSA fully operational by September 2006.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Momentum • Community Care Planning & Implementation Partnership	Baseline number of Specialist SSAs completed will be established during 2006/07.	Progress report will be submitted to the February 2007 meeting of the HISJP.	Progress on target will be reported to the Joint Strategy Group on a regular basis.	
Better involvement and support of carers	**ABI3.** Undertake a consultation of ABI service users and their carers.	Consultation to be completed by Jan 07	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Momentum • Community Care Planning & Implementation Partnership	Baseline target will be set as result of consultation.	Review report will be submitted to the February 07 meeting of the HISJP.	Progress on target will be reported to the Joint Strategy Group on a regular basis.	

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SENSORY IMPAIRMENT Supporting more people at home to live full and independent lives.	**SI1**. Increase the number of people receiving rehabilitation services for sight loss by 2%	Total number of individuals accessing the service.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Community Care Planning & Implementation Partnership • Focus • Visibility • RNIB • Bankie Talk • Rockvale Rebound	Baseline: 2005/06 number of people receiving the service = 34	Information Source: Report from Carefirst via Business Objects	Progress on target will be reported to the Sensory Impairment Strategy Group and Joint Strategy Group on a regular basis.	

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Ensuring people receive an improved quality of care through faster access to services and better quality services.	**SI2.** Increase the number of users of the Outreach services within the community by 2% (including increased services delivered by Lomond Care and Repair for sensory impaired clients)	Number of clients attending Outreach Services increased	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Community Care Planning & Implementation Partnership • Deafblind Scotland • Focus • Visibility • Deaf Connections • RNID • RNIB • Bankie Talk • Rockvale Rebound	Baseline: 2005/06 number of people receiving the service = 225	Through the consultation process and final agreement at the Health improvement and Social Justice Partnership. Target date for agreement is February 07.	Progress on target will be reported to the Sensory Impairment Strategy Group and the Joint Strategy Group on a regular basis.	Some issues around sensory impairment need to be identified at a very early stage to ensure optimum outcome for the affected person before deterioration of their condition affects mobility, access to information and communication

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Ensuring people receive an improved quality of care through faster access to services and better quality services.	**SI3.** Further implement of Specialist Sensory Impairment SSA September 2006.	Specialist SSA fully operational by March 2007.	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde • Community Care Planning & Implementation Partnership • Deafblind Scotland • Focus • Visibility • Deaf Connections • RNID • RNIB • Bankie Talk • Rockvale Rebound	Baseline number of Specialist SSAs completed will be established during 2006/07.	Progress report will be submitted to the February 2007 meeting of the HISJP.	Progress on target will be reported to the Joint Strategy Group on a regular basis.	SSA needs to count number of assessments offered, refused & accepted
EQUIPMENT & ADAPTATIONS Ensuring people receive an improved quality of care through faster access to services	**E&A1**. Decrease the number of people age 0-17 on the waiting list by 5%	Number of people aged 0-17 on waiting list	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline under development	Target in column 2 will be measured against the baseline figures in column 5 to determine improvement	Quarterly waiting list figures	

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Ensuring people receive an improved quality of care through faster access to services	**E&A2.** Decrease the number of people age 18-64 on the waiting list by 5%	Number of people aged 18-64 on waiting list	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline under development	Target in column 2 will be measured against the baseline figures in column 5 to determine improvement	Quarterly waiting list figures	
Ensuring people receive an improved quality of care through faster access to services	**E&A3.** Decrease the number of people age 65+ on the waiting list by 5%	Number of people aged 65+ on waiting list	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline under development	Target in column 2 will be measured against the baseline figures in column 5 to determine improvement	Quarterly waiting list figures	
Ensuring people receive an improved quality of care through faster access to services	**E&A4**. Increase the number of people age 0-17 receiving an assessment by 5%	Number of people aged 0-17 on waiting list	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline under development	Target in column 2 will be measured against the baseline figures in column 5 to determine improvement	Quarterly assessment figures	

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Ensuring people receive an improved quality of care through faster access to services	**E&A5**. Increase the number of people age 18-64 receiving an assessment by 5%	Number of people aged 18-64 on waiting list	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline under development	Target in column 2 will be measured against the baseline figures in column 5 to determine improvement	Quarterly assessment figures	
Ensuring people receive an improved quality of care through faster access to services	**E&A6**. Increase the number of people age 65+ receiving an assessment by 5%	Number of people aged 65+ on waiting list	• West Dunbartonshire Council • NHS Greater Glasgow & Clyde	Baseline under development	Target in column 2 will be measured against the baseline figures in column 5 to determine improvement	Quarterly assessment figures	

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WELFARE RIGHTS Ensuring people receive an improved quality of care through faster access to services and better quality services.	**WR1.** Increase the number of people given advice / support (where a benefit / grant claim is not applicable) by 2%.	Number of people given advice / support.	• WDC • Macmillan • WDCHP	Baseline to be developed.	The targets (column 2) will be measured against the baseline figures in column 5 to determine level of improvement.	Quarterly Performance Report	People tell us that advice and/or support is extremely valuable when coming to terms with a cancer diagnosis. It is therefore important to reflect this part of the service, even if there is no financial improvement for patients or their families.
Improve Social Inclusion in respect of disadvantaged groups.	**WR2**. Increase the number of lone parents supported to return to work by 2%	Number of lone parents supported to return to work.	• WDC • WDCHP	Baseline to be developed.	The targets (column 2) will be measured against the baseline figures in column 5 to determine level of improvement.	Quarterly Performance Report	New service area and performance management framework still under development.
Improve Social Inclusion in respect of disadvantaged groups.	**WR3.** Increase the number of people referred from *Working for Families* to the Welfare Rights Debt Money Advice Service by 2%	Number of people referred from *Working for Families* to the Welfare Rights Debt Money Advice Service.	• WDC • WDCHP	Baseline to be developed.	The targets (column 2) will be measured against the baseline figures in column 5 to determine level of improvement.	Quarterly Performance Report	New service area and performance management framework still under development.