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

Performance Indicator	2012/13	2013/14					
	Value	Value	Target	Mid-Year Status	Long Trend	Short Trend	Note
Percentage of babies breast-feeding at 6-8 weeks	14%	14%	16%				Provisional - Data for Quarter 2 not yet available and June 2013 reported as interim figure. It has been confirmed that local practice is in line with best practice being undertaken in other areas, and that differences in incidence likely influenced by demographic and cultural differences between communities.
Percentage of babies breast-feeding at 6-8 weeks from the 15% most deprived areas	9.2%	9.2%	16%				
Percentage smoking in pregnancy	16.7%	16.3%	20%				Provisional - Data for Quarter 2 not yet available and June 2013 reported as interim figure.
Percentage smoking in pregnancy - Most deprived quintile	25.8%	25.8%	20%				
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	93.2%	92.8%	95%				Provisional - Data for Quarter 2 not yet available and June 2013 reported as interim figure.
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	342	243				Target achieved.
Number of children with or affected by disability participating in sports and leisure activities	179	149	129				Target achieved.
Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	6.5	7.5	18				Target achieved.
Balance of Care for looked after children: % of children being looked after in the Community	87.1%	88.8%	88%				Target achieved.
Number of children with mental health issues (looked after away from home) provided with support	30	36	11				Target achieved.
Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	60%	0%	63%				Of the 3 young people who left care between April and September, none have entered positive destinations.

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Percentage of child protection referrals to case conference within 21 days	95.1%	90%	95%				Those case conferences which were carried out beyond the timescale were due to unavoidable delays.
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%	100%				Target achieved.
Percentage of those invited attending for breast screening	72.7%	72.5%	71.4%				Target achieved.
Total number of successful quits (at one month post quit) delivered by community-based universal smoking cessation service	141	41	48				Provisional.
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	31	28				Target achieved.
Number of inequalities targeted cardiovascular Health Checks (Cumulative)	1,547	864	398				Target achieved.
Number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention	975	302	419				ABIs being maintained as integral part of Live Active Exercise Referral Scheme in West Dunbartonshire, and included in service level agreement with Y Sort It (Youth information service) for Wrecked and Wasted social marketing campaign.
Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	92.3%	92.1%	91.5%				Target achieved.
Percentage of designated staff groups trained in suicide prevention	100%	100%	50%				Target achieved.
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	78.6%	85.4%	85%				Target achieved.
PCMHT average waiting times from referral to first assessment appointment (Days)	20	29	14				Provisional figure as at July 2013.
Proportionate access to psychological therapies - Percentage waiting no longer than 18 weeks SIMD1	89.5%	75%	85%				Provisional - figure as at July 2013.
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	0	0				Target achieved.

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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	N/A	0	0				Target achieved.
Average length of stay adult mental health delayed discharge	33	32.7	35				Target achieved.
Number of bed days lost to delayed discharge elderly mental illness	611	265	266				Target achieved.
Number of patients on dementia register	589	630	672				Indicative targets have not been achieved however performance is continuing to improve.
Long Term Conditions - bed days per 100,000 population	9,267	8,764	10,000				Target achieved.
Long Term Conditions - bed days per 100,000 population COPD (crude rate)	3,424.1	3,069.9	4,000				Target achieved.
Long Term Conditions - bed days per 100,000 population Asthma (crude rate)	361.9	334.2	310				Provisional - Data for Quarter 2 not yet available and April - June 2013 reported as interim figure.
Long Term Conditions - bed days per 100,000 population Diabetes (crude rate)	616.4	519	740				Target achieved.
Long Term Conditions - bed days per 100,000 population CHD (crude rate)	4,865	4,840.6	5,300				Target achieved.
Average waiting times in weeks for musculoskeletal physiotherapy services - WDCHCP	6	6	9				Target achieved.
Percentage of Care Plans reviewed within agreed timescale	65.73%	65.1%	70%				Indicative targets have not been achieved and performance is under review.
Percentage of community pharmacies participating in medication service	N/A	100%	80%				Target achieved.
Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)	35%	27.9%	35%				Target achieved.
Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	40%	49.3%	40%				Indicative targets have not been achieved and performance is being reviewed.
Number of acute bed days lost to delayed discharges	6,050	1,952	1,910				Provisional – Data for month of September 2013 unavailable and April - August reported as interim figure.

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Number of acute bed days lost to delayed discharges for Adults with Incapacity	1,872	608	234				Provisional – Data for month of September 2013 unavailable and April - August reported as interim figure.
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	1	0				Indicative targets have not been achieved and performance is being reviewed.
Unplanned acute bed days 65+	51,748	19,524	27,500				Target achieved.
Unplanned acute bed days 65+ as a rate per 1,000 population	3,502	1,294	1,869				Target achieved.
Unplanned acute bed days (aged 75+)	39,314	14,232	19,300				Target achieved.
Emergency inpatient bed days rate for people aged 75 and over (per 1,000 population)	5,750	2,060	3,200				Target achieved.
Number of emergency admissions 65+	4,398	1,691	2,126				Target achieved.
Emergency admissions 65+ as a rate per 1,000 population	298	112	150				Target achieved.
Number of unplanned admissions for people 65+ by SIMD Quintile 1	588	251	294				Target achieved.
Average length of stay for emergency admissions 65+	2.8	2.7	3				Target achieved.
Percentage of people 65+ admitted twice or more as an emergency who have not had an assessment	34.16%	39%	33%				Indicative targets have not been achieved and performance is being reviewed.
Number of people aged 75+ in receipt of Telecare - Crude rate per 100,000 population	21,889	22,824	21,280				Target achieved.
Percentage of adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes	47%	55.5%	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.
Percentage of people receiving free personal or nursing care within 6 weeks of confirmation of 'Critical' or 'Substantial' need	98%	100%	100%				Target achieved.
Total number of homecare hours provided as a rate per 1,000 population aged 65+	652.9	660.6	678				In line with the focus on reablement, service is being targeted towards those

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							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%	82.3%	81%				Target achieved.
Percentage of people aged 65 and over who receive 20 or more interventions per week	50.47%	52.43%	44.5%				Target achieved.
% of people aged 65 or over with intensive needs receiving care at home	42.4%	41.5%	49%				Indicative targets have not been achieved and performance is being reviewed.
Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	77.6%	84.1%	85%				Indicative targets have not been achieved.
Number of weeks of respite provided for carers of Older People / Dementia 65+	3,057	1,288	1,528				Provisional – Data reported subject to review and change. Target is provisional.
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 in November 2012.
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. The new older people's care homes are scheduled for completion in 2015 and this will positively influence the direction of travel towards target.

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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 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 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%	87%	70%				Target achieved.
NMC Registration compliance	100%	100%	100%				Target achieved.
Sickness/ absence rate amongst WD CHCP NHS employees (NHSGGC)	5.1%	5%	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). An absence audit is currently underway to review practice plus policy awareness sessions delivered.
Average number of working days lost per WD CHCP Council Employees through sickness absence	17.35	7.73	5				
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 managers and individual members of staff responsibilities for undertaking PDP processes.
Percentage of WD CHCP NHS staff who have an annual e-KSF review/PDP in place	66%	75.24%	80%				
Percentage of staff with mandatory induction training completed within the deadline (NHS)	100%	100%	100%				Target achieved.

WD CHCP Strategic Plan: Key Actions – Summary of Progress within Quarters 1 & 2 of 2013/14

Key Outcomes 2013-14	Brief note on action taken and numeric information
Deliver and open the Vale Centre for Health & Care.	The new Vale Centre for Health & Care was delivered on schedule and within budget, successfully opening to the public on Monday 19th August 2013. As reported to CHCP Committee, a comprehensive and intensive external Gate 4 Review for this project was undertaken at end of June 2013 to assess the Vale Centre's readiness for service. The Review Team assessed overall delivery confidence as green, i.e. on target to succeed. The Gate 4 Review specifically highlighted a range of best practice involved with the overall scheme, including community engagement, staff involvement in design, degree of CHCP senior management involvement, and how the Centre has been designed to promote interaction between service teams plus encourage education and training. The new Centre has already received enthusiastic feedback, with the local West Dunbartonshire Access Panel having recognised the facility (and the scheme as a whole) with a best practice award for "accessible design and innovation"; and the Centre winning the "best design category" at the Health Facilities Scotland Awards 2013. The Centre will be formally opened by the Cabinet Secretary for Health & Wellbeing at a short ceremony on the 27th November 2013.
Deliver quality assured NHSGGC-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.	This continues to work well, although there are significant challenges in terms of the funding gap between the Government Grant and the actual cost of the service. We await the outcome of Scottish Government Review of Criminal Justice Structures which is expected towards the end of the year. If Option B is agreed (i.e. Return to Local Authority model) the intention would be to retain the Partnership as at present.
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 into any of the three tragic cases; and it has been confirmed that there will be no Fatal Accident Inquiry into any of the three deaths. A multi-agency improvement action plan has been developed, which has been approved by the Chief Officer's Public Protection Group and presented to CHCP Committee for endorsement.

Implement 30 month assessment for all children and establish Health Support Team.	Implementation continues to go well. There have been no major issues other than a higher request for assistance from Speech & Language Therapy (SLT) similar to other partnership areas.
Develop local implementation plan of GIRFEC National Practice Model.	Progress to date includes: • Significant numbers of awareness raising sessions - all children and families staff across agencies, support projects, adult services and third sector. • Named Person and Lead Professional training delivered to Heath Visitors and School nurses – this will now be rolled out further. • WDC Education Services have developed a Single Agency Assessment – currently being piloted. • Reviews being undertaken of section 22 cases to see if they meet the 'Lead Professional' test. • Employed a part-time researcher to work with families and raise awareness of GIRFEC, seeking their views of how this should be publicised and what key information parents need to know. This will be particularly important given the current media backlash on the concept of 'named person'. • Exploring options for a Single Child's Plan process that will apply to all agencies should the case move beyond universal services.
Develop Anticipatory Care as a model of prevention and work with GPs to develop self care models, and preventative interventions.	Integrated teams have been introduced with easy access for GPs to service and have set waiting time targets for these services. Access to emergency respite in care or at home has been developed; and access improved to avoid admission, support carers and reduce risk. Since introducing a local enhanced service with GPs to undertake anticipatory care plans (ACPs) for high risk patients during 2012/13, 1000 patients have been identified and reviewed; and ACPs uploaded on to the e-KIS system (for which West Dunbartonshire is an early implementer site). Practices are well placed to complete a considerable number of reviews supported by Older People's Change Fund resourced CHCP services.
Introduce early referral for assessment by integrated health and social care teams.	Achieved: the team is available to all practices and works with consultant geriatricians to provide home based interventions such as reablement.
Plan rapid response and alternative choices on behalf of at risk clients.	Urgent access to Integrated teams is 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; and can be accessed by partners such as GPs, GEMS and MAU.

Further develop Hospital Discharge team to increase early supported discharges.	The hospital discharge team is in place and working well, with an exponential increase in the number of patients being supported. All patients referred for home care are offered medication compliance reviews.
Increase appropriate use of Telecare and Step Up, Step Down provision.	There is high uptake of telecare, with demonstrations for carers, health and social care staff (including GPs) undertaken regularly. Four step up/ down beds are available in local sheltered housing provision alongside one residential rehabilitation bed.
Offer increased support for self-care and self management which reduces demand on other services.	The CHCP-CVS Link Up project brings together hundreds of third sector organisations under a quality assured brand to provide advice information and support to older people and their families. These include programmes from condition specific charities (such as Asthma and Diabetes UK); and is being actively promoted to GPs as well as other health and social care staff.
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.	As part of Older People's Change Fund programme, work underway with WDC HEED and also third sector organisations to review 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.
Develop respite provision to include respite at home.	The local respite bureau allows clients and carers to self book at a time and place of choice: the year one data shows increased uptake and improved satisfaction of carers. Respite at home has been introduced for those who are assessed as appropriate. Carer training for practical care issues and condition specific information has been developed in partnership with Carers of West Dunbartonshire. The CHCP has also introduced a carer support worker to work with families with older people at transition from hospital or home to care settings.
Making further reductions in avoidable harm and in hospital acquired infection.	Core standards monitored routinely and currently showing high compliance. Clinical incidents regularly reviewed.
Maintain national Patient Focused, Public Involvement (PFPI) Participation Standards.	The CHCP's commitment to listening and effectively responding to patient feedback has been recognised by its "Let's See If We Can Help" medicines management initiative being shortlisted as a finalist in the Compassionate Patient Care category of the 2013 UK Health Service Journal Awards.

Deliver plans for the design and location of two Older People's Residential Care Homes with Day Care facilities.	As reported CHCP Committee, key appointments have now been made to develop designs for the Project, including the Architect; Landscape Architect; Mechanical and Electrical Consultant; Civil and Structural Consultant; and Cost Consultants. These organisations have been carefully vetted and selected by the Council and hWS and bring appropriate knowledge, skills and experience to the Project. As reported to CHCP Committee, the building of the Dumbarton care home and day care centre has been accepted by hub West Scotland (hWS) under the terms of their Territory Partnering Agreement with West Dunbartonshire Council. This provides an agreed cost and risk framework within a specified timescale which should see the completion of this home within the first quarter of 2016. Similar arrangements, within the same timescale, will be concluded with hWS when a site for the Clydebank home is finalised. Site investigations, options appraisal and the consultations locally have identified that the Crosslet House site is the preferred option for the site of the Dumbarton care home and day care centre.
Consolidate improvement in CI Gradings for Older People's Care Homes (older people), Day Care and Home Care.	The implementation of Care Inspectorate requirements and recommendations are key objectives for 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 (new posts). Care home and day care documentation (e.g. care plans and case recording) have been reviewed and improved. Staff learning and development is being progressed, with staff supported to implement improvements with the assistance of specialists such as pharmacists and community nurses. The CHCP has sponsored the MY Home programme for all care homes across West Dunbartonshire which is developing system wide standards and ways of working as well as introducing new and innovative models of care to care homes across all sectors.
Consolidate improvement in CI Gradings for Children's Residential Care Homes.	For the Children's Residential Care Homes, grades have continued to be 'Very Good' in the main and standards of care have remained high. The most recent gradings for the local Fostering service has been disappointing: awarded two grades of 'Adequate' and one 'Weak' (the latter of which has been acknowledged as requiring immediate remedy). In the main the requirements and recommendations have been related to failure of processes and lack of administrative follow up The Care Inspectorate recognises both the disappointment of the staff team and their commitment to improvement and as such has suggested an early follow up in order to confirm improvement and review grades. We are confident that improvement will be achieved under the leadership of the recently appointed new manager and can confirm that several actions on the improvement plan have already been concluded.

Implement local Smoking Cessation Service Action Plan.	Smoking cessation action plan now implemented. Work includes service review (now completed); delivery of social marketing programme; continuing work of the CHCP HEAT Promotion Group; and targeting Primary Care e.g. via GP locality briefings, development of quarterly GP newsletter/GP leaflet, Keep Well Networking Events and at flu clinics. Actions to address and target smoking cessation in SIMD 1 communities have also been developed; as have actions to address smoking in pregnancy (as an explicit component of local CPP Early Years Collaborative programme).
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 local Single Outcome Agreement (SOA), with activity evidenced within the recent SOA Annual Report. It has been confirmed that the CHCP Committee (foreshadowing the new Joint Integration Board) is the formal forum for leading and overseeing the "older peoples" and "health inequalities" dimensions of the local SOA on behalf of Community Planning Partners.
Work with CVS to establish social transport support scheme.	At its May 2013 meeting, the CHCP Committee agreed the implementation plan to replace historical arrangements for social care transport with an equitable social transport grant programme established as an explicit enhancement to the Council's Community Chest grant scheme. As reported to Committee, the transition to the new arrangements have been managed smoothly, with all agreed actions completed ahead of the transfer of routine reporting to the WDC Corporate Services Committee. As committed to, the new scheme has been extensively promoted to local community groups; and support provided by members of West Dunbartonshire CVS staff.
Maintain Healthy Working Lives Gold Award.	Single application for WD CHCP and WDC was submitted to Scottish Centre for HWLs and was successful (July 2013). Ongoing collaborative work continues to maintain Gold Award Criteria to progress joint annual assessment (July 2014). The CHCP's commitment to improving the way staff work together and support one another has also been recognised by its being shortlisted as a finalist in the Health in the Workplace Award at the 2013 Scottish Health Awards.