AGENDA ITEM No.15

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 1 June 2016
Agenda Item	15
Title	End of Year Performance Report

Summary

This report advises the members of the Integration Joint Board of the performance of the HSCP and former CHCP over 2015/16.

Presented by	Candy Millard, Head of Strategic Services

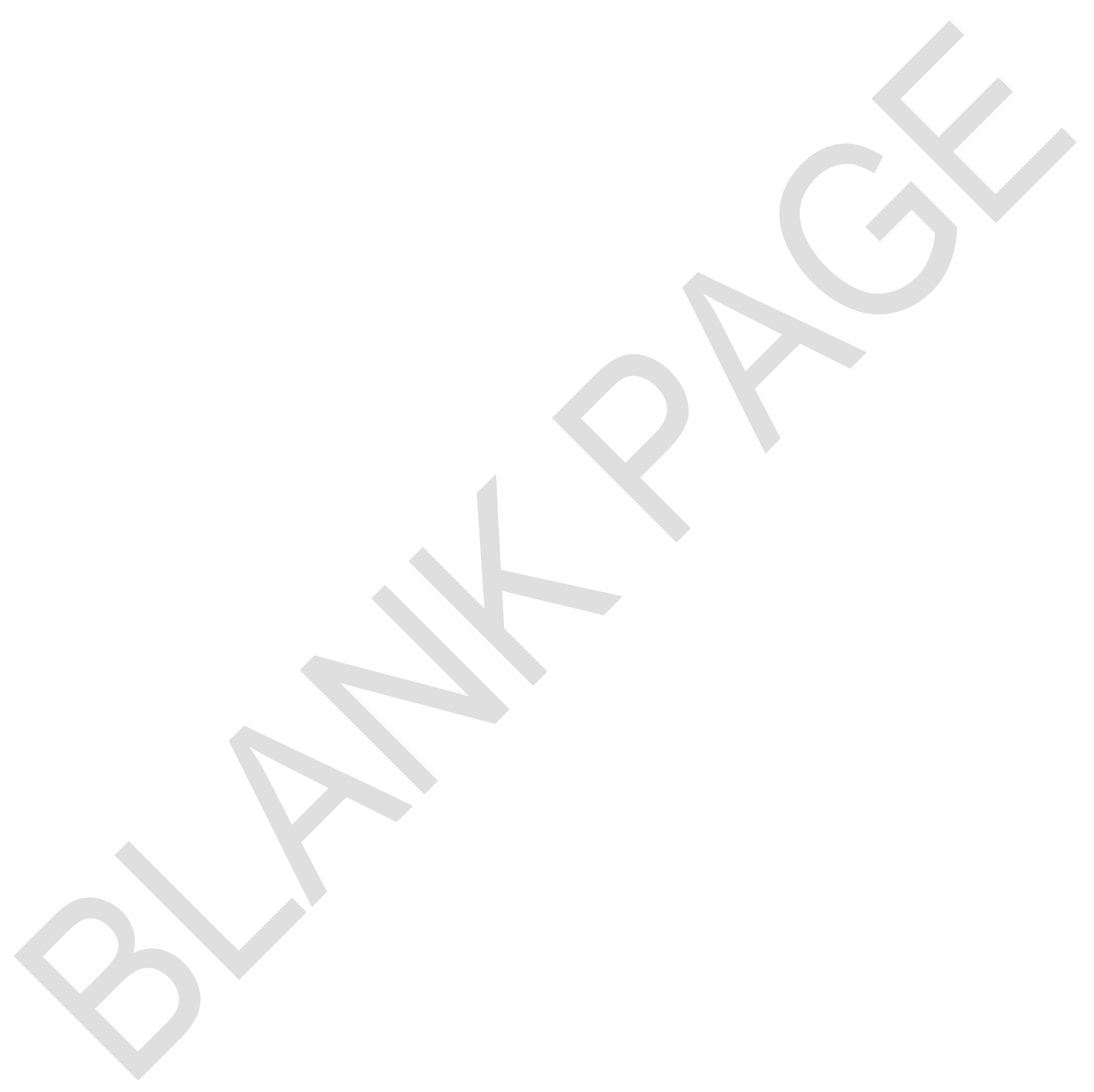
Action Required

The Integration Joint Board is asked to

- Note and comment on the contents of the report
- Approve the report being shared with East Renfrewshire Council and NHS Greater Glasgow and Clyde

Implications checklist – check box if applicable and include detail in report

☐ Financial	☐ Policy	☐ Legal	☐ Equalities
☐ Efficient Government	☐ Staffing	☐ Property	☐ IT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EAST RENFREWSHIRE INTEGRATION JOINT BOARD

1 JUNE 2016

Report by Julie Murray, Chief Officer

END OF YEAR PERFORMANCE REPORT

PURPOSE OF REPORT

1. This report advises the members of the Integration Joint Board of the performance of the HSCP and former CHCP over 2015/16.

RECOMMENDATION

2. The Integration Joint Board is asked to:-
   - Note and comment on the contents of the report
   - Approve the report being shared with East Renfrewshire Council and NHS Greater Glasgow and Clyde

BACKGROUND

3. The Integration Joint Board of the East Renfrewshire Health and Social Partnership had its inaugural meeting in August 2015, with formal delegation of health and care services commencing in October 2015. This new arrangement built on the successful Community Health and Care Partnership (CHCP) between East Renfrewshire Council and NHSGGC, which operated from 2006 until the formal delegation to the Integration Joint Board in October.

4. Scottish Government recently published statutory guidance setting out the prescribed content of a performance report relating to an integration authority. This guidance does not come into force until 2016/17 but the HSCP considers it helpful to cover the main reporting areas and provide performance information where the data is available. The key reporting areas are:
   - Service Planning including national health and wellbeing outcomes and indicator performance; and integration planning and delivery principles
   - Financial Planning and Performance
   - Best value in planning and carrying out integration functions
   - Performance in respect of locality arrangements
   - Inspections of services
   - Review of strategic plan

5. In our Strategic Plan we stated that progress and performance would be reported for 2015-16 in the form of the Organisational Performance Report, which was the reporting format used by the Community Health and Care Partnership. A copy of the end of year Organisational Performance Report is attached, which covers both the CHCP and HSCP performance from April 2015 until end of March 2016 in relation to commitments to East Renfrewshire's Outcome Delivery Plan and NHCGGC Local Delivery Plan.

REPORT

Outcomes

6. A series of National Health and Wellbeing Outcome indicators based on survey feedback, emphasises the importance of a personal outcomes approach and the key role of user feedback in improving quality. The Scottish Health and Care Experience Survey asks people about their experiences of their GP practice, as well as their local care and support services provided by their local council and other organisations. Results from the survey carried out In December 2015 show:
   - 83% of adults supported at home agree that they are supported to live as independently as possible.
   - 78% of adults supported at home agree that they had a say in how their help, care or support was provided.
   - 69% of adults supported at home agree that their health and care services seemed to be well co-ordinated.
   - 83% of adults receiving any care or support rate it as excellent or good
   - 89% of people reported positive experience of care at their GP practice.
   - 82% of adults supported at home agree that their services and support had an impact in improving or maintaining their quality of life.
   - 42 % of carers feel supported to continue in their caring role.
   - 84% of adults supported at home agree they felt safe.

7. User Feedback. Each year East Renfrewshire Council undertakes a Citizen Panel survey. The latest report from December 2015 had a response from over 700 residents of whom 5% were adult health and social care service users.
   - 92% of users rated health and social care services good or very good (6 % rise on the previous year)
   - 100% of home care users rated the service as good or very good

8. <u>Personal Outcomes</u>. Whilst national personal outcomes data has only recently become available, locally the CHCP was one of the first areas to adopt the use of talking point personal outcomes data, recording user and carer experience and outcomes at the point of review.

2015/16	MET				PARTIALLY MET				UNMET			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Confidence / morale	74%	69%	70%	76%	22%	25%	25%	21%	5%	6%	5%	4%
Feeling safe	84%	83%	78%	84%	12%	11%	17%	12%	3%	6%	5%	4%
Having things to do	67%	59%	56%	64%	25%	32%	34%	30%	8%	9%	9%	6%
Living where you want	82%	74%	73%	72%	14%	18%	19%	22%	4%	8%	8%	6%
Mobility	68%	65%	62%	67%	26%	27%	26%	29%	6%	8%	12%	4%
Quality of life for carer	72%	66%	70%	74%	17%	23%	21%	18%	11%	11%	9%	8%
Seeing People	78%	70%	70%	77%	18%	27%	26%	21%	3%	3%	4%	2%
Skills	72%	65%	62%	69%	23%	27%	31%	25%	5%	8%	7%	6%
Staying as well as you can	83%	77%	70%	82%	13%	19%	25%	14%	4%	4%	5%	4%
Symptoms	75%	63%	69%	73%	22%	32%	28%	22%	3%	4%	3%	4%
Treated with respect	97%	96%	93%	96%	3%	3%	7%	3%	0.0%	0.4%	0.4%	0.5%

National Indicators and Trends over time

9. A second set of National Indicators are taken from organisational/system data primarily collected for other reasons. These indicators are.
   - Premature mortality rate
   - Rate of emergency admissions for adults
   - Rate of emergency bed days for adults
   - Hospital readmissions of discharge
   - Proportion of last 6 months of life spent at home or in community setting
   - Falls rate per 1,000 population in over 65s*
   - Proportion of care services graded 'good' (4) or better by Care Inspectorate
   - Percentage of adults with intensive needs receiving care at home
   - Number of days people spend in hospital when they are ready to be discharged
   - Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency
   - Percentage of people admitted from home to hospital during the year, who are discharged to a care home*
   - Percentage of people who are discharged from hospital within 72 hours of being ready*
   - Expenditure on end of life care*

10. Whilst much of the data above is not yet available for 2015/16, some of the information forms a useful baseline for the new Health and Social Care Partnership. Chart 2 illustrates an increase in emergency admission rates (per 100,000 population) between creation of the CHCP in 2006/7 and 2014/15. Despite this increase, Chart 1 illustrates a decrease in the emergency bed day rates (per 100,000 populations) across the same time period. Whilst some of this decrease in emergency bed day rate relates to changes in acute hospital care, it also demonstrates that primary care, community health and social care have worked together to support increasing numbers of people to be discharged home. East Renfrewshire has consistently has a strong performance on reducing bed days lost to delayed discharges illustrated from 2012 in Chart 3.

Chart 1: Rate per 100,000 population of all emergency admission bed days for East Renfrewshire patients aged 18+ (2006/07 - 2014/15 data)

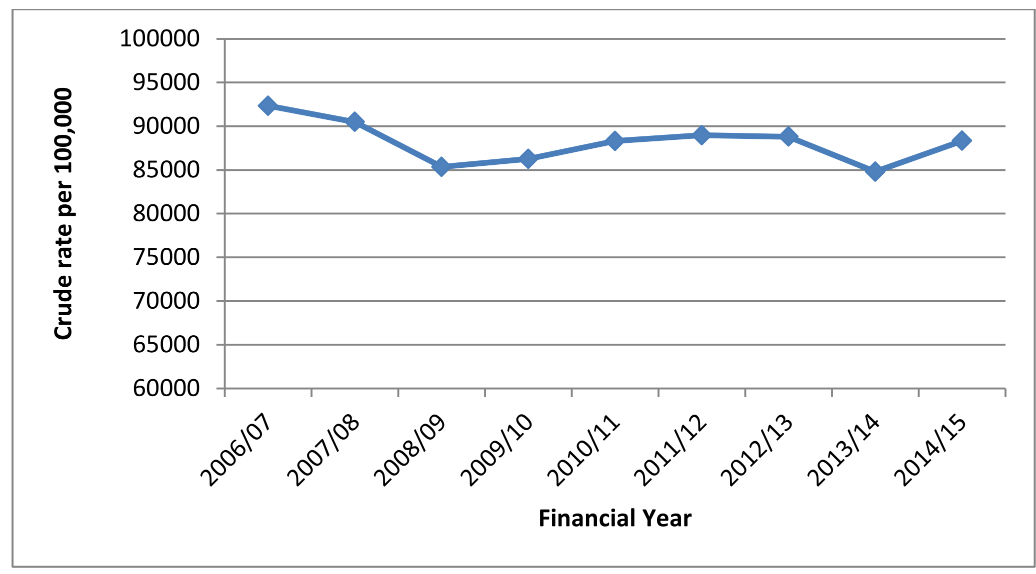


Chart 2: Rate per 100,000 population of all emergency admissions for East Renfrewshire patients aged 18+ (2006/07 - 2014/15 data)

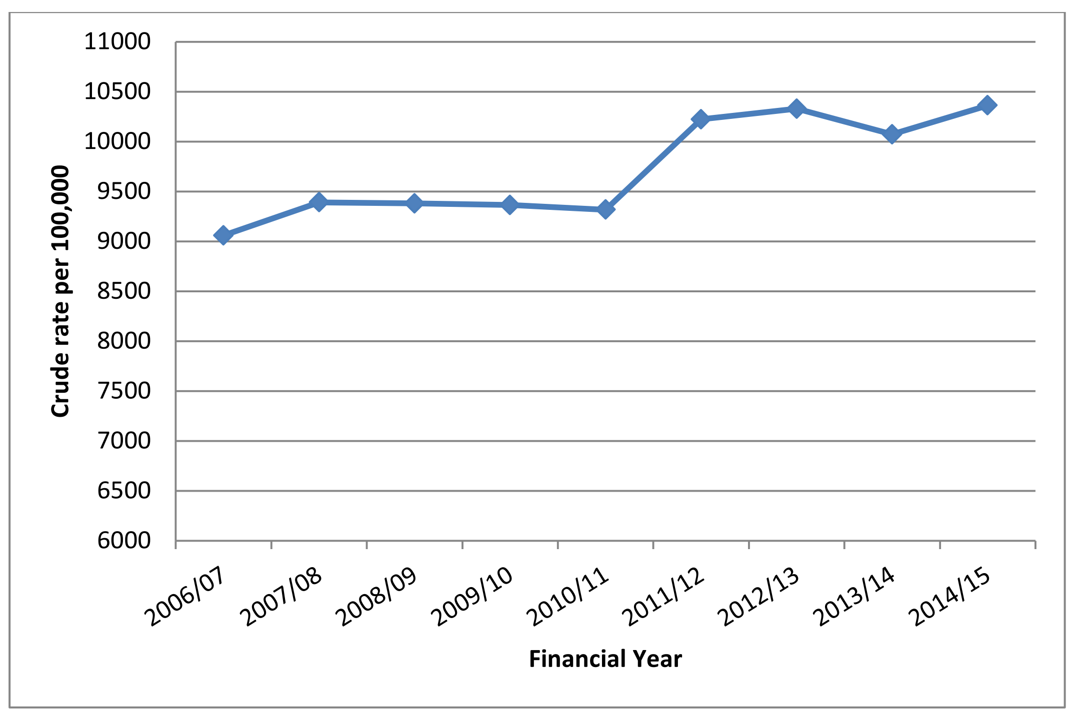
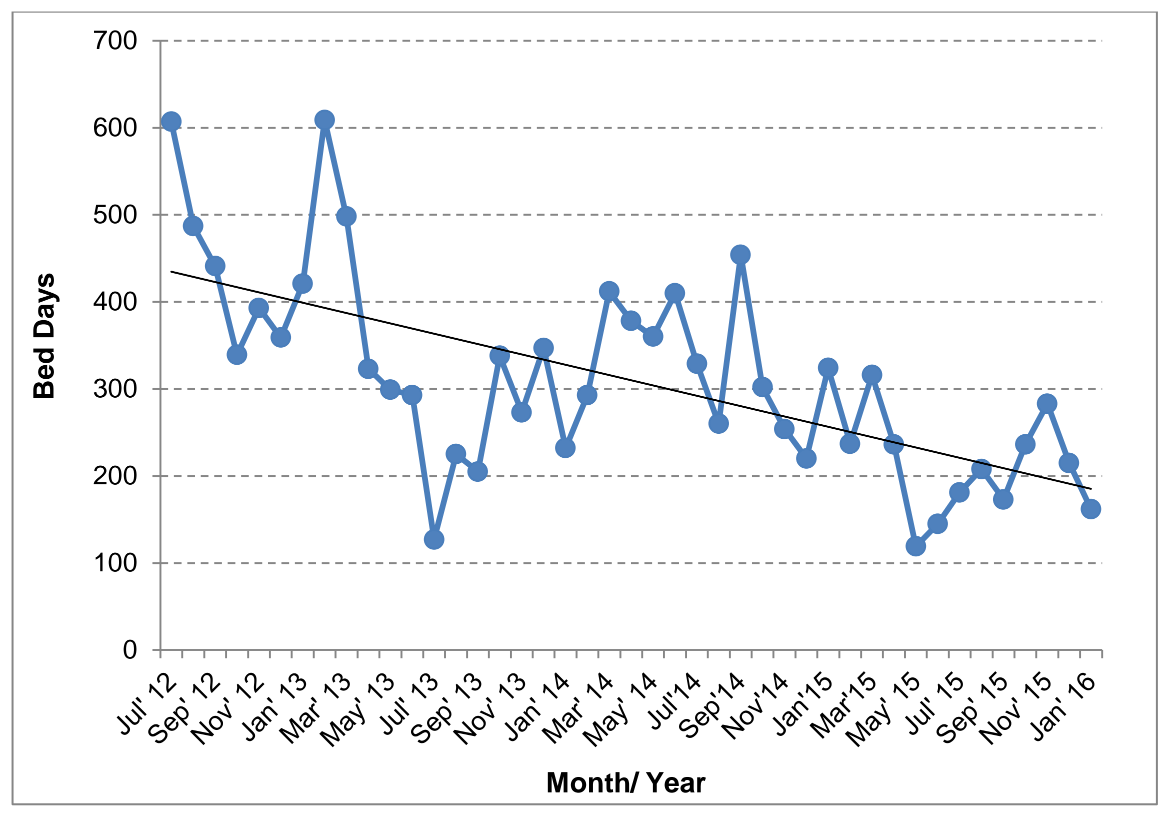


Chart 3. Number of bed days lost to delayed discharge patients (East Renfrewshire data, July 2012 - January 2016)



Getting it Right for Every Child

11. For children's services all activity is underpinned by Getting it Right for Every Child and the wellbeing indicators of Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible and Included. In East Renfrewshire, local partners have worked in a collaborative way over the last 6 years to plan and deliver for children through our integrated children's services planning approach. We have also played a key role in developing and delivering the Early Years Collaborative and Strategy. Children's social work and health services form part of the services delegated to the Health and Social Care Partnership.

12. Our campaign to recruit foster carers who live within East Renfrewshire, launched in March 2015, and enabled us to increase our own local authority foster carers. Kinship and close family support is utilised when it is assessed as safe to do so and in the child's best interests and this is an area that the greatest growth has happened over the last two years, with the number of looked after children in kinship care increasing by 100%. The use of external care placements purchased from the independent sector has reduced by 35% between 2014 and 2016, as costs were exceptionally high and outcomes for children unclear. The use of residential school accommodation is now minimal except for those young people who have additional support needs. There were no young people in secure placements from 2014 to 2016.

13. Implementing Self Directed Support in a fair, transparent and equitable way for children and young people with disabilities was a key priority for the CHCP and has continued under the HSCP. Our approach was designed in partnership with families. Families are now carrying out their support plans using their resource flexibly. Initial reports are that families feel more in control of their lives and are clear and focused on the outcomes they want to achieve for their children.

Integration Planning and Delivery

14. The Integration Joint Board has invested heavily in the development of the Strategic Plan to reflect the ranges of needs of different communities and health and social care staff in East Renfrewshire. The Strategic Plan directs the work of the Health and Social Care Partnership towards achieving the National Health and Wellbeing Outcomes. It is underpinned by the Integration Planning Principles which emphasise the importance of respecting rights, and taking into account particular needs, characteristics and circumstances. The Strategic Plan was based on a Strategic Needs Assessment which took account of the particular the needs and circumstances of local communities and users of services. A high level summary of this needs assessment is published on the HSCP webpages.

15. User and carer representation on the Integration Joint Board and its governance structures is drawn from the Public Partnership Forum. The Public Partnership Forum includes representatives from community care groups, representatives from our localities and representatives from equality organisations including disability and faith groups. It is committed to regularly reviewing its operation to ensure removal of potential barriers to participation.

16. The Health and Social Care Partnership has maintained the integrated management structure and services established under the CHCP. These include the integrated Rehabilitation and Enablement Service including social workers, district nurses, occupational therapists, physiotherapists, advanced nurse practitioners and District nurses; integrated Learning Disability Team, integrated Community Addictions and Recovery Team.

17. A redesign of Children and Families services is moving to a more integrated service management structure. The newly formed Request for Assistance service, comprising health and social work staff, can be accessed by the public, Named Person or any other organisation, where they believe that a child or young person needs help, advice or direct support from the Health and Social Care Partnership

Financial Planning and Performance

18. The Integration Joint Board has held a series of seminars on financial planning and the Financial Strategy to support the Strategic Plan will be taken to the next Integration Joint Board in August. The Performance and Audit Committee was the first Integration Joint Board governance body to be established and has received reports on financial regulations, audit arrangements, audit reports and the development of performance measures.

19. The HSCP has provided regular budget monitoring reports to both the Integration Joint Board and Cabinet for information and scrutiny. Current budget outturn projections show a slight favourable variance for 2014/15. The Chief Finance Officer of the HSCP is implementing a finance improvement programme. This includes the use of Care Finance, development of detailed supporting procedures and restructuring of the finance team, which will report directly to the Chief Finance Officer.

20. Financial year end for 2015/16 is ongoing. To date there is no significant movements since the last report to the IJB. Draft accounts will be taken to the Performance and Audit Committee at the end of this month and will be available thereafter.

Best Value

21. The following table sets out the progress made during 2015/16 in relation to the Best Value characteristic and gives some areas for further development in 2016/17.

Characteristic	**Progress 2015/16**	**Area for development**
Use of Assets	Development of Eastwood Health and Care Centre Modernising the way we work update programme planned for other sites including Barrhead Health and Care and Civic	Greater community use of resource centres
Challenge and improvement	Change programme in place Self- evaluation at service level feeding into service plans	Increase use of benchmarking
Community engagement	Strategic planning conversations Early Years engagement in Auchenbach Review of Public Partnership Forum to reflect range of community and equality groups Community led support work commencing locality discussions	Community Engagement strategy to be updated in light of community empowerment
Customer-focus and responsiveness	Personal outcomes focus in both adult and children's services Complaints data analysis and improvements undertaken	Positive conversations training for staff

Efficiency	Strong links to Council and NHSGGC processes Programme management approach in place to deliver savings	Further work on business processes
Equalities	Equalities outcomes developed Equality mainstreaming report approved by Integration Joint Board	Complete agreed Equality impact Assessments
Financial management	Implementation of Care Finance Review and restructure of HSCP finance team	Further work on supporting procedures
Governance and accountability	Developed and agreed Integration Scheme Establishment of Integration Joint Board, Performance and Audit , Clinical and Care Governance committees	Consolidate new governance arrangements
Information management	Information Sharing Protocol in place Local Information Services Team provide links to national data	Improve use of analytics for planning
Partnership working/community leadership	Voluntary Action (Third Sector Interface) leadership role Strong partnership working with providers Collaborative work with East Renfrewshire Carers Working together approach to service reviews and redesigns	Evidence of closing the in-equalities gap
People management	Establishment of Joint Staff Forum Regular leadership sessions with managers	Update workforce plan
Performance management	Mid and End of year performance report Agreed performance indicators with NHSGGC and Council	Exception reporting to Performance and Audit
Planning and resource alignment	Strategic Plan agreed Commitments to SOA, ODP and LDP honoured 15/16 Set aside budget proposition agreed by IJB	Financial Strategy to support Strategic Plan
Procurement	Review of contracts Care at Home tender	Care and support tender
Public performance reporting	First performance report developed Implementation Plan developed with key measures	Development of website to improve access to reports.
Risk management	Development of strategic risk register and risk management strategy	Risk reporting to IJB and governance bodies
Sustainability	Continued work with Council and NHSGGC on carbon emissions and recycling	
Vision and strategic direction	Vision and Touchstones developed and shared widely Strategic Plan and Implementation Plan in place	Individual work objectives for 2015/16 to reflect vison and direction

Locality Arrangements

22. All Health and Social Care Partnerships are required to establish locality planning arrangements providing a forum for professionals, communities and individuals to inform service redesign and improvement.

23. In our strategic planning conversations local people, staff and partners demonstrated a keen interest to working together in shaping health and social care in East Renfrewshire. We consulted widely on how we should develop localities and agreed up on a system which had:-
    - close alignment of health and care services with GP practices in localities based on GP practice populations,
    - a focus on the different health and wellbeing outcomes in different local areas of East Renfrewshire; and
    - strong links and engagement with different communities within East Renfrewshire.

24. The CHCP adult health and care services to locality clusters of GPs, in Rehabilitation and Enablement teams.
    - Eastwood 1 (Netherlee, Stamperland, Clarkston, Eaglesham, Waterfoot and Busby)
    - Eastwood 2 (Newton Mearns, Giffnock and Thornliebank)
    - Levern Valley (Barrhead, Neilston and Uplawmoor)

25. In developing the HSPC link GPs from the clusters were invited onto our strategic planning group and have been working with us giving their locality perspectives, supported by locality data and information. We also invited them to take part in our ' 'Safe and Supported' work groups looking at unscheduled care and delayed discharge and in shared IJB and Strategic Planning group seminars including on the Clinical Services Review.

26. Recently the IJB has agreed that we should become to become one of three Health and Social Care Partnerships in Scotland to test a new transformation programme. The programme works on the principle that frontline community health and social care support and services can be delivered out of "Hubs" based in and working with local communities. Experience of delivering the model in England and Wales with social work services is that this results in reduced bureaucracy, better outcomes for individuals and greater efficiency.

Inspection

27. The Health and Social Care Partnership runs a number of services which are subject to external inspection from the Care Inspectorate. All have been graded 4 (good) or more in their most recent inspection reports (see table on next page). There are a number of areas where services have received grades of 6, the highest grade possible.

28. Eleven of the 13 local care homes (85%) have grades of 4 for care and support. All are graded 3 and above. Twenty of the twenty two providers (90%) on the care and support framework have grades of 4 and above for quality of care and support. Four of these providers have grades of 6 for care and support.

East Renfrewshire In-house Services Most Recent Care Inspectorate Report Grades	Date of last Inspection	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Bonnyton Care Home	10/02/2016	4	5	5	4
Bonnyton Resource Centre	26/04/2013	5	4	5	4
Holiday Programme and Inclusive Support Service	23/07/2014	6	6	5	5
Care at Home	05/02/2016	5	NA	5	5
Fostering Service	19/02/2015	5	NA	5	5
Adoption Service	19/02/2015	4	NA	4	4
Thornliebank Resource Centre	28/05/2013	5	6	5	5
Barrhead Resource Centre	11/02/2015	5	6	6	6
Kirkton Older People's Service	24/10/2014	4	5	5	4

Review of Strategic Plan

29. The Strategic Plan is a living, dynamic plan, intended to evolve over time. The integration Joint Board approved updates to the plan in March this year in response to national policy changes and legislative requirements relating to carers and children and families.

30. The other change to the strategic plan related to planning for delayed discharge and unscheduled care, which was identified as a priority area by the Strategic Planning Group. It agreed to set up four 'Safe and Supported' work groups to develop proposals for tests of change using improvement methodology.

    a) Prevention and Anticipatory Care
    b) Point of Possible Admission
    c) During Admission
    d) Discharge from Hospital

31. These task and finish groups which included third sector, independent sector, carers, health and social care staff and managers, locality GPs and acute clinicians identified a range of additional improvement opportunities for testing during 2016/17.

Organisational Performance

32. The HSCP Organisational Performance Year report is attached as Appendix 1. The report is set out under the previous Strategic Priorities, with clear links to the Single Outcome Agreement and Local Development Plan.

Early Intervention and Preventing Ill-health (SOA1&2)

33. Overall the report shows that we are improving health in the population, however there are a number of measures (dental health, smoking and breastfeeding) where we are struggling to close the inequality gap. In East Renfrewshire these represent very small areas with a number of families who have lived there for generations. We need to work closely with these communities to improve health and wellbeing, building on the successful start of the Early Years work in Auchenback.

34. There has been significant improvement in the stability of placements for looked after children, which is an important measure of attachment and future outcomes. The percentage of children experiencing three or more placements has fallen from 4.05% to 1.07%. Along with colleagues in Education we have reviewed parenting programmes and put in place a range of evidence based interventions.

35. Waiting times for mental health services have improved, although psychological therapies are slightly below target. It is anticipated that the reestablishment of therapeutic groups will improve this performance.

Shifting the Balance of Care (SOA 4)

36. The number of people self-directing their support has continued to increase during 2014-15. Supported living arrangements for people with a learning disability were reviewed using a public social partnership approach. All involved are benefiting from individually redesigned services which better meet their personal outcomes.

37. Our commitments to the North Strathclyde Criminal Justice Authority have come to an end, with a number of changes to service provision. Work to rectify delays to the start of community placement order work placements has seen considerable improvement with 18 of 21 orders on time in the final quarter.

Reshaping Care for Older People (SOA 5)

38. Performance remains positive for meeting people's personal outcomes, despite a change a target to measure outcomes that were fully met rather than both fully and partially met. Work to develop opportunities for older people has continued. Walking groups and chair based exercise have proved very popular.

39. The HSPC has performed very well in relation to delayed discharge meeting the new 72 hour delayed discharge targets most months. Whilst overall lengths of stay are reducing, the level of unplanned admissions continues to be a challenge impacting on overall bed days. A programme of tests of change developed though our Safe and Supported work stream, will be implemented during 2015/16.

40. In relation to NHSGGC targets despite having one of the lowest levels of bed days lost East Renfrewshire struggles to meet the 75% reduction in bed days target set. This is due to the target being set on a very strong CHCP baseline performance and thus being a great deal more challenging than that set for other previously poorer performing areas.

HSCP	Actual Days lost April-Dec 2015	50% target days lost amount	75% target days lost amount
East Dunbartonshire	2,793	2,760	1,380
East Renfrewshire	1,223	1,810	905
Glasgow City	15,092	19,916	9,958
Inverclyde	1,121	2,522	1,261
Renfrewshire	2,939	6,078	3,039
West Dunbartonshire	2,279	2,864	1,432
Total	25,447	35,950	17,975

FINANCE AND EFFICIENCY

41. This report relates to health and social care performance. The Integration Joint Board will receive a separate report on finance following production of year end accounts.

CONCLUSIONS

42. This performance report demonstrates a strong start to the work of the Health and Social Care Partnership building on the successful Community Health and Care Partnership between East Renfrewshire Council and NHSGGC, which operated from 2006 until the formal delegation to the Integration Joint Board in October.

RECOMMENDATIONS

43. The Integration Joint Board is asked to
    - Note and comment on the contents of the report
    - Approve the report being shared with East Renfrewshire Council and NHS Greater Glasgow and Clyde

REPORT AUTHOR AND PERSON TO CONTACT

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May 2016

BACKGROUND PAPERS

http://www.gov.scot/Resource/0047/00473516.pdf

KEY WORDS
Performance, planning, strategic plan,

East Renfrewshire HSCP- Organisational Performance Review Year-End 2015-16

Report Type: Scorecard Report
Report Author: Ian Smith
Generated on: 18 May 2016

Section 1a: SOA / Strategic Priorities

SOA 1: All children in East Renfrewshire experience a stable and secure start to their lives and are supported to succeed

SOA 2: East Renfrewshire residents are fit and active and have skills for learning, life and work

SP 1: Early intervention and preventing ill-health

A: Performance Measures

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
INCREASE - 005.1A Male Life expectancy at birth	79.8	78.1	Green	The most recent NRS figure for male life expectancy at birth for 2012 - 2014 has improved marginally since the previous estimate, at 79.8 years.
Female life expectancy at birth	82.8	82.3	Green	The most recent NRS figure for female life expectancy at birth for 2012 - 2014 has fallen marginally from 83 years in the previous estimate, at 82.8 years.
Male life expectancy at birth in 15 per cent most deprived communities	71.9	71.7	Green	Latest figures available from NRS are for 2009 - 2013 (published October 2014), these show life expectancy for males in 15% most deprived areas as 71.9 years. This compares to 80.9 years in the least deprived areas of the authority.
Female life expectancy at birth in 15 per cent most deprived communities	78.8	78.1	Green	Latest figures available from NRS are for 2009 - 2013 (published October 2014), these show life expectancy for females in 15% most deprived areas as 78.8 years. This compares to 83.7 years in the least deprived areas of the authority.
To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths by 2015.	1.2	3.6	Green	There was one stillbirth in East Renfrewshire in 2014, compared to three in 2013. Still births for the calendar year 2014 was 1.2 per 1,000. For Scotland the rate for 2014 is 4.0 per 1,000
To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rate of infant mortality by 2015.	1.2		Data Only	There was one infant death in 2014 in East Renfrewshire, compared to four in 2013. Infant mortality for the calendar year 2014 was 1.2 per 1,000 - this compares favourably to the Scottish national rate of 3.6 per 1,000.

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review, by end-2016.	96%	85%	Green	First two quarters only of 2015 available report 96% as of Nov 2015 (June 2013-Nov 2015)). EMIS was introduced in October 2015 and local child health teams are being trained to use EMIS which will enable reporting to be more accurate in the coming year.
Smoking in pregnancy	6.9%	8%	Green	Data for Jan to Dec 2015 indicates 6.9% of East Renfrewshire residents smoking at booking compared to 14% across NHS GGC area and 8.5% in East Dunbartonshire.
Smoking in pregnancy - most deprived areas	29.7%	20%	Red	Data for Jan to Dec 2015 indicates 29.7% of East Renfrewshire residents smoking in pregnancy across our most deprived areas compared to 22.8% across NHS GGC area and 20.5% in East Dunbartonshire.
Percentage of newborn children exclusively breastfed at 6 - 8 weeks.	37.6%	36.8%	Green	This is the latest available figure (Oct 2014 - Sep 2015) by comparison the NHS GGC figure was 25.1% and East Dunbartonshire was 32.6%. Further improvement work in this area will be progressed through the early years planning group.
Breastfeeding at 6-8 weeks most deprived SIMD data zones	10.3%	29.3%	Red	10.3% latest available figure (Sep 2015). Activity around this indicator has been reviewed and resource identified for coming year for targetted work to rectify performance. In comparison NHS GGC figure was 16.1% and East Dunbartonshire was 10.7%
Percentage of children looked after away from home who experience 3 or more placement moves	1.1%	11%	Green	The stability of placement for looked after children, an important measure of attachment and future outcomes, has significantly improved on the 2014/15 quarterly average with those experiencing 3 or more placements falling to 1.07 per cent (from 4.05%).
Percentage of obese children in primary 1	3.5%		Data Only	Data from seven schools was not able to be entered within the set timescale and therefore is not included in the most recent publication. This equates to approximately 230 children. As a result the figures quoted school year 2013/14 should be treated with extreme caution.
Number of smokers supported to successfully stop smoking in the most deprived areas.	11	21	Red	Quarter 1 and quarter 2 complete at 100% and 80% respectively, quarter 3 figure incomplete and data not yet available for quarter 4
Percentage of people waiting longer then 18 weeks for access to psychological therapies	10%	5%	Red	The NHS GGC 2015/16 target amended was amended in 2015/16 to 95% (patients starting treatment within 18 weeks of referral). Throughout the year in each Quarter 10% of people have waited longer than 18 weeks for treatment.
Dental decay - P1 SIMD1	50%	60%	Red	The latest data for 2014/15 indicates 50% of P1 children had no obvious decay experience in our most deprived areas. This compares to 54% across NHS GGC and 73.3% in East Dunbartonshire.

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
Dental decay - P1 SIMD5	86.3%	60%	Green	The latest data for 2014/15 indicates 86.3% of P1 children had no obvious decay experience in our least deprived areas. This compares to 83.6% across NHS GGC and 81.9% in East Dunbartonshire.
Child & Adolescent Mental Health - longest wait in weeks at month end	16	20	Green	Child and Adolescent Mental Health service longest monthly wait during 2015/16 was 18 weeks, in contrast shortest monthly wait was 12 weeks.
Percentage of child protection re-registrations within 12 months of de-registration.	8.3%	17%	Green	Thirty six children were registered in 2015-16.
Low birth weight live singleton births as a % of total live singleton births	4.7%	2.2%	Red	The percentage of babies born with a low birthweight (under 2,500 grammes) fell in the 2015 calendar year to 4.7%. In comparison the NHS GGC figure over the period was 6.1% and East Dunbartonshire was 4.6%. Reasons for low birthweight are complex and relate to both deprivation and maternal age. The current target is recognised as very ambitious and further work is being carried out to assess and review this.

B: Planned Activities

Action Description	Status Progress Bar	Notes & History Latest Note
We will work through an Early Years Collaborative model to share good practice and take concerted action to shift towards early intervention, tackle inequalities and deliver positive outcomes for children	100%	All of the work to date to date will continue to be integrated further with Community planning partners and in particular via the Early Years Planning Group. A full review of the EY strategy and key performance areas was supported in Dec / Jan 2016, and key actions identified to feed directly into planning process for the SOA 2016-19. Resource has been reviewed and identified for moving forward. This has included the on-going support of a data analyst role to build on the initial improvement work around early intervention.
Deliver local public health programmes in partnership with others - smoking, alcohol, physical activity, healthy eating with a focus on deprivation and vulnerable groups	100%	HWL Gold Award for ERC and HSCP successfully maintained 2015/16. Will be reviewed again September 2016
Progress Eastwood Health and Care Centre in partnership with key stakeholders.	95%	The building is coming to completion albeit slightly behind schedule and we are currently waiting the final handover date. A social enterprise has been appointed to run the café in the building as a training opportunity for people with learning disability. Through our arts and environment strategy we have been working with local artists and schools to produce art work for the building and enhance the surrounding landscaping.
Key partners will work together to embed *Getting it right for every child* in the pre birth/maternity and early years setting in order to identify vulnerable parents and children at the earliest stage and put measures in place to reduce risk and improve outcomes	85%	We are on track to implement the named person role in September in line with our statutory duty.
The Getting It Right For Every Child implementation plan will further embed cultural, systems, and practice change into children and young people's services with the introduction of the named person and lead professional roles and the one child, one plan approach.	85%	We are on track to implement the named person role in September in line with our statutory duty.

Action Description	Status Progress Bar	Notes & History Latest Note
Review parenting programmes including Triple P and put in place tiered evidence based interventions.	100%	Psychology of Parenting Programme which is a combination of Triple P level 4 and Incredible Years and targets 3 and 4 year olds with challenging behaviour has began implementation overseen by a steering group of partners. To date with partners 3 and 4 years old are being identified and a programme established for parents to access in the local areas.

Section 1b: SOA / Strategic Priorities

SOA 4: East Renfrewshire residents are safe and supported in their community

SP 2: Shifting the balance of care

A: Performance Measures

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
Drug-related deaths per 100,000	5.4	4.6	Amber	The most recent data shows there were 5.4 deaths per 100,000 population in 2014. (This figure includes accidental poisonings and intentional self-poisoning). In comparison the NHS GGC figure was 16.5 deaths and East Dunbartonshire was 3.7 deaths.
Number of suicides per 100,000 population.	5.4	7.7	Green	By convention the number of suicides are derived from codes relating to 'Intentional self-harm' and 'Events of undetermined intent' However, this over-estimates the true number of suicides, because some 'undetermined intent' deaths will not have been suicides - but their numbers are unknown. The latest data for 2014 puts the local rate at 5.4 deaths per 100,000, compared to a NHS GGC rate of 13.3 deaths and an East Dunbartonshire rate of 10.3 deaths. Data for 2015 will not be available until late 2016.
Rate of alcohol related hospital admissions per 100,000 population.	397	490	Green	Data from 2010/11 to 2014/15 revised to reflect latest information from the NHS Information and Statistics Directorate. The absolute number for 2014/15 was 355 admissions.
Community Payback Orders - Percentage of unpaid work placements commencing within 7 days	50.73%	80%	Red	Low figures for this Indicator earlier in the year were due to the backlog of placements resulting from staff shortages in the previous year. Work to rectify this has seen the commencement figure rising again with 3 of of 21 Orders commencing outwith the timescale in the final Qtr of the year.
Community Payback Orders - Percentage of unpaid work placement completions within 6 months - New Disposal baseline to be established in Y1.	75	80	Amber	The percentage of unpaid work completions (75%) has fallen slightly below target (80%) this year.
Number of people self directing their care through receiving direct payments and other forms of self-directed support.	384	274	Green	The number of people self-directing their support has continued to increase during 2015/16 rising to 384 at mid-year from 279 at year end 2014/15.

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
Percentage of people with learning disabilities with an outcome-focused support plan	97%	70%	Green	Although Scottish Government funding of the Public Social Partnership redesign of supported living has now ceased the work of the PSP continues using the model. All clients have now been reviewed bar two who are in progress at present.
People reporting 'quality of life for carers' needs fully met (%)	68.9%	70.0%	Green	Of 740 valid responses 511 reported their needs fully met with a further 152 (20.5%) reporting their needs partially met. A total of 77 people (10%) reported their needs being unmet.
% of service users moving from drug treatment to recovery service	7%	13%	Red	We have seen positive improvement and increase in the numbers of individuals moving through treatment to recovery in the first two years of operation of the recovery service with 10.3% in 2012/13 and 11.9% 2013/14. The current position in 2014/15 is 7% this is short of the original target set. This is due to a high initial caseload of individuals who made positive progress in their recovery journey and were ready to move on to the new recovery service. The base position has stabilised and new 3 year targets are set against the new baseline. We are participating in a national pilot of the new Scottish Government Recovery Outcome Web Tool within community addiction and recovery services. This national pilot is due to conclude and report by October 2015. We will roll out the implement the recovery outcome tool following completion of the pilot across addiction and recovery from December 2015 to ensure compliance with Daisy by April 2016.

B: Planned Activities

Action Description	Status Progress Bar	Notes & History Latest Note
Improve outcome focused interventions with women offenders and persistent offenders through public social partnership approach using the Reducing Re-offending Change Fund.	100%	Referrals have continued to be made to East Renfrewshire Council's adult learning service. Public Social Partnerships have also continued to be funded nationally, and provided by third sector organisations across the North Strathclyde Community Justice Authority area. These have targeted persistent offenders in Low Moss Prison and women leaving custody or at high risk of breaching community-based disposals. The latter has been arranged in partnership with Renfrewshire Council to share limited third sector resources. With the transition to local community justice partnerships and the dis-establishment of Community Justice Authorities on 31 March 2017, dialogue is ongoing with Scottish Government to determine whether the existing PSPs will be funded centrally or whether an alternate financial model will be developed. All East Renfrewshire residents are assessed for suitability in each PSP.
Redesign day services for people with a learning disability to meet requirements of self directed support.	75%	Work continues to explore potential relating to social enterprise, leisure and learning opportunities.
Complete review of supported living and commence redesign using co-production and public social partnership approach.	100%	Review now completed and all individuals are benefiting from redesigned services which better meet their personal outcomes.

Action Description	Status Progress Bar	Notes & History Latest Note
Work with primary care professionals to identify carers, signpost and refer for support.	100%	As highlighted previously links to GP practices are through the HSCP Cluster teams and the Carers' Centre has strong links to each of these teams. Carers Centre staff attend the allocation meeting of the Community Mental Health Team and pick up new referrals directly from this team. In September 2015 the Carers Centre facilitated a meeting with staff from local pharmacies to share the learning of the pilot reported earlier and will build on this work with local pharmacies across East Renfrewshire.
Foster professional awareness of carers through an on-going programme of training and culture change aimed at positively valuing and including unpaid carers.	100%	Carers Centre produced a drama during carers' week which was aimed at raising awareness of carers issues to HSCP staff. The dram was filmed and copies will be made available throughout the HSCP. Carers Centre took part in the consultation about the redesign of Children and Families services and now have closer links and information sharing arrangements with this team. Similarly the Carers Centre has links to teams throughout the CHCP and maintain an awareness of carers' issues and the supports available. The HSCP partnership are leading on a programme of training with In Control Scotland which highlights the values and importance of carers involvement and support and several pieces of work such as MY Life My Way, Pilot Light, Dementia Strategy all have active carers involvement.
Improve the range of short breaks or 'respite' care available to give carers and cared for a break from their caring relationship.	100%	ERCarers Centre continues to administer the Creative Breaks Short Breaks Fund, funded by the Scottish Government and there is Scottish Government commitment to continue this, subject to election outcomes. ERCarers Centre will continue to apply for this funding although it should be noted that this will be a competitive process. ERCarers Centre also use additional fundraising to provide other short break opportunities such as coffee mornings, lunches and walking groups. For carers across Scotland and East Renfrewshire statutory provision of short breaks remains an area of apprehension around demand outstripping demand and something that will require consideration nationally and locally.
Consider the implications of forthcoming Carers (Scotland) Bill	30%	East Renfrewshire continues to develop the support for carers locally. Drawing upon the Carers Information monies in 15/16 we have been able to prioritise young carers; peer mentoring projects for adult carers; and minority ethnic carers of women who have experienced domestic abuse.. Our TSI is working with ERCarers to develop their capacity to undertake a Trusted Assessor role in preparation for the Carers legislation.
Redesign day services for people with a learning disability to meet requirements of self directed support.	75%	Work continues to explore potential relating to social enterprise, leisure and learning opportunities.
Promote increased up-take of self-directed support in mental health services	100%	In April 2016 the SDS work stream became incorporated in the AMH Public Social Partnership. The ongoing implementation of SDS for AMH is being developed through plans for 'safe and supported' funded link workers for social prescribing in GP practices. Other developments include SDS practice development in statutory case work, collaboration with Culture & Leisure services, and service modeling around therapy pets. A range of general awareness raising activities have been facilitated by the NHS SDS lead across the area these include the development of a new resource booklet and the facilitation of specific awareness raising sessions to support implementation.

Action Description	Status Progress Bar	Notes & History Latest Note
Improve Community Adult Mental Health Services towards a Recovery and Well-Being Model of Care	100%	The programmer management and preparation for service redesign is complete. This has now moved into an implementation phase this will be facilitated by a PSP with a first meeting taking place on 14th April.

Section 1c: SOA / Strategic Priorities

SOA 5: Older people in East Renfrewshire are valued, their voices heard and they are supported to enjoy full and positive lives for longer

SP 3: Reshaping care for older people

A: Performance Measures

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
Delayed discharge: people waiting more than 14 days to be discharged from hospital into a more appropriate care setting	1	0	Amber	Indicator changed from April 2015 to 14 days from 28 days, further revision of this indicator will see this being further reduced to 72 hours from April 2016. There was one person waiting more than 14 days for discharge in December 2015 though in the previous two months of the Quarter there were none.
Delayed discharges bed days lost to delayed discharge (incl AWI's)	1,958	2,010	Green	Currently below target with data available to January 2016.
People reporting 'having things to do' needs fully met (%)	61.7%	62.0%	Green	Of a total of 965 responses, 596 reported their needs fully met with a further 286 (29.6%) reporting their needs partially met. a total of 83 (8.6%) respondents stated their needs were not being met in this regard this year.
People reporting 'staying as well as you can' needs fully met (%)	76.9%	77.0%	Green	A total of 746 respondents reported their needs being fully met in regard to staying as well as they can. A further 179 (18.5%) stated their needs were partially met in this regard, with only 44 (4.5%) claiming their needs remained unmet this year.
People reporting 'feeling safe' needs fully met (%)	82.0%	84.0%	Green	Of 971 valid responses 796 reported their needs fully met with a further 134 (13.8%) reporting their needs partially met. A total of 41 (4.2%) people reported their needs being unmet.
People reporting 'seeing people' needs fully met (%)	73.7%	75.0%	Green	Of 967 valid responses 713 reported their needs fully met with a further 215 (22.2%) reporting their needs partially met. A total of 39 (4%) people reported their needs being unmet.
People reporting 'living where you want to live' needs fully met (%)	77.6%	80.0%	Green	Of 957 valid responses 742 reported their needs fully met with a further 158 (16.5%) reporting their needs partially met. A total of 57 (6%) people reported their needs being unmet.

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
People reporting 'being respected' needs fully met (%)	95.8%	94.0%	Green	Of 946 valid responses 906 reported their needs fully met with a further 38 (4%) reporting their needs partially met. A total of two people (0.2%) reported their needs being unmet.
Citizens' Panel % agree that their community supports older people	65%		Data Only	This figure continues to increase year on year.
Percentage of those whose care need has reduced following re-ablement.	70	30	Green	The reason for such a large value in comparison to target is that the service is still fairly small and it focuses on hospital discharge. The target for 2016/17 has been increased to 50%. As the service grows to include all referrals the number of people with reduced needs is anticipated to fall. The national average is currently estimated to be around 40%.
Percentage of time in the last six months of life spent at home or in a homely setting.	90.9	92.1	Green	The measure is a proxy for preferred place of death. The measure indicates the extent to which end of life care is person centred and effective better support at home or closer to home reducing time spent in an acute setting. East Renfrewshire shows improvement from under 90 to almost 91 per cent. (This latest available data was published Aug 2015)
Percentage of people aged 65+ who live in housing rather than a care home or hospital	97.5	97	Green	There is continuing stability in the number of people living in housing rather than a care home or hospital. At April 2016 there were 575 East Renfrewshire residents (65 and over) living in care homes.
Rate of emergency inpatient bed-days for people aged 75 and over per 1,000 population	3,699	4,510	Green	The figures provided for financial year 2015/16 are provisional, only relating to April' 15 - Dec'15. These figures are subject to change and should be treated with extreme caution. A more realistic representation of the true number of emergency admissions and associated bed days occupied for East Renfrewshire patient's, aged 75+, will be released in mid July 2016.
Mental health hospital admissions (age standardised rate per 1,000 population)	2.9	2.3	Red	Rates (age standardised) to March 2014 published and corrected for previous years May 2015 . Data for 2014/15 and 2015/16 not currently available (next ISD Mental Health Statistics release due in May 2016). Latest data for 2013/14 corresponds to 251 hospital admissions.
Long-term Conditions COPD crude admission rate per 100,000	413.9		Data Only	Data for Jan - Dec 2015. Figure of 531.5 per 100,000 compares to NHS GGC figure of 1066.2
Long-term Conditions Asthma crude admission rate per 100,000	185.1		Data Only	Data for Jan - Dec 2015. Figure of 214.3 per 100,000 compares to NHS GGC figure of 249.6
Long-term Conditions Diabetes crude admission rate per 100,000	171		Data Only	Data for Jan - Dec 2015. Figure of 171 per 100,000 compares to NHS GGC figure of 244.4
Long-term Conditions CHD crude admission rate per 100,000	1,391		Data Only	Data for Jan - Dec 2015. Figure of 1391 per 100,000 compares to NHS GGC figure of 1548.4

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
Long-term Conditions All LTCs crude admission rate per 100,000	2,307.9	1,941	Red	Data for Jan - Dec 2015. Figure of 2307.9 per 100,000 compares to NHS GGC figure of 3108.6 The current target is under review at present.
Long-term Conditions All LTCs bed days	6,022	9,640	Green	Data for Jan - Dec 2015. Figure of 6,022 bed days per 100,000 compares to NHS GGC figure of 9,034
Percentage of people aged 75 and over with telecare support	21.4%	19%	Green	The percentage of people aged 75 and over with telecare support has increased from 19 to 20 per cent in the last two years from a baseline level of 14 in 2011/12.
Residents (%) dying in East Renfrewshire care homes as opposed to hospital	79.7%	80%	Green	Supporting end of life care for people within care homes is preferred to transferring them from the home to hospital. Increased community support allows care homes to support their residents at home more effectively. Our place of death census reveals 137 residents died at home rather than hospital (35 deaths) in 2014/15. This corresponds to around 80% of deaths in total occurring at home, a figure which has been relatively stable over the past four years. Data is only available for this indicator at the end of year point, when quarterly figures are also calculated. The 2015/16 Place of Death Census is currently underway.

B: Planned Activities

Action Description	Status Progress Bar	Notes & History Latest Note
Build on co-production approach with the public & community e.g., Reshaping Care for Older People, redesign of the rehabilitation and enablement service	60%	*A range of programmes that are co-produced with local people have been developed across the authority* *Men's Shed - based in Barrhead this project gives local people a place to socialise and a workshop to undertake community and personal projects e.g. woodworking* *Chair Based Exercise (Barrhead Foundry and Newton Mearns) These groups deliver seated exercise to improve strength and balance to build confidence in older people to participate in exercise* *Chair based exercise pilot with Wise Connections - this group from Neilston supports people to improve their mental health through groupwork and physical activity* *Walking programme - walking groups developed across the authority area - local people trained as walk leaders to run their own groups.* *Long term conditions group - a peer support group to support people to self manage their condition(s)* *'Give it a Grow' based at the Waterworks in Barrhead - local people volunteer to set up a small community garden* *Stride (activity group for older adults) aims to keep people active and a programme devised by the group themselves looks at a range of topics e.g. money advice, reducing stress,* *Memory Lane dementia peer support group, run by volunteers this group provides a local drop in for people with dementia and their carers.* *A new group in Busby is being piloted for older adults*
The CHCP will contribute to the 'Home from Hospital' Better by Design initiative, led by Voluntary Action, to support our older people who do not have local and flexible family/carer supports, to return home and re-engage with their community following a period of time in hospital.	100%	This work has been absorbed into the Safe and Supported programme of work. Opportunities have been identified and will be tested and reviewed within this programme of work, continuing to work in partnership with cross sector stakeholders and people who use services and carers.

Action Description	Status Progress Bar	Notes & History Latest Note
Ensure technology enabled care options are embedded within integrated care and support plans to improve personal outcomes and support individuals safely at home through increased awareness and uptake.	100%	The Technology Enabled Care programme has now completed its first year, and has worked across several project areas in the HSCP including My Life, My Way and Safe and Supported. Telecare is now embedded as part of hospital discharge care planning for all individuals, with positive outcomes already being demonstrated. We are targeting home care users who currently don't access telecare but would benefit.
Support timely and safe hospital discharge by building on our partnership infrastructure, through the awarded three-year delayed discharge funding.	50%	We have reviewed how we currently manage delayed discharges (i.e. the Safe and Supported programme) and this has allowed us to work with our partners to design more effective ways of working. During April 2016, work to finalise our plans to use the additional Scottish Government funding to build on current good practice and add new approaches that will prevent unnecessary admissions was progressed.

Section 2: Effective Organisation

Customer, efficiency and people outcomes

SP4: Improving quality, efficiency and effectiveness

A: Performance Measures

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
Citizens' Panel - Health and Social Care service for Adults	92%		Data Only	The latest report from December 2015 had a response from over 700 residents of whom 5% were adult health and social care service users. 92% of users rated health and social care services good or very good (6 % rise on the previous year)
Percentage of HSCP (NHS) complaints received and responded to within timescale	100%	70%	Green	Data relates to period Jul - Sep 2015. All NHS complaints to the HSCP were responded to within 20 days. The NHS GGC Partnership average was 96%
Percentage of HSCP (local authority) complaints received and responded to within timescale	77%	100%	Red	Ten of thirteen complaints received were responded to within timescale in Quarter 3 2015/16
Primary care performance - cost per patient (unweighted)	£120.00		Data Only	The unweighted cost per patient is £120 for East Renfrewshire.
Primary care prescribing performance - cost per patient (weighted)	£176.00		Data Only	The cost per patient has increased from £165 in 2013/14 to £176 in June 2015.
Primary care prescribing performance	£68,268		Data Only	Annual outturn to February 2016 shows a £68,268 overspend on budget of £13.5M. This equates to a 0.51% overspend on budget
Absence: days lost per employee (all staff LA)	3.91	2.45	Red	There were 2,579 lost working days in Qtr 1, 2,360 of these were medically certificated

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
Absence: days lost for long-term absence as percentage of all days lost (all staff LA)	81.2		Data Only	1,741 days lost to long term absence from a total of 2,144 total days lost in Qtr 2.
Absence: days lost for short-term absence as percentage of all days lost (all staff LA)	19.2		Data Only	A total of 495 days were lost in Quarter 1 to short term absence from a total of 2,579 lost working days.
Sickness absence (%) NHS	5.6	4	Red	Data up to February 2016, latest monthly figure 4.8% (NHS GGC figure 6.4%).
Sickness absence - short-term (%) NHS	2.5%		Data Only	Data to February 2016 - 2.5% , NHS GGC figure 2.7%
Sickness absence - long-term (%) NHS	67.5%		Data Only	This measure has changed during 2013/14 and reporting will be revised for Q1 2014/15.
Percentage of NHS HSCP Staff with an e-KSF (Knowledge and Skills Framework) review in last 12 months	73%	80%	Amber	73% (159 staff) of the 219 NHSGGC HSCP staff had a completed and signed off review at January 2016.
Percentage of HSCP local authority staff with Performance Review and Development (PRD) plans in place	91%	100%	Amber	Whilst the overall completion rate for 2015/16 stands at at 91% across the HSCP PRD completion rates vary: Health & Community Care staff - 95%; Children & Families - 91%; and Strategic Services staff - 87%

B: Planned Activities

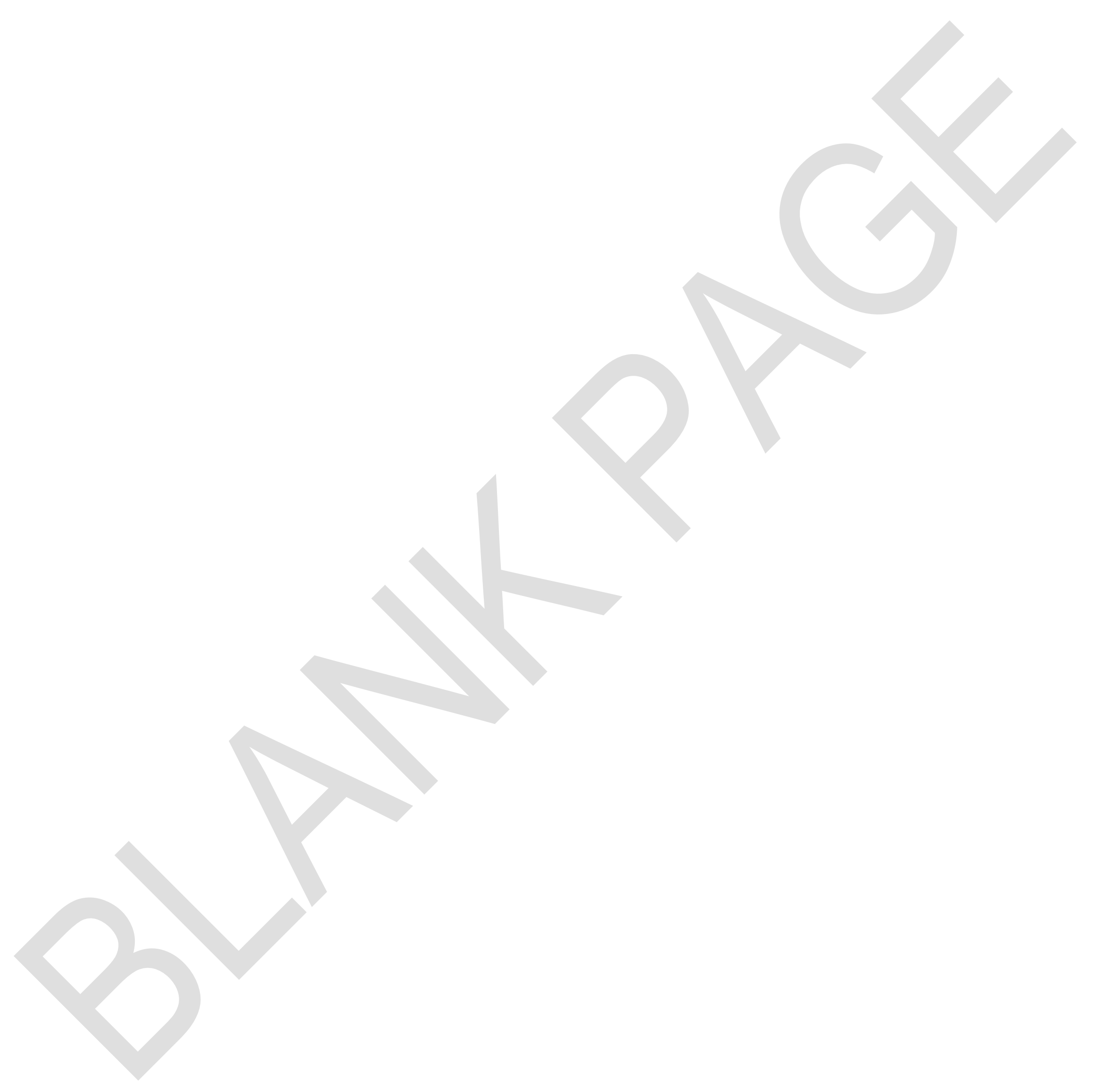
Action Description	Status Progress Bar	Notes & History Latest Note
Engage Public Partnership Forum in the development of the new Eastwood Health & Care Centre to enhance service delivery from a patient experience perspective	100%	Stakeholders have been fully involved in key reference and planning groups throughout the design and development of the Eastwood Health and Care Centre.
Review of externally purchased CHCP services to ensure value for money and fit with self directed support.	90%	Roll-out of the Care Finance Commissioning Module continues and is anticipated to go live in the near future. A tender for Care and Support will be issued in 2016.
Redesign care at home to make the long term service as efficient and flexible as possible.	70%	We are now working on Phase 2 of Care at Home Programme of Work. The programme was structured as a 5 year plan in line with budgetary planning cycles. Phase 2 includes with following: . Further £370K savings . Full scale Reablement . Integration with RES services . Re-structure of workforce . Eliminate over 500 spreadsheets that currently maintains the service . Turn on full digital solution for Service Users

Section 3: Tackling Inequalities

A: Performance Measures

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
Number of staff undertaking routine sensitive enquiry	140		Data Only	Baseline initial estimate includes community addictions, drug treatment and testing staff, children and families social workers, adult support and protection officers and primary care practice staff involved in pilot.
Number of referrals to advocacy services	150		Data Only	A new contract for advocacy services went live in June 2015. Data is for period from 1 June 2015 to 31 March 2016. Three types of advocacy are now delivered : 1. The Advocacy Project (Remit: Vulnerable Adults prioritising Mental Health) Referrals: 116 2. Who Cares Scotland (Remit: Looked after Children & Young People) Referrals: 12 3. Partners in Advocacy (Remit: Vulnerable Children and Young People prioritising Child Protection and Additional Support Needs) Referrals: 22
Access to psychological therapies among older people aged 65 and over	8	7	Green	From baseline position of 4% of the primary care mental health caseload being aged 65 and over access has improved to 8 per cent in 2013/14.
First outpatient Did Not Attend (%)	8.6	8.1	Amber	Data to December 2015. Between January and December 2015 there were 2,233 DNA episodes.
Did not attend outpatient appointment - male	8.8%	8.6%	Green	Current performance (Jan -Dec 2015) reveals 8.8% of our male patients did not attend their appointments. This compares to 14.1% across NHS GGC and 8.3% in East Dunbartonshire.
Did not attend outpatient appointment - female	8.3%	8.1%	Green	Current performance (Jan -Dec 2015) reveals 8.3% of our female patients did not attend their appointments. This compares to 12% across NHS GGC and 7.6% in East Dunbartonshire.
Did not attend outpatient appointment - SIMD1 Male	16.9%	11.3%	Red	Men within the most deprived communities of East Renfrewshire have a DNA rate of 16.9%. In comparison the data for the same period (Jan -Dec 2015) shows the NHS GGC rate is 18.6% and East Dunbartonshire is 14.9%. The DNA rate among SIMD1 males has remained fairly constant in recent years locally.
Did not attend outpatient appointment - SIMD1 Female	15%	11.3%	Red	Women within the most deprived communities of East Renfrewshire have a DNA rate of 15%. In comparison the data for the same period (Jan -Dec 2015) shows the NHS GGC rate is 15.9% and East Dunbartonshire is 13.7%. The DNA rate among SIMD1 females has remained fairly constant in recent years locally.
Access to psychological therapies - % starting treatment within 18 weeks of referral - SIMD1	100%		Data Only	Data up to February 2016.
Access to psychological therapies - % starting treatment within 18 weeks of referral - SIMD5	100%		Data Only	Data at February 2016

PI Short Name	Current Value	Current Target	Traffic Light	Notes & History Latest Note
Cancer screening - bowel SIMD1	43.8%	60%	Red	Latest data refers to March 2015. In comparison NHS GGC figure was 44.4%.
Cancer screening - bowel SIMD5	65.2%	60%	Green	Latest data refers to March 2015. In comparison NHS GGC figure was 64.6%.
Cancer screening - bowel male SIMD1	39.3%	60%	Red	Latest data refers to March 2015. In comparison NHS GGC figure was 42.7%.
Cancer screening - bowel male SIMD5	61.4%	60%	Green	Latest data refers to March 2015. In comparison NHS GGC figure was 61.1%.
Cancer screening - bowel female SIMD1	48%	60%	Red	Latest data refers to March 2015. In comparison NHS GGC figure was 46.1%.
Cancer screening - bowel female SIMD5	68.7%	60%	Green	Latest data refers to March 2015. In comparison NHS GGC figure was 67.8%.
Cervical screening - SIMD1	69.5%	80%	Red	Data at 31 Mar 2015. NHS GGC figure is 70.1%
Cervical screening - SIMD5	81.8%	82.1%	Green	Data at 31 Mar 2015. NHS GGC figure is 75.5% (GGC target 80%)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