Introduction

Welcome to West Dunbartonshire Health and Social Care Partnership’s second Public Performance Report for 2016/17.

Building on our Strategic Plan for 2016-2019 we are committed to providing clear and transparent updates on our progress in key priority areas; on an ongoing basis.

More information about Health and Social Care Partnership services is available on our website at www.wdhscp.org.uk.

We are always keen to receive feedback, so whether you want to provide constructive comments on the contents of this report or any of our services more generally, please contact us at www.wdhscp.org.uk/contact-us/headquarters/.

Mr Soumen Sengupta
Head of Strategy, Planning & Health Improvement

The West Dunbartonshire Health and Social Care Partnership Board’s:
- Mission is to improve the health and wellbeing of West Dunbartonshire.
- Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.
- Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.
264 children had an MMR immunisation at 24 months and 230 children had an MMR immunisation at 5 years in Qtr2 2016/17.

98 children and young people were referred to CAMHS in Qtr2 2016/17.
350 of the 384 children were looked after in the community in Qtr2 2016/17.

Of the 9 looked after children who happened to be BME (Black & Minority Ethnic), 8 were looked after in the community in Qtr2 2016/17.

2 of the 3 children who left care in Qtr2 2016/17 entered a positive destination.

18,787 children had an identified "named person" in Qtr2 2016/17.
Supporting Older People

Delayed Discharges

The Scottish Government have changed the way delayed discharges are counted from 1st July 2016. The previous figure for delays of more than 14 days has been included in the chart for context/comparison.

Acute bed days lost to delayed discharge

No of acute bed days lost to delayed discharges including AWI
No of acute bed days lost to delayed discharges for Adults with Incapacity
No of acute bed days lost to delayed discharges including AWI (Cumulative)
Target for acute bed days lost to delayed discharges including AWI to be achieved by end of March 2017
No of acute bed days lost to delayed discharges for Adults with Incapacity (Cumulative)
Target for acute bed days lost to delayed discharges for Adults with Incapacity target to be achieved by end of March 2017
There were 1,032 emergency admissions and 10,733 unplanned bed days used by people aged 65 and over in Qtr2 2016/17. 4,204 people attended A&E in Qtr2 2016/17.
This is a new indicator in line with NHSGGC’s replacement of the number of non-elective inpatient episodes/spells (rolling year). The target for 2016/17 is to be confirmed.

The proportion of people aged 65 and over dying in hospital rather than at home or in a homely setting continues to be lower in Qtr2 2016/17 than at any point since April 2015.
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Reablement

- Blue: No of clients 65+ receiving a reablement intervention
- Purple: No of clients 65+ receiving a reablement intervention (Cumulative)

- Red: Target for no of clients 65+ receiving a reablement intervention to be achieved by March 2017
- Green: % adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes
- Dotted Green: Target for % adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes to be achieved by March 2017

Number of people in anticipatory care programmes

- Blue: Value
- Red: Target for number of people to be sustained in anticipatory care programmes at the end of March 2017

98 out of 157 people achieved their agreed personal outcomes through a reablement service in Qtr2 2016/17.
1,652 people aged 75 and over received a Telecare service in Qtr2 2016/17.

7,355.5 hours of homecare per week were provided to people aged 65 and over and 384 out of 1,263 people received 20 or more homecare interventions per week in Qtr2 2016/17.
226 people aged 65 and over with intensive needs received 10 or more hours of care at home in Qtr2 2016/17.

1,132 out of 1,263 people aged 65 and over received personal care at home in Qtr2 2016/17.

773 people aged 65 and over with complex needs were living in a homely setting in Qtr2 2016/17. 291 people aged 65 and over admitted to hospital twice or more did not have an assessment while 640 received an assessment in Qtr2 2016/17.

* A change in the 2015/16 guidance for the collection of Continuing Care data will affect comparability with previous figures. Scottish Government are currently examining options to resolve this and this may result in an update to the data presented here.
119 people on the Palliative Care Register died in Qtr2 2016/17, 37 of whom died in hospital: 17 people due to cancer and 20 people due to non-cancer conditions.

% of people on the Palliative Care Register dying in hospital

- % people dying in hospital - cancer deaths
- % people dying in hospital - non-cancer deaths
- Target for % people dying in hospital - cancer deaths to be achieved by end of March 2017
- Target for % people dying in hospital - non-cancer deaths to be achieved by end of March 2017
- Total number of deaths (Palliative Care Register)

% of people newly diagnosed with dementia who have been offered post-diagnostic support

- This is a new PI for 2016/17.
- Target % of people newly diagnosed with dementia who received a minimum of a year’s worth of post-diagnostic support to be achieved by end of March 2017

All 12 people newly diagnosed with dementia were offered post-diagnostic support in Qtr2 2016/17.
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1,966 people from West Dunbartonshire and 19,526 from across NHS GGC were referred to the MSK service in Qtr2 2016/17.

#### % people seen within 4 weeks for musculoskeletal physiotherapy (MSK) services

- **2015/16**
- **Q1 2016/17**
- **Q2 2016/17**

- **West Dunbartonshire**
- **NHS Greater Glasgow & Clyde**
- **Target to be achieved by end of March 2017**

- This is a new target from 2016/17. Previous target was 90% seen within 9 weeks.

441 people were referred to the Homecare Pharmacy Team in Qtr2 2016/17. 85 people declined the support and 64 people were being supported by other service teams.

WDHSCP’s prescribing cost target is the average cost across NHS Greater Glasgow & Clyde as calculated at the end of March 2017.

#### Number of people receiving Homecare Pharmacy Team support

- **Q1 2015/16**
- **Q2 2015/16**
- **Q3 2015/16**
- **Q4 2015/16**
- **Q1 2016/17**
- **Q2 2016/17**

- **Quarter Total**
- **Year to Date Total**
- **Target to be achieved by end of March 2017**

#### Prescribing cost and compliance with Formulary Preferred List

- **2015/16**
- **Q1 2016/17**
- **Q2 2016/17**

- **Prescribing cost per weighted patient (£Annualised)**
- **Compliance with Formulary Preferred List**
- **Target for compliance with Formulary Preferred List to be achieved by end of March 2017**
All 48 carers asked felt supported to continue in their caring role during Qtr2 2016/17.

* Sample data from Carer Support Plans completed during Qtr2 2016/17.
Supporting Safe, Strong and Involved Communities

% people waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

- Value
- Target to be achieved by end of March 2017

231 out of 245 people received treatment within 3 weeks of referral in Qtr2 2016/17.

210 of the 216 Social Work Reports were submitted on time in Qtr2 2016/17.

75 of the 101 new Community Payback Orders attended induction within the timescale and 88 of the 135 unpaid work requirements commenced within 7 days in Qtr2 2016/17.
All 3 Adult Support and Protection clients had a current risk assessment and care plan in Qtr2 2016/17.

There were 53 children on the Child Protection Register at the end of Qtr2 2016/17. 38 out of 46 case conferences were carried out within 21 days during Qtr2 2016/17.
Our Staff

There were 749 NHS employees (629.4 Whole Time Equivalent) and 1,422 WDC employees (1,152.57 Full Time Equivalent) working within the HSCP during Qtr2 2016/17.
Our Finance

Health and Social Care Net Expenditure £000’s

HSCP Expenditure to the end of September 2016 of £68.535m against a budget of £68.375m (not including Set-Aside).

Budget v Net Expenditure Variance

Less than planned expenditure - More than planned expenditure
Complaints

5 complaints were dealt with through the Social Work Complaints policy and 6 through the NHS policy in Qtr2 2016/17. The 3 complaints which were responded to outwith the timescales were between 5 and 9 days late.

Upheld complaints in Qtr2 2016/17 concerned Employee Attitudes (2), Learning/Training Opportunities (1) and Quality of Service (1). Any learning from these complaints is being considered within the relevant service areas.
Community Hospital Discharge Team
The HSCP’s Community Hospital Discharge Team were nationally recognised as finalists in the Integrated Care for Older People category at the Scottish Health Awards 2016.

Through the Community Hospital Discharge Team, the HSCP brings together key services into one integrated team, including Occupational Therapy, Physiotherapy, District Nursing, Speech and Language Therapy and Social Care. Close links to Care at Home Pharmacy and Home Care services mean that people receive a joined up service across our entire HSCP provision.

The Scottish Health Awards recognised that in West Dunbartonshire, through timely and integrated planning, people’s lives were made easier and more comfortable, enabling them to live as independently as possible. The Team maximise opportunities for recovery at home, identifying the need for ongoing support and ensuring timely transfer to appropriate services.

Case Study: ‘Boots On’ – Work Connect
Work Connect, based in Levengrove Park, is a specialist HSCP supported employment service for people with mental health issues, addictions and learning disability. In partnership with Greenspace, it gives disabled or vulnerable people the safe space, tools and support to improve their quality of life through opportunities to learn and apply their skills and creativity.

Initially a horticulture project, it now includes arts exhibitions and classes, catering, and social activities, often led by service users. These activities provide practical skills, often used as a non-medical option alongside existing health and care treatment, and support to improve health and well-being.

The ‘Boots On’ film project, one of the initiatives, demonstrates the impact of focusing on positive person centred outcomes. Developed and created by the people supporting and supported by Work Connect, it reflects the skills and interests of attendees and the project’s flexibility in developing personal projects that work toward individuals’ personal outcomes. Participants report it has improved mental health and physical health, and increased confidence across its whole team of participants and in doing so records its own success. Collectively they have created evidence of the positive person centred outcomes of the project.

The project was visited by the Minister for Employability and Training (Jamie Hepburn, MSP) due to it being recognised as a strong example of how, by thinking out-of-the-box, capacity and resources in two separate public sector services can be combined to improve outcomes for individuals who might otherwise struggle to access support.