Key
Measure from the Improvement Plan
Additional measure
WG Tracking Indicator

Strategic theme: 21st Century Health Care	**Flintshire County Council**
Broad Outcome: Ensuring people receive the help they need to live fulfilled lives	Outcome 3
Why are we focusing on this outcome? • To support more people to live in an ageing population. • To meet the growing demand for specialist care for people with dementia. • To support whole families to live independently. • To develop a model of support for persons with a disability which encourages independent living. • To prevent homelessness. • To avoid unnecessary admissions to hospital and support early and successful hospital discharges. • To work with Betsi Cadwaldr University Health Board (BCUHB) to develop the Enhanced Care Model in all localities in Flintshire as a result of the *Health Review Health Care in North Wales is Changing*. • To co-ordinate the provision of support for service users more effectively with BCUHB and others. • Make effective use of Intermediate Care Funds to support unscheduled care pressures, transformation of services and improvements in people's wellbeing.	**What will success look like?** Improving people's quality of life and helping more people to live independently and well at home.

	2013-14 Outturns	2014-15 Targets	2015-16 Targets
How much did we do? Input/ throughput indicators taken from any source including the tracking indicators in the *Programme for Government*			
• Purchase and pilot the use of multi-room censors for people with learning disabilities to assist in increasing their independence (Telecare/Telehealth).	N/A	4	N/A
• Agree an action plan for the use of Intermediate Care Funds to support individuals to remain in their own homes.	N/A	Summer 2014	N/A
• Recruitment of 1.5 Occupational Therapists and 1 Social Worker to the Reablement Team.	N/A	Summer 2014	N/A
• Development of co-located community based health and social care teams	North West (Holywell) established March 2014	North East (Quay Health Centre) March 2015	South Locality Team Established December 2015
• Number of homes disabled adaptions were provided to, to promote independence (measure of demand/pressure on service to be reported each year, hence no targets set for future years)	583 homes	Not Applicable	Not Applicable
• Referrals to the Homesafe Service (victims of domestic abuse) (measure of demand/pressure on service to be reported each year, hence no target set for future years)	215 people	Not Applicable	Not Applicable
How well did we do it? Qualitative assessment of effectiveness/ evidence from surveys/ output data etc			
• The average number of calendar days taken to deliver a Disabled Facilities Grant for adults (PSR/009b)	247 Days	300 – 350 days *1	280 – 320 days
• The average number of calendar days taken to deliver a major adaptation for adults in Local Authority dwellings, which do not go through the DFG process	120 Days	120 Days	120 Days
• The average number of calendar days taken to deliver a Disabled Facilities Grant (PSR/002)	246 days	300 – 350 days *2	280 – 320 days
• Rate of delayed transfers of care for social care reasons (SCA/001) (Also an Improvement Plan measure)	2.59 per 1,000	2.39 – 2.58 per 1,000 * 3	2.19 – 2.38 per 1,000

• The percentage of referral that are re-referrals within 12 months (SCC/010a). We are seeking to reduce re-referrals using a whole family approach through the Integrated Family Support Service.	13%	Below 15%	Below 15%
• Percentage of adult protection referrals where the risk has been managed (SCA/019)	98%	95 - 98% *4	95 – 98%
Is anyone better off? Quantative evidence of the outcome achieved using tracking indicators from the *Programme for Government* and your single integrated plans			
• Percentage of referrals where support was maintained or reduced or no further support was required at the end of a period of Reablement (SCAM2L)	76.6%	71-75%	75-80%
• Number of adults receiving a personal budget for services via either a direct payment or Citizen Directed Support (IA1.1L4)	302 people	302-315 people	315-325 people
• Homeless prevention for at least 6 months for households and individuals (including care leavers) (HHA/013)	84.89%	85-90%	85-90%
• Gather further patient stories where the patient has had positive experiences of Enhanced Care Service	3	3	Not Applicable
• The percentage of identified carers of adult service users who were assessed or reassessed in their own right during the year who were provided with a service (SCA/018c)	85%	75-80% *5	80-85%

Notes

*1 - As an increasing number of adaptations are progressed through the minor adaptation route the remaining adaptations going through the DFG route are of a far more complex nature. This means that we are no longer measuring like with like. If only the complex adaptations had been measured in the past performance would not appear to be deteriorating through setting a higher and wider target range. A absolute baseline can not be provided as there are no specific perameters set for what a constitutes a 'complex' adaptation.

*2 – In addition to the note made for *1, the performance indicator PSR/002 includes adaptations for children as well as adults. Whilst there are significantly fewer adaptations required for children they are far more complex works and as a result a small number of cases can have a substantial impact on the overall 'average days'. For this reason a higher and wider target range has been set. The target will be challenging to achieve.

*3 – A small number of delays can arise that are outside our control; for example service users whose properties are unsuitable but choose not to go into residential care, or service users who stay in hospital waiting for a mental health placement. We are seeing an increase in complexity of cases coming through and for this reason believe the target set will be challenging.

*4 – This PI has seen an increase in performance on previous years (approx 92%) to that achieved for 2013/14. Work is undertaken to encourage clients to accept interventions but some clients will decline. For this reason the target range has been set at a realistic but challenging level.

*5 – It is now known that there is a larger population of carers than was known at the end of last year. For this reason the target is lower than the outturn for 2012/13 year end.

Story behind the data? Brief analysis of the context, updated each year. What are the factors that are at work in determining the outcomes? Which other organisations have a significant role to play in achieving the outcomes?

Flintshire County Council continues to make progress and has been able to evidence a range of positive outcomes which have been delivered through our strategic transformation of services. It is our intention to put people in control of the services they receive and to support more people to live independent lives. We seek to reduce dependency on services by strengthening support in communities and through the use of new technology.

Flintshire County Council have two key Improvement priorities that will significantly contribute to this Strategic Theme: -

- Independent Living
- Integrated Community Social and Health Services

Independent Living

Key activities for 2014/15 include: -

- Maintain the success of the reablement/recover approach, engaging in regional working for the further roll out of telecare/telehealth and improve the timeliness of adaptations.
- Implement a series of actions to support greater independence for individuals with a frailty and/or disability including completion of rightsizing exercises for all supported living projects provided and commissioned. Implement a nigh support service.
- Use a whole family approach through the Integrated Family Support Service
- Examine the Children's Services structure with a view to remodelling the teams to create capacity to do more preventative work.
- Prevent homelessness for people who are:-

- Alcohol and drug dependent; and/or
- Ex-offenders; and/or
- Victims of domestic violence; and/or
- Young people including care leavers

- Carry out a major review of the Transition Service and implement findings.

Key Risks/Challenges being faced: -

- Keeping up with specialist demand such as the specific residential needs of those with dementia.
- Ensuring we have enough capital for disabled facilities grants alongside other competing demands for capital resources.
- How we encourage service users and carers to embrace greater independence.
- Service user/family resistance to using new technologies e.g. telecare/
- Managing demand and expectations with limited resources.

Integrated Community Social and Health Services

Key activities for 2014/15 include: -

- Continue the integration of community based health and social care teams within three localities.
- Support the introduction of Enhanced Care Service (ECS) in North East and South Localities by March 2015.
- Ensure that effective services to support carers are in place as part of the integrated social and health services.
- Ensure Single Integrated Plan (SIP) priorities are progressed through localities.
- Effective and efficient use of Intermediate Care Funds to support individuals to remain in their own homes.

Key Risks/Challenges being faced: -

- Ensuring effective joint working with BCUHB to achieve common goals.
- Ensuring that the new model does not result in unexpected increased costs to the Council
- Spending the Intermediate Care Fund on mainstream services that we can continue with once the funding stream has finished.