THIS PAPER RELATES TO ITEM 05 ON THE AGENDA

CLACKMANNANSHIRE COUNCIL

Report to Partnership & Performance Committee

Date of Meeting: 27 September 2018

Subject: Health and Social Care Partnership - Clackmannanshire

Report by: Shiona Strachan, Chief Officer, Integration Joint Board and Health & Social Care Partnership

1.0 Purpose

1.1 The purpose of the paper is to provide an update to the Partnership and Performance Committee of the activity of the Health and Social Care Partnership through the Transforming Care Programme; Clackmannanshire social care service performance information; financial performance and the 'in year' actions to manage demand.

2.0 Recommendations

2.1 To note the content of this paper and the work taking place to review and develop services.

2.2 To note the work taking place to mitigate the level of demand for services and the resulting budget pressures

3.0 Considerations

3.1 It is important to recognise that the Partnership is engaged in a significant redesign programme – this is designed to ensure that the services can meet the needs of the population going forward but also to ensure that we maximise the opportunities for efficiencies and work towards bringing the service offer into line with the available resources.

3.2 Re design on this scale is not an instant 'answer' to the growing pressures on all service areas and planning with the Integration Joint Board has developed a short and medium term approach which bridges between the current Strategic Plan and the developing Strategic Plan for 2019-22.

3.3 Following the development of the Strategic Plan 2016-19 a programme of transforming care activities were commenced to deliver the key Strategic Plan priorities. This report provides an end of year update on the Transforming Care Programme.

3.4 As a key part of the assurance process the Integration Joint Board requires to produce an Annual Performance Report [APR]. The APR, now published on the Integration webpages, demonstrates an overall strong performance in the key areas.

3.5 The Council and its partners, as part of the Integration Joint Board, have been subject to a Strategic Inspection, J*oint Inspection [Adults] of the Effectiveness of Strategic Planning*, with a final report due in Autumn 2018. The areas of focus for the inspection are the following Quality Indicators –

What key outcomes have we achieved?	How good is our management of whole systems in the partnership?	How good is our leadership?
1. Key performance outcomes	6. Policy development and plans to support improvement in service.	9. Leadership and direction that promotes partnership.
1.1 Improvements in partnership performance in both healthcare and social care.	6.1 Operational and strategic planning arrangements. 6.5 Commissioning arrangements.	9.1 Vision, values and culture across the partnership. 9.2 Leadership of strategy and direction.

Quality Indicator 9 will not be fully evaluated – that is, this area will not be given a formal grading in the final inspection report but will be subject of some commentary. The final report is due in the next few weeks and will be the subject of a report to the Council.

4.0 Transforming Care

4.1 Following the development of the Partnership's Strategic Plan 2016-2019, a programme of transforming care activities were commenced to deliver the strategic priorities of the Strategic Plan. This diagram below illustrates the key priorities of the Strategic Plan which have a focus on strengthening community based supports.

The activities under each of the broad headings is detailed below.

5.0 Model of Neighbourhood Care

5.1 The Partnership set out to develop a model of neighbourhood care on a pilot basis in rural southwest Stirling, which will provide a framework for the service delivery within the three planning localities across the Partnership. The model is based on the "Buurtzorg" principles of neighbourhood care, adapted to our local circumstances. The pilot team will consist of staff currently delivering reablement, adult social care and district nursing to people in rural southwest Stirling. The multi disciplinary, integrated team will work on the principles of placing the individual at the centre, with promotion of supported self-management, independence, and active involvement of friends, family & the community. The team will work towards developing greater levels of autonomy for staff, streamlining administration, supported by a team coach.

Intermediate Care

5.2 Approval was provided at the April 2017 Integration Joint Board [JB] meeting to review the model of service delivery under the umbrella of Intermediate Care as part of the "step into" the Health and Care Village [due in November 2018], covering bed based intermediate care and the supporting intermediate care at home services.

5.3 Within the HSCP intermediate care services are largely focused on supporting older people and are provided as Intermediate Care at Home and Bed Based Intermediate Care. There are a number of challenges identified in the current models of service.

- There is no single model of Reablement or Intermediate Care at Home, with 5 overlapping service delivery models. All have a focus on early

intervention and prevention and were developed at various times to respond to local needs or utilise resources more effectively. The 5 models are – Clackmannanshire Reablement, Stirling Home Care Assessment and Reablement Team (HART), Stirling: the Rural Partnership, Stirling: the North West Rural Partnership and, Stirling: Rapid Response.

- There is also bed based Intermediate Care within residential care homes owned by the local authorities. The units currently used for this purpose in Stirling will 'step into' the Health and Care Village when it is completed in November 2018. Services in Clackmannanshire will be reviewed over 2018-2019 to ensure consistency across the whole HSCP. .

5.4 Additional support was sought by the Partnership from iHub [the national improvement service] to guide the evaluation of these services, while providing 'critical friend' support.

5.5 For the Reablement service, which is a care at home service, the Living Well in Communities section of iHub have supported the development of a logic model to evaluate the range of models currently in place, and will guide the Partnership in deciding on a preferred model for future service delivery. Meanwhile, the range of models has reduced over the past year, with Clackmannanshire Reablement being rationalised, while the service areas in the rural locality of Stirling are being evaluated alongside the continued development of the Neighbourhood Model of Care.

5.6 These evaluations have now concluded and will inform the development of a strategy and implementation plan for intermediate care services. This will contribute to effective development of a whole systems approach which will support the care of people closer to home, avoiding unnecessary acute hospital admission, supporting effective discharge and will align to the teams and structures within the localities of the Health and Social Care Partnership.

6.0 Day Services [Older People]

6.1 A management review of Day Services has been undertaken with the aim of identifying how a more responsive and cost effective service could be developed. This work has focussed on service provision within Clackmannanshire.

6.2 There are currently traditional models of day supports provided within Ludgate House Day Service for older people, and The Whins Resource Centre for adults with physical disabilities. Meanwhile, therapeutic day care is also provided within Clackmannanshire Community Healthcare Centre, for both physical disability and old age psychiatry services.

6.3 There is a need to re-design and align these models of service to modernise current practice, and ensure equity of access to services which meet the priorities of the Strategic Plan as well as to fit with Self-directed Support opportunities.

6.5 The growing older population, along with the drive for people to be supported to live in their own homes means that there is a requirement for services to be able to respond in different ways to promote successful ageing wherever possible. However, it is also recognised that for some older people, additional support may be required to both support themselves and their carers when living with long term or life limiting conditions. The key issues are:

- Growing older population [by 2033, 1 in 4 people in Clackmannanshire will be over 65]
- Focus on rehabilitation, recovery and living well in later life
- Appropriate and timely pathways for high resource users of health and social care services
- The challenge to meet budget priorities
- Supporting carers
- Promoting choice and control over the types of services which individuals wish to access in planning their own care support

6.6 A short life working group was established during 2017, to scope out existing service models and provide a level of scrutiny on the outcomes being achieved within these services. Consideration was also given to other Health and Social Care Partnership areas and the range and types of services available in other areas. It was identified that there was an on-going need for 4 different types of service provision:

- Specialist Support
- Short Term service based upon rehabilitation and recovery
- Maintenance programmes to support benefits of rehabilitation programmes or to continue with long-term outcomes
- Long-term day respite for users and unpaid carers

6.7 Work commenced in February 2018 with Clackmannanshire Third Sector Interface [CTSi] to consider the range and types of services which could support place based, community supports, and a consultation was commenced in May 2018 to consider how local assets could be used more effectively to support older people to live well in their communities. This engagement has focussed on the use of Ludgate House in order to maximise this space as a social hub for older people. This engagement has also considered how best to support people living with dementia as well as their carers. It is expected that CTSi colleagues will report on their findings in the autumn 2018 to allow for appropriate planning. In working collaboratively with

the Third Sector, there is opportunity to co-design services which seek to support those who can self-managed in a more pro-active and preventative way.

6.8 This approach will lead to the co-production of supports for older people and their carers, utilising part of Ludgate House as a Third Sector resource, while developing Clackmannanshire Community Healthcare Centre's Day Therapy Unit as a key location to support people with more complex needs [often referred to as High Health Gain needs].

7.0 High Health Gain

7.1 The focus of work within the High Health Gain work stream over the last year was our innovation work "Supporting full and independent lives through innovative technology approaches". The Health and Social Care Partnership's poster was accepted for display at the national NHS Scotland event in June 2018 as an example of innovation and practice. .

7.2 This area of work is linked to the Primary Care Improvement Plan and Technology Enabled Care.

8.0 High Health Gain - Primary Care Transformation

8.1 After a period of review and primary care consultation, the outline plan for our local approach to implementation and governance of the Primary Care Transformation Programme was approved by Clackmannanshire and Stirling IJB on 30 August 2017. The three strands of the programme being:

- Urgent Care GP Out of Hours Transformation: Implementing the recommendations of the "Report of the Independent Review of Primary Care Out of Hours Services".

- Primary Care Transformation: This strand aims to encourage GP practices to work together in clusters, taking a multi-disciplinary approach to care within practice and the community.

- Mental Health in Primary Care: The investment for mental health services aims to improve access for people with mental health needs to the most appropriate support as quickly as possible, in the most appropriate setting.

8.2 This work has informed and supported the development of a Forth Valley wide Primary Care Implementation Plan, which was approved at NHS Forth Valley's Board in July 2018.

8.3 A key achievement of this work has been delivered in partnership with the Cluster Quality Lead and Locality Lead GP in Clackmannanshire, where we have focussed the core of transformational work. Initial exploration of priorities with all of the practices resulted in a clear set of aims

- To introduce primary care mental health practitioner capacity to all GP practices in Clackmannanshire, offering more than 200 new appointments per week

- To test the model of training a pharmacist in an extended set of skills so they can comprehensively manage diabetic patients within a primary care setting and free up GP capacity

- To provide alternative support model to care homes which will reduce the need for GP call outs to care homes in Clackmannanshire initially for two practices

- To introduce Home Blood Pressure Monitoring to 5 practices and 100 patients

8.4 A further development will see improvement to post diagnostic support for people diagnosed with dementia. The Dementia Outreach Team will be re-designed from September 2018 onwards to deliver integrated post-diagnostic support and timely access to a Social Worker, delivered in partnership with Alzheimer's Scotland. The developments to date have been well received and evaluated.

9.0 Mental Health

9.1 The Mental Health services across the Partnership are presently subject to redesign. The planned benefits of the review are consistent with the national Mental Health Review (Scottish Government) and spans a variety of issues from general Human Rights to the development of services consistent with Self Directed Support, innovative commissioning of services and day supports for those with profound and mental health issues.

9.2 The Mental Health Service is required to evidence how it implements local, operational priorities:

- Change from traditional single agency services to integrated services at operational level across the NHS and the 2 councils.

- Redesign of traditional day services to personal outcome services, 5/7 shift work etc. In house or commissioned the service specification should be the same.

- The development of a Commissioning Plan that focuses on the development of financially sustainable, alternative services to long term hospital care, external high cost residential and nursing care and the development of supported living opportunities , care and home and day services that are developed local where possible and are outcomes focussed and consistent with best practice.

9.3 There is a clear commitment to developing, where practical, a service based on a single integrated management structure operating from a pooled budget and which is co-located. The proposals were agreed at the IJB meeting of 28 March 2018 and have agreed with staff and Trade Unions/Staff representatives. The job evaluation and recruitment process for the new Team Leader posts is now in progress with a view to having the posts in place and managing both community nursing and social work posts within an integrated team by October 2018.

9.4 The Joint Commissioning Plan was signed off by the Integration Joint Board on 28 March 2018 and provides the basis of a plan for the next 3 years and will proceed on the following basis:

- Commission services within the Partnership's geographical area and / or the NHS Forth Valley area where possible.

- Commission services that promote choice and innovation and focus on personal outcomes.

- Commission independent living services as a direct alternative to low/medium dependency residential care (note it is accepted that alternative to high dependency, specialist residential nursing care will create a challenge in developing alternative local services).

9.5 The re-design of mental health services also includes consideration of in-house day services to ensure that the provision of flexible and innovative community based services is consistent with the principles of client specific outcomes and Self-directed Support, operating seven days per week including the option of providing opportunities during evenings and weekends.

9.6 The Alloa based, Integrated Mental Health Team presently operates within this model and services within the Stirling locality are commissioned from the Third sector likewise. However, further review of the service is being progressed in order to meet the requirements of a consistent approach across the Partnership area that also meets the requirements of the agreed Eligibility Criteria and compliments the redesign of community mental health services that are managed by the NHS Board.

9.7 The models being developed are designed to move towards a more fully integrated team and supporting management structure, which should help reduce duplication and provide a positive basis for more integrated working across the wider service areas.

10.0 Learning Disability

10.1 The review of Learning Disability services across the Partnership are consistent with the national "Keys to Life" strategy (Scottish Government 2013) which spans a variety of issues from general Human Rights to the development of services consistent with Self-directed Support, innovative commissioning of services and day supports for those with profound and multiple learning disabilities.

10.2 The Learning Disability Service is required to evidence how it implements local, operational priorities:

- Change from traditional single agency services to integrated services at operational level across the NHS and the 2 councils.

- Redesign of traditional day services to personal outcome services, 5/7 shift work etc. In house or commissioned the service specification should be the same.
- The development of a commissioning plan that focuses on the development financially sustainable, alternative services to long term hospital care, external high cost residential care and the development of supported living opportunities , care and home and day services that are developed local where possible and are outcomes focussed and consistent with best practice.

10.3 There is a clear commitment to developing, where practical, a service based on a single integrated management structure operating from a pooled budget and which is co-located. The job evaluation and recruitment process for the new Team Leader posts is now in progress with a view to having the posts in place and managing both community nursing and social work posts within an integrated team by October 2018.

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- Commission services within the Partnership's geographical area and / or the NHS Forth Valley area where possible.

- Commission services that promote choice and innovation and focus on personal outcomes.

- Commission independent living services as a direct alternative to low/medium dependency residential care (note it is accepted that alternative to high dependency, specialist residential nursing care will create a challenge in developing alternative local services).

10.5 It has been important to consider the range and approaches to day services for people with a learning disability as part of this review. The projected benefits of the redesign of in-house day services are as follows:

- The development of flexible and innovative community based services consistent with the principles of client specific outcomes and Self Directed Support operating seven day per week including the option of providing opportunities during evenings and weekends.

- Building based services primarily being used for high dependency service users who require high levels of supervision and personal care as well as their social development including the option of providing opportunities during evenings and weekends.

10.6 An initial assessment of need is subject to further clarification on a case by case basis via detailed planned reviews with service users, their unpaid carers/family and appropriate professionals and support workers. There has been regular engagement with the staff and the Trade Unions on the redesign and this has been supplemented by carer and service user engagement in relation to the proposals and will continue on an ongoing basis.

10.7 It is expected that in re-designing day support services, there will be a rationalising of building bases, with services operating from The Whins Resource Centre. This will release previously rented properties at both Miller Court and Mill Street, releasing a revenue saving for Clackmannanshire Council.

11.0 Stirling Health and Care Village

11.1 Stirling Health and Care Village is a £37m health and care development on the Stirling Community Hospital site which is being taken forward through an innovative partnership between NHS Forth Valley, Stirling Council, the Scottish Ambulance Service, the Integration Joint Board and Forth Valley College. The project is on budget and running slightly ahead of time.

11.2 The site consists of three main purpose built facilities – the Bellfield Centre which will provide intermediate bed based care; GP/primary care, with two practices moving onto the site from existing premises in Stirling; the Scottish Ambulance facility, which will replace the existing base at Riverside; X ray and Minor Injuries. The existing outpatient facilities will be retained within their current buildings on the wider Stirling Community Hospital site.

11.3 The Bellfield Centre will offer bed based intermediate care for older people – essentially a ‘step up’ for older people at risk of admission to acute hospital or long term care home admission or a ‘step down’ from hospital.

11.4 The Bellfield Centre is scheduled to ‘go live’ in November 2018 and will involve the retraction of services from the existing community hospital wards and from Allan Lodge and Beech Gardens, which are residential care homes now providing largely bed based intermediate care services for older people.

11.5 At the time of writing the GP and Minor Injuries Centre and Scottish Ambulance Service base are now being prepared for occupancy and will ‘go live’ over the next few weeks.

12.0 Delayed Discharge

12.1 In the Partnership there has been a very focussed approach to the prevention of avoidable Hospital Admissions and on the reasons for people experiencing delays in their discharge. The governance and reporting arrangements for all

the strands of work is to the Delayed Discharge Steering Group. This Group plays a pivotal role in the process of overseeing the Improvement Plan and agreeing implementation arrangements and timeframes. The group ensures there is a collective ownership of targets and actions for improvement across services. Local performance information relating to Delayed Discharge can be found at section 22.7 of this report.

12.2 Overall, the performance of the Partnership has been maintained and in the majority of areas (e.g. occupied bed days) has improved. The impact of this is that patients are able to move more quickly to their next stage of care. There are also positive benefits in relation to hospital flow.

12.3 In common with other areas across Scotland there is an increasing pressure on hospitals. The Partnership is now engaged with a range of measures which seek to develop a whole systems approach to both prevent unnecessary admission to hospital as well as timely and safe discharge and to help us more effectively manage the pressure and ensure the provision of high quality services. These initiatives include:-

- The Unscheduled Care Programme Board
- Frailty at the Front Door Collaborative
- Daily Dynamic Discharge within Community Hospitals and Intermediate Care
- Community Front Door initiative
- Advanced Nurse Practitioners supporting care homes to avoid unnecessary admission from these settings

13.0 Self-directed Support

13.1 This programme is part of a ten year strategy (2010-2020) which supports the implementation of the Social Care (Self-directed Support) Scotland Act 2013. The Act intends to ensure that care and support is offered, and delivered, in a way that supports choice and control and respects the right to live an independent life and the right to participate in society. The Act applies to adults, children and young people and their families and carers. The legislation enshrines the following principles: participation, dignity, involvement, informed choice and collaboration.

13.2 This work stream operates within in a new Programme Implementation Board with working groups, in each locality, taking forward the next stage of implementation. The Board is chaired by Operational Senior Management and includes representatives from Finance, Strategic Commissioning, Business Support (IT) and Business and Finance and covers the full Partnership area.

13.3 Training of operational staff and Team Managers was completed during the final quarter of 2017 and the first quarter of 2018. This will be an ongoing

issue with emphasis put on Team Leaders to be the “champions” for SdS and lead the operational practice issues: Completed in both Stirling and Clackmannanshire

13.4 A “Test of Change” on the new assessment & care management electronic documents was carried out across the Partnership involving operational staff. This will be reviewed again during 2018 and thereafter annually: Completed across the Partnership.

13.5 Electronic documents are now updated and ‘live’. Clackmannanshire and Stirling have different client based information systems: Stirling has been working to implement new assessment document which links into the Resource Allocation System [RAS].

13.6 The Partnership will continue to work towards full implementation of the electronic documents required to operate to the RAS, while practitioners gain confidence in the approach and develop consistency of practice. Commissioning models will also be further developed to inform both staff and service users of the range of provision available within the range of their resource allocation.

14.0 Enablers

14.1 The areas of activity in this section described as ‘enablers’ are supporting activities and are long term in nature. These areas support each of the transformation programmes, facilitating innovation and intelligence led planning.

15.0 Strategic Needs Assessment

15.1 On 1 April 2016 Clackmannanshire & Stirling Health & Social Care Partnership published its first Strategic Plan to cover the period 2016-2019. The plan set out how the Partnership intended to meet the current needs of the population as well as considering projected population changes. A key theme throughout was making the best of resources to deliver efficient and effective health and social care.

15.2 In order to support the production of the plan a strategic needs assessment was produced to provide an understanding of the health and care needs of the local population. The needs assessment was extensive and covered a wide range of topics including demographics, life circumstances, risk factors, population health and service provision. Many of the data sources will have been updated but the key messages will remain relevant given only a short period of time has passed. With that in mind this iteration of the needs assessment is designed to be a more focussed update to sit a long side the original document to support the next iteration of the strategic plan. The agreed areas of focus included gaps from the first iteration as well as refreshing the following areas: Population, Unscheduled Care, Delayed Discharges, Care at Home, Residential Care and Respite Care

15.3 In order for the Partnership to produce a detailed Strategic Plan that best meets the needs of its local population we require a clear understanding of the health and care needs of the population. The needs assessment, alongside the first iteration, aims to bring together the available data in order to describe the current pattern and level of supply of services.

15.4 Some emerging findings have recently been presented to the Strategic Planning Group and a draft to support the priority setting for the next Strategic Plan is now being worked on.

16.0 Technology Enabled Care

16.1 Clackmannanshire and Stirling Health and Social Care Partnership have been awarded £212,000 from the Scottish Government Technology Enabled Care Fund to support the expansion of Telecare for people living in the community. The aim of the project is to successfully support people to live full and positive lives within supportive communities.

16.2 Technology Enabled Care [TEC] can be used successfully to support people with care needs and those that care for them, to have greater choice and control over their own lives; and enable them to live well in their own homes for longer with greater independence and safety, while reducing the need for unplanned or over care.

16.3 The approach of the Clackmannanshire TEC Service MECS [Mobile Emergency Care Service] is to have a TEC first approach to all assessments, with the service evaluating well when benchmarked with similar services in Scotland.

16.4 To date, the project has seen a net increase of 15% across the HSCP in people accessing technology to support them with their care needs, supporting them to live longer in their own homes, while reducing “over-care” and increasing self-management.

16.5 It is expected that analogue phone lines will be replaced with digital technologies by 2025. This will have a significant impact on Telecare Services, which are currently reliant upon analogue phone lines. To address this, the Scottish Government TEC Programme and Digital Office have developed a work stream specific to the needs of Telehealthcare Services, which is using an Agile approach to identify new and innovative ways in which digital technology could support people to live well in their communities.

17.0 Information and Directories

17.1 The Partnership has engaged with CTSi to develop a suite of information directories mapping out the range of services and community based initiatives available throughout Clackmannanshire. This project originally scoped out services available to people living in Tullibody, and has since been developed across all local towns and villages. CTSi intend to make this available in leaflet form which will be available within libraries, GP surgeries etc, but have also developed a spreadsheet of information which they have shared with the

Partnership and Primary Care Services. This will be used to support effective sign-posting for people to access opportunities in their local communities.

17.2 Consideration of digital platforms is being taken forward by the Partnership, and recent discussion with National Services Scotland [NSS] may provide an opportunity to link to national work to develop supported access to a digital platform will assist in self-management approaches in the future.

18.0 Housing Contribution

18.1 A Housing and Social Care Group has been established to develop a distinct Action Plan for the Partnership that would create a framework to allow priority objectives to be delivered. This Action Plan focuses on four key areas relating to housing that will be developed going forward. These are: Governance, Homelessness, Mental Health and Older People.

- *Governance* – New Group structure and terms of reference have been agreed. This is informed by the Action Plan.

- *Homelessness* – Stirling Council are currently working with Forth Housing Association to develop a 'Housing First' pilot for the area for homeless clients with complex support needs. This will provide an alternative to standard temporary accommodation, and assist with meeting the aims for the Scottish Government's ambitions for repaid rehousing of homeless people.

- *Mental Health* – Strong links have been developed with colleagues in Social Work to ensure a greater understanding of different client groups with mental health issues/learning disabilities etc. This closer working has helped planning for new affordable housing, to ensure that specific client needs can be incorporated into the design of homes from an early stage.

- *Older People* – The Partnership is working closely with Clackmannanshire Housing colleagues to plan new models of core and cluster housing to support older people in their communities. Engagement with a service user reference group has commenced which will inform future planning and investment.

19.0 Data Sharing and Shared Assessment

19.1 The Forth Valley Data Sharing Partnership identified priorities for 17/18;

- Delayed Discharge [Edison Replacement]
- Single Shared Assessment [SSA]
- Health and Social Care Information Sharing Portal

- File Share [ensuring that operational staff within the Partnership can work effectively in a range of locations within and between all 3 of the constituent authorities]

19.2 Work has progressed in all of these key areas to support.

20.0 Commissioning – Market Position and Providers

20.1 The Market Position Statement for Clackmannanshire and Stirling (2017) was presented and approved by the IJB in June 2017. The Market Position Statement was revised in November 2017 and was published in March 2018. It sets out key pressures, summarises current supply and expected demand and provides key messages about future priorities. Included in the Market Position Statement is the Market Facilitation Statement which sets out how the partnership will work with providers to deliver high quality, person-centred and cost effective services and supports. There was full consultation on the Market Position Statement.

20.2 The key messages set out in our Market Position Statement demonstrate a holistic approach, with a balance between prompting health and wellbeing, early intervention and prevention and more intensive care and support. We have set out the key messages for providers and areas for anticipated future developments in service design and delivery. This is evidenced by the work that has taken place with Care at Home Providers, where a shared approach to supporting reduced delayed discharges and unplanned admissions has been successful to both the indicators, the quality of the care and to building relationships.

21.0 Workforce

21.1 Our workforce continues to plays a key and valued role in the delivery of our priorities and our aims are to ensure the availability of a flexible, responsive Partnership workforce with the right skills, in the right place and at the right time, confident and competent, to help ensure that our service users get the right level of support early enough to deliver on our strategic outcomes.

21.2 The Partnership has continued to deliver on our *'Caring Together'*, our Integrated Workforce Plan (2016/19) focusing on the following key areas:

- Workforce Information, Demographics and Role Development
- Organisational Design and Processes
- Workforce Engagement and Support
- Leadership and Management Development
- Workforce Learning, Training and Development

21.3 As the Partnership deliverables have moved into implementation phases, organisational development plans, service designs and transformations have started to be co-produced with staff, Joint Staff Forum representatives and Partnership agencies.

21.4 The promotion of working in integrated ways has also been supported by the introduction of quarterly "Big Team Meetings" for health and social care staff which have seen over 150 staff from health and social care attending a number of networking involving and engaging staff in topics including National Health and Care Standards, Neighbourhood Models of Care, Stirling Health and Care Village, Technology Enabled Care, Mental Health Services and Carer's [Scotland] Act 2016 to name a few.

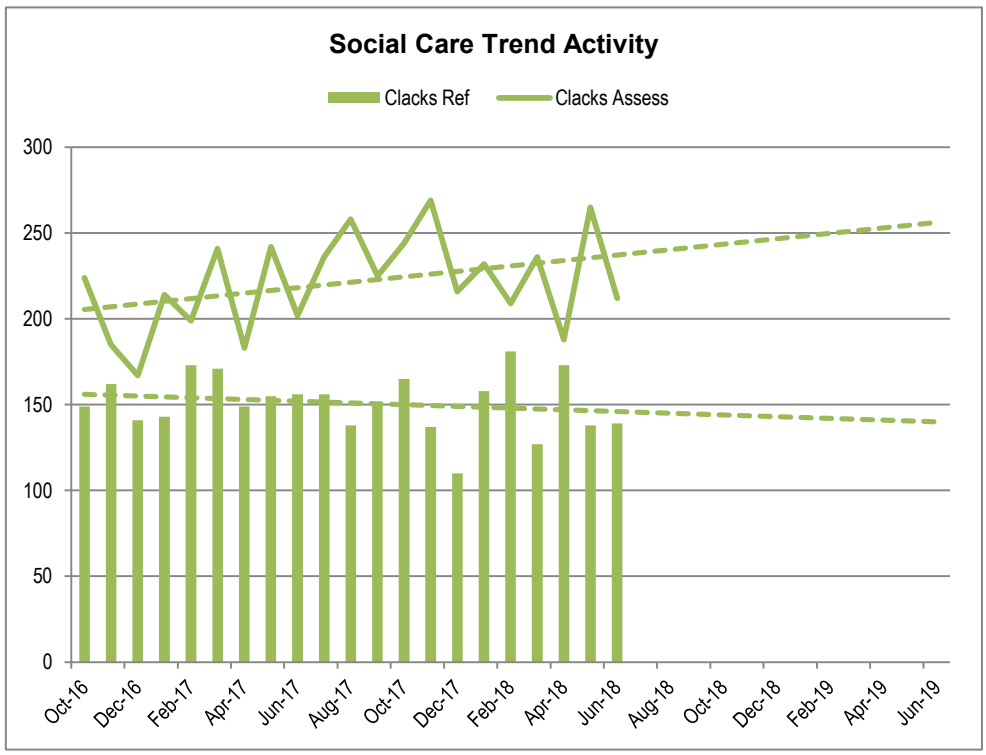
22.0 Performance Reporting - Outcomes Framework and Improvement Objectives

22.1 Over the last year the Partnership has statutory deadlines set by the Scottish Government to meet in relation to reporting progress against core integration indicators and the nine national outcomes, as well as formal reporting of agreed targets and improvement objectives on Unscheduled Care.

22.2 The Partnership has now published its second Annual Performance Report . This report tells us that we have maintained an overall good performance against the national Health and Wellbeing Outcomes, with the Partnership performing above or in line with the national average in most of the core indicators.

22.3 A Clackmannanshire social care scorecard has been developed and is now being refined (Appendix 1). This is an area that will continue to develop as integration moves forward. This is analysed at the monthly Service Manager meeting.

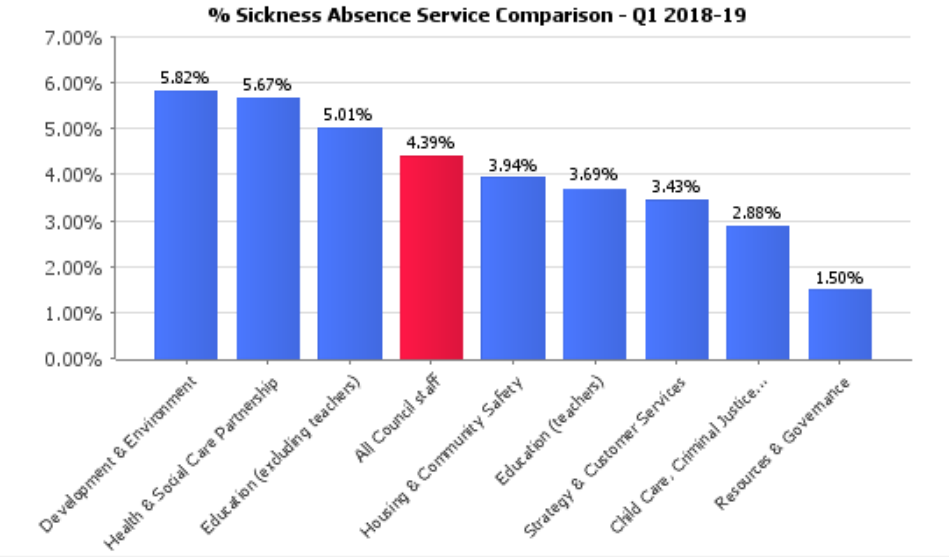
22.4 Referral rates are demand led and do vary from month to month. The rates are shown in the table below as a bar chart. The number of assessments carried out shows an upward trend.



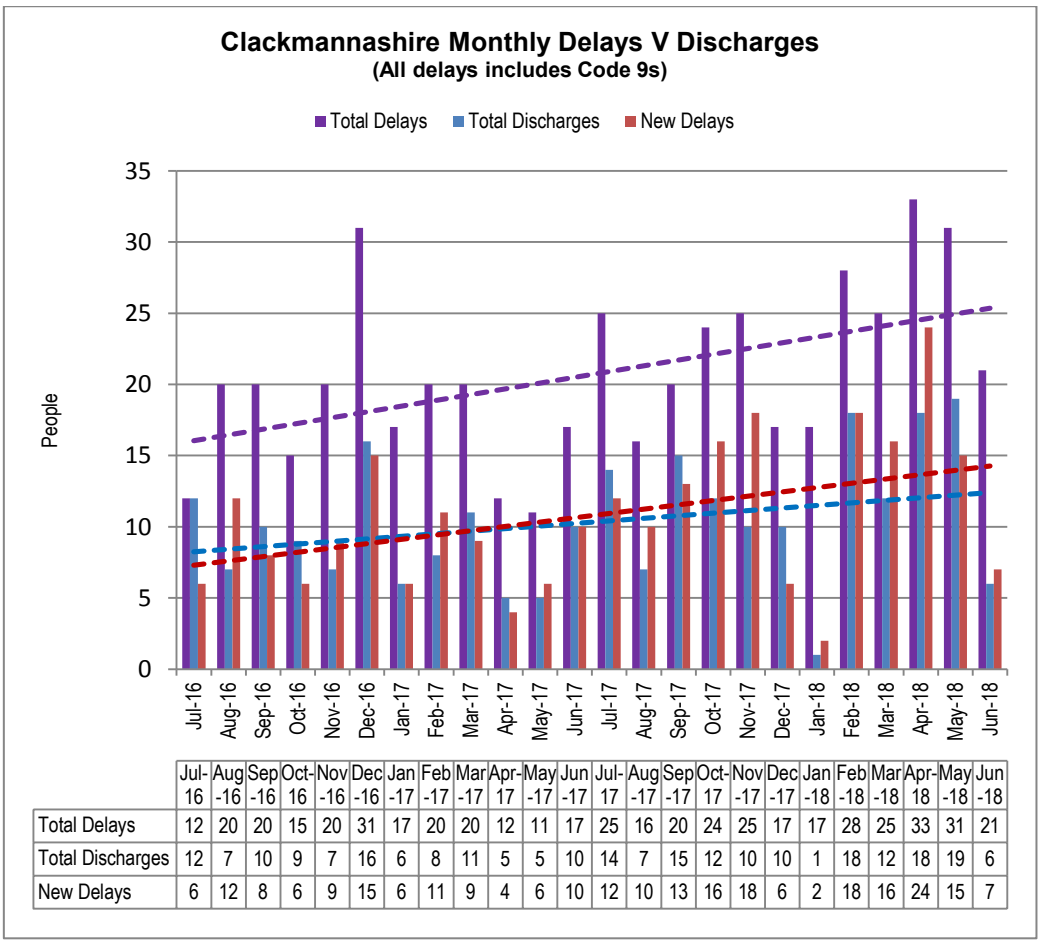
22.5 Further improvement work is required within the service to sustain and further develop the level of assessment activity in line with budget recovery actions.

22.6 **Absence across the service –** Quarter 1 figure for 18/19 shows that absence is now 5.67%, a considerable improvement on previous years figures and those of the last quarter. Focused work is ongoing in relation to management of attendance across all areas of the service.

Service comparison: % sickness absence

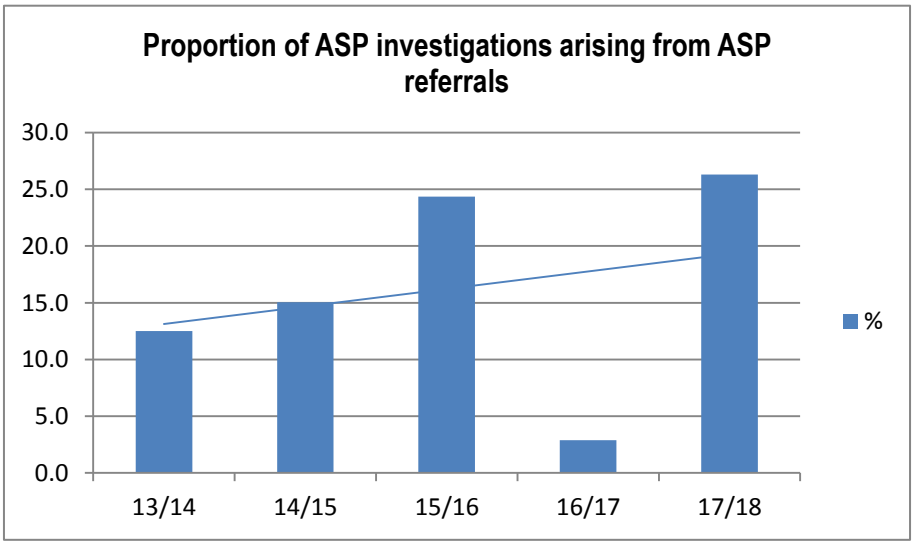


22.7 Clackmannanshire has maintained a strong performance in respect of delayed discharge, with the first quarter figure showing a reduction in the number of standard delays over 2 weeks- with 3 people delayed against a target of zero. The graph below shows long term trends and the impact on capacity of the rise in new delay patients being higher than those patients being discharged by the service. This is an area that is driving demand and budget pressure as the service is targeted at the upper tiers of need and risk.



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Delays	12	20	20	15	20	31	17	20	20	12	11	17	25	16	20	24	25	17	17	28	25	33	31	21
Total Discharges	12	7	10	9	7	16	6	8	11	5	5	10	14	7	15	12	10	10	1	18	12	18	19	6
New Delays	6	12	8	6	9	15	6	11	9	4	6	10	12	10	13	16	18	6	2	18	16	24	15	7

22.8 Adult Support and Protection activity has increased throughout the year [17/18] for the Partnership and the table below shows the increase in activity for Clackmannanshire Social Care in relation to the proportion of investigations following a referral last year.



23.0 Budget

23.1 Fortnightly meetings are in place between the service managers and the service accountants to review the commitments and to support the planning for any service changes.

23.2 The payment from Clackmannanshire Council to the Integration Joint Board for 2017/18 to deliver in-scope functions is £16.041m. This has been directed back to Clackmannanshire Council to deliver in-scope services within this resource envelope and in line with the budget approved by the Integration Joint Board in March 2018. The initial projected over spend based on the first quarter of the financial year is estimated at £1.485m largely driven by activity and cost levels in Care at Home and Residential and Nursing Homes and limited observable impact of efficiency and savings programmes to date.

The broad budget headings are as follows –

	Full Year Budget 2018/19	Full Year Forecast 2018/19	Forecast to Budget
	£'000	£'000	£'000
Employee Expenditure	7,700	7,121	-579
Premises Expenditure	11	41	30
Transport Expenditure	48	55	7
Supplies and Services	530	670	140
Misc Third Party Payments	908	908	0
Transfer Payments	452	578	126
Nursing Homes	7,021	7,509	489
Residential Homes	3,271	3,570	299
Housing with Care	163	203	40
Respite	175	240	65
Care at Home	6,455	7,674	1,219
Day Care	267	325	58
Garden Aid (HRA)	108	108	0
Resource Transfer (Health)	-7,081	-7,238	-157
Income	-3,987	-4,239	-252
Total	**16,041**	**17,526**	**1,485**

23.3 Further work is now required to re-align the budget headings to better reflect the anticipated income levels arising from charging and payments activity; the Health and Social Care Partnerships Locality and Service Management structures, the service staffing structures following re design work; the areas of service delivery; and, budget holding arrangements. It is proposed that the future budget structure for reporting will be developed to show a clear separation between older people and physical disability as they relate to the Clackmannanshire Locality and the learning disability and mental health services which cover the full Partnership area. This should assist clearer reporting of activity and pressures and will ensure that there is some

consistency of reporting across the Partnership area and into the Integration Joint Board.

23.4 There is some variation across the budget with significant pressures arsing from care at home and care home placement rates.

- Expenditure on **Employee Related Expenditure** is forecast to be (£0.579m) under the current allocated budget. The majority of this relates to the re design of mental health and learning disability services. A number of other vacancies are being held across the Partnership pending the delegation of services to support the implementation of a management and locality structure.

- Expenditure on **Supplies and Services** is forecast to be £0.140m over the allocated budget. This is due to high levels of demand for minor adaptations and equipment. This is an area of demand we would expect to see grow as more people are supported to live at home. A review of the equipment store arrangements and the service standards is currently taking place across the Partnership.

- Expenditure on **Misc Third Party Payments** covers payments to other local authorities and the NHS and is forecast to be on budget.

- Expenditure on **Long Term Placements** (this includes nursing and residential care home placements and housing with care) is forecast to be £0.788m over the allocated budget. This is due to the rate of nursing home placements, often for people being discharged from hospital and who are unable to live at home. It should be noted that the service applies strict eligibility criteria to placement within any care home and that placements are authorised at service manager level.

- Included within the long term placement budget line is a live Ordinary Residence claim relating to 3 high cost care packages for people with a learning disability. Ordinary residence is where a local authority can recover the costs of providing services to a person 'ordinarily resident' in another local authority area – in this case the 3 people are receiving services from another local authority and have been for many years.

- £0.376m of the overall pressure within Long Term Placements relates to an ordinary residency issue that arose at the year end. This has not yet been agreed but provided for in the forecast on a prudence basis.

- Expenditure on **Community Based Care** (Care at Home; Day Care; Respite and Self-directed Support) is forecast to be £1.382m over the allocated budget. This is primarily due to increasing demand for care at home services. Again it should be noted that the provision of care at home services is only for personal care and is provided where people meet the eligibility criteria for services.

- **Income from clients and from the NHS through Resource Transfer,** is forecast to be (£0.409m) in excess of the allocated budget, this projection is as a result of the high levels of activity reported above.

However, some caution should be exercised around this projection due to challenges within business support services in fully servicing the charging and payments at this time due to ongoing staffing issues.

23.5 The Integration Joint Board's Finance Committee has considered the quarter 1 report and further options for budget sustainability at the meeting on 24 August 2018, with a further follow through meeting on 18 September 2018. The other elements of the Health and Social Care Partnership budget are also experiencing significant financial pressure and challenges in achieving

23.6 In line with the terms of the Integration Scheme there is a financial risk to the Council associated with the overall financial performance across the Health and Social Care Partnership.

24.0 In Year Actions

24.1 There is a statutory requirement for the Partnership to provide assessments of care needs for all adults, within a framework of service standards and eligibility criteria. The overall aim of this service is to provide consistent and equitable service which is person centred and achieves positive outcomes for people.

24.2 Within Assessment and Care Management, there has been a focus on meeting the service needs of those who have been assessed as requiring 'critical' or 'substantial' levels of support in order to deliver services within allocated resources. This assessment is intrinsically lined to Self-directed Support, [described above]. It should be noted by the Committee that working at this level of service offer means that there is very little scope for further limits to be safely placed on service offers to individuals assessed as having a community care need. Service Managers authorise all requests for care and support through a Panel system to ensure consistency.

24.3 This approach is also being applied to review activity across Care Management to ensure consistency of eligibility criteria to services. These reviews are based on individual need.

24.4 The Intake service is being reviewed with the intention of re-aligning this team to create a "front door" to services which fits with the Partnership vision of supporting people closer to home. This allows for appropriate sign-posting to support self-management of care and support wherever possible. This approach will also support people in their safe and timely discharge from hospital, or prevent their unnecessary admission.

24.5 A review of all posts across the service has also taken place to ensure that this is both appropriate and that there is effective vacancy management. This is being built into decisions for any staff members applying for voluntary severance across the service.

24.6 It has been previously noted that absence rates have reduced in the first quarter of 2018/19. This is largely due to robust adherence to attendance management policies across all services, along with focussed work within

Menstrie House to reduce absence, and work with those who are long term sick. This has seen a resultant reduction in agency usage in this service. Meanwhile, a 12 hour shift pattern was introduced following considerable consultation with staff during June 2018. Initial feedback on this is very encouraging with staff finding an improved work life balance, and a reduction in pressure/stress at work.

24.7 The Partnership is now working to procure and implement a live time scheduling and commissioning system for care at home. This system will allow for outcome focussed commissioning, and equally, closer monitoring of care activities and accurate invoicing. This will support effective and efficient systems which reduce error or any potential for over-payment to commissioned care at home.

24.8 There is a review programme in place to confirm that people are in receipt of the level of care following assessment and application of the Eligibility Criteria for the Service. The Assessment and Care Management service requires to ensure that the focus on this area is maintained over the financial year. .

25.0 Conclusions

25.1 This report outlines the work taking place across the Partnership and within Clackmannanshire to review and develop services to meet the needs of the population and maximise our use of the available resources.

25.2 As noted above there continues to be considerable pressure on the budget – both across the Partnership and within the Clackmannanshire social care services. This is arising from the growing population of older people and the increasing complexity of people [all ages] who are being supported at home.

25.3 The services are currently working to the two highest levels of eligibility – critical and substantial. As noted above this means that there is very limited scope for further restriction of service to people who have been assessed as requiring community care services.

26.0 Sustainability Implications

26.1 Meeting assessed and rising need in a safe, efficient and effective manner in line with eligibility criteria and within available resources remains the key sustainability risk.

27.0 Resource Implications

27.1 *Financial Details*

27.2 The full financial implications of the recommendations are set out in the report. This includes a reference to full life cycle costs where appropriate. Yes **X**

27.3 Finance have been consulted and have agreed the financial implications as set out in the report. Yes **X**

27.4 Staffing- not applicable

28.0 Exempt Reports

28.1 Is this report exempt? No **X**

29.0 Declarations

The recommendations contained within this report support or implement our Corporate Priorities and Council Policies.

(1) **Our Priorities** (Please double click on the check box ☑)

The area has a positive image and attracts people and businesses	☐
Our communities are more cohesive and inclusive	**X**
People are better skilled, trained and ready for learning and employment	☐
Our communities are safer	☐
Vulnerable people and families are supported	**X**
Substance misuse and its effects are reduced	☐
Health is improving and health inequalities are reducing	**X**
The environment is protected and enhanced for all	☐
The Council is effective, efficient and recognised for excellence	☐

(2) **Council Policies** (Please detail)

30.0 Equalities Impact

30.1 Equalities and Human Rights Impact Assessment is not required at this stage in relation to the report, which is for noting. Yes **X** No ☐

31.0 Legality

31.1 It has been confirmed that in adopting the recommendations contained in this report, the Council is acting within its legal powers. Yes **X**

32.0 Appendices

Appendix 1 Adult Care Balanced Scorecard

33.0 Background Papers

33.1 Have you used other documents to compile your report? (All documents must be kept available by the author for public inspection for four years from the date of meeting at which the report is considered)

Yes ☐ (please list the documents below) No X

All reports relating to the Integration Joint Board are available on line.

http://nhsforthvalley.com/about-us/health-and-social-care-integration/clackmannanshire-and-stirling/

Author(s)

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Approved by

NAME	DESIGNATION	SIGNATURE
Shiona Strachan	Chief Officer	[redacted]

Clackmannanshire Locality - ADULT CARE BALANCED SCORECARD - Summary Report

2018 -2019

Report Author: Carol Johnson
Updated on: 12/08/18

PI Status	
	Alert
	Warning
	OK
	Unknown
	Data Only

Short Term Trends	
	Improving
	No Change
	Getting Worse

Local HSCP Outcomes	RED	AMBER	GREEN	DATA ONLY	Unknown
1.0 Live well for longer at home or homely setting	2	0	0	0	0
2.0 Self management of health	1	0	0	2	7
3.0 Individuals will have a fair & positive experience of health and social care	1	0	3	1	0
4.0 Individuals, carers and families involved and supported to manage decisions about their care	0	0	2	0	1
5.0 H&SC support systems keep people well and safe	0	0	2	4	0

Exceptions

	Description	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Year End 18/19	Target 18/19	Trend	Latest Note
1.1	% of carers assessments completed	9%							ADC ADA 011 17/18 9.9%
1.2	% annual reviews completed within timescale	13% 42/327 within timescale					100%		Baseline ADC ADA 021 Q3 17/18 - Methodology for counting review has changed. Unplanned reviews now included in referrals. Other reviews now included in assessments. Q4 17/18 (11%)
1.3	All delays (standard and Code 9)	11 | 9 | 11					7		ADC ADA 008b 17/18 (total 64, average 5))

1.0 HSCP local outcome: Community Focussed Supports -to live well for longer at home or homely setting
National Health & Wellbeing Outcomes - Outcome 6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

	Description	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Year End 18/19	Target 17/18	Trend	Latest Note
1.1	% of carers assessments completed	9%							ADC ADA 011 17/18 9.9%
1.2	Number of carers assessments offered	220					Data only		17/18 839
1.3	Number of eligible carers assessments completed	19					Data only		Baseline 15/16 (79), 16/17 (67), 17/18 (83)
1.4	% annual reviews completed within timescale	13% 42/327 within timescale					100%		Baseline ADC ADA 021 Q3 17/18 - Methodology for counting review has changed. Unplanned reviews now included in referrals. Other reviews now included in assessments. Q4 17/18 (11%)

2.0 HSCP Local Outcome – Self Management of Health
National Health & Wellbeing Outcomes
Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

	Description	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Year End 18/19	Target 18/19	Trend	Latest Note
2.1	% of people aged 65 and over with intensive care needs (10+ hours) receiving services at home as a % of all older people receiving long term care.	Delays due to data no longer being provided corporately .					45%	?	Baseline at Q4 year end 15/16 (48%), 16/17(43%), 17/18 (50%). (Stirling target 30%) ADC ADA 01a
2.2	Number of people aged 75+ in residential care						Data Only	?	Methodology Snapshot taken from last month in quarter. Only includes those know to local authority and may not include some self funders. ADC ADA 01k 17/18 (187)
2.3	% (of population) people aged 75+ in care homes who have been placed by the local authority						Data Only	?	Methodology 75+ mid 2016 pop estimate for clacks is 3,928 . Snapshot taken from last month in quarter. ADC ADA 002k 17/18 4.8%
2.4	Total number of weekly hours care assessed for at start of reablement for all people receiving a service						Data Only	?	Baseline 15/16 (517.7), 17/18 (533) Methodology Based on all service ADC ADA 01m

<table>
<tr><th></th><th>Description</th><th>Q1 17/18</th><th>Q2 17/18</th><th>Q3 17/18</th><th>Q4 17/18</th><th>Year End 17/18</th><th>Target 17/18</th><th>Trend</th><th>Latest Note</th></tr>
<tr><td rowspan="2">2.5</td><td>Number of hours care post reablement for all people receiving a service in the quarter</td><td>381.50</td><td></td><td></td><td></td><td></td><td rowspan="2">Data Only</td><td rowspan="2">  </td><td rowspan="2">WHAT IMPACT HAS DELAYS FOR ASSESSMENT HAVING?
<table><tr><th>Quarter
weekly care hours</th><th>Completed
Hours & Mins</th><th>Not completed[1]</th><th>Total</th></tr><tr><td>1</td><td>210.50</td><td>171.00</td><td>381.50</td></tr><tr><td>2</td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td></tr></table>Average number of weeks reablement
<table><tr><th>Quarter</th><th>Weeks</th></tr><tr><td>1</td><td>10</td></tr><tr><td>2</td><td></td></tr><tr><td>3</td><td></td></tr><tr><td>4</td><td></td></tr></table><u>Methodology</u>
Based on clients who have completed the service in the quarter – post reablement is after about 6 weeks. Includes crisis care clients in 17/18.
ADC ADA 01n
17/18 (366 av hours)
Q1 - 32.50 hours post Reablement hours on double up care (4/51 service users who went through the service in Q1). OR - 15 %based on completed only - 4/33 service users who completed the service (4 service users with double up care all completed with an assessed outcome</td></tr>
<tr><td>% hours double up</td><td>9%</td><td></td><td></td><td></td><td></td></tr>
<tr><td>2.6</td><td>% of clients with reduced care hours at end of reablement</td><td>48%</td><td></td><td></td><td></td><td></td><td>Data Only</td><td>  </td><td><u>Methodology</u>
Based on those service users who completed reablement with reduced care hours. Does not include those those admitted to hospital, or respite etc. Includes crisis care clients in 17/18
ADC ADA 01p
Baseline – 17/18 (33%)
Q1 - 16 / 33 service users who completed the service</td></tr>
<tr><td>2.7</td><td>% of clients with increased care hours at end of reablement</td><td>6%</td><td></td><td></td><td></td><td></td><td>Data Only</td><td>  </td><td><u>Methodology</u>
Based on those service users who completed reablement. Does not include those those admitted to hospital, or respite etc. Includes crisis care clients in 17/18
Baseline – 17/18 (12%)
Q1 - 2 / 33 service users who completed the service</td></tr>
<tr><td>2.8</td><td>% of clients receiving no care after reablement.</td><td>24%</td><td></td><td></td><td></td><td></td><td>Data Only</td><td>  </td><td>ADC ADA 01q
<u>Methodology</u>
Includes crisis care clients in 17/18Methodology
Baseline 17/18 (44%)Q1 - 8 /33 service users who completed the service</td></tr>
</table>

[1] These are those who did not complete reablement service due to hospital admission or respite admission, or death.

<table>
<tr><td>2.9</td><td>Number of clients who have received a reablement service (i.e. been enabled).</td><td>33</td><td></td><td></td><td></td><td></td><td>Data Only</td><td></td><td>
IS THERE A BOTTLE NECK DUE TO DELAYS?
<table>
<tr><td>Quarter</td><td>commenced</td><td>completed</td><td>Not completed</td><td>ongoing[2]</td></tr>
<tr><td>Q1</td><td>77</td><td>33</td><td>18</td><td>22</td></tr>
<tr><td>Q2</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Q3</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Q4</td><td></td><td></td><td></td><td></td></tr>
</table>
<table>
<tr><td>Quarter</td><td>service users completed the service with full care hours</td><td>average time for an accurate assessment to be carried out (weeks)</td><td>Post assessment period waiting to transfer to a FWP weeks)</td><td>average length of time on the service for these service users</td></tr>
<tr><td>1</td><td>33</td><td>7</td><td>6</td><td>4 week for those independent 11 week for those awaiting a FWP</td></tr>
<tr><td>2</td><td></td><td></td><td></td><td></td></tr>
<tr><td>3</td><td></td><td></td><td></td><td></td></tr>
<tr><td>4</td><td></td><td></td><td></td><td></td></tr>
</table>
<u>Methodology</u>
Includes crisis care clients in 17/18. Q4 7 of 31 admitted were crisis care clients.
ADC ADA 01s
Baseline – 17/18 (185 admitted, 138 completed)
</td></tr>
<tr><td>2.10</td><td>Total number of intermediate beds occupied by clients in the quarter. (new admissions – 9 beds available)</td><td>11</td><td></td><td></td><td></td><td></td><td>Data only</td><td></td><td>17/18 (24)
Q1 - 9 completed and 2 ongoing
ADC ADA 002a</td></tr>
<tr><td>2.11</td><td>Number of clients who moved from intermediate to long term care in the quarter.</td><td>6</td><td></td><td></td><td></td><td></td><td>Data only</td><td></td><td>17/18 (6)
Q1 - based on 9 completed
ADC ADA 002b</td></tr>
<tr><td>2.12</td><td>Number of clients who went home from intermediate care with a package of care in the quarter.</td><td>0</td><td></td><td></td><td></td><td></td><td>Data only</td><td></td><td>17/18 (4)
ADC ADA 002c</td></tr>
<tr><td>2.13</td><td>Number of clients who went home from intermediate care with no package of care in the quarter.</td><td>2</td><td></td><td></td><td></td><td></td><td>Data only</td><td></td><td>17/18 (3)
ADC ADA 002d</td></tr>
<tr><td>2.14</td><td>Number of clients who went from intermediate care to hospital.</td><td>1</td><td></td><td></td><td></td><td></td><td>Data only</td><td></td><td>17/18 (3)</td></tr>
<tr><td>2.15</td><td>Number of clients who passed away whilst occupying an intermediate care bed in the quarter.</td><td>0</td><td></td><td></td><td></td><td></td><td>Data only</td><td></td><td>17/18 (0)
ADC ADA 002e</td></tr>
<tr><td>2.16</td><td>Average length of stay (weeks) in intermediate care bed in quarter</td><td>9 weeks</td><td></td><td></td><td></td><td></td><td>Data only</td><td></td><td>17/18 (7 average weeks)
ADC ADA 002f</td></tr>
</table>

[2] The figures will not add up to the total admitted because this will include those admitted in previous quarter.

	Description	Q1 18/19			Q2 18/19			Q3 18/19			Q4 18/19			Year End 18/19	Target 18/19	Trend	Latest Note
2.17	All delays (standard and Code 9)	11	9	11											7		ADC ADA 008b 17/18 (total 64, average 5))
2.18	Standard delays less than 2 weeks	10	7	5											Data only		ADC ADA 008a 17/18 (total 31, average 2.5)
2.19	Standard delays more than 2 weeks	0	0	3											0		ADC ADA 008 17/18 (total 13, average 1)

	Description	Q1 17/18	Q2 17/18			Q3 17/18			Q4 17/18			Year End 17/18	Target 17/18	Trend	Latest Note
2.20	Clients assessed as a critical priority (priority 1) case at referral who had their assessment completed within one working day.	56											Data only		In development – this is the number of intake and unplanned review assessments completed in quarter. Still working on the one working day from referral.
2.21	Clients assessed as a substantial risk (priority 2) case at referral who had their assessment completed within three working days.	98											Data only		In development – this is the number of intake and unplanned review assessments completed in quarter. Still working on the one working day from referral.
2.22	Number of people with assessments completed using SDS approach.	522											Data Only		data requested ADC ADA 023 this covers all assessments – need to clarify what Stirling count.
2.23	Overall Self Directed Support spend on people aged 18 or over as a % of total social work spend on adults.												5%		data requested ADC ADA 024
2.24	Clients on Option 1	33											Data Only		Lillian to confirm figures 17/18 (17) Methodology Cumulative. Year end is total for year. ADC ADA 025
2.25	Clients on Option 2	38											Data Only		Lillian to confirm figures 17/18 (23) Methodology cumulative. Year end is total for year. ADC ADA 026

2.26	Clients on Option 3					582	Data Only	?	Methodology data requested ADC ADA 027
2.27	Clients on Option 4						Data Only	?	Methodology data requested ADC ADA 029

3.0 HSCP Local Outcome Experience - Individuals will have a fair & positive experience of health and social care
National Health & Wellbeing Outcomes. Outcome 8:. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

	Code & Description	Q1 18/19			Q2 18/19			Q3 18/19			Q4 18/19			Year End 18/19	Target 17/18	Trend	Latest Note
3.1a	FTE Days Lost Per Employee	0.51 HSCP 0.94 Council	0.81 HSCP 0.86 Council	1.04 HSCP 1.05 Council												↓	Methodology RAG against council fig for that month. Data source – J:\Council Absence Stats. HSC AB1 GOV Baseline 17/18 (20)
3.1b	% sickness absence	7.20 %	4.93 %	4.84 %											7%	↑	CLACKS ONLY Corporate agreed target.
3.2	Actual number of employees for Adult Social Services (including relief)	235 Head 155.09 FTE	238 Head 153.88 FTE	239 Head 151.71 FTE	Head FTE	Head FTE	Head FTE	Head FTE	Head FTE	Head FTE	Head FTE	Head FTE	Head FTE		Data only	↓	Methodology J:council absence stats – this is headcount and FTE including relief. ADC SAB 001A Baseline 17/18 (237 head, 158.91 FTE).

4.0 HSCP Local outcome – Decision Making -Individuals, carers and families involved and supported to manage decisions about their care
National Health & Wellbeing Outcomes. Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected. Outcome 4: Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services

	Code & Description	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Year End 18/19	Target 18/19	Trend	Latest Note
4.1	Stage 2 Complaints due and responded to within target timescales	0/0					Data only	↑	17/18 (2/2)
4.2	Stage 1 Complaints due and responded to within target timescales	3/3					Data only	↑	Overall for 17/18 19 out of 21 stage one complaints were completed within timescale.
4.3	% Adult Care Services who achieve Care Inspectorate evaluation scores of 5 (very good) and above across residential and day services						90%	?	**SERVICE which FAILED TO MEET 5 OR ABOVE** Date / Care and Support / Environment / Staffing / Management and Leadership 17/18 (87.5%) Baseline 16/17 81% ADC CUS 002c

5.0 HSCP Local outcome - Safety - H&SC support systems keep people well and safe National Health & Wellbeing Outcomes. Outcome 5: Health and Social Care services contribute to reducing health inequalities. Outcome 7: People using health and social care services are safe from harm																	
	Code & Description	Q1 18/19			Q2 18/19			Q3 18/19			Q4 18/19			Year End 18/19	Target 18/19	Trend	Latest Note
5.1	% of Adult Protection (initial) discussions within timescale	100% 4/4	100% 6/6	100% 2/12											100%		Methodology Timescale is within 1 working day of referral. ADC ADA 019 Baseline 17/18 (94%)
5.2	Number of Emergency Detention Certificates (Mental Health) Section 36	2	1	2											Data only		ADC MHO 001 17/18 (25)
5.3	Number of Short Term Detention Certificates (Mental Health) Section 44	7	2	7											Data only		ADC MHO 002 17/18 (50)
5.4	Number of Compulsory Treatment Orders (existing)	21	21	21											Target ? 13		**Meeting 3/518 agreed these stats are not reliable at present. Work ongoing to ensure reporting is more robust. Team Manager working with staff to ensure more accurate reporting.** Baseline 16/17 baseline is 13 CTO, rate per 100,000 pop is 25.3 (nat average rate 22.3). ADC MHO 003 17/18 (23)
5.5	Number of Compulsory Treatment Orders (new applications)	3	2	3											Data only		ADC MHO 004 17/18 (45)
5.6	Total number of Existing Guardianships (private and local authority)	119	114	114											Data only		ADC MHO 007 17/18 (118)
5.7	Total number of new Guardianships (private and local authority	2 Total	0	1											Data only		Baseline 16/17 baseline is 35, rate per 100,000 pop is 83 (nat average rate 64, comparator rate 62). 17/18 (28, 11 LA 17 Private) Methodology Combined (LA ADC MHO 012 & Private ADC MHO 013).
		0 LA	0	0													
		2 Private	0	1													
5.8	Number of Compulsion Orders (new)	0	0	0											Data only		ADC MHO 023 17/18 (6)
5.9	Number of Compulsion Orders with restrictions	0	0	0											Data only		ADC MHO 024 17/18 (2)

HSCP Clackmannanshire Locality Complaints Report

Quarterly 18/19 SUMMARY

	Q1	Q2	Q3	Q4	17/18
Enquiries received	3				21 single service 1 joint
Result of enquiries	Stage 1 3 Stage 2 0				Stage 1 20 Stage 2 1
Outcome of enquiry	1 upheld 2 not upheld				7 upheld 3 partially upheld 10 not upheld
Complaints completed within timescale	3				19 1 joint (agreed extension periods of 10 days)
	0				1 completed within 5 working days past timescale 1 completed within 5-10 working days past timescale
Compliments	0				3