This Business Plan extract contains information in relation to the delivery of the Council's following strategic priority area

A Healthy Halton

Our overall aim is to improve the health and wellbeing of Halton people so that they live longer, healthier and happy lives.

The priorities from the Health Policy and Performance Board in relation to Adult Social Care have been identified as:

- **Reablement Pathway** - **Reablement First**: Halton Borough Council has introduced a Reablement First approach to care and support. This means that no person within the borough of Halton will receive long term care within their own homes without receiving a full functional assessment first. The first phase of this model has been introduced for people discharged from Hospital and the second phase for all community referrals for care is due to commence in 2019-2020.

- **Safeguarding:** Halton Safeguarding Adults Board will continue to implement and develop processes to adhere to its statutory requirements, roles and responsibilities under the Care Act 2014. The Board will be working towards implementing its Strategic Plan which details its six priority areas: Empowerment; Prevention; Proportionality; Protection; Partnership and Accountability. The local authority will also continue to further embed Making Safeguarding Personal (MSP) and provide regular progress updates to the Board, which will include a review of the MSP Outcomes Framework Pilot. In addition to this, the Safeguarding Unit will be going through a restructure to look at some additional responsibilities in relation to safeguarding. This will include the triage of Safeguarding Alerts/care concerns with a view to have more overview of Safeguarding across Adult Services, focusing on Provider Services and support to other Adult Social Care Teams.

- **Deprivation of Liberty Safeguards** : Deprivation of Liberty Safeguards (DoLS) came into force on 1 April 2009 as a response to an identified breach of the European Convention on Human Rights. This is a particular challenge for the Council in responding to this large increase in the number of DoLS assessments and making sure we keep people safe. As a result of the mounting criticism of DoLS the Government requested the Law Commission undertake a review and in March 2017 they produced their final proposal on a replacement for the DoLS, and suggested amendments to the Mental Capacity Act itself. The changes to the act are to incorporate the new scheme, called the Liberty Protection Safeguards (LiPS), and to strengthen people's rights in areas such as best interest decisions. The Mental Capacity Amendment Bill 2017-2019 is currently going through Parliament, which proposes a different approach to what had been originally proposed by the Law Commission however the details are still being debated. There will be greater responsibilities attached to other bodies such as CCG's, Hospitals and Care Home Managers. The LiPS Code of Practice is due to be released in the summer of 2019, which will give clearer guidance to Responsible Bodies, as well as other stakeholders in how the LiPS will be implemented.

- **Finance**: Finances continue to be a challenge across Adult Social Care. There is a Financial Recovery Working group across Adult Social Care to focus on reviewing specific areas with the aim of achieving some efficiencies and streamlining processes. The Care Home sector, both nationally and locally, continue to experience financial issues, in particular around the fee rates. The Care Home Development Project has a financial workstream which is looking to develop a generic dependency assessment tool which then links to fees and safe staffing levels.

Key Developments from 2018/19

ADULT SOCIAL CARE

1. Older People

i) **Transforming Domiciliary Care (TDC)** – The TDC programme has worked to progressively to refine and implement an outcomes model for domiciliary care into a workable, effective solution, delivering clear outcomes for service users in terms of independence, wellbeing, and commissioners in terms of value for money. As part of the TDC programme, a lead provider has been commissioned to deliver domiciliary care to people. The work to date has focused on managing the demand for care by improving the interface between in house Reablement care and Domiciliary care including a shared care record and embedding a robust Multi-Disciplinary team approach to care provision . Work has been completed to develop a recruitment strategy to ensure the demand for care can be met, inclusive of incentives for care staff This work will continue over the next 12 months and will include the development of Trusted assessor model within care and support and investment into the introduction of apprenticeships across care and support, in addition to the roll out and full implementation of Reablement First.

i) **Sustainability and Quality of the Care Home Sector: –** Work is ongoing with NHS Halton CCG and care home providers to ensure we continue to improve the health and wellbeing of people who live in care homes. The Care Home Development Project Group continues its' work to enable stakeholders representing key sectors to work collaboratively in exploring and implementing identified work streams. The work streams aim to:

- Share best practice and resources via sector-led improvements;
- Deliver dignified, quality, outstanding care within residential and community settings;
- Be proactive and identify early warnings of potential reductions in quality;
- Provide value for money and sustainability; and
- Provide seamless transfers of care to and from hospital.

2) Adults with Learning and/or Physical Disabilities

i) **Transition** - Recognising the importance of effective transition for people with disabilities and/or complex needs (including those with autism), Halton established a dedicated Transition Team early in 2017 alongside the development of a new multi-agency Transition Protocol for the period 2017-2020. This approach ensures that legislative obligations are met and the transition process is joined up across education, health and social care with increased and targeted co-ordination and communication from all agencies starting from Year 9 (age 13/14) up to the age of 25 years or until an individual's appropriate transfer into generic adult services. Building on this work, the Transition Team took part in a Named Social Worker pilot led by the Department of Health & Social Care in 2017/18. Funding from the pilot allowed the creation of additional capacity within the Transition Team, which meant intensive work could take place with young people and their families as part of a preventative approach in order to avoid crisis intervention. Work is currently taking place to identify funding to enable the continuation of this work supported by a multi-disciplinary team approach.

3) Adults with a Mental Health Condition:

i) The Halton Dementia Strategy Delivery Plan is in the process of being updated, as part of the work of the Mental Health and Dementia Delivery group work plan. It is anticipated that there will be a working group formed to look at developing and 'monitoring' a dementia specific dashboard to understand demand on provision and to support service and quality development. Other priorities include the commissioning of dementia community support provision beyond September 2019, and preparation for the development of a Dementia Community Hub, part of a new dementia specific extra care housing scheme under development in Runcorn. Maintaining and improving upon the dementia diagnosis rate and primary care 'care plan' reviews and activity to maintain our 'Dementia Friendly Community' status also remain priorities.

4) Safeguarding:

i) **Deprivation of Liberty Safeguards** :

The projected total amount of referrals that Halton will receive for the current financial year 2018-2019 will be approximately 500.

Currently, the IASU manage the requests for authorisation on behalf of the supervisory body. This involves the administrative tasks, as well as the process of allocations and requesting Section 12 Doctors/Mental Health Assessors and processing payments of these. With each accepted request, there is a triage processes taken/adapted from the ADASS screening tool guidance, which determines if requests are Very High, High, Medium or Low risk. Very high Risk are cases where there is evidence that a Section 21(a) may be needed. These are allocated to 2 full time Best Interests Assessors who ensure that these requested are completed within timescales, regardless of whether these are urgent/standard requests or just standard requests. When a request is deemed High, Medium or Low risk, these are allocated to a pool of Best Interests Assessors where their role is in addition to their substantive post. At present, the pooled BIA's are allocated 1 assessment per month. Depending on numbers of Very High screenings, the 2 full time Best Interests Assessors also complete High risk cases

5) Carers:

A new Carers Strategy Group has recently been established to focus on the development of a new One Halton Carers Strategy and ensure that we have a holistic and joined up approach across Halton. The group involves a range of community and voluntary organisations, as well as statutory groups who work with carers and a carer representative.

6) Homelessness

i) **Homelessness -** During the past few years there has been a National increase in homelessness. Halton also continues to experience a gradual increase in homelessness presentations, with the main causes identified as loss of home due to family exclusions, relationship breakdown, loss of a private sector tenancy. The welfare reform has had an impact upon the increase of homelessness, with benefit changes and affordability being the contributory factors.

ii) **Homelessness Prevention** – Prevention is key to reducing homelessness, and the introduction of a number of preventative initiatives has proven successful among statutory and none statutory homeless households. This change from reactive

assessment to proactive prevention, coupled with a housing options service, proved to be a significant factor in improvement and overall service delivery.

iii) In accordance with statutory requirement, Halton has completed a review of the **Homelessness Strategy,** which identifies the key priorities and devised action plan for 2019 - 2024. The homelessness strategy will be implemented from April 2019 and will be reviewed annually, to ensure it is current and meets future economic and legislative changes.

iv) The introduction of the Homelessness Reduction Act was implemented on 1st April 2018 and has had a gradual impact upon homelessness provision and service delivery. The 'Gold Standard' which previously steered the Homelessness Strategy has now been superseded by the new Act. The strategy will include and reflect the 'Housing First Model' which is due to me implemented late autumn 2019. The strategy will also incorporate current and future activity around the resettlement of refugees and dispersal of asylum seekers.

PUBLIC HEALTH

The key developments for Public Health are: A 2018 – 2023 Whole System Healthy Eating and Exercise Strategy and Action Plan to tackle the challenge of overweight and obesity in the local population; linking in with the Cheshire & Merseyside Cancer Alliance to highlight the importance of early detection and recognition of signs and symptoms and work together to utilise the significant funding for Halton and Knowsley on lung health checks; joint working across Cheshire & Merseyside on Mental Health with a particular emphasis on tackling self-harm in young people and reducing suicide rates, men's mental health and building a Mental Health Commission; building on our strategy to tackle high blood pressure by working with community pharmacies and implementing quality improvement programmes for Primary Care; and focussing on the Thrive Model for Child Mental Health which will ensure swift access to support and services.

1. Child Development

Child development continues to be the main priority for children for the One Halton Health and Wellbeing strategy, and a multiagency steering group are working to improve outcomes through integrated working, delivered through a child development action plan.

In Halton 19.6% (2016) of children live in poverty despite the majority of their parents being in full time employment. Evidence suggests that by 3 years of age children in families living below the poverty line are 8 months behind in language and 9 months behind in school readiness compared to those with incomes above. However, activities such as daily reading, regular bedtimes and library visits can improve cognitive development.

Despite improvements locally, 2017/18 data shows that in Halton 64.5% of children achieved a good level of development at aged 5, compared to an average of 71.5% in England. Improvements have been made in Halton, and focused work is underway to address specific areas such as training of health visitors to support children to develop better speech, language and communication skills.
Halton has a comprehensive 0-19 service that aims to ensure that all children and families receive the help and support needed to maximise their child's development. Universally all families receive regular development checks, and first time teenage mothers will also get enhance support from the family nurses to build their knowledge of how to build babies brain.

There is a wide range of programmes on offer that contribute to child development. Community midwifery services work with parents from early in the pregnancy to encourage a healthy pregnancy, and all families are invited to antenatal 'your baby and you' sessions, which help to prepare for parenthood. Perinatal mental health services and support are available through health visitors and mental health teams, and encouraging breastfeeding, active play, healthy eating and emotional wellbeing are all work streams underway for this age group.

2. Healthy Weight & Physical Activity for Adults

Overweight and obesity present a big Public Health challenge both nationally and locally. This is really due to its association with serious chronic diseases such as Type 2 diabetes, hypertension and hyperlipidaemia. These are major risk factors for cardiovascular disease and cardiovascular related deaths. Obesity is also associated with cancer, disability, reduced quality of life and can lead to premature death (Healthy Lives, Healthy People, A call to action on obesity in England).

The Health Profile for England 2018 showed that 65.2% of adults were physically active and 61.1% of adults had excess weight. Both these figures are similar to the England average. However, the excess weight figure is still high. The causes of obesity are complex. Tackling obesity requires action at every level, from the individual to society, and across all sectors. In Halton we promote a coordinated life course approach to tackling overweight and obesity which recognises the barriers local people face when trying to practice a healthy diet or undertake regular physical activity. The focus on healthy

weight rather than obesity reflects intentions to encourage people from an early age to maintain a healthy weight, to minimise the stigma attached to the term obese and encourage people to see their weight in a positive way.

A review of weight management services took place in 2017/18 and the service has subsequently been brought in house and is now being delivered by the Halton Borough Council Health Improvement team. The service offers fully integrated holistic support to adults and children in healthy eating, physical activity, healthy eating and offering cognitive behaviour therapy where appropriate. There is also access to dietetic support.

Halton is also a pioneer site for implementing a Whole Systems approach to tackling obesity. This approach was developed by Public Health England, the Local Government Association and the Association of Directors of Public Health working in partnership with Leeds Beckett University. During 2017/18 Halton worked closely with Leeds Beckett University trialing the Whole Systems approach and this is now being implemented more widely across the country.

The Whole Systems Obesity work recognises the crucial role of local authorities (LAs) in tackling and working to prevent obesity. Halton Borough council has responsibility for many of the contributing factors (leisure services, parks and green spaces, planning, economic regeneration) and we have worked with wider partners (health, education, housing providers, and the community and voluntary sector) to draw together a truly multidisciplinary partnership.

The Whole systems work enabled us to bring together local stakeholders and develop a broader shared perspective on what influences and obesity. A number of workshops have been held with a broad range of stakeholders and through the use of a whole system route map and tools, a detailed action plan has been devised. This work has also been used to develop the framework for Halton's Healthy Weight Strategy.

In 2019/20 the Healthy Weight Strategy will be ratified, with an affiliated whole systems action plan. Work will continue to maintain the momentum of the Whole Systems work, and to fulfil the ambitions outlined in the action plan.

3. Alcohol

There have been improvements in recent years, however the rates of alcohol-related health harms, hospital admissions, and mortality remain higher in Halton than the national average. Nationally, the number of adults accessing support for alcohol problems has decreased and recent prevalence estimates suggest that there is significant unmet need for alcohol treatment across the region.

Due to the high levels of preventable alcohol-related harm in the region, all Health and Wellbeing Boards across C&M have identified alcohol as a core prevention priority. The C&M Health and Care Partnership Prevention Board has developed the C&M Alcohol Harm Reduction Board which is working on a suite of initiatives to address the issue. These include: a focus on actions across the health and social care system which will support both the reduction and prevention of alcohol-related harm and an improvement in access to alcohol treatment, strengthening the actions of acute hospital trusts, improving the quality of alcohol care team provision, scaling up alcohol identification and brief advice (IBA) and the development of a standard alcohol pathway. Work is also underway from a regional perspective to campaign for the introduction of Minimum Unit Price (MUP) for alcohol.

On a local level there is a need to support a reduction in the number of Alcohol-related admission episodes (narrow definition (Directly Standardised Rate per 100,000 population)). Significant progress has been made to reduce the number of young people (under 18) being admitted to hospital due to alcohol and partnership work must continue to continue to focus on this important area. There is a need to raise awareness within the local community of safe drinking recommendations through the

delivery of alcohol awareness campaigns and health education events. There is a significant opportunity to increase the number of front line staff trained to provide screening and brief advice (IBA) and interventions as well as improving the referral process for those in need of additional support. It is essential that those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support in the community and within secondary care.

4. Cardio-Vascular Disease (CVD)

This continues to be a local priority as one-quarter of all deaths in Halton are caused by cardiovascular diseases and one in five of the CVD deaths are premature (occurring in people under 75 years of age). The prevalence of strokes was 2% last year; the two biggest risk factors for this are hypertension and atrial fibrillation. For men in Halton 1 in 20 deaths are due to coronary heart disease and for women it is higher at 1 in 13. Hypertension is the most common long term condition in Halton, and the second highest risk factor for early death and disability, addressing high blood pressure has already been identified as a prevention priority locally as well as regionally for the Cheshire and Merseyside Health and Care Partnership (formerly STP). A system wide approach to tackling CVD is required. Staring with prevention of risk factors, supporting healthy lifestyles, earlier detection and improving how clinical services manage these conditions. The C&M strategy to tackle high BP 'Saving lives: Reducing the pressure' was launched in May 2016 and set out a series of high-level deliverables for a five year period. Significant progress has been made. Work on tackling blood pressure and on atrial fibrillation (AF) with partners across the region has already realised direct local benefits. The lifestyle risks that contribute to cardiovascular disease are largely preventable and include lack of physical activity, excess alcohol consumption, smoking and obesity. The Health Improvement team offers a diverse range of services to enable people moderate their lifestyle risks, the underlying causes of these causes remain societal contributing factors like poverty, poor life chances, low educational attainment and the built environment.

We are updating the Cancer strategy this year, which will focus on prevention, early detection and improving access to treatment and treatment pathways. Halton is closely associated with the various work streams across the Cheshire and Merseyside Cancer Alliance and is supporting the development and implementation of a Cheshire and Merseyside wide Cancer Prevention Plan. Halton has been selected to be an early trial site for the Long Term Plan implementation of Lung Health Check, which will provide those in our population at the highest risk of lung cancer an opportunity to identify any potential cancers much earlier to improve treatment and outcomes.

5. Mental Health

Mental Health is a key health and wellbeing priority and as such, is supported by the Mental Health Strategy and Action Plan. This provides a robust framework which identifies need and co-ordinates activity across the life-course from maternal mental health, through to childhood and into old age. The strategy also covers the spectrum of need from prevention and early intervention to treatment services.

1 in 4 people attending their GP seek advice on mental health problems and levels of hospital admissions due to self-harm are significantly higher than the England average. Many social factors make children more at risk of development mental health problems.

Halton has been selected as one of eight areas to tackle mental health stigma locally after winning a bit to become one of the 2019 Time to Change Hubs. This will make Halton part of a network of 40 hubs across England that aim to change the way we think and act about mental health. We will need to ensure that we are continuing to support communities, workplaces and schools to take action around negative attitude and behaviours towards people experiencing mental health problems.

Currently suicide rates in Halton are lower than the England average across all ages and gender but in line with national trends, this is rising. Halton has a current suicide prevention strategy and action plan

and are currently involved in collaborative work across Cheshire and Merseyside on the Zero Suicide strategic approach which has been highlighted as best practice at national level.

6. Cancer

Cancer remains one of the main causes of death and illness for residents in Halton. Our highest rates for cancer are lung, bowel and breast; these are related to lifestyle issues. Smoking rates have been falling but there is the legacy of previously high rates. Alcohol-related hospital admissions mean an increase in cancers related to gastro intestinal disease.

Efforts in Halton focus on preventing cancer through promoting healthy lifestyles (not smoking, maintaining a healthy body weight, being active, eating a healthy and balanced diet, reducing alcohol consumption and enjoying the sun safely) and early detection of cancer (participating in breast, cervical and bowel screening programmes when eligible, and seeking early help based on early signs and symptoms). Nationally and locally cervical screening uptake is declining, though bowel screening locally has seen a great improvement in uptake.

7. Older People

The number of older people in Halton is increasing year on year, for this reason ensuring that older people can continue to live fulfilling, healthy and independent lives remains a priority. Halton has a higher than average aging population and this trend will continue. The 65+ population increased by 3% between 2001 and 2011 compared to a 1.6% increase across England as a whole.

Compared to the national average Halton men aged 65+ live 1.4 years less than men across England as a whole with Halton women living 2.3 years less. Older people in Halton spend more time living with a disability than the rest of England: Halton women spend 50.6% of their lives free from disability. The figure for men is 51.3%. This compares to the England averages of 53.2% for women and 57% for men.

Halton continues to see a higher rate of admission for injuries related to falls in people over the age of 65 than the England average (In Halton 2,937 older people per 100,000 population were admitted to hospital as an emergency resulting from falls in 2017/18, compared to 2,170 older people per 100,000 population in the rest of England as a whole). While we harm from falls remains significantly higher in Halton, the rate has decreased hugely in the last 7 years, seeing the gap between Halton and te rest of England narrow considerably, as a result of focused multi-agency working to deliver an integrated falls prevention programme. We will review and evaluate the performance of the integrated falls pathway and explore all opportunities to reduce harm from falls across Halton.

Older people are at much greater risk of more serious harm as result of infections such as flu and pneumonia. Halton has a higher rate of admissions for preventable infections such as flu and pneumonia. In Halton the emergency admission rate in 2017/18 for flu was 57.4 per 100,000 population which equates to 73 admissions and unfortunately this number has increased steadily over the last three years.

On a more positive note the emergency admission rate in 2017/18 for pneumonia was 594.5 per 100,000 population which equates to 678 admissions and this number has decreased over the last 3 years. Flu and pneumonia resulting from pneumococcal bacteria are preventable through vaccinations, although the number of older people taking up the offer of vaccination has been falling in recent years. In 2018, 73.7% of people aged 65 and over had their flu vaccination. While this is greater than the England average (72.5%), the national target is set at 75% to maximise the community protection that vaccination can provide and to protect the most vulnerable people in our community.

Pneumonia vaccine is also recommended for older people and is offered as a single vaccine from the age of 65, it does not need to be repeated every year. The vaccine protects serious and potentially fatal pneumococcal infections. In Halton only 70% of all people over the age of 65 have received their vaccine.

In Halton we are not meeting the vaccination targets for older people and therefore, a significant number of older people remain at serious risk of complications as a result of flu and pneumonia. We will continue to work closely with NHSE England and local GP practices to increase access to vaccination and encourage local people to take the opportunity to protect themselves.

Emerging Issues in Public Health

Public health is continuing to facing reductions in funding from both local and national budget reductions. A significant challenge going forward will be the continued need to meet council financial efficiency expectations alongside a reduction in the Public health funding allocation.

The ongoing development of the One Halton Accountable Care structures will provide challenge to public health in ensuring that prevention is embedded as a priority within, and wrapped around the developing structures and work streams. It is also vital to ensure that widespread system change does not destabilise the existing programmes and initiatives.

Appendix 1

Objectives, Milestones and Measures

Adult Social Care

Service Objective: 1	Working in partnership with statutory and non-statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for people with Complex Care needs.		
Key Milestone(s) (19 / 22)	**Mental Health:** ▪ Monitor the Local Dementia Strategy Action Plan, to ensure effective services are in place. **Homelessness:** ▪ The Homelessness strategy be kept under annual review to determine if any changes or updates are required.		
Responsible Officer:	Lindsay Smith	**Linked Indicators:**	ASC 10, 11, 12, 13, 14

Service Objective: 2	Working in partnership with statutory and non-statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for vulnerable people		
Key Milestone(s) (19 / 22)	▪ Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target**.** ▪ Integration of Health and social care in line with one Halton priorities. ▪ Monitor the Care Management Strategy to reflect the provision of integrated frontline services for adults**.**		
Responsible Officer:	Damian Nolan	**Linked Indicators:**	ASC 01, 02, 03, 04 (Annual Collection Only)

Service Objective: 3	Continue to effectively monitor the quality of services that are commissioned and provided in the borough for adult social care service users and their carers.		
Key Milestone(s) (19 / 22)	▪ Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets. ▪ Monitor and review all ASC milestones in line with three year planning cycle.		
Responsible Officer:	Helen Moir	**Linked Indicators:**	ASC 19, 20, 21, 22, 23, 24, 25, 26 (Annual Collection Only) ASC 20, 21, 22 (Biennial Collection Only)

Service Objective:	Working in partnership with statutory and non-statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for vulnerable people		
Key Milestone(s) (19 / 22)	**Safeguarding:** ▪ Monitor and review all milestones in line with three year planning cycle.		
Responsible Officer:	Damian Nolan	**Linked Indicators:**	ASC 15, 16 17 (A), (B), 18 (Annual Collection Only)

Service Objective:	Effectively consult and engage with people who have Complex Care needs to evaluate service delivery, in the form of an annual survey to highlight any areas for improvement and contribute towards the effective re-design of services where required		
Key Milestone(s) (19 / 22)	▪ Monitor and review all ASC milestones in line with three year planning cycle.		
Responsible Officer:	Damian Nolan	**Linked Indicators:**	ASC 23, 24, 25, 26 (Annual Collection Only)

Service Objective:	Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs		
Key Milestone(s) (19 / 22)	▪ Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. **Mar 2020**. ▪ Monitor and review all ASC milestones in line with three-year planning cycle. **Mar 2020**		
Responsible Officer:	Damian Nolan	**Linked Indicators:**	N/A

Ref	Description	16/17 Actual	17/18 Target	17/18 Actual	18/19 Target	18/19 Actual	19/20 Target	20/21 Target	21/22 Target
ASC 01	Permanent Admissions to residential and nursing care homes per 100,000 population 65+ ***Better Care Fund performance metric***	515.3	635	623.3	635	TBC	TBC	TBC	TBC

Ref	Description	16/17 Actual	17/18 Target	17/18 Actual	18/19 Target	18/19 Actual	19/20 Target	20/21 Target	21/22 Target
ASC 02	Delayed transfers of care (delayed days) from hospital per 100,000 population. ***Better Care Fund performance metric***	5245	5247	TBC	5147	TBC	TBC	TBC	TBC
ASC 03	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population. ***Better Care Fund performance metric***	18657	17570	TBC	13,289	TBC	TBC	TBC	TBC
ASC 04	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B) ***Better Care Fund performance metric***	62.12 %	63%	78%	63%	TBC	80	82	84
ASC 05	Percentage of items of equipment and adaptations delivered within 7 working days	93%	96%	94%	97%	TBC	97	97	97
ASC 06	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support – include brief definition) (Part 1)	74%	80%	NA	NA	TBC	ABOVE NW AVERAGE	ABOVE NW AVERAGE	ABOVE NW AVERAGE
ASC 07	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support – include brief definition) (Part 2) DP	44%	46%	NA	NA	TBC	45	45	45
ASC 08	Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G)	86.9%	87%	88.84 %	87%	TBC	88	88	88
ASC 09	Proportion of adults with learning disabilities who are in Employment (ASCOF 1E)	5.94%	5%	5.30%	5%	TBC	5.5	5.5	5.5

Ref	Description	16/17 Actual	17/18 Target	17/18 Actual	18/19 Target	18/19 Actual	19/20 Target	20/21 Target	21/22 Target
ASC 10	Homeless presentations made to the Local Authority for assistance, in accordance with Homelessness Reduction Act 2017 Relief Prevention Homeless	New	500	117	500	TBC	TBC	TBC	TBC
ASC 11	LA accepted a statutory duty to homeless households in accordance with Homelessness Act 2002	New	100	10	100	TBC	TBC	TBC	TBC
ASC 12	Homelessness prevention, where an applicant has been found to be eligible and unintentionally homeless.	New	1650	TBC	TBC	TBC	TBC	TBC	TBC
ASC 13	Number of households living in Temporary Accommodation Hostel Bed & Breakfast	1	17	6	17	TBC	TBC	TBC	TBC
ASC 14	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough)	6.62%	6.00%	1.64%	6.00%	TBC	TBC	TBC	TBC
ASC 15	Percentage of individuals involved in Section 42 Safeguarding Enquiries.	NA	NA	NA	NA	TBC	TBC	TBC	TBC
ASC 16	Percentage of existing HBC Adult Social Care staff that have received Adult Safeguarding Training, including e-learning, in the last 3-years (Previously PA6 [13/14] change denominator to front line staff only.	48%	56%	61%	56%	TBC	TBC	TBC	TBC

Ref	Description	16/17 Actual	17/18 Target	17/18 Actual	18/19 Target	18/19 Actual	19/20 Target	20/21 Target	21/22 Target
ASC 17 (A)	DoLS – Urgent applications received, completed within 7 days.	73%	80%	N/A	80%	TBC	TBC	TBC	TBC
ASC 17 (B)	DoLS – Standard applications received completed within 21 days.	77%	80%	N/A	80%	TBC	TBC	TBC	TBC
ASC 18	The Proportion of People who use services who say that those services have made them feel safe and secure – Adult Social Care Survey (ASCOF 4B)		82%	89%	89%	TBC	89%	89%	89%
ASC 19	Proportion of Carers in receipt of Self Directed Support.	99.4%	99%	99.27 %	TBC	TBC	99	99	99
ASC 20	*Carer reported Quality of Life (ASCOF 1D, (this figure is based on combined responses of several questions to give an average value. A higher value shows good performance)*		N/A	8.1% 2016/17	9	7.6	NA	8	NA
ASC 21	*Overall satisfaction of carers with social services (ASCOF 3B)*		N/A	48.9% 2016/17	50	51.8	NA	52	NA
ASC 22	The proportion of carers who report that they have been included or consulted in discussions about the person they care for (ASCOF 3C)		N/A	76.6% 2016/17	80	77.7	NA	80	NA
ASC 23	Do care and support services help to have a better quality of life? (ASC survey Q 2b) ***Better Care Fund performance metric***		93%	93.30 % 2016/17	93%	TBC	93	93	93

Ref	Description	16/17 Actual	17/18 Target	17/18 Actual	18/19 Target	18/19 Actual	19/20 Target	20/21 Target	21/22 Target
ASC 24	Social Care-related Quality of life (ASCOF 1A). (This figure is based on combined responses of several questions to give an average value. A higher value shows good performance)	19%	20	NA	NA	TBC	20	20	20
ASC 25	The Proportion of people who use services who have control over their daily life (ASCOF 1B)	74%	80	NA	NA	TBC	80	80	80
ASC 26	Overall satisfaction of people who use services with their care and support (ASCOF 3A)	71.80 %	70	NA	NA	TBC	71	71	71