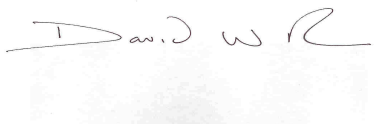
Public Document Pack

Healthy Halton Policy and Performance Board

Tuesday, 12 June 2007 6.30 p.m.
Civic Suite, Town Hall, Runcorn



Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	Labour
Councillor Kath Loftus (Vice-Chairman)	Labour
Councillor Robert Gilligan	Labour
Councillor Trevor Higginson	Liberal Democr at
Councillor Margaret Horabin	Labour
Councillor Christopher Inch	Liberal Democrat
Councillor Martha Lloyd Jones	Labour
Councillor Joan Lowe	Labour
Councillor Kelly Marlow	Liberal Democrat
Councillor Geoffrey Swift	Conservative
Councillor Pamela Wallace	Labour

Please contact Caroline Halpin on 0151 471 7394 or e-mail caroline.halpin@halton.gov.uk for further information.
The next meeting of the Board is on Tuesday, 11 September 2007

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

Agenda Item 3

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 12 June 2007

REPORTING OFFICER: Strategic Director, Corporate and Policy

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To consider any questions submitted by the Public in accordance with Standing Order 33(5).

1.2 Details of any questions received will be circulated at the meeting.

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

3.1 Standing Order 34(11) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for members of the public who are residents of the Borough, to ask questions at meetings of the Policy and Performance Boards.

(ii) Members of the public can ask questions on any matter relating to the agenda.

(iii) Members of the public can ask questions. Written notice of questions must be submitted by 4.00 pm on the day prior to the meeting. At any meeting no person/organisation may submit more than one question.

(iv) One supplementary question (relating to the original question) may be asked by the questioner, which may or may not be answered at the meeting.

(v) The Chair or proper officer may reject a question if it:-

- Is not about a matter for which the local authority has a responsibility or which affects the Borough;
- Is defamatory, frivolous, offensive, abusive or racist;
- Is substantially the same as a question which has been put at a meeting of the Council in the past six months; or
- Requires the disclosure of confidential or exempt information.

(vi) In the interests of natural justice, public questions cannot relate to a planning or licensing application or to any matter, which is not dealt with in the public part of a meeting.

(vii) The Chairperson will ask for people to indicate that they wish to ask a question.

(viii) **PLEASE NOTE** that the maximum amount of time each questioner will be allowed is 3 minutes.

(ix) If you do not receive a response at the meeting, a Council Officer will ask for your name and address and make sure that you receive a written response.

Please bear in mind that public question time lasts for a maximum of 30 minutes. To help in making the most of this opportunity to speak:-

- Please keep questions as concise as possible.
- Please do not repeat or make statements on earlier questions as this reduces the time available for other issues to be raised.
- Please note that public question time is not intended for debate – issues raised will be responded to either at the meeting or in writing at a later date.

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

There are no background papers under the meaning of the Act.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 12 June 2007

REPORTING OFFICER: Strategic Director, Corporate and Policy

SUBJECT: Executive Board Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health Portfolio which have been considered by the Executive Board and Executive Board Sub since 7 December 2006 are attached at Appendix 1 for information.

1.2 The Minutes are submitted to inform the Policy and Performance Board of decisions taken in their area.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

None.

4.0 OTHER IMPLICATIONS

None.

6.0 RISK ANALYSIS

None.

7.0 EQUALITY AND DIVERSITY ISSUES

None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

There are no background papers under the meaning of the Act.

APPENDIX 1

Extract of Executive Board and Executive Board Sub Committee Minutes Relevant to the Healthy Halton Policy and Performance Board

EXECUTIVE BOARD SUB COMMITTEE MEETING HELD ON 22ND FEBRUARY 2007

90. AWARD OF CONTRACT FOR THE PROVISION OF CARE AND SUPPORT AT BREDON SHORT TERM RESPITE SERVICE

The Sub Committee were on advised on the five tenders received for the provision and support at Bredon short term respite service. The tenders had been evaluated for quality and value for money and three organisations were invited to make a presentation. Of the three organisations invited for interview, Creative Support scored high against the published criteria of evaluation and at interview. Therefore the report sought approval to award the contract to Creative Support on the basis that this organisation offers value for money in terms of both cost and quality.

RESOLVED: That the Strategic Director Health and Community be authorised to award the 3 yr contract (with an option to extend for a further 2 years) to Creative Support.

EXECUTIVE BOARD SUB COMMITTEE MEETING HELD ON 29TH MARCH 2007

107. REVIEW OF FEES AND CHARGES – HEALTH & COMMUNITY DIRECTORATE 2007-2008

The Sub-Committee considered a report which outlined the proposed increases in fees and charges for the Health and Community Care Services and Consumer Protection Services.

A consultation exercise on the proposals for changes to the charges for Social Care services was undertaken in 2007. All service users/carers were sent a copy of a survey form to complete and 8 open forums were held. As a result of the consultation exercise, comments have been received by Service Users and their Carers and details of which were summarised in the report.

The results of the survey had been considered and recommendations for changes to charges for Social Care Services were outlined.

With regard to Bereavement, Consumer Protection and Registration Service charges most had increased, some above inflation.

The Sub-Committee was advised that para 3.8 and Appendix 2 to the report, “charges for transport” had been amended to remove the words “ to those aged under 55”.

RESOLVED: That

(1) the results of the survey about charging for Social Care Services be noted;

(2) changes to charges for Care Services outlined in the report be approved, subject to the amendment detailed above; and

(3) the proposed changes in fees and charges outlined in the report be approved.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 12 June 2007

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: Mens Health Programme

WARDS: Riverside, Appleton and Kingsway, Hallwood Park, Palacefields and Castlefields and Windmill Hill

1.0 PURPOSE OF THE REPORT

1.1 To update the Healthy Halton Policy and Performance Board on the Mens Health Programme.

2.0 RECOMMENDATION: That Members note and comment on the programme.

3.0 SUPPORTING INFORMATION

Nationally there are issues in men not accessing health services appropriate to their health needs. This programme seeks to address local gaps in targeting men's health, which has been cause for concern.

The programme will deliver bespoke interventions whilst utilising a joined up approach. Given the strong correlation between levels of poverty and deprivation and poor indicators of morbidity and mortality, men will be targeted in the most deprived communities of Halton in attempt to improve the uptake of healthier lifestyles.

4.0 POLICY IMPLICATIONS

None

5.0 OTHER IMPLICATIONS

None

6.0 RISK ANALYSIS

Failure to reduce inequalities in health and improve on levels of morbidity and mortality will result in key targets not being met in the LAA.

7.0 EQUALITY AND DIVERSITY ISSUES

The programme will target some of the most deprived communities in Halton.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of this Act.

Activity Code No: 07/001
to be completed by NM Team

Building Stronger **COMMUNITIES**
Neighbourhood Management in Halton

Project Plan for interventions starting in 2007/8 requiring more than £3,000 Neighbourhood Element funding.

Title of Intervention: Mens Health Programme

Date of Approval:

SECTION 1: ORGANISATION DETAILS

1.1 Name of Lead Organisation: Halton & St Helens PCT

Type of Organisation:

☐ X**Public Sector Service** Provider
☐ Community /Voluntary Organisation
☐ RSL
☐ Other, please specify .....
.....

1.2 Project Manager who will be responsible for overseeing the intervention:

Name: Anna Nygaard

Address: Suite 1E Midwood House Midwood Street Widnes Cheshire

Postcode: WA8 6BH

Telephone: 0151 495 5450

Fax: 0151 420 6788

E-mail: anna.nygaard@hsthpct.nhs.uk

1.3 In which of the pilot neighbourhood(s) will the intervention be delivered?

The programme will include all of the NMTs and men from the designated NMT areas in Riverside, Appleton and Kingsway, Hallwood Park, Palacefields and Castlefields and Windmill Hill will be targeted to use the MOT service . An active promotion and awaereness programme will be delivered in these locations.

1.4 If only part of a neighbourhood and/or areas outside the neighbourhood will be included please give details and an explanation.

1.5 Please give brief details of the services currently delivered by you in the neighbourhood(s) together with an approximation of how much these cost.

The Mens Health Programme will be extended to deliver Male MOTs , signposting, clinical referral and healthy living advice across the wider NMT areas. Healthy weight and fitness activities are delivered through the HiM (Health in Men Sessions). The Men's Health Programme is a bespoke tailored programme which works with over 200 men per year and is now utisilising the extensive healthy lifestyle programmes through The Healthy Living Programme (HLP) which currently offers a range of services and interventions across the borough and promotes good health in its broadest sense to reduce health inequalities and improve the health of the worst off in society . The programme targets those who are socially disadvantaged ie Older adults, those suffering from Long term conditions including CHD and cancers, low income families and people suffering from mental ill health in Widnes and Runcorn. This includes; super output areas and disadvantaged wards.

Services currently delivered within the HLP are documented in the table below;

Service/ Programme	**Neighbourhood(s)**	**Approximate Annual Cost (**non pay/revenue only)
Cook and Taste Sessions	All SOAs and 20% most disadvantaged wards	10k
Fresh Start ; diet and exercise Lifestyle Programme	As above	20k
Recipe for Health	As Above	90k
Mens Well Being Clinic	As Above	8k
Complementary Therapy GP Referrals	As Above	15k
Carers Sanctuary	As Above	14k
Health Trainer Service	As Above	
Reach for the Stars	As Above	35k
Specialist weight management	As Above	
Community classes	As Above	15k

Recharge Long Term conditions programme	As Above	15k

1.6 Are there any major problems in delivering your services in the neighbourhood at present? If so, state what they are and how the intervention will help to address them.

Issue	Evidence	Solution
Men do not access health services and so diseases that could be prevented are allowed to develop.	Service user data indicates that is women and children who access the services the Healthy Living Programme delivers. Only 30% of users are men.	To provide a service that specifically targets men in a way they find acceptable and encourages them to address health issues.

SECTION 2: YOUR INTERVENTION

2.1 Please give an outline of the intervention.

Programme aims and objectives

The aim of this initiative is to encourage men living in the areas documented in section 1.3 to take better care of their health and to make more use of health services. More must be done to improve men's health since too many men die prematurely and do not know the symptoms of prostate, testicular and other diseases. Men are often also reluctant to visit their doctor until health problems have become serious and harder to treat. The intervention will include the following;

- To recruit a Mens Health coordinator to specifically work with men in areas of disadvantage . These areas have been defined as Kingsway, Appleton Riverside, Hallwood Park, Palacefields, Castelfields and Windmill Hill. This includes development of a campaign of male health checks and male MOT / sustainable solutions
- Hard hitting, humorous non judgmental campaign developed.

- Delivery of key messages; Men die younger than women, Get a free health check, Its never too late to get healthier
- Use of non health venues; pubs, social clubs, community centres, workplaces
- Health venues to include GP practices, pharmacies
- To provide excellent services to clients thereby encouraging the development of long-term relationships and sustainability.
- To provide an infrastructure that can support and coordinate a diverse range of activity in an area which has a diverse range of needs. To offer a variety of creative services that initiate and /raise levels of participation in health and health related issues on both an individual and community level specifically targeted at men
- To develop these in the most appropriate way for the local area identifying enablers, and champions to disseminate the services accordingly.
- To provide an information network to support the service and provide liaison, training and education for users.

2.2 What other partners are going to be involved? List them and explain why and how each of them will contribute.

The Programmes outlined below are currently operational. Males will be identified, and be invited to attend community lifestyle and screening programmes and where necessary signposted to the relevant programmes listed below. Funding for those programmes is already in place.

Partner	Budget	Contribution
HLP HLP Management contribution	7k Big Lottery fund 5400k NRF (1 years funding) £11,760	Programme concept/design/awareness/financial management/sustainability/development and growth
Alcohol Programme Men's Sexual Health Mental Health Workplace programme Stress management for men, staying mentally active and healthy in work	20k Choosing Health 75k Choosing Health 45k Choosing Health /NRF PCT,HBC/Social Services Funding in all of this section will be year on year funding	Men can access lifestyle advice and tailored behaviour change packages in the community. Free contraceptive services, Chlamydia screening in the community, specialist GUM clinic services. Positive mental health workplace training and services specifically for males. In addition the PCT have commissioned the Samaritans to deliver the Worklife Programme targeted at unemployed men and men in routine occupations.

2.3 Proposed start date; Ongoing MOTs Coordinator to be appointed in July 2007

Finish date; : **April 2010**

SECTION 3: PROPOSED ACTIVITIES OR CHANGES IN SERVICE DELIVERY

3.1 What are the key objectives of the intervention?

Evidence demonstrates that men are becoming increasingly aware of their health needs but are not necessarily showing a willingness to participate in activities that relate to their health. This intervention will deliver a specific health improvement programme for Health in Men – which will include a joined up approach to health screening and referral, health education (both clinical and social), and a social marketing approach to service delivery and engagement.

The project team will employ evidence-based practice in planning, developing, implementing and evaluating a health improvement programme and activities specifically targeted for and with men. A project group will include community, health professionals and consumers with expertise and interest in men's health, to ensure the most appropriate delivery of achievable and holistic health outcomes for men. Consumers will be represented by SOA ward areas and will focus on how men experience poor physical health and mental distress, and the social and physical contexts of illness.

Common assumptions

- Men don't like talking about their health
- Men are reluctant to go to the doctors
- Late diagnosis = early death
- This doesn't mean men don't care about their health

Core programme aims

- Using a social marketing approach, raise awareness of men's health as a significant issue in Halton, particularly amongst 50 – 65 year old men.
- To encourage and support positive behaviour change amongst target group of men
- To increase male life expectancy

Strategy

- Social marketing approach putting men at the centre
- Understanding men and starting from 'where they are at'
- A targeted campaign
- Focus on motivational behaviour change

- Men's health checks in non health venues
- Deliver health screening and referral
- Healthy Eating awareness for men in designated SOA areas
- Men's health resource development
- Education and training in men's health promotion and men's health screening
- Tool Box meetings - men's health education sessions
- Men's health research (eg prostate cancer)

Audience and segment

- Primary target audience men 50-65 years
- Secondary audiences ; women, men other ages
- GPs, pharmacies, health professionals
- Other stakeholders

3.2 What difference will it make to the neighbourhood and how will it be sustained and continue after the end of neighbourhood management funding?

This intervention will deliver real improvements in our most deprived areas and communities and will make a difference in the following areas;

- Improving the mental well being of men in the most disadvantaged communities
- To remove the barriers that disable men and contribute to their poor health through ensuring that they have ready access to a wide range of referral services, and diet and exercise activities that enhance their quality of life.
- To reduce the burden of disease in Halton by concentrating on lowering the rates of male cancers and heart disease, mental ill health and diabetes and addressing their health needs
- To promote a healthy living environment and lifestyles to protect the health of the public, sustain individual good health and well being, and help prevent and efficiently manage illness.
- To develop a 'joined up approach' to healthy living opportunities for men in designated disadvantaged areas.

The intention is that the programme will be supported by the Choosing Health budget after NMT funding has ceased. Additionally, many of the community classes` which will be used to refer men onto through a healthy lifestyle approach are already self sustaining.

3.3 Give brief details of an example where this approach is or has worked elsewhere together with some evidence.

- There are a number of regional male specific programmes which have demonstrated success in both awareness and increased uptake of services. The Knowsley Pit Stop programme has made over 1,500 male health checks men checked and its evaluation has reported a 57% increase of campaign awareness in its target group with 85% of men followed up cited lifestyle changes made and maintained.
- Halton has been running its own Mens Health Programme for over a year known as Health in Men (HiM). This is a highly successful pilot programme with potential to grow rapidly. The funding will sustain and develop the programme delivering highly successful behaviour change outcomes.

3.4 Who is/are your 'target group(s)'? Explain why and how they will benefit.

Our target is the male population residing in the areas documented in section 1.3. Men's health is emerging as an important issue in an increasing number of countries around the world, notably the United Kingdom, Austria, Switzerland, Australia, and the United States. More locally, in Halton the 2006 Life style survey demonstrated more than half of men and women are overweight for their height. Obesity within Halton has increased quite substantially since 2001; with 20.2% of residents currently measuring as obese, this compares with 15.1% at the time of the last survey. A higher proportion of males are overweight, (63% compared with 50% of females) with highest prevalence amongst males in the 40-64 age band (71%).

In the majority of the target wards these figures were even higher; 28.1% in Windmill Hill, 25.6% in Halton Lea, 25.4% in Norton South, 25.3% in Castlefields and 25.1% in Grange. Over 50% of residents lead sedentary lifestyles in Halton, according to a local survey in 2001. Diet is strongly correlated with coronary heart disease which is the commonest cause of death in the United Kingdom. All men are at risk of heart disease (pre-menopausal women are protected by their hormones) and this is reflected in the rates of incidence, presentation, referral, recovery and rehabilitation. However, current interventions on coronary heart disease are delivered in a gender neutral context. Given the impact of this disease on men there is a need for health strategy that is gender sensitive.

Halton has very poor respiratory health Overall, 25.6% of Halton residents currently smoke; this suggests and there are approximately 24,500 adult smokers in the borough. Current estimates suggest that there is a slightly higher proportion of male smokers overall – 26.1% compared with 25% of females.

Smoking prevalence is higher in Runcorn, with 26.5% of residents reporting that they currently smoke, compared with 24.7% in Widnes. Prevalence varies considerably across age bands and by gender, with Runcorn males aged 40-64 years reporting highest prevalence (32.1%).

Diseases related to Alcohol are reaching epidemic proportions.
Overall, 17.5% of Halton respondents indicated that they drank more units per week than considered safe under these guidelines. This represents an increase on the 2001 figure of 15.7%. Whilst a greater proportion of males drink to unsafe levels, (22.5% compared with 12.4% of females)

Males in the 18-34 age group have the poorest diet, with lower intake of fruit and vegetables, and more poor diet habits.

Older men

Older men have the highest suicide rates in the UK. Suicide in older men is strongly associated with depression, physical pain or illness, living alone, and feelings of hopelessness and guilt. One factor is the lack of medical resources for older men: while Well Women clinics are a common feature in primary care, there are few male equivalents. A few Well Man Clinics have been set up, but these are far from being commonly available.

3.5 Give details of who and how you have consulted about this, and what were the results. (Where possible this should include members of the community).

We (The steering group) have reviewed the evidence base using international, national and regional data. We are aware of the success of several regional programmes and are continuing to consult with current service providers in South Sefton and Knowsley. We have organised a number of focus groups in the local community including work with parents through local childrens centres engaging grandparents and the extended family through the childrens centre focus.

Our research findings considred the feedback and evaluation from the men who have attended the pilot group. The results of our research have highlighted the need for specific tailored services which deliver short term clinical support through cholesterol

testing , Blood pressure monitoring and diabetes screening, but also taking a long term, holistic approach which supports the male population to make healthier lifestyle choices. We have also examined the external evaluations from the Pit Stop Programme which have identified successes and weaknesses in programme development.

3.6 What other relevant activities are already taking place in the neighbourhood and how will your intervention join up and add to them?

The HLP have been delivering lifestyle programmes very successfully over the last five years and have incorporated all of the existing programme of work into a comprehensive lifestyle referral service. It is obvious that the Mens Health programme will be integrated into this system and will also be a key part of a new database which connects all individuals and services.

There are over 60 community classes currently operating within the HLP work programme as well as a wide variety of services within Health promotion which include smoking cessation and sexual health. The Health Visitor team who will manage a dedicated clinical practitioner will be very familiar with existing clinical and lifestyle service provision and will ensure that all male clients will be supported appropriately.

The HLP currently work in partnership with a number of organisations and all HLP practitioners are able to identify appropriate referral pathways for our clients. Examples of our regular partners are listed below;

- St Johns Psychological therapies Unit
- Campaign against living miserably
- Samaritans
- Relationship Centre
- Pain management clinic
- HVA
- Acute sector
- YMCA
- HBC eg Schools Community centres Social services Culture and leisure services
- NHS ,Halton & St Helens PCT GPs and practice staff Acute services Dietetics, community pharmacies, health trainer programme
- Housing Associations
- Other private and public sector organisations eg DC Leisure
- Age concern
- MIND
- DAT

SECTION 4: DELIVERY AND PERFORMANCE MANAGEMENT

4.1 What are the management arrangements for the intervention?

The coordinator will be managed by the Health Visitor Manager supported by the Helath Improvement Manager, both employed by Halton & St Helens PCT. A multi agency steering group will oversee the programme delivery by regular quarterly meetings. A comprehensive service plan will be developed by this group.

4.2 Please complete the following table to show how your intervention will be delivered. Detail how and when key milestones will be achieved.

Activity	Milestone	How Measured/ Evidence	Risks/ Assumptions	Timescale
Funding secured	Funding in place		Funding not approved	May 2007
Appointment	Advertise/recruitment of coordinator	Recruitment of the coordinator	Appointment unsuccessful	July 2007
Delivery Plan devised	Roll out commence	Tactician Database Well being score/ baseline measurement and post treatment comparison/3 month review		May/June 2007
Evaluation team appointed	Quarterly review	Quantiative and qualitative Baselines established by University Evaluators		June 2007
Agree baseline for interventions areas	Established by Coordinator across SOA areas.	Milestones for alcohol, smoking, sexual health, mental health weight management	That baseline information be provided by PCT analyst	July 2007
Marketing Strategy produced	12 month promotional plan in place	Activity in community		June 2007
Men's Well Being Clinic	First cohort complete session	Tactician database well being evaluation		Amy 2007
Coordinator 'joins up ' all male referral services and increases	Networking plan in place Identification of stakeholders	Incorporated into Business `plan		July 2007 - ongoing

uptake of Him programme in NMT areas				
Multi agency steering group recruited	First meeting scheduled for April 2007			April 2007 & quarterly.

4.3 Set out in the table below the outputs your intervention will achieve and the outcomes it will impact upon.

Unable to establish baseline due to non specific and untailored male programmes which currently exist . The coordinator will be responsible for establishing baselines for male attendance across alcohol, smoking cessation, sexual health, mental health and weight management services . This is outlined in table above.

Baseline	Change	Timescale	Output/Outcome	How Measured/ Evidence

4.4 How are you going to 'mainstream' what you are doing into your current services? How are you going to 'roll out' what has been achieved and learned throughout your organisation and partners?

The HLP Tactician database will provided a comprehensive analysis of health outcomes including service uptake and behaviour change. This will be used as an evidenced based tool to support investment in prevention for future funding through statutory services. The programme will be closely monitored by the Health Improvement Manager at the PCT who will work with an external evaluation team to advise on future development and growth. The NMT coordination team will be kept informed of mainstreaming potential in its quarterly reports.

4.5 Set out how residents. councillors and community groups will be involved, particularly in decision making and evaluation.

The Multi agency steering group will be representative of all of the above and will ensure that each area will be considered. The Health Improvement Manager will be responsible for steering group recruitment.

4.6 Explain how you are going to reach and engage 'hard to reach' and minority groups and communities

An extensive and comprehensive marketing plan will determine how this will be achieved and will be developed with the support of the Health Improvement manager. A social marketing approach will be applied to this delivery starting from 'where the client is at'.

SECTION 5: FUNDING REQUIRED

5.1 Why do you require neighbourhood element funding to carry out the intervention?

The campaign is specific and targeted in the NMT areas and has` the potential to make a significant impact if appropriate funding is secured. Additionally, the programme will be based within a highly successful partnership of the Health Visitor Team and the HLP which ahs a proven record in excellent service delivery.

5.2 Give details of the total cost of the intervention. If it is an enhancement of an existing service provision, give details of the mainstream resources you will commit over the life of the intervention. Remember to include <u>ALL</u> additional resources that will support the activity. If some are 'in kind' contributions they should be included with an estimate of the monetary value.

Funding Requirement	**£'s**
3 year Programme of work	**130,840**
Other Funding Sources	
1. PCT	320,280
2. Big Lottery Fund	6000
3.PCT/NRF/HBC collaborative	135,000
4. Vulnerable Adults Task Force	40,000
OTHER FUNDING SUB TOTAL	501,280
GRAND TOTAL	**632,120**

If your intervention is to be delivered beyond 31st March 2008, set-out the annual funding requirement below.

	2007-2008	2008-2009	2009-2010	Total
Coordinator (PCT Band 5 x3 days incl on cost)	14640	15079	15531	45250
Well Being Clinic	12000	12000	12000	36000
Evaluation	3942	4207	4441	12590
Marketing	4000	2000	2000	8000
Equipment	5000	5000	5000	15000
T&S	500	500	500	1500
Venue & Instructors		6000	6500	12500
Total	**40082**	**44786**	**45972**	**130,840**
OTHER FUNDING (Cash)				
1. Venue & Instructors (PCT/ HLP)	6000			6000
2. VATF	40k			40k
3.				
Other Funding (In kind)				
1. Management	11760	11760	11760	35280
2. Referral to alcohol services (PCT)	20k	20k	20k	60k
3. Referral to Sexual Health Services (PCT)	75k	75k	75k	225000
4. Referral to Mental Health Programme in workplace (PCT/NRF/HBC)	45k	45k	45k	135000
OTHER FUNDING SUB-TOTAL	157760	151760	151760	501280
GRAND TOTAL	**237842**	**196546**	**197732**	**632120**

5.3 Give a breakdown of how the neighbourhood element funding will be spent.

DESCRIPTION	AMOUNT

1. Coordinator (PCT Band 5 x 3 days incl on cost) 2.Well Being Clinic 3. Evaluation 4. Marketing 5. Equipment 6. T&S 7. Venue & Instructors		45250 36000 12590 8000 15000 1500 12500
	TOTAL	**130,840**

5.4 In the table below explain the advantages and disadvantages of each option.

Option	Cost	Advantages	Disadvantages	Assessment of Option
A 100% funding	130,840	Services commences May 2007	None	Desirable outcome
B Less than 100% funding.		None	Service unable to start as coordinator is planned as a part time post	
C 0% funding. 'Do nothing'.			Service unable to start	

SECTION 6: RISK ASSESSMENT

Using the matrix below identify any significant risks you have identified involved in delivering the intervention.

Risk Matrix

Very Likely (4)				
L I				

K **E** **L** **I** **H** **O** **O** **D** **Likely (3)**				That the service take up is minimal due to typical take up of health services by males.
Unlikely (2)				Coordinator appointment delayed
Very Unlikely (1)				
	Minor (1)	**Significant (2)**	**Serious (3)**	**Major (4)**
	SEVERITY			

RISK = Likelihood (L) x Severity (S)

Explain how you will manage and minimise any risks you have identified that score 8 and above.

Risk	Score (L X S)	Action
That the service take up is minimal due to typical take up of health services by males.		The innovative nature of this programme will take the services to the men rather than the traditional approach will expects men to engage with health care services. The Programme will be delivered in non health venue settings .

SECTION 7: MONITORING ARRANGEMENTS

7.1 Who is to provide information and reports to the Neighbourhood Management Team on the progress and achievements of the intervention against milestones and outcomes?

This will be done by the coordinator who will have the support of the HLP Tactician Database. They will submit a quarterly SLA which will be signed by their accountable manager .

7.2 Who will be responsible for evaluating the activities or changes in service delivery and for disseminating good practice lessons?

External evaluation by Liverpool John Moores University will inform the steering group and disseminate good practice.

7.3 How will you involve local residents in the evaluation of the intervention?

This is built into the external evaluation programme using quantitative and qualitative processes. Focus groups and semi structured interviews /questionnaires will be used.

SECTION 8: SIGNATURE

I declare that the information given in this proposal is correct to the best of my knowledge and has the commitment of the organisation I am representing.

Name: _____ Signature: _____

Organisation: _____ Date: _____

PLEASE FORWARD YOUR COMPLETED FORM TO:

Neighbourhood Management Team
Runcorn Town Hall,
Heath Road,
Runcorn, Cheshire, WA7 5TD

Email; nicholas.mannion@halton.gov.uk

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 12 June 2007

REPORTING OFFICER: Strategic Director health and Community

SUBJECT: Widnes Primary care Estates Strategy

WARDS: **All wards in Widnes**

1.0 PURPOSE OF THE REPORT

1.1 To appraise members of progress following the consultation carried out by Halton and St Helens Primary Care trust (PCT) in 2006**.**

2.0 RECOMMENDATION: That the report be noted.

3.0 SUPPORTING INFORMATION

3.1 During 2006 the PCT undertook a public consultation to develop the future options for the use of primary care premises in Widnes. The responses were considered by the PCT Board in January 2007. This paper summarises progress in implementing the Board decisions.

3.2 The building of new premises to relocate Beaconsfield Road Surgery to a new site on Peelhouse Lane is expected to commence August 2007. Ditton Medical Centre on Blundell Rd has relocated to the Health Care Resource Centre (HCRC). A service specification has been developed to encompass the delivery of service for Upton Rocks and Hale Village surgery by one provider. Tenders have been received and the bids are being considered. This approach sustains the service In Hale Village. Negotiations are taking place to extend the lease for the premises.

3.3 The specification requested 'bidders' to make proposals to develop the service in the Halebank access centre. The aim is to sustain the service currently being delivered from the centre and to be able to respond to the increase in population predicted by the housing developments in the area.

3.7 One issue that was causing concern to the PCT was the lack of capacity at Halebank to cope with the demand for phlebotomy services. This has been alleviated by the introduction of additional clinics at the HCRC.

3.8 A pharmacy has now opened in Halebank, sited next to the Co-op shop.

3.9 A financial appraisal is being undertaken to look at the options for the location of Upton Rocks Medical Centre. This will not be concluded until the new provider has been identified and contract awarded for the list

4.0 POLICY IMPLICATIONS

4.1 None

5.0 OTHER IMPLICATIONS

5.1 None

6.0 RISK ANALYSIS

6.1 Failure to improve and develop primary care premises will mean they will not meet the requirement of the Disability Discrimination Act.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of this Act.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 11 June 2007

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: Joint Commissioning Strategy for Adults with Physical and/or Sensory Disabilities 2007-2011

1.0 PURPOSE OF THE REPORT

To present to Healthy Halton Policy and Performance Board a draft Joint Commissioning Strategy for Adults with Physical and/or Sensor Disabilities for discussion.

2.0 RECOMMENDATION: That members note and comment on the Draft Strategy

3.0 SUPPORTING INFORMATION

3.1 Purpose of the Strategy
This document sets out the overarching strategy for the commissioning, design and delivery of services to people in Halton who are physically disabled (including those with sensory disabilities), their families and carers. This is the first strategy to be produced for this group of people.

3.1.1 The strategy is written as a practical document to assist Physical and Sensory Disability (PSD) services move towards a more focussed way of commissioning services for adults in the 18-64 age range over a four year period. It is also expressed in a style to satisfy the Commission for Social Care Inspection (CSCI) and is consistent with other similar Commissioning strategies. The document will be used as evidence as part of the CSCI evaluation of the Councils approach to Policy development

3.1.2 There is a commitment to promoting the social model of disability which emphasises the need to remove the barriers to access faced by disabled people and gives them the ability to control their own lives.

3.1.3 The White Paper Our Health, Our Care, Our Say, promotes the alignment of Health and Social care planning. This strategy has been developed jointly between the Council and PCT, and through working with our partners will maximise capacity and enable more effective services which promote independence to be offered. The strategy has been shared with the PCT and comments received inserted into the document.

3.2 Consultation
The strategy was developed from consultation events involving all stakeholders and evidence from the Housing Needs Survey 2005. These are summarised in Section 3 of the strategy. Managers and practitioners attended a workshop to further develop ideas, which emerged from consultation.

3.3 Action Planning
A half-day action-planning event was held in April chaired by the Operational Director for Adults of Working Age. It was well attended by managers representing PSD care management and assessment services, provider services, commissioning and colleagues from Housing Strategy, PCT and North Cheshire Hospitals. Transportation has also contributed to the action plan.

3.3.1 Section 6 - Implementing the Strategy, summarises the agreed actions resulting from the contributions made at this event. The action plan (page 64) has been linked to the CSCI Adult Social Care Outcomes framework. This framework will measure performance in achieving the seven outcomes detailed in the white paper together with two additional measures relating to effective leadership and effective commissioning and use of resources.

4.0 POLICY IMPLICATIONS

4.1 PSD services have been successful in supporting people to remain in their own homes but the service is under considerable pressure. This strategy will provide the focus needed for managers to prioritise service developments and raise corporate awareness of responsibilities to provide mainstream services that include people with physical and/or sensory disabilities.

4.2 The report will be presented to the Health PPB for Scrutiny and thereafter presented to the Executive Board. This is consistent with the approach to all other Commissioning strategies produced.

5.0 OTHER IMPLICATIONS

5.1 Financial/Resource implications
Section 6 of the strategy sets out the spending patterns of PSD services. In general the service has not faced any significant financial pressures.

Whilst the strategy relates to the 18-64 age group visual rehabilitation and independent living services work with those over age 65. The number of referrals from this older group has increased and capacity in these service areas has been possible by utilising specific grants. These grants cease in March 2008 whilst the demand on these services will rise. A financial strategy to support the commissioning strategy is to be developed which will identify areas for dis-investment and re-investment.

6.0 RISK ANALYSIS

As with any change programme we can expect the implementation of the strategy to may be met with resistance and objections. This will be managed by ensuring all staff, service users and carers are fully informed of proposals and rationale and by listening to and acting on their suggestions.

7.0 EQUALITY AND DIVERSITY ISSUES

The Commissioning Strategy addresses Equality and Diversity there are no particular implications arising as a result of the proposed action. An Equality Impact Assessment (EIA) will need to accompany this strategy and be subject to review by the next available Directorate Equalities Group.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 See page 70 of the strategy.

HALTON BOROUGH COUNCIL

Halton and St. Helens NHS
Primary Care Trust

Health & Community Directorate

Joint Commissioning Strategy

For People with Physical and/or sensory Disabilities

2007-2011

DRAFT 09.05.07

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PREFACE

It is important in today's society that physically disabled people, their families and carers have access to services based on recognition of their rights as citizens, social inclusion in local communities, choice in their daily lives and real opportunities to be independent.

This strategy is written as a practical document to assist Physical and Sensory Disability (PSD) services in Halton move towards a more focussed way of commissioning services for adults in the 18-64 age range over a four year period. However, it is crucial that this is seen and used in the context of a "*living document*".

The commissioning agenda is based on consultation and engagement with stakeholders who provide services to those who are physically disabled, people who access those services and their carers and on needs analysis, which will evolve as people's individual needs and circumstances change. This should be reflected as services modernise and improve.

We also need to work jointly to eliminate unnecessary duplication of effort between health and social care and in partnership with the voluntary sector, providing where possible an integrated response based on services which meet assessed needs and which are designed to improve lives and give new opportunities.

Halton Borough Council and Halton Primary Care Trust together with their partners make a pledge to improve services and quality of life for physically disabled people. In doing so, as primary commissioners we expect all those who work with us to uphold these principles.

Councillor Ann Gerrard
Executive Board Member for Health & Social Care
Halton Borough Council

Chairman
Halton and St Helens
Primary Care Trust

Dwayne Johnson
Strategic Director
Health & Community Directorate
Halton Borough Council

Rebecca Burke Sharples
Chief Executive
Halton and St Helens
Primary Care Trust

SECTION ONE: COMMISSIONING IN CONTEXT

INTRODUCTION

This document sets out the overarching strategy for the commissioning, design and delivery of services to people in Halton who are physically disabled (including those with sensory disabilities), their families and carers. . The document stands alongside and complements the Corporate Plan for the Council, the Health and Community Directorate's Business Plan 2006-09, the Adult Services Departmental Service Plan 2006-09, and annual Physical and Sensory Disability Team Plans.

The Disability Discrimination Act 1995 defines a disabled person as a person who '…. has a physical impairment which has a substantial and long-term adverse effect on his (her) ability to carry out normal day-to-day activities'.

The Strategy outlines the vision, aims and fundamental values and principles underpinning the design and delivery of services to physically disabled adults and identifies the local and national drivers and influences that impact on its delivery. It aims to begin a process that outlines the commissioning intentions about the type, volume, quality and price of services that will be purchased and the activity needed to deliver those services. It also initiates exploration of how current supply can be changed, innovation encouraged and redundant or inefficient services decommissioned.

The Strategy attempts to facilitate better business planning for current and prospective provider organisations. It aims to enhance and assure quality with regard to the provision of services to adults who are physically or sensory disabled and to demonstrate value for money.

The Strategy focuses on commissioning services to physically disabled adults aged 18 onwards whose needs are identified within the eligibility criteria for the service. The needs of younger physically disabled people entering transition into adult services are also considered.

THE COUNCIL'S VISION

'Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality; sustained by a thriving business community; and a safer, stronger and more attractive neighbourhood.'

The Council has five strategic priorities for the Borough which will help to build a better future for Halton:

- **A healthy Halton**
- **Halton's Urban Renewal**
- **Employment learning & skills in Halton**
- **Children & young people in Halton**
- **A safer Halton**

These underpin the key mission statement of the Directorate for Health and Community :

"To promote effective, affordable, quality services that are accessible, equitable, timely and responsive and to enable individuals and groups in Halton to make informed choices. "

HALTON'S VISION, VALUES AND PRINCIPLES

Vision for Physical and Sensory Disability Services

- To promote a social environment where people feel motivated and able to participate fully and constructively in the life of the local community and do not feel excluded.
- To enhance quality of life by supporting individuals and communities who experience marginalisation and exclusion.
- To promote the independence of physically disabled people in order that they can achieve their full potential through our commitment to the social model of disability.

The social model of disability emphasises the need to remove the barriers to access faced by disabled people and defines independence as 'the ability to control your own life'. Future commissioning will, therefore, aim to develop services which provide service users with more control. Central to this development is In Control / Individualised budgets which the Council is committed to establishing for all service users by 2009. This will offer individuals more choice on how they access support and promote independence.

In Control is an organisation whose role is to be the authoritative source of information and research on how self-directed support will best work: to provide a new operating system for social care. In Control's mission is to "change the organisation of social care in England so that people who need support can take more control of their own lives and fulfil their role as full citizens: The complete transformation of social care into a system of self directed support".

The six keys to citizenship
In Control identifies six different things which contribute to full citizenship:

1. Self-determination

We have self-determination when other people treat us as people who can speak for ourselves. If we have difficulty in speaking for ourselves then we can get help from other people to achieve self-determination.

2. Direction

We have direction when we know what we are doing, when we have a purpose or a plan for our lives. Although we can all get stuck or taken over by other people's ideas, there is a lot that can be done to help us get our own direction in life. Person Centred Planning tells us about how to get direction.

3. Money

We need money to be a citizen. Not just so we can buy what we need to live, but also so that we can control how we live and how others treat us. It is especially important for people to control the money that is used to pay for their own support services, as this will affect every part of life.

4. Home

We all need a home, a place that belongs to us and where we can belong. Much has been learnt about how we can all have a home, and disabled people are increasingly buying their own homes.

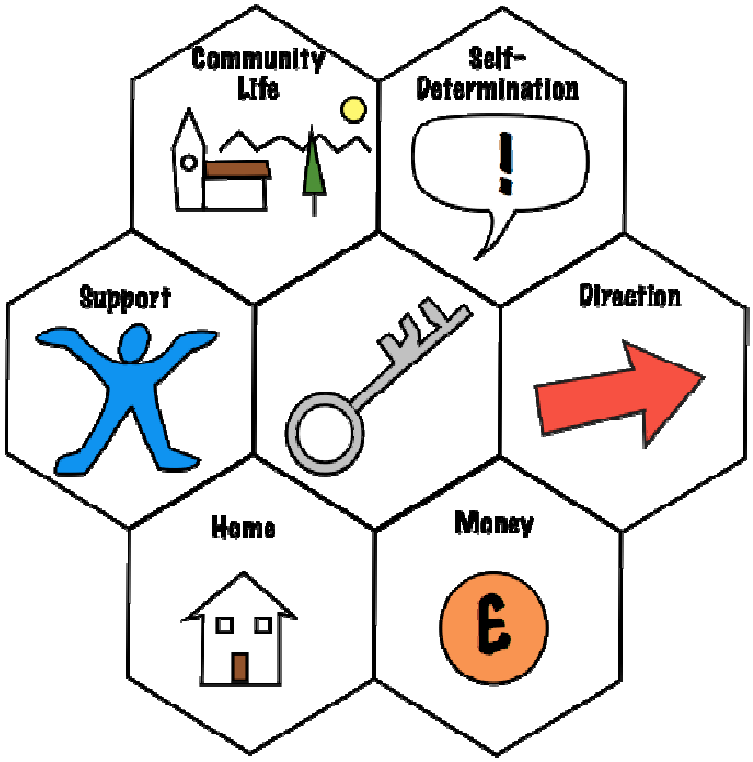
5. Support

We all need help, but if you have a significant physical disability this means that you will need ongoing and regular help. This does not mean you have to live a life controlled by other people. There are now many examples of people having support that is really helpful, flexible and individual.

6. Community Life

It is also very important that we play a part in our community. This means working, playing, learning or praying with our fellow citizens and making friends along the way.

Diagram 1: The 6 keys to Citizenship



(Source Keys to Citizenship by Simon Duffy 2006)

Halton's vision is one where physically disabled people and their carers have a voice and real influence. Friendships and relationships with families, friends, colleagues and neighbours are seen as essential to the vision.

Opportunities to develop relevant skills, to have opportunities to make choices, big and small, and to be supported in taking risks are seen as necessary conditions for self-confidence, a sense of personal identity and achievement in adult life.

Relationships, skills and self-confidence are themselves seen as far more likely through active support for integration and inclusion in work, education, employment, leisure and housing. Sharing places and activites with other non-disabled people is something that should start early on and be continued into old age.

Safety is also considered very important, as are supports for healthy lifestyles and the right to equitable access to the NHS and other community facilities and resources that can promote health.

Supporting and promoting the independence of disabled people is not just a health and social care responsibility but one for the whole community and there are opportunities to join up existing action plans and strategies in Halton within the Local Strategic Partnership (LSP) key priorities of social inclusion and quality of life.

Local Opinion and Aspirations

Through engaging with stakeholders who provide services to the physically disabled, including staff, and physically disabled people who use those services and their carers, we are aware that the society in which disabled people would want to live in 5 years time is one where they would be able to lead more independent lives.

To achieve this a wide change in public attitudes towards disability from one where disabled people are defined by their impairment, eg, arthritic, epileptic, (known as the medical model of disability) to one where there is an acceptance that society needs to make adjustments so that disabled people are able to take up the same opportunities and make the same choices as everyone else (the social model of disability) needs to be made.

People who use services have identified the most important issues for them as being:
- Action which will change attitudes towards disability.
- Promotion of independence.
- More inclusion.
- Support which enhances their dignity.
- Effective and flexible transport.
- Better access to all community facilities.
- More flexible access to rehabilitation services.
- Accessible and useful information, advice and support.
- Supported representation at all levels of decision making.
- More IT enabled choice and control of their care packages.
- Faster provision of equipment and adaptations.

Much of the above is reflected in the social model of disability, which looks at the way in which the lives of disabled people are affected by the barriers that society imposes. It understands that people are not disabled but are disabled by their environment, so pavements without ramps are disabling not the fact that someone uses a wheelchair.

Values

All agencies involved in the provision of services to physically disabled people should share the following set of common values:

- Promote independence and self-determination for physically disabled people and their carers.

- Have respect for physically disabled adults regardless of their gender, race, religion, disability and/or sexual orientation.

- Promote and practice the understanding that people with disabilities have the right to live as a valued and equal member of the community while being shown respect and afforded privacy.

- Afford people with disabilities the right to exercise informed choice about the way they live their lives and in the take-up of services.

- Afford people with disabilities the right to have their views listened to in the planning and provision of services.

Principles
The following principles should apply in implementing this Strategy:

- The Commissioning Strategy should reflect and be integrated with Community Planning, the NHS Plan (and Local Delivery Plans), the NHS Modernisation process and other planning processes.

- Partnership working should be facilitated and developed.

- Stakeholders should be open, honest and consistent.

- All processes and information should be clear, understandable by all stakeholders and jargon free.

- Best Value requirements should be applied across all sectors, ensuring that the money invested results in the best possible service for service users.

- Planning decisions should be evidence based wherever possible.

- Clinical governance arrangements should be in place to ensure staff are appropriately skilled and maintain competence in their roles.

- All planning decisions and service developments should be sustainable, improving the quality of life of people in Halton without jeopardising that of future generations.

THE NATIONAL CONTEXT

Many national Government policies are influencing local policy and the development, improvement and commissioning of services for disabled people, the main drivers of which are:

The National Service Framework for Long Term Conditions (DH March 2005)

This NSF was developed in consultation with people with long-term neurological conditions in order to raise standards of treatment, care and support across health and social care services. It does this by providing 11 Quality Requirements to be used by health and social care professionals. Whilst the NSF is mainly for people with long-term neurological conditions many aspects of the Quality Requirments apply to people with other long-term conditions. Health and Social Services in Halton will be expected to deliver each of the Quality Requirements over the next 10 years. The NSF does not prescribe how these requirements should be implemented but outlines the early steps we need to take to ensure that we are able to deliver them.

Neurological conditions are caused by damage to the brain, spinal cord and other parts of the nervous system. Approximately 10 million people across the UK have a neurological condition. They account for 20% of acute hospital admissions and are the third most common reason for seeing a GP. There are many such conditions which affect people's daily lives in different ways and to different degrees. Some are relatively common (e.g. mulitple sclerosis), others are rare (e.g. motor neurone disease). Neurological conditions affect people of all ages, but this NSF concentrates on services for adults.

White Paper: Our Health, our care, our say: a new direction for Community Services (January 2006)

The White Paper signals the next stage in implementing the NHS Plan and describes a vision and set of proposals with the intention of developing modern and convenient health and social care services. The 2 consultations, which led to publication of this document, are the Green Paper 'Independence, Well-Being and Choice' and the listening exercise ' Your Health, Your Care, Your Say'.

The key strategic shift contained in the White Paper is to locate services in local communities closer to people's homes and to improve the health and well being of the population. A range of initiatives and proposals, which can be summarised as follows, will achieve these strategic objectives:

- Improve access to community services, especially in poorer areas.
- Improve preventative services and earlier intervention.
- Improve care for those with long-term conditions and more support for their carers.
- Shift care out of acute hospitals to where people live.

The key drivers for change to achieve these will be Payment by Results and Practice Based Commissioning. Improvements will be dependent on increased partnership working across health and social care. To support this policy initiative the Adult Social Care Outcome Framework has been developed.

Adult Social Care Outcome Framework

The following broad outcomes are set out in the above framework:

- **Improved Health**
  Enjoying good physical and mental health (including protection from abuse and exploitation). Access to appropriate treatment and support in managing long term conditions independently. There are opportunities for physical activity.

  Services promote and facilitate the health and emotional well being of people who use the services

- **Improved Quality of Life**
  Access to leisure, social activities and life-long learning, and to universal public and commercial services. Security at home and confidence in safety outside the home.

  Services promote independence and support people to live a fulfilled life making the most of their capacity and potential

- **Making a Positive Contribution**
  Maintaining involvement in local activities and being involved in policy development and decision-making.

  Councils ensure that people who use their services are encouraged to participate fully in their community and that their contribution is valued equally with other people

- **Exercise Choice and Control**
  Through maximum independence and access to information. Being able to choose and control services and helped to manage risk in personal life.

  People, who use services, and their carers, have access to choice and control of good quality services and helped to manage risk in personal life

- **Freedom from Discrimination and Harassment**
  Equality of access to services for all who need them.

  Those who need social care have equal access to services without hindrance from discrimination or prejudice; people feel safe and are safeguarded from harm

- **Economic Well Being**
  Access to income and resources sufficient for a good diet, accommodation and participation in family and community life.

  People are not disadvantaged financially and have access to economic opportunity and appropriate resources to achieve this

- **Personal Dignity and Respect**
  Not being subject to abuse. Keeping clean and comfortable. Enjoying a clean and orderly environment. There is a availability of appropriate personal care.

  Adult Social Care provides confidential and secure services, which respects the individual and preserves people's dignity.

In addition there are two further 'management' measures, as follows:

- **Leadership**
  A council with Adult Social Services responsibility (CASSR) will provide a key professional role for staff working in Adult Social Services. They will also have a key role in assuring accountability of services to local communities through consultation with local people and in particular people who use services.

- **Commissioning and Use of Resources**
  Adult Social Care Leaders commission and deliver services to clear standards of both quality and cost, by the most effective, economic and efficient means available and so demonstrate value for money.

These outcome statements are broad overall objectives and the task for commissioners is to translate them into desirable outcomes for individual service users, and achievable (and measurable) goals for service providers.

Government Strategy 'Improving the Life Chances of Disabled People'

This Strategy looks to transform the life chances of disabled people. It states that by 2025, disabled people should have full opportunities and choices to improve their quality of life and be respected and included as full members of society. It makes recommendations in 4 key areas:

1. Independent Living
2. Early Years and Family Support
3. Transition to Adulthood
4. Employment

Disability Discrimination Act 1995 and 2005

The new Disability Discrimination Act 2005, an update of the 1995 Act, requires all public authorities to produce and have in place a Disability Equality Scheme by December 2006. Halton Borough Council therefore needs to ensure that it is compliant with the requirements of both the Act and Scheme and that necessary actions have been identified and steps taken to implement them.

Progress in Sight

Progress in Sight, published in October 2002, outlined 16 National Standards of social care for visually impaired adults. Local Authorities self assessed against these Standards in the form of a survey conducted in 2003 by the Association of Directors of Social Services Sensory Sub-Committee. (Halton's results are summarised in Section 5 Performance and Finance).

Supporting People

The Supporting People programme, implemented in April 2003, changed the funding arrangements for housing related support services with the arrangements for funding these services transferring to Local Authorities. The funding available for housing services is now cash limited, but the Programme gives the opportunity for Authorities to integrate their strategies and funding for housing support needs with wider local strategies, especially health, social care and neighbourhood renewal.

The aims of Supporting People include enabling people to live at home independently and being part of preventative strategies, giving early help to avoid the need for crisis or acute care.

Local government efficiency agenda (Gershon)

The aim of the local government efficiency agenda is a simple one. It is to ensure that the resources available to local government are used in the optimum way to deliver better public services according to local priorities.

In August 2003, Sir Peter Gershon undertook a review of public sector efficiency focussing on the Government's key objective to release resources to fund the front line services that meet the public's highest priorities by improving the efficiency of service delivery. The subsequent report required local government to achieve efficiency savings of 2.5% per annum to 2007/08.

In June 2004 the Care Services Efficiency Delivery Programme (CSED) was established to support the implementation of the Gershon report recommendations in the NHS and social care services. They are currently working with a number of pilot sites in the North West but have made contact with a number of authorities, including Halton, who are interested in sharing the learning from these pilots. Efficiency measures being looked at include 'reducing the amount of contact points within a council, removing work that does not add value, making processes simpler, eliminating duplication and transferring work to administrative teams to free up capacity for professional staff.'

THE LOCAL CONTEXT

The key issues arising from the national context such as modernisation, integration, joint working, partnerships, social inclusion, designing services around the service user and actively involving physically disabled people, their families and carers feature significantly in local planning and developments.

Government thinking and the Commissioning Strategy focus on joining up services across departments and health services to more effectively support people independently at home in communities. There is greater emphasis on prevention of ill-health, providing choice and well-being, as well as supporting carers. The future of a number of services lies in working collaboratively to support the provision of health care, general social care services and statutory personal care to vulnerable people. Two services are particularly well placed to respond to this agenda - intermediate care - such as Rapid Access Rehabilitation Services and

Joint Equipment. The roll-out of Single Assessment Process across Health and Social Care is also supporting integration at the front line. There will be some reduced costs and improved efficiency (less duplication) from such integration. There are also a number of future challenges around contributing to the wider government agenda for preventative services, developing and sustain the capacity for independent living and helping to address social exclusion amongst disabled people. Service changes around new assistive technology and supporting people will support this.

Physical and Sensory Disability services have a major role in delivering the Borough's priorities. Local Futures links include:

- Health – Social care for older people and adults supports the culture change to prevention and community-based services.
- Employment – Social care is one of the fastest growing sectors of employment both locally and regionally. Disabled adults are often excluded from employment and improving employment in this area reduces peoples care needs.
- Crime and disorder – Adult protection is a key statutory responsibility and links to preventing bogus callers through to financial, physical and sexual abuse. Fear of crime is a key issue and wardens and community alarms, key safes and risk assessments all support this agenda.
- Increasing wealth and equality though maximising benefits, improved targeting of resources to those most in need and access to transport.

A multi-agency Physical and Sensory Disabilities Local Implementation Team (LIT) has been established in Halton whose primary role is to discuss proposals and agree plans for an integrated network of co-ordinated services for physically disabled adults. The LIT acts as a meeting point for representatives from a wide range of stakeholders and provides a shared forum for making recommendations to the Halton Health Partnership on the strategic direction of physical and sensory disability services from a 'whole service' perspective.

A pooled budget made up of monies from Halton PCT and the Borough Council has been established for the running of Halton's Home Equipment Store, which administers, stores and dispenses equipment to assist independent living. The Store is operationally managed by Halton PCT and a Multi-Agency Advisory Board (MAAB) with representation from both organisations has overall responsibility for the management of the Store.

WHAT IS COMMISSIONING?

Commissioning is about enhancing the quality of life of service users and their carers by:

- Having the vision and commitment to improve services
- Connecting with the needs and aspirations of users and carers
- Understanding demand and supply
- Linking financial planning and service planning
- Making relationships and working in partnership

Commissioning should be based on:

- A common set of values that respect and encompass the full diversity of individual differences
- An understanding of the needs and preferences of present and potential future service users and their carers
- A comprehensive mapping of existing services
- A vision of how local needs may be better met
- A strategic framework for procuring all services within politically determined guidelines

- A bringing together of all relevant data on finance, activity and outcomes.
- A continuous cycle of planning services, commissioning services, contracting services and revising or reviewing those services.

Definitions

Commissioning, procurement (or purchasing) and contracting are not the same activity despite the terms being used interchangeably.

Commissioning

The Audit Commission describes commissioning as **'the process of specifying, securing and monitoring services to meet individual needs both in the short and long term'**. Commissioning adopts a strategic approach to shaping the market for care to meet future needs.

Procurement

Procurement is the **'process of securing services and products which best meet the needs of users and the local community for the time the specific need exists'**. Halton Borough Council has a Procurement Strategy 2006-09 which aims to set a clear framework for procurement throughout the Authority. The Strategy reflects the Council's Corporate Plan, the Borough's Community Strategy, provides a framework for best value and stands alongside the Council's Constitution, including the Contract and Financial Standing Orders. It also sets out an action plan for achieving the corporate approach to procurement and includes the expectation that the procurement of services will be based on 3 principles:

- Purchasing a service via a contract to meet the current need.
- Maintaining effective and up to date procurement procedures.
- Ensuring that procurement meets the Borough's key Corporate Objectives.

Contracting

If commissioning is seen as providing strategic direction, then contracting can be defined as **'the management of the legal agreements between the Local Authority and service provider agencies which lay down the standards of the service, costs and monitoring arrangements. As such it provides a quality assurance service to the Local Authority'.**

Integrated Commissioning

Integrated commissioning is the ultimate aim of this Strategy and works at both a strategic and individual level.

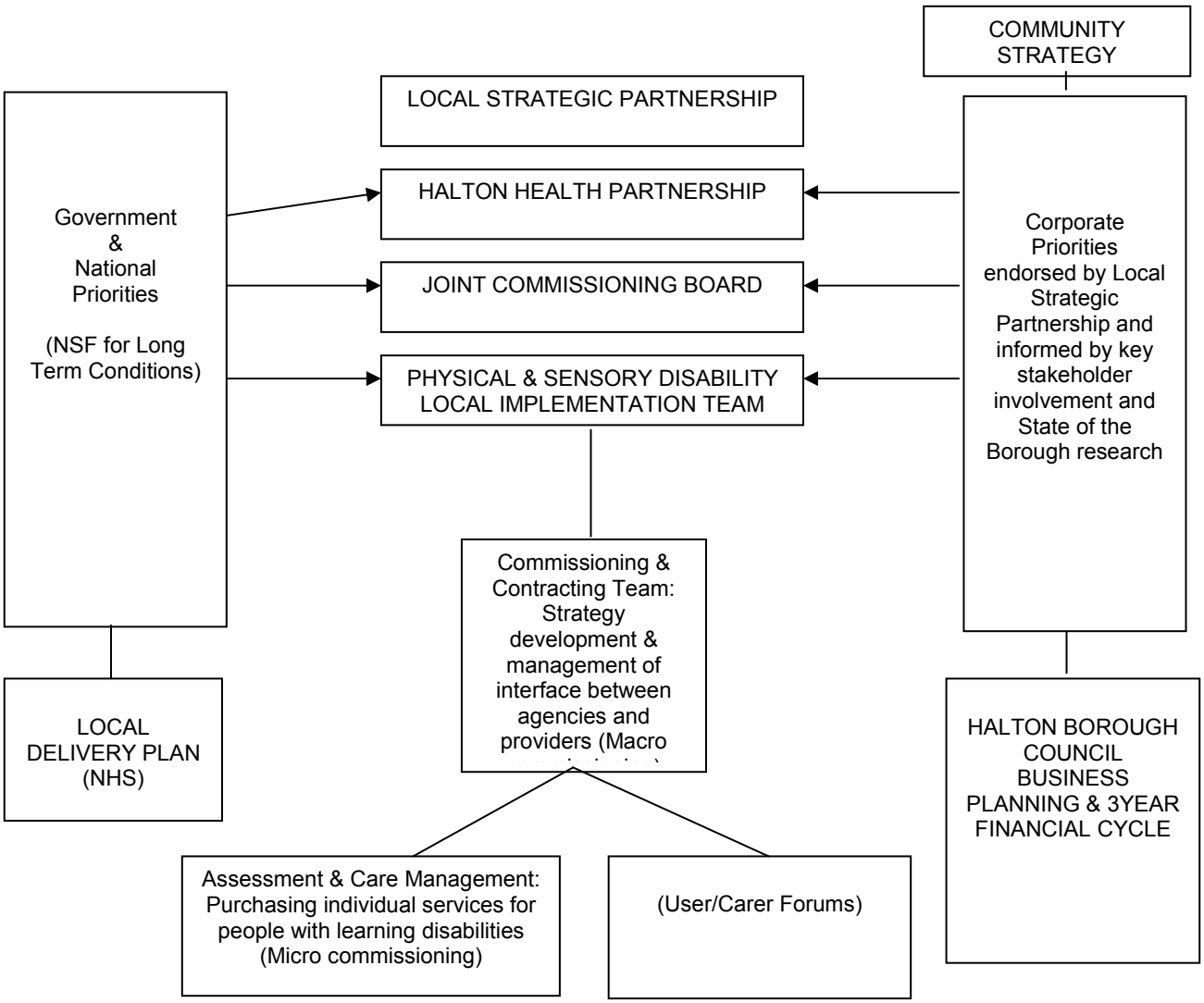
Integrated strategic **(macro)** commissioning integrates the components of the commissioning process within 4 main functions:

- Information gathering (needs analysis and mapping of resources).
- Establishing policy and strategy for the investment and dis-investment of services.
- Developing good practice in service delivery.
- Research and evaluation.

Care management **(micro)** commissioning involves:

- Identifying needs and priorities for the individual.
- Design of care package.
- Developing support arrangements.
- Monitoring and reviewing.

Diagram 2: How do we apply commissioning locally?



This diagram highlights planning processes and links between strategy (macro) and individual (micro) commissioning carried out by Social Workers, Community Care Workers and Occupational Therapists when they purchase care for individuals according to assessed need.

This Commissioning Strategy will not replace or duplicate existing strategic planning and development structures and should be perceived as an overarching framework that facilitates further work and development. It is envisaged that this Strategy will be a working document that will evolve and respond to change.

The Health Clinical Executive Board (CEB) and Local Delivery Plan (LDP)

It will be important that the commissioning agenda for physical and sensory disability services can be taken through the statutory framework within Health. Key areas of work will be presented through the Clinical Executive Board (CEB).
It will also be essential that issues for physical and sensory disability services influence the Local Delivery Plan (LDP), which provides the focus for much of the Health Authority's work over the coming years. In essence, the LDP is a local plan of action which aims to improve health and modernise health services. Tackling the priorities identified in the LDP will require services to be planned in a co-ordinated way with collaboration between NHS agencies, social care services and partner organisations.

THE 5 LEVELS OF CARE

A whole systems approach to integrated commissioning has been adopted based on Peter Fletcher Associates 5 Levels of Care, illustrated in the diagrams below. At the strategic level work will include setting the vision and direction for service development by senior officers. At service level the vision and strategy are translated into action, both in terms of commissioning and providing. In terms of service level commissioning, it will be necessary to ensure that services are clearly specified with service providers and that they are regularly monitored. Providers of services will be performance managed by service level commissioners.

Diagram 3: Planning and Commissioning

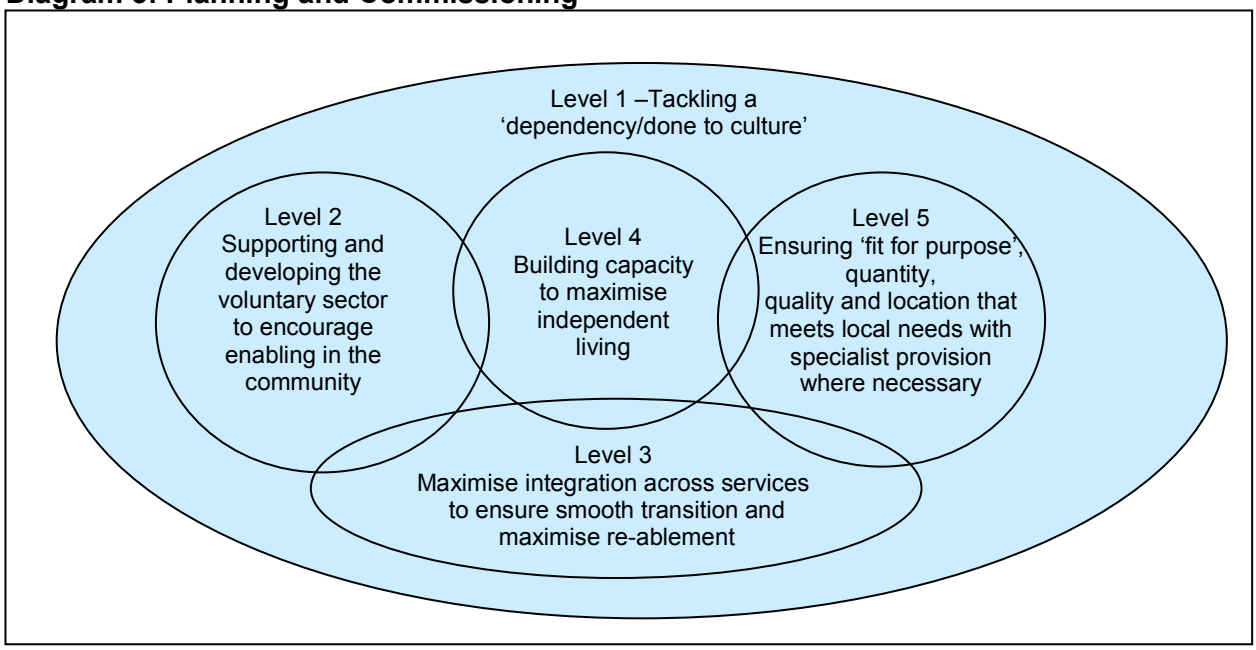


Diagram 4: Building on Levels of Care

Halton has a historical legacy of investment in acute and reactive services. However, it is clearly better to prevent than to treat. In order to understand this, a model examining the local balance was developed, which is laid out below in Diagram 3.

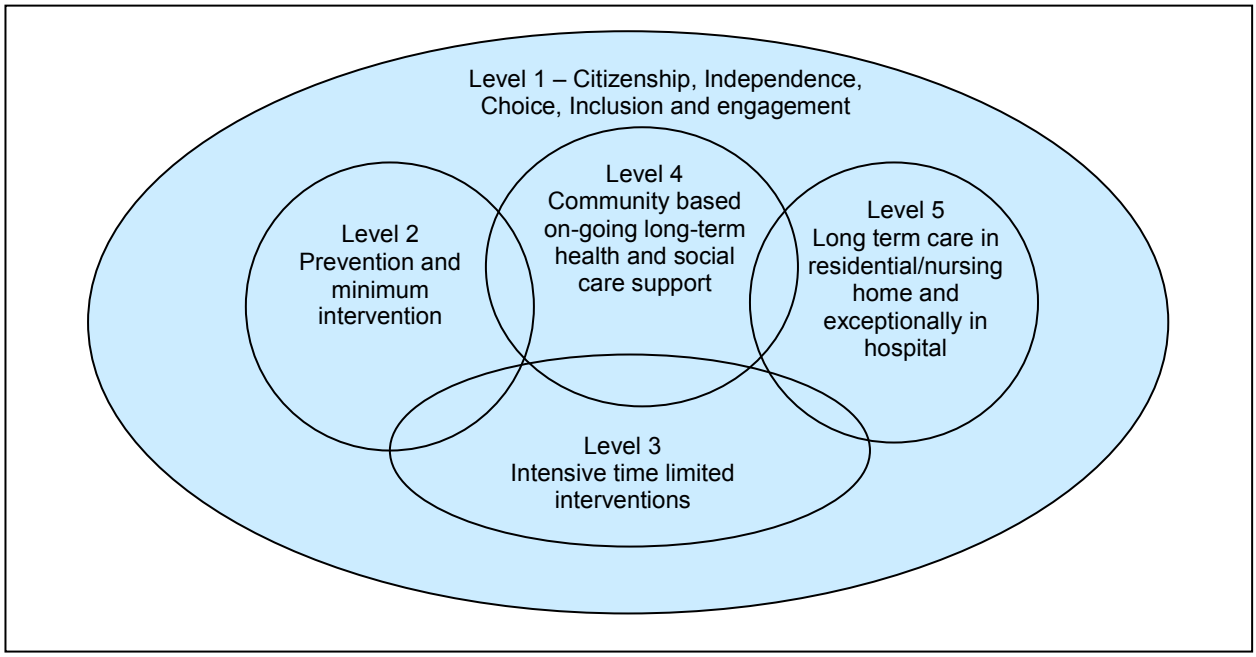
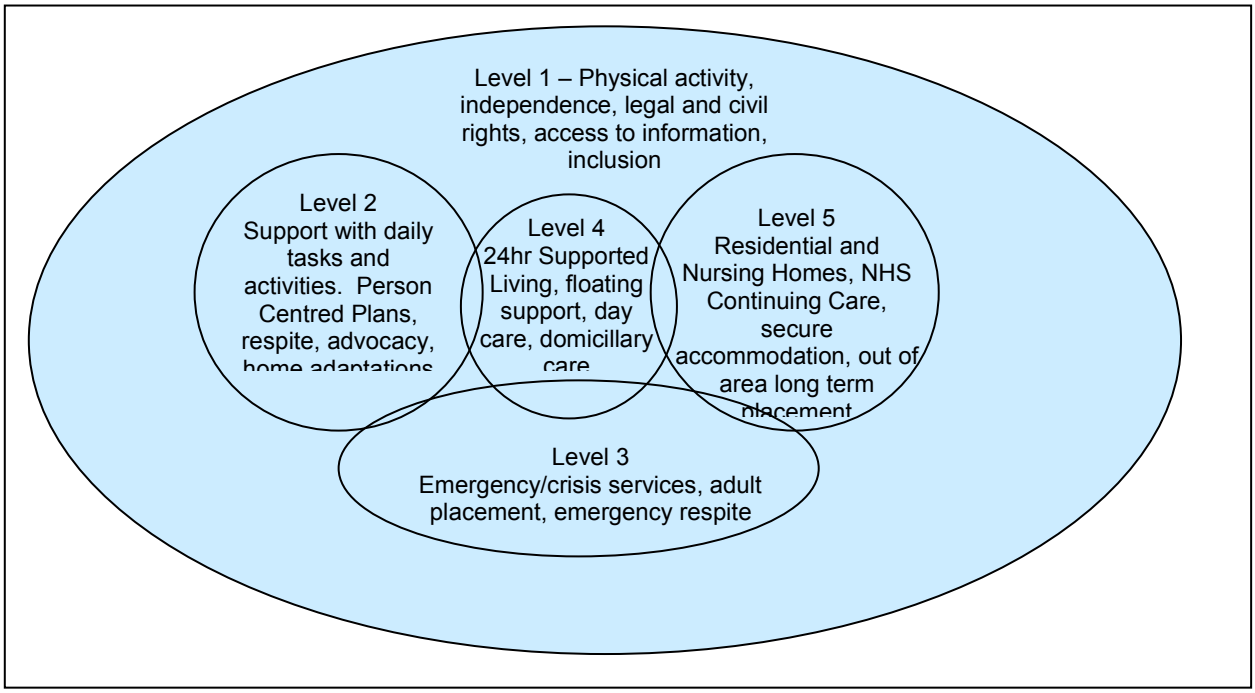


Diagram 5: Levels of Care - Activities

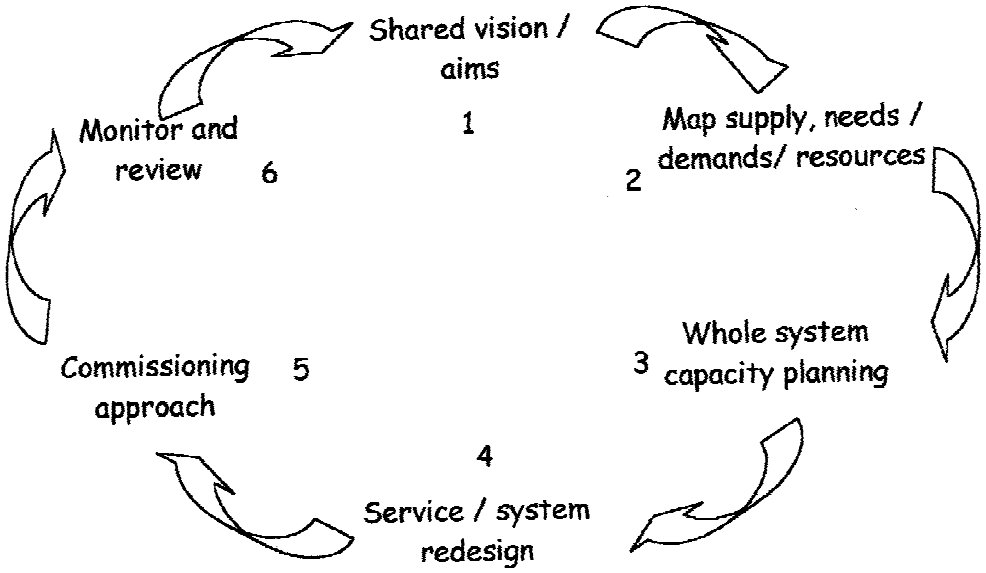
Diagram 5 below gives some examples of activities associated with each level and begins to explain how each section of the Local Authority and health can play their parts in providing services for people with physical disabilities which are effective and which truly reflect need.



Elements of the Strategic Approach

Partnerships across health and social care commissioners and providers and with people who receive services have become increasingly important in effecting integrated planning and commissioning of services. The Section 31 partnership arrangements in the Health Act 1999 are intended to give services the flexibility to be able to respond to people's needs, either by integrating existing services or developing new co-ordinated services, and to work in partnership with other organisations to fulfil this. Crucial to this is a shared vision and aims which give guidance and direction.

Diagram 6: Whole System Partnership



Whole System Partnership

QUALITY

Service user perception is fundamental to the provision of quality services and this is directly linked to their expectations of services. Research shows that if a service user expects poor quality from an organisation and the service is higher than their expectations, then this service will be viewed as 'good'. Conversely, high expectations of a service which does not match the expectations is viewed as 'poor.' Managers should try and achieve a balance by continually striving to increase the expectations of their service users whilst at the same time continually improving performance.

To achieve continuous improvement in services there is a need to:

- Ensure physically disabled people and their carers are encouraged to have high expectations of services and are enabled to have a part in raising the standards of services.

- Ensure that feedback about services is continuously collected to allow adjustments to service design and delivery when necessary.

- Ensure people understand their right to comment or complain about a service (or lack of a service) and for those comments to be demonstrably listened to by the organisation and its representatives.

Quality needs to be 'built in' rather than 'inspected' and is the responsibility of all individuals, teams and departments. To achieve this, people must be involved in all aspects of the process and most importantly of all this includes the people who will receive the service.

CONCLUSION: SECTION ONE

There is a need to ensure that managers are able to make decisions informed by accurate timely data, which will increase the pro-activity of management action for physically disabled people living in Halton.

However good the quantitative data, qualitative data is also very important to ensure that quality services are developed and maintained. There is a need, therefore, to ensure that wherever practical people with physical disabilities, their families and carers, should be involved in planning processes.

The planning of services and service delivery should be completed by taking a 'whole systems' approach to ensure the most efficient and effective use of resources. The end product should provide a seamless service to the person with a physical or sensory disability, which also ensures 'quality of life' for the individual. Quality of life includes listening and acting on the wishes and aspirations of the individual.

To achieve the above there needs to be a clear understanding of partnership working and commissioning should be jointly agreed and developed to ensure a solid financial basis for the commissioning of services, with effective quality control and monitoring systems in place.

Peter Fletcher's 5 Levels of Care give a framework in which to identify actions that are required for investing in the modernisation of services to ensure that the expressed wish of people with physical disabilities can be supported.

SECTION TWO: NEEDS ANALYSIS

INTRODUCTION

The issues identified nationally as creating barriers which prevent physically disabled people of working age from leading the life of their choice include information provision, transport, housing, the physical and built environment, access to healthcare and personal assistance, low income, social attitudes to disability, and psychological barriers such as low self esteem.

DEMOGRAPHY

It is not easy to estimate overall numbers in any given population, not least because the age bands used by the 2001 Census do not fit neatly with the 18-64 age group covered by this strategy.

The 2001 Census gives an estimate of 9.76% of people in Halton aged 16-74 who are permanently sick or disabled (8355), nearly as high as the Merseyside average and nearly twice as high as the England average (5.52%). Reducing the number by subtracting 9.76% of the 65-74 age group (900) gives a figure of 7345. Further reduction of the 16/18 age group would probably give an estimate of around **7,000** people aged 18-64 who are permanently sick and disabled. The usefulness of such a figure is that of a range finder, and it is difficult to be more precise. A potentially more accurate estimate is given in the **Housing Needs Survey** which suggests that 5031 people aged 16-64 have a level of physical and/or sensory disability serious enough to be reported. The best estimate is, therefore, that between 5,000 and 7,000 people aged 18-64 in Halton have a significant level of physical and sensory disability.

The population projections for the age groups in question for the years 2006-2011 are as follows (the figures being in thousands).

Table 1 : Halton's Population change ages 18-64

Age	2006	2011	Change
15-19	8.5	7.6	-0.9
20-24	7.9	7.8	-0.1
25-29	7.0	7.9	+0.9
30-34	7.6	7.0	-0.6
35-39	8.7	7.5	-1.2
40-44	9.0	8.6	-0.4
45-49	8.5	8.9	+0.4
50-54	8.2	8.4	+0.2
55-59	8.6	7.8	-0.8
60-64	6.1	8.0	+1.9
Total	80.1	79.5	-0.6

Source: ONS Sub-national population projections.

The population trend is relatively stable (with some reductions) with the only notable increases being the 25-29 age group (+900) and the 60-64 age group (+1,900). Both of these increases may have significance especially the 60-64 age group which contributes to 29% of the current client group (see paragraph on **Age** in Housing Issues Paper in Appendix 2).

It is difficult to gain an accurate breakdown of age range within the current services, other than the considerable number of older people (aged 65+) across all provision (see section on Current Services for more details of this). What can be said from an analysis of the age ranges of clients who have undergone a comprehensive assessment with the PSD team in 2005-06 is that the weighting, towards the 50-64 age spectrum, is confirmed. The figures for the different age ranges undergoing an assessment in 2005-6 were as follows:

Total number (duplicate assessments excluded)	171
Age 18-30	5
31-50	39
51-64	49
65+	78

There were therefore 93 (or 55%) assessments of people aged 18-64.

Within this total of 93, in the 51-64 age group, 40 of the 49 were aged 55+, or 43% of the 18-64 age group who were assessed.

There are several different sources of numbers that need to be commented upon and understood. The first is based on the Carefisrt system.

Table 2: Numbers of people in receipt of a service (all figures as at 01.04.2006)

Number of people provided with a service by the Health and Community Directorate	474
Number of people on system with primary client group of physical disability, sensory disability and frailty	4,920
Number of people in receipt of a service from the Independent Living Team	1,082
Current service packages open to ILT	1,151

It is assumed that all these numbers include a proportion of older people. The numbers of clients' aged 18-64 who are PSD clients is 355 The total number of people with a physical or sensory disability, by residency, is recorded as 394.

Housing needs and market assessment survey 2005
This report, carried out independently, is based on extensive surveys and questionnaires, but again the age range is different (16-59). As stated, the estimated number of people in that age group with a physical and/or sensory disability was 5031. Of these, 2679 people said they required support, and that support was provided as follows:
88% from family/neighbours/friends
8% from social services/voluntary sector
4% from both

This would give a number, supported by social services or the voluntary sector, of 321 people (in line with the figures provided by Halton Borough Council).

The range of estimates suggests between 320 and 400 adults aged 18-64 as active service recipients at any one time. However, this figure does not accurately reflect the high workload within both the PSD team and the ILT (see section 5 for details).

Table 3: Halton's Resident Population who are of black or other minority ethnic (BME) origin

Grouping	Total Numbers and % of overall population
White British	115,959 (98.9%)
Irish	824 (0.7%)
Mixed (white & Black Caribbean, Black African, Asian)	705 (0.5%)
Asian or British Asian	273 (0.2%)
Black or Black British	132 (0.1%)
Chinese or other ethnic group	315 (0.2%)

(Figures in brackets are % of the total population.) Source: Census 2001

A total of 1.21% or 2249 people of the total population in Halton are of BME origin. The wards with the highest populations (all ages) of people of BME origins are Birchfield and Mersey wards.

Views of People from Black and Minority Ethnic Groups

People from BME communities have the same main priorities as all other people. However there are also specific issues that arise generally when people are consulted:

- Poor knowledge of and access to services by some BME groups
- Specific issues around particular services relating to the appropriateness of accommodation to support people's independence
- Mainstream services could do more to be culturally sensitive to specific BME groups
- Some additional services are needed specifically for particular BME groups e.g. interpreting
- Differing perceptions amongst different BME groups about their health and well being
- BME groups feel that their cultural and religious needs are not identified or assessed and as a result their needs are not met.

The small numbers of black and ethnic minority people in Halton means there are no large groups for which services can be targeted. The focus therefore needs to be on strong individual assessments, creative packages of care that can meet specific individual identity and heritage needs and on developing services that acknowledge and value diversity.

There are no community groups within the borough for people of any BME origin and the implications of this suggest that service design for residents of BME origin in Halton may need to be centred on individuals. Additionally, community groups have traditionally been the first method of making contact and consulting with any BME population. This avenue is clearly not available to staff in Halton so other imaginative ways will need to be found to engage with parts of the community. This emphasises the importance of diversity training for staff in all agencies and the close monitoring of practice. It will be important to ensure that staff have an understanding of and are sensitive to issues of culture and communication which they demonstrate through their day to day practice as key aspects of any needs led assessment for someone of BME origin.

A research study into the current and future needs of Halton's BME community in respect of adults social care is currently being undertaken. The findings of this study will identify any service development required to ensure that current and future service provision is tailored to meet the needs of this community.

ECONOMIC FACTORS

Deprivation and Health

Halton is ranked as the 21st most deprived Local Authority area out of 354 Local Authorities in England according to the 2004 Index of Multiple Deprivation. Halton has well documented poor health statistics, having amongst other health issues one of the highest standardised mortality ratios in England.

Rates of permanent sickness and disability amongst the 16-74 age group are also high in Halton at 9.76%, against an England Wales average of 5.5% (the averages for the North West and Merseyside being 7.75% and 10.02% respectively).

According to the 2001 Census 11.6% of Halton's population (13,770 people) reported their health as 'not good'. This ranks Halton as being in the lowest quartile of boroughs in England and Wales.

The percentage of Halton's population with a limiting long-term illness (eg chronic health disease, stroke, dementia, depression, diabetes, cancer, arthritis) is 21.5% (25,440 people), higher than the England and Wales average of 18.2% and the North West average of 20.7%. In the last quarter of 2005, 11,000 people of working age were claiming benefit as a result of sickness and disability. The total working age population is 75,500, so the number of sickness related benefit equates to 16% of the working age population.

Health Factors

The **Halton Health Study** (Lancaster University 2002) is particularly relevant in painting the picture of health in Halton, and investigated the causes of high death rates and illness rates reported in Halton. At 23%, Halton has the fourth highest standardised mortality rate in the country. The study confirmed that death rates in 1998-2000 were especially high for cancers, heart disease, stroke, suicide and infant mortality.

A key finding of the study was that health in Halton was primarily affected by material deprivation and unhealthy lifestyle. The report also showed that social capital and community issues, especially the lack of someone to confide in, have a significant impact on all health outcomes including limiting long term illness. Most important were the levels of reciprocal help and support among members of the community and maintaining a sense of control or ability to influence their surroundings.

The implication is that solutions to the high rates of ill health in Halton are a community wide responsibility and not restricted to support in the traditional domains of health and social care. Having a strong sense of social capital could be harnessed to further improve health through community-based projects and, therefore, policy initiatives should continue to concentrate on material deprivation and unhealthy lifestyles. Reducing unemployment, raising income levels, improving housing, increasing educational attainment, reducing smoking, improving diet and increasing exercise should all have positive impacts on the health of the people of Halton and thus reduce limiting long term illness.

PSD managers, meeting at a workshop in November 2006, confirmed many of the issues raised above. A picture was painted of an isolated and dependent population amongst PSD clientele, often without the confidence to take control. This led to a need amongst PSD service personnel to support individuals for far longer than technically necessary, because of problems relating to a culture of dependency and a lack of accessible community resource. Hence the managers made the point about corporate responsibility particularly in respect of accessible

housing, accessible public buildings, and transport. In addition they made the point about the lack of capacity to support PSD clients psychologically, as well as physically.

Employment

The Borough has a high unemployment rate especially amongst young people, which at 4% is higher than the national average of 2.6%. Of Halton's population, 21.5% have a limiting long-term illness, compared to the England and Wales Average of 18.2% (see Table 9).

The probabilities of disability are highest among those who are permanently unable to work or retired, who have no qualifications, are in a manual social class, live in social housing or are renting privately. A national survey conducted in 2001 by the Joint Health Surveys Unit of the National Centre for Social Research and the Department of Epidemiology at the University College London, estimated that the risk of having one or more disabilities was 24% higher for those in manual classes than for those in non-manual classes.

RATES OF DISABILITY

It is estimated that there are about 11 million disabled adults in the UK – one in five of the total adult population – and 770,000 disabled children (Source: Improving the Life Chances of Disabled People, Jan 2005). Many of these people would not define themselves as disabled. The majority of these people experience low level impairments – wheelchair users, blind people and deaf people make up an important minority. The population of disabled people is distinct from and much larger than the 3 million in receipt of disability related benefits.

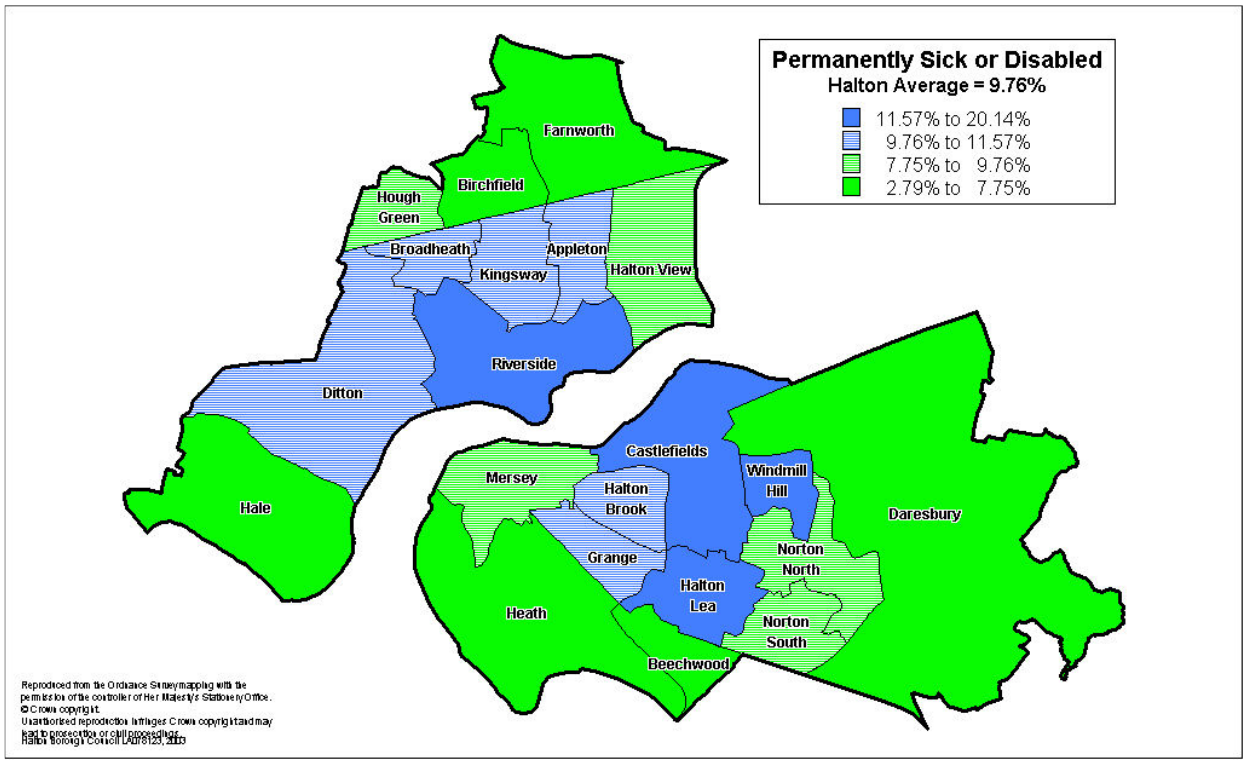
Table 4: Permanently Sick or Disabled People in Halton

Wards	Number of Permanently Sick or Disabled	Percentage of People Aged 16-74	Halton Rank	Greater Merseyside Rank
Appleton	482	10.70	7	65
Beechwood	168	5.24	19	130
Birchfield	90	2.79	21	138
Broadheath	499	10.49	8	68
Castlefields	751	15.53	2	16
Daresbury	95	3.29	20	137
Ditton	472	10.17	9	72
Farnworth	287	6.61	17	112
Grange	541	11.15	6	55
Hale	91	6.09	18	121
Halton Brook	543	11.57	5	53
Halton Lea	658	14.81	3	23
Halton View	475	9.47	13	85
Heath	272	6.64	16	110
Hough Green	479	9.37	14	86
Kingsway	426	9.90	10	75
Mersey	414	9.57	12	82
Norton North	375	7.75	15	99
Norton South	492	9.63	11	80
Riverside	408	12.39	4	42
Windmill Hill	337	20.13	1	2
Total	**8,355**	**9.76**	**21 Wards**	**138 Wards**

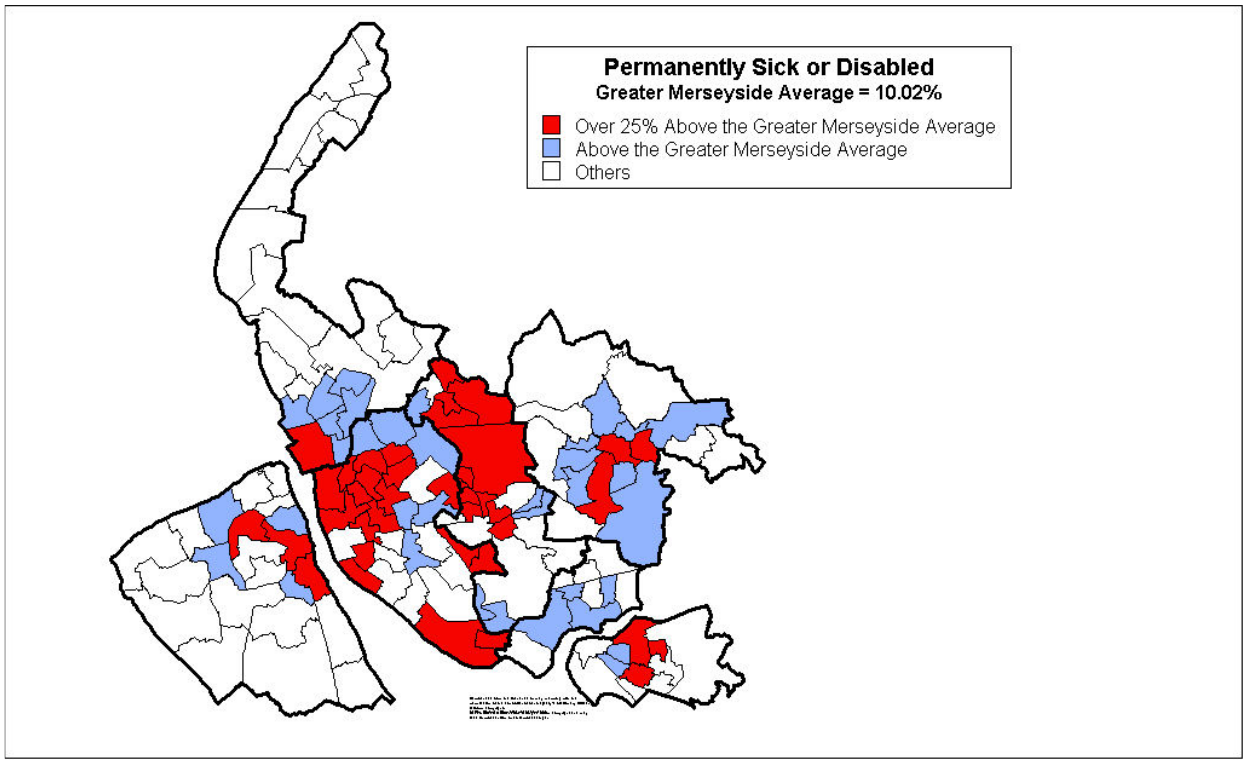
Greater Merseyside Average	***10.02***
North West Average	***7.75***
England Average	***5.52***

Locally, what is known from the 2001 Census is that the rates of people aged between 16-74 living in Halton who are permanently sick or disabled reflect the overall trend of rates being higher in the Northwest than the national average. The Northwest Average is 7.7%, the England and Wales Average is 5.5% and Halton's figure is 9.7%. Windmill Hill has the highest proportion of permanently sick or disabled people in Halton (20.1%) followed by Castlefields (15.5%) and then Riverside (12.4%). The lowest proportion are found in Birchfield (2.8%) and Daresbury (3.3%).

Map 1 - Number of People Permanently Sick or Disabled in Halton



Map 2 - Wards over 25% above the Greater Merseyside Average



CARERS

Carers and carers' needs are the subject of a separate strategy 'The Carers Strategy 2006-2008', therefore, their needs will only be referred to here as they link to the overall strategy for physically disabled people.

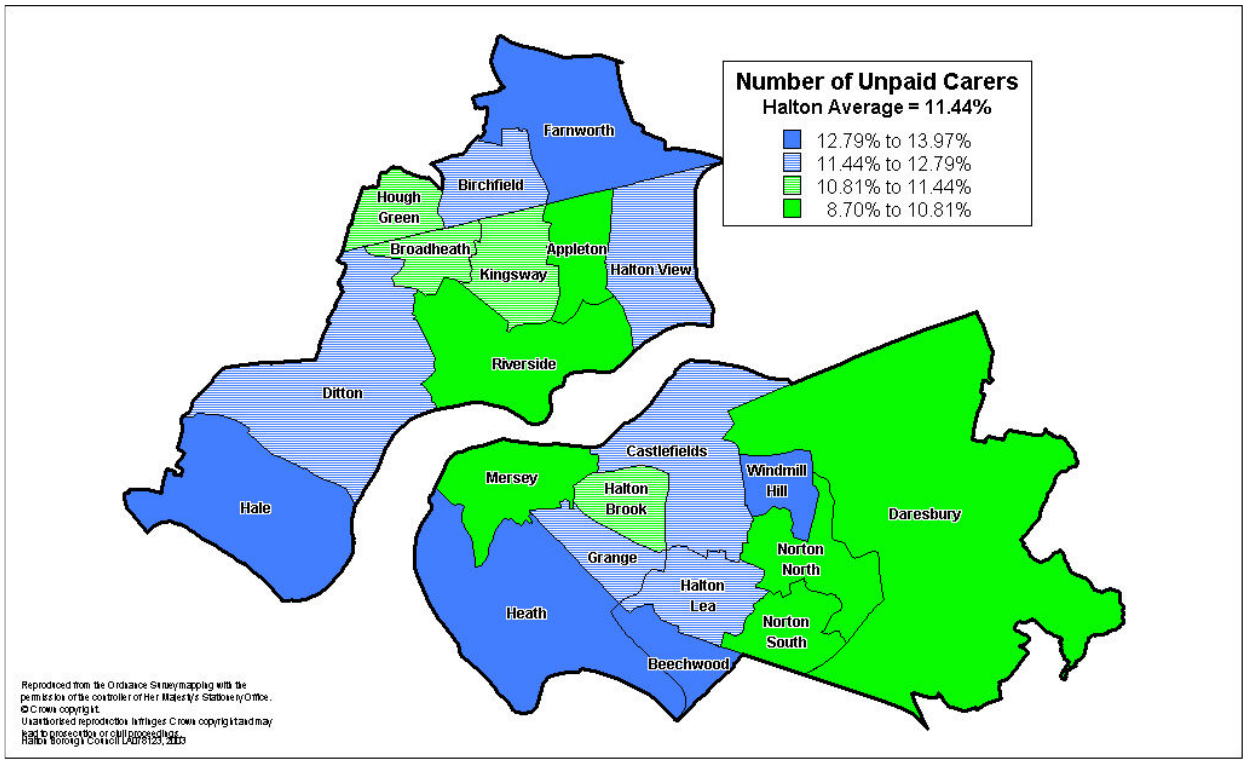
Table 5: Provision of Unpaid Care

Wards	Number of Unpaid Carers	Proportion of Total Population	Halton Rank	Greater Merseyside Rank
Appleton	678	10.61	16	111
Beechwood	524	13.15	4	15
Birchfield	553	12.43	7	33
Broadheath	726	11.26	14	85
Castlefields	771	11.99	8	47
Daresbury	340	8.70	21	135
Ditton	799	12.79	6	23
Farnworth	760	12.86	5	20
Grange	796	11.60	9	67
Hale	264	13.91	2	4
Halton Brook	744	11.28	13	84
Halton Lea	739	11.52	10	71
Halton View	793	11.52	11	72
Heath	748	13.58	3	6
Hough Green	764	10.81	15	106
Kingsway	688	11.29	12	83
Mersey	645	10.49	17	117
Norton North	680	10.47	18	118
Norton South	721	9.98	19	125
Riverside	455	9.45	20	131
Windmill Hill	340	13.96	1	3
Total	**13,528**	**11.44**	**21 Wards**	**138 Wards**

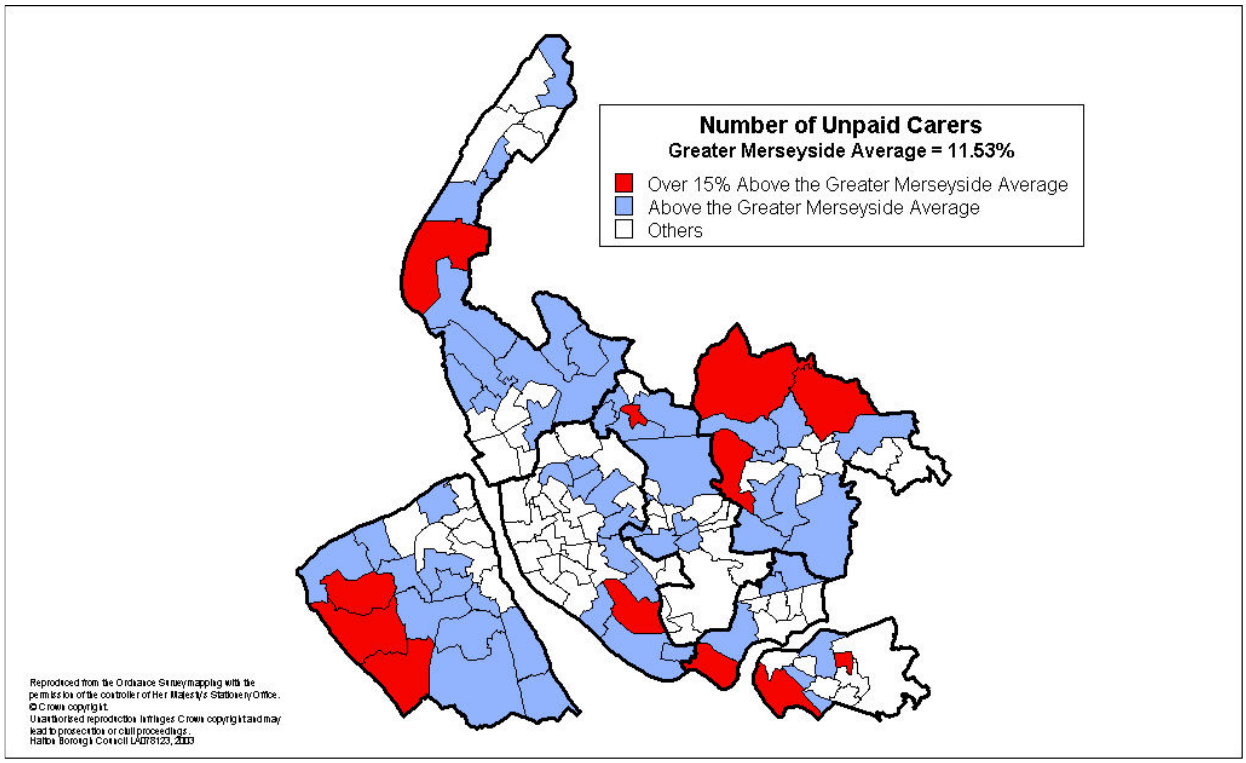
Greater Merseyside Average	***11.53***
North West Average	***10.77***
England Average	***10.03***

The percentage of people in Halton who provide unpaid care to others, usually a close relative, is 11.4%. This means that 13,528 people are providing care for someone for more than 50 hours every week. This figure ranks 5th highest in Greater Merseyside and 8th highest in the Northwest. The Wards with the highest numbers of unpaid carers are Windmill Hill, Hale, Heath and Beechwood where the figures are above 13%.

Map 3 - Number of Unpaid Carers in Halton



Map 4 - Wards over 15% above the Greater Merseyside Average



Recent consultation with carers includes a pilot study undertaken by the Occupational Therapy division of the University of Liverpool School of Health Sciences 'Informal Carers' Experiences of an Intermediate Care Service'. The study focussed on 4 male carers' experiences of Intermediate Care from the Rapid Access Response Service (RARS) in Halton. It recommended that a full-scale study should take place to review carers' experiences further.

TRANSITION

In January 2007 CSCI published a report Growing Up Matters Better Transition planning for young people with complex needs. The report outlined six key prerequisites for successful transition.

The Borough Council employs a Transitions Co-ordinator and has a Transitions Protocol in place. Children and Young Peoples Directorate and the Health and Community Directorate are developing a joint Transition Strategy to incorporate the priorities highlighted in Growing up matters.

Table 6: Number of children with physical or sensory disabilities in Education in Halton by school year

Year	PSD
13	1
12	3
11	9
10	7
9	5
8	9
7	8
6	4
5	3
4	8
3	2
Average	4.8

The number of children with physical and sensory disabilities appears likely to stay fairly similar over time and they represent only a small proportion of the overall referral numbers for PSD services.

Entering the world of work is part of the process by which young people develop adult roles and responsibilities and ultimately independence and autonomy. The more young people and their families are supported in achieving this, the less demand there will be for traditional service provision.

A range of initiatives could be employed to divert young people from entering traditional services, such as:

- Embarking on a project to get young people in transition on ILF. This would enable this group to attract additional funding and promote more individual support packages.
- Promoting and prioritising Direct Payments and Individual Budgets for the transition population to offer choice and control over when and how support is accessed.
- Implementation of the Person Centred Planning agenda. This would clearly identify wishes and hopes and vocational aspirations.
- Extending the remit of the Supported Employment service to develop a Transitions Supported Employment Scheme.
- Expanding voluntary work opportunities.

- Offering increased work experience/supported employment placements in the Borough Council. Many young people identify vocational interests in areas of work that the Council directly provides, eg, gardening, catering, etc.
- Developing Social Enterprise Firms that could utilise and develop skills that young people have developed at school and college. This would be a natural progression from Supported Employment placements and college.

HOUSING

The point has already been made above concerning the dearth of accessible housing for PSD clients in Halton. This must be seen, as suggested above, as a corporate responsibility to be taken seriously given the very high health and deprivation indices in the borough.

The issue in respect of accessible housing is further explored in the Housing Needs and Market Assessment Report (2006) – Appendix 1 provides a summary of the main points. During the survey, respondents were asked whether their house had been built or adapted to meet the needs of a disabled person. In total 35% (1396) indicated that their home had been so adapted (i.e. 65% had not). However, there were large differences according to the type of disability. The figures are as follows:

Disability	% Adapted
• wheelchair user	94%
• walking difficulty	35%
• other physical disability	8%
• sensory disability	9%
• physical and sensory disability	50%

It is not surprising, reading these figures, that a **major problem** for the ILT team is the very high level of demand for equipment and adaptations for houses and flats. This is manifestly an area for urgent action in the near future.

Unmet Need

A database will be established to record all unmet needs and service deficits formally identified through the assessment process. These will be presented to Resources Panel and quarterly reports produced for Management Teams, Service Development Officers and Commissioning Managers with a view to meeting those needs in the future through reviewing or revising services or the commissioning of new services.

CONCLUSION: SECTION TWO

The development of services needs to be informed by a comprehensive set of data indicating met and unmet service need and performance against national performance indicators and targets.

The small numbers of black and ethnic minority people in Halton means there are no large groups for which services can be targeted. The focus, therefore, needs to be on strong individual assessments, creative packages of care that can meet specific individual identity and heritage needs, and developing services that acknowledge and value diversity, ie, person centred planning.

Transition arrangements, will need to have the process developed and tightened up to ensure this is a positive experience for all Young People and their Families. Early identification of needs and PSD involvement for complex cases would assist a smooth transition.

SECTION THREE: CONSULTATION

INTRODUCTION

In order to develop services that meet the needs of those who use those services, we need to consult with service users and other stakeholders to identify whether those needs are being met. This consultation process then informs the future commissioning of services. On-going consultation takes place with physically disabled people in Halton and specific consultation exercises have been conducted in recent years, as detailed below.

PSS USER SURVEY 2003/04

The national PSS User Survey for 2003/04 was conducted via questionnaire with a sample group of adults aged 18-64 with physical and sensory disabilities in receipt of community based services at that time. Clients who were receiving respite or carers break services at that time could not be sampled, nor could those in receipt of equipment as a stand alone service from the Independent Living Team or any service users with a learning disability. Service users who were in hospital during the time of the survey were not eligible to be included in the sample. Locally, this resulted in a final sample group of 238 service users in Halton.

The survey was administered between January-March 2004. The total number of respondents within Halton amounted to 173 (out of 238), which gave a response rate of 72.6%.

A summary of the findings for Halton is outlined below with comparisons made to Halton's CIPFA comparator group of 15 similar Local Authorities:

- 58% of respondents knew about Direct Payments, 31% had not been told and 10% were unsure as to whether they had been told about Direct Payments by their social or care worker. Compared to Halton's comparator group, Halton ranked 2nd for this question.

- 19% of respondents used Direct Payments, however, as the survey responses were anonymised, in some cases the validity of responses could not be checked. Compared to the comparator group, Halton ranked 8th for this question.

- Of those using Direct Payments, 73% felt that they had been very well supported in the use of them. Compared to the comparator group, Halton ranked 2nd for this question.

- The number of people answering 'Always' to the question "Do you feel that your opinions and preferences are taken into account when decisions are taken about what services are provided to you?" as a % of people answering 'Always', 'Usually',' Sometimes' or 'Never' was 42%. This provided a figure for the performance indicator PAF D58. Compared to the comparator group Halton had the highest satisfaction levels.

- 33% of respondents did not know how to make a complaint about social services in Halton while 5% did not feel that they could make a complaint if they needed to. Compared to the comparator group, Halton ranked 3rd for this question.

- 81% of respondents strongly agreed or agreed with the statement "My life would be a lot worse if I didn't have help from Social Services or Direct Payments". Compared to the comparator group, Halton ranked joint 9th for this question.

- 11% of respondents felt that Social Services did not provide them with all the information they needed.

- 84% of respondents felt that they could easily contact social services if they needed to. Compared to the comparator group, Halton ranked joint 6th for this question.

- 44% of respondents felt that care workers always came at times that suited them. This question can be compared to 2002/03 user survey of elderly home care users when the same question was put to them – 55% of respondents at that time felt that care workers always came at suitable times. This may be due to different expectations of care by service users of different ages. 29% of respondents did not have a care worker or personal assistant, which may demonstrate the use of more flexible services. Compared to the comparator group, Halton ranked joint 6th for this question.

- 57% of respondents felt that they were extremely or very satisfied with the help they received from Social Services. Compared to the comparator group, Halton ranked 3rd for this question.

Two non-statutory questions were asked:

- 'Would you like to be involved in the Physical and Sensory Disability Local Implementation Team service improvements and decisions being made?' to which 39 respondents said that they did wish to be involved (permission for their details to be passed on was obtained and their details forwarded).

- 'Would you like to be involved in the review of Transport services?' to which 34 respondents said that they did wish to be involved.

Permission for the above respondents' details to be passed on was obtained and their details subsequently forwarded.

STAKEHOLDER AWAY DAY 2005

A stakeholder day was held in April 2005, facilitated by LCS Limited and hosted by Halton Borough Council and Halton PCT. The purpose of the day was to consult with stakeholders and work together on how the vision in the Government's consultation Green Paper 'Independence, Well-being and Choice' might be achieved and to inform this Commissioning Strategy.

The day was attended by 38 people representing a cross-section of people with an interest in services for the physically disabled and included service users and carers, Vision Support, Halton Voluntary Action, Independent Living Centre staff, Independent Living Team staff, Social Care staff, Halton Voice of the Disabled, Deafness Support Network, Bridgewater Day Centre staff, Supported Employment staff, North Cheshire Hospital staff and Halton PCT staff.

There was a general agreement amongst attendees that the society in which people would want to live in 5 years time was one where disabled people would be able to lead more independent lives. This would mean a wide change in public attitudes towards disability from one where disabled people are defined by their impairment, eg, arthritic, epileptic, which is known as the medical model of disability, to one where there is an acceptance that society needs to make adjustments so that disabled people are able to take up the same opportunities and make the same choices as everyone else, known as the social model of disability.

Attendees recognised that it would take time to move to a society-wide acceptance of the social model and it would also need a realisation at every level that supporting disabled people to lead independent lives was not just a health and social services responsibility but part of a wider agenda to improve social inclusion. To achieve this agenda, people felt it would be necessary to take a holistic approach to support disabled people where all services seamlessly worked

together, pooled their funding, rationalised red tape and communicated more effectively. It was also felt that disabled people ought to be able to influence decisions at every level in service planning, design and development and in monitoring the results.

Service users have identified the most important issues for them as being:

- Action which will change attitudes towards disability
- Promotion of independence
- More inclusion
- Support which enhances their dignity
- Effective and flexible transport
- Better access to all community facilities
- More flexible access to rehabilitation services
- Accessible and useful information, advice and support
- Supported representation at all levels of decision making
- More IT enabled choice and control of their care packages
- Faster provision of equipment and adaptations

Much of the above is reflected in the social model of disability, which understands that people are not disabled but are disabled by their environment.

People appreciated the outreach service with its one-to-one support and the carers' breaks. Transport services were praised for being of high quality but concerns were raised about reliability and availability and the knock-on effect this has on the quality of life for disabled people.

Aligned to transport difficulties was a similar problem around getting around the community in wheelchairs. A lack of wide doorways, lifts, suitable toilet and changing facilities in public places as well as dropped kerbs and ramps were cited as affecting the quality of life for disabled people. For many these restrictions mean that they are reliant on day care and facilities provided by specialist services and are unable to take up opportunities for mainstream leisure and socialisation.

The lack of suitable housing for disabled people and the waiting lists for adaptations were a big issue for attendees, staff and service users alike. It was felt that the process needed to be streamlined to cut bureaucracy and waiting times.

Whilst funding, sharing resources and the effects of short-term funding were recognised as challenges, people felt that some changes could be made quite easily and that 'the simple things were often the biggest problem'. Ideas for improvements suggested on the day included:

- Re-use of existing resources in new and creative way, ie, through partnerships.
- Rationalising the differences in building regulations between the Planning Department and Social Services.
- Widening the existing Physical and Sensory Disability Local Implementation Team to include more service users and carers.
- Setting up a Council-wide access team to improve inclusivity and quality.
- Recognition and rewarding of good practice by a system of awards and introducing financial incentives for services to improve their access for disabled people.
- Having a more responsive rehabilitation service, for periods of rehabilitation to be longer and for rehabilitation teams to be integrated across services. People felt that the current focus of rehab was short and did not respond to the changing and long-term needs of disabled people.
- Extend day-time service hours which are not restricted to 9am-5pm.

To make a more influential contribution to effect change, the following suggestions were made on the day:

- Increase the representation of disabled people at higher levels within organisations. For example, having a Champion for disabled people's issues at senior levels of key organisations whose role would be to make sure the implications and advantages to disabled people of major decisions were taken into account and to advocate for the social model of disability.
- Increase the representation of disabled people at all levels of decision making, to be involved at the beginning of discussions and projects and to be actively listened to.
- Deliver disability awareness training to Members and senior managers within the Borough Council and PCT, which does not emphasise medical conditions but promotes the social model of disability and active, holistic thinking about service developments.
- Increased support for disability groups to function and advocate for their membership.

'**How We Are Doing" Consultation 2006**

This major consultation over two days gained feedback from service users and staff using the framework of the National Standards for Adult Services. Many points raised in these two days have already been covered, but there were some notable additions:

- Some concern over 'transition' services (college → adulthood, 64+ → old age)
- Absolute necessity to have a **needs led** rather than service led assessment
- Adult service provision (18-64) was seen to be less than that available to older people
- Need to deal with the psychological effects of disability, as well as the physical side.

Housing Needs Survey 2005

This survey was the result of a randomly selected sample of 2321 people responding to a question about whether care and support was required, and whether it was being received. The following needs were identified from those respondents requiring support. The list is written in descending order:

- Claiming welfare benefit/managing finances
- Help with personal care
- Someone to act for you
- Looking after your home
- Accessing training/employment
- Establishing personal safety/security
- Establishing social contact/activities.
-

The first two items accounted for more than 55% of responses. In addition, the survey found that 25% of wheelchair users indicated that they received insufficient care and support, see Appendix 1.

Manager/Practitioner Consultation November 2006

This consultation formed part of a workshop organised to develop material and ideas for the production of this Commissioning Strategy. The following points were made :

- As regards caseloads, there is a preponderance of high levels of dependency and support which tend to block new work, for example, supporting clients through a major adaptation process, or helping to maintain habitable standards, whilst continuing to provide person centred care.
- Whilst some cases are straightforward, many are complex in relation for example to:
  - degenerative neurological conditions

  - alcohol/drug related physical disability
  - homeless people who are physically disabled
  - some parts of the system have high waiting lists (ILT waiting list for OT assessment was 281 on 1 April 2006)
- There is a particular need concerning the provision of very high levels of personal care to a defined small group
- Adaptations are difficult where there is not space for hoists for example.
- Houses used for adult placements are not wheelchair adapted
- There is a need to continue to increase direct payments for respite purposes, and so minimise the few remaining residential admissions for this purpose
- **Transport** and access to it was seen by the group as the key to other improvements in people's lives
- It was important not to underestimate the camaraderie and support between disabled people themselves.

In addition, the group identified a list of needs overall which it is worth repeating in full, in order to compare with those from the service users and the Housing Needs Survey. It is as follows:

- **accessibility**
  - houses
  - community facilities
  - transport
- **worthwhile activity** (employment integrated in community, other valued integrated activity)
- **more focused** personal care/support and rehabilitation – helping the client to move to the most independent state possible
- **psychological rehab** - need to work through this as well as physical rehab – hence need for greater counselling input
- **palliative support** – recognition that some people's conditions will deteriorate rapidly
- identify the areas of **corporate responsibility** – housing, public places, general access, attitudes, culture, thinking about the bigger picture
- develop an **accessible homes** register
- more **spontaneity and flexibility** in services.

Many of the themes are now familiar, and do not need repeating, but it is important that so many issues (corporate responsibility, accessible housing and public places, psychological rehab) are reaffirmed as important. But there are two items on the list which merit further attention, namely:

- worthwhile activity
- more focussed personal care/rehab.

Both of these, voiced by service managers, point to the need to tighten up on the content of what is offered to PSD clients. There needs to be a serious examination of any activity or regime which 'passes the time' all the time (endless bingo sessions, meaningless, devalued social activities etc). Further, because of the pressure of referrals and what has already been said about a dependent population in need of ongoing support, more emphasis needs to be put on 'active rehab' and resources need to be found, and diverted for that purpose. Such programmes do not have to happen in institutions (day centres etc) but in people's homes or in community facilities. The case studies provided by service managers, and an analysis of the contracts types and individual costs suggest that there is a three way split in the client group (the age of which is biased toward the 50-64 age group, ie the age of stroke, heart problems etc). This split appears to be as follows:

- highly disabled, often younger people with extensive care packages
- dependent, though less needs, people who hang on the system because there is nowhere else to go

- low dependency people, some of whom only use the service for a short time, but whose resource use level is low.

This may be a way of beginning to understand the dynamics in the PSD client group, but the managers' call for more worthwhile activity and focused rehab is a call not to be missed.

SERVICE USER COMMITTEE

A Service User Committee is in place at Bridgewater, providing the service users with a means of raising issues with centre management and to provide feedback on centre services and activities on a regular basis. The use of service user funds (eg, the comforts fund) is determined by the Committee and needs to be authorised by 3 Committee members.

A number of arrangements exist to obtain service user feedback at Bridgewater, including the annual review for each service user, the fully elected and constituted Service User Committee, the Building Improvement Programme. It is evident that these arrangements provide some useful information and have 'shaped' the care provision. The current arrangements do not include feedback from other stakeholders such as carers and family members. However, there are a number of ways in which carers have a voice in Halton, eg, through the Carers Umbrella Group, Carers Strategy Group, specific consultation events, the Carer Development Officer, the carer Information Centres.

It is recognised that current feedback/consultation arrangements may not be obtaining the right level of feedback on all relevant issues and from all relevant parties, which may result in the services being provided not meeting the needs of all service users. To address this, a questionnaire will be devised and added to the annual review process to provide a better response rate. The questionnaire will be given out a week before the annual review.

CONCLUSION: SECTION THREE

The needs outlined in this consultation sub section can largely be grouped under the following headings:

(1) Improved Services/Availability of Basic Requirements

- access in the home
- worthwhile, valued activity
- more focussed personal care/rehab
- faster equipment/adaptations (assessment and delivery)
- transport (availability and access)
- advice which is available and can be understood
- financial advice (including benefits advice)
- advocacy and support in the public arena.

(2) Reduction of Barriers Which Separate

- accessible housing
- better access to community facilities
- safety and security
- valued social contact
- IT enabled choice and control of care packages.

(3) Improved Service/Corporate Attitudes and Style

- all items concerned with
  - dignity
  - respect
  - independence
  - access
  - control.

The picture emerges of Halton PSD clients and services as one of a largely middle aged group, often living in high areas of deprivation and with generally poor health status. Importantly, self-esteem and confidence are generally low so the psychological/social side of rehabilitation is as important as the physical side. Certain service areas jump out as needing attention:

Mainly PSD	• more focused rehab • more focused worthwhile activity • faster access to equipment and adaptations • access to psychological support
Corporate	• improved accessible housing • a real attempt to deal with transport • raising the profile of PSD services generally • access to public places
In partnership with health	• greater emphasis on healthy lifestyles • measures to increase social participation and reduce isolation

SECTION FOUR: CURRENT PROVISION OF SERVICES

INTRODUCTION

Halton's approach to services for disabled adults is to support more people in their own homes and communities and less people in hospital and care homes. The information below represents a snapshot of current service provision.

Physical and Sensory Disability Services are made up of 2 arms - Care Management & Assessment and Provider Services. Care Management & Assessment assess needs and Provider Services are then commissioned to meet those identified needs. Both Assessment and Provider services rely heavily upon a shared approach and in particular the strong partnerships that exist with Health Services, private and voluntary sectors. The whole system is based on inter-dependency with other agencies and organisations and partnerships that involve service users and carers, and increasingly looking to Single Assessment across services.

Much of our work is set down within statutory requirements, eg, the NHS and Community Care Act 1990.

CARE MANAGEMENT, ASSESSMENT AND PROVISION

Assessment & Care Management

The service provides an assessment and care management function through its social work (or fieldwork) team for adults with a physical and/or sensory disability aged 18-64, those of all ages with a visual impairment and those who care for them. The service provides, monitors and reviews care packages and offers a range of services to support re-enablement, encouraging people to retain or regain independence or to offer supported environments for them to live within Halton whenever possible.

Eligibility for services is established through 'Fair Access' to Care Services, implemented in April 2003 and reviewed annually, which determines the Council's eligibility threshold. The FACS approach requires Councils to prioritise their support to individuals in a hierarchical way. However, whilst services to those at greatest risk are a priority, it is essential that our investments enable agencies within the community to develop preventive, promotional and enabling services.

In Halton, the current policy is that people are eligible for support if there needs are critical or substantial:

Critical

- Life is or will be threatened
- Significant health problems have developed or will develop
- There is or will be little or no choice ands control over vital aspects of the immediate environment
- Serious abuse or neglect has occurred or will occur
- There is or will be an inability to carry out vital personal care or domestic routines
- Vital involvement in work, education or learning cannot or will not be sustained
- Vital social support systems and relationships cannot or will not be sustained
- Vital family and other social roles and responsibilities cannot or will not be undertaken

Substantial

- There is or will be only partial choice and control over the immediate environment
- Abuse or neglect has occurred or will occur
- There is or will be an inability to carry out the majority of personal care or domestic routines

An indication of the level of activity is given by looking at the data on completed assessments and reviews. As has been mentioned, assessments were carried out on 169 individuals during 2005-6. In the age range 18-64, the breakdown between physical disability and visual impairment was as follows:

• Physical disability	62
• Visual impairment	29
Total	91

Apart from the assessments, a total of 721 reviews were carried out during the year, which suggest a service working very hard with complex, long term cases, with potentially problematic capacity problems.

Around 78-80 people are supported contractually in day care. Another 250 people are supported at one time or another during the year in residential care and there are 60-90 cases for support at home and personal care.

Most of the contracts for PSD are let via the PSD team, the main ones being:

- Deafness Support Network
- Vision Support
- Verna Care
- Sankey Care
- Medico Nursing
- Lifeway Community.

An analysis of the contract periods suggests the following patterns. In any give period there are about 200 contractual episodes. Of these 124 (or 62%) are worth less than £200 per month (£2400 per annum), and of these 67 (or 33%) are worth less than £100 per month. These figures are balanced by larger care packages including one which costs around £85k per annum. The impression is however, of a large number of small scale interventions which may be important to keep under review.

Independent Living Team

Physical and Sensory Disability Services focus on adults aged 18-64 years old, however, the Independent Living Team is responsible for assessing children, adults and older people, resident in Halton, who have a permanent and substantial disability. The team also provides assessments to people with similar needs who have learning disabilities, mental health problems, frail older people and support to carers. This Team incorporates the provision of Occupational Therapy services, the Independent Living Centre, the prescribing of equipment through Halton Equipment Store and the carrying out of major and minor adaptations to homes to assist independent living.

In April 2006 the following people for waiting for assessment by:

- **Occupational Therapist**
  There were 281 on the waiting of whom
  28 (11%) are children
  125 (44%) are aged 18-64
  128 (45%) are age 65+.

- **Community Care Worker waiting list**
  There were 454 on this waiting list

0 children
150 aged 18-64
304 aged 65+

The team works within the whole system of health and community services and has established links with Halton Primary Care Trust, North Cheshire Hospital Trust and other outlying hospitals e.g. Aintree & Walton, Whiston & St Helens, Royal Liverpool, Broadgreen, Countess of Chester etc.,

The team uses a rehabilitative approach to service delivery. During their assessments they will consider if there are alternative ways of carrying out everyday tasks to enable service users to improve or retain their best level of independence, to live independently at home or in a care home, in their community and enjoy fulfilled, healthy and active lives.

If an alternative method does not work then the team may provide equipment, (via Halton Integrated Community Equipment Service) or recommend adaptations to the user's home. The Independent Living Team work closely with all other teams within the directorate to ensure that all needs are considered.

Some of the issues faced by the PSD team appear to belong to the ILT as well. In particular there is an issue about capacity. In 2005 – 2006 those receiving minor adaptations numbered 619, and major adaptations 63, The ILT states that there are 1980 cases either open or pending review. In addition, as already mentioned, the OT waiting list was 281 and the CCW waiting list was 454 in April 2006.

On the surface, these numbers are unmanageable and it may have something to do with the comments, already reported from the November workshop, concerning a culture of continuing need and dependence amongst Halton residents, which makes it difficult to close cases and move on, because there are not other support networks available.

The high caseload may also highlight another theme of this report – ie the dearth of adapted and accessible housing in Halton, and the difficulty of adapting in often narrow cramped space, both inside the house and in the immediate environment.

A further complication may well be the considerable strain on running an all age service, with growing pressure from older people sometimes in more acute need than younger referrals.

It is important to understand some of these problems, and to act as appropriate in particular in respect of:

- consider caseload review mechanisms to sharpen closure, and reduce the log-jam
- put pressure on corporately to improve accessibility generally within the existing housing stock
- consider re-investing from some current services into a more focussed rehabilitation programme.

<u>Equipment</u>

Without the right equipment, eg, grab rails, and adaptations to support independent living people often repeatedly go in and out of hospital. The equipment contract is currently provided by Halton and St Helens PCT and is provided through Halton Equipment Store (HES). The amount of equipment being issued continues to increase year on year as the population ages. This service will be reviewed alongside that of St Helens to determine how to increase capacity to meet the growing demand.

Adaptations

Key to supporting people to live at home is the ability to have the home improved to enable someone to cope with their changed circumstances. There are a number of services which assist people to remain in their own homes such as the Care and Repair Agency, the Vulnerable Tenants Scheme and the Handyperson Scheme. The Care and Repair Agency also assists homeowners with obtaining renovation and Disabled Facilities Grants and carrying out adaptations. Common adaptations are level access showers, ramps, door widening, stair lifts, etc.

A contract for minor adaptations has been awarded.
Service users want the whole process for the prescribing of equipment and carrying out of adaptations to be streamlined to cut bureaucracy and waiting times. Temporary adapted accommodation is needed for people to move into whilst their homes are being adapted as there have been instances where families have had to be split up and expensive respite facilities used whilst work has been done on their homes.

An Adaptations review is underway within the Council and a Project Group set up to review the processes, practices and procedures involved in the provision of minor and major adaptations.

Independent Living Centre

Halton's Independent Living Centre is a resource centre for anyone who wants to know more about equipment for independent living. The Centre houses permanent displays of basic and specialist equipment that assist with independence and caring and holds regular open days for equipment demonstrations.

The Centre provides an Occupational Therapy service, which gives free impartial assessment, information and advice on the purchase of a range of equipment. A wheelchair service is also available via referral from a GP, Consultant or a health care professional.

PROVIDER SERVICES

Provider services are commissioned to meet assessed needs. These services are an essential component of services to manage demand, reduce dependency and fill gaps in the market. They also support a large number of Carers by offering a break.

Bridgewater Day Centre

Bridgewater provides a community day care service for adults and older people as well as an Outreach service and an Adult Placement Scheme. While gaining in personal confidence and undertaking rehabilitative skills programmes, which are subject to guidance from occupational therapists, psychotherapists and speech therapists, users at Bridgewater can opt to pursue social, leisure and educational activities. Service Users feel particularly supported by the comradeship of meeting with their peers, generally in group settings, as they report that this is beneficial in dealing with the "psychological" difficulties presented to some by disability.

Table 7: Snapshot of attendance at Bridgewater taken during October 2006.

Service	Daily		Weekly		Monthly	
	Places	Taken	Places	Taken	Places	Taken
Bridgewater Day Centre	40 per day (5 days pw)	Range from 21 to 31 per day	200	Range from 132 to 149	800	558
Outreach Service	-	M = 1 T = 0 W = 1 Th = 1 F = 2	-	5	-	12
Adult Placement Service	M = 20 T = 15 W = 21 Th = 21 F = 18	M = 16 T = 12 W = 14 Th = 18 F = 14	95	74	380	296
Community Day Care	T = 75 W = 40 Th = 40 F = 20	T = 56 W = 33 Th = 32 F = 17	175	138	700	552

Explanatory Notes:

- Bridgewater has 86 service users who use the Centre. Only 1 service user attends the Centre 5 days per week.
- The Outreach Service supports service users enabling them to access a variety of community activities and facilities with one to one, experienced support. Since October 2006 this service has been offered to those over age 65.

Table xx: Number of service users utilising Bridgewater Day Centre

No. of Days Attendance	No. of People Using Service
1	31
2	39
3	13
4	2
5	1
Total	86

Currently 50 of the people attending Bridgewater are aged 65 years of age. Within this group, the majority (66%) have become disabled by means of some aspect of chronic ill health. The other third of under 65s tend to be the younger set that have either been disabled as children (and often passed through the Special Education system) or have become disabled after some traumatic accident (commonly a severe head injury). Also, of particular note are the numbers of users from BME groups who attend the centre. Although low in number, they make up over 3% of the entire group, which is more than the average population in Halton.

An elected, constituted Service User Committee is in place at Bridgewater, providing service users with a means of raising issues with centre management and to provide feedback on centre services and activities. The Committee determine how service user funds (eg, the comforts fund) should be spent and they have funded many items within and around the Centre and elsewhere.

Halton has one day centre for physically disabled adults (Bridgewater). SCOPE have day service provision based at Frodsham Business Centre, however, eligibility has recently been changed and only those in residential care can attend. The Supporting People team have one unit within SCOPE at 11 Daresbury Court, Runcorn. Other authorities originally placed all service users here but one person from Halton has recently become a tenant.

An updated analysis of the current needs of people within day services is required to inform the continued modernisation of day services.

Traditionally opportunities have been service-led, not needs-led, resulting in a narrow band of activities and life-styles for people that use services. This has resulted in limited informed choice being exercised by users of services, which in turn has led to limited service delivery. *Person-centred planning must be at the heart of service development and services must be able to respond to demands made through this process.*

Halton Borough Council has been reviewing day services provided to local disabled people, of all ages, and seeking ways to improve accessibility into a range of activities provided at local community centres. This review, supported by the newly formed Community Bridge Building service which aims to promote social inclusion for all adults and older people by helping them access mainstream services, will ensure that all community venues can be accessed and used by all adults within the borough.

Outreach Service

The Outreach Service has capacity to support up to 14 service users enabling them to access a variety of community activities and facilities with one to one, experienced support. The service is offered to adults with physical disabilities between the ages of 19-65 years and has been extended to a small number of people aged over 65. Users of this service are contemplating independence in the future, others are independent but wish to increase their community involvement, and others are building up their skills in preparation for transferring to Direct Payments.

Adult Placement Scheme

Adult Placement is a direct alternative to traditional residential and day care for some and is provided by individuals and families in the community. The Service has also provided respite weeks for one or two young people with acquired brain injuries very successfully and can be a suitable venue for some people with hearing loss. The number of placements is limited by the numbers of carers available and the regulations, which limit the number of service users to be supported by one carer to three at any one time. There are restrictions to some people with physical disabilities accessing this service as carers homes are generally not be suitably adapted.

There is potential to develop the role of Adult Placement Service to support some people with a wider range of needs through day, short stay and long stay placements in a cost effective way.

Rehabilitation

The Visual Impairment Rehabilitation Services is a generic; all age service. It has a high referral rate and is unable to provide long-term intensive rehabilitation on the scale needed. Of the 169 individuals assessed in 2005-6:

78 were aged 65+
49 were aged 51-64
37 were aged 31-50
5 were aged 18-30.

A Service Level Agreement is in place with Vision Support who provide a wide range of support to visually impaired people in Halton, including a resource centre, network of support workers, information and benefit advice, counselling, specialist equipment, adaptive technology training and Braille/large print transcription.

A Service Level Agreement is also in place with the Deafness Support Network who provide services to children and adults who are deaf, hearing impaired or deaf/blind in Halton and with Guide Dogs for the Blind, provide mobility training to visually impaired people. However, there is no low vision service in Halton, therefore, service users attend a clinic in St Helens.

Community Bridge Building Service

This is a new generic service in Halton for all adults over the age of 18, which supports the national and local modernisation agendas for day services and enhances social inclusion for people with a range of disabilities. This Service aims to:

- Modernise day service provision in line with the requirements of government legislation, guidance and good practice.
- promote enhanced social inclusion and greater engagement in mainstream services for people with disabilities
- Challenge stigma and discrimination by raising profiles in service areas and the community
- Enhancing the capacity of mainstream services to promote full social inclusion of people with disabilities

HEALTH

GPs and Primary Care teams have a key role in providing health care for people with physical disabilities. They are responsible for making sure that physically disabled people can access the full range of health services to meet their ordinary health needs, eg, health screening and immunisations, as well as their additional needs through referral to specialist services.

Primary Care Trusts are the lead NHS organisation for assessing need, planning and securing all health services and improving health. They are expected to work in partnership with local communities and lead the NHS contribution to joint work with local government and other partners. They can use their discretion in commissioning care to:

- Re-shape how local health services are delivered to reduce waiting times, increase responsiveness and improve clinical outcomes.
- Ensure a focus on prevention as well as treatment.
- Forge local partnerships to more effectively address health inequalities.
- Ensure an appropriate balance between investment in primary and community services as well as acute services.

Halton and St Helen's Primary Care Trust is responsible for creating a Local Delivery Plan that describes how the PCT will use its resources to deliver on national and local priorities for health and service improvements in Halton.

A range of community health services is available to physically disabled people in Halton, including speech and language therapy, physiotherapy and occupational therapy and the provision of wheelchairs.

Halton and St Helens PCT fund the Independent Living Centre and jointly fund with the Borough Council, the Halton Equipment Store that administers, stores and dispenses equipment to assist independent living.

The Borough Council have a Physical Activity Co-ordinator and have produced a Physical Activity Strategy that makes the links between physical activity and health gains.

TRANSPORT

Currently coaches are used to transport people to and from day services. Some people spend over an hour on the coach yet live only 10 minutes from the centre. The special transport services in Halton are in some cases the only current option for some disabled people and these were praised by users for being of high quality, but there were concerns raised around reliability and availability and the knock on effect this has on the quality of life for disabled people. Buses often arrive late, have to be booked at least one day in advance and may take a longer route because of the need to pick up others on the way.

Through consultation, service users have identified the following needs:

- Transport which can be ordered the same day so they do not need to plan ahead and are able to take part in spontaneous activities. Users said if they had this freedom, their quality of life would be vastly improved.
- Accessible and affordable transport which is available 24 hours a day, 7 days a week.
- Bus routes, which go to where people are and need to be and which link to shops, leisure, education and health facilities.
- One point of contact for transport.

ACCESSIBLE ENVIRONMENT

The Shop Mobility scheme is widely appreciated by service users, as is the help and advice offered by the Halton Disability Service.

Users and carers have expressed concerns about the problems of getting around the community in wheelchairs. A lack of wide doorways, lifts, suitable toilet and changing facilities in public places as well as dropped kerbs, ramps were all cited as affecting the quality of life for disabled people. For many, these restrictions mean that they are reliant upon day care and facilities provided by specialist services and are unable to take up opportunities for mainstream leisure and socialisation. Users want effective and sufficient services they can access in the community.

EMPLOYMENT

Management responsibility for the Council's Supported Employment Service rests with the Enterprise and Employment Division of the Economic Regeneration Service. This has enabled the service to be integrated with the Council's enterprise and employment services that have provided better access to main stream employment and enterprise opportunities for people with disabilities.

Table 9: Number of new supported employment placements of people with a physical or sensory disability during the period 1st April 2005 to 31st March 2006:

Education & Training	Voluntary Work	Supported Permitted Work	Full-time or Part-time Work
18	19	11	7

Table 10: Number of PSD clients being supported in training or work placements as at 31st March 2006 regardless of their start date was:

Education & Training	Voluntary Work	Supported Permitted Work	Full-time or Part-time Work
33	34	21	26

A revised strategy will be developed for Employment opportunities in 2007. This will encompass Paid Employment/Voluntary work opportunities through Supported Employment and Bridge Building.

ADULT LEARNING

The Acorn Lifelong Learning Centre in Runcorn currently supports adult learners and has an open access policy with the majority of provision being free of charge. They currently support:

- 11 people with visual impairment
- 12 people with a hearing impairment
- 42 people with mobility problems
- 12 people with other physical problems
- 1 person with a profound disability
- 4 people with multiple disabilities

The Learning Skills Council (LSC) is undertaking a review of how adult learning is funded and currently Acorn, Halton College and Widnes and Runcorn 6th Form College all have a contract for adult learning in Halton.

SUPPORTING PEOPLE

The Supporting People programme provides essential housing related support services for over 1.2 million vulnerable people across England. It enables people to live more independently in their homes than would otherwise be possible, providing them with greater choice about how they live. It can also help to prevent social exclusion and the need to go into institutionalised type care settings.

A grant is paid by the Office of the Deputy Prime Minister (ODPM) to 150 Administering Authorities (top tier and unitary authorities) who then contract with service providers to deliver housing related support services (this does not include care services) to vulnerable people. A Commissioning Body (a partnership of local housing, social services, health and probation services) sits above the Administering Authority and plays a key role in advising and approving decisions on priorities, de-commissioning of services and the local 5 year Supporting People Strategy.

There are 108 Supporting People services operating in Halton with capacity to offer housing related support in 2,074 homes. There is also low provision of supported accommodation for people with mental health problems, people with a physical/sensory disability and for people with drug problems.

The Supporting People Strategy for the 5 year period from 2005 has identified support for disabled people as its second priority for expansion. Halton is working on the development of registers detailing adapted social housing stock in order to match up people to appropriate rented accommodation.

HOUSING

The Council's Housing Strategy 2005-2008 shows there are no designated accommodation based units for people with physical disabilities and because of this service users who would normally live in the borough live outside of the borough. Out of area placements are made to Hillside in the Huyton area of Liverpool and Callands Court in Warrington.

There is also an identified need for the provision of 3 units of accommodation for visually impaired people.

The council has identified 577 units of supported housing in Halton with an additional 2,777 units identified as suitable for people with additional needs. In addition, there are 1,422 units designated for older people and 10 units providing very sheltered/extra care and 182 units identified for cross-authority referrals. It is also estimated that 28 disabled people out of a total of 1,423 people with other needs use the floating support services that are available.

There are a number of services which assist people to remain in their own homes such as the Care and Repair Agency, the Vulnerable Tenants Scheme and the Handyperson Scheme. The Care and Repair Agency also assists homeowners with obtaining renovation and Disabled Facilities Grants and carrying out adaptations.

CARERS

Halton has a Carers Strategy and Action Plan 2006-2008 for carers across all services. The Borough has 2 Carers Centres, one in Runcorn and one in Widnes, which are open 5 days a week from Monday to Friday, and a dedicated full-time Service Development Officer for Carers.

An updated Carer Information Pack has been produced and provides details of local support services available to all of Halton's carers. Carers Grant, available to the Directorate, has paid for the development of a Carers Breaks service. A wide range of Carers Breaks were provided during the last year by voluntary organisations and teams within Social Care.

Services available to support carers in their caring role include:

- Day Care – away from the home, to allow the carer some time at home away from caring.
- Night sitting services – to help the carer to get a good night's sleep.
- Evening or day sitting services – to allow the carer to go out or to do something for themselves (eg, meet friends, go to the cinema or an evening class or do some shopping).
- Carers Breaks Scheme – free daytime care at weekends for older people.
- Short Term Breaks – for the person being cared for, in a range of places (eg, activity breaks, family based care, residential care, Bridgewater Day Centre).
- The voluntary sector and Halton's Carers Centres also provided breaks for carers in the form of holidays, day trips and pamper sessions

Between April 2006-March 2007 Physical and Sensory Disability Team supported 62 carers to receive a break from their caring role. Of these, 2 carers received support more than once. Thirty three carers received the funding via a Direct Payment. A further 10 service users received the funding via a Direct Payment to enable the carer to remain at home and allow the cared for person to receive respite in an appropriate format. Bridgewater Day Centre, Halton's Carers Centres and the voluntary sector provided breaks to a further 241 carers.

The expenditure on providing breaks to carers of individuals with a Physical and Sensory Disability in 2006/07 was:

- PSD Team £30,032
- Bridgewater Day Centre, voluntary sector and the Carers Centres spent an additional

£23,482.

SUMMARY OF MAIN PROVIDERS

Block Contracts

Fieldworkers are currently utilising block purchased Domiciliary Care agencies, eg, Sankey HC, Medico, Carewatch and Verna. However, there are no block purchased specialist domiciliary agencies specifically for PSD clients.

Spot Purchase

In addition to block contracts, Fieldworkers are accessing validated Domiciliary Care agencies on a spot purchase basis, eg, Allied Medicare, PSS, Lifeways.

There is currently no specific bed based respite facility for physical and sensory disabled clients within Halton. Fieldworkers are able to pursue spot purchases from older people's establishments subject to CSCI variations.

Younger people with respite needs are offered services in out of area facilities on a spot purchase basis. These are predominantly Hillside Younger Persons Unit (Huyton) and Callands Court NH (Warrington). Disability specific resources are also spot purchased in out of area resources.

SCOPE have 5 establishments providing residential care provision which have been utilised by teams:

- 10 Coronation Dive, Widnes
- 1-3 Edward Street, Widnes
- 102-108 Warrington Road
- 1-3 The Hollies
- 8-11 Harbour Close, Runcorn

SCOPE also has a day service provision based at Frodsham Business Centre. Service provision has recently been changed and only those in residential care can attend. The Supporting People team have one unit within SCOPE at 11 Daresbury Court, Runcorn.

In-House Services

- Day care provision from Bridgewater Day Centre, which covers 18 years, and over.
- The Adult Placement Service, which is predominantly an older person's resource. There is currently one physically disabled client using the service.
- The Adult Placement service currently has a placement available for respite provision. Last year 2 people with an acquired brain injury were able to utilise the service.
- Intermediate care beds are based in older people's establishments.

Intermediate Care is currently provided by the Council's Home Care team for short term intervention. There are, however, several service users who utilise this service whose needs are of a long-term nature and cannot be transferred to the Independent Sector due to the complexity of their cases.

The Bridgewater Outreach Service is specifically designed for physically disabled service users to enable them to access and integrate into the community and to promote their independence. It is a small-scale service and does not provide any personal care. Previous difficulties have

been around service provision when workers have been on leave or off sick. More recently, however, extra hours have been funded which should reduce these incidents.

Halton and St Helens PCT

Halton and St Helens PCT fund the Independent Living Centre and jointly fund the Halton Equipment Store with the Council, which is responsible for the prescribing of home equipment to assist independent living.

Voluntary Sector

Service Level Agreements are in place with Vision Support who provide a rehabilitation service, with the Deafness Support Network who provide services to children and adults who are deaf, hearing impaired or deaf/blind in Halton and with Guide Dogs for the Blind to provide mobility training to visually impaired people. However, there is no low vision service in Halton, therefore, service users attend a clinic in St Helens.

Crossroads Caring for carers provide a sitting and home care service (at no charge to the service user) to allow the carer short periods of respite. There is currently a waiting list for this service. There is no age limit on this service. They also have lottery funding for palliative care hours.

CONCLUSION: SECTION FOUR

Many of the services accessed by disabled people in Halton are designed for older people and there are few dedicated services for those with physical disabilities. For example:

- The Rapid Access Rehabilitation Service is only for service users who are 55 years and over.

- Provision from Bridgewater Day Centre covers those aged 18 years and over but there are a significant number of service users who are aged over 65 years. The challenge is to make the service appropriate for the younger service users who feel it is an older people's service. Difficulties are in providing a range of meaningful, community based daytime opportunities linked to leisure, education and employment.

- The Adult Placement Service is predominantly an older person's resource with only one physically disabled service user accessing the service at the moment.

- There is only residential respite provision for disabled people in an older peoples' home and for those with brain injuries the only facility is within the family placement service and this is only suitable for those who are more able.

- Intermediate Care beds are based in older people's establishments and referrals have to be age appropriate, which prohibits a significant amount of physically disabled service users from using them.

There are only community based rehabilitation or intermediate care services for those with visual impairments or those needing home care. This means that inappropriate and expensive residential and nursing placements have to be used.

Only one domiciliary agency specialising in complex neurological disorders has been validated by the Council in 2004 and this means re-tendering to meet needs.

<u>Occupation/Vacancy Levels</u>

There is little central information available on occupancy and information included below has emerged from service plans. There is a need to collate this information centrally and use it to monitor services.

- There is currently a waiting list for Crossroads Care Attendant services.
- The Visual Impairment Rehabilitation Services works with users of all ages and not just adults and the large referral rate means it is unable to provide long term intensive rehabilitation on the scale needed.
- There is a greater demand on the equipment and adaptations budget than can be met.
- The Council's Housing Strategy 2005-2008 shows there are no designated accommodation based units for physical and sensory disability services, therefore, 75 service users who would normally live in the borough live outside of the borough. There is also an identified need for the 3 units of accommodation for visually impaired people.

SECTION FIVE: PERFORMANCE AND FINANCE

PERFORMANCE ASSESSMENT

Halton Borough Council is currently rated as an 'Excellent' Authority and a 2 Star Social Services Authority. A number of indicators are relevant in assessing the performance of Physical and Sensory Disability Services, which are outlined below.

Table 13: Performance Indicators

Ref.	Indicator	2005-06 Performance	2006-07 Performance	2007-08 Target
PAF D40 & BVPI 55	Clients receiving a review	80%	81%	
BVPI 195	Waiting time for new clients from (i) Contact to start of assessment (ii) Contact to end of assessment	79% 79% **79% Combined Result**	92% 75% **84% Combined Result**	
PAF E50	Assessments of adults and older people leading to provision of service	60%	67%	
BVPI 196	Waiting time for new clients from completion of assessment to provision of service	93%	92%	
BVPI 56 & PAF D54	Delivery of equipment within 7 working days	76%	92%	
PAF C51	Direct Payments	165 per 10,000 pop.	189 per 10,000 pop.	
PAF D39 & BVPI 58	% of people receiving a statement of their needs and how they will be met	99%	99%	
PAF C29	Adults and older people helped to live at home	7.10 per 1,000 pop.	7.60 per 1,000 pop.	
PAF C73	Admission to permanent residential and nursing care (adults of working age)	0.4 per 10,000 pop.	0.8 per 10,000 pop.	
PAF D42	Carers assessments	38.9%	No longer a PAF Indicator	
PAF C62	Services for Carers	6.9%	10.2%	

Independent Living

The increase in disabled adults helped to live at home is dramatic and regionally, comparators are at similar levels to Halton.

Halton also has high levels of people using direct payments (8th in UK), which provide greater control over people's choice of who provides their care. Government is keen for this to move towards personalised budgets, which although powerful, does reduce efficiency due to reduced economies of purchasing activity. Halton plan to pilot this approach as an efficiency gain.

Residential Placements

In 2004/05 residential placements were at an all time low. This reflects a fundamental change in culture to improved assessment and better working across social care and health services and promoting independence by supporting service users to remain living in their community. No physical and sensory disability service users have been placed into residential or nursing home care.

Waiting Times

Waiting times are service measures of efficiency and effectiveness for social care, and are increasingly measured in both CSCI Self Assessment Survey (SAS) and by Health and Social Care Information Centre performance indicators, and relates to both time for assessments and for provision of service.

Targets are now about reducing waiting times for assessment and provision of service, the Government rightly having a view that all assessment should be started with 48 hours and all care should be in place within 4 weeks. Year on year the target is tightened as to how many of these are completed within these timescales. This has meant the need for additional assessment staff (social workers and community care workers) to undertake that assessment work.

In 2006/07 nearly 1,415 adults of a working age were assessed and/or reviewed.

Equipment

Government have been emphasising equipment as a key service that supports independence, recognising that without the right equipment and adaptations people often repeatedly go in and out of hospital. Equipment is, therefore, seen as a good measure of how well we promote independence. Halton has surpassed local and national targets for delivery of equipment within 7 days. In 2006/07 92% of community equipment was delivered within 7 days. However, there is an expectation that this will increase year on year, putting pressure of the equipment budget.

Halton and St Helens PCT currently provides the equipment contract. Further work will need to be undertaken to predict future demand and resource pressure.

The amount of equipment issued continues to increase year on year, particularly more high cost, specialist and new catalogue items. The changes within the PCT to cease being a direct provider of services may mean that the contract will be re-tendered to a different provider. This may reduce long term costs.

Adaptations

A significant number of complaints made to Adult and Older People's Services in 2004/05 related to adaptations to property. The majority of these complaints were about delays in procedures and the length of time taken to complete adaptations. The average length of waiting time in 2006/07 for minor adaptations from assessment to work beginning was less than 1 week.

The average length of waiting time in 2006/07 for major adaptations from application of Disabled Facilities Grant to approval of the Grant was approximately 15 weeks. Obviously putting an extension on someone's house is a major piece of work, but timescales need to continue to be reduced. Improvement in performance in this area must be an objective of any future plans to fund or provide adaptations.

Self-assessment against Progress in Sight

Progress in Sight produced national standards of social care for visually impaired adults in October 2002. In 2003 a survey was conducted on behalf of the Association of Directors of Social Services Sensory Sub-Committee in 2003 to determine progress against the Standards. This involved Local Authorities self-assessing against the Standards.

Halton's performance is compared to the English Average Score in the Table 12 below. Overall, Halton ranked 30th of all Local Authorities in England against these Standards.

Table 12 Halton score compared to English Average Score

Standard	England Average Score/10	Local Authority Score/10
1 Involving visually impaired adults in service planning	5.83	5
2 Planning services	5.78	6
3 Commissioning services	6.28	8
4 Managing services	6.46	8
5 Managing the workforce	7.00	8
6 Resourcing services	6.40	7
7 Making services more accessible	7.00	6
8 Reaching adults with a newly diagnosed sight problem	7.34	8
9 Involving service users in developing care pathways	7.85	8
10 Supporting carers	7.55	9
11 Assessing individual needs	7.46	9
12 Agreeing the care plan	7.55	6
13 Providing emotional support	5.96	6
14 Training people for life	7.98	7
15 Equipping people for life	7.35	9
16 Achieving continuous improvements to services	6.17	8

FINANCIAL ANALYSIS

Table 13 below shows the breakdown of the Council's Physical & Sensory Disability expenditure by service type. The 2007/08 budgets are included for comparative purposes. In 2006/07 in recognition of the increased number of referrals for over 65's and to ensure hospital discharges were facilitated specific grants were invested to increase capacity of community care workers, vision rehabilitation workers and occupational therapists as well as minor adaptations and equipment services. This investment is likely to be repeated in 2007/08 but the

grants cease on 31st March 2008 and to date the Government has not indicated what if any alternative monies will be able beyond this date.

Table 13: Gross Expenditure on PSD services (£000)

Service	2004/05	2005/06	2006/07	2007/08 Budget
Management/overheads	165	680	766	488
Community Day care	111	117	127	136
Adult Placement	56	83	108	94
Bridgewater	344	450	385	405
PSD	1,829	1,445	1,632	1,753
Independent Living Team	596	748	768	647
Equipment Service		104	166	110
Contracts with voluntary sector	104	92	90	93
Total	**3,205**	**3,615**	**4,042**	**3,726**

Diagram 7: Percentage expenditure by service in 2006/07

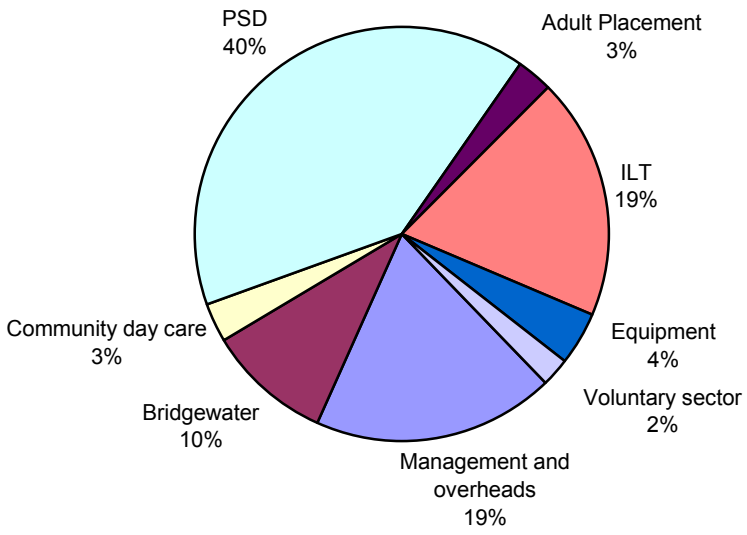
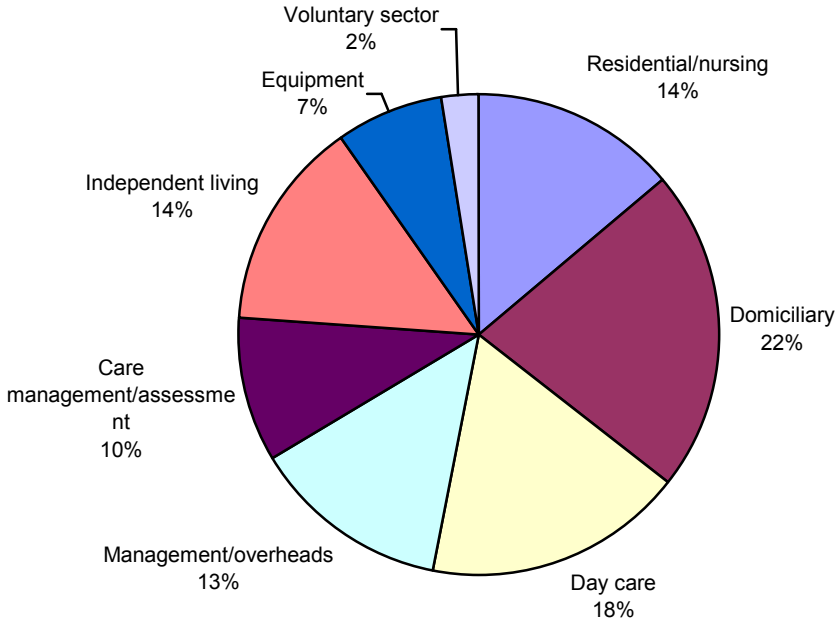


Table 14: Physical and Sensory Disabilities – Budget by Service Type 2007/08

Service	£000
Residential and Nursing	514
Domiciliary care, direct payments and meals	814
Day care	653
Management /overheads	488
PSD care management and assessment	364

Independent living team	535
Equipment – including audio, visual and minor adaptations	265
Voluntary sector – audio/visual services	93
Total	**3,726**

Diagram 8 : Percentage budget by service type 2007/08



Community Care

Expenditure on community care in the independent sector for the last three years is shown below together with the budget for 2007/08. expenditure for Physical and Sensory Disability Services for 2004/05 and 2005/06 is shown below in Table 21.

Table 15: Community Care expenditure 2004/05 to 2007/08

2004/05 Expenditure	2005/06 Expenditure	2006/07 Expenditure	2007/08 Budget
£1,227,768	£1,441,308	£1,413,322	

			£1,346,490

The Directorate operates a policy that encourages individuals to access Independent Living Fund, which has helped reduce the budget pressure in the service. There are a small number of complex packages jointly funded with Health.

Regional Procurement

Across the North West region, there is recognition that it is beneficial to work collaboratively on a Regional basis to commission services more cost effectively across boundaries. There are several strands of this work lead by the North West Centre of Excellence, who have launched, a project to Audit, across the Region, high cost placements. The project scope will look at variations in cost and quality, inconsistencies in charging, the need for more complete picture of clients, cost, care and contracting. It aims to provide baseline information to support service development and improved commissioning/contracting. The scope will cover Adults 18-65 with Learning and/or physical disabilities.

Disabled Facilities Grant

Adapting properties (within owner occupied, private and council tenancies) to meet the needs of disabled people can be funded by use of Disabled Facilities Grants (DFGs). The current upper limit per grant is £25,000 per adaptation and eligibility for a DFG is means tested. Adaptation work above the grant limit is funded through the Independent Living Team budget (£111,590 for the year 2007/2008).

The ILT budget is also used to fund minor adaptations (eg, grab-rails); top up where the available grant is below the maximum, falls short of the amount required to complete work and the service user is unable to identify alternative funding; and fund adaptations for disabled service users in all service user groups and for of all ages.

The demands on this budget will increase in the future due to:

- The anticipated growth in Halton's ageing population.
- More extensive work being recommended to take advantage of new equipment/technology and assessing service users needs for the longer term rather than the immediate future.
- The drive to enable more service users to remain independent in the community.
- Service user awareness of their right to adaptations and determination to remain in the community.
- The increased cost of materials and building work.

The following options exist to manage the growing demand on this budget:

- Support to service users to move to adapted or more easily adapted properties -an Adapted Housing Register is currently being established.
- The use of prefabricated adaptations – "pods".
- Introduction of an equity release scheme.
- Introduction of a loan/interest free loan scheme.

The Government has issued a consultation document "Disabled Facilities Grant Programme: The Governments Proposals to Improve Programme Delivery" which contains proposals for a staged increase on the upper limit to £50,000 and giving authorities powers to recover grant on

future sale. The latter is a long term solution to recycle money but in the short term additional funding will be required to implement these proposals.

CONCLUSION: SECTION FIVE

Activities to achieve our overall objectives to promote independence, help more people to live at home and give them more choice are bearing fruit as can be seen from performance evidence. In 2006/75 92% of community equipment was delivered within 7 days and Halton also has high levels of people using direct payments, which provide greater control over people's choice of who provides their care.

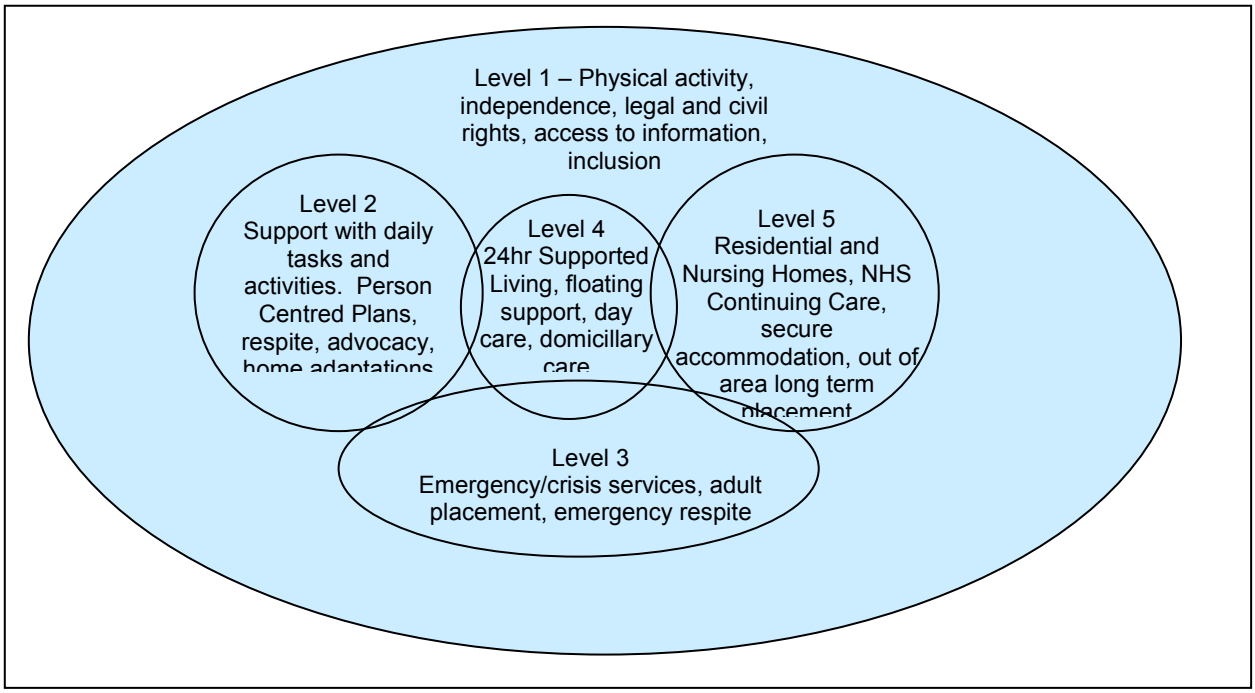
Waiting times with regard to major adaptations are lengthy and need to be reduced, however, a review of the adaptations service is underway, which aims to improve processes and practices and reduce waiting times.

A culture of continuous improvement is needed to ensure improved performance against performance indicators. Detailed financial planning will inform decisions for funding service developments and meeting future demand for services.

SECTION SIX: IMPLEMENTING THE STRATEGY

This Strategy in relation to the commissioning of services for physically disabled people is structured on the Peter Fletcher Associates' 5 Levels of Care outlined in Section One, which underpin the whole system approach to strategic commissioning. Most health and social care provision and financial resources are geared towards the higher dependency needs of vulnerable people in the community. Any move therefore to increase investment in citizenship and lower level support services depends to some extent on disinvestment in the higher cost services at Levels 4 and 5 or using resources more effectively.

The diagram below, first outlined in Section One, gives some examples of activities associated with each level and begins to explain how each section of the Local Authority and PCT can play their parts in providing services for people with physical disabilities which are effective, outcome focussed and which truly reflect need.



LEVEL 1 - CITIZENSHIP

Information

A full range of information needs to be provided in an accessible format to enable people with sensory impairments resident in the borough to know what services are available and to fully participate in services they access.

- All services commissioned or accessed by people with sensory impairments will be required to produce a statement of purpose for commissioners and accessible information for users.

- All written publicity, information and documentation will be produced in a format which is accessible to service users and their carers.

Service User and Carer Involvement

The provision of services needs to be informed by service users and their carers both at a macro and micro level of commissioning.

- Service users and carers' views should be considered and recorded in all assessments, plans and reviews. The full implementation of person centred planning is essential in developing full user participation and services will need to be responsive to the challenges this presents.

- Service user forums should be developed for those using Physical and Sensory Disability Services. These should be supported and membership encouraged. Consultations about service improvements and developments should be referred to the forum for comment.

- An active forum for carers to articulate their views exists within the Halton Carers Umbrella Group existing in its own right and having representation on the Carers Strategy Group. The development of further carer forums and consultation events for those caring for physically disabled people should be encouraged.

- The needs of carers should be identified through carers' assessments.

Social Inclusion

Strong partnership working with the whole range of organisations in the Borough is fundamental in contributing to the development of fully accessible services. Within Social Care, services provide stepping stones for disabled people towards full social inclusion. These services enable access to employment, education, community and leisure facilities, voluntary societies and self-help groups, disability arts and sports, peer support, advocacy services and community participation.

LEVEL 2 - PREVENTION AND MINIMUM INTERVENTION

Halton's approach to services for disabled adults is to support more people in their own homes and communities and less people in hospital and care homes.

Promoting Independence

- Care planning will be outcome focussed by taking a person centred approach and will require services which promote independence by giving service users more control over service delivery and by offering a rehabilitative approach.

Independent Living

- A Direct Payment scheme operates in Halton and is available to all service user groups. As at April 2006, 55 disabled people were in receipt of Direct Payments. The take-up of direct payments will be encouraged as the most effective way of giving service users control of services and from 2008 Individualised budgets will be available to all.

- Every effort will be made to enable service users to live independently in the community. This will require a range of domiciliary support services including personal assistance services and community support services.

- Intermediate care services include the needs of physically disabled adults under 65. Short term rehabilitation services will be needed both in residential and nursing care and in the community.

- Respite care services should offer high quality care and be a positive and stimulating experience for the service user.

- The provision of special equipment and adaptations to assist independent living should be improved. A review of the adaptations service is underway within the Council and a Working Group set up to review the processes, practices and procedures involved in the provision of minor and major adaptations.

- A review of day services provided by the Physical and Sensory Disability Service will commence in January 2006. Currently, day service provision for physically disabled people of working age is primarily through Bridgewater. This review, together with the Modernisation of Daytime Opportunities Review across the Health and Community Directorate of the Council, will determine the future shape and provision of day services.

- Links with the Supported Employment service will be strengthened to encourage those who wish to work to gain access to and be supported in employment.

- The Community Bridge Builder service will promote enhanced social inclusion and greater engagement in mainstream services for people with disabilities

- Accessibility to community centres in the borough has been reviewed and the recommendations will be acted on to ensure mainstream services can be used by physically disabled people.

Transition

- A joint strategy with the Children and Young People's Directorate will be in place by September 2007 and is crucial in enabling a proactive approach to young people having a positive experience of transition into adult services.

Advocacy

- A generic advocacy service has been commissioned with time limited funding. Joint working with the provider will be undertaken to identify alternative funding sources and secure the future of this service.

LEVEL 3 - INTENSIVE TIME-LIMITED INTERVENTIONS

- Adult Placement is a direct alternative to traditional residential and day care and is provided by 'foster' families in the community. There is considerable scope to develop this service to prevent hospital admissions and speed up transfers.

LEVEL 4 - COMMUNITY-BASED ONGOING LONG-TERM HEALTH & SOCIAL CARE SUPPORT

- Alternative options to manage the growing demand on the Independent Living Team budget to top up Disabled Facilities Grants will be explored, for example:

    - Support to service users to move to adapted or more easily adapted properties and linked to an Adapted Housing Register.

  - The use of prefabricated adaptations – “pods”.
  - Introduction of an equity release scheme.
  - Introduction of a loan/interest free loan scheme.
- Comprehensive information about housing and support options will be made available to all service users, carers, staff and other stakeholders.
- Consideration should be given to the development of Adult Placement as an option for support and accommodation. This is significantly under developed in Halton, but has proved to be a positive option in other areas.

LEVEL 5 - LONG-TERM CARE IN RESIDENTIAL OR NURSING HOMES AND HOSPITAL

In April 2006 there were 13 people aged 18-64 with physical or sensory disabilities placed in permanent residential or nursing care placements. The service is successful in supporting people to remain in their own homes.

ADULT SOCIAL CARE OUTCOMES FRAMEWORK

The White Paper Our Health, Our Care, Our Say requires a strategic shift to locate services in the local community and sets out seven broad outcomes for services to deliver for individuals – these were outlined in Section 1, page 10.

ACTION PLAN

The action plan at the end of this section links each specific outcome to the broader outcomes set out in the white paper and also shows which of the five levels of care an action will promote. Actions are weighted towards achieving citizenship and lower levels of support - levels 1, 2 and 3, which maintain independence and prevent admission to acute or high dependency services.

OPTIONS FOR CHANGE

Five over-arching options exist for the commissioning and planning of services to ensure the needs of service users are met:

- Disinvest or de-commission – Disinvestment is the process of reducing or eliminating investment in services because they no longer align with need.
- Re-configure services – Re-configuration is the process of negotiating changes to the service specification with an existing provider to ensure that they align with needs.
- Re-negotiate or end contracts – Re-negotiation is the process of improving performance in delivering the contract.
- Maintain contracts – Maintenance is the process of ensuring continuity of service provision, price and quality.
- Commission new services – Commissioning new services is the process of securing services to meet new or changed needs.

Factors affecting the decision on which of the above processes are appropriate include:

- None or poor alignment with needs.
- Poor quality services.
- Adversarial relationship.
- High cost service.
- Contract details.

Given the range of actions in the plan all of these options will be utilised as appropriate.

PSD Joint Commissioning Strategy Action Plan

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Level of Care	Accountable Manager	Timescale
Improved Health	Rehabilitation	Develop a consistent approach to physical and psychological rehabilitation services and establish community based services and support groups.	Individuals learn strategies to help manage their condition and remain independent.	3	Divisional Managers Independent Living Services and Assessment and Care Management	December 2007
		Identify how short-term neuro-rehab can be accessed.		3		December 2007
		Ensure continuity of rehabilitation and follow up reviews.		3		December 2007
		Extend intermediate care to those aged under 65.		3		April 2008
Improved Quality of Life	Voluntary Sector contracts	Review contracts to identify gaps / improvements and develop action plans with agencies.	Individuals will be able to access appropriate effective services	2	Divisional Manager Assessment and Care Management	March 2008 Work topic for PPB
		Implement ongoing provider monitoring arrangements			Joint commissioning Manager Adults with Disabilities	March 2008
	Deaf/Blind Strategy	Checklist/mapping exercise leading to action plan	Individuals have access to specific support.	4	Principal Manager - PSD	October 2007

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Level of Care	Accountable Manager	Timescale
Improved Quality of Life	Transport	Replacement programme for HBC fleet and HCT vehicles will support modernisation of day activities.	Accessible transport available and passenger journey times reduced.	4	Team Leader - Client Services (Transportation)	March 2008
		Offer travel training and improve information to enable individuals to access public transport.	Individuals are enabled to travel independently.	2	Team Leader - Client Services (Transportation)	September 2007
		Improve frequency of public transport services.	All areas of the Borough are accessible by public transport 7 days a week and including bank holidays.	1		March 2008
		Encourage bus companies to replace remaining non-accessible vehicles.	Accessible vehicles will be available on all public transport routes at all times.	1		March 2009
	Care management	Care plans will be person centred and specify measurable outcomes for individuals.	Services will focus on enablement and be able to demonstrate achievement.	3	Principal Manager -PSD	2008
Making a positive contribution	Service user/carer involvement	Formalise opportunities for involvement	Service provision will be informed by service users and their carers at both micro and macro levels of commissioning.	1	Principal Manager -PSD	September 2007

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Level of Care	Accountable Manager	Timescale
Making a positive contribution		Review access to Advocacy services	Individuals can express their views and be heard. Implications of IMCA are addressed.	2	VATF Programme Manager Divisional Manager Assessment and Care Management	December 2007 December 2007
Exercise choice and Control	Individualised Budgets	Pilot IB's for Adults with physical disabilities as part of the In Control project work. Care managers to encourage self assessment and support planning	IB's will be made available to all who want them. Individual sets the outcome they wish to achieve.	2	Divisional Manager Assessment and Care Management	Full implementation 2008
	Independent Living Team	Self Assessment for equipment	Reduced waiting times and individual's are in control.	2	Principal Manager ILT	December 2007
	Carers Support	Ensure services are available to meet carers needs identified through assessment.	Carers will be supported to maintain their health and social networks.	2	Divisional Manager Assessment and Care Management	April 2008
	Information	Explore opportunities to promote services/support and signpost individuals appropriately. Ensure people have full information about their condition and what this may mean for them.	Individuals will make informed choices.	1 1	Divisional Managers Independent Living Services and Assessment and Care Management	December 2007

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Level of Care	Accountable Manager	Timescale
Exercise choice and Control	Independent Living Centre	Re-establish vision/purpose	Effective use of building.		Divisional Manager Independent Living Services	April 2008
	Equipment services	Scope of HICES	Clarity around support for C&YP			December 2007
		Build capacity to expand HICES in response to aging population.	Equipment is available within time target.	2	Divisional Manager Independent Living Services	April 2008
		Direct payments for equipment	Greater choice for individuals	2		April 2008
Freedom from discrimination and harassment	Diversity monitoring	Record diversity data in assessment, planning and review.	Individuals' cultural and religious needs are met.	1	Principal Managers ILT and PSD	December 2007
		Training to ensure diversity is addressed in care planning / service provision.			Divisional Managers Assessment and Care Management and Independent Living Services	December 2007
Economic well-being	Life chances	Consider best use of Bridgewater	Available services will be designed to move people on.	3	Divisional Manager Independent Living Services	April 2008
		Ensure Management Responsibility protocol is in place for all in-house services.	Council managers working alongside agency staff will ensure care plans are followed.			October 2007
	Employment	Develop support for maintenance of existing employment skills.	Individuals can continue or return to employment.	2	Joint Commissioning Manager Adults with Disabilities/Supported	April 2008

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Level of Care	Accountable Manager	Timescale
Economic well-being		Offer training to access employment		3	employment	
	Housing	Set up adapted housing register.	Housing need will be quickly matched with suitable accommodation	2	Principal Manager ILT	March 2008
	Housing	Colleagues responsible for Housing elements of local development framework to sit on PSD LIT	Need for an accessible environment compliant with both Lifetime Homes and Decent homes standards is promoted.	1	Joint Commissioning Manager Adults with Disabilities	July 2007
	Community bridge building	All aspects of PSD services to link to the Bridge Building Service and ensure appropriate referrals are made	Opportunities for social integration and employment are identified and realised.	1	All Principal Managers within PSD services	July 2007
	Cultural and Leisure services	Implement findings of accessibility review and actively promote mainstream services to people with disabilities.	Barriers that disable people will be removed.	1	Divisional manager Independent Living services	Ongoing
Personal dignity and respect	Adult Protection	Safe Guard Vulnerable Adults in Line with Halton's *no secrets* Inter-Agency, Policy Procedures and Guidance	Vulnerable Adults are protected from abuse and their personal dignity and respect remain intact.	1	Principal Manager PSD and all relevant agencies in line with no secrets policy.	Ongoing

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Accountable Manager	Timescale
Leadership	Transition	Develop strategy for transition from Children's to Adult services.	Joint planning so young people experience a positive move into adulthood.	Divisional Manager Children with disabilities/Joint commissioning manager.	September 2007
	PSD/OP Care Management	Review process for Adults approaching age 65	Continuity of care management will be maintained.	Principal manager PSD	September 2007
		Develop and implement clear and robust interface agreements across AOWA, OP and Children's services	Impact of service changes will be fully assessed and consulted on.	Operational Director OP and AOWA	September 2007
	Primary Care Services	Build relationships with local clinicians to influence PBC and promote whole system working	Promote preventative services and early intervention.	Operational Director AOWA	Ongoing
Commissioning and use of resources	HBC Independent Living Team/North Cheshire Hospital Trust /PCT	Whole system review of Therapy services	Effective utilisation of staff. Single assessment pre-hospital discharge	To be determined	April 2008
	Independent Living Services	Whole system redesign of Equipment and Adaptations processes including safer handling. Modernisation of Halton major adaptations service.	Streamlined working practices creating capacity to respond to demand of aging population and maximising staff skills and resources.	Divisional Manager Independent Living Services	2008/09

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Accountable Manager	Timescale
Commissioning and use of resources	Visual Impairment Service	Determine where this service is best situated.	Integrated, effective support available.	Divisional Manager Assessment and Care Management	December 2007
	Providers	Ensure staff are appropriately trained. Incorporate person centred working practices into staff induction and ensure implemented.	Only skilled staff will provide care/support. Individuals will be in control of how and when they receive care and support.	Divisional Manager Independent Living Services / Joint Commissioning Manager Adults with Disabilities	December 2007
		Review specifications within contracts and SLA's to promote continuous improvement.	Commissioners will be able to monitor performance and know when intervention is required.	Joint Commissioning Manager Adults with Disabilities	Ongoing
	Joint Council/PCT Financial Strategy	Identify funding available over next three years and link service redesign to dis-investment / retraction	Re-focussed services within available resources.	Divisional Managers and Joint Commissioning Manager	October 2007

REVIEW ARRANGEMENTS

This Strategy will be launched in mid 2007 and implementation and monitoring of progress will be through the Physical and Sensory Disability Local Implementation Team (PSD LIT) and service planning processes. The LIT will review annually to:

- Measure progress against actions set out in the Strategy
- Identify any barriers to achieving progress and identify solutions
- Ensure that existing service and new service proposals reflect changes in people's needs over time

REFERENCES

1991 Halton Census Atlas

2001 Halton Census Atlas

Index of Multiple Deprivation 2004

'Independence Matters: An overview of the performance of social care services for physically and sensory disabled people' Dec 2003 (DoH Report)

'Improving the Life Chances of Disabled People' January 2005 (ODPM Report)

DH NSF for Long-term Conditions

Carers in Halton Report

Physical & Sensory Disabilities Business Plan 2002-03

Physical & Sensory Disabilities Joint Investment Plan 2001-04

Halton Borough Council Corporate Equality Plan 2006-09

LCS Limited Stakeholder Away Day Report April 05

APPENDIX 1

Adults under 60 with a physical and/or sensory disability
Housing related statistics

Background

The statistics presented in this report are calculated from the responses to the Housing Needs Survey 2005 and relate to people over the age of 15 and under the age of 60 who indicated that they have either a physical or a sensory disability or both. Some 2,321 randomly selected households across the Borough participated in the survey. The statistics presented here have been weighted from the original responses according to tenure and location to represent the Borough wide position.

Number of people

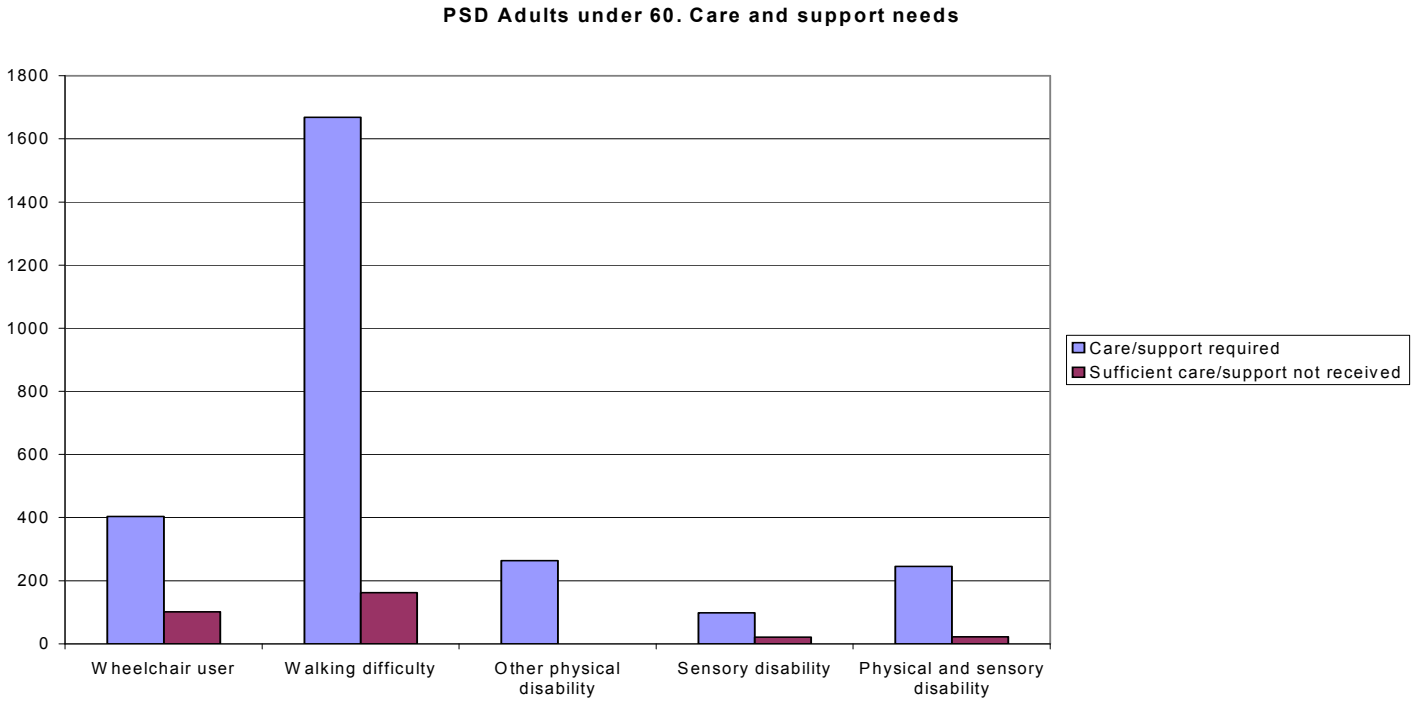
The findings show that 5,031 people between the ages of 16 and 59 have a physical and/or sensory disability. The majority of these (72%) are aged between 45 and 59 with 23% aged between 25 and 44 and 5% between 16 and 24.

The majority (88% equating to 4,438 people) have a physical disability only with 71% of these having a walking difficulty, 9% in a wheelchair and the remaining 20% with another physical disability. 343 people have a sensory but no physical disability and 250 have both a physical and a sensory disability. The table below shows the type of disability for each age group and also indicates the number of responses on which the borough wide data is based.

	16 - 24		**25 - 44**		**45 - 59**		**Total**	
	Weighted data	No. of responses	**Weighted data**	No. of responses	**Weighted data**	No. of responses	**Weighted data**	No. of responses
Physical disability only								
Wheelchair user	**62**	3	**113**	6	**242**	11	**417**	20
Walking difficulty (not in wheelchair)	**105**	6	**521**	24	**2528**	113	**3154**	143
Other physical disability	**35**	2	**270**	13	**562**	25	**867**	40
Total physical disability only	**202**	11	**904**	43	**3332**	149	**4438**	203
Sensory disability only	**23**	1	**225**	9	**95**	6	**343**	16
Physical and sensory disability								
Wheelchair user with a sensory disability	**0**	0	**0**	0	**3**	1	**3**	1
Walking difficulty with a sensory disability	**0**	0	**33**	2	**195**	8	**228**	10
Other physical disability with a sensory disability	**0**	0	**0**	0	**19**	1	**19**	1
Total physical and sensory disability	**0**	0	**33**	2	**217**	10	**250**	12
Total people with a physical and/or sensory disability	**225**	12	**1162**	54	**3644**	165	**5031**	231

Care and support required

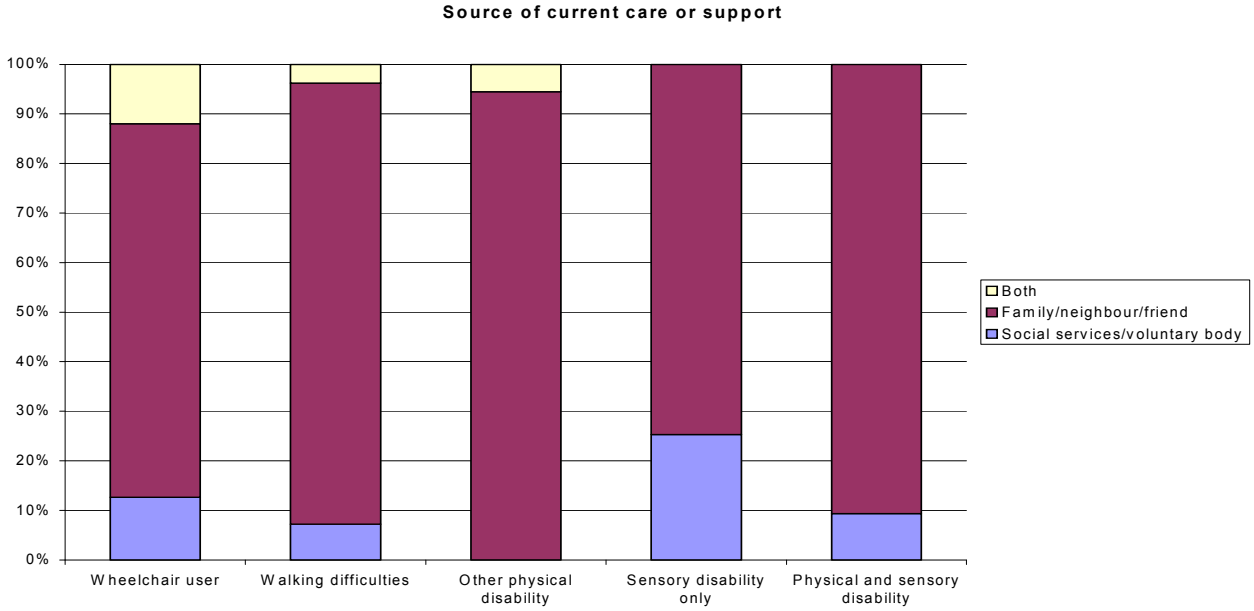
Respondents were asked to indicate whether the household member with the disability required care or support and whether they are currently receiving sufficient care or support. The results



are illustrated in the chart above.

Over half (53%) of those with a physical and/or sensory disability indicated that they did, equating to 2,679 people. However, care and support is more likely to be required for people with both a physical and a sensory disability (98%, 245 people) and those in a wheelchair (97%, 404 people). In total 12% are not receiving the care or support they need. Wheelchair users are least likely to be receiving the care or support they need with 25% indicating insufficient care or support.

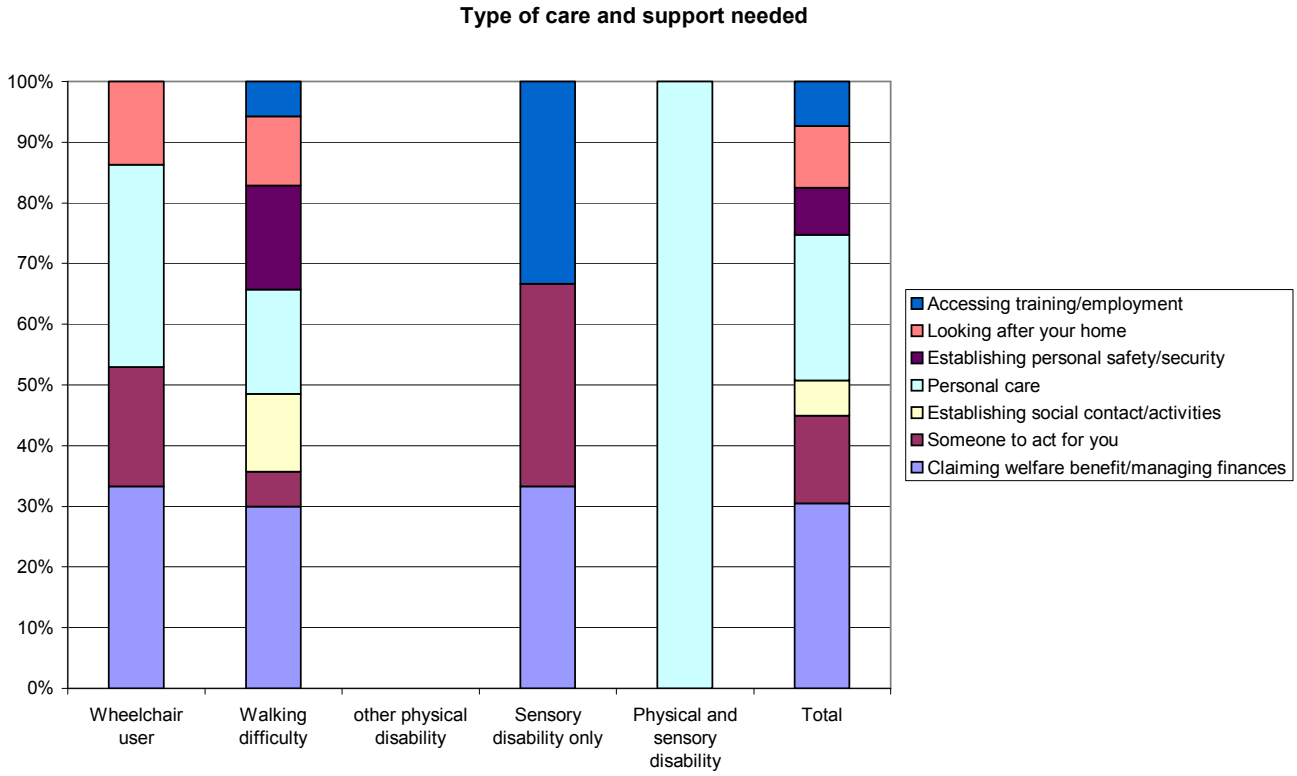
Where sufficient care or support is provided this is most likely to come from family, neighbours or friends rather than Social Services or a voluntary body as illustrated in the chart below. 88% of adults with a psd received care or support from family/neighbours or friends, with 8%



from Social Services or a voluntary organisation and 4% from both.

The chart below illustrates the type of care and support needed for each category.

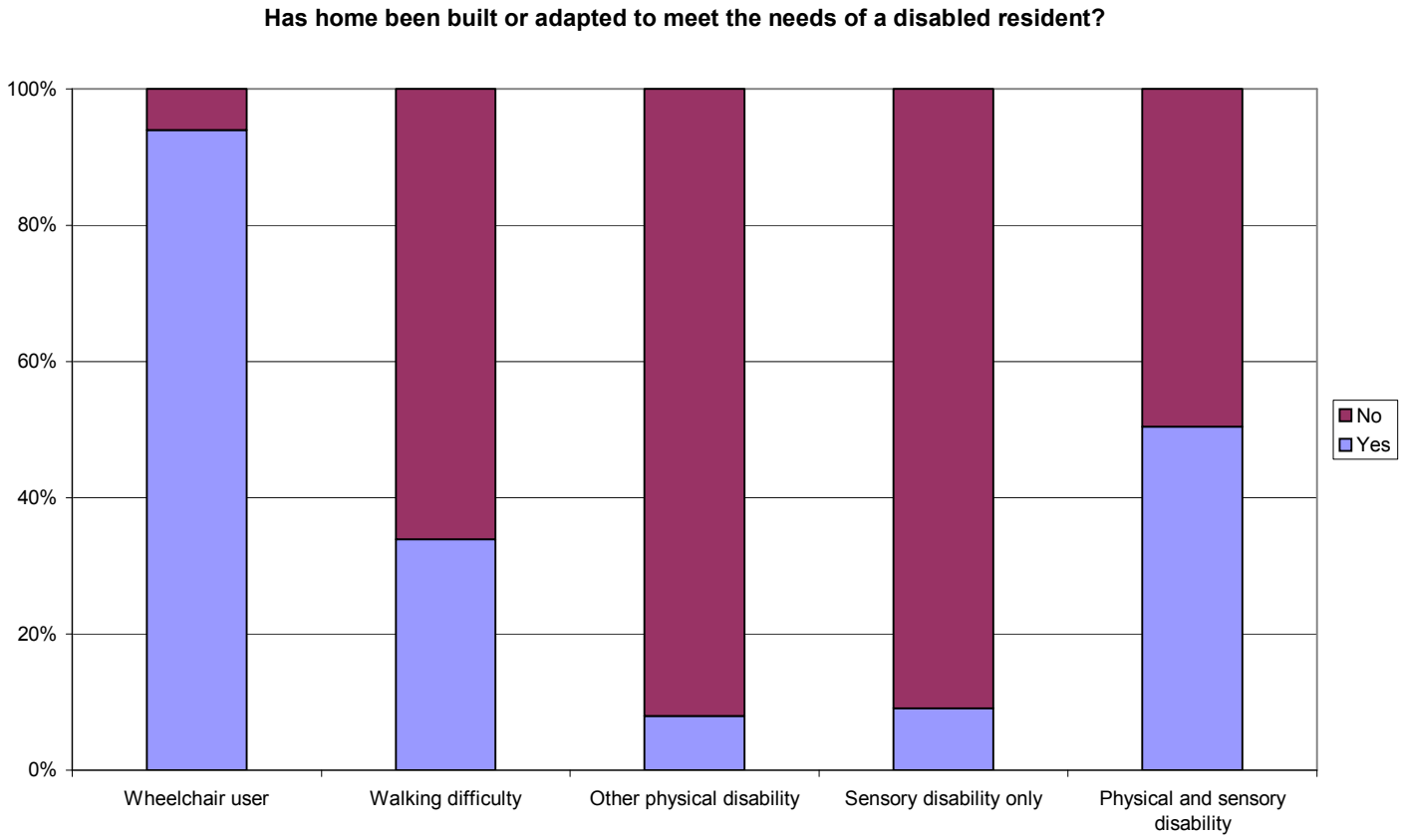
The main types of care/support required are help to claim benefits and manage finances (141



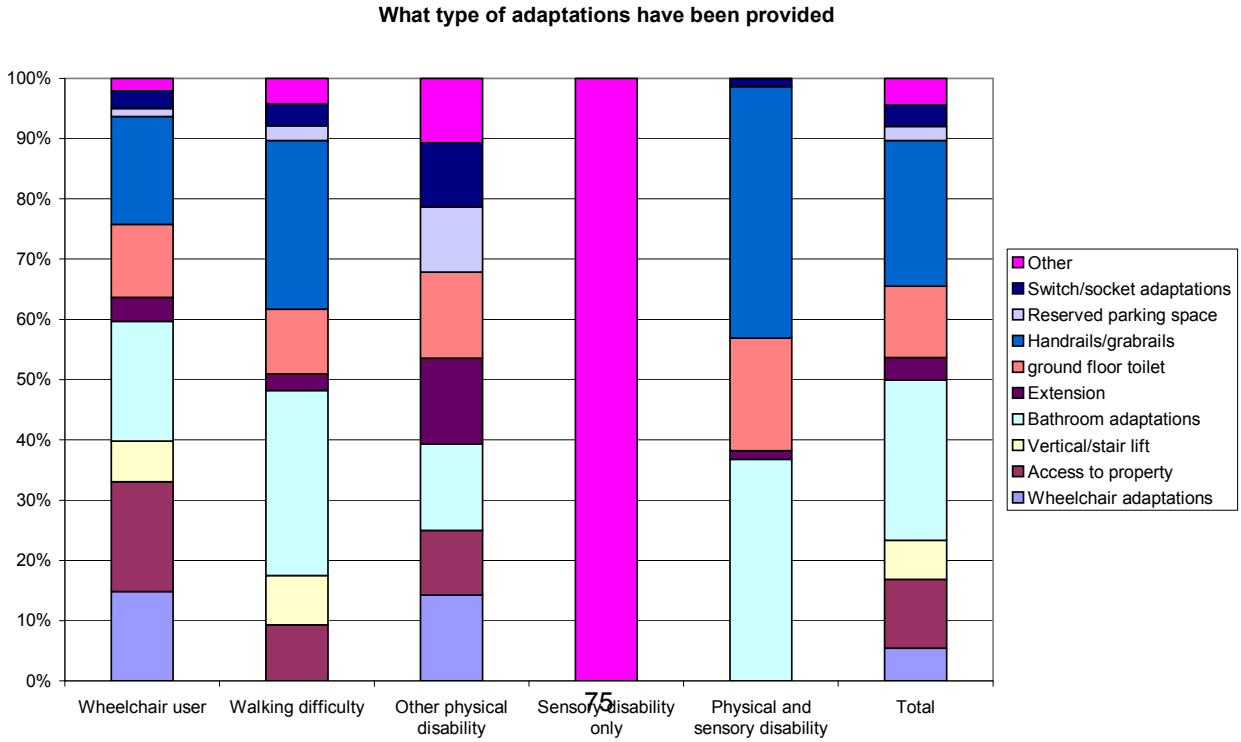
people) and help with personal care (111 people).

Adaptations

Respondents were asked whether their home has been built or adapted to meet the needs of a disabled person. In total 35% (1,396) indicated that their home had been built or adapted for a disabled person. However, there were large differences according to the type of disability as illustrated in the chart overleaf. As might be expected wheelchair users were more likely to live in adapted property (94%) and half of people with both a physical and sensory disability lived in adapted property. Only 9% of people with a sensory disability only lived in an adapted property.



Two thirds of properties (919) that have been built or adapted for a disabled person have had bathroom adaptations and 60% have had handrails or grabrails installed. Other common adaptations are provision of a ground floor toilet (30%) and alterations to provide access to the property (28%). 14% of adapted properties have been adapted for a wheelchair. The chart below illustrates the type of adaptation by type of disability.



Respondents were asked what adaptations, if any, needed to be provided to ensure that current members of the household can remain in the property now and in the next three years. Bathroom adaptations were the most commonly requested amongst adults under 60 with psd followed by handrails/grabrails and reserved parking. The following table shows the number of adaptations needed for each type of disability.

	Wheelchair user	Walking difficulty	Other physical disability	Sensory disability only	Physical and sensory disability	Total
Wheelchair adaptations	84	28	0	0	3	115
Access to property	29	115	0	0	50	194
Vertical/stair lift	34	99	0	0	0	133
Bathroom adaptations	72	453	45	0	19	589
Extension	23	52	74	0	0	149
ground floor toilet	76	112	38	0	19	245
Handrails/grab rails	0	465	85	0	0	550
Reserved parking space	33	288	21	0	78	420
Switch/socket adaptations	33	58	0	0	29	120
Other	23	43	58	23	79	226

Financial support received

Respondents were asked to indicate what type of financial support, if any, their household received. The findings show that 69% of households containing someone with a physical and/or sensory disability aged between 16 and 59 claim Disability Allowance, 48% claim Housing Benefit and 42% claim Income Support. The numbers of claimants are shown in the table below.

	Wheelchair user	Walking difficulty	Other physical disability	Sensory disability only	Physical and sensory disability	Total
Housing Benefit	208	1263	239	88	116	1914
Income Support	160	1189	171	88	71	1679
Job seekers allowance	0	69	0	0	32	101
Working family tax credit	14	145	55	56	0	270
Pension credit	33	38	33	0	0	104
Disability Allowance	368	1649	372	131	215	2735
Council Tax Benefit	124	1165	178	0	155	1622
Other	68	398	173	72	72	783
Total	**975**	**5916**	**1221**	**435**	**661**	**9208**

APPENDIX 2

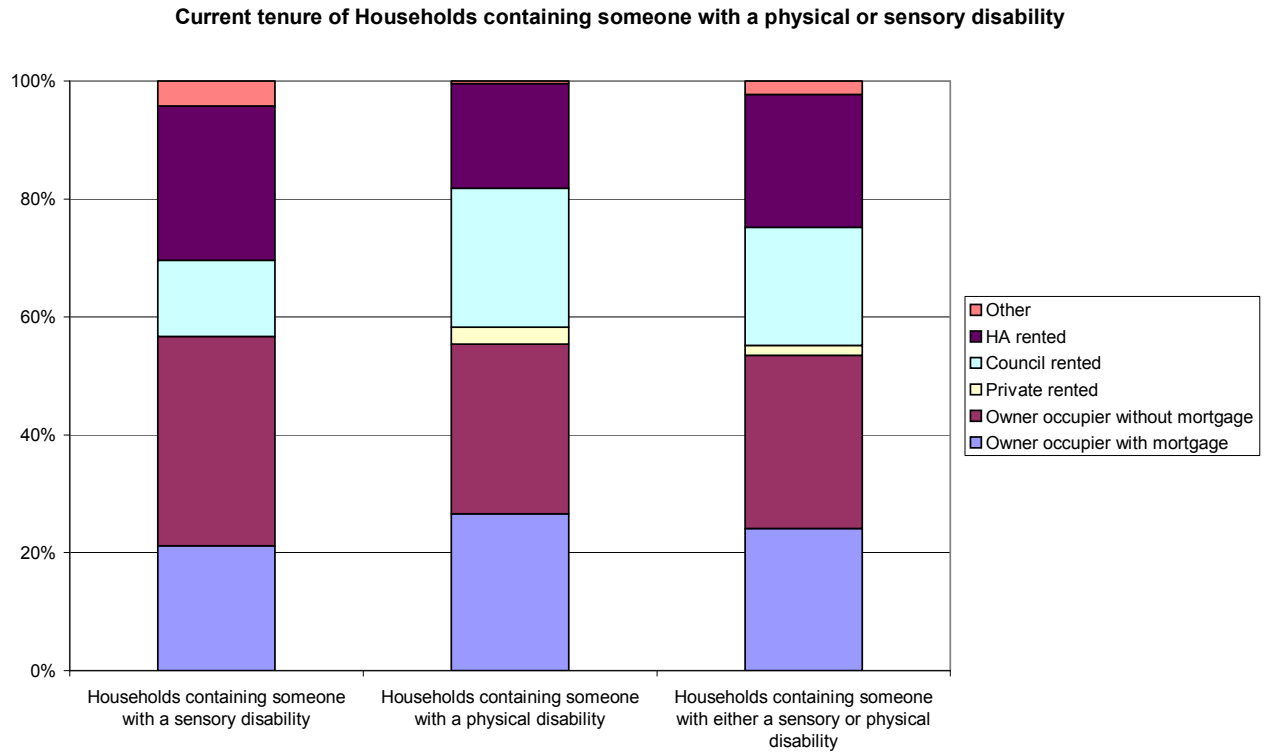
Housing Issues for the Joint Commissioning Strategy for PSD

Housing

The Housing Needs Survey 2005 provides an indication of the needs and circumstances of both physically disabled people and those with a sensory disability. According to the survey findings, some 5,288 households in the Borough contain at least one person with either a physical or sensory disability. In terms of numbers of people, 2,063 people have a sensory disability only, 3,123 people have a physical disability only and 493 have both a physical and a sensory disability.

Current tenure

Over half of households containing someone with a disability (53%) live in owner occupied accommodation with the majority (29%) not paying a mortgage as shown in the chart below. Despite this, households containing someone with a disability are more prevalent in social rented housing as a third of social rented housing is occupied by households where at least one person has a disability, compared to 19% of owner occupied housing.



Age

Analysis of the age of people with a disability from the Housing Needs Survey findings shows that 72% of people with a sensory disability only are aged over 60, and 43% over 74. Almost half (47%) of people with both a physical and a sensory disability are 75 or over and 37% between 60 and 74. The age range for physically disabled people is more evenly spread as illustrated in the chart below.

Care and support issues

The survey results show that 30% (149 people) of people with both a physical and sensory disability are currently not receiving the care or support they need, while only 6% of those with a physical disability only (172 people) and 6% of those with a sensory disability only (134 people) are not receiving sufficient care or support.

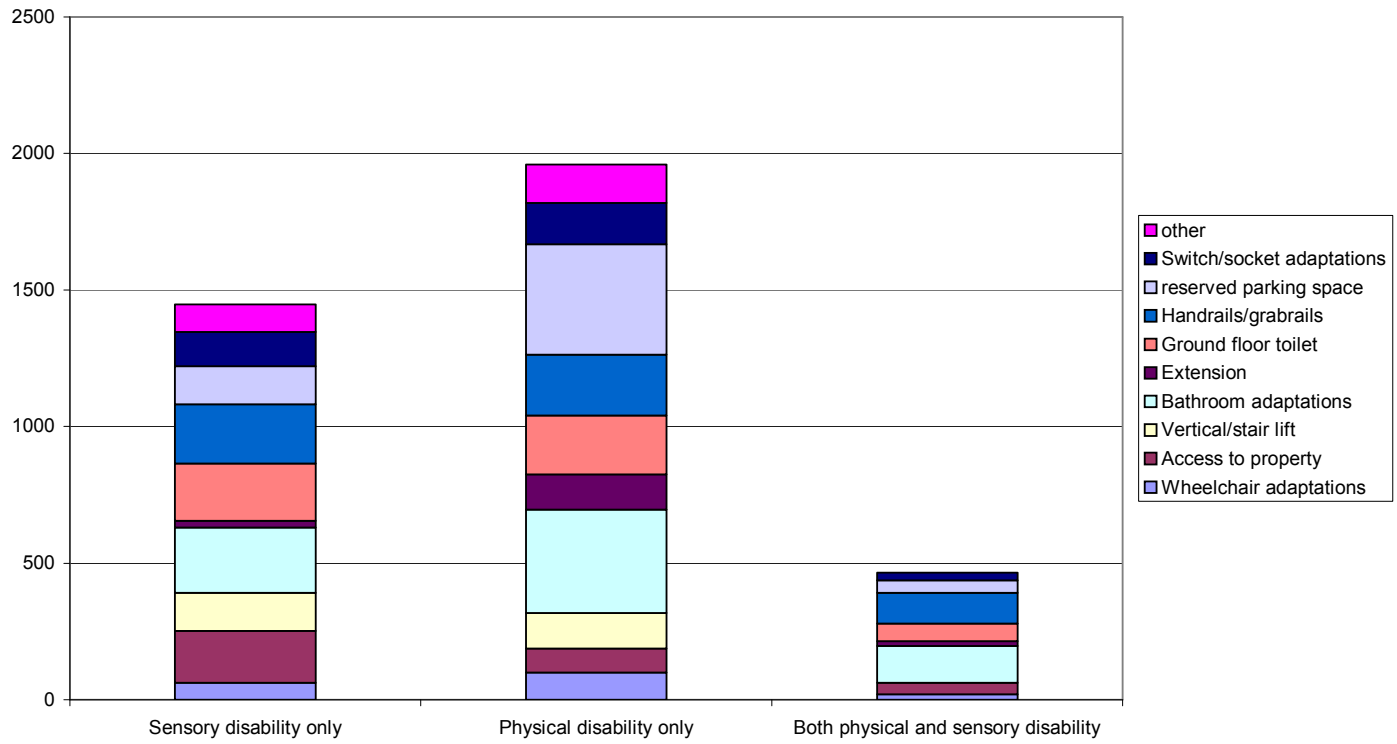
The main types of care or support required are in looking after the home (34%), personal care (22%) and in claiming welfare benefits/managing finances (19%).

Adaptations required

44% of households containing someone with a physical disability and 32% of households containing someone with a sensory disability said that their home had been built or adapted to meet the needs of a disabled person.

In terms of adaptations required to the property, 29% of households containing someone with both a physical and sensory disability require bathroom adaptations, while 24% require handrails or grabrails and 13% a ground floor toilet. A reserved parking space (15%) is the most commonly requested adaptation amongst households containing a physically disabled person, followed by bathroom adaptations (14%). 12% of households containing someone with a sensory disability require bathroom adaptations, 11% handrails or grabrails and 10% a ground floor toilet. The chart below gives and indication of the numbers of adaptations required.

Adaptations required by households containing someone with a physical or sensory disability



REPORT TO: Healthy Halton Policy & Performance Board

DATE: 12 June 2007

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Work Topic : Adults with Learning Disabilities Day Service Redesign

WARDS: Borough wide

1.0 PURPOSE OF REPORT

1.1 To present the final report of the work topic undertaken by the Board in September 2006 – June 2007.

2.0 RECOMMENDED: That

1) Members note and comment on the report; and
2) Members agree the recommendations of the report.

3.0 SUPPORTING INFORMATION

3.1 Healthy Halton Policy & Performance Board agreed the terms of reference for this work topic in September 2006. These are attached as **Appendix 5.**

3.2 Three members participated in a small working group and worked with officers to examine the significant changes that have taken in Day Services for Adults with Learning Disabilities. This work included visits to neighbouring authorities and to day services within Halton.

3.4 The report covers findings of this work and includes the views of carers and adults who currently access these services. **Appendix 1** is the final report, and recommendations of the outcome of the review are contained in section 14. **Appendix 2** summarises the views of carers; **Appendix 3** summarises the views of adults currently accessing day services and **Appendix 4** identifies the common themes both before and after the closure of Astmoor.

3.5 Overall while the review identifies server areas for development the move from a large segregated building to local community bases has been successful.

3.6 A number of recommendations have been made including further work on services for people with profound and multiple disabilities. Continued involvement of service users and carers in development of services and consideration of the development of a ‘one-stop

shop'.

4.0 POLICY IMPLICATIONS

4.1 This report supports the move for more localised and inclusive services for people with adults with learning disabilities.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 None.

6.0 OTHER IMPLICATIONS

6.1 None.

7.0 RISK ANALYSIS

7.1 None.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 These services seek to ensure that people with additional needs can participate in community life.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 There are no background papers under the meaning of this Act.

Scrutiny Review of the Re-design of Learning Disability Day Services

Report to Healthy Halton Policy & Performance Board

Contents

1 Purpose of Report

The purpose of the report is to provide a final report on the work of the Day Service Scrutiny Topic Group. The Topic Group was set up to make recommendations in the light of scrutinising the implementation of day service modernisation following the White Paper "Valuing People" and the modernisation plan for Halton Day Services.

2 Why this topic was chosen

The decision to re-design day services signalled the initiation of a longer-term development and modernisation of day service provision in Halton. Although these changes were long overdue, the vulnerable nature of the client group meant that there was likely to be considerable concern and sensitivity to the proposed changes. Given this context the Healthy Halton Policy and Performance Board considered it important that the process was subject to a scrutiny process to ensure the principles of equity, effectiveness, appropriateness and transparency were adhered to and that outcomes for people accessing services would reflect those incorporated in the White Paper *Valuing People*.

It was anticipated that, where appropriate, learning points from the redesign process would be used within the review of Day Services for other client groups.

3 Parameters of the scrutiny review

Topic description and scope

The aim of the Work Topic, agreed by Healthy Halton PPB in September 2006, is as follows:

- to scrutinise the process of the redesign of Day Services for adults with learning disabilities, as outlined in the White Paper, *Valuing People: A New Strategy for Learning Disability for the 21st Century,* and as agreed by Halton Borough Council's Executive Board in November 2005.

The scope of the Work Topic was:

i) to review the process undertaken to decommission Astmoor Day Centre.
ii) to review the expectations and experiences of stakeholders, including people accessing services, carers and staff members.
iii) to benchmark Halton Day Services against other local authority providers.
iv) to assess the extent to which the redesign of Day Services has fulfilled the criteria outlined within Valuing People.
v) to identify any barriers that may exist hindering redesign.

Key outputs and outcomes sought

i) To ascertain to what extent progress has been made in terms of redesigning Day Services in Halton, as outlined in *Valuing People*.

ii) To produce a critical appraisal of the process undertaken in decommissioning Astmoor as a Day Centre, and developing alternative service provision.

iii) To ensure that learning points from the experiences and expectations of key stakeholders – most notably people accessing services, carers and staff – are noted and used during similar exercises.

iv) To identify any service gaps and necessary service improvements, and barriers to redesign and to make recommendations regarding future service development and provision.

4 The Scrutiny Process

The Scrutiny Panel comprised the following people:

Members:	Ellen Cargill	Officers:	Martin Loughna
	Sue Blackmore		Nigel Parker
	Kath Loftus		

At a Work Topic Meeting on 31 October 2006 it was agreed that the methodology to be used to scrutinise the re-design of day services would entail the following:

- Detailed review of steps taken to ensure the process utilised was inclusive, thorough, effective and appropriate.
- Analysis and comparison of the surveys of carers undertaken pre and post redesign of day services.
- Visits of a range of day services, internal to the borough.
- Visits of a range of day services, external to the borough.

5 Introduction

Until the 1950's, it was generally accepted that people with learning disabilities could enjoy a better quality of life living with other disabled people in segregated institutions rather than in the community with their families. However, by the end of the 1960s it became clear that the quality of care in long-stay hospitals was often extremely poor. Parental pressure became an important influence in the drive for change. The 1970 Education Act ensured that education should be provided for all children, no matter how severe their disability.

The 1971 White Paper *Better Services for the Mentally Handicapped* paved the way for change. It set an agenda for the next two decades which focused on reducing the number of places in hospitals and increasing provision in the community. It committed the Government to helping people with learning disabilities to live "as normal a life as possible", without unnecessary segregation from the community. It emphasised the importance of close collaboration between health, social services and other local agencies.

As people moved out of long-stay hospitals, residential care home places expanded and day service places also increased greatly. However, the social exclusion experienced by people with learning disabilities remained a significant problem resulting in the White Paper, *Valuing People. A New Strategy for Learning Disability for the 21st Century,* being published in 2001. This set out the Government's proposals for

improving the lives of people with learning disabilities and their families and carers, based on recognition of their rights as citizens, social inclusion in local communities, choice in their daily lives and real opportunities to be independent.

6 National Context

A Government Objective within *Valuing People* was 'To enable people with learning disabilities to lead full and purposeful lives within their community and to develop a range of friendships, activities and relationships.' It stated that for decades, services for people with learning disabilities had been heavily reliant on large, often institutional, day centres. Whilst these had provided much needed respite for families, they had made a limited contribution to promoting social inclusion or independence for people with learning disabilities. People with learning disabilities attending them had not had opportunities to develop individual interests or the skills and experience they needed in order to move into employment.

In 2005, a Social Care Green Paper *Independence, well-being and choice: our vision for the future of social care for adults in England* was published. The key proposals to deliver the vision for social care over the next 10 – 15 years included:

- wider use of direct payments and the piloting of individual budgets to stimulate the development of modern services delivered in the way people want;
- greater focus on preventative services to allow for early targeted interventions, and the use of the local authority well-being agenda to ensure greater social inclusion and improved quality of life;
- encouraging the development of new and exciting models of service delivery and harnessing technology to deliver the right outcomes for adult social care.

In 2006 the White Paper *Our health, our care, our say: a new direction for community services* set out a vision to provide people with good quality social care and NHS services in the communities where they live. It emhasised the fact that social care services are changing to give service users more independence, choice and control over their lives.

7 Local Context

i) Description of Current Day Service provision

In 2004 Halton's in-house Day Services consisted of two large Day Centres, Astmoor in Runcorn and Pingot in Widnes, together with a Supported Employment Service. The latter offered support to all people with disabilities, including those with learning disabilities, to help them access employment.

Pingot provided a service for up to ninety-nine people and Astmoor to one hundred and twenty people. Both centres offered day care in segregated settings. The age range of people accessing the services was from nineteen to seventy six years old. Both Day Centres offered a range of activities within the buildings, but had also developed links with other services, including the Arts Council, Woodland Trust, Norton Priory, and various other agencies and community groups.

The services also supported service users to access a range of community facilities and resources such as Further Education Colleges, sports complexes, parks, leisure services and public libraries.

Several small-scale projects had developed out of the Day Services. These included:

- Country Garden Buffet Service
- Environmental projects such as the Woodland Trust and Norton Priory.
- Hopes, a service supporting older people with learning disabilities.

ii) Future demand

There is significant pressure on current day service provision. Future demand for day services is likely to increase. In March 2006, 402 people with learning disabilities were known to the Council, 33 of whom were over 65. In addition to the 209 people using day services, 27 people were in transition. There were 49 people over the age of 19 with profound and multiple disabilities, 29 people aged 3 - 19 currently accessing special schools and 10 known pre-schoolers (0 – 3). Whilst these numbers are not necessarily high, they are steadily growing. In 20 years there could be at least at a 50% increase in the numbers of people with PMLD that are supported in ALD services.

However, it is recognised that traditional day service provision is not outcome-focussed, can result in people who use services becoming dependent and that opportunities have been resource-led, resulting in a narrow band of activities and life-styles for people that use services. As people continue to use services at the same level over a long period of time, this fails to create capacity for new referrals.

iii) Local process

In July 2004 a report – 'Options for Lifestyle Opportunity Services for people with learning disabilities - *Translating the Vision*' - was presented to Halton Borough Council's Executive Board. This report outlined Halton's response to *Valuing People, A New Strategy for Learning Disability for the 21st Century*, which set out the Government's agenda to develop and modernise services, in order to promote social inclusion and independence for people with learning disabilities.

Local authorities were required to examine their dependence on traditional segregated Day Services, such as Day Centres, to ensure that resources were re-focused on providing people with learning disabilities with new opportunities to lead full and purposeful lives.

The report made the following recommendations which were approved by the Executive Board:

- The need to appoint a Principal Manager to oversee a new unified service, and drive forward change.

- The need for one 'seamless' Day and Supported Employment Service for Halton.

- The need for accelerated movement away from traditional buildings-based services.

- The need to work in partnership with a range of Council and external bodies to promote the Valuing People agenda, and challenge current service delivery practices.

Following this, significant progress was made in developing opportunities. A Principal Manager was appointed in December 2004 to drive forward the changes, new services were developed and existing community based services strengthened.

In keeping with the national policy drivers, agreement was gained from the Executive Board in November 2005, to close Astmoor Day Centre, and to operate a 'hub and spoke' model with Bredon acting as the hub, and Pingot, Community Centres and other venues acting as the spokes. It was agreed that Astmoor would not close until Bredon had opened as a resource base, following refurbishment.

It had been identified that there was capacity within community centres to provide dedicated areas for Day Services. A formal partnership between Leisure and Community Services and Adults with Learning Disabilities Services could lead to the development of a range of activities and form the "spokes" of this model. In turn this would lead to increased opportunities for adults with learning disabilities to participate in existing mainstream activities within the community centres.

It was also agreed that a single staffing structure should be developed for Halton Day Services, and additional funding of £48,000 was agreed by the Executive Board to set up a Floating Support Team to reflect the need for additional resources to support a community based service.

iv) Buildings

Astmoor Day Centre was a large building situated on an industrial estate, physically isolated from the local community and people attending the service had to travel further to any community-based activities that they were accessing. Pingot Day Centre is better located, being based in the community and close to Widnes Town Centre. Both buildings are large, run down and offer segregated provision. They are not considered fit-for-purpose, in terms of Valuing People.

There are, however, a number of factors that need to be taken into account when considering the use of buildings for this client group, including:

- The need for dedicated, fully accessible rooms, toilets and showers etc. to support the need for personal care.
- The need for specialist aids and adaptations, to support personal care.
- The need for a range of safe, secure, stimulating environments that will meet the basic needs of the people using services.
- The need to integrate safely and appropriately with a range of people, with and without disabilities.
- The need to develop facilities within community venues, including shopping areas, libraries, leisure centres, community centres etc.
- The need for flexible, accessible, reliable transport, and for appropriate accompanying support.

8 Process of Closure of Astmoor Day Centre

Following the Executive Board meeting in November 2005, a Project Board and Project Group was set up to oversee the closure of Astmoor and the modernisation process.

During 2006, considerable work was undertaken by the management team to take this process forward. This included the following:

- Extensive consultation with users and carers was conducted as detailed in Appendix 1 and 2.

- The two Day Centre management and staff teams were restructured to form one team, which would reflect the need to manage and develop a unified service throughout Halton.

- Individuals' Care Plans were revisited, to develop timetabled community based activities, that would, as far as possible, accommodate current activity being undertaken and would support the continuation of friendships.

- From January to March, all Carers received individual visits from Day Service staff, to discuss any concerns and ideas they had regarding the modernisation process.

- Agreements were made for dedicated use of Castlefields, Grangeway and Upton Community Centres which would act as local community bases.

- Capital funds were secured to provide fully accessible toileting facilities, including tracking, in Grangeway and Upton Community Centres. Additional capital funds were also secured to make structural changes to the first floor of Bredon, to accommodate the Day Service Management Team.

- Considerable work took place with the transport department to arrange for service users to access community centres and other activities directly from home. This was an important factor in breaking the need to use Astmoor Day Centre as a base to access other activities from.

- Risk assessments were carried out for all community-based activities – linked to individuals - to ensure that any risks associated with accessing new environments or activities were identified.

- Provision was made to transfer a number of people with profound and multiple disabilities from Astmoor Day Centre to Pingot and for people with challenging behaviour from Astmoor to Bredon, following completion of refurbishment in November 2006. As part of this process, additional visits were made to carers of these people to discuss and plan the moves.

- New venues and community-based activities were developed – including Murdishaw Community Café, Lord Taverners' Community Centre, and a project in Victoria Park, Widnes.

9 The Challenges

Rob Greig, Valuing People Director of Implementation wrote:

'The modernisation of day services is one of the most important pieces of work facing Partnership Boards……The changes needed are much more than a move from large day centres to small ones. People want lifestyle opportunities that are based on them being real and full members of communities, with the opportunities to have jobs, go to college, meet friends, relax and enjoy themselves. At the same time, the genuine need of families to have support to get on with their own lives must be recognised."

Experience of reviewing day services has demonstrated the following issues to be key challenges:

i) Services must be designed to support people to access a wide range of opportunities, including employment, education and leisure. Traditional day centres can result in people who use services becoming dependent, and in redesigning services, it is important to ensure that choice and independence are promoted and outcomes for individuals are developed. As far as possible opportunities should be accessed directly from home, and should take place in ordinary, valued integrated settings.

ii) Person-centred planning must be at the heart of service development and services must be able to respond to demands made through this process. Hence activities need to be continuously reviewed and developed especially with small groups of service users. There must be a multi-agency approach to service delivery, to ensure people's needs are met in an holistic manner.

iii) Current staffing levels were designed to support the delivery of services within the day centre settings. This has led to a situation where collective activity, rather than focused individual activity, is the culture. Currently, staff work during the day, from Monday to Friday. A modern day service will need to be responsive to user need throughout the whole week, including evenings. Staffing structures, levels and working practices must be challenged to achieve this goal.

iv) Funding pressures occur when developing new services whilst retaining current ones, and due to the need to develop more outcome-focussed services for individuals. Currently funding is designed to support congregate, segregated provision. Whilst some new initiatives have been developed, this has been within the current funding structure, and has resulted in financial pressures both within the developments and in the traditional services. Additionally, future planning will need to take into account the fact that there are a number of children in transition with high support needs and the increasing numbers of older people with learning difficulties and those with profound and multiple disabilities.

v) We need more support for people to work. Day services must examine their role in this process.

vi) Redesigning services requires flexibility and understanding of the Valuing People agenda within the Borough Council and beyond. There are a range of issues that must be taken on board, including:

- Integrated educational opportunities should be increased and, in particular, for those leaving school.
- Current transport funding does not support individual need and choice, resulting in large scale 'bussing' of people using services.
- The Borough Council should ensure that new developments are in keeping with the principles of valuing people and are fully compliant with DDA requirements.
- Whilst Valuing People clearly states that day centres are not the way forward, it is important to recognise that some people will need environments that are appropriate to their special needs. Ideally, this will be in normal, valued settings, such as leisure centres, community centres and similar environments.

10 The nature of service provision post redesign of day services

i) Buildings

Astmoor Day Centre, identified as the most inappropriate building in terms of size and location has now closed as a Day Service. People accessing the service are now utilising a range of resource centres, activities and venues, including Castlefields, Grangeway and Murdishaw Community Centres, Lord Taverners, Bredon and Pingot Day Centre.

Transport takes people directly to activity or base. Some of these venues are community centres used by the general public, which has facilitated a move towards more integrated service delivery. Other venues are used solely by people with learning disabilities during the day, such as Lord Taverners, and others are learning disability specific – e.g. Pingot and Bredon. All venues other than Pingot provide a service for a much smaller number of people – a maximum of 25 – and, in the main, people access different bases on different days.

Dedicated space has been negotiated, at a cost, within community centres, to act as a base from which service users can access community activities or activities within the community centres.

However, some venues are not used by the general public, and especially those people with challenging behaviours or those with profound disabilities are likely to still receive a segregated service. For people with challenging behaviours this is likely to be in a more appropriate environment to meet their needs, such as Bredon, rather than a large Day Centre. People with multiple and profound disabilities accessing Astmoor have in the main been re-located to Pingot. This is primarily because of the specific personal care and additional ongoing health and support needs of this service user group. Whilst personal care facilities have been installed in two community centres, often space is too limited to safely provide a service.

As stated above, Rob Grieg remarked that "…..*The changes needed are much more than a move from large day centres to small ones.* To some extent this is the case in

Halton. However, managers are very clear that this is a step on a journey, and that having a foothold in the door of community centres allows us to create links with the public, and opportunities to influence future developments through close partnership.

Murdishaw Community Café is a good example of a successful venture within the community. The café, staffed by people with learning disabilities who access Halton Day Services, took over the facilities at Murdishaw last August, as they were not being used at that time. During discussions with community centres' management it became apparent that there was a need to provide a community cafeteria, and that this would meet the aims and objectives of both partners, adding great benefit to the local community.

Indeed, the local community have embraced this project and numbers of people accessing the cafe are rising rapidly. It also provides an opportunity to influence the community's perception and understanding of people with learning disabilities, as they are recognised as valued citizens providing a much needed community service. The café recently won a Regional Equality and Diversity Award with North West Employers.

This success is more in keeping with the ethos of Valuing People. Service users are participating positively within the community, offering a valuable resource, rather than just having community presence, which, whilst being a positive step forward from segregation, does not in itself mean that they are active, valued members of the community.

ii) Promoting Choice and Independence

Significant work took place by the management team during the planned closure of Astmoor to ensure that opportunities being accessed by service users were continued as far as possible. Progress was made in terms of ensuring that service users access bases and opportunities directly from home, and this has been an important step forward. More activities and opportunities are taking place in community settings, and again this is a positive move. Currently, a number of people in receipt of ILF payments use this money to access Day Centres such as Pingot, supported through agency staff. This may be indicative of a current lack of alternative provision or resources.

Work should continue to restructure the nature of the service, developing further person-centred and outcome-focussed approaches. This would necessitate re-assessment from the social work team, and could lead to less, but more targeted staff input.

iii) Staffing

An additional sum was agreed by the Executive Board to fund additional staff, in recognition of the additional pressures of providing a service within a number of community venues. This facilitates the ability to recruit 3 people to act as a ‘Floating Support Team’ to cover A/L, training, sickness and other staff absences.

iv) The broader context

- Person Centred Planning should be intrinsically embedded throughout the service. The implementation of this, linked with the roll-out of In Control, and re-

assessment of all people with learning disabilities and their carers, will be significant in terms of determining how Day Services will develop in future.

- Significant work has taken place with the Transport Department to provide a service to individuals that now takes them directly to resource base or activity, rather than the large centre at Astmoor. Whilst this is an improvement, many people are still using segregated Council transport. A step-change is now required to support people to travel on public transport independently or with appropriate support, or to use a variety of alternative transport, such as small people carriers, volunteer drivers, that will allow more flexibility to meet individual need.

- Access to College provision for people with learning disabilities, and especially those with profound disabilities needs to be improved. There are a number of courses operating, though often these are 'discrete', and are not targeted at, for example, giving people specific skills they may need to move into employment.

- The Bridge Building Team that has recently been created through the use of Supporting People funding will begin to challenge other services, including Adult Education, Employment, Leisure etc., to take a more robust role in supporting people to access services, and to develop support mechanisms and networks within their services.

11 Analysis of carer and user feedback

A range of methods and initiatives were used in order to ascertain a wide spectrum of users, carers and advocates views. These events were held in a place the respondent was familiar with and all responses have been anonymized to ensure feedback was in-depth and thorough.

Since the closure of Astmoor users of day services have been asked for feedback on their activities (see Appendix 3) through the distribution of an accessible questionnaire to people supported by the service. Assistance to complete these questionnaires has been provided by Key Workers and Support Workers who work within the service. Overall feedback has been positive with 88% recording they were happy with their timetable. The only issues to arise where a number of users saying more staff would make the service better and a small number of users have raised issues about transport.

Halton Speak Out have made a substantial amount of information available which will greatly enhance the quality of service delivery. Overall feedback from the work of Halton Speak Out in consulting with members has demonstrated that the redesign of day services has gone well. The positive feedback covers the key areas of the change process – organisation of activities, range of activities and opportunities to get to meet new people as well as seeing friends. We congratulate all the efforts of staff in this respect especially given these consultations were at an early stage in the changes before they had time to bed-in. There are, however, a number of specific points, as listed in the recommendations. The majority of these issues can be addressed in the short-term whereas the latter two points are more pertinent to the way in which day services as a whole are managed.

Before embarking on the re-design of day services, a survey was conducted of carers. During spring 2007, this survey was repeated. In the details given below we have collated the outcome of both of these surveys and compared the issues raised now with those raised before the closure of Astmoor. In both cases the meetings were conducted at the person's home address; where this was not possible an alternative was offered which in some cases was via telephone.

Appendix 1 contains tables summarising carers concerns and how these have been dealt with. There appear to be few issues or ongoing concerns arising from the utilisation of new premises and the activities undertaken by users of day services. Overall, comments and feedback has been largely positive. As services are developed and reviewed, particular attention should be given to resolve areas where dissatisfaction remains.

One area that stands out as having ongoing issues is that of transport. Whilst we acknowledge that this is not under the direct control of Day Services, staff do seem to be making significant efforts to resolve these issues. We endorse these efforts and emphasise the importance of close collaboration. As is currently recognised, these services can only be provided in a seamless fashion and to a high standard if all take responsibility to achieve that aim.

The consultation process with carers has highlighted that some of the buildings are less than ideal. In certain cases this is being addressed through the current regeneration programme (e.g. Castlefields).

The newsletter appears to have been successful in improving communication. Given some of the carers' comments, however, the content should be reviewed, to see if there should be more detail on the 'bedding in' process and potential changes to service delivery.

Whilst we recognise that increasing employment opportunities are part of the longer term modernisation of day services and there have been many positive developments such as Murdishaw Café, this is an area requiring special attention.

12 Findings of visits

Internal Services:

- Pingot Day Centre	22 November 2006
- Murdishaw and Castlefields Community Centres	29 January 2007
- Bredon/Lord Taverners	8 March 2007
- Astmoor/Norton Priory	30 November 2006

Other Authorities:

- Oldham Day Services	20 December 2006
- St Helens Day Services	27 February 2007

i) Oldham Visit

Day Services in Oldham are based in three localities – Oldham, Failsworth and Chadderton, and have been historically well regarded by members, leading to favourable allocation of resources. The notion of large day centres was challenged in Oldham in the late 1980's, and since then about 15 outreach bases have been developed. Slow, steady progress has been made over the years, with much involvement with parents and carers.

Oldham Council is a pilot site for 'In Control' – the mission of which is to change the organisation of social care in England so that people who need support can take more control of their own lives and fulfil their role as full citizens: the complete transformation of social care into a system of Self-Directed Support. This has facilitated a move away from people accessing day services, as they have chosen to spend their individual funds in other ways. This is achieved through an informal brokerage system – people being given an indicative amount of money, with which they must devise a Care Plan to meet assessed needs. It was felt that this system could work well for people with complex needs who can access different pots of money, including benefits, community care, ILF, and Continuing Health Care monies.

Oldham's service development has been through gradual development, rather than a 'big bang' process. Big meetings did take place with parents and carers regarding day service modernisation, but these proved very difficult. The process of consultation now takes place in smaller groups or on an individual basis. Managers felt that carers now do feel valued by being involved in this process.

Managers felt that there was clarity regarding what was and what was not offered by Day Services. New opportunities would be set up using a small number of service users, to monitor success. A Risk Enablement Panel, including a range of professionals, is responsible for shared decision making.

Key characteristics of the Oldham Day Services include:-

- A Community Occupational Team, similar to a Supported Employment service, refers people onto employment schemes, such as allotments or recycling.

- People living in Supported Living houses do not access Day Services, but are supported from home.

- Managers have been recruited with a proven track record of managing change, and the management team is resourced sufficiently to enable change to be implemented quickly.

ii) St Helens visit

St Helens went through the process of closing a 70 place Day Centre (Greenacres) about 4 years ago. They were given 6 months to reprovide the service, with no service reduction, no increase of resources, but within an expectation of making savings.

A number of community centres were used, and the intention was not to recreate mini Day centres within them. No provision was made for charges for the use of community centres. The result was a major overspend and hence a major challenge was the lack of resources for people who needed good access and personal care facilities.

Initially, a respite care facility and another Day Centre (Stephenson) was used for some activity and some people were transported there for personal care. Some people with profound and multiple disabilities were moved to the Stephenson Centre, as other venues were inappropriate. However, some places did accommodate all service users, and changing areas were installed.

Managers tried to retain a mix of people in each venue, to ensure there was stimulation and conversation for all people. However, Managers felt that the Greenacres closure had brought much conflict. In comparison the Stephenson Centre has recently been closed with much less conflict as a result of:

- Many of the concerns regarding the Greenacres closure were worked through at that time.
- St Helens is clearer about its vision – and the process to get there. This includes using community resources as a way of supporting people in their local communities.
- A series of carers' workshops had taken place.
- Carers were shown new venues.
- Key workers had built up good relationships with carers.

The Stephenson Centre will be reopened as a resource centre, but will offer space to other partners, e.g. 5 Boroughs, Training venue.

iii) Murdishaw

Country Garden Catering Service runs the café at Murdishaw Community Centre two days per week, as the café was not being used. There has been a good response from the community – there are now 30 – 40 customers per day. The service accommodates 8 people, concentrating on cooking, food hygiene, customer skills, and handling money. Some service users are using public transport to access the centre. It is hoped that the project will develop as a Social Enterprise. There is a challenge in terms of moving people on from the project, as there will otherwise be a blockage in terms of new people coming through.

iv) Castlefields

During the visit a number of people were accessing the general dance session in the main hall, and others had gone swimming.

A third group were sitting in the dedicated space allocated for Day Services with two staff members. There was some feeling amongst the members that the space provided was inadequate – and poorly resourced. The staff felt that opportunities for some people at Castlefields may have been reduced following the move from Astmoor, due to the need to monitor the movement of vulnerable people more closely in an integrated community venue, and that for some people the space had been reduced.

The members were also unhappy that some people with high support needs may have reduced opportunities. It was pointed out that people accessing Castlefields would do so for only part of the week. It was also recognised that it is important to compare levels of activity now with those that took place within Astmoor, to ascertain if generally opportunities have increased or not. We are reassured that the initial move to

Castlefields and other community venues is the beginning of the journey, and that new opportunities will develop as relationships grow.

13 Conclusion

As part of the closure of Astmoor Day Centre clearly a significant amount of work took place with users, carers and staff to identify current appropriate activity being undertaken, individuals' specific support needs, friendships to be maintained, local bases that could be accessed and transport issues. Service Level Agreements were made with Community Centres and capital monies were gained to provide appropriate personal care facilities in two Community Centres. A staged process was undertaken to move out of Astmoor over a period of time, to allow users, carers and staff to become accustomed to new environments and ways of working, and to identify any unforeseen issues or risks that might arise. This is not to say, however, that all issues have been resolved to the satisfaction of users, carers and staff.

Person-centred planning is developing as an integral part of the modernisation process, though this needs to be developed further. This requires multi-agency input, including purchasing and providing services, and work is taking place to progress person-centred planning for some people. This should include use of individual budgets and/or direct payments to shift the emphasis from service-led planning to planning for individuals.

Whilst some steps have been taken to improve flexible working these do not constitute the sea-change in staffing deployment as required to achieve the approach set out in Valuing People. Further options need to be explored through the involvement of staff in the process and offering flexible working opportunities. Introducing flexible working options can create a healthier and more productive workforce with reduced sickness levels. Evidence from the benchmarking exercise would suggest that this process can take significant time.

Whilst we recognise the efforts that have been made and the complexity of the issues involved more work needs to be done to address the needs of people with multiple and profound disabilities, with particular reference to integration within the local community.

As far as possible individuals' community activity that had been taking place was sustained, though this was not possible in all cases.

As has already been stated some of the buildings are in need of development. Whilst not all buildings were visited we did observe an ongoing programme to refurbish and improve the physical environment. We suggest that carers and users should be involved in the ongoing process of reviewing premises. Not only might this help with an improved understanding of the constraints and efforts being made but also users and carers may have ideas and suggestions as to how existing premises might be better utilised.

In our visit to St Helens we were impressed with the development of a resource base used by a range of organisations. We believe this collaborative approach to the use of facilities is a model worthy of further exploration in Halton.

Whilst we recognise that the development of outcome-focussed services is difficult and nationally in its early stages, St Helens appear to have made some progress through

the building of community relationships. This process will form part of the broader strategy to develop person-centred approaches which means change will be a constant feature of future service provision plans. Oldham has advanced more down the Individual Budgets route, and this has resulted in some people opting for more targeted Day Service provision.

The details contained within this report have demonstrated that there has been effective and widespread engagement with users, cares and advocates. We are satisfied that there have been active steps to be inclusive and that the information made available from these consultations provides a true and accurate picture of user, carer and advocate views. From the work undertaken in scrutinising the redesign of day services, including the closure of Astmoor, we believe the closure to have been largely successful. This statement is made by setting the process and outcomes against the requirements of Valuing People. More specifically, service users are more likely to receive a service in their home locality, reducing journey times on transport, and are more likely to receive a service in an integrated community environment. In conclusion, within the context of the redesign of day services being a long-term process, there are a number of ongoing issues which we believe there should be a clear timetable for action.

14 Recommendations

1. Development of robust mechanisms for a multi-agency approach to person centred planning underpinned by a commissioning framework reflective of the ethos of Valuing People.

2. A clear action plan should be developed in collaboration with carers of people with multiple and profound disabilities and those with challenging behaviour and their advocates to maximise opportunities for addressing their needs and supporting them to access integrated community settings.

3. The potential for developing a one-stop facility similar to the one in St Helens should be considered.

4. Carers and users should be involved, through development of a Focus Group, in the ongoing process of reviewing premises, and service developments needed to meet increased capacity of people in transition and older people.

5. An analysis should be conducted of the potential for developing outcome-focussed services. This should entail a review of the suitability of community relationships, the development of daily living skills, people receiving opportunities or socialising in community settings and opportunities in employment.

6. Support for people to access employment is still under-developed and in need of further review. Targeted activity for people needing pre-employment skills needs to be developed.

7. Assess future needs of the service and explore opportunities for putting into practice flexible working options that meet those needs, and offer work-life balance solutions for staff.

8. Lessons from the redesign process should be cascaded to other service areas, through workshops, for example.

9. Use of transport should be reviewed to address complaints regarding pick-up times, and to decrease reliance on larger Council buses, through an increase in independent travelling and other 'valued' forms of transport.

As detailed in the conclusion there are a number of issues that have arisen from the work undertaken by Halton Speak Out. The following recommendations seek to resolve these concerns:

- Consult with users and carers about the refurbishments at Lord Taverners.

- Concerns have been raised about the environment and activities at Castlefields and it is important to establish whether these concerns remain. In the event they do, there should be more work with users and carers to establish what could be done in terms of creating a safe and pleasant environment in advance of regeneration initiatives and improving the range of activities. With respect to the latter, this should be done, as always, in consultation with users.

- Clarify that a safe drop-off point has been found at Halton Lea Library.

- Clarify any ongoing concerns about the personal belongings at Grangeway Community Centre.

- Review the range of activities using a variety of consultation methods as appropriate with users and support staff, especially those with high support needs.

- Undertake work with Halton Speak Out to design appropriate methods (e.g. well in advance) of meaningful involvement instead of questionnaires.

Appendix 2

Table to show results of survey of the Second Carers Visits conducted in the spring of 2007

Question asked	Response	Evaluation
What current community activities are going well? .	38 carers (sometimes more than one carer at each meeting) have stated that the person they care for is enjoying the activities that they take part in. One care was happy because of 'knowing where he is daily'.	Satisfactory outcome.
Are there activities that need to change?	6 carers felt that some activities should be changed and where this is possible it has been done. 25 carers felt that no changes were necessary. 6 carers felt that the person they cared for would benefit from more community activities.	Satisfactory outcome.
What are your experiences with the current transport arrangements? (timings and frequency for example).	26 carers are happy with the transport arrangements. 10 carers were unhappy with transport, at least one of these was an out of borough placement. Unhappiness tended to concentrate around drop off and pick up times and how much this varied.	This situation should be monitored to ensure that issues are resolved and the carers are satisfied with the system of putting things right.
Communication – do you have any suggestions to improve communication between day services and yourselves?	24 carers liked the newsletter. 13 carers felt that communication was good and 4 carers were given contact numbers for day services. 9 carers thought that they 'needed to be kept informed'	More work should be done to identify what it is the carers need in terms of more information.
Would you be interested in being part of a focus group to be consulted when carers have concerns?	15 carers did not want to be part of a focus group and 18 carers were happy to be part of a focus group for carers.	Attempts should be made to improve carer representation in the focus group or alternative methods should be found to ascertain their views.
Any general comments on the service?	3 carers had no comment to make, 1 carer preferred it when people were based in Astmoor. 2 x carers raised concerns about seeing old friends. Other comments included the following (these are direct quotes from the meetings):	Satisfactory outcome. Overall comments seem to be positive but work should continue to build

	Person is ‘really happy’. ‘No complaints’. ‘Since the changes staff think that (name) is much happier’. ‘Going well’. Person is ‘really happy’ ‘no complaints’ Carers ‘feel that the service is not the same’ ‘Service is running good at the moment’ ‘Would not be able to cope if Day Service was not available for (name)’ ‘Could not find fault with the service’ ‘Would like (name) to attend a community activity’ ‘More opportunities to access employment’ ‘Senior managers do not listen to carers, they do not listen to carers views on the service. Carers should be paid to give advice to other carers’ ‘The service works for (name)’ ‘Mum is concerned for the future of the service’. ‘More than pleased with the service’ ‘Mum is not happy with the service’ ‘Quite happy with (name)’s service. Happy that (name) is starting to speak up for herself’ ‘Communication has deteriorated’ In one case carers were unhappy with the level of service, as a result the individual was referred to the Community Bridge Building Team. Initial indications are that this was a positive move for the individual concerned. Comments recorded above are intended to give a balanced view of the view of the service as it stands at the moment.	trust and confidence of those less satisfied maybe by asking them what they would like to see to change.

Appendix 3

Halton Day Services for Adults with Learning Disabilities – Activity Feedback Questionnaire

Over recent weeks and months we have asked people we support to provide feedback on the activities that they take part in, to this end we have provided an accessible format questionnaire that has been distributed to people supported by the service. Assistance to complete these questionnaires has been provided by Key Workers and Support Workers who work within the service.

The results of this survey are produced below. The results are intended to complement the Carers Visits information produced recently and also to support informal feedback received from people using the service and also to complement formal/commissioned feedback from independent surveys.

The questionnaire asked seven questions in total, they were:

1. Are you happy with your activity timetable?
2. What activities do you like?
3. What activities don't you like?
4. Which venues do you like?
5. Which venues don't you like?
6. Is there anything that would make the service better for you?
7. Would you like to change anything?

As at the 9 may 2007 we have received 106 completed questionnaires.

Results

Q1. Are you happy with your activity timetable?

The answer to this question was provided by the use of a tick box, the alternatives were 'Yes' or 'No'.

93 people answered yes to this question.
5 people answered no.
8 people did not respond to this question.

Q2. Which activities do you like?

It is important to remember that each person indicated more than one preferred activity. People we support attend an average of approximately 5 different activities (some more, some less).

Assertiveness	1
Drama	24
Catering	5
Women's Group	4
Bowling/Boccia	17
Crafts	9
Computers	19
Card Making	3
5 a day (healthy eating)	1
Art/Drawing	27
Exercise/Keep Fit	30
(this includes walking and other exercise)	
Sensory	7
Social History	3
Ranger Group	2
Relaxing	10
Community Outings	34
Music (inc Samba)	19
Shopping	5
Horticulture/Gardening	15
Dance	4
Golf	7
Baking/Cooking	23
Football	3
Hairdressing/Beauty	10
Committee Group	1
Dominoes	2
Knitting	2
Bingo	3
Pool	3
Darts	1
Snooker	1
Swimming/Hydrotherapy	16
Line Dancing	13
Table Tennis	2
Shopping	5
Tea Dance	3
Tap Dancing	2
Film Making	3
Ironing	1
Doing the Dishes	1

Q2. Which activities don't you like?

For this question it is important to note that even though the activity may not be liked by the individual, it doesn't actually mean that the person answering the question accesses the activity on the 'don't like' list.

Don't know	7
Art	2
Music	2
Catering	2
No answer entered	21
Boccia/Bowling	2
Football	1
Noisy activities	7
Cooking	1
Dancing	3
Committee	1
Drama	3
Computers	1
Crafts	1
Non disliked	31
Walking/keep fit	5
Going out	3
Group activities	1
Crowded places	6
Gardening	8
Loud music	2
Indoor activities	1
Staying in	1
Hairdressing	4
Sport/exercise	1
New places	1
Swimming	1

Q4. Which venues do you like?

Stadium	6
Pingot	16
Community Centres (not named)	5
Bowling alley	5
Grangeway CC	20
Coach House	12
Lord Taverner's	14
Golf range	2
Albert Dock	1
Halton Lea	14
Kingsway Leisure	2
Victoria Park	2

MacDonald's	1
Grosvenor House	1
Shopping city	1
Library	1
Widnes town centre	3
John Briggs Hse	1
Gym	3
Learning Centre	1
Hopes	6
Castlefields CC	16
Swimming baths (Kingsway)	8
Bredon	4
Laburnum Gve	1
John Lennon Airport	1
No answer	6
Spike Island	5
Ditton CC	6
Pub	7
Upton CC	1
Restaurant	4
Cinema	3
Murdishaw	1
Anfield	1
Hough Green Park	2

Q5. Which venues don't you like?

Don't know	26
(Mainly because of not having been to any other venues)	
No response	32
(As above?)	
None	22
Grangeway CC	5
Lord Taverner's	4
Wigg Island	1
Castlefields CC	2
Community Centres	1
Asda	1
Don't understand	1
Not able to answer	1
Pingot	1
Anything outside	1
Widnes	1
Stadium	1

Comments include the following quotes; 'Didn't like Lord T's, but now its been painted (name) has changed their mind'. 'I like all of them'. 'I don't like noisy places'. 'I don't know other places'.

Q6. is there anything that would make the service better for you?

Don't know	18
More staff	14
More activities	1
More equipment	3
Transport times	11
Changing rooms (ie; facilities at all venues)	2
Quiet room	1
More cinema	1
No answer	12
No	19
Visit my friends (at other venues)	3
Discontinue Boccia	1
Horse riding	1
Extra day (service)	1
More swimming	5
Hydrotherapy	1
Snooze Room	1
Ball pool	1
New Minibus (with a tail lift)	3
More outside Activities	4
Staff training	1
Communicate better	1
To do Samba	1
To do keep fit	1
To do cookery	1
A job	2
Shopping	2
Listen to music	2
Have a day off	1
Café at Grangeway	1
To do baking	4
Belly dancing	1
Tap dancing	1
Bowling	1

Comments include the following quotes; 'Improve transport times, I am always the last to go home!'. 'I am happy with the current service'. 'Bring back the Day Centre'.

Q7. Would you like to change anything?

Don't know	13
No response	20
No	49

First on the bus	1
Change activity	7
Shorter day	2
Carpeted floor	1
Transport times	2
Extra day	1
More staff	1
Go out more	1

Comments in this section include the following quotes; 'I would like to go to an art exhibition'. 'I like my timetable'. 'My timetable is very flexible'. 'No, overall I am happy with my routine'. 'My timetable suits me well since moving to (venue)'.

Questionnaires are a useful tool for gathering feedback regarding activities of the type provided by Day Services. It is important that the results are considered as part of the overall evaluation. Set within the context of multiple types of feedback, such as; carer's feedback, other sources of commissioned and non-commissioned feedback, such as Advocate report and also Halton Speakout's report and the Political Scrutiny Report due to be published, the feedback from these questionnaires helps to put the general views of the people who access the service and who may be more independent and vocal regarding their likes and dislikes.

Appendix 4

Tables to show issues raised before the redesign of day services and how these have been dealt with.

Common Themes arising from survey before closure of Astmoor.	Common Themes arising from survey after closure of Astmoor.	Evaluation
Transport: Concerns regarding people travelling independently, even if they are able too - vulnerability, bad experiences in past. Many people accessing services already travel independently, this will not change, venues may change over time but transport will remain reasonably fixed. Risk assessment regarding vulnerability will help to identify any possible problems in this area.	There continue to be some concerns regarding transport. This would seem to mainly revolve around transport timings with regard to dropping off and picking up. Generally speaking people have been encouraged to speak directly to transport/SWT.	Whilst Day Service managers and transport staff work very closely together to organise transport arrangements, this is made more complex by the move to community venues. Important that we ensure people are not passed around the system and that they have single point of contact for transport issues.
Taxi drivers, are they just going to drop off people, or will they make sure people go direct to staff (hand over?) Taxi drivers must make sure that people enter the building. This has also been raised with transport and we can have a clause put into the contract to ensure that there is no ambiguity about who does what – it's a very good point and a reasonable question. I will speak to transport about this.	This has gone reasonably well (probably a couple of hiccups) as we have had no major problems or concerns regarding taxis from within the borough. There have been individual concerns regarding transport (taxi) pick up from out of borough placements, in this case Knowsley. This has been addressed.	Satisfactory outcome.
Issues already with some people who are already out with transport pick-up times. Some service users are not getting picked up until 9.45am. The pick up times have been problematic. However this is one that transport will have to address as they moved some pick up times around not us. It will take time to bed in but we have made representation to transport – this issue should be resolved reasonably soon – we will need to monitor it and would ask that people bring to our attention any transport difficulties.	As above, transport have had problems with timings, there are still a number of carers complaining about this – it continues to be a problematic.	Important that this is addressed by Day Services and that carers and users are kept informed of progress.

Appendix 4

Common Themes arising from survey before closure of Astmoor.	Common Themes arising from survey after closure of Astmoor.	Evaluation
Continuity of service, some service users are affected by change (particular individuals, change needs to be gradual) There are a number of activities that have been moved into the community over the years and these moves have been done on the understanding that different people manage change in different ways. We agree with this comment and will do our utmost to lessen any change or disruption and to support people who have to make changes within their activities – we intend keeping change to the minimum where we can. As far as possible, we will ensure consistency of staffing during the period of change, as this can be a major factor in supporting people positively.	In the main people we support have managed any change of activity and venue extremely well. Change has been kept to a minimum and we are getting positive feedback from carers and people we support. We have completed an activity questionnaire for people we support, the details will be available in due course.	Satisfactory outcome.
Person will talk to anyone and may go off with them, how will we prevent this? Again, these concerns are understandable. Our current practices work well in this regard and it is about us recognizing when someone accessing our service is at risk and ensuring that adequate risk control methods are in place.	There have been no cases of people wandering off and/or being targeted that we are aware of.	Satisfactory outcome.
Person having problems recognising/distinguishing gents toilets from ladies, and access toilets with mobility problems, how will we support this? This is initially about having the right kind of signs on the doors. Easily solved by adding a picture of a man/woman or other agreed symbol to distinguish between either toilets. People with mobility problems currently access toilets, however the building work to be completed in Community Centres will actually improve on facilities currently being used and so this will make things easier. Support will be provided as it is now and as a result of assessment.	There have been no reported incidents of this type so far.	Satisfactory outcome.
Concerns if staff do not turn up to venues, who will be supporting the people there if this happens? In many respects this is about good planning and logistics. If staff do not 'turn up' at venues then we need to know why, if this is legitimate (i.e.; sickness, accident on the way to work etc) then we would have to get another member of staff there very quickly. Planned absences such as annual leave would be covered by the floating support team It is going to be difficult to give a definitive answer to this, as there are so many variables that can come into play. But the principle is to get someone to the venue ASAP.	There have been no major problems in this area of concern. We have had staffing problems but have now recruited and staff will soon begin work (subject to the usual checks etc) Management duty rota ensures single point of contact to deal with crisis/emergency situations.	Satisfactory outcome.
Security around premises, sharing places with the general public - risk factors i.e. School holidays and gangs hanging about etc. Again, I think risk assessment is the key to this. I don't wish to minimize any concerns and can understand how this might be seen to be a problem.	There are no reported problems with this area of concern either. One carer has recently voiced a concern around the impending summer holidays and that kids might 'name-call' etc. We will monitor this as necessary.	Satisfactory outcome.

Common Themes arising from survey before closure of Astmoor.	Common Themes arising from survey after closure of Astmoor.	Evaluation
What would happen if a person is not settling into their community activity, would the service be withdrawn If a person is not happy with the service they receive (not settling) then we would examine, with the person, what alternatives there may be. Usually activities are for more than one person and so the activity would not be withdrawn. If this means would support for the individual be withdrawn if they were not settling then it would not be withdrawn.	When people have reported dissatisfaction with activities (numbers remain low overall) we have changed them.	Satisfactory outcome.
Inappropriate/unsuitable venues - would not meet the needs of particular people with special needs (real concern for carers) This is a real concern for us as well. We do not have any plans to use unsuitable venues and always take into account the needs of the individual accessing services.	Currently people with complex needs are in the main accessing dedicated learning disability buildings. Supporting this group into integrated settings is a challenge for the next 12 months. Some carers and advocates feel that some venues are unsuitable in terms of location (e.g. 'rough' area) or in terms of space available within the venues. Work is ongoing to improve specific environments (e.g. furnishing, decorating) Venues used are community venues, used by the local community, and reflect the physical environment of Halton – this will at times cause concern to some people.	Closer working with carers might help understand the constraints and efforts being made.
Will there be thorough risk assessments and contingency plans for people accessing new venues and appropriate staffing Risk assessments are completed for all activities and venues, this is an on-going process as risk changes. Contingency plans: If an activity was cancelled at short notice – say the building burned down – then people accessing that activity would probably be taken to the Community Centre (or other agreed site) whilst an alternative activity was arranged. Or they would be taken by those staff supporting them directly to another activity (transport and logistics would probably be the difficult bit – but not insurmountable) Appropriate staffing - all activities will be staffed as they are currently and in line with identified needs,	Recently, there was an incident when high winds meant that transport could not get to every person at the usual time and we had to use our own initiative to make arrangements to get everyone home. The service remained open until 2000 on the day and our operation was successful. We are pleased with our response but will continue to develop how the service reacts during times of crisis.	Satisfactory outcome.

Appendix 4

Common Themes arising from survey before closure of Astmoor.	Common Themes arising from survey after closure of Astmoor.	Evaluation
How will people receive their medication, who will be responsible? People receive medication now, this is managed appropriately. We are currently discussing any potential problems with our colleagues in Health and will implement their recommendations. Staff will be responsible for those people who do not self-medicate and others will be supervised according to need.	As above. There have been no recorded medication incidents and the system appears to be robust and working well.	Satisfactory outcome.
How will people be supported with special dietary needs? The levels of support that people currently receive will not change, special dietary needs are a fundamental aspect of the support that we provide for people. This will be maintained.	As above.	Satisfactory outcome.
How will people be able to maintain their friendships and links with other people? There are a number of options here, they range from; organized meetings in a community setting (people already go to the pub and other places to socialise), to an organized disco perhaps, or activities organized that are specific to maintaining these friendships. Many activities that people currently share will of course continue, so people will also maintain friendships this way.	Many people do still see their friends on a regular (if not daily) basis. Where there is an issue, we will make arrangements for people to keep in touch. We plan to hold friendship groups throughout the year. Details TBA	Satisfactory outcome.
Who do carers contact/report if a person if off sick, or needs to be picked up later for appointments etc. As they do now, except that the phone numbers will probably change. Any change in phone numbers will be widely circulated in good time.	As above. No reported problems. Contact numbers have been confirmed to some carers. Changes to contact numbers will be advised accordingly and in good time. Duty Senior and Clerical Support on Duty Day applies, they deal with the daily operational running/problems within the service.	Satisfactory outcome.
Will people keep their key workers - staff who know them well and who carers have a regard for? Where this is appropriate for the individual concerned key workers and staff will remain involved and will not change unless necessary. However, services can and do change to meet the changes needs of people accessing those services, the staff team may need to be used to meet the exigencies of the service and this could mean change.	As above. Some changes have been made, but not many.	Satisfactory outcome.
How will we maintain communication links with staff and carers? We are committed to maintain the levels of communication that we currently have with carers. We will strive to continuously improve the way we communicate and to remove the ambiguous and misleading messages that have been circulated. We must work together to do this.	Telephone, carers meetings, newsletter, staff supervision, group supervision etc. Communication is considered positive by the latest carers visit forms. Each Day Service Officer and each Senior Day Service Coordinator, Practice Manager, performance Manager and Principal Manager have all been issued with mobile phones.	Satisfactory outcome.

Appendix 4

Common Themes arising from survey before closure of Astmoor.	Common Themes arising from survey after closure of Astmoor.	Evaluation
Will there be consistency of routines and staffing for people with particular complex needs? Yes, our priority will be to maintain routines where we can and to minimize disruption where we can't. Subject to the exigencies of the service, staffing will be as consistent as it is currently.	Staffing is consistent. Although we must sometimes introduce new faces to facilitate training and to allow the people we support to get to know new people.	Satisfactory outcome.
Lunch times - will people be able to have hot meal (concerns over provision and supervision of people) There are a number of community facilities that provide hot food and some of the Community Centres also have a canteen.	There have been no reported problems in this area of concern.	Satisfactory outcome.
Supported employment - future concerns about existing placements. Existing placements will continue to be managed by the Supported Employment Service. Opportunities for employment will increase as changes within SES begin to make themselves felt. Current placements are not under threat from the re-design of day services.	The Supported Employment Service will work more specifically with people who are work or nearly work ready. This will present a challenge for Day Services in terms of developing activities focussing on pre-employment skills, and the development of projects such as Murdishaw Café.	Need to evidence progress in this respect as this is an important element of Valuing People.
Will my son/daughter just sit in a community centre each day? No, some activities will take place in Community Centres and people will have the opportunity to access them if they so wish.	This appears to work reasonably well. Community Centres act as bases to access activity within the Centre or within the local community from.	Satisfactory outcome.
Will they still be picked up and dropped off by transport? Yes, there are no plans at this time to change the transport provided, obviously venues may change and so a change to the journey undertaken is possible for some people accessing services.	As above, some changes have been made, but kept to a minimum	Satisfactory outcome.
Why are service users from Pingot not given the same opportunities as Astmoor service users? It is not our intention to deny equality of opportunity. People currently accessing services via Pingot will enjoy the same opportunities as everyone else – one service, not two!	Currently the service is 'bedding in' its processes and procedures surrounding the moves in Runcorn, this may give the impression that we have stopped but we have not. Changes within service delivery within Widnes will come in the near future.	Satisfactory outcome but suggest more information about ongoing changes in the newsletter.
What will happen when staff ring in sick? We will replace them using the floating support team, at times of high level of absence it may be necessary to move people around, although this will be kept to a minimum.	This has been working reasonably well, although it has resulted in some groups being amalgamated during times of high unexpected absence. The recruitment of additional Support Workers will have a positive affect on the service and staffing.	Satisfactory outcome.

Appendix 5

TOPIC BRIEF

TOPIC TITLE: ALD Day Service Redesign

PPB(s) responsible: Healthy Halton

Officer Lead: Audrey Williamson

Planned start/end dates: July 2006

Target PPB meeting: March 2007

Topic description and scope:

To scrutinise the process of the redesign of Day Services for adults with learning disabilities, as outlined in the White Paper, Valuing People: A New Strategy for Learning Disability for the 21st Century, and as agreed by Halton Borough Council's Executive Board in November 2005.

Scope:

i) To review the process undertaken to decommission Astmoor Day Centre.

ii) To review the expectations and experiences of stakeholders, including people accessing services, carers and staff members.

iii) To benchmark Halton Day Services against other local authority providers.

iv) To assess the extent to which the redesign of Day Services has fulfilled the criteria outlined within Valuing People.

v) To identify any barriers that may exist hindering redesign.
Why this topic was chosen

i) It is recognised that the agreed closure of Astmoor as a Day Centre was accompanied by considerable concern from a number of stakeholders, especially carers. In agreeing to the redesign of Day Services, the Executive Board was keen to ensure that a transparent and effective process was followed.

ii) It is anticipated that, where appropriate, learning points from the redesign process will be used within the review of Day Services for other client groups.

Appendix 5

Key outputs and outcomes sought

i) To ascertain to what extent progress has been made in terms of redesigning Day Services in Halton, as outlined in Valuing People.

ii) To produce a critical appraisal of the process undertaken in decommissioning Astmoor as a Day Centre, and developing alternative service provision.

iii) To ensure that learning points from the experiences and expectations of key stakeholders – most notably people accessing services, carers and staff – are noted and used during similar exercises.

iv) To identify any service gaps and necessary service improvements, and barriers to redesign and to make recommendations regarding future service development and provision.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve

Priority 1 Improving Health

Outcome 2 (Service Plan) – To improve the health of Halton residents.
The Integrated Services Department aims to promote and support working aged people and their carers to make positive choices about their lifestyle and health.

Enhancing Life Chances and Employment

Overall Aim: To enhance the personal development, training and employment opportunities and overall life chances of local people, encouraging all to reach their full personal and work potential.

Key Objective A – To promote access to suitable education, training and means for personal development for residents of all ages.

Key Objective E – To improve opportunities for the personal development of young people, particularly those who are disenfranchised, disaffected or hard to reach.

Nature of expected/desired PPB input:

Member led review of the implementation of the redesign of ALD Day Services and its impact on key stakeholders.

Appendix 5

Members:

Ellen Cargill, Kath Loftus, Sue Blackmore (for approval at PPB)

Preferred mode of operation:

Working group to be set up.

Media/communication implications:

To be agreed.

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 12 June 2007

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Working Arrangements and liaison between Local Authority Overview & Scrutiny Committees and 5Boroughs Partnership Trust

WARDS: Borough wide

1.0 PURPOSE OF REPORT

1.1 To inform members of the proposals by the 5Boroughs Partnership Trust for future working with this Policy & Performance Board.

2.0 RECOMMENDED: That Members note and agree the proposals.

3.0 SUPPORTING INFORMATION

3.1 5Boroughs Partnership Trust is seeking to formalise arrangements, using national guidance, on its work with Overview and Scrutiny Committees across the 5Boroughs. These proposals are attached as **Appendix 1**. This will allow a consistency across the five local authorities and is based on the principles of openness and dialogue to ensure that members are sufficiently well informed of the work of the Trust.

3.2 The policy identifies who should attend the Overview and Scrutiny Committees, writing of any relevant reports and the timeliness of consultation.

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 None.

6.0 OTHER IMPLICATIONS

6.1 None.

7.0 RISK ANALYSIS

7.1 None.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 There are no background papers under the meaning of this Act.

Appendix 1

Document Information

Work Area	Policy Review
Subject/Title	Liaison with Local Authority Overview and Scrutiny Committees
Version	Rev Apr/May 07
Status	Draft v 4

Key Personnel

Author(s)	Jan East
Reviewer(s)	Executive Directors – pre Trust Board consideration for approval
Contributor(s)	Policy consultation panel – via K Fitzpatrick

Distribution

Copy(ies) to	Executive Directors Policy consultation panel – via K Fitzpatrick

Document History

Version	Date produced	Version Description	Owner Initials
V 1	03.04.07	Revision and update of Policy as per requirement. Circulated for comment and impact assessment	JE
V 2	05.04.07	Addition of reference of guidance re: Annual Health Check – Adv by S Hooton	JE
V 3	08.05.07	Addition of reference and cross references to liaison and co-ordination meetings with OVERVIEW AND SCRUTINY COMMITTEEs. Re-formatting for easier reading.	JE
V4	09.05.07	Revisions recd from NM and addition of table of approved attendees	JE

References

Reference	Title/Description	Author(s)	Date

Appendix 1

Appendix 1

LIAISON WITH LOCAL AUTHORITY OVERVIEW AND SCRUTINY COMMITTEES POLICY

Policy Number: Org/R/004

Status: Ratified

Originating Date: September 2002

Date Ratified: September 2003

Reviewed: February 2006

Reviewed: March and May 2007

Accountable Director: Chief Executive

Policy Author: Assistant Chief Executive/Trust Board Secretary

Appendix 1

CONTENTS

Appendix 1

1. INTRODUCTION

1.1. Rationale

1.1.1. Local Authority Overview and Scrutiny Committees are part of the arrangements for local government under Part II of the Local Government Act 2000. Under the Act, Local Authorities are given the power to review and scrutinise the totality of local services planned and provided as part of their wider responsibility to seek health improvements and reduce health inequalities for their area and its inhabitants.

1.1.2. Under section 11 of the Health and Social Care Act 2001, some Overview and Scrutiny Committees have additional powers in relation to the NHS and NHS bodies. Local Authorities that hold responsibility for social services may review and scrutinise the operation of the health service in their area and make reports and recommendations to NHS bodies in respect of that review and scrutiny. In addition, Overview and Scrutiny Committee functions in relation to the NHS include, under certain circumstances, referring contested proposals for major service changes to the Secretary of State.

1.1.3. The Overview and Scrutiny Committees of Local Authorities with social services responsibility have the power to scrutinise the social care services provided or commissioned by NHS bodies exercising local authority functions under section 31 of the Health Act 1999. This is in addition to their existing power to scrutinise local authority social services.

1.1.4. The 5 Boroughs Partnership NHS Trust, referred to hereafter as the Trust, will be subject to scrutiny by the Overview and Scrutiny Committees of five Local Authorities. These Local Authorities are Halton Borough Council, Knowsley Metropolitan Borough Council (MBC), St. Helens MBC, Warrington Borough Council and Wigan Council. The Trust wants to develop and sustain co-operative working relationships with the Overview and Scrutiny Committees to which the organisation will be held publicly accountable. The Liaison with Local Authority Overview and Scrutiny Committees Policy establishes and explains our intentions to work in partnership with these bodies.

1.2. Scope

1.2.1. The Liaison with Local Authority Overview and Scrutiny Committees Policy will apply to all Trust employees and to Non-Executive Directors.

1.2.2. The Policy will provide a framework within which liaison arrangements with Overview and Scrutiny Committees will take place. The policy will operate in conjunction with the other corporate policies listed in section 4.0 of this document.

Appendix 1

1.2.3. The Policy will be supported by operational procedures that will be applicable to the whole Trust.

1.3. **Principles**

1.3.1. The Trust wants to develop a co-operative working relationship with the Overview and Scrutiny Committees in the local authority boroughs in which it operates. This Policy provides a mechanism through which the Trust can take forward meaningful partnership working.

1.3.2. The Trust wishes to create a climate of openness and dialogue with the Overview and Scrutiny Committees. We believe that the timely provision of appropriate information will enable Overview and Scrutiny Committees to undertake effective scrutiny and make well-founded and sound decisions. The policy supports a culture of openness and dialogue, to ensure that councillors are sufficiently well informed of the work of the Trust and the pressures it faces, in order for them to discharge their functions effectively.

1.3.3. The Trust believes that staff should have access to expert knowledge, guidance and support if they are called before an Overview and Scrutiny Committee. The Policy sets out a framework to provide this support.

2. LIAISON WITH LOCAL AUTHORITY OVERVIEW AND SCRUTINY COMMITTEES POLICY

2.1. **Provision of Information to Overview and Scrutiny Committees**

2.1.1. The Trust will provide Overview and Scrutiny Committees with any information about the planning and operation of health services for which it is responsible as the committee may reasonably require in order to discharge its functions, subject to certain exemptions. These exemptions are listed in Appendix One of this Policy.

2.1.2. The Trust will only provide personal identifiable information to an Overview and Scrutiny Committee if the individual concerned agrees to its disclosure or in a way that ensures identification is no longer possible. The decision to give consent will be made by the individual or their advocate. Where this is not the case, the Trust can provide the Overview and Scrutiny Committee with the required information in an anonymised format.

2.1.3. In the event of a dispute over disclosure of information, a local resolution procedure will be established with the Overview and Scrutiny Committee. This process does not replace the right of an Overview and Scrutiny Committee to appeal to the body responsible for performance managing the Trust i.e. North West Strategic Health Authority.

Appendix 1

2.2. **Attendance by Trust Staff and Non-Executive Directors at Overview and Scrutiny Committees (Ref: Appendix Three)**

2.2.1. Regulations enable Overview and Scrutiny Committees to request the attendance of any officer from the Trust to answer questions. The Trust will ensure that it complies with this statutory requirement by assisting Overview and Scrutiny Committees in identifying the most appropriate officer to provide the information they require. The corporate lead for Overview and Scrutiny Committee liaison[1] will provide the contact point for the discharge of this duty.

2.2.2. Statutory Instrument 2002 N$^{o.}$ 3048 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 , section 6, paragraph (1) states that :-

'… *an Overview and Scrutiny Committee may* ***require*** *an officer of a local NHS body to attend before the committee to answer such questions as appear to the committee to be necessary for discharging its functions*.'

The Trust also recognises that local Overview and Scrutiny Committees may wish to invite them to discuss issues of governance and policy relating to the Trust. The guidance for Overview and Scrutiny Committees compiled by the Centre for Public Scrutiny states that:-

' … *officers from NHS bodies must attend meetings when requested to answer questions …'*[2]

2.2.3. If invited to attend an Overview and Scrutiny Committee meeting, it is incumbent upon all staff and Non-Executive Directors to immediately inform the Chief Executive and the corporate lead for Overview and Scrutiny Committee liaison of the nature of the invitation i.e. is it for a matter of scrutiny, liaison, training, consultation or other reason.

2.2.4. When attending an Overview and Scrutiny Committee scrutiny event, officers will ensure that, wherever possible, they are accompanied by **either** the Chief Executive, **and**/**or** the appropriate Director, **or** their nominated deputy(ies), **and** by the corporate lead for Overview and Scrutiny Committee liaison.

2.2.5. All staff and Non-Executive Directors invited to attend Overview and Scrutiny Committee scrutiny meetings will be required to participate in pre-committee briefings/information sharing with the Chief Executive, the appropriate Director or their nominated deputy(ies), and the corporate lead for Overview

[1] The corporate lead for OVERVIEW AND SCRUTINY COMMITTEE liaison as of May 2007 is the Assistant Chief Executive/Trust Board Secretary. This may change over time and will be updated.
[2] Centre for Public Scrutiny (CFPS), February 2005, *Tackling the democratic deficit in health: an introduction to the power of local authority health scrutiny*, page 2.

Appendix 1

and Scrutiny Committee liaison.

2.2.6. Where the Trust proposes developments or changes in service(s) which have affect across boroughs and which are considered to be substantial variations to services, the Direction from the Secretary of State to Local Authorities directs that a Statutory Joint Overview and Scrutiny Committee be established. The Trust and its managers will provide information and response to a Statutory Joint Overview and Scrutiny Committee in the same way as for single borough Overview and Scrutiny Committees.

2.2.7. It should be noted that there will be meetings with members or representatives of Overview and Scrutiny Committees that are not related to a scrutiny event. Attendance at such other meetings should be agreed between the relevant Director and the corporate lead for Overview and Scrutiny Committee liaison. Examples of such meetings are general liaison, training sessions, and dialogue relating to third party comment by Overview and Scrutiny Committees on the Annual Health Check submission.

2.3. **Attendance at Overview and Scrutiny Co-ordinating Groups/Meetings (Ref: Appendix Three)**

2.3.1. To assist in the co-ordination and management of programmes of work for Overview and Scrutiny Committees and to further enhance working relationships and shared knowledge base, some Councils may hold co-ordinating meetings on a regular or ad hoc basis. The corporate lead for liaison with Overview and Scrutiny Committees and/or other nominated Directors/Senior Managers of the Trust will attend such meetings to provide a conduit of two-way communication. (See also sections 2.5 and 2.6).

2.3.2. The Trust will encourage and support the Chair Persons and Councillor members of Overview and Scrutiny Committees in learning more about the Trust, its services and the key issues pertaining to its operation.

2.4. **Responding to Overview and Scrutiny Committee Reports**

2.4.1. The Trust will respond to completed reports by Overview and Scrutiny Committees within 28 calendar days of receipt of the report as required by the legislation and guidance.

2.4.2. The response by the Trust will set out the views of the organisation on the recommendations, proposed action in response to the recommendations and any reasons for inaction in response to the recommendations made.

2.4.3. If the Trust is unable to provide a comprehensive report within 28 calendar days, the Overview and Scrutiny Committee will be approached in order to negotiate an interim response. Any interim response must include details of

Appendix 1

when the final report will be produced.

2.4.4. The Trust will work with the relevant Overview and Scrutiny Committee to ensure that their report and the organisation's response is copied to key stakeholders, examples of which are listed in Appendix Two.

2.5. **Active Liaison with Overview and Scrutiny Committees**

2.5.1. The Trust will ensure that a co-operative working relationship is developed with local Overview and Scrutiny Committees and the appropriate lead officers of the Councils through active liaison arrangements. These arrangements will be facilitated by the corporate lead for Overview and Scrutiny Committee liaison, as described in 2.6 below.

2.5.2. The Trust will actively consult and involve Overview and Scrutiny Committees at an early stage on its plans for:

- substantial developments of the health service in the council's area;
- any proposals to make variation(s) to the provision of such services which Overview and Scrutiny Committees may consider to be substantial.

2.5.3. The Trust will also demonstrate to local Overview and Scrutiny Committees that sufficient time has been allowed for consultation to take place in accordance with its duty to make arrangements to involve and consult under Section 11 of the Health and Social Care Act 2001.

2.6. **Corporate Support for Overview and Scrutiny Committee Liaison**

2.6.1. The Trust will appoint a corporate lead for liaison with the five Overview and Scrutiny Committees identified in paragraph 1.1.4 above. The corporate lead for liaison with the Overview and Scrutiny Committees will be accountable directly to the Chief Executive.

2.6.2. The corporate lead for Overview and Scrutiny Committee liaison will be of at least an Assistant Director level. (See paragraph 2.2.1, footnote [1])

2.6.3. The corporate lead for Overview and Scrutiny Committee liaison will support the Trust in fostering a culture of openness and transparency with the Overview and Scrutiny Committees, by acting as a central contact point with LA officers supporting these bodies.

2.6.4. The corporate lead for Overview and Scrutiny Committee liaison will act as a source of expert knowledge and support for all staff that are required to

Appendix 1

engage with local Overview and Scrutiny Committees.

2.6.5. The corporate lead for Overview and Scrutiny Committee liaison will co-ordinate the response of the Trust to scrutiny reports by local Overview and Scrutiny Committees.

2.6.6. The corporate lead will attend communications meetings with Overview and Scrutiny Committee coordinators/administrators as required and will maintain regular periodic contacts regarding planned forward programmes and issues arising in the Trust that require communication for Overview and Scrutiny Committee function. (See also paragraph 2.3.1)

3. IMPLEMENTATION AND COMPLIANCE

3.1. Responsibilities of all Staff and Non-Executive Directors

3.2. All staff and Non-Executive Directors are obliged to adhere to this Policy. Managers at all levels are responsible for ensuring that the staff for whom they are responsible are aware of and adhere to this Policy. They are also responsible for ensuring staff members are updated in regard to any changes in this Policy.

3.3. Corporate Oversight

The corporate lead for liaison with Overview and Scrutiny Committees, on behalf of the Chief Executive, will take steps to ensure that all staff and Non-Executive Directors adhere to this Policy.

3.4. Training

The corporate lead for liaison with Overview and Scrutiny Committees will work with the Education Centre to ensure that training on effective communications with these bodies is available to senior staff and Non-Executive Directors who require it.

4. REFERENCE DOCUMENTS

- Health and Social Care Act 2001
- Statutory Instrument 2002 No. 3048, The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002
- Department of Health, *Overview and Scrutiny of Health - Guidance*.
- 5 Boroughs Partnership NHS Trust, Communications Policy
- 5 Boroughs Partnership NHS Trust, Operational Procedures for Liaison with Local Authority Overview and Scrutiny Committees.
- Centre for Public Scrutiny (CFPS), February 2005, *Tackling the democratic deficit in health: an introduction to the power of local authority health scrutiny*, page 2.

Appendix 1

- Centre for Public Scrutiny (CFPS), November 2006, *The Annual Health check: A Guide for Health Overview and Scrutiny Committees.*

5. DISTRIBUTION

5.1. This Policy will be available at all the Trust's designated locations. The Policy Unit will manage distribution of this policy and its placement on the Trust's Intranet.

6. REVIEW

6.1. This Policy will be reviewed annually or sooner if significant changes occur in the interim period.

Appendix 1

APPENDIX ONE:

EXEMPT INFORMATION

Appendix C of the Overview and Scrutiny of Health Guidance produced by the Department of Health lists the following as exempt information under the Health and Social Care Act 2001, Schedule 1:

1. Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, a relevant body.

2. Information relating to any particular occupier or former occupier of, or applicant for, accommodation provided by or at the expense of a relevant body.

3. Information relating to any particular applicant for, or recipient or former recipient of, any service provision by a relevant body.

4. Information relating to any particular applicant for, or recipient or former recipient of, any financial assistance provision by a relevant body.

5. The amount of any expenditure proposed to be incurred by a relevant body under any particular contract for the acquisition or disposal of property or the supply of goods or services.

6. Any terms proposed or to be proposed by or to a relevant body in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

7. The identity of a relevant body (as well as off any other person, by virtue of paragraph 6 above) as the person offering any particular tender for a contract for the supply of goods or services.

8. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matters arising between a relevant body or a Minister of the Crown and employees of, or office-holders under, a relevant body.

9. Any instructions to counsel and any opinion of counsel (whether or not in connection with any proceedings) any advice received, information obtained or action to be taken in connection with:

   a) any legal proceedings by or against a relevant body; or

   b) the determination of any matter affecting a relevant body, (whether, in either case, proceedings have been commenced or are in contemplation).

Appendix 1

10. Information relating to a particular person who is or was formerly in, or is an applicant for inclusion in, a list of persons undertaking to provide services under Part 2 of the 1977 Act prepared by a health authority.

11. Information relating to a particular person who is or was formerly included in, or is an applicant for inclusion in, a list of persons undertaking to provide services under Part 2 of the 1977 Act prepared by a health authority.

12. Information relating to a particular person who is or was formerly performing personal medical services or personal dental services in accordance with arrangements under section 28C of the 1977 Act.

13. Information relating to any particular employee, former employee, or applicant to become an employee, of a person referred to in paragraph10, 11 or 12.

14. Information relating to the physical or mental health of a particular individual.

Appendix 1

APPENDIX TWO

EXAMPLES OF KEY STAKEHOLDERS

Paragraph 5.5.5 of the Overview and Scrutiny of Health Guidance produced by the Department of Health lists the following as examples of key stakeholders to whom an Overview and Scrutiny Committee report and the NHS response should be sent.

- The mayor (if any) or executive
- The full council of the committee's local authority
- Joint or Partnership boards
- Local Strategic Partnerships
- Local MP(s)
- The Strategic Health Authority
- Relevant patient forum(s)
- Local voluntary organisations with an interest
- Other NHS trusts and Primary Care Trusts (PCTs)
- Other local authorities and Overview and Scrutiny Committees, for example District councils or neighbouring authorities.

The Guidance also recommends that the report and the response should be made available within local libraries, community venues and on websites.

Table of Attendees at Overview and Scrutiny Committees and Related Management and Administrative Meetings

MEETING/FUNCTION	PURPOSE	ATTENDEE(S)
Local Authority Overview and Scrutiny Committee/Panel meetings *(NB: the meetings may be differently titled e.g. The Health Policy and Performance Board – Halton Council)*	To undertake the overview and scrutiny of changes and developments in the provision of health care (and social care services) to the residents of the relevant council borough.	Chief Executive **and/or,** Designated appropriate Executive Director (most often the Trust Lead Director for OSC – i.e. Director of Operations, Standards and Nursing). **and/or** , Designated Associate Director (as relevant to the topic under scrutiny) **and,** Trust's OSC Link/Liaison – (Assistant CE/Trust Board Secretary)
Statutory Joint Overview and Scrutiny Committees	A special Overview & Scrutiny Committee established under the Directions to Local Authorities in respect of particular health issues/topics that have impact across more than one borough.	Chief Executive **and/or**, Designated appropriate Executive Director (most often the Trust Lead Director for OSC – i.e. Director of Operations, Standards and Nursing). **and/or**, Designated Associate Director (as relevant to the topic under scrutiny) **And,** Trust's OSC Link – (Assistant CE/Trust Board Secretary)
OSC Co-ordinating and information sharing meetings e.g. Warrington OSC Core Group	Some Councils arrange regular meetings of a core group of invited health and social care representatives for communication/ information sharing, early development of the forward programme of work and early alerts of impending service changes.	Trust's OSC Link – (Assistant CE/Trust Board Secretary) **and (or as alternate),** Designated appropriate Executive Director (most often the Trust Lead Director for OSC – i.e. Director of Operations, Standards and Nursing) **and (or as alternate),** Assistant Director – Clinical Effectiveness and Governance

MEETING/FUNCTION	PURPOSE	ATTENDEE(S)
Annual Health Check preparation and information sharing meetings for 3rd Party commentary	Liaison regarding receipt of the 3rd Party commentaries of OSCs.	Director of Operations, Standards and Nursing **or**, Assistant Director – Clinical Effectiveness and Governance
Training events	Training and education events mutually arranged between Council OSC Administration and Management and 5 Boroughs Partnership NHS Trust.	As per nominations for attendance.
Workshops	Arranged either to look at a particular topic related to the OSC functions or, to develop the forward programme of work with input from health care partners and PPIF/LINks.	As per nominations for attendance

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 12 June 2007

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: North West Ambulance NHS Trust

WARDS: Borough Wide

1.0 PURPOSE OF REPORT

1.1 To inform members of the proposed configuration of the North West Ambulance NHS Trust strategy.

2.0 RECOMMENDED: That

(1) Members note the proposed changes; and

(2) Members agree a future presentation by North West Ambulance NHS Trust on future services to Halton residents.

3.0 SUPPORTING INFORMATION

3.1 **Appendix 1** describes the reconfiguration of the Ambulance Control Room Service, which is required to deliver the government initiatives; 'Taking health care to the patient' and 'Call to Connect'. This document details the technical requirements to deliver services through a single virtual call handling arrangement.

3.2 The Ambulance Service reconfiguration has been led by Government requirements and also linked to the reconfiguration of strategic health authorities.

3.3 **Appendix 2** outlines the strategic vision for the Ambulance Service. It notes that the Trust is developing three main documents:

- Service Strategy – to underpin the development of a Trust as an organisation
- An operational Performance Plan
- The detailed Implementation Plan

This document describes a broad picture for the North West Ambulance Trust, which covers a large area.

3.4 To explore the implications for Halton, members may wish a representative from the Trust to present a future Healthy Halton Policy & Performance Board.

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 None.

6.0 OTHER IMPLICATIONS

6.1 None.

7.0 RISK ANALYSIS

7.1 None.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 There are no background papers under the meaning of this Act.

North West Ambulance Service NHS
NHS Trust

Ambulance Control Room Reconfiguration

CONTENTS

1 Introduction

The Ambulance Control Room Reconfiguration document underpins the Trust Service Strategy & Vision and is central to the delivery of the Operational Performance Plan detailing the main changes required to deliver the requirements of *"Taking Healthcare to the patient"* and *"Call to Connect"*.

There is a need for the North West Ambulance Service to ensure that the infrastructure within the separate control rooms is common to enable resilience and allow economies of scale from the merger to be realised. In line with the implementation of the National Digital Radio and the Electronic Patient Record as well as delivering against the "call to connect" targets, the Trust needs to ensure that all vehicles have common AVLS (satellite tracking) and data capabilities

2 Changed Service Model

A new model for the operational delivery of services for the North West Ambulance Service is outlined in the Operational Performance Plan, designed to meet the performance required from 'Call to Connect' and also to reengineer the service delivery around the concepts for 'Taking Healthcare to the Patient'.

To meet the increased performance targets of *'Call to Connect'* requires a significantly improved capacity and efficiency of operation within the control function. This is best achieved through a single virtual call handling arrangement that can route callers to the next available receiver within the North West. Once a requirement for a face to face assessment is determined, a more 'front-end' orientated model with a predominance of Rapid Response Vehicles available to attend and assess patients quickly would be enabled. The ability to respond quickly on a consistent basis with more emphasis on assessment and access to a wider range of services will allow the principles of *"Taking Healthcare to the patient"* to be realised. This approach would be supported by improved infrastructure arrangements within the control environment to ensure consistency, resilience and good governance at all sites. In essence, the service would operate in the following way:

1. A 999 call is connected to the NWAS switchboard (which has a router over a 'virtual network' to every call handler in the different communication centres) and allocated to the next available call handler who picks the call up within 5 seconds. If the call is not answered within 10 seconds, 'call line identification' creates an address and the nearest response unit is automatically responded pending a category determinant.

2. The call handler uses a rapid clinical protocol (such as NHS Clinical Pathways) to determine whether the call is an emergency (Red) or not, within 30 seconds. If the call determinant is Red, then the nearest Rapid Response Vehicle with a level 5 practitioner would be responded via the local dispatch centre.

3. If an Urgent (Amber) call determinant that requires a face to face assessment then the nearest Rapid Response Vehicle with a level 6 practitioner would be responded.

4. Alternatively, the call could be determined Non-urgent (Green) and passed to the clinical advisor (level 6 practitioner) within the local communications centre to assess and process.

5. Once a clinical assessment of the patient has been undertaken and an outcome determined, any transport requirements would then be undertaken by a double manned ambulance.

3 Infrastructure

The national Ambulance Radio Project (ARP) will deliver two systems into predetermined locations within the North West Ambulance Service. The systems are intended to provide a resilient fallback for each other to ensure continuity of service. As the equipment needs to be connected to the ambulance control equipment the logical option is to co-locate the equipment within the control complex itself.

Control sites not receiving this equipment will be reliant upon networks and network equipment to provide the connectivity, and due to the nature of the emergency operation should provide dual routing. Costs of networking are based upon radial distance between the buildings with significant increases being applied over certain distances. These costs have both one-off capital costs plus ongoing revenue consequences of line rental.

To take advantage of the technology being delivered by the radio project it is beneficial from both a resilient point of view and financially for the Trust to extend this functionality to all control room systems and deliver them through the network locally and through the Wide Area Network (WAN). Moving to centralised systems allow the technology to target calls to where capacity exists, to enable all controls to have access to all resources and for managers to have control of the whole system. Again, by maintaining more than one centre the Trust will have fallback options if the primary system fails. Additionally, the Trust will benefit from reduced IT costs as the systems can be maintained, upgraded and repaired from central locations or from data centres.

Technology allows Trusts to build virtual centres where the controls are linked together allowing excess capacity to be used throughout the region. This ensures that peaks and troughs can be accommodated much easier and means that Trusts only need to establish the number of seats required rather than a number of controls it needs to maintain. This ensures that finances are directed away from expensive, fixed buildings and invested in increasing the front line delivery.

For example, the volume of calls may indicate that the Trust needs to provide 90 seat positions throughout the region. This could then be accommodated by 1 control with 90 positions, 2 with 45, 3 with 30 etc. It is important that whatever numbers of control sites are maintained that they are all roughly similar in size otherwise they are unable to contribute towards a resilient configuration. For example if 90 seats were spread across 3 controls in a distribution of 40, 30 and 20 seats respectively and the larger control failed, the smaller two remaining controls would struggle to accommodate a requirement for nearly 100% extra capacity.

There is a balance in terms of the amount of additional capacity required within each control based on the number of controls within the system. The following table demonstrates this point.

Control Rooms	Standard	Call Connect	Fallback	Total per Control
4	22	5	5	32
3	30	7	9	46
2	45	11	28	84

The above assumes that 90 seats are required within the system and allows for a growth of 25% for 'Call to Connect' and increased activity. Within a 4-control system each control needs to provide 5 additional seats for fallback, 3 controls need 9 seats and 2 controls 28 seats. The above shows that the 4 control system overall requires the lowest number of seats overall but that's based on the premise that all are roughly equal size in the first instance e.g. they have 22 seats. This is not the case with the existing sites.

In addition, the impact of a failed control in terms of the increase in calls is also significant. The following table shows a regional distribution of 2,500 emergency calls per day.

Controls	Calls	Fallback	Total
4	650	220	870
3	875	430	1305
2	1250	1250	2500

The above shows that in a 4-control system any single failure would increase calls by 33% whilst a 2-control system would receive an increase of 100% but again this is based upon an assumption that all controls were of a similar size.

The above description demonstrates that a 2 control system would struggle to absorb the increase particularly for a protracted period of time and also if the failure occurred at a peak point in activity. Four controls, whilst requiring overall the least number of seats is not significantly different from 3 controls. A 3-control option would therefore appear to provide the most cost-effective approach to providing a fallback. The 3-control option is also the recommendation from the independent Capita report commissioned collectively by the four previous ambulance Trusts.

The control configuration would rely heavily upon the network provision to ensure that the system operated in the manner described. Proximity is important, as previously described. Each control should be geographically independent but close enough to move staff from a control that has failed to the fallback site within a reasonable time.

4. Developments

Within the context of developing the service model in line with *"Taking Healthcare to the patient",* modernisation needs to be in conjunction with the developments in both primary and secondary care. This should include developments in partnership with the wider health economy. As outlined in the recent Department of Health publication *"Direction of Travel for Urgent Care",* there is a consistent message about efficient use of resources:

"6. We need to develop urgent and emergency care services that are more responsive to people and more efficient in the way they deploy resources, and make the most of opportunities from medical and technological advances to deliver better care and support more conveniently for people.

7. This means a consistent way of assessing what people need when they contact services with an urgent care need, whether by telephone or in face-to-face settings. It means changing the way services are configured locally, re-deploying existing resources for optimal care.

8. Understanding how people access urgent and emergency care will help commissioners and providers shape services in a way that best responds to changing local needs and the changing healthcare environment. Different solutions will be appropriate in different places but these should be based on the same criteria and evidence of what works best and offers the highest quality. "

There are potential possibilities for reutilising the skills of staff and the current facilities of ambulance control centres to provide a different 'health gateway' model for local determination. This may be a model that can be incorporated into existing sites or developed on an available site.

5. Summary

The optimum model for the most cost effective and resilient configuration for the new North West Ambulance Service is 3 controls. How this model is developed over time in conjunction with other ambulance Services and other Emergency and Health Services is yet to be determined, and the eventual sites may well be different to those currently in existence. However, in the short term the configuration of maintaining the controls in Manchester, Liverpool and Preston would seem to be the most efficient. They have geographic independence and are close enough to move staff around if necessary. They are close enough to ensure that network costs are minimised and are all of a similar size or have the capacity for minimal expansion to match their counterparts.

The ambulance service delivery currently provided in the Cumbria region would benefit directly by the technology developments the other legacy Trusts have previously invested in. For example, vehicle tracking, mobile data and integrated navigation systems on all front line vehicles, none of which is currently available in the Cumbria vehicles.

In addition, convergence of systems means that the IM&T department can provide many of the back office functions previously unavailable to Cumbria staff due to its small size and its inability to keep pace with larger, better resourced Trusts. This will ensure that good governance would be assured in terms of data extraction and management information reporting.

A Full Business Case will need to be developed to determine the affordability of the reconfiguration stages and consultation with all stakeholders engaged. Both will need to be completed before final approval can be obtained from the Strategic Health Authority.

Appendix 2

North West Ambulance Service NHS
NHS Trust

A SERVICE STRATEGY & VISION

CONTENTS

1 Introduction

The publication of *"Taking Healthcare to the patient"*[1] places responsibility on Ambulance Services to review and re-engineer services to provide more appropriate care to patients in an appropriate setting in their home or community. There is also a major stress on improving response times as targets become more stringent.

There is a real opportunity for Ambulance Services to improve the clinical outcomes for patients by:

- Utilising the skills and capability of staff to provide a wider range of service provision and reduce the need for patients to go to hospital
- Maximising the use of despatch and communication technology and capability to improve response times and provide more convenient access to services for patients
- Maximise the potential for providing an enhanced range of accessible services by utilising the transport/communication capability of the Trust to provide more mobile facilities/services

The achievement of these aims will need to be done in the context of the needs of patients, the requirements of the various Primary care Trusts as the commissioners of health care services, and National targets and policy guidelines.

A significant part of the change process will be to involve the public, patients, carers and staff in developing the new service models.

The pace of change will also need to be carefully managed to ensure that standards of care are maintained and improved as the service changes are implemented.

A key element of the process will be to enhance the skills and capabilities of staff to perform a wider range of responsibilities. This will require a shift from the current training methodology to one of continuous professional education with an appropriate clinical accountability and responsibility for each member of staff. This will allow the real development of staff to utilise different skill sets from that currently in place, in line with the Knowledge and Skills Framework principles contained within Agenda for Change.

To plan the way forward the Trust is developing three main documents;

1. A Service Strategy and vision (this document) which will be the subject of extensive discussion and development. The Strategy will need to underpin the development of the Trust as an organisation.
2. An Operational Performance Plan which will outline how the Trust can maintain and improve performance as the new Service strategy is implemented.
3. A detailed Change Implementation Plan which will be developed to guide and monitor a wide range of initiatives and programmes required to implement the new Service Strategy

These will be further supported by a range of Strategy and Plan documents including Facilities Management, IMT, Workforce Changes and Communications.

2 The Service Strategy & Vision

The main elements of the strategy are identified in Figure 1.

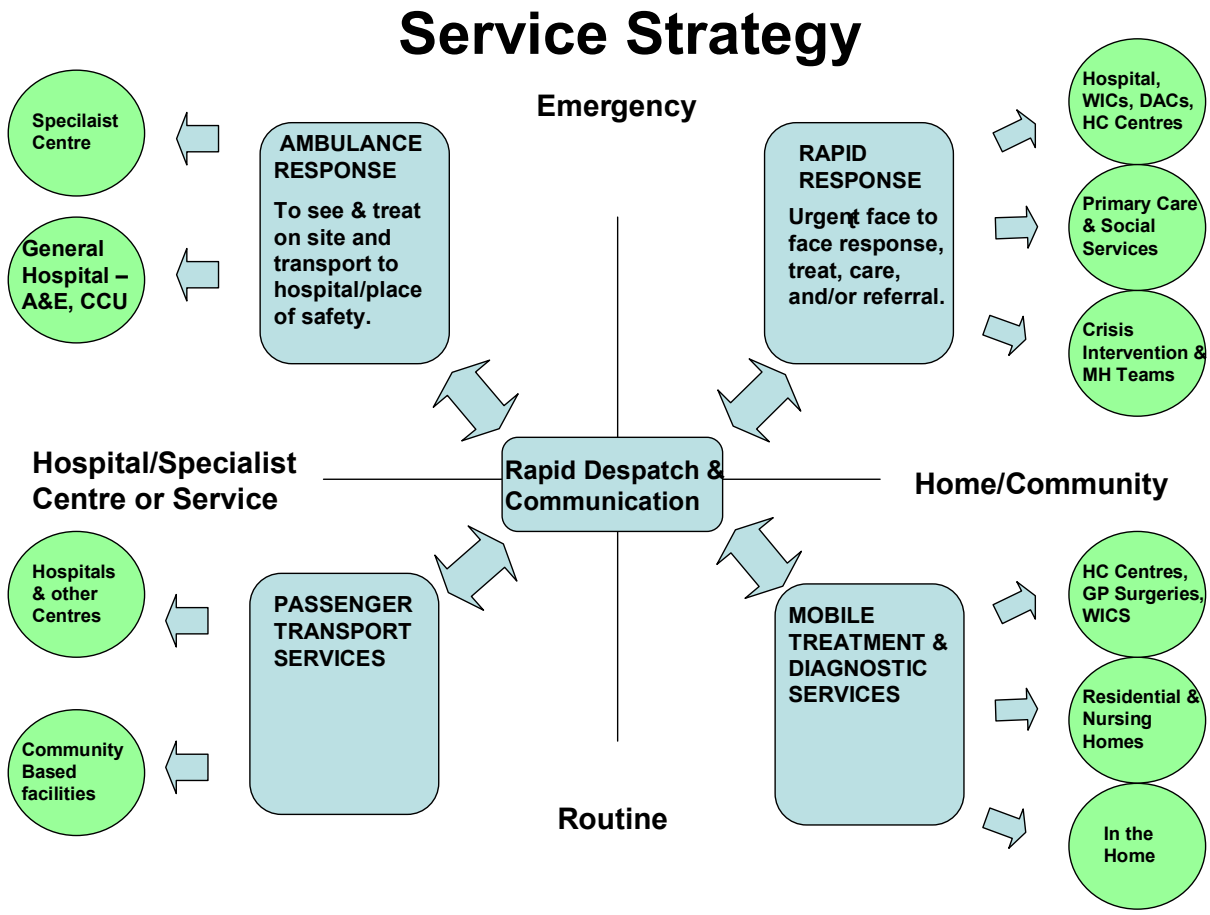


Figure 1. Service Strategy Model

There are five components:

1. The core despatch and communications capability. This aspect covers the Control Centres and the communications with individual vehicles/crew. This capability is central to the development of the new portfolio of service provision.
2. Ambulance response which will be required in particular types of emergency and inter-hospital transfers, and which will be increasingly despatched following assessment of patients by rapid responders.
3. The rapid response service which will take a variety of forms dependent on the needs of patients and the local geography. The rapid response crews will increasingly identify different forms of appropriate responses for patients and will be able to access support and care from a range of sources as well as the traditional journey to hospital.

4. Passenger Transport Services (PTS) which will continue to carry patients to more routine appointments and services.
5. Mobile treatment and diagnostic services will increasingly be developed to utilise the Trusts despatch and transport facilities to provide more convenient services in patients' homes or in local facilities such as the new diagnostic and treatment centres. This element will be developed within both the traditional Emergency and PTS streams.

The aim of the strategy is that the Trust effectively utilises all it' staff and physical resources to ensure that each patient obtains:

- the appropriate level of response, assessment and treatment within the specified time requirements
- appropriate access to routine/urgent/emergency care services
- appropriate services where possible in convenient settings outside hospital

There will need to be a wide ranging discussion on how the strategy can be developed within different areas across the Trust. There are a number of stakeholders who will wish to be involved and the Trust will develop a full communication programme to ensure that views, ideas and concerns can be collated and properly addressed.

The Trust will also need to ensure that performance standards are maintained and enhanced whilst the strategy is developed and change begins to occur.

3 Strategic Performance Plan

The standards expressed within *"Call to Connect"*[2] require the Ambulance Service to improve the delivery of the service from an operational performance perspective. The change in performance monitoring times commencing from the current point (after establishing name, location and key problem) to the point of connection to the switchboard in April 2008, will reduce the existing response time by approximately 50 seconds. The response comparison (Figure 2) from the available Manchester data shows an average 15% drop in Category A_3 response performance below the current threshold.

Looking back over the last ten years within the ambulance service, this level of performance increase has only been achieved with substantial additional income as well as fundamental change in service delivery models, such as the introduction of Rapid Response Vehicles (RRV)[4] and Intermediary Tiers[5].

The expectation for the future is that now the improvements will be made by redirecting existing resources into modernising the service. There will be a requirement to ensure that full engagement with the commissioners takes account of the reconfiguration of Primary Care Trusts and the reconfiguration work being undertaken within both Acute Hospital and Primary Care services.

The two drivers in the strategy outlined above are to deliver a response to each patient as quickly as possible and deliver the most appropriate care to the patient. These two drivers can be difficult to reconcile and are dependent on effective and efficient delivery systems and clinically competent staff educated to appropriate levels of skill and competency.

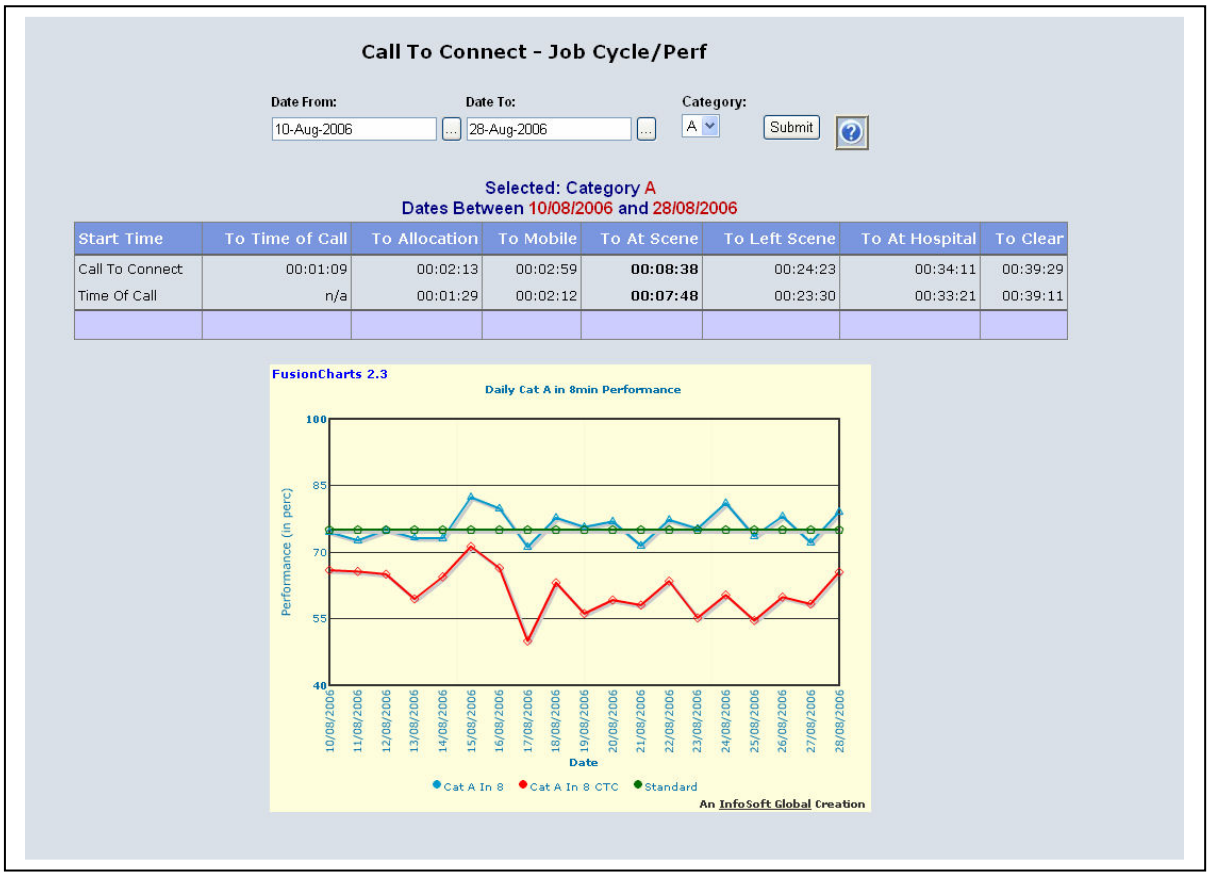


Figure 2 – Manchester performance comparison

4 Enhancement of the Rapid Response Capability

The emerging model identified by the Bradley report and by consultancy firm Operational Research in Health, is that the only viable solution is to develop a more 'front-end' orientated model with a Rapid Response capability enabling staff available to attend and assess patients quickly. The ability to respond quickly on a consistent basis with more emphasis on assessment and access to a range of services will require fewer double crewed ambulance vehicles.

There has been a significant amount of work on defining the future workforce model based on the future work patterns. This suggests a fundamental change in staff methodology and skill sets from the current position. In addition, there is a growing recognition both amongst the organisational managers and within some of the staff groups themselves that the ambulance service will have to change to a clinical professional model. This change can only occur over time and will require adjustments at all levels of the organisation. For example, a change in culture and attitudes from operating within a hierarchical command and control structure, to a more devolved model.

The new Trust has an opportunity and a requirement to establish a new strategic framework for shaping and delivering best practise patient care pathways to become a truly world class service. It is easier to set those goals and targets at the outset of the new organisation with

realistically achievable timeframes, rather than trying to introduce them as potentially disjointed incremental changes later.

In essence, the service will operate in the following way:

1. A 999 call is connected to the NWAS switchboard (which has a router over a 'virtual network'[7] to every call handler in the different communication centres) and allocated to the next available call handler who picks the call up within 5 seconds. If the call is not answered within 10 seconds, 'call line identification'[8] creates an address and the nearest response unit is automatically responded pending a category determinant[9].

2. The call handler uses a rapid clinical protocol[10] (such as NHS Clinical Pathways[11]) to determine whether the call is an emergency (Red) or not, within 30 seconds. If the call determinant is Red, then the nearest Rapid Response Vehicle (RRV) with a level 5 practitioner (bulk of RRV's) would be responded via the local dispatch centre. If an Urgent (Amber) call determinant that requires a face to face assessment then the nearest Rapid Response Vehicle with a level 6 practitioner would be responded. Alternatively, the call could be determined Non-urgent (Green) and passed to the clinical advisor (level 6 practitioner) within the local communications centre to assess and process.

3. Once a clinical assessment of the patient has been undertaken and an outcome determined, any transport requirements would then be undertaken by a crew consisting of a level 3 driver and level 4 attendant.

This model would be the predominant model in urban areas with appropriate variations designed for more rural areas. In rural areas, it may be better to have more ambulances with a level 3 driver and level 5 attendant acting as response and transport, with only level 6 practitioner solo responders for the non Red calls. These would then be supported by a more robust community responder scheme network for the very remote and rural locations.

5 Change Implementation Plan

To deliver the strategy outlined above and to take forward the requirements contained within *"Call to Connect"* and enabling the provision of *"Taking Healthcare to the Patient"* six streams of work have been identified:

- Technology,
- Communication Centres,
- Response Capability,
- Transport elements,
- Clinical competency
- Organisational structure and effectiveness.

All these streams of work will need to be carefully phased and monitored for delivery against agreed targets and plans. Regular reports to the Programme Board and trust Board will be prepared to ensure that the timescales and resource allocations are adhered to.

The changes will also have implications for the Knowledge and Skills Frameworks within the Agenda For Change framework. Some staff and organisational restructuring for managers will be required to provide a professional basis for the clinical services in the long term. It should be recognised that these changes may well be unsettling in the immediate future.

The fundamental concept expressed in figure 3 below, shows how both drivers for the future service delivery can be met. The individual elements within each of the work streams will be addressed slightly differently and at a potentially different pace within each of the local Areas.

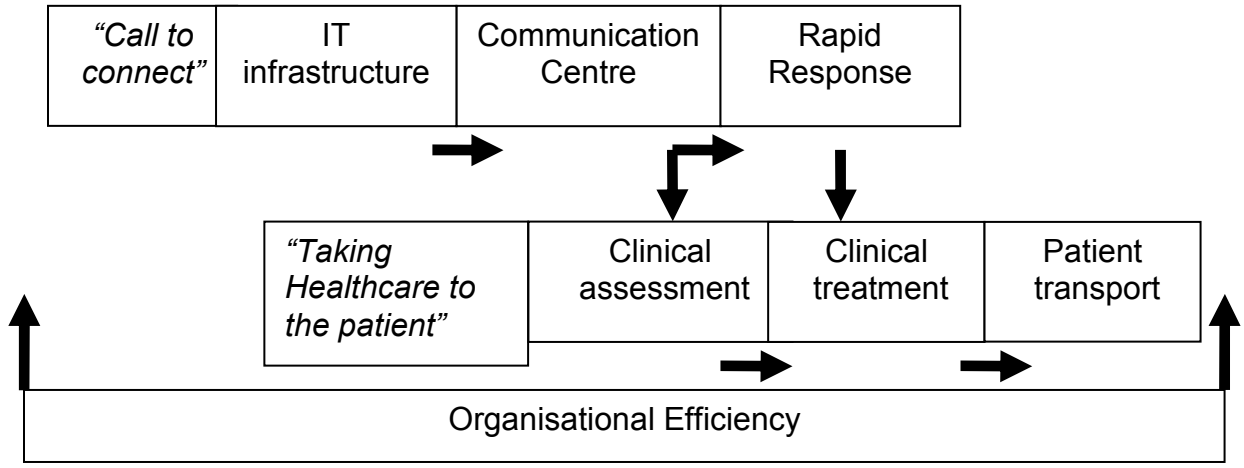


Figure 3 Performance Model

The principle elements of change in each of the work streams can be summarised as follows:

- **Technology:**

A. The Ambulance Service nationally has procured a new digital radio system that is being implemented in all Ambulance services over the next 2 years. The Trust is responsible for ensuring the infrastructure is in place and the technology will work effectively once implemented.
B. A regional procurement within the National Programme for Information Technology[13] framework will implement a laptop within the vehicles for the clinicians to record assessments and treatments and create and send an Electronic Patient Record[14].
C. There is a need to ensure that the infrastructure within the separate control rooms is common to enable resilience and allow economies of scale from the merger to be realised.
D. In line with the implementation of the National Digital Radio and the Electronic Patient Record as well as delivering against the "call to connect" targets, the Trust needs to ensure that all vehicles have the correct and common AVLS (satellite tracking) and data capabilities.

- **Communication Centres:**

A. The communication centres need to be reconfigured to provide optimum resilience and cost efficiency in line with the introduction of National Radio Project, electronic Patient Record. The rationale for the change is supported by the independent Capita report[15] commissioned by the four previous Trusts. They then need connecting through a virtual network to enable distribution of 999 calls to the next available call handler wherever they may be sited.
B. Advancing from the above, standardisation of software systems and the ability to view all areas deployment screens would allow for resilience and a more 'Trust wide' resource and deployment plan to be effected.
C. The utilisation of appropriate hospitals depending on bed states and the co-ordination of transfers between hospitals need to be consistent across the Trust sites, utilising Health Information desks[16].
D. In order to reduce admissions and deliver most appropriate care to the patients, the greater utilisation of Practitioners within the Communications Centres needs to be enabled.

- **Response elements:**

A. The change to a 'front end' model will require the implementation of significantly greater numbers of RRV's with different profiles for the different practitioners that would be responding to the appropriately graded calls.
B. In order to ensure effective response coverage, a complete active standby deployment plan[17] for all areas will need to be implemented so that resources are held where the need is predicted rather than on ambulance stations.
C. An education programme to take existing Paramedics and future staff to level 5 practitioner against the new KSF[18] framework (likewise current ECP's[19] to level 6) will need to be developed and implemented.
D. Workforce resource profiles need to be more flexible to meet daily, weekly and seasonal variations in the demand patterns. This may require a move away from the 12 hour shift rota's to a more individual annualised hours style of working.

- **Transport elements:**

A. An education programme to take existing Technicians and future staff to level 4 practitioner will need to be developed and implemented, along with a programme to create level 3 dedicated driver assistants in order to implement dedicated transport crews (fewer than current ambulance fleet) for 999 incidents.
B. The current model for separate 'high dependency' or 'intermediary tier' vehicles and crews needs to be expanded and made consistent for General Practitioner and 'out of area'[20] transfers. It also needs incorporating with the other resource profiles to enable a rotation of staff through different working.
C. Use of active standby model. The same principles of utilising these resources most effectively should apply, with crews held where the demand is predicted not left on ambulance stations.

D. Workforce resource profile to be more flexible to meet daily, weekly and seasonal variations in the demand patterns. This may require a move away from the 12 hour shift rota's to a more individual annualised hours style of working.

- **Clinical competence:**

A. There is a requirement to move from traditional ambulance training to continuous education for the new skill set levels outlined above based on clinical assessment and treatment.
B. There is a need for every Individual practitioner to take ownership of their own clinical competence, audit and development.
C. Supporting the development of the new clinical workforce will require the utilisation of level 7 and 8 practitioners for supervision, incident management and further advice. The clinical workforce will then be managed by senior operational managers for each sector area supported by general managers undertaking the logistics and administration duties.

- **Organisational effectiveness**:

A. A review of the current estate, fleet and supply facilities compared against the strategic service delivery for the future will inevitably result in the Rationalisation of logistical resources.
B. The Operational Performance Plan will set the framework for Local variation dependant on Area topography, demographics and health system infrastructure.
C. Sector Managers to be responsible for managing the operational function of a designated geographical area on an 'office hours' basis. They, along with the senior Control Manager, would report to the Head of Service responsible for the delivery of the operational service within the local Area. A separate 'general manager' could be assigned to each sector for the administrative and logistical control of non-clinical operational resources Operational managers within the existing structure could be redeployed into the various roles.
D. The concept of matrix management to be fully incorporated into the operational structure with, for example, each Sector having an Emergency Planning Officer who is responsible for ensuring the local plans through the Sector manager are in place and tested, but would also report to the Assistant Director for Emergency Planning to ensure consistency across the Trust for the function of Emergency and Business Continuity planning.
E. A complete review of the current estate and fleet requirements and infrastructure. The changing workforce skill mix and resource profiling will undoubtedly result in a rationalisation of the estate.

6. Summary

The Service Strategy for the Trust outlined in this paper is required to meet the National policy requirements, local service changes and the need to enhance performance and standards. This document contains a broad outline of how the change process can commence together with a major exercise to discuss issues with patients, carers, local communities and all staff.

The development of the implementation plan for this Strategy and the more detailed proposals required to make the necessary changes in the different work streams will continue and a range of further documents will be prepared to support the process, that will include:

- Operational Performance Plan
- Control Room Strategy
- Support Services Strategy
- Communications Strategy
- Finance Strategy
- Workforce Change Strategy
- ICT Strategy

As with all change management programmes there are always differences in performance whilst any individual change element is introduced. With a change programme on the scale of that outlined in this paper, it is essential that the performance trajectory is reviewed over the long term as variations will be experienced as individual elements are realised. Performance management of the implementation plan will need to be robust in order to ensure that the implementation of the individual elements do not negatively impact on each other, and this will be monitored within the remit of the Trust's Programme board.

GLOSSARY OF TERMS

1	*Taking Healthcare to the patient*	Department of Health document mandating the transformation of Ambulance Services
2	*Call to Connect*	Department of Health document stipulating the change in performance reporting measures
3	Category A	999 calls coded as Life threatening following categorisation (also known as Red call)
4	Rapid Response Vehicles	Vehicles operated by a single member of staff for response and assessment
5	Intermediary Tier/High Dependency	Ambulances with non-paramedic staff utilised for GP urgent calls and transfers
6	Agenda for Change	NHS pay and modernisation framework
7	virtual network	Technological connection between different control centres
8	call line identification	Software that identifies the location of a caller from a landline to the operator
9	category determinant	The coding of the potential severity of a caller's problem (e.g. category A, B or C)
10	clinical protocol	Software system designed to question a caller to determine the potential severity of their problem
11	NHS Clinical Pathways	New NHS developed clinical protocol software system
12	make ready bays	Bays on large ambulance stations that clean and restock ambulances with support staff
13	National Programme for Information Technology	NHS programme for implementation of the national patient care record
14	Electronic Patient Record	Electronic record for each patient that should be linked through all stages of care
15	Capita report	Independent report into the potential configuration model for control centres for NWAS
16	Health Information desks	Desks within the control centre that co-ordinate and monitor the bed state of hospitals in order to best utilise ambulances and A&E units
17	active standby deployment plan	Vehicles deployed to standby points in the community or roadside where activity predictions are high based on historical data
18	KSF	Knowledge and Skills Framework for career and pay progression within the NHS
19	ECP	Emergency Care Practitioner (current skill grade above Paramedic)
20	out of area	Transfers between hospital units across Trust boundaries

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 12 June 2007

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Work Topics to be undertaken by Healthy Halton Policy & Performance Board

WARDS: Borough wide

1.0 PURPOSE OF REPORT

1.1 To agree two work topics to be undertaken by Healthy Halton Policy & Performance Board.

2.0 RECOMMENDED: That Members agree the topics and the Terms of Reference (attached).

3.0 SUPPORTING INFORMATION

3.1 Healthy Halton Policy & Performance Board annually agrees future work topics which are related to the priorities of Halton Council and which cover health and social care issues.

3.2 There has been informal discussion at Healthy Halton Policy & Performance Board about identifying and agreeing two work topics; one of these to be specifically a health care issue.

3.3 Work Topic 1 : Health of Carers

Members will be aware that carers needs have been increasingly recognised by the Government and are also a priority for Health & Community Directorate. Members received a presentation report on the Strategy for Carers 2006/2008 at a Healthy Halton Policy & Performance Board meeting last year and noted that meeting health needs was perceived by carers as a priority within that strategy.

3.4 The Terms of Reference are attached **(Appendix 1)** to undertake this work topic; support will be needed from the Primary Care Trust to ensure that the work topic can be fully undertaken.

3.5 Work Topic 2 : Contracted Services for People with Physical and Sensory Disabilities

The Council has a small number of contracts with external agencies to provide services for people with physical and sensory disabilities. While these are only small in number they are very important given the complex needs of people receiving those services.

3.6 It is proposed that a review of the contracts is undertaken with a view to assessing how they meet the needs of people with physical and sensory disabilities. The work topic brief is attached as **Appendix 2.**

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 None.

6.0 OTHER IMPLICATIONS

6.1 None.

7.0 RISK ANALYSIS

7.1 None.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Both work topics ensure that people with additional needs receive services they require.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 There are no background papers under the meaning of this Act.

Appendix 5

TOPIC BRIEF

TOPIC TITLE: ALD Day Service Redesign

PPB(s) responsible: Healthy Halton

Officer Lead: Audrey Williamson

Planned start/end dates: July 2006

Target PPB meeting: March 2007

Topic description and scope:

To scrutinise the process of the redesign of Day Services for adults with learning disabilities, as outlined in the White Paper, Valuing People: A New Strategy for Learning Disability for the 21st Century, and as agreed by Halton Borough Council's Executive Board in November 2005.

Scope:

i) To review the process undertaken to decommission Astmoor Day Centre.

ii) To review the expectations and experiences of stakeholders, including people accessing services, carers and staff members.

iii) To benchmark Halton Day Services against other local authority providers.

iv) To assess the extent to which the redesign of Day Services has fulfilled the criteria outlined within Valuing People.

v) To identify any barriers that may exist hindering redesign.
Why this topic was chosen

i) It is recognised that the agreed closure of Astmoor as a Day Centre was accompanied by considerable concern from a number of stakeholders, especially carers. In agreeing to the redesign of Day Services, the Executive Board was keen to ensure that a transparent and effective process was followed.

ii) It is anticipated that, where appropriate, learning points from the redesign process will be used within the review of Day Services for other client groups.

Appendix 5

Key outputs and outcomes sought

i) To ascertain to what extent progress has been made in terms of redesigning Day Services in Halton, as outlined in Valuing People.

ii) To produce a critical appraisal of the process undertaken in decommissioning Astmoor as a Day Centre, and developing alternative service provision.

iii) To ensure that learning points from the experiences and expectations of key stakeholders – most notably people accessing services, carers and staff – are noted and used during similar exercises.

iv) To identify any service gaps and necessary service improvements, and barriers to redesign and to make recommendations regarding future service development and provision.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve

Priority 1 Improving Health

Outcome 2 (Service Plan) – To improve the health of Halton residents.
The Integrated Services Department aims to promote and support working aged people and their carers to make positive choices about their lifestyle and health.

Enhancing Life Chances and Employment

Overall Aim: To enhance the personal development, training and employment opportunities and overall life chances of local people, encouraging all to reach their full personal and work potential.

Key Objective A – To promote access to suitable education, training and means for personal development for residents of all ages.

Key Objective E – To improve opportunities for the personal development of young people, particularly those who are disenfranchised, disaffected or hard to reach.

Nature of expected/desired PPB input:

Member led review of the implementation of the redesign of ALD Day Services and its impact on key stakeholders.

Appendix 5

Members:

Ellen Cargill, Kath Loftus, Sue Blackmore (for approval at PPB)

Preferred mode of operation:

Working group to be set up.

Media/communication implications:

To be agreed.

Appendix 2

TOPIC BRIEF

Topic Title:	Contracted Services for People with Physical and Sensory Disabilities
Officer Lead:	Marie Mahmood
Planned start date:	July 2007
Target PPB Meeting:	January 2008

Topic Description and scope:

A review of the contracts for the provision of services for people with physical and sensory disabilities.

Why this topic was chosen:

While only a small number of contracts exist providing for example, services for people who are blind, these contracts are important. Services for people with physical and sensory disability have been perceived nationally as cinderella services and a focus on such services will ensure that the importance of meeting the needs of people with physical and sensory disabilities are locally recognized and improved upon.

Key outputs and outcomes sought:

i) To identify existing and future need within Halton for specific services, particularly in relation to deafness and blindness
ii) To ascertain how effective current provision is in meeting the needs of this small group of people
iii) To look at future services, identify any service gaps and necessary service improvements
iv) To make recommendations regarding future service development and provision

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve:

<u>Improving Health</u> –

Key Objective C : To promote a healthy living environment and lifestyles to protect the health of the public, sustain individual good health and well-being, and help prevent an efficiently managed illness.

Appendix 2

Nature of expected/desired PPB input:

Member led review of a small number of contracted services.

Members: To be agreed at June Policy and Performance Board

Preferred mode of operation:

Working group to be established.

Media/communication implications:

To be agreed.

Agreed and signed by :

PPB chair …….. Officer ……

Date …… Date …….

REPORT: Healthy Halton Policy and Performance Board

DATE: 12 June 2007

REPORTING OFFICER: Strategic Director, Environment

SUBJECT: Healthy Halton PPB 2006/7Annual Report

WARDS: Borough-wide

1.0 PURPOSE AND CONTENT OF REPORT

1.1 This report presents a draft Annual Report of the activities of the Healthy Halton PPB during 2006/7 for comment/amendment. Subject to endorsement by the PPB, the Annual Report will go forward with the Annual Reports of other PPBs to a forthcoming meeting of the full Council for adoption.

2.0 RECOMMENDED: That

(1) the PPB consider, comment upon and if necessary agree amendments to, the attached Annual Report of the PPB's activities in 2006/7; and

(2) the PPB endorse the attached/amended Annual Report for the purpose of its adoption at a forthcoming meeting of the full Council.

3.0 SUPPORTING INFORMATION

3.1 Annex comprising the draft Healthy Halton PPB Annual Report for 2006/7.

4.0 POLICY IMPLICATIONS

4.1 None arising from this report itself.

5.0 OTHER IMPLICATIONS

5.1 None arising from this report itself.

6.0 BACKGROUND PAPERS

6.1 2006/7 departmental service plans

Cllr Ellen Cargill
Chairman

ANNUAL REPORT
HEALTHY HALTON POLICY AND PERFORMANCE BOARD
APRIL 2006 – MARCH 2007

My first priority in this report is to express appreciation for all the support I have received over the past twelve months from my vice Chairman Cllr Kath Loftus and all of my colleagues who have served with me on the Board. Their enthusiasm has been infectious. Officer support has also been vital to the Board and my thanks go to Audrey Williamson, Martin Loughna, Peter Barron Nigel Parker and Dwayne Johnson.

Once again, this has been a challenging year for the Healthy Halton Policy and Performance Board, particularly in relation to work with Health partners. A number of important consultations were undertaken during this year including North Cheshire Hospital Trust on services to be provided in both Halton and Warrington Hospitals, and Mental Health proposals from the 5Boroughs Partnership Trust in 'Change for the Better'.

As part of the Board's response to these consultations a Joint Statutory Committee was established with St Helens and Warrington to enable the three Borough Councils' to look in detail at the changes proposed for Mental Health Services. I would like to thank all Members, Officers and health colleagues for their efforts and support during this year. I had the privilege of chairing the Joint Committee with the support of vice Chair Cllr Andy Bowden, from St Helens also Cllrs Loftus and Inch, from Halton, McGuire and Stephanie Topping from St Helens and Councillors Hoyle, Johnson and Banner from Warrington.

MEMBERSHIP AND RESPONSIBILITIES

During 2006/07 the Board comprised eleven Councillors – Councillors Ellen Cargill, Loftus, Blackmoor, Howard, Hodgkinson, Horabin, D Inch, Jones, Lloyd-Jones, Swift, and Wallace. The primary function is to focus on the work of the Council (and its Partners) in seeking to improve health in the Borough and to scrutinise progress against the Corporate Plan in relation to the Healthy Halton Priority.

REVIEW OF THE YEAR

The Board met seven times in 2006/07 and received reports on a wide range of both Health and Social Care issues, which affected Halton residents. These included:

Short-term Respite Care for People with Learning Disabilities
The Board looked at a model of short-term breaks, which offered increased choice and opportunities for adults with learning disabilities to participate in activities within the community. The Board supported this model and it is hoped this will be implemented later in the forthcoming year.

Carers Strategy
Services for carers have had an increasing focus for the Council during this year. It was noted that the new Carers Strategy had been developed with the valuable input of carers themselves identifying priorities and areas for development.

Vulnerable Adults
The Board received the Annual Report of Halton's Multi-Agency Adult Protection Committee. The Council is the lead agency for this important area of work. The growing awareness of vulnerability of some adults who need additional support has led to an increase in the number of referrals and strengthening Multi-Agency arrangements.

Local Area Agreements which were established this year and which the Council plays an important role alongside its partners.

Changes within the Health Service
The changes within Health Services and reconfiguration of organisations remained a strong focus for the Healthy Halton Policy and Performance Board this year. The Board contributed to the Annual Health Care Assessments of the Primary Care Trust, 5Boroughs Partnership Trust and North Cheshire Hospital Trust. The Board received reports from all three health organisations, which chartered progress on government set standards. Contributions were made by the Policy and Performance Board, which were incorporated into the final Health Care Self Assessments.

Royal Liverpool Children's NHS Trust application for foundation status. A special joint meeting was held with the Children and Young People Policy and Performance Board to receive consultation on the foundation status application. While only a few children actually access this hospital based in Liverpool, nevertheless it was important that consultation took place because the services provided are specialist and valuable.

	'Better Care Sustainable Services' The Board received a presentation by North Cheshire Hospital Trust on their new model of service delivery. The proposals affected both Warrington and Halton hospital and are potentially very significant in Halton. They were the subject of detailed debate by the Healthy Halton Policy and Performance Board. Regular reports on the development of the changes have been requested by the Board. 'Change for the Better' This model for Mental Health Services was proposed by the 5Boroughs Partnership Trust. There will be a significant impact on Mental Health Services, particularly within Halton, which has traditionally relied on a large number of beds for people with Mental Health problems and fewer community resources. The model seeks to reverse this and support more people within the community. In recognition of the significance of the proposed changes, a Joint Scrutiny Committee was established with members from St Helens and Warrington Scrutiny Committee. Halton was pleased to host and chair this Committee. The Joint Board met regularly and looked in detail at the proposals submitted by the 5Boroughs Partnership Trust. This process ensured that changes were made to the original proposals improving the model of change; for example, single sex wards were identified and accepted as necessary rather than the original model of mixed gender wards. The Policy and Performance Board noted that the reconfiguration of the Primary Trust now covering both St Helens and Halton local authorities will lead to an increased need to work jointly with Scrutiny Committees, particularly from St Helens. Changes to services are likely to affect both residents within St Helens and Halton. Positive relations were established through the Joint Scrutiny process, which will facilitate further working arrangements. Members from St Helens and Halton Policy and Performance Boards attended two seminars to examine the establishment of a protocol between the two Councils. The protocol will identify when joint working arrangements are required and how such arrangements will be established. A full draft protocol will be considered by the Board in Autumn 2007. **WORK TOPICS** In addition to the Board meetings, Members participated in two work topics: ▪ 'Choosing Health' in Halton was explored in some detail and while there has been some delay due to the reconfiguration of the Primary Care Trust a valuable presentation was made by the Director of Public Health looking at the priorities for Halton in improving Halton residents' health. The Board will receive a full report of the outcome of this work during the next Committee cycle.

- Day Services for Adults with Learning Disabilities
  Three members looked at this area of service. There has been a significant change in the way that services are delivered in Halton with the closure of Astmoor this year and increasing use of local community centres. Visits took place to other Councils to explore the services as well as the scrutiny of services within Halton. A full report will be submitted to the Policy and Performance Board in May 2007.

PERFORMANCE ISSUES

Healthy Halton Policy and Performance Board has received quarterly monitoring reports on Social Care performance. Performance has continued to remain strong this year with the following:

- No delays in hospital discharge due to Social Care since fines for delays were introduced three years ago
- The opening and development of Dorset Gardens, Halton's first extra care scheme
- Development and roll-out of new telecare services linked to further expansion of wardens and lifeline
- Modernisation of Independent Living Team has improved waiting times for assessment
- Joint End of Life service established with Halton and St Helens PCT
- Contractual arrangements with Warrington, St Helens and Knowsley to establish an Advocacy Service as required under the Mental Capacity Act
- Significant increase and support for carers of people with mental health problems. This support was recognised by the recent Mental Health Inspection
- Establishment of a Bridge Building Service to increase access for mainstream services for people requiring additional support

WORK PROGRAMME 2007/08

Healthy Halton Policy & Performance Board has not yet formally agreed work topics for the following year, but will consider the following two areas:

- Health of Carers
  There are a large number of carers within Halton and their health needs are important given their additional responsibilities

- Services for People with Sensory Disabilities
  The carers has a small number of contract providers to meet the needs of this group of people. The work topic, if agreed will offer the opportunity to scrutinise these in detail and seek any potential improvements identified

Councillor Ellen Cargill
Chairman, ***Healthy Halton*** Policy and Performance Board

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 12 June 2007

REPORTING OFFICER: Chief Executive

SUBJECT: Performance Management Reports for 2006/07

WARDS: Boroughwide

1. PURPOSE OF REPORT

1.1 To consider and raise any questions or points of clarification in respect of the 4th quarter year-end performance management reports on progress against service plan objectives and performance targets, performance trends/comparisons, factors affecting the services etc. for:

- Older Peoples and Physical & Sensory Impairment Services
- Adults of Working Age
- Health & Partnerships

2. RECOMMENDED: That the Policy and Performance Board

1) Receive the 4thd quarter year-end performance management reports;

2) Consider the progress and performance information and raise any questions or points for clarification; and

3) Highlight any areas of interest and/or concern where further information is to be reported at a future meeting of the Policy and Performance Board.

3. SUPPORTING INFORMATION

3.1 The departmental service plans provide a clear statement on what the services are planning to achieve and to show how they contribute to the Council's strategic priorities. The service plans are central to the Council's performance management arrangements and the Policy and Performance Board has a key role in monitoring performance and strengthening accountability.

3.2 The quarterly reports are on the Information Bulletin to reduce the amount of paperwork sent out with the agendas and to allow Members access to the reports as soon as they have become available.
It also provides Members with an opportunity to give advance notice of any questions, points or requests for further information that will be raised to ensure the appropriate Officers are available at the PPB meeting.

4. POLICY AND OTHER IMPLICATIONS

4.1 There are no policy implications associated with this report.

5. RISK ANALYSIS

5.1 Not applicable.

6. EQUALITY AND DIVERSITY ISSUES

6.1 Not applicable.

7. LIST OF BACKGROUND PAPERS UNDER SECTIONS 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer

AGEND ITEM NO:

REPORT TO:	Healthy Halton Policy and Performance Board
DATE:	11 June 2007
REPORTING OFFICER:	Strategic Director, Health and Community
SUBJECT:	Joint Commissioning Strategy for Adults with Physical and/or Sensory Disabilities 2007-2011

1.0 PURPOSE OF THE REPORT

To present to Healthy Halton Policy and Perormance Board a draft Joint Commissioning Strategy for Adults with Physical and/or Sensor Disabilities for discussion.

2.0 RECOMMENDATION

i) That members note and comment on the Draft Strategy

3.0 SUPPORTING INFORMATION

3.1 Purpose of the Strategy
This document sets out the overarching strategy for the commissioning, design and delivery of services to people in Halton who are physically disabled (including those with sensory disabilities), their families and carers. This is the first strategy to be produced for this group of people.

3.1.1 The strategy is written as a practical document to assist Physical and Sensory Disability (PSD) services move towards a more focussed way of commissioning services for adults in the 18-64 age range over a four year period. It is also expressed in a style to satisfy the Commission for Social Care Inspection (CSCI) and is consistent with other similar Commissioning strategies. The document will be used as evidence as part of the CSCI evaluation of the Councils approach to Policy development

3.1.2 There is a commitment to promoting the social model of disability which emphasises the need to remove the barriers to access faced by disabled people and gives them the ability to control their own lives.

3.1.3 The White Paper Our Health, Our Care, Our Say, promotes the alignment of Health and Social care planning. This strategy has been developed jointly between the Council and PCT, and through working with our partners will maximise capacity and enable more effective services which promote independence to be offered. The strategy has been shared with the PCT and comments received inserted into the document.

3.2 Consultation
The strategy was developed from consultation events involving all stakeholders and evidence from the Housing Needs Survey 2005. These are

summarised in Section 3 of the strategy. Managers and practitioners attended a workshop to further develop ideas, which emerged from consultation.

3.3 Action Planning

A half-day action-planning event was held in April chaired by the Operational Director for Adults of Working Age. It was well attended by managers representing PSD care management and assessment services, provider services, commissioning and colleagues from Housing Strategy, PCT and North Cheshire Hospitals. Transportation has also contributed to the action plan.

3.3.1 Section 6 - Implementing the Strategy, summarises the agreed actions resulting from the contributions made at this event. The action plan (page 64) has been linked to the CSCI Adult Social Care Outcomes framework. This framework will measure performance in achieving the seven outcomes detailed in the white paper together with two additional measures relating to effective leadership and effective commissioning and use of resources.

4.0 POLICY IMPLICATIONS

4.1 PSD services have been successful in supporting people to remain in their own homes but the service is under considerable pressure. This strategy will provide the focus needed for managers to prioritise service developments and raise corporate awareness of responsibilities to provide mainstream services that include people with physical and/or sensory disabilities.

4.2 The report will be presented to the Health PPB for Scrutiny and thereafter presented to the Executive Board. This is consistent with the approach to all other Commissioning strategies produced.

5.0 OTHER IMPLICATIONS

5.1 Financial/Resource implications

Section 6 of the strategy sets out the spending patterns of PSD services. In general the service has not faced any significant financial pressures.

Whilst the strategy relates to the 18-64 age group visual rehabilitation and independent living services work with those over age 65. The number of referrals from this older group has increased and capacity in these service areas has been possible by utilising specific grants. These grants cease in March 2008 whilst the demand on these services will rise. A financial strategy to support the commissioning strategy is to be developed which will identify areas for dis-investment and re-investment.

6.0 RISK ANALYSIS

As with any change programme we can expect the implementation of the strategy to may be met with resistance and objections. This will be managed by ensuring all staff, service users and carers are fully informed of proposals and rationale and by listening to and acting on their suggestions.

7.0 EQUALITY AND DIVERSITY ISSUES

The Commissioning Strategy addresses Equality and Diversity there are no particular implications arising as a result of the proposed action. An Equality Impact Assessment (EIA) will need to accompany this strategy and be subject to review by the next available Directorate Equalities Group.

8.0 BACKGROUND PAPERS

See page 70 of the strategy.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Older Peoples and Physical & Sensory Impairment Services**

PERIOD: **Quarter 4 to year-end 31 March 2007**

1.0 INTRODUCTION

This quarterly monitoring report covers the Older Peoples and Physical & Sensory Impairment Services Department fourth quarter period up to 31 March 2007.

Given that there are a considerable number of year-end transactions still to take place a Financial Statement for the period, which will be made available in due course, has not been included within this report in order to avoid providing information that would be subject to further change and amendment.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 6

2.0 KEY DEVELOPMENTS

Halton Hospital Team relocated to Warrington Hospital, redesign of team complete.

Carers sub group of OP LIT established to meet LPSA targets. Funding for two carers assessor posts identified, will be in post early in the new financial year.

Redesign of urgent care pathway jointly with the PCT progressing, steering group and subgroups established.

Independent Living Team waiting list has been reduced significantly to 62 at end of March 2007. Performance against assessment timescale targets is therefore expected to improve during next performance period.

Grading of Moving and Handling advisor has delayed appointment and work currently being undertaken by agency worker.

Community Care Worker to review equipment to be appointed to ensure equipment provided to people continues to meet need.

Bi-monthly meetings between representatives of the 17 Registered Social Landlords operating in Halton and staff involved in adaptations to properties for disabled people established.

Successful first inspection of Adult Placement Service by Commission for Social Care Inspection completed. All aspects of service achieved or exceeded service standards required.

Web based self-assessment for some items of equipment for disabled people is to be introduced using the Activities for Daily Living - Smartcare system.

3.0 EMERGING ISSUES

The Heath ward in the 5 Boroughs Partnership Brooker centre is now closed, arrangements to improve community Mental Health services for Older People are under discussion with 5 Boroughs Partnership and the PCT. Issues in respect of hospital team relocation resolved.

PCT reconfiguration still underway, middle management posts still to be clarified.

Domiciliary Care market continues to operate at near capacity. Reduction in the number of beds within the acute hospital continues to result in additional pressures on community services, and budgets, with a further reduction in beds planned for June 2007.

Discharge policies for out of area hospitals subject to wider consultation to achieve comprehensive coverage.

Commissioning Strategy for Physical and Sensory Disabilities in draft and further work to complete strategy planned for April.

Partnership Agreement for Halton Integrated Equipment Service to be finalised by April 2007. Growth in service demand is being quantified for future planning and budgeting purposes.

Some initial problems with the Halton Integrated Community Equipment Service computer system are being resolved.

Work is being progressed with the police and NHS Trusts on joint adult protection protocols and training. Revised data collection arrangements in place from April 2007 will provide better information on outcomes. Learning from local and national inquiries is being progressed through action plans.

4.0 PROGRESS AGAINST KEY OBJECTIVES / MILESTONES

Total	**24**		**24**		**N/A**		**0**

Satisfactory Progress has been made against all key milestones for the service at the year-end stage. For further details please see Appendix 1.

4.1 PROGRESS AGAINST OTHER OBJECTIVES / MILESTONES

Total	**14**		**13**		**N/A**		**1**

Satisfactory Progress has been made against thirteen of the fourteen other milestones for the service at the year-end stage. One milestone was not achieved. For further details please see Appendix 2.

5.0 SERVICE REVIEW

Care Management review final report submitted to SMT with recommendations for improvements. Action plan to be developed with date of implementation yet to be agreed.

CSCI visit to all OP services, offered inspector an opportunity to examine services and meet service users.

Home Care review complete, awaiting decisions on job evaluation for further implementation.

The Project Brief for the further development of the Independent Living Team is being implemented and a temporary Service Development Officer is to be appointed.

Progress In Sight benchmarking he final signing off and subsequent action plan to be completed in April.

“See It Right” (a government leaflet and self referral form for users to refer to social services if they have visual problems) due for publication and distribution to opticians.

The Day Services Review work and community centre access audit now complete. Access report has been produced. Preparation of Day Service Review report in progress.

Review of major adaptation service provided by Independent Living

Team and Housing Strategy Team is underway. Proposals to co-locate or integrate elements of the teams are being explored further.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**9**		**6**		**N/A**		**3**

Of the nine key performance indicators for the service, the target for six of them has been achieved. Three have not achieved target. Please note that for five of the indicators, the commentary indicates that data is still being processed so a final year-end out turn cannot yet be provided. Where the indicators are part of the PAF framework, a traffic light has also been assigned to reflect the performance against the PAF target. Please see Appendix 3 for further details.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**15**		**7**		**N/A**		**6**

Of the fifteen other performance indicators for the service, the target for seven of them has been achieved. Six have not achieved target.
Please note that for three of the indicators, the commentary indicates that data is still being processed so a final year-end out turn cannot yet be provided. Two unit cost indicators (PAF B12 & B17) cannot yet be reported and have not been assigned traffic light colours. The figures will be available on the closure of accounts in June/July 07. For further details, please see Appendix 4.

7.0 PROGRESS AGAINST LPSA TARGETS

Total	**2**		**2**		**N/A**		**0**

For details of progress against LPSA targets, please refer to Appendix 5

8.0 RISK CONTROL MEASURES

During the production of the 2006-09 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

None of the Key Service Objectives for this service were assessed as having associated High Risk, there is no progress to report.

9.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2005/06 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report.

There are no High priority equality actions for this service, there is no progress to report.

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Other Objectives/ Milestones
Appendix 3- Progress against Key Performance Indicators
Appendix 4- Progress against Other Performance Indicators
Appendix 5- Progress against LPSA targets
Appendix 6- Explanation of traffic light symbols

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
OPS1	Plan and commission services to meet the needs of the local population	Review of Day Services complete (12/06)		Work has been completed and report in preparation.
		Increase number of Adult Placement carers by 50% to 18 (03/07)		Twenty carers approved. Target exceeded.
		Agree future provision for Equipment including pooled budget (05/07)		Agreement to be signed by April 2007.
		Identify tenants for Dorset Court (08/06)		Dorset Court fully occupied, waiting list in place for future tenancies
		Partners sought for additional extra care housing (03/07)		On-going discussions underway with two Registered Social Landlords.
		New contracts for extra care (03/06), minor adaptations (9/06) & meals service let (04/06)		All completed within agreed timescales
		Directory of all services for older people in place. (09/06)		Directory of services complete and now available through the Help4me website.

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
OPS1 continued		Cross cutting healthy ageing strategy for Halton complete (Culture & Leisure, employment, transport, benefits, health, prevention etc) (10/06)		Final draft completed.
		Supporting people refocused to low / moderate (05/06)		Completed.
		Commissioning Strategy for disabled people completed and action plan agreed (09/06)		As a result of the government opening a consultation on the Disabled Facilities Grant Programme, the original brief for this piece of work was widened. A draft Commissioning Strategy has now been prepared. Workshop to further develop strategy planned for April 2007.
		Benchmark services for people with visual loss against "Progress in Sight" and prepare action plan (09/06)		Benchmarking complete. To be signed off in April along with Action Plan.
		Benchmark PSD services against CSCI standards and prepare action plan (08/06)		Completed

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
OPS3	Maximise opportunities for people to benefit from rehabilitation, recuperation and intermediate care services	New 'Telecare' service in place (03/07)		Completed ahead of timescales
		New role of warden service agreed and business plan completed (03/07)		Completed ahead of timescales
		Section 31 pooled budget to be in place (03/07)		Completed ahead of timescales
		Explore options with Adults with Learning Disabilities and Mental Health for using new technology. (07/06)		Options identified, to be included in team plans
		Seek external evaluation of intermediate tier in Halton (09/06)		Complete – report will be available in April 07.
		Explore options for Adult Placement to facilitate discharge and avoid admissions to hospital		Completed, further potential to expand service to meet overnight accommodation being explored

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
OPS4	To deliver effective and efficient care management	Review /update of adult protection procedures completed (06/06)		Completed within timescales, constant review takes place to incorporate learning and government directions.
		Full role out of Single Assessment Process (04/06)		Completed within timescales, constant review takes place to incorporate learning and government directions.
		Establish a Community Mental Health Team for older people (05/06)		OP CMHT now fully operational
		Redesign hospital discharge service to respond to changes in NCHT, to deliver timely discharges (09/06)		Redesigned service was operational in Q3. Review has identified that the service is working well. Reductions in hospital beds will mean that ongoing review is required to maintain fitness for purpose
		Capacity & skills of the social work teams reviewed.		Review complete, report has been to SMT, action plan to be developed to ensure recommendations are met
		All social care staff registered with CSCC		Fully completed

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
OPS2	Deliver provider services that are high quality and meet registration requirements	Continuing registration for Adult Placements, Homecare, & Oakmeadow achieved		All services now registered.
		Exceed minimum standards in services		Actions identified for further improvements completed. Oakmeadow has new carpets, and some additional work completed in relation to garden areas, as required by CSCI.
		Work to explore economic impact of health and care services (12/06)		Included in Local Area Agreement
OPS5	Establish quality assurance and systems	Achieve at least 1 award for services		An application was submitted for a Guardian award earlier in the year, but was not successful. The service continues to identify opportunities to achieve awards
		Seek to exceed minimum standards across the service (10/06)		Continue to achieve above minimum standards for services
		Increase the use of surveys to evaluate quality of service provided (07/06)		Service user surveys completed for Vulnerable Adults Abuse (VAA), Oakmeadow, mobile meals and Homecare

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
		Commence emergency planning group to support business continuity planning and response. (05/06)		Work on Rest Centre plan complete, flu pandemic planning across system is ongoing
OPS6	Work in partnership across traditional boundaries always keeping the service user at the centre of the service	LPSA developed on reduction in emergency bed days, and an increase in the number of carers receiving a service (03/07)		Emergency bed days reduced and exceed agreed levels. Two new carers assessors have been appointed to ensure increased number of carers receive support
		LAA developed to include Health (03/07)		Completed.
		Improve contracts with Age Concern to support business continuity (06/06)		Contract with Age Concern in place
		Link to healthy ageing strategy for Halton (03/07)		Healthy Ageing Strategy complete. Awaiting Senior Management Team sign off

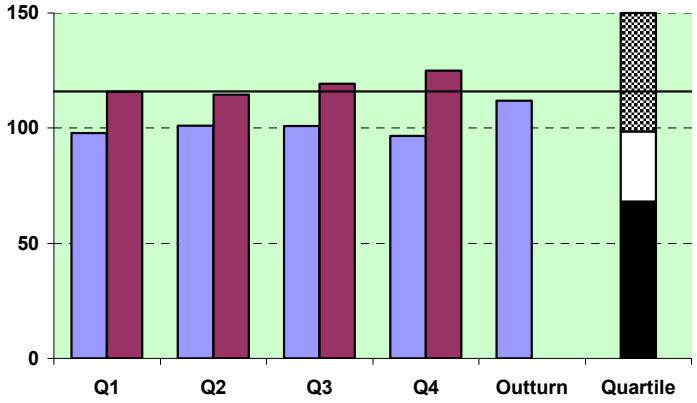
APPENDIX TWO – PROGRESS AGAINST OTHER OBJECTIVES/ MILESTONES
Older Peoples & PSI Services

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
OPS7	Ensure all services offer equality of access and delivery to all people and implement processes to assess the effectiveness of this.	Plans and strategies reviewed using impact assessments(07/06)		All completed, all new policies will have automatic impact assessments prior to agreement and implementation
OPS7 continued		Monitor targets in equality strategy		Directorate group meeting quarterly and monitoring.
		Use results of BME survey and unmet need/service deficit process to identify service gaps and commission accordingly		No formally identified unmet needs/service deficits have been identified. Actions as a result of issues identified through the BME survey have been incorporated into the Directorate Equalities Group's action plan. A consultant has been commissioned to work with Mental Health front line staff in the first instance with a view to increasing an understanding of how to assess, record and deal with the equality and diversity needs of service users and carers.

APPENDIX TWO – PROGRESS AGAINST OTHER OBJECTIVES/ MILESTONES
Older Peoples & PSI Services

BVPI 54

Over 65s helped to live at home per 1000 population



Higher figures represent better performance

Key

- 2005/6
- 2006/7
- Target
- Top 25%
- Middle 50%
- Bottom 25%

PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend

Green

Better than this time last year

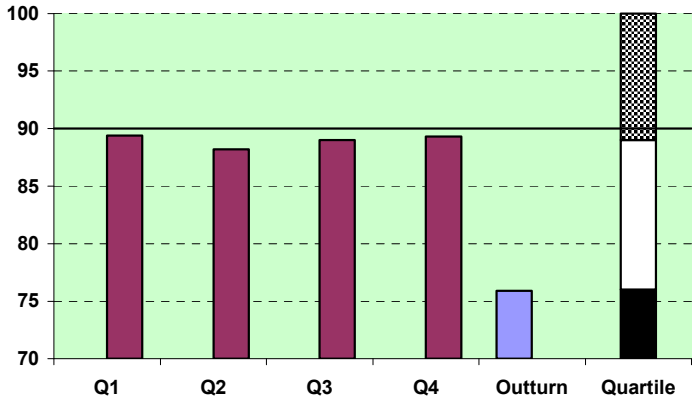
Annual target hit or exceeded

Commentary

Currently, 124.93 older people per 1000 population, aged 65 and over are helped to live at home. This indicator continues to improve as more people benefit from lifeline services and professional support (support given by workers outside the care management process). Current performance would be awarded the maximum PAF Band 5, target for 2006/7 has been exceeded. Final year end figure not yet known as admin staff are still backloading data onto Carefirst.

BVPI 56

Percentage of items of equipment delivered within 7 working days



Higher figures represent better performance

Key

- 2005/6
- 2006/7
- Target
- Top 25%
- Middle 50%
- Bottom 25%

PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend

Red

No data for same Qtr last year

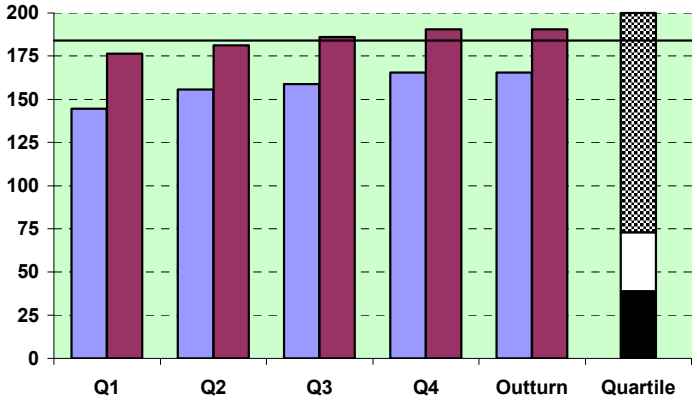
Annual target missed

Commentary

Figure for quarter 4 is an estimate as final figure not yet available. Although the target of 90% has been narrowly missed, current performance of 89.32% would be awarded a PAF Band 5.

BVPI 201

Number of adults and older people receiving Direct Payments



Higher figures represent better performance

Key

2005/6
2006/7
Target
Top 25%
Middle 50%
Bottom 25%

PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend

Green

Better than this time last year

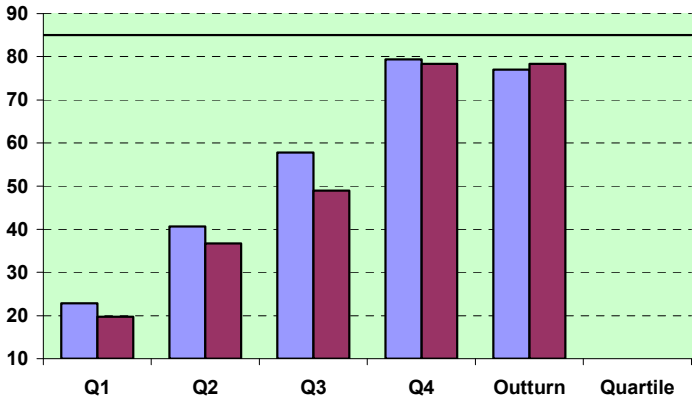
Annual target hit or exceeded

Commentary

Current performance of 190.43 people per 100,000 population in receipt of direct payments. This indicator is in relation to client users only. Direct payments used to benefit the carer (I.e respite or carers break) are reported in a separate performance indicator to measure carers services. Current performance would be awarded a PAF Band 5, and target for 2006/7 has been exceeded.

OPPSIPAF C72

Admissions of supported residents aged 65+ to permanent residential/nursing care (per 10,000 population)



Lower figures represent better performance

Key

2005/6
2006/7
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend

Green

Better than this time last year

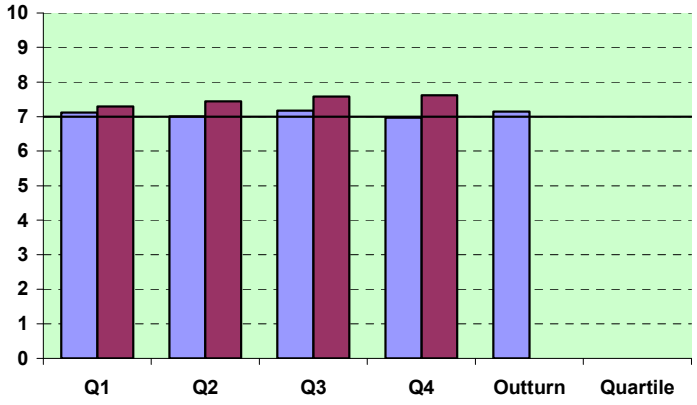
Annual target hit or exceeded

Commentary

Current performance of 78.35 admissions per 10,000 population will be awarded the maximum PAF Band 5.

OPPSIPAF C29

Adults with physical disabilities helped to live at home



Higher figures represent better performance

Key

2005/6
2006/7
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend

Green

Better than this time last year

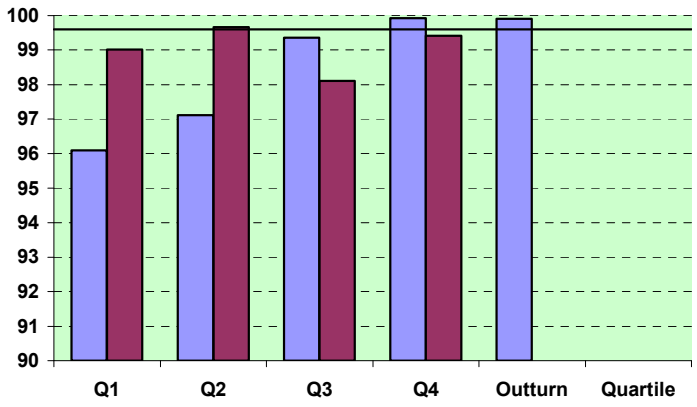
Annual target hit or exceeded

Commentary

Currently 7.62 people per 1000 population are helped to live at home. Target has been exceeded. Final year end figure not yet known as admin staff are still backloading data onto the Carefirst system.

OPPSIPAF D39

Percentage of people receiving a statement of their needs and how they will be met.



Higher figures represent better performance

Key

2005/6
2006/7
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

PAF Assessment

Better

Band	5	4	3	2	1
Target		X			
Current		X			

Likely to hit PAF target

Trend

Red

Worse than this time last year

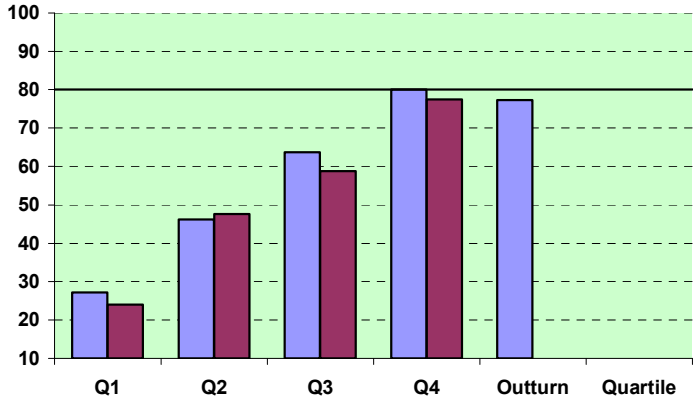
Annual target missed

Commentary

Currently, 99.41% of clients receiving services during the year to date have received a copy of their care plan. This area of performance is still subject to continual monitoring and all operational teams are informed on a monthly basis of those clients not in receipt of a copy of their care plan. As admin staff are still backloading data, the target may still be achieved. Current performance would be awarded a PAF Band 4. Movement to Band 5 requires performance of 100%.

OPPSIPAF D40

Clients receiving a review as a %age of adult clients receiving a service



Higher figures represent better performance

Key

2005/6
2006/7
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

PAF Assessment

Better

Band	3	2
Target		X
Current	X	

Likely to hit PAF target

Trend

Red

Worse than this time last year

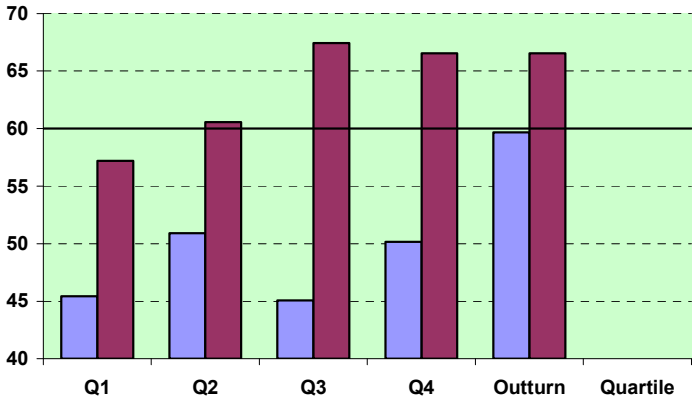
Annual target missed

Commentary

Currently, 77.48% of adult clients receiving a service have been reviewed to date. As admin staff are still backloading data, the target may still be achieved. Current performance would be awarded a PAF Band 3.

OPPSIPAF E50

Assessments of adults and older people leading to provision of a service



Higher figures represent better performance

Key

2005/6
2006/7
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

PAF Assessment

Better

Band
Target
Current

Not banded for 2006/7

Trend

Green

Better than this time last year

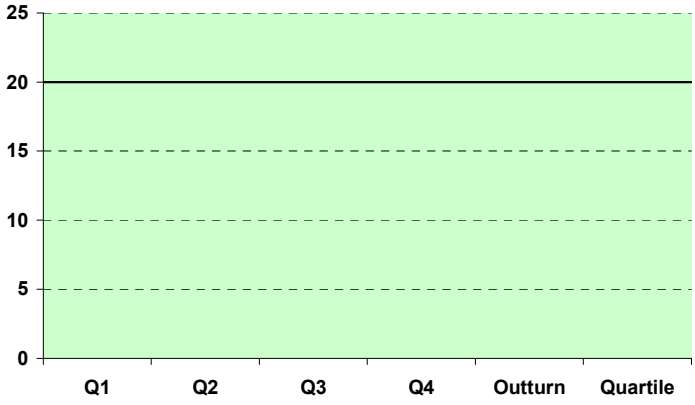
Annual target hit or exceeded

Commentary

Currently, 66.55% of assessments led to services being provided. Target for 2006/7 has been exceeded. This indicator is not banded.

OPPSILI 4

No. of days reimbursement as a result of delayed discharge of older people



Lower figures represent better performance

Key

- 2005/6
- 2006/7
- Target
- Top 25%
- Middle 50%
- Bottom 25%

No quartile data available

Trend

Same as this time last year	Annual target hit or exceeded
	Green

Commentary

There have been no re-imbursable delays reported by Social Services during 2006/7.

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	*PAF band Target*	*PAF band Actual*	*PAF Progress*	Commentary
	Service Delivery Indicators								
PAF C28 / BVPI 53	No of households receiving 10 or more contact hours and 6+ visits during a week 1000 head of population aged 65+** Key threshold >8	9.79	12	11		4	3		The trend for the indicator had been downwards over the last 3 years. This year, although target has not been met, the result has reversed that trend and made significant progress. As the figure is based on a snapshot in September it cannot be improved by actions each month. Further progress is anticipated next year. The intermediate care services in Halton also help reduce levels of dependency so we expect our figure to be slightly less than comparators.
PAF C62	Number of carers receiving a specific carers service as a percentage of clients receiving community based services	7.04%	9%	8.45%		4	3		Figure provided is as at end February 2007, target may still be achieved. Final year end figure not yet known as admin staff are still backloading data onto Carefirst.
OP LPI 1	%age use of intermediate care beds	90%	85%	98%		N/A – Local PI			Target exceeded. Increased pressure on the use of Intermediate Care Beds in line with the reduction in acute hospital beds.
	Quality of Service Indicators								
PAF D37	Availability of Single Rooms	100%	100%	100%		5	5		All service users offered single rooms in line with contract requirement.
PAF D55 / BVPI 195	Acceptable waiting times for assessment Key threshold >60%	75.43 %	82%	82.74%		3	3		Final year-end figure not yet known, as it is dependent on file check which is still ongoing.

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	*PAF band Target*	*PAF band Actual*	*PAF Progress*	Commentary
PAF D56 / BVPI 196	Acceptable waiting times for care packages Key threshold >60%	80.49 %	85%	87.46%		4	4		Final year-end figure not yet known, as it is dependent on file check which is still ongoing.
PAF D52	Older people home care user survey – satisfaction with services	N/A	60%	50.76%		5	1		Indicator was based on clients answering extremely or very satisfied to the question "Overall how satisfied are you with the help from social services that you receive in your own home." Satisfaction levels have decreased since the survey was last undertaken in 2002/3, this is more than likely due to a change in home care provision – since 2002/03 more of our care has been externalised, and people are getting less time for less critical tasks It is planned to re-let the contract next year.
	Fair Access Indicators								
PAF E47	Ethnicity of older people receiving assessment	0.43	1.1	0.28		3	2		Small numbers of people with ethnicity other than white (2) out of approximately 1362 older people receiving an assessment. This indicator is subject to great fluctuation given the small numbers of non-white clients and in the general population. Work has been done to support front line staff to respond effectively to asking questions about both ethnicity and needs arising from ethnicity. Listening to you leaflet has info in number of languages, and we have language line, which can be

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	*PAF band Target*	*PAF band Actual*	*PAF Progress*	Commentary
									accessed though Direct Link.
PAF E48	Ethnicity of older people receiving services following assessment	0.33	1.0	1.49		3	2		Out of approximately 912 assessments which led to provision of service, 2 clients had ethnicity other than white. This indicator is subject to great fluctuation given the small numbers of non-white clients and in the general population. Work has been done to support front line staff to respond effectively to asking questions about both ethnicity and needs arising from ethnicity. Listening to you leaflet has info in number of languages, and we have language line, which can be accessed though Direct Link.
OP LPI 2	% of older people being supported to live at home intensively, as a proportion of all those supported intensively at home or in residential care	22	26	27.96		N/A – Local PI			The trend for this local indicator has been downwards over the last 3 years. The target has been met, reversing previous trends. As part of the calculation is based on a snapshot in September it cannot be improved by actions each month, although the bottom line in relation to residential placements including (unlike PAF B11) both intensive support and placements, is on target. Further progress is anticipated next year. The intermediate care services in Halton help to reduce levels of dependency so we expect our figure to be slightly less than comparators.

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	*PAF band Target*	*PAF band Actual*	*PAF Progress*	Commentary
OP LPI 3	Percentage of adults assessed in year where ethnicity is not stated	1.44	1.5%	0.95%		N/A – Local PI			Production of monthly exception reports has ensured the target has been exceeded.
OP LPI 5	Percentage of adults with one or more services in year where ethnicity is not stated	0.76	0.6%	0.17%		N/A – Local PI			Production of monthly exception reports has ensure the target has been exceeded.
	Cost & Efficiency Indicators								
PAF B17	Unit cost of home care for adults and older people	£17.10	£14.20	-	Refer to comment	3	-	Refer to comment	Actual unit cost not available until closure of accounts in June/July 2007.
PAF B11	Intensive home care as a percentage of intensive home care and residential care	22%	26%	25.22%		4	4		The trend for the indicator had been downwards over the last 3 years. This year the result has reversed that trend an made significant progress. Further progress is anticipated next year. The intermediate care services in Halton help to reduce levels of dependency so we expect our figure to be slightly less than comparators.
PAF B12/ BVPI 52	Cost of intensive social care for adults and older people	£527	£473	-	Refer to comment	4	-	Refer to comment	Actual unit cost not available until closure of accounts in June/July 2007.

LPSA Ref	Definition	LPSA Target (Stretch)	Interim Target (Annual)	Progress (Traffic lights)	Commentary
8	**Improved care for long term conditions and support for carers.** **1.** Number of unplanned emergency bed days (Halton PCT registered population)	**-6%** 08/09	N/A		The LPSA2 stretch target is a 6% reduction on the 2004/05 figure of 52,245. The target is therefore 49,110. Outturn for 2005/06 was an increase to 55,568. Performance for 2006/07 based on 10 months data is 44,749. This means we have already achieved our LPSA stretch target, although as can be seen the volatility is high. The overall trend for the emergency bed days is downwards throughout the course of the year compared to previous years. The levels of admissions throughout the winter period are lower than anticipated. However there appears to be a mismatch between the LPSA 2004/05 baseline (58,649) supplied by the department of health and the PCT's own figure of 52,245 which needs to be further investigated.
	2. Number of carers receiving a specific carer service from Halton Borough Council and its partners, after receiving a carer's assessment or review	**600** 08/09	N/A		As at end of February 2007, 336 carers have received a service following an assessment or review. Final figure for 2006/7 not yet known as admin staff are backloading data onto Carefirst. A new process has been introduced to record services against the carer which will enable the target to be closely monitored on a monthly basis.

The traffic light symbols are used in the following manner:

		Objective	Performance Indicators (Excl. LPSA)	LPSA Indicators Only
Green		Indicates that the objective has been achieved within the appropriate timeframe.	Indicates that the annual 06/07 target has been achieved or exceeded	Indicates that the target is on course to be achieved.
Amber		N/A	N/A	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that that the objective has not been achieved within the appropriate timeframe.	Indicates that the annual 06/07 target has not been achieved.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Health & Partnerships**

PERIOD: **Quarter 4 to year-end 31 March 2007**

1.0 INTRODUCTION

This quarterly monitoring report covers the Health & Partnerships Department fourth quarter period up to 31 March 2007.

Given that there are a considerable number of year-end transactions still to take place a Financial Statement for the period, which will be made available in due course, has not been included within this report in order to avoid providing information that would be subject to further change and amendment.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 6

It should be noted that this report is presented to a number of Policy and Performance Boards. Those objectives and indicators that are not directly relevant to this Board have been shaded grey.

2.0 KEY DEVELOPMENTS

Direct Payments
The number of service users in receipt of Direct Payments continues to rise. Currently there are 357 service users and 126 carers receiving their services via a Direct Payment.

Appointee & Receivership
The Appointee & Receivership service continues to be considerably oversubscribed. Measures are in hand to reduce the numbers of service users receiving this service, so that a better quality service can be delivered. Discussions are at an initial stage to pilot the transfer of some appointeeships to a local 'not-for-profit' company, with checks being made into the background of the company and reasonableness of future charges to service users.

Human Resources
Protection of Vulnerable Adults Policy, Procedure and Practice updated and distributed to all relevant managers.

National Minimum Dataset for Social Care – organisation questionnaires completed for all regulated services.

Consumer Protection

Warrington Borough Council will be initiating a project and pulling together a project team to move forward the proposals to deliver the Consumer Protection Service for both Halton and Warrington. Staff and Trade Unions from both authorities will be involved in the project from the outset. There are key risks to be managed: the partnership may prove too costly or fail to generate the required efficiencies and we will therefore need to focus on reducing internal management and administration costs.

As part of his recent Budget statement the Chancellor announced the publication of the findings of Peter Rogers, Chief Executive of Westminster City Council, recent review on regulatory policy prioritisation. Five priority areas have been highlighted for Environmental Health and Trading Standards Services. The two priorities that will impact on the work of the Consumer Protection Service are "Alcohol, entertainment and late-night refreshment licensing and its enforcement" and "Fair Trading (trade description, trade marking, mis-description and doorstep selling)".

The national launch of the web-based system for the registration of births and deaths took place on 26 March 2007. Significant problems have been experienced both with the national Registration On Line database and with the Council's IT infrastructure.

Housing

The revised Private Sector Housing Renewal Strategy was approved by Executive Board in March 07.

Contracts/Supporting People

Supporting People (SP) and the contracts team have been merged to improve the effectiveness of the service. In conjunction with ALD services, the contracts team successfully procured care services for the new respite service at Bredon, Palacefields.

A project team has been established to reconfigure/procure domiciliary care services. An outline project plan was presented to provider agencies in March.

The Supporting People Commissioning Body approved the development of the following short-term pilot services:

- Homelessness intervention/prevention welfare service
- Expanded LD floating support service

Carers' Centres

Discussions relating to the transfer of the Carers' Centres to the voluntary sector have identified two main options. Option one involves

establishing an independent Princess Royal Trust for Carers' Centre for Halton. The second option would involve merging Halton's local authority run Carers' Centre with St Helens Carers Centre. Discussions will be ongoing. They would then be aware of the outcome of the Government's comprehensive spending review and the Council's ability to enter into associated financial commitments.

3.0 EMERGING ISSUES

Direct Payments

A Pilot Scheme delivering Individualised Budgets will be in place by the end of 07/08. Staffing resources within the Client Finance Team are currently being considered to deliver this pilot.

Human Resources

The completion of the individuals' questionnaire for the National Minimum Dataset for social care will be required during 2007/08 and will impact upon resources. A working group will be set up April 2007 to progress this requirement.

Performance Management

A new Performance Assessment Framework for Adults and Older People that will focus on outcomes has been developed by CSCI. The Directorate continues to review how outcomes are measured by all services, and is working with the NW Leads Performance organisation to provide information to CSCI.

Consumer Protection

The Executive Board has agreed to the pursuance of new governance arrangements for the delivery of the Registration Service. All the necessary information has been given to the General Register Office in order for them to draft a new Scheme.

Housing

Work is advanced sub regionally in developing a Liverpool City Region Housing Strategy as part of the sustainable communities workstream under the City Region Development Programme. It will seek to ensure the "housing offer" supports the planned economic growth within the City Region. Cross authority endorsement is likely to be sought early in 2007/08.

A number of workstreams are being developed in an effort to reduce homeless presentations and the use of temporary accommodation. Examples include a rent deposit scheme, a new SP funded welfare/prevention service, and increased use of HDL to filter applications/signpost clients to appropriate support services.

4.0 PROGRESS AGAINST KEY OBJECTIVES / MILESTONES

Total	**11**		**8**		**N/A**		**3**

Of the eleven key objectives for the service, eight have made satisfactory progress and have been achieved by the year end point. Three have not been completely achieved. For further details, please refer to Appendix 1.

4.1 PROGRESS AGAINST OTHER OBJECTIVES / MILESTONES

Total	**12**		**8**		**N/A**		**4**

Of the twelve other objectives for the service, eight have made satisfactory progress and have been achieved by the year end point. Four have not been completely achieved. For further details, please refer to Appendix 2.

5.0 SERVICE REVIEW

Direct Payments
Promotions to increase the uptake of Direct Payments continue through events for professionals, carers and voluntary organisations.

Appointee & Receivership
Work continues to reduce the numbers accessing the service in order to provide a more responsive and qualitative service. Refer to item in section 1.0, Key Developments.

Housing
A project group has been established to reconfigure homelessness services. Some of the early outcomes are described in section 3 above.

Contracts/Supporting People
The Supporting People Commissioning Board has now approved all service review reports.

Commissioning (Mental Health)
Following the CSCI visit, Halton received the Improvement Review Report in March 07. It identified the areas that require improvement – leadership, partnership and integration, service user and carer

experience and involvement, assessment and care planning, interface and transition between services.
An action plan will be developed to address the areas requiring improvement and will be monitored by CSCI and the Healthcare Commission.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**6**		**5**		**N/A**		**1**

Of the six key performance indicators for the service, five have made satisfactory progress and the target has been achieved by the year end point. One target has not been achieved. For further details, please refer to Appendix 3.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**24**		**17**		**N/A**		**7**

Of the twenty-four key performance indicators for the service, seventeen have made satisfactory progress and the target has been achieved by the year end point. Seven indicators have not achieved target. For further details, please refer to Appendix 4.

7.0 PROGRESS AGAINST LPSA TARGETS

There are no current LPSA targets for this service.

8.0 RISK CONTROL MEASURES

During the production of the 2006-09 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

At the half-year stage, all relevant risk treatment measures have been implemented for key service objectives that were initially assessed as high risk in the Directorate Risk Register.

9.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2005/06 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report.

There are no High priority equality actions for this service.

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Other Objectives/ Milestones
Appendix 3- Progress against Key Performance Indicators
Appendix 4- Progress against Other Performance Indicators
Appendix 5- Explanation of traffic light symbols

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
HP1	Review the Fairer Charging Policy	The revised Fairer Charging Policy will be implemented Income generation using the revised Fairer Charging policy will be monitored		Community Care Charges for services have been consulted on and new charges were agreed by Exec Sub on 29/3/07. A new charging Policy Group will convene in May 2007.
HP2	Maximise the number and range of people using Direct Payments.	Promote and continue to develop DP and ensure that support, advice, and information is offered. Explore the delivery of Individualised Budgets		Numbers in this quarter continue to rise, again with a great emphasis on carers receiving funding for support. A steering group has been formed to oversee the implementation of the Individualised Budgets pilot scheme, which will be in place by the end of 07/08.
HP3	Develop IT solutions which enable delivery of services electronically in support of the e-Government agenda	A pilot of remote working systems will be implemented and evaluated. The first phase of the electronic social care record system will be implemented in 2006 to meet e-government requirements by 2008.		The Mobile working project was delayed because of problems with supply of 14 Tablet PC's which have now been replaced by laptops and care currently being set up. CareStore has been purchased and C&YP are using the HDL Contact centre to scan documents which H&C will review as part of the project.

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
HP5	Develop a three year financial strategy, matching funding to changing service requirements	Develop three year financial strategy for each service area, in conjunction with the commissioning strategies		Completed – needs linking to Government Comprehensive Spending Assessment and alignment of the information into future commissioning strategies
HP6	Develop and implement Halton's 5yr Supporting People Strategy to meet the needs of vulnerable people locally.	Delivery of strategic objectives identified for action 2006/7 Commence renegotiation of high cost contracts. Develop financial plan for 2007/8		Good progress has been made against targets in strategy: • Develop 6 bed unit-young single homeless-achieved - Orchard House opened in 2006 • Develop 2 bed unit for MH-achieved –Pickering close Opened in 2005. • Develop 42 units of extra care housing for OP-achieved-Dorset gardens opened in 2006. • Increase provision for drug and Alcohol by 4units- target achieved-increase in SHAP contract from 7 to 11units at no additional cost. • Target to encourage development of 2 private developments of sheltered housing for sale- achieved –2 private developers withdrew-1 opened by McCarthy Stone in Widnes. • Develop 6 units of support for

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
HP6 continued				ex-offenders-target exceeded-new pilot service for drug using ex-offenders-30units. In addition HHT have approved an additional 6 units of supported accommodation for ex-offenders in 2007/8. • Teenage parents-target exceeded-new service for young homeless and teenage parents-20units carr-gomm. Reconfiguration of generic floating support-target achieved-over 50% now client specific at no extra cost. Good progress with reconfiguration of Adults with Learning Disabilities services- SP savings to date over £300,000 pa. Gross savings through contract negotiations approx £700,000pa Target to develop financial planning strategy linked to govt announcement on long-term funding-on target to be developed in response to announcement.
HP11	Review and consult on local housing strategy, in partnership with stakeholders, and report on progress and new developments annually	Produce annual progress statement by Summer 2006		An annual progress statement was submitted to the Housing Partnership in September 2006.

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
HP12	Develop and consult on strategic homelessness service and ensure that homelessness services are delivered in accordance with Agency Agreement	Implement service changes where necessary		A formal review of the current Homelessness Strategy has been deferred whilst efforts are focussed on developing the homelessness prevention approach to reduce presentations and reliance on the use of B&B. The strategy review will probably now commence in the Autumn.
HP13	Ensure that sufficient longer-term cemetery provision exists to meet the future needs of the Halton community.	Present options to members for decision and formulate project plan to deliver preferred option		The options appraisal work requested by members has commenced but will roll forward into 2007/2008. This will delay member decision but will ensure that all appropriate options will have been considered.
HP15	Reduce the access that children and young people have to certain age restricted products by developing and implementing an under-age-sales strategy, informed by the results of previous research and activity, and having regard to the joint national enforcement statement issued in November 2005.	Strategy developed and implementation commenced		The strategy has been developed and is constantly evolving based on the additional information the Service receives throughout the year. Implementation has commenced.
HP16	Improve Access to the service for the socially excluded (Consumer Protection)	Resources permitting, implement 20% of actions in the action plan (developed from the consultation in 2005) by the end of 2007 or research possible opportunities for external funding of actions by end Dec 06		Some 20% of the actions have now been completed. A number of actions have been taken to raise the profile of the Service in the 5 most deprived wards via contact with all primary schools in those wards and by attendance at 'coffee mornings' at two of the schools plus 3 sessions on current "scams" at the Brow Primary School in Castlefields.

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
				Relationships with community groups that are likely to come into contact with the most disadvantaged consumers have been enhanced and a system of alerting such groups to current scams has been developed. A beer-mat campaign advertising the service has been launched.
HP20	Ensure the smooth transfer of statutory Registration officers to local authority employment once legislation permits	Career development & training needs identified as legislative changes are implemented during 2007/08.		Officers have been consulted on the new registration scheme and are awaiting the results of job evaluation. New letters of appointment will be produced by Personnel in time for the proposed scheme change on 4 July 2007.

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
HP4	Ensure effective information management systems are in place	To ensure security of information in line with Caldicott principles Develop information governance Implement requirements of Freedom of Information Act and Data Protection Act Full financial mapping with each service area		Caldicott principles are being followed. Information Governance in Social Care is still to be introduced although a new Toolkit is available no deadlines have been set. FOI procedures are well established. Full financial mapping is now well under way across H&C
HP7	Work with Operational Managers to produce a performance management framework that meets their needs. Provide high quality performance monitoring and management information to improve the quality of information and report service delivery to assist services to continuously improve	Implement Performance Monitoring Framework for each service area Manage data quality issues through the use of reporting mechanisms as part of overall performance management Consult and implement Performance Monitoring Framework for each service area		A Performance Management Framework has been implemented which directs the flow of performance information throughout the year. Data quality reports are circulated to all teams and subsequent actions are progress chased. All operational teams have established Performance Management Groups and frameworks. The teams are advised and supported by an allocated performance specialist on what actions they need to take

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
				throughout the year to demonstrate and improve performance. The performance dashboard is being launched w/b 14th May 2007 so that performance information is accessible from the desktop.
HP8	Develop workforce plans to ensure that there are appropriate resources to deliver services	Review and update the Directorate Workforce plan		The Workforce Development Plan for 2006/07 has been reviewed. The WDP for 2007/08 has been drafted ready to be approved at SMT during April 2007.
HP9	Deliver and improve a range of services and support for carers, according to the Halton Carers Strategy	Develop and implement an effective carer and service user involvement strategy		The Directorate developed a Service User and Carer Payments Policy during 2006/7. It was not approved at Corporate level and therefore could not be implemented during 2006/7. It has now received full approval and a pilot project will commence from 30th April 2007
HP10	Develop and implement joint commissioning strategies in each service area, in partnership with key stakeholders, service users and carers, that fully reflect national and local priorities and the social inclusion agenda Develop robust contract management and monitoring arrangements across all service areas.	Review and revise all strategies in the light of changing national and local priorities. Ensure consolidation of strategy format takes place. Evidence is available for all contracts or SLAs, which demonstrates quality and VFM and can		Strategies in place for ALD, OP, MH. PSD strategy and action plan drafted and on target for July 07. Work to merge Supporting People and Contracts teams will ensure robust contracts management is priority in monitoring Framework &

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
HP10 continued		be used to plan and commission / decommission future services.		Minimum Data Set agreed re: Voluntary Sector Contracts
HP14	Enable members to make informed decisions about crematorium facilities in the Borough, with particular regard to the issue of mercury abatement.	Present options to members for development of longer-term policy		Options presented to members via Executive Board Sub Committee meetings in May and June 2006. Policy agreed.
HP17	Introduce prevention measures to protect vulnerable adults from falling pray to doorstep crime	Research the possibility of funding in order to implement a Voice Connect system for vulnerable adults for the purpose of Doorstep crime alerts. Seek funding for a pilot 'No Cold-callers Zone' in one street.		Funding has been identified for 2007/2008 and work on the Voice Connect ICAN system will commence in April 2007. Once funding was identified, a two-street No-Cold-Calling-Zone was set-up in Widnes.
HP18	Identify and implement improvements to the Registration Service from intelligence gleaned from surveys of customers each year, to ascertain their views on the quality and scope of services provided	Survey all customers visiting the office during a particular week in the first quarter of 07 Survey all couples marrying during one of the peak summer months of 2006		Service improvements that flowed from 2005/2006 surveys included supplying maps covering the register office to all couples and the simplification of information pages for marriages and civil partnerships The marriage survey in September had a 33% response rate. Of these 100% said they were extremely

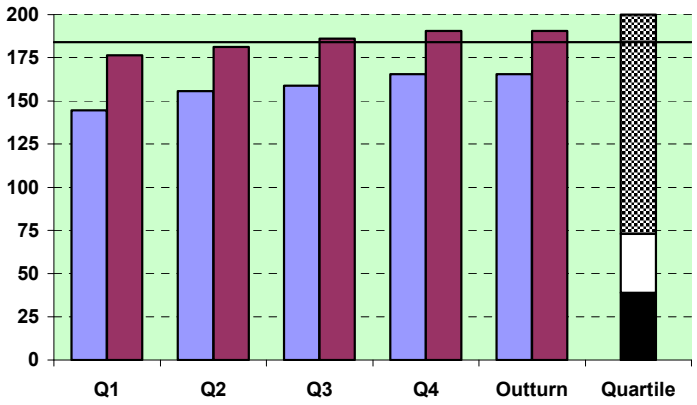
Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
		Analyse results by 31.12.2006 Implement any service improvements from previous year's survey by end 2006		satisfied with the service, both when organising the event and on the day of the marriage. 100% said it represented good value for money and that the facilities offered and service given could not be improved upon.
HP19	Ensure that the Council meets its statutory responsibilities with regard to the provision of Civil Partnership registrations	Procedures agreed and structure in place for provision of ceremonies in 2006		A total of 17 civil partnership registrations have been conducted since 1 April 2006.
HP21	All supervisors to discuss and record within EDR and monitored in supervision, work life balance issues with staff ensuring that staff are fully aware of Council policy	Work life balance policies distributed and communicated to staff and monitored via staff supervision audit process		Due to a reprioritisation of activity around the development of a Work Life Balance Strategy, it has not been possible to undertake the audit process this year. A Corporate Work-life Balance Strategy has been drafted to strengthen work-life balance initiatives across the Council.
HP22	Identification of staff with caring responsibilities	Identify staff as carers. Provide staff with information to enable them to be supported with flexible working		Eight HBC employees responded to the messages inserted on the salary document. Four of these were Halton residents and have been referred to receive carer support. The Carer Development Team now have a presence at Corporate Induction courses to help identify Carers.

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
HP 22 continued				A message aimed at identifying carers employed within HBC has been inserted in the monthly salary document three times during 2006/2007. It is planned to repeat this three times in the forthcoming year. A section on working carers has been inserted into the HBC Work life Balance Strategy. One event planned for Carers Week 2007 will be targeted at HBC employee's who are carers
HP23	To develop a comprehensive Health Improvement Strategy	Implementation of Health Improvement Strategy Mapping exercise conducted of all local health or associated partnerships. Self-assessment performance tool adopted.		We already have a Baseline Report and Health Equity Audit, which are in the process of being brought together to form a Health Improvement Strategy. This has been done and shared with the PCT. The Joint Halton & Warrington Youth Offending Service use the OPDM Partnership Audit Tool and as a result have their partnership agreement. Use has also been

Service Plan Ref.	Objective	2006/07 Key Milestone	Progress to date	Commentary
HP 23 continued				made of this model for a new partnership emergency duty tram service which is across St. Helens and Halton.
		Analysis conducted of authorities similar to HBC.		A benchmarking exercise has been conducted.
		Production of Health Impact Assessments bundle.		An example of the utilisation of HIA is with respect to proposals for all-day drinking. Joint training has recently been delivered to council and PCT staff on health needs assessment and health impact assessments.

BVPI 201

Number of adults and older people receiving Direct Payments



Higher figures represent better performance

Key

2005/6
2006/7
Target
Top 25%
Middle 50%
Bottom 25%

PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend

Better than this time last year

Green

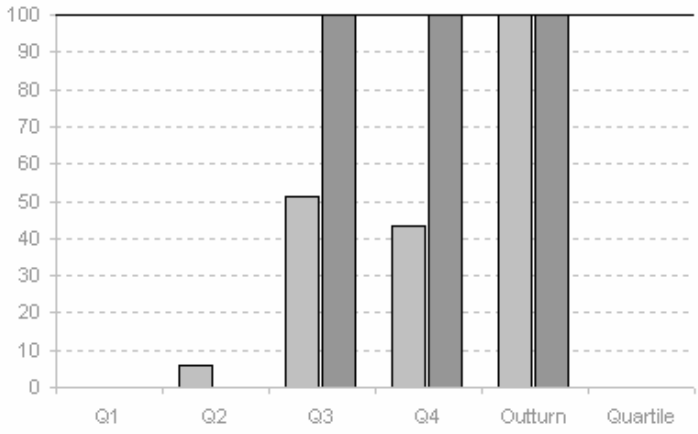
Annual target hit or exceeded

Commentary

Current performance of 190.43 people per 100,000 population in receipt of direct payments. This indicator is in relation to client users only. Direct payments used to benefit the carer (I.e respite or carers break) are reported in a separate performance indicator to measure carers services. Current performance would be awarded a PAF Band 5, and target for 2006/7 has been exceeded.

BVPI H&PARLI 4

Percentage of schools (incl. Yr 11 and Sixth pupils) offered a Validate card.



Higher figures represent better performance

Key

2005/6
2006/7
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

Trend

Same as this time last year

Green

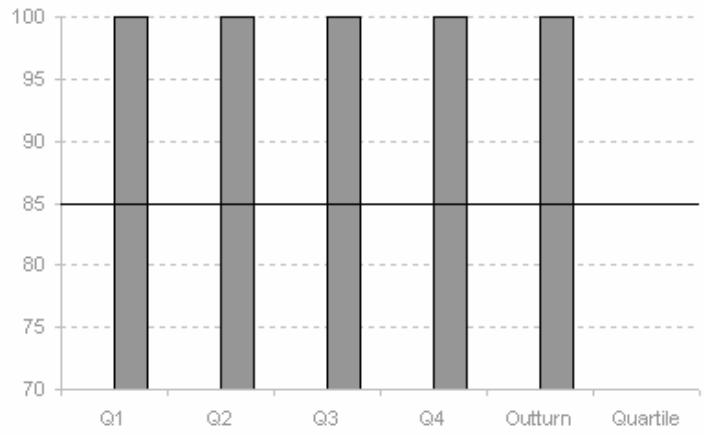
Annual target hit or exceeded

Commentary

100% of schools and 6th form colleges were offered the Validate card. Some 8 out of the 10 schools took up that offer. All 6th form Colleges including St Chads, St Peter and Paul and the 3 Riverside College sites were all visited and offered Validate cards. In total 856 cards were requested and issued to 16 year olds attending Halton schools and 183 were issued to 6th form pupils, making a total of 1,039 cards

BVPI H&PARLI 10

% of times service has offered 2 burial appointments within 9 working days (Dec to Feb inclusive) or within 7 working days at other times



Higher figures represent better performance

Key

2005/6

2006/7

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

No data for same Qtr last year

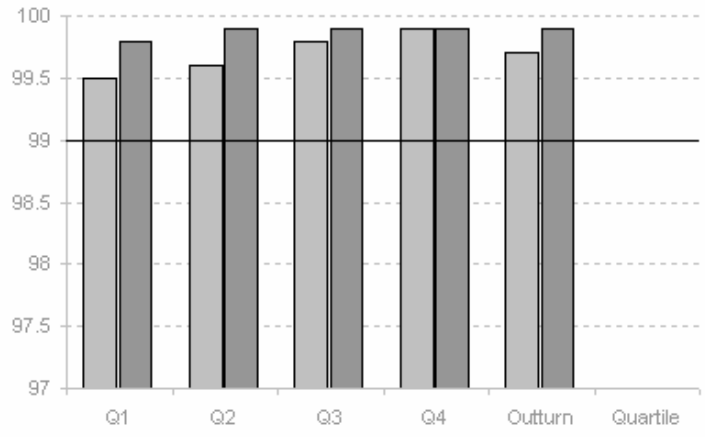
Annual target hit or exceeded

Commentary

Bereavement Services were able to meet this standard for all 311 full burials that took place during the 2006/2007 financial year. Longer booking periods were accepted where there was a specific family request for a longer period (for example where family members were away or where a family wished to wait until a specific minister was available).

BVPI H&PARLI 13

Percentage of clients attended to within 10 minutes of their appointment time.



Higher figures represent better performance

Key

2005/6

2006/7

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

Better than this time last year

Annual target hit or exceeded

Commentary

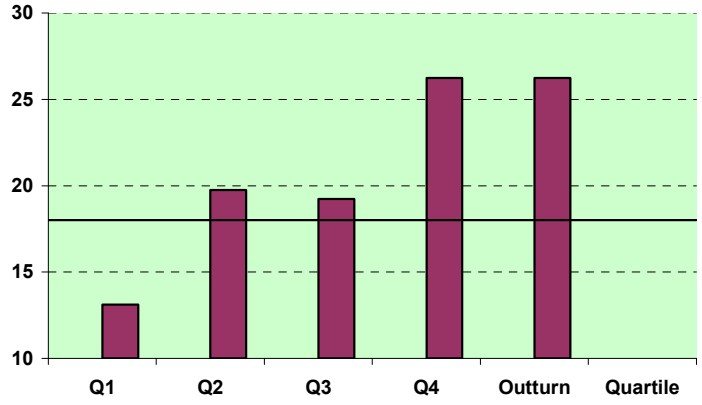
99.9%, or 4170 customers were seen within 10 minutes of their appointment time during the year, an increase of 248 on the previous twelve months. Five clients were not seen within the 10-minute standard, delays to 3 of these clients being caused by IT problems.

In addition 951 clients were seen without an appointment.

H&PARPA F 59

No. of assessed social work practice learning days per whole time equivalent social worker

Higher figures represent better performance



Key

2005/6
2006/7
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

Trend

Green

No data for same Qtr last year

Annual target hit or exceeded

Commentary

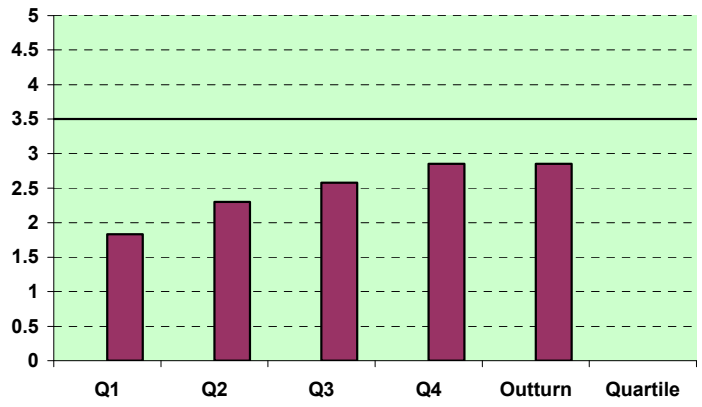
This PI is calculated by dividing the number of placement days, both directly provided and those supported in the vol sector, by the no of WTE social workers. Last year we were awarded 1080 vols and although this will not be confirmed until the end of the year, we can confidently anticipate at least this number in future years because the total no of students has increased.

To date, we have provided 1484 days, which gives a total of 2564 (including vols) divided by WTE 97.7=26.24

H&PARLI 17

% of SSD gross current expenditure on staffing which was spent on training the Council's directly employed staff during the financial year

Niether high or low figures represent better performance



Key

2005/6
2006/7
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

Trend

Red

No data for same Qtr last year

Annual target missed

Commentary

Training Budget spend April-March against cost centres 6060, 6000, 5647, 6200 & 6220, including Children Services. T&D Spend £538,108 divided by £18,870,277 multiplied by 100. Staff costs provided by finance. Doesn't include spend on Ind Sector (£27,332)

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	Commentary
	Service Delivery Indicators.					
PAF C62	The number of carers receiving a specific carers service as a percentage of clients receiving community based services	7.04	9%	8.45%		Figure provided is as at end February 2007, target may still be achieved. Final year end figure not yet known as admin staff are still back loading data onto Carefirst.
BVPI 166b	Score against a checklist of enforcement best practice for Trading Standards	100%	100%	100%		This 'year end' best value performance indicator provides an indication of the performance of Halton's Consumer Protection Service when measured against a checklist of enforcement best practice. The checklist has regard to written enforcement policies, risk based inspection programmes and sampling and surveillance regimes, educational and information programmes, customer complaint/enquiry processes, benchmarking and consultation arrangements and performance reporting mechanisms.
BVPI 64	Number of private sector dwellings returned into occupation or demolished as a direct result of action by the local authority.	0	2[1]	2		The target has been achieved.

1 Target for BVPI 64 – due to the low number of empty properties in Halton, along with the absence of grants to encourage landlords to take on and improve any empty properties, the target is set below bottom quartile figure.

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	Commentary
BVPI 183a	The average length of stay in B&B accommodation of homeless households that are unintentionally homeless and in priority need (weeks)	1.86	1.8	4.92		Estimated figure. Increased homeless presentations, coupled with a reduction in the supply of relets, has resulted in a fall in performance. A Project Group has been established to redesign homelessness services to address this problem.
BVPI 183b	The average length of stay in hostel accommodation of homeless households that are unintentionally homeless and in priority need[2]	0	0	0		Halton does not have any accommodation that that falls into the criteria of a hostel.
BVPI 202	Number of Rough Sleepers	N/A	0	0 est		This is an estimate as there has not been a formal rough sleepers count since March 2004. One is planned for Autumn 2007.
BVPI 203	The % change in the average number of families placed in temporary accommodation	10.85%	13.0%	16.66%		Estimated figure. See comments for BV 183a above.
BVPI 213	The number of households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (expressed as the number divided by the number of thousand households in the Borough)	0	1.06	0.3		Estimated figure. Whilst this is an improvement over 2005/06, it is below the target for 2006/07. Improved performance should result in 2007/08 from the initiatives being developed under the homelessness service redesign.

[2] Halton does not have any accommodation that falls within the definition of a hostel as stated in the guidance for this indicator.

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	Commentary
BVPI 214	The proportion of households accepted as statutorily homeless who were accepted as statutorily homeless by the same LA within the last 2 years	4.89	9.5%	1.26%		Estimated figure. Performance was significantly better than the target, evidence of the success of the support services developed under the Supporting People programme.
BVPI 225 Part 8	*Has there been a reduction in the percentage of* cases accepted as homeless due to domestic violence that had previously been re-housed in the last 2 years by that LA as a result of domestic violence	-	-7.5%	YES		The wording of this PI has changed from the % reduction in cases to whether or not there has been a reduction. The provisional outcome is that there were no repeat cases during 2006/07.
HP/ LPI 1	Percentage of SSD directly employed staff that left during the year.	7.4%	13.5%	7.69%		We monitor and analyse all exit interview questionnaires every six months to continually improve our systems and processes to further aid retention, as well as regularly reviewing policies and procedures in relation to retention, such as Exit Interview Policy, Procedure and Practice, Recruitment and Retention Strategy, etc.
HP/ LPI 2	Percentage of Social Services working days/shifts lost to sickness absence during the financial year.	7.94%	7.5%	7.98%		% figure subject to validation as part of the SAS process

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	Commentary
HP/ LPI 3	% of Halton pupils completing a survey on the supply of age restricted products	60% of appropriate School year	45% of appropriate School year	70%		A cigarettes survey was carried out in relation to Year 9 pupils. The 70% response rate far exceeded the 45% target we aimed for. This increases the validity of the results. We have received the individual school reports, which Officers are working through in order to provide information to tackle future problems. We are awaiting the full Halton report so we can produce a list of relevant intelligence based actions for the coming year.
HP/ LPI9	Carry out all cremations within 24 hours of receipt of written instructions.	100%	100%	100%		A total of 587 cremations took place during the 2006/2007 financial year.
HP/ LPI 12	Applications for current certificates processed on the day of receipt.	98.3%	99%	99.7%		1035 applications for current certificates were received during the year. Of these 1032 were issued on the day of receipt.
HP/ LPI 18 (Based on BVPI 8)	The percentage of undisputed invoices which were paid in 30 days (BVPI 8)	89%	95%	96%		Target achieved due to improved monitoring and weekly chasing of invoice authorisers by the Financial Services team to ensure prompt payment.

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	Commentary
	Quality of Service Indicators.					
HP/ LPI 7	Percentage of consumer service users satisfied with the Trading Standards Service, when last surveyed	New for 06/07	88%	80%		It should be noted that the above relates to the return of only 1 consumer feedback form plus 4 returned questionnaires. The low return rate, which included a single expression of dissatisfaction, has resulted in a failure to meet the locally set target. Consultation methods are to be reviewed in light of the poor return rate.
HP/ LPI 8	Percentage of Business service users satisfied with the Trading Standards Service, when last surveyed	New for 06/07	88%	100%		Target exceeded, but note that the above relates to only 7 trader feedback forms plus 18 returned questionnaires.
HP/ LPI 11	Percentage of Bereavement Service users who rated the staff courteousness / helpfulness as reasonable / good / excellent when last surveyed	New for 06/07	70%	100%		The above is based on 76 feedback forms from clients who had made contact with Bereavement staff.
HP/ LPI 14	Percentage of couples who felt that they received an excellent or good service from staff on the day of their marriage / partnership, when last surveyed.	New for 06/07	88%	100%		The response rate for the marriages survey of 33% was poor. However, everyone said that they had received a very good or good service on the day of their ceremony.

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	Commentary
HP/ LPI 15	Percentage of other Registration Service users who rated the staff's helpfulness / efficiency as excellent or good, when last surveyed.	New for 06/07	88%	100%		The general survey of clients had an 81% response rate. Of these everyone said the helpfulness and efficiency of the staff had been very good or good. One comment made: "Every Borough should provide this excellent service."
	Fair Access Indicators.					
HP/ LPI 5	No. of initiatives undertaken to raise the profile of the Service in the 5 most deprived wards	9	3	13		Some 20% of the actions have now been completed. A number of actions have been taken to raise the profile of the Service in the 5 most deprived wards via contact with all primary schools in those wards and by attendance at 'coffee mornings' at two of the schools plus 3 sessions on current "scams" at the Brow Primary School in Castlefields. Relationships with community groups that are likely to come into contact with the most disadvantaged consumers have been enhanced and a system of alerting such groups to current scams has been developed. A Service beer-mat advertising campaign has been launched.

Ref	Indicator	Actual 05 / 06	Target 06 / 07	Quarter 4	Progress	Commentary
HP/ LPI 6	% of Improving Access Action Plan implemented (resources permitting)	N/A	20%	20%		Some 20% of the actions have now been completed. A number of actions have been taken to raise the profile of the Service in the 5 most deprived wards via contact with all primary schools in those wards and by attendance at 'coffee mornings' at two of the schools plus 3 sessions on current "scams" at the Brow Primary School in Castlefields. Relationships with community groups that are likely to come into contact with the most disadvantaged consumers have been enhanced and a system of alerting such groups to current scams has been developed. A Service beer-mat advertising campaign has been launched.
	Cost & Efficiency Indicators.					
HP/ LPI 16	% of SSD directly employed posts vacant on 30 September	9.77%	8%	11.78		We continue to raise the profile of a career within social care through various means, for example the northwest authorities Thinkcare website (www.thinkcare.gov.uk). Representatives attended the SOCNOW recruitment fair in May 2006, which is also planned for May 2007, as well as regularly reviewing our policies and procedures in relation to recruitment.

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective has been achieved within the appropriate timeframe.	Indicates that the annual 06/07 target has been achieved or exceeded.
Red		Indicates that the objective has not been achieved within the appropriate timeframe.	Indicates that the annual 06/07 target has not been achieved.