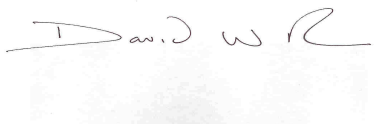
Public Document Pack

Healthy Halton Policy and Performance Board

Tuesday, 9 March 2010 6.30 p.m.
Civic Suite, Town Hall, Runcorn



Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	**Labour**
Councillor Bob Bryant	**Liberal Democrat**
Councillor Dave Austin	**Liberal Democrat**
Councillor Robert Gilligan	**Labour**
Councillor Trevor Higginson	**Liberal Democrat**
Councillor Margaret Horabin	**Labour**
Councillor Martha Lloyd Jones	**Labour**
Councillor Joan Lowe (Vice-Chairman)	**Labour**
Councillor Ged Philbin	**Labour**
Councillor Geoffrey Swift	**Conservative**
Councillor Pamela Wallace	**Labour**
Mr Paul Cooke	**LINk Co-optee**

Please contact Lynn Derbyshire on 0151 471 7389 or e-mail michelle.simpson@halton.gov.uk for further information.
The next meeting of the Board is on Date Not Specified

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 Services Policy & Performance Board

DATE: 9 March 2010

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 34(9).

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(9) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for dealing with questions from 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 given by 4.00 pm on the working day prior to the date of the meeting to the Committee Services Manager. At any one 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 your 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 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 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton** - none.

6.2 **Employment, Learning and Skills in Halton** - none.

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

6.5 **Halton's Urban Renewal** – none.

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 the Act.

REPORT TO: Healthy Halton Services Policy and Performance Board

DATE: 9 March 2010

REPORTING OFFICER: Chief Executive

SUBJECT: Executive Board Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Social Care Portfolio which have been considered by the Executive Board and Executive Board Sub 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

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

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 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 MEETING HELD ON 28 January 2010

EXB81 CARE QUALITY COMMISSION PERFORMANCE RATING 2008/09

The Board received a report of the Strategic Director, Health and Community on the Care Quality Commission (CQC) Performance Rating 2008/09.

The Board was advised that the Health and Community Directorate have their performance rated annually by the CQC, and was linked to how well the Directorate provided social care services to adults. The rating fed into the Comprehensive Area Assessment rating for Halton Borough Council.

Since September 2006 in addition to quantitative data, performance was also judged on the outcomes that were delivered to people. Seven new outcomes and two new domains were announced against which performance would be judged, details of which were given in the report. Members were advised that the performance for 2008/09 had been given an overall grade rating for delivery of outcomes as excellent, classified by the CQC as 'overall delivering well above the minimum requirements for people'.

The CQC looked at how well the Directorate performed on leadership and identified that in order for the Council to improve, it needed to continue with transformation to achieve the personalisation of social care services, but did not identify any areas in need of improvement in terms of the commissioning and use of resources.

The Board wished to place on record their thanks to all staff involved in the provision of social care services to adults.

RESOLVED: That the continuing improved performance of the Health and Community Directorate be noted.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 9 March 2010

REPORTING OFFICER: Chief Executive

SUBJECT: Specialist Strategic Partnership minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Social Care Portfolio which have been considered by the Health Specialist Strategic Partnership are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

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 the Act.

Halton Strategic PARTNERSHIP

HALTON HEALTH PARTNERSHIP BOARD

MINUTES OF THE MEETING held on

19 November 2009

Present : Fiona Johnstone (Chair)
Cllr Ellen Cargill
Glenda Cave
Melissa Critchley
Mike Foy (part)
Cllr Ann Gerrard
Keeley Harrison
Dwayne Johnson (part)
Mike Kennett
Diane Lloyd
Cllr Tom McInerney
Eileen O'Meara
Dave Sweeney
Karen Tonge
Jane Trevor
Jim Wilson

In Support: Margaret Janes

		ACTION
1.	**Apologies** John Kelly, Eugene Lavan, Ian Stewardson, Sue Wallace-Bonner,	
2.	**Minutes of the previous meeting** 4. Community Feedback- 'to be developed through PQASSO' this should read 'to develop with the commissioners'. The minutes were agreed as a correct record	
3.	**Matters Arising** **Health Summit** – agenda item. **LIT Group** – Visit to be organised. **Commissioning Update** – to be given at next meeting. **Tribal Review** – Dwayne Johnson advised the preliminary report had been received. There were a number of recommendations - meeting held and changes had been made. Currently waiting for a revised document from Tribal. Strategically heading in right direction and there is evidence of good practice and partnership. Communication could be improved between local implementation teams and Tribal group as a number of people do not understanding issues with regard to accountability and governance and were unclear of outcomes from this group.	

Halton Strategic PARTNERSHIP

	Joint Commissioning – Ensure we strengthen joint commissioning and identify mechanisms, particularly with regard to HPP groups. Fiona Johnstone will ensure group receive final report. **Updated Finance Report** – This had been circulated. **Priority Setting** –We want to maintain targets despite the current economic climate, consideration will be given as to how savings are made. Over the next 6-8 weeks work will be carried out to look at this and the matter will be discussed at the February 2010 meeting.	**FJ**
4.	**Community Feedback:** Melissa Critchley reported upon the following: ▪ Commissioning Guides available, workshop day held. ▪ Latest newsletter released. ▪ Training on 20th November on Commissioning for Third Sector on effects of tendering. ▪ Reports being compiled re national indicators. Dwayne Johnson asked whether people were accessing training for adult safeguarding. Karen Tonge confirmed they were. Fiona Johnstone thanked Melissa Critchley for her report.	
5.	**Vision for the Third Sector in Halton:** Dave Sweeney gave presentation to group • Each organisation has contract within PCT. • Simple template been circulated and commissioners and contractors working together resulting in improved communications. • Need to improve work on targets and the matrix will allow us to collect one set of outcomes and will free up third Sector to do the work they are contracted for. • Do not have one assurance model, likely to work on PQASSO, this will ensure every voluntary sector provider has some form of quality assurance. • Copies of presentation to be circulated.	**DS**
6.	**Update on Health Summit:** Fiona Johnstone advised it would be useful to establish a working group to take this forward. This was an opportunity to reiterate our intentions and plans. We should reflect on progress made in the last 12/18 months and our achievements and plans for 2010/11. There will be an introduction section followed by workshops to provide feedback on particular areas. At HSP Board on 18th November there was a proposal re total place initiative. There are currently 13 pilots where all agencies look at single issues together. This gives better understanding of control, local resources and impact on outcomes. Fiona Johnstone asked how the group felt about having a focused event to test this process locally. This could be linked to a significant priority in 2010 and attach tangibility. The group were asked to contact Fiona Johnstone if they had any additional thoughts.	**All**

	Fiona Johnstone asked for volunteers – these were Laura??, Diane Lloyd, Jane Trevor and Ann Gerrard. Diane Lloyd and Fiona Johnstone would discuss the matter further.	**FJ/DL**
7.	**Health Partnership Performance Group Feedback:** Jim Wilson advised meeting held on 11th November previous two meetings had not focused on performance management; at the last meeting reports were submitted. Capacity building project linked into N17 which links into third sector. This was chosen because there was concern over what the project did and its effectiveness. Work needed with voluntary groups to skill them up to PQASSO standard. Targets have all been met as set out in the business plan. Working with 4 groups to get to PQASSO standard. Good start/no overlap with commercial service – we will review in 12 months. Colette Walsh (Alcohol Lead) gave presentation to the group. They are developing performance management framework which will be shared with the group. The group understood targets and investments that were in place. This was a challenging target to met, however we are able to demonstrate plans are in place in order to work towards attaining results. Teenage pregnancy – Sue Forster submitted report and the early indications were that the trend seemed to be going in the right direction toward 2006 figures. A strategic group had been established with considerable investment. It was noted that the report was encouraging. The Q2 LA report was not available. Q&A - see sheet	
8.	**HSPB Performance Management Framework –** Mike Foy gave a presentation, which included: ▪ Report and summary – need to understand whether figures are actual or estimated. ▪ Performance commentary. ▪ Summary of key activities. Mike Foy asked whether exception report was still the approach that the group wanted. Jim Wilson agreed with exception reporting but advised we should also celebrate the successes. Mike Foy would like the Performance Subgroup to challenge the information that is available; if necessary people could attend the meeting to explain why targets had not been met.	
9.	**Commissioning Group Feedback** – Dave Sweeney advised the Commissioning Board had signed the agreed pathway to enable pilot services next year. Meeting with Mike Treharne and currently awaiting further piece of information.	
10.	**CAA** – Fiona Johnstone advised the formal report will be published on 10th December; she had seen the draft report from CAA and in terms of this	

Halton Strategic PARTNERSHIP

	particular partnership there were two areas of concern – Health Inequalities and Teenage Pregnancy. The red flag had been removed from Health Inequalities but it remains an area of concern. Teenage pregnancy is also an area of concern. The opportunity should be taken to promote the work that we are doing. Fiona Johnstone to contact Helen ?, Lead for LSP to see how we can help.	**FJ**
11.	**SSP Chairs Meeting Feedback** – Fiona Johnstone advised Performance framework, funding and WNF had been discussed. We needed to ensure that we spent the allocation given and this should be performance monitored. LSP had an away day planned for January. There will be a half day development session around three workshops – Improving Governance Improving Partnership working Token Place approach Fiona Johnstone to circulate SSP report for information.	**FJ**
12.	**LPSA 2 Reward Grant** – Diane Lloyd tabled the report and advised the grant was attached to targets. The Government will pay reward grants on targets achieved. The report had been tabled at the Halton Strategic Partnership Board, some of the targets had been achieved, however we await further information. The reward grant would be used across LSP areas. LSP had requested SSP's to provide proposals against reward grants before 5th January 2010. Due to the group not meeting until 14th January Fiona Johnstone proposed the group put forward what the funds should be allocated against via email. If no proposals were received she would like the decision to take place within the Commissioning group; if no response she would take this as acceptable.	**All**
13.	**AOB** ▪ 2010 Meeting dates – Diane Lloyd advised meetings would be held in the Municipal offices. ▪ Jane Trevor advised she had a new role of Mental Health Coordinator at Job Centre Plus. The role will develop partnership with key stakeholders to promote services available for people with mental health conditions and to help them get back into the workplace. Ellen Cargill asked if someone could come along and talk to a group she was involved with. Dave Sweeney asked Jane Trevor if she would like to attend a Mental Health Implementation Team meeting. ▪ Diane Lloyd tabled an email from Janet Dunn which gave an update on Falls Strategy. She would be invited to attend the February meeting to discuss some of the issues. ▪ Health Summit 14th January – Jim Wilson advised a flyer should be sent out as soon as possible.	**DL**
10.	**Date and time of next meeting: 4th February at 10 am, Conference Room 2 Municipal Building**	

Halton Strategic PARTNERSHIP

Action Summary – previous meetings

Reference	On Whom	Action	Status / Update
19/11/09 3	Fiona Johnstone	Tribal Review Final report to be circulated	
19/1109 5	Dave Sweeney	Circulate presentation	
19/11/09 6	All Fiona Johnstone/ Diane Lloyd	Total price initiative – focused event – advise Fiona Johnstone. Volunteers –to discuss.	
19/11/09 10	Fiona Johnstone	To contact Helen ?, Lead for LSP	
19/11/09 11	Fiona Johnston	To circulate SSP report.	
19/11/09 12	All	Proposals for allocation of funds.	
19/11/09 13	Diane Lloyd	Invite Janet Dunn to February meeting	

REPORT TO: **Healthy Halton Policy & Performance Board**

DATE: **9 March 2010**

REPORTING OFFICER: **Strategic Director, Health & Community**

SUBJECT: **Transforming Community Services**

WARDS: **All**

1.0 PURPOSE OF THE REPORT

To inform Healthy Halton Policy and Performance Board of the presentation by the Chief Executive of NHS Halton and St Helens on the requirements of Transforming Community Services.

2.0 RECOMMENDATION: That

Healthy Halton Policy and Performance Board note and comment on the presentation.

3.0 SUPPORTING INFORMATION

Healthy Halton Policy and Performance Board received a presentation from NHS Halton and St Helens in January 2010 on Transforming Community Services in Halton. The presentation today will give details of progress and next steps.

4.0 POLICY IMPLICATIONS

The Council will need to identify the implications in detail once the decision has been reached on the location of Community services.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton Health services for children work closely with Council services to meet the needs of children in Halton including safeguarding.

6.2 **Employment, Learning and Skills in N/A**

6.3 A Healthy Halton Decisions on the future of Community Services will need to ensure that the health needs of Halton residents are met**.**

6.4 **A Safer Halton**

N/A

6.5 **Halton's Urban Renewal**

N/A

7.0 RISK ANALYSIS

7.1 Many of the services concerned work closely with Adult Social Care. Any future arrangements will need to be carefully managed both through transition and after to ensure that there is no impact on the Council's performance.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Services will need to continue to meet the needs of all Halton residents.

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 4 March 2010

REPORTING OFFICER: Strategic Director – Health & Community

SUBJECT: Update on Resource Allocation System

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update members of the Healthy Halton Policy & Performance Board on the implementation of a resource allocation system (RAS).

2.0 **RECOMMENDED THAT:**

Members of the Healthy Halton Policy & Performance Board:-

(1) Note the contents of the report.

3.0 **SUPPORTING INFORMATION**

3.1 Background

'Personalisation' is the vision for the future of social care provision. We need to enable people to have more choice and control about what services they want, need and when. Whilst Halton has been successful at introducing Direct Payments (second highest performer in the 2008-09 definition of NI 130 having 868.8 adults and carers per 100,000 population being given self directed support via direct payments, this equates to 14.1 per cent of all service users) it needs to introduce Individual Budgets for people and streamline funding streams into one budget that people can access including funds from Supporting People.

3.2 The National Indicator Set, Performance Indicator N1 130, is seen as an important link to the self-directed support strand of Putting People First. Halton will need to achieve a 30% take up of PBs by March 2011.

3.3 Unlike Direct Payments a Personal Budget can be used to purchase Local Authority services, and therefore a package of care may be a mixture of Local Authority services and services provided by Personal Assistants or provider agencies, e.g. an older person may receive home care provided by the Local Authority and a meal provided by a local pub.

3.4 As with Direct Payments, Halton Borough Council's internal audit will undertake audits of how people receiving a personal budget are spending this money.

3.5 Comparison of traditional service model and proposed model

Table 1 compares the proposed model for self-directed support with the traditional service model for delivering social care.

Table 1

Traditional service model	**Proposed model**
Assessment by professionals	Early supported self-assessment
Lack of transparency in the process of allocating resources; budget decided at the end	Transparency in resource allocation; budget decided at the start
Care plan decided by professionals	Support plan designed by individual with people or professionals of their choice
Money managed by local authority	Money managed by individual or nominated person or organisation
Services commissioned by local authority	Services commissioned by individual
One-off planning process, with yearly review	Reflexive process; support plan constantly reviewed and learned from
No flexibility in spending	Flexibility in spending
Responsibility for risk lies with local authority	Responsibility for risk lies with the individual and the local authority
Individual receives services from the state – no incentive to innovate	Individual designs and commissions their own services – opportunity to be creative and innovative
Individual as part of public services machine	Individual as empowered community member

3.5 As can be seen from the table above one of the main changes to be adopted is the provision of an up front allocation of budget, prior to the design of a support plan which addresses how a clients' needs

will be met. Halton has decided on a points based system for calculating an indicative budget. A short presentation to describe this system will be given as part of this report.

4.0 POLICY IMPLICATIONS

4.1 Over the next 5 years, Personalisation is likely to substantially affect the way in which people receive services and will require political support.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 There are no financial implications at present, and it is expected that the introduction of the RAS will be cost neutral.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Personal Budgets have been used by some councils to support young people with disabilities in transition from Children's to Adult's Services and this is at early stages of development in Halton. It will be important to ensure Children's and Adult's services work closely to ideally develop a single process for individualised budgets.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

It is clear that the Government anticipates that the use of Personal Budgets will lead to health gains and further work is needed on the interface with Health services.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

Not applicable

7.0 RISK ANALYSIS

7.1 Failure to introduce the RAS quickly may delay the up-take of PBs and may result in HBC not meeting the NI 130 targets set for March 2011. However, good progress has already been made in meeting this target.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Equitable policies and practice will need to be introduced for all client groups.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 9th March 2010

REPORTING OFFICER: Strategic Director – Health & Community

SUBJECT: Scrutiny Review of Adaptations for Disabled People

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To introduce the draft report of the Scrutiny Review of Adaptations for Disabled People for consideration by the Board.

2.0 **RECOMMENDATION: That:**

i) The Board comment on the findings of the Scrutiny Review;

ii) The Board endorse the Scrutiny Review and its recommendations.

3.0 **SUPPORTING INFORMATION**

3.1 This report (attached as Appendix 1) was commissioned by the Healthy Halton Policy and Performance Board. A scrutiny review working group was established with four Members from the Board, an officer from the finance team and officers from the Halton Home Improvement and Independent Living Service (HHIILS).

3.2 The report was commissioned as historically a high level of complaints had been received regarding the waiting time for adaptations for service-users, the costs/financial output was identified as very high and the importance of adaptations in the independence of disabled people staying longer in their own homes was highlighted. Over the last two years, major changes have been made internally to the structure and processes within the adaptations service. In April 2008 the Independent Living Team, Grants Team and Home Improvement Agency integrated becoming the new HHIILS team based at John Briggs House in Widnes.

3.3 The scrutiny review was conducted through a number of means between April 2009 and January 2010, as follows:

- Bi-monthly meetings of the scrutiny review topic group;

- Presentations by various key members of staff (detail of the presentations can be found in *Annex 2*);
- Regular financial activity updates regarding each aspect of the Disabled Facilities Grant at each meeting from the Budget Monitoring Officer;
- Provision of information;
- Service-user consultation;
- Field visit to a modular building; and
- Meeting with members of the HHIILS team.

4.0 POLICY IMPLICATIONS

4.1 Existing policies are endorsed by the report.

5.0 FINANCIAL IMPLICATIONS

5.1 The following recommendations will have financial/resource implications:

a) Consider developing a Business Plan for a financial contribution from Health towards adaptations to set against the savings achieved for health as described in 5.1.2.
b) Ensure adequate training for staff within the Contact Centre dealing with the feedback forms is in place.
c) Approve the in-house design of a bespoke IT system that brings together all the current systems therefore considerably cutting down on time and resources of the admin team.

5.2 The report makes a series of recommendations under each separate area of evidence that was scrutinised and have been collated into an Action Plan at Annex 4 for ease of reference and monitoring.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

As described in 5.1.2, the provision of adaptations for children promotes a healthy living environment, sustain individual good health and well-being and help prevent and efficiently manage illness.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

As described in 5.1.2, the provision of adaptations for disabled people promotes a healthy living environment, sustain individual

good health and well-being and help prevent and efficiently manage illness.

6.4 **A Safer Halton**

Providing disabled people with suitable adapted housing gives them the opportunity to stay living in the area they want, to continue enjoying their lives. All major adaptations are developed to high standards in keeping with the local environment.

6.5 **Halton's Urban Renewal**

In line with "Lifetime Homes, Lifetime Neighbourhoods – A National Strategy for Housing in an Ageing Society" by the Communities for Local Government, the recommendations within this scrutiny review report have a huge role to play in helping people live independently for longer in their own homes.

7.0 RISK ANALYSIS

7.1 Taking on board the recommendations from the report will be positive steps to improving the efficient and effective running of the HHIILS team and providing an improved service to the residents of Halton to help them live independently in their own homes.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The implementation of the recommendations will improve the independence of older people and disabled people within Halton.

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

None.

HALTON
BOROUGH COUNCIL

Scrutiny Review of Adaptations for Disabled People

DRAFT
Report
January 2010

CONTENTS

1.0 Purpose of the Report

The purpose of the report, as outlined in the initial topic brief (at *Annex 1*) is to:

- Gain an understanding of the complexities of the financial processes/issues around adaptations;
- Consider national best practice and research in terms of self-assessment, personalisation and the use of modular buildings;
- Raise awareness generally of the service and the value of adaptations for service-users (including finance and independence);
- Examine the effectiveness of specifications/plans to ascertain if these could be simplified; and
- Consider resources available in terms of IT systems to ensure adequate monitoring of the DFG.

2.0 Structure of the Report

This report is structured with the introduction, a brief summary of the methodology followed by evidence, analysis with findings/conclusions and recommendations. The annexes include the topic brief, methodology detail, IT systems and Action Plan.

3.0 Introduction

3.1 Reason the report was commissioned

Historically a high level of complaints had been received regarding the waiting time for adaptations for service-users, the costs/financial output was identified as very high and the importance of adaptations in the independence of disabled people staying longer in their own homes was highlighted.

Over the last two years, major changes have been made internally to the structure and processes within the adaptations service. In April 2008 the Independent Living Team, Grants Team and Home Improvement Agency integrated becoming the new HHIILS Team (Halton Home Improvement and Independent Living Service) based at John Briggs House in Widnes.

There are different routes for adaptations, particularly in relation to the tenure and whether the property is owner-occupied/privately rented or it is owned by a Registered Social Landlord.

3.2 Policy and Performance Boards

This report was commissioned as a scrutiny working group for the Healthy Halton Policy and Performance Board.

3.3 Membership of the Topic Team

Membership of the Topic Team included:

Members	Officers
Cllr Ellen Cargill Cllr Joan Lowe Cllr Dave Austin Cllr Bob Gilligan	Ruth McDonogh – Divisional Manager for Halton Home Improvement and Independent Living Service and Chairperson Phil Brown – Principal Housing Inspector Graham Foxley – Budget Monitoring Officer Emma Mookerji – Service Development Officer HR

4.0 Methodology Summary

This scrutiny review was conducted through a number of means:

- Bi-monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff (detail of the presentations can be found in *Annex 2*);
- Regular financial activity updates regarding each aspect of the Disabled Facilities Grant at each meeting from the Budget Monitoring Officer;
- Provision of information;
- Service-user consultation;
- Field visit to a modular building; and
- Meeting with members of the HHIILS team.

5.0 Evidence (summary of evidence gathered) and Analysis with findings/conclusions

5.1 Financial Processes

The most complex area of the major adaptations process is the financial aspect particularly in the administration of the Disabled Facilities Grants (DFGs). To enable members of the topic group to

gain a good grasp of the financial processes involved, a detailed presentation during one of the first topic group meetings was given by the Principal Housing Inspector and the Budget Monitoring Officer. At every meeting the Budget Monitoring Officer also gave an update summarising the current financial position.

5.1.1 Financial Allocations

The table below details the allocation of funds towards the various aspects of the adaptations service as well as the staff costs for the team as a whole.

Budget for staff costs for the whole team	**£ 1,182,552**
Allocations for Capital are:	**£**
Disabled Facilities Grant	686,000
RSL Adaptations (Joint Funding)	650,000
Stair lifts	120,000
Modular Buildings	62,000
Total for Capital	**1,518,000**

5.1.2 Savings brought about by the use of adaptations in properties

In the Office for Disability Issues document *Better Outcomes, Lower Costs – Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence by Frances Heywood and Lynn Turner* a study was conducted and found that the provision of housing adaptations and equipment for disabled people produce savings to health and social care budgets in four major ways. These are summarised below:

(i) Saving by reducing or removing completely an existing outlay

a) Saving the cost of residential care – For a seriously disabled wheelchair user, the cost of residential care is approximately £700-£800 a week, or £40,000 in ten years. The provision of adaptation and equipment that enables someone to move out of a residential placement produces savings, normally within the first year. Providing adaptations to enable a person to remain in the community rather than going into residential care will save £26,000 per person per year. The average cost of an adaptation would be £6,000 to provide a level access shower and a stair lift, for example.

b) Reducing the cost of home care – An hour's home care per day costs in the region of £5,000 a year.

(ii) Saving through prevention of an outlay that would otherwise have been incurred

Savings under this heading include the prevention of accidents with their associated costs, prevention of admission to hospital or to residential care and prevention of the need for other medical treatments, for example:

a) Prevention of hip-fractures – Falls leading to hip fracture are a major problem internationally, but in the UK in 2000 they cost £726 million. Housing adaptations reduce the number of falls. The average cost to the State of a fractured hip is £28,665.

b) Prevention of other health costs – the provision of adaptations and equipment can save money by speeding hospital discharge, as well as preventing admission to hospital by preventing accident and illness.

c) Prevention of health care costs for carers – For parent care-givers without adaptations and equipment there is a 90% chance of musculoskeletal damage, falls leading to hospitalisation, and stress caused through inadequate space. When suitable adaptation/equipment is supplied there is improvement to physical and mental health of the carers.

d) Prevention of admission to residential care – Adaptations give support to carers. By preventing back injuries and reducing stress, they lessen the costs to the health service. Carers in turn, if they are well supported, will save the costs of residential care.

(iii) Saving through prevention of waste

Waste is money spent with no useful outcome. There is evidence that much of the waste in regard to adaptations comes from under-funding that causes delay or the supply of inadequate solutions that are ineffective or psychologically unacceptable.

(iv) Saving through achieving better outcomes for the same expenditure

a) Adaptations produce improved quality of life for 90 per cent of recipients and also improve the quality of life of carers and of other family members.

b) A disabled person may have a carer come every day to lift them on and off a commode and help them to wash, but for the same amount of money they would normally choose the solution that offers more dignity and autonomy.

c) The average cost of a disabled facilities grant (£6,000) pays for a stair lift and level-access shower, and these items will last at least 5 years. The same expenditure would be enough to purchase the average home care

package (6.5 hours a week) for just one year and three months.

d) There is substantial evidence that for the average older applicant, an adaptation package will pay for itself within the life-expectancy of the person concerned and will produce better value for money in terms of improved outcomes for the applicant.

The information provided within section 5.1.2 has been taken from "Better Outcomes, Lower Costs" Executive Summary by Frances Heywood and Lynn Turner.

5.1.3 Financial Detail

The detailed presentation on 25th August 2009 covered Major and Minor Adaptations in the Registered Social Landlord (RSL) stock within the borough, private sector – people who own their own homes and those who rent from private landlords, Housing Grant expenditure, joint arrangements with some RSLs on a 50/50 funded basis, spend on 50/50 agreements and a detailed spreadsheet for the capital programme. Throughout this presentation many questions were asked to clarify the financial processes. It was a very thorough session focussing on the detail of the financial processes.

Although close relationships have now been established with the RSLs through both formal meetings and informal connections, one of the issues raised during this presentation was that process issues remain and careful and regular monitoring of the arrangements is essential. Some RSLs were originally slow to send in invoices and there were some delays in Community Care Workers and Occupational Therapists agreeing schemes. These teething difficulties have been managed and processes amended to ensure greater efficiency.

5.1.4 Entitlements, Application Process and Financial Eligibility of Service-User

At the meeting on 6th August 2009 the Project Manager and Housing Renewal Support Officer gave presentations on Entitlements/How people apply for grants and the Application Process and the Financial Eligibility of Service-Users (Means Test).

Again, this is another complex area of the DFG process. The background to the Halton Home Improvement Agency was described with an explanation of the team members and the services offered by the team. The mandatory nature of the grants was discussed with two main pieces of legislation covering them, Housing Grants, Construction and Regeneration Act 1996, with additional guidance in the Department of Health's publication Delivering Housing Adaptation for Disabled

People (A Good Practice Guide) issued in 2004. The types of work that could be considered as DFG eligible were highlighted. It was also confirmed that there is not a waiting list for assessments. A folder was circulated around the group showing photos of before and after situations for various projects that have been completed and some case studies were discussed. Sometimes the proposed works have to be altered because for instance from initial referral by the assessment worker the health of the service-user may have deteriorated so the scheme needs to be changed accordingly. A different scenario can occur because the adaptation process in now much quicker than it used to be so that service-users with degenerative conditions sometimes withdraw from the process as they find it difficult to accept that in future they may need significant adaptations.

The presentation on the application process and financial eligibility of the service-user described how all applicants must go through the financial assessment (except where the DFG is for a disabled child or young person). The various financial forms and processes involved were described at length with examples of the forms being circulated around the group. The financial assessments take into account all income, savings and investments, but not outgoings, e.g. mortgage. The main DFG application form is produced by the Government and can seem quite daunting for applicants to complete, so the Housing Renewal Support Officer offers assistance by going out to visit the service-user at their home. Supporting evidence in the form of statements and documents is required with the form, and again, this can cause delays with the application process. A lot of discussion took place around this area with questions and clarification on the processes involved.

Conclusion

At the end of the topic group meetings, all members felt they had a good understanding of the financial processes involved with major adaptations and DFGs, in particular, the complex nature of some of the financial areas and methods used within the processes. The Disabled Facilities Grant is difficult to comprehend without the background and understanding of the financial procedures and processes involved, as well as the application process and eligibility. It was also highlighted the financial savings to other organisations, in particular health services, with the implementation of adaptations.

Recommendations:

(i) Continue to closely monitor the financial processes that are in place between the Council and the RSLs.

(ii) Consider arranging a further Members Briefing Session focussing on some of the financial complexities of the DFG and including the application/eligibility procedures.

(iii) Consider developing a Business Plan for a financial contribution from Health towards adaptations to set against the savings achieved for health as described in 5.1.2.

5.2 Personalisation and the use of Modular Buildings

5.2.1 Personalisation

Some research was undertaken via the Internet into the links between the DFG process and personalisation/self-assessment. During October 2008 a report by the Individual Budgets Evaluations Network (IBSEN) "Evaluation of the Individual Budgets Pilot Programme" was issued. There was only a small paragraph around DFGs stating *"While it was acknowledged that equipment or adaptations could transform a person's need for personal care, and also reduce social care costs, most Individual Budget (IB) lead officers and lead officers for DFG did not feel that DFG was a suitable or legitimate funding stream to align with IBs. Applications for DFGs required specialist assessments; timescales were not compatible with the IB process; and DFGs involved capital sums, not an income stream to the individual. Most interviewees did not expect individuals would benefit from taking responsibility for managing a DFG (for example, contracting with builders)."*

Despite the difficulties with the current constraints of the present DFG legislation we have already started to move towards the personalisation agenda in working more flexibly to make the process more straightforward and efficient for service users. The provision of stair lifts under the contract agreement is one example of this. Another example is where a family with a disabled child is applying for DFG and so would have no contribution to make. The HHIILS team have identified that the most cost effective way to meet the child's needs could be through providing access to the first floor by a vertical lift and modifications to the first floor bathing facilities. The family instead wish to provide a ground floor bathroom and bedroom extension which would also meet the needs but at much higher cost. Consequently we have agreed to offer grant support to the building of the extension to the estimated value of the scheme proposed by HHIILS. The government has already started to simplify the DFG process with some changes implemented in 2008 and these changes are also about promoting the more flexible approach that has been adopted by HHIILS.

"Shaping the Future of Care Together" A Green Paper sets out a vision for a new care and support system. The Green Paper highlights the challenges faced by the current system and the need for radical reform, to develop a National Care Service that is fair, simple and affordable for everyone.

"Lifetime Homes, Lifetime Neighbourhoods - A National Strategy for Housing in an Ageing Society" by the Communities for Local Government. The ageing of the population will be one of the greatest challenges of the 21st century for housing. This strategy sets out our response to this challenge and plan to create Lifetime Homes in

Lifetime Neighbourhoods. It outlines our plans for making sure that there is enough appropriate housing available in future to relieve the forecasted unsustainable pressures on homes, health and social care services.

5.2.2 Modular Building

Two modular buildings have now been installed in Halton. One being an RSL property in Widnes managed by Halton Housing Trust and the other being in private ownership in Runcorn. The RSL installation was jointly funded with the Council in line with the 50:50 the partnership arrangement but was organised by HHT. The private sector scheme was organised by Property Services with the assistance of consultants Cassidy & Ashton.

On 27th October members of the topic group had the opportunity to take a field visit to observe the Halton Housing Trust modular building being craned into position at the property in Widnes. This was a property requiring an additional bedroom and shower room for a disabled child.

During the meeting on 4th January 2010 the Practice Manager gave a presentation to the topic group on the background to the modular buildings. Research was done into what worked well in other authorities and modular buildings were identified, in particular Salford Council who had been using them successfully for 15 years. The team put forward proposals for the private sector scheme and was successful in gaining funding for a modular building for a family with a disabled son who required an extension to their terraced property in Runcorn. A few people from the team along with representatives from HHT were able to visit the factory of the company that Salford used, at a time when the company was manufacturing a modular building for Salford. The company was then asked to check the Runcorn property to ensure it was viable for a modular building. The installation of modular buildings requires planning permission and building regulation clearance. Legal were also involved. The pod was installed and there was a small issue with the drains not lining up that meant installation was delayed, but this was rectified. The service-user was extremely pleased with the end result and could not fault the staff who had been involved. As this was the first modular building for Halton, feedback was sought from everyone involved in the process, which was extremely positive. The outcome for both of the service users was that they were delighted with the end product and the building work had been less disruptive than a traditional build.

Conclusion
As these were the first two modular buildings to be used for adaptations in conjunction with Halton Borough Council, the success was not fully known until after installation. Members of the group who

attended the actual siting of the second pod confirmed that the process was well managed on the day and went very smoothly. Although building work did take place in both cases, this was less disruptive than a traditional build, which is another positive outcome for the service-users involved. The most significant negative in terms of the use of modular building is the high initial cost of installation at the first location where the cost of the pod and the groundwork are likely to be well in excess of traditional build. The economies only come into effect with the re-use of the module particularly at the third siting when savings are likely to be made.

Throughout the research carried out and with the example case studies given, the link between independent living and the personalisation agenda goes hand-in-hand. It is clear to see that adaptations have a huge role to play in helping people live independently for longer in their own homes.

Recommendations:

(i) Support the continued use of modular buildings for any other relevant situations that require extensions.

5.3 Raising Awareness, the value of Adaptations for Service-Users

5.3.4 Raising Awareness

At the initial meeting of the topic group on 23rd June 2009, the Divisional Manager gave a presentation on the background to the service area, the team and the modernisation of the adaptations service. During 2007 it was agreed that the two teams of Independent Living Service and the Home Improvement Agency and Grants Section would be merged to create the Halton Home Improvement and Independent Living Service (HHIILS) and the team would be located in one base at John Briggs House in Widnes. This change involved staff throughout the whole process, expert support, a programme of meetings focussing on different areas of the merger and research into other services. During the meeting on 4th January 2010 members of the topic group had the opportunity to meet with staff from the HHIILS team and have an informal chat about their work.

Conclusion

The modernisation of the adaptations service has already shown improvements within the delivery of the service, in particular through streamlined processes and improved communications from being located together and part of one service improved problem-solving and further innovation in the development of the service.

Recommendations:

(i) Continue ongoing evaluation/review of the adaptations service so that improvements can be continual.

5.3.5 The Value of Adaptations to Service-users/Carers

At the meeting on 4th January 2010 a service-user and carer attended to give their perspective and experience of the DFG process. The service-user had experience of two adaptations, a kitchen and a shower, one as a Council Tenant and one through Halton Housing Trust (HHT). Following a stroke the service-user described having communications difficulties, but felt that the builders involved in the adaptation went above and beyond to ensure that they gave him all the information to ensure the works were completed with the least disruption. With both adaptations, the service-user chose to stay in the properties while the building works were carried out, although he was offered the option to go into respite care. He felt less anxious staying there and watching the progress for himself. If any minor issues arose he could deal with them there and then. Members of the topic group asked the service-user and carer various questions regarding the adaptations. The service-user thanked the officer from Halton Borough Council who had been pivotal in the success of his adaptations.

Also during this meeting the Divisional Manager distributed copies of draft service-user feedback forms for members of the group to take away and comment on. The aim of the feedback forms is to gather monitoring information from service-users at various stages of the DFG process. It was highlighted that with the introduction of new feedback forms careful consideration was required around training.

Conclusion

It was clear from the experiences described by the service-user and carer that having a new kitchen and shower fitted had made a considerable difference to their quality of life.

The implementation of service-user feedback forms would give the service valuable information throughout the DFG process so that changes and amendments could be made to continually improve the service offered to the residents of the borough.

Recommendations:

(i) Support the implementation of the service-user feedback forms at various stages within the DFG process to ensure ongoing improvements.

(ii) Ensure adequate training for staff within the Contact Centre dealing with the feedback forms is in place.

5.4 Effectiveness of Specifications/Plans

On 25th August 2009 the Project Leader HIA gave a detailed presentation to the topic group on plans and specifications. The presentation covered the detail of these from the initial drawing stage right through to the planning approval stage. A "real" example was used to show exact data such as timescales at various stages. The timescales for Building Regulations is on average six weeks and for planning approval approximately two months. The complex nature of some of the drawings done either manually or using the computer program Autocad was highlighted. The Project Leader also brought along a file containing "before" and "after" photographs of different types of adaptations. This gave a greater understanding to the topic group as to the works involved in the different adaptations, being able to see how a room would alter following the building work.

The Project Leader explained that due to limited resources in the form of technical staff, the Council (through Property Services) has been using Cassidy and Ashton to produce technical drawings. This extra design capacity has helped to increase the number of DFGs to 100.

Conclusion
Having the plans and specifications explained in detail with the differential timescales put this part of the process into context with the other areas. Looking at the before and after photographs made it so much easier to understand the changes rather than just looking at a technical drawing. Knowing that this process is used with service-users, taking them through from start to finish so that they understand the overview of the work involved, the disruption that will take place, but also, the end result. Explaining in this way gives the service-user confidence in what's going to happen, bringing them along the way so they understand every part of the process.

Having more technical staff in-house would reduce the staffing costs that are currently being used on a regular basis with Cassidy and Ashton, although retaining them as a back up for times of pressure would be advantageous.

Recommendations:

(i) Continue to work in this way, closely with the service-users so they fully understand what will be involved with any installation of an adaptation.

(ii) Proceed with the recruitment of the vacant technical post, so that the consultant designers only need to be used on an ad-hoc basis.

5.5 Administration and IT Resources

On 25th January 2010 the Team Support Officer for the HHIILS team attended to present information regarding the role of the administration team. The broad range of tasks that the admin team carry out was discussed and this highlighted both the variety of tasks and the limited resources that were available. Chasing up contractors was described as a regular and time-consuming task as two quotes are required prior to an order for works being placed. The admin team also takes on board chasing up the backlog from RSLs due to the volume of work some of them are currently dealing with. The Team Support Officer confirmed that having in place the 50/50 funding has speeded up the process with RSLs, although some are still experiencing delays purely due to the volume of work. The admin team have a pro-active role in phoning RSLs to find out exactly where their situation is up to and recording it on a spreadsheet. The team would like to appoint an Adaptations Liaison Officer to take on the role of liaising with RSLs so that the admin staff can concentrate on their own role.

The Team Support Officer circulated examples of various spreadsheets that the admin team maintain and explained that each system used to record information is stand-alone, requiring manual input. As well as recording information, these spreadsheets are used to monitor/measure timescales and milestones so that the team know exactly where all projects are up to. A list of each computer system that is used, along with the different spreadsheets used can be found at *Annex 3*.

There are also forms and letters for every stage in the process, and again, these are completed manually. This is very time consuming, especially as each form requires the same personal information inputting for each person.

Conclusion

It was clear to see from the presentation the sheer volume of tasks that the admin team deal with. Not only that, but the fact that the lack of one computerised system to produce, retain and update the information regarding the whole process has a detrimental effect on the team in terms of time wasted duplicating information on each form/spreadsheet, and having to input data onto so many different systems that are completely stand alone and are not able to communicate with each other. The role of progress chasing was identified as a very important part of the success in moving projects forward, but again, this took away time from the admin team to carry out their own tasks.

Recommendations:

(i) ***Approve the in-house design of a bespoke IT system that brings together all the current systems therefore considerably cutting down on time and resources of the admin team.***

(ii) ***Proceed with the recruitment of the Adaptations Liaison Officer post.***

6.0 Overall Conclusion

This scrutiny review has been both a successful and a worthwhile exercise in terms of covering all the outputs and outcomes from the initial topic brief and gaining a thorough knowledge of the whole adaptations service within Halton. All elements of the Disabled Facilities Grant process have been explored and in particular, an in depth examination of the complex financial procedures has taken place.

The recommendations from the scrutiny review have been arranged into an Action Plan at Annex 4 for ease of reference and monitoring.

Annex 1

TOPIC BRIEF

Topic Title: Disability Facilities Grant

Officer Lead: Operational Director (Adults of Working Age)

Planned start date: April 2009

Target PPB Meeting: March 2010

Topic Description and scope:

A review of the Disability Facilities Grant, focussing on developing an understanding of the complexities of the finances within adaptations.

Why this topic was chosen:

Over the last two years, major changes have been made internally to the structure and processes within adaptations. In April 2008 the Independent Living Team, grants team and Home Improvement Agency integrated becoming the new HHIILS Team (Halton Home Improvement and Independent Living Service) based at John Briggs House.

Key outputs and outcomes sought:

- An understanding of the complexities of the financial processes/issues around adaptations;
- Consider national best practice and research in terms of self-assessment, personalisation and the use of modular buildings;
- Raise awareness generally of the service and the value of adaptations for service-users (including finance and independence);
- Examine the effectiveness of specifications/plans to ascertain if these could be simplified; and
- Consider resources available in terms of IT systems to ensure adequate monitoring of the DFG.

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 and efficiently manage illness.

Key Objective E: To remove the barriers that disable people and contribute to

poor health through ensuring that people have ready access to a wide range of social, community and housing services, and cultural and sporting activities that enhance their quality of life.

Halton's Urban Renewal
To transform the urban fabric and infrastructure. To develop exciting places and spaces and to create a vibrant and accessible Halton - a place where people are proud to live and see a promising future for themselves and their families.

A Safer Halton
To ensure pleasant safe and secure neighbourhood environments, with attractive, safe surroundings, good quality local amenities, and the ability of people to enjoy life where they live.

Children and Young People in Halton
To ensure that in Halton children and young people are safeguarded, healthy and happy, and receive their entitlement of high quality services that are sensitive to need, inclusive and accessible to all.

Nature of expected/desired PPB input:

Member led scrutiny review of the Disability Facilities Grant.

Preferred mode of operation:

- Review of the Disability Facilities Grant – including assessment process, other grants, specifications and plans
- Literature review/best practice in other areas, in particular the impact of Personalisation
- Field visits including:
    - To a local authority who use Self-Assessment within DFG;
    - To a local authority who use Modular buildings;
    - Teams involved with DFG working at Halton BC; and
    - Service-users

Agreed and signed by:

PPB chair …… **Officer ……**

Date …….. **Date …….**

Annex 2

Methodology Detail

a) Presentations

The following officers gave presentations as part of this scrutiny review:

Name of officer	**Title of Presentation**
Ruth McDonogh, Divisional Manager	Modernisation of Major Adaptations Service in Halton
Janet Wood, Principal Manager	The Assessment Process for Major Adaptations
Phil Brown, Principal Housing Inspector and Graham Foxley, Budget Monitoring Officer	Financial Assistance for Improving Housing in Halton
Jean Cunningham, Project Manager and Carole Heywoode, Housing Renewal Support Officer	Entitlements/how people apply for grants
Phil Brown, Principal Housing Inspector	Building Works, Monitoring and Meeting Needs
Michele Finney, Occupational Therapist	Accessible Homes Register
Norman Lloyd, Service-User and Glenys Bagley, Carer	Service-user/Carer Perspective
Lynne Royle, Practice Manager	Modular Building
Ruth McDonogh, Divisional Manager	Service-user Feedback Forms
Cherrie Walker, Team Support Officer	Administration within the HHIILS team

Annex 3

IT Systems currently in use

1. ***Carefirst*** – All details and information is recorded onto Carefirst, including basic information, assessments, letters, activities, recommendations and events.

2. ***Msoft*** – This is the system we use to order equipment from the equipment service. All basic detail are recorded on Msoft, also details of the equipment ordered and delivery dates. These are subsequently recorded on Carefirst and in the service users case notes.

3. ***Femis*** – This is the system that records all enquires and outcomes for DFG Major adaptations also Major and Minor Works Assistance Grants. It also monitors performance and time scales. The information regarding DFG Major adaptations is also then recorded on Carefirst, service users case notes and the relevant spreadsheet.

4. ***Home Grants Package*** – This is an in-house system which records financial information, costs of adaptations and calculates grant eligibility. This information is also then recorded on Carefirst, service users case notes and the relevant spreadsheet.

5. ***Excel Adaptations spreadsheets*** – We keep a spread sheet for the following different types of adaptations
   (A new spreadsheet is created each year for each):

   - Major Adaptations DFG Funded
   - Major Adaptations ILT Funded
   - Minor Adaptations – Contracted items
   - Minor Adaptations – Outside of contract
   - Major Adaptations separate spreadsheet for each RSL
   - Minor Adaptations separate spreadsheet for each RSL

Each spreadsheet records all the basic details about a service user's name, address, date of birth, carefirst number, types of adaptation, all dates for specified milestones until completion. This information is already recorded somewhere on one of the other databases above and also in the workers case note for the service user.

We also have a couple of other systems that we use:

- Crimson - this is the Zurich Insurance system, which they use to notify HBC when an annual inspection has been completed on equipment, which has been supplied and is maintained by HHIILS. Each time an inspection is carried out a copy of the report needs to be looked at on Crimson and any issues or queries raised need to be followed up and actioned.

- ADL Smartcare – this is an on line self-assessment tool for service users. Activity on this system needs to be monitored and the admin team on a monthly basis creates summary reports.

All of these different systems and spreadsheets, which do not “talk” to each other, create a great deal of work for the clerical team within HHIILS. But if we had a bespoke system that could communicate with other systems and populate information into specified fields – for instance basic details onto forms, this would improve efficiency considerably and improve the teams overall performance.

ACTION PLAN **ANNEX 4**

Action No.	Action	Responsible person	Timescale	Resources Required	Progress
1	Continue to closely monitor the financial processes that are in place between the Council and the RSLs.				
2	Consider arranging a further Members Briefing Session focussing on some of the financial complexities of the DFG and including the application/eligibility procedures.				
3	Consider developing a Business Plan for a financial contribution from Health towards adaptations to set against the savings achieved for health as described in 5.1.2.				
4	Support the continued use of modular buildings for any other relevant situations that require extensions.				
5	Continue ongoing evaluation/review of the adaptations service so that improvements can be continual.				
6	Support the implementation of the				

	service-user feedback forms at various stages within the DFG process to ensure ongoing improvements.				
7	Ensure adequate training for staff within the Contact Centre dealing with the feedback forms is in place.				
8	Continue to work in this way, closely with the service-users so they fully understand what will be involved with any installation of an adaptation.				
9	Proceed with the recruitment of the vacant technical post, so that the consultant designers only need to be used on an ad-hoc basis.				
10	Approve the in-house design of a bespoke IT system that brings together all the current systems therefore considerably cutting down on time and resources of the admin team.				
11	Proceed with the recruitment of the Adaptations Liaison Officer post.				

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 4 March 2010

REPORTING OFFICER: Strategic Director – Health & Community

SUBJECT: Prevention & Early Intervention Strategy

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the local Prevention and Early Intervention Strategy.

2.0 **RECOMMENDATION: That:**

i) Comment on the draft strategy;
ii) Comment on the implementation plan

3.0 **SUPPORTING INFORMATION**

3.1 There is an increasing need to change the way in which Health and Social Care services are commissioned and delivered in the future. The changing needs of society alongside the ageing population and the emerging personalisation agenda will require different solutions than we have provided in the past.

3.2 The increase in the older population is likely to have an impact on the number of people with a long-term condition or with increased health needs. The current resources available through Health and Social Care will not be sufficient to address this challenge. A number of National documents have been identified (see section 4) to support the shift towards prevention services and the local prevention and early intervention strategy aims to identify the direction of travel in Halton.

3.3 In addition to the rapid increase in the older population we are currently facing some of the most difficult economic challenges for some years. This will further increase the need to take a radical new approach to the services we provide.

3.4 The implementation plan will be owned by the Older People's Commissioning Manager and will be performance managed through the Older People's Local Implementation Team. In addition a steering group will be developed to support the completion of the project plan.

4.0 POLICY IMPLICATIONS

4.1 Prevention

There are a number of National and local documents that further support the development of the prevention and early intervention strategy. The **Government White Paper: Our Health, Our Care, Our Say (January 2006)** outlines the overall shift from complex care to prevention and this is further evidenced in Putting **People First – Transforming Adult Social Care (2007)** and **High quality care for all (Darzi report 2008)**. These documents demonstrate the importance of prevention and how an agreed model of early intervention could work across a number of service areas.

4.2 Personalisation

On 17th January 2008, the **Department of Health issued a Local Authority Circular entitled 'Transforming Social Care'.** The circular sets out information to support transformation of social care and at the heart of this change is the personalisation agenda. As we develop community provision within dementia services we will need to consider the implications of personalisation for people diagnosed with dementia to maintain their independence.

4.3 Local perspective

Locally, to support these National documents, the **Older People's Commissioning Strategy and the Advancing Well Strategy** identify the need to support Older People to maintain their independence and a high quality of life. These documents look at the need for a range of support services to help people achieve the best outcomes for them including information, transport, advocacy and health promotion.

5.0 FINANCIAL IMPLICATIONS

5.1 One of the agreed actions from the implementation plan is to complete the financial mapping of each of the ten service areas as described in the Performance Triangle (figure 1 in Executive Summary of the strategy). This financial mapping will identify current spend across the whole system and will consider the future need based on the development of the strategy. Any additional resources for this strategy will be within existing budgets. The evidence base for early intervention and prevention is sufficiently robust to support the principal of an invest to save approach.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The intergenerational strand of the strategy will promote greater understanding and respect between generations, and contribute to building more cohesive communities.

6.2 **Employment, Learning & Skills in Halton**

The strategy supports improved access to employment and volunteering opportunities

6.3 **A Healthy Halton**

Investment in early intervention and prevention across a very broad range of organisations can impact on the health and wellbeing of older people and the degree to which their communities are 'strong and supportive.'

6.4 **A Safer Halton**

Early intervention and prevention is focussed on community support and social inclusion, this includes the need to develop safer neighbourhoods. One example of this is the use of Telecare services, which supports people to feel safer and more supported in their own homes.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 This strategy outlines the key risks and issues that commissioning faces in relation to the changing demography and needs of older people in Halton. If these areas are not addressed then the risk to health inequalities, economic burden, strain on frontline health and social care services would be extreme. It is also clear that the strategy must be implemented alongside the emerging personalisation agenda.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The prevention and early intervention strategy will play an important role within the emerging dignity agenda as well as cutting across a number of service areas including adults of working age, improved access to services and improved quality of care.

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

None.

DRAFT

Halton Prevention and Early Intervention Strategy

February 2010

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Executive Summary

Halton Borough Council and NHS Halton and St Helens have drawn up this Joint Prevention and Early Intervention Strategy to establish a clear framework and rationale to support an increased shift to improving preventive and early intervention services in the borough. The document is a local response to the National picture and is informed by a number of National documents 'Making a strategic shift to prevention and early intervention – a guide' Department of Health (2008), 'Our health, our care, our say' (2006), 'Putting People First' (2007), 'Transforming Social Care (2008) and 'High quality care for all' ('the Darzi report', 2008).

The strategy defines the three distinct areas of prevention as:

- Primary Prevention / Promoting Wellbeing

This is aimed at people who have no particular social or health care needs. The focus is on maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc.

- Secondary Prevention / Early Intervention

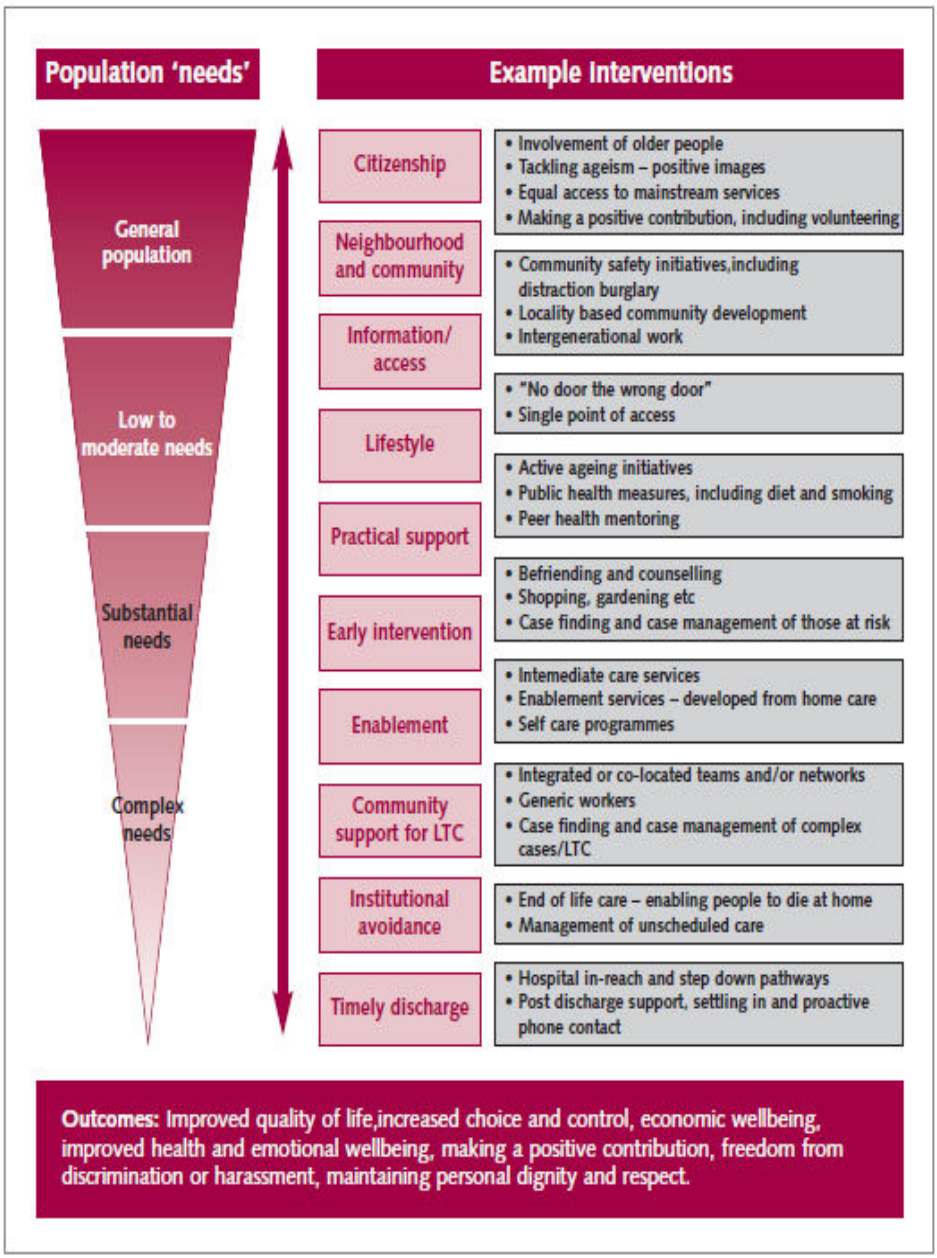
This is aimed at identifying people at risk and to halt or slow down any deterioration, and actively seek to improve their situation. Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those that they have existing low level social care needs.

- Tertiary Prevention

This is aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus is on maximising people's functioning and independence through interventions such as rehabilitation / enablement services and joint case-management of people with complex needs.

By clearly defining prevention in this way we can begin to consider how addressing people's low-level needs and wants we can begin to shift service provision from high cost complex care to more cost effective low-level support. The strategy is structured around a spectrum of interventions that is illustrated in figure 1 later in the document. The **'Triangle Framework'** outlines ten example interventions that can support people regardless of their health and social care needs.

Figure 1 'Triangle Framework' showing the relationship between different levels of population need and a relevant range of intervention



The prevention and early intervention strategy maps the current activity in Halton against one of the ten headings. The first five headings Citizenship, Neighbourhood and Community, Information / access, Lifestyle, Practical Support fall under primary prevention. Secondary prevention includes early intervention and enablement. Tertiary prevention includes Community support for long-term conditions, institutional avoidance and timely discharge.

There is emerging evidence from the evaluation of the Partnerships for Older People Projects (POPP) that by funding more services at the top of the triangle then the greater the impact on acute services. For example the Department of Health evaluation of POPP suggests that for every £1 spent on prevention services an average of £0.73 is saved on the per month cost of emergency hospital bed days (an overall benefit to the health and social care economy of £1.73). This is the first major piece of evaluation that adds a financial element to demonstrate and further enhance the benefits enjoyed by most service users.

When we consider the local context in Halton there is no shortage of low-level services, information provision on a generic or specialist level is widely available, carers support, Advocacy, practical tasks, health improvement the list is endless and the mapping that has been carried demonstrates the huge level of services that are being delivered. However, the clear gap is the co-ordination of these services. This strategy sets out to address this and consider the benefits of developing a system of improved partnerships (by further developing the Partnerships in Prevention work) and increased navigation through the system to improve an individual's service experience.

Halton Joint Commissioning Strategy for Prevention and Early Intervention

1. Introduction

This strategy has been drawn up to establish a clear commissioning framework to support the development of a coherent system for prevention and early intervention, informed by and consistent with current Department of Health guidance: '*Making a strategic shift to prevention and early intervention – a guide'* (2008). The objective is to make communities safer and more supportive, provide earlier and more appropriate support and care to enable citizens to remain independent for longer.

The strategy is also intended to be consistent with and promote the objectives of *'Our health, our care, our say'* (2006), *Putting People First* (2007), *Transforming Social Care* (2008) and *'High quality care for all'* ('the Darzi report', 2008.)

It is a 3-5 year joint health and local authority strategy that is broadly based and which has been developed with a wide range of partners. The focus, in accordance with the Department of Health guidance, is on promoting the independence of all adults.

The strategy places particular emphasis on the development of 'low level' arrangements to support prevention. This reflects the fact that while there has been some significant development of earlier and lower level interventions there has been more investment and greater focus, in recent years on developing higher level, more focused and intensive interventions.

Current provision for prevention and early intervention in Halton has been looked at through a mapping exercise, and considered alongside national guidance on the development of a balanced array of interventions. This has helped to identify gaps in provision, areas where services need further strengthening and priorities for the commissioning programme.

2. Background

There has been a significant and growing emphasis, in recent national strategy reports, on the need to change the way adult social care services are delivered in response to the demographic challenge of an ageing population, and on the need for

a whole system response built around personalised services with increased emphasis on prevention, early intervention and enablement.

The change in the structure of the population presents a significant challenge to health and social care services. Life expectancy has increased considerably with a doubling of the number of older people since 1931. Between 2006 and 2036, the number of people over 85 in England will rise from 1.055 to 2.959 million, an increase of approximately 180%. Ill health and disability increase with age and this is reflected in the forecast that the number of people over 65 with a limiting long term illness in England will increase from 3.9 million in 2009 to 6.1 million in 2030 (DH, www.poppi.org.uk) which is likely to be accompanied by an increase in the demand for support across the continuum of need.

The 3 'Wanless reports' (DH, 2002, and 2004, Kings Fund, 2006) showed that the cost to the public purse is greater when services are focussed on intensive interventions to manage complex health and social care needs, and that it is cost effective to shift the focus to prevention and the promotion of good health, supporting people in the community and reducing reliance on residential and acute hospital care.

'Our health, our care, our say,' outlined the reform needed in both social and health care services to respond to the demographic challenge and rising expectations in the population. 'High quality care for all', the Darzi report, building on the direction set in the White Paper highlighted the need to improve prevention, deliver services as locally as possible, and deliver patient choice and personalisation. Putting People First and Transforming Social Care have provided clear direction for the required transformation of social care and have made it clear that the new adult care system requires a collaborative approach with a broad range of partners to redesign local systems around the needs of citizens.

In Putting People First the development of this collaborative approach to the transformation of adult social care was formally acknowledged through a 'concordat' 'between central and local government, the sector's professional leadership, providers and the regulator.' This collaborative approach reflected the recognition that while some of the transformational reforms could be made through local adult social care policies 'others required adult social care to take a leadership role within local authorities, across public services and in local communities.'

A central objective of the transformation is that 'ultimately every locality should have a single community based support system focussed on the health and wellbeing of the local population. Binding together local Government, primary care, community based health provision, public health, social care, and the wider issues of housing, employment, benefits advice and education training.' The local approach should therefore utilise all relevant community resources especially the voluntary sector so that prevention and enablement become the norm, supporting people to remain in

their own homes for as long as possible, with the alleviation of loneliness and isolation as a major priority.

The system-wide nature of the transformation envisaged in Putting People First requires clear linkage with the local strategic planning arrangements provided by the Sustainable Community Strategy and Local Area Agreements, and to be informed by the picture of need established through the local Joint Strategic Needs Assessment.

The central themes of Putting People First were reinforced in Transforming Social Care which said that 'the direction is clear: to make personalisation, including a strategic shift toward early intervention and prevention the cornerstone of public services.'

More recently in *'Building a society for all ages'* (DWP, 2009) the government has set out for consultation a broadly based programme of action to achieve a 'shift in attitude and behaviour across society so that old age is no longer perceived as a time of dependency and exclusion.' The programme is intended to support changes for individuals, families, for the workplace and economy and for public services and communities. The proposals include:

- More support to assist people who want to keep working for longer, and to enable businesses to tap into the experience and commitment of older people
- Improved access to support for mid-life decisions on such matters as financial and health concerns through an interactive 'one-stop shop'
- Initiatives to help people as they get older take advantage of sporting, educational or social opportunities including 'all-in-one cards' to give access to a range of local activities
- A 'grandparents summit' to consider the changing structure of families, with more active grandparents having the opportunity to play a greater role in their families lives including caring for grandchildren, and to consider what extra help they may need
- A health prevention package focusing on preventative services for conditions that affect people in later life (such as footcare, falls prevention, continence care, depression and arthritis)
- Recognition for the key role that people fulfil in later life in providing the lifeblood of communities through volunteering, caring and playing an active role in community life, through support for intergenerational projects to breakdown barriers and challenge negative stereotypes

To assist localities to achieve the strategic shift outlined in Putting People First and Transforming Social Care, the Department of Health has provided practical guidance for local authorities and health communities on how to make the shift to early intervention and prevention in 'Making a strategic shift to prevention and early intervention – a guide' (DH 2008) (hereafter referred to as 'the Guide'), and more

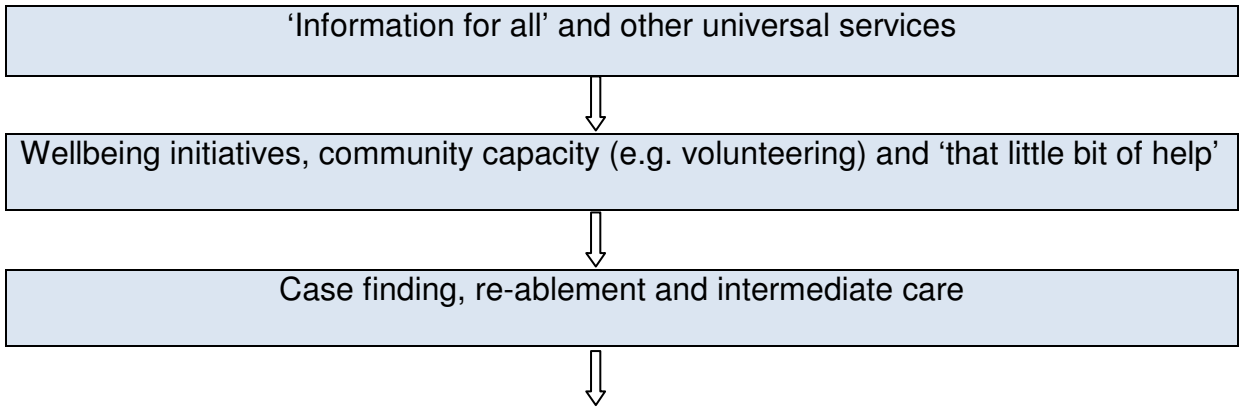
recently has published 'Prevention Package for Older People Resources' which provides examples of successful approaches in relation to such areas as falls and fractures, footcare, telecare/telehealth, hearing services, accidental injuries and intermediate care. Both documents provide evidence based examples of best practice with reference to the evaluation of demonstrator sites, the Partnerships for Older People Projects (POPPs) and the LinkAge Plus projects.

The focus of the Guide is on promoting the independence and wellbeing of citizens.

The following sections follow the framework that is set out in the guidance, which builds on the model of four interdependent themes at the heart of the vision for social care in Putting People first:

- Facilitating access to **universal services**[1]
- Building **social capital**[2] within local communities
- Making a strategic shift to **prevention and early intervention**
- Ensuring people have greater **choice and control** over meeting their needs

These interdependencies can be considered as a pathway. Initially people access *mainstream or universal services,* then as their needs progress and they prepare for old age they are likely to require a wide range of support and *capacity developed within local communities*. A rapid deterioration or crisis may occur, leading them to benefit from *preventative work* – such as enabling or rehabilitative support which helps people to regain a level of their previous functioning. Any ongoing needs are then met in a personalised way through the provision of an individual budget which gives them maximum *choice and control* over how they arrange their support.



[1] Services such as Education, Transport, and Leisure and services that may be available to all older people in an area such as handyman schemes, gardening, shopping, and signposting services.
[2] 'Key indicators of social capital include social relations, formal and informal social networks, group membership, trust, reciprocity and civic engagement.' Office of National Statistics (2001)

Ongoing support: Individual budget / Choice and control over how they are deployed / Personalised care plan for those with Long Term Conditions

3. What is 'Prevention'

Health England the national reference group for health and wellbeing (established to oversee the evidence base for the strategic shift envisaged in 'Our health, our care, our say') has proposed that in this context 'prevention' is defined as:

'*a clinical, social, behavioural, educational, environmental, fiscal or legislative intervention or broad partnership programme designed to reduce the risk of mental and physical illness, disability or premature death and/or to promote long-term physical, social, emotional and psychological wellbeing*'.

The approach in the Guide, on the other hand, is to propose a framework which has a broad focus and which identifies three categories of prevention:

3.1 Primary Prevention / Promoting Wellbeing

This is aimed at people who have no particular social or health care needs

The focus is on maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc

3.2 Secondary Prevention / Early Intervention

This is aimed at identifying people at risk and to halt or slow down any deterioration, and actively seek to improve their situation

Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those that have existing low level social care needs

3.3 Tertiary Prevention

This is aimed at minimising disability or deterioration from established health conditions or complex social care needs

The focus is on maximising people's functioning and independence through interventions such as rehabilitation / enablement services and joint case-management of people with complex needs.

The key message is that interventions are required across the whole spectrum of need, to help older people who are healthy to continue to live independently for longer and to assist older people who are unwell to regain their independence or to prevent or delay the onset of further health problems.

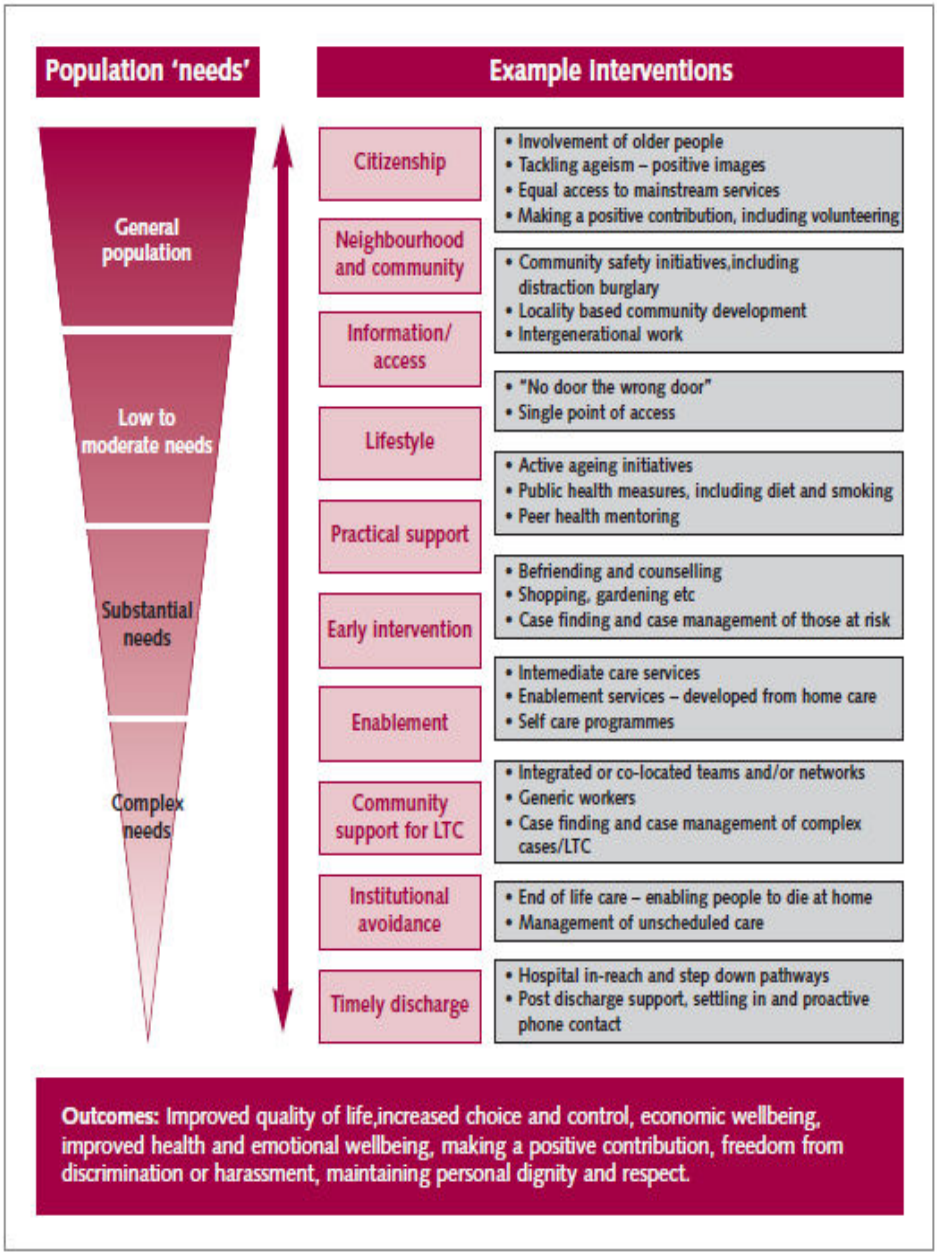
4. A Broad Spectrum of Interventions is Required

The generally prevalent model of care in the recent past has been shown to have developed an increasing focus on providing intensive interventions for a relatively small number of people with the greatest needs (*All Our Tomorrows – Inverting the Triangle of Care',* (ADSS, 2003) and *Cutting the cake fairly: CSCI review of eligibility criteria for social care* Commission for Social Care Inspection (2008.))The strategic shift required to deliver the transformation envisaged in Putting People First requires an approach that 'inverts the triangle' and addresses the whole population of citizens. This approach requires a broad spectrum of interventions ranging across:-

- **Citizenship Rights**: promoting active involvement, ensuring equality of access, tackling discrimination
- **Neighbourhood and Communities:** that have a clear identity and vibrancy, that are safe to live in, with cohesion across the generations
- **Information:** about ways to maintain independence or to access support to do so, with help available to 'navigate' around the system. Access routes and information systems joined up so that 'no door is the wrong door' and support to make sense of information.
- **Health Lifestyles Promotion:** working with Public Health promotion and including mental wellbeing and emotional health
- **Practical Support:** through a range of low cost services that may include emotional help as well as low cost practical support, that generally involve 'simple' eligibility criteria or fall outside social care eligibility criteria and are principally delivered by the voluntary and community sector
- **Early Intervention:** working proactively to identify people whose independence is at risk, using tools to predict risk and case finding
- **Enabling** or rehabilitative response: maximising peoples functioning, through for example 're-engineering home care' and intermediate care developments
- **Community Support for Long Term Conditions:** which is best delivered through health and social care working closely together
- **Institutional Avoidance:** through initiatives to prevent inappropriate admissions to care homes or hospital. Intensive care management and extra care housing are examples
- **Timely Discharge:** interventions which enable people to spend no longer than is necessary in hospital and to return safely to their own homes, for example hospital Inreach services

The following diagram illustrates the spectrum of interventions and the relationship to the areas of need to which the interventions relate, although it is important to note that even those with complex needs will want to make use of many of the 'lower level' interventions.

Figure 2 'Triangle Framework' showing the relationship between different levels of population need and a relevant range of intervention



5. Key interventions for generating the strategic shift to prevention and early intervention:

Within this broad range of interventions the Guide identifies the following as the key interventions required to create the shift to prevention and early intervention:

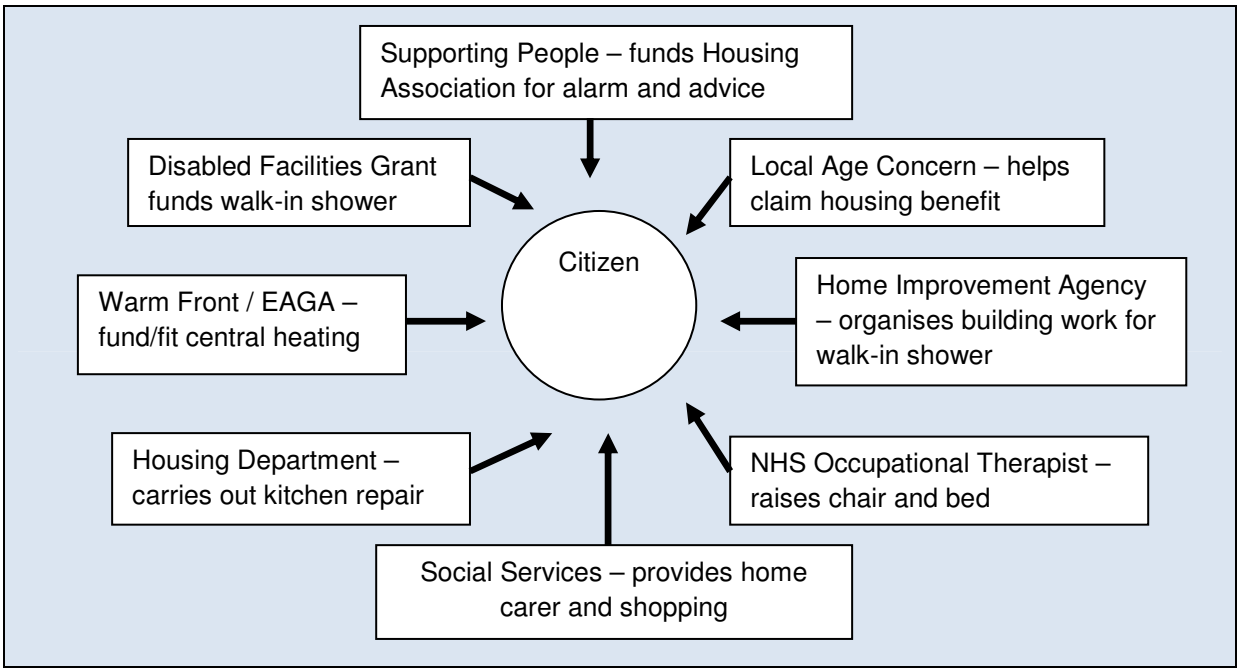
- Age proofing mainstream services
- Range of wellbeing services
- Providing information to all
- Case finding
- Case co-ordination / service navigation
- Managed pathway for those not eligible for ongoing social care
- Building capacity in local neighbourhoods
- Re-ablement
- Joint health and social care community support for people with long term conditions / complex needs
- Support to care homes
- Crisis response / out of hours services
- Telecare
- Extra Care Housing
- Supporting People Programme
- Falls
- Carers

6. Engaging with Partners in a Whole System Approach

Delivering the strategic shift to prevention and early intervention requires a 'whole system' approach that does not just involve health and social care, it needs to involve a broad range of other council departments or statutory organisations 'with a responsibility to act, and with money to invest' including supporting people, public health, community safety, leisure and cultural services, together with community and voluntary organisations and other stakeholders such as the Pensions Service, and the Fire and Rescue Service.

The contributions of resources from partners in the whole system is well illustrated in the following figure taken from *'Lifetime Homes, Lifetime Neighbourhoods: a national strategy for housing in an ageing society'* (CLG, 2008)

Figure 2: Resource Contributions from a Whole Systems Perspective



6.1 Promoting independence, active citizenship and participation

The model of the vulnerable adult as simply the passive recipient of support is inappropriate and unhelpful in this context. The prevention and early intervention model should be one in which there is 'a shift in the perception of vulnerability from one of dependency and decline into one of active citizenship, participation and independence. Underpinning this is a move towards earlier intervention to make communities safer and more supportive, provide earlier and more appropriate support and care to enable vulnerable adults to remain independent for longer, reduce social isolation and exclusion, maximise income and the ability to work, and encourage healthier more active living.' *LinkAge Plus National Evaluation: End of Project Report'* (DWP – 2009)

As Age Concern has observed in a recent report on prevention projects 'Services that promote interdependence and social involvement may be more effective than those that encourage self-sufficiency. Timely provision of practical support, which enables older people to maintain their homes and gardens in a safe, comfortable and attractive state, sustains a sense of competence and wellbeing. Services that provide opportunities for social engagement, or which facilitate access to social and community facilities, enable older people to lead more fulfilling and rewarding lives. Opportunities for older people to contribute can be more beneficial than the passive

receipt of help. Familiar services may need to be re-examined, with commissioners, service providers and older people jointly clarifying the purpose, intended outcomes and methods used.' *'Prevention in Practice, service models, methods and impact'* (Age Concern, 2009)

Similarly the LinkAge Project evaluation noted that 'A key feature of the pilots is the way in which they have engaged older people in activities that help them to develop and sustain social networks, are enjoyable and/or educational and/or involve physical exercise, and help improve the experience of growing older. These include initiatives designed to improve physical and mental health, education and lifelong learning, leisure, employment, welfare entitlements, social benefits and access to transport.'

7. Measuring the Impact of Prevention and Early Intervention – Evidence of Effectiveness

A wide range of effective interventions have been demonstrated through programmes such as the Partnership for Older People Projects (POPP) and LinkAge Plus which have been used to stimulate innovative approaches and to encourage innovative partnership working.

7.1 The POPP Programme

The POPP programme, funded by the Department of Health has supported 470 projects in 29 pilot sites aimed at creating a sustainable shift in resources and culture away from institutional and hospital-based crisis care for older people towards earlier, targeted interventions within their own homes and communities. The projects have been stratified into those focused toward Universal Services, Additional Support and Specialist Support. The interim national evaluation has shown that:

- For every £1 spent on POPP, an average of £0.73 is saved on the per month cost of emergency hospital bed-days (an overall benefit to the health and social care economy of £1.73)
- Analysis of those sites where data was currently available (October 2008 - 11 out of 29 sites) appeared to demonstrate the cost-effectiveness of POPP projects.
- Service users reported that their health-related quality of life improved in five key domains

The recent Department of Health guide on the 'Use of Resources in Adult Social Care' (October 2009) concludes that: 'Findings from the POPPs pilots are beginning

to provide a stronger evidence base that demonstrates that particular approaches can save money for both the health and social care economy.'

Evidence from the evaluation of the POPP projects suggests the savings are most pronounced with interventions focused on:

- Hospital Avoidance interventions such as intermediate care, rapid response, hospital in-reach, case management of long term conditions etc

And that that they have also demonstrated a 'discernable' savings effect when focused on:

- Improving peoples quality of life such as befriending, peer support, practical assistance etc

Key learning from the POPP programme is that:

- A balanced portfolio of investment across the full range of interventions is needed
- Engagement with older people is an essential requirement for successful service redesign

7.2 The LinkAge Plus Programme

The LinkAge Plus programme was funded by the Department of Work and Pensions, and involved support for 2 years for over 100 initiatives in 8 pilot areas. The initiatives were characterised by joining up services and partnership working. The approach was preventative with a focus on providing a 'little bit of help' to enable older people to remain independent for longer. They adopted a 'whole person' approach, going beyond adult social care and health to promote wellbeing and independence including practical support to improve the take up of benefits and reduce social exclusion. They also had a focus on developing 'single access channels' avoiding duplication and making it easier for people to contact services with an emphasis on 'no wrong door'.

The national evaluation findings were that:

- The initiatives broke even in the first year after the investment period
- The net present value of savings up to the end of the five-year period following the investment was £1.80 per £1 invested.
- LinkAge Plus helped to facilitate services that are cost effective in their own right, including fire and crime prevention, and reduced falls associated with balance classes and home adaptations

- Combining the costs and benefits of these services in LinkAge Plus areas with the holistic approach to service delivery was shown to increase the net present value to £2.65 per £1 invested;
- In addition to taxpayer savings they calculated that there were benefits to older people that could be monetised at £1.40 per £1 invested.

In its conclusion the evaluation report says that 'Preventative services are likely to lead to improved quality of life and a reduction in the need for more costly interventions in the longer term. Partnership working has helped local services to be more 'joined up', particularly between the voluntary and community and statutory sectors, resulting in a reduction in duplication and overlap' and that the LinkAge projects have 'demonstrated a range of activities that help older people grow older in strong and supportive communities in a cost effective way.' 'LinkAge Plus is providing 'that little bit of help' (Joseph Rowntree Foundation, 2005) which enables older people to retain choice, control and dignity in their lives and is helping to deliver services that are contributing to the improvement of older people's quality of life and healthy life expectancy and active participation.'

A clear indication of the perceived value of the POPP and LinkAge Projects can be seen in the fact that only 4% of the projects across the POPP programme have indicated that they do not intend to sustain their service after the end of DH funding and that local funding has been secured to continue all of the LinkAge projects.

8. A Whole System Perspective on Investment and Impact

It is important for partners to understand how investments in one part of the system can produce benefits in another part. The recent Department of Health publication on making the best use of resources in adult social care points out that 'the POPP programme has shown that investment in social care interventions can produce capacity gains in the acute health sector (DH, 2009). This strengthens the case for working together and to make best use of the sectors' collective resources, with an agreement on which party invests its money in which areas.'

The DH Guide advises that social care and health commissioners should work together to 'consider how resources may be released from across the whole system and redirected to enable investment in early intervention and prevention for all levels of need'. It also encourages engagement with Practice Based Commissioning, for example, 'in relation to people with long term conditions, where there may be a possibility of initiating a 'virtuous cycle' of investment, - i.e. re-investing savings from reduced hospital admissions into more joint working on preventative approaches. In relation to which case finding and joint health and social care teams may be of particular relevance'

The LinkAge Projects have shown that investment across a very broad range of organisations can impact on the health and wellbeing of older people and the degree to which their communities are 'strong and supportive.'

9. The Local Context

9.1 Demographic Factors

From the 2005 Housing Needs Survey and 2001 Census statistics we can estimate that 1 in 5 people in the Borough (24,920) have a Limiting Long-term illness. Locally, research undertaken to support the implementation of the NSF for Long-term neurological conditions (LTNC) estimates that 2.5% of the population across the PCT footprint have a LTNC excluding those who have suffered a stroke – for Halton this is just under 3000 people.

Population projections for people over 65 for Halton and for St Helens from 2009 – 2030 are shown in the table below along with the projections for limiting long-term illness. (The Office for National Statistics data for people below the age of 65 appears in bands from 45-55 and 55-65, it is not possible therefore to extract data for the 'over 50' population.)

Table 1: Population and Long-Term Illness Projections

Total population 65 and over					
	2009	**2015**	**2020**	**2025**	**2030**
Halton	17,100	20,500	23,100	25,500	27,900
St Helens	30,200	34,500	37,200	39,800	43,200
Total population aged 65 and with a limiting long-term illness					
	2009	**2015**	**2020**	**2025**	**2030**
Halton	9,464	11,299	12,742	14,188	15,566
St Helens	17,123	19,573	21,195	22,887	24,845

As can be seen, the Office for National Statistics forecast is that that there will be a very significant growth in the population of older people in the boroughs between 2009 and 2030 with an increase in the number of people over 65 in Halton of 63% and in St Helens of 43% compared to a national average increase of 53%. This is anticipated to be accompanied by a corresponding increase in limiting long-term illness, for people in this age range, of 64% for Halton and 45% for St Helens, the national average increase being forecast to be 55%. Without further development of prevention and early intervention measures the increased numbers of older people, many with limiting long-term illnesses will be likely to significantly increase the local demand for residential and acute hospital care

The increase in the number of older people and in the number of people with long term conditions will put additional pressure on carers. This pressure will be experienced particularly by older carers as over the same period the available pool of younger carers will be shrinking as the population of people aged 18-64 is forecast to reduce by 4.3%.

Nationally the number of adults with learning disabilities is around 2% of the population and it is estimated that around 20% of these people are known to social care. The remaining 80% have mild/moderate learning disabilities and may not be known to services needing little support beyond their own families, friends and social networks. Projections by the Centre for Disability Research (2008) suggest that more people with mild to moderate learning disability will become known to and start using services and it is anticipated that by 2018 the number of people accessing services will increase by 50%. Thus it is crucial to provide information about and access to a range of preventative or early intervention services to ensure that existing informal support networks can continue.

9.2 Local Drivers, Priorities and Targets

9.2.1 Sustainable Community Strategies

Sustainable Community Strategies provide the overarching strategic framework for local authority areas setting out key stakeholders' locally agreed priorities for long term programmes of development.

Considerable identity of purpose is evident in the development of community strategies and the development of prevention and early intervention strategies with both concerned to prevent ill health and disability and promote well-being in the local community. Similarly both recognise the need to look at the wider determinants of health, to respond to the needs of an ageing population, to encourage community engagement and social inclusion, recognise the key role of the voluntary and community sectors, and the need to develop safer neighbourhoods. There should therefore be a strong positive interaction between achieving the objectives of the Prevention and Early Intervention Strategy and achieving the objectives of the local community strategies.

9.2.2 Local Area Agreements

A Local Area Agreement (LAA) is an agreement between Central Government and the local authority and its partners about the priorities for the local area, expressed in terms of a set of targets taken from a National Indicator set of 198 targets. They are integral to the Sustainable Community Strategies and have been identified as fulfilling the role of a delivery plan for them.

9.2.3 NHS Halton and St Helens 'Our Ambition for Health – Commissioning Strategic Plan' (2009)

'Our Ambition for Health' sets out a clear direction for commissioning health provision in Halton and St Helens based on:

- Helping people to stay healthy
- Detecting illnesses earlier
- Improving the quality and safety of services

This translates into 6 Ambition for Health goals:

- Supporting a healthy start in life
- Reducing poor health resulting from preventable causes
- Supporting people with long term conditions
- Providing services to meet the needs of vulnerable people (including older people and people with physical and sensory disabilities)
- Making sure our local population has excellent access to services and facilities
- Playing our part in strengthening disadvantaged communities

The strategic plan for the commissioning of health services for Halton has a clear focus on prevention and early intervention, on responding to the needs of the ageing population and to people with long-term conditions, and providing services accessible to people in their local communities. It is clearly consistent with the objectives of this strategy, which should contribute to the achievement of its goals.

9.2.4 Advancing Well – Improving the Quality of Life for Older People in Halton, 2008-11

Halton's 'Advancing Well' Strategy was developed to promote more independent living and reduce the social isolation often experienced by older people, with a focus on those aged 50 or older. It promotes joint action by the various departments of the Council with partners in organisations such as transport, job centres, colleges, health facilities, sport and leisure facilities, and housing with an approach based on ensuring older people have a say in the development of their local services.

The strategy aims to ensure that older people:

1. Are helped to get around through better **transport** links

2. Are given opportunities for **employment** whether paid or volunteer work

3. Remain in **good health** longer

4. Feel **safe** and secure and are given support to **live independently** both inside and outside their home

5. Have easy access to **advocacy services and financial advice**

6. Receive effective **communication** and **information**

Advancing Well has provided a sound foundation for the closely related work that is now being developed around prevention and early intervention. The focus on promoting independent living and reducing the social isolation of people aged 50 and over through joint action by a range of local organisations is reflected in a number of the key themes of this strategy, which in turn will help to consolidate and progress the earlier strategy's objectives.

9.2.5 Joint Commissioning Strategy for Older People, 2009-2014

This provides an overarching strategy for the commissioning, design and delivery of services to older people in Halton. The theme of prevention and early intervention is central to the section of the strategy on 'Quality of Life' which commits partners to a 3 year programme of developing and implementing the 'prevention agenda,' a process which is being initiated through the development of the strategy set out in this paper.

9.2.6 Halton and St Helens Joint Commissioning Strategy for Dementia 2009

Currently there is a lack of awareness and a cycle of stigma that prevents or delays people with dementia and their carers from getting the help that they need. As a result most people with dementia never receive a diagnosis, increasing the likelihood that they will need admission to hospital and residential or nursing home care. The services available to support those that are referred for assessment and treatment are acknowledged to be limited and under-resourced. The National Dementia Strategy 2009 (NDS) recognised these failings in current health and social care systems and produced a set of recommendations to remedy these systemic failings and enable local commissioners develop to develop comprehensive local services

The Joint Commissioning Strategy for Dementia addresses all of the recommendations of the NDS and sets out a broad programme of development for the boroughs that is intended to address public health issues, raise awareness,

combat stigma, facilitate the development of peer support, and provide comprehensive early assessment, care and treatment to all who need it.

As the number of older people in the population rapidly increases this will be accompanied by a proportional increase in the number of people with dementia. The development programme set out in the Joint Commissioning Strategy for Dementia will therefore play an increasingly important role within the boroughs' overall prevention and early intervention strategy.

9.2.7 Intermediate Care Services

The National Service Framework for Older People promoted intermediate care services as a way to impact on unnecessary hospital admissions, reduce length of hospital stay and prevent unnecessary admissions to long term care in residential establishments. The key role played by Intermediate Care services in supporting secondary and tertiary tier prevention and early intervention is highlighted in the Guide. In the spectrum of interventions they can be seen as playing a key role, in particular in relation to the 'Early Intervention', 'Enablement' and 'Timely Discharge' categories.

Intermediate care services have played a significant part in achieving improvements in overall outcomes for people in Halton over the past 5 years. This has been reflected in a steady reduction in emergency admissions and acute hospital bed utilisation, the reduction being greater in the over 65 population. The number of people living in care homes has more than halved. Over the same period of time the number of people over 65 supported at home has tripled, so Halton is now one of the highest performers in England. This approach has also reduced the size of on-going care packages so that people are able to live more independently with lower levels of support.

Intermediate Care services in Halton have been delivered through 4 main services:

- Rapid Access Rehabilitation Services (RARS)
- Residential intermediate care beds
- Nursing intermediate care beds
- Domiciliary re-ablement service

Recently further service developments have been approved in response to identified pressures such as the ageing population projections and increasing levels of demand on the existing service to:

- Reduce the age criteria for RARS down to 18+

- Establish a sub-acute Intermediate Care Unit on the Halton Hospital campus, and decommission the nursing intermediate care beds.
- Develop an assessment service to manage community, A&E and hospital referrals.
- Implement the Gold Standard and Performance Management Framework for Intermediate Care in Halton

While there maybe potential for further developments in Intermediate Care services in Halton, it is clear that the current service is already making a significant contribution to secondary and tertiary tier prevention.

9.2.8 Telecare and Telehealth Services

Telecare and telehealth services use technology, typically sensors/ monitors linked to contact centres or health professionals to help people live more independently at home. They include environmental and health-monitoring devices and personal alarms and are especially helpful for people with long-term conditions, as they can give the user and their relatives peace of mind that they are safe in their own home. They can also help people to live independently in their own home for longer, avoiding the need for hospital admissions and delaying or preventing the need to move into a residential care home. The key role that telecare/telehealth can play in the further development of prevention services is emphasised in the Guide.

Halton B. C. has been providing a Telecare service for over 3 years and has experienced year on year growth in the number of people receiving the service. The technology has developed rapidly in recent years and the range of applications is steadily expanding.

A Service Evaluation report on Telecare has recently been completed for the Health and Community Directorate which clearly demonstrates the positive impact that the service has had and details areas that will need to be addressed as the service expands and develops.

The Widnes Practice Based Commissioning (PBC) Consortium, Halton and St Helens Primary Care Trust (PCT) and HBC are currently commissioning a community based integrated care service known as the ‘Virtual Ward.’ This will actively support the most vulnerable individuals and those with long-term conditions at home, in order to reduce unnecessary hospital admissions making use of Telehealth devices to support self-management and the close monitoring of physiological observations.

Local developments in Telecare and Telehealth services can play a significant role in the developing spectrum of preventive interventions.

9.2.9 The Carers Strategy

It is important that Carers have access to services based on recognition of their rights as individuals, choice in their daily lives and real opportunities to have a life of their own outside of the caring role.

The Joint Commissioning Strategy has been developed via ongoing consultations and contributions from stakeholders who provide services to carers as well as carers themselves. We have listened to what carers have told us about the help and support that they need and have responded by addressing the issues throughout the Strategy.

This Strategy is written as a practical document, including an action plan, to support services in Halton move towards a more focussed way of commissioning services over the next three years

We are committed to working jointly and in partnership with the voluntary sector within Halton, providing where possible an integrated response based on services which meet assessed needs and which are designed to improve lives and give new opportunities.

We are proud of what we have achieved for Carers within Halton since the production of the last Carers Strategy, but we also recognise the need for continual improvement and Halton Borough Council and Halton and St Helens Primary Care Trust, together with their partners have made a pledge to continually improve services and the quality of life for carers

We recognise and value the essential role that carers play in supporting some of the most vulnerable people in our community and we believe that this Strategy demonstrates our commitment to recognising, valuing and working with local carers.

9.2.10 Halton Healthcare for All Group

This group is hosted by NHS Halton and St Helens and was set up to address locally the recommendations in the Healthcare for All report (DH, 2008) relating to access to healthcare by people with learning disabilities. Membership includes the local authorities, acute hospitals and service users and their carers. It also oversees work in the Borough to promote well-being and prevent ill health among people with learning disabilities as required by Valuing People Now (DH 2009). This will be achieved by generic services making reasonable adjustments in how they operate to ensure equitable access by disabled people including those with learning disabilities.

10. Mapping and Gap Analysis

A mapping exercise has been undertaken in Halton to map current interventions, identify gaps or unmet needs and consider how best to meet those needs. The methodology employed has been to analyse the current position with regard to the 10 'spectrum of intervention categories' as detailed above in Section 4 and illustrated in Figure 1.

The detailed findings of the mapping exercises can be found in Appendix 1

11. Developing a Local Strategic Commissioning Framework

Analysis of the key themes that run through the DH Guide, and the evaluations of the POPP and LinkAge Plus Pilots, together with the analysis of the mapping exercise have provided the basis for the development of an outline framework within which local commissioning decisions can be effectively developed, together with a number of broad strategic objectives. The framework sets out key structures and actions required to achieve the shift to prevention and early intervention, while the key strategic objectives clarify the direction of travel

11.1 The Commissioning Framework

To make the shift to prevention and early intervention commissioners will:

- Adopt a whole system approach involving a broad range of partners
- Involve citizens at all stages in the planning and delivery of services
- Ensure that there is agreement with partners on the 'shared responsibility for resourcing' which underpins the approach
- Establish appropriate planning structures to oversee and implement the development programme, ensuring that it is effectively managed and sustainable
- Ensure integration with other areas of the Transformation of Social Care agenda and that the developments support the personalisation of health and social care
- Systematically analyse and apply the learning from, the POPP and LinkAge projects and other prevention work (such as that set out in Age Concern's 'Prevention in Practice, service models, methods and impact' 2009)
- Ensure the programme of interventions is aligned with and contributes to the Sustainable Community Strategy and Local Area Agreement priorities and is linked to the relevant National Indicators

- Make use of the Social Care Reform Grant and other relevant funding opportunities as they arise
- Adopt an 'Investment' approach to funding (to achieve a return)
- Ensure performance requirements and measures are outcome focused (measuring the return on investment)
- Use both quality of life and financial impact measures – for many services at the primary intervention end of the spectrum the financial impact will inevitably be more difficult to measure

11.2 Strategic Commissioning Objectives

In making the shift to prevention and early intervention commissioner will:

- Focus initially on meeting the needs of all adults.
- Develop a balanced spectrum of provision across the 3 levels of intervention and the intervention types
- Give particular focus to the development of primary tier and 'wellbeing' services
- Encourage investment in the third sector and stimulate the market to develop innovative approaches to prevention and early intervention
- Support participation and active citizenship and help to foster independence.
- Encourage intergenerational projects / activities
- Achieve more effective use of investment by reducing overlap or duplication within current preventive interventions
- Further develop the efficiency and effectiveness of current prevention services / activities through joint work and improved coordination
- Ensure there is greater focus on providing quality information and advice - simplifying access with an emphasis on 'no wrong door'
- Look for opportunities to shift investment from high level interventions where a clear cost benefit can be established across the system
- Recognise the significant contribution that can be made by health promotion and promoting active lifestyles
- Encourage initiatives that help to alleviate loneliness and isolation
- Improve people's access to employment and volunteering opportunities

11.3 Partnerships in Prevention (PIP)

The PIP group was developed to improve partnership working between agencies working in the field of prevention. At present membership of the group includes The Red Cross, Age Concern, Sure Start to Later Life, Community Bridge Builders and The Health Improvement Team. The group meets quarterly with a flexible agenda around partnership working and prevention issues in Halton. This group needs to expand to include many more prevention organisations such as the Fire Service, Telecare and Community Wardens with service level agreements likely to be developed in the near future. The Early Intervention and Prevention Strategy action plan will include actions around making this group more inclusive, effective and robust. PIP will be the operational arm of the strategy while the strategy implementation group will steer the project at a strategic level with an emphasis on a whole systems approach to shifting resources from crisis orientated provision towards prevention and improved well being.

Intergenerational Strand of the Strategy

“Intergenerational practice aims to bring people together in purposeful, mutually beneficial activities, which promote greater understanding and respect between generations, and contributes to building more cohesive communities. Intergenerational practice is inclusive, building on the positive resources that the young and old have to offer each other and those around them.” (Beth Johnson Centre for Intergenerational Practice 2010)

Changes in society have caused generations to becoming segregated from one another. Lack of positive interaction between these generations leads to negative stereotypes developing of younger and older people. However, anyone working within the intergenerational arena can’t help but observe that both generations have shared areas of concern e.g. community safety, and have valued resources available to offer one another.

In the past 12 months Halton Borough Council has been promoting intergenerational projects across the borough. These have included an intergenerational conference, intergenerational Halloween events and intergenerational radio programmes. Many departments within the council have been involved in these initiatives. These include Health and Social Care, Community Development, Sports Development, Libraries Service and Children and Young People. These initiatives now need developing into a more strategic and coordinated approach towards intergenerational activities.

The aim of the intergenerational strand of the EIP strategy will be to bring younger and older people together in purposeful, mutually beneficial activities, which promote greater understanding and respect between generations and contribute to building more cohesive communities. The objective of this strand will be to embed intergenerational work as a key well-being and prevention activity of Halton Borough

Council and to develop and promote intergenerational work and its benefits. Key activity will be the development of the council's intergenerational group into a robust strategic body that meets regularly to coordinate intergenerational activity across the borough.

APPENDIX 1 – Mapping of existing provision.

The mapping contained within the following attachment uses the 'Triangle Framework' (figure 1 page 5) as a basis to describe what is already in place, where there is an identified gap or unmet need and any plans that have already been developed for the future. The framework takes ten key elements to describe the varying levels of prevention and the range of interventions available.

CITIZENSHIP

Involvement

Current Position

Halton currently have in excess of 700 older people as signed up members of Halton's Older People's Empowerment Network (OPEN). Although this is an extremely positive position to be in there is a question over the number of people involved regularly and effectively. Halton OPEN has it's own constitution and is supported administratively through Age Concern Mid Mersey. There is an Executive Committee of between 15 and 20 people who meet on a regular basis (monthly). In addition a number of these committee members also represent Halton OPEN in other forums, e.g. Older People's Local Implementation Team, Carer's Sub-group, Stroke Core Strategy group etc.

Gaps or unmet needs

To ensure that all 700 members and beyond are involved in planning and having their say. It is clear that the members of the Executive are the most active people in Halton OPEN and therefore their involvement is not fully representative of all local older people. More needs to be done to ensure that being a member of Halton OPEN is more inclusive and offers anyone an opportunity to be involved.

Future plans

Halton OPEN and local commissioners are working together to develop new and innovative methods of ensuring that more people are involved. The Joint Older

People's Commissioning Manager will now attend all Executive meetings of Halton OPEN along with an agreed local Councilor. In addition OPEN and Commissioners will agree each year what the priorities are and work together to carry out quarterly focus groups that will be available to all of the wider membership and facilitated by the Local Authority. These focus groups will then feed into the Older People's Local Implementation Team, Halton Health Partnership etc.

In addition the findings will also be published in a quarterly newsletter that will be sent to the remainder of the Halton OPEN members.

Tackling Ageism

Current Position

Work to tackle ageism is sporadic and generally follows the National agenda. The NHS development plan: from good to great (2010-2015) does mention the need to change the culture in relation to Age discrimination throughout Primary, Secondary and Acute Care.

Locally we have the Dignity Co-ordinator post whose job is to ensure all people are treated with dignity and respect, one aspect of this is ensuring that there are no discriminatory practices within services.

The Government Equalities Office issued a policy statement **'Making it work: Ending age discrimination in services and public functions'** in January 2010. This document sets out consultees' views on planned proposals and the Government's response to those views. In particular, it makes clear that:

- Beneficial age-based treatment such as free bus passes, discounts for students and pensioners will still be allowed.
- The new law will ban harmful discrimination in health and social care, but allow a person's age to be taken into account where it is right to do so.
- Age will continue to be used in financial services provision, but only where it is related to risks or costs. Access to motor and travel insurance will be improved by the introduction of signposting and referral. People will be given confidence that their age is being used appropriately by the publication of aggregate industry data for motor and travel insurance that everyone can check.

This statement adds more detail to the White Paper published in June 2008 **Framework for a fairer future – The Equality Bill** that states: 'Promoting equlity is essential for individuals to fulfil their potential, for the creation of a cohesive society and for a strong economy. A substantial body of equality legislation has been introduced over the last four decades, protecting millions of people from discrimination and promoting greater equality. But the legislation has become complex and hard to understand. The Bill will de-clutter and strengthen the law.'

Specifically in relation to age discrimination the Bill will contain powers to outlaw unjustifiable age discrimination by those providing goods, facilities and services in the future. To allow businesses and public authorities to prepare, and to make sure the law does not prevent justified differences in treatment for different age groups.

More information is available at:

http://www.equalityhumanrights.com/your-rights/age/

Gaps or unmet needs

Although the way people are treated is an important part of tackling ageism, the major issue relates to how we change the image of ageing in Halton. Generally the health messages and lifestyle messages locally do not portray a positive image of aging and how we can value older people and the role they play in the local community.

Pre-retirement courses are available but they generally focus on what is on offer for an individual and not what they can still offer.

Future Plans

Culture change is required in relation to developing a positive image of ageing, this will be through the work of the dignity network and services such as sure start to later life.

Review the content and accessibility of the pre retirement courses with a focus on opportunities in later life.

We need to support people to continue to work for as long as they want to (although this will depend on National Legislation), all people will have access to the same information upon retirement and those who retire are supported to utilize their skills in different ways, volunteering, training, mentoring etc.

Equal access to mainstream services

Current position

The majority of services offer open and equal access to all service users, however there is enough anecdotal evidence to suggest that this is not always the case in practice. For the purposes of this strategy we would need to look beyond traditional Health and Social Care services and look at areas such as Sport, Arts, social clubs, libraries, housing, transport etc. It is clear that people with communication difficulties, mental health or long-term conditions and other disabilities that have an impact on them, do have difficulties accessing mainstream activities.

Gaps or unmet needs

This is not because of any discrimination or criteria constraints imposed by providers, but is generally training related and more needs to be done to look at how people and providers are equally supported to ensure they can participate fully in community or social activities that enhance their quality of life.

Future plans

The continued development of personalization, with increased uptake of individual budgets will help to support vulnerable adults to make the choices that are right for them. For example a recent local case study clearly demonstrated the positive health impact that yoga had on a service user with dementia. The service user demonstrated improved confidence, behaviour and communication and the carer attributed this to the weekly yoga session. It is clear that individual budgets will support further development of this type of approach.

Making a positive contribution, including volunteering

Current Position

Previous Adult Social Care Annual Performance Assessments ad highlighted that the Directorate needed a more coordinated approach to volunteering. It was therefore agreed that a volunteer strategy be produced, initially within the Health & Community Directorate, and then subsequently the strategy would be broadened out to apply across the Council.

As part of the development of the Strategy a 'Building Common Ground' workshop was held that involved staff from both the statutory and voluntary sector. The workshop spent some time looking at the vision for volunteering that they felt Halton should adopt and the way in which we could create an effective volunteer service, what was currently working well and ways in which current activities could be improved. The work undertaken by this Group formed the basis of the Strategy.

Gaps or unmet needs

During the development of the Strategy it became evident that informal volunteering is extensive despite the lack of a proper framework, for example within Bridgewater and Day Services, however in order to increase, promote and fill the range of volunteering opportunities available it was accepted that a clear framework and associated processes were needed.

Due to the Care Quality Commission's specific requirements for the Health & Community Directorate to increase volunteering activities within Adult Social Care, the Directorate commissioned Halton Voluntary Action (HVA) to undertake a 6 month project which would: -

- Establish an accurate baseline of current and potential volunteering across the Council, via a Staff Survey.
- Offer training in Volunteer Management to Managers in the Health & Community Directorate.
- Develop a volunteer recruitment and management system within the Health & Community Directorate.

Work has focused within the Directorate within two specific service areas i.e. Community Bridge Building and Sure Start to Later Life and the project would aim to demonstrate that the interventions undertaken in terms of training and the development of systems would lead to an increase in the number and quality of volunteering opportunities within those two areas.

Future plans

At the end of the six month project HVA, in conjunction with the Project Board set up to oversee the Strategy's development and implementation, will draw together the key findings and recommendations from the project and these will be presented back to Chief Officers for consideration, with a view to agree a plan for how the Strategy could be further implemented across the Council.

NEIGHBOURHOOD AND COMMUNITY

Community safety initiatives, including distraction burglary

Current Position

There is a range of work that is currently being developed to support improvements in crime and perceptions of crime for vulnerable adults in the borough, e.g. the Alleygates project, mischief night initiatives and ward based community safety projects.

Gaps or unmet needs

The links between Health and Social Care and community safety are limited and although there is data available through the corporate place survey, there are positive opportunities for improved partnership working to develop specific initiatives across the whole sector.

Future plans

To develop a partnership approach to community safety across the system.

Locality based community development

Current Position

Halton Borough Council already has a well established and vibrant Community Development department. A team of five full time equivalent Community Development officers are aligned to one of the seven area forum regions. The team sits alongside Sports, Leisure, Arts, Parks, Libraries and Community Safety. The embedded ethos in Culture and Leisure for joint working means there are established and intrinsic mechanisms to broad service delivery. This provides cost effective opportunities to utilize a broad range of themed and focused activity as a catalyst in building participative, engaged communities whilst maximizing our impact.

Gaps or unmet needs

There is a need to improve the links between community development and commissioning. Although this has developed in the last two years, more can still be done. Particularly in relation to examining the possibility of geographical commissioning and supporting the overall data collection that commissioning requires.

Future Plans

To develop an extended outcome based approach to the local Intergenerational work in Halton. This will include developing more Information Technology work between older and younger people, an ideas sharing workshop to support locally commissioned services and a intergenerational arts group.

Another key development will be agreeing the links and role of Community Development within the Partnerships in Prevention (PIP) work that is currently being led through Halton Borough Council, but already has involvement from NHS Halton & St Helens, 5 Boroughs Partnership and the voluntary sector.

Intergenerational Work

Current position

Community development have led an initial 12 month pilot that began in April 2009 to develop a range of projects relating to intergenerational work in Halton. This consisted of an initial conference that was attended by over 200 older and younger people taking part in a range of activities including family tree, facebook, Nintendo wii, bridge, table tennis and more. The idea behind the event was to get people's views on what they would like to see within our intergenerational work and also to break down some of the barriers that currently exist behind younger and older people.

In addition six intergenerational Halloween events took place across the borough and Castlefields are currently developing an intergenerational memorabilia group.

Gaps or unmet needs

As this is quite a new piece of work we are still in the process of establishing what people want. From the conference last year there was a real interest in IT, new technology and genealogy.

Future plans

Last year Halton applied for a Government pilot to develop a range of intergenerational projects in the borough. Although the application was unsuccessful it has given us the opportunity to use the proposal to inform our direction of commissioning. This will include more IT based work, a summer conference and use of the Mersey to create a history based intergenerational project. This work will stimulate education, volunteering and will tackle stereotypes and discrimination. Older People's services, Community Development and Children and Young People directorate are currently developing joint working processes to deliver on this agenda.

INFORMATION / ACCESS

No door the wrong door / Single Point of Access

Current Position

Halton has a range of services offering information to older people. Age Concern, Sure Start to Later Life, Reach for the Stars and Community Bridge builders all support low-level information provision in the borough. However, there are many other services that offer some level of signposting although they are not necessarily contracted to do so.

The following shows the number of contacts for each service:

Age Concern	2007/08:	5084 (people receiving signposting)
		1429 (people receiving full casework)
	2008/09:	2327 (people receiving signposting)

		1289 (people receiving full casework)
Sure Start to Later Life	2007/08:	108 (all full assessments)
	2008/09:	327 (all full assessments)
Reach for the Stars	2007/08:	315 (number of people supported)
	2008/09:	361 (number of people supported)

Sure Start to Later Life is the council's information service for over 55s. While it provides information on a range of activities and services for older people it also provides home visits from Information Officers who support people to engage in community activities and look again at some of their interests and dreams. The philosophy of the service is that the earlier people engage in physical, mental and social activities the less likely and later that they will need acute services. This has financial benefits for acute services but, just as importantly, it improves people's quality of life.

Gaps or unmet needs

There is more than enough information available and service provision / capacity is high. The issue is the co-ordination of the services. There are too many services that are offering similar, but not consistent, levels of information, signposting, assessment and referral. This can lead to discrepancies or delays in people reaching the services they really need.

Service users generally like to build up a trust with a member of staff or an organisation and there is anecdotal evidence to demonstrate that people prefer to stay with one organisation irrespective of their overall role. For example somebody might access the Stroke Association for specialist support, but six months later that individual might need different generic support, often that person will still go to the Stroke Association even though it might not be appropriate. It will be important to develop services that offer services the right level of support to ensure that in turn they can support their service users.

Future plans

The first step to improve the co-ordination of information and the navigation through the system will be to develop a closer partnership arrangement between the two main providers Age Concern and Sure Start to Later Life. This will ensure more full assessments will be undertaken, more consistency on paperwork, information provision and training.

The service is only available to people aged 55+, we will amend the criteria to ensure the service is available to all adults.

LIFESTYLE

Well being and Active Ageing Initiatives – this covers all elements of the lifestyle heading

Current Position

- APEX – Accident Prevention Exercise – 15 week programme of education and exercise to improve muscle and bone strength, balance, co-ordination and confidence. For individuals who have had a recent fall, fear of falling or osteoporosis.
- APEX Follow-on – Ongoing weekly classes of strength and balance exercises to maintain gains achieved during 15-weeks at APEX
- Recharge – Ongoing programmes for over 50s, carers and those recovering from health conditions. Activities at each session include physical activity, healthy eating, arts and complementary therapy.
- Diamond Lives is a BIG Lottery funded project and is part of the Target Wellbeing Grant. The project is a joint venture between NHS Halton & St Helens Health Improvement Team and Age Concern Mid Mersey.
- Diamond Lives works with socially isolated and vulnerable older people to develop and implement personal lifestyle plans, focussing on improving physical activity levels, and improving weight management and nutritional knowledge.
- Age Concern's Participation Organiser works with sheltered accommodation providers, registered social landlords, and existing Age Concern networks. All individuals sourced as suitable for intervention through the service are then referred on to the Lifestyle Advisor, who will work with the participant to identify their key health issues, and develop an individual lifestyle plan.

Reach for the Stars supports the following aims and objectives.

- Decrease social isolation particularly amongst those most isolated through bereavement, low confidence & anxiety, illiteracy, mild mental illness, mobility/fear of falling concerns including those people who are new to the area
- With the support of a Health Trainer, Older People through motivational behaviour change methods are given the opportunity to receive a higher level of intervention to achieve their health goals. (Personal Health Plans and ongoing support).
- Support people into activities of their choice with or without Volunteer Buddies.

- Recruit & train Volunteer Peer Health Champions (STARS) to work on placement across the borough delivering healthy lifestyle sessions supporting people to access services across the borough to improve their quality of life and general wellbeing

Community Bridge Builders

The Community Bridge Building Team support people with disabilities, older people and carers who are socially isolated. They also work with children with disabilities in transition to adulthood. They work in a person centred way to promote social inclusion, this enables people to participate and feel valued within their local community carrying out meaningful activities that promote self-esteem and well being and therefore prevents social isolation.

Halton Borough Council Culture and Leisure Department

The department organises many prevention type activities for vulnerable adults and older people across the borough. These include New Age Bowling, Boccia, Chair based exercise, gentle exercise, Tai Chi, Table Tennis and Health Walks. Free swimming sessions for people over 60 have been introduced across the borough as have free swimming lessons. An “Older Adult Olympics” is planned for the future.

Halton Borough Council Community Development Department

Community development workers are aligned to one of the seven area forum regions and work in that locality with the community. This helps to establish current activity, issues and develop new initiatives e.g. Castlefields memorabilia group.

A range of projects relating to intergenerational work in Halton has been developed by the department. This consisted of an initial conference that was attended by over 200 older and younger people taking part in a range of activities including family tree, facebook, Nintendo Wii, bridge, table tennis and more. The idea behind the event was to get people’s views on what they would like to see within our intergenerational work and also to break down some of the barriers that currently exist between younger and older people.

In addition six intergenerational Halloween events took place across the borough and Castlefields are further developing an intergenerational memorabilia group.

As you can see there are a number of services that support an active ageing and well being agenda. In addition Age Concern have developed five social participation groups and a men’s health project to help with a range of issues relating to

remaining active. Although the numbers of people accessing the services above are high, more data needs to be collected on the impact the service has had on an individual. This also has to be measured over a longer period as most of the interventions will relate to behaviour or lifestyle changes.

Gaps or unmet needs

Again the major opportunity relates to the overall coordination of active ageing and well being services in the borough. The main source of information available is the public health annual report 2008/09 from the NHS Halton & St Helens website.

Future plans

It is the aim to continue to develop the Partnerships in Prevention work that Health promotion, reach for the stars and health trainers are all part of the group and they will be supporting the information partnership between Age Concern and Sure Start as well as helping to develop robust and pathways for all service users.

Future plans for intergenerational work include closer partnership working between Health and Social Care, Community Development and Children and Young People departments around an intergenerational strategy.

PRACTICAL SUPPORT

Befriending and counselling

Current Position

Age Concern Mid Mersey offer a befriending and telefriending service (not funded through Local Authority or health).

In relation to counselling, Halton Voluntary Action have run a successful Voluntary Sector Counselling Partnership for a number of years. This partnership is an umbrella for any voluntary sector organisation offering counseling in Halton.

The partnership ensures that each organisation who applies reaches the relevant standard and information is collected on their performance and the level of counseling that they can reach. This service is also available for commissioners to help them collect evidence to establish what services are available and where the gaps are in the local borough.

Gaps or unmet needs

There is limited provision of befriending in the local area, however there needs to be some work carried out to establish if befriending is the correct solution for all people.

Some volunteers have expressed that they feel trapped once they have been introduced and it can sometimes be detrimental if the service creates some level of dependency. It would be more beneficial to start looking at how people can be supported to access other services and activities within the borough and not be reliant on an individual member of staff or volunteer.

Although the counseling partnership has been extremely successful there are specific issues relating to the performance monitoring of the overall project. For example if an organisation joins the partnership they are expected to reach a particular level, however they are not rechecked and there is a risk of services not maintaining an acceptable standard.

Future plans

Review existing befriending provision in the borough, analyse need and identify best practice in other areas to establish the direction of future commissioning of these services.

Shopping, Gardening etc.

Current Position

Four major services are provided by Age Concern and British Red Cross to deliver a range of low-level practical support for older people in Halton. **Home Safety service** offers in depth checks into an individual's environment and suggests solutions to improve the home in relation to falls, fire and crime. The **Traders Register** is a list of local traders who have been recommended who have received some training and support on understanding the needs of older people. The Helping Hand service is a volunteer led service that offers low-level handyperson jobs to older people in the borough. British Red Cross offer a low-level **shopping service** to people who have no other means of getting their own food.

The table below shows the number of people who have accessed each service over each of the last three years.

	2006/07	**2007/08**	**2008/09**
Home Safety	358	690	816
Traders Register	1115	1366	1464
Helping Hand	N/A	N/A	67
Shopping Service	166	222	261

Gaps or unmet needs

The main gap is in relation to gardening, however previous services have been difficult to operate and have never been able to manage the demand for a pure gardening service. There also remains an issue in relation to how the services above are funded and what is there exit strategy. The issue in relation to practical tasks is not gaps or unmet needs, but the future sustainability of the individual elements of the service.

Future Plans

Halton Borough Council is currently developing a local handyperson service, that will offer a service that will enhance the existing service provision as described above.

ENABLEMENT

Intermediate Care Services

Current Position

Intermediate Care services have played a significant part in achieving improvements in overall outcomes for people in Halton over the past six years. This has been reflected in a steady reduction in emergency admissions and acute hospital bed utilization, the reduction being greater in the over 65 population. The number of people living in care homes has more than halved. Over the same period of time the number of people over 65 supported at home tripled, so Halton is now one of the highest performers in England. This approach has also reduced the size of on-going care packages so that people are able to live independently with lower levels of support.

There are a range of community and bed based services available within Halton to support peoples needs for reablement, rehabilitation, telecare and falls.

Gaps or unmet needs

The capacity available is often insufficient to meet demand.

The falls service is not currently fully integrated with other reablement services within the section 75-partnership agreement.

Implementation of the revised criteria

Future plans

To review capacity available within the services, and develop a business plan for further investment as required.

Complete a review of the current falls service, with the aim of further integration.

To bench mark all services against the revised guidance for Intermediate Care and implement any changes required.

Self Care Programmes

Current position

There is some provision of self care programmes in Halton. The Expert Patient is an approach that aims to enable people to cope better with long term conditions through improved self-management. It is designed to help:

- Improve ability to cope with pain,
- Manage medication,
- Reduce levels of depression, fatigue and anxiety,
- Improve communication with Health workers,
- Enhance relaxation, exercise and diet.

The programme offers two trainers who are themselves living with a long-term condition, they run the courses. The courses are participatory and follow a workshop style. Topics are introduced by the tutors and people attending the course are involved in the discussions, share their ideas about the different topics, problem solve and try to find solutions.

The topics included in the course include:

- Relaxation techniques
- Healthy Eating
- Exercise and Fitness
- Symptom Management Techniques
- Communication Skills
- Problem Solving
- Goal Setting
- Action Planning

Gaps or unmet needs

There are a number of gaps that need to be addressed in relation to Self care, there is limited support for people with Mental Health diagnosis, stroke survivors, people diagnosed with dementia. There also needs to be an improved link between self care

and peer support services to ensure that there is ongoing support for service users and their carers.

Future plans

Need to develop improved working policies and protocols to support an enhanced level of self care programmes in the borough. This would include completing a full mapping exercise on current provision.

COMMUNITY SUPPORT FOR LTC

Integrated or co-located teams and / or networks

Current Position

Over the past three years Halton has developed a vibrant Telecare service to support the needs of vulnerable people in their own home. Telecare is a set of electronic sensors installed in a person's home. These include: temperature sensors, falls detectors, smoke alarms, motion detectors, a personal alarm pendent and a 24 hour 7 days a week emergency response service. When coupled with an appropriate support plan Telecare helps individuals to live more independently and safely at home. Once installed, it can reduce risk by providing reassurance that help will be summoned quickly if a problem occurs. Telecare in Halton comprises three components: an emergency response, environmental monitoring and lifestyle monitoring.

The Stroke Association offers the following aims and objectives of there services:

- Provision of a Dysphasia support group to be operated on a weekly basis in Runcorn and Widnes.
- To undertake assessment of communication support needs of service users attending the groups.
- Develop appropriate goal orientated support plans
- Define desired outcomes of support plan with target date/s
- To signpost and support access to appropriate support services including, Housing, Welfare benefits, socialisation opportunities with support, Health related support, home insurance support, budget management support, support to manage debt, support to access legal services, Advocacy etc.
- Referral on to other agencies and services
- Participation in Multi agency planning processes around the need of stroke services e.g. the stroke core strategy group.

In addition Rapid Access and Rehabilitation Service carries out Case Management for crisis intervention, community support and hospital discharge.

Social Care in practice is based on a number of organisational links, integrated working, understanding of roles, and the avoidance of duplication. Underpinned by a collaborative, integrated working between a Social Care Manager and Primary Care Team (usually District Nurse). The approach adopts the following principles:-
• Close links between the Practice and Acute hospitals
• Timely information about admissions, A&E attendance and other inpatient services
• The adoption of an 'in reach' approach with early discharge as an underpinning philosophy
• Case finding - the identification of vulnerable patients
• The use of shared eligibility criteria
• Case Management of people with chronic disease
• Active review of pharmacy needs
• Attention to impairment of the daily living routines

Community Matrons offer a proactive case management / case finding role to support clear access to services and improved referral processes.

Gaps or unmet needs

There needs to be further work on how we progress community support for people with long term conditions, the evidence is available to support the development of integrated working, including Telecare and Telehealth, district nurses/community matrons and social care.

Future plans

The existing Telecare service has been evaluated, this will feed into the overarching Telecare strategy that will be developed and implemented alongside the evaluation.

Progressing towards using virtual sensor technology and lifestyle monitoring technology to enable us to identify changes in individual circumstances, and therefore deliver early intervention to changing needs and potential crisis to maintain independence. Consideration is being given to joint work between the Borough and PCT/Practice based commissioner in the use of Telehealth applications to monitor and manage long-term conditions. Telehealth provision is currently being piloted by the PCT.

A case Management tool is being developed Nationally to support professionals across Health and Social Care. This use of this tool would be considered at a local level.

Case Finding and Case Management of Those at Risk

Current position

Crossroads for Carers provides respite care for carers where suitably trained Care Support Workers will take over the role of the regular carer for an appropriate period of time, as determined by the agreed eligibility criteria to allow the carer to take a break from caring and to use the free time to take up whichever pursuit they wish. The service is aimed at reducing the levels of stress, which exist within the family home of their dependent and to avoid crisis admission into hospital or residential care or breakdown of the carer situation. The service is available to residents of Halton only and service provision will be agreed as part of the care plan supplied through Halton Borough Council's Care Management.

The Alzheimer's Society established a local branch in 2005 and currently employs one Family Support Worker who provides practical and emotional support, advice and information, support groups and social activities for carers in that area. They liaise with Health & Social Care on behalf of carers, attend relevant local meetings and are currently involved in devising training packages for care staff.

The business case to develop a virtual ward has been completed and agreed. The service is supported by the Widnes Practice Based Commissioners who are seeking to provide a mobile integrated Health and Wellness service, seeking out illness, and delivering prevention in the heart of the community. The mobile service will focus on hard to reach groups and those who do not regularly attend the registered practice using practice information.

Gaps

There needs to be more support offered to carers and although there is a separate commissioning strategy for carers there are specific gaps in relation to telecare and assistive technology.

Future plans

Develop telecare service to support the needs of carers.

INSTITUTIONAL AVOIDANCE

End of Life Care – enabling people to die at home

Current Position

A multi-professional group of specialists in Palliative Care, Older People's Mental Health services, the Alzheimer's Society, General Practice, Dietetics, Speech Therapy and Care of the Elderly met to formulate symptom control guidelines for health care professionals caring for patients with end stage dementia. These focus on symptoms, which are common or troublesome in this patient group. The Care Pathway, symptom control guidelines developed will be followed up by a series of educational events for health care professionals. The Care Pathway aims to help provide continuity of care for this patient group, whose care needs are often provided by a range of carers.

Homecare End of Life service is funded through NHS Halton & St Helens to offer up to 13 weeks of support to people in their own homes. Referrals are received from District nurses.

The palliative care and end of life strategy has recently been completed and agreed.

Gaps or unmet needs

Clarity around direction of service provision and multi-agency working. Also need to ensure future funding is in place for Homecare End of Life service.

Future plans

Full implementation of the Palliative Care and End of Life Strategy in partnership between Health and Social Care.

Management of Unscheduled Care

Current Position

A number of work areas contribute to the management of unscheduled care, Intermediate Care as mentioned earlier in the mapping alongside the walk-in centres, community extra care housing and the Single Point of Acccess all play a role in this.

Gaps

Although the Single Point of Access is available it still requires further work to ensure that it is a fully integrated service. If this was the case the quality and efficiency of the service and the navigation through the system would improve significantly.

Future plans

To ensure a fully integrated Single Point of Access is in place.

TIMELY DISCHARGE

Hospital In-reach and Step Down Pathways

Current Position

We currently operate an integrated pathway linked to the Effective Care Coordination policy delivered through the 5 Boroughs Partnership. This is an admission and discharge procedure with an overall objective of ensuring that we have in place an entire pathway from admission to discharge and that this is supported in a timely manner.

In addition to the above there is a Multi-disciplinary Team that offers care reviews to discuss care as well as plan appropriate discharge. This is further supported by weekly monitoring of any delayed discharges. All service users are followed up within seven days to ensure that service users have resumed normal functioning after discharge.

The Intermediate Care Assessment Team proactively identifies people in need of assessment no matter where they are placed. The service is able to work across Accident and Emergency and Hospital wards to ensure complete access to assessment for all patients.

Currently the Adult Hospital team manage the discharge pathway in relation to social care, with a separate team for the hospital and District Nurses.

Gaps

Although the existing systems work well together there is still a significant opportunity to develop an integrated discharge team.

Future plans

To develop and implement an integrated hospital discharge team.

Post Discharge Support, Settling In and Proactive Phone Contact

Current Position

The British Red Cross offer low-level support for six to eight weeks to persons discharged from Hospital and those with non critical illnesses within the community to support and maintain their independence in their own homes. Practical tasks are undertaken and help to support the emotional wellbeing of the service user. The service works on enabling and prevention to build up resilience for service user, family carer etc. Service Users are supported to appointments and social activities

as appropriate during the period the service is in place. In addition work is carried out to support confidence building and improving mobility. They link in with other agencies and partner services within the Red Cross e.g. medical loan, equipment services and therapeutic care as appropriate.

Gaps or unmet needs

There are capacity issues within the existing service that need to be addressed and there needs to be additional support to the provider in relation to the referral process and navigation of services. This will be taken forward by the Partnerships in Prevention project.

Halton currently as no designated telephone contact to review people's assessment of their own care or to determine if their needs have been adequately addressed.

Future plans

Merge the existing service with the Red Cross shopping service to increase existing capacity within the service.

Assess existing review mechanisms across the system to support people on discharge.

Appendix 2

No	Action	Tasks	Lead	Timescale
1	Agree overall coordination of the prevention agenda for older people	• Agree roles & responsibilities • Agree Capacity • Agree Lead Organisation	Prevention Steering Group	April – June 2010
2	Develop infrastructure within existing services to ensure partnership and pathway development	• Agree Current Capacity • Agree Data Sharing • Develop & Implement Pathway	Partnership in Prevention	July – Oct 2010
3	Develop Performance Management Framework	• Agree parameters of work • Agree governance arrangements • Agree reporting mechanism	Older People's Commissioning Manager OP LIT	July – Oct 2010
4	Develop Marketing Strategy (For Low Level Services)	• Agree implementation of segmentation information • Agree Outcomes • Develop joint activity plan within borough.	Partnership in Prevention	July – Dec 2010
5	Complete service delivery diagram	• Agree scope of diagram • Link to finance • Complete data collection	Older People's Commissioning Manager	April – June 2010

6	Develop Financial plan	• Map current spend against each heading within the prevention and early intervention strategy	Older People's Commissioning Manager / Finance department	April – June 2010
7	Develop falls pathway	• Agree process to integrate falls service into Intermediate Care • Develop pathway • Agree data sharing protocols • Complete shared paperwork to facilitate integration	Divisional Manager Intermediate Care	April – June 2010
8	Pre – Retirement Courses	• Ensure courses are available to a wider range of people in the borough • Review the content of the courses to ensure people have opportunities available.	Partnership in Prevention	March 201
9	Implement Dignity Action plan	• By fully implementing the dignity action plan this will support a culture change within services to tackle discrimination	Dignity Co-ordinator	March 2011
10	Volunteering pilot	• Evaluate the findings from the six month pilot projects in Sure Start to Later Life and Community Bridge Builders • Report recommendations for future	Halton Voluntary Action	October 2010

		work		
11	Community Safety	• Develop Partnership approach to community safety across the whole system.	Community Development / Community Safety Team	Ongoing
12	Intergenerational Work	• Complete commissioning plan for intergenerational work. • Ensure intergenerational work is embedded in the Partnerships in Prevention project.	Commissioning Manager's and Partnership in Prevention	May 2010 for the plan, implementation of initial phase by March 20
13	Information provision	• Agree joint working protocols for Sure Start to Later Life and Age Concern Mid Mersey • Explore opportunities with other information providers in relation to joint working	Older People's Commissioning Manager	October 201
14	Review existing befriending services in the borough	• Work across commissioning to establish the need and provision of befriending services across all service areas • Report findings and recommendations to relevant Boards	Commissioning Managers	December 2010

15	Intermediate Care Services	• Review capacity available within the services, and develop a business plan for further investment as required • Complete a review of the current falls service, with the aim of further integration • Benchmark all services against the revised guidance for Intermediate Care	Divisional Manager Intermediate Care	March 2011
16	Telecare services	• Complete and implement telecare strategy • Develop enhanced telecare services for carers	Divisional Manager Intermediate Care	March 201?
17	End of Life Care	• Full implementation of the Palliative Care and End of Life Strategy	NHS Halton And St Helens	March 201?
18	Unscheduled Care	• Review existing processes in relation to the Single Point of Access • Ensure processes and pathways in place to deliver a fully integrated Single Point of Access	NHS Halton & St Helens	2011/2012
19	Timely Discharge	• Develop a fully integrated Hospital Discharge Team	Multi-agency partnership to be established	2011/2012

20	Post Discharge Support	• Merge existing Red Cross Services • Assess existing review mechanisms to support people on discharge	Commissioning Managers	Point 1 by April 2010, point 2 by March 2011

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 9 March 2010

REPORTING OFFICER: Strategic Director – Health & Community

SUBJECT: Safeguarding Vulnerable Adults

WARDS: All

1.0 **PURPOSE OF REPORT**

1.1 To update the PPB on key issues and progression of the agenda for the protection of vulnerable adults in Halton.

2.0 **RECOMMENDATION:**

i) That the PPB note and comment on the report's content.
ii) PPB note and comment on the reviewed Anti-Bullying Policy, Procedure and Practice document attached as Appendix 1.

3.0 **SUPPORTING INFORMATION**

Since the last report to the PPB in November 2009, key issues to report are:

3.1 **Locally**

3.1.1 Dwayne Johnson, Strategic Director, took over the Chair of the Safeguarding Adults Board (SAB) to increase the level of leadership, link in more firmly with related forums and take forward the Portfolio.

3.1.2 The SAB terms of reference, sub-groups, structure and reporting arrangements were reviewed in January 2010 and a Policy & Procedures sub-group has been established.

3.1.3 Safer Recruitment is being considered in terms of sub-group remits and will be and incorporated since a gap was identified.

3.1.4 Dignity and Personalisation leads report regularly to the SAB, including Self-directed Support/Safeguarding Adults Task Group updates.

3.1.5 SAB chair and sub-group chairs will begin to meet regularly early in 2010 and will ensure a strong interface between safeguarding adults, safeguarding children, domestic abuse and mental capacity & deprivation of liberty safeguards.

3.1.6 Regular reports of the SAB activity will be brought to the Safer Halton

and Healthy Halton PPBs from early 2010.

3.1.7 St Helens & Knowsley NHS Hospitals Trust recently appointed to a new post of Safeguarding Adults Coordinator and the 5 Boroughs Partnership NHS Trust to a new post of Senior Safeguarding Adults Practitioner.

3.1.8 A Safeguarding and Personalisation specific task group is being established, to address this emerging agenda.

3.1.9 Riverside College have recently reviewed and updated their Safeguarding Adults Policy & Procedure. The college Safeguarding Lead will be attending Safeguarding Adults courses, to enable him to ensure the safeguarding training he delivers to college staff is current. In addition, the College have been asked to join the Safeguarding Adults Board again.

3.1.10 Voluntary sector training needs have been considered [with HVA Training lead] who confirmed that courses available would meet training needs. Further follow up being undertaken, to confirm whether any dedicated or evening session[s] are needed.

3.1.11 Consideration is being given to whether customised training is needed for the Local Involvement Network (LINKs) Board.

3.1.12 An event specific to the voluntary sector will be hosted in May 2010.

3.1.13 Course outline and objectives for courses related to Challenging Behaviours have been revised and updated to ensure they are in line with a newly developed [draft] Restrictive Physical Interventions Policy, Procedure and Guidance, which will be implemented by HBC and the PCT.

3.1.14 The SAB considered training attendance April – Sept 2009. Action taken includes:

- HBC's Quality Assurance Manager reported that many of the Supporting People providers have their own training departments and access a wealth of training courses; HBC is in the process liaising with its training departments and the Supporting People providers to encourage greater take up of training, in particular the safeguarding courses.
- Residential Social Landlords (RSLs) are being contacted about low attendance rates.

3.1.15 The easy read/accessible version of public/service user information leaflet has been updated and revised (in draft). It will be distributed, but later also launched at an event in April 2010.

3.1.16 An easy read/Accessible Hate Crime leaflet being produced [will be

launched at an event in April 2010]. Police are being consulted in its content.

3.1.17 Demonstration/information packs are taken to prospective clients of the Community Alarm (Lifeline) service, following a request or referral for the service, contain public information flier [Safeguarding]. HBC complete a demonstration and installation where leaflets and paperwork are left with the client [who is in need of community alarm] and their family.

3.1.18 The task group being set up to focus on safeguarding and personalization will consider information and awareness-raising. Draft booklets intended for DP/PB recipients have been considered in respect of safeguarding.

3.1.19 CQC have confirmed that an Inspection of Adult Social Care, including an emphasis on Safeguarding, will be undertaken in 2010. Further details will be reported when confirmation is received.

3.1.20 The multi agency Anti Bullying Policy, Procedure and Practice document has been updated, after consultation. A copy of the draft document is attached as Appendix 1 and comments are invited from the PPB.

3.1.21 The Adult Protection Committee approved the original Anti Bullying Policy & Procedure in March 2006. The refreshed document will go to the Halton Safeguarding Adults Board to be ratified after any further comments have been received. A sub-group of the SAB will consider 'roll out'. This policy interfaces with and should be used in conjunction with, 'Adult Protection in Halton Inter-Agency Policy, Procedures and Gudience'.

3.2 **Nationally**

3.2.1 It was recently announced that, in response to the Government's consultation on strengthening protection for vulnerable adults, new legislation will be introduced to enshrine in law the need for every local area to have in place a Safeguarding Adults Board - a body made up of the local social services authority, the police, the NHS and working with all other groups involved in protecting vulnerable adults. The board will ensure that vulnerable adults who suffer abuse will have quick and easy access to the people who can help them best.

3.2.2 The Government, working with stakeholders, will now set in train a programme of work to lead and support all agencies involved in safeguarding adults. It will ensure that everyone involved in the care of vulnerable adults has the skills to protect them.

3.2.3 There will also be a new cross Government Ministerial group which will oversee the safeguarding of vulnerable adults, set priorities, work up new policy and provide national leadership.

3.2.4 The Government is also working with the General Social Care Council on a system of registration for home care workers. This will strengthen protection of vulnerable people, raise the quality of care provided and help prevent abuse.

4.0 POLICY, LEGAL AND FINANCIAL IMPLICATIONS

4.1 There are no policy, legal or financial implications in noting and commenting on this report.

4.2 All agencies retain their separate statutory responsibilities in respect of safeguarding vulnerable adults/adult protection, whilst Halton Borough Council's Health and Community Directorate has responsibility for coordination of the arrangements.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children & Young People in Halton

Review of the SAB and sub-groups took account of the need for strong links between safeguarding adults and safeguarding children & young people, to ensure they are robust.

5.2 Employment, Learning & Skills in Halton

None identified.

5.3 A Healthy Halton

The safeguarding of vulnerable adults is fundamental to their health and well-being.

5.4 A Safer Halton

The effectiveness of Adult Protection/Safeguarding Adults arrangements is fundamental to making Halton a safe place of residence for vulnerable adults.

5.5 Halton's Urban Renewal

None identified.

6.0 RISK ANALYSIS

6.1 Failure to address a range of safeguarding adult issues could expose individuals to abuse.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 It is essential that the Council addresses equality issues, in particular those regarding race, gender, sexuality, age and disability when considering its safeguarding policies.

Policy, Procedure and Practice

Anti Bullying

2010

Areas	ll organisations that are members of the Halton Safeguarding Adults Partnership Board: Halton Borough Council Halton & St Helens NHS Halton & Warrington Hospitals Trust St Helens & Knowsley Hospitals Trust 5 Boroughs Partnership Cheshire Constabulary 3rd Sector Partners Private Sector Partners
Date effective from	TBA
Responsible officer(s)	Service Development Officer (Health), Halton Borough Council
Date of review(s)	TBA
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory
Target audience	All managers, staff and volunteers working in those organisations who are a member of the Halton Safeguarding Adults Partnership Board who have contact with Service Users and/or Carers
Date of Committee/SMT decision	HBC SMT - To be confirmed Safeguarding Adults Board – To be confirmed
Related document(s)	• 'Adult Protection in Halton – Inter-agency Policy, Procedures & Guidance • Smile, No Bullying Guide for Adults with Learning Disabilities • Mental Capacity Act 2005 and associated policies, procedures and guidance • Deprivation of Liberty Safeguards [DoLS]
Superseded document(s)	Anti-Bullying Policy and Procedure, April 2006
File reference	To be confirmed

Contents	Page

Ref.	POLICY	*PRACTICE*
1	**Policy Statement**	*This policy should be applied in conjunction with:*
1.1	The aim of this Policy is to ensure a unified approach is practiced across the Borough Council and all its partner agencies within Halton when dealing with bullying behaviour towards vulnerable adults. This Anti-Bullying Policy provides employees, service providers, partner agencies, care staff, family carers and advocates working with adults aged 18 or over with learning disabilities, mental health problems, physical disabilities and/or sensory impairments, including older people, with an outline of what constitutes bullying and what to do when an incident occurs.	*'Adult Protection in Halton – Inter-agency Policy, Procedures & Guidance'* *Halton Borough Council's 'Mental Capacity Act 2005 - Policy, Procedure and Guidance (March 2007).'*
1.2	Halton's inter-agency Safeguarding Adults Board and Halton Borough Council (which has a lead responsibility for coordinating arrangements for safeguarding vulnerable adults in Halton) recommend that partner agencies and carers adopt and implement this Anti-Bullying Policy and Procedure.	
1.3	Some instances of bullying and harassment will constitute a criminal offence. This Policy does not offer advice or guidance on what to do when a criminal offence has been committed. In these circumstances individuals and their parents/carers should be advised to contact the Police.	
1.4	This policy will interface with the 'Adult Protection in Halton – Inter Agency Policy, procedures and Guidance' with regards to taking decisions on whether that be implemented or this Anti Bullying policy is applied.	
2	**DEFINITIONS FOR THE PURPOSE OF THIS POLICY**	
2.1	**Policy**: This policy is a statement about what the Partnership Board plans to do to carry out its responsibilities in relation to preventing/dealing with Bullying of Vulnerable Adults	
2.2	**Procedure:** The steps that need to be taken to carry out the policy will follow each key principles of the policy	
2.3	**Practice:** Practice material identifies good professional practice in order to meet the Service User's needs.	
2.4	**Bullying:** Bullying behaviour may be defined as 'the unjustified display of verbal or physical aggression on the part of one individual or group towards another'. Anyone can be a bully – friends, family members, members of staff, members of the public.	
2.5	Bullying tends not to be a one-off incident, but something that happens again and again over a period of time. Often as an incident it does not warrant any Police intervention.	

2.6	Bullying involves some form of of power and sometimes involves hitting or kicking, but threats, teasing and taunting are more common and can be more damaging. An individual's perception of bullying, or tolerance to behaviour that might be perceived as bullying, will be different from person to person. Behaviours that one person does not perceive as bullying may be perceived as bullying by another. Bullying can take one or more forms, including: • **Verbal**, eg, name calling, swearing or making abusive comments. • **Indirect**, eg, ignoring or excluding another person. • **Material**, eg, when possessions are stolen or damaged or extortion takes place. • **Emotional/Psychological**, eg, when intimidation is used or pressure to conform is applied. • **Physical**, eg, when a physical assault is made Some people know that they are bullying others and they mean to bully, ie, there is intent. However, some people bully others without knowing that what they are doing is bullying.	
3	**MENTAL CAPACITY ACT 2005**	
3.1	Individual's who lack capacity to make decisions regarding their health and wellbeing maybe covered by the Mental Capacity Act 2005 in order to protect their right to access appropriate health and well being services.	
3.2	The Mental Capacity Act applies to all individuals in England and Wales who are aged 16 and above and who lack capacity to make decisions. Hence everyone directly involved in the care of such individuals or employed in health and social care will be subject to the Act.	
3.3	An individual demonstrably lacking capacity will need someone to make decisions on their behalf. The more important the decision the greater the likelihood that more people will be involved. An assessment must be made for each decision.	
4	**CONTEXT**	
4.1	Vulnerable adults face prejudice and widespread discrimination in all areas of their lives - at work, in shops and leisure centres, in residential homes and day centres, in their community, on public transport - and so simple activities such as leaving the house, walking to work or catching a bus can often be upsetting and distressing experiences. Such experiences can often make people feel like outcasts and prevents them from taking a full part in society.	
4.2	The effect of regular bullying can be devastating. Being called a name may appear trivial in itself but it becomes significant when it happens all the time to the same person. Such intimidation constantly weighs on the daily lives of those people and can	

	have cumulative and devastating	
4.3	Bullying is stressful and, therefore, produces the same problems as other forms of stress. It is embarrassing and humiliating and undermines both the self-confidence and self-esteem of vulnerable adults and their confidence in those around them. It can also add to feelings of being different and isolated that many older people or people with a learning disability, a mental health problem, physical disability or sensory impairment already experience.	
5	**RIGHTS & RESPONSIBILITIES**	*The Disability Discrimination Act 1995 makes it unlawful to discriminate against disabled persons in the provision of facilities and services. Under the Disability Discrimination Act 2005, all public bodies have a duty to have regard to the need to eliminate discrimination and harassment on grounds of disability and promote positive attitudes towards disabled people. Tackling disablist bullying is a key part of fulfilling this duty.*
5.1	All agencies involved in the provision of services to vulnerable adults and supporting this Policy share a common set of values to ensure that vulnerable adults have: • The same **human rights** as everyone else to not live in fear and to be free from bullying and harassment. • The right to live as a valued and equal member of the community while being shown **respect** and afforded privacy. • The right to exercise informed **choice** about the way they live their lives and in the take-up of services. • The right to high **quality**, flexible and accessible services and a support network of professionals. • The right to their **independence**, to achieve their full potential and to live according to their wishes and beliefs. • The right to have a **voice** and their views listened to in the planning and provision of services available. • The right to have the same **opportunities** in life as others and not be bullied, harassed or discriminated against because of their disability. As per National Minimum Standards for Care, fundamentally care and support workers should 'treat others as you would wish to be treated yourself'	
5.2	Halton Safeguarding Adults Partnership Board and its partner agencies recognise that all vulnerable adults are potentially at higher risk of discrimination, bullying and harassment and have therefore developed this Anti-Bullying Policy, and Procedure which applies to all vulnerable adult groups and complements 'Adult Protection in Halton – Inter-agency Policy, Procedures and Guidance'	
5.3	Every employee of member agencies in the Halton Safeguarding Adults Partnership Board and its partner agencies, service providers, care workers or advocates working with vulnerable adults have the responsibility to be aware of,	

	notice and pass on allegations of bullying immediately. Whether the incident is observed or reported, prompt action should be taken to ensure the safety of the victim and to challenge and address the behaviour of the bully.	
5.4	Employees of the Halton Safeguarding Adults Partnership Board members and its partner agencies, service provider, care workers and advocates have a responsibility to: • Respond immediately to any observed incident of bullying • Do not ignore any observed or alleged incident of bullying • Take any allegation seriously, however insignificant it may seem to them. • Where the allegation comes directly from the alleged victim or their carer, to accept it and avoid making any judgements or comments other than to be comforting and sympathetic. People's tolerance levels and perceptions of behaviours vary from person to person. If a person reports that they feel like they are being bullied, this is enough reason to address the behaviours. • Urgently report concerns to their Supervisor / Manager. • State their concerns clearly.	
6	**THE SIGNS OF BULLYING**	*Staff should be vigilant when dealing with service users to identify any of these physical or behavioural changes in a person as soon as possible.*
6.1	There is no certain way of spotting that a person is being bullied, however, the following physical and behavioral signs can be indicators that bullying has or is taking place : • Significant changes in normal behaviour or attitude • Challenging behaviour • Upset • Anger • Being withdrawn • Quietness • Depression • Appearing frightened or subdued in the presence of particular people • Refusal to eat or join in • Unwillingness to travel on public transport • Not wanting to go to a certain venue • Starting to bully others • Incontinence • Vomiting • Unexplained illness • Claims of feeling unwell • Bruising or physical marks • Torn clothing • Unexplained loss of money or goods • Sleepless nights • Repeating words the perpetrator has said to them, eg, "shut up or I'll hit you".	

1 PROCEDURE

1.1 If any employee or service provider is worried about a service user or becomes aware that a service user is being bullied via a colleague, another service provider, partner agency, parent/guardian, care worker, family carer or advocate, they should try to sensitively bring this up at an appropriate time with the service user and invite them to communicate their experience in whichever way is appropriate to them. The following guidelines should be used:

1. Find out what support the victim will need before talking to them about their experience. People with a disability may not always have the communication skills to report, effectively and in detail, specific incidents of being bullied and will need specific assistance with this. For example, he/she may wish to have another person present, such as a friend, carer or advocate, or may require the use of communication aids.

!Many people will find it upsetting to talk about their experience of bullying and will need emotional support during and after the meeting.

2. Ensure the meeting takes place in a quiet place without interruptions.

3. Try to establish what type of bullying is taking place and where.

4. Try to establish who is carrying out the bullying.

5. Try to establish how often the bullying is happening.

6. Try to establish how the victim is responding to the bullying.

7. Ask the victim to write everything down that the alleged perpetrator has said or done, or ask the person they have been accompanied by to do this for them.

8. Advise the victim not to hit out at the bully or bullies as they themselves may end up being accused of bullying.

9. Establish what outcome the victim wants.

10. Discuss options to resolve the situation.

11. Agree actions.

! Action(s) agreed may not always solve a bullying situation, but they can help.

12. Reassure the victim that they have done the right thing

	by communicating with you the victim that the bully is the one with them. 13. Advise the victim of what happens next. **!**The end of the meeting is as important as the start. The victim should feel as though the problem is being resolved. 14. Arrange to speak with the alleged perpetrator, if known, and/or other relevant people. If the perpetrator is unable to be dealt with due to a bullying incident occurring in public, emotional support should be provided to the victim, together with advice on how to deal with such incidents if they re-occur. For example, if the service user is being bullied by a fellow tenant he/she should be advised to report this to their landlord; if the service user is being bullied by a fellow student at college he/she should be advised to report it to a lecturer. 15. Consider why the alleged perpetrator is bullying - think about their environment, relationships and communication. Bullies can have distress in their own lives and use fighting and threatening behaviour as a way of coping 16. Define the experience from each person's view. **!**Information should only be disclosed on a need to know basis. 17. Keep a written record of what has been said to you, your responses and any other actions taken. 18. After following the above guidelines it is the Manager's responsibility to determine whether further action is required, e.g. referral for the matter to be considered or to be deal with through the inter-agency Adult Protection Procedures, permanent or temporary exclusion from services, police involvement, etc. 19. Information will be kept on the service user's file and each incident will be monitored to minimise the possibility of reoccurrence and ensure that any further action needed is taken.	
1.2	Decisions around if the 'Adult protection in Halton – Inter Agency Policy, Procedures and Guidance' should be adopted over this Anti Bullying Policy will depend on the on the nature of the allegations or concerns, their gravity, the level of risk to the individual or others and whether the 'victim' can and wants to engage in the process and the 'victim's level of vulnerability and ability. Referring to the 'Adult protection in Halton – Inter Agency Policy, Procedures and Guidance will assist in identifying if concerns should be taken down the adult protection procedures route or whether this policy would be appropriate. However, if this Anti Bullying Policy is initially adopted to deal with concerns/allegations, should they escalate,	

	this may be a trigger for the adult dures to be implemented, especially if there is or if there is a need for other investigations or possible sanctions.	
2	**PROFESSIONAL CONDUCT**	
2.1	In talking with a victim about their experience of being bullied remember to: • Be patient • Listen • Not judge • Take the allegation seriously • Not interrogate the victim • Show that you care • Avoid promising confidentiality	
2.2	Some people bully others without knowing that what they are doing is bullying, therefore, the alleged perpetrator must also be listened to and supported and not be judged or interrogated.	
2.3	Sometimes an individual can provoke another to such an extent that they are then bullied themselves or are bullying others. We should all be aware of our own actions and the effect they might have or are having on other people.	
2.4	In some instances, talking about bullying can be a key that unlocks the door to unhappy secrets and those dealing with bullying must be prepared to deal with any problems they find.	
3	**RELATIVES AND ADVOCATES**	
3.1	It is beneficial to everyone to inform a relative sooner rather than later of incidents of bullying and to let them know that the procedures within this Policy will be followed. Relatives and advocates of service users who are alleged as bullying may find it hard to believe or accept that the individual is capable of such behaviour. It is therefore important that discussions are based on well-documented evidence.	
3.2	Often it is useful to use a problem-solving approach, for example by saying "It seems your son/daughter and 'x' have not been getting on very well lately" rather than "Your son/daughter has been bullying or has been bullied". They should also be advised of independent agencies that may be able to offer additional support, such as independent advocacy services and the Patient Advisory and Liaison Service (PALS).	
3.3	Strong measures, including temporary or permanent exclusion, may sometimes be necessary as an outcome, but only after risk assessment and, where appropriate, other plans and talking have been tried and have not worked.	

3.4	If a relative or advocate reports b • Recognise that they may be angry or upset. • Keep an open mind. • Remain calm and understanding • Make clear that you care and that something will be done. • Agree to meet or speak with them further to explain the procedure and actions. • Follow the guidelines in Section 7.1.	
4	**STAFF/PAID CARERS ACCUSED OF BULLYING**	
4.1	Allegations against staff and paid carers must be taken seriously and should be dealt with through the adult protection procedures and relevant employer's disciplinary procedures followed.	
5	**COMPLAINTS**	
5.1	The Halton Safeguarding Adults Partnership Board is committed to listening to people who may use or are affected by the services we provide and to dealing with complaints and suggestions in a positive and constructive manner. People may voice their dissatisfaction through the member organisations complaints procedure.	
6	**ROLE OF THE POLICE**	
6.1	It is the responsibility of the Police (not The Halton Safeguarding Adults Partnership Board) to investigate allegations of crime. When a crime is being investigated in Halton, Cheshire Police are committed to working in accordance with 'Adult Protection in Halton – Inter-Agency Policy, Procedures and Guidance' and will consult and work with other agencies and individuals as appropriate.	
6.2	Where a person believes that a criminal offence may have been committed they should speak to the victim and encourage them to contact the police or where there is a risk of harm to the individual the referrer should consider contacting the police themselves	
7	**CONTACT NUMBERS**	
7.1	**Referrals for assessment, support, investigation through the inter-agency Adult Protection Procedures via Halton Borough Council's 24 Hour Contact Centre:** Telephone: 0151 907 8306 (for Safeguarding Adults referrals) The Emergency Duty Team operates when day offices within Social Services are closed and can be contacted directly on **0845 050 0148**	

7.2	**Police:** Vulnerable Adults Officer Cheshire Constabulary **Telephone: 01244 613937.**	
7.3	**For more information about safeguarding vulnerable adults / adult protection, visit Halton's website at www.halton.gov.uk/adultprotection**	

Why do we have an Anti Bullying Policy?

We have a responsibility to safeguard vulnerable adults who we provide services for.

What is in the Anti Bullying Policy?

The policy sets out the rights and responsibilities of service users and staff on relation to bullying.

It contains definitions of bullying and signs and signals for staff to be vigilant of that may indicate that a person has been, or is being bullied.

The policy provides procedures to deal with allegations of bullying.

The policy outlines the key principles of professional conduct in dealing with a potential bullying situation

What to do if you suspect, witness or hear of bullying of a service user
(summary of procedure, full procedure found in main policy, procedure and practice document):

- Record what you saw/heard/were told using exact wording
- Talking to alleged victim them about their experience. He/she may wish to have another person present, such as a friend, carer or advocate, or may require the use of communication aids.
- Try to establish what type of bullying is taking place and where, how often the bullying is occurring, who is carrying out the bullying and how the victim is responding to the bullying
- Ask the victim to write everything down that the alleged perpetrator has said or done, or ask the person they have been accompanied by to do this for them.
- Advise the victim not to hit out at the bully or bullies as they themselves may end up being accused of bullying.
- Discuss options to resolve the situation, agree actions advise the victim of what happens next.
- Arrange to speak with the alleged perpetrator, to be able to define the experience from each person's view
- Keep a written record of what has been said to you, your responses and any other actions taken.
- After following the above guidelines it is the Manager's responsibility to determine whether further action is required, e.g. referral for the matter to be considered or to be deal with through the inter-agency Adult Protection Procedures, permanent or temporary exclusion from services, police involvement, etc.

Do NOT:

- Keep concerns, allegations, disclosures or your own worries to yourself.
- Speculate
- Ask leading questions
- Stop someone who is freely recalling a significant event
- Make promises you can't keep (eg This wont happen again)
- Pass on information anyone who doesn't have a need to know

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 9 March 2010

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Telecare Service Evaluation

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with the results of the Telecare Service Evaluation of January 2010.

2.0 **RECOMMENDATION:**

That the Healthy Halton Policy & Performance Board:

i) Note the contents of the report.

3.0 **SUPPORTING INFORMATION**

3.1 Telecare consists of electronic sensors installed in a person's home. Typically they include: fall detectors; smoke alarms, motion detectors, temperature sensors, a personal alarm pendant and a 24 hour 7 days a week emergency response service. When coupled with an appropriate support plan Telecare helps individuals to live more independently and safely at home. It can reduce risk by providing reassurance that help will be summoned quickly should a problem occur.

3.2 The report summarises the Telecare service in Halton over the past three years and examines it within a local and national context. The clear picture emerging is that Telecare has been operating successfully in Halton for this period and there is good evidence that it is broadly welcome and is making a difference to individuals, their carers and to the delivery of health and social care as a whole. Specifically, It is helping to improve people's independence and confidence by allowing them to remain at home longer. There is also evidence that it can relieve stress on informal carers and can improve clinical and care outcomes.

3.3 The service evaluation carefully defines Telecare and stresses its importance in Halton in terms of Partnership Agreements within the context of key national drivers and regional agendas. Early engagement with the voluntary sector as service user

representatives is considered important. In addition, the Widnes Practice Based Commissioning Consortium (PBC), Halton and St Helens PCT and HBC are currently commissioning a community based integrated care service known as the 'Virtual Ward.' An important component part of this will be the planned use of Telecare. This will support self-management at home among the most vulnerable individuals and those with long-term conditions in order to reduce unnecessary hospital admissions.

3.4 Telecare is likely to have a significant future role monitoring long-term conditions such as: Hypertension, Diabetes, Coronary Heart Disease and Dementia. The outcome of such monitoring would be a reduction in hospital length of stay among those with complex histories.

3.5 Halton is currently developing an Early Intervention/ Prevention strategy that will focus on individual dignity, independence and equality, as a means of reducing social isolation while enhancing reablement. Assistive technology in the form of Telecare will be central to this.

4.0 POLICY IMPLICATIONS

4.1 Telecare will be a significant part of HBC's Early Intervention/ Prevention strategy (currently in development), which stresses the importance of individual dignity, independence and equality.

4.2 Telecare can have a crucial role in 'Vital Signs Monitoring' to assist individuals to manage their long-term conditions such as diabetes at home. This will hopefully be offered via the PCT with HBC in a supportive role and would be a useful precursor to developments such as the Virtual Ward. In this respect, Widnes-based GP surgeries are interested in piloting Telecare/ Telehealth within the Virtual Ward Concept. This will result in an increase in referrals for current Telecare sensors as well as a possible installation and technical support service for Telehealth applications.

4.3 Halton, through its Community Extra Care (CEC) programme is committed to providing vulnerable people with fast dedicated help in the comfort of their own home among familiar faces and surroundings, where they can recover more quickly after a period in hospital. This is part of the general nationwide trend of offering people greater independence and choice. Telecare can also be a component part of Extra Care if the CEC rapid assessment team consider it necessary.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 When Telecare is coupled with an appropriate support plan, the most significant outcome is that the individual is able to remain

safely and independently at home for longer. Thus safety and security monitoring is an important function of Telecare. As evidence of this, during the period 2007-2008, 17 service users eventually had to move into residential placements. However prior to their residential move and thanks to Telecare, 6 of these remained at home for over a year and the remainder between one and twelve months.

6.0 OTHER IMPLICATIONS

6.1 To meet future need in Halton, Telecare will have to be developed on a larger scale and involve many more sensors and devices. It needs to be fully integrated into the care system and be predictive in order to allow observation of longer-term trends and earlier intervention. Future qualitative analyses (reviews and surveys etc) would need to be able to demonstrate that:

- People are happy with its quality and accessibility
- Levels of self-management have increased
- Positive changes in behaviour have occurred
- Fewer symptoms are being reported

6.2 Halton's third area of focus 'vital signs monitoring' needs to be expanded and individuals assisted to manage long-term conditions such as diabetes at home. Monitoring would be done by the PCT with HBC in a supportive role providing the necessary Telecare/ Telehealth units. This would be a useful precursor to current developments such as the 'Virtual Ward.'

6.3 Halton is currently (January 2010) in the process of developing its Early Intervention/ Prevention Strategy. This will stress the importance of individual dignity, independence and equality while at the same time reduce social isolation. It is the intention that Telecare will be a means of achieving this kind of personal control for long-term conditions, especially when combined with Halton's Direct Payments facility and individual budgets. Page 20 offers a glimpse of what the immediate and more distant future of local Telecare may offer. Telecare in Halton has three principal areas of focus:

1. Information, advice and support – being able to demonstrate that as a form of support it has had an impact on clinical and care outcomes for vulnerable people with specific conditions.
2. Safety and security monitoring – being able to demonstrate that Telecare has enabled vulnerable people to feel safer and more secure at home.
3. Vital signs monitoring – putting a case for funding Telehealth as a cost-effective means of monitoring and assisting individuals to manage their diabetes (for example) at home.

6.4 The third of these has an important role in future plans to expand the service. The first two are evidenced by the fact that there has been an increasing trend year on year in the number of individuals connecting to a Level 2 or Level 3 lifeline package. There are currently almost 25% more people receiving Telecare in 09/10 than in the previous year 08/09./ There has also been a significant decrease in the number of call-outs. Such data would suggest that not only is the service becoming better known, but confidence in its ability to manage risk is growing among those who wish to maintain their independence at home.

6.5 There has also been a 145% increase in environmental referrals in the period 2008 – present, suggesting that people are becoming more aware of what the technology can achieve in terms of monitoring. Consequently, they have been more inclined to make use of environmental monitors such as heat, cold, water…detectors, as an additional 'safety blanket.' Clearly Telecare has been a success in Halton.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children & Young People in Halton

None identified.

7.2 Employment, Learning & Skills in Halton

In order to raise awareness among staff of the current and future importance of Telecare all relevant staff will need to receive the new Telecare training as part of their normal continuing Professional Development.

7.3 A Healthy Halton

Telecare will be a significant part of HBC's Early Intervention/ Prevention strategy (currently in development), which stresses the importance of individual dignity, independence and equality. Telecare can have a crucial role in 'Vital Signs Monitoring' to assist individuals to manage their long-term conditions such as diabetes at home. This will hopefully be offered via the PCT with HBC in a supportive role and would be a useful precursor to developments such as the Virtual Ward. In this respect, Widnes-based GP surgeries are interested in piloting Telecare/ Telehealth within the Virtual Ward Concept. This will result in an increase in referrals for current Telecare sensors as well as a possible installation and technical support service for Telehealth applications.

7.4 A Safer Halton

None identified.

7.5 **Halton's Urban Renewal**

None identified.

8.0 **RISK ANALYSIS**

7.1 Risk is balanced against individual need and rather than being seen as imposed surveillance. Telecare operates as a carefully agreed set of responses that enable previously identified risks to be managed efficiently and safely.Vulnerable people who are receiving technological and professional support to live at home, feel more secure in the knowledge that help is readily available, should they require it.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 It is essential that the Council addresses equality issues, in particular those regarding race, gender, sexuality, age and disability when considering its Telecare policies.

HALTON
BOROUGH COUNCIL

Telecare Evaluation
20 January 2010

Contents

Appendices

Section 1

1.0 Introduction

Telecare is a set of electronic sensors installed in a person's home. These include: temperature sensors, fall detectors, smoke alarms, motion detectors, a personal alarm pendant and a 24 hour 7 days a week emergency response service. When coupled with an appropriate support plan Telecare helps individuals to live more independently and safely at home. Once installed, it can reduce risk by providing reassurance that help will be summoned quickly if a problem occurs. Telecare in Halton comprises three components: an emergency response, environmental monitoring and lifestyle monitoring (see section 2.0).

Telecare has been operating successfully in Halton for over 3 years and as this document shows there is clear and substantial evidence that it is broadly welcome and is making a difference to individuals, their carers and to the delivery of health and social care as a whole. It is helping to improve people's independence and confidence by allowing them to remain at home longer. There is also clear evidence that it can relieve stress on informal carers and can improve clinical and care outcomes, by significantly delaying hospital and care home admissions. As a consequence, Telecare has resulted in substantial pre-admission savings of over £0.4 million in the period 2007-2009.) This figure is based on a current average cost of residential care in Halton of £456.00 per week.)

2.0 Telecare Technology Defined

Thanks to rapid developments within electronics, computing, engineering and telecommunications, over the past few years a number of new technologies have arisen. Many of these can be used to support or maintain independence at home and are commonly known as assistive technologies. Generally an Assistive Technology (AT) can be defined as any product, system or service that enables a person to:

- Improve their independence
- Improve their quality of life
- Increase their likelihood of being included and participating in society through recreational, educational and work-related activities.

The technology is manually activated by the person, by using an alarm button. Alternatively, activation can occur automatically when a home-based sensor's parameters have been exceeded. Accordingly, as a form of assistive technology, Telecare tends to be categorised into the following three distinct generations:

- ***First generation*** Telecare refers to user activated (push button, pendant or pull cord) alarm calls to a Control Centre where a call handler organises an appropriate response by contacting a neighbour, relative or friend who is acting as key holder.

- ***Second generation*** Telecare represents a step beyond the basic Community Alarm service with the addition of specific sensors such as smoke and flood detectors. Second generation also includes sensors that are designed to monitor the home environment, vital signs, physiological measures and lifestyle. They can collect and transmit information continuously about door opening, bathwater running, the use of electrical appliances and movement within and from the house. All Telecare at HBC is 2nd Generation.
- ***Third generation*** Telecare stems from improvements in wireless, audio-visual technology and the increasing availability of broadband. Together these enable virtual or actual tele-consultations between the service user and the appropriate health professional (doctor, nurse, support worker…etc). In this way it can significantly reduce the need for home-visits or hospital appointments. It can also lead to increasing opportunities for people (particularly those who are housebound) to visit libraries, shops and maintain regular contact with extended family and friends.

Telecare is the generic name for advanced community alarm services, which use the telephone network and associated assistive technology to provide a combination of environmental and lifestyle monitoring services to vulnerable people in the own homes. In this way, Telecare can be used as an additional aid to service users and responsible others by helping them to manage identified risks.

Within Halton, Telecare offers a personalised mix of environmental and lifestyle-monitoring sensors all of which can be added to a basic community alarm unit (Lifeline 400, Lifeline 4000+ and Lifeline Connect+). This unit comes with a call button (pendant) which can be worn by the individual who can then summon help from anywhere in the home or garden. Service users can also wear sensors capable of detecting if they have had a fall. If any of the sensors in the house or on the person detect an event they send a wireless signal to the base unit. This automatically dials through to the contact centre where an appropriate response is triggered. Hence, Halton currently offers a combination of 1st and 2nd generation devices, but is moving into the third.

The base unit is able to provide details 24-7 on screen at a control centre. Lifeline (both 400, 4000+ and Connect +) units have a powerful loudspeaker and sensitive microphone. These allow a hands-free two-way conversation between the service user and the control centre operator. If the alert is an emergency, or if the contact centre operator cannot contact the person at home, then the individual support plan protocol is triggered and the response activated by the Contact Centre and underpinned by the Warden Service.

3.0 Key National Drivers – Living Longer with Greater Expectations

As far back as 1999, the Royal Commission on Long Term Care predicted that the cost of providing long-term health and social care for older people in the UK would double to £12 billion per annum by 2025 and double again by

2050. Such projected costs were considered unsustainable using the then current approaches to older peoples care. They were also compounded by changes in the structure and expectations of society. These have led to:

- People living much longer into retirement. Over the next 50 years, the population of over 65s is expected to rise from the current 9.3 million to almost 17 million, with an estimated 90% of people wanting to live in their own home with whatever support is available to them.
- An increase in the number of people living alone and outside family networks.
- More expensive healthcare interventions, particularly for lengthy stays in hospital and care homes. By 2020, around 20.5 million people are expected to suffer from long-term conditions and the World Health Organisation predicts it will become the 'biggest killer. Hence, the number of individuals requiring community-based health and social care support will increase considerably.
- People and their families have much higher expectations regarding quality and choice in care delivery. As a consequence of this, a shift towards care in the wider community, patient empowerment and self-care is already well established.

(Data from E-Health Media Ltd, (2007))

These trends, coupled with an expected decrease in the numbers of informal carers and capacity strongly limits the system as costs continue to rise. All of this points to Telecare becoming a dominant influence as we progress towards 2020. Hence the role of councils such as Halton is to raise awareness by showing how the technology can: help mitigate risk while the person remains in their own home, improves their functionality and offers a level of prevention from physiological, environmental or lifestyle problems that are likely to occur, in the course of their daily lives (see also 9.0)

Over the past few years, the accepted approach has been two-fold: changing the way in which care is delivered with the emphasis on home-based care and making more use of enablement and assistive technology (ICT and communication in the form of Telecare and Telehealth) to assist in such care.

This assistive technology enables an individual living at home to: achieve a greater level of independence, enhance their quality of life and reduce their social isolation by helping them to participate in recreational activities with others.

Telecare services in the UK reflect the changes that have occurred as public resources have shifted from secondary to primary health care. Support services associated with community alarms have expanded to include more people with health care and medical support needs within the community. The result has been a convergence of health and social care. Cost and capacity are fundamental drivers here. Data in the 'Telecare Service Strategy for Wrexham' (2006) showed that community based care is more than £10,000 less per person per year, than the cheapest institutional care!

Telecare is currently undergoing intense expansion and considerable research. It's early beginnings some 20 years ago were as a first-generation product offering a personal response without intelligence. This has evolved into the second and third generation systems we have currently and which are being developed, that can automatically detect and generate alerts calls. During the next few years, the expectation is that Telecare will be available to all those who need it, be personalised and able to meet the important requirement of predicting acute situations before they actually occur.

4.0 The Political Context – National Regional and Agendas

The Department of Health's report on The Expert Patient (2001) stressed that the era of the patient as a passive recipient of care is being eroded by a new approach in which health professionals and those they are caring for are genuine partners in which the use
of home-based technology would enable the recipients of health care to monitor the progress of their disease.

Halton's Corporate Plan (2006-11) stresses the need for partnerships in service delivery and especially the importance of consulting with those who will be using the services offered. A joint commissioning framework and pooled budgets have been established with the PCT. All of these will enable service development to continue in such areas as mental health, learning and disability and older people services.

Halton's strategy for Older People places emphasis on a variety of objectives such as: enhancing the engagement and participation of older people, tackling ageism, age discrimination and age stereotyping. To achieve all of these, collaborative links between transport, sport and leisure, neighbourhood renewal, health care, education, citizenship and community engagement have been forged.

The overall image of the future in Halton is that individuals are involved and have a direct say in all community activity to the extent that all of Halton's services are triggered from the ground up, rather than from the traditional, more distant and less effective, top-down paternalism.

Within this picture Telecare and Telehealth are seen as crucial in supporting people's choices for the kind of social and health care they want at home. The government's recent 'Personalisation Agenda' was created to ensure the person is kept centre-stage in their own home, where they prefer to be and where medical evidence shows they recover better from illness, due to support from their own social and community network. Telecare and future developments in Telehealth are tailor made for this approach.

In Lord Darzi's (2008) review and 10-year vision of the future Health Service, he stressed that the NHS will not be confined to hospitals, health centres or GP surgeries. It will also be available on-line in people's homes. Also, where previously people were once confined to hospital, Wireless, Bluetooth and digital technologies will allow health to be monitored at home.

A key component in Darzi's vision was the role that good quality accessible housing, education, employment, local transport and recreational facilities play in the health and wellbeing of the population. Darzi's review highlights the following 5 key areas of which Telecare/Telehealth and housing are crucially important:

- Prevention
- Empowering service users
- Quality of care
- Integration of services
- Innovation

It is clear from Darzi's review and various visions for future health and social care across much of the developed world, that Telecare and Telehealth will have prominent roles to play. The challenge for commissioners and providers is to realise their importance and adopt them even when the evidence base to support them may be far from risk free!

5.0 Telecare In Halton – Partnership Agreements

The successful implementation and delivery of Telecare requires a 'whole systems' approach and it is vital that all partners are fully engaged at an early stage. Halton is a Unitary Authority and therefore the involvement of a number of departments including: housing and social services is necessary to deliver the Telecare agenda. Similarly, early engagement with the voluntary sector in their role of service user representatives is also required.

In addition, the Widnes Practice Based Commissioning (PBC) Consortium, Halton and St Helens Primary Care Trust (PCT) and HBC are currently commissioning a community based integrated care service known as the 'Virtual Ward.' This will actively support the most vulnerable individuals and those with long-term conditions at home, in order to reduce unnecessary hospital admissions.

An important component part of the Halton's Virtual Ward concept will be its planned use of Telehealth devices to support self-management and the close monitoring of physiological observations. Telecare could have a significant role monitoring such long-term conditions as: Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Coronary Heart Disease (CHD) and Dementia. The incidences of all of these conditions in various Halton practices, significantly exceed the national average. The important outcome in this respect would be to reduce hospital lengths of stay among people with complex histories, due to emergency admissions.

Halton is also developing an 'Early Intervention / Prevention Strategy.' This will focus on individual dignity, independence and equality in order to reduce social isolation while enhancing reablement. An important component of this overall strategy will be assistive technology in the form of Telecare / Telehealth, the supporting people agenda and greater control through direct payments and individual budgets.

HBC are partnered with Age Concern. During the initial assessment the person is asked whether they would like an Age Concern Stay Safe Check. This is helpful as a means of identifying potential danger zones in the home that would carry a high risk of a fire or fall. They also provide additional advice. HBC arrange the Stay Safe Check and Age Concern carry it out.

6.0 Training

Training is central to the continued development of the current Telecare service. For all Community Warden staff it occurs on induction to the service or as new products are made available. Currently, training is delivered by the Telecare Implementation Officer and involves a PowerPoint presentation and product demonstration. Staff also have the opportunity to address any training issues as they arise and Wednesday each week is set-aside for this.

In addition, training has targeted other staff from health and social care, the independent and voluntary sectors. This also takes the form of a presentation and product demonstration. Such sessions usually last fro 2-3 hours to a half-day. The emphasis is to highlight how Telecare forms an integral part of a support plan. Currently 112 people (averaged over 17 dates in 2008-9) have received this training. These were staff from: Alzheimer's Society, the Supporting People Forum, Community Extra Care, Halton Multiple Sclerosis Group, Cheshire Fire Service, all sector groups and Private Reablement Providers.

Future training plans will be linked to the level of training required for staff who are directly involved in the assessment process. Such high-level training (see section 8.5) will be commissioned through the training section.

A 'Telecare Training Group' (TTG) has been set up led by Steve Kelly to drive forward the training agenda. This progresses the introduction of new Continuing Professional Development (CPD) training modules and actively promotes take-up of these new training opportunities by professional staff engaged in the assessment of those with potential long-term care needs.

The TTG also progresses the development of training courses to meet the needs of staff within the service and referrers who will use the service (Telecare handlers /responders and more generally those involved in equipment installation). The TTG also give advice to service users and their carers on how to use the equipment.

7.0 Concerns, Strengths and Weaknesses

There is an increasing body of research related to telecare. Those who are generally supportive see it as an important means of helping vulnerable individuals to maintain a level of independence. At the same time, Telecare offers a means of significantly reducing healthcare costs, by enabling vulnerable people to remain at home.

Those who are less supportive, view it as a cost-cutting substitute that is more about “replacing human contact rather than complementing it.” Miskelly and Mickel (2009) also stress a number of factors that can act as a barrier to making Telecare happen - including finance, attitude, inefficient structures, inappropriate prescriptions, inadequate training and poor response services as major barriers to change. However, the government’s recent Green Paper “ Shaping The Future of Care Together” firmly positions Telecare within it’s forward looking prevention strategy:

> “*We will continue to support Telecare so that people feel more confident about staying in their own home*."
> (p. 51)

Nonetheless, the very real and documented fear that an increase in Telecare can result in vulnerable people having fewer human contacts and feeling more isolated as a consequence, remains a cause for concern (Percival & Hanson, 2006). As they point out, a health professional making regular contacts can observe subtle changes in a person’s condition – “little things that can be missed … that you can’t quantify.” Such contacts allow the less accessible emotional, psychological and motivational issues to be dealt with, in additional to the more usual practical tasks. Bowes and McColgan (2002, 2003) observed that people with Telecare reported feeling less safe and received fewer GP visits, than a comparative group without it. Such findings support Graham and Wood (2003) who concluded that digital technology and automated surveillance can encourage less human intervention and increase levels of anxiety.

A corollary of this frequently expressed by professionals is that local authority budget constraints could lead to staff being withdrawn, as Telecare becomes perceived as the less expensive option. However, as Percival and Hanson (2006) point out, rather than being a threat to the professional’s livelihood adequately staffed backup services are necessary for effective Telecare provision. The challenge for professionals is to be able to respond within a 24-hour situation. In this respect, Lyall (2005) has pointed out that Telecare as a support tool is only as effective as the speed of response of appropriate services. In addition, specialist training would be required enabling staff to respond effectively in cases of falls and to the needs of people with sensory and cognitive impairments.

The Directorate is paying particular attention to the potential problem of isolation as a consequence of Telecare, and questions related to this are incorporated as part of the service user questionnaire used to monitor performance (see para.13, below).

8.0 Target Audiences for Telecare Services

Telecare is needs based and once it has been embedded into current health and social care systems, it acts, not as a replacement, but as an additional support to professional care staff. In particular, it can help to avoid a loss of

independence and reduce the frequency and likelihood of admission to hospital or residential care.

Within Halton, Telecare is used as an electronic means of supporting the following vulnerable individuals:

- Those recently discharged from hospital who can be assisted to live at home in order to avoid the need for re-hospitalisation.
- For older people living alone Telecare offers a means of passive risk-management that serves to increase self-esteem and individual confidence in relation to accidents and security.
- People with dementia – reminders and sensors to detect dangerous situations.
- People with a learning disability – provides opportunities to maximise independence through electronic aids and emergency detection.
- People with physical disabilities (including auditory and visual) – remote control devices with risk management to provide easier access to emergency services in the event of an accident.
- People with increased frailty

9.0 Procurement and Choice Issues

There is considerable interest and enthusiasm for Telecare within Halton. The current service is well integrated with other support services (section 2.5 shows the variety of service referrals). Further, a key aspect of the service is the relevant person's ability to choose the level of service that suits them best. This best fit approach is tailored to the individual's needs and aspirations and can be extended or reduced accordingly as the person's support plan changes.

NHS Purchasing and Supply Agency (PASA) negotiated a four year national framework agreement covering Telecare equipment, installation, maintenance, monitoring and response services in support of the Department of Health's vision to build a strong Telecare infrastructure. The agreement went live on 30 June 2006 and will runs until May 2010. Regular product and pricing reviews are undertaken to ensure that the suppliers continue to offer cost effective solutions.

The framework covers 1st and 2nd generation Telecare systems (including remote vital signs monitoring equipment). It enables the development of consortia, as a means of taking advantage of price bands in which major savings can be made without the need to undertake expensive and time-consuming tendering processes. Currently only the UK's largest Telecare suppliers (Tunstall and Initial) have been accepted onto the PASA framework.

Like many councils HBC has tended to opt for a single supplier (Tunstall). This has a number of significant advantages - it simplifies: stock control, installation procedures and training requirements. In addition, Tunstall are the current market leaders in R & D and technical support

However, as personalised budgets for health and social care become common-place, individuals are needs assessed and Telecare /Telehealth devices are more readily available, people will be likely to choose whatever appeals rather than just being HBC led. Essentially they have three options under Personalisation: (1) purchase their own equipment and come to HBC for a response; (2) Purchase the whole package from HBC; (3) Not come to HBC at all.

10.0 Financial Outcomes – The Halton Charging Policy

The three service levels are charged every 28 days (4 weeks) in arrears as follows:

Service Level 1 - £5.42 (weekly) - this is the Community Warden Service. The charge is applied from the connection date. This level of service consists of a base alarm unit, with a pendant and smoke alarm. Private individuals pay the full amount, whereas those who are eligible are funded by the Supporting People Team.' Weekly charges to housing associations and trusts vary from £3.09 to £3.17.

Service Level 2 - £6.49 (weekly) – this is the Telecare (Environmental Monitoring) Service. There is an initial 2-week assessment period that is charged as for Service Level 1. After assessment, the charge is weekly as above. In addition to the base unit, pendant and smoke alarm, two further environmental sensors may be fitted. Examples of these are: Extreme Heat or Cold, Flooding, Carbon Monoxide and natural gas.

Service Level 3 - £8.65 (weekly) – this is the Telecare (Lifestyle Monitoring) Service. There is an initial 2-week assessment period that is charged as for Service Level1. After this the charge is weekly as above. In addition to the Environmental monitoring offered in Service Level 2, this service also provides a selection of Lifestyle Monitoring sensors. These detect motion (or lack of it) e.g. if someone has stopped moving, fallen, has gone outside, is in bed or sitting in a chair, for a prolonged period when they would normally be active.

All three service level costs above can be maintained at moderate levels year-on-year due to partial recycling. Base units and sensors such as: smoke alarms, fall, movement, carbon monoxide and door entry detectors can all be used many times over.

11.0 Objectives, Assessment and Installation

Service Objectives:

- To provide 24 hour response to an alarm call.
- To provide reassurance to individuals using the service and carers.
- To contact emergency services such as ambulance, fire or police on behalf of the service user.

- To reduce admission to hospital, residential or nursing home care.
- To assist in the early discharge of people from hospital.
- To provide a quality, cost-effective service that matches the individual needs of each service user.

Strategy Objectives:

- Promote assistive technology as a means of supporting independent living.
- Raise public awareness of Telecare within Halton.
- Maximise the time people are able to manage their long-term conditions at home.
- Promote home safety and security.
- Develop partnership agreements to facilitate Telecare.
- Improve the social and medical support to vulnerable people in order to reduce social isolation.

Currently some 1600 people are using the emergency response (Lifeline service) and of these around 70 have additional Environmental and Lifestyle devices installed. The Telecare and Lifeline service team is based in Widnes. It consists of 14 Community Wardens (a further 2 are currently on secondment) who operate a shift pattern, a dedicated team support officer, a technical specialist (Telecare Implementation Officer), a Telecare Installation officer, a team manager and a principal manager. The installation officer position is a shared by two individuals in a partnership agreement with Age Concern.

The team's principal role is to provide a 24 hour 365 day a year Telecare alarm service that is split into the following three levels by the cumulative addition of extra monitoring devices:

1. A Community Warden Emergency Response
2. Telecare Service Environmental Monitoring
3. Telecare Service Lifestyle / Environmental Monitoring

All of the above services rely upon the Level 1 emergency service being in place.

Telecare equipment will automatically activate a sensor when a certain critical threshold (e.g. temperature) has been reached, or if movement is no longer detected.

Referrals for a Telecare assessment can come from a wide variety of sources including self referral, family, GPs, other health professionals, social work staff, housing staff police and other community workers who may come into contact with a vulnerable person who could benefit from the service. The service is also beneficial to:

- People with Clinical /medical conditions such as MS.

- People with epilepsy, heart conditions, diabetes, dementia.
- People with Hearing, visual, speech or learning disabilities.
- Those living alone or with another vulnerable person.
- Those living with a carer or carers where the service is essential to maintain care arrangements.
- Carers who require support to alleviate some of the difficulties they experience in caring for a dependent.
- Families where a child may be at risk due to the medical condition of their carers.
- Families where there is a history of domestic violence and the partner is vulnerable when living alone.

The service is available to anyone of any adult (aged 18+) who would like to feel safer, more protected and independent in their own home. Within HBC referrals to the service generally come from the following teams:

Rapid Access & Rehabilitation Service - RARS
Older Peoples Team Widnes - OPW
Older Peoples Team Runcorn - OPR
Physical & Sensory Disability Team - PSD
Adult Hospital Team - AHT
Community Psychiatric Nurse - CPN
Adults With Learning Disabilities - ALD
Extra Care
Oakmeadow
Community Warden Service - CWS
Falls Service
Reablement
Next of Kin / Self
Community Mental Health team
Community Matron Service

The Referral Pathway: The Telecare alarm service pathway is outlined visually in Appendix 10. When an assessment has been completed (via Team or self) and the need for Telecare becomes clear, then the service user is informed and appropriate options are discussed. A referral is made to the Contact Centre (CC) and the appropriate Referral Proforma is completed. At this point, relevant information is passed to the Team Administration, who then contact the referrer to arrange an assessment. At this meeting a lifestyle assessment is carried out, the type of service required is identified and appropriate parameters and responses are set. Consent for all responses is obtained and a contract agreed with the service user.

At this point the CWS passes all information to the Contact Centre staff. Normally the CC becomes the first professional point of contact for the SU. However, this is flexible and the SU may choose to have others in this role (generally family member, partners or close friends).

The CC continues to monitor the installed system 24/7. As the person's activity patterns become apparent, the CC will ensure response protocols are

adjusted appropriately. At the end of each of the first two weeks, both the CWS and the referrer will review the service to ensure it is meeting the appropriate need. If this is the case after discussion with the Service User and carers and agreement is reached, then after week two Telecare is continued.

Charges are applied according to which package (1,2,or 3) is adopted and the CWS take over as the key worker. The service is reviewed annually or after there has been a significant change in the person's care needs.

If at any point Telecare is no longer required CWS will remove the equipment. At this stage certain equipment will be identified as suitable for recycling as a means of off -setting future costs.

The Assessment Process and Installation

Halton Community Alarm Service Assessment Version 4 (revised Jan. '09) is the assessment tool (Appendix 1) currently used. The assessment is carried out in the person's home and details of: the type of dwelling (e.g. whether a sheltered flat, house, bungalow…etc), personal and financial information, form part of the assessment document. In addition, health needs such as any current illness and a detailed inventory of the care and support that is required, plus any equipment or individuals who are available to assist with specific tasks. It also includes: any help with medication, specific communication needs and details of visiting health professionals such as a Community Nurse and GP.

Details of all devices to be fitted are logged along with appropriate responses for each. If for any reason, agreed protocols cannot be met then the CWS must respond and notify next of kin should an event occur. At level 1 (Community Alarm) it is important to establish contact with the person. If this is not possible, CWs are despatched, next of kin are made aware of the situation (lack of contact or a smoke detector triggered) and the fire service contacted. At Levels 2 and 3 (Telecare) each sensor has an appropriate response. For example if the absence alarm for a bed sensor has been triggered, it is important to establish contact with the person as soon as possible. If voice contact is not possible, then the CWS will operate the appropriate response protocol.

Any additional response protocols agreed with the individual, or their next of kin…etc, are included along with a detailed physical description of the person, an agreement slip for a digital image to be taken to help identification if the person is found wandering.

12.0 Dealing With Risk

At any time the person or their representative can contact Telecare service to have their support plan updated. This reviews the risks and the interventions required to manage each in order to meet the person's needs (Appendix 2).

For all three service levels any appropriate response is always agreed with the service user / and or significant others. This is important, because Telecare is not a form of imposed surveillance, but incorporates a carefully agreed set of responses that enable previously identified risks to be managed efficiently and safely. Its overall aim is to highlight potential problems before they become crises. By targeting such difficulties quickly, the person will inevitably feel safer, knowing that the kind of assistance they require will soon be on its way.

13.0 Monitoring and Measuring Performance

The flowchart on page 16 shows how evidence on performance is collected, for either the Community Alarm Service or Telecare and by whom. Shortly after installation (typically 1 -2 weeks) all new users of Telecare are asked to provide comments on the effectiveness of the service they are receiving (Appendix 7). This is known as a 'post-installation review' and provides the user with an opportunity to individualise the system to meet their behaviour, need and level of activity.

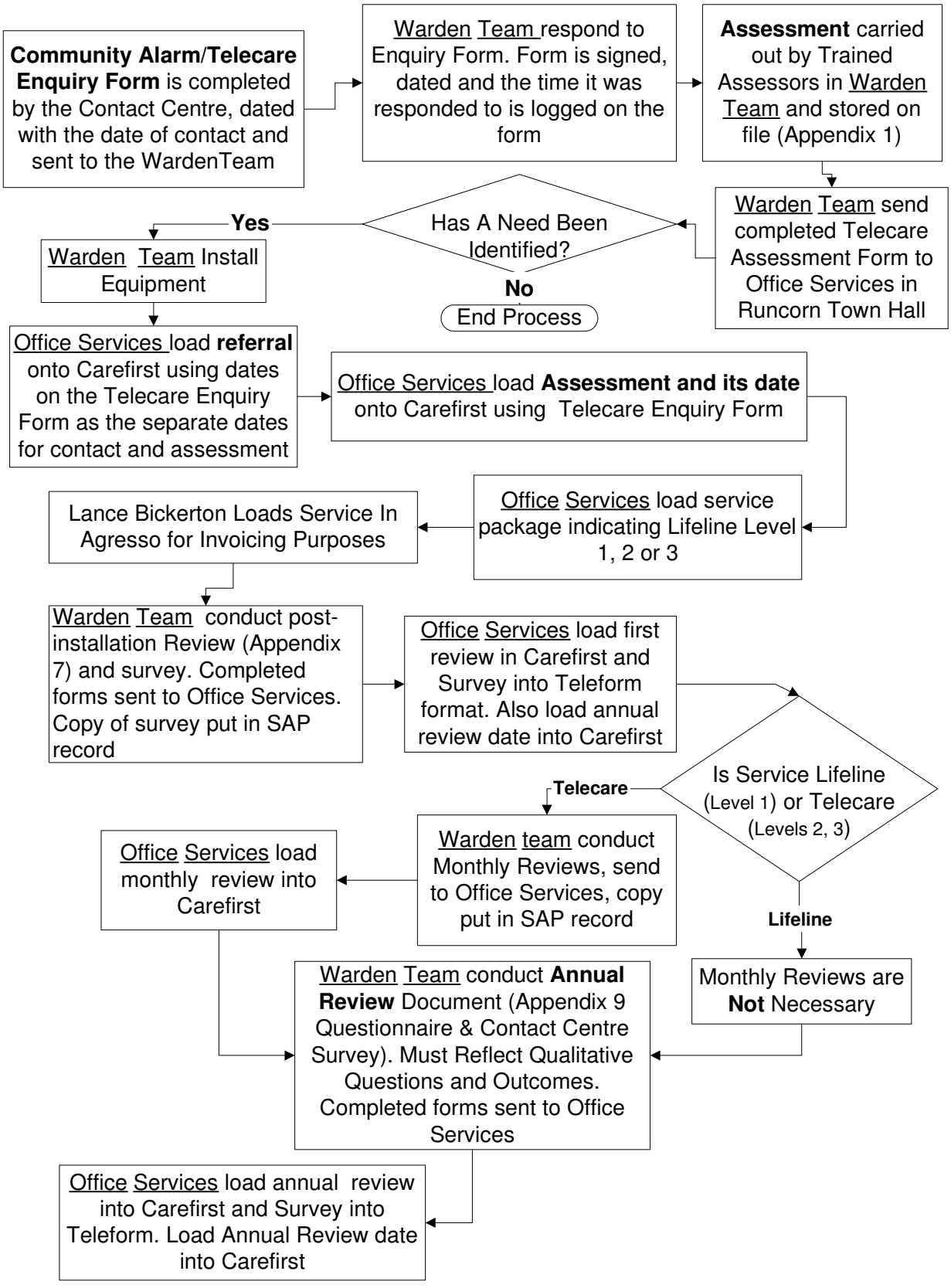
In addition, levels of satisfaction with the service are recorded on a monthly basis by the Community Warden team and all documentation placed in the SAP record. The Community Warden team also conduct an annual review of the service by questionnaire (Appendix 9). Data from this are uses to provide a qualitative analysis of the service, plus outcomes. Throughout (Installation review, monthly reviews (appendix 8) and annual review) the Community Warden team deals with any issues that are raised by Telecare users.
All installed Telecare equipment is evaluated and reviewed to ensure it meets a user's individual needs and their support plan outcomes. Statistical information on outcomes delivered is also collated. The flowchart below shows how and by whom evidence of outcomes is obtained.

The qualitative question set used at the initial and later annual review will be a separate document that reviewers take out with them. This will be forwarded to the IT systems Team in Runcorn Town Hall as this will enable outcome data to be collated and analysed using 'Teleform.' When this process is established there will be no further need for the Contact Centre to continue asking new Community Alarm Service /Telecare users to provide qualitative /outcome information.

The current Telecare Document (August 2009) can be consulted for the following:

- How the Commencement and Termination of the Telecare Service is notified to: the supporting People, Financial Services and Performance Monitoring Teams.
- The CareFirst procedure for connecting Telecare
- Annual Reviews on CareFirst
- How a Telecare account is closed by the Administrative Officer using the Aggresso System
- The CareFirst procedure for disconnecting Telecare

Flowchart Showing How Evidence for Lifeline (Level 1 Service) and Telecare (Level 2 or 3 Service) is Obtained.



14.0 Future Developments

In Halton, consultation is viewed as a central component in evaluating any of its services. This allows the service user to have a direct role in service planning, ensuring it is targeted accurately and meets all relevant needs.

Future consultation will involve monthly and annual reviews. The intention is that all consultation data will be accessible via CareFirst. Over time this will accumulate as a valuable service user resource, detailing personal profiles, specific individual Telecare preferences, problems and solutions. It is the intention that this database will inform all future development of Telecare within Halton.

The infrastructure for Telecare services includes the equipment needed to enable communications to be made rapidly and reliably between: sensors, disperse alarms, a monitoring centre and emergency responders. It also includes the methods employed to include access to appropriate services, assessments and provision of equipment.

The present Call Handling System at the HBC contact centre has been operating since February 2007. A new system upgrade (Tunstall PNC5) will be introduced to handle all calls from the autumn of 2009. This will slightly enhance the ability to take calls and will make it easier to pull off reports and provide more scope for the development of Telecare in Halton.

To date the main focus of Telecare has been on (1) home safety and security monitoring and (2) lifestyle monitoring and risk management, within a reactive mode approach where an alert triggers a response from an appropriate service. In general, the use of Telecare employs a small selection of standardised devices.

To meet future needs Telecare will have to be developed on a larger scale and involve many more sensors and devices. It must be capable of being personalised to individual user need, fully integrated into the care system and predictive in order to allow observation of longer-term trends and earlier intervention.

For example, future changes in demography and developments in policy will continue to transform the way services are delivered in Halton. As separate initiatives two aspects of Telecare are being proposed within the Halton business case: Telecare will be included as a component part of the standard social care assessment; those individuals who are over 85 will be entitled to free Telecare. In order to ensure quality social care, related primary care and support services to people, all those involved in providing the service, will need to work beyond their traditional organisational boundaries, structures and systems.

Future Training and service reporting needs to demonstrate that the structure of Telecare in Halton is meeting the needs of all its service users. It should emphasise the importance of delivering a quality service that is outcomes

focused. In this sense, any future qualitative analyses (annual reviews…etc) that are proposed, need to be able to demonstrate that:

- Individuals using the service are happy with its quality and accessibility (questions: 1 – 12 Appendix 9).
- Levels of individual self-management have increased (question 7: b, d, e)
- Positive changes in behaviour have occurred (questions (question 7: a, d, g).
- Fewer symptoms are being reported (c, f).

Increase the use of sophisticated Telecare platforms such as 'Community Alarm Service Connect+.' This makes it possible to monitor a set of additional sensors prior to raising a specific alarm. For example, a person may be out of bed at a time that is outside agreed parameters, but active elsewhere in the house as detected by PIR movement sensors. This would typically result in a delayed or cancelled alarm (if the person got back into bed). This type of passive alarm would reduce the number of unnecessary alarms and also allow the individual greater independence to behave in a way that is outside previously agreed conditions yet nonetheless perfectly normal.

Expand Halton's third area of focus ('vital signs monitoring') as a cost-effective means of monitoring remotely and assisting individuals to manage long-term conditions such as diabetes at home. The monitoring would be done via the PCT with HBC in a supportive role providing the necessary Telecare/ Telehealth units. This would also be a useful precursor to developments currently under way such as the Virtual Ward. In this respect, Widnes based GP surgeries are interested in piloting Telecare /Telehealth within the Virtual Ward concept. This will result in an increase in referrals for current Telecare sensors as well as a possible installation and technical support service for
Telehealth applications.

At an early stage in Telehealth planning the following would need to be looked at:

- Response protocols for any alarms triggered by the various Telehealth applications must be clearly set out.
- Storage, installation, de-installation, decontamination and maintenance procedures will need to be developed and put in place.
- There will be a need to train all call handlers and installers.

The implementation of Telehealth could significantly reduce the need for home-visits or hospital appointments. The technology fully developed has the potential to enable those who are housebound to have a virtual presence in libraries and shops and maintain contact with friends and relatives as well as professionals.

Keeping Track of Upgrades. Some service users move between different levels of the Lifeline, upgrading to a higher-level service when required and then later downgrading. Such movement cannot be tracked by the present data capture system, as the Community Alarm Service upgrading is not

separately recorded on CareFirst. For example, there are currently 25 individuals on the Level 2 package and 39 on Level 3 – many have been upgraded from Level 1, but exactly how many cannot be ascertained. Clearly, this difficulty needs to be looked at in any future monitoring and data capture procedures.

Currently there are a number of sheltered housing providers within the Borough who use their own Telecare systems. It is important to ensure that these are compatible with current and planned future systems in order to avoid duplication and potential confusion for the user. By establishing regular quarterly management meetings with sheltered housing providers, it will be possible to determine the level of compatibility and the potential for clear and effective response protocols. As growth area they would commission HBC as a response service.

Telecare is one component in a multi-agency health and social care approach. The principal aim is to provide the necessary professional back up to enable the individual to maintain their independence at home for as long as possible. The principal challenge for Halton in caring for its ageing population is to improve the care of long-term conditions. In order to take care of its frailer older people with continuing health problems, it must focus on better support for them at home (together with support for carers). It needs to develop early recognition and management (at home) of new or increasing health problems in order to avoid admission to an acute sector bed. It naturally follows that better communication across agencies would be beneficial (see 6.7).

Halton is currently January 2010) in the process of developing its Early Intervention / Prevention Strategy which will stress the importance of Individual dignity, independence and equality. The overall purpose of this strategy is to reduce the likelihood of social isolation while enhancing reablement. It is the intention that Telecare will offer a means of achieving this kind of personal control and dignity for those with long-term conditions, especially when combined with Halton's direct payments facility and individual budget s.

Also, the capacity and structure of the call-handling system needs to be flexible enough such that all data collected can be shared with appropriate others in a common format. To this end the Halton contact centre has already upgraded to the Tunstall PNC 5 Call Handling System. This will enable reports to be produced and shared more quickly.

As their needs change, individuals at home may benefit from some form of activity monitoring. This comes under the umbrella term Activity of Daily Living Monitoring (ADL) and can reduce the number of visits required from carers and GPs. Connect + carries out a 'Just Checking' which can work well with individuals who have Dementia. At present families may purchase this system privately, but Halton are looking at the implications of adopting such a system as it would allow those with dementia or memory loss to maintain their independence.

The system monitors the person's movements at home and produces a chart of their activity at intervals throughout the day and night. Thus this kind of system can provide reassurance to family /carers and professionals that an individual with early onset dementia can maintain their usual living pattern without undermining their independence of movement. Being able to target early-onset dementia in such a way might make adopting such a system more acceptable financially.

Telecare – A Glimpse of the Future in Halton. Telecare is already a success story in Halton, but in the immediate future:

- The hope is that it will be more widely understood and accepted by service users, carers, health and care professionals alike. Local members and political leaders will appreciate what it can do for their constituents and actively promote its use.
- All housing providers will be active partners in implementing care solutions based on Telecare and Halton's housing strategy will actively promote Telecare solutions for vulnerable people.
- The boundaries between health and care services will become far less rigid as the technology helps to redefine roles, options and more efficient working arrangements. These will be geared toward consultation reflecting the person's desire to remain independent and at home for as long as possible.

Looking further ahead:

- In the short-term through an established Personalisation Agenda service users and their carers will be able to request and purchase directly Telecare based services as part of a broader package involving elements of health care monitoring and response. Telecare and Telehealth (remote health care) will be widely recognised by individuals and their carers as the way to greater independence and quality of life.
- In the longer term all new homes both public and private will be fitted with the capacity for care and health services to be provided interactively via broadband from day one of occupation.
- In the short-term, remote condition monitoring from home for extended periods will be the norm.
- Those receiving care services in Halton within a care home or hospital environment, will in future be able to benefit from Telecare at home.

15.0 Summary

Telecare in Halton has three principal areas of focus:

1. Information, advice and support – being able to demonstrate that as a form of support it has had an impact on clinical or care outcomes for vulnerable people with specific conditions.
2. Safety and security monitoring – being able to demonstrate that Telecare has enabled vulnerable people to feel safer and more secure at home.

3. Vital signs monitoring – putting a case for funding Telehealth as a cost-effective means of monitoring and assisting individuals to manage their diabetes at home.

The last of these has an important role in future plans to expand the service and will be dealt with under 'Recommendations' and more fully in 'Future Service Propositions'. The first two are dealt with below.

Since its introduction in 2005, the number of individuals who have been referred for and subsequently had Telecare packages installed, has been increasing. The following table shows cumulative annual data from October '05 to November '09.

Cumulative Telecare Packages (Levels 2 & 3) Installed in Halton

	Oct '05 Mar '06	Apr '06 Mar '07	Apr '07 Mar '08	Apr '08 Mar '09	Apr '09 Nov '09	Totals
Active from previous yr.		22	48	46	72	
Referrals	25	102	111	131	83	**452**
Assessments	25	102	106	99	77	**409**
New Connections	25	95	74	76	40	**310**
Connection Removed	3	69	76	50	38	**236**
Active	**22**	**48**	**46**	**72**	**74**	

Falls and wandering issues have accounted for 76% (07/08) and 73% (08/09) respectively of these referrals (Appendix 6). There is also evidence to suggest an increasing trend year on year in the number of individuals connecting to a Level 2 or Level 3 Lifeline package as shown by the **Active** data. For example the number of 'Active' individuals for the full year Apr 09 to Mar 10 would be expected to increase to approximately 100.

The increase in the number of Telecare packages has impacted on the response element of the service. The following table aptly demonstrates this:

Callout Data For Telecare in Halton

	Apr '07 Mar '08	Apr '08 Mar '09	Apr '09 Nov '09
Total Active for period	122	122	112
Total Callout	920	1067	625
Monthly Av. (mean)	77	89	78

However, there are currently (09/10) almost 25% more people in receipt of Telecare than the previous year (08/09). Consequently, these data represent significant decrease in the number of callouts. This would seem to suggest that not only is the service becoming better known, but that confidence in its

ability to manage risk is also growing among those who wish to maintain their independence at home.

Further, the number of new service users aged 65 and over, that have already been provided or are scheduled to be provided with 1 or more items of Telecare level 2 0r 3 packages in their own homes (or an equivalent such as extra care /warden assisted housing) is expected to rise by some 8% (for adult social care alone) and 4% (Adult social care in partnership) during 09/10 (416 –450 and 7-10 respectively).

There are two important factors underlying this. First, people's general awareness of the service that is available has been greatly increased over the past two years. This has largely been due to: Halton Direct Link, the HBC website and word of mouth from current users, Community Wardens and health professionals. Secondly, as a consequence of people living longer, there is an underlying significant increase in the number of those developing dementia.

Such increasing levels of dementia year on year will undoubtedly result in annual increases on the number of future referrals received by the service and in the type of device selected by users and / or their carers. The majority of referrals have been for individuals with dementia and hence the most frequent devices installed are to detect falls and wandering.

Service users and their carers are becoming more aware of what the technology can achieve in terms of monitoring. Consequently, they have been more inclined to make use of environmental monitors such as heat, cold, water … detectors, as an additional safety blanket. To this effect there has been a 145% increase in environmental referrals, resulting in more of these being installed in the period 2008 - 2009.

When Telecare is coupled with an appropriate support plan an important outcome is that the individual is able to remain safely and independently at home for longer. Thus, safety and security monitoring is an important function of Telecare. As evidence for this, during the period 2007–2008, 17 service users eventually had to move into residential placements. However, prior to their residential move and thanks to the use of Telecare, 6 of these individuals remained at home for over a year and the remainder between one and 12 months. This represents a substantial pre-admission saving of approximately £240,000.

This suggests that people using the service with the right kind of equipment are able to be more independent. However, as the number of individuals connected to Telecare equipment increases, then so does the total number of activations and call-outs. One way of reducing this would be for Halton to make use of Virtual Sensor technology.

Telecare has been a success, not only within Halton as evidenced above, but also nationwide. More people in Halton are transferring upwards from the basic Level 1 service as they develop confidence in its ability to minimise risk

through its rapid response capability. This confidence is evidenced by the reduction in call-outs. In a sense, the past three years have been an experimental period: enabling the public to experience directly how supportive the technology can be and HBC to establish how daily living patterns can best be monitored, by whom, what new technology to employ and how the current structure needs to evolve to accommodate an expansion of the service and the future implementation of Telehealth /Telehealth.

16.0 Recommendations*:*

The following recommendations stem from discussions with colleagues from: the Warden's Team (who lead on Telecare), Finance & Support Team (currently logging Telecare onto CareFirst), and Business / Policy Support (service quality). Service user comments have also been incorporated into the overall document.

At present logging of referrals and assessments is being carried out by one individual from the Finance and Support Team. This situation is recognised as not ideal and is likely to become less satisfactory as Telecare expands as a service and Telehealth becomes available. However, due to capacity limitations this situation is unlikely to change in the immediate future.

A Telecare Training Group (TTG) will inform the new Telecare/ Telehealth agenda. All relevant staff will receive the new Telecare training as part of their normal continuing Professional Development. This would help improve awareness among staff of the current and future importance of Telecare. When capacity allows, training and procedures will be developed to enable the Warden's team to log all referrals and assessments.
The TTG could also drive forward the development and introduction of new training opportunities for all professional staff with the responsibility of assessing individuals with long-term needs. The use of 'Telecare Champions' within other referral teams would enable such teams to keep abreast of new Telecare developments and training opportunities.

The TTG will also continue to develop training courses to meet the needs of Telecare handlers /responders and more generally those involved in equipment installation and advice to service users and their carers on how to use the equipment.

Implement improved quality and performance measures as a means of evaluating the overall effectiveness of Lifeline, Telecare and Telehealth (when operational). These will take the form of: post-installation bedding-in checks/reviews to ensure operating parameters are appropriate, followed by monthly reviews in the case of Telecare and annual reviews in the case of both Lifeline and Telecare. This annual review will be structured as a teleform for automatic analysis.

Increase the use of more sophisticated Telecare platforms so as to allow delay or cancellation of alarms, depending upon the person's activity. This

would greatly reduce the level of false alarms while allowing people to move around their house in whatever way is normal for them.

Widnes Practice Based Commissioning (PBC) in partnership with Halton and St Helen's MHS Primary Care Trust (PCT) have put forward a business case for a community based integrated care service. Part of this would involve working in partnership with Halton Borough Council to deliver innovative solutions to support people at home with long-term conditions.

Such support would enable individuals, families, carers and professionals to communicate, coordinate and manage seamless care at home. This could include the use of Telecare devices as a means of supporting self-management and the close monitoring of physiological observations.

Any such future use of Telecare by the PBC would be advised by data from its current use in Halton. Hence HBC could supply relevant Telecare/Telehealth equipment that would support diabetes monitoring, where the monitoring is carried out by the PBC. Hence, it is important to ensure that the development of the 'Virtual Ward' concept, by the PBC will be closely linked to current and future developments in Telecare /Telehealth

There is a need to address system compatibility problems where Sheltered Housing providers have opted for different detectors from HBC. It is important in such circumstances to hold regular meetings with providers so that clear and unambiguous response protocols can be developed.

Currently there is no facility for tracking those individuals who opt to upgrade or downgrade their current Lifeline / Telecare system. This information is not currently recorded on CareFirst, but could be made available via monthly reviews for Telecare or at the post-installation inspections for Lifeline or Telecare by incorporating an appropriate question.

Virtual sensor technology is an important feature of the new Connect + base unit. This allows information to be combined from a number of sensors, thus enabling alarms to be delayed or cancelled, reducing the number of false alarms. For example, before an out of bed alarm is raised, the unit can be set to monitor other Telecare sensors that may be indicating that the user is active elsewhere in the house (they may have got up for a drink and will have triggered PIR sensors on the way to and in the kitchen). The unit can then react to this additional information by either delaying or cancelling the initial virtual out of bed alarm.

Enuresis is a common problem among older people. Telecare offers an enuresis sensor that Halton could offer as a new component in its Telecare service. The sensor provides a discreet and efficient means of detecting instances of enuresis the moment they occur. This enables carers to provide a higher level of service without the need for regular intrusion. This equipment is available and If there is a local demand then HBC will approach the PCT for future funding to expand into this new area of service.

There are currently some 1.75 million people in the UK who rely on Telecare. The Telecare Services Association (TSA) formed in 1995 represents service providers and those who commission Telecare services such as local government, housing associations, manufacturers, academics and others with a professional interest in Telecare. After taking part in a TSA consultation exercise in 2008, HBC is currently in the process of adopting the TSA Code of Practice. This TCOP covers the whole Telecare system from referral to response and identifies the importance of each component along the way (e.g. profiling, service set-up, monitoring…etc). By adopting the TCOP and the recommendations of the TSA's independent inspection body (Insight Certification), HBC will ensure that its Telecare service is offering the best practice to service users, providers and commissioners.

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REPORT TO: Healthy Halton Policy & Performance Board

DATE: 9th March 2010

REPORTING OFFICER: Chief Executive

SUBJECT: Performance Management Reports for 2009/10

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To consider and raise any questions or points of clarification in respect of the 3rd quarter performance management reports on progress against service plan objectives and performance targets, performance trends/comparisons, factors affecting the services etc. for;

- Adults of Working Age
- Older People's and Independent Living Services
- Health & Partnerships

2.0 RECOMMENDATION: That the Policy & Performance Board;

1) Receive the 3rd 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.

3.0 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.

4.0 POLICY IMPLICATIONS

There are no policy implications associated with this report.

5.0 OTHER IMPLICATIONS

There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

The quarterly performance monitoring reports demonstrate how services are delivering against the objectives set out in the relevant service plan. Although some objectives link specifically to one priority area, the nature of the cross-cutting activities being reported means that to a greater or lesser extent a contribution is made to one or more of the priorities listed below;

6.1 **Children and Young People in Halton**

6.2 **Employment, Learning and Skills in Halton**

6.3 **A Healthy Halton**

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

6.6 **Corporate Effectiveness and Efficient Service Delivery**

7.0 RISK ANALYSIS

N/A

8.0 EQUALITY AND DIVERSITY ISSUES

N/A

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

Document	Place of Inspection	Contact Officer
N/A		

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Adults of Working Age**

PERIOD: **Quarter 3 to period end 31stDecember 2009**

1.0 INTRODUCTION

This quarterly monitoring report covers the Adults of Working Age Department third quarter period up to 31st December 2009 It describes key developments and progress against key objectives and performance indicators for the service.

The way in which RAG symbols have been used to reflect progress to date is explained in Appendix 5

2.0 KEY DEVELOPMENTS

Personalisation

A Transformation Team is now established to progress the personalisation agenda. There is a project management structure with dedicated work streams. The planning live programme has enabled 7 individuals across Adults with Learning Disabilities and Physical and Sensory Disabilities services (ALD & PSD) to receive an indicative allocation and support plan and this programme has now started in mental health services. Physical and Sensory Disabilities are currently implementing the conversion of current direct payment recipients to an individual budget service and set up 'PSD Live' moving into a self directed support process.

Mental Health

Employment: the employment worker continues in post, and has developed strong links with the local mental health services and with employment services. There has been some limited success in accessing employment opportunities for people with severe mental health problems, but it has been agreed that the employment worker can now market potential employees directly to employers. The Richmond Fellowship project has also begun and there is a regular steering group for both processes.

Personalisation: the Planning Live process continues within mental health services and six people are developing their indicative allocations and support plans. Halton has been selected as a national pilot site for person-centred reviews, and three mental health provider services will be taking part in this. An event for senior staff from the 5BoroughsPartnership, along with St Helens, Warrington and Knowsley Councils mental health and personalisation leads, will be taking place on 26th January 2010, with a follow-up event planned for April 2010. This will be facilitated by national leads in personalisation, Helen Sanderson Associates.

Mental Health Single Point of Access: this continues to be developed in partnership with the PCT, with the intention that the service should be fully operational by April 2010, with partial operation from January 2009. A social worker is in place and is supporting the development of the service.

Care Programme Approach: this is an essential policy and procedure within mental health services, as it describes the process of assessment and care management that people can expect to receive. Following intensive and detailed work by officers of the Council on this, the 5Boroughs have now issued a revised draft. This will be taken for approval within Borough Council processes.

Approved Mental Health Professionals: due to the focus of the 5Boroughs on obtaining Foundation status, no further work has taken place to develop the AMHP role within health care staff. This will be taken forward in the next Quarter.

Adults with Learning Disabilities & Physical Sensory Disabilities

The Transition co-ordinator has secured funding from the Learning Skills Council (Sept 09 - July 2010). This will be used to identify more options for young people with learning difficulties in Halton who are about to leave school. The project is called Transforming Transition. Halton Speak Out, a self-advocacy charity, will conduct a person centred review with each young person targeted. A copy of the review will be sent to colleges. A Broker from the college will look at the person centred review to identify what can be offered to the young person, in relation to work, college or social and leisure activities.

A person has been identified as part of the out of area review project to return to the Borough. A property has now been identified and work is in progress to identify an appropriate support provider. This is part of a wider project to further improve the figures for NI 145: Adults with learning disabilities in settled accommodation.

A local authority learning disability register has been established and the ALD team are completing health action plans alongside the annual health checks provided by GP practices or via Learning Disability Nurses for those people who are not registered with a participating practice. The DES has been extended to March 2011 which shows the commitment to this important area of work.

3.0 EMERGING ISSUES

Mental Health

Halton Council has been awarded national pilot status for a project to develop person-centred reviews within provider services, and has agreed that the sole focus of this will be on mental health services. This pilot will be beginning in February 2010. Additionally, the Halton is part of a regional pilot for outcome focused planning in mental health services, and these two processes will be

linked together.

A high-level review of the role and function of Community Mental Health Teams is currently taking place across the four Boroughs of Halton, St Helens, Warrington and Knowsley, led by the PCT commissioners. Local reviews are being added to this to ensure that the services meet local requirements, and these reviews are currently under way. It is expected that reporting on the outcome of the review will take place in April 2010.

A review of the role and function of the Mental Health Outreach Team is also taking place, in partnership with NHS Halton and St Helens. This will be reporting in Spring 2010.

Adults with Learning Disability and Physical Sensory Disability

PSD have been identified as the team to take forward the personalisation agenda. The pilot 'PSD Live' will require that all new community based assessments that are presented will be accompanied by a support plan and not a care plan. Additionally six week reviews will be completed using a person centred review. It is envisaged that once the Resource Allocation System (RAS) is agreed the current assessment documentation will cease and will be replaced by RAS to identify an up front allocation of funding.

The tri partite collaboration 'Next Steps' between Halton Borough Council, Halton and St Helens PCT and St Helens Council have successfully attracted a further £20,000 funding from the Department of Health in order to help to achieve PSA 16 targets.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**6**	✓	**6**	?	**0**	✗	**0**

All key milestones/objectives on target.

5.0 SERVICE REVIEW

Mental Health

A review of the role and function of the Mental Health Outreach Team is taking place and should be reporting by Spring 2010. This is being done jointly with NHS Halton and St Helens.

A review of the role and function of Community Mental Health Teams is taking place across the four boroughs of Halton, St Helens, Warrington and Knowsley. This is being led by the health service commissioners but with

substantial input from local authority partners. Although the review is overarching across the four boroughs, each locality is also undertaking its own review to ensure that services meet the requirements of local commissioning. The overarching review is expected to report by the end of March 2010, with local reviews reporting by the summer of 2010.

A review of the Mental Health Partnership Agreement is being undertaken by Internal audit and will report at the end of March 2010.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**8**	✓	**7**	?	**1**	✗	**0**

All KPIs are on target as at Q3, the exception being 'Carers receiving needs assessment or review'.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**3**	✓	**0**	?	**3**	✗	**0**

Non key indicators are reported at Q3 only by exception and in this quarter three attracted amber RAG symbols.

7.0 RISK CONTROL MEASURES

During the production of the 2009-12 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. No risk control measures were identified

8.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2008/09 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 in quarters 2 and 4.

9.0 DATA QUALITY

The author provides assurances that the information contained within this report is accurate and valid and that every effort has been made to avoid the

omission of data. Where data has been estimated, has been sources directly from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated**.**

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress Against Key Performance Indicators
Appendix 3- Progress against Performance Indicators
Appendix 4- Financial Statement
Appendix 5- Explanation of RAG Symbols

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
AWA 1	Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for Adults of Working Age	Analyse the impact of Valuing People Now on service delivery to ensure that services met the needs and improve outcomes for people with LD **Mar 2010** (AOF 6 & 7)	✓	Annual Report now in draft form and will assist in identifying areas for development
		Implement strategy to deliver improved services to younger adults with dementias **Mar 2010** (AOF 6)	✓	The dementia strategy continues to be developed and has incorporated all the recommendations arising from the review of services for younger adults with dementia earlier this year. An action plan will be developed to implement this.
		Review implementation of Mental Health Act 2007 to ensure all policies, procedures and processes are fit for purpose **Oct 2009** (AOF 6)	✓	All comments and proposals for amendments to the Mental health Act policies and procedures have now been received. Policies are to be amended in Q4.
		Implement agreed recommendations of review of services and supports to children and adults with Autistic Spectrum Disorder **Mar 2010** (AOF 6)	✓	Strategy still in process of being drafted and linked to service for Positive Behaviour which is in development
		Review implementation of Mental Health Act 2007 to ensure all policies, procedures and processes are fit for	✓	All comments and proposals for amendments to the Mental health Act policies and procedures have now been received. Policies are

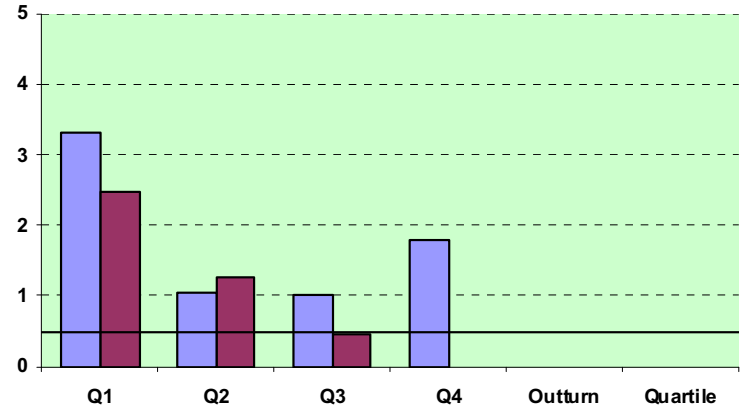
Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
AWA 2	Effectively consult and engage with Adults of Working Age to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required	purpose **Oct 2009** (AOF 6)		to be amended in Q4.
		Implement agreed recommendations of review of services and supports to children and adults with Autistic Spectrum Disorder **Mar 2010** (AOF 6)	✓	Strategy still in process of being drafted and linked to service for Positive Behaviour which is in development

APPENDIX ONE - PROGRESS AGAINST OBJECTIVES/MILESTONES
Adults of Working Age

AWA LI4

Percentage of adults assessed in year where ethnicity is not stated

Lower figures represent better performance



Key

2008/9

2009/10

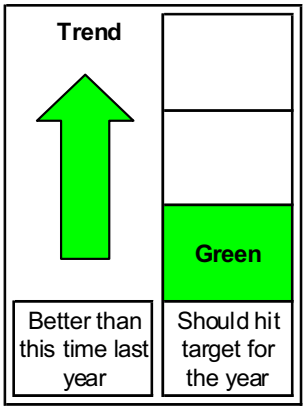
Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available



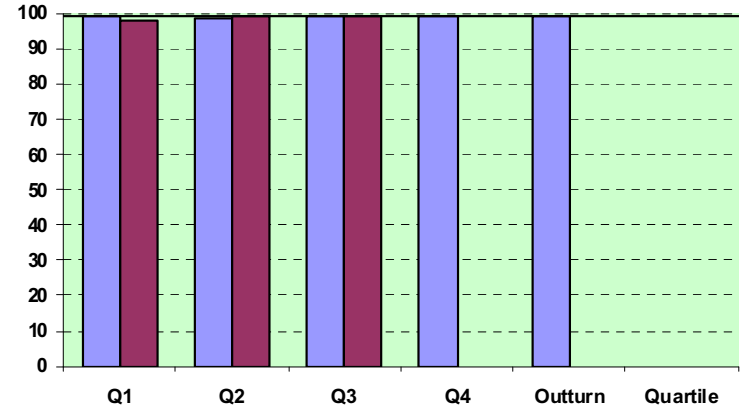
Commentary

Out of 1112 assessments this year, 1107 clients do not have an ethnicity recorded. In order to ensure the target will be met at year end, monthly exception reports of unknown ethnicity are sent to operational teams to action.

AWA LI8

Percentage of people receiving a statement of their needs and how they will be met.

Higher figures represent better performance



Key

2008/9

2009/10

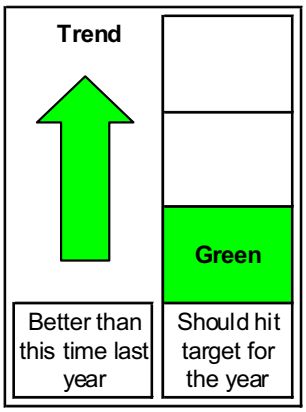
Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available



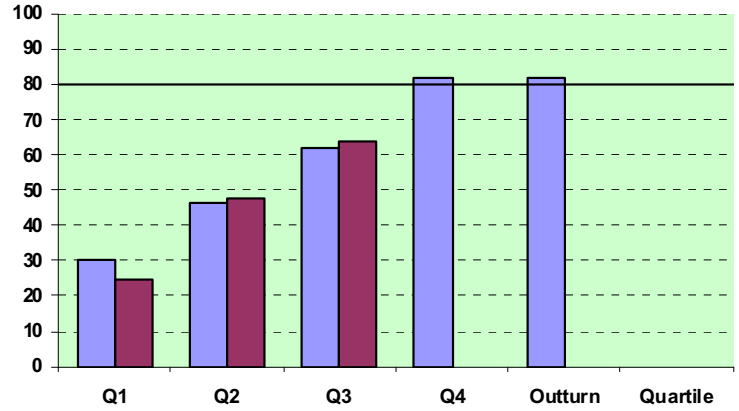
Commentary

99.54% of people in receipt of services have been given a statement of their needs and how they will be met. Target already achieved, however, monthly exception reports are still produced for operational teams to action of those clients who are not in receipt of their statement of needs.

AWA LI9

Clients receiving a review as a % of adult clients receiv)ng a service (cost effectiveness PSA Target)

Higher figures represent better performance



Key

2008/9

2009/10

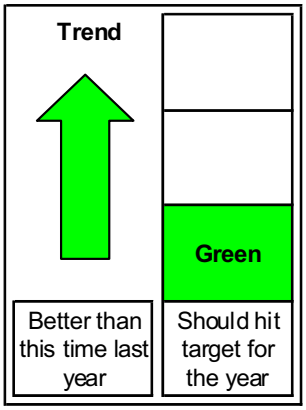
Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available



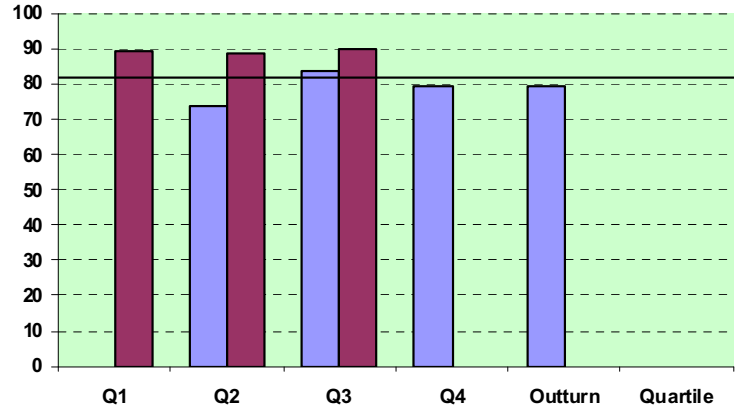
Commentary

63.61% of clients receiving services have been reviewed so far. In order to ensure the target will be met at year end, monthly exception reports of outstanding reviews are sent to operational teams to action.

AWA NI 132

Timeliness of social care assessment DH DSO

Higher figures represent better performance



Key

2008/9

2009/10

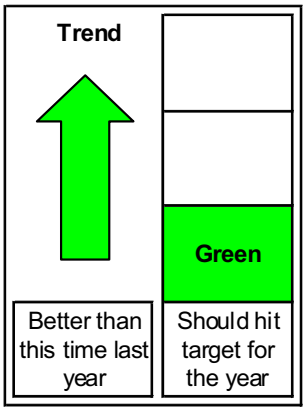
Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available



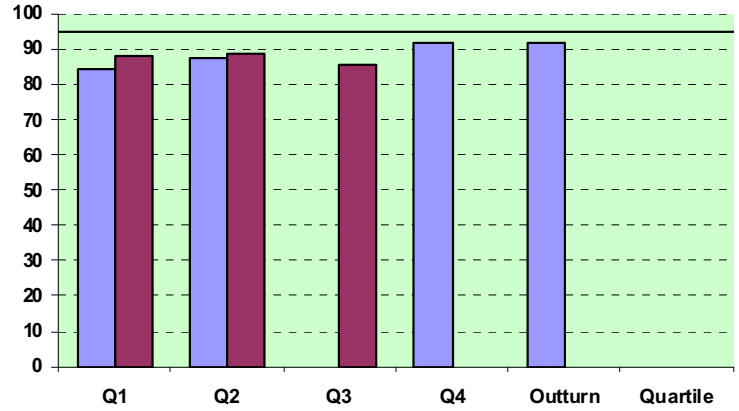
Commentary

Target exceeded. However, final year end figure is determined by a file check which is ongoing.

AWA NI 133

Timeliness of social care packages DH DSO

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

No data for same Qtr last year

Should hit target for the year

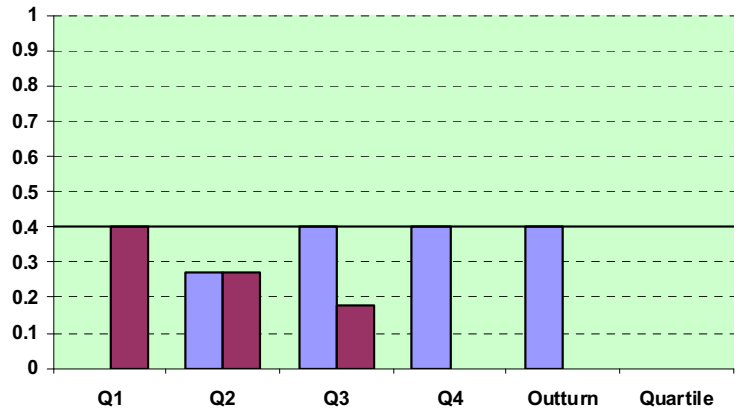
Commentary

Final year end figure is determined by a file check which is ongoing

AWA LI10

Admissions of Supported Residents aged 18-64 into residential/nursing care

Lower figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

Better than this time last year

Should hit target for the year

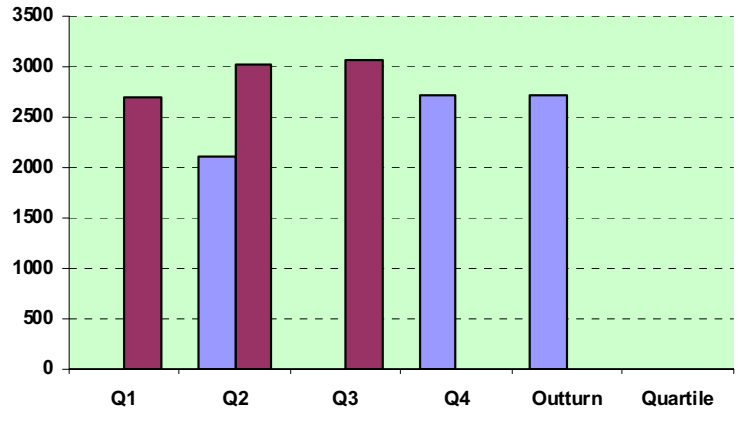
Commentary

1 person admitted to permanent residential/nursing care this year. Target equates to 3 people

AWA NI 136

People supported to live independently through social services (all ages) PSA 18

Higher figures represent better performance



Key

2008/9
2009/10
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

Trend

No data for same Qtr last year

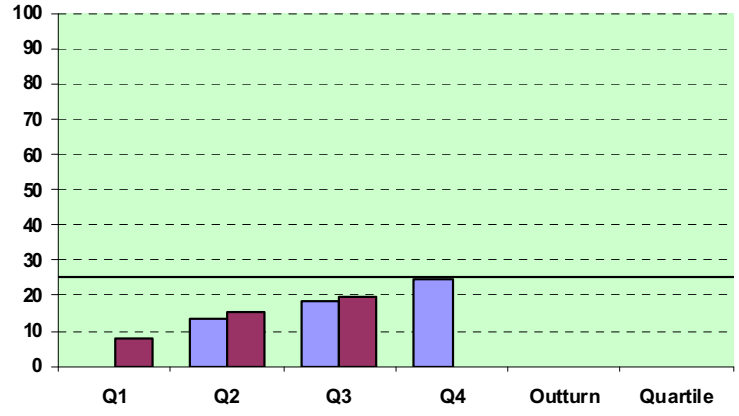
Commentary

Q3 performance has increased from Q2 performance. Helped to live at home continues to be good. No target has been set for 2009/10, therefore a traffic light indicator cannot be allocated

AWA NI 135

Carers receiving needs assessment or review and a specific carer's service, or advice and information DH DSO

Higher figures represent better performance



Key

2008/9
2009/10
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

Trend

Green

Better than this time last year

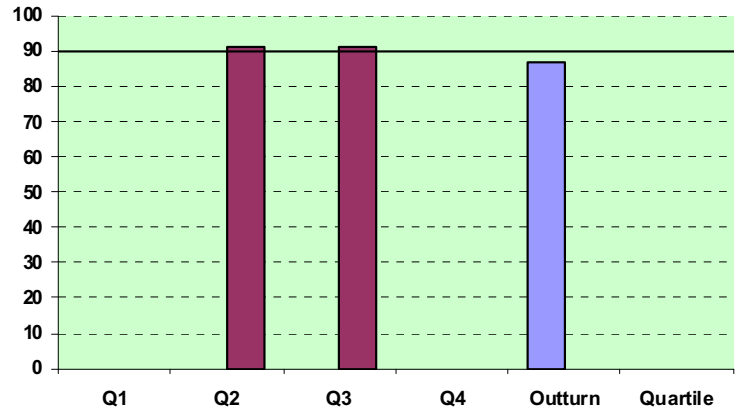
Should hit target for the year

Commentary

To date 830 carers have received an assessment/review and a specific carers service, or advice and information. Exception reports are produced on a monthly basis of carers who have not yet received an assessment/review but have had a service for operational teams to action.

NI 145

Adults with learning disabilities in settled accommodation PSA 16



Higher figures represent better performance

Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

No data for same Qtr last year

Should hit target for the year

Commentary

We are currently working as a pilot project in conjunction with the NDTi to further improve our performance.

The following indicator could not be included as a table for the reason stated: -

NI 131 Delayed transfers of care

Data derived from health, which is not yet available

Ref.	Description	Actual 2008/09	Target 20091/0	Quarter 3	Progress	Commentary
Cost & Efficiency						
AWA LI 5	Number of learning disabled people helped into voluntary work in the year	56	43	34	?	34 learning disabled people have been helped into voluntary work in the year. In order to achieve the target at year end, a further 9 clients are required.
AWA LI 6	Number of physically disabled people helped into voluntary work in the year	14	5	3	?	3 physically disabled people have been helped into voluntary work in the year. In order to achieve the target at year end, a further 2 clients are required.
AWA LI 7	Number of adults with mental heath problems helped into voluntary work in the year	8	17	6	?	6 adults with mental health problems have been helped into voluntary work in the year. In order to achieve the target at year end, a further 11 clients are required.

HEALTH & COMMUNITY – ADULTS OF WORKING AGE (ALD, MH, PSD)

Revenue Budget as at 31st December 2009

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Employees	3,422	2,466	2,407	59	2,410
Premises	197	146	146	0	146
Other Premises	66	52	44	8	59
Joint Equipment Service	231	95	93	2	93
Supplies & Services	379	242	213	29	228
Food Provisions	9	7	2	5	2
Aid & Adaptations	113	85	106	(21)	131
Transport of Clients	633	435	413	22	488
Departmental Support Services	1,089	0	0	0	0
Central Support Services	524	393	393	0	393
Contract & SLAs	915	640	611	29	611
Emergency Duty Team	95	48	44	4	44
Community Care:					
Residential Care	871	588	653	(65)	653
Home Care	687	460	482	(22)	482
Direct Payments	759	556	610	(54)	610
Supported Living	60	42	18	24	18
Day Care	26	18	0	18	0
Unallocated Grants	147	0	0	0	0
Asset Charges	203	0	0	0	0
Contribution to ALD Budget	6,963	4,399	4,141	258	4,283
Total Expenditure	**17,389**	**10,672**	**10,376**	**296**	**10,651**
Income					
Residential Fees	-136	-94	-67	(27)	-67
Fees & Charges	-151	-105	-120	15	-120
Preserved Rights Grant	-92	-69	-68	(1)	-68
Supporting People Grant	-371	-257	-242	(15)	-242
Mental Health Grant	-600	-475	-475	0	-475
Carer Grant	-518	-388	-388	0	-388
Mental Capacity IMCA Grant	-85	-64	-64	0	-64
Aids Support Grant	-5	-5	-11	6	-11
Local Involvement Network Grant	-110	-82	-82	0	-82
Community Roll Out Funding	-31	-31	-41	10	-41
Tobacco Control Grant	-100	-100	-100	0	-100
Training Support Implementation	-14	-14	-15	1	-15
PCT Reimbursement	-503	-252	-247	(5)	-247
Other Income	-31	-31	-31	0	-31
Total Income	**-2,747**	**-1,967**	**-1,951**	**(16)**	**-1,951**
Net Expenditure	**14,642**	**8,705**	**8,425**	**280**	**8,700**

Comments on the above figures:

In overall terms revenue spending at the end of quarter 3 is below budget profile by £22k, excluding the ALD pool budget.

Employee costs are less than expected at this stage of the financial year due to a number of vacancies relating to front line staff within the department particularly within PSD services.

The Community Care budget for service users with mental health needs and physical and sensory disabilities as a whole, including associated fees and charges is £111k over budget profile. This is due to a number of high cost packages being agreed in quarter 2 which continue to put pressure on the budget. The community care budget will be closely monitored throughout the remainder of the financial year to ensure it is contained within the departments' budget.

The Aids and adaptations budget is also over budget profile, as expected, as more service users are supported within their own homes as opposed to moving into residential homes.

Note: A summary of the H.B.C. Contribution to ALD Pooled Budget can be found on the following page:

Adults of Working Age

Capital Budget as at 31st December 2009

	2009/10 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Social Care & Health				
Mental Health Centre	115	115	115	0
Pods utilising DFG	17	17	0	17
Total Spending	**132**	**132**	**115**	**17**

HEALTH & COMMUNITY – ADULTS WITH LEARNING DISABILITIES

Contribution to ALD Pooled Budget

Revenue Budget as at 31st December 2009

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Residential Care	1,259	841	673	168	673
Supported Living	2,030	1,488	1,434	54	1,456
Home Care	1,362	921	915	6	915
Direct Payments	726	621	670	(49)	670
Day Services	1,866	1,318	1,292	26	1,348
Specialist LD Team	553	415	470	(55)	526
Management Costs	1,181	309	318	(9)	318
Respite	361	236	195	41	203
Support for Advocacy	42	20	19	1	19
Other Expenditure	107	50	54	(4)	54
Total Expenditure	**9,487**	**6,219**	**6,040**	**179**	**6,182**
Income					
Rents & Service Charges	-28	-19	-12	(7)	-12
Community Care Fees	-87	-60	-76	16	-76
Residential Fees	-111	-77	-66	(11)	-66
Direct Payments	-35	-24	-37	13	-37
Supporting People Grant	-956	-685	-685	0	-685
Preserved Rights Grant	-374	-280	-277	(3)	-277
Campus Closure Grant	-57	-57	-57	0	-57
LDDF	-149	-112	-112	0	-112
CITC – Astmoor	-53	0	0	0	0
CITC – Special Needs	0	0	0	0	0
PCT Income	-79	0	0	0	0
CHC – PCT Reimbursement	-437	-347	-375	28	-375
Other Fees & Charges	-158	-158	-202	44	-202
Total Income	**-2,524**	**-1,819**	**-1,899**	**80**	**-1,899**
Net Expenditure	**6,963**	**4,400**	**4,141**	**259**	**4,283**

HEALTH & COMMUNITY – LOCAL STRATEGIC PARTNERSHIP BUDGET

Budget as at 31st December 2009

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000	Actual Including Committed Items £'000
Priority 1 Healthy Halton					
Diet & Exercise Programme	23	17	0	17	0
Vulnerable Adults Task Force	100	75	194	(119)	194
Vol. Sector Counseling Proj.	41	31	23	8	23
Info. Outreach Services	35	26	17	9	17
Reach for the Stars	36	27	17	10	17
Complementary Therapies	21	15	10	5	10
Capacity Building	58	43	27	16	27
Dignity	53	39	11	28	11
Living Well with Dementia	48	0	0	0	0
Autism Spectrum Disorder	0	0	-4	4	-4
Priority 4 Employment Learning & Skills					
Voluntary Sector Sustainability	7	5	0	5	0
LSP TEAM					
Unallocated Funds	11	8	0	8	0
Total Expenditure	**433**	**286**	**295**	**(9)**	**295**

Please note:
Autism Spectrum Disorder has £4k carry forward from 2008/9 not yet committed.

Additional costs incurred against the Vulnerable Adults Task Force will be met by the PCT.

Application of RAG symbols:

		Objective	Performance Indicator
Green		Indicates that the milestone/objective will be achieved within the identified timeframe.	Indicates that the annual target will, or has, been achieved or exceeded.
Amber		Indicates that at this stage it is uncertain as to whether the milestone/objective will be achieved within the identified timeframe.	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 the milestone/objective will not, or has not, been achieved within the identified timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Older People's Services**

PERIOD: **Quarter 3 to period end 31st December 2009**

1.0 INTRODUCTION

This quarterly monitoring report covers the Older People's Services Department third quarter period up to 31st December 2009 It describes key developments and progress against key objectives and performance indicators for the service.

The way in which RAG symbols have been used to reflect progress to date is explained in Appendix 7

2.0 KEY DEVELOPMENTS

Community Extra Care service, evaluation completed and to be presented to SMT this month. Plans to establish the service within base budget now developmental stage completed.

Virtual Ward model still progressing, social work input agreed. Therapy increases planned within same timescale.

Second phase of SCIP evaluation will continue until February 2011, agreement on long term service will follow full evaluation of the effectiveness of the integrated service.

Agreed redesign of information services to develop a partnership service with Age Concern Mid Mersey and Sure Start to Later Life, offering a consistent assessment and more effective and efficient service delivery across the borough.

Completion of the local dementia strategy and associated business case to outline the commissioning priorities and performance measures that will support the full implementation of the plans.

Additional funding of £200k has been secured for the Registered Social Landlord Partnership Agreement.

Following the recruitment of a handyperson the service will commence once employment checks and induction are complete.

The second consultation event for the Affordable Warmth Strategy is scheduled for the 12th January and a draft action plan has been developed.

The Adult Placement Service has recruited two additional staff (1.5 full-time equivalents) who have taken up posts in January. Plans to further expand the service are to be developed.

Following a period of consultation and to the success of the development of satellite units to provide day activities in the community the decommissioning of Bridgwater day centre from January 2010 has been agreed.

3.0 EMERGING ISSUES

Review of the Palliative Care and End of Life services has been completed by the PCT. The outcome of the review is to develop a gold standard for End of Life services across PCT and Social Care across the whole PCT footprint. The Halton social care model is seen as a model of good practice and is expected to be replicated within St Helens Borough Council.

A business case for the Halton Home Improvement and Independent Living Services is being developed, first draft completed.

The opportunity to expand the footprint of the Halton Integrated Community Equipment Service to provide a service in the St Helens area is being explored, to improve efficiencies within the service.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**15**	✓	**14**	?	**1**	✗	**0**

All key objectives/milestones are on target, with one exception. In this case decisions are awaited relating to Extra Care Housing funding and negotiations with providers.
Appendix 1 refers

5.0 SERVICE REVIEW

The second phase of the environmental improvement work within Oakmeadow, including the integrated care monitoring/call system, will be completed on target by the end of December.

The 6 month review/evaluation of the re-ablement service has been completed and reported to SMT, recommendations agreed and a further report to SMT in April 2010. The report will be presented to the IC Executive Board by the end of the financial year.

The restaurant at Dorset Gardens is now fully operational under new management as agreed within the review.

As part of the review of the OPCMHT additional SW support was recommended. This was agreed and an additional social worker has been appointed and will commence in the new year.

Age Concern Mid Mersey information provision and British Red Cross Home From Hospital services have been reviewed and proposals for redesign and efficiencies have been submitted and agreed through Senior Management Team.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**8**	✓	**6**	?	**2**	✗	**0**

Most key indicators are on target, however delivery of equipment is not meeting target at Q3 and numbers of carers receiving assessment is also below target. Appendix 2 refers

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**1**	✓	**0**	?	**1**	✗	**0**

Non key indicators are reported by exception at Q3, one indicator has attracted an amber RAG symbol.
Refer to Appendix 3

7.0 RISK CONTROL MEASURES

During the production of the 2009-12 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, however in this quarter some have been included at management's request.
See Appendix 4

8.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2008/09 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 in quarters 2 and 4, however in this quarter some have been included at management's request.
See Appendix 5

9.0 DATA QUALITY

The author provides assurances that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, has been sources directly from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Key Performance Indicators
Appendix 3- Progress against Performance Indicators
Appendix 4- Progress against Risk Control Measures
Appendix 5 – Progress against High Priority Equality Actions
Appendix 6- Financial Statement
Appendix 7 - Explanation of RAG symbols

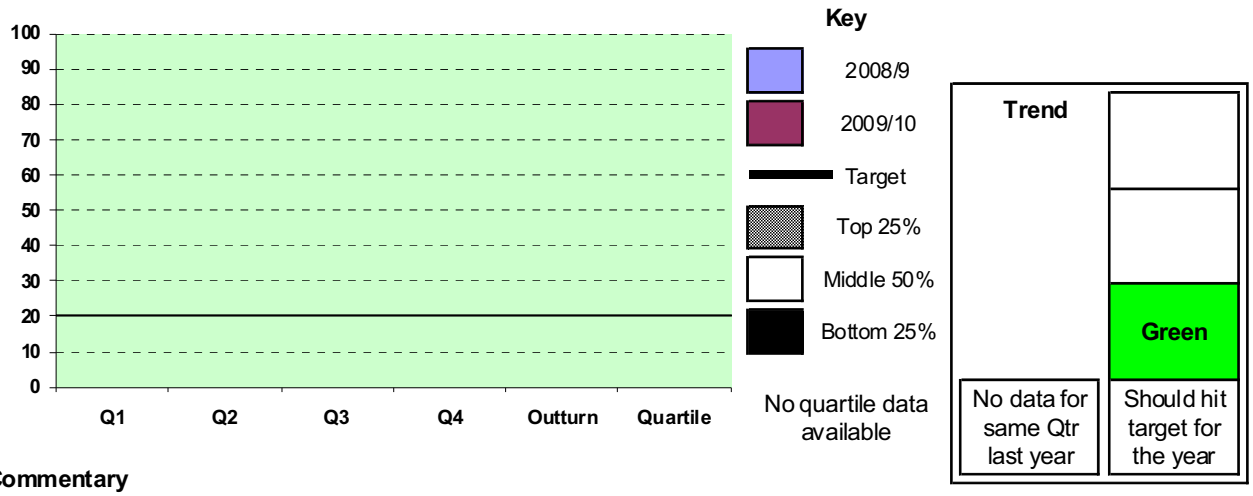
Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
OPS 1	Evaluate, plan, commission and redesign services to ensure they meet the need of vulnerable people within the local population, including those from hard to reach group (including the black and minority ethnic community)	Commission specialist housing provision for older people with higher levels of need **Mar 2010.** (AOF6 & 7).	?	Still awaiting decisions relating to Extra Care Housing funding and negotiations with providers.
		Implement of the Gold Standard and Performance Management Framework for Intermediate Care **Apr 2009** (AOF 6 &7)	✓	Completed on target
		Increase the numbers of carers provided with assessment leading to the provision of services, to ensure Carers needs are met **Mar 2010.** (AOF7)	✓	OP teams continue to identify new carers and deliver support to meet their needs, and target will be met
		Maintain the number of carers receiving a carers break, to ensure Carers needs are met **Mar 2010.** (AOF7)	✓	Carers sub group is now well established and monitors carers breaks to ensure carers needs are met.
		Comprehensive pathways for using transitional care within Halton are in place **Mar 2010** (AOF 6 &7)	✓	On target for completion

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Intergenerational activities project established as part of the review on early intervention and prevention aimed at improving outcomes for Older People **June 2009** (AOF 6 &7)	✓	Successful Halloween events have taken place with more than 200 older and younger people from different communities participating. Currently a new service specification for 2010-11 is being developed to ensure delivery of newly agreed outcomes. In addition a prevention and early intervention strategy is being developed and intergenerational work is included within this strategy.
		Review of Long Term Conditions and Therapy services commissioned jointly with NHS Halton and St Helens **Apr 2009** (AOF 6 &7) NB. Deadline dependent on contribution from the Primary Care Trust	✓	Final report recommendations accepted. Steering group of all stakeholders established. Business case in preparation and to be presented to PCT Board in February.
		Agreement with the PCT on the responsibility for Medication Prompts in place **Sept 2009** (AOF 7)	✓	Agreement with PCT for responsibility completed. A pilot with Northwest Medicines Management Network has been agreed to develop a re-ablement approach to supporting people with medication needs, and will commence in February.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
OPS 2	Effectively consult and engage with older people to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required	Review local arrangements for continuing health care following National Review **Apr 2009** (AOF 2&7) NB. Dependent on National Review being completed to timescale of Jan 2009	✓	National review completed on target. However, significant changes within the new guidance will lead to further review of local arrangements within the next months.
		Implement revised Joint Commissioning Strategy for Older People **March 2010** (AOF 2&7)	✓	Implementation plan on target, monitored through Older People's Local Implementation Team
		Evaluate joint service developed with Runcorn PBC **Mar 2010** (AOF 2&4)	✓	Due to the success of the first phase, a new period of evaluation under the second phase agreed as ongoing until February 2011.
		As part of the review on early intervention and prevention aimed at improving outcomes for Older People, develop a meaning engagement strategy with Service Users **June 2009** (AOF 7)	✓	First draft of the prevention and early intervention strategy will be complete in January 2010.
		Establish Social Care element of the 'Virtual Ward' established with Widnes PBC **March 2010** (AOF 2)	✓	Still on target for completion as above.
OPS 3	Ensure that there are effective processes and services in place to enable the Directorate	Analyse need and submit bids to DOH, Housing Corporation or other pots for at least one extra care development to provide additional extra care tenancies in Halton **Mar 2010.** AOF 6&7)	✓	Maintained regular contact with RSL partners to progress a number of options for the development of extra care housing. On target to submit two bids to HCA before March 10.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
	to manage, procure and deliver high quality, value for money services that meet peoples needs	Implement new residential and domiciliary care contracts for older peoples services **Sept 2009** (AOF 6&7)	✓	Complete.

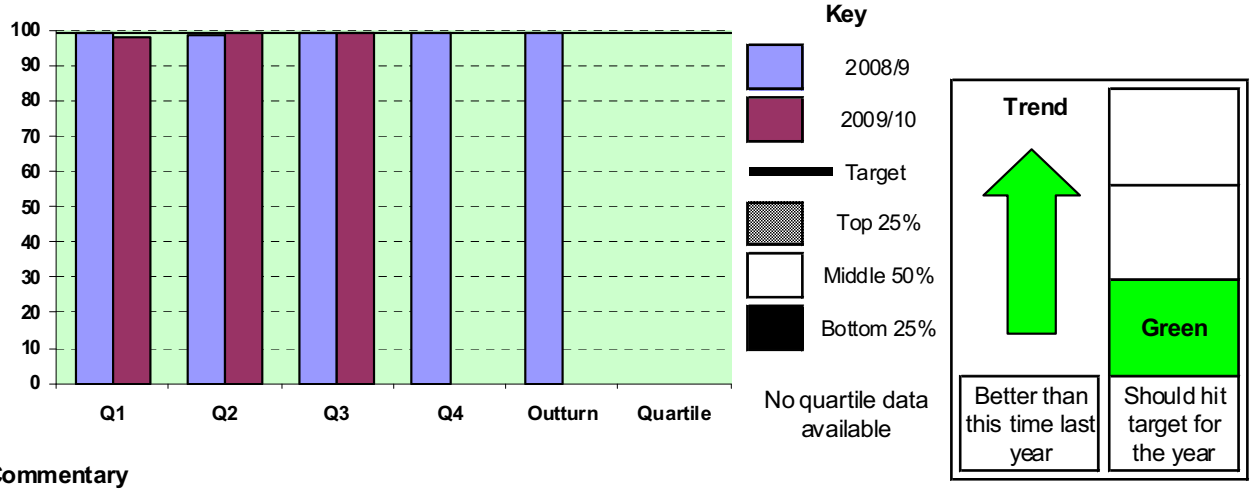
OP LI3 **Unit cost of home care for adults and older people**



Commentary

There have been no re-imbursable delays during this period

OP LI7 **Percentage of people receiving a statement of their needs and how they will be met.**

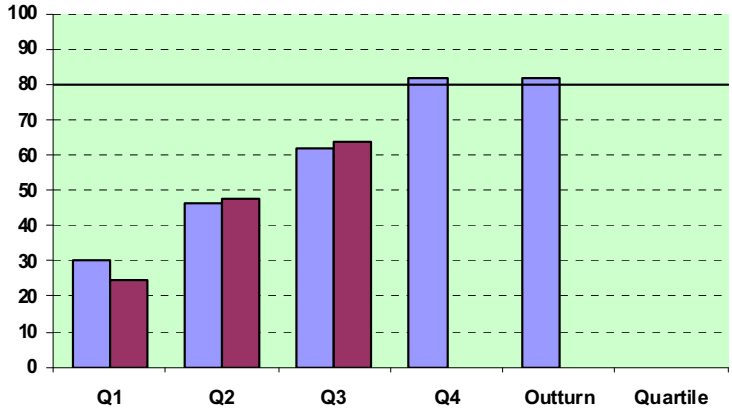


Commentary

99.54% of people in receipt of services have been given a statement of their needs and how they will be met. Target already achieved, however, monthly exception reports are still produced for operational teams to action of those clients who are not in receipt of their statement of needs.

OP LI8

Clients receiving a review as a %age of adult clients receiving a service



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Better than this time last year

Green

Should hit target for the year

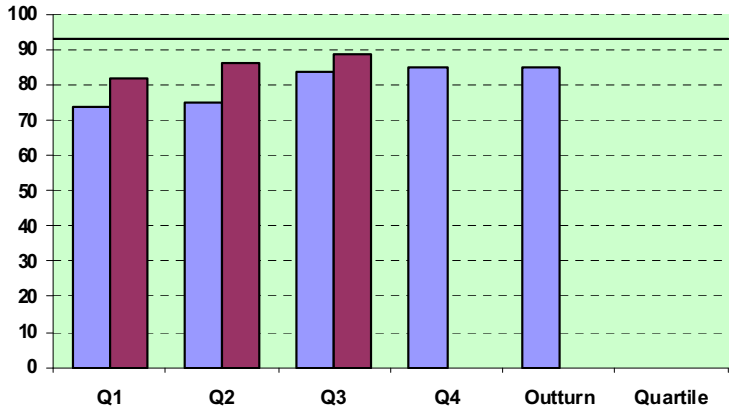
Commentary

63.61% of clients receiving services have been reviewed so far. In order to ensure the target will be met at year end, monthly exception reports of outstanding reviews are sent to operational teams to action.

OP LI9

Percentage of items of equipment delivered within 7 working days

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

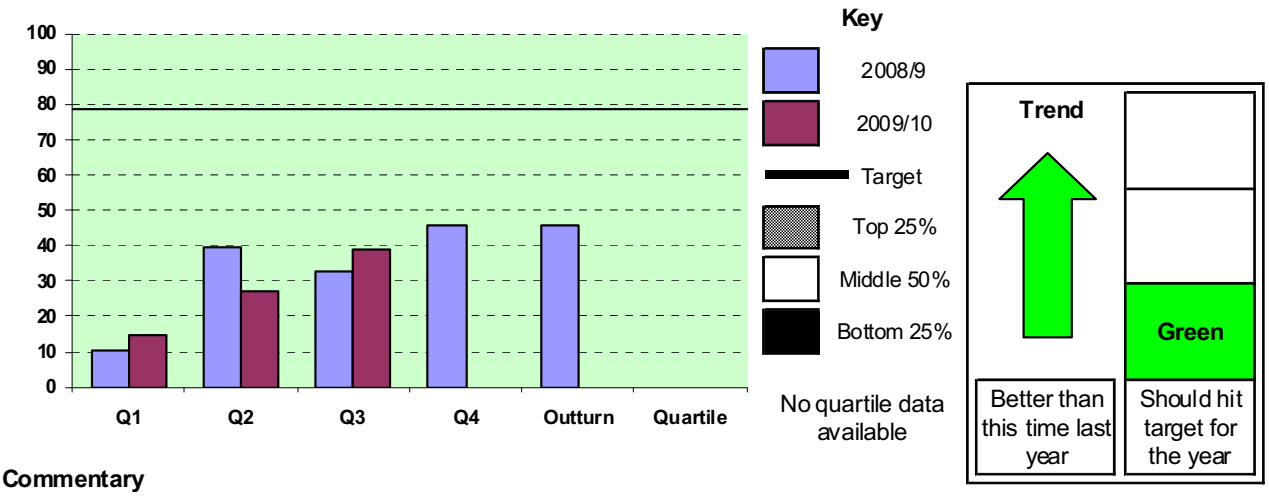
Better than this time last year

Amber

May hit target for the year

Commentary

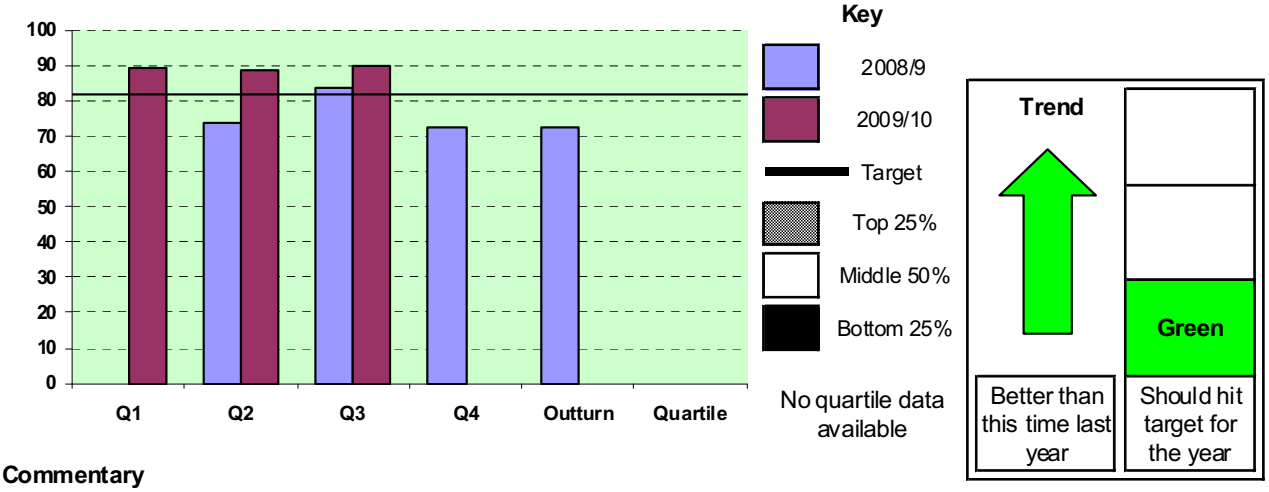
OP LI10 **Admissions of supported residents aged 65+ to permanent residential/nursing care (per 10,000 population)**



Commentary

To date, 65 older people and 1 adult have been admitted to permanent residential and nursing care. All clients are allocated a single room.

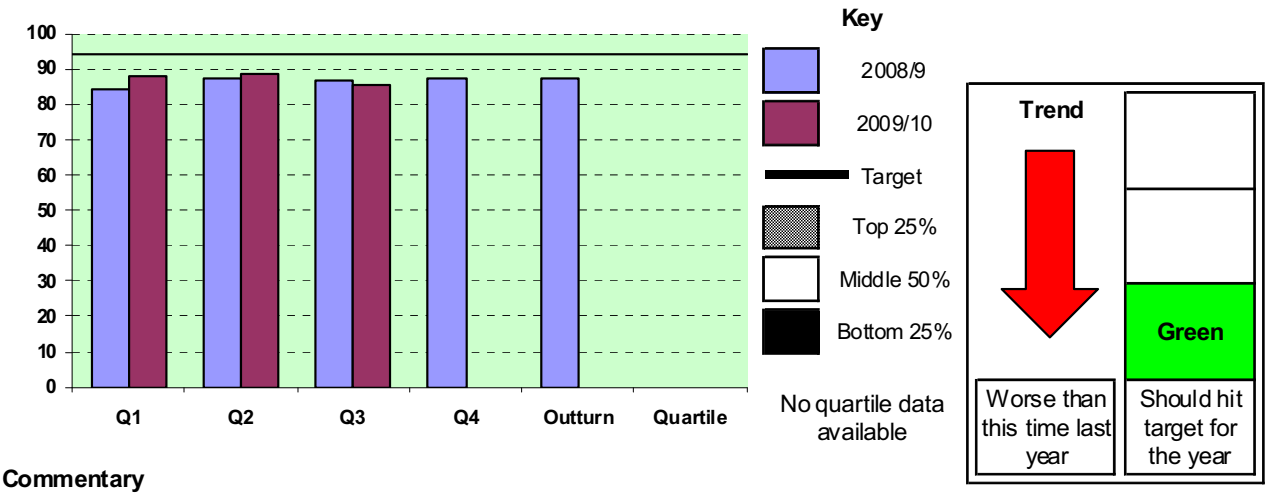
OP NI 132 **Timeliness of social care assessment DH DSO**



Commentary

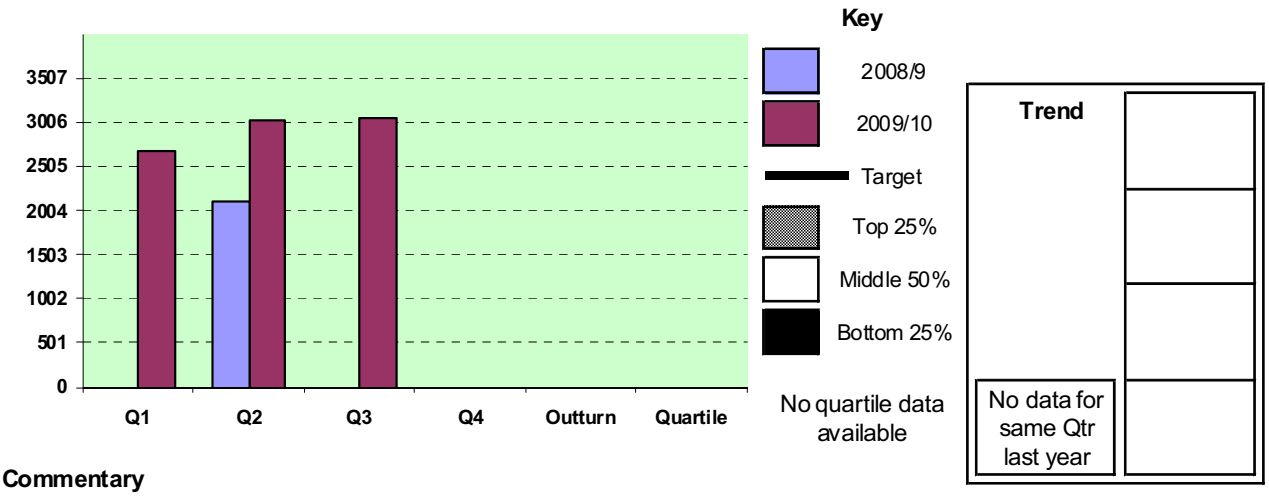
Target exceeded. However, final year end figure is determined by a file check which is ongoing

OP NI 133 **Timeliness of social care packages DH DSO**



Commentary
Final year end figure is determined by a file check which is ongoing

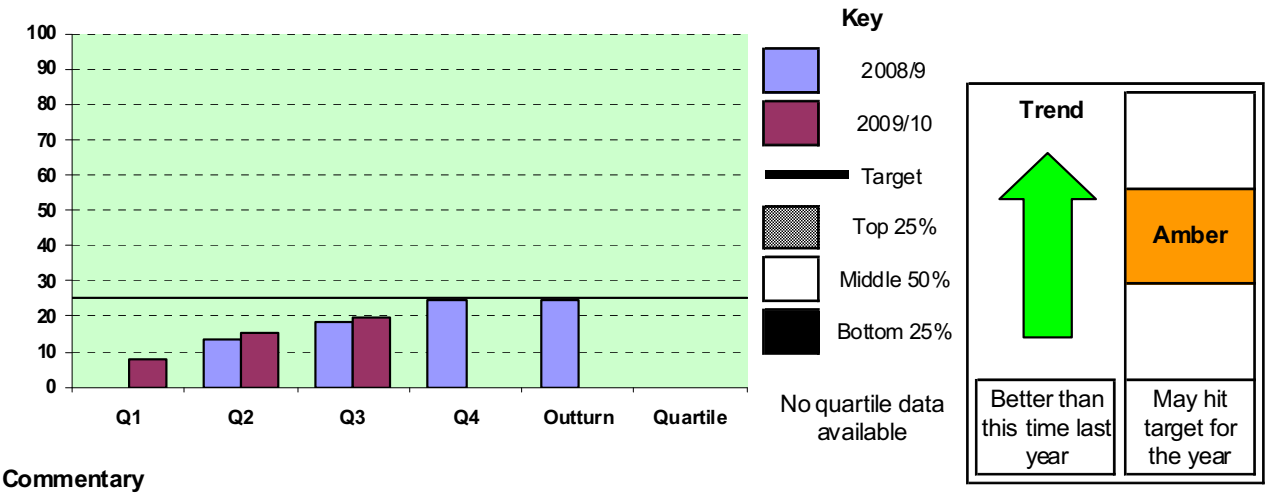
OP NI 136 **People supported to live independently through social services (all ages) PSA 18**



Commentary
Q3 performance has increased from Q2 performance. Helped to live at home continues to be good. No target has been set for 2009/10, therefore a traffic light indicator cannot be allocated.

OP NI 135

Carers receiving needs assessment or review and a specific carer's service, or advice and information DH DSO



Commentary

To date 830 carers have received an assessment/review and a specific carers service, or advice and information. Exception reports are produced on a monthly basis of carers who have not yet received an assessment/review but have had a service for operational teams to action.

The following KPIs are not shown in tabular form for the reasons stated below: -

NI 131 Delayed transfers of care;
Data derived from health, which is not yet available

NI 125 Achieving independence for Older People through rehabilitation/Intermediate Care;
Indicator derived from a sample was undertaken in December. Figure will not be known until year end.

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 3	Progress	Commentary
Quality						
OP LPI 4	Ethnicity of older people receiving assessment	1.7	1.5	0.71	?	Out of 1112 clients who have received an assessment this year, 4 clients have an ethnic origin other than white. Given the small proportion of ethnic minority clients, this indicator is fluctuation to change.

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
OPS3	Availability of suitable land and funding to develop extra care housing	• Development of alternative community services	March 2010	✓	A number of potential sites have been identified and work is ongoing to work up scheme proposals for submission to the Homes & Communities Agency (HCA).

Policy/Service	HIGH Priority Actions	Target	Progress	Commentary
Housing	Private Sector Housing Conditions survey to be carried out, with resulting data disaggregated and analysed for race and disability	March 2010	✓	Survey completed. Draft report on key findings to be completed by April 10.

HEALTH & COMMUNITY – OLDER PEOPLE

Revenue Budget as at 31st December 2009

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Employees	6,140	4,631	4,638	(7)	4,781
Premises Support	215	161	162	(1)	162
Other Premises	58	39	25	14	51
Food Provisions	255	191	155	36	185
Supplies & Services	467	125	120	5	267
Transport	242	123	115	8	115
Departmental Support Services	1,704	0	0	0	0
Central Support Services	646	221	476	0	476
Community Care:					
Residential Care	7,115	4,106	3,484	622	3,484
Home Care	2,360	1,416	1,206	210	1,206
Supported Living	355	213	249	(36)	249
Day Care	29	22	25	(3)	25
Direct Payments	351	211	179	32	179
Other Agency	2,591	10	9	1	9
Asset Charges	52	0	0	0	0
Total Expenditure	**22,580**	**11,724**	**10,843**	**881**	**11,189**
Income					
Residential Fees	-2,426	-1,820	-1,592	(228)	-1,592
Fees & Charges	-1,081	-811	-825	14	-825
Preserved Rights Grant	-91	-72	-73	1	-73
Supporting People Grant	-857	-430	-430	0	-430
PCT Reimbursement	-21	-10	-10	0	-10
Intermediate Care PCT Contribution	-2,961	-1,920	-1,916	(4)	-1,916
PCT Contribution to Care	-35	-18	-21	3	-21
Joint Finance – PCT	-33	-8	-9	1	-9
Adult Stroke Services Grant	-170	-170	-170	0	-170
Community Roll Out Grant	-18	-17	-18	1	-18
Other Income	-325	-325	-320	(5)	-320
Total Income	**-8,018**	**-5,601**	**-5,384**	**(217)**	**-5,384**
Net Expenditure	**14,562**	**6,123**	**5,459**	**664**	**5,805**

Comments on the above figures:

In overall terms revenue spending at the end of quarter 3 is under budget profile by £664k. This is due to expenditure on the community care budget continuing to be lower than anticipated at this point of the financial year as service users are increasingly being supported at home using home care and telecare services. This has resulted in a reduction in residential and nursing care expenditure and income.

APPENDIX SIX – FINANCIAL STATEMENT
Older People's Services

The continued success in gaining continuing health care funding, investment in re-enablement services and a reduction in the number of high cost packages during quarter 3 means expenditure on the community care budget is significantly less than expected. However, the Primary Care Trust is currently reviewing some CHC funded packages, which may lead to demands for funding from the Local Authority. This budget will continue to be scrutinised closely throughout the remaining quarter of the financial year.

The under spend on employees costs has reduced considerably from quarter 2 due to the payment of redundancy costs to the Operational Director. This budget is expected to balance at year-end.

Food provisions budget is under budget profile due to the Meals on Wheels service delivering more hot meals and tea packs resulting in additional income.

Older People

Capital Budget as at 31st December 2009

	2009/10 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Redesign Oakmeadow Phase 2	60	30	41	19
Major Adaptations for Equity release/Loan Schemes	100	0	0	100
ILC market garden canopy	16	16	13	3
Bridgewater	2	2	0	2
Total Spending	**178**	**48**	**54**	**124**

The RAG symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage whether the objective will be achieved within the appropriate timeframe.	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 it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	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 3 to period end 31st December 2009**

1.0 INTRODUCTION

This quarterly monitoring report covers the Health & Partnerships Department third quarter period up to 31st December 2009 It describes key developments and progress against key objectives and performance indicators for the service.

The way in which RAG symbols have been used to reflect progress to date is explained in Appendix 7

2.0 KEY DEVELOPMENTS

Housing

In line with a national initiative and new guidance, Govt. has awarded the Council £10,000 to promote and develop anti fraud initiatives around unlawful sub letting and non occupation of social housing. Officers are working with RSLs to develop a consistent approach which will be launched in 2010.

As a consequence of Govt. increasing spend by £1.5 billion nationally on new affordable housing (as set out in 'Building Britain's Future'), local authority housing capital allocations in the North West are set to reduce by 40% in 2010/11. At the same time the NW Regional Housing Group has recommended a revised formula for distributing resources that, if approved by 4NW Leaders and the Government, will see Halton's allocation fall from £2.9m this year to £1.6m next year.

Tenders

The Domestic Abuse Service - is now in place, all job vacancies have been filled and feedback from the Police and other external stakeholders is good. A monitoring visit has been scheduled in February 2010. This service now incorporates floating support, IDVA (Independent Domestic Violence Advisor) and the Sanctuary scheme, which enables people to stay in their own tenancy with additional security measures.
The Meals on wheels tender is ongoing. The award of contract will take place February 2010. This service provides 61,445 meals to 204 people.
The Dementia Respite support contract. The award of contract was made to one of the existing Halton services (Caring Hands) on the 23 December 2009. This service will commence in April. This is a 1-year contract to be extended for a maximum of 3 years.(Grant funded)

Minor Adaptations contract - This contract provides low level adaptations (steps, grab rails etc) 120 – 150 jobs each year**.** The award of contract date is the 11th February 2010 and the contract commences 1st April 2010 – 2012 that can be extended for a maximum of 1 year**.**

Stairlift framework agreement – Assisted a framework agreement to be used through the Northern Housing Consortium – (Free lift and Stannah) are the chosen contractors. Commencement date, 1st April 2010. This is a 1-year contract to be extended to a maximum of 5 years.

- The QA officers are in the process of using the new electronic tendering system (Due North – pro contracting system). This will be fully implemented in April 2010 by the Council.
- Mental Health provision of accommodation based services. – The consultant has completed the draft version of the findings. This will feed into the new specifications for the Mental Health commissioned accommodation based services.

Service Planning & Training

- The Draft Joint Carers Commissioning Strategy 2009 - 2012 was presented to the Executive Board on 5.11.09
- The updated Joint Strategic Needs Assessment (JSNA) Health & Wellbeing Position Statement 2009 was presented to the Healthy Halton Policy and Performance Board on 12.1.10
- The Training Section have commissioned an external provider to evaluate, including the Return on Investment, specific areas of the Training and Development Programme. The project shall be completed within a 6-month period and will involve colleagues from the Adult of Working Age (18-65) and Older Peoples Divisions.

Commissioning

Decommissioning of existing service for statutory community care assessments of need for children, adults who are deaf or deafblind and their carers is in progress. Arrangements for provision beyond March this year are being progressed with a focus on developing a service with greater community presence.

Direct Payments/ Individualized Budgets

The number of service users in receipt of Direct Payments continues to increase. At the 31st December there were 251 service users and 470 carers receiving their service using a Direct Payment. A number of Direct Payment promotional activities have been organized for operational teams and carers groups and to promote direct payments/ individualized budget and carers break take up.

3.0 EMERGING ISSUES

In line with the directorate's plan, the QA Team supported the Independent Providers to complete and submit robust Business Contingency Plans that would emphasise specific focus to swine flu planning.
As part of this project, the QA team delivered a comprehensive training package and developed user-friendly documents that could be used as part of the plans.

The training sessions took place over 3 sessions, which saw 28 independent Providers attending.
48 BCM plans have been submitted across Adult Social Care and Supporting People services
Domiciliary Care – all plans returned – 11 in total
Residential Care – plans returned – 25 (2 not yet returned)
Supporting People – plans returned – 12

The QA team worked in collaboration with Corporate Risk Management and assessed all plans that were submitted. Advice was then given to the Providers in a bid to improve the plans.
In addition steering groups have been set up and 12 interagency agreements have been submitted. The interagency document allows Providers to share their resources in the event of a major incident. Some providers have offered the use of vehicles, shared use of staff, offices etc. This agreement is particularly useful for the smaller Providers.

There is a number of problematic services requiring intensive monitoring across adult social care and Supporting People services.
One SP mental health service has been closed down and there is a possibility of a home closure within Older People services.
In addition Halton are in negotiation with all the Providers around the Continuing Health Care rates. This may have a negative impact on some of the nursing homes within Halton.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**16**	✓	**13**	?	**3**	✗	**0**

Non key milestones/objectives are reported at Q3 only by exception.
In this Quarter three have attracted an amber RAG. One is due to the re-designation of Grangeway court, one refers to the RAS model, which as needs further testing, and the 3 year financial strategy is in need of further clarification with the PCT.

5.0 SERVICE REVIEW

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**4**	✓	**2**	?	**1**	✗	**1**

One indicator is not expected to reach target until 2010/11 (no of temporary homeless. This is due to the re-classification of Grangeway Court. A change in definition also accounts for one indicator attracting an amber RAG for Q3.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**1**	✓	**0**	?	**0**	✗	**1**

Non key indicators are reported by exception at Q3. One indicator, relating to vacant posts, is not expected to reach target as the situation has been put on hold.

7.0 RISK CONTROL MEASURES

During the production of the 2009-12 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, but in this quarter have been included at management's request. For further details please refer to Appendix 4.

8.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2008/09 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 in quarters 2 and 4 but in this quarter have been included at management's request. Please refer to Appendix 5

9.0 DATA QUALITY

The author provides assurances that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, has been sources directly from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated**.**

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress Against Key Performance Indicators
Appendix 3- Progress against Performance Indicators
Appendix 4- Progress against Risk Control Measures
Appendix 5- Progress Against High Priority Equality Risk Actions
Appendix 6- Financial Statement
Appendix 7- Explanation of RAG symbols

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
HP 1	**Working in partnership with statutory and non statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for the community of Halton**	Develop commissioning strategy for challenging behaviour/Autism Spectrum Disorder **Mar 2010** (AOF 6 & 30)	✓	Business case presented in Jan. 2010. Awaiting final decision (Feb 2010).
		Commission combined advice, support and sanctuary service for people experiencing domestic violence **Mar 2010** (AOF 6, 30 and 31)	✓	Complete. Contract awarded to Halton & District Women's Aid.
		Commission feasibility study for Supporting People 'Gateway' or single point of access service **Mar 2010** (AOF 6, 30 and 31)	✓	Feasibility study complete.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Establish effective arrangements across the whole of adult social care to deliver self directed support and personal budgets **Mar 2010** (AOF6)	✓	Transformation Team now established. Good progress being made. Project structure in place. A comprehensive training programme underway and phase 2 being developed.
		Commission supported living services for Adults with Learning Disabilities and People with Mental Health issues **Mar 2010** (AOF 6, 30 and 31)	✓	Two people whose deteriorating health Needs required more accessible accommodation have now moved to their adapted home enabling them to continue sharing and avoid admittance to residential care. Contract extension to March 2011 has been approved. The time will be used to examine how we can move away from existing block contracts and shift control to the individual. Progress is being made with residential provider to reconfigure services to offer greater independence. NFTi demonstration site project in collaboration with St Helens Council and the PCT, has been launched and training date set for Inclusion web training.
		Redesign the housing solutions service to ensure the continued	✓	Service redesign is complete, although plans to relocate the

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		effective delivery of services **Mar 2010** (AOF6 &)		service are on hold until the outcome of the corporate accommodation review.
		Deliver against the government target to reduce by half (by 2010) the use of temporary accommodation to house homeless households **Mar 2010** (AOF 6, 30 and 31)	?	Measures have been put in place to achieve the target, including the re-designation of Grangeway Court as supported housing and negotiations with RSLs to provide a smaller number of units for use as temporary accommodation. Whilst there is every likelihood that the target will be attained by the Govt. deadline of Dec 2010, it is unlikely to be achieved by March 2010.
		Introduce a Choice Based Lettings System to improve choice for those on Housing Register seeking accommodation **Dec2010** (AOF 11&30)	✓	It is anticipated that a report will be presented to Exec Board in Jan/Feb 2010 seeking key decisions to endorse a common sub regional allocations policy, the ICT supplier, and cost sharing details. The project is still on track to be implemented in 2010.
		Commission floating services for vulnerable groups **Mar 2011** (AOF 6,30,31)	✓	In procurement work plan for 2010/11.
		Work with the Council's Planning Department to introduce an affordable housing policy within the Local	✓	Consultation on the Core Strategy ended 5/11/09. Following formal adoption, work will commence on the Development Plan

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Development Framework **Mar 2011** (AOF 11)		Documents, one of which will be for affordable housing policy. Currently on track to meet target.
HP 2	**Effectively consult and engage with the community of Halton to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required**	Continue to survey and quality test service user and carers experience of services to evaluate service delivery to ensure that they are receiving the appropriate outcomes **Mar 2010** (AOF 32)	✓	Quality of life service data has now been collected and teams are updated on two specific questions respect and safety on a monthly basis as these are deemed to key questions. Data analysis is ongoing. A new carer survey feedback form has been designed and carers have been consulted on it. The design will be finalised shortly and the form will start to be used when it is completed.
HP 3	**Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs**	Assess, on a quarterly basis, the impact of the Fairer Charging Policy strategy to ensure that the charging policy is fair and operates consistently with the overall social care objectives **Dec 2009** (AOF34)	✓	Revised policy presented to Exec. Board Sub Committee on 10/09. Draft proposals for 2010/11 prepared and submitted.
		Develop a preliminary RAS model and explore impact on related systems **Apr 2010 (AOF 34)**	?	Further testing on the RAS model will be undertaken in January 2010 prior to roll out. Feedback from Managers is also contributing to the development of the questionnaire. Training plans well developed.

Service Plan Ref.	Objective	2009/10 Milestone	Progress to date	Commentary
		Review existing Direct Payment arrangements to ensure alignment with the personalisation agenda **May 2010** (AOF 34)	✓	Staffing reviewed and additional capacity created to meet personalisation agenda. Progress made in quarter redesigning Direct Payment guides e.g. Employing a Personal Assistant following service user consultation. The previously piloted North West in line Personal Assistant Register went live in October 2009. To date four direct payment clients have used this service to advertise for a PA vacancy.
		Review & update, on a quarterly basis, the 3 year financial strategy **Mar 2010** (AOF 34)	?	Support to a number of projects is ongoing. The financial impacts of Continuing Health Care funding and the Valuing People Now settlement for Adults with Learning Disabilities are being further clarified with Halton and St Helens PCT.
		Review and deliver SP/Contracts procurement targets for 2009/10, to enhance service delivery and cost effectiveness **Mar 2010**. (AOF35)	✓	SP / Contracts procurement projects on target. The ALD tender was given a 12-month extension. A range of measures are being developed to integrate Personalisation and achieve the target date of 31.3.11

APPENDIX ONE - PROGRESS AGAINST OBJECTIVES/MILESTONES
Health & Partnerships

NI 156

Number of households living in Temporary Accommodation

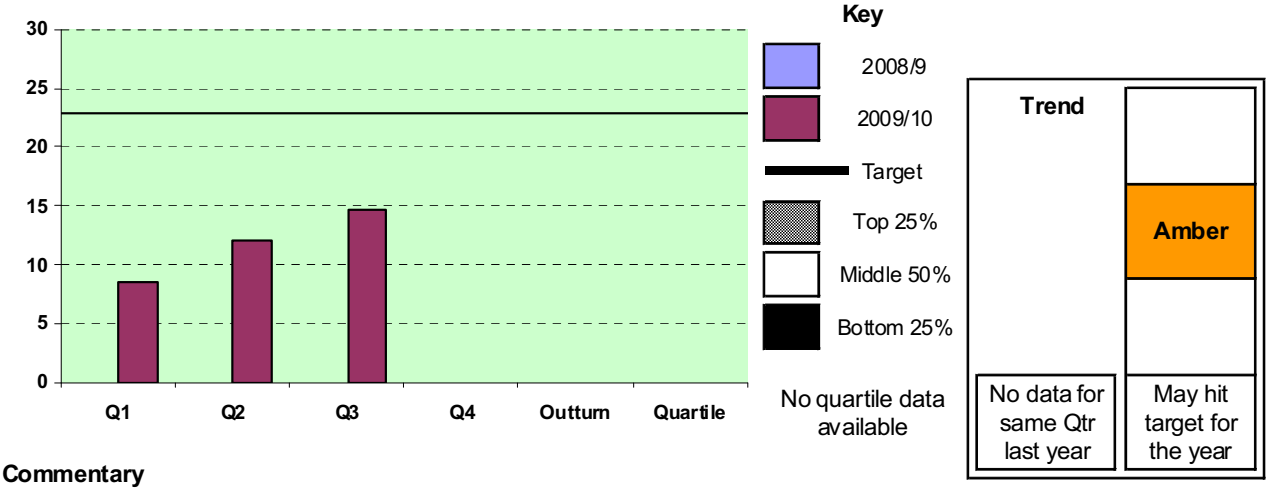
Commentary

The key to achieving this target is the re-designation of Grangeway Court as supported housing. Approval has been obtained to do this and is in the course of being implemented. However the effects of this change will not be enjoyed until the 2010/11 year as it was classed as temporary homeless accommodation for most of the 2009/10 year.

NI 130

Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets) DH DSO

Higher figures represent better performance



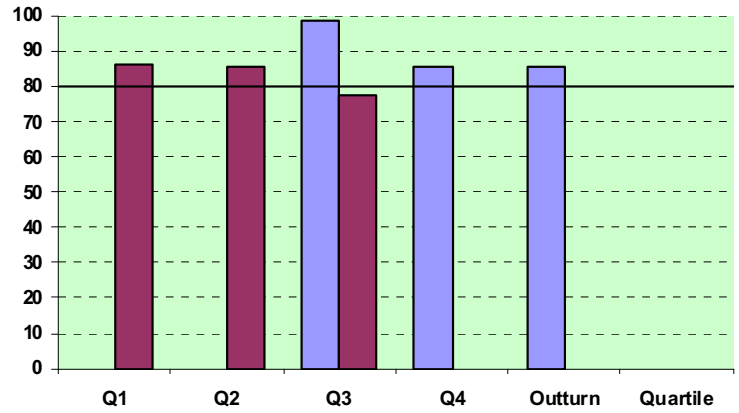
Commentary

Indicator now monitored against the new definition, which is clients and carers in receipt of self directed support as a percentage of clients and carers in receipt of services, as opposed to the old definition of clients and carers in receipt of self directed support per 100000 population.

HP NI 141

Number of vulnerable people achieving independent living CLG DSO

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Worse than this time last year

Amber

May hit target for the year

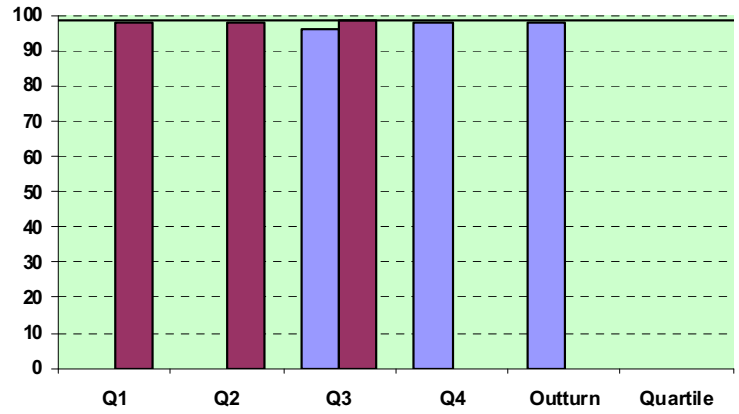
Commentary

Target has not been achieved for quarter 3 due to 3 services not achieving their individual performance targets. One homeless service has only achieved 31.3% planned moves, with 5 planned moves from 16 departures. A monitoring visit has been flagged & arranged to discuss the performance issues & agree an action plan to resolve. The other 2 services will continue to be monitored & monitoring visits will be arranged should there be further cause for concern.

HP NI 142

Number of vulnerable people who are supported to maintain independent living CLG DSO

Higher figures represent better performance



Key

2008/9

2009/10

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Better than this time last year

Green

Should hit target for the year

Commentary

Majority of client groups continue to meet their individual targets. Older peoples services have met their target but a number of service users have moved into residential & nursing care or hospital/hospice during this quarter. The teenage parent service is still not meeting its performance targets, and a joint approach between Supporting People, Children's Services and the support provider is being adopted to resolve issues & improve performance.

The following key indicator cannot be reported for the explanation given;
NI 127 Self expected experience of Social Care Workers: -

Indicator is derived from the Equipment Survey. Value will be reported either at year end if value known or in Quarter 1 2010.

Ref.	Description	Actual 2008/09	Target 2009/10	Quarter 3	Progress	Commentary
Cost & Efficiency						
HP LI 1	% of SSD directly employed posts vacant on 30 September	7.9	8	12.84		With the Efficiency Review and the modernisation agenda of adult social care in full flow during 2009/2010, many vacant posts within Adult Social Care have been put on hold. This has created a variance with the target figure that had been set, and it is unlikely that this figure will alter too much by the end of March 2010.

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
HP2 Milestone: Update JSNA summary following community consultation	Failure to identify resources/skills required to refresh data and summary on an annual basis and produce full JSNA on 3yr basis	Work with colleagues in Public Health, Corporate Intelligence Unit and CYP to identify staff with appropriate skills/knowledge to undertake work Ensure that work on JSNA is built into identified staffs work programmes Establish formal reporting mechanism for progress with JSNA to Health PPB	March 2010	?	Working groups set up- attendance could be improved. Service Development Officer assigned to work on JSNA is off on long-term leave – protracted recruitment process has affected progress with full JSNA. Temporary appointment now confirmed. Draft summary of refresh completed in December. Presented to Health PPB in January.
	Failure to implement comprehensive community consultation	Work with colleagues in Public health, corporate communications and CYP to identify staff with appropriate skills/knowledge to carry out annual consultation. Ensure that work on JSNA consultation is built into	March 2010	?	Road show, street and on-line surveys undertaken in Oct 09. Service Development Officer assigned to work on JSNA is off on

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
		identified staffs work programmes			long-term leave – protracted recruitment process has affected progress with full JSNA. Temporary appointment now confirmed
HP 2 Milestone: Continue to survey and quality test service user and carers experience of services to evaluate service delivery to ensure that they are receiving the appropriate outcomes	Failure to demonstrate outcomes and work with service users to improve them could mean that poor services are provided to the people that need them and ultimately reduce the Directorate's performance rating	Contact Centre Surveys undertaken on new service users to test service experience Surveys undertaken on specific topics through the year so that outcomes are tested and views on service improvements are sought.	Nov 2010	✓	The Contact Centre continue to test Lifeline users but there are plans to replace this with a new survey that will be undertaken at review by the wardens. This will enable direct feedback to those whoa re responsible for organising and managing the service.
HP 3 Milestone: Following the publication of the new national guidance on complaints, review, develop, agree and implement a joint complaints policy and procedure to ensure a consistent and holistic approach	Failure to respond to the statutory performance agenda and care frameworks could impact on the people the Directorate provides services to and the performance rating of the Directorate.	An annual performance strategy is created that details all the checks and balances in place so that performance is monitored appropriately. This includes a timetable of the reporting and testing mechanisms that are used to monitor performance.	Septe mber 2009	✓	Complaints are being process in line with the new national guidelines/legislation. Reports are made to Senior Management Team and other managers quarterly, to report lessons learned and outcomes along with the statutory annual report. Outcomes of complaints and learning are reported to help inform the development of services. Joint complaints procedures have been agreed

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
					locally and are being developed regionally.
HP3 Milestone: Develop a preliminary RAS model and explore impact on related systems	Failure to follow a staged approach to developing the preliminary RAS model will not highlight areas of concern and meet NI 130 targets.	A ongoing monitoring of performance development, highlighting findings and taking appropriate action to amend the RAS	March 2010	?	The Personalisation team is evaluating Halton's bespoke questionnaire. Points allocated will feed into the developing Desktop RAS which will be available at the end of January 2010 to test a further 20 physical and sensory disability service users, with a working model rolled out in April 2010. The Personalisation team has also evaluated the National RAS and questionnaire and has decided to continue with the development of th existing model given current ownership from staff and recognition of informal care in Halton's model.
	Failure to review on going performance development to ensure RAS is continually updated	Regularly review RAS with appropriate managers, and provide progress reports on a monthly basis	March 2010	?	All social work teams have been informed of their Direct payment/ Individualised budgets targets for service users and carers for 2009/10 with monthly performance monitoring reports used to monitor progress to date. Feedback from Managers is also contributing to the development of

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
					the questionnaire and RAS future model.
	Failure to explore areas of concern on related systems and flag issues with manager	Regularly review RAS with appropriate managers, and provide progress reports on a monthly basis	March 2010	?	Progress is reported via the Finance Work stream Group, TASC Board and Self Directed Support Board to address areas of concern. Training Plans have also been put in place for the Mental Health Team.
HP3 Milestone: Review existing Direct Payment arrangements to ensure alignment with the personalisation agenda	Not consulting with all relevant parties throughout the process may delay the alignment of the agenda	Regular meetings of the Self Directed Support Groups will ensure all parties are informed and any areas of concern highlighted and considered. Consultation with service users arranged.	May 2010	✓	Various consultation events have been held this quarter by the Direct Payments/ Individualised Budgets team e.g. Meeting with Carers forums, Social Work Teams to promote the use of Direct payments and IBs. A support group for service users and their carers receiving a DP has also re-commenced which will be held every two months to update and engage service users on the progress of the personalisation agenda. Quarterly Newsletters also provide useful feedback.
HP3 Milestone: Review and deliver SP/Contracts procurement targets for	Failure to secure/retain adequate staffing resources within team to project manage tender process	Secure support from SMT to resource team at level needed to complete 2009/10 work programme Limit opportunities for	March 2010	✓	Additional staff were recruited in order to complete work programme. Seconded staff now returned to the QA Team in order to strengthen the skills and knowledge of current

Key Objective	Risk Identified	Risk Treatment Measures	Target	Progress	Commentary
2009/10, to enhance service delivery and cost effectiveness		secondment to reduce loss of skills/knowledge within the team Agree priority work areas (based on risk) and offer advice and guidance only in respect to projects/tenders deemed low risk			team. Advice and guidance is offered to the projects that are lower risk and not detailed on work plan
	Unable to award contract due to lack of or poor quality of tender submissions	• Maximise opportunities for providers to submit comprehensive tenders by building in sufficient time for returns at each stage of the tender process. • Advertise tenders on a national basis. • Develop contingency plans for the extension of existing services subject to tender.	March 2010	✓	Sufficient time is built into the workplan for tender, though the officers are now using the Due Nort e tendering system at present whic is adding to the time allocated. This is the new system that the Council will be fully implementing from April 2010. All tenders are advertised through the national trade journals and local press. Currently working on the contingency plans for the extensions of services prior to tendering.

APPENDIX FOUR - PROGRESS AGAINST RISK CONTROL MEASURES
Health & Partnerships

Strategy/Policy/Service	HIGH Priority Actions	Target	Progress	Commentary
Housing	Private Sector Housing Conditions survey to be carried out, with resulting data disaggregated and analysed for race and disability	March 2010	✓	Survey complete. Draft report on finding to be delivered by April 10.

HEALTH & COMMUNITY - HEALTH AND PARTNERSHIP

Revenue Budget as at 31st December 2009

	Annual Revised Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance To Date** (overspend) £'000	Actual Including Committed Items £'000
Employees	4,405	3,186	3,185	1	3,372
Premises Support	121	78	75	3	75
Other Premises	44	34	32	2	55
Supplies & Services	521	376	372	4	374
Training	96	20	16	4	16
Transport	19	14	21	(7)	22
Departmental Support Services	174	0	0	0	0
Central Support Services	787	590	590	0	590
Agency Related	219	136	106	30	130
Supporting People Payments to Providers	7,222	4,685	4,684	1	4,684
Unallocated Grants	65	0	0	0	0
Asset Charges	963	0	0	0	0
Total Expenditure	**14,636**	**9,119**	**9,081**	**38**	**9,318**
Income					
Sales	-15	-11	-10	(1)	-10
Receivership Income	-69	-52	-62	10	-62
Rents	-122	-121	-138	17	-138
Departmental Support Services Recharges	-3,687	0	0	0	0
Supporting People Main Grant	-7,411	-5,640	-5,637	(3)	-5,637
Social Care Reform Grant	-559	-559	-559	0	-559
Adult Social Care Workforce Grant	-364	-273	-273	0	-273
Supporting People Admin Grant	-113	-84	-85	1	-85
Training Support Implementation Fund	-83	-83	-91	8	-91
Homelessness Grant	-30	-30	-30	0	-30
Disabled Facilities Grant	-40	-40	-40	0	-40
Mortgage Rescue Scheme	-38	-38	-38	0	-38
Other Grants	-68	-64	-68	4	-68
Re-imbursements	-145	-195	-199	4	-199
Other Income	-170	0	0	0	0
Total Income	**-12,914**	**-7,190**	**-7,230**	**40**	**-7,230**
Net Expenditure	**1,722**	**1,929**	**1,851**	**78**	**2,088**

Comments on the above figures:

In overall terms revenue spending at the end of quarter 3 is £78k below budget profile, due in the main to the overachievement of income targets and expenditure incurred to date relating to bed & breakfast accommodation being less than anticipated at this stage of the financial year.

Receivership income continues, for a third quarter in succession, to overachieve against budget profile despite lower interest rates reducing income from fees.
The additional income generated is being used to fund a post in order to meet the increased demand of appointee service users requesting to be managed by the Appointee & Receivership team.

Rents received during the period continue to be higher than expected at budget setting time.

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Health & Partnership

Capital Budget as at 31st December 2009

	2009/10 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
IT	28	10	0	28
Total Spending	**28**	**10**	**0**	**28**

Housing Strategy & Support Services

Capital Projects as at 31st December 2009

	2009/10 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Allocation Remaining £'000
Private Sector Housing				
Housing Grants/Loans	354	150	80	274
Disabled Facilities Grants	1,501	975	540	961
Home Link	10	0	3	7
Energy Promotion	100	66	43	57
Choice based lettings	50	0	0	50
Handy Person Van	12	0	0	12
Contingency	50	0	0	50
	2,077	**1,191**	**666**	**1,411**

The RAG symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage whether the objective will be achieved within the appropriate timeframe.	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 it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.