ADULT AND PUBLIC HEALTH SERVICES PORTFOLIO

DECISION SCHEDULE

HARTLEPOOL
BOROUGH COUNCIL

Monday 12th December 2005

at 9.30 am

in Committee Room "B"

Councillor R Waller, Cabinet Member responsible for Adult and Public Health Services will consider the following items.

Also invited: Councillor Jayne Shaw, Chair of Children's Services Scrutiny Forum

1. **KEY DECISIONS**
   1.1 None

2. **OTHER ITEMS REQUIRING DECISION**
   2.1 Discharge of Mercury from Crematoria – *Head of Public Protection and Housing*
   2.2 Public Health Strategy – *Director of Public Health and Well-being*

3. **ITEMS FOR INFORMATION**
   3.1 Annual Review of Performance for Adult Social Care – *Acting Director of Adult and Community Services*

4. **REPORTS FROM OVERVIEW OF SCRUTINY FORUMS**
   4.1 Adult Learning – Final Report – *Children's Services Scrutiny Forum* – (to be presented by Councillor Shaw, Chair of Children's Services Scrutiny Forum)

EXEMPT ITEMS

Under Section 100(A)(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information as defined in the paragraphs referred to below of Part 1 of Schedule 12A of the Local Government Act 1972 as amended by the Local Government (Access to Information) Act 1985

5. **KEY DECISION**
   5.1 None

6. **OTHER ITEMS REQUIRING DECISION**
   6.1 None

ADULT AND PUBLIC HEALTH SERVICES PORTFOLIO

12th December 2005

HARTLEPOOL
BOROUGH COUNCIL

Report of: Head of Public Protection and Housing

Subject: **DISCHARGE OF MERCURY FROM CREMATORIA**

SUMMARY

1. PURPOSE OF REPORT

To inform the Portfolio-holder of new requirements by the Department for Environment, Food and Rural Affairs (DEFRA) regarding Mercury emissions and operation of cremation equipment.

To indicate the costs involved in implementing the requirements and recommend a course of action.

2. SUMMARY OF CONTENTS

The report outlines the background to the new DEFRA requirements and puts forward costings for the works necessary.

3. RELEVANCE TO PORTFOLIO MEMBER

Portfolio-holder is responsible for Cemeteries and Crematorium.

4. TYPE OF DECISION

Non-key.

5. DECISION MAKING ROUTE

Adult and Public Health Services Portfolio

6. DECISION(S) REQUIRED

Approval for recommended course of action to meet the requirements of the Department for Environment, Food and Rural Affairs (DEFRA)

Report of: Head of Public Protection and Housing

Subject: **DISCHARGE OF MERCURY FROM CREMATORIA**

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1. PURPOSE OF REPORT

To inform the Portfolio-holder of new requirements by the Department for Environment, Food and Rural Affairs (DEFRA) regarding Mercury emissions and operation of cremation equipment.

To indicate the costs involved in implementing the requirements and recommend a course of action.

2. BACKGROUND

Crematoria have been regulated under Part I of the Environmental Protection Act 1990 since 1991.

Government concern over the toxicity of mercury and the increasing emissions of the element from crematoria has led to the implementation of steps to sharply reduce this source of pollution derived from fillings in teeth, and which is estimated to be responsible for up to 16% of all UK emissions.

In October 2004, DEFRA published detailed requirements regarding emissions and operation of cremation equipment, including more stringent requirements for new crematoria from October 2006.

On 10th January 2005 DEFRA issued additional guidance which has significant implications for existing crematoria. Cremation authorities and companies must consider options for achieving a 50% reduction in the emissions of mercury and indicate to their relevant local authority regulator by 31st December 2005 their intention to install cleaning equipment (by 31st December 2012), or their expectation to rely on emissions trading through the Crematoria Abatement of Mercury Emissions Organisation (CAMEO) or other approved scheme.

The CAMEO scheme is a nationwide ‘burden sharing system’ being considered by the Federation of British Cremation Authorities and the Cremation Society, although there is still some doubt about whether this scheme will be allowed to operate and details of the required payments by Local Authorities into the scheme have not yet been announced.

At Stranton Grange Crematorium, two cremators were installed in 1998. The expected life-span of these cremators is 10-15 years and they may therefore need to be replaced between 2008 -2013.

DEFRA issued a further note on 15th September 2005 stating that, because of the finite capacity of cremator and abatement equipment manufacturers, it is very unlikely to meet the deadline of 31st December 2012 if all crematoria that are upgrading attempt to do so in the last couple of years before the deadline.

For the deadline to be fully met, DEFRA expect a phased programme of upgrades to be necessary and will be asking the relevant organisations for evidence annually of progress. As well as monitoring the percentage of upgrades completed, DEFRA will also be asking for data on what is committed (i.e. contracts signed and work programmed or begun) as a pointer towards future compliance.

3. FINANCIAL IMPLICATIONS

Following discussions with J.G Shelton & Co., Ltd (provider and maintainer of current cremators) the costs (at 2005/6) involved are estimated as:

Provision	**Cost (£s)**
Option 1 Remove one cremator and install gas cleaning system to remaining cremator	240,000
Option 2 Install gas cleaning system to two existing cremators	380,000
Option 3 Replacement of two cremators and provision of gas cleaning system with allowance for building costs.	750,000
Continuous emissions monitoring (required for options 1 and 2)	60,000
Replacement of inadequate electricity supply (required for all options)	30,000

There will also be additional ongoing costs: energy and water consumption and maintenance of the system.

4. FUNDING OPTIONS

The costs of the above works will need to be funded from Prudential Borrowing, as no other corporate resources will be available within the timescale for replacing the cremators. A strategy for funding the resulting repayment costs will need to be developed as part of the 2006/7 Budget and Policy proposals, which will be considered by Cabinet on 19th December 2005. There are several options which could be considered as a means of financing the repayment of Prudential Borrowing costs.

Option 1. – Increase Cremation and Burial fees in the year the works are completed

This option will require a one off increase in fees of 15%. This will be in addition to the normal inflationary increase.

Option 2. – Increase Cremation and Burial Fees on a phased basis commencing 2006/7

This option will require an annual fee increase of 2.3%, in addition to the normal inflationary increase, commencing 2006/7. Assuming the works are completed in 2010/11 the additional fee income earned over the five years 2006/7 to 2010/11 will be earmarked to offset the capital cost of replacing the cremators. The remaining investment will be funded from Prudential Borrowing and the repayment costs will be funded from the available fee income.

Option 3. – Meet loan repayment costs from overall budget

This option will require a specific budget saving of £71,000 to be identified in 2010/11.

A decision on which option to implement will need to be made as part of the overall Budget and Policy framework process.

5. RECOMMENDATIONS

That the Portfolio-holder notes the report and refers the issues for consideration by Cabinet as part of the 2006/7 Budget and Policy Framework process.

That approval ‘in principle’ be given to replacement of both cremators with associated gas cleaning equipment and replacement of inadequate electricity supply, at a cost of approximately £780,000 (estimated to be £904,000 by 2010/11)

ADULT AND PUBLIC HEALTH SERVICES PORTFOLIO

Report To Portfolio Holder

12th December 2005

HARTLEPOOL BOROUGH COUNCIL

Report of: Peter Price, Director of Public Health and Well-Being, Primary Care Trust

Subject: PUBLIC HEALTH STRATEGY

SUMMARY

1.0 PURPOSE OF REPORT

To provide a Public Health Strategy for Hartlepool.

2.0 SUMMARY OF CONTENTS

The Public Health Strategy aims to provide a five-year framework (2006-2010) of action for the prevention of ill-health and the promotion of positive health and well-being. The focus of the Strategy is on partnership approaches to community-based prevention programmes. It pulls together, within a common framework, elements which have been developed within a range of multi-agency working groups.

The Public Health Strategy is a Hartlepool Partnership Strategy which will contribute to achieving objectives in the Community Strategy and Neighbourhood Renewal Strategy.

The Strategy identifies the mechanisms for implementation to which the Council will be a major contributor.

3.0 RELEVANCE TO PORTFOLIO MEMBER

Public Health is a key component of the Portfolio Member's responsibility.

4.0 TYPE OF DECISION

Non key

5.0 DECISION MAKING ROUTE

Portfolio holder

6.0 DECISION(S) REQUIRED

The Portfolio holder is asked to:

- Endorse the Strategy
- Recommend the Strategy to the Hartlepool Partnership

A Public Health Strategy for Hartlepool 2006 – 2010

Introduction

This Public Health Strategy for Hartlepool has been developed within the following national and local context.

Inequalities in Health

The health of Hartlepool residents is improving; on average they are living healthier and longer lives. However, they still suffer more ill health and disability, higher death rates from diseases such as cancer, heart disease and respiratory disease and live shorter lives than in most other parts of the country. There is evidence to indicate that this 'health gap' is widening. There are also inequalities in the 'health experience' of communities within Hartlepool; the most deprived communities suffering significantly poorer health than the more affluent areas.

National Health Policy – Emphasis on Prevention

Government health policy is placing a greater emphasis on the prevention of ill-health and addressing health inequalities. The White Paper, *Choosing Health: making healthy choices easier*, published in November 2004 by the Department of Health, sets out a programme of action to support people in making healthy choices. It identifies the following priorities:

- Reducing the numbers of people who smoke
- Reducing obesity and improving diet and nutrition
- Increasing exercise
- Encouraging and supporting sensible alcohol consumption
- Improving sexual health
- Improving mental health

It stresses the need for partnerships, local leadership and commitment to develop a shared vision and agenda to improve health. This Strategy sets out what we aim to implement jointly as a partnership in relation to the promotion of healthy lifestyles.

The Hartlepool 'Vision for Care'

The Hartlepool Partnership has agreed a 'Vision for Care' which outlines how care, and services which impact upon health, will be developed and delivered in the future. This vision places an emphasis on the prevention of ill health and the targeting of services and resources to those in greatest need.

Hartlepool Community Strategy

The implementation of the Public Health Strategy will contribute to achieving the following objectives from the Community Strategy:

- To protect and improve health, reduce health inequalities in Hartlepool and increase life expectancy.
- To encourage people to adopt active and healthy lifestyles and healthy eating, and take greater responsibilities for their own health.
- To reduce smoking and alcohol, drugs and solvent abuse.
- To reduce ill health caused by heart disease, cancers and strokes.
- To reduce the death rate and the rate of serious injury from accidents.
- To help people resist drugs and alcohol abuse and enable people with related problems to overcome them.
- To tackle barriers to mental health and improve mental well-being.
- To reduce the rate of teenage conceptions and improve teenage sexual health.

Appropriate public health initiatives will be targeted at specific groups who face additional barriers to a healthier life and therefore the Public Health Strategy will also contribute to achieving the following objectives relating to vulnerable groups:

- To improve the health, emotional development and well being of all children and young people and their families, and particularly prepare 'looked after children' for life and bring stability to their lives.
- To improve the health and well-being of older people by removing barriers to maintaining independence, in creating awareness, providing a range of affordable care and support services in their homes and community and encouraging their active engagement with family, friends and neighbours.
- To improve the well-being and independence of people with learning disabilities.
- To improve the well-being and independence of people with physical disabilities or sensory loss by providing a range of affordable and accessible services.
- To improve the health and wellbeing of people with a range of mental health needs by working collaboratively to reduce the barriers of social exclusion people with mental health problems face.

Hartlepool Neighbourhood Renewal Strategy

Public health initiatives will also be targeted at neighbourhoods of greatest need whose residents face additional barriers to a healthier lifestyle because of the socio-economic and environmental circumstances in which they live. Initiatives to promote healthier lifestyles will seek to overcome these additional barriers by providing personal support and structural changes to create supportive environments for healthy living. Consequently the Public Health Strategy will also contribute to the Neighbourhood Renewal Strategy and the narrowing of the inequality gap between the Neighbourhood Renewal Area and the rest of Hartlepool.

The Commitment to Developing a Public Health Strategy

There has been a strong history of partnership initiatives to promote health in Hartlepool and there have been some notable achievements. However, up until now, there has been no overarching public health strategy which identifies shared priorities and which can guide the development of locally targeted action to achieve the most positive impact on health.

A Hartlepool Partnership workshop identified the need for developing such a strategy and increased funding and resources for prevention as key strategic actions required to securing significant improvement in public health.

Development of a Hartlepool Public Health Strategy

The Strategy pulls together, within a common framework, elements that have been developed within a range of multi-agency working groups, some of which were already in existence and others that were formed specifically to develop that element of the Strategy. The groups have had varying degrees of involvement from both partner organisations and the community. Staff from across the PCT and Local Authority have led on developing the different elements.

The Scope of the Public Health Strategy

The Public Health Strategy aims to provide a five-year framework (2006-2010) of action for the prevention of ill-health, the protection of health and the promotion of positive health and well-being (not just the absence of disease).

The main focus of the Strategy is on partnership approaches to community-based prevention programmes.

This Strategy does not include the work being developed within Primary Health Care to address lifestyle risk factors. This includes interventions with the general population i.e. those without a disease diagnosis (primary prevention) and the targeting of those with a disease with lifestyle behaviour change interventions as part of the management of the condition (secondary prevention). This work is guided by other strategies such as the Nursing Strategy and the Primary Care Strategy, which includes the Management of Long Term Conditions and the provision of General Medical and Personal Medical Services. However, there is a commitment to making the links between the support that people get from Primary Care and the community-based programmes outlined in this Strategy.

Similarly this Strategy does not include the contribution of social care to prevention of ill-health as part of individual assessments and packages of care. However, links also need to be established between this and community programmes.

Principles of the Public Health Strategy

Actions to prevent ill-health, protect health and the promote positive health and well-being should:

- Target groups and communities in greatest need
- Be based upon evidence of local need
- Work in partnership with individuals, communities and organisations
- Adopt a community development approach: involving individuals and groups in the identification of needs and planning, delivery and evaluation of initiatives which directly affect them
- Address the additional barriers to a healthier life faced by those living in disadvantaged socio-economic and environmental situations
- Be sensitive to the diverse needs of 'minority groups', for example racial and cultural differences
- Promote personal responsibility and commitment to change behaviour
- Be based upon evidence of effective practice
- Be adequately resourced to ensure sustainability
- Have specific health-related outcomes
- Have clear lines of accountability for the organisations responsible for delivery
- Be actively monitored and evaluated
- Promote the development of an adequately trained workforce

These principles will underpin and guide the development and implementation of the Strategy.

'Elements' of the Strategy

The following have been identified as priority elements within the Strategy:

- Smoking
- Physical Activity
- Health eating
- Obesity
- Mental Health promotion
- Sexual Health / Teenage Pregnancy
- Prevention of substance misuse (alcohol & illegal drugs)

These priorities have been identified and ranked according to the following criteria:

- 'Strength' of the evidence linking the issue with the diseases which are the major killers: cancer and circulatory diseases.
- The local prevalence ('size' of the problem locally).
- Contribution to health inequalities i.e. impact upon the most disadvantaged
- Evidence of effective interventions.
- Local support for action from the public and organisations (questionnaire surveys and workshops).

However, the Strategy also includes the following elements which, whilst important, are not considered of equal priority as those listed above:

- Accident Prevention
- Promotion of screening and immunisation
- Wider determinants of health

How the Strategy is Organised

Each element of the Strategy identifies:

- **Aims** – what we are trying to achieve
- **Objectives** – the ways in which the aims are to be achieved
- **Key Actions** – the range of activities that are planned to achieve the objectives

Implementation of the Strategy

Annual Action Plans

The Strategy provides a five-year framework of action we are aiming to implement. However, annual action plans will be developed which provide the detail on actions / initiatives to be developed in any one year. These will include detail on responsibilities, resources, timeframes, and performance indicators. Some initiatives / actions will be able to be achieved using existing resources, whilst others will be dependent on new funding.

Monitoring and evaluation

One of the Public Health Strategy Group's terms of reference is to develop and monitor local public health targets and indicators. Various local and national targets exist for many of the issues addressed by the Strategy. National documents such as the Public Service Agreement, National Service Frameworks, *National Standards, Local Action- Health and Social Care Standards Planning Framework 2005/2006- 2007/2008,* and even the historic Health of the Nation have set targets. Locally, the Hartlepool Community Strategy, Neighbourhood Renewal Floor Targets, and the Hartlepool Teenage Pregnancy Strategy have set targets for many of the issues as well. The Department of Health suggests the following:

Principles for Local Target Setting

In developing local plans PCTs should ensure they:

- are in line with population needs;
- address local service gaps;
- deliver equity;
- are evidence-based;
- are developed in partnership with other NHS bodies and LAs; and
- offer value for money.

(National Standards, Local Action- Health and Social Care Standards Planning Framework 2005/2006- 2007/2008

However, for some of the areas there are sizeable gaps in the local baseline data for many of the issues addressed in the Strategy. Data on prevalence and rates of incidence are necessary in order to set meaningful targets and measure the subsequent impact of the key actions. Gathering baseline information and setting local targets should be ensured by the Strategy through the ensuing action plans. Please see Appendix 2 for currently existing information on targets and baseline data for the Strategy issues.

Structures for Implementation

The Public Health Strategy Group will oversee the implementation of the Strategy (see Appendix 1 for its terms of reference and membership): the development and implementation of the annual action plan. Figure 1 indicates how the Group links into wider strategic forums.

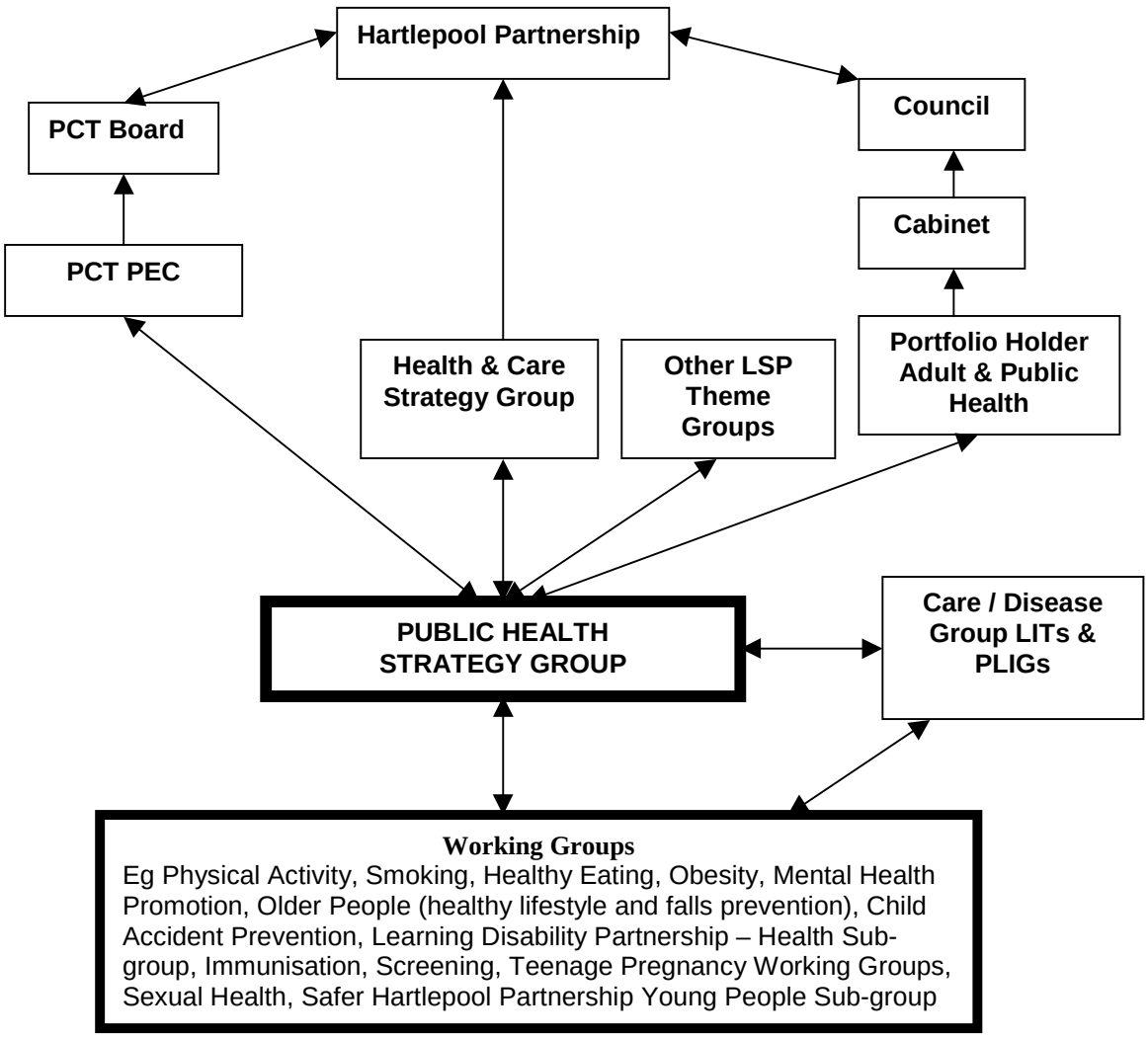
There are a number of public health multi-agency working groups which will feed into the Public Health Strategy Group, around different elements of the Strategy. These groups are in varying stages of development; some already having formal terms of reference and identified leads, others require further development. These working groups will provide, in relation to their element of the Public Health Strategy, a forum for:

- Networking and sharing good practice
- Identification of needs and priorities
- The development of approaches to community involvement and targeting disadvantaged groups
- Development and implementation of action plans
- Monitoring and evaluation

The Working Groups will report to the Public Health Strategy Group via a designated lead for each group.

The Working Groups will need to demonstrate that they are working within the principles that underpin and guide the development and implementation of the Strategy (previously identified).

Structures for Implementation



Hartlepool Partnership Theme Groups

All the theme groups can contribute to the implementation of this Strategy and not just the Health & Care Theme Group. All theme groups should identify their specific contribution.

Workforce Development

As part of the Public Health Strategy Group's terms of reference it is the intention of this group to work toward strengthening the public health capacity in Hartlepool. The ability to deliver the aims and objectives of the Strategy will be assisted by linking staff from partner organisations to workforce development opportunities such as the Public Health Capacity Building Programme.

Smoking Issues

Overall Aim: To reduce smoking prevalence in Hartlepool

Smoking is the single largest preventable cause of ill health in the UK. More than 120,000 people die each year in the UK from smoking. It causes lung cancer, chronic lung disease, coronary heart disease and many other cancers.

Second hand smoking is taking in the smoke from other people's cigarettes, cigars and pipes and this too seriously affects health. Children are especially vulnerable and should be protected from second hand smoke, as there is an increase in risk of respiratory infection, asthma and impaired lung growth. In adults, second hand smoke is a cause of lung cancer and heart disease in non-smokers, as well as many other illnesses and minor conditions.

Outside of the home, the greatest chance of exposure to tobacco smoke is likely to be at work. This results in high costs of short and long-term sickness absence for employers. Measures to control smoking at the workplace should be seriously considered by employers.

Smokers have more complications during pregnancy and childbirth than non-smokers. There is a 26% higher chance of miscarriage or stillbirth. In addition, those exposed to second hand smoke have a greater risk of low birth weight and sudden infant death syndrome.

The most recent household survey undertaken in Hartlepool highlights that 40% of Hartlepool adults smoke, however, in the Neighbourhood Renewal Area it is reported that 42% of the population smoke. Smoking disproportionately affects those already disadvantaged by poverty. However, it is also suggested in the Health and Lifestyle Tees area survey 2000 (Reilly, M et al, 2001) that large proportions of these smokers have expressed a desire to give up.

There are 5 **objectives** that contribute to that aim:
1. To increase access to smoking cessation support
2. To reduce the number of women smoking in pregnancy
3. To promote a Smoke Free Hartlepool
4. To reduce illegal sales of tobacco to under 16s, smuggling, counterfeiting and tobacco advertising and promotion
5. To increase smoking education/prevention work with young people

Key Actions to achieve objectives:

1. To increase access to smoking cessation support
- Identifying and training more nurse prescribers to deliver NRT
- Increasing 'out of hours' provision of clinics
- Target support for NHS employees
- Exploring and pursuing additional points of contact for smoking cessation support, eg pharmacists and dentists

- Providing alternative smoking cessation support without the use of NRT, eg the Allen Carr method
- Publicising the availability of the Smoking Cessation Service and the variety of options available
- Updating training for primary care staff
- Training successful quitters to offer smoking cessation support
- Actively promoting the use of NRT with young people under the age of 18
- Gathering evidence base for successful interventions with young people

2. To reduce the number of women who smoke during pregnancy

- Actively promoting the use of NRT in pregnancy
- Optimise therapies for pregnant women, eg the Allen Carr method
- Increasing support for pregnant women in smoking cessation
- Improving access to data to inform practice

3. To promote a 'Smoke Free' Hartlepool.

- Continuing the development of the Action on Smoking Award in Hartlepool
- Supporting the National Clean Air Award at a local level
- Partnership working with local Environmental Health Officers
- Supporting the re-establishment of the Heartbeat Award in Hartlepool – linking to the Healthy Eating sub group of the overall CHD Prevention Strategy.
- Lobbying for smoke free public places in the Town
- Advising/training everyone involved in childcare of the dangers of second hand smoke
- Contributing to regional Tobacco Control Strategy through Smoke Free North East initiatives and campaigns

4. To reduce prevalence of illegal sales of tobacco to under 16s, smuggling, counterfeiting and tobacco advertising and promotion by:

- Partnership working with local Trading Standards Officers
- Participating in Regional campaigns to raise awareness of illegal sales, smuggling, counterfeiting and tobacco advertising and promotion.

5. To increase smoking education/prevention work with young people by:

- Working in partnership with Healthy School Co-ordinator to increase number of schools working on the smoking module of the National Healthy School Standard
- Advising schools on appropriate resources available for smoking education work
- Developing training opportunities for those who work with young people

Physical Activity

Overall aim: To increase participation in Physical Activity within Hartlepool

An active lifestyle is very important for health. Increased physical activity significantly reduces the risk of coronary heart disease, high blood pressure developing (or reducing it when already occurs), in the control of diabetes, keeping weight stable and reducing the risk of osteoporosis and cancer of the colon.

At present the cost of physical inactivity in the UK stands at £8.2 billion annually. Only 30.4% of the UK population participate in the recommended 30 minutes of physical activity five times a week. If this amount of activity were undertaken, a 20-30% reduction in mortality could be achieved, with the greatest benefits being seen in the 50+ age group. Over one third of coronary heart disease deaths are estimated to be attributable to physical inactivity.

The level of participation in the North East is not an encouraging one. Despite increased investment in facilities and sports development and the hard work and effort of many sports professionals and volunteers, participation levels are currently running at 28% and have not grown over the past 10 years.

There are 5 **objectives** that contribute to the aim:

1. To raise awareness of the importance of participating in physical activity
2. To improve and increase access to local physical activity
3. To promote and deliver a range of physical activity initiatives and ensure that they are provided in a variety of settings and populations
4. To improve and co-ordinate the training of volunteers and professionals
5. To improve the co-ordination and administration of physical activity across the town

Key Actions to achieve objectives:

1. **To raise awareness of the importance of participating in physical activity**
   - Working with the local media to create more positive media coverage to raise awareness and improve education about the benefits of being active
   - Supporting National campaigns at a local level
   - Working with GPs and primary care teams to increase awareness of physical activity opportunities and use of local referral scheme
   - Create a forum for health, sport and physical activity professionals to share information and identify any gaps in provision
   - Improve marketing and advertising to highlight where activities are held locally

2. **To improve and increase access to local physical activity**
   - Identify barriers to participation and access and work with local people to overcome these
   - Establish a 'buddy' system to support people in participating in physical activity
   - Provide opportunities for individuals to watch before they join activities
   - Further develop and expand activities in the Hartlepool GP referral scheme (HELP)

3. **To promote and deliver a range of physical activity initiatives and ensure that they are provided in a variety of settings and populations**
   - Promotion of National Healthy Schools programme with particular reference to physical activity
   - Setting up a range of community-based initiatives to cater for a wide spectrum of age and experience
   - Supporting local workplaces in developing physical activity policies

4. **To improve the co-ordination and administration of physical activity across the town**
   - To seek funding and make the case for a physical activity co-ordinator as a multi-agency commitment to physical activity improvement
   - To establish a management group to support the co-ordinator
   - Identify a team of officers and or trainees to work underneath to improve opportunities across the town
   - Use existing audit to improve and identify needs for further activity
   - Identify training needs within the town for existing instructors and funding new instructors

5. **To improve and co-ordinate the training of volunteers and professionals**
   - Using existing research to create a pathway of progression for instructors to improve qualifications
   - Identify tutors to deliver local training for new and existing instructors in a wide range of activities linking with FE/HE
   - Identify specialist training to assist new and existing instructors to deliver activities to those with special needs
   - Create a training package to encourage new people to become instructors by offering free training for free instruction
   - Create an inclusive professional approach to finding appropriate volunteers to train
   - Link into current CSL/HSL training to identify new instructors

Healthy Eating

Overall aim: To increase the number of people eating healthily across Hartlepool.

What we choose to eat is fundamental to our health. While many people eat well, a large number do not, particularly among the disadvantaged and vulnerable in society. In particular, a significant proportion of the population consume less than the recommended amount of fruit and fibre but more than the recommended amount of fat, saturated fat, salt and sugar. Such poor nutrition is a major cause of ill health and premature death. A poor diet is a significant risk factor for coronary heart disease, type 2 diabetes, hypertension, osteoarthritis and some cancers. Up to a third of deaths from cancer may be due to unhealthy diets. Consuming five portions of fruit and vegetables per day is seen as the second most important cancer prevention strategy after reducing smoking. There are also links between a poor diet and infertility, respiratory disease and poor mental health.

There are many inequalities in nutrition and health with those living in disadvantaged circumstances, for example about a third of those in managerial and professional groups eat the recommended 5 portions of fruit and vegetables a day, compared with only about a sixth of those in the lowest socio-economic groups.

The main conclusion from the Health and Lifestyle Tees Area Survey 2000/3 is that many eating habits are strongly related to, or influenced by age, by being male or female and by being wealthy or poor. Women, older people, and the affluent are more likely to eat more healthily than men, younger people, and people who are disadvantaged. Across the Teesside area Hartlepool has the lowest consumption of fruit with only 34.4% of males and 45% of females eating fruit most days.

There are five **objectives** that contribute to the above aim:

1. To raise awareness of the importance of a healthy balanced diet
2. To increase access to healthy eating advice and training to those delivering healthy eating messages
3. To increase access to training for the general public in skills to improve nutrition.
4. To increase access and availability of healthy food options
5. To promote and deliver a range of evidence based healthy eating initiatives and ensure that healthy eating initiatives are provided in a variety of settings and populations.

Key actions to achieve objectives:

1. **To raise awareness of the importance of a healthy balanced diet.**
   - Working with the local media to create more positive media coverage
   - Supporting National campaigns at a local level, including the national 5 A DAY initiative

- Working with local supermarkets to promote healthy eating

2. To increase access to healthy eating advice and training to those delivering healthy eating messages

- Provide up to date accredited training opportunities delivered by dieticians or nutritionists
- Provide ongoing support for those undertaking healthy eating work
- Support the Teesside 5 A DAY initiative for economies of scale

3. To increase access to training programmes for the general public in skills to improve nutrition.

- Provide training opportunities on a range of issues, e.g. healthy eating, cooking skills, basic food hygiene, food labelling, cooking on a low income
- Provide ongoing support for those trained
- Provide weight loss groups in a variety of locations in the town

4. To increase access and availability of healthy food options

- Develop community food co-operatives
- Promote and support the healthy eating module within the National Healthy School Standard
- Promote and support participation in the National School Fruit and Vegetable Scheme
- Promote and support the use of the Food in Schools Toolkit
- Re-establish, develop and encourage the uptake of the local Heartbeat Award
- Work with local supermarkets to promote consumption of fruit and vegetables
- Promote and support the government initiative to improve nutrition in school meals

5. To promote and deliver a range of evidence based healthy eating initiatives and ensure that healthy eating initiatives are provided in a variety of settings and populations

- Promotion of National Healthy Schools Programme with particular reference to healthy eating and nutrition
- Encourage the use of allotments to grow fruit and vegetables
- Promote food safety issues – training, enforcement, monitoring
- Promote and support the government initiative to improve nutrition in school meals
- Promote and support the use of the Food in Schools Toolkit
- Promote and support breastfeeding
- Promote and support healthy weaning, including the Healthy Start Scheme.
- To ensure that primary prevention healthy eating initiatives are linked into secondary prevention obesity initiatives.

Obesity

Overall aim: To reduce the prevalence of obesity

Obesity occurs when a person puts on weight to the point that it seriously endangers health. The main cause of increasing levels of obesity is a combination of increased calorific intake alongside decreased energy expenditure. Unhealthy diets and lack of physical activity have contributed to the increase in the proportion of the population who are obese. Obesity rates in England have trebled since the 1980s: 22% of men and 23% of women are now obese while 65% of men and 56% of women are either overweight or obese. Obesity is a growing problem among children and young people too with around 16% of 2 to 15 year olds being obese. Obesity is more prevalent in the lowest socio-economic groups, and this difference is most marked for women.

Clinicians commonly define obesity in terms of body mass index (BMI). This is a measure of how appropriate a person's weight is for their height. BMI is calculated by dividing a person's weight in kilograms by their squared height in meters. A desirable BMI is considered to be between 18.5 and 24.9 $kg/m^{2.}$ A BMI equal to 25 and above is defined as 'overweight' and one above 30 is defined as 'obese'.

Obese and overweight children are likely to become obese or overweight adults. Tackling established behaviour is difficult and preventing the problem arising is likely to be easier than overcoming an established weight problem amongst children. The promotion of healthy eating and physical activity within the National Healthy Schools Standard is therefore particularly important.

People experiencing mental health needs are often at risk of increased problems with their weight and NIHME report that obesity is more prevalent amongst people living with a mental illness.

The sections of the Public Health Strategy that aim to promote physical activity and improve diet will contribute to reducing obesity levels. Improving diet includes highlighting the potential positive impact of breastfeeding and proper weaning on healthy weight levels for children. However, action targeting those who are overweight or already obese is required to assist them to reduce or manage their weight. These actions should combine support for people to eat healthier and become more physically active as well as addressing the emotional issues that contribute to overeating.

Some important factors which increase the likelihood of continuing weight gain, include having recently stopped smoking, giving birth, belonging to some ethnic minority groups, being physical inactive due to age or disability, and having a family history of obesity. There are also important factors which increase the likelihood of serious adverse health effects of being overweight or obese such as having obesity-linked serious disease (co-morbidity) such as type 2 diabetes and coronary heart disease.

There are 4 **objectives** that contribute to the aim:

1. Develop systems to monitor the prevalence of overweight and obesity
2. Develop community-based weight management support
3. Develop interventions which address the link between obesity and emotional well-being
4. Develop interventions for groups who have a higher risk and specific needs

Key actions to achieve objectives:

1. **Develop systems to monitor the prevalence of overweight and obesity amongst children and adults**
   - Develop protocols and system for the recording the BMI of children at school entry health check
   - Develop protocols and systems for recording the BMI of children at the transition between primary and secondary school
   - Develop the use of GP systems for recording BMI and monitoring of obesity prevalence
   - Explore opportunities for gathering prevalence data from lifestyle surveys.

2. **Develop community-based weight management support**
   - Develop and deliver appropriate accredited training for staff and community activists.
   - Identify suitable venues
   - Establish mechanisms for self referral and referral from others for those ready to change behaviour.

3. **Develop interventions which address the link between obesity and emotional well-being**
   - Develop an emotional well-being pilot scheme to which people who are obese can be referred
   - Evaluate the scheme

4. **Develop interventions for groups who have a higher risk and specific needs**
   - Develop weight management support alongside smoking cessation support
   - Develop appropriate activities to promote healthy eating and physical activity and weight management support for ethnic minority groups
   - Develop appropriate weight management support for those who have become physically restricted due to disability or age.
   - Develop family approaches to healthy eating and promoting physical activity
   - Develop the 'Exercise Referral Scheme' so that physical activity opportunities are available that are sensitive to the needs of people who are overweight or obese and referral mechanisms established.

- Develop approaches to target and improve accessibility for people with mental health needs who experience barriers in accessing traditional approaches.

Mental Well being

Overall Aim: To promote good mental health and well being

Mental health promotion works towards enabling people to reach their full potential and achieve a state of emotional resilience. It fosters good interpersonal relationships, a sense of self worth, an ability to make decisions, to cope with or change circumstances and to adopt a way of life that is considerate to others and the environment. Mental health promotion involves any action to enhance the mental well being of individuals, families, organisations or communities.

Mental health is more than an absence of mental illness. Mental well being is influenced by many factors, including genetic inheritance, childhood experiences, life events, individual ability to cope and levels of social support, as well as factors like adequate housing, employment, financial security and access to appropriate health care. Racism, homophobia and other forms of discrimination also affect mental health and can be an underlying cause of mental health problems.

Everyone has mental health needs, whether or not they have a diagnosis of mental illness, therefore the need for mental health promotion is universal and of relevance to everyone. These needs are met, or not met, at home, at work, on the streets, in prisons and hospitals, in schools and neighbourhoods everywhere. Mental health promotion does have a role in preventing mental health problems, such as anxiety, depression, drug and alcohol dependence and suicide. However, mental health promotion also has a wider range of health and social benefits. These include improved physical health, increased emotional resilience, greater social inclusion and participation and higher productivity.

Good emotional health and wellbeing is also the underpinning, cross-cutting factor for all other health components and has an impact on behaviour and lifestyle choices affecting health. Programmes that seek to promote lifestyle change should incorporate work to promote emotional health such as confidence and self esteem.

Mental health promotion works at three levels and at each level is relevant to the whole population, to individuals at risk, vulnerable groups and people with mental health problems

These three levels form the objectives that contribute to the overall aim:
1. Strengthening individuals
2. Strengthening communities
3. Reducing structural barriers to mental health

Key Actions to achieve objectives:

1. **Strengthening individuals**
   - Promote opportunities for social support and interaction
   - Increase emotional resilience through interventions designed to promote self esteem, life skills and coping skills
   - Maintain and extend support for families and develop parenting skills

2. **Strengthening communities**
   - Promote social inclusion and participation as the responsibility of a wide variety of partner organisations
   - Support the improvement of neighbourhood environments
   - Promote the importance of good emotional wellbeing in all settings – workplaces, schools and community
   - Support the voluntary sector in strengthening communities through their network of social support

3. **Reducing structural barriers to social inclusion and active citizenship that can improve mental health**
   - Help more individuals with mental health problems to find, or return to work
   - Help more individuals with mental health problems to access education
   - Help more individuals with mental health problems to access housing
   - Work with the media to reduce discrimination against those with mental health problems
   - Help more individuals with mental health problems to access appropriate financial advice

Teenage Pregnancy & Sexual Health

Overall Aim: To reduce teenage conceptions and improve sexual health

Sexual Health

In July 2001 the first National Strategy for Sexual Health & HIV was published for consultation. The strategy was released in 2002 and a commissioning toolkit to support the implementation and development of local plans has also been published. The aims of the strategy are to:

- Reduce the transmission of HIV and STI's
- Reduce the prevalence of undiagnosed HIV and STI's
- Reduced unintended pregnancy rates
- Improve health and social care for people living with HIV
- Reduce the stigma associated with HIV and STI's

The strategy has identified key issues in relation to Genito Urinary Medicine.

- Improved access to services
- Three levels of service provision
- Increased role of health advisors
- Increased education role
- Targets for Chlamydia screening, HIV testing, reduction in infections (gonorrhoea/HIV), and hepatitis B vaccination

The 2001 Census identified the North East was the English region with the highest level of "not good health". Inequalities in health repeat themselves as inequalities in sexual health. Sexual health services across the country have seen an unprecedented rise in demand in recent years. Data from the Health Protection Agency Communicable Disease Surveillance Centre show that there was a 15% increase in attendances to genitourinary medicine (GUM) clinics in from 2001 to 2002. Diagnoses of acute bacterial STIs have more than doubled between 1995 and 2000.

The situation locally reflects a high incidence of Chlamydia and indicates potential under diagnosis. The incidence of gonorrhoea in Hartlepool is higher than elsewhere across the Tees Valley. There was an increase in incidence of almost 153% between 2001 and 2002.

Teenage Pregnancy

In 1999, at the time of the publication of the Social Exclusion Unit's Teenage Pregnancy Report, the UK had the highest teenage pregnancy rate in Europe. The teenage birth rate at that time was twice that of Germany, three times that of France and 6 times the Dutch rate.

The Hartlepool Teenage Pregnancy Strategy provides a multi-agency vision for reducing the teenage pregnancy rates in Hartlepool over 10 years. For a number of years Hartlepool has experienced significantly higher teenage conception rates than the rest of England. The Teenage Pregnancy Strategy incorporates both the prevention of pregnancies and the provision of services and support to teenage parents. The Public Health Strategy focuses just on the preventative aspect of the agenda.

There are 4 **objectives** that contribute to the aim:

1. Develop media and communications to promote sexual health
2. Develop sex and relationships education
3. Develop community based contraception and advice services
4. Improve access to sexual health services

Key actions to achieve objectives:

1. Develop media and communications to promote sexual health

- Implement the teenage pregnancy communication strategy
- Develop text messaging services for young people
- Ensure proactive media responses

2. Develop sex & relationship education

- Deliver the APAUSE programme in all 6 secondary schools
- Roll out and deliver a curriculum SRE resource for primary schools
- Support the dissemination and training of a SRE policy and guidance for the Social Services Department
- Develop and deliver SRE programmes in non-school settings
- Support the on-going development and delivery of the Personal, Social and Health Education Certificate for teachers and community nurses

3. Develop community based contraception & advice services

- Establish specialised contraception and sexual health services for young people in non-clinical settings in areas which have the highest teenage conception rates.
- Provide a condom distribution scheme
- Carry out a review of contraception services
- Delivery of a condom distribution scheme
- Provide free emergency contraception in community pharmacies

5. Improve access to sexual health services

- Develop integrated contraception and sexual health services
- Develop the pathway of care across primary and secondary care and community settings
- Develop primary care services for the treatment of sexual infections
- Support the national roll out of the chlamydia screening programme

Drugs & Alcohol

Overall Aim: To reduce levels of drug use and binge drinking in Hartlepool.

Hartlepool has adopted a multi-agency approach in dealing with drugs and alcohol. Through partnership working it is aimed to reduce the harmful effects that drugs and alcohol cause to society, communities, individuals and their families.

Problematic drug and alcohol use in Hartlepool impacts on many people in many ways. Drugs not only ruin lives, but also have a great impact on the physical and social well being of the individual. Other risks associated with drug use often include blood-borne diseases (hepatitis & AIDS) from the sharing of needles and paraphernalia or risk of overdose when tolerance levels have decreased after a period of abstinence. The high cost and need for a substance often leads to criminal activity to feed a habit, which impacts on immediate family and the community in which they live.

There are 3 objectives that contribute to the aim:

1. To provide education and information.
2. Provide harm minimisation services for those involved in drugs.
3. To reduce drug & alcohol related crime.
4. To provide holistic approaches from a physical and mental health perspective, to address the causative factors behind increase substance misuse within Hartlepool.

1. To provide education and information on drugs and alcohol

- Support the delivery of the drugs module of the National Healthy Schools Standard through the Drug Education Team.
- Support and deliver drug and alcohol training through the youth training programme.
- Support the delivery of Drug Awareness training through The Drug Action Team for staff working with the most vulnerable groups.
- Provide and deliver the Straight-Line Programme for vulnerable young people involved in alcohol and binge drinking.
- Support national campaigns.
- To establish and monitor the holistic approach addressing drug and alcohol needs, especially in relation to Dual Diagnosis (mental health and substance use).

2. Provide harm minimisation services for those involved in drugs

- Support the needle exchange in planning and development of health promoting activities for the more chaotic drug user.
- Development of community Hep B clinic particularly for clients who are unable to access other available services.
- Ensure that harm minimisation approaches are accessible to those who are especially vulnerable including those with mental health needs.

3. **To reduce drug & alcohol related crime**
   - Partnership working with Police Anti-Social Behaviour Unit, Youth Offending Service & Hartlepool Safety Partnership to support the planning processes.
   - Provide and deliver the Straight-Line Programme for vulnerable young people involved in alcohol.

4. **To provide holistic approaches from a physical and mental health perspective, to address the causative factors behind increase substance use within Hartlepool**
   - Ensure services address both the physical and mental health needs of individuals presenting to services.
   - Ensure clear protocols exist between services working within individuals with substance use needs.

Accidents

Overall Aim: To reduce the death rate and the rate of serious injury from accidents

Accidents are a major cause of avoidable ill health, injury and death. Most accidents are preventable but, for preventive action to be effective, it must be co-ordinated across a range of agencies and be recognised as a priority.

Every year 10,000 people die in England from accidental injury. It is the leading cause of death among children aged 0-14 years. Over 300,000 people are hurt every year in road traffic accidents, 5% of them children. Over half a million accidents result in admission to hospital. Treating injury costs the NHS £2 billion a year and the consequences of injuries received at home cost society £25 billion a year. Therefore accidental injury takes a heavy toll on society, particularly on children and older people and strikes hardest at the most disadvantaged.

There are 5 **objectives** that contribute to the aim:

1. Improve the co-ordination of accident prevention initiatives across the town
2. Raise awareness of the risks of accidents
3. Develop and deliver home accident prevention initiatives
4. Develop and deliver road safety initiatives
5. Develop and deliver falls prevention initiatives for older people and initiatives to reduce the risk of injury as a result of a fall

Key actions to achieve objectives:

1. **Improve the co-ordination of accident prevention initiatives across the town**
   - Create a multi agency injury prevention working group
   - Develop a comprehensive information system to gather and record data on accidents

2. **Raise awareness of the risk from accidents**
   - Deliver local / national safety campaigns on accidental injury prevention
   - Promote accident prevention programmes through workplace and education settings
   - Provide opportunities for first aid training for members of the community eg parents (including baby and child resuscitation) linked to campaigns.

3. **Develop and deliver home accident prevention initiatives**
   - Increase awareness of the hazards in the home and actions to reduce the risk of accidents
   - Provide effective safety equipment loan schemes to target groups
   - Promote family support / parenting skills

- Deliver free home fire safety checks linked to the provision of smoke alarms and one-to-one education for targeted individuals
- Provide electric blanket testing
- Reduce the use of baby walkers
- Highlight the dangers of hot drinks in the home (child safety)

4. Develop and deliver road safety initiatives

- Increase awareness of road safety, including for example; driver behaviour, cycle safety, pedestrian safety
- Provide pedestrian training
- Promote and deliver cycle proficiency schemes
- Introduce effective traffic calming measures / speed management
- Promote drink driving campaigns
- Promote the correct use of child car seats and safety checks
- Promotion of the use of cycle helmets
- Deliver Safer Routes to schools scheme

5. Develop and deliver falls prevention initiatives for older people and initiatives to reduce the risk of injury as a result of a fall

- Employ a Falls Prevention Co-ordinator
- Develop a falls prevention service which includes a range of support
- Develop and promote physical activity opportunities for older people
- Establish mechanisms for the identification of older people who are at risk of falling and referral to the falls prevention service.
- Promote a healthy diet which has sufficient calcium and vitamin D intake for bone health
- Promote medication reviews for older people and regular eye checks

Immunisation and Screening

Immunisation
Overall Aim: To promote the uptake of immunisation programmes

After clean water, vaccination is the most effective public health intervention in the world for saving lives and promoting good health. It should be recognised that universal immunisation programmes present an important opportunity to maintain health equity related to communicable diseases. Coverage rates of at least 95% are desirable in order to achieve herd immunity and protection for those who have not been immunised. Statistics reveal that there is still some considerable distance to go in terms of achieving an appropriate level of coverage.

Many agencies have a role to play in promoting and facilitating the delivery of immunisation programmes designed to protect the population of Hartlepool from various key communicable diseases. Reaching the 95% coverage target will require a coordinated multi-agency approach and should focus on three key areas.

Screening
Overall Aim: To promote the uptake of screening programmes

Screening makes an important contribution to improving our Nation's health. Screening programmes include screening for diseases such as breast, cervical, bowel and prostate cancer, diabetic retinopathy, and also includes ante-natal and child health screening. National screening programmes are designed to confer more benefit than harm to the population in terms of lives saved or suffering avoided. All agencies have a role to play in promoting and facilitating the delivery of all screening programmes designed to reduce the impact of various diseases on the population of Hartlepool.

Improving coverage will require a coordinated multi agency approach and should focus on some key areas.

There are 3 **objectives** that contribute to the aims:

1. Improve access to immunisation and screening programmes
2. Raise awareness of the importance of immunisation and screening
3. Adopt a multi-agency approach to the delivery of immunisation and screening programmes

Key actions to achieve objectives:

1. **Improve access to immunisation and screening programmes**
   - Adopt a multi-agency approach to the assessment of availability of access, utilizing information from all sources on where gaps in access to immunisation and screening programmes may lie.

- Plan improvements in access on a multi-agency basis by examining all aspects of access including transport issues and social and economic barriers to the uptake of immunisation and screening by targeted service users.
- Provide up to date accredited training for all appropriate staff so that access to immunisation and screening can be assured at as many points as is possible.
- Ensure that immunisation and screening is provided at a variety of locations throughout Hartlepool that optimize accessibility for those living in peripheral or more service-isolated areas.

2. Raise awareness of the importance of immunisation and screening

- Work with the local media to create a positive message in relation to immunisation and screening
- All agencies to support national and local campaigns to promote immunisation and screening.
- All agencies will give a positive message wherever possible in relation to the efficacy of immunisation and screening and their roles in promoting health and reducing health inequality.
- Ensure that the message being transmitted from all agencies is a consistent and unambiguous one in relation to the importance of immunisation and screening programmes.

3. Adopt a multi agency approach to the delivery of immunisation and screening programmes

- Adopt a multi agency approach to the delivery of immunization and screening programmes, which seeks to integrate delivery of the programmes with other activities that generate contact with key target groups.
- All agencies should agree that the delivery of immunisations and screening is a key element of their plans for individuals, communities, and the overall population of the town.
- All agencies will recognize their potential to promote and support the delivery of immunisation and screening programmes within the context of their contact with specific groups in particular settings including e.g. schools, residential care homes, health care settings including those in the mental health services, etc and coordinate their efforts to optimise uptake and delivery of immunisations and screening.
- All agencies will play a part in gathering and sharing evidence to inform improvements in the delivery of immunisation and screening programmes.

Wider Determinants of Health

The main focus of the Public Health Strategy is on the promotion of healthy lifestyles, however, socio-economic factors such as housing, employment, income, poverty, transport and education are fundamental factors that contribute to the health of individuals and communities. Action to address these wider determinants of will make significant contributions to health improvement and addressing health inequalities.

This Strategy does not focus on addressing these wider determinants of health but does seek to promote the more explicit health dimension of these issues outlined below.

Employment – Health-related Actions
- Promote health at work initiatives
- Develop smoke free workplaces
- Develop occupational health services for small and medium enterprises
- Develop the capacity to support workplace health initiatives
- Develop support for those with health problems back into work e.g. Pathways to Work
- Support opportunities for local people to be employed in health & social care and the 'healthy lifestyle industry'.

Transport – Health-related Actions
- Promote alternatives to car usage such as walking and cycling
- Promote green travel plans
- Monitoring of air quality
- Ensure that the Transport Plan incorporates journeys to health care facilities and services
- Reduce risk of accidents on the road

Housing – Health-related Actions
- Implement home energy efficiency schemes in particular for vulnerable groups and those with chronic disease
- Raise awareness amongst healthcare staff who visit patients in their homes of what fuel poverty is, the associated health problems, and services available to patients that assist with heating costs
- Develop support for those with health problems such as mental illness and drug dependency, to ensure tenancies can be maintained and homelessness prevented
- To undertake risk assessments to identify hazards and actions to reduce the risk of home accidents

Poverty
- Develop initiatives which overcome barriers of low income from living a healthy lifestyle
- Develop debt and benefit advice services in healthcare settings
- Provide benefit awareness training for healthcare staff

Education

- Promote and support the Healthy Schools Standards
- Support the development of health promoting initiatives in Colleges and Universities
- Develop and promote health related further and higher education courses

Appendix 1

Public Health Strategy Group - Terms of Reference

- To increase awareness of the underlying 'public health deficits' in Hartlepool.
- To oversee and monitor progress on the development and implementation of the Public Health Strategy and Action Plan.
- To agree priorities for development in public health programmes (prevention of ill-health), which can inform investment from a range of sources, eg LDP, NRF.
- To develop and monitor local public health targets and indicators.
- To monitor and evaluate the effectiveness of public health programmes and initiatives.
- To support the development and implementation of an explicit prevention of ill-health dimension to other Community Strategy Themes and to the Children and Young People's Plan.
- To promote the incorporation of health (inequalities) impact assessment in the decision making processes of the Partnership.
- To report to the LSP on action and progress in the implementation of the Public Health Strategy.
- To develop effective communication mechanisms for raising awareness of public health programmes and initiatives.
- To debate 'new public health issues' identified by the community or new Government policy and agree an approach to how these should be taken forward.

Membership

- Director of Public Health & Well-being
- PCT Non-Executive Director Public Health 'Champion'
- PCT Directorate Representatives – Nursing & Operations, Primary Care & Modernisation
- Local Authority Public Health Portfolio Holder
- Local Authority Department Representatives – Adult Services, Children Services, Neighbourhood Services, Regeneration & Planning
- North Tees & Hartlepool Trust Representative
- TNEY mental Health Trust Representative
- HVDA representative
- 3 Community Network representatives
- 3 Neighbourhood Forum representatives (I from each).

Frequency of Meetings

At least every 3 months.

Administrative Support

The PCT Public Health Directorate will provide the administrative support for the Group.

Development Support

Development support for the Group and the groups feeding into it (see below) will be provided by members of the public health function from the PCT and Local Authority.

Groups feeding into the Public Health Strategy Group

There will be a range of public health multi-agency working groups feeding into the Public Health Strategy Group, around different aspects of the Strategy, for example:

- Physical Activity
- Smoking / Tobacco Control
- Healthy Eating
- Obesity
- Mental Health NSF Standard 1 & 7 (Mental Health Promotion & Suicide Prevention)
- Older People NSF Standard 6 & 8 (Healthy Lifestyle & Falls Prevention)
- Child Accident Prevention
- Learning Disability Partnership – Health Sub group
- Immunisation
- Screening
- Teenage Pregnancy Working Groups
- Young People Safer Hartlepool Partnership Group (Substance Misuse)

The specific role of these groups is detailed in other documents but generally they, in relation to 'their part' of the prevention agenda: provide a forum for:

- Networking and sharing good practice
- Identification of needs and priorities
- The development of approaches to community involvement and targeting disadvantaged groups
- Development and implementation of action plans
- Monitoring and evaluation

The Working Groups will report to the Public Health Strategy Group via a designated lead for each group.

Other working groups may need to be established in the future.

Appendix 2

Baseline information and current targets

One of the Public Health Strategy Group's terms of reference is to develop and monitor local public health targets and indicators. Various local and national targets exist for many of the issues addressed by the Strategy. National documents such as the Public Service Agreement, National Service Frameworks, *National Standards, Local Action- Health and Social Care Standards Planning Framework 2005/2006- 2007/2008,* and the historic Health of the Nation have set targets. Locally, the Hartlepool Community Strategy, Neighbourhood Renewal Floor Targets, and the Hartlepool Teenage Pregnancy Strategy have set targets for many of the issues as well. The Department of Health suggests the following principles for local target setting:

In developing local plans PCTs should ensure they:

- are in line with population needs;
- address local service gaps;
- deliver equity;
- are evidence-based;
- are developed in partnership with other NHS bodies and LAs; and
- offer value for money.

(National Standards, Local Action- Health and Social Care Standards Planning Framework 2005/2006- 2007/2008

However, for some of the areas there are sizeable gaps in the local baseline data for many of the issues addressed in the Strategy. Data on prevalence and rates of incidence are necessary in order to set meaningful targets and measure the subsequent impact of the key actions. Gathering baseline information and setting local targets should be ensured by the Strategy through the ensuing action plans. This Appendix collates currently existing information on targets and baseline data for the Strategy issues.

Neighbourhood Renewal Floor Targets for Health

Through the Spending Review 2004 (SR04) the Office of the Deputy Prime Minister (ODPM) has refined and strengthened the floor targets for Neighbourhood Renewal. The floor targets for health are set out below:

<u>Life expectancy:</u>
Substantially reduce mortality rates by 2010:

- From heart disease and stroke and related disease by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
- From cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

PMF Reference: Health & Care, Objectives: 'Reduce Death Rate for CHD' and 'Cancer Death Rate'

Health Inequalities:
Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

Tackle the underlying determinants of ill health and health inequalities by:
- Reducing adult smoking rates to 21% or less by 2010 with a reduction in prevalence among routine and manual groups to 26% or less;
- Reducing the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health.

PMF Reference: Health & Care, Objectives: 'Reduce Smoking Among Adults' and 'Conception Rates- Under 18s'

Smoking issues

Overall Aim: To reduce smoking prevalence in Hartlepool
For some groups within our society there have been marked improvements in relation to reducing the impact of this risk factor over the last three decades. Among 16 to 44 year olds nationally, smoking rates among the more affluent three-quarters of the population have declined sharply since the mid-1970s. However, the proportion of smokers amongst the poorest sections of the population has remained unchanged at about 50%.

Baseline data
- 40% of Hartlepool adults smoke
- In Hartlepool Neighbourhood Renewal areas 42% of adults smoke

Targets
Neighbourhood Renewal Floor Targets for Health
- Reducing adult smoking rates to 21% or less by 2010 with a reduction in prevalence among routine and manual groups to 26% or less;

PMF Reference: Health & Care, Objectives: 'Reduce Smoking Among Adults' and 'Conception Rates- Under 18s'

National Targets from Public Service Agreement and Health and Social Care Standards and Planning Framework (2004):
- To reduce smoking among adults (16 and over) from 26% in 2002 to 21% or less by 2010
- To reduce smoking in routine and manual groups from 31% in 2002 t0 26% or less by 2010
- To have 800,000 smokers from all groups successfully quitting at the 4-week stage by 2006

Smoking Kills targets:
- Among all adults, from 28% in 1998 to 26% by 2005 and 24% by 2010. The 2005 target was met by 2002, hence the new tougher PSA target (with stronger inequalities focus).
- Among children, from 13% in 1998 to 11% by 2005 and 9% by 2010 (rate was 10% in 2002).
- In pregnancy, from 23% in 1998 to 18% by 2005 and 15% by 2010 (rate was 19% in 2000)

(APHO)

Physical Activity

Overall aim: To increase participation in Physical Activity within Hartlepool

Baseline
- 34% of respondents in a recent survey at Mill House and Eldon Grove Community Sports Centres said they never took intensive exercise, such as going to the gym, playing football, doing aerobics, etc.
- 46% took more than 30 minutes of moderate physical activity such as walking children to school, washing the car, hoovering or gardening, etc 5 or more days a week.

National Indicators
- 31% of adults meet the government's health activity guidelines – gender differences occur with 37% of men meeting the guidelines compared with 25% of women.
- 17% of people with a disability meet the government health activity guidelines
- Four in ten adults are classified as sedentary – 35% of men compared with 41% of women; 42% of black and ethnic minorities are sedentary
- Greatest decline in participation in sport and active recreation occurs amongst those aged 60 and over
- Greater proportion of lower social groups DEs (39%) in sedentary group than ABs (36%)

Targets

Government targets for England (including those set jointly with the Department for Education and Skills and Department of Culture, Media and Sport):
- Increase the proportion of individuals undertaking 30 minutes of physical activity on 5 or more days a week to 70% by 2020 (interim target: 50% by 2011). This level of physical activity has been recommended in the UK since 1996, but reaching it would require a doubling of activity levels in less than 20 years. Children's target levels are higher – 60 minutes a day.
- Enhance the take-up of sport by 5–16 year olds by increasing the percentage of schoolchildren spending two or more hours a week on high

quality physical education and school sport from 25% in 2002 to 75% by 2006 and 85% by 2008 (75% in each School Sport Partnership by 2008).
- For people aged 16 and above from priority groups (those with physical or mental disabilities, from black or minority ethnic groups, from lower socio-economic groups, and women), increase by 3% by 2008 the proportion (a) participating in sports, excluding walking, at least twelve times a year and (b) engaging in at least 30 minutes of moderate intensity level sport, including walking, at least three times a week.

(APHO)
Sport England's regional plan for sport and physical activity aims to increase participation by at least 1% each year between now and 2020.

Healthy Eating

Overall aim: To increase the number of people eating healthily across Hartlepool.

Baseline
The Health and Lifestyle Tees Area Survey 2000/3 indicates:
- Only 34.4% of males and 45% of females eat fruit most days
- 16-34 year olds consume the least fruit
- 25.9% of males and 10.4% of females eat fried food 2 or 3 days per week

Targets
The NHS Plan, NHS Improvement Plan and other key policy documents such as National Service
Frameworks all highlight diet and nutrition as key areas for action, and the recent White Paper *Choosing*
Health reinforces this. Increasing fruit and vegetable consumptions to "5 A DAY" is a Government priority.
- Average intake recommended by the Committee on Medical aspects of Food and Nutrition Policy (COMA) and the World Health Organisation (WHO) is 5 portions of fruit and vegetables a day, while the National Diet and Nutrition Survey 2000/01 found the average intake per person in 2.8 portions per day.
- The Food Standards Agency has set a target to reduce average salt intake by 10% (around 1g per day) by 2005–06, and by a third (to 6g a day) in five years.

(APHO)

Obesity

Overall aim: To reduce the prevalence of obesity.

Baseline
- 22% of men and 23% of women in England are obese
- 65% of men and 56% of women In England are either overweight or obese
- Approximately 16-20% of children in England aged 2 to 15 are obese

Targets

National target from Public Service Agreement 2004:

- To halt the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole. (Obesity in children rose by an average of 0.8% per year between 1995 and 2002.)

Historic Health of the Nation targets aimed to reduce obesity in men from 7% in 1986–7 to 6% in 2005, and in women from 12% in 1986-7 to 8% in 2005. This shows how far adrift we are from earlier aspirations: rates of obesity have trebled in the UK since 1980, and well over half of all adults are now overweight or obese. The new targets focus on obesity in children, which is a particularly pressing public health problem.
(APHO)

Teenage Pregnancy and Sexual Health

Overall Aim: To reduce teenage conceptions and improve sexual health

Baseline

- The situation locally reflects a high incidence of Chlamydia and indicates potential under-diagnosis.
- The incidence of gonorrhoea in Hartlepool is higher than elsewhere across the Tees Valley.
- There was an increase in incidence of gonorrhoea of almost 153% between 2001 and 2002.

For a number of years Hartlepool Has experienced significantly higher teenage conception rates than the rest of England.

- In 1998 (the baseline year for the target) the under-18 conception rate was 75.6 per 1000 in Hartlepool, compared with the national rate of 46.4 per 1000.

Data from the Health Protection Agency Communicable Disease Surveillance Centre show that there were 1.5 million attendances at genitourinary medicine (GUM) clinics in 2002. This is a 15% increase on 2001. Diagnoses of acute bacterial STIs have more than doubled between 1995 and 2000. Gonorrhoea has increased by 102%; Chlamydia has increased by 107% and infectious syphilis by 145% in the same period.

Targets

The white paper Choosing Health sets a target of 48 hours maximum wait to be seen at genitor-urinary medicine clinics.

The Social Exclusion Unit's Report on Teenage Pregnancy set out two national targets:

- To reduce by 50% the 1998 under 18 conception rate by 2010, with an interim target of a 15% reduction by 2004.

- To increase to 60% the participation of teenage parents in education, training or employment to reduce their risk of long-term social exclusion by 2010.

The Department of Health and Department for Education and Skills are responsible for these targets. They are included in the PCT Local Delivery Plans and Local Government Public Service Agreements. They are also performance indicators for PCTs and Local Government Best Value.

The Hartlepool Teenage Pregnancy Strategy provides a multi-agency vision for reducing the teenage pregnancy rates in Hartlepool over 10 years.

- The local target is to reduce the conceptions amongst under-18s by 55% (on the 1998 baseline) by 2010, with an interim target of a 15% reduction by 2004.

Drugs and Alcohol

Overall Aim: To reduce levels of drug use and binge drinking in Hartlepool.

Baseline

Drugs

- 30% of 16-24 year olds nationally have used drugs in the past year.
- 19% of 16-24 year olds have used drugs in the past month.
- 1-2% of the population experience serious problems with heavy drug use.

Alcohol

- Nationally over 90% of the adult population drink.
- Around a quarter of the population drink above the recommended weekly guidelines and some 6m above recommended daily guidelines.
- Nationally alcohol is a factor in around half of all violent crime.

Health Surveys published in March 2004 looking at alcohol consumption across England found that in both Strategic Health Authority Areas (SHAs) in the North East, alcohol consumption in both men and women was higher than the national average, and male consumption exceeded the national average by over 15%, i.e. by more than 5 units of alcohol per week

Targets

There are no targets for alcohol use, but the Government's alcohol harm reduction strategy includes a commitment to monitor progress against indicators of harm. Government recommendations for drinking alcohol are now based on daily benchmarks rather than weekly limits – not exceeding 3–4 units a day for men, or 2–3 units a day for women. This reflects the particular dangers of binge drinking, when drinking is concentrated on one or two days a week.

Local alcohol targets will be agreed between CDRPs/DATs and Government Office for the North East.

(DPAS draft report)
The National Drug Strategy launched in 1998 and updated in December 2002 has the aim of reducing the harm that drugs cause to individuals and their families, communities and society. There are four main strands to the Strategy: reducing supply, young people, communities, and treatment. (DPAS draft report)

Accidents

Overall Aim: To reduce the death rate and the rate of serious injury from accidents

Baseline

- Every year 10,000 people die from accidental injury.
- Over 300,000 people are injured in road traffic accidents, 3% of those are children.
- Treating injury costs the NHS 2 billion pounds a year

Targets

Saving Lives: Our Healthier Nation set targets in 1999 to reduce the death rates from accidents by 20% and to reduce the rate of serious injury from accidents by 10% by 2010, which will save up to 12,000 lives in total. (Department of Health, 1999)

Immunisation and Screening

Overall Aim: To promote the uptake of immunisation and screening programmes

Baseline: Immunisation

It is currently difficult to generate an accurate picture relating to the uptake of childhood immunisations in Hartlepool, however the national picture gives some indication of current trends in uptake of childhood immunisations. In 2003-04 immunisation coverage for the cohort of children reaching their second birthday shows that:

- 94% had been immunised against diphtheria, tetanus and polio, similar levels to 2002-03 and 2001-02, but lower than the peak coverage of 96% achieved in 1995-96 to 1997-98
- 93% had been immunised against pertussis and Haemophilus influenzae b (Hib), similar levels to those in 2002-03 and 2001- 02 but lower than the peak coverage achieved in 1996-97 and 1997-98
- 93% had been immunised against meningitis C, compared with 92% in 2002-03.
- 80% had been immunised against measles, mumps and rubella with the combined MMR vaccine, compared with 82% in 2002-03; this is well below the peak coverage of 92% achieved in 1995-96

In addition in 2003-04:

71% of persons aged 65 and over were immunised against flu, compared with 69% in 2002-03

Targets
In the UK, the immunisation target is 95% uptake rate for all immunisations (including MMR) by the child's 2nd birthday.
Baseline: Screening

- For Quarter ending September 2004, uptake of cervical screening was 79.5% of eligible women, down about 1% from the same quarter the previous year.

Cervical Screening Coverage - Quarter ending Sept 2004 (5 year coverage)

PCT	No of women resident in age 25-64 target group	No of women age 25-64 eligible for screening	No screened in last 5 years	% uptake	% uptake same quarter 2003
H'pool	24215	21598	17170	**79.50**	80.49
Tees	147488	133495	106906	**80.08**	80.90

- Number of additional smears over last 5 years needed to achieve 80% target in Hartlepool 108 (= 22 per year, =1.4 per GP Practice per year)
- Number of additional smears over last five years needed to achieve 85% coverage in Hartlepool 1188 (= 237 per year, = 15 per GP Practice per year)

What the statistics reveal is that there is still some considerable distance to go in some areas in terms of achieving a full coverage for screening.

Target

Hartlepool has a target of 80% uptake for cervical screening
NHSBP standards state that more than 90% of women should have a screening round length of less than or equal to 36 months.
(CDTVSHA Performance of Cancer Screening Services)

ADULT AND PUBLIC HEALTH SERVICES PORTFOLIO

Report To Portfolio Holder

12th December 2005

HARTLEPOOL BOROUGH COUNCIL

Report of: Acting Director Of Adult And Community Services

Subject: ANNUAL REVIEW OF PERFORMANCE FOR ADULT SOCIAL CARE

SUMMARY

1.0 PURPOSE OF REPORT

To present the 'Annual Review of Performance for Adult Social Care' letter from the Commission for Social Care Inspection (CSCI).

2.0 SUMMARY OF CONTENTS

The report outlines the CSCI performance appraisal of Adult Social Care, together with an Action Plan.

3.0 RELEVANCE TO PORTFOLIO MEMBER

The report covers a key external monitoring document, which must be presented to an appropriate public meeting of Council.

4.0 TYPE OF DECISION

Non Key: For information.

5.0 DECISION MAKING ROUTE

Adult and Public Health Services Portfolio.

6.0 DECISION(S) REQUIRED

To note the report and receive the Action Plan.

Report of: Acting Director Of Adult And Community Services

Subject: ANNUAL REVIEW OF PERFORMANCE FOR ADULT SOCIAL CARE

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1. PURPOSE OF REPORT

1.1 To present the 'Annual Review of Performance for Adult Social Care' letter from the Commission for Social Care Inspection (CSCI).

2. PERFORMANCE APPRAISAL SYSTEM

2.1 There is an extensive system of monitoring by the Commission for Social Care Inspection (CSCI), involving inspections, monitoring meetings, returns in Spring and Autumn, and performance indicators.

2.2 This array of qualitative and quantitative data is used by CSCI to produce a Record of Performance Assessment, giving their views of our performance for the last year and areas to improve for the year ahead. The results of Performance Assessments will be published on the CSCI Website on 1st December, but Hartlepool's own result was also made available to the Council via the attached letter **APPENDIX 1**.

2.3 Amongst the service improvements acknowledged in the report are:

- Performance Indicators generally good, with a number improving
- Partnership working around extra care, 'connected care' etc
- Improvements in assessments and reviews
- Waiting list for OT eliminated, and Home Care Services re-organised and more flexible
- Additional funding available, and focussed on priorities
- Staff turnover and vacancies have been kept low.

2.4 Areas for future improvement include:

- Plans to pilot integrated teams with PCT
- Need for speedier provider response following assessment
- Person centred planning to be more widely available in LD
- Carers strategy and provision to be revised
- Need to develop consultation networks with ethnic minorities.

3. ACTION PLAN

3.1 A departmental Action Plan has been drawn up in response to these recommendations **(APPENDIX 2)** and the actions included in plans for 2005/6 and 2006/7.

4. STAR RATING

4.1 The Commission also published their judgements on services for adults and for children, along with a combined star rating.

4.2 Adult Services in Hartlepool were judged to be continuing to 'serve most people well' and to have 'promising' capacity for improvement.

4.3 The Council was again awarded **two stars** out of a maximum of three.

4.4 The national results are as attached (**APPENDIX 3**). Overall there were slightly more stars awarded than in previous years, but the majority of authorities are still in receipt of two stars. This includes all of the Tees Valley authorities. In the broader region three authorities achieved 3 stars.

5. PERFORMANCE INDICATORS

5.1 Locally an analysis has been carried out of Hartlepool's performance indicators for 2004/5, in comparison with previous years and other authorities (**APPENDIX 4**). This shows continuing improvement overall, with 70% of indicators banded as stable or improving, and almost 90% rated 'acceptable' or better.

6. CONCLUSION

6.1 Adult Services have continued to make steady progress over the past year and there are clear directions identified to continue this improvement.

7. RECOMMENDATIONS

7.1 To note the report and receive the Action Plan.

Commission for Social Care Inspection
Making Social Care Better for People

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3.1

APPENDIX 1

Mr I McMillan
Acting Director of Adult & Community Services
Hartlepool Borough Council
PO Box 96
Civic Centre
Victoria Road
Hartlepool
TS24 8YW

22 August 2005

Ref: CSCI/LR/pjw

Dear Mr McMillan

ANNUAL REVIEW OF PERFORMANCE FOR ADULT SOCIAL CARE

Thank you for our recent annual review meeting. This letter and the attached Record of Performance Assessment provide a record and an evaluation of currently available evidence of the council's performance on Adult social care. It was informed by discussion at the meeting.

The attached Record of Performance Assessment (ROPA) includes:

- The Performance Review Report (PRR) which sets out the Commission for Social Care Inspection's (CSCI) view of the performance of adult social care services in your area during the last year, and comments on improvements for the year ahead; and
- The Record of Evidence, which lays out, the admissible evidence accumulated from the range of admissible sources and CSCI's evaluation of that evidence.

In assessing performance in adult social care, CSCI reaches judgements about performance against a set of standards and criteria, drawing on evidence from a number of standard sources. These include:

- The published PAF performance indicators and other statistical data up to 2004-05, plus data supporting planned targets for 2005-06.
- Evidence agreed in the course of our monitoring meetings that have been formally recorded.
- Monitoring information from the Delivery and Improvement Statements completed in October 2004 and May 2005.

Details of the standards and criteria have been published, and are available from CSCI, or may be seen on the CSCI's performance website.

The contents of this letter and the attached Record of Performance Assessment represent our **provisional** assessment at this stage in the Performance Assessment cycle. They are provided **in confidence and should not be shared publicly**. The judgements and assessments indicated are subject to later moderation including following consideration of CSCI data for 2004-2005, including Key Thresholds, and findings and judgements from any recent service inspections. The judgements form the basis of later ratings, namely the CPA Adult social care rating and the Social care star rating. The final report published to the authority in late October will update these ratings, where necessary. Councils will have an opportunity to make representations about these judgements at that stage. Details of the representations process are available separately.

When you receive the final report in October, you will be asked to:

- Present this letter to an open meeting of the relevant executive committee of the council by 31 January 2006 and to inform us of the date on which this will take place.
- Make the report available to members of the public at the same time.
- Copy this letter and report to the council's appointed auditor, and to relevant partners.

The finalised Record of Performance Assessment will be published on the CSCI website on 1 December.

At this stage in the process, it is our provisional assessment that social care services in your area are serving most adults well and the council's capacity to improve these services is promising.

Any factual inaccuracies in the Record of Performance Assessment should be brought to my attention by 9 September 2005.

Progress will continue to be monitored during the year through our usual processes.

Linda Robinson

Linda Robinson
Business Relationship Manager
Copy: Council Chief Executive : Mr P Walker

We welcome your feedback to help us improve our service.
Please feel free to contact the Customer Service Unit on 0845 015 0120

RECORD OF PERFORMANCE ASSESSMENT FOR ADULT SOCIAL CARE

Name of Adult Services Authority

Hartlepool

Contents

Business Relationship Manager: Linda Robinson
Date: 19/08/05

Part 1: Performance Review Report

Summary of Improvements

The Council continues to pursue a programme of modernisation, with a range of service developments in place or planned. Performance against national indicators is generally good, with a number of improvements this year.

Some innovative partnership developments have been agreed for older people's services. These include an extra care housing village, and the piloting of a neighbourhood approach through "connected care". Intermediate care provision continues to increase, and there have not been any reimbursement payments for delayed transfers of care. The very high number of new assessments of people aged over 65 reported last year has reduced considerably. More people are receiving reviews. There is no longer a waiting list for OT services and the home care service has been reorganised, with "preferred" independent providers operating on a locality basis. This allows a more flexible response to people's needs.

The number of people helped to live at home remains excellent across all service user groups. Mental health services are making good progress towards national targets.

There were considerable budgetary pressures during the year, in response to which additional funding was made available by the Council, and there has been renewed focus on delivering priority activities.

A public engagement strategy is now in place.

There has been a substantial increase in the number of people accessing Direct Payments, although further work is needed to improve up-take.

Staff turnover and vacancy levels are low.

Summary of Areas for Improvement

A number of strategies are in the process of implementation. Amongst them is the plan to develop closer working with the PCT through integrated teams (an integrated service for older people is soon to be piloted). The timetable for full implementation of this plan is dependent upon the outcome of significant change both within the Council and amongst health partners.

As OT services have responded more promptly to referrals, there has been an inability amongst some service providers to offer a similar speed of response and a lower proportion of older people received their care packages within four weeks of assessment than last year.

The Council has recognised that person centred planning should be more widely available for young people with learning disabilities.

The number of breaks for carers has not increased. There is to be a review of the carers' strategy, to identify the scope and range of support that carers need, together with the development of performance outcomes and measures.

The number of people from ethnic minority backgrounds who are assessed or receive services are lower than would be expected from population statistics, and work is taking place to develop appropriate consultation networks.

STANDARD 1: National Priorities And Strategic Objectives

The council is working corporately and with partners to deliver national priorities and objectives for social care, relevant National Service Frameworks and local strategic objectives to serve the needs of diverse local communities

Improvements achieved / achievements consolidated since the previous annual review

There are clear service development strategies in place.
All assessments of older people began within 48 hours of first contact
There have been no reimbursement payments for delayed transfers of care
Intermediate care provision continues to increase.
The level of intensive home care has reduced slightly. The Council identifies this as an outcome of improvements in short term services, which have reduced the levels of care required on a long term basis.
There has been a successful partnership bid for funding for an innovative extra care housing village.
There has been a successful bid for 6 shared equity properties for people with learning disabilities.
Mental health services' performance against NSF targets is good.
There have been two best value reviews, relating to mental health and learning disabilities
A Public Engagement strategy has been produced.

Areas for improvement

Person centred planning for young people with learning disabilities need to be developed.

STANDARD 2: Cost and efficiency

Social services commission and deliver services to clear standards of both quality and cost, by the most effective, economic and efficient means available

Improvements achieved / achievements consolidated since the previous annual review

There are good indicators in relation to the balance of care for older people, although the level of intensive home care has reduced slightly.
The department's budget has been reconsidered this year, to ensure that priority needs can be met. Spending priorities are being aligned with the PCT, to reduce duplication of expenditure.
Unit costs are acceptable or good.
Block contracting arrangements have been introduced for the provision of home care through the independent sector, enabling the development of a more efficient and responsive service.

Areas for improvement

There is further work to do before the Council's approach to "collaborative commissioning" with health partners, an alternative approach to the formal mechanism of pooled budgets, can be agreed and implemented.

STANDARD 3: Effectiveness of service delivery and outcomes

Services promote independence, protect from harm, and support people to make the most of their capacity and potential and achieve the best possible outcomes

Improvements achieved / achievements consolidated since the previous annual review

There is very good performance in relation to the number of people in all service user groups who are helped to live at home.
The average waiting time for minor adaptations, from assessment to work beginning, is excellent. An acceptable percentage of equipment and adaptations are delivered within seven working days.
A crisis resolution team is in place for people with mental health problems, along with a crisis bed for local use. An innovative service is available through a voluntary organisation, offering support to people before they reach crisis point.
There has been a substantial increase, from a low base, in the number of people receiving Direct Payments, and further development is planned to improve up-take.

Areas for improvement

Person centred planning should be available for young people with learning disabilities, in transition between children's and adults' services.
There is to be a review of the carers' strategy, to identify the scope and range of support that carers need, together with the development of performance outcomes and measures.

STANDARD 4: Quality of services for users and carers

Services users, their families and other supporters, benefit from convenient and good quality services, which are responsive to individual needs and preferences

Improvements achieved / achievements consolidated since the previous annual review

The length of time older people wait for an assessment has improved significantly and performance is now good.
The very high number of assessments undertaken of new clients aged 65 and over last year has reduced considerably, partially in response to a change in screening arrangements, and the level is now comparable to similar councils.
There is no longer a waiting list for OT services.
A high number of people received a statement of their needs.
A Public Engagement Strategy has been implemented.
Arrangements have been formalised with an independent organisation for the provision of information which is accessible to people who are blind or partially sighted.

Areas for improvement

The single assessment process is being implemented, and this development needs to be completed.
The number of adults and older people receiving a review as a percentage of those receiving services has increased and is in line with comparators, but needs to improve further.
Fewer older people received their care packages within four weeks of the completion of their assessment than last year.

STANDARD 5: Fair access

Social services act fairly and consistently in allocating services and applying charges

Improvements achieved / achievements consolidated since the previous annual review

A diversity training programme has been developed and implemented.
A contact officer from a minority ethnic background has been appointed to promote access to services.
Key services are available 24 hours a day 7 days a week.

Areas for improvement

A range of work is needed on equality issues. Consultation networks are to be established with people from diverse backgrounds
A smaller number of older people from ethnic minorities received assessments or services than would be expected from the population statistics.
The mental health local implementation team has established a sub-group to focus on black and minority ethnic issues, to improve access and ensure the service is culturally sensitive.
Arrangements for a wider range of independent advocacy options are to be developed.

STANDARD 6: Capacity for improvement

The council has corporate arrangements and capacity to achieve consistent, sustainable and effective improvement in social services

Improvements achieved / achievements consolidated since the previous annual review

A range of service developments have been put in place, resulting in improve outcomes for some people. Examples include alternative living arrangements for people with learning disabilities and increased access to work and mainstream education for people with physical disabilities.
The reconfigured internal home care service and block contracting with patch-based home care providers have improved the response to service users' needs.
The joint equipment service is in place.
There are links between the human resource strategy and the Community Strategy, and workforce development plans in social care, health and the independent sector are to be formed into a single document.
A set of core competencies has been implemented for social workers
Staff turnover and vacancy levels are very low, and sickness levels have reduced.
There is currently a full establishment of social workers, and a strategy is in place to address the poor availability of qualified and experienced staff, which is a national problem
There is a new corporate policy on support for employees with caring responsibilities.
Management information reports are described as "more analytical".
Document image processing is being implemented, and mobile working is to be piloted.
There is good performance against the practice learning indicator

Areas for improvement

A corporate restructuring has just taken place, with the establishment of separate children's and adults' departments. The limited management capacity in a small council can be a risk to delivery during a period of such significant change.
Plans for working jointly with health partners underlie a number of modernisation plans, and their success will depend upon all partners having sufficient capacity and financial resources to implement the changes identified.

Part 2: Record of Evidence

STANDARD 1: National Priorities And Strategic Objectives

The council is working corporately and with partners to deliver national priorities and objectives for social care, relevant National Service Frameworks and local strategic objectives to serve the needs of diverse local communities

Summary of admissible evidence (including sources)
Source: DIS
Older people. Strategy in "Vision for Care", range of key areas identified. There will be phased implementation of integrated locality teams(SWs OTs & Community nursing).
B11 int HC as % of intensive HC & res care 30.2, little change from last year.
2155 no extra care housing tenancies currently provided, but there has been a successful bid for funding from DH and the Housing Corporation for a large "care village" development in partnership with the Joseph Rowntree Foundation, and a further bid has been submitted.
The number of people supported in care homes has remained stable since 2001 (652) to the present (675) (autumn)
100% assessments older people began within 48 hours, 55% completed within 4 weeks.
2147-48 Intermediate care: number of people receiving non-residential IC has increased substantially
Delayed transfers of care – continue to be none.
2150 There are discussions planned with NHS partners to develop risk management procedures to reduce the risk of OP falling, and 2151 plans to introduce multi agency teams to prevent strokes have been agreed with NHS partners.
2201 learning dis: the strategy is linked with the community strategy. Modernising day services, developing collaborative commissioning strategy with PCT, Transitions strategy to be developed.
2301 phys dis: strategy linked with the community strategy. Modernising day services, with support to access direct payments, working with housing associations to increase access to independent living.
2401 Mental health: Performance against NSF targets "very successful" Plan to move towards person centred recovery based services across all agencies, and will develop outcome measures. Will complete day service review, with focus on employment opportunities. Plan to update the integrated workforce development plan. Developing a protocol with NHS for provision of services for OP with MH problems.
2701 Carers: carers strategy is incorporated into community plan.
C62 carers services doubled from 4 to 8
2204 learning dis: BVR of accommodation completed & action plan in place. Successful bid for 6 shared equity properties. Carers support and training commissioned. Plan to resettle remaining two people from hospital. Will develop transition policies & procedures; advocacy options. Will implement service user/carer evaluation.
2404 mental health. Recovery based services commissioned from voluntary sector. SW induction includes equality issues. 3 service users & 3 carers completed research training. A head of social care (mental health) to be appointed. Crisis beds operational, assertive outreach further developed. Plan to develop primary care mental health strategy. Will develop joint commissioning strategy. Will review day services, carers strategy, review of LIT to improve representation.
HIV/AIDs awareness/training maintained
Drug/alcohol. Access and retention in treatment improved, social services linked into new developments.
3204 A best value review was completed for mental health ("more people are being helped as a result") – no indication of how. "The results of implementing

our learning disability review will become clearer during 2005/06" 3208 Ld BVR action plan will be implemented. Link between business plans & corporate BV PP will be made more explicit. There will be a service review of Supporting People floating support scheme.
Service users: Produced a Departmental Public Engagement Strategy.
OP: to be revised to develop increased participation. Following advocacy review will develop different advocacy options. SUs involved in transport review. DP steering group will involve SUs. SUs to be involved in Extra Care design.
Learning disability: Partnership Board and sub groups are to be revised to develop increased participation. Following advocacy review will develop different advocacy options. SUs involved in transport review. DP steering group will involve SUs.
Phys dis: Welfare to Work group to be reviewed, aim to increase SU involvement in planning & review. DP group to involve SUs. Will establish deaf user forum and peer groups for blind people to offer feedback.
Mental health: SUs involved in LIT & subgroups, to be involved in a review. PCP developed. SUs to be trained in recruitment & selection. Annual quality day to review progress. Integrated service established SU/carer public involvement governance team.
2807 OP Improved clarity of LIT membership has improved participation, involved in development of new home care contracts. Will be involved in integration developments and extra care proposals.
LD Use of self advocacy drama group & self advocacy group for partnership board activity.
Phys dis: SLAs with Blind Welfare and Deaf centre to develop involvement. Further work needed with PCT to support participation.
MH: SUs on the Board and involved in developments. 6 SUs to be offered recruitment & retention training this year.
2811 OP strategy will have an action plan, with commitment to involvement, anticipating increased representation in planning.
LD Partnership Board to be reviewed, range of advocacy options & involvement in DPs.
Phys dis: plan to review welfare to work groups, develop QA through review of processes.
MH: To redesign LIT to be more participative. To develop strategy document for user/carer charter, improve public info, use of internal questionnaires.
2817 Responsiveness. OP DP support service being changed following feedback, influence on home care commissioning and extra care proposals. LD BVR of accommodation & support resulted in development of adult placement scheme and bid for 6 extra care properties. Day service modernisation. Unspecified learning from comments and complaints. Phys dis : changes to direct payments support service. 2 videos produced following feedback from deaf community about information. Unspecified learning from comments & complaints. MH SU views led to development of dual diagnosis service, changes to communication strategies. Influenced modernisation programme, joint SSD Trust protocol on complaints to be developed following feedback.
Have maintained a zero delayed transfers of care, have reviewed residential intermediate care service
2137 OP: have successfully bid for funding for extra care housing village in partnership with JR Foundation and PCT. Integration of care management and district nursing, based on geographical patches, linking with SSD's OP's MH provision. Developing a project to promote day opportunities and reduce social isolation. Developing bid for Partnership with OP Project to improve low level support and OP's social contribution.

Performance meetings:

There has been a successful bid for an extra care retirement village, with the Joseph Rowntree Foundation. This bid is for 225 homes, of which 60 would be extra care. The development would include leisure facilities for use by the community, and health would be involved to provide nursing and rehabilitation

services. Health and Acute Trust have been involved in the proposal. A second bid is still with DOH to redevelop an existing sheltered scheme. Consultation is currently taking place. (PM 3/6/05)
ARM meeting: The level of intensive home care has reduced slightly. The Council identifies this as an outcome of improvements in short term services, which have reduced the levels of care required on a long term basis.

Evaluation
The council has developed a range of strategies which are clearly linked with the overarching community strategy. The emphasis is upon modernising services to ensure that people are able to make individual choices about their lives and the support they receive. A substantial range of local developments are planned, including a number of reviews and implementation of new approaches.
There have been best value reviews in mental health and learning disability services. There is a strong history of service user involvement in service development, and evidence that some areas of service delivery have changed in response to people's wishes. There are plans to review some of the planning processes to ensure that people who use services are able to participate fully.
There are a range of joint working initiatives in place, and plans for some innovative partnership developments including a major extra care housing scheme.

STANDARD 2: Cost and efficiency

Social services commission and deliver services to clear standards of both quality and cost, by the most effective, economic and efficient means available

Summary of admissible evidence (including sources)
OP: Have home care and day service "quality circles", planned integration with district nursing service. Will evaluate intermediate care changes and effectiveness of dom. care block contracts. Developing "connected care". Will review cost of care model for res care and revise rates from April 06.
C32 OP helped at home remains excellent, C28 intensive home care slight reduction (banding good). B11 int HC as % int hc and res care remains very good. C26 99, all residents are admitted on a temporary basis initially, which skews statistical presentation. C27 admissions 18-64 slight increase improved banding to very good.
2603 Number of drug misusers accessing treatment has substantially increased.
Social Services spending per head of population, particularly for older people's services, was higher than in similar councils in 2004-05.
3205 efficiency – sickness absence targets were exceeded, and an office base was declared surplus. Further alignment of spending priorities is expected with Hartlepool PCT.
3209 efficiencies planned this year: no figures again. Corporate restructure, and service integration. A third senior management post jointly with PCT. Sickness absence projected to fall. Demolition of a building and sale of site, establishing shared office bases with PCT, replacement of a residential intermediate care facility with care at home. Savings from changes to in-house home care. Collaborative commissioning with PCT, connected care model for meeting complex needs through virtual integrated teams. Use of assistive technology, use of new financial systems.
B12 cost of intensive social care remains good.
B17 unit cost home care performance has reduced from good to acceptable.
B13 unit cost res and nursing OP good
Health Act flexibilities are in place in three services: mental health, drug misuse and community equipment, and others are under consideration. Other partnership developments include a partnership of the SSD, PCT and the community is to undertake a social audit to advise on local needs. Work is also underway to improve capacity in the voluntary sector.

3201 The council has developed a more policy-led approach to its financial plans, so that it can respond to external changes. Funding has been shifted to meet priority needs in LD services, and additional income will be generated from home care charges. Two extra care housing schemes are planned, will help manage demand for OP's residential care. New adult placement scheme and telecare developments planned. High percentage of contracted services, limited capital programme. Support services are part of a corporate restructure.
3203 savings from staff vacancies and OP placements were used to balance budget pressures. Zero based budget exercise.
3207 Home care re-tendered on block contacts with guaranteed hours, stabilised market and led to better focus on outcomes. Risk registers established.
3229 no auditors' recs.

Evaluation
The commissioning of services is increasingly informed by the views of the people who use them, so that appropriate weight is given to quality requirements. The balance of services for older people has remained good. Expenditure has been reviewed to reflect priorities and will be further aligned with the PCT. Spending per head of population was higher than in similar councils. A range of efficiency measures are planned for the coming year, although the projected impact has not been identified.
The Department's budget has been re-examined this year, to ensure that policy requirements and priority needs can be met. A range of service improvements will be introduce that will be more cost-effective, including extra care housing and an adult placement scheme for people with learning disabilities. The Department has limited capital assets and most services are purchased through contracts.
Unit costs are good, apart from residential and nursing care for older people and adults with learning disabilities which are acceptable
Joint financial arrangements are in place in mental health, drug misuse and community equipment services, and others are under consideration. An innovative partnership development is a project involving the SSD, PCT and members of the community in one area of town, who will together undertake a social audit to advise on local needs.

STANDARD 3: Effectiveness of service delivery and outcomes

Services promote independence, protect from harm, and support people to make the most of their capacity and potential and achieve the best possible outcomes

Summary of admissible evidence (including sources)
2154 healthy active ageing – plans include bid to look at low level support; remodelling day opportunities; improved public information
LD: 2209 spend on advocacy rounds down to 0.
C30 number of adults ld helped to live at home remains excellent
2215 proportion of expenditure on day and domiciliary services to expenditure on res provision is 0.6, lower than IPFs
2217 no of people with ld in work has fallen by half this year, change in definition to exclude those who are doing voluntary and unpaid work.
Phys dis: 8 younger disabled people have moved into independent living with support. 17 people now receive direct payments. One specialist package provided for a service user from a minority faith. Priorities for this year: develop a commissioning strategy that helps providers meet needs for short break options & support services for younger disabled people. Increase direct payments, establish in house DP support service. Develop different advocacy options across disability services.
C29 younger phys dis helped at home has fallen slightly but remains excellent. Time waiting for minor adaptations has reduced to 1.8 weeks from 8 weeks in 2003/04 which is a very good improvement. Time waiting for major adaptations

has increased from 24 to 26.7 weeks. There is an integrated community equipment store, plan to introduce web based ordering. Pilot has taken place on a single point of contact. Establishing Direct Payments for equipment, will upgrade IT systems, have reviewed management arrangements and will implement findings.
D54 % items of equipment and adaptations delivered within 7 working days 73.5%, reduced by 3% from last year. Welfare to work: day opportunities have increased, 2 paid jobs and 8 supported employment, 5 in mainstream employment. 17 receive direct payments. SLA with deaf centre to develop interpretation services. Carers support and respite to be reviewed. Will revise planning groups and develop user-led projects. Plan to increase service users' level of IT skills. Will continue day opportunity modernisation, with more direct payments and greater access to employment.
Service user involvement in corporate review of transport. A Public Engagement strategy has been produced. Plan to promote user/carer led evaluation, and use of self-assessment for simple aids.
Mental health: C31 number helped to live at home: reduced from 4.2 last year to 3.4.
2232 learning dis – use of LDDF - advocacy, advocacy arts worker had 18 drama sessions dealing with sexuality & independent living. SUs put together DVD on accommodation needs, art exhibition in gallery. 34 carers 70+ receive support through SLA with Hartlepool Partners. PC Planner funded to increase production of PCPs.
2407 MH: Crisis services 24/7, all targets met, crisis bed in locality. Inreach & support at home. Service acts as single point of access to MH 2ndy services. Plan user/carer led evaluation. 2408 05/06 plans include evaluation of crisis resolution/access team, expand crisis accommodation, develop service to include 24 hr CR res to all eligible clients 18+.
2409 early intervention teams, Hartlepool's service established 2 years, Tees-wide service agreed and staged implementation. More development needed but no resources identified.
2816 work in progress to include race equality in procurement arrangements.
C51 direct payments, increased from 24.2 last year to 44. Examples of DPs use: short breaks, day support, personal care, overnight support & transport. Highest use is phys dis (17) and OP (10). None for MH or carers.
Carers: Annual event for carers, support through "voluntary led contracted services", carers trained in research and evaluation. This year's priorities: evaluate info from carers event, develop quality commitments with outcome measures, review carers' information & accessibility, produce joint commissioning strategy, increase carer participation in planning.
2715 carers' assessments 3.8.
2716 carers' breaks same as last year, no breaks BEM.
Multi agency adult protection procedures are in place, and an annual report is produced.
Performance meeting: A comprehensive Mental Health Day Services Review is planned, with long arm support from NIHME. (PM 3/6/2005)
In November 2004 DOH and 'Turning Point' met with the PCT, H.B.C Social Services, Housing Hartlepool and three residents' groups. It was agreed that Hartlepool would commence a 12 month PCT led Connective Care pilot project. £50k has been secured for this. The University of Lancashire is to undertake an audit with local people. (PM 3/6/2005)

Evaluation
The number of working age adults helped to live at home is very good. The number of people with learning disabilities in paid employment has reduced substantially this year, as a result of a change in definition which excludes people in voluntary or unpaid work.
Services offer greater choice than previously, for example 8 younger people with physical disabilities have moved into independent living. Priorities for this year

include the development of a commissioning strategy that helps providers meet people's needs for short a break.
Waiting times for minor adaptations have reduced to under two weeks, but people are having to wait slightly longer for major adaptations. The percentage of items of equipment and adaptations delivered within seven working days has reduced slightly. Welfare to work arrangements have expanded the opportunities for disabled people to be in paid employment.
The range of services available is being expanded, so that people's needs can be met in a way that suits them. The number of people receiving Direct Payments has doubled since last year, although there is scope for much wider use across all service user groups.
The council reports that support to carers, provided through a contract with the voluntary sector, has been increased. Arrangements for carers' support and short breaks are to be reviewed
Multi agency adult protection procedures are in place.

STANDARD 4: Quality of services for users and carers

Services users, their families and other supporters, benefit from convenient and good quality services, which are responsive to individual needs and preferences

Summary of admissible evidence (including sources)
2110 Assessment timescales: People are not delayed in hospital once they are medically fit for discharge. The increased use of information technology is planned, to help OTs undertake assessments and speed the delivery of equipment. It is planned to complete the implementation of the single assessment process in 2005/06.
D40 clients receiving a review has increased from 58.8 to 62.7 and is now acceptable. D55 waiting times for assessments has moved from 55.9 to 75.7 and is now good. E61 assessments of new clients 65+ has improved from 118 to 57.5 and is now acceptable. Single assessment: the process of implementation continues and most elements are expected to be completed by April 2006.
Fewer older people received their care packages within four weeks of the completion of their assessment than last year (81.2, now 70.2,) acceptable
Arrangements for contracting with independent home care providers have been improved, with a focus upon the quality of the service that people receive. A Public Engagement strategy is being implemented, and this will include additional monitoring of quality standards for services.
The Social Services Department has IIP accreditation, but no other external accreditation.
Single assessment summaries are not yet available. The percentage of people receiving a statement of need has improved from 93.1 to 97.1 which is good.
Evaluation
People are not delayed in hospital once they are medically fit for discharge. An acceptable proportion of people have their needs reviewed. The length of time people have to wait for an assessment has reduced. Previously, a very large number of people over the age of 65 had their needs assessed (or were recorded as having had their needs assessed), but the approach taken in Hartlepool has been reviewed and the number of assessments undertaken is now similar to that in other Councils (banding is acceptable).
The number of people receiving services who have a review has risen to an acceptable level. Fewer older people received their care packages within four weeks of the completion of their assessment than last year, although performance is acceptable.
There has been continued progress on implementing the single assessment process.
New arrangements were made to ensure that contracts with independent home care providers delivered the service that people needed, and a Public

Engagement Strategy is now being implemented which will include additional monitoring of quality standards.

STANDARD 5: Fair access

Social services act fairly and consistently in allocating services and applying charges

Summary of admissible evidence (including sources)
E47 & E48 ethnicity of OP receiving assessments and services are low assume due to small number and age distribution of minorities. E50 assessments leading to service –12% lower than last year (despite reduction in assessments).
2218 Learning disability. % people with learning dis receiving services who are from minority ethnic groups is in proportion to the number in Hartlepool.
Mental health: the joint commissioning strategy is to offer a choice of service providers for people from ethnic communities. Following the themed review the LIT subgroup will work to improve the access of people from minority communities to mental health services, and ensure that the workforce have the necessary skills to deliver a culturally sensitive service. In future will include BME issues in review and evaluation of services.
3126 12.3% of adults assessed or reviewed in the year, and 14.5% of adults with one or more services in the year had no ethnicity stated, although all staff records do indicate ethnicity.
3501 key services are available 24 hours a day, 7 nights a week apart from specialist support to family placements.
3109 Resources were allocated to improve equality practice. An Ethnic Minorities Contact Officer is funded, and consultation networks are to be established for people from diverse backgrounds.
The Council plans to increase the number of disabled and ethnic minority staff it employs.
Advocacy and interpreter services are always available when needed.
Mental health: Generic advocacy services are provided by CAB through a contract, but funding has also been agreed for a user -led advocacy service for the next two years. In 05/06 an evaluation of advocacy services will take place, involving users and carers.
2205 Learning disability: promote and develop different advocacy options
2809 Arrangements have been formalised with an independent organisation for the provision of information which is accessible to people who are blind or partially sighted.

Evaluation
The percentage of older people from ethnic minority communities receiving an assessment, and those receiving services following an assessment, is low. However this needs to be seen in the context of the low number of people from ethnic minorities living in Hartlepool.
The number of assessments of adults and older people that lead to the provision of a service reduced by 12% this year.
A subgroup of the mental health Local Implementation Team will work to improve the access of people from minority communities to mental health services, and to ensure that the workforce has the necessary skills to deliver a culturally sensitive service.
There is poor performance on the ethnicity of adults who have been assessed or reviewed, and of those who are receiving services, although all staff records do indicate ethnicity. Consultation networks are to be established for people from diverse backgrounds. 3129 onwards: Work is being undertaken to assess the impact of policies on ethnic minorities.
An Ethnic Minorities Contact Officer is funded.
The Council plans to increase the number of disabled and ethnic minority staff it

employs.
Key services are available 24 hours a day, 7 nights a week.
People with mental health problems use a generic advocacy service, but user-led advocacy services are being funded until 2007/08, and will be reviewed in 05/06.

STANDARD 6: Capacity for improvement

The council has corporate arrangements and capacity to achieve consistent, sustainable and effective improvement in social services

Summary of admissible evidence (including sources)
DIS: There are a range of planned developments which will increase people's choice of service and promote their independence. These include planning for a major extra care housing scheme, PLD owner occupied housing, service user led mental health services, and increased work and leisure opportunities for people with physical disabilities.
6.2 PCT financial deficit impacts on health resources for improvements. Plans for greater health/social care integration are being revised and depend on a clear agreement which includes financial commitments. PCT funding for integrated mental health working is uncertain, but are considering some localised changes to maximise effectiveness. Initiated implementation of older people's strategy. C26 placements dropped due to changed admissions management, "only counting those already in residential care requiring upgrading". OT waiting list reduced to 0.
2107 reconfigured in-house home care has increased rapid response interventions, including overnight care at critical times, by over 100%. Patch based block contracting with preferred providers has improved dom care, selection of contractors involved user input. Introduction of intensive social care team at Multi-link expanded capacity to focus on key assessment rather than routine service delivery.
Learning dis: risks include no formalised partnership agreement or agreed governance arrangements between PCT and SSD, minimal choice from monopoly providers for special clinical support, complex needs to independent living. Partnership board and sub groups to be revised. Joint commissioning strategy to be developed between PCT/SSD to stimulate the market and develop more choice.
Phys dis: risks include lack of capacity in health services to achieve desired actions/targets. Plan visioning days with SUs, carers and other stakeholders to develop a plan for service development and change. Plan closer working relationships with partner agencies to develop joint plans for services.
Mental health: risks include lack of development funding, recruitment and retention of staff, accuracy and completeness of data, effectiveness of integration. Plan to redesign services where possible including "invest to save" approach. Short term targeted recruitment solutions, "grow your own" model. Will review employment link and day services pulling together multi agency resources. Plans for major drive to promote employment opportunities. Carers: have agreed a policy on support for employees with caring responsibilities.
6.3 There is a business plan and an action plan is developed following the Annual Review meeting. A new corporate training programme is planned to increase management capacity and leadership skills. Risks: some posts remain unfilled whilst a major corporate restructure is underway, but there are acting up arrangements, augmented by the use of consultants. Management information reports are now more analytical. Priorities for improvement for performance management do not specify developments, a consultancy is being used to advise on improved coherence between policy, plans and performance management.
Information: Plan to improve access to information from remote locations, at home and in the field. Moving to document image process. Working with partners to ensure consistent plans. To pilot mobile working. Have led corporate review of information security. Public access strategy is being reviewed and

plans made for links to the corporate contact centre.
6.5 There is a human resource strategy, which focuses on equipping staff to deliver the modernisation agenda. This links to the corporate HR strategy and through that to the Community Strategy. Workforce development plans across social care, health and the independent sector will be formed into a single document in future. The Social Services plan identifies a range of recruitment and retention schemes, as the availability of qualified and experienced staff is seen as a potential risk.
3104 a set of core competencies has been implemented for social workers and there are plans to develop competencies for integrated care workers across social care/primary care. Integrated teams across adults/health to be implemented from October 05, this will involve a review of organisational structures.
3105 Turnover across adult services has fallen below the expected target overall. Full establishment levels for social workers have been maintained.
3118 staff turnover very low, 4.3, staff vacancies also very low compared to similar councils. Evidence of staff qualifications.
3121 2.6% SSD gross current staffing expenditure spent on training. Sickness levels have reduced. Practice learning indicator good. All 80 qualified sws registered with GSCC.

Evaluation
There is a clear vision of the strategic direction for social services, and resources within the council's control are allocated in response to priorities and identified need. Many planned developments are dependent upon making new arrangements for joint working with NHS partners, backed by the necessary resources. This is seen as a considerable risk to the achievement of modernisation plans.
There have been a range of service developments this year, including the greater use of non-residential intermediate care, alternative living arrangements for people with learning disabilities, and increased access to employment opportunities for people with physical disabilities.
There is a departmental business plan, and performance is systematically tracked. Work has been undertaken this year to ensure that management information offers a better analysis of performance to managers, and a consultancy is being used to advise how the department might improve the links between policy, plans and performance management There is continued work to maximise the use of IT.
Hartlepool is a small council, and management capacity can become stretched. A major corporate restructure has been planned for some time, and there have been a number of acting-up arrangements for key management posts. This should be resolved during 2005/06, but has posed a risk to the successful delivery of modernisation plans.
The social services HR strategy links to the corporate strategy and through that to the community plan. The social services plan has a focus on equipping staff to deliver the modernisation agenda. Recruitment and retention initiatives are in place, as the poor availability of experienced and qualified staff is identified as a potential risk. A set of core competencies has been implemented for social workers, and there are plans to develop competencies for integrated care workers across social care/primary care.
Figures for staff turnover and vacancies are half the level of similar councils, and sickness absence figures are good.

2005/2006 ARM ACTION PLAN **APPENDIX 2**

Recommendations	***Outcomes to be Achieved***	***Actions required (including PI's, Milestones)***	***Evidence Required***	***Progress To Date***	***Responsible Manager***
Improve take-up of Direct Payments.	Enhanced choices and empowerment for users to be independent.	Set up support service in-house. Work towards user-led support arrangements.	Improvement in D51.	▪ Service in Place (Nov) ▪ Half year figures (39) improved ▪ Partnership working with Job centre, etc	JL / LB
Continue to improve proportion of people who's needs are reviewed.	Needs assessment kept up to date.	Identify those not reviewed and key areas for improvement. All levels of staff made aware of need to fully record reviews on Carefirst. Systems for quarterly monitoring.	Improvement in D40.	Q2 data predicts top banding for year	JL / LB
Develop extra care housing.	Enhanced choices and capacity. Staying fit and well. Safety at home.	Planning permission and pre-contract work. 2 additional sites identified. Shared ownership housing scheme LD.	On site Middle Warren March 06. Portfolio Reports	▪ OP Focus Group reported ▪ Public Presentation (August) ▪ Planning application made (October) ▪ Telecare plans discussed.	SR / RT LB / PH
Develop collaborative commissioning, spending priorities aligned with PCT (alternative to pooling)	Resources maximised for local priorities.	Work with Directorates and Joint Forum in context of LAA and "Commissioning a PL NHS"	Commissioning agreement. Consistent budget decisions 2006/2007.	▪ Officer and Member level discussions continue. ▪ Meetings scheduled for alignment of budgets.	AD/ JWs / PH

2005/2006 ARM ACTION PLAN

Recommendations	***Outcomes to be Achieved***	***Actions required (including PI's, Milestones)***	***Evidence Required***	***Progress To Date***	***Responsible Manager***
Closer working with PCT through integrated teams.	Improve access to integrated services.	Pilot for Older People's team in place March 2006. "Connected Care" Pilot?	Team in place.	▪ Weekly ops meeting in pilot area. ▪ Further planning suspended pending PCT restructuring	SR / JL
Speedier delivery of services following assessment.	Improved access to services. Staying healthy and safe.	Analyse data on nature and level of delays. Day care contract varied to better manage waiting list.	Older People receiving services within 4 weeks (D56). Equipment / Adaptions delivered more quickly (D54).	▪ Data suggests performance improving.	SR / JL
Person centred planning for younger Learning Disabilities People (including Transitions)	Increase capacity to enjoy a full life in society.	Make person centred plans more widely available.	Plans in place at Transition.	In process of commissioning Plans will be in place for March	SR / LB
Review Carers Strategy and develop performance outcome measures.	Carers enjoy a better quality of life, and continue caring	Increase breaks for carers. Support carers to enjoy employment, education and leisure.	Improvement in C62.	▪ Working groups established to review strategy (Oct) ▪ Training course for unpaid carers launch (Dec)	SR / JL

2005/2006 ARM ACTION PLAN

Recommendations	***Outcomes to be Achieved***	***Actions required (including PI's, Milestones)***	***Evidence Required***	***Progress To Date***	***Responsible Manager***
Develop consultation networks with BEM Communities. Ensure access is culturally sensitive	Freedom from discrimination. Improve access tailored to need.	Develop networks in partnership. Review access and services.	Networks in place. Review completed feedback analysed	▪ In hand ▪ Review completed.	MH SR / MH LIT
Complete SAP Process.	Improve access to integrated services.	Put paper process in place Develop Electronic Version	SAP process completed.	▪ Paper process only at present ▪ Discuss with partners and providers over software	SR / JL / ST
Implement DIP / ECSR	Information available to all who need it.	Implement DIP (RKYV) Oct 05 ESCR available October 2005	Scanning available. ESCR target met.	▪ RKYV implemented (Nov) ▪ ESCR available (Nov)	AD / TS
Pilot Mobile Working	Efficient front line services with up to date information.	Partnership Board funding applied for October 2005. Pilot in place January 06 (OT's)	Bid approved Pilot Begins	▪ Funding agreed.	AD / TS / JL
Ensure sufficient management capacity and financial resources to implement change.	Resources identified for local priorities.	Complete restructuring and opportunities. Identify resources required for priority development 06/07. Delivery Efficiency Gains for 05/06	All appointments made Good budget build February 2006 AES	▪ Appointments completed. ▪ Pressures and priorities identified and submitted for Scrutiny. ▪ Efficiencies in hand.	IM / AD

Annex B: Judgements and Ratings for all councils

Key:
Arrows indicate a change in judgement and/or star rating since November 2004.

Key to Type of Council:
Inner London = **IL**, Outer London = **OL**, Metropolitan District = **M**,
Shire County = **S**, Unitary Authority = **UA**

Key to Regions:
North East = **NE**, North West = **NW**, Yorkshire & Humber = **Y&H**,
East Midlands = **EM**, West Midlands = **WM**, Eastern = **E**, London = **L**,
South East = **SE**, South West = **SW**

Councils subject to a Joint Area Review for children's services

The eight councils below have still to complete their Joint Area Reviews of children's services and cannot yet be given an overall rating. The Commission will publish the overall rating for these 8 councils as soon as possible after the conclusion of the Joint Area Review process.

			Adults' Social Care			
Council	Type of Council	Region	Serving People Well?		Capacity to Improve?	
Bournemouth	UA	SW	Most	↑	Promising	
Calderdale	M	Y&H	Most		Promising	
Enfield	OL	L	Some		Promising	
Herefordshire	UA	WM	Some		Uncertain	↓
Slough	UA	SE	Most		Excellent	↑
Staffordshire	S	WM	Most	↑	Promising	
Stoke-on-Trent	UA	WM	Some		Uncertain	
Wirral	M	NW	Most		Promising	

Three Star Councils

★★★

			Adults' Social Care		Children's Social Care		Star Rating	
Council	Type of Council	Region	Serving People Well?	Capacity to Improve?	Serving People Well?	Capacity to Improve?		
Barnsley	M	Y&H	Yes ↑	Excellent ↑	Most ↑	Excellent ↑	***	↑
Bexley	OL	L	Yes	Excellent	Yes	Excellent	***	
Bolton	M	NW	Yes ↑	Excellent	Most ↓	Excellent	***	
Camden	IL	L	Yes ↑	Excellent ↑	Most	Excellent ↑	***	↑
City of London	IL	L	Yes ↑	Promising	Yes	Excellent ↑	***	
Derbyshire	S	EM	Yes	Excellent	Most	Excellent	***	
Gateshead	M	NE	Most	Excellent	Most	Excellent	***	
Kent	S	SE	Most	Excellent	Most	Excellent	***	
Kingston upon Thames	OL	L	Most	Promising ↓	Yes	Promising	***	
Kirklees	M	Y&H	Yes ↑	Excellent	Most	Excellent	***	
Knowsley	M	NW	Most	Excellent	Yes ↑	Excellent	***	
Leicestershire	S	EM	Most	Excellent	Yes ↑	Excellent	***	
Newcastle upon Tyne	M	NE	Yes	Excellent	Most	Promising ↓	***	
Redbridge	OL	L	Yes ↑	Excellent ↑	Yes ↑	Promising	***	↑
Salford	M	NW	Yes ↑	Excellent ↑	Most ↑	Promising	***	↑
Shropshire	S	WM	Most	Excellent ↑	Yes ↑	Excellent	***	↑
Somerset	S	SW	Yes	Excellent	Most	Promising	***	
Southampton	UA	SE	Most	Excellent ↑	Most	Excellent ↑	***	↑
Southwark	IL	L	Most	Excellent	Most	Excellent	***	
Suffolk	S	E	Most ↑	Excellent ↑	Most	Excellent ↑	***	↑
Sunderland	M	NE	Most	Excellent	Most	Excellent	***	
Thurrock	UA	E	Most	Excellent ↑	Most	Excellent ↑	***	↑
Tower Hamlets	IL	L	Yes ↑	Excellent	Yes ↑	Excellent	***	
Wandsworth	IL	L	Most	Promising ↓	Yes	Excellent	***	
West Berkshire	UA	SE	Most	Excellent	Most	Excellent ↑	***	↑
Worcestershire	S	WM	Most	Excellent ↑	Yes ↑	Excellent	***	↑

Two Star Councils

★★

			Adults' Social Care				Children's Social Care				Star Rating	
Council	Type of Council	Region	Serving People Well?		Capacity to Improve?		Serving People Well?		Capacity to Improve?			
Bath and North East Somerset	UA	SW	Some		Promising		Most		Promising		**	
Blackburn with Darwen	UA	NW	Most		Excellent		Some	↓	Promising	↓	**	↓
Bracknell Forest	UA	SE	Some		Promising	↑	Most		Promising		**	↑
Bradford	M	Y&H	Most		Promising		Most		Excellent	↑	**	
Brent	OL	L	Most		Promising		Most	↑	Promising		**	
Brighton and Hove	UA	SE	Most	↑	Promising		Most	↑	Promising		**	↑
Bromley	OL	L	Most	↑	Promising		Some		Promising		**	↑
Buckinghamshire	S	SE	Most	↑	Promising		Some		Promising		**	↑
Bury	M	NW	Most		Promising		Most		Promising		**	
Cheshire	S	NW	Most		Promising		Most		Promising		**	
Cornwall	S	SW	Most	↓	Promising	↓	Some		Promising		**	
Coventry	M	WM	Most		Excellent	↑	Some		Promising		**	
Croydon	OL	L	Most		Excellent		Most		Promising		**	
Darlington	UA	NE	Most	↑	Promising		Most		Excellent	↑	**	
Derby City	UA	EM	Most		Promising		Most	↑	Promising		**	
Devon	S	SW	Most	↑	Promising		Some		Promising		**	↑
Doncaster	M	Y&H	Some		Promising		Most		Promising		**	
Dorset	S	SW	Some	↓	Promising		Most		Promising		**	
Dudley	M	WM	Most		Excellent		Most	↑	Promising		**	
Durham	S	NE	Most		Excellent		Most		Promising		**	
East Riding of Yorkshire	UA	Y&H	Most		Promising		Most		Promising		**	
East Sussex	S	SE	Some		Uncertain	↓	Most		Excellent	↑	**	
Essex	S	E	Most	↑	Promising		Most		Excellent	↑	**	
Gloucestershire	S	SW	Some		Promising		Most	↑	Excellent	↑	**	↑
Hackney	IL	L	Most	↑	Promising		Most		Promising		**	
Halton	UA	NW	Most		Promising		Most	↑	Promising	↓	**	
Hammersmith & Fulham	IL	L	Most		Excellent	↑	Most		Promising	↓	**	
Hampshire	S	SE	Most		Promising		Most	↑	Excellent	↑	**	
Haringey	OL	L	Most		Promising		Some		Promising	↑	**	↑
Hartlepool	UA	NE	Most		Promising		Some	↓	Promising		**	
Havering	OL	L	Some		Promising	↑	Most	↑	Promising		**	↑
Hertfordshire	S	E	Most		Excellent		Some		Promising		**	
Hillingdon	OL	L	Most	↑	Promising	↑	Most	↑	Promising		**	↑
Hounslow	OL	L	Most		Promising		Most		Promising		**	
Isle of Wight	UA	SE	Most		Promising		Some		Promising		**	
Islington	IL	L	Most		Promising		Most	↑	Promising		**	
Kensington & Chelsea	IL	L	Most		Excellent	↑	Most	↓	Promising	↓	**	↓
Kingston upon Hull	UA	Y&H	Most		Promising	↑	Most		Promising		**	
Lancashire	S	NW	Most		Excellent	↑	Some		Promising	↓	**	
Leeds	M	Y&H	Most		Promising		Most		Promising	↑	**	
Leicester City	UA	EM	Most		Excellent		Most		Promising		**	
Lewisham	IL	L	Most		Promising		Some		Promising	↑	**	↑
Manchester	M	NW	Most		Promising		Some		Promising		**	
Merton	OL	L	Most	↑	Promising		Most		Promising		**	
Middlesbrough	UA	NE	Most		Promising		Most		Promising		**	
Newham	OL	L	Some		Promising		Most	↑	Promising		**	↑
North Lincolnshire	UA	Y&H	Most	↓	Promising	↓	Most		Excellent		**	↓
North Somerset	UA	SW	Most	↑	Promising		Most		Promising	↓	**	
North Tyneside	M	NE	Most	↑	Promising	↓	Most	↑	Promising		**	↑
North Yorkshire	S	Y&H	Most		Promising		Most		Promising	↓	**	
Northamptonshire	S	EM	Most	↑	Excellent	↑	Most	↑	Promising		**	↑
Northumberland	S	NE	Most		Promising		Most	↑	Promising		**	
Nottinghamshire	S	EM	Most	↑	Promising	↓	Most		Excellent		**	
Oxfordshire	S	SE	Most	↑	Promising		Some		Promising	↑	**	↑
Peterborough	UA	E	Most	↑	Promising		Some	↓	Promising		**	
Poole	UA	SW	Most		Promising		Most	↑	Promising		**	
Redcar & Cleveland	UA	NE	Most	↑	Excellent	↑	Most		Promising		**	
Richmond upon Thames	OL	L	Most	↑	Promising		Most		Promising		**	

Two Star Councils

★★

			Adults' Social Care				Children's Social Care				Star Rating	
Council	Type of Council	Region	Serving People Well?		Capacity to Improve?		Serving People Well?		Capacity to Improve?			
Rochdale	M	NW	Most	↑	Promising		Some		Promising		**	↑
Rotherham	M	Y&H	Most		Promising		Most	↑	Promising	↑	**	↑
Rutland	UA	EM	Most		Promising		Most		Promising		**	
Sefton	M	NW	Most		Promising		Most	↑	Promising		**	
Sheffield	M	Y&H	Most	↑	Excellent	↑	Most		Promising		**	
Solihull	M	WM	Most		Promising		Most	↑	Promising	↓	**	
South Gloucestershire	UA	SW	Some		Promising		Most		Promising		**	
South Tyneside	M	NE	Most		Promising		Most	↑	Promising		**	
St Helens	M	NW	Most		Promising		Most		Promising		**	
Stockport	M	NW	Most		Uncertain	↓	Most	↑	Promising		**	
Stockton-on-Tees	UA	NE	Most		Promising		Some		Promising		**	
Surrey	S	SE	Most		Excellent	↑	Some		Promising		**	
Tameside	M	NW	Most		Excellent		Some		Promising		**	
Telford & Wrekin	UA	WM	Most		Promising	↓	Some		Promising		**	
Trafford	M	NW	Most	↑	Promising		Some		Promising		**	↑
Wakefield	M	Y&H	Most		Excellent		Most		Promising		**	
Walsall	M	WM	Some		Promising		Most	↑	Promising		**	↑
Warwickshire	S	WM	Some		Uncertain	↓	Most		Excellent	↑	**	
Westminster	IL	L	Most	↓	Promising	↓	Most	↓	Promising	↓	**	↓
Wigan	M	NW	Most		Excellent		Most		Promising		**	
Wiltshire	S	SW	Most		Excellent	↑	Some		Uncertain	↓	**	
Windsor & Maidenhead	UA	SE	Most	↑	Promising		Some		Promising		**	↑
Wolverhampton	M	WM	Most		Promising		Some		Promising	↑	**	↑
York	UA	Y&H	Most		Promising		Most		Excellent	↑	**	

One Star Councils

★

			Adults' Social Care			Children's Social Care			Star Rating		
Council	Type of Council	Region	Serving People Well?		Capacity to Improve?	Serving People Well?		Capacity to Improve?			
Barking and Dagenham	OL	L	Most	↑	Promising	Some		Uncertain	↓	*	
Barnet	OL	L	Some		Promising	↑ Some	↓	Promising	↓	*	↓
Bedfordshire	S	E	Some		Excellent	↑ Some	↑	Promising		*	↑
Birmingham	M	WM	Some		Promising	Some	↑	Promising		*	↑
Blackpool	UA	NW	Some		Promising	Some		Promising	↑	*	
Bristol City	UA	SW	Some		Uncertain	↓ Some		Uncertain	↓	*	
Cambridgeshire	S	E	Some		Uncertain	↓ Some	↓	Uncertain	↓	*	↓
Cumbria	S	NW	Some		Uncertain	Some	↑	Promising	↑	*	↑
Ealing	OL	L	Some		Uncertain	↑ Most		Promising	↑	*	↑
Greenwich	IL	L	Some		Promising	Some		Promising		*	
Harrow	OL	L	Some		Uncertain	Some		Uncertain	↓	*	
Lambeth	IL	L	Some		Promising	Some		Promising	↑	*	
Lincolnshire	S	EM	Some		Uncertain	Some		Uncertain		*	
Liverpool	M	NW	Some		Uncertain	↓ Most	↑	Promising		*	
Luton	UA	E	Some	↓	Uncertain	↓ Most		Promising		*	↓
Medway	UA	SE	Most	↑	Promising	Some		Uncertain		*	
Milton Keynes	UA	SE	Most		Promising	Some	↓	Uncertain	↓	*	↓
Norfolk	S	E	Some		Promising	Some		Promising		*	
North East Lincolnshire	UA	Y&H	Some		Uncertain	↓ Most	↑	Promising		*	
Nottingham City	UA	EM	Some	↓	Promising	Some	↓	Promising		*	↓
Oldham	M	NW	Some		Promising	↑ Some		Uncertain	↑	*	↑
Portsmouth	UA	SE	Most		Uncertain	↓ Some		Promising		*	↓
Reading	UA	SE	Some		Uncertain	↓ Most		Promising		*	↓
Southend-on-Sea	UA	E	Some		Promising	Some		Uncertain	↓	*	
Sutton	OL	L	Most	↑	Promising	Some		Uncertain	↓	*	
Swindon	UA	SW	Some		Promising	↑ Some	↑	Uncertain		*	↑
Torbay	UA	SW	Some		Uncertain	Some		Promising	↑	*	
Waltham Forest	OL	L	Some		Promising	Some		Promising		*	
Warrington	UA	NW	Most		Promising	Some	↓	Uncertain	↓	*	↓
West Sussex	S	SE	Some	↓	Uncertain	↓ Most		Promising		*	↓
Wokingham	UA	SE	Some		Promising	Some	↓	Promising		*	↓

Zero Star Councils

			Adults' Social Care			Children's Social Care			Star Rating	
Council	Type of Council	Region	Serving People Well?	Capacity to Improve?		Serving People Well?	Capacity to Improve?			
Isles of Scilly	S	SW	Some	Poor		Some	Poor		-	
Plymouth	UA	SW	Some	Promising	↑	No	Uncertain		-	
Sandwell	M	WM	Most	Promising		No	Uncertain	↓	-	↓

Annex C: Councils changing performance rating

Councils Moving Up		
To 1 Star	**To 2 Star**	**To 3 Star**
6 Councils	**20 Councils**	**10 Councils**
Bedfordshire	Bracknell Forest	Barnsley
Birmingham	Brighton and Hove	Camden
Cumbria	Bromley	Redbridge
Ealing	Buckinghamshire	Salford
Oldham	Devon	Shropshire
Swindon	Gloucestershire	Southampton
	Haringey	Suffolk
	Havering	Thurrock
	Hillingdon	West Berkshire
	Lewisham	Worcestershire
	Newham	
	North Tyneside	
	Northamptonshire	
	Oxfordshire	
	Rochdale	
	Rotherham	
	Trafford	
	Walsall	
	Windsor & Maidenhead	
	Wolverhampton	

Councils Moving Down		
To 0 Star	**To 1 Star**	**To 2 Star**
1 Councils	**10 Councils**	**4 Councils**
Sandwell	Barnet	Blackburn with Darwen
	Cambridgeshire	Kensington & Chelsea
	Luton	North Lincolnshire
	Milton Keynes	Westminster
	Nottingham City	
	Portsmouth	
	Reading	
	Warrington	
	West Sussex	
	Wokingham	

Annex D: Distribution of performance ratings, 2005

	Number of councils				% of councils			
	Zero	*	**	***	-	*	**	***
Eastern	0	5	3	2	0%	50%	30%	20%
East Midlands	0	2	5	2	0%	22%	56%	22%
North East	0	0	9	3	0%	0%	75%	25%
North West	0	5	13	3	0%	24%	62%	14%
London	0	8	17	7	0%	25%	53%	22%
South East	0	6	9	3	0%	33%	50%	17%
South West	2	3	9	1	13%	20%	60%	7%
West Midlands	1	1	7	2	9%	9%	64%	18%
Yorkshire & Humber	0	1	11	2	0%	7%	79%	14%
Inner London	0	2	6	5	0%	15%	46%	38%
Outer London	0	6	11	2	0%	32%	58%	11%
Metropolitan Districts	1	3	22	8	3%	9%	65%	24%
Shire Counties	1	6	20	7	3%	18%	59%	21%
Unitary Authorities	1	14	24	3	2%	33%	57%	7%
England	**3**	**31**	**83**	**25**	**2%**	**22%**	**58%**	**18%**

APPENDIX 4

PUBLICATION OF 2004/2005 DATA FOR THE PERSONAL SOCIAL SERVICES PERFORMANCE INDICATORS

1. BACKGROUND

The Commission for Social Care Inspection (CSCI) has published data on Social Services performance relating to the year 2004/2005. The document contains data and ratings for each Social Services authority. The listing is not a simple 'league' table and needs some interpretation. The purpose of this note is to provide a summary briefing on the data and how to read the attached data sheet.

2. STRUCTURE OF DATA SHEET

There are two blocks of data: adult services, and the health interface. For each block, there are groups of columns have been colour coded:

- The yellow columns group the performance indicators according to the relevant 'domain' of the CSCI performance assessment framework, list the letter and number code of the performance indicator and give the title of the performance indicator. It also gives the BVPI reference, where applicable.
- The middle green columns give the data values for up to 6 successive years,
- The peach columns give the CSCI rating systems (see below for further detail)
- The purple columns provide the averages for all unitary authorities and all English authorities for 3 years.

The final green columns have been added locally to aid interpretation. They show where we have achieved the highest band score (√) or lowest band score (x).

3. CSCI RATING SYSTEM

There are four elements to the rating system. The first is an arrow and the direction of the arrow denotes the CSCI assessment of how the Local Authority's performance is moving over time.

So, ↗ denotes that the performance banding has improved, ↘ denotes that it has declined and → denotes that it has stayed the same. All these direction pointers compare 2004/2005 bandings to the previous year.

The second element of the rating is a banding, or 'blob' rating. Thus

●	advise urgent investigation (significantly below average)
●●	suggests that performance is questioned
●●●	acceptable, with possible room for improvement
●●●●	good (above average)
●●●●●	is very good (significantly above average)

For most indicators, all 5 bandings are used, although for some, such as the unit cost PIs there is continuing caution over data quality, so two to four blobs are the only options available. For others, such as E47, 3 blobs is the best performance.

The third element of the rating system is a letter symbol at the end of the blob rating. The CSCI have adopted the view that, in many vases, a very high or a very low value for an indicator suggests poor performance, with best performance lying somewhere in between; the letter H (higher) or L (lower) therefore denotes whether our indicator value is deemed higher or lower that the ideal. Frequently, however, a "H" rating is still below the national average.

4. HIGHLIGHTS OF THE PERFORMANCE RATINGS

In relation to Adult care services Hartlepool has:

0 x 1 blob rating
3 x 2 blob ratings
6 x 3 blob ratings
8 x 4 blob ratings
8 x 5 blob ratings

Allowing for the fact that for some indicators 3 or 4 blobs is the top category, Hartlepool has 12 indicators with the maximum rating out of the 25 indicators given bandings. (See ticket on far right of table) (48%)

Twenty two (88%) of the blob ratings are ranked as acceptable or above, which is better than last year. Two (8%) of the ratings were in the lowest category (see below); with none scoring a one-blob rating.

In terms of direction of performance, Hartlepool has:

8 ↗
8 →
7 ↘

So 70% (16 out of 23) of the ratings are ranked by the Commission as steady or improving. It should be noted that many of the 'steady state' arrows the areas of activity already at full performance, and so could not show an 'improved' rating for this yea. In total 21 (65%) of actual indicators were either in the top band or improving towards it.

5. TOP CATEGORY RATINGS

Hartlepool has top rating for adults services in:

Cost and efficiency indicators (B12 and B13)
Helping adults stay at home (C26, C27,C29-32)
Single Room Occupancy (D37)

Client receiving a review (D40)
Balance of assessments (E61)
Delayed discharges (D41)

6 LOWEST CATEGORY RATINGS

Lowest ratings ratings were given to two indicators for adults services:

E47 – Ethnicity of older people receiving assessment (●●) proportionately fewer older people from minority communities were assessed, but as the number is only small the result is of dubious significance.

E48 – Ethnicity of older people receiving services (●●) proportionately fewer people from minorities receive a service following assessment, but again the numbers are quite small.

Some of the indicators are designated key threshold indicators ('KT'), in that poor performance may put a ceiling on our overall judgement and rating. None of the Hartlepool indicators for adults has triggered such limitations.

Analysis of Hartlepool 2004-05 PAF Scores/Bandings

Adults

1. Average Band score

2001/02	2002/03	2003-04	2004-05
3.97	**3.74**	**3.74**	**3.84**

1. Top & Low Scores:

	2001/02	2002/03	2003-04	2004-05
Top	17	16	13	12
Low	2	3	4	2
% Top	**55%**	**52%**	**48%**	**48%**
% Low	**6%**	**10%**	**15%**	**8%**

2. Top band or improving

	2001-02	2002-03	2003-04	2004-05
No. indicators	31	31	27	25
Top Band or improving	19	18	15	15
% Top band or improving	**61.3%**	**58.1%**	**55.6%**	**60.0%**

3. Bandings changes (from year to year)

	2001/02	2002/03	2003-04	2004-05
Constant	15	17	14	8
Improved	12	3	4	8
Worsened	2	7	4	7
Total	**29**	**27**	**22**	**23**
% Improved/constant	**93.1%**	**74.1%**	**81.8%**	**69.6%**

4. Score

	2001-02	2002-03	2003-04	2004-05
●	0	0	0	0
●●	4	6	6	3
●●●	5	8	4	6
●●●●	9	5	8	8
●●●●●	12	12	9	8
Total scores	**30**	**31**	**27**	**25**
No. 3 ●●● or better	**26**	**25**	**21**	**22**
% 3 ●●● or better	**86.7%**	**80.6%**	**77.8%**	**88.0%**

● and above	30	31	27	25
●● and above	30	31	27	25
●●● and above	26	25	21	22
●●●● and above	21	17	17	16
●●●●●	12	12	9	8

● and above	100%	100%	100%	100%
●● and above	100%	100%	100%	100%
●●● and above	87%	81%	78%	88%
●●●● and above	70%	55%	63%	64%
●●●●●	40%	39%	33%	32%

5. Key Thresholds
(formerly Key Indicators)

	2001-02	2002-03	2003-04	2004-05
●				
●●			2	
●●●		3		3
●●●●			3	2
●●●●●	4	1	1	1
Average KT Score	5.0	3.5	3.5	3.7

6. Financial Indicators

	2001-02	2002-03	2003-04	2004-05
●●		2	1	
●●●	2	2	1	1
●●●●	4	2	4	2
Average KT Score	3.7	3.0	3.5	3.7

Note:
(1) Childrens indicators not included in this analysis
(2) E50 is collected, but not banded in 2004-05 and is therefore not included in above analysis
(3) Finance indicators B14, B15 and B16 are not included for 2004-05.
(4) Information on A5 is not yet available and is therefore not included.
(5) D42, D57 and D58 are not collected for 2004-05.

PAF Summary 2004-05
A. ADULT INDICATORS

Section 1: Domain of Performance and Indicator Description					Section 2: Performance Indicators						Section 3: Bandings						Section 4: Comparator Information						Section 5: Top/Low Scores					
Domain of Performance	Code	Indicator	Key Threshold	Best Value Ref	Hartlepool UA						2002-03		2003-04		2004-05		2002/03 comparison		2003/04 comparison		2004-05 Comparison		2002-03		2003-04		2004-05	
					1999/00	2000/01	2001/02	2002/03	2003/04	2004-05	HBC Band	Vaild Bands	HBC Band	Vaild Bands	HBC Band	Vaild Bands	Unitary Average	England Average	Unitary Average	England Average	Unitary Average	England Average	Top	Low	Top	Low	Top	Low
A. National Priorities and Strategic Objectives	A5	Emergency admissions			..	..	-2.0	-2.6 →	-1.1 ↘		●●●●H ↗	1-4H, 5	●●●H ↘	1-4H, 5			0.2	0.5	5.1	5.6								
	A60	Participation in Drug Treatment Programmes		198						46					●●●●L	1-4L, 5	-	-										
B. Cost and Efficiency	B11	Intensive home care as a % of intensive home & residential care			18	25 ↗	28 →	34.3 ↗	29.5 →	25.9 ↘	●●●●● ↗	1-4L, 5, 2-4H	●●●●● →	1-4L, 5, 2-4H	●●●●L ↘	1-4L, 5, 2-4H	20	24	19	24			✔		✔			
	B12	Cost of intensive social care for adults and older people		52	202	346 ↗	345 →	381.1 ↘	353.8 ↗	352.0 →	●●●H ↘	2-4	●●●● ↗	2-4	●●●● →	2-4	386	421	435	443					✔		✔	
	B13	Unit cost of residential and nursing care for older people			171	317 ↗	343 ↘	380.8 ↘	383.2 →	352.0 ↗	●●H ↘	2-4	●●H →	2-4	●●●● ↗	2-4	338	360	361	337				✘		✘	✔	
	B14	Unit cost of residential and nursing care for adults with LD			346	953 ↘	594 ↗	855.4 ↘	638.8 ↗	-	●●H ↘	2-4	●●●H ↗	2-4	-	-	567	655	723	734				✘				
	B15	Unit cost of residential and nursing care for adults with mental illness			225	410 ↘	365 →	388.8 →	381.4 ↗	-	●●●H →	2-4	●●●● ↗	2-4	-	-	383	439	426	447					✔			
	B16	Unit cost of residential and nursing care for adults with PD			135	482 ↗	397 ↗	420.0 →	488.7 →	-	●●●● →	2-4	●●●● →	2-4	-	-	465	533	576	573			✔		✔			
	B17	Unit cost of home care for adults and older people			7.2	7.9 →	9.5 ↗	9.7 →	12.1 →	13.0 ↘	●●●● →	2-4	●●●● →	2-4	●●●H ↘	2-4	11.4	12.1	12.9	12.9			✔		✔			
C. Effectiveness of Service Delivery & Outcomes	C26	Admissions of supported residents aged 65+ to residential/nursing care	KT		166	116 ↗	99.7 ↗	128.8 ↘	55.1 ↗	98.7 ↗	●●●H ↘	2-4L, 5, 1-4H	●●●●L ↗	2-4L, 5, 1-4H	●●●●● ↗	2-4L, 5, 1-4H	107	101	102	98							✔	
	C27	Admissions of supported residents aged 18-64 to residential/nursing care			4.5	4.3 →	2.3 ↗	2.5 →	1.9 ↘	2.05 ↗	●●●●● →	2-4L, 5, 1-4H	●●●●L ↘	2-4L, 5, 1-4H	●●●●● ↗	2-4L, 5, 1-4H	2.9	2.7	2.4	2.3			✔				✔	
	C28	Intensive home care	KT	53	11.6	15.9 ↗	17.5 ↗	18.8 →	17.4 →	15.2 ↘	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	●●●●L ↘	2-4L, 5, 1-4H	9.0	10.4	9.0	11.0			✔		✔			
	C29	Adults with PD helped to live at home			31.3	8.7 →	10.6 ↗	10.6 →	10.3 →	9.7 ↘	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	4.4	4.2	4.5	4.2			✔		✔		✔	
	C30	Adults with LD helped to live at home			3.6	3.7 →	3.8 →	3.2 →	3.5 →	3.4 →	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	2.8	2.7	2.8	2.7			✔		✔		✔	
	C31	Adults with mental health problems helped to live at home			1.3	1.1 ↘	4.1 ↗	4.2 →	4.2 →	3.4 →	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	3.4	3.3	3.4	3.4			✔		✔		✔	
	C32	Older people helped to live at home		54	294	117 ↗	124 ↗	123.1 →	124.6 →	119.0 →	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	86	85	84	84			✔		✔		✔	
	C33	Avoidable harm for older people			23.8	21.1 →	21.4 →	26.1 ↘			●●H ↘	1-4L, 5																
	C51	Direct Payments	KT		..	..	..	17.9	24.0 →	45.7 ↗	●●L	1-4L, 5	●●L →	1-4L, 5	●●●L ↗	1-4L, 5	24	23	35	36								
	C62	Services for Carers								7.6					-	Not banded	-	-	-	-								
D. Quality of Services for Users and Carers	D37	Availability of single rooms			100	100 →	100 →	100 →	100 →	100 →	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	●●●●● →	1-4L, 5	92	93	93.6	92.5			✔		✔		✔	
	D38	% items of equipment costing less than £1000 delivered in 3 weeks		56	93.1	95.6 ↗	95.9 →	89.5 ↘			●●●L ↘																	
	D39	% of people receiving statement of their needs & how they will be met		58	83	84 →	97 ↗	99.5 →	93.1 ↘	97.1 ↗	●●●●● ↗	1-4L, 5	●●●L ↘	1-4L, 5	●●●●L ↗	1-4L, 5	88	86	88.6	88.6			✔					
	D40	Clients receiving a review		55	..	24	35 →	36.4 →	58.8 →	62.7 ↗	●●L →	2-3L, 5, 3H	●●L →	2-3L, 5, 3H	●●● ↗	2-3L, 3H	52	51	56	59				✘		✘	✔	
	D42	Carer assessments			..	7	5.4 →	20.3 ↗	9.8	18.3	●●●L ↗	2-4L, 2H		Not banded	-	-	27	26	21	20								
	D43	Waiting times for Care packages					29.5	34.0 →			●●●H →																	
	D52	Users satisified with Social Services		182				64.2			●●●●●																	
	D53	Users that asked for changes to services who were satisfied with changes		190				70.9			●●●●L																	
	D54	% of items of equipment/adaptations delivered within 7 days	KT	56					76.7	74.0 ↘			●●●●L	1-4L, 5	●●●L ↘	1-4L, 5	-	-	79	77								
	D55	Acceptable waiting times for assessment	KT						55.9	75.7 ↗			●●L	1-4L, 5	●●●●L ↗	1-4L, 5	-	-	62	62								
	D56	Acceptable waiting times for care packages	KT						81.2	70.2 ↘			●●●●L	1-4L, 5	●●●L ↘	1-4L, 5	-	-	81	81								
	D57	Users who said there opinions/preferences were taken into account							NC	-			N/A	1-4L, 5	-	-	-	-	31	29								
	D58	Users who said that they can contact Social Services easily							NC	-			N/A	1-4L, 5	-	-	-	-	81	79								
	D59	Practice Learning							17.1	15.3 ↘			●●●●●	1-4L, 5	●●●●L ↘	1-4L, 5	-	-	10.0	8.8					✔			
E. Fair Access	E47	Ethnicity of older people receiving assessment			..	0.0	1.25 →	1.20 →	0.80 ↘	0.63 →	●●● →	2-3L, 2H	●●L ↘	2-3L, 2H	●●L →	2-3L, 2H	0.94	1.05	1.01	1.04			✔			✘		✘
	E48	Ethnicity of older people receiving services following an assessment			..	0.0	1.04 ↗	0.65 ↘	0.59	0.33	●●L	1-4L, 1-3H		Not banded	●●L	2-3L, 2H	1.02	0.98	1.07	1.05								✘
	E49	Assessments per head of population		59		133.0	168.7 →	168.3 →			●●●●● →																	
	E50	Assessments of adults and older people leading to provision of service			..	73.7	67.7 ↗	63.4 →	44.5	32.2	●●●●● →	1-4L, 5, 1-4H	-	Not banded	-	Not banded	72	69	49	47			✔					
	E61	Assessments of new clents aged 65 or over			..				118.1	57.5 ↗			●●H	2L,3L,2H	●●● ↗	2-3L, 2H	-	-	59	62						✘	✔	

B. ADULTS SERVICES - INTERFACE INDICATORS (Tees HA)

Section 1: Domain of Performance and Indicator Description					Section 2: Performance Indicators						Section 3: Bandings						Section 4: Comparator Information						Section 5: Top/Low Scores					
Domain of Performance	Code	**Indicator**	Key Threshold	Best Value Ref	Hartlepool UA						2002-03		2003-04		2004-05		2002/03 comparison		2003/04 comparison		2004-05 comparison		2002-03		2003-04		2004-05	
					1999/00	2000/01	2001/02	2002/03	2003/04	2004-05	Band	Vaild Bands	Band	Vaild Bands	Band	Vaild Bands	Unitary Average	England Average	Unitary Average	England Average	Unitary Average	England Average	Top	Low	Top	Low	Top	Low
A. Nat. Priorities and Strat. Obj.	A6	Emergency psychiatric re-admissions			5.1	10.9 →	11.6 ↘	8.2 ↘	13.0 →	16 ↘	●●●H ↘	1-4H, 5	●●●H →	1-4H, 5	●●H ↘	1-4H, 5	10	10	13	11								
D. Quality	D41	Delayed transfers of care			12.5	10.9 →	4.7 →	14.0 ↗	11.0 →	12.0 →	●●●●● ↗	1-4H, 5	●●●●● →	1-4H, 5	●●●●● →	1-4H, 5	63	58	49	46			✔		✔		✔	
																							14	3	13	4	12	2

Key Thresholds for 2004-05:	
C26	if >= 140, Max. Judgement is "Most" [Joint with C28]
C28	if < 8, Max. Judgement is "Most" [Joint with C26]
C51	if < 15 per 100,000, Max. Judgement is "Most"
D54	if < 45%, Max. Judgement is "Some"; if < 55%, Max. Judgement is "Most"
D55	if < 45%, Max. Judgement is "Some"; if < 55%, Max. Judgement is "Most"
D56	if < 45%, Max. Judgement is "Some"; if < 55%, Max. Judgement is "Most"

Banding Analysis:

	31	27	25
●	0	0	0
●●	6	6	3
●●●	8	4	6
●●●●	4	8	8
●●●●●	13	9	8
Average	**3.77**	**3.74**	**3.84**

Bands:
The meaning of the bands is different for the interface indicators (A5, A6 & D41), than the rest, these are given in brackets (below):

- ● **Investigate urgently (significantly below average)**
- ●● **Ask questions about performance (below average)**
- ●●● **Acceptable, but possible room for improvement (average)**
- ●●●● **Good (above average)**
- ●●●●● **Very good (significantly above average)**

Adults:	2000/01 **20**	2001/02 **26**	2002/03 **28**	2003/04 **22**	2004/05 **23**
Constant	9	12	17	14	8
Improved	8	12	3	4	8
Worsened	3	2	8	4	7

	2002/03 **27**	2003/04 **22**	2004/05 **23**
Constant	15	14	8
Improved	5	4	8
Worsened	7	4	7

Notes:
(1) C26 - CSCI have received amended figure - from 21.1 to 98.7 (through DIS validation process).
(2) Section 4: 2004-05 national comparator information is not yet available (28-Nov-05)
(3) E59 and C62 are not banded in 2004-05, but are collected.
(4) Financial Indicators B14, B15 and B16 have been deleted from the PAF dataset from 2004-05.
(5) Three figures have been revised by DoH due to population revisions
- C28 from 15.4 to 15.2; C32 from 120.3 to 119; E47 from 0.65 to 0.63.
(6) D59 - CSCI have received amended figure - from 10.3 to 15.3 (through DIS validation process).
(7) Those indicator descrptions in red, e.g C33, were last collected in 2002-03.
- Banding and comparator information has not been included for these indicators.

Summary:
(1) In 2004-05, 22 out of 25 indicators (88%) were LLL or better.
(2) In 2004-05, 15 out of 23 indicators (65%) were top band or improving.
(3) In 2004-05, 16 out of 23 (70%) indicators were steady or improving.
(4) The average indicator score has increased from 3.7 in 2003-04 to 3.8 in 2004-05.

ADULT AND PUBLIC HEALTH SERVICES PORTFOLIO

Report To Portfolio Holder

12 December 2005

HARTLEPOOL BOROUGH COUNCIL

Report of: Children's Services Scrutiny Forum

Subject: ADULT LEARNING – FINAL REPORT

SUMMARY

1. PURPOSE OF REPORT

To present the findings of the Children's Services Scrutiny Forum's inquiry into Adult Learning.

2. SUMMARY OF CONTENTS

The report provides a brief outline of the Children's Services Scrutiny Forum's inquiry into Adult Learning.

3. RELEVANCE TO PORTFOLIO MEMBER

The report relates to the provision of adult learning.

4. TYPE OF DECISION

Non key.

5. DECISION MAKING ROUTE

Portfolio Holder only.

6. DECISION(S) REQUIRED

To agree the findings and recommendations of the report.

ADULT AND PUBLIC HEALTH SERVICES PORTFOLIO

Report To Portfolio Holder
12 December 2005

Report of: Children's Services Scrutiny Forum

Subject: FINAL REPORT – ADULT LEARNING INSPECTION

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1. PURPOSE OF REPORT

1.1 To present the findings of the Children's Services Scrutiny Forum's inquiry into Adult Learning.

2. BACKGROUND INFORMATION

2.1 On 21st April 2005 the (then) Culture and Learning Scrutiny Forum examined the inspection results of Hartlepool's Adult Education Service, during its last meeting of the 2004/05 Municipal Year. Members of the Forum were keen to explore this issue given the poor inspection results the service had received in March 2004.

2.2 Having explored the issue with the Adult Education Co-ordinator on 21st April 2005, Members of the Forum determined that they would like one further meeting to explore this issue once the re-inspection of the Adult Education Service had taken place in May 2005. It was agreed at the meeting on 21st April 2005 that the Forum should:

(a) Seek to make recommendations to the Portfolio Holder strongly supporting Adult Learning. Prior to doing this the Forum should explore the funding criteria of Adult Education Services as a basis for taking this matter to the Portfolio Holder.

(b) Discuss this matter with a representative from the Learning and Skills Council (LSC) to clarify the basis of its current and future funding policies for Adult Education in Hartlepool compared with the other authorities within its responsibility; and

(c) Consider the importance of the contribution of Adult Education to the Authority's social inclusion objectives.

2.3 Since the Forum first looked at this matter the remit of the Forum changed to Children's Services, which means that the scrutiny topic now falls outside of its remit. However, when the Forum determined its work programme on 5th July 2005 it was agreed that this item should remain with this Scrutiny Forum because of the work carried out in the previous municipal year. This approach was agreed by the Scrutiny Co-ordinating Committee on 5th August 2005.

2.4 On 30th August 2005 the following reports were presented to the Forum:

(a) Re-inspection of the Adult Education Service – Adult Education Co-ordinator (HBC) **(see Appendix A)**;

(b) Future funding of Adult Education – Adult Education Co-ordinator (HBC) **(see Appendix B)**; and

(c) Reforming the Funding and Planning Arrangements for First Steps and Personal and Community Development Learning for Adults – Senior Learning Advisor (LSC) **(see Appendix C)**.

3. FINDINGS

3.1 During discussions Members reached the following conclusions about Adult Learning:

(a) Members noted the 'Re-inspection of the Adult Education Service' report and presentation and commented that there appeared to have been a dramatic improvement in a short space of time. Without wishing to take anything away from the work undertaken by staff, Members commented that the first inspection had possibly been too severe;

(b) That the Adult Services and Public Health Portfolio Holder be advised that it is this Forum's view that Adult Education is vital to the Town, especially in community areas and in local venues where people can feel comfortable in the learning environment; and

(c) That Scrutiny Co-ordinating Committee be requested to arrange for Adult and Community Services Scrutiny Forum to receive future updates from of the Senior Learning Advisor of The Learning and Skills Council.

3.2 The contents of this report were approved by the Children's Services Scrutiny Forum on 25th October and Scrutiny Co-ordinating Committee on 14th November 2005.

4. RECOMMENDATIONS

4.1 That the Adult Services and Public Health Portfolio Holder endorses the contents of this report and agrees the findings outlined in Section 3.1, with the exception of (c), which has been approved by Scrutiny Co-ordinating Committee.

COUNCILLOR JANE SHAW
CHAIR OF THE CHILDREN'S SERVICES SCRUTINY FORUM

Contact Officer: **Jonathan Wistow – Scrutiny Support Officer**
Chief Executive's Department
Corporate Strategy
Hartlepool Borough Council
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BACKGROUND PAPERS

The following background papers were used in the preparation of this report:-

(i) Culture and Learning Scrutiny Forum Minutes 21st April 2005

(ii) Children's Services Scrutiny Forum Minutes 30th August 2005

(iii) Children's Services Scrutiny Forum – Re-inspection of the Adult Education Service – Adult Education Co-ordinator (HBC).

(iv) Children's Services Scrutiny Forum – Future funding of Adult Education Adult Education Co-ordinator (HBC).

(v) Children's Services Scrutiny Forum – Reforming the Funding and Planning Arrangements for First Steps and Personal and Community Development Learning for Adults – Senior Learning Advisor (LSC).

CHILDREN'S SERVICES SCRUTINY FORUM REPORT

30th August 2005

HARTLEPOOL
BOROUGH COUNCIL

Report of: Director of Adult and Community Services

Subject: RE-INSPECTION OF THE ADULT EDUCATION SERVICE

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1. PURPOSE OF REPORT

1.1 To update the scrutiny forum on the re-inspection of the Adult Education service.

2. BACKGROUND

2.1 The Adult Education service was first inspected by the Adult Learning Inspectorate in March 2004. This was as part of the first inspection schedule for all LEA Adult Education services.

2.2 This first inspection identified a number of weaknesses in some aspect of the provision which led to the service being re-inspected in May 2005.

2.3 The first inspection was reported to the Culture and Learning Scrutiny Forum in April 2005. The re-inspection is the subject of this report.

2.4 The re-inspection took place between the 9th and 13th May 2005.
A total of nine inspectors visited the service for the five days. Full details of the scope of the inspection is included in the published inspection report, which is available.

2.5 All of the areas of learning were subject to re-inspection as were Leadership and Management. Areas which were graded as satisfactory or better in the last inspection received only a 'right touch' inspection. For these areas the inspectors were not present for the full five days and the areas were not regraded.

2.6 In the first inspection three areas of learning were found to be unsatisfactory. These were Foreign Languages, Family Learning and Foundation Subjects. These areas underwent a full re-inspection.

2.7 Similarly Leadership and Management received an unsatisfactory grade in the first inspection and was therefore subject to a full re-inspection.

2.8 The full inspection report was published on the ALI website on 24th June 2005. The report consists of 2 parts. The first section is a summary and is the part which is published on the website. The second part contains more details and is available on request from the ALI. The summary report is attached and the full report is available on request.

2.9 In the re-inspection the inspection team found that all areas of the service were satisfactory or better. All areas of learning which were deemed to be unsatisfactory at the last inspection were now satisfactory. Furthermore the inspection found that Leadership and Management was now good, as was Equality of opportunity. Quality assurance was also now found to be satisfactory.

2.10 During the re-inspection the following strengths and weaknesses were identified in Leadership and Management.

Strengths

- Good and successful actions to rectify identified weaknesses
- Well-integrated and successful strategies to widen the participation of learners from under-represented groups
- Particularly effective observation of teaching and learning

Weaknesses

- Insufficient strategic planning in curriculum areas
- Unsatisfactory self-assessment report

2.11 Similarly the following general strengths and weaknesses were Identified in the areas of learning.

Strengths

- Good retention rates
- Good range of provision to attract news learners.
- Good development of learners confidence and personal skills
- Very effective development of parents' confidence in supporting their children's learning

Weaknesses

- Insufficient planning to meet individual learning needs
- Limited range of Family Learning provision.

2.12 The re-inspection also found that the weaknesses that had existed in the satisfactory areas had also been removed. Furthermore they found

that the standard of learners work in all areas of learning is good and that the standard of teaching and learning has improved since the previous inspection.

2.13 Table 1 shows the comparisons in the teaching grades of the first and second inspections. As can be seen the standard of the majority of teaching is now good or very good

TABLE 1

TEACHING GRADES

	Excellent **1**	Very Good **2**	Good **3**	Satisfactory **4**	Unsatisfactory **5**	Poor **6**	Very Poor **7**
First Inspection	0	3	35	31	27	4	0
Second Inspection	0	58	25	17	0	0	0

2.14 Table 2 shows the comparisons in overall grades for the 2 inspections.

TABLE 2

	Previous Inspection	Re-inspection
Leadership and Management	4	2
Equality of Opportunity	3	2
Quality Assurance	4	3
Business Administration, Management & Professional	2	2 *
Information & Communications Technology	3	3 *
Hospitality, Sport, Leisure & Travel	3	3 *
Health, Social Care & Public Services	2	2 *
Visual & Performing Arts & Media	2	2 *
English, Languages & Communication	4	3
Foundation Programmes	5	3
Family Learning	4	3

- Not regraded

3. FINANCIAL IMPLICATIONS

3.1 As all areas of the service are now deemed to be satisfactory or better the service will not be re-inspected until the next cycle of inspections which is likely to be in approx 3 years. Further more the satisfactory nature of the inspection will ensure that the LSC will continue to fund the Adult Education Service to provide learning opportunities.

4. RECOMMENDATIONS

4.1 It is recommended that the scrutiny forum note the inspection report.

CHILDREN'S SERVICES SCRUTINY FORUM REPORT

30th August 2005

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Adult and Community Services

Subject: FUTURE FUNDING OF ADULT EDUCATION

---

1. PURPOSE OF REPORT

1.1 To update the Scrutiny forum on the possible changes to the funding from the LSC of Adult Education.

2. BACKGROUND

2.1 Since April 2001, the majority of the funding for Hartlepool Adult Education Service has been provided from the Learning and Skills Council (LSC) rather than directly by the local education authority. The service is funded through 2 funding streams from the LSC, ie (Further Education [FE] and Adult and Community Learning [ACL]). It should also be noted that a small number of Adult Education courses are funded from other sources such as European Social Fund (ESF).

2.2 The Further Education funding stream is directly related to the amount and type of approved vocational courses which are provided. This funding stream is the same as other FE providers and is not subject to the review of Adult Learning. The ACL funding stream is the main subject of this report.

2.3 Since the formation of the Learning and Skills Council funding for ACL, provision has been allocated for adult education services according to the historic funding provided by the LEA prior to the formation of the LSC in 2001. It was expected that as from August 2003 Adult and Community Learning (ACL) would be funded on a 'Formula Funded' basis, however this has been postponed and it is now likely that a new funding methodology will be in place in August 2006.

2.4 In the Spring of 2005 the LSC proposed changes to the funding methodology ACL provision.

2.5 All learning activities funded through ACL will be categorised in 1 of 6 types. These 6 types and their definitions are shown in Appendix 1

2.6 Under the new proposals the categories could be funded at different levels. At present it is thought that the first 4 categories will be funded by a similar formula to the FE strand. The other 2 categories would need to be funded under a 'guarantee' of funding.

2.7 The figure for the guarantee of funding would be disaggregated nationally and will be based on the adult population of the authority. It may also include allowances for local disadvantage.

2.8 In order to determine the level of provision which would need to be covered by the 'guarantee' of funding, each LEA was asked, in Autumn 2004, to carry out a segmentation exercise to determine how much of its provision fell into each of the 6 categories.

The results for Hartlepool are shown in Appendix 2 .

The analysis shows that in academic year 2003/04, 32% of course hours were delivered in categories 5 and 6, with 28% of the total expenditure.

2.9 A similar exercise is being carried out by the service for the academic year 2004/05, but as yet the final figures are not available.

3. FINANCIAL IMPLICATIONS

3.1 At present it is difficult to predict the effect of any future funding. It is believed that the service is in line with national averages for the percentage of provision to be covered by the ACL guarantee

4. RECOMMENDATIONS

4.1 It is recommended that the scrutiny forum note the report.

APPENDIX 1

Descriptor	Definition
First steps	Learning which is offered as an initial entry point into learning, and from which learners are actively encouraged to progress to other forms of learning.
Skills for Life - and embedded basic skills	Learning for which, whatever the title of the course, the primary intention is to improve the basic skills of literacy, numeracy and/or English Language for speakers of other language.
Skills for Independent Living	Learning which develops the knowledge, skills and understanding of adults with learning difficulties and/or physical and sensory disabilities for independent living in the community or which supports adults recovering from mental illness to re-engage in learning.
Skills for Work	Learning which enables people to develop the skills they need for paid or voluntary work and which will enhance their employability.
Learning for personal development and well being	Learning for personal development, cultural enrichment, intellectual stimulation and for enjoyment and for which there is no requirement that learners must necessarily progress to other learning.
Learning for Active Citizenship and/or Community Development	Community based learning developed with local residents and others to build the skills, knowledge and understanding for community participation and involvement, including those required for social and community action.

APPENDIX B
4.1

SEGMENTATION EXERCISE: Autumn 2004 **Local Authority:** Hartlepool Adult Education

Descriptor	Definition	Course hours	Learners	Enrolments		Relative Total Expenditure	Relative Fee income if possible
		%	%	%		%	%
First steps	*Learning which is offered as an initial entry point into learning, and from which learners are actively encouraged to progress to other forms of learning.*	48%		52%		54%	37%
Skills for Life - and embedded basic skills	*Learning for which, whatever the title of the course, the primary intention is to improve the basic skills of literacy, numeracy and/or English Language for speakers of other language.*	3%		3%		3%	0%
Skills for Independent Living	*Learning which develops the knowledge, skills and understanding of adults with learning difficulties and/or physical and sensory disabilities for independent living in the community or which supports adults recovering from mental illness to re-engage in learning.*	16%		9%		14%	0%
Skills for Work	*Learning which enables people to develop the skills they need for paid or voluntary work and which will enhance their employability.*	1%		1%		1%	5%
Learning for personal development and well being	*Learning for personal development, cultural enrichment, intellectual stimulation and for enjoyment and for which there is no requirement that learners must necessarily progress to other learning.*	31%		34%		27%	58%
Learning for Active Citizenship and/or Community Development	*Community based learning developed with local residents and others to build the skills, knowledge and understanding for community participation and involvement, including those required for social and community action.*	1%		1%		1%	0%
Total course hours, learners and enrolments in numbers		**3998**	**1081**	**1670**			

CHILDREN'S SERVICES SCRUTINY FORUM REPORT

30th August 2005

HARTLEPOOL BOROUGH COUNCIL

Report of: The Learning and Skills Council – Senior Learning Advisor

Subject: Reforming the Funding and Planning Arrangements for First Steps and Personal and Community Development Learning for Adults

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1. **The Background**

1.1 When the Learning and Skills Council was established, a commitment was made to change the arrangements for funding adult and community learning (ACL) within two years, so that the funding system for this provision would be formula based and more closely aligned to that currently applying to further education.

1.2 Arrangements for reforming ACL funding were overtaken by the publication of the government's Skills Strategy. The Skills Strategy made provision for basic skills and Level 2 qualifications the major priorities for public funding for adults. The Skills Strategy also recognises the value of wider lifelong learning and the paper included a commitment to safeguard the availability of this type of learning. The paper identified a range of provision that would need to be secured:

1.3 *There are some with low skills who would welcome opportunities to improve their skills but would feel daunted by full qualifications. They want a "first step" on the learning ladder or opportunities to try out learning before committing themselves. Reaching such reluctant learners is an important part of achieving our aims. (4.39)*

1.4 *Others pursue learning for its own sake……there must continue to be a broad range of opportunities for those who get pleasure and personal fulfilment from learning. A civilised society should provide opportunities to enable everyone, including those who have retired, to learn for its own sake. (4.40)*

1.5 The White Paper proposed that:

Adult and Community Learning programmes will be seen as an integral part of the wider learning opportunities for the area. But to safeguard the availability of these types of learning opportunities, the Government and the LSC will

agree an overall indicative budget for the funds that should be used to support non-qualification bearing programmes. Nationally this will be based on the broad proportion of LSC funds currently spent on this kind of learning. The budget will be able to cover, for example, family learning, learning for older people, active citizenship, community development, learning through cultural activities and work with libraries, museums and art galleries. (4.42b)

2. The Descriptors

2.1 In January 2004 the LSC commissioned NIACE to develop a concise series of descriptors, which would identify the distinctive strands within adult learning provision for LSC planning and funding purposes, and which would enable the identification of provision that would be subject to the safeguard in the Skills Strategy for wider lifelong learning opportunities.

2.2 NIACE completed this work by June 2004. The product was a set of six descriptors:

First Steps Learning which is offered as an initial entry point into learning and from which learners are actively encouraged and supported to progress to other forms of learning. ***Skills for Life, and Embedded Basic Skills*** Learning for which, whatever the title of the course, the primary intention is to improve the basic skills of literacy, numeracy and/or English language for speakers of other languages.
Skills for Work
Learning which enables people to develop the skills they need for paid or voluntary work and which will enhance their employability.
Learning for Personal Development and Well Being
Learning for personal development, cultural enrichment, intellectual or creative stimulation and for enjoyment, and for which there is no requirement that learners must necessarily progress to other learning.
Learning for Active Citizenship and/or Community Development
Community based learning developed with local residents and other learners to build the skills, knowledge and understanding for social and community action.
Skills for Independent Living Learning which develops the knowledge, skills and understanding of adults with learning difficulties and disabilities for independent living in the community or which supports adults recovering from mental illness to re-engage in learning.

2.3 NIACE recommended that the safeguard should apply to two strands of this framework: Learning for Personal Development and Well Being and Learning for Active Citizenship and/or Community Development, as the other four were all legitimate calls on the LSC main funding system.

3. The Consultation

3.1 The LSC published a consultation paper on the future funding of adult learning in September 2004. The main proposals in the document were:

- To establish a safeguard for learning for personal and community development;
- To redistribute the funding available for the safeguard, based on adult population, disadvantage and area costs, to ensure a more equitable availability of provision of this kind; and
- To fund first steps learning through the existing FE funding methodology.

3.2 In the paper, An LSC Consultation on Reforming the Funding and Planning Arrangements for First Steps and Personal and Community Development Learning, the LSC proposed a distinction between First Steps Learning and Learning for Personal and Community Development.

3.3 The paper proposed that First Steps Learning should be funded as mainstream FE provision, receiving a high level of public subsidy in recognition of the potential of such provision for contributing to the achievement of the Skills Strategy Level 2 targets. It also proposed that Learning for Personal and Community Development should receive a lower level of public subsidy, with LSC funding operating more as a contribution towards the costs of making such provision, and with the expectation that locally determined fees would form a significant element in the provider's overall funding equation.

Consultation on the funding paper closed in late December 2004.

4. The Key Issues arising from the Consultation

- **Fees -** There was a general willingness to charge fees at the highest level which can be tolerated, but most providers were very clear about the negative impact once this threshold is reached, on recruitment and on the viability of community class sizes;

- **Impact on Vulnerable Learners -** The majority expressed a view that any arrangements must safeguard the use of the curriculum by adults with learning difficulties and disabilities and older learners, many of whom were not used to paying a fee for their learning;

- **Family Learning -** There was widespread concern about the negative impact of the reforms on Family Learning, and many providers described the difficulty of fitting it into the NIACE descriptors;

- **Tracking Progression Effectively -** There was widespread concern about the major difficulties of tracking and measuring progression, particularly in the light of what was identified as frequently a very long period before some learners reach a point where the NQF might accredit their learning; and

- **Developing a Credit Framework -** There was a very common view that if the NQF could be extended to incorporate pre-Entry and Entry levels, provision could be accredited via the Open College Network or other means.

5. The Next Steps and Timetable

August/September 2005:

- Share the NIACE report with local LSC colleagues and providers;

- Agree the size of the safeguard budget. Produce indicative shadow regional allocations for safeguard activity funding and obtain agreement to the redistribution process;

- Establish framework/protocol for implementing redistribution, whilst maintaining quality of provision, and minimising destabilisation for providers; and

- Incorporate the reforms within the Agenda for Change* proposals.

September/October 2005:

- On the basis of indicative shadow regional allocations, nominated regional colleagues develop an outline as to how provision will be shaped to take account of proposed increases/reductions.

November 2005:

- Local LSC to begin discussions with providers regarding safeguarded provision and indicative shadow allocations;

- Grant letter confirms LSC funds for 2006/07and LSC Annual Statement of Priorities published.

January 2006:

- Initial allocation of funds to regions;
- Regional assessment of priorities for distribution of funding; and
- Annual review of colleges and providers' development plans.

* Agenda for Change Prospectus available from 5 August 2005 at www.lsc.gov.uk

February 2006:

- Calculation of indicative allocations. Indicative allocations for 2006/07 notified to all providers, together with issues to be addressed in development plans.

March 2006:

- Discussion of indicative allocations and final adjustments.

April 2006:

- Funding allocations for 2006/07 confirmed to providers.

6. The Funding Position of Hartlepool Adult Education Services

a. The History

6.1 All Local Authorities were required to produce Revenue Outturn data for 1999/2000, which confirmed how much was spent on Adult and Community Leaning activity at that time and this was reflected in future ACL budgets. This was pre-LSC, however the amounts agreed at that time have continued to be honoured by the LSC up to 2005/2006. It is now felt that this is not the most equitable way to distribute this funding, hence the current reforms.

b. The Budgets 2005/2006

6.2 The following budgets have been agreed for 2005/2006.

ACL Budgets

Main ACL Allocation	£449,510
Neighbourhood Learning in Deprived Communities	£101,659
Family Learning	£ 37,769
Family Literacy Language and Numeracy	£77,687
Total	£666,625

Budgets have been maintained at the same rate as 2004/2005, however there has been no increase for inflation.

Further Education Budget	£310,590

6.3 This includes an increase of 1.5% on the FE budget for 2004/2005.

Additional Budgets

Neighbourhood Learning in Deprived Communities Capital	£32,865
Disability Discrimination Act Capital	£55,451
ESF Project Re-engaging Learners	£100,000
ESF Project Skills for Life	£60,000

c. The Future Funding of Hartlepool Adult Education Services

6.4 It would be unwise to guess at this stage how the Reform of First Steps and Personal and Community Development Learning for Adults will affect the amount of funding given to Hartlepool Adult Education Services. A clearer picture will be available once the National LSC and NIACE have worked together to agree the amount of safeguarded budget and shadow allocations have been distributed to the Local LSCs.

6.5 Initial findings would suggest that nationally, about two thirds of Local Authority ACL provision would fit with the two descriptors that fall within the safeguard - Learning for Personal Development and Well Being and Learning for Active Citizenship and/or Community Development. An exercise undertaken by Hartlepool Adult Education Service in Autumn 2004 showed that 32% of course hours and 28% of ACL expenditure fits within these two descriptors, considerably lower than the national figures.

6.6 The Consultation Paper on the Reform of First Steps and Personal and Community Learning for Adults suggests that, among other factors, budgets may be based on percentages of adult population. Using the electorate figures from December 2004, Hartlepool accounts for approximately 14% of the adult population of Tees Valley. The Service currently attracts 16% of the FE budget contracted to Local Authorities in the Tees Valley and 15% of the ACL budget. This would indicate that Hartlepool Adult Education Service is currently attracting an equitable proportion of funding in comparison to other Local Authority providers in the Tees Valley. However, what is not yet known is how the factors used to allocate the budgets nationally will affect regional and local budgets.

6.7 The Local LSC will be in a better position to comment on allocations to individual providers in early 2006.

Susan Ellis
August 2005