ADULT SERVICES COMMITTEE

AGENDA

Thursday 14 September 2017

at 10.00am

**in Committee Room B, Civic Centre
Hartlepool.**

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Beck, Hamilton, Hind, Loynes, McLaughlin, Richardson, and Thomas.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To receive the Minutes and Decision Record in respect of the meeting held on 27 July 2017 *(for information as previously circulated)*.

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   4.1 Savings Programme 2018/19 and 2019/20 – *Director of Adult and Community Based Services*

5. **KEY DECISIONS**

   No items.

6. **OTHER ITEMS REQUIRING DECISION**

   6.1 Director of Public Health Annual Report 2016/17 – *Interim Director of Public Health*

7. **ITEMS FOR INFORMATION**

7.1 Adult Safeguarding Performance Report – *Director of Adult and Community Based Services*

7.2 Home Care for Older People – *Director of Adult and Community Based Services*

7.3 Lifetime Homes Standards – *Director of Adult and Community Based Services*

8. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

FOR INFORMATION

Date of next meeting – Thursday 5 October 2017 at 10.00am in the Civic Centre, Hartlepool

ADULT SERVICES COMMITTEE

MINUTES AND DECISION RECORD

27 July 2017

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor: Stephen Thomas (In the Chair)

Councillors: Paul Beck, Brenda Loynes, Mike McLaughlin and Carl Richardson

Officers: Jill Harrison, Assistant Director, Adult Services
Jeanette Willis, Head of Strategic Commissioning
Garry Hutchison, Building Control Manager
Angela Armstrong, Principal Democratic Services Officer

The Chair welcomed Councillor Mike McLaughlin to the Adult Services Committee.

10. Apologies for Absence

Apologies for absence were received from Councillor Lesley Hamilton.

11. Declarations of Interest

Councillor Stephen Thomas declared a personal interest as an employee of Healthwatch.

12. Minutes of the meeting held on 22 June 2017

Received.

13. Fire Safety in Residential Care Homes (*Director of Child and Adult Services*)

Type of decision

For information.

Purpose of report

To provide information regarding the safety regulation within care homes in Hartlepool following the Grenfell Tower disaster in London.

Issue(s) for consideration

The report included a summary of the fire safety requirements within residential care homes as provided by the Council's Health and Safety Team. It was highlighted that the Care Quality Commission (CQC) were the regulator of care homes and would identify any risks to residents and take appropriate action which may be in the form of advice and guidance or enforcement action if there was potential immediate danger to residents of a home. In addition to this, the Council's Quality Standards Framework (QSF) included an assessment of Health and Safety which again encompasses fire safety. Cleveland Fire Brigade also undertake regular checks at each establishment and provide feedback on these checks but do not provide Fire Risk Assessments; this was for the provider to obtain independently as the legal responsibility for all Health and Safety measures rests with the provider of care under the CQC regulatory framework.

It was noted that in addition to fire safety checks carried out by the regulator, the Fire Service and the Council, each home also operated a system of 'Personal Evacuation Plans' (PEEPs) which were individual to each resident and identify how each resident was supported in the event of a fire. Where residents require additional support, appropriate equipment was provided in order to facilitate their safe evacuation.

In response to a question from a Member, the Head of Strategic Commissioning confirmed that PEEPs would identify any additional equipment or assistive technology required for an individual's evacuation. A Member sought clarification on the reference to a competent person undertaking a suitable and sufficient fire risk assessment. The Head of Strategic Commission provided more detail around PEEPs which were developed around individuals' needs and the Chair requested further information be circulated to Members on the staffing levels, induction of staff and training in place in relation to PEEPs (including the provision of specialist equipment), training in relation to the undertaking of fire risk assessments and the measures in place to ensure all evacuation procedures were robust. A Member highlighted the need for additional training around events that were held within residential care homes that were outside the day to day operation of the home.

The Assistant Director, Adult Services reassured Members that the CQC take an extremely robust approach to managing any concerns in relation to health and safety and fire and as part of their regulatory work would request to see that appropriate policies and procedures were in place, appropriate staff training was undertaken on a regular basis and that all evacuation procedures were effective.

A Member questioned why buildings do not appear to have external fire escapes any more. The Building Control Manager commented that the Building Regulations always look at whether buildings had adequate stair cases for means of escape, travel distances to that means of escape and

the number of people likely to be in a building and the majority of buildings now were constructed with internal means of escape.

Decision

(1) The report was noted.
(2) That further information on the staffing levels, induction and training of staff in relation to PEEPs (including the provision of specialist equipment), frequency of fire drills, training in relation to the undertaking of fire risk assessments and the measures in place to ensure all evacuation procedures were robust be circulated to Members before the next meeting of the Committee.

14. Care Quality Commission State of Care Report and Consultation: Next Phase of Regulation (*Director of Child and Adult Services)*

Type of decision

Non key.

Purpose of report

To provide the Adult Services Committee with information regarding the Care Quality Commission's consultation on the next phase of regulation and to give the Committee an opportunity to inform the Council's response to this consultation which was attached at Appendix 1.

Issue(s) for consideration

The background to the publication of the Care Quality Commission's Strategy for 2016 to 2021: Shaping the Future was provided in the report. An outline of the response to the first round of consultation was included in the report with the full response being available on www.cqc.org.uk/nextphase1. In addition to this, the CQC had published a report which was attached at Appendix 2.

Alongside this report, a second stage of consultation was launched on 12 June 107 which will run until 8 August 2017 and the consultation document was attached at Appendix 3. An element of the consultation related specifically to adult social care services and the CQC had found the quality of care in adult social care services to be variable. The CQC proposed a targeted approach to regulate adult social care services and these proposals were detailed in the report. Members' views were sought on the draft response to the consultation which was attached at Appendix 1. Members were informed that the consultation had also been shared with the Audit and Governance Committee in relation to the regulation of health services. In addition, questions 6-10 relate to the regulation of primary medical services and were therefore not included in the draft response in respect of adult services.

Members were supportive of the draft response attached at Appendix 1

and pleased to see that this type of review was undertaken regularly as social care changes on a frequent basis, particularly in view of the transforming care agenda and the importance of local authority input into these reviews was emphasised.

The Chair requested that once the outcome of the consultation was known, a representative from the Northern Regional Care Quality Commission be invited to a meeting of the Adult Services Committee to present the outcomes and how they would be incorporated into the future inspection regime.

Decision

(1) The draft response attached at Appendix 1 was approved for submission as the final response on behalf of Hartlepool Borough Council to the Care Quality Commission.
(2) That once the outcome of the consultation was available, a representative of the Northern Regional Care Quality Commission be invited to a meeting of the Adult Services Committee to present the outcomes and how they would be incorporated into the future CQC inspection regime.

15. Transport for People with a Disability – Action Plan Update (*Director of Child and Adult Services*)

Type of decision

Non key.

Purpose of report

To provide an update on the Action Plan that was developed in response to the recommendations of the Audit and Governance Committee investigation into Access to Transport for People with a Disability.

Issue(s) for consideration

Members were asked to review the updated action plan which was attached at Appendix 1 and note the additional information from Hartlepool and Stockton on Tees Clinical Commissioning Group (HaST CCG) regarding Patient Transport Services attached at Appendix 2.

The Assistant Director, Adult Services confirmed that there had been a positive development with the establishment of a new Dial-a-Ride service. In addition to this, the transport arrangements for people with a disability had recently been reviewed and consolidated in view of the facilities available at the new Centre for Independent Living in Burbank Street. It was noted that whilst the recent bid for lottery funding for the provision of transport for people with a disability was not successful, there had been positive development with the recruitment of volunteer drivers. Appendix 2 summarised the provision available via the CCG to assist people attending health appointments.

The private provider of the new Dial-a-Ride service was in attendance and gave a brief overview of the service provided and the associated costs for the users.

At this point in the meeting, Councillor Paul Beck declared a non-prejudicial interest in this item.

During the discussion that followed Members were pleased to see the development of the new Dial-a-Ride service and suggested for publicity be undertaken on this service provision to raise awareness potentially in the Council's quarterly publication Hartbeat.

The Chair referred to the ongoing work in relation to the Health and Wellbeing Strategy which included transport issues and suggested that the action plan attached at Appendix 1 be forwarded to the Interim Director of Public Health to inform the development of the Strategy as well as being used to inform the ongoing work in relation to social isolation. It was highlighted that access to transport continued to be an issue for certain communities across the Town particularly in the Burbank area and it was suggested that pressure be placed on transport providers to explore the potential of operating a bus service through this area. It was suggested that the Passenger Transport Services Team Leader who was the co-ordinator of the Council's Transport Forum be invited to a future meeting of the Committee to discuss the issues around social isolation.

The Chair requested that a report be submitted to a future meeting of the Committee examining the needs of older people, people with disabilities including learning disabilities and how the ongoing workstreams about transport support these needs and identify and shortfalls that may exist and proposals to deal with those shortfalls.

Decision

(1) The progress made on the Action Plan over the last six months was noted.
(2) That the Action Plan be forwarded to the Interim Director of Public Health to inform the development of the Health and Wellbeing Strategy.
(3) That the Passenger Transport Services Team Leader be invited to a future meeting of the Committee and the Action Plan be revisited as part of the ongoing work in relation to social isolation.
(4) That the Committee continue to be updated on the development of the action plan, in particular in relation to examining the needs of older people, people with disabilities including learning disabilities and how the ongoing workstreams about transport support these needs and identify any shortfalls that may exist and proposals to deal with those shortfalls.

16. Commissioning Award for Integrated Approach to Hospital Discharge (*Director of Child and Adult Services*)

Type of decision

For information.

Purpose of report

To notify the Committee that the work that has been done locally to improve the hospital discharge process has been recognised in the North East, Cumbria, Yorkshire and Humber Commissioning Awards, winning the award for the Best Innovation Project.

Issue(s) for consideration

As reported previously to Committee, a significant amount of work had been undertaken locally to improve the experience of people who were being discharged from hospital and a number of factors that contributed to this improvement in performance were noted in the report. The report provided a detailed update on the current position in relation to work that had been undertaken to develop an Integrated Approach to Discharge from Hospital. Staff representing the partner organisations attended an award ceremony in Newcastle and were delighted to accept the award on behalf of all involved in the development of this approach. Everyone involved in the successful implementation of this integrated approach to hospital discharges was congratulated on all their hard work and determination to ensure it was a success.

In response to a question from the Chair, the Assistant Director, Adult Services confirmed that the Integrated Discharge Team worked across the North Tees and Hartlepool Trust area and work was ongoing with the authorities across the South Tees area to look at improving the service at James Cook University Hospital.

Decision

(1) It was noted that the hard work and commitment to improve hospital discharge had been recognised through this Award.
(2) The Committee continued to support initiatives that reduce delayed transfers of care and improve outcomes for people using services.

17. Care Quality Commission: Appreciate Review Programme (*Director of Child and Adult Services*)

Type of decision

For information.

Purpose of report

To provide information regarding the Care Quality Commission's programme of appreciative reviews in 2017/18 and Hartlepool Borough Council's involvement in the programme.

Issue(s) for consideration

The background to the announcement of additional funding for social care and the work undertaken nationally to develop performance measures associated with this allocation was provided in the report. A notification was received on 4 July 2017 advising that Hartlepool Borough Council had been identified as one of the first twelve Councils to be reviewed. It was anticipated that the reviews would take place between August and November 2017 with a six week preparation phase included. During the site visit, inspectors will meet with a range of people including commissioners, providers, frontline staff, people who use services and carers, local Healthwatch organisations and third sector organisations. In addition, they will review some cases and meet with senior leaders from across health and social care organisations within the locality. It was expected that following completion of the site visit, a summit with key partners will be held with feedback to be provided in writing to the Chair of the Health and Wellbeing Board with a report published nationally upon the completion of all the reviews.

The Assistant Director, Adult Services indicated that further updates would be brought to Committee as and when they were available. The Chair suggested that any update available before the next meeting of the Committee be forwarded to Members direct.

Decision

It was noted that the CQC will be undertaking a programme of appreciative reviews in 2017/18 and that Hartlepool Borough Council had been identified as one of the first twelve Councils to be reviewed. The outcome will be reported to the Adult Services Committee at the earliest opportunity following completion of the review.

18. Any Other Items which the Chairman Considers are Urgent

None.

The meeting concluded at 11.15 am

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 2 AUGUST 2017

ADULT SERVICES COMMITTEE

14 September 2017

Report of: Director of Adults and Community Based Services

Subject: SAVINGS PROGRAMME 2018/19 AND 2019/20

1.0 TYPE OF DECISION/APPLICABLE CATEGORY

1.1 Budget and Policy Framework.

2.0 PURPOSE OF REPORT

2.1 The purpose of this report is to enable Members to consider proposals to achieve further savings in 2018/19 and 2019/20.

3.0 BACKGROUND

3.1 A comprehensive report on the "Council Plan and Medium Term Financial Strategy – Capital and Revenue" was considered at the Finance and Policy Committee on 2 December 2016. The report stated that despite the impact of continuing austerity and cuts in Government funding the Council needs to remain ambitious for the town.

3.2 The Council Plan 2017 to 2020 sets out the priorities we are committed to delivering and is based around six strategic priorities:

- Growing our economy, jobs and skills;
- Regenerating our town;
- Developing and promoting Hartlepool as a great place to live;
- Developing new services for people and communities;
- Building better beginnings and futures for our children and young people;
- Providing effective leadership based upon innovation and efficiency.

3.3 A report to Council on 23 February 2017 approved the Medium Term Financial Strategy (MTFS) 2017/18 to 2019/20. The multi-year MTFS enabled a balanced budget be set for 2017/18. It also approved savings of £1.685m in 2018/19 and £0.785m in 2019/20 to begin to reduce the budget deficits in these years

3.4 However, the savings proposals approved for 2018/19 and 2019/20 did not address the full deficits and savings of £2.320m still need to be identified. This deficit is after reflecting forecast increases in Council Tax income and the use of the Budget Support Fund, as summarised below:

Summary of measures to reduce 2018/19 and 2019/20 gross budget deficits

	2018/19 £'m	2019/20 £'m	Total 2018/19 and 2019/20 £'m
Gross Deficit	**7.314**	**3.758**	**11.072**
Less - Social Care Precept (3% 2018/19, 0% 2019/20)	(1.093)	0	(1.093)
Less - Council Tax increase 1.9%	(0.692)	(0.740)	(1.432)
Less - Growth in Council Tax base (742 Band D equivalent properties over the period 2018/19 and 2019/20)	(0.574)	(0.478)	(1.052)
Sub Total – Deficit after Council Tax increases and forecast housing growth	**4.955**	**2.540**	**7.495**
Less – Use of Budget Support Fund	(2.448)	(0.257)	(2.705)
Less – Savings approved February 2017	(1.685)	(0.785)	(2.470)
Cuts still to be identified	**0.822**	**1.498**	**2.320**

3.5 An update of the MTFS was considered by Finance and Policy Committee on 24 July 2017 and this confirmed the financial forecasts detailed in the previous paragraph. The update report also highlighted the continuing financial risks facing local authorities over the next few years. This underlines the importance of ensuring the Council sets balanced budgets for 2018/19 and 2019/20. For 2019/20 this needs to be based on minimising the use of one off funding to avoid deferring a budget deficit to 2020/21.

3.6 The MTFS forecasts are currently based on the Government's 1% pay cap remaining in place for 2018/19 and 2019/20. If actual pay awards are greater than 1% and the Government does not provide additional funding, the budget deficit will increase. Each additional 1% equates to an increase in the budget deficit of approximately £400,000.

3.7 The financial position facing the public sector for 2020/21 and future years is extremely uncertain and will depend on the state of the economy, including the impact of Brexit, policies adopted at a national level in relation to the overall size of the public sector and the level of national debt.

3.8 For Local Authorities, policies implemented by the national Government will have a significant impact and cover the following key issues:

- **100% Business Rates Retention** - the exclusion of a bill to move from 50% to 100% Business Rates Retention creates significant financial uncertainty regarding future funding arrangements for local authorities;

- **Business Rates indexation** - confirmation by the Treasury at the end of July 2017 that Business Rates indexation will switch from RPI (Retail Prices Index) to CPI (Consumer Prices index) from 2020 will be welcomed by the businesses. However, from local government's perspective this change will result in lower annual increases in this income stream, which will not keep pace with increases in the cost of delivering existing services.

- **Reform of the Local Government funding system** - the Government has indicated that work is continuing on a 'Fair Funding' review and they will be consulting on proposals during 2017. However, without 100% Business Rates Retention it is unclear how any changes will be funded. The Department for Communities and Local Government has recently indicated that this may not be implemented until 2020/21. Based on our current understanding of the significant work which needs to be completed before the Government can consult on detailed proposals the suggestion that any changes will be delayed until 2020/21 seems realistic;

- **Adult Social Care funding** - the significant financial challenges in this area were recognised by the Government prior to the General Election and short term funding has been provided. The Government has indicated they will be consulting on a number of options regarding the long term funding arrangements in due course;

- **Children's Social Care funding** - many councils, including Hartlepool, are experiencing significant financial pressures in this area. The Local Government Association (LGA) has recently issued a report warning of the significant financial challenges facing children's social care services. The LGA report shows that three quarter of English councils exceeded their budget for children's services last year, totalling a £605m overspend. The LGA forecast a £2 billion funding gap by 2020. This issue has not yet been recognised by the Government providing increased funding;

- **National Council Tax policy** - following a policy of encouraging Council Tax freezes for five years there was a significant shift in Government policy when they introduction of the Adult Social Care precept for the period 2016/17 to 2019/20. Government Council Tax policy for 2020/21 and future years will have a significant impact on the financial sustainability of councils.

- **Public Sector pay levels and funding arrangements** - public sector pay has been subject to a prolonged period of restraint and the Government had previously indicated that a 1% Public Sector pay cap would continue for 2018/19 and 2019/20. However, there have been increasing calls on the Government to remove the pay cap and to fund higher pay increases. If, or when, the Government remove the pay cap there will be significant financial pressures if additional Government funding is not provided for public sector organisations, including councils.

3.9 A further update report was considered by Finance and Policy Committee on 18 September 2017 and detailed corporate savings which can be achieved in 2018/19 and 2019/20 to reduce the savings still to be identified from £2.320m to £1.641m. As these measures are front loaded this provides a slightly longer lead time to implement additional savings and the revised deficits for these years are as follows:

	2018/19 £'000	2019/20 £'000	Total £'000
Savings still to be identified	822	1,498	2,320
Less Corporate savings/updated planning assumptions	(544)	(135)	(679)
Revised Savings still to be identified	278	1,363	1,641

3.10 Additional savings proposals to be considered by individual Policy Committees in September 2017 are designed to address the remaining 2018/19 deficit of £278,000. Proposals to address the remaining forecast 2019/20 deficit will be developed during 2017/18 and will be reported to future meetings.

4.0 SAVINGS PROPOSALS 2018/19 AND 2019/20 – INCLUDING FINANCIAL CONSIDERATIONS

4.1 The 2018/19 and 2019/20 savings proposals approved in February 2017 are summarised below:

Adult Services Committee	**Approved Savings 2018/19 £'000**	**Approved Savings 2019/20 £'000**	**Total Approved Savings £'000**
Review of Prevention and Housing Related Support (Adult Services)	150	0	150
Total Adult Services Committee:	**150**	**0**	**150**

4.2 The 2018/19 approved saving of £150,000 represents the full year effect of a part year saving in 2017/18. This relates to the review of preventative services and housing related support within adult services which realised a part year saving in 2017/18 of £150,000 with the full year effect of £300,000 being achieved in 2018/19.

4.3 In 2018/19 and 2019/20 work is also being undertaken within Adult Services to manage pressures through demand management. There are pressures identified in a number of areas including; transition of complex cases from Children's Services to Adult Services; increased demand within adult mental health services and a recurrent financial pressure in relation to Deprivation of Liberty Safeguards.

4.4 While managing pressures is very challenging in the context of an ageing population and growing demand in some areas, there are early indications that the approach outlined in the Savings Report to Adult Services Committee in December 2016 is starting to have a positive impact. Initiatives that are contributing to the management of demand include:

- Better Care Fund developments targeted at admission avoidance;
- Changes to the Resource Allocation System;
- Implementation of the Adult Resource Panel, and
- A revised approach to managing contingencies within Direct Payments.

4.5 In addition to the proposals outlined above, the following additional savings that will have an impact on Adult Services are recommended for implementation over the next two years. A number of these savings are managed across Adult Services and Children's Services and have not been apportioned to individual service areas. Part of these savings needs to be earmarked to fund departmental budget pressures. As summarised in the following table the impact of these savings and pressures is a net saving towards the remaining budget deficit for 2018/19:

	Pressure /(saving) 2018/19 £'000
Additional savings	
(i) Departmental Salary Abatement target An overall increase of £100,000 can be included in the base budget to reflect turnover of staff and incremental progression. This is a target that is managed across Children's Services and Adult Services with £92,000 contributing to the 2018/19 savings target for Children's Services.	(8)
(ii) Income Generation Increase room hire and conference income at the two venues managed across Adult Services and Children's Services - CIL and CETL.	(50)
Additional savings towards remaining budget deficit	(58)

5. RISK IMPLICATIONS

5.1 There are a number of risks implicit in the delivery of any package of savings and it is important to recognise these as part of any decision making. The primary risk relates to maintaining capacity to deliver the front line services and support to the Council/departments.

5.2 It is considered that the proposed 2017/18 savings can be delivered, although not without difficulty or some degree of risk. This can be managed in the coming year; however achieving these savings becomes more difficult each year.

5.3 There are risks associated with increasing the departmental salary abatement target as vacancies may not arise during the year or may be filled immediately and staff may move through the pay grades and reach the top of pay scale quicker than anticipated i.e. qualifications and experience based progression for Social Workers and Social Care Officers.

5.4 There are significant risks associated with achieving savings to manage pressures through demand management. Given the increasing demographic pressures from an ageing population and increasing numbers of adults with complex physical or learning disabilities there is a significant risk that demand will not reduce and may in fact increase. There are also risks that the cost of commissioning services to meet eligible assessed needs increases further linked work that is underway nationally in terms of fair cost of care for residential and domiciliary care. This may result in increased costs for services, even if demand can be constrained or reduced.

5.5 Sustainability beyond 2018/19 will require careful management and if the proposed approach does not deliver the savings required on a sustainable basis, alternative savings proposals will need to be identified.

6. EQUALITY AND DIVERSITY CONSIDERATIONS

6.1 By definition, all savings proposals within adult services will affect people who access adult services, including some of the most vulnerable groups within the local population. This includes all those who are over eighteen and assessed as having eligible needs (older people, people with learning disabilities, sensory loss or a physical disability, people with mental health

needs, people who have alcohol dependency or substance misuse issues and carers).

6.2 An assessment has indicated that none of the current proposals require an Equality Impact Assessment as the proposals will have limited impact on people accessing services and no disproportionate impact on people who share protected characteristics.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations identified.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no child and family poverty considerations identified.

9. STAFF CONSIDERATIONS

9.1 Staffing implications associated with the savings proposals considered by individual Policy Committees will be managed at a corporate level by the Finance and Policy Committee. This approach will seek to maximise staffing reductions which can be achieved by managing vacancies and accepting requests for voluntary redundancies, where this can be achieved within the requirements of the service. Where compulsory redundancies cannot be avoided the corporate approach will seek to maximise redeployment opportunities.

9.2 There are no staffing implications associated with savings proposals for Adult Services in 2018/19.

10. ASSET MANAGEMENT CONSIDERATIONS

10.1 There are no asset management considerations identified.

11. CONSULTATION

11.1 The majority of the approved savings for 2018/19 and 2019/20 were subject to consultation as part of the 2017/18 budget process. Where these proposals have changed significantly they will be subject to separate consultation alongside any additional savings proposed for 2018/19 and 2019/20. This consultation will include Trade Unions and individual staff groups affected by the proposals.

12. CONCLUSION

12.1 The Council approved a multi-year financial strategy in February 2017, which included the phased use of reserves to help manage budget reduction over the period 2017/18 to 2019/20. The strategy also approved savings for implementation in 2018/19 and 2019/20 to begin to address the budget deficits for these years.

12.2 The proposals in this report details changes to the approved 2018/19 and 2019/20 savings to reflect changes in circumstances since February. In addition, further savings proposals are outlined to address departmental pressures and to make a contribution towards addressing the remaining 2018/19 and 2019/20 budget shortfalls.

12.3 At a corporate level the proposal identified for individual Policy Committees will enable a balanced budget to be set for 2018/19. The position for 2019/20 is less positive and a significant budget deficit remains. Proposals for addressing the remaining 2019/20 of £1.363m will be developed during 2017/18.

12.4 Achievement of further savings for 2019/20 will be challenging and will require further changes, whilst ensuring services are maintained as far as practical, or the implications of reducing capacity are reflected in service requirements.

12.5 There are a number of risks which may increase the 2019/20 deficit, including the funding arrangements for Children's Services and the actual level of pay awards. These issues will be kept under review and details of any changes will be reported to future meetings.

12.6 The multi-year strategy being adopted by the Council is designed to manage the impact of continuing cuts in Government funding on a phased basis to minimise, as far as is possible within the reduced resources available to the Council, the impact on services and jobs. The strategy also aims to ensure the Council is in the best possible financial position to manage the challenges and uncertainty facing councils in 2020/21 and future years.

12.7 The achievement of further savings in Adult Services is challenging due to known pressures, potential pressures that are not yet quantified and the demand led nature of the service area. The proposals set out in this report to achieve a previously approved saving of £150,000 and further savings towards the remaining budget deficit for 2018/19 are based on further efficiencies and service reviews, with an expectation that service delivery can be transformed in 2018/19 and 2019/20 to manage pressures.

13. RECOMMENDATIONS

13.1 It is recommended that Members of the Committee note the content of the report and formulate a response to be presented to Finance and Policy Committee on 20 November 2017.

14. REASON FOR RECOMMENDATIONS

14.1 The proposals included in this report have been identified as being sustainable and deliverable.

15. BACKGROUND PAPERS

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

Council
Medium Term Financial Strategy 2017/18 to 2019/20 - 25 February 2017

Finance and Policy Committee
Medium Term Financial Strategy 2018/19 to 2019/20 - 24 July 2017

16. CONTACT OFFICER

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Adult Services Committee

14th SEPTEMBER 2017

Report of: Interim Director of Public Health

Subject: DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2016/17

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1. TYPE OF DECISION/APPLICABLE CATEGORY

For information only.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to present for information to Adult Services Committee the final version of the Director of Public Health Annual Report for 2016/17. The final report including updated ward profiles for elected members will be presented to full Council on 28th September 2017

3. BACKGROUND

3.1 The requirement for the Director of Public Health to write an Annual Report on the health status of the town and the Local Authority duty to publish it is specified in the Health and Social Care Act 2012.

3.2 Director of Public Health Annual Reports are not a new requirement, as prior to 2012, Directors of Public Health in the National Health Service (NHS) were expected to produce annual reports.

3.4 Historically, the equivalent of the Director of Public Health Annual Report was produced by the Local Authority Medical Officer of Health.

4. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT - PROPOSALS

4.1 The 2016/17 Report focuses on 'ageing well' in Hartlepool, highlighting the excellent services, good practice and partnership working taking place across the Borough in order to sustain and improve the physical and mental wellbeing of older people.

4.2 Previous reports have focused on how public health priorities have changed over the past 40 years (2013/14 report), the importance of how work and employment influence health and wellbeing (2014/15) and 'understanding need' (2015/16), utilising info graphics around the themes of the Joint

Strategic Needs Assessment (JSNA), so it was felt that a focus on older people's wellbeing represents a logical progression and addresses an important gap by highlighting some of the excellent work in this area.

4.3 The 2016/17 report is split into four key themes relating to the services and projects that improve health and wellbeing and support the population of Hartlepool to 'age well':

1. Promoting social inclusion
2. Improving health and wellbeing
3. Promoting independence, and
4. Practical support services

4.4 The report also highlights some of the key public health indicators and statistics around the older people's agenda, demonstrating where good progress and improvements have been made, but also where further effort is required for Hartlepool to move closer to its neighbouring Authorities or the rest of England in order to reduce widening health inequalities.

4.5 The latter part of the report highlights some 'top tips' and useful contacts, which will be of interest and practical use to the target population, and to partners and stake holders and concludes with some next steps and future plans around this important agenda, linking to key projects such as the Better Care Fund and Community Hubs.

4.6 As in previous years, the final report to full Council will be accompanied by a revised set of 'Ward Profiles' for Elected Members, which will highlight the key public health issues in a given area with a specific focus on the theme of the report i.e. older people's health and wellbeing, and enable comparison of these statistics across each ward and help Elected Members to prioritise which issues to tackle in their local constituencies.

5. RISK IMPLICATIONS

5.1 It is a mandated responsibility for Directors of Public Health in Local Authorities to publish an annual report on the health of their population.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial issues associated with the development and publication of the report.

7. LEGAL CONSIDERATIONS

7.1 There are no legal implications arising from this report. It is a statutory requirement.

8. CONSULTATION

8.1 There was no consultation required for this report.

9. CHILD AND FAMILY POVERTY (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

9.1 There are no Child and Family Poverty issues arising from this report.

10. EQUALITY AND DIVERSITY CONSIDERATIONS (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

10.1 There are no equality and diversity issues arising from this report.

11. STAFF CONSIDERATIONS

11.1 There are no staffing implications arising from this report.

12. ASSET MANAGEMENT CONSIDERATIONS

12.1 There is no impact on asset management.

13. RECOMMENDATIONS

13.1 Adult Services Committee note the final report and agree it can be taken to the wider committees and full Council.

14. REASONS FOR RECOMMENDATIONS

14.1 Ensures compliance with the statutory duties under the Health and Social Care Act 2012 for the Director of Public Health to produce a report and the Local Authority to publish it

15. BACKGROUND PAPERS

15.1 There are no background papers to this report.

16. CONTACT OFFICER

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HARTLEPOOL
BOROUGH COUNCIL

Director of Public Health

Annual Report 2016/17

Ageing well in Hartlepool

Contents

Foreword

I am delighted to introduce my first Director of Public Health Report since joining Hartlepool Borough Council in January 2017. This will be the fourth Annual Report produced by the Borough Council since responsibility for Public Health transferred from the NHS in 2013. The first three Reports focused on how public health priorities have changed over the last half a century, the importance of work and employment in influencing health and well-being and finally how we might understand the changing needs of the population over a number of years.

However, I think the time is right to adopt a different approach so over the next few years the emphasis will be on 'Starting Well' (Children and Young People), 'Working Well' (Working Age Adults irrespective of their employment status) and 'Ageing Well' (Older People). This 2016/17 Annual Report - the first in that series - focuses on a key issue that is challenging local authorities, the NHS and other agencies across the country, which is about the demographic challenges of an ageing population. This Report therefore examines, through a series of case studies and reports, how well we are working with key stakeholders, partner organisations, communities and residents to promote better health and well-being of some of our older residents and I have called the Report "Ageing Well in Hartlepool".

There is a statutory responsibility on Hartlepool Borough Council and Hartlepool & Stockton Clinical Commissioning Group to understand the composition of the local population and assess its needs by producing a Joint Strategic Needs Assessment (JSNA). The JSNA is then used to develop the Health and Well-being Strategy for the Borough and to help shape the services we commission and provide. We know from the JSNA that the population aged 65 and older was 17,300 in 2015, will be 18,800 in 2020 and will have risen to 20,900 by 2025. Similarly, the population aged 85 and over will rise from 2,100 in 2015 to 2,700 in 2020 and then to 3,300 by 2025. Therefore, by 2025, over a quarter of the local population will be over 65 years of age.

The two key issues are to promote social inclusion and independence so as to reduce the risk of isolation, ill health and dependency so that older people remain a valuable and valued part of our communities. They have a wealth of experience, skills, knowledge and often time that need to be encouraged, fostered and utilised to keep them as fit and healthy as possible and to encourage and help others to do so too. The Report examines how older people are encouraged and supported to seek help, to help themselves and indeed to provide help to other people. It also looks at how practical support can be provided to older people as their needs and circumstances change.

I hope you enjoy reading this Report and hope that it may stimulate you to think of different ways in which we can champion the experience and wisdom of our older residents and how we can encourage and help them to play a major role in the day to day life of our Borough and enhance their own health and well-being by doing so.

Finally, I would like to acknowledge the enormous contribution my predecessor, Louise Wallace, made to Hartlepool as Director of Public Health from 2013-2017 and as part of the Tees Public Health Team for many years before that. She was hugely respected by all her colleagues and we wish her well in her new role in North Yorkshire.

Paul Edmondson-Jones
Director of Public Health Hartlepool Borough Council.

SECTION 1
Promoting Social Inclusion

KEY PROJECTS

3Fs Group (Fun, Food and Friendship)

The 3Fs luncheon club at Cafe 177, York Road provides residents with the opportunity to come along and meet new friends whilst enjoying a free, wholesome and healthy two course meal. We offer a warm welcome, relaxing activities and the chance to chat with our registered Nurse. Members are welcome to attend every week and forge new friendships that will hopefully last for many years to come. The group is aimed at adults aged 55 and over who:

- have been recently discharged from hospital
- have any form of memory loss or
- who are vulnerable due to loneliness

For further details visit www.hartlepoolfamiliesfirst.org.uk or tel 01429 867 016.

Hartlepool Men's Shed

What is Hartlepool Men's Shed? It's a place for males to make and mend things, a larger version of your typical garden shed! But they are much more than that. They are equally about reducing isolation, helping people to make friends and improving health and well-being. Sheds are fine places to share a problem – hence the suggestion men prefer to talk 'shoulder to shoulder'. Men's Sheds originated in the 1990's in Australia, where there are now over 500. Hartlepool Men's Shed is aimed at all males living in the Borough and features a workshop environment where men can `make and mend` things of their choosing, for themselves or the wider community. It is open, Tuesdays and Thursdays (10am – 3pm) on Osborne Road, TS26 9EW. For further details visit www.hartlepoolmensshed.co.uk

Hartlepool Armed Forces Covenant

In 2012, Hartlepool Borough Council welcomed the opportunity to sign the North East Armed Forces Community Charter, supporting partnership working between local Armed Forces and civilian communities across the North East to provide improved services for service personnel and their families.

Building on this Charter, 2012 also saw the establishment of Hartlepool's own Armed Forces Community Covenant with clear objectives and measures to encourage support from the Armed Forces Community in the town. One of these measures was the appointment of an Armed Forces Champion and as a result, significant progress has been made against the top five policy changes identified by the Royal British Legion:

85
children from armed forces families in school within Hartlepool

723
patients with veteran status or military history recorded within GP clinical records (Hartlepool and Stockton CCG)

5
servicemen or women and their families have been housed in Hartlepool through Government-sponsored affordable housing schemes since the introduction of the Armed Forces Covenant

Policy Change One

In line with The Housing Act 1996 (Additional Preference for Armed Forces) (England) Regulations 2012, the Council's Allocations Policy has been reviewed, with preference for Armed Forces Personnel. The Allocations Policy also awards the highest priority for people leaving HM Armed Forces.

Policy Change Two

Hartlepool Borough Council now fully disregards War Pensions Scheme and Armed Forces Compensation Scheme payments from calculations in relation to Housing Benefit and Local Council Tax Support Awards.

Policy Change Three

Disabled Facilities Grant (DFG) applications are prioritised where the disability is as a result of service in the Armed Forces.

Policy Change Four

The needs of the Armed Forces community are considered as part of the Council's Joint Strategic Needs Assessment and Equality Impact Assessments. 'Ex-forces Personnel' is now a key theme within our Joint Strategic Needs Assessment.

Policy Change Five

Service children are prioritised for in year admission, in accordance with the School Admissions Code 2012.

Hartlepool are also active participants in bi-monthly meetings of the Armed Forces Forum which facilitates partnership working, and information sharing, between the five Tees Valley Local Authorities, Army, Veterans Support Agency, Military Charity and organisations responsible for Housing, Health, Employment and Training. This has helped to improve working relationships and links with Armed Forces Associations across Hartlepool and the north east region, including the North East Reserve Army Cadets Association.

35.5%
of pensioners in Hartlepool live alone (compared to 31.5% nationally)

10.8%
of people provide over 1 hour of unpaid care per week (10.2% nationally)

3.3%
provide over 50 hours of unpaid care per week (2.4% nationally)

23
excess winter deaths across all ages from 2012-2015 (compared to 19.6 nationally)

Ricochet and Project 65 'Improving social inclusion through technology

Services are aimed at people aged over 65 in Hartlepool and provide a mobile device loan service to enable people to access Information, Advice and Guidance whilst reducing social isolation. 'In Your Dreams' is a separate project using digital technology to reignite memories with people living with Dementia. For further details visit www.incontrol-able.co.uk/ or tel 01429 401 742.

SECTION 2
Improving Health and Wellbeing

KEY PROJECTS

Food Hygiene and Health & Safety interventions in care settings

Environmental Health Officers (EHOs) and Food Technical Officers advise care providers on the management of food safety, including hygiene, kitchen design, pest control and waste disposal. Their duties include the inspection of food premises, as well as enforcing the provisions of the UK laws and the EU food hygiene legislation.

Every care home is given a hygiene rating when it is inspected and this considers:

- How hygienically the food is handled – how it is prepared, cooked, re-heated, cooled and stored
- The condition of the structure of the buildings – the cleanliness, layout, lighting, ventilation and other facilities
- How the business manages and records what it does to make sure food is safe

At the end of the inspection, the business is given one of the six ratings from 0-5. The top rating of '5' means that the business was found to have 'very good' hygiene standards. These ratings are published online at www.food.gov.uk/ratings. In addition, officers will ensure that the composition of the food and labelling meets legal requirements.

Officers also investigate complaints about food and collaborate with the local Public Health England Health Protection Unit in the investigation of outbreaks, particularly of food or water-borne illness. EHOs will provide advice and carry out interventions to ensure the health, safety and welfare of employees and liaise and collaborate with other enforcing authorities including the Health and Safety Executive and Care Quality Commission regarding matters affecting the health and safety of residents. Inspections have highlighted high levels of compliance with food and health & safety legislation within care settings.

Adult Services - Supporting Older People

Adult Services commission and provide support for older people who have eligible social care needs, with a focus on promoting independence and preventing unnecessary admissions to hospital and care homes. Adult Services support all people aged 65+ who have been assessed as having eligible social care needs. Public health funding contributes £149,000 annually towards a net budget of approximately £30m, £10m of which is spent on commissioning support for older people.

The key aim of services for older people is to ensure that eligible needs for care and support are met in line with the Care Act Legislation. This includes ensuring that people have access to appropriate information and advice and advocacy, as well as promoting individual wellbeing and preventing the need for care and support.

Services provided range from basic information and advice, advocacy and low level services such as befriending support and luncheon clubs to care at home, extra care and, at the most intense level of support, 24 hour residential care. Carers are also supported through Adult Services.

Maintaining independence and reducing dependence in services is a key objective throughout various strands of work with individuals in the community.

Promotion of self care and support for carers to maintain their caring role are key outcomes for the department and further successes have been as follows:

Increased uptake of information and advice: Hartlepool Now (www.hartlepoolnow.co.uk) had 17,853 users, 22,413 sessions and 72,999 hits in 2016/17. Hartlepool Now is also now available as an App and is used by frontline staff in people's homes as a tool for information, advice and signposting.

Low level support: Over 706 people used the handyperson service with 765 minor repairs/adaptations completed and a further 713 referrals to signposting service.

Tackling social isolation: Average attendance of 120 people per week at Social Inclusion service for older people (day time activities). Hartlepool Befriending Network commissioned. Project 65 developed by HBC and funded by Northgate Community Fund to support older people to access the internet.

Investment in reablement: 583 reablement packages started with 78.4% of people having no ongoing social care needs following

provision of a completed reablement package and 91.5% of reablement goals achieved at the end of a period of reablement.

Promoting independence / care at home: over 2,200 people supported using assistive technology / telecare and approximately 5,000 hours of domiciliary care provided per week to support people in their own homes.

Support for people living with dementia: The Dementia Advisory Service at The Bridge supported 269 people living with dementia and carers in 2016/17. The Dementia day service supports approximately 30 people per week. Over 4,000 hours of support are provided each year within people's own homes in addition to building based day service. Dementia Friendly accreditation secured. Continued awareness raising regarding dementia through the North of Tees Dementia Collaborative including 3729 Dementia Friends and 46 Dementia Champions trained in Hartlepool. The collaborative are presently engaging with 10 primary schools, 3 secondary schools and 2 colleges in the Borough.

Support for carers: over 150 carers received direct payments in 2016/17 and this is projected to increase further in 2017/18.

Hartlepool Exercise For Life/GP Referral Programme (H.E.L.P)

This is a town-wide service that delivers supervised specialist exercise from various community venues. Target audience is the adult population (18yrs+) who wish to benefit from a more active lifestyle to assist in the self management of a wide range of chronic health conditions. This in turn can reduce further health risks linked with an inactive sedentary lifestyle which is associated with the natural ageing process.

The service aims to improve quality of life with a holistic approach that is client-led and strives to meet the needs of the individual and encourage physical activity participation in the long term. This supports both improved physical and mental wellbeing, through the natural physiological responses to suitable graded exercise to address specific health problems and aims to motivate and educate the individual about the benefits of maintaining an active lifestyle in relation to improving all aspects of general health and wellbeing. The service offers a positive experience that instils confidence and empowers the individual to continue with an active lifestyle beyond their introductory 10-week course with the service, empowering the individual to make more choices and feel confident in their ability to do so.

In 2016/17, 591 referrals were received by the service, of which 494 were for clients aged 45 or over (302 female and 192 male).

In this period, 88 individuals have completed a 10 week introductory course. Evidence from 6 month post-completion questionnaires shows that 84% of clients have continued with regular structured activity.

11% have reduced their medication/prescription from the GP Surgery.

16% have indicated a reduction in their visits to their GP.

The service has successfully established a well attended weekly session to accommodate those with neurological issues such as M.S, Parkinson's and post-Stroke at Brierton Sports Centre.

"I was a carer for my husband at the time after his heart attack. I also joined the gym. The girls that looked after us were brilliant; they motivated us both and devised my own programme even though I wasn't the patient. We are both now members. We will return to the gym beginning of Sept. Excellent motivational course."

"I found this course was very good and motivating, because of this course I will return to Brierton gym, at the moment I work 5am-7pm so really is impossible. The course helped me get over the feeling of helplessness. The staff were extremely supportive & understanding".

"I have restarted Alexa's water fitness class on Wednesday afternoon. I enjoy this would like more of the same. Have started to swim once a week now that I have retired, with husband to encourage & motivate. Can't fault the help I've received from Lorraine's team & Steve Gaffney, Health Trainer."

"Professional advice & supervision doing exercises that were of benefit to me & my injury. Helped me to understand how I could improve my pain & maintain fitness. Thank you for your professional help. You provide a good service".

Escape Diabetes Act Now (E.D.A.N)

Lifestyle intervention project to support those at risk of developing Type 2 Diabetes - EDAN project (Escape Diabetes Act Now) preventative model. The project also supports those with Type 2 Diabetes to better self-manage their condition to deter further ill health, which is directly associated with this condition, namely increased risk of coronary heart disease, retinal eye damage, nerve damage and in the worst cases, amputation.

There are two components of support, supervised physical activity opportunities for up to 12 months to initiate clinical changes, plus access to either educational group 8 week workshops or 1:1 - 12 week Healthy Eating weight management courses. This input is delivered by the Health Trainer team who can explore with the client their existing eating patterns, identifying where change is needed. This can encourage long-term behaviour change which is realistic and achievable if the client is receptive and motivated to comply.

For EDAN referrals, this can reverse their situation and take them out of the pre-diabetic category, this can be clinically verified when repeat HbA1c blood tests are carried out at their GP surgery. For those referrals with existing Type 2 Diabetes, the service aims to educate and encourage a better understanding of how to live well with Type 2 Diabetes.

The project has seen increased support from local surgeries and Diabetes Specialist Nurse teams to encourage uptake to the EDAN project. In 2016-17, we have received 96 referrals over 45 years of age (57 Female & 39 male). In the Type 2 Diabetes patient group, we have received 33 referrals over 45 years (11 female & 22 male). Some clinical evidence has been received from surgeries where follow up appointments have been carried out - this work is ongoing. **For further information about HELP or EDAN/T2D contact 01429 284 363.**

Dementia Advisory Service – The Bridge

Drop in service supporting people of all ages in Hartlepool who may have memory impairment or have received a diagnosis of dementia. The service offers:

- Dementia advice, information and support to enable people to live well with dementia.
- Support to carers, families and friends.
- Signposting to other services.
- Practical and emotional support.
- IT access to services and advice.

Over 500 people have accessed The Bridge in the last 12 months with excellent feedback received from users of the service. **For further details contact 01429 279 005 or 01429 868 587.**

Dementia Friendly Hartlepool initiative

Dementia Friendly Hartlepool aims to develop Hartlepool as a nationally recognised dementia friendly community. We want to ensure that people living with dementia are able to remain active and involved in their communities. Our work will help the local community be aware of and understand more about dementia. People living with dementia and their carers will be able to live life well and able to seek the help and support they need. The collaborative aims to;

- Raise awareness about dementia in key organisations and businesses within Hartlepool that support people with dementia.
- Develop a strong voice for people with dementia living in Hartlepool.
- Raise the profile of Dementia Friendly Hartlepool to increase reach and awareness to different groups in the community.
- Support local groups, businesses and charities to be dementia friendly and more accessible to those living with dementia in Hartlepool.

Key successes in 2016/17

- Hartlepool has an active DEEP group which is a local branch of a national dementia empowerment and engagement network for people living with dementia. The group is supported by TEWV NHS Trust and The Bridge, Hospital of God.
- A multi-agency steering group are working together to promote dementia awareness in Hartlepool.
- A comprehensive programme of events is held throughout National Dementia Awareness Week and during the year to promote awareness and engage those living with dementia and care givers.
- 17 businesses and companies have become dementia friendly. This includes pharmacies, florists, cafes, shops, sports facilities and more. Others are being actively sought.
- Open dementia friends sessions are offered weekly and customised sessions are provided as required and tailored to the needs of a business.
- Partnership with public health has supported in reach to primary and secondary schools to work towards a dementia friendly generation.
- Since September 2016, 10 Primary schools have engaged with Dementia Friendly Hartlepool. Grange Primary, Holy Trinity, St Cuthberts. West View, St Teresa's, Dyke House, High Tunstall, Stranton, St Aidan's and Eldon Grove are engaged in ongoing work.

For further information visit www.hartlepoolnow.co.uk/DFHpool or tel 01429 803 660.

Male life expectancy at birth in Hartlepool
76.8
compared to 79.5 nationally

Female life expectancy at birth in Hartlepool
81.3
compared to 83.1 nationally

Healthy life expectancy in males (proportion of life spent in "good" health)
57.0
in Hartlepool (2nd lowest in region) compared to 63.4 nationally

Healthy life expectancy in females
55.2
in Hartlepool (lowest in region) compared to 64.1 nationally

Not only are there significant inequalities between Hartlepool and the rest of England, there are huge differences between wards within Hartlepool. Life expectancy varies by as much as 10 years from the most to the least affluent areas of the Borough:

	Male	Female
Life expectancy at birth in the most deprived quintile of Hartlepool, 2012-2014	**72.8**	**77.8**
Life expectancy at birth in the least deprived quintile of Hartlepool, 2012-2014	**83.0**	**87.2**
Absolute gap in life expectancy between most deprived and least deprived areas within Hartlepool	**-10.2**	**-9.4**

For males, 30% of this gap is explained by circulatory diseases and for females 23% of the gap is explained by cancer and 20% due to circulatory diseases. Circulatory disease is therefore is the single biggest contributor to inequalities in life expectancy within the Borough (50%).

Bowel cancer screening coverage in Hartlepool: 55.5% compared to 57.9% nationally

AAA (abdominal aortic aneurism) screening coverage in Hartlepool: 77.0% compared to 79.9% nationally

Health-related quality of life for older people is significantly lower in Hartlepool than the England average

Admission episodes for alcohol-related conditions in over 65s – 265.5 per 100,000 (7th highest rate in England for 2014/15) compared to 190.5 nationally

Emergency admissions for Coronary Heart Disease (CHD), stroke, heart attacks and Chronic Obstructive Pulmonary Disorder (COPD) all higher than the national average

Early (under 75) mortality from cancer and all causes considered preventable, and deaths from CVD and cancer in over 65s, are all higher than the regional and national averages:

	Hartlepool	North East	England
Under 75 mortality rate from cancer considered preventable	**110.4**	**98.9**	**81.1**
Mortality rate from all causes considered preventable (all ages)	**243.9**	**227.5**	**184.5**
Rate of deaths from cardiovascular disease (CVD) among people aged 65+	**1290.5**	**1263.6**	**1191.9**
Rate of deaths from cancer among people aged 65+	**1344.7**	**1294.3**	**1122.0**

Lung cancer incidence (165.7) is significantly higher than the England rate (100)
Dementia prevalence age 65+ = 4.9% compared to 4.3% nationally

SECTION 3
Promoting Independence

KEY PROJECTS

New build bungalows

Through the Hartlepool Housing Strategy 2015-2020, consultation identified a demand for older persons' accommodation, namely bungalows to meet the needs and aspirations of Hartlepool's ageing population. One of the long-term actions within the Housing Strategy is to "Work with partners to develop accommodation for older people".

As a result, 21 new build 2 bedroom bungalows were purchased by HBC during 2015 and 2016 at Alexandra Square, Dyke House – first let on an affordable rent from August 2015 and managed by the Council's Housing Service. Although not exclusively aimed at older people, these bungalows are available primarily to applicants with a medical need for 2 bedrooms and level access shower.

21 families and couples with medical needs have now been successfully re-housed into good quality new build accommodation with level access showers. These are let and managed by Hartlepool Borough Council on secure tenancies with an affordable rent.

Special needs housing service

Priority 4 within the Hartlepool Housing Strategy 2015-2020 is "Improving health and wellbeing; promoting sustainability by supporting people with specific housing needs"

This priority details how the Council works with partners to meet the specific housing needs of vulnerable people to support independent living. The challenges faced in achieving this priority include ensuring that there is a variety of housing options to meet different needs. There are particular pressures for finding suitable housing solutions for people with learning and other disabilities, as well as housing for a growing older population, and funding housing adaptations to enable independent living.

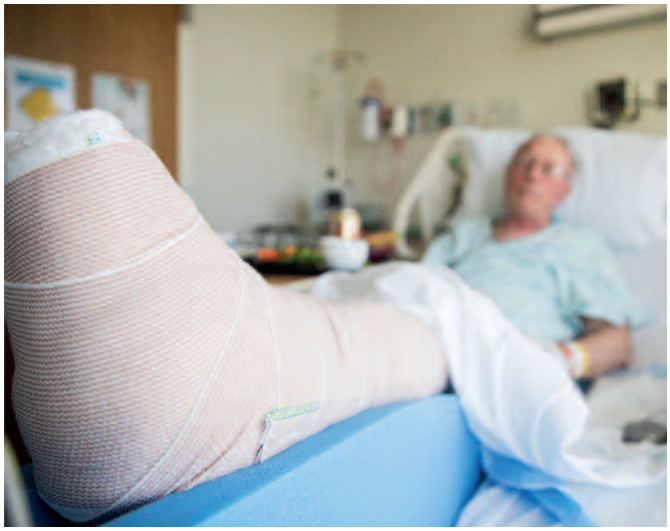
The adaptations service is delivered through minor adaptations (under £1000) and major adaptations (over £1000 funded via Disabled Facilities Grant) to assist and enable independent living.

During 2016/17, the following major adaptations have been undertaken:

DFGs completed Q1 – Q4 (cumulative)

Type of adaptatiom	Under 18	18 - 40 years	40 - 65 years	65 - 80 years	80+ years
Straight Stairlift	0	1	9	14	17
Curved Stairlift	0	1	2	8	13
Extension	4	0	2	1	0
Level Access Shower	0	3	40	51	41
Overbath Shower	2	2	7	1	1
Ramp	3	0	1	2	1
Other	2	2	2	2	0
Cost	£126,115.67	£43,494.68	£235,064.40	£273,557.42	£236,434.13

In addition, 1265 minor adaptations were carried out during 2016/17 and although data (within Housing Services) is not kept on age, the majority of these will be for older people.



Hartlepool Falls Prevention Service

The new service commenced in April 2016 after Hartlepool Borough Council Public Health commissioned Adult Social Care to deliver this contract. The team is made up of occupational therapy staff from a variety of backgrounds which brings a wide and varied skill set to the service. The primary aim of this service is to offer residents within Hartlepool the opportunity to have access to a falls prevention plan to reduce the risk of falls, either within the home, or the local community.

We are aware there are a number of reasons that people fall and that this can lead to people not being confident to be a part of their local community and may lead to social isolation or a decline in health and wellbeing. With this in mind, Public Health and Adult Social Care have worked closely together to develop a holistic service, that looks at the causes of falls, but also provides a vital link to a variety of low level intervention services, along with giving you the necessary tools to keep safe, keep active and reduce the risk of falls.

Starting the service from scratch has been challenging and the service continues to evolve as we understand more about the needs of the residents of Hartlepool in relation to falls prevention. To date, we have screened over 700 residents who live in their own homes and over 1400 people have been provided with their own Falls Prevention Plan as Care Management Teams now complete Falls Prevention Plans.

Further initiatives within the service include supporting all Hartlepool Care Homes to implement new Falls Prevention documentation and raised awareness of the risk of falls with a 'bottom up approach' (care staff through to management) with staff through a series of on-going training sessions.

Falls Prevention has also worked closely with the Fire Brigade across the region devising a Fall Prevention checklist and then delivery various training sessions to Fire Fighters before going live with their agenda for Falls in October 2016. **For further information tel 01429 523 755.**

Scam prevention

The Council's trading standards team in public health has been working to protect the elderly and vulnerable from mail order and telephone scams. Officers have dealt with a number of shocking examples in Hartlepool where victims have lost many thousands of pounds, and in one case over £50,000, to mass marketing frauds.

Beginning with the 'guarantee' of a prize for only a small claim fee, or a bargain that is 'too good to miss' consumers can find they are soon overwhelmed with similar offers of bargains that can ultimately cost thousands. The 'guaranteed' prizes never arise and the offers of cheap goods are never cheap. Consumers have been known to receive dozens of phone calls and letters each day. This can have a significant detrimental impact on a vulnerable person's health and wellbeing.

Trading standards officers have been working closely with the Council's social services team, Community Safety Team and local Banks and Post Offices to help protect those who may be at risk. In addition, public health grants and funding provided through the Council's community safety team has been used to supply and fit 'call blocking' devices to the phones of those most vulnerable. This has had a dramatic effect on the numbers of unwanted calls being received – finally giving people peace of mind. Work is ongoing with the Post Office to see whether obvious scam mail can be returned to the sender rather than delivered to its unsuspecting victims.

Hartlepool has been at the forefront of tackling scams and the North East of England is the first area outside London to be selected for the roll-out of the new banking protocol – a multi-agency approach involving the Police, Trading Standards and the Banks aimed at identifying customers who are in the process of being defrauded.

No Cold Call Zones

The trading standards team has been promoting, and has subsequently established, No Cold Call Zones (NCCZs) in 40 streets/neighbourhoods throughout the town. Once established, a NCCZ makes it an offence for doorstep traders to operate within that area. This protects the residents of that area from unwanted, unsolicited visitors such as cowboy builders and roofers. NCCZs have been introduced as a consequence of a number of complaints being received by trading standards – in some cases vulnerable people have lost several thousands of pounds to unscrupulous and criminal traders. All residents within the area are also provided with a free 'I don't deal with doorstep traders' sticker for them to place on their front door/window.

As a result, residents of these areas face fewer cold callers at their doors and many will feel empowered to say no to a cold caller who knocks on their door.

Fewer residents will face the risk of losing substantial sums of money to conmen and will not suffer the stress caused by having to deal with conmen – both in saying 'no' to them or having to deal with the consequences if they do get conned.

Protecting the vulnerable and elderly is a high priority for the trading standards team and public health grant funding has been used to fund an officer to focus on this area of work.

40%
of victims said it had resulted in them having **reduced confidence** generally

28%
said it had left them feeling **down** or **depressed**

46%
said it had caused them **financial detriment**

16%
had **not told anyone** about the crime, and 40 per cent of these said the reason was **embarrassment**

(National Trading Standards National Tasking Group Doorstep Crime Report, March 2014)

23.2%
of adults have a limiting long term illness or disability (compared to 17.6% nationally)

71%
Flu vaccination coverage 65+(equal to national average)

1,975
per 100,000 Injuries due to falls aged 65+ compared to 2,125 nationally

684
per 100,000 Hip fractures aged 65+compared to 571 nationally (Fewer injuries due to falls in Hartlepool BUT those injured are more serious i.e. fractures)

64.8%
PPV population vaccination coverage 65+ (pneumonia) (lowest in region) compared to 70.1% nationally

Certain sections of the community are more prone to scammers and fraud, as highlighted by Age UK in their 2015 report, 'Only the tip of the iceberg: Fraud against older people':

- Over half (53%) of people aged 65+ believe they have been targeted by fraudsters (Scams survey by Populus for Age UK, 2015)
- Age UK is particularly concerned that recent changes to private pensions allowing people aged 55+ to take all their pension savings in cash will encourage the scammers to target this age group even more
- While younger people may be more likely to be at risk of online fraud, increasing numbers of older people are likely to be at risk as the percentage online is expected to grow.
- Older people may be especially at risk of becoming a victim at particular times because of personal circumstances, such as social isolation, cognitive impairment, bereavement and financial pressures.
- A 2013 estimate by the former National Fraud Authority put total losses for individuals at over £9 billion per annum.

Fraud techniques

Research has identified a range of core techniques used by fraudsters:

- **Use of appropriate and latest technology,** particularly the use of the internet.
- **Professional** and **legitimate** appearance of information.
- **Illegitimate appearance**, where the involvement in an illegal activity, such as money laundering, makes it more difficult for the victim to report the fraud.
- **Small sums of money**, which make it less likely the victim will report the fraud.
- Clever **sales techniques**.
- **Selling a dream**, where the fraudster offers something someone wants at a low price or something that promises to make above average returns.
- **Operating in a legal hinterland**, where the tactics used make it difficult to unambiguously identify it as fraud.
- **Intimidation** and **threats** of violence.
- **Identity fraud techniques**, where the fraudster acquires either genuine identity documents, such as a passport or driver's licence, credit card or specific personal information.
- **Pretext calling**, where fraudsters pretend to be someone they are not to secure bank account and other personal data. It may be done in person, on the telephone or most commonly through email.

(Button et al, Fraud typologies and victims of fraud: Literature review, National Fraud Authority and the Centre for Counter Fraud Studies, 2009)

Doorstep crime appears to be targeted at older people

According to analyses of victim impact surveys in England and Wales:

85% of victims were aged 65+, 59% were 75+, and 18% were aged 80 to 84.

63% had a physical impairment, 43% a sensory impairment, 15% a mental health condition, 14% a cognitive impairment, and 35% had a long standing illness.

37% missed having people around and 40% were lonely.

9% were known to be repeat victims.

62% lived alone.

24% had concerns about their memory, or their family or carers had such concerns.

33% had experienced bereavement in the past two years.

36% had experienced depression in the past six months.

(National Trading Standards National Tasking Group Doorstep Crime Report, March 2014)

The negative impact of financial abuse, regardless of the source, can result in someone becoming in need of support from social services, having not previously required such help.

Analysis of the effects of doorstep crime found that:

40% of victims said it had resulted in them having reduced confidence generally.

28% said it had left them feeling down or depressed

(Research on impact of mass marketed scams: A summary of research into the impact of scams on UK consumers, OFT, 2006)

46% said it had caused them financial detriment.

16% had not told anyone about the crime, and 40 per cent of these said the reason was embarrassment.

SECTION 4
Practical Support Services

KEY PROJECTS

Tees Community Equipment Service (TCES)

Tees Community Equipment Services (TCES) is a Middlesbrough Council-led service and is commissioned by partner organisations including Hartlepool to deliver a Tees-wide Integrated Community Equipment Service. TCES is one of the largest and most complex equipment services in England and delivers, collects and services equipment for reissue in the community. This equipment plays an important part in helping people to develop their full potential and to maintain their health and independence.

The TCES customer base covers a range of clients of all ages and predominantly meets the needs of people in the community with physical disabilities and people who are suffering with long term conditions which impact on the quality of life.

2016 has seen the introduction of an online web ordering system for health and social care professionals and aims to streamline service provision by enabling professionals to order directly, avoiding the use of email and fax, to avoid duplication and improve governance, improve timeliness of delivery and collection of equipment, empower professionals to make decisions regarding the priority/urgency given to orders and to enable professionals to track client activity and plan follow-up assessment visits accordingly.

The service has resulted in increased ownership for professionals and ability to plan follow up assessments so that clients can commence using equipment, provided system accessibility 24hrs daily, introduced new scanners so system data is updated in real time and improved governance for partners, eliminating use of faxes and emails.

High standards of service delivery have been realised with 93.8% of equipment deliveries made within 7 days from assessment and a same day service delivery to prevent admission to hospital, to facilitate end of life issues and repair critical equipment without which respite or other care packages would be necessary.

High levels of customer satisfaction - customer engagement surveys (460 Teeswide) 2015-16 indicated that 74% of respondents felt that equipment provision helped them to maintain their independence, 70% felt it improved their quality of life and 57% felt safer for having the equipment. **For further details contact 01642 225 205.**

Hartlepool Now Equipment Finder

The Hartlepool Now website **www.hartlepoolnow.co.uk** helps people access a wide range of support and advice from across the town to help them live as independently as possible. The online equipment finder tool **www.hartlepoolnow.co.uk/equipmentfinder** helps residents and staff to assess needs and areas of the home in which people need assistance from products and mobility equipment that are available to purchase. The tool will take you through a series of questions concerning day to day life and will make some recommendations around aids and products that might make life in the home easier. There are also links to external websites where products can be purchased.

HBC have recently developed an App for 'Hartlepool Now' which is now available to download on mobile phones and tablets via Apple iStore and Google Play. Since the App went live the equipment finder has been one of the top visited sections on the App.

Connecting Communities Handyman and Signposting Service

The Service is available to any person who is a resident in the borough of Hartlepool aged 60+ or vulnerable people who are moving on from temporary supported accommodation and who need support to set up home. It is also available to Hartlepool adults aged under 60 who have a chronic illness, disability, sensory impairment or other problems which restrict their functioning on a day to day basis.

The service provides information, advice and signposting and a handyperson service to provide practical support to promote prevention and early intervention through the provision of minor repairs and adaptations to enable older people to continue to live in their own home.

The main objectives are to empower people to live independently in their own home, have more autonomy, choice and control in their lives and the services they receive, and will contribute to improving people's physical and mental health and overall wellbeing.

The service supports people to participate in their communities and contributes to the development and maintenance of social networks, preventing people from experiencing social isolation.

There were a total of 542 individuals worked with by the project in 2015, 374 of these worked with the handyperson service. 68% of service users who returned satisfaction questionnaires said that they felt they were able to move around their home more easily since the work was carried out. This led to 66% feeling more confident to remain in their own home. This demonstrates that the Handyperson scheme is empowering people to have more autonomy, choice and control around their ability to remain in their homes. **For further information contact 01429 269 303**

Home Fire Safety Visits / Stay Safe and Well

Cleveland Fire Brigade undertake Home Fire Safety Visits in households where vulnerable adults or families live in order to give free fire safety advice and information and supply and fit risk reduction equipment i.e. smoke alarms, free of charge. The project aims to reduce the risk of fire within the home and support vulnerable residents by signposting them to appropriate support agencies to assist in resolving their issues and vulnerabilities.

As a result, the Brigade has seen a reduction in accidental dwelling fires, increased fire safety awareness across Cleveland and over 4000 vulnerable residents are receiving home fire safety visits across Cleveland annually.

The Brigade also supports anyone within Tees Valley who is struggling to stay safe and warm within their own homes. The Stay Safe and Warm campaign aims to deliver emergency heating equipment in the form of portable heaters, thermal blankets, fleecy mattress toppers, electric blankets, wind up lighting units, torches etc. giving a holistic assessment of need and onward referrals to agencies for longer term support.

The Brigade has demonstrated an improvement in health and wellbeing both in the short and long term and contributes to the reduction of non-elective hospital admissions due to negative health impacts of living within cold and damp homes. Income maximisation is improved within vulnerable populations and the project is able to identify the more vulnerable residents and refer on for further support, contributing to the wider health and wellbeing agenda. **For further information contact 01429 874 054.**

Macmillan Advice Service / Keep Warm without the Worry (West View Advice and Resource Centre)

The Macmillan Advice Service is available to anyone in Hartlepool, whose life is affected by cancer, offering benefits advice to cancer patients, their carers and family, access to grants and services, priority appointments and home visits for the housebound. The project aims to offer maximisation of income via a benefit check and grants eligibility assessment so the clients are assured of receiving the maximum income and other benefits to which they are entitled.

West View Advice and Resource Centre also offer a Home Energy Advice Service for people affected by cancer, providing assistance to relieve clients of the further stress of increased costs of energy so they can fully concentrate on their recovery. The project offers advice on keeping warm; energy company & tariff switching; fuel debt support; energy discounts & insulation grants and emergency funding. **For further information about either scheme contact 01429 271 275.**

HomePlus grants

The scheme is aimed at owner-occupiers, aged over 60 and in receipt of a means-tested benefit (also includes under 60s where there is an additional qualifying disability related benefit). Assistance is not limited to a geographical location. Small grants up to a maximum of £4,000 in a three year period are available to remove serious hazards from the home which may have a detrimental impact on health.

10 grants have been awarded in a 12 month period; 9 of these related to the replacement of defective boilers or the provision of heating systems. In doing these works, hazards relating to excess cold, personal hygiene and food safety were removed. One grant was awarded to replace a leaking flat roof to a ground floor room which was occupied as a bedroom by a dementia sufferer who was bedridden; the result of this was to remove hazards relating to excess cold and damp & mould growth which could have lead to respiratory infections. Two other households were assisted in the form of a charge which was placed on the properties to be repaid on sale or transfer to carry out essential works to make them safe. These were exceptional cases as the owner-occupiers were considered vulnerable due to their age and other factors. **For further information contact 01429 523 324.**

11.8%
of households in Hartlepool living in fuel poverty compared with 10.6% nationally

(A household is said to be in fuel poverty if they have required fuel costs that are above the national median level and were they to spend that amount they would be left with a residual income below the official poverty line).

58.3%
of social care clients in Hartlepool aged 65+ receiving self directed support compared with 66.3% nationally, however

88.8%
of those receiving self directed support, also receive direct payments (similar rate to national average)

93%
of people aged 65+ receiving winter fuel payments compared with 96.7% nationally

In 2015/16, Hartlepool accounted for over 22% (n=68) of referrals to the Stay Safe and Warm campaign provided by Cleveland Fire Brigade. Despite a mild winter, the campaign saw the third highest number of referrals since its instigation in 2009.

Hartlepool saw a gradual increase in referrals from the previous two years with 57% of all food parcels distributed in the area.

Age demographics of main referrer

	16 - 24 Years	25 - 35 Years	36 - 45 Years	46 - 55 Years	55 - 65 Years	66+ Years	Unknown	**Total**
Hartlepool	7	8	11	8	9	14	11	**68**

There is no clear pattern in the proportion of households which are fuel poor in progressively older occupants. There is, however, a clear pattern of increasing depth of fuel poverty in older households. Those where the oldest occupant is aged under 34, for example, have a mean fuel poverty gap of approximately £260, whereas those aged over 60 have a gap of around £450. This may reflect the longer heating requirement for older households who are more likely to be at home for longer periods of time during the day.

Distribution of equipment

	Thermal Blankets	Electric Blankets	Electric Heaters	Fleecy Mattress Toppers	Childs Blanket	Foods Parcels	Home Fire Safety Visits	Smoke Detectors
Hartlepool	**56**	**8**	**82**	**7**	**6**	**39**	**68**	**45**

Case study

A neighbour of a Hartlepool resident was so concerned by the cold conditions within her neighbour's home that she contacted social services. She reported that not only was it terribly cold but there was a level of hoarding and general dilapidation within the property. It was suggested that the neighbour contact Cleveland Fire Brigade who would be able to assist with heating and hopefully gain the gentleman's confidence which could result in onward referrals for other support.

Fire crew were notified and attended the property with emergency heating. Heaters and blankets were accepted and the resident also agreed to a further visit to see what other assistance could be given.

Both the Advocate and the neighbour spoke with the resident who agreed to further help and onward referrals. A full Home Fire Safety Check was conducted and some electrics were found to be faulty. Hartlepool Borough Council Environmental Health dept was contacted and, following a home visit, agreed to look into funding that could allow central heating to be installed, and for the electrics within the property to be rewired. Social services agreed to look into arranging Telecare and other services. HBC also arranged for financial assessment to ensure income maximisation.

When the electrical work was completed, CFB issued fleecy mattress toppers and further heaters so that every room could be heated. A panic alarm was also installed and the resident has demonstrated that he knows how and when to use it. Following extensive partnership collaboration, a highly vulnerable resident has had his health, safety and wellbeing greatly improved.

Summary Indicators 2016/2017

The table below summarises the data presented within the report and highlights additional statistics related to ageing well in Hartlepool. The Hartlepool, North East and England rates and numbers have been included where possible:

Indicator	Description	Hartlepool	North East	England
Life expectancy at birth (male)	Based on contemporary mortality rates	76.8%	77.9%	79.5%
Life expectancy at birth (female)	Based on contemporary mortality rates	81.3%	81.6%	83.1%
Male healthy life expectancy (years)	Based on prevalence of self-reported good health	57.0%	59.6%	63.4%
Female healthy life expectancy (years)	Based on prevalence of self-reported good health	55.2%	60.1%	64.1%
Fuel poverty	Proportion of households in fuel poverty based on "low income, high cost" methodology	11.8%	12.2%	10.6%
Social isolation	% of adult social care users who have as much social contact as they would like	54.3%	49.9%	45.4%
Recorded diabetes	Recorded cases of diabetes by GP practices aged 17+	6.3%	6.7%	6.4%
Bowel cancer screening coverage	% of eligible people (aged 60-74) screened	55.5%	59.4%	57.9%
AAA screening coverage	% of men eligible who are tested	77.0%	77.6%	79.9%
Injuries due to falls	Aged 65+ per 100,000 population	1975	2167	2125
Hip fractures	Aged 65+ per 100,000 population	684	618	571
Flu vaccination coverage	% eligible population screened (aged 65+)	71.0%	72.1%	71.0%
Preventable sight loss due to age-related macular degeneration	Crude rate aged 65+ per 100,000 population	163.4	156.9	118.1
Health-related quality of life for older people	Average health status score for adults aged 65+	0.673	0.706	0.733
Excess winter deaths index	3 years, all ages	23.0	19.3	19.6
Dementia recorded prevalence	Aged 65+ as recorded on practice disease registers	4.9%	4.68%	4.31%
% deaths in usual place of residence	Aged 65+	42%	47.2%	47.5%
% social care clients aged 65+ receiving self directed support	Via direct payment or personal budget	58.3%	68.7%	66.3%
% social care clients who receive self directed support, and those receiving direct payments	As a percentage of all clients receiving community based services and all carers receiving carer specific services	88.8%	96.9%	88.6%
% of population receiving winter fuel payments	Aged 65+	93.0%	93.8%	96.7%

Indicator	Description	Hartlepool	North East	England
Population vaccination coverage - PPV	% eligible adults aged 65+ receiving PPV (pneumonia) vaccine	64.8%	72.2%	70.1%
Admission episodes for alcohol-related conditions aged 65+	Persons over 65 admitted to hospital for alcohol-specific conditions	265.5	233.6	190.5
Under 75 mortality rate from cancer considered preventable	Age standardised rate of mortality in those aged <75 per 100,000 population	110.4	98.9	81.1
Under 75 mortality rate from cardiovascular disease considered preventable	Age standardised rate of mortality in those aged <75 per 100,000 population	56.0	54.5	48.1
Under 75 mortality rate from respiratory disease considered preventable	Age standardised rate of mortality in those aged <75 per 100,000 population	27.5	25.4	18.1
Mortality rate from all causes considered preventable (all ages)	Age standardised rate of mortality from all causes considered preventable per 100,000 population	243.9	227.5	184.5
Pensioners living alone	Self reported, ONS Census	35.5%	-	31.5%
Cancer incidence (all)	Standardised incidence ratios estimated from MSOA level data	104.2	-	100
Cancer incidence (lung)	As above	165.7	-	100
Cancer incidence (bowel)	As above	98.0	-	100
Limiting long term illness/disability	Self reported, ONS Census	23.2%	-	17.6%
Provides 1+ hrs unpaid care per week	Self reported, ONS Census	10.8%	-	10.2%
Provides 50+ hrs unpaid care per week	Self reported, ONS Census	3.3%	-	2.4%
Elective admissions for hip replacement	Standardised admission ratios estimated from MSOA level data	104.4	-	100
Elective admissions for knee replacement	Standardised admission ratios estimated from MSOA level data	132.7	-	100
Emergency admissions for CHD	Standardised admission ratios estimated from MSOA level data	145.1	-	100
Emergency admissions for stroke	Standardised admission ratios estimated from MSOA level data	115.8	-	100
Emergency admissions for MI	Standardised admission ratios estimated from MSOA level data	173.8	-	100
Emergency admissions for COPD	Standardised admission ratios estimated from MSOA level data	191.0	-	100
Rate of deaths from cardiovascular disease among people aged 65+	Directly standardised rate per 100,000	1290.5	1263.6	1191.9
Rate of deaths from cancer among people aged 65+	Directly standardised rate per 100,000	1344.7	1294.3	1122.0
Rate of deaths from respiratory disease among people aged 65+	Directly standardised rate per 100,000	783.8	764.0	646.2

(Data correct as of April 2017)

Next Steps and Future Plans

I hope it is clear from the report that there is a fantastic range of projects and initiatives in place, through a wide range of partners and services, to support the ageing well agenda in Hartlepool.

It is vitally important that Public Health in Hartlepool continues to lead and support these services and initiatives and promote partnership working and shared leadership to help all residents of the Borough to grow old with the dignity, support and respect they deserve.

Joint Health and Wellbeing Strategy

The Health and Social Care Act (2012) establishes Health and Wellbeing Boards as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) for their area. The JHWS is a strategic document outlining how Hartlepool Borough Council, Hartlepool and Stockton Clinical Commissioning Group and other key organisations, through the Health and Wellbeing Board, will fulfil this mandate. The existing strategy was established in 2013 and is being reviewed in 2017/18 in order to develop a revised set of actions and priorities for 2018-25. The Strategy is underpinned by the JSNA and views of our communities and will provide a foundation for strategic, evidence-based, outcomes-focused commissioning and planning for Hartlepool.

Our vision

is that Hartlepool will develop a culture and environment that promotes and supports health and wellbeing for all.

Our ambition

is to improve health and wellbeing outcomes and reduce inequalities for our population.

Community Hubs

Three innovative, new Community Hubs will be launching in 2017/18, which will offer a range of advice, guidance, health, learning, employment and community support and services for local people, all under one roof.

The Hubs will offer support and services from a range of different organisations to make it easier for residents to access the help and support they need. Every resident in Hartlepool will be within two miles of their nearest Hub site.

Whether you require information about welfare benefits, debt advice, library services, training and jobs, how to stop smoking or make other behaviour/lifestyle changes, specialists will be on hand to give you all the guidance and help you need.

HARTLEPOOL BOROUGH COUNCIL

Community Hub North

Location West View Advice and Resource Centre, Miers Avenue.

Open Mon - Fri 9am - 5pm

Contact 01429 271275

HARTLEPOOL BOROUGH COUNCIL

Community Hub Central

Location Hartlepool Central Library, Victoria Road.

Open Mon - Fri 10am-6pm and Sat 10am - 2pm

Contact 01429 272905

HARTLEPOOL BOROUGH COUNCIL

Community Hub South

Location Owton Manor Community Centre, Wynyard Road.

Open Mon - Fri 8.30am - 10.30pm (dependant on bookings) and Sat - Sun (dependant on bookings)

Contact 01429 272631

What do we want to achieve and why?

Starting well

All children and young people living in Hartlepool have the best start in life.

Children who grow up in loving and supportive families are most likely to be happy, healthy and safe. Life experiences involve critical transitions - emotional and physical changes in early childhood; moving from primary to secondary and tertiary education; starting work; leaving home and starting a family; and retirement. Each transition stage can affect health and wellbeing by pushing people into more or less disadvantaged paths. Children and Young people who have been disadvantaged in the past are at the greatest risk and their children are more likely to be also disadvantaged. We want to ensure access to high quality universal services such as health care and education; early intervention when needed, and targeted support for children, young people and families who are in difficulties. We want to prevent children and young people from developing emotional problems; having to live in poverty, or where they or their families are affected by abuse, violence or misuse of substances, so that we prevent problems being passed from generation to generation.

Working well

Workplaces in Hartlepool Borough promote and support healthy living.

Access to fulfilling, paid work has long been a significant determinant of people's wellbeing. Economically, fulfilling work provides a secure income, while in social terms, such work can offer a sense of purpose, social connections and personal agency. People who are economically less well-off have substantially shorter life expectancy and more illnesses than those in meaningful employment. In addition, supporting those who work to be healthy and well means they are able to better support and care for their dependents (children and/or the elderly). We want workplaces in Hartlepool to be healthy places with supportive practices and environments that enable employees sustain healthy lifestyle choices. Also we want to work with our communities to support people into fulfilling employment for positive health and wellbeing gains.

Ageing well

Older people in Hartlepool live active and independent lives and are supported to manage their own health and wellbeing.

Similar to most areas in England, the proportion of older people in Hartlepool is increasing. For instance the number of people who were aged 85 years or more in 2005 was 1,400, this increased to 2,100 by 2015 and will continue to increase to 3,330 by 2025 and to 4,700 by 2035. Although most people are living longer, the majority of their latter years (approximately 20years for males; and 26years for females) are lived with poor health and wellbeing. We want to support older people to develop and maintain health and independence as long as possible so that they can live life to the full. When people start to develop a long-term health problem, we want to focus on preventing them from developing further health and social problems. We want to see local services focused on those who have the greatest need, to reduce health inequality and to enable a greater focus on prevention of ill health.

Living well

Hartlepool is a Safe and Healthy place to live with strong communities.

Enabling those who live in Hartlepool to be healthy and well for a life time involves much more than good health and social care services. Many different things impact on health and wellbeing – housing, jobs, leisure, sport & access to open spaces, education, health services and transport. We want Hartlepool to be a healthy place with supportive neighbourhoods and communities which are strong and resourceful, making best use of their community assets.

The Health and Wellbeing Strategy will provide the opportunity to maximise partnerships and evidence base, generating new ways of tackling health and wellbeing challenges. This includes recognising and mobilising the talents, skills and assets of local communities to maximise health and wellbeing.

Top Tips

Remember these 10 golden rules to help you beat the scammers:

1 Be suspicious of all 'To good to be true' offers and deals. There are no guaranteed get rich-quick schemes.

2 Do not agree to offers or deals straight away. Insist on time to obtain independent/legal advice before making a decision.

3 Do not hand over money or sign anything until you have checked the credentials of the company or individual that you are dealing with.

4 Never send money to anyone you do not know or trust. This includes sending money abroad and using methods of payment that you are not comfortable with.

5 Never give bank or personal details to anyone you do not know or trust. This information is valuable so make sure you protect it.

6 Always log on to a website directly rather than clicking on links provided in an email.

7 Do not rely on glowing testimonials: find solid independent evidence of a company's success.

8 Always get independent/legal advice if an offer involves money, time or commitment.

9 If you spot a scam or have been scammed, report it and get help. Contact ActionFraud on 0300 123 2040 or online at www.actionfraud.police.uk. Contact the Police if the suspect is known or still in the area.

10 Always remember: scammers are cunning and clever. They know how to manipulate you to produce the response they want. Do not be embarrassed to report a scam.

Adapted from 'Little Book of Scams, Metropolitan Police Service'

Useful Contacts

Age UK 01429 424002

Befriending Network (Lee) 07808 306184

Blue Badge Scheme 01429 523331

Carewatch 01429 857206

Citizens Advice 01429 408401

Community Hub Central (Central Library) 01429 272905

Community Hub North (West View ARC) 01429 271294

Community Hub South (Owton Manor Community Centre) 01429 272361

Council Waste Collection 01429 523333

Disabled Person Bus Pass 01429 523331

Fire Brigade 01429 872311

Hartlepool Police Station 01429 221151

Hartlepool Water 01429 858050

HBC Contact Centre 01429 266522

NHS non-emergency helpline 111

One Life 01429 890947

Police (non-emergencies) 101

Social Care Adults Team 01429 523390

The Bridge - Dementia Care and Advice 01429 868587

Thirteen Group 0800 0525399

Looking Ahead

For the last 40 years, not only has the North of England had persistently poorer health than the rest of England, but the gap has widened year on year. This is because poverty is more widespread in the North of England than elsewhere and its residents generally live in poorer quality housing, have poorer working conditions and greater unemployment as well as being more badly affected by the chronic disease and disability left by the historical legacy of heavy industry and its decline. To make matters worse, there are far more children growing up in poverty in the North with significantly reduced life chances than there are elsewhere in the country.

Hartlepool is the 18th most deprived local authority area in the country and the people of Hartlepool do experience, in many respects, poorer health than the average person in England. We know that men in Hartlepool have a life expectancy (76.8 years) nearly 3 years lower than the England average and for women it is nearly 2 years lower (81.3 years). We also know that the Healthy Life Expectancy, that is the proportion of life spent in "good health" and without disability, is the tenth worst in the country for men (57.0 years) and the second worst in the country for women (55.2 years).

That means that many older Hartlepool residents are carrying an enormous burden of ill health, disability and long term conditions (e.g. diabetes, high blood pressure, bronchitis) and, on average, women are only enjoying good health for two thirds of their life and men for just three quarters. There are many causes for this – some are societal in terms of poverty, deprivation and poor housing while others are lifestyle choices in terms of smoking, obesity and the harmful effects of too much alcohol, but a significant proportion are and due to poor access or uptake of health services such as cervical cancer and breast cancer screening services, or late diagnosis of lung cancer, strokes and heart conditions.

Hartlepool is one of the smallest local authorities in the country and has been disproportionately hit by the effects of austerity, by the impact of service reductions, by the lack of employment opportunity and by the long term legacy of heavy industry in terms of health and well-being. However, it has a proud heritage and a strong sense of identity and cohesion. We must build on that and provide more support to the Voluntary and Community Sector, to Community Champions and Community Groups to provide the leadership and sense of purpose that will improve health and wellbeing, reduce health inequalities and enable residents to make appropriate lifestyle choices.

To complement this Report, I will also be publishing updated versions of the Ward Profiles 2016-17, which summarise the key public health statistics and indicators for each ward within the Borough. The profiles aim to support councillors, officers, staff and residents to identify key issues, challenges and priorities for future action within their local area and Hartlepool as a whole.

Thank you for reading this Report and I very much hope that you will work together with us to improve health and wellbeing and reduce the impact of disease, ill health and disability on the lives of the people of Hartlepool.

Paul Edmondson-Jones
Director of Public Health Hartlepool Borough Council.

This document is also available in other languages, Braille, large print and audio format upon request.

Bengali

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

Cantonese

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Hindi

अनुरोध पर यह दस्तावेज़ अन्य भाषाओं में, बड़े अक्षरों की छपाई और सुनने वाले माध्यम पर भी उपलब्ध है

Kurdish

ئەم بەلگەیە هەروەها بە زمانەکانی کە، بە چاپی درشت و بە شریتی تەسجیل دەس دەکەویت

Arabic

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

Polish

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku lub w formacie audio.

Urdu

درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔

HARTLEPOOL BOROUGH COUNCIL

For further information please contact:
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Email: customer.service@hartlepool.gov.uk

Telephone: (01429) 266522

ADULT SERVICES COMMITTEE

14 September 2017

Report of: Director of Adults and Community Based Services

Subject: ADULT SAFEGUARDING PERFORMANCE REPORT

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required, for information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to present to the Adult Services Committee the adult safeguarding performance information for 2016/17 and to provide an overview of the safeguarding activity during this period linked to the requirements of the Teeswide Safeguarding Adults Board (TSAB) of which Hartlepool Borough Council (HBC) is a core member. The report also provides information regarding activity linked to Deprivation of Liberty Safeguards (DoLS) for the same period, as this activity is inextricably linked to adult safeguarding.

3. BACKGROUND

3.1 Throughout 2016/17, HBC worked alongside the TSAB to ensure that all safeguarding policies and procedures complied with the requirements set out in the Care Act 2014 and to ensure that these were implemented consistently and equitably.

3.2 An integral part of the arrangements that protect adults is DoLS, and this legislation is linked to the Mental Capacity Act (MCA) 2005. With regards to this legislative framework, HBC is the lead agency and supervisory body for the lawful application of DoLS. This entails ensuring that those people who are ordinary residents of Hartlepool who, for their own safety and in their own best interests need to be accommodated under care and treatment regimes that may have the effect of depriving them of their liberty but who lack the capacity lack the mental capacity to consent, are lawfully detained.

4. 2016/17 PERFORMANCE

4.1 The performance report for 2016/17 is attached as **Appendix 1** and provides an overview of safeguarding activity including categories and location of abuse and the outcomes of safeguarding investigations, as well as a summary of DoLS activity. Included within this information is a comparison with the previous reporting year and a brief summary of local perspectives and operational views on developments in 2016/17.

4.2 The report identifies that the number of concerns (alerts regarding potential safeguarding issues) reported to HBC increased by 24% in 2016/17 compared to 2015/16, whilst the number of Section 42 enquiries (concerns that progressed to formal safeguarding referrals) increased by 25%. It is interesting to note that Section 42 enquiries are back to the level reported in 2014/15, while concerns have continued to increase. Systems and processes are in place to review and analyse all reported concerns to ensure that those that do not meet the threshold for a formal Section 42 enquiry are appropriately risk managed through interventions by social work and care management teams, input from health professionals or action taken by the Commissioned Services Team.

The top three categories of reported abuse continue to be Neglect, Physical and Psychological; however throughout 2016/17 the new categories of abuse introduced by the Care At 2014 (Self Neglect, Domestic Violence and Sexual Exploitation) were also being reported.

The main locations of reported abuse continued to be people's own homes and residential and nursing care homes.

4.3 The number of DoLS referrals peaked in the first quarter of 2016/17 followed by a slight reduction throughout the remainder of the year. Overall there was an 11% increase in activity in 2016/17 in comparison to the previous year.

4.4 The Law Commission completed a consultation exercise about potential changes to the DoLS system, with a discussion at Adult Services Committee informing HBC's response. As yet there have been no definitive decisions made about the future direction of travel, and increases in activity mean that challenges for the Council's financial and staffing resources continue.

5. SUMMARY OF DEVELOPMENTS IN 2016/17

5.1 At the start of 2016 each Local Authority area within the TSAB had a Local Executive Group (LEG) for adult safeguarding. LEGs supported the TSAB by focusing upon local issues and the consistent implementation of safeguarding arrangements across the four Tees Local Authority areas. However due to the duplication of resources across the area especially for the police, fire service and NHS partners, a decision was taken to discontinue the LEGs from July 2016. A range of TSAB sub-groups continue to operate, working collaboratively across Tees, focused on Policy,

Procedures & Practice Guidance; Communication & Engagement; Learning Training & Development; Performance Audit & Quality and Safeguarding Adult Reviews. A regular meeting of the four Local Authority Assistant Directors with the TSAB Independent Chair has also been established to ensure that local issues continue to be reflected in the work of the TSAB.

5.2 Throughout 2016/17 the sub-groups worked on ensuring that all policies and procedures were implemented consistently and equitably, with a particular focus on embedding the MCA and DoLS. There was also work undertaken to develop new policies and procedures linked to emerging themes affecting safeguarding adult arrangements such as Self Neglect, Self Harm, Human Trafficking and Domestic Violence.

5.3 To ensure all interested parties are kept informed of developments within adult safeguarding, a TSAB Bulletin was created and is circulated widely on a quarterly basis along with a TSAB newsletter. Within Hartlepool this is disseminated to all adult services staff by e-mail and is also made available via Hartlepool Now and the HBC website.

5.4 A regional marketing campaign was delivered from July – September 2016 using adverts on Smooth Radio. The adverts were designed to raise public awareness of adult safeguarding. Alongside the radio campaign TSAB held footfall events to raise awareness and provide information to members of the public.

Additionally, through Hartlepool Now, HBC continues to provide up to date information about how to access local help and support if a person or organisation has safeguarding concerns. The HBC website is also updated with relevant policies and procedures in relation to safeguarding and DoLS.

5.5 Awareness raising campaigns appear to have been successful, as evidenced by the increased number of safeguarding concerns that were raised during 2016/17, and this pattern is continuing in 2017/18.

5.6 TSAB commissioned the Virtual College to provide E-learning at foundation level on Safeguarding, DoLS and MCA and also introduced a new module entitled Working with Adults who Self Neglect. Training was offered to HBC staff, providers and carers with the following modules completed:

Modules Offered						
	Sexual Exploitation	DoLS	MCA	Safeguarding Adults	Self Neglect	Total
HBC Staff	4	5	4	35	5	53
Care Providers	55	104	108	151	30	448
Carers	5	11	7	11	4	38
Total	64	120	119	197	39	539

Further modules are planned for the 2017/18 financial year and an alternative method to E-Learning was also developed via a range of Training Workbooks which can be used to achieve the same knowledge base as that provided by the Virtual College for those that prefer this method of learning.

5.7 During the year several 'Safeguarding Adult Training for Managers of Services' sessions were held by the TSAB free of charge. The course aims to equip managers of services to be confident in their role of preventing and responding to abuse; applying MCA and DoLS legislation and managing safe services. 21 managers from Hartlepool accessed this training.

5.8 HBC also continued to facilitate safeguarding training and MCA and DoLS legal updates for a range of staff to ensure that best practice is promoted and lessons from case law are embedded in operational decision making. 114 HBC staff received safeguarding training and 34 staff received MCA and DoLS legal updates in 2016/17.

5.9 The senior management team within HBC adult services undertook the first 'Practice Month' during March 2017. The purpose of Practice Month is to provide assurance regarding the quality of social work practice and to ensure that the application of key principles such as best interest decisions, determining mental capacity, promoting human rights and delivering on adult safeguarding are embedded within working practice. This approach involved case file audits, observations of practice and feedback from people using services, and enabled senior managers to retain close links with frontline practice at a time of significant change.

5.10 Also during 2016/17, at the request of the TSAB, a Peer Audit of Safeguarding Processes and Decision Making was coordinated across the four local authorities, looking specifically at the front of house arrangements and the decision making processes / thresholds applied to safeguarding concerns in each area.

The findings from the Peer Audit indicated that the very robust way that HBC operates front of house arrangements may mean that there are occasions when a fairly detailed 'further enquiry' takes place to inform decision making, which could be recorded as a Section 42 enquiry rather than 'No Further Action to Adult Safeguarding'. This may account for the fact that HBC has a lower rate of concerns progressing to adult safeguarding enquiries than the other local authorities that are members of TSAB. However, in terms of the national context HBC conversion rates are closer to the norm. This is a matter that needs further consideration to ensure consistency of reporting across the TSAB. However, it should be noted that it would be challenging to change the system for analysing safeguarding activity mid-year without careful thought and a clear rationale, particularly as the outcome for people being supported through adult safeguarding will be unaffected.

The Peer Review also advised that the way in which HBC implements the Making Safeguarding Personal process right at the start of the safeguarding episode lends itself to a more person centred approach and keeps the vulnerable adult or their representative at the forefront of the discussions throughout the safeguarding process.

5.11 HBC completed the TSAB Quality Assurance Framework (QAF) in 2016/17; a self audit of performance in relation to safeguarding. The outcomes of the

QAF were summarised in a report back to TSAB in June 2017. The process identified a number of areas for consideration including:

- Evaluators were not able to readily see the name of the lead strategic officer for safeguarding vulnerable adults and queried whether the organisation has sufficient management resources in relation to safeguarding.
- There was limited evidence of how safeguarding arrangements are managed within the complaints procedure.
- The organisation needs to strengthen audit arrangements in terms of being clear what audit and monitoring activity will be undertaken, how actions are taken forward and where aggregated audit findings are reported.

The process also identified good practice including:

- Good example of a Quality Standards Framework and monitoring tool in place.
- Good work being undertaken around communication and engagement, specifically in relation to safeguarding. Reference was made to World Mental Health Day, a Domestic Violence event, Community Safety Partnership messages and engagement work.
- The 'Prevent' presentation to staff evidenced good practice.

5.12 In accordance with recommendations from the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA), the Making Safeguarding Personal approach (MSP) has been fully implemented. MSP is an initiative introduced to assess and evaluate the experience and outcomes of people who use safeguarding services.

In 2015/16 there was a pilot exercise undertaken which focused upon those people in residential and nursing care however throughout 2016/17 the initiative was extended and offered to all individuals or their advocates subject to safeguarding enquires. HBC worked with Skills for People to deliver this service to those people who wished to participate, and analysis showed that those who were subject to the safeguarding process were provided with support and information throughout the process and felt that their views and feelings had been considered, giving them reassurance that they should not have to be subject to the process in the future.

This analysis has enabled HBC to learn from the people who are at the centre of the process, so improvements to safeguarding arrangements can be made and lessons learnt.

5.13 In line with the requirements of the Care Act 2014, the TSAB instigated a Safeguarding Adults Review (SAR) in relation to the murder of a vulnerable female in Hartlepool in December 2014. The review process has concluded and the final report was published in June 2017 along with findings and questions for the TSAB to consider. An action plan has been developed to address the findings and progress will be monitored through the TSAB SAR Sub Group and reported to TSAB.

5.14 During 2016/17 some providers of residential and / or nursing care experienced difficulties providing satisfactory care and HBC along with strategic partners took action through the Serious Concerns Process to address shortfalls in practice and support the provider(s) to make the necessary improvements. Whilst provider(s) were supported to make and sustain improvements, suspensions of new placements were in place which resulted in capacity challenges, especially within the nursing care sector where capacity was already reduced following home closures. Once improvements were made HBC supported providers to ensure that new admissions were safely and effectively managed.

6. RISK IMPLICATIONS

6.1 There are no specific risk implications in relation to this report. Risks associated with delivering statutory services to safeguard vulnerable adults are monitored quarterly through the Council's strategic risk register.

7. FINANCIAL CONSIDERATIONS

7.1 There is a continued financial pressure associated with the activity levels in relation to DoLS with spend of £386,000 in 2016/17.

7.2 The Council, along with all other statutory partners, contributes to the costs of the TSAB Business Unit and the TSAB Independent Chair.

8. LEGAL CONSIDERATIONS

8.1 There are no legal considerations associated with this report.

9. CHILD AND FAMILY POVERTY CONSIDERATIONS

9.1 There are no child and poverty considerations associated with this report.

10. EQUALITY AND DIVERSITY CONSIDERATIONS

10.1 The TSAB and all partner members continue to raise awareness of adult safeguarding, including with minority and hard to reach groups, to improve access to services for those who are at risk of abuse.

10.2 Age, gender and ethnicity of people who are the subject of safeguarding concerns or enquiries are recorded and data is analysed on a quarterly basis. Information is also collected in relation to asylum seekers and refugees.

11. STAFF CONSIDERATIONS

11.1 There are no staffing considerations associated with this report.

12. ASSET MANAGEMENT CONSIDERATIONS

12.1 There are no asset management considerations associated with this report.

13. RECOMMENDATIONS

13.1 It is recommended that the Adult Services Committee note the contents of this report including: 2016/17 performance; the ongoing financial pressure in relation to Deprivation of Liberty Safeguards and developments in adult safeguarding over the past twelve months.

13.2 Members are also asked to note that the TSAB Annual Report 2016/17 and Strategic Business Plan 2017/18 will be presented to the Adult Services Committee in December 2017 by the TSAB Independent Chair.

14. REASONS FOR RECOMMENDATIONS

14.1 The Local Authority has lead responsibility for the delivery and co-ordination of adult safeguarding and Deprivation of Liberty Safeguards.

15. CONTACT OFFICER

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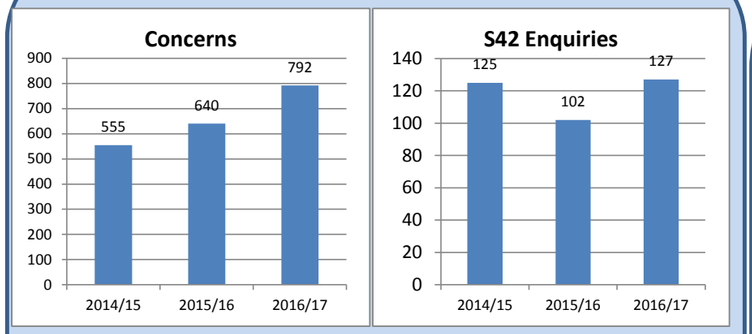
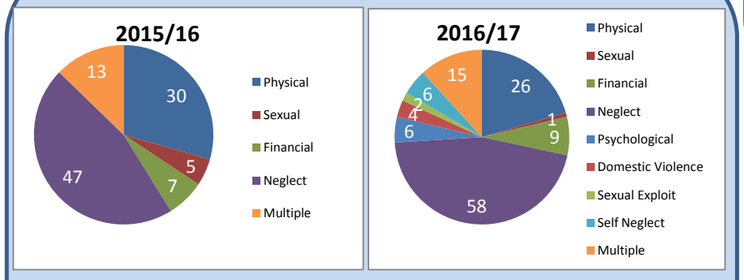
HARTLEPOOL - Annual Performance Report 2016/17

Number of Concerns / Enquiries



Concerns (alerts) reported to the Council increased by 24% in 2016/17 compared to 2015/16 while the number of S42 enquiries (safeguarding referrals) increased by 25%. Enquiries are back to the level recorded in 2014/15, while concerns have continued to increase. Systems and process are in place to analyse all reported concerns to ensure that those that don't meet the threshold for a formal enquiry are appropriately managed and addressed.

Type of Abuse / Risk



Enquiries have increased compared to last year, with the main focus on neglect and physical abuse - which in both years accounts for over two thirds of S42 enquiries. In 2016/17, the new categories of abuse introduced in the Care Act 2014 , (e.g. self neglect) are starting to be recorded.

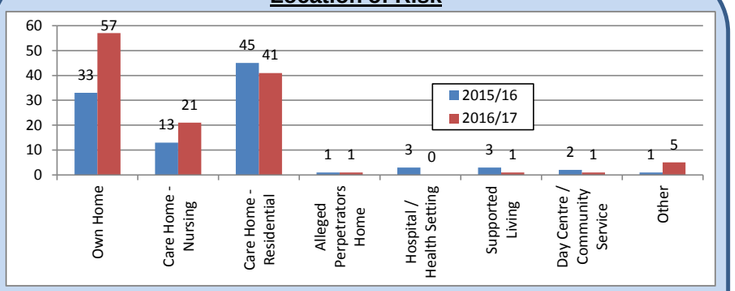
Demographics

Ethnicity - In 2016/17, 1% of enquiries related to people with ethnicity other than white, which is the same as in 2015/16 and is consistent with the local population.

Age - In 2015/16 , 74% of enquiries focused on people aged over 65 whereas in 2016/17 58% of enquires related to people in this age category.

Gender - In 2015/16, 67% of enquires related to females, compared to 54% in 2016/17.

Location of Risk



The main settings where abuse is reported continue to be care homes and users own homes.

Summary

This report provides an overview of safeguarding adults activity in Hartlepool during 2016/17. Some key areas to highlight during this period include:

(1) Throughout 2016/17 the DoLS activity has continued to increase, which has an ongoing impact on the Council's staffing and financial resources.

(2) Following the Law Commission's consultation about potential changes to DoLS, no definitive decisions have yet been made about the future of DoLS. Therefore in April 2017 HBC proceeded to implement the DoLS ADASS documentation.

(3) The overall number of concerns reported in 2016/17 continued to rise, with the main categories reported being Neglect and Physical Abuse. Concerns are now being reported relating to the new categories of abuse that were introcuced by the Care Act 2014 - Self Neglect, Domestic Violence and Sexual Exploitation.

(3) The main locations of reported abuse continue to be people's own homes and care homes.

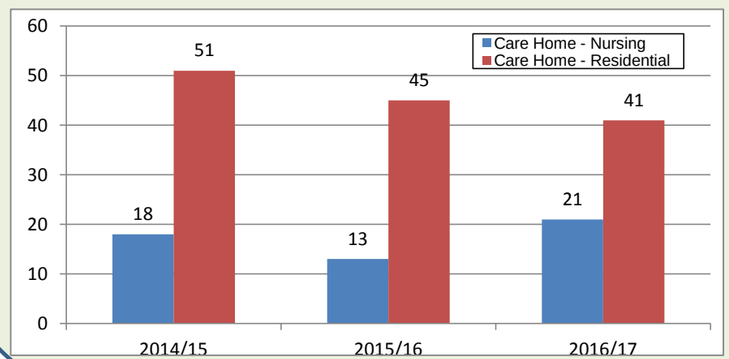
(4) HBC has fully implemented Making Safeguarding Personal (MSP) - an initiative offered to those subject to safeguarding services. Throughout 2016/17 HBC worked with Skills for People to deliver this service to those people who wished to participate and outcomes have informed practice..

Care Homes

In relation to residential care, the information outlined confirms that enquiries peaked during 2014/15 with the general trend now reducing. Activity in this area continues to be closely monitored and proactive work with providers is ongoing. The overall use of residential care beds has reduced slightly from 520 (Mar 2016) to 517 (Mar 2017), but there are peaks and troughs during this period. This is in the context of ongoing support being provided to over 4,600 adults.

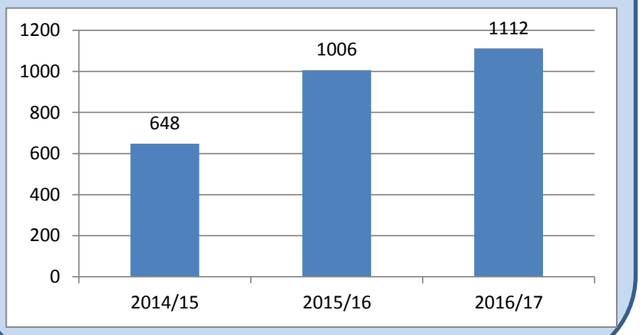
Safeguarding activity in relation to nursing care seems relatively low, but the number of people receiving nursing care is substantially lower than those receiving residential care or other commissioned services with 152 adults in receipt of nursing care in Mar 2016 and 165 in Mar 2017.

During 2016/17 there was an increase in Out of Borough placements for older people, reaching a peak of 90 in September 2016. Safeguarding issues for Out of Borough placements are dealt with by the host authority, so there may be an increase in activity for HBC going forward as more nursing placements are made available in Hartlepool .



DoLS

The number of DoLS referrals continued to rise in 2016/17. For comparison, the annual total increased from 1,006 in 2015/16 to 1,112 in 2016/17 - a further 11% increase in activity.



Outcomes

Outcomes for Adults at Risk

In 2016/17, 44% of cases completed resulted in 'Increased Monitoring', with a further 30% resulting in 'No Further Action', compared to 29% and 34% respectively for 2015/16.

Outcomes of Episodes

In 2016/17, 45 out of 92 cases (49%) with identified outcomes were either substantiated or partly substantiated.
This differs to the level reported in 2015/16 with 43 out of 68 (63%)

Local Perspective & Operational Views

1) In line with the requirements of the Care Act 2014, a Safeguarding Adult Review (SAR) in relation to a vulnerable female who was murdered in Hartlepool in 2014, was instigated. The final report along with findings have now been published and an action plan has been developed to address the findings.

2) During 2016/17 some providers of residential and / or nursing care experienced difficulties providing satisfactory care . HBC along with strategic partners took action through the Serious Concerns Process to address shortfalls in practice and to support providers to make necessary improvements.

3) A new 50 bed care home opened in May 2017 providing residential and nursing care for older people. This development will help to ease pressure on these services areas and reduce out of area placements. Two further care home developments are underway with one care home expected to open in 2017 and another planing to be operational in early 2018.

ADULT SERVICES COMMITTEE

14 September 2017

Report of: Director of Adults and Community Based Services

Subject: HOME CARE FOR OLDER PEOPLE

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to outline to Adult Services Committee the requirement to initiate tendering procedures for homecare services to older people.

3. BACKGROUND

3.1 Homecare (or domiciliary care) refers to support provided in someone's own home. Support can include help with daily activities such as getting dressed; washing; going to the toilet as well as support with medication.

3.2 The amount of support an individual receives is determined following a social work assessment and tailored to meet individual needs. As with all adult social care services, the individual receiving the support will be offered a financial assessment and may be required to make a contribution to the costs of the care they receive (of up to 100% of the total cost) based on a means test and their ability to pay. The exception to this is a situation where a person has recently come out of hospital and meets the criteria to access reablement services. In this case, they will be offered a package of support, usually for up to six weeks, which is free of charge. The aim of this service is to support people to regain or learn new skills that enable them to remain as independent as possible for as long as possible.

3.3 Homecare providers (of which there are over 4,000 in the UK) are regulated by the Care Quality Commission in the same way as care homes.

3.4 There has been significant interest nationally in the provision of domiciliary care in recent years and the National Institute for Health and Care Excellence (NICE) published guidance on this topic in September 2015; 'Home care: delivering personal care and practical support to older people living in their own homes'. This guidance makes recommendations in relation to:

- Ensuring care is person centred;
- Providing information about care and support options;
- Planning and reviewing home care and support;
- Delivering home care;
- Joint working between health and social care;
- Ensuring safety and safeguarding people using home care services; and
- Recruiting, training and supporting home care workers.

4. CURRENT POSITION

4.1 Homecare for older people is currently provided primarily by two organisations (Care Line and Care Watch) that have contracts with the Council and between them these organisations provide over 4,700 hours of home care support per week. These contracts were awarded following a tendering process and have been in place for over six years with an initial contract end date of 30 September 2016.

4.2 A report to Adult Services Committee on 23 April 2016 set out options to review the model of delivery of homecare, which included consideration of re-commissioning using the current service specification, re-commissioning with a revised service specification, direct provision of home care services and delivery through an alternative model, such as a Local Authority Owned Company.

4.3 It was decided by the Committee that an independent consultant would be commissioned to review the options in further detail. At the same time an exemption to Corporate Procurement Rules was granted to extend current contracts to allow the review to be undertaken. Current contracts were extended until 31 March 2018 with no option to extend further.

4.4 Ernst & Young were commissioned to carry out the review and the outcome of this work was reported to Adult Services Committee in March 2017. The review concluded that continuing with the current model had financial risks for the Council due to growing demand for services, and this financial risk would increase significantly if the Council was to provide services directly. The study recommended that the Council should target investment to change the delivery of care and identified a range of opportunities for the Council to be more active in the market. These included re-commissioning homecare in line with Ethical Care Charter standards and strengthening the Council's role in delivering reablement and intermediate care.

5. REQUIREMENT TO TENDER

5.1 Legal advice confirms that the Department cannot extend the current contracts any further while work continues to determine future service delivery models for health and social care.

5.2 A tendering process will commence in mid-September to enable the required evaluations of tenders and the transition period should the contracts be awarded to new providers.

5.3 To take into account the commitment of the Adult Services Committee to ensure that all services are compliant with the Unison Ethical Care Charter, the tendering process will be undertaken in a two staged approach. The first stage will assess potential providers on their ability and willingness to adhere to the Ethical Care Charter (subject of a previous report in February 2017) to ensure providers meet the requirements. The second stage will assess tenders against the quality and outcome frameworks set as part of the specification, alongside an evaluation of finances and value for money.

5.4 This tender will also include elements of service to encompass Telecare response and carers emergency respite support. These services have previously been provided outside of the core homecare contracts and bringing them together as a single service will improve consistency and continuity for people using the services, as well as being more cost effective and allowing the Council's own service to have an increased focus on intensive short term support, such as intermediate care and reablement.

5.5 As reported previously these contracts will be let under a framework agreement without any guaranteed hours. This means that should there be a decision in future to change the way in which homecare is delivered, the Council is only bound by the general terms and conditions of the contract.

6. RISK IMPLICATIONS

6.1 There are risks associated with any tendering process. There may not be sufficiently qualified organisations who are interested in taking on the service and potential providers may not meet the specifications set out in the Ethical Care Charter. These risks are low given that the two current providers meet the requirements and have accepted contract extensions previously.

7. FINANCIAL CONSIDERATIONS

7.1 There are financial considerations to note, as any tendering process can lead to an increase in costs. Homecare providers may take the opportunity to link their bids with hourly rates proposed by the UK Home Care Association and may also take into account recent announcements about additional funding being provided to Local Authorities through the Improved Better Care Fund allocations to support the local care market.

8. LEGAL CONSIDERATIONS

8.1 There are legal implications in that the current contracts cannot be extended beyond 31 March 2018.

9. CHILD AND FAMILY POVERTY CONSIDERATIONS

9.1 There are no child and family poverty considerations identified.

10. EQUALITY AND DIVERSITY CONSIDERATIONS

10.1 There are no equality and diversity considerations identified.

11. STAFF CONSIDERATIONS

11.1 There are no staffing considerations for the Council. If one or more of the contracts was awarded to a new provider TUPE would apply to staff in current services which would be managed by existing providers and any new providers.

12. ASSET MANAGEMENT CONSIDERATIONS

12.1 There are no asset management considerations identified.

13. RECOMMENDATIONS

13.1 It is recommended that the Adult Services Committee note the current position and the requirement to initiate tendering for domiciliary care services.

14. REASONS FOR RECOMMENDATIONS

14.1 There is a legal requirement to re-procure homecare services and framework contracts will be used to ensure flexibility to accommodate future service delivery models.

15. CONTACT OFFICER

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ADULT SERVICES COMMITTEE

14 September 2017

Report of: Director of Adults and Community Based Services

Subject: LIFETIME HOMES STANDARDS

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 To provide members of the Adult Services Committee with information regarding the Lifetime Homes Standards.

3. BACKGROUND

3.1 Following a discussion at a previous Adult Services Committee regarding adaptations that support people to live independently, Members asked for further information regarding Lifetime Homes Standards.

3.2 In 2008 the Government published 'Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society' which set out the need to build more flexible and inclusive housing in order to meet the future requirements of the ageing population.

3.3 To encourage the development of more Lifetime Homes the Government then incorporated the standard into the Code for Sustainable Homes.

3.4 Revisions to the Lifetime Homes criteria were introduced to achieve a higher level of practicability for volume developers in meeting the requirements of the Code for Sustainable Homes. The revisions are the result of work by the Lifetime Homes Technical Advisory Group representing a cross-section of practitioners involved in housing design, housing development, access consultancy and provision of adaptations.

3.5 The revised Lifetime Homes Standard was published in July 2010. The Code for Sustainable Homes technical guidance was updated to include the revised Lifetime Homes Standard in November 2010. Further detail regarding the Lifetime Home Standard is attached as **Appendix 1.**

4. PLANNING

4.1 The Lifetime Homes Standard is generally higher than that required by Part M of the Building Regulations (which deals with accessibility), although some elements of Part M are equal to the Lifetime Homes requirements or need relatively minor changes to comply.

4.2 Some Lifetime Homes features need to be in place from the start, while for others, the requirement is provision for future adaptations. For example, the shower provision means that there should be drainage that allows for an accessible shower, if and when one is required. It does not mean that a sloping floor, waterproof finish or shower equipment have to be initially provided.

4.3 Access Statements are now an essential part of planning applications and, to ensure local authority access needs for housing are met, Lifetime Home designs should be considered as early as possible in the planning process.

4.4 The design of Lifetime Homes makes it easy for wheelchair users to visit the property, but does not necessarily provide full wheelchair access throughout the home. Accessibility for wheelchair users within the household can be increased by utilising some of the cost-effective adaptability criteria built in from the outset, but space and access will not match wheelchair housing standards and some degree of compromise will be required by a member of the household who uses a wheelchair.

4.5 Where a scheme is being built to the Lifetime Homes Standard and the development was submitted for detailed planning approval prior to the publication of the revised standard on 5 July 2010, the Standard (and Criteria) applicable at the time of detailed planning submission would normally apply unless the local planning authority agree, or state, otherwise.

4.6 Subject to any necessary agreement of the planning authority, Lifetime Homes procedures would not prevent the revised standard being applied to any development retrospectively.

5. RISK IMPLICATIONS

5.1 Lifetime Homes have both a direct and an indirect cost benefit to local authorities; in addition there are non-quantifiable qualitative benefits for the community they serve.

5.2 **Adaptations -** A reduction in the provision of money for works to existing stock for housing association properties means that more housing associations and their tenants are utilising the Disabled Facilities Grant system. This, coupled with increased numbers of disabled and older people in the other housing sectors in our communities, puts greater demands on local authorities' Disabled Facilities Grant budgets.

Lifetime Homes are built with accessibility and adaptability incorporated at the design stage. Should the occupant's needs change, the homes are cheaper to adapt and there is minimal disruption to the occupant.

5.3 **Better stock management -** As the homes meet the needs of a broader client base (disabled people, non-disabled people and older people) there is more effective use of resources and void periods are cut.

5.4 **Social Services -** As Lifetime Homes are designed to meet changing needs, people are able to remain at home and live independently for longer. There is less likelihood of people being placed in sheltered accommodation or residential / nursing homes prematurely.

5.5 **Long-term community benefits -** With recent legislative changes there is a greater duty on local authorities to meet the needs of the community which they serve. Lifetime Homes have benefits which impact across departments and agencies. The fact that older and disabled people do not have to move unless they choose to adds to the social cohesion of a community.

6. FINANCIAL CONSIDERATIONS

6.1 The most up to date analysis of the costs of building to the Lifetime Homes Standard was summarised in the Department for Communities and Local Government (DCLG) document: The Future of the Code for Sustainable Homes' which was published in July 2007.

6.2 There have been a number of studies into the costs and benefits of building to the Lifetime Homes Standard. These have concluded that the costs range from £545 to £1,615 per dwelling, depending on the experience of the home designer and builder; the size of the dwelling and whether Lifetime Homes design criteria were designed into developments from the outset

6.3 The net cost of implementing the Lifetime Homes Standard will diminish as the concept is more widely adopted, and as design standards and market expectations rise.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations associated with this report

8. CONSULTATION

8.1 There are no consultation requirements associated with this report

9. CHILD AND FAMILY POVERTY

9.1 There are no child and family poverty considerations associated with this report

10. EQUALITY AND DIVERSITY CONSIDERATIONS

10.1 There are no equality and diversity considerations that require an impact assessment. The Lifetime Home Standards have been developed nationally to support people with disabilities and older people to have improved access to more accessible or adaptable accommodation.

11. STAFF CONSIDERATIONS

11.1 There are no staff considerations associated with this report

12. ASSET MANAGEMENT CONSIDERATIONS

12.1 There are no asset management considerations associated with this report

13. RECOMMENDATIONS

13.1 It is recommended that members note the information provided.

14. REASONS FOR RECOMMENDATIONS

14.1 This report provides the additional information that Members requested in relation to the Lifetime Homes Standards.

15. CONTACT OFFICERS

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Lifetime Home (LTH) Revised Criteria

July 2010

(Quick Print version)

Criterion 1– Parking (width or widening capability)

Principle: *Provide, or enable by cost effective adaptation, parking that makes getting into and out of the vehicle as convenient as possible for the widest range of people (including those with reduced mobility and/or those with children).*

1a – 'On plot' (non-communal) parking

Where a dwelling has car parking within its individual plot (or title) boundary, at least one parking space length should be capable of enlargement to achieve a minimum width of 3300mm.

Required specification to achieve Criterion 1a ('on plot' parking)

If a 2400mm wide parking space has a 900mm access path (as required by Part M) adjacent to, and level with it, then this will automatically satisfy the requirement. Where this does not occur, a parking space should have a strip of soft landscaping (or similar) adjacent to, and approximately level with it, so that this can be re-surfaced and made level with the parking space in the future, to achieve an overall parking width of 3300mm. Whenever possible, the wider space (or potential wider space) should be at least 4800mm in length.

The entire parking space (whether pre or post widened) should have a firm surface and be level (no gradient exceeding 1:60 and/or no crossfall for drainage exceeding 1:40).

Garages are exempt from the width / widening requirements. However, any hard-standing for a parked car, leading to any garage, should conform to the Criterion's requirements.

Other private covered parking spaces (e.g. car ports) are also exempt from the width widening requirements unless they provide the only parking space available for a dwelling. If they provide the only parking space for the dwelling they should have a minimum clear width of 3300mm.

Good practice recommendations that exceed, or are in addition to, the above requirements

- Increase the width or widening capability of the parking from 3300mm to 3600mm.
- Increase the length of the widened space as much as practicable.
- Provide all carports with a minimum clear width of 3300mm (3600mm preferred) regardless of whether or not they provide the only parking space for the dwelling.
- Where garages are provided, provide them with a minimum clear width of 3300mm (3600mm preferred), particularly if the garage provides the only parking space for the dwelling.

1b – Communal or shared parking

Where parking is provided by communal or shared bays, spaces with a width of 3300mm, in accordance with the specification below, should be provided.

Required specification to achieve Criterion 1b (communal or shared parking)

Provide at least one parking space (or a greater number as determined by the local planning authority), at least 3300mm wide x 4800mm deep adjacent to (or close to) each block's entrance or lift core. Where some dwellings in a development are designated as "wheelchair housing", any specific parking for such dwellings should be in addition to those provided in respect of this Lifetime Home Criterion.

The access route between the parking and communal entrance (or in the case of basement parking, the lift core) should maintain a minimum clear width of 1200mm.

Good practice recommendations that exceed, or are in addition to, the above requirements

- Increase the width of these spaces from 3300mm to 3600mm.
- Increase the length of these spaces from 4800mm to 6000mm.
- Where feasible, design the communal parking layout and adjacent spaces to enable some further additional spaces to be widened in the future.
- Where a Local Planning Authority wishes to ensure that adequate parking provision is made for disabled people they may wish to consider a planning condition that requires a Parking Management Plan (see Appendix 2).

Note: Criterion 1 is not relevant to developments that do not contain any parking provision. However, consultation with the local planning department regarding parking arrangements for Lifetime Homes and wheelchair accessible properties on such developments will be required.

Criterion 2 – Approach to dwelling from parking (distance, gradients and widths)

Principle: *Enable convenient movement between the vehicle and dwelling for the widest range of people, including those with reduced mobility and/or those carrying children or shopping.*

2 – Approach to dwelling from parking

The distance from the car parking space of Criterion 1 to the dwelling entrance (or relevant block entrance or lift core), should be kept to a minimum and be level or gently sloping. The distance from visitors parking to relevant entrances should be as short as practicable and be level or gently sloping.

Required specification to achieve Criterion 2

Note: Relevant entrances in respect of this Criterion are either the principal or secondary entrance doors to an individual dwelling or the main communal entrance door to a block of dwellings, and (in the case of basement parking) the entrance door to the lift core.

The principal approach route between parking spaces and relevant entrances should preferably be level (i.e. no gradient exceeding 1:60, and/or no crossfall exceeding 1:40).

Where the topography or Regulation (e.g. in relation to flooding) prevent a level principal route between parking and entrances, the principal route may be gently sloping with maximum gradients as set out in Criterion 3.

Where topography restricts the provision of a level or gently sloping approach from parking to only one entrance of a dwelling, this approach should typically be to the dwelling's main entrance. This approach should only occur to a secondary entrance where it can be demonstrated that topography or Regulation prevents such a route to the main entrance.

If the principal approach to a communal entrance is gently sloping (i.e. with maximum gradients as set out in Criterion 3), a secondary stepped approach in accordance with Approved Document M domestic requirements, should also be provided.

The distance between all parking and entrances should be as short as practicable. Parking adjacent to entrances is the optimum arrangement. On large developments communal parking should be within 50 metres of the relevant communal entrance or (in the case of underground parking) the lift core. If a distance in excess of 50 metres cannot be avoided, level resting areas should be provided along the route.

Paths on all approach routes between parking and entrances should have a firm, reasonably smooth and non-slip surface. Those within the curtilage of an individual dwelling should have a minimum width of 900mm. Communal paths should have a minimum width of 1200mm.

Good practice <u>recommendations</u> that exceed, or are in addition to, the above requirements

- Increase the width of the path between the parking and the dwelling within individual dwelling curtilages to 1200mm, particularly if there is a change in direction.
- Increase the width of communal paths to 1800mm.
- Where the approach route exceeds 50m, provide seating and weather protection at the required level resting places along the route.

Criterion 3 – Approach to all entrances

Principle: Enable, as far as practicable, convenient movement along other approach routes to dwellings (in addition to the principal approach from a vehicle required by Criterion 2) for the widest range of people.

3 – Approach to all entrances

The approach to all entrances should preferably be level or gently sloping, and in accordance with the specification below.

Required specification to achieve Criterion 3

The approach to all entrances should preferably be level (no gradient exceeding 1:60 and/or no crossfall exceeding 1:40) or gently sloping. A 'gently sloping' approach may have a gradient of 1:12 for a distance of up to 2 metres and 1:20 for a distance of 10 metres, with gradients for intermediate distances interpolated between these values (e.g. 1:15 for a distance of 5 metres, or 1:19 for a distance of 9 metres - see Figure 3.1). No slope should have a going greater than 10 metres long.

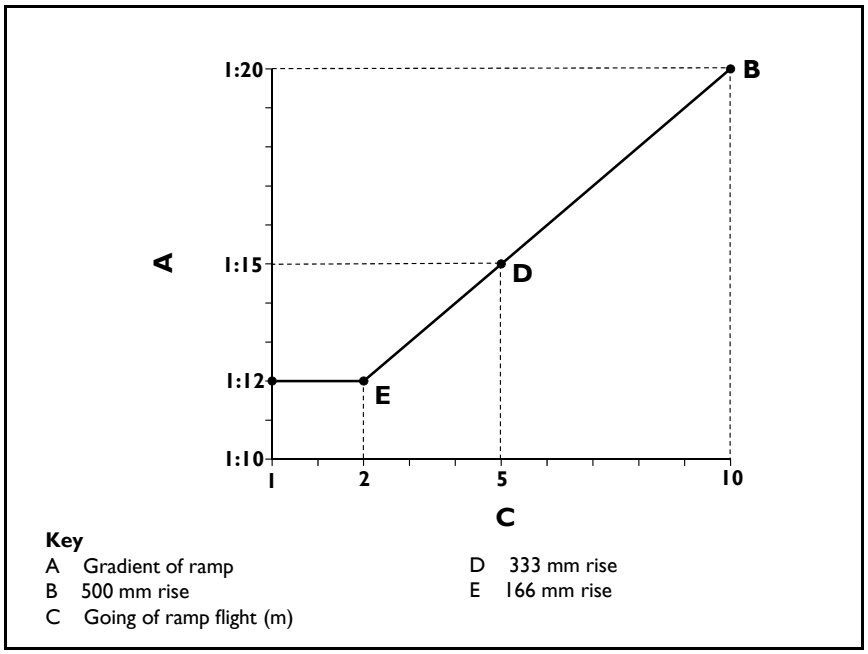

Figure 3.1 – Relationship between the gradient and going of a slope

All slopes should have top and bottom level landings of not less than 1.2 metres, excluding the swing of doors and gates. Equivalent intermediate landings should be provided for each 10 metre length of slope.

This requirement applies to all footpath approaches between:

i) parking and all associated entrances (including secondary entrance doors where a footpath link exists);

ii) approaches between any drop off points and associated communal entrances, and;

iii) on principle footpath routes between the overall site boundary and entrances.

iv)

On steeply sloping sites it is accepted that this requirement may not be practicable, or achievable, and should be discussed with the local planning authority to agree a workable solution.

Paths on all approach routes between parking and entrances should have a firm, reasonably smooth and non-slip surface. Those within the curtilage of an individual dwelling should have a minimum width of 900mm. Communal paths should have a minimum width of 1200mm.

Good practice <u>recommendations</u> that exceed, or are in addition to, the above requirements

- Increase the width of the path between the parking and the dwelling within individual dwelling curtilages to 1200mm, particularly if there is a change in direction.
- Increase the width of communal paths to 1800mm.

Criterion 4 – Entrances

Principle: *Enable ease of use of all entrances for the widest range of people.*

4 - Entrances

All entrances should:

a) Be illuminated

b) Have level access over the threshold; and

c) Have effective clear opening widths and nibs as specified below.

In addition, main entrances should also:

d) Have adequate weather protection*

e) Have a level external landing.*

***Note: For the purpose of requirements d) and e) of this Criterion, main entrances are deemed to be: the front door to an individual dwelling, the main communal entrance door to a block of dwellings, plus any other entrance door associated with the approach route from parking required by Criterion 2.**

Required specification to achieve Criterion 4

All entrances should be lit with fully diffused luminaires.

All entrances should have an accessible threshold with a maximum 15mm up-stand. The 15mm 'up-stand' relates to the total height of the threshold unit (often a one piece proprietary product). In practice the threshold will consist of a number of lesser up-stands and sloping infill connections. Transition units (with a maximum slope of 15 degrees) may be provided on one or both sides of the threshold. Examples of acceptable thresholds are provided within: 'Accessible thresholds in new housing – Guidance for house builders and developers' The Stationary Office Ltd. ISBN 0 11 702333 3. 1999.

The above accessible threshold requirement applies to any entrance where any person may move across the threshold. All entrances of a dwelling, including balcony and roof terrace doors (subject to the two exemptions below) and all communal entrances within blocks of dwellings (to any communal area or facility) should meet this requirement. Only 'Juliet balconies', where no access onto the balcony is intended, and roof terraces/balconies over

habitable rooms, which require a step up to increase slab thickness (e.g. for thermal insulation to the accommodation below), are exempt.

The minimum effective clear opening width at all entrances to a dwelling (including balcony and roof terrace entrances) should be 800mm. The minimum effective clear opening width at communal entrances (and other communal doors) should be 800mm or 825mm, depending on the direction and width of approach, as detailed in the table below:

Dwelling entrance doors	
Direction and width of approach	**Minimum effective clear width (mm)**
All	800
Communal entrance doors	
Direction and width of approach	**Minimum effective clear width (mm)**
Straight-on (without a turn or oblique approach)	800
At right angles to an access route at least 1500mm wide	800
At right angles to an access route at least 1200mm wide	825

Note: The effective clear width is the width of the opening measured in the same plane to the wall in which the door is situated, between a line perpendicular to the wall from the outside of the door stop on the latch side and the nearest obstruction on the hinge side when the door is open. The nearest obstruction may be projecting door furniture, a weatherboard, the door, or the door stop.

There should be a 300mm nib (or clear space) to the leading edge on the pull side of all entrance doors to dwellings and all communal entrance doors. See Figure 4a.

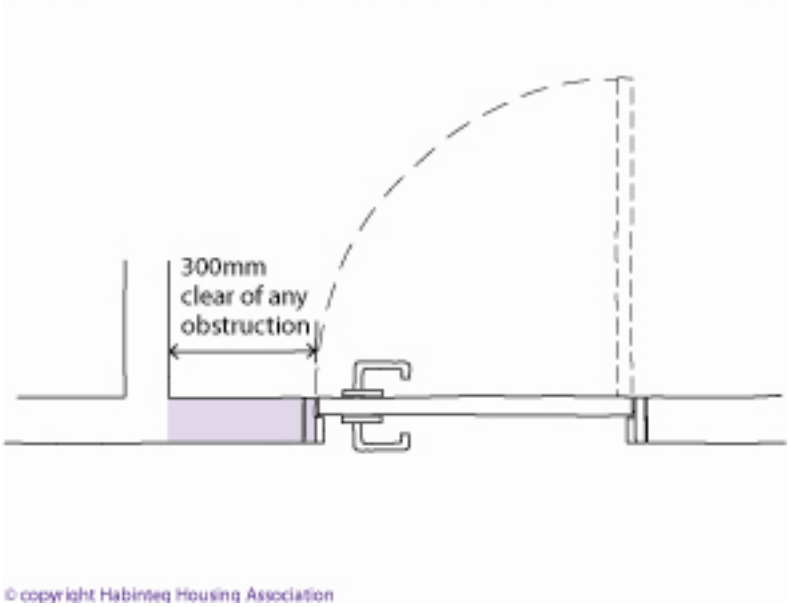

Figure 4a – 300mm door nib (or clear space) to leading edge (pull side only)

All main entrances* should be covered to provide weather protection for those unlocking, or waiting at, the door. The size and form of the cover should have regard for local conditions to provide effective weather protection. As a general guide, the cover at an individual dwelling door should have a minimum depth of 600mm (900mm being typical). As a general guide, the cover at a communal door should have a minimum depth of 900mm (1200mm being typical). The width of the cover should exceed the width of the doorset plus any associated controls. At exposed sites additional cover and protection may be necessary.

A level external landing (maximum gradient 1:60 and/or maximum crossfall 1:40 for effective drainage) should be provided at all main entrances*. The minimum dimensions for this at an entrance to an individual dwelling should be 1200mm x 1200mm. At a communal entrance the minimum dimensions should be 1500mm x 1500mm. These dimensions for level landings should be clear of any door swings.

Good practice <u>recommendations</u> that exceed, or are in addition to, the above requirements

Wider effective clear widths at communal doors (greater than the minimum required above) can be beneficial for the movement of furniture and personal effects of residents. Whilst a resident may be able to momentarily leave a number of items at their own personal entrance door prior to moving them into the dwelling, it may be less convenient, or inappropriate, to leave items at communal entrances some distance from the private

dwelling. Wider communal entrance doors can therefore assist residents in uninterrupted movement of possessions to and from the dwelling.

Criterion 5– Communal stairs and lifts

Principle: *Enable access to dwellings above the entrance level to as many people as possible.*

5a – Communal Stairs

Principal access stairs should provide easy access in accordance with the specification below, regardless of whether or not a lift is provided.

5b – Communal Lifts

Where a dwelling is reached by a lift, it should be fully accessible in accordance with the specification below.

Required specification for Criterion 5a - Communal Stairs

Communal stairs providing a principal access route to a dwelling regardless of whether or not a lift is provided should be easy going, with:

- Uniform rise not exceeding 170mm.
- Uniform going not less than 250mm.
- Handrails that extend 300mm beyond the top and bottom.
- Handrails height 900mm from each nosing.
- Step nosings distinguishable through contrasting brightness.
- Risers which are not open.

Required specification for Criterion 5b – Communal Lifts (where applicable)

Provision of a lift is not a Lifetime Home requirement (see recommendations below), but where a lift is provided, it should:

- Have minimum internal dimensions of 1100mm x 1400mm.
- Have clear landings adjacent to the lift entrance of 1500mm x 1500mm.
- Have lift controls at a height between 900mm and 1200mm from the floor and 400mm from the lift's internal front wall.

Good practice recommendations that exceed, or are in addition to, the above requirements

- Provide lift access to all dwellings above entrance level as far as practicable.
- Provide access to two lifts within blocks of 4 or more storeys.
- Where lift access is not provided, consider potential to enable provision at a later date (by provision of space and/or adaptation).

Criterion 6 – Internal doorways and hallways

Principle: Enable convenient movement in hallways and through doorways.

6. Internal doorways and hallways

Movement in hallways and through doorways should be as convenient to the widest range of people, including those using mobility aids or wheelchairs, and those moving furniture or other objects.

As a general principle, narrower hallways and landings will need wider doorways in their side walls.

The width of doorways and hallways should conform to the specification below.

Required Specification for Criterion 6

Hallway widths

Subject to provision of adequate door opening widths (as detailed in the table below), the minimum width of any hallway/landing in a dwelling is 900mm. This may reduce to 750mm at 'pinch points' (e.g. beside a radiator) as long as the reduced width is not opposite, or adjacent to, a doorway.

The minimum width of any hallway/corridor/landing within a communal area is 1200mm, which may reduce to 1050mm at 'pinch points' (e.g. due to a structural column) as long as the reduced width is not opposite, or adjacent to, a doorway.

Doorway widths within dwellings

Head on approach to door within dwelling

The minimum clear opening width of any doorway within a dwelling, when the approach to the door is 'head on', is 750mm.

Turning to pass through a door within dwelling

When the approach to a doorway is not head on, and a turn is required to pass through the doorway, the minimum clear opening for that doorway will relate to the width of the approach (typically a hallway or landing), and should be in accordance with the table below:

Internal dwelling doors	
Direction and width of approach	**Minimum clear opening width (mm)**
Straight-on (without a turn or oblique approach)	750
At right angles to a hallway / landing at least 1200mm wide	750
At right angles to a corridor / landing at least 1050mm wide	775
At right angles to a corridor / landing less than 1050mm wide (minimum width 900mm).	900

These clear width requirements apply to any doorway where movement through the doorway is intended. They do not apply to storage/cupboard doors unless the storage/cupboard is 'walk in'.

Communal doors

Head on approach to a communal door

The minimum clear opening width of any communal doorway when the approach to the door is 'head on' is 800mm.

Turning to pass through a communal door

When the approach to a communal doorway is not head on, and a turn is required to pass through the doorway, the minimum clear opening for that doorway will relate to the width of the approach (typically a corridor or landing), and should be in accordance with the table below:

Communal doors	
Direction and width of approach	**Minimum clear opening width (mm)**
Straight-on (without a turn or oblique approach)	800
At right angles to a corridor / landing at least 1500mm wide	800
At right angles to a corridor / landing at least 1200mm wide	825

Provision of nibs

All communal doorways should have a 300mm nib (or clear space in the same plane as the wall in which the door is situated) to the leading edge of the door, on the pull side.

Similarly, all doors to rooms on the entrance level of each dwelling, should have a 300mm nib (or clear space in the same plane as the wall in which the door is situated) to the leading edge of the door, on the pull side. See Figure 6a.

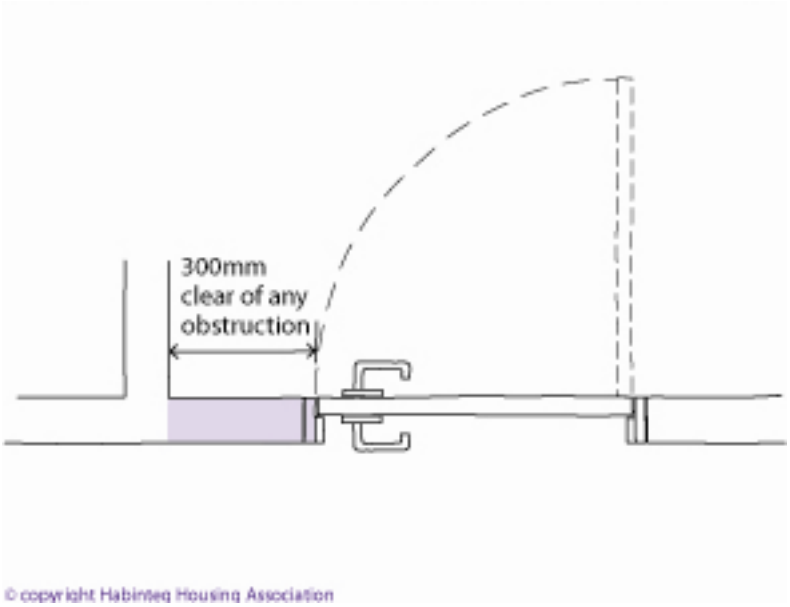

Figure 6a - 300mm door nib (or clear space) to leading edge (pull side only)

Note: For clear opening widths for dwelling entrance / communal entrance doors, and nib requirements at entrance doors, please refer to Criterion 4 - Entrances.

Criterion 7 – Circulation Space

Principle: Enable convenient movement in rooms for as many people as possible.

7. Circulation Space

There should be space for turning a wheelchair in dining areas and living rooms and basic circulation space for wheelchair users elsewhere.

Required specification for Criterion 7

The minimum basic circulation spaces required, as detailed below, are not intended to match the equivalent space requirements within dwellings to wheelchair housing, or wheelchair adaptable standards. They recognise that a wheelchair user within a Lifetime Home will need to accept a degree of compromise on available manoeuvring & circulation space.

Basic circulation space for a wheelchair user is used as a guide for the minimum requirement as this will result in circulation space that will also assist a wide range of occupants and visitors, including those using sticks or other mobility aids, or households with young children.

WC compartments and bathrooms

Functional spaces requirements for WC compartments and bathrooms are detailed in Criteria 10 and 14.

Hallways and landings within dwellings

Circulation widths and spaces for hallways and landings within dwellings are detailed in Criterion 6.

Living rooms/areas and dining rooms/areas

Living rooms/areas and dining rooms/areas should be capable of having either a clear turning circle of 1500mm diameter, or a turning ellipse of 1700mm x 1400mm. Where dwelling layout plans include furniture layouts, occasional items of furniture (typically coffee tables & side tables) can be within or overlap these turning zones.

Where movement between furniture is necessary for essential circulation (e.g. to approach other rooms, or the window) a clear width of 750mm between items should be possible.

Kitchens

Kitchens should have a clear width of 1200mm between kitchen unit fronts / appliance fronts and any fixed obstruction opposite (such as other kitchen fittings or walls). This clear 1200mm should be maintained for the entire run of the unit, worktop and/or appliance.

An additional good practice recommendation in respect of kitchen planning and layout is given below.

Bedrooms

The main bedroom in a dwelling should be capable of having a clear space, 750mm wide to both sides and the foot of a standard sized double bed.

Other bedrooms should be capable of having a clear space, 750mm wide, to one side of the bed. In addition, in these bedrooms, where it is necessary to pass the foot of the bed (e.g. to approach the window as required by Criterion 15), a clear width of 750mm should also be provided at the foot of the bed.

Note: Bedside cabinets may be sited within the required clear spaces beside beds.

Good practice recommendation that exceed, or are in addition to, the above requirements

Kitchen

- Kitchen layouts, whenever possible, should be planned so that they can include (following adaptation) a continuous run of units, unbroken by doorways, including: a built in oven at an accessible height beside a minimum 600mm of work surface, a hob beside a further minimum 600mm of work surface, and a sink/drainer. This continuous run, uninterrupted by doorways, (c. 3600mm in length measured along the front face) could be straight, L shaped, or U shaped. In addition, window positions should not impede on the oven or hob positions. Space for other typical 'white goods' and fittings should be available elsewhere in the kitchen (so that only the oven and hob are contained within this particular length of run).
- Provide a clear 1500mm diameter circular, or 1400mm x 1700mm elliptical, manoeuvring space from floor for a minimum height of 900mm.

Criterion 8 – Entrance level living space

Principle: Provide accessible socialising space for visitors less able to use stairs.

8. Entrance level living space A living room / living space should be provided on the entrance level of every dwelling (see Appendix 1 for definition of 'entrance level').

Required specification to achieve Criterion 8

A living room or living space in the context of this Criterion is categorised as: Any permanent living room, living area, dining room, dining area (e.g. within a kitchen/diner), or other reception area that provides seating / socialising space for the household and visitors.

Note: In dwellings with two or more storeys, this living space may also need to provide other entrance level requirements (e.g. the temporary entrance level bed-space of Criterion 9, or the through floor lift space of Criterion 12).

Good practice recommendations that exceed, or are in addition to, the above requirements

Also provide the kitchen on the entrance level.

Criterion 9 – Potential for entrance level bed-space

Principle: Provide space for a member of the household to sleep on the entrance level if they are temporarily unable to use stairs (e.g. after a hip operation).

9. Potential for entrance level bed-space

In dwellings with two or more storeys, with no permanent bedroom on the entrance level, there should be space on the entrance level that could be used as a convenient temporary bed-space.

Required specification to achieve Criterion 9

The definition of entrance level in the context of this Criterion is as defined in Appendix 1.

A corner of a room that can accommodate a single bed with a 750mm wide space to one side of the bed is suitable as a temporary bed space. This area should be capable of being screened (with a portable screen) from the rest of the room. Provision of an electrical socket within the space is required.

This space is typically provided in the corner of a living room following rearrangement of the furniture – however, the living room should remain functional (despite a compromised layout). A dining room or dining area can also provide for the temporary bed space as long as the dining function can continue (or be relocated elsewhere). However, providing this facility within a dining space of a kitchen/diner provides the least convenient arrangement and should be avoided whenever possible.

Note: This temporary bed-space, and the identified through floor lift space of Criterion 12, may overlap - as the temporary bed space will not be required if a through floor lift is available.

Good practice recommendations that exceed, or in addition to, the above requirements

Provision of a window for ventilation and a heat source within the space would be beneficial.

A layout which provides potential for a suitable recess / area that is easier to screen and provides better separation from the remaining room is beneficial.

Criterion 10 – Entrance level WC and shower drainage

Principle: Provide an accessible WC and potential showering facilities for:

i) any member of the household using the temporary entrance level bed space of Criterion 9, and:

ii) visitors unable to use stairs.

10. Entrance level WC and shower drainage

Where an accessible bathroom, in accordance with Criterion 14, is not provided on the entrance level of a dwelling, the entrance level should have an accessible WC compartment, with potential for a shower to be installed – as detailed in the specification below. (See Appendix 1 for definition of entrance level).

Required specification to achieve Criterion 10

In dwellings with two or more storeys, and no more than two habitable rooms in addition to the main living room and any kitchen/diner (typically a one or two bedroom house), a Part M WC compartment will satisfy this Criterion provided that the floor drain for a future accessible shower (not required by Part M) is available in the compartment, or in a suitable location elsewhere.

In all other dwellings (where an accessible bathroom in accordance with Criterion 14 is not provided on the entrance level) the compartment's specification should be as detailed below:

An accessible WC compartment should contain:

1. A WC with:

i) A centre line between 400mm – 500mm from an adjacent wall.

ii) A flush control located between the centre-line of the WC and the side of the cistern furthest away from the adjacent wall.

iii) An approach zone extending at least 350mm from the WC's centre-line towards the adjacent wall, and at least 1000mm from the WC's centre-line on the other side. This zone should extend forward from the front rim of the WC by at least 1100mm. The zone should also extend back at least 500mm from the front rim of the WC for a width of 1000mm from the WC's centre-line.

A basin which may be located either on the adjacent wall, or adjacent to the cistern, should not project into this approach zone by more than 200mm.

This zone is demonstrated by Figure 10a.

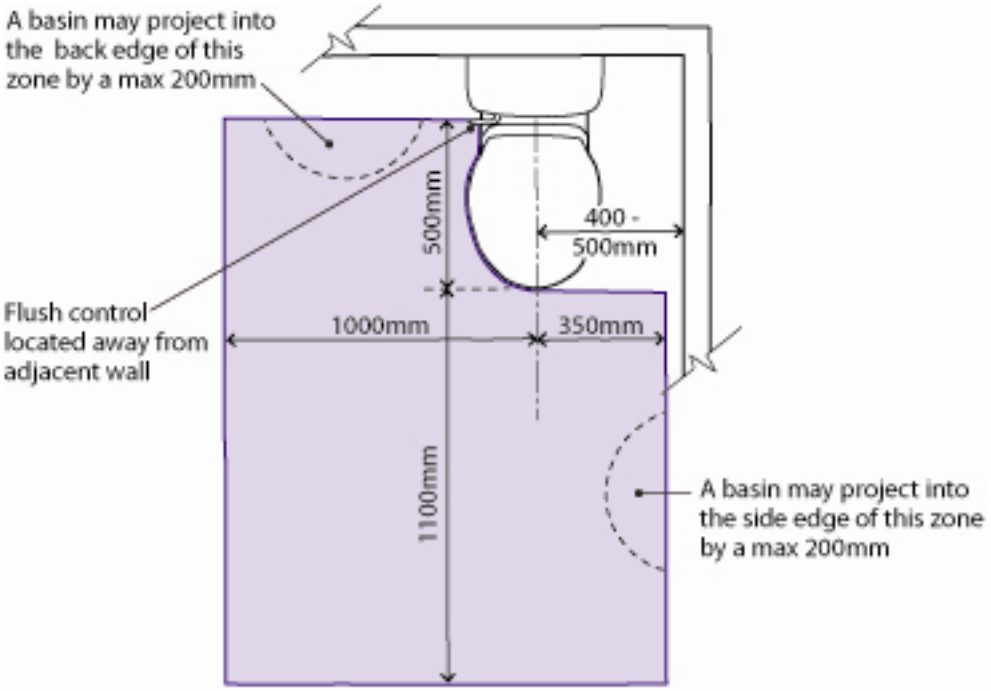

Figure 10a - Approach zone to WC

2. A basin with:

   A clear frontal approach zone extending back for a distance of 1100mm from any obstruction under the basin – whether that be a pedestal, trap, duct or housing. This zone will normally overlap with the WC's approach zone as detailed in item 1iii) above.

3. Unless provided elsewhere on the entrance level (see Note 1), floor drainage for an accessible floor level shower with:

A floor construction that provides either shallow falls to the floor drainage, or (where the drainage is initially capped for use later following installation of a shower) that allows simple and easy installation of a laid-to-fall floor surface in the future.

Whether provided from the outset, or by subsequent adaptation, fall gradients in the floor should be the minimum required for efficient drainage of the floor area. Crossfalls should be minimised.

The floor drain should be located as far away from the doorway as practicable.

Requirements 1 – 3 above are demonstrated within Figure 10b.

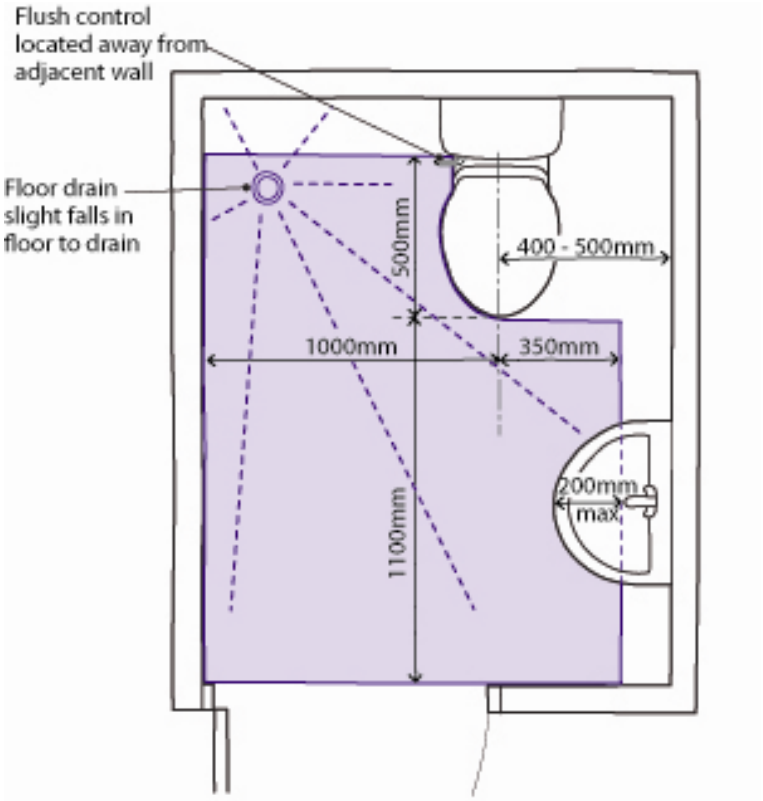

Figure 10b - Example accessible WC conpartment layout

Whilst a variety of solutions (and footprint sizes) can be created to satisfy the above layout requirements, it is noted that an overall compartment footprint of 1450mm x 1900mm will enable increased choice of fittings.

If the compartment contains the only accessible entrance level WC within the dwelling, an outward opening door to the compartment will be required to satisfy Approved Document M.

Good practice recommendations that exceed, or are in addition to, the above requirements

- Position the WC and a hand rinse basin so that the basin can be reached from the WC position (as shown in Figure 10b).
- Provide wall hung fittings to create greater manoeuvrability at floor level and ease of cleaning.

Criterion 11 - WC and bathroom walls

Principle: Ensure future provision of grab rails is possible, to assist with independent use of WC and bathroom facilities.

11 – WC and bathroom walls

Walls in all bathrooms and WC compartments should be capable of firm fixing and support for adaptations such as grab rails.

Required specification to achieve Criterion 11

Adequate fixing and support for grab rails should be available at any location on all walls, within a height band of 300mm – 1800mm from the floor.

Criterion 12 – Stairs and potential through-floor lift in dwellings

Principle: Enable access to storeys above the entrance level for the widest range of households.

12 - Stairs and potential though-floor lift in dwellings

The design within a dwelling of two or more storeys should incorporate both:

a) Potential for stair lift installation; and,

b) A suitable identified space for a through-the–floor lift from the entrance level to a storey containing a main bedroom and a bathroom satisfying Criterion 14.

Required specification to achieve Criterion 12a - Stairs

In dwellings with two or more storeys, the stairs and associated area should be adequate to enable installation of a (seated) stair lift without significant alteration or reinforcement.

A clear width of 900mm should be provided on stairs. This clear width should be measured 450mm above the pitch height.

Required specification to achieve Criterion 12b – Potential for through floor lift

Unless the entrance level of the dwelling contains the living accommodation, the kitchen, a main (twin or double) bedroom and a bathroom meeting the requirements of Criterion 14, a suitable route for a wheelchair accessible through-the-floor lift from the entrance level should be identified. This route should enable potential access to those rooms listed in the preceding sentence that are not on the dwelling's entrance level.

The identified route for the lift may be from a living room/space directly into a bedroom above. Alternatively, the route may be from, or arrive in, circulation space.

The potential aperture size for the route through the floor should be a minimum1000mm x 1500mm - with the potential approach to the lift being to one of the shorter sides. This potential aperture area should be clear of services.

Where the identified lift route within the dwelling passes through a concrete floor, a 'knock out' panel should be pre-formed within the floor. Traditional wooden joist floors, 'I'beam floors, and metal web floors need not be provided with a 'knock out' panel along the lift route, provided that their design has taken account of associated point loads to enable the creation of the void if required.

It is acceptable for the identified route to require some degree of alteration / moving of demountable partition walls (e.g. timber stud walls) if this can provide the most efficient and practical layout arrangement following lift installation. However, where this is the case, the partitions to be moved should be clear of services.

When the potential arrival point for the lift arrives directly into a bedroom, there must be space to exit and approach the lift. A compromised room layout would be expected following lift installation, but as a basic minimum the room should still be able to function as a single bedroom. It is also a requirement that if the lift route is to arrive directly into a bedroom, the dwelling must have at least one bedroom that remains functional as a double bedroom.

Additional good practice <u>recommendations</u> that exceed, or are in addition to, the above requirements:

<u>Stairs</u>

Although stair lifts are available for installation on most forms of stair, a straight flight with clear landings at the top and bottom, will provide for a more cost effective installation.

A straight flight of stairs with goings (treads) of consistent depth (i.e. no winders) is safer to use, particularly for those less agile.

A straight stair, without winders, is therefore recommended.

Where winders are incorporated onto a stair consideration should be given to ensure that an adequate going depth remains on the winders if a stair lift is installed.

<u>Potential through floor lift</u>

At the identified route, provide an electrical point to assist in any future adaptation / installation of the lift. This plate should be annotated with 'lift position' (or similar) to assist in future identification of the possible route.

Criterion 13 – Potential for fitting of hoists and bedroom / bathroom relationship

Principle: Assist with independent living by enabling convenient movement between bedroom and bathroom facilities for a wide range of people.

13 – Potential for future fitting of hoists and bedroom / bathroom relationship

Structure above a main bedroom and bathroom ceilings should be capable of supporting ceiling hoists and the design should provide a reasonable route between this bedroom and the bathroom.

Required specification to achieve Criterion 13

Structure above ceiling finishes over a main (twin or double) bedroom and over the bathroom should be capable of supporting, or capable of adaptation to support, the future installation of single point hoists above the bed, bath and WC. This bedroom and bathroom should be on the same storey level. This storey (unless at entrance level) should have potential for access via the through floor lift (see Criterion 12). This bathroom should also satisfy the requirements of Criterion 14. The route between this bedroom and bathroom should not pass through any living / habitable room or area.

Good practice recommendations that exceed, or are in addition to, the above requirements

Locate this bedroom and bathroom adjacent to each other with a connecting full height 'knock out panel' sufficient to form a direct doorway with a minimum clear opening width of 900mm between the two rooms, or have a direct (en-suite) link with a minimum clear doorway opening of 900mm from the outset.

Where locating these two rooms adjacent to each other is not practicable, have their doorways adjacent to each other, or opposite each other.

Criterion 14 – Bathrooms

Principle: Provide an accessible bathroom that has ease of access to its facilities from the outset and potential for simple adaptation to provide for different needs in the future.

14 – Bathrooms

An accessible bathroom, providing ease of access in accordance with the specification below, should be provided in every dwelling on the same storey as a main bedroom.

Required specification to achieve Criterion 14

An accessible bathroom, providing ease of access, should be provided in every dwelling, close to a main (double or twin) bedroom.

In dwellings with more than one storey this bathroom should either be on the entrance level (see Note 1), or on a level with potential for access by a through floor lift (see Criterion 12b).

The following facilities, and associated clear approach zones, should be provided within the accessible bathroom.

1. A WC with:

    i) A centre line between 400mm – 500mm from an adjacent wall.

    ii) A flush control located between the centre-line of the WC and the side of cistern furthest away from the adjacent wall.

    iii) An approach zone extending at least 350mm from the WC's centre-line towards the adjacent wall, and at least 1000mm from the WC's centre-line on the other side. This zone should extend forward from the front rim of the WC by at least 1100mm. The zone should also extend back on one side of the WC for at least 500mm from the front rim of the WC, for a width of 1000mm, from the WC's centre-line.

    A bowl of a basin which may be located either on the adjacent wall, or adjacent to the cistern, should not project into this approach zone by more than 200mm.

    This zone is demonstrated by Figure 14a.

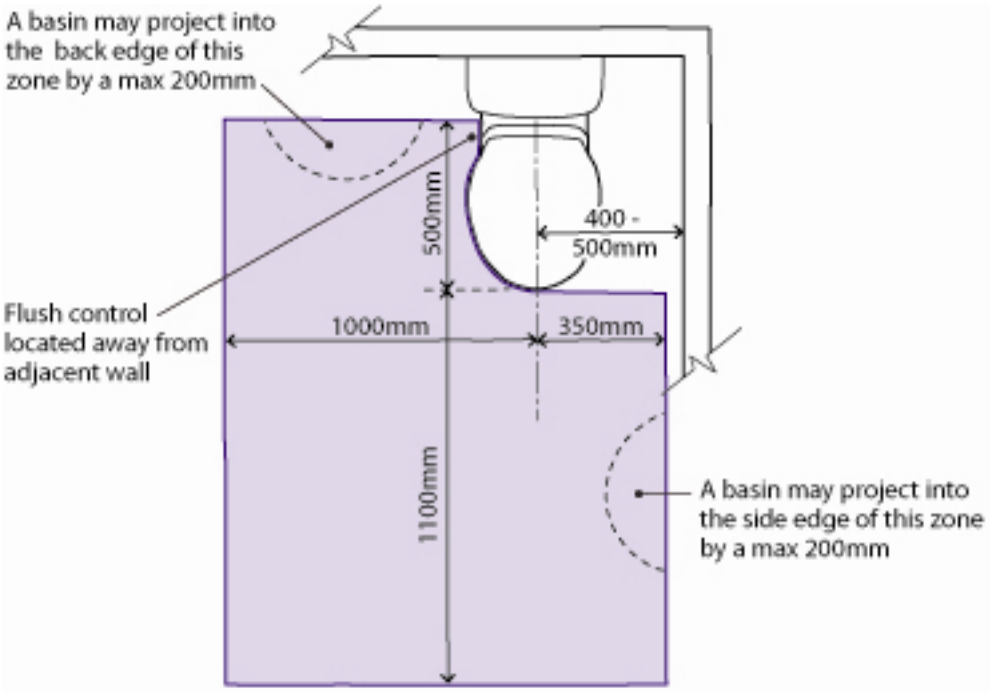

Figure 14a - Approach zone to WC

2. A wash basin with:

   A clear frontal approach zone, 700mm wide, extending 1100mm from any obstruction under the basin's bowl – whether that be a pedestal, trap, duct or cabinet furniture. This zone will normally overlap with the approach zone to the WC (see item1iii above) and/or bath (see item 3i below).

3. Either a bath or an accessible floor level shower:

   i) Where a bath is provided, there should be a clear zone alongside the bath, at least 1100mm long and 700mm wide. This zone will normally overlap with the approach zone to the WC (item 1iii above) and/or the approach zone to the basin (item 2i above).

   ii) Where an accessible floor level shower is provided instead of a bath, there should be provision of a clear 1500mm diameter circular, or 1700mm x 1400mm elliptical, clear manoeuvring zone (see Note 2). This manoeuvring

zone should overlap with the showering area. The drainage for the shower should be as detailed in item 4 below.

iii) Where both a bath and an accessible floor level shower are provided from the outset, the clear floor space for showering activity should be a minimum 1000mm x 1000mm. The drainage for the shower should be as detailed in item 4 below.

4. Unless provided elsewhere in the dwelling (see Note 3), floor drainage for an accessible floor level shower with:

   A floor construction that provides either shallow falls to the floor drainage, or (where the drainage is initially capped for use later following installation of a shower) that allows simple and easy provision of a laid-to-fall floor surface in the future.

   The drainage, when capped for use following adaptation, may be located under a bath.

   Whether provided from the outset, or by subsequent adaptation, fall gradients in the floor should be the minimum required to effect efficient drainage from the catchment area of the shower. Crossfalls should be minimised.

5. Where a bath is provided with capped drainage for an accessible floor level shower beneath it, potential for a clear 1500mm diameter circular or 1700mm x 1400mm elliptical clear manoeuvring zone if the bath is removed (see Notes 2 and 3).

The requirements of Criterion 11 (WC and Bathroom walls), & Criterion 13 (Potential for hoists), should also be noted and incorporated.

Figure 14b, an example bathroom layout, demonstrates the spatial requirements of items 1) – 5). It is noted that an internal footprint dimension of 2100mm x 2100mm increases the degree of choice and flexibility in respect of fittings, layout, orientation and future adaptability. An outward opening door will be required to satisfy Approved Document M if the bathroom contains the only accessible entrance level WC within the dwelling.

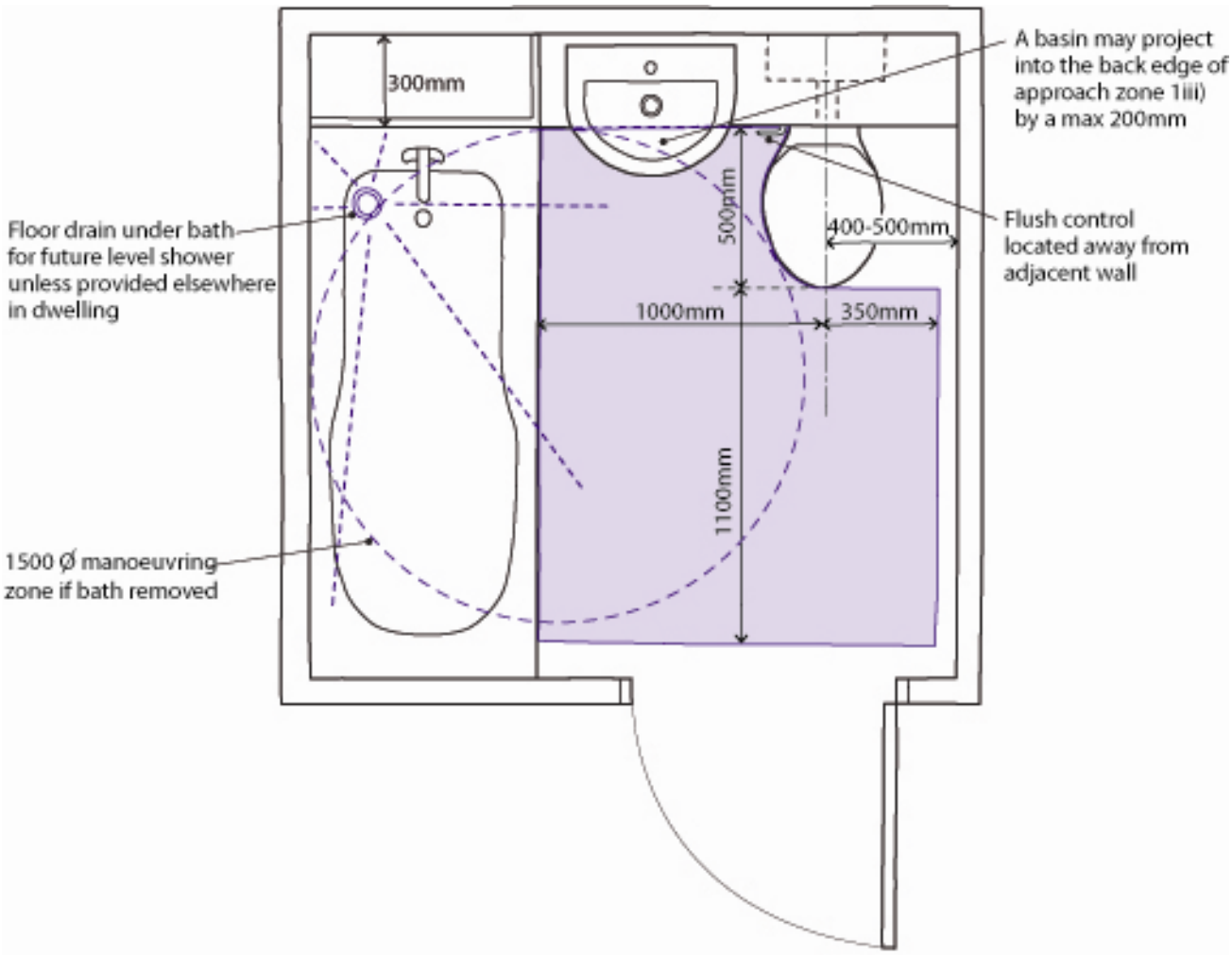

Figure 14b - Example bathroom layout

Good practice <u>recommendations</u> that exceed, or are in addition to, the above requirements

- Where possible, the bathroom should also provide for a direct connection with a main bedroom. This will normally take the form of a full height knockout panel, capable of being fitted with a doorset, which achieves a clear opening in accordance with Criterion 6.
- It is preferable that other bathrooms within a dwelling, in addition to the required accessible bathroom, have as many facilities as described in items 1 – 5 above, as practicable (item 6 being required in all bathrooms/WC compartments by Criterion 11).

- Providing floor drainage as described in item 4) above within the bathroom even when it is provided elsewhere in the dwelling, will increase choice and convenience for adaptation and future use.

Note 1: See Appendix 1 for definition of 'entrance level'.

Note 2: The manoeuvring circle or ellipse (see items 3ii and 5) may pass under a wash basin subject to it being clear of any pedestal, trap, duct or cabinet furniture.

Note 3: In dwellings with more than one storey, if drainage for an accessible shower is provided elsewhere (e.g. on the entrance level as required by Criterion 10b), items 4 and 5 need not apply.

Criterion 15 – Glazing and window handle heights

Principle: Enable people to have a reasonable line of sight from a seated position in the living room and to use at least one window for ventilation in each room.

15. Glazing and window handle heights

Windows in the principal living space (typically the living room), should allow people to see out when seated. In addition, at least one opening light in each habitable room should be approachable and usable by a wide range of people – including those with restricted movement and reach (see Note 1).

Required specification to achieve Criterion 15

To allow a reasonable view from the principal living space, the principal window in this living space, or glazed doors (where these are in lieu of the principle window) should include glazing that starts no higher than 800mm above floor level. In addition, any full width transom or cill within the field of vision (normally extending up to 1700mm above floor level) should be at least 400mm in height away from any other transom or balcony balustrade. All dimensional requirements within this paragraph are nominal (+/- 50mm acceptable).

There should be potential for an approach route 750mm wide to enable a wheelchair user to approach a window in each habitable room (see Note 1). In addition, this window should have handles/controls to an opening light no higher than 1200mm from the floor.

Note 1: In kitchens areas or bathrooms with only one window situated behind kitchen units or bathroom fittings, the requirement for a potential clear approach space to that window need not apply. However, the window handle height/control requirement remains applicable. Any other window within the kitchen area or bathroom, not behind fittings, is required to satisfy both the approach and window handle/control height requirements.

Criterion 16 – Location of service controls

Principle: Locate regularly used service controls, or those needed in an emergency, so that they are usable by a wide range of household members - including those with restricted movement and limited reach.

16. Location of service controls

Service controls should be within a height band of 450mm to1200mm from the floor and at least 300mm away from any internal room corner.

Required specification to achieve Criterion 16

Any service control needed to be operated or read on a frequent basis, or in an emergency, should be included within the height band of 450mm – 1200mm from the floor and at least 300mm away from any internal corner.

For example, this would include the following: Electrical switches & sockets, TV / telephone / computer points, consumer service units, central heating thermostatic and programming controls, radiator temperature control valves, and mains water stop taps/controls.

Good practice recommendations that exceed, or are in addition to, the above requirements

Locate the different types of service controls within the more specific height bands as detailed in BS8300:2009 Figure 26.

Whenever possible, locate similar controls in consistent locations throughout the dwelling.

Specify taps that are operable by people with less hand dexterity.

Provide controls that give tonal contrast against their surroundings.

Provide fused spurs to assist with potential future adaptations (e.g. future provision of stair lift, through floor lift, and shower).

Appendix 1

Definition of 'entrance level' for the purpose of Lifetime Home Criteria

The entrance level of a dwelling for the purposes of the Lifetime Home Criteria is generally deemed to be the storey containing the main entrance door as defined by Criterion 4. This will usually be the ground floor of a house, or the storey containing the entrance door of a flat approached a communal hall, stair, or lift.

Where there are no rooms (habitable or non-habitable) on the storey containing the main entrance door (e.g. most flats over garages, some flats over shops, some duplexes and some townhouses), the first storey level containing a habitable or non-habitable room can be considered the 'entrance level' if this storey is reached by an 'easy going' stair with maximum risers 170mm, minimum goings 250mm, and a minimum width of 900mm measured 450mm above the pitch line.

Appendix 2

Communal Car Parking Management Plans

The parking management plan should include a mechanism to ensure that the supply and demand of wider bays / blue badge bays are regularly monitored and provision reviewed, to ensure that provision equates to any change in the demand from disabled residents and visitors and that the bays are effectively enforced to stop abuse by non blue badge holders. The needs of residents who occupy a home designated for wheelchair users and any residents who hold a blue badge and occupy any other home should be addressed.