Health and Wellbeing Scrutiny Committee

Performance Report 2009/2010 – Health, Social Care and Sport and Leisure Services

Report of the Chief Executive, Executive Director Health, Housing and Adults Services and Executive Director City Services

1.0 Purpose of the report

The purpose of this report is to provide Health and Wellbeing Scrutiny Committee with a performance update relating to the period April 2009 to March 2010. This report includes key achievements during 2009/10, residents satisfaction with services and progress in relation to the LAA targets and other national indicators.

2.0 Background

2.1 Members will recall that a new performance framework was implemented during 2008/2009. This includes 198 new National Indicators which replaces previous national performance frameworks. As part of this new framework 49 national indicators have been identified as key priorities to be included in the Local Area Agreement (LAA). Performance against the priorities identified in the LAA and associated improvement targets have been reported to Scrutiny Committee throughout 2009 as part of the quarterly performance monitoring arrangements. The LAA priorities have been a key consideration in CAA in terms of the extent to which the partnership is improving outcomes for local people. CAA was introduced in April 2009 to provide an independent assessment of how local public services are working in partnership to deliver outcomes for an area. However, the coalition government have abolished CAA with immediate effect. Progress in the LAA will continue to be monitored through 2010/11 (which is the last year of the agreement) through the Council and the Sunderland Partnership's performance management and reporting arrangements. The performance will be reviewed when further national direction is available to ensure that it is fit for purpose.

As part of the development of Scrutiny particularly in terms of strengthening performance management arrangements, Policy Review recommendations have been incorporated in to the quarterly performance report on a pilot basis. The aim is to identify achievements and outcomes that have been delivered in the context of overall performance management arrangements to enhance and develop Scrutiny's focus on delivering better outcomes and future partnership working. The next progress report will be provided in December 2010.

2.2 ***Appendix 1*** provides an overview of the position for relevant national indicators and also any local performance indicators that have been retained to supplement areas in the performance framework that are not well covered by the national indicator set.

3.0 Findings

3.1 Key Achievements

The council opened three new 'Extra Care' schemes in Silksworth (Beckwith Mews), Washington (Woodridge Gardens) and Hetton (Bramble Hollow). The Extra care schemes enable people to live in their own homes independently providing access to tailored care and support to meet individuals needs, it also gives access to other social health and wellbeing opportunities. The new extra care housing schemes have come about thanks to an inventive partnership between the council, Housing 21 and Frank Haslam Milan North East (FHM). A further scheme is being developed with Gentoo Group at the Racecourse Estate in Houghton le Spring, this will provide 47 two bedroom units of accommodation. It is due to be completed and opened by summer 2011.

Our Moorside Contact Centre has been accredited by the Telecare Services Association (TSA) for meeting new stricter call handling standards and answering 98.5% of Telecare Alarm calls within 60 seconds and 99% of calls within 3 minutes. The Contact Centre handles more than 23,000 alarm calls per month and provides a critical service to vulnerable residents. The accreditation is nine months ahead of the new standards deadline.

Grindon Mews a centre for people with learning difficulties officially opened in November 2009. The £2.6million community social care facility offers specialist social care support to adults aged 18-65 who have profound and multiple learning disabilities. The centre is designed to maximise independence, promote individual choice and help aid social inclusion. It includes specialist day opportunities for up to 28 adults per day and opportunities and re-enablement for up to 15 adults per day who have physical disabilities.

Two new 25m Community Pools opened in Silkworth and Hetton. The new sites mean that even more people have access to excellent sporting facilities close to where they live, encouraging people of all ages and abilities to enjoy the pools, be physically active, and have fun. There were a total of 2,265,877 visits to leisure centres during 2009/2010. The number of swims has increased from 608,807 in 2008/2009 to 657,016 during 2009/2010. The opening of the two new 25m community pools in Hetton and Silksworth will increase this figure further during 2010/2011.

3.2 Customer Focus

More residents feel that older people in their local area were able to get the services and support they need to continue to live at home for as long as they want to, 40% said they did feel such support was available compared to 36% in 2008/09. This is higher than the national average of 30% and also the regional average of 35.5%.

Residents consider themselves to be healthier, 69% describe their health as either good or very good compared to 66% in 2008.

The Community Spirit Summer survey 2009 asked about how easy people find it to be healthy in their local area. The findings highlighted that respondents generally find it easy to be healthy in their local area but slightly less so when it comes to being physically active and having good emotional well being. A range of activity has been introduced to address the findings in the survey which includes:

- Working with schools to educate children on healthy eating, how to cook healthily and how to improve school meals, referral programmes to support individuals and families who have weight issues with their diets, and introduction of the Heartbeat Award which recognises restaurants and other food retailers who offer healthy alternatives.
- Increased opportunities to do physical activity by developing a city wide network of Wellness Centres and more localised Community Wellness Venues to improve accessibility
- A Happiness and Well Being Network has been established where representatives from a number of organisations and members of the public meet to help improve their mental health, happiness and well being through interactive workshops. A review of services people with mental health problems access initially is currently taking place.
- Intervention services are being introduced in terms of referring people into alcohol treatment services if they go to hospital because of alcohol related injuries/illnesses or are arrested while drunk. Campaigns are being run to raise the awareness of the number of units in alcoholic drinks, safe drinking levels and where to go for advice
- There are a number of services available to help people stop smoking, including, the NHS Stop Smoking Service, staff in Wellness Centres and advisors in various locations across the city e.g. community pharmacies and GP practices. Extra support is also available for pregnant women who smoke.

3.3 Performance

In relation to health and wellbeing six national indicators are priorities identified in the LAA. An overview of available performance can be found in the following table

Performance Indicator	Performance 2008/09	Performance 2009/10	Trend	Target 2009/10	Target achieved
NI119 % of residents who consider themselves to be in good health	66.2%	68.9%	▲	69.2%	×
NI120 All – age mortality rates expressed per 100,000 population	579 (F) 878(M)	578.70(F) 851 (M)	▲	546 (F) 748 (M)	× ×
NI39 Alcohol-harm related hospital admission rates expressed per 100,000	2378	2659	▼	2204	×

NI123 16+ current smoking rate prevalence	1100	1289	▲	1437	✗
NI136 People supported to live independently through social services (all ages)	3124.19	3008.31	▼	3415	✗
NI130 Social care clients receiving Self Directed support (per 100,000 population)	5.83%	7.42%	▲	8.50%	✗
NI139 People over 65 who say they receive the information, assistance & support needed to exercise choice & control to live independently	36.2%	39.8%	▲	39.2%	✓

A full overview of performance can be found in appendix 1 the following section contains those performance indicators that are declining and / or haven't achieved the target set for 2009/10.

3.3.1 Social Care

NI 136 People supported to live independently through social services

The number of adults of all ages supported to live independently per 100,000 population declined from 3124.19 per 100,000 in 2008/09 to 2008.31 per 100,000 in 2009/10. Work began in 2009/10 to develop community in reach programmes (e.g. working with GP Practices) to identify potential new customers who may require social services. This work will continue and expand in 2010/11. For example, the Directorate completed an older people's population profiling for the city, and used this as the basis for a more targeted and pro-active approach to supporting individuals. The Council is working on a Department of Health pilot with Church View Medical Practice to better identify people who might need some help, e.g. who feel isolated, need financial advice or improve their health and wellness, and has already identified a small number of people that both the GP practice and the Council need to provide a greater level of support. The principles of the pilot are about to be rolled out with another GP practise to better support people with learning disabilities, whilst a similar exercise is being undertaken to identify older people living alone on low benefits in the Fulwell and Southwick wards who might need a "little bit of help" in daily living, as part of community in-reach solutions. These solutions will mean that the Council will start to improve its performance against this indicator as a result of this locality-based working, including the use of in-reach teams to penetrate into communities, improved marketing and working with the Third Sector to build capacity and more focussed outcomes.

NI 130 Social care clients receiving self-directed support

The percentage of social care clients receiving self-directed support has improved from 5.83% during 2008/09 to 7.42% during 2009/10; however the target of 8.50% has not been achieved. The Council is currently revising its Community Care Assessment and Care Management processes to better ensure that customers are more able to identify solutions to meet their needs

and preferences, including through Personal Budgets and Direct Payments. This may include, for example, support via Personal Assistants, that enable people to carry out not just daily living tasks such as personal care, but also access to leisure and social activities.

There's expected to be a significant increase in the number of new and existing clients will be offered self directed support from 1st November 2010 to help achieve the 30% target set for 2010/11. Personal Budgets and Direct Payments are a form of financial payments to enable assessed individuals to make direct choices about their social care. There were 819 social care clients receiving self directed support in 2009/2010 compared to 693 in 2008/2009. Aside from offering greater choice and control for individuals, Direct Payments are also a more cost-effective way of providing support to individuals. During 2009/10 6,689 older people have been supported to live independently in their own home.

3.3.2 Health Inequalities

NI120 All age all cause mortality rate

Latest performance relates to 2006 – 2008 pooled rates and mortality rates have slightly improved since the previous reporting period and have not achieved the 2009/10 target of 546 for females and 748 for males per 100,000 population.

A number of projects that aim to improve performance are currently underway examples can be found below.

The Community Delivery Team (CDT), which is a nurse led service, has started to deliver NHS Health Checks in community venues across Sunderland. A telephone service where people can ring to book a NHS Health Check is also due to be launched. The number of pharmacies offering NHS Health Checks is 7. From 1st November 2009 to 30th June 2010 over 500 eligible Health Checks have been carried out. 60% of men who have had a NHS Health Check in a pharmacy have been identified as high risk.

The delivery of Wellness Services across Sunderland continues with increased opportunities for individuals to access a range of physical activity opportunities to prevent individuals developing health risks. Activities include walking and cycling.

Work continues to evolve both the children's and adults weight management intervention programmes to develop into a seamless life course approach to a support programme. Work continues with the STPCT to ensure targeted and specialist interventions and services are targeting areas and individuals with the most need through the exercise referral and the weight management programme.

NI123 16+ current smoking rate prevalence

Latest performance shows 1289 smoking quitters per 100,000 population. Performance has improved compared to 2008/09 however, the target of 1437 quitters per 100,000 population for 2009/10 has not been achieved. Key actions to improve this position include:

- Expanding and improving intermediate services (tier 2) for existing and new providers to support the doubling of throughput of stop smoking services, with an additional 38 providers and 117 advisers in 2009/10. This included recruiting mentors to support existing providers and advisors and working more closely with GPs to better identify smokers who may want to quit to signpost individuals, particularly those with chronic conditions, to Stop Smoking Services;
- Expanding and improving specialist services (tier 3) to support the doubling of throughput of stop smoking services in line with AOP and contractual targets, with an additional 4 advisors in 2009/10. Activities included development of workplace initiatives in ASDA, "More Than" insurance and City Hospitals Sunderland. This also included follow-up of people using the service who then did not fulfil the programme;
- Commissioning the voluntary sector to deliver brief intervention for stop smoking. 14 community groups have now been trained delivering a service, with 31 people in total. All groups are in deprived communities.
- Improved commissioned service models, and training, to improve rates of access to smoking cessation services, including in the community and with "hard-to-reach" groups. This includes marketing the services through the Community Development Officer, who recruited and trained Third Sector organisations to undertake interventions, with significantly improved "community in-reach" which will drive improvements towards NI 123, as well as marketing events such as publicity material and No Smoking Day;
- Re-establishment of local tobacco alliances for the purpose of delivering against national and local tobacco control priorities and supporting the achievement of smoking 4 week quit targets;
- The Sunderland Smokefree Tobacco Alliance has held facilitated sessions and developed an action plan covering:
- Reducing exposure to second-hand smoke
  FRESH have undertaken a media campaign around Smoke Free Families and recently been involved with a campaign around 'why it's a good idea to take 7 steps out…'. 6 people have been trained to deliver Reducing Second Hand Smoking in homes.

NI39 Alcohol Related admissions

The rate of hospital admissions per 100,000 for alcohol related harm will continue to increase as a consequence of NHS investment in alcohol treatment services. Latest performance is 2659 admissions per 100,000 population which is considerably more than the 2009/10 target of 2204. Improvement interventions include:

- Develop Hospital Liaison Project in line with national good practice to help reduce alcohol related hospital admissions.

- Commission Gastro nurse specialist within the FT to work with dependant drinkers and develop pathways into Tiers 3 and 4 from the hospital.
- Enhance the Hospital Liaison Project to a 7 day per week service.
- Develop a care co-ordination process with key partners to help reduce the number of frequent flyers attending hospital.
- Develop an out-patient clinic with the Gastro Nurse specialist to reduce the number of admissions.
- Enhance pathways within the hospital and community.

4.0 Recommendation

That the committee considers the continued good progress made by the council and the Sunderland Partnership and those areas requiring further development to ensure that performance is actively managed.