Chief Executive's Office
Chief Executive: CJ Bull

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To: All Members of Cabinet:
RJ Phillips (Chairman)
LO Barnett
AJM Blackshaw
H Bramer
JP French
JA Hyde
JG Jarvis
DB Wilcox

2nd April, 2008

Dear Councillor,

MEETING OF CABINET
THURSDAY, 10TH APRIL, 2008 AT 2.00 P.M.
THE COUNCIL CHAMBER, BROCKINGTON, 35 HAFOD ROAD, HEREFORD

AGENDA (08/21)

HEREFORDSHIRE COUNCIL - NOTICE UNDER REGULATION 15 OF THE LOCAL AUTHORITIES (EXECUTIVE ARRANGEMENTS) (ACCESS TO INFORMATION) REGULATIONS 2000 (AS AMENDED)

Notice is hereby given that the following reports contain key decisions. When the decisions have been made, Members of the relevant Scrutiny Committee will be sent a copy of the decision notices and given the opportunity to call-in the decisions.

Item No	Title	Portfolio Responsibility	Scrutiny Committee	Included in the Forward Plan Yes/No
5	Draft Capital Programme 2008/09	Resources	Strategic Monitoring Committee	No
6	Children and Young People's Plan 2008-2011	Children's Services	Children's Services	Yes
7	Development of Local Area Agreement	Corporate Strategy and Finance	Strategic Monitoring Committee	Yes

9	Renewal of Contract: Microsoft Enterprise Agreement	Corporate and Customer Services and Human Resources	Strategic Monitoring Committee	No
10	Assessment of 18-64 year olds' Future Needs and Services: Mental Health and Physical Disabilities	Social Care Adults and Health	Adult Social Care and Strategic Housing/Health	No

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

To receive any declarations of interest by Members in respect of items on the Agenda.

3. MINUTES

To receive and sign the Minutes for the meeting held on 27 March 2008 (to follow).

4. COUNCIL ASSET MANAGEMENT PLAN 2008/09

The purpose of this report is for Cabinet to approve the contents of the Council's Asset Management Plan (AMP) for 2008/09 and endorse the ongoing process of managing land and property assets on a corporate basis. *(Pages 1 - 50)*

5. DRAFT CAPITAL PROGRAMME 2008/09

To put forward further capital programme proposals following Council's decision on 7 March 2008 to allocate additional resources to fund prudential borrowing in 2008/09 and 2009/10.
(Pages 51 - 56)

6. CHILDREN AND YOUNG PEOPLE'S PLAN 2008-2011

To consider and approve the Children and Young People's Plan 2008-2011.
(Pages 57 - 94)

7. DEVELOPMENT OF THE LOCAL AREA AGREEMENT

To agree the Performance Indicators to be included in the final Local Area Agreement (LAA) super refresh document. *(Pages 95 - 102)*

8. DATA QUALITY POLICY

To approve the data quality policy. *(Pages 103 - 108)*

9. RENEWAL OF CONTRACT - MICROSOFT ENTERPRISE AGREEMENT

To agree the renewal of the current Microsoft Enterprise Agreement licence, support and maintenance contract covering all corporate (excluding schools, education and research) Microsoft computer software in use within the authority for a period of three years. *(Pages 109 - 114)*

10. ASSESSMENT OF 18-64 YEAR OLDS' FUTURE NEEDS AND SERVICES: MENTAL HEALTH AND PHYSICAL DISABILITIES

To make proposals for the development of high-performing health and social care services by 2012 to meet the expected future needs of 18-64 year-olds in Herefordshire with mental health problems and physical disabilities, having regard to the views expressed on the proposals by the Adult Social Care and Strategic Housing Scrutiny Committee and the Health Scrutiny Committee. *(Pages 115 - 276)*

Yours sincerely,

CJ BULL
CHIEF EXECUTIVE

Copies to:
- Chairman of the Council
- Chairman of Strategic Monitoring Committee
- Vice-Chairman of Strategic Monitoring Committee
- Chairmen of Scrutiny Committees
- Group Leaders
- Directors
- Head of Legal and Democratic Services

COUNCIL ASSET MANAGEMENT PLAN 2008/09

PORTFOLIO RESPONSIBILITY: RESOURCES

CABINET **10 APRIL 2008**

Wards Affected

County-wide.

Purpose

The purpose of this report is for Cabinet to approve the contents of the Council's Asset Management Plan (AMP) for 2008/09 and endorse the ongoing process of managing land and property assets on a corporate basis.

Key Decision

This is not a Key Decision.

Recommendation(s)

THAT (a) **Cabinet approve the content of the Council's Asset Management Plan for 2008/09;**

(b) **Cabinet note that the Council's Asset Management Plan for 2008/09 will form part of the Resources Directorate's service plans for the year with performance being managed in line with the Council's performance management framework.**

Reasons

1 This is the third corporate property Asset Management Plan to be developed by Herefordshire Council since central government introduced the requirement in 2001. This requirement has since been relaxed as corporate property asset management planning has been mainstreamed into the Corporate Performance Assessment arrangements.

2 Central government has a clear agenda for improving quality and efficiency in public service delivery and this clearly includes the efficient and effective use of property assets. The Council's AMP therefore sets out the systems and procedures by which corporate assets will be managed to secure value for money in support of corporate priorities. This involves co-ordinating decisions affecting property use, maintenance, disposal, procurement, funding and reviews across the Council as set out in the AMP.

Considerations

3 The appended Asset Management Plan updates the background and actions contained within the Council's Asset Management Plan 2006.

The plan outlines proposed actions to be undertaken within the Resources Directorate and with the assistance of officers from all directorates.

Financial Implications

4 There are no direct financial implications with respect to this report.

Risk Management

5 The Asset Management Plan is monitored and updated by the Strategic Asset Management Team within Asset Management and Property Services.

Alternative Options

There are no alternative options.

Consultees

Not applicable.

Appendices

Appendix 1 – Asset Management Plan 2008/09.

Background Papers

Asset Management Plan 2006.

CONTENTS

SECTION	TITLE	PAGE
INTRODUCTION		1
SECTION ONE	**ORGANISATIONAL ARRANGEMENTS FOR CORPORATE ASSET MANAGEMENT**	
1.1	HEREFORDSHIRE COUNCIL'S CORPORATE OBJECTIVES	2
1.2	CORPORATE PROPERTY MANAGEMENT	2
1.3	STRATEGIC FOCUS OF ASSET MANAGEMENT IN HEREFORDSHIRE	2
SECTION TWO	**CONSULTATION**	
2.1	REVIEW OF CONSULTATION OVER THE LAST 12 MONTHS	4
2.1.1	Review of Action Plan for 2007/08	4
2.1.2	Identification of Stakeholders	4
2.1.3	Consultation	4
Graph 2.1	Customer Satisfaction Survey Results - Amey Wye Valley	5
Graph 2.2	Customer Satisfaction Survey Results - All Contractors	6
Graph 2.3	Customer Satisfaction Survey Results – Professional Services	7
2.1.4	Joint Working	8
2.2	CONSULTATION OVER THE NEXT 12 MONTHS	9
2.2.1	Action Plan for 2008/09	9
2.2.2	Consultation	9
2.2.3	Joint Working	9
2.2.4	Partnership	9
SECTION THREE	**DATA MANAGEMENT**	
3.1	REVIEW OF DATA MANAGEMENT OVER THE LAST 12 MONTHS	10
3.1.1	Review of Action Plan for 2007/08	10
3.1.2	Strategic Data Management	10
3.1.3	Data Management Systems	10
3.1.4	Staffing and Training	10
3.2	DATA MANAGEMENT OVER THE NEXT 12 MONTHS	11
3.2.1	Action Plans for 2008/09	11
3.2.2	Strategic Data Management	11
3.2.3	Data Management Systems	11
3.2.4	Staffing and Training	11
3.2.5	Data Validity	11

SECTION FOUR	PERFORMANCE MANAGEMENT, MONITORING & INFORMATION	
4.1	REVIEW OF PERFORMANCE MANAGEMENT MONITORING AND INFORMATION OVER THE LAST 12 MONTHS	12
4.1.1	Review of Action Plan for 2007/08	12
4.1.2	Property Performance Indicator	12
4.1.3	Property Services Plan 2008 -2011	12
4.1.4	Area Property Studies and Service Specific Property Studies	12
4.1.5	Monitoring of the Capital Programme	12
4.2	PERFORMANCE MANAGEMENT, MONITORING AND INFORMATION OVER THE NEXT 12 MONTHS	13
4.2.1	Action Plan for 2008/09	13
4.2.2	Area Property Studies and Service Specific Property Studies	13
4.2.3	Monitoring of the Capital Programme	13
4.2.4	Property Performance Assessment	13

SECTION FIVE	PROGRAMME AND PLAN DEVELOPMENT AND IMPLEMENTATION	
5.1	REVIEW OF PROGRAMME AND PLAN DEVELOPMENT AND IMPLEMENTATION OVER THE LAST 12 MONTHS	14
5.1.1	Review of Action Plan for 2007/08	14
5.1.2	Programme Developments	14
5.1.3	Option Assessment and Project Appraisal	14
5.1.4	Capital Programme	14
5.1.5	Acquisitions and Disposals Programme	14
5.1.6	Planned Maintenance Programme	15
5.2	PROGRAMME AND PLAN DEVELOPMENT AND IMPLEMENTATION OVER THE NEXT 12 MONTHS	16
5.2.1	Action Plan for 2008/09	16
5.2.2	Programme Development	16
5.2.3	Option Assessment and Project Appraisal	16
5.2.4	Capital Programme Over the Next 4 Years	16
5.2.5	Acquisitions and Disposals Programme	16
5.2.6	Planned Maintenance Programme	16
5.2.7	Carbon Management	16
5.2.8	Disabled Access Programme	16

APPENDIX		
1	HEREFORDSHIRE COUNCIL'S PROPERTY STRATEGY	17
2	THE ROLES AND RESPONSIBILITIES OF THE CORPORATE PROPERTY OFFICER (CPO)	18
3	REMIT OF THE CAPITAL STRATEGY GROUP (CSG)	18
4	REMIT OF THE CAPITAL PROGRAMME MONITORING GROUP (CPMG)	18
5	REVIEW OF ACTION PLAN FOR 2007/08 – SECTION TWO CONSULTATION	19
6	ACTION PLAN FOR 2008/09 – SECTION TWO CONSULTATION	19
7	REVIEW OF ACTION PLAN FOR 2007/08 – SECTION THREE DATA MANAGEMENT	20
8	ACTION PLAN FOR 2008/09 – SECTION THREE DATA MANAGEMENT	20
9	REVIEW OF ACTION PLAN FOR 2007/08 – SECTION FOUR PERFORMANCE MANAGEMENT, MONITORING & INFORMATION	21
10	ACTION PLAN FOR 2008/09 – SECTION FOUR PERFORMANCE MANAGEMENT, MONITORING & INFORMATION	21
11	REVIEW OF ACTION PLAN FOR 2007/08 – SECTION FIVE PROGRAMME AND PLAN DEVELOPMENT AND IMPLEMENTATION	22
12	ACTION PLAN FOR 2008/09 – SECTION FIVE PROGRAMME AND PLAN DEVELOPMENT AND IMPLEMENTATION	22
13	PROPERTY PERFORMANCE INDICATOR -pPI 1A	23
Graph 13.1	pPI 1A Graph 6 Year Comparison Condition A	24
Graph 13.2	pPI 1A Graph 6 Year Comparison Condition B	24
Graph 13.3	pPI 1A Graph 6 Year Comparison Condition C	25
Graph 13.4	pPI 1A Graph 6 Year Comparison Condition D	25
14	PROPERTY PERFORMANCE INDICATOR -pPI 1B	26
Graph 14.1	pPI 1B Graph 6 Year Comparison Priority 2	27
Graph 14.2	pPI 1B Graph 6 Year Comparison Priority 3	27
Graph 14.3	pPI 1B Graph 6 Year Comparison Total Backlog	28
15	PROPERTY PERFORMANCE INDICATOR -pPI 3	29
16	PROPERTY PERFORMANCE INDICATOR – pPI 4A	30
17	PROPERTY PERFORMANCE INDICATOR – pPI 4B	31
18	PROPERTY PERFORMANCE INDICATOR – pPI 4C	32
GLOSSARY		33

INTRODUCTION

This document is to be read in conjunction with the Council's Asset Management Plan 2006, which sets out the contextual background to the creation of the Council's Asset Management Planning process.

Asset management planning is an organic process and the provision of a printed Asset Management Plan (AMP) has to be seen as a one-off snap shot, at a particular point in time, of the utilisation of the Council's land and buildings to support the delivery of front line services to the public. Asset management plans are created to be flexible in their approach to allow for changes in service requirements as circumstances change over time. Asset Management and Property Services (AMPS) continues to review, with officers from all Directorates, the ongoing needs of the services in order to improve the suitability of the property assets utilised to deliver services.

The recent appointment of a joint Chief Executive for the Council and Primary Care Trust has extended the scope of property review to be undertaken and the current AMP process is designed to adapt to such circumstances to incorporate the opportunities which may now arise to share property assets.

Given the strategic nature of asset management planning, it is proposed to include the AMP as an appendix to the Resources Directorate service plan.

SECTION 1 -ORGANISATIONAL ARRANGEMENTS FOR CORPORATE ASSET MANAGEMENT

1.1 COMPREHENSIVE AREA ASSESSMENTS (CAA)

1.1.1 As with all Councils in England, the Council is in a transitional phase to best respond to the requirements of Comprehensive Area Assessments and Local Area Assessments (LAA), which will replace the existing Comprehensive Performance Assessments (CPA).

1.1.2 The Council has also restructured the Resources Directorate, which has responsibility for Asset Management Planning. The former Property Services has been restructured to create a new service – AMPS to incorporate a new Strategic Asset Management team with specific responsibility for developing the Council's asset management planning process.

1.1.3 The Head of AMPS is designated as the Council's Corporate Property Officer.

11.1.4 Member responsibility lies with the Cabinet Member for Resources.

1.1.5 Over the past year the AMP process has been reviewed and areas for improvement identified, including:

- Improved data collection and retrieval.
- Broader base of survey data.
- Better support and advice to Service managers.
- Closer operating relationships/integration between the Corporate AMP and the Education AMP.

1.2 CORPORATE PROPERTY MANAGEMENT

1.2.1 The corporate management of property at the strategic level is overseen by the Corporate Asset Strategy Group (CASG). This group consists of senior officers from all Directorates with responsibilities for the property resource and who have knowledge of service plans and objectives. The group meets at regular intervals and is chaired by the Director of Resources. The Head of AMPS and Head of Financial Services are members of this group.

1.2.2 Two sub-groups have been created which report to the CASG, the Strategic Asset Review Group (SARG), chaired by the Head of AMPS and the Capital Strategy Monitoring Group, chaired by the Head of Financial Services.

1.2.3 AMPS continues to utilise the Institute of Public Finance AMP Network to share good practice.

1.2.4 In order to provide crossover with Schools Asset Management Planning activities, the Property Operations Manager and Property Review and Contract Commissioning Manager attend the Education Asset Management Group that exists to manage education properties under guidance provided by the Department for Children, Schools and Families (DCSF).

1.3 STRATEGIC FOCUS OF ASSET MANAGEMENT IN HEREFORDSHIRE

1.3.1 The Council recognises the importance of property towards meeting its aim and objectives. The Council has identified a set of property "drivers" that summarise the strategic management approach, in support of the Corporate Plan, for all property issues over a long-term planning period:

i) **Rationalisation**

ii) **Environmental sustainability**.

iii) **Sharing assets**

iv) **Accessibility**

v) **Economic development**

vi) **Suitability**

vii) **Conservation**

viii) **Innovative and flexible ways of working**

ix) **Sound data management and data processing practices**

x) **Economic viability**

xi) **Flexible approach**

1.3.2 The informed utilisation of property assets will improve and support service delivery. As such AMPS are involved with a variety of projects to meet the aspirations of the property drivers:

i) AMPS are leading on a major review of the Council's office accommodation needs in Hereford City. This project is a cross sector project, involving the PCT and West Mercia Police.

ii) AMPS has undergone recent audits of the Council's GEM Policy towards achieving environmental sustainability. External funding from Salix was received (see section 5.2.7 and Appendix 11, reference 6).

iii) Encouragement of sharing assets to include cross-service use and sharing with external partnering organisations, as noted in 1 above.

iv) Accessibility with particular emphasis on meeting the Disabled Discrimination Act (DDA) requirements. AMPS has improved accessibility to public buildings from 50% of to 66%.

v) Support for economic development to promote employment and agriculture.

vi) Provision of property that is suitable, sufficient and of appropriate condition.

vii) Conservation of the unique built and natural environment within Herefordshire and promotion of better quality of life.

viii) Support for innovative and flexible ways of working and provision of property where financial and social benefits exist.

ix) Development and maintenance of sound data management and data processing practices in order to provide information upon which informed strategic property

decisions can be made. The existing property databases are inadequate and a brief and specification will be prepared, in conjunction with colleagues in ICT.

x) The Council's non-operational portfolio, which provides an annual income stream of £3,600,000 to support Council services, will be subject of a major review to assess the potential to increase the return on the capital invested in the portfolio.

SECTION 2 – CONSULTATION

2.1 REVIEW OF CONSULTATION OVER THE LAST 12 MONTHS

2.1.1 Review of For Action Plan 2007/08

2.1.1.1 The action plan for 2007/ 08 together with the outcomes as at January 2008 are detailed in Appendix 5.

2.1.2 Identification of Stakeholders

2.1.2.1 The Council recognises the importance of consulting with stakeholders on property-related issues and employs a variety of methods that are used on a 'one-off' scheme based arrangement, or repeatedly, over time in order to establish performance trends. Stakeholders include statutory authorities, building users, the general public and partnering organisations.

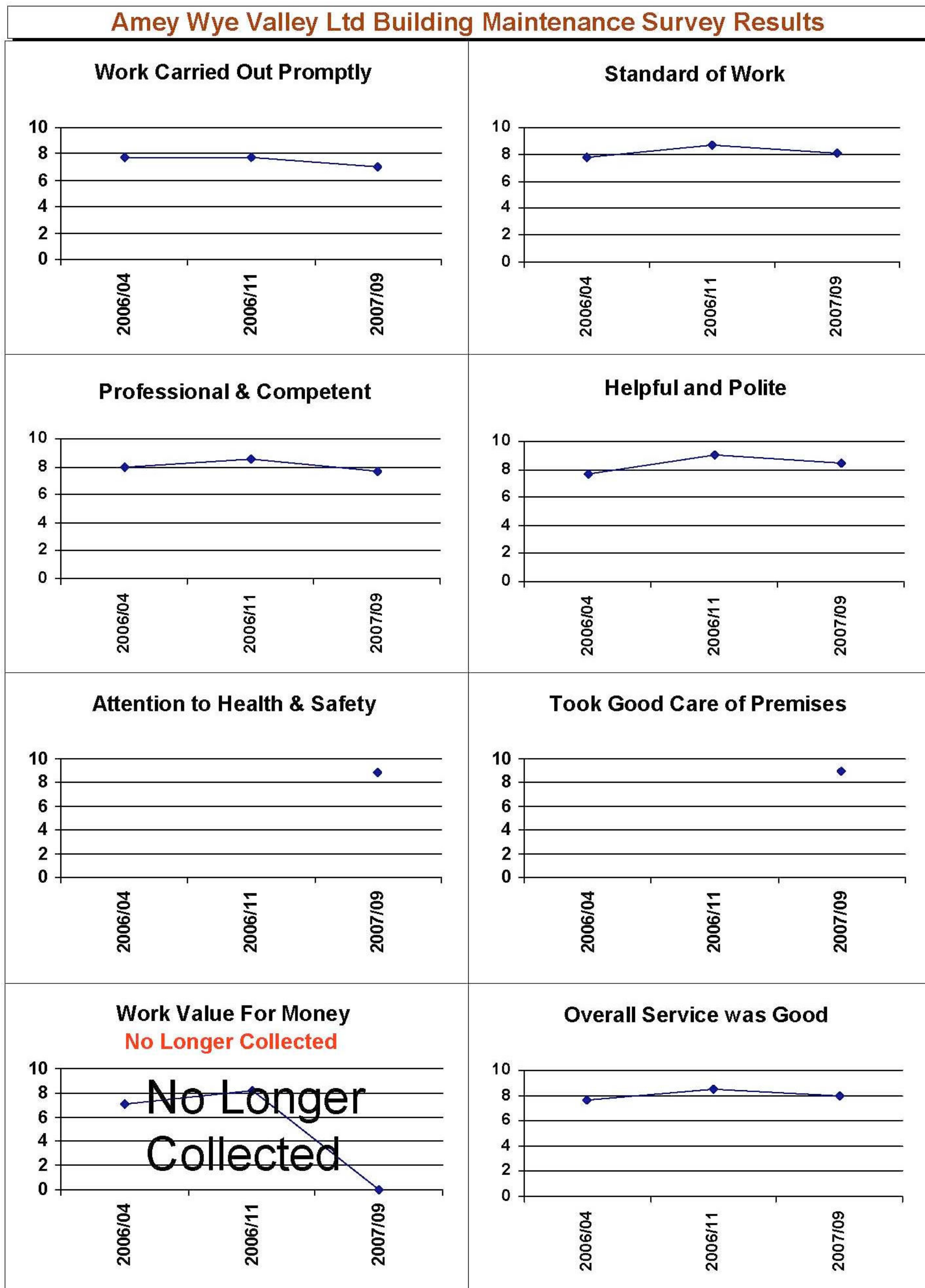
2.1.3 Consultation

2.1.3.1 As in previous years use has been made of the COPROP questionnaires survey undertaken by (to be confirmed). This enables us to benchmark our performance over a period of years and also against an average of other authorities within the group.

2.1.3.2 The result for are shown as follows:

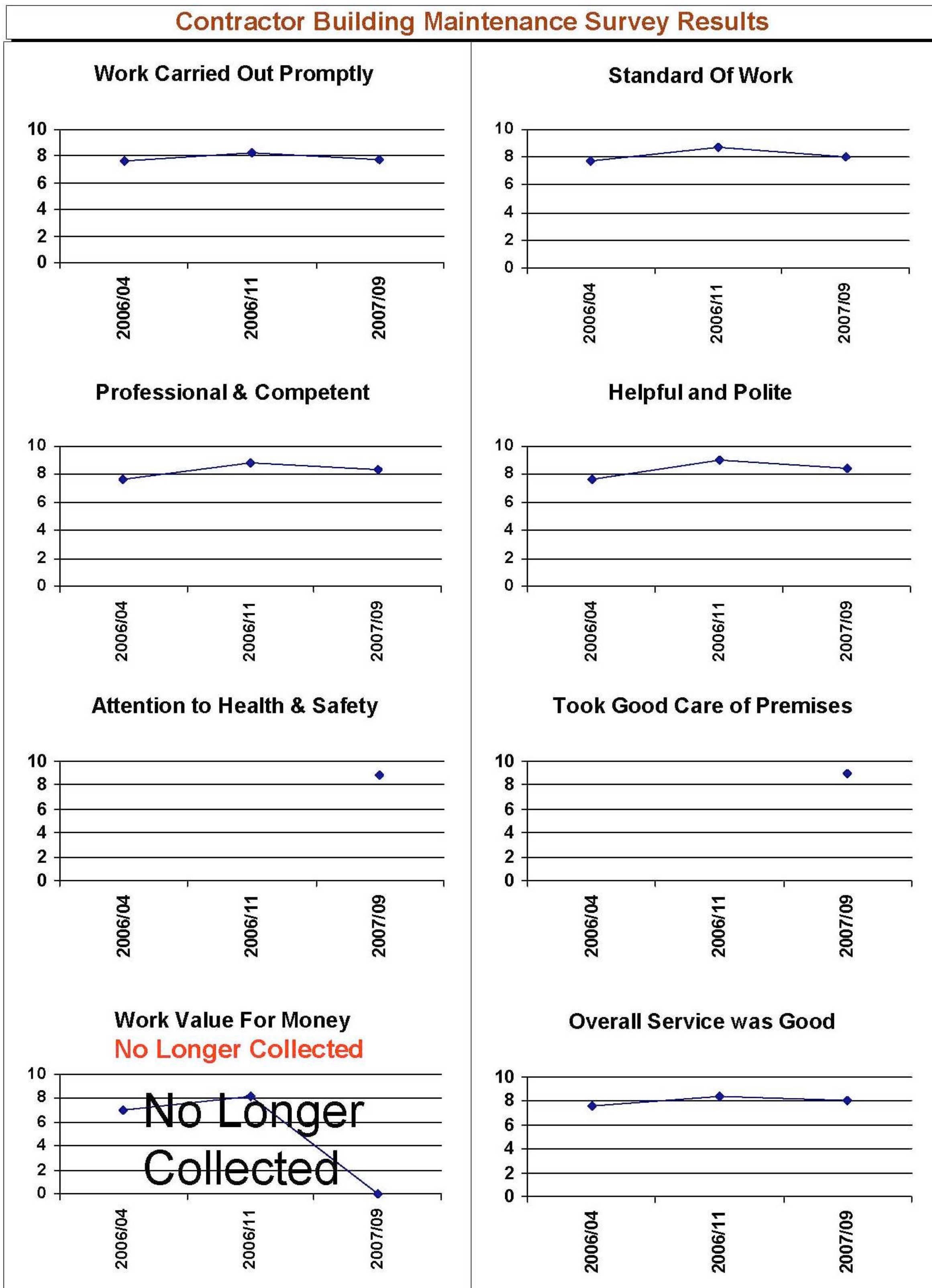
- Amey Wye Valley Service/COPROP Average Customer Satisfaction Assessment
  Graph 2.1 (page 6)
- All Contractor Services/COPROP Average Customer Satisfaction Assessment
  Graph 2.2 (page 7)
- Professional Services/COPROP Average Customer Satisfaction Assessment
  Graph 2.3 (page 8)

Graph 2.1 – 2006 to 2007 Customer Satisfaction Survey Results – Amey Wye Valley Performance

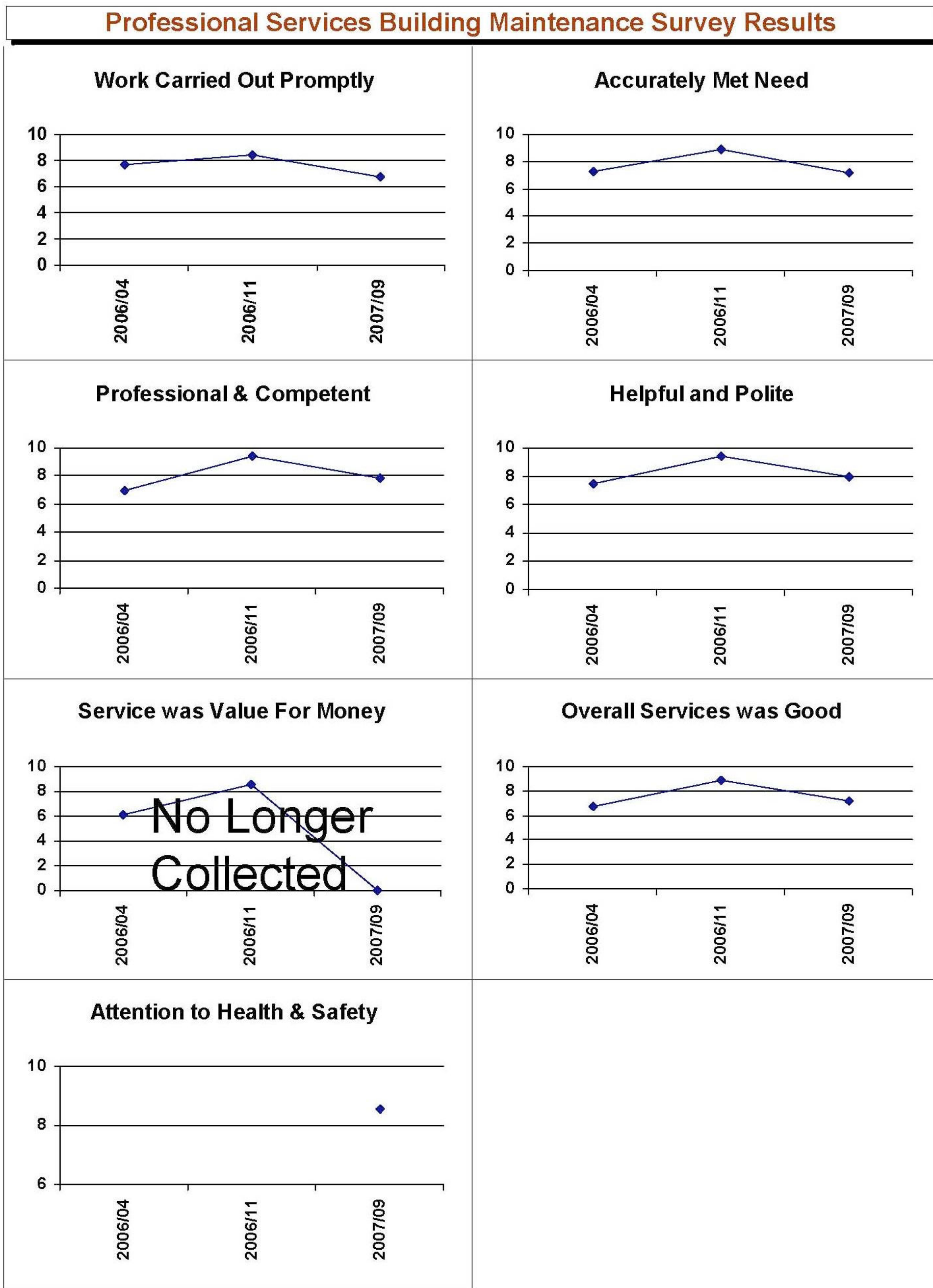


Y Axis is Average Score where 1 = Totally Dissatisfied and 10 = Totally Satisfied

Graph 2.2 – 2006 to 2007 Customer Satisfaction Survey Results –All Contractors Performance



Graph 2.3 – 2006 to 2007 Customer Satisfaction Survey Results – Professional Services



Y Axis is Average Score where 1 = Totally Dissatisfied and 10 = Totally Satisfied

2.1.4 Joint Working

2.1.4.1 AMPS continues to be involved with joint working projects throughout the County:

- The ESG development enters into a more intensive phase with the appointment of the preferred developer in March 2008 for the £200,000,000 retail development of the former livestock market site at Newmarket Street and Edgar Street in Hereford. The preferred strategic partner for the second phase, the Urban Village, will be appointed late in 2008 and the brief and tender process for the third phase, the Civic Quarter, will also be brought forward later this year. All of these developments require detailed input from professional and technical staff in AMPS.
- West Mercia Police – as part of the proposals for ESG and the Council/PCT accommodation strategy, formal discussions will also take place to incorporate, where appropriate, the known accommodation needs of the Police Authority.
- AMPS are also involved in a number of proposed projects to be considered as part of the Council's response to the Quirk Review whereby Council assets may be transferred to Third Sector organisations. Specific projects include working with Leominster and Area Regeneration Company in a project to refurbish and revitalise Grange Court, Leominster; and with Ledbury and Area Development Trust for St Catherine's hospital; and the Master's House in Ledbury.

2.2 CONSULTATION OVER THE NEXT 12 MONTHS

2.2.1 Action Plan for 2008/09

2.2.1.1 The action plan for 2008/09 is detailed in Appendix 6.

2.2.2 Consultation

2.2.2.1 The Facilities Management team will consult with schools regarding Grounds/Catering/Maintenance contracts due for renewal as part of the Service Level Agreement between AMPS and the Schools.

2.2.2.2 Consultation will also be undertaken by the Council, involving Asset Management & Property Services, with stakeholders regarding the potential for the future development of the Buttermarket and with stakeholders in respect of the provision of a new Livestock Market.

2.2.3 Joint Working

2.2.3.1 The next twelve months will see increased joint working with:

- The PCT following the appointment of a joint Chief Executive and the creation of Herefordshire Public Services.
- Halo on the Halo Vision Statement. AMPS will continue to work with Halo to jointly fund DDA improvement works and also to indentify further Salix funding to carry out carbon emission reductions.
- Shaw Health on Homes For Older People. AMPS will manage the Energy Management System on two homes for older people and provide data on energy use.
- ESG. The preferred developer for the Retail Quarter has been announced and work is already underway to conclude the Joint Venture Agreement between the

Council, AWM and ESG Developments Ltd and the Heads of Terms and Development Agreement between the Council and Stanhope, the developers.

- Rotherwas Futures. Work is ongoing with AWM on the provision of an enterprise hub by Evans Easy Space, and the future development of Rotherwas Estate.

2.2.4 Partnership

2.2.4.1 The Service Delivery Review for improved service delivery for the provision of Highways and Transportation and elements of grounds and property maintenance, which began in 2007, involves members of AMPS on the Project Team considering options for alternative models of service delivery. The review will continue with the Council's partners, Amey Wye Valley and Owen Williams.

2.2.4.2 In 2008 the Council will complete the preparation of the Joint Venture Agreement between the Council, Advantage West Midlands and ESG Developments Ltd for the onward delivery of the three phases of the ESG development; the Retail Quarter, the Urban Village and the Civic Quarter. The potential value of the completed developments will be close to £1 billion. The Head of AMPS will continue as the Council's main liaison officer with the ESG Board and Company.

2.2.4.3 The development agreement for the delivery of the Retail Quarter by Stanhope, who were announced in March 2008 as the preferred developers, will be completed between the Council and Stanhope in the autumn of 2008.

2.2.4.4 The preferred strategic partner for the delivery of the Urban Village will be decided and announced in summer 2008 and the tender process for the delivery of the Civic Quarter will be brought forward by summer 2008.

SECTION 3 – DATA MANAGEMENT

3.1 REVIEW OF DATA MANAGEMENT OVER THE LAST 12 MONTH

3.1.1 Review of Action Plan for 2007/08

3.1.1.1 The action plan for 2007/08 together with the outcomes as at January 2008 are detailed in Appendix 7.

3.1.1.2 A review of the systems utilised by AMPS in the delivery and management of data was taken, which highlighted the need for future investment into a Corporate Property Database, to replace the numerous legacy, non-supported systems currently in operation.

3.1.2 Strategic Data Management

3.1.2.1 The use of GIS (Geographical Information System) MapInfo has continued, and is the preferred tool for providing the front end of any new Corporate Property Database. The information captured on the systems has continued, and proved invaluable with the land mapping project required for the ESG.

3.1.2.2 Coupled with the use of a Unique Property Reference Number (UPRN) created locally to record new sites, the service has adopted BS7666 guidelines for the Land and Property Gazetteer, when naming properties, and highlighted the need to purge existing data to ensure conformity to this national standard.

3.1.2.3 Electronic property drawings for all principal operational properties now exist and are usually plotted at a 1:500 scale. However, the detail contained in these plans has proved to be rather limited in Asset Management terms, and larger scale, more detailed plans have been sourced where possible, and a new room naming standardisation regime has been drawn up, but yet to be implemented.

3.1.2.4 The Asbestos Register Database has been rebuilt to take into consideration HSE comments regarding our management of Asbestos Containing Materials, and will now enable the Council to proceed with improvements to the on-site management of these materials.

3.1.3 Data Management Systems

3.1.3.1 Due to the Herefordshire Connects programme being temporarily suspended, a service decision was made to carry out a review of the IT systems utilised by AMPS. This review highlighted that a lot of the systems were legacy, non supported and generally not fit for purpose. The main areas of data are split between 5 or more data platforms, Evolution – Asset Data and Condition Surveys, CUPID - Building Maintenance ordering and contract management, MapINFO – mapping of Council assets & deeds, DataEase – Property Terrier and in-house access databases and excel spreadsheets – Asbestos & Legionella management and asset valuations. Time and effort is then taken to extract data form all these various IT platforms to manage the assets.

3.1.4 Staffing and Training

3.1.4.1 GIS training has been given to the Information Assistants and to the Terrier Officer, from basic to intermediate level, to allow for greater use and interrogation of the data tables held within the system. AutoCAD training has also been available at a basic entry level as well as more advanced, and also user specific training identified through a survey has been completed.

3.2 DATA MANAGEMENT OVER THE NEXT 12 MONTHS

3.2.1 Action Plan for 2008/09

3.2.1.1 The action plan for 2008/09 is detailed in Appendix 8.

3.2.2 Strategic Data Management

3.2.2.1 The potential of GIS to provide a usable and more adaptable end users interface will be explored more fully, with the intention of being able to provide a more comprehensive and user friendly method for AMP staff, members and other services to interrogate our data.

3.2.2.2 The issue of a Corporate Property Database will be addressed and proposals for the replacement of the legacy systems with integrated procedures for improved ways of data management.

3.2.3 Data Management Systems

3.2.3.1 The whole Data Management structure will be reviewed to ascertain what data any new system or systems will be required to hold, report and utilise to provide the wide and varied utilisation of property related data in conjunction with Service and Corporate Plans. A brief and specification will be prepared in association with colleagues from ICT as part of business plan for approval.

3.2.4 Staffing and Training

3.2.4.1 Training for staff on any new system will need to be provided, plus the continuation of existing training schedules for new staff.

3.2.5 Data Validity

3.2.5.1 Existing Data will need to be validated and purged prior to any transfer to a new system.

SECTION 4 – PERFORMANCE MANAGEMENT MONITORING AND INFORMATION

4.1 REVIEW OF PERFORMANCE MANAGEMENT MONITORING AND INFORMATION OVER THE LAST 12 MONTHS

4.1.1 Review of Action Plan 2007/08

4.1.1.1 The action plan for 2007/08 with the outcomes as at January 2008 are detailed in Appendix 9.

4.1.2 Property Performance Indicator

4.1.2.1 AMPS continue to contribute to the performance indicators of the Council at three levels:

- National Best Value Performance Indicators
- Regional Benchmarking, and association level
- Local Performance Indicators.

4.1.2.2 The sole national P.I. for Property is B.V.P.I. 156 which indicates the percentage of public buildings accessible by persons with disabilities. The Council performance in this area has continued to improve as a result of building adaptations and some disposal of non-compliant properties.

4.1.2.3 In 2003/04 access was provided to 32% of property, in 2006/07 this had increased to 50%. The target for 2007/08 of 63% was exceeded with over 66% of buildings now being compliant. The target for 2008/09 is 80%.

4.1.2.4 At a regional level the Council produces 15 P.I.s as detailed in this AMP. These are submitted to I.P.F and benchmarked with similar Councils. The Council also participates in the COPROP Survey comparing Maintenance and Estate Services with other Councils (section 2.1.3 refers).

4.1.2.5 Finally at local level AMPS have a list of P.I.s contained in the Directorate and Service plans.

4.1.3 AMPS Plan 2008-2011

4.1.3.1 The AMPS Service Plan 2008-11 is in preparation as is the AMPS contribution towards the Resources Directorate service plan.

4.1.4 Area Property Studies and Service Specific Property Reviews

4.1.4.1 Through the CASG and SARG, AMPS continues to support the frontline Council services by raising the awareness of the importance of efficient and effective use of property assets to improve service delivery.

4.1.5 Monitoring of the Capital Programme

4.1.5.1 As in previous years Prince 2 Methodology for the monitoring of the capital programme has been adopted. Property Services now sits at Board or Project level for the following schemes:

- Replacement Crematorium
- Accommodation Project

- Weobley Sports Hall
- The Minster College
- Wyebridge Sports College
- Livestock Market
- Edgar Street Grid
- Sutton Primary School
- Children and Family Centres

4.2 PERFORMANCE MANAGEMENT, MONITORING AND INFORMATION OVER THE NEXT 12 MONTHS

4.2.1 Action Plan for 2008/09

4.2.1.1 The action plan for 2008/09 is detailed in Appendix 10.

4.2.2 Area Property Studies and Service Specific Property Studies

4.2.2.1 AMPS continues to give advice regarding the review of Social Care Training Centres.

4.2.2.2 The provision of suitable accommodation for Info Centres continues, focussing on Ledbury and Ross-on-Wye.

4.2.2.3 The DDA access audits will continue and the present programme of upgrading property in line with the access audits will be implemented.

4.2.2.4 AMPS involvement in the review of educational establishments will continue, to identify the appropriate disbursement of over £30 million in government funding for the improvement of school buildings.

4.2.3 Monitoring of the Capital Programme

4.2.3.1 All capital schemes are now undertaken utilising through Prince 2 project management methodology.

4.2.4 Property Performance Assessment

4.2.4.1 AMPS will continue to benchmark through appropriate networks.

SECTION 5 – PROGRAMME AND PLAN DEVELOPMENT AND IMPLEMENTATION

5.1 REVIEW OF PROGRAMME AND PLAN DEVELOPMENT AND IMPLEMENTATION OVER THE LAST 12 MONTHS

5.1.1 Review of Action Plan 2007/08

5.1.1.1 The action plan for 2007/08 together with the outcomes as at January 2008 are detailed in Appendix 11.

5.1.2 Programme Developments

5.1.2.1 The previously identified objectives continue to be relevant:

- To secure significant efficiency saving in line with the Carbon Management Action Plan.
- To ensure that the Council's essential assets are in the right condition for the long term and cost effective in delivery of services.
- To understand the needs and preferences of service users and council taxpayers.
- Recruit, retain and motivate high quality staff.
- Embed corporate planning, performance management and project management systems within the ethos of Asset Management and Property Services.

5.1.3 Capital Programme

(This section to be provided by Financial Services)

5.1.4 Acquisitions and Disposals Programme

5.1.4.1 The Council has continued with its programme of disposals of surplus assets, this includes the disposal of a number of barns on the Smallholdings estate, offices and a large high school site. The target of £1 million per annum on average for the Smallholdings estate has been exceeded and the total capital receipts for 2007/08 to date are in excess of £1.8 million. In addition to disposals the Council has acquired a number of properties, paid for by AWM on behalf of ESG (Hereford) Ltd. The list of acquisitions and disposals is as follows:

Property Disposals

1. New House Farm
2. Westbrook Manor Farm Barns
3. Tow Tree Farm Land
4. Pool Farm Offices
5. Former Whitecross High School (Conditional)
6. Toll House, Hoarwithy
7. Former Ledbury Road Nursery, release of restrictive covenant.

Property Acquisitions

1. Blueschool House
2. 32 Conningsby Street
3. 5 Blackfriars Street
4. Livestock Market Site
5. Cradley Primary School Playing Field
6. Crematorium Site

5.1.6 Planned Maintenance Programme

5.1.6.1 The Council uses the following criteria to select priorities for the maintenance programme.

i) Health and Safety requirements
ii) Keeping the building wind and watertight
iii) Works to prevent further deterioration
iv) Works to keep the property fit for purpose

5.1.6.2 The Council has continued to reduce its maintenance backlog by:

i) Disposing of high maintenance cost buildings
ii) Using low maintenance materials in constructing properties
iii) Eliminating felt roofs

5.1.6.3 Guidance notes have been issued to in-house staff and external consultants advising them of the good practice guide for building design and construction for Herefordshire Council.

Total Backlog Cost Per/m2 By Directorate

Directorate	**GIA m2**	**Total Cost £**	**Cost Per/m2 £**
Adult & Community Services	30,505	1,634,766	53.59
Children's Services/Schools	199,387	12,227,414	61.32
Corporate & Customer Services	1,224	103,274	84.37
Environment	11,682	233,766	20.01
Resources	146,904	3,631,809	24.72
TOTAL	**389,702**	**17,831,029**	**244.01**

5.1.6.4 As part of the AMPS process the Councill will begin to benchmark these costs with other Councils.

5.2 PROGRAMME AND PLAN DEVELOPMENT AND IMPLEMENTATION OVER THE NEXT 12 MONTHS

5.2.1 Action Plan for 2008/09

5.2.1.1 The action plan for 2008/09 is detailed in Appendix 12.

5.2.2 Programme Development

5.2.2.1 The Council will continue to develop its property strategy, which is linked to the property drivers detailed in Section 1.3.

5.2.3 Option Assessment and Project Appraisal

5.2.3.1 The arrangements for project appraisals will continue and be developed to take into account whole life costing. Staff training for options appraisal will be organised in conjunction with IPF who hold a number of workshops each year.

5.2.4 Capital Programme Over The Next 4 Years

5.2.4.1 The Council has a very ambitious capital programme over the next 4 years, which will put a strain on the limited resources available within AMPS. Decisions will need to be taken on a case by case basis as to the appropriate level of internal and external support provided for each project. A list of the major projects requiring AMPS resources is given below:

- Replacement Minster College = £20m
- Replacement Wyebridge Sports College = £22.5m
- Other Schools = £30m
- Replacement Crematorium = £3.4m
- New Livestock Market = £5+m
- Info Centres = £3.5m
- New Back office = £30m+
- ESG = £200m+

5.2.5 Acquisitions and Disposals Programme

5.2.5.1 The acquisition of properties within the Edgar Street Grid will continue as opportunities arise. The disposal programme for the Smallholdings estate will reflect the fact that Farm Business Tenancies give the Council greater opportunity to continue its programme of rebuilding the estate.

5.2.6 Planned Maintenance Programme

5.2.6.1 Expenditure on the landlord elements for schools has increased from £900,000 in 2007/08 to £1.2 million for 2008/09. Expenditure on the Councils Corporate estate is set at £1.17 million and £184,000 on the agricultural estate.

5.2.6.2 Specific capital works have been included in the 2008/09 programme to carry out Legionella preventative measures and this is to be funded from the Capital Programme.

5.2.7 Carbon Management

5.2.7.1 The present commitment against the Salix allocation of £200,000 is £140,000. The expenditure has included installing lighting controls to properties and fixing the Power Perfector system to the incoming mains of larger sites. This results in a reduction in energy consumption of approximately 10% per annum and produces a payback period within 5 years. Similar schemes will continue to be identified.

5.2.7.2 The installation of a Trend Energy Management System to Council properties will be extended to include school buildings. The system permits remote monitoring and control of building energy usage.

5.2.8 Disabled Access Programme

5.2.8.1 The undertaking of adaptation works to improve disabled access to council properties will continue in 2008/09. Capital funding of £200,000 has been secured and properties will be identified from access audits and in discussions with the disability group.

APPENDIX 1 Herefordshire Council's Property Strategy

Herefordshire Council's Property Strategy March 2008
Justify Council property holding, rationalise, release capital, reduce revenue costs, maximise revenue from Investment holdings and achieve critical service factors

What are the Council's Top Service Priorities?

- The best possible life for every child, safeguarding vulnerable children and improving educational attainment
- Reshaped adult health and social care, so that more older and other vulnerable people maintain control of their lives
- The essential infrastructure for a successful economy, enabling sustainable prosperity for all
- Affordable housing to meet the needs of local people

What are the Council's Organisational Priorities?

- Better services, quality of life and value for money, particularly by working in partnership with the Herefordshire Primary Care Trust and other local organisations

This drives the Council's Property Objectives.

- To provide cost-effective and up to date property meeting service needs.
- To minimise property ownership to that necessary for the Council's needs.
- To justify fully, continued ownership of all property no matter what its use.
- To release capital, to reduce total revenue costs and to achieve value for money.
- To maximise revenue income from investment properties.
- To use property in a sustainable and environmentally friendly manner.
- To improve access to council property.

Which influence the way we manage the portfolio.

Office Accommodation:

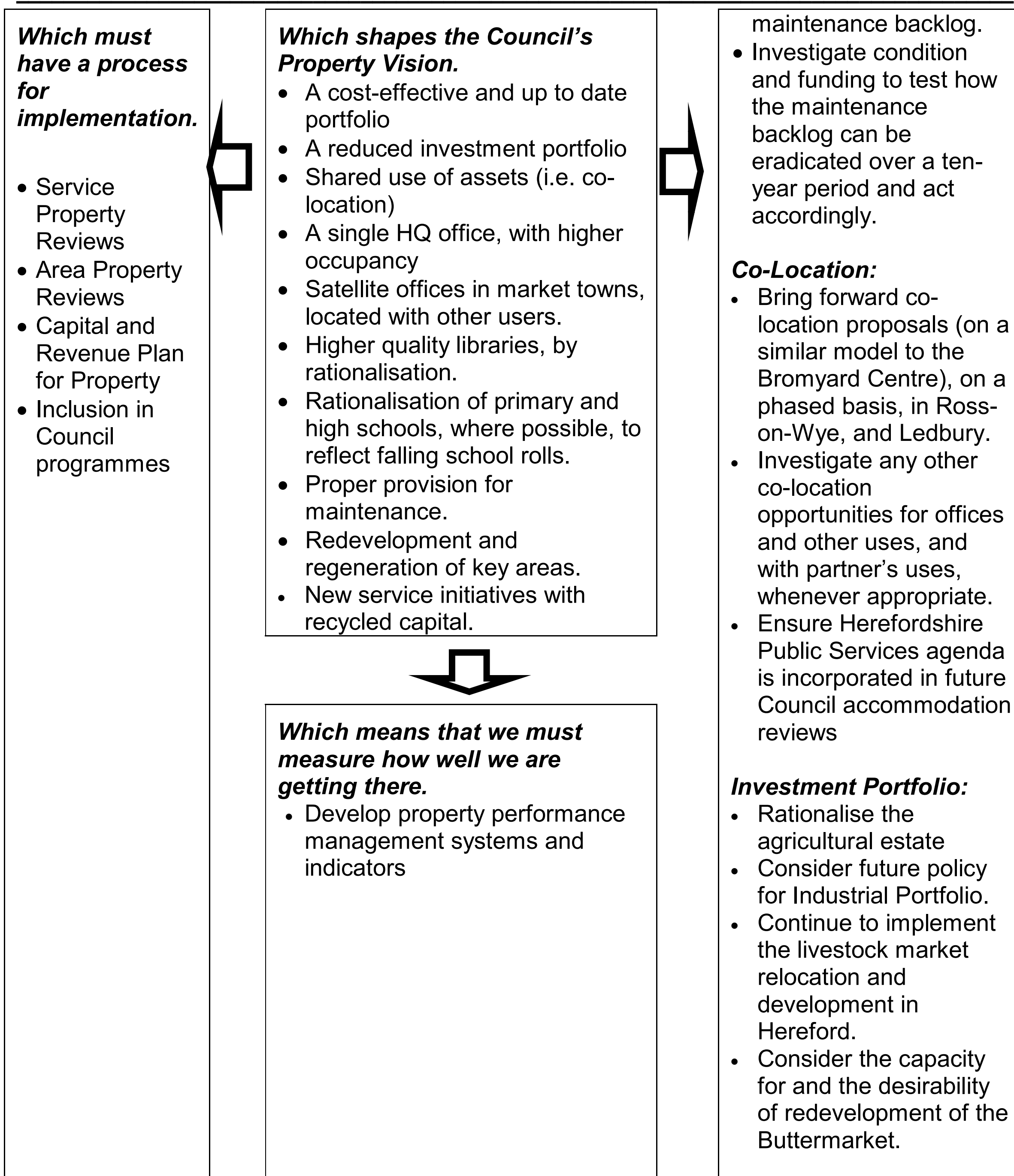
- Consolidate offices in Hereford
- Increase utilisation by improved use of space and new work style.
- Satellite offices in market towns.

Direct Service Property:

- Build new crematorium.
- Review Library provision and assess scope for rationalisation and improvement.
- Investigate refurbishment of the museum and bring the heritage centres up to full DDA compliance.
- Continue to implement the public conveniences Best Value Review recommendations.
- Ongoing review of schools to assess scope for rationalisation in light of falling schools rolls.

Maintenance:

- Seek to eradicate the maintenance backlog.



Which must have a process for implementation.

- Service Property Reviews
- Area Property Reviews
- Capital and Revenue Plan for Property
- Inclusion in Council programmes

Which shapes the Council's Property Vision.

- A cost-effective and up to date portfolio
- A reduced investment portfolio
- Shared use of assets (i.e. co-location)
- A single HQ office, with higher occupancy
- Satellite offices in market towns, located with other users.
- Higher quality libraries, by rationalisation.
- Rationalisation of primary and high schools, where possible, to reflect falling school rolls.
- Proper provision for maintenance.
- Redevelopment and regeneration of key areas.
- New service initiatives with recycled capital.

Which means that we must measure how well we are getting there.

- Develop property performance management systems and indicators

maintenance backlog.

- Investigate condition and funding to test how the maintenance backlog can be eradicated over a ten-year period and act accordingly.

Co-Location:

- Bring forward co-location proposals (on a similar model to the Bromyard Centre), on a phased basis, in Ross-on-Wye, and Ledbury.
- Investigate any other co-location opportunities for offices and other uses, and with partner's uses, whenever appropriate.
- Ensure Herefordshire Public Services agenda is incorporated in future Council accommodation reviews

Investment Portfolio:

- Rationalise the agricultural estate
- Consider future policy for Industrial Portfolio.
- Continue to implement the livestock market relocation and development in Hereford.
- Consider the capacity for and the desirability of redevelopment of the Buttermarket.

APPENDIX 2 – REMIT OF THE CAPITAL ASSET STRATEGY GROUP (CASG)

- To promote capital strategy and asset management issues throughout the Council
- To ensure that asset based strategies were linked in to other council strategies
- To develop and maintain the Council's medium and short term property aims
- To present the AMPto the Cabinet Members for approval
- To promote a long term (in excess of 5 years) strategic overview by considering Directorate accommodation bids and service development strategies.
- To challenge property use, retention or disposal, taking into account the long-term drivers towards a Corporate Property Strategy.

• APPENDIX 3 – REMIT OF THE STRATEGIC ASSET REVIEW GROUP

- To assist Services and Departments to achieve a sustainable property asset base, which is both sufficient and suitable for service delivery.
- To assess the Council's operational land and property needs.
- To consider the property content of Service and Departmental Plans.
- To consider departmental and service delivery proposals that have an impact on Council land and property.
- To prepare the Council's Asset Management Planning documentation at a strategic level, covering the assessed or perceived needs of the Council in the medium to long term.
- To assess the opportunities to co-locate with other public sector and third sector organisations.
- To assess the opportunities for joint working with other public sector organisations.

APPENDIX 4 – REMIT OF THE CAPITAL STRATEGY MONITORING GROUP (CSMG)

- To assist the CASG with the development of Council-wide capital monitoring procedures.
- To monitor capital expenditure on behalf of the CASG .
- To prepare capital outturn reports for each financial year for the CASG to consider.
- To collate information on capital expenditure needs and proposals in order to assist the CASG with their task of reviewing and updating the capital programme.
- To promote capital monitoring procedures throughout the Council.

APPENDIX 5 – REVIEW OF ACTION PLAN FOR 2007/08

SECTION 2 - CONSULTATION

Short-Term Action Plan 2007/08

Ref	Task	Target	Outcome
1.	Send out monthly Customer Satisfaction Survey questionnaires on maintenance	March 2008	Completed
2.	Consult with partners on the HJS and Owen Williams arrangements	June 2007	Completed
3.	Organisation Consultation meeting with companies and individuals involved in the Edgar Street Grid	June 2007	Completed
4.	Undertake a major exercise on sustainability as part of the Council's Carbon Management Plan	March 2008	Completed
5.	Participate in the DDA initiative on improvements to Council Property	December 2007	Completed

APPENDIX 6 – ACTION PLAN FOR 2008/09

SECTION 2 - CONSULTATION

Short-Term Action Plan 2008/09 (Within 12 Months)

Ref	Task	By Whom	Completion Date
1.	Consult with schools regarding Grounds /Catering/Maintenance SLA Contracts	CPO	December 2008
2.	Stakeholder consultation on Livestock and Buttermarket	CPO	March 2009
3.	Continue Service Area Review with partners Amey and Owen Williams	CPO	September 2008
4.	6 monthly Customer Satisfaction Surveys on Estates and Maintenance issues	L & P I O	May and November 2008

APPENDIX 7 - REVIEW OF ACTION PLAN FOR 2007/08

SECTION 3 – DATA MANAGEMENT

Short Term Action Plan 2007/08

Ref	Task	Status	Outcome
1.	Continue with data capture of GIS system for terrier data (deeds, lease and disposals) in conjunction with deed registration schedule..	On Going	Continuing
2.,	Continue with programme of five-yearly building/mechanical/electrical condition surveys.	Completed	18% of portfolio surveyed
3.	Initiate programme of asbestos priority risk assessments and re-surveys.	Completed	Superseded by Asbestos Policy Revision
4.	Carry out audit of status of drawings held by Property Services to compile a Drawing Register	Completed	Superceded. New task under development.
5.	Provide AutoCAD training for existing and new users with reference to new software release	Completed	On site training completed for basic users plus advanced training for new staff
6.	Provide additional Geographical Information System (GIS) training to Property Services staff.	Completed	All necessary staff have had initial training
7.	Explore options to link databases to produce a Property Details Folder of Corporate Assets	Completed	Project superseded by requirement for new Corporate Property Database

APPENDIX 8 – ACTION PLAN FOR 2008/09

SECTION 3 - DATA MANAGEMENT

Short-Term Action Plans 2008/09(Within 12 Months)

Ref	Task	By Whom	Completion Date
1.	Continue with data capture of GIS system for terrier data (deeds, lease and disposals) in conjunction with deed registration schedule.	L & P I O and Terrier Officer	March 2009
2.	Continue with programme of five-yearly building/mechanical/electrical condition surveys.	Property Information	November 2008
3.	Roll out programme of new Asbestos Surveys following revised Asbestos Policy and creation of Asbestos Management Logbooks	Property Information & Asbestos Surveyors	20% completed by March 2009
4.	Provide GIS Property Data via Exponare Software for all of Property Services and reduce numbers of MapINFO licences	Property Information section	December 2008

5.	Review AMPstructure	Strategy Team	October 2008
6.	Carry out assessment of data requirements for a Corporate Property Database to replace legacy and non supported existing databases	Strategy Team	November 2008

APPENDIX 9 – REVIEW OF ACTION PLAN FOR 2007/08

SECTION 4 – PERFORMANCE MANAGEMENT MONITORING AND INFORMATION

Short Term Action Plan 2007/08

Ref	Task	Target	Outcome
1.	Produce monthly Customer Satisfaction Survey Questionnaires on maintenance performance	Review results March 2007	Completed
2	Continue with external benchmarking exercises	November 2007	Completed
3.	Audit OIC's energy returns and move information collection to WMS website.	October 2007	Completed
4.	Improve BVPI 156 from 50% to 60%by works and property disposals	March 2007	Completed (Achieved 66%)
5.	Implement an action plan to reduce the backlog of maintenance by 10%	December 2007	Completed
6.	Complete Social Services Property Review and make recommendations on a strategy	December 2007	Target revised to March 2009
7.	Carry out Area Property Review of Ross-on-Wye	December 2007	Completed
8.	Participate in review of Educational Properties by producing performance data on property	March 2007	Completed
9.	Implement Prince 2 Project Management on all Capital Projects	September 2007	Completed

APPENDIX 10 – ACTION PLAN FOR 2008/09

SECTION 4 – PERFORMANCE MANAGEMENT MONITORING AND INFORMATION

Short Term Action Plan 2008/09 (Within 12 Months)

Ref	Task	By Whom	Completion Date
1.	Produce 6 monthly Customer Satisfaction Survey Questionnaires on maintenance performance	L & P I O & Lead Surveyor	May 2008 and November 2008
2.	Continue with external benchmarking exercises	L & P I O	November 2008
3.	Improve BVPI 156 from 60% to 80%by works and property disposals	D&M Manager/ E&V Manager	March 2009
4.	Complete Social Services Property Review and make recommendations on a strategy	CPO	March 2009

APPENDIX 11 – REVIEW OF ACTION PLAN FOR 2007/08

SECTION 5 – PROGRAMME PLAN DEVELOPMENT AND IMPLEMENTATION

Short Term Action Plan 2007/07

Ref	Task	Target	Outcome
1.	Produce a programme of objectives for both the Investment and Direct Services panels as detailed in the Property Strategy	October 2007	Superseded
2.	Implement option appraisal to the Scheme Selection and Prioritisation System	December 2007	Completed
3.	Disposal of property and land on the Council's Smallholding Estate to produce capital receipts in excess of £1 million	December 2007	Annual target achieved
4.	Join the Edgar Street Grid (ESG Ltd) Projects Board to represent the Council's property interests within the grid.	September 2007	Completed
5.	Implement the outcome of the Ledbury Property Review	March 2008	On going
6.	Establish and operate an 'Invest to Save', scheme for Carbon Management Plan objectives using the £200,000 grant awarded from the Salix Fund.	September 2007	£140,000 committed. £30,000 annual savings
7.	Implement £200,000 worth of DDA works in accordance with the Council's Disable Strategy	March 2008	Target achieved £232,000 spent
8.	Review the Value for Money concept of the HJS/Council partnership	December 2007	Superseded Service Delivery Review

APPENDIX 12 – ACTION PLAN FOR 2008/09

SECTION 5 – PROGRAMME PLAN DEVELOPMENT AND IMPLEMENTATION

Short Term Action Plan 2008/09 (Within 12 Months)

Ref	Task	By Whom	Completion Date
1.	Implement remainder of £200,000 budget for DDA works	D & M Manager	March 2009
2.	Continue 'Invest to Save' scheme for carbon Management Plan on remaining £60,000 grant	D & M Manager	March 2009
3.	Disposal of property and land on the Council's Smallholding Estate to produce capital receipts in excess of £1 million	E & V Manager/Land Agent	March 2009
4.	Implement any Improved Methods of Working resulting from the Service Delivery Review	CPO	December 2009

5.	Implement 'Whole Life Costing' into Option Appraisal arrangements.	CPO/D&M Manager	December 2009
6.	Implement the outcome of the Ledbury Property Review.	D & M Manager	March 2009

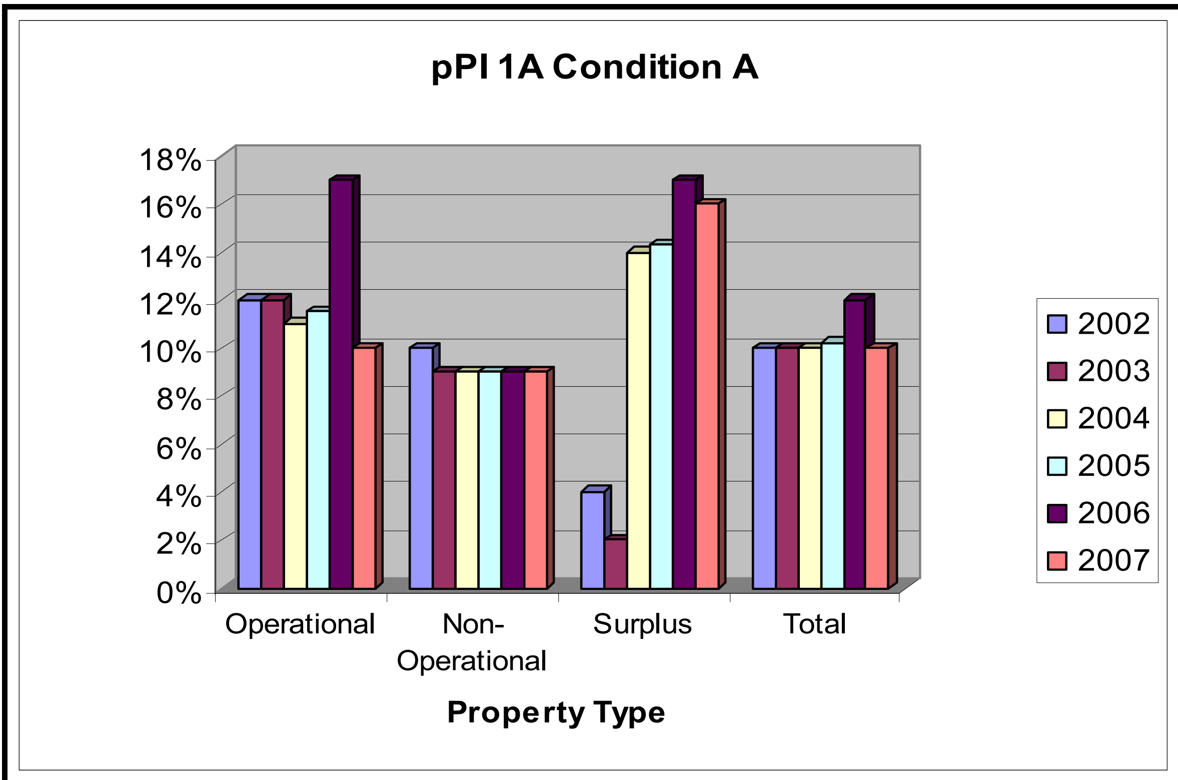
APPENDIX 13 – pPI 1A

HEADING	***DESCRIPTION***
PERFORMANCE INDICATOR REF:	pPI 1A
NAME:	% Gross internal floor space in ODPM condition categories A –D
SOURCE	ODPM
REASON	Support annual AMP Submission
FREQUENCY	Annual
TARGET AUDIENCE	ODPM Government Office for West Midlands Elected Members CASG CMB
METHOD	Analysis of condition categories for all buildings / land using GIA floor area data. Grade A – Good - Performing as intended and operating efficiently. Grade B – Satisfactory - Performing as intended but exhibiting minor deterioration. Grade C – Poor – Exhibiting major defects and/or not operating as intended. Grade D – Bad – Life expired and/or serious risk of imminent failure.
INCLUSIONS	All operational and non-operational properties.
EXCLUSIONS	Schools
DATE	Data as at end December 2007. Report date January 2008.
RESULTS	**The total GIA excluding schools is 259,453 m^2** **The results are set out in the table below.**
LESSONS LEARNT	The data proves that the majority of the Herefordshire Council's building assets are in a satisfactory condition.
ACTIONS TO BE TAKEN	A target will be added to the AMPS annual business plan to achieve an overall level of 85% of the Council's buildings being Good or Satisfactory.

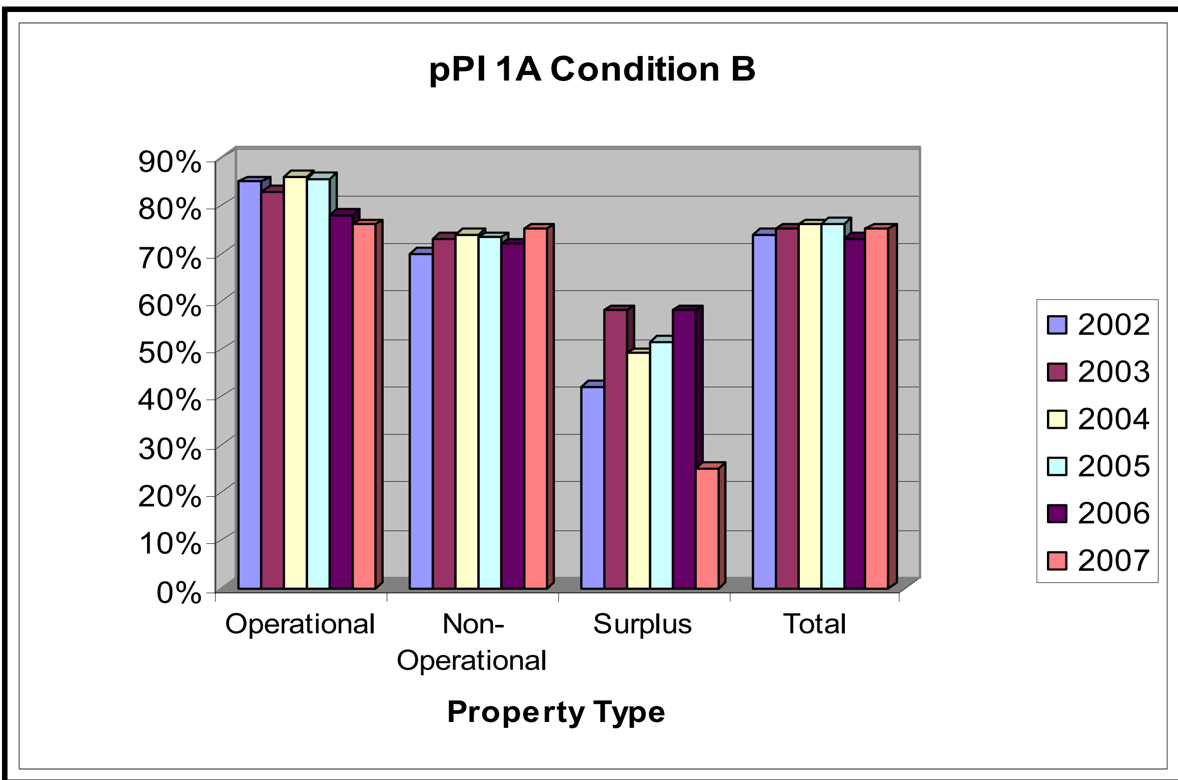
	GIA Floor Area (m^2)	A (Good) %	B (Satis.) %	C (Poor) %	D (Bad) %	Total %
Operational	81965	10%	76%	11%	3%	100%
Non-Operational	167700	9%	75%	14%	2%	100%

Surplus / Empty	9788	16%	25%	31%	28%	100%
Total	**259,453**	**10%**	**75%**	**11%**	**3%**	**100%**

APPENDIX 13 – pPI 1A GRAPHS 6 YEAR COMPARISSON

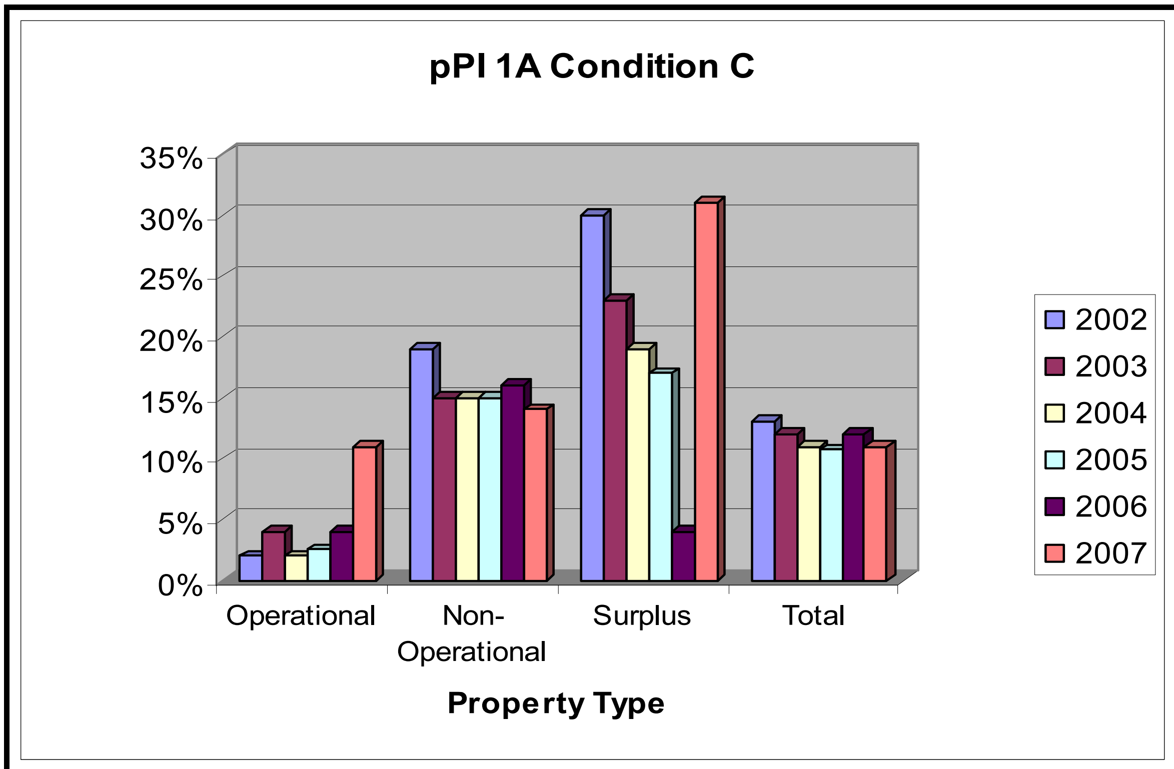


Graph 13.1 Condition A 2002 to 2007

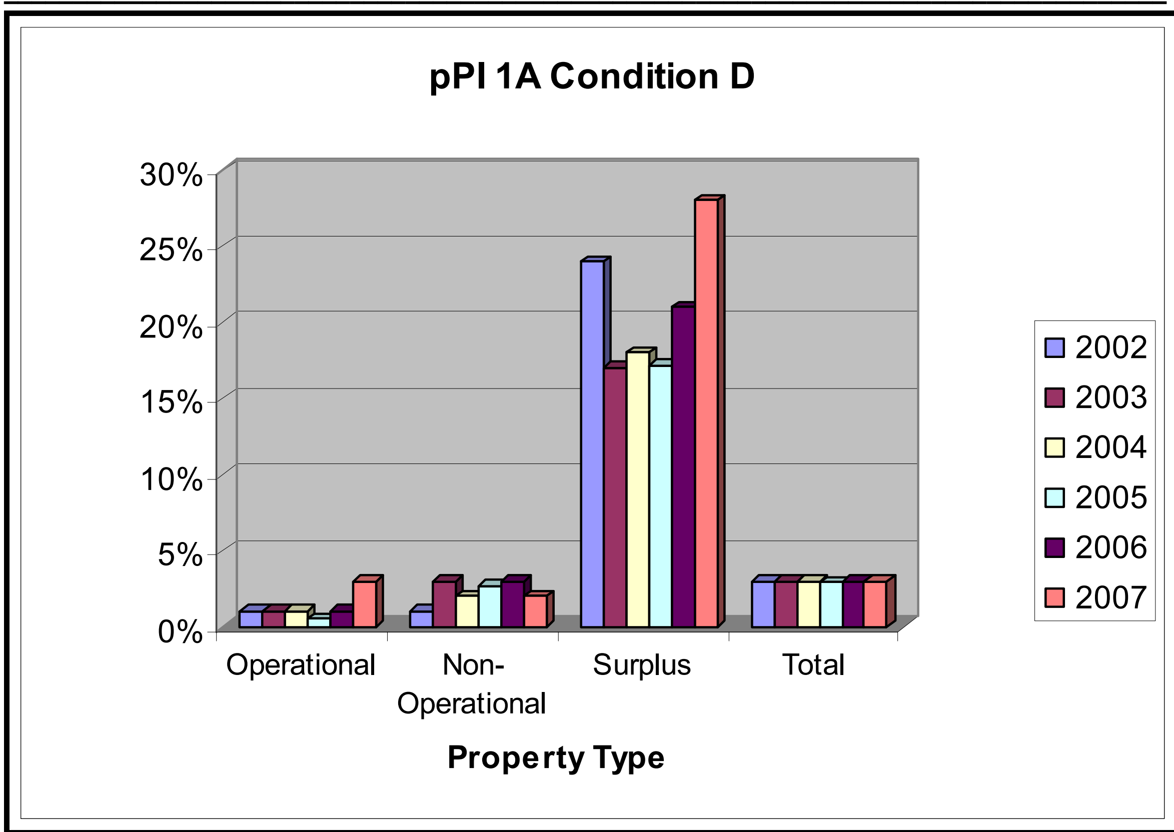


Graph 13.2 Condition B 2002 to 2007

APPENDIX 13 – pPI 1A GRAPHS 6 YEAR COMPARISSON Cont.



Graph 13.3 Condition C 2002 to 2007



Graph 13.4 Condition D 2002 to 2007

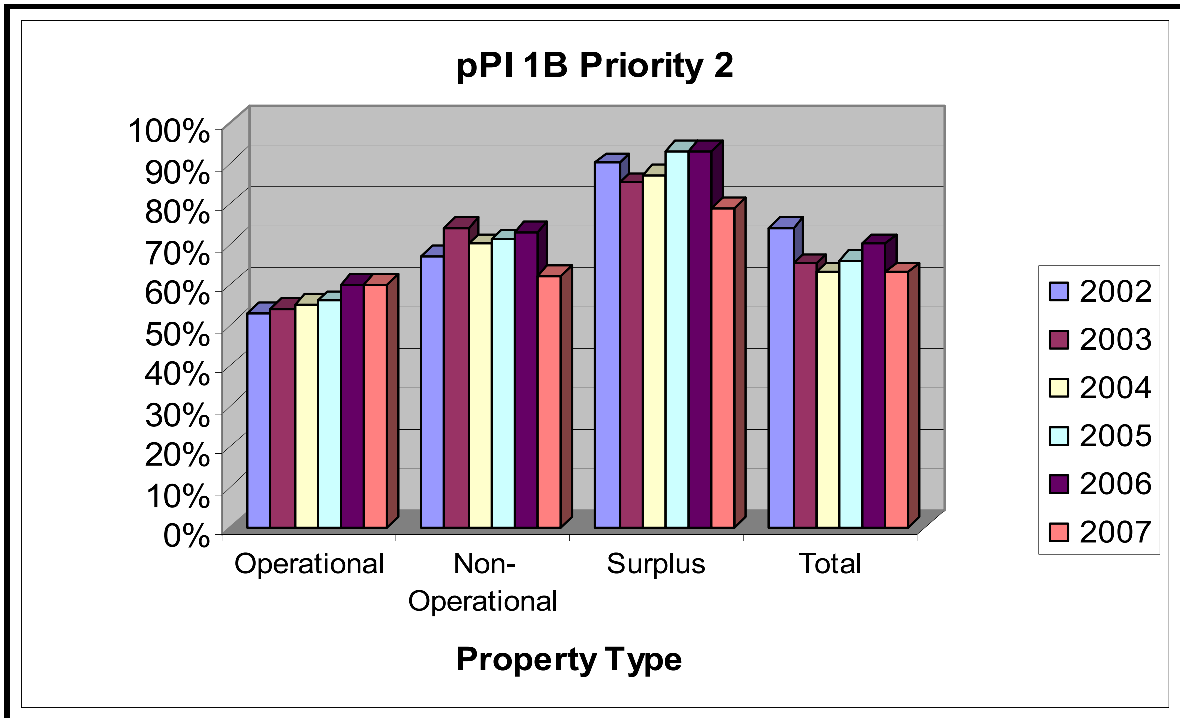
APPENDIX 14 – pPI 1B

HEADING	DESCRIPTION
PERFORMANCE INDICATOR REF:	pPI 1B
NAME:	Backlog of maintenance by cost expressed (1) as total value and (2) as a % in priority levels 1-3.
SOURCE	ODPM
REASON	Support annual AMP Submission
FREQUENCY	Annual
TARGET AUDIENCE	ODPM Government Office for West Midlands Elected Members CASG CMB
METHOD	Total maintenance backlog for all Operational and Non-Operational Properties. Total value of maintenance backlog divided into work priority 1-3 at individual job level and expressed as an overall % of the total in priorities 1-3. Priority 1 – Urgent works that will prevent immediate closure of premises and/or address an immediate high risk to the health and safety of occupants and/or remedy a serious breach of legislation. Priority 2 – Essential work required within 2 years that will prevent serious deterioration of the fabric or services and/or address a medium risk to health and safety of the occupants and/or remedy a less serious breach of legislation. Priority 3 – Desirable work required within 3-5 years that will prevent deterioration of the fabric or services and/or address a low risk to the health and safety of the occupants and/or remedy a minor breach of legislation.
INCLUSIONS	All operational and non-operational properties
EXCLUSIONS	Schools
DATE	Data as at end December 2007. Report date January 2008
RESULTS	The cost and percentage results are shown in the table below.
LESSONS LEARNT	The Herefordshire Council now has an accurate figure for the overall maintenance backlog. This can be used to target improvements.
ACTIONS TO BE TAKEN	The Council will seek to continue to manage the maintenance backlog within acceptable limits.

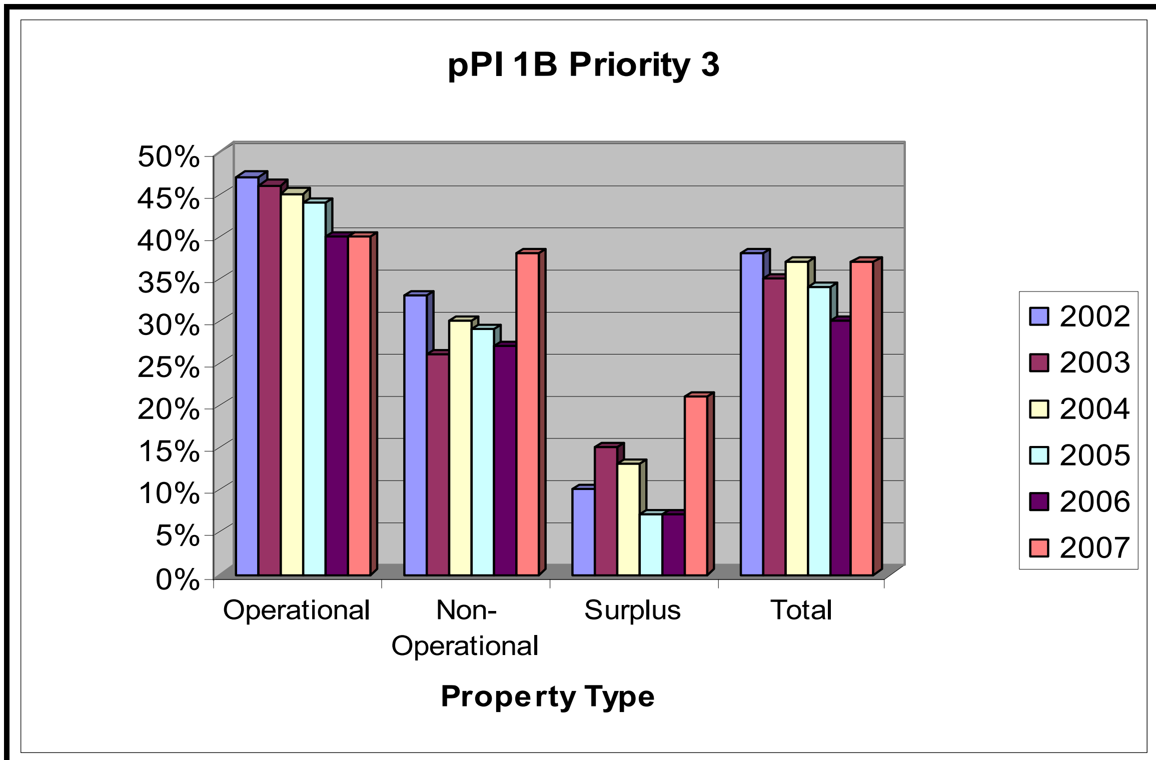
	Priority 1	Priority 2	Priority 3	Total
Operational	£650.00	£2,069,351	£1,356,735	£3,426,736

	0%	**60%**	**40%**	**100%**
Non-Operational	£8600.00 **0%**	£1,652,7721 **62%**	£992,083 **38%**	£2,653,404 **100%**
Surplus	£0.00 **0%**	£559,726 **79%**	£151,081 **21%**	£710,807 **100%**
Total	£9250.00 **0%**	£4,281,798 **63%**	£2,499,899 **37%**	£6,790,947 **100%**

APPENDIX 14 – pPI 1B GRAPHS 6 YEAR COMPARISSON

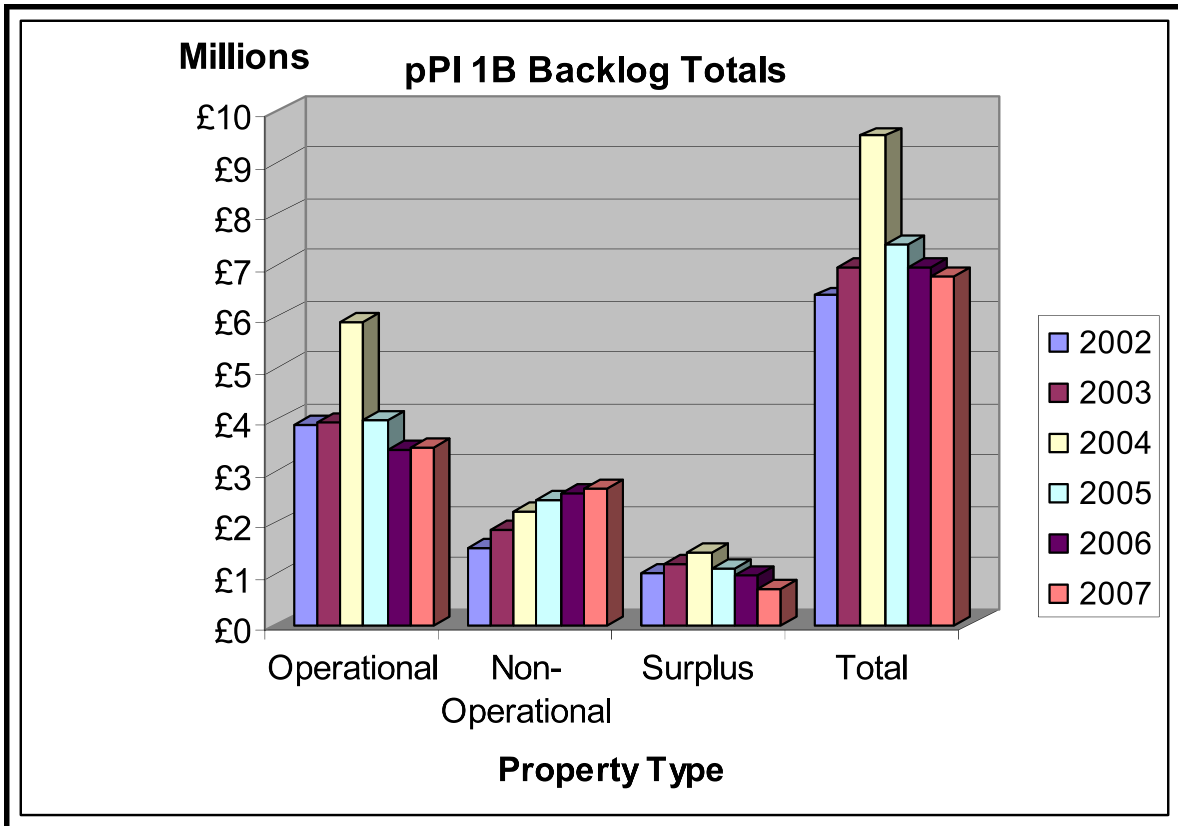


Graph 14.1 Priority 2 2002 to 2007



Graph 21.2 Priority 3 2002 to 2007

APPENDIX 14 – pPI 1B GRAPHS 6 YEAR COMPARISSON Cont.



Graph 14.3 Total Backlog 2002 to 2007

APPENDIX 15– pPI 3

HEADING	***DESCRIPTION***
PERFORMANCE INDICATOR REF:	pPI 3
NAME:	Total annual management costs per square metre (GIA) for the property portfolio
SOURCE	ODPM
REASON	Support annual AMP Submission
FREQUENCY	Annual
TARGET AUDIENCE	ODPM Government Office for West Midlands Elected Members CASG CMB
METHOD	Assessment of staff time spent on strategic property management
INCLUSIONS	The indicator covers the strategic management of the portfolio of the whole estate including; • Corporate preparation of both AMP and Capital Strategy documents • Preparation of other property related programmes and strategies • Corporate management of programmes • Condition and suitability surveys • Data management • Option appraisal, prioritisation • Input to service reviews • Corporate property reviews
EXCLUSIONS	• Management of projects • Carrying out condition surveys • Data entry
DATE	Data based upon financial year 2007/08. Report date January 2008.
RESULTS	• The Total Cost is £96,937.24 • The Total Floor Area is 389,702m2 **Total annual management costs per square metre (GIA) for the property portfolio is £0.25/ per m^2.**
LESSONS LEARNT	This figure has increased from last year.

ACTIONS TO BE TAKEN	Results of the pPI will be compared with figures from other authorities with a similar property portfolio so that conclusions can be made.

APPENDIX 16 – pPI 4A

HEADING	***DESCRIPTION***
PERFORMANCE INDICATOR REF:	pPI 4A
NAME:	Repair and maintenance costs per square metre GIA
SOURCE	ODPM
REASON	Support annual AMP Submission
FREQUENCY	Annual
TARGET AUDIENCE	ODPM Elected Members CASG CMB
METHOD	Repair and maintenance costs per square metre GIA for operational buildings only. Data is based upon information from Cedar Financials (corporate financial system) for full financial year 2006/07
INCLUSIONS	The following financial codes for all Operational properties: • Code 1000 - Repairs and maintenance • Code 1050 - Emergency work • Code 1051 - Planned maintenance • Code 1052 - Local Orders • Code 1054 - Revenue funded capital • Code 1055 - Energy management • Code 1056 – Servicing • Code 1010 – Alarm maintenance
EXCLUSIONS	• Schools • HALO Properties • Code 1053 - Minor improvements
DATE	Data for Financial Year 2007/08. Report date January 2008.
RESULTS	• The total floor area for operational properties excluding HALO properties, housing and schools as at 01/04/2007 was 55,288.64 m2. • The total repair and maintenance cost for 2007/08 was £801,455.54. **Repair and maintenance costs were £14.50 per square metre for the financial year 2006/07 for operational properties.**
LESSONS LEARNT	The Herefordshire Council now has an accurate figure for repair and maintenance costs that can be used as a benchmark for

	targeting of future improvements.
ACTIONS TO BE TAKEN	This figure needs to benchmarked against figures from other local authorities that have a similar size and profile of operational estate.

APPENDIX 17 – pPI 4B

HEADING	DESCRIPTION
PERFORMANCE INDICATOR REF:	pPI 4B
NAME:	Energy costs per square metre GIA (gas, electricity, oil, solid fuel)
SOURCE	ODPM
REASON	Support annual AMP Submission
FREQUENCY	Annual
TARGET AUDIENCE	ODPM Government Office for West Midlands Elected Members CASG CMB
METHOD	Energy costs per square metre GIA for operational buildings only. Data is based upon information from Cedar Financials (corporate financial system) and from West Mercia Supplies (bulk energy purchaser) for full financial year 2006/07
INCLUSIONS	All Operational properties
EXCLUSIONS	• Leisure Centres/Swimming Pools now managed by the Herefordshire Community Leisure Trust (HALO)
DATE	Data for Financial Year 2007/08. Report date January 2008.
RESULTS	The available data has considerable shortcomings for a variety of reasons. A decision has been taken to report upon the core of the operational properties where a good data set exists. On this basis • The total GIA for the core sample properties is 45,924.75.m^2 (approximately 83% of the total GIA of 55,288.64 m^2) • The total fuel cost for the properties was £645,495.80 **The energy cost per square metre GIA for 2006/07 was £14.05/m^2**
LESSONS LEARNT	The Herefordshire Council has a mixture of energy purchased direct from energy suppliers and of energy purchased through a bulk-purchasing organisation – West Mercia Supplies. Data from West Mercia Supplies has been of a far better quality than from the Council's corporate financial system Cedar financials. There are numerous operational issues that prevent a comprehensive set of data being available. Amongst these are properties where fuel costs are paid for within rents and properties with shared supplies where sub-metering needs to be introduced.

ACTIONS TO BE TAKEN	Work already started to rationalise and improve energy data will be continued.

APPENDIX 18 – pPI 4C

HEADING	DESCRIPTION
PERFORMANCE INDICATOR REF:	pPI 4C
NAME:	Water costs per square metre GIA
SOURCE	ODPM
REASON	Support annual AMP Submission
FREQUENCY	Annual
TARGET AUDIENCE	ODPM Elected Members CASG CMB
METHOD	Water costs per square metre GIA for operational buildings only. Data is based upon information from Cedar Financials (corporate financial system) for full financial year 2007/08.
INCLUSIONS	All Operational properties
EXCLUSIONS	• Schools • Leisure Centres/Swimming Pools now managed by the Herefordshire Community Leisure Trust (HALO)
DATE	Data for Financial Year 2007/08. Report date January 2008.
RESULTS	The available data has considerable shortcomings for a variety of reasons. A decision has been taken to report upon the core of the operational properties where good data exists. On this basis • The total GIA for the core sample properties is 55,288.64m^2 • The total water cost for the core sample was £94,006.50. **The water cost per square metre GIA for 2007/08 was £1.70/m^2**
LESSONS LEARNT	There are numerous operational issues that prevent a comprehensive set of data being available. Amongst these are properties where water costs are paid for within rents, and properties with shared supplies where sub-metering needs to be introduced
ACTIONS TO BE TAKEN	Work already in-hand to consolidate water accounts will be continued. Further consideration will be given to reviewing supplies at properties where water is paid for on a rateable value basis as opposed to a metered basis.

GLOSSARY

AMP	Asset Management Plan
AMPS	Asset Management and Property Services
CAA	Comprehensive Area Assessment
CAWR	Control of Asbestos at Work Regulations 2006.
CEDAR	Herefordshire Council's Corporate Financial System
CFs	Community Forums
COPROP	Chief Corporate Property Officers in Local Government
CIPFA	Chartered Institute of Public Finance and Accountancy
CPA	Comprehensive Performance Assessment
CSMG	Capital Strategy Monitoring Group
CPO	Corporate Property Officer
CPO	Compulsory Purchase Order
CROW	Countryside and Rights Of Way Act (2000)
CASG	Corporate Asset Strategy Group
CUPID	Property Services 'in-house' property maintenance system
CMT	Corporate Management Team
DDA	Disability Discrimination Act (1995)
DCSF	Department for Children, Schools and Families
ESCO	Energy Services Company
EVOLUT1ON	Herefordshire Council's Corporate Asset Management Planning System
GEM	Good Environmental Management
GIA	Gross Internal Area
GIS	Geographic Information System
GOWM	Government Office of the West Midlands
HALO	Herefordshire Community Leisure Trust
ICT	Information and Communications Technology
IEG	Implementing Electronic Government

IPF	Institute of Public Finance
IRR	Internal Rate of Return
LAA	Local Area Assessments
L&PIO	Land and Property Information Officer
LPSA	Local Public Service Agreement
NDS	New Deals For Schools
ODPM	Office of the Deputy Prime Minister
PDs	Property Drivers
pPI	Property Performance Indicator
PFI	Private Finance Initiative
SCE (R)	Supported Capital Expenditure (Revenue)
SCQS	Society of Chief Quantity Surveyors
UDP	Unitary Development Plan
UPRN	Unique Property Reference Number

DRAFT CAPITAL PROGRAMME 2008/09

PORTFOLIO RESPONSIBILITY: RESOURCES

CABINET **10 APRIL 2008**

Wards Affected

Ross-on-Wye, Ledbury and Hereford wards.

Purpose

To put forward further capital programme proposals following Council's decision on 7 March 2008 to allocate additional resources to fund prudential borrowing in 2008/09 and 2009/10.

Key Decision

This is a Key Decision because it is likely to result in the Council incurring expenditure above agreed budgets for the service or function (shown as a line in the budget book) to which the decision relates but allowing for virements between budget heads and savings within budget heads of up to £500,000.

It was not included in the Forward Plan, however inclusion in the agenda gives the required notice in accordance with Section 15 of the Local Authorities (Executive Arrangements) (Access to Information) Regulations 2000.

Recommendation(s)

THAT (a) additional capital resources of £440,333 be allocated to the scheme bringing together Ross-on-Wye Library and Info Services on one site;

(b) capital resources of £2.92m be allocated to the Masters House scheme in Ledbury;

(c) additional capital resources of £751,000 be allocated to the Hereford City Centre refurbishment; and

(d) the balance of the additional funding be held pending greater certainty about funding of other major projects.

Reasons

1 To bring the Council's capital spending plans up to date following Council's decision on 7 March 20008 to allocate additional resources. This is in addition to the £1m of capital funding already allocated as part of the 2008/09 budget.

Considerations

OVERALL

2 The 2008/09 budget and Medium Term Financial Strategy 2008-2011 allows for additional prudential borrowing of £4.188m in 2008/09 and £4.635m in 2009/10. The

Further information on the subject of this report is available
from David Powell, Head of Financial Services on (01432) 383173

overall total of £8.823m has been earmarked for significant projects. Following Council's decision on 7 March to agree the budget and financial strategy, three significant projects were submitted for consideration as additional capital expenditure.

3 The Council faces a number of uncertainties around future capital projects with the precise likely financial commitment being unknown. These areas include office accommodation, Edgar Street Grid and the Livestock Market. It is for this reason that the Council needs to exercise caution when releasing funding for the capital programme.

CAPITAL BIDS

The Ross-on-Wye Scheme

4 The project for Ross-on-Wye was initiated to bring Library and Info services together and offer services from a single site. Any relocation of the Info Service that is currently based at Swan House (a non-council property) will produce savings as the property is rented. In 2008/09 the anticipated rent is £52,000 per annum.

5 The original capital budget of £800,000 for the refurbishment of Ross-on-Wye Library was estimated in 2004 and covered the projected building costs only as a starting point for the scheme. It did not take account of relocating the Tourist Information Centre (TIC), providing an alternative library service, refit costs for the library service resulting from the "re-organisation" of the internals of the site or the ICT costs.

6 During the construction phase of the refurbishment of Ross-on-Wye Library alternative service provision will be required for 9-12 months. This has not been provided for within the original projected budget. The preferred option is to maintain a front and back office library service on site during the period of refurbishment. Although this will present some management challenges it presents the best option balancing cost with value of service.

7 There is currently an allocation from the Corporate Capital Programme of £800,000 for the scheme. However, as shown from the cost estimate below there is a shortfall of £440,333:

Item	**Estimate £**
Building Costs for library / info	696,342
Professional Fees	109,674
Purchase of Land	45,000
Alterative service provision	97,000
Cost to relocate TIC	70,000
Library refit costs	58,500
ICT costs	104,000
Project management*	5,000
Book stock	20,000
Contingencies	34,817
Total Estimated Cost	1,240,333

*joint project board / manager with Ledbury Centre

Current allocation from the Corporate Capital programme	800,000
Shortfall	**440,333**

The Ledbury Centre

8 The current proposals see the Masters House in Ledbury becoming a central focus for the community with an extension to the building to house Info, the library, visitor / tourist centre, heritage and also community facilities. The Masters House is owned by the Council and is a Grade II Listed Building. The scheme will solve a number of issues including the current library's inability to be Disability Discrimination Act (DDA) compliant as well as meeting the needs of customers. The scheme also makes use of an historic asset which has been under utilised for a number of years as it currently fails to meet the requirements of the Corporate Customer Services Strategy.

9 The proposals have been developed from public consultation in 2007 conducted by the Ledbury and Area Development Trust. An Audience Development Plan and Business Plan have been produced. The estimated cost of £2.92m is itemised below. More detailed costs are being prepared (and should be available by the time of the Cabinet meeting) based on outline drawings (not architectural drawings).

Item	**Estimate £**
Refurbishment of existing building	375,000
Construction of new extension	695,000
Electrical Services installation and BWIC	282,000
Mechanical service installation and BWIC	293,000
Allowance for external work	100,000
contingency on building work	87,250
Heating / electrics	100,000
Structural repairs	150,000
Fixtures	200,000
fees	250,000
Project management	50,000
RFDI (self service)	34,000
PC network	9,200
Book stock	15,000
Landscaping	25,000
Preliminaries	157,000
Other Contingency	100,000
Total	**2,922,450**

10 An application for £400,000 has been submitted to Advantage West Midlands (AWM) for Multi Use Centre funding which has been approved by the Herefordshire Rural Access Partnership. However, this has yet to be approved by AWM who indicate there are no monies remaining for 2008/9 so funds, if agreed, will come forward in 2009/10. There is also an allocation to the Community Asset fund which is uncertain and a relatively small request for local fundraising. The Head of Economic and Community Services indicates there is also potential for raising funds locally though this will not be forthcoming until local individuals and groups see the scheme started.

Hereford City Centre Refurbishment

11 The Hereford City Centre refurbishment was started in 2005 when the Council agreed to spend £2m on refurbishing the centre of Hereford, following on from the refurbishment of Eign Gate.

12 High Street was the first area to be re-paved, from January to March 2006. High Town was refurbished from April to November 2006, with some features completed by March 2007.

13 The current proposal is estimated to cost £1.001m and seeks to refurbish Widemarsh Street to provide a level pedestrian-friendly surface from High Town to Blue School Street. The design would be upgraded in keeping with Widemarsh Street's importance as a link between Edgar Street Grid (ESG) retail quarter and the old city centre.

14 Whilst there is no legal requirements for this project to be carried out there is an expectation that it will proceed following the decision to pedestrianise Widemarsh Street. The design includes an allowance for using natural materials but this is based on the best available estimates.

15 It is anticipated that the scheme may be completed in 2009/10 and so allow time for discussions with the ESG developer about the final design and possible contribution to the overall cost.

Financial Position

16 The estimated expenditure for the three proposed schemes is as follows:

Scheme	2008/09 £	2009/10 £	Total
Ross-on-Wye Library	440,333	-	440,333
Masters House Ledbury	470,000	2,452,450	2,922,450
Hereford City Centre	751,000	-	751,000
TOTAL	**1,661,333**	**2,452,450**	**4,113,783**
Available funding	4,188,000	4,635,000	8,823,000
Balance brought forward	0	2,526,667	
Balance carried forward	2,526,667	4,709,217	4,709 ,217

17 The above indicates that after funding the Ross-on-Wye Library additional requirement, the Masters House development and the Hereford City Centre refurbishment, £4.709m remains. This can be held pending the need to fund other existing projects that may have a shortfall. After this has been resolved this may lead to the release of funds for other significant projects

Risk Management

18 The risks associated with proceeding or not with each bid need to be considered on an individual basis.

Appendices

None

Consultees

None identified

Background Papers

Medium Term Financial Management Strategy
Capital strategy

APPENDIX 1

2008/09 PRUDENTIAL BORROWING BIDS

BID	AMOUNT				LIFE	ESTIMATED CAPITAL FINANCING COSTS				
	2008/09 £	2009/10 £	2010/11 £	2011/12 £		2008/09 £	2009/10 £	2010/11 £	2011/12 £	FUTURE YEARS £

Additional Prudential Borrowing Bids

BID	2008/09 £	2009/10 £	2010/11 £	2011/12 £	LIFE	2008/09 £	2009/10 £	2010/11 £	2011/12 £	FUTURE YEARS £
Ross-on-Wye Library										
To create a one stop shop for information in Ross-on-Wye combining information and library services in one centre.	440,333				50	19,815	28,225	27,829	27,433	842,313
Masters House, Ledbury										
To create a multi-use combined centre in Ledbury, including Info, Library, visitor and heritage service, potential youth and community centre.	470,000	2,452,450			50	21,150	140,487	186,906	184,276	5,734,142
Hereford City Centre refurbishment										
Refurbishment of Widemarsh Street to provide a level pedestrian friendly surface from High Town to Blue School Street.	751,000				25		33,795	62,483	61,131	1,032,925
TOTAL BIDS RECEIVED	**1,661,333**	**2,452,450**	**-**	**-**		**40,965**	**202,507**	**475,347**	**272,840**	**7,882,220**

CHILDREN AND YOUNG PEOPLE'S PLAN 2008-2011

PORTFOLIO RESPONSIBILITY: CHILDREN'S SERVICES

CABINET **10 APRIL 2008**

Wards Affected

County-wide

Purpose

To consider and approve the Children and Young People's Plan 2008-2011.

Key Decision

This is a Key Decision because it is likely to be significant in terms of its effect on communities living or working in Herefordshire in an area comprising one or more wards.

It was included in the Forward Plan.

Recommendation

> **THAT Cabinet commends to Council for approval the Children and Young People's Plan 2008-2011, subject to any comments.**

Reasons

The Children and Young People's Plan is a statutory document and forms part of the policy framework for the local authority. It is a crucial vehicle to enable services to be delivered effectively across partners to improve outcomes for children and young people in Herefordshire.

Considerations

1. The local authority has a duty to prepare a Children and Young People's Plan, to review it annually and to secure cooperation amongst partners. This is the second plan that has been developed for Herefordshire. This new plan has been produced by the Children's Trust, a statutory partnership of local agencies across Herefordshire that commission and deliver services to children, young people and their families. This covers children and young people from 0-19 years of age and up to 25 for those young people with learning difficulties and disabilities.

   The partner agencies include:

   - Herefordshire Council, including schools
   - Herefordshire Primary Care Trust, including GPs
   - Learning and Skills Council
   - Connexions
   - Youth Offending Service

Further information on the subject of this report is available from
Philippa Granthier, Business Manager (01432) 260226

- Probation Service
- Voluntary Sector organisations
- West Mercia Police
- Herefordshire Hospitals NHS Trust

2. The Children and Young People's Plan, a statutory document, contains the key priorities for children and young people. These priorities have been arrived at through a needs mapping exercise, which was then debated and discussed during November and December 2007 at various forums to arrive at a draft document. Children, young people and professionals from schools, services and partner organisations were involved in these discussions. The document was then subject to an eight week consultation period for individuals, and agencies to feedback views.

3. This final document has been amended, where appropriate, to take account of the consultation responses received. The plan has been approved by all those agencies within the Children's Trust arrangements.

4 The outcome groups within the Children's Trust arrangements will be considering more detailed responses from the consultation in the annual delivery plans. These delivery plans will support the three year strategic document by detailing the actions needed to achieve the priorities. Outcome groups are overseen by a management group and a Children's Trust Board, whose membership includes chief officers and directors of partner agencies and the Chief Executive of Herefordshire Council and PCT.

5. The Children and Young People's Plan supports the Local Area Agreement and its priorities, as well as covering statutory and preventative service areas for the Council and for partners

Financial Implications

The plan will be used as the basis for commissioning services for children and young people in Herefordshire, alongside emerging commissioning arrangements under the Public Service Trust in Herefordshire. It will also be used to make the most of existing resources across partners targeted towards children and young people.

Risk Management

The Local Authority has a statutory duty to act as the lead agency in the development of the Children and Young People Plan and there is a duty to have a plan in place. Failure to do so would adversely affect service delivery to children and young people and the reputation of the Council and its partners.

Alternative Options

There are no alternative options, Herefordshire has to have a plan in place. This has been a requirement since 2005 and this is the second plan for the county.

Consultees

The following list includes those agencies which statutorily must be consulted with:

- Children, young people and families (including persons with parental responsibility for, or who have the care of children)
- Persons / bodies representing children, young people and families
- The appropriate diocesan authority for any foundation or voluntary school situated in

the authority's area which is a Church of England or Roman Catholic Church school

- The school organisation committee for the authority's area
- Persons / bodies providing voluntary services relating to children and young people
- Groups / persons representing local communities
- The Local Safeguarding Children Board
- Each of the authority's relevant partners
- The proprieter of each school in the authority's area
- The Schools Forum for the authority's area
- The Admission Forum for the authority's area

Additionally the plan has been through a consultation process for eight weeks and has been widely circulated including Councillors.

Appendices

Appendix 1 – Children and Young People's Plan 2008-2011

Background Papers

None identified.

The Vision for Herefordshire

Welcome to the second Children and Young People's Plan for Herefordshire. This plan has been developed through the Children's Trust arrangements in Herefordshire and takes us to a new level in partnership working, something which has always been a strength in this county.

Our vision is to achieve the very best for all our children and young people, from birth until 25 years of age for those young people with complex needs, by ensuring all those involved with them, see them holistically and work effectively together to improve their life chances. We need to work closely together, with families and young people themselves to achieve this. The role of parents, carers and families is paramount and we must provide the services to support them. We have high aspirations for all our children and young people and want specifically to narrow the gap for those that are more disadvantaged.

We want every child to grow to reach their full potential within a happy, healthy and secure environment both at home and during their learning. There should be opportunities for children and young people to explore their environment through stimulating play, outdoor adventure and social and cultural experiences. They need to develop their own skills so they are better prepared for adult hood, able to manage their own affairs and inter relate with others effectively. We hope our young people will want to continue their learning and development as adults, taking an increasingly active part as citizens.

We will provide high quality universal and targeted services, whilst also ensuring that specialist services are available to children and young people who have complex needs. Through the delivery of this plan, and our emerging Children's Trust, we aim to be seen as one team, one service through joint working across partner agencies. Together we will pursue the provision of high quality outcomes for children and young people through earlier identification of need and intervention, and provision of preventative services. Joint working will achieve greater efficiency, coordination and integration in planning and service delivery.

Dr Sharon Menghini
Director of Children's Services

Councillor Jenny Hyde
Lead Member for Children's Services

DRAFT

1. Introduction

This is the second Herefordshire Children and Young People's Plan, and will cover the next three years from April 2008 to March 2011.

The Children Act 2004 requires all Local Authorities to develop a Children and Young People's Plan with its partners, which identifies the local priorities to promote the well-being of children and young people. Well-being is defined through the five shared outcomes which are, being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being. The government's intention is that there is one overarching strategic plan for a local area, detailing the services for children and young people up to the age of 19, young people aged 20 and over leaving care, and young people up to the age of 25 with learning difficulties.

This plan has been agreed by all those partner agencies that provide or commission services for children and young people in Herefordshire, through the Children's Trust (see section 4). It details the priority areas where improvements are needed to enhance outcomes for children and young people, and to lessen the gap between those who are disadvantaged and those more fortunate. These priority areas have been decided through a comprehensive analysis of need (see section 7), in partner discussions and workshops, and gathering children and young people's views. The outcome groups of the Children's Trust have undertaken much of the detailed planning work, which is contained within an annual delivery / action plan that supports this main strategic plan.

2. National Context

The government, through its challenging Every Child Matters (ECM) programme aims to deliver joined-up arrangements that puts children and young people at the centre, with agencies working together to support them and their families.

The NHS *National Service Framework for Children, Young People and Maternity Services* was launched in 2004 and gives a ten year strategy for change. The Herefordshire Primary Care Trust is leading on this work, although it will be delivered in partnership and links well with the Every Child Matters approach. There are eleven standards against which quality and performance can be measured:

Standards
1. Promoting health and well-being
2. Supporting parenting
3. Child, young person and family-centred services
4. Growing up into adulthood
5. Safeguarding and promoting welfare
6. Children and young people who are ill
7. Children and young people who are in hospital
8. Disabled children and young people and those with complex health needs
9. Mental health and psychological well-being
10. Medicines for children and young people
11. Maternity services

At the time of writing, there are NSF delivery action plans in place and on track for Standards 1-5 and 8-9. Standards 10 and 11 now have working groups in place to develop delivery action plans and some work has already been done. Work on action plans for Standards 6 and 7 are to be developed, although some work has already taken place.

The involvement of local schools in delivering the ECM agenda is critical. The Education and Inspections Act 2006 extends the duty on local authorities to promote high standards of education to embrace the whole well-being of the child. The legislation now recognises schools as having a duty to promote well-being and community cohesion, and the views of parents must be taken into account. Again the changes brought about in this legislation can only be delivered in partnership and collaboration by integrating services through children's centres, extended schools initiatives and children's trust arrangements.

The UN Convention on the Rights of the Child is an international human rights treaty that applies to all children and young people aged 17 and under. It gives children and young people a set of comprehensive rights, many of which are compatible with the five ECM outcomes, and also gives them the right to express their views and be taken seriously by adults. There are 54 "articles" most giving children social, economic, cultural or civil and political rights and there are additional rights for some vulnerable groups, for example, children in care or with disabilities. The government has agreed to make all laws and policies compatible with the UN Convention and this must be adhered to by all those agencies delivering services to children and young people in the county.

A new national ten year Children's Plan was launched by the Department for Children, Schools and Families (DCSF) in December 2007. This plan for Herefordshire picks up many of the main areas highlighted in the national plan, particularly the need to support parents and families in raising their children and by involving them in decision making and developing services that they need for their children and young people. The national plan sets out the government's vision and ambitions and this will be supported by new initiatives and action plans over time. The weblink to the plan is: http://www.dcsf.gov.uk/publications/childrensplan/

3. Local Context

In Herefordshire, the local strategic partnership is the Herefordshire Partnership (HP), under which the Children's Trust sits (see glossary). The HP manages the Local Area Agreement (LAA) which details the priorities for the whole of the county, negotiated with government. The current LAA covers the same time period as this Children and Young People's Plan and the priorities identified for children were fed into the LAA negotiation process. Additionally, the Community Strategy for Herefordshire launched in 2006 contains a vision for the county to 2020, which links with the LAA priorities. This means that all these strategic documents contain the same priorities for children and young people ensuring consistency and concentration of effort by all agencies in the county.

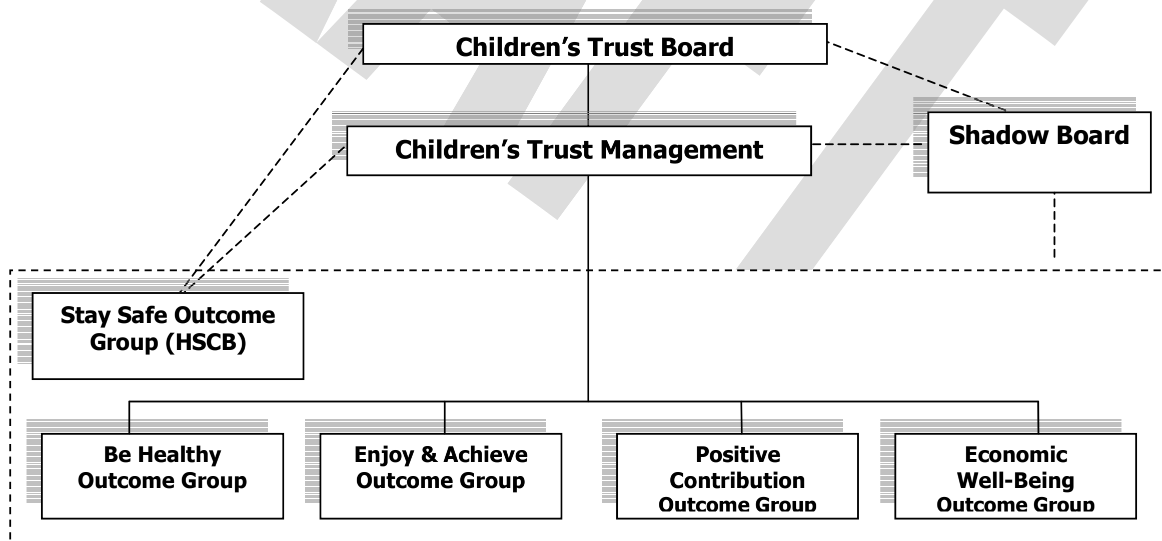
The production of this new plan comes at an exciting time in Herefordshire with the appointment of a joint chief executive across the Council and Primary Care Trust to strengthen partnership working. These changes will complement the Children's Trust.

4. Children's Trust Arrangements

During the summer of 2007, new arrangements were put in place to support the move to a Children's Trust in Herefordshire, replacing the existing Children and Young People's Partnership Board. Whilst in its early embryonic stages (as this plan is written), the new groups are starting to work well together and will support the move to more integrated working across the partner agencies. There is an annual review process to ensure appropriate representation and procedures are in place. Current membership includes:

- Herefordshire Council, including schools
- Herefordshire Primary Care Trust, including GPs
- Herefordshire Voluntary Sector Health and Social Care Alliance
- West Mercia Constabulary
- Learning and Skills Council, Herefordshire, Worcestershire and Shropshire
- Connexions, Herefordshire and Worcestershire
- Hereford Hospitals NHS Trust
- Worcestershire and Herefordshire Youth Offending Service
- Herefordshire Probation Service

The current structure is shown below



Key:
HSCB – Herefordshire Safeguarding Children's Board

Key roles and responsibilities within the Trust are as follows:

- The Children's Trust Board is the decision-making body, comprising those agencies that currently commission or buy services that impact on children and young people. The Board is supported in this work by a Management Group.

- For each of the five Every Child Matters outcomes, there is an outcome group that is responsible for delivering an agreed work programme that aligns with specific elements of the Children and Young People's Plan and the supporting annual delivery plan.

- The Stay Safe outcome group is the Herefordshire Safeguarding Children Board and has a key role to report to and challenge the Children's Trust on arrangements that safeguard and promote the welfare of children and young people. Currently an audit of section 11(2) of the Children Act 2004 is being undertaken across agencies that have an involvement with children and young people to assess their arrangements to safeguard and promote welfare. An action plan will be produced and implemented.

- The third sector (community and voluntary sector) is represented at every level of the structure, particularly in terms of its role as a key provider of local services.

- The Children's Trust Shadow Board is made up of children and young people and they take an active role in the work of the Children's Trust, commenting on documents and attending meetings of outcome groups, the management group and board.

Further details on the governance structures of the Children's Trust can be found at:
http://www.herefordshire.gov.uk/community_and_living/young_people/29111.asp

The Performance Improvement Team in the Council's Children and Young People's Directorate support the groups with regular performance reports to inform decisions around actions and improvements. Quarterly performance reviews take place at the Board and Management Group levels to review all the performance indicators that link to the priorities and the actions detailed in delivery plan. The quarterly performance review is informed by exception reports from each of the outcome groups.

The Herefordshire Council's Children and Young People's Directorate Plan sets out the contribution that the directorate makes to deliver the priorities set out in this plan. The directorate plan is then supported by a network of team plans which link to individual staff appraisals.

The Primary Care Trust's (PCT) Local Delivery Plan sets out the strategic vision for the PCT, together with its commissioning framework, and covers adults and children.

Other links with organisations, agencies and forums will be through structured reporting lines or representation on the outcome groups.

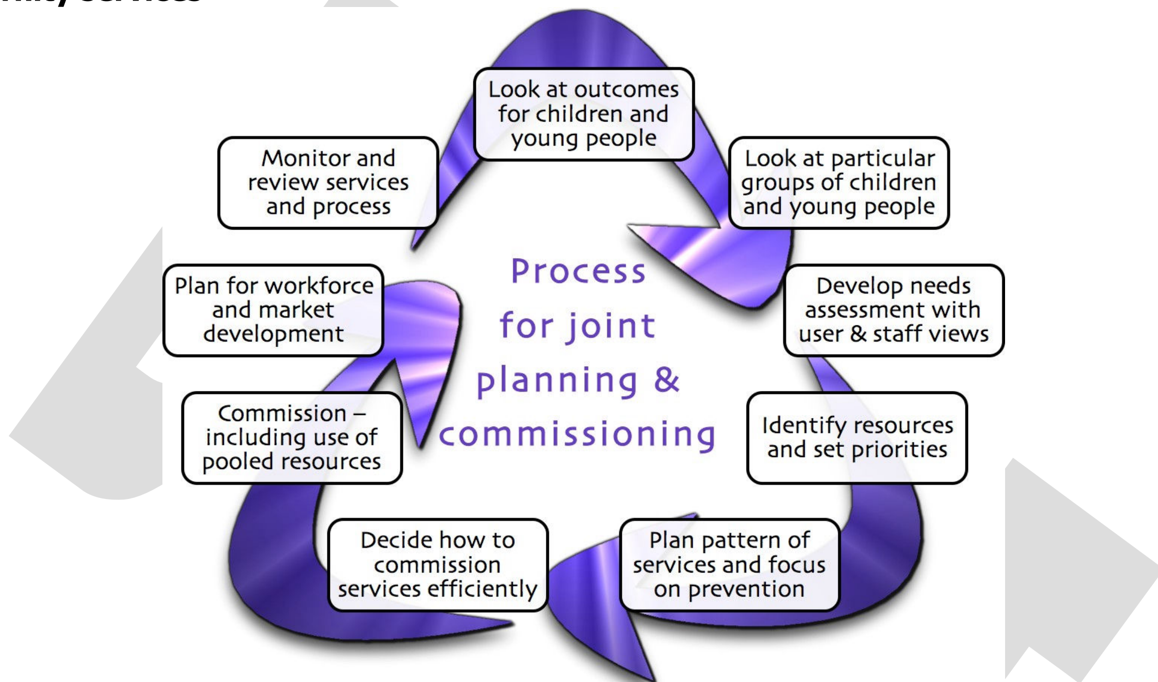
4.1 Joint Commissioning

One of the main aims in developing Children's Trusts is to enable partner agencies to share resources and pool budgets ensuring greater efficiencies and avoiding duplication, when buying services.

To support this in Herefordshire, a joint commissioning function will be set up, though plans are at an early stage. This will sit within a joint commissioning unit under a new, joint Council and PCT Director of Integrated Commissioning. Further details will be picked up through the service management annual delivery plan as this work progresses (see section 9.6).

By undertaking the needs assessment and identifying the priorities in this plan, the next stage will be to develop commissioning plans that enable the priorities to be delivered. A joint commissioning unit would support this work, as well as placing and monitoring contracts and moving in time toward developing the market, and de-commissioning services where necessary. Additionally, through the Compact with the third sector there is agreement over commissioning and contracting processes. Commissioning is a continuous cycle as shown in the nine stage diagram below.

Department for Education and Skills and Department for Health 2006
Joint Planning and Commissioning Framework for children and young people and maternity services



5. Key opportunities and challenges in the delivery of the plan

Over the next three years, and beyond, there are significant opportunities and challenges that must be faced by the Children's Trust which are outlined below and throughout this plan.

5.1 Integrated Services

The ECM agenda is very much about directing resources to delivering multi-agency services based around the needs of the child, young person and their family. Herefordshire has a good track record of working well with partners and the co-terminous county and PCT boundaries have been one driver in achieving good joint working. The government's aim is to deliver services locally and in a more integrated way. In Herefordshire this is being developed, within the level of resources available, in hubs, possibly based around school clusters or partnerships. This links closely with the provision of children's centres and extended schools, where a variety of services are available at a local level. However access and transport are issues that need to be considered, along with information-sharing across agencies for any new model of provision. It will be important to secure a good fit between health, education and social care services.

It is intended that having services delivered at a much more local level, than currently, along with the implementation of a Common Assessment Framework, will enable earlier intervention with more preventative work being undertaken to support children and young people's needs before they escalate. This work is being led by the Director of Children's Services initially, with a restructure of the Children and Young People's Directorate services being implemented for January 2009, with other agencies coming alongside gradually either virtually or through co-location. At the same time there are some services that will need to remain county-wide to foster a cohesive

approach (such as the provision of school transport). Some services are crucial to the safeguarding of children of the county and are therefore more cost effectively delivered centrally.

5.2 Extended Schools / Children's Centres

Linked closely with the move to integrated teams is the use of extended schools and children's centres. The intention is that these facilities will bring together services for children at a local level, providing support for families and responding to local needs. Children's centres aim to support parents and communities through the integration of early education, childcare, health and family support services for under 5's. The aim behind the extended schools agenda is that by 2010 every primary and secondary school will be expected to offer access to childcare, a varied menu of activities (e.g. sport, arts, music, homework clubs etc), parenting support, swift and effective referral to specialist services and community access to ICT, sports and art facilities, including adult learning. How these services are delivered and sustained is an element of partnership working for the Children's Trust.

5.3 14-19 Reform Programme

This is a key area, driven by central government to focus on raising attainment of young people and equipping them for further education and work. Locally, this involves designing new curriculum with schools and colleges in providing new and varied qualifications, for example, vocational qualifications, apprenticeships, that engage more young people in training. Stimulating local collaborative delivery not just with educational establishments but also by engaging local employers, is another key aspect of this.

6. Involvement and Participation

Listening to the voice of children and families in Herefordshire is a critical element to all those involved in delivering services to children. The Children's Trust will continue to ensure that listening and responding to children, young people, families and carer's views is an integral part of its work and over this three year period will develop and implement a participation strategy, using the Hear by Right standards, to further strengthen the existing structures and processes in place.

6.1 Children and Young People

As mentioned above there is already a Shadow Board in existence, plus a Youth Council, Youth Funding Panel, schools councils in 70% of schools, youth forums plus groups specifically dealing with more vulnerable children, like those in care or with learning difficulties and disabilities. Regular consultation events, like "You Talk, We Listen" and surveys, such as the Youth Survey are further methods in which the views of children and young people can be gathered. Ensuring primary and younger children and hard to reach groups are included needs to be further addressed through the participation strategy.

6.2 Parents, families and carers

The Children's Trust is committed to improving the involvement and participation of parents, families and carers, enabling them to shape the services that they need to support their children and young people. The traditional concept of a family unit has changed and the Children's Trust needs to adapt its consultation methods to reflect this.

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7. Needs analysis

This piece of work has been developed from a wide variety of sources (see appendix 1). As the population changes, and its needs, this analysis will be regularly refreshed with a major review every three years to support each subsequent children and young people's plan. This will ensure our resources are focused appropriately to address these changing needs.

7.1 Herefordshire – the county context

Herefordshire is a predominantly rural county, covering some 218,283 hectares. The City of Hereford is the major centre of population and there are five market towns – Ledbury, Leominster, Ross-on-Wye, Kington and Bromyard. Its usual resident population is 177,800, a growth of 4.6% since 1998, and the average population density is 0.8 persons per hectare, giving Herefordshire the 4th lowest population density in England.

54 areas in the county, predominantly rural, fall within the 10% most deprived against the Access to Services domain (Index of Multiple Deprivation), which measures road distances to a GP, supermarket, primary school and Post Office.

The recent growth in the population is due to net in-migration, predominantly from London and the South East which accounts for 64% of the net migrants. The largest flows, in and out of the county, are in the 20-24 year old age group.

Herefordshire has an older age profile than the rest of England and Wales – those aged 60 and over represent 26.6% of the total population. 27.6% of the population is under 25.

7 areas in Herefordshire are in the 25% most deprived in England – six in Hereford City and one in Leominster. Two of these areas also fall within the 20% most deprived – the Ridgemoor area in Leominster and the Golden Post-Newton Farm area in Hereford City. However, there are significant areas of deprivation in small pockets throughout the county.

Mid-2004 estimates suggest that 3.5% of the population is from minority ethnic groups, representing a growth of 40.9% compared with a 1.7% growth for the whole population. Migrant workers continue to have the most significant impact on the workforce in the county and Herefordshire has seen the fastest growth in the number of migrant workers, over the last three years, of all the counties in the West Midlands. The majority of migrant workers are single and aged under 35 years of age, and mainly find work in agricultural and related activities.

The employment rate in Herefordshire is good at around 78%. However, there are a higher proportion of part time employees (27.9%) than both the West Midlands and England. Wage levels are, on average, 6% less than in the West Midlands region as a whole and generally people in the county work much longer hours than the rest of the region. Over a quarter of the working age population have no qualifications with higher proportions in the urban areas and rural towns, compared with the rural villages.

Low levels of earnings, coupled with relatively high house prices, mean that affordability of housing is a major issue in the county. There is a higher proportion of detached properties than other areas – but a lower stock of affordable housing.

Given the sparsely populated nature of the county, transport and travel is a significant issue. There are 1.3 cars per household and the 2006 Lifestyle survey suggests that 58% of residents travel to work in a car or van and 46% use the local bus service.

Overall levels of recorded crime are falling although Hereford city centre falls within the 10% most deprived against the Crime and Disorder Domain (Index of Multiple Deprivation). The level of vehicle crime is still relatively low (5.5 per 1000 population) compared with other English authorities. The fear of crime has gone down across all crime categories.

7.2 Herefordshire – Children and Young People

In Herefordshire, 27.6% of the population is under 25 years of age, compared with 31% in England and Wales. Since 1998, Herefordshire's population has grown by 4.6% which is broadly similar to the national rate (3.2%), but there are large differences within individual age groups. The numbers of people in the older age groups have grown much more in Herefordshire than in England and Wales as a whole; conversely, the numbers aged 25-34 and 0-4 have fallen more rapidly.

The only average net out-flows from the county are in the 15-19 and 20-24 year old age groups, the largest in the former group. In general, the highest concentration of the under 25 age groups is in the Hereford City wards and Ledbury.

The population forecasts to 2011, from the State of Herefordshire report 2007, suggest that changes within age-groups in Herefordshire will generally be in the same direction as those seen between 1998 and 2005, i.e. growth in the older age-groups (from 45-54 onwards) and falls in the younger age-groups.

The last school census showed that 3.96% of pupils were from minority ethnic groups.

7.3 Key data is shown at appendix 1

7.4 Annual Performance Assessment 2007

The 2007 Annual Performance Assessment (APA) judged that:

> "Herefordshire Council delivers adequate services for children overall. Children's services are making good contributions to improving the educational achievement and health of children and young people. Provisions for safeguarding children, involving them in their community and equipping them for future prosperity are adequate."

The overall recommendations from the APA were to:

- Improve dental health of children and young people.
- Increase compliance with timescales for initial and core assessments.
- Improve services to combat domestic violence.
- Complete audit of compliance with safe recruitment practice across agencies.
- Monitor Key Stage 1 standards to ensure the effectiveness of guided writing programmes.
- Increase attendance by reducing unauthorised secondary school absence.
- Complete and implement the family support strategy.
- Reduce re-offending of young people.
- Increase the proportion of young offenders in education, employment and training.
- Deliver the revised strategy for a coherent area-wide 14–19 curriculum that provides access to a wider range of vocational courses.
- Improve performance management across front-line services.
- Strengthen the capacity for children's services to influence local priorities by ensuring children's services targets are integral to wider local authority plans.

Further information is shown at appendix 1. The complete letter can be viewed at http://www.herefordshire.gov.uk/community_and_living/young_people/27226.asp

7.5 Priorities meeting with Government Office

An annual Priorities meeting is held with Government Office West Midlands in order to agree the priorities on which the Children's Trust will focus in the coming 12 months. The priorities are derived from an analysis of performance and the recommendations from the APA. The priorities for 2008/2009 have been agreed as:

- Improve dental health of children and young people
- Increase the percentage of initial assessments completed in timescale
- Improve educational attainment, particularly at Key Stages 1 and 2
- Reduce offending of young people
- Deliver the revised strategy for a coherent area-wide 14-19 curriculum
- Deliver an effective strategy for education, employment and training of 16-19 year olds, particularly vulnerable groups

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8. Priorities

Based on the needs assessment work, and through various consultation and involvement events with children and young people and professionals across the partner agencies, the following table identifies the main priority areas that will guide the work of the Children's Trust through this plan over the next three years.

Whilst these priorities have been "assigned" to an ECM outcome area, there is clear overlap across the five outcomes and this must always been borne in mind. The achievement of these priorities means they are everyone's business, not just a particular outcome group.

There are specific vulnerable groups (see section 8.1), that are an ongoing priority for the Trust, so for example, priorities for children who are looked after or have learning difficulties or disabilities will be addressed by each outcome group. Additionally specific issues like transitions at key life stages, particularly transition from child to adult services, are critical areas that need to be considered by all outcome groups. This will be monitored through annual delivery plan actions.

Cross-cutting priorities are further emphasised by the enablers. These are mainly processes or tools which will support all five outcomes and will join up and facilitate the services, actions and initiatives identified in this plan. Enablers are described further under the service management section at 9.6. The reorganisation planned for January 2009 in the Council's Children and Young People Directorate will play a major part in ensuring services are structured in a way to enable delivery of these priorities.

This plan is a strategic document, and includes a summary of actions and some key performance indicators or measures that will show progress toward achieving the priority areas (see section 9). Wherever possible the new national indicator set has been used to provide key indicators; in some cases locally set indicators have also been used. This plan does not provide the detail of specific actions that will help to deliver the priorities in this plan. These details will be in an annual delivery plan which will be managed and monitored quarterly by the five outcome groups, reporting to the Management Group and Board. These will also be published on the council's website.

Priorities for Children and Young People in Herefordshire 2008-2011

Be Healthy	*Stay Safe*	*Enjoy and Achieve*	*Positive Contribution*	*Economic Wellbeing*
• To promote emotional health and well-being and improve access to universal and targeted mental health services • To promote healthy lifestyles generally and, in particular, to reduce obesity and dental health problems in children and young people • To provide quality information and services to reduce substance misuse, including alcohol abuse • To provide quality information and services to improve sexual health	• To reduce the impact of domestic abuse on the lives of children in Herefordshire • To ensure that referrals of children in need to children's services are timely and appropriate • To promote e-safety in order to reduce the risks associated with media and the commercial world • To raise awareness of bullying in order to reduce the impact and incidence of bullying (in and out of school) • To ensure safer recruitment practices across all agencies working with children within Herefordshire	• To improve the educational attainment of children and young people, particularly at Key Stages 1 and 2 • To improve school attendance, particularly at Key Stages 3 and 4 and for looked after children • To provide a broad, balanced curriculum (both in and out of school) that engages children and young people in learning, play, cultural and recreational activities at all ages • Improve prospects of children and young people, particularly vulnerable groups, in terms of addressing social inclusion	• To increase the participation of children and young people in shaping strategies and services that affect their lives • To increase access to positive activities for all children and young people, including volunteering and targeted activities for vulnerable groups • To reduce offending, anti-social behaviour and bullying by children and young people	• To implement a strategic approach to support young people into employment, education and training • To ensure all 14 to 19 year olds have access to the 14-19 learning entitlement • To implement a strategic approach to employer engagement that fits with the 14-19 learning entitlement

Enabled by…

A quality infrastructure to support service delivery across partner agencies

Quality assured services based on effective performance management and active involvement of service users

Targeted and pooled resources providing cost-effective services

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8.1 Specific Groups

At any time, children and young people can come up against situations that make them vulnerable, sometimes requiring additional support. The Children's Trust is mindful of particular groups that have more complex needs. A multi-agency group have agreed a number of categories of vulnerable children (see appendix 3); a child can move in and out, or be included in several categories at any time. Whilst some of these are explicit to a particular outcome group, others need to be considered by all outcome areas, as highlighted below.

Gifted and talented children

Children and young people who show particular talents need to be provided with greater challenge and opportunities to develop their potential, whether this is academic, recreational or cultural pursuits. Without acknowledging and supporting these children, they themselves can become vulnerable through boredom or being treated differently by their peers.

Children with learning difficulties and disabilities

Children and young people with disabilities are valued members of their communities and, as they grow into adulthood, they need support to realise their full potential in personal and social terms. As far as possible, opportunities will be provided to enable children and young people with disabilities to be successful in all the activities typically available to a young person of the same age.

A multi-agency strategy for children with disabilities is currently being developed as this plan is written; the resulting action plan will be implemented through the Children's Trust arrangements.

Looked after and adopted children and young people and those leaving care

There is a statutory obligation across all agencies to monitor and support the needs of looked after children and their families. These children are some of the most vulnerable as a consequence of their traumatic early experiences and it is likely that earlier and more comprehensive support would prevent the tragedy of adoption breakdowns and children having to re-enter the looked after system.

Children from minority ethnic groups, including Travellers and Gypsies

From the needs assessment work (section 7) plus latest information and feedback, it is clear that there is an increase in the number of minority ethnic groups and non-English speaking children in Herefordshire. This is a new challenge for the Children's Trust to ensure these vulnerable children are adequately supported and that services are best delivered to suit their, and their families, needs.

Pregnant teenagers and young parents

Nationally through the government's teenage pregnancy strategy there is clear evidence that these vulnerable young people suffer poorer outcomes than older mothers due to poor emotional health and well-being experienced by teenage mothers, poor child health, and increased risk of teenage parents and their children living in poverty.

Young Carers

There are strong links between being a young carer and underachieving at school, with many failing to attain formal qualifications. Almost a third of young carers have serious educational problems or have dropped out of school, with nearly all reporting missing school when the person they care for is having difficulties. These children often miss out on other aspects of childhood that their peers enjoy.

9. Outcomes into action

9.1 Outcome area: BE HEALTHY

We aim to….	Success will be measured by ….	The actions needed to achieve this are …
1. Promote emotional health and well-being and improve access to universal and targeted mental health services	Increasing % of children waiting 11 weeks or less from referral to assessment for CAMHS Increasing % of children waiting 18 weeks or less from referral to treatment for CAMHS NB May use the proposed indicator for emotional health of children once published	▪ increasing the number of locality based outreach workers at tier 1 and 2 ▪ raising awareness of existing mental health services ▪ supporting and encouraging schools to promote universal spiritual, mental and emotional health through curriculum / school ethos
2. Promote healthy lifestyles generally and, in particular, to reduce obesity and dental health problems in children and young people	Reducing obesity among primary school aged children in reception year (NI55) and in year 6 (NI56) Increasing % of 5 year olds free from dental decay from 2001/2002 baseline (1020HC – local indicator)	General ▪ developing and implementing the Healthy Care Programme for children and young people who are looked after Dental ▪ proceeding with investigation of the feasibility of fluoridation of drinking water ▪ employing a Health Promotion worker in dental public health ▪ strengthening capacity in dental public health ▪ developing a dental health promotion action plan ▪ improving communication on how the public can access dental health services Obesity ▪ implementing a targeted intervention programme to tackle obesity ▪ developing a sustainable peer support approach to breastfeeding ▪ referring children to specific targeted programmes to tackle obesity ▪ developing universal services around physical activity

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We aim to….	Success will be measured by ….	The actions needed to achieve this are …
		▪ providing targeted training and development for the children's workforce to enable them to deliver messages to tackle obesity more effectively
3. Provide quality information and services to reduce substance misuse, including alcohol abuse	Reducing substance misuse by young people (NI115) Reducing alcohol related hospital admissions among young people Reducing smoking in young people	▪ ensuring youth workers and healthy schools staff have up to date information to advise and refer young people appropriately ▪ implementing the annual Young Persons Substance Misuse Plan ▪ implementing the Hidden Harm action plan ▪ delivering theatre in education project: teenage alcohol abuse programmes in secondary schools ▪ effective enforcement of underage cigarette sales legislation
4. Provide quality information and services to improve sexual health	Increasing detection of Chlamydia and the number of young people receiving treatment	▪ ensuring schools have a Relationship and Sex Education (RSE) policy and action plan ▪ training professionals to deliver education on RSE ▪ increasing the availability of 4Us clinics ▪ providing greater support for younger parents ▪ increasing the detection rate of Chlamydia

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9.2 Outcome area: STAY SAFE

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We aim to….	Success will be measured by ….	The actions needed to achieve this are …
1. Reduce the impact of domestic abuse on the lives of children in Herefordshire	Reducing the repeat incidence of domestic violence (NI32)	▪ raising public awareness of the impact of domestic abuse ▪ raising professional awareness of the impact of domestic abuse through training ▪ launching the multi-agency risk assessment conferences (MARAC) process
2. Ensure that referrals of children in need to children's services are timely and appropriate	Improving initial assessments for children's social care (NI59)	▪ raising awareness of the Herefordshire Safeguarding Children Board (HSCB) and its work ▪ developing a methodology to gather evidence on identified topics e.g. alcohol abuse, road safety, to inform the HSCB about safeguarding arrangements ▪ improving the timeliness of initial assessments
3. Promote e-safety in order to reduce the risks associated with media and the commercial world.	Establishing a baseline in line with the new strategy, and subsequently setting targets	▪ developing and implementing an e-safety strategy ▪ developing an education package for parents / carers ▪ implementing and evaluating a pilot restorative justice programme for schools
4. Raise awareness of bullying in order to reduce the impact and incidence of bullying (in and out of school)	Reducing the number of children who have experienced bullying (NI69)	▪ developing an education package for parents / carers ▪ implementing and evaluating a pilot restorative justice programme for schools ▪ ensuring schools have an effective anti-bullying strategy in place ▪ promoting peer support schemes in schools and other children and young people's settings
5. Ensure safer recruitment practices across all agencies working with children	All HSCB member agencies undertaking regular checks, in line with safer recruitment practices, for their staff working with children and young	▪ appointing a Local Authority Designated Officer (LADO) ▪ developing a network of named senior managers and officers across all agencies ▪ establishing a position statement on safeguarding arrangements for

within Herefordshire	people	all agencies ▪ developing a safer recruitment checklist and quality standard to be used across all agencies ▪ training Human Resource officers/operational managers in safer recruitment practices ▪ considering the wider involvement of young people in recruitment of children's workforce, as part of the participation strategy

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9.3 Outcome area: ENJOY AND ACHIEVE

We aim to….	Success will be measured by ….	The actions needed to achieve this are …
1. Improve the educational attainment of children and young people, particularly at Key Stages 1 and 2	Progression by 2 levels in English between Key Stage 1 and 2 (NI93) Progression by 2 levels in Maths between Key Stages 1 and 2 (NI94)	▪ improving Early Years Foundation Stage Profile results ▪ improving Key Stage 1 (KS1) results year on year ▪ improving Key Stage 2 results in Maths and English by 2 levels progress through the delivery of the Primary action plan ▪ implementing the social, emotional and spiritual aspects of learning ▪ implementing the primary national strategies for assessment for learning, pupil tracking and assessing pupil progress ▪ implementing the Quality Assurance processes for the primary school improvement partners in order to provide greater rigour and challenge to school leadership ▪ maintaining improvements at GCSE level and value added between Key Stages 2 and 4. ▪ working with the School's Library Service to support reading and literacy
2. Improve school attendance, particularly at Key Stages 3 and 4 and for looked after children	Reducing the Secondary school persistent absence rate (NI87) Reducing children looked after absent from school (HCS 35a,b,c)	▪ implementing the school attendance strategy action plan ▪ closely monitoring and providing appropriate interventions for the attendance of looked after children at school

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We aim to….	Success will be measured by ….	The actions needed to achieve this are …
3. Provide a broad, balanced curriculum (both in and out of school) that engages children and young people in learning, play, cultural and recreational activities at all ages	Increasing young people's participation in positive activities (NI110) Schools and children's centres offering the core range of extended services by 2010 (NI88 and NI109)	▪ improving opportunities to play, through implementation of the play strategy ▪ developing partnerships outside schools to deliver learning, leisure and cultural activities ▪ providing broader experiences and opportunities to try new activities by maximising the use of other local facilities ▪ promoting schemes such as Bookstart, Bookcrawl and the Reading Challenge to parents and carers to engage children and families in reading and learning ▪ full implementation of the extended schools and children's centres activity countywide ▪ developing primary stage curriculum to enable breadth, balance, enrichment and opportunity for cross-curricular skills development ▪ developing collaborative approaches to the curriculum through local area networks
4. Improve prospects of children and young people, particularly vulnerable groups, in terms of addressing social inclusion	Overall reduction in rate of permanent exclusions from school (NI114)	▪ moving to zero permanent exclusions from primary schools through promotion of managed transfer protocol ▪ considering zero permanent exclusions from secondary schools for vulnerable groups, particularly from minority ethnic groups, pupils in the Looked After System, and those with a Statement of Educational Needs ▪ maintaining a consistent approach to dealing with exclusions across the county

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9.4 Outcome area: MAKE A POSITIVE CONTRIBUTION

We aim to….	Success will be measured by ……..	The actions needed to achieve this are …
1. Increase the participation of children and young people in shaping strategies and services that affect their lives	Increasing the proportion of 13-18 year olds who feel they can influence decisions affecting local services (local indicator HCS38)	▪ consideration of developing an advocacy service wider than just for looked after children ▪ improving service user data, information gathering and dissemination to inform service development ▪ promoting the voice of children and young people in wider community agendas, e.g. transport, housing, environment, adult services, education, employment and community safety ▪ feasibility of undertaking research with specific vulnerable groups of children
2. Increase access to positive activities for all children and young people, including targeted activities for vulnerable groups	Increasing young people's participation in positive activities (NI110)	▪ raising awareness of what positive activities are available and how to access information about them ▪ implementing an ongoing programme of seeking views on what children and young people want ▪ enhancing activities available through extended schools and children's centres
3. Reduce offending, anti-social behaviour and bullying by children and young people	Reducing first time entrants to the youth justice system aged 10-17 (NI111) Reducing the rate of proven re-offending by young offenders (NI19)	▪ developing, promoting and implementing a county wide anti-bullying policy ▪ implementing the annual Capacity and Capability Assessment action plan ▪ implementing the children and young people's elements of the Herefordshire Community Safety and Drugs Partnership Strategy and action plan 2008-2011 in respect of offending, anti-social behaviour and bullying

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9.5 Outcome area: ACHIEVE ECONOMIC WELLBEING

We aim to….	Success will be measured by ….	The actions needed to achieve this are …
1. Implement a strategic approach to support young people into employment, education and training	Reducing the number of 16-18 year olds that are NEET (NI117)	▪ developing early identification, intervention and support systems for young people at risk of disengagement. ▪ developing more flexible post-16 provision for young people not in education, employment and training (NEETs) ▪ supporting national initiatives e.g. National Apprenticeship Service, Skills pledge etc. to increase the availability of jobs with training ▪ ensuring that there is both sufficient and a broad range of childcare provision available and accessible to meet the needs of young people. ▪ ensure young people aged 16-17 who are homeless/estranged from parents are placed in appropriate accommodation and in receipt of relevant support
2. Ensure all 14 to 19 year olds have access to the 14-19 learning entitlement	Increasing the achievement of a level 2 qualification by the age of 19 (NI79) Increasing the achievement of a level 3 qualification by the age of 19 (NI80)	▪ increasing the number of learners undertaking vocational, applied and collaborative options at Key Stage 4 ▪ increasing the number of young people accessing Apprenticeship provision in Herefordshire ▪ mapping progression pathways in priority subject areas ▪ mapping a progression pathway for foundation learning tier provision ▪ implementing an area wide strategy for information, advice and guidance in line with national standards ▪ developing an area wide action plan for workforce development to enable the implementation of 14-19 in the county
3. Implement a strategic approach to employer engagement that fits with the 14-19 learning entitlement	Increasing the participation of 17 year olds in education or training (NI91)	▪ increasing the level of employer engagement in 14-19 in Herefordshire ▪ ensuring 14-19 strategy reflects labour market demand by developing links with the County Economic Development Team ▪ increasing the range and opportunities provided by the public service

We aim to....	Success will be measured by	The actions needed to achieve this are ...
learning entitlement		sector

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9.6 SERVICE MANAGEMENT

We aim to….	Success will be measured by ….	The actions needed to achieve this are …
1. Provide a quality infrastructure to support effective service delivery across partner agencies	Implementing area based teams from January 2009 Increasing the number of staff across all agencies achieving common core standards Increasing the proportion of children and young people who do not require access to more specialised / complex services i.e. whose needs can be met via CAF and CAFTAC (see glossary)	▪ reorganising the Children and Young People's Directorate ▪ implementing the workforce development strategy, as resources allow ▪ working with partners, as appropriate, to support virtual location of teams and possible co-location in the future ▪ highlighting with relevant partners, and the Rural Access Partnership, the need for accessible, rural transport services, and supporting its delivery ▪ developing and implementing information sharing arrangements across partner agencies ▪ developing and implementing action plans for the early identification and targeted support of children and young people with additional needs through the implementation of the Common Assessment Framework and the team around the child concept ▪ critically evaluating and developing early intervention and preventative services to support families, children and young people in local schools and communities ▪ improving access to, and the availability of, good quality Information, Advice and Guidance to service users, professionals and partners
2. Quality assure services based on effective performance management and active involvement of service users	Improved inspection results, survey responses, and RAG ratings on Field Force visits Improvement in key indicators	▪ embedding performance management processes across the Children and Young People's Directorate and Children's Trust arrangements

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We aim to….	Success will be measured by ….	The actions needed to achieve this are …
	Increasing the % of people who feel they can influence decisions in their locality (NI4) Increasing the % of 13-18 year olds who feel they can influence decisions affecting local services (HCS38)	▪ developing and implementing a participation strategy ▪ evaluation of children, young people's, families and carers responses to consultation processes
3. Target and pool resources providing cost-effective services	Improvement in key indicators Increase in services delivered via pooled budgets	▪ ensuring mainstream and grant funding structures are in place to support the priorities within this plan ▪ developing joint commissioning capacity to enable partners to pool resources and budgets in buying services that deliver the priorities in this plan ▪ embedding performance management processes across the Children's Trust arrangements, moving to integrated performance and financial management reporting

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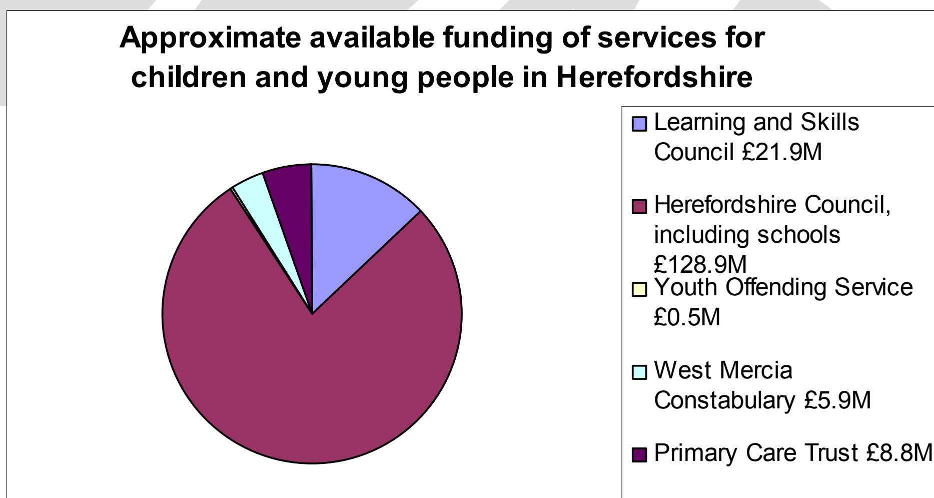
10. Financial Arrangements – deployment of resources to achieve outcomes

Under the Children Act 2004 and subsequent government changes to finances, there is increasing expectation that services will be commissioned though the Children's Trust, maximising opportunities for the alignment and pooling of resources and budgets.

The pie chart below shows a very approximate figure of the funding available for children and young people's services in Herefordshire. This must be viewed with caution however. Some partners cover a wider geographical area than Herefordshire; others financial reporting processes do not specifically capture expenditure on children but for the whole population. These figures, therefore, are estimates based on reasoned rationale and calculations.



Area based grant (ABG)

A new Local Area Agreement (LAA) will be in place from April 2008 (see glossary) with funding from the area based grant to support its delivery. Many existing funding sources are being directed through this grant and the Children's Trust will manage this for all children and young people's activities. With the flexibility offered by the ABG in that it is not ring-fenced and can be carried over into subsequent financial years, this is a real opportunity, and challenge, to ensure that resources are directed towards priority areas. This further emphasises the need for effective joint working to ensure the Children's Trust provides value for money and targets resources effectively. Whilst there is very little new money, meaning current activities will need to be reviewed as to whether they are continued or not, the ABG amounts to £3.7million in 2008/09, rising to just over £4million in 2009/10.

Glossary

14-19 Programme
The development of education and training for young people aged 14-19 including new diplomas, qualifications and vocational work to ensure all young people can experience a mix of learning which motivates and challenges them.

Area Based Grant
A non-ring fenced grant which can be used flexibly to address the actions needed to achieve the priorities identified within Herefordshire.

Common Assessment Framework (CAF)
A common approach for determining an individual child's current need which leads to better understanding as to how these needs might be met.

Emotional health and well-being
The spiritual, moral, social and cultural development of children to prepare them for the opportunities, responsibilities and experiences of life. (National Curriculum definition)

e-Safety
Using information and communications technology safely and with an awareness of the benefits and risks involved.

Hear by Right
A standards framework for statutory and voluntary sector organisations to assess and improve the engagement and active involvement of children and young people.
http://www.nya.org.uk/hearbyright/home.asp?cid=180&cats=215

Herefordshire Partnership
The local strategic partnership for Herefordshire, combining public, private, community and voluntary sector agencies. http://www.herefordshirepartnership.com/Partnership.aspx

Herefordshire Safeguarding Children Board (HSCB)
A statutory Board consisting of all those agencies involved in safeguarding children to ensure their effectiveness in safeguarding and promoting the welfare of children in Herefordshire.

Integrated Services
Multi-agency services working together in a co-ordinated way, normally under one roof, with the common purpose of meeting the needs of children, young people and their families.

Key Stage
Early Years Foundation stage covers children aged 0 to 5 years.
Key Stage 1 – ages 5 to 7
Key Stage 2 – ages 7 to 11
Key Stage 3 – ages 11 to 14
Key Stage 4 – ages 14 to 16 (GCSE)
Key Stage 5 – ages 16 to 18

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Local Area Agreement
A formal agreement between Herefordshire and the Government Office for the West Midlands on the priorities and service developments that will be delivered over a certain time period.

Team around the child (cafTAC)
A way of providing interprofessional support to a child and his/her family which involves professionals and family forming a Team Around the Child.

Further information can be found at the Department of Children, Schools and Families website at http://www.dfes.gov.uk/

and the Every Child Matters website at
http://www.everychildmatters.gov.uk

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Appendix 1 – Key data from the Needs Assessment

Please note that the following provides a selection of key points from a needs mapping exercise undertaken in the autumn of 2007. Data has been drawn from a number of sources, including State of Herefordshire Report 2007, Health in Herefordshire: Annual Report of the Director of Public Health 2007, Tellus2 Survey 2007, Youth Survey 2007, Key Stage examination results 2007 and Performance Digest 2006/2007.

The full report can be viewed at:

http://www.herefordshire.gov.uk/docs/CommunityAndLiving/Every_Child_Matters_in_Herefordshire_November_2007.pdf

Key Data: Be Healthy

- 48% of babies are breastfed at six weeks of age. Although this represents a sharp decrease from initiation when the figure is at 78%, it is above national and regional averages.
- Dental decay rates are high – an average of 1.75 teeth per five year old are either decayed, missing or filled
- Obesity levels are similar to national levels – a weight survey of reception and year 6 classes in 2006 showed that 22.9% of reception and 31.2% of year 6 were either overweight or obese
- Teenage pregnancy levels are relatively low – the conception rate for girls aged 15-17 years was 32.9 per 1000 girls, compared with 45.8 in the West Midlands region. However, the overall low rates mask hotspots in the Belmont, St Martins and Hinton and Leominster South wards.
- The Teenage Lifestyle Survey (2006) revealed that 7% of respondents smoked at least one cigarette in the week before the survey, of which 25% were Year 10 girls. Overall, 8% say they smoke 'regularly' or 'occasionally'. 26% had at least one alcoholic drink in the week before the survey – the biggest consumers were Year 10 girls at nearly 50%. The Tellus2 survey (2007) showed higher levels of drinking and smoking in Herefordshire respondents, than nationally.
- The health of children and young people in Herefordshire is generally good, although here, as elsewhere in the country, poorer health outcomes are experienced by those living in the socially deprived parts of the county. Infant mortality, hospital admissions for falls and hospital admissions for alcohol related conditions are all higher in the areas of highest social deprivation.

Key Data: Stay Safe

- The number of looked after children in Herefordshire averages around 170 per year, the majority of which are placed in local authority foster care.
- On average, less than 10% of looked after children have three or more placements during the year, which is significantly better than national figures.
- The number of children on the child protection register averages around 54 per year and the biggest category of registration is neglect.
- In the Youth Survey (2007), 24% of young people reported being bullied in the last 12 months. Younger ages were more likely to say that they had been bullied and bullying covered "calling them names" and "getting them into trouble", mainly in school/college. Just under half had asked for help or advice and 39% reported that it had been dealt with seriously/very seriously.

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Key Data: Enjoy and Achieve

- There are 81 primary schools, 14 high schools, four special schools and three pupil referral units in the county
- Key Stage 1 is an area for improvement. Whilst reading is above the national average, there has been a 3% decline in results for science which is 2% below the national average. The decline in writing mirrors the national decline but maths is also declining and is now 1% below national results.
- There have been improvements at Key Stage 2 compared with 2006. In the summer 2007 exams, 81% achieved level 4 or above in English (compared with the national average of 80%) and 77% achieved level 4 or above in Maths, which is in line with national performance.
- The results at Key Stage 3 are all ahead of the excellence cluster and national comparisons with 80.5% achieving level 5 or above in English and 79.2% achieving level 5 or above in Maths.
- Similarly, at GCSE, results are all ahead of the excellence cluster and national comparisons with 94.3% achieving 5 or more A*-G including English and Maths.
- Herefordshire is just below the median of all English authorities for the percentage of half days missed in primary schools, and just above the median for secondary schools. Issues at individual schools have had an adverse effect on the overall figures.
- The Tellus2 survey (2007) showed that 48% of pupils enjoy school always/most of the time and would enjoy it more or do better if it was more fun and there were more interesting lessons.

Key Data: Make a Positive Contribution

- The Youth Survey (2007) revealed that 31% of young people undertake some kind of volunteering outside of the home, at least once a month, which is ahead of the adult volunteering rates.
- In the same survey, 31% of 13-18 year olds felt that Herefordshire Council did enough to enable them to influence decisions, which is a significant improvement from the 2005 baseline of 19.2%.
- In 2006, 50% of Herefordshire's 2004 cohort of young offenders had re-offended over the last two years – an improvement of 4% on the previous cohort.
- In 2005/2006, 344 young people entered the Youth Justice System for the first time – a decrease of 35 from the previous year. The majority of young offenders are male, aged 15-17 years. Theft and handling, violence against the person and criminal damage are the most common offences committed by young people.

Key Data: Achieve Economic Wellbeing

- In 2006/2007, 5.5% of 16-18 year olds in Herefordshire were not in education, employment or training, compared with 7.7% nationally.
- 81.5% of 16-19 years olds with learning disabilities or difficulties and 31% of 16-19 year old teenage mothers were in education, employment or training.
- Around 13% of children aged under 14 live in households dependent on 'workless' benefits
- Transport is a major issue for the county. Around 20% of respondents to the Youth Survey (2007) said that lack of transport prevented them getting involved in activities outside of

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school/college or work time. Young people in the Golden Valley, Kington area and Ross surrounds were more likely to be affected.

Key Data: Additional needs

- Government guidance suggests that as many as 20-30% of children and young people could be defined with additional needs for either short or long term periods
- The number of pupils in Herefordshire with statements has fallen by 16% over the last four years. Increasingly, these pupils are having their needs met through additional resources allocated via the banded funding system.
- Analysis of banded funding applications over the last year show that 43% were to meet specific learning difficulties and 17% to meet behaviour needs. 17% were to meet learning development delays and this category is rising each year. Overall, banded funding applications show significant growth, particularly at levels 3 and 4.
- Up to 90% of children with disabilities aged 14+ have a transition plan to support their move to adult services.
- Around a quarter of the young people identified as at risk of becoming involved in anti-social behaviour or criminal activity are recorded as having special educational needs.

Annual Performance Assessment 2007

A summary of the strengths and areas for development, by outcome, is shown below:

Outcome	Strengths	Areas for development
Be Healthy "The contribution of services to improving outcomes for children and young people in this aspect is good"	All schools engaged in the Healthy Schools programme and 68% have achieved Healthy Schools Status. Very good progress on provision of a comprehensive Child and Adolescent Mental Health Service (CAMHS). Very good access to, and services for, looked after children with health assessments being maintained at 90%.	Improve the oral health of children and young people
Stay Safe "The contribution of services to improving outcomes for children and young people in this aspect is adequate"	Thresholds for service reviewed and understood across agencies Significant increase in numbers of referrals to social care services and proportion of referrals leading to initial assessments Very good compliance with requirements for allocating child protection cases and timeliness of reviews Good arrangements to support looked after children, good placement stability and good quality of care in foster	Some weaknesses remain in safeguarding arrangements Falling performance against timescales for initial and core assessments Delay in auditing of compliance with safe recruiting practices across agencies Need to improve provision to combat domestic violence

	placements	
Enjoy and Achieve "The contribution of services to improving outcomes for children and young people in this aspect is good"	Substantial improvement in educational standards at Key Stage 4 since 2005 Good educational outcomes for looked after children, and those with learning difficulties and/or disabilities Significant increase in the proportion of schools judged to be good or better	Decreasing standards at Key Stage 1, with writing the weaker of the three measures Recently increased unauthorised absence figures in the secondary sector, focused on specific schools Limited participation in out-of-school activities because of transport challenges and limited variety
Positive Contribution "The contribution of services to improving outcomes for children and young people in this aspect is adequate"	Progress on improving coordination and provision of earlier intervention and preventative services through the development of a comprehensive family support strategy Good consultation processes for children and young people including the Youth Council, school councils, and Shadow Children and Young People Partnership Board	Family support strategy needs finalisation and implementation Need to effectively address the numbers of first-time entrants into the youth justice system, and the rate of recidivism Increase the proportion of young offenders aged 16 and above in education, employment and training
Economic Wellbeing "The contribution of services to improving outcomes for children and young people in this aspect is adequate, with several good features"	Good outcomes for young people in terms of basic qualifications and training Reduction in numbers of 16 to 18 years olds not in education, employment or training, to below the national average Satisfactory outcomes for 16–19 year old learners and good for vulnerable young people Higher proportion of young apprentices complete their training than nationally	Slow progress towards developing an area-wide programme for 14–19 learning, although now improving More involvement with schools to provide a wider range of vocational opportunities
Service management "The capacity to improve, including the management of children's' services is adequate, with some good features"	Good partnerships between agencies to improve health and welfare for children and young people. Good leadership and effective participation by schools Good outcomes for children and young people with learning difficulties and/or disabilities, and those looked after Sense of common purpose amongst service managers.	Performance management strengthened but needs to be embedded across all service areas. Downward pressure on resources because of falling rolls Challenge to ensure a sufficient proportion of local authority resources is allocated to children's services.

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Appendix 2 – Links to local, regional and national strategies

(NB this is not an exhaustive list)

Local

- Children with Disabilities strategy
- Parenting strategy
- Child and adolescent mental health (CAMHS) strategy
- Workforce Development strategy
- Anti-bullying policy
- Primary and secondary school strategies
- Herefordshire Community Safety and Drugs Partnership strategy
- Capacity and Capability Assessment and action plan (Youth Offending Service)
- Early Years foundation stage framework
- School attendance strategy
- Play strategy
- Economic Development strategy
- Early Years and extended schools strategy
- Childcare Sufficiency strategy
- Teenage pregnancy strategy
- Sustainable school travel strategy
- 14-19 strategy and education plan
- HSCB business plan

Regional

- "Choosing health for the West Midlands"
- Regional health and well-being strategy

National

- Children's Plan (DCSF)
- Primary and secondary school National Strategies
- Health Care Matters White Paper
- Every Child Matters; agenda for change
- Children Act 2004
- National Service Framework for Children, Young People and Maternity Services

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Appendix 3 - Categories of Vulnerable Groups

as defined by the Vulnerable Young People's Group

Those in looked after system including aftercare
Pregnant teenagers and young parents
Those excluded from school – permanent and temporary
Home educated young people
Those out of education system / 'local' arrangements
Those in receipt of hospital education
Young offenders and those at risk of offending
Substance misuse including alcohol
Homeless (including those in temporary accommodation)
Young carers
Learning difficulties and disabilities and 'statemented' children
Those with difficult home circumstances including those on Child Protection Register and those identified as part of Child Concern Model
Non English speaking young people and those with English as a second language
Minority ethnic groups including migrant working families, and those from the travelling community.
Disaffected young people
Lower ability young people requiring access to provision other than mainstream including those needing access to pre E2E (Entry to Employment) provisions
Young people subject to bullying
Truants / non-attenders
Young people with mental health issues
NEET (Young people not in education, employment or training)
Young people who are rurally isolated
Vulnerable young people in further education and in work based learning
Young people who self harm
Young people who have been sexually abused

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HEREFORDSHIRE COUNCIL

AGENDA ITEM 7

DEVELOPMENT OF THE LOCAL AREA AGREEMENT

PORTFOLIO RESPONSIBILITY: CORPORATE STRATEGY AND FINANCE

CABINET **10 APRIL 2008**

Wards Affected

County-wide

Purpose

To agree the Performance Indicators to be included in the final Local Area Agreement (LAA) super refresh document.

Key Decision

This is a key decision because it is likely to result in the Council incurring expenditure above agreed budgets for the service or function (shown as a line in the budget book) to which the decision relates but allowing for virements between budget heads and savings within budget heads of up to £500,000.

The LAA will be the only place where Central Government sets and monitors targets for the local area. Alongside this the Area Based Grant (currently estimated to be in the region of £8.88million for 2008/9), a Reward Grant (as yet unspecified) and other Regional Funding Streams could be focussed on the priorities and performance indicators identified in the LAA in the future.

It was included in the Forward Plan.

Recommendation

THAT: the proposed list of Indicators included in the LAA be supported.

Reasons

To ensure that Cabinet is included in the LAA super refresh process, and has the opportunity to contribute to its development, agree the Story of Place, Priorities and Performance Indicators. Herefordshire Council is the accountable body for the LAA and will have a key leadership role in ensuring its successful delivery. The LAA will also be an essential feature in the Comprehensive Area Assessment. The new Area Based Grant (expected to be in the region of £8.88m in 2008/09) will be paid to Herefordshire Council as the accountable body, with decision making processes and performance monitoring going through the Local Strategic Partnership (The Herefordshire Partnership), and relevant statutory/themed Partnerships as specified in National Guidance. There is an indication that there maybe a Reward Grant paid at the end of the 3 years based on achievements against targets.

Considerations

1. The LAA consists of the Story of Place, a set of priorities that reflect the key issues for

Further information on the subject of this report is available from
Jennifer Watkins, Herefordshire Partnership Team Manager, (01432) 260610

the County, and performance indicators which will be the means by which progress towards achievement of the priorities is measured. There will be up to 35 indicators drawn from the National Indicator Set, which will form the basis of the LAA and will be performance managed Central Government. Local Indicators can be included as appropriate, but these will be monitored locally, and possibly as part of the Comprehensive Area Assessment.

2. Only the Priorities and Indicators are submitted to Central Government as part of the LAA, but the Story of Place is equally important. At the Cabinet Meeting on 21st February 2008, Cabinet considered and agreed the Story of Place and considered progress towards identifying the draft set of Performance Indicators. Work has continued since this Cabinet meeting on negotiating those Indicators, including taking views from Corporate Management Board and respective Performance Improvement Managers, specialist Officers, Partner agencies as appropriate and relevant Partnerships, such as the Children's Trust, Herefordshire Community Safety Partnership etc. This has culminated in a reduction in the number of potential Indicators to 31.

3. The technical guidance for the Performance Indicators is now available for 138 of the Indicators, and the proposed Performance Indicators have been assessed against these. This has led to a number of changes and a number of Performance Indicators being withdrawn where the technical specification does not work positively for Herefordshire, the specification could be difficult to manage or does not fully support the priority.

4. Feedback on the current version of the LAA from Government Office has been broadly positive, and ongoing negotiations are being held. These will continue until the indicators and targets have been agreed with National Government.

5. The conclusion of this further work on Performance Indicators was brought to the Herefordshire Partnership Performance Management Group meeting on 29th February 2008. The Performance Management Group debated each of the Performance Indicators, made a number of changes, and recommended this list to the Herefordshire Partnership Chief Executives' Group. The Chief Executives' Group met on 14th March 2008, and discussed and supported the set of Performance Indicators attached in Appendix 1 as a basis to bring to Cabinet for support.

6. NI175 is 'Access to Services and Facilities by Public Transport, Walking or Cycling'. This is defined by reference to people being able to travel to the city or market towns. It is not concerned with the provision of access to facilities in rural areas and therefore would not be impacted by the Council and Herefordshire Partnership's emphasis on delivering services more locally for example through shared facilities. Achievement of access measured in this way is already high and it is difficult to see how this can be significantly improved over the course of the LAA. It is proposed that the indicator is replaced with a locally defined one which more accurately reflects the local priority of access within rural communities. However access to services is a national priority and GOWM is indicating that it will not sign off the LAA without a national indicator in this category.

7. Cabinet is asked to consider all the indicators currently proposed in the LAA including a locally defined indicator for access.

8. On the basis of support from Cabinet and resolving the issues around NI 175, Government Office would be recommending this set of indicators to National Government. The Council may yet receive requests from National Government Departments regarding indicators in our LAA, and there may be a request for Cabinet's view on these over the coming months.

9. The next steps in this process will be to set targets against the Performance Indicators. Work is ongoing with Corporate Management Board and Partner agencies to identify Lead Officers, and to work with these specialist Lead Officers and relevant Partnerships to identify improvement targets that are achievable over a three-year period, to make sure the Council have buy-in from all the agencies that contribute to achieving this improvement target. The target should be challenging enough to really make a difference to the local area, but does need to be realistic and achievable within the three-year timescale of the LAA. Some targets where a baseline is not available will be the subject of a data collection exercise before targets are agreed. Lead Officers have been requested to produce the first cut of targets by 11th April 2008, and these will go to Joint Management Team on 12th May 2008 for support and final comment. It is expected that the final version of the LAA with these targets will come to Cabinet on 29th May 2008 and will also be considered by the Herefordshire Partnership Chief Executives' Group on 30th May 2008. The final version of the LAA will then be sent to Government Office on 30th May 2008.

Financial Implications

The new Area Based Grant is expected to be in the region of £8.88m in 2008/09, and will be paid to Herefordshire Council as the accountable body with decision making processes and performance monitoring through the Local Strategic Partnership (Herefordshire Partnership), and relevant statutory/theme Partnerships as specified in National Guidance. The Area Based Grant will be routed through relevant themed Partnerships for 2008-09 (such as the Children's Trust), to ensure co-ordination and to consider efficiencies alongside similar activity. A broader discussion around the most appropriate way to manage Area Based Grant Funding in 2009 onwards will also be held over the coming months. There is an indication that there may be an Award Grant paid at the end of the next three years based on achievements against targets.

It should be noted that the £8.88m is made up of existing grants. As such there is an expectation that some of these will need to continue to be used for their current purpose in 2008/09 as there may be no exit strategy in place.

Risk Management

1. Without the commitment and support of all partners in the development of the LAA, the Council risks submitting a document that will not have the ownership and buy-in from those who will be delivering the activity, thus making it impossible to optimise the benefit to the people of Herefordshire. Through a considered approach, the support of Herefordshire Council and by involving partners at every stage of the LAA's development the Council can mitigate this risk.

2. If the indicators are not clearly linked with the LAA priorities and if they prove impossible to measure and monitor the Council and its partners will not be able to prove progress towards achievement of the targets. This will undermine the potential impact of the LAA and minimise the potential to achieve the reward grant. This risk has been mitigated by ensuring the full involvement of the Herefordshire Council Research Team and the Herefordshire Partnership during the development process of the LAA.

3. There is a clear financial risk around the diversion of some of 2007/08 specific grants into an overall area based grant. It is important that the holders of the grants in 2007/08 are communicated with to ensure there is a full understanding of the need to manage any risks and justify the expenditure more clearly in future.

Alternative Options

There are no Alternative Options as the Council will not be able to access the £8.8m available through the LAA. There is also a legal requirement that all Councils enter into LAA's to identify priorities and objectives for delivery and benefit of the people of Herefordshire.

Consultees

Key Partners of Herefordshire Partnership through the Board, Chief Executives' Group and Performance Management Group, this includes:

Chamber of Commerce Herefordshire and Worcestershire
Herefordshire Association of Local Councils
Herefordshire Primary Care Trust
Herefordshire Council (including checks with CMB. Lead Officers and Directorate Management Teams)
The Learning and Skills Council
Voluntary and Community Organisations
West Mercia Constabulary
Herefordshire and Worcestershire Fire and Rescue Service Appendices
Advantage West Midlands
Government Office for the West Midlands
Partnership Groups
Herefordshire residents through public consultation, newsletters, attendance at workshops and events
Herefordshire Council Councillors

Appendix 1 – List of Performance Indicators

Background Papers

None identified.

APPENDIX 1

HEREFORDSHIRE
LOCAL AREA AGREEMENT

INDICATORS FOR THE
LAA 2008-2011

Total numbers of indicators: ## (including local)

Proposals for LAA from National Indicator Set: **31** (ones in bold)

National Indicators we would like to use locally: 7

Indicators proposed to be within the Local Area Agreement

1	**% of people who believe people from different backgrounds get on well together in their local area**
4	**% of people who feel they can influence decisions in their locality**
6	**Participation in regular volunteering**
9	**Use of public libraries**
17	**Perceptions of anti-social behaviour**
19	**Rate of proven re-offending by young offenders**
30	**Re-offending rate of prolific and priority offenders**
40	**Number of drug users recorded as being in effective treatment**
47	**People killed or seriously injured in road traffic accidents**
51	**Effectiveness of child and adolescent mental health (CAMHs) services**
56	**Obesity among primary school age children in Year 6**
57	**Children and young people's participation in high-quality PE and sport**
110	**Young people's participation in positive activities**
117	**16 to 18 year olds who are not in education, training or employment (NEET)**
121	**Mortality rate from all circulatory diseases at ages under 75**
123	**Stopping smoking**
130	**Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets) per 100,000 population**
135	**Carers receiving needs assessment or review and a specific carer's service, or advice and information**
136	**People supported to live independently through social services (all adults)**

142	**Percentage of vulnerable people who are supported to maintain independent living**
152	**Working age people on out of work benefits**
155	**Number of affordable homes delivered (gross)**
156	**Number of households living in temporary accommodation**
163	**Proportion of the population aged 19-64 for males and 19-59 for females qualified to at least Level 2 or higher**
167	**Congestion - average journey time per mile during the morning peak**
168	**Principal roads where maintenance should be considered**
169	**Non-principal roads where maintenance should be considered**
171	**New business registration rate**
186	**Per capita reduction in CO2 emissions in the LA area (will be in 35 depending on being able to set achievable milestone targets)**
191	**Residual household waste per household**
197	**Improved local biodiversity – proportion of local sites where positive conservation management has been or is being implemented**

National Indicators that are proposed as local indicators

11	Engagement in the Arts
13	Migrants English language skills and knowledge
37	Awareness of civil protection arrangements in the local area – using a local definition so not directly comparable with national indicator
39	Alcohol-harm related hospital admission rates
69	Children who have experienced bullying - using a local definition so not directly comparable with national indicator
115	Substance misuse by young people - using a local definition so not directly comparable with national indicator
187	Tackling fuel poverty - people receiving income based benefits living in homes with a low energy efficiency rating - using a local definition so not directly comparable with national indicator

DATA QUALITY POLICY

PORTFOLIO RESPONSIBILITY: CORPORATE, CUSTOMER SERVICES AND HUMAN RESOURCES

CABINET **10 APRIL 2008**

Wards Affected

County-wide

Purpose

To approve the data quality policy.

Key Decision

This is not a Key Decision.

Recommendations

THAT Cabinet

(a) note the actions being taken by the Chief Executive to improve data quality; and

(b) approve those elements of the data quality policy at Appendix 1 that relate to its own role and those of the Leader, lead Cabinet Member and all Members.

Reasons

The high quality of the data the Council receives, creates, uses and reports to others is too often taken for granted. It is a matter of public and regulatory concern nationally that procedures exist to demonstrate and improve data quality. The Audit Commission assesses each Authority annually and, like all regulators, increasingly emphasise appropriate systems and processes rather than individual indicators or returns. The Council's 2007/08 audit highlighted the lack of a formal policy which has now been produced for adoption.

Further information on the subject of this report is available from
Tony Geeson, Head of Policy & Performance on (01432) 261855

Considerations

1. Nationally, all the regulatory bodies, including the Audit Commission, are paying an increased amount of attention to data quality. It will be a fundamental part of the CAA from 2009, with a major influence on the Use of Resources assessments of the Council, the PCT and other partners. CAA will not be a 'lighter touch' unless external regulators share a considerable confidence in locally generated and assured data. If collectively they view data quality as a risk, it could lead to further, more detailed inspections in future.

2. As part of the preparations for CAA, a set of voluntary data quality standards has been issued by the Commission in conjunction with other national audit bodies, CIPFA and with the full support of the national audit office. These standards are virtually identical to the key lines of enquiry already used by the Commission for their audits.

3. It is important to recognise that the emphasis of the national regulatory regime has fundamentally changed. The new approach is more systemic. Regulators will examine the existence and use of policies, procedures and practices as well as the responsibilities of officers and elected members. Their approach mirrors that being taken to the wider risk and the use of resources assessments proposed for the CAA. Individual performance indicators will still be examined but this will be primarily to confirm that the overall governance arrangements of organisations like the Council, the PCT and their partners are in place and working effectively.

4. The results of the 2007 data quality audit are now known and, although the Audit Commission do not formally 'score' these, it is clear that the Council is at level 2 out of a possible 4 as anticipated. This overall ranking will combine elements from across the entire audit ranging from 1 to 3. A score of 1 is 'below the required standard'.

5. A draft data quality policy has been produced, considered by the Information Policy Group and the Joint Management Board. This is attached at **Appendix 1**. It is a short, focussed document that conforms to the voluntary standards referred to earlier. It includes the role of Cabinet, the Leader, the lead Cabinet member and elected members generally along with the arrangements for monitoring and review. The policy is underpinned by a more detailed action plan based on the key lines of enquiry used in last years audit and the feedback that followed. This has been reported to the Audit & Corporate Governance Committee as part of the formal response to the 2007 audit.

6. Finally; while the drive to improve data quality is currently coming from performance management; the requirement clearly applies more widely to all data used by officers for planning, commissioning and the operational management of services as well as by elected members in their strategic, community leadership and scrutiny roles.

Further information on the subject of this report is available from
Tony Geeson, Head of Policy & Performance on (01432) 261855

Financial Implications

There are no financial implications

Risk Management

The risks of not adopting a policy and vigorous action to improve data quality are increased inspection and intervention and a decline in the Authority's reputation amongst the public and partners.

Alternative Options

There are no Alternative Options.

Consultees

Joint management team
Information policy group
Performance improvement network

Appendices

Appendix 1 – Draft data quality policy.

Background Papers

Improving information to support decision-making: standards for better quality data. Audit Commission. March 2007

Further information on the subject of this report is available from
Tony Geeson, Head of Policy & Performance on (01432) 261855

APPENDIX 1

Herefordshire Council Data Quality Policy

1. Purpose

1.1 This policy sets out the Council's intentions as regards assuring data quality, so as to secure reliable and timely information and intelligence to account for its performance and to drive continuous improvements in services and outcomes for citizens and customers.

1.2 This is one of the underpinning elements of the Council's Performance Improvement Framework.

1.3 This policy is given effect through the Council's *Data Quality Action Plan* and associated procedures and protocols.

2. **Introduction**

2.1 The Council, its Cabinet and Corporate Management Board recognise the importance of ensuring data quality of the highest standard to maintain effective corporate governance and raise performance.

2.2 Across the Council, data are collected, analysed and used to monitor service delivery and outcomes, report performance, and aid decision-making, including the allocation of resources.

2.3 Good quality data are essential for sound planning, commissioning, routine service and performance management. Data must therefore be accurate, valid, reliable, timely, relevant and complete as well as well presented. Above all data must be fit for purpose and the Council recognises the need to balance the importance of the information requirement and the cost of collecting the supporting data.

2.4 The Council has a statutory duty to publish information about its performance and to assure that the data are accurate. The Council is judged on the adequacy of its arrangements to do this. This requires that robust arrangements are in place across the organisation for the collection, recording, collation, analysis and reporting of performance data.

3. Responsibility and accountability

3.1 Overall responsibility and accountability for data quality rests with the Chief Executive on behalf of the Corporate Management Board. It is the role of the Leader and Cabinet to ensure this system is properly held to account, on behalf of the Council.

3.2 Strategic responsibility and accountability is vested in the Director of Corporate and Customer Services. Data quality is included in the Cabinet portfolio for Corporate and Customer Services and Human Resources.

3.3 Operational responsibility and accountability is vested corporately in the Head of Policy and Performance and, for their respective services, the **h**eads of services. They are supported in the discharge of these duties by the individual

designated performance improvement managers. Each performance improvement manager has a personal responsibility, in respect of which they account to the Head of Policy and Performance, for ensuring in their respective areas that data quality protocols, procedures and systems are in place and operating efficiently and effectively.

3.4 All managers and staff have a personal responsibility and accountability for the accuracy and sound presentation of data, and for observing associated protocols, procedures and systems that apply to their designated areas of work.

3.5 As such every member of staff has a responsibility for ensuring that the highest possible standards relating to data quality are adhered to.

4. Principles governing data quality

4.1 Data quality is an integral part of all Council business and performance management

4.2 Data used to inform plans and decision-making, including resource allocation, must be right first time and fit for purpose

4.3 Data quality is the responsibility of all who contribute to it, directly or indirectly, whether they are producers of data or users of it

5. Key requirements for assuring data quality

5.1 All staff must be aware of the importance of data quality and take responsibility for securing it.

5.2 Up-to-date arrangements and control procedures must be documented and in operation for the ownership, security, collection, recording, collation, analysis and reporting of data

5.3 Staff must be equipped with the knowledge, understanding, skills and tools necessary to maximise the quality of data and their effective use

5.4 Clear performance management arrangements must be in place across the organisation to ensure that data are used appropriately to inform decision-making, including resource allocation

5.5 Data quality must be assured through routine reporting of errors and performance reviews

5.6 All out-turn data and collection processes must be subject to periodic audit and review

5.7 Business continuity and security arrangements must be in place for all data and information systems

5.8 In furtherance of the Council's commitment to working with partners to deliver the *Herefordshire Sustainable Community Strategy*, protocols agreed with partners and any relevant third parties must be in place to ensure that fit-for purpose data can be shared in compliance with legal and confidentiality standards

5.9 A documented validation process must be in operation for all data provided by partners or third parties

6. Securing a data quality culture

6.1 The Council is determined to embed a culture of data quality across the organisation. Elected members, managers and staff alike must act at all times with an awareness of the importance of data quality and of accuracy and integrity in the use of data.

6.2 It is therefore imperative that all receive the training or development appropriate for their particular roles, responsibilities and accountabilities; and that this is reviewed and refreshed over time to meet changing requirements, needs and circumstances.

6.3 As a basis for this training and development the Council will develop a set of data quality standards and guidelines to establish a common understanding of what good quality data entails.

7. Monitoring and review

7.1 Progress in giving effect to this policy, through the associated operational arrangements and the Data Quality Action Plan, will be monitored continuously. The Head of Policy and Performance will report on it quarterly to the lead Cabinet member and Corporate Management Board, and six-monthly to Cabinet and the Audit and Governance Committee.

7.2 The Chief Internal Auditor will present an annual data quality audit report to the lead Cabinet member and director. This will also be reported to the Audit and Governance Committee and the Corporate Management Board. It will form the basis for continuous improvements in data quality.

7.3 This policy and its associated operational arrangements and Action Plan will therefore be reviewed and reported alongside the annual data quality audit report.

Draft for approval by Cabinet April 2008

RENEWAL OF CONTRACT: MICROSOFT ENTERPRISE AGREEMENT

PORTFOLIO RESPONSIBILITY: CORPORATE AND CUSTOMER SERVICES AND HUMAN RESORCES

CABINET **10 APRIL 2008**

Wards Affected

Countywide

Purpose

To agree the renewal of the current Microsoft Enterprise Agreement licence, support and maintenance contract covering all corporate (excluding schools, education and research) Microsoft computer software in use within the authority for a period of three years.

Key Decision

This is a Key Decision because it is likely to result in the Council incurring expenditure above agreed budgets for the service or function (shown as a line in the budget book) to which the decision relates but allowing for virements between budget heads and savings within budget heads of up to £500,000.

It was not included in the Forward Plan, however, inclusion in the agenda gives the required notice in accordance with Section 15 of the Local Authorities (Executive Arrangements) (Access to Information) Regulations 2000.

Recommendations

THAT

a) **the funding available is noted; and**

b) **the contract is renewed in the sum of £645,000 over the three year period.**

Reasons

To ensure that all corporate Microsoft software is covered in terms of support, maintenance and licence compliance for a period of three years and to ensure that the Council continues to receive the associated forty percent discount for new Microsoft software.

Considerations

1. The focus of this report is the corporate Microsoft Enterprise Agreement.

2. The Council has over 2000 corporate desktop users of Microsoft software. This includes

Further information on the subject of this report is available from
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Robert Knowles, Project Manager (01432) 383674
Sandra Dallimore, Technical Services Manager, ICT Services (01432 261965)

the operating systems used to run the desktop computers across the authority and software such as Outlook, Word, Excel, Access and PowerPoint that staff and Members use daily.

3. The Council has over 100 servers that run Microsoft operating systems and a large number of business critical applications in use across the authority including: Geographic Information Systems (Mapping); Planning software; the Council's websites including the intranet; Members committee agenda and minutes system; Trading Standards; adult and children's social care systems; and Human Resource management systems.

4. The Council, similar to nearly all other local authorities, Central Government departments and agencies, NHS organisations and private sector businesses across the UK, uses Microsoft software on the majority of its desktops and servers.

5. The way that Microsoft licences its products means that the Council has two distinct agreements. A "Select Agreement" covers all educational, research and schools usage whilst an "Enterprise Agreement" covers all other corporate users. The "Select Agreement" is cheaper per unit but is only available for educational and academic purposes – the Council has this in place as a matter of course for these areas and this is not covered by this report.

6. The Microsoft Enterprise Agreement allows the Council to ensure that all Microsoft software is fully supported with:

    - licensing flexibility allowing licences to be transferred between people and computers;
    - 24/7 technical support;
    - security updates and major version upgrades;
    - extended support for end-of-life products;
    - technical support for all products;
    - access to training materials for staff and engineers;
    - access to enterprise only Microsoft software including a specific version of the desktop operating system for use in large organisations;
    - free training vouchers for technical training totalling 30 days;
    - help and support for upgrades;
    - planning and deployment of desktop services;
    - free licences for cold backup (duplicate server switched off until an incident or failure occurs) systems for disaster recovery;
    - free software training licences;
    - free consultancy days from Microsoft and partners.

7. The current Enterprise Agreement ends on 31st March 2008. The Council has a 30 day

grace period to renew at a discounted rate of £215k per year for three years totalling £645k.

8. If there is a delay agreeing the renewal past the 30 day grace period the Council will become ineligible for the renewal and must put a new agreement in place.

9. A new agreement would cost £249k per year for three years totalling £747k. This would give the same benefits as the current Enterprise Agreement but would mean an extra £102k over three years for the same terms and conditions as the renewal.

10. There is no pressure or leverage the Council can exert on Microsoft to change or further discount software past what is already offered. Prices are set at a negotiated national level by Microsoft and the Office of Government Commerce (OGC) under the CATALIST framework agreement for software. All resellers of Microsoft software under this agreement charge the same price. This is the only deal available for local authorities across England.

11. The current CATALIST framework agreement is being reviewed by Microsoft and OGC and will end 31st May 2008. Negotiations are due to complete in June and the expectation and advice from both Microsoft and Trustmarque (our current Microsoft reseller) are that prices will increase. They are advising all Councils who have the option to renew to take that option.

12. The Council cannot use the cheaper NHS PCT software agreement under a Herefordshire Public Services banner as this would break licensing laws and leave the Council subject to heavy financial penalties in excess of £1m (typical amount).

13. If it is decided not to renew the Council can still use existing software at current licence numbers but will become ineligible for all the benefits of an Enterprise Agreement and subject to much higher prices (40% above what the Council would pay under an Enterprise Agreement) for all new Microsoft software and upgrades of existing software past the current version of Microsoft products.

Financial Implications

14. The funds for this have already been budgeted for in ICT Services base budget. There is no requirement for additional funding.

15. The cost of renewal will be £215k per annum over three years totalling £645k.

16. There will be a decrease in money spent on this agreement with the remaining budgeted amount being used to purchase new Microsoft software requested by directorates that fall under the corporate agreement at no cost to them. This excludes services that are licensed through the Academic and Research Select Agreement. This will go alongside the standardisation project approved by CMB to pool software licences under the existing ICT budgetary arrangements thus reducing budgetary pressures on Directorates.

Risk Management

17. Delaying the decision to renew past this Cabinet meeting will mean that the Council no longer qualifies for the cheaper renewal price. Deciding to renew at a later meeting will incur extra costs of at least £102k over three years placing further budgetary pressure on both ICT Services and directorates.

18. Enterprise Agreements allow the authority more flexibility to transfer and reallocate software licences between staff and departments. If the Council do not have an agreement in place we must invest in further staff resources to ensure the Council is compliant with the licensing agreement with Microsoft. Microsoft schedules regular audits for all customers and the penalties for non-compliance are severe.

Alternative Options

19. There are no realistic alternative options in terms of supplier. The majority of partners, local Councils, Central Government departments, NHS agencies and businesses use Microsoft software.

20. To switch to another supplier would be problematic at best as the majority of business applications within the Council only work on and with Microsoft operating systems and Office software. They would, therefore, become unworkable, necessitating their replacement. In short, the Council are locked into this supplier as are all other organisations who predominantly use Microsoft software on such a scale.

21. Microsoft software costs are seen as a "cost of doing business" by most organisations as there is no real alternative supplier that provides the same breadth of software to the same high quality and most importantly, to the same level of usability for staff and engineers.[1]

22. The authority could choose not to renew the Enterprise Agreement. However, this means the Council will lose out on the benefits of having an organisation-wide agreement and face a much larger cost when rolling out projects that require desktops or servers or when purchasing Microsoft products. When Microsoft upgrades its current line of products the Council would not be able to upgrade them and would have to buy the new version at full price. At over 2000 desktop users and over 100 servers this would be at a much higher cost (40% extra per unit of Microsoft software). Additional staff resource would be required to provide licence compliance support.

Appendices

No additional appendices.

Background Papers

No additional background papers.

Glossary

Corporate – in the context of this report this term is used to describe all internal activities carried out by the Council and those staff who perform them. It excludes services that fall under an academic or research category as these are provided for under a "Select Agreement"

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[1] The only alternative to Microsoft software is open source software. This is provided by many different companies. Whilst appearing to be free, the total cost of ownership is similar if not slightly higher than when using Microsoft software on such an organisation-wide scale. The majority of the business applications in use do not work on this platform so most of the other software in use across the Council would need to be replaced as well as the core desktop and server software. Full retraining of all staff and technical engineers would need to take place and further integration with the Primary Care Trust who use Microsoft software would be made more difficult and costly.

Desktops - a generic term for computers that includes laptop and tablet computers used by staff within the authority.

Enterprise Agreement – a generic term used to describe an overall framework agreement between a vendor and an entire organisation such as the Council. This is a different approach than having individual contracts between individual departments.

HPS – Herefordshire Public Services; a term used to describe the joint working arrangements between the Council and the Herefordshire NHS Primary Care Trust.

ICT Services -

Microsoft – the largest software company in the world. They provide the server and desktop platform for the majority of computers within the authority.

Microsoft Office – collective term used to describe a set of software from Microsoft, including: Word, a word processing tool; Excel, a spreadsheet tool; Access, a database tool; PowerPoint, a presentation tool; and Outlook, an email and calendaring tool.

MTFS – Medium Term Financial Strategy; a term used within the Council to refer to the financial strategy for the revenue account, the capital account, treasury management, reserves and balances, financial management etc…

NHS – National Health Service.

PCT – Primary Care Trust; commissioners / providers of public health services

Select Agreement -

Server – computer running application software to which many *desktops* connect to access information and applications.

ASSESSMENTS OF 18 – 64 YEAR-OLDS' FUTURE NEEDS AND SERVICES: MENTAL HEALTH AND PHYSICAL DISABILITIES

PROGRAMME AREA RESPONSIBILITY: SOCIAL CARE ADULTS AND HEALTH

CABINET **10 APRIL 2008**

Wards Affected

County-wide

Purpose

To make proposals for the development of high-performing health and social care services by 2012 to meet the expected future needs of 18-64 year-olds in Herefordshire with mental health problems and physical disabilities, having regard to the views expressed on the proposals by the Adult Social Care and Strategic Housing Scrutiny Committee and the Health Scrutiny Committee.

Key Decision

This is a Key Decision because it is likely to be significant in terms of its effect on communities living or working in Herefordshire in an area comprising one or more wards.

It was not included in the Forward Plan, however inclusion in the agenda gives the required notice in accordance with Section 15 of the Local Authorities (Executive Arrangements) (Access to Information) Regulations 2000.

Recommendation

THAT (a) the proposed patterns of high-performing mental health and physical disability services be approved and put in place between April 2008 and March 2012;

(b) these should be achieved by means of detailed joint commissioning plans of the Council and the Herefordshire Primary Care Trust;

(c) the adequacy of the new patterns of services should be subject to a further full review of needs and services by 2012 in the light of better data and of actual demand for modernised services; and

(d) the results of the review be used to inform budget planning at that time.

Reasons

Notwithstanding additional investment in recent years and some improvements, in important respects Herefordshire's services for mental health and physical disability are not performing as well or as efficiently as those in a number of comparable parts of the country; neither do

Further information on the subject of this report is available
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they provide a sound or sustainable basis for meeting future needs.

Considerations

1. To provide a sound basis for the continuous improvement of adult health and social care services in the county, a programme of assessments of future needs and the patterns of efficient and effective services required to meet them has been carried out with the Herefordshire Primary Care Trust (PCT) over the past two years. Last year Cabinet approved the recommendations of assessments in respect of older people and adults with learning disabilities, which are now being implemented.

2. The suite of assessments has now been completed with those in respect of 18-64 year-olds with mental health problems and physical disabilities. The completed assessments are attached at appendices 1 and 6. Each begins with a short summary.

3. In respect of **mental health**, no significant increase in demand is expected by 2012 from those with the most serious disorders, such as schizophrenia, or those with the most common disorders, such as depression. However, there may be a need for some more services for those with eating or personality disorders. The nature and extent of these cannot be determined until some time in 2008; in the case of eating disorders in the light of the findings from a piloting of local services in the county, which is currently taking place; and, in the case of personality disorders, until the Government publishes promised guidance.

4. Although no significant increase in the needs of those with either the most serious or most common mental disorders is expected over the medium-term, the pattern of services needs to change significantly. In particular, there is a need to rely much less on residential and nursing home placements, including out-of-county; to provide much more support for people in their own homes and communities; and to give users and carers considerably more clout in the planning and delivery of services.

5. In respect of **physical disabilities**, an increase of some 5% is expected by 2012 in the number of people needing services. This is largely because the prevalence of some physical disabilities increases with age and the number of people aged 55-64 will increase as that of younger age groups decreases.

6. Once again, the pattern of services needs to change significantly; and, again, the core changes are to make much less use of residential and out-of-county provision; to do a lot more to enable people to live as independently as possible in their own homes and communities; and to give users and carers a good deal more influence in the planning and delivery of services.

7. In respect of **both mental health and physical disability**, it will be important to:

    (i) conduct a further review of needs and services by 2012 in light of better data and of actual demand for modernised services;

    (ii) integrate the joint commissioning plans with the management of in-year overspending against budget;

    (iii) maximise the contribution of GP commissioning;

    (iv) be prepared to adjust the balance of social care and health funding within pooled budgets to achieve shared commissioning targets for users, with the balance of the respective funding contributions of the Council and the PCT to be negotiated as part of the development of the joint commissioning plans;

(v) work with the third sector to mobilise voluntary and community resources; and

(vi) ensure, through an associated programme of organisational development, that those managing and providing care have the right skills, behaviours and shared systems to deliver the modernised services successfully.

8. The arrangements for funding and accounting for joint expenditure to deliver the changes by means of joint commissioning plans will be made under the powers in Section 75 of the National Health Service Act 2006. There are no other legal implications.

9. The Joint Health and Social Care Commissioning Board of the Council and PCT has considered the assessments and agreed that improved services should be developed along the recommended lines. We are advised that no further approval is required from the PCT until such time as the detailed commissioning plans to give effect to the assessments, together with associated proposals for expenditure, have been prepared.

10. At its meeting on 24 January, Cabinet deferred its decision on these proposals pending their consideration by the Adult Social Care and Strategic Housing Scrutiny Committee and the Health Scrutiny Committee. The committees met to consider the proposals on 19 March. Their resolutions are recorded in the extracts from the draft minutes of their meetings at Appendix 9.

11. The committees endorsed the recommended new patterns of services but reinforced the concerns in the assessments regarding the fragility of some important elements of the underlying data currently available and the need to keep under review the adequacy of the new services and their resourcing. Recommendations (c) and (d) above have been added to those put to Cabinet in January to ensure that these concerns are addressed. The committees' other resolutions will be taken into account in the course of implementing the new patterns of services.

Financial implications

Mental health

Bearing in mind the apparently higher number of people with serious mental disorders in Herefordshire than would be expected on the basis of national prevalence, and with Herefordshire's combined health and social care unit costs higher than the comparator authorities but lower than those for England as a whole, the assessment recommends that the total PCT and Council spending in 2006-07, maintained in real terms, is the minimum necessary recurrent funding. This includes the £1.3 million overspending against budgets.

The assessment suggests that non-recurrent bridging finance, peaking at £300K a year, will be needed to help develop the new services before existing services that will not be required in the future can be de-commissioned.

It also suggests that, depending on their nature and extent, it *may* be possible to provide any additional services for those with personality disorders from within these totals. That will need to be determined during 2008, in the light of the additional information that should become available, which is described in paragraph 3 above.

Physical disability

The current gross cost of social care services to the Council is about 12% higher per head of population than the average of the comparator authorities, although the difference is small

compared with Shropshire, which is the closest comparator in terms of its demographic and geographical characteristics. Where Herefordshire differs from Shropshire is in raising only about half as much income from external sources, such as the *Supporting people* programme.

Considering together the expected 5% growth in the need for services, the additional costs arising from Herefordshire's uniquely high proportion of people living in sparsely populated areas, inefficiencies in the current pattern of services, and on the basis that Herefordshire should be capable of generating proportionately equivalent levels of external funding as those achieved by Shropshire, it would seem reasonable to conclude that the aggregate level of spending by the Council in 2006-07 will be needed recurrently until 2012.

The assessment suggests that non-recurrent bridging finance, peaking at £250K a year, will to needed to help develop the new social care services before existing services that will not be required in the future can be de-commissioned.

It goes on to suggest that annual social care savings of some £209K should be possible by 2012-13.

As a result of the way in which information about health care services and expenditure has been required to be collected up to now, there is no ready basis for establishing and comparing the current level of spending on physical disability services by the Herefordshire PCT. But there can be no doubt that it makes, and will need to continue to make, a major contribution, not least in helping people to manage long-term chronic conditions. More work will have to be done to establish the current position as part of the production of the joint commissioning plan to be developed together by the Council and the PCT to bring about the improved pattern of services. Pending that, the assessment assumes that at least the current level of PCT funding will be maintained, in real terms.

Proposed financial provision

The Medium Term Financial Management Strategy (MTFMS) approved by Cabinet in January provides for substantial additional cash resources to be added to the Adult Social Care baseline. This is reflected in the Budget proposals. These resources will need to be supplemented by increased external funding, for example where greater use can be made of the national *Supporting People* programme. Taken together, these additional resources should enable the recommended new patterns of services to be put in place.

Additionally, in recognition of the identified requirement for bridging finance, the MTFMS and Budget proposals include a further £275k modernisation funding for adult social care services in 2008/09, rising to £550k in 2009/10. This figure will remain in the base budget for 2010/2011 but be reviewed during the course of future revisions of the financial strategy in the light of the negotiations with the PCT as the joint commissioning plans to implement the improvements are developed, the potential for future savings once the new patterns of services are established and progress with de-commissioning existing services.

Risk Management

There are two principal risks: that the improvements will not be achieved because of inadequate capacity to plan and deliver them; and that the actual demand for services will exceed the levels of future need identified in the assessment.

There are three main capacity issues: people, systems and money.

Capacity to manage and deliver major changes has already been improved significantly in Adult Social Care, with the appointment of an additional interim head of service, a change

manager and additional contracting and other staff. The development of joint commissioning structures and processes between the Council and the PCT will strengthen capacity further.

Linked and shared systems and procedures in respect of service users and financial and other data are being addressed through the implementation of the new target operating model, including the new, ICT-based social care system recently approved by Cabinet.

The financial elements are addressed in the preceding part of this paper. The situation as regards the costs of future services for people with eating or personality disorders will need to be reviewed in 2008.

The actual levels of demand for services will be kept under review; hence the recommendation that a further full review of needs and services (and of the appropriate level of funding) should take place by 2012.

Alternative Options

The Council's current 1* Commission for Social Care Inspectorate rating for Adult Social Care and the PCT's "Fair" services rating from the Health Care Commission constrain alternative options. In short, unless services are modernised and significantly improved, those ratings would be likely to deteriorate, with damaging consequences for the reputation of both bodies. This would be happening at the same time as the Council and the PCT are seeking to make a success of much closer joint working, under a single chief executive and joint management team, to achieve better services and outcomes for users.

Making the changes over a longer time-span would be a false economy, since not only would costly, inefficient and ineffective elements of services continue for longer but also there would be a danger that a lengthier period of inadequately developed local services would result in even greater use of inappropriate residential and out-of-county care and, therefore, even greater spending pressure against budgets.

There are, therefore, no alternative options.

Consultees

The assessments have been developed taking account of the views of users and carers expressed at specially organised events. These views are summarised in the assessments.

The steering group for the assessments included service managers and staff from the PCT and the Council, as well as two senior people from the third sector with considerable expertise in mental health and physical disabilities. The details are in the first appendix to each of the assessments.

The steering group was advised, and the assessments quality-assured, by two distinguished national experts. Their details are in the second appendix to each of the assessments.

The Adult Social Care and Strategic Housing Scrutiny Committee and the Health Scrutiny Committee have considered the assessments in detail.

Appendices

Appendix 1: *Future needs and services for 18-64 year-olds in Herefordshire with mental health problems*

Appendix 2: Membership of the Adult Care Assessment Steering Group 2007

Appendix 3: Adult Social Care Assessment Report – The Expert Advisers

Appendix 4: Needs Analysis: Adults with Mental Health Problems

Appendix 5: Current and Future Services for Adults with Mental Health Problems

Appendix 6: *Future care needs and services for 18-64 year-olds in Herefordshire with physical disabilities*

Appendix 7: Needs Analysis: Adults with Physical Disabilities

Appendix 8: Current and Future Services for Adults with Physical Disabilities

Appendix 9: *Extracts from the draft minutes of the meetings of the Adult Social Care and Strategic Housing Scrutiny Committee and the Health Scrutiny Committee on 19 March 2008*

Background Papers

None identified

Future needs and services for 18 – 64 year-olds in Herefordshire with mental health problems

November 2007

Herefordshire Council Corporate Policy and Research Team
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Contents

	Page
Summary	3
Section 1 - Introduction	6
Section 2 - Assessment of future care needs	9
Section 3 - The pattern and levels of services to meet needs in 2012	12
Section 4 - The capacity needed to deliver the improvements	18
Section 5 - The costs	25
Appendices	
Appendix 1 – Membership of the Steering Committee	
Appendix 2 – Details about the expert consultants	
Appendix 3 – Needs analysis	
Appendix 4 – Present and future services	

Final report: future care needs and services for 18-64 year-olds with mental health problems

Summary

Working together and with their partners, Herefordshire Council and the Herefordshire Primary Care Trust are committed to maximising the independence, well-being and choice of people with mental health problems. In doing this, they face a major double challenge: despite additional investment and service improvements in recent years, in important respects they still lag behind what is achieved by high-performing authorities serving comparable areas; and the cost of services has continued to escalate.

Mental health disorders are one of the major causes of ill-health, suffering and social problems in the county. The 874 people between 18 and 64 with psychosis and the other most serious mental health disorders reported by services in Herefordshire is much higher than the 600 that would be expected on the basis of national prevalence rates. There is no present reason to believe that more people will require treatment in either 2012 or 2021.

An estimated 18,000 18 to 64 year-olds suffer from depression and other more common mental disorders. This number is not expected to change by 2012 but seems likely to increase slightly by 2021.

In addition, an estimated 4,650 18-64s have a personality disorder, a number that is expected to increase by 50 by 2012 and by 150 by 2021. However, only 60 of these people currently receive secondary mental health care and it is at present impossible to predict the long-term need for services.

About 50 people aged 30-64 suffer from dementia. This number is not expected to increase by either 2012 or 2021.

Over the past five years, an average of seven 14-17 year-olds a year were identified as having experienced a first psychotic episode. This number seems unlikely to change significantly. This is the only current measure of the numbers of young people with mental health problems who may be in transition to adult services.

Major gaps in current data need to be filled, which means that these estimates will need to be kept under review, in the light of actual demand for fully modernised services and through the new process of Joint Strategic Needs Assessment. Even so, it is possible to be reasonably confident about the needs estimated for 2012.

Users and carers say that services as a whole have improved but that many aspects leave a lot to be desired. They point to a need for much better communications between staff and users, and between services; 24/7 direct access to secondary services and information; refuge at times of crisis; more education, training, work and other day opportunities; and better services for young people, including those from Eastern Europe. The Government and the inspectorates have similar expectations.

Final report: future care needs and services for 18-64 year-olds with mental health problems

Compared with high-performing Dorset, Somerset and West Berkshire, Herefordshire spends a lot more on secure and high-dependency residential and nursing home care, especially on out-of-county placements, but much less on supporting people at home and on supporting carers. Unlike the comparators, it has limited specific mental health primary care services and doesn't provide direct access for users and carers to advice and support 24/7. It does much less to involve users and carers. It does have a good level of psychology services.

Herefordshire lags behind the best practice in helping people with mental health problems to gain or retain employment and in preventative services, including the promotion of mental health.

Overall, Herefordshire spends more per head of population than the comparators but less than the all-England average. It raises significantly more income from users than the comparators but needs to increase external funding, including from the national *Supporting People* programme

To achieve high-performing, cost-effective services by 2012 Herefordshire needs to do much more to support people before they need specialist secondary services; to provide the great bulk of services in, or close to, people's own homes and communities; and to do more to help people recover and stay well after they have received secondary services. This will require the cost-effective, local replacement of much of the current out-of-county provision and, more generally, a significant reduction in the use of residential and nursing home care.

Considering together the demands for new forms of services, the additional costs of provision arising from Herefordshire's uniquely high number of people living in sparsely populated areas, inefficiencies in the current pattern of services and the small increases so far identified in expected demand, **overall it would seem reasonable to conclude that the aggregate level of spending by the Council and the PCT in 2006-07 (i.e including the over-spending against budget of £1.3 million) is the minimum necessary recurrent funding to meet the needs of those with the most serious and the most common mental health problems up to 2012.**

This conclusion should be reviewed by 2012 in the light of better data, including the actual demand for fully modernised services.

Since it is not possible to stop current provision before more efficient and effective services have been put in place, non-recurrent bridging funding of £269K in 2008-09, £298K in 2009-10 and £158K in 2010-11 will be needed.

To avoid a vicious circle of decline, the transformation plans to bring about the new pattern of services must be fully integrated with the steps taken to manage current in-year over-spending against budget.

Existing resources will not do the job without the full and quickest possible integration of all aspects of planning, commissioning, delivery and performance management of health and social care across the Council and PCT.

It will also require a substantial extension of direct payments and personal budgets; better support for carers; maximising the contribution and effectiveness of GP-based commissioning; adjusting the balance of PCT and Council funding to achieve a single, shared set of commissioning targets; attracting significant additional funding from external sources; and working closely with the third sector to mobilise voluntary and community resources behind the development of preventative services, access to generic local services and facilities, advocacy for individuals and help-lines.

The new services will only work if all those caring for and supporting people with mental health problems are developed to have the right skills and behaviours. This will need to be done as part and parcel of the introduction of the streamlined processes and ICT-based systems being put in place under the *Herefordshire Connects* programme, buttressed by strong, disciplined performance management at all levels.

The needs of those with personality or eating disorders and the services required to meet them will need to be determined during 2008; in the case of personality disorders, in the light of emerging government expectations; and, in the case of eating disorders, having regard to the results of a local pilot service. This report therefore makes no allowance for the costs of developing additional services for these groups, although it is not out of the question that they could be funded from within the current real terms level of spending in the light of the review in future years recommended above.

Section 1: Introduction

Working together and with their partners, the Council and the Herefordshire Primary Care Trust (PCT) are committed to maximising the independence, well-being and choice of people with mental health problems.

Despite additional investment over previous years, and changes aimed to enable people to lead safe and fulfilled lives in their own homes and communities rather than in unnecessary residential or in-patient care, the Council's and PCT's current pattern and levels of services are not, in important respects, achieving as much and providing the same value for money as are the highest performing comparable areas.

This was confirmed in the results of the Health Care Commission's and Commission for Social Care Inspection (CSCI)'s joint review of community mental health services across England in 2006, *No voice, no choice*. Although it identified some areas of strength, it also found weaknesses, with the net effect that Herefordshire's services were amongst the 43% of areas rated "fair". This compares with 9% of areas being rated "excellent", 45% "good" and 3% "weak".

In addition, the costs of services in Herefordshire have risen substantially in recent years and continue to do so, to the extent that expenditure has significantly exceeded budgets.

This is taking place against the background of the ambitious developments in Government policy for health and social care set out in the White Paper of January 2006, *Our health, our care, our say: a new direction for community services*. This calls for a fundamental shift in services to local communities, to be developed by local partners in ways that better meet the needs of individual people. It sets four main goals:

a. **better prevention and earlier intervention** – reducing the chances of people becoming ill or dependent in the first place;

b. **more choice and a louder voice** – ensuring that people are in control of the services they receive, through involvement in the planning and development of services, and by means of self-directed care, including direct payments and budgets for individuals;

c. **tackling inequalities and improving access to a wider range of community services** – ensuring that the areas, groups of people and individuals with greatest need get the services they deserve;

d. **more support for people with long-term needs** – better integration of services and joint planning across health and social care for those who make the most intensive use of services.

These goals are developed in more detail for mental health services in other authoritative publications, including *No voice, no choice*, the Sainsbury Centre's *Vision for 2015* and the National Director for Mental Health's *Ten years on* review. They are expressed most concretely in the seven outcomes for people used by the CSCI in their assessments of care: *Improved health and emotional well-being; Improved quality of life; Making a positive contribution; Exercise of choice and control; Freedom from discrimination and harassment; Economic well-being;* and *Personal dignity and respect*.

The goals are underpinned by national consultation showing strong support for more community services. That is reflected in the consistent findings of public consultation in Herefordshire, including that carried out with users and carers specifically to inform this assessment (details are given in Section 3 below). The Council, the PCT and their partners in the Herefordshire Partnership have made *Healthier Communities and Older People* one of the *Herefordshire Community Strategy's* four priorities for better outcomes.

In the light of these considerations, the Council and the PCT are committed to working with their partners, service users themselves and their carers and representatives, to develop and deliver better, sustainable services for the future. They want, in particular, to strike the right balance between preventative services and the provision of more intensive support and care.

In doing this, the Council and PCT are particularly conscious not only of the inter-dependence of health and social care one upon the other in achieving the best outcomes for people, but also of the vital contribution that needs to be made by housing, employment services, education, welfare benefits, generic community-based opportunities (such as cultural and leisure services), the voluntary and community sector, and, not least, by users and carers themselves and by their advocates.

1.10 Crucial too are effective links to ensure smooth transition between the services provided for children and young people and those for adults; and between services for 18-64 year-olds and those for older people.

The purpose of this report

1.11 Having last year assessed future needs for older people and adults with learning disabilities, and agreed how services would be developed to meet them, the Council and the PCT decided to carry out, with the *Herefordshire Alliance*, a thorough assessment of future needs of 18-64 year-olds with mental health problems; of the services needed to meet those needs; and of the costs involved in doing so, taking into account the scope for greater efficiency in moving from the present services to a new, more effective pattern.

Final report: future care needs and services for 18-64 year-olds with mental health problems

1.12 This report has been prepared under the leadership of the Council's Corporate Policy and Research Team, working with staff in the PCT, in the Council's Adult Social Care Department and Resources Directorate, and with *The Herefordshire Alliance* and *Herefordshire MIND*. The membership of the Steering Group is at Appendix 1.

1.13 The Steering Group has been advised by distinguished experts in the field, Professor Gerald Wistow and Eileen Waddington. Further information about the expert advisers is at Appendix 2.

1.14 The first stage of the project was to estimate the need for care of 18-64 year-olds with mental health problems through to 2021. This was to provide the long-term context for the second stage: the assessment of what patterns and levels of cost-effective services would be needed to meet expected needs in 2012.

1.15 Rather than conduct a theoretical assessment of the services that will be needed, the best possible comparator areas were identified; that is those with high-performing services in areas with broadly similar settlement patterns and demographic characteristics to those found in Herefordshire. The selected areas were Dorset, Somerset and West Berkshire.

1.16 Through analysis of comparative data about services and costs, of inspection reports, and by visiting the authorities, we established what patterns and levels of services they provide; how they intend further to change and improve them to meet future challenges; and, crucially, how they manage and deliver them successfully. These findings were then applied, having regard to the distinctive needs and circumstances of Herefordshire and to wider relevant comparisons.

1.17 The final stage was to translate these findings into costed proposals for the development of high-performing services through to 2012.

The structure of the report

1.18 Section 2 of the report examines future needs to 2012 and 2021. Section 3 describes what pattern and levels of services will be needed to meet those needs in 2012. Section 4 looks at the capacity needed to develop and deliver these services successfully. Section 5 sets out the estimated costs of doing so.

Section 2: Assessment of future needs

2.1 The full assessment of future needs for 18-64 year-olds with mental health problems is at Appendix 3. It begins with a summary.

2.2 The crucial points are:

- mental health disorders are one of the major causes of ill-health, suffering and social problems in the county

- **the most serious and disabling mental health disorders** (psychosis, schizophrenia and bi-polar affective disorder) affected 874 people aged 18-64 known to GPs in Herefordshire in January 2007; this is significantly higher than the 600 people that national prevalence rates would suggest

- there is no present reason to assume that more people with these most serious conditions will require treatment in either 2012 or 2021

- **suicide rates** in Herefordshire have appeared in the past to be relatively high, but the 20% reduction target between 1995-97 and 2010 is expected to be met

- **more common mental health disorders** (anxiety, depression, neuroses, phobias, compulsions and stress) are estimated to affect over 18,000 adults aged 18-64 in a year, which is more than 17% of the total age group

- no notable change is expected in this number by 2012; however, an increase of 1% is expected by 2021, which might, on the basis of the proportions currently accessing secondary mental health services, equate to an extra 5 or 6 people needing to do so

- on the basis of national estimates, 4,650 18-64 year-olds in Herefordshire (over 4% of the total age group) may have a **personality disorder**, but only 60 receive secondary mental health care

- this total might be expected to increase by 50 people by 2012 and 150 by 2021; although, on the basis of the current level of access, this would lead to only marginal changes in the demand for care, this could increase more were the county to develop specialist provision for this group in response to changing national and statutory requirements; it is not at present possible to quantify this potential demand but it could be substantial

- **early onset dementia** affects about 50 people aged 30-64 in Herefordshire; currently only 22 of these receive a secondary service, an estimated one-third of whom are suffering from preventable dementia as a result of substance mis-use

- the total number of sufferers is expected to remain at about this level in 2012 and 2021

- although nationally it is estimated that around one-third of patients with serious mental illness have a substance mis-use problem, and that about half of drug and alcohol service users have a mental health problem, it is not at present possible to estimate the extent of **dual diagnosis** in Herefordshire or what it might be in the future

- neither is it possible at present to estimate the numbers of people in **different ethnic groups** in the county experiencing mental health problems; nor to produce estimates of the numbers of people likely to suffer from such problems in **different parts of Herefordshire**

- over the past five years, an average of seven **14-17 year-olds** a year were identified as having experienced a first psychotic episode; on the basis of demographic trends, this number seems unlikely to change significantly; this is the only current measure of the numbers of young people with mental health problems who may be **in transition to adult services**

- an estimated 3,300 people in the county aged 18-64 (3%) are **carers** of someone with a mental disability, with about three-quarters of those cared for also having a physical disability; the number might be expected to increase slightly as a result of the modest increases described above in the expected numbers of people suffering from mental disorders

- a recent survey has identified at least 133 mental health service users living in unsuitable **accommodation**, two-thirds of whom require general needs rather than supported housing

2.3 In considering these estimates, it is important to bear in mind the paucity of reliable data currently available internationally, nationally, regionally and locally as regards both present and future levels of need.

2.4 Some of the international and national estimates suggest a growth in needs at odds with the conclusions in this report. For example, the World Health Organisation predicted in 2001 that there would be world-wide increase in depression that would make it the leading cause of disability by 2021; while, in its March 2007 study for the

Disability Rights Commission, the Institute of Public Policy and Research (IPPR Trading Ltd) projected possible big increases by 2020 in impairments caused by mental health problems, including a doubling – to an enormous 38% - in the proportion of 20-29 year-olds experiencing them.

2.5 It plainly makes no sense to take a world-wide forecast and apply it to Herefordshire, while the IPPR's UK projection was based on self-reporting as part of a labour force survey and doesn't distinguish between the different types and severity of mental health problems. The IPPR report itself says, "*Given the limitations of the data….this report cannot offer a definitive account of the circumstances and experiences of disabled people in 2020*."

2.6 Within Herefordshire difficulties with data arise either because it simply hasn't been collected or because the various separate data-bases maintained by the Council and the PCT about individuals mean that there is likely to be extensive double-counting or more. On the other hand, some things are probably not being counted at all. These deficiencies will need to be addressed to provide a sound basis for the future monitoring and planning of services, as well as to meet fully statutory requirements in respect of equalities and those to come requiring a Joint Strategic Needs Assessment for health and social care.

2.7 It is of great importance that we rectify these deficiencies as quickly as possible. Much of this will be made possible by the introduction of a single user data-base and other improvements under the *Herefordshire Connects* programme, including the development of shared systems between the Council and PCT within the Public Service Trust. The longer-term estimates of need in this report should be reviewed as these improvements bear fruit.

2.8 That said, the present estimates are the best possible current basis for planning and delivering improved services to 2012, in respect of which it is possible to be reasonably confident about the extent and nature of future needs.

Section 3 - The pattern and levels of services to meet needs in 2012

3.1 Drawing on the views expressed by users and carers in Herefordshire, on Government and other authoritative national requirements and guidance regarding mental health services, together with the evidence about high-performing services gathered from the comparator areas – Dorset, Somerset and West Berkshire – this section describes what needs to be done, to what extent, to achieve services that will meet the needs identified in section 2.

The views of users and carers

3.2 The views of users and carers on present and future services were sought at two forums in July 2007. Nearly 40 took part, expressing clearly and forcefully what they want from services.

3.3 Their main points were:

- although services as a whole have improved a lot over the past decade, many aspects of them still leave much to be desired
- the need for much improved two-way communications between staff and those receiving assessments and care, with all staff exhibiting a positive, respectful attitude to users and carers
- and for much better communications between professionals in respect of individuals receiving assessments and care, so as to ensure continuity and consistency
- in particular, the need to tackle a lack of co-ordination between mental health and acute hospital services, including as regards user records
- the need for all GPs, acute hospitals and accident and emergency departments to have an acceptable minimum level of understanding about mental health problems; for example, in respect of self-harm
- being able to access the crisis team whenever they feel the need to do so, rather than having to be referred by primary care, which was reported to be reluctant to do so, particularly at evenings and weekends; they believed that this would have the effect of avoiding at least some admissions to the Stonebow hospital unit
- the particular value of a designated 24/7 telephone helpline that would give users and carers immediate access to information and support

- the need for a safe place in the community to go to in a crisis, particularly out-of-hours and at weekends

- the day centres provided by MIND were regarded as crucial by many, not least as somewhere they feel supported, safe and not judged

- others had mixed feelings about them, but it was noted that MIND is aiming to develop a wider range of provision to cater for diverse needs

- a general call for a wider, more flexible range of services, extending beyond specialist mental health services and those prescribed under the *National Service Framework*

- linked with this, the need for support to enable them to access generic community services and facilities, coupled with educating the public on mental health issues to break down barriers

- and more secure long-term funding for suitable educational opportunities, not least those that help people to gain qualifications in preparation for employment

- a need to improve the quality of services for young people (it was said they will not attend day centres), including Eastern Europeans who have mental health problems but are not known to services

- and to ensure a smooth transition for those moving between young people's services and those for adults

Government and inspectorate requirements

3.4 The things users and carers want to see reflect most of the national requirements and guidance on good practice. Other key elements expected by Government and the inspectorates are:

- the fullest possible participation in society being the touchstone, including meaningful employment

- the promotion of emotional health in schools

- all public services playing an active role in mental well-being

- access for all to psychological and other "talking" therapies

- the extension of direct payments and individualised budgets to as many people as want them, with all users and carers involved in the development of care packages

- and plans agreed between users and staff for personal recovery goals

- advance planning with users and carers for crises, including anti-psychotic treatment
- attending to the needs of the whole person, with a particular emphasis on improving the physical health of those with mental health problems
- advocacy and other help for individuals to promote their social inclusion
- user and carer involvement in service planning and development
- choice about appointment times
- an effective partnership between primary and secondary care
- treatment in the community, wherever possible, rather than in hospital
- good, timely information for users and carers about medicines and their side-effects
- under the Department of Health *National Service Framework*, a prescribed minimum level of staffing for specified services, including carers' support, securing access to services for black and other ethnic minorities, and mental health promotion
- the provision of information, advice and, where appropriate, assessment to the whole population, including self-funders

Comparing with high-performers

3.5 In comparison with the relatively high-performing Dorset and Somerset (and, where indicated, West Berkshire, in respect of which there is incomplete comparative data), Herefordshire:

- commissions substantially more continuing residential and nursing home care (57 per 100,000 population aged 18-64, compared with an average of 20, spending proportionately about a third more); Herefordshire's lower costs per placement support the view that it has a lower threshold of needs before it resorts to these forms of care
- commissions a lot more secure and high-dependency provision, spending almost double per head of population more than Dorset; about half of this spending is on 21 out-of-county placements
- has the same trends in terms of falling hospital admissions (424 in 2002-03; 368 in 2006-07); fewer discharges (431 down to 371); and increased average lengths of stay (median up from 12 to 17 days), but these are magnified in the comparator areas

- secures a tiny level of home support services (only ten people were receiving home care on 31 March 2007), spending at one-fortieth the average level of the comparators

- provides a good level of psychology services, at the level of the best of the three comparators

- has more people attending day care centres (over 100 per 100,000 aged 18-64, compared to an average of 54), with fewer accessing more flexible, community-based and generic opportunities

- unlike the comparator areas, doesn't have 24/7 direct access for users and carers to advice and support (although a crisis assessment and treatment service is available 24/7)

- has a low number of people receiving direct payments, similar to the comparators

- has a lower level of advocacy services, particularly for individuals

- has a similar level of social workers in community mental health and other specialist teams (18 per 100,000 of the 15-64 population, compared with an average of 17)

- like the comparators, provides no specialist services for people with personality disorders

- apart from practice counselling, has limited primary care services specifically for people with mental health needs, compared with the well-established arrangements in the comparators

- has a lower level of community eating disorder services

- has very much lower provision for carers, incurring expenditure about a tenth of Dorset's (but with a carers' support worker about to be appointed)

- does much less to involve users and carers in the planning and development of services

- spends a little below the average on housing

- provides less support to prepare people to gain or maintain employment

- overall across health and social care, has gross spending above the average of the comparator areas (£135 per head of the 15-64 population, compared with an average of £114 in Dorset and Somerset) but less than the all-England average (£156)

  (For detailed consideration of this comparison see paragraphs 4.2 to 4.10 in section 4 below.)

- social care expenditure is slightly above average (£26.71 per head of the 18-64 population, compared with an average of £25.55)

- generates significantly more income from client contributions (nearly ten times the level in the lowest, West Berkshire)

- has far less effective and efficient systems for data collection, analysis and performance management

3.6 In addition, Herefordshire lags behind best practice as regards preventative services, including the promotion of mental health. It also needs to do more to maximise external funding, including from the national *Supporting People* programme.

The new pattern of services required

3.7 This analysis leads to our recommending the following principal changes to achieve the more balanced, modern pattern of services that would meet Herefordshire's needs cost-effectively.

3.8 The fundamental strategic shifts needed are to do much more to support people before they need specialist secondary services; to provide the great bulk of secondary services in, or close to, people's own homes and communities; to do more to help people recover and stay well after they have received secondary services; and to place much more influence and control in the hands of users and carers.

3.9 The specific changes to achieve this should be:

- commissioning cost-effective services within the county to replace many of the current out-of-county placements and, wherever possible, avoid them in the future, including through the existing residential rehabilitation unit

- developing own-home and community-based services so as to reduce to the absolute minimum the use of residential and nursing home care

- improving crisis provision, ensuring direct access 24/7 for users and carers to information and advice; and, where necessary, home treatment

- providing temporary refuge, integrated with day care

- enhancing recovery and rehabilitation services, including home support, housing, education, training and employment opportunities, and support, where necessary, to access general community facilities

- the maximum possible number of people securing their own care with direct payments or personal budgets

- securing effective, independent advocacy for individuals

- developing primary care mental health services, including therapies, closely linked to the work of the community mental health teams (members of which should operate at least partly within GP practices) and the enhanced domiciliary and community-based services, with the objective of there being a lead GP for mental health in each practice

- greatly enhancing preventative services, mobilising community resources and volunteers, including from amongst the ranks of service users and carers

- securing services to support carers to continue in their role and improve their own health and well-being, including, where necessary, help to retain or gain employment

- extending mental health promotion services

- all of the above enabling both a reduction in acute hospital bed provision and a greater capacity within the acute hospital to provide effective treatment for those with the most intensive needs

- systematic, continuous user and carer involvement in the planning and development of services, including financial assistance and capacity-building to make this possible

- developing a shared philosophy and approach across children's and adults' services, reflected in fresh protocols, to ensure a smooth and successful transition for young people moving between them

- taking equal care to achieve fair and effective transition for people to older people's services

- determining the nature and extent of services needed for people with personality disorders (the aim is to develop a service specification by March 2008)

- evaluating the pilot community eating disorder service (scheduled to take place after twelve months, in July 2008) and determining the nature and extent of future services

- identifying the needs of ethnic minority groups, including the significant number of young people who have come from Eastern Europe in recent years, and tailoring services to meet them

3.10 A number of the necessary improvements are already beginning to happen or are planned. For example, over the past year there have been significant developments at the Stonebow Unit, including a suite to assess those arrested under Mental Health Act powers rather than the use of police cells; the piloting of a consultant working closely with the crisis team over admissions, which has reduced the occupancy rate by 15% and will be rolled out generally in January 2008; and funding secured to provide single-sex accommodation.

3.11 Other important recent developments include:

- tighter scrutiny of out-of-county and long-term care home placements, with reviews of existing placements that will be repeated regularly; already this has led to the repatriation from out-of-county placements of two service users, saving £200,000 a year

- strengthening staffing in the early intervention service to meet the target of supporting at least 20 people experiencing a first episode of psychosis

- a mental health services housing plan and a development officer to make sure it is implemented

- service users and carers sitting on the reference group for adult mental health services, and a regular programme of meetings between carers and senior managers

- getting an expert to develop urgently the detailed specification for improved rehabilitation and recovery services that will lead to the reduction of out –of –county placements and other long-term care, and generally create a more user-led service

3.12 The overall pattern and levels of high-performing services proposed are set out in Appendix 4, which also explains the underlying assumptions

Section 4 - The capacity needed to deliver the improvements

4.1 Achieving successful change on the scale necessary to meet future needs cost-effectively requires not only careful, detailed planning across health and social care (and beyond) but also a firm, co-ordinated grip on all aspects of managing projects, finance, human resources and performance.

Funding

4.2 Assessing the adequacy of Herefordshire's 2006-07 level of budget and spending (i.e. including the overspend against budget of £1.3 million) to meet future needs is complicated by there being two bases for comparing Herefordshire with our chosen comparator areas, and also with the wider group of statistical neighbours and England as a whole. One is to do this by comparing funding on the basis of the total actual populations; the other is to apply the weighted populations used by central government for the financial mapping of mental health services across England.

4.3 The results of these two methods are as follows (data on the numbers of people between 15-64 is the nearest available to the 18-64 population in question):

Area	Gross spend per head of ***weighted*** population 15-64 (£)	Gross spend per head of ***un-weighted*** population 15-64 (£)
Herefordshire	174	135
Dorset	144	102
Somerset	161	125
West Berkshire	162	Not available
Average of Dorset and Somerset	153	114
ONS statistical neighbours average	141	Not available
England	156	156

4.4 Compared with Somerset and Dorset, both methods show Herefordshire to be a high spending area.

4.5 On the other hand, on the basis of actual, un-weighted population,

Herefordshire is shown as a low spender compared with the all-England average.

4.6 Although it would be wrong wholly to disregard the weightings applied nationally (there is, for instance, a well-established link between relative deprivation and levels of mental disorder), there are good reasons neither to accept them as definitive nor to apply them mechanically.

4.7 The effect of the weightings is to reduce Herefordshire's actual 15-64 population figure of 15-64 year-olds from some 109,000 to about 84,000 – a reduction of nearly 22%. This is achieved by applying various indices about expected levels of mental illnesses derived from data going back, in some cases, to the early 1990s; and also factors from the national resource allocation formula that take no account of the current known level of mental illness in an area. Nor do the weightings take account of the recent work of the Council's Research Team that demonstrates the higher costs associated with delivering services in a county that has the highest proportion of people living in areas with fewer than 0.25 persons per hectare.

4.8 Crucially, as paragraph 2.2 in section 2 above shows, the number of 18-64 year-old people in Herefordshire identified by services to have serious mental illnesses (i.e the group which has the greatest need for services and in respect of which the lion's share of expenditure needs to be incurred) is nearly 46% higher than the 600 people that national prevalence rates would suggest. The reasons for this are not known but, even if the data were not wholly reliable (the level does seem improbably high), it would be both perverse and dangerous to base the appropriate level of funding on an assumed level of prevalence rather than the recorded number of people who need and will continue to need services. (It should be borne in mind that, even were the actual prevalence in Herefordshire to be as low as 600, the use of the un-weighted figures would be justified.)

4.9 Based on the comparisons with Dorset and Somerset alone and without regard to Herefordshire's distinctive circumstances, there could be no argument that our mental health services are relatively well-funded: taking the Somerset level of funding alone and applying it proportionately to Herefordshire, we would have spent £1.1 million less in 2006-07 (i.e about £200K above budget, as opposed to the £1.3 million actual over-spend).

4.10 On the other hand, the available figures suggest that we are having to cope with a level of serious mental illness that may be in excess of the national prevalence, which makes the wider comparison with the England average of more than academic interest. On that basis, Herefordshire's spend in 2006-07 might be considered to have been light to the tune of about £2.3 million, and its budget by £3.6 million.

4.11 There is the further, pragmatic consideration that a cost-effective

service cannot be achieved in Herefordshire until the recommended high-performing new pattern has been established. Thus, while it might be possible, over the long-term, to realise cash-releasing savings from the new pattern of services, reducing the level of spending before the new pattern is substantially in place and a more accurate understanding of demand for modernised services has been gained would not only have a damaging impact on current service users but also make it impossible to establish the new services.

4.12 Considering together the demands for new forms of services, the additional costs of provision arising from Herefordshire's uniquely high number of people living in sparsely populated areas, inefficiencies in the current pattern of services and the small increases so far identified in expected demand, **overall it would seem reasonable to conclude that the aggregate level of spending by the Council and the PCT in 2006-07 (i.e including the over- spending against budget of £1.3 milion) is the minimum necessary recurrent funding to meet the needs of those with the most serious and the most common mental health problems up to 2012.**

4.13 For the reasons explained in paragraphs 2.3 to 2.7 in section 2 above and earlier in this section, **this conclusion should be reviewed by 2012 in the light of better data, including the actual demand for fully modernised services**.

4.14 **This assumption about the adequacy of the 2006-07 level of spending until 2012 would hold true only if it were to be maintained in real terms and if the efficiency savings that would be secured under the new pattern of services were retained for investment in those new services, at least until the position is reviewed in the circumstances pertaining by 2012.**

4.15 **Moreover, although the reduction in services no longer required, for example many of the expensive out-of-county residential placements, should be expected to pay the recurrent costs of the new pattern of services, this can only happen if there is targeted, time-limited, non-recurrent funding to develop the new services to the point where the current services can be discontinued.**

4.16 It remains to be seen, in the light of further, detailed work and piloting over the coming year, what will be needed to provide services in the future to meet the needs of those with personality or eating disorders.

4.17 The assumption that the 2006-07 real level of spending by the Council and the PCT combined should be an adequate minimum basis for emulating the achievements of the high-performing comparator areas rests on six crucial additional provisos:

- that the large-scale extension of direct payments and personal budgets will be managed in such a way that efficiency savings are generated for recycling in mental health services

- that support for carers will be strengthened (recent research by the University of Leeds estimates that the average carer saves the nation more than £15,000 a year)

- that the contribution and effectiveness of GP-based commissioning will be maximised

- that the balance between PCT and Council funding will, where necessary, be adjusted within the Public Service Trust to achieve a single, shared set of commissioning targets

- that we will attract significant additional funding from external sources (such as Government grants, including Supporting People, charities, private business and the National Lottery)

- that this and wider benefits will be achieved by working in close partnership with the third sector, so as to provide access to wider sources of external funding and, even more important, to mobilise voluntary and community resources behind the development of preventative services, access to generic local services and facilities, advocacy for individuals and help-lines; this may include the development of user-led organisations as service providers

4.18 Moreover, the plans for radical transformation that will produce sustainable, affordable and cost-effective services must be fully integrated with the steps taken in response to the current over-spending. Unless this is done, on the basis of establishing an agreed programme of change for the coming four years, underpinned by the necessary minimum recurrent and targeted non-recurrent funding, services will deteriorate in a vicious circle of ad hoc cuts and retrenchment that will render them incapable of meeting future needs
.

4.19 These considerations underpin the costings in section 5 below.

Human resource, organisational and systems considerations

4.20 Developing and delivering the new pattern of services will require considerable, sustained management effort and a systematic approach to workforce planning and performance management, so as to ensure that all those providing care and other support to people with mental health problems have the right skills and exhibit the right behaviours.

4.21 Elements of a good basic infrastructure have now been created in the Council and the PCT which, together with an increasingly productive relationship with both the third and private sectors, has the potential to bring about the necessary changes. Notably, this includes an Interim Head of Adult Social Care, a dedicated Head of Learning Disability, a Change Manager, the strengthening of the PCT and Council joint Planning and Change Team, including a Mental Health Commissioning Manager, and additional appointments to the Council's contracts and adult safeguarding teams.

4.22 However, this strengthened capacity is already tackling a comprehensive transformation programme that includes the fundamental reshaping of older people's and learning disability services, and the development of wholesale new procedures and management systems; to which will now need to be added, as well as that in respect of mental health, a similar reshaping of physical disability services. These and other **existing resources will not be able to do the job without the full and quickest possible integration of all aspects of planning, commissioning, delivery and performance management of health and social care across the Council and PCT**. In turn, this will require the putting in place of single procedures, processes and ICT systems as part of the *Herefordshire Connects* programme.

4.23 **Additional operational capacity will be needed at the start of the programme** to meet Department of Health National Service Framework targets for key elements of the new services, as follows:

- 1.5 whole-time equivalent (wte) posts to develop support for carers

- 1 wte post to ensure good access to services for members of black and other ethnic minorities

- 1 wte post to further develop mental health promotion

4.24 These will need to be funded either from existing budgets or, if that is not possible, from the first tranche of non-recurrent investment in 2008-09, with the recurrent costs absorbed as the new pattern of services produces off-setting savings.

4.25 Underpinning all of this, there will need to be a cross-agency development programme for all those caring for or supporting people with mental health problems. A partnership workforce strategy for the whole of adult health and social care is already in the early stages of development. This will need to include a dedicated element to deliver the mental health improvements.

4.26 Similar considerations apply to the rolling out of the communications strategy and action plan for the comprehensive

transformation programme.

4.27 The adequacy of the new pattern of services should be subject to regular review and periodic formal evaluation, taking account of a progressively better understanding of the nature and level of need. This should include an external, independent element, if possible linked to national evaluation programmes.

Section 5 - The costs

5.1 Appendix 4 contrasts the proposed high-performing services in 2012 with the services in place in 2006-07.

5.2 Unless services are fundamentally reshaped along the lines proposed in this report, they would fail to meet the needs and wishes of users and carers, and also the expectations of Government and the inspectorates. Worse still, this would take place in a context where the performance of other areas can be expected, on average, to continue to improve year-on-year and in which Government and the inspectors are likely to have ratcheted up the minimum acceptable standard for services and, therefore, the threshold for intervention.

5.3 Additionally, the maximum possible sustainable improvements in efficiency can be achieved only if services are modernised as proposed. This is illustrated by the growth, from 16 in 2005-06 to 21 in 2006-07, in the number of out-of-county placements, which cost nearly £1.7 million a year. There is a substantial danger that, in the absence of adequate local, community-based services, this trend will continue, with the effect of even higher levels of over-spending against budgets.

5.4 **The total expenditure of £16.65 million in 2006-07, maintained in real terms, will be required recurrently through to 2012. This should be reviewed by 2012 in the light of better data, including the actual demand for fully modernised services**.

5.5 **In addition to these recurrent costs, non-recurrent investment of the following order will be required to put in place the new pattern of services so that inefficient, poor value for money current services can be discontinued**:

Year	£
2008-09	269
2009-10	298
2010-11	158
2011-12	(-62)

5.6 The needs of those with personality or eating disorders and the services required to meet them will need to be determined during 2008; in the case of personality disorders, in the light of emerging government expectations; and, in the case of eating disorders, having regard to the results of a local pilot service. **This report therefore makes no allowance for the possible costs of developing additional specialist services for people with personality or eating disorders, but it is not out of the question that that they**

could be funded from within the 2006-07 level of spending, maintained in real terms, in the light of the review recommended in paragraph 5.4 above.

Membership of the Adult Care Assessment Steering Group 2007: 18-64 year-olds in Herefordshire with mental health problems or physical disabilities

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Formerly:

- Director of Nuffield Institute for Health and Professor of Health and Social Care, University of Leeds
- Co-Director, Centre for Research in Social Policy, University of Loughborough
- Chair of Hartlepool Primary Care Trust
- Department of Health Research Coordinator, Outcomes of Social Care for Adults programme
- Member of Community Care and Disability Committee, Joseph Rowntree Foundation
- Member of Inquiry into Long-Term Care (Chair, Sir Peter Barclay)
- Member of Inquiry into Community Care for People with a Severe Mental Illness (Chair, Sir William Utting)
- Princess Royal Trust for Carers: member of Carer Support Advisory Committee
- Specialist adviser to the House of Commons Social Services Committee and Health Committee, including in respect of public expenditure, community care, funding of residential and care homes, and relationships between the NHS and local government
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- Director of Community Care, North-West Regional Health Authority
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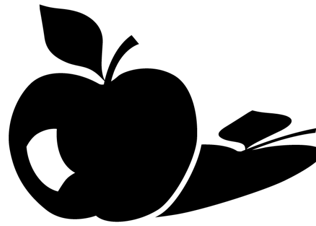
Current and Past Projects include:

- co-ordination of Department of Health research programme on Outcomes in Social Care
- developing National Quality Standards for Voluntary Community Care Services (Age Concern)
- researching views of older people regarding long-term care services (Help the Aged)
- whole systems reviews of older people's services to re-shape care provision (City of Westminster, York, Rochdale, St. Helens and Knowsley)
- reviews of services for people with learning disabilities (Kensington, Chelsea, Westminster, Hartlepool)
- development of Royal College of Nursing Strategy for Nursing Older People
- developing strategies for an ageing population (Warrington and Salford)
- Authoring ADSS/LGA-commissioned paper on implementing the *Our health, our care, our say: a new direction for community services* White Paper (with Gerald Wistow)



NEEDS ANALYSIS: ADULTS WITH MENTAL HEALTH PROBLEMS

Principal factors that will determine the need for services for people aged 18 to 64 with mental health problems

October 2007

Final Version (4.4)

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TABLE OF CONTENTS

EXECUTIVE SUMMARY III

INTRODUCTION 1

DEMOGRAPHICS OF HEREFORDSHIRE 2

THE COUNTY OF HEREFORDSHIRE 2
CURRENT POPULATION 2
RECENT TRENDS 3
MIGRATION 3
ETHNICITY 5
FUTURE POPULATION 6
COMMUNAL ESTABLISHMENT POPULATION 8

GENERAL HEALTH IN HEREFORDSHIRE 9

LIFE EXPECTANCY & GENERAL HEALTH 9
LIMITING LONG-TERM ILLNESS 10

HEREFORDSHIRE'S OVERALL MENTAL HEALTH 10

MEASURE OF MENTAL HEALTH 10
SUICIDE 11

SOURCES OF INFORMATION ON ADULTS WITH MENTAL HEALTH PROBLEMS 11

KNOWN SERVICE USERS 11
DISABILITY-RELATED BENEFIT CLAIMANTS 11
NATIONAL ESTIMATES OF PREVALENCE OF MENTAL HEALTH PROBLEMS 15

MENTAL HEALTH PROBLEMS AMONGST ADULTS IN HEREFORDSHIRE 16

COMMON MENTAL HEALTH PROBLEMS (NEUROTIC DISORDERS) 16
PSYCHOTIC DISORDERS 20
PERSONALITY DISORDERS 23
EARLY ONSET DEMENTIA 24
EATING DISORDER 26
BEHAVIOURAL DIAGNOSES 26
DUAL DIAGNOSIS 26

ETHNICITY OF PEOPLE WITH MENTAL HEALTH PROBLEMS 28

GEOGRAPHIC DISTRIBUTION OF PEOPLE WITH MENTAL HEALTH PROBLEMS 29

MENTAL HEALTH OF PRISONERS 30

CARERS 31

NUMBERS OF CARERS 31
THE CARED FOR 32
CARERS' HEALTH 32

ABILITY TO PAY 34

EARNINGS 34
INCOME 35
EMPLOYMENT & FINANCIAL CHARACTERISTICS OF PEOPLE WITH MENTAL HEALTH PROBLEMS 35

HOUSING 36

HEREFORDSHIRE MENTAL HEALTH SERVICES HOUSING PLAN 36

APPENDIX: ADULT MENTAL HEALTH SERVICE DATA 39

ADULT MENTAL HEALTH SERVICE: CPA DATABASE 39
ADULT MENTAL HEALTH SERVICE CASELOAD AUDIT 39
RESIDENTS OF MANAGED ACCOMMODATION 40

REFERENCES 41

EXECUTIVE SUMMARY

Introduction

Looking forward to 2012 and 2021, this report is an assessment of the principal factors that will determine the need for social and health care for adults aged 16 to 64 years with mental health problems. According to the London Health Observatory[1], "the term 'mental health problem' can be used to describe the full range of mental health issues, from common experiences such as 'feeling depressed' to more severe clinical symptoms such as 'clinical depression' and enduring problems such as schizophrenia". This report considers the likely future mental health needs of Herefordshire's adult population, in order that these needs can be anticipated and planned for by service providers.

Demographics of Herefordshire

- Herefordshire's current[2] estimated population of 18-64 year-olds is 105,600 – 59% of the total population. The county has an older overall age profile than both the West Midlands region and England and Wales.
- Office for National Statistics (ONS) projections suggest numbers of 18-64 year-olds may increase by 2.0% by 2012, although more conservative local forecasts which take in to account expected housing provision suggest this increase will only be 0.1% by 2011.
- Projections suggest the 18-64 year-old population could be 107,000 in 2021, an increase of just 1.3% from 2005.
- Recent years have seen a more rapid growth in numbers in older age-groups (55-64s) and a more rapid decline in the younger ones (18-34s) than nationally. This ageing of the age profile is expected to continue, with the 55-64 year-old age-group growing most rapidly (by 7% in the short-term and 21% by 2021).

- The county has a smaller proportion of people from 'Black and Minority Ethnic' (BME) backgrounds than England as a whole (3.5% compared to 14.7%), but this population grew by 40.9% between 2001 and 2004 – much more rapid than the overall population growth of 1.7%. It is likely that numbers have increased further since the expansion of the EU in May 2004: between 2,500 and 3,000 workers from new member states were cleared to work in Herefordshire in 2005, although it is not known how many remain in the county. The county also experiences an annual influx of around 3,000 temporary seasonal agricultural workers – mainly over the summer months.
- In 2004, 3.8% of 18-64 year-olds in Herefordshire were estimated to be from a BME background; just under half of these were non-white.

General Health in Herefordshire

- Herefordshire's population is expected to live longer, on average, than nationally.
- Similar proportions of 18-64 year-olds in Herefordshire were in 'not good' health and/or had a 'limiting long-term illness' as nationally and regionally, according to the 2001 Census.

Sources of Information on Adults with Mental Health Problems

- It is not possible to obtain robust, comprehensive estimates of the number of people experiencing mental health problems who are in receipt of services. This is due to the potential for double-counting as a result of the independent databases used by the different service providers, and also to do with inconsistent recording and difficulties in extracting and obtaining information.
- It is estimated that around 780 people aged 18-64 in Herefordshire may be claiming Disability Living Allowance (i.e. may need some level of care) for a 'mental health

[1] http://www.lho.org.uk/HIL/Disease_Groups/MentalHealth_Prevalence.aspx

[2] ONS 2005 mid-year estimate. In August 2007, after this needs analysis work was completed, the ONS published revisions to the population estimates and projections. As a result, Herefordshire's population was reduced, which has a minor impact on the estimated and projected numbers of people with mental health problems in Herefordshire. This does not change any of the conclusions drawn.

reason' in August 2006, and that at the same time around 2,175 are claiming Incapacity Benefit or Severe Disablement Allowance because of a 'mental disorder'.

- Estimates and future projections have been produced for the purpose of this report, mainly using the *Survey of Psychiatric Morbidity among Adults in Private Households*, carried out in 2000 by the Office for National Statistics on behalf of the Department for Health. These assume that prevalence rates in Herefordshire will remain at the same level as in Great Britain as a whole in 2000. This is despite some suggestions that prevalence may increase, for which no robust information exists, even at a national level.

Common Mental Health Problems

- An estimated 18,250 adults aged 18-64 were experiencing common mental health problems in Herefordshire in 2005.
- Assuming that the national prevalence rates from 2000 remain appropriate, no notable change is expected in the number of adults experiencing common mental health problems in the county in the short-term (i.e. up to 2012).
- The same assumption yields an expected 1% increase in numbers by 2021: 100 extra people;
- Assuming that those who need to are currently accessing secondary services, this could be expected to equate to an extra 5 or 6 people requiring secondary mental health services in 2021.

Psychotic Disorders

- There are an estimated 874 cases of 'psychosis, schizophrenia or bi-polar affective disorder' known to GPs in Herefordshire in January 2007.
- This figure is higher than national prevalence rates would suggest (600 household residents) - even after accounting for approximately 50 people in communal establishments, and it has not been possible to reconcile these figures.
- Despite this large discrepancy, there is no reason to assume that more people in Herefordshire will require treatment for a psychotic disorder either in 2012 or 2021, than do currently.

Personality Disorders

- There were an estimated 4,650 household residents aged 18-64 in Herefordshire with a personality disorder in 2005.
- If prevalence were to continue at the same levels, forecast population changes would result in this number increasing by around 50 people (1%) in the short-term (up to 2012).
- In the longer term, in 2021, projections would suggest a 3% growth in the number, to 4,800 adults (an increase of around 150 people).
- It is estimated that currently around 60 adults receiving secondary specialist mental health care have a primary diagnosis of 'personality disorder' – just 1.3% of all estimated cases. It is not possible to determine how many people are diagnosed within primary care.
- This large discrepancy may be explained by considering that large numbers of people with a personality disorder do not require specialist services, or may be misdiagnosed with another mental health problem. There has also been a history of secondary services not taking them on because of a lack of treatments and associated statutory constraints, although national policy is starting to challenge this.

Early onset dementia

- It is estimated that there are approximately 50 people aged 30-64 with dementia in Herefordshire; numbers are expected to remain at a similar level up to 2012 and in 2021.
- Currently, only two-fifths (22) of these people are receiving a secondary service, and an estimated one-third of these are suffering from preventable dementia related to substance misuse.

Dual Diagnosis

- 'Dual diagnosis' refers to "the coexistence of mental health and substance misuse problems", and is important to consider in the context of service planning as it seems to result in high levels of service use, particularly expensive resources (e.g. emergency services and inpatient beds), compared to mental health problems alone.
- Little is known about the extent of dual diagnosis at a national level. It is estimated that around one third of psychiatric patients with serious mental illness have a substance misuse problem, and that around half of drug and alcohol service users have a mental health problem.
- It has not been possible to identify the extent of dual diagnosis in Herefordshire.

Ethnicity of People with Mental Health Problems

- It is not possible to produce estimates of the number of people in different ethnic groups in Herefordshire experiencing mental health problems.
- Information on ethnic group of patients is not currently collected by GPs, so there is no way of knowing the ethnicity of people with mental health problems known to primary care in Herefordshire.
- In April 2007, 3.5% of Herefordshire mental health service users (aged 18+) are recorded as being from a 'Black and Minority Ethnic' population, almost equal to the proportion of over 18s in the population as a whole in 2004 (3.4%).
- Nothing is known about the general mental health of migrant and seasonal workers in Herefordshire.

Geographic Distribution of People with a Mental Health Problem

- It is not possible to produce projections of the number of people in different parts of Herefordshire who will experience mental health problems.
- Further work would be required to assess whether current services are provided equitably across the county and that access to these services is equal, regardless of location.

Mental Health of Prisoners

- The number of people from Herefordshire in prison is unknown; the only available relevant information is that the Herefordshire Forensic Assessment Community Team is currently working with 6 people.
- Prevalence of mental health problems is high amongst the prison population in general.

Carers

- Assuming that the prevalence of caring in Herefordshire is as it was at the 2001 Census, 14,100 people aged 18-64 in Herefordshire are estimated to have been providing at least one hour of unpaid care a week in 2005, with 3,600 providing care for 20 hours or more per week.
- At the same time, 1.3% of 18-64 year-olds in the county (1,340 people) were entitled to Carers' Allowance, i.e. were not in employment or full-time education and were caring for a severely disabled person for at least 35 hours a week.
- Carers are more likely to be in 'not good' health than non-carers, and the disparity increases with the amount of time spent caring per week. People who provide care over a long period of time are particularly at risk of poor health. Carers' health is also more likely to deteriorate over time than that of non-carers, with many of the detrimental changes attributable to the caring role.
- Using national observations, an estimated 800 people aged 18-64 in Herefordshire are estimated to have been caring for someone with a 'mental disability' in 2005. A further 2,500 care for someone with both a 'physical and mental disability', and around 700 of this latter group could be expected to have a neurotic disorder.

Housing

- National research points toward a higher likelihood of housing instability in people with mental health problems. People with neurotic disorders and people with probable psychotic disorders are both more likely than those without to be socially renting, and the former group are more likely to have moved three or more times in the last two years.
- Although it is not possible to estimate the extent of social renting amongst people with mental health problems in Herefordshire who are *not* accessing secondary mental health services, a housing assessment of 1,361 Adult Mental Health service users supports the national observation. Almost half of service users in private households were renting (either privately or socially), in comparison with less than a quarter of all household residents in the county.
- A survey of care co-ordinators for the *Herefordshire Mental Health Services Housing Plan* identified at least 133 service users living in unsuitable accommodation, with incomplete information provided for around 400 service users. A wide range of single-figure accommodation units were identified as needed to suitably house these people, with the majority (66%) requiring ‘general needs housing’.

INTRODUCTION

Looking forward to 2012 and 2021, this report is an assessment of the principal factors that will determine the need for social and health care for adults aged 16 to 64 years with mental health problems. These include demographic change, taking into account the expected levels and characteristics of in-migration; the implications of changing patterns of health, treatment, and the development of health care services in response to them; the extent to which people might be able to pay for their social care; and housing.

According to the London Health Observatory[3], "the term 'mental health problem' can be used to describe the full range of mental health issues, from common experiences such as 'feeling depressed' to more severe clinical symptoms such as 'clinical depression' and enduring problems such as schizophrenia".

The Mental Health Foundation[4] elaborates:
"…a wide range of problems which affect someone's ability to get on with their daily life. Mental health problems can affect anyone, of any age and background, as well as having an impact on the people around them such as their family, friends and carers.

"Most people recover from their mental health problems. Long-term problems can lead to considerable disruption and difficulty in people's lives, but many of the people affected find ways of managing their problems and are able to lead active lives".

This report considers the likely future mental health needs of Herefordshire's adult population, in order that these needs can be anticipated and planned for by service providers.

Like the Herefordshire Primary Care Trust and Herefordshire Council's 'Joint Commissioning Plan for People with Mental Health Problems' (2006), this report only considers alcohol or drug use and dependence where they co-exist with other mental health problems.

Note on revisions to Office for National Statistics' population estimates
In August 2007, after the needs analysis work was completed, but before the needs assessment was finalised, the ONS published estimates of population for mid-2006 using a new methodology for estimating international migration at the local level. At the same time, it revised the 2005 mid-year estimates – upon which the estimates and projections of the numbers of people with a physical disability in this needs analysis are based.

The local 2005-based forecasts for Herefordshire will not be revised, but the ONS 2004-based sub-national population projections have been revised to take account of the new methodology.

Herefordshire's estimated population of 18-64 year-olds in 2005 was revised down from 105,600 to 104,300; the estimate for mid-2006 is 104,800. The projection for 2012 is now 105,600 (down from 107,700), and that for 2021 is 103,800 (reduced from 107,000)

These changes have some minor impacts on the estimated and projected numbers of people with mental health problems in Herefordshire, but these are not significant enough to change any of the conclusions drawn.

[3] http://www.lho.org.uk/HIL/Disease_Groups/MentalHealth_Prevalence.aspx
[4] http://www.mentalhealth.org.uk

DEMOGRAPHICS OF HEREFORDSHIRE

THE COUNTY OF HEREFORDSHIRE

Herefordshire is a predominantly rural county of 842 square miles situated in the south-western corner of the West Midlands region, bordering Wales. With a population of approximately 56,000, the city of Hereford is the major location in the county for employment, administration, health, education facilities and shopping. The five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington are the other principal centres, with populations ranging from 11,000 (Leominster) to 2,500 (Kington).

The county has beautiful unspoilt countryside, distinctive heritage, remote valleys and rivers, including the river Wye, which flows east through Hereford and the Wye Valley Area of Outstanding Natural Beauty. The south-west of the county includes the Black Mountains, and the Malvern Hills form part of the boundary with Worcestershire to the east.

Herefordshire has limited access to the motorway network via the M50, which starts near Ross-on-Wye and joins the M5 north of Tewkesbury in Gloucestershire. The other main road links, which all pass through Hereford, are the A49 (running from north to south), the A438 (east to west) and the A4103 to Worcester.

The nature of Herefordshire's rurality presents unique challenges to service providers, with a relatively small population of 178,800[5] scattered across the 2nd largest[6] unitary authority in England. Furthermore, although three English counties[7] have a lower population density than Herefordshire, no other top tier local authority has a greater proportion of its population living in "very sparse" areas[8].

CURRENT POPULATION

Herefordshire's current total population is 178,800[5], of which 59% (105,600) are aged 18-64. Herefordshire has an older overall age profile than both the West Midlands Region and England and Wales, and this is apparent in the older groups within the population of interest in this report. Table 1 shows how Herefordshire has a larger proportion of 55-64 year-olds in its population than either the region or England and Wales as a whole, and a smaller proportion of 18-34 year-olds.

It should be noted that the mid-year estimates exclude around 2,700[9] Herefordshire students who live away from home during term-time, the majority of whom are likely to be aged 18-21. As the county has no universities, this group is not compensated for by students from other areas living within the county during term-time.

Table 1: Proportion of total population in adult age-groups, 2005

Area		18-34	35-54	55-64	18-64
Herefordshire	No.	*29,400*	*51,000*	*25,200*	*105,600*
	%	16.4%	28.5%	14.1%	59.1%
West Midlands Region	%	21.6%	27.6%	11.9%	58.4%
England & Wales	%	22.3%	28.1%	11.7%	62.0%

Source: 2005 mid-year estimates, ONS. Note: figures may not sum due to rounding.

Whilst gender distribution is an important issue when considering older people due to the longer life expectancy of females, it is less of one for adults aged 18-64; there is a roughly

[5] 2005 mid-year estimate, ONS
[6] Behind East Riding of Yorkshire
[7] Northumberland, North Yorkshire and Cumbria
[8] According to the sparsity measures used in the calculation of the Local Government Finance Settlement 2006/07, 29% of Herefordshire's population live in wards with a density of 0.5 persons per hectare or lower and 25% live in Output Areas with a density of 0.5 or lower.
[9] 2001 Census

50:50 split between males and females in the age groups of interest in Herefordshire, as nationally.

RECENT TRENDS

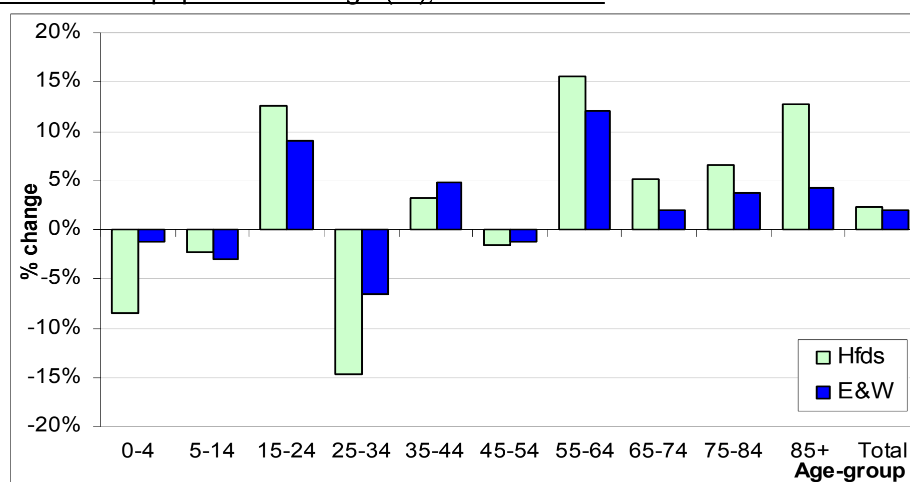
Herefordshire's population grew by 2.2% between 2001 and 2005, which is broadly similar to the national growth (2.0%), but change was not consistent across age-groups (Figure 3). The number of people aged 18-64 increased by 2,500 over this period – a growth similar to the total population growth but, as Table 2 shows, numbers of 18-34 year-olds fell by 4.5%, whilst the population aged 55-64 increased by 15.6%. These changes were in the same direction as national trends, but larger.

Table 2: Observed population change (%), 2001 to 2005

Age-group	Herefordshire	England & Wales
18-34	-4.5%	-0.5%
35-54	+1.0%	+2.0%
55-64	+15.6%	+12.1%
18-64	+2.4%	+2.8%

Source: mid-year population estimates, ONS

Figure 3: Observed population change (%), 2001 to 2005



Source: mid-year population estimates, ONS

MIGRATION

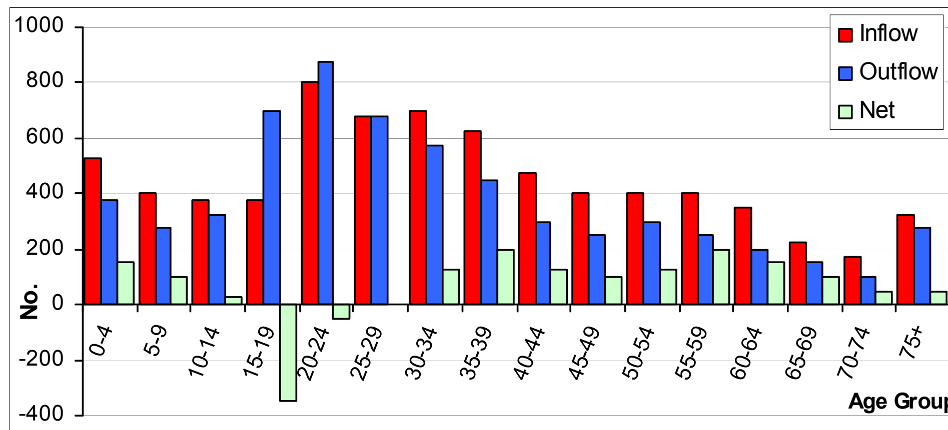
Within UK Migration

Herefordshire experiences an average annual net gain of just over 1,000 residents from elsewhere in the UK. Analysis of migration within *England and Wales*[10] shows that about two-thirds (65%) of the net migrants into Herefordshire come from London and the South-East (including Bedfordshire, Hertfordshire and Essex); just under a quarter (24%) from neighbouring English counties (Gloucestershire, Worcestershire and Shropshire); 13% from non-neighbouring parts of the West Midlands region and the rest from other parts of England; on average more people move from Herefordshire to Wales than vice versa, giving a net loss.

The average numbers of people in each age group moving into and out of Herefordshire each year, along with the average net in-flow (people moving *in* minus people moving *out*), are shown in Figure 4. The largest flows, both into and out of Herefordshire, are in the 20-24 year-old age group. This is one of the age groups where people are most mobile generally, so the pattern is not necessarily unique to Herefordshire.

[10] Over the period mid-1998 to mid-2004

Figure 4: Average annual migration between Herefordshire and rest of UK



Source: derived from ONS Internal Migration Estimates; average over period mid-2000 to mid-2004

Notably, the only average net *out*-flows are in the 15-19 and 20-24 year-old age-groups, with the largest in the former: on average 350 more 15-19 year-olds leave the county each year than move into it. This may be explained by the fact that Herefordshire does not have a major centre of higher education, coupled with the fact that young people leaving home to start university are generally aged 18-19 and are counted at their term-time address.

However, it is worth noting that although there is an average annual net loss of 400 15-24 year-olds, this only represents around 2% of the county's population of these ages. To put this into perspective, Rutland UA in the East Midlands 'loses' around 7% of its population of this age-group each year, whilst Westminster 'gains' around 7%.

International Migration

According to the ONS mid-year estimates of population, until 2004 Herefordshire had an average of zero net international migrants per year. In the 2005 estimates, the county had a net in-flow of 440.

The only detailed information available regarding permanent international migration is the number of people moving into Herefordshire from outside the UK in the year before the 2001 Census. This figure was 567, which represents just 0.3% of the total population of the county at the time, and the number moving in the other direction is unknown. 54% of these international in-migrants were aged under 30, which is much higher than the corresponding figure of 44% of in-migrants from within the UK; both figures are higher than the proportion of under 30s of Herefordshire's population (33%).

Migrant workers

Between 2,500 and 3,000 workers from new European Union accession states[11] were cleared to work in Herefordshire in 2005. The ages of these migrants are unknown, but it is likely that most were young adults. However, there is currently no information on how long they remain in the county, or even the UK.

The county also experiences a significant influx of temporary seasonal agricultural workers each year (around 3,000[12]) – mainly over the summer months, with the majority from Ukraine and Russia. These are, by definition, students who are permitted to work on participating farms for up to 6 months.

[11] Source: Worker Registration Scheme; Work Permits (UK), Home Office. States are: Poland, Lithuania, Estonia, Latvia, Slovenia, Slovakia, Hungary and the Czech Republic.

[12] Source: Seasonal Agricultural Workers Scheme; Work Permits (UK), Home Office.

ETHNICITY

Experimental statistics[13] suggest that in 2004, 3.5% of Herefordshire's total resident population was from an ethnic minority (6,200 people). This proportion is still very low by national (14.7%) and regional (15.5%) comparisons, but reflects a growth of 40.9% in the BME population from 2001 compared to just 1.7% for the total county population. It is very likely that numbers have increased even more since the expansion of the EU in May 2004 given the migrant worker statistics discussed above.

This information is also available for Herefordshire's 18-64 year-old population, and indicates that younger age-groups have a slightly higher proportion of people from ethnic minorities: 3.8% of 18-64 year-olds are estimated to be from an ethnic group other than 'white British', in comparison with 3.5% of the total resident population (Table 5). This figure rises to 5.1% of 18-34 year-olds.

For all age-groups, 'White other' was the largest ethnic minority group (1.5% of total population aged 18-64). 'White Irish' was the second largest group for 50-64 year-olds (0.8% of all 50-64s), whilst 'Asian or Asian British' was the second largest for 18-34 year-olds (1.0% of all 18-34s). These two ethnic groups were equally sized for 35-50 year-olds (0.5% of all 35-50 year-olds each).

Table 5: Percentage of Herefordshire residents in ethnic group, by age-group, 2004

Age-group	'White British'	Ethnic group other than 'White British'
18 to 34	94.9%	5.1%
35 to 49	96.1%	3.9%
50 to 64	97.3%	2.7%
18 to 64	96.2%	3.8%
Total population	96.5%	3.5%

Source: ONS © Crown copyright.

The small numbers of people aged 18-64 from ethnic minority groups are shown in Table 6, as is the distribution amongst these groups: just under half of people from an ethnic minority are non-white.

Table 6: Percentage of Herefordshire's 18-64 year-old non-'white British' residents in each ethnic group, 2004

Ethnic Group	No. aged 18-64 in ethnic group	% of total 18-64 year-old non-'White British' in group
White British	100,800	-
White Irish	600	15.0%
White Other	1,600	40.0%
Mixed	400	10.0%
Asian or Asian British	600	15.0%
Black or Black British	300	7.5%
Chinese	200	5.0%
Other ethnic group	200	5.0%
Non-'White'	1,800	45.0%
Total non-'White British'	4,000	100.0%

Source: ONS © Crown copyright. Figures may not sum due to rounding (to the nearest 100).

[13] ONS experimental population estimates by ethnic group.

FUTURE POPULATION

The Office for National Statistics produces population ***projections*** for local authorities based on recent and nationally projected trends in births, deaths and migration – i.e. estimates of what could be reasonably expected to happen to the population *if recent trends were to continue.* The most recent set of sub-national projections are 2004-based and project forward to 2029.

Herefordshire Council's Research Team produces population ***forecasts*** for Herefordshire which are also based on recent and nationally projected trends in births, deaths and migration, but, unlike the projections, also take into account anticipated housing provision under the Unitary Development Plan – which has a constraining effect on in-migration. Until the Regional Spatial Strategy is decided it is not possible to anticipate what housing provision there may be after the UDP, so forecasts can only be produced up to 2011. 2005-based interim forecasts have been produced which take account of a higher than average net international in-migration between 2004 and 2005 (but do not make any attempt to forecast future trends in international migration)

As this needs analysis is interested in expected demand for services up to 2012, and longer term to 2021, the ONS projections are considered alongside the local forecasts; the latter is considered as an alternative scenario for the short-term assessment.

Both the forecast and projected figures for 2011 are presented in Table 7a, along with the projections for 2012 and 2021.

- The key point to note is that according to the ONS projections, the population aged 18-64 in Herefordshire will rise to a peak in 2011 (at 108,100) before falling slowly but steadily to 107,000 in 2021.

- The local forecasts predict less growth by 2011 (to 105,700 people), so that numbers would have to continue to increase to reach the level projected for 2021.

- In the long term (up to 2021), by far the biggest rate of change is expected to be in the population of 55-64 year-olds: an increase of 20.6% from 2005, which represents an extra 5,200 residents. The population aged 35-54 is expected to fall by 5,000 over the same period, although this only represents a fall of 9.8% due to the larger numbers in this group.

- Comparing the ONS projections for 18-64 year-olds in Herefordshire to the corresponding national ones shows that even the expected rise in numbers to 2011 would result in a slightly lower rate of growth than in England and Wales as a whole (2.4% to 3.7%). The subsequent projected fall in Herefordshire's population of 18-64 year-olds would result in a much lower overall rate of growth between 2005 and 2021 (1.3% compared to 5.5% in England and Wales).

All of the potential changes discussed here would result in an older age-structure of the 18-64 year-olds in Herefordshire, as illustrated in Table 7b. The proportion of this group aged 55-64 is expected to increase from 24% in 2005, to 25-26% in 2011/12, and to 28% by 2021. Conversely, the proportion aged 35-54 is expected to decrease from 48% in 2005 to 47% in 2001/12 and 43% in 2021. The proportion in the 18-34 age-group is expected to remain fairly constant, fluctuating between 27% and 29%.

Table 7a: Expected change in population aged 18-64, Herefordshire and England & Wales

		Current	Short-term			Long-term
		2005	2011		2012	2021
		Estimate	Forecast	Projection	Projection	Projection
18-34	No.	29,400	28,700	29,700	30,100	30,500
	% change from 2005	-	*-2.4%*	*+1.0%*	*+2.4%*	*+3.7%*
35-54	No.	51,000	50,000	51,100	50,600	46,000
	% change from 2005	-	*-2.0%*	*+0.2%*	*-0.8%*	*-9.8%*
55-64	No.	25,200	27,000	27,300	27,000	30,400
	% change from 2005	-	*+7.1%*	*+8.3%*	*+7.1%*	*+20.6%*
18-64	No.	105,600	105,700	108,100	107,700	107,000
	% change from 2005	-	*+0.1%*	*+2.4%*	*+2.0%*	*+1.3%*
18-64: projected % change, England & Wales		-	-	*+3.7%*	*+3.7%*	*+5.5%*

Source: ONS 2005 mid-year estimates & 2004-based sub-national projections; HC Research Team 2005-based interim forecasts using ONS estimates and Gov't Actuary's Department projected trends; GAD 2004-based national population projections.

Table 7b: Expected proportion of 18-64 year-old population by age-group, Herefordshire

Age-group	Current	Short-term			Long-term
	2005	2011		2012	2021
	Estimate	Forecast	Projection	Projection	Projection
18-34	28%	27%	27%	28%	29%
35-54	48%	47%	47%	47%	43%
55-64	24%	26%	25%	25%	28%
18-64	100%	100%	100%	100%	100%

Source: ONS 2005 mid-year estimates & 2004-based sub-national projections; HC Research Team 2005-based interim forecasts using ONS estimates and Gov't Actuary's Department projected trends; GAD 2004-based national population projections.

As only projections are available for the years after 2011, the only long-term scenario considered is the 2021 ONS projection. Although the focus of the short-term needs analysis is 2012, since the projections suggest that the total population aged 18-64 will peak in 2011 it seems appropriate to consider the forecasts and projections concurrently. The combined factors of different age-groups being expected to peak at different points throughout the period and age-sex-specific prevalence rates mean that different mental health problems could peak at different times in the short-term. In terms of service planning it seems appropriate to consider the 'worst case scenario', i.e. take the population scenario that suggests the highest number of cases of each mental health problem. In fact, as will be discussed in subsequent sections, the differences in the numbers estimated to be experiencing mental health problems between the short-term forecast and projections are relatively minor.

It must be noted that the forecasts and projections presented here are only possible scenarios of what might happen to Herefordshire's population in the future – if trends change and/or fertility, mortality and migration assumptions are not met the population could be very different.

As mentioned above, the local forecasts take into account the higher than average international in-migration in 2004, without making any assumptions about the effect of any sustained increase. The international migration assumptions for the 2004-based projections are based on movements in the few years prior to the expansion of the European Union; little is known, even at a national level, about the impact of these changes on the population in the longer term.

COMMUNAL ESTABLISHMENT POPULATION

A communal establishment is defined[14] as an establishment providing managed (i.e. supervised full or part-time) residential accommodation. This includes small hotels and guesthouses if they have capacity for 10+ guests (excluding the owner/manager and family), and sheltered housing unless half or more of the residents possess their own facilities for cooking (in which case the whole establishment is classified as separate households).

The only comprehensive information regarding the population living in communal establishments is from the 2001 Census. As Table 8 shows, the numbers and proportions within the age-groups of interest are small, but it is important to consider them, since prevalence rates tend to relate to the population living in private households. A further complication is that some Census information includes resident staff and their families whilst others exclude them.

Table 8: Household & communal establishment residents in Herefordshire, 2001 Census

	Age-group			
	18-34	35-49	50-64	18-64
Total population	30,992	37,193	34,902	103,087
Household residents	30,636	37,028	34,766	102,430
Communal establishment residents (inc. staff)	356	165	136	657
% of age-group living in a communal establishment (inc. staff)	1.2%	0.4%	0.4%	0.6%
Residents (non-staff) of medical & care establishments	112	83	68	263
Residents (non-staff) of education establishments (inc. halls of residence)	84	11	6	101
Residents (non-staff) of other communal establishments*	52	26	26	104
Communal establishment residents (non-staff)	248	120	100	468

Source: 2001 Census, tables S001 & S126 © Crown copyright.
** Hotel; boarding house; guest house; hostel (including youth hostel, hostel for the homeless & people sleeping rough; or other. Residents of Hereford Garrison at Credenhill are not included in any of these figures. Note: the age-groups in this table are different to those used throughout the report due to constraints in published Census data.*

The majority (56%) of residents were in 'medical & care establishments', although a third (34%) of 18-34 year-old residents were in 'education establishments' – likely the halls of residence of the Royal National College for the Blind. Of the 263 residents of medical & care establishments, 17 were in a psychiatric hospital or home.

In their sub-national household projections, which run to 2026, the Office for the Deputy Prime Minister[15] assume that the numbers of people living in communal establishments will remain constant for all ages below 75. In the absence of any other local information, this assumption will be adopted for the purposes of this report.

- In January 2007, there were 81 people aged 18-64 known to the Adult Mental Health Service living in communal establishments: 13 in secure unit placements, 10 in nursing homes, 36 in residential homes (including adult placements) and 22 in supported housing.[16] These would all fall under the classification of 'medical & care establishments' in Table 8.

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[14] 2001 Census, Office for National Statistics
[15] ODPM, now Department for Communities and Local Government (DCLG); 2003-based household projections released in 2006.
[16] Source: Adult Mental Health Service, Herefordshire Primary Care Trust.

Summary: Demographics of Herefordshire

- Herefordshire's current estimated population of 18-64 year-olds is 105,600 – 59% of the total population. The county has an older overall age profile than both the West Midlands region and England and Wales.
- Office for National Statistics projections suggest numbers of 18-64 year-olds may increase by 2.0% by 2012, although more conservative local forecasts which take in to account expected housing provision suggest this increase will only be 0.1% by 2011.
- Projections suggest the 18-64 year-old population could be 107,000 in 2021, an increase of just 1.3% from 2005.
- Recent years have seen a more rapid growth in numbers in older age-groups (55-64s) and a more rapid decline in the younger ones (18-34s) than nationally. This ageing of the age profile is expected to continue, with the 55-64 year-old age-group growing most rapidly (by 7% in the short-term and 21% by 2021).
- The county has a smaller proportion of people from 'Black and Minority Ethnic' (BME) backgrounds than England as a whole (3.5% compared to 14.7%), but this population grew by 40.9% between 2001 and 2004 – much more rapid than the overall population growth of 1.7%. It is likely that numbers have increased further since the expansion of the EU in May 2004: between 2,500 and 3,000 workers from new member states were cleared to work in Herefordshire in 2005, although it is not known how many remain in the county. The county also experiences an annual influx of around 3,000 temporary seasonal agricultural workers – mainly over the summer months.
- In 2004, 3.8% of 18-64 year-olds in Herefordshire were estimated to be from a BME background; just under half of these were non-white.

GENERAL HEALTH IN HEREFORDSHIRE

LIFE EXPECTANCY & GENERAL HEALTH

Herefordshire's population is expected to live longer, on average, than the national population. Based on 2002-04 data, life expectancy at birth in Herefordshire is 77.5 years for males and 82.5 years for females, compared to 76.6 and 80.9 respectively for England. Increases in life expectancy over the last ten years have been broadly in line with national trends.

The 2001 Census asked residents to say how their health had been overall in the last year (from options: good, fair or not good). Overall, 69% of Herefordshire's household residents said they were in 'good' health and 8% were 'not good'.[17] This split is broadly similar to nationally (9% 'not good') and regionally (10%).

7% of Herefordshire residents aged 18-64 said that their health was 'not good', which is again broadly similar to England & Wales and the West Midlands Region (8% and 9% respectively). Propensity to state that health was 'not good' increased with age, from 3% of the county's residents aged 18-24 (2% of those aged 18-19) to 14% of those aged 60-64.

Unsurprisingly, across all ages, much higher proportions of residents of communal establishments stated that their health was 'not good' than in the population as a whole: 11% of 18-19 year-olds, increasing to 42% of 60-64 year-olds in communal establishments.[18] As noted in Table 8, Herefordshire's communal establishment population aged 18-64 was 468 in 2001 (0.5% of all 18-64 year-olds), and 56% of these were resident in medical and care establishments.

[17] 2001 Census, Table T07
[18] 2001 Census, Table T09

LIMITING LONG-TERM ILLNESS

A 'limiting long-term illness' (LLI) is defined as an illness, health problem or disability, which limits daily activity or work. At the 2001 Census, 18% of Herefordshire's total population reported having an LLI – the same proportion as nationally and similar to regionally (19%). Of the county's 18-64 year-olds, 14% said they had an LLI, which is broadly equal to the national and regional figures (both 15%). Table 9 shows how the prevalence of limiting long-term illness increases with age.

Table 9: Percentage of Herefordshire residents* that have an LLI by age group

Age-group	% with LLI	No. with LLI
18-24	7%	964
25-44	9%	4,183
45-59	18%	6,502
60-64	28%	2,818

** All people, including those living in communal establishments.*
Source: 2001 Census, ONS – Crown Copyright

There is no information from the Census regarding the nature of LLIs, and due to the self-reporting nature of the question, it could well be that what is 'limiting' for one person may not be for another. It should also be noted that an LLI in not necessarily a *physical* impairment.

Summary: General Health in Herefordshire
- Herefordshire's population is expected to live longer, on average, than nationally.
- Similar proportions of 18-64 year-olds in Herefordshire were in 'not good' health and/or had a 'limiting long-term illness' as nationally and regionally, according to the 2001 Census.

HEREFORDSHIRE'S OVERALL MENTAL HEALTH

MEASURE OF MENTAL HEALTH

The Regional Lifestyle Survey (2005) examined mental health using a validated measure[19], with raw scores transformed onto a scale of 0 to 100 (100 = best possible health state), and indicated that Herefordshire residents have very slightly better mental health than residents of the region overall. Men report slightly better mental health than women for both geographies (see Figure 10).

Figure 10: Mental health in 12 months prior to Regional Lifestyle Survey, 2005

Source: Regional Lifestyle Survey 2005, Herefordshire Report; HC Research Team

[19] Based on questions which asked people to rate how much they agreed with certain statements related to mental & physical health. The measure is subject to intellectual property rights & may not be reproduced without prior permission being sought from the publishers. Interested parties should either consult WMRO or WMPHO or consult the supplementary technical report.

SUICIDE

Suicide rates in Herefordshire have appeared high in the past relative to England and Wales as a whole, although the difference is not statistically significant due to the small numbers (annual average of 15-16 deaths). Annual fluctuations can be expected because of the small numbers, but the Director of Public Health's Report (2006) recommends the rates should be closely monitored. Suicide prevention has had a high priority in Herefordshire, and the government target of a 20% reduction in the suicide rate between 1995-97 and 2010 is expected to be met.[20]

Consistently more men that women commit suicide, with the 25 to 44 year-old age group particularly vulnerable. This reflects the national situation, where suicide is the biggest single cause of death for men aged 18 to 35.

Table 11: Number of deaths from suicide of people aged 15 to 64, Herefordshire

Year	Male	Female	Total
2002	8	5	13
2003	10	0	10
2004	12	5	17
2005	8	5	13
2006	4	3	7

Source: Health in Herefordshire: Director of Public Health Annual Report, 2006

Summary: Herefordshire's Overall Mental Health

- The Regional Lifestyle Survey indicated that Herefordshire residents have very slightly better mental health than those of the region overall.
- Suicide rates have appeared relatively high in the county in the past; prevention has had a high priority and the government target of a 20% reduction between 1995-97 and 2010 is expected to be met.

SOURCES OF INFORMATION ON ADULTS WITH MENTAL HEALTH PROBLEMS

KNOWN SERVICE USERS

Although information on users of mental health services does exist, it is not possible to obtain robust, comprehensive estimates of the current number of people experiencing mental health problems who are in receipt of services. This is due to the potential for double-counting as a result of the independent databases used by the different service providers, and also to do with inconsistent recording and difficulties in extracting and obtaining information. The available data is presented in subsequent sections, where appropriate. Many systems do not enable the extraction of historic data, so only a snapshot can be provided.

DISABILITY-RELATED BENEFIT CLAIMANTS

People with a disability can claim specific benefits, and whilst there are no specific benefits for mental health disorders, if such a condition significantly interferes with a person's way of life they are eligible to claim. The two benefits that are available to adults aged 18-64[21] are

[20] *Health in Herefordshire: The Annual Report of the Director of Public Health 2006*, Herefordshire Primary Care Trust, p.9.
[21] People over 65 can claim Attendance Allowance.

Disability Living Allowance (DLA) and Incapacity Benefit (IB)/Severe Disablement Allowance (SDA).

Benefits data is presented here to give an indication of actual numbers of people in Herefordshire who meet the criteria for disability-related benefits, but this information is of limited value because:

- although the number aged 18-64 claiming each benefit in Herefordshire is available, it is not possible to obtain detailed information about this age-group at a county level, for example the reason for claim, or numbers who claim both benefits;
- it is not possible to calculate take-up rates as the total number eligible is unknown, so is therefore not possible to determine whether any increases in the numbers of claimants are due to increases in eligible numbers, or to improved take-up due to publicity of welfare rights.

Disability Living Allowance (DLA)

DLA is not income-related, and is paid to people who have required help for three months and are likely to need that help for at least six more months. It comprises two components with different levels depending on the severity of the disability:

- Care component – for people who need help with their personal care(i.e. attention in connection with their bodily functions and/or continual supervision to avoid substantial danger to themselves or others), with three possible rates (higher, middle or lower)[22];
- Mobility component – for people who have difficultly walking, with two possible rates (higher or lower).[23]

A person can only begin claiming DLA if they are under 65, but can continue to receive it after this age if they satisfy the criteria. As shown in Table 12, roughly two-thirds of Herefordshire claimants are aged 18-64. In 2005, 4.5% of the county's population aged 18-64 are claiming DLA: 4,700 people.

The number of claimants in Herefordshire increased by 7.1% between 2003 and 2005, whilst the population grew by just 1.2%. However, this rise could be related to improvements in take-up rates rather than an increase in prevalence.

Table 12: Claimants* of either (or both) component(s) of Disability Living Allowance, Herefordshire

	2003	2004	2005	2006
All ages	6,560	6,890	7,200	7,430
Aged 18-64	4,390	4,550	4,700	4,860
% of all claimants aged 18-64	*67%*	*66%*	*65%*	*65%*
% of population aged 18-64 claiming	4.2%	4.3%	4.5%	-

Source: Work and Pensions Longitudinal Study, Department for Works and Pensions.
** All entitled: those in receipt of payment and those whose payment has been suspended, e.g. if in hospital. Count is snapshot as at 31st August each year; all figures rounded to nearest 10.*

Information on the numbers of people claiming each rate of DLA is also published, but it is only possible to obtain exact counts at a county level for the population of working age[24] (see Tables 13 & 14).

[22] Higher rate paid to those who need help during the day *and* night; middle to those who need help during the day *or* night; lower rate to those who need help during some of the day or cannot prepare a cooked meal for themselves given the ingredients.
[23] Higher rate paid to those who are (virtually) unable to walk; lower to those who can walk but need help outside on unfamiliar routes.
[24] 16 to 59 for females; 16 to 64 for males.

Table 13: Claimants* of Disability Living Allowance (DLA) *Care Component* (working age), Herefordshire

Rate	2003	2004	2005	2006
Higher	880	880	920	980
Middle	1,170	1,250	1,300	1,330
Lower	1,410	1,480	1,570	1,630
Nil (i.e. eligible for mobility comp. only)	560	530	530	510
All rates	4,020	4,150	4,320	4,450

Source: Work and Pensions Longitudinal Study, Department for Works and Pensions.
** All entitled: those in receipt of payment and those whose payment has been suspended, e.g. if in hospital. Count is snapshot as at 31st August each year; all figures rounded to nearest 10.*

Table 14: Claimants* of Disability Living Allowance (DLA) *Mobility Component* (working age), Herefordshire

Rate	2003	2004	2005	2006
Higher	2310	2350	2390	2420
Lower	1200	1300	1370	1470
Nil (i.e. eligible for care comp. only)	500	500	560	550
All rates	4020	4150	4320	4450

Source: Work and Pensions Longitudinal Study, Department for Works and Pensions.
** All entitled: those in receipt of payment and those whose payment has been suspended, e.g. if in hospital. Count is snapshot as at 31st August each year; all figures rounded to nearest 10.*

People can claim DLA because of any disabling condition, but it is not possible to obtain information on the reason for claim at county level. As at August 2006 the main disabling condition of 19% of all DLA claimants aged 18-64 in Great Britain was 'mental health causes' – the largest single disabling condition. The equivalent figure for the West Midlands region was slightly lower, at 16%; only 'arthritis' was more common (18%).

- As the Regional Lifestyle Survey suggests that mental health in Herefordshire is slightly better than in the region as a whole, it seems most appropriate to take this lower percentage to estimate that around 780 people aged 18-64 in Herefordshire may be claiming DLA for this reason – i.e. may need some level of care because of a 'mental health reason'.

The number of people aged 18-64 claiming each level of each component of DLA for a 'mental health reason' is not available for any geography, and as rates may vary with age it is therefore not appropriate to attempt to estimate how many claimants of each type in Herefordshire are aged 18-64 and claiming for a 'mental health reason'.

Incapacity Benefit (IB) / Severe Disablement Allowance (SDA)

IB is paid to those who cannot work because of an illness or disability and who meet certain National Insurance contribution requirements. Until 2001 SDA was paid to those who were unable to work but did not meet the contribution criteria; these people can still receive SDA but no new claims can be made.

Although these benefits are primarily for people of working age, some claimants are still able to receive them once they pass state retirement age.[25] However, as Table 15 shows, almost all claimants in Herefordshire have been aged 18-64 (98%) since 2003: around 5,900 each year. These figures indicate that 5.6% of the population aged 18-64 in Herefordshire are claiming IB/SDA each year.

Detailed data regarding the reason for a claim is only available for the population as a whole (i.e. all claimants aged 16 and above). Over a third of people claiming IB/SDA each year are unable to work because of a 'mental disorder' (Table 15). This is the single most

[25] Currently 60 for women; 65 for men. There is no upper limit for SDA once it has been claimed, and the short-term rate of IB can be paid for up to a year after retirement age.

common reason for claiming, and the proportion has increased slightly each year since 2002 (from 35% to 38%). These proportions are similar to regionally, and about two percentage points lower than the proportion in England as a whole each year.

Table 15: Claimants of Incapacity Benefit (IB) or Severe Disablement Allowance (SDA), Herefordshire

	2003	2004	2005	2006
Total IB/SDA claimants (all ages)	5,960	5,970	6,040	5,890
No. of people (all ages) claiming IB/SDA due to ‘mental disorders’	2,090	2,150	2,190	2,220
% of all IB/SDA claimants (all ages) claiming due to ‘mental disorders’	*35%*	*36%*	*36%*	*38%*
No. of IB/SDA claimants aged 18-64	5,850	5,850	5,920	5,800
% of all IB/SDA claimants aged 18-64	*98%*	*98%*	*98%*	*98%*
% of population aged 18-64 claiming IB/SDA	5.6%	5.6%	5.6%	-

Source: Work and Pensions Longitudinal Study, Department for Works and Pensions. Count is snapshot as at 31st August each year; all figures rounded to nearest 10.

The increasing trend in claims due to mental disorders is further illustrated by considering the change in numbers: whilst the total number claiming IB/SDA has fluctuated annually, and *fell* by 70 people (1.2%) overall between 2003 and 2006, the number claiming due to mental disorders has increased each year up to a total of 130 people over the period (a growth of 6.2%).

- Although the exact number of people aged 18-64 claiming because of a mental disorder cannot be obtained, if it can be assumed that the distribution of reasons claiming are the same for 18-64 year-olds as for all people aged 16 and over[26] it could be estimated that, as at August 2006, around 2,175 18-64 year-olds in Herefordshire are claiming IB/SDA because of a ‘mental disorder’.

Discussion

The claimant figures suggest that more people aged 18-64 in Herefordshire are unable to work because of a disability (5,800) than require care because of a disability (4,860), although it is not possible to determine how many people are unable to work *and* require care. It is estimated that over 2,000 people aged 18-64 are unable to work because of a ‘mental disorder’. These facts should be noted when considering ability to pay for services.

The reason for there being 940 more claimants of IB/SDA than DLA is unknown; there could be a real difference in the effects of disabilities on peoples’ lives, or there may be differences in take-up. No estimates of the proportion of people who are eligible for a disability-related benefit exist, even at a national level, although the Department for Works and Pensions have commissioned a study into the feasibility of estimating DLA take-up.[27] However, ‘best guesses’ of take-up are said to be ‘discouraging’, particularly in relation to younger people’s take-up of DLA (not least because half of applications fail). It is expected that a greater proportion of those who are eligible for IB are claiming it (i.e. take-up is higher), as it is accessed through long-term sick pay. [28]

[26] This is possibly an unrealistic assumption, particularly if considering older people. However, given that 98% of claimants are aged 18-64 it seems reasonable for this purpose.
[27] By the Policy Studies Institute: www.psi.org.uk/research/project.asp?project_id=151
[28] Marsh, A (2006) *The trouble with take-up. The Monitor: Blue Skies.* Issue no. 143, Vol. 1 http://www.epolitix.com/EN/Publications/Blue+Skies+Monitor/143_1/home.htm

NATIONAL ESTIMATES OF PREVALENCE OF MENTAL HEALTH PROBLEMS

There are several different ways of measuring mental health problems:
- 'prevalence' – number of cases of a particular diagnosis at one point in time;
- 'lifetime prevalence' – number of people who have experienced a particular problem at any time in their lives;
- 'incidence' – number of new cases arising over a particular time period.

To get a true understanding of the extent of mental health problems, it is best to consider these measures in conjunction with each other, although it is not always possible to obtain data on all of them.

The most reliable way of estimating rates is to undertake a survey of the general population. In Great Britain the largest survey of this kind was the *Survey of Psychiatric Morbidity among Adults in Private Households*, carried out in 2000 by the Office for National Statistics on behalf of the Department for Health.[29] The rates derived from this survey are the most widely quoted amongst the relevant literature so are used as much as possible in this Herefordshire Needs Analysis.

The ONS survey provides age-sex specific rates for the prevalence of neurotic disorders (common mental health problems), personality disorders and probable psychotic disorders.

Organic psychoses (such as dementia) are not covered by the ONS survey – and neither are eating or sexual disorders[30] [pp.13 & 14]

Other surveys relating to specific conditions have been published; a survey into the prevalence of early onset dementia has been utilised to estimate numbers with this condition.

The following sections are arranged by type of mental health problem, with estimated and projected numbers of people in Herefordshire according to national observations presented alongside any available information about known service users in the county.

Underlying the subsequent sections is the assumption that future prevalence will remain at current levels. It is impossible to be categoric about this, and it is important to bear in mind some suggestions that it could increase; as well as changes in incidence, it is possible that there could be changes in treatment and diagnosis. However, there is a lack of information – even at a national level – on likely future scenarios with regard to mental health problems.

In a recent Institute of Public Policy Research report for the Disability Rights Commission on "…the possible circumstances and experiences of disabled people by 2020"[31], possible future trends are projected using observed changes in self-reporting of a long-term health problem or disability and type of impairment in the ONS Labour Force Survey between 2001 and 2004.

'Mental illness' is one of the impairment groups, and the work indicates that there could be "…a notable increase in the number of people with mental health impairments across all the younger age groups"[32] (i.e. all age groups below 50 years). The authors note that "[t]his is consistent with the World Health Organisation prediction that depression will be the leading cause of disability by 2020 (WHO 2001)."

However, they qualify all of their work with the caution that "…the fact that a pattern has occurred between 2001 and 2004 is not a guide to the pattern occurring over the next four

[29] www.mind.org.uk/Information/Factsheets/Statistics/Statistics+1
[30] Singleton, N. et al (2001) *Psychiatric Morbidity among Adults living in Private Households, 2000.* The Stationery Office, London. pp.13 & 14.
[31] Pillai, R et al (March 2007) *Disability 2020: Opportunities for the full and equal citizenship of disabled people in Britain in 2020*. Disability Rights Commission; p.18.
[32] Ibid, p.49.

years, much less over the next 15 years. None the less, these extrapolations give at least some indication of one possible future scenario, although we cannot make any claims for its likely accuracy."[33] Their findings for the UK could be applied to Herefordshire's population, but the broad classification of 'mental illness' would not give any real insight with regard to likely future demand for services from adults with mental health problems.

Summary: Sources of Information on Adults with Mental Health Problems

- It is not possible to obtain robust, comprehensive estimates of the number of people experiencing mental health problems who are in receipt of services. This is due to the potential for double-counting as a result of the independent databases used by the different service providers, and also to do with inconsistent recording and difficulties in extracting and obtaining information.
- It is estimated that around 780 people aged 18-64 in Herefordshire may be claiming Disability Living Allowance (i.e. may need some level of care) for a 'mental health reason' in August 2006, and that at the same time around 2,175 are claiming Incapacity Benefit or Severe Disablement Allowance because of a 'mental disorder'.
- Estimates and future projections have been produced for the purpose of this report, mainly using the *Survey of Psychiatric Morbidity among Adults in Private Households*, carried out in 2000 by the Office for National Statistics on behalf of the Department for Health. These assume that prevalence rates in Herefordshire will remain at the same level as in Great Britain as a whole in 2000. This is despite some suggestions that prevalence may increase, for which no robust information exists, even at a national level.

MENTAL HEALTH PROBLEMS AMONGST ADULTS IN HEREFORDSHIRE

COMMON MENTAL HEALTH PROBLEMS (NEUROTIC DISORDERS)

Definition

Common mental health problems are conditions traditionally referred to as "neuroses", which exhibit symptoms that can be regarded as severe forms of 'normal' emotional experiences.[34] These symptoms include fatigue and sleep problems, forgetfulness and concentration difficulties, irritability, worry, panic, hopelessness, and obsessions and compulsions, but to such a degree that they cause distress and problems with daily activities.[35]

Estimated Numbers

The possible numbers of household residents aged 18-64 in Herefordshire with different types of neurotic disorders for the different years of interest are shown in Table 16. These estimates are derived from applying the age-sex-specific prevalence rates from the ONS survey of psychiatric morbidity. Interviewees in the survey were classified as having a neurotic disorder if they had experienced symptoms of the particular disorder[36] during the past week. Clearly 'mixed anxiety and depressive disorder' is much more prevalent than any other, but this "…is a 'catch-all' category which included people…who could not be coded into any of the other five neurotic disorders"[37] (ONS, 2000, p. 24).

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[33] Ibid, p.46.
[34] Mental Health Foundation website: http://www.mentalhealth.org.uk/information/mental-health-overview/mental-health-introduction
[35] Singleton et al (2001), p.153
[36] By applying algorithms based on the ICD-10 diagnostic criteria for research (ibid, p.24)
[37] Ibid, p.24

Assuming that these rates are appropriate for Herefordshire's household population, both at the time of the survey and into the future, there is not expected to be a dramatic change in the number of people with any particular neurotic disorder, particularly in the longer term.

Table 16: Household residents aged 18-64 with neurotic disorder(s), Herefordshire

Disorder	Past Estimate	Current Estimate	Short-term Projection				Long-term Projection	
	2001	2005	2011 (forecast pop'n)	2011 (projected pop'n)	2012 (projected pop'n)	*% change in short-term**	2021 (projected pop'n)	*% change in long-term*
Mixed anxiety & depressive disorder	9,300	9,450	9,450	9,700	9,650	*3%*	9,500	*1%*
Generalised anxiety disorder	5,150	5,250	5,200	5,350	5,350	*2%*	5,250	*0%*
Depressive episode	3,000	3,050	3,050	3,100	3,100	*2%*	3,050	*0%*
All phobias	2,000	2,050	2,000	2,050	2,050	*0%*	2,000	*-2%*
Obsessive compulsive disorder (OCD)	1,250	1,300	1,300	1,350	1,350	*4%*	1,300	*0%*
Panic disorder	800	800	800	850	850	*6%*	850	*6%*
ANY NEUROTIC DISORDER(S)	17,900	18,250	18,250	18,700	18,650	*2%*	18,350	*1%*

Source: Herefordshire Council Research Team using ONS estimates, projections and rates.
** Percentage change is presented as change between 2005 estimate and the highest number of cases suggested by the rates according to either the 2011 forecast; 2011 or 2012 projection.*
Note: counts rounded to nearest 50; totals don't sum as people can have more than one disorder.

The rates suggest that 1 in 6 (17%) of Herefordshire's household residents aged 18-64 were suffering from a common mental health problem in 2005 (18,250 people). Assuming that these prevalence rates remain constant, this proportion is expected to be the same in 2021: this would represent a 1% growth in the number of people with common mental health problems (an extra 100 people).

According to these national rates, the largest number of adults with common mental health problems living in households would be expected in 2011 – if the ONS projection were realised (18,700 people; a growth of 2% from 2005). According to the more conservative local forecast, the overall number in 2011 would be expected to remain at similar levels to 2005.

As already mentioned (p.15), the Institute of Public Policy Research report that the World Health Organisation predict "…depression will be the leading cause of disability by 2020…"[38], but it has not been possible to establish any quantifiable relationship between this suggestion and the incidence of common mental health problems in Herefordshire.

Known service users & discussion

Although notably higher than the proportion of those without neurotic disorder, according to the ONS survey only two-fifths (39%) of those identified as having a neurotic disorder had spoken to their GP about a mental or emotional problem in the previous year (6% of those without).[39] Less than a quarter (24%) of those exhibiting significant neurotic symptoms were currently receiving treatment (either medication or therapy) for a mental or emotional problem.[40] For these reasons, it would be impossible to ascertain whether the national prevalence rates produce accurate estimates.

[38] [38] Pillai, R et al (March 2007) *Disability 2020: Opportunities for the full and equal citizenship of disabled people in Britain in 2020*. Disability Rights Commission; p.49.
[39] Singleton et al (2001), p.105.
[40] Ibid, p.103.

However, despite the above, many statistics point to mental health problems being very common in GP consultations. For instance, the Department of Health's *Choosing Health* consultation in March 2004 indicated that up to 1 in 4 GP consultations concern mental health issues[41], and Mann (1992)[42] suggested that 90% of depression is managed in primary care – with this problem being the third most common reason for GP consultations.[43]

Whilst GPs have to supply a certain amount of information regarding patients to the Primary Care Trust[44], much of the specific information is held in their local systems and it was not possible to access this for this report, although it may be possible in the future.

- The only statistic that is available is that 1,285 patients[45] *of any age*, of all 24 GP practices in Herefordshire, were newly diagnosed (i.e. incidence) as experiencing a single major depressive episode in 2006-07. It is not possible to estimate how many of these may be aged 18-64 as prevalence, and therefore incidence, varies according to age.[46]

The only more detailed information on adults experiencing common mental health problems is from the Adult Mental Health Service caseload audit in January 2007. This secondary service deals with cases that are too serious to be dealt with by a GP alone. There were 1,004 such cases, which are presented in Table 17. It must, however, be noted that a person may be counted more than once if they saw more than one care co-ordinator, although it is not possible to ascertain the extent of this. It would be expected that most of these people would also be known to GPs, so therefore some may be included in the *incidence* figure of 1,285 – although not all, as some cases would have occurred before April 2006.

Table 17: 18-64 year-olds identified by caseload audit as receiving care from Herefordshire Adult Mental Health Service for a common mental health disorder (primary diagnosis), January 2007

Diagnosis	Caseload	% of common mental health problem cases
Anxiety	197	19.6%
Depression	606	60.4%
Neuroses	75	7.5%
Obsessive compulsive disorder (OCD)	80	8.0%
Post traumatic stress disorder (PTSD)	46	4.6%
Total common mental health problem	1,004	100%

Source: Adult Mental Health Caseload Audit, Herefordshire PCT, January 2007

Due to differences in classifications, the only possible comparison is between known and estimated obsessive compulsive disorder (OCD). It is to be expected that prevalence rates would estimate many more cases than are being treated by secondary services – the rest

[41] Sainsbury Centre for Mental Health (2006) *Prevalence – how common are mental health problems?* www.scmh.org.uk

[42] Cited in: NHS (2005) *Marginalised groups – people with mental health problems*. www.library.nhs.uk/mentalhealth

[43] Effective Health Care Bulletin (2002) *Improving the recognition and management of depression in primary care* Vol. 7. No. 5. NHS Centre for Reviews and Dissemination. The University of York. Cited in: *Fast Forwarding Primary Care Mental Health – Graduate primary care mental health workers: Best Practice Guidance (2003)*

[44] GPs are required to supply data on certain performance targets to the PCT under the Quality and Outcomes Framework (QOF) for GPs, as part of the new GP contract.

[45] Not necessarily residents of Herefordshire, as there is no restriction on registering with a GP outside county of residence. Conversely, Herefordshire residents with mental health problems may be registered with a GP outside the county.

[46] Singleton et al (2001), p.24.

would be expected to be either not be receiving treatment, or being treated in primary care – by their GP. However, the proportions are reasonably similar: 7.1% of the estimated number of people with any neurotic disorder have OCD, in comparison with 8.4% of all cases identified in the caseload audit. However, a significant caveat with this comparison is that it assumes no double-counting in the audit.

If these figures could be considered robust counts of adults receiving a service from the Adult Mental Health Service run by Herefordshire PCT because of a common mental health problem, it could be estimated that around 5% of people experiencing such a problem require secondary care. If this were the case, none of the population scenarios considered would result in a noticeable increase in potential service users: no more than 10 extra by 2011 if the ONS projection were realised, but only 5 or 6 more than in 2005 by 2021.

- There are (April 2007) 15 people aged 18-64 with common mental health problems living in managed accommodation in Herefordshire: one in a nursing home, three in residential homes and eleven in supported housing. These people are not included in any of the estimates using the prevalence rates, but would be expected to be included in the caseload audit, and in the GP figures if onset was in 2006-07.

Summary: Common Mental Health Problems

- An estimated 18,250 adults aged 18-64 were experiencing common mental health problems in Herefordshire in 2005.
- Assuming that the national prevalence rates from 2000 remain appropriate, no notable change is expected in the number of adults experiencing common mental health problems in the county in the short-term (i.e. up to 2012).
- The same assumption yields an expected 1% increase in numbers by 2021: 100 extra people;
- Assuming that those who need to are currently accessing secondary services, this could be expected to equate to an extra 5 or 6 people requiring secondary mental health services in 2021.

PSYCHOTIC DISORDERS

Definition

Psychotic symptoms are less common than 'neurotic' symptoms, and interfere with a person's perception of reality, possibly including hallucinations - i.e. seeing, hearing, smelling or feeling things that no-one else can.[47] In the ONS *Survey of Psychiatric Morbidity among Adults in Private Households* psychotic disorders were defined as "…one of a number of disorders under the ICD-10 categories of 'schizophrenia, schizotypal and delusional disorders' and affective disorder such as manic episodes and bipolar affective disorder." These disorders are known as 'severe and enduring mental health problems'[48], and people with them would be expected to need higher levels of treatment and/or care than the majority experiencing 'common mental health problems'.

Due to the way that the survey was conducted, and as it is very difficult for a non-specialist interviewer to make assessments of psychotic disorders, ONS present prevalence of 'probable' psychotic disorder.[49] Respondents were diagnosed as having a 'probable' psychotic disorder if they were assessed as such at a clinical interview, or if they didn't have a clinical interview but had two or more indicators of psychosis in the initial interview.[50]

Estimated Numbers

The national prevalence rates suggest that there has not been any noticeable change in the number of people in the county with these conditions between 2001 and 2005, and numbers are not expected to change either by 2012 or 2021 (see Table 18).

Table 18: Household residents aged 18-64 with probable psychotic disorder(s), Hfds

Disorder	Past Estimate	Current Estimate	Short-term Projection				Long-term Projection	
	2001	2005	2011 (forecast pop'n)	2011 (projected pop'n)	2012 (projected pop'n)	*% change in short-term**	2021 (projected pop'n)	*% change in long-term*
Probable psychotic disorder	600	600	600	600	600	*0%*	600	*0%*

Source: Herefordshire Council Research Team using ONS estimates, projections and rates.
** Percentage change is presented as change between 2005 estimate and the highest number of cases suggested by the rates according to either the 2011 forecast; 2011 or 2012 projection.*
Note: counts rounded to nearest 50.

Known service users

Primary Care

- According to data provided to the Primary Care Trust by GPs under the 'Quality and Outcomes Framework' (QOF), there were 1,210 cases of psychosis, schizophrenia or bi-polar affective disorder (i.e. psychotic disorders) known to GPs in Herefordshire[51] as at 31st March 2007. This equates to an overall prevalence (in the total population) of 0.7%[52] (678 per 100,000 population). This prevalence is based on the total number of patients, but it is extremely unlikely that any of these 1,210 cases would be under 16.

The overall prevalence of 0.7% is identical to the equivalent figure for England, which indicates that local prevalence is the same as national – although an overall figure such as this takes no account of differences in age structure. Having said this, although age-specific

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[47] Mental Health Foundation: http://www.mentalhealth.org.uk/information/mental-health-overview/mental-health-introduction
[48] London Health Observatory: http://www.lho.org.uk/HIL/Disease_Groups/MentalHealth.aspx
[49] Singleton et al (2001), pp.16-17.
[50] Ibid, p.82.
[51] i.e. registered with a Herefordshire GP. Therefore could include some cases living out of county, and could exclude some cases in Herefordshire registered with a GP in another county.
[52] Based on 178,341 registered patients – of all ages.

prevalence rates were presented, the ONS survey found no significant differences in prevalence between age-groups amongst household residents aged 18 and over.[53]

- Making the major assumption that the age distribution of psychotic disorders known to GPs in Herefordshire in 2006-07 is equal to the age distribution of the population as a whole at mid-2005, it could be estimated that there were 874[54] cases of psychosis, schizophrenia or bi-polar affective disorder in patients aged 18-64 known to GPs in Herefordshire.

The equivalent count for 2005-06 was 943 (an estimated 681 aged 18-64 using the same assumptions as previously), but an additional 267 cases of psychotic disorder in one year seems unrealistic. It is expected that this 28% increase in known cases is related to changes in GP recording/reporting systems rather than a sudden jump in prevalence or registered patients (the number of people registered with a GP grew by less than 1% over the same period).

Secondary care

- According to the Adult Mental Health Service caseload audit in January 2007, 832 people aged 18-64 were receiving a service because of a psychotic disorder (see Table 19). The audit suggests that over two-thirds of cases are diagnosed as 'schizophrenia'. However, there is significant doubt as to how accurate the counts are due to these large numbers. It is likely that some service users worked with more than one care co-ordinator, and would therefore be double counted in the audit.

Table 19: Caseload of 18-64 year-olds receiving care from Adult Mental Health Service for a psychotic disorder (primary diagnosis), Herefordshire, January 2007

Diagnosis	Caseload	% of psychotic disorder cases
Bipolar	156	18.8%
Psychosis	108	13.0%
Schizophrenia	568	68.3%
Total psychotic disorder	832	100%

Source: Adult Mental Health Caseload Audit, Herefordshire PCT, January 2007

It would be expected that most of the Adult Mental Health service users identified by the caseload audit would also be known to GPs; the estimated numbers aged 18-64 from both of these sources are reasonably similar.

Discussion

Both the estimated number of cases known to GPs (874) and the (possible) number receiving a service from the Adult Mental Health service (832) seem markedly higher than the prevalence rates would suggest (600), but the following must be borne in mind:

- the GP estimate is based on a significant assumption regarding the age distribution of these disorders in Herefordshire;
- the caseload audit may include double counting where a person has seen more than one care co-ordinator;
- the 600 is an estimate of the number of *household* residents.

In early 2007, there were 49 people aged 18-64 diagnosed as having a 'psychosis' or 'psychopathic disorder' living in managed accommodation in Herefordshire.[55] It is expected that these are included in the counts of known service users, but they would not be included in the estimate from the rates.

[53] Singleton et al (2001), p.26.
[54] 2005 mid-year estimate: 72% of population aged 16+ is aged 18-64.
[55] Source: Adult Mental Health Service, Herefordshire Primary Care Trust; 33 in residential/ nursing homes; 7 in secure units; 9 in supported housing.

Nevertheless, even after adding an extra 50 people to the estimate of 600 using national prevalence rates, it would appear that there are 200 more adults with psychotic disorders currently accessing either primary or secondary care services in Herefordshire than the rates suggest. As this group of people are the most likely to require intensive services, this kind of discrepancy would have a significant impact on the cost of providing these services. Therefore, it is important to try and understand the large difference.

It is not possible to ascertain the extent of double counting in the Adult Mental Health caseload audit – therefore it is not appropriate to assume that the figure of 832 is an accurate count of the number of 18-64 year-olds with a psychotic disorder receiving secondary services.

It would be hoped that information from the GP Quality and Outcomes Framework would be more accurate, but it is still possible that there are definitional differences between what constitutes 'psychosis, schizophrenia or bi-polar affective disorder' according to a GP and what is a 'probable psychotic disorder' based on the national survey.

Indices produced by Durham University[56] suggest that, in view of its social characteristics, Herefordshire would be expected to have a lower prevalence of severe mental health problems (such as psychotic disorders) than nationally (by approximately 20%). Crudely[57] applying this to the 600 people estimated using the national rates would suggest that the county would be expected to have just under 500 household residents aged 18-64 with a probable psychotic disorder. This would further widen the gap between the estimated and 'known' figures.

However, as mentioned above, this is in direct conflict with the QOF data, which suggests (using a crude overall prevalence rate) that Herefordshire has a similar prevalence to England as a whole.

Therefore, it is not possible to reconcile the figures suggested by the national prevalence rates and the estimated number of adults known to GPs with psychosis, schizophrenia or bi-polar affective disorder.

Nonetheless, a useful conclusion can still be drawn from the fact that the estimated numbers of 18-64 year-old household residents with a probable psychotic disorder using the national prevalence rates do not change over the period 2001 to 2021. Therefore, despite the discrepancies discussed above, there is no reason to assume that more people in Herefordshire will require treatment for a psychotic disorder, either in 2012 or 2021, than do currently.

Summary: Psychotic Disorders

- There are an estimated 874 cases of 'psychosis, schizophrenia or bi-polar affective disorder' known to GPs in Herefordshire in January 2007.
- This figure is higher than national prevalence rates would suggest (600 household residents) - even after accounting for approximately 50 people in communal establishments, and it has not been possible to reconcile these figures.
- Despite this large discrepancy, there is no reason to assume that more people in Herefordshire will require treatment for a psychotic disorder either in 2012 or 2021, than do currently.

[56] On behalf of the Department of Health & the Care Services Improvement Partnership; Adult Mental Health Service Mapping website: www.amhmapping.org.uk/reports/workbook.php

[57] i.e. not taking age structure into account. However, although age-specific rates were presented and used to calculate the estimate, the national survey found no significant difference in prevalence by age.

PERSONALITY DISORDERS

Definition

The ONS *Survey of Psychiatric Morbidity among Adults in Private Households* uses the American Psychiatric Association's DSM-IV definition of a personality disorder, i.e. 'an enduring pattern of inner experience and behaviours that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment.'[58]

Estimated Numbers

Assuming that they are appropriate for Herefordshire's current and future population, the national prevalence rates suggest that there were 4,650 household residents with a personality disorder in mid-2005 – as shown in Table 20. Both short- and long-term projections could be expected to result in a 3% rise in this number: to 4,800. However, the more conservative local forecast would suggest only a 1% increase in the short-term (to 4,700).

Table 20: Household residents aged 18-64 with personality disorder(s), Herefordshire

	Past Estimate	Current Estimate	Short-term Projection				Long-term Projection	
Disorder	2001	2005	2011 (forecast pop'n)	2011 (projected pop'n)	2012 (projected pop'n)	*% change in short-term**	2021 (projected pop'n)	*% change in long-term*
Personality disorder[59]	4,500	4,650	4,700	4,800	4,800	*3%*	4,800	*3%*

Source: Herefordshire Council Research Team using ONS estimates, projections and rates.
** Percentage change is presented as change between 2005 estimate and the highest number of cases suggested by the rates according to either the 2011 forecast; 2011 or 2012 projection.*
Note: counts rounded to nearest 50.

Known service users

Nothing is known about adults with a personality disorder in Herefordshire who are receiving treatment or care from a GP; the only information is from the Adult Mental Health Service caseload audit in January 2007, which suggests that care co-ordinators in the secondary service were working with 62 people with this diagnosis.

In early 2007, there were 4 people aged 18-64 diagnosed as having a 'personality disorder' living in managed accommodation in Herefordshire: one in a residential home, one in a medium secure unit, and two in supported housing.[60] It is expected that these are included in the caseload audit, but they would not be included in the estimate from the rates.

Discussion

The known cases are tiny in comparison with the estimated number according to the prevalence rates (just 1.3% of this estimate), but it is it to be expected that not all people with a personality disorder will come into contact with secondary mental health services[61] - probably even the majority. There is a history of these services not taking on people with personality disorder (not least because of a lack of treatments to offer them and associated statutory constraints), although recent national policy[62] is starting to challenge this. Some people may receive the treatment they need from their GP, or cases may be not be known to service providers at all. It is also possible that personality disorders are misdiagnosed or co-exist with another mental health problem, so that the person is recorded as having

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[58] Singleton et al (2001), p.17.
[59] Including the following types of personality disorder: obsessive-compulsive, avoidant, schizoid, paranoid, borderline, antisocial, dependent, schizotypal, histrionic and narcissistic.
[60] Source: Adult Mental Health Service, Herefordshire Primary Care Trust.
[61] Hawkings, C. and Gilburt, H. (2004) *Dual diagnosis toolkit; mental health and substance misuse: a practical guide for professionals and practitioners*. Rethink and Turning Point, p.19
[62] Such as *No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder*. National Institute for Mental Health in England (2003)

another mental health problem instead. This is a particular problem because the symptoms of personality disorders can be more general than those of other mental health problems.[63]

Therefore, it is not possible to determine whether the rates produce an accurate estimate of the actual numbers, but in the absence of any other information it must be assumed that they do.

Summary: Personality Disorders

- There were an estimated 4,650 household residents aged 18-64 in Herefordshire with a personality disorder in 2005.
- If prevalence were to continue at the same levels, forecast population changes would result in this number increasing by around 50 people (1%) in the short-term (i.e. up to 2012).
- In the longer term, in 2021, projections would suggest a 3% growth in the number, to 4,800 adults (an increase of around 150 people)
- It is estimated that currently around 60 adults receiving secondary specialist mental health care have a primary diagnosis of 'personality disorder' – just 1.3% of all estimated cases. It is not possible to determine how many people are diagnosed within primary care.
- This large discrepancy may be explained by considering that large numbers of people with a personality disorder do not require specialist services, or may be misdiagnosed with another mental health problem. There has also been a history of secondary services not taking them on because of a lack of treatments and associated statutory constraints, although national policy is starting to challenge this.

EARLY ONSET DEMENTIA

Definition

Early – or young – onset dementia is defined by the Alzheimer's Society[64] as a 'broad range of conditions that can cause dementia in [people under 65]'. As it is rare, no national population based surveys have been conducted to estimate prevalence rates – so the only sources are relatively small, local studies based on known cases. A recent report[65] for the Alzheimer's Society considered all such studies and used an 'expert consensus group' to produce more robust prevalence rates.[66]

Estimated Numbers

Assuming that once age and gender are accounted for these rates are suitable estimates of prevalence for Herefordshire, the current and projected numbers of people with early onset dementia are shown in Table 21.[67] The projected growth in the population could be expected to result in a small increase in the number of cases of early onset dementia in the county, from an estimated 52 in 2005 to 55-56 in 2011/12, and 60 in 2021. For all years, around three-quarters of cases could be expected to be people aged 55-64.

[63] Hawkings and Gilburt (2004), p. 19

[64] *Younger people with dementia: an approach for the future* (2005), Alzheimer's Society, London.

[65] Knapp, Prof. M. et al (2007) *Dementia UK: The Full Report.* Alzheimer's Society, London

[66] Using the Expert Delphi Consensus methodology, whereby ten leading UK and European experts systematically reviewed currently available research data and "…reached a consensus to produce the best possible estimates" (Knapp et al, p.xii).

[67] The Alzheimer's Society will be publishing local authority estimates using these rates "…in due course" (Knapp et al, p.24).

Table 21: Estimated & projected number of Herefordshire residents aged 30-64 with dementia

Age-group	Current	Short-term			Long-term
	2005	2011 (forecast pop'n)	2011 (projected pop'n)	2012 (projected pop'n)	2021 (projected pop'n)
30-54	15	15	16	16	15
55-64	37	40	40	40	45
Total	52	55	56	56	60

Source: Herefordshire Council Research Team. Note: unrounded figures presented due to very small numbers, but these cannot be assumed to be exact as the population figures upon which they are based are only estimates.

Even after assuming that these rates are appropriate for Herefordshire, it should be noted that the studies that these rates were based on would have had large confidence intervals given the small sample sizes. For instance, according to one study[68] the 95% confidence interval for prevalence amongst women aged 60-64 was between 75 and 207 cases per 100,000 population. Confidence intervals are not presented in the new report, but the estimates should still be considered with caution.

It is also likely that these rates under-estimate the true prevalence, as the studies depend on known cases where dementia is diagnosed in someone under 65, and therefore assume that all people seek help in the early stages of the disease[69] - and are correctly diagnosed.

Furthermore, the rates are based on studies that are at least 15 years old – no epidemiological studies of dementia have been carried out in the UK more recently. Current age- and sex-specific prevalence rates may be different if "[c]hanges in incidence (perhaps linked to improvements in diet and cardiovascular health) and[/or] survival (improved medical and social care)…"[70] have occurred. The same caveat applies to projecting future numbers.

Prevalence rates for type of dementia have been produced, but given the small numbers it is not appropriate to attempt to estimate local numbers. However, points worth noting regarding potential causes are:

- Alzheimer's disease was considered the dominant subtype among women of all ages;
- Fronto-temporal dementia[71] was considered the dominant subtype among younger men (30-54), whilst vascular dementia[72] was dominant amongst the older age-groups (55-64);
- Furthermore, the Harvey study (1998) found that 12.5% of cases of early onset dementia were attributable to alcohol-related brain impairment, which is preventable.

Known service users

There are currently (March 2007) 22 people with dementia under the age of 65 known to Mental Health Services in Herefordshire, i.e. about two-fifths of the number suggested by the national prevalence rates. A study in Southampton found a similar pattern: one-third of estimated cases were known to service providers.[73]

[68] Harvey, Dr. R J (1998) *Young Onset Dementia: Epidemiology, clinical symptoms, family burden, support and outcome*. Dementia Research Group, Imperial College School of Medicine.
[69] Knapp et al (2007), p.15.
[70] Knapp et al (2007), p.20.
[71] A rare form of dementia (including Pick's disease), that affects the front of the brain. Memory can remain intact in the early stages, although behaviour and personality change (Knapp et al p.xii).
[72] Caused by problems with the supply of oxygen to the brain, e.g. due to a stroke or small vessel disease, or conditions such as hypertension - which affect the heart, arteries or circulation of blood to the brain.
[73] Moore, P. & Buss, L. (2004) *A review of early onset dementia services in Southampton.* Hampshire Partnership NHS Trust.

The Older People's Mental Health Service (DMHOP) is providing a service to 15 of these 22, whilst 7 are receiving a service from the Adult Mental Health Service. It is very likely that this latter group are suffering from dementia related to substance misuse.

A further 8 adults are receiving a service from the Adult Mental Health Service for organic illnesses that are not early onset dementia. Nothing more is known about these people.

Summary: Early onset dementia

- It is estimated that there are approximately 50 people aged 30-64 with dementia in Herefordshire;
- This number is expected to remain at a similar level up to 2012 and in 2021;
- Currently, only two-fifths (22) of these people are receiving a secondary service, and an estimated one-third of these are suffering from preventable dementia related to substance misuse.

EATING DISORDER

It has not been possible to identify any robust sources relating to the prevalence of eating disorders at a national level.

According to an audit of care co-ordinators' caseloads, in January 2007, 39 people aged 18-64 in Herefordshire were being treated for an eating disorder by the Adult Mental Health Service – although it is not possible to be certain that these figures do not include any double-counting.

According to the Transitions database, 14 young people under the age of 18 were referred to the Eating Disorder Service in 2005/06. No information relating to their ages is available at this point in time, so it is possible that some of these are now over 18 and counted in the 39 discussed above. Of these 14 young people, 5 being treated for anorexia nervosa had 'serious' mental health co-morbidity including self-harm and attempted suicide.

BEHAVIOURAL DIAGNOSES

The Adult Mental Health Service caseload audit in January 2007 identified 6 cases of 'autistic spectrum' and 11 cases of 'adjustment disorder'. These are behavioural diagnoses which should be considered by both the mental health and learning disabilities services. It is not possible to combine them with any of the categories considered in this report, and no estimates of national prevalence have been identified.

DUAL DIAGNOSIS

'Dual diagnosis' refers to "the co-existence of mental health and substance misuse problems" – although there is a danger that this label over simplifies people's problems by implying that there are only two, and there is also the possibility of it being used to refer to co-existence of other problems (e.g. mental health problem and learning disability).[74] It is also important to consider the differing likely treatment needs of people labelled as 'dual diagnosis' – for example a person with a bipolar disorder who is alcohol dependent in comparison with a person with schizophrenia who smokes cannabis a few times a week.[75]

[74] Hawkings, C. and Gilburt, H. (2004) *Dual diagnosis toolkit; mental health and substance misuse: a practical guide for professionals and practitioners*. Rethink and Turning Point, p. 2

[75] Banerjee, S. et al (eds.) (2002) *Co-existing problems of Mental Disorder and Substance Misuse (dual diagnosis): An Information Manual.* The Royal College of Psychiatrists' Research Unit, commissioned by the Department of Health. p. 2

Another complication with the term arises because "[i]n practice, people are usually only given a formal diagnosis of dual diagnosis if they have severe mental health problems (generally psychotic disorders) **and** severe substance misuse problems that meet the criteria for specialist services". This may mean that a person who has, for instance, a serious substance misuse problem and a common mental health problem such as anxiety or depression may not receive the most appropriate care for all of their problems.[76]

People with dual diagnosis are an important group to consider in the context of service planning as they, in comparison with "…people with mental disorder alone, seem to have a worse prognosis, with high levels of service use and particularly heavy use of expensive resources such as emergency services and inpatient beds (where they typically spend twice as long). More effective ways of managing people with dual diagnosis therefore have the potential to reduce crises and to be more cost effective."[77]

Little is known about the extent of dual diagnosis at a national level. It is estimated that around one third of psychiatric patients with serious mental illness have a substance misuse problem, and that around half of drug and alcohol service users have a mental health problem[78]. In a study by Marsden *et al* (2000)[79] 20% of people in substance misuse treatment reported recent psychiatric treatment.

The literature around dual diagnosis specifically mentions people with personality disorders; the Department of Health's guide states that they "…are at high risk of substance misuse and are at greater risk of mental illness. They also have difficulty in forming trusting and supporting relationships. This makes working with them a particular challenge."[80]

It has not been possible to identify the full extent of dual diagnosis in Herefordshire; what has been obtained follows:

- Two people aged 18-64 living in a residential home are classified as 'dual diagnosis';
- Twelve people aged 18-64 in the Adult Mental Health Service caseload audit in January 2007 who were receiving a mental health service were classified as 'substance misuse';
- As at 31st March 2007, ten people aged 18-64 were receiving a service from the Community Alcohol Service Team of the Adult Mental Health Service;
- A total of 429 people aged 16+ whose principal problem is drug misuse are currently (April 2007) receiving a service from DASH.[81] Although it is not possible to identify how many of these are diagnosed with mental health problems, the estimates mentioned above would suggest that approximately 215 of these would have some form of mental health problem and that around 85 may have received recent psychiatric treatment.

Summary: Dual Diagnosis

- 'Dual diagnosis' refers to "the coexistence of mental health and substance misuse problems", and is important to consider in the context of service planning as it seems to result in high levels of service use, particularly expensive resources (e.g. emergency services and inpatient beds), compared to mental health problems alone.
- Little is known about the extent of dual diagnosis at a national level. It is estimated that around one third of psychiatric patients with serious mental illness have a substance misuse problem, and that around half of drug and alcohol service users have a mental health problem.
- It has not been possible to identify the extent of dual diagnosis in Herefordshire.

[76] Hawkings and Gilburt (2004), p. 2
[77] Ibid, p. 3
[78] Ibid, p. 4
[79] Marsden, J. et al (2000) Psychiatric symptoms among clients seeking treatment for drug dependence. Intake from the National Treatment Outcome Research Study. *British Journal of Psychiatry.* 176, 285-289. Cited in Hawkings and Gilburt (2004).
[80] Banerjee, S. et al (eds.) (2002) p. 2
[81] The largest provider of drugs services in Herefordshire.

ETHNICITY OF PEOPLE WITH MENTAL HEALTH PROBLEMS

It is not possible to produce estimates of the number of people in different ethnic groups in Herefordshire experiencing mental health problems as, although the ONS *Survey of Psychiatric Morbidity among Adults in Private Households* considered prevalence by ethnic group and found some apparent differences, none of these differences were statistically significant due to the small numbers in minority ethnic groups with mental health problems in the sample.[82]

Information on ethnic group of patients is not currently collected by GPs, so there is no way of knowing the ethnicity of people with mental health problems known to primary care in Herefordshire.

The ethnicity of users of the secondary Adult and Older People's mental health services is collected in the Care Programme Approach (CPA) database, but it is not possible to obtain information regarding Adult Mental Health service users alone. Furthermore, whilst this is the most comprehensive count of the number of people accessing secondary mental health services in Herefordshire, there are known gaps in the database. For instance, some teams are more thorough than others in completing relevant documentation.

Therefore, the only possible comparison of people with mental health problems in Herefordshire with the population as a whole is of current secondary service users aged 18 and above with the general population at the time of the 2001 Census (see Table 22), although this has limited value given the change in the structure of the total population since then, and the gaps in the database. This data suggests that 3.5% of Herefordshire mental health service users aged 18 and over are non-'White British', which is similar to the 3.4% of all people of that age in the county in 2004.

Table 22: Ethnicity of Herefordshire Mental Health Service Users (aged 18+) from CPA database, April 2007

Ethnic Group	Mental Health Service Users (aged 18+)		% of population (aged 18+), 2001 Census
	Number	%	
White British	2,127	91.3%	96.6%
White Irish	7	0.3%	0.6%
White Other	38	1.6%	1.4%
Mixed	13	0.6%	0.4%
Asian or Asian British	9	0.4%	0.5%
Black or Black British	4	0.2%	0.3%
Chinese	1	0.0%	0.2%
Other ethnic group	9	0.4%	0.1%
Unknown ethnic group	121	5.2%	-
Total non-'White British'	81	3.5%	3.4%
All People	2,329	100%	100%

Source: CPA database, Herefordshire PCT & ONS experimental population estimates by ethnic group © Crown copyright. Figures may not sum due to rounding.

The Rethink and Turning Point *Dual Diagnosis Toolkit* explains that "[a]lthough there are some local studies, data on substance misuse among ethnic minorities in the UK is sparse, and there is danger of making estimations and broad generalisations", but that "[t]he special issues relating to members [of] minority ethnic groups with mental health problems are well known."[83]

It should be noted that nothing is known about the general mental health of the recent inflow of migrant workers to Herefordshire, or of any temporary seasonal workers working in the county.

[82] Singleton et al (2001), pp.24 & 27.
[83] Hawkings and Gilburt (2004), p. 50.

Summary: Ethnicity of People with Mental Health Problems

- It is not possible to produce estimates of the number of people in different ethnic groups in Herefordshire experiencing mental health problems.
- Information on ethnic group of patients is not currently collected by GPs, so there is no way of knowing the ethnicity of people with mental health problems known to primary care in Herefordshire.
- In April 2007, 3.5% of Herefordshire mental health service users (aged 18+) are recorded as being from a 'Black and Minority Ethnic' population, almost equal to the proportion of over 18s in the population as a whole in 2004 (3.4%).
- Nothing is known about the general mental health of migrant and seasonal workers in Herefordshire.

GEOGRAPHIC DISTRIBUTION OF PEOPLE WITH MENTAL HEALTH PROBLEMS

It is not possible to produce projections of the number of people in different parts of Herefordshire who will experience mental health problems, as there are no population forecasts or projections below county level.

Table 23 shows the number of people who are currently (March 2007) receiving a service from area-based community teams of the secondary Adult Mental Health Service run by Herefordshire PCT. People are allocated to community teams on the basis of the location of their GP, although if a person were registered with a GP outside their area of residence it would be usual for them to be allocated to their local community team.

This is the most comprehensive count of the number of people receiving an area-based service in Herefordshire, but there are known gaps in this data; for instance some teams are more thorough than others in completing relevant documentation.

Table 23: Distribution of area-based cases, Adult Mental Health Service Community Teams, Herefordshire, 31st March 2007

Community Team	Number	% of area-based cases
Hereford (City)	560	28.0%
Leominster (North Herefordshire)	289	14.5%
Ross (South Herefordshire)	300	15.0%
Ledbury / Bromyard (East Herefordshire)	49	2.6%
Total area-based cases	1,998	100.0%

Source: CPA database, Herefordshire PCT

Further work would be required to assess whether this represents mental health problems across the county, and whether current services are provided equitably across the county.

A further 108 people are receiving a service from a countywide team/service, but it is not possible to identify where in the county they reside.

Summary: Geographic Distribution of People with a Mental Health Problem

- It is not possible to produce projections of the number of people in different parts of Herefordshire who will experience mental health problems.
- Further work would be required to assess whether current services are provided equitably across the county and that access to these services is equal, regardless of location.

MENTAL HEALTH OF PRISONERS

As at April 2007 the Herefordshire Forensic Assessment Community Team (FACT) was working with six people aged 18-64 in prisons (outside Herefordshire) who have been identified as having mental health problems.

The number of residents of Herefordshire aged 18-64 who are in prison is not known, so it is not possible to ascertain whether this figure is what would be expected. Prisoners are not included in any estimates based on national prevalence rates as they are not 'household residents'.

An ONS survey of *Psychiatric Morbidity Among Prisoners*[84] in 1997 found the following in respect of prisoners:

- About 20% of males (both sentenced or on remand) had received help or treatment for a mental or emotional problem in the year before entering prison. This is half the proportion of female prisoners (40%) [p.9];
- About 15% of male prisoners (both sentenced and on remand) had received help or treatment for a mental or emotional problem since entering prison, in comparison with 23% of female remand and 30% of female sentenced prisoners [p.9];
- Female prisoners were significantly more likely to have a neurotic disorder than male prisoners, as in the household population. 59% of males on remand and 40% of sentenced males were found to have a neurotic disorder, in comparison with 76% and 63% of females, respectively [p.16];
- Prevalence of personality disorder was 78% among sentenced males, 64% among males on remand, and 50% among females (either sentenced or on remand) [p.10];
- Prevalence of psychotic disorder, based on clinical interviews, was 7% for sentenced males, 10% for males on remand, and 14% for female prisoners (either sentenced or on remand) [p.11]. This was noted to be much higher than prevalence amongst the general household population in the 1993 survey of psychiatric morbidity (0.4%).

Also, a large proportion of prisoners had several mental disorders – no fewer than 70% of any of the sample groups mentioned above had at least two of the five disorders[85] considered.

Summary: Mental Health of Prisoners

- The number of people from Herefordshire in prison is unknown; the only available relevant information is that the Herefordshire Forensic Assessment Community Team is currently working with 6 people.
- Prevalence of mental health problems is high amongst the prison population in general.

[84] Singleton, N. et al (1998) *Psychiatric morbidity among prisoners: summary report*. The Government Statistical Service.
[85] Personality disorder; psychosis; neurosis; alcohol misuse and drug dependence.

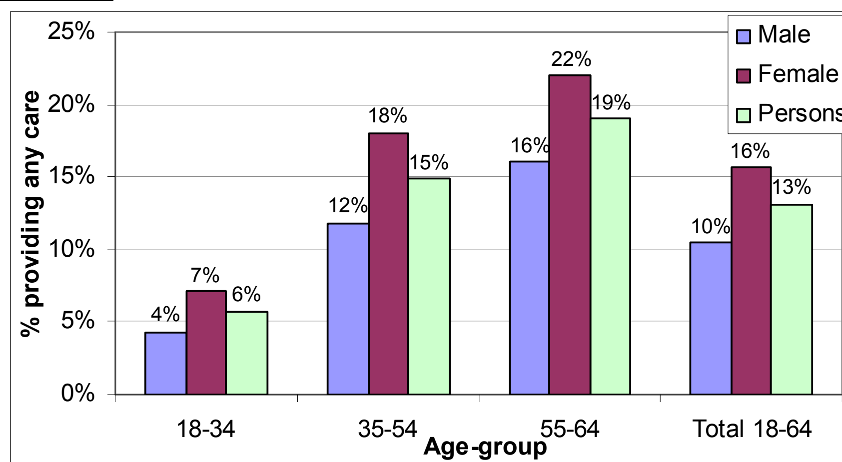
CARERS

NUMBERS OF CARERS

2001 Census

According to the 2001 Census, 13% of 18-64 year-old residents of households in Herefordshire provide at least 1 hour of unpaid care[86] a week: a total of 13,373 people. However, the gender proportions aren't equal: only 10% of men (5,333 men) compared to 16% of women (8,040 women). Figure 24 illustrates that this disparity is evident across all ages, and also how the proportion providing unpaid care increases with age. This pattern is identical to that across England and Wales as a whole, although each of the Herefordshire figures is one percentage point below the national.

Figure 24: Proportion of household population providing at least one hour of unpaid care per week, Herefordshire



Source: 2001 Census, Table S025 © Crown copyright

- Assuming that prevalence of caring by age and gender has remained consistent since 2001, it could be estimated that 14,100 people aged 18-64 were providing at least one hour of unpaid care per week in 2005, with 60% of them female. Of these, 3,600 would be expected to be providing care for 20 hours or more per week (65% female).

However, it is also likely that snap-shot estimates of the number of carers at a point in time, like the Census provides, are an underestimate of the number of carers over time. Nationally, more than 40% of carers start or stop caring over the course of a year, and less than two-thirds of the actual number of people who provide care over a year are captured at one point within that time.[87]

Carer's Allowance Claimants

The only other information regarding carers in Herefordshire are numbers of people claiming Carer's Allowance. This is likely to be a very small subset of all carers as it is only available to people not in employment or full-time education who care for a severely disabled person[88] for at least 35 hours a week. Nevertheless, 1,370 people aged 18-64 were entitled[89] to Carer's Allowance in August 2006 – a similar number to the previous two years (see Table

[86] Any unpaid help; looking after or supporting family members; friends; neighbours or others because of long-term physical or mental ill-health or disability or problems related to old age.

[87] Hirst, M (2005) *Estimating the prevalence of unpaid adult care over time*; Research Policy and Planning vol. 23, no. 1.

[88] i.e. a person in receipt of the medium or higher level of the care component of Disability Living Allowance, Attendance Allowance or a Constant Attendance Allowance at the maximum rate under the War Pensions or Industrial Injuries Scheme (DWP).

[89] 'Entitled' includes some people who are entitled to receive Carer's Allowance, but do not because they are receipt of another benefit which exceeds their weekly rate; it does not necessarily include everyone in the population who is eligible to claim.

25). The number entitled in 2005 represents 1.3% of the population aged 18-64; the proportion entitled increases slightly with age, from 0.7% of 18-34 year-olds to 1.9% of 55-64 year-olds (in 2005).

Table 25: Numbers entitled[89] to Carer's Allowance in Herefordshire, by age.

Year (August snapshot)	18-34	35-54	55-64	18-64
2006	210	680	480	1,370
2005	220	650	470	1,340
2004	210	670	450	1,330
2003	220	650	380	1,250

Source: Work and Pensions Longitudinal Study (WPLS), Department for Works and Pensions.

THE CARED FOR

The Census didn't ask for whom care is provided, so nothing can be deduced about people who *require* care from this source. However, a national survey of adults living in private households[90] (2000) identified carers and asked for more detail about their situation. 6% of carers cared for someone with only a 'mental disability' (as defined by the respondent) and a further 18% were looking after someone with both a physical and mental disability. It is not possible to estimate numbers of people aged 18-64 being cared for in each of these categories as there is no information regarding the ages of people being cared for.

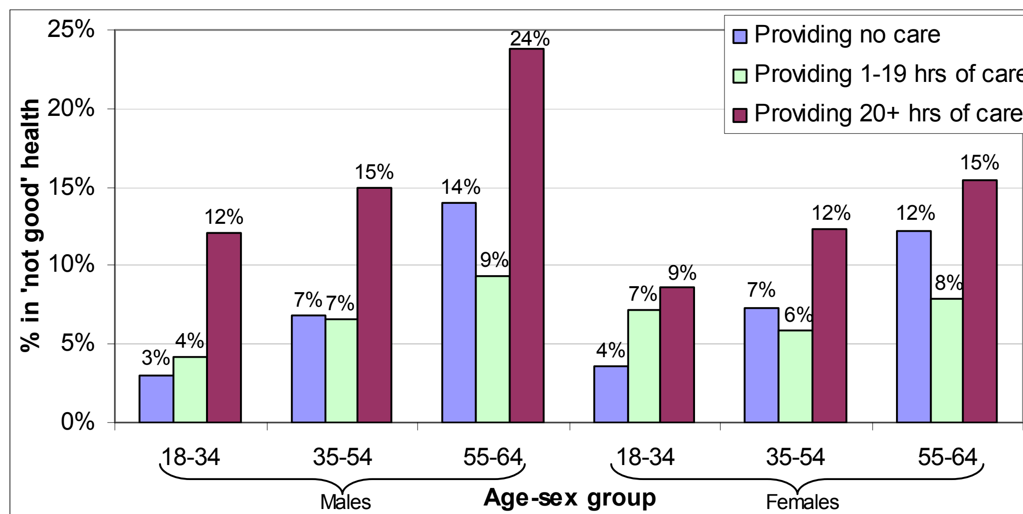
It has not been possible to identify any sources of information regarding children providing care for adults with mental health problems.

CARERS' HEALTH

National analysis of the Census[91] has shown that carers are more likely to be in 'not good' health and/or have a limiting long-term illness themselves than non-carers.

- In Herefordshire, 14% of 18-64 year-olds who provide 20+ hours of care per week are in 'not good' health, compared with 7% of both those providing 1 to 19 hours and those providing no care. The difference is particularly marked in males of all ages, as illustrated by Figure 26.

Figure 26: Proportion of household population in 'not good' health by age, sex & amount of care provided, Herefordshire



Source: 2001 Census, Table S025 © Crown copyright

[90] Maher, J and Green, H (ONS) (2002) *Carers 2000*. London: The Stationery Office
[91] *Facts about carers* (2005), Carers UK: www.carersuk.org

Furthermore, people who provide care over a long period are at particular risk of poor health, and carers' health is more likely to deteriorate over time than that of non-carers – with many of the detrimental changes attributable to the caring role.[92]

An ONS survey, *Mental Health of Carers*[93] in 2001 found the following key points:

- Female carers were found to be 23% more likely to have neurotic symptoms than women in general; no significant difference in male carers.
- Carers in rural or semi-rural areas were found to have a *lower* prevalence of neurotic symptoms than those in urban areas (12% to 21%), although a Carers UK members' survey (2002) found that over half of the respondents living in 'remote rural areas' experienced some form of social exclusion.[94]
- Strong association between carers' assessment of their own health and their mental health: over a third (37%) of carers who said they were in fair or poor health had neurotic symptoms, in comparison with only 7% who said they were in very good or excellent health. Similar associations were found between limiting and long-standing physical health conditions and mental health.
- The majority of carers (71%) said that their caring responsibilities caused them to be worried at least a little of the time, with 18% saying that it caused worry a lot of the time. A third said that caring made them depressed at least a little of the time. However, only 8% said that caring had a direct impact on their physical health.
- Overall 7% of carers said they smoked more, 7% drank more alcohol and 3% took more prescribed or non-prescribed drugs due to the strains of caring; those who had increased their use of these substances were more likely to display significant neurotic symptoms.

This survey included people of all ages over 16, and no analysis is available for different age groups. It was noted however [p.15], that there were no significant differences between the proportions displaying significant neurotic symptoms in different age-groups – although the data did suggest a decline with age.
The survey found that the carers with the following characteristics were more likely to exhibit significant neurotic symptoms:

- Those caring for people with both physical and mental health problems, compared to those caring for people with physical problems or old age (28% of the former to 14% of the latter);
- Carers providing both personal and physical care, compared to those providing practical and/or other types of help;
- Sole carers, in comparison with those who did not have the main responsibility for the person they cared for;
- Those who needed someone else to look after the person they cared for in order to take a break and had not been able to do this since becoming a carer, in comparison to those who had been able to get this alternative help and had taken a break (17% to 36%);
- Those who felt that caring had had a detrimental effect on their relationships with friends, social life and leisure activities (which was about a third), compared to those who did not (30% to 12%).

Also, research by Carers UK indicated that 70% of carers worried about their finances and 60% believed this had an effect on their health, and many report that lack of alternative care leads to the neglect of their own health – including some cases of carers discharging themselves from hospital because of this.[95]

- Assuming that people aged 18-64 care for the same 'type' of people as all people aged 16 and over; the caring situation in Herefordshire in 2005 was the same as in Britain as a whole in 2000; and prevalence of caring by age and sex has not changed locally since

[92] Hirst, M (2004) *Health inequalities and informal care*; quoted by Carers' UK in *Facts about carers*
[93] Singleton, N, et al (2002) *Mental Health of Carers*. London: The Stationery Office
[94] Carers UK (2003), Policy Briefing: *Rural Carers*. www.carersuk.org
[95] *Back me up: supporting carers when they need it most* (2005) Carers UK

2001, it could be estimated that around 800 adults aged 18-64 in Herefordshire care for someone with a 'mental disability' (as defined by the respondent). An estimated further 2,500 care for someone with both a physical and mental disability. Using the results of the ONS survey, 28% of this latter group (around 700 people), could have a neurotic disorder.

These findings indicate that it is important to ensure proper support is available to carers in order to reduce their chances of suffering from mental health problems - particularly around the times when a heavy care role begins or ends, when adverse effects on psychological well-being are most pronounced.[96]

Summary: Carers

- Assuming that the prevalence of caring in Herefordshire is as it was at the 2001 Census, 14,100 people aged 18-64 in Herefordshire are estimated to have been providing at least one hour of unpaid care a week in 2005, with 3,600 providing care for 20 hours or more per week.
- At the same time, 1.3% of 18-64 year-olds in the county (1,340 people) were entitled to Carers' Allowance, i.e. were not in employment or full-time education and were caring for a severely disabled person for at least 35 hours a week.
- Carers are more likely to be in 'not good' health than non-carers, and the disparity increases with the amount of time spent caring per week. People who provide care over a long period of time are particularly at risk of poor health. Carers' health is also more likely to deteriorate over time than that of non-carers, with many of the detrimental changes attributable to the caring role.
- Using national observations, an estimated 800 people aged 18-64 in Herefordshire are estimated to have been caring for someone with a 'mental disability' in 2005. A further 2,500 care for someone with both a 'physical and mental disability', and around 700 of this latter group could be expected to have a neurotic disorder.

ABILITY TO PAY

EARNINGS

The only information on earnings is for the total population of the county as a whole; the only available relevant breakdown is by gender.

- In 2006, average (median) gross weekly earnings for full-time employees who work in Herefordshire were £390.60, compared to £415.50 for the West Midlands region and £453.30 for England.[97] Whilst Herefordshire's median earnings appear lower than regionally *and* nationally, the difference with the region is not statistically significant.

- Herefordshire's lower quartile earnings are also significantly lower than England's: 25% of people who work in the county earned less than £297.00 per week, whereas the equivalent national figure is £320.30.

- The top 25% of earners in Herefordshire earned more than £551.20. The equivalent figure for England as a whole was £642.0, but this is not significantly higher (due to the sample size).

- Herefordshire has one of the largest gender pay gaps of neighbouring English authorities, and of all authorities in the West Midlands region: on average, full-time female workers earn only 72% of the amount earned by their male counterparts. The national equivalent figure is 79%.

[96] Hirst, M (2004) *Hearts & Minds: The health effects of caring*. University of York, in association with Carers UK

[97] 2006 Annual Survey of Hours & Earnings, Office for National Statistics (ONS)

INCOME

There are no data on levels of *income*[98] in Herefordshire, but the Indices of Deprivation 2004[99] included an 'income' domain based on the extent to which households in an area were dependent on income related benefits. Overall, Herefordshire is more 'income deprived' than two-thirds of English local authorities.[100]

In addition, income deprivation 'hotspots' exist within the county: ten areas[101] in Herefordshire were in the 25% most deprived areas in England. Six of the ten areas of the 'South Wye' part of Hereford city are amongst these; the remainder are north of the river in Hereford ('College Estate' and 'Courtyard') and in Leominster ('Ridgemoor') and Bromyard ('Central').

EMPLOYMENT & FINANCIAL CHARACTERISTICS OF PEOPLE WITH MENTAL HEALTH PROBLEMS

- As already discussed (see p.14), an estimated 2,000 people aged 18-64 in Herefordshire each year are unable to work, and are therefore claiming Incapacity Benefit or Severe Disablement Allowance, because of a 'mental disorder'. Some of these people may also be claiming Disability Living Allowance to help with the cost of any care they may need because of their disability(ies), but it is not possible to determine how many.

According to the ONS *Survey of Psychiatric Morbidity among Adults in Private Households*[102] (i.e. those aged 16-74):

- People with neurotic disorders were more likely than those without to be economically inactive, i.e. not working or seeking employment (39% of those with neurotic disorder compared to 28% of those without); and less likely to be employed (58% to 69%). This was particularly found to be the case for people with phobias.

- People with probable psychotic disorders were more likely than those without to have qualifications no higher than GCSE level (84% to 64%) and to be economically inactive (70% to 30%), and were less likely to be employed (28% to 67%).

Summary: Ability to pay

- There is little available information about earnings and income in Herefordshire, although median weekly earnings are lower than nationally (£390.60 compared to £453.30, in 2006);
- An estimated 2,000 people aged 18-64 in the county are unable to work, and are therefore claiming Incapacity Benefit or Severe Disablement Allowance because of a 'mental disorder';
- There is no specific information available about the levels of income of people with mental health problems in Herefordshire. If national trends apply, people with neurotic or psychotic disorders are significantly less likely to be in employment, and significantly more likely to be economically inactive (i.e. not working and not seeking employment), than people without. This would be expected to be reflected in lower average incomes of people with these disorders, limiting the extent to which they could be expected to pay for services.

[98] Earnings plus unearned income from investments, etc.
[99] Office for the Deputy Prime Minister (ODPM), now Department for Communities & Local Government (DCLG). Based on data from 2001.
[100] Herefordshire ranked 114th out of 354 English local authorities in terms of income deprivation.
[101] Lower Super Output Areas (LSOAs): statistical geographies of about 1,500 people that nest into wards. They were determined by ONS, but names were given by HC Research Team.
[102] Singleton et al (2001)

HOUSING

It is not possible to identify housing issues relating to adults aged 18-64 specifically, so the facts and figures discussed in this section pertain to adults of all ages.

According to the ONS *Survey of Psychiatric Morbidity among Adults in Private Households*[103]:

- People with neurotic disorders were more likely than those without to be socially renting (26% of those with a disorder compared to 15% of those without) and more likely to have moved three or more times in the last two years (6% to 3%) [p.80].
- People with phobias and those who experience depressive episodes were particularly likely to be socially renting (37% & 36% to 15% of those without), whereas people with obsessive compulsive disorder were particularly likely to be private renting (22% to 10% of those without) [p.80].
- People with probable psychosis were more likely to be socially renting than those without (49% to 17%) [p.82].
- Analysis of people with personality disorders was not carried out for the report; a separate topic report on this group of people was planned [p.76] but has not been published.

These figures point towards a higher likelihood of housing instability in people with mental health problems, but it is not appropriate to attempt to estimate numbers in Herefordshire, as these percentages do not relate specifically to the population of interest (i.e. aged 18-64) and do not take into account any underlying factors that may affect tenure regardless of mental health status. Furthermore, according to the 2001 Census, household residents in Herefordshire aged 16-74 are generally less likely to be socially renting than those in England and Wales as a whole (12.8% to 15.6%).

HEREFORDSHIRE MENTAL HEALTH SERVICES HOUSING PLAN

Herefordshire Mental Health Services are about to publish a Housing Plan[104], covering the period 2007 to 2010, to "review the current accommodation needs for people with mental health problems with a view to developing a range of housing options to ensure people are able to live in the most appropriate environment".

The Plan will mainly focus on the needs of those with severe and enduring mental health problems who require "…more intensive and sustained community treatment" than the majority of those with mental health problems who "will be supported within the community".

Three surveys were carried out in the development of the plan, the largest being of care co-ordinators (in December 2006) about the people with whom they were working. Not all co-ordinators completed the survey, but of the 1,361 service users (of all ages but mostly 18+) in respect of whom information was provided, 133 (9.8%) were living in accommodation that was deemed unsuitable, and 74 (5.4%) were living in temporary accommodation, including eight who were homeless. However, the situation was deemed unsuitable for only 26 (35%) of those living in temporary accommodation.

Of the 133 service users identified as being in unsuitable accommodation, 65 (49%) cannot stay in their current accommodation for longer than two years, 40 (30%) have a forensic history and 49 (37%) have been detained under the Mental Health Act.

The Plan sets out future need on the basis of what type of accommodation would be required for the 133 service users identified as currently living in unsuitable accommodation; this is reproduced in Table 27. However, it was noted that information regarding accommodation for around 400 service users was incomplete, so these needs are likely to

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[103] Singleton et al (2001)

[104] Roche, T (2007) *Mental Health Services in Herefordshire: Housing Plan – 2007 to 2010*

be an underestimate. Regular surveys to identify future need are recommended, with the acknowledgement that these would require the full co-operation of all care co-ordinators.

Table 27: Required accommodation identified by survey of care co-ordinators for Adult Mental Health service users in Herefordshire in currently in unsuitable accommodation

Type of Accommodation	Units Required	Location required
Sheltered Housing	4	2 in Hereford; 1 in Ledbury; 1 in Leominster
Warden Controlled Housing	6	5 in Hereford City; 1 in Kington
Accommodation unit for service users with medium to high support needs	10	10 in Hereford City
Supported Housing	9	1 in Bromyard; 5 in Hereford; 1 in Leominster; 1 in Ross; 1 in 'Herefordshire'
Young Persons Supported scheme	1	1 in Hereford City
Residential Care Home	9	4 in Hereford; 2 in 'Herefordshire'; 2 in Leominster; 1 out of county
Rehabilitation	1	1 in Hereford City
Dry House	1	1 in 'Herefordshire Rural'
Support whilst living at home	4	N/a
General Needs Housing	88	
Total units required	133	

Source: Mental Health Services in Herefordshire, Housing Plan – 2007 to 2010

1,170 service users were identified as living in permanent accommodation, with the majority (78.5%) in private households (see Table 28). Of those in private households, almost half (48.4%) were renting a house or flat – although it is not possible to identify which of these were socially renting. This supports the view that people with mental health problems are more likely to live in rented accommodation than those without: only 22.7% of all household residents in Herefordshire aged 18 and above live in rented accommodation.

Table 28: Current accommodation of mental health service users (surveyed via care co-ordinators in December 2006)

Type of accommodation		No. of identified service users	% of all identified service users
Permanent accommodation	Rented flat or house	517	38.0%
	Owner occupied house or flat	435	32.0%
	Living with family or friends	117	8.6%
	Residential home	54	4.0%
	Sheltered scheme	27	2.0%
	Warden scheme	12	0.9%
	Nursing home - in county	7	0.5%
	Out of county	1	0.1%
Temporary accommodation		74	5%
Unanswered		117	9%
Total service users		1361	100%

Source: Herefordshire Mental Health Services Housing Plan

It is not known whether there was any potential for double counting if more than one care co-ordinator responded for the same service user. However, this survey identified 61 people living in nursing or residential homes in December 2006, whereas Adult Mental Health Service figures indicate that only 46 people were living in these types of homes in January 2007.

Eight mental health accommodation providers[105] responded to a separate survey, which asked whether residents were suitably placed; all 33 residents (aged 34 to 69) assessed were judged to be so at the time, but five as requiring alternative accommodation within the next six months. The figure of 33 is clearly lower than even the 61 in residential or nursing homes identified in the survey of care co-ordinators (Table 28), let alone the 81 known to be living in communal establishments in January 2007 (p.8), so it is unclear how comprehensive these figures are.

Summary: Housing

- National research points toward a higher likelihood of housing instability in people with mental health problems. People with neurotic disorders and people with probable psychotic disorders are both more likely than those without to be socially renting, and the former group are more likely to have moved three or more times in the last two years.
- Although it is not possible to estimate the extent of social renting amongst people with mental health problems in Herefordshire who are *not* accessing secondary mental health services, a housing assessment of 1,361 Adult Mental Health service users supports the national observation. Almost half of service users in private households were renting (either privately or socially), in comparison with less than a quarter of all household residents in the county.
- A survey of care co-ordinators for the *Herefordshire Mental Health Services Housing Plan* identified at least 133 service users living in unsuitable accommodation, with incomplete information provided for around 400 service users. A wide range of single-figure accommodation units were identified as needed to suitably house these people, with the majority (66%) requiring 'general needs housing'.

[105] The Shires, Aston Lodge, Elm Lodge, Francis House, Merrivale Farm, Sands Care Home, The Chestnuts and Wykenhurst.

APPENDIX: ADULT MENTAL HEALTH SERVICE DATA

ADULT MENTAL HEALTH SERVICE: CPA DATABASE

Table A1 includes everyone who was receiving a service from the secondary Adult Mental Health Service run by Herefordshire PCT as at 31st March 2007, and which team they were receiving that service from.

This is the most comprehensive count of the number of people accessing secondary mental health services in Herefordshire. However, despite this, there are known gaps in this data; for instance some teams are more stringent than others in completing relevant documentation.

It would be expected that most of these cases are also known to GPs in Herefordshire.

Table A1: People receiving a service from the secondary Adult Mental Health Service run by Herefordshire PCT, 31st March 2007

Team		Service Users
Community Teams	Hereford City 1	254
	Hereford City 2	306
	Leominster	289
	Ross	300
	Ledbury / Bromyard	49
Countywide Services	Forensic Assessment Community Team (FACT)	34
	Community Alcohol Service (CAS)	10
	Assertive Outreach	32
	Early Intervention	22
	Crisis Assessment Home Treatment (CAHT)	1
	Oak House (residential rehabilitation centre)	9
Total		1,306

Source: CPA database, Herefordshire PCT

ADULT MENTAL HEALTH SERVICE CASELOAD AUDIT

Table A2 details the results of the caseload audit of care co-ordinators providing care to adults aged 18-64 in January 2007. No further detail is available, and it is not possible to be sure that cases are not double-counted if seen by more than one care co-ordinator – or to ascertain the extent of any double-counting.

Table A2: Herefordshire Adult Mental Health Service caseload audit, January 2007

Diagnosis (primary)	Caseload	Classification for needs analysis
Anxiety	197	Common mental health problem
Depression	606	
Neuroses	75	
Obsessive compulsive disorder (OCD)	80	
Post traumatic stress disorder (PTSD)	46	
Bipolar	156	Psychotic disorder
Psychosis	108	
Schizophrenia	568	
Personality disorder	62	Personality disorder
Organic	15	7 are young onset dementia; 8 are other organic illness
Eating disorder	39	Eating disorder
Autistic spectrum	6	Behavioural diagnoses
Adjustment disorder	11	Behavioural diagnoses
Substance misuse	12	-
Other	6	-
Total cases	1,987	

Source: Adult Mental Health Service, Herefordshire PCT

It is concerning that the caseload audit appears to identify 681 more people than the CPA database, particularly since they were only two months apart. This seems to indicate significant double-counting, but the fact that the CPA database is known to be incomplete for certain teams means that it is impossible to determine which is the more accurate.

RESIDENTS OF MANAGED ACCOMMODATION

Tables A3 to A5 show the diagnoses of residents of managed accommodation in Herefordshire in the early part of 2007. It should be the case that they have been included in the figures in Tables A1 & A2, as care co-ordinators were asked for information on everyone on their caseload, but it is not possible to check that this is so.

Table A3: Diagnoses of adults aged 18-64 with mental health problems in residential or nursing homes in Herefordshire, 1st January 2007

Diagnosis Type	Nursing Home	Residential Home	Total
Common mental health problems	1	3	4
Dual diagnosis (substance misuse)	-	2	2
Learning disability and mental health problem	-	1	1
Organic	3	-	3
Personality disorder	-	1	1
Psychosis	6	27	33
Unknown	-	1	1
Autism	-	1	1
Total	10	36	46

Source: Adult Mental Health Service, Herefordshire PCT

Table A4: Diagnoses of adults aged 18-64 with mental health problems in secure unit placements in Herefordshire, 31st March 2007

Diagnosis Type	High secure	Medium secure	Low secure	Total
Psychopathic disorder	-	2	1	3
Psychosis	1	1	2	4
Personality Disorder	-	1	-	1
Unknown	-	3	2	5
Total	1	7	5	13

Source: Adult Mental Health Service, Herefordshire PCT

Table A5: Diagnoses of adults aged 18-64 with mental health problems in supported housing in Herefordshire, April 2007

Diagnosis Type	Residents
Common mental health problem	11
Psychosis	9
Personality disorder	2
Total	22

Source: Adult Mental Health Service, Herefordshire PCT

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Current and future services for adults with mental health problems

Overview

The bar charts that follow compare the current pattern and levels of services for adults with mental health problems with the proposed future models of service by 2012.

Diagram 1: the proportions of people with severe and enduring mental health problems receiving different types of service per annum.

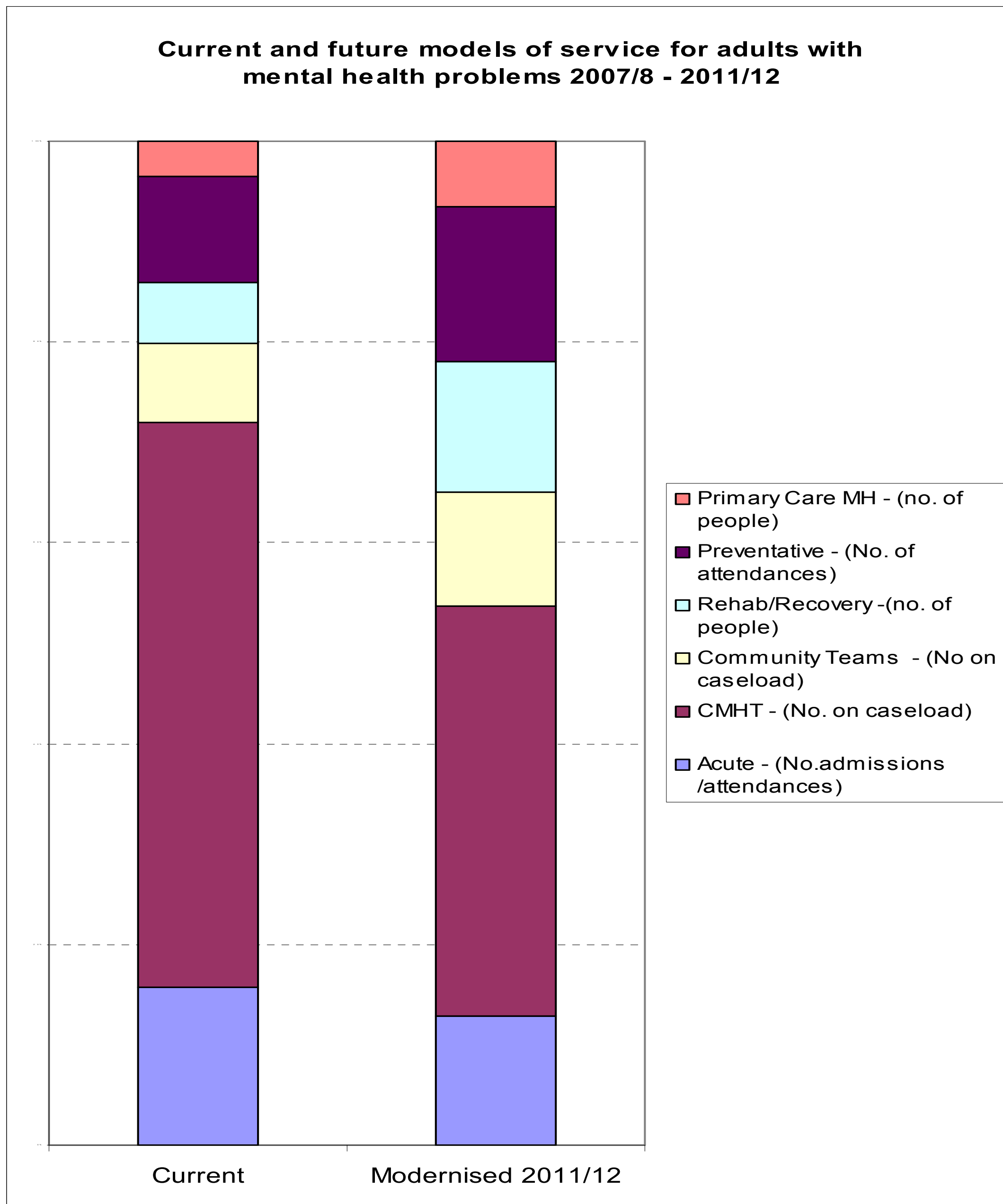
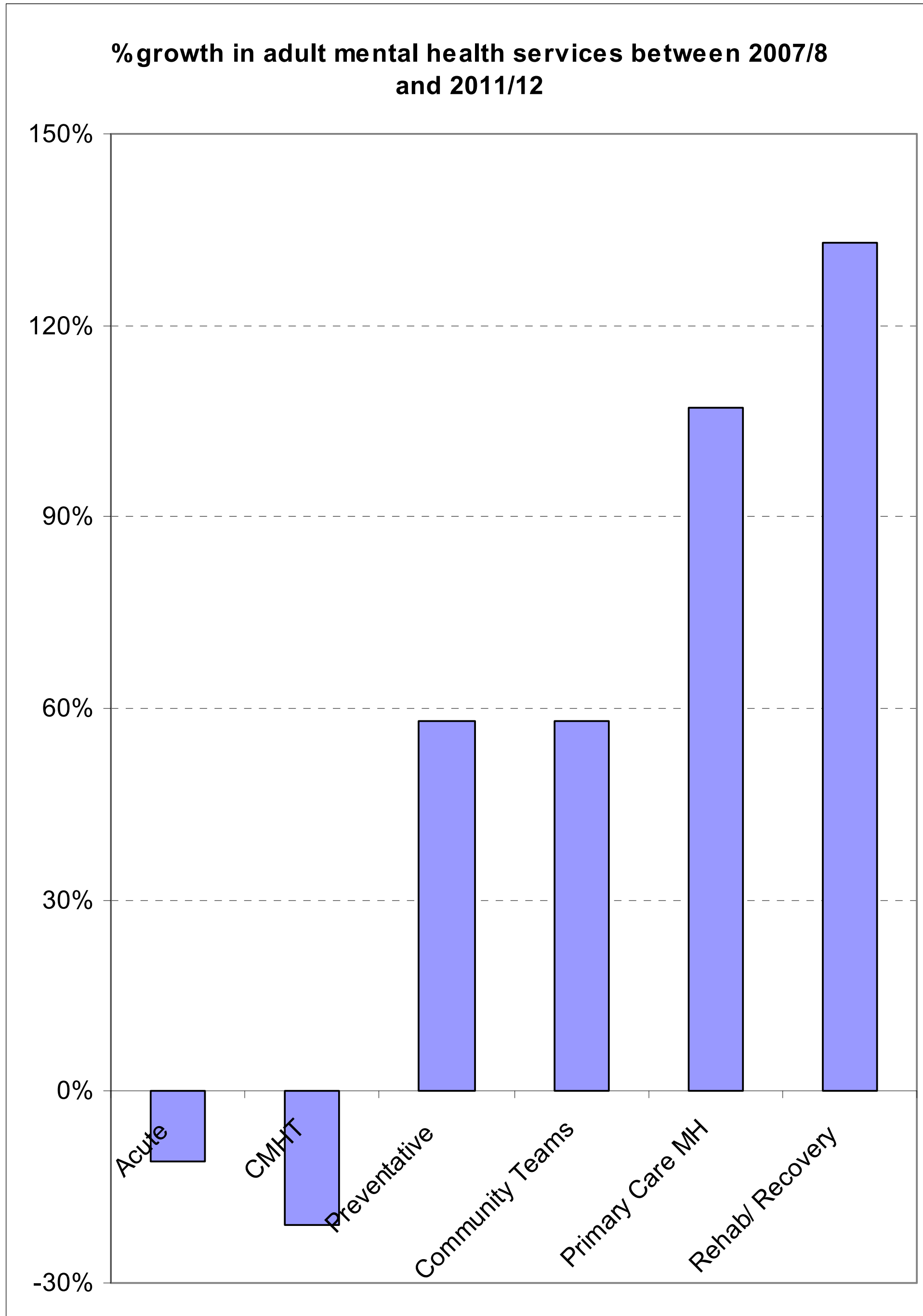


Diagram 2: Percentage change required in adult mental health services to achieve higher performing services



Details of proposed service levels for proposed higher performing services

Acute Services

In-patient services
The trend over the last few years has been a 3.5% reduction in admissions per annum. With an increase in admission prevention services provided by the Crisis Assessment and Home Treatment Team, this is estimated to rise to 5% per annum. The target would be a reduction of 24 admissions per year to 276.

Crisis Resolution and Home Treatment
It is anticipated that the increase in early planned discharge work will result in a 10% increase over 4 years. In 2006/07 number of people receiving home treatment during the year was 154. It is expected that this number of people will increase to 180.

Day Hospital
It is anticipated that the number of people accessing the day hospital will be increased by 20%, to 43, in order to support the crisis team.

Community Mental Health Service

Community Mental Health Teams
It is expected that CMHTs will see a reduced caseload due to the development of rehabilitation and recovery services, Primary care, and other specialist services (eg. Eating disorder and personality disorder services). A 25% reduction, to 1500 people on the caseload, is estimated over 4 years.

Safe House
The form of the safe house is still under discussion. However, assuming a safe house is provided with 2 beds, it is anticipated that there would be about 80 admissions per annum (assuming an average of 80% occupancy)

Community Teams

Early Intervention Service
The Early Intervention Team reached full capacity in 2007/08. The caseload will increase to meet the national target of 20 new referrals each year and reach the target of 61 people on the overall caseload in 2010/11.

Forensic Assessment Community Team
It is assumed that FACT will continue to operate with the current caseload level over the next 4 years.

Assertive Outreach Team
It is anticipated that the caseload will increase by 21 over the next 4 years, which would meet the national target of 54 for the team.

Psychology
As stepped care is introduced more people will be seen in primary care and fewer by highly specialist services. Estimate a 10% reduction over 4 years, to 127. No change in level of staffing, as will be concentrating more on long-term, complex cases and supporting primary care.

Eating Disorder Service
A new community team of three workers was established in August 2007 as a pilot project. It is not possible to say how the service will develop until the pilot has been evaluated, therefore this service has not been included in the service increases.

Personality Disorder Service
In 2006/07 60 people were seen within the Community Mental Health Teams (caseload survey). National community pilots are currently being evaluated, as a result of which guidance on providing services for this group is expected in 2008 . This service has therefore not been included in the costings.

Rehabilitation and Recovery Service

Employment
50 people are currently supported into employment each year. The target is to support an extra 80 people per year into employment.

Adult Education
MIND and Oak House currently support people to access adult education. The new Rehab. and Recovery Service will assist more people into adult education by accessing community services. The target is to increase the number of people accessing adult education by 20% per year, to 100 by 2011/12.

Home Support Services
In 2006/07 14 people received home care at any time during the year. It is anticipated that the new Rehabilitation and Recovery Service will support many more people in the community. The target is to support 100 per annum.

Residential/Nursing Home placements
Improved community support services developed by the Rehabilitation and Recovery service should result in a 30% reduction of residential/nursing placements over 4 years to 34.

Supported Housing
There are currently 21 supported housing placements. It is anticipated that, by working with Herefordshire Housing, this will increase to a minimum of 35 over four years.

Out of county placements
There are currently 13 people placed out of county and/or in specialist placements. It is anticipated that, with improved community services developed by the Rehabilitation and Recovery Service, this number will be reduced by 50% by 2011/12 to 7.

Residential Rehabilitation
This service will become an integral part of rehabilitation and recovery services and will work with the most complex group of people. It is anticipated that the current number of placements (10) will remain static.

Direct Payments/Individualised budgets
There will be a drive to encourage adults with mental health problems to access direct payments and individualised budgets. The target will be to encourage 20 people per annum to take up direct payments or individualised budgets. The target is relatively low because direct payments/individualised budgets are only possible, at present, in respect of people receiving social care and many people receive health, supporting people or preventative services rather than social care.

Preventative Services

Leisure
It is proposed that 300 more people should access community services. This is partially off-set by a decrease in the number of people accessing day centres for vocational purposes during the four years from 199 to 100.

Advocacy
Herefordshire MIND currently provides a limited individual advocacy service funded by external short term monies. This is helping 80 people per annum. However, due to limited resources this service has seen many people referred in a crisis and not been able to provide sufficient support to prevent crises occurring. Access to advocacy will therefore be expanded to ensure more people have access to independent individual advocacy services. It is anticipated that this would support all of the some 200 people per annum who are expected to need it.

Primary Care Mental Health Services
No major changes in demographics are anticipated, but with improved services more people will be supported in primary care and fewer will "graduate" to secondary services.

Future care needs and services for 18-64 year-olds in Herefordshire with physical disabilities

November 2007

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Contents

	Page
Summary	3
Section 1 - Introduction	6
Section 2 - Assessment of future care needs	9
Section 3 - The pattern and levels of services to meet needs in 2012	12
Section 4 - The capacity needed to deliver the improvements	19
Section 5 - The costs	23
Appendices	
Appendix 1 – Membership of the Steering Committee	
Appendix 2 – Details about the expert consultants	
Appendix 3 – Needs assessment	
Appendix 4 – Present and future services	

Final report: future care needs and services for 18-64s with physical disabilities

Summary

Working together and with their partners, Herefordshire Council and the Herefordshire Primary Care Trust are committed to maximising the independence, well-being and choice of people with physical disabilities. In doing this, they face a major double challenge: despite additional investment and service improvements in recent years, in important respects they still lag behind what is achieved by high-performing authorities serving comparable areas; and the costs of services have continued to escalate.

Currently there are an estimated 4,600 people aged 18-64 with moderate disabilities who are likely to require personal care at some time. This number is expected to increase by no more than 5% (250 people) by 2012, and 8% (350 people) by 2021.

An estimated further 950 people with serious disabilities currently are likely to require care at some time; a figure expected to increase by 5% (50 people) by 2012, but not further by 2021.

The principal driver of these increases in need is the projected rise in the number of people aged 55-64, of 7.1% by 2012 and 20.6% by 2021; this is because a number of the most common physical disabilities are more often found in this age-group than amongst younger adults.

The prevalence of physical disability is much higher than the number of people who need services: in March 2007 328 people were receiving core social care services, while a further 293 were being helped by means of information, advice and annually serviced equipment. During 2006-07 as whole, there were 650 users of core social care services.

Between five and seven young people with physical disabilities a year are likely to be in transition from children's to adults' services.

It would appear appropriate to plan to provide care and other support for 5% more people by 2012. This would equate to an additional 37 users of core social care over the year as a whole; and, at any one time, an additional 16 users of core social care and 15 additional users of less intensive services.

Major gaps in current data need to be filled, which means that these estimates will need to be kept under review. Even so, it is possible to be reasonably confident about the needs estimated for 2012.

Users and carers want much better communications with staff, and also between professionals; more consistent support from social workers and occupational therapists, with reduced waiting times for services; better, clearer information about services; more local, flexible day opportunities; more opportunities for self-assessment, housing and employment; the extension of direct payments and individual budgets; and better services for those with

acquired brain injury. The Government and the inspectorates have similar expectations.

Compared with generally high-performing North Somerset, Somerset and Shropshire, Herefordshire is slower to begin and complete assessments; much slower to deliver care packages; quicker to deliver equipment but much slower in carrying out major adaptations; provides less home care overall because of its low level of intensive home care, and does so at a relatively high unit cost; provides much more residential care; provides more of its day care in buildings-based settings rather than in local and generic facilities; does less to help people into employment; has fewer people in receipt of direct payments; doesn't provide a single point of access for users and carers; does less to support carers; and does less to enable users and carers to shape the planning and development of services. It incurs higher gross and net costs, attracting proportionately less than half the external income secured by Shropshire.

To achieve high-performing, cost-effective services by 2012 Herefordshire needs to do much more to support people, including those with intensive care needs, in their own homes and communities, placing much more influence and control in the hands of users and carers. This will require the cost-effective, local replacement of the current out-of-county provision and, more generally, a significant reduction in the use of residential care. There is an urgent need to emulate the high-performers by integrating the county's occupational therapists into single community teams under common line management.

Considering together the expected 5% increase in demand for services over the medium-term, the need for new forms of services to meet this cost-effectively, the additional costs of provision arising from Herefordshire's uniquely high number of people living in sparsely populated areas and the manifest inefficiencies in the current pattern of services, **overall it would seem reasonable to conclude that the aggregate level of spending by the Council in 2006-07 (i.e including the over-spending against budget of just over £1 million), maintained in real terms and with the proceeds of efficiency savings reinvested in the new services will be needed recurrently until 2012, but that annual savings of some £209K a year should be possible by 2012-13.**

In addition, to establish the more efficient and effective new pattern of services, non-recurrent bridging funding for social care of between £200K and £250K a year will be required through to 2011-12.

Limitations of currently available information about PCT funding mean that there is no basis for comparisons with other areas in respect of health expenditure. The prudent assumption for now, pending the further work that will be done to develop the joint commissioning plan to deliver the improved pattern of services, is that at least the current level of expenditure, maintained in real terms, will be required.

To avoid a vicious circle of decline, the transformation plans to bring about the new pattern of services must be fully integrated with the steps taken to manage current in-year over-spending against budget.

Moreover, these resources will not do the job without the full and quickest possible integration of all aspects of planning, commissioning, delivery and performance management of health and social care across the Council and PCT.

It will also require the large-scale extension of direct payments and individualised budgets; better support for carers; maximising the contribution and effectiveness of GP-based commissioning; adjusting the balance of PCT and Council funding to achieve a single, shared set of commissioning targets; attracting significant additional funding from external sources; and working closely with the third sector to mobilise voluntary and community resources behind the development of preventative services, access to generic local services and facilities, advocacy for individuals and help-lines.

The new services will only work if all those caring for and supporting people with physical disabilities are developed to have the right skills and behaviours. This will need to be done as part and parcel of the introduction of the streamlined processes and ICT-based systems being put in place under the *Herefordshire Connects* programme, buttressed by strong, disciplined performance management at all levels.

Section 1: Introduction

1.1 Working together and with their partners, the Council and the Herefordshire Primary Care Trust (PCT) are committed to maximising the independence, well-being and choice of people with physical, including sensory disabilities.

1.2 Despite additional investment over previous years, and changes aimed to enable people to lead safe and fulfilled lives in their own homes and communities rather than in unnecessary residential care, the Council's and PCT's current patterns and levels of services are not, in important respects, achieving as much and providing the same value for money as are the highest performing comparable areas.

1.3 In addition, the costs of services in Herefordshire have risen substantially in recent years and continue to do so, to the extent that expenditure has significantly exceeded budgets.

1.4 This is taking place against the background of the ambitious developments in Government policy for health and social care set out in the White Paper of January 2006, *Our health, our care, our say: a new direction for community services*. This calls for a fundamental shift in services to local communities, to be developed by local partners in ways that better meet the needs of individual people. It sets four main goals:

a. **better prevention and earlier intervention** – reducing the chances of people becoming ill or dependent in the first place;

b. **more choice and a louder voice** – ensuring that people are in control of the services they receive, through involvement in the planning and development of services, and by means of self-directed care, including direct payments and budgets for individuals;

c. **tackling inequalities and improving access to a wider range of community services** – ensuring that the areas, groups of people and individuals with greatest need get the services they deserve;

d. **more support for people with long-term needs** – better integration of services and joint planning across health and social care for those who make the most intensive use of services.

1.5 These goals are developed in more detail for physical disability services in other authoritative publications, including *Improving Life Chances for Disabled People* (PM's Strategy Unit 2005); *Long-Term (Neurological) Conditions* (NSF, DH 2005); and *Supporting People with Long Term Conditions to Self Care* (DH 2006). They are expressed most concretely in the seven outcomes for people used by the CSCI in their assessments of care: *Improved health and emotional well-being;*

Improved quality of life; Making a positive contribution; Exercise of choice and control; Freedom from discrimination and harassment; Economic well-being; and *Personal dignity and respect*.

1.6 The goals are underpinned by national consultation showing strong support for more community services. That is reflected in the consistent findings of public consultation in Herefordshire, including that carried out with users and carers specifically to inform this assessment (details are given in section 3 below). The Council, the PCT and their partners in The Herefordshire Partnership have made *Healthier Communities and Older People* one of the *Herefordshire Community Strategy*'s four priorities for better outcomes.

1.7 In the light of these considerations, the Council and the PCT are committed to work with their partners, service users themselves and their carers and representatives to develop and deliver better, sustainable services for the future. They want, in particular, to strike the right balance between preventative services and the provision of more intensive support and care.

1.8 In all of this, the Council and PCT are particularly conscious not only of the inter-dependence of health and social care one upon the other in achieving the best outcomes for people, but also of the vital contribution that needs to be made by housing, employment services, education, welfare benefits, generic community-based opportunities (such as cultural and leisure services), the voluntary and community sector, and, not least, by users and carers themselves and by their advocates.

1.9 Crucial too are effective links to ensure smooth transition between the services provided for children and young people and those for adults; and between services for 18-64 year-olds and those for older people.

The purpose of this report

1.10 Having last year assessed future needs for older people and adults with learning disabilities, and agreed how services would be developed to meet them, the Council and the PCT decided to carry out, with the *Herefordshire Alliance*, a thorough assessment of future needs of 18-64 year-olds with physical disabilities; of the services needed to meet those needs; and of the costs involved in doing so, taking into account the scope for greater efficiency in moving from the present services to a new, more effective pattern.

1.11 This report has been prepared under the leadership of the Council's Corporate Policy and Research Team, working with staff in the PCT, in the Council's Adult Social Care Department and Resources Directorate, and with *The Herefordshire Alliance* and *The Herefordshire Centre for Independent Living*. The membership of the Steering Group is at Appendix 1.

1.12 The Steering Group has been advised by distinguished experts in the field, Professor Gerald Wistow and Eileen Waddington. Further information about the expert advisers is at Appendix 2.

1.13 The first stage of the project was to estimate the need for care of 18-64 year-olds with physical disabilities through to 2021. This was to provide the long-term context for the second stage: the assessment of what patterns and levels of cost-effective services would be needed to meet expected needs in 2012.

1.14 Rather than conduct a theoretical assessment of the services that will be needed, the best possible comparator areas were identified; that is those with high-performing services in areas with broadly similar settlement patterns and demographic characteristics to those found in Herefordshire. The selected areas were North Somerset, Somerset and Shropshire.

1.15 Through analysis of comparative data about services and costs, of inspection reports, and by visiting the authorities, we established what patterns and levels of services they provide; how they intend further to change and improve them to meet future challenges; and, crucially, how they manage and deliver them successfully. These findings were then applied, having regard to the distinctive needs and circumstances of Herefordshire and to wider relevant comparisons.

1.16 The final stage was to translate these findings into costed proposals for the development of high-performing services through to 2012.

The structure of the report

1.17 Section 2 of the report examines future needs to 2012 and 2021. Section 3 describes what pattern and levels of services will be needed to meet those needs in 2012. Section 4 looks at the capacity needed to develop and deliver these services successfully. Section 5 sets out the estimated costs of doing so, comparing them with current costs.

Section 2: Assessment of future needs

2.1 The full assessment of future care needs for 18-64 year-olds with physical disabilities is at Appendix 3. It begins with a summary.

2.2 The crucial points are:

- an estimated 13,200 people between the ages of 18 and 64 in Herefordshire have **some kind of physical disability**, meaning one that reduces the person's locomotion, sight, hearing, communication and/or ability to wash, dress, feed, go to the toilet, or get in or out of a bed or a chair

- of these, an estimated 3,200 have a **serious disability**

- by 2012 the numbers with moderate disabilities are expected to grow by 5%, as are the numbers with serious disabilities

- however, the current estimated number with **moderate disabilities who are likely to require personal care** at some time is much lower, at 4,600; a figure that is expected to increase by no more than 5% (250 people) by 2012 and 8% (350 people) by 2021

- the estimated current number with **serious disabilities likely to require personal care** at some time is fewer still, at 950; a figure that is expected to increase by a maximum of 5% by 2012 (50 people) but not further by 2021

- almost all people with a personal care disability are likely to have a **locomotor disability**

- within these totals, 1,450 are estimated to have a **sight disability**, which is serious for an estimated 250; these numbers are not expected to change by 2012, but they are expected to increase by 50 for people with serious disability by 2021

- an estimated 3,000 people have a **hearing disability**, but for only 100 people is this serious; that 100 is expected to increase to 150 by 2012, and to remain at this level in 2021

- an estimated 1,250 people have a **communication disability**, which in 300 cases is serious; the maximum expected change in the number with a moderate disability is an additional 50 by 2012, but no change is expected in the number with a serious disability

- the **principal driver of these increases** in need is the projected rise in the numbers of people aged 55-64, of 7.1% by 2012 and

20.6% by 2021 (compared with 3.7% and 5.5% for England and Wales as a whole); this is because a number of the most common physical disabilities are more often found in this age-group than amongst younger adults

- it is not possible at present to estimate the numbers of people in **different ethnic groups** in the county with physical disabilities; nor to produce estimates of the numbers of people likely to have these in **different parts of Herefordshire**

- it is estimated that between five and seven young people with physical disabilities a year are likely to be in **transition from children's to adults' services**

- the prevalence of physical disability is much higher than those who need – or probably want – social or most other forms of care and support; this underlies the huge disparity between some of the numbers above and the **number of people aged 18-64 known to services**. In March 2007, 328 were receiving core social care services, while a further 293 were being helped less intensively by means of information, advice and annually serviced equipment. During 2006-07 as a whole, there were over 650 users of core social care services; the large difference between this figure and the snapshot figure for March is accounted for by the turnover of people receiving short-term services, such as intermediate care and welfare benefits

- taking into account the estimated increases in physical disabilities in the population summarised above, **it would appear appropriate to plan to provide care and other support for an additional 5%. This would equate to an additional 37 users of core social care over the year as a whole; and, at any one time, an additional 16 users of core social care and 15 additional users of less intensive services**

- there were, in 2005, an estimated 14,100 people in the county aged 18-64 acting as unpaid **carers** for at least one hour a week, of whom 3,600 were providing care for 20 hours or more; we have no reliable basis on which to estimate the number of these caring for someone with a physical disability, but it would seem safe to assume that the number is substantial; and it would also seem safe to assume as likely a modest increase in this number to reflect the expected growth in the number of younger people with physical disabilities

- although we do not have detailed information about either the **incomes or accommodation** of people with physical disabilities, there is enough evidence nationally and locally to

assume that they are likely to have lower than average incomes and to be more likely to live in social rented accommodation

2.3 In considering these estimates, it is important to bear in mind the paucity of reliable data currently available nationally, regionally and locally as regards both present and future levels of need. A study for the Department of Work and Pensions concluded in 2004 that, "*there is no single 'gold standard' measure of disability. The multi-dimensional and dynamic nature of disability makes it inherently difficult to measure*." And a 2007 study of possible future trends by the Institute of Public Policy Research for the Disability Rights Commission, based on self-reporting of long-term health problems and disability, qualified their finding that there could be substantial increases with the words, "..*the fact that a pattern has occurred between 2001 and 2004 is not a guide to the pattern over the next four years, much less over the next 15 years*."

2.4 It has been suggested that the substantial rise in obesity will lead eventually to higher levels of a range of disabilities, for instance those associated with diabetes, stroke and coronary heart disease. On the other hand, intensifying health promotion together with legislation, such as the ban on smoking in public places, may result in improved diet and health. It is not possible at the present time to be clear about even the broad net effect of these and other factors that may give rise to either more or fewer physical disabilities in the future.

2.5 Within Herefordshire difficulties arise because data have not been collected and because the various separate data-bases maintained by the Council and the PCT about individuals mean that there is likely to be extensive double-counting or more. On the other hand, some things are probably not being counted at all. These deficiencies will need to be addressed to provide a sound basis for the future monitoring and planning of services, as well as to meet fully statutory requirements in respect of equalities and those to come requiring a Joint Strategic Needs Assessment for health and social care.

2.6 It is of great importance that we rectify these deficiencies as quickly as possible. Much of this will be made possible by the introduction of a single user data-base and other improvements under the *Herefordshire Connects* programme, including the development of shared systems between the Council and PCT within the Public Service Trust. The longer-term estimates in this report should be reviewed as these improvements bear fruit.

2.7 That said, the present estimates are the best possible current basis for planning and delivering improved services to 2012, in respect of which it is possible to be reasonably confident about the extent and nature of future needs.

Section 3: The pattern and levels of services to meet needs in 2012

3.1 Drawing on the views expressed by users and carers in Herefordshire, on Government and other authoritative national requirements and guidance regarding physical disability services, together with the evidence about high-performing services gathered from the comparator areas – North Somerset, Somerset and Shropshire – this section describes what needs to be done, to what extent, to achieve services that will meet the needs identified in section 2.

The views of users and carers

3.2 The views on present and future services of users and their carers and personal advocates were sought at a forum in July 2007. 26 took part, expressing clearly and forcefully what they want from services.

3.3 Their main points were:

- communications between staff and those receiving assessments and care need to improve a lot
- as do communications between professionals about individuals' care
- especial concern about the need for better, more consistent communications and support from social workers and occupational therapists, with a particular need to reduce waiting times for assessments and occupational therapy services
- the need for better, clearer information about services
- a need to increase opportunities for self-assessment
- the need to eliminate delays in the provision of equipment, in the carrying out repairs and, especially, in making major adaptations
- a need for improved housing opportunities
- the need to increase employment opportunities, including through avoidance of the benefits trap
- the majority wanting more community-based/generic day opportunities, but a minority concerned about the possible loss of valued current buildings-based services
- on the back of a perception that those in receipt of them are

living more independently than others, the importance of increasing the number of people receiving direct payments or individual budgets

- the need to improve services for those, often younger people, with acquired brain injury

Government and inspectorate requirements

3.4 The improvements users and carers want to see reflect key elements of the national requirements and guidance on good practice. Other key elements expected by Government and the inspectorates are:

- the fullest possible participation in society being the touchstone, including meaningful employment
- advocacy and other help for individuals to promote their social inclusion
- user and carer involvement in service planning and development
- the fullest possible integration of the commissioning and provision of services across health and social care
- a single point of contact and continuity for users and carers across agencies
- the systematic and effective management of the transition of young people from children and young people's services to those for adults
- the provision of information, advice and, where appropriate, assessment to the whole population, including self-funders

Comparing with high-performers

3.5 In comparison with the relatively high-performing North Somerset, Somerset and Shropshire, Herefordshire:

- is slower to begin assessments (88% of contact within 48 hours, compared with an average of over 96%, with Somerset achieving 99%)
- is slower to complete assessments (83.6% within 28 days, compared with an average of 89%, with Somerset achieving 94.9%)

- is much slower to deliver care packages (76% within 28 days, compared with an average of 92.5%, with Shropshire achieving 96%)

- the proportion of its total net social care expenditure classified as assessment and care management is the lowest (6%); substantially lower than the average (18%); and massively lower than Shropshire (26%)

- is much slower in carrying out major adaptations (average waiting time 39 weeks, compared with 33 in Shropshire and 16.5 in Somerset)

- is best at delivering equipment within seven working days (96%, compared with an average of 93%)

- helps a slightly higher proportion of 18-64 year olds with physical disabilities to live at home (6 per 1,000 population, compared with an average of 5.5)

- but provides less intensive home care for all adults (6.7 per 1,000 population, compared with an average of 9.4)

- despite this lower level of intensive home care, its unit costs for home social care as a whole are much higher than the average (£295 per person per week, compared with an average of £160)

- provides substantially more residential and nursing care than two of the three comparator areas (32 per 1,000 population, compared with an average of 24 in North Somerset and Shropshire, and 57 in Somerset); most dramatic is the comparison with Shropshire: whereas 32% of Herefordshire Council's total net expenditure is on these forms of care, Shropshire spends only 14%.

- most of its day care is buildings-based as opposed to being shaped around the needs of individuals, with an emphasis on community-based and generic facilities; this is reflected in a social care cost per user per week that is higher than the average for Shropshire and Somerset (£102, compared with £83; with Shropshire alone £69)

- does less to enable people to gain or retain employment

- all Herefordshire's occupational therapists are employed by the PCT and, unlike the comparator areas, are not integrated into single community teams under common line management; this is a principal cause of our relatively poor performance, including delays in assessments, the delivery of care packages and major adaptations

- doesn't provide a single point of access across health and social care for users and professionals

- does less to support carers (services provided to carers in respect of 10% of service users, compared with an average of over 12% and North Somerset's nearly 14%)

- does less to enable users and carers to make an influential contribution to the planning and development of services

- has improving, but still weak and inefficient, systems for the collection and analysis of data, on the basis of which the performance of services can be continuously monitored and improved

- overall, incurs higher social care gross costs (£47 per head of the 15-64 population per annum, compared with an average of £42; and with North Somerset's figure of only £34)

- attracts about the same level of income as the average of the comparators per head of the 15-64 population from charging service users for social care, but this will rise under the new fairer charging arrangements

- generates about the same level of other external income for social care per head of the 15-64 population, but under half of that secured by Shropshire (£1.46 compared with £3.16)

- limitations of currently available information about PCT funding mean there is no basis for comparisons with other areas in respect of health expenditure

The new pattern of services required

3.6 This analysis leads to our recommending the following principal changes to achieve the modern, cost-effective patterns of services that would meet future needs in Herefordshire.

3.7 The fundamental strategic shifts needed are to do much more to support people, including those with intensive care needs, in their own homes and communities; place much more influence and control in the hands of users and carers; and integrate fully the planning, commissioning and delivery of care and support across the Council and the PCT.

3.8 The specific changes to achieve this should be:

- commissioning cost-effective services within the county to replace current out-of-county placements and avoid them in the future, wherever this is in the interests of users

- developing own-home and community-based services so as to reduce to the absolute minimum the use of residential and nursing home care

- maximising the targeted use of telecare, so that people are able to live safely in their own homes

- moving away from traditional, buildings-based services by developing and enhancing access to community-based, often generic opportunities

- working closely with the third sector to mobilise voluntary and community resources behind the development of preventative services, access to generic local services and facilities, advocacy for individuals and help-lines.

- enhancing recovery and rehabilitation services, particularly for people with acquired brain injury; these improvements should include home support, housing, education, training and employment opportunities, and support, where necessary, to access general community facilities

- the maximum possible number of people securing their own care with direct payments or individual budgets

- securing effective, independent advocacy for individuals

- providing better, clearer information about services, tailored to meet the needs of different groups of users

- securing services to support carers to continue in their role and improve their own health and well-being, including, where necessary, help to retain or gain employment

- systematic, continuous user and care involvement in the planning and development of services, including financial assistance and capacity-building to make this possible; with regular surveys of users' and carers' views about services and the quality of their lives, and the systematic use of complaints to improve services

- developing a shared philosophy and approach across children's and adults' services, reflected in fresh protocols, to ensure a smooth and successful transition for young people moving between them

- identifying the needs of ethnic minority groups and then tailoring services to meet them

- as a pre-condition for the necessary service improvements, and therefore as a matter of urgency, putting in place a single set of arrangements across the Council and the PCT for the planning, commissioning, delivery and performance management of health and social care

- as an essential part of this, creating wholly integrated community-based teams including the occupational therapists, under single line-management

- establishing a single point of contact for users, carers and professionals, buttressed by shared business processes and information systems

- improved preventative and intermediate care services for people with chronic conditions by means of joint management of health and social care

- doing all this in partnership with GP practices to achieve effective integration between community teams, therapy services, GPs and practice and district nurses, and to maximise the effectiveness of GP-based commissioning

3.9 A number of the necessary improvements are already beginning to happen or are planned. These include:

- the expert patient programme, which helps people with long-term conditions to improve their quality of life, delivered by volunteers who themselves have long-term conditions

- chronic back-pain classes and insulin management groups for insulin-dependent patients and their carers

- two well-being co-ordinators promoting targeted preventative services with GP practices to avoid inappropriate hospital and care home admissions

- the initial roll-out of telecare, with over 97% of service users feeling that this has increased their independence

- the appointment of a Physical Disability Co-ordinator to identify opportunities for young people in residential care to live with support in the community

- intermediate care flats to enable people to undertake daily living activities and increase their independence

- working in partnership with voluntary bodies to maximise the take-up of direct payments and, through welfare rights information and advice, people's income

- the temporary appointment of an officer to draw up the joint commissioning strategy that will secure the improved pattern of services

3.10 The overall pattern and levels of high-performing services proposed are set out in Appendix 4, which also explains the underlying assumptions.

Section 4: The capacity needed to deliver the Improvements

4.1 Achieving successful change on the scale necessary to meet future needs cost-effectively requires not only careful, detailed planning across health and social care (and beyond) but also a firm, co-ordinated grip on all aspects of managing projects, finance, human resources and performance.

Funding

4.2 Overall and pro rata to the 15-64 population, the current level of social care ***gross funding*** is almost 12% above the average for the comparator areas. It is, however, only marginally above that for Shropshire, which provides the closest match to Herefordshire's circumstances.

4.3 However, the ***net cost*** to the Council is a significant 4% higher per head of population than Shropshire. Since Shropshire raises less per head of population from charges to users, this is entirely because Shropshire raises more than twice as much external income per head.

4.4 Considering together the expected 5% growth in the need for services, the additional costs of provision arising from Herefordshire's uniquely high number of people living in sparsely populated areas, inefficiencies in the current pattern of services, and on the basis that Herefordshire should be capable of generating proportionately equivalent levels of external income to those achieved by Shropshire, in addition to the additional income that would result from the proposed new fairer charging arrangements, **overall it would seem reasonable to conclude that the aggregate level of spending by the Council in 2006-07 (i.e including the over-spending against budget of just over £1 million), will be needed recurrently until 2012.**

4.5 **This would hold true only if this level of spending were to be maintained in real terms and if the efficiency savings that would be secured under the new pattern of services were retained for investment in those new services.**

4.6 **Moreover, although the reduction in services no longer required, for example expensive out-of-county residential placements, should be expected to pay the recurrent costs of the new pattern, this can only happen if there is targeted, time-limited, non-recurrent funding to develop the new services, such as for reablement, advocacy and carers.**

4.7 The PCT has not hitherto been required to collate expenditure figures in respect of care for particular age-groups. For the purposes of this assessment, it has estimated that its total costs of commissioning

services and directly providing physiotherapy and occupational therapy for 18-64 year-olds with physical disabilities were £1.16 million in 2006-07 and are likely to be some £1.22 million in 2007-08. Despite this initial estimate, **there is no basis currently for comparisons with other areas in respect of health expenditure. The prudent assumption for now, pending the further work that will be done to develop the joint commissioning plan to deliver the improved pattern of services, is that *at least* the current actual level of expenditure, when it has been determined, maintained in real terms, will be required.**

4.8 The assumption that the current real levels of recurrent funding should be an adequate basis for emulating the achievements of the high-performing comparator areas rests on six crucial additional provisos:

- that the large-scale extension of direct payments and individualised budgets will be managed in such a way that significant efficiency savings are generated for recycling in physical disability services

- that support for carers will be strengthened (recent research by the University of Leeds estimates that the average carer saves the nation more than £15,000 a year)

- that the contribution and effectiveness of GP-based commissioning will be maximised

- that the balance between PCT and Council funding will be adjusted, where necessary, to achieve a single, shared set of commissioning targets

- that we will attract significant additional funding from external sources (such as Government grants, including Supporting People, charities, private business and the National Lottery)

- that this and wider benefits will be achieved by working in close partnership with the third sector, so as to provide access to wider sources of external funding and, even more important, to mobilise voluntary and community resources behind the development of preventative services, access to generic local services and facilities, advocacy for individuals and help-lines; this may include the development of user-led organisations as service providers

4.9 Moreover, the plans for radical transformation that will produce sustainable, affordable and cost-effective services must be fully integrated with the steps taken in response to the current over-spending. Unless this is done, on the basis of establishing an agreed programme of change for the coming four years, underpinned by the necessary minimum recurrent and targeted non-recurrent funding,

services will deteriorate in a vicious circle of ad hoc cuts and retrenchment that will render them incapable of meeting future needs .

4.10 These considerations underpin the costings in section 5 below.

Human resource, organisational and systems considerations

4.11 Developing and delivering the new pattern of services will require considerable, sustained management effort and a systematic approach to workforce planning and performance management, so as to ensure that all those providing care and other support to people with physical disabilities have the right skills and exhibit the right behaviours.

4.12 Elements of a good basic infrastructure have now been created in the Council and the PCT which, together with an increasingly productive relationship with both the third and private sectors, has the potential to bring about the necessary changes. Notably, this includes an Interim Head of Adult Social Care, a dedicated Head of Learning Disability, a Change Manager, the strengthening of the PCT and Council Planning and Change Team, including a Physical Disabilities Commissioning Manager, and additional appointments to the Council's contracts and adult safeguarding teams.

4.13 However, this strengthened capacity is already tackling a comprehensive transformation programme that includes the fundamental reshaping of older people's and learning disability services, and the development of wholesale new procedures and management systems; to which will now need to be added, as well as that in respect of physical disabilities, a similar reshaping of mental health services. These and other **existing resources will not be able to do the job without the full and quickest possible integration of all aspects of planning, commissioning, delivery and performance management of health and social care across the Council and PCT**. In turn, this will require the putting in place of single procedures, processes and ICT systems as part of the *Herefordshire Connects* programme.

4.14 Physical disabilities planning and commissioning capacity will be needed; the present Commissioning Manager post is temporary, filled by a secondment and due to end in April 2008.

4.15 This will need to be funded either from existing budgets or, if that is not possible, from the first tranche of non-recurrent investment in 2008-09, with the recurrent costs absorbed as the new pattern of services produces off-setting savings.

4.16 Underpinning all of this, there will need to be a cross-agency development programme for all those caring for or supporting people with physical disabilities. A partnership workforce strategy for

the whole of adult health and social care is already in the early stages of development. This will need to include a dedicated element to deliver the improvements in physical disability services.

4.17 Similar considerations apply to the rolling out of the communications strategy and action plan for the comprehensive transformation programme.

4.18 The new pattern of services should be subject to regular review and periodic formal evaluation, taking account of a progressively better understanding of the nature and level of need. This should include an external, independent element, if possible linked to national evaluation programmes.

Section 5: The costs

5.1 Appendix 4 contrasts the proposed high-performing services in 2012 with the services in place in 2006-07.

5.2 Unless services are fundamentally reshaped along the lines proposed in this report, they would fail to meet the needs and wishes of users and carers, and also the expectations of Government and the inspectorates. Worse still, this would take place in a context where the performance of other areas can be expected, on average, to continue to improve year-on-year and in which Government and the inspectors are likely to have ratcheted up the minimum acceptable standard for services and, therefore, the threshold for intervention.

5.3 Additionally, the maximum possible sustainable improvements in efficiency can be achieved only if services are modernised as proposed. This is illustrated by the growth, from 16 in 2005-06 to 20 currently, in the use of residential care, with an increase to ten out-of-county placements, which are costing the Council over £500,000 a year. There is a substantial danger that, in the absence of adequate local, community-based services, this trend will continue, resulting in even greater spending pressure against budgets.

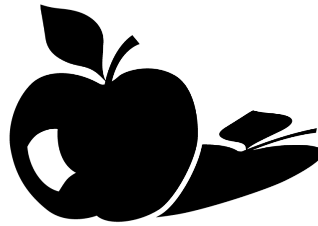
5.4 **The recurrent spending required annually on social care from 2008-09 through to 2011-12 is the 2006-07 expenditure of £4.826 million, maintained in real terms.**

5.5 **Pending the further work that will be done to develop the joint commissioning plan to deliver the improved pattern of services, the prudent assumption is that *at least* the current actual level of PCT expenditure, maintained in real terms, will be required recurrently.**

5.6 **In addition to these recurrent costs, non-recurrent investment of the following order will be required to put in place the new pattern of services** :

Year	£000
2008-09	200
2009-10	250
2010-11	250
2011-12	200

5.7 **Annual savings of some £209K a year in social care costs should be possible by 2012-13.**



NEEDS ANALYSIS: ADULTS WITH PHYSICAL DISABILITIES

Principal factors that will determine the need for services for people aged 18 to 64 with physical disabilities

October 2007

Final Version (4.4)

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TABLE OF CONTENTS

EXECUTIVE SUMMARY ..... **iii**

INTRODUCTION **1**

DEMOGRAPHICS OF HEREFORDSHIRE **2**

The County of Herefordshire 2
Current Population 2
Recent Trends 3
Migration 3
Ethnicity 5
Future Population 6
Communal Establishment Population 8

GENERAL HEALTH IN HEREFORDSHIRE **9**

Life Expectancy & General Health 9
Limiting Long-term Illness 10
Physical Health Functioning 10

KNOWN ADULTS WITH A PHYSICAL DISABILITY **11**

Service Users 11
Benefit Claimants 12

ESTIMATING NUMBERS WITH A PHYSICAL DISABILITY (CURRENT & FUTURE) **16**

National Prevalence of Disability 16
Any Type of Physical Disability 19
Personal Care Disability 19
Locomotor Disability 21
Sight Disability 21
Hearing Disability 22
Communication Disability 23

ETHNICITY OF ADULTS WITH PHYSICAL DISABILITIES **25**

GEOGRAPHIC DISTRIBUTION OF ADULTS WITH PHYSICAL DISABILITIES **26**

CARERS **27**

Numbers of Carers 27
The Cared For 28
Carers' Health 28

ABILITY TO PAY **30**

Earnings 30
Income 30
Employment and financial characteristics of people with a disability 30

HOUSING **32**

Home Point register 32
Tenure of people with disability / limiting long-term illness 32

REFERENCES **34**

EXECUTIVE SUMMARY

Introduction
Looking forward to 2012 and 2021, this report is an assessment of the principal factors that will determine the need for social and health care for adults aged 16 to 64 years with physical disabilities. A physical disability can be defined as a disability which reduces the individual's locomotion, seeing, hearing, communication and/or ability to carryout activities of daily living (ADLs).[1] Different levels of severity will present different issues to public authorities in terms of what, if any, services people with physical disabilities require.

Demographics of Herefordshire
- Herefordshire's current[2] estimated population of 18-64 year-olds is 105,600 – 59% of the total population. The county has an older overall age profile than both the West Midlands region and England and Wales.
- Office for National Statistics projections suggest numbers of 18-64 year-olds may increase by 2.0% by 2012, although more conservative local forecasts which take in to account expected housing provision suggest this increase will only be 0.1% by 2011.
- Projections suggest the 18-64 year-old population could be 107,000 in 2021, an increase of just 1.3% from 2005.
- Recent years have seen a more rapid growth in numbers in older age-groups (55-64s) and a more rapid decline in the younger ones (18-34s) than nationally. This ageing of the age profile is expected to continue, with the 55-64 year-old age-group growing most rapidly (by 7% in the short-term and 21% by 2021).

- The county has a smaller proportion of people from 'Black and Minority Ethnic' (BME) backgrounds than England as a whole (3.5% compared to 14.7%), but this population grew by 40.9% between 2001 and 2004 – much more rapid than the overall population growth of 1.7%. It is likely that numbers have increased further since the expansion of the EU in May 2004: between 2,500 and 3,000 workers from new member states were cleared to work in Herefordshire in 2005, although it is not known how many remain in the county. The county also experiences an annual influx of around 3,000 temporary seasonal agricultural workers – mainly over the summer months.
- In 2004, 3.8% of 18-64 year-olds in Herefordshire were estimated to be from a BME background; just under half of these were non-white.

Estimating numbers with a physical disability (current & future)
Numbers of household residents aged 18-64 in Herefordshire with disabilities were estimated (for 2005) and projected using national prevalence rates from 2000-01:
- Currently, an estimated 13,200 people have a disability of any type, 3,200 of whom have a 'serious' disability. The maximum expected increase would be 5%, in both 'serious' and 'moderate', by 2012; 7% in 'moderate' and 8% in 'serious' by 2021.
- There are an estimated 950 household residents with a 'serious' personal care disability, the type of disability most pertinent to social care service planning. This number is expected to increase by a maximum of 5% (50 people) by 2012. No further change is expected in the longer term. Therefore, if all who need such a service are receiving care, there can be expected to be no notable change in demand in either the short or long-term.
- The number of people with a 'moderate' personal care disability (4,600) is expected to increase by a maximum of 5% (250 people) in the short-term, and 8% (350) by 2021.
- Locomotor disabilities are the most common type of disability; the national survey found that almost all of the people with a personal care disability also had a locomotor disability.

[1] Being able to wash, dress, feed, toilet, get in/out of bed or a chair; Health Survey for England, 2001
[2] ONS 2005 mid-year estimate. In August 2007, after this needs analysis work was completed, the ONS published revisions to the population estimates and projections. As a result, Herefordshire's population was reduced. Analysis has shown that the revisions have no notable effect on the estimates or projections of the numbers of people with a physical disability.

- An estimated 9,200 people have a locomotor disability; 2,050 are classified as 'serious', a number which is expected to increase by a maximum 7% (150) in the short-term and 10% (200) by 2021.
- 1,450 household residents are estimated to have a sight disability, 250 of them 'serious'. This group is expected to remain at a similar level in the short-term, and increase by around 50 people by 2021 (no notable change in 'moderate' numbers).
- An estimated 3,000 people have a hearing disability, but only 100 of these are classified as 'serious'. The latter number would be expected to increase by 50 people by 2012, and remain at this level in 2021.
- It is estimated that there are 1,250 people with a communication disability, 300 of which are classified as 'serious'. The maximum expected change is an increase of 50 people with a 'moderate' communication disability by 2012, with no change in 'serious' in either the short or long-term.

Ethnicity of Adults with Physical Disabilities

- It is not possible to produce estimates of the number of people in different ethnic groups in Herefordshire with physical disabilities.
- The proportion of Physical Disability service users of an ethnic origin other than 'White British' in 2006/07 was less than half the proportion in the total population of 18-64 year-olds in 2004 (which itself may have increased, given anecdotal changes in the ethnicity of the total population since the expansion of the European Union in May 2004).
- Nothing is known about the general health and social care needs of migrant and seasonal workers in Herefordshire.

Geographic Distribution of Adults with Physical Disabilities

- It is not possible to produce projections of the number of people in different parts of Herefordshire who will have a physical disability.
- Further work would be required to determine the distribution of adults with physical disabilities across Herefordshire, and if current services are provided equitably regardless of location.

Carers

- Assuming that the prevalence of caring in Herefordshire is as it was at the 2001 Census, 14,100 people aged 18-64 in Herefordshire are estimated to have been providing at least one hour of unpaid care a week in 2005, with 3,600 providing care for 20 hours or more per week.
- At the same time, 1.3% of 18-64 year-olds in the county (1,340 people) were entitled to Carers' Allowance, i.e. were not in employment or full-time education and were caring for a severely disabled person for at least 35 hours a week.
- Carers are more likely to be in 'not good' health than non-carers, and the disparity increases with the amount of time spent caring per week.
- People who provide care over a long period of time are particularly at risk of poor health. Carers' health is also more likely to deteriorate over time than that of non-carers, with many of the detrimental changes attributable to the caring role. However, these risks are more likely to be in relation to carers' mental health; in an ONS survey only 8% of carers reported that caring responsibilities had a direct impact on their physical health.

Ability to Pay

- Average earnings in Herefordshire are significantly below those in England as a whole, but there is no information on *incomes* locally.
- There is no information about the financial situation of adults with disabilities in Herefordshire, but national evidence suggests that it is reasonable to assume that people with a disability are more likely to have a low income than those without. This will have implications for their ability to pay for the costs of services

Housing

- Although little is known about the housing situation of adults with disabilities in Herefordshire, national and local information suggests that it seems reasonable to assume that people with physical disabilities are more likely to be living in socially rented accommodation that people without.
- In November 2006, 6.5% of 18-64 year-olds registered with Home Point were 'registered disabled', 'registered blind', were deaf or had partial hearing difficulties.

INTRODUCTION

Looking forward to 2012 and 2021, this report is an assessment of the principal factors that will determine the need for social and health care for adults aged 16 to 64 years with physical disabilities. These include demographic change, taking into account the expected levels and characteristics of in-migration; the implications of changing patterns of health, treatment, and the development of health care services in response to them; the extent to which people might be able to pay all or part of the costs of their social care; and housing.

A physical disability can be defined as a disability which reduces the individual's locomotion, seeing, hearing, communication and/or ability to carryout activities of daily living (ADLs).[3] Different levels of severity will present different issues to public authorities in terms of what, if any, services people with physical disabilities require.

The Disability Discrimination Act covers people who would be considered to be disabled under this condition, but also includes people with mental impairments and people with cancer, HIV and multiple sclerosis from the point of diagnosis (before the condition has necessarily had an impact on their day-to-day living). It defines a disabled person as: "…someone who has a physical or mental impairment that has a substantial and long-term (i.e. 12 months or more) adverse effect on his or her ability to carry out normal day-to-day activities…like eating, washing, walking and going shopping", in relation to "…mobility, manual dexterity, speech, hearing, seeing and memory".[4]

There are differing views in defining disability: the traditional, medical definition which classifies people on the basis of the impairment from which they suffer, and the social model which defines people as being disabled not by their impairment but by the barriers that society creates for them. Due to the prevalence data that is available, the medical model is used in this report. But the findings will be applied in terms of future services having regard to the social model and therefore the removal of barriers to people's full participation in society.

Note on revisions to Office for National Statistics' population estimates
In August 2007, after the needs analysis work was completed, but before the needs assessment was finalised, the ONS published estimates of population for mid-2006 using a new methodology for estimating international migration at the local level. At the same time, it revised the 2005 mid-year estimates – upon which the estimates and projections of the numbers of people with a physical disability in this needs analysis are based.

The local 2005-based forecasts for Herefordshire will not be revised, but the ONS 2004-based sub-national population projections have been revised to take account of the new methodology.

Herefordshire's estimated population of 18-64 year-olds in 2005 was revised down from 105,600 to 104,300; the estimate for mid-2006 is 104,800. The projection for 2012 is now 105,600 (down from 107,700), and that for 2021 is 103,800 (reduced from 107,000)

Analysis has shown that the revisions have no notable effect on the estimates or projections of the numbers of people with a physical disability. There are some minor changes in some of the categories, but the key figure of the number of people with a serious personal care disability is not affected at all.

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[3] Health Survey for England 2001; ADLs are being able to wash, dress, feed, toilet, get in and out of bed or a chair.
[4] *Definition of 'disability' under the Disability Discrimination Act (DDA)*. Directgov website: http://www.direct.gov.uk/en/DisabledPeople/RightsAndObligations/DisabilityRights/DG_4001069

DEMOGRAPHICS OF HEREFORDSHIRE

THE COUNTY OF HEREFORDSHIRE

Herefordshire is a predominantly rural county of 842 square miles situated in the south-western corner of the West Midlands region, bordering Wales. With a population of approximately 56,000, the city of Hereford is the major location in the county for employment, administration, health, education facilities and shopping. The five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington are the other principal centres, with populations ranging from 11,000 (Leominster) to 2,500 (Kington).

The county has beautiful unspoilt countryside, distinctive heritage, remote valleys and rivers, including the river Wye which flows east through Hereford and the Wye Valley Area of Outstanding Natural Beauty. The south-west of the county includes the Black Mountains, and the Malvern Hills form part of the boundary with Worcestershire to the east.

Herefordshire has limited access to the motorway network via the M50, which starts near Ross-on-Wye and joins the M5 north of Tewkesbury in Gloucestershire. The other main road links, which all pass through Hereford, are the A49 (running from north to south), the A438 (east to west) and the A4103 to Worcester.

The nature of Herefordshire's rurality presents unique challenges to service providers, with a relatively small population of 178,800[5] scattered across the 2nd largest[6] unitary authority in England. Furthermore, although three English counties[7] have a lower population density than Herefordshire, no other top tier local authority has a greater proportion of its population living in "very sparse" areas.[8]

CURRENT POPULATION

Herefordshire's current total population is 178,800[5], of which 59% (105,600) are aged 18-64. Herefordshire has an older overall age profile than both the West Midlands Region and England and Wales, and this is apparent in the older groups within the population of interest in this report. Table 1 shows how Herefordshire has a larger proportion of 55-64 year-olds in its population than either the region or England and Wales as a whole, and a smaller proportion of 18-34 year-olds.

It should be noted that the mid-year estimates exclude around 2,700[9] Herefordshire students who live away from home during term-time, the majority of whom are likely to be aged 18-21. As the county has no universities, this group is not compensated for by students from other areas living within the county during term-time.

Table 1: Proportion of total population in adult age-groups, 2005

Area		18-34	35-54	55-64	18-64
Herefordshire	No.	*29,400*	*51,000*	*25,200*	*105,600*
	%	16.4%	28.5%	14.1%	59.1%
West Midlands Region	%	21.6%	27.6%	11.9%	58.4%
England & Wales	%	22.3%	28.1%	11.7%	62.0%

Source: 2005 mid-year estimates, ONS. Note: figures may not sum due to rounding.

[5] 2005 mid-year estimate, ONS
[6] Behind East Riding of Yorkshire
[7] Northumberland, North Yorkshire and Cumbria
[8] According to the sparsity measures used in the calculation of the Local Government Finance Settlement 2006/07, 29% of Herefordshire's population live in wards with a density of 0.5 persons per hectare or lower and 25% live in Output Areas with a density of 0.5 or lower.
[9] 2001 Census

Whilst gender distribution is an important issue when considering older people due to the longer life expectancy of females, it is less of one for adults aged 18-64; there is a roughly 50:50 split between males and females in the age groups of interest in Herefordshire, as nationally.

RECENT TRENDS

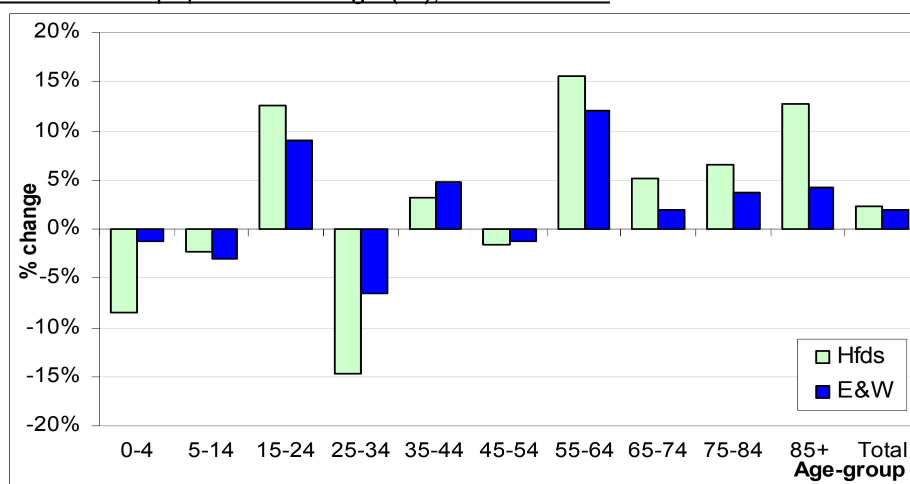
Herefordshire's population grew by 2.2% between 2001 and 2005, which is broadly similar to the national growth (2.0%), but change was not consistent across age-groups (Figure 3). The number of people aged 18-64 increased by 2,500 over this period – a growth similar to the total population growth but, as Table 2 shows, numbers of 18-34 year-olds fell by 4.5%, whilst the population aged 55-64 increased by 15.6%. These changes were in the same direction as national trends, but larger.

Table 2: Observed population change (%), 2001 to 2005

Age-group	Herefordshire	England & Wales
18-34	-4.5%	-0.5%
35-54	+1.0%	+2.0%
55-64	+15.6%	+12.1%
18-64	+2.4%	+2.8%

Source: mid-year population estimates, ONS

Figure 3: Observed population change (%), 2001 to 2005



Source: mid-year population estimates, ONS

MIGRATION

Within UK Migration

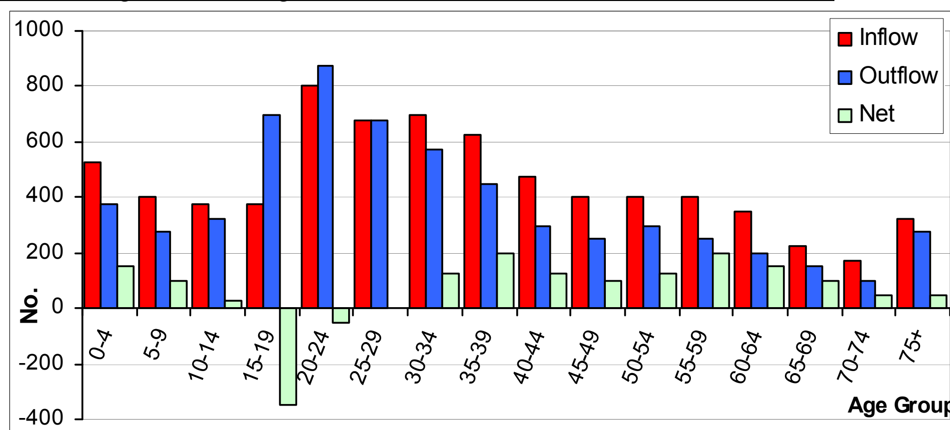
Herefordshire experiences an average annual net gain of just over 1,000 residents from elsewhere in the UK. Analysis of migration within *England and Wales*[10] shows that about two-thirds (65%) of the net migrants into Herefordshire come from London and the South-East (including Bedfordshire, Hertfordshire and Essex); just under a quarter (24%) from neighbouring English counties (Gloucestershire, Worcestershire and Shropshire); 13% from non-neighbouring parts of the West Midlands region and the rest from other parts of England; on average more people move from Herefordshire to Wales than vice versa, giving a net loss.

The average numbers of people in each age group moving into and out of Herefordshire each year, along with the average net in-flow (people moving *in* minus people moving *out*), are shown in Figure 4. The largest flows, both into and out of Herefordshire, are in the 20-

[10] Over the period mid-1998 to mid-2004

24 year-old age group. This is one of the age groups where people are most mobile generally, so the pattern is not necessarily unique to Herefordshire.

Figure 4: Average annual migration between Herefordshire and rest of UK



Source: derived from ONS Internal Migration Estimates; average over period mid-2000 to mid-2004

Notably, the only average net *out*-flows are in the 15-19 and 20-24 year-old age-groups, with the largest in the former: on average 350 more 15-19 year-olds leave the county each year than move into it. This may be explained by the fact that Herefordshire does not have a major centre of higher education, coupled with the fact that young people leaving home to start university are generally aged 18-19 and are counted at their term-time address.

However, it is worth noting that although there is an average annual net loss of 400 15-24 year-olds, this only represents around 2% of the county's population of these ages. To put this into perspective, Rutland UA in the East Midlands 'loses' around 7% of its population of this age-group each year, whilst Westminster 'gains' around 7%.

International Migration

According to the ONS mid-year estimates of population, until 2004 Herefordshire had an average of zero net international migrants per year. In the 2005 estimates, the county had a net in-flow of 440.

The only detailed information available regarding permanent international migration is the number of people moving into Herefordshire from outside the UK in the year before the 2001 Census. This figure was 567, which represents just 0.3% of the total population of the county at the time, and the number moving in the other direction is unknown. 54% of these international in-migrants were aged under 30, which is much higher than the corresponding figure of 44% of in-migrants from within the UK; both figures are higher than the proportion of under 30s of Herefordshire's population (33%).

Migrant workers

Between 2,500 and 3,000 workers from new European Union accession states[11] were cleared to work in Herefordshire in 2005. The ages of these migrants are unknown, but it is likely that most were young adults. However, there is currently no information on how long they remain in the county, or even the UK.

The county also experiences a significant influx of temporary seasonal agricultural workers each year (around 3,000[12]) – mainly over the summer months, with the majority from Ukraine and Russia. These are, by definition, students who are permitted to work on participating farms for up to 6 months.

[11] Source: Worker Registration Scheme; Work Permits (UK), Home Office. States are: Poland, Lithuania, Estonia, Latvia, Slovenia, Slovakia, Hungary and the Czech Republic.

[12] Source: Seasonal Agricultural Workers Scheme; Work Permits (UK), Home Office.

ETHNICITY

Experimental statistics[13] suggest that in 2004, 3.5% of Herefordshire's total resident population was from an ethnic minority (6,200 people). This proportion is still very low by national (14.7%) and regional (15.5%) comparisons, but reflects a growth of 40.9% in the BME population from 2001 compared to just 1.7% for the total county population. It is very likely that numbers have increased even more since the expansion of the EU in May 2004 given the migrant worker statistics discussed above.

This information is also available for Herefordshire's 18-64 year-old population, and indicates that younger age-groups have a slightly higher proportion of people from ethnic minorities: 3.8% of 18-64 year-olds are estimated to be from an ethnic group other than 'white British', in comparison with 3.5% of the total resident population (Table 5). This figure rises to 5.1% of 18-34 year-olds.

For all age-groups, 'White other' was the largest ethnic minority group (1.5% of total population aged 18-64). 'White Irish' was the second largest group for 50-64 year-olds (0.8% of all 50-64s), whilst 'Asian or Asian British' was the second largest for 18-34 year-olds (1.0% of all 18-34s). These two ethnic groups were equally sized for 35-50 year-olds (0.5% of all 35-50 year-olds each).

Table 5: Percentage of Herefordshire residents in ethnic group, by age-group, 2004

Age-group	'White British'	Ethnic group other than 'White British'
18 to 34	94.9%	5.1%
35 to 49	96.1%	3.9%
50 to 64	97.3%	2.7%
18 to 64	96.2%	3.8%
Total population	96.5%	3.5%

Source: ONS © Crown copyright.

The small numbers of people aged 18-64 from ethnic minority groups are shown in Table 6, as is the distribution amongst these groups: just under half of people from an ethnic minority are non-white.

Table 6: Percentage of Herefordshire's 18-64 year-old non-'white British' residents in each ethnic group, 2004

Ethnic Group	No. aged 18-64 in ethnic group	% of total 18-64 year-old non-'White British' in group
White British	100,800	-
White Irish	600	15.0%
White Other	1,600	40.0%
Mixed	400	10.0%
Asian or Asian British	600	15.0%
Black or Black British	300	7.5%
Chinese	200	5.0%
Other ethnic group	200	5.0%
Non-'White'	1,800	45.0%
Total non-'White British'	4,000	100.0%

Source: ONS © Crown copyright. Figures may not sum due to rounding (to the nearest 100).

[13] ONS experimental population estimates by ethnic group.

FUTURE POPULATION

The Office for National Statistics produces population ***projections*** for local authorities based on recent and nationally projected trends in births, deaths and migration – i.e. estimates of what could be reasonably expected to happen to the population *if recent trends were to continue.* The most recent set of sub-national projections are 2004-based and project forward to 2029.

Herefordshire Council's Research Team produces population ***forecasts*** for Herefordshire which are also based on recent and nationally projected trends in births, deaths and migration, but, unlike the projections, also take into account anticipated housing provision under the Unitary Development Plan – which has a constraining effect on in-migration. Until the Regional Spatial Strategy is decided it is not possible to anticipate what housing provision there may be after the UDP, so forecasts can only be produced up to 2011. 2005-based interim forecasts have been produced which take account of a higher than average net international in-migration between 2004 and 2005 (but do not make any attempt to forecast future trends in international migration)

As this needs analysis is interested in expected demand for services up to 2012, and longer term to 2021, the ONS projections are considered alongside the local forecasts; the latter is considered as an alternative scenario for the short-term assessment.

Both the forecast and projected figures for 2011 are presented in Table 7a, along with the projections for 2012 and 2021.

Both the forecast and projected figures for 2011 are presented in Table 7, along with the projections for 2012 and 2021.

- The key point to note is that according to the ONS projections, the population aged 18-64 in Herefordshire will rise to a peak in 2011 (at 108,100) before falling slowly but steadily to 107,000 in 2021.

- The local forecasts predict less growth by 2011 (to 105,700 people), so that numbers would have to continue to increase to reach the level projected for 2021.

- In the long term (up to 2021), by far the biggest rate of change is expected to be in the population of 55-64 year-olds: an increase of 20.6% from 2005, which represents an extra 5,200 residents. The population aged 35-54 is expected to fall by 5,000 over the same period, although this only represents a fall of 9.8% due to the larger numbers in this group.

- Comparing the ONS projections for 18-64 year-olds in Herefordshire to the corresponding national ones shows that even the expected rise in numbers to 2011 would result in a slightly lower rate of growth than in England and Wales as a whole (2.4% to 3.7%). The subsequent projected fall in Herefordshire's population of 18-64 year-olds would result in a much lower overall rate of growth between 2005 and 2021 (1.3% compared to 5.5% in England and Wales).

All of the potential changes discussed here would result in an older age-structure of the 18-64 year-olds in Herefordshire, as illustrated in Table 7b. The proportion of this group aged 55-64 is expected to increase from 24% in 2005, to 25-26% in 2011/12, and to 28% by 2021. Conversely, the proportion aged 35-54 is expected to decrease from 48% in 2005 to 47% in 2001/12 and 43% in 2021. The proportion in the 18-34 age group is expected to remain fairly constant, fluctuating between 27% and 29%.

Table 7: Expected change in population aged 18-64, Herefordshire and England & Wales

		Current	Short-term			Long-term
		2005	2011		2012	2021
		Estimate	Forecast	Projection	Projection	Projection
18-34	No.	29,400	28,700	29,700	30,100	30,500
	% change from 2005	-	*-2.4%*	*+1.0%*	*+2.4%*	*+3.7%*
35-54	No.	51,000	50,000	51,100	50,600	46,000
	% change from 2005	-	*-2.0%*	*+0.2%*	*-0.8%*	*-9.8%*
55-64	No.	25,200	27,000	27,300	27,000	30,400
	% change from 2005	-	*+7.1%*	*+8.3%*	*+7.1%*	*+20.6%*
18-64	No.	105,600	105,700	108,100	107,700	107,000
	% change from 2005	-	*+0.1%*	*+2.4%*	*+2.0%*	*+1.3%*
18-64: projected % change, England & Wales		-	-	*+3.7%*	*+3.7%*	*+5.5%*

Source: ONS 2005 mid-year estimates & 2004-based sub-national projections; HC Research Team 2005-based interim forecasts using ONS estimates and Gov't Actuary's Department projected trends; GAD 2004-based national population projections.

Table 7b: Expected proportion of 18-64 year-old population by age-group, Herefordshire

Age-group	Current	Short-term			Long-term
	2005	2011		2012	2021
	Estimate	Forecast	Projection	Projection	Projection
18-34	28%	27%	27%	28%	29%
35-54	48%	47%	47%	47%	43%
55-64	24%	26%	25%	25%	28%
18-64	100%	100%	100%	100%	100%

Source: ONS 2005 mid-year estimates & 2004-based sub-national projections; HC Research Team 2005-based interim forecasts using ONS estimates and Gov't Actuary's Department projected trends; GAD 2004-based national population projections.

As only projections are available for the years after 2011, the only long-term scenario considered is the 2021 ONS projection. Although the focus of the short-term needs analysis is 2012, since the projections suggest that the total population aged 18-64 will peak in 2011 it seems appropriate to consider the forecasts and projections concurrently. The combined factors of different age-groups being expected to peak at different points throughout the period and age-sex-specific prevalence rates mean that different mental health problems could peak at different times in the short-term. In terms of service planning it seems appropriate to consider the 'worst case scenario', i.e. take the population scenario that suggests the highest number of cases of each physical disability. In fact, as will be discussed in subsequent sections, the differences in the numbers estimated to have a physical disability between the short-term forecast and projections are relatively minor.

It must be noted that the forecasts and projections presented here are only possible scenarios of what might happen to Herefordshire's population in the future – if trends change and/or fertility, mortality and migration assumptions are not met the population could be very different.

As mentioned above, the local forecasts take into account the higher than average international in-migration in 2004, without making any assumptions about the effect of any sustained increase. The international migration assumptions for the 2004-based projections are based on movements in the few years prior to the expansion of the European Union; little is known, even at a national level, about the impact of these changes on the population in the longer term.

COMMUNAL ESTABLISHMENT POPULATION

A communal establishment is defined[14] as an establishment providing managed (i.e. supervised full or part-time) residential accommodation. This includes small hotels and guesthouses if they have capacity for 10+ guests (excluding the owner/manager and family), and sheltered housing unless half or more of the residents possess their own facilities for cooking (in which case the whole establishment is classified as separate households).

The only information regarding the population living in communal establishments is from the 2001 Census. As Table 8 shows, the numbers and proportions within the age-groups of interest are both small, but it is important to consider them, since prevalence rates tend to relate to the population living in private households. A further complication is that some Census information includes resident staff and their families whilst others exclude them.

Table 8: Household & communal establishment residents in Herefordshire, 2001 Census

	Age-group			
	18 to 34	35 to 49	50 to 64	18 to 64
Total Population	30,992	37,193	34,902	103,087
Household residents	30,636	37,028	34,766	102,430
Communal establishment residents (inc. staff)	356	165	136	657
% of age-group living in a communal establishment (inc. staff)	1.2%	0.4%	0.4%	0.6%
Communal establishment residents (non-staff)	248	120	100	468
Residents (non-staff) of medical & care establishments	112	83	68	263
Residents (non-staff) of education establishments (inc. halls of residence)	84	11	6	101
Residents (non-staff) of other communal establishments*	52	26	26	104

Source: 2001 Census, tables S001 & S126 © Crown copyright.
** Hotel; boarding house; guest house; hostel (including youth hostel, hostel for the homeless & people sleeping rough; or other. Residents of Hereford Garrison at Credenhill are not included in any of these figures. Note: the age-groups in this table are different to those used throughout the report due to constraints in published Census data.*

The majority (56%) of residents were in 'medical & care establishments', although a third (34%) of 18-34 year-old residents were in 'education establishments' – likely the halls of residence of the Royal National College for the Blind in Hereford.

In their sub-national household projections, which run to 2026, the Office for the Deputy Prime Minister[15] assume that the numbers of people living in communal establishments will remain constant for all ages below 75. In the absence of any other local information, this assumption will be adopted for the purposes of this report.

- At the end of March 2006, Herefordshire Council's social services were funding 31 18-64 year-olds with physical disabilities to live permanently in communal establishments: 21 in residential homes and 10 in nursing homes. 7 of the former and 2 of the latter are living in homes outside the county.

- It has not been possible to obtain information about numbers of students at the Royal National College for the blind; in particular the numbers who settle in the county once they leave college would have been helpful.

[14] 2001 Census, Office for National Statistics
[15] ODPM, now Department for Communities and Local Government (DCLG); 2003-based household projections released in 2006.

Summary: Demographics of Herefordshire

- Herefordshire's current estimated population of 18-64 year-olds is 105,600 – 59% of the total population. The county has an older overall age profile than both the West Midlands region and England and Wales.
- Office for National Statistics projections suggest numbers of 18-64 year-olds may increase by 2.0% by 2012, although more conservative local forecasts which take in to account expected housing provision suggest this increase will only be 0.1% by 2011.
- Projections suggest the 18-64 year-old population could be 107,000 in 2021, an increase of just 1.3% from 2005.
- Recent years have seen a more rapid growth in numbers in older age-groups (55-64s) and a more rapid decline in the younger ones (18-34s) than nationally. This ageing of the age profile is expected to continue, with the 55-64 year-old age-group growing most rapidly (by 7% in the short-term and 21% by 2021).
- The county has a smaller proportion of people from 'Black and Minority Ethnic' (BME) backgrounds than England as a whole (3.5% compared to 14.7%), but this population grew by 40.9% between 2001 and 2004 – much more rapid than the overall population growth of 1.7%. It is likely that numbers have increased further since the expansion of the EU in May 2004: between 2,500 and 3,000 workers from new member states were cleared to work in Herefordshire in 2005, although it is not known how many remain in the county. The county also experiences an annual influx of around 3,000 temporary seasonal agricultural workers – mainly over the summer months.
- In 2004, 3.8% of 18-64 year-olds in Herefordshire were estimated to be from a BME background; just under half of these were non-white.

GENERAL HEALTH IN HEREFORDSHIRE

LIFE EXPECTANCY & GENERAL HEALTH

Herefordshire's population is expected to live longer, on average, than the national population in general. Based on 2002-04 data, life expectancy at birth in Herefordshire is 77.5 years for males and 82.5 years for females, compared to 76.6 and 80.9 respectively for England overall. Increases in life expectancy over the last ten years have been broadly in line with national trends.

The 2001 Census asked residents to say how their health had been overall in the last year (from options: good, fair or not good). Overall, 69% of Herefordshire's household residents said they were in 'good' health and 8% were 'not good'[16]. This split is broadly similar to nationally (9% 'not good') and regionally (10%).

7% of Herefordshire residents aged 18-64 said that their health was 'not good', which is again similar to England & Wales and the West Midlands Region (8% and 9% respectively). Propensity to state that health was 'not good' increased with age, from 3% of the county's residents aged 18-24 to 14% of those aged 60-64.

Unsurprisingly, across all ages, much higher proportions of residents of communal establishments stated that their health was 'not good' than in the population as a whole: 11% of 18-19 year-olds, increasing to 42% of 60-64 year-olds in communal establishments[17]. As noted in Table 8, Herefordshire's communal establishment population

[16] 2001 Census, Table T07
[17] 2001 Census, Table T09

aged 18-64 was 468 in 2001 (0.5% of all 18-64 year-olds), and 56% of these were resident in medical and care establishments.

LIMITING LONG-TERM ILLNESS

A 'limiting long-term illness' (LLI) is defined as an illness, health problem or disability which limits daily activity or work. At the 2001 Census, 18% of Herefordshire's total population reported having an LLI – the same proportion as nationally and similar to regionally (19%). Of the county's 18-64 year-olds, 14% said they had an LLI, which is broadly equal to the national and regional figures (both 15%). Table 9 shows how the prevalence of limiting long-term illness increases with age.

Table 9: Percentage of Herefordshire residents* that have an LLI by age group

Age-group	% with LLI	No. with LLI
18-24	7%	964
25-44	9%	4,183
45-59	18%	6,502
60-64	28%	2,818

** All people, including those living in communal establishments.*
Source: 2001 Census, ONS – Crown Copyright

There is no information from the Census regarding the nature of LLIs, and due to the self-reporting nature of the question, it could well be that what is 'limiting' for one person may not be for another. It should also be noted that an LLI in not necessarily a *physical* impairment.

Research at a national level[18] indicates that the prevalence of LLI is higher than that of disability for all ages below 85, when disability becomes higher (probably due to older people considering activity limitation to be a normal consequence of ageing).

PHYSICAL HEALTH FUNCTIONING

The Regional Lifestyle Survey (2005) examined physical health functioning using a validated measure[19], with raw scores transformed onto a scale of 0 to 100 (100 = best possible health state), and indicated that Herefordshire residents have very slightly better physical health functioning than residents of the region overall. Men report slightly better physical health than women for both geographies (see Figure 10).

Figure 10: Physical health functioning in 12 months prior to Regional Lifestyle Survey, 2005

Source: Regional Lifestyle Survey 2005, Herefordshire Report; HC Research Team

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[18] Bajekal, M. & Prescott, A. (2003) *Health Survey for England 2001: Disability*. London: The Stationery Office.

[19] Based on questions which asked people to rate how much they agreed with certain statements related to mental & physical health. The measure is subject to intellectual property rights and may not be reproduced without prior permission being sought from the publishers. Interested parties should either consult WMRO or WMPHO or consult the supplementary technical report.

Summary: General Health in Herefordshire

- Herefordshire's population is expected to live longer, on average, than nationally.
- Similar proportions of 18-64 year-olds in Herefordshire were in 'not good' health and/or had a 'limiting long-term illness' as nationally and regionally, according to the 2001 Census.
- The Regional Lifestyle Survey indicated that Herefordshire residents have slightly better physical health functioning than those of the region overall.

KNOWN ADULTS WITH A PHYSICAL DISABILITY

SERVICE USERS

Prevalence of 'physical disability' is much wider than those who need – or indeed want – help from social services. Herefordshire Council currently uses the National Eligibility Framework FACS (Fairer Access to Care Services) definition of 'critical and substantial need' when determining a need for care.

A person is considered to have a 'critical or substantial need' when any of the following is true:

- Life is, or will be, threatened;
- Significant health problems have developed or will develop;
- There is, or will be, partial or no choice and control over the immediate environment;
- Abuse or neglect has occurred or will occur;
- There is, or will be, an inability to carry out *the majority of personal care or domestic routines*;
- Involvement in many aspects of work, education or learning cannot or will not be sustained;
- The majority of social support systems and relationships cannot or will not be sustained;
- The majority of family and other social roles and responsibilities cannot or will not be undertaken.

If a person is unable to carry out 'several' personal care or domestic routines and/or sustain involvement in 'several' aspects of work, education or learning; sustain 'several' social support systems and relationships; undertake 'several' family and other social roles and responsibilities, their need is classified as 'moderate'. If the word 'several' in these statements can be replaced by the words 'one or two', the need is classified as 'low'.

However, for many reasons, not least the fact that the government guidance specifically includes the qualifying statement that care should be given to people without a 'critical or substantial need' if they are at risk of developing such a need if care is not provided, it is likely that not *all* clients on the database have a 'critical and substantial need'. With current systems, it is impossible to know the extent of this. Having said this, everyone on the database as a physical disability service user has a physical disability and is in need of care from social services.

Information is recorded about people who receive a service from the Physical Disability Team. Table 11 shows the number of physical disability service users in each age group for the last two financial years: both snapshot figures on the last day of the year, and the total number of people who used the service during the year.

Table 11: Physical Disability service users aged 18-64, Herefordshire

Age-group	Service users at 31st March				All service users during year					
	Physical Disability service users*		Other vulnerable people		Physical Disability service users*		Other vulnerable people		Signposting service**	
	2006	2007	2006	2007	2005/06	2006/07	2005/06	2006/07	2005/06	2006/07
18-34	38	36	4	6	57	72	19	34	2	17
35-54	150	153	36	29	246	296	97	135	20	21
55-64	131	139	23	20	240	284	92	116	43	53
18-64	319	328	63	55	543	652	208	285	65	91

Source: Herefordshire Council Adult and Community Services Directorate

** Coded as either 'physical & sensory disability' or 'frail'; ** people who are referred by the council to other partner organisations, and are not coded.*

Due to the way data is collected, and the complexities involved in trying to classify service users, there is limited information about the nature of these people's disabilities. Physical Disability service users are classified as either 'physical & sensory disability' or 'frail', neither of which provides much information.

'Other vulnerable people' fall under the remit of the Physical Disability Team, but may or may not have a physical disability; this group includes people who may have received welfare benefits advice from the council's Joint Working Team.

The people included in the annual count as 'signposting service' include those who contact the council for help but are subsequently referred to a partner organisation, for example someone who needs smoke alarms installed is added to the database, but then signposted to the Fire Service. Their contact may be by telephone, so it is not possible to assign them a FACS code, and it is therefore not possible to know whether or not they have a physical disability.

The large differences between the 'snapshot' counts on the 31st March and the count of all users over the course of a year are due to the turnover of people receiving short-term services such as welfare benefits and intermediate care.

- A wider group of adults with physical disabilities are counted as being 'helped to live at home'; as well as the 328 people receiving 'traditional' social care services in March 2007, a further 293 were helped by less intensive services – mainly the information service, Herefordshire ABLE[20] and Maintained Equipment.[21]

An average of five young people with physical disabilities make the transition from children's services to adult social care per year.

BENEFIT CLAIMANTS

People with a disability can claim specific benefits; the two that are available to adults aged 18-64[22] are Disability Living Allowance (DLA) and Incapacity Benefit (IB) or Severe Disablement Allowance (SDA).

It should be noted that 'disability' in the context of claiming benefits could equally relate to a physical or mental problem.

[20] 'Access to Benefits, Leisure, Employment': "A free, impartial and confidential service of information, advice, and in some cases, practical help…for people connected with any aspect of disability" - http://www.ablehereford.com/what_is.htm

[21] Equipment that requires servicing annually.

[22] People over 65 can claim Attendance Allowance.

Benefits data is presented here to give an indication of actual numbers of people in Herefordshire who meet the criteria for disability-related benefits, but this information is of limited value:

- although the number aged 18-64 claiming each benefit in Herefordshire is available, it is not possible to obtain detailed information about this age-group at a county level, for example the reason for claim, or numbers who claim both benefits;
- it is not possible to calculate take-up rates as the total number eligible is unknown, so is therefore not possible to determine whether any increases in the numbers of claimants are due to increases in eligible numbers, or to improved take-up due to publicity of welfare rights.

Disability Living Allowance (DLA)

DLA is not income-related, and is paid to people who have required help for three months and are likely to need that help for at least six more months. It comprises two components with different levels depending on the severity of the disability:

- Care component – for people who need help with their personal care (i.e. attention in connection with their bodily functions and/or continual supervision to avoid substantial danger to themselves or others), with three possible rates (higher, middle or lower)[23];
- Mobility component – for people who have difficulty walking, with two possible rates (higher or lower)[24].

A person can only begin claiming DLA if they are under 65, but can continue to receive it after this age if they satisfy the criteria. As shown in Table 12, roughly two-thirds of Herefordshire claimants are aged 18-64. In 2005, 4.5% of the county's population aged 18-64 were claiming DLA: 4,700 people.

The number of claimants in Herefordshire increased by 7.1% between 2003 and 2005, whilst the population grew by just 1.2%. However, this rise could be related to improvements in take-up rates rather than an increase in prevalence.

Table 12: Claimants* of either (or both) component(s) of Disability Living Allowance, Herefordshire

	2003	2004	2005	2006
All ages	6,560	6,890	7,200	7,430
Aged 18-64	4,390	4,550	4,700	4,860
% of all claimants aged 18-64	*67%*	*66%*	*65%*	*65%*
% of population aged 18-64 claiming	4.2%	4.3%	4.5%	-

Source: Work and Pensions Longitudinal Study, Department for Works and Pensions.

** All entitled: those in receipt of payment and those whose payment has been suspended, e.g. if in hospital. Count is snapshot as at 31st August each year; all figures rounded to nearest 10.*

Information on the numbers of people claiming each rate of DLA is also published, but it is only possible to obtain exact counts at a county level for the population of working age[25] (see Tables 13 & 14).

[23] Higher rate paid to those who need help during the day *and* night; middle to those who need help during the day *or* night; lower rate to those who need help during some of the day or cannot prepare a cooked meal for themselves given the ingredients. Source: Work & Pensions Longitudinal Study, DWP.

[24] Higher rate paid to those who are (virtually) unable to walk; lower to those who can walk but need help outside on unfamiliar routes. Source: Work & Pensions Longitudinal Study, DWP.

[25] 16 to 59 for females; 16 to 64 for males.

Table 13: Claimants* of Disability Living Allowance (DLA) *Care Component* (working age), Herefordshire

Rate	2003	2004	2005	2006
Higher	880	880	920	980
Middle	1,170	1,250	1,300	1,330
Lower	1,410	1,480	1,570	1,630
Nil (i.e. eligible for mobility comp. only)	560	530	530	510
All rates	4,020	4,150	4,320	4,450

Source: Work and Pensions Longitudinal Study, Department for Works and Pensions.
** All entitled: those in receipt of payment and those whose payment has been suspended, e.g. if in hospital. Count is snapshot as at 31st August each year; all figures rounded to nearest 10.*

Table 14: Claimants* of Disability Living Allowance (DLA) *Mobility Component* (working age), Herefordshire

Rate	2003	2004	2005	2006
Higher	2,310	2,350	2,390	2,420
Lower	1,200	1,300	1,370	1,470
Nil (i.e. eligible for care comp. only)	500	500	560	550
All rates	4,020	4,150	4,320	4,450

Source: Work and Pensions Longitudinal Study, Department for Works and Pensions.
** All entitled: those in receipt of payment and those whose payment has been suspended, e.g. if in hospital. Count is snapshot as at 31st August each year; all figures rounded to nearest 10.*

Assuming that the proportion claiming each level of each component in Herefordshire is the same for people aged 18-64 as for all people of working age, it could be estimated that, in August 2006:

- 4,300 people aged 18-64 were claiming the care component - 1,070 the higher rate, 1,450 the middle rate and 1,780 the lower rate (4,120; 1,000; 1,410 and 1,710, respectively in 2005);
- 560 people were only eligible to claim the care component (580 in 2005);
- 4,260 people aged 18-64 were claiming the mobility component - 2,650 the higher rate and 1,610 the lower rate (4,090; 2,600 and 1,490, respectively in 2005);
- 600 people were only eligible to claim the mobility component (610 in 2005).

People can claim DLA because of any disabling condition, although it is not possible to obtain information on the reason for claim at county level. As at August 2006 the largest single reason for claiming DLA, at both a national and regional level was ‘mental health causes’: 19% of 18-64 year-old claimants in Great Britain and 16% in the West Midlands. The reasons for claim presented tend to relate to the impairment that a person has rather than their disability[26], so it is not possible to quantify the number of people claiming because of a ‘physical disability’.

Incapacity Benefit (IB) / Severe Disablement Allowance (SDA)

IB is paid to those who cannot work because of an illness or disability and who meet certain National Insurance contribution requirements. Until 2001 SDA was paid to those who were unable to work but did not meet the contribution criteria; these people can still receive SDA but no new claims can be made.

Although these benefits are primarily for people of working age, some claimants are still able to receive them once they pass state retirement age.[27] However, as Table 15 shows, almost all claimants in Herefordshire have been aged 18-64 (98%) since 2003: around 5,900 each year. These figures indicate that 5.6% of the population aged 18-64 in Herefordshire are claiming IB/SDA each year.

[26] For example: ‘arthritis’, ‘epilepsy’, ‘stroke related’, ‘chest disease’, ‘renal disorders’, ‘AIDS’.
[27] Currently 60 for women; 65 for men. There is no upper limit for SDA once it has been claimed, and the short-term rate of IB can be paid for up to a year after retirement age.

Detailed data regarding the reason for a claim is only available for the population as a whole (i.e. all claimants aged 16 and above). It should be noted that the single most common reason for claiming IB/SDA each year is 'mental disorder' (over a third of claimants). This is similar to the regional proportion, and about two percentage points lower than the proportion in England as a whole each year (not presented here). 'Mental disorder' is also the only reason for which numbers claiming have increased notably between 2003 and 2006 – the numbers claiming for most other reasons fell slightly.

People with mental health problems are not specifically covered by this report, being the subject of a separate needs analysis. However, they are not excluded from the analysis if they are also physically disabled.

Table 15: Claimants of Incapacity Benefit (IB) or Severe Disablement Allowance (SDA) by reason for claim (all people aged 16+), Herefordshire

Medical reason for claiming		2003	2004	2005	2006
Mental disorders	No.	2,090	2,150	2,190	2,220
	%	*35%*	*36%*	*36%*	*38%*
Diseases of the nervous system	No.	440	450	440	460
	%	*7%*	*8%*	*7%*	*8%*
Diseases of the respiratory or circulatory system	No.	480	450	470	450
	%	*8%*	*8%*	*8%*	*8%*
Musculoskeletal diseases	No.	1,160	1,120	1,110	1,060
	%	*19%*	*19%*	*18%*	*18%*
Injury or poisoning	No.	390	380	390	360
	%	*7%*	*6%*	*6%*	*6%*
Other	No.	1,390	1,420	1,430	1,340
	%	*23%*	*24%*	*24%*	*23%*
Total IB/SDA claimants	No.	5,960	5,970	6,040	5,890
No. of IB/SDA claimants aged 18-64	No.	5,850	5,850	5,920	5,800
% of all IB/SDA claimants aged 18-64	%	*98%*	*98%*	*98%*	*98%*
% of pop'n aged 18-64 claiming IB/SDA	%	5.6%	5.6%	5.6%	-

Source: Work and Pensions Longitudinal Study, Department for Works and Pensions.
Count is snapshot as at 31st August each year; all figures rounded to nearest 10.

Discussion

The claimant figures suggest that more people aged 18-64 in Herefordshire are unable to work because of a disability (5,800) than require care because of a disability (4,860), although it is not possible to determine how many people are unable to work *and* require care.

The reason for this difference between the numbers of DLA and IB/SDA claimants is unknown; there could be a real difference in the effects of disabilities on peoples' lives, or there may be differences in take-up. No estimates of the proportion of people who are eligible for a disability-related benefit exist, even at a national level, although the Department for Works and Pensions have commissioned a study into the feasibility of estimating DLA take-up.[28] However, 'best guesses' of take-up are said to be 'discouraging', particularly in relation to younger people's take-up of DLA (not least because half of applications fail). It is expected that a greater proportion of those who are eligible for IB are claiming it (i.e. take-up is higher), as it is accessed through long-term sick pay.[29]

[28] By the Policy Studies Institute: www.psi.org.uk/research/project.asp?project_id=151
[29] Marsh, A (2006) *The trouble with take-up. The Monitor: Blue Skies.* Issue no. 143, Vol. 1 http://www.epolitix.com/EN/Publications/Blue+Skies+Monitor/143_1/home.htm

Summary: Known Adults with a Physical Disability

- There is limited information regarding current numbers of social care service users with a physical disability, but it is estimated that 'core' social care services are provided to just over 300 people, and that other services (particularly the information service, ABLE, & maintained equipment) are reaching a wider group of around 300 more adults with physical disabilities.
- Benefit claimant figures suggest that 5,800 people aged 18-64 in Herefordshire are unable to work because of a disability and 4,860 require care because of a disability, although it is not possible to determine how many people are unable to work *and* require care.
- National and regional figures would suggest that a significant proportion of both of these groups would be claiming primarily for a mental health problem rather than a physical disability (although the two may co-exist), so it is not possible to use these figures as a proxy for disability.

ESTIMATING NUMBERS WITH A PHYSICAL DISABILITY (CURRENT & FUTURE)

NATIONAL PREVALENCE OF DISABILITY

As the discussion of what is known locally in the previous section indicated, accurate information on the numbers of adults with disabilities is lacking, but this is also the case at a national level. A Department for Work and Pensions study[30] (2004) concluded that "[t]here is no single 'gold standard' measure of disability. The multi-dimensional and dynamic nature of disability makes it inherently difficult to measure."

National estimates are calculated from surveys, and vary from source to source due to real changes over time and methodological differences, but particularly how disability is defined for the purpose of each particular survey, namely:

- Whether severity is taken into account;
- Whether aids are included in the definition (e.g. some surveys classify a person as deaf only if they cannot hear *with* a hearing aid);
- Whether people are asked to self-classify or are objectively assessed;
- Whether the survey is a dedicated survey of disability or a general survey attempting to capture a range of information.

As a result of these differences, estimates of the number of disabled adults in England range from 8.6 million (20%) according to the 1996/7 Disability Survey to 11 million (23%) according to more recent estimates of the number of adults covered by the Disability Discrimination Act. Whilst this is a dramatic difference at a national level, in an area such as Herefordshire with a population of 146,100[31] adults, the difference between 20% and 23% is not that great (around 4,500 people). However, it must be noted that these percentages relate to the whole adult population and are therefore not appropriate to apply to Herefordshire given the older age structure in the county compared to England overall.

Furthermore, the DWP study concluded that there are no marked differences in age-specific disability rates for the working age population between any of the surveys. The major sensitivity to definitional differences comes in older age-groups where people who are less likely to self-declare a disability, considering limiting illnesses to be a natural consequence of ageing.

[30] Bajekal, M. et al, on behalf of the Department for Work and Pensions (2004) *Review of Disability Estimates and Definitions*. Her Majesty's Stationery Office (HMSO).
[31] 2005 mid-year estimate of population aged 16+, ONS.

The most comprehensive prevalence rates for physical disability come from the Department of Health Report: *Health Survey for England 2001 (Disability),* which had the specific aim of providing "…latest estimates of the prevalence of disability…and to assess changes in prevalence over time" by comparing rates from the 1995 Health Survey for England with those observed in the 2000 and 2001 surveys combined (for improved precision).[32]

The survey provides age-sex specific prevalence rates for moderate and serious disabilities of the following types:

- Locomotor: difficulty, or inability, in walking or bending;
- Personal care: inability to perform self-care tasks or activities of daily living (ADLs)[33] without help;
- Hearing;
- Sight;
- Communication.

Applying these age-sex specific rates to the most recent (i.e. mid-2005) estimate of Herefordshire's household population indicates that there were around 13,200 people with at least one disability, 3,200 of whom have at least one 'serious' disability (Table 16). Locomotor disabilities are most common, followed by personal care. The survey found that almost all of the people with a personal care disability also had a locomotor disability.[34]

It is likely that personal care disabilities are most relevant for consideration by social care service providers, as by definition people with this type of disability require some form of assistance – and 'personal care routines' are specifically mentioned in the National Eligibility Framework for social care provision. This is the approach taken by Wanless[35] in his report on the future demand for social care services among older people, and was adopted in the Herefordshire *Older People Needs Assessment Report* [36] in 2006.

People with the other types of physical disability would certainly fall under the protection of the Disability Discrimination Act (DDA), but it is not possible to estimate how many of these would need – or indeed want – services from social care. If they do have a need for assistance because of their disability they would also be classified as having a personal care disability.

Table 16: Estimated numbers of household residents with a physical disability in Herefordshire, 2005

Disability Type	Moderate	Serious	Total
Personal Care	4,600	950	5,550
Locomotor	7,150	2,050	9,200
Sight*	1,200	250	1,450
Hearing*	2,850	100	3,000
Communication	950	300	1,250
One or more physical disability(ies) of any type	10,000	3,200	13,200

Source: Herefordshire Council Research Team, using ONS estimates and rates.
Note: different types of disability cannot be summed as a person may have more than one type.
** Hearing or visual problems remedied by hearing aids or glasses/corrective lenses are not classified as disabilities under the definition adopted here*[37]

[32] Bajekal, M. & Prescott, A. (2003) *Health Survey for England 2001: Disability*. London: The Stationery Office, p.13.
[33] being able to wash, dress, feed, toilet, get in and out of bed or a chair.
[34] Bajekal & Prescott (2003), p.20.
[35] Wanless Review Team (2005) *Social Care Needs and Outcomes: A background paper for the Wanless Social Care Review*. Wanless Social Care King's Fund Report.
[36] HC Corporate Policy & Research Team (2006) *Future social care needs and services for older people and adults with learning disabilities in Herefordshire.*
[37] Bajekal & Prescott (2003), p.15.

It should be noted that participants were asked what the cause of their disability was, and of all people aged 16+, 2% cited a 'mental disorder' as (one of) the cause(s) of a moderate disability and 5% as (one of) the cause(s) of a serious disability. 3% of all people with any type or number of disabilities said that their disabilities were caused by a 'mental disorder'. This data is not available by age or for different types of disability.

However, these people may have also considered their disabilities to be caused by a physical disease. It is therefore not possible to exclude adults with disabilities caused by 'mental disorders' from the figures considered in this report, although people with mental health problems are also the sole focus of a separate needs analysis.

The overall pattern of diseases cited as the causes of disability were the same as in 1995; by far the most common causes were diseases of the musculoskeletal system and connective tissue such as arthritis, back and other joint problems (40%), although it would seem likely that a large proportion of this group would be aged 65 and over. The only other notable proportion was 'diseases of the circulatory system' (13%).

Accidents were a common cause of disability in under 65s – around 24% of males aged 16-64, and 16% of females. This was highest in males aged 35-44: 33% said their disability was as a result of an accident.

By applying the national prevalence rates to Herefordshire's forecast and projected population, it is possible to also estimate likely future numbers with each kind of disability; the different types are considered separately in subsequent sections.

These projections are based on the assumptions underlying the population forecasts/projections being satisfied, and also on the assumption that prevalence of disability within the household population aged 18-64 will remain constant up to 2021. The latter could be an unrealistic assumption, but in the absence of any national work on likely changes in prevalence there is no way of knowing.

The lack of information nationally is highlighted in a recent Institute of Public Policy Research report for the Disability Rights Commission.[38] The authors project possible future trends using observed changes in self-reporting of a long-term health problem or disability and type of impairment in the ONS Labour Force Survey between 2001 and 2004. However, they qualify their work with the caution that "…the fact that a pattern has occurred between 2001 and 2004 is not a guide to the pattern occurring over the next four years, much less over the next 15 years. None the less, these extrapolations give at least some indication of one possible future scenario, although we cannot make any claims for its likely accuracy."[39] Their findings for the UK could be applied to Herefordshire's population, but the lack of detail regarding type and severity of disability would not provide any insight with regard to likely future demand for services from adults with a physical disability.[40]

There are health factors that may affect the incidence of particular diseases and subsequently increase the future prevalence of physical disability. For example recent increases in rates of obesity may result in an increase in stroke, coronary heart disease and diabetes, which could affect demand for social care. Smoking rates, and incidence of cancer, may also have an impact. However, on the other hand, if national promotion of health awareness encourages people to improve their diets, stop smoking, etc., there may be a positive effect in terms of reducing prevalence.

These matters will need to be kept under review as and when more information becomes available on trends in the prevalence of chronic diseases, and the link between these diseases and physical disability. Nonetheless, any such changes are unlikely to have a

[38] Pillai, R et al (March 2007) *Disability 2020: Opportunities for the full and equal citizenship of disabled people in Britain in 2020*. Disability Rights Commission.
[39] ibid, p. 46
[40] The categories of impairment are: joint/limb disorder; sensory disorder; organ disorder; mental illness; progressive illness; other illness.

significant impact on the extent of need for social and health care services in the short-term (i.e. up to 2012).

As the prevalence rates are age-specific they do take account of the particular age structure in Herefordshire, but it should be noted that as they are assumed to be constant over time any projected changes in numbers are only as a result of expected population changes, i.e. a small fall in the numbers of 35-54 year-olds and a large increase in the number of 55-64s (as discussed on p.7).

ANY TYPE OF PHYSICAL DISABILITY

Table 17 shows the likely future numbers of people with at least one disability of any of the types mentioned on p.17. The following points should be noted in relation to these figures:

- the numbers in this table will be less than the sum of the corresponding numbers in each of the subsequent tables: a person can have more than one disability, but are only included once in the 'any type' estimates;
- a person is classified according to their most serious disability, e.g. if they have a serious locomotor disability and a moderate personal care disability, they are classified as having a serious disability.

Also, as mentioned in the footnote to Table 12, it should be noted that hearing or visual problems remedied by hearing aids or glasses or corrective lenses are not classified as disabilities under the definition adopted here.[41]

Assuming that the rates are suitable to apply to the current and future population of Herefordshire, there an estimated 13,200 household residents aged 18-64 in 2005 with a disability of any type, 3,200 of whom have a 'serious' disability. The maximum expected increase by 2012 would be 5%, in both 'serious' and 'moderate' disability. There is expected to be a 7% increase in 'moderate' disability and 8% in 'serious' by 2021.

Table 17: Estimated and projected number of household residents aged 18-64 with any type of physical disability[42], Herefordshire

Severity	Past Estimate	Current Estimate	Short-term Projection				Long-term Projection	
	2001	2005	2011 (forecast pop'n)	2011 (projected pop'n)	2012 (projected pop'n)	*% change in short-term**	2021 (projected pop'n)	*% change in long-term*
Moderate	9,450	10,000	10,300	10,500	10,450	*5%*	10,700	*7%*
Serious	2,950	3,200	3,300	3,350	3,350	*5%*	3,450	*8%*
Total	12,400	13,200	13,600	13,850	13,800	*5%*	14,150	*7%*

Source: Herefordshire Council Research Team, using ONS estimates, projections and rates.
**Percentage change is presented as change between 2005 estimate and the highest number of cases suggested by the rates according to either the 2011 forecast; 2011 or 2012 projection. Counts rounded to nearest 50; figures may not sum due to rounding.*

PERSONAL CARE DISABILITY

A person is classified as having a 'moderate' personal care disability if they have any difficulty in performing any of the six 'Activities of Daily Living' (ADLs):

- Getting in and out of bed;
- Getting in and out of a chair;
- Dressing/undressing;
- Washing hands and face;
- Feeding themselves (including cutting up food);

[41] Bajekal & Prescott (2003), p.15.
[42] i.e. one or more of the following types of disability: locomotor, personal care, sight, hearing or communication.

- Getting to and using the toilet.

Their disability is classed as 'serious' if they are unable to perform any of the ADLs without the help of someone else.

As already discussed (p.17), in terms of service provision, it is anticipated that people with a personal care disability would be most likely to require involvement from social services. People with other types of disability that have difficulty performing any of the ADLs will be also be captured within these 'personal care' estimates.

An interesting point to note is that the Health Survey for England found that "almost all personal care disability can be attributed to problems with bed and chair transfer and dressing, for both sexes" and at all ages between 18 and 64. The rates suggest that the highest prevalence of problems with washing, feeding or toileting is amongst men aged 55-64 (3% have some problem getting to or using the toilet).

Table 18: Estimated and projected number of household residents aged 18-64 with a personal care disability, Herefordshire

Severity	Past Estimate	Current Estimate	Short-term Projection				Long-term Projection	
	2001	2005	2011 (forecast pop'n)	2011 (projected pop'n)	2012 (projected pop'n)	*% change in short-term**	2021 (projected pop'n)	*% change in long-term*
Moderate	4,300	4,600	4,750	4,850	4,800	*5%*	4,950	*8%*
Serious	900	950	950	1,000	1,000	*5%*	1,000	*5%*
Total	5,250	5,550	5,700	5,850	5,800	*5%*	5,950	*7%*

Source: Herefordshire Council Research Team, using ONS estimates, projections and rates.
** Percentage change is presented as change between 2005 estimate and the highest number of cases suggested by the rates according to either the 2011 forecast; 2011 or 2012 projection. Counts rounded to nearest 50; figures may not sum due to rounding.*

Comparison with Physical Disability service users
According to the definition of 'critical and substantial need' used by Herefordshire Council to determine eligibility for social care, not even everyone classified as having a 'serious' personal care disability (i.e. someone who is unable to perform any one of the six ADLs without assistance) would be considered to have this level of need (see p.11). In other words, those household residents with a 'critical and substantial need' would be a subset of the estimated number with a 'serious' personal care disability.

This is reflected in the relatively small number of Physical Disability service users (319 in March 2006 and 328 March 2007 – presumably including those in communal establishments) in comparison with the estimated number of household residents with a serious personal care disability (950 in June 2005).

Comparison with claimants of the care component of Disability Living Allowance
According to the Department for Works & Pensions definitions (p.13), it would be expected that all of the people claiming any level of the care component of DLA would be classed as having a 'serious' personal care disability, because they require some form of help with their personal care. It therefore seems odd that the numbers claiming DLA (4,300 in 2005) are so much larger than the estimated number of people with a personal care disability (950 in 2005), even given that the latter doesn't include those living in communal establishments.

However, whilst DLA is designed to provide some benefit related to increased living costs due to a disability, guidance[43] states that people are still entitled to claim it if they live alone with no-one providing care, and don't want anyone to provide care for them. This indicates that the classification is not a strict as in the *Health Survey for England: disability*, whereby

[43] *Information about disability living allowance*. East Bristol Advice Service: www.bhas.org.uk/dla/index.shtml

people are only classified as having a serious personal care disability if they are *unable* to perform tasks without help.
Having said this, and although it is not possible to be sure that the comparison is of like with like, the number of people claiming the higher rate of DLA care component (i.e. who need help throughout the day & during the night) (1,000 in 2005) is very close to the number of people estimated to have a 'serious' personal care disability (950 in 2005). Furthermore, the number of claimants of the two lower rates of the DLA care component (3,120 in 2005) is not that much lower than estimated number with a 'moderate' personal care disability (4,600 in 2005).

LOCOMOTOR DISABILITY

A person is classified as having a 'serious' locomotor disability if they are unable to do one or more of the following:

- walk for more than a few steps on their own without stopping and without discomfort;
- walk up and down a flight of 12 stairs;
- bend from standing to pick up a shoe off the floor.

Their disability is classified as 'moderate' if they can bend, walk more than a few steps but not as far as 200 metres, and walk up and down a flight of stairs if they hold on and take rests.

Table 19: Estimated and projected number of household residents aged 18-64 with a locomotor disability, Herefordshire

Severity	Past Estimate	Current Estimate	Short-term Projection				Long-term Projection	
	2001	2005	2011 (forecast pop'n)	2011 (projected pop'n)	2012 (projected pop'n)	*% change in short-term**	2021 (projected pop'n)	*% change in long-term*
Moderate	6,700	7,150	7,400	7,550	7,500	*6%*	7,700	*8%*
Serious	1,950	2,050	2,150	2,200	2,150	*7%*	2,250	*10%*
Total	8,650	9,200	9,550	9,700	9,650	*5%*	9,950	*8%*

Source: Herefordshire Council Research Team, using ONS estimates, projections and rates.
** Percentage change is presented as change between 2005 estimate and the highest number of cases suggested by the rates according to either the 2011 forecast; 2011 or 2012 projection. Counts rounded to nearest 50; figures may not sum due to rounding.*

Comparison with claimants of the mobility component of Disability Living Allowance
From the respective definitions (above & p.13), those people classified as having a 'serious' locomotor disability (2,050 household residents in 2005) should all be eligible for the higher rate of the mobility component (2,600 claimants in 2005), but it is not possible categorically to exclude those with a 'moderate' locomotor disability. It may be that someone who can walk for more than a few steps but not as far as 200m (and therefore has a 'moderate' locomotor disability) is also eligible for the higher rate.

Therefore, the 2,600 claimants of the higher rate of the mobility component may include *some* of the estimated 7,150 household residents with a 'moderate' locomotor disability, as well as those 2,050 with a 'serious' locomotor disability. However, given the issues regarding take-up at a national level (see p.15), it is likely that not all of this latter group would in fact be claiming DLA.

SIGHT DISABILITY

A person is classified as having a serious sight disability if they cannot recognise a friend at arms length (1 metre), or a moderate disability if they can recognise a friend at arms length but not across a road (four metres) – both whilst wearing any corrective glasses or lenses that they require.

Assuming that the rates are suitable to apply to the current and future population of Herefordshire, Table 20 shows that there are approximately 1,450 household residents with a sight disability based on the estimated 2005 population; 250 of these are classed as 'serious'. Looking to the future, the only expected change is a 20% increase in the number of household residents aged 18-64 with a serious sight disability between 2005 and 2021, although the small numbers mean that this represents an increase of just 50 people.

Table 20: Estimated and projected number of household residents aged 18-64 with a sight disability, Herefordshire

Severity	Past Estimate	Current Estimate	Short-term Projection				Long-term Projection	
	2001	2005	2011 (forecast pop'n)	2011 (projected pop'n)	2012 (projected pop'n)	*% change in short-term**	2021 (projected pop'n)	*% change in long-term*
Moderate	1,150	1,200	1,200	1,200	1,200	*0%*	1,200	*0%*
Serious	200	250	250	250	250	*0%*	300	*20%*
Total	1,350	1,450	1,450	1,500	1,500	*3%*	1,500	*3%*

Source: Herefordshire Council Research Team, using ONS estimates, projections and rates.
** Percentage change is presented as change between 2005 estimate and the highest number of cases suggested by the rates according to either the 2011 forecast; 2011 or 2012 projection. Counts rounded to nearest 50; figures may not sum due to rounding.*

It should be noted again here that these figures do not include any students at the Royal National College of the Blind, as they are not residents of private households. However, if a significant number of students settle in Herefordshire after leaving the college, it may be that the county would have a higher prevalence of sight disability than in England as a whole. If this were the case, these numbers would be underestimates, but has not been possible to obtain information on how many students do actually settle in Herefordshire.

The students do not receive care from Herefordshire Council whilst they are at the college, but they would be entitled to if they were to remain in the county after leaving the college.

HEARING DISABILITY

A person is classified as having a moderate hearing disability if they can only follow a TV programme whilst wearing their hearing aid (if they have one) with the volume turned up. If they cannot follow it even with the volume turned up they are classed as having a serious hearing disability.

Table 21: Estimated and projected number of household residents aged 18-64 with a hearing disability, Herefordshire

Severity	Past Estimate	Current Estimate	Short-term Projection				Long-term Projection	
	2001	2005	2011 (forecast pop'n)	2011 (projected pop'n)	2012 (projected pop'n)	*% change in short-term**	2021 (projected pop'n)	*% change in long-term*
Moderate	2,700	2,850	3,000	3,050	3,000	7%	3,100	9%
Serious	100	100	150	150	150	50%	150	50%
Total	2,800	3,000	3,100	3,150	3,150	5%	3,250	8%

Source: Herefordshire Council Research Team, using ONS estimates, projections and rates.
** Percentage change is presented as change between 2005 estimate and the highest number of cases suggested by the rates according to either the 2011 forecast; 2011 or 2012 projection. Counts rounded to nearest 50; figures may not sum due to rounding.*

It is estimated that approximately 3,000 of Herefordshire's household residents had a hearing disability in 2005, and that 100 of these would be classified as serious.

There is little variation in the numbers with a hearing disability according to the different short-term population scenarios. All suggest a 50% increase in the number with a serious hearing disability (an additional 50 people), and the number with a moderate hearing disability could increase by between 150 and 200 people (5-7%).

In the longer term, the number with a serious hearing disability is not expected to increase any further from 2011/12 levels by 2021; an additional 100 people are expected to have a moderate hearing disability by this time.

No data is available to enable comparison of the numbers suggested by national prevalence rates with the 'real' situation in Herefordshire.

COMMUNICATION DISABILITY

A person is classified as having a communication disability if they are unable to speak without difficulty and/or have problems communicating with other people; the disability is classed as serious if they have difficulty in communicating with even close relatives.

Prevalence of communication disability amongst 18-64 year-olds is much lower than any other type of disability. According to the ONS report[44], this could be the result of under-counting due to non-response bias (people with a communication disability may be less likely to participate in a survey), or it could be that people with a communication disability are more likely to live in communal establishments.

Applying the rates to the estimated household population of Herefordshire in 2005 suggests that there are approximately 1,300 people with a communication disability; 300 of these have a serious communication disability (Table 22).

Table 22: Estimated and projected number of household residents aged 18-64 with a communication disability, Herefordshire

Severity	Past Estimate	Current Estimate	Short-term Projection				Long-term Projection	
	2001	2005	2011 (forecast pop'n)	2011 (projected pop'n)	2012 (projected pop'n)	*% change in short-term**	2021 (projected pop'n)	*% change in long-term*
Moderate	900	950	1,000	1,000	1,000	*5%*	950	*0%*
Serious	300	300	300	300	300	*0%*	300	*0%*
Total	1,200	1,250	1,300	1,300	1,300	*4%*	1,250	*0%*

Source: Herefordshire Council Research Team, using ONS estimates, projections and rates.
** Percentage change is presented as change between 2005 estimate and the highest number of cases suggested by the rates according to either the 2011 forecast; 2011 or 2012 projection. Counts rounded to nearest 50; figures may not sum due to rounding.*

Assuming that these rates are suitable estimates for the future prevalence, a slight (5%) increase in the number of people with a moderate communication disability can be expected by 2012 (50 people), but then numbers can be expected to return to a similar level as 2005 by 2021. The numbers with a serious communication disability are not expected to change over either period.

No data is available to enable comparison of the numbers suggested by national prevalence rates with the 'real' situation in Herefordshire.

[44] Bajekal and Prescott (2003), p.19

Summary: Estimating numbers with a physical disability (current & future)
Numbers of household residents aged 18-64 in Herefordshire with disabilities were estimated (for 2005) and projected using national prevalence rates from 2000-01:

- Currently, an estimated 13,200 people have a disability of any type, 3,200 of whom have a 'serious' disability. The maximum expected increase would be 5%, in both 'serious' and 'moderate', by 2012; 7% in 'moderate' and 8% in 'serious' by 2021.
- There are an estimated 950 household residents with a 'serious' personal care disability, the type of disability most pertinent to social care service planning. This number is expected to increase by a maximum of 5% (50 people) by 2012. No further change is expected in the longer term. Therefore, if all who need such a service are receiving care, there can be expected to be no notable change in demand in either the short or long-term.
- The number of people with a 'moderate' personal care disability (4,600) is expected to increase by a maximum of 5% (250 people) in the short-term, and 8% (350) by 2021.
- Locomotor disabilities are the most common type of disability; the national survey found that almost all of the people with a personal care disability also had a locomotor disability.
- An estimated 9,200 people have a locomotor disability; 2,050 are classified as 'serious', a number which is expected to increase by a maximum 7% (150) in the short-term and 10% (200) by 2021.
- 1,450 household residents are estimated to have a sight disability, 250 of them 'serious'. This group is expected to remain at a similar level in the short-term, and increase by around 50 people by 2021 (no notable change in 'moderate' numbers).
- An estimated 3,000 people have a hearing disability, but only 100 of these are classified as 'serious'. The latter number would be expected to increase by 50 people by 2012, and remain at this level in 2021.
- It is estimated that there are 1,250 people with a communication disability, 300 of which are classified as 'serious'. The maximum expected change is an increase of 50 people with a 'moderate' communication disability by 2012, with no change in 'serious' in either the short or long-term.

ETHNICITY OF ADULTS WITH PHYSICAL DISABILITIES

It is not possible to produce estimates of the number of people in different ethnic groups in Herefordshire with physical disabilities as the *Health Survey for England 2001: Disability* did not analyse the prevalence of disability by ethnic group.

Table 23: Ethnicity of Herefordshire service users over year 2006-07 compared to general population in 2004

Ethnic Origin	% of Physical Disability Service users	% of 'other vulnerable adults'	% of pop'n aged 18-64 in ethnic group, 2004
White: British	*97.6%*	*95.7%*	*96.1%*
White: Irish	-	-	*0.6%*
White: Other	*0.8%*	*1.0%*	*1.5%*
Mixed	-	*0.7%*	*0.4%*
Black or Black British	-	-	*0.3%*
Asian or Asian British	*0.6%*	*0.4%*	*0.6%*
Chinese	-	-	*0.2%*
Other Ethnic Group	*0.2%*	*0.4%*	*0.2%*
Not Stated	*0.9%*	*1.8%*	-
Total non 'White British'	*1.5%*	*2.5%*	*3.8%*
Total	*100%*	*100%*	*100%*

Source: Physical Disability Service, Herefordshire Council & ONS experimental population estimates by ethnic group © Crown copyright. Figures may not sum due to rounding.

The distribution of service users across minority ethnic groups is different to the population as a whole, and the percentage of 'other vulnerable people' of an ethnic origin other than 'White British' is slightly lower than that of the population as a whole in 2004 (although this latter proportion may well have increased further – see discussion on p.5). The proportion of Physical Disability service users in 2006-07 of an ethnic origin other than 'White British' is less than half of proportion in the total population of 18-64 year-olds in 2004.

As discussed in an earlier section (p.12), 'other vulnerable adults' are included because they fall under the remit of the Physical Disability service, although they may not necessarily have a physical disability; the way information is currently collected means that it is not possible to know. This group includes people who, for example, have received welfare benefits advice from the council's Joint Working Team or other advice from Herefordshire ABLE.

It should be noted that nothing is known about the general health of the recent inflow of migrant workers to Herefordshire, or of any temporary seasonal workers working in the county.

Summary: Ethnicity of Adults with Physical Disabilities

- It is not possible to produce estimates of the number of people in different ethnic groups in Herefordshire with physical disabilities.
- The proportion of Physical Disability service users of an ethnic origin other than 'White British' in 2006/07 was less than half the proportion in the total population of 18-64 year-olds in 2004 (which itself may well have increased, given anecdotal changes in the ethnicity of the total population since the expansion of the European Union in May 2004).
- Nothing is known about the general health and social care needs of migrant and seasonal workers in Herefordshire.

GEOGRAPHIC DISTRIBUTION OF ADULTS WITH PHYSICAL DISABILITIES

It is not possible to produce projections of the number of people in different parts of Herefordshire who will have a physical disability, as there are no population forecasts or projections below county level.

Herefordshire Council's Physical Disability Service has locality teams that cover specific parts of the county. People are allocated to a team based on the location of their GP. These teams' referrals and caseloads are the only information that can be presented about where people with physical disabilities are in the county.

Table 24: Herefordshire Physical Disability Service locality teams' referrals & caseloads, 2006-07

Team	Referrals 2006/2007	Caseload*	Average monthly assessments/ reviews**	% of county population in area (*all ages*, 2004)
City *(Hereford, plus Credenhill, Clehonger, Lower Bullingham, Lugwardine, Withington & Moreton-on-Lugg)*	56 *(37%)*	236 *(47%)*	47	*38%*
West *(incl. Leominster, Kington, Golden Valley & Much Birch)*	38 *(25%)*	124 *(25%)*	21	*32%*
East *(incl. Bromyard, Ledbury & Ross)*	57 *(38%)*	144 *(29%)*	23	*31%*
Total	151 *(100%)*	504 *(100%)*	-	*100%*

Source: Physical Disability Service, Herefordshire Council
** Open cases held by Social Services teams. (Generally cases are held open where active work (e.g. an assessment) is taking place, or a service is being provided.)*
*** Average number of assessments, re-assessments or reviews per month during 2006/07*

A comparison with the total population (of all ages) of the areas shows that the West team had fewer referrals than the population would suggest compared to the other areas, and the East team had more. The City team had almost half of the total caseload. However, this comparison takes no account of age structures or the numbers of patients registered with each GP, and how this relates to resident population.

Further work would be required to determine whether this represents the distribution of people with physical disabilities across the county, and whether current services are provided equitably regardless of location.

Work has been done in the past to map the locations of people receiving care in their homes, but this included people of all ages, and the vast majority were over 65.

Summary: Geographic Distribution of Adults with Physical Disabilities
- It is not possible to produce projections of the number of people in different parts of Herefordshire who will have a physical disability.
- Further work would be required to determine the distribution of adults with physical disabilities across Herefordshire, and if current services are provided equitably regardless of location.

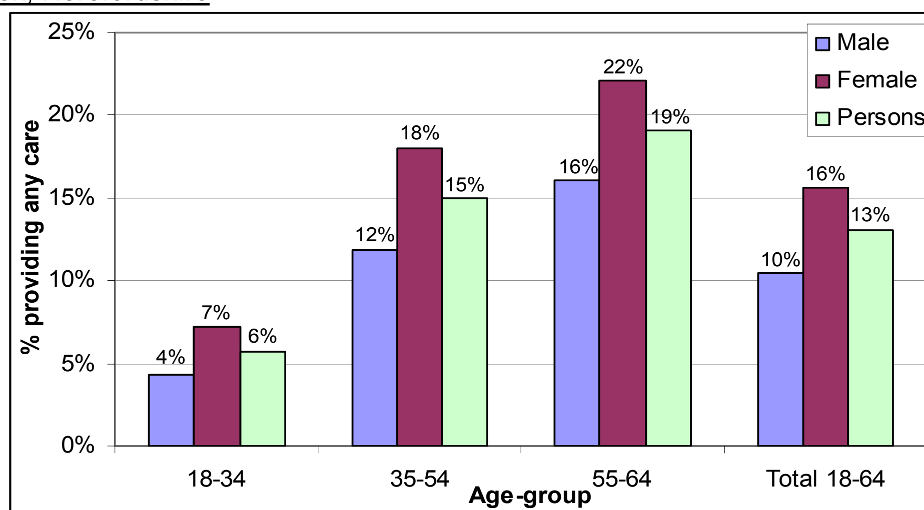
CARERS

NUMBERS OF CARERS

2001 Census

According to the 2001 Census, 13% of 18-64 year-old residents of households in Herefordshire provide at least 1 hour of unpaid care[45] a week: a total of 13,373 people. However, the gender proportions aren't equal: only 10% of men (5,333 men) compared to 16% of women (8,040 women). Figure 25 illustrates that this disparity is evident across all ages, and also how the proportion providing unpaid care increases with age. This pattern is identical to that across England and Wales as a whole, although each of the Herefordshire figures is one percentage point below the national.

Figure 25: Proportion of household population providing at least one hour of unpaid care per week, Herefordshire



Source: 2001 Census, Table S025 © Crown copyright

- Assuming that prevalence of caring by age and gender has remained consistent since 2001, it could be estimated that 14,100 people aged 18-64 were providing at least one hour of unpaid care per week in 2005, with 60% of them female. Of these, 3,600 would be expected to be providing care for 20 hours or more per week (65% female).

However, it is also likely that snap-shot estimates of the number of carers at a point in time, like the Census provides, are an underestimate of the number of carers over time. Nationally, more than 40% of carers start or stop caring over the course of a year, and less than two-thirds of the actual number of people who provide care over a year are captured at one point within that time.[46]

Carer's Allowance Claimants

The only other information regarding carers in Herefordshire are numbers of people claiming Carer's Allowance. This is likely to be a very small subset of all carers as it is only available to people not in employment or full-time education who care for a severely disabled person[47] for at least 35 hours a week. Nevertheless, 1,370 people aged 18-64

[45] Any unpaid help; looking after or supporting family members; friends; neighbours or others because of long-term physical or mental ill-health or disability or problems related to old age.
[46] Hirst, M (2005) *Estimating the prevalence of unpaid adult care over time*; Research Policy and Planning vol. 23, no. 1.
[47] I.e. a person in receipt of the medium or higher level of the care component of Disability Living Allowance, Attendance Allowance or a Constant Attendance Allowance at the maximum rate under the War Pensions or Industrial Injuries Scheme (DWP).

were entitled[48] to Carer's Allowance in August 2006 – a similar number to the previous two years (see Table 26). The number entitled in 2005 represents 1.3% of the population aged 18-64; the proportion entitled increases slightly with age, from 0.7% of 18-34 year-olds to 1.9% of 55-64 year-olds (in 2005).

Table 26: Numbers entitled[48] to Carer's Allowance in Herefordshire, by age.

Year (August snapshot)	18-34	35-54	55-64	18-64
2006	210	680	480	1,370
2005	220	650	470	1,340
2004	210	670	450	1,330
2003	220	650	380	1,250

Source: Work and Pensions Longitudinal Study (WPLS), Department for Works and Pensions.

Carers' Assessments

Herefordshire Council carries out carers' assessments for people who are providing care; there is the facility to record information about these people and the care they are providing, but there are known to be significant gaps in the data.

THE CARED FOR

The Census didn't ask for whom care is provided, so nothing can be deduced about people who *require* care from this source. However, a national survey of adults living in private households[49] (2000) identified carers and asked for more detail about their situation. 62% of carers cared for someone with only a 'physical disability' (as defined by the respondent) and a further 18% were looking after someone with both a physical and mental disability. It is not possible to estimate numbers of people aged 18-64 being cared for in each of these categories, as there is no information regarding the ages of people being cared for, although it would seem reasonable to expect that the majority of people being cared for have a physical disability.

CARERS' HEALTH

National analysis of the Census[50] has shown that carers are more likely to be in 'not good' health and/or have a limiting long-term illness themselves than non-carers.

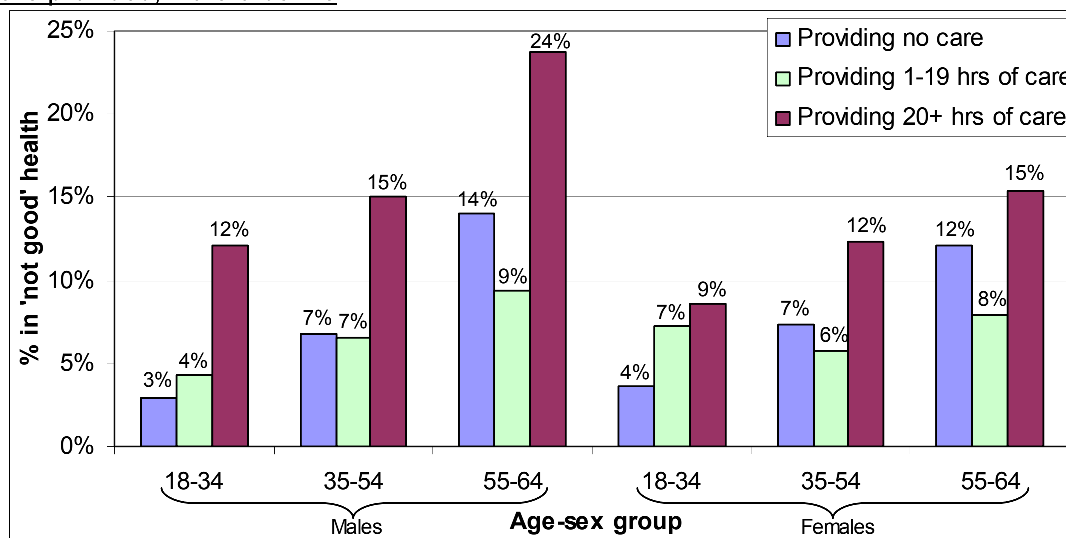
- In Herefordshire, 14% of 18-64 year-olds who provide 20+ hours of care per week are in 'not good' health, compared with 7% of both those providing 1 to 19 hours and those providing no care. The difference is particularly marked in males of all ages, as illustrated by Figure 27.

Furthermore, people who provide care over a long period are at particular risk of poor health, and carers' health is more likely to deteriorate over time than that of non-carers – with many of the detrimental changes attributable to the caring role.[51]

However, the risks to carers' health are more likely to be related to mental health than physical health: in a survey of carers' mental health[52] (2001), ONS found that only 8% said their caring responsibilities had a direct impact on their physical health.

[48] 'entitled' includes some people who are entitled to receive Carer's Allowance, but do not because they are receipt of another benefit which exceeds their weekly rate; it does not necessarily include everyone in the population who is eligible to claim.
[49] Maher, J and Green, H (ONS) (2002) *Carers 2000*. London: The Stationery Office
[50] *Facts about carers* (2005), Carers' UK: www.carersuk.org
[51] Hirst, M (2004) *Health inequalities and informal care*; quoted by Carers' UK in *Facts about carers*
[52] Singleton et al (2002) *Mental Health of Carers.* London: The Stationery Office

Figure 27: Proportion of household population in 'not good' health by age, sex & amount of care provided, Herefordshire



Source: 2001 Census, Table S025 © Crown copyright

- Assuming that people aged 18-64 care for the same 'type' of people as all people aged 16 and over; the caring situation in Herefordshire in 2005 was the same as in Britain as a whole in 2000; and prevalence of caring by age and sex has not changed locally since 2001, it could be estimated that around 8,800 adults aged 18-64 in Herefordshire care for someone with a 'physical disability' (as defined by the respondent). An estimated further 2,500 care for someone with both a physical and mental disability.

Summary: Carers

- Assuming that the prevalence of caring in Herefordshire is as it was at the 2001 Census, 14,100 people aged 18-64 in Herefordshire are estimated to have been providing at least one hour of unpaid care a week in 2005, with 3,600 providing care for 20 hours or more per week.
- At the same time, 1.3% of 18-64 year-olds in the county (1,340 people) were entitled to Carers' Allowance, i.e. were not in employment or full-time education and were caring for a severely disabled person for at least 35 hours a week.
- Carers are more likely to be in 'not good' health than non-carers, and the disparity increases with the amount of time spent caring per week.
- People who provide care over a long period of time are particularly at risk of poor health. Carers' health is also more likely to deteriorate over time than that of non-carers, with many of the detrimental changes attributable to the caring role. However, these risks are more likely to be in relation to carers' mental health; in an ONS survey only 8% of carers reported that caring responsibilities had a direct impact on their physical health.

ABILITY TO PAY

EARNINGS

The only information on earnings is for the total population of the county as a whole; the only available relevant breakdown is by gender.

- In 2006, average (median) gross weekly earnings for full-time employees who work in Herefordshire were £390.60, compared to £415.50 for the West Midlands region and £453.30 for England.[53] Whilst Herefordshire's median earnings appear lower than regionally *and* nationally, the difference with the region is not statistically significant.

- Herefordshire's lower quartile earnings are also significantly lower than England's: 25% of people who work in the county earned less than £297.00 per week, whereas the equivalent national figure is £320.30.

- The top 25% of earners in Herefordshire earned more than £551.20. The equivalent figure for England as a whole was £642.0, but this is not significantly higher (due to the sample size).

- Herefordshire has one of the largest gender pay gaps of neighbouring English authorities, and of all authorities in the West Midlands region: on average, full-time female workers earn only 72% of the amount earned by their male counterparts. The national equivalent figure is 79%.

INCOME

There are no data on levels of *income*[54] in Herefordshire, but the Indices of Deprivation 2004[55] included an 'income' domain based on the extent to which households in an area were dependent on income related benefits. Overall, Herefordshire is more 'income deprived' than two-thirds of English local authorities.[56]

In addition, income deprivation 'hotspots' exist within the county: ten areas[57] in Herefordshire were in the 25% most deprived areas in England. Six of the ten areas of the 'South Wye' part of Hereford city are amongst these; the remainder are north of the river in Hereford ('College Estate' and 'Courtyard') and in Leominster ('Ridgemoor') and Bromyard ('Central').

EMPLOYMENT AND FINANCIAL CHARACTERISTICS OF PEOPLE WITH A DISABILITY

The Family Resources Survey[58] defines 'disability, including limiting long-standing illness' as: "people with a long standing illness, disability or infirmity, and who have a significant difficulty with day-to-day activities. Everyone in this group would meet the definition of disability in the Disability Discrimination Act (DDA); however these estimates do not reflect the total number of people covered by the DDA as the FRS does not fully collect this information." It should be noted that this definition includes people with disabilities that are not physical.

[53] 2006 Annual Survey of Hours & Earnings, Office for National Statistics (ONS)
[54] Earnings plus unearned income from investments, etc.
[55] Office for the Deputy Prime Minister (ODPM), now Department for Communities & Local Government (DCLG). Based on data from 2001.
[56] Herefordshire ranked 114th out of 354 English local authorities in terms of income deprivation.
[57] Lower Super Output Areas (LSOAs): statistical geographies of about 1,500 people that nest into wards. They were determined by ONS, but names were given by HC Research Team.
[58] Family Resources Survey, Great Britain: 2005/06: www.dwp.gov.uk/asd/frs

The 2005/06 survey found that, when considering people *of all ages* living in households, those who said they had a disability were less likely to be employed or self-employed than in the sample as a whole: 27% of disabled males and 21% of disabled females were employed / self-employed compared to 66% of all males and 54% of all females. It is not appropriate to apply these percentages to estimates of Herefordshire's disabled population aged 18-64 as no account has been taken of age. Disability is more likely in the over 65s, whilst this age-group are also less likely to be in employment than younger people. If age-specific rates were considered the differences in these percentages may not be as great, but it is not possible to do this.

The increased prevalence of disability at older ages may well be linked to the finding from the same survey that the main source of household income was a pension for a greater proportion of disabled people than in the sample as a whole (36% of disabled males and 45% of disabled females compared to 15% and 19% respectively, overall).

A greater proportion of disabled people were reliant on social security benefits as their main source of household income than the sample as a whole, particularly males: 25% of disabled males compared to 12% of all males, and 18% of disabled females compared to 13% of all females. Again though, it is not possible to apply these percentages to the estimated 18-64 year-old disabled population in Herefordshire.

The *Health Survey for England: Disability* ranked the 'equivalised household income'[59] of all survey respondents, and found that over a third (34%) of people aged 16-64 with any disability were in the lowest income quintile (ie the 20% of households with the lowest equivalised income), with only 8% in the highest quintile. The comparative figures for those without a disability were 13% and 26%, respectively.

Summary: Ability to Pay

- Average earnings in Herefordshire are significantly below those in England as a whole, but there is no information on *incomes* locally.
- There is no information about the financial situation of adults with disabilities in Herefordshire, but national evidence suggests that it is reasonable to assume that people with a disability are more likely to have a low income than those without. This will have implications for their ability to pay for the costs of services

[59] a measure that adjusts the total household income to account for the number of people in the household

HOUSING

It is recognised that Herefordshire needs to develop a range of housing options for younger adults and supported housing schemes are being explored in partnership with Housing Association, Strategic Housing and Care Providers.

HOME POINT REGISTER

As at November 2006, 5,896 people aged 18-64 were registered with Home Point, the agency which implements choice-based lettings in Herefordshire. Of these, 339 (5.7%), said on their application form that they were 'registered disabled', 42 (0.7%) said they were 'registered blind', and 37 (0.6%) said they were deaf or had partial hearing difficulties.

Responses to these questions are subjective as there is no clear definition of 'registered disabled', and some people who are 'registered blind' may not consider themselves to be disabled. This is illustrated by the fact that the only person who was blind and had hearing difficulties said that they were *not* 'registered disabled'. In fact, only 36% of those who were 'registered blind' (15 people) also said that they were 'registered disabled'. The proportion for people with hearing difficulties was higher: 43% (16 people) were also 'registered disabled'.

- To clarify these figures: in total, 386 people aged 18-64 (6.5%) stated that they were either 'registered disabled', 'registered blind' or were deaf or had partial hearing difficulties on their Home Point application form.

It is worth noting that at least seven applications from the 42 people who were 'registered blind' were linked to the Royal National College for the Blind, either because of courses coming to an end and wanting to remain in the area or relationships to current students at the college.

TENURE OF PEOPLE WITH DISABILITY / LIMITING LONG-TERM ILLNESS

According to the *Health Survey for England 2001*, the majority of people (aged 16 and over), both with and without a disability, were owner-occupiers, but the proportion was significantly higher for those without a disability. Approximately 25% of people aged under 65 with a disability were living in social housing, compared to 10% of those without a disability.[60]

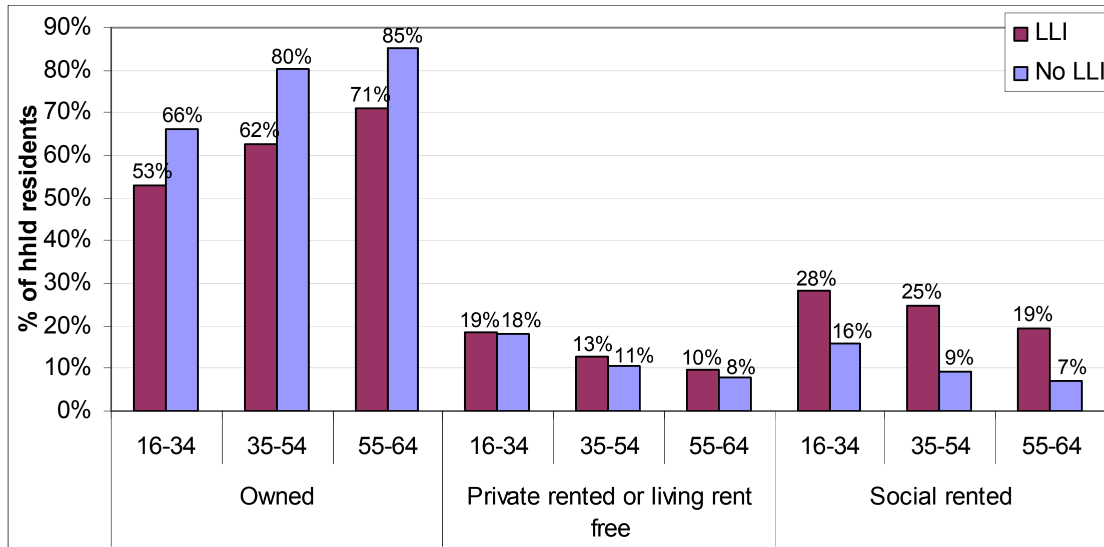
The likelihood of living in either socially or privately rented accommodation decreases with age, but even taking this into account, household residents aged 18-64 in Herefordshire with a limiting long-term illness (LLI) are considerably more likely to live in socially rented accommodation than those without an LLI – as Figure 28 illustrates. However, it should still be noted that, despite this, across all age-groups the majority of people with an LLI live in owner-occupied accommodation – as was the case with people with disabilities nationally.

- To put this in a different way, 25% of Herefordshire residents aged 18-64 living in socially rented accommodation have an LLI, in comparison with just 11% of those living in owner occupied accommodation and 13% in privately rented. These figures are remarkably similar to the proportions in the *Health Survey for England 2001.*

Therefore, although little is known about the housing situation of adults with disabilities in Herefordshire, it seems reasonable to assume that people with physical disabilities are more likely to be living in socially rented accommodation that people without.

[60] Bajekal and Prescott (2003)

Figure 28: Tenure of household residents, by age and presence of limiting long-term illness (LLI), Herefordshire



Source: 2001 Census, table S017 © Crown copyright

Summary: Housing

- Although little is known about the housing situation of adults with disabilities in Herefordshire, national and local information suggests that it seems reasonable to assume that people with physical disabilities are more likely to be living in socially rented accommodation that people without.
- In November 2006, 6.5% of 18-64 year-olds registered with Home Point were ‘registered disabled’, ‘registered blind’, were deaf or had partial hearing difficulties.

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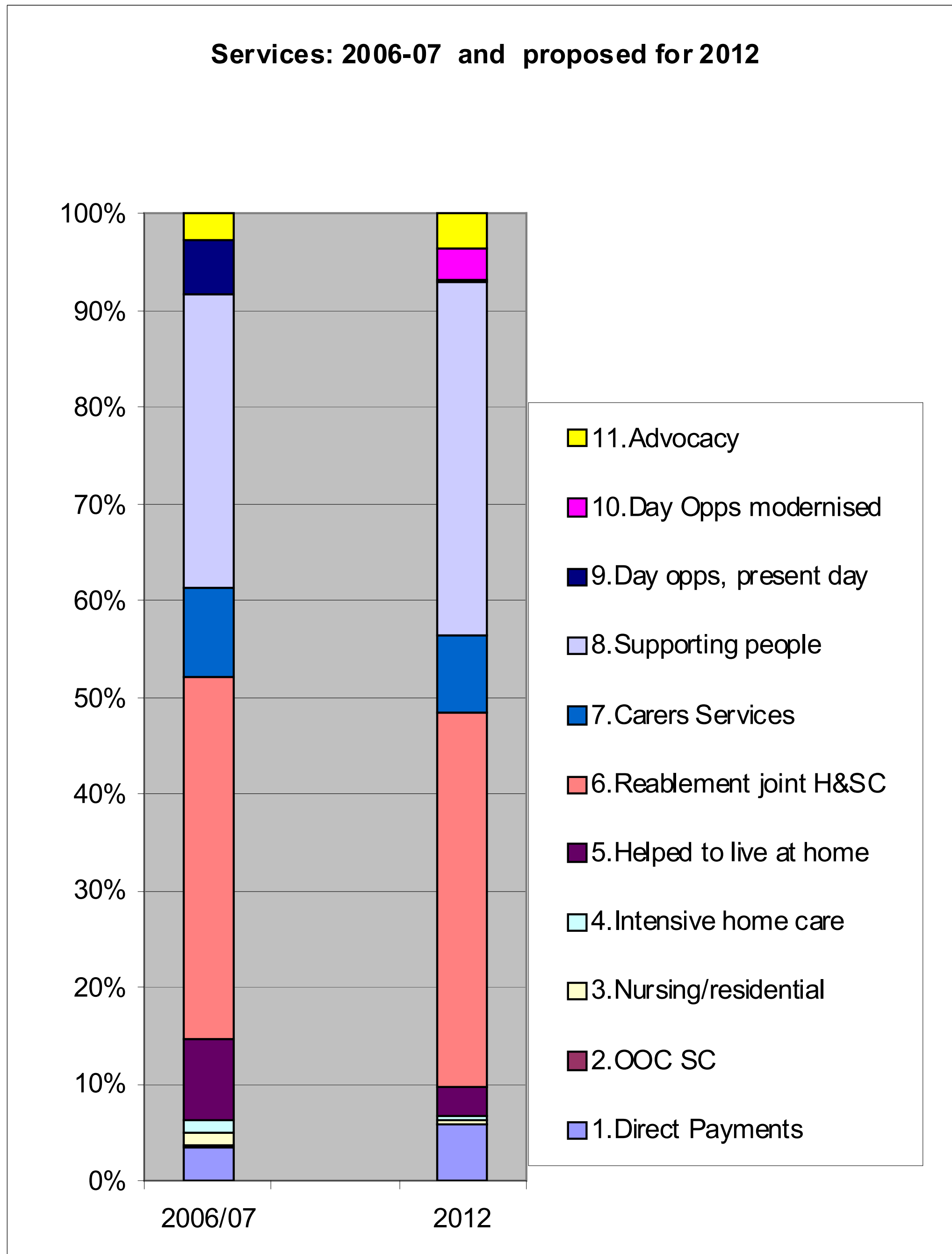
Current and future services for adults with physical disabilities

Overview

The bar chart below compares the current pattern and levels of services for adults with physical disabilities with the proposed future models of service by 2012.



Details of proposed service levels for proposed higher performing services

Direct payments

Increasing the number of people receiving direct payments or personalised budgets by 28% a year – from 88 currently to 236 in 2011-12. This would match the proportionate level achieved by the highest performing comparator area.

N.B. This number includes those with direct payments or personalised budgets receiving intensive homecare and those with less intensive needs who are helped to live at home. Only those **not** in receipt of direct payments or personalised budgets are included in the numbers in respect of intensive home care and help to live at home shown below.

Out-of-county placements

Through the development of specialist local services, the number of social care out-of-county placements should fall from the current 10 to 3 by March 2010.

Nursing and residential care

The comparator area achieving the lowest use of nursing and residential care secures 1.91 places per 10,000 population, compared with Herefordshire's 3.04. Community-based living options should eliminate the need for residential care, but the current level of nursing home placements will need to continue – resulting in an overall reduction from 32 places to 16.

Intensive home care

The number people receiving intensive home care packages not secured by means of direct payments or personalised budgets should fall from 34 to 18.

Help to live at home

The number of people receiving less intensive support to live at home not secured by means of direct payments or personalised budgets should fall from 216 to 124.

Community-based reablement service

All users should have access to a reablement programme. Taking into account the estimated 5% in need and the national target of a 5% reduction in hospital admissions, there should be an increase from 975 to 1,590 in the number of people assessed and receiving step down/step-up intermediate care.

Services for carers

Based on national good practice and the increased number of assessments of users, services should be provided for 33% more carers – from 245 to 326.

Supporting People

To emulate the best performance in comparator areas, meet cost-effectively in their own homes and communities the non-care needs of people with intensive care needs, and improve preventative capacity and low-level case management, the number of people supported by *Supporting People* funding should rise from 792 to 1,500.

Buildings-based day opportunities

A much-reduced number of people, comprising some existing users with complex needs, should need buildings-based day opportunities – down from 144 to 11.

Community-based day opportunities

Modern and flexible, community-based day opportunities, maximising the use of personalised budgets and invalidity benefit, should be provided for 141 people (there are none at present).

Advocacy

To emulate performance in the high-performing authorities and meet the 5% estimated increase in need, double the number of people should receive personal advocacy - from 72 to 144.

EXTRACTS FROM DRAFT MINUTES OF THE MEETINGS OF THE ADULT SOCIAL CARE AND STRATEGIC HOUSING SCRUTINY COMMITTEE AND THE HEALTH SCRUTINY COMMITTEE HELD ON 19 MARCH 2008

Draft Resolutions - Adult Social Care and Strategic Housing Scrutiny Committee

That:

(a) The Committee believes that the recommendations to improve both Mental Health and Physical Disabilities are sound, although it remains concerned that the some of the conclusions are based on data that is far from robust. Herefordshire Council and the Primary Care Trust (PCT) need to ensure that, as a matter of urgency, better systems of data collection and analysis are in place, so that future improvement plans are more securely evidence-based. (The Committee understands that new systems for Herefordshire Council's social care services will be installed in the Autumn, which should greatly improve both assessments and data collection. It is hoped that the PCT will make similar improvements.) The Committee intends to focus on key outcomes, and will therefore require regular reports to the Committee on the success of achieving the reports' recommendations;

(b) The Committee supports Recommendation B as outlined in the paper before it, but believes that joint commissioning and provision between the Council and the PCT should be strengthened (including, for example, in respect of occupational therapy), with absolute clarity about financial matters. The Committee was glad to note that recruitment to the post of Director of Integrated Commissioning was imminent. It was requested that a progress report should be brought to the Committee once the post-holder had been in position for six months, and thereafter on a regular basis;

(c) The Committee is uncertain whether the total resources proposed will be adequate to deliver the recommended improved services, especially as their introduction might bring increased demand, particularly if services not currently provided (e.g. for personality disorders) are introduced. This consideration should be taken into account in setting budgets for future years;

(d) The Committee notes the high dependence on the support of the voluntary sector in the achievement of these improvement plans, and suggests that in order to achieve this the voluntary sector must have the confidence that adequate and secure funding is in place.

(e) Outside funding sources should be sought as a matter of priority, and internal funding should be made available to support this function;

(f) A report on action on the workforce improvements necessary to implement the reports' recommendations, including as regards the training, recruitment and retention of staff, should be made to this Committee in three months' time; and

(g) The importance of the integration of ICT systems between the Council and the PCT be emphasised, and that this matter should therefore be monitored

to ensure that the work being undertaken delivers the outcomes required. A progress report should be provided to the Committee in six months' time.

Draft Resolutions - Health Scrutiny Committee

RESOLVED:

That (a) whilst the Committee welcomes the positive changes in mental health provision in recent months, it also recognises that further changes in the way services are delivered are necessary, particularly with regard to residential care levels and improved preventative measures. It therefore supports the general findings of the report;

(b) the decision to appoint a Joint Head of Integrated Commissioning for the Primary Care Trust and Herefordshire Council is supported and the Committee requests that the Joint Commissioning Strategy currently being prepared for physical disabilities is presented at the earliest opportunity for the Committee's consideration, together with an updated version of the Joint Commissioning Strategy already in place for mental health services. Thereafter, the Committee asks that implementation progress reports should be made on a regular basis, including as regards the integration of occupational therapists into community teams under common line management and the development of the new ICT system for social care (with effective links to the PCT);

(c) the Committee notes the large number of assumptions made within the mental health data and suggests caution over the financial projections which result. It therefore supports better local data collection for service users and that updated actual data is taken into account in future budget setting;

(d) the Committee would like the sourcing of outside funds to be a priority and would support the relevant personnel being employed to achieve this aim;

(e) a report be made to the Committee on the workforce plan being prepared, which will include training, recruitment and retention issues for the Primary Care Trust, social care and provider organisations in the independent sector; and

(f) in addition to emphasising the points above from a health perspective, the recommendations made by the Adult Social Care and Strategic Housing Scrutiny as set out below be endorsed:

That:

(a) The Committee believes that the recommendations to improve both Mental Health and Physical Disabilities are sound, although it remains concerned that the some of the conclusions are based on data that is far from robust. Herefordshire Council and the

Primary Care Trust (PCT) need to ensure that, as a matter of urgency, better systems of data collection and analysis are in place, so that future improvement plans are more securely evidence-based. (The Committee understands that new systems for Herefordshire Council's social care services will be installed in the Autumn, which should greatly improve both assessments and data collection. It is hoped that the PCT will make similar improvements.) The Committee intends to focus on key outcomes, and will therefore require regular reports to the Committee on the success of achieving the reports' recommendations;

(b) The Committee supports Recommendation B as outlined in the paper before it, but believes that joint commissioning and provision between the Council and the PCT should be strengthened (including, for example, in respect of occupational therapy), with absolute clarity about financial matters. The Committee was glad to note that recruitment to the post of Director of Integrated Commissioning was imminent. It was requested that a progress report should be brought to the Committee once the post-holder had been in position for six months, and thereafter on a regular basis;

(c) The Committee is uncertain whether the total resources proposed will be adequate to deliver the recommended improved services, especially as their introduction might bring increased demand, particularly if services not currently provided (e.g. for personality disorders) are introduced. This consideration should be taken into account in setting budgets for future years;

(d) The Committee notes the high dependence on the support of the voluntary sector in the achievement of these improvement plans, and suggests that in order to achieve this the voluntary sector must have the confidence that adequate and secure funding is in place.

(e) Outside funding sources should be sought as a matter of priority, and internal funding should be made available to support this function;

(f) A report on action on the workforce improvements necessary to implement the reports' recommendations, including as regards the training, recruitment and retention of staff, should be made to this Committee in three months' time; and

(g) The importance of the integration of ICT systems between the Council and the PCT be emphasised, and that this matter should therefore be monitored to ensure that the work being undertaken delivers the outcomes required. A progress report should be provided to the Committee in six months' time.