

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

CONTENTS

- 1. Introduction**
- 2. The Hounslow Vision for jointly commissioned Health and Care services**
- 3. National context**
 - The Commissioning Framework for Health & Well Being
 - The State of Social Care in England 2005-06
 - Local Government White Paper: Strong and Prosperous Communities
 - Health Well-being and Prevention (Our Health, Our Care, Our Say)
 - Key challenges to achieving our vision
 - Other Policy Drivers
 - *Practice Based Commissioning*
 - *Assistive Technology*
 - *Continuing Care*
 - *Long Term Conditions*
 - *Carers*
 - *Direct Payments, Choice and Individual Control*
 - *A Stronger Local Voice - LINKS*
 - *Housing Policy and Supporting People*
 - *Standards and Regulation*
 - *Equalities*
- 4. Hounslow context**
- 5. The Local Population – Needs Analysis**
- 6. Performance**
- 7. Finance & Resources**
 - Efficiencies
 - Capital Assets
 - Information Technology
 - Financial Strategy for 2007/10
- 8. Workforce**
- 9. Employment and Social Inclusion**
- 10. Promoting Health and Well-being and Reducing Inequalities**
- 11. Partnership Working and Involvement**
- 12. Commissioning and Market Management**
- 13. Risk Management**
- 14. Monitoring and Reviewing the Strategies**
- 15. Appendices**
 - *Action Plan*
 - *A Framework for Joint Commissioning and Purchasing*
 - *Summary of Key Reference Documents*
 - *Summary of Key Stakeholder Involvement in producing this Strategy*
 - *Acknowledgments*
 - *Glossary(attached as separate document)*

“Commissioning offers an opportunity to transform people’s lives through better services – it is not simply about procedures and processes.” CSCI 2006

1. Introduction to the Joint Commissioning Strategies Overview

1.1 What is Commissioning

Commissioning is the process of developing or purchasing services to meet identified needs and monitoring services to see that the outcomes sought are achieved. Health and social care agencies produce joint commissioning strategies set out plans which make clear the national and local priorities, which set out a whole system approach to delivering services and which provide a baseline against which progress can be assessed.

1.2 Vision

This overarching document defines out the principles and vision for adult health and social care in the period 2007 to 2010. The strategy draws together various streams of work overseen by the multi agency Hounslow Health and Social Care Partnership; a subgroup of the Local Strategic Partnership (LSP). It is a joint statement of intent between Hounslow Primary Care Trust (PCT) and Hounslow Council’s Housing and Community Services Department.

The overall **Commissioning Strategy for Hounslow** can be summarised as follows:

- to commission health and care services that people need at the right time, in the right place and in a way that promotes their independence;
- to commission services based on joint analysis of needs within Hounslow;
- to commission and deliver services within the available resources;
- to provide a range of preventative services, including employment and leisure opportunities, that help people maintain their independence for as long as possible and support the wider principles of social inclusion;
- to develop a range of carer support services based on joint analysis of needs;
- to ensure sufficient and appropriate nursing and residential care for the more frail and vulnerable people;
- to develop appropriate local housing and housing support services;
- to maximise the use of Assistive Technology (telehealth & telecare) and IT to support these approaches; and
- to best utilise of assets and buildings to support these approaches and enable co-location of staff

1.3 Care Group Strategies

This overview summarises the national and local context for commissioning and the resources available. It aims to show clearly the key national and local priorities for health and care services over the next 3 years and the commissioning actions that need to be taken to implement changes in services to meet those priorities. It draws out the threads common to some, or all, care groups and is supported by separate detailed strategies for each of the care groups and their related action plans. The care groups are as follows:

- Older people
- Mental Health
- Learning Disabilities
- Physical Disabilities
- Carers
- Supporting People
- Drug and Alcohol

The individual strategies set out:

- Why the service developments are needed: based on legislation, research, needs, service and market analysis;
- Why existing arrangements will not meet users/patients' needs in the future (gap analysis);
- What redistribution of resources is required;
- Priorities to maintain existing service provision, price and quality;
- Options for reshaping services and clinical pathways working with existing providers to achieve shifts in existing provision;
- Options for disinvestment and decommissioning and renegotiation to improve performance in delivering a contract and
- Commissioning new developments to meet changing needs and priorities.

They each establish a multi-agency plan for achieving tangible outcomes related to the service vision and set out an annual delivery plan and reporting mechanisms.

1.4 Key issues for Commissioning

Some of the Key Issues for Commissioning that the individual strategies will cover are:

- financial pressures on Councils and NHS and lower levels of planned growth mean that resources will not grow to meet increased demand;
- mental health services locally are comparatively under-resourced;
- the need to support move from bed based to community based services;
- the need to develop joint procurement further;
- the need to resource effective preventative and well-being approaches;
- workforce planning :- recruitment, retention and development of new skills;
- buildings/estate infrastructure;
- development of new user and carer involvement approaches;
- the increasing numbers of people in transition who have complex needs and
- developing an effective relationship with the third sector (voluntary/not for profit) as a key provider.

Success will be defined by:

- reduced inequalities & improved access to services;
- more support for people with long-term needs and mental health needs;
- more choice & stronger voices for users and carers;
- commissioning driving service redesign with demonstrable value for money;

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

- services provided within available budgets;
- performance focussed services with clear and specified outcomes;
- integrated care plans – Long Term Conditions in 2008, everyone by 2010; and
- better prevention/early intervention for improved health, independence & wellbeing.

A key principle is that people should receive **the right care, in the right place and at the right time**. Success will be a shared approach to care including:

- following a single, co-ordinated approach to identifying health and care needs and to arranging services;
- sharing information about users (with consent) to make this happen;
- actively seeking and listening to user and carer views and wishes and involving them in decisions; and
- offering a continuum of care along agreed care pathways.

2. The Hounslow Vision for Jointly Commissioned Health and Care Services

Our vision is that, in partnership with local people, we will provide local health and care services within the available resources, that:

- promote health and well-being for the whole community;
- help people maintain their independence and safety;
- are of high quality and meet required standards;
- are equitable and provided in a timely and responsive way;
- promote dignity, self-respect and individuality;
- offer choice, wherever possible;
- meet individual needs;
- meet the needs of carers;
- safeguard vulnerable adults;
- are appropriate and take account of age, gender, ethnicity, religion & sexuality;
- are publicised widely and made accessible to all; and
- engage and involve users and carers in the development, delivery and review of services.

3. National Context

3.1 The Commissioning Framework for Health & Well being

3.1.1 New guidance has been issued by the Department of Health (DH) in 2007 setting out a shift in focus to strong and effective commissioning to deliver improved outcomes for the public across health and care services. It sets out key commissioning principles which underpin care commissioning and covers:

- health and well-being for all ages and care groups;
- joint commissioning between health and local government;
- services for people with long-term conditions;
- social care;
- mental health;
- primary and community services; and
- engagement and participation of Third Sector providers.

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

3.1.2 The guidance states that effective commissioning makes the best use of allocated resources to achieve the following goals:

- improvements in health and well-being
- reductions in health inequalities and social exclusion
- better access to a comprehensive range of services
- improved quality, effectiveness and efficiency of services
- increased choice for patients and a better experience of care
- improved integration of health and social care

3.1.3 The document includes a stated intention that 5% of health funding should shift from acute hospitals to community based services in primary care and into prevention.

3.2 The State of Social Care in England 2005-06

3.2.1 In its second annual report, published in January 2007, the Commission for Social Care Inspection (CSCI) reviewed the state of social care. It identified successes and areas for improvement.

Social care is performing well in:

- providing good quality information which is readily accessible to all;
- seeking feedback from service users and carers and acting on it;
- having sound financial management systems to support commissioning; and
- having systems to safeguard vulnerable adults.

Areas for improvement include:

- continuing to improve commissioning and the value for money of services;
- arrangements for referral, care planning and review;
- ensuring service quality and consistency and using incentive payments or variable fees to improve quality;
- analysis of need, demand and supply in commissioning strategies needs to be strengthened;
- corporate strategies on well-being need to link clearly with commissioning strategies; and
- strategic approach to carers.

3.2.2 CSCI concluded that social care is modernising, but that modernisation is gradual and that progress is hampered by the pressures on the social care sector.

3.3 Local Government White Paper: Strong and Prosperous Communities

3.3.1 This White Paper removes barriers to support better collaborative working between Councils and the NHS and supports their strong strategic, collaborative leadership on health and well-being issues to deliver services that reflect local needs. Much of the White Paper is about legislating to require Council's and the NHS to implement arrangements which already exist in Hounslow, such as:

- developing strong local user and carer involvement;
- joint Commissioning arrangements; and
- setting up partnerships for health and well-being under the LSP.

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

3.3.2 The White Paper expects local government to champion the interests and improve the lives and opportunities of people and places that face disadvantage and discrimination. It expects Councils to make tough decisions about the allocation of resources, and develop innovative delivery options for vulnerable people and traditionally under-represented communities. Furthermore, it encourages local authorities to move away from a narrowly defined approach to service delivery and, like PCTs, to develop the commissioning role to use the best possible ways of securing service outcomes.

3.4 Health Well Being and Prevention

3.4.1 The Green Paper on social care and the subsequent White Paper on community services set out proposals for the future direction of health and social care for all adult care groups. The papers emphasise the importance of increasing control, choice and quality for those who use care services and highlights the necessity for social inclusion. The intention is to reduce the dependence on acute and specialist bed based care for vulnerable people and instead focus on ensuring that community based services are the cornerstone of service delivery.

3.4.2 The DH White Paper “Our Health, Our Care, Our Say” sets out four main goals for health and social care services:

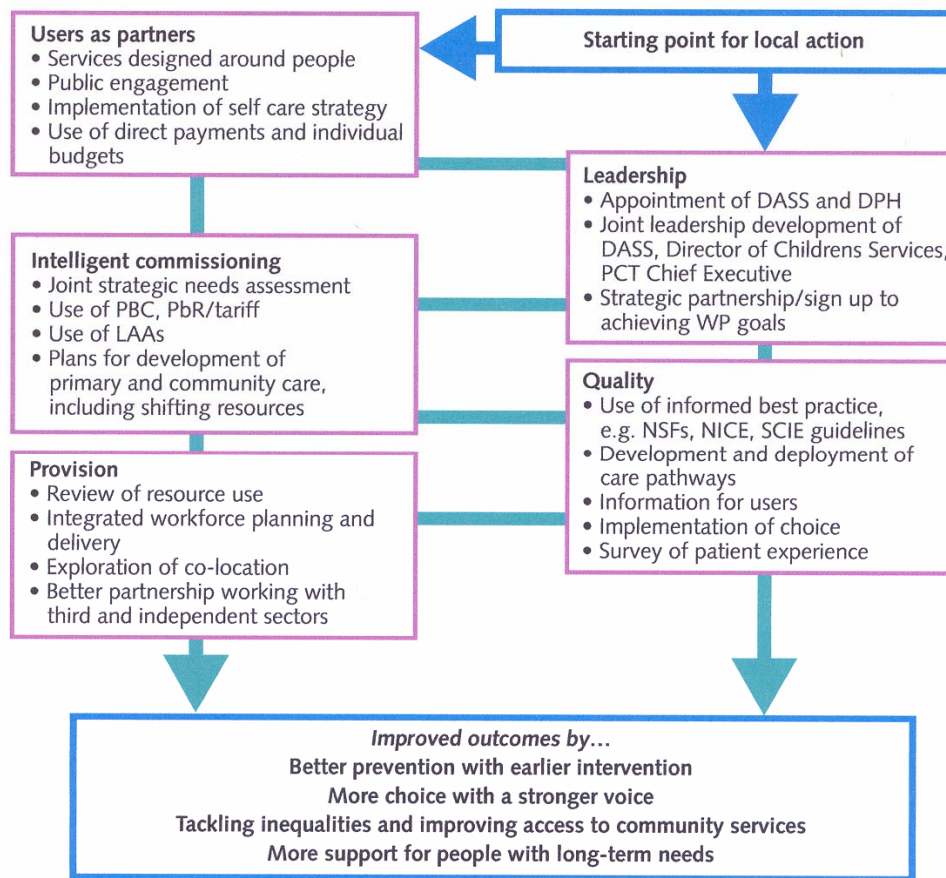
- to provide better prevention services with earlier intervention;
- to give people more choice and greater control over decisions about their lives;
- increased access to community services; and
- increased support for people with long-term conditions.

3.4.3 The White Paper sets out seven outcomes for social care to aim for in partnership with health and other colleagues. These are:

- Improving health and emotional well being
- Improved quality of life
- Making a positive contribution (maintaining involvement in local activities and being involved in policy development and decision-making)
- Increased choice and control
- Freedom from discrimination or harassment (including equality of access)
- Economic well-being
- Maintaining personal dignity and respect.

OUR HEALTH, OUR CARE, OUR HOUNSLOW
An Overview of Joint Commissioning Strategies 2007-10

“Our Health, Our Care, Our Say” sets out a roadmap for change. The map for making it happen is reproduced below.



3.4.4 Additional themes and proposals in the Green Paper to deliver this vision included:

- increased use of direct payments and individual budgets;
- the use of the local government well-being power to promote social inclusion; and
- a greater focus on preventative services.

3.5 Key Challenges to Achieving Our Vision

3.5.1 A number of challenges have been identified by the DH and CSCI to progressing improvements to health and care services. These include:

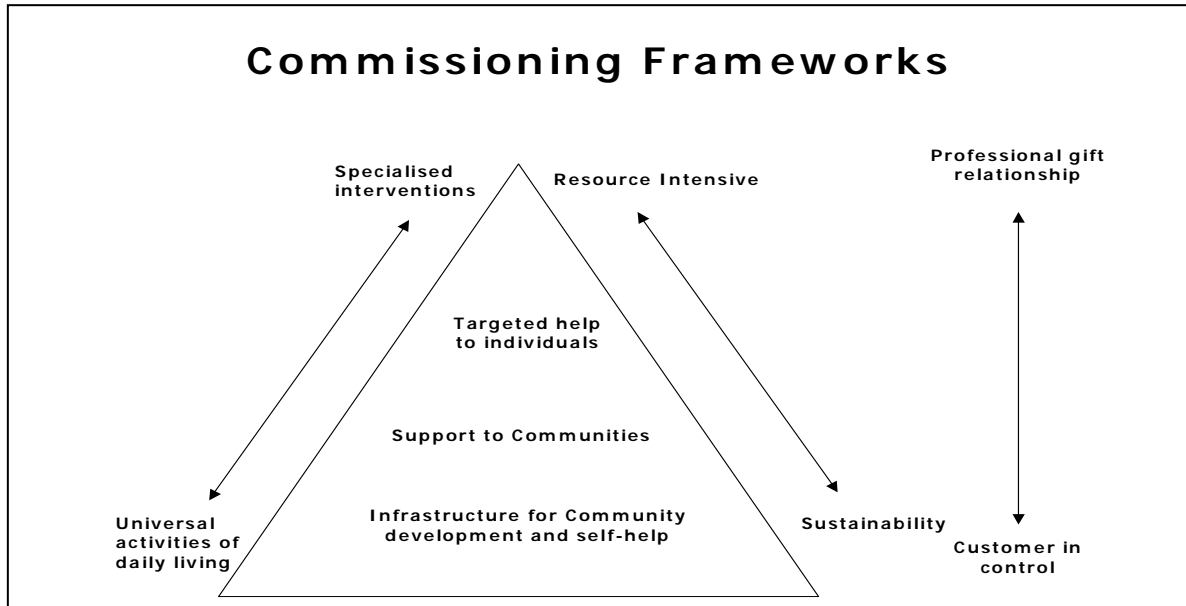
- a rapidly changing policy agenda;
- increasing financial pressures on health and care budgets;
- considerable organisational change and turbulence in the NHS and Councils;
- unresolved debates about the appropriate dividing line between state and individual responsibilities;
- increasing numbers of self funders;
- rising numbers of people who require the most intensive support and the cost of services increasing by more than the rate of inflation;
- increased expectations and higher demand;

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

- efficiency gains not always sitting comfortably with strategic objectives for flexible, person-centred high quality services;
- lack of priority for improving health and wellbeing;
- practical and cultural obstacles to closer joint working and service delivery;
- workforce transformation across health and care being sought at the same time as recruitment and retention difficulties and an increasingly stringent regulatory framework/qualification requirements;
- Ageing population;
- Disabled people living longer;
- Carers living longer; and
- Impact of higher social care eligibility criteria on users and carers.

3.5.2 The first objective of commissioning should be to support self-care and circles of community involvement. So, support to communities who will in turn support individuals is the next priority. Behind that is the need to provide help to targeted individuals directly. This means a continuum from universal support for the activities of daily living – such as housing, access to work, promotion of healthy living – through to specialised interventions secondary and tertiary health care. A continuum also runs from the sustainable to the resource intensive. In addition the customers may sit on a continuum from the passive recipient of the ‘professional gift relationship’ to being in control of their care. (This whole concept is called by some ‘shifting the settings of care’ or ‘care closer to home’, and by others ‘inverting the triangle’). These principles are fundamental as we develop both care and health services. The following diagram details these continuums.



3.5.3 The most significant of the challenges above is to sustain the long term preventive approach (which can only be effective over a period of several years) alongside the need to deliver services to people in substantial need now, balancing budgets and achieving savings in the short-term. This investment to deliver future benefits can only be achieved when budgets are balanced. It is the intention of the Council and PCT to achieve and sustain balanced budgets so that such preventive investment can be resourced.

3.6 Other Policy Drivers

(a) Practice Based Commissioning (PBC)

- 3.6.1 Under PBC, the PCT continues to hold the ultimate responsibility for the health budget, but GP practices are given an “indicative” budget so that they can consider how to change the way in which health care is provided to meet the needs of their patients more effectively. They can then change service agreements within an agreed framework with health service providers to reflect these new approaches. It is expected that this will lead to a reduction in hospital-based care and more treatment and care, provided within the practice, closer to the community.
- 3.6.2 There are two PBC consortia operating within Hounslow. With a large proportion of practices being run by single-handed GPs there are potential challenges to engaging with GPs and them taking the commissioning agenda forward in the shorter term. The PCT’s financial deficit leaves limited opportunities to create incentives for GPs to closely engage with the commissioning frameworks.

(b) Assistive Technology

- 3.6.3 The government expects Councils and the NHS to take advantage of developing technology to support the delivery of care. Examples of ways in which assistive technologies and telecare can support people include:
- sensors on taps and ovens and infra-red movement sensors to detect inactivity.
- 3.6.4 Locally we are implementing an Assistive Technology Strategy across Hounslow PCT, West London Mental Health Trust (WLMHT), West Middlesex University Hospital (WMUH) and the London Borough of Hounslow (LBH). This includes developing appropriate pilots and a demonstration suite within the Calen Centre for the promotion of and training to use telecare equipment. Further details will be included in the specific service strategies.

(c) Continuing Care

- 3.6.5 “Continuing care” means care provided over an extended period to someone aged 18 or over to meet physical or mental health needs which have arisen as the result of disability, accident or illness. Currently there are three principal funding streams for continuing care:
- 100% NHS-funded: the service user’s primary need is assessed to be a health need and, therefore, the care is free to the patient
 - Shared arrangements: these are care packages jointly funded by the NHS and individual councils and are provided to users whose primary need is not a health need but who need increased levels of support at home or in a care home
 - Social care packages: to the service users need is not assessed to be a health need and the care is 100% funded by the local authority (LA) and the user may be charged.
- 3.6.6 Deciding on the balance between LA and PCT responsibilities with respect to continuing care has been the subject of key court judgements. The newly published National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in England is intended to make the continuing care system easier

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

to navigate and to stamp out the existing “care funding lottery”. This is where different authorities use different criteria to determine whether an individual receives free NHS care or has to pay for social care. The Framework has implemented on 1 October 2007. The DH has issued a Decision Support Tool to assist in making assessments of need for NHS continuing healthcare. The Council and PCT are working together to implement the new arrangements.

- 3.6.7 The PCT currently has a target to make savings on continuing care based upon work undertaken in other London PCTs. However two studies undertaken in West London by private sector consultants in 2006 have confirmed that joint commissioning and contracting arrangements for continuing care in Hounslow are already highly efficient and cost effective by comparison with other areas in West London and the scope for further savings in expenditure for both the Council and the PCT is small.

(d) Long Term Conditions

- 3.6.8 Seventeen and a half million people in this country report living with a long term condition. Of these many live with a condition that limits their ability to cope with day-to-day activities. For some people, especially older people and those who have more than one condition, discomfort and stress is an everyday reality.
- 3.6.9 For those living in disadvantaged circumstances or for whom English is not their first language, the challenges are even greater. And for the most vulnerable, a lack of co-ordinated, personalised care can lead to a significant deterioration in health and often avoidable emergency admissions. The NHS and social care services are working together to provide more integrated support to people with long term conditions.
- 3.6.10 In Hounslow the existing model of care focuses upon those patients attending acute care as unscheduled admissions when their long term condition is exacerbated. The community matron service which commenced in 2006/7 is still in its infancy, but is already (anecdotally) reducing the number of unscheduled admissions from nursing homes. The Medihome nursing service has also begun to have an impact on unscheduled admissions following attendance at A&E. There is a community rehabilitation team linked to a 16-bed rehabilitation ward at WMUH as well as a 10-bed intermediate care community unit.

(e) Carers

- 3.6.11 It is estimated that there are nearly six million unpaid carers in the UK providing care for friends or relatives who require support because of their age, physical disability, sensory impairment, learning difficulty or because they are experiencing mental ill health or substance misuse difficulties.
- 3.6.12 The support that carers provide is worth £57 billion a year; an average of £10,000 per carer. Carers UK estimate that an additional 6,000 people take on a caring role daily, with over 3 million working carers in the UK. The need for carers to continue in their employment is important for well-being, income and to keep social contacts. In the 2001 Census, 18,921 Hounslow residents stated that they were carers. Of 3,583 said they provided more than 50 hours of care per week. Taking on a caring role has a huge impact on the life of the carer as it affects their financial, emotional and physical well being.

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

- 3.6.13 Hounslow has demonstrated a great commitment to the development of services for carers and has successfully trained staff, set up a carers register and produced carers support packs for each different customer group by working in partnership with carers. We have piloted a very successful training course for carers in partnership with the PCT, promoted a scheme which encourages carers to make their caring role known to their GP and designed referral pads to enable GPs to request carers assessments and record these referrals for their Quality Outcomes Framework (QOF).
- 3.6.14 We have established the post of Carers Rights Worker based in the voluntary sector and developed a range of services allowing carers to choose more flexible planning and delivery of respite services.
- 3.6.15 The New Deal for Carers, announced in February 2007, will include additional funding for emergency support, a national helpline for carers and an expert carers programme. Gordon Brown announced an extensive consultation with carers as the National Strategy for Carers is revised.
- 3.6.16 Hounslow's Carers Strategy is currently being rewritten in the light of recent developments and the implementation of new legislation for carers including the Equal Opportunities Act 2004, the Work and Families Act 2006, the New Deal for Carers and the new National Strategy for Carers. The revised Hounslow Carers Strategy will take on board the achievements of the first strategy including a review of existing support services for carers.

(f) Direct Payments, Choice and Individual Control

- 3.6.17 Direct Payments is a scheme where cash payments are made to individuals who are entitled to social care services and they then arrange the services themselves, instead of those services being arranged on their behalf by the council. This way people can decide who provides their care and at the place and time that suits them best. A Direct Payment is NOT a benefit and does not affect any benefits they may receive. This arrangement provides users with greater choice and control over the services they receive. Hounslow has one of the highest numbers of Direct Payments in the country.
- 3.6.18 However, increasing choice in this way has additional costs. The costs to users include needing to research and obtain information on options available to them, how to compare costs and ensure they get good value and the burden of being an employer. To Councils this includes recruiting and training staff to support, advise and guide clients and also to regulate the quality of care packages chosen by users. It also reduces the ability to negotiate reductions in the costs of services through block contracting for a large number of users.
- 3.6.19 Direct payments are gradually being superseded by "In Control". This is a partnership involving central and local government and the third sector which aims to put disabled people in control of their own lives through the power of self-directed support. Crucially, this change involves giving people control of a personalised budget.
- 3.6.20 Hounslow is building on its success in developing Direct Payments and is

establishing an “In Control” pilot to help develop this new approach. The new model involves people having more autonomy over housing, community life, money, support, self-determination and direction. As part of our vision we will continue to increase the provision of direct payments and other methods of empowering users whilst seeking cost effective ways to achieve this within limited budgets.

(g) A Stronger Local Voice - LINKS

3.6.21 In July 2006 the Government consulted on this document which set out a framework for creating a stronger local voice in the development of health and social care services. Among other proposals was the establishment of LINKs – local involvement networks for each local authority area to provide flexible ways for communities to engage with health and social care organisations in ways which suit the communities and the people in them.

3.6.22 LINKs will have a specific relationship with Overview and Scrutiny Committees (OSCs) and have the power to refer matters to the OSCs. Final guidance will be issued after the Bill becomes law but in the meantime local authorities are expected to begin preparations so that they will be ready to implement the new arrangements from April 2008. A Hounslow approach is currently being developed.

(h) Housing Policy

3.6.23 The Local Government White Paper sees Local Authorities taking a more strategic housing role. Local Authorities are expected to align and co ordinate strategies within the Sustainable Communities Strategy which cover housing, health, education, transport, waste management and environmental protection. As part of this, local authorities Housing and Homelessness Strategies should be incorporated within the Sustainable Community Strategy wherever possible.

3.6.24 The Government’s Five Year Plan Sustainable Communities: Home for All 2005 sets out the national policy context and targets for the delivery of Housing Services. The plan sets out a number of important housing targets to be met by 2010, specifically:

- 70% of vulnerable people in the private sector living a in decent home by 2010; and
- Halving numbers of homeless households in temporary accommodation by 2010.

3.6.25 The Housing Strategy for Hounslow (2002 & 2003 Action Plan) remains the main service delivery strategy for housing. We plan, in 2007/08, to update and refresh the Housing Strategy taking account of strategic developments at the national, regional, sub-regional and local levels. The Mayor’s Housing Strategy for London is also currently out for consultation.

3.6.26 In addition to the over-arching Housing Strategy, other strategies which direct the work of the Housing Division include:

- Homelessness Strategy 2003
- Older People’s Housing Strategy 2005

- Allocation Plan 2007
- Private Sector Housing Strategy 2006

3.6.27 Housing stock in Hounslow is inadequate and current rates of new construction cannot accommodate the growth in population. Soaring house prices and rents mean that many West Londoners cannot afford to buy or rent a decent home.

(i) Supporting People

3.6.28 Supporting People is the Government's long-term policy, which enables LAs, PCTs and local probation services to plan, commission and provide housing related support services. These services help vulnerable people to live independently.

3.6.29 The Hounslow Supporting People Strategy (date) is based upon a comprehensive review of existing services and needs in the borough. The strategy outlines the strategic objectives and provides an action plan that meets the Government's requirements. The strategy will be reviewed and updated in the next year to reflect the changing context in which services are provided.

3.6.30 The highest priority will be to commission and remodel services to ensure the most effective use of resources and where possible to address unmet needs. New services will be funded from within the Supporting People budget with some joint commissioning of services. Supporting People services make a significant contribution to supporting the well-being of vulnerable people.

(j) Standards and regulation

3.6.31 The emphasis is on driving service improvement through national standards, excellent commissioning, competition and cooperation between providers. There is recognition of the particular importance of independent regulation and inspection for users of social care services, who are often vulnerable and highly dependent on the services they use.

3.6.32 The LA works to Standards set up the Audit Commission in 'CPA The Harder Test'. External inspectors and standards for health and care services are controlled by a range of bodies including the Audit Commission, Healthcare Commission, Commission for Social Care Inspection (CSCI), the National Institute for Clinical Excellence (NICE) and the Health and Safety Executive. National Service Frameworks and related statutory guidance define standards for care groups. The Audit Commission produces Key Lines of Enquiry (KLOEs) for housing services including Supporting People. (Information about our Local Standards can be found in 'Better Care, Higher Standards', Hounslow's Long-Term Care Charter. These include our Customer Care Standards).

3.6.33 CSCI registers, inspects and reports on social care services in England. There are now three different types of inspection for care homes (key inspections, random inspections and thematic inspections). Inspection reports are public documents, accessible through the CSCI website, and are used by commissioners, care managers and contracts officers in helping to assess the quality of a service.

3.6.34 NHS providers are expected to be compliant with all of the core standards as

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

identified in “Standards for Better Health”, or have robust action plans in place to achieve compliance and ensure the necessary level of assurance.

3.6.35 The DH has been consulting on proposals for “The Future Regulation of Health and Social Care”, which recommend the merger of three of the bodies responsible for regulating health care, adult social care and monitoring the operation of the Mental Health Act. The Government has defined principles for better regulation to achieve safety, quality, responsiveness, fairness and efficiency.

(k) Equalities

3.6.36 An integrated public sector duty covering not just race, disability and gender but also sexual orientation and religion or belief. The Equality Act 2006, which updates previous legislation and is reflected in the Equalities Standards for Local Government. The PCT and the LA are committed to implementing the equalities legislation and standards in both employment and service delivery, and Impact Assessments are undertaken for each strategy to ensure compliance as they are developed.

4. Hounslow Context

4.1 Borough – wide plans

Currently health and social care services are provided through **Hounslow Council** and three main NHS Trusts - **Hounslow PCT**, **WMUH** and **WLMHT**. They are also provided by a wide range of private and third sector organisations.

4.1.2 The **Hounslow Community Plan** provides an overarching framework, direction and objectives for organisations in the Borough to work in and towards partner by 2010. The vision is to provide, whenever needed, help and support for the vulnerable. A key theme is to make Hounslow “A Healthier and Caring Community”, to enable residents to be healthier for longer and to access support services when they need them.

4.1.3 The **Hounslow Plan** sets out the Council Executive’s vision and priorities up to 2010. It includes commitments to work closely with healthcare providers throughout the Borough to ensure a cohesive service and make sure that those who cannot look after themselves do not suffer from cuts in funding. The 3 themes of the Hounslow Plan are: Organisation Delivery; Quality of Life and Looking to the Future. Priorities include:

- to ensure value for money, high performance and quality services;
- transparency, accountability and participation; and
- to support and care for the vulnerable in society.

Hounslow plan objectives include:

- better services for disabled people;
- a higher priority for Mental Health;
- developing Resource Centres for Older People and Adults; and
- improved health and well being for all, especially vulnerable groups.

4.1.4 The **Local Area Agreement (LAA)** is an agreement between LSP partners and central government to tackle key issues across the borough by ensuring services are co-ordinated to deliver real improvements in delivery. The LAA includes targets for improvement for achievement by 2009/10.

Delivery of these targets is key to successfully achieving the vision and objectives set out in the Community Plan. The LAA enables partners to target funding to areas most in need to effectively manage performance. The Healthier Communities and Older People block of the LAA represents the main focus in relation to partnership working between the LA, PCT and other borough agencies. The seven outcomes included in this block include:

- improve the control of tuberculosis (TB) and reduce transmission rates;
- reduce adult smoking rates;
- increase life expectancy and reduce health inequalities by reducing risk factors for CHD, cancers and diabetes (focusing on obesity);
- improve the sexual health of the local population;
- reduce winter deaths in people aged 65 years;
- improve the well-being and independence of people aged 65 years and over;
- and

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

- reduce serious mental illness among Asian women.

A new LAA will be agreed in 2008.

4.2 Health-led Plans

In parallel with the preparation of the Joint Commissioning Strategies the PCT is preparing a **Commissioning Strategic Plan** for 2007-12, with a related 3-year financial strategy.

4.3 Collaboration in London

4.3.1 Increasingly what happens in the Borough is determined by groupings across London. The Mayor of London and regional government is developing an increasingly important role in areas such as Emergency Planning, enhanced responsibility for planning, allocating housing development monies and producing a statutory London Housing Strategy. The powers include “s106” agreements which can provide additional capital and revenue funding for health and social care linked to new residential developments.

4.3.2 Six councils in West London have formed the West London Alliance and have been developing collaborative approaches including approaches to joint social care procurement and a “Shared Solutions to Realising Efficiencies” programme. The Council and PCT are committed to continuing to explore ways of delivering better value for money services through collaboration. In the NHS there is collaboration across the North West London sector particularly on Learning Disability services.

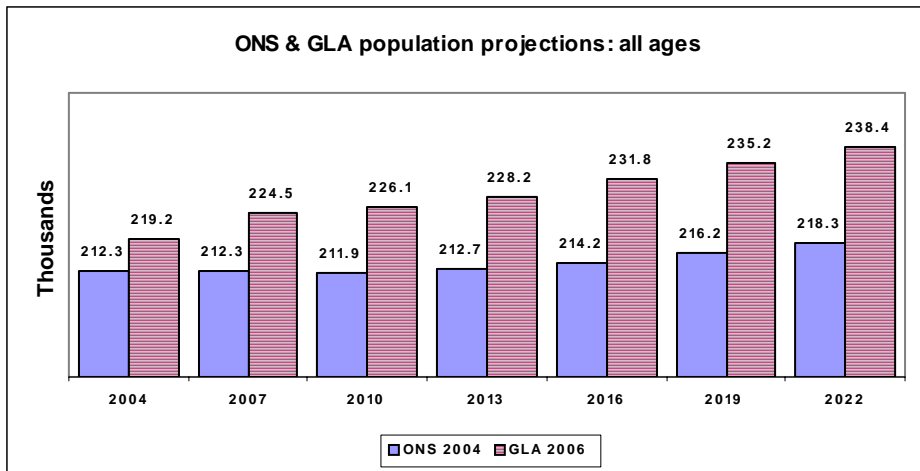
4.3.3 The PCT commissions in accordance with the London-wide Terms of Business, and the 2007/08 Planning Framework for London.

The Local Population – Needs Analysis

5.1 Population Data

- 5.1.1 Hounslow is the 9th largest borough in London, covering 22 square miles and stretching from Chiswick in the east to Bedfont in the west. The local areas and communities are different in character and Hounslow is often characterised as a “community of communities”.
- 5.1.2 Hounslow’s population was 216,000 in 2001 (Census 2001). There is a significant transient element the population due to the presence of Feltham Young Offenders Institute, the Hounslow Army Garrison, the accommodation centre for asylum seekers and the proximity to Heathrow airport. Recent and planned commercial property developments, combined with good transport links, indicate that there will be a growing daytime population. Unfortunately, there is limited information on this group.
- 5.1.3 The population is ageing, and becoming more ethnically diverse. By 2010 it is likely that 50% of the population will be from minority communities, including large numbers from the Eastern European accession states. This will create additional pressure on housing and community services.
- 5.1.4 While the 2001 population figure was up on 1991 by 8,400 (4%), recent ONS population projections have suggested a downturn, in line perhaps with the estimated migration figures. This is at odds with, for example, figures for newly-built houses and flats registered with the Council. We have seen a growth in the number of properties and would expect this to mean a growth in numbers of households and people. The degree of population growth estimated is currently being debated: both the ONS and the Greater London Authority (GLA) forecast a growth in Hounslow’s population, however the GLA estimate a much steeper increase.
- 5.1.5 The Greater London Assembly (GLA) projections give a picture closer to the local expectations. Indeed, they show sharp differences from the ONS data. The GLA estimate of 150,300 Hounslow adults aged 18-64 in 2010 is 7,100 higher than the ONS figure. Both sets of projections do agree however that, over the period from the start of the last commissioning strategies (2004) to the end of the latest strategies (2010), there will be an increase in numbers in this age group. The ONS puts the increase at 2.1%, the GLA at 3.4%. This is illustrated in the table below.

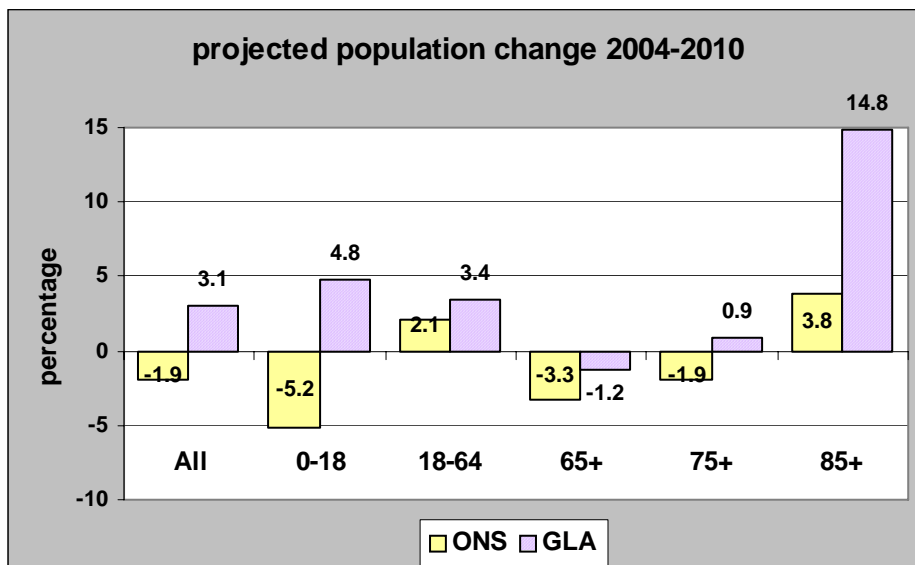
OUR HEALTH, OUR CARE, OUR HOUNSLOW
 An Overview of Joint Commissioning Strategies 2007-10



sources: ONS projections 2004-base; GLA projections 2006-base

5.1.6 For people aged 75 and over, probably the main users of health and social care, there is no agreement on population trends. The GLA projections suggest that numbers of over 75s will rise by around 100 (0.9%) between 2004 and 2010. The ONS data predict a fall of 200 (1.9%) over the same period. For over 85s, however, both the datasets predict increases. The GLA estimate a rise of almost 15%, whereas the ONS figure is less than 4%.

5.1.7 It is in the under 18s that the biggest disagreement occurs. The GLA projection for 2010 is 51,900, up from 49,500 in 2004. The ONS shows a trend in the opposite direction. By 2010, the gap between the two estimates is 6,400. The GLA estimate for the number of children living in Hounslow in 2010 is 10% higher than the ONS figure. This is illustrated in the table below.



sources: ONS projections 2004-base; GLA projections 2006-base (65+ comprises all people aged 65 & over)

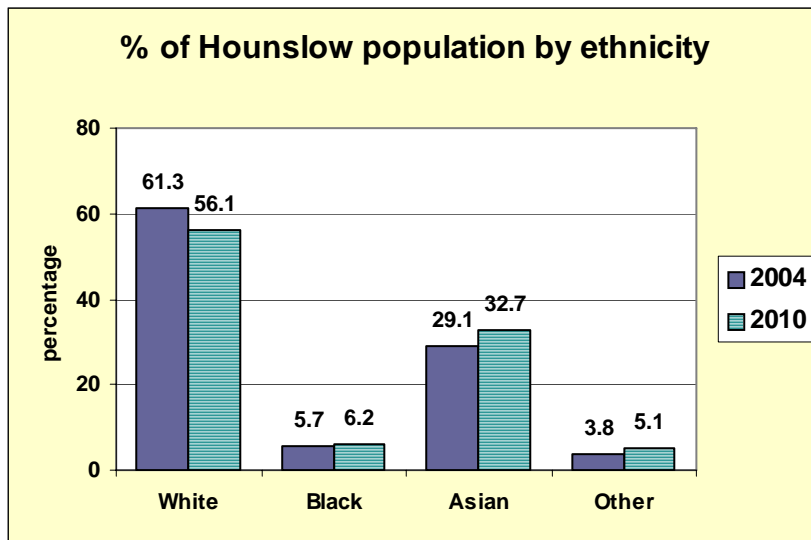
5.1.8 Clearly the discrepancy between the two datasets means we have to be cautious in making predictions about current and future changes in population and about the resulting impact on demand for services. The GLA questions how far the ONS estimates are robust [Data Management and Analysis Group, DMAG Briefing 2006/32]. It is confident that the GLA projections are closer to reality and identifies the scale of international, inward migration to London as one reason for

the differences. Furthermore, it states that, “the distribution of London population between some of the boroughs is questionable, as acknowledged by ONS”.

5.1.9 Whilst this strategy was being written, the ONS announced it was adjusting its 2005 mid-year population estimate for Hounslow upwards from 212,500 to 216,800, an increase of 2.02% on the previous estimate. The next population projections are not expected until later in 2007 but, assuming they reflect the revised calculation, they should roughly halve the difference between the ONS and GLA figures.

5.1.10 The GLA also produce borough-based ethnicity projections. These too, inevitably, must be considered in light of above ONS/GLA discrepancies. However they do seem to contain several unambiguous messages:

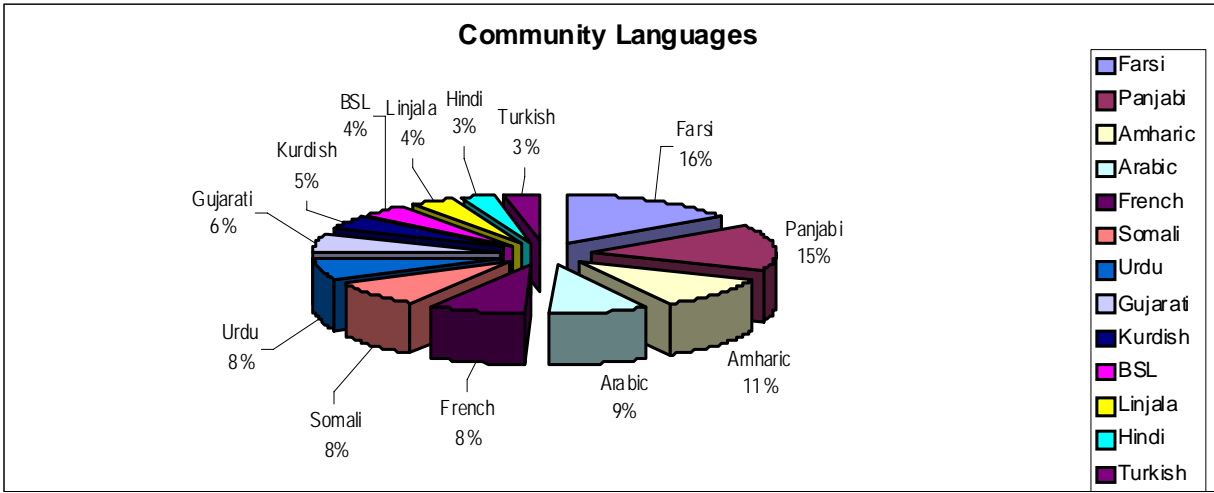
- the proportion of Hounslow’s population from Black & Minority Ethnic (BME) communities will continue to grow - although it may not be until the decade after next before white people comprise the minority;
- the largest increases will be in the Asian population, particularly in people of Indian origin (estimated at 21.8% of the total by 2010); and
- the population will continue to become more diverse, as people from a widening number of countries arrive and/or have children. This is illustrated in the table below.



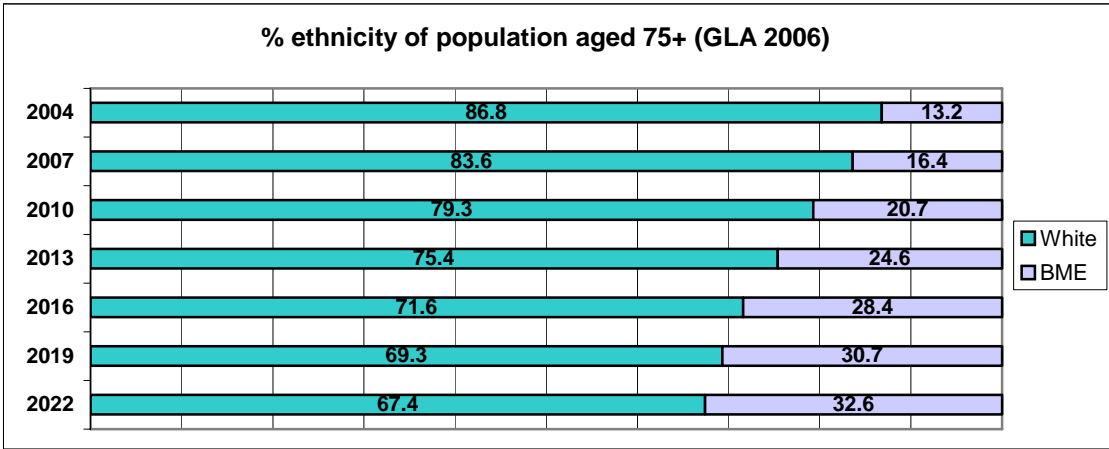
source: GLA ethnicity projections 2006

5.1.11 The figures do not tell us about the widening diversity among the white population that has been taking place since the expansion of the European Community. Of 10,600 foreign nationals living in Hounslow and registered for National Insurance purposes in 2006, a quarter were from Poland, with many of the remainder from elsewhere in Eastern Europe and the Baltic States.

5.1.12 The following table illustrates the range of community languages used in the borough:

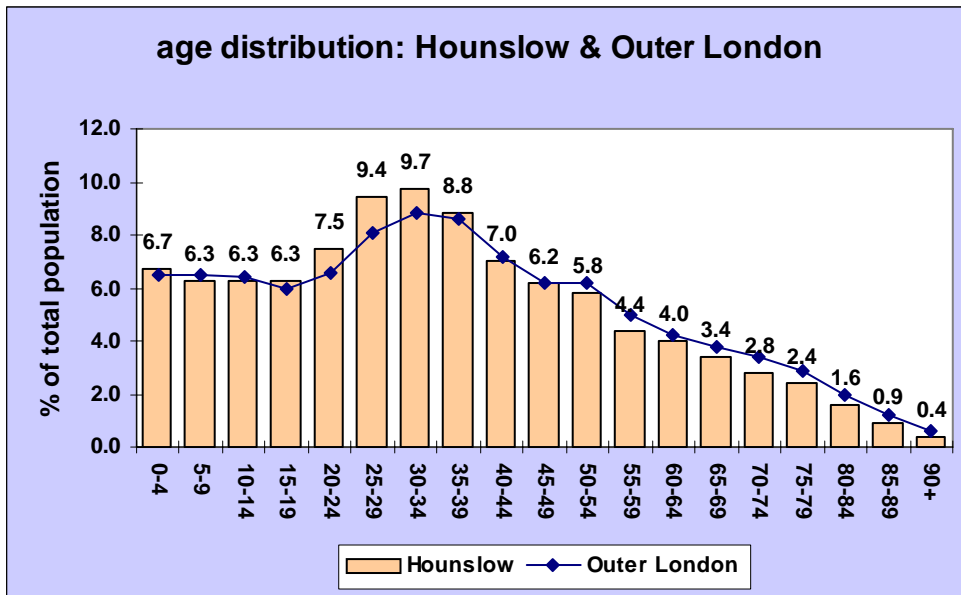


5.1.13 While it seems likely due to their age that few of these foreign nationals will make heavy demands on health and social care in the foreseeable future, the long-anticipated increase in the proportion of BME elders is now taking place. This is shown in the table below.



5.1.14 How far the increase will translate into requests for additional specialist residential provision for older people or for other specialist services remains to be seen. What is clear is that mainstream services will have to continue to adapt to the changing user profile, to ensure that language, dietary, religious and cultural needs can be met.

5.1.15 Overall, Hounslow at the time of the last Census had a slightly lower-than-average number of residents aged 50 and over and more young adults aged 20-39 than average for Outer London or England as a whole. Hounslow appears to be a place people move to early in their working lives. This view is reinforced by 2005 migration statistics, which show a net outflow of population from the borough in all age groups, except for 20-24 year-olds, where there was a net inflow. However the way migration statistics – particularly on international migration - are collected and analysed means such data must be interpreted with considerable caution. The age distribution in the borough is shown in the table below.



source: 2001 census; figures shown are percentages for Hounslow

5.2 Life Expectancy and Health

5.2.1 Despite increased prosperity and reductions in mortality in the UK over the last 50 years, unacceptable inequalities in health outcomes still exist between:

- socially disadvantaged and affluent groups;
- males and females;
- people from different ethnic groups; and
- different geographical locations.

5.2.2 Hounslow has an overall life expectancy at birth of 75.7 years for men and 79.9 for women (2002-04). This is 0.8 years and 1.3 years below the average for London and England respectively (ONS, Health Statistics Quarterly 28). Interestingly and in contrast in 2001, 14.92% of Hounslow's population reported to having a limiting lifelong illness. This is lower than the London rate (15.49%) and significantly lower than the rate for England (17.93%) (Census, ONS, 2001).

5.2.3 The Hounslow resident has a life expectancy of about one year less than the average Londoner and has, by far, the shortest life spans in North West London. The most recently published Standardised Mortality Ratio, an indication of early deaths, shows Hounslow as the highest in Outer London (109, compared with the UK average of 100 and the Outer London average of 95). More importantly the improvement in life expectancy in Hounslow has been more gradual than in other London boroughs.

5.2.4 A large majority of Hounslow's residents in 2001 reported their health to be good or fairly good (91.94%). This is a higher level than the London and England average.

5.2.5 Cancer and coronary heart disease are the most common causes of premature death in both men and women in Hounslow; this is mirrored nationally.

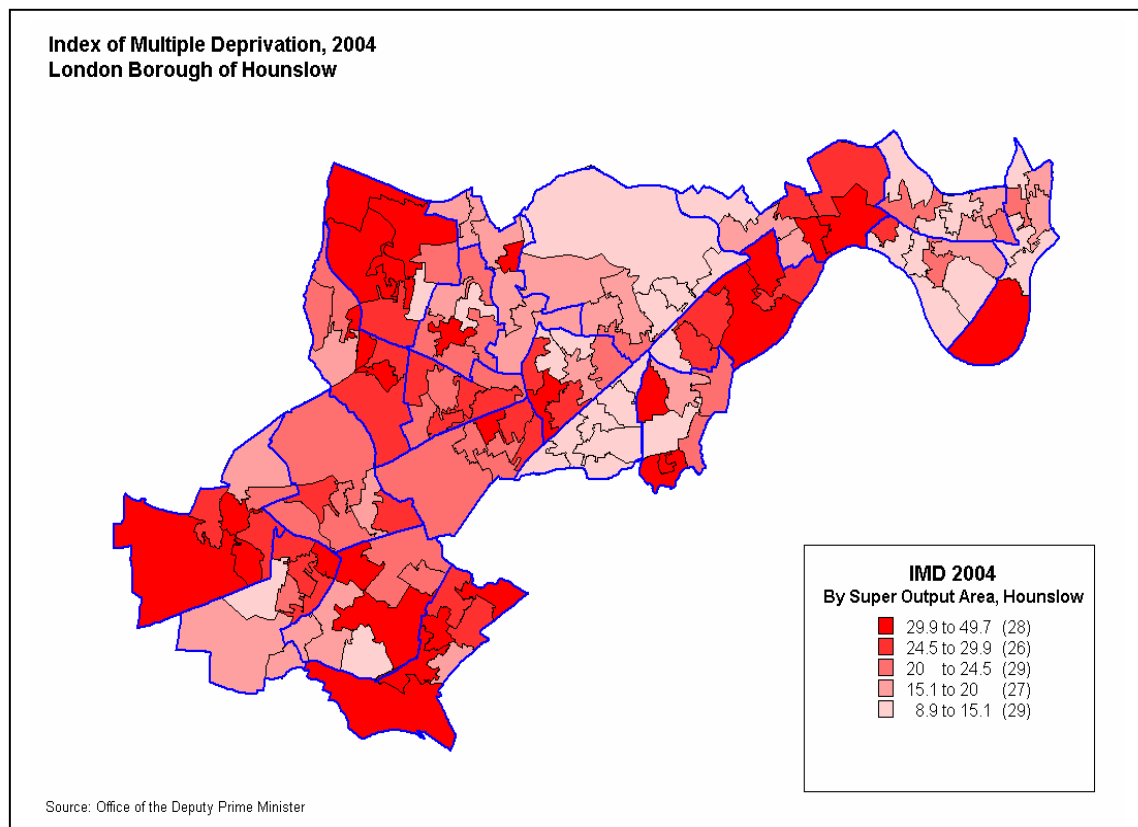
OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

5.2.6 The PCT's 2005 Annual Health Report noted concerns about a growing incidence of diabetes and tuberculosis. The number of cases of tuberculosis in Hounslow had more than doubled in the six years to 2002 and at that point was five times the average for England & Wales

5.3 The Five Areas of Hounslow

5.3.1 Like many other London boroughs, there is considerable variation across the area in the age and ethnicity of the population and in the health, housing and income of the people who live there. Although, overall, the residents of Hounslow exhibit a health and socioeconomic status that is significantly below London and national averages. The following table shows how deprivation manifests in different areas of the borough.



5.3.2 The borough is split into five districts each displaying distinct characteristics and healthcare needs. Male and female life expectancy is highest in the centre and east of the borough and lowest in the west of the borough. The five areas show marked variations in prevalence and cause of death. The west area shows a high proportion of deaths from cancer and respiratory disease. Central Hounslow area has significantly higher rates of coronary heart disease, stroke and respiratory disease than the borough average.

5.3.3 There are often distinct differences not only between areas but also within a single locality at ward level. There are big variations in the age composition of individual wards. Feltham West, for example, has the lowest proportion in the borough of people aged 65 and over (7.6%), whereas Feltham North, adjacent; next door has the highest (14.2%).

5.3.4 The borough's five main localities are listed below.

Chiswick

This is the smallest of the areas. A higher proportion than the borough average are aged 65+, many of them living on their own and often without ready access to family and community networks. Much of the area is affluent with expensive housing but there are pockets of deprivation. Life expectancy is high and premature death rates are markedly below average for the borough. Unemployment is low.

Isleworth & Brentford

This is a mixed area, ranging from owner-occupied family houses, to new apartments in regenerated neighbourhoods close to the river, to two large council estates. At the 2001 Census, 26% were of BME ethnicity including a long-established Caribbean community. Premature death rates are high for cancers but about the borough average for other causes. Unemployment is average for the borough (3.3% at 2001).

Central Hounslow

This is an area characterised by predominantly owner-occupied housing, of varying age and quality. There is a large Asian population in most wards. - In 2001, the proportion was 41% overall. Life expectancy for both men and women varies by as much as 7 years between wards. Premature deaths from respiratory disease, coronary heart disease and stroke are all higher than borough averages. Unemployment is low.

Heston & Cranford

This area is characterised by mostly semi-detached houses, with pockets of poor housing and associated low incomes. BME communities are in the majority (63% in 2001) with Asians (53%) making up the greatest percentage of the population. Somalis are the other main ethnic group. It has the highest proportion of under-20s in the borough. There are variations in life expectancy. Premature deaths from stroke are the highest in the borough. Unemployment is also the highest of the five areas (3.9% at 2001).

Feltham & Bedfont

This area has the largest population, the highest proportion of people aged 65+ (14%) and the lowest percentage of BME residents (17%). Proximity to Heathrow means unemployment is low for London, although most jobs are relatively poorly paid. The locality is far from affluent and parts are significantly deprived. Premature death rates are generally about or a little above average for the borough but are high for cancers.

6. Performance

6.1 NHS

The results for the local NHS announced in October 2007 were as follows:

6.1.1 WMUH:

- Fair for quality of services (down from Good in 05/6)
- Weak for use of resources (the same in 05/6)

The trust has a major new PFI scheme and significant historic and current deficits. A disproportionate share of its activity is from emergency admissions primarily as a result of the jump in A&E attendances brought about by the closure of the A&E department of Ashford and St Peters Hospital. The Trust aims to build on its strong reputation for maternity services, to develop its role as an elective surgical centre and to develop its stroke services.

6.1.2 WLMHT:

- Excellent for quality of services (up from Good in 05/6)
- Good for use of resources (up from Fair in 05/6)

It covers a wide geographical area and is the local mental health provider for 3 boroughs.

6.1.3 Hounslow PCT:

- Fair for quality of services (the same in 05/6)
- Weak for use of resources (the same in 05/6)

6.2 Local Authority

6.2.1 In **Hounslow Council's** Corporate Assessment by the Audit Commission (CPA) the Council scored 3 out of 4. The inspection found that Hounslow is performing well with clear strengths in many of its services it delivered effectively with partners.

6.2.2 In the Joint Area Review (JAR) of **Children's Services** local services also scored 3 out of 4.

6.2.3 On the **Housing** side of the Department both the Supporting People programme and the ALMO, Hounslow Homes, have previously received the top 3 Star in inspections.

6.2.4 Hounslow's **Community Care** Services received the top rating of 3 Stars from CSCI in December 2006 on performance between April 2005 and March 2006. The star rating was based on the judgement that Hounslow's adult social care services were serving most people well with excellent capacity for further improvement. Across England out of 150 councils with responsibilities for adult social care, 44 councils achieved a 3 star rating. In outer London only 4 councils including Hounslow achieved a 3 star rating. The Council's Adult Performance Assessment for 2006/2007 is underway as this draft Strategy goes to print

6.2.5 In 2005/2006 Hounslow LA performed well compared to the average performance of its Institute of Public Finance (IPF) comparator group and the other outer London Boroughs. The IPF comparator group was developed by the IPF based on councils with similar deprivation levels and demography and is used by CSCI when assessing Hounslow's performance. The challenge for

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

future years will be maintaining and improving on the current position. Effective and efficient commissioning will be key to this.

6.2.6 Improvements noted by CSCI in 2005/2006 included:

- good progress on national and local priorities in 2005/2006, whilst consolidating on areas of good performance from 2004/2005;
- good performance on waiting times for assessment, clients not waiting for services;
- good performance on waiting times for care packages, clients not waiting for services;
- timely client reviews;
- timely hospital discharge service;
- recognised as a local leader with respect to Single Assessment Process (SAP);
- 3 star "Supporting People" review;
- the success of the 'Finding a Voice' initiative in engaging older people in commenting on service provision and shaping service developments;
- engagement with users and carers;
- sustained high use of direct payments; and
- strong track record of improving efficiency.

6.2.7 Areas for improvement included:

- ensuring that the Early Intervention Service in mental health is fully developed and the target number of 43 new clients by March 2007 is reached;
- continuing to work with the PCT to achieve stability in joint strategic working and maximise delivery within resources;
- further improvement in support delivered to carers and number of carers supported; and
- improvements needed in resource planning for transition cases i.e. young disabled people becoming adults.

6.2.8 In terms of the areas highlighted above for improvement the following has been achieved in 2006/2007:

- the Early Intervention Service in mental health has been developed and the target number of clients has been achieved. Hounslow has also hosted a well-attended Early Intervention Conference to share good practice;
- the Council and the PCT have continued to work in partnership to manage the challenges facing Hounslow, this has included a professional approach to Continuing Care decisions and effective purchasing through the well established Joint Commissioning arrangements;
- support has improved to carers with an increased number of carers now receiving an assessment and services. Other initiatives for carers have included the development of a Voucher Scheme and the Expert Carers Training Programme; and
- improvements have been made in the resource planning for transitions cases through the, strengthening of the Steering Group which meets termly to develop the Councils strategic approach to transition and the Operational Tracking Group which meets monthly to plan for individuals between the ages of 14 to 19.

6.2.9 Key performance challenges for 2007/2008 include:

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

- continuing to work effectively with partner organisations, especially given the challenging financial position of the Council and PCT;
- successfully recruiting ICT project staff to support the implementation of range of business improvement projects;
- continued robust management of Long Term and Continuing Care funding with the PCT, avoiding cost shunting in either direction and working together to limit unjustified cost increases; and
- a focus on self funders and people who do not meet the FACS criteria including the provision of wider information.

6.2.10 How performance in social care is measured and reported is currently undergoing review. Work is underway on developing an approach which focuses more strongly on outcomes for people and the engagement and involvement of citizens in the commissioning, design and review of services. Commissioning Strategies will play an important part in setting out how Hounslow will achieve this.

7. Finance & Resources

7.1 Overview of funding

7.1.1 Over recent years, the NHS has benefited from the increased government funding

made available to it in order to keep pace with new demands. The increasing pressures on social care departments have not been matched by similar funding increases for local authorities. Nationally, as shown in the table below, over the period 2004/05 to 2007/08, total budgets increased by an average of 9.9% per annum for the NHS but just 5.4% per annum for Personal Social Services. There are significant cost pressures to meet the increasing demand faced by social care departments in London and to maintain quality standards under existing eligibility criteria.

	04-05	05-06	06-07	07-08
National NHS budget (Yearly increase in brackets)	£69,369m	£76,384m (10.1%)	£83,318m (9.1%)	£92,143m (10.6%)
National Personal Social Services budget (Yearly increase in brackets)	£10,643m	£11,520m (8.2%)	£11,970m (3.9%)	£12,470m (4.2%)

7.1.2 The key factors in London underpinning the increase in costs include:

- increasing numbers of older people (projected to increase by an average of 0.5% per annum over the next 3 years);
- numbers of older people over the age of 85 increasing by over 1.2% p.a. over the same period. This cohort is more likely to require care and also to require intensive care packages;
- increasing incidence of learning disabilities (projected to increase by between 1.3% and 2.7% per year over the next 3 years);
- more people with complex needs being supported intensively at home;
- increasing number and complexity of care assessments; and
- staff and property cost pressures in London.

Financial pressures on LAs are particularly acute: –

- the 2007 grant settlements were not favourable for local authorities in London;
- there is concern that this trend will be continued in the Comprehensive Spending Review and grant settlements for the years 2008-11;
- demographic trends are increasing the pressure on finances and financial settlements;
- the government expects that councils will make year on year efficiency gains in line with the Gershon proposals. These required councils to realise efficiencies of 7.5% of their 2004/5 baseline expenditure by 2007/08;
- inflation in the public sector is higher than the general rate; and there is a political desire to keep Council Tax increases low.

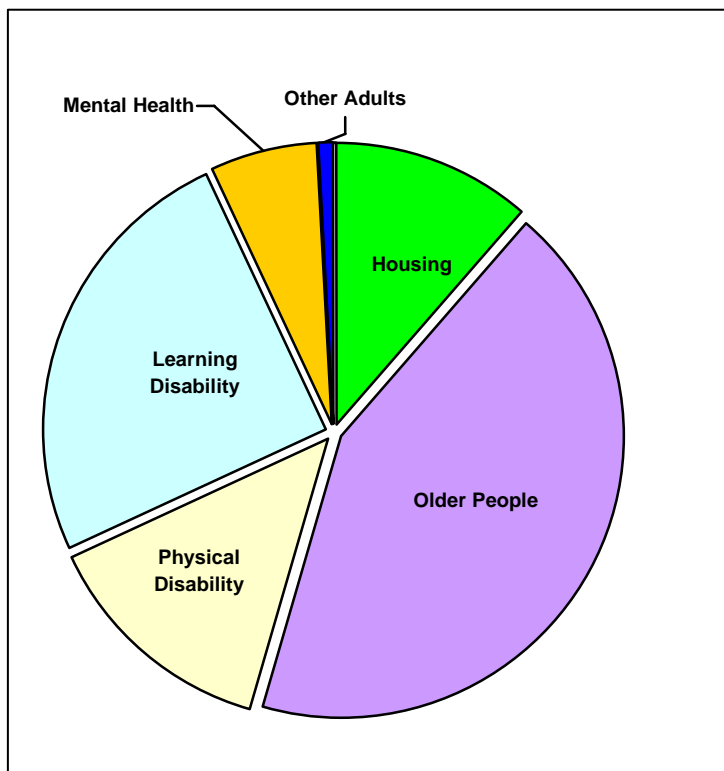
7.2 Hounslow PCT

7.2.1 **Hounslow PCT** is required by the government to achieve financial balance. The strategic objective of the PCT is to maximise improvements in the health status of its resident population subject to constraints of available resources. In 2006/7 the PCT spent around £300m on local health services including budgets of £6.719m on Older people, £1.858m on Physical Disability services, £25.961m on Mental health services, and £9.791m on Learning Disability services.

7.2.2 The PCT ended 2005/06 with a significant financial deficit of £10.3m and a turnaround plan to meet this in 06/07. The PCT ended 2006-07 with a deficit of £13.5m. With the prior year accumulated deficit the PCT has to deal with an accumulated debt of £23.4m. The PCT has been allowed by the Strategic Health Authority (SHA) to use 2007/8 to return to financial balance in its day-to day activities and will then be required to pay back the deficit in 2008-10. This coincides with a significant reduction in NHS growth funding to possibly less than 3% pa. For 2007/8, the PCT has a Recovery Plan in place which is designed to deliver savings totalling £10.5m to bring the PCT into financial balance so that the outstanding deficit can be repaid over the following two years. As part of this plan, the PCT is aiming to reduce expenditure on joint commissioning and continuing care budgets by £3.5 m.

7.3 Hounslow Council

7.3.1 **Hounslow Council** are also required to manage within budget. The Council's 2006/2007 Gross Budget is £613 million of which Housing and Community services (HCS) budget is £207m (34%). That total includes Government Grants, Health and client contributions (charges). The net Hounslow HCS budget is £64m. Adult care delivered savings of over £2m to support the Council policy of a low Council tax in 2007/8 and is expected to plan for savings over the next years 2007-10 which will reduce the net expenditure by 23% over the 3 years. The table below shows the breakdown of the budget.



Housing	£ 7.4m
Older People	£27.7m
Learning Disability	£16.1m
Physical Disability	£ 8.7m
Mental Health	£ 3.8m
Other	£ 0.6m
Total	£64.3m

7.3.2 The Supporting People programme to provide housing support to vulnerable people funds about £5m of services annually. This grant is being reduced year-on-year.

7.4 Efficiencies

7.4.1 The Public Sector Efficiency Review, led by Sir Peter Gershon, identified over £20 billion worth of efficiency gains across all of government spending to be achieved by 2007/08. These savings have been directly factored into the 2004 Treasury Spending Review and consequently already form part of the long-term budget settlements for both local government and the NHS with expectations of around 3% savings each year.

7.4.2 Both the PCT and the Council have undertaken a wide range of work to improve efficiency and reduce duplication. These include:

- partnership working with the West London Alliance of Councils and the North West NHS Sector to improve procurement and to jointly manage relationships with providers;
- implementation of SMART working in the Community Team for People with a learning disability (CTPLD);
- redesigning processes and care pathways;
- improving and increasing the use of block contracts;
- establishing the Heston Office as a single point of contact for Adult Care; and
- effective Home Care monitoring by the introduction of E-monitoring of time/invoices.

7.4.3 Adult Care delivered £1.5 million in Gershon efficiencies in 2007/8 and, across the Department, supported the delivery of the zero council tax increase by identifying cost reductions of £2.6m for 2007/8. The PCT is planning to make efficiency savings of £2.4m in 2007/8 as part of the Turnaround plan.

7.4.4 As part of a national DH initiative, the Council is working with the Care Services Improvement Partnership (CSIP) and its subsidiary CSED to review efficiency in care management processes during 2007/8.

7.5 Capital Assets

7.5.1 Significant developments and improvements have occurred in the last 3 years to the buildings within which health and care services in the Borough are delivered. These include:

- redevelopment of the WMUH site;
- opening of Pharmacia House as a one stop for Drugs and Alcohol services;
- opening of the new Heart of Hounslow and Feltham Health centres;
- refurbishment of the Heston Local Office for Adult Care;
- opening of School Road and Canal House user led Mental Health services;
- interim refurbishment to a range of day and residential care establishments; and
- development of a jointly funded facility for older people with mental health needs at Clifton Gardens Resource Centre.

7.5.2 Future plans include developing Older People's Resources Centres in the

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

Centre and West of the Borough, developing new resources and models of care for people with learning and/or physical disabilities and further developing resources for older people with mental health needs.

- 7.5.3 In 2007, the Council is updating its Capital Asset Management Strategy to prioritise further developments in an environment where capital funding is severely limited. The PCT is also updating its asset strategy following completion of two major developments.

7.6 Information Technology and ITC Strategy for 2007/10

- 7.6.1 The health and local authority economies face significant challenges to put in place modern IT systems to support commissioning. In recent years the Council has implemented the SWIFT client information system and the NHS is currently implementing the RIO system.

- 7.6.2 SAP has been implemented but needs further development. A significant development in the last year has been the introduction of electronic call monitoring in home care which the time spent by carers on visits to clients. Checks and validates.

Future developments include:

- further progressing e-procurement;
- developing a Housing & Community Services IT Strategy in 2007/8;
- implementing a Council-wide electronic document management system to deliver the electronic Social Care Record;
- purchase of a commercial off-the-shelf Customer Financial Affairs system;
- implement SWIFT Financial Module to link financial and activity data;
- implementing new contract management software to link with financial and activity data; and
- planning for, and procuring, a replacement for SWIFT.

- 7.6.3 These developments will then provide:

- faster financial assessments;
- improved, and faster, budget and commitment information for both residential and domiciliary care spend;
- comprehensive records of all clients receiving residential and domiciliary care; and
- integrated contract management.

- 7.6.4 An information sharing protocol is in place and has been signed off by the PCT, WMUH, WLMHT and the LA. Briefing sessions linked to written guidance have been completed. Data Protection checks are an integral part of the 'No Surprises' audit programme run within the Council and in joint PCT/Council teams.

7.7 Financial Strategy for 2007/10 and Implications for commissioning

- 7.7.1 Both the health and local authority economies are facing significant financial challenges and substantial savings requirements across the health and care economy during recent years. In future years all organisations will have to remain in financial balance and, if there are adverse pressures, will have to reduce expenditure to match the funds that are available. The organisations

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

agreeing this strategy are committed to providing value for money and to maximising available resources and will, wherever possible, identify efficiency savings and Invest to Save projects. Overall, during the period 2007-10, and indeed beyond, there may be real reductions in available resources.

- 7.7.2 The PCT and LA expect that over 2007-10 there will be less growth in both health and care budgets than is required to sustain existing expenditure. This means that the PCT and the Council will need to look at the full range of services currently provided, focus resources on those services where there is a statutory requirement to provide them and regularly review processes to ensure they are provided in the most cost effective way to deliver the required service quality.
- 7.7.3 Comparatively small, additional sums of new money may become available through grants; although often this requires spare staff capacity to prepare bids. These windfall gains cannot be planned for, are normally ring-fenced and are not available to meet priority needs. The preparation of comprehensive joint strategies enables appropriate bids to be made with limited additional preparation, where the funding clearly supports agreed commissioning intentions. However, in general it is not expected that significant new monies will become available for service developments.
- 7.7.4 Major shifts in provision to meet changing need will therefore need to be financed from disinvestment and re-investment. There are always opportunities, which may include a combination of:
- revenue savings from cost efficiencies;
 - disinvestments from existing services;
 - shifts in the balance of in-house and external provision; and
 - shifts in the balance of contracts.
- 7.7.5 However, it is likely that both organisations will continue to have annual savings targets to meet and that much of the above savings will be required to meet these targets leaving only small sums to invest in services to meet changing needs. It is not possible at present to predict the degree to which growth in needs and demand will be funded.
- 7.7.6 The financial strategy for commissioning for 2007-10 will be to:
- deliver the PCT and Council overall financial plans;
 - seek efficiencies and savings from rigorously reviewing areas of expenditure and implementing demand management initiatives;
 - work jointly across the health and social care economy and avoid cost shunting between sectors;
 - seek efficiency savings from provider organisations as well as commissioning and management through procurement and joint procurement at local and a wider West London level;
 - seek opportunities to Invest to Save (particularly in preventative services and will by switching resources from bed-based to community services over periods of up to 2 years);
 - be clear about the expected impact of service reductions where financial savings are required to balance budgets and how these reductions are in areas of lesser priority and consistent with organisational and joint strategies;

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

- seek, over the 3 years, to increase the share of total funding for adult and older people's mental health services by redirecting resources from other groups to increase the proportion of spent on mental health services; and
- sustain, at least, current levels of funding for the carers services.

8. Workforce

8.1 The Housing and Community Services Department directly employs 841.5 fte staff of whom 124.5 fte are employed in Housing services. The PCT directly employs 558.79 fte staff. Predicted demographic changes in the workforce estimate a continual increase in the over 35 age group in Hounslow. This has implications for targeting recruitment initiatives to the older working population where the workforce pool will be greater. Changes in the way services are managed and delivered and the greater involvement and empowerment of users, means new roles and more flexible working practices are needed to optimise the time of all workers in the health and care sector. Employers need to devise the best skill mix within their teams to ensure services are focused on improving user outcomes. The Council and PCT will work towards integrating their workforce planning in order to facilitate joint working on the ground. The following table details changes in Social and Health Care workforce trends

Workforce Trends – Changes in Models of Service Delivery	
From	To
<ul style="list-style-type: none"> ➤ Building based Services ➤ Options based on traditional models ➤ Residential care ➤ Arranged and paid for by the LA ➤ Defined care management role ➤ Services based on inputs ➤ Risk averse 	<ul style="list-style-type: none"> ➤ Community based Services ➤ Greater choice and flexibility ➤ Domiciliary care and Extra Care housing ➤ Arranged and paid for by the individual using Direct Payments and individual budgets (self directed support) ➤ Care facilitator and self assessment ➤ Outcomes based commissioning ➤ Risk aware

8.2 Work Force Planning

The overall purpose of workforce planning is to ensure that there are sufficient numbers of staff with appropriate capabilities and values, who are well supported and led, reflecting the population they serve and delivering services that meet the needs and wishes of the people who use those services and their family and friends. Effective workforce planning minimises the risk that service delivery and quality is compromised by skill shortages in the future. It focuses on the need to integrate workforce plans with needs led service development and within the service and organisation planning and management frameworks.

A workforce strategy is built on the following principles:

- services should be commissioned, provided and evaluated with the key purpose of making a positive difference to users and carers;
- staff, including professionally qualified and non-professionally trained staff, are the means of delivering effective services and they need to be valued and

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

supported in doing so;

- interagency work force planning must work towards achieving sufficient numbers of staff with the appropriate range of skills to meet local service needs;
- the workforce should be representative of the community it serves through genuine equality of opportunity for all staff members regardless of race, gender, disability or sexual orientation;
- staff should reflect the culture of the local communities they serve, including the experience of those using mental health and learning disability services;
- staff should have the appropriate education, training and supervision to enable them to deliver person centred, socially inclusive services;
- education and training should focus on positive outcomes for users and carers and the importance of empowerment, self-help and prevention;
- all staff, including non-professional staff, should receive appropriate support and supervision to promote quality health and social care delivery and to meet their needs for career and personal development within a framework of life long learning;
- staff should work collaboratively and flexibly across disciplines and teams, overcoming professional and organisational boundaries, to meet the needs of people using services; and
- service users' and carers' contributions are crucial to planning, providing and evaluating education and training and delivering effective services.

The Council and PCT are signed up to developing our workforce and delivering training on the basis of these principles and to develop plans to achieve this by working with service providers.

Current issues around workforce development:

- recognition of complexity of roles;
- achieving the right skills mix;
- review of Social Work roles and tasks;
- GSCC Registration;
- sector skills councils – skill base and competencies;
- sustainability for health and care – age profile, expertise and values; and
- developing expertise in commissioning.

In addition there is a need, for managers to continue to develop their skills in commissioning and procurement in a health and care economy and the following ongoing development opportunities will be included within the workforce plan:

- action Learning Sets for Managers working in health and social care in Hounslow;
- membership of Department of Health Learning and Improvement networks;
- general procurement training (LBH);
- General commissioning training (PCT); and
- Specialist Joint Commissioning and Joint Procurement Training for joint teams.

8.3 Indicators

In Adult Social Care staff turnover continues to reduce. In 2006/7 turnover was only

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

8.6%. Sickness/absence rate also continued to reduce at 4.7% in 2006/07 Expenditure on Training & Development was 4.9 % of all expenditure. The intention is to, at least, sustain these levels over the next 3 years. Overall recruitment, and retention is generally good but continues to be a challenge in some areas; especially OTs; care management staff in Learning Disability and Independent Living, and some central and strategic staff.

In order to maintain and improve these indicators developments will include:

- continuing to implement the new Post Qualifying framework for social workers;
- procuring specialist commissioning and contracting training;
- maintaining Graduate SW trainee and staff secondment schemes;
- an initiative to “passport” practice learning students to fill permanent vacancies once qualified;
- overseeing the re-registration of social workers with the GSCC;
- and the extension of registration to other work groups;
- continuing departmental “Celebration of Achievement” events;
- agreeing a protocol for employment policies for those staff employed in services jointly managed with the PCT;
- regular employee surveys; and
- renewal of Investors in People award.

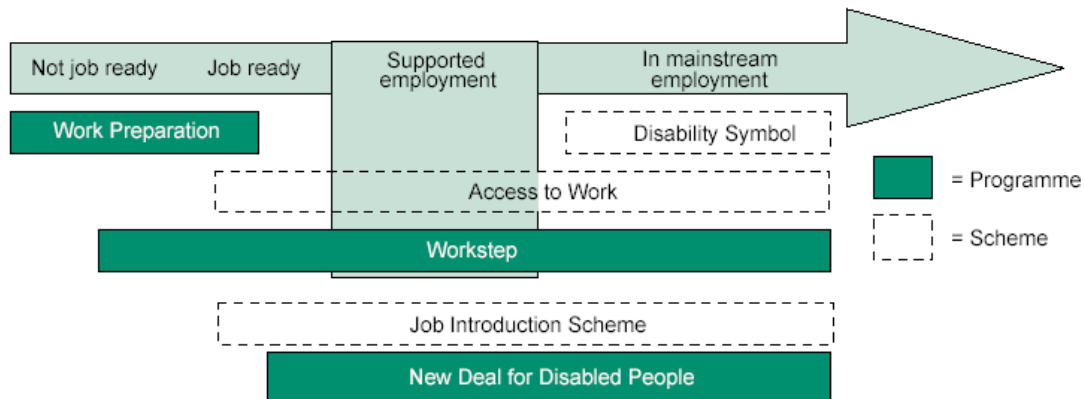
Initiatives to make training opportunities available for the independent sector will continue including:

- CSCI minimum requirements for foundation training;
- courses in medication, cross cultural care & dementia care;
- TB awareness; and
- Safeguarding Adults training.

9. Employment and Social Inclusion

9.1 National Policy

In 2005, 50% of people with a disability and of working age were in employment compared to 75% of the working age population as a whole. More than 1 million of the 2.7 million people on incapacity benefit say they want to work. Over recent years the government has introduced a number of programmes to help disabled people find, and return to, work but these have been complex and overlapping and have only reached a small proportion of those who might benefit. The diagram below demonstrates the different types of intervention and Government programmes.



<p>Not job ready - have significant, perhaps multiple, barriers to overcome to move into work. Needs support to develop confidence and general skills, which may include basic literacy and numeracy.</p> <p>Job ready - ready to move in to employment, but may need help and assistance with interview techniques and skill development.</p> <p>Supported employment - provides the opportunities to develop skills in a work environment and to find out about different types of jobs. Support is there to ensure the employer and employee receive assistance and is ongoing as long as it is needed.</p> <p>Support in mainstream employment - the terms and conditions of employment should be the same as for people without disabilities including pay at the going rate, equal employee benefits, safe working conditions and opportunities for career development and promotion.</p>

9.1.1 In January 2006 the Department of Work and Pensions issued a Green Paper for consultation entitled *A new deal for welfare: empowering people back to work*, which placed particular emphasis on moving people off benefits. Economic independence through work is a key target and employment also provides social interaction and raised self-esteem. The longer term vision for H&CS as “drive-through” rather than “end point” – a support in times of need, rather than a permanent crutch. Providing early intervention to prevent breakdown of employment, intensive support to get people back to work and/pr ongoing advice and mentoring can reduce the amount of long term support required from statutory services.

9.1.2 It is recognised that not everyone can participate in paid or full time employment and that different models of support will be required to meet the diverse needs of health and social care clients. There is a need to develop a spectrum of services. There is also a need to change the culture of our organisations so that staff in HCS and in partner agencies positively encourage and support access to work rather than foster dependence and reinforce barriers.

9.2 Local Strategy

Hounslow PCT has already consulted on a Self Care Strategy which includes the extension of its Expert Patients' Programme providing training and support to people with long term conditions. WLMHT manage a number of schemes to support mental health users back to work.

9.2.1 Hounslow Council are developing further initiatives and are consulting on a strategy for HSC on Empowering Disabled People to Work as a framework for these strands of work. Changing the culture, extending current initiatives, developing new routes into employment, increasing prevention and early intervention to support those at risk of losing their jobs are key strands.

9.2.2 The aims of the strategy are to:

- contribute to reducing the gap between the percentage of disabled and non-disabled people in work by helping disabled people in Hounslow find and stay in meaningful employment;
- change the culture in Hounslow so that health and social care staff focus on what disabled people can do rather than what they cannot and support them in achieving their potential;
- work closely with partners to provide swift and easy access to information on advice, training and support available to empower disabled people to find, or stay in, work;
- promote the development of a range of early intervention, access to work and support provision tailored to the different needs of disabled people within the locality; and
- provide timely and appropriate support to people with long term conditions to enable them to sustain, or return to, work where possible.

9.2.3 The issues raised will be reflected in both commissioning strategies and operational plans for the coming years. Key elements already in process include:

- re-focussing the Leaders Employment Service to provide a pan-disability approach; and
- development of Acorn Day Services as a training and life-skills centre with a focus on prevention.

9.3 Support with Financial Affairs

9.3.1 It is planned to continue to provide support with financial affairs to those who need social care assistance. This support includes:

- a Joint Visiting Team with the Pensions Service to ensure benefit entitlements are received by clients;
- welfare benefits and Money Advice Service campaigns and leaflets; and
- provision of a Financial Affairs Service for those who are unable to manage their own financial affairs.

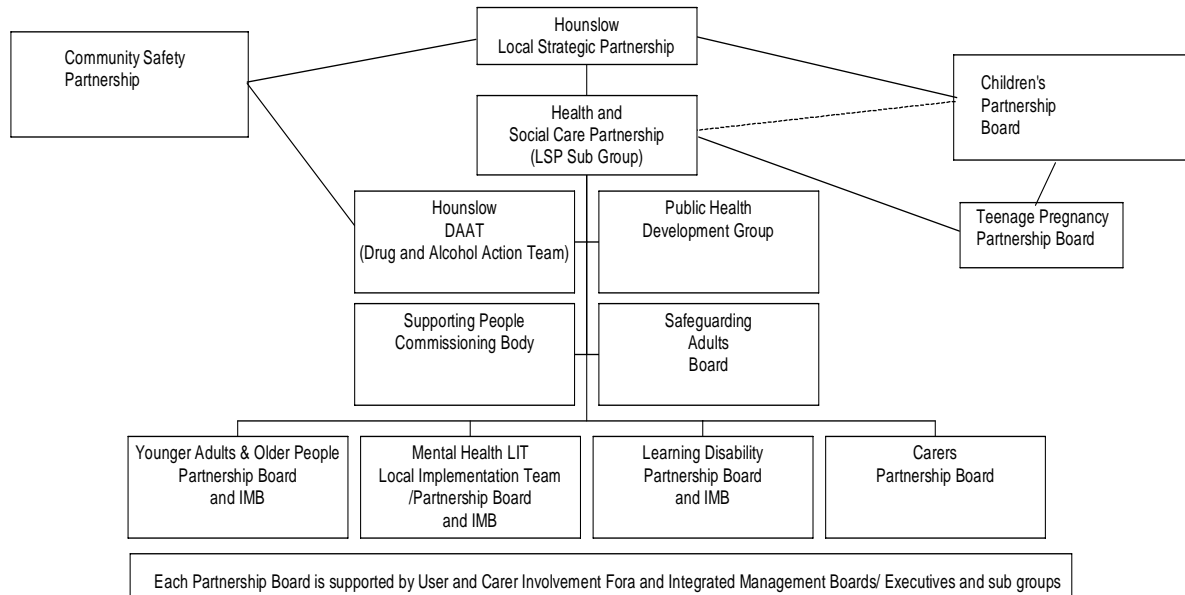
10. Promoting Health and Well-being and Reducing Inequalities

- 10.1 The Hounslow Health Inequalities Strategy aims to support the improvement of the health of the population with particular reference to those individuals, groups or communities who suffer, or are likely to suffer, more ill health than the general population. Areas of activity include promoting healthier lifestyles relating to smoking, exercise, eating and drinking.
- 10.2 The Council and PCT are also committed to supporting and developing services which prevent, or delay, the need for more costly, intensive services and which focus on helping people to maintain their independence for as long as possible, no matter how frail or vulnerable they are.
- 10.3 By definition, therefore, these approaches need to develop clear and specific links to the following range of universal services:
- housing;
 - transport;
 - lifelong learning;
 - primary care and community health;
 - community clubs and societies;
 - faith communities;
 - pensions and benefits;
 - crime prevention;
 - voluntary services/ third sector; and
 - leisure services.
- 10.4 Although there are some good local services addressing some of these issues, there are a number of gaps or inadequacies. These will be identified through the Public Health Development Group and monitored through the HSCP.

11. Partnership Working and Involvement

11.1 Overviews

11.1.1 The current partnership arrangements are detailed in the diagram below



11.1.2 The general aims of the Partnerships are to bring together representatives of key organisations, users and carers to plan and work in partnership, identifying local needs and inequalities and developing effective plans and services to improve the health and wellbeing of our communities.

11.1.3 The partnership arrangements for each Board will be reviewed as part of the 2007/8 workplan to ensure they remain appropriate to meet the aims and ensure engagement and involvement from users, carers and stakeholders.

11.2 Accountability Frameworks and Involvement

11.2.1 There is a range of accountability for decisions about health and care services. At the highest level decisions are made by:

- London Borough of Hounslow – the Executive and the full Council
- Hounslow PCT – the Board and the Professional Executive Committee (PEC)
- NHS Trusts – the Board

11.2.2 By law there are various methods for proposals to be influenced and reviewed. These include:

- OSCs
- NHS Patient and Public Involvement Forums (PPI Forums)

11.2.3 The Council also supports a range of user and carer groups to enable them to become involved and actively contribute to service planning and evaluation. A good example of this is the annual “Find a Voice” event where in November 2006 over 450 older people fed back their own thoughts on services provided

for them.

11.2.4 The Council and local NHS Trusts also aim to learn lessons from complaints and serious incidents (and near misses) where things have gone wrong.

11.2.5 A new law currently going through Parliament will strengthen the role of OSCS and establish LINKs to replace PPI Forums. The lead responsibility for commissioning the LINKs is given to Councils and consultation with local stakeholders will begin in mid 2007 to develop a specification for the service, which is likely to be tendered in 2008. This is an opportunity to review, and strengthen, arrangements for involvement and engagement of patients, users and carers across health and care services in the Borough.

11.3 Advocacy

11.3.1 The Council and PCT are committed to developing and supporting a range of advocacy services to support users. This includes the recent implementation of new arrangements for advocacy linked to the new Mental Capacity Act. More detailed information will be found in each of the Joint Commissioning Strategies.

12. Commissioning and Market Management Framework

12.1 Context

The Council and PCT procurement of care services is supported by a Joint Commissioning Team funded by the Council and the PCT. Joint needs analysis is undertaken by the Council and PCT Public Health Directorate to support commissioning and identify gaps and inequalities. Resources are allocated to meet priority needs.

12.2 Market Strategy

Our market management strategy is to continue, and extend, our purchasing influence in ways that stimulate and support providers to invest in services and increase standards. Where possible we encourage competition amongst providers to drive up quality and offer best value for money. We undertake analysis of need, supply and demand to inform our commissioning.

12.2.1 The independent sector, including the third sector, are key partners and we have established provider forums with local care providers to discuss gaps and service improvements and address concerns and problems. We also work across the health, housing and social care economy to “manage the market” to combine purchasing power.

12.3 The Third Sector Agreements

The Council and PCT have a variety of funding arrangements with the voluntary sector. These range from small grants to local community and voluntary groups, to contracts for specific services. As grant funding arrangements come up for renewal the need for the service and the specification is reviewed. If the service is still required a reused specification is agreed and a competitive procurement exercise undertaken or a funding agreement with clear performance standards and monitoring is agreed

12.3.1 The agreements set out the price and payment arrangements, mechanisms for

addressing difficulties and a service specification that sets out service delivery arrangements, quality and quantity performance indicators and monitoring arrangements. The monitoring arrangements are flexible dependent on the level of resources involved. All new service level agreements and contracts contain requirements of quality standards specific to the service being commissioned and relevant to the client group.

12.4 Contract Monitoring

Contract monitoring of care suppliers with Council contracts is overseen through the Council Contracts Team. Monitoring arrangements aim to ensure that the services supplied meet the quality, volume and costs specified. Monitoring activity includes:

- planned Monitoring visits and contract management meetings;
- unplanned visits in response to serious concerns of non-compliance;
- service specific and cross-cutting user surveys;
- CSCI Inspection reports;
- authorised supplier approval;
- monitoring of all complaints received and of vulnerable adults incidents;
- quality monitoring by a variety of methods;
- monitoring and reporting of supplier activity and performance;
- benchmarking with other authorities; and
- care management and operational manager feedback.

12.4.1 The Council has agreed a set of standing orders and financial regulations that govern the way in which all goods and services are purchased. In addition to its own standing orders and financial regulations, the Council is subject to European public procurement directives which set down a series of procedural requirements. The Council also works within the confines of the 1998 Local Government Act and national legislation including the Competition Act.

12.5 Procurement Strategy

An updated Procurement Strategy for care services in Hounslow will be developed to match the latest market conditions. This will describe the strategic vision and objectives of procurement with the overarching aim of supporting the achievement of national and local objectives through best practice procurement and effective use of financial, activity and comparator data. As now, annual workplans in service plans will be used to progress the priorities in the strategy.

12.5.1 To complement this we will also be developing a West London Procurement Strategy to describe our approach to cross-authority care procurement. As part of this we will be developing standardised documentation and looking to develop standardised processes to deliver efficiencies for both commissioning and provider organisations.

12.5.2 Future developments include:

- further developing brokerage in the Contracts Team;
- updating and standardising LBH contracting systems and processes;
- implementing Fair Pricing Tools;
- piloting an open book efficiencies benchmarking approach with a major supplier; and
- Work with the West London Alliance on two work streams.

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

- Costs / VFM – including undertaking analysis of market segments and developing quality reward uplifts for suppliers
- Processes / Systems / Documentation – to develop standardised forms and processes

12.6 Standards for Commissioning and Procurement

In commissioning and procuring services we work to the following standards.

The organisations commissioning will:

- develop services with the involvement of local communities;
- actively involve users in all choices and decisions relating to their needs;
- ensure that users and carers receive a proper assessment of their needs and proportionate to those needs;
- set clear standards for all services and monitor providers against these;
- ensure that all services commissioned meet national standards;
- ensure that services are of a high quality and regularly monitored ;
- ensure that the arrangements for letting contracts are fair, transparent, accessible and easily understood;
- aim to achieve the best value and best possible outcomes for users;
- use a partnership approach which recognises the needs of all parties;
- obtain feedback from providers through consultation forums and other mechanisms and use this to inform our commissioning arrangements; and
- maintain contractual arrangements which have the capacity to change and adapt to reflect the changing needs of users and the social care market.

13. Risk Management

13.1 There are two key linked risks to delivering the Joint Commissioning Strategies. These are resources and workforce. Firstly, the availability of resources, both to fund services and to fund the required commissioning and redesign, will impact on the ability to deliver the most efficient and effective performance and meet national and local objectives and targets. Secondly, the availability of suitably skilled staff will affect the ability to deliver the strategies. Recruitment and retention of staff is an ongoing challenge which particularly affects both operational staff and also other key management/support posts.

13.2 In addition, workforce development is critical in developing staff with new skills cutting across traditional health and care roles and professional boundaries. Both organisations operate risk management approaches and will use these systems and the monitoring and review processes to manage risks.

14. Monitoring and Review Process

14.1 The actions in the Action Plans will be linked to each organisation's business plans and monitored and performance managed by the Council and local NHS Trusts. In addition, progress on each of the Joint Commissioning Strategies will be monitored quarterly by the relevant care group Integrated Management Boards. Reports on this monitoring will be reported to the relevant Partnership Board. The HSCP will review progress on each strategy annually. The aim of this

OUR HEALTH, OUR CARE, OUR HOUNSLOW

An Overview of Joint Commissioning Strategies 2007-10

monitoring will be:

- to review implementation of the planned actions and identified risks;
- to assess the effectiveness of current monitoring and performance management arrangements;
- to determine whether the planned actions are shaping services in the way intended; and
- to amend planned actions in the light of these reviews and changing circumstances.

Appendices

Appendix I - Action Plan

The following strategies and policies are to be agreed following consultation:

Service Area	Venue for decision	When
Older People Joint Commissioning Strategy	LBH Executive and PCT Board and PEC	November 2007
Agree approach to procuring LINKs Involvement Network	LBH Executive	November 2007
Learning Disability Joint Commissioning Strategy	LBH Executive and PCT Board and PEC	December 2007
Physical Disability Joint Commissioning Strategy	LBH Executive and PCT Board and PEC	February 2008
Mental Health Joint Commissioning Strategy	LBH Executive and PCT Board and PEC	March 2008
Carers Joint Commissioning Strategy	LBH Executive and PCT Board and PEC	May 2008
Drugs and Alcohol Joint Commissioning Strategy	LBH Executive and PCT Board and PEC	June 2008
Supporting People Joint Commissioning Strategy	LBH Executive	July 2008
Better Care Higher Standards updated charter	LBH Executive and PCT Board and PEC	May 2008

Appendix II - A Framework for Joint Commissioning and Purchasing

Effective commissioning of services requires partners across health and social care economies, including the independent sector, voluntary sector and users and carers, to have a shared vision for services and a strategy to implement it. This strategy makes reference to other existing documents and aims to provide a single reference point for the key national and local drivers for health and social care.

There are four commissioning activities:

- Analysis - of guidance/best practice, population needs, market, risks and resources and establishing common service priorities through partnerships between agencies;
- Planning – undertaking gap analysis, designing services and models of care, writing joint commissioning strategies, all with user , carer and stakeholder involvement;
- Doing – managing the balance of services, service/pathway redesign, developing good relationships with providers, and user/stakeholder involvement in ensuring service quality and purchasing services; and
- Reviewing - the success of the strategy in meeting the needs of the population.

There are four related purchasing activities:

- Analysis - of the commissioning strategy, the market opportunities, patients/service user needs and provider strengths and weaknesses;
- Planning - by designing specifications and deciding contract type and terms;
- Doing - through day-to-day care and contract management, brokerage and tendering; and
- Reviewing - the success of the contract in meeting patient/service user needs

and commissioning priorities.

All four elements of the cycle are sequential and equally important. The commissioning cycle drives purchasing and contracting activities. However, the contracting experience must inform the ongoing development of commissioning.

Appendix III - Summary of Key Reference Documents

National Context – a selection

- Opportunity Age – Meeting the Challenges of Ageing in the 21st Century, DWP, 2005
- Sure Start to Later Life: Ending Inequalities for Older People, Social Exclusion Unit, 2006
- Improving the Life Chances of Disabled People, Cabinet Office, 2005
- Everybody's Business: Integrated mental health services for older adults: a service development guide, DH/CSIP, November 2005
- Our Health, Our Care, Our Say DH – 2006
- Independence, Well-being and Choice: Our vision for the future of social care for adults in England – DH – 2005
- Choosing Health: Making Healthier Choices Easier
- Securing Good Health for the Whole Population (Wanless 2004)
- Supporting people with long term conditions
- National Service Frameworks for: Older People; Mental Health; Coronary Heart Disease; Long Term Conditions; Diabetes and the National Cancer Plan
- Independent Review of Public Sector Efficiency: Releasing resources to the front line, Gershon, P. (2005) HM Treasury
- The NHS in England: the operating framework for 2007/8 DH Dec 2006
- Third Sector Commissioning Taskforce Report
- State of Social Care in England 2005-06 CSCI
- Options for Excellence – Social Care Workforce Planning
- New Outcomes Framework – Performance of Adult Social Care
- Relentless Optimism – Commissioning for Personalised Services
- Commissioning Framework for Health & Well-being, DH - 2007

Local context

- Hounslow Community Plan 2007-2010
- Hounslow Local Area Agreement (LAA)
- The Hounslow Plan
- PCT Commissioning Strategy Plan
- Empowering Disabled People to Work (Draft) Strategy 2007

Appendix IV- Summary of key stakeholder involvement in producing this strategy

This document has been circulated to Partnership Boards and IMBs and discussed at OSC and the HSCP. In addition, a Stakeholder event was held in July 2007. Feedback from all these events has contributed to the final document.

Appendix V - Acknowledgments

This document has been produced drawing on material not only from Hounslow Council and PCT but also, amongst others, from DH, Care Services Improvement Partnership, IPC at Oxford Brookes University, East Berkshire Health and Care Community, Ealing Health and Care Community, amongst others. We are pleased to acknowledge these sources and thank the relevant authors for sharing their material for the benefit of all.

Appendix VI – Glossary - See attached document