



London Borough  
of Hounslow

Hounslow **NHS**  
Primary Care Trust

# Joint Commissioning Strategy for Older People

## 2007 - 2010



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**This strategy is available in Braille by  
contacting the Joint Commissioning  
Team on 020 8583 4509**

# 1 INTRODUCTION

## 1.1 Purpose of the Strategy

1.1.1 This Commissioning Strategy for Older People sets out a clear guide about the specific ways in which the London Borough of Hounslow and Hounslow Primary Care Trust (PCT) will seek to develop services for older people in the next three years. Whilst there has been significant progress since the first Strategy was launched in 2004, there are substantial challenges facing the Council and the PCT. Reflecting on the priorities for Hounslow's residents will help to ensure that both organisations continue to commission quality services, which are in touch with people's needs and aim to improve **outcomes for older people**.

1.1.2 At the heart of this strategy is a firm commitment to promoting **the independence and quality of life for older people**. Over the next three years, Hounslow Primary Care Trust and Hounslow Council's Housing and Community Services Department will commission services that aim to reach all of our diverse community and that support older people in living with independence in their homes.

1.1.3 Effective commissioning of Older People's services requires partners across health and social care economies, including the independent sector, voluntary sector, users and carers, to have a shared vision for services and a strategy to implement it. The strategy describes **the key national and local priorities (chapter 1)** for older people's services and the commissioning arrangements that are required to fulfil these priorities. This draft strategy aims to provide the context for that **vision for service delivery (chapter 2)** and serve as a single reference point for the Hounslow Older People's Partnership Board and the Older People's Executive.

- 1.1.4 The process of commissioning is informed by undertaking **needs analysis of our local population (chapter 3)**, using demographic information to understand the challenges facing the borough as a whole, but also as smaller localities. The strategy analyses how the **current pattern of services has performed (chapter 4)** through the lifetime of the Commissioning Strategy for Older People 2004/2007 and examines whether previous set targets have been met (targets are determined as being achieved where performance equates to the banding of the target for the Department of Health's Performance Assessment Framework). **The resources available are examined (chapter 5)** and the strategy concludes with **an action plan detailing prioritised objectives, responsibilities and timetables (chapter 6)**.

The most substantial service development implications contained in this strategy are to be found in chapter 4.6. These concern:

- The development of a whole systems approach to intermediate care is crucial to achieving the headline aim of the strategy. This will require a substantial shift in investment, with £300,000 being invested in new intermediate care services, with the aim of reducing acute hospital spend of £1m; and
- A continued shift in investment by the Council, so that by 2010, there is a reduction the amount spent on supporting older people in care homes by £1m annually, and an increased investment in domiciliary services (both care and equipment) of £750,000 annually.

Both of these developments are founded in principle of investing in order to save, and consequently should provide both more appropriate services in line with older people's needs, as well as address the financial circumstances of the Council and the PCT.

- 1.1.5 It is imperative that we continue to commission quality services in order to make the best use of scarce

resources. It must be recognised that if services are inadequately funded then quality and consistency of service provision will suffer, with the inevitable consequence that support arrangements will break down, and the overall burden to the whole health and care economy will increase. A key question for this strategy is how much support should be provided to older people early (and how early it should be provided) to help prevent future deterioration.

1.1.6 The strategy will be used as an integral part of the Council and PCT's decision making and planning processes and should be considered alongside:

- The Hounslow Plan 2006/2010;
- The PCT's Local Delivery Plan;
- The Hounslow Local Area Agreement;
- The Older People's Mental Health Strategy; and
- The Older People's Housing Strategy.

In addition, it should be noted that this strategy is part of a family of joint commissioning strategies covering:

- Physical Disabilities
- Learning Disabilities
- Mental Health
- Carers
- Drug & Alcohol; and
- Supporting People.

There is a significant overlap between these strategies as often people have multiple needs. This strategy should, in particular, be read alongside the strategies for adults with physical disabilities and sensory impairment (as there are substantial areas where services are provided as a response to a long-term condition, where there is no age differential) and for carers.

1.1.7 The strategy has been subject to extensive consultation, individual chapters have been extensively discussed at the Adults and Older People's Partnership Board through

2007 and the Board's component subgroups have been responsible for providing the detail. A Stakeholder event in was held in July, which included representatives from the Older People's Panel, voluntary sector partners, and statutory organisations. Additionally, issues discussed and actions recommended by the Older People's Panel in the last two years are reflected in the strategy.

The strategy was also discussed at Provider Forums with Domiciliary care providers and the Voluntary Sector

1.1.8 Partnership arrangements for services for older people and adults with physical disabilities and sensory impairment are detailed in chapter 6.

1.1.8 The crucial role of carers with relation to older people's services is highlighted in chapter 4.10.

## 1.2 National priorities

1.2.1 The Commissioning Strategy for Older People 2007/2010 has been developed within the context of national policy and legislation. The following summaries draw particular attention to the issues raised for Older People.

### 1.2.2 *Keeping Vulnerable People Safe*

***The National Assistance Act 1948 and The NHS and Community Care Act 1990*** and other legislation provides a statutory framework to assess older people who may be in need and arrange for the provision of care when needs are eligible. ***The Mental Health Act 1983*** sets out a legislative framework for the compulsory admission and detention in hospital of people with mental health needs. ***The Mental Capacity Act 2005*** provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions.

***Securing Better Mental Health for Older Adults (2005)*** sets out the Department of Health's vision of how

mainstream and specialist health and social care services should work together to secure better mental health services for older people.

***Fair Access to Care Services (2003)*** is the Department of Health framework provided to Councils for setting their eligibility criteria for adult social care. Locally, the London Borough of Hounslow will continue to meet assessed needs where these address critical and substantial risks to older people. Assessors will still need to signpost older people with moderate and low risks to other support networks, some of which remain jointly funded by the London Borough of Hounslow and Hounslow PCT.

In March 2000 the Department of Health and the Home Office issued ***No Secrets*** as Guidance under s7 of the ***Local Authority Social Services Act 1970***. One of the



Hounslow Multi-Agency  
Safeguarding Adults

Policy

March 2007



main objectives of the No Secrets Guidance was to ensure that all local authorities in England take the lead in developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. From April 2004 the five statutory agencies (London Borough of Hounslow, Hounslow PCT,

West Middlesex University Hospital, West London Mental Health Trust and Hounslow Police) have jointly funded two Adult Protection Coordinators. In March 2007, the ***Hounslow Multi-Agency Safeguarding Adults Policy*** was launched

### 1.2.3 ***Focusing on Prevention***



**Our health, our care, our say:**  
a new direction for community services

Health and social care working together in partnership 

***Our Health, Our Care, Our Say: A new direction for community services (2006)*** and ***Independence, Well-being and Choice: Our vision for the future of social care for adults in England (2005)*** 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 key proposals in the White Paper are that:

- Health and Social Care Services will provide better prevention services with earlier intervention;
- People will be given more choice and a louder voice, including the development of a risk management framework to enable people using services to take greater control over decisions about the way they want to live their lives;
- Increased access to community services; and
- Increased support for people with long-term conditions.

**A New Ambition for Old Age**

*Next Steps in Implementing the National Service Framework for Older People*  
A Resource Document  
from Professor Ian Philip,  
National Director for Older People,  
Department of Health



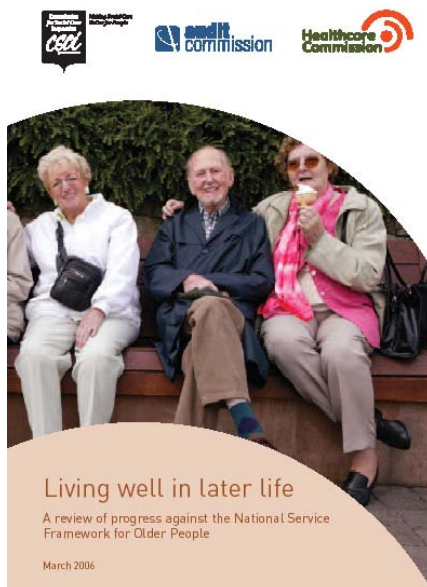
***A New Ambition for Old Age - Next Steps in Implementing the National Service Framework for Older People (2006)***

refreshes the original National Service Framework for Older People and establishes ten Programmes under three key themes: Dignity in Care, Joined-Up Care, and Healthy Ageing.

The **Dignity In Care** theme aims to ensure that older people are treated with respect for their dignity if they become ill (Programme 1) and that they will receive good end of life care (2). The theme seeks to challenge deep-seated negative cultural attitudes towards older people.

The theme of **Joined-Up Care** updates many of the standards that formed the strand of **providing evidence-based specialist care** in the original NSFOP. The programmes on Stroke Services (3), Falls and Bone Health (4), and Mental Health in Old Age (5) have direct links to previous standards. The theme also focuses on Complex Needs (6), Urgent Care (7) and Care Records (8). The theme promotes the early identification of problems and treatment to prevent a crisis and rapid response to a crisis when it occurs to quickly restore health, independence and well-being. Programme 6 in particular builds upon **Supporting People with Long Term Conditions (2005)**, a Department of Health's model designed to help improve the care of people with long-term conditions.

The theme dedicated to **Healthy Ageing** builds upon the **promoting an active, healthy life** strand of the NSFOP. The Department of Health intend to promote opportunities for older people to increase their levels of physical, mental and social activities, recognising that a broad range of organisations from the independent sector, the NHS and Local Government are involved in this work. Two specific programmes are developed covering Healthy Ageing (9) and Independence, Well-being and Choice (10).



In 2006, the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission undertook a joint review of the state of services for older people entitled ***Living well in later life (2006)***, and examined progress against the National Service Framework for Older People

The report found that services have improved since the publication of the NSF for Older People, but progress was not evident consistently across the country and improvement in some areas has been slow.

Consequently, the three bodies are strengthening and aligning their inspection regimes to drive improvements in key areas of partnership working, falls, mental health and medicines management and dignity in care. In addition, the Audit Commission's Comprehensive Performance Assessment of councils now includes a strand on older people's independence and well-being.

#### 1.2.4 ***Ensuring Participation, Inclusion and Choice***

The Social Exclusion Unit in the Office of the Deputy Prime Minister has produced a series of reports highlighting the impact of social exclusion for older people (***Breaking The Cycle 2004, Excluded Older People 2005, Opportunity Age: Meeting the challenges of ageing in the 21st century, 2005***). The Social Exclusion Unit defines social exclusion as "an experience characterised by poverty and the lack of access to social networks, activities and services that results in a poor quality of life".

The reports highlight that nationally:

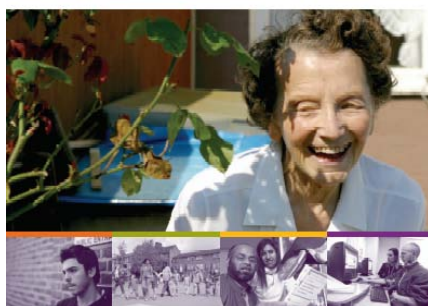
- 2.1 million people of pension age live in poverty;
- Nearly 2 million people over 65 either do not see any friends or relatives or see them less than once a week;
- 10-15 per cent of the population aged 65 and over have depression;
- Over half of over 85s have chronic ill health;
- Approximately two-thirds of people living in “non-decent” homes are 60 or over; and
- Every year, there are more than 20,000 excess winter deaths amongst older people.



### **A Sure Start to Later Life**

Ending Inequalities for Older People

A Social Exclusion Unit Final Report



***A Sure Start to Later Life: Ending Inequalities for Older People (2006)*** aims to bring together education, health and care and family support services through a single point of delivery, building on the successes identified in the Sure Start programmes operating in Children’s Services.

The programme highlights that many older people are isolated from family, friends and neighbours; and that there are a complex range of factors which increase and older persons vulnerability.

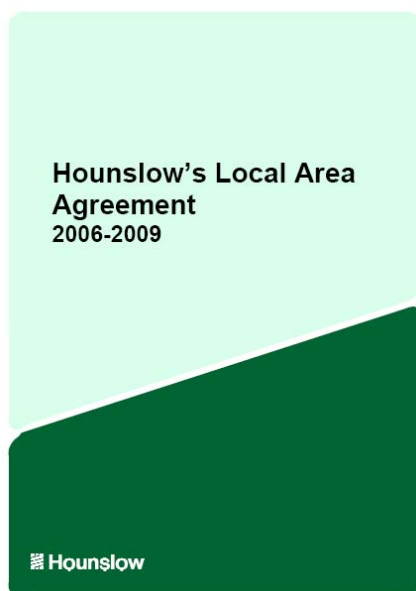
A pilot programme, Link-Age Plus is operating in eight local authorities and is currently testing out the Sure Start approach for older people. The pilot sites are being overseen by a steering group drawn from a range of central government, voluntary sector and local government organisations including the Social Exclusion Unit, Age Concern, Help the Aged, Citizens Advice, Department of Health, and the Local Government Association.

The programme involves:

- Older people being involved in the design and delivery of services;
- A range of services that are person-centred and reflect the diverse needs of individuals;
- Services that reflect the needs and aspirations of older people and anticipate changing environments;
- Accessible services;
- Services will be preventative and will go beyond health and social care to leisure and transport.

### 1.2.5 ***Developing Partnerships and Integrating Services***

A ***Local Area Agreement*** (LAA) is a three year agreement, based on local Sustainable Community Strategies, that sets out the priorities for a local area agreed between Central Government, represented by the Government Office (GO), and a local area, represented by the local authority and other key partners through Local Strategic Partnerships (LSPs).



launched from 1<sup>st</sup> April 2006. The LAA has four overarching themes: Children & Young People, Healthier Communities & Older People, Safer & Stronger Communities and Economic Development & Enterprise. Two broad outcomes concern older people, these being:

**Hounslow's Local Area Agreement** was part of the second wave nationally, and was

- To reduce winter deaths in people aged 65 and over and;
- To improve the well being and independence of people aged 65 and over

Hounslow will be entering into a new Local Area Agreement with effect from April 2008, which will have a maximum of 35 improvement targets on which our local area performance will be assessed. The new LAA will include elements related to:

- Supporting people, including children and young people, to make healthy lifestyle choices - obesity, sport and healthy schools; culture and cultural activity; and
- Supporting Older People - including physical activity, sport, culture and health and well-being

From 2008, the Government has agreed a single set of national priorities and a new national indicator set through which to measure these. The national indicator set will be the only measures on which central government will performance manage outcomes delivered by local government working alone or in partnerships. From April 2008, all other sets of indicators, including Best Value Performance Indicators and Performance Assessment Framework indicators, will be abolished. As a result, a number of the indicators, for which this strategy had developed three-year targets will not form part of statutory returns.

The national indicator set relating to Adult Health and Wellbeing is attached as Appendix B.

### 1.2.6 ***Supporting the Whole Community***

***The State of Social Care in England 2005-06*** produced by the Commission for Social Care Inspection highlights the need for councils to provide more support and advice for older people resident in the borough, who are purchasing their own care, in response to the broadening

of responsibilities of the Director of Adult Social Services. The report highlights the need for commissioning to actively work to ensure quality, and notes that councils tend to place too much focus on contract compliance and less than a third of councils use variable fees or incentive payments to incentivise providers in this regard. **This is picked up in Chapter 7.**

The report also draws attention to the need for councils to address social exclusion and promote the health and well-being of local people.

### 1.2.7 ***Achieving Outcomes by Ensuring Quality and Value***

The ***Local Government Act 1999*** introduced the duty of Best Value on local authorities.

The public sector efficiency review led by Sir Peter Gershon, ***Releasing Resources for the Frontline: Independent Review of Public Sector Efficiency (2005)*** identified over £20 billion worth of efficiency gains across all of government spending to be achieved by 2007/08. These savings were 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.

For local government, six key areas for efficiencies were highlighted. These being:

- Contact Centres;
- Procurement Best Practice;
- Improving and Increasing the use of Block Contracts;
- Better Demand Forecasting and Capacity Planning;
- Effective Home Care Monitoring by the introduction of E-monitoring of time/invoices; and
- Increased uptake of Direct Payments.

The review is, however, not unproblematic for health and social care services aimed at older people, as these tend to be labour intensive and accordingly, procurement

efficiencies (aimed mainly at increased efficiency in office costs) are unlikely to form the basis of major savings. Trimming service costs will place pressure on the direct staffing costs and will have an impact on the statutory and independent sector's ability to recruit, retain and train staff.

## 1.3 Local Priorities

### 1.3.1 The Hounslow Plan 2006-2010



The Council aspires to be a low tax authority, as it believes that government, as a whole should tax less and deliver more for people's money. The Council is committed to see a fair level of council tax with money being spent wisely on front-line essential services and not wasted on expensive overheads, inefficiency and duplication.

In the Hounslow Plan, the Council made a commitment to work closely with healthcare providers throughout the borough to ensure a cohesive service. This includes making sure that those who cannot look after themselves do not suffer from cuts in funding.

The plan contains a number of key objectives for the development of Older People's Services.

- Target 2.5(b): Develop a strategy for improving Mental Health services to older people (delivered in February 2007);
- Target 2.5(d): New Dementia unit in Chiswick is operational by April 2007 (delivered in September 2007);
- Target 2.5 (d): Develop and extend the Resource Centre approach across the Borough (underway);
- Target 2.5(g): Work with health and voluntary sector partners to promote exercise and healthy living for older people (underway).

- 1.3.2 The local framework for the development of services includes the results of the **Social Services Best Value Review of Older Peoples Services 2001**, local priorities adopted by the Hounslow Partnership Board for Older People and in the Hounslow Plan 2006-2010.
- 1.3.3 In July 2004, Social Care services for Older People in Hounslow were inspected by the Commission for Social Care Inspection (CSCI). The Commission found that “the council had made significant progress in implementing plans to improve older people’s services, which were producing better outcomes for older people. Some changes were too recent to have made an impact, but were clearly focused on continued improvement in performance. We concluded that Hounslow was serving most people well and that the capacity for improvement was promising”<sup>i</sup>.
- 1.3.4 Since the creation of Hounslow Primary Care Trust, achieving financial balance has been a major challenge. The PCT inherited serious financial deficits on its creation and fundamental changes are needed to correct this underlying problem. The bulk of the PCT budget is spent on commissioning services from other NHS Trusts, independent practitioners (GPs) or independent sector providers (both private and voluntary). Of this budget, 57% is spent on Acute Hospital activity, the majority of which is spent on older people. The increasing expenditure on commissioning over the last three years has broadly reflected the following factors:
- Increased emergency hospital activity (resulting from more walk-in patients and A&E 4-hour targets affecting admissions);
  - Increased planned hospital activity, as health needs are identified and addressed and Trusts have increased work to reduce waiting times and deliver NHS Plan targets; and
  - Increasing numbers of people with long term care needs living longer.

This has led to increased expenditure on hospital care and on long term care.

1.3.5 If Hounslow PCT are to achieve financial balance, two things need to be achieved:

- Matching annual expenditure to income in year, commissioning a reduced portfolio of services to meet local needs within the annual allocation; and
- Over the next three years find ways, recurrent and non-recurrent, to pay back debts amounting to approximately £23m (both inherited and accumulated).

1.3.6 Financial pressures are however not unique to the NHS. As set out in the Overview Strategy, expenditure on Older People forms the single largest portion of the Housing & Community Services budget (£27.7m, 43% of the departmental total). The budgets for care of older people will be expected to achieve savings over the next three years to contribute to achieving the Council wide objective of minimal increases in local Council Tax.

1.3.7 Hounslow is committed to working in partnership to ensure the safety and effective risk management of adults and children who may be at risk from abuse and/or neglect.

Hounslow aims to ensure that people who access services have a right to live a life free from abuse, neglect and discrimination.

A multi agency Safeguarding Adults procedure is in place to ensure there are appropriate procedures to address physical, sexual, psychological, financial or material and discriminatory abuse and acts of neglect or omission. All providers are expected to adhere to the principles and procedures laid out within this.

Whilst this strategy focus's on vulnerable adults the Council and Primary Care Trust expect all providers to be mindful of the risks to children and to forge appropriate links with the Councils Child Protection Team.

## OUR VISION FOR OLDER PEOPLE'S SERVICES

2.1.1 Hounslow Social Services & Health Partnerships, Hounslow Primary Care Trust, West Middlesex University Hospital and West London Mental Health Trust originally adopted a vision for older people's services in 2004, and the Hounslow Older People's Partnership Board has renewed this commitment in 2007.

2.1.2 Our vision is that, in partnership with local people, we will provide local health, care and housing services that:

- Promote social inclusion and encourage active aging to promote health and wellbeing
- Help you maintain your independence and safety
- Are of high quality and meet required standards
- Are provided in a timely and responsive way
- Promote dignity, self-respect and individuality
- Offer choice and meet your unique and individual needs
- Meet the needs of your carer, if you have one
- Are appropriate and take account of age, gender, ethnicity, religion & sexuality
- Are publicised widely and made accessible to all
- Provide opportunities for you and your carer to influence the development and delivery of services

2.1.3 We will take a shared approach to your care:

- We will actively seek and listen to your views and wishes and we will involve you in decisions.
- We will follow a single, co-ordinated approach to identifying your health and care needs and to arranging your services. With your agreement, we will share information about you to make this happen.

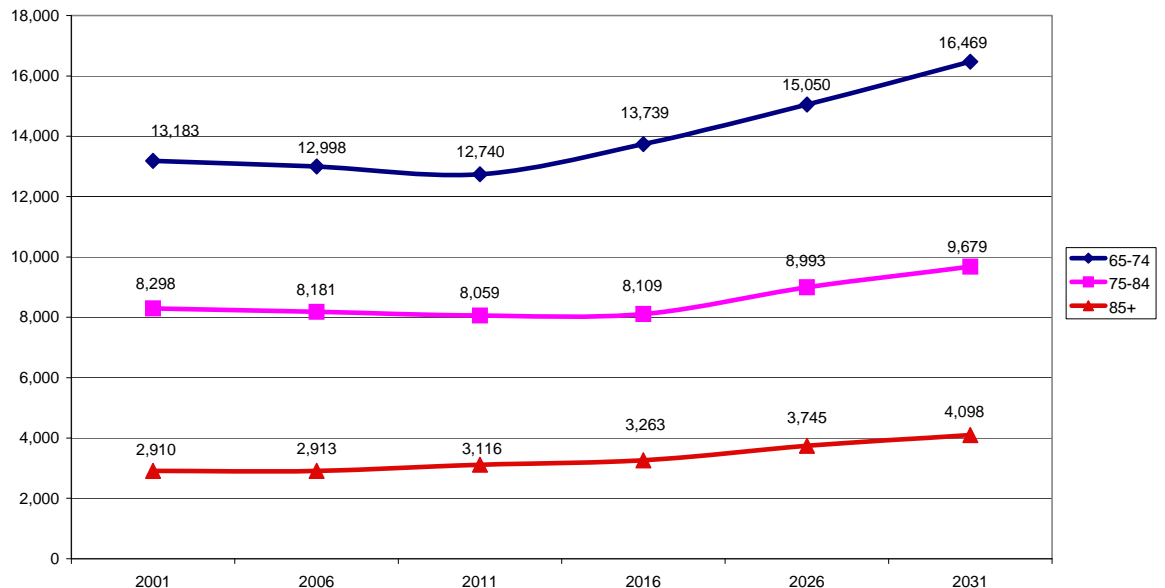
### **3. NEEDS ASSESSMENT**

#### **3.1 Demographic trends – population figures**

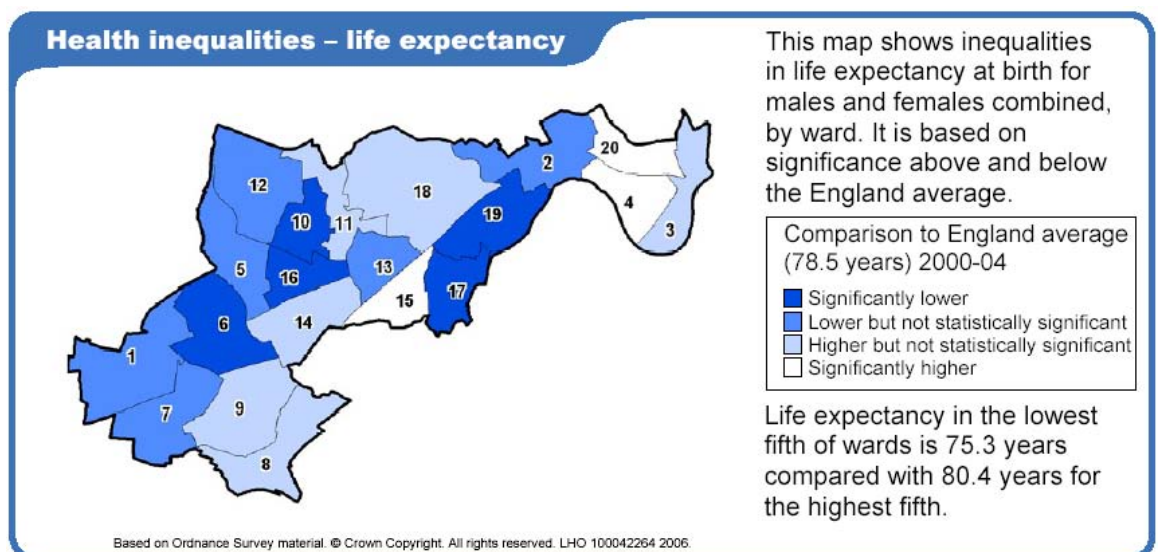
- 3.1.1 The Greater London Authority 2005 Interim Demographic Projections were published in October 2005. They project forward the mid-year 2004 population estimates to give an indication of future trends in population by age and sex for the next 25 years to 2031. Being trend-based projections, assumptions for future levels of births, deaths and migration are based on observed levels over the previous years.
- 3.1.2 The projections are produced on a consistent basis across all local authorities in England. They do not take into account any future policy changes or local development policies that have not yet occurred.
- 3.1.3 Compared to the population projections used in the Commissioning Strategy for Older People 2004/07, they suggest that there will be a less pronounced reduction in the number of older people in Hounslow and that this will reach a turning point in 2009 after which the population of older people will start to increase. By 2012/13, the numbers of older people resident in Hounslow are projected to have returned to the levels found in the 2001 Census.<sup>ii</sup>
- 3.1.4 For the older population as a whole, this represents a decrease to 2009 from 2001 of approximately 560 people or 2.2%. The decrease in population by age group shows that the 65-74 and 75-84 age groups are projected to decline at 3.7% and 2.8% respectively, whilst for over 85s the population is projected to increase by 5.9%. This increase in the oldest group in the population is in contrast to previous projections.
- 3.1.5 The rate of growth for all three age groups is projected to be fairly similar after 2009. From 2009-2031, there is a projected increase in the numbers of older people living

locally of 27% (approximately 1.2% per year over the period). By 2031, the demands placed on health and social care services by older people will have increased significantly.

Population Projections, Age Groups by total, 2001-2031 (GLA 2005 Round Demographic Projections - Scenario 8.07)



3.1.6 Life expectancy is low in Hounslow. Deaths from smoking, heart disease and stroke, and cancers are all more common than average for England. Deaths from heart disease and stroke are not falling as fast as they are nationally.<sup>iii</sup>



Life expectancy is significantly lower than the national average in five wards (Feltham North, Hounslow West, Heston Central, Isleworth and Syon).

3.1.7 The national PSA target aims for life expectancy in England overall to increase to 78.6 for men and 82.5 for women by 2010. In Hounslow male life expectancy has increased over recent years and during 2003-05, was 76.2 years, whereas female life expectancy has fluctuated and during 2003-05, was 80.2 years.

3.1.8 Local data on all age all cause mortality has been introduced into Local Area Agreements from 2007/08 to provide the incentives for effective partnership working between Primary Care Trusts and Councils.

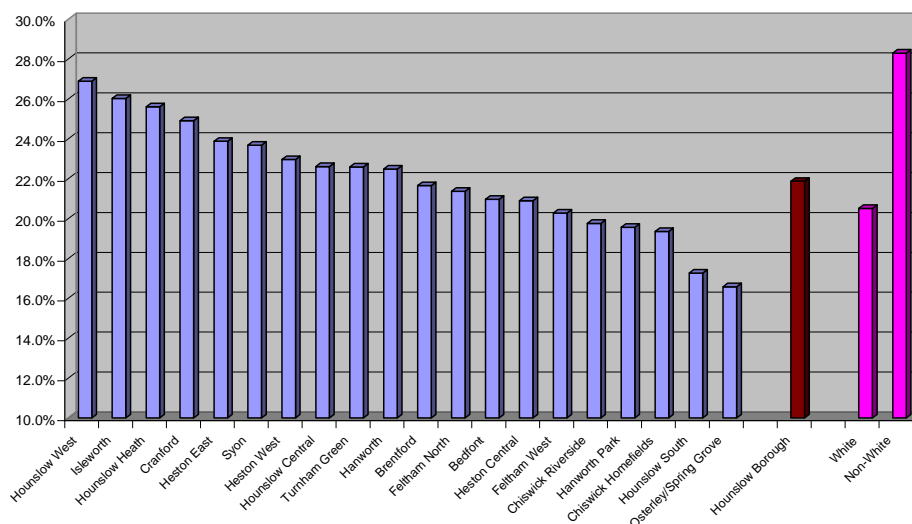
During 2003-05, male all age all cause mortality in London was 756 per 100,000, locally, male all age all cause mortality was 821. For females, all age all cause mortality in London was 520 per 100,000, compared to 582 in Hounslow.

3.1.9 The Race Relations (Amendment) Act (2001) means that from May 2002, all public bodies have a statutory duty to demonstrate that they are promoting race equality. In order to demonstrate that these duties are being fulfilled, services need to gather and analyse ethnicity-monitoring data. In 2006, the Healthcare Commission published the results of a review assessing whether trust level patient surveys provide accounts of the experience of black and minority ethnic group patients that are as accurate as the accounts they provide of the experiences of white patients, and made recommendations about how accuracy might be improved.

3.1.10 Furthermore, in 2005, the London Health Observatory found that the lowest levels of patient satisfaction were recorded amongst Asian respondents<sup>iv</sup>.

3.1.11 The health experience of different ethnic groups is not uniform. At the 2001 census, in Hounslow, older people from non-White ethnic groups were 38% more likely to report their health as 'not good' and to be affected by a limiting long-term illness than older people from white UK backgrounds.

Older People with Limiting Long-Term Illness [LLTI] reporting 'Not Good Health' in previous year by ward (2001 census)



3.1.12 Lowdell et al note that “there are some important differences between ethnic groups in terms of health-related behaviours and health status”. There are:

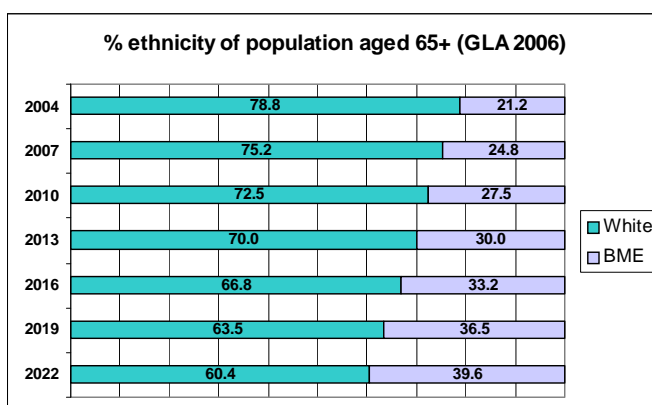
- higher admissions for diabetes amongst all minority ethnic groups;
- high admission rates for coronary heart disease in South Asian groups;
- low admissions for coronary heart disease in Black Caribbean and Black African groups;
- higher rates of stroke admissions in Black Caribbeans, Indians and Bangladeshis;
- higher admission rates for cancer in the white group;
- high admission rates for infectious disease in South Asian and Black African groups;
- higher admission rates for mental illness in Black Caribbeans and Bangladeshis<sup>v</sup>.

3.1.13 The updated population projections support the previous assumption that older people from black and minority

ethnic backgrounds will form just over a quarter of Hounslow older people by 2010<sup>vi</sup>.

65+	2007	%	2010	%
White	18115	75.2	17380	72.5
Black Caribbean	345	1.4	374	1.6
Black African	246	1.0	285	1.2
Black Other	88	0.4	107	0.4
Indian	3585	14.9	3875	16.2
Pakistani	635	2.6	721	3.0
Bangladeshi	66	0.3	72	0.3
Chinese	134	0.6	153	0.6
Other Asian	549	2.3	607	2.5
Other	314	1.3	393	1.6

The projected trend is for a further increase of about 1% annually in the proportion of older people coming from black and minority ethnic backgrounds through to 2022.



3.1.14 At the time of the 2001 census, older people from black and minority ethnic backgrounds elders made up over 40% of all older people in two wards (Hounslow Heath and Hounslow West), and over 30% in a further five wards. These wards are all located in the Heston & Cranford and Central Hounslow areas (where older people from black and minority ethnic backgrounds elders made up 35.1% and 30.8% of all older people respectively). The five wards with the lowest proportion of older people from black and minority ethnic backgrounds are all in the West area.

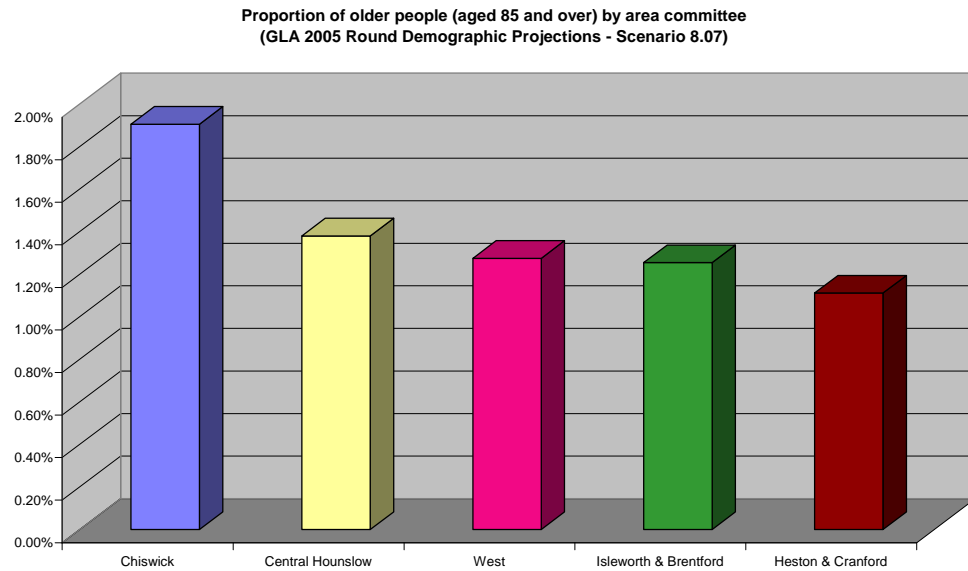
- 3.1.15 Given these demographic projections, it is very likely that older people from black and minority ethnic backgrounds now form the majority in Hounslow Heath and Hounslow West, and are likely to be reaching that point in Heston East, Heston Central and Cranford by 2010. Given the health status differences mapped out in 3.1.12, specific initiatives to tackle diabetes, coronary heart disease and stroke are likely to be best targeted in the Heston/Cranford and Central Hounslow areas.
- 3.1.16 Broader service development, however, needs to be mindful of the expressed views of Black and Minority ethnic communities. At the annual Jan Pachaan Older People's Consultation event held in early 2005, older Asian residents in Hounslow made it clear that they wished to see the development of more integrated services for all of Hounslow's older people rather than future services being specifically developed for Asian elders. The day involved consultation, training and information aimed at older users from Asian Communities.

## 3.2 Locality Focus

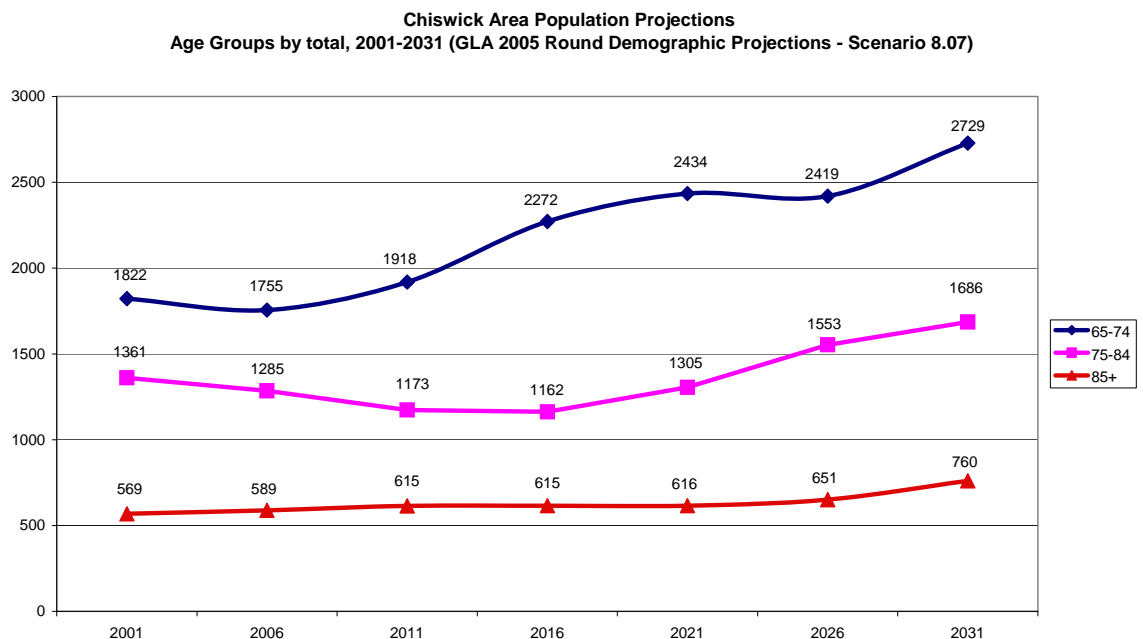
- 3.2.1 **Chiswick Area** comprises of Turnham Green, Chiswick Riverside and Chiswick Homefields wards, and is the smallest of the five areas of the borough. Chiswick has the highest proportion of older people resident in the borough (11.2% aged 65 and over, compared to the borough average of 10.8%), almost half of them living on their own (48.4% compared to the borough average of 39.7%), often without ready access to family and community networks. The older population of the Chiswick Area is made up of the lowest levels of those 65-74 in the borough, and the highest levels of those aged 85 and over.

Consultation with the local community has identified that promoting independence through equality of access to

services is a key issue for local residents. 84% of those surveyed in 2006 agreed or strongly agreed that an older people’s community was important issue for the borough and community plan.



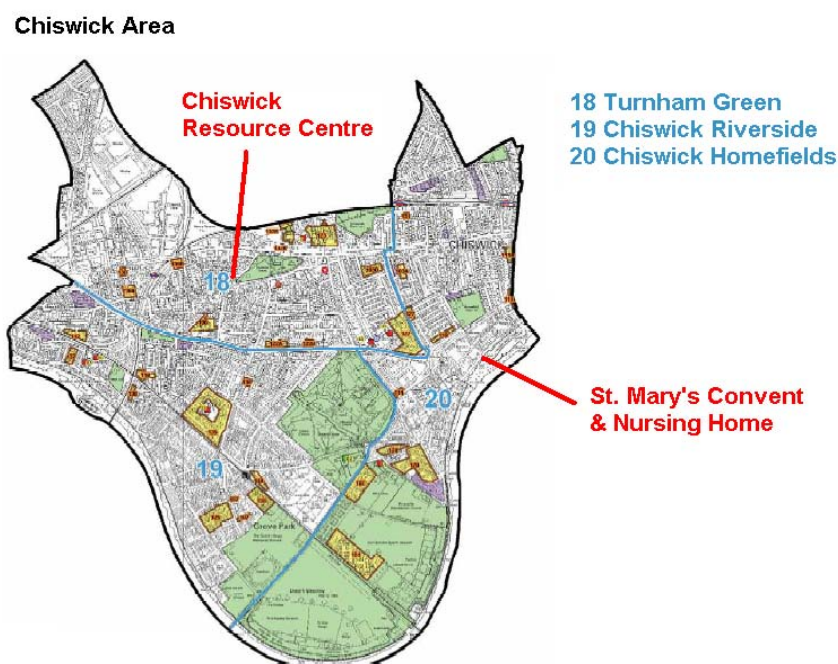
Locally, GLA population projections suggest that there will be a reduction in the numbers of older people aged 75 and over through the period covered by this strategy and beyond to 2016 after which time there is a significant increase in those aged 75 and over. Throughout the time covered by this strategy and beyond there is a marked projected increase in the 65-74 age group.



Much of the Chiswick area is affluent, with expensive housing, but there are pockets of deprivation. Pensioner Owner Occupation is lower than the borough average at 59.2% (as compared to 62.8%), and the area had the highest amount of housing without central heating in the borough at the 2001 census. Property prices are significantly higher than across the rest of the borough. For October to December 2006, the average price for all properties with W4 postcodes was £485, 478, substantially higher than the rest of the borough.<sup>vii</sup>

Life expectancy is high and premature death rates are markedly below average for the borough. Unemployment is low. The area has significantly lower than average admission to hospital rates. The three wards in Chiswick area ranked lowest for all hospital admissions in 2005/06.

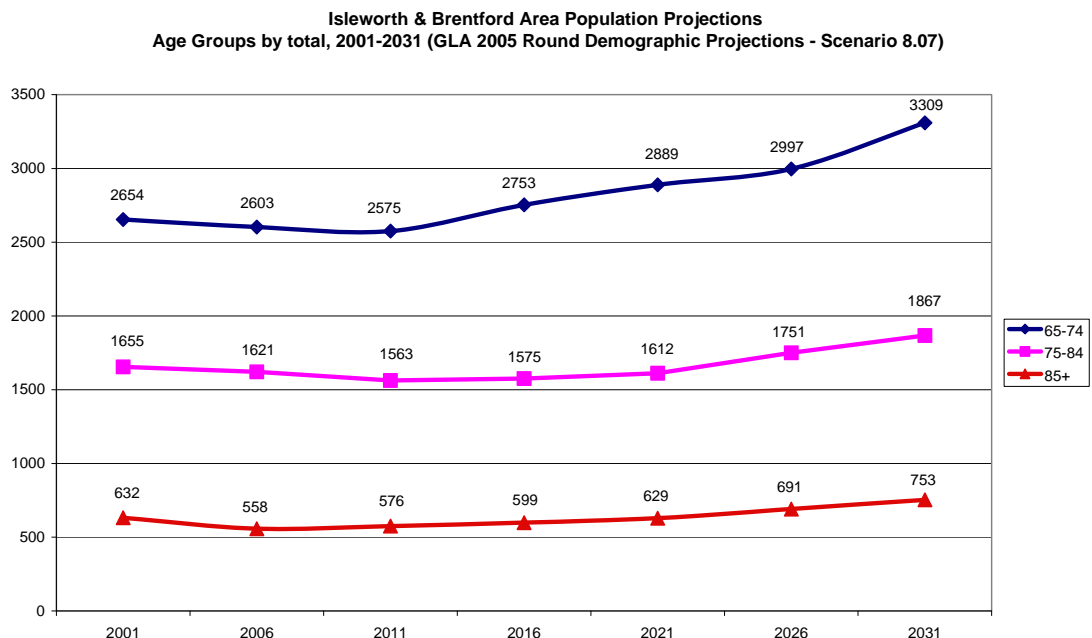
Levels of Care Home provision are slightly lower than average for the borough, at 28.9 places per 1,000 older people, compared to the borough average of 32.8. Two homes operate in the area, the Council's recently extended Clifton Gardens (as part of the Chiswick Resource Centre), and St Mary's Convent & Nursing Home.



Day Services are provided at Chiswick Day Centre, also as part of the Chiswick Resource Centre.

3.2.2 **Isleworth & Brentford Area** comprises of Osterley and Spring Grove, Isleworth, Brentford and Syon wards. It 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. The area contains the ward with the highest levels of pensioner owner occupation, Osterley & Spring Grove (89.8%), however Isleworth, Brentford and Syon wards have the lowest levels, being the only wards in the borough with less than 50% pensioner owner occupation. Property prices averaged £270,497 and £284,623 in the period October to December 2006, for TW7 and TW8 postcodes.

Premature death rates are high for cancers but about the borough average for other causes.

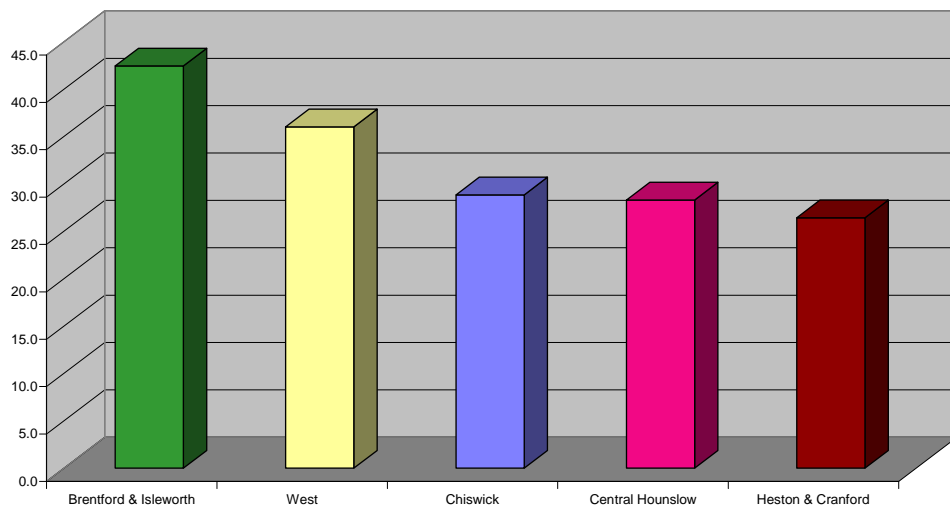


Consultation with the local community has identified that increased access to health facilities is a local priority.

Access to services is a major determinant of deprivation including people’s health and well being, and access is particularly vital for the elderly.

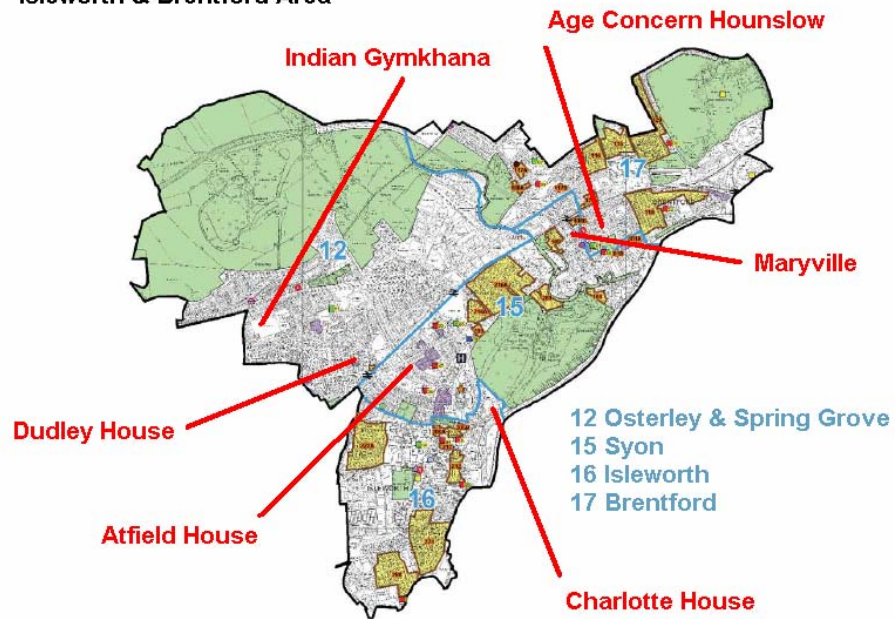
Isleworth & Brentford Area has the highest levels of Care Home provision in the borough, with 42.4 beds per 1,000 older people. Four care homes operate in the area, Maryville which is registered for both residential and nursing care, and Dudley House, Atfield House, and Charlotte House which are all care homes with nursing.

Care Home Places per 1,000 residents aged 65 and over by area committee (2007)  
 (GLA 2005 Round Demographic Projections - Scenario 8.07)



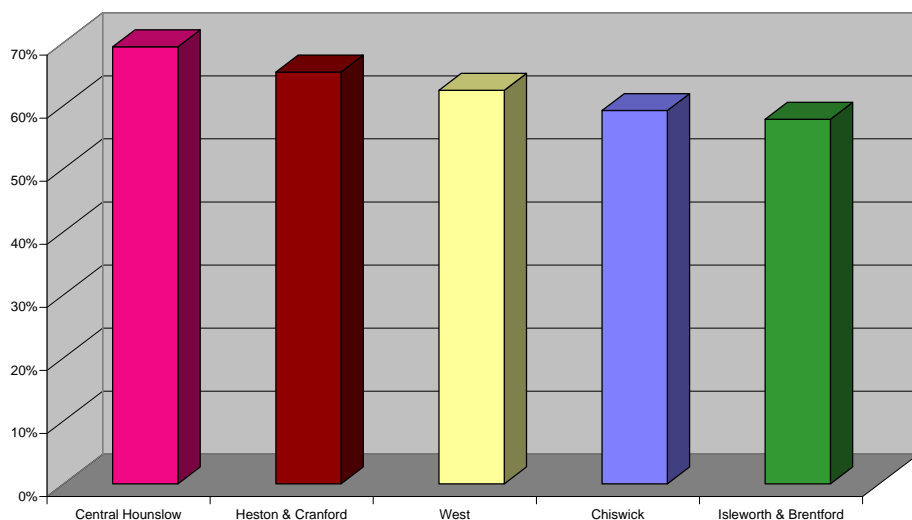
A Social Day Centre is operated by Age Concern Hounslow at Alexandra House in Brentford. Healthy Ageing sessions are run from the Indian Gymkhana at Osterley.

Isleworth & Brentford Area



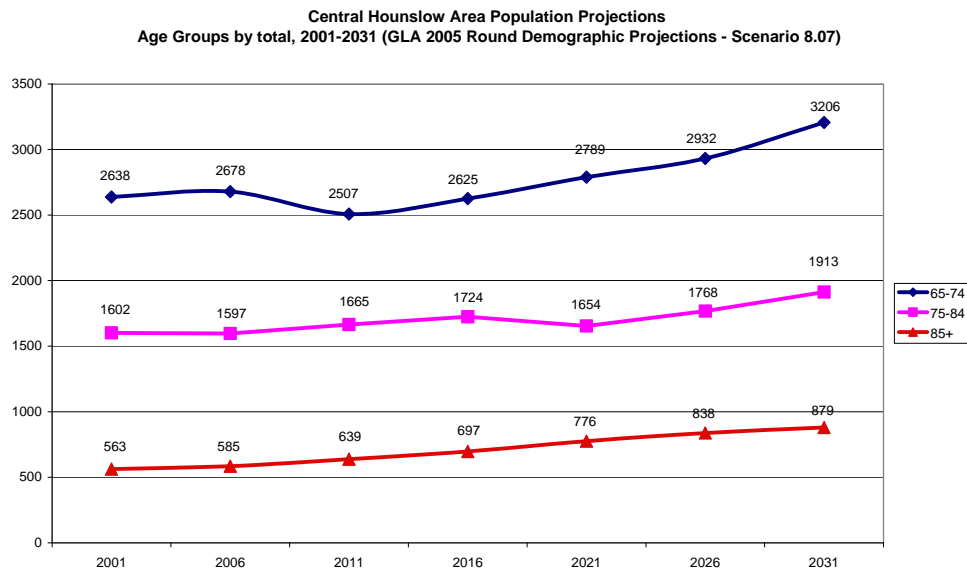
3.2.3 **Central Hounslow Area** comprises of Hounslow Heath, Hounslow West, Hounslow Central and Hounslow South wards. It is characterised by predominantly owner-occupied housing, of varying age and quality, with the highest levels of pensioner owner occupation in the borough (69.3%). Average property prices for the period October to December 2006 were £234,324 and £214,820 for TW3 and TW4 postcodes.

Pensioner Owner Occupation, by Area (Census 2001)



There is a large Asian population in the area - in 2001, the proportion of older people from BME backgrounds was 30.8%, and the area contained the two wards with

the highest proportions in Hounslow Heath and Hounslow West, where over 40% of older people were from BME ethnicities.



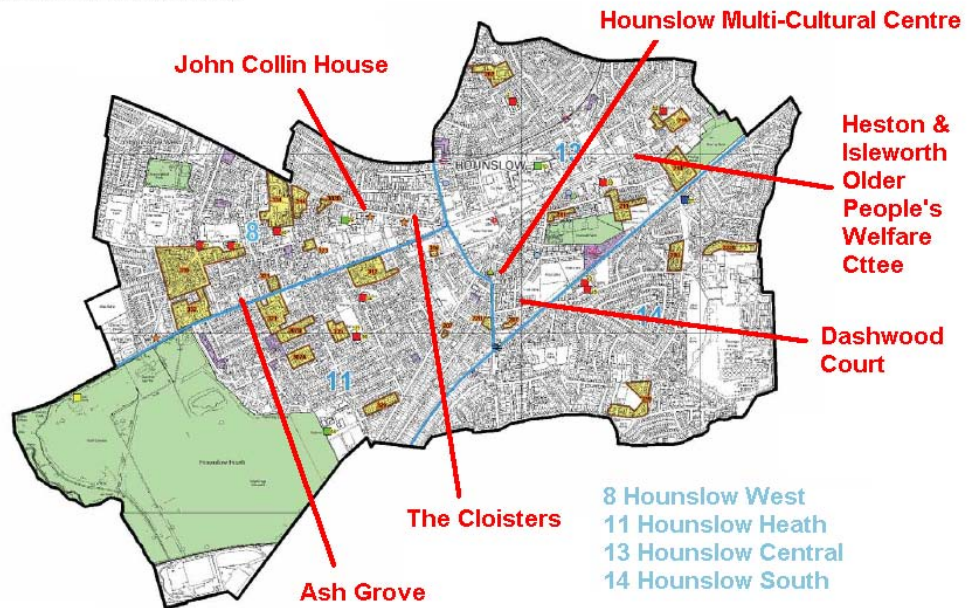
Life expectancy for both men and women varies by as much as 7 years between wards. Premature deaths from respiratory disease, coronary heart disease and stroke are all higher than borough averages.

There are three care homes in the area, John Collin House is registered for residential care, and The Cloisters and Ash Grove, which provide nursing care.

The borough’s first extra care unit is located in the area at Dashwood Court, providing 38 flats including two assessment flats.

There is lunch-club provision at Hounslow Multi-Cultural Centre and Heston & Isleworth Older People’s Welfare Committee.

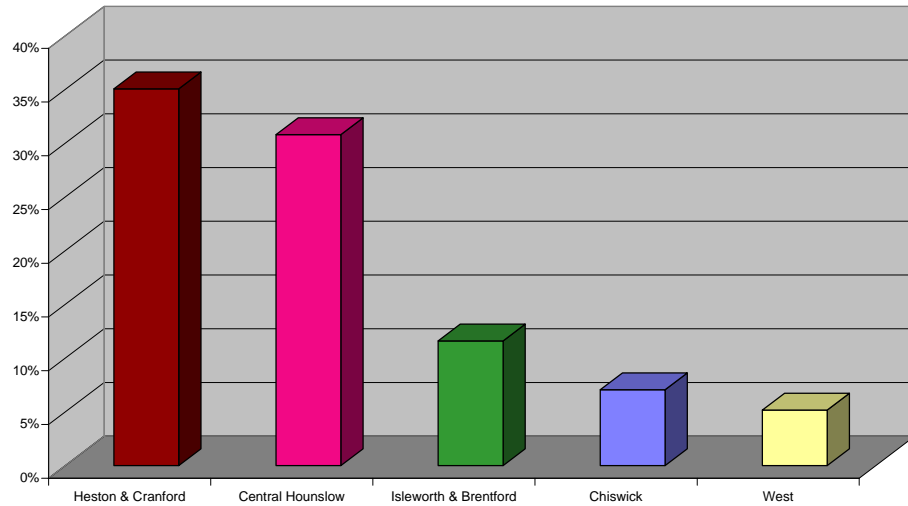
## Central Hounslow Area



3.2.4 **Heston & Cranford Area** comprises of Heston Central, Heston East, Heston West & Cranford wards. The area consists of mostly semi-detached houses, with pockets of poor housing and low incomes. Pensioner owner occupation is high (65.3%). Average property prices for the period October to December 2006 were £242,173 for TW5 postcodes.

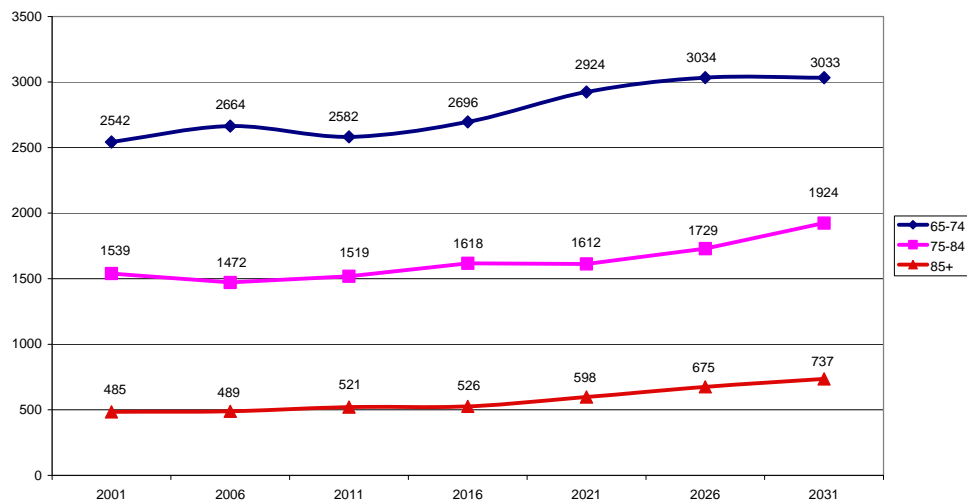
Amongst older people, BME communities made up 35.1% of the population at the 2001 census. The majority of older people from BME communities are Asian, and there is a substantially increasing older Somali population. The area has variations in life expectancy. Premature deaths from stroke are the highest in the borough.

Older People from Black and Minority Ethnic backgrounds as a proportion of all older people, by Area (Census 2001)



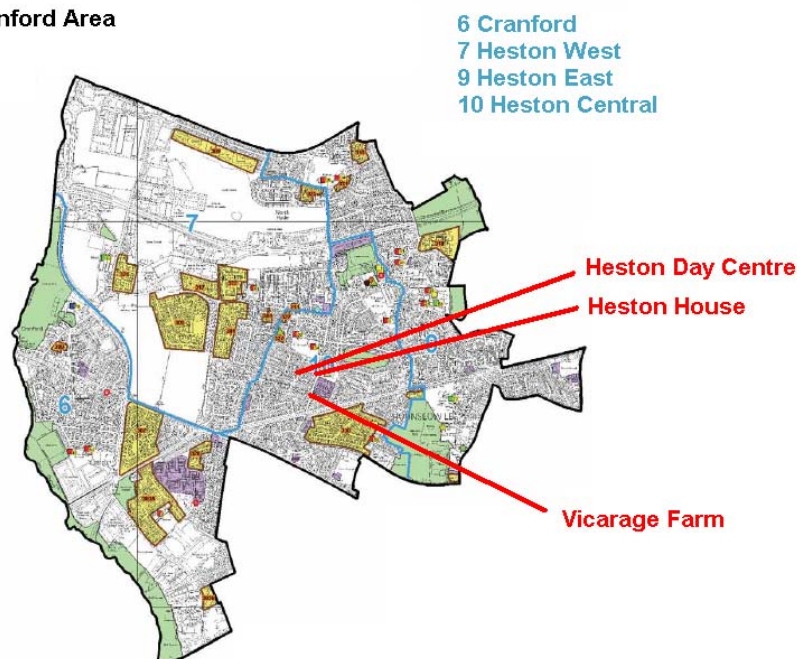
Locally, priority areas are improving the health of the area, in particular addressing the high rates of cancer, Coronary Heart Disease and strokes within the area, and improving access to services. 40% of respondents to a 2006 resident’s panel survey said accessing local services was a serious problem.

Heston & Cranford Area Population Projections  
Age Groups by total, 2001-2031 (GLA 2005 Round Demographic Projections - Scenario 8.07)



There are two care homes in the area, Heston House which provides residential care, and Vicarage Farm, which is a nursing home.

## Heston &amp; Cranford Area

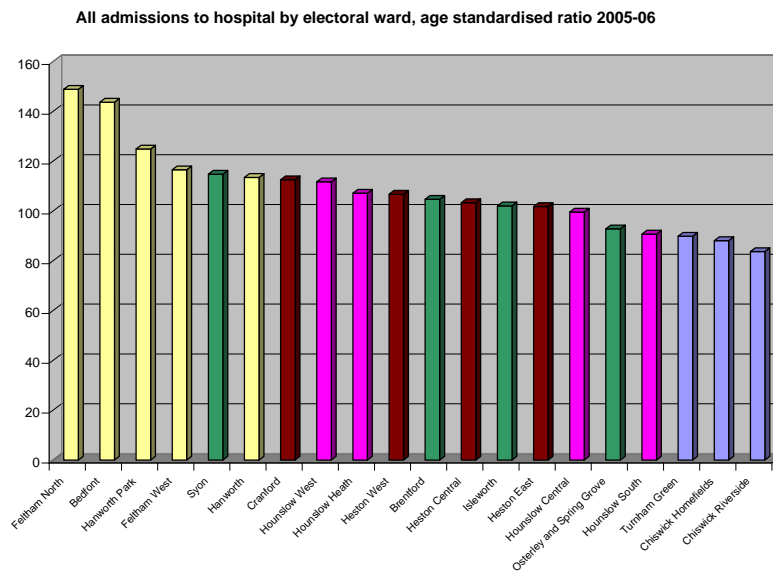


3.2.5 **West Area** comprises of Bedfont, Feltham North, Feltham West, Hanworth and Hanworth Park wards. The West area is one of the largest geographically.

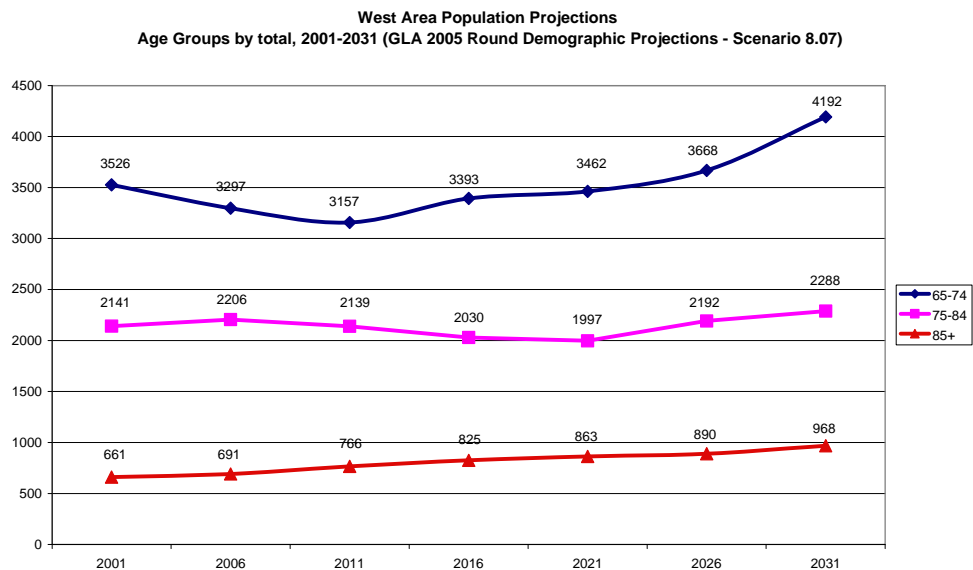
Parts of the locality are significantly deprived. Average property prices are the lowest in the borough, £193,545 and £187,502 for the period October and December 2006 for TW13 and TW14 postcodes.

Premature death rates are generally about or a little above average for the borough, but high for cancers. 84% of those surveyed in 2006 agreed or strongly agreed that an older people's community was important issue for the borough and community plan.

West area has the highest admissions to hospital, with Feltham North having the highest Standardised Age Ratio for admissions in London for 2005/06 (a ward-level ratio is a measure of how more or less likely a person living in that ward is to have a hospital admission compared to the standard population of England).

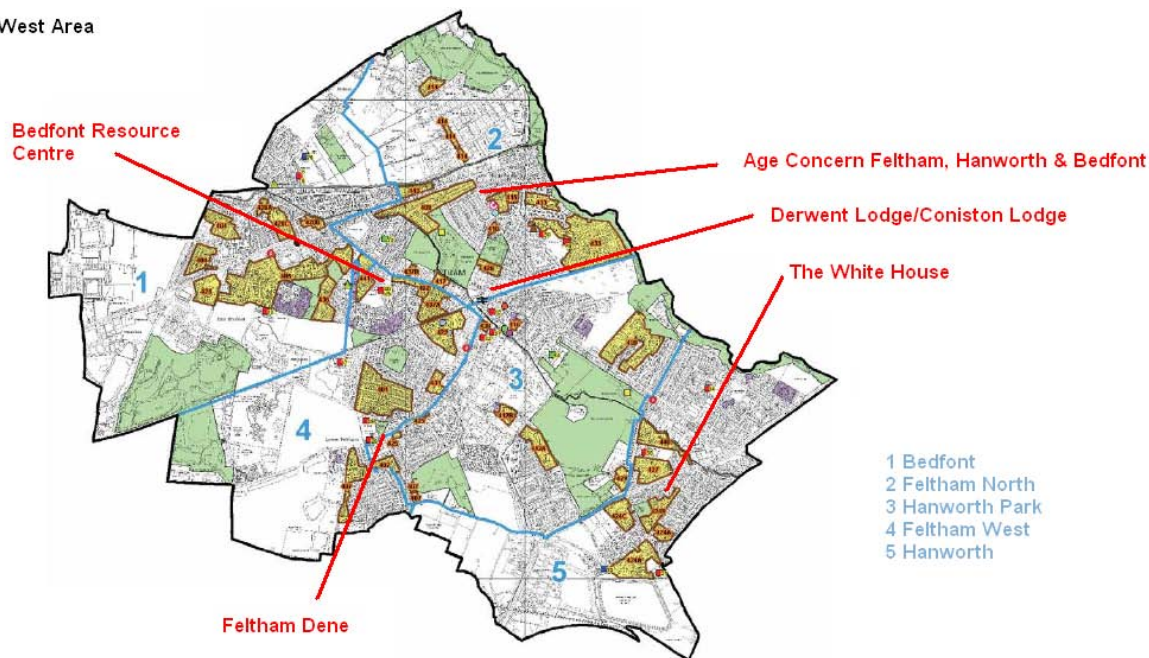


There are two nursing homes in the west area, Coniston and Derwent Lodge, with residential care provided at Bedfont Resource Centre (in the Sandbanks Care Home), Feltham Dene and The White House.



Age Concern Feltham, Hanworth & Bedfont are commissioned to provide Social Day Care.

West Area



### 3.3 Dementia Profiling

3.3.1 The level of mental health problems in older people of people is high, increasingly so as people age. Research suggests that depression may affect between 10-15% of people aged 65 and older living at home and approximately 40% of older people who live in care homes, although the incidence of more severe forms of clinical depression are thought to be substantially lower<sup>viii</sup>. The risk of depression is doubled for older people with ill health and disability<sup>ix</sup>. Dementia affects 6% of older people, with marked increases in prevalence in people aged 85 and over.

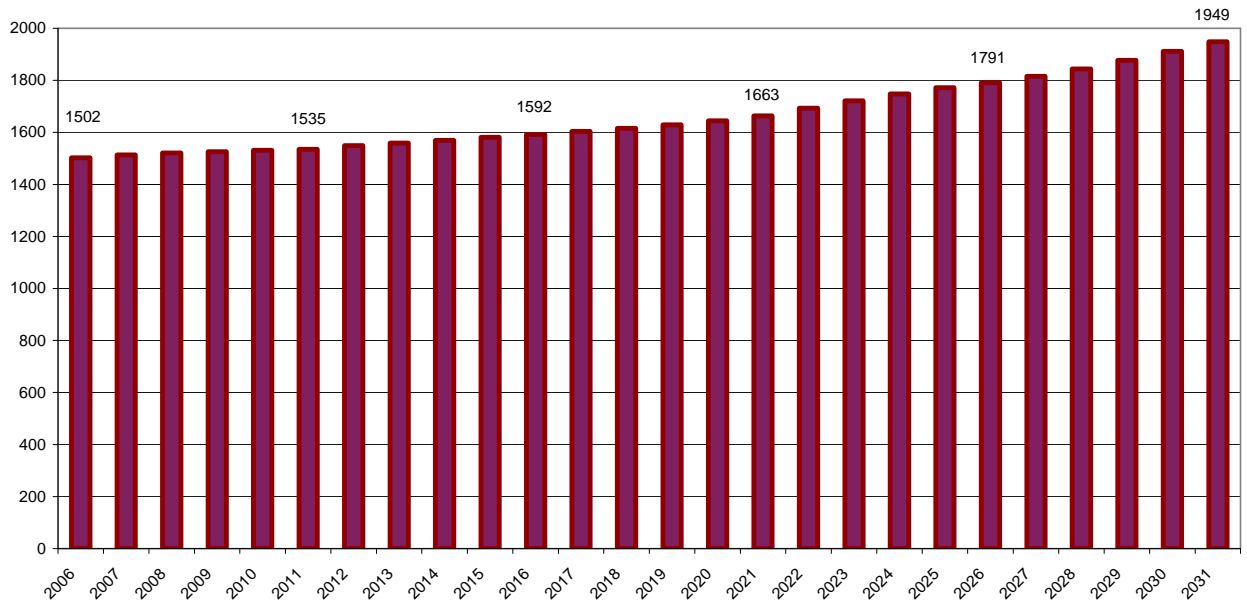
3.3.2 In the ONS psychiatric morbidity survey of adults quoted in 4.2.5 above<sup>x</sup>, the lowest prevalence rates for any common mental health problem were among those aged 65-to-69 (10.2%) and 70-to-74 (9.4%), compared with 16.4% for all ages). This was most noticeable amongst men aged 65-to-74 (5.7% compared with 13.5% for all ages). Overall, 10% of the sample of people aged 65-to-74 years were thought to have a common mental health problem which equates to approximately 1,300 people aged 65-to-74 living in Hounslow in 2006.

- 3.3.3 Using the model for predicting the prevalence of dementia in local areas developed by the Audit Commission for ***Forget Me Not***, the changes in population projections suggest that there is likely to be a consequent increase in the numbers of older people living with dementia in Hounslow. This model suggests that the prevalence of dementia is approximately 23% in the over 85-year-old group, 7% in the 75-84 year old group and 2% amongst the 65-74 year old group.<sup>xi</sup>
- 3.3.4 This would suggest that given the latest Hounslow population projections, the local prevalence for Dementia amongst older people in the borough should increase slightly over the next five years. Thereafter, there is likely to be an increased rate of change, averaging just over 1% a year, until 2021, when the rate increases in line with the significant changes in population projection.

<b>Year</b>	<b>Projected Numbers of Older People with Dementia</b>	<b>5 Yearly Change</b>	<b>5 Yearly Change %</b>
<b>2006</b>	<b>1502</b>		
<b>2011</b>	<b>1535</b>	<b>33</b>	<b>+2.2%</b>
<b>2016</b>	<b>1592</b>	<b>57</b>	<b>+3.7%</b>
<b>2021</b>	<b>1663</b>	<b>71</b>	<b>+4.5%</b>
<b>2026</b>	<b>1791</b>	<b>128</b>	<b>+7.7%</b>
<b>2031</b>	<b>1949</b>	<b>158</b>	<b>+8.8%</b>

- 3.3.5 The Older People's Mental Health Strategy 2006-2010 spells out how this increase in population is to be handled in the next three years. The relatively low rates of increase in the next three years (equivalent to between 6 and 7 people living with the experience of dementia each year) will be managed by expanding our capacity to manage people in the community. The rate of increase does not become a major issue until the latter part of the next decade. A careful watch will need to be kept on services to ensure sufficient capacity as we reach that point.

Projected Numbers of Older People Living With Dementia (2006-2031)  
(GLA 2005 Round Demographic Projections - Scenario 8.07)



### 3.4 Conclusions

3.4.1 The change in demographic projections means that it now appears likely that there will be a increase in demand for long-term care services in the future, and that this will pick up speed in the latter part of the next decade. Current commissioning patterns need to be sensitive to these changes and plans made with a view on ensuring that the short and medium-term plans do not constrain the likely service delivery needs of older people in the long-term.

## 4. THE PATTERN OF SERVICES

### 4.1 Programme 1: Dignity in Care

#### **National Aims:**

We will strengthen activities in the following areas:

- Nutrition
- The physical environment
- Skills, competence and leadership in the workforce
- Assuring quality
- Equalities and human rights
- Championing Change

4.1.1 Programme 1 of *A New Ambition for Old Age* renews the commitment made in the NSFOP to ensuring respect for the dignity and human rights of older people will be central to the delivery of care in all care settings.

4.1.2 Locally, Hounslow PCT has approved a Patient Experience and Quality Strategy, which will also enable the PCT to provide evidence that key quality standards are being achieved by commissioned and provided services and that feedback is acted upon. All provided and commissioned services will be required to demonstrate that they have effective mechanisms to engage with their users. The Key Quality Indicators for Joint Commissioning are appended to this strategy.

#### 4.1.3 **Nutrition**

The national aim to ensure that older people receive the assistance they require with eating and drinking. Within the population as a whole malnutrition affects less than 5%. However amongst hospital inpatients and those in care homes, as many as 40% could be suffering from malnutrition. More than 10% of over 65's in the general population are at medium or high risk of malnutrition and this figure rises to as much as 60% amongst those in hospital<sup>xii</sup>.

The Council currently commissions meals services in a variety of ways. These are delivered as lunch clubs, as part of social day care and as meals delivered to older people in their own homes.

In 2005, the Local Strategic Partnership endorsed **Seniors Matter – A Preventative Strategy for Older People in Hounslow**. This included a three tier model for social day opportunities including a tier focusing on lunchtime provision developing opportunities for healthy eating and social interaction.

Lunch club provision currently operates only in the centre of the borough provided by Heston and Isleworth Older Peoples Welfare Committee and Hounslow Multi-Cultural centre. Seniors Matter foresaw that “the further development of this level of provision would be well linked to the development of Extra-Care Housing Units and provide a community focus to the development of that service”. To this end, lunch club provision has been included in the specification for the development of the new Extra Care Unit, Greenrod Place in Brentford scheduled to open in January 2008.

The London Borough of Hounslow has recently sought expressions of interest from companies wishing to bid for the provision of a home meals service for delivery to vulnerable adults. The contract is for a complete meal service of hot meals and some frozen meals to be delivered within the London Borough of Hounslow, to vulnerable adults who meet the Council's qualification criteria for this service. The contract will be for a period of 3 years with options to extend for one year.

In March 2007, Hounslow PCT adopted a Patient Experience and Quality Strategy, which requires service providers to take active measurable steps to improve the quality of services and to improve the patient experience. The strategy states that “good care depends on getting the basics right: good food which takes into account

patients religious and cultural needs, care provided in clean and pleasant environments, patients feeling welcome and confident. A quality care environment and appropriate support is not a luxury – it is a fundamental part of good care and needs to be underpinned with appropriate standards”<sup>xiii</sup>.

West Middlesex University Hospital has introduced the ‘Red Tray’ project, which helps nurses to identify and support patients at risk of malnutrition. Under the scheme, nurses assess patients according to their weight, appetite, and ability to eat, stress factors and the existence of pressure ulcers or wounds. Those who are already malnourished upon admission or who may become so as a result of their treatment will be considered ‘at risk’ and have their meals served on a red tray.

We propose to:

- Review existing arrangements for lunch club provision, ensuring that they deliver Best Value; and
- Ensure that all contracted services ensure that older people receive excellent fundamental care including good food and necessary fluids with particular regard paid to supporting patients who are not able to feed themselves

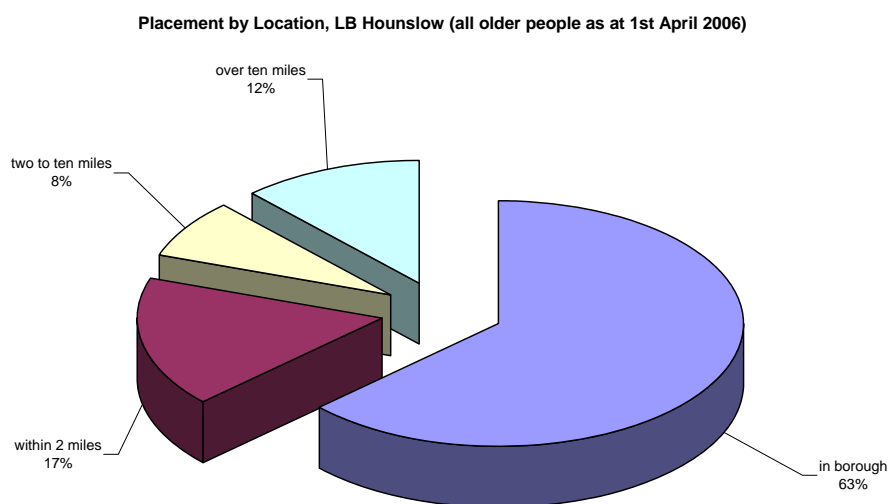
#### 4.1.4 ***The Physical Environment***

The national aim is to continue to improve the environment in hospital and care homes, ensuring that the environment of care more closely meets the needs of older people.

Locally, care home stock is generally good in terms of key indicators of availability of single rooms and access to en-suite facilities. Within the Hounslow area, as at April 2007, 95% of residents are in single bedded rooms and 63% of bedrooms have en-suite facilities. These figures are substantially in excess of the national average of 71% and 46% respectively.

The Council and PCT believe that there is no case for an expansion in local care home provision. Any new development would have associated direct costs for both the Council and the PCT, without substantial local benefit.

The majority of placements for older people supported by the Council, are made within the borough. (63% as at 1<sup>st</sup> April 2007) However, this figure requires careful understanding. A further 95 older people (17%) are placed within two miles of the borough's boundaries, and in total 88% are placed within ten miles. It is our assessment that this proportion is entirely appropriate and reflects the fact that older people do not perceive 'local' as necessarily meaning within borough boundaries, largely due to the shape of the borough. For an older person in Brentford, placement in Hanwell will feel far more local than one in Bedfont, despite the former being just outside the borough. Of the 65 placements that are supported over ten miles from the borough, the primary reasons are a decision to be placed close to family and/or the need for specialist provision (for example, specialist homes dealing with functional mental illness).



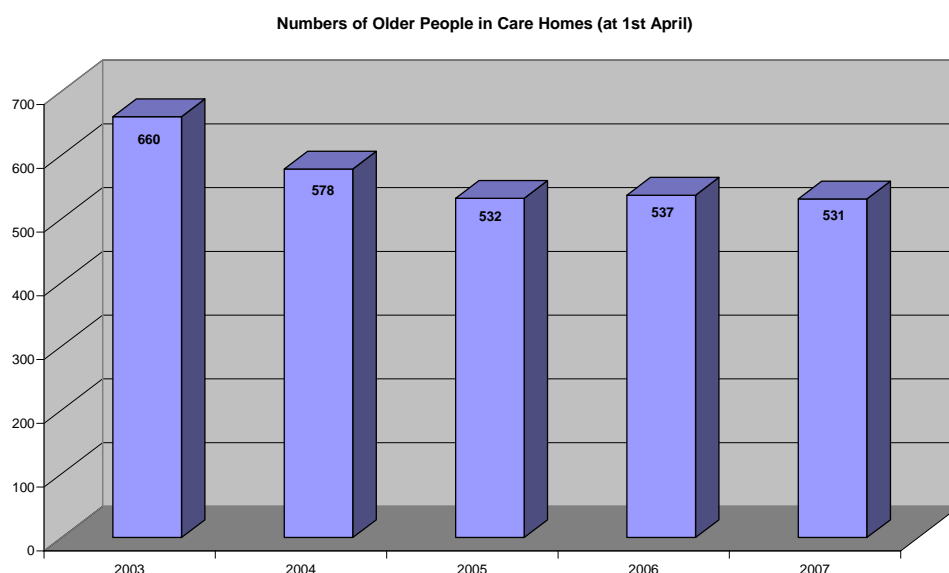
There is also substantial two-way traffic in terms of placement. The PCT's database of Nursing Home placements shows that more of the borough's stock is

occupied by Council supported residents from other boroughs (186 people), than from Hounslow (159). The net impact of this migration is neutral, with approximately 200 Council supported residents placed externally by Hounslow, and placed into the borough by other Councils.

### **Demand for Residential and Nursing Care**

The demand for residential and nursing care in Hounslow was initially evaluated for the Commissioning Strategy for Older People 2004/07, and this has subsequently been further reviewed following the publication of new population projections (as set out in chapter 3).

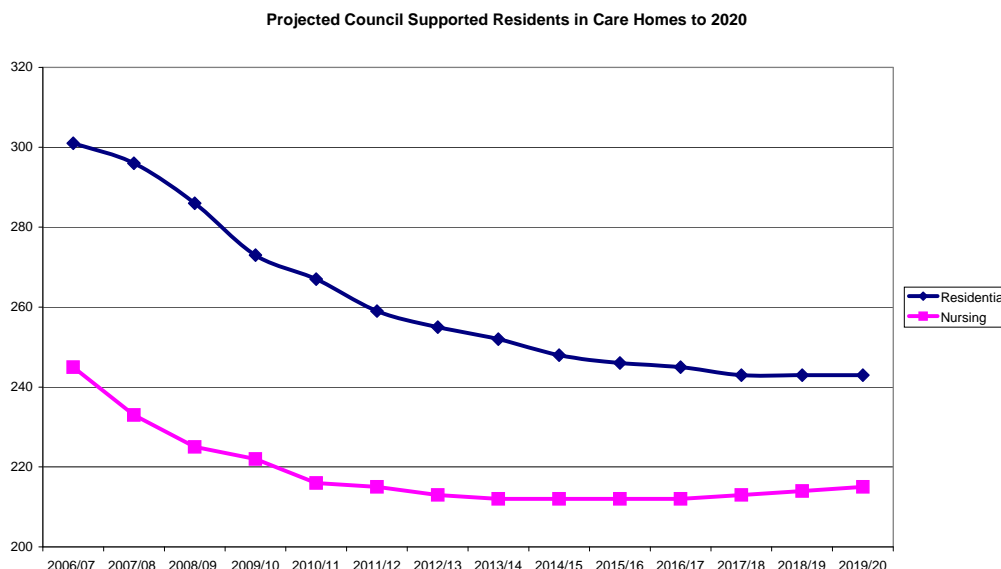
As at 31st August 2007, the Council supported 298 residential care beds (191 permanent places either on block contracts or directly provided, with 107 spot placements), and 224 nursing care beds (95 permanent places on block contracts and 129 spot placements). There has been a 9.7% reduction in Council supported placements from 1st April 2004 to 31st August 2007, reducing from 578 to 522.



Ongoing demand has been estimated using the following assumptions:

- Overall demand for new Residential and Nursing placements will continue to reduce by 4% per annum. This has been reflected in the Hounslow Local Area Agreement as one of the stretch targets, with Council supported admissions of people aged 65 and over to residential care (PAF C26) reducing from 171 in 2005/06, to 152 in 2008/09. It is assumed that new placement activity will reduce more gradually thereafter (1% per annum). This echoes predictions by market analysts, Laing and Buisson, whose market projections assume that there will be a 15% reduction in council activity over the next five years.
- Attrition rates will continue at 25% of the annual level of existing and new placements.
- In the short-term, there will be reduced demand for nursing care, as residential care options for older people with dementia expand. Thereafter, numbers of older people entering nursing care are likely to stabilise.
- Over the longer term, some of the current demand for long term residential care is likely to be reduced as the impact of an increase in rehabilitation and intermediate care provision, Extra Care Housing and the provision of increased amounts of intensive home care is felt.

The chart below demonstrates the number of places projected as required in residential and nursing care through to 2020. The shows that the number of places required in each sector would largely stabilise by 2010, with any increases based thereafter only on an aging population.



At August 2007, there were 258 permanent residential care places in Hounslow (of which 195 are in either Hounslow Social Services homes, or block contracted to the Department, the remaining 63 were in the independent sector). The independent sector provision has a number of entry criteria that affect its usability, e.g. Maryville Care Home includes specialist provision for older people with a learning disability. The Council currently purchases 10 places in the independent sector in Hounslow and the projections assume this will remain constant.

It is clear that, with regard to residential places, continued availability is likely to be reliant on Social Services either acting as provider or contractor.

It is calculated that 10 intermediate care places, 5 respite beds and 148 permanent beds will be needed as part of the overall long-term plan for residential care in Hounslow. This means that a total of 163 care home places will be required, compared to the 194 currently provided across Clifton Gardens, Heston House, John Collin House, Feltham Dene and Sandbanks. This can be delivered by an expanded Clifton Gardens, and building two new resource centres delivering 120 beds.

## **Older People's Resource Centres**

The Older People Best Value Review in 2001 recommended the creation of three resource centres. The vision for the centres is a 'one stop shop' integrated service for older adults with care needs – both residential, and a local centre for community based support, open 7 days a week, 24 hours. This includes: day support, extra care housing, residential care, home care, and therapies.

The three centres were designed to serve the three major populations in the west, centre and east of the borough. The starting assumption was that the new service design should be self financing – with capital from all the current sites being used to develop 'state of the art' integrated facilities on fewer sites. The assumption regarding revenue was that the new service design should be cost neutral. There are five existing residential care homes in the localities, and these formed the natural starting point for possible developments. These are Clifton Gardens in Chiswick; Heston House in Heston; John Collin House in Hounslow; Feltham Dene in Feltham; and Sandbanks in Bedfont. Whilst the immediate need to upgrade care homes to meet national minimum standards was relaxed in 2003, the 'life' of such units cannot be extended indefinitely, and a plan to ensure fully modernised units still needs to be resourced.

The model in the east of the borough has already been achieved without a complete new build. Capital from the Primary Care Trust and the Strategic Health Authority has funded a new Dementia Unit at Clifton Gardens, which opened in September 2007. With the close proximity of Day Care facilities, a 'virtual' centre will be realised.

In the centre and west of the borough, the new Resource Centre would re-provide a range of bed-based services and community day services in purpose designed buildings. The current buildings were opened between 1963 and 1970, and are nearing the end of their viable

lifecycles. The provision of high quality physical environments will play an important part in the continued wellbeing of residents.

In February 2007, the Council's Executive approved a plan to modernise this stock. Assuming no other changes, this will maintain the figure around single-bedded rooms and improve the availability of en-suite facilities to over 80%. Performance against the PAF indicator D37 shows significant improvement following the establishment of the older people's placement service. In the last two years, the borough has achieved the highest banding for this indicator, and the target for the next three years is to maintain this.

<b>PAF D37 – AVAILABILITY OF SINGLE ROOMS</b>		
Description (the percentage of single adults and older people going into permanent residential and nursing care that were allocated single rooms)		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>Target</b> 98.00 ●●●●●	<b>Target</b> 98.00 ●●●●●	<b>Target</b> 99.00 ●●●●●
<b>Performance</b> 89.90 ●●● <i>Not Achieved</i>	<b>Performance</b> 98.50 ●●●●● <i>Achieved</i>	<b>Performance</b> 98.31 ●●●●● <i>Achieved</i>

<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> 98.00 ●●●●●	<b>Target</b> 98.00 ●●●●●	<b>Target</b> 98.00 ●●●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

#### 4.1.5

#### ***Skills, competence and leadership in the workforce***

The national aim is improving skills and competencies across the workforce and developing identifiable or named practice based leaders in nursing, which will be

accountable for ensuring older people are treated with respect for their dignity.

Workforce planning is covered in detail for all care groups in the Overview Strategy.

The Hounslow Plan 2006-2010 states that the council will deliver less itself directly but act as co-ordinator and enabler of a range of local public services. The future council will employ fewer people, but those who are will be better skilled. Over the four years of the plan, the Council will review human resources and change the way they operate to free up resources to fund service improvements. Hounslow Council will be more efficient. This is needed not just to save on cost but to transform the way the Council deals with the public.

#### 4.1.6 ***Assuring quality***

The national aim is that commissioners and providers will work closely with the inspectorates and regulators to ensure the issue of dignity is central to their work, so that breaches of dignity are regarded as serious failures.

The Older People's Panel was established in April 2004 as a forum to ensure that older people in Hounslow have fair access to health and social care funded services, to identify and tackle any areas of age discrimination and to monitor the quality and responsiveness of services available.

The panel consists of thirteen older people appointed via the Hounslow Older People's Volunteer Project (administered by the Council on behalf of the local statutory agencies), as well as representatives from community groups belonging to the Finding A Voice network and carers and carers' representatives. Membership also includes the Older People's Champions from Hounslow PCT, West Middlesex University Hospital and Hounslow Council (these are non-executive board

members from the NHS organisations and the Lead Executive Member for Health and Adult Social Care for the Council).

Lead directors and officers from Health and Social Care are present at panel meetings to ensure actions are appropriately taken back to their organisations.

In the last two years, the Older People's Panel has reviewed:

- Community Equipment;
- Home Care
- Day Services and Respite Care;
- Podiatry;
- Wheelchairs;
- Nursing Homes;
- District Nursing;
- Continence Services;
- Twilight Nursing;
- Continuing Care;
- Assistive Technology;
- Sensory Impairment Services;
- Discharge Planning;
- Community Matrons; and
- Stroke Services

The action plans from these discussions have heavily informed the development of this Older People's Commissioning Strategy. In 2005, Hounslow Housing & Community Services created a Placements Service with a central remit for purchasing care home places. This service carries out regular quality assurance checks with all local care home providers.

For domiciliary care, Hounslow Housing & Community Services has expanded the central contracts monitoring team to allow for a rolling programme of home visits to older people in receipt of care that aims to gather

quantitative and qualitative information regarding older people's experience of receiving care at home.

In addition, Hounslow Housing & Community Services has introduced electronic call monitoring as a part of the letting of new contracts in 2006. This was designed to address a major concerns regularly expressed in these face to face interviews, notably those of carers arriving late and not staying for the amount of time booked.

Surveys have been undertaken by the Contracts Team to assess the reaction and satisfaction to electronic call monitoring among domiciliary care users.

In June/July 2007, 92% of domiciliary care users surveyed stated that they preferred electronic call monitoring because it released them from the responsibility of checking times, challenging their care workers and having to certify attendance. Overall the domiciliary care users surveyed felt thought the service had either improved following introduction of electronic call monitoring or had at least stayed the same. No one surveyed expressed the view that the service they received had got worse,

Hounslow Housing & Community Services has also introduced a quality threshold for the Domiciliary Care Approved List based on the inspection reports received by local providers. Failure to meet an acceptable level will mean that an organisation is not considered for the Approved List until such time as validated action is taken to address the identified shortcomings.

We propose to:

- Report on new CSCI inspection reports quarterly to the Hounslow Older People's Panel, including summarising the actions required by providers to meet standards; and
- Maintain regular formal monitoring of care home and domiciliary care providers.

#### 4.1.7 ***Championing change***

The Council has organised a series of provider forums, covering the voluntary sector, domiciliary care providers and residential and nursing homes. These forums are intended to be provider-led and work to address issues of common interest and drive up quality across the borough.

Hounslow Housing & Community Services has also created the post of Independent Living Training Co-ordinator in order to facilitate access to training and education opportunities for private and voluntary sector partners.

## 4.2 Programme 2: Dignity at the end of life

### National Aims:

- To adapt and spread the three best practice models, as appropriate, for end of life care of older people living at home or in hospital.
- To facilitate best practice in commissioning, delivery and education in end of life care in care homes.

4.2.1 Inevitably, the end of 'the end of life' is death. It is far more problematic to define the beginning and this can vary according to individual and professional perspectives. The end of life does not normally begin earlier than one year before death and for most individuals it may come much later than that. However, in some cases discussions with individuals about end of life may start much earlier (e.g. at the point of recognition of incurability). In some cases it may be the patient who first recognises its beginning. In other cases the principal factor may be the judgement of the team responsible for the care of the patient.

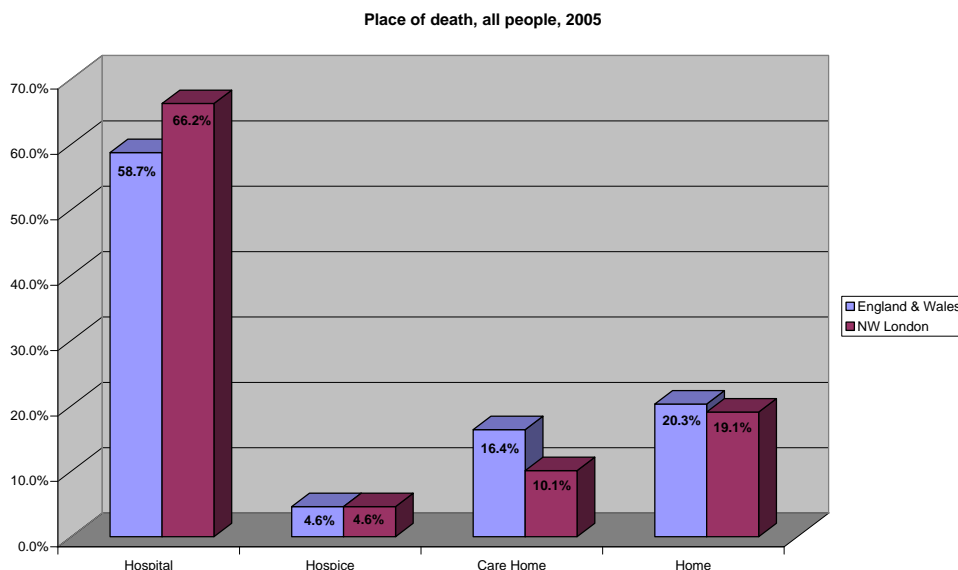
In England & Wales in 2005, there were 513,000 recorded deaths. The major recorded primary causes of death amongst all ages were:

- Diseases of the circulatory system (35.8%)
- Cancer (26.9%)
- Diseases of the respiratory system (14.1%)
- Others (23.2%)

4.2.2 In 2005, death rates at home were lower in the North West London Strategic Health Authority area than was the case nationally, with 19.1% of people dying at home. Compared to the national average, deaths in hospital were notably higher at 66.2%, compared to 58.7% for England & Wales.

A 2007 study has found that "although most people say that they would prefer to die at home, there has been a

persistent fall in the proportion of people doing so....The trend in falling home death rate has continued despite the rise in community palliative care services in the UK over the last 20 years<sup>14</sup>.



4.2.2 Much of best practice in end of life care has been developed for people dying from cancer. Nationally, three models show particular promise for adaptation and use for end of life care of other groups.

- **The Preferred Place of Care Plan (PPC)** is a document that the patient holds for himself or herself and takes with them if they receive care in different places. It has space for the patients' thoughts about their care and the choices they would like to make, including saying where they would want to be when they die. Information about the family can also be recorded so that any new care staff can read about who's who and what matters to them too. If anything changes, this can be written in the plan so it stays up to date.
- **The Gold Standards Framework (GSF)** is a systematic evidence based approach to optimising the care for patients nearing the end of life in the community. It is concerned with helping people to live

well until the end of life and includes care in the final year of life for people with any end stage illness in the community. There are now three separate strands to the GSF programme:

- *GSF in Primary Care* - supporting primary care teams and PCTs;
  - *GSF in Care Homes* - supporting Care Home (with nursing) staff to improve end of life care, and improve collaboration with primary care and specialist teams; and
  - *Developments in end of life care* - developing an end of life care strategy using GSF, development of Prognostic Indicator Guidance, Advance Care Planning, After Death Analysis audit tools, better collaboration and care for non-cancer patients, care of children
- ***The Liverpool Care Pathway for the Dying Patient (LCP)*** was developed to take the best of hospice care into care for people in hospital and other settings including care homes. It is used to care for patients in the last days or hours of life once it is known that they are dying. The LCP involves promoting good communication with the patient and family, anticipatory planning including psychosocial and spiritual needs, symptom control (pain, agitation, and respiratory tract secretions) and care after death.

4.2.3 A national project has been established to support spread of best practice in end of life care to non-cancer groups. Hounslow PCT have appointed an End Of Life Care Co-ordinator (jointly with Ealing PCT) in order to improve end of life care.

4.2.4 By March 2008, PCTs are required to undertake a baseline review of end of life care services in preparation for the national End Of Life Care Strategy. The purpose of this review is to provide PCTs and Local Authorities with information that will enable them to:

- Assess the population need for end of life care services
- Map current provision including its quality
- Compare current provision with population need
- Identify where service improvements are needed
- Be prepared to respond to the End Of Life Care Strategy when published.

- 4.2.5 Locally, the review will include services for adults with any advanced, progressive, incurable illness and in any setting (e.g. their own home, acute hospital, care home, extra care housing, hospice, hostels or other institution). It will also include services for carers and family members during the illness and after bereavement. The review will build on research showing that patients coming to the end of life tend to follow one of three trajectories (short decline, exacerbated organ system failure, and long term dementia or frailty), with different response required for each. Small scale trials of tailored care based on these trajectories have helped improve patient outcomes<sup>xv</sup>.
- 4.2.6 This will lead to a local strategy aimed at improving the quality of care and support available to people with long term conditions in their last 6 to 12 months of life. The strategy will start from the basis that good practice in end of life care should be built around the individual, and deliver high quality and effective care of the dying and bereaved irrespective of age and the cause of death.
- 4.2.7 The strategy will build on existing good practice and seek to enhance care in all settings where people are dying. In particular, it will build on the excellent work already carried out in specialist palliative care.
- 4.2.8 The strategy will define targets for the following key deliverables:
- Reduced admissions to acute hospital for end of life care;

- Reduced admissions from residential and nursing homes in the last days of life;
- Reduced length of stay in hospital through better discharge planning;
- Increase in the number of people, in agreement with their carers, who wish to be supported at home at end of life;
- Coordinated care and development of shared individual care plans; and
- Increases in the number of services provided to carers and the number of carer assessments.

In 2007/10, we propose to:

- Complete the *PCT baseline review of services for end of life care* review no later than 30<sup>th</sup> November 2007;
- Complete a local End Of Life Care Strategy no later than September 2008;
- Roll-out a comprehensive End Of Life Care training programme to care providers (bed-based and domiciliary) in the borough.

## 4.3 Programme 3: Stroke Services

### National Aims:

- To raise public awareness about stroke symptoms and risk factors, and to improve primary and secondary prevention of those vascular risk factors.
- To ensure that people who suffer Transient Ischaemic Attacks (TIA) have rapid access to high quality, appropriate diagnostic and treatment services.
- To accelerate the emergency response to stroke, including through improved access to CT scanning.
- To recommend the models of service provision and ways of working in the acute phase of stroke, appropriate to delivering new treatments.
- To support stroke survivors as they transfer from hospital to home and to provide the long-term support services needed after stroke.
- To ensure that the workforce is developed, in terms of numbers and skills, to enable the implementation of the strategy.

### Relevant targets:

- PSA Target/Healthcare Commission: Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
- From April 2007, PCTs are asked to report the expected prevalence of the number of people with high blood pressure. This will act as an aid to assessing the coverage of registers of patients with high blood pressure, and focus efforts on identifying patients with high blood pressure who are not on registers and offering them therapy and advice.
- Risk registers are required to move to a new baseline based on a 10-year cardiovascular (CVD) risk of 20% or greater.

4.3.1 Stroke is the third biggest cause of death in the UK and the largest single cause of severe disability. Each year more than 110,000 people in England suffer from a stroke, 20% of those affected by stroke die by 30 days, and 30% within 3 months. In 2005, 8% of deaths in men and 12% of deaths in women were caused by stroke. Over 50% strokes occur in people over age of 70.

Nationally, there are 300,000 stroke survivors in the community. It is unlike most long-term conditions, in that the precipitating event is sudden, and consequently stroke has devastating physical, social, and psychological effects, and a profound effect on family and carers lives.

There are two primary types of stroke:

- Infarction (death of tissue) of part of the brain due to embolism (clot travelling in an artery from heart or arterial wall) or thrombosis in an artery or vein, which accounts for approximately 85% of strokes, and
- Haemorrhage into or around the surface of the brain due to rupture of blood vessel, which accounts for approximately 15%

There are many underlying causes of both types. Risk factors such as atrial fibrillation, hypertension, diabetes, smoking, hyperlipidaemia and excess alcohol are particularly important.

4.3.2 Nationally, the Department of Health is consulting on a strategy for stroke services. **A New Ambition For Stroke - a consultation on a national strategy** was published in July 2007.

The national strategy is expected to:

- Provide a quality framework against which local services can secure improvements to stroke services, and address health inequalities relating to stroke;
- Provide advice, guidance and support for commissioners, strategic health authorities (SHAs), hospitals, primary care trusts (PCTs) and social care in

the planning, development and monitoring of services;  
and

- Inform the expectations of those affected by stroke and their families, by providing a guide to high-quality health and social care services<sup>xvi</sup>.

4.3.3 Stroke services in London are a major focus of ***Healthcare for London (2007)***. The working group on Acute Care notes that “in the past, the only good care for stroke was rehabilitative treatment. However technological advances have made interventional treatment for some stroke patients possible, if done soon after a stroke’s onset. Such interventions are dependent on skilled staff and dedicated technologies that cannot operate at every district general hospital. What is needed are specialist stroke units with CT scans to determine if a patient is having an ischaemic or a haemorrhagic stroke (thrombolysis can be used on ischaemic stroke patients but harms people with a haemorrhagic stroke) available as soon as possible and prompt physiotherapy. Treating stroke victims in specialist treatment centres saves lives and reduces disability”<sup>xvii</sup>.

This is likely to lead to the creation of a hub-and-spoke model of acute stroke services in the next few years across London. Hounslow PCT will work closely with all of our acute providers to ensure that they are best prepared to perform specialist treatment and rehabilitation functions.

4.3.3 Locally, the Stroke Steering Group has completed a stock-take of local services to assess progress in meeting the quality targets and recommendations in national stroke guidance documents:

- NSFOP standard 5 (2001) and A New Ambition for Old Age (2006);
- National audit office report – reducing brain damage: faster access to better stroke care (2005)
- NSF for Long Term Conditions (2005)

- Improving stroke services: guide to commissioners (2006)
- Royal College of Physicians national clinical guidelines for stroke (2004)

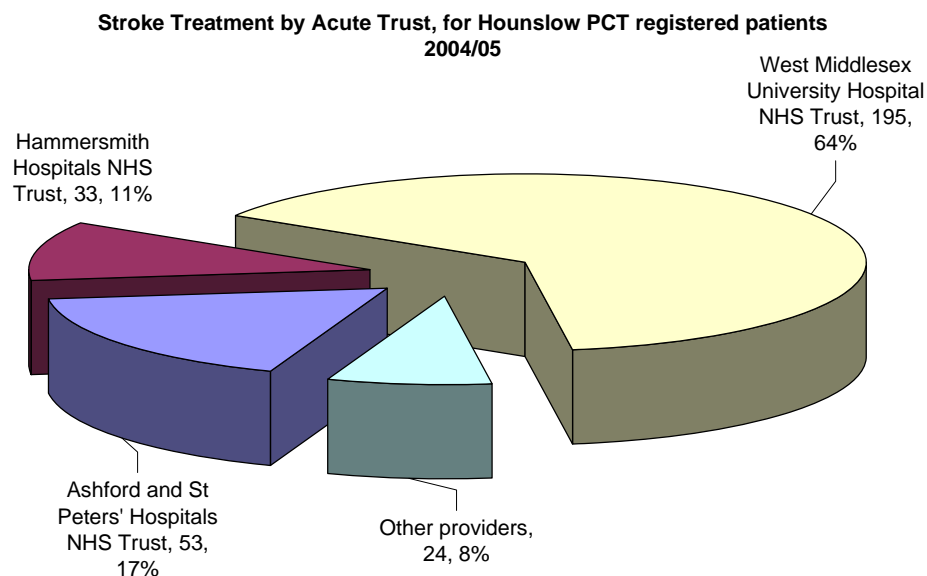
4.3.4 The Department of Health have estimated that, for Hounslow PCT, there are 320 strokes and 160 transient ischaemic attacks (TIA's) per year. In the total population, the Department estimates that there are 3019 stroke and TIA survivors, of which 970 have moderate or severe disabilities caused by stroke. These estimates are based on the age/gender/ethnic profile of the PCT.

The ASSET 2 Tool<sup>xviii</sup> benchmarks PCT performance on key performance measures for stroke. In 2004/05, there were 305 acute admissions for the registered population of Hounslow. Of these, over half returned to their usual place of residence and in this Hounslow exceeds the national average, deaths in hospital and discharges to care homes were lower than the national average.

Average length of stay (ALOS) for all outcomes exceeded the national average.

Performance Indicator (2004/05):	Hounslow PCT	England average
Stroke acute admissions:	305	<i>n/a</i>
% strokes that die in hospital:	24%	27%
% strokes discharged home:	54%	50%
% strokes discharged to care home or other hospital:	15%	18%
ALOS of those that die in hospital:	22.5	16.5
ALOS of those discharged home:	26.2	22.6
ALOS of those discharged to care home or other hospital:	55.9	39.8

4.3.5 Of these 305 admissions, just under two-thirds were to West Middlesex University Hospital, with substantial amounts of activity being carried out at Ashford & St. Peter's and Hammersmith & Charing Cross hospitals. Hounslow accounted for 68% of strokes treated at West Middlesex University Hospital and about 10% of all strokes treated at both Ashford & St. Peter's, and Hammersmith & Charing Cross hospitals.



4.3.6 The Royal College of Physicians, on behalf of the Intercollegiate Working Party for Stroke, conducted the fifth round of the National Sentinel Audit of Stroke in 2006 to monitor the progress of stroke care delivery following the NSFOP. Key findings for West Middlesex University Hospital were that:

- 77 % of those having a stroke get a CT scan within 24 hours, as compared to the national average of 40% and the London average of 58%;
- 85% get aspirin within 48 hours, compared to the national average of 73%;
- All get preventative antiplatelet drugs (e.g. aspirin) or warfarin if indicated, by discharge;
- All get home visit if indicated; and
- Communication about diagnosis and prognosis and reducing risk is better than national figures

However:

- 49% get seen by a physiotherapist within 72 hours of admission, compared to the London average of 74%; and
- Only 54% of stroke patients are seen in an acute stroke unit, as compared to 67% for London.

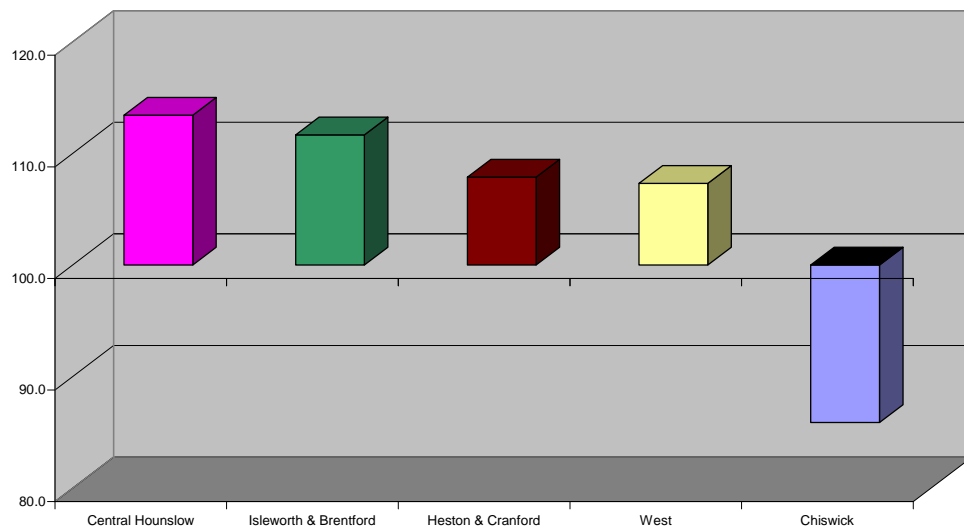
The following areas for improvement were identified:

- Earlier access to therapy for those not on the stroke unit
- To Increase % reaching the unit and spending more than half their stay on the unit
- Weighing, early swallow screening, mood assessment
- Nationally there is poor psychology support

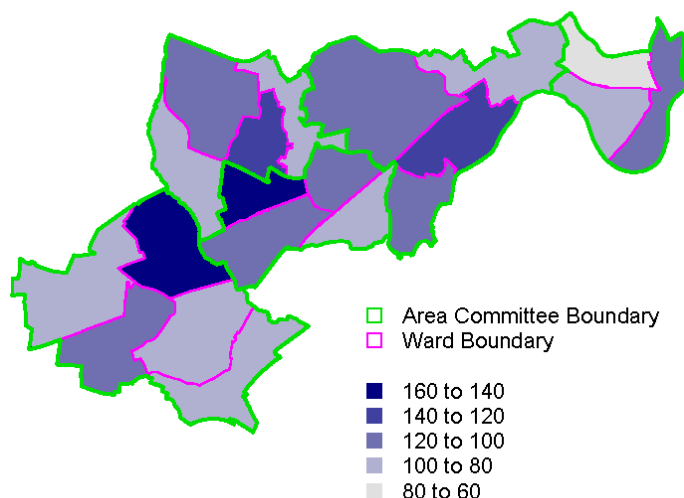
#### 4.3.7

A standardised mortality ratio (SMR) measures how far from the national average local areas are, calculated by comparing an observed number of deaths to an expected number taking into account differences in age structure, multiplied by 100. At area level, deaths from circulatory diseases (mainly strokes and heart disease) for all ages in the period 2000-2004 are one-quarter above the above the national average in four wards (Hounslow West, Feltham North, Syon and Heston Central), and one-quarter below the national average in one ward (Turnham Green).

Standardised Mortality Ratios (SMR) for Circulatory Disease, 2000-2004, All Ages, by Area



Standardised Mortality Ratio, Circulatory disease, all ages,  
2000-2004, by Area



4.3.8 Acute stroke care is currently funded under rules governing Payment by Results (PbR), which introduced a national tariff for the great majority of acute care episodes. Stroke is one of a small number of Health Resource Groups (HRGs), in which it is possible to pay acute trusts less than the national price for a specified episode by unbundling the tariff. The principle is that patient pathways are changed locally in such a way that the acute trust no longer has responsibility for one aspect which is normally provided by them and the costs of that are then removed from the price paid by the commissioner. If a PCT provides rehabilitation outside of the acute episode then the PCT could pay lower prices for HRGs that normally involve such rehabilitation and use the funding withdrawn from the tariff price to pay.

The HRG's related to stroke (A22/A23) have had Indicative Acute Phase Tariffs published for 2007/08<sup>xix</sup>. In the case of stroke, clinicians considered that 7 days was the typical point by which the acute phase had come to an end and the patient was assessed for continuing rehabilitation. Clinicians were keen to emphasise that rehabilitation should start from day 1, and that there is significant rehabilitation takes place in the acute phase. As a consequence of this work, there is a need to audit

the acute stroke pathway and ensure that appropriate stroke rehabilitation services are commissioned.

- 4.3.9 The Stroke Steering Group has identified that whilst there has been good progress in some areas (mostly related to care for stroke patients in the acute hospital), other areas require further attention. This is particularly the case with developing the community pathway for stroke and developing preventative services. Green indicates performance against national standards is good, amber indicates work is underway but there remain outstanding actions, red indicates areas of weakness with a need for substantial action.

### **Green**

- Specialist stroke services, as described in stroke service model
- Hospital clinical audit systems deliver RCP guidelines
- Emergency response: 24 hour standard for CT scans
- Prompt access to specialist neurological expertise for diagnosis & treatment
- Care for people with neurological conditions
- Access to OP stroke & TIA service
- Acute Stroke Unit

### **Amber**

- Public awareness about stroke & risk factors
- Improving primary & secondary prevention
- Rapid access to diagnostic & treatment services
- Support in transfer from hospital to home & longer term
- Access to specialist care & rehab after hospital
- Urgent care response for stroke & TIA
- Carers information & support needs
- Developed workforce
- Encouragement of independence

### **Red**

- Regular review of patients & carers psychosocial & support needs
- Regular GP audit of secondary prevention/management of chronic disability
- Assessment for rehab 6/12 post stroke
- GP stroke register

We propose to:

- To complete the stroke stock take, and to take action on the issues identified as falling into the red and amber areas;
- To develop and implement new community stroke pathway;
- To complete an audit of practice at West Middlesex University Hospital with a view to implementing unbundling of the acute tariff for stroke, and specifying a stroke rehabilitation pathway;
- To develop a local stroke strategy (subsequent to the publication of the national strategy); and
- To assess services provided to Hounslow residents attending other acute hospitals (primarily Ashford & St. Peter's and Hammersmith & Charing Cross hospitals)

## 4.4 Programme 4: Falls and Bone Health

### National Aims:

- To extend council, PCT and voluntary sector initiatives to improve exercise, balance, medicines management, environment and footwear for older people to reduce falls risk.
- To improve emergency response to falls with a key role for emergency care practitioners to assess people who have fallen prior to transfer to an emergency department and mobilize intermediate care services where a need for hospital assessment is not required.
- Every economy to have access to a falls assessment service for people with recurrent falls, or one fall with serious consequences.
- To increase capacity in osteoporosis services in DXA scanning for bone density as a guide to treatment. In 2005-06 £3 million has been allocated from a centrally held revenue budget for purchasing of additional scans (mainly from independent sector (IS) providers) in SHAs where there are the most pressing short-falls. Capital provision of £17m has been made in 2006/7 and 2007/8 to improve NHS capacity through investment in new DXA scanning equipment.
- To improve rehabilitation services for people who have lost functional ability or confidence after a fall.

### Relevant Targets:

HDP Line 8304: Number of health and social care systems with integrated falls services

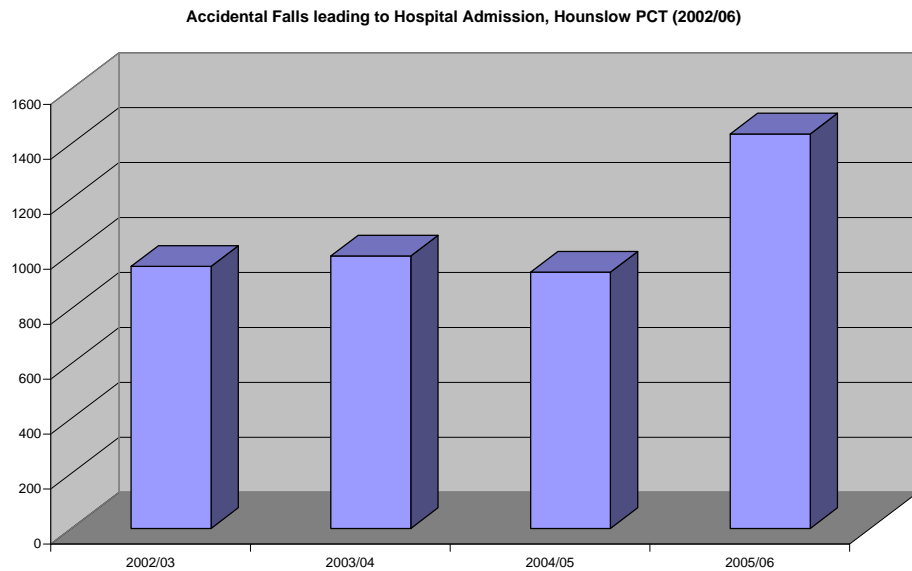
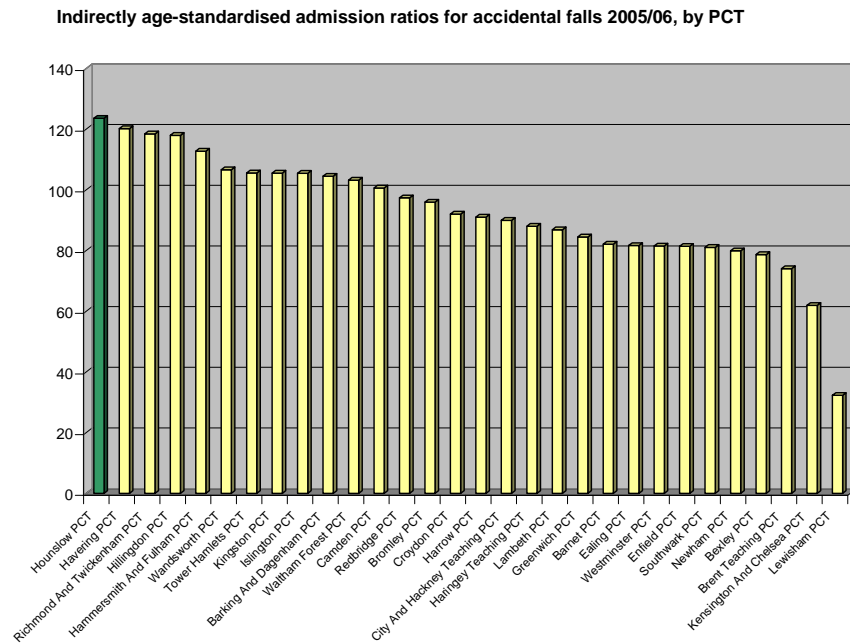
- 4.4.1 Falls are the commonest cause of serious injury in older people, of hospital attendance and are the commonest precipitating event for care home admission. In the UK, 28–33% of the population over 65 years, and 32–42% of the population over 75 years will fall each year. The associated mortality, physical injury, loss of function and loss of independence from a fall is great.

Hip fracture, which occurs in approximately 60,000 people per year who fall, is associated with up to 14,000 deaths annually.

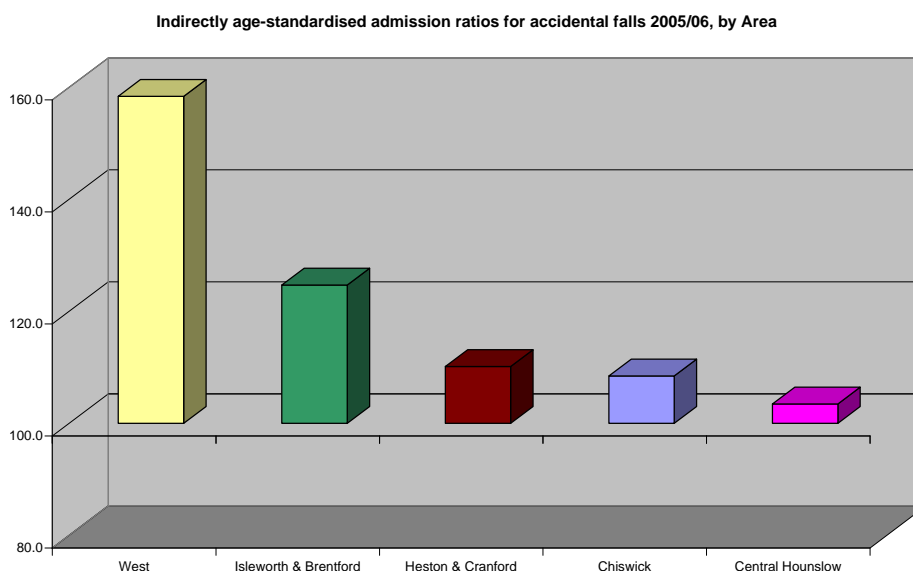
Over 200,000 falls were reported to the National Patient Safety Agency in the 12 months to August 2006, with reports of falls coming from 98 per cent of organisations that provide inpatient services. The NPSA estimates that there are over 530 patients every year who fracture a hip following a fall in hospital, and a further 440 patients who sustain other fractures.<sup>xx</sup>

- 4.4.2 Although the majority of falls are reported to result in no significant physical harm, even falls without injury can be distressing and seriously affect an older person's confidence. There is however a danger that in avoiding activity in the hope of minimising the risk of falls, older people increase their dependence on others. Generally, it remains preferable to remain mobile than to seek to prevent falls by being inactive.
- 4.4.3 The prevalence of falls within Hounslow is high as are corresponding hospital admissions. Analysis of hospital admission ratios for accidental falls in 2005/06 show that Hounslow had the highest level of finished admissions to hospital for all London PCT's, and this had increased significantly on the period 2002/05, with a 49.6% increase in falls leading to hospital admission<sup>xxi</sup>.

A conservative estimate is that these additional 500 falls and the consequent hospital admissions experienced in 2005/06 would cost Hounslow PCT £1.5m, in the first instance purely for the cost of the hospital stay. Additional costs to the health and social care system would accrue from the increase in dependency experienced by many older people following a fall.



Data about hospital admissions following a fall is available to ward level, and in 2005/06, there was a significantly higher level of falls in the west of the borough. Expressed as an age standardised admission ratio, Feltham North had the highest level of admissions in London (ranking 1<sup>st</sup> out of 604 wards) with a ratio of 245, i.e. nearly two and a half times the expected level for the ward given the demographic profile. Hanworth Park was second, with Syon and Bedfont wards also featuring in the ten wards with the highest admission ratios.



4.4.5 A 2007 study<sup>xxii</sup> found that a multi-factorial, multi-disciplinary falls prevention programme could be effective in both reducing the incidence of risk of falling in people over 75 and in the number of falls sustained. A cohort of 50 older people were assessed and had a number of interventions tailored to address their individual risk of falling (input from primarily occupational therapy, physiotherapy and physical exercise programme, but also social services, podiatry, pharmacy, district nursing, general practitioner and footwear expert). The study demonstrated a reduction in the number of falls occurring of approximately 1.1 falls per person during the course of the study. Results found that several risk factors significantly changed during the programme i.e. activity levels, balance, presence of a no slip sole, adequate sole thickness and environmental hazard level.

4.4.6 Locally, a PCT wide approach to falls prevention could improve outcomes for the people of Hounslow and would be a potential cost saving for the organisation. This would require a change in current thinking which seen a freeze in the budget for falls work. This has had the effect of curtailing of activity and progression of work planned for this area.

The Falls Pathway was agreed at the Older Peoples Partnership Board in 2006 with a move towards a

multidisciplinary one stop triage and assessment team directing care for various aspects of falls to existing and some 'new' services. This has been put on hold until resources are re- available from the budget to recruit to this dedicated team as indicated in the proposed pathway.

- 4.4.7 In the interim time the following activities have occurred:-
- Continuation of carers, service users and professionals training in regards to recognition of risks and sign posting to areas of intervention. These are run jointly by Hounslow PCT and Housing & Community Services. Given resources an audit is planned to follow up those trained as to the ongoing impact and usage of the training.
  - Community rehab team balance group.(exercise group)
  - Falls Awareness Day, education and advice at Montague Hall.
  - A Calcium and Vitamin D audit was carried out with two local care homes. This found that only 7 out of 91 patients audited were on calcium or vitamin D supplements. The audit tool is established but there is lack of capacity to roll this out across all care homes. Also due to the numbers indicated from the 2 care homes audited it could be assumed that there will be low numbers throughout and that compliance with guidelines would have considerable impact on GP prescribing budgets. The trust would therefore need to make a decision on the necessity of this in light of new evidence on the use of calcium & vitamin D supplements in the older population in preventing fracture following a fall.

We propose to:

- Produce a local falls strategy
- Develop a specialist falls service to be integrated within intermediate care; and
- Provide basic falls awareness training to include GPs, practice staff and contracted care providers

## 4.5 Programme 5: Mental Health in Old Age

### National Aims:

- To ensure age equality in the development of mental health care for adults of all ages, with access to services on the basis of need, not age. This will also include the integration of underpinning programmes of work, such as support for service improvement, workforce development, guidelines development, research and development, information systems, performance management, and inspection and audit, across the younger and older adult mental health services.
- To improve the skills and competencies of staff to enhance detection and management of mental illness in all non-specialist settings, so that wherever people are, they are not discriminated against, and have their mental health needs managed well.
- To secure comprehensive specialist mental health services for older adults, with a particular emphasis on community mental health teams, memory assessment clinics, and liaison services.
- To promote mental health as part of active ageing.

### Relevant Targets:

Healthcare Commission New National Target: Older people's mental health: assessment of needs and services. PCTs assessed on the existence and content of an up to date local assessment of older people's mental health needs and services

- 4.5.1 In 2006/2007, Hounslow PCT, Hounslow Housing & Community Services, and West London Mental Health Trust produced a joint Strategy for Older People's Mental Health Services in Hounslow 2006/2010.

The strategy is designed to show clearly the key national and local priorities for older people's mental health services and the commissioning actions that need to be



taken to implement changes in services to meet those priorities. The strategy sets out the vision for services for older people with mental health needs in Hounslow and following the formal adoption of the strategy by the three organisations, work is underway to establish a four-year multi-agency plan for achieving outcomes related to the vision and reporting mechanisms.

4.5.2 The strategy covers the 15 key areas set out in Care Services Improvement Partnership (CSIP) service development guide, ***Everybody's Business***:

- Primary Care
- Suicide Prevention
- Home Care
- Day Services (Day Hospital/Day Support)
- Bed-based Respite Care
- Housing
- Assistive Technology
- Care in Residential Settings
- Intermediate Care
- Care for Older People in General Hospital Settings
- Memory Assessment Services
- Psychological Therapies
- Inpatient Care
- Younger People With Dementia
- Older People with Learning Disabilities

4.5.3 An in-depth action plan has been drawn up by the Hounslow Older People's Mental Health Integrated Management Board (consisting of Hounslow Council,

Hounslow Primary Care Trust, West London Mental Health Trust and West Middlesex University Hospital).

This covers the following areas:

- Monitoring of the uptake of services;
- Ensuring a person-centred approach is taken to assessment and care planning so to avoid stereotyping on the basis of assumed characteristics;
- Review shared care protocols for the management of depression/dementia and support implementation (with particular regard to the co-prescribing of medication);
- Establish greater links between specialist OPMH services and primary care;
- Work with local GPs to help them to provide improved services to older people with mental health needs and to their carers (examining the potential of new arrangements under Practice-Based Commissioning);
- Establish a baseline and uptake monitoring mechanism for 'hard to reach' groups, including a review of service provision to ensure that services are accessible;
- Ensure that specific training is offered to healthcare professionals across all care settings to raise awareness of the risk factors linked to suicide in older people;
- Ensure that funding decisions about preventative services across health and social care are taken mindful of the need to promote healthy aging as a direct contributing factor in reducing depression and social isolation for older people;
- Work with domiciliary care providers to ensure that there the needs of older people related to mental health are addressed in training;
- To expand the Day Hospital from 7 places to provide at least 12 places daily by the end of 2006/07; with the aim of utilising some of this expansion to create a bed-based mental health intermediate care service (up to 2 beds at the expanded Chiswick Resource Centre & up to 4 beds at Charlotte House);

- To provide 5 beds for bed-based respite care on Dove Ward (with particular regard to first admissions/assessments), and utilising up to 4 beds for bed-based respite care at Charlotte House; and continue to utilise 2 beds for bed-based respite care at Chiswick Resource Centre;
- Complete a comprehensive assessment of all regular users of bed-based respite care against the prevailing NHS Continuing Care criteria to ensure equity of access (and equity regarding finance). Establish the feasibility of introducing a voucher scheme for bed-based respite care co-ordinated through the Hounslow Older People's Placement Service;
- Build capacity in sheltered/extra care housing to enable the provision of independent living in the community for wider groups of vulnerable older people, including people with dementia, mental health and cognitive problems, through training, information, and support;
- Develop an Assistive Technology Strategy across Hounslow Primary Care Trust, West London Mental Health Trust, West Middlesex University Hospital and the London Borough of Hounslow;
- Ensure future commissioned and directly provided residential/nursing home placements reflect the anticipated demand for older people with mental health needs;
- To develop a whole system OPMH training programme;
- Develop a tiered model of intermediate care for older people with mental health needs;
- Cease making placements into long-term care directly from an acute general hospital ward, unless it has been demonstrated that all reasonable options for enabling the person to be maintained in the community have been exhausted;
- Expand the opportunities for memory assessment;
- Monitor referral patterns to the new Counselling providers in primary care to ensure that older people

are not under-represented in service receipt, and work with primary care where there is under-representation to address any shortfalls;

- Develop a psychological therapies clinical governance strategy to monitor the quantity and quality of psychological therapies within health organisations;
- Monitor admission patterns across West London Mental Health Trust to audit practice in use of the Mental Act 1983;
- Monitor Delayed Transfers of Care from Dove Ward;
- To develop a young on-set Dementia service;
- To develop a register of people with learning disabilities (establish a working party to examine the specific needs of adults with learning disabilities and dementia, tasked with making recommendations about the service development needs of this group).

4.5.4 In the Older People's Mental Health Strategy 2006-2010, a commitment was given that all existing respite patterns would be honoured, albeit on a different site. Likewise, it was flagged that new service users are likely to be offered less frequent respite, in line with that offered by other older people's services (the standard being six to eight weeks annual maximum). However, there will be exceptions allowed to this based on individual assessment. All cases where respite is part of the package arranged by the NHS will remain free at the point of delivery to the service user.

4.5.5 As of November 2007, the respite service previously provided at Brentford Lodge will move to Dove Ward or registered care homes dependent on the clinical assessment of the consultant. For the vast majority of older people who have been receiving regular respite, this will mean a transfer to the new respite unit at Dove Ward. In a small number of cases, the PCT will commission care homes places for respite.

4.5.6 Building work at Brentford Lodge will be completed in Spring 2008. At this time, the building will house the

Community Mental Health Team for Older People and the Day Hospital/Memory Clinic (which will expand from 7 places daily to 12).

We propose to:

- Implement the action plan from the Older People's Mental Health Strategy.

## 4.6 Programme 6: Complex Needs/Long-Term Conditions

### National Aims:

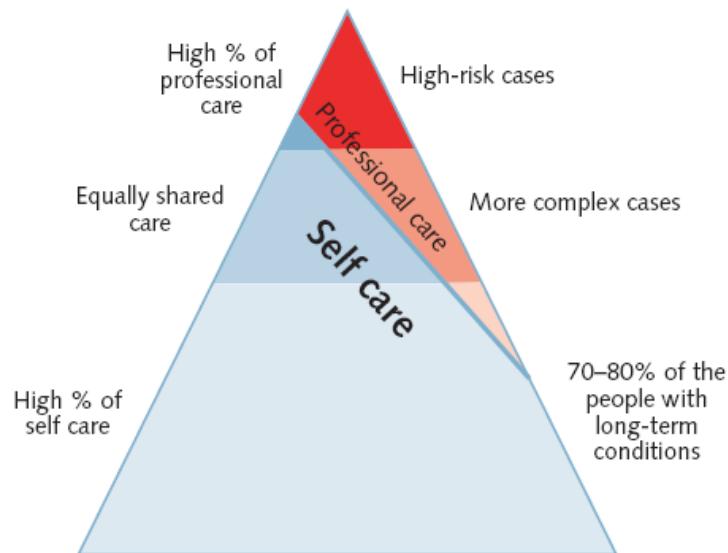
- To achieve better coordination of care for people with complex needs.
- To strengthen commissioning arrangements by the NHS and Councils for people with complex needs.
- To develop managed networks for older people with complex needs.
- To build on successful developments in intermediate care services.

### Relevant Targets:

- Healthcare Commission (New): the actual number of whole time equivalent (WTE) staff in the community matron role providing case-management in primary and community settings for people with complex long term conditions and high intensity needs, as at March 31st 2008.
- Healthcare Commission (New): The actual number of emergency bed days for April 2007 to January 2008 in Hospital Episode Statistics (HES) data minus the planned number of emergency bed days in the local delivery plan for ten months of the financial year 2007/2008.
- Healthcare Commission (New): The actual number of very high intensity users (VHIUs) under the case management of a community matron or additional case manager.
- LAA 60: Uptake in influenza immunisation in people aged 65 years and over
- LAA 61: Reduction in Hospital Admissions of People with Chronic Obstructive Pulmonary Disease (respiratory disease) using assistive technology to remotely monitor their condition
- LAA 62: Reduction in Hospital Bed Days of People with Chronic Obstructive Pulmonary Disease (respiratory disease) using assistive technology to remotely monitor their condition

- LAA 63: People with Chronic Obstructive Pulmonary Disease (respiratory disease being contacted with health forecasting project calls)

- 4.6.1 Older people with complex long-term conditions who are not managed effectively in a primary and secondary care setting are more likely to become frequent unscheduled users of secondary care services. By managing this cohort of patients effectively, the PCT can contribute to the increased health and wellbeing of older people and helping to achieve key targets such as reducing emergency hospital admissions.
- 4.6.2 Locally, the focus of the PCT's long-term conditions strategy is on promoting self-care, the appropriate use of existing health services and the proactive case management of Very High Intensity Users (VHIUs). This mirrors the Department of Health expectation set out in both ***Supporting People with Long Term Conditions – an NHS and Social Care Model*** and ***Supporting people with long term conditions - liberating the talents of nurses who care for people with long term conditions***, that whole health and social care systems will work together to deliver a more systematic care planning approach to better benefit all patients with long term conditions.
- 4.6.3 In ***Our Health, Our Care, Our Say***, it is clear that the expectation is that for the majority of people with long-term conditions, initial involvement should be in facilitating self-care (as per the diagram below).



Source: Department of Health

For 2008/09, the PCT will develop clear care pathways and thresholds for our unscheduled patients with the aim of reducing the number of emergency admissions of patients with chronic disease. This pathway should be seen as three distinct pathways, one for each of the three tiers of patients with chronic diseases, and thresholds will need to operate against each of the tiers of complexity.

Care Pathway 1	For patients who are monitored in general practice, and largely self managing
Care Pathway 2	For patients who are in the middle tier, and largely case managed at home. These are the patients who we need to focus on keeping out of hospital
Care Pathway 3	For very high intensity patients, who are frail and medically complex and for whom hospital admission to stabilise may be appropriate.

Hounslow PCT has developed a Self Care Management Strategy, which looks to support people to manage self care through integrated packages, which includes information, self monitoring devices, self care skills education and training and self care support networks.

The strategy highlights that “one of the barriers to self care management is scepticism and lack of interest from health professionals. Much of this is to do with lack of awareness of best practice in self care management and the time required with competing pressures and demands to look at evidence to support it. Success will enable the public to gain access to reliable health information and advice when and where they need it”.

Delivering effective self care support also needs greater cooperation between organisations with PCTs, GPs, local authorities and others working together with the community, voluntary and private sectors to provide local solutions to embed supported self care into service delivery as a practical option.

- 4.6.4 The second tier of local work on complex needs management is around ensuring that services are used appropriately in ways which do not compromise long-term outcomes and inadvertently move people from self care to professional care. In particular, this involves ensuring that acute hospital care is not seen as the default option due to lack of either awareness and understanding of opportunities in primary care or because of gaps in services either in primary care or at the interface with secondary care.
- 4.6.5 Community matrons and additional case managers will provide case management. Within the cohort of VHIU's there is a group of patients who will only be able to be managed by community matrons. Other practitioners may also work as additional case managers where there is strong evidence that they will deliver similar outcomes both for patients and in terms of bed day reductions. The PCT information team are reviewing 150 patients on the community matron caseload to assess their admission profile for 2006/07 and since they were admitted to the caseload to establish a measure of the effectiveness of the Community Matrons intervention.

4.6.6 Our commissioning framework for community services will reflect the best practice commissioning processes that we are aiming to establish with other sectors that is that they are:

- Driven by Public Health needs
- Within an overall strategic framework for the PCT
- Demonstrating a continuum of care across patient pathways
- Clear and specified outcomes
- Demonstrable value for money

The PCT will seek to focus the efforts of its provider services on those activities which have the maximum effect in generating greater efficiency throughout the healthcare continuum of services, i.e. community matrons and initiatives to support very high users of healthcare services, patients with long term conditions and coronary obstructive pulmonary diseases. Community Health Services are invited to share their expertise in the development of services out of hospital as part of preventing inappropriate hospital admissions, achieving early discharge and maximising the potential of individuals and carers to maintain independence and choice. Priorities for care pathway review are case management making best use of the development of the role of Community Matrons, rehabilitation services building on the model of Intermediate Care, and support for people with long term conditions, especially those with neuro-disability. This work will be undertaken in close co-operation with the PBC Localities and Social Care partners.

4.6.6 The concept of intermediate care was first signalled in the National Beds Inquiry in 2000, described as “services designed to prevent avoidable hospital admissions to acute settings and to facilitate the transition from hospital to home and from medical dependence to functional independence”<sup>xxiii</sup>.

In 2001, The National Service Framework for Older People included a specific standard related to Intermediate Care aimed at providing “integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living”<sup>xxiv</sup>. The standard stipulated that “older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care”.

The Department of Health introduced a definition for intermediate care in 2001, and expected that the NHS and councils would apply this definition in reporting investment and activity plans for intermediate care.

“Intermediate care should be regarded as describing services that meet all the following criteria:

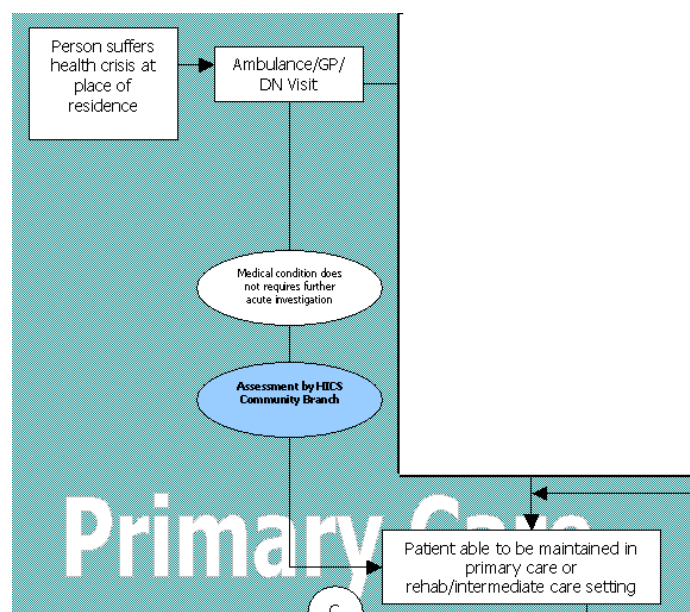
- are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care;
- are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
- have a planned outcome of maximising independence and typically enabling patient/users to resume living at home;
- are time-limited, normally no longer than six weeks and frequently as little as 1-2 weeks or less; and
- involve cross-professional working, with a single assessment framework, single professional records and shared protocols”<sup>xxv</sup>.

4.6.7 From 2001 onwards, Hounslow Council, Hounslow Primary Care Trust and West Middlesex University Hospital have provided substantial elements of intermediate care. The next step will be to form a unified Hounslow Intermediate Care Service, which seeks to bring all of the existing elements together under an integrated structure, as well as developing new services to meet identified gaps in the system.

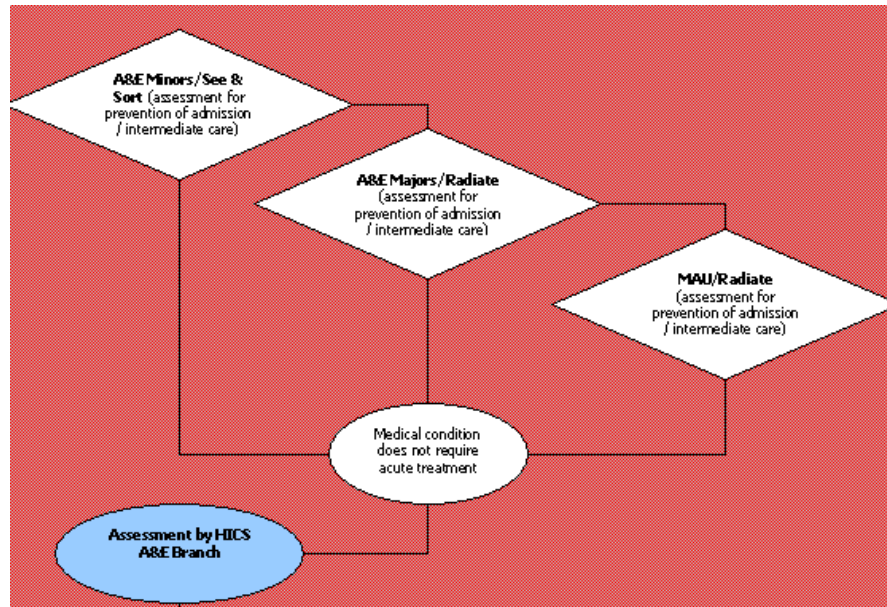
The diagram attached maps out the interface between primary and secondary care, and highlights three settings in which skilled and proportionate assessment needs to be extensively available.

These are:

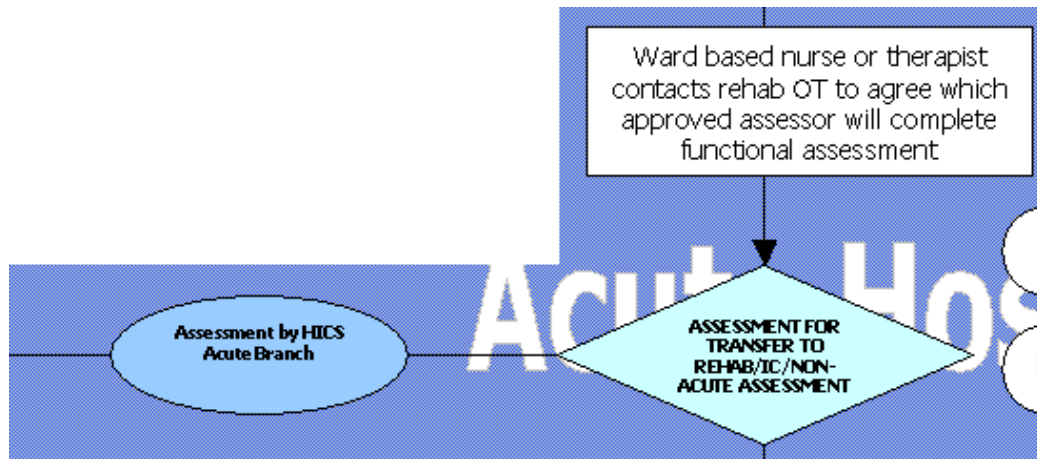
- Primary Care (the green box) – rapidly available assessment, usually by a nurse, and the urgent mobilisation of domiciliary care are often the defining factors in determining whether an older person suffering from with rapidly deteriorating condition can be maintained in their own home. At present, there is no coherent system for providing such a response across the whole borough in Hounslow.



- Accident & Emergency (the red box) – the PCT currently commissions the RADIATE service working in A&E and the Medical Assessment Unit at West Middlesex University Hospital. This provides an assessment service, 8am to 8pm, seven days a week.

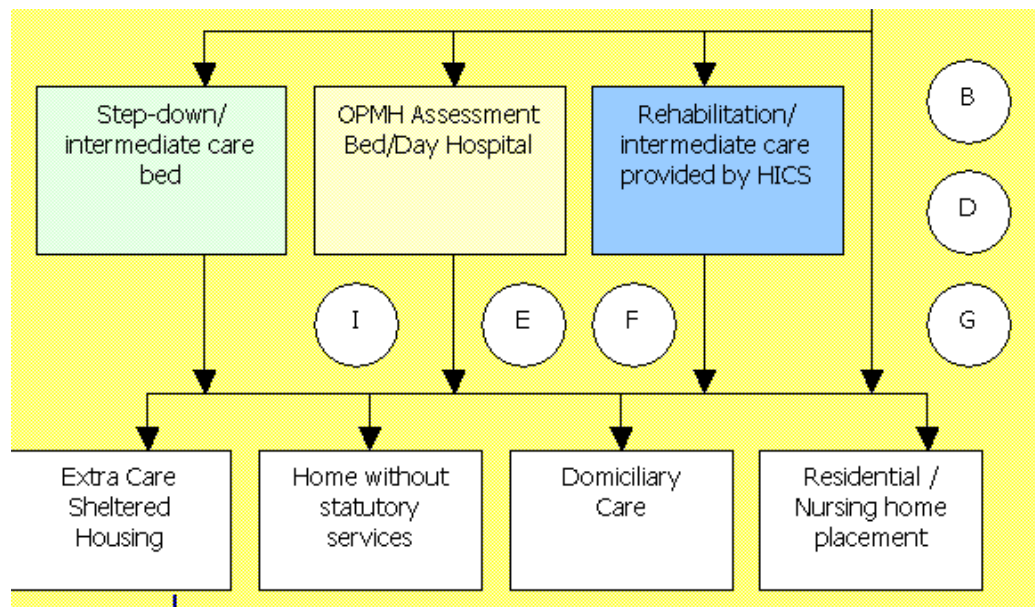


- Secondary Care (the blue box) – timescales for social care assessment are laid out in the Community Care (Delayed Discharges Etc) Act 2001. Assessment for discharge are likely to involve a wider multi-disciplinary team for the majority of older people, including but not exclusive to ward nurses, occupational therapists, physiotherapists, social workers, speech and language therapists, dieticians, and psychologists. The PCT will make additional investment in creating a post that will work collaboratively with West Middlesex University Hospital in ensuring that lengths of stay are kept to their reasonable minimum. The post will provide additional case management for all people with a stay of twenty days or more. It will also focus on case managing re-admitted cases who have been discharged to the Intermediate Care Service.



4.6.8 The resources needed to tackle these current gaps in the intermediate care system are currently tied up in unproductive activity for the PCT, either in potentially avoidable admissions or in excess bed days. Given the nature of acute hospital funding under Payment by Results (PbR), each hospital admission coded to one of the complex elderly codes incurs a tariff cost of approximately £4,000.

Community Services (the yellow box) required to enable patients to be managed back towards independence will need to be provided jointly by the council and the PCT. Hounslow Council have made a significant investment in redeveloping the In-House Domiciliary Care Services to work to a re-ablement model. The Assessment & Rehabilitation Service needs to have closely relationship with Community Rehabilitation Services to allow for maximisation to the potential benefit to the patient. Care plans should be drawn up with clear therapeutic goals in mind and delivered by trained home carers, working to therapists. In addition, the Council currently provides a seven bedded rehabilitation unit at Sandbanks Care Home.



#### 4.6.9 Preventing Avoidable Admissions

Analysis of admissions in the first five months of 2007/08 at West Middlesex University Hospital shows significant over-performance in codes related primarily to older people.

Focusing on codes related to activity described as 'Complex Elderly' shows over-performance against planned admissions of 10 per month. If this pattern is maintained, the full year effect will amount to £456,676 of unplanned expenditure. The table below shows that most of this over-performance relates to two codes, both of which are likely to be an effective target group for a comprehensive intermediate care service.

In addition to the complex elderly codes, a number of codes have age-related tariffs. Across these areas (containing '>69' in the title), there is also considerable over-performance, averaging around 12 admissions over plan per month. The full year effect of these admissions will amount to a further £350,280 of unplanned expenditure.

Accordingly across both areas, the PCT has a risk of incurring approximately £800,000 of unplanned expenditure in 2007/08, should admission patterns remain unchecked.

Hounslow PCT activity by HRG at WMUH Numbers admitted to Month 5, 2007/08			
HRG	Activity	Plan	Over
D99 - Complex Elderly with a Respiratory System Primary Diagnosis	81	64	+17
L99 - Complex Elderly with a Urinary Tract or Male Reproductive System Primary Diagnosis	39	16	+23
All 99 codes – Complex Elderly	224	174	+50
All >69 codes	545	483	+62

#### 4.6.10 Supporting Discharge

There are similar financial risks associated with long lengths of stay. Each admission code has a 'trimpont' beyond which the PCT becomes liable for further payment to the acute hospital. For the 'Complex Elderly' codes alone, activity is running at over twice the planned level. The full year effect is **£248,688** of unplanned expenditure.

Hounslow PCT activity by HRG at WMUH Excess Bed Days to Month 5, 2007/08.			
HRG	Activity	Plan	Over
All 99 codes – Complex Elderly	1204	569	+635

We propose that:

- The PCT will invest £100k in the first tier of Hounslow Intermediate Care Service, which would ensure the availability of a nursing assessment within two hours of referral, on an extended hours basis, covering seven days a week. The District Nursing service is also working to implement an IV cannulation at home service, which will support this work. Additionally, the PCT invest £20k in domiciliary care for patients where

the Hounslow Intermediate Care Service is involved in preventing admission to hospital;

- The PCT will continue to commission the RADIATE service from West Middlesex University Hospital;
- The PCT will invest £50k in creating a post of Discharge Facilitation Clinician to case manage the over twenty day caseload at West Middlesex University Hospital;
- The PCT will invest £130k in the Community Rehabilitation Service to enable patients to be managed back towards independence in the community, either after prevention of admission or supported discharge. This service will work in a unified management structure with the Council's Assessment & Rehabilitation Service.

## 4.6 Programme 6: Complex Needs/Long-Term Care

### Relevant Targets:

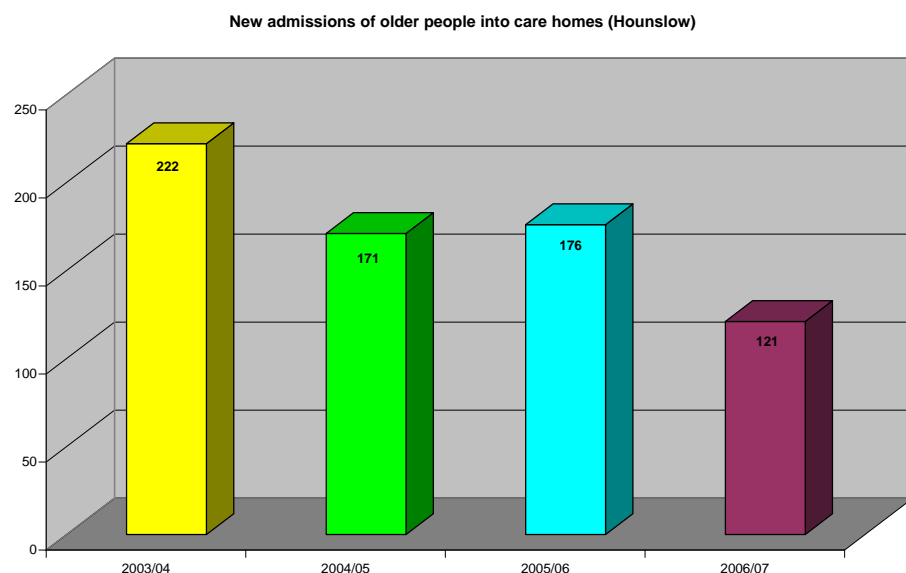
- PSA (Public Sector Agreement): Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by: increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008 (PAF C32); and increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care (B11).
- PAF B11 Intensive home care as a percentage of intensive home and residential care
- PAF C28/BVPI 53/LAA 5b Intensive home care
- PAF C32/BVPI 54 Older people helped to live at home (BVPI 54)
- PAF C72/LAA 5a Older people aged 65 or over admitted to residential/nursing care during the year
- PAF D54/BVPI 56 Percentage of items of equipment and adaptations delivered within 7 working days
- LAA 64: Numbers of people aged 65 and over supported by home care assessment service

4.6.8 In the 2004/07 Commissioning Strategy for Older People, Hounslow PCT and Hounslow Council made an explicit commitment to supporting people in their own homes wherever possible. The commitment was made to achieve a fundamental shift in the proportions of investment in institutional based care and care at home.

The strategy proposed a staged reduction in the numbers of older people admitted to care homes, consistent with placing neither too many nor too few older people (as to place at higher levels would potentially be indicative of a lack of alternatives to placement, to place at lower levels than this would be to run the risk of not providing appropriate care for older people who need it).

In the last three years, Housing & Community Services set challenging targets in reducing permanent admissions to long-term care. In all three years, the target was met. For 2006/07, this indicator formed part of the Hounslow Local Area Agreement, and an additional reduction in placements was agreed with the Government Office for London, as a **stretch target**. Stretch targets are set in order to improve performance above and beyond that already agreed, and if achieved in year three, a locality is entitled to receive Performance Reward Grant (for this indicator totalling £198,690). In 2006/07, we have substantially exceeded the target set. The challenge is to maintain this performance in the light of increased pressures across the health and social care economy.

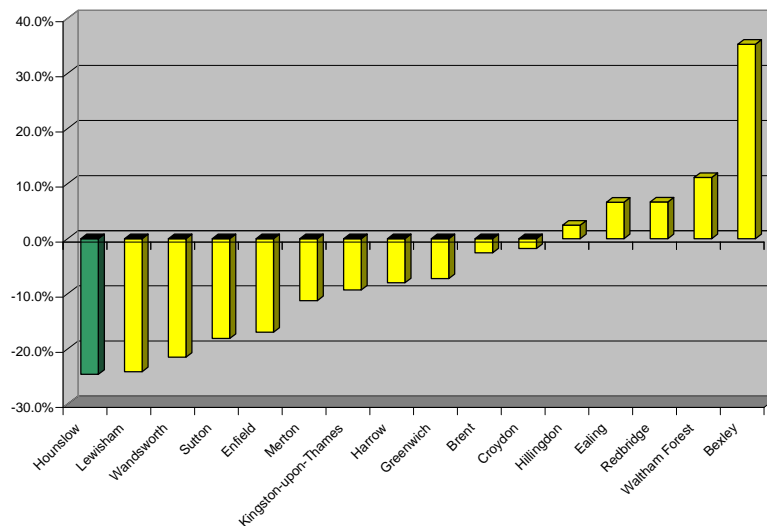
<b>PAF C72 - SUPPORTED ADMISSIONS OF OLDER PEOPLE TO RESIDENTIAL AND NURSING CARE</b> Description (supported admissions of older people to permanent residential and nursing care per 10,000 population aged 65 or over)		
2004/05	2005/06	2006/07
<b>Target</b> 80.00 ●●●●●	<b>Target</b> 71.88 ●●●●●	<b>Target</b> 69.50 ●●●●●
<b>Performance</b> 71.38 ●●●●● <i>Achieved</i>	<b>Performance</b> 73.44 ●●●●● <i>Achieved</i>	<b>Performance</b> 49.00 ●●●●● <i>Achieved</i>



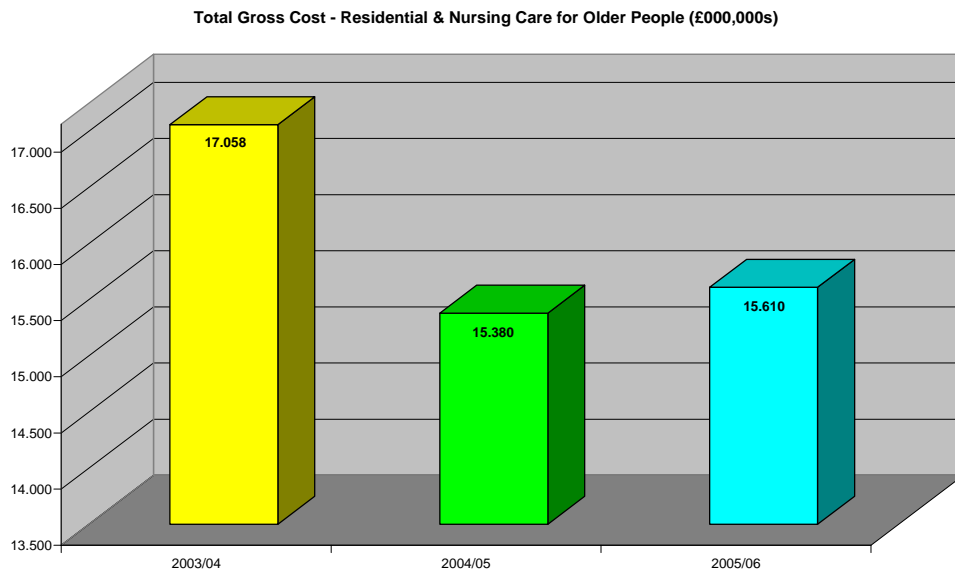
PAF C72 - SUPPORTED ADMISSIONS OF OLDER PEOPLE TO RESIDENTIAL AND NURSING CARE		
LAA STRETCH TARGET		
2007/08	2008/09	2009/10
<b>Target</b> 50.00 (67.00 for LAA) ●●●●●	<b>Target</b> 64.00 ●●●●●	<b>Target</b> 64.00 ●●●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

4.6.9 The significant reduction in new admissions over the last three years has led to an overall reduction in the number of long-term placements being supported by Housing & Community Services. Measured at 31<sup>st</sup> March annually, there has been a nigh-on 25% reduction in supported occupancy levels in the period 2003/06 (690 places in 2003 to 520 in 2006). This is the most substantial reduction recorded across our comparator group.

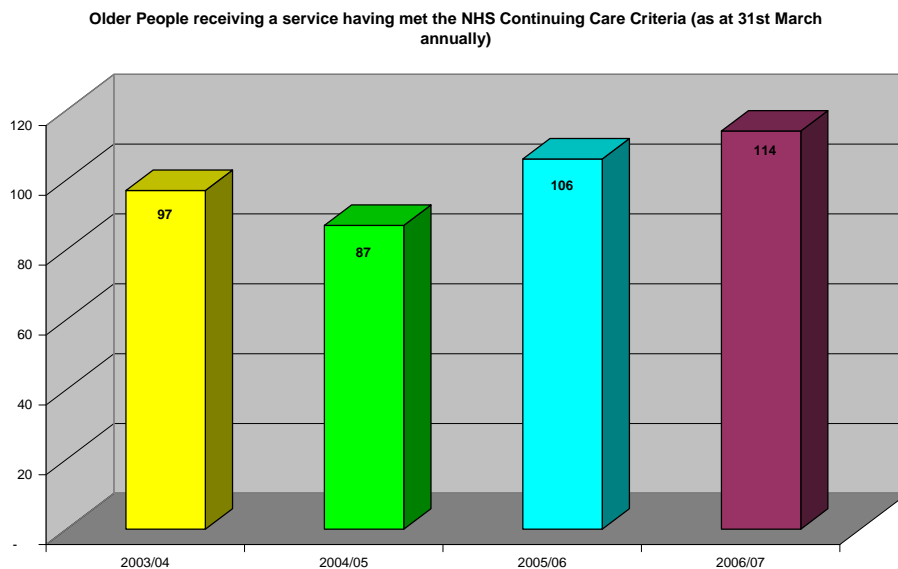
Rate of change in numbers of older people in permanent residential and nursing care (2003 to 2006)



4.6.10 As a consequence of the reduction in the use of long-term care, Housing & Community Services has been able to reduce spend on residential and nursing care, and increase support for domiciliary care. Allowing for inflation, there has been a decrease of 12.4% in real terms in expenditure in this area.

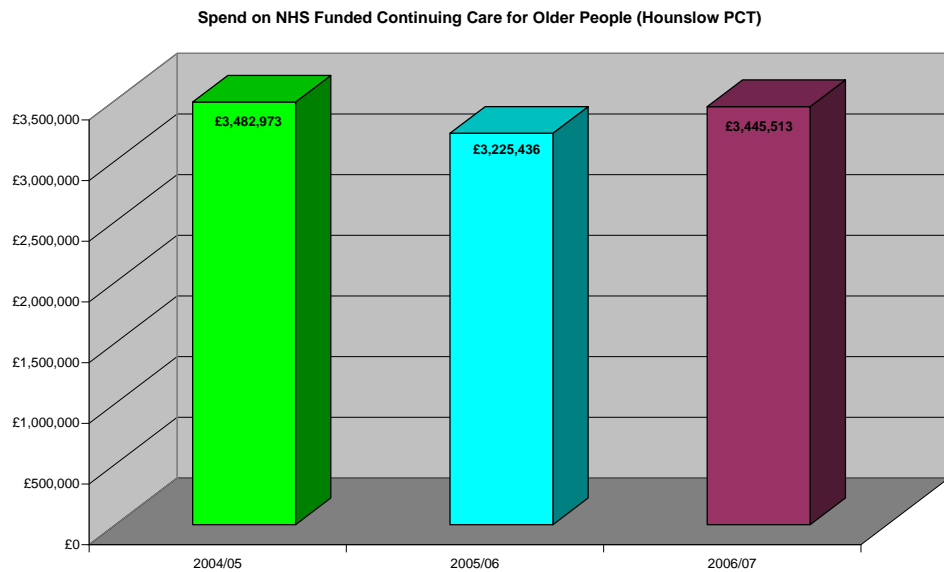


4.6.11 Whilst the total number of people placed by Housing & Community Services has fallen, there has been a slight increase in the numbers of older people receiving a service after meeting the criteria for NHS Funded Continuing Care, which has risen by 17 over the last three years to 114.

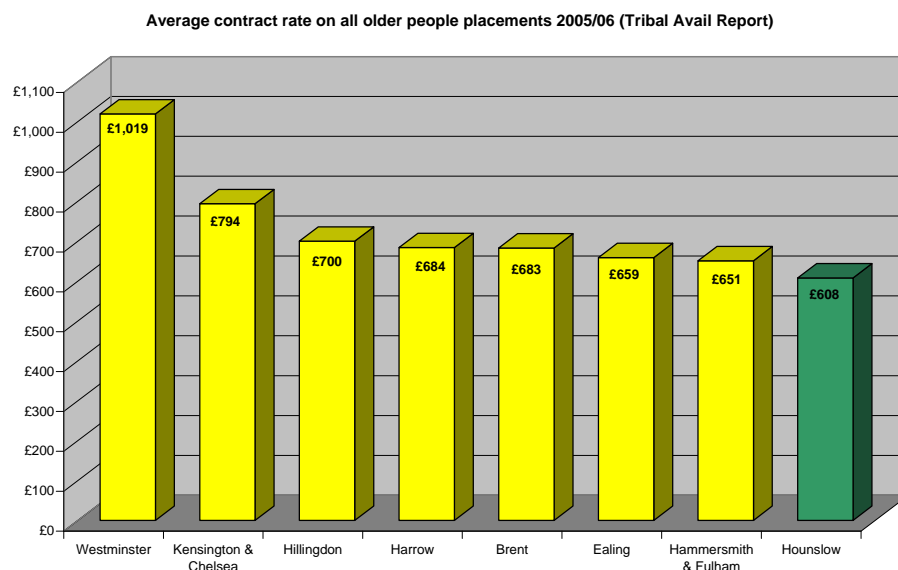


4.6.12 This increase in activity has been offset by improvements in commissioning arrangements. Block contracts have been renegotiated to ensure that they operate at optimum occupancy levels (which have increased from 82% in 2004/05 to 97% in 2006/07), whilst remaining at a competitive fee level. Consequently, despite an increase

in activity of 20% from 2004/05 to 2006//07, total spend has reduced by 5% in real terms.



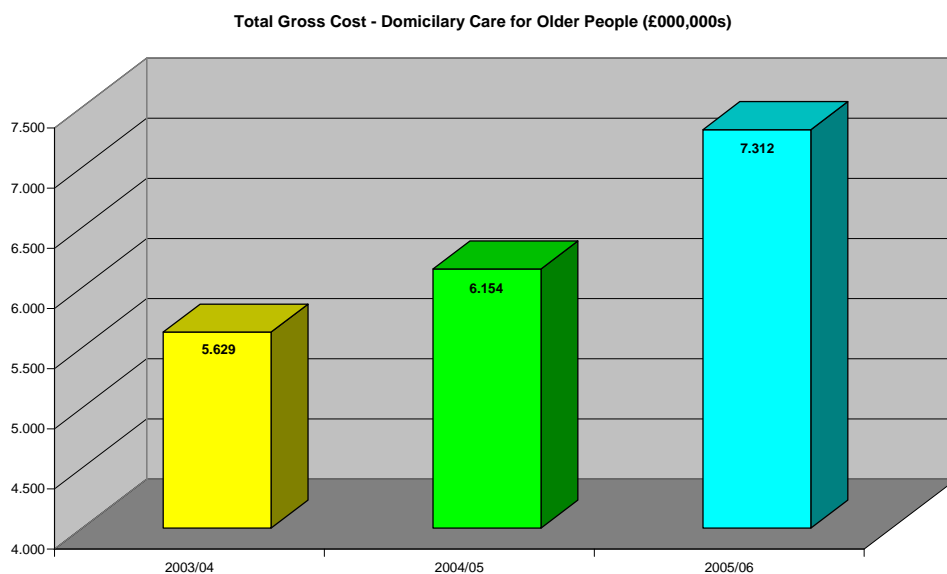
4.6.13 A benchmarking exercise carried out by Tribal Avail for the North West London Shared Healthcare Board has shown that in 2005/06, Hounslow has the lowest average rates for care home placements, rates being at least £43 per week lower than in any other PCT in the sector. This equates to a saving of £217,000 annually.



It is crucial that commissioning focuses on quality as well as cost. To this end, quarterly monitoring reports are to be submitted to the Hounslow Older People’s Panel

detailing the most recent inspection reports for Hounslow services as produced by the Commission for Social Care Inspection. This will include any action plans agreed with local providers in order to improve their services.

4.6.14 As spending on residential and nursing care has fallen, there has been a consequent rise in expenditure on **domiciliary care**. The indicator measuring intensive home care also forms part of the Local Area Agreement as a stretch target, and this area has a potential Performance Reward grant of £248,362.

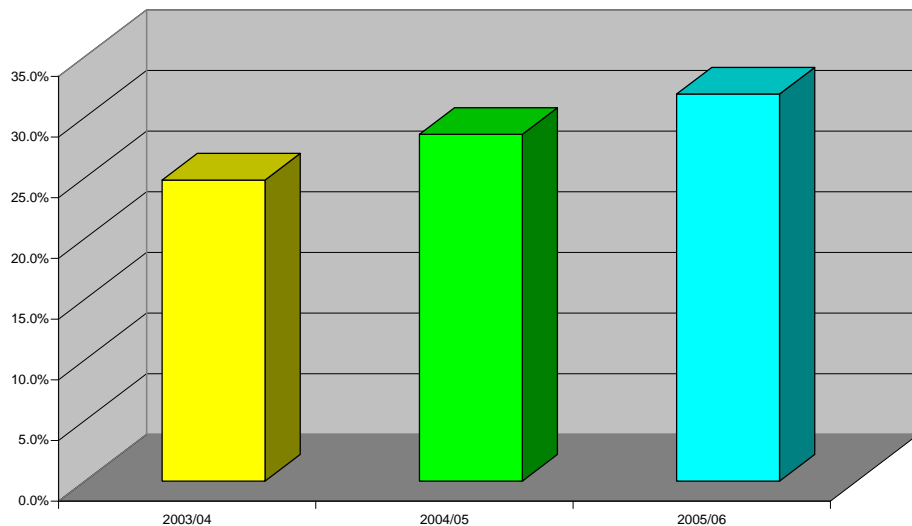


<b>PAF C28 – INTENSIVE HOME CARE</b>		
Description (supported admissions of older people to permanent residential and nursing care per 10,000 population aged 65 or over)		
2004/05	2005/06	2006/07
<b>Target</b> TBC ●●●●●	<b>Target</b> TBC ●●●●●	<b>Target</b> 16.90 ●●●●●
<b>Performance</b> 13.82 ●●●●● <i>Achieved</i>	<b>Performance</b> 16.23 ●●●●● <i>Achieved</i>	<b>Performance</b> 16.27 ●●●●● <i>Achieved</i>

PAF C28 - INTENSIVE HOME CARE		
LAA STRETCH TARGET		
2007/08	2008/09	2009/10
<b>Target</b> 17.40 ●●●●●	<b>Target</b> 17.90 ●●●●●	<b>Target</b> 17.90 ●●●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

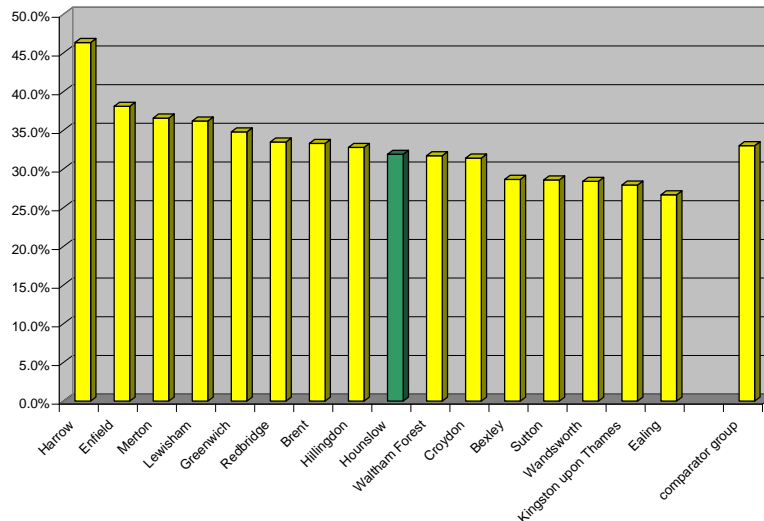
4.6.15 The balance of investment between institutional and domiciliary care has shifted over the last three years, with an increasing proportion spent on caring for older people at home. It is anticipated that this shift will continue to across the three years of this strategy.

Proportion of residential, nursing and domiciliary care budgets spent on domiciliary care, Hounslow



This shift has helped to improve our position relatively against that of our comparator group, where for 2005/06, we ranked as 9<sup>th</sup> from 16, and spent only slightly less than the average proportionately on domiciliary care. Hounslow has also achieved the associated performance indicator (B11) for the last two years.

Proportion of residential, nursing and domiciliary care budgets spent on domiciliary care (2005/06)



PAF B11 - INTENSIVE HOME CARE AS A PERCENTAGE OF INTENSIVE HOME AND RESIDENTIAL CARE		
Description (the number of households receiving intensive home help/care as a percentage of all adults and older people in residential and nursing care and households receiving intensive home help/care.)		
2004/05	2005/06	2006/07
<b>Performance</b> 25.96 ●●●●	<b>Performance</b> 35.41 ●●●●●	<b>Performance</b> 36.00 ●●●●●
<b>Target</b> 35.00 ●●●●● <i>Not Achieved</i>	<b>Target</b> 28.00 ●●●●● <i>Achieved</i>	<b>Target</b> 35.00 ●●●●● <i>Achieved</i>

PAF B11 - INTENSIVE HOME CARE AS A PERCENTAGE OF INTENSIVE HOME AND RESIDENTIAL CARE		
2007/08	2008/09	2009/10
<b>Target</b> 37.00 ●●●●●	<b>Target</b> 37.00 ●●●●●	<b>Target</b> 37.00 ●●●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

- 4.6.16 Performance against the indicator C32 has been largely static throughout the last three years.

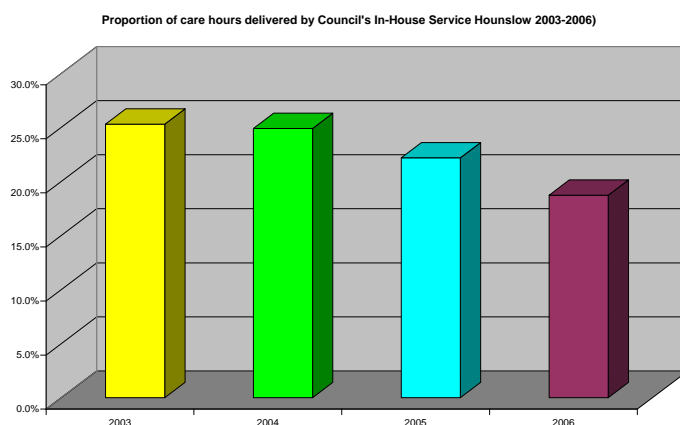
<b>PAF C32 – OLDER PEOPLE HELPED TO LIVE AT HOME</b>		
Description (older adults helped to live at home per 1000 population aged 65 over)		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>Target</b> 82.00 ●●●	<b>Target</b> 84.00 ●●●	<b>Target</b> 83.00 ●●●
<b>Performance</b> 82.03 ●●● <i>Achieved</i>	<b>Performance</b> 83.04 ●●● <i>Achieved</i>	<b>Performance</b> 83.08 ●●● <i>Achieved</i>

<b>PAF C32 – OLDER PEOPLE HELPED TO LIVE AT HOME</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> 83.00 ●●●	<b>Target</b> 83.00 ●●●	<b>Target</b> 83.00 ●●●
<b>Top PAF Band</b> x	<b>Top PAF Band</b> x	<b>Top PAF Band</b> x

- 4.6.17 In 2006, the Council let new block contracts for domiciliary care. These introduced shorter call lengths and electronic call monitoring (ECM). ECM is a powerful tool in helping social workers to make changes to packages where it is clear that the actual time being spent on a call varies from that planned (both where a call is booked and the time is insufficient and where the time booked is too generous).
- 4.6.18 From a financial perspective, the actual service received by an older person as recorded by ECM is chargeable. The evidence of service delivery from electronic call monitoring provides the Council and domiciliary care users with an accurate description of the service. Care Worker timesheets are significantly less reliable as evidence of service delivery.

In early monitoring, the Council has found that the difference between planned and actual time was 8%. If this were to be the case across all provision, the Council could expect to make a saving of approximately £250,000, without affecting the quantity of care being received by older people.

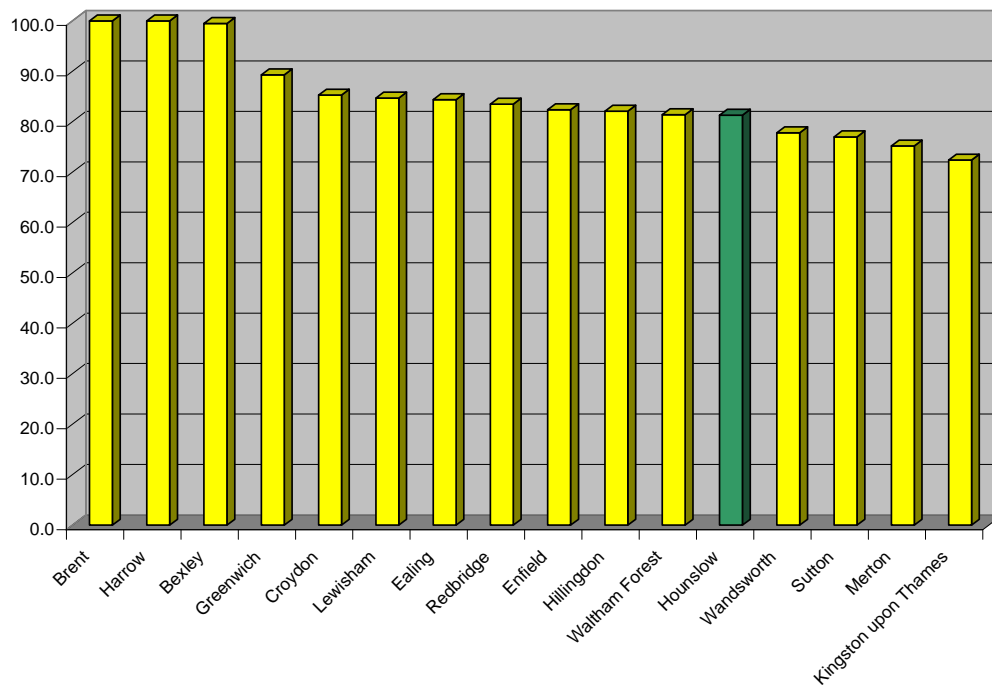
- 4.6.19 Year on year there has been a fall in the proportion of care provided by the In-House Service, whilst the hours delivered have remained static, there has been an increase in care hours delivered by the independent sector, leading to a shift in the balance of provision.



The proportion of care delivered by the independent sector in Hounslow is lower than the average for our comparator group, but not markedly so. The majority of comparators fall in the range 80%-90% independent provision, with three Councils having no In-House service.

The current Service Level Agreement with the In-House Service runs until 30<sup>th</sup> August 2008. A review of the In-House Service will need to carefully consider the higher unit cost of the service (approximately 33% higher than the costs of externally provided services), against the added value of having a high-quality (as consistently assessed by the Commission for Social Care Inspection) and flexible service.

Domiciliary care contact hours provided by independent sector (% , 2006-07)



We propose to:

- Review the implementation of the domiciliary care block contracts (length of calls/electronic call monitoring); and
- Review the Councils In-House Service Level Agreement for domiciliary care.

## 4.7 Programme 7: Urgent Care

### National Aims:

- To redesign urgent care response to falls, mobilising intermediate care services and avoiding inappropriate attendance in emergency departments or hospital admission where there is no life-threatening illness or need for surgery, with early assessment and management by a multi-disciplinary falls service.
- To redesign urgent care response to people with acute confusion (delirium) on a background of dementia or arising de novo in the context of medical crises, with early assessment by old-age specialists to investigate and treat underlying medical problems and with subsequent review of mental health needs.
- To redesign urgent care response for stroke and transient ischaemic attack as part of the work to develop a new national stroke strategy.

4.7.1 Older people are not only heavy users of urgent care services, they are also more likely to experience longer waits in emergency departments, to be admitted to hospital and to have more prolonged length of stay once admitted. A significant proportion of those admitted could benefit from alternatives to admission. Whether admitted, or provided with alternatives to admission, early access, review or management by specialist multi-disciplinary old age-related teams will improve outcomes for patients and be an efficient use of resources.

4.7.2 Both nationally and locally there has been a marked increase in Accident & Emergency attendances. Total attendances at West Middlesex University Hospital A&E have been increasing year on year (total attendances at WMUH A&E has risen from 59,000 in 2000/01 to 89,000 in 2005/06).

Analysis of patient presentations indicates that the majority of attendances between April 2006 and January 2007 were 'minor' attendances, of whom 69% were

discharged from A&E without requiring any follow up. Information from patient surveys shows that people attend A&E for a variety of reasons that do not require an A&E attendance:

- because they did not know where else to go to get help;
- they wanted a second opinion to that of their GP
- they did not feel the GP could deal with the problem; or
- they could not get an appointment with their GP.

To address these issues the PCT proposes to work collaboratively with West Middlesex University Hospital to develop a primary care 'front end' to A&E to ensure that the services provided by A&E are used appropriately and the clinicians staffing this facility utilise their skills, knowledge and expertise on those who genuinely require this level of intervention.

In 2006, the Department of Health produced a discussion document, *The Direction of Travel for Urgent Care*, which identifies the need for new methods of working in A&E<sup>xxvi</sup>. These need to be responsive to the needs of the patient, taking into account the urgency of the problem and best value for money. Hounslow PCT are clear that urgent care will only be truly effective when it is able to respond in an integrated way to health and social care needs.

- 4.7.3 It is the intention of Hounslow PCT to commission a service that will provide a primary care led front end to A&E at West Middlesex University Hospital. The See & Sort service will provide a triage service that will assess the patient using a recognised IT triage system to support clinical decisions and practice. Triage will re-direct the patient to their own GP when their practice is open and to a primary care clinician in A&E when not, or directly into an A&E stream (e.g. A&E minors, majors, resuscitation or A&E paediatrics). Patients referred to primary care minors will be seen, treated discharged and or referred to primary care services for ongoing treatment / follow up. All patients will remain the responsibility of the provider of

the primary care front end to A&E until triage has taken place and the patient directed and accepted by A&E at West Middlesex University Hospital. The model described above applies to all patients, and not just older people. This will include people arriving by ambulance, unless it is obvious they require immediate access to A&E resuscitation or A&E majors. In these circumstances the primary care front end to A&E must in no way constitute to a delay in the patient receiving immediate secondary care assessment and intervention.

- 4.7.4 Where a patient does require access to A&E Majors, then the Radiate team will make an assessment where there is felt to be the potential for the person to return home rather than need hospital admission. For those who may only need a short time in hospital the team will also follow up those who are admitted to the Medical Assessment Unit and support them to return home as soon as is possible. The team provides an 8am-8pm service from Monday – Sunday, and consists of nurses, occupational therapists, physiotherapists and social workers.
- 4.7.5 Where an older person presents to A&E with a primary issue regarding their mental health, work is required between West London Mental Health Trust and West Middlesex University Hospital to ensure that there is a proportionate response to the presenting difficulty. In the first instance, this will involve medical tests to confirm whether the person has an underlying medical condition which requires acute treatment (this is of particular importance given that many older people experience the rapid onset of a confusional state secondary to the effects of infection). Where no underlying medical cause is found, the PCT's expectation is that West Middlesex University Hospital will not admit older people presenting with a dementia. An urgent referral should be made to West London Mental Health Trust and consideration given to the appropriate setting for further assessment. This may be in the person's own home with care and

support, or it may involve a short admission to Dove Ward.

We propose to:

- Introduce the See & Sort model to A&E at West Middlesex University Hospital;); and
- Develop a thorough service specification for the Radiate Service at West Middlesex University Hospital (as part of the development of a comprehensive Intermediate Care Service for Hounslow).

## 4.8 Programme 8: Care Records & Assessment

### National Aims

- To simplify and extend the Single Assessment Process approach to all adults with long-term conditions.
- To fit Single Assessment Process implementation into the wider work across local and national government in developing personalised and integrated record systems.
- To ensure that comprehensive assessment is undertaken prior to long-term or residential nursing home care.

### Relevant Targets:

- PAF D55/BVPI 195 – Acceptable waiting times for assessment
- PAF D56/BVPI 196 – Acceptable waiting times for care packages
- PAF D39 – Percentage of people receiving a statement of their needs and how they will be met
- PAF D40 – Clients receiving a review
- PAF E47 – Ethnicity of older people receiving assessment
- PAF E48 – Ethnicity of older people receiving services following an assessment
- PAF E82 – Assessments of adults and older people leading to provision of service

4.8.1 Assessment is inevitably central to the first contact older people have with both Housing & Community Services and the Primary Care Trust. Nationally, the introduction of the Single Assessment Process (SAP) as a unified process for assessing the health and social care needs of older people, developing personal care plans and sharing this information as people move through the care system was a key objective of the NSFOP.

4.8.2 Locally, there has been widespread engagement of health and social care at both front-line and managerial

levels. The work done in Hounslow on developing shared care plans has been influential nationally.

#### 4.8.3 ***To simplify and extend the Single Assessment Process approach to all adults with long-term conditions.***

***Our Health, Our Care, Our Say*** builds on the Single Assessment Process (SAP) and introduces a Common Assessment Framework for Adults to be developed primarily from the experience to date from implementing SAP for Older People, the Care Programme Approach (CPA) for Mental Health and Person Centred Planning for People with Learning Disabilities. The aim of adopting a common framework is to remove the artificial boundary of 'older age', and provide continuity of a person centred approach throughout adult life, geared towards self-determination and planning for independence. The Department of Health views that CAF implementation will be at least a four-year programme at the end of which, CAF will be fully electronic.

Locally, Community Matrons and Primary Care Social Workers are all working within the SAP Framework and are using the standard SAP tools for generic assessment. Additionally, the Community Matrons are using the FACE Coronary Obstructive Pulmonary Disease (COPD) assessment tool. This fits into the SAP toolset.

#### 4.8.4 ***Fit SAP implementation into the wider work streams (local and national) in developing personalised and integrated record systems***

Nationally, NHS Connecting for Health is currently considering how to fit Social Care into the scope of its contract and funding is likely to be diverted to cover this. This is a new and crucial step, as previously this has not been considered. This is particularly significant as RiO is now the strategic long-term electronic solution for London.

Hounslow is very involved in the development of the RiO patient administration system from a community nursing perspective. Involvement in this work is crucial to ensure that duplication is as limited as is possible.

SAP is also integral to the current customer administration system used in Social Care, SWIFT. Currently, all SAP generic tools are produced as outputs (forms) from SWIFT.

No developments are currently underway for any means of sharing information across the two systems or with the systems of other key stakeholders including WMUH, West London Mental Health. However, it is anticipated that CAF will be the roadmap for achieving information sharing across health and social care.

#### 4.8.5 ***To ensure comprehensive assessment is undertaken prior to long-term or residential nursing home care***

This is already in place in Hounslow with a fully functioning Panel overseeing this work. The development of the Assessment and Rehabilitation Team service ensures that appropriate assessment and decision-making is carried out in the appropriate setting and not whilst someone is ill in hospital and better assesses a person's longer-term needs.

A Continuing Care decision-making tool has recently been published by the Department of Health.

Additional Continuing Care (CC) guidance has still to be published. This keeps being delayed and a publication date is not yet known. Work on fully incorporating the SAP process into CC in Hounslow is on hold until this guidance is published.

#### 4.8.6 ***Local performance and future priorities***

In 2004/07, Housing & Community Services Assessment and Care Management teams have benefited from additional investment (up from £3.567m in 2003/04 to £4.179m in 2005/06, an increase of 17%), and there has been a substantial improvement in performance against the most important performance indicators D55 and D56 over the last two years in particular (acceptable waiting times for assessment and care packages).

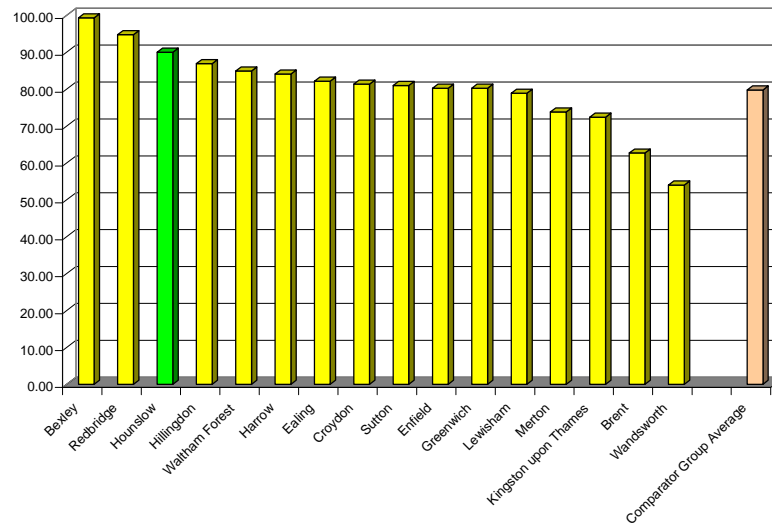
- 4.8.5 D55 and D56 were revised indicators for 2004/05, and the threshold for the banding system was raised for both in 2005/06.

<b>PAF D55 - Acceptable waiting times for assessment</b> Description (average % of assessments commenced within 48 hours and completed within 4 weeks)		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>Target</b> 70% ●●●	<b>Target</b> 77.5% ●●●	<b>Target</b> 91.3% ●●●●●
<b>Performance</b> 71.0% ●●● <i>Achieved</i>	<b>Performance</b> 90.0% ●●●●● <i>Exceeded</i>	<b>Performance</b> 89.3% ●●●●● <i>Not Achieved</i>

<b>PAF D56 - ACCEPTABLE WAITING TIMES FOR CARE PACKAGES</b> Description (for new older clients, % for whom the time from completion of assessment to provision of all services in the care package is less than or equal to 4 weeks)		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>Target</b> 85% ●●●●●	<b>Target</b> 87.5% ●●●●●	<b>Target</b> 92% ●●●●●
<b>Performance</b> 90.5% ●●●●● <i>Achieved</i>	<b>Performance</b> 91.1% ●●●●● <i>Exceeded</i>	<b>Performance</b> 86.4% ●●●●● <i>Not Achieved</i>

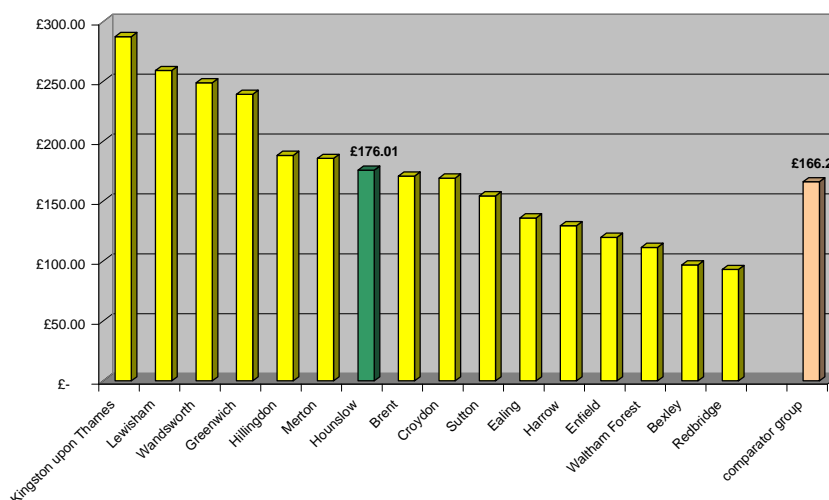
4.8.6 Hounslow performs well judged against our comparator group for 2005/06 ranking 3<sup>rd</sup> out of 16 for D55, and 5<sup>th</sup> for D56.

D55 (Acceptable Waiting Times For Assessment) - Hounslow & Comparator Group (2005/06)



4.8.7 The most recently available comparable data on investment in assessment and care management for older people is from 2005/06<sup>xxvii</sup>. The chart below shows that Hounslow spent slightly above the comparator group average on a per capita basis on assessment and care management.

Gross expenditure on assessment and care management for older, per capita aged 65 and over, 2005-06



4.8.8 Over the next three years, as there is likely to be far less opportunity for new investment, we anticipate maintaining current levels of performance for both indicators.

<b>PAF D55 - ACCEPTABLE WAITING TIMES FOR ASSESSMENT</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> 90.5% ●●●●●	<b>Target</b> 90.5% ●●●●●	<b>Target</b> 90.5% ●●●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

<b>PAF D56 - ACCEPTABLE WAITING TIMES FOR CARE PACKAGES</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> 90.5% ●●●●●	<b>Target</b> 90.5% ●●●●●	<b>Target</b> 90.5% ●●●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

## 4.8.9

With regard to other assessment related indicators; Hounslow has also performed well in the last three years. For D39, performance has improved year on year, and our performance rating is good. The bandings for D40 were changed for 2004/05, and ●●● is the highest banding achievable. Hounslow performs well judged against our comparator group ranking 4<sup>th</sup> out of 16, in 2005/06.

<b>PAF D39 - PERCENTAGE OF PEOPLE RECEIVING A STATEMENT OF THEIR NEEDS AND HOW THEY WILL BE MET</b>		
Description (the percentage of adults and older people receiving a statement of their needs and how they will be met)		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>Target</b> 97% ●●●●	<b>Target</b> 98.5% ●●●●	<b>Target</b> 98% ●●●●
<b>Performance</b> 92.4% ●●● <i>Not Achieved</i>	<b>Performance</b> 96.3% ●●●● <i>Achieved</i>	<b>Performance</b> 97.7% ●●●● <i>Achieved</i>

<b>PAF D40 - CLIENTS RECEIVING A REVIEW</b>		
Description (adult and older clients receiving a review as a percentage of those receiving a service)		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>Target</b> 65% ●●●	<b>Target</b> 70% ●●●	<b>Target</b> 80% ●●●
<b>Performance</b> 64.8% ●●● <i>Achieved</i>	<b>Performance</b> 76.5% ●●● <i>Achieved</i>	<b>Performance</b> 68.9% ●●● <i>Achieved</i>

The forward targets for both indicators reflect the likely position with little prospect of additional investment, and consequently we anticipate maintaining current levels of performance for both indicators.

<b>PAF D39 -PERCENTAGE OF PEOPLE RECEIVING A STATEMENT OF THEIR NEEDS AND HOW THEY WILL BE MET</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> 100% ●●●●●	<b>Target</b> 100% ●●●●●	<b>Target</b> 100% ●●●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

<b>PAF D40 - CLIENTS RECEIVING A REVIEW</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> 75% ●●●	<b>Target</b> 75% ●●●	<b>Target</b> 75% ●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

4.8.10 The indicators E47 and E48 measure equality of access to assessment and care. It is unlikely that people from black and minority ethnic groups will have less need to access social services than white people, and in some cases their need may be greater. People whose first language is not English may have difficulty in accessing services. For both indicators, a value of less than one would suggest that people from black and minority ethnic communities have less access to services than white people.

Both indicators were not banded in 2004/05, and only the ●● and ●●● bands are used by CSCI until we become more confident about how to interpret this indicator. In 2005/06, 'key thresholds' were introduced which aimed to ensure all councils were able to report the ethnicity of at least 90% of users.

In 2005/06, 66% of all councils achieved ●●● in respect of E47, up from 57% the previous year. For E48, in 2005-/06, all council types reported a fall other than Outer London boroughs. Hounslow has remained in the ●●● band throughout the last three years for E47 and for the last two years for E48.

### PAF E47 – ETHNICITY OF OLDER PEOPLE RECEIVING ASSESSMENT

Description (the percentage of older service users receiving an assessment that are from minority ethnic groups, divided by the percentage of older people in the local population that are from minority ethnic groups)

2004/05	2005/06	2006/07
<b>Target</b> 1.01 ●●●	<b>Target</b> 1.01	<b>Target</b> 1.10 ●●●
<b>Performance</b> 1.09 ●●● <i>Achieved</i>	<b>Performance</b> 1.28 <i>Achieved</i>	<b>Performance</b> 1.33 ●●● <i>Achieved</i>

### PAF E48 - ETHNICITY OF OLDER PEOPLE WITH SERVICES FOLLOWING AN ASSESSMENT

Description (ratio of the percentage of older service users receiving services following an assessment that was from a minority ethnic group to the percentage of older service users assessed who were from a minority ethnic group)

2004/05	2005/06	2006/07
<b>Target</b> 1.01 ●●●	<b>Target</b> 1.01	<b>Target</b> 1.00 ●●●
<b>Performance</b> 0.89 ●● <i>Not Achieved</i>	<b>Performance</b> 1.04 <i>Achieved</i>	<b>Performance</b> 0.98 ●● <i>Not Achieved</i>

The forward targets for both indicators are to maintain performance in the top band, with the target for E47 being set higher than E48 to reflect the problems that older people from black and ethnic minorities may have in initial access.

<b>PAF E47 – ETHNICITY OF OLDER PEOPLE RECEIVING ASSESSMENT</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> 1.10 ●●●	<b>Target</b> 1.10 ●●●	<b>Target</b> 1.10 ●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

<b>PAF E48 - ETHNICITY OF OLDER PEOPLE WITH SERVICES FOLLOWING AN ASSESSMENT</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> 1.01 ●●●	<b>Target</b> 1.01 ●●●	<b>Target</b> 1.01 ●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

- 4.8.11 E82 has a revised definition for 2005/06, and E50 covering assessments and reviews was replaced by E82 covering assessments only. The indicator wasn't banded for either 2004/05 or 2005/06. This indicator is related to Increased choice and control in the Department of Health's *Our Health, Our Care, Our Say* outcomes framework, and good performance is seen as being neither too high nor too low.

<b>PAF E82 – ASSESSMENTS OF ADULTS AND OLDER PEOPLE LEADING TO PROVISION OF SERVICE</b>		
Description (the percentage of assessments which lead to service being provided)		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>Target</b> 60.0	<b>Target</b> 60.0	<b>Target</b> 60.0
<b>Performance</b> 35.2	<b>Performance</b> 52.9	<b>Performance</b> 78.1

As performance against this indicator has varied considerably, the future target is to move closer to the national average on a consistent basis, for 2005/06, this was 70%.

<b>PAF E82 – ASSESSMENTS OF ADULTS AND OLDER PEOPLE LEADING TO PROVISION OF SERVICE</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> 70	<b>Target</b> 70	<b>Target</b> 70
<b>Top PAF Band</b> TBC	<b>Top PAF Band</b> TBC	<b>Top PAF Band</b> TBC

We propose to

- Continue work jointly across Housing & Community Services, the Primary Care Trust, West London Mental Health Trust and West Middlesex University Hospital to implement SAP;
- Locally evaluate specialist tools for long-term conditions as developed by FACE, and roll-out as necessary;
- Pilot person-held records;

- Test any changes to care plans and mechanisms for information sharing at a paper level, involving Community Matrons, Primary Care Social Workers and one team of District Nurses and Care Managers.
- Develop self-assessment and life history books;
- Develop the FACE tools as e-forms;
- Work with the London RiO development team to ensure that future versions of RiO are SAP compliant and is as simple to use as possible at a local level; and
- Ensure that the SAP framework is considered and incorporated into local plans via the local clinical transformation workshops

## 4.9 Programme 9: Healthy Ageing

### **National Aims:**

- To improve physical fitness through encouraging and communicating the benefits of moderate regular exercise for older people.
- To overcome barriers to active life for older people through giving attention to equipment, foot-care, oral health, continence care, low-vision and hearing services.
- To improve access to health care and health promotion services for older people who are socially isolated, living in poverty, have mental health problems and those from black and minority ethnic groups, and protect vulnerable older people from cold and heat-related illness.
- To extend healthy active life expectancy through disease prevention and modifying health behaviour through life checks and social marketing techniques.

4.9.1 Promoting healthy ageing is a strong theme in the National Service Framework for Older People, and a top priority of many organisations which represent older people. Contrary to popular belief, health promotion services are popular amongst older people, with a strong evidence base for effectiveness in producing good health outcomes and reducing pressure on services and families by reducing impairments and disabilities. Activities such as exercise classes and dancing, promote not only health and independence, but also increase social interaction leading to improved emotional well-being.

4.9.2 The Council have commissioned physical exercise sessions through contracts with the Indian Gymkhana and Age Concern (Hounslow). Additional sessions will be made available from January 2008, with the opening of Greenrod Place Extra Care Unit. Uptake has been monitored to date through the Hounslow Local Area Agreement.

- 4.9.3 A bid for the development of a Social Foot-care service will be considered in the next round of the Housing & Community Services Invest To Save programme.
- 4.9.4 Services for adults and older people with sensory impairment are considered in detail in the Joint Commissioning Strategy for Physical Disabilities & Sensory Impairment.
- 4.9.5 Many older people living in residential and nursing care or sheltered accommodation experience difficulties due to sight problems. The Royal National Institute of the Blind has developed Visibly Better<sup>xxviii</sup> as a comprehensive accreditation scheme for residential and nursing homes, and for providers of sheltered housing. The scheme has been introduced by RNIB to address the large number of enquiries requesting details of accommodation suitable for older people with a sight problem and to assist providers in ensuring that their service is accessible under the Disability Discrimination Act.

Visibly Better involves achieving a set of standards based around three areas:

- staff training;
- communication and information; and
- environment (internal and external).

- 4.9.6 The Council and PCT commission services for adults of all ages with physical disabilities and sensory impairment, which are designed to ensure that the environment of care more closely meets the needs of older people. Again, more detailed information about wheelchairs, the integrated community equipment service and environmental controls is to be found in the Joint Commissioning Strategy for Physical Disabilities & Sensory Impairment.

Hounslow Integrated Community Equipment Service was re-tendered in 2006, and operates across health and

social care to develop community equipment services in England, remove unnecessary barriers for users and modernise services.

<b>PAF D54 – PERCENTAGE OF ITEMS OF EQUIPMENT AND ADAPTATIONS DELIVERED WITHIN 7 WORKING DAYS</b> Description (percentage of items of equipment and adaptations delivered within 7 working days)		
2004/05	2005/06	2006/07
<b>Target</b> 90.00 ●●●●●	<b>Target</b> 90.00 ●●●●●	<b>Target</b> 91.00 ●●●●●
<b>Performance</b> 75.20 ●●● <i>Not Achieved</i>	<b>Performance</b> 81.32 ●●●●● <i>Not Achieved</i>	<b>Performance</b> 93.00 ●●●●● <i>Achieved</i>

<b>PAF D54 – PERCENTAGE OF ITEMS OF EQUIPMENT AND ADAPTATIONS DELIVERED WITHIN 7 WORKING DAYS</b> Description (percentage of items of equipment and adaptations delivered within 7 working days)		
2007/08	2008/09	2009/10
<b>Target</b> 95.00 ●●●●●	<b>Target</b> 95.00 ●●●●●	<b>Target</b> 95.00 ●●●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

- 4.9.7 Since April 2006, the assessment and provision of wheelchairs has been contracted to Hounslow PCT. The service is based at Manor House, Feltham, offering both clinics and home visits. The delivery, collection, modification, maintenance and repair service is sub-contracted to Synergy Healthcare Group, located in Park Royal. Waiting times for assessment have been minimised, where they had been had been averaging nine months prior to bringing the service in-house.

Waiting times remain an issue for the specialist seating and indoor/ outdoor powered wheelchairs contracted out to the Disability Services Centre at Stanmore. In July 2006, 33 Hounslow residents were waiting for a service, as against 83 others who already had a chair or seat from the centre.

- 4.9.8 Contenance care is a substantial issue for older people, however it remains one of society's major taboos. One in four women and one in ten men will suffer with incontinence at some time. One-third of older people in residential homes and two-thirds of those in nursing homes have problems with their continence.

From September 2007, the PCT's Contenance Service will see all clients not visited by the District Nursing Service presenting with bladder and bowel problems. This will offer a more treatment-focused assessment, looking at the cause, treating the problem and providing the correct management.

The Contenance Service will continue to offer continence promotion clinics at Heart of Hounslow and Brentford Health Centres. These are weekly for female clients and monthly for male. Home visits are offered to those with impaired mobility.

- 4.9.9 Further information relating to healthy ageing is contained in the following chapter.

We propose to:

- Ensure that all residential care services operating in the borough are aware of the RNIB accreditation scheme; and
- Ensure that all block contract providers work towards accreditation
- Explore the possibilities of the PCT prescribing physical activities courses for older people

## 4.10 Programme 10: Independence, Well-being and Choice

### National Aims:

- To increase the use of assistive technology to promote independence.
- To strengthen leadership and partnership between councils, the local NHS and the voluntary sectors in the promotion of the well-being of older people and their families.
- To increase the use of direct payments and individual budgets to increase choice for older people and their families in social care.
- To increase the uptake of assessment and response to carers' needs.

### 4.10.1 Assistive Technology

In 2005, the Department of Health launched **Building Telecare in England**, a strategy designed to pump-prime the market for Assistive Technology and to strengthen the partnership between health, local government and industry. Over the two years 2006/07 and 2007/08, £80m has been made available to Councils via the release of the Preventative Technology Grant for the promotion of Assistive Technology. Funds were not ring fenced but the document states that “the grant should be used to increase the numbers of people who benefit from telecare, by at least 160,000 older people nationally”, and the progress Councils are making is monitored through their annual returns to the Commission for Social Care Inspection.

The allocation for Hounslow for 2006/7 was £111,000, followed by a further £182,000 in 2007/08. At this time, it is not anticipated that additional funds will be made available beyond 2007/8. Telecare service provision is expected to form a standard part of any care package where a benefit is seen to exist. Consequently, expectations are that savings generated in other service

areas will fund the mainstreaming of Telecare on an 'invest to save' basis.

Locally, a multi agency, cross care group, Project Board encompassing Health, Housing and Social Services, has been established in order to:

- Design and implement a pilot project focusing on the use of Telecare/Telehealth devices by:
  - People living with dementia
  - People affected by Chronic Obstructive Pulmonary Disease;
- To establish partnership working with the London Fire Brigade and Metropolitan Police to facilitate the provision and monitoring (where necessary) of smoke alarms and intruder/bogus caller alarms within the homes of vulnerable borough residents;
- To develop a Borough wide processes and pathways for accessing Telecare and/or Telehealth devices;
- To establish an Intermediate Care assessment flat at Dashwood Court, with Telecare peripherals and connected to the monitoring service; and
- To create a demonstration site at the Calen Centre for the purpose of training and raising awareness of Telecare equipment.

The overall aim of the pilot projects is to demonstrate whether the use of Telecare can reduce risk, enhance choice and maintain levels of independence for older people living in the community and their carers. The pilot started in November 2006 and will run until the end of November 2007. The pilot aims to:

- Evidence the benefits of Telecare for service users and carers.
- Test the use of a broad range of technologies to ensure the study can usefully inform the mainstreaming of Telecare equipment in the future.
- Ensure data related to the installation, monitoring and response is collated in a regular and systematic fashion.

- Increase awareness of the potential use of Telecare and how it can be used in the home, informing service users, their carers and associated professionals.
- Establish through the review/monitoring system whether the use of Telecare has enabled service users to remain in their own property for a longer period of time.
- Establish whether the use of Telecare prevents or delays inappropriate admissions into hospital or a care establishment and whether it has facilitates earlier hospital discharge.
- Establish whether or not the use of Telecare achieves the specific, individualized objectives set by the care manager, in partnership with the user and carers prior to installation.
- Establish if there has been a potential cost saving as a result of the use of Telecare.

The pilot is a partnership between

- Hounslow Homes Community Care Alarm Service who will act as the monitoring centre for alarm calls from service users, co-ordinate the purchase, installation and removal of equipment and provide call information to assist in the review of individual referrals;
- Housing & Community Services Social Services Teams (commencing with the Older People's Community Mental Health Team) who will identify potential service users, secure their agreement to take part in the study, liaise with other relevant agencies involved with the service user and lead in the review of those cases; and
- Tunstall, who will provide the equipment to be used in the pilot and give technical advice as required to ensure that the telecare sensors are used effectively.

The equipment available for use at the beginning of the pilot study is listed below. If the need exists additional sensors may be provided from an exceptional items list, subject to further authorisation.

**Standard Items List:**

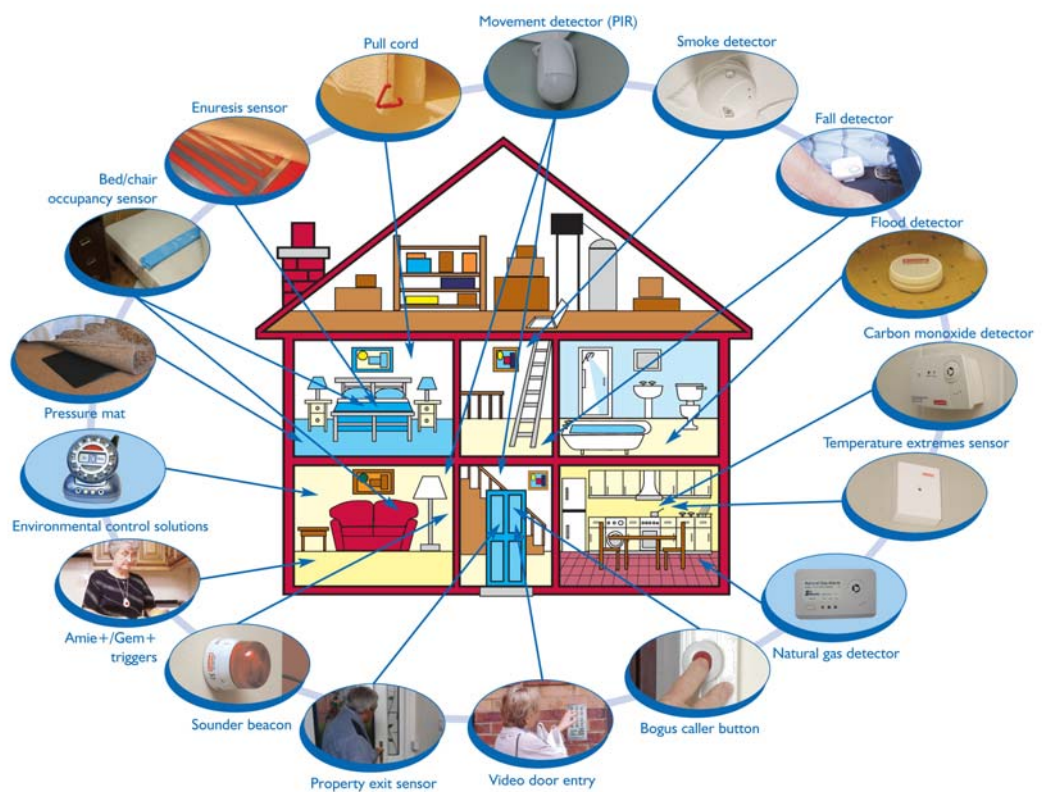
Linkline Pendant  
 Pillow Alert  
 Smoke Alarm  
 Natural Gas Detector

Carbon Monoxide Detector  
 Property Exit Sensors  
 Bogus Caller Button

**Exceptional Items List**

Flood Detector  
 Pressure Mat  
 Memo Minder

Temperature Extremes Sensor  
 Bed Occupancy Sensor



Hounslow Housing & Community Services have also entered into an arrangement with 'Alertacall'. 'Alertacall' has adapted a standard big button telephone handset to incorporate a "special button" which, when pressed by a

predefined time each day allows the service user to confirm their safety.

If the service user is unable to confirm their safety, if for example they have fallen or are too unwell to get out of bed, the call centre will try to contact them to find out what is wrong. In some circumstances it may simply be that the service user has forgotten to press the “button” however should the need arise the call centre operator can call for the emergency services and/or a nominated responder to come to the service user’s aid.



Alertacall Telephone with Special Button

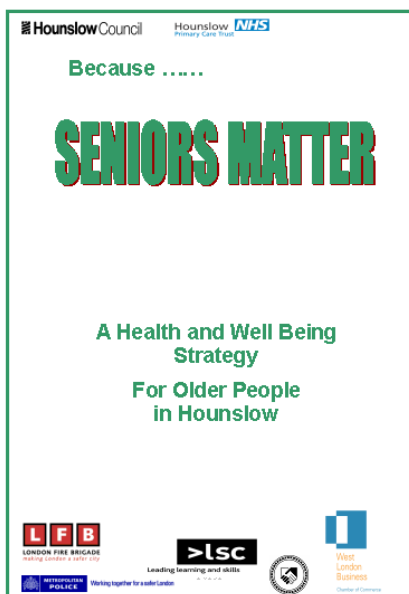
<b>SAS LINE 2.1OP026 - 2.1OP028 – ASSISTIVE TECHNOLOGY</b> DESCRIPTION (NUMBER OF NEW PEOPLE WHO USE SERVICES AGED 65 AND OVER PROVIDED IN WITH 1 OR MORE ITEMS OF TELECARE EQUIPMENT IN THEIR OWN HOMES (OR EQUIVALENT SUCH AS EXTRA CARE / WARDEN HOUSING))		
2004/05	2005/06	2006/07
NA	NA	Performance 273
NA	NA	Target 433 <i>Not Achieved</i>

<b>SAS LINE 2.1OP026 - 2.1OP028 – ASSISTIVE TECHNOLOGY</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target 425</b>	<b>Target TBC</b>	<b>Target TBC</b>

We propose to:

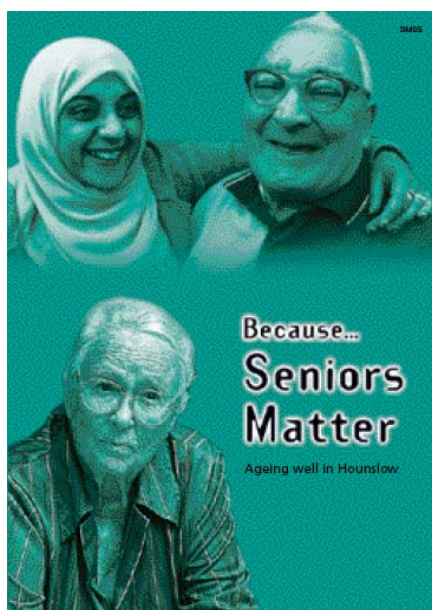
- Complete the Telecare/Telehealth pilots for people living with dementia and people affected by Chronic Obstructive Pulmonary Disease; and
- Develop a long-term strategy for Assistive Technology based on the findings of the pilots, and on learning from other authorities experience

## 4.10.2 Leadership, Partnership and the Promotion of the Well-Being of Older People



In 2005, the Local Strategic Partnership endorsed **Because Seniors Matter, A Health & Well Being Strategy for Older People in Hounslow**. The strategy seeks to promote the quality of life for older residents in Hounslow’s diverse communities by supporting people to live as active citizens able to continue with their contribution and safely

participate in social, economic, cultural, spiritual and civic affairs.



11 key aims are encompassed within the strategy, and most mirror the themes discussed within the **Older Persons Handbook – A Guide To Ageing Well In Hounslow**. The handbook was one of the first “products” of this strategy and emphasises the important role of information and advice by serving as a signposting document to increase

awareness and recognition of the wealth of needs and wants experienced by older people in the borough and the services, facilities and networks that exist to support this.

The 11 aims cover:

- Increase Older People's engagement
- Looking after your health, keeping mentally healthy and exercising your mind and body
- Looking after your finances
- A positive attitude
- Keeping yourself safe
- Assisted transport
- Maintaining Independence and Accident prevention at home
- Social care
- Information and Advice
- Lifelong learning
- Caring for someone else

The strategy and its action plan are overseen by a group led by members of the Hounslow Older People's Volunteer Pool. Subsequent to this strategy, specific targets related to improving the well-being and independence of people aged 65 and over were included in Hounslow's Local Area Agreement. These covered increasing the numbers of older people taking moderate exercise and increasing the numbers of older people actively engaged in the Council's Older People's Volunteer Pool.

Research has shown that a ***moderate programme of physical exercise*** can significantly offset the risk factors for heart disease and diabetes<sup>xxix</sup>. Regular exercise may also speed up the wound healing process in older people<sup>xxx</sup>.

There are clear links with the Falls and Bone Health Programme, a Canadian study found that resistance

training and agility exercises in older women with lower bone mass or osteoporosis reduces the likelihood of falling. The findings show that individuals with osteoporosis should be encouraged to be active with the proper supervision, rather than to avoid physical activity due to concerns about safety<sup>xxxii</sup>.

A Dutch study examined whether the fear of falling among older adults contributed to restricted outdoor physical activity levels. It was found that 22% of the adults reported fear of falling down outside their home, of which 3% did actually fall during the ten month follow-up. The study suggests that people with a high fear of falling outside restrict their physical activity to reduce their risk of falling and that older people should first build up their physical abilities in a safe environment before increasing physical activity outside<sup>xxxiii</sup>.

<b>LAA 65 – NUMBERS OF OLDER PEOPLE TAKING MODERATE EXERCISE THROUGH IDENTIFIED PROGRAMMES (DEVELOPMENT OF ‘AGEWELL’)</b>		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>NA</b>	<b>NA</b>	<b>Performance Increase by XX</b>
<b>NA</b>	<b>NA</b>	<b>Target Increase by XX Achieved</b>

<b>LAA 65 – NUMBERS OF OLDER PEOPLE TAKING MODERATE EXERCISE THROUGH IDENTIFIED PROGRAMMES (DEVELOPMENT OF ‘AGEWELL’)</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target 80 (LAA)</b>	<b>Target 85 (LAA)</b>	<b>Target 85</b>

Active engagement with older people is demonstrated by statutory agencies involving local older people to actively establish local priorities, devise plans, develop and design services, deliver services, monitor and evaluate processes and outcomes.

Since 2004, ***Hounslow Older People's Volunteer Pool*** has provided opportunities for local older people to

- Review publicity material, ensuring that it's accessible, appropriate and understood by older people;
- Participate in the Older People's Panel to monitor the quality and access to community (social), health and community services for older people; and
- Participate in the interview and selection procedures for staff to be employed in older people's services for Hounslow
- Participate in the tendering procedures for new external contracts for services to be provided to older people in Hounslow.

<b>LAA 67 - NUMBERS OF PEOPLE AGED 65 AND OVER VOLUNTEERING AS PART OF THE NSF STANDARD 8 VOLUNTEER POOL</b>		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>NA</b>	<b>NA</b>	<b>Performance</b> Increase by XX
<b>NA</b>	<b>NA</b>	<b>Target</b> Increase by XX <i>Achieved</i>

<b>LAA 67 - NUMBERS OF PEOPLE AGED 65 AND OVER VOLUNTEERING AS PART OF THE NSF STANDARD 8 VOLUNTEER POOL</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> <b>80 (LAA)</b>	<b>Target</b> <b>85 (LAA)</b>	<b>Target</b> <b>85</b>

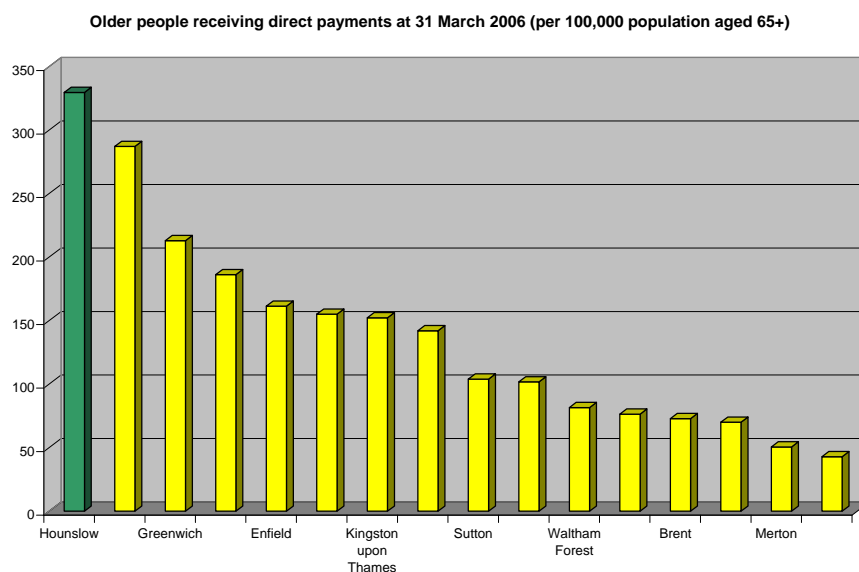
We propose to:

- Prioritise commissioning services for older people which promote active exercise opportunities;
- Expand the opportunities for older people to volunteer

### 4.10.3 Direct Payments

Direct payments are cash payments made in lieu of social service provisions, to individuals who have been assessed as needing services. The aim of a direct payment is to give more flexibility in how services are provided to many individuals who are assessed eligible for social services support. By giving individuals money in lieu of social care services people are able to make their own decisions about how their care is delivered.

Hounslow performs well in this area, particularly with regard to uptake of Direct Payments by older people. As at March 31<sup>st</sup> 2006, the proportion of older people in receipt of Direct Payments locally, was two and a half times that of our comparator group.



For 2006/07, Direct Payments for Older People formed part of the Hounslow Local Area Agreement, and increase in performance was agreed with the Government Office for London, as a stretch target. Achievement of this target year three would entitle Hounslow to receive Performance Reward Grant (for this indicator totalling £49,672). In 2006/07, we have marginally exceeded the target set.

<b>PAF D51 – DIRECT PAYMENTS</b>		
DESCRIPTION (ADULTS AND OLDER PEOPLE RECEIVING DIRECT PAYMENTS AT 31ST MARCH PER 100,000 POPULATION AGED 18 OR OVER)		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>Performance</b> 118.66 ●●●●	<b>Performance</b> 153.05 ●●●●●	<b>Performance</b> YTD 143.29 ●●●●
<b>Target</b> TBC ●●●●● <i>Achieved</i>	<b>Target</b> TBC ●●●●● <i>Achieved</i>	<b>Target</b> 160.00 ●●●●● <i>Not Achieved</i>

<b>PAF D51 – DIRECT PAYMENTS</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> TBC ●●●●●	<b>Target</b> TBC ●●●●●	<b>Target</b> TBC ●●●●●
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

<b>LAA 5c – DIRECT PAYMENTS</b>		
DESCRIPTION (OLDER PEOPLE RECEIVING DIRECT PAYMENTS AT 31ST MARCH PER 100,000 POPULATION AGED 65 OR OVER)		
<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>Performance</b> 60	<b>Performance</b> 79	<b>Performance</b> 78
<b>Target</b> 50 <i>Achieved</i>	<b>Target</b> 70 <i>Achieved</i>	<b>Target</b> 75 (LAA) <i>Achieved</i>

<b>LAA 5c – DIRECT PAYMENTS (OLDER PEOPLE)</b>		
<b>LAA STRETCH TARGET</b>		
<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
<b>Target</b> 80 (LAA)	<b>Target</b> 85 (LAA)	<b>Target</b> 85

**Individual Budgets** were announced in 2005 as a collaboration between the Department of Health, the Department of Communities and Local Government and the Department of Work & Pensions. The idea behind individual budgets is to enable people needing social care and associated services to design that support and to give them the power to decide the nature of the services they need, extending the concept of Direct Payments. There are currently 13 pilot sites nationally of which 8 are working with older people. The funding for Individual Budgets has included social care funding, as well as combinations of Independent Living Fund, Supporting People, Community Equipment, Disabled Facilities Grants and Access to Work budgets.

Pilots have identified issues around engaging older people's interest and acceptance of Individual Budgets, particularly informed by the experience of the relatively low take-up of Direct Payments by older people (the overwhelming majority of pilot sites have substantially lower take-up of Direct Payments by older people than Hounslow).

Research from the pilots indicates that "older people generally express high levels of satisfaction with the care services they receive. When given the choice, some people with less than ideal support packages are still willing to trade the security and quality of a known provider for loss of flexibility. For them, this can be a positive choice. Even for those who decide to retain their conventional care package, the process of undertaking the self assessment and discussing the option of an Individual Budget can make older people feel they matter from the start"<sup>xxxiii</sup>.

We propose to:

- Increase the uptake in Direct Payments by older people in line with our LAA target; and

- Continue to monitor the evaluation of the IB pilots and embed the learning from these into future commissioning plans.

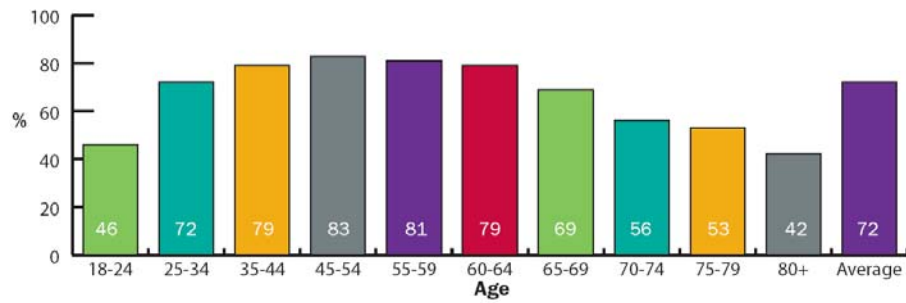
#### 4.10.4 **Carers Assessment & Services**

This strategy should be read in conjunction with the forthcoming Carers Strategy, which will be considered by the Council and PCT in Spring 2008.

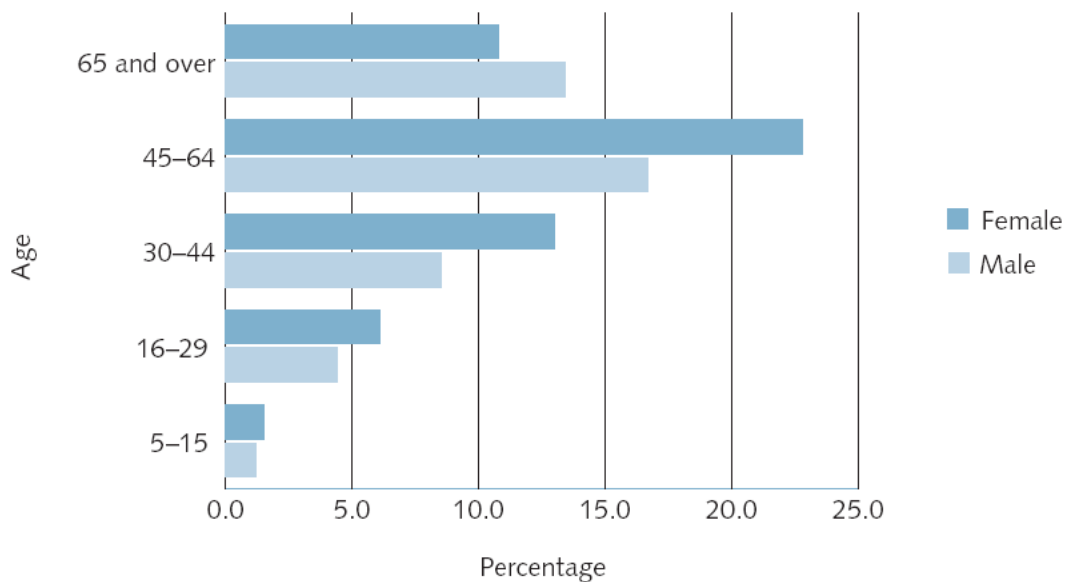
The 2001 Census, for the first time, asked a question about whether people provided unpaid care for a family member or friend and for how many hours. The resultant picture was one of a substantial amount of care being provided. There are six million people caring in the UK, including over a million providing more than 50 hours a week. Around 2.2 million people either start or stop caring every year.

Locally, the census identified 18,921 carers in Hounslow, with 3,583 providing 50 hours a week or more, equating to 1 in 40 adults of working age.

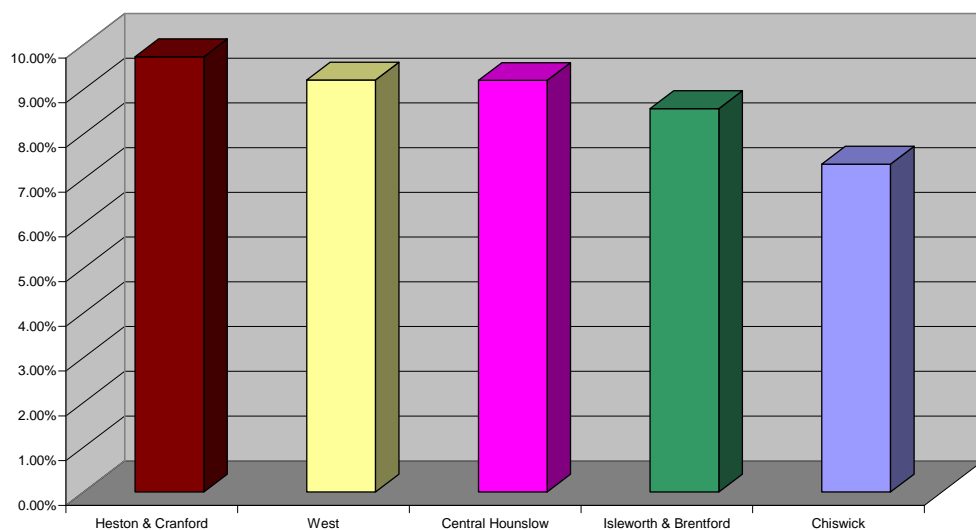
Three-quarters of carers are financially worse off because of their caring responsibilities. Carers UK have found that 54% of carers have had to give up work to care because they find it so hard to juggle caring with work. Carers are half as likely to be in paid work as the national average<sup>xxxiv</sup>. 72% of carers have become financially worse off since becoming a carer (see diagram below) and the longer someone is a carer, the more likely they are to be on a poor income - those caring long term are more likely to be in receipt of Income Support.



Over 225,000 people providing 50 or more hours of unpaid care per week state they are 'not good health' themselves. More than half of the people providing this much care are over the age of 55.



% Carers identified at 2001 census (all people)



Carers who provide high levels of care for sick, or disabled relatives and friends, unpaid, are more than

twice as likely to suffer from poor health compared to people without caring responsibilities. Analysis of the Census shows that in Hounslow nearly 19.3% of carers providing over 50 hours of care say they are in poor health compared to nearly 9.3% of the non-carer population<sup>xxxv</sup>.

Locally, a number of carers support schemes have been funded under Joint Finance arrangements (originally under the under the Ealing, Hammersmith and Hounslow Health Authority) and the Carers Grant. Joint Finance was an annual sum of money allocated to the health authority for use in encouraging joint working with other agencies. Investment was agreed by a Joint Consultative Committee consisting of representatives from health and local authorities and voluntary organisations. Such monies were normally spent on jointly agreed projects to provide wider social care outside of hospitals. The Carers Grant was introduced in 1999, following the publication of the **1999 National Carers Strategy ('Caring for Carers')**.

The national '**Your health, Your care, Your say**' listening exercise revealed considerable public support for carers. Better support for carers came third in the 'people's options' at the national Citizens' Summit. The Department of Health have encouraged councils and PCTs to nominate leads for carers' services.

In 2003, the Department of Health issued guidance to PCTs reminding them that "in line with the 1999 National Carers Strategy, they should be actively working in partnership with social services to consult, inform and support carers"<sup>xxxvi</sup>. Lord Warner, speaking in the House of Lords in June 2004, made it clear that "it should be for the local NHS to demonstrate to their strategic health authorities that they are effectively taking account of the needs of carers in their planning processes. If strategic health authorities are not satisfied that that is the case or

if the Department of Health has specific examples of how the process is not working, we will intervene”<sup>xxxvii</sup>.

In 2007, the Government launched the New Deal for Carers. This will include additional funding for emergency support, a national helpline for carers and an expert carers programme. In addition, there will be consultation on future support for carers, as the 1999 National Strategy for Carers is updated.

In 2004, the Audit Commission published research, ***The Effectiveness and Cost-effectiveness of Support and Services to Informal Carers of Older People***, into the effectiveness of services found evidence to suggest that daycare, home help/care and institutional respite care can be effective in delaying admissions to institutional care. However, in some cases institutional respite care can increase the probability of admissions. The Evaluating Community Care for Elderly People study in 2000 found that provision of institutional respite care increased the length of time spent by the older person in the community in some cases (for example, carers of older people with behavioural problems), but decreased it in others (in particular, those with ‘bad user-carer relationships’ and more reliant older people).

The Audit Commission found insufficient evidence to evaluate effectiveness of in-home respite care (of the kind locally commissioned from Hounslow Crossroads and The Asian Health Agency). It was noted that this was unfortunate “because this is a form of service that older people and carers particularly value and for which there are expressed unmet needs”.

There was no conclusive evidence to suggest that carer support groups (commissioned locally from the Alzheimer’s Society) are an effective intervention for carers. However, the literature suggests that support groups are valued by those who attend.<sup>xxxviii</sup>

The Audit Commission concluded that “there is evidence that older people are often ambivalent about services such as daycare and institutional respite care. Daycare that is provided primarily to benefit the carer may not be what the user wants, especially when this involves frequent attendances at a day centre. Equally, many older people do not want to go into an institution, even if this is just for a short stay”.

The lack of evidence cited above is concerning, but it should be noted that this reflects a lack of research rather than a serious suggestion that such forms of care are not effective. The absence of evidence should not in any way be used a pretext for minimising the value of these services.

<b>PAF C62 – SERVICES FOR CARERS</b> DESCRIPTION (THE NUMBER OF CARERS RECEIVING A ‘CARER’S BREAK’ OR A SPECIFIC CARERS’ SERVICE AS A PERCENTAGE OF CLIENTS RECEIVING COMMUNITY BASED SERVICES)		
2004/05	2005/06	2006/07
<b>Performance</b> 8.61 <b>Unbanded</b>	<b>Performance</b> 9.39 ●●●●	<b>Performance</b> 13.00 ●●●●●
<b>Target</b>	<b>Target</b> 20.0●●●●● <i>Not Achieved</i>	<b>Target</b> 12.00 ●●●●● <i>Achieved</i>

<b>PAF C62 – SERVICES FOR CARERS</b>		
2007/08	2008/09	2009/10
<b>Target</b> 14.0	<b>Target</b> 14.0	<b>Target</b> 14.0
<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓	<b>Top PAF Band</b> ✓

We propose to:

- Adopt the Carers Charter; and
- Tender for one contract for the same hours currently provided on the contracts provided by Crossroads and TAHA.

## 4.11 Substance Misuse and Older People

4.11.1 Substance abuse among older people, including abuse of alcohol and prescription and over-the-counter drugs, has been called an “invisible epidemic”<sup>xxxix</sup>. The signs of abuse in older adults tend to vary from those presented in younger adults and this variation can complicate the diagnosis. For a number of reasons, substance misuse problems can go undetected for longer among older people. In many ways, the lack of detection mirrors issues related to identifying depression in older people. Substance misuse can present in a number of non-specific ways – accidents, depression, insomnia, confused states and self-neglect – some of which are may be mistaken as being related to linked to the aging process.

4.11.2 Alcohol Concern report that in Britain adults aged 55 and over are more likely than their European counterparts to be regular drinkers and Britain is the only country in Europe to have a statistically significant number of adults aged 55 and over drinking more than 6 units per day (1%). The number of men over 65 exceeding 21 units per week increased by 31% between 1988 and 2000 (from 13% to 17%); the number of women over 65 drinking more than 14 units per week rose by 75% in the same period (from 4% to 7%)<sup>xl</sup>.

4.11.3 Factors that can trigger heavy drinking in older people include:

- Bereavement;
- Mental stress;
- Physical ill health
- Social isolation; and
- Loss (of occupation, function, skills, income or important people in their lives).

Physiological changes that occur as part of the aging process also mean that older people are more vulnerable

to the effects of alcohol and drugs and consequently older people experience problems at lower levels of consumption. There is a substantial increase in the risk of falls and accidents, increased likelihood of incontinence, as well as substance misuse contributing to memory loss and depression.

- 4.11.4 Older people's access to health and social care services often stems from their interactions with primary care. At one level, this can take the form of primary care acting as a signpost to other services. However, as problems become more complex, older people, their families and carers want timely support, advice and onward referral where appropriate. For these reasons, staff in primary care need adequate awareness training on substance misuse issues in later life.
- 4.11.5 There is also an ongoing need for GPs to be trained and supported, if they are to recognise and appropriately deal with substance misuse issues in older people.
- 4.11.6 The Joint Commissioning Strategy for Substance Misuse 2007-2010 is currently being written, and will be considered by the Council's Executive and the PCT Board in 2008.

We propose to:

- Review eligibility criteria/service provision to ensure equity across age groups;
- Ensure that commissioned services addressing issues of substance misuse are accessed proportionately by older people; and
- Identify GPs – especially those who make few referrals – and offer support and training.

## 4.12 Accommodation for Older People

- 4.12.1 In 2005, Hounslow Council produced an Older Peoples Housing Strategy. This strategy aims to provide the Council, and its partners from health, community and provider organisations, particularly Hounslow Homes (the Council's Arms Length Management Organisation), with a framework for the future planning of accommodation and related services for older people.
- 4.12.2 The scope of the strategy is wider than the 15% of vulnerable older people who are regular users of health and social care services. It is aimed at all older people in the borough, across tenure and income groups, and across all types of housing provision, both ordinary as well as specialist housing. In order to address the wider aims around quality of life and social inclusion, the strategy also relates to the broader local strategic context as set out in the Hounslow Community Plan.
- 4.12.3 The strategy makes 11 main recommendations supported by a large number of more detailed recommendations. These include recommendations for the direction of travel for older people's accommodation over the next 10 years and development of housing services for older people in the private housing sector. One of the main recommendations relates to integrating housing into the current social care and health Older People's Commissioning Strategy. The recommendation has fourteen detailed recommendations to be achieved over the ten-years of the strategy:
- i. Integrate Initial Contact Form from the Single Assessment Process (SAP) with Support Plans, and ensure housing is part of SAP;
  - ii. Bring together assessment and allocation procedures for sheltered and extra care housing schemes, including the development of clear, shared criteria for allocation to schemes with care provision and/or specialist services

- iii. Linking housing support services into case finding
- iv. Develop the role of sheltered housing, and time limited use of Linkline and assistive technology for older people perceived to be at risk on discharge, to support the reduction of delayed discharges from hospital, or as part of a package of care to prevent admission, through joint funding from Supporting People, Social Services and Health Partnerships
- v. Use the housing sector to help to deliver the targets in the Older People's Commissioning Strategy to shift the balance of care away from residential and nursing home care
- vi. Build the future commissioning approach for domiciliary care to deliver focused domiciliary care to meet the needs of current and future residents in designated sheltered schemes where the level of dependency provides opportunities for economies of scale in service delivery
- vii. Use the opportunity of unused capacity to develop day care services in selected sheltered housing schemes, including capital investment to improve facilities for care on schemes
- viii. Build capacity in sheltered/extra care housing to enable the provision of independent living in the community for wider groups of vulnerable older people, including people with dementia, mental health and cognitive problems, through training, information, and support
- ix. Develop the role of the housing sector to support older people with dementia in the community
- x. Use the housing sector as one arm of developing preventative services
- xi. Examine the potential of linking Direct payments for care funded through social services with Direct Payments for housing support funded through Supporting People
- xii. In partnership with Social Services and Health Partnerships (SSHP) develop intermediate care and step up/step down beds (i.e. providing more – or less–care to meet the specific needs of an individual

for example following hospitalisation) in sheltered/extra care housing

- xiii. Develop the role of sheltered housing and housing support services as part of the approach to manage older people with chronic conditions in the community and out of hospital and institutional care
- xiv. Integrate housing related support providers in one of the three established SSHP provider forums.

4.12.4 Substantial progress has been made on a number of these recommendations.

- Recommendations (ii), (vi), (vii), (viii) and (ix) are being addressed by the provision of a new Extra Care Unit, Greenrod Place in Brentford, which is scheduled to open in January 2008. A unified Housing & Community Services panel now exists as the single access point to Extra Care Housing. There will be a single care provider for the scheme, and Age Concern (Hounslow) have been commissioned to provide a programme of social activities from the unit. Five flats in the scheme have been earmarked for older adults with learning disabilities and the scheme will meet the needs of older adults with mild/moderate dementia
- Recommendation (iv) has been met through the development of Assistive Technology as set out in Chapter 4.10.1
- Recommendation (xii) has been progressed by the successful pilot of an intermediate care assessment flat at Dashwood Court (in Central Hounslow). A second flat has been opened in 2007. This supplements the seven bedded Community Rehabilitation Unit at Sandbanks.

4.12.5 Elsewhere in the recommendations, the Older People's Housing Strategy sets out a clear staged plan to develop additional extra care housing for rent. The strategy concludes that around 225 places of extra care housing are required to meet departmental targets related to the avoidance of institutional care.

The strategy proposed that this be developed in two stages. Stage 1 would be to develop a third scheme in the ideally in the west of the borough (to supplement Dashwood Court in Central Hounslow and Greenrod Place in Brentford) to bring the level of provision up to 150 units. This figure is probably too high as this would require a development containing 69 flats. Consequently, this figure should be revised down to 130, to allow for a development of approximately 50 flats. Additionally, the programme should be revised to encompass three stages.

The priority for stage 2 would remain a scheme in the Heston/Cranford area, with stage 3 focussing on Chiswick. This would allow for the development of an Extra Care Unit in each of the five areas of the borough, whilst retaining the headline figure of 225 units.

As current provision is all rented, apart from 5 units at Greenrod Place, it is proposed that all new schemes include a proportion of shared ownership, and leasehold units (if the location is appropriate) to reflect the tenure pattern in the borough, if there is demand for such units.

We propose to:

- Review the recommendations of the Older People's Housing Strategy and produce an interim report making any necessary amendments in 2008; including
- Monitoring the uptake of Extra Care at Greenrod Place, and make recommendations for the timetable of the development of a third Extra Care Unit

## **5. RESOURCES**

### **5.1 Overview**

- 5.1.1 The current service model is designed on the basis of a continuum, that has at one end 'individual well-being', and travels through various stages where mental health problems may be encountered and recognises at the other extreme, serious ill health and end of life care. The model recognises that the journey for an individual older person is not likely to be a smooth linear path along the continuum, and enables us to clearly define the input required at each stage, as well as underlining the importance of the multi-agency, multidisciplinary nature of such a service.
- 5.1.2 Hounslow Primary Care Trust and Hounslow Council's Housing And Community Services Department are seeking to support the modernisation of Services for Older People through the development of integrated assessment processes and the development of a range of services designed to meet the needs of older people at different points on the criteria rather than continued reliance on either in-patient beds or residential and nursing care.
- 5.1.3 The current patterns of service provision for older people are delivered through a mix of discrete services aimed solely at older people and generic services, where it is far harder to quantify the element related to older people's activity. For example, older people are significant users of primary care and around half of acute hospital beds are occupied by older people at any given time.
- 5.1.4 The figures in this section relate to budgets as set for 2007/08.

## 5.2 Acute Care & Rehabilitation

5.2.1 The single largest element of Hounslow PCT's expenditure is on acute hospital services. Since April 2006, hospital activity has been commissioned under Payment by Results (PbR), which introduced a national tariff for the great majority of acute care episodes.

<b>PCT:</b>	
West Middlesex University Hospital:	£62,730,000
Hammersmith Hospital:	£29,724,650
Ashford & St.Peter's Hospitals:	£12,149,211
Other Acute Hospitals:	£22,288,896
<b>TOTAL:</b>	<b>£126,892,757</b>

Over the course of this strategy, the PCT expects to **substantially reduce** the amount it spends on acute hospital services, by reproviding services in primary care in line with the recommendations of the forthcoming ***Hounslow PCT 5 Year Commissioning Strategy Plan (CSP)***. The target reduction is subject to confirmation in the CSP, but includes **£1m** specifically identified as expenditure on older people, and outlined in chapter 4.6.

5.2.2 A proportion of this saving will need to be invested in expanding Intermediate Care Services order to achieve the desired outcome.

<b>Council:</b>	
Directly Provided Services (Beds):	£220,700
Assessment & Rehabilitation Team:	£750,000
<b>TOTAL:</b>	<b>£970,700</b>
<b>PCT:</b>	
Radiate (A&E Assessment):	£234,000
Rehabilitation Ward (West Middx) & Stroke Rehab:	£1,276,914
Clayponds Hospital:	£213,251
<b>TOTAL:</b>	<b>£1,724,165</b>

Over the course of the strategy, the PCT expects to increase by **£300k** the amount it spends on rehabilitation/intermediate care. This investment is mapped in chapter 4.6.

- 5.2.3 From 2006, the Council's In-House Home Care Service has started to focus on the provision of an assessment and rehabilitation team (ART). This provides the care element of intermediate care in all cases where new packages are required, particularly focusing on hospital discharge. The ART Service is a time-limited service, providing a standard of four weeks care, which is not subject to financial assessment. Should care be required on discharge from ART, a transition to a long-term care provider occurs.

### 5.3 Residential & Nursing Care

- 5.3.1 Both the council and PCT commission substantial amounts of care home placements.

<b>Council</b> (gross spend):	
Independent Sector Spot Contracts:	£6,582,000
Independent Sector Block Contracts:	£4,639,000
Directly Provided Services:	£3,103,000
<b>TOTAL:</b>	<b>£14,324,000</b>
<b>PCT:</b>	
Independent Sector Spot Contracts*:	£1,800,000
Independent Sector Block Contracts:	£1,770,000
<b>TOTAL:</b>	<b>£3,570,000</b>

Over the course of the strategy, the Council expects to be able to **reduce by £1m** the amount it spends on care home placements and transfer money into domiciliary care budgets. This will be achieved by funding fewer placements (as set out in chapter 4.6).

Over the course of the strategy, the PCT expects to **maintain** the amount it spends on care home placements. The PCT expects the number of NHS Funded Continuing Care placements it supports to remain relatively stable. The figure given for spot contracts includes domiciliary care activity.

Both the Council and the PCT will regularly monitor the existing pattern of block and spot contracts throughout the life of this strategy, with a view to achieving the optimum balance of cost, occupancy and choice. Where both organisations have contracts with the same provider, these have been negotiated jointly.

The PCT holds current block contracts with the following nursing homes:

- **Charlotte House**, for 22 beds (EMI registered);
- **Coniston Lodge**, for 15 beds (mix of EMI and Elderly Frail);
- **Derwent Lodge**, for 8 beds (mix of EMI and Elderly Frail); and
- **The Cloisters**, for 9 beds (Elderly Frail).

The Council holds current block contracts with the following nursing homes:

- **Coniston Lodge**, for 28 beds (mix of EMI and Elderly Frail);
- **Derwent Lodge**, for 28 beds (mix of EMI and Elderly Frail);
- **Dudley House**, for 17 beds (Elderly Frail);
- **Norwood Green Care Centre**, for 22 beds (mix of EMI and Elderly Frail);

The Council has three residential care homes, which are directly provided and all provide a mix of EMI and Elderly Frail beds, these are:

- **Clifton Gardens**, which has 43 beds;

- **Heston House**, which has 60 beds; and
- **Sandbanks**, which has 34 beds (7 of which form the Community Rehabilitation Unit)

The Council also owns two residential care homes, which operate under contract to not for profit organisations with charitable status, these are:

- **Feltham Dene**, operated by Shaw Homes (providing 40 beds, of which 20 are registered for dementia care); and
- **John Collin House**, operated by Servite Houses (providing 26 beds, all elderly frail).

5.3.2 In addition to these block contracts, Hounslow Council is responsible for 237 placements, which are contracted on a 'spot' basis, with the PCT commissioning 45 such placements (both figures as of as of 1<sup>st</sup> September 2007).

5.3.3 Care homes are regulated by the Commission for Social Care Inspection (CSCI), which 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 domain documents, accessible through the CSCI website, and are used by commissioners and contracts officers in helping to assess the quality of a service.

## 5.4 Extra Care Housing

5.4.1 Extra care housing provides extra support whilst enabling older people to live as independently as possible and retain a tenancy. This is for older people who are physically or mentally frail and need extra help to manage, and who might otherwise need residential or nursing care. . The aim is to promote independence, while offering an on-site care team to meet needs flexibly 24 hours a day.

3.4.2 There is currently one scheme in Hounslow, which is at **Dashwood Court** (36 flats), with Thames Valley Housing providing housing management and the Council directly providing the care element. It is for older people with both physical health and mild to moderate mental health difficulties, either living on their own or with a partner. A second scheme, **Greenrod Court**, is under construction in Brentford at present and will provide 43 flats, some of which will be available on a shared ownership basis. This scheme is scheduled to open in early 2008 and will be managed by Housing 21.

## 5.5 Day Services

5.5.1 Day Services for older people fall into three main categories:

- The first tier covers day centre services provided by Hounslow Social Services and Health Partnerships within the existing model of Resource Centres (located in Chiswick, Heston and Bedfont);
- The second tier focuses on the development of voluntary sector Social Day Care Centres in the east, centre and west of the borough (i.e. services operating a full day programme for older people). Currently such a service exists in the West of the borough provided by **Age Concern Feltham, Hanworth & Bedfont**, and in the East of the borough provided by **Age Concern Hounslow**.
- The third tier covers on lunchtime provision focussing on opportunities for healthy eating and social interaction. This links with the emerging focus on healthy diet as a key determinant in the prevention of circulatory disease and in the prevention and management of diabetes. This kind of service currently operates only in the centre of the borough provided by **Heston and Isleworth Older Peoples Welfare Committee**, and **Hounslow Multi-Cultural Centre**. Further provision of this type will open in 2008 at

## **Greenrod Court** (with Housing 21 and Age Concern Hounslow working in partnership).

In addition, to this model, The Council commissions a healthy ageing service from the **Indian Gymkhana** (a community based sports organisation), which provides sessions of yoga, body conditioning and walking classes.

<b>Council:</b>	
Directly Provided Services:	£1,613,100
Age Concern Hounslow:	£207,047
Age Concern Feltham, Hanworth & Bedfont	£136,237
Indian Gymkhana:	£47,341
Heston & Isleworth Older People's Welfare Committee:	£31,000
Hounslow Multi-Cultural Centre	£7,956
Southall Day Centre:	£6,808
Centre for Armenian Information & Advice	£2,856
<b>TOTAL:</b>	<b>£2,052,345</b>

Over the course of the strategy, the Council will endeavour to **maintain** the amount it spends on day centres/healthy ageing. This area will, however, be more vulnerable to budgetary pressure than other statutory responsibilities.

## **5.6 Domiciliary Care**

<b>Council:</b>	
Independent Sector Contracts:	£3,047,000
Directly Provided Services:	£2,350,600
<b>TOTAL:</b>	<b>£5,397,600</b>

5.6.1 The Council entered into new block contracts for domiciliary care, commencing in October 2006. Six contracts were let, with two providers covering the east, centre and west of the borough. Simultaneously, the Council tendered for places on an approved list of spot

providers. These contracts introduced shorter units (care can now be booked 15 minute blocks) and electronic call monitoring. The Council will monitor the use of 15-minute calls to ensure that care can be appropriately delivered in short calls.

The block contracts were let to the following providers:

- **Care UK**, covering the east of the borough;
- **Medico**, covering the east and centre of the borough;
- **Seva Care**, covering the west and centre of the borough; and
- **QCL**, covering the west of the borough.

5.6.2 Over the course of the strategy, the Council expects to **increase by £750k** the amount it spends on domiciliary care, in response to supporting more older people at home.

## 5.7 Carers Services

5.7.1 Carers services are commissioned from Alzheimer's Society, Crossroads, The Asian Health Agency (TAHA) and Age Concern (Feltham, Hanworth & Bedfont). Further information regarding investment in services for cares will be contained in the Carers Strategy 2007-2010.

<b>Council:</b>	
Crossroads	£161,605
Alzheimer's Society	£38,005
Age Concern Feltham, Hanworth & Bedfont	£6,336
Respite (Care Homes)	£62,000
<b>TOTAL:</b>	<b>£267,946</b>
<b>PCT:</b>	
Crossroads	£120,375
Alzheimer's Society	£43,295
TAHA	£45,138
<b>TOTAL:</b>	<b>£208,808</b>

Over the course of the strategy, the Council will endeavour to **maintain** the amount it spends on carers services. The PCT expects to **reduce by £20k** the amount it spends on carers services as a result of tendering for one contract for the hours currently provided on the two contracts provided by Crossroads and TAHA. Both of these contracts run until 31<sup>st</sup> March 2009.

## 5.8 Older Peoples Mental Health Services

5.8.1 Over the course of the strategy, the PCT expects to **maintain** the amount it spends on commissioning Older People's Mental Health Services, in line with the recommendations in the Hounslow Older People's Mental Health Strategy 2006-2010.

<b>PCT:</b>	
West London Mental Health Trust:	£3,890,000
<b>TOTAL:</b>	<b>£3,890,000</b>

## 5.9 Community Equipment

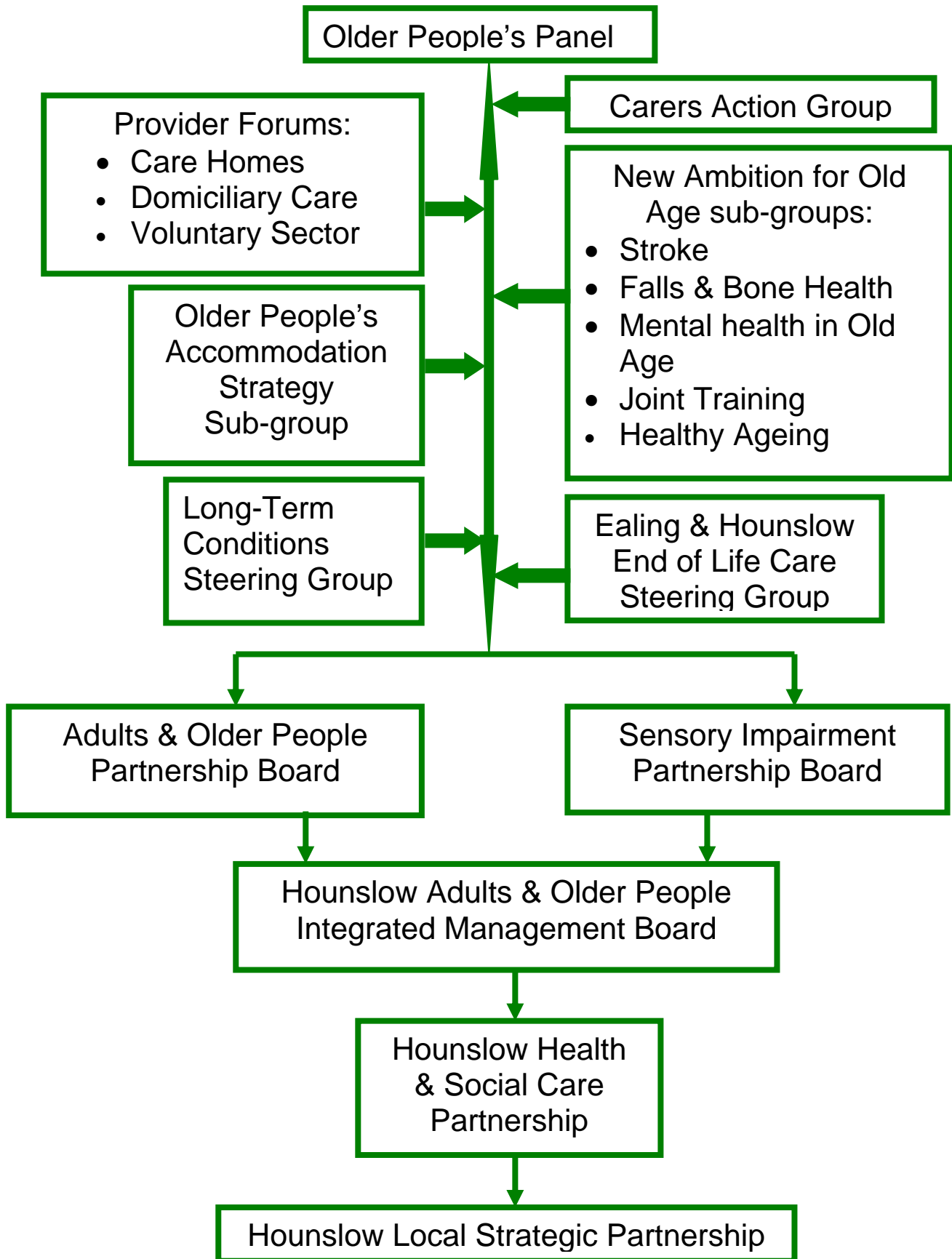
5.9.1 Over the course of the strategy, both the Council and the PCT will endeavour to slightly increase the amount it spends on community equipment in line with supporting more older people at home.

<b>Council:</b>	
<b>TOTAL:</b>	<b>£322,100</b>
<b>PCT:</b>	
<b>TOTAL:</b>	<b>£390,825</b>

## **6. IMPLEMENTING AND MONITORING THE STRATEGY**

- 6.1 As this strategy is necessarily broad, arrangements for implementation and monitoring will take place through existing partnership structures. A number of changes have been introduced in the last year to these structures partnership structures, with the aim of streamlining the number of meetings that managers and community representatives have to attend; and to help ensure that issues and potential responses that cut across services for Older People and for Adults with Physical Disabilities and Sensory Impairment (PDSI) are not considered in isolation from each other (e.g. development of services utilising assistive technology).
- 6.2 The integrated approach is not entirely new. The National Service Framework local sub-groups had previously been considering a number of cross-cutting topics with regard to both Older People's and PDSI services. The changed structures take this a step further.
- 6.3 There is now a single Partnership Board for Adults and Older People. It has primary responsibility for developing local vision; monitoring service provision against quality, access and resources; and identifying and prioritising areas for service improvement.
- 6.4 The Partnership Board in turn reports to an Adults and Older People Integrated Management Board and then onwards from there, as for other customer groups, to the Hounslow Health and Social Care Partnership and the Hounslow Local Strategic Partnership. See the partnership map below.
- 6.5 In addition, since late 2006 there has been a Sensory Impairment Partnership Board. Its purpose is to ensure that full consideration is given to sensory impairment needs and services, which otherwise might risk being marginalised within the structures, this board covers issues for all adults including older people.

## 6.6 OLDER PEOPLE'S PARTNERSHIP ARRANGEMENTS



6.7 The action plan below sets out the objectives listed in the body of the strategy, and details the lead officer and/or the group, which will have responsibility for the objective. Each objective has a timescale laid out and a priority rating between 1 and 5, with 5 representing the priorities most critical to achieving the headline aim of the strategy, that is **promoting the independence and quality of life for older people**.

The Partnership Board for Adults and Older People will review all objectives in a rolling programme.

<b>Objective (and page number)</b>	<b>Lead &amp; Group</b>	<b>Time-scale</b>	<b>Priority</b>
Review existing arrangements for lunch club provision, ensuring that they deliver Best Value;	SJCM OP (Healthy Ageing)	April 2008	3
Ensure that all contracted services ensure that older people receive excellent fundamental care including good food and necessary fluids with particular regard paid to supporting patients who are not able to feed themselves	SJCM OP (Healthy Ageing)	April 2008	3
Ensure that all residential care services operating in the borough are aware of the RNIB accreditation scheme	SJCM OP (Sensory Impairment Partnership Board)	April 2008	2
Ensure that all block contract providers work towards Visibly Better accreditation.	SJCM OP (Sensory Impairment Partnership Board)	April 2008	2
Report on new CSCI inspection reports quarterly to the Hounslow Older People's Panel, including summarising the actions required by providers to meet standards	SJCM OP (Older People's Panel)	On-going	4
Maintain regular formal monitoring of care home and domiciliary care providers.	Contracts manager	On-going	5
Review contracts and service specifications to ensure that Safeguarding responsibilities are explicit and that all staff are appropriately trained, so that vulnerable people are protected from abuse, neglect or self-harm	SJCM, JCM for Supported Housing, Contracts and Placements Team Manager	April 2009	5

Complete the PCT baseline review of services for end of life care review	SJCM OP (EOLCSG)	Nov 2007	5
Complete a local End Of Life Care Strategy	SJCM OP (EOLCSG)	July 2008	5
Roll-out a comprehensive End Of Life Care training programme to care providers (bed-based and domiciliary) in the borough	EOLC Co-ordinator (EOLCSG)	July 2008	4
Complete the stroke stock take, and to take action on the issues identified as falling into the red and amber areas	ADTIL (Stroke SG)	On-going	4
Develop and implement new community stroke pathway	CRM (Stroke SG)	Jan 2008	4
Complete an audit of practice at West Middlesex University Hospital with a view to implementing unbundling of the acute tariff for stroke, and specifying a stroke rehabilitation pathway	SJCM OP (Stroke SG)	April 2008	3
Develop a local stroke strategy (subsequent to the publication of the national strategy)	SJCM OP (Stroke SG)	Sept 2008	3
Produce a local falls strategy	SJCM OP (Falls SG)	April 2008	4
Develop a specialist falls service to be integrated within intermediate care	SJCM OP (Falls SG)	April 2008	4
Provide basic falls awareness training to include GPs, practice staff and contracted care providers	ILTC (Falls SG)	On-going	4
Implement the action plan from the Older People's Mental Health Strategy	SJCM OP (OPMH)	On-going	5
Develop an Intermediate Care Service capable of proving rapid assessment in primary care, A&E and in-patient settings, mobilising care to prevent	SJCM OP (OPAIMB)	Jan 2008	5

unnecessary hospital admissions, facilitating early discharge and minimising admissions to long-term care			
Roll out the PCT Self-Management Strategy	EPL (LTC)	On-going	3
Continue with the Met Office Health Forecasting Project; and	SJCM OP (LTC)	On-going	2
Review the implementation of the domiciliary care block contracts (length of calls/electronic call monitoring)	Contracts Manager (OPAIMB)	June 2008	4
Review the Councils In-House Service Level Agreement for domiciliary care.	SJCM OP (OPAIMB)	April 2008	4
Introduce the See & Sort model to A&E at West Middlesex University Hospital)	JCM Acute Comm	April 2008	5
Develop a thorough service specification for the Radiate Service at West Middlesex University Hospital (as part of the development of a comprehensive Intermediate Care Service for Hounslow)	SJCM OP (OPAIMB)	April 2008	3
Continue work jointly across Housing & Community Services, the Primary Care Trust, West London Mental Health Trust and West Middlesex University Hospital to implement SAP	SAP (Joint Training)	On-going	3
Locally evaluate specialist tools for long-term conditions as developed by FACE, and roll-out as necessary	SAP (Joint Training)	On-going	2
Pilot person-held records	SAP (Joint Training)	On-going	2
Develop self-assessment and life history books;	HOPS (Joint Training)	On-going	1
Test any changes to care plans and mechanisms for information sharing at a	SAP (Joint Training)	On-going	2

paper level, involving Community Matrons, Primary Care Social Workers and one team of District Nurses and Care Managers			
Develop the FACE tools as e-forms	SAP (Joint Training)	On-going	1
Work with the London RiO development team to ensure that future versions of RiO are SAP compliant and is as simple to use as possible at a local level	SAP (Joint Training)	On-going	2
Ensure that the SAP framework is considered and incorporated into local plans via the local clinical transformation workshops	SAP (Joint Training)	On-going	2
Explore the possibilities of the PCT prescribing physical activities courses for older people	SJCM OP (Healthy Ageing)	April 2008	2
Complete the Telecare/Telehealth pilots for people living with dementia and people affected by Chronic Obstructive Pulmonary Disease	AJCM (OPAIMB)	April 2008	4
Develop a long-term strategy for Assistive Technology based on the findings of the pilots, and on learning from other authorities experience	AJCM (OPAIMB)	April 2009	4
Prioritise commissioning services for older people which promote active exercise opportunities;	SJCM OP (Healthy Ageing)	April 2008	2
Expand the opportunities for older people to volunteer	SJCM OP (Healthy Ageing)	April 2008	1
Increase the uptake in Direct Payments by older people in line with our LAA target	HOPS (Joint Training)	April 2009	5
Continue to monitor the evaluation of the IB pilots and embed the learning from these into future commissioning plans	HOPS (Joint Training)	April 2009	2
Adopt the Carers Charter	SJCM OP (CAG)	Dec 2007	3

Tender for one contract for the same hours currently provided on the contracts provided by Crossroads and TAHA	SJCM OP (CAG)	April 2009	2
Review the recommendations of the Older People's Housing Strategy and produce an interim report making any necessary amendments in 2008	HSP (OPASG)	April 2008	3
Monitoring the uptake of Extra Care at Greenrod Place, and make recommendations for the timetable of the development of a third Extra Care Unit	HSP (OPASG)	April 2008	4
Review eligibility criteria/service provision in substance misuse to ensure equity across age groups	SJCM SM	June 2008	2
Identify GPs – especially those who make few referrals to substance misuse services – and offer support and training	SJCM SM	June 2008	2
Ensure that commissioned services addressing issues of substance misuse are accessed proportionately by older people	SJCM SM	June 2008	2

### Posts listed:

- SJCMOP – Senior Joint Commissioning Manager for Older People, Physical Disabilities and Palliative Care
- EOLC Co-ordinator – End Of Life Care Co-ordinator
- ADTIL – Associate Director for Therapies & Independent Living
- CRM – Community Rehabilitation Manager
- ILTC – Independent Living Training Co-ordinator
- SAP – Single Assessment Process Project Manager
- HOPS – Head of Older People's Services
- AJCM – Assistant Joint Commissioning Manager for Older People and Physical Disabilities
- HSP – Head of Strategy & Performance (Housing)
- SJCM SM - Senior Joint Commissioning Manager for Substance Misuse

**Groups listed:**

- EOLCSG – Ealing & Hounslow End of Life Care Steering Group
- OPAIMB - Hounslow Adults & Older People Integrated Management Board
- CAG – Carers Action Group

## Appendix 1

### Key Quality Indicators for Joint Commissioning

- To introduce a culture within community care where all members of staff take responsibility for ensuring patients receive a good patient experience, which is clinically effective and consider it a priority.
- That patients and their families are seen as the key person in their care and that health staff are there to support them in that, always being mindful of their wishes, whilst recognising that sometimes there is a requirement for health staff to take control e.g. with sectioning.
- That the Care Plan Approach is seen as fundamental to quality care, and that all patients have a care plan
- That the whole patient approach is taken consideration which includes their physical and social well being as well as their emotional and mental health
- That through verbal and non-verbal communication patients feel welcomed, informed, treated with honesty respect and dignity, are communicated with and listened to as an equal, and have the right information at the right time to enable the right choices to be made. This specifically includes patients for whom English is not a first language
- That all information and communication conforms to the principles of informed consent and confidentiality
- That all patients who have been an inpatient have an opportunity to feedback and comment on the care received.
- That all patients receive appropriate information in a format and at a level of complexity appropriate to their needs.
- That all patients receive care in an environment they consider clean, welcoming and well furnished and provides them with privacy when needed.
- That all patients receive consistently good clinically effective care in a supportive, and safe environment delivered in a confident and reassuring way
- That all patients have access to spiritual and religious support and that this is seen as an integral part of health care.

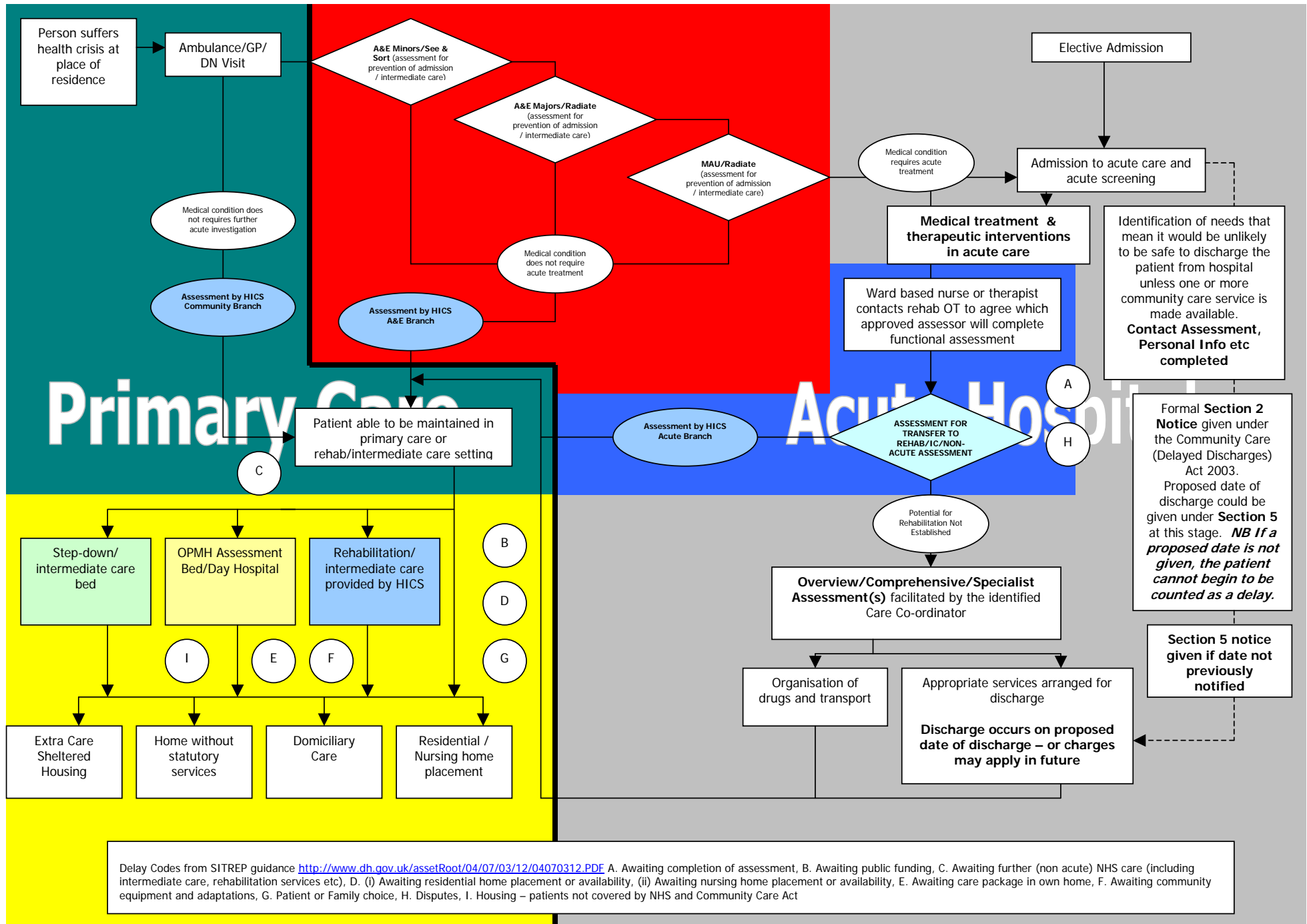
- That family members and carers have access to practical and emotional support including those family and friends communicating from a distance.

## Appendix 2

### **The New Performance Framework for Local Authorities & Local Authority Partnerships: Adult health and wellbeing**

- NI 119 Self-reported measure of people's overall health and wellbeing
- NI 120 All-age all cause mortality rate
- NI 121 Mortality rate from all circulatory diseases at ages under 75
- NI 122 Mortality from all cancers at ages under 75
- NI 123 16+ current smoking rate prevalence
- NI 124 People with a long-term condition supported to be independent and in control of their condition
- NI 125 Achieving independence for older people through rehabilitation/intermediate care
- NI 126 Early access for women to maternity services
- NI 127 Self reported experience of social care users
- NI 128 User reported measure of respect and dignity in their treatment
- NI 129 End of life access to palliative care enabling people to choose to die home
- NI 130 Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets)
- NI 131 Delayed transfers of care from hospitals
- NI 132 Timeliness of social care assessment
- NI 133 Timeliness of social care packages
- NI 134 The number of emergency bed days per head of weighted population
- NI 135 Carers receiving needs assessment or review and a specific carer's service, or advice and information
- NI 136 People supported to live independently through social services (all ages)
- NI 137 Healthy life expectancy at age 65
- NI 138 Satisfaction of people over 65 with both home and neighbourhood
- NI 139 People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently





## Appendix 4: References

<sup>i</sup> CSCI (2004), 'Inspection of social care services for older people, London Borough of Hounslow (July 2004)'

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<sup>ii</sup> GLA (2005), GLA 2005 Round Demographic Projections - Scenario 8.07

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<sup>vi</sup> Greater London Assembly (2006), need reference

<sup>vii</sup> Property Prices sourced from

<http://www.upmystreet.com/property/prices/all/l/w4.html>

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<sup>viii</sup> Evans, O., Singleton, N., Meltzer, H., Stewart, R., & Prince, M. (2003), "The Mental Health Of Older People", HMSO: London.

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<sup>ix</sup>

[http://www.helptheaged.org.uk/NR/rdonlyres/5EECFED0-0513-4983-8B61-716219CD4E2F/0/depression\\_and\\_older\\_people\\_summary.pdf](http://www.helptheaged.org.uk/NR/rdonlyres/5EECFED0-0513-4983-8B61-716219CD4E2F/0/depression_and_older_people_summary.pdf)

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<sup>x</sup> Singleton, N., Bumpstead, R., O'Brien, M., Lee, A., & Meltzer, H. (2001), "Psychiatric Morbidity Among Adults Living In Private Households", 2000. HMSO:

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<sup>xi</sup> Audit Commission (2000) 'Forget Me Not';

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<sup>xii</sup> [www.nice.org.uk/download.aspx?o=403699](http://www.nice.org.uk/download.aspx?o=403699)

<sup>xiii</sup> <http://www.hounslowpct.nhs.uk/cgi-bin/documents/patient%20experience%20and%20quality%20strategy.pdf>

<sup>xiv</sup> Munday, D., Dale, J. & Murray, S. (2007), "Choice and place of death: individual preferences, uncertainty, and the availability of care", Journal of the Royal Society of Medicine 100:211–215

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<sup>xv</sup> Dy, S. & Lynn, J. (2007), "Getting services right for those sick enough to die", BMJ; 334 (7592): 511-513

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<sup>xvii</sup>

<http://www.healthcareforlondon.nhs.uk/documents/AcuteCareReport.pdf>

<sup>xviii</sup> (accessed 24/09/07)

<sup>xix</sup>

<http://www.changeagentteam.org.uk/library/rehab%20unbundling.pdf>

<sup>xx</sup>

[http://www.npsa.nhs.uk/site/media/documents/2337\\_0461\\_PSO\\_Falls\\_WEB.pdf](http://www.npsa.nhs.uk/site/media/documents/2337_0461_PSO_Falls_WEB.pdf)

<sup>xxi</sup> A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of people admitted, as a person may have more than one admission within the year.

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<sup>xxiv</sup> Department of Health. *National Service Framework for Older People*. London: Department of Health, 2001.

<sup>xxv</sup> Health Service Circular 2001/01: LAC 2001/01.

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<sup>xxvii</sup>

<http://www.ic.nhs.uk/webfiles/publications/pssex0506/DetailPSSByCouncil.xls>

<sup>xxviii</sup>

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<sup>xxxiv</sup> Real change not short change 2007

<sup>xxxv</sup>

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<sup>xxxvi</sup>

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<sup>xxxvii</sup>

<http://www.publications.parliament.uk/pa/ld200304/ldhansrd/vo040625/text/40625-08.htm>

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# **Joint Commissioning Strategy for Older People**

**2007 - 2010**