



London Borough  
of Hounslow

**Physical Disabilities and Sensory Impairment**

# **Joint Commissioning Strategy 2007-2010**



Hounslow  
Primary Care Trust



# **JOINT COMMISSIONING STRATEGY 2007-2010: SERVICES FOR ADULTS WITH PHYSICAL DISABILITIES & SENSORY IMPAIRMENT**

**London Borough Of Hounslow  
Hounslow Primary Care Trust  
December 2007**

## **Table of Contents**

<b>1. Policy Context</b>	<b>1</b>
<b>2. Needs in Hounslow</b>	<b>11</b>
<b>3. Pattern of Services</b>	<b>31</b>
<b>4. Performance in Hounslow</b>	<b>46</b>
<b>5. Use of Resources</b>	<b>53</b>
<b>6. Empowering Disabled People to Work</b>	<b>62</b>
<b>7. Housing</b>	<b>67</b>
<b>8. Partnership Working</b>	<b>72</b>
<b>9. Commissioning, Contracting and In-house Services</b>	<b>75</b>
<b>10. Implementing &amp; Monitoring the Strategy</b>	<b>90</b>

# POLICY CONTEXT

## 1.1 Our common purpose

This strategy is one of four joint care group commissioning strategies being developed and published simultaneously (the others cover Learning Disabilities, Older people, and Mental Health). It should be read in conjunction with *Our Health, Our Care, Our Hounslow*, which gives an overview of the four joint commissioning strategies and the current commissioning environment.

Together, these documents form a joint statement of intent between Hounslow Primary Care Trust (PCT) and Hounslow Council's Housing and Community Services Department (HHCS) for the years 2007-2010.

Their common purpose is, in partnership with local people, to provide local health and care services at the right place, at the right time, and utilising the right skills within the available resources, that:

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

Success will be reflected in:

- reduced inequalities and improved access to services
- more support for people with long-term needs and mental health needs
- more choice and stronger voices for users and carers
- commissioning driving service redesign
- integrated care plans – long term conditions in 2008, everyone by 2010
- better prevention/early intervention for improved health, independence & well being.

## 1.2 Vision for Physical Disabilities & Sensory Impairment services

### 1.2.1 The Physical Disabilities and Sensory Impairment

Partnership Boards' vision, as updated in 2007, is that, in partnership with local people, we will provide local health, care and housing services that:

- promote social inclusion in all aspects of life and allow disabled people to participate fully within society
- encourage independent living and enable disabled people to exercise choice and control over services and treatment

1.2.2 We will seek to do this by working together with you to take a shared approach to your care. To this end, we will actively seek and listen to your views and wishes and we will assist you to make your own decisions about your care.

1.2.3 We will ensure services provided:

- are of high quality and meet required standards;
- are responsive to your unique and individual needs;
- promote dignity, self-respect and individuality;
- maintain your independence and safety and adjust to changing needs;
- take account of your age, gender, ethnicity, sexuality and religion and do not discriminate against you because of your disability;
- are delivered in a timely and responsive way;

- maximise your opportunities for access to independent living, education, employment and leisure;
- support you to play an active part in family life;
- meet the needs of your carers and dependents;
- encourage and support you in managing your own health;
- enable you to access health services when you need them;
- ease and assist transition from child to adult services and from younger adult to older person;
- are publicised widely and made accessible to all;
- offer opportunities for you and your carers to influence the further development and delivery of services.

1.2.4 We will review and develop services in the context of specified commissioning objectives – see 10.1 below.

### 1.3 Scope of Strategy

1.3.1 This commissioning strategy is about health and social care provision for:

- adults with physical disabilities aged 18-64
- adults with visual impairments (blind/ partially sighted) aged 18 and over
- adults with hearing impairments (deaf/ hard of hearing) aged 18 and over

1.3.2 In other words, it includes people with a sensory impairment who are 65 and over, as this is the way specialist services are arranged. However because their needs are often also related to ageing, such needs are addressed additionally in the Older People's Commissioning Strategy.

1.3.3 The Physical Disability and Sensory Impairment (PDSI) strategy takes account of transition, when someone moves from child to adult or adult to older person. At these important periods, continuity of care and support through life changes are paramount in addressing needs.

1.3.4 There is no clear dividing line between physical disabilities/ sensory impairments and long-term health conditions. Many

people would consider themselves to have both. Services provided by different health and social care teams can address needs across this invisible line.

1.3.5 Anti-viral treatments have transformed HIV/AIDS into a long-term condition like many others. However, Government AIDS-specific funding and the requirement to consider HIV as part of the local Sexual Health Strategy<sup>1</sup> have tended to set it apart. This PDSI strategy provides a summary of current HIV needs, issues and services, within the context of the local Sexual Health Strategy.

## 1.4 National Policy

1.4.1 Physical Disabilities and Sensory Impairment are unusual in not being directly covered by a National Service Framework. However there are several NSFs that do overlap with the PDSI strategy or relate indirectly to certain parts of it:

- Diabetes<sup>2</sup>
- Coronary Heart Disease<sup>3</sup>
- Long Term (neurological) Conditions<sup>4</sup>
- Older People<sup>5</sup>
- Children<sup>6</sup>

The PCT also commissions services with regard to guidance issued by the National Institute for Health and Clinical Excellence (NICE). During the period of this strategy, we will adjust commissioning arrangements in line with future changes in NICE guidance.

1.4.2 Recent Government legislation, policy and guidance include:

- Disability Discrimination Act (2005)
- Carers (Equal Opportunities) Act (2004)

---

<sup>1</sup> Hounslow PCT/ LB Hounslow 'Sexual Health Strategy 2003-2006' and subsequent updates

<sup>2</sup> Department of Health, January 2003 – search for this and other DoH publications at: [www.dh.gov.uk](http://www.dh.gov.uk)

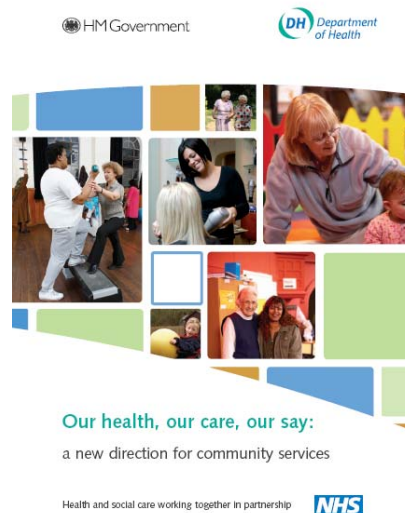
<sup>3</sup> Department of Health, March 2000

<sup>4</sup> Department of Health, March 2005

<sup>5</sup> Department of Health, March 2001

<sup>6</sup> Department of Health, September 2004

- Improving the Life Chances of Disabled People (2005)<sup>7</sup>
- Choosing Health: Public Health White Paper (2004)<sup>8</sup>
- Independence, Well-being and Choice: adult social care Green Paper (2005)<sup>9</sup>
- Our Health, Our Care, Our Say: a new direction for community services: adult social care White Paper (2006)<sup>10</sup>



- Social Care for Deafblind children and adults (2001)<sup>11</sup>
- A New Deal for Welfare: empowering people back to work<sup>12</sup> – Green Paper (2006) and the subsequent Welfare Reform Act
- Dignity in Care<sup>13</sup> - campaign to eliminate tolerance of indignity in health and care services
- A New Ambition for Stroke – consultative document on a national stroke strategy<sup>14</sup>
- Making Choices, Taking Risks<sup>15</sup> re supporting individuals who choose to take informed risks about their care

<sup>7</sup> Prime Minister's Strategy Unit, January 2005

<sup>8</sup> Department of Health, November 2004

<sup>9</sup> Department Of Health, March 2005

<sup>10</sup> Department of Health, February 2006

<sup>11</sup> Department of Health Local Authority Circular LAC(2001)8

<sup>12</sup> Department for Work and Pensions, 2006 [www.dwp.gov.uk](http://www.dwp.gov.uk)

<sup>13</sup> Department of Health, November 2006 [www.dh.gov.uk/en/Policyandguidance/](http://www.dh.gov.uk/en/Policyandguidance/)

<sup>14</sup> Department of Health, July 2007

<sup>15</sup> Commission for Social Care Inspection, December 2006 <http://www.csci.org.uk/>



#### 1.4.3 National standards mentioned in various documents include:

- NHS Improvement Plan: Putting People at the heart of public services (2004)
- National Standards, Local Action - Health and Social Care Standards and Planning Framework 2005/6–2007/8
- Progress in Sight: national standards of social care for visually impaired adults (2002)<sup>16</sup>
- Standards for Services for Adults who are Deafblind or have a Dual Sensory Impairment<sup>17</sup>

#### 1.4.4 Standards adopted by the Commission for Social Care Inspection in their inspection of services for disabled adults<sup>18</sup> comprise expectations that:

- 1) The council is working with health and other agencies to ensure the delivery of national priorities for social care, the national personal social services objectives and their own local strategic objectives.
- 2) Service users, and people who support them, experience social care services which promote inclusion, choice and independence.

<sup>16</sup> Association of Directors of Social Services, 2002 [www.adss.org.uk](http://www.adss.org.uk)

<sup>17</sup> Lewin-Leigh, Benedict, Sense on behalf of Department of Health, 2001?

<sup>18</sup> see inspection reports at Commission for Social Care Inspection website: <http://www.csci.org.uk/>

- 3) Social services have clear procedures for referral, assessment, care planning and review, which involve relevant professionals, service users and those who support them, which are widely known and the outcomes of which are clearly recorded.
- 4) The council and social services acts fairly and consistently in ensuring that disabled people's social care needs are met.
- 5) Social services commissions and delivers services to clear standards, covering both quality and costs, by the most effective, economic and efficient means available, using Best Value principles to achieve continuous improvement.
- 6) Policies for the support of disabled people are delivered via robust planning and commissioning arrangements and appropriate structures and procedures.

## 1.6 Hounslow policy

1.6.1 This document supersedes the previous 2005-2008 Hounslow PDSI strategy agreed in July 2005.

1.6.2 Policy development since that time has focused on the central role of independent living in assessment and care management and in service provision. Two relevant Hounslow documents completed in 2007 are:

- Service Plan for Independent Living Services 2007-2008
- Empowering Disabled People to Work Strategy (consultation draft prior to formal consideration and publication).

1.6.3 PDSI policies have much in common with those for other adult services 'customer groups'. The focus is on people, not services. It is on trying to ensure that people have the right kinds of support, at different times and in different circumstances, to enable them to make informed choices about their care and about how they wish to lead their lives. It is about maximising individual potential and self-fulfilment, not about creating dependency.

## 1.7 Commissioning priorities

1.7.1 Commissioning intentions and priorities for the next three years are influenced by various commissioning objectives. These state that PDSI services will:

- be of the highest quality and promote independence, choice and well-being;
- continuously demonstrate value for money;
- be effective in delivering desired and measurable outcomes;
- be delivered in a person-centred way through local partnerships that cross organisational boundaries;
- reflect the needs and wishes of local disabled people and be culturally acceptable;
- meet the requirements of disability legislation and strive to meet national disability standards;
- are accessible to all;
- provide full opportunities for users and carers to have involvement in service planning and development;
- promote uptake of Direct Payments and assist people to self-manage their own care;
- offer enhanced support for carers and families;
- enable people, unless it would be unsafe for them to do so, to live independently in their own homes;
- to this end, make the most effective use of equipment, adaptations and assistive technology;
- be provided locally unless there are exceptional circumstances otherwise.

1.7.2 Priorities for service development in the previous three-year PDSI strategy, agreed in July 2005, included:

- improving partnership arrangements to assist service development and strategic planning;
- developing systems to support self management;
- re-tendering domiciliary care, community equipment and wheelchair services;
- developing pathways for brain injury management;

- developing protocols to support transition from childhood to adult services;
- developing a single assessment process across health and social care;
- introducing more assistive technology in users' homes;
- implementing a Housing strategy for PDSI;
- developing employment initiatives;
- developing community-based rehabilitation services;
- developing a Community Matron service to proactively support people in managing their long-term condition;
- palliative care.

1.7.3 Considerable progress has been made – see later in this strategy for details. Some new or changed priorities have emerged too. They include:

- reviewing commissioning arrangements for Continuing Care and specialist residential and nursing home placements, with the aim of reducing sharply-rising costs and increasing local provision;
- considering service re-provision options to achieve better prevention and early intervention, in line with national policy and disabled people's wishes;
- developing plans and obtaining funds for local Extra Care housing for PDSI service users;
- considering whether, with the objective of reducing overall expenditure and providing better outcomes for disabled people, resources should be shifted out of residential provision and into adaptations and equipment budgets;
- reviewing in-house residential and day provision for Older People against RNIB standards for people who are blind or partially sighted;
- reviewing expenditure on HIV services in the context of reducing grant provision and of changing needs of service users;
- evaluating accessibility of services to Black & Minority Ethnic (BME) communities and the extent to which BME service users may be over- or under-represented;

- improving access to information, advocacy and new kinds of independent living support, to enable service users and carers to better manage their care;
- in this regard, introducing an Advocacy and Information service for people who are deaf or hard of hearing;
- increasing participation in the Expert Patients' Programme and starting an Expert Carers' Programme;
- pro-actively monitoring domiciliary care, wheelchair and community equipment contracts and ensuring quantitative and qualitative targets are met.

1.7.4 Other important areas for action, as identified by the Commission for Social Care Inspection<sup>19</sup>, include:

- improving access arrangements for individuals who do not easily fit into specific care teams e.g. asylum seekers ('dual diagnosis' etc);
- making it easier for service users to receive the right therapy, advice and support at the right time (access and timeliness);
- removing environmental and attitudinal barriers and challenging discrimination (access and attitudes).

1.7.5 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.

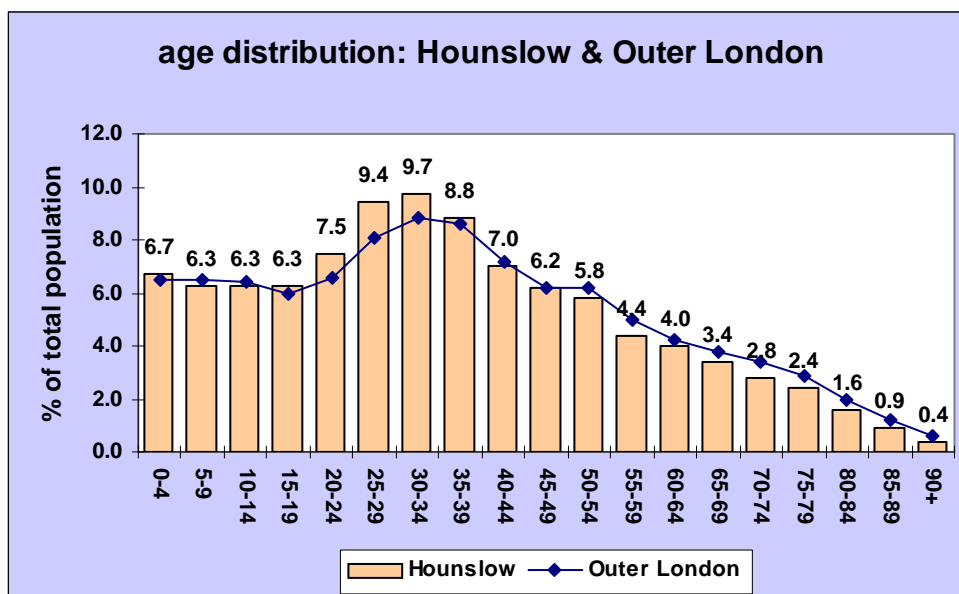
---

<sup>19</sup> 'Adult Social Care Performance in London: Councils' assessment of progress in 2005-06', CSCI 2006

## 2. NEEDS IN HOUNSLOW

### 2.1 Population profile

2.1.1 Hounslow's population is particularly noteworthy for the proportion of young adults. 35.4% of borough residents were aged 20-39 at the 2001 Census, compared with the 32.1% average for Outer London. Hounslow also had a lower proportion of over 65s than average: 11.5%, as against 13.9% for Outer London as a whole.



source: 2001 census; figures shown are percentages for Hounslow

2.1.2 The prevalence of most types of disability increases with age. We might expect therefore that, all other things being equal, that Hounslow may have a smaller percentage of disabled people than most other boroughs. However this is not the same as saying that the scale of demand for health and social care is likely to be lower than in comparable areas. The most thorough investigation of disability ever undertaken in this country was carried out by the Office of Population, Censuses & Surveys (OPCS) during the 1980s.<sup>20</sup> The various surveys found that 83% of younger disabled adults had moderate or severe disabilities, while the figure for disabled over 65s was

<sup>20</sup> Martin, J, Meltzer, H & Elliott, D, 'The Prevalence of Disability Among Adults', Office of Population Censuses & Surveys, HMSO 1988

75%. Younger disabled adults thus may have greater needs on average. Almost certainly they have different sorts of needs, with different aspirations and expectations of life.

2.1.3 Hounslow's population is very diverse. The proportion of black and minority ethnic adults continues to grow – see section 2.7 below.

## 2.2 Physically & Sensorily Disabled Adults in Hounslow

### (a) Numbers of people

2.2.1 It is exceptionally difficult to calculate with any certainty numbers of disabled adults, in Hounslow or elsewhere. It depends on what we are trying to measure. For example, is it:

- adults registered as disabled by Housing & Community Services?
- adults in receipt of certain disability-related benefits?
- adults who told the Census they had a limiting long-term illness?
- adults who consider themselves to have a disability or impairment, including those with mild to moderate disabilities who do not meet HHCS and/or benefits eligibility criteria?

2.2.2 Further complications arise in the way statistics are collected:

- Some statistics relate to all disabled people – adults, children, older people, physical disabilities, sensory impairment, learning disabilities, even people with long-term mental health problems, while others relate to two or more of these;
- Few surveys have attempted to quantify numbers of people with dual diagnosis or with multiple disabilities – which also means some of the data is affected by double-counting;

- Little attempt has been made to measure the extent of disability and its effect on different types of functioning (mobility etc) – the OPCS research was an exception here;
- None of these sources provides information on variations between individuals in their experiences of disability or of the barriers they face to independent living.

2.2.3 The following table gives some idea of statistics we do have.

Number of people in Hounslow	18 - 64	65+	Total
Total Population (2001 Census)	143,851	24,391	168,242
Projected population at 2010 (2006 GLA population projections)	147,863	23,968	171,831
Long-term illness, health problem or disability, which limits daily activities or work (2001 census)	18,269	6,799	25,068
Estimate of number of people with physical disability or sensory impairment (ONS 1988)	-	-	21,204
Estimate of number of people with health problems or disabilities affecting their employment (Labour Force Survey 1995)	14,385	-	14,385
Incapacity Benefit recipients (people of working age) [Age breakdown: 100 (16-17), 490 (18-24), 1090 (25-34), 1920 (35-44), 2520 (45-54), 2380 (55-64)] Department for Work & Pensions, Feb 2006	8,410	-	8,410
Disablement Living Allowance recipients (people of working age). [4620 receive the higher-rate mobility allowance, 2250 the lower rate and 1260 a nil rate] Dept for Work & Pensions, Feb 2006	8,430	-	8,430

2.2.4 On the basis of the above, if asked for an approximate idea of the number of Hounslow adults aged 18-64 with physical disabilities or sensory impairment, a figure of 15,000 or one adult in ten might be close to the mark.

2.2.5 We have little reliable local information on numbers of adults with different types of disability. However, by using a variety of health-related sources and applying national prevalence data on long-term conditions to local Census figures on an all-other-things-being-equal basis, we could produce the following table.

This shows approximately the distribution of numbers of people with different types of condition or causes of physical disability we might expect to find in Hounslow.

Condition	Estimate	Condition	Estimate
Heart Disease	25,526	Traumatic Head Injury (severe, requiring 24-hour care)	486
Arthritis	25,193	Multiple Sclerosis	300
Asthma	18,715	Muscular Dystrophy	108
Diabetes	6478	Cystic Fibrosis	27
Congestive obstructive pulmonary disease	3,239	Motor Neurone Disease	11-15
Epilepsy	1583	Spinal Injury (new admissions p.a.)	2
Parkinson's Disease	1415	Renal failure (0-80 yrs) (new cases p.a.)	17
Stroke	900	Cancer (diagnosis during lifetime)	72,000
Cerebral palsy	510		

Source: Physical Disability and Sensory Impairment Commissioning Strategy 2005-2008

2.2.6 The statistics are across age groups. The effects are varied. For some conditions, the majority of people affected are over the age of 65. Yet, to take stroke as an example, a quarter of strokes are in people under 65; 2% in people aged under 45.<sup>21</sup> About a third of people experiencing stroke die within 10 days, a third make a recovery within a month and the remaining third are left with disabilities and needing rehabilitation.<sup>22</sup>

2.2.7 Further information on types of disability is available from the Physical Disability (General Classes) register held by Housing & Community Services. Although the figures almost certainly under-count the true incidence of physical disability in the borough, they do include over 1200 people (6% of the total) who are registered as a result of chronic mental illness:

Medical Condition	18-64	65+	Total
AE – Amputation	54	99	153
F – Arthritis and Rheumatism	676	1602	2278
G – Congenital malformations and deformities	172	45	217

<sup>21</sup> 'Reducing Brain Damage: Faster Access to Better Stroke Care', National Audit Office 2005

<sup>22</sup> Bosenquet and Franks, 'Stroke Care: Reducing the Burden of the Disease', Stroke Association 1998

HL- Diseases digestive, genito-urinary, heart and circulation, respiration (Except T.B.) and skin	571	1485	2056
QT- Injuries – head, face, neck, thorax, abdomen, pelvis, trunk and injuries or diseases (Except T.B.) of limbs	551	409	960
UW - Organic nervous diseases, epilepsy, disseminated sclerosis, polio-mellitus, hemeplegia, sciatica, etc	860	136	996
V - Neuroses, Psychoses and other nervous and mental disorders not included in UW	633	615	1248
X - Tuberculosis (Respiratory)	8	14	22
Y - Tuberculosis (Non respiratory)	6	15	21
Z - Other diseases and injuries	215	170	385
Total	3746	4590	8336

Source: General Classes (Physical Disabilities) register, March 2004

2.2.8 Five separate statutory registers of people with sensory disabilities are maintained by HHCS. Again the information only tells us how many are actually registered, rather than giving us the number of people who are registerable, i.e. eligible to be registered. At March 2007, the figures were:

	18-64	65+	Total
Deaf With Speech	63	28	91
Deaf Without Speech	164	32	196
Hard Of Hearing	143	435	578
Blind	169	586	755
Partially Sighted	148	561	709
Total	687	1642	2329

Housing & Community Services Management Information Team, data at 14 March 2007

Compared with March 2004, the total number on the three hearing impairment registers had increased – by 75 or 9.5%. In contrast, the number on the two visual impairment registers had fallen – by 94 or 6%. Note that this may say less about changes in actual prevalence in Hounslow than in differences in how information about people dying or leaving the borough reaches the different registers. However it may still under-count people with hearing impairment, as there is no equivalent to the CV1 form automatically sent to the local authority re people newly-assessed as having a visual impairment.

2.2.9 Based on figures that 20% of people aged 75 or over are registered blind or partially sighted<sup>23</sup>, one estimate is that numbers of people aged 75+ with visual impairment will

<sup>23</sup> Progress in Sight: National Standards of social care for visually impaired adults, October 2002, RNIB

remain steady at about 2,120 in Hounslow to 2010, rise to 2,180 by 2015 and then increase significantly to 2,540 by 2025. The post-war baby boom 'time bomb' has particular resonance re likely future demand for PDSI services.

- 2.2.10 One exception to fairly 'flat' population projections for Hounslow in the period to the end of this strategy is the increase expected in the number of very elderly people. It is estimated there will be 3,100 Hounslow residents aged 85+ in 2010, 16% more than in 2004.<sup>24</sup> This has implications for deaf-blind services, as the large majority of people with dual sensory loss are in this age group.
- 2.2.11 The table in 2.2.2 above tells us there are almost certainly more people who consider themselves disabled than are actually registered with the Council. Incentives to be registered include eligibility for disabled bus passes and Blue Badge parking permits. One reason some are not registered is that they may not meet registration criteria – they are not disabled enough. Others may choose not to be registered. Perhaps this is because they are wary of the registration process or because they may fear a loss of independence or of being stigmatised as a result. And an unknown number may simply not know about registration or about other services available from social care.
- 2.2.12 On the other hand, compared with five neighbouring areas of North West London, in October 2006, Hounslow had the highest proportion of benefits claimants on Incapacity Benefit (44.1%) as a percentage of total claimants.<sup>25</sup> There were variations within the borough, with the Chiswick Riverside and Syon wards recording 50% or more of claimants receiving Incapacity Benefit. Similarly, back in 2002 more than 10,000 Hounslow residents were receiving long-term sickness/disability benefits. At 7.3% of the working age population, this was the 4<sup>th</sup> highest rate of the 19 Outer London boroughs.

---

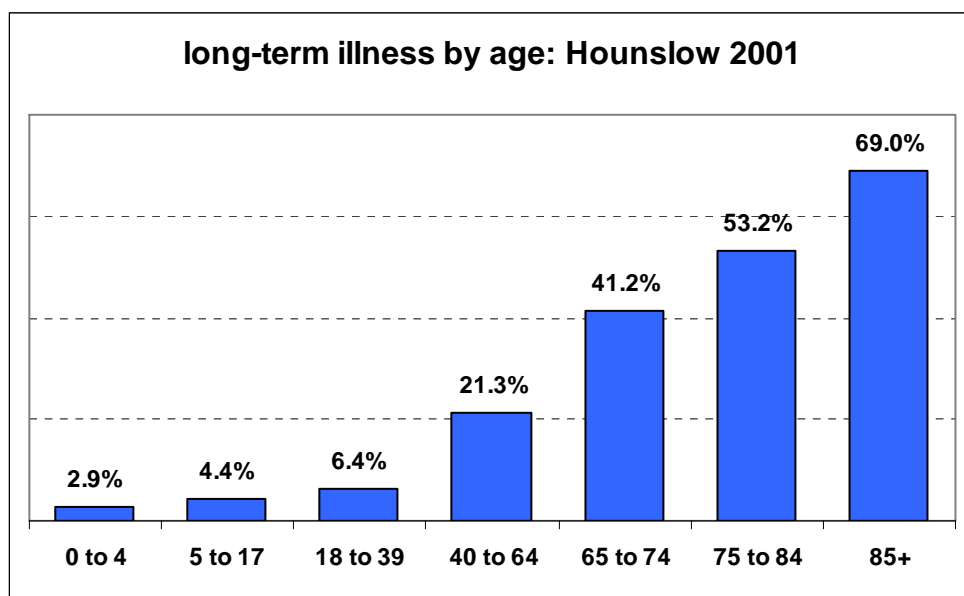
<sup>24</sup> Greater London Assembly population projections, October 2005

<sup>25</sup> West London Working GIS data, October 2006

2.2.13 Disabled people are more likely to be receiving benefits and less likely to have a job. Of those people of working age with disabilities affecting their mobility (legs, feet, arms, hands, back, neck), some 50% are out of work<sup>26</sup>. There are well-researched links between disability and poverty. About 30% of disabled adults of working age live in poverty, double the average for the population as a whole<sup>27</sup>. Disabled people face greater difficulties in achieving financial independence, which can have a significant knock-on effect to their wider ability to live independently.

(b) Age prevalence of disability

2.2.14 As indicated above, many types of physical disability and long-term condition are more prevalent in middle and older ages. The following chart shows the percentage of Hounslow residents in different age groups who said at the 2001 Census that they had a limiting long-term illness, health problem or disability which limits daily activities or work:

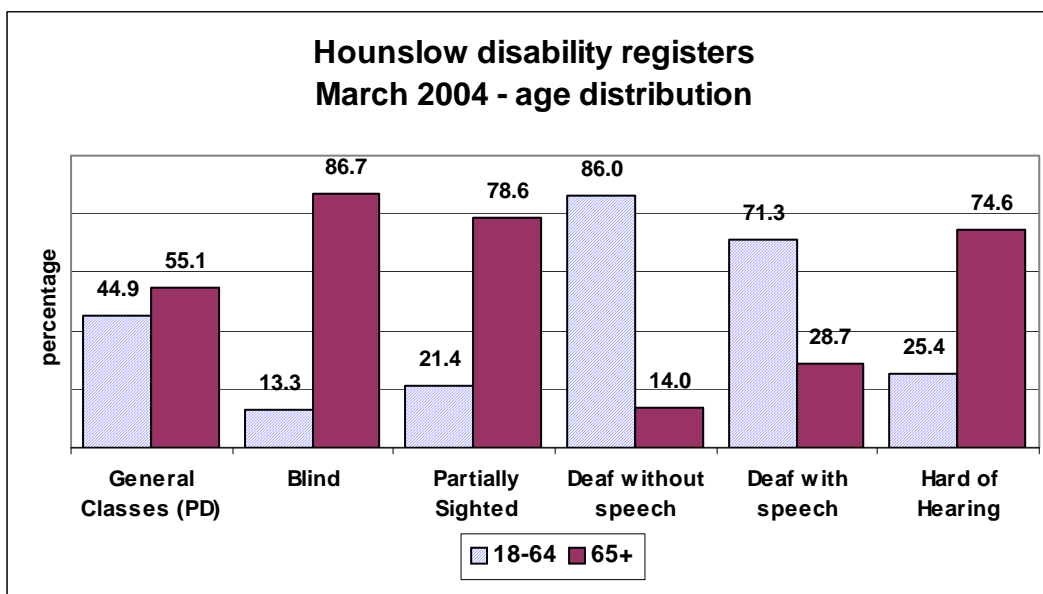


source: 2001 Census

2.2.15 The age distribution for most registers follows a similar pattern, with the majority of registrations being of people aged over 65. For the deaf registers, however, most of those registered are under 65, as shown in the table below:

<sup>26</sup> Labour Force Survey 2005

<sup>27</sup> Palmer, Guy 'Disabled People, Poverty and the Labour Market', New Policy Institute 2007



source: Housing & Community Services Management Information Team

2.2.16 So, while for many disabled people their disability is one unwelcome complication of getting older, at any one time a significant proportion of deaf people are a different point in their lives, with differing needs, wishes and expectations. Note however they are a relatively small number. In March 2004, the deaf registers contained only 2.3% of total PDSI registrations. By contrast, the General Classes register comprised 78% of all registrations.

### (c) Dual conditions

2.2.17 There is considerable overlap between the categories covered by the registers. For example, Department of Health statistics indicated that in March 2003:

- two-thirds of people registered as blind or partially-sighted also had another disability;
- a quarter of those blind or partially-sighted people with an additional disability were registered as deaf or hard of hearing.

2.2.18 Additionally, there is overlap with other 'customer groups':

- about 30% of people with learning disabilities are estimated also to have a physical disability<sup>28</sup> ;

<sup>28</sup> Learning Disabilities Commissioning Strategy 2007-2010

- the majority of people with physical or sensory disabilities are aged 65 or older;
- at least the same proportion of physically disabled people as in the wider population – and possibly a greater percentage<sup>29</sup> - are also users of mental health services.

The social care of people with physical disabilities aged 65 and over is usually co-ordinated by Older People's services. Most adults with learning disabilities or long-term mental health problems who also have a physical disability or sensory impairment receive care from the specialist Learning Disabilities and Mental Health services. In other words, statistics on usage of PDSI services in Hounslow undercount the true incidence of physical disabilities and sensory impairment in the borough.

## 2.3 Health and social care needs

2.3.1 People with physical disabilities and sensory impairment comprise a diverse group. Disability varies in its cause, its severity, its onset and whether and how quickly it is progressive: the experience of disability is very varied for different people. Consider, for example, the differences in needs, wishes and aspirations between:

- an 18 year-old school leaver with lifetime cerebral palsy;
- a 25 year-old who suddenly becomes a wheelchair user as a result of spinal injury in a motor cycle accident;
- a 35 year-old mother recently diagnosed with MS and, while still quite able, facing an uncertain future;
- a 55 year-old stroke victim, with opportunities for limited rehabilitation but requiring considerable medical intervention and care help.

2.3.2 Disability is not the same as dependency. Varying social, psychological and care circumstances mean that at any one time two people with similar disabilities may have differing abilities to manage their own lives independently.

---

<sup>29</sup> Morris, Jenny, 'One town for my body, another for my mind: services for people with physical impairments and mental health support needs', Joseph Rowntree Foundation 2004

2.3.3 All of this means it is not realistic to plan for people with physical disabilities as if they were a single entity. What is required, possibly more than for other customer groups, are assessments and service plans geared closely to individuals' specific needs and wishes. Specialist services may be necessary to respond to the often-complex health and care needs associated with different disabilities and long-term conditions.

2.3.4 Assessments and care plans also have to take account of the needs of carers. The 2001 Census indicated that in Hounslow unpaid care was being undertaken by almost 19,000 people, of whom over 3,500 provided care for 50 hours or more a week. We do not know how many of these were caring for adults aged 18-64 with physical or sensory disabilities, but we must assume the numbers were significant. Informal carers have a demanding role. Difficulties can be accentuated if, say, they are an elderly parent looking after their adult son/ daughter or if they are a youngster still at school and providing care to a parent/ other relative.

## 2.4 Housing need

2.4.1 Accessible and adaptable housing is pivotal to enabling disabled people to live independent lives. The 1995 Housing Needs Survey found that in Hounslow:

- 21,800 households contained at least one person who had at least one special need or problem (physical or sensory disability, learning difficulties, mental health problems);
- 2,500 households stated a requirement for level access to their property;
- 4,600 households contained someone with a medical problem that was likely to change their housing needs in the future.

2.4.2 Additionally, the 2003-04 Housing Needs Survey revealed that, of 1.4 million people in England with a serious medical s

condition or disability, some 315,000 (23%) lived in unsuitable accommodation<sup>30</sup>.

2.4.3 The diversity of PDSI experience and need has implications for housing provision too. One size does not fit all. Many people with physical or sensory disabilities only require minor modifications to their homes to enable them to live independently. Others may need, at short notice or over time, major housing adaptations, such as a downstairs bedroom with hoist and shower room. Some may want and need specialist housing, with care facilities on site or via floating support.

2.4.4 Access needs and facilities required vary according to circumstances. Someone in a wheelchair may need wider doors and low-level kitchen surfaces. People with sensory impairment often have safety needs, such as appropriate smoke detectors and kitchen equipment. Research has shown that, for people with visual impairment, location is critical to the degree of independence that can be attained – people want accommodation in an area close to public transport, local amenities and employment and leisure opportunities.<sup>31</sup>

2.4.5 A recent attempt has been made to quantify the extent of need for housing support. A toolkit has been developed which suggests that the current supply of 19 specialist supported housing units at Davenport House is 11 short of the total of 30 required for the borough. See chapter 7 on Housing.

## 2.5 Children, young people and transition

2.5.1 Some young disabled people do not leave school until they are 19. However that applies only to certain children attending Special Schools. PDSI youngsters in mainstream schools leave at the same age as other children. The move from children's to adults' services and the transfer of responsibility generally occurs at age 18.

---

<sup>30</sup> quoted in 'Better Outcomes, Lower Costs', Department for Work & Pensions 2007

<sup>31</sup> Julienne Hanson, 'Housing and Support needs of People aged 18-55 with Sight Loss', 2006

- 2.5.2 Adult services can be different in both kind and in the level of provision. The focus of adult services is on independent living. It is on helping young people achieve their aspirations and on making care services available to meet identified needs. Yet it can also be a time when there is a 'step down' in the amount of contact with statutory services and in the level of care provided to users and carers.
- 2.5.3 The amount of spending on care of disabled children seems not to be matched by spending on adults. Part of the reason may lie with a less-developed contracting process for children's specialist placements and with the absence of financial assessments for them. But there is also pressure on adult care budgets, given that either the Housing & Community Services Department or the PCT (depending on Continuing Care eligibility) has to meet 100% of the net placement cost of each placement. By contrast, the cost of many children's placements is shared jointly and sometimes with Education budgets too.
- 2.5.4 There is much anecdotal evidence to suggest that the quality of facilities and care in adult homes frequently does not match that in children's establishments. The move from a home for PDSI children to one for adults thus can be a dispiriting experience, perhaps with insufficient opportunity to maximise individual independence and choice.
- 2.5.5 The numbers of young people with physical disabilities or sensory impairment moving from school to a long-term care package arranged by adult services are very small, as few as one a year. However this undercounts actual numbers of disabled school leavers, many of whom do receive short-term or occasional service help. Pinning down exact numbers is problematic because what statistics we have are collected for different purposes. Figures for relevant 'statemented' secondary school children at March 2007 were as follows:

Physical Disabilities (PD)	24
Hearing Impairment (HI)	29
Visual Impairment (VI)	8
Complex Medical (MED)	12

*source: LBH Special Educational Needs team, March 2007*

2.5.6 That could mean around 10 young people with physical or sensory disabilities or chronic health conditions leaving school each year. Yet despite some of them not being eligible for service help, the above may still underestimate the true scale of such types of disability. The figures exclude, for example, 42 children in special schools in Hounslow for whom visual impairment was one of multiple disabilities.

2.5.7 The figures also tell us little about the nature of needs or the potential to promote independence. For example, there may be children placed out-of-borough who might benefit from mobility training and other support that could help them to move back to Hounslow and perhaps live at home.

2.5.8 One review of research found that across the country, “transition planning is often characterised by poor liaison between different agencies and professionals, a failure to involve young people and a failure to cover the issues of most importance to them and their families.... [They] frequently lack easily accessible, comprehensive, up-to-date information about options, choices and possibilities.”<sup>32</sup> While this may not necessarily be the view of Hounslow school-leavers and their parents, the findings do pinpoint the critical importance of this time in the lives of young disabled people.

2.5.9 We are committed to effective co-working with Education providers, both for young people still at school and for those in further education.

2.5.10 Hounslow’s Children and Young People’s Strategic Plan 2007-2010<sup>33</sup> states that the Local Safeguarding Children

<sup>32</sup> Morris, Jenny, ‘Young Disabled People Moving into Adulthood’, Joseph Rowntree Foundation, 2002

<sup>33</sup> ‘Expanding Horizons’, LBH Children’s Services & Lifelong Learning Department, April 2007

Board will review the safeguarding children protocol to ensure that it reflects the needs and experiences of disabled young people and their families. A survey of numbers and needs of young carers is being undertaken. There is also a commitment by adult services to re-consider transition protocols and to introduce appropriate methods of supporting transition, e.g. via a transition group at the Acorn Centre.

2.5.11 The Social Work Team for Children with a Disability has had a Transition Social Worker in post since early 2006. She has set up a multi-professional Transition Tracking Group that meets monthly to track progress of transition plans for young people. The early emphasis has been on Learning Disability planning but the PD Independent Living Team has now begun attending meetings too.

2.5.12 A new Transitions Protocol is being drafted, for implementation during 2008. We are also waiting to hear more about a Government announcement in December 2007 that new monies will be made available to Children's Services to help enable local Councils, among other things, to develop or bolster a transition support programme.

We propose to:

- Further develop and review co-working arrangements and transition protocols with Children & Families' services – and learn from the experiences of individual young people what works well and where improvements are needed.

## 2.6 HIV/ AIDS

2.6.1 In 2006, 538 people resident in Hounslow were accessing HIV care. Numbers have been increasing year on year; this latest figure is 61% higher than in 2002<sup>34</sup>. A growing proportion of infections, now over half the total, have been acquired heterosexually. About a third of patients obtain their health care and treatment locally at West Middlesex Hospital, another

---

<sup>34</sup> SOPHID (Survey of Prevalent HIV Infections Diagnosed 2006, provisional data), Health Protection Agency, 2007

third travel to Central London specialist HIV centres and the remainder to a wide range of other hospitals outside the borough, notably Ealing Hospital.

2.6.2 Only a minority of the above were in touch with social care, generally through the Independent Living Team or Children & Families social work teams. The Asylum Team often was involved too – many care recipients were or had been asylum seekers, who may have accompanying complex needs and circumstances. The Government Office for London has identified the needs of asylum seekers with HIV as a significant issue for Hounslow.

## 2.7 Access to services

2.7.1 Hounslow's black and minority ethnic (BME) adult population is growing. Recent population projections by the Greater London Assembly<sup>35</sup> suggest that by 2010 some 43.5% of adults in Hounslow aged 18-64 will be from BME communities, compared with 38.5% in 2004. The largest predicted increase is among Asian groups, who are expected to comprise a third of the 18-64 population in 2010. More 'Others' are expected too, up from 3.9% to 5% over the same period. This may indicate a widening diversity of the population and a widening number of languages spoken.

2.7.2 In most respects, except for refugees fleeing wars, there is little reason to believe that the prevalence of disability among the BME population is any different from that of the borough as a whole. However there are a few indicators to the contrary:

- Council wards with the highest proportion of Asian residents are, for the most part, those with the highest rates of premature deaths from chronic heart disease and stroke<sup>36</sup>. We have had a number of Asian men aged 50+ receiving substantial care packages at home as a result of stroke.

---

<sup>35</sup> Greater London Assembly ethnicity projections 2005, issued 2006

<sup>36</sup> Hounslow Primary Care Trust, Annual Health Report 2005

- African-Caribbean people are twice as likely as White people to have a stroke. They also tend to have their first stroke at a younger age.<sup>37</sup>
- Levels of visual impairment are generally higher among people of African-Caribbean background (as a result of glaucoma) and Asian ethnicity (cataracts). Higher numbers with diabetes also add to the potential for visual impairment.

2.7.3 Although ethnicity of PDSI social care service users is broadly in line with the wider adult population, Black African and Black Caribbean adults seem to be over-represented. In 2006-07, they comprised 84 of the 792 PDSI service users aged 18-64. This was 10.6% of the total. GLA ethnicity projections for 2004 suggested that only 5.1% of Hounslow's population in that age group were Black.

2.7.4 Reasons for this possible over-representation will be investigated. We intend to produce and analyse statistics from our computer records, so that we have more detailed information on service demand and use, by types of disability and by ethnicity, gender and age. This should give us a better idea of how far services are proving accessible and whether action may be required to overcome any barriers to them.

## 2.8 Likely future trends

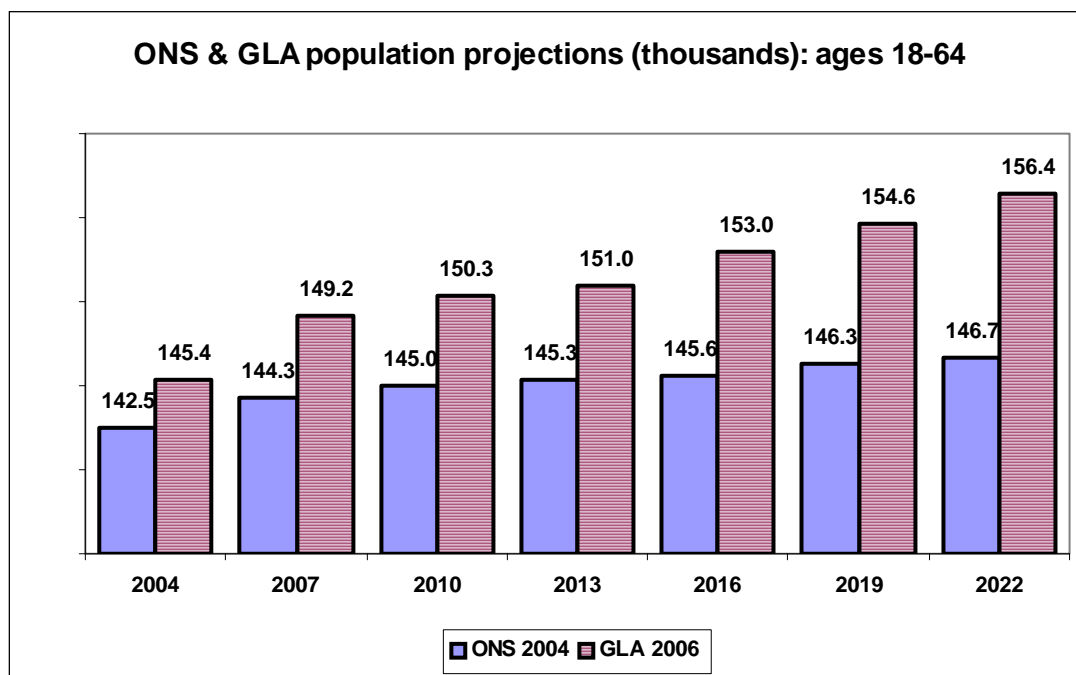
2.8.1 We expect that numbers of people with physical disabilities will grow during the period of the strategy, if only because Hounslow's population aged 18-64 is estimated to increase.

2.8.2 The two most recent sets of population projections, one from the Office for National Statistics (ONS 2004, revised 2007) and the other from the Greater London Assembly (GLA, published 2006), provide very different total numbers but show an upward trend. Hounslow, in common with a number of other Councils, had argued that the original ONS figures published in 2005 considerably under-counted its population. Although the revised statistics narrow the gap between the

---

<sup>37</sup> Stewart, Dundas, Rudd & Wolfe, 'Ethnic Differences in Incidence of Stroke', 1999, BMJ, Vol 318, No 7

GLA and the ONS projections, the GLA figure for 18-64 year-olds in 2010 is 5,300 or 3.7% greater than the ONS projection.



*sources: GLA 2006; ONS 2004 base data, revised Sept 2007*

2.8.3 The revised ONS data for Hounslow's 18-64 year-old population suggest an increase of only around 700 between 2007 and 2010. [Compared with 2004, however, the ONS 2010 figure is 2,500 higher.] The GLA estimate a somewhat larger increase of 1,100 between 2007 and 2010. After 2010, the scale of the population increase projected by the GLA remains greater than the ONS calculations. A gap of 4,900 between the two data sets in 2007 becomes 9,700 by 2022.

2.8.4 If we translate these figures into very approximate numbers of physically disabled adults in the borough, using Labour Force Survey data and omitting people with other disabilities, we might expect perhaps in this age group an additional 50 people with physical disabilities in 2010 compared with 2007. However, the increase compared with 2004 could be as much as 400. We cannot say what proportion of these might require ongoing health and social care. If it were, say, 10%, that could mean 40 more long-term PD cases in 2010 than in 2004.

2.8.5 The same trends should influence numbers of people with sensory impairment. However prevalence of most types of sensory impairment increases sharply with age, particularly

after 65. This strategy covers all adults with sensory impairment, including those over 65. As previously stated, while GLA population projections are that numbers of older people should only increase very slightly over the period of the strategy, for people aged 85+, where the prevalence of sensory impairment is highest, they will grow more quickly. Accordingly, we might predict that overall numbers of adults with sensory impairment will also rise slightly between now and 2010.

2.8.6 Although we have only anecdotal evidence that they already apply in Hounslow, at least two other factors could serve to further increase demands on health and social care over the period of the strategy:

- there could be more young people with complex disabilities entering adult services, perhaps as a result of advances in medical care in childhood and a resulting improved life expectancy;
- the number of younger disabled adults continuing to live with severe disabilities and long-term conditions could increase for a similar reason.

As indicated above, the number of young physically disabled people in transition to adult services each year is usually very low. Even so, an overall annual increase of just one young person requiring a high level of specialist care would have a significant impact on budgets.

2.8.7 Other demands from people newly-referred with high-level needs are also increasing budget pressures on local health and social care services, e.g. a growing number of people with acquired head injury. The fast-increasing incidence of diabetes, while felt most of all in Older People's services, is having an impact on PDSI care too. As a result, we can anticipate more people with visual impairment.

2.8.8 A recent report<sup>38</sup> predicts that across London the total cost of continuing and community care for vulnerable adults with physical disabilities will increase by 39% between 2004-05 and 2010-11. It says that while it expects PD numbers to rise in proportion to population growth, cost pressures will be greater: “in particular, the unit cost of home care is projected to rise by over 7% p.a. due to the increasing intensity of needs of service users being cared for in their homes.”

2.8.9 A sharp rise in the unit cost of nursing home placements is also predicted in this report, at the same time as Direct Payments are expected to have to increase to meet increasing demand.

2.8.10 There are so many uncertainties about future trends that we cannot predict with any confidence the scale of future additional pressures on budgets. Having regard to the above, one very approximate guess is that we might need another 3% each year on top of inflation if we are to keep pace with demand. The additional amount might comprise:

- 0.5% p.a. for population growth
- 2.5% p.a., say, to reflect changing needs and costs

The latter figure is a cautious one. It could be considerably higher. The six-year London-wide average estimated in the report above is for 5.5% per year. All current indications for residential and nursing home care are that prices are increasing considerably more quickly than 2.5%. However it assumes that efficiency savings and PCT/ Council expenditure reductions will have the effect of containing some of the budget pressures – see chapter 9 below.

## 2.9 Changes in public expectations

2.9.1 The high uptake of Direct Payments by physically and sensorily disabled people in Hounslow since 2004 provides evidence of their desire to make independent and flexible

---

<sup>38</sup> RSe consulting, ‘Review of costs of community care and continuing care in London: a report for London Councils, March 2007

choices about care, rather than accepting traditional services. This trend seems likely to continue, with Government's adult social care White Paper<sup>39</sup> policy signalling the probable introduction of individual budgets. These would give disabled people greater control over their care arrangements and enable them to be personalised to needs rather than bulk-purchased.

2.9.2 The White Paper envisages a change in emphasis for social services departments, moving away from being 'gatekeepers' to care services and concentrating instead on supporting disabled people and facilitating decisions about independent living.

2.9.3 The White Paper adds that it wishes greater priority to be given to preventative services. This is almost certain to meet with approval from the general public. It would probably increase the number of referrals to statutory agencies and it would require a rethink on the national framework of Fair Access to Care Services (FACS) eligibility criteria. The challenge will be in finding the resources to meet aspirations.

2.9.4 The importance of reducing the burden on informal carers has been recognised in legislation. A growing awareness of this fact seems likely to increase the number of carers requesting a carer's assessment and service help.

2.9.5 At the time of writing, the effects of the full implementation of the Disability Discrimination Act have had only limited impact. Case law, when it is established, could affect expectations of service provision.

2.9.6 The strong emphasis being placed by Government on reducing numbers on long-term benefits is almost certain to increase the number of disabled people who will seek support from local agencies to find employment and stay in work. See chapter 6 on Empowering Disabled People to Work.

---

<sup>39</sup> 'Our Health, Our Care, Our Say: a new direction for community services', White Paper on adult social care, Department of Health, February 2006

### 3. THE PATTERN OF SERVICES

#### 3.1 Current services available

3.1.1 The following is a brief description of services currently provided or arranged by health and social care in Hounslow:

- A social work service for people with physical disabilities is supplied by the Independent Living Team, based at Heston. The team also has an HIV/AIDS 'champion', though HIV cases are also shared with other team members.
- The Neuro-rehabilitation Team is part of the PCT and is located at the new Heart of Hounslow building.
- Assessment for wheelchairs is funded by and also carried out by the PCT. The provider contract was recently awarded to Synergy Healthcare. Outdoor-powered chairs are provided through the Disablement Services Centre at Stanmore Hospital.
- Community Equipment is provided following an assessment by a health or social care practitioner. Some items of equipment can be demonstrated at the Calen Centre in Feltham. This will shortly include a range of telecare equipment. More complex electronic and environmental controls provided through Hillingdon Hospital.
- The Calen Centre is also the base for the Sensory Disability Team where there is a resource room that holds a range of sensory equipment. It is also where the Middlesex Association for the Blind screen initial referrals of people with visual impairment.
- Occupational Therapy (OT) is supplied partly through the community OT Team located in Feltham and Chiswick and also by OT's within West Middlesex Hospital.
- West Middlesex Hospital's Audiology service is part-way through converting its 10,000 users' hearing aids from

analogue to digital. Other communication aids are provided by the hospital's Speech & Language Therapy Department for adults with speech and language deficits, within the limited funds available.

- Also at West Middlesex Hospital, the IARDS (Integrated Assessment, Rehabilitation and Discharge Services) team provides a rapid response service, an integrated care management team to expedite discharge, and a community rehabilitation service.
- The Sexual Health Clinic at West Middlesex Hospital provides a specialist HIV service. The Council's Money Advice & Welfare Benefits team holds weekly surgeries there for people with HIV.
- Domiciliary care is arranged by the social work team and supplied by external agencies through a block contract.
- Following the closure of Eldridge House, some residential provision for physically disabled adults has moved to Heston House and some to the independent sector. Other independent sector placements continue.
- Specialist and complex Continuing Care nursing home placements are made through a contract with Hammersmith & Fulham PCT.
- A few physically disabled Hounslow residents are funded to attend a day centre outside the borough. The emphasis of day services, however, is on enabling disabled adults to acquire skills for independent living. The Acorn Centre in Heston is an in-house provider here, while Leader's is an employment resource that supports disabled people to find a job and stay in work.
- Housing provides a Care and Repair team with a particular remit to assist people with special needs. It has responsibility also for Disabled Facilities Grants (DFGs) for people in private sector property and for specialist public

sector housing provision. One small accommodation scheme receives Supporting People funds, while two 'floating support' schemes provided by local voluntary organisations also have part-funding through Supporting People.

- 3.1.2 There are few private sector PDSI service providers in Hounslow but a wide range of voluntary organisations and groups operate locally. Some like Middlesex Association for the Blind, the Independent Activities Project and Disability Network Hounslow are contracted to provide specific services. Others such as the MS Society offer services to their own members and make an input to the Neuro-Rehabilitation Partnership, the Disability Community Forum and elsewhere.
- 3.1.3 More detail about service provision and service expenditure is contained in chapter 5 of this document.

## **3.2 Achievements in Hounslow in 2006 & 2007**

- 3.2.1 The community equipment (iCES) contract has been re-tendered, with a new provider delivering on-budget and also meeting contract targets. The local wheelchair service has been re-tendered too, with a remit to reduce waiting times.
- 3.2.2 An approved list of physical disability domiciliary care providers has been developed, following the re-tendering of contracts and in response to issues raised by carers. Training on promoting and enabling independence has been given to the providers.
- 3.2.3 The social work team in Heston has been re-named the Independent Living Team to reflect the change in its focus. It has recently recruited Independent Living Advisers to review assessments and develop outcome-focused care plans. The Single Assessment Process developed for Older People is being used by the team.
- 3.2.4 Sensory impairment services have been strengthened by a new Strategy Group to give added profile to sensory

impairment issues. At the Calen Centre, a Senior post has been created to manage the Sensory Impairment team and provide an OT input. A sensory room with IT equipment and training has opened there.

- 3.2.5 Additional posts have been established at Leader's Employment Resource, to support disabled people in acquiring employment skills, find a job and stay in work. The Acorn Centre has been remodelled as a pan-disability Life Skills and Training Centre. An 'Empowering Disabled People to Work' strategy and action plan, led by Housing & Community Services, is currently being considered by Partnerships and Boards.
- 3.2.6 Middlesex Association for the Blind (MAB) now provide an Early Intervention service: referrals from blind and partially-sighted people are signposted quickly on or sent to the social work team for assessment. MAB also now offer a Deaf-Blind Communicator service and a Mid-sight desk at West Middlesex Hospital – although recent funding reductions have meant this has had to be scaled back.
- 3.2.7 Waiting lists for OT assessments have been eliminated through a service from Able 2 when demand is high or Council OT's are not available. An on-line OT self-assessment facility is being introduced.
- 3.2.8 Individual advocacy was provided to Eldridge House residents to help them decide where they would live. This followed its sudden closure after a health & safety report into the heating and ventilation system.
- 3.2.9 Expert Patient programmes are being developed through the Self Care Self Management Strategy – see 3.3.5 below.
- 3.2.10 Waiting lists for Neuro-Rehabilitation services have been reduced and closer links formed with community services. A part-time specialist post for Acquired Brain Injury has been developed from existing resources. An MS Specialist Nursing Service has been established and sponsorship obtained to

carry out a research project to identify local MS patients and share information and practice.

3.2.11 In line with Government Policy including the guidance on Supporting People with Long Term Conditions, four Community Matron posts have been established to support case management of very high intensity users of services aged 18 and over, including PDSI service users. A further eight Community Matron posts are planned.

### **3.3 New models of care**

3.3.1 New models of care are fast-evolving in response to developments in Government policy and changing public attitudes. The focus has moved away from viewing disabled people as largely passive recipients of 'packages' of one or more care services, agreed with them at assessment and then arranged for them. Instead there is a shift towards enabling disabled people to make their own decisions and choices and to manage their own care. Hence the change of name for the social work team to the Independent Living unit. The adult social care White Paper acknowledges that users, carers, staff and the public as a whole will have to adjust to the fact that inevitably this will involve a greater degree of risk taking.

3.3.2 We referred previously to the significantly increased uptake of Direct Payments in Hounslow. At December 2007, 101 PDSI service users were receiving Direct Payments out of the 550 whose care was co-ordinated by the Independent Living Team. There are plans to increase numbers further, e.g. by enabling people to use Direct Payments for telephone rental under the Chronically Sick and Disabled Persons Act. See also Chapter 9 below.

3.3.3 Research on the effectiveness of direct payments for people with disability has highlighted that Direct Payments:

- are seen as having a positive impact on the social, emotional and physical health of people who use them;
- can enable culturally relevant services to be accessed;

- are seen by users as a key element in giving them to access more flexible care services to enable them to lead the lifestyles that they wish.

3.3.4 We have also mentioned Government intentions to introduce individual budgets.<sup>40 41</sup> Now that pilots in a few local authorities are underway and the Government has confirmed it intends to extend them nationally<sup>42</sup>, the budgets would enable services users to choose the services they wish to receive up to a budget maximum agreed according to their assessed needs. Users would be able to decide to receive these as cash payments or actual services or a combination of the two.

3.3.5 Individual budgets are designed to:

- give people a clear, up-front idea about how much money there is for their support;
- make assessment quicker and easier and mean that people have to give out information fewer times;
- bring together different kinds of support or funding from more than one agency – this is one area that makes them different from Direct Payments;
- let people use the money in a way that best suits their own needs and situation;
- have support to plan what they want and to organise it, from a broker or advocate, family or friends, as the individual wants;
- not cost the Local Authority any more.

We propose to:

- Launch an ‘In Control’ pilot project during 2008 to, among other things, examine how individual budgets might be introduced in Hounslow and ensure that safeguards are built in to enable vulnerable adults to manage their finances safely;

<sup>40</sup> HMSO, ‘Our health, our care, our say: an new direction for community services’, Jan 2006

<sup>41</sup> Prime Minister’s Strategy Unit, ‘Improving the life chances of disabled people’, Jan 2005

<sup>42</sup> ‘Putting People First: a shared vision and commitment to the transformation of adult social care’, Department of Health, Dec 2007

- Appoint a Service Manager – Transformation to lead on the pilot and the introduction of individual budgets, utilising Government funding for the purpose,

- 3.3.6 The adult social care White Paper ‘Our Health, Our Care, Our Say’ makes clear an expectation that for most people with long-term conditions the focus should be on facilitating self care. To this end, Hounslow PCT has developed a Self Care Management Strategy. This aims to support people to manage self care through integrated packages which include information, self monitoring devices, self care skills education and training and self care support networks.
- 3.3.7 The development of self-help strategies and community-based groups, in partnership with users, carers, local communities and voluntary agencies, can play a major part in enabling individuals to manage their own care and health condition. Hounslow was one of the London pilot sites on Expert Patients, a self-management course giving people the confidence, skills and knowledge to manage their condition better and be more in control of their lives.
- 3.3.8 Hounslow’s Long Term Conditions Integrated Change Programme 2006 included a project for the development and implementation of a local strategy for self management to inform users, carers and potential referrers of services available. It set a target of a 40% reduction in GP visits by people who have received a self-management service. This is part of changing the culture of health and social care from “doing for” to “enabling”. As with other aspects of independent living, it involves allowing individuals to make their own decisions and take risks.
- 3.3.9 A critical time for the right kind of support to be available is when people are newly-diagnosed with a long-term condition. It is important for them to be able to come to terms with their situation, to adjust to their impairment or disability and to consider how to manage their own condition. So, for example, this is a key standard for Progress in Sight, the national standards for visual impairment services. The Midsight desk at

West Middlesex Hospital, run by Middlesex Association for the Blind, offers advice and support to people with who have newly diagnosed sight problems. Similarly, the new Community Matron posts will provide case management support for people with complex long-term conditions who are very high intensity users of service.

3.3.10 Information and support to people with recently-acquired disabilities or newly-diagnosed conditions (neurological or otherwise), perhaps by others with a similar shared experience, can make an important contribution to understanding how to live with changed circumstances and how to maintain independence. There is a growing demand for community-based information, support, training and advice to patients/users and carers.

We propose to:

- Implement the local Self Care, Self Management Strategy and monitor its effectiveness in enabling people to manage their own care;
- Improve health and care information available to service users and carers, as part of self management;
- Identify, with voluntary organisations, the potential to establish condition-specific support services, e.g. via self-help groups or 'buddying' arrangements.

3.3.11 Electronic, internet-based information systems are assisting the development and increased use of self-management packages by disabled people. A web-based self-assessment process has been trialled for Occupational Therapy referrals. The results have been encouraging and it has been agreed to continue with the process. The OT Initial Response Team will offer the process to new referrals and provide assistance where needed.

3.3.12 Health and social care teams for PDSI care in Hounslow are not based together geographically. They operate as separate services. It seems unlikely that computer-based information systems will be integrated in the foreseeable future but there may be opportunities, with approved protocols

in place, for greater information sharing. Hounslow is committed to exploring opportunities for a more co-ordinated approach to care and case management for people with a physical disability or sensory impairment. In particular, we aim to improve effectiveness and reduce delays by developing better-integrated physical disability services across health and social care.

**We propose to:**

- Revise local information-sharing protocols relating to health and social care data;
- Extend the self-assessment process to allow physically disabled and deaf people to prescribe themselves equipment or, for those not eligible for service help, to receive information about equipment suppliers.

3.3.13 Information technology is providing increasing opportunities for disabled and chronically ill people to be discharged safely back home from hospital and/ or to remain at home living independently, when previously they might have been considered to be too much at risk. Telecare is a term used to describe the use of equipment installed at home to enable “the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living.<sup>43</sup>”

3.3.14 Hounslow is receiving a Preventative Technology Grant of £182,000 in 2007-08. The grant aims, among other things, to:

- reduce the need for residential/ nursing care;
- reduce the burden placed on carers and provide them with more personal freedom;
- contribute to care and support for people with long term health conditions;
- reduce acute hospital admissions;
- reduce accidents and falls in the home;

3.3.15 A pilot project is underway in Hounslow, run by Linkline, a part of Hounslow Homes. Standard equipment is available for

---

<sup>43</sup> Curry, Trejo, Tinoco & Wardle, Department of Health 2003

a small fee to people who may be at risk in their own homes. This includes a pendant for emergencies, smoke alarms, carbon monoxide and natural gas detectors, property exit sensors and a bogus caller button. Additional equipment is supplied as needed. Most of the recipients have been Older People but the pilot also accepts younger adults with cognitive impairment, e.g. as a result of acquired head injury.

3.3.16 Telehealth is another emerging area of provision. The technology allows patients to take the same vital signs measurements that their nurse or GP takes at the surgery without the need for frequent visits. The PCT and the Council are undertaking a pilot project focusing on people with Chronic Obstructive Pulmonary Disease (COPD) and heart failure.

3.3.17 An Emergency Response Service is currently being launched in association with Linkline. It provides night-time care staff who will act as key-holders during an emergency for people who otherwise might have to call out family or friends to respond to an urgent need.

We propose to:

- Evaluate these new services during 2008, with a particular focus on differences the technology has made to individual safety and to enabling people to remain living in their own homes. We then intend to make equipment more widely available thereafter.

### **3.4 Views about Hounslow's services**

3.4.1 In 2005, physical disability and sensory impairment user groups were formally established on the Mini Finding A Voice model developed for Older People's services. Since then, meetings of four such groups have been held bi-monthly. They have been co-ordinated by two voluntary organisations, with Council funding and input from Council officers. Physical Disability, Visual Impairment and Hard of Hearing groups have been led by the Independent Activities Project (IAP), while the Deaf Group has been the responsibility of Disability Network

Hounslow. Further such groups are being developed for Wheelchair and Community Equipment users.

- 3.4.2 The groups choose the topics they wish to discuss. Speakers are arranged and they provide information and answer questions. Comments are fed back in various ways, notably to Partnership Board meetings and, as appropriate, to the Council's Disability Community Forum.
- 3.4.3 During 2006-07, feedback from the groups led to a number of improvements, including better signage for people with visual impairment at the Disability Living Centre. Comments made also helped influence the shape of the restructuring of the Independent Living Team.
- 3.4.4 A major area of concern continues to be access to buildings and community facilities - both physical access and transport to get there and back. While few of these issues raised are the direct responsibility of health and social care agencies, the problems disabled people encounter with access can significantly affect their ability to lead an independent life. They are taken to the Disability Community Forum, which considers action that might be needed and often invites external organisations to listen to comments made.
- 3.4.5 Communication needs are the other main topic raised in the user groups. Various communication methods are required. A regular page in the Council's Hounslow Matters magazine, delivered free to households, has begun to raise the profile of disabled people in the borough. It also provides them with news and information about services. The user groups have successfully campaigned to have 'Hounslow Matters' published in Braille and on audio tape, but most other Council or Health publications are not routinely produced in these formats. Blind and partially-sighted service users continue to ask for a system whereby Council Departments (and other agencies) automatically communicate with individuals in their preferred format – large print, Braille or audio tape.

- 3.4.6 Deaf people have long experienced difficulties in obtaining BSL interpreters. The Council's Interpreting & Translation Unit does provide BSL interpreters whenever possible but they are in short supply and cannot fully meet demand. As a result of expressed concerns, better contact has been established with the unit and improved access to interpreters has been achieved. However this remains a vital issue for deaf people.
- 3.4.7 People with sensory impairment flag up various housing needs. Some of these are for specific adaptations and for adequate and appropriate lighting inside the home and outside (see also Section 7 below). But there are also wider issues of ready access to and safe use of community facilities and transport. Accommodation in places far from shops and buses does not facilitate independent living.

**We propose to:**

- Work closely with local authority Planners to ensure that the physical access needs of disabled people are fully taken into account in housing developments, street improvements and community facilities;
- Ensure that transport issues of PDSI users are actively taken up with transport providers.

- 3.4.8 Following a survey of views of wheelchair users carried out in 2006 by the Hounslow Neurological Partnership, it was agreed to issue publicity on the three different parts of the wheelchair service, how they fit together and who to contact with queries or problems. Other documentation, including the calling card, is also being reviewed.
- 3.4.9 Many disabled people consider that health and social care agencies are not sufficiently sensitive to their needs. They would wish to see all staff required to attend disability awareness workshops. Users have also called in the past year for a public awareness campaign, perhaps through Hounslow Matters magazine and other community media and forums.
- 3.4.10 Local disability organisations stress the importance of ready availability of advocacy. Disabled people can

experience particular difficulties in accessing care services and in dealing with day-to-day issues essential to maintaining independence.

3.4.11 Carers make their views felt in various ways, including at events organised for the annual Carers' Week and in meetings of the pan-disability Carers' Forum. Their main concerns are about obtaining time off from their caring task. Carers have asked for:

- better information about respite care available;
- increased respite services and choices about them;
- day services for physically disabled adults that would enable carers to work the hours they want;
- holiday provision for younger disabled people who attend college during term time;
- more supported employment opportunities for people whose disability may mean it would be difficult for them to find work and keep a job.

3.4.12 During 2007-08 it is intended to develop a carers' drop-in at the Calen Centre for people providing informal care for PDSI service users. In addition, in early 2008 the Council will be carrying out a local research project into numbers and needs of young carers, i.e. children who find themselves providing care to their disabled parents. Further information on plans for carers' services will be contained in the Joint Commissioning Strategy on Carers, to be agreed during 2008.

3.4.13 Clearly, many of the improvements people wish to see would require additional resources. However a view strongly expressed at the Commissioning Strategies' stakeholder event in July 2007 was that preventative services are often inexpensive. This can be particularly true of services delivered by voluntary organisations. The voluntary sector can offer value for money and sometimes can tap into other funding sources. By commissioning voluntary organisations to provide additional services, this viewpoint contends, much of the need for later and costly residential care could be avoided.

### 3.5 Links to other services

3.5.1 This Commissioning Strategy, as has been pointed out previously, has much in common and a degree of overlap with strategies to meet several of the National Service Frameworks. There is also commonality with dual diagnosis issues in the Mental Health and Learning Disabilities' strategies. There are protocols governing transition between children's and adult services and between adult services and those for Older People.

3.5.2 A growing proportion of new referrals to adult PDSI services are of younger adults with multiple and complex needs. Many of these are in transition from children's services. Some present behaviour that challenges existing services. Some have care needs that cut across service boundaries. How should PDSI services respond effectively to someone with both a physical disability and impaired cognitive functioning? Or to someone who has had a failed suicide bid?

#### We propose to:

- Analyse information on numbers of service users with multiple and complex needs and on their placements and services received, with a view to commissioning specialist provision as necessary;
- Agree joint protocols with mental health, learning disability, substance misuse and older people's services to support people with more than one condition or whose needs cut across customer groups.

3.5.3 Housing needs of PDSI service users are considered in various strategies and submissions, as well as within the Accommodation Strategy Sub-Group for People with Physical or Sensory Disability.

3.5.4 Some disabled people unfortunately are at risk of physical, financial, emotional or other abuse. HHCS and the PCT attach the greatest importance to identifying and responding to instances of abuse. Referrals are investigated by Safeguarding Adults Co-ordinators under the Multi-Agency

Safeguarding Adults Policy<sup>44</sup>. See 3.3.5 above for action proposed in relation to individual budgets.

3.5.5 For most disabled people, however, an appropriate response to their needs requires partnership working that is wider than between health, social care and housing agencies. Many of the most intractable barriers to independent living are physical in nature, e.g. insufficient adapted or specialist transport, inadequate access to shops and public buildings, and issues relating to disabled parking, raised kerbs, street furniture etc. They can present considerable problems and can make it much more difficult for disabled people to get out and about and to organise their lives with minimal support. Issues like these that do emerge in user and carer forums are now being channelled to the Council's Disability Community Forum, where they are raised by community representatives and/or direct to agencies responsible for the service/ facility.

3.5.6 Early in the decade, the Government's Fair Access to Care Services national framework of adult social care eligibility criteria<sup>45</sup> provided a higher profile for access to education, learning and employment, as did the requirement for Councils to produce a Joint Investment Plan on Welfare to Work for Disabled People<sup>46</sup> by March 2001. Links have been developed accordingly with the Council's corporate/ inter-agency Skills and Employment Group and with Hounslow partnerships. See also chapter 6 on Empowering Disabled People to Work.

---

<sup>44</sup> Hounslow Mutli-Agency Safeguarding Adults Policy, March 2007

<sup>45</sup> Department of Health Circular LAC(2002)13, May 2002

<sup>46</sup> Department of Health Circulars LAC(99)39 and HSC 1999/244

## **4. PERFORMANCE IN HOUNSLOW**

### **4.1 How performance is measured**

- 4.1.1 As previously noted and unlike other groups, adults with physical disabilities and sensory impairment are not covered by a National Service Framework or by the targets associated with delivery of NSFs. PDSI services are the subject of relatively few of the local authority indicators performance indicators submitted to Government agencies. These include the national Performance Assessment Framework statistics that enable 'benchmarking' comparisons to be made with the performance of other Councils. These and other statistics are also contained in the annual Self Assessment Survey (SAS) on adult social care that HHCS has to produce for the Department of Health.
- 4.1.2 However the Commission for Social Care Inspection (CSCI) does lay down a robust performance framework. This includes 27 quantitative indicators, as well as a large number of indicators relating to quality of care.
- 4.1.3 Monitoring of health provision for disabled people is carried out separately and differently. Activity data tend to focus on the health setting (primary health, hospital provision, nursing home care etc) and on different health conditions (e.g. coronary heart disease) that don't readily identify the age of patients or the existence of a long-term disability.

### **4.2 Hounslow's performance**

- 4.2.1 The proportion of PDSI adults under 65 helped to live at home increased between 2003-04 and 2005-06 but dropped back slightly by the end of 2006-07 – see table below. This was still a satisfactory enough performance to be rated as "good" by the Department of Health.

**Younger physically disabled people helped to live at home per 1,000 population aged 18-64 (PAF indicator C29)**

2003-04	2004-05	2005-06 Plan	2005-06 Outturn	2006-07 Plan	2006-07 Outturn	2007-08 Plan
3.0	4.6	4.8	4.7	4.7	4.3	4.3

4.2.2 In part the improvement in 2005 was due to the considerable growth in the uptake of Direct Payments and the opportunities they provided people to make independent decisions about the care they received. Figures for March 2007 indicate that the rapid improvement in numbers of PDSI recipients of Direct Payments had eased off a little:

**Number of recipients of Direct Payments**

At 30 Sept 2002 (Autumn 02)	At 30 Sept 2003 (Autumn 03)	At 30 Sept 2004 (Autumn 04)	At 30 Sept 2005 (Autumn 05)	At 31 Mar 2006 (Spring 06)	At 31 Mar 2007
<b>People with Physical Disabilities &amp; Sensory Impairment (18-64)</b>					
5	20	37	60	80	76

4.2.3 Some 44% of PDSI Direct Payments recipients obtained £5000 or more in total during 2006-07; another 33% obtained payments between £2000 and £5000. Just under a quarter were receiving Direct Payments for the first time. PDSI recipients made up almost half the total number (162) receiving Direct Payments.

4.2.4 The speed of delivery of aids and adaptations had been proving less successful, particularly during 2004-05 when problems with the Integrated Community Equipment Service (ICES) contract were most apparent and before the contract was re-tendered and awarded to a different provider. The situation has since improved substantially and the March 2007 result was better than the England average and rated as “very good” by the Department of Health. Hounslow has set a target for a further significant improvement during 2007-08.

**Percentage of items of equipment and adaptations delivered within 7 working days (PAF indicator D54)**

2003-04	2004-05	2005-06 Plan	2005-06 Outturn	2006-07 Plan	2006-07 Outturn	2007-08 Plan
85.8	75.2	90.0	81.0	91.0	92.6	95.0

4.2.5 Much of the data required for Department of Health statistical returns relate to Older People only. However there is no obvious reason to believe that performance by Housing & Community Services Occupational Therapists on assessments of younger adults is likely to be much different from the same team's performance re people aged 65+. During 2006-07, some 259 people out of 318 had their OT assessment completed within 28 days of first contact. This 81.4% success rate is short of the average for all assessments across all adult groups (87.1%) but still represents a very real improvement on performance from several years ago.

4.2.6 The performance figures on adaptations show the average number of weeks' waiting time between assessment and the start of work. Clearly the average waiting period for major adaptations, while improving in 2006-07, is longer than desirable. Reasons for this have been identified and action is being taken during 2007-08 to reduce delays.

**Average length of time in weeks waiting for minor adaptations from assessment to work beginning (Promoting Independence indicator)**

2004-05	2005-06 Plan	2005-06 Outturn	2006-07 Plan	2006-07 Outturn	2007-08 Plan
1.0	1.0	1.0	1.0	1.0	1.0

**Average length of time in weeks waiting for major adaptations from assessment to work beginning (Promoting Independence indicator)**

2004-05	2005-06 Plan	2005-06 Outturn	2006-07 Plan	2006-07 Outturn	2007-08 Plan
39.0	38.0	38.0	38.0	34.0	32.0

4.2.7 There has been an increase since 2004-05 in the number of carers of PDSI adults receiving 'breaks services'. A further increase is anticipated for 2007-08.

2003-04	2004-05	2005-06 Plan	2005-06 Outturn	2006-07 Plan	2006-07 Outturn	2007-08 Plan
51	51	60	60	72	76	87

4.2.8 During 2006-07, HHCS social work and OT activity data included the following information. Note that only the Independent Living Team's workload related specifically to adults aged under 65; other teams covered Older People too.

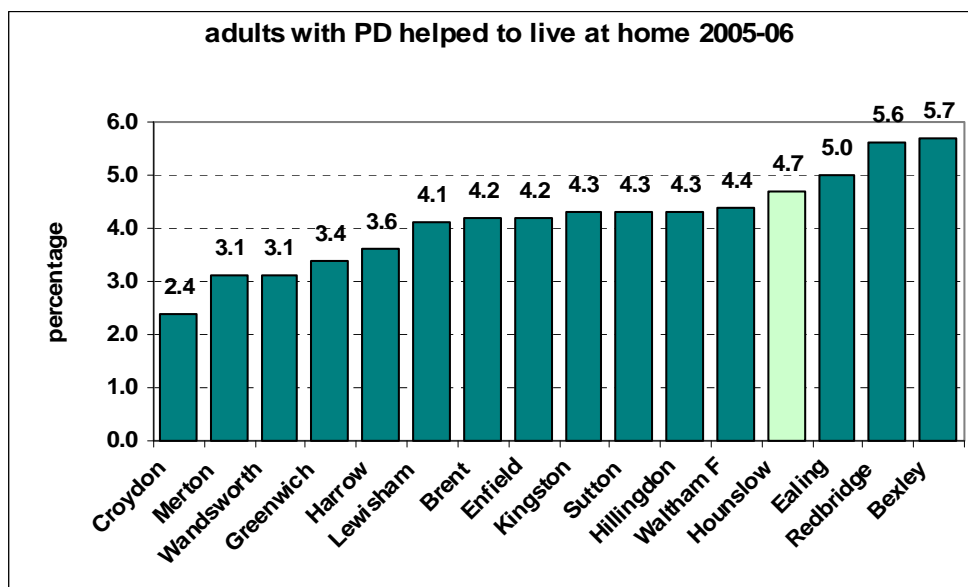
team	assessments completed 2006-07	assessments leading to a service	reviews completed 2006-07
Independent Living Team	122	73	284
O.T. Feltham	173	160	117
O.T. Chiswick	182	175	68
Calen Centre (inc Sensory)	87	82	11
Other O.T.	22	22	20

4.2.9 NHS performance standards for wheelchairs, updated in 2005, have been incorporated within the new wheelchair contract. They include 15 working days from prescription to delivery of wheelchairs and 3 working days for completion of repairs (24 hours in the case of emergency repairs). In August 2006, there was a waiting list of approximately 200 for the Hounslow Wheelchair Service. However the backlog was due mainly from having to set up the new service and find semi-permanent premises. Waiting lists have progressively reduced since that time; in February 2007 it was 41.

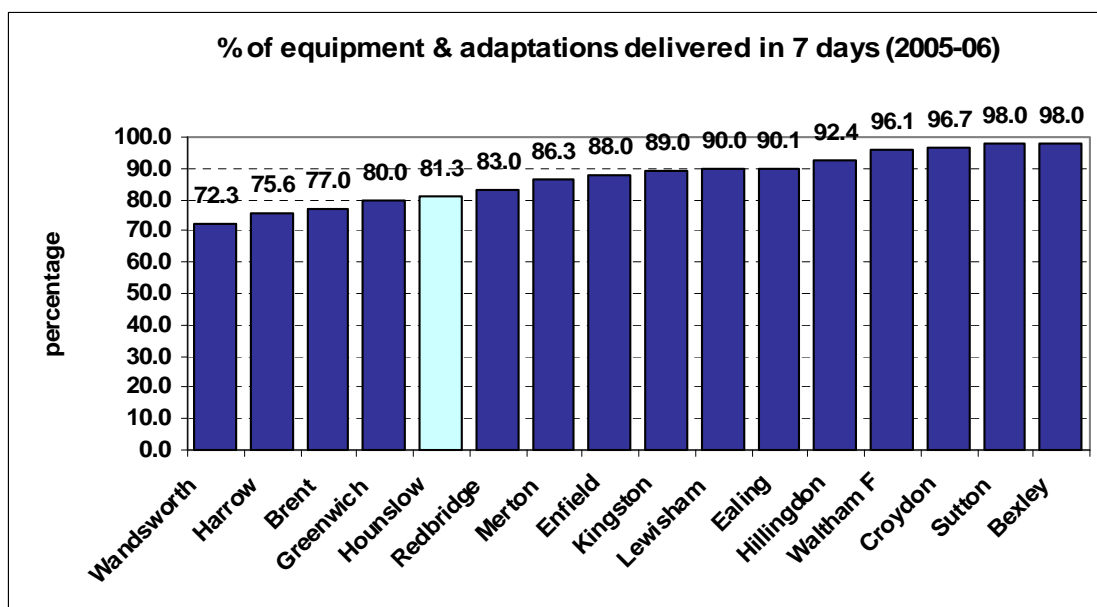
### 4.3 How Hounslow's performance compares

4.3.1 In the proportion of adults helped to live at home, Hounslow performs better than most of the other comparator Councils in the Department of Health's Key Indicators Graphical System (KIGS) database. A recent report<sup>47</sup> notes that the "rate of adults with physical and sensory disabilities helped to live at home has risen both nationally and in London. London councils have increased the rate from 3.9 to 4.3 per 1000 between 2004-05 and 2005-06, although London remains below the England average, which is currently 4.5". In 2005-06, the latest year for which we have comparative data, Hounslow exceeded the Outer London average, at 4.7.

<sup>47</sup> 'Adult Social Care Performance in London: Councils' assessment of progress in 2005-06', Commission for Social Care Inspection, 2006



4.3.2 KIGS also provides comparisons on delivery of aids and equipment for daily living. Here, as a result of the difficulties with the ICES contract, Hounslow did less well in 2005-06 compared with other like authorities. However, as for London as a whole, there was an improvement at least on 2004-05.



4.3.3 On minor adaptations, Hounslow continues to perform well. In the plans submitted by London boroughs to the Department of Health for 2006-07, the average wait for work to start after assessment was expected to improve to 1.9 weeks. The figure for Hounslow was better than that, at 1.0 weeks.

4.3.4 As previously indicated, performance on major adaptations

has been less satisfactory. The average wait in London between assessment and the start of work had fallen to 31.1 weeks in 2005-06, with a further planned reduction to 27.4 weeks planned for 2006-07. However this latter figure hid wide variations between Councils, from a 5-week waiting time expected in the quickest authority to 68 weeks in the slowest. Hounslow's performance was a little below average but it did manage to improve on the 38.0 weeks in its 2006-07 plan: the eventual outturn for the year was 34.0 weeks.

4.3.5 Hounslow's performance on Direct Payments is rated as "excellent" overall by the Department of Health. National data specifically on PDSI service users is not entirely reliable but Hounslow would seem to have slightly more PDSI Direct Payments recipients than similar Councils. Of these, some 44% had payments of over £5,000 during 2006-07. Hounslow's 2007-08 target is 76 PDSI Direct Payments users.

4.3.6 We do not have up-to-date comparative data on residential and nursing home placements. Since 2001, the proportion of PDSI placements had been about average for England, measured as placements per 10,000 population aged 18-64. By 31 March 2005, however, Hounslow had fewer placements than average, 2.77 per 10,000 population, compared with 3.01 for England as a whole. This might imply a focus instead on care packages in people's own homes. However any such 'success' may prove to have been a short-lived, given the recent increased demand for placements.

#### **4.4 Other Hounslow targets**

4.4.1 In the absence of a PDSI National Service Framework, there is no Government requirement for the Council to set medium-term targets for service performance. Annual targets are developed for the performance indicators listed above, while other less formal targets are also set for individual services as part of the business planning process. In all cases, the objective at minimum is to maintain service performance. More usually, it is to improve it. The focus is on quality as well

as quantity. It is on achieving outcomes that meet needs as expressed by service users and carers.

- 4.4.2 There is one relevant 2007-08 target selected by the Council to further its Hounslow Plan priority of supporting and caring for the vulnerable in society. To reflect the Departmental policy of improving opportunities for disabled people to work, the Council has introduced an adult social care target of 75 clients (physical disabilities/ sensory impairment/ learning disabilities/ mental health) supported in employment (permanent/ temporary/ voluntary) during the year.
- 4.4.3 In the longer term, new targets will emerge for independent living criteria. So for example, once individual budgets are introduced, national targets are likely to follow. It may necessitate the transfer of monies out of Housing & Community Services mainstream budgets and to individual service users and carers. This will have implications for both in-house and block contract care providers.

## 5. USE OF RESOURCES

### 5.1 Finance available

#### Health

- 5.1.1 It is not possible to quantify the full cost to the NHS of health services to adults with physical disabilities and sensory impairment. Like any member of the public, disabled adults make use of GP and other primary care and acute services. It seems quite likely that those with long-term conditions make more use of such services.
- 5.1.2 The situation is further complicated by the fact that certain services, e.g. the Community Neuro-Rehabilitation Team and the Occupational Therapists at West Middlesex Hospital, are funded by the Primary Care Trust through non-PDSI budgets. This also applies to care provided at certain specialist hospitals like Stoke Mandeville.
- 5.1.3 The figures we do have show how much the PCT spends on those disability-specific and specialist services shown against its PDSI budgets. In 2006-07, overall expenditure was £2,725,000. This was considerably more than the original budget. Certain of the budget heads for 2007-08 have been increased to reflect the changed circumstances, although this may prove difficult to sustain in future years.

#### Hounslow Primary Care Trust funding

	<b>2006-07 (£) expenditure</b>	<b>2007-08 (£) budget</b>
Specialist Physical Disability Service – Hammersmith & Fulham	1,338,602	1,370,860
Northwick Park Rehabilitation Unit	140,279	143,780
Hillingdon PCT inc environmental controls & rehabilitation engineers	168,498	172,760
Wheelchair Service		
(a) Hounslow wheelchairs & vouchers	106,696	109,090
(b) Synergy Healthcare contract	144,464	148,340
(c) EPIOC & specialist seating	50,002	51,250
(d) other wheelchair services	8,582	9,210

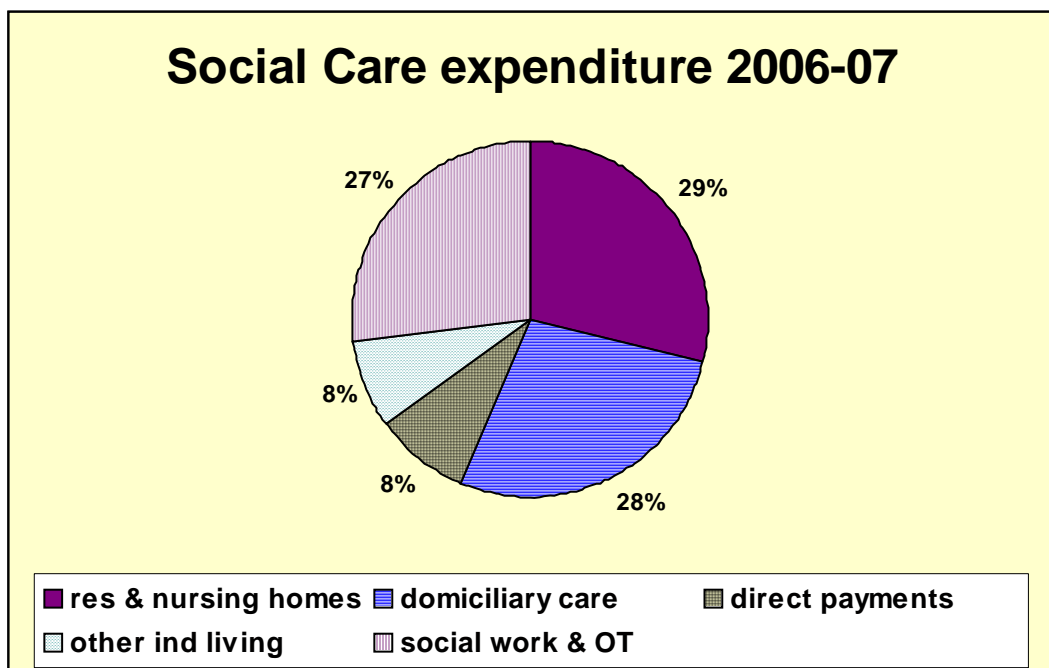
Private Extra Contractual Referrals (ECRs)	163,992	166,780
Brain Injuries Rehab Unit – Barnet PCT	159,678	162,770
Integrated Community Equipment Services (ICES)	390,825	390,830*
Voluntary organisations	4,000	4,160
<i>totals</i>	2,675,618	2,728,800

5.1.4 The majority of the PCT's PDSI spending is thus on services provided externally and through consortia. Funding previously often has been agreed on a per-capita basis, which has not reflected actual activity. A project to develop fairer costing methods was commissioned and the resulting changes to re-charging arrangements are now beginning to be implemented.

5.1.5 There was a significant overspend in 2006-07 on the budget allocated to the Hammersmith & Fulham Specialist PD Service for nursing home placements. The outturn figure was £1.34m, compared with a budget of under £1m. The high cost of new placements has been the key factor. The budget for 2007-08 has been increased to the previous expenditure level, although it is evident that even this will prove insufficient.

### Adult social care

5.1.6 The adult social care expenditure is perhaps easier to identify. It is also greater, with a total 2006-07 expenditure of £7,397,800. A reducing amount went on residential and nursing home care, now less than a third of the total. Most of the budget was spent on enabling people to live independently – on domiciliary care, on social work and occupational therapy, on community equipment and increasingly on Direct Payments. See the chart below and the table follows paragraph 5.1.9.



source: Housing & Community Services Finance Team, May 2007

5.1.7 The 2006-07 budget was in place before a health and safety decision led to the overnight closure of the Council's residential hostel for adults with physical disabilities, Eldridge House. Each of the residents was provided advocacy to enable them to make an informed decision on what should happen next. As a result, six of them were accommodated in other HHCS homes, while the seven remaining residents opted for placements in local independent nursing homes.

5.1.8 The large proportion of the PCT's expenditure on HIV services is on treatment. The 2007-08 budget for London-wide HIV Specialist Commissioning Consortia is £5.6 million. HIV activity also comprises a significant part of the work of the Sexual Health Clinic, which has a budget of £1.6 million. Funding to a number of specialist community-based care providers, some of whom had been receiving AIDS Support Grant funding as well, has been cut or reduced.

5.1.9 Hounslow Council currently receives an AIDS Support Grant allocation of £196,000. This is less than the 2006-07 allocation, which itself was lower than in 2005-06. The indications are that the grant may reduce again in the future. This is bad news, when the number of local residents accessing HIV care is increasing so rapidly. The grant is

shared between support and care services provided or arranged by voluntary organisations, Children & Families and the Independent Living Team.

...

**LONDON BOROUGH OF HOUNSLOW ADULT SOCIAL CARE: NET EXPENDITURE 2006/07:  
SERVICES FOR PEOPLE WITH PHYSICAL DISABILITIES and/or SENSORY IMPAIRMENT**

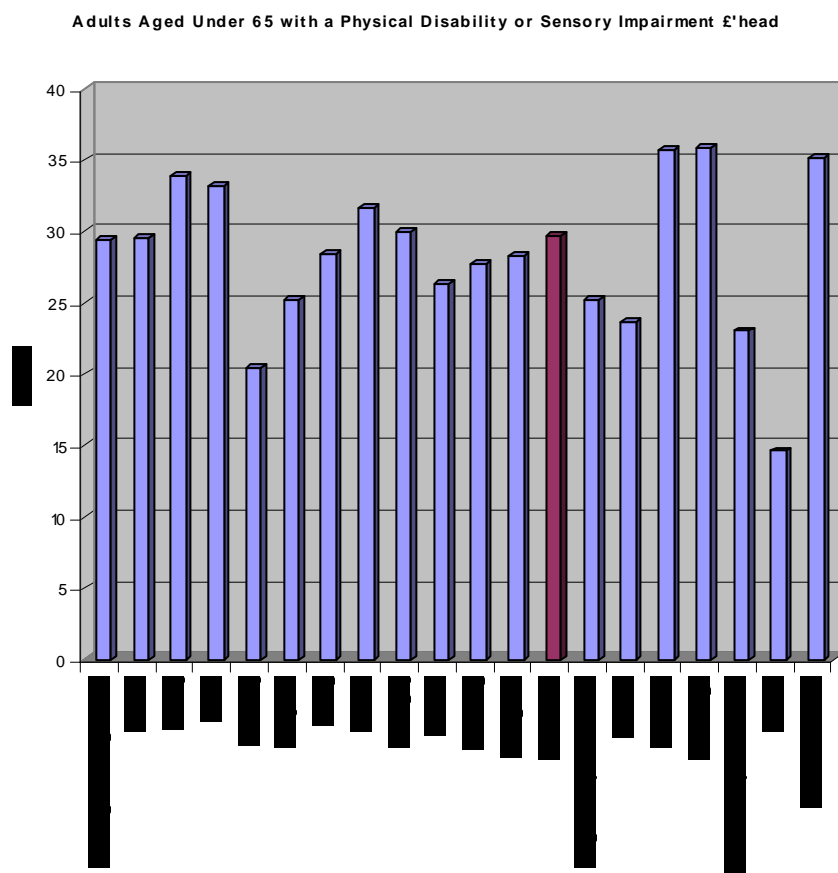
RESIDENTIAL & DAY CARE	INDEPENDENT LIVING AND SUPPORT AT HOME	WHAT PEOPLE DO	COMMUNITY SUPPORT THROUGH VOLUNTARY GROUPS
Eldridge House * £752,100	Integrated Community Equipment Service (iCES) £237,200	Assessment and Care Management (including OT service) £1,986,700	Independent Activities Programme £8,000  Hounslow Association for the Blind £26,000
Residential Care and Nursing Home Placements £1,391,700	Direct Payments £621,800		
Day Support services £170,000	Domiciliary Care £2,037,700		
	Independent Living Centre (Calen Centre) £165,900		
£ 2,313,800	£3,062,600	£1,986,700	£34,000
			<b>Grand Total: £7,397,100</b>

N.B. Figures are for **net expenditure**, after income from customer contributions etc.

\* Eldridge House closed in August 2006 but staff transferred to other duties continued to be paid from the previous budget codes. True expenditure on Eldridge House April-Aug 06 was less.

## 5.2 How Hounslow compares

5.2.1 There is wide variation between Outer London boroughs in their social care expenditure on adults with physical disabilities and sensory impairment. In 2005-06, three authorities in east London each budgeted the highest amount at around £35 a head, while Sutton allocated only £14. Hounslow's budget was just under £30 per adult, a little above the Outer London average.



source: CIPFA Finance & General Statistics, based on 2005-06 budgets

5.2.2 The scale of the differences in spending may owe less to variations in need and/or in service response than it does to the ways services are organised by different boroughs. In one local authority, for instance, day services might be provided on a pan-disability basis and not be identified as PDSI expenditure.

5.2.3 The mix of PDSI spending by the PCT and the Council ranges from the very large to the comparatively small. At the

high end, the average cost of a Continuing Care package in a nursing home was £1300 a week in 2006, in a range between £580 and £3500 per week. This reflects the complexity of needs of the small number of disabled adults who require this kind of care. The cost is also influenced by an imbalance in between demand and supply. There are relatively few suitable placements available and these tend to be expensive.

5.2.4 Residential placements funded by HHCS are not necessarily less costly, because of a high level of staff time is often required to meet care needs. At January 2007, the gross cost of residential placements before customer contributions varied between £470 and £1600 per week. The highest charges were for deaf-blind residents.

5.2.5 At the other end, HHCS deals with a high volume of referrals for Occupational Therapy services, including requests for community equipment. These tend to be comparatively inexpensive. The demand swells the numbers of service users and helps to reduce the average cost of the Council's PDSI services.

### **5.3 National cost pressures**

5.3.1 The escalating cost of PDSI care packages and of placements in specialist hospitals, nursing homes and residential care homes is a fact of life across most if not all the country. In 2006, some 53% of local authorities reported they were experiencing significant cost pressures in residential PDSI placements, up from 33% two years earlier.<sup>48</sup>

5.3.2 The pressures are the result partly of an increasing number of new service users presenting with complex needs and/or multiple disabilities. It requires only a handful of new clients with needs leading to care packages costing £1,000 and more a week to make for considerable budget overspends.

---

<sup>48</sup> Social Services Finance Survey 2006-07, Association of Directors of Social Services/ Local Government Association

5.3.3 However the high costs also reflect the relatively small number of providers who cater for people with complex needs and multiple disabilities. Supply is barely able to meet demand. Not only does this push prices up, it often fails to create sufficient incentives for providers to maintain and improve service quality. And placements often have to be made some considerable distance from Hounslow.

5.3.4 We have previously referred to a recent report prepared for London Councils<sup>49</sup> which has predicted an average cost increase (excluding inflation) of 39% or 6.5% p.a. between 2004/05 and 2010/11 to pay for community care and continuing care for people with physical disabilities and sensory impairment. This provides further evidence of London-wide cost pressures.

## **5.4 Local cost pressures**

5.4.1 The pressures on budgets, particularly on purchasing budgets and Disabled Facilities Grants, remain a real concern. See chapter 9 for a discussion of the implications.

5.4.2 One noticeable local trend has been an increase in numbers of people with acquired head injury. The resulting high levels of need have repercussions for PCT and Council budgets.

5.4.3 During 2006-07, a decision was made to increase the hourly rate paid to domiciliary care block contract providers. While this should help to ensure providers can continue to recruit and retain staff and offer a quality service, it has meant that the size of some care packages (the number of hours of care provided to certain individuals) has had to be reduced.

5.4.4 One way we may be able to reduce the level of demand on statutory care services is by providing disabled adults with greater financial independence. During 2006, a decision was made to allocate temporary funding to buy in a part-time

---

<sup>49</sup> RSe consulting, 'Review of costs of community care and continuing care in London: a report for London Councils, March 2007

welfare benefits specialist from the Council's Welfare Benefits and Money Advice Unit. Working from the social work team, she has been advising service users on their entitlements and helping them to make benefits claims and to apply for Independent Living Fund (ILF) money. The post has now been made permanent.

We propose to:

- Maintain funding of services that enable disabled people to maximise their income and that reduce pressures on care budgets.

## **5.5 Workforce issues**

5.5.1 Many of the workforce issues identified in the Commissioning Strategies' Overview Document apply to PDSI services. Recruitment and retention of trained staff is one priority, in an effort to reduce reliance on agency staff.

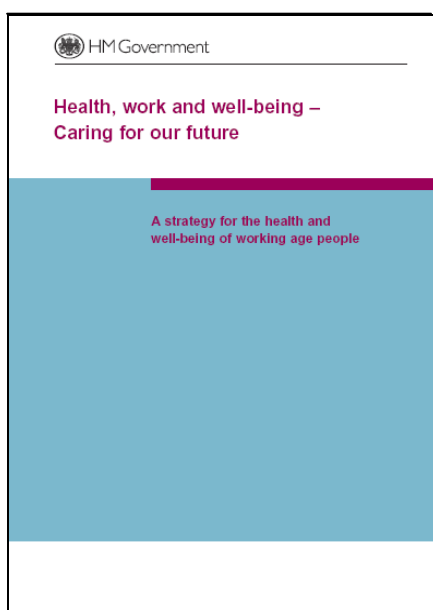
5.5.2 The job descriptions of social work staff have been changed to give them more of an independent living focus. A team of four Independent Living Advisers is currently being recruited to the newly-titled Independent Living Team to review needs assessments and develop care plans that are outcome-focused and user-centred.

5.5.3 The contract with Able2 means that Occupational Therapy referrals can be forwarded to them for action whenever vacancies occur in the in-house team or cover cannot easily be provided for OTs on annual or sick leave.

## 6. EMPOWERING DISABLED PEOPLE TO WORK

6.1 The importance of providing support to enable disabled people obtain employment skills, find a job and stay in work has been underlined by various developments during the past few years, including:

- Government initiatives on Welfare to Work for Disabled People, such as the appointment of Disability Equality Advisers in local Job Centre Plus offices;
- a national strategy on Health, Work and Well-being<sup>50</sup> .....



- .....followed by a Green Paper and the 2007 Welfare Reform Act<sup>51</sup>, with an objective to move during a ten-year period one million people (out of 2.7 million) from incapacity-based benefits into work;
- Government policy<sup>52</sup> and local priorities on independent living;
- the introduction of a national framework of adult social care eligibility criteria<sup>53</sup>, with involvement in work, education or learning highlighted as one of the criteria for offering service help.

<sup>50</sup> 'Health, work and well-being – caring for our future', Department for Work & Pensions/ Department of Health 2005: [www.dwp.gov.uk/publications](http://www.dwp.gov.uk/publications)

<sup>51</sup> HMSO, Welfare Reform Act 2007 (Royal Assent 3<sup>rd</sup> May 2007)

<sup>52</sup> 'Our Health, Our Care, Our Say: a new direction for community services', White Paper on adult social care, Department of Health, February 2006

<sup>53</sup> 'Fair Access to Care Services', Department of Health, April 2003

- 6.2 Many disabled people are concerned that the Government's policy of reducing numbers on benefits could force them to look for work even if they might find it difficult to hold down a job. However few would deny that, for those who can work, being in paid employment brings greater financial independence and, often, greater self-fulfilment too.
- 6.3 Recent research<sup>54 55</sup> has revealed that 50% of adults of working age who had mobility problems were unemployed and that 50% of disabled Londoners were 'economically inactive', compared with 21% of non-disabled people. Some 28% of all economically inactive disabled adults would have liked a job. If applied to local circumstances, this unmet demand for work would equate to 275 PDSI adults who were accessing community services in 2005-06 following an assessment.
- 6.4 An earlier research review<sup>56</sup> found that disabled people were six times more likely than non-disabled people to be out of work and claiming benefits. Unsurprisingly, it also revealed that half of all disabled people had incomes below half the general population average (often taken as an indicator of poverty), after making an adjustment for extra costs. Even without adjustment, two in five were found to be in poverty.
- 6.5 This finding was replicated in a survey of household incomes in a neighbouring borough<sup>57</sup>. The average household income there for non-special needs households was £494 per week but only £293 for physical disability households and £267 in households with someone with a severe sensory disability. Economic independence is an important component of satisfactory independent living.
- 6.6 A local survey of barriers to employment experienced by disabled people<sup>58</sup> revealed that what they want is not skills

---

<sup>54</sup> Labour Force Survey Spring 2005, Office for National Statistics: [www.statistics.gov.uk](http://www.statistics.gov.uk)

<sup>55</sup> 'Health in London: Looking Back, Looking Forward', London Health Commission, March 2007

<sup>56</sup> Tania Burchardt, 'Enduring economic exclusion: disabled people, income and work', Joseph Rowntree Foundation, October 2000

<sup>57</sup> Ealing Supporting People Strategy 2006

<sup>58</sup> Residents' Panel survey, Hounslow Council, November 2006

development but support in finding a job and staying in work, including help with tax and benefits.

- 6.7 In recent years, a relatively small proportion of PDSI service users have been receiving employment support through Housing & Community Services. Some have been signposted to Disability Equality Advisers at Job Centre Plus or to other employment specialists. Some have been attending the Acorn Centre in Heston, via a contract from physical disability budgets. Acorn is a pan-disability centre that provides short-to-medium-term development of skills for independent living, including employment skills.
- 6.8 Leaders' employment service, based in Brentford, has seen a number of recent changes.
- The launch in 2006 of Leaders' pan-disability 36-week programme got off to a positive start, with the first cohort supporting 17 (77%) of clients on the scheme into open paid employment and 15 of them retaining their jobs to date.
  - Extra and permanent funding was secured for 2007-08, enabling Leaders to have staff for dedicated roles in Work Preparation, Job Retention and Career Progression across customer groups. Funding was also secured for a designated mental health specialist role. These positions were recruited to in Spring 2007.
  - The new staff mean that Leaders can deliver a pan-disability service, with PDSI adults now included in work preparation, job finding and post-employment support programmes.
- 6.9 During 2008, following a review of Leaders' services, it is likely that a target will be set for Leaders to move PDSI users into employment.
- 6.10 There are some specialist services available to adults with sensory impairment too. Information technology training for people who are blind or partially-sighted is offered at the Calen Centre. Education services are also available from the Hearing Impaired Support Unit at Uxbridge College.

6.11 The draft report on Empowering Disabled People to Work<sup>59</sup>, led by HHCS and recently consulted on, envisages that action is required to:

- change the culture, e.g. through disability awareness training for all front-line staff and by ensuring that employment support for disabled people focuses on confidence-building as well as skills development;
- prioritise employment, through a higher profile in assessments and via better information and information exchange;
- clarify who should do what within the Council and outside – and decide who should co-ordinate and lead activity;
- reduce barriers to employment, by prioritising welfare benefits advice and discussing flexible working with employers;
- lead by example – the NHS and the Council to take practical steps to ensure they employ more disabled people.

6.12 This last action point is one area where health and social care agencies, as major employers themselves, can have a direct benefit. Some developments have taken place already, e.g. the Council's decision to allocate an apprenticeship place to a disabled youngster. Others will follow, notably in contractual arrangements the Council and the PCT make with care providers.

6.13 To ensure these efforts are effective will require strategic co-ordination and good partnership working with employers and with Job Centre Plus, the Learning & Skills Council, local colleges and other organisations with employment responsibilities. There is a need to take full advantage of a widening range of funding sources. It will be important to learn from and co-work with Mental Health in their experience in implementing psychological therapies<sup>60</sup> as part of the

---

<sup>59</sup> 'Empowering Disabled People to Work', LBH Housing & Community Services, consultation draft April 2007

<sup>60</sup> 'Commissioning a brighter future: improving access to psychological therapies - positive practice guide', Care Services Improvement Partnership/ Department of Health, May 2007

Government's programme to maintain people in work and help them return to work.

6.14 The skills training and other support required must fit with people's work aspirations and their preferred choices of occupation. It must be user-led. It should not follow any preconceptions of what might be suitable or appropriate for individual disabled people.

We propose to investigate further to:

- Identify numbers of adults with physical disabilities and sensory impairment in Hounslow who may seek employment in the next few years;
- Establish their employment-related needs and wishes;
- Plan employment support services accordingly;
- Create opportunities for co-working with other Council Departments (e.g. re education and leisure provision), with the Community & Mental Health Trust (e.g. re psychological therapies) and with other external agencies and employers;
- Ascertain and make best use of available funding streams.

## 7. HOUSING

- 7.1 Hounslow Homes was established in 2002 to manage the Council's housing stock. A new choice-based system of allocating properties, known as Locata, was introduced the same year.
- 7.2 Housing waiting lists grew during the 1990s. Although new developments of social housing are only possible through Housing Associations, the Council often has nomination rights for places. The Enabling Team liaises with Registered Social Landlords (housing associations) on adaptations and on availability of accessible units. Work continues to influence private sector new builds to try to ensure that 10% of properties meet accessible housing standards.
- 7.3 There are a number of ready-adapted dwellings for use by disabled people in Hounslow but the information about quantity, quality and availability of such accommodation is limited. In the past at least, there have been too many single-bedroom adapted properties and too few properties suitable for families. The properties available often do not match disabled people's needs. In addition, in late 2006 there were over 100 disabled people living in temporary accommodation, usually without any adaptations they might require, and a further 100 were on the housing register waiting list.
- 7.4 As a result, an Accessible Housing Project is underway. It is researching the supply of accommodation (types, quantity and quality) for disabled people available locally. It will then compare this with current and anticipated future demand.
- 7.5 A critical factor in improving the availability and quality of accessible housing will be a strong working relationship with Planning Officers, particularly in the access requirements they negotiate with housing developers. We are committed to strengthening these links.
- 7.6 A PDSI/ HIV housing strategy was approved in 2004. It is being implemented and updated by an Accommodation Sub-

Group, which also has oversight of the Accessible Housing Project. Accessibility will take account of wider factors, such as easy access to shops, which can be a key factor in enabling independent living.

- 7.7 There is only limited local provision of supported housing for PDSI adults. John Grooms, a Housing Association, offers 19 tenancies at Davenport Lodge in Heston to physically disabled people with fairly low level needs. It receives Supporting People funding. Unfortunately, access to the site is poor and the properties do not meet the decent homes standards. John Grooms is currently seeking to redevelop the building, either on the existing site or elsewhere, and to increase the number of tenancies. There is a risk that even the current small number of tenancies could be lost in the interim.
- 7.8 Two ‘floating support’ services provided by voluntary organisations also receive Supporting People funds: a home visiting service from Hounslow Association for the Blind and a British Sign Language service from Disability Network Hounslow. Additionally, there is a contract with the Shepherd’s Bush Housing Association to supply floating support to 12 people with HIV/AIDS.
- 7.9 A PDSI/ HIV housing strategy was approved in 2004. It is being implemented and updated by an Accommodation Sub-Group, which also has oversight of the Accessible Housing Project. Accessibility will take account of wider factors, such as easy access to shops, which can be a key factor in enabling independent living.
- 7.10 On the Building for All model for establishing demand for supported housing, Hounslow provision as at 2007 was 11 units short of the level estimated as being required – 30 units in total. The local Supporting People Strategy<sup>61</sup> has highlighted the need for:
- expansion of floating support services
  - some remodelling of existing accommodation (as proposed for Davenport Lodge)

---

<sup>61</sup> London Borough of Hounslow, ‘Supporting People Strategy 2005-2010’

- greater choice in independent living options

7.11 Extra Care Housing, with 24-hour care support, is a priority area. As a first stage, older PDSI adults (aged 55 plus) are able to apply for places at Greenrod, the new Extra Care development of 43 one- and two-bedroom flats scheduled to open in Brentford in January 2008. Applications for tenancies and shared ownership are made to and considered by a unified Housing & Community Services panel, with a single care provider and a programme of activities commissioned from Age Concern Hounslow.

7.12 A further shift of provision away from residential care and into Extra Care Housing would make considerable sense:

- it would enable people to retain a greater measure of independence than in a residential setting;
- it could be provided within the borough, whereas many residential placements are currently outside;
- it could be less costly, particularly if it could attract Housing Corporation or similar funding.

7.13 Resources permitting, it is anticipated that there will be three further stages to the extension of local Extra Care Housing provision for people aged 55 and over - in the west of the borough, then in the Heston/ Cranford area and finally in Chiswick. Total provision is envisaged to be 225 places.

**We propose to:**

- Monitor the uptake of Extra Care Housing at Greenrod Place and the extent to which it is meeting care needs, before it similar projects are developed in other parts of the borough;
- Evaluate its sufficiency and suitability for people with physical disabilities and sensory impairment and to consider accommodation needs for those aged under 55.

7.14 Money for adaptations, both to private property and Council-owned accommodation, is not sufficient for all the applications received. This is not new. In 1998, the Audit Commission calculated that nationally Disabled Facilities Grants (DFGs)

were enough for just one in 26 of eligible households. Within budgets available, Occupational Therapists and Housing staff work together closely to assess needs and arrange for adaptations to be carried out. There are two OTs on the Housing Allocation Panel. Meanwhile requests for DFGs have been increasing, currently 20% more than a year ago.

7.15 To improve the situation, the Disabled Facilities Grant (DFG) policy for private sector housing has been revised during 2007, with targets<sup>62</sup> set as follows:

- 75 DFG cases completed during 2007-08, with full spend of budget;
- 150 properties occupied by vulnerable persons brought up to the Decent Homes standard;
- 97% of cases completed within 12 months of approval;
- 95% customer satisfaction.

7.16 Barriers to swift processing of DFG applications remain. External fraud checks have to be carried out to ensure applications are from people in genuine need. Further hold-ups are caused by there being no fast-track procedure to approve planning applications for building work. Even so, Hounslow's performance on the waiting time for building starts is a little longer than the London average.

7.17 In mid-2007, Hounslow Homes had a waiting list of over 200 people for disability adaptations to its own properties. This was partly the result of a significant reduction in budgets for the purpose. Investigation continues as to whether new monies could be found to address the problem. Meanwhile, the Accessible Housing Project is looking at future opportunities.

7.18 At least two reports have provided evidence that increased investment in equipment and adaptations could result in savings to health and social care budgets, as well as improving outcomes for individuals.<sup>63</sup> <sup>64</sup> There is also little doubt that most disabled people would prefer to remain in their

---

<sup>62</sup> Housing & Community Services Business Plan 2007-08

<sup>63</sup> 'Fully Equipped', Audit Commission 2000

<sup>64</sup> 'Better Outcomes, Lower Costs', Department for Work & Pensions May 2007

own homes with suitable adaptations, rather than accepting residential care. We return to this topic later in the strategy.

We propose to take concerted action to:

- Work with colleagues in housing to meet CSCI targets for housing adaptations within the available budgets;
- Consider potential for shifting resources to provide additional funding for both community equipment and adaptations.

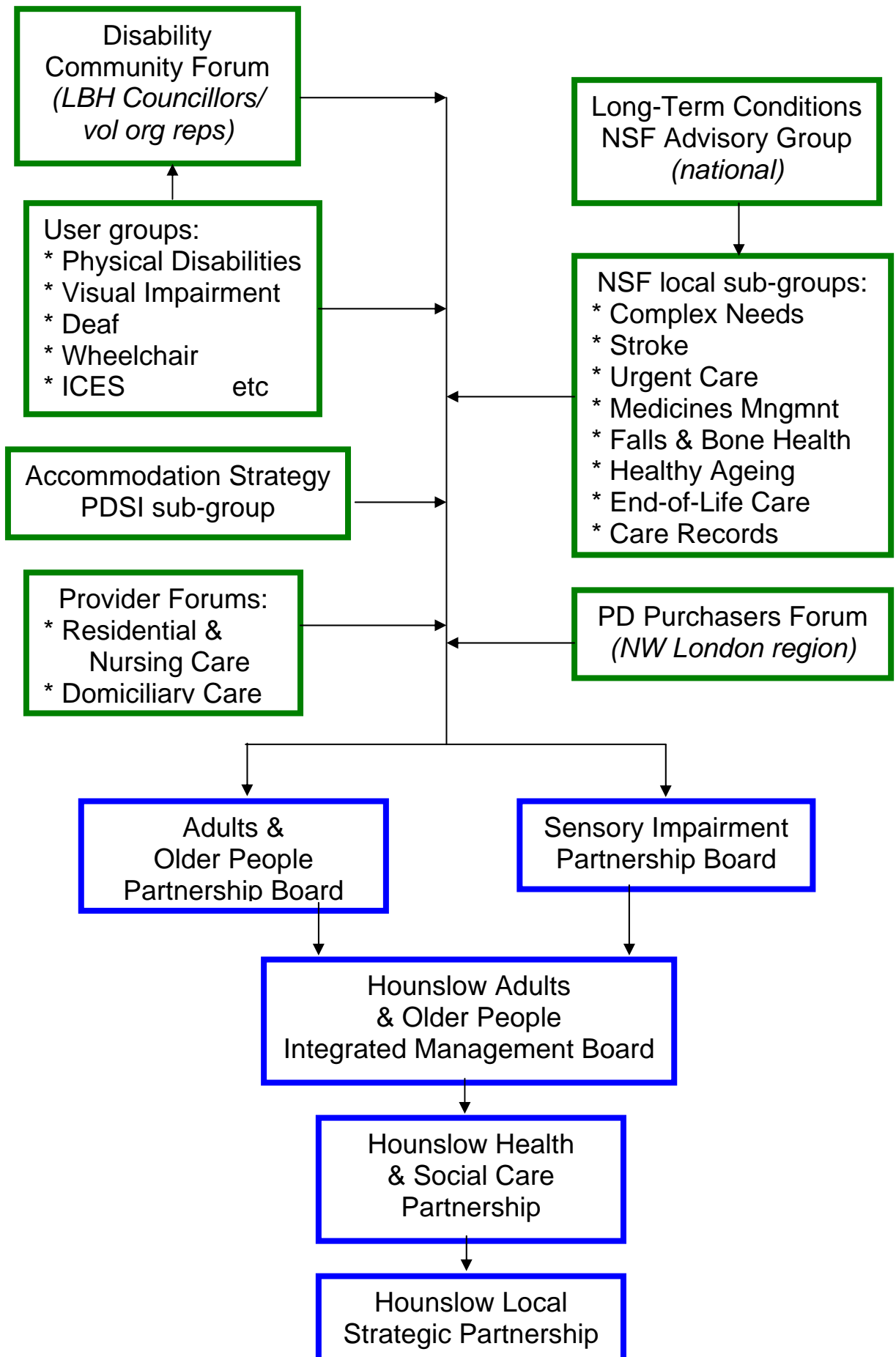
## **8. PARTNERSHIP WORKING**

- 8.1 A number of changes have been introduced during 2007 in partnership structures. The objective is two-fold:
- to streamline the number of meetings that managers and community representatives have to attend; and
  - to help ensure that issues and potential responses that cut across PDSI and Older People's services are not considered in isolation from each other (e.g. development of services utilising assistive technology).
- 8.2 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.
- 8.3 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.
- 8.4 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.
- 8.5 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.
- 8.6 Two voluntary organisations, the Independent Activities Project and Disability Network Hounslow, have been funded since 2005 to run PDSI user groups, with input from the Consultation and Participation Manager. Points made by the user groups are taken by the two voluntary organisations either to meetings

of the appropriate Partnership Board, if the comments relate to health and social care, or to the Disability Community Forum. Carers' views are also fed into the meetings. It is recognised that ready access to transport and community facilities, while not a direct responsibility of the PCT or Health and Community Services, can have a significant impact on disabled people's ability to live independently.

- 8.7 2008 will see the introduction of LINKs user involvement networks covering both health and adult social care but led by local authorities. Patient Forums will be replaced. Existing adult social care user group feedback mechanisms will also need to be adapted to meet the new requirements.
- 8.8 Contact is maintained with a range of other PDSI voluntary organisations, particularly those that have a strong local presence, like the MS Society. Several of the organisations are members of the Hounslow Neurological Partnership, which is led by the voluntary sector.
- 8.9 Contractual arrangements for PDSI are an increasingly important part of service provision. The joint health and social care ICES community equipment contract was introduced to meet a Government requirement, but others, like the service level agreements with Middlesex Association for the Blind, have developed through effective co-working with providers offering specialist expertise.
- 8.10 A 'whole systems' approach to PDSI service planning will continue to evolve, in the context of the further development of independent living services and support. This is likely to require service re-design and changes in service investment. It will also require a co-ordinated approach across Housing, Leisure, Employment and Transport services within the Council and also with partners outside.

**PHYSICAL DISABILITIES/ SENSORY IMPAIRMENT PARTNERSHIP MAP**



## 9. COMMISSIONING, CONTRACTING & IN-HOUSE SERVICES

### 9.1 Financial context

9.1.1 We have noted that expected population growth and increased prevalence of disability, while not considerable, might increase demand for PDSI services in Hounslow by around 0.5% for each year of the period of the strategy. We have also concluded that this figure would be likely to be dwarfed by steeply rising costs of domiciliary care and residential and nursing home placements. Our guesstimate of total in-built budgetary pressures was 3% per annum. This was a cautious estimate; the actual increase in expenditure required just to stand still could be greater.

9.1.2 We also know there will be a continued expectation by both the PCT and the Council that budget reductions will have to be achieved. It is not unrealistic to estimate that the overall budget savings' requirement will also average 3% per year. Indeed, current indications are that it could prove to be a considerable under-estimate.

9.1.3 Let us take the cautious estimate of an annual 3% real increase in care costs, combined with a 3% real reduction in care budgets. If this pattern were maintained over the full three years of the strategy, a significant gap would open up between needs and budgets.

	<i>Budget required to keep up with needs*</i>	<i>PCT/LBH budget available</i>	<i>difference</i>
2007-08	£10,000,000	£10,000,000	-
2008-09	£10,300,000	£9,700,000	- £600,000
2009-2010	£10,609,000	£9,409,000	- £1,200,000
2010-2011	£10,927,000	£9,127,000	- £1,800,000

\* at current prices and current levels of provision

9.1.4 After three years, on this basis, the gap would be equivalent to an 18% cut in current budgets. Clearly it is only a hypothetical calculation. If it happened to be true, however, there will be a growing gap between the PCT/LBH finance required to maintain services at their current level and the

money actually available. On the basis above, the gap would increase by 6% of total expenditure each year.

9.1.5 There is no easy answer. The trend is towards Direct Payments and individual budgets. However, except in relation to management and other on-costs, there is little evidence these will prove cheaper than domiciliary care packages. Indeed, they may well be more expensive. Equally, we cannot expect there to be much potential to save money by switching resources out of residential care and into domiciliary care. Care at home is only sometimes the cheaper option.

9.1.6 The effects are already being felt. For example, some care packages for people living at home have had to be reduced. The PCT have had to review all the services they fund and have ceased their funding of the Middlesex Association for the Blind (MAB) Mid-Sight desk at West Middlesex Hospital.

## 9.2 Health care priorities

9.2.1 The Government has flagged up that it wishes to see a shift of expenditure away from acute, bed-based care and into community health and social care, with an emphasis on preventative services. This will have to be addressed nationally if savings are to be achieved locally on a scale sufficient to make the objective much of a reality. It has to be seen against the backcloth of a growing need for acute and long-term health care. We have noted the increasing demand for health care from new patients with traumatic head injuries and from young people with chronic and severe disabilities. For this reason, whatever the policy, there is considerable merit in examining current health care provision and care pathways to identify potential for reducing pressures on acute services.

We propose to:

- Prepare options for service re-provision out of acute care, e.g. by enhancing and improving the effectiveness of community-based services, with the objective of reducing the number of hospital admissions, the length of hospital stays and the number of re-admissions.

9.2.2 This review will also have to take account of the nature and extent on demand for acute neurological care at West Middlesex Hospital. There is evidence of an increasing number of Hounslow residents with acute neurological conditions being 'repatriated' from other hospitals, including specialist hospitals, at an earlier stage.

9.2.3 While the Stroke Unit Team at West Middlesex Hospital has put much effort into developing an efficient acute stroke pathway, community support after discharge from hospital has been more patchy. Achieving seamless care across acute and community services is a priority.

9.2.4 A draft National Stroke Strategy has been issued<sup>65</sup>. Among other things, it calls for:

- prompt access to high-quality stroke specialist acute care
- high-quality stroke rehabilitation care
- seamless transfer of care from hospital to home or care home, followed by regular screening and access to social, emotional and psychological support
- access to vocational rehabilitation leading to employment
- health promotion campaigns for the public generally and health care information, advocacy and other support for service users and carers
- a strong commitment by commissioners to a skilled workforce and to staff training

9.2.5 Stroke is dealt with in detail in the Joint Commissioning Strategy for Older People. There is a PSA/ Healthcare Commission target to substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at

---

<sup>65</sup> 'A New Ambition for Stroke', Department of Health, July 2007

least 40% in people under 75. A stroke stock-take is underway in Hounslow to move this on.

9.2.6 There is no speech and language therapy service for PDSI adults. Young people leaving the Hearing Impairment Unit at Heston Community School and the Physical Disability Unit at Feltham Community College have no further speech and language service available to them. An increase in referrals to the Speech and Language Therapy Team and a decrease in funding for the service means there is little scope at present to extend the existing service to PDSI adults. We will ascertain how this gap in provision might be addressed when we review our current care pathways.

We propose to:

- complete the stroke stock-take and take action on priority issues
- develop and implement a new community stroke pathway
- 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
- develop a local stroke strategy
- assess services provided to Hounslow residents attending other acute hospitals (primarily Ashford & St. Peter's and Hammersmith & Charing Cross hospitals)
- identify to what extent GP protocols are in place
- involve public health & general practice in steering group

We also propose to:

- identify funding opportunities for establishing a community-based Parkinson's Disease specialist nurse and training post;
- include Speech & Language Therapy in our review of care pathways for people with sensory impairment – see 9.7 below.

### 9.3 Residential and nursing home care

9.3.1 Hounslow remains committed to reducing the proportion of PDSI adults in residential and nursing home care, as part of the policy of facilitating independent living and user choice. We have noted, for example, the high priority being given to the development of local Extra Care Housing (see 7.10 above). However there will always be a need for some residential provision for people with the most severe and complex disabilities. As stated, this need seems likely to continue to increase, in line with advances in medical care.

9.3.2 Whether people should receive fully-funded NHS residential or nursing home care is assessed on the basis of needs being predominantly health-related, in accordance with NHS Continuing Care criteria. A new Continuing Care framework has been introduced in October 2007<sup>66</sup>. Up to then, Hounslow had been using the North West London Continuing Care Assessment Tool.<sup>67</sup> Decisions on placements and who funds them are made at fortnightly meetings of the joint local authority/ PCT Adult Placements Panel.

9.3.3 By January 2007, HHCS had been supporting 49 PDSI adults in residential and nursing homes during that financial year – one of these placements had ended. The total commitment for the year at that time, net of customer contributions, was £1,279,000. In July 2004 by comparison, HHCS was supporting fewer people, 37 in total. This growth in numbers has put considerable pressure on care management budgets.

9.3.4 Of the placements current at January 2007, ten had reached the age of 65. It is unclear whether any of these were PD adults who had reached the age of 65 and no longer should have been paid for out of PDSI budgets. Most if not all of the over 65s would have paid from this source because people with sensory impairment remain a PDSI responsibility:

---

<sup>66</sup> Department of Health, 'The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care', June 2007

<sup>67</sup> North West London Strategic Health Authority, 'An Agreement and Assessment Tool for NHS funded Continuing Care for Younger Adults, Older People, Physical Disabilities or Mental Illness', revised 2006

	nursing homes	independent res homes	in-house res homes	all placements
under 65	18	16	5	39
aged 65+	9	-	1	10
all ages	27	16	6	49

9.3.5 The fees paid to the homes by the local authority vary considerably. At January 2007, the range was from £469 to £1609 a week. The net cost was a little less, because customers are expected to contribute - on average about £80 a week, though one person at the time was a self-funder. The highest fee was for each of three deaf-blind adults in a specialist home outside the borough. The total net cost to the Council, excluding the six people in in-house accommodation (Heston House and Sandbanks), was about £27,000 a week or £1.4 million for the year.

We propose to:

- Establish a Placements Officer post, shared between PDSI and Learning Disabilities, to help find suitable, quick and cost-effective Council-funded residential and nursing home placements.

9.3.6 In January 2007, the PCT was paying the full cost of 16 placements in nursing homes plus a small number of people in specialist rehabilitation or respite centres. Most placements were made by Hammersmith & Fulham PCT who the PCT commission to provide their physical disability continuing care service. Seven of the placements were new ones made during 2006-07. Fees were generally higher, but again there was a wide range, from £567 to £3820 a week. Usually they were between £1200 and £1600 a week.

9.3.7 A London-wide Neuro-Rehabilitation Consortium has also recently been established to meet specialist and complex needs and to offer equitable access to services with a consistently high standard of care. Hammersmith & Fulham PCT provide the North West London lead on the consortium.

9.3.8 Despite the wish to reduce reliance on residential provision, there remains a strong upward demand pressure that has

continued into 2007-08. Given the very high cost, an annual increase of just one or two placements can place – and is placing - a considerable financial burden on the PCT.

9.3.9 With similar pressures being faced by both the Council and the PCT, greater scrutiny of requests for residential and nursing home placements will be essential to identify whether other, less costly alternatives may be available. There is also a priority to continue to promote community-based health and social care.

We propose to:

- Review PCT-funded placements and commissioning consortium arrangements, with the objective, wherever practicable, of containing expenditure and providing care close to Hounslow;
- Develop plans for disinvestment in residential and nursing home care, to reduce numbers admitted to long-term care and shift the balance of provision further toward community-based care – including housing adaptations, supported housing and/or community equipment, as identified above;
- Consider how best Telecare might be introduced in residential settings, to reduce demands on night staff and improve residents' privacy and independence.

## 9.4 Care at home

9.4.1 As previously noted, a significant proportion of the PDSI social care budget – over £2 million in 2006-07 – is spent on providing domiciliary care support in people's own homes. In addition, four of those PDSI adults receiving NHS Continuing Care at January 2007 had domiciliary care packages and a further three were receiving day hospital/ day service support at a total annual cost of £170,000.

9.4.2 Most people who previously had domiciliary care arranged by the Independent Living Team on a spot contract basis now receive care through the block contract introduced in 2006 and shared with Older People's services. One provider (Quality

Care) covers the east and west of the borough, while another (Medico) provides domiciliary care for the central area.

- 9.4.3 During 2008-09, as part of the policy of promoting independence, we intend to extend to PDSI the Integrated Assessment and Rehabilitation (IARDS) service based at West Middlesex Hospital. As for Older People, the focus will be on people being enabled to stay at home, with appropriate support. The objective will be to reduce the number of admissions to hospital and to residential care.
- 9.4.4 It is also hoped to extend to PDSI domiciliary care users the Assessment & Re-enablement Service (ART) recently introduced for Older People through the in-house Home Care teams. The service operates for the first six weeks during the period before the first review of care, before handing over provision to the independent sector.
- 9.4.5 In other respects, the in-house teams have been moving towards more specialist provision, while leaving mainstream care to external contract providers. For example, neurology, palliative care, rehabilitation and complex physical care previously have been poorly served by mainstream domiciliary care provision. Disabled people have been at risk of being admitted into long-term residential and nursing care because of the lack of a viable alternative. The in-house service, with appropriate training for staff, should be able to fill some of this gap, although some spot purchasing from specialist care organisations is likely to continue to be needed for a few.
- 9.4.6 One major concern around domiciliary care, as highlighted by the Carers' Action Group and others, used to be the length of time paid carers stayed with service users. Some recipients found themselves under pressure to sign that their home carer had stayed for a longer period of time that had been booked. For this reason, an electronic clocking-in and clocking-out system has been introduced as a requirement of the new block contracts. The system monitors the length of time carers are with individual service users and the number of missed calls. The Housing & Community Services' Contracts Team, which

carries out quality monitoring, has noted positive customer feedback. Service users receive weekly reports of care planned and care actually provided.

- 9.4.7 Action is being taken to ensure that efficient use is made of the budget for domiciliary care budget. This includes reviewing and simplifying processes to achieve greater uptake by service users of benefits and Independent Living Fund monies. This should release more money for care, thus making it easier to provide intensive domiciliary care packages and to enable disabled people to continue to live at home.
- 9.4.8 Another objective is to introduce more robust financial assessment procedures to help maximise the collection of customer contributions.
- 9.4.9 A further review of domiciliary care provision and budgets and probable service re-design will be necessary in due course as more people take up Direct Payments and, perhaps, individual budgets.

We propose to:

- Help ensure the appropriateness of care plans and opportunities for rehabilitation by extending to PDSI the IARDS assessment service at West Middlesex Hospital and the in-house domiciliary care Assessment & Rehabilitation Service for the first 6 weeks of domiciliary care received;
- Take further measures to maximise users' income and the collection of charges.

## 9.5 Wheelchair and equipment services

- 9.5.1 Since April 2006, the initial assessment and provision of manual and indoor powered 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 until March 2009 to Synergy Healthcare Group,

located in Park Royal. The service has successfully reduced the waiting time for assessments.

- 9.5.2 Waiting times remain an issue for the specialist seating and indoor/ outdoor powered wheelchairs contracted out to the Disability Services Centre at Stanmore until March 2008. 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. Negotiations are underway to secure suitable re-provision of the contract.
- 9.5.3 Another, smaller contract via a consortium is to Hillingdon Hospital to provide specialist wheelchair services and environmental controls: mainly electronic systems that enable people with limited mobility to control lighting, appliances, telephones and security systems.
- 9.5.4 Both the PCT and the Council jointly fund the Integrated Community Equipment Store (ICES). After early difficulties with the store, the service has been re-provided under a new contract, with considerable improvements in delivery times and service quality.
- 9.5.5 An in-depth review of wheelchair services in Scotland<sup>68</sup> concluded that services should be provided in a more holistic way that addresses lifestyle needs of patients/ users and enhances social inclusion. There should be less of a focus on chairs meeting medical needs and more on providing chairs that enable users to play a full part in community life. We support these principles and will take them into account in reviewing our wheelchair service provision.
- 9.5.6 The demand for both wheelchairs and community equipment could increase if current plans for enhanced Intermediate Care provision reach fruition. To meet any such demand, resources would have to be transferred out of residential care.

---

<sup>68</sup> Moving Forward: Review of NHS Wheelchair and Seating Services in Scotland, Scottish Executive Health Department, March 2006

We propose to:

- Re-provide wheelchair contracts as necessary and ensure monitoring arrangements identify and address issues of service timeliness, continuity and quality;
- Monitor demand and address any resulting issues of the need for additional investment,
- Obtain user/ carer feedback and service involvement, by means of wheelchair and equipment user groups
- Investigate whether we could make better use of environmental controls to enable people to live independently .

## 9.6 Occupational Therapy

9.6.1 The success of the Occupational Therapy Team's previous service redesign is being evaluated to ensure demand for services can continue to be managed and to help further move on independent living. As mentioned earlier, a web-based self-assessment facility has been introduced and an Initial Response Team established to speed up assessments.

We propose to:

- Re-tender the OT contract, with a new contract in place during 2008;
- Develop options for introducing OT-trusted assessor schemes and implement the chosen proposal.

## 9.7 Sensory Impairment services

9.7.1 The Sensory Disability team at the Calen Centre in Feltham comprises two Rehabilitation and Mobility Officers for visual impairment and a Technical Officer for people who are deaf or hard of hearing. The team has been strengthened by the appointment of a Senior Occupational Therapist in a case management role.

9.7.2 The resource centre at the Calen Centre now provides computer training, supplied by Middlesex Association for the Blind (MAB). Other MAB services, part-funded by various

means, include the Mid-sight desk at West Middlesex Hospital and Early Intervention, Home Support and Advocacy services.

9.7.3 There are specific responsibilities on HHCS<sup>69</sup> to maintain a database of deaf-blind people in the borough and to ensure that appropriate services are available to them. Staff have been trained and MAB has been providing a Deaf-Blind Communicator Service to 7 local residents.

9.7.4 Despite recent improvements, some Sensory Impairment services are limited in scale and others, like BSL interpreters, are in scarce supply. Many of the needs and issues are shared with Physical Disabilities as above. However, there are certain service areas where people with Sensory Impairment have particular needs, e.g. most deaf people are of working age and would like to work but may require different kinds of support to enable them to do so. The recently-established Sensory Impairment Partnership Board will give added profile to this 'customer group' and develop annual work programmes.

9.7.5 There seems to be some uncertainty about the extent to which there is 'joined-up' thinking on care needs and provision at important times in the lives of people with sensory impairment, e.g. at transition and when an impairment is acquired after the age of 65.

**We propose to:**

- Review current care pathways for people with sensory impairment and to introduce identified improvements;
- Review numbers and needs of deaf-blind people;
- Introduce and publicise an Advocacy and Information Service for Deaf and Hard of Hearing people, early in 2008;
- In association with Middlesex Association for the Blind, issue a local information booklet on Visual Impairment Services.

---

<sup>69</sup> Social Care for Deafblind children and adults, Department of Health 2001

## 9.8 Independent Living generally

9.8.1 We have already discussed a number of issues relating to independent living and identified a number of actions we propose to take – see chapter 3 above in particular. Here are a few more.

9.8.2 The emphasis on enabling disabled people to live independently and to make their own decisions and choices about their care has gathered pace in recent years. It has been reflected in organisational structures, notably the move away from a Disability social work team to an Independent Living service. The service includes a re-focused social work function, alongside other provision assisting independent living, such as Direct Payments, Leaders' Employment and Occupational Therapy.

9.8.3 No longer can care services see themselves as an end in themselves, but rather as a means to an end. For some disabled people, significant health and social care involvement may be required only at a particular time or times in their lives. Otherwise it can and should be disabled individuals themselves determining how they live, with as much independence as possible.

9.8.4 A necessary consequence of this changing role for statutory services must be a greater emphasis on the needs of informal carers and family members. Access to information, advice and advocacy also will be important, as part of the Expert Patient programme. As mentioned previously, new kinds of support systems may have to be commissioned too, e.g. self-help groups and buddying services.

9.8.5 Looking further ahead, the future introduction of individual budgets will create new opportunities and new challenges. Not least of the challenges will be how care commissioners, care providers and disabled people themselves can adjust to the risk-taking that is inherent in such a system. A significant programme of training will be needed to help staff understand and adjust to their new role. The changes will have to be

communicated to the public as a whole and accompanied awareness raising and discussion at community forums etc.

- 9.8.6 The changes will place greater responsibilities on disabled individuals who choose to take the budgets. No longer will they be merely service recipients; they will also be service organisers. It will require statutory agencies to operate in a framework that allows people the freedom to take risks, without unduly compromising their care and safety. And it is likely to necessitate establishing brokerage arrangements to put individuals in touch with services that offer quality care at reasonable cost. During the period this strategy was being formally adopted by the Council and the PCT, the Government has now issued guidance on how the changes should be introduced.<sup>70</sup>
- 9.8.7 The introduction of individual budgets will present considerable challenges. Not least of these will be changing the way staff work
- 9.8.8 The overall service objective for the Independent Living service is to continue the development of policy and practice to ensure care management achieves a sustainable balance between independence and affordability and also proves to be genuinely empowering.<sup>71</sup>
- 9.8.9 Health promotion is one of the building blocks to effective independent living. Many people with physical disabilities or sensory impairment have difficulty in accessing health information, advice and support. Of course, such access can also benefit the wider population by reducing their likelihood of acquiring chronic heart disease, stroke and other potentially disabling long-term conditions. The introduction of GP registers for people with long-term conditions and the ability to aggregate information from them will inform commissioning intentions and assist the development of further support for health screening.

---

<sup>70</sup> 'Transforming Social Care', Department of Health Circular LAC (DH) (2008) 1, January 2008

<sup>71</sup> Housing & Community Services Business Plan 2007-08

9.8.10 A small number of Hounslow PD service users continue to travel to day centres outside the borough. This may not be the most appropriate service response for them, nor one guaranteed to promote their social inclusion within the local community.

9.8.11 What we can say with some certainty is that the pressures on budgets will mean that in the near future we will not be able to meet the all the independent living and other needs that disabled people would wish us to. We know that relatively small amounts of additional expenditure can produce positive outcomes, as instanced by new initiatives we have financed via voluntary sector organisations.

9.8.12 We will bear this in mind when we review plans and budgets across PDSI services as a whole. We will also strive to ensure that this message is understood across all of health and social care and that the needs of PDSI users are highlighted. The establishment of the Adult and Older People Partnership Board in 2007 will help facilitate this objective.

We propose to:

- Review policy and practice in the light of the continuing move towards service user control, having regard to individual safety and the statutory duty of care and to the introduction of individual budgets;
- Develop a PDSI shopping service to further facilitate independence and extend the uptake of Direct Payments;
- Introduce new options for day service provision, perhaps combined with an outreach service;
- Identify further service development proposals that would enhance independent living, for introduction should additional funding become available.

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

- 10.1 As this strategy is necessarily broad, arrangements for implementation and monitoring will take place through existing partnership structures, as set out in chapter 8.
- 10.2 The action plan overleaf sets out the objectives listed in the body of the strategy, and it details the lead officer and/or the group that will have responsibility for each objective.
- 10.3 Alongside each objective is a timescale and a priority rating between 1 and 5. Priority 5 represents those objectives most critical to achieving the headline aims of the strategy, which are:
- promoting social inclusion in all aspects of life and allowing disabled people to participate fully within society; and
  - encouraging independent living and enabling disabled people to exercise choice and control over services and treatment.
- 10.4 The Partnership Board for Adults and Older People will review all objectives in a rolling review programme – see also 9.8.9 & 9.8.10 above.

## Physical Disabilities/ Sensory Impairment Strategy Action Plan

Note: priorities on scale 1-5, with highest priority = 5

Objective (and page number)	Lead	Time-scale	Priority
1.1. Further develop and review co-working arrangements and transition protocols with Children & Families' services – and learn from the experiences of individual young people what works well and where improvements are needed (p24)	HIL	April 2009	3
2.1. Launch an 'In Control' pilot project during 2008 to, among other things, examine how individual budgets might be introduced in Hounslow and ensure that safeguards are built in to enable vulnerable adults to manage their finances safely (p36)	HIL	Dec 2008	5
2.2. Appoint a Service Manager – Transformation to lead on the pilot, the introduction of individual budgets (p36)	HIL	April 2008	5
2.3. Review policy and practice in the light of the continuing move towards service user control, having regard to individual safety and the statutory duty of care and to the introduction of individual budgets (p88)	HIL	Dec 2008	5
2.4 Review contracts and service specifications to ensue 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

2.5. Implement the local Self Care, Self Management Strategy and monitor its effectiveness in enabling people to manage their own care (p38)	SJCM	Dec 2008	2
2.6. Improve health and care information available to service users and carers, as part of self management (p38)	AJCM	Dec 2008	2
2.7. Identify, with voluntary organisations, the potential to establish condition-specific support services, e.g. via self-help groups or 'buddying' arrangements (p38)	SJCM	Dec 2008	2
2.8. Revise local information-sharing protocols relating to health and social care data (p39)	SJCM	April 2009	2

3.1. Extend the self-assessment process to allow physically disabled and deaf people to prescribe themselves equipment or, for those not eligible for service help, to receive information about equipment suppliers (p39)	HIL	Jun 2008	4
3.2. Evaluate Telehealth/Telecare services during 2008, with a particular focus on differences the technology has made to individual safety and to enabling people to remain living in their own homes. We then intend to make equipment more widely available thereafter (p40)	AJCM	Dec 2008	3
3.3. Consider how best Telecare might be introduced in residential settings, to reduce demands on night staff and improve residents' privacy and independence (p81)	AJCM	Dec 2008	1

4.1. Work closely with local authority Planners to ensure that the physical access needs of disabled people are fully taken into account in housing developments, street improvements and community facilities (p42)	SJCM	On going	3
4.2. Ensure that transport issues of PDSI users are actively taken up with transport providers (p42)	AJCM	On going	2
4.3. Analyse information on numbers of service users with multiple and complex needs and on their placements and services received, with a view to commissioning specialist provision as necessary (p44)	SJCM	Jun 2008	4
4.4. Agree joint protocols with mental health, learning disability, substance misuse and older people's services to support people with more than one condition or whose needs cut across customer groups (p44)	HOJC (HSCP)	Dec 2008	4
4.5. Maintain funding of services that enable disabled people to maximise their income and that reduce pressures on care budgets (p61)	DASS	On going	3

5.1. Identify numbers of adults with physical disabilities and sensory impairment in Hounslow who may seek employment in the next few years (p66)	SJCM/ JCM SI	Sep 2008	3
5.2. Establish their employment-related needs and wishes (p66)	SJCM/ JCM SI	Sep 2008	3

5.3. Plan employment support services accordingly (p66)	SJCM/ JCM SI	Sep 2008	3
5.4. Create opportunities for co-working with other Council Departments (e.g. re education and leisure provision), with the Community & Mental Health Trust (e.g. re psychological therapies) and with other external agencies and employers (p66)	JCM SI	Sep 2008	3
5.5. Ascertain and make best use of available funding streams (p66)	JCM SI	Sep 2008	3

6.1. Monitor the uptake of Extra Care Housing at Greenrod Place and the extent to which it is meeting care needs, before it similar projects are developed in other parts of the borough (p69)	SJCM	Jun 2008	3
6.2. Evaluate its sufficiency and suitability for people with physical disabilities and sensory impairment and to consider accommodation needs for those aged under 55 (p69)	SJCM	Jun 2008	3
6.3. Work with colleagues in Housing to meet CSCI targets for housing adaptations within the available budgets (p71)	HIL	Apr 2009	4
6.4. Consider potential for shifting resources to provide additional funding for both community equipment and adaptations (p71)	SJCM	April 2010	4

7.1. Prepare options for service re-provision out of acute care, e.g. by enhancing and improving the effectiveness of community-based services, with the objective of reducing the number of hospital admissions, the length of hospital stays and the number of re-admissions (p76)	SJCM	April 2010	5
7.2. Identify funding opportunities for establishing a community-based Parkinson's Disease specialist nurse and training post (p78)	SJCM	April 2008	2

8.1. Complete the stroke stock-take and take action on priority issues (p.76)	SJCM	Dec 2008	5
8.2. Develop & implement a new Community Stroke Pathway and develop a local Stroke Strategy (p.76)	SJCM/ CRM	April 2009	4
8.3. Audit practice at West Middlesex Hospital, with a view to unbundling the acute tariff for stroke and specifying a stroke rehabilitation pathway (p.76)	DHCP	Dec 2009	3
8.4. Assess services provided to Hounslow stroke patients attending other acute hospitals (p.76)	DHCP	April 2009	3
8.5. Identify how far GP protocols are in place and involve GPs and Public Health in steering group (p.76)	SJCM/ ADHCP	April 2009	3

9.1. Establish a Placements Officer post, shared between PDSI and Learning Disabilities, to help find suitable, quick and cost-effective Council-funded residential and nursing home placements (p80)	CM	Sep 2008	2
9.2. Review PCT-funded placements and commissioning consortium arrangements, with the objective, wherever practicable, of containing expenditure and providing care close to Hounslow (p81)	SJCM	Dec 2008	4
9.3. Develop plans for disinvestment in residential and nursing home care, to reduce numbers admitted to long-term care and shift the balance of provision further toward community-based care – including housing adaptations, supported housing and/or community equipment, as identified above (p81)	SJCM	Dec 2008	4
9.4. Help ensure the appropriateness of care plans and opportunities for rehabilitation by extending to PDSI the IARDS assessment service at West Middlesex Hospital and the in-house domiciliary care Assessment & Rehabilitation Service for the first 6 weeks of domiciliary care received (p83)	HIL	Jun 2008	3
9.5. Take further measures to maximise users' income and the collection of charges (p83)	HIL	Dec 2008	2

10.1. Re-provide wheelchair contracts as necessary and ensure monitoring arrangements identify and address issues of service timeliness, continuity and quality (p84)	SJCM	April 2009	4
10.2. Monitor demand and address any resulting issues of the need for additional investment (p84)	SJCM	April 2009	4
10.3. Obtain user/ carer feedback and service involvement, by means of wheelchair and equipment user groups (p84)	SJCM	April 2009	4
10.4. Investigate whether better use can be made of environmental controls to enable people to live independently	AJCM	April 2009	3

11.1. Re-tender the OT contract, with a new contract in place during 2008 (p85)	HIL	April 2008	4
11.2. Develop options for introducing OT-trusted assessor schemes and implement the chosen proposal (p85)	HIL	April 2008	3

12.1. Introduce and publicise an Advocacy and Information Service for Deaf and Hard of Hearing people, early in 2008 (p86)	HIL	April 2008	2
12.2. In association with Middlesex Association for the Blind, issue a local information booklet on Visual Impairment Services (p86)	AJCM	April 2008	2
12.3. Review numbers and needs of deaf-blind people (p86)	HIL	April 2009	3

12.4. Review current care pathways for people with sensory impairment and to introduce identified improvements (p86)	HIL / SJCM	Sept 2008	4
12.5. Include Speech & Language Therapy in the review of care pathways (p77)	SJCM	Sept 2008	4

13.1. Develop a PDSI shopping service to further facilitate independence and extend the uptake of Direct Payments (p89)	HIL	April 2008	2
13.2. Explore new options for day service provision, perhaps combined with an outreach service (p89)	HIL	April 2009	1
13.3. Identify further service development proposals that would enhance independent living, for introduction should additional funding become available (p89)	SJCM	on-going	3

**Posts listed:**

- SJCM – Senior Joint Commissioning Manager for Older People, Physical Disabilities and Palliative Care
- AJCM – Assistant Joint Commissioning Manager for Older People and Physical Disabilities
- HOJC – Head of Joint Commissioning
- DASS – Director of Adult Social Services
- DHCP – Director of Health Care Procurement
- ADHCP – Associate Director of Health Care Procurement (Primary Care)
- HIL – Head of Independent Living
- SJCM SI - Senior Joint Commissioning Manager for Learning Disabilities and Social Inclusion
- CRM – Community Rehabilitation Manager
- CM – Contracts Manager
-

**Groups listed:**

- HSCP – Health & Social Care Partnership



London Borough  
of Hounslow

## **Physical Disabilities and Sensory Impairment Adult Services**

# **Joint Commissioning Strategy 2007-2010**