Promoting wellbeing and independence

A Joint Prevention Strategy for Adult Services in Hounslow

2015 – 2019
This strategy is complemented by two other new strategies which collectively set out our overall approach and priorities for improving the health and wellbeing of local people in Hounslow.

The first of these is the **Joint Children and Young People’s Strategy** which focuses on how we will give every child the best start in life and the ability to reach their full potential. There is also the **Public Health Commissioning Strategy** which outlines our vision to transform public health services to improve health and wellbeing for our local communities.

There are links across all three strategies and taken together they will drive the delivery of the objectives described in our Joint Health and Wellbeing Strategy. Close partnership working will be key to implementing our goals. The delivery will be overseen by the local Health and Wellbeing Board which holds both the Council and the Hounslow CCG to account to ensure delivery of our ambitions for local people.
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Foreword

Hounslow Council and Hounslow Clinical Commissioning Group (HCCG) are working together to ensure residents are supported and encouraged to live independent lives. As people live longer and the expectations of how they want to live changes, so too does our role as commissioners, balancing our statutory duties to deliver services to those most in need with encouraging independence, personal responsibility and increasing choice for individuals and their families.

This strategy focuses on promoting independence for those at risk of or already using health and social care services.

Our aim is to develop a prevention offer for residents in Hounslow that continues to ensure services for those with significant needs are provided for and which are delivered flexibly, responsively and timely; whilst also supporting service innovation and models that sustain an individual’s levels of independence for longer.

This will mean less people residing permanently in residential and nursing homes, reductions in emergency hospital admissions and more people living independently in their own homes with less reliance on mainstream services such as homecare.

To support the move away from more traditional and institutional models of care this strategy will provide a framework for the further transformation of our care services to ones that will further promote independence and which are delivered in the community and in an individual’s home. Creative solutions at individual and community level will be required to support this transition.

In this document we have set out our strategic intentions for the next four years, aligning with the overall Health and Wellbeing Strategy as agreed by the Health and Wellbeing Board. It will ensure that additional and related council work areas are complemented, particularly Housing, Public Health and Leisure in offering both universal and targeted prevention initiatives. In addition, this strategy will support the Council’s Community Partnership Unit in the development of a vibrant voluntary and community sector within the borough. This will ensure that over the lifespan of this strategy, plans are shared as we progress and that robust oversight of delivery is maintained by all stakeholders.

Developing relationships with local partners is essential to create good quality and safe services that offer people real choice in the type of care that they receive and the way in which it is delivered. We expect all of our services - both Council provided and those externally commissioned - to operate within a philosophy of promoting and developing independence. This will be built in to future contracts with providers as we develop co-produced, outcome-focused services developed through a co-commissioning model.

We are committed to working together to enable people in Hounslow to live more independent and healthier lives by giving them greater choice and control, maximising their social support systems, assessing their assets and strengthening support in the community.
Nicola Burbidge –
Chair, Hounslow Clinical Commissioning Group

Councillor Lily Bath –
Lead Member for Adult Social Care and Health Services
1. Introduction

This strategy sets out the high level plans to transform the way Hounslow residents will be supported in their homes to maintain their independence, health and wellbeing for as long as possible, and avoid hospital admission unless clinically necessary.

In Hounslow, the CCG and the Council will work together to ensure integrated, high quality care and support that promotes independence and wellbeing so that people are prevented from becoming unwell and are supported to maintain their social and community links. Early intervention and prevention will ensure that people only attend hospital when, and for as long as is clinically necessary and the need for residential or nursing care is delayed or avoided.

The strategy sets out the initiatives we aim to introduce in the areas of: prevention and early intervention, short-term targeted care and support to delay or prevent the need for longer term care and support. These will be introduced in a phased manner, with existing services being scaled-up and consolidated in 2014-2015 as we prepare to introduce larger-scale transformational changes from 2015-2016 onwards. These will include responding to the actions outlined in the Care Act and building on the work already started as part of whole systems transformation and the Better Care Fund.

All initiatives will be performance monitored in keeping with key service outcomes frameworks, and through a process of continuous stakeholder engagement. This is to ensure the services deliver the best possible outcomes for our patients, service users and carers.

The London Borough of Hounslow and Hounslow Clinical Commissioning Group (HCCG) serve a diverse population of over 250,000 people with the fifth fastest growing population in the country in the census period 2001–2011. In common with the rest of England, we are experiencing an unprecedented period of growing demands on current services, with limited resources to meet these demands. Despite progress in our efforts in recent years, the resulting pressures are being reflected daily across our hospitals, our GP surgeries, our community healthcare teams, our mental health services and our social care services. As our population grows and people live longer, so the challenge of balancing available resources and meeting local needs will continue to grow. Our starting point in responding to this challenge is that we need to work in partnership as pressures in one part of our public services cannot be solved in isolation from the others.

In Hounslow we are well set up to meet this challenge together as we have a strong history of working together, both as a CCG and Council and also with our providers, to meet challenging circumstances. Our Health and Wellbeing Board reflects this, having our local main health service providers and voluntary sector representatives as members of the Board.

Older people are now generally healthier and more active than previous generations and national research shows that where older people are supported to be independent the benefits on their general health and wellbeing are significant. The evidence of the
effectiveness of some prevention schemes is limited and over the life of this strategy we will explore different options and emerging examples of good practice nationally, to ensure that we utilise our limited resources in the best way. While some areas of development, such as extra care housing, Telecare and falls prevention, have a good evidence base other areas need further development.

Although people are living longer there is evidence that for many people these additional years are not necessarily healthy years and often require higher levels of health and social care interventions. Demographic changes in Hounslow, like the rest of the country, mean that there is the potential for a significant increase in the numbers of people accessing social care and health services in the years to come. This is largely due to increases in the ageing population but we are also anticipating an increase in demand for services to support people with disabilities and mental health issues. This increase in demand is taking place alongside a reduction in the resources available to support people through social care and health services.

Over the course of the next four years the amount of money available will continue to reduce and the challenge for us is to use these resources more effectively. In addition to using resources more wisely we also recognise the need to transform how we work including integrating health and social care services where this will improve services and outcomes for people in Hounslow. Managing demographic demand is a key issue as it will place greater pressure on health and social care structures if we do not utilise alternative models of provision.

The current model of health and social care provision in Hounslow is in the main reactive, based upon provision of support when problems arise and this can lead to the creation of dependency. We recognise the need to continue to provide reactive services where appropriate but also the need to shift our focus more towards facilitating community based service development and signposting to alternatives which promote health and wellbeing, prevent or limit deterioration and support recovery following a period of crisis.

The strategy aims to identify the priorities for health and social care and to demonstrate how we can make this shift of investment from reactive services, to early intervention and preventative services for the whole adult population. It describes how social care and health will work collaboratively in order to move away from a culture that focuses on a small number of people with the greatest needs to one that addresses the whole population with a range of early interventions and profiling to identify people at risk of developing long term conditions and avoid wherever possible, admission to an acute setting.

Rather than replacing existing policies and strategies, this document aims to build on and complement them. Some of the key local strategies already in place and fundamental to the delivery on our vision for prevention are:

- Hounslow Corporate Plan 2014-19
- Better Care Closer to Home (2012)
- Hounslow Health and Wellbeing Strategy (2012)
- Hounslow Housing Strategy 2014-2018
Additional supporting documents, expanding on themes developed in this document will be published in due course. These will include:

- Extra Care Housing
- Primary Prevention
- Community Equipment and Assistive Technology
- Dementia Action Plan
- Refreshed commissioning strategies e.g. learning disabilities

The Council and HCCG are committed to achieving a mixed economy of public, independent and third sector providers in order to meet the wide-ranging needs of its residents. We also recognise the strengths of the existing relationships with the voluntary sector and community groups and the vital contribution they make in building a sustainable community.

The changes described in this strategy must be affordable and financially sustainable and deliver long-term savings and efficiencies. Commissioning decisions should be based on freeing up resources from traditional services to allow residents to enjoy choice and control over their care and support and delay or prevent the need for long-term services. Above all, services must deliver positive outcomes and demonstrably improve people’s lives based on a co-commissioning model where residents are at the centre of co-designing our services and desired outcomes.

Our collective vision is developed from and reflected in our Adult Social Care ‘Change and Deliver’ Adult Transformation Programme, our Out of Hospital Delivery Strategy and the Whole Systems Outline Business Case. This approach is central to informing our future joint commissioning intentions.

This strategy helps to meet key priorities in our Joint Health and Wellbeing Strategy 2013-17; that adults retain their independence and good quality of life for longer, with an
emphasis on reducing the dependence on bed based care. In addition, we are guided by the Hounslow Together Local Strategic Partnership’s ambitions to help communities become stronger and encourage local people and organisations to express their views and aspirations. We aim to do this by involving them in planning for the future and to work together to identify gaps in provision as well as eliminating duplication of effort and inefficient use of resources and adding value to activities through coordinating and sharing resources and information between existing and identified initiatives. We will use the NW London Whole Systems Work and the Better Care Fund as key enablers for the Health and Wellbeing Board and the LSP to realise these ambitions for health and social care.
2. About Hounslow

The London Borough of Hounslow and Hounslow Clinical Commissioning Group serve a diverse population. The estimated resident population of 268,875 (Greater London Authority estimates for 2014) and has the fifth fastest growing population in the country in the census period 2001 - 2011. The patient population registered with a Hounslow GP is 292,609.

In common with the rest of England, we are experiencing an unprecedented period of growing demands on current services, with limited resources to meet these demands. Despite progress in recent years, the resulting pressures are being reflected daily across our hospitals, our GP surgeries, our community healthcare teams and our social care services. As our population grows and people live longer, so the challenge of balancing available resources and meeting local needs will continue to grow.

Our starting point in responding to this challenge is that we work in partnership as pressures in one part of our public services cannot be solved in isolation from the others. In Hounslow we are well set up to meet this challenge together as we have a strong history of working in partnership to meet challenging circumstances. Our Health and Wellbeing Board reflects this, being unusual in having our local main health service providers as members of the Board.

To enable us to achieve our vision we will ensure our residents have safe, affordable and high quality services and by working in partnership with others, maximise outcomes from health, social care, community and voluntary sectors. This approach will be based on the principles of integration as the key driver to secure better outcomes for our population and deliver the financial efficiencies that are required given the ever increasing demand for support and our restricted budgets.

Hounslow Council has recently refreshed its Adult Social Care Transformation Programme and the key objectives are:

- To ensure social care and support provided to adults is safe, affordable and meets the needs of service users and carers
- To ensure resources are targeted to deliver improved outcomes for individuals
- To support people to live independently for longer in the community and ensure vulnerable adults are able to maximise their independence, choice and control and empower them to actively participate in the community
- To develop integrated approaches in partnership with health so that people with health and social care needs in Hounslow receive the right care, at the right time, in the right way, in the right place, from the right people

The Hounslow CCG Out of Hospital Delivery Strategy goals are:
- Easy access to high quality responsive primary care that makes out of hospital care the first point of call for people
- Rapid response to urgent needs so that fewer people need to access hospital emergency care
- Appropriate time in hospital for people when required with early supported discharge into well organised community care
- Health and social care providers working together with the patient at the centre to proactively manage long term conditions, care of older people and end of life care out of hospital

To develop this strategy we have taken full account of the data within the Joint Strategic Needs Analysis (JSNA) which defines and describes the future local health and social care needs across the borough.

**Demographics:** Hounslow is experiencing a growing demand. The Hounslow population is due to rise by 6.8% between 2012 and 2020, with a growing ageing (over 65’s) population that is projected to increase by 18% in the same time period.

**Increased complexity of need:** In part due to a growing ageing population the diagnosis of dementia is expected to increase between 2012 and 2020 by 23.5%. The volume of younger adults with learning disabilities is also due to increase by 3.6%. The increasingly complex nature of needs that social care and health need to respond to is also leading to an increase in unit cost per service user and with the increased volume of service users, the costs are exceeding the funding levels.

**Poor health challenges:** The latest Joint Strategic Needs Assessment shows that Hounslow has significantly more deaths from heart disease and stroke than the England average, and that the proportion of our residents with diabetes is expected to rise significantly in the next ten years. We also have high rates of smoking, alcohol and obesity-related hospital admissions, and longer hospital stays for those recovering from a stroke or a fall. We have a higher proportion of adults in residential and nursing home care than our comparators and underdeveloped community based alternatives for some groups in our population. We must find ways of addressing these long-term challenges.

**Financial** - Hounslow CCG has operated within a tight resource allocation, receiving the lowest allocation per weighted population in North West London in 13/14; despite allocation uplift for 14/15 and 15/16 the financial position is forecast to become worse in coming years, as growth in demand and unit costs driving a financial deficit if no action is taken. There are also significant financial challenges for the Council. The London Borough of Hounslow has had to deliver £60million of savings between 2010 and 2015 with additional funding reductions expected in future years. The adult social care budget is approximately one third of the LBH budget and future savings will need to be realised in the Adults Social Care budgets.

**Sustainability** - The health and social care system is facing unprecedented challenges. One reason for the need to think about the long-term future of health and social care spending pressures is the sustainability of rising spending trends.
The 2014 update of the Joint Strategic Needs also highlighted the following:

- Need for awareness and adaptation to the population change over the last 10 years
- Integrated care in the community to transform adult and elderly care using local resources
- Provide for rising levels of elderly in the population and growing needs for supporting people including dementia/continuing care.
- Address opportunities for improvement in screening and managing long term conditions (e.g. Diabetes and Heart disease).
3. Purpose and Scope

_In Hounslow, we are committed to enabling people to live more independent and healthier lives by giving them greater choice and control over their care and support options, maximising their social support systems and strengthening support in the community._

The purpose of this strategy is to set out a framework that supports a real shift to more preventative services and addresses the requirements of the increased demand on the health and social care system. This strategy will outline how the Council and HCCG will work in partnership with providers to achieve better outcomes for residents.

- Encourage the development of a joined up approach to services which support independence
- Highlight the ways in which we can support independence to reduce deterioration for those with critical or substantial social care needs
- Consider the use of information and advice to signpost to community based services for those with low or moderate social care needs
- Reduce dependency and the need for ongoing support by using short-term interventions to aid community recovery (rehabilitation and reablement) following a period of illness, fall or hospital admission.

Our strategy ensures a joined up approach to delivering services which are focused upon the preventative agenda across all adult social care and health. By delivering this approach we will build a stronger community infrastructure which is underpinned by an improvement and expansion of information and advice which is focused towards reducing health inequalities, delaying or preventing social exclusion and the need for intensive, costly support from social care and health agencies.

**The Care Act (2014)**

The Care Act (2014) is a significant legislative development with a major impact on the commissioning and delivery of local services; bringing into a single statute, all care and support legislation, as well as considering the findings of the Dilnot Commission into the funding of care and support and seeking to address the findings of the Francis Inquiry into the failings of Mid-Staffordshire Hospital.

The Care Act (2014) places a new duty on local authorities to promote individual wellbeing and provide prevention services. This requires the Council to provide or arrange services that reduce needs for support among people and their carers in the local area, and contributes towards preventing or delaying the development of such needs.

The draft statutory guidance states that preventive services should operate at three levels: primary prevention to stop care and support needs from developing among those who do not have them, for example through health promotion or action to reduce isolation;
secondary prevention, for people at increased risk of developing needs, which could involve housing adaptations, floating support or Telecare that prevent deterioration; and tertiary prevention for people with established needs to help improve independence, for example through reablement and rehabilitation.

Social care assessments will need to promote independence and resilience by identifying people’s strengths and informal support networks, as well as their needs and the risks they face, and asking what a good life means to them and how they think it can be achieved in partnership with professionals.

In summary, the Care Act:

- Clarifies entitlements to care and support to give people a better understanding of what is on offer, help them plan for the future and ensure they know where to go for help when they need it
- Provides for the development of national eligibility criteria, bringing people greater transparency and consistency across the country
- Treats carers as equal to the person they care for including entitlement to assessment and support
- Reforms how care and support is funded, to create a cap on care costs which people will pay, and give everyone peace of mind in protecting them from catastrophic costs
- Supports our aim to rebalance the focus of care and support on promoting wellbeing and preventing or delaying needs in order to reduce dependency, rather than only intervening at crisis point
- Provides new guarantees and reassurance to people needing care, to support them to move between areas or to manage if their provider fails, without the fear that they will go without the care they need
- Simplifies the care and support system and processes to provide the freedom and flexibility needed by local authorities and care professionals to integrate with other local services, innovate and achieve better results for people.

The Care Act 2014 together with the Health and Social Care Act (2012) has placed new duties on NHS organisations and local authorities to work towards integrated care and support. The Health and Social Care Act 2012 promotes better integration of health and care services. The Acts contain a number of provisions to encourage and enable the NHS, local government and other sectors, to improve patient outcomes through far more effective coordinated working, better collaboration, partnership working and integration across local government and the NHS at all levels.

In order to encourage integration, the Government has established the Better Care Fund (BCF). This creates a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between Clinical Commissioning Groups and local authorities. Hounslow is using the BCF is a catalyst for improving outcomes for patients and value for money through whole system transformation in health and social care and will pool existing health and social care budgets from 2015-16 to enable greater integration and transformation of local services in order to meet the 2018 target for whole system integration. BCF plans must meet the following national principles:
• Reducing unplanned acute hospital admissions
• Protecting social care services
• 7-day services to support timely hospital discharge
• Data sharing and the use of the NHS number
• Joint assessments and model of accountable lead professional

The NHS’s ‘A Call to Action’ makes clear that the NHS must change if services are to remain free at the point of access. It wants to see a greater focus on preventative rather than reactive care; services matched more closely to individuals’ circumstances instead of a one size fits all approach; people better equipped to manage their own health and healthcare, particularly those with long term conditions; and more done to reduce inappropriate admissions to hospital and avoidable readmissions, particularly amongst older people.

• Diabetes - The recorded diabetes rate is significantly higher with 14,000 people diagnosed (6.1%) compared to the national rate (5.8%). There are an estimated 5,000 undiagnosed cases of diabetes.
• Cardiovascular disease - emergency admission rates for chronic heart disease are significantly higher than the national rates (237 in Hounslow, 198 in England)
• Falls - Every year around one in three over-65s living in the community and one in two people over 85 will have at least one fall.

Moving Forwards

In the strategy we will outline how the Council and HCCG will meet new duties under the Care Act and ensure that short-term recovery and prevention is embedded throughout all of our commissioned services and what the overall direction of travel will be. Specific actions will be detailed in specific care group commissioning plans and intentions. The care groups included and which will inform future joint commissioning plans, include:

- Older People
- People with Learning Disabilities
- Older People with Mental Health Problems
- Mental Health
- Physical Disability including sensory impairment
- Carers

Defining the scope of this work is critical to its potential for success; the prevention agenda in its widest sense can be seen to encompass all of the services that are accessed by a local community. To ensure that the development and delivery of this strategy is manageable it is restricted to the direct role of adult social care in partnership with the CCG. Where other key interdependencies are identified these have been flagged. For this reason the strategic emphasis is on supporting independence which includes our contribution to the prevention agenda rather than seeking to be an all encompassing prevention strategy.
Working together with colleagues in public health, housing, community safety and community partnerships is a key factor to some of the essential deliverables.

Throughout the development of the strategy we have made clear reference to the wider prevention agenda and have ensured that the actions we propose to take are supportive of this agenda but our focus must be upon our existing and potentially imminent customer base. There is clear linkage to a range of other activities taking place across the public sector in Hounslow and as a result there is no intention to replicate information presented elsewhere. Instead the focus will be on bringing this activity together and highlighting additional specific approaches that will need to take place to ensure that we deliver against this agenda.

Our strategy is designed to cut across all the client groups within which adult social care holds commissioning responsibilities, namely older people, learning disability, physical disability (including sensory impairment), mental health and their carers who:

- Require or will require access to information, advice and advocacy services
- Care for someone currently in receipt of health and/or social care services or may need them without short-term support
- Require or are at risk of requiring intensive health or ongoing social care support
- Require or will require low level non health or social care based support to maximise their independence.

**Priorities for prevention and early intervention**

By identifying the risk factors to poor health early on we aim to provide general low level support and care that will help people stay healthy and avoid problems escalating.

In order to avoid unnecessary hospital admissions and put people in control of their health and wellbeing our aim is that people with long-term conditions will have a care plan that takes account of deterioration and emergency care. Care plans will include signposting to both local NHS, voluntary or community organisations for support. We will provide more accessible information about self care and look to the use of social marketing to encourage, support and educate people to maintain their wellbeing.

We are committed to expanding the use of assistive technology with a focus on systems that assist people with long term health conditions and who are at risk of frequent hospital admissions as a result. The following key groups of people would benefit from the use of assistive technology and will be targeted in Hounslow:

- People who are at risk from falls, isolation or increasing frailty in old age
- People who are at risk of frequent hospital admission due to long-term health conditions
- People managing diabetes
- People with dementia
- People who need support with medicines management
• People with additional needs, including those who have a learning disability, who may be able to move from care homes to live more independently with assistive technology and other support

**Voluntary and Community Sector Services**

Voluntary and community sector services are key to enabling people to live independently, be active in their community, create a local support network and help navigate the health and social care system should they need to. In Hounslow we have over 600 voluntary and community sector organisations and a wide network of volunteers who give their time to help local people, including older and vulnerable adults.

We have been reshaping the way the Council funds some voluntary sector services and will work with the Council Community Partnership Unit to ensure a coordinated and joined up approach to developing and supporting the local voluntary and community sector. (Thriving Communities Funding Plan 2015 -19).

Future commissioning intentions will look to engage with the local third sector to support older people (and other vulnerable groups) to continue living as independently as possible in their local community, and to achieve and maintain their abilities in relation to physical, intellectual, emotional and social well-being. Services will be commissioned that promote independence and reduce social isolation by:

• providing information on and support to access services available to maintain older people living in their own home, e.g., information services, care navigators
• delivering a range of physical and social activities that promote both physical and mental health and wellbeing;
• provision of befriending service to older people living alone where this does not already exist.

**Carers Support**

We recognise that unpaid carers play a significant role in enabling people with health and social care needs to remain independent and at home. It is important that carers are supported to look after their own health and wellbeing and access support to enable them to continue with their caring role. In commissioning carers services, we will look to ensure that people can access information, advice and support around their caring role. Our aim is to improve the way we identify carers (including young carers), and ensure they are offered carers support and services including short-break respite provision.

We will continue to commission carers’ support services, whilst ensuring they meet current requirements within an integrated model of care. This will include meeting requirements under the Care Act for an expansion in carers’ assessments and additional support. Ensuring that Carers and family members are given the right amount of support is essential to preventing the breakdown of existing support networks and key to preventing unnecessary use of Emergency Departments as well as nursing and residential placements. In order to support our Carers better we aim to bring together our commissioned services to deliver a more coherent and joined up approach to include assessment of need, information, advice and signposting, short-breaks respite and training. Changes will be
designed with Carers and commissioners will work closely with carers forums and the newly established carers partnership board

Dementia

The Council and Hounslow CCG are committed to improving the lives of people with dementia and creating a dementia-friendly borough that has a greater awareness of the symptoms of dementia and are willing to support people with dementia to live more fulfilling lives. The Council and CCG will further develop their Joint Hounslow Dementia Strategy that will seek to develop a whole community approach to supporting people with dementia and their carers. There remains a need to have a more coordinated pathway for care from earlier diagnosis in general practice, through an improved quality of care when in acute care. We aim to increase the number of people formally diagnosed so that they can access specialist dementia support services. There is a need for improved post diagnosis support and earlier discharge of people who have dementia and are in hospital care. There is a need to ensure that within this pathway the approach to dementia care isn’t overly medical and the social and care and housing needs of people with dementia and their carers are also addressed. Linked to the NW London integrated care pioneer process we will redesign a coordinated pathway to improve the early diagnosis, care planning and quality of care that service users receive.

Adopting the national campaign to develop dementia-friendly communities, in support of the Prime Minister’s Challenge on Dementia, the strategy will link together core services not only within health and social care but across the wider community. We aim to work with local businesses and organisations to raise awareness and advise people working in public-facing jobs how they can best support people with dementia.

Fundamental to this development is the direct engagement of people with dementia, their families and carers as well as community groups (e.g. faith groups, voluntary organisations), statutory services (e.g. health, social care, public health, police) and local business. The overall whole systems approach will look at how a dementia-friendly community can develop community resilience and support people with dementia from early diagnosis through to end of life; redesigning existing services with the potential to develop new initiatives to reflect what the local community needs and aspires to.

Mental Health

We aim to improve mental health wellbeing as well as access to support people at times of a mental health crisis. Our future commissioning intentions will set out how we aim to prevent a large number of inappropriate admissions to hospital or residential care as well as reducing the flow of frequent attendees at hospital emergency departments. We aim to provide timely, responsive and proactive services for people in a crisis to avoid mental health conditions escalating. In order to improve support to people in a crisis we will be looking at improving our current services including focus on IAPT, shifting settings of care, hospital based psychiatric liaison.
Learning Disability

People with a learning disability continue to face significant barriers to accessing some healthcare services. We will improve pathways and treatment options that ensure reasonable adjustments are made for the person with a learning disability at the point of referral. We will ensure that everyone with a learning disability has a current health action plan and patient passport. These will support access to appropriate treatment options and ensure planned admissions with accessible treatment plans and coordinated discharge planning with after care is delivered in their home.

In line with the final report on Winterbourne, all people with a learning disability living in a hospital setting have been reviewed and health and social care commissioners are working in partnership with people and their carers to ensure that people can receive their treatment and care needs closer to home. A revised local Commissioning Strategy is being developed in 2015/16 to ensure high quality care and support for all adults with a learning disability and those with autistic spectrum conditions.

The London Borough of Hounslow is committed to reducing the barriers faced by people with learning disabilities in accessing universal and community services available across the borough. Increasing the confidence, ability and independence of people with learning disabilities using public transport remains a priority to support community participation. The travel buddy service, provided by the London Borough of Hounslow currently provides independent travel training and travel support to adults with disabilities using public transport with the main aim and objective to deliver a tailor-made service in supporting residents to become independent travellers through effective training and support. The service plays a vital role in enabling individuals to access services in a way that promoted their independence and

The development of ‘keep safe’ packs and a safe haven scheme for people with learning disabilities has been widely viewed as proactive approach to helping individuals feel safer and have increased confidence in accessing and participating in community activities. These schemes support increased awareness around hate and mate crime, supporting individuals on how to get help and support within the community. A successful trial of this was conducted by the London Borough of Hounslow within the Feltham Town Centre and a further programme of action is being led by the Metropolitan Police.
4. Aims and Objectives

Our primary aim is to create a shift to supporting people to retain their independence for as long as possible through effective early intervention and an increased emphasis on preventative services. While good progress has been made with enabling people to take greater choice and control over how their needs are met through personal budgets and direct payments, further work needs to take place on efforts that enable people to stay healthy and actively involved in their communities.

The aim throughout this document is to ensure a shared and common vision of the term ‘prevention’ and what this means in the local context of service delivery. Our vision for a modern care and support system in Hounslow is one that promotes people’s well-being by enabling them to prevent and postpone the need for care and support, and puts them in control of their lives so that they can pursue opportunities, including education and employment, to realise their full potential.

It is critical that we ensure that all adults in Hounslow are supported and encouraged to live independently and we will work with a range of stakeholders to ensure that all adults are supported to be able to take control and maximise their possibilities of a fulfilling and active role in community life. This will involve:

- Ensuring people have easy access to information, advice and signposting to enable them to make decisions about their own care and support needs
- Delaying, reducing or preventing people’s care and support needs as far as possible
- Enabling people to remain in their own homes living independently for as long as possible
- Reducing unnecessary use of hospital emergency departments
- Reducing unplanned emergency hospital admissions
- Putting people at the centre of decisions about how their care and support needs are met
- Ensuring adults and their carers and families have a positive experience of care and support
- Supporting people in need or crisis to remain in their own homes and help them build and maintain and maximise their independence

Prevention and independence are key to reducing dependency and mitigating the need for ongoing support through social care and health services. We have looked at the available evidence and national policy and in conjunction with what people have told us about how they want to live their lives; the following key themes have emerged. These will be our focus over the next 4 years of a change from one of reliance on mainstream services, to one of self-determination and supporting and maintaining independence. Key themes that will be developed and built upon include:

- Early Intervention
- Information, advice and signposting
- Recovery through reablement and rehabilitation
- Integration and partnership
- Greater and smarter use of assistive technology
- Development of alternatives to traditional care such as extra care housing

This will be achieved through:
- Supporting people with complex health, social and mental well-being needs to live independently with reduced reliance on statutory services
- Improved access to universal services with an emphasis on prevention
- A focus on early intervention approaches to prevent people requiring long-term care
- Ensuring that choice and control is offered to all residents on how care and support is designed and delivered
- Shifting the emphasis from long-term residential care to prevention, independent living and improved life choices.
- Safeguarding people whilst allowing them control and decision making regarding positive risk taking.
- Recognising the role and contribution of unpaid carers through increasing the number of carer assessments and the range of services available for them.

This strategy is intrinsically linked to the transformation of adult social care, health and social care integration and the move away from traditional services to a more personalised approach and the development of community based alternatives to care. This will include the expansion of extra care housing, increased use of assistive technology, an increase in floating support to promote independent living, and community recovery across the borough.

Our work will recognise the contribution that carers make to the health and social care economy and the support they require to help them to maintain their caring role for as long as they choose.

The Council and HCCG are committed to moving away from traditional methods of providing health and social care. In future, all services will be co-designed with the resident (and their family and/or informal carers) at the centre of planning their own support. As we move towards a more personalised approach to services for residents with high health and social care needs we also aim to increase and improve the availability of prevention and well-being provision across the borough.

The Council’s Children’s and Adult’s Services department and HCCG will work with partners in the Council (including Housing, Public Health, Leisure and Community Partnerships), the voluntary sector, statutory sector and universal services to ensure that all services in the borough promote independence. We will ensure that the experiences and aspirations of our residents are fully incorporated into future commissioning intentions.

The role of commissioning, as a result of transformation, will change over time and will be reflected in the care group commissioning plans:
- Ensuring that residents are aware of information, advice, signposting and advocacy services in the borough
- Ensuring there is the right balance of investment between different services and care groups
- Ensuring that any gaps in local provision are identified early
- Shaping the market so that high quality services are available to residents in the borough, including supporting a strong local market
- Ensuring there is a balance between prevention and early intervention services and self directed support
- Ensuring value for money at a time of pressure on public sector funding
- Ensuring that safeguarding vulnerable adults remains a priority for all services
- Commissioning services which are outcome focused, based on impacts and results for individuals and communities
- Promoting the use of universal services for all residents.

Prevention is a term that is used increasingly frequently when describing health and social care services and policy. There is no definition or consensus as to what constitutes ‘preventive services’. Compounding this lack of clarity is a further haziness around the boundary between health and social care and between social care and wider community services such as housing and transport. Prevention refers to upstream interventions which seek to help people maintain or improve health before it is compromised.

From a narrow perspective, a preventive service may be one that aims to prevent or delay a specific condition or outcome. An example could be a service that aims to prevent admission to hospital because of a fall, where there is a well-defined outcome. However, using a wider definition, prevention includes activity that enhances and extends quality of life.

Prevention is often broken down into three general approaches – primary, secondary and tertiary prevention – which are described in more detail below. This strategy focuses on promoting independence for those at risk of or already using health and social care services, primarily through activities seen as secondary or tertiary prevention.

The spectrum of prevention diagram (below) shows the range of activities and emphasises that preventative interventions are important even where people are already in receipt of long-term health and social care services.
Public health and prevention

Prevention needs to address both the person and the environment in which they live, work and socialise in order to have real impact on outcomes and promote health, wellbeing and independent communities and people as outlined in the diagram below.
A sustainable approach (Sustainable, Resilient, Healthy People & Places: Sustainable Development Strategy for the NHS, Public Health and Social Care system)

The approach to delivering a preventative approach will be evidence based, people-centred and use behaviour insights to understand with residents, service users and carers, where real need is, how things could be done differently, manage expectations, build trust and potentially reduce costs.

Building on the work of ‘Making Every Contact Count’, there are opportunities for all services to promote health and wellbeing, support the idea of people considering their health and wellbeing and what they can do to look after it.

“Everyone who comes into contact with members of the public and has the opportunity to have a conversation to improve health.”

The work of the Public Health team in Hounslow will align with the three approaches outlined in the strategic objectives; primary, secondary and tertiary prevention in this strategy. Current and developing work of public health is outlined here against the three levels of prevention and will work with key partners to ensure ‘every contact counts’.

1 Making Every Contact Count [Available online] http://www.makingeverycontactcount.co.uk/
Prevent: Primary Prevention/Promoting wellbeing

These are activities and services aimed at individuals who have no current particular health or care and support needs, though may be used by them. These are largely universal activities delivered or commissioned outside the main scope of this strategy. However, they are fundamental to overall success of the other two types of prevention. Promoting Wellbeing services are often provided outside of the scope of traditional health and social care settings and provided in the community through voluntary groups or not for profit organisations. These services are focused towards people who are basically healthy but require some form of low level support or intervention to maintain their health, to be safe or get the most out of their lives.

Delivering and driving improvements in our approach to supporting independence within social care services must be seen in the context of this wider preventative agenda. Actions to address healthy lifestyle and the determinants of health through changes in behaviour can result in better health in the longer term, reduction in disease and limiting conditions and an associated reduction in demand for health and social care services and we will work closely with public health colleagues to do this.

Adopting a universal approach to this type of prevention across all sectors can help to reduce levels of need and the associated pressure that this places upon the health and social care sector as well as improving life experience and chances for Hounslow residents. However, it is clear that much of the activity to deal with the wider prevention operates over a significant length of time and the outcomes of such interventions are not always clear. For this reason the focus of our approach in the short term must complement this by working in ways which support independence within the services that people access.

Primary prevention includes services, activities, facilities or resources provided or arranged that may help an individual avoid developing needs for care and support, or help a carer avoid developing support needs by maintaining independence and good health and promoting wellbeing. They are generally universal (i.e. available to all) services, which may include, but are not limited to interventions and advice that:

- promote access to good quality information
- support safer neighbourhoods
- promote healthy and active lifestyles (e.g. physical activity, health walks)
- encourage lifestyle changes (e.g. stop smoking, weight loss, health trainers)
- reduce social isolation (e.g. befriending schemes)
- encourage early discussions in families or groups about potential changes in the future, e.g. conversations about potential care arrangements or suitable accommodation should a family member become ill or disabled.

The Public Health team in the borough is developing an integrated lifestyle service offering a range of support to meet the needs of local residents, with a single point of access for referring organisations. Services will include; health checks, stop smoking services, physical activity, alcohol services and weight management. These services can reduce the
cost of health and social care with:

- £1 spent on Health Walks saves the NHS £7  
- 6% of social care budget spent on smoking related care
- 5,000 patients screened for alcohol consumption may prevent 67 A&E visits

The model will align to locality team working being developed through whole systems working linking GPs, district nursing and social work in the 5 locality areas of Hounslow. It will ensure that those residents age 40-74 receiving a Health Check get the appropriate support and advice to maintain or improve their health.

Alongside the one stop shop, Public Health will develop work with the community and voluntary sector to work with targeted priority groups within the communities they live or socialise. The current Health Champion programme will be revamped to ensure it drives our priority populations through lifestyle services.

Building on the work of the Cranford Stronger Together research, led by Policy and Scrutiny, Public Health is working with Community Partnership Unit and Adult Education to take a targeted area based approach to improve the health and wellbeing of one of the boroughs most deprived wards. The approach will look at identifying and developing community assets, taking a community based approach to identifying and tackling health and wellbeing needs and building resilience. The work will be estate based and incorporate training and employment, development of social enterprise and social prescribing alongside more traditional health and wellbeing services. This work will inform future commissioning intentions as we move forwards.

The Joint Commissioning team, from Children’s and Adults’ Services and the CCG, are working with Public Health to commission a piece of research to better target primary preventative services. The research will examine a representative sample of Adult Social Care cases to determine what the health and social conditions were which led them to need statutory social care services. The research will also attempt to trace Adult Social Care customers’ journeys to consider when and what interventions could have delayed or prevented their conditions deteriorating. The findings of the research will help shape Public Health primary prevention work, (e.g. publicity campaigns) more effectively by focusing on health conditions which lead onto people needing Adult Social Care services. Joint Commissioning will use the findings to target the information and advice available to the public in accordance with the duties of the Care Act and to shape and better target secondary preventative services. This joint approach with Public Health will bring a more scientific and evidence based approach to prevention.

Striving for a borough where the infrastructure promotes mental and physical wellbeing. Joint working with Transport, Planning, Environmental Health and Licensing to improve the built environment, active spaces, and access to alcohol and healthier affordable food. Going

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2 Local Government Information Unit (2010) Walk This Way: Recognising Value in Active Health Prevention
4 Public Health England. Alcohol and drugs prevention, treatment and recovery: why invest?
forward we aim to achieve a point where all new commissioning considers the impact on the health and wellbeing of residents.

Reduce: Secondary Prevention/early intervention

These are more targeted interventions aimed at individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration or prevent other needs from developing.

In order to identify those individuals most likely to benefit from such targeted services, the Council, CCG or commissioned providers may undertake screening or patients may be identified through risk stratification in primary care. This is to identify individuals at risk of developing specific health conditions or experiencing certain events (such as strokes, or falls), or those that have needs for care and support which are not currently met by the Council.

Targeted interventions also include approaches to identifying carers, including those who are taking on new caring responsibilities. Early intervention also includes fall prevention, floating support to help people to live in their own homes, minor adaptations to housing which improve accessibility or provide greater assistance for those at risk of a fall, and assistive technology including Telecare services. Carers can benefit from support to help them develop the knowledge and skills to care effectively and look after their own health and wellbeing.

Maximising Independence services such as reablement type activities are designed to help those who already have an illness or disability to live as active and full a life as possible and to be safe in the services that they access. These services could be traditional social care and health based interventions but they need to be tailored to give people the right sort of support and help so that they can do more for themselves and remain independent for longer. Interventions will be for a short-term defined period, rather than on-going which can inadvertently lead to a reliance on services and reduce independence.

As a policy intention we would be seeking to support residents through the increased use of assistive technology including Telecare and Telehealth equipment which will contribute to reducing dependency on traditional provision. Short-term targeted care and support is support required in the short term to assist people to recover their health and wellbeing. This theme includes support received from GPs as well as the support needed when in a crisis (ie unplanned care).

The new Community Recovery Service (CRS), currently being developed for implementation in 2015/16, aims to support independence by providing rehabilitation and reablement by focusing on the individual capabilities and needs following an acute illness, injury or change in health and social care circumstances. The new service also has an early intervention and prevention function by being a first point of contact for many people. The service will aim to restore, maximise or prevent deterioration in physical, psychological and social functioning through episodes of rehabilitation and reablement.
The development of the Community Recovery Service will be a service redesign bringing together four services and two organisations to work in partnership to deliver the service from 1 April 2015. The four areas being brought together are:

- Community Rehabilitation Service (Hounslow and Richmond Community Healthcare Trust (HRCH))
- Community Neurological Rehabilitation Service (HRCH)
- Occupational Therapy (LB Hounslow Children’s and Adult’s Services (CAS))
- Assessment and Reablement Team (LB Hounslow CAS)

The CRS will work closely with local GPs, 111 service, district nurses and local acute hospitals and support people to avoid hospital admission and where necessary be discharged home from hospital as quickly as possible and continue to remain independent and well. The joined up service, bringing together health and social care will ensure people get the right care, at the time and for the duration they need it, from appropriate highly skilled workers. We aim to reduce delays in discharging people from hospital by working with local acute hospitals to identify the main reasons for delays occurring. In addition, Hounslow CCG and the Council will continue to work in partnership to reduce the number of delayed transfers of care, through improved patient pathways and improved communication between partners.

Through key documents (the JSNA and the Public Health Outcomes Framework) and partnerships (Health and Wellbeing Board and whole systems Integrated Care), Public Health and Joint Commissioning are defining who their priority populations are for secondary prevention interventions. Some populations identified so far are: older people, those with identified risk of disease, carers and socially excluded groups.

An example of work to support a targeted priority group is the Better Homes, Better Health offering support to Hounslow residents most at risk from the health effects of cold weather.

Both Public Health and Joint Commissioning currently commission a range of social activities and befriending services for vulnerable groups in order to reduce isolation. However, with growing evidence around such services and the development of whole systems integrated care, these services will need to be re-commissioned to ensure they are flexible to meet the needs of individual users and build on community assets. Research highlights effective interventions to tackle loneliness are: community navigators, befriending, social interaction through community involvement and hobbies. Social group activities included group exercise, art, therapeutic writing and aspirating activities, with different studies showing a reduction in falls and improved physical health.

Additionally, falls prevention needs to be integrated with the rest of the falls pathway being developed locally, building on the evidence base but also being person centred to understand key causes of falls.

Type 2 diabetes is on the increase and there are thought to be about 5,000 undiagnosed diabetics in Hounslow (JSNA 2014). As part of a wider programme to support our approach to long-term conditions our Public Health team is working with the CCG to develop a pre-diabetic healthy lifestyle support package for those who are at high risk of developing
diabetes. The new Diabetes Intermediate Care service will be integral to the delivery of preventative diabetic education in the borough. The CCG has commissioned an increased volume and variety of nationally accredited diabetes education for adult patients at high risk of developing diabetes and for those diagnosed with Type 1 and Type 2. These programmes have specific aims and objectives to support individuals and their family/carers in developing positive attitudes, beliefs, knowledge, healthy lifestyles and skills to self-manage their diabetes.

Cardiac rehabilitation provision will be increased for patients who have a confirmed diagnosis of Heart Failure; these patients are supported following acute cardiac episodes, by encouraging them to increase their levels of physical activity and make lifestyle changes through an agreed plan that minimises the potential for a further cardiac episode.

**Delay: tertiary prevention**

These are interventions aimed at minimising the effect of disability or deterioration for people with established health conditions, complex care and support needs or caring responsibilities, including supporting people to regain skills and reduce need where possible.

The Council and CCG already provides or arranges services, resources or facilities to maximise independence for those already with such needs, for example, interventions such as rehabilitation/reablement service. This will include joint case-management of people with complex needs, Community Recovery Service and Locality Teams. This will also include helping carers to continue to care, enabling them to have a life of their own alongside caring, to have breaks from their caring responsibilities, develop mechanisms to cope with stress associated with caring and awareness of their own physical and mental health needs, e.g. emotional support or stress management classes.

For people at risk of significant deterioration in their condition or after an acute hospital admission we would seek to use a range of services, including ICRS, CRS and locality based multi-disciplinary teams, to provide recovery based interventions to mitigate or reduce the need for on-going social care support. However we recognise that for people with this level of need it is likely that a proportion will still require support of some kind through the locality teams.

Extra care and other specialist housing is being developed as our longer term replacement to residential provision and where possible residents will be encouraged to use personal budgets to identify and commission their own support to meet their needs in ways which are outside of the scope of traditional services.

Joint Commissioning and Public Health will undertake research to look at what are the determinants which lead people to go into residential and nursing care and what interventions are likely to have delayed or prevented it.
There are then a number of services linked to treatment, to slow the deterioration of health or aids recovery, for example: we are looking to expand the books on prescription programme to include prescribing books for dementia and good mental health.

**Social Services Reviews**

Prevention and promoting independence is also a key priority for those people already receiving support from the Council. Social work reviews will all have a focus on prevention, including:

- within 6 weeks of a package of care starting
- following a period of reablement/rehabilitation, or period in hospital
- through the statutory annual review process

These reviews will look to ensure that people do not receive services that have a detrimental impact on their long-term independence through creating unnecessary dependence on services. The review will ensure that people receive the right level of care to meet their needs and continue to ensure that support plans are, where appropriate, focused on recovery.

Through reviews, social Workers will work with residents and their families to explore options for reducing social isolation, linking with local voluntary and community sector provision, and increasing use of assistive technology such as Telecare. At assessment, and moving forwards Social Workers will look at opportunities for practical support, including linking with the Supporting Independence Service, floating support another key support services, and focussing on short term intervention where needed. Supporting carers, families and building links to faith groups, community groups and other local networks will be central to this approach.
5. Priorities for Prevention

Our strategy will guide how the Council and HCCG will in future commission prevention and early intervention services and support. Some services and support are and will be ‘universal’ and available to all adult residents. There are and will be services and support that are specifically for older people, people with physical disabilities and sensory impairments, people with learning difficulties, people with mental health problems, and their carers who:

- are deemed at risk of social isolation and social exclusion or of needing more intensive health and social care support
- require access to information and advice, and from that, access to relevant services that will assist them to retain/regain their independence and wellbeing.

Services and support need to be available for those people who fund their own support as much as it is for those whose personal social care and support services are funded by the Council. This is a key element of the Adult Care universal offer for Hounslow residents. In the provision of a range of prevention services, there is a need to work with local partners from all sectors to ensure there is a good balance in respect of services available for:

- the general population (universal services); generally equates to primary preventative services and support
- low level preventative services for more vulnerable groups of people; generally equates to secondary preventative services and support
- people with high level, more complex needs; generally equates to tertiary preventative services and support.

We recognise that good commissioning promotes health and wellbeing, including physical, mental, emotional, social and economic wellbeing. Our future commissioning intentions and activity will therefore include promoting protective factors and maximising people’s capabilities and support within their communities. We will commission services to promote wellbeing, and protecting people from abuse and neglect, and will seek to influence other organisations in order to shape the local environment and strengthen social and economic participation to facilitate wellbeing.

To achieve our goal of improving the wellbeing of adults in Hounslow and supporting them to stay active and live as independently as possible in their home and community of choice, there must be pre-investment in preventative and community based services that meet identified needs. This investment will deliver future savings and improved outcomes for patients/service users and carers. The reconfiguration of existing services will generate potential revenue for reinvestment in preventative and early interventions.

Timely, early intervention not only improves outcomes for people but also reduces the longer term costs of care, for example by reducing the need for support by carers, hospital bed use and delaying the need for more intensive long term care services.
The Department of Health’s Partnerships for Older People Programme (POPPs) findings suggested that small services providing practical help and emotional support can significantly affect the health and wellbeing of older people, alongside more sizeable services designed to avoid the need for hospital admission. We also have a body of evidence that early intervention can cut need for residential and nursing care by 22% (National Dementia Strategy, DH, 2009). There is also strong evidence of the benefits of exercise in older people reducing circulatory disease, which causes up to 50% of dementia cases. (Under Pressure, Audit Commission, 2010)

As such, evidence is that prevention and early interventions should be focused on:

- **Access to Information, advice and signposting to community resources**, so people are well informed, can help themselves. It is also needed to support people who do not meet social care eligibility criteria, or who fund themselves, in finding services that can meet their needs.
- Focus on **community recovery**, encompassing reablement and rehabilitation, to reduce the reliance on home care and promote independence
- Develop our **falls prevention** activities
- Focus on developing and supporting community activities through working in **localities**
- Increased use of **assistive technology**, including Telecare and Telehealth
- Specific **proven early interventions** e.g. housing related support
- Development of **extra-care and supported housing** across the borough as an alternative to residential and nursing home use
- Situations where someone has a **major life change** and may need support to help them regain their independence, e.g. illness, bereavement
- **Low level, practical services and support** that enable people to continue to live in their own homes if they choose to do so, e.g. Handyman services, floating support, assisted shopping
- **Reducing social isolation** e.g. befriending services, intergenerational practice; as loneliness and depression are recognised as major factors in the quality of life for people, particularly older people
- Promoting mobility and the accessibility of community facilities, e.g. adequate transport services
- Services and/or support that promote people’s **engagement** in their community and social cohesion, e.g. volunteering, intergenerational practice.
- **Healthy living advice and support**, e.g. smoking cessation, dietary advice.

We think that the above outlined menu of provision provides the right balance of preventative services and is the right focus for our continued investment in prevention and the commissioning of services in partnership with public health, housing and the Community Partnerships Unit.

Key elements to focus on will be:
1. Information, advice and signposting
2. Community Recovery
3. Locality working
4. Reduce social isolation
1. Information and advice and signposting

Good information and advice is key to enabling people to make decisions about their health and social care needs. A key component and running thread throughout all of our commissioning approach is to ensure that the people of Hounslow have suitable information, advice and advocacy to access the most appropriate services, as well as ensuring that professionals are able to signpost people to preventative services rather than more costly statutory provision. This will include developing robust and reliable sources of advice and support for older people and their families before they become frail or need to access the statutory system. Such information will be easy to access, clear, friendly and personalised and made available in the right formats (including easy read formats). We will seek opportunities to transform how we do this with new and developing technologies and social media. The development of Careplace as a signposting and brokerage tool will be further explored as well linking with other community facilities in the voluntary sector as well as Council services such as libraries, children’s centres and other community buildings.

By delivering this approach we will build a stronger community infrastructure which is underpinned by an improvement and expansion of information and advice which is focused towards reducing health inequalities, delaying or preventing social exclusion and the need for intensive, costly support from social care and health agencies.

Hounslow is committed to continuing to meet the needs of those with the highest social needs (currently those who meet FACS\(^5\) criteria for substantial and critical need), while simultaneously maintaining a stronger emphasis on early intervention and prevention as well as improved support for carers. The provision of information, advice and advocacy services for all residents, including those who do not meet eligibility criteria, will be at the forefront of this transformation of an integrated adult health and social care system alongside an improved access to universal services.

There is a clear need for people to be able to access services early to prevent bigger problems in the future, for the most part these early intervention services are not part of the social care or statutory sector market so our role in this will be to signpost and inform people as to the options available to them through the local community. To deliver this we have committed to the development of an online resource directory as part of CarePlace\(^6\), which will identify the services that are available and how they can be accessed. This will be available to residents and adult health and social care providers. In addition to this, through our market facilitation function we will offer development advice and support to voluntary sector organisations to encourage and grow them to be self-sufficient.

\(^5\) Fair Access to Care Services – in Hounslow this is set at substantial and critical need. Under the Care act new national eligibility criteria will be established.

\(^6\) Describe CarePlace
We will deliver this by:

<table>
<thead>
<tr>
<th>Ensuring that people, including staff, can easily and reliably access health and wellbeing information and community resources, by:</th>
</tr>
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<tbody>
<tr>
<td>• developing Adult Social Care, Health and wellbeing web content and use of social media</td>
</tr>
<tr>
<td>• developing content and promoting use of the Careplace</td>
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Ensuring Careplace (sign posting system) is embedded across Hounslow.

Ensuring that advocacy provision is readily available to residents including carers (including specific complex needs groups such as learning disability and mental health)

2. Community Recovery

We will continue to invest in an Integrated Community Response Service (ICRS) that provides rapid response to support individuals so they can remain at home. We are now redesigning our rehabilitation and reablement service model and pathway to provide, alongside the ICRS, a Community Recovery Service which will work with individuals who have lost their independence and support them to build confidence, regain skills and with appropriate information and support, to self-manage their health conditions and medication. The service, a combination of reablement and rehabilitation, will introduce individuals to the potential of assistive technologies and where these are to be employed will ensure individuals are familiarised and comfortable with their use.

It is intended that the volume of emergency activity in hospitals and the planned care activity in hospitals will reduce through alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and Community Recovery, will mean we will reduce delays in transfers of care, reduce pressures in our hospital Emergency Departments and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on community nursing and residential care.

We currently have a range of fragmented reablement services which work in a reactive way. Discharge processes can be complex and reablement services' contribution to prevention of admission to care homes is not as significant as it should be. As a priority for 2015/16, we will look to ensure that all providers, including acute and mental health providers, are clear about their contribution to community based recovery following injury, fall or illness. This will also look at the links into the personal care framework and housing related support services when longer term care and support is required.
The key objective is to develop a service that can reduce demand on acute services and long-term health and social care systems through a range of integrated short-term interventions delivered in the home. The Community Recovery Service (CRS) is in development and its remit will be:

- Reducing admission to and length of stay in hospital
- Co-ordinating discharge planning to health and social care services
- Decreasing need for domiciliary home care
- Reducing admission to long-term care (residential and nursing home)
- Facilitating safe and timely discharge from hospital
- Increasing the level of independence and self-management

The CRS will be an integrated health and social care service for and will provide short-term intensive support with a focus on enabling people to achieve their maximum level of independence. The focus will be on achieving reduced levels of dependency and restore previous independence wherever possible.

All health and social care professionals within the CRS will have a set of core skills that all staff in the team are able to deliver regardless of profession. This supports the single assessment process, maximises use of resources and minimises duplication. In addition, team members will retain specialist skills and knowledge, which will be utilised as required. Specialists will also supervise other team members’ work to ensure fulfilment of relevant goals.

The service will work in partnership, liaising and communicating with the primary care teams in the five Hounslow Localities, health and social care community services commissioned by Hounslow CCG and LBH, Voluntary Sector and other external providers.

We will deliver this by:

1. Developing a new Community Recovery model linking Council reablement with community health rehabilitation services.

2. Expansion and further investment in the Integrated Community Response Service.

3. Implementation of the Personal Care Framework, a recovery focused alternative to traditional homecare services.

4. Linking floating support services to the Community Recovery Service when on-going preventative support is needed to keep people living at home.

5. Development of the health and social care market place to ensure appropriate service provision is available.

6. Explore options for development of diabetes intermediate care service
3. Multi-disciplinary locality teams

Over the next 5 years community health and social care teams will work together in an increasingly integrated way in the five localities in Hounslow, with care co-ordinated around the person and their family, maximising the ability for people to remain in their home throughout life. The focus of the teams will be to support people to be medically, functionally and socially stable as their condition allows. We will invest in social workers to work generically in localities providing social support that maximises people’s independence and supports their social stability within vibrant and sustainable communities.

Our teams will work with the voluntary, community and independent sector to ensure those not yet experiencing acute or on-going care needs, but requiring support, are helped to remain healthy, independent and well. We will develop the personal care framework to provide people with effective, quality and appropriate health and social personal care at home. We will invest in empowering local people through effective care navigation, supporting people’s own self-management of their long term condition with programmes that maximise their independence and wellbeing; we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

Locality teams will encompass social care professionals working alongside GPs, care navigators, community matrons, mental health workers and other health professionals to support people who require earlier intervention to support social and functional stability and person centred life planning that prevents reliance on expensive health and social care. Multi-disciplinary locality teams will take a whole person approach to:

- Prevention
- Positive risk stratification and risk taking
- Keeping people safe
- Active case coordination
- Coordinated care and support planning
- Self-management
- Supporting parents, carers and families

We will invest in empowering local people through effective Care Navigation, supporting individuals own management of their long term conditions with programmes that maximise their independence and wellbeing and we will help identify and combat social isolation as a major influence on overall health and wellbeing. The CCG and the Council have commissioned a care navigation service for the last year; the service is currently being evaluated to assess the effectiveness and the outcomes and to inform future commissioning decisions from April 2015.
We will deliver this by:

1. Positioning access to floating support and supported housing options at the front of the customer journey and join their pathway with the Community Recovery Service and multi disciplinary working in localities.

2. Ensuring the availability and equity of advocacy provision for all Adult Social Care client groups and people with long-term conditions.

3. Minimising any falls through increasing primary prevention, foot care provision and by developing further [evidence based] exercise provision.

4. Increasing support and advice available to carers.

5. Linking the Supporting Independence Service with multi disciplinary locality teams to ensure other preventative services are offered as the first option when people in need are identified.

4. Reducing Social Isolation

Many voluntary and community organisations already provide health and social care to Hounslow residents; however this is often not within the framework of any other care they receive. We want to ensure that the huge value of the voluntary and community sector is realised as part of integrated care. We will work with the network of local voluntary organisations, Hounslow Community Network, to map the services that they offer and engage them better in plans over the coming months in order to involve them fully in plans for integrated care and promoting independence.

Building on existing investments through NHS monies for social care under section 256 agreements, we will continue to invest in preventative activities, primarily through the local voluntary and community sector, including low cost/no cost solutions, initiatives to combat social isolation and the development of contracts with in-built incentives to re-invest in the community and targeted work at the most vulnerable populations.

We will pilot initiatives during 2014/15 to take forward as part of wider integrated health and social care programme. This will include closer integration with the wider public health programme, with which our plans have been aligned. We will continue to review existing commitments, including services commissioned under existing section 256 agreements, to ensure they represent value for money and re-procure services where necessary to enable integrated working. This will include ensuring that we continue to invest in preventative services as well as increasing investment in support services for carers.
We will deliver this by:

1. Reviewing existing activities and services to promote health and wellbeing for older people in partnership with public health and leisure
2. Increasing the availability of befriending services across the borough
3. Reviewing and developing the range of day opportunities provision for people with learning disabilities
4. Expanding the current offer to support carers in continuing their caring role including short-breaks.

5. **Supported Housing, Floating Support and Supporting Independence Service**

The Supporting Independence Service (SIS) acts as a gateway into Supporting People (SP) services in Hounslow. The team is based in Housing and carries out a single assessment process for people to access commissioned services including floating support, supported housing and Telecare services funded through the SP programme. SP services are secondary preventative services with the aim of preventing or reducing the need for statutory services.

The SIS manages the access and move on from supported accommodation (including extra care) and floating support services to ensure that the services are targeted appropriately to maximise their prevention potential and that service users move on at the appropriate time. The SIS also provides time limited brief interventions of up to eight weeks when service users need specialist housing support or until they can be referred to another service.

In order to maximise the preventative potential of SP services in general, people should become known and receive support before their needs reach a level where they require statutory services. This currently works well in some areas, housing and mental health in particular, where vulnerable people are referred and provided with supported housing, floating support or Telecare as appropriate and they do not require a statutory provision. This needs to be improved with older people and people with long term conditions as they are often not identified until their needs are too high.

Access to supported housing and floating support needs to be at the front end of the new pathways being developed for adult social care so that SP services are considered at the earliest opportunity. It needs to join up with the new Community Recovery Services, encompassing current rehabilitation and reablement services, to provide housing solutions and ongoing floating support to enable people who have had reablement to remain living independently.

SIS officers will be paired with the 5 locality areas to work jointly with the multi-disciplinary teams in these areas, providing access to and advice about floating support, supported
housing, housing options and Telecare for the multi-disciplinary teams working in each locality.

Floating support services provide support to individuals and households, delivered through person centred support plans and key work sessions to support vulnerable service users to remain living independently. There are currently a range of floating support services available in Hounslow including services specifically for people with learning disabilities, mental health problems, substance misuse problems, sensory and physical disabilities, people with long term conditions and older people. The support is related to housing and aimed at helping vulnerable people to maintain their accommodation or move to more suitable accommodation. As housing is such an important element in people’s lives and broad factors such as finances, physical and mental wellbeing, employment and being linked into services affect people’s ability to live independently, the support can be broad and holistic in nature.

Support can last from three months to two years in duration and takes place in the service users own home or a location of their choice. The service user and support worker develop an outcomes focused support plan together based on identified needs and risks which is delivered through key work sessions with a named worker. A range of outcomes are reported by providers via the Supporting People Outcomes Framework when the support ends. Results for Hounslow show that approximately 97% of service users receiving support maintain their independence, which is the overarching outcome for floating support services.

There is a need for better support and advice for older people to make decisions about moving to a more suitable property as they grow more elderly and frail before there is a crisis and they are admitted to hospital or care. Floating support services will be reconfigured to more generic provision, while still providing some specialist support in areas such as young people and mental health. Service users will be offered more choice between providers based on the findings of the current pilot scheme. New floating support services will support vulnerable people to remain independent even if there is not a specific housing need and we will link floating support services to new customer pathways and access arrangements in health and adult social care to ensure that floating support is considered at the earliest stages at the front of the pathway. Services will offer advice and assistance to older people to consider a range of housing options at an early opportunity including aids and adaptation, Telecare and moving to sheltered or extra care housing when appropriate.

Access to floating support services will be linked to our locality working arrangements to ensure that Locality Managers, GPs, Care Navigators and Community Psychiatric Nurses (CPNs) working in localities are fully aware and can arrange support for vulnerable people at the right time and place.

Supported housing also known as ‘supported living’ consists of accommodation with support on site, where the accommodation and support comes together as a package. It is a more enabling setting than residential care; service users are tenants with security of tenure and a key to their own door. The accommodation is their own home and they pay rent. As well as being more enabling than residential care it is also more cost effective as it is generally cheaper to provide and the rent and service charge from the service user, often paid for
through Housing Benefit, forms another stream of funding which social care or health does not need to meet.

There are different models of supported housing ranging from blocks of self contained flats to smaller shared houses with only two or three service users. Support can be high with 24 hour waking staff to low with support staff coming to the property for periods of the day, depending on the needs of the service users. Some provide only support while others provide help with care tasks to assist with daily living.

There is a range of supported housing provision in Hounslow including schemes for people with mental health problems, learning disabilities and younger people. These can be divided into two main types, those that provide only support to live independently which are funded through the Supporting People programme and those where assistance with daily living tasks and hands on care is provided which is funded through adult social care and health.

We will review current supported housing provision in Hounslow to ensure there are a range of supported housing options appropriate to meet the needs of people with learning disabilities and mental health problems in particular. We will work with partners in Housing to improve the current stock and increase the provision of supported housing to provide more enabling alternatives and “step down” from institutional care. We will review the pathways to ensure that people move into and on from supported housing at the right time and so that people currently placed in out of borough placements can move back to their communities where appropriate.

We will deliver this by:

1. Reviewing, reconfiguration and increased provision of a range of supported housing options for people with mental health problems, learning disabilities and young people transitioning to adulthood.

2. Improving the pathways through services so that people do not become dependent and are able to step down to lower levels of support as soon as is appropriate.

3. Reviewing and reconfiguration of floating support provision, to ensure both specialist and generic provision is available to Hounslow’s residents with a clear focus on maximising independence.

4. Working with Children’s Services to reconfigure young people’s services to better meet the needs of young people leaving care who require higher need provision as part of transition into adult services.
6. Extra Care Housing

Extra care housing is sometimes referred to as very sheltered housing or housing with care. It is social or private housing that has been built to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home. Extra care housing can be run by registered providers (housing associations) and charities, local authorities or private sector providers.

Most residents are older people, but this type of housing is becoming popular with people with disabilities regardless of their age. Some specialise in care for people with dementia.

Extra care housing gives people the opportunity to live independently in a home of their own, but with other services on hand if they need them. The flats are self contained and people have the key to their own front door with security of tenure. It is usually seen as a long-term housing solution where people’s needs can increase without them needing to move on somewhere else, it is sometimes described as a home for life. The features and extra facilities vary depending on the site and the model, but generally include:

- 24-hour access to emergency support
- an on-site care team
- a restaurant or some kind of meal provision
- laundry
- full wheelchair accessibility
- communal facilities for activities
- activities held on site to promote health and wellbeing and prevent isolation
- Telecare equipment installed to alert staff when someone needs assistance or may be in danger

Moving forwards, some schemes may also include:

- rehabilitation services
- a base for healthcare workers
- specially designed dementia flats/wings

Extra Care housing is enabling people to live in their own homes, retaining their independence while receiving the care and support they need. Care staff are available on site to deal with emergencies 24 hours a day. Extra Care Housing is an essential element in our strategy to prevent people going into residential and nursing care or hospital when this is not absolutely necessary. Moving into Extra Care schemes at the appropriate time prevents vulnerable residents’ needs increasing to a level when they are unable to live independently, reducing reliance on residential care. The care and support available in schemes support clients to maintain their health and prevent hospital admissions. When people are living in Extra Care accommodation delays in hospital discharge are less likely as the hospital can liaise with care and support teams and be confident that the patient will be supported in their home environment.
As we develop the extra care housing plan it is essential that the key interdependencies and impact on other services is identified. These include the role of GPs, district nursing and community matrons and dementia services.

Clearly it is not as simple as to say that everyone currently in residential care should move to Extra Care. Many people currently in residential care would not be suitable for Extra Care Housing, people with higher needs particularly around dementia may not be suitable. Although the development of dementia specific provision within schemes will contribute towards meeting these high needs. People should move into Extra Care at an earlier stage than they would to residential care so they can ‘age in place’.

There are currently only 43 units of purpose built extra care housing in the London Borough of Hounslow. A further 36 social rented units under construction is scheduled to open in April 2015. Another similar sized scheme is in the development stage; by 2018 it is proposed to have 5 schemes and 250 units available.

While the current and under construction extra care schemes are designed to be dementia friendly, there is currently no dementia specific extra care provision in the borough. This is an essential part of our plans as we develop schemes in partnership with colleagues in Housing.

We will deliver this by:

1. Increasing the provision of Extra Care housing by 3 schemes and 216 units by 2018 including dementia specific provision.

2. Further develop sheltered and extra care housing schemes as community hubs in localities for older people, with new extra care schemes helping to cater for the needs of people with dementia in the surrounding locality.

3. Increasing resources and staffing for the Activities Coordinator programme linked to Sheltered and Extra Care Housing schemes.

4. Promoting and increasing the use of volunteers from and into sheltered housing and extra care schemes.

5. Review GP input, role of Community Matron and dementia advisor in relation to extra care housing provision.

7. **Assistive Technology**

In Hounslow we wish to ensure that people are able to access assistive technology (AT), alongside other aspects of health and social care to enable them to remain living as independently as possible within the home of their choice. This means that provision of AT should be:
- Inclusive of all ages and across conditions
- Embedded in every pathway of care
- Individual solutions for individual needs
- Comprehensive from simple to complex: from self management to bespoke integrated multi-technologies
- Cost effective and financially sustainable and considered whenever costs in alternative health and social care services can be avoided or reduced
- Equitable in terms of processes and criteria for provision
- Able to respond and take advantage of new technological innovations
- Integrated and co-ordinated in the approach to provision
- Clear in its objectives
- Avoiding unnecessary admissions to hospital, by:
  - Promoting, self management, independence and living at home
  - Supporting early discharge from acute care
  - Avoiding delayed transfers of care
  - Supporting carers
  - Postponing the need for care packages and placements in care homes

Assistive technology is defined by the Audit Commission as ‘any item, piece of equipment, product or system that is used to increase, maintain or improve the functional capabilities and independence of people with cognitive, physical or communication difficulties.’ Telecare is an aspect of assistive technology and relates to a combination of equipment, monitoring and response and has been defined as 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. It can help individuals maintain independence, increase safety and confidence and support carers alongside traditional healthcare, social care and housing initiatives.

Building on the overarching vision of promoting independence and prevention, a specific agreed priority area is the increased use of equipment and assistive technology. This will incorporate adaptations and greater utilisation of Telehealth and Telecare. There will be a review of the use and access to complex equipment in relation to outcomes such as reducing pressure sores, preventing falls and speeding up hospital discharges. This review will be across health, housing and social care, ensuring there is an effective interface across the sectors and that we are getting best value from our contracts. The volume of emergency activity in hospitals and the planned care activity in hospitals will reduce through greater use of alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and the new Community Recovery model, will mean we will eliminate delays in transfers of care, reduce pressures in our hospital emergency departments and wards and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

Reviewing and revising the pathway for accessing all community equipment, assistive technology alongside minor and major adaptations will form part of this work agenda. This
will include the joint working relationships with Housing colleagues and maximising opportunities to promote independence through the Disabled Facilities Grant.

Moving forwards, and over the lifetime of this strategy, we will ensure that high quality and accessible information is available to people through a range of formats to enable them to make informed choices about the use of assistive technology. This will need to include implementation of an online self help tool alongside telephone advice and assessment. A review of all pathways of care needs to be undertaken to ensure that access to AT, including Telehealth, is embedded at all stages of care and support. This will be achieved through:

- Undertaking work to review and redesign AT pathways
- Focusing on pathways for older people, long term neurological conditions, dementia, diabetes, COPD and CHD
- Ensuring all documentation for pathways includes prompts for AT (i.e. within assessments, reviews, care plans and support plans).
- Ensure that the Community Recovery Service utilises technology to increase service users' ability to self manage at home, introducing AT as part of the care package at an early stage so that service users and carers become conversant with the technology.

**We will deliver this by:**

1. Carrying out a review of current arrangements, provision and pathways, benchmark against other Local Authority area.

2. Continuing expansion of both Linkline and telecare as a preventative measure before people's needs become statutory.

3. Trialling telehealth to support whole systems locality working and better support self management.

4. Promoting better take up and use of telecare and telehealth to stakeholders carers and service users, though road shows, demonstration sites.

**8. Falls Prevention**

Services are not always well coordinated or consistently delivered and despite some progress from the 2009/14 Hounslow Older People’s Falls Strategy, there is still considerable room for improvement. There is a need to review progress in implementing an integrated falls pathway and there remains a perceived shortage of capacity for the specialist assessment and treatment of people at risk of falls and osteoporosis.

The vision of the falls strategy is that all people at risk of falling and sustaining fractures and injuries:

- know of this risk and what they can do to minimise it
• are supported by health and social care staff to minimise the risk
• receive timely good quality assessment, treatment and care should they sustain a fracture or injury through falling
• are rehabilitated to their pre-fall health and wellbeing or even better
• are provided with services irrespective of their gender, ethnicity, culture or disability
• have their right to make choices and take risks respected.

Over the course of this strategy we aim to achieve the following outcomes.
• a reduction in falls and associated injuries and fractures
• a reduction in the number of falls related admissions into acute care
• greater use of assistive technology including Telecare
• an effective integrated care pathway
• the widespread use of an effective falls risk assessment tool
• better standards for effective prevention and rehabilitation services
• increased patient satisfaction/wellbeing
• an associated reduction in acute, community, rehabilitation and social care costs.

We will deliver this by:

1. Reviewing and integrating provision provided by Public Health, the Clinical Commissioning Group and Adult Social Care.

2. Ensuring a range of accessible information is available to residents, carers and voluntary sector.
6. Programme of Action

There are gaps in the provision of preventative services in Hounslow. We know that we have work to do to improve equity and extend the availability of certain provision, to better meet the needs of people across all cultures and communities, to continue to grow our prevention package of services and support for Hounslow adults.

We aim to focus on improving the way we work across all agencies: health, social care, housing, public health, transition from children’s services, employment and community safety to ensure that we work in an integrated way to benefit all of our residents. We want to improve communication and signposting so that people receive the most appropriate support that will contribute to their health and wellbeing. For example, anti-social behaviour picked up by housing officers or the police may be symptomatic of a mental health illness and would be best treated by the community mental health teams so joint working is essential to provide personalised support. We plan to look at ways to support homeless people to access health services since many are not registered with a GP and often end up at hospital emergency departments to access services.

By working with housing we can better enable people to continue to live independently at home and better support families including children with disabilities and also delay moves into residential care homes. We will continue to provide disabled facility grants to help people who cannot afford to adapt their homes. The home improvement agency also assists people who can afford to adapt their homes but need a reliable agency to organise and carry out adaptation work.

We will know that we have succeeded if, by 2018, we can demonstrate that:

- People can easily and reliably access health and wellbeing information and advice services and community resources.
- People are well informed about options available to them when faced with potential risks and support needs.
- More people are accessing a preventative service.
- More people have been supported to maintain their independence.
- More people have been supported to maintain or become involved in a range of activities.
- More people are helped to avoid a crisis that could lead to unnecessary admissions to hospital or into longer-term care, through joined up early intervention.

Annual commissioning plans will be developed to provide updates and intentions in relation to the following actions outlined to support the delivery of the prevention agenda in Hounslow:
### Actions

<table>
<thead>
<tr>
<th>Information advice and signposting</th>
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<tbody>
<tr>
<td>1. Ensure that people, including staff, can easily and reliably access health and wellbeing information and community resources, by:</td>
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<tr>
<td>• developing Adult Social Care, Health and wellbeing web content and use of social media</td>
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<td>• developing content and promoting use of the Careplace</td>
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<tr>
<td>2. Ensure Careplace (sign posting system) is embedded across Hounslow.</td>
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<tr>
<td>3. Ensure that advocacy provision is readily available to residents including carers (including specific complex needs groups such as learning disability and mental health)</td>
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<tr>
<th>Community Recovery</th>
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<tr>
<td>1. Develop a new Community Recovery model linking Council reablement with community health rehabilitation services.</td>
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<td>2. Expand and further invest in the Community Recovery Service.</td>
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<td>3. Implement the Personal Care Framework, an outcomes and recovery focused alternative to traditional homecare services.</td>
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<tr>
<td>4. Develop the market to ensure appropriate service provision.</td>
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<tr>
<td>5. Explore options for development of diabetes intermediate care service</td>
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<th>Locality Working</th>
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<tr>
<td>1. Position access to floating support and supported housing options at the front of the customer journey and integrate with Community Recovery service and multi-disciplinary working in localities.</td>
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<tr>
<td>2. Ensure availability and equity of advocacy provision for all Adult Social Care client groups and people with long-term conditions.</td>
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<tr>
<td>3. Minimise falls through increasing primary prevention, foot care provision and by developing further [evidence based] exercise provision.</td>
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<tr>
<td>4. Increase support and advice available to carers.</td>
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<tr>
<td>5. Link the Supporting Independence Service with multi-disciplinary locality teams to ensure preventative services are offered as the first option when people in</td>
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</table>
Reducing Social Isolation

1. Review existing activities and services to promote health and wellbeing for older people in partnership with public health and leisure

2. Increase the availability of befriending services across the borough

3. Review day opportunities provision for people with learning disabilities

4. Expand current offer to support carers in continuing their caring role including short-breaks

Supported Housing and Floating Support

1. Review, reconfigure and increase provision of a range of supported housing options for people with mental health problems, learning disabilities and young people transitioning to adulthood

2. Improve pathways through provision so that people do not become dependent and step down to lower levels of support as soon as is appropriate

3. Review and reconfigure floating support provision, to ensure both specialist and generic provision is available to Hounslow’s residents with a clear focus on maximising independence.

4. Work with Children’s Services to reconfigure young people’s services to better meet the needs of young people leaving care who require higher need provision as part of transition to adult services.

Extra Care Housing

1. Increase the provision of Extra Care housing by 3 schemes and 216 units by 2018 including dementia specific provision.

2. Further develop sheltered and extra care housing schemes as community hubs in localities for older people, with new extra care schemes helping to cater for the needs of people with dementia in the surrounding locality.

3. Increase resources and staffing for Activities Coordinator programme linked to Sheltered and Extra Care Housing schemes.

4. Promote the use of volunteers from and into sheltered housing and extra care schemes
5. Review GP input, role of Community Matron and dementia advisor in relation to extra care housing provision.

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<td>2. Continue expansion of Linkline and telecare as a preventative measure before people’s needs become statutory.</td>
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<td>3. Trial Telehealth to support whole systems locality working and better support self management.</td>
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<td>4. Promote better take up and use of Telecare and Telehealth to stakeholders, carers and service users, though road shows, demonstration sites.</td>
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## 7. References and Further Reading

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<tr>
<th>Document or information title</th>
<th>Synopsis</th>
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<tr>
<td>“Living Longer, Living Well” Pioneer Application June 2013</td>
<td>The vision for whole system integrated care in NW London - people, their carers and families will be empowered to exercise choice and control; GPs will be at the centre of organising and co-ordinating people’s care; systems will not hinder the provision of integrated care.</td>
</tr>
<tr>
<td>“Shaping a Healthier Future” NHS North West London</td>
<td>The strategy for future healthcare services in North West London including how care will be brought nearer to people; how hospital provision will change, including centralising specialist hospital care onto specific sites so that more expertise is available more of the time; and how this will be incorporated into a co-ordinated system of care so that all the organisations and facilities involved in caring for the people of North West London can deliver high-quality care and an excellent experience.</td>
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<tr>
<td>Better Care Closer to Home CCG Out of Hospital Strategy</td>
<td>Hounslow CCG strategy for commissioning and delivering better care for people, closer to home. These focus on local care provided out of hospital, integrating with the future development of acute services across the region as outlined in “Shaping a Healthier Future”.</td>
</tr>
<tr>
<td>Joint Strategic Needs Assessment (JSNA)</td>
<td>Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities for Hounslow.</td>
</tr>
<tr>
<td>Joint Health &amp; Wellbeing Strategy (JHWS)</td>
<td>The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2017 for Hounslow.</td>
</tr>
<tr>
<td>Joint Commissioning Intentions</td>
<td>A single view of commissioning intentions across the London Borough of Hounslow and Hounslow CCG. The CCG and council’s commissioning intentions for 2014/15 and 15/16 have been mapped bringing them together into a joint commissioning strategy.</td>
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<tr>
<td>Delivering Seven Day Services</td>
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<tr>
<td>Individual CCG QIPP, operating and local authority corporate and service medium term financial plans.</td>
</tr>
<tr>
<td>Hounslow Together Local Strategic Partnership (LSP) Future Borough Sustainable Community Strategy</td>
</tr>
<tr>
<td>Whole Systems Integrated Care Programme Outline Business Case (May 2014).</td>
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<tr>
<td>Children’s and young People Strategy 2015 -2019</td>
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### Key national documents and policies in developing the strategy

**Our Health, Our Care, Our Say: A new direction for community services (2006)** This initiated the move towards providing joined-up health and social care services citing: Convenience of access; Cost effectiveness; Quality of services; Cost savings

**Equity and Excellence: Liberating the NHS (2010)** This outlines the framework for service development, placing the focus of progress in health development not changes to structures/processes

**The No Health Without Mental Health government strategy (in full Feb 2011)** This sets out the ambitions of the coalition government to mainstream mental health in England, through greater integration and recognition, to result in improved outcomes for all those with mental health problems.
The Health and Social Care Act (2012) This called for a health system based on systematic user involvement in the design of health and social care services

The Welfare Reform Act (2012) This introduced the biggest changes to the welfare system for over 60 years. It simplified the system, removing the need for people to claim different benefits from different agencies. The changes will result in approximately 3.1 million claimants being better off and 2.8 million claimants being worse off

The Department of Health Review: Transforming Care: A national response to the Winterbourne View Hospital (in full Dec 2012) This sets out a series of mandated actions for health and local authority commissioners, designed to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. It sets out the strategic direction for greater integration leading to the right care being provided in the right place for people with learning disabilities or autism, and also the measures that will be used to measure progress on this direction.

The Francis report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (in full Feb 2013) This sets out a number of recommendations that focus on developing a common patient-centred culture within the NHS that is based on transparency, high-quality care and timely response to evidence-based performance monitoring.

Integrated Care and Support: Our Shared Commitment (May 2013) This outlines the aim for all localities to have adopted models of joined-up (integrated) commissioning within the next two years and for integrated services to be the norm within five years

The NHS belongs to the people: A Call to Action (2013) This states that if current flat funding is combined with stagnation in service delivery, the funding gap will grow by £30bn between 2013/14 and 2020/21

The Care Act (2014) This requires that Local Authorities develop services that are wide-ranging and personalised ensuring that people can get better care that works for them including promoting wellbeing when carrying out any care and support functions.