

Leicester  
City Council

**WARDS AFFECTED  
ALL**

**Cabinet**

**3rd April 2006**

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## **City Strategy for Older People**

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### **Report of the Corporate Director, Adult & Community Services Department**

#### **1. Purpose of Report**

- 1.1 This report notes the progress that has been made on the production of a shared city strategy for older people and asks Cabinet to approve the strategy.

#### **2. Background**

- 2.1 The Joint Inspection of Older People's Services, reported July 2005, highlighted the need for a shared strategic document to provide a framework for the many areas of activity that are underway in Leicester City regarding older people's services. This strategy needed to be broad, encompassing not only the social care and health activity, but all activity that supported older people, including the Council's other Departments and the voluntary and community sectors.
- 2.2 The resultant action plan set a timescale for a completed strategy to be produced for April 2006. Due to the tight timescales, the strategy builds on existing consultation to inform its priorities, and will be widely consulted upon during its first year. Indeed, the need for a consultation framework for older people is one of the strategic priorities.
- 2.3 The work in preparing the draft has been led by Leicester City West Primary Care Trust and facilitated by Annie Topping, Assistant Director (Commissioning). Annie has linked with a range of forums, either specifically set up to work on the production of a draft, or pre-existing groups who have been asked to contribute. Through this, a range of Council staff have been engaged, notably planning staff, mental health staff, Older Persons Strategy Group leads, other wider departmental representatives including housing, leisure and transport, public health representatives and leads for work streams in relation to priority areas.

**3. Recommendations**

Cabinet is asked to approve the shared city strategy for older people.

**4. Headline Financial and Legal Implications**

**Financial**

This strategy outlines intentions to develop a coordinated approach to work that is already undertaken. The financial implications of any new work or priorities within the strategy will be scoped as part of the development of the implementation plan, once the strategy is adopted.

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**Legal**

There are no legal implications directly arising from this report

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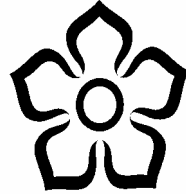
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<b>Key Decision</b>	No
<b>Reason</b>	N/A
<b>Appeared in Forward Plan</b>	No
<b>Executive or Council Decision</b>	Executive (Cabinet)

DJ043



Leicester  
City Council

Leicester City  
Older People Strategy  
(Draft 5 - final)

Prepared by: Annie Topping, Joint Assistant Director of  
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### Acronyms

Appendix 1 – Services provided by LCC Housing Department

Appendix 2 – Services for falls in Leicester City



## FOREWORD

*'Moving forward together'*

We are delighted to launch the Leicester City Strategy for Older People. For the first time we are able to share with the public and other organisations how the vision of the future for Leicester's diverse older population will be achieved jointly by Health, Council and community partners.

This document builds on the opinions of older people and their carers, taking into account the feedback that has been gathered through listening events, forums for older people and in work with groups and individuals. It brings together the many areas of good partnership working in the city and sets out a framework in which to take forward the recommendations of the Joint Inspection of Services to Older People in 2005. It is a living strategy and will continue to develop and respond to consultation over time.

We share an ambition to drive forward improvements in the well-being and health of older people, so that they can enjoy their later life, are able to participate fully as citizens of this city and feel safe and supported within their homes and communities.

As Champions of Older People, we will become champions for this strategy, and for ensuring that those responsible for achieving Leicester's priorities forge ever-stronger partnerships, working together to deliver our vision for older people.

Philip Parkinson  
Older People Champion,  
Eastern Leicester PCT

Councillor Parmjit Singh Gill  
Older People Champion,  
Leicester City Council

## EXECUTIVE SUMMARY

### 1.0 Purpose of the Plan

Older People services in Leicester are provided by a number of departments and organizations across the Local Authority, Health and the voluntary sector. There are also several plans in Leicester related to the older people services. The purpose of this document is to bring together the existing strategies into one single framework. The aim is to establish an integrated model of care and services that are responsive to the needs of the older people in Leicester City, which in turn will inform the commissioning process.

### 2.0 Leicester Vision for Older People Services

This strategy is underpinned by a joint vision:

*People from Leicester's diverse communities will enter their older years healthier and better resourced to enjoy life. They will benefit from an increasing range of community support and universal services that will enrich their health and well-being. Where needed people will benefit from services that encompass the following values:*

- *Accessible*
- *Culturally sensitive*
- *High quality*
- *Competent*
- *Support independence*
- *Maintain personal dignity*
- *Promote active citizenship.*

### 3.0 Older People in Leicester

2001 census showed there are just over 49,000 people living in Leicester who are aged over sixty. This is equivalent to about 17.5% of the total population. 57% are women and 43% are men. 21.9% of the population aged over 65 comes from an ethnic background.

Most of those over 60's live at the edge of the City. 95.4% of those over 65 reside in households, and around 47% live as couples. Many of those aged 65+ reported to provide 20 – 50+ hours of unpaid care each week.

Around 50% of those over 65 in the City are reported to have a limiting long-standing illness. Many of them do not have personal transport, which further worsen the issues of mobility and isolation.

Most people aged 65+ are adequately nourished and their intakes of most vitamins and minerals are generally sufficient. The LLR Health



Equity Audit project found emergency admission rates for those over 65s are significantly higher in Leicester. Cataract operation rate is also higher in the City. Admission rate for falls is similar to the East Midlands'.

Approximately 6.6% of the elderly population in Leicester has some form of cognitive impairment / dementia.

This means:

- Changing ethnic profile over time will require more services to meet the diverse needs of the ethnic communities in Leicester.
- Older people has a proportionally higher needs. With the increasing number of older people particularly those 70+, more services will be required to meet the needs.

#### **4.0 Services for Older People**

Much work has taken place across all agencies and departments within LCC to establish the local need and gaps described in this strategy. City specific analysis as well as LLR strategies have been taken into account to ensure the proposed priorities are in line with local and regional plans.

The strategy has examined the current provision in 10 different areas and identified actions to further improve the service. They will be further reviewed when the plans for improving services for older people are published by the National Director for Older People, following the issue of the White Paper. Leicester is a diverse City, and the need to address the needs of the BME communities is an underpinning principle that applies to all areas.

##### **4.1 Involving older people**

Patient and user involvement is at the heart of this strategy, and is particularly important when working with people with mental health needs. In Leicester, there is a range of specific planning / consultation groups for older people services in the City with various level of user involvement.

*Priorities:*

- To strengthen the existing networks and structures, and ensure effective user engagement, particularly with those from the BME communities and hard to reach groups e.g. the frail and elderly that are house bound.

##### **4.2 Well being in old age**

A sustainable community plays a key role to support older people stay healthier and live independently, and this will require the local authority, health and the voluntary / community sector working together. Health intelligence will be used to help focus on those people who are most in need of support.

*Priority:*

- To develop neighbourhood support networks for the deprived communities. Developments such as LIFT center will act as a hub for the local services where staff and advice / support from different agencies are co-located.

#### 4.3 Person Centred care

Feedback from users and the public highlighted that the important issues are more and better information, easier access to services, less bureaucracy in the process, being listened to, being in control and co-ordinated services across agencies.

*Priorities:*

- To implement single assessment process across health and social care.
- To promote self assessment process in social care.
- To increase the number of people receiving direct payments in social services.

#### 4.4 Promoting independence

To facilitate longer and healthier lives will require a different commissioning approach. Extra care housing and assistive technology will enable more community / home based options for care, and shift the balance from residential care to other alternatives.

*Priorities:*

- To integrate developments in intermediate care and rehabilitation facilities across health and social services.
- To develop closer to home provision.

#### 4.5 Falls

There is a strong emphasis on falls prevention and early detection of at risk factors. For those who have fallen, more work has to be done to standardise the assessment process and ensure care pathways are being adhered to.

*Priority:*

- To appoint a City falls co-ordinator to drive forward the development of an integrated falls services in the City.

#### 4.6 Strokes

A LLR strategy has just been developed, which will provide a framework for future service development. Better education to general public and healthcare professionals is needed to allow early diagnosis. Services e.g MRI scan at UHL can be further developed to improve access during out of hours. The structure of the stroke specialist team at UHL can be further strengthened to include other support. Integration across primary and secondary care, and social care is critical.

*Priorities:*

- To implement the LLR strategy for stroke.
- To develop a commissioning strategy for stroke.
- To explore the development of an early supportive discharge service.

#### 4.7 Long Term conditions (LTC)

There are 3 levels of care provision to support people with LTC: self care, disease specific and case management. So far work to date has been focused on setting up a case management team to support those users with very high intensity needs.

*Priorities:*

- To further develop the services for self care and disease specific care.
- To promote integrated working across different agencies, particularly between health and social services to support those people with very intensity needs.

#### 4.8 Older People with mental health needs

Currently older people with mental health needs do not have the same level of access to generic and mental health services. Some mainstream services also have difficulties to meet the needs of those users with both physical and mental health needs. Services will be improved for people with dementia, and a review of the current service provision for younger people with dementia is needed. The requirement for more specialist placements has also been highlighted.

*Priorities:*

- To ensure older people can access services available to adults, e.g. CMHPS and crisis resolution.
- To develop the model for older people mental health liaison.
- To determine the future direction for dementia care and integration of services.

#### 4.9 General hospital care

An integrated medicine model is being adopted by UHL for caring of older people. A matron is in post with specific responsibility for older people. In response to the NSF standard and the Healthcare Commission Inspection Report, UHL has planned a number of developments. These include appointment of a clinical director for older people services, introduction of a fragility score tool to facilitate early assessment, and a specialist team in A&E for older people.

*Priorities:*

- To meet NSF standard 4, and implement actions in the Healthcare Commission action plan that are related to general hospital care.
- To ensure patients are receiving prompt assessment, and effective planning discharge is in place.

#### 4.10 Carers

Carers play an important role in supporting and caring for the older people. Many of the carers are older people themselves, and in some cases, mental health users. The responsiveness and quality of services for the user are often the crucial issues for the carer. In Leicester, a carers strategy has been developed to improve the carer support by raising awareness and better identification of carers' needs.

*Priority:*

- To implement the multi-agency carers strategy.

### **5.0 Next Steps**

An integrated workforce plan will be developed for the priority areas, and the work will be led by Human Resources Leads from Health and Social Services.

A number of areas have identified as priorities for joint working. They are:

- Intermediate care services
- Assistive technology
- Accommodation and intensive support
- Managing people with Long Term Conditions

A number of system reforms have provided the levers to change how these services are being commissioned and provided, and the PCTs and LCC will work together to exploit these opportunities fully for the benefits of the older people in the City. In line with the White Paper, the PCTs and LCC will continue to strengthen the existing partnership

and further develop joint commissioning initiatives and framework including staff appointments.

It is proposed that the Leicester City Directions of Travel Group will be responsible for performance managing the overall delivery of this strategy.

Timetable:

Draft strategy to existing forums	Feb to Mar 2006
Amendments following feedbacks	Mar 2006
Sign off by organizations	Apr 2006
Establish joint commissioning group	Apr 2006

## 1 INTRODUCTION

This document describes the strategy for commissioning and development of services for older people in Leicester City. It brings together a number of existing plans across different agencies in the City into one single framework. The aim is to establish an integrated model of care and services that are responsive to the needs of the older people in Leicester City, with particular emphasis on prevention.

This strategy is the product of partnership working, and has included contributions from the Local Authority, health organizations in primary and secondary care, and voluntary sector organizations. They are:

- University Hospitals of Leicester (UHL)
- Leicestershire Partnership Trust (LPT)
- Leicester City Council Social Care & Health Department (SC&H)
- Leicester City Council Housing, Education, Regeneration and Culture and Environment and Development Departments
- Eastern Leicester Primary Care Trust (EL PCT)
- Leicester City West Primary Care Trust (LCW PCT)
- Age Concern, Leicester.
- Voluntary Action Leicester.
- Leicester City Supporting People Team.

The strategy is underpinned by a joint vision and principle:

*People from Leicester's diverse communities will enter their older years healthier and better resourced to enjoy life. They will benefit from an increasing range of community support and universal services that will enrich their health and well-being. Where needed people will benefit from services that encompass the following values:*

- *Accessible*
- *Culturally sensitive*
- *High quality*
- *Competent*
- *Support independence*
- *Maintain personal dignity*
- *Promote active citizenship.*

There are a number of local and national strategic documents with references to older people services, and they have been taken into account in this strategy. They are:

- Leicester City Council Corporate Plan 2003-2006
- Community Plan / Neighbourhood Renewal Plan 2006 - Healthier communities and older people section
- Leicester's Local Area Agreement (draft)
- Social Care Green Paper - Independence, well being and choice
- Leicester City SC&H Department Older Person' Service Plan
- Leicester City Supporting People Strategy 2005 - 2010
- NSF Older People (2001)

- NSF Mental Health (1999)
- Everybody's Business - Integrated Mental Health services for older adults: a service development guide
- White Paper – Our Health, Our Care, Our Say
- 'No secrets' – guidance on protection of vulnerable adults

The local partners recognize successful delivery of this strategy can only be achieved through collaboration with each other. All organisations involved are committed to this and will continue working in partnership with the users to make it happen. The strategy is a working document and aspects of it will continue to be developed and refined as new information emerges. This version of the strategy will form the foundation for further work to develop the services for older people in the City of Leicester.

## 2.0 PROFILE OF OLDER PEOPLE IN LEICESTER

### 2.1 Population

Leicester has a younger population as compared to the rest of UK. 2001 census showed there are just over 49,000 people living in Leicester who are aged over sixty. This is equivalent to about 17.5% of the total population. 57% (27, 975) are women and 43% (21,048) are men. Amongst them, 37,847 are over 65 years of age.

#### 2.1.1 Ethnicity

21.9% (8282) of the population aged over 65 comes from an ethnic background and this figure will rise steadily over future years.

#### 2.1.2 Residence

Most of those over 60's live at the edge of the City. Figure 1 shows the distribution of those over 65s in the city.

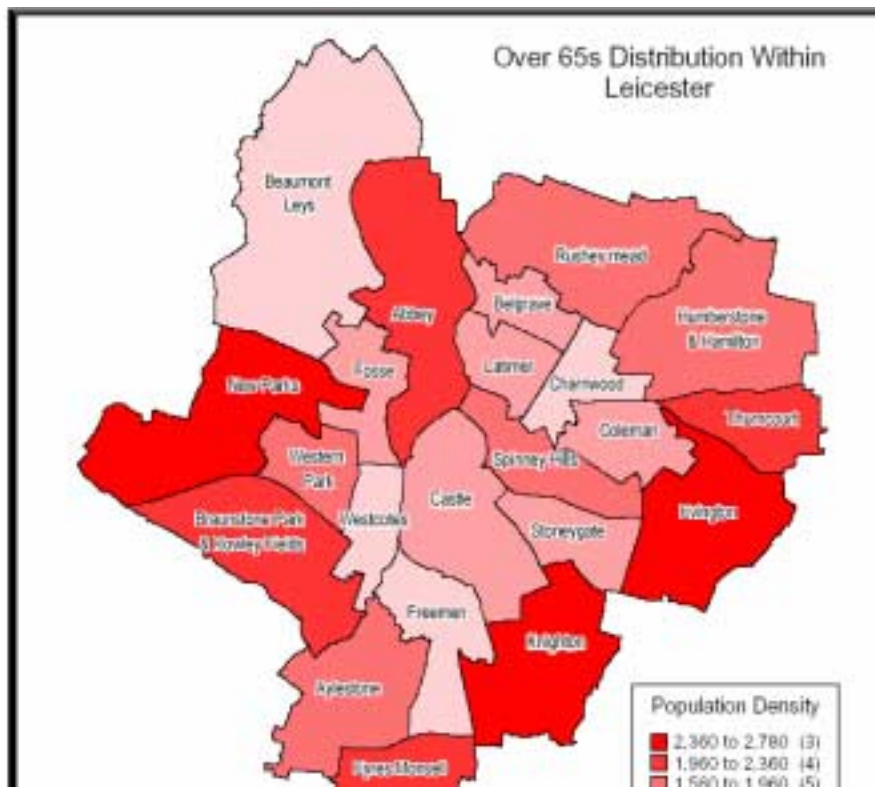
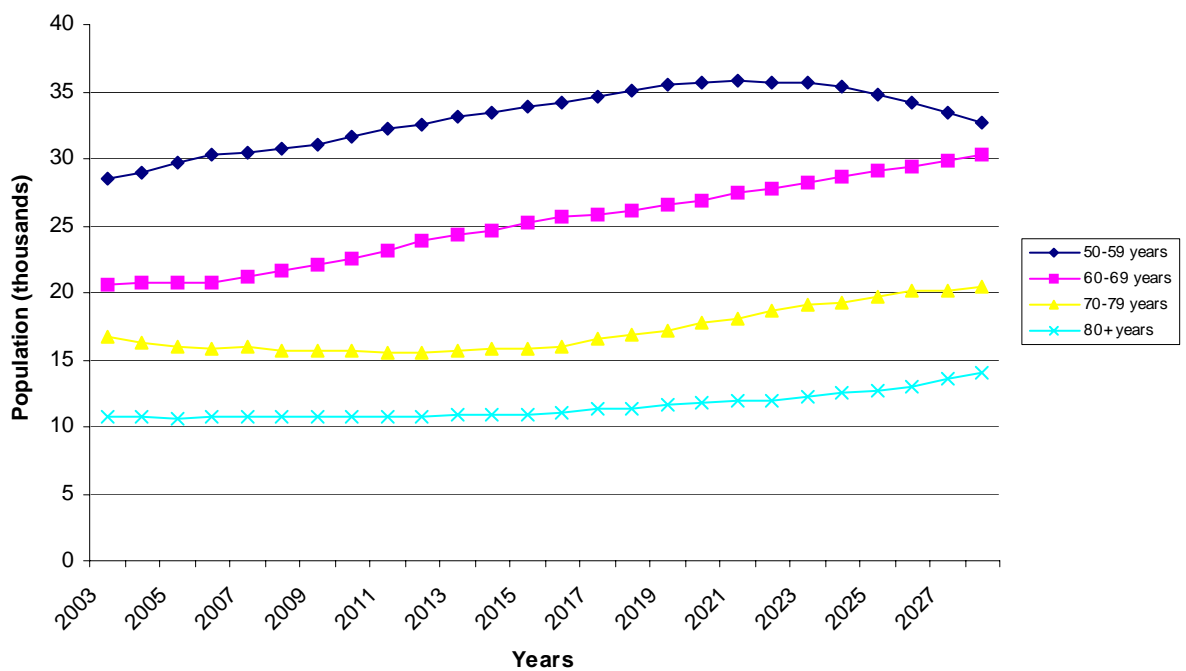


Figure 1: Over 65 distribution in Leicester City

2.1.3 Projections and Growth

The number of people aged 50+ is projected to increase over the next 25 years. The number of those aged between 50 to 69 is expected to grow at a faster rate in the next 15 to 20 years, while the number of those aged 70+ will increase steadily throughout the 25-year period. Diagram 2 shows the forecast increase by age groups.

In terms of females to males ratio, there will be little change for the over 50's population as a whole. However, marked changes are likely to be seen in the 80+ age group, where the ratio of 1.9 to 1 in 2003 will fall to 1.5 to 1 in 2028. Detailed population projection by ethnic group is not



available.

Figure 2: Older People population projections 2003 – 2023 by age group

2.1.4 Living Arrangements



95.4% (36,094) of those over 65 reside in households, and Knighton, Rushey Mead and Weston Park record a high proportion of elderly people living in privately owned property. 24.6% (9,310) of the over 65's population live in rented property from the City Council, and New Parks, Braunstone Park and Rowley Fields, and Eyres Monsell have the highest number. 11.2% (4,239) of those over 65 live in rented accommodation. Castle and Westcotes have the largest percentage of residents in rented property that are over 65. The areas with the largest proportion of socially rented accommodation are Belgrave, and Castle. Around 47% (17,788) of those over 65 live as couples.

### 2.1.5 Education

The census 2001 found that around 40% of the Leicester population were without any educational qualifications. Around 50% of those in their 50's and 60's and 67% of those aged 65 years and above had no qualifications.

### 2.1.6 Income

Around 40,000 (15,000 males and 24,000 females) elderly people received a State pension in 2003. Recent analysis of Pension Credit take up by the Advice & Economic Development Services of Leicester City Council indicates a link between means testing in older age, general areas of deprivation, and ethnicity. More work is required to understand the income available to the older persons population.

A number of studies have indicated a relationship between employment and income. A recent ONS study showed significant differences in employment rates for those aged over 50 depending on their jobs and qualifications. The report '*East Midlands Tomorrow: Ageing and Demographic Change*' has also highlighted two factors that contributed to the risk of social exclusion in older life of an ageing ethnic minority population. Firstly, migrants have a shorter working life in UK resulting in lesser time to build up a pension. This is particularly relevant to Asian pensioners who migrated to the UK more recently than black pensioners. Secondly, the over representation of ethnic minorities groups with low income and a higher rate of unemployment increases the risk of social exclusion both in working life and in retirement.

## 2.2 Lifestyle

### 2.2.1 Limiting Long Standing Illness

Around 50% (18,924) of those over 65 in the City are reported to have a limiting long-standing illness. Amongst them 25% (4,731) are male, 75% (14,193) are female, and 44% (8,326) live alone.

### 2.2.2 Unpaid Care

Around 1% (378) of those aged 65+ reported to provide 20 – 49 hours of unpaid care each week, and 5% (1892) reported to provide over 50 hours of unpaid care each week. Amongst these 1892 carers, 40.8% (629) are over the age of 75 years. Braunstone Park and Rowley Fields have been found to have the highest number of elderly carers. New Parks, Evington, Thurncourt and Eyres Monsell have higher than average levels.

Information from the Learning Disabilities Register (2005) shows there are 219 known carers of people with a learning disability over the age of 60 years in the City.

### 2.2.3 Transport

Around 36% (13,625) of the 65+ population reported that they have no personal transport. This means a large proportion of those who have a limiting long-standing illness and live alone do not have personal transport, which further worsen the issues of mobility and isolation.

### 2.2.4 Physical Activity

Physical activity helps to reduce the risk of heart disease and stroke, reduce weight and improve mobility. The Leicester Lifestyle Survey found the proportion undertaking any physical activity for 20-30 minutes or more declines with age. 79% in the 55-64 age group exercise regularly, compared to 73% in the 65-74 age group, and 51% in the over 75's. Self-perception of age also appears to play a role in physical activity. Around 22% of men and 26% of women in the 55+ age group felt they are too old to do so.

### 2.2.5 Smoking

Around 23% of the City's population smoke cigarettes. The Lifestyle survey (2002) showed 18% of those aged 55+ living in the most disadvantaged areas are smokers. Older smokers are also more reluctant to quit smoking, and only 50% of those 55 and over said they would consider doing so.

### 2.2.6 Alcohol

Evidence suggested people over 55 are more likely to drink every day. However, the Lifestyle Survey (2002) found that of those people who had drunk alcohol in the past twelve months, many had not drunk in the previous seven days or drunk within the recommended limits of 14 units. It should be noted that a large proportion of the sizable South Asian population in Leicester has never drunk.

### 2.2.7 Diet

The National Diet and Nutrition Survey (Finch et al., 1998) revealed most people aged 65+ are adequately nourished and their intakes of most vitamins and minerals are generally sufficient. However there is cause of concern for those without their own teeth, living in institutions, older age groups and low socio-economic groups. The Leicester Lifestyle Survey showed there is high awareness of the need for a healthy diet. Around 50% of those aged 55 plus said that they would like to eat more fruit and vegetables.

### 2.2.8 Daily Activities and Community

The Lifestyle Survey found 72% of those aged 55+ in the most disadvantaged areas are satisfied with their neighbourhood as a place to live, compared to 80% for the rest of the city. Activities such as talking to friends, listening to music, watching TVs, videos and DVDs also decline with age.

## 2.3 Health

### 2.3.1 Hospital Admission, Mortality Rate & Accidents

The LLR Health Equity Audit project found emergency admission rates for those over 65s are 50% higher in areas of socio economic deprivation, and significantly higher in Leicester with no clear pattern at a ward / general practice level. The rate of hospital admission for serious injury is 20 – 27% higher in Leicester than LLR, which is equivalent to around 750 excess admissions in the elderly per year.

Excess winter mortality for those 55+ is also significantly higher in the City, with 9 deaths per 10,000 of population compared to 3 or 4 per 10,000 in the county. The overall LLR mortality rate from accidents is 79 per 100,000 of population with no relationship to social deprivation.

### 2.3.2 Falls and fracture of the neck and femur

Admission rate for falls in the 65+ age group is similar to the East Midlands'. However, mortality attributable to falls in this age group is significantly higher in Leicester than the East Midlands or England, although the number is small.

The local data also shows admission rate is higher in women than men, and there is no obvious equity dimension to the distribution of admissions.

### 2.3.3 Cataract operation rates

The average rate in LLR is 23 per 100 of population for those 65 and above. The rate is higher in the City, and there is a positive correlation of cataract operations with deprivation.

#### 2.3.4 Hip & knee replacement rates

The average hip and knee replacement rate in LLR for those 65+ is 4.5 and 4 per 1,000 respectively. The most deprived areas have relatively low rates, a negative correlation with deprivation. The rate of hip replacement is higher in women.

#### 2.3.5 Mental Health & Dementia

National estimates of mental health problems in older adults suggest a prevalence of around 40% of those attending their GP, 50% of general hospital inpatients, and 60% of care home residents. National depression prevalence rate indicates between 15% (5681) and 21% (7954) of those over 65 have depression / severe depression in Leicester.

Approximately 6.6% (2,500) of the elderly population in Leicester has some form of cognitive impairment / dementia. Table 2 shows the forecast of the number of people with dementia in Leicester.

Age	2001		2006		2011		2016		2021		2026	
	Total	MH*	Total	MH*	Total	MH*	Total	MH*	Total	MH*	Total	MH*
65-74	19233	442	18400	423	18500	425	20800	478	23000	529	24600	56
75-84	13728	998	13100	943	12300	885	12600	907	13200	950	15200	10
85+	4866	1066	5000	1095	5400	1183	5700	1248	6200	1358	6900	15
<b>All</b>	<b>37827</b>	<b>2496</b>	<b>36500</b>	<b>2461</b>	<b>36200</b>	<b>2494</b>	<b>39100</b>	<b>2634</b>	<b>42400</b>	<b>2837</b>	<b>46700</b>	<b>31</b>

Table 2: Forecast of people with dementia using prevalence rates  
MH\* - no of people with dementia

#### 2.3.6 Learning Disabilities

The Learning Disability Register (2005) shows there are 81 people aged 65+ with learning disabilities in Leicester. This is equivalent to 5.5% of all adults with learning disabilities. A 10 year forecast of survival rate carried out by the Leicester University in 2003 is showed in table 3.

Age Group	2003	2013	Increase %
60 – 65	110	163	49
70+	42	66	57

Table 3: Leicester City survival data 10 year forecast (Source: Leicester University)

### 2.3.7 Oral Health

35% of 65-74 year olds and 25% of those aged 75 and over are registered with a General Dental Practitioner. Approximately 30% of general dental practices in Leicester City are on the first floor, and this does not enhance easy access.

Older people are less likely to attend the dentist. However, oral cancer is more frequently found in older adults particularly those from deprived backgrounds. Together with general poorer health status and reduce in mobility / ability to care for themselves, the level of needs in elderly are likely to increase.

## 3.0 INVOLVING OLDER PEOPLE

### 3.1 Strategic Aim

To ensure Older People are actively involved in planning and delivering of services across the Health & Social Care Community.

The objectives are:

- To deliver a more strategic approach to user involvement that enables effective planning across different agencies and the best use of resources.
- To ensure that all communities (geographic or interest) in Leicester are able to participate effectively, with particular emphasis on those who are currently not involved in our activities.
- To ensure that the outcome of involvement activities is used to inform the Health & Social Care Communities.

### 3.2 Target Group

In line with NSF for Older People, the term 'Older People' refers to those over 50 and is divided into 3 subgroups:

- 50+ 'Young' older people –Those between 50 and 64 who are usually  
at the pre-retirement stage of their economic lives.
- 65+ Older people – 65 to 79 year olds who have retired or are working  
reduced hours.

- 80 + 'Older' older people – some of whom are frail.

Currently most of the users participate in the consultation activities are those over 65 of age. More work has to be done to involve the younger user group.

### 3.3 Strategic Analysis

Section 11 of the Health and Social Care Act 2001 requires the health and social care organisations to consult and involve the public in:

- Ongoing planning of services.
- Developing and considering proposals for service changes.
- Decisions that affect how services operate.

Currently each organization employs a range of methods to consult and engage with their service users and carers. These include:

- People being involved individually in assessment and care planning processes.
- Feedbacks from questionnaires, quality checks and complaints.
- Patient/user committees and advocacy at a department and service level.
- High-level involvement in service planning and whole organisation issues e.g. project groups, planning day.

Involvement and advocacy are particularly important when working with people with mental health needs. The PCTs have funded a Specialist Advocacy Service for older people with dementia. Further work is needed to address the gaps in specialist advocacy for people with functional health problems, within institutional care and their carers. Older people with mental health needs are regularly consulted during service reviews and within assessments and care planning.

In Leicester, a number of consultative forums for older people services are already existed. They are:

#### a) Leicester City Council Older People's Consultative Forum

This is a user forum and is open to people who are 55+ from all ethnic and cultural background. The aim of the forum is to empower users and support older people to lead fuller lives in the community. The forum meets monthly and is attended by representatives from the City PCTs, Housing department, Voluntary Action Leicester, Social Care & Health and other City Council Departments. Champions of older people and also attend this forum. Members can raise specific questions relating to older people services, and senior officers of the Council are invited to respond to specific issues if necessary.

#### b) Leicester City Council Forum for Older People- Steering group

This group meets monthly and forms part of the Older People Consultative Forum. Membership includes council members, and representatives from PCTs, and Voluntary Action Leicester.

c) The Older Persons Mental Health Planning Group (OPMHPG)

This is a multi agency planning group and the role is to monitor the delivery of the OPMH Strategy 2006/9. The group meets bi-monthly and reports to the Leicester City Older Persons Direction Of Travel Group. The views of carers are sourced through involvement on the planning group, and a bi-yearly consultation exercise. More work needs to be carried to engage the users.

d) Patient and Public Involvement (PPI) Forum

PPI Forum plays an active role in health related decision making within their communities. There is one PPI forum for each NHS Trust and PCT in England, and the City PCTs, LPT and UHL are required to consult with their PPI forum on key strategic issues.

### 3.4 Commissioning Priorities

In terms of the intensity of user involvement and the level of interaction and feedback, there are variations within and across organizations. A recent review by the Commission for Health Improvement (CHI) has confirmed the need for improvement, and the next step is to develop an implementation plan to deliver this strategy across different agencies in the City.

Currently, there is a range of specific planning / consultation groups for older people services in the City with various level of user involvement. While there are notable achievements, the need is to strengthen these structures and ensure effective user engagement, particularly with those from the BME communities and the hard to reach groups e.g. frail and elderly that are house bound, asylum seekers and homeless. Different format and languages should be used in order to address the diverse needs of the population.

It has been agreed that there will be further consultation with older people during 2006 on specific elements of this strategy.

### 3.5 Action Plan

Priorities	Measurable Outcome	Lead Agency	Time scale	£ 2006/7	£ 2007/8	£ 2008/9	Source of funding
Improve the involvement of the BME	Feedback from target	LCC & PCT	On going	Staff Time	Staff Time	Staff Time	Existing resources

communities and those hard to reach groups	group to inform planning						
To establish the input of older people to the Area Committees		LCC	2006-7	Staff time			Existing resources

## 4.0 WELL BEING IN OLD AGE

### 4.1 Strategic Aim

To improve and maintain the well being of older people by:

- Improving the access to community services.
- Enabling older people to live in their own homes.

### 4.2 Strategic Analysis

It has not been possible to define the term ‘well-being’, as this implies to different things to different people at different stages of their lives. However, it is clear that the community has a major role to play in supporting people’s well-being. Older people have identified that the ability to access all the services such as NHS, social care, and other agencies e.g. housing and benefits providing services on the same site would improve their well being.

Research also shows fear of crime is an important issue for older people, which impacts on the community safety and individual well being.

A community is made by a wide range of informal and formal networks / structures. These include family, friends, neighbours, shops, health, housing, education, transport, libraries, and neighbourhood and community centres etc. A sustainable community to support older people stay healthier and live independently will require different organisations working together including the voluntary sector. This section describes the approach and priorities of different agencies in Leicester City. Activities will be co-ordinated and delivered by the Leicester Partnership via the ‘Strategy For Leicester’ and the Local Area Agreement.

#### 4.2.1 Public Health: Choosing Health in Leicester

The aim is to improve the health of Leicester residents and reduce health inequalities. The target is to reduce the life expectancy gap between Leicester and the rest of the country by 10% by 2010.



The Annual Report of the Director of Public Health 2005 has established a baseline of current health status in the city, and identified 'the Leicester Public health Challenge': 10 priority areas for action. Many of these actions are relevant to older people and they have included:

- Work towards a city with smoke-free public places
- Reduce the upward trend in obesity
- Review the impact of alcohol on health and develop a multi-agency strategy for reducing the harm it causes locally.
- Take action to minimize the stigma of mental illness
- Review the health needs of asylum seekers
- Continue to tackle the specific health needs of black and minority ethnic communities

The above actions will be taken forward through the PCTs' SDDP and the Local Area Agreement. Please refer to [www.phleicester.org](http://www.phleicester.org) for full details of Choosing Health in Leicester.

#### 4.2.2 Locality / Neighbourhood initiatives

The PCTs and SC&H have worked together to develop the local LIFT strategic plans, with the aim to promote service planning for neighbourhoods. The first health and social care centre has opened in 2006 in Braunstone, and accommodates both social care and NHS staff. Next stage of the development will involve broad plans to establish local networks.

#### 4.2.3 Cultural Services

These include arts, sport, media, museums, heritage, markets, parks and green spaces, leisure and learning. The aims are to:

- Improve access and participation by all ages.
- Make the city a more attractive place.
- Improve health and well being of people living in Leicester.
- Promote community cohesion.

Leicester City Council monitors the take up of different services, and the information is used to inform service planning. Current analysis shows the take up of services by older people is above average in Museums, Markets and Parks. The take up in Sports and Arts is lower than expected, and targets have been set for improvement. Targets have also been set to improve the take up of Arts, Museums and Sports facilities by disabled people. A range of interventions is in place to support the delivery of these targets. Please refer to 'Diverse City: Leicester's multi-agency Cultural Strategy' for more details.

#### 4.2.4 Sports & leisure services

The aim is to promote active lifestyle and encourage the participation by older people. Currently 8% of the users are aged over 60, and most of them attend the 'active 50+' Clubs. The target is to increase the percentage attendance to 20% in the next 3 years. Leicester City Council has put in place a number of new initiatives to engage with the communities and health agencies in the City. Greater discounted admissions will also be implemented, and awareness will be raised by better communication systems.

#### 4.2.5 Transport

The aim is to support more older people to live independently by improving physical access to the transport system. This is a relatively new and complex area for the local authority to address. Local research has highlighted a number of issues related to accessibility, which include frequency / availability, physical and financial. To take this forward, the City Council will continue to work closely with local partners and ensure resources are directed to those socially excluded neighbourhoods and groups. Work to identify and prioritise the target areas has already been completed. Please refer to the 'Central Leicestershire Local Transport Plan' for more details

As a result of changes in government policy, LCC concessionary pass holders will be able to travel free on local bus services as from April 2006. This applies to journeys within Leicester City on Mondays to Fridays after 0930, and any time at weekends. The cost implications of this development are currently being assessed, and it is unclear at this stage if this can be further extended to include journeys during peak hours and outside Leicester.

#### 4.2.6 Housing and Housing Services

Housing is key to health and well being, and the aim is to provide accessible, appropriate, and affordable housing for all residents. Leicester City Council is currently in the process of producing its first Older Persons Housing Strategy. The strategy will also help to review its existing housing and housing support services. To inform the commissioning priorities, a focused survey has been commissioned to take place in Spring 2006.

The Housing Department currently provides a range of services to support the independence of older people. The department can also make referrals to other providers. Please refer to appendix 1 for details of schemes.

#### 4.2.7 Voluntary and Community Sector (VCS)

The VCS plays a key role in the community. It helps to break down social isolation in old age, and often reaches people more effectively than a statutory provider. VSC organizations provide a very wide range of services. These include day care, luncheon clubs, information and advice, education, support groups, social groups, home support, transport, outings and opportunities for physical activities and volunteering. There are also support groups for older people or their carers with specific medical conditions or disabilities. In Leicester, there are 1800 identified voluntary and community groups and 800 are registered VAL members.

#### 4.2.8 Others

Income maximization is an important element of the well being agenda. The welfare right teams play a key role by increasing the take up of attendance allowance, which contributes to the payment of care packages. This in turn helps people to live independently.

### 4.3 Diversity Issues

Studies showed older people have more in common in respect of their culture, ethnicity, religion and socialization. However, Leicester is a diverse city and particular attention has to be paid to the needs of the BME communities. Different strategies and approaches have to be explored to ensure reaching out to older people from different backgrounds. Public Health has planned a programme of health equity audits to identify inequalities in access. Work is also underway to improve ethnic monitoring in primary care.

### 4.4 Workforce & training issues

Expansion of the capacity and capability of the public health team is required in order to deliver the Choosing Health agenda.

VSC has limited capacity and this restricts its role and commitment to participate.

### 4.5 Commissioning Priorities

- To develop the Choosing Health programme in line with Department of Health national priorities for Health.
- To develop a model for locality / neighbourhood support networks for older people with a priority in the 'supra output' areas with highest deprivation.

## 4.6 Action Plan

Priorities	Measurable Outcome	Lead Agency	Time scale	£ 2006/7	£ 2007/8	£ 2008/9	Source of funding
To implement the Choosing Health actions		Public Health	2006-9	TBA	TBA	TBA	SDDP LAA
To develop measurements for 'well-being'	Indicators in place	Leicester Partnership	2006-7	Staff Time			Existing resources
To improve up take of services and participation by older people	Increase in uptake	LCC	2006-9	Staff Time	Staff Time	Staff Time	Existing resources
To implement the transport policy on free bus service	Policy in place	LCC	Apr 06	Staff Time	Staff Time	Staff Time	Existing resources
To meet the PSA target for take up of pension credit and attendance allowance	Met targets	LCC	On going	Staff time	Staff time	Staff time	Existing resources
To carry out the older people housing needs survey	Completion of survey	LCC	Aug 2006	Jeann e Nichol s to confir m			LCC
Produce an Older People's Housing Strategy	Strategy in place	LCC	2006-7	Staff Time			Existing resources
Develop a model for locality support networks	An agreed model is identified	SC&H & PCT	2006-7	Staff Time	Staff Time		DoH POPP funding

## 5.0 PERSON CENTRED CARE

### 5.1 Strategic Aim

- To improve & streamline access to health, care and support services
- To enable older people to control the processes and services that they might need
- To promote choice

## 5.2 Strategic Analysis

Access & information are critical in the development of a person centred service. Feedback from users, carers and the public highlighted that the important issues are:

- More and better information
- Easier access to services
- Less bureaucracy in the process
- Being listened to
- Being in control
- Co-ordinated services across agencies

### 5.2.1 Information

Currently, different agencies have their own information made available to the public. Feedback from the recent White Paper consultation indicated that older people do not feel they can access the information required. 70% of those attended the Birmingham citizen's summit last autumn said the ability to access all those services on one site would improve their well being. Quite often information available is either fragmented and being made available in the wrong place. New and creative ways of giving information may fill some of the existing gaps and should be considered, e.g. mobile libraries, milk delivery, utility bills, supermarkets or mobile hairdressers. A shared approach and signposting leaflet across different agencies would be beneficial.

### 5.2.2 Access to agencies

Access to housing related support services is either by self referral, or referral by a range of agencies e.g. SC&H or Housing. Older people can find out details about what services there are in the city by going to the Supporting People website at [www.leicester.gov.uk/supportingpeople](http://www.leicester.gov.uk/supportingpeople).

Access to SC&H older people services is through the Access Teams located at Grey Friars in the city Centre. Over 95% of all contacts are made by telephone.

At the Braunstone Health & Social Care Centre, the jointly employed Community Advice Worker acts as a central referral point for Health and Social Services. Signposting services are also provided. This is a new model of working and yet to be fully evaluated. However, this has improved current access by offering a one-stop service for older people.

Cross agencies referrals are made if a need is identified. Some contact is made directly with specialist services e.g. Community Mental Health social work, via ward meetings. There are some shared referral arrangements existed across health and social care e.g. intermediate care.

### 5.2.3 Single Assessment Process (SAP)

The aim of SAP is to reduce duplication and promote joined up working across different agencies. At the moment, different organizations have their own assessment processes, and users with complex needs often have to undergo different assessment process in accessing different elements of care.

Work has already begun to implement the SAP but the progress so far has been slow. Plans have been made to roll out the SAP including a dedicated manager to work across health and social service.

### 5.2.4 Self-Assessment

Self assessment is central to a patient led service, and supported by the Social Care Green Paper – Independence, well being and choice. To take this forward, Leicester City Council is currently exploring opportunities for real self-assessment. It is recognized that some people will need help to carry out self-assessment e.g. access to information technology, and plans will take these issues into account.

### 5.2.5 Choice & Direct Payments

Making choice a reality is a relatively a new venture in Health and Social Services. In Social Care & Health, the challenge is to modernise many of the larger scale and more institutional in-house services, and provide a range of flexible services that are able to meet the individual needs.

The introduction of direct payments enables people to make more choices about services that are available to them. This puts users / carers in control, and is a significant step moving forward the choice agenda.

Direct payments are cash payments made to individuals by local authorities. This allows people with assessed eligible needs to purchase services directly or employ their own staff as an alternative to services provided by the local authority. Direct payments are currently available in Leicester to adults, older people, and people with mental illness and learning disabilities. In 2004- 5, 15 older people had received Direct Payments. While the number is small, it is growing steadily and the plan is to increase this further.

Leicester is one of the thirteen DoH pilot sites selected to develop individual budgets in November 2005. Although older people are not currently within the scope of the pilot, lessons learnt will help future implementation. A strategy to further develop Direct Payments and other initiatives to promote choice such as Individual Budgets will be developed in 2007.

In Health, arrangements are already in place to allow choice at the point of referral. As from December 2005, patients will be able to choose from 4 – 5 providers for their elective operations. Choice will expand more widely in line with the White Paper, and there will be greater variety of services to be provided in the primary care.

#### 5.2.6 Planning in learning disabilities

The White Paper 'Valuing People' raised the need for person centred planning as a way to achieve community involvement, and ensure access to mainstream health and social care services for people of all ages with learning disabilities. In Leicester, the significance of this is being recognised by the appointment of a Person Centred Planning Co-ordinator. The aim is to create a culture where an individual's right, wishes, and dreams are the starting point for change and the centre of the decision making process. Support is designed around the matters that are important to each individual and their families, with their full involvement. Modernisation of services into the community is taking place, and integration of specialist health and social care services will be further developed through joint working as from April 2006. It has been recognised that people from Asian communities often miss out on information about services and developments that could help them. In order for people with learning disabilities from these communities to start making their own plans, both they and the important people in their lives need to understand what person planning is. With this in mind an Asian Person Centred Planning Toolkit has been developed. This consists of a guide to raise the awareness of communities, and help people facilitating the plan to deal with the culturally sensitive issues in an appropriate manner.

### 5.3 **Diversity Issues**

The needs of new and existing BME groups have to be considered in service reviews and development of strategies such as access, information and service provision. In particular, different approaches have to be taken to communicate with those hard to reach groups. Access to some services by BME communities is known to be low e.g. intermediate care. Issues have to be identified and addressed to ensure equity. There are also diversity issues for those older people who are gay and lesbian, and with substance misuse including alcohol.

Different age ranges within the older people group also have different needs. Strategies to promote control and choice have to ensure they are appropriate to all individuals.

#### **5.4 Workforce and training issues**

The Social Care Green Paper signals a very different type of workforce. In the future, social care staff will act as facilitators or care navigators and assist users to exercise choice and control. This is very different from the current position where staff control the services and give them out as required.

At the moment, the make up of the workforce does not reflect the population profile. This has to be addressed particularly in areas that provide direct help and support to older people.

Older people can play a key role in the current workforce. Areas such as disease self-management, social support and advocacy could benefit from the contributions from older people.

To develop direct payments as a mainstream service will need to address issues such as employment status, recruitment, development and training of personal assistants.

#### **5.5 Commissioning Priorities**

To improve the current information provision, the PCTs and LCC will explore and consider a joint model, and take advantage of opportunity such as Braunstone Social Care & Health Centre.

In order to increase the amount of Direct Payments to be offered, it will require major changes in procurement, contracting and market management processes. Currently many services are provided in-house in large building based services, or via block contracts with providers. Diversion of funding on an individual basis is unlikely to reduce the cost of the blocked contract / large services. A balance has to be made between the financial gain from bulk purchasing and the flexibility to enable individuals to purchase their own care. Changes will need careful management in order not to de-stabilise the market.

Short and longer-term financial planning for Direct Payments also needs to be addressed in commissioning budgets. For example, if people are encouraged to employ Personal Assistants using Direct Payments rather than receiving domiciliary care, then the budget and target numbers of people / packages to be provided will have to adjust accordingly.

#### **5.6 Action Plan**



Action	Measurable Outcome	Lead Agency	Time scale	£ 2006/7	£ 2007/8	£ 2008/9	Source of funding
Explore a joint model and develop co-ordinated approach to provide information	Improved access to information	SC&H & PCT	2007-8		Staff time		Existing resources
Develop models for self-assessment	Numbers of people able to access services via self-assessment	SC&H	April 2008	Staff time			Existing resources
Implement SAP	Identified a project manager  Review action plan & agree delivery plan	C&H, PCT & UHL	May 2006	Staff time			Existing resources in PCT and SC&H
Roll out direct payment & increase the uptake by older people	Increased numbers of older people receiving Direct Payments	SC&H	2006-7	30	50	75	DoH pump priming fund
Develop the strategy for Direct Payment & individualised budget	Produced the strategy	SC&H	2007-8		Staff time		Existing resources
Develop a fit for purpose workforce	Met new requirements and other targets e.g. NVQ	SC&H & PCT	On-going	Staff time	Staff time	Staff time	Existing resources

## 6.0 PROMOTING INDEPENDENCE

## 6.1 Strategic Aim

To facilitate longer and healthier lives for all older people and their carers by promoting independence, choice and control:

- Support the development of community & universal services
- Develop social care, health & housing options that facilitate social inclusion and quality of life for older people with higher needs.
- Increase the home-based options for care and shift the balance from residential care to other alternatives
- Implement the vulnerable adults policy and procedures
- Develop good continence management

## 6.2 Strategic Analysis

### 6.2.1 Social Care

The Social Care and Health Department of Leicester City Council provides social work assessment and care management for older people aged sixty-five and above. Assessments are carried out within the National Fair Access to Care eligibility criteria. Each year the Local Authorities decide which of the four standard bands within this will be used, and the groups of users these will apply to. (Each year, Local Authorities decide which of the four standard bands within this criteria will be the ones for which people will be eligible for services.) In recent years, Leicester has set this to include those people who have been assessed to have critical or substantial needs but not the ones with low or moderate needs. Policy has been to target those in greatest need, which is where the majority of the social care budget is currently spent. At the time of referral, many service users are already experiencing ill health and / or may be at risk in their present situations. Services are often delivered in order to deal with or to avert crises.

The recent Social Care Green Paper is putting a greater emphasis on maintaining full active lifestyles and promoting independence, for a wider range of older people starting from fifty plus. No additional funding is available, and the expectation is that this will be resourced from the existing revenue and through more creative use of the full range of Council and universal services available.

People with low and medium needs are currently supported, where possible, to use universal services. However, many of these services are not easily accessible by older people. Social care also funds some preventative services that are not based on eligibility criteria. The aim of these services is to prevent further increase in the level of needs e.g. luncheon clubs.

Currently domiciliary care is the service commissioned for the largest number of older people. However, the largest proportion of the

resources is spent on a smaller number of people in residential care homes, including those providing nursing care.

A major service gap has been identified. At the moment, there is no 24 hours on-call support available to older people living in their own homes, or to services that provide both accommodation and support such as sheltered housing. Response to care alarm services is via a call to a nominated informal carer or the emergency services, and paid staff support service is not available. As a result, the only service option for people whose needs cannot be met at home with day time domiciliary care is to move into either residential or nursing care.

### 6.2.2 Vulnerable adults

The aim is to create a framework to support and protect those who are at risk of abuse. All responsible agencies including PCTs, LCC and the voluntary sector will work together to ensure a coherent policy and a consistent effective approach to any circumstances giving ground for concern or formal complaints or expressions of anxiety. Users, carers and representative groups will also be involved where appropriate.

In the City, a multi-agency adult safeguarding board has been established to take forward this development. Multi-agency training is key and each organisation contributes to the training fund.

### 6.2.3 Medicines Management

Older people are heavier users of medicines than younger people. They are also more vulnerable to the side effects of medicines. All this, together with the deterioration of mental function in old age, leads to a greater risk of confusion and risk of harm with regard to medicine taking. This will be addressed by having a robust plan to focus on the medication needs of older people.

### 6.2.4 Extra Care Housing

In partnership with Hanover Housing Association and Supporting People, the SC&H Department has placed a successful bid in 2004 for the DoH Grant and Regional Housing Corporation funding. This was for the capital build element of Leicester's first extra care housing project with 24 hours support.

The building work is due to begin in June 2006 and the unit will be operational in early 2007. A separate contract will be tendered for the care and support service. The care element will be funded by SC&H from existing residential and domiciliary care resources, and Supporting People has made a commitment to identify resources for the housing related support element in the 2007 budget setting.

### 6.2.5 Nursing Home Review

A review of Leicester City Council elderly person's homes is being carried out. This will help to inform the strategy for the future.

### 6.2.6 Assistive Technology

Across the country Local Authorities are expanding the range of technology available through Community Alarm and Community Equipment Services. The aim is to monitor people's safety, provide 24 hours response services when needed, reduce risks and enhance independence. In some areas work is being done in partnership with Health colleagues to develop telehealth services. Pilots evaluations show assistive technology can support length of time people live independently, reduce carers' stress levels and decrease costs by reducing or postponing the need for residential care.

Department of Health funding is being made available to Local Authorities for two years from 2006/2007. Through the grant, DoH expects the councils to invest in telecare to help support individuals in the community. The national target is to support an additional 160,000 older people to live at home, safely, securely, and reduce the number of avoidable admissions to residential / nursing care and hospital.

A draft multi-agency strategy for assistive technology will be developed by March 2006.

### 6.2.7 Supporting People

Supporting People plans and commissions housing related support services to vulnerable client groups. This includes sheltered housing, community alarms and floating support services to older people. Older people are the largest client group receiving Supporting People services.

Leicester has a significantly lower quantity of older persons provision (both supported accommodation and floating support\* type services) than national and regional averages, and lower unit costs. There are 1400 older people receiving supported accommodation services, 124 receiving floating support services and around 3500 receiving SP funded community alarm services. There are 10 sheltered housing schemes that support BME elders. There are 79 people living in very sheltered supported accommodation. However, they do not have on site care and support. Supporting People is currently jointly commissioning the first Extra Care Sheltered Housing Scheme in Leicester, which will support 57 people.

The Supporting People Strategy (2005-10) identified a need to increase the number of Extra Care housing schemes over the next 10 years. It also identified a need for more floating support services to older people, more supported accommodation for older people with mental health needs and supported accommodation for Chinese elders. However, further analysis will be needed to confirm this requirement.

A strategic review of Community Alarms and floating support services will be carried out during 2006/7 to establish how they should be delivered to older people in the future. It will be important that these reviews are informed by robust needs information.

\* These are housing related support services that go to people in their own home as distinct from supported housing services where people have to move into the scheme to receive the support

#### 6.2.8 Housing

Please refer to section 4.2.6 for details.

#### 6.2.9 Single Assessment Process

Please refer to section 5.2.3 for details.

#### 6.2.10 Direct Payments

Please refer to section 5.2.5 for details.

#### 6.2.11 Community nursing, Intermediate Care & rehabilitation

The PCTs provide district nursing services, and recently reviewed the role of the nurses with plans for development. PCTs have also employed other specialist nurses to provide specific care management e.g. continence care and heart failure.

The aim of intermediate care services is to avoid unnecessary hospital admissions or long-term residential care. A range of services and care packages are provided by the PCT and SC&H to users as close to home as possible. These include:

- A community intermediate scheme (incorporated the rapid access support & hospital at home services) providing a home based service up to 14 days.
- 10 clinical intermediate care bed (CICB) available up to a maximum stay of 14 days
- A 12 bedded residential rehabilitation facility at Brookside Court for social care assessment and re-enablement up to a maximum of 6 weeks.

- Intensive Community Independence Service (ICIS) provides a domiciliary service for a maximum of 6 weeks period.
- Night nursing service for all adult city residents up to 11pm everyday.

Since summer 2005, city care homes can also access the community intermediate scheme. Additional specialist input has been commissioned to provide specialist support. Medical consultant support is now in place, together with pharmacy advisory support. Further work is required to provide mental health support.

Currently, certain rehabilitation facility is provided by UHL at Leicester General Hospital on ward 11 and 18. The PCTs need to understand the bed requirement for alternative provision outside the acute hospitals. Longer term rehabilitation is currently commissioned from the county PCTs through community hospitals. There had been significant delays in the assessment and discharge of patients from the community hospital beds. The situation has now been improved and will be maintained. Leicester residents have indicated that they would prefer to access city based services. The plan is to develop alternative options including provisions in the City.

### **6.3 Diversity Issues**

A large proportion of the older people population has some kind of mental health problem, and there is a need to ensure older people with mental health needs have equitable access to local services. This is also highlighted in the Healthcare Commission report (2005).

Currently there is not sufficient appropriate day service capacity to meet the needs of Leicester's ethnic communities, where the elderly population is steadily increasing.

A programme of Equality Impact Assessment is due to be carried out over the next two years on all major areas of policy and service. Issues identified will be fed into service plans and departmental equality plans as appropriate.

Current issues for Intermediate Care Services are:

- Uptake of services not reflective of population profile
- More female to male uptake
- Mental Health needs are not well served

### **6.4 Workforce & training Issues**

A number of developments are about to be introduced in Social Care, and this will require appropriate training for staff and users in some cases. They are:

- 'Heritage' model to be incorporated in the assessment process

- Assistive Technology
- Equality Impact Assessments
- Supporting People developments

Issues related to the Intermediate Care Services are:

- The make up of current workforce does not reflect the population profile.
- To develop more opportunities for cross agencies working e.g. generic worker role.
- Extend the current skills base to include IV antibiotics, cannulation, and advanced nurse practice skills.

## 6.5 Commissioning Priorities

Overall, there is a need to change the current care provision from traditional residential based services to a range of individualised and home-based options. Development such as the Extra Care housing and assistive technology will enable more older people to live independently.

The PCTs and SC&H have to agree a joint approach to the current Intermediate Care services ensuring its fitness for purpose. Priorities for development are:

- Extra Care Scheme and assistive technology.
- Intermediate care and rehabilitation services.
- Accommodation and intensive support.
- Pooled budget and integrated service provision across health & social care intermediate care services.
- Improving access for older people with mental health difficulties.

## 6.6 Action Plan

Action	Measurable Outcome	Lead Agency	Time Scale	£ 2006/7	£ 2007/8	£ 2008/9	Source of funding
To complete the residential home review	Strategy for residential care in place	SC&H	Apr 06	Staff time			Existing resources
Increase Extra Care places	57 place unit by 2007	SC&H	2007/8	Capital 8 million	Revenue		Capital* Revenue-SC&H, Supportin

							g People
Develop Assistive Technology strategy	Draft multi-agency strategy by March 2006  Equipment and call out service in place Aug 06	SC&H	Jun 06	174K estimate	290K estimate	TBA	Preventative Technology Grant  Potential use of other funding streams to be assessed
Undertake a commissioning review of the current intermediate care & rehabilitation services	Completed review  Agree future model	SC&H & PCT	2006-7	Staff time	TBA		Invest to save
Improve day service provision for BME groups	Completed review  Long-term strategy in place	SC&H	Mar 06  Mar 07	Staff time			Existing resources
Develop intermediate care model for people with organic mental health problems	Service modelling work for crisis response  Review IC strategy + model	SC&H & LPT  PCT & SC&H	Sept 06  Sept 06	Staff time	TBA		SDDP 07/08

Capital\* - DoH Extra Care Housing Grant, Regional Housing Corporation, Hanover Housing

## 7.0 FALLS

### 7.1 Strategic Aim

To develop a joined up, coordinated, responsive and patient-focused integrated falls service, which will:

- Prevent falls and reduce resultant fractures or other injuries.
- Provide effective treatment and rehabilitation closer to home to those who have fallen.

This leads to a reduction of inpatient emergency bed days by 2.5% by March 2008, as part of the Public Service Agreement (PSA) target.



## 7.2 Strategic Analysis

### 7.2.1 Falls prevention

Promotion of more physical activity opportunities is key, and this also links to the Choosing Health Programme. Currently the City has the Fit and Active Braunstone, which will be explored to roll out to other areas of the City where appropriate. The City Council also provides a range of opportunities for people 55+ to be involved in physical activities. There are proposals to extend this further over the next 3 years.

Increasing older adults' intake of calcium helps to reduce their bone loss and fractures. Improving diet also contributes to the overall health and fitness of the older persons, as does reducing smoking and alcohol intake. More work needs to be carried out to understand the impact and the requirements in this area.

Older people have to be aware of issues they face with regards to the potential for falls. This would apply to a number of settings including older tenants and home owners as well as people in residential settings of various kinds. A baseline assessment of current health education provision has to be carried out to inform future planning.

Leicester City Council Housing Department along with other agencies provides a number of services which address the environmental factors, and offer advice and help to tackle the causes of falls that relate to the home. Please refer to section 4.2.6 for more details.

As a Highway Authority, the Council also provides a number of services that help address the causes of falls. These include:

- Inspections and repair of public roads and footways.
- Provide adequate lightings for public roads and footways. City Centre lighting is changing to white lights to improve safety levels.
- Winter services e.g. gritting and salting of roads and parks etc.
- Ensure work to take place on the highway or in the City centre have adequate safety protection for the public and pedestrians.

There are a number of useful resources for falls prevention and professionals need to be made aware of their availability.

### 7.2.2 Identification & assessment of those at risk of falling

At the moment, the City does not have a central register of those at risk of falling. A falls register tool has been developed for GP practices, and so far the uptake is low. The Falls Prevention Co-ordinator will co-ordinate the setting up of the 'at risk' register, and work with GPs,

practice staff and other Health Care professionals to put in place the falls register tool in Practices.

In Leicester City, an integrated care pathway is in place. However more work is needed to involve the voluntary sector in supporting the work to identify people at risk of falling and facilitating preventative services. Leicester Partnership Trust also has a falls pathway. This is designed specifically for mental health patients.

An LLR generic risk assessment tool has also been developed. The plan is to roll out the training to all agencies including the housing department. It is also important to raise the awareness amongst voluntary sector organisations, as they are often the first point of contact for those at risk of falling. It is envisaged that the tool will be widely used by Health and Social Services as from January 2006 onwards. At present, the referral routes are service specific and do not always allow continuity for people. Modification of these pathways will take place to enable patients have access to different services at the time they needed. This work will be taken forward by the City Falls Steering Group.

A directory of services available to people who are at risk or have fallen is accessible to staff of the local organisations. This is accessible via the internet and intranet. Paper copies are also available.

The City PCTs have asked pharmacists to include patients who are at risk of falls in their criteria for selecting patients for medicine use reviews.

### 7.2.3 Service Provision for those who have fallen

For those who have fallen, the aim is to offer an appropriate intervention to help reduce the incidence of further falls. At the moment different professionals use different assessment tools, and the plan is to review these and standardize where possible.

Community based rehabilitation programmes are key to support independence. Currently patients are visited at home and assessed by health and social services staff. A care plan will then be compiled to meet individual needs. In the future, rehabilitation programmes based in Health & Social Care Centres will also be developed. This will also help to provide peer support and exclude social isolation.

Please refer to appendix 2 for services currently available for falls patients.

Most of the above are generic services and not falls specific. Care and rehabilitation programmes are tailored to suit the needs of those who have fallen or at risk of falling.

#### 7.2.4 Osteoporosis

Osteoporosis is one of the major risk factor for falls related injury, and it is important that people with suspected osteoporosis could be diagnosed rapidly and treated quickly. DEXA scanners measure bone density and are used to diagnosis osteoporosis. As part of the national investment, LLR is about to receive additional funding to increase our capacity in DEXA scanning, thus improving access to diagnosis for osteoporosis.

Currently a baseline assessment is being carried out to map out the services available to people with osteoporosis. The work has just been completed, and findings will be used to inform future planning and commissioning priorities. Guidelines on osteoporosis are currently being developed by NICE. They are due to be published in May 2006.

### 7.3 Diversity Issues

With reference to the epidemiology data presented in section 2, more work will need to be carried out to understand the relationship between falls and different ethnic groups and wards etc. Tailored prevention and management programmes will need to be developed appropriately.

### 7.4 Workforce & Training

LLR has an established 'older person's training team' which is based in UHL. Staff in the city are able to access a range of training including a falls training programme.

The appointment of a City falls co-ordinator is key to driving forward the development of an integrated falls services in the local community. The job is currently being advertised.

A training needs assessment across all agencies in Leicester City will be co-ordinated by the falls co-ordinator. Where current staff groups have taken on extended role, a tailored education programme will be put in place to support the development. Multi-agency training will be promoted.

Generic workers are in place in the intermediate care services. Further roll out will be implemented where appropriate and / or as the service expands.

### 7.5 Commissioning Priorities

The priorities for the City are:

- Appointment of a City Falls Co-ordinator.

- Develop a co-ordinated falls prevention programme
- Establish the 'falls' and 'at risks' registers.
- Develop a community based care model for the city falls services.
- Further work on needs analysis in relation to ethnic groups and wards.

## 7.6 Action Plan

Action	Measurable Outcome	Lead Agency	Time scale	£ 2006/7	£ 2007/8	£ 2008/9	Source of funding
Employ a Falls Co-ordinator for the city	Co-ordinator in place	SC&H & PCT	Apr - Jun 2006	NR Reciprocity	NR Reciprocity		LPSA Monies
Improve take up of falls register	Increased no. of Practices with register in place	PCTs	2006-7	Staff time			Existing resources
Develop a community based model for falls services	A care model in place	PCTs	2006-7	Staff time	TBA		TBA
Review falls assessment tools currently in use and standardise where possible.	A tool in place	All Agencies including Housing	2006-7	Staff time			Existing resources
Increase dexa-scans	Improve access and reduce waiting time	Rachel Holynska PCT	2006-7	National			National funding
Implement NICE guidance for Osteoporosis	NICE guidance implemented	PCTs	2007-9		Drug costs	Drug costs	SDDP
Carry out a training needs assessment and establish a training programme across agencies including mental health	All staff will be skilled to assess risk and refer on where necessary to appropriate services.	Falls co-ordinator	2006/7	Staff time			Existing resources

## **8.0 STROKES**

### **8.1 Strategic Aim**

NSF standard 5:

- To reduce the incidence of stroke and ensure that those who have had a stroke have prompt access to integrated stroke care services.
- To ensure that older people receive the specialist help they need in hospital and that they receive the maximum benefit from having been in hospital.

### **8.2 Strategic Analysis**

A quality stroke service consists of 4 elements:

- Prevention
- Immediate specialist care
- Early and continuing specialist rehabilitation
- Long term support

In LLR, a stroke strategy has just been developed by the Older Persons' Stroke Services Steering Group and is due to be signed off by the City Directions of Travel Group. This includes the stroke service model, a care pathway and an action plan for service development. A stroke network manager is in post working across the primary and secondary care to develop an integrated stroke network.

In October 2005, a review of the stroke service was carried out by the HACAS, and the report is expected to be available in January 2006.

#### **8.2.1 Prevention**

There are 10 stroke indicators in the QoF for General Practices. These include putting in place a stroke register, and monitoring and treating of at risk factors e.g. smoking, high blood pressure and cholesterol level. These indicators are regularly examined by the PCTs as part of the clinical governance process. All Practices have established stroke registers, which allow clinical audits to take place.

Early detection and recognition of symptoms of stroke is important to allow rapid access to treatment. This is a major issue requiring better education of the general public and healthcare professions.

#### **8.2.2 Immediate specialist care**

This is provided at the Stroke Unit UHL. Patients who have had a stroke are looked after by specialist stroke teams in the designated unit. A multidisciplinary approach is being taken to ensure appropriate care delivery and discharge planning. The unit has a matron and a stroke co-ordinator. Referral guidelines and management protocols for transient ischaemic attacks and stroke care are in place.

An assessment and triage tool has just been introduced to EMAS, and at the moment, not all ambulance staff are using this tool. During 0800 to 1600, ambulance crew can take the stroke patients directly to the Stroke Unit. Patients have to be seen and assessed in A&E outside these hours.

Thrombolysis is a fairly new treatment in UK for stroke patients, and it is only available in a small number of specialist centre. UHL has planned to develop the expertise and provide this service locally. This will require regular access to MRI to monitor the progress, and increase the current demand further.

Stroke patients at UHL have access to MRI within 24 hours Mondays to Fridays only.

The priority is to ensure patients have rapid access to the beds on the Stroke Unit and early scanning.

### 8.2.3 Early and continuing rehabilitation

In line with the national situation, there is a shortage of Speech and Language therapists and dieticians to support the rehabilitation services.

The stroke service at UHL has recently been centralised. Stroke patients on other wards do not have access to the same level of specialist service.

UHL is planning to introduce an early supportive discharge service in the community, which will enable early discharge of stroke patients with intensive support in the patient's home / community. This could be provided as an outreach service from UHL or a PCT service. In both situations, staff will need to work very closely with the specialist team at UHL.

The priority is to establish a structured rehabilitation programme with support services.

### 8.2.3 Long Term Support

Stroke is one of the long-term conditions, and support services for stroke patients will also be considered and developed through that agenda.

A recent assessment by the HASCAS has highlighted the need of a clear commissioning strategy, particularly for continuing rehabilitation and long term support services. The formal report is due out in January 2006, and will inform the development priorities.

### 8.3 Diversity Issues

The needs of the younger people have to be addressed.

### 8.4 Workforce & Training Issues

The limited number of health professionals with training in stroke is a barrier to delivery. It is also recognised that more training is required for all those involved in the patient's journey.

There should also be more integration of the local stroke service, particularly across the acute and primary care. Joint appointment should be considered where appropriate.

The funding to employ a Therapy Consultant has not been secured. The infrastructure of the stroke specialist teams has to be further developed to include a stroke co-ordinator, clinical psychologist input, counselling service and family care support workers

A competency based skill framework should be developed. Currently a programme of stroke awareness training for carers is underway.

### 8.5 Commissioning Priorities

The development of a commissioning strategy for stroke is key to informing a future service model and planning priorities in the City. In particular, the service model and requirements for health prevention, rehabilitation and long term support services. In line with the White Paper, it is likely that there will be more closer to home services and joint commissioning initiatives with local partners.

The PCTs have to monitor and ensure stroke patients are able to access the stroke unit facilities promptly.

### 8.6 Action Plan

	Measurable Outcome	Lead Agenc	Time Scale	£ 2006/	£ 2007/	£ 2008/	Source of
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		y		7	8	9	funding
Implement NSF standard 5 on stroke	Compliant with standards	UHL & PCT	On-going	Staff time	Staff time	Staff time	Existing resources
Develop a commissioning strategy	Strategy in place	PCT	2006-7	Staff time			Existing resources
Better stroke education to public and professionals	Improve early recognition	PCT	On-going	Staff time	Staff time	Staff time	Existing resources
Monitor the number of outliers	Regular Monitoring	UHL & PCT	On going	Staff time	Staff time	Staff time	Existing resources

## 9.0 MANAGING LONG TERM CONDITION

### 9.1 Strategic Aim

To enable people with chronic conditions to lead independent and full lives. Users will receive the care that is appropriate and timely to their needs.

PSA targets:

- To improve the health outcomes for people with long term conditions by offering a personalised care plan for the most at risk vulnerable people.
- To reduce overall emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long term conditions.

### 9.2 Strategic Analysis

#### 9.2.1 Needs assessment

The exact number of the total LTC population in Leicester City is unclear at the moment and further work has to be carried out. However, QoF (Quality Outcome Framework) in General Practices helps to provide an understanding of the current situation. Table 1 shows the number of registered patients in the City with some of the long-term conditions.

	Eastern Leicester		Leicester City West		Leicester City	
Population	179,807		147,246		327,053	
	No. of patients	% of the resident population	No. of patients	% of the resident population	No. of patients	% of the resident population



Coronary Artery Disease	5701	3.2	4686	3.2	10,387	3.2
Stroke	1806	1	1715	1.2	3,521	1.1
Diabetes	10201	5.7	5620	3.8	15,821	4.8
COPD	1819	1	2070	1.4	3,889	1.2
Epilepsy	918	0.5	986	0.7	1,904	0.6
Mental Health	1450	0.8	1112	0.8	2,562	0.8
Cancer	689	0.4	698	0.5	1,387	0.4
Asthma	1041	0.6	8536	5.8	9,577	2.9
<b>Total</b>	<b>23,625</b>	<b>13.1</b>	<b>25,423</b>	<b>17.3</b>	<b>49,048</b>	<b>15</b>

Table 1: Number of registered patients with chronic conditions  
(Source: QoF Sept 04 – Oct 05)

### 9.2.2 Level 1 care provision - Self care support

Self care support exists in a range of formats:

- Information provisions e.g. leaflets
- Support and advice services
- Self help and support groups
- Training on skills and knowledge development
- Education about self management

A baseline assessment has been carried out in Oct 2005.

### 9.2.2 Level 2 care provision - Disease specific care management

Proactive management is essential to this level of care, and support for this group of patients will consist of:

- Primary / community based multi-disciplinary teams to manage the care across all settings. The team will include specialist nurses, and dedicated medical input from a community based consultant and / or GPwSI.
- 'At risk' and disease registers to provide a system for recall and review.
- Medicine use reviews to be carried out by community pharmacist.
- Specialist clinics in primary care / community.
- Local enhanced services (LES) to meet the needs of the users, which include specific services to reflect the local diversity.
- Evidenced based care pathways and protocols to ensure consistency of care delivery in all settings.

A benchmarking exercise against the outline specification has been carried out in October 2005.

### 9.2.3 Level 3 care provision - Case management

This group of users has complex LTC and high intensity needs, and are currently admitted into an acute hospital on an unplanned basis. Each user will have a personalized care plan. A community matron will oversee the care co-ordination and joined up services across health and social care.

The City nursing component of the case management team has been up and running since the beginning of October 2005. The team is located at the Braunstone Social Care and Health Centre where the social care and health team for the west of the city also based there. Four community matrons and a project lead nurse are in post, and four more community matrons are due to start by Mar 2006. The case management team works very closely with UHL colleagues. An alert system is currently being established, where the matrons will be informed by UHL staff if a LTC patient is presented to the A&E / admissions unit, or admitted to the hospital.

### 9.2.4 Health Prevention

Specific public health initiatives related to LTC include:

- Peer educators in the East of the City to work with people with diabetes and coronary heart disease in disease prevention.
- Development of Healthy Living Centre Network in NW Leicester.
- Fit and Active Braunstone (FAB) project in partnership with New Deal for Braunstone and Sport England.

Please refer to the section 4.2.1 for details of other Public Health programmes on health prevention.

## 9.3 Diversity Issues

A number of issues have been identified and require actions:

- Low uptake of the EPP programme by men from ethnic backgrounds.
- Under-diagnosis of COPD in ethnic groups.
- Low usage of the intermediate care services by people from an ethnic background.

## 9.4 Workforce and training issues

- Level 1 - To support further expansion of the EPP programme, the current infrastructure has to be strengthened.

- Level 2 - Educational support and professional development are required for staff currently working in the primary care and community.
- Level 3 - The role of newly recruited community matrons will continue to develop.
- Redesign of the District Nursing Service will modernise the role and function of the community workforce to ensure responsiveness to the need of the users.
- The degree of integration with social services and the final configuration of the case management teams will impact on workforce and training, which are unclear at this stage.

## 9.5 Commissioning Priorities

There is a need to further develop the current services to support self-management. This could include city specific disease leaflets, patient hand held record, expansion of the EPP programme, and provision of generic lifestyle advice locally.

Rolling out of the common disease management model across different disease groups will help to improve access and maximise the impact.

Recruitment of community matrons as per trajectory is key to ensure the benefits are delivered. Further work is required to integrate the existing service with other agencies including social care.

## 9.6 Action Plan

Action	Measurable Outcome	Lead Agency	Time scale	£ 2006/7	£ 2007/8	£ 2008/9	Source of funding
To expand the EPP programme.	Resources are secured to expand the service	PCT	2006-7	3400+	3400+	3400+	SDDP
To prepare a work programme for development of level 2 services as per service specs	Produce a project plan	PCT	2006-7	Staff time			Existing resources
To recruit community matrons as per trajectory	Matrons in post as planned	PCT	On-going	TBA	TBA	TBA	SDDP

Agree the model and timescale of establishing an integrated case management team across health and social services.	Action plan in place	PCT & SC&H	2006-7	Staff time			Existing resources
Agree the specs and timescale for single point of access	Action plan in place	PCT & SC&H	2006-7	Staff time			Existing resources

## 10.0 OLDER PEOPLE WITH MENTAL HEALTH NEEDS

### 10.1 Strategic Aim

To develop comprehensive and accessible integrated services for older people with mental health needs.

### 10.2 Strategic Analysis

#### 10.2.1 Health promotion

Day services and Day Hospitals promote healthy living, and work is also carried out with the Adult Education to encourage taking up of hobbies and interests.

The PCT and social services are working together on a joint Health promotion strategy that includes OPMH. However, wider engagement is needed to include areas such as transport, leisure and adult education, and employment. Developments have to address the needs of mental health and well-being in later life, and actively promote social inclusion of all older people.

#### 10.2.2 Primary care

The Common Mental Health Problem service is currently only available for users under 65. This will be expanded as from February 2006 providing access for users over 65 as well.

The Quality Outcome Framework allows some clinical data on mental health to be collected. Protocols for the screening and treatment of

mental health illness have been developed but not used widely by the PCTs. Further work is needed to understand the reasons and address the issues. Some prescribing guidelines are available in the primary care such as the NICE guidelines and the periodic guidance issued by the LPT Psychiatric Drug Prescribing group.

Some GP practices have liaison workers to link up with the CMHTs and GP Practices.

### 10.2.3 Crisis

The Community Intermediate Scheme has a remit to prevent unnecessary hospital admissions. However, the team has difficulties in meeting the needs of those users with both physical and mental health problems. The PCTs are currently exploring the option of appointing specialist mental health workers into vacancies.

A Mental Health Crisis Resolution Team service has been provided by the Leicestershire Partnership Trust since April 2004. This service is currently available for working age adults, and will be extended to users over 65 as from April 2006. A rapid response service for people with dementia is still required to ensure equity of access for all older people, and further work on service modelling will be carried out.

### 10.2.4 Community Teams and care co-ordination

The role of the Common Mental Health Team is to assess, treat and support older people with complex and / or long-term mental health problems as well as younger people with severe dementia, in the community. The Audit Commission has recommended a single point of access for all routine referrals to ensure a co-ordinated and prompt multi-disciplinary response.

Multi-discipline specialist teams are well established and located together in all localities. The City has well established community memory clinics for early recognition of mental health difficulties. A Specialist Older Person Psychological therapy service is available at LPT, and psychologists are established members of the CMHTs. A review of these services will help an understanding of their availability, and explore development of new roles such as the assertive outreach, which are commonly seen in working age adult services. It is also important that a clear connection is made with the out of hours service.

Care co-ordination is via the CPA, and the SAP process will further develop the joint care planning and case review. A Specialist SAP has also been piloted in one team in the east of the city. This has been positively received and will be rolled out to the rest of the City.

Joint management has been identified as a priority in the OPMH strategic action plan, and additional funding may be required to progress the development.

Staff in the CMHTs and the Access Teams are able to access a large range of community social care services. These include:

- a) Home Care  
LCC has a specialist care service for older people with mental health difficulties including additional intensive support service called CaSS. A significant amount of home care is provided from a range of Independent Sector providers. Further training and development have been highlighted by providers and SC&H to support these services.
- b) Respite care  
This is provided by a 9 bedded short stay / respite unit specifically for OPMH, and the independent sector. The need in this area is likely to continue to grow as more people are supported at home.
- c) Day care  
There are over 500 specialist day care places provided by two day hospitals, SC&H, the voluntary sector, and a small proportion in the independent sector. Further work is needed to strengthen the care pathways and joint working arrangements between different agencies.
- d) Residential care  
Most residential care homes are now dual registered, and approximately 380 older people are managed in a residential / nursing home initially by the CMHTs. National evidence suggests that 60% of residents in residential and nursing care have mental health needs. This means the number of older people living in the residential / nursing homes in the City with some mental health needs is nearer the 1000 mark. Further work is needed with this sector to look at how to support residents with mental health needs better e.g. specialist residential care, more input into training, and liaison or link workers.
- e) Non –specialist services  
The need to further develop this area has been highlighted nationally as well as locally. Further work is required to support the non-specialists services such as day care, home care residential and supported housing providers.
- f) Others  
There is a need to develop appropriate services for younger people with dementia.

#### 10.2.5. Intermediate & Inpatient Care

The locality wide intermediate care strategy has identified mental health as a priority for development, and there are two main areas. Firstly, it is important to ensure the current generic intermediate care services are able to recognize mental health problems and provide basic mental health assessments, particularly in those people with mainly physical health problems. One option is to appoint a CPN into the Intermediate Care Team when the post becomes vacant, and this is currently being explored. Secondly, there is a need to consider the development of specialist intermediate care services for people whose primary needs are mental health problems. Currently the CMHT provides an element of this function. However, the team does not have the capacity to support these people intensively following hospital discharge.

It is recommended that older people in need of mental health assessments or intervention should have access to intermediate care and in-patient care services. In LPT, clients who have contacts with the working age adult services in the last 12 months are not automatically transferred to the MHSOP team at the age of 65. Effective care co-ordination is another important issue. Current care co-ordination is provided by the CPA.

There is also a need to review the current level of service provision available within LPT for younger people with dementia. Currently patients are cared for alongside older people with dementia and this is considered to be inappropriate for many reasons.

As the projected number of those over 65+ is going to increase over the next 15 – 20 years, there is an urgent need to undertake a health needs assessment in relation to the requirement of the number of in-patient beds. Given the current situation, it is very likely that the existing service provision / model may not be able to meet the growing demand for specialist mental health services to be generated from this growing population.

#### 10.2.6 Liaison across the health system

UHL and LPT are developing a joint proposal for an older people psychiatric liaison at the acute hospitals. UHL highlights the lack of skills and the need is supported by the national prevalence data (50% OPMH in general hospital inpatient).

There is also a need for effective liaison arrangements between the specialist services and the primary care and other providers. Work has been carried out to develop the protocols between primary and secondary care. They are currently under discussions with GPs.

#### 10.2.7 Specialist placements

Specialist placements are required for older people with complex mental health needs. Currently there is only one nursing home in the City that is able to provide support to people with significant behavioural challenge, and patients often have to be managed outside the county. More placements for people with complex needs will be needed, particularly for those with challenging behaviours.

#### 10.2.8 Suicide prevention

The local suicide prevention strategy has to be reviewed. This is to ensure the issues related to older people are included, and actions are agreed and communicated to all relevant parties.

### 10.3 Diversity Issues

Compared to the census information, it would appear that people from BME communities are under represented in the numbers of older people with mental health needs using the SC&H services. SC&H needs to progress work to address this issue and engage with these communities. There is a multi- agency task group hosted by LPT named Ethnic Minority Older People Planning Group. An action plan is currently being developed to address issues of service delivery on the wards and day hospitals, and raise awareness of the needs of the BME communities.

There are approximately 90 younger people with dementia living in the City, and their needs are met largely by the older persons services. A new support service has been launched for younger people with dementia to engage in leisure activities. The scheme, called Side by Side, is run by the Alzheimer's Society and funded by SC&H. There are gaps in age appropriate service delivery for this group who has more complex mental health needs.

### 10.4 Workforce Development

The range of services, both specialist and general services supporting older people with mental health needs, poses a particular recruitment and training issue. The level of mental health training for basic grade workers needs to be improved, within residential and home care services. New intermediate and crisis services will also put a strain on the recruitment of Trained Specialist mental health workers.

More work needs to be progressed, jointly between the PCT, LPT, UHL and SC&H, to meet the workforce challenges and this must be a priority.



## 10.5 Commissioning priorities

- Develop access to Crisis Resolution, Common Mental Health Service and a Specialist Intermediate care service, and pathways to link in with the current intermediate care services.
- Develop an integrated model of service provision, including joint CMHT / day services manager and access to services unrelated to age.
- Day Care - strengthen the care pathways, service delivery and joint working between LPT, SC&H and independent day care providers, including access for BME elders.
- Develop liaison psychiatry with the acute sector, and establish more links with PCT, including tools for the early detection, assessment and treatment of people with mental illness (GP Protocols).
- Develop housing with care and support including Extra Care Housing.
- Explore the potential for specialist residential / nursing care.
- Co-ordinate the information available to carers in primary secondary care and SC&H.
- Produce a workforce development plan, which highlights the issues in relation to new services and increasing the support to non-specialist services.

## 10.5 Action Plan

Action	Measurable Outcome	Lead Agency	Time scale	£ 2006/7	£ 2007/8	£ 2008/9	Source of funding
Open the access to the Crisis Resolution Service to over 65s	Number of OPMH using the service. Reduced admissions to hospital	PCT & LPT	Apr 06	Staff time			Existing resources
Open the access to the Common Mental Health Service	Number of OPMH using the service	PCT	Feb 06	Staff time			Existing resources
Develop an Integrated service model for CMHTs / day services.	Joint / single management, commissioning, Single assessment	LPT & PCT & SC&H	2007-8	Staff time			Existing resources
Agree a Day Care -Joint Strategy	Strategy in place	PCT & SC&H & LPT	2007-8	Staff time			Existing resources
Review the	Complete	LPT	2006-	Staff			Existing

service provision for younger people with dementia within LPT	review		7	time			resources
Develop liaison Psychiatry	Reduce delays in pathways	PCT & LPT	2007-9		50k	50k	SDDP
Develop more housing with care and support.	Reduce admissions	LCC	2008-9			TBA	LCC
OPMH liaison with community matrons / intermediate care	Reduce admissions	PCT& LPT	2006/8	37.5k	45k		SDDP Invest to save
Explore Specialist residential, nursing & intermediate care	Reduce admissions to hospital	PCT & SC&H	2007-8		Staff time		Existing resources
Develop a joint workforce plan, including training	Raise standards	All	2006-7	Staff time			Existing resources

## 11.0 GENERAL HOSPITAL CARE

### 11.1 Strategic Aim

Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs

### 11.2 Strategic Analysis

The current approach of care at UHL is an integrated medicine model with patients being treated on the basis of their clinical need. There are Geriatricians working across the three sites at UHL who are based in the Acute Medicine Directorate. These clinicians are available to provide medical advice about older people to colleagues outside the Medicine Directorate.

There is a Matron for Older People, and her key role is to ensure older people are receiving appropriate care during their hospital stay. The Matron is also responsible for the implementation of the Single

Assessment Process. The Older Person's Training & Development Team provides training to medical and nursing and AHP staff across the Trust. This includes general and specific training to ensure best practice in caring for older people. The team also work with the ward staff to set specific objectives to improve their skills.

Ward 11 at the Leicester General Hospital (19 beds) is currently a nightingale ward. However, plans are well developed to improve the existing arrangements to assure privacy and dignity. The rehabilitation ward has a therapy area and day room facility available for meals and activities.

Intermediate care beds are located at Leicester General Hospital, and they can be accessed via the wards at UHL.

In response to the NSF standard 4 and the Healthcare Commission action plan, a number of developments have been planned:

- A specialist team in the Accident and Emergency Department with a particular focus on frail older people who require elective surgery.
- A fragility score tool to be used in the Emergency Department, which will allow early assessment of the older patient.
- Implement the strategy for caring of the ward patients with dementia or mental health problems.
- Develop an integrated continence service across UHL.
- Development of direct access clinics in outpatients to prevent hospital admission.
- Implement the Single Assessment Process and appoint an Educator Facilitator to facilitate the roll out of the electronic SAP.
- Appointment of a Clinical Director for older peoples services, who will be working with colleagues in UHL, primary care and social care to develop the best model of care of the elderly.
- Reduce the delays for surgery and the length of stay on acute wards after theatre.
- Improve discharge processes and bed management.

### **11.3 Diversity Issues**

There is a training package to ensure equality of care for the older person. Through feedback from BME users, commissioners have identified concerns about access to culturally appropriate services including interpreter services.

### **11.4 Workforce and Training Issues**

There is a need to improve the knowledge of staff in Dementia and Depression in the older person. There is continued training in elderly issues by the older persons training team.

## 11.5 Commissioning Priorities

- To develop existing services to meet the requirements in NSF standard 4 and the Healthcare Commission action plan.
- To ensure patients are receiving prompt assessment, and effective planning discharge is in place in the acute care.

## 11.6 Action Plan

Action	Measurable Outcome	Lead Agency	Time scale	£ 2006/7	£ 2007/8	£ 2008/9	Source of Funding
Implement an integrated continence service	Improved access  Better patient experience	UHL	Aug 06	Staff time			TBA
Improve the quality of care / services for BME communities, e.g. the interpreting & translation service.	User feedback  Less complaints	UHL	Ongoing				TBA
Put in place a Specialist team in A&E to focus on elderly patients	Improved access	UHL	April 07				Existing resources
Implement a fragility score tool	Early assessment	UHL	April 06	Staff time			Existing resources
Implement the strategy for caring of patients with dementia or mental health problems	Reduced accidents  Improved patient experience	UHL	Ongoing	Staff time			Existing resources
Development of direct access clinics in outpatients	Reduce unnecessary admissions	UHL	Jan 06				Existing resources
Appoint a clinical director for older people	Improved patient outcome & experience	UHL	April 07				UHL
improve discharge	Reduction	UHL	Ongoing	Staff	Staff	Staff	Existing

planning	of LOS		g	time	time	time	resource s
EMAS strategy to avoid admissions	Reduce admission	EMAS	Ongoing	Staff time	Staff time	Staff time	Existing resource s

## 12.0 CARERS

### 12.1 Strategic Aim

To improve carer support by raising awareness and better identification of carers' needs

### 12.2 Strategic Analysis

#### 12.2.1 Identifying carers

'Carers' refer to a range of people that provide practical or supervisory care to another person without pay. They could be wives, husbands, partners, parents, daughters, sons, or relatives. Census 2001 shows 25,473 carers aged 18+ provide one or more hour of care each week in Leicester. Amongst them, many of those over 65+ reported to provide over 20 hours of unpaid care each week.

Carers in Leicester have reported that staff do not recognise their role as carers. Consultation that took place also showed nearly half of the carers felt the professionals did not understand their needs. However, the gradual increase in carers' assessments by the local authority has improved their recognition. As part of the QoF, General Practices are required to have a protocol to identify carers and a mechanism to refer carers for social services assessment. Over 80% of all General Practices in the City have a Carers register in place.

#### 12.2.2 Informing carers

Carers reported they often find it difficult to gain access to information about services and support. They become aware of their rights usually when they first get in touch with services about the needs of the person they are caring for. Staff in these areas such as social services, GP receptionists, primary health care team and hospital staff, should therefore take an active role in giving out information to carers.

Progress has been made to improve the information available to carers. Leaflets in different formats / languages are produced to reach out different audiences. Some of the most successful ones have included the multi-agency 'signpost' leaflet and the "Do You Need Help

In Looking After Someone?" leaflet. Current work on the Carers Information Strategy will need to address specific requirements for particular settings in the older people's services.

### 12.2.3 Assessing and supporting carers

Under the Carers Acts (1995, 2000, 2004), carers have the right to an assessment of their needs. This includes not only their ability to continue to care, but also their health, well-being, and aspirations to continue in / return to employment or training. The local authority has the primary responsibility to carry out the assessments and this can be delegated to a health professional. Parts of the assessment can also be delegated to a third party e.g. a voluntary organisation. In the context of SAP and self-assessment, these arrangements have to be examined.

The responsiveness and quality of services for the user are often the crucial issues for the carer. In the consultation, carers have also identified other issues that are important to them, which are:

- Time off from caring
- Emergency care
- Emotional support
- Practical help around the house and garden,
- Appropriate specialist services (e.g. for carers of older people with mental health difficulties).

Some carers have physical impairment which will require additional support. In the document 'Family Matters', a report on the perspectives of family carers of people with learning disabilities, the importance to address the needs of the older carers who are 70+ years of age is highlighted. In some cases, the older carer becomes more physically or mentally frail and is cared for by their son / daughter with a learning disability with no recognition or support.

Specific issues related to older carers have included:

- They are continuing to care and getting older at the same time.
- They are more likely to be the sole carer.
- More likely to have reduced networks.
- They have had a different experience of services from younger family carers.
- They are less likely to ask for help just when they might need it.

Many of the support services for carers are available locally. However, they are either inflexible, or culturally inappropriate, or simply not enough of them available.

Currently a small service is commissioned from the Alzheimer's Society for specialist information, advice and support to mental health carers, which includes a specialist advocacy service. Both CMHTs have a carers support worker to promote and complete carers assessments.

Further work is needed to support carers of mental health users from BME communities who are under-represented in service delivery, and provide support in crisis particularly at night. The plan is to improve the uptake of direct payments in carers to help arrange their own respite support.

### **12.3 Diversity issues**

Carers from BME groups have identified a number of barriers that have prevented them to access the help. These include:

- Staff cannot communicate in the right language
- Staff do not recognise the relevant cultural needs
- Lack of specialised provision and limited support for community or voluntary groups
- Poor awareness and assessment of needs
- Lack of outreach service

In Leicester, there are many voluntary and community organisations working closely with the ethnic communities. A number of them also have a particular role in supporting carers. Four schemes within the Carers Special Grant programme are specialist minority ethnic projects. The take-up of other carer support schemes supported by the City Council also indicates that carers from the BME groups are represented in proportion to the population profile. However, the issues of unmet needs and the requirement for reliable evaluation and monitoring systems still exist.

### **12.4 Workforce and training issues**

As described above, many carers felt staff in the health and social care sectors do not understand their needs. There is a need to roll out the current carers' awareness training as it is not readily available.

### **12.5 Commissioning Priorities**

Many of the services for older people have an impact on carers, and service developments should take this into account at different levels: service planning, individual assessment and care planning.

Specific carer support services should be developed in line with the Leicester Carers Strategy. This includes practical and preventative services as well as the relevant mainstream services e.g. respite care.

### **12.6 Action Plan**

Action	Measurable Outcome	Lead Agency	Time scale	£ 2006/7	£ 2007/8	£ 2008/9	Source of funding
Agencies agree identification model and put in place a 'carer' register	Model agreed and recording established	LCC Carers Strategy Group	2006-7	Staff time			Existing resources
Carer awareness to be incorporated into training programmes.	Relevant training programmes include carer awareness.	All agencies	2006-7	Staff time			Existing resources
Identify needs of carers and agree a programme of work	Health needs work programme agreed and implemented	LCC Carers Strategy Group	2006-8	Staff time	Staff time		Existing resources
Consider the potential for joint commissioning in services to support carers	Strategy / plan in place	LCC & PCT	2006-8	Staff time	Staff time		Existing resources
Continue to monitor the effectiveness of carers support groups	Regular monitoring and issues and addressed gaps / issues	LCC Carers Strategy Group	On-going	Staff time	Staff time	Staff time	Existing resources

### 13.0 WORKFORCE & TRAINING

A coherent and integrated workforce is essential to deliver a comprehensive and seamless service for the older people in Leicester. There will be a strong emphasis on supporting independence and health prevention.

A broad range of issues has been highlighted in the above sections, and they will be further prioritised. Once this is carried out, the Human Resources Leads from Health and Social Services will now work together with stakeholders to take this forward and develop integrated workforce plan.

### 14.0 COMMISSIONING FRAMEWORK



This section outlines the approach and principles to underpin the delivery of the service model described in this strategy.

A number of system reforms have provided the levers to change how services are being commissioned and provided. These include:

- Direct payments and personal budget in social care
- Contestability
- Practice based commissioning
- Payment by results
- Local area agreement

The PCTs and LCC will work together to exploit these opportunities fully for the benefits of the older people in the City.

There is also much emphasis on joint working and commissioning arrangement between health and social services in areas such as older people. In the White Paper 'Our Health, Our Care, Our Say', the government has signalled its intention to impose a duty on local authorities and the NHS to work together to improve the health and well being of older people. Joint commissioning initiatives and appointments will be considered by LCC and the PCTs by April 2007.

To maximise the resources and address inequality issues, health intelligence information will be utilised to facilitate service planning and delivery. Locality / neighbourhood support networks will be developed to target areas of highest needs / deprivation. Services will be commissioned focusing on the local population profile, and health, social services and voluntary / community organisations will work together on the delivery. Unit cost is a useful indicator for value for money, and will be applied to compare services across different organisations alongside with other quality measurements.

Following the discussions between health and social services, and with members of the City Strategic / capacity planning group for Older People, the following have been identified as priorities for joint working:

- Intermediate care services
- Assistive technology
- Accommodation and intensive support
- Managing people with Long Term Conditions

There will be a second opportunity to bid for POPP (Partnership for Older People Project) funding to support joint working, and the local community has planned to submit a proposal.

#### Action Plan

Action	Lead Agenc	Time scale	£ 2006/7	£ 2007/8	£ 2008/	Source of
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	y				9	funding
Submit a joint POPP bid to DoH	LCC & PCT	Mar 06	Staff time			Existing resources
Establish a joint health and social care commissioning group	LCC & PCT	Apr 06	Staff time			Existing resources
Consider opportunities for joint post	All agencies	Apr 07	Staff time			Existing resources

## 15.0 PERFORMANCE MONITORING

The Leicester City Directions of Travel Group will be responsible for performance managing the overall delivery of this strategy. Day-to-day responsibility for development and performance management is delegated to the Leicester City Capacity / Strategic Planning Group for older People.

## 16.0 NEXT STEPS

Draft strategy to existing forums	Feb to Mar 2006
Amendments following feedbacks	Mar 2006
Sign off by organizations	Apr 2006
Establish joint health & social care Commissioning group	Apr 2006

## 17.0 REFERENCES

A strategic framework for developing stroke services, LLR Health & Social Care Community (2006)

Community Plan / Neighbourhood Renewal Plan 2006 - Healthier communities and older people section

Commissioning and Developing Mental Health Services for Older People, National Mental Health Partnership (2005)

Everybody's Business - Integrated Mental Health services for older adults: a service development guide (2001)

Social Care Green Paper - Independence, well being and choice (2005)

Leicester City Council Corporate Plan 2003-6

Leicester City Falls Prevention Management Strategy draft (2005)

Leicester City PCTs

Leicester City SC&H Department draft Older Person' Service Plan (2005)

Leicester City Supporting People Strategy 2005 – 2010

Leicester's Local Area Agreement third draft (2006)

National Service Framework for Mental Health (1999)

National Service Framework for Older People (2001)

No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse

Safeguarding Adults – a national framework of standards for good practice & outcomes in adult protection work (2005)

'The Strategy – Supporting People with Long Term Conditions' Edition 2, Leicester City PCTs (2006)

White Paper – Our Health, Our Care, Our Say: a new direction for community services (2006)

## **ACRONYMS**

<b>DOH</b>	<b>Department of Health</b>
<b>CMHTs</b>	<b>Community Mental Health Teams</b>
<b>CPA</b>	<b>Care Programme Approach</b>
<b>GPwSI</b>	<b>General Practitioner with Special Interest</b>
<b>LAA</b>	<b>Local Area Agreement</b>
<b>LCC</b>	<b>Leicester City Council</b>
<b>LLR</b>	<b>Leicester, Leicestershire and Rutland</b>
<b>OPMH</b>	<b>Older Persons Mental Health</b>
<b>NRF</b>	<b>National Regeneration Fund</b>
<b>LPT</b>	<b>Leicestershire Partnership Trust</b>
<b>PCTs</b>	<b>Primary Care Trusts</b>
<b>POPP</b>	<b>Partnership for Older People Project</b>
<b>QOF</b>	<b>Quality of Outcome Framework</b>
<b>SDDP</b>	<b>Strategic Development and Delivery Plan</b>
<b>SP</b>	<b>Supporting People</b>
<b>UHL</b>	<b>University Hospitals of Leicester</b>

### Housing Related Services

Leicester City Council's Housing Department offers one of the most comprehensive and successful ranges of housing services in the country, providing front line services for all individuals, including older people, and communities.

These include:

**Decent Affordable Homes to Rent** - The Council owns and lets 2719 1 bedroom bungalows, which are designated for older people. Many are adapted. All will be at the 'Decent Homes Standard' by 2010 with central heating, double glazing, modern facilities and a high quality maintenance service. Some other accommodation is also age designated.

Older people live throughout the Council stock ( 32.6 % of tenants are aged 60+).

The Council Allocation Policy gives recognition for those wishing to move because their homes are too large.

**Sheltered Housing** – The Council has 15 schemes in Leicester offering 432 units of sheltered housing, in 1 bedroom and studio properties. The service offers a sheltered housing officer, alarm service and housing related support services including assistance with benefits. LCC also nominate to Housing Associations throughout the City such as Leicester Housing Association, Anchor Housing Association, Asra Housing Association, etc. Through 'Homes Mobility' people can be nominated for sheltered housing elsewhere in the country.

**Supporting People** – The SP programme offers vulnerable people the opportunity to improve their quality of life by enabling them to live more independent lives in the community. This includes sheltered housing support offered to older tenants, and some support services offered to highly vulnerable adults as alternatives to hospital and residential care. The programme also places a particular emphasis on ensuring that there is a diversity of support, which is responsive to the needs of hard to reach groups and Black and Minority Ethnic communities.

**Housing Community Care Team** – Community Care Officers provide specialist housing advice and assistance to older people, including facilitating hospital discharges.

**Adapted Homes Matching Service** – A database of LCC and Registered Social Landlord properties, including wheelchair accessible, adapted for people with disabilities, to facilitate appropriate matching.

**Disabled Facilities Grant/Adaptations** – The DFG is a mandatory entitlement to help fund adaptations to enable disabled people to live as comfortably and independently as possible in their own homes. The Housing Department implement appropriate adaptations in council housing and private homes in response to recommendations from Social Care and Health.

**Citywide Home Maintenance Service** - This service is for private sector homeowners and tenants and includes advice on costs, builders, fire and safety advice and energy advice, including:

**Home Handypersons Service** – Minor maintenance, plumbing, carpentry, minor repairs to garden walls, gates, fences, etc.

**Home Improvement Agency** – This in-house agency assists people who are having major renovation work done with grant aid on their own home

**Crime and Community Safety Initiatives** – There are 5 community safety projects across the City available free of charge to people in the defined areas who meet the City Wide Home maintenance criteria, and also anyone who is vulnerable to being burgled

**Leicester Accident and Prevention and Safety Scheme** – The aim of the Scheme is to provide safety and energy measures that will help to reduce the risk of accidents in the home. LAPSS is available to vulnerable households living in the most deprived neighbourhoods in the city. LAPSS is a free scheme (up to £150 maximum) to specific residents, including people over 65 and disabled people over 16. Work includes stair and barrier gates, smoke detectors, grab rails, anti-slip bath and shower mats, tap turners etc.

**Fire Risk Assessment** – Housing staff working on the Citywide Home Maintenance Service are trained by Leicestershire Fire and Rescue service to advise on fire prevention.

**Home Owners Helpline** - Dedicated helpline available primarily to professionals visiting people in their own homes, e.g. district nurses, social workers and occupational therapists. They can 'phone through their concerns about the condition or safety of a person's home and the homeowner will be referred to services that can remedy the situation.

**Emergency Alarm Services** – The City Council Alarm Service (LeicesterCare) provides 24 hour assistance and advice to customers.

**Home Energy Strategy** – 'Health Through Warmth' provides affordable warmth measures to people suffering from cold, damp related illnesses.

**Care and Repair** – Voluntary sector home improvement agency (funded by LCC and Supporting People) providing home maintenance service, advice and assistance on home maintenance grants to people aged 60+.

**Green Doctor** – A ‘man with a van’ advice service for home owners on reducing fuel consumption and increasing the safety and comfort of their home.

There is also a range of other providers of housing related support services to older people in the City. For a full list of these go to [www.leicester.gov.uk/supportingpeople](http://www.leicester.gov.uk/supportingpeople)

## **7.4 Services and resources**

The majority of these services are not falls specific, instead they tailor their care and rehabilitation packages on the basis of individual need which may, or may not, include being a faller or being 'at risk' of falling.

### **7.4.1 Services at UHL (based on Leicester General Hospital)**

After a multidisciplinary falls assessment, treatment, rehabilitation and prevention programmes are put in place to address the underlying condition(s) and to prevent further falls. Inclusion criteria include (i) two or more falls over the last 12 months, (ii) significant hearing loss, (iii) the ability to walk 6 metres independently or with supervision only, with or without, a walking stick, (iv) the ability to take part in group work and (v) two of the following: 4 plus medications, impaired gait or balance, reduced muscle strength or joint range of movement, fear of falling, low body mass index, chronic disease that may contribute to falls or visual impairment. The service does not accept fallers scoring less than 7 out of 10 on the Abbreviated Mental Test. Appendix 5 presents the referral forms and pathway for the UHL falls clinic. See Appendix 4 for details.

### **7.4.2 Community Learning Disability Teams**

This service addresses the identified health needs of adults with learning difficulties aged 19 years plus. The team has relationships with housing, care and day care providers and Social Services and covers all Leicestershire PCTs with referral through the relevant locality team. Falls are considered the same as other referrals by a Multi-disciplinary Team (MDT) which includes Occupational Therapy, Physiotherapy, Community Nursing, SALT, Psychiatry and Psychology.

### **7.4.3 Primary Care Community Physiotherapy/Occupational Therapy**

The aim is to promote independence and safety in accordance with patients own goals. Services include access to falls and balance clinics, Social Services, home improvement, informal falls assessment within the Physiotherapy/Occupational Therapy and environmental assessment. Clients are adults (aged over 18) with physical disabilities registered with a Leicester GP. Services are provided in residential, patient, nursing homes and day centres. Referral is through GP and other Health Care Professionals. Cases are prioritised and a waiting list system is in place. A number of evaluation measures include audit using various outcome measures. The lead agency is Charnwood & North West Leicestershire PCT working with Social Services, Intermediate Care Schemes, District Nurses, Red Cross, GP's and Hospitals.



#### **7.4.4 Rapid assessment support service (RASS)**

The RASS aims to avoid unnecessary admissions, to support home discharge through providing prompt, effective, multidisciplinary assessment and support. MDT assessment is for patients who are at severe risk of decreased function which includes a high percentage of falls. Clients are over 18s with the service set in patient's own homes. For referral, the GP must be based in Leicester and the patients should have more than one MDT need. Exclusion criteria include only requiring physiotherapy, occupational therapy or those with a mental health problem. Referral is by telephone, GP or health care professional. The service can cope with six or seven patients at once. Patients are expected to be on the scheme for no longer than five days. The lead agency is City West PCT working with Social Services, Occupational Therapists, District Nurses, SALT, the Red Cross, Intermediate Care Schemes, GP and Hospitals. Evaluation includes outcomes measures, audit and goal achievement as negotiated with the patient.

#### **7.4.5 Brookside Court – Clinical Intermediate Care Beds (CICB)**

Services offered include physiotherapy, occupational therapy (OT), nursing, GP and Consultant Geriatrician supported by underpinning MDT assessment and weekly case conference. Provision of two weeks of Intermediate Care for those who will potentially be admitted to hospital, with accelerated discharge. The client group is from eighteen years, mostly aged 60 plus with an average age of 80. Referrals should be medically stable, although in need of 24 supervision/care, with the aim of returning home. The service is clinical nurse led and based within a larger residential building. A capacity of approximately 260 per year is based on a 10 bed unit and a two week turnaround. The lead agency is City West PCT in conjunction with Social Care & Health. Other agencies involved include Social Services, the Red Cross, GP West & East and a Consultant Geriatrician. Evaluation is through the application of setting of SMART goals, for example, graduated improvements in self-confidence and mobility as assessed by objective measures.

#### **7.4.6 Brookside Court – Social Services Reablement Bed**

Provision of MDT assessment including: OT, Physiotherapy; Social Worker and District Nurses. Many are fallers. Provides residential rehabilitation (intensive care) service for up to 6 weeks to facilitate a safe and confident return to home living. There are 12 beds and a possible six assessment beds. The lead agency is Leicester Social Care and Health working with GP and District Nurse Cover, the Red Cross and Social Workers. Service evaluation is through outcome measures, goal setting and reviews.

Referral is through social worker or via the RASS. Pre-assessment is carried out verbally or in person by Physiotherapist or Occupational Therapist. The inclusion criteria are: (i) 18 plus years old, (ii) a need for 24 hour supervision/care and (iii) the individual looking to return home. Clients are

largely 55+ with an average age of 80. Exclusion criteria are (i) no pre-determined residence to return to (ii) a severe cognitive impairment.

#### **7.4.7 Hospital at Home (H@H scheme) - Occupational Therapy & Physiotherapy**

MDT assessment. A high proportion are fallers or are at risk of falling due to acute illness. A home based service. It aims to prevent hospital admission and promote early discharge from hospital. The service is for adults aged 18 plus. Referral mainly by GP and occasionally from other health professionals. Inclusion criteria include those with acute illness/problem who do not need hospital admission. Service capacity of 12 patients for a maximum of 2 weeks at a time. Capacity is a function of the level of patient need. The lead agency is Leicester City West PCT with other agencies including OT, Red Cross, other Intermediate Care schemes, physiotherapy and District Nurses, Social Services and GP's. Evaluation is on the basis of individual therapy specific outcomes measures. Patients are referred to Primary Care or more rehab based Intermediate Care Scheme if further OT and physiotherapy input is required after discharge.

#### **7.4.8 Intensive Community Independence Service (ICIS)**

Multidisciplinary assessment is undertaken. Many patients are fallers. A home based service that includes balance and strength training and addressing environmental hazards. The service aims to (i) promote independence, (ii) provide rehabilitation at home and (iii) prevent admission to long-term care. Referral is through Social Worker. Inclusion criteria include (i) the potential to respond to rehabilitation and to relearn skills, (ii) medical stability and (iii) be motivated to return home. Exclusion criteria include: (i) unmotivated, (ii) people going into residential care and (iii) cognitive impairment. Service capacity is one to two people per week (6-8 a week) with a maximum of 12 on the scheme at any one time. The lead agency is Leicester Social Care & Health working with District Nurse, Intermediate Care Scheme, Red Cross, Hospital Staff, other Health Care Professionals, GP's and Social Services. Evaluation is through the use of audit, goal setting and outcome measures.

#### **7.4.9 Community Nursing City West PCT**

Falls assessment is part of a holistic nursing assessment to identify the most appropriate pathway. Based in the inner city and working in GP practices and patient homes. Referrals are from the hospital, other GP services and through the Health Centre receptionist. It covers people of all ages with a specific nursing need. Service capacity is a function of variable District Nurse caseloads. It has links to both Social Services and Therapists.

#### **7.4.10 Leicestershire Partnership Trust (LPT)**

Services organised around a Falls Pathway for mental health services for older people. It aims to reduce the prevalence and severity of falls within the LPT patient population. The service is set within wards, day hospital and the community including care homes. Referral is only for patients already under the care of LPT and assessed at high risk of falling. Service capacity is a function of demand and workforce at the time.

Services include: (i) analysis of falls patterns / clusters to prevent further falls, (ii) reviewing patient footwear, (iii) providing hip protectors if need identified and (iv) individual care and advice on a 1:1 basis from physiotherapy and OT as required in wards, day hospitals and in the community. A therapist/ nurse led falls clinic in mental health is planned.

Mental Health Services for Older People are the lead agency. There is a Slips, Trips and Falls group, chaired by Head of Physiotherapy as part of clinical governance. Other agencies include OT, nursing, psychiatrist, research department and UHL consultant with responsibility for falls. A falls reduction co-ordinator is to be appointed. Patients, relatives and carers are also involved in service provision. The service takes place where the patient is. The use of the pathway to be audited the 2nd half of this year. The care pathway, strategy for mental health and falls for LPT are presented in Appendix 6.

#### **7.4.11 Care & Repair (Leicester) Ltd – Voluntary Sector**

Home based service enables older and disabled people to remain independent at home in comfort and security. Inclusion criteria: individuals aged 60 years plus and disabled people who own or privately rent. Self referral, or by anybody else in contact with clients. Approximately 1,600 referrals per annum. Part funded by Leicester City Council with links with voluntary and statutory agencies. Services provided include: (i) Home visits by Housing Adviser who gives comprehensive advice, (ii) benefit entitlement checks, (iii) advice on options – repairs, improvements, adaptations, (iv) advises on energy efficiency, crime and safety, (v) provides the services of a technical adviser, (vi) finds funds (grants, charity) to support work, (vii) specifies, seeks quotations and supervises building work, (viii) provides handyperson service for small repairs, (ix) referral to other services e.g. Age Concern, Social Services etc and (x) provides information on other services available.

#### **7.4.12 Podiatry**

The city podiatry service is provided in community clinics for both PCTs and by contract arrangements to UHL, LPT, LOROS (Leicester Organisation for the Relief of Suffering) and Arnold Lodge (Forensic Psychiatry Unit). Service access is through application from patients, carers, healthcare professionals and GPs. Assessment for tailored treatment plans covers mobility.



## **APPENDIX 1**

**Leicester City Council Housing Department** provide a number of services, outlined below, which specifically help support the Leicester Falls Strategy by seeking to tackle the causes of falls that relate to the home.

### **1. Citywide Home Maintenance Service**

This service is for private sector homeowners and tenants and includes advice on costs, builders, fire and safety advice and energy efficiency advice. This service includes the following:

a) **Home Handypersons Service**

Minor maintenance for private sector homeowners and tenants, includes plumbing, carpentry, minor repairs to garden walls, gates and fences

b) **Leicester Accident Prevention and Safety Scheme**

LAPSS offers accident prevention measures to vulnerable households living in the most deprived neighbourhoods in the city, following a home assessment on the risk of falls.

LAPSS is a free scheme (up to £150 maximum) to single parents with a child or children under 5, people over 65, disabled people over 16 and low income families Includes: stair and barrier gates, smoke detectors, grab rails, anti-slip bathroom mats, etc. The Housing Department would be interested in discussing referrals to LAPSS of people who have been identified as being at risk.

c) **Fire Risk Assessment**

Housing staff working on the Citywide Home Maintenance Service are trained by

Leicestershire Fire and Rescue Service to advise on fire prevention.

d) **Home Owners helpline**

Dedicated helpline available primarily to professionals visiting people in their own homes, i.e. district nurses, social workers and occupational therapists. They can phone through their concerns about the condition or safety of a persons home and the homeowner will be referred to services that can remedy the situation

e) **Care and Repair**

Voluntary sector home improvement agency (funded by LCC and Supporting People) providing home maintenance service and advice and assistance on home maintenance grants to people over the age of 60

f) **Green Doctor**

A 'man with a van' - advice for home owners on reducing fuel consumption and increasing the safety and comfort of their home

**2. Adaptations/Disabled Facilities Grants**

The Housing Department implement appropriate adaptations in council housing and private homes in response to recommendations from Social Care and Health.

**3. Home Energy Strategy includes:**

Health Through Warmth – providing affordable warmth measures to people suffering from cold, damp related illnesses

**4. LeicesterCare**

Alarm service providing 24 hour emergency assistance and advice

**5. STAR etc.**

Floating support schemes that give advice and support to older people in their homes to maintain independence, funded by Supporting People

**6. Sheltered Housing**

## **APPENDIX 2**

### **7.4 Services and resources**

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#### **7.4.1 Services at UHL (based on Leicester General Hospital)**

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#### **7.4.6 Brookside Court – Social Services Reablement Bed**

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Referral is through social worker or via the RASS. Pre-assessment is carried out verbally or in person by Physiotherapist or Occupational Therapist. The inclusion criteria are: (i) 18 plus years old, (ii) a need for 24 hour supervision/care and (iii) the individual looking to return home. Clients are



largely 55+ with an average age of 80. Exclusion criteria are (i) no pre-determined residence to return to (ii) a severe cognitive impairment.

#### **7.4.7 Hospital at Home (H@H scheme) - Occupational Therapy and**

##### **Physiotherapy**

MDT assessment. A high proportion are fallers or are at risk of falling due to acute illness. A home based service. It aims to prevent hospital admission and promote early discharge from hospital. The service is for adults aged 18 plus. Referral mainly by GP and occasionally from other health professionals. Inclusion criteria include those with acute illness/problem who do not need hospital admission. Service capacity of 12 patients for a maximum of 2 weeks at a time. Capacity is a function of the level of patient need. The lead agency is Leicester City West PCT with other agencies including OT, Red Cross, other Intermediate Care schemes, physiotherapy and District Nurses, Social Services and GP's. Evaluation is on the basis of individual therapy specific outcomes measures. Patients are referred to Primary Care or more rehab based Intermediate Care Scheme if further OT and physiotherapy input is required after discharge.

#### **7.4.8 Intensive Community Independence Service (ICIS)**

Multidisciplinary assessment is undertaken. Many patients are fallers. A home based service that includes balance and strength training and addressing environmental hazards. The service aims to (i) promote independence, (ii) provide rehabilitation at home and (iii) prevent admission to long-term care. Referral is through Social Worker. Inclusion criteria include (i) the potential to respond to rehabilitation and to relearn skills, (ii) medical stability and (iii) be motivated to return home. Exclusion criteria include: (i) unmotivated, (ii) people going into residential care and (iii) cognitive impairment. Service capacity is one to two people per week (6-8 a week) with a maximum of 12 on the scheme at any one time. The lead agency is Leicester Social Care & Health working with District Nurse, Intermediate Care Scheme, Red Cross, Hospital Staff, other Health Care Professionals, GP's and Social Services. Evaluation is through the use of audit, goal setting and outcome measures.

#### **7.4.9 Community Nursing City West PCT**

Falls assessment is part of a holistic nursing assessment to identify the most appropriate pathway. Based in the inner city and working in GP practices and patient homes. Referrals are from the hospital, other GP services and through the Health Centre receptionist. It covers people of all ages with a specific nursing need. Service capacity is a function of variable District Nurse caseloads. It has links to both Social Services and Therapists.

#### **7.4.10 Leicestershire Partnership Trust (LPT)**

Services organised around a Falls Pathway for mental health services for older people. It aims to reduce the prevalence and severity of falls within the LPT patient population. The service is set within wards, day hospital and the community including care homes. Referral is only for patients already under the care of LPT and assessed at high risk of falling. Service capacity is a function of demand and workforce at the time.

Services include: (i) analysis of falls patterns / clusters to prevent further falls, (ii) reviewing patient footwear, (iii) providing hip protectors if need identified and (iv) individual care and advice on a 1:1 basis from physiotherapy and OT as required in wards, day hospitals and in the community. A therapist/ nurse led falls clinic in mental health is planned.

Mental Health Services for Older People are the lead agency. There is a Slips, Trips and Falls group, chaired by Head of Physiotherapy as part of clinical governance. Other agencies include OT, nursing, psychiatrist, research department and UHL consultant with responsibility for falls. A falls reduction co-ordinator is to be appointed. Patients, relatives and carers are also involved in service provision. The service takes place where the patient is. The use of the pathway to be audited the 2nd half of this year. The care pathway, strategy for mental health and falls for LPT are presented in Appendix 6.

#### **7.4.11 Care & Repair (Leicester) Ltd – Voluntary Sector**

Home based service enables older and disabled people to remain independent at home in comfort and security. Inclusion criteria: individuals aged 60 years plus and disabled people who own or privately rent. Self referral, or by anybody else in contact with clients. Approximately 1,600 referrals per annum. Part funded by Leicester City Council with links with voluntary and statutory agencies. Services provided include: (i) Home visits by Housing Adviser who gives comprehensive advice, (ii) benefit entitlement checks, (iii) advice on options – repairs, improvements, adaptations, (iv) advises on energy efficiency, crime and safety, (v) provides the services of a technical adviser, (vi) finds funds (grants, charity) to support work, (vii) specifies, seeks quotations and supervises building work, (viii) provides handyperson service for small repairs, (ix) referral to other services e.g. Age Concern, Social Services etc and (x) provides information on other services available.

#### **7.4.12 Podiatry**

The city podiatry service is provided in community clinics for both PCTs and by contract arrangements to UHL, LPT, LOROS (Leicester Organisation for the Relief of Suffering) and Arnold Lodge (Forensic Psychiatry Unit). Service access is through application from patients, carers, healthcare professionals and GPs. Assessment for tailored treatment plans covers mobility.