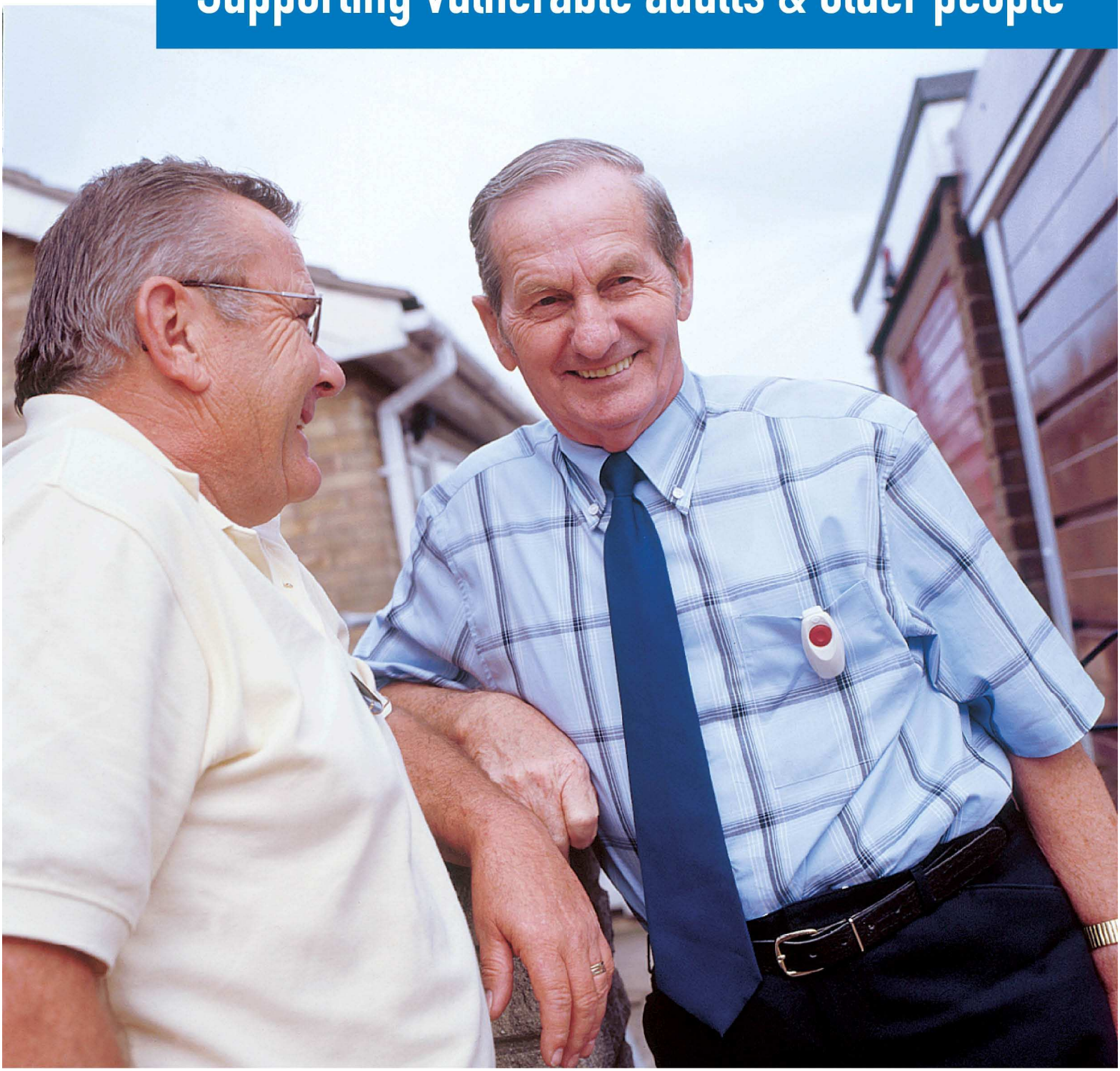
Havering Joint Strategic Needs Assessment 2011/12

Supporting vulnerable adults & older people



NHS

Outer North East London

Havering
LONDON BOROUGH

Supporting Vulnerable Adults and Older People

SUMMARY

What is the Level of Need in Havering?

- There are a large proportion of older people in Havering. Some of these people may have long term conditions or support needs, for example:
- Nearly 15,000 older residents are estimated to be unable to manage at least one self care task on their own, and more than 18,000 are estimated to be unable to manage at least one domestic task on their own (e.g. shopping, washing etc)
- It is estimated that 3,760 older people have depression, which is predicted to increase to 4,146 by 2020
- 16,300 older residents are estimated to be living alone, which is predicted to increase to 17,948 by 2020
- More than 1,100 residents are registered as being blind or partially sighted in Havering
- There are estimated to be 5,276 older residents with diabetes
- There are around 140 excess winter deaths annually among Havering residents, many of whom are vulnerable older people
- More than 1,200 Havering residents are admitted to hospital annually as a result of a fall
- St Francis' hospice end of life care services were used nearly 19,000 times by Havering residents in 2010/11 and demand for services is increasing
- It is estimated that around 3,050 older people in Havering have dementia, which is predicted to rise to 4,691 by 2030
- In 2011, there were approximately 560 users of learning disability services in Havering (of all ages), of which around 70 were aged 60 or older

Current Service Provision in Havering

There are a range of services that may be used to provide support to vulnerable adults and older people in Havering. These include:

- Social care services, many of which support people to be independent and contribute to preventing ill-health – e.g. reablement services, telecare and telehealth, support from social workers and occupational therapists, aids and adaptations and extra care housing
- Integrated health and social care services e.g. integrated case management for high risk individuals, the information and advice service and a planned 'help not hospital' service
- Voluntary sector services e.g. Age Concern Havering provide services such as befriending, active living, day centres and dementia support services
- Support for those with a specific long term condition or health issue – e.g. the Yew Tree low vision service, a range of services to tackle falls prevention and bone health and telehealth and rehabilitation support for those with chronic obstructive pulmonary disease
- Support for residents in keeping their homes warm e.g. providing free or heavily discounted home insulation and training for volunteers and front line services in identifying those in fuel poverty and signposting to services that can help
- A variety of culture facilities, such as libraries, museums, arts space, theatre, parks, historical buildings and sports and leisure facilities, which can help to improve physical and mental health and emotional wellbeing. Many of these facilities cater specifically for older people, such as: a reminiscence programme at Havering Museum, the 'Walking the Way to Health' programme which has a large percentage of walkers aged 50+, 'Knit and Natter' groups and 'BBC First Click' groups at local libraries, the 60+ Musician of the Year competition at Queen's Theatre, and the 60+ Artist of the Year competition and exhibition provided by the Arts Service.

Gaps in Knowledge and Service Provision in Havering

A number of gaps have been identified in supporting older and vulnerable people including:

- Opportunities have been identified for health and social care to work together more closely to support older people in the community
- There are opportunities to expand the scope of the reablement service
- There is limited use of assisted technologies
- There is scope for better information sharing between partners and for greater engagement with social care users
- There is scope for personal budgets to be made available to a greater proportion of eligible social care users
- There are opportunities for transport provision by social care to offer more choice and to be more cost effective
- Currently self funders receive advice and information but if they are financially independent, no further support is offered unless specific risk is identified

Gaps in end of life care include:

- Poor communication of end of life care
- Referrals to end of life care services not taking place early enough (possibly due to lack of awareness of when to use these services)
- No single register of those on end of life care pathways
- Limited support for the families of those reaching the end of their lives
- No regular mandatory training for care homes and GPs on palliative care
- Limited transport options to hospice facilities in Havering
- No end of life care strategy in Havering

Gaps in services for adults and older people with learning disabilities include:

- A need for better recording of information about those with learning disabilities in Havering (e.g. by GPs, on disease registers, by sexual health services etc)
- A need for learning disabilities awareness training to be delivered across primary care
- A need for protocols/guidance to be developed for reasonable adjustments for those with learning disabilities using GP practices and community primary care services e.g. pharmacies and dentists

Gaps in fuel poverty and excess winter deaths services:

- Work undertaken in 2012 has identified that a formal procedure needs to be adopted at a borough level to support vulnerable residents during extreme cold weather spells

Supporting Vulnerable Adults and Older People: for decision makers and commissioners to consider

- Work with Havering's Vision Strategy Group to undertake more in depth needs assessment work around eye health e.g. gap analysis of service provision and consultation with local people to identify un-met need
- Develop a vision strategy for Havering incorporating the findings of needs assessment
- Continue development of the integrated care strategy for Havering (health and social care), which will deliver increased support in the community, thus reducing demand on hospital services and supporting improved outcomes for the frail elderly and those with dementia
- Continue to increase the capacity of the reablement service, including creating confidence in and awareness of the role of this service in reducing the need for hospital admissions and reducing length of stay (where hospital admission required)
- Continue to deliver the actions from Havering's falls prevention and bone health strategy e.g. delivering falls prevention and management training for staff in care homes and telecare staff and delivering a falls prevention community exercise programme, which will be linked with robust and effective discharge planning

- As part of the integration strategy actions, implement a "case finding" approach to social care, so that health and social care colleagues actively engage with each other at the point when an individual is admitted to hospital and start planning for discharge. This will involve a move away from the current model which is referral led
- Continue to deliver actions from Havering's personalisation framework, such as extending the use of personal budgets and providing more choice in transport provision
- Reduce fuel poverty and excess winter deaths by continuing to deliver actions from Havering's fuel poverty strategy e.g. improving energy efficiency of Havering's housing and raising awareness of how to reduce energy costs and keep warm
- Develop a borough level Cold Weather Plan to guide partners in supporting vulnerable residents during extreme cold weather spells (i.e. through the Borough Resilience Forum Risk Sub-Group), and undertake joint initiatives to ensure older residents are prepared for cold weather.
- Implement Havering's prevention strategy for older people and people with a disability
- Continue to work with partners in Culture and Leisure to support a high standard of mental, physical and emotional health for all by increasing the number of people engaging with libraries, parks and open spaces, sport and physical activity, arts and historic environment.

Future Actions/Recommendations for Older People with Learning Disabilities:

Some key actions and further areas of work identified in the 2011 learning disabilities self assessment (which applies to older people with learning disabilities as well as younger adults) included:

- Introduce more consistent recording of learning disabilities information in identified areas (e.g. by GP practices)
- Identify resources with which to undertake further work about the needs of those with learning disabilities in Havering e.g. an audit of current data and service provision. Incorporate the findings into the JSNA
- A review of all placements for those with learning disabilities in Havering to be undertaken
- Protocols/guidance to be developed for reasonable adjustments for those with learning disabilities using GP practices and community primary care services e.g. pharmacies and dentists
- Learning disabilities awareness training to be delivered across primary care. This should include training for community based health services to enable identification, treatment and support of those with learning disabilities to improve care and reduce avoidable hospital admissions
- An audit to be undertaken of the choices of healthcare available to those with learning disabilities and the accessibility of these options.

Future Actions/Recommendations for End of Life Care:

- Work with partners to improve co-ordination of and communication about end of life care (this could include service mapping and mapping of end of life care pathways)
- Implement a single register similar to the Co-ordinate My Care pilot for individuals on end of life care pathways (as part of the NHS 111 telephone service project)
- Work with partners to ensure individuals are referred to end of life care services at the earliest appropriate opportunity
- Ensure GPs, nurses and care homes undertake regular training about end of life care, including when it is appropriate to refer to such services
- Ensure the Outer North East London (ONEL) end of life care strategy and actions reflect the needs of Havering residents
- Consider the resource implications of increasing demand for end of life care services in Havering and how these will be met in future

- Consider transport arrangements to hospice services in Havering and any opportunities to improve these.

1. Vulnerable Adults and Older People in Need of Support in Havering

Identifying Those at Risk and Level of Need

Age

Increasing age is one of the most significant risk factors for long term conditions, which may require support. In Havering:

- 36% of Havering's population are aged 50+ (85,999 people)
- 21% of the population are of retirement age (60+ females, 65+ males; 49,122 people)

Figure 1: Estimated Older Population in Havering by Age and Gender. 2010 Mid Year Estimates, Office of National Statistics, 2011 (37)

	60F/65M +
Males	17,372
Females	31,750

Further information about Havering's population can be found in the demographics section of the JSNA.

Socio-economic Status and Vulnerable Pensioner Households

There is an association between low income and long term conditions. This could be due to some of those with long term conditions being unable to work or due to low income in itself increasing risk of long term conditions.

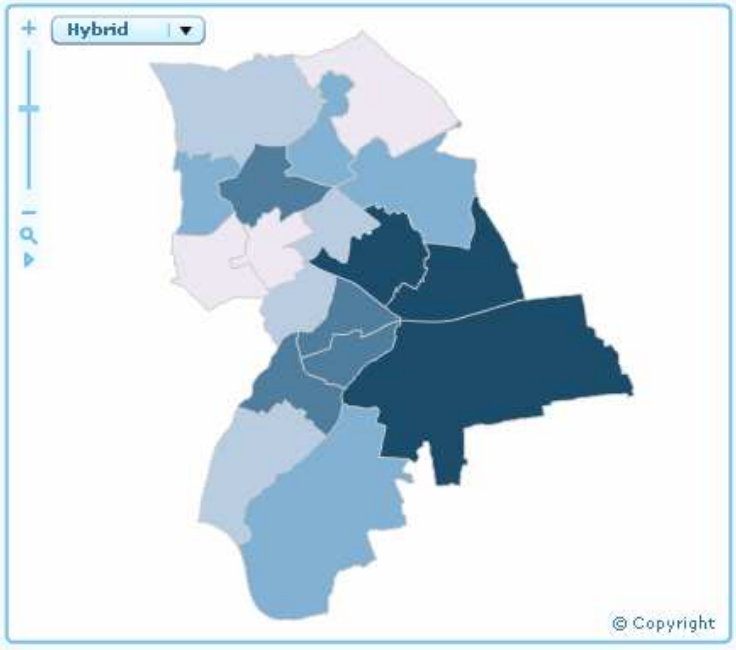
The Indices of Multiple Deprivation for Older People 2010 (IDAOPI) uses information on areas such as income, education and health to assess how deprived or affluent older people living in certain areas area (38). Key findings are that:

- In 10.1% of small areas in Havering, older people are within the 20% most deprived nationally (15 small areas across the Borough)
- In 1.3% of small areas in Havering, older people are within the 10% most deprived nationally (2 small areas across the Borough)

In comparison, London overall has a high proportion of older people living in deprivation (23.2% of areas in London overall have older people living within the 10% most deprived nationally). This suggests that whilst older people overall in Havering are not as deprived as in London overall, there are still pockets within Havering where older people are living in deprivation.

Area of Residence

Figure 2: Proportion of Havering Population Aged 65 or Over, ONS Population Estimates, 2010. Data accessed on Havering Data Intelligence Hub (39)



The map illustrates the proportion of the total Havering population aged 65 or older who live in each ward. The darker the colour, the higher the proportion of those aged 65 or over in that ward. Cranham, Upmister and Emerson Park wards have the largest proportion of those aged 65 or older and Gooshays, Romford Town and Brooklands wards have the lowest proportions of those aged 65 or older.

Long Term Conditions and Disabilities

- 49% of Havering residents aged 65 or older have a limiting long term illness (around 19,500 people). This compares to 51% in London and 52% in England (8)
- However, more recent research (11) estimates there to be 39,000 Havering residents with one or more long term conditions. Of these, the number of older people (age 65+) in Havering with long term conditions is estimated at 18,600, where 1,200 older people have particularly complex health and social care needs. Around 900 of these 1,200 people account for 38% of all emergency bed days.
- In addition to this, a 2010/11 survey reported that 17.5% of working age people in Havering have a disability (26,900 people). This compares to 17.4% in London and 20.4% in England (19)
- People aged 65 in Havering will on average have a further 13.9 years of good or fairly good health ahead of them. This compares to an England figure of 13.1 and a London figure of 13.6. Women in Havering live an extra 2 years in good health than men (9)
- Nationally, those with long term conditions are the most intensive users of the most expensive services, accounting for 52% of all GP appointments, 65% of all outpatient appointments and 72% of all inpatient bed days (10)
- People with long term conditions are also high users of social care and community services and are less likely to be in work (10)

Eye Health

According to the NHS Information Centre (2011) (4), at the end of 2010/11, there were:

- 480 people registered with Havering Council as being blind. 66% of these were aged 75 years or older

- A further 675 people are registered with Havering Council as being partially sighted. 69% these were aged 75 years or older
- The above figures however only reflect those who are registered with Havering Council as being blind or partially sighted so could be an underestimate of the true prevalence
- Modelled data estimates that 5,264 Havering residents aged 65 years or older have a moderate or severe visual impairment (2)
- The number of Havering residents aged 65 or older with a moderate or severe visual impairment is estimated to increase to 5,468 by 2015 and to 5,774 by 2020 (2)
- Havering falls needs assessment identified that poor eye health such as visual acuity, contrast sensitivity, visual field, cataract, glaucoma and macular degeneration all contribute to risk of falls as do bifocal and multifocal lenses (5).
- 8% of falls that result in hospital admissions occur in individuals with vision impairment, accounting for 21% of the cost of treating accidental falls (40)

Cancer

There is a dedicated JSNA chapter on cancer where further information can be found. However some key findings about level of need from the chapter include:

- Overall, the incidence (new cases) of cancer in Havering is lower (better) than the national average
- Nonetheless, high numbers of Havering residents are diagnosed with and die from cancer each year; due in part to the older population. This will increase even further as the population continues to get older
- Breast, bowel, and lung cancer are the most common cancers in women in Havering, and prostate, lung and bowel cancer are most common in men
- The prevalence of risk factors for cancer among Havering's population are similar to or greater than (in the case of obesity) the national average. There is low awareness among Havering residents that diet and obesity increase the risk of cancer
- Overall, cancer mortality rates in Havering are similar to the national average
- However, for those who do have cancer in Havering, cancer survival is not improving and is significantly worse than the national average
- The number of people living following a diagnosis of cancer has still increased in Havering however, as a result of population ageing and improvements in survival
- There is evidence of inequalities in Havering regarding mortality rates and the prevalence of lifestyle related risk factors associated with levels of socio-economic disadvantage

Cardiovascular Disease

There is a dedicated JSNA chapter on cardiovascular disease (CVD) where further information can be found. However some key findings about level of need from the chapter include:

- Around a third of deaths in Havering are caused by CVD, a large proportion of which are deaths from Coronary Heart Disease and Strokes
- However overall, mortality from CVD in Havering is lower than the England average, but above the London average
- For many types of CVD, including heart failure and atrial fibrillation, the prevalence (among those registered with GPs) is lower than the England average but above the London average
- However, 13.5% of those registered with GPs in Havering have hypertensive disease. This is higher than the London (10.9%) and England (13.4%) figures, with Havering having the highest prevalence of hypertension out of the London Boroughs
- There are inequalities in cardiovascular health in Havering
- 8% of hospital admissions in Havering in 2010/11 were due to circulatory disease (around 7,000 admissions), however this was a lower rate than in England or London overall in 2009/10

Diabetes

- Approximately 11,000 Havering residents currently have a diagnosis of diabetes, with approximately 500 new cases being diagnosed annually (7)
- This equates to 5.3% of people on GP registers having a recorded diagnosis of diabetes, which is significantly lower than the England average of 5.5% (7)
- Estimates suggest that in 2012 there are 5,276 Havering residents aged 65 or older with diabetes (2)
- This is estimated to increase to 5,528 by 2015 and to 5,867 by 2020 (2)

Hearing Loss

- It is estimated that in 2012, around 18,800 Havering residents aged 65 or older will have a moderate or severe hearing impairment and 480 Havering residents of this age have a profound hearing impairment (2)
- The number of older people with hearing loss is expected to continue to increase in future, and it is estimated that by 2015, 19,610 older people will have a moderate or severe hearing impairment, and 528 older residents will have a profound hearing impairment (2).

Fuel Poverty and Excess Winter Deaths (16)

Fuel poverty in the UK is currently defined as a household spending more than 10% of their income to maintain a satisfactory heating regime (21^{o}C). Households that are unable to sufficiently heat their homes can experience poor quality of life, damage to their house, increased risk of winter illness, children at greater risk of respiratory illness, greater difficulty in recovery from winter illness, increased winter death rates and social exclusion. In particular, older residents who are already at risk and have difficulty recovering from winter illness are even more vulnerable when they are living in underheated homes.

An estimated 15.2% of households in Havering were at risk of fuel poverty in 2009. This is an increase from 2003, when estimates indicated Havering had 5.5% of households at risk of fuel poverty. There have been similar increases across the UK over the same period. The substantial increase in fuel prices has been the main factor leading to this increase in fuel poverty. However, in Havering the rise can also be attributed to increased numbers in the groups most vulnerable to fuel poverty – residents over 60 years and residents on benefits.

Although fuel poverty will affect households across the borough, there are some areas within Havering which are at higher risk of fuel poverty, particularly due to poor housing stock and low household incomes. Poor housing stock and low household incomes are risk factors for fuel poverty. Data from 2008 indicates that the wards with the highest numbers of households in fuel poverty are Romford Town, Gooshays and South Hornchurch.

For the period 2006-2009 there was an average 137 excess winter deaths in Havering, which are the additional deaths occurring during winter months as compared to non-winter months. Excess winter deaths increase with age, with more than 1 in 4 additional winter deaths involving persons aged 85+ as compared to 1 in 10 among those aged below 65. The percentage of excess winter deaths in Havering is higher than the London average, but is average among east London boroughs. However, because of the greater number of deaths overall in Havering, the borough has the second highest numbers of excess winter deaths in London.

Figure 3: Average Number of Excess Winter Deaths in Havering, 2002-2009 (17)

	Under 65s	65-84	85 and over
Havering	13 (11.9%)	66 (17.2%)	67 (29.2%)

Independent Living and Social Care

Aids and Adaptations

A Housing Needs Survey carried out in Havering in 2006 found that 10.8% of older people surveyed live in an adapted home, 48.1% of whom are aged 75+. Levels of adaptation were far higher in Council housing (22.9%) than in owner occupation (8.4%). Only 50.5% of wheelchair users live in wheelchair adapted accommodation. There was a high outstanding need for adaptation, with bathroom and toilet adaptations being a priority. Lifts were the particular priority for households with a member aged 75+ (1).

The number of aids and adaptations delivered to Council tenants during 2009/10 was 1,682. These ranged from installation of grab rails and stair rails to ramps and stair lifts. The average cost of aids and adaptations is £1,152 each. The cost of meeting this annual flow of needs would be £1,937,664. In private housing, an average of 175 home adaptations are delivered to older people (aged 60+) per year through Disabled Facility Grants (DFG). The average cost per annum of delivering adaptations through DFGs is £1,426,583 – or £6,666 per grant.

An extra care housing needs assessment (1) recommended that to meet care needs in the shorter term, and reduce the overall need for some individuals to move into extra care schemes, provision of aids and adaptations and preventative technology should be a priority. These facilities and technologies can increase quality of life immediately, reduce the number of falls and accidents leading to hospital admissions and enable greater independence of older people without them moving home.

Extra Care Housing and Social Housing for Older People (1)

Extra care housing enables people to self care for longer, and gives them access to care and other services that enable them to keep their independence for longer. Needs assessment work on extra care housing for older people in Havering in 2010 identified that:

- There were 182 extra care units in Havering, compared with 972 people living in residential and nursing homes. There is hence a considerable scope for developing provision of extra care housing while reducing the number of people in residential homes, achieving significant savings for both social care users and the Council by enabling people to live independently
- Savings generated through enabling older people to move to extra care housing as an alternative to residential care would amount to an average saving of £125 per person per week (41%) for the Council and £166 per week (94%) for the individuals concerned
- The greatest concentrations of older people applying for social housing are found within Gooshays and Heaton wards, with other isolated but dense concentrations in Havering Park, Brooklands, Rainham and Wennington and Cranham
- The most popular areas that older applicants for social housing wish to move to are Romford and Hornchurch, followed by Gidea Park and Harold Wood
- As part of Havering's extra care housing strategy, actions are being taken forwards to make more extra care housing for older people available in Havering

Residential Care, Nursing Care and Community Based Services (30)

- Fewer people (per 100,000 population) receive residential care, nursing care and community services in Havering than the England average
- There are also fewer permanent admissions (per 100,000 population) to residential and nursing care in Havering than the England average
- However, these figures relate to local authority supported residential and nursing care and do not include those who might be receiving this kind of care without local authority support

- 92.2% of permanent admissions to residential care, nursing care and adult placements in Havering in 2010/11 were for individuals who were aged 65 or older (30)
- Future demand can be seen in the "future level of need" section below.

Figure 4: Number of People per 100,000 Population Receiving Residential Care, Nursing Care and Community Based Services in Havering and England, 2008-2011

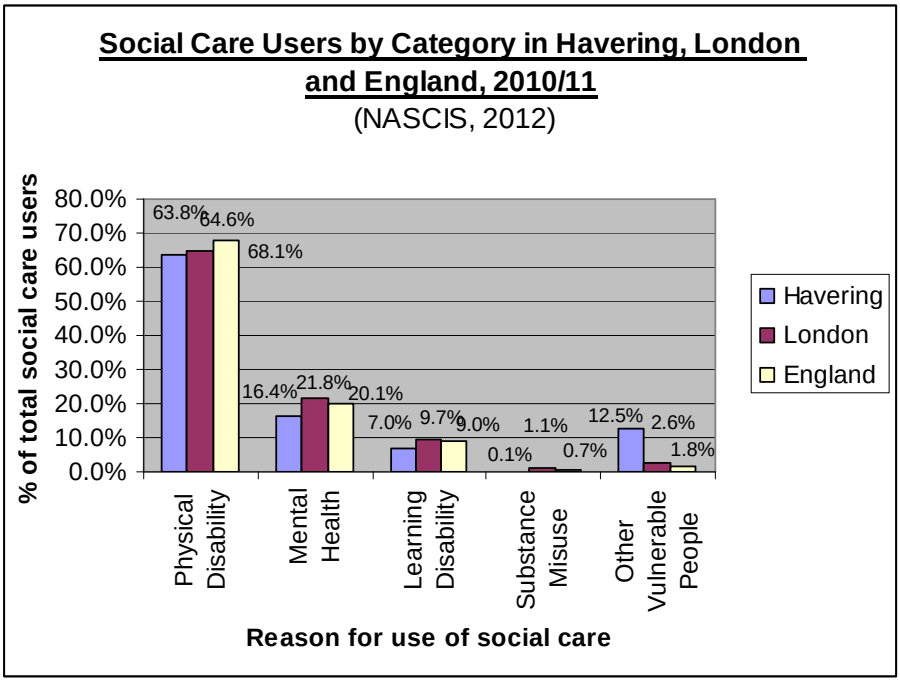
	Havering 2008-09	Havering 2009-10	Havering 2010-11	England 2010-11
Residential Care	923	819	798	1,386
Nursing Care	685	560	508	586
Community Based Services	8,408	6,592	6,150	6,407
Number of Permanent Admissions to Residential Care	287	337	313	464
Number of Permanent Admissions to Nursing Care	270	286	176	222

Source: NASCIS, 2012 (30)

Adult Social Care Users

- A greater proportion of Havering's social care service users are aged 65 or older than is the case in London or England overall. 74.2% of Havering social care clients were aged 65 or over in 2010/11 (4920 clients). This compares to 61.7% in London and 67.6% in England (35)
- This equates to a rate of social care users aged 65+ of 11,855 per 100,000 population. This is lower than the England rate of 12,370 and the London rate of 13,305 per 100,000 population. This could suggest that a smaller proportion of older people in Havering use social services when compared to other areas in London and England. However, of those that do use social care services in Havering, a greater proportion of total service users are older people than is the case elsewhere in London and England (35)
- Those with a physical disability are the biggest users of social care services in Havering, accounting for nearly two thirds of all service users (4235 clients). Havering has a smaller proportion of social care clients with physical disabilities, mental health issues (1090 clients), learning disabilities (470 clients) and substance misuse (less than 5 clients) than London or England. However Havering has a much greater proportion of social care clients who are in the "other" vulnerable people category than London and England (830 clients) (35)
- The proportion of social care clients with a physical disability has increased year on year from 36.8% in 2005/06 (35)

Figure 5: Social Care Users by Category in Havering, London and England, NASCIS, 2011



- In 2010, 77% of Havering residents with a long term condition report that they are supported by health and social care services to be independent and in control of their condition. This compares to a London figure of 75.4% and an England figure of 81%). However, this percentage of people who feel supported is increasing, having increased from 68.7% in 2008 (33)
- 84% of Havering's social care users were happy that they had been treated with respect and dignity, which compares to a London figure of 81.9% and an England figure of 87.1% (34)
- 90.4% of adult social care users in Havering were at least quite satisfied with the care and support they receive from social services in 2010/11 (36)

Direct Payments

The Community Care (Direct Payment) Act 1996, which came into effect in April 1997, gave local authorities the power to make Direct Payments. The aim was to enable disabled people aged 18 - 65, assessed by the local authority as needing community care services, to have cash rather than services to meet their assessed needs. This was extended to older people in February 2000, and in 2001 the Carers and Disabled Children Act further widened the eligibility to include carers, parents of disabled children and disabled young people (aged 16 or 17 years).

The Health and Social Care Act 2001 reinforced the previous Acts and gave local authority Social Services directorates the power to make cash payments to individuals instead of the community care services they had been assessed as needing. Recipients of Direct Payments use the money to secure services to meet their assessed needs and become responsible for arranging and directing those services.

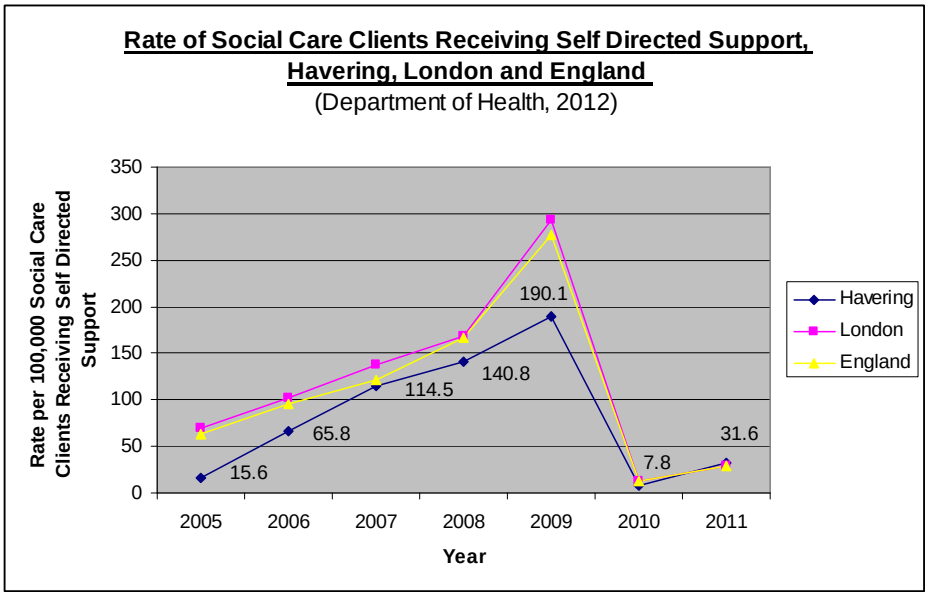
Direct payments give individuals independence, choice and flexibility and can provide the opportunity to create innovative care packages where citizens are recognised as experts of their own needs. Eligible individuals use their allocated money to buy care and services to achieve an agreed outcome, with checks ensuring appropriate outcomes are met. Direct payments could also be utilised to provide access to services which would not form part of a traditional care package but that may still improve quality of life for residents, such as cultural activities, e.g. theatre trips, art classes and physical activity workshops.

In Havering, around 550 service users are currently in receipt of a direct payment in Havering (93 of these are parents of disabled children). In Havering, direct payments are most commonly used for the following services:

- Home Care
- Respite
- Social Inclusion (day centres, out and about in the community)
- Equipment in some cases
- Items that support service users in meeting their agreed outcomes

In 2011, the rate of social care clients receiving self directed support in Havering was 31.6 per 100,000 (aged 18+). This compares to a London figure of 29.4 and an England figure of 28.9 (29). The drop in the rate of individuals receiving directed support between 2009 and 2010 is due to changes in the definition of directed support, and which services were included in this definition.

Figure 6: Rate of Social Care Clients Receiving Self Directed Support in Havering, London and England, Department of Health, 2012



Frail Elderly

Depression, Loneliness and Social Isolation

Social isolation among older people is an important public health issue that is associated with poor outcomes such as increased mortality and increased susceptibility to dementia (15)

- Older people living alone can be an indicator of social isolation and may require more support from health and social care services
- It is estimated that 16,300 Havering residents aged 65+ are living alone in 2012
- This is predicted to increase to 17,948 older people living alone by 2020 (2)
- It is estimated that 3,760 people aged 65+ in Havering have depression
- This is estimated to increase to 3,925 by 2015 and 4,146 by 2020 (2)

Falls (5)

- There were 1,733 falls related admissions in Havering in 2010/11 at a cost of more than £6 million. This compares to 866 admissions in Barking and Dagenham, 1,625 in Waltham Forest and 1,487 in Redbridge
- The number of admissions to hospital due to falls is expected to increase by 14% in Havering by 2020

- 11,190 pensioners were predicted to fall in 2010 and this is expected to rise by 42% to 15,909 by 2030, with women twice as likely to fall as men
- 61% of falls are in the home, and a further 7% of falls are in care homes
- 62 people were discharged from hospital to care/residential homes as a result of falls injuries costing £1.6M to social services

Dementia

There is a dedicated JSNA chapter on dementia where further information can be found. However some key findings from the chapter about level of need include:

- It is estimated that around 3,050 people in Havering (aged 65+) currently have dementia
- This is predicted to rise to 4,691 by 2030, with Havering having a greater number of residents with dementia than the majority of other London Boroughs
- The recorded number of people with dementia in Havering is significantly lower than the expected number, suggesting that more than 2,000 local people are living with undiagnosed dementia
- Around 60 people in Havering are estimated to be affected by early onset dementia (age 30-64)
- It is estimated that around 63% of those with late onset dementia live in private homes in the community, and around 37% live in care homes

End of Life Care

The National End of Life Care Intelligence Network produce profiles for each local authority summarising data relevant to end of life care. Key findings for Havering include:

- 61% of Havering residents die in hospital. This is significantly higher than the national figure of 54% but the same as the London figure of 61% (2008-2010) (41)
- Compared to this, only 18% of Havering residents die in their own homes, 13% in a care home, 4% in a hospice and 1% elsewhere (2008-2010) (41)
- Numbers of Havering residents using St Francis' Hospice end of life services can be seen in the below table. A high number of Havering residents use St Francis' hospice end of life services compared to the rest of Outer North East London. For example, 55% of the total admissions to St Francis' Hospice and 60% of the day hospice attendees are Havering residents. This could be due to Havering's elderly population relative to the other Boroughs (26)

Figure 7: Use of St Francis' Hospice End of Life Services by Havering Residents, 2009-2012 (26)

Service	2009/10	2010/11	2011/12 (at Dec 11)	2011/12 Forecast
Admissions to hospice	175	152	145	193
Day hospice attendances	1,054	1,131	1,030	1,373
Community palliative care (face to face)	1,405	1,446	1,274	1,699
Community palliative care (phone contact)	7,105	6,757	5,860	7,813
Hospice at home (visits)	1,584	1,525	1,259	1,679
Hospice at home (telephone calls)	1,998	1,893	1,980	2,640
Triage (assessment) telephone calls	3,442	3,843	3,243	4,324
Bereavement contacts (face to face and telephone)	N/A	1,774	971	1,295
Multidisciplinary team community visits	842	745	642	856
Outpatients	170	216	181	241

Carers

- In 2010/11, of those having carer's assessments and reviews (by social care), 59.5% of carers were aged 18-64 (825 carers), 16.4% were aged 65-74 (230 carers) and 23.9% were aged 75+ (335 carers) (35)
- 31.4% of carers in contact with social care in 2010/11 received services, and the remaining 68% received information (35)
- In May 2011, 0.81% of Havering's population were claiming carers' allowance (1,900 people). This compared to 0.88% in London and 0.92% in England (18)
- It is estimated that in 2012, 4,752 Havering residents aged 65+ are providing unpaid care. It is estimated that this will rise to 5,005 by 2015 (2)

Adults and Older People with Learning Disabilities or Mental Health Issues

- In 2010/11, 6.8% of Havering adults with learning disabilities were in paid employment. This is similar to the England figure of 6.6% but below the London figure of 8.7% (20)
- Since 2009, the proportion of adults in Havering with learning disabilities in Havering has been increasing, being 4.7% in 2009, 5.4% in 2010 and 6.8% in 2011 (21)
- In 2010/11, 43.9% of adults with learning disabilities lived in settled accommodation (e.g. in their own home or with their family). This is lower than the England figure of 59.1% and the London figure of 59.4% (20)
- The proportion of adults with learning disabilities in Havering living in settled accommodation is increasing, being 34.3% in 2009, 42.1% in 2010 and 43.9% in 2011 (20)
- In 2011, there were approximately 560 users of learning disability services in Havering (of all ages), of which around 70 were aged 60 or older (21)
- It is estimated that there are 1786 adults (aged 18+) in Havering with autistic spectrum disorder, of which 362 are estimated to be of retirement aged (65+) (25)
- 7.4% of adults in contact with secondary mental health services were in paid employment in 2011, compared to a London figure of 6.9% and an England figure of 9.5% (25)
- The proportion of adults in contact with secondary mental health services in paid employment in Havering has fluctuated, being 5.2% in 2009, 3.3% in 2010 and 7.4% in 2011 (25)
- 92.8% of adults in contact with secondary mental health services were living independently, with or without support in 2011. This is higher than the London figure of 73.2% and the England figure of 66.8% (23)
- The proportion of adults in contact with secondary mental health services living independently in Havering has fluctuated, being 63.9% in 2009, 43.5% in 2010 and 92.8% in 2011 (23)

Mental health issues may be experienced by some vulnerable adults and older people. In 2011, mental health scorecards were produced for every local area in England (31). Below is a summary of the key findings from Havering's scorecard. This is intended to give a snapshot of some of the issues, but is not a comprehensive needs assessment, and it is recommended that a separate JSNA chapter on mental health may need to be developed in future to fully examine mental health issues in Havering. Please also see the JSNA chapter on dementia for further details on this issue.

Havering Mental Health Scorecard

- Havering has a lower rate of people in contact with secondary care community mental health services than the London average.
- Havering has lower admission rates for mental health problems than the London average
- Compared to the London average, Havering has lower rates of admission for organic and mood disorders in those aged 65 years and over.

- Havering has a lower rate of people on Incapacity Benefit / Severe Disablement Allowance for mental health problems than the London average
- Taking into account the population need, Havering has a larger mental health employment scheme caseload than the London average
- The number of those with mental health problems receiving direct payments is considerably lower than the London PCT average
- In 2006-08, Havering's suicide rate was not significantly different from the London average (6.0 Havering, 7.3 London age standardised mortality rate)
- Overall Havering spends less on mental health problems, per 100,000 weighted population, than the London average. However expenditure on organic mental health problems is higher than the London average
- Compared to the London average Havering has a similar prevalence of common mental health problems, but a lower need for inpatient services
- In any given week approximately 15% of adults in Havering will have a mental health problem, which is similar to the London average of 16%
- It is estimated that 10% of the adult population in Havering have depression (compared to 11% in London, and 8% in England)
- Need for inpatient services for severe mental illness in Havering is thought to be 20% lower than the England average (compared to London overall which has a need that is 60% higher than the national average)
- Compared to the London average, a lower percentage of patients with Coronary Heart Disease or diabetes have been screened for depression. However of those patients with depression, a higher percentage have had the severity of their depression assessed than the London average

Future Level of Need

It is estimated that the number of older people in Havering with support needs such as being unable to manage self care tasks (e.g. washing, dressing) and domestic tasks (e.g. shopping, cleaning) will continue to increase in Havering in the future. This will have an impact on the level of demand for social care services that help people to live independently. Similarly, the number of older people with learning disabilities is estimated to continue to increase in the future as shown in the below table.

Figure 8: Projected Level of Need, Service Use and Residential Care for Older People in Havering, POPPI, 2012 (2)

Support Need	**2012**	**2015**	**2020**
People Aged 65+ Unable to Manage at Least One Self Care Task on Their Own	14,842	15,503	16,691
People Aged 65+ Unable to Manage at Least One Domestic Task on Their Own	18,150	18,933	20,426
Services Provided			
Helped to Live Independently (aged 65+)	3,416	3,591	3,765
Admissions to Supported Permanent Residential and Social Care aged 65+	268	282	295
People aged 65+ Receiving Community Based Services	4,578	4,812	5,045
Supported Residents in Care Homes aged 65+	873	917	962

Figure 9: Projected Number of Older People with Learning Disabilities in Havering, POPPI, 2012 (22)

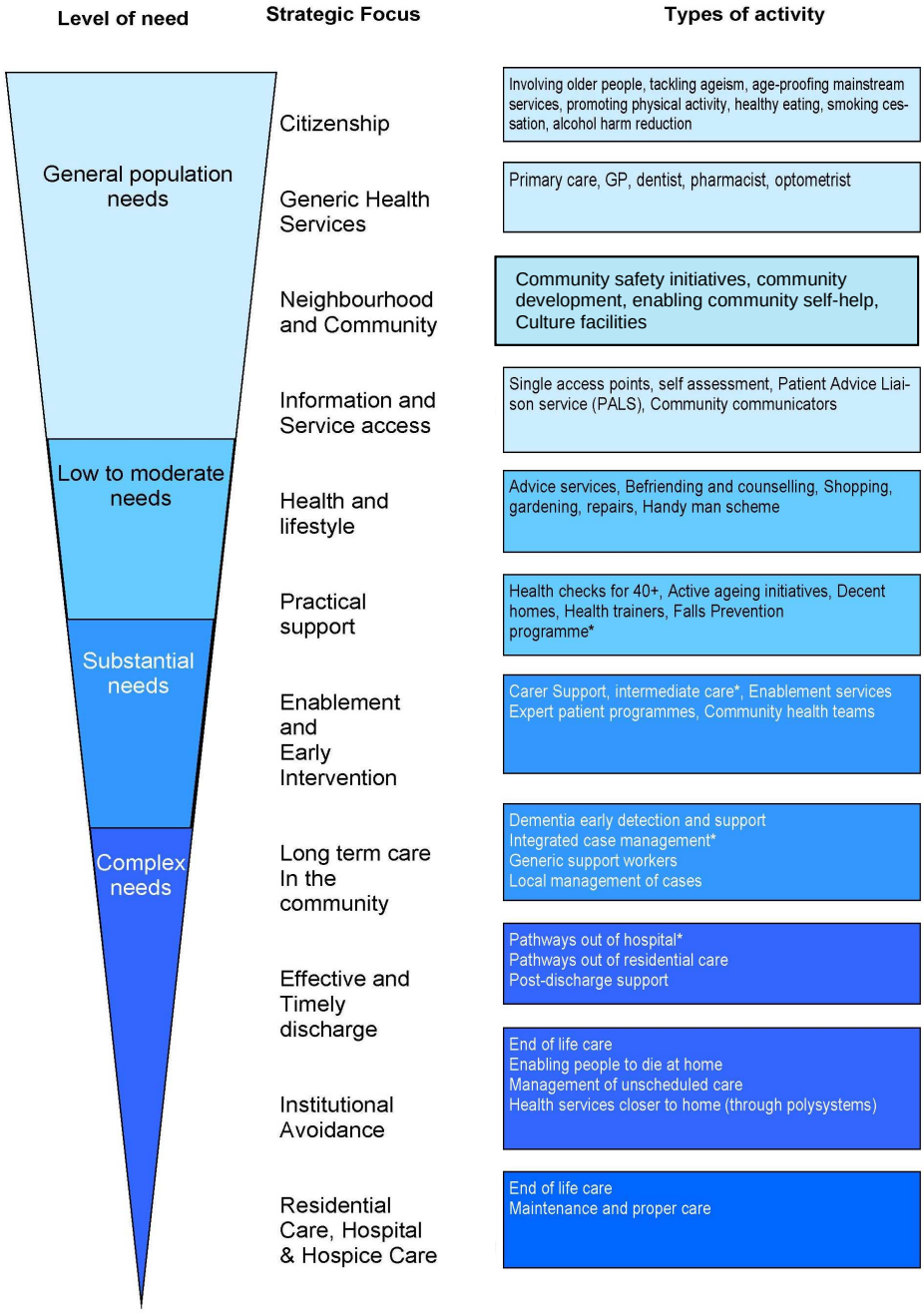
Support Need	**2012**	**2015**	**2020**
People aged 65+ Estimated to have a Learning Disability	887	934	989
People aged 65+ Estimated to have a Moderate or Severe Learning Disability	119	125	130

2. Current Service Provision for Vulnerable Adults and Older People in Havering

Prevention Services

There are a wide range of prevention services in Havering that support adults and vulnerable people to lead healthy and independent lives. A summary these services can be seen in the below diagram. Specific services providing support to adults and older people are also outlined in more detail below.

Figure 10: Triangle of Needs for those Aged 50+ in Havering, Havering 50+ Strategy, London Borough of Havering and NHS Havering



Helping People to Keep Warm at Home
The Council's Energy Strategy team works with partners to improve the energy efficiency of housing in Havering, increase awareness among residents on how they can reduce their energy costs and help them cope with the cold weather. Initiatives include training front-line services staff and voluntary groups to identify residents at risk from the cold and help them to access a range of services. The Council works in partnership with East London WarmZones and other agencies to provide free or heavily discounted insulation across the Borough.

Direct Payments
Direct payments to individuals (eligible people with disabilities, carers or older people) can be used to purchase services such as:

- Agency care provision
- Recruitment of Personal Assistants
- Residential homes providing short term respite care
- Day Centres providing social inclusion and education towards independent living

Further details of Direct Payments in Havering can be found elsewhere in the chapter.

Self Care Services
There are a wide rage of self care services available to eligible Havering residents, which include extra care housing and aids (e.g. bath seats and hoists) and adaptations (e.g. grab rails and ramps).

Telecare Services
Havering offers a Telecare service to provide a range of electronic devices in older and vulnerable people's homes e.g. alarm call systems to alert emergency services, sensors to detect if someone has taken a fall, appliances to check if the gas has been left on, and aids to ensure timely consumption of medicines. These support older and vulnerable people to live independently for longer in their homes and reduce the need to move into supported housing of any kind or care homes. Evaluation of a Telecare pilot in Havering found that 'Telecare has the potential to reduce the costs of residential care placement, even when the costs of Telecare are taken into account' and also, that 'early use of Telecare will prevent/slow down loss of independence and thus reduce home care costs in the short to medium term' (Homes in Havering, 2009) (1).

Integration Services
There is an existing prevention strategy for older people and adults with disabilities in Havering. Refer to the JSNA chapter on reducing hospital admissions for a summary of the Adults Transformation Programme integration projects.

Urgent and Emergency Care Services
Refer to the JSNA chapter on reducing hospital admissions for details of the urgent care workstream e.g. rapid response project.

Low Vision Services

- Low vision (when sight condition can no longer be further corrected by glasses, contact lenses or surgery) can have a dramatic impact on ability to perform every day tasks and enjoyment of life
- The low vision service at Yew Tree Resource Centre in Havering offers a two stage assessment of both individual circumstances and medical condition ensuring both of these elements of your life are taken into consideration when assessing needs and offering solutions (thus integrating both health and social care needs)
- Case studies from Havering residents who have used this service have identified that individuals who have used this service have felt supported to undertake daily activities, cope with their condition, and continue to enjoy life

End of Life Care

St Francis' Hospice offers a range of end of life care services for residents of Havering, Redbridge, Brentwood and Barking and Dagenham. These include:

- A residential facility (18 beds)
- A hospice at home service, with support available 24 hours a day (staffed by around 12 junior nurses and healthcare assistants and 12 specialist nurses)
- A day facility (providing a range of services e.g. pain management). Individuals can attend one day a week for a time limited period
- A telephone assessment and support service (first point of call for assessment of an individual's physical, emotional and social needs)
- An equipment service providing e.g. wheelchairs free of charge
- A bereavement support service
- Training on end of life care
- A range of other services such as chaplaincy, occupational therapy and a lymphodema clinic
- End of life services are also available at Queen's hospital including there being a Consultant in palliative/end of life care

Age Concern Havering

Age Concern Havering offers a number of services that support older people in Havering. These include:

- Befriending of lonely and vulnerable older people
- Active living activities to reduce isolation whilst improving mental and physical wellbeing
- Dementia support services including advice, training in the community, peer support club, a companion service for carers of those with dementia, a group for younger people with dementia and the SHIELD project which aims to improve the health and wellbeing of those with dementia and their carers
- Support to older people with day to day activities to help them stay in their homes for longer
- Day centre services, information and advocacy and transport services

Falls Prevention Services

- Falls clinic – a falls service operates from the day hospital at St George's Hospital in Hornchurch. The service provides multifactorial assessment, and a range of intensive prevention and evidence based exercise programmes based on OTAGO
- Falls community exercise programme – the falls community exercise programme provides falls management and balance exercises at community venues. The service aims to improve independence for older residents and runs exercise classes to improve mobility, bone density and cardiovascular fitness
- Falls outreach service for care home residents and telecare clients – an outreach service is available to care home residents and telecare clients. The service raises awareness of falls, identifies residents who may be at risk of a fall and ensures appropriate referral and management
- Falls prevention and management training for care home staff and telecare staff – this is a training programme for residential, care home and telecare staff to improve falls prevention and management.
- GP service – the service provides care for the general health and wellbeing of the individual who has had a fall or fracture, as well as osteoporosis case finding and management. An osteoporosis DES was implemented in Havering prior to 2012. However, from April 2012, this DES will be replaced by QOF, as osteoporosis becomes a QOF indicator
- Fracture liaison service based at the BHRUHT Queens Hospital – the service carries out osteoporosis assessment of patients who have had a fragility fracture and evaluates patients for future risks of osteoporosis, falls and further fractures. Patients

are given written information on falls prevention and osteoporosis; they are also started on treatment and referred as appropriate

Culture Facilities

- Havering has over 108 parks and open spaces, providing valuable space for reflection and relaxation, sport and exercise, and socialising with others. Public green space constitutes an integral part of the borough's environment, and makes Havering a pleasant place to live.
- There are three Council-owned Leisure Centres, which deliver a wide programme of activities. There are also extensive sports facilities available within parks, schools, and throughout the borough.
- The Fairkytes Arts Centre provides a year-round programme of activities and events from painting, drawing and pottery to open-air theatre and open days, including hosting a wide variety of activities staged by community and voluntary groups. The centre has approximately 70,000 annual adult attendances – with roughly 60% of all users being over-50.
- The Arts Service also regularly targets older people through outreach activity, such as working with former Vickers employees to create public art, and running music events for people with dementia. They deliver the annual 60+ Artist of the Year Competition and exhibition, and The Queens Theatre coordinates the 60+ Musician of the Year competition.
- The Health and Sports Development Team deliver an on-going programme of sport and physical activity for adults, many of are targeted at older people, including yoga, dance, armchair exercise, and tai chi.
- The Havering 'Walking the Way to Health' programme, which offers an excellent way to exercise and socialise particularly for older residents, had 786 registered walkers make 11,423 attendances across 19 walking venues in 2011-12.
- Havering Museum runs a number of activities, including a reminiscence programme for older people in the local community.
- Libraries hold a massive number of events and activities (approx. 3,000 per year), with many targeted at the older generation, and ranging from one-off author visits and speakers to on-going sessions such as Knit and Natter groups, poetry group, creative writing classes and reading groups. The Reader Development team also does outreach and promotional work with over 50s groups, such as the Perky Pensioners and Harold Wood over 60s group.

3. Evidence of What Works to Support Vulnerable Adults and Older People

Integration of Health and Social Care

The King's Fund publication "A report to the Department of Health and the NHS Future Forum" highlights the need for integration. The report highlights that no best practice model of integration exists, however states that "in all of the successful integrated care projects we examined, additional and improved services outside hospital were required…shining a light on the lack of current capacity and capability in community services to deliver care co-ordination and more intensive care in the home environment" (27:p3). The report states that integration should be targeted to individuals who stand to benefit most and should have the needs and perspectives of the individual at the centre of the discussions. Earlier reviews by the King's Fund concluded that integration can result in significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated. The King's Fund also suggest ways in which barriers to integration can be overcome, such as introducing payment incentives, innovative approaches to sharing data and evaluating the impact of integrated care (27).

Reducing Social Isolation in Older People
A 2011 systematic review of interventions aiming to reduce social isolation in older people (15) concluded that effective interventions offered social activity and/or support in a group format, were based on theory and were more effective when older people were actively involved. However more research is needed to strengthen the evidence base on this area.

End of Life Care
The Department of Health's End of Life Care Strategy identifies a number of key elements to effective end of life care, such as identifying people approaching the end of life, appropriate care planning, effective co-ordination of care, rapid access to care and involving and supporting carers. The strategy is available online here:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277
NICE have also produced a draft Quality Standard on End of Life Care, which is available online here:
http://www.nice.org.uk/guidance/qualitystandards/indevelopment/endoflifecare.jsp?domedia=1&mid=B7C38F4D-19B9-E0B5-D477151ADF086A21

In 2009 the National End of Life Care Programme piloted an end of life care register, with a common template developed to be shared across all organisations and settings. The aim of the register is to improve the coordination of care in a patient-centric manner to ensure that patients' wishes are met during the final stages of their lives. So far the pilot has been shown to enhance communication and transfer of information across acute and community health sectors and social care, an improvement in the patient experience and an increase in the number of patients dying in their preferred place. Further information can be found at *http://www.royalmarsden.nhs.uk/consultants-teams-wards/clinical-services/pages/coordinate-my-care.aspx*

Falls Prevention
NICE clinical guidelines on the assessment and prevention of falls recommends the following priorities for implementation: Case/Risk identification, Multifactorial risk assessment, Multifactorial interventions, Professional education. Evidence based interventions for falls prevention recommended by NICE include:

- Strength and balance training – FAME and Tai-chi for balance exercise classes
- Home hazard assessment and intervention
- Medication review with modification/withdrawal
- Education and information giving

The Department of Health document 'Fracture Prevention Services: An economic evaluation' advocates prevention and treatment of osteoporosis, to reduce the risk of fracture following a fall.

4. What Local People Think

Older People's Views: Your Council, Your Say Survey
The Your Council, Your Say Survey provides a snapshot of which areas local people see as priorities in making an area a good place to live and priorities for improvement. Key Findings for older people from the 2011 Your Council Your Say survey included:

- Health services were the top priority in making Havering a good place to live for those aged 65+. This was also the top priority for those with disabilities or long term limiting illnesses
- Crime, clean streets, roads and pavements and public transport are also important priorities for those aged 65+ in making Havering a good place to live. These were also important priorities for those with disabilities or long term limiting illnesses

- There are high levels of resident satisfaction among older people with Havering as a place to live. Those with long term limiting illnesses or disabilities have similar levels of satisfaction
- Older people feel better informed about the Council than younger people. Those with disabilities or long term limiting illnesses felt as well informed as those without disabilities
- Older people are more likely to feel that people in the local area get on well together than younger people. People with disabilities or long term limiting illnesses have similar views on how well local people get on together as those without disabilities
- Older people see the following areas as most in need of improvement: roads and pavements, traffic congestion, clean streets, activities for teenagers and older people and crime
- People with disabilities or long term limiting illnesses ranked similar areas most in need of improvement as those without disabilities

Service User Feedback on Telecare (1)

Feedback from a survey of telecare service users, their carers and stakeholders include:

- 92% of service users felt safer in their homes because of Telecare
- Over 70% of carers stated that their stress levels had reduced significantly with the use of Telecare and increased their ability to care for their family member at home for longer, with 94% stating that they would recommend Telecare to others
- 63% of stakeholders identified that Telecare had reduced the need for residential placements with 80% reporting it had relieved carer fatigue and improved carers' lives
- Nearly 80% of stakeholders considered Telecare could lead to budgetary efficiencies for their service

Service User Feedback on Direct Payments (28)

A 2008 survey of users of Direct Payments in Havering found that:

- 94% felt that Direct Payments had improved their lives, with the flexibility the scheme offers being stated as the main benefit
- 96% stated they would recommend the service
- The majority of those surveyed sample (74%) were recommended the service by their care manager and 14% requested the service themselves. 2% were advised of the service by a voluntary agency and 10% via other sources
- 88% felt they had received enough information and advice when beginning the service, however suggestions for improvements included more support with the form pack, a detailed explanation of the service and more advice on quarterly returns

Views on Falls Prevention

- Customer satisfaction questionnaires completed by falls clinic patients – in all surveys completed patients were very satisfied with the service received at the falls clinic
- Questionnaires received in response to falls prevention and bone health strategy consultation –supported the proposals and objectives of the strategy. A few questionnaires offered suggestions on other key aspects they believed should be addressed and these included the bad condition of pavements, requests for more education around safety in the home and more information on osteoporosis, and a suggestion that screening for osteoporosis should be offered routinely to people over 65

Culture and Leisure Annual Survey

Culture is central to the quality of life of Havering residents and recent Culture and Leisure Annual surveys have demonstrated how important these services are to residents. The 2010 Culture and Leisure Annual Survey (sample size of 1,000) noted that:

- 80% of people agree that culture and leisure services give people a sense of community (32% giving the maximum score)

- 84% of people believe that culture and leisure activities give them the opportunity to meet and mix with local people.
- 57% of people reported that culture and leisure activities make them feel more positive about the borough
- 62% of respondents felt that culture and leisure activities strengthen community spirit.

5. Gaps in Knowledge and Service Provision in Havering

- Opportunities have been identified for health and social care to work together more closely to support older people in the community, with some case studies illustrating this need. This more integrated working could help reduce the need for hospital admission or admissions to residential care as well as providing better outcomes for the individuals involved
- Until recently, there was no central source of consistent information and advice for adults and older people in Havering, or single overarching organisation to provide this advice. Therefore provision is not as effective or co-ordinated as it could be in meeting the needs of the community. However, projects are currently underway to address this, such as a shop in Romford, a website and the establishment of a user led organisation
- Currently, personal budgets are not available those in permanent placements
- Currently there is limited use of assisted technologies and lengthy additional assessment process required to incorporate within the care package. The benefits of assistive technologies need to be understood and further communicated to staff, partners and the community, promoting independence and an improved quality of life
- There is a need to expand the scope of the current reablement service and streamline the pathway for admission avoidance and hospital discharge. A key element of this is increasing knowledge and understanding of reablement and its benefits to the workforce and the community as a whole
- There are opportunities for transport provision by social care to offer more choice and to be more cost effective
- There are opportunities for more consistent engagement with users of adult social care services
- Transition to adult social care for children with a disability needs to be more streamlined
- Self funders receive advice and information but if they are financially independent, no further support is offered unless specific risk is identified
- There is scope for better information sharing between partners relating to the end of life care wishes of individuals. Forms which state an individual's preference to die at home may be held by an individual's GP but not by ambulance or accident and emergency services, so that these services may be unaware of an individual's preferences
- Osteoporosis case finding and prescribing – there is a gap in osteoporosis case finding and management, as recorded prevalence of osteoporosis is below the expected prevalence. It is estimated that for 2009/10, only about 38% of eligible women were on osteoporosis medication

Users of direct payments have indicated they feel that there is not enough service provision in the following areas:

- Services providing day respite for younger client group. There are currently only a small number of providers within the Borough for these types of services. However, since the introduction of direct payments and personalisation, three new providers of day centre activities and one new provider of respite have emerged.
- Residential respite homes for younger people with physical disabilities and those with learning difficulties
- A strength is that Havering's libraries are well used and provide a trusted point of first contact on a wide variety of issues

Gaps: Learning Disabilities

- Learning disabilities self assessment work in 2011 identified that in some areas there was a need for better recording of information about those with learning disabilities in Havering. For example, there was a need for the recording of learning disabilities by GP practices to be more consistent and to include diagnosed medical conditions (including on disease registers such as the Quality Outcomes Framework). This was also the case for use of screening, sexual health and prison services by those with learning disabilities. Further areas for future work were also identified which have been included in the future actions/recommendations section below.
- Needs assessment work for Havering's adults with autism strategy identified that the number of people with Autistic Spectrum Disorder (ASD) in contact with services in Havering is much smaller than the estimated number of people with ASC in the area. This difference could be for a number of reasons. Possible reasons include: services not recording users as having ASD, individuals not receiving a diagnosis of ASD, individuals with ASD purchasing privately provided services or using third sector services, prevalence being an over-estimate, or individuals with ASD not using or not needing to use services provided. Consultation with those with ASD, service providers and other stakeholders could help explore these reasons

Gaps: End of Life Care

- Those approaching the end of their life have mentioned that communication around end of life care is poor, with individuals being "passed between" a huge range of different agencies, without anyone having a conversation with you to tell you that there are not any further active treatment options available
- Feedback from St Francis' hospice suggests that in many instances, referrals to end of life services do not happen early enough. Many referrals are made when an individual is very close to the end of their life, when an individual might have benefitted from using services (e.g. pain management) at an earlier stage. This could be because GPs and other health professionals aren't familiar with when end of life care services can be used. The majority of referrals to St Francis' hospice services are from hospitals (44% of referrals), GPs (16%) and district nurses (13%). Very few of the referrals are from social care (less than 1%) (26)
- Currently there is no single register of individuals on end of life pathways
- Transport options to St Francis' hospice are limited (only one bus every one and a half hours during the week and buses only available on Saturday mornings at the weekend)
- St Francis' hospice would like to further engage with community groups and minority groups to ensure that all groups of local people are aware of and able to access end of life care services
- There was also a perception that there is limited support available for the families of those reaching the end of their life
- Demand for end of life services from St Francis' hospice is continuing to increase, and is forecast to increase yet further. Without an increase in resources, this is resulting in longer waiting lists. Extra capacity is particularly needed for the telephone support and assessment line, to enable this to be available 24 hours a day (it currently is not)
- A previous one off initiative providing palliative care training to nursing homes was successful, however it was felt that in order for this skills to be retained annual training in nursing homes and for District Nurses and GPs would be required (which could be mandatory)

Gaps: Fuel Poverty and Excess Winter Deaths

- A survey undertaken in early 2012 by NHS Havering on what measures partners are implementing to assist residents during extreme cold weather spells (linked to the Met Office Cold Weather Alerts and the North-East London and City NHS Cold Weather Plan), indicated that there is no formal procedure adopted at a borough level to assist

vulnerable residents. Partners indicated that they would find it helpful to have overarching guidance/messages and participate in joint initiatives where feasible.

6. Future Actions and Recommendations

- Work with Havering's Vision Strategy Group to undertake more in depth needs assessment work around eye health e.g. gap analysis of service provision and consultation with local people to identify un-met need
- Develop a Vision Strategy for Havering incorporating the findings of needs assessment
- Continue development of the Integrated Care Strategy for Havering (health and social care), which will deliver increased support in the community, thus reducing demand on hospital services and supporting improved outcomes for the frail elderly and those with dementia
- Continue to increase the capacity of the reablement service, including creating confidence in and awareness of the role of this service in reducing the need for hospital admissions and reducing length of stay (where hospital admission required)
- Continue to deliver the actions from Havering's falls prevention and bone health strategy e.g. delivering falls prevention and management training for staff in care homes and telecare staff and delivering a falls prevention community exercise programme
- Closer partnership working with neighbouring boroughs to ensure hip fracture care is delivered to blue book standards Work with GP and secondary care to improve case finding and management of osteoporosis
- As part of the Integration Strategy actions, implement a "case finding" approach to social care, so that health and social care colleagues actively engage with each other at the point when an individual is admitted to hospital and start planning for discharge. This will involve a move away from the current model which is referral led
- Continue to deliver actions from Havering's personalisation framework, such as extending the use of personal budgets and providing more choice in transport provision
- Reduce fuel poverty and excess winter deaths by continuing to deliver actions from Havering's fuel poverty strategy e.g. improving energy efficiency of Havering's housing and raising awareness of how to reduce energy costs and keep warm
- Develop a borough level Cold Weather Plan to guide partners in supporting vulnerable residents during extreme cold weather spells (i.e. through the Borough Resilience Forum Risk Sub-Group), and undertake joint initiatives to ensure older residents are prepared for cold weather.
- Implement Havering prevention strategy for older people and people with a disability
- Develop and implement a policy around guidance of the use of personal budgets, to meet need for clearer guidance in this area requested by service users
- Ensure that people with mental health needs are being referred to the community services they require
- Continue to work with partners in Culture and Leisure to support a high standard of mental, physical and emotional health for all by increasing the number of people engaging with libraries, parks and open spaces, sport and physical activity, arts and historic environment.

Future Actions/Recommendations for Adults and Older People with Learning Disabilities

Some key actions and further areas of work identified in the 2011 learning disabilities self assessment (which applies to older people with learning disabilities as well as younger adults) included:

- Introduce more consistent recording of learning disabilities information in identified areas (e.g. by GP practices)

- Identify resources with which to undertake further work about the needs of those with learning disabilities in Havering e.g. an audit of current data and service provision. Incorporate the findings into the JSNA
- A review of all placements for those with learning disabilities in Havering to be undertaken
- Protocols/guidance to be developed for reasonable adjustments for those with learning disabilities using GP practices and community primary care services e.g. pharmacies and dentists
- Learning disabilities awareness training to be delivered across primary care. This should include training for community based health services to enable identification, treatment and support of those with learning disabilities to improve care and reduce avoidable hospital admissions
- An audit to be undertaken of the choices of healthcare available to those with learning disabilities and the accessibility of these options

Future Actions/Recommendations for End of Life Care

- Work with partners to improve co-ordination of and communication about end of life care (this could include service mapping and mapping of end of life care pathways)
- Implement a single register similar to the Coordinate my Care pilot for individuals on end of life care pathways (as part of the NHS 111 telephone service project)
- Work with partners to ensure individuals are referred to end of life care services at the earliest appropriate opportunity
- Ensure GPs, nurses and care homes undertake regular training about end of life care, including when it is appropriate to refer to such services
- Ensure the needs of Havering residents are reflected in the Outer North East London end of life care strategy and action plan
- Consider the resource implications of increasing demand for end of life care services in Havering and how these will be met in future
- Consider transport arrangements to hospice services in Havering and any opportunities to improve these

7. Further Information

References

1. Evidence of the Current and Projected need for Extra Care Housing, the London Borough of Havering, (2010).
2. Projected Level of Need for Older People in Havering, POPPI, (2012). Available online at: www.poppi.org.uk
3. End of Life Care profiles, National End of Life Care Intelligence Network, (2012). Available online at: http://www.endoflifecare-intelligence.org.uk/profiles/2/Place_of_Death/atlas.html
4. Registered Blind and Partially Sighted People, NHS Information Centre, (2011).
5. Falls Prevention and Bone Health Needs Assessment, NHS Havering, (2011).
6. Falls – Costs, Numbers and Links with Visual Impairment, the Royal National Institute for the Blind, (2011).
7. Havering Health Profile, Department of Health, (2012).
8. Limiting Long Term Illness in Havering, Census: Office of National Statistics, (2001).
9. Good or Fairly Good Health in Havering (NI137), Audit Commission, (2009).
10. Raising the Profile of Long Term Conditions Care, Department of Health, (2008). Available online at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082069
11. Long Term Conditions, University of East London, (2009).
12. COPD Spells and Costs, London Borough of Havering Adult's Transformation Programme, (2012).

13. Depression in Older People, POPPI, (2012). Available online at: www.poppi.org.uk
14. Older People Living Alone, POPPI, (2012). Available online at: www.poppi.org.uk
15. Interventions targeting social isolation in older people: a systematic review. Dickens, A, Richards, S, Greaves, C, Campbell, J. 2011, BMC Public Health, 11:647.
16. Fuel Poverty Strategy, the London Borough of Havering, (2012).
17. Excess Winter Deaths 1990 – 2009 Analysis, NHS Havering, (2012). Based on Excess Winter Deaths statistics, West Midlands Public Health Observatory, http://www.wmpho.org.uk/excesswinterdeathsinenglandatlas/H/atlas.html
18. Carer's Statistics, Department for Work and Pensions, (2012). (Data accessed on Havering Data Intelligence Hub).
19. Working Age People with Disabilities, Annual Population Survey: Department for Work and Pensions, (2012). (Data accessed on Havering Data Intelligence Hub).
20. Learning Disabilities in Paid Employment (NI145), Cabinet Office, (2011). (Data accessed on Havering Data Intelligence Hub)
21. Learning Disabilities Self Assessment Framework, the London Borough of Havering, (2011).
22. Projected number of older people with disabilities, POPPI, (2012). Available online at: www.poppi.org.uk
23. Mental Health and Settled Accommodation (NI149), Cabinet Office, (2011). (Data accessed on Havering Data Intelligence Hub).
24. ?
25. Mental Health and Employment (NI150), Cabinet Office, (2011). (Data accessed on Havering Data Intelligence Hub).
26. Autistic Spectrum Disorder: Prevalence and Service Use Information for Havering's Adults with Autism Strategy, the London Borough of Havering, (2011).
26. Service User Statistics St Francis's Hospice, St Francis's Hospice, (2012).
27. A report to the Department of Health and the NHS Future Forum, the King's Fund, (2012).
28. Direct Payments Survey, the London Borough of Havering, (2008).
29. Social care clients receiving self directed support, Department of health, (2011). (Data accessed on Havering Data Intelligence Hub).
30. Permanent admissions to residential care, nursing care and adult placements NASCIS, (2011). Available online at: https://nascis.ic.nhs.uk/Portal/Reports/Pdf.ashx?r=N002_726_03_2012.pdf&t=PublishedReport&type=standardreports
32. Mental Health Scorecard, London Health Observatory, (2011). Available online at: http://www.lho.org.uk/Download/Public/16873/1/MHscorecard_Havering_Jan2011.pdf
33. People who feel supported by health and social care services to be independent and in control of their condition (NI124), Department of Health, (2012). (Data accessed on Havering Data Intelligence Hub).
34. Social care users were happy that they had been treated with respect and dignity (NI128), Department of Health, (2011). (Data accessed on Havering Data Intelligence Hub).
35. Social Care Service Users Statistics, NASCIS, (2012).
36. Adult Social Care Survey, the London Borough of Havering, (2012)
37. Estimated older population in Havering by age and gender, 2010 Mid Year Estimates, Office of National Statistics, (2011).
38. The Indices of Multiple Deprivation for Older People 2010 (IDAOPI), Communities and Local Government, (2011)
39. Proportion of Havering Population Aged 65 or Over, 2010 ONS Population Estimates, Office of National Statistics (2011)
40. Falls – Costs, Numbers and Links with Visual Impairment, RNIB, (2011).
41. End of Life Care Statistics. National End of Life Care Intelligence Network, 2012). Available online at: http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/default.aspx

NB. Please note throughout the document, percentages may not sum due to rounding.