Independence, Choice and Control: Services for older people

An integrated Commissioning strategy for Barnet 2008-2017

Developed by:

- Barnet Primary Care Trust
- London Borough of Barnet Council
- Barnet, Enfield and Haringey Mental Health NHS Trust
- Barnet Partnership Board for Older People

BARNET LONDON BOROUGH

Barnet NHS Primary Care Trust

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1. Summary

Independence, Choice and Control sets out the commissioning intentions of the London Borough of Barnet and Barnet Primary Care Trust for services for older people over the period from 2007-2017.

The commissioning strategy was developed by the London Borough of Barnet and Barnet Primary Care Trust (Primary Care Trust), and with Barnet, Enfield and Haringey Mental Health NHS Trust and builds upon the joint work and consultations with older people which led to the plan 'Living Longer, Living Better (2006-2009) and the wide range of service developments over the last 3 years.

It is based on the current and future requirements of older people living in Barnet. It is designed to secure appropriate provision of services to meet the population's health and social care needs, to meet people's changing aspirations, offering them and family and informal carers control and choice in the way those needs are met.

Overall, the numbers of people with impairment and dependency will increase in Barnet over the next 20 years and the policy directives for the NHS to 'shift care closer to home', aims to deliver more choice and flexibility in how health needs are met. Both these changes potentially place significant pressures on social care systems as more people are treated in the community.

The new national policy direction challenges local authorities and primary healthcare trusts to focus on whole communities not as in the past on smaller numbers with acute needs. The challenge is to prevent dependency on services. Meeting this challenge will provide better outcomes with the opportunity for more fulfilling lives for older people. It will also be more affordable to the public purse and provide good value for individuals.

The vision for the future role of older people's services reaches beyond Adult Social Services to support the corporate objectives of the borough in creating the environment to support community well being. This strategy will be used to develop and inform other programmes and targets such as those set out in the Local Area Agreement, the Corporate Plan and the Sustainable Community Strategy.

The strategy covers all the health and social care services that older people are likely to use. Its focus is on maintaining the health and well being of older people, but it recognises that age can bring disability and mental or physical ill health – and these must be diagnosed quickly and treated appropriately.

To meet aspirations of older people into the future it is important that commissioners continue to seek the views and experiences of people who are in receipt of services, listen to older people who may be planning for the future and also use population and needs analyses to predict and forecast future requirements. In addition, in order to make effective decisions for individuals and groups, the local authority and Primary Care Trust need to use and share information in an effective way.

The need analysis demonstrates that demand for social care services for people in the older age groups will be influenced by the future numbers of older people, the success of healthcare interventions in prolonging life; the prevalence of dependency and the future availability of informal care. The strategy recognises that commissioning for health and well-being means involving the local community to provide services that meet their needs, beyond just treating them when they are ill, but also keeping them healthy and independent, including effective management.

The Primary Care Trust and local authority are both committed to developing services which are more personalised. For social care, this means changing the way that people's needs are assessed and provided for. More than that, it means consulting people about their needs and preferences and making a radical shift to giving them direct control over the decisions about the services they receive so they can shape these to support a lifestyle of their choosing. For the NHS, this means delivering services which are timely, well coordinated and available close to home and, when hospital based care is necessary, choice for people about the timing and location for that care. The local authority and Primary Care Trust acknowledge that this commitment involves a considerable change and all developments cannot proceed at the same pace: hence a 10 year strategy

The Primary Care Trust and local authority will commission services which promote independence, choice and control and will build upon work with a wide range of independent and voluntary sector organisations, and with NHS and local authority providers, to achieve those ends.

The analysis of current and projected needs leads to the conclusion that, over the next 10 years, all services will be more flexible and diverse and tailored to the needs of individuals; the number of places required in residential care homes will fall; and the volume of services delivered in or close to people's own homes will rise.

At the heart of the strategy is the determination to shape services so that they deliver better outcomes for older people and their carers. Any plans for developing and changing services must be rooted in what people need and want from services, and what can be achieved by those who provide services, working together.

An outcomes-based approach is important because it defines the reason for changes in service delivery, and the measures of achievement and quality.

The strategy, and services themselves, will be measured against seven key outcomes:

1. Older people and their carers enjoy the maximum level of independence, enabling them to exercise choice and control in the way their care needs are met.
2. Older people and their carers enjoy emotional and mental well-being
3. Older people and their carers are well informed about their mental and physical health problems.
4. Older people and their carers feel valued, have their cultural needs met, and remain part of the wider community,
5. An older person's health problem is recognised and responded to in a timely, effective, appropriate and respectful manner. This is particularly relevant to older people with mental health needs.
6. Older people and their carers feel safe and secure.
7. Older people to enjoy the usual risks associated with independence and exercising personal choices.

The commissioning strategy establishes the basis for a service ethos for older people that draws on the talents of people providing all sorts of care, support and services: housing, employment, social contact, income, information, getting out and about as well as the NHS and social services. They are part of a 'whole system' which offers individuals independence, choice and control.

This approach, which engages a wide range of stakeholders and providers in developing more person centred services is well supported by research, including the work by Better Government for Older People that contributed to identifying seven 'Dimensions of Independence for Older People', described in more detail in the "Opportunity Age" consultation document (DWP 2005).

Key local drivers

In common with the national picture Barnet faces an increase in the numbers of older people in the borough. The relatively high proportion of the very old and the predicted growth in this area leads to a growth in the number of people with more complex needs and long term conditions, including mental health problems.

The following is significant to influencing future demand:

- Barnet has the second highest number of people over 65 in Greater London with nearly 53,000 people over pensionable age in 2006.
- Currently Barnet has the second highest proportion in Greater London of its population over 85 at 2.08% (England average 1.98%)
- The number of people over 65 in Barnet is set to increase gradually from 2010 rising each year, with a steep increase beyond 2020; the first phase of the baby-boomer generation will reach the age of 75 in 2020; this generation will be more familiar with a 'consumerist' approach when accessing services.
- An increase in the number of frail older people: in particular people aged in excess of 90 years of age – an age when people become more dependent on additional support, accompanied by a rise in the number of unpaid carers.
- An increase in the number of older people from BME groups, with the sharpest increase expected to occur in the Indian, Chinese and Black African groups.

Sources: ONS Revised Pop. Projections 27 Sep 2007

There remain considerable health inequalities within the borough amongst the general population including amongst elders:

- The deprivation indices* places Barnet 15th out of 33 London Boroughs due to some pockets of severe deprivation in the borough leading to greater dependencies on health and social services. Targeted work can be undertaken to ensure supplementary pension benefits are claimed to help reduce: depression, poor nutrition, hypothermia and social isolation.

Further needs analysis also shows the following:

- Barnet has a diverse population which requires diverse services that meet the aspirations of local communities.
- Increased life expectancy implies longer periods for individuals where health, social care and support are required.
- People when they fall ill in later life, whether that is an acute physical or mental illness, an acute phase of a chronic illness, or a chronic condition that affects an individual's mental or physical well-being often use services in an unplanned or uncoordinated way which leads to poor outcomes for the service users and is not cost effective.
- A significant proportion of care services are purchased independently by individuals (self-funders) in Barnet. The procurement activities of the council are unlikely to be sufficient to meet the needs of those individuals and the strategy must ensure a viable and varied choice of services are available for those individuals and that appropriate information, advice and guidance is offered at those critical points in their lives.
- As family compositions change, more people are set to become older carers and legislation will continue to enhance their rights and give consideration to their needs.
- A higher number of older people will live alone reflecting the divorce rates amongst the over 50s and the lower proportion of older people who live with their children.
- Average savings are set to decrease as a result of changes in pension arrangements and more peoples working lives will extend beyond the age of 65.
- Many of the diseases experienced in old age are preventable through lifestyle changes which include increases in exercise, healthy eating/weight control and smoking cessation.
- Some degree of dementia is present in about 5% of people aged 65 years and over and more than 20% of those over 80 years of age. Research evidence on the prevention of dementia is sparse. Evidence-based research should be utilized by the various authorities to reduce the prevalence of dementia in the older age groups.

While some illnesses demand specific outcomes and specialist services, the principles of independence, choice and control are common to all. The commissioning strategy is built on this approach and is designed to promote:

- A widely accepted well-being agenda, in terms of access to sport, leisure, adult education, libraries and arts and transport as part of a wider environment that enhances health and the continued contribution of older people in their neighbourhoods.
- Improved income, through close working with the Department of Work and Pensions to ensure that older people have access to benefits that can help them find solutions to their care needs.

And assure:

- Information and advice that supports choice and empowers as many people as possible to live fulfilling lives in later years.
- Improved access to rehabilitation and recovery from illness in people's own homes.
- Better, more cost effective ways of managing higher level care needs in people's own homes through the use of innovations like assistive technologies and complementary working across health and social care services to shift care closer to home for people with complex needs.
- Changes to the way services are contracted to create more flexible service delivery that meets older people's expectations for person centred care, and outcomes tailored to the individual.
- An overall balance in the future care market which sustains high quality support to people with complex needs to live in the way they choose, however preventing dependency wherever possible by ensuring older people can access support systems and services as part of a wide network of services for the benefit of older people in Barnet within sustainable communities.

2. Introduction

The strategy for commissioning services for older people sets out the basis for service development over the next 10 years. It builds upon the White Paper "Our Health, Our Care, Our Say" which promised to help people stay healthy and independent, to give people choice in their care services, to deliver services closer to home and to tackle inequalities. The Primary Care Trust and local authority intend to move swiftly towards ways of delivering care that encourage independence, promote greater choice and help communities to develop networks of support that may both improve health and well-being and enable people to live independently for as long as possible.

The strategy describes a vision for future services and the basis upon which the local authority and the Primary Care Trust will approach its implementation. They will

- Involve people who use services and their carers
- Work with service providers to change services in an orderly and effective way
- Work closely with their partners in commissioning and delivering care
- And, in all their work, promote equal access to services that meet the diverse needs of people living in Barnet

2.1 Vision

"To support older people, including those with mental health needs, and their carers in the community setting of their choice, with an increased emphasis on prevention, promoting independence and improved health and well-being. This will be achieved by engaging a wide range of people and providers of service in work together, and so ensuring that public funds are used in the most effective, targeted and sustainable way."

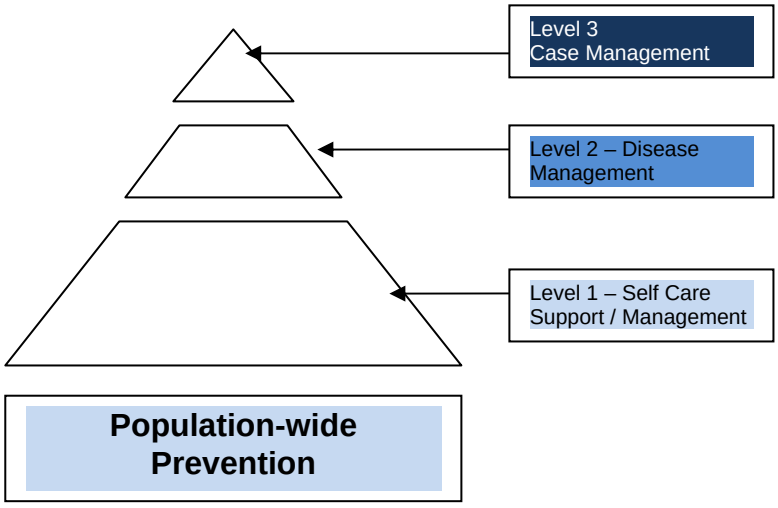
The local authority and Primary Care Trust will plan together to reshape the way older people have their care needs met, reflecting Department of Health recognition that "Older people are likely to be the main beneficiaries of reforms that strengthen the ability of GPs, Primary Care Trusts and Local authority Councils to jointly design and buy new services" (A Recipe for Care - Not a Single Ingredient, Department of Health 2007). Their joint commitment to helping people direct and manage their own care is a powerful force for change.

The commissioning strategy has taken account of national and local research on service users' views; national and local strategy and policy; the national performance agenda and comparator group data; and research into good practice. It focuses on securing and appropriate range, volume and model of service and so the seven key outcomes for older people.

In developing the commissioning strategy the local authority and Primary Care Trust have adopted an approach based on the principles of the Kaiser Permanente model of care. The planning assumption is that by identifying and providing support to people with long term complex needs in a more proactive way, it will, over time, lead to less reliance on unplanned, emergency, and relatively expensive services and allow predictable cost savings to be reinvested into more preventative work and earlier interventions. Improved outcomes for individuals will complete this positive circle.

Kaiser Permanente model of care

The 10 year time span for the strategy will ensure that transition to a new model of care is achieved through a well-managed process, and involves local people and providers in a positive way.



Helping people stay at home for as long as they want to will require a fundamental shift away from the focus on treating the results of ill-health towards health promotion and the wider well-being agenda. Providing people with good information and advice on how to manage their condition, increasing investment in active rehabilitation and prevention and improving the way that services are delivered in terms of flexibility and quality will all help avoid the costly and distressing consequences of merely responding to health crises.

The local authority and the Primary Care Trust will change the way they work together to help bring this shift about. In the future, for those who are eligible for social care:

- The local authority will be a facilitator, or broker, of care - local authority provided social services for older people are externally managed. This will offer an opportunity to divert resources to driving up quality and streamline local authority and Primary Care Trust contracting and procurement processes.
- More people will commission care for themselves through the Direct Payment system and Individual Budgets. The local authority and Primary Care Trust will provide leadership to help the providers plan for this change and deliver greater choice and flexibility in the way services are delivered.
- Those most in need of support will receive a first class Assessment and Case Management service. By promoting person centred outcomes tailored to the individual, the assessment process will drive the transition between current and future ways of delivering services.

For people with lower levels of need:

- The local authority and Primary Care Trust will work with local communities to develop support through easily accessible networks which will help promote health and well being and prevent isolation and loss of independence.

2.2 Involving people who use services and their carers

The involvement of local people in making decisions about health and social care services has, to date, been inconsistent and lacking in focus. This strategy recognises that the local authority and Primary Care Trust must exercise community leadership to ensure that "new ways of working are focussed and driven by the views of older people" (Local Government Association Older People Action Learning Set 2007).

The strategy is based on national research about what older people want from services, supported by a limited amount of local data from service reviews and quality monitoring exercises. It is, therefore, a starting point for changing the way that health and social care is delivered over the next 10 years. The strategy will be reviewed after one year and annually, involving people who use services, their carers and service providers. The outcome of these reviews will inform the development of action plans and policies as the strategy evolves over its ten year course. A regular process of engagement, consultation and involvement in auditing quality of services will ensure they meet the needs of Barnet's diverse local communities.

Involving people in decisions about their own health and social care is as important as involvement in decisions about services in general. Local authority and Primary Care Trust staff will ensure that individual care plans reflect the principles of independence, choice and control for those using services, and that services commissioned on their behalf are delivered in line with these principles. The strategy recognises the important and growing part that advocacy plays in ensuring the voice of service users is heard, that this drives changes in services at all levels and will continue to develop mechanisms for people to express their views.

2.3 Orderly and effective changes in services

Moving from the way care is currently provided, towards more flexible and individualised delivery, demands a robust commissioning process which guides the transition from one model of care to another. The local authority and the Primary Care Trust recognise the importance of working with local providers to develop their business plans in response to the independence, choice and well-being agenda and so avoid destabilising the care sector in the short term. It is for this reason that the commissioning strategy requires a 10 year planning timeframe. They will work together to improve the collection and analysis of data about the demand for and supply of services so that changes to the strategy are made in a timely way and are based on good evidence.

The local authority and Primary Care Trust do not underestimate the challenges that the strategy may pose for the both the health and social care sectors, as they respond to a fall in demand for some types of provision, such as in residential care, and work to expand capacity in others. The greatest challenge will be in providing flexible, person centred care that is of the highest quality and will attract people who want to pay for services directly, use individual budgets, influence practice based commissioning, or those who will increasingly wish to purchase their own care. It may well be that the long term viability of some existing providers will be at risk if they are not able to respond to the changing care market.

2.4 Working closely with partners in commissioning and delivering services

The partnership between organisations responsible for commissioning and delivering services for older people has made a significant contribution to the development of the strategy. It reflects the aims and intentions shared by the Primary Care Trust, the mental health trust, and the wider Council.

The strategy also looks forward to the changes that will come about with the further development of practice based commissioning. As practice based commissioning clusters broaden their focus they will build upon practices' knowledge of their patients and deliver 'a higher standard of patient care through improved commissioning, the redesign of services and the more efficient use of resources." (CSIP Integrated Care Network Sept 2006). Close working between the Council, Primary Care Trust and practice based commissioners will assure locality focussed, integrated and preventative service models.

2.5 Equal access to services for a diverse population

The development and implementation of this strategy provides a real opportunity to address equalities issues as they relate to older adults.

The assessment of need for services makes it plain that Barnet is home to a very diverse population made up of people from different ethnic and religious backgrounds. The strategy sets down a framework for planning local services for older people from the heart of each community. This will allow local services to develop which promote cultural diversity and equality of access and are tailored to the needs of individuals. Partnership with minority ethnic community groups will ensure that people from those communities may influence service planning, monitoring and evaluation and see that services take account of the particular needs and values of minority communities. This work will be entirely in keeping with the Department of Health's commissioning framework for health and well-being (2006), through which the local authority and the Primary Care Trust will cooperate to ensure that Services are shaped by local communities, inequalities are reduced, social inclusion is increased and these outcomes are maximised at minimum cost.

This approach to service development will also be supported by the wider work of the parties to the strategy to promote diversity and equality and, specifically, to eliminate unlawful discrimination and harassment, promote equality of opportunity and promote good relations between people, through the mechanisms of the Race and Disability Equality Schemes, the work on Single Equality Schemes, the community consultation process, and the use of equality impact assessments to help target resources on reducing inequalities in older people's services.

2.6 Monitoring the strategy

The strategy represents a far reaching and long term plan which will be implemented over the next 10 years; the Older Adults Partnership Board will monitor and review progress every 6 months.

The comprehensive performance assessment which is used to monitor the performance of local authorities nationally contains key lines of enquiry including assessment against the healthier communities and older people's agendas:

- What has the council, and its partners achieved in its ambition for promoting healthier communities and narrowing health inequalities?
- What has the council and its partners done to promote and support independence and well being of older people?

The future regulation of health and adult social care in England, is set to change as the government sets out a new vision for the overall regulatory framework for care services for implementation next year .In particular the government aims to examine the effectiveness of commissioning by local authorities and Primary Care Trusts, and to ensure regulatory processes reflect the growth of more diverse and innovative provisions in the health and care sector.

As the role of the local authority moves increasingly towards the role of broker and care navigator, and the Primary Care Trust towards commissioning services exclusively, locally they will ensure that robust monitoring and review processes are in place that record providers' progress towards delivering better, person centred outcomes for older people. Proposals for how to achieve this are set out in the Service Quality section of this strategy.

Key Messages

The local authority and the Primary Care Trust will:

- Prioritise better prevention services with early intervention
- Work in partnership to deliver more support that helps older people stay in the community and invest in the health and well being agenda.
- Give people more choice and a louder voice so they can take greater control over decisions about the way they want to live their own lives and choice in the way services are delivered.
- Tackle inequalities and social exclusion that leads to poor health and so improve access to the services people may require.
- Provide more support in the community for people with chronic health conditions. Building on the Expert Patient Programme the aim is to support people to manage their condition themselves, supported by closely integrated health and social care teams, implementing the long term conditions case management model.
- Through effective management of existing commitments, ensure that joint commissioning across the community and voluntary sector is structured to support the prevention agenda, and strategic priorities.
- Engage and involve older people, carers and stakeholders in future planning during the lifespan of this strategy to shape future service delivery to 2017 and beyond.

3. The case for change

3.1 National imperatives, supported by evidence from research and reports of effective practice

This strategic commissioning document goes to the heart of current policy initiatives:

- Putting people at the centre of commissioning which involves giving people greater choice and control over services and treatments (including self-care), and access to good information and advice to support these choices.
- Delivering services which are more integrated and responsive, and significantly improve people's experience and choice.
- Services which contribute to the well being of communities, tackling health inequalities and promoting public health.

There are clear incentives to provide:

- greater choice and control for services users and carers
- more support to enable people with mental and physical health problems to live in their communities independently
- support provided to people to maintain their health and well-being and prevent the deterioration in mental and physical health

There are also targets for statutory authorities which lead them to:

- work together closely in terms of planning of services at the local level
- commission services that deliver more personalised care
- develop the health and well-being agenda with a greater emphasis on prevention and dealing with the causes of ill health
- work together to improve the care pathway and help older people navigate their way through the health and social care by designing simpler, more integrated services
- Ensure that older people carers and other stakeholders are engaged and involved in shaping services, in line with national and local priorities.

The most recently published Public Service Delivery Agreement 'Tackle Poverty and Promote Greater Independence and Well Being in Later Life', seeks to ensure that the specific needs of the older population are given due priority and describes 5 key indicators that can be used to measure the progress against this vision.

Key to the government agenda for social care is the recently published 'The National Strategy for Carers' which requires a focus on the carer as well as the person using a service, and new legislation which will require authorities to address carers' needs. In February 2007, the government announced a funding package to support New Deal for Carers and a public consultation exercise on a revised strategy for carers ended in September 2007. Proposals include an extension of the 1999 Strategy for Carers to reflect carers' rights, direct payment regulations, carers' assessment and carers' grants. The new legislation is due in spring 2008.

The commissioning strategy also responds to evidence of effective practice from the following sources:

- National sources include Department of Health guidance, King's Fund research publications, the National Institute of Health and Clinical Excellence, Social Care Institute for Excellence and NHS Institute for Innovation and Improvement.
- Best practice models on integrated working, commissioning and service delivery.
- Local sources include Public Health, Information Observatory, and quality monitoring evaluations, user and carer forums, and local consultation events.
- Commissioning Workshop facilitated by King's Fund on improving services for older people with mental health needs.

3.2 Local drivers for change

The local authority and the Primary Care Trust share a commitment to improving the lives of local people and this shapes the commissioning strategy. In practical terms, they aim to:

- create environments that are safe and where local people can flourish
- lead developments in housing, transport, employment opportunities and so improve quality of life
- raise the profile of and access to mental health services for older people
- Work together to, for example, reduce admissions to hospital, improve support for carers, improve housing and supported accommodation, information sharing, and more efficient processes for managing care.
- Increase the focus on better case management with people with a long term condition and ensure the best possible care for palliative and end of life care patients and their carers.
- deliver improved access to rehabilitation and intermediate care closer to peoples' homes
- delivering the National Service Framework for neurological conditions (many of which are associated with ageing)

3.3 Research and local information

- Common themes emerging from national research and local surveys demonstrate that older people value:
  - help with taking control of the types of chronic conditions that are prevalent in older age. This includes involvement in care planning, and decision making processes
  - better access to good quality information and advice on a range of issues including information on their condition, benefits advice, transport and help to maintain the fabric of their home in later life. Information on recreation and leisure activities in their locality was seen as having value.
  - feeling safe in their homes
  - earlier intervention with a greater focus on prevention.
- More detail on Carers want support as and when they need it, provided in ways that suit their personal circumstances. There is evidence for example that respite care in residential settings for older people with mental health needs may actually have a long term negative impact on the carer on return to their own home.
- Home care support is welcomed, but the task centred model most commonly adopted is restrictive, inflexible, does not meet social and emotional needs, and creates

greater dependency. There is criticism about visits of less than 30 minutes as being impersonal and hurried in terms of dealing with personal care tasks.
- Access is restricted to intermediate care and rehabilitative care at home, and yet may have a more positive impact than in-patient episodes.
- Access to intermediate care for older people with mental health problems is underdeveloped.
- People with dementia are often excluded from opportunities available to older people.
- There is generally a lack of access to low level preventative services such as housework, gardening, laundry and home maintenance.

4. Needs Assessment

The nature of current and forecast local demand is a product of several factors including: information about age profile, diversity and deprivation, households, employment and transport and existing patterns of health and social care service usage.

4.1 Population Overview

Information about Barnet's population is drawn from the Office for National Statistics sub population projections (2007 revised estimates).

The Greater London Authority has predicted that, between 2001 and 2016, there will be an overall growth of 10% in population of London as well as a significant change in age structure. The predicted changes are as follows:

9% more children aged 0-15
4% fewer persons aged 16-29
20% more persons aged 30-49
25% more persons aged 50-59
3% more persons over the age of 60, mainly those over 75.

The result of an analysis of information available is summarised below.

Local Population Profile

With an estimated population of 328, 760 persons (ONS 2006 estimate) Barnet has the second highest population when compared to the other London boroughs. It has a younger and more diverse population than the national profile. Barnet is the 20th most ethnically diverse area in England with 29% of its population belonging to a black or minority ethnic group. It is the 2nd most religiously diverse Borough in the country: 14.8% of its population is Jewish and 8.5% of residents describe themselves as Indian, Bangladeshi, Pakistani or otherwise as Asian.

According to the latest official estimate there are 58,700 people aged 60 and above resident in the borough. Barnet currently has the second highest volume and percentage of people over 85 in London.

It is assumed that the large scale residential developments that will be providing new accommodation over the next ten to fifteen years will be acquired more readily by younger people however this assumption will need to be regularly reviewed.

4.2 Population Change: Older People in Barnet (2004-2029)

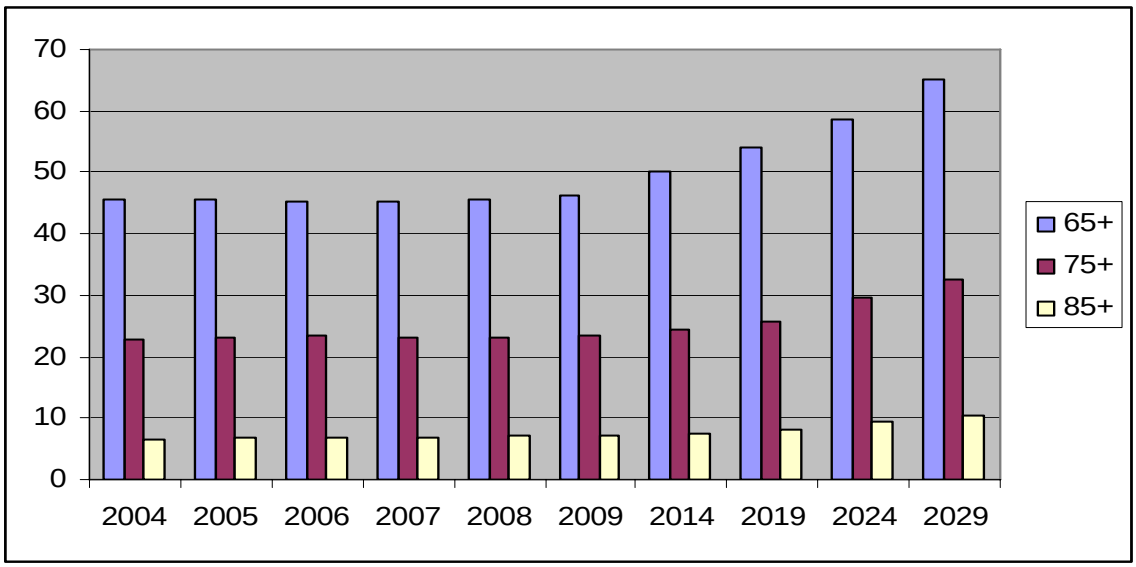
The number of Barnet residents achieving 75 years of age has been increasing steadily and this growth will be compounded when the post war generation (referred to as the baby boomers) will, by 2020 begin to reach 75 years old. The "Baby-boomer generation" is likely to have very different expectations and a more consumerist approach towards their care needs. This could create inequalities of access and care among poorer, less-demanding persons.

The predicted growth in the number of people aged 65 years and above living in Barnet over the next 10 years to 2017 is below the national average. Towards the end of this period however, both the ONS and GLA projections show an increase in the 65+ population.

The Office for National Statistics, which uses a consistent methodology for data collection and analysis throughout the country shows consistently lower percentage rates of growth in the number of older people for Barnet compared with the overall rate for England, although higher rates than for London as a whole. It is possible that these projections overestimate the percentage rate of increase in the number of older people living in Barnet.

The chart and table below demonstrate the ONS projections for the 65, 75 and 85 plus age groups for the years 2004 to 2029.

Chart 1: Estimate of the Growth in the 65, 75 and 85+ Age Groups (000's) 2004-2029.



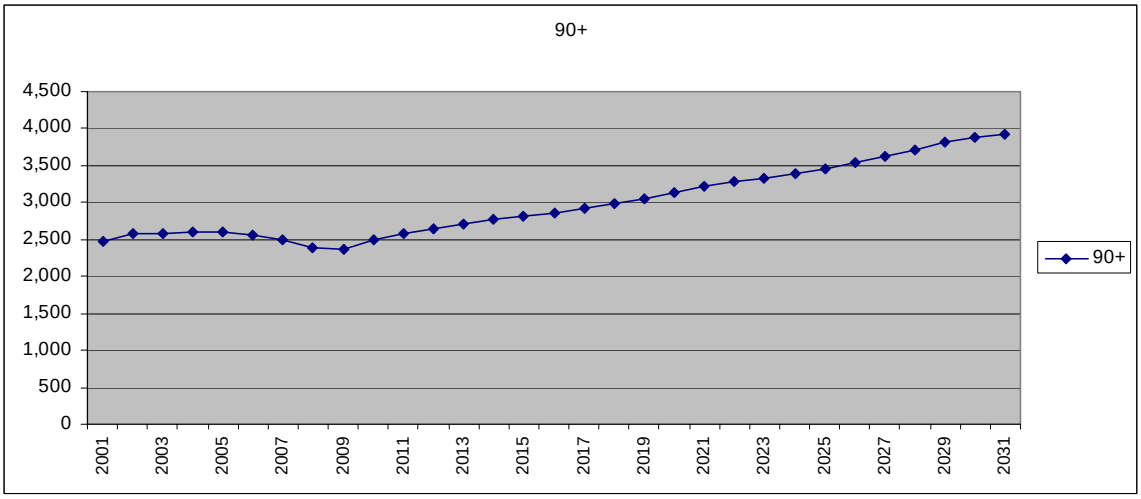
	2004	2005	2006	2007	2008	2009	2014	2019	2024	2029
65+	45.5	45.5	45.4	45.2	45.5	46.1	50.3	53.9	58.7	65.1
75+	22.8	23	23.3	23.2	23.2	23.3	24.3	25.6	29.5	32.4
85+	6.6	6.8	6.9	7	7.1	7.2	7.6	8.3	9.4	10.5

ONS revised population projections (Sept 2007)

At the same time, the number of people living beyond 90 years of age is set to increase. The GLA projection for the years 2006 to 2022 shows an increase of approximately 800 people. Although this increase is small, in terms of overall population growth, there will be

a significant impact on the demand for services due to the higher number of complex high-dependency conditions more frequently found in this age group.

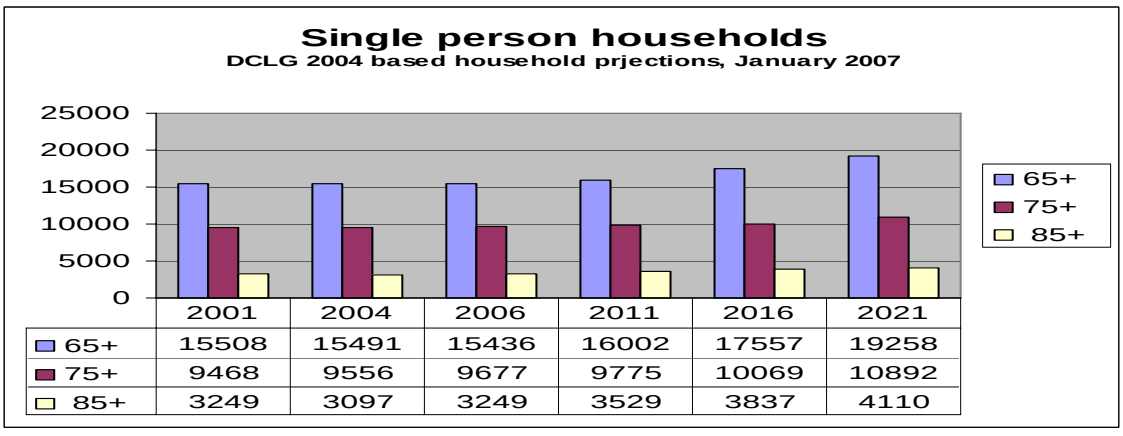
Chart 2: Increase in people aged 90 years and over (2006 to 2022)



- **Living Alone**

Approximately 18,000 (31%) of older people in Barnet live alone and due to a higher rate of divorce in the 50+ age group the number of older people living alone is set to increase Older people who live alone, and who are in poor health, are more likely to require help from sources other than their family. Social changes of this nature are very likely to increase the demand for social care and health services. However, there is strong evidence that social networks make a contribution to healthy ageing. Creating the opportunities for people to socialize and to become involved in local voluntary networks will be an important factor in prolonging the well-being and independence of older people who live alone.

Chart 3: Projection: Single Person Households



	2001	2004	2006	2011	2016	2021
65+	15508	15491	15436	16002	17557	19258
75+	9468	9556	9677	9775	10069	10892
85+	3249	3097	3249	3529	3837	4110

- **Life Expectancy**

During 2005, the Office for National Statistics announced that life expectancy at the age of 65 was at its highest ever in the UK and that, on average, men aged 65 could expect to live a further 16.6 years, and women a further 19.4 years, if mortality rates remain the same as they were in 2003-05.

Women will continue to live longer than men, but the gap has been closing in recent years. In 1983-85 there was a difference of 4 years between male and female life expectancy at age 65 in the UK (13.2 and 17.2 years respectively). By 2003-05 this had narrowed to 2.8 years. The implication of this is that historically women have spent a larger proportion of their final years in poor health. This difference in the number of years over which, older males and females experience poor health may become less obvious as life expectancy for men increases. On the other hand, as more people can be expected to live beyond 90 years of age, so an increase in the prevalence of limiting long-term conditions is also very likely to increase.

- **Deprivation**

Audit Commission data shows that 15% of residents aged over 60 years of age live in households that are income deprived. This is slightly higher than the national mean and is near the average for London, where the range is 23.1% (Brent) and 9.9% (Bromley).[1] The Joseph Rowntree Foundation [2] study of the material resources of older people found that women, persons living alone, those that are widowed, divorced or separated, poorly educated are disproportionately represented in the lower socio-economic groups and to be in poor health.

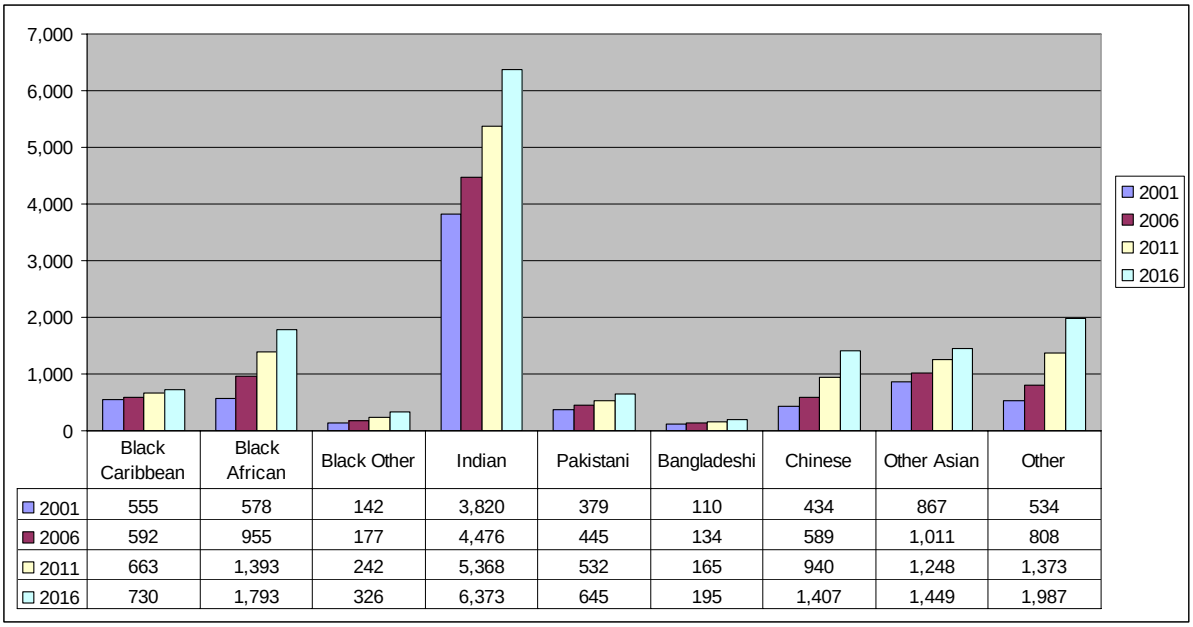
A recent analysis of the location of people aged 85+ shows there are pockets of older people at a variety of locations within the borough. This is significant in terms of the targeting of selected geographical areas to reduce the impact of undue poverty on the demand for social care and health services due to: social isolation, depression, poor nutrition or hypothermia.

- **Population Diversity: Ethnic Impact**

Barnet is the 20th most ethnically diverse area in England with 26% of its population belonging to a black or minority ethnic (BAME) group. The table below illustrates the scale of ethnic diversity within the borough. The age structure of London's black and minority ethnic population is expected to change. For example an authoritative estimate (GLA, 2006) indicates that 18.1 percent of Londoners aged 60 belong to a Black or other minority ethnic group. By 2026, this figure this projected to be over 32.3%.[3]

[1] www.areaprofiles.audit-commission.gov.uk/(3bvskyb3l10ctr55caci15vi)/DataSelection.aspx
[2] The material resources and well-being of older people, Vanessa Burholt and Gill Windle. Joseph Rowntree Foundation, 2006.
[3] DMAG Briefing 2007 = 14. July 2007, GLA 2006 Round Ethnic Group Population Projections.

Chart 4: Barnet residents reporting ethnicity other than White in 2001, and forecasts to 2016



	Black Caribbean	Black African	Black Other	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	Other
2001	555	578	142	3,820	379	110	434	867	534
2006	592	955	177	4,476	445	134	589	1,011	808
2011	663	1,393	242	5,368	532	165	940	1,248	1,373
2016	730	1,793	326	6,373	645	195	1,407	1,449	1,987

4.3 Carers

The local authority has commissioned research into the local profile of carers and estimates that there are 28,000 carers in Barnet- 9.7% of the general population aged 5+ years. 58.4% are women. Almost 2000 carers are aged 75 plus years and almost half of these provide over 20 hours of care each week. Most carers are looking after a person who is older including those with mental health problems. The wards with the highest number and proportion of carers: Edgware, East Barnet, Hale and Oakleigh. The wards with the highest number of carers providing over 50 hours of care each week: Burnt Oak, Underhill. These areas also coincide with the greatest number and percentage of people (whether carers or not) who are not in good health and have a limiting long term illness. The numbers of carers is set to rise according to population estimates and more of these carers will be older themselves and / or caring for an older person.

4.4 Employment

In 2001, 27% of people aged between 60 and 74 years were in work. Recent changes in employment legislation mean that people need not retire at 65, but the effect this will have remains to be seen. It is not unreasonable, however, to assume that older people on low incomes, or who have poor pension prospects, will work on and that the income will be used for essential expenses, rather than improved quality of life.

4.5 Transport

The most recent figures available suggest that more than 30% of people aged at least 60 years had no access to a car. While it is difficult to predict whether this proportion will fall or rise in the future (there are several, and potentially conflicting, factors at play), older people report consistently that transport is an issue in terms of social isolation and access to community services such as shops, leisure, recreational activities as well as to GP surgeries. Therefore the predicted increase in the older population demands plans for transport links and access to local services that are not dependent on car ownership.

4.6 Housing

Older people in Barnet make up 21% of the population as a whole and 75% of these households own their own property without a mortgage. 75% of older owner-occupiers live in 3 or 4 bedroom properties. Many of these households are asset rich, but cash poor, and struggle to maintain their homes. National research has shown that the majority of older people would prefer to either remain living in their home, or would prefer accommodation which is part of the ordinary housing stock but suitable to meet their needs through design. Older people increasingly expect a high standard of accommodation, with a spare room for visitors, a study and car parking facilities.

- **Leasehold sheltered/retirement housing in Barnet**

This type of support is generally provided by the independent sector, and the existing properties tend to be in the more affluent areas of the Borough. A number of new schemes are planned and this may be an indication that the supply is not yet sufficient to meet demand. People moving into such schemes are likely to be downsizing from larger properties, and therefore access to funding is not significant issue. What may be significant is the type of support and care that is based on site in the private schemes and a comparison with the type of product on offer for tenants in terms of care and support and where possible the strategy needs to refer to the research being carried out by the independent sector and /or commission sample research to support a whole population perspective on housing for older age.

4.7 Health Needs Analysis

- **Aging and Health**

The 2001 census reported that 11,553 of the 58,263 Barnet residents aged 60+ (20%) said that they were in poor health. 25,304 (43%) reported a limiting long-term illness or disability. Estimates suggest that the residents of Barnet live healthy lives compared to England overall, none-the-less, estimates show that 1 in 5 adults are obese and that smoking kills, on average, 400 people annually.

The diseases most commonly associated with ageing are: coronary heart disease and stroke, diabetes, cancer, chronic pulmonary obstructive disease, incontinence, Alzheimer's disease, osteoporosis and osteoarthritis. There is also some decline in hearing, vision, physical strength and balance and there may be some loss in mental acuity.

However, many of the diseases experienced in old age are preventable. For example, obesity increases the risk of type-2 diabetes 20-fold and doubles or triples the risk of other chronic conditions including high blood, pressure, heart disease, and colon cancer. Smoking accounts for nearly one-fifth of all deaths from cardiovascular disease. Men who smoke increase their risk of dying from lung cancer by 22 times, and women by nearly 12 times.

Also, there is evidence that lifestyle alterations can reduce the risk of developing osteoarthritis and can alleviate joint symptoms and disability, in particular: the promotion of

strengthening exercises [4]; general (aerobic) fitness[5], weight reduction programmes for the overweight and obese[6]; and the use of appliances (sticks[7], insoles and braces[i]). Notwithstanding the proactive pursuit, by an individual of a health promoting lifestyle, the Primary Care Trust in collaboration with the London Borough of Barnet and other voluntary organizations are able to offer a range services. These, essentially fall into three groups listed below.

Prevention	Examples of Services
Primary: Extending independent living.	Benefits, advice, health checks, access to recreational and social networks, housing and warmth, balanced nutrition.
Secondary: To avoid residential care.	Therapeutic intervention, social care services to maintain independent living, Carer support and extra care housing.
Tertiary: Hospital and Nursing Home avoidance.	Reduce immobility, illness, falls prevention, the avoidance or management of incontinence and the avoidance of recurrent infections and serious medical problems.

However, there is an imperative to optimize the opportunities for people, as they age, to adopt and maintain a health promoting lifestyle, if the onset of poor health is to be avoided and their quality of life and independence is to be optimized.

- **Hospital Admission**

Hospital admission should not necessarily be viewed negatively. The hospital plays a significant role in enhancing the independence of older people and improving their quality of life. For example, osteoarthritis is a major cause of disability in people aged 65 and older. A study undertaken by Barnet Primary Care Trust during 2007 showed hip replacements to be more cost effective than the medical treatment of hypertension, coronary artery bypass, haemodialysis, and liver transplantation. The study also showed that the number of total knee joint replacements had risen, in Barnet, from 149 in 2002-2003 to 284 during 2005-2006 both. This trend, which is reflected nationally, is undoubtedly contributing to an increase in the mobility and independence of many older people.

- **Coronary Heart Disease**

Premature death rates for coronary heart disease and stroke for people under 75 years of age have been falling in Barnet and across England. This chart reflects that overall, the proportion of people dying of coronary heart disease and stroke is lower than the national average. This trend is likely to continue due to the introduction of the New GP Contract. Under this contract GPs have targets for the recording cholesterol and blood pressure readings and undertaking risk assessments. This work will enable early intervention of health promotion, and medical regimes that prevent further deterioration.

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[4] Minor MW, Exercise in the treatment of osteoarthritis. Rheumatic Disease Clinics of North America 1999; 25: 397 – 415.

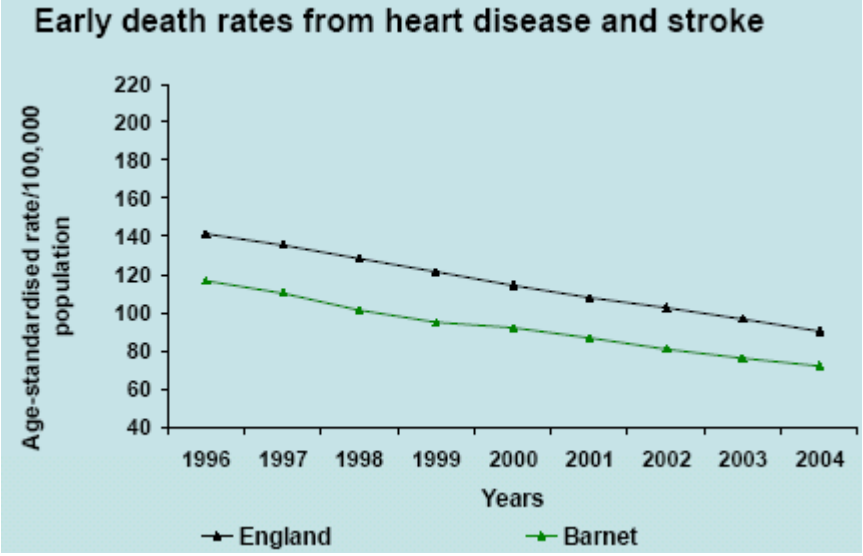
[5] Kovar PA, Allegrante JP, MacKenzie CR, Peterson MG, Gutin B, Charleston ME, Supervised fitness walking in patients with osteoarthritis of the knee. A randomized controlled trial. Annals of Internal Medicine 1992; 116:529 – 534.

[6] Felson DYT, Zhang Y, Anthony JM, Naimark A, Anderson JJ. Weight loss reduces the risk of symptomatic knee osteoarthritis in women; The Framingham Study. Annals of Internal Medicine, 1992; 116: 535 – 539.

[7] Rogers JC, Holm MB, Assistive Technology device use in patients with rheumatic diseases: a literature review. American Journal of Occupational Therapy. 1992; 46:120-127.

[7] Hewett T, Noyes F, Barbaer-Westin S, Heckmen T. Decrease in knee joint pain and increase in function in patients with dedial compartment arthrosis: a projective analysis of valgus bracing. Orthopaedics 1998; 21:131-138.

Chart 5: Premature death rates due to heart disease and stroke.



Data source: Barnet health profile. Department of Health, 2007

Hospital admission rates for people with coronary heart disease have been rising in Barnet. In 2002-2003 the age standardised admission rate was 638 per 100,000 people. By 2005-2006 this had increased to 708 per 100,000, whereas the rates for London and England have declined.

Hospital admission rates for stroke have declined slightly. In 2002-2003 the age standardised admission rate was 115 per 100,000 by 2005-2006 it had reduced to 108 per 100,000. The admission rate in Barnet is lower than that for London and England. Medical and surgical treatments for heart disease may initially reduce the level of chronic disease due to heart disease, but in the longer term, will impact on the prevalence of chronic disease in the older community due to increases in life expectancy.

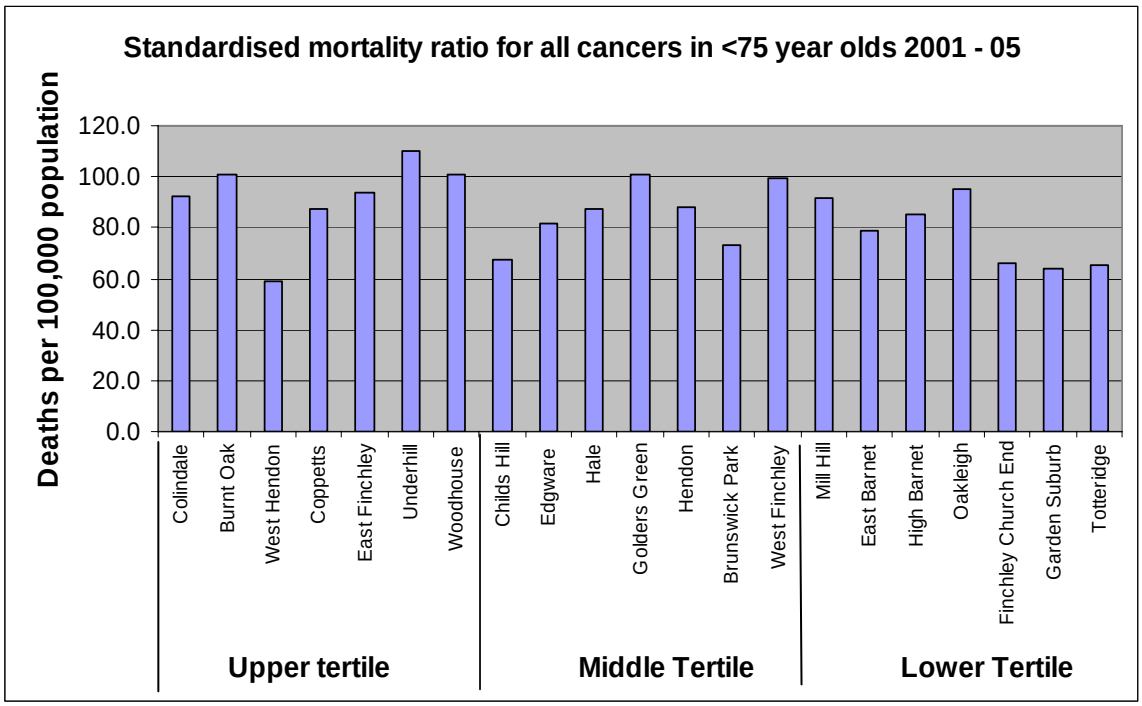
- **Cancer**

Although various cancers can be associated with different population groups it occurs more frequently amongst older people. For example, people aged 60 – 79 years of age are at high risk of developing bowel cancer. However, due to the introduction of the new screening programme, the mortality rate could drop by 15 per cent.[8] Indeed, well over half of all cancers are potentially preventable through relatively simple lifestyle changes. These are two of the priorities set out in the NHS Cancer Plan and other key NHS documents.

Smoking still causes considerable morbidity and mortality, albeit the mortality rate in Barnet is lower than the average mortality rate for England. However, while overall death rates from cancer are falling in Barnet, the cancer mortality rates vary between residents living in the more affluent areas and those living in the more deprived ones, the rate of reduction in the most deprived electoral wards has not been as marked as that in the more affluent wards.

[8] Cochcrane Database of Systematic Reviews, 2006. Screening for colorectal cancer using the faecal occult blood test: An update.

Chart 6: Standardised mortality ratio for all cancers in people aged less than 75 years 2001-2005, by Barnet wards

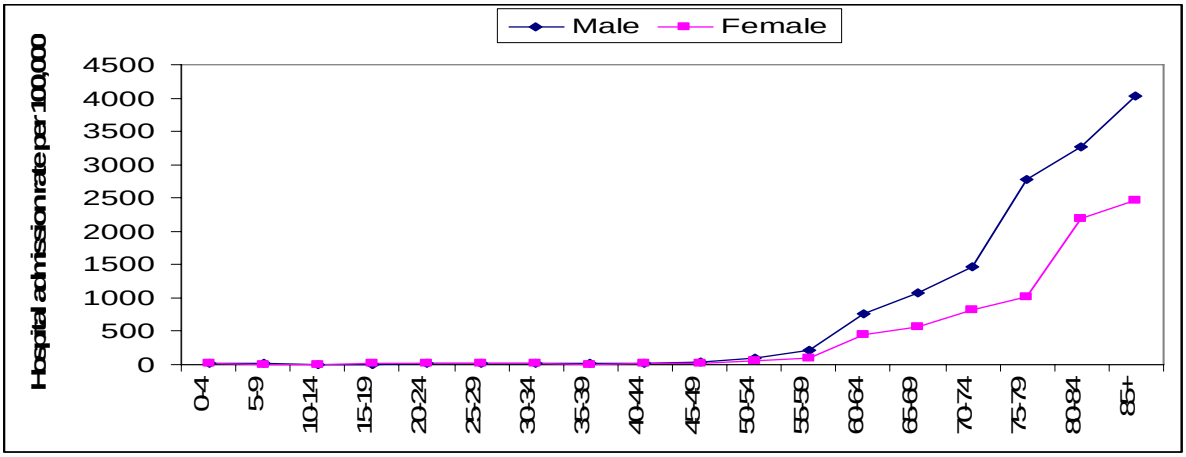


- **Chronic Obstructive Pulmonary Disease**

Long term conditions such as chronic obstructive pulmonary disease (COPD), is the main cause of disability and death in both men and women. Smoking is responsible for 40% of all respiratory deaths. The COPD death rate for women continues to rise from 63 to 80 per 100,000 while the rate for men has fallen (116 to 71 per 100,000).

Hospital admission rates for men with COPD are higher in every age group although in the general population there are fewer men than women – particularly in the older age groups. However, if the increasing trend for smoking among women is not halted, the hospital admission rate for women may match that for men. The overall hospital admission rate for COPD in Barnet in 2003-2004 was 94 per 100,000. This increased to 120 per 100,000 in 2005-2006. This increase in COPD admissions, in contrast to the reduction in the mortality rate, may indicate an increase in the number of years people are living with a respiratory problem - and possibly a reciprocal increase in the services needed to support their care needs.

Chart 7: Age-sex specific admission rates for COPD 2005/06



Source: Secondary User Service Table 12: Age-sex specific admission rates for COPD 2005-2006

Chart 8: Trends in deaths from COPD (Male) 1993-2005

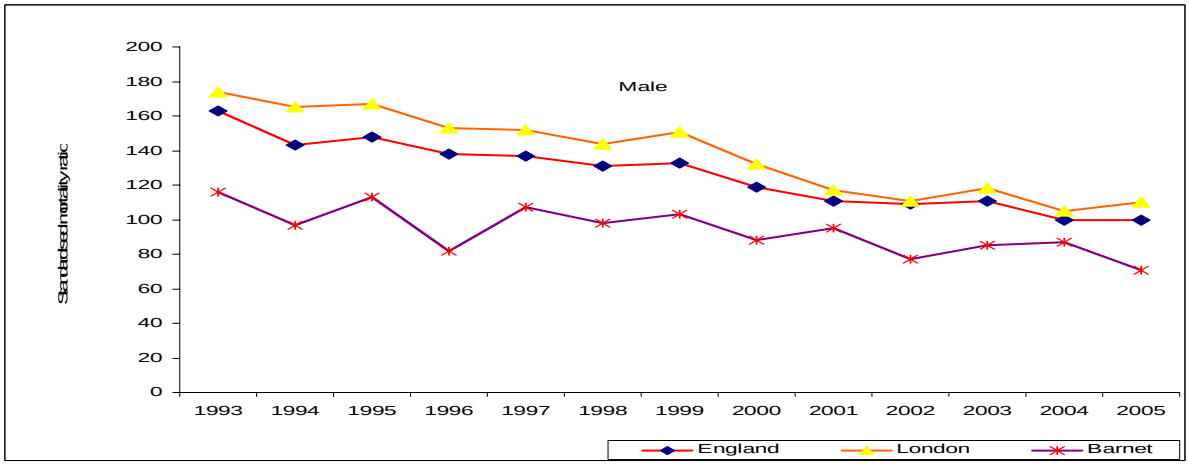
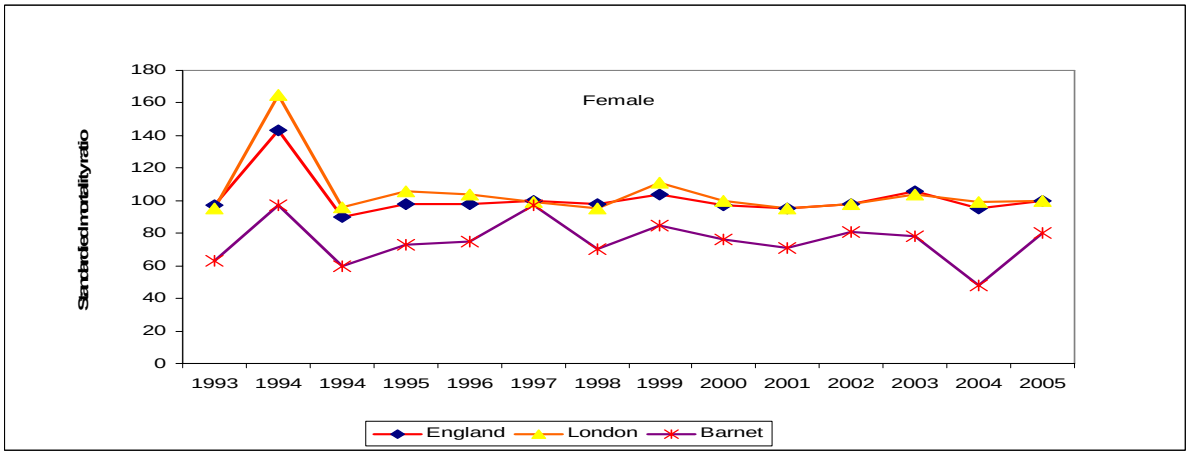


Chart 9: Trends in deaths from COPD (female) 1999-2005



Source: Compendium of Clinical and Health Indicators

- **Diabetes**

The prevalence of Type 2 diabetes, once known as adult-onset or non-insulin-dependent diabetes, is on the rise - fuelled largely by the rise in the number of people who are overweight or obese but also people of South Asian and African-Caribbean origin are at higher risk of developing diabetes.

The majority of deaths from diabetes in Barnet were in people aged 65 years and over – due to the higher prevalence of Type 2 Diabetes in this age group. Diabetic Retinopathy is a leading cause of blindness under the age of 60 and in older people, and another risk associated with Diabetes is that of Nephropathy or Renal Disease.

Hospital admission rates for diabetes have been rising in Barnet. In 2003-2004 the age standardised admission rates was 43 per 100,000. In 2005-2006 the admission rates had increased to 59 per 100,000. A similar picture is seen in London and England, although Barnet's hospital admission rates were lower.11

4.8 Mental Health in Barnet

The mental health conditions of older people are often grouped under two headings:

a) Common mental illness or neurotic illnesses, and
b) Cognitive impairment, which affects functions such as memory, concentration, reasoning and mental speed and include dementia.

It is likely that:

- 10-15% of the 65 and over population will have depression
- 3-5% of the 65 and over population will have severe depression
- 5% of the total population aged 65 and over will have dementia
- 20% of the total population aged 80 and over will have dementia
- The number of people in Barnet who have dementia is likely to be about 3% higher in 2011 that there were in 2006.

Tables 10 and Table 11 show an estimate of the number of people living in Barnet who are over 60 years old with a mental illness and or cognitive impairment, by ward; and a projection of the number of people that could be affected over the coming 10 years.

Chart 10: Estimate of the number of people over 60 years old with mental health disorder living in Barnet, by electoral ward. (2001)

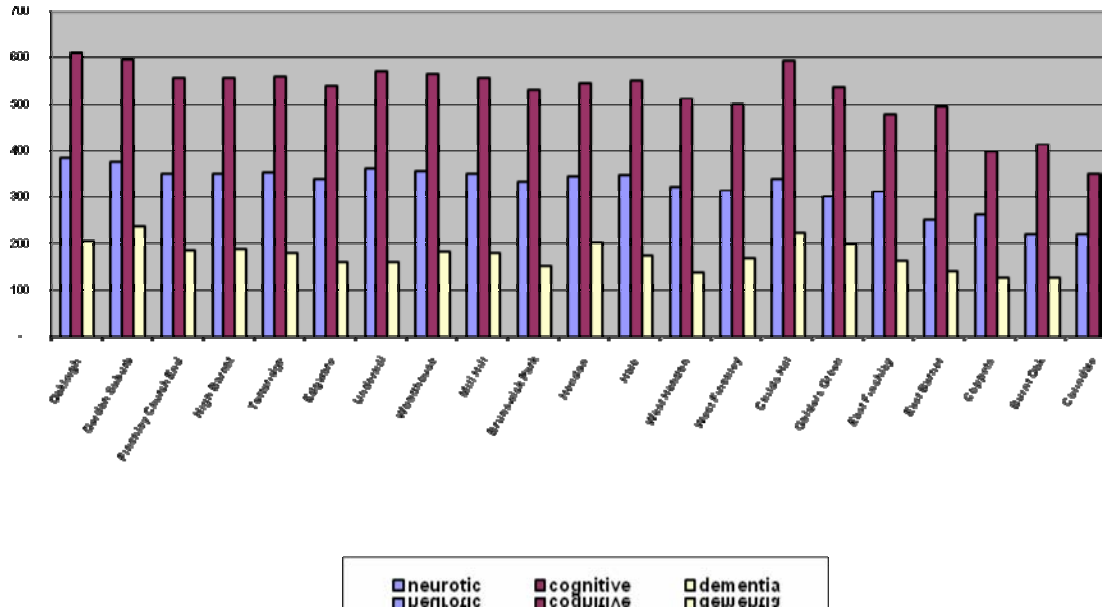


Table 11: A projection of the number of people over 60 years affected by a mental health disorder (2001 – 2016)

People aged 60 years and over in Barnet	2001	2006	2011	2016
Total number	58,221	58,746	61,306	64,673
No. affected by neurotic disorder	6,987	7,050	7,357	7,761
No. affected by cognitive impairment	11,062	11,162	11,648	12,288
No. affected by dementia	3,363	3,448	3,370	3,154

Common mental illnesses among older people include late life depression, anxiety disorders, panic and phobias, which in general are called neurotic disorders. Depression is a common disorder affecting 10-15% of the over 65 year old population (Beekman et al, 1999; Copeland et al, 1999[9,10]). Prevalence rates for 'major depression' (the most severe form of clinical depression) are substantially lower.

Depression associated with ill health is a striking risk factor for older people. It has been estimated that up to 70% of all new cases of depression arising in older people may be caused by disability associated with ill health (Prince et al, 1998[11]).

[9] Beekman A T F, Copeland J R M and Prince M J (1999) Review of community prevalence of depression in later life. *British Journal of Psychiatry* **174**, 307–11.

[10] Copeland J R M, Hooijer C, Jordan A, Lawlor B, Lobo A, Magnusson H, Mann A, Meller I, Prince M J, Reischies F M, Turrina C and Wilson K C M (1999) Depression in Europe: Geographical distribution among older people. *British Journal of Psychiatry* **174**, 312–21.

[11] Prince M J, Harwood R, Thomas A and Mann A H (1998) A retrospective population-based cohort study of the effects of disablement and social milieu on the onset and maintenance of late-life depression. Gospel Oak VII. *Psychological Medicine***28**, 337–350.

Cognitive impairment is defined as relatively poor function in one or more of the memory, attention/concentration, and reasoning or mental speed areas. In older age groups this category includes people with clinical dementia (cognitive function which has declined to a sufficient extent to impair activities of daily living).

While there is often a focus on the effects of dementia (severe cognitive impairment), the more mild cognitive impairment (MCI) potentially has a higher public health impact because of the much larger numbers of people affected. It is a strong risk factor for the later development of dementia (Elias et al, 2000[12]), and is associated with an increased risk of other adverse outcomes such as mortality and stroke (Ferucci et al, 1996; Gale et al, 1996[13,14]). It has also been found to be strongly associated with disability, and subsequent functional decline (Hébert et al, 1999; Zuccalà et al, 2001[15,16]), as well as with depression (Fuhrer et al, 1992). Associations between cognitive impairment and increased service use would therefore be expected.

Dementia, the loss of intellectual ability, affects a significant number of older people and is a severe cognitive impairment. People with dementia often have complex health needs, and can make considerable demands on carers and health and social services. Dementia may be the result of a range of diseases and pathological processes, the commonest of which are Alzheimer's disease and vascular dementia.

Vascular dementia is usually caused by brain damage resulting from very small 'strokes' over a long time that affect blood flow to areas of the brain related to memory and thinking. Some neurological diseases, such as Parkinson's disease, can cause dementia because of their effects on brain tissue. Parkinson's disease is less common as a cause of dementia than Alzheimer's disease or vascular dementia. Infections that can cause dementia include HIV, tuberculosis, syphilis, meningitis and encephalitis15.

The prevalence of dementia is strongly associated with age. Some degree of dementia is present in about 5% of people aged 65 years and over and more than 20% of those over 80 years of age. The increasing number of older people, and therefore the increase in the number of people suffering from dementia, means that primary care and community services will have to support more people with dementia and hospitals will find that more of the patients they admit with acute medical problems will also suffer from dementia or from lesser degrees of cognitive impairment.

- **Prevention of Dementia**

The projected increase in the prevalence of dementia raises issues as to how the quality of life can best be maintained or even how the risk of developing dementia can be reduced. Limited research in this area has identified possible genetic factors and risk factors including vascular disease, high blood pressure and high cholesterol but to date there is no treatment available to alter the progressive nature of the illness. Treating the

[12] Elias M F, Beiser A, Wolf P A, Au R, White R F and D'Agostino R B (2000) The preclinical phase of Alzheimer disease: a 22-year prospective study of the Framingham cohort. *Archives of Neurology* **57**, 808–813.
[13] Ferucci L, Guralnik J M, Salive M E, Pahor M, Corti M, Baroni A and Havlik R J (1996) Cognitive impairment and risk of stroke in the older population. *Journal of the American*
Geriatrics Society **44**, 237–241.
[14] Gale, C. R., Martyn, C. N. and Cooper, C. (1996). Cognitive impairment and mortality in a cohort of elderly people. *British Medical Journal* **312**, 608-611.
[15] Hébert R, Brayne C and Spiegelhalter D (1999) Factors associated with functional decline and improvement in a very elderly community-dwelling population. *American Journal of Epidemiology* **150**, 501–510.
[16] Zuccalà G, Onder G, Pedone C, Cocchi A, Carosella L, Cattel C, Carbonin P U and Bernabei R (2001) Cognitive dysfunction as a major determinant of disability in patients with heart failure: results from a multicentre survey. *Journal of Neurology, Neurosurgery and Psychiatry* 70, 109–112.

symptoms of dementia and offering appropriate support services however can make a significant difference to the lives of people with dementia and their caregivers.
"The way each person experiences dementia, and the rate of their decline, will depend on many factors – not just on which type of dementia they have, but also on their physical make-up, their emotional resilience and the support that is available to them." Dementia UK Report 2007 (Alzheimer's Society).

- **Prevention of Depression**

Unlike cognitive impairment there are a range of treatments for depression which is an intermittent illness and often ignored in older people. There is evidence to show depression increases likelihood of cognitive impairment in older people, and leads to more rapid physical decline (K. Yaffe, Archives of Gen Psychiatry 1999). In terms of the risk factors for developing depression in older age including; bereavement/loss, chronic physical illness or disability, care giving responsibilities and early dementia (Goldberg Early diagnosis and prevention, London HMSO 1992) whilst they cannot be eliminated there can clearly be some mitigation. Support to carers, empowering people to manage their own disability or illness and the fostering of support networks to reduce isolation are arguably powerful prevention factors for depression.

- **Parkinson's disease**

Parkinson's disease is the second most common cause of chronic neurological disability in the UK and is estimated to affect between 100 and 180 people per 100,000 of the general population[17] and 1–2% of people over 65 years of age[18]. As the condition progresses is causes severe disability with impaired quality of life for the affected person, the family and Carers. The table below shows an estimate of the number of residents with Parkinson's disease living in Barnet during 2006 and a forecast for 2016.

Table 12: Estimate of numbers of people in Barnet with Parkinson's Disease 2006 and 2016

Age Group	Population Size	Prevalence	Number people with Parkinson's Disease in Barnet (2006)	Number people with Parkinson's Disease in Barnet (2016)
0 – 29 years	-	0	0	0
30 – 39 years	58523	.008%	4	5
40 – 49 years	47776	.012%	6	7
50 – 59 years	36932	.109%	40	48
60 – 69 years	25200	.342%	86	105
70 – 79 years	19321	.961%	185	188
80 – 89 years	10595	1.265%	134	141
		TOTAL	455	494

GLA 2006 population estimates and the national Institute of Clinical Evidence national prevalence estimates.

[17] Dodel, R.C., Eggert, K.M., Singer, M.S. et al. (1998) *Costs of drug treatment in Parkinson's disease*. Movement Disorders 13(2), 249-254.
[18] Bandolier (2003) *Incidence of Parkinson's disease.* Bandolier. www.jr2.ox.ac.uk/bandolier [Accessed: 06/06/2007].

5. Resources Analysis

5.1 Supply and Demand

This section begins to describe the care market in relation to services for older people in Barnet. 'Market' is defined both as the available supply of care provision and support, and also the demand placed upon this. Included in this must be the expectations of service users and carers in recognition that the market will increasingly be influenced by the choices they make and their purchasing power.

Please note - A full market analysis will require knowledge of the full range of support utilised by older people and their carers and the challenge for commissioners is to broaden their understanding beyond that of traditional services and start to map the complex network of provisions which support people and communities.

- **Demand**

    - As well as understanding assessment of individual need, demand is influenced by assessment of population health needs. This can help to identify those who may not be accessing services and in answering questions of whether resources are being targeted to those whose need is greatest.

    - Need and demand are influenced by availability of choices – analysis of the market starts to draw out what is an appropriate measure of future demand and what services are being provided but not explicitly demanded by those who are using them.
    - The commissioning strategy is influenced by the current patterns of demand for services. Services under pressure, and services with excess or fluctuating capacity, are indicators of a need for change.
    - There are requirements for more profiling information about the 'known populations' and to develop the capacity jointly with stakeholders to know more about key decision points along the care pathway to support a whole population perspective on demand.

For the purposes of this resource analysis services will be grouped under the following headings:

- Residential and nursing care including respite
- Rehabilitation and Homecare
- Housing including housing support services
- Daycares
- Support for carers
- Meals
- NHS services including community based intermediate care and end of life care

Residential and nursing home placements and respite

- Residential and nursing homes may register places for the care of older people who have dementia and places for people who require nursing care. Places for people who require neither type of specialist care are referred to as 'mainstream places'.
- The current supply of mainstream residential places is greater that the number of placements made by the local authority: the demand is falling by 2-3 placements a month reflecting national experience.
- There is a shift away from commissioning places registered for the care of older people towards a higher numbers of places registered for caring for people with dementia.
- The demand for nursing home places is currently constant overall, with increased numbers of placements countered by decreased lengths of stay. Supply is generally sufficient to meet demand, although people may have to wait to move to the home of their choice.
- There are a small number of out of borough placements predominantly linked to choice.
- The demand for specialist short term provision such as intermediate care and rehabilitation beds is increasing, as is the demand for interim care beds and mental health assessment beds. This is partly the result of a greater focus on promoting independence and facilitating prompt discharge from acute hospital settings.
- There are a total of 76 registered care/nursing homes for older people in Barnet. The local authority currently purchases approximately 1100 residential and nursing home places and the Primary Care Trust purchases nursing care for more than 500 older people.
- The Primary Care Trust currently commissions a small number of rehabilitation beds in the independent sector on very limited basis.
- There are assessment and treatment beds in private hospitals for a small number of older people, including those with acute functional mental health problems, learning disabilities and traumatic brain injury.
- Two large nursing homes (250 beds and 94 beds) are being developed in Barnet which will further increase the supply of places however place additional demand on primary care and specialist mental health care resources. The effect of this additional supply is to increase the potential of cross border purchasing from other boroughs and health trusts and current funding rules have a high impact on the local Primary Care Trust services and budgets in particular.
- The utilisation rate for respite beds is low, in common with other authorities. Whilst demand is relatively constant throughout the year, the need to ensure that carers have access to respite when they need it makes capacity planning difficult.

Home Care

- There are currently 1514 older people supported by 15 home care providers from a budget of £13.4m.

- Demand for home care is growing in line with ambitious improvement targets to increase the numbers of people supported at home.

- Funds are not presently available to meet the increasing demand for home care commissioned by the local authority, and local unit costs are higher than those of a comparable group of local authorities.

- Demand for home care at specific times during the day and during evenings and weekends is greater than current supply, resulting in delays and lack of choice which limits the ability of people to remain supported at home.

- The development of this market is essential if people are to be supported in their own homes in a way that reflects increased choice and control. A range of services are required which address specialist needs such as those of people with dementia, are flexible and responsive and available 24/7, and offer the full benefit of assistive technology. The growth in the use of direct payments, individual budgets and older people who are funding their own care will change the focus from services wholly commissioned by the local authority and the Primary Care Trust from providers, towards people who specify how they expect their care to be delivered, whether that is by direct payment or exercising choice about their health care provider. Providers will need to demonstrate they can respond to these changes in the nature of demand, which will include attention to training and workforce planning.

Housing

The Council is reviewing its strategy for older people's housing, agreed in 2001, which has achieved much of the reconfiguration of the Council's sheltered housing stock and developed the first extra care housing in the borough[19]. The new draft strategy which will reflect needs and aspirations of older residents in all tenures includes the following key aims:

- Agreeing a new sheltered housing strategy to achieve more flexible service provision and to ensure that the very best facilities are provided in remaining sheltered housing, the strategy will include sheltered housing provided by housing associations (see Supporting People section below).
- Developing comprehensive housing information and advice services including equipment and adaptations, access to care and repair services, the returning home (from hospital) scheme and advice on security and energy efficiency.
- Promotion of private sector options through the planning system and as part of the review of our Private Sector Housing strategy and developing closer links with existing sheltered housing providers and managers within the independent sector.
- Renewing our approach to culturally specific accommodation, ensuring that sheltered housing is inclusive to all communities and that older people from black and minority ethnic communities are supported to access sheltered and other supported housing.
- Developing opportunities to make better use of assistive technology which can support tenancies better in the future, in particular the aids to daily living that are available as part of the Telecare remit.

[19] 2 newly built extra care housing schemes, one on each side of the borough open in spring 2008, inclusive for older people with mental health problems.

Home based support services: Supporting People

The Floating Support Service provides home based, housing related care to people regardless of tenure. The demand for this style of home support is very high. The scheme has identified approximately 23% of the 160 people who make up its caseload as having a diagnosed mental health condition and/or dementia.

Supporting People invests just under £1m of its total budget on services for more than 2000 older people. It provides low level, practical, housing-related, home based support to people in sheltered housing, and in the form of floating support services to people regardless of tenure, Barnet Care and Repair and Barnet Lifeline, the community alarm service.

The service is commissioned via the Supporting People Commissioning Body (a partnership between the health and probation services and the local authority) which is currently updating its five year strategy in line with a recent needs analysis which said that:

- There is a significant unmet support need for older home owners
- There is a need to increase floating support services, and an emerging need for a specialist service to for those with mental health problems who have become socially excluded and have formerly refused services.
- There needs to be better integration for ethnic minority groups.
- There is a need to explore alternative models in order to make the best use of existing sheltered housing, such as on linking home care teams to specific sheltered schemes, provision of floating support models, and the need to make better use of communal facilities (health checks ups etc - Sure Start model), which has also been highlighted by the Day Care review.

The demand for flexible and responsive home-based support is also reflected in the Telecare pilot which, although still being evaluated, suggests that demand could increase still.

Assistive technology

Provision of packages of care with elements of assistive technology has slowly grown, stimulated by the provision of funding from the department of health. There is some evidence from the pilot of benefits to carers and older people however more work is needed to embed the principles of assistive technology in the process of early intervention where patterns of usage can be effectively studied and monitored for a prevention effect.

Where viable, provision of systems e.g. alarm / call systems, need to be effectively joined up across agencies using a shared platform to avoid duplication and promote holistic coverage.

Day care

- Day care services which have been directly provided by Adult Social Services in the past and are now commissioned from Catalyst and subcontracted to the Fremantle Trust. The Trust provides a total of 701 day care places each week, including 241 places for people with dementia and 100 for Asian Elders.

- A pattern of demand has emerged in the six years since the contract was established. Overall demand for mainstream places has not increased - although clients' dependency levels have increased, reflecting overall changes in population profile.

- The demand for places for people with dementia has increased markedly, and so places for this client group have been increased which is reflected in the figures above. A recent informal survey suggested that up to 20% of those attending general centres have either dementia or a functional mental illness. Dependency levels have increased also: as a result it is difficult to provide services for people have dementia and those who do not in the same setting.

- The demand for places among Asian elders has not increased.

- A change is service is planned in 2008, when one of the centres will have been redeveloped as a centre largely for service users with dementia, and there will be a reduction in places for people who do not have dementia and for Asian elders. Although overall capacity will be slightly reduced there will be more capacity for service users with dementia, with an increased staffing ratio and an improved distribution of places across the borough.

The London Borough of Barnet and Barnet Primary Care Trust also commission a range of services from the NHS, the independent health and social care sectors and the voluntary sector.

Voluntary Sector

Adult Social Services and the Council's grant unit offers support to voluntary sector organisations to provide day care for older people with lower dependency needs. Whilst the provision has provided a valuable function for some older people, it has not linked to the overarching commissioning strategy for older people. The Primary Care Trust and local authority are currently mapping service provisions in relation to how they fulfil outcomes for older people. All available resources will need to be deployed in the modernisation agenda for older people in the borough- for example in promoting activity and innovative engagement with sports. The overall intention is to promote social inclusion and mental and physical health and well being.

The extent of voluntary sector-provided day care can best be described under four headings:

- Organisations under contract to the Older Adult Services
- Services designed to support carers
- Organisations that are largely self supporting with some assistance from the Council
- Organisations supported by the Jewish community including Jewish Care.

Table 13 Voluntary Day Care under contract to Older Adult services:

Organisation	Type of contract	Contracted places per week
Age Concern Barnet	Contract for day services – open referral	550
Anand Centre (Asian elders of 'Indian background'.	Contract for day services	60
Barnet African Caribbean Assoc. (BACA)	Contract for outreach and day care	60
Barnet Asian Old Peoples Assoc. (BAOPA)	Contract for outreach and day care	150
Friend in Need (FIN)	Contract for flexible day care	114
Alzheimer's Society (for elders with dementia)	Contract for support to day care centre (also funded by Mental Health grant)	60
Total		**994**
Included in the above - block places for those with mental health problems		241

During a recent informal survey it is estimated that up to 20% of those attending at general centres have either dementia or a functional mental illness.

Council Grant Unit Aided Centres

There are approximately 20 organisations (a number associated with ethnic minority groups) offering social/luncheon clubs that are largely self funded but some apply for funding from the Council's Grants unit on occasion.

Jewish Centres

The main centre for Elders from the Jewish Community has been run by Jewish Care (without direct Council funding) at the Sobel Centre, which offers more than 100 places, five days a week for older people from North West London. The centre is due to close during 2007 and it is unclear what form any replacement centre will take. Several synagogues run social luncheon clubs with funding from their communities.

Support for carers

Care and support is provided to carers that includes respite services and one off Direct Payments.

Barnet Council contribute funding towards a range of other services which are provided via the Voluntary sector.

They include:

- The Barnet Carers Centre, a key point of contact for carers, jointly funded by the local authority and Primary Care Trust, are in contact with over 4000 carers in the borough.

- Barnet Care and Support Service (BCASS) which provided 28,000 hours of paid care to enable carers to have a break (includes all groups)
- Friend in Need
- Casework and helpline provided by The Alzheimer's Society
- A dedicated carer's nurse post is funded by the Carers Grant (LA) and managed by the Primary Care Trust
- Adult Social Services has appointed a Carers Co-ordinator to champion services for carers in Barnet, and to work closely with Barnet Carers Centre to promote services.

In addition carers contribute to Partnership Boards, carer sub groups and various consultations. Their feedback is recording in detail in the Barnet draft Multi-Agency Carers Strategy however key points include concern about poor customer service offered at times to carers, lack of understanding by professional staff about the experience of carers, information is still patchy, there needs to better access to out of hours support and emergency interventions and more training for carers required.

The Home Meals Service

A Home Meals Service, contracted for jointly with the London Borough of Enfield, has been awarded to Sodexho. 350 people will be provided with hot meals 365 days a year including festivals. A wider range of meals than was previously the case will be available to people from BME communities.

NHS Services

Mental Health
The Primary Care Trust commissions services for older people with mental health needs from Barnet, Enfield and Haringey Mental Health Trust. The agreement for 2007-2008 includes the following features and planned developments:

- Supporting primary care, improving monitoring of older people's mental health problems and creating a model for early intervention
- Improvement in the interface between mental health specialist services and acute trusts so both respond effectively to people with mental health care problems
- Involving older people in individual and strategic planning and improving access to advice and advocacy
- A robust approach to the assessment of carers needs
- Recommendations for individuals who would benefit from a service from telecare
- Interventions to help people remain independent in their own homes
- Services which are provided in the settings that best meet the needs of older people.
- An assessment of the need for psychology services for people with dementia
- Develop guidelines for direct referral to the independent sector for MRI scans
- Plan for improved access to Memory Clinics for people with Alzheimer's disease
- Review current service provision and scope new models of care for people with Young On Set Dementia and for crisis services
- Development of models of care which mean that people may have a dignified death

A theme running through the agreement is that pathways of care must account for both the mental and physical health needs of older people and their support by both health and social care staff.

Primary care services

- There are 75 GP practices, 76 dental practices, 79 pharmacists and 81 optometrists commissioned to provide primary care to residents of Barnet. All of these contractors provide services to the elderly population of Barnet.
- Of the 75 GP practices commissioned, 7 practices are commissioned through a PMS (Personal Medical Services) contract to provide additional services to the basic contract that are specifically aimed at elderly people.
- Domiciliary dental services are available to residents that are unable to attend a dental surgery (such as people who are housebound or residents in care homes) from 29 of the commissioned dental practices and the Primary Care Trust Salaried Dental Service. Optometry domiciliary services are also provided within the borough
- There is a pharmacy service targeted at residents in care homes that is designed to support the improvement of medication processes in care homes. This service is in the process of being re-launched.
- There are plans to review primary care services to homes (nursing and residential) during 2007-2008 to ensure that the appropriate services are being delivered.
- Eight GP practices are now involved in an end of life care programme which will also be delivered to a pilot group of residential and nursing homes within the borough.

All GP practices in Barnet are participating in the Quality and Outcomes Framework (QOF) which is the national quality improvement incentive scheme for primary care. Many of the clinical areas within the QOF are areas which particularly affect older people. Generally, Barnet GP practices achieve high scores in the QOF and some of these are listed below. The average percentage achievement of the total points available in key clinical domains is listed below. It should be noted that dementia, depression and palliative care were new domains for 2006-2007 and it is anticipated that scores will increase still further in 2007-2008

Heart Failure	93%
Stroke	97%
Diabetes	98%
COPD	94%
Dementia	87%
Depression	83%
Palliative Care	86%

Intermediate Care

Barnet's Intermediate Care Service is a multidisciplinary team which currently provides support to over 90 people per week who are either leaving hospital to return to their own homes, or who need support to prevent hospital admission whilst in their own homes. Within intermediate care services there is access to community physiotherapy and occupational therapy to enable greater streamlining of services. The district nursing service provides day and night care, supporting people at home and in residential care. In addition, Primary Care Trust therapy services include dietetics, speech and language therapy and podiatry support people in the community and in care homes. The three continuing care nurse managers manage the cases of approximately 550 people each year living at home or in care homes and the Primary Care Trust's community matrons help people to manage their own long term conditions at home.

The Primary Care Trust budget for district nursing, community matrons, therapists and continuing care is around £20m.

Secondary care services

The Primary Care Trust does not commission secondary services for older people separately from those for all adults in Barnet. It recognises, however, that some services will be more heavily used by older residents, and all services must be sensitive to the clinical and other needs of older people.

The redevelopment of the Finchley Memorial Hospital to provide local services for people who have had a stroke, and rehabilitation services, will be of particular importance to older people.

The commissioning focus is on the links between acute care provided in hospital, as close to home as possible, and community-based services. This takes the form of work with providers to reduce delayed discharges from secondary care, improving the ratio of new to follow up outpatient attendances, reducing the number of people re-admitted to hospital and making the important link to the development of a commissioning framework for palliative care.

End of Life Care

The Marie Curie Delivering Choice Programme has a project team working in Barnet seeking to develop patient focussed 24 hour care service models which provide best possible care for palliative care patients and improve the equity of access to services. The development of these service models build upon the findings of phase 1 which provided a clear picture of services locally for Barnet people nearing the end of life. Generally the services were found to be of a high quality. The provision of specialist and non-specialist services involves a high number of stakeholders and the following work streams have been agreed to take the project into phase 2:

1. Improving access to palliative and end of life care
2. Providing good quality community care
3. Providing good quality care in hospital and appropriate and timely discharge
4. Education and training- identifying and addressing any gaps
5. Commissioning, including quantifying the amount of resource necessary to achieve the desired vision.

Falls

National research and local figures demonstrate a high number of hospital admissions are due to falls. Prevention of falls is linked to exercise and mobility and a locally agreed target for falls will require a coordinated programme of prevention based on more available exercise programmes geared to a wide range of mobility and lifestyles.

5.2 Needs Analysis - Key Messages

- Close working with Barnet housing and housing providers to develop clear understanding of housing needs of older people and develop continuum model of housing and support, including access to good quality information which support informed choices about housing options.

- Expansion of extra care, other supported housing in general, which offers a range of tenures to meet a wide range of need, including for people with dementia.

- Develop the capability of sheltered housing to deliver a full range of care and support services and appropriate facilities which support an inclusive approach to individuals who may be isolated.

- Learn further from research into why people come into residential care and understand whether this is preventable or whether it is through informed choice.

- Through participation in joint needs assessment, identify and target areas and populations at greatest risk of deteriorating health and in greatest need.

- Gather evidence from prevention strategies to inform future planning.

- Need to develop joint planning and commissioning arrangements across local authority and Primary Care Trust to prioritise multi-agency improvements.

- Need to develop easier routes into and processes into support services for older people.

- Need to deliver workforce strategy with partners delivering community health, social care and housing services to both secure a future workforce and equip it to meet the requirements of the new models of service delivery.

- Create effective care pathways which join up services and systems for people with mental health problems and those needing complex care, including end of life care. To meet the key outcomes of maintaining independence and staying healthy sought by older people we need to be smarter in way info is collected and used between health and social care.

- To recognise more fully the needs of carers, particularly the needs of older carers, and their critical role in supporting large numbers of older people at home.

6. Service quality

Information about service quality is derived from a number of sources: the reports of regulators, review and audit of services, information drawn directly from the experience of people who use services and routine management of provider performance through the contract system.

6.1 Reports of regulators

A review of the latest inspection reports for Residential, Nursing Home and Home Care providers operating in Barnet, or who are contracted with outside the borough suggests that there is a small number of providers where the current standards of care are poor. In line with recent CSCI guidance (Relentless Optimism - Creative Commissioning for Personalised Care Sept 2006) the Primary Care Trust and local authority will ensure that they use commissioning, and contract monitoring, as levers to improve services where they are deemed to be poor.

Inspection reports are not presently available for Day Care, but recent user surveys confirm the need for day care provision as part of a spread of community support options. They suggest, however, that the traditional form that day care often takes no longer meets many people's expectations for social contact. Respondents also said they had had a poor experience of transport services and, as a result, of their day care experience.

The latest inspection report for physical and sensory impairment services (2007) drew particular attention to the need to ensure an Adult Protection ethos across all services. Actions to reinforce this will include using the updating of contracts and service level agreements to ensure all services purchased operate robust safeguarding protocols,

6.2 How to improve quality monitoring and measurement of progress

The Older People Action Learning Set (2007) suggests that qualitative measures should be developed to complement the current target focussed national performance assessment framework. The measures should be used in a way that:

- Keeps the focus on outcomes and what matters to older people locally – as a whole community, as well as to different communities of older people
- Supports a whole systems approach, creating and sustaining a shared view of what is happening across services
- Encourages the whole system to shift its focus towards promoting well-being, by helping people to understand which interventions work
- Helps partners to understand their actual and potential contributions to quality of life so they can exploit the connections between quality of life and their other agendas and priorities.

The local authority and Primary Care Trust will strike a balance between quantitative and qualitative monitoring and so determine whether older people and carers are benefiting from changes in services. They will:

- Match performance indicators to the targets listed in the strategy.
- Develop local quality indicators, including user and carer feedback which will alert providers to issues they may need to address, and provide suggestions for improvement.
- Align contract specifications for new services to outcomes.

- Consult stakeholders regularly about the extent to which the seven key outcomes are being met, so that the commissioning strategy can be updated and revised accordingly.
- Monitor contract compliance, collect data on unmet needs, and provide business intelligence on trends to the independent and voluntary sector to ensure that they can base business plans on good local and national data.
- Include requirements which ensure that providers collect and present information about service activity and outcomes in contracts, service level agreements, and grant funded schemes rules.
- Use the new outcomes Framework for Performance Assessment of Adult Social Services proposed by CSCI, which describes an approach that is outcome rather than output focused, to help them to assess care services they commission.
- Require providers to demonstrate high levels of involvement by service users in describing how they want their care to be delivered.

7. Commissioning Implications

- **Given the over provision for Barnet residents** and the predicted trend away from long stay placements, Adult Social Services and the Primary Care Trust will challenge any new planning applications for residential care services on the basis that additional places are not required within the Borough. New applications will need to demonstrate that they will either replace existing places, or refurbish existing provision in order to improve quality standards.

- **It is forecast that, with improved support to carers, the impact of assistive technology**, and better management of illness within the community, growth in demand for services will be slower than the demographic trend and prevalence data suggest.

- **There will be increased emphasis on developing a range of short term service provision**, which builds on the existing programme of intermediate care, rehabilitation and mental health assessment services. The intention is that these services will support effective discharge from acute hospital settings and, through referral from home, help avoid admission to hospital. There will be scope for some of these services to be provided by independent and voluntary sector organisations.

- **The forecast demand for nursing home care is for an increase in the number of places** needed, but a reduction in the average length of stay. There are two reasons for this. The first is that better management of ill-health will sustain people at home for longer and it is, therefore, more likely that admissions of older people to nursing homes will be predominantly for the end of life period when they require a higher level of nursing care than can be delivered effectively at home. Second, nursing home will be expected to promote treatment and rehabilitation work with their clients.

- **All staff working with older people will need to continue to improve the quality of services**, particularly for those with complex needs residing in care homes to ensure that promoting dignity is embedded within the culture of service provision.

- **Commissioners will focus on an approach to home and services** which incorporates the needs of older people, regardless of tenure. The considerable number of older home owners in the borough means that commissioners will work

with independent housing and care home providers to stimulate new extra care developments aimed at the home ownership market.

- **There will be continued demand for day services but new models of service are required**. There is dissatisfaction with transport and location issues and inflexibility in delivery. More effective coordination and linking across voluntary schemes are required to improve overall outcomes for older people. There are a growing number of examples in other area of effective working across the voluntary sector to provide a 'gateway' to access the Sure Start to Later Life programme commended to local authorities.

- **The local authority and Primary Care Trust will encourage the development of the Voluntary Sector Consortium** to establish support for everyday social meeting places such as neighbourhood cafes, community recreation activities and community groups using local community centres. This approach may help older people join in activities that cut across age and generation barriers.

- **There are no changes planned for the hot meals service contract, however, there is scope for added diversity in this area**. The local authority and Primary Care Trust will encourage the growth in home delivery services of fresh and frozen meals in partnership with existing supermarket suppliers. This approach recognises that more people who will enter the 65-75 age group over the next ten years will be more familiar with internet shopping, microwave cooking and will wish for wider choice in meal types. The cost to the individual may be less than that of the home meals service.

- The London Health Strategy is expected to lead to a big expansion in the range of services provided in primary care that have traditionally been provided in acute hospitals. Many of these will relate to the management of long term conditions, and therefore older people in Barnet, making access much easier by providing them more locally. The Primary Care Trust Primary Care Strategy is being refined and elaborated to reflect these changes. Specifically the Primary Care Trust is in the process of plans to redevelop Finchley Memorial Hospital to provide new models of care within a modernised environment. This is subject to approval by the Department of Health of a bid for additional ring fenced funds to achieve this the final outcome of which will be known by 2009-2010.

- Practice based commissioning clusters will continue to focus on some services that predominantly affect older people including care for people who have COPD (Chronic Obstructive Pulmonary Disease), diabetes and cataracts.

- During 2007-2008, a further review of primary care services to care homes will be carried out. This will identify any gaps in care provision and the most effective way of meeting the primary care service needs of these patients. The additional services for the elderly being provided by 7 of the GP practices will be reviewed to identify any best practice that can be spread across primary care.

- **The Primary Care Trust has reviewed stroke services across acute and community providers** because to analyse capacity which does not meet need appropriately. In the autumn of 2007, the Royal Free Hospital will no longer provide rehabilitation for stroke patients and this responsibility will pass to the community

provider. There will be an emphasis on establishing the number of rehabilitation beds required to meet demand. This will reduce delays in hospital discharge from Barnet Hospital's acute stroke unit and to ensure that referrals for rehabilitation from the Royal Free occur without delay. It may be that the Strategic Outline Case for redevelopment of the Finchley Memorial site offers a longer term solution to the issues of dedicated stroke services accommodation. Of particular concern is the lack of local rehabilitation accommodation for younger stroke victims, who have to be cared for outside the borough at present. This is being addressed as part of the Primary Care Trust's specification for rehabilitation services and is likely to be supported through stroke support services commissioned from the voluntary sector.

- **The Intermediate Care Team will be expected to improve their response rate** to the discharge of patients from acute trusts and to develop expertise in areas such as stroke to facilitate earlier discharge.

- **The Primary Care Trust has already set in place a new model of care to meet the needs of patients with long term conditions** and the caseloads managed by specialist staff are rising. This trend will continue in 2007-208 with the focus on preventing hospital admission where possible by closer clinical management in the community. This has already been an effective approach to managing patients with respiratory disease in Barnet. Further work will be undertaken to implement case management arrangements across health and social services and establish integrated teams caring for people with long term conditions.

- **The Primary Care Trust is strengthening its work on commissioning continuing care by increasing resources and the use of technology**. There are regular reviews of services provided to clients receiving continuing care and to those whose care is jointly funded by the Primary Care Trust and LA to ensure that care provided is appropriate and lawfully funded. This is an area that is being actively considered for joint commissioning between the Primary Care Trust and the London Borough of Barnet to improve consistency of procurement and outcomes for service users with complex needs.

8. Performance Targets

The national performance frameworks for the local authority and Primary Care Trust play a significant part in driving change.

The chart below illustrates the necessary changes in performance if the local authority is to be ranked as 'high performing' under the Comprehensive Performance Assessment Framework.

Performance Target Indicator	Target Source	Lead Agency	Current Performance	2007/8 Target	2008/9 Target	2009/10 Target
C28 – Intensive Home Care	PSS PAF	Barnet Council	11.64	16	22	28
C51 – Direct Payments	PSS PAF	Barnet Council	108	180	250	400
C62 – Services for Carers	PSS PAF	Barnet Council	9.58	12	25	50
C72 – Permanent admissions (65+) to residential or nursing care	PSS PAF	Barnet Council	69.88	65	60	55
D40 – Clients receiving a review	PSS PAF	Barnet Council	56-10	75	80	85
D55 – Acceptable waiting times for assessments.	PSS PAF	Barnet Council	90.20	95	97	100

The Performance indicators form a quantitative part of an overall judgement made by the regulators in how far progress is being achieved against outcomes.

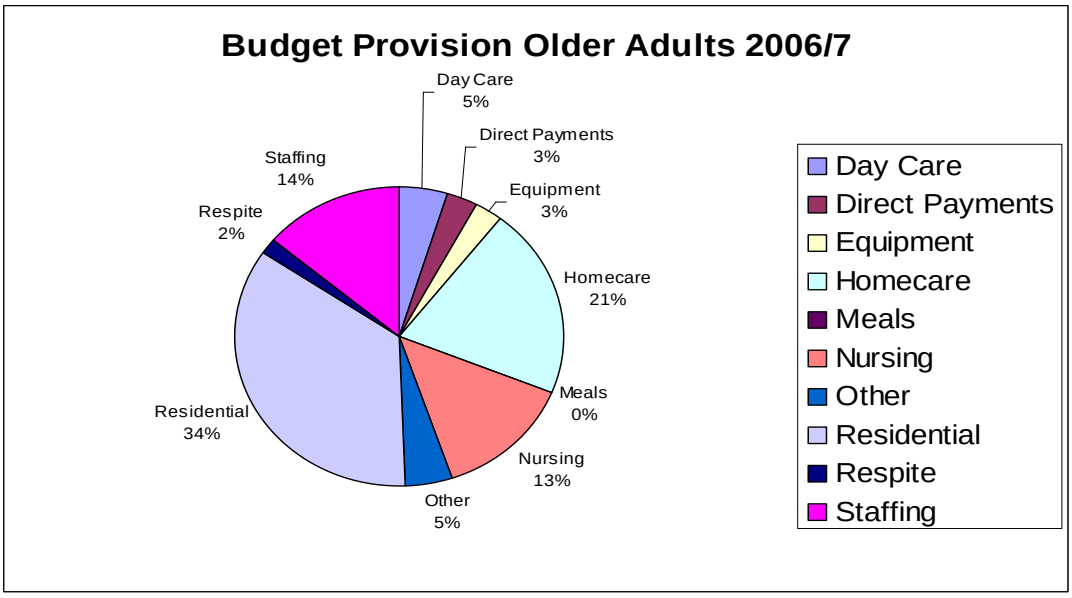
In addition cross cutting Local Area Agreement targets include range of targets and indicators which measure impact on well-being for older people and include the reduction of health inequalities. The current Local Area Agreement is subject to review following the publication of the new performance framework for local authorities and local authority partnerships in October 2007.

The outcomes for this strategy will be measured using a combination of targets and indicators from across health and social care and include a set of measurements agreed with service users and carers. Progress against the action plan will be reported via a template on a quarterly basis to the Older People's Partnership Board. This template will also reflect any new requirements as a result of the new regulation framework Commissioning for Health and Well being due for implementation in 2008-2009.

9.0 Funding services

9.1 Financial and planning assumptions for London Borough of Barnet

Spending on services for older people by the London Borough of Barnet is expected to change as a result of the commissioning strategy over the next three years. Current funding is illustrated in the following chart:



This breakdown will be reviewed as part of the annual progress report to the Older People's Partnership Board.
The local authority will promote the take up of direct payments and individual budgets and so enable people to exercise choice and control in the ways their care needs are met.

The Primary Care Trust has sought legal advice on the use of Section 28a agreements in conjunction with the local authority as a way of enabling greater choice and control of packages of care delivered at home. This is specifically for continuing care funded home placements. It is not currently lawful for the NHS to transfer funding for care directly to individuals or their families/carers to pay for care. However, solicitors have confirmed that is lawful for the NHS to use a Section 28a agreement to overcome this problem. The Primary Care Trust therefore transfers funds to the local authority so that a payment can be made to individuals or their families in a similar manner to direct payments or individual budgets.

9.2 Financial and planning assumptions for the Primary Care Trust

Planned expenditure

The Primary Care Trust's funding assumption for 2007-2008 is given in the chart below.