APPENDIX 1

BRENT POPP BUDGET

EXPENDITURE	Description	Unit cost	Annual cost	2-year cost
CASE MANAGERS	Per care co-ordinator per year	37,000	185,000	370,000
DEPUTY MANAGER	New deputy manager post	42,000	42,000	84,000
FLEXIBLE POOLED BUDGET	Approx 2600 care packages in 2 years	215	280,000	560,000
BEFRIENDING CO-ORDINATOR	Match funding for Timebank initiative pa	20,000	20,000	40,000
WELFARE BENFITS ADVISER	Annual contribution to DWP adviser	16,000	16,000	32,000
MENTAL HEALTH LIAISON	P/T H grade & F/T G grade nurse	61,000	61,000	122,000
HOUSING LINKWORKER	Willow F/T posts inc on costs	44,000	44,000	88,000
HANDYPERSON	Elders Voice - 2 days per week post	22,000	22,000	44,000
PROJECT MANAGER	Project manager - 2-year post	38,300	38,300	76,600
ADMIN	F/T admin/research assistant pa	21,500	21,500	43,000
AUDIT/RESEARCH/EVAL.	Commissioned on daily rate of:	600	40,000	80,000
CARERS' EVALUATION	Brent Carers' Centre discovery int.		5,000	10,000
STAFF TRAINING	Staff induction and MDT events		15,000	30,000
DISEASE MANt. IT PROJECT	Contribution to set up and running		10,000	20,000
SET UP COSTS	Adverts, PCs, Project Board, office exps.		25,200	50,400
Less reduction in Grant Awarded	***(reduction of £688per year in the set up costs)***			
POPP GRANT AWARDED			***825,000***	***1,650,000***

APPENDIX 2

POPP SUMMARY

Partnership for Older People Projects (POPP)

Published by DOH: Tuesday 8 November 2005 **Reference number:** 2005/0390

More than 150,000 older people will now receive care designed to keep them healthier and active for longer as a result of 19 ground-breaking new projects, announced on 8th November by Patricia Hewitt, Secretary of State for Health. Following stiff competition, nineteen councils across England have won a share of the two year £60m Partnership for Older People scheme, (POPP) with the first phase to begin by May 2006. The second phase will be announced next year and begin in May 2007.

During a visit to the Charlie Ratchmord Resource Centre, an older people's centre in Camden, one of the winning boroughs, Health Secretary Patricia Hewitt, said:

"We know, because older people tell us, that they want to live independently for as long as possible. Too many older people are being admitted to hospital, often as an emergency, when this could be avoided if the right community services were in place at the right time. What we want to achieve with POPP are services that avoid these crisis scenarios and that will give our older people more choice and control over their lives."

The winning councils are:

- Bradford: £1,334,000
- **Brent: £1,650,000**
- Camden: £1,546,000
- Dorset: £2,394,000
- East Sussex: £3,188,000
- Knowsley: £1,226, 000
- Leeds: £4,049,000
- Luton: £861,000
- Manchester: £2, 601,000
- Norfolk: £2,510,000
- North Lincolnshire: £870,000
- Northumberland: £2,030,000
- North Yorkshire: £3,000,000
- Poole: £796,000
- Sheffield: £3,876,000
- Somerset: £1,347,000
- Southwark: £1,847,000
- Wigan: £1, 768,000
- Worcestershire: £2,000,000

The successful projects share a range of common factors, including a shift to prevention , reducing emergency admissions and/or bed days for older people, and will meet the specific needs of older people who are socially excluded, those with or at risk of mental health problems and black and ethnic minority groups.

They also demonstrate partnership arrangements across health and social care, which are underpinned by pooled budgets and joint commissioning, and a commitment to continue to involve older people, carers and staff in the delivery and evaluation of services. Partnership for Older People Projects will see services taking a more pro-active approach to identifying and responding to needs as they emerge. They will provide direct support for achieving two key PSA targets on long term conditions and supporting vulnerable older people. By targeting people with low level needs today services can prevent the need for higher intensity or institutionalised care and improve well-being.

The White Paper, Your Health, Your Care, Your Say, due for publication later this year, will continue to drive forward the commitment to investing in care outside of hospitals, and the Partnership for Older People Projects are one of the ways in which this is being delivered.

A fifth of the population of England is over 60, and older people make up the largest single group of patients using the NHS and local authority social services. Older people can now expect to live longer than those in the past and future generations can expect to live longer still. An average man aged 65 today can expect to live a further 19 years. By 2051, his counterpart can expect to live a further 21 years, almost double the life expectancy of a 64 year old man a century earlier. By 2051 then projected life expectancy at birth for men will have risen to 84 and 88.

The Brent POPP Project

Title: Brent Integrated Care Co-ordination Service **Client Focus:** Older People

Project Key Elements

- Develop existing care co-ordination service to become an integrated health and social care team with a particular focus on BME communities. Each case manager multi-skilled to carry out health and social services assessments. Case finding and intensive case co-ordination.
- Involvement of Timebank, Pension Service, housing, mental health link worker etc
- Development of protocols to allow staff from rehabilitation services, care management and district nursing to access co-ordinated short term preventative care packages from a pooled budget
- Commissioning of preventative services from the voluntary sector (e.g. Elders Voice Environmental Assessors – providing home safety checks)
- Telecare,
- In-reach into hospital to facilitate discharge
- 'Discovery interviews' by carers centre

Project Outline

The Integrated Care Co-ordination Service (ICCS) will provide holistic person-centred assessments of vulnerable older people (65 years plus) and co-ordinate a range of interventions responding to their identified needs. The existing Care Co-ordination Service, will be enhanced and developed to include Social Services and other partners in the wider health and care community (e.g. housing, HIA, Pension Service, Timebank etc). There will be a clear focus on reducing hospital, nursing home and residential care admissions – both in the short and longer term. The ICCS will therefore focus upon vulnerable older people who are at risk of admission, to hospital - including via Accident and Emergency Departments, nursing home or residential care, who, by timely intervention, may improve their quality of life, and be treated and supported outside an institutional setting.

The ICCS will work with users and carers from the outset, to ensure that interventions are based on a shared understanding with professionals of realistic goals and agreed actions, which will address identified needs. On referral, the service will provide a nominated care co-ordinator who will be empowered to undertake a single

assessment of need. The older person and carer, if there is one, will always be at the centre of the process. The care co-ordinator will liaise with the primary care team and refer directly to other specialist members of the ICCS team where appropriate. Specialist assessments and support will be rapidly available from the mental health liaison worker, the housing linkworker, the handyperson and the Pension Service liaison worker. Timebank will offer befriending to those who would benefit from extending their social contacts to improve their quality of life.

The care co-ordinator will have access, where necessary, to new a pooled budget to give rapid, flexible support to avoid admission, to support rehabilitation or give short-term care up to 6 weeks. The care co-ordinator will also be able to assess for minor equipment and Telecare devices for the home. The ICCS care co-ordinator will also 'in-reach' into hospital for those people who are on their caseload and will ensure that the appropriate community support is arranged in a timely way, thus reducing the time spend in hospital.

Both Timebank and the local Pensions Service are members of the partnership. The ICCS team will be a joint health and social care team, jointly managed by Brent Council and Brent Primary Care Trust (PCT), with additional members managed by other partners: housing hospital linkworker (Willow Housing and Care); mental health liaison worker (Central and North West London Mental Health NHS Trust); environmental assessor/handyperson (Elders Voice); volunteer co-ordinator (Timebank); and the welfare benefits advisor (Pensions Service). Discovery interviews will be undertaken by Brent Carer Centre to provide feedback on carer needs/views to the ICCS service and the evaluation team.

APPENDIX 3

BRENT POPP

List of current agencies and individuals on POPP Reference Group

Brent Pct
Brent Housing and Community Care
CNWL Mental Health NSH Trust
Willow Housing and Care
Elders Voice
Timebank
Jean Brewer (Pensioners Users Consultative Forum)
Miriam Green (Pensioners Users Consultative Forum)
Iris Brown (Community Representative)
Carers Centre
African & Caribbean Carers
Brent Supporting People
Dr Tony Burch GP with special interest
Work & Pensions Services
National Primary Care
Commissioning Collaborative