Sandwell NHS
Primary Care Trust

Sandwell
Metropolitan Borough Council

Frail Older People

Joint Strategic Needs Assessment

Working Draft
April 2012

List of contributors

Authorship

Dr Carl Griffin, Consultant in Public Health, Sandwell PCT

Laura Broderick, Interim Divisional Manager Strategy, Community and Partners, Sandwell MBC

Nick Drew, Strategic Engagement Manager, Sandwell Council of Voluntary Organisations

Contributors

Mohammed Khalil, Lloyd Brackstone, Sharon Liggins, Sandwell PCT, Sandwell LINk, Sandwell PCT PPI.

Data sources

Ralph Smith, Deputy Head of Public Health Intelligence, Sandwell PCT

Alex Hawley, Improvement and Efficiency Lead Officer (Research Manager), Sandwell MBC

Enderjit Aujla, Information Team, Sandwell PCT

Greg Barbosa, Health Protection Team, Sandwell PCT

This review of health and social care need has been brought together by a partnership of organisations listed below

Sandwell NHS Primary Care Trust

Sandwell Metropolitan Borough Council

Research Sandwell

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Addendum

Additional work has been captured and included in this version of the JSNA. This data included input from Sandwell LINk and Sandwell PPI teams. The data enriches and adds; it builds the narrative around experience, counterbalanced by data and includes Agewell champions as early indication of asset mapping. It is fair to add that this is far from a complete picture of where we would like to be but work is ongoing that will continue to build on, and improve, our ability to capture and include the three components (Experience, Need and Assets) of the Sandwell JSNA.

Further analysis of secondary care admissions is also included.

Carl Griffin 2nd May 2012

1. Definition

1.1 The operational definition of a frail elderly person is over 65 years old with an associated condition. The literature indicates that aged 75 or over is a functional proxy with broad markers (disability, institutional living, and disease – cardiac, vascular, diabetes and dementia), clinical markers (muscle weakness or loss, exhaustion, weight loss and inactivity or slowed gait) and biological markers (immune and inflammatory, endocrine and clotting systems) (Broe 2009). Although common agreement that frailty is age related but not always present with ageing (Bergman *et al* 2004).

1.2 Broader approach include biological, social, clinical (cognitive), psychological and environmental factors that interact in order to delay, promote or protect against frailty (Bergman *et al* 2003). These include identification of precursors and risk factors that can be indentified, modified and managed. Other definitions describe frailty as the diminished ability to carry out the important practical and social activities of daily living (Brown *et al* 1995).

1.3 Bergman *et al* (2004) proposed model of frailty has components that include weight loss, under nutrition, weakness, lack of endurance, physical inactivity, slowness, cognitive decline and depressive symptoms. Other researchers have added attention, memory and executive function processes such as loss of interest, slowed cognitive processing and mild cognitive impairment as indicative of frailty (Broe 2009).

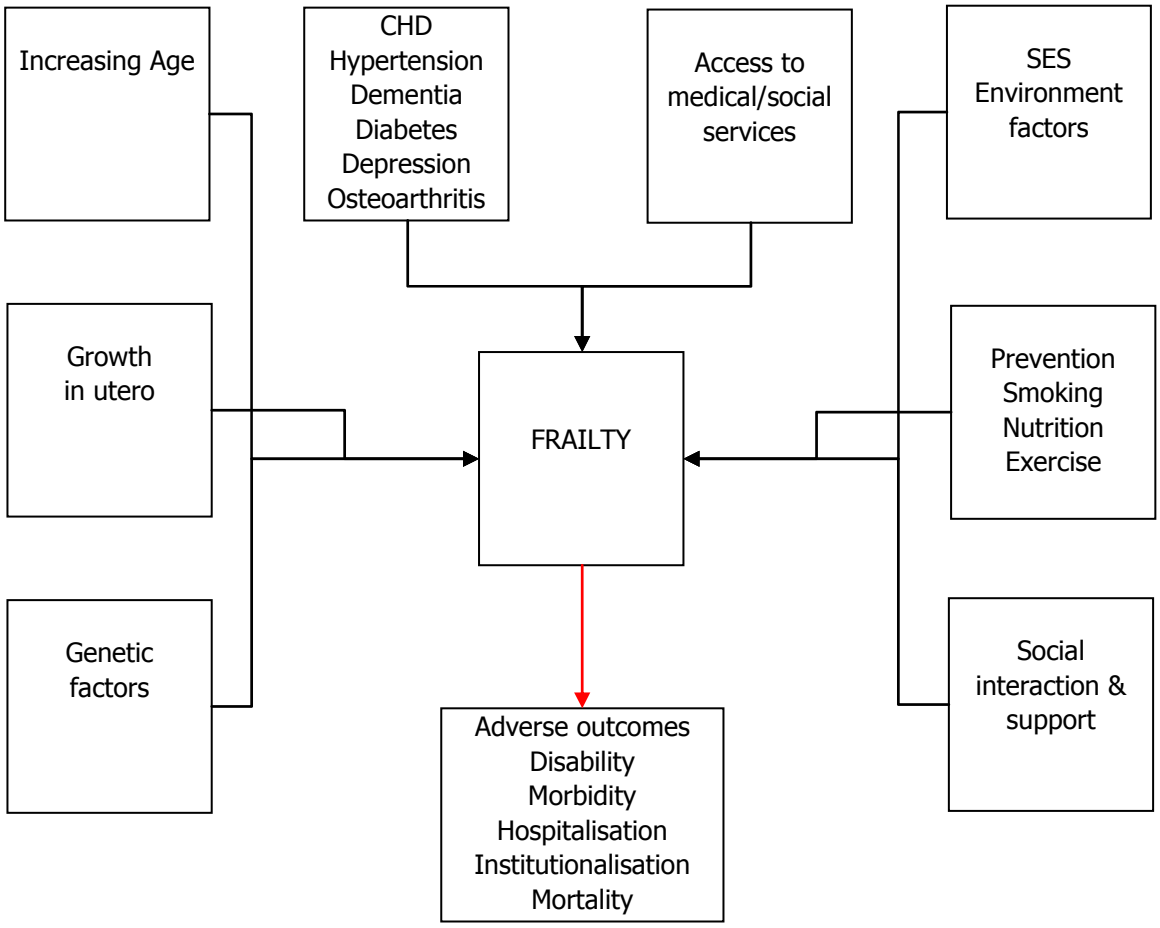
1.4 In a recent review Markle-Reid & Browne (2011) identified an approach to the concept of frailty in older adults across four areas. These include frailty as a multi-factorial concept that

- considers the complex relationship across physical, psychological, genetic, social and environmental factors;
- is not solely age-related;
- takes into account an individual's context and subjective views;
- takes into account the contribution of both individual and environmental factors.

This multi-factorial model of frailty is presented in Figure 1.1. The factors can all influence each other and also have both a direct and indirect impact on the likelihood of a person becoming at risk and also therefore, on the adverse outcomes associated with being frail.

1.5 Although there is limited clinical agreement on definitions or clinical markers (Broe 2009), there is a growing consensus that frailty involves multiple signs and symptoms and that a reduction in functioning indicates a heightened vulnerability bases on age related decline in multiple physiologic systems (Hue 2011). This decline across a range a systems results in greater risk of adverse events including disability, hospitalisation, social care placements and mortality (Figure 1.1, Rockwood 2005)

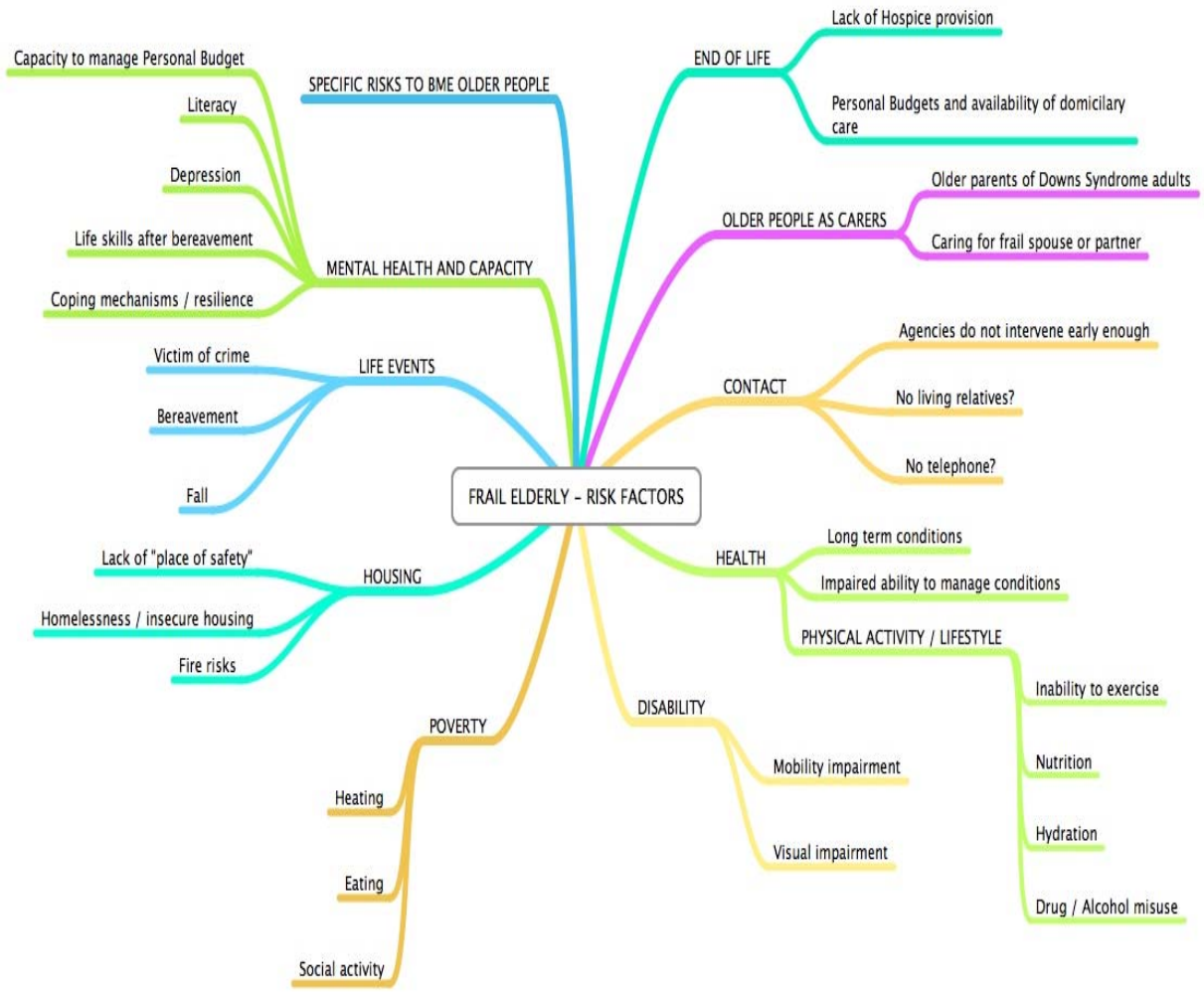
Figure 1.1: Multi-Factorial Risk Model of Frailty and related outcomes



Source: Ben Sholomo, Kull 2002

1.6 In terms of the "touch points" we have begun to describe those in terms of risk and risk factors. This approach of identifying the range of experiences elderly frail people have is presented in Fig 1.2. This method of examining 'touch points' and linking those to resident/patient or client experience together with robust data analysis and mapping of community assets does require further work but it may be the model for all future JSNA.

Figure: 1.2: Range of "Touch Points" risk factors



1.7 The natural history of frailty and onset has been modelled and there is some evidence that education, prevention, health improvement (lifestyles (nutrition, exercise, and social community activity) at early age and continued into older age may promote healthy ageing and reduce either the incidence of frailty or delay the start of dependency (Bergman et al 2003),

1.8 Furthermore it would follow that secondary prevention through the effective management of chronic conditions such as hypertension, diabetes, heart disease and osteoporosis will help together with opportunities to promote and enhance social interaction and support within communities.

1.9 The delay in onset is also related to a decline in physiologic reserve based on the presence or absence of disease. This points to the interrelationship between individual assets and deficits (Lebel *et al* 1999).

1.10 In terms of the assessment or identification of frailty, the evidence indicates precursors include weakness (low grip strength), slowness (waking speed and gait), low physical activity and/or unintentional weight loss (Hue 2011). In addition, the role of cognitive decline and mood (depression) in the assessment frailty should be considered (Sternberg *et al* 2011).

1.11 Alternative approaches include the development of a Frailty Index. This tool includes the assessment of deficits such as disability, chronic disease, physical and

cognitive impairments, psychosocial risk factors and geriatric syndromes (e.g. falls, delirium and urinary incontinence (Hue 2011)).

1.12 In terms of outcomes frailty can lead to a range of adverse outcomes such as disability, morbidity, hospitalisation, institutionalism and death depending on the individual context and biological, psychological, social and societal modifiers (Bergman *et al* 2004). In particular, the model suggest a person would be at risk of social isolation, increased instability (e.g. Falls and fractures), increased confusion and incontinence (resulting in longer recovery time or hospital stays), increased likelihood of early residential or nursing placements and increased risk of early death (Bergman *et al* 2003, Broe 2009).

1.13 The consequence of frailty could also lead to dependence on others for activities and daily living and have considerable impact on families and carers (Bergman *et al* 2003). The consequence of this would include individuals requiring costly medical and social care services, including early residential or nursing care (Woodhouse et al 1988)

1.14 Finally, in terms of this need assessment, the key point is that frailty, functional decline and adverse outcomes are not inevitable and appropriate interventions across the health and social care system can have a significant impact on risk and therefore on health, quality of life, social care services and bring benefits to families and carers (Bergman *et al* 2003). Clearly, as system focused around prevention, assessment, early intervention and effective management should be considered within the area of health and social care.

2. Demography and Population Level Data

Key Findings

- In Sandwell the proportion of the population who are aged 65 years and over is projected to grow to 20% (n≈61,700) by 2033. This is due to the baby boomers born in the 1960's.
- Currently nine out of ten persons aged 65+ are classified as White. This ratio is expected to decrease up until 2030 with more of the population coming from Asian and Black ethnic groups
- The gender gap and inequality in life expectancy will decrease over the next two decades and the number of men living into older age will increase by 2033.
- The majority of the housing stock in Sandwell is in the private and rented sector. In the private and rented sector between a quarter and a third of households live in non-decent housing. In terms of old age, over a third persons aged 65+ are likely to live in non-decent homes
- The elderly are three times more likely to live in cold housing compared to all households (14% compared 47%, Health and safety rating system).
- Future housing needs in both sheltered housing and extra care accommodation will increase in the short to medium term.
- Income deprivation affecting older people is high in Sandwell with around a third of adults aged 60+ are entitled to pension credit.

Consultation Findings

Sandwell LINk:

"'Home Care' or 'supported housing' is 'zilch' i.e. nonexistent from either 'Sandwell Housing' or the Landlord, which is SMBC. As for 'Sandwell homes' they are inefficient.".

AgeWell

- Case Study A. "First contact made with Mr and Mrs B they informed us that they enjoyed going on outings and visits to restaurants, they also enjoy different leisure activities example snooker. Mr and Mrs sang along to a movie that we watched together and were able to reminisce about times gone by. Mr and Mrs B took part in some gentle exercise with soft balls and found this enjoyable and useful. On one of the visits the weather was good so Mr and Mrs B both went for a walk which they thoroughly enjoyed and when they returned home they say out in the garden having a cup of team and chat. During our time with Mr and Mrs B it was their wedding anniversary and their one request was that they wanted a Chinese take away for their tea we organised for a take away to be delivered so that they could celebrate another milestone.
- Older People's Champion Case Study D: Referral was received from an 80 year old gentlemen who living in an upstairs flat which had eighteen steps to access it. His health was very poor and is also deaf. I was most concerned after my initial visits. I arranged a visit from the benefits agency to recalculate and improve his income. I also liaised with Sandwell Homes to try and get MR D

rehoused. MR D insists that he wants to stay in this street which delayed any move. I continue to support him

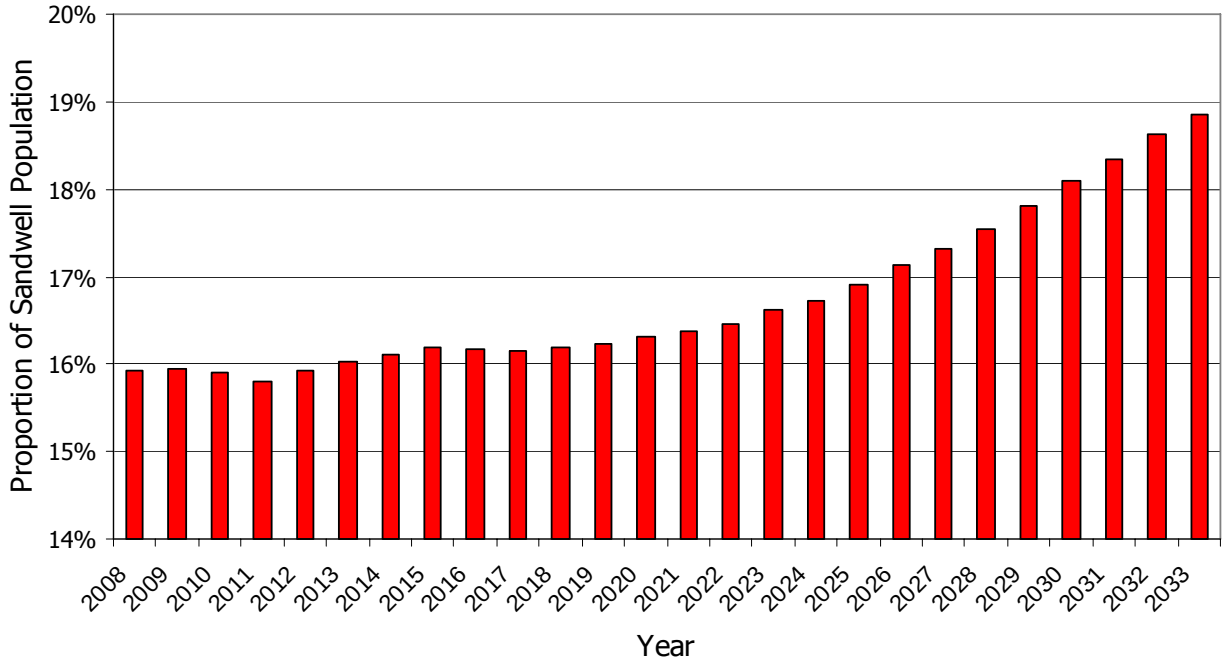
Strategic Actions

- All agencies will need to plan for an expansion in the elderly population in terms of services and resources.

Demography

2.1 The structure of the population in Sandwell is growing older. The 2012 estimate indicates that 15.9% (n≈48,200) of the population are aged 65 years and over (Figure 2.1). The proportion of the population who are aged 65 years and over is projected to increase slowly in the next decade but approach 20% (n≈61,700) by 2033.

Figure 2.1: Sandwell Population Age 65+ as a Proportion of Total Sandwell Population



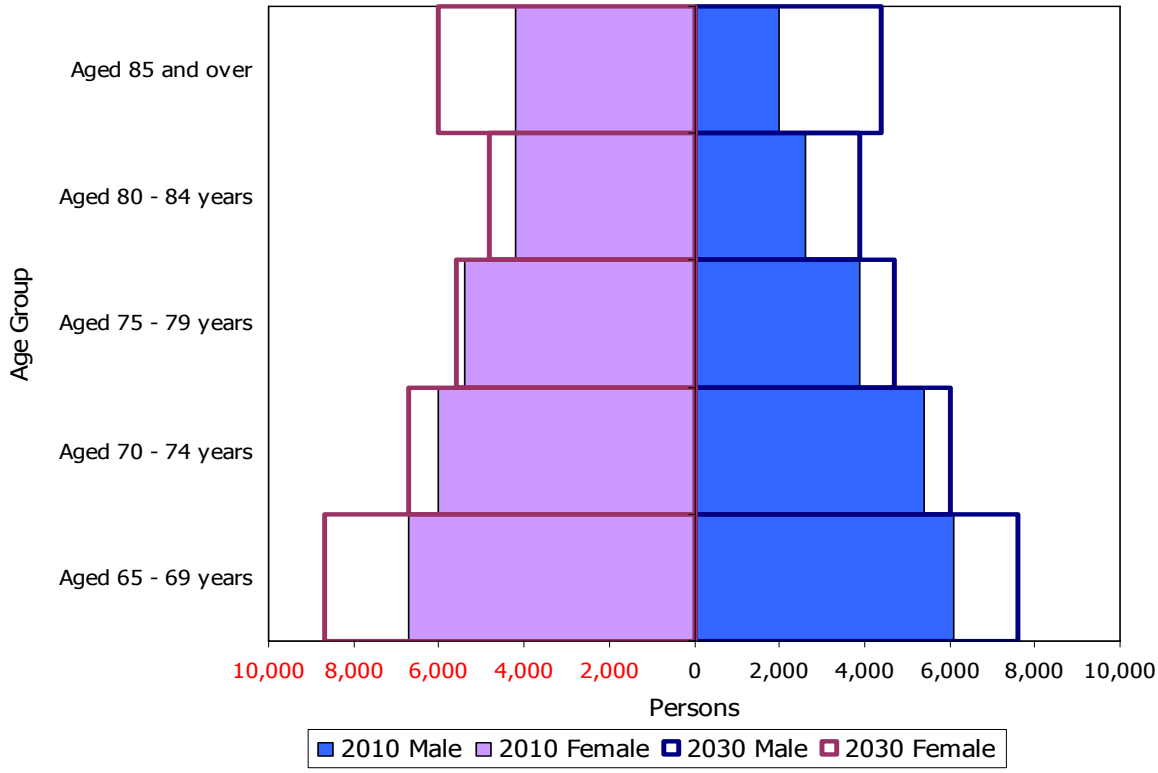
Source: ONS Population Projections (Base 2008)

2.2 The age and sex structure of in Sandwell in presented in Figure 2.2. The estimates indicate a growth in the overall numbers of persons in old age and also a change in the current unbalanced sex ratio in later life.

2.3 The population projections assume a similar birth rate over the next twenty years and continued expected better survival in older age, especially for men.

2.4 The data on net migration into Sandwell suggest that the projected population in 2030 is the result of the birth rate in the 1960's (baby boom) and better survival rates into older age.

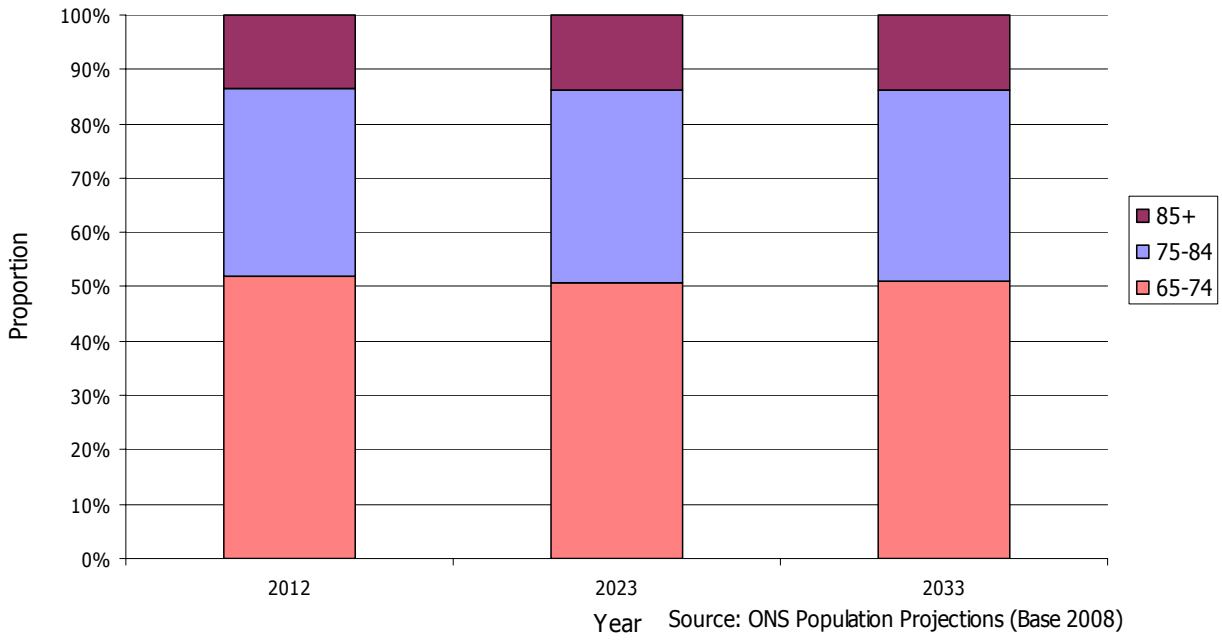
Figure 2.2: Sandwell Population Age 65+ and sex, 2010 and 2030



Source: ONS Mid-Year Estimates 2010, ONS Population Projections 2030 (Base 2008)

2.5 Examining the population projections by age composition, the data indicates a similar proportion of persons aged 65 and over living over the next two decades (Figure2.3)

Figure 2.3: Sandwell Population composition Age 65+, 2012, 2023 and 2033



Source: ONS Population Projections (Base 2008)

2.6 Table 2.1 provides estimated numbers and proportions of the elderly population in Sandwell by Ethnicity. The data indicate that overall nine out of ten persons aged 65+ are

classified as White. This proportion increases with age. This ratio is expected to decrease up until 2030 with more of the population coming from Asian and Black ethnic groups.

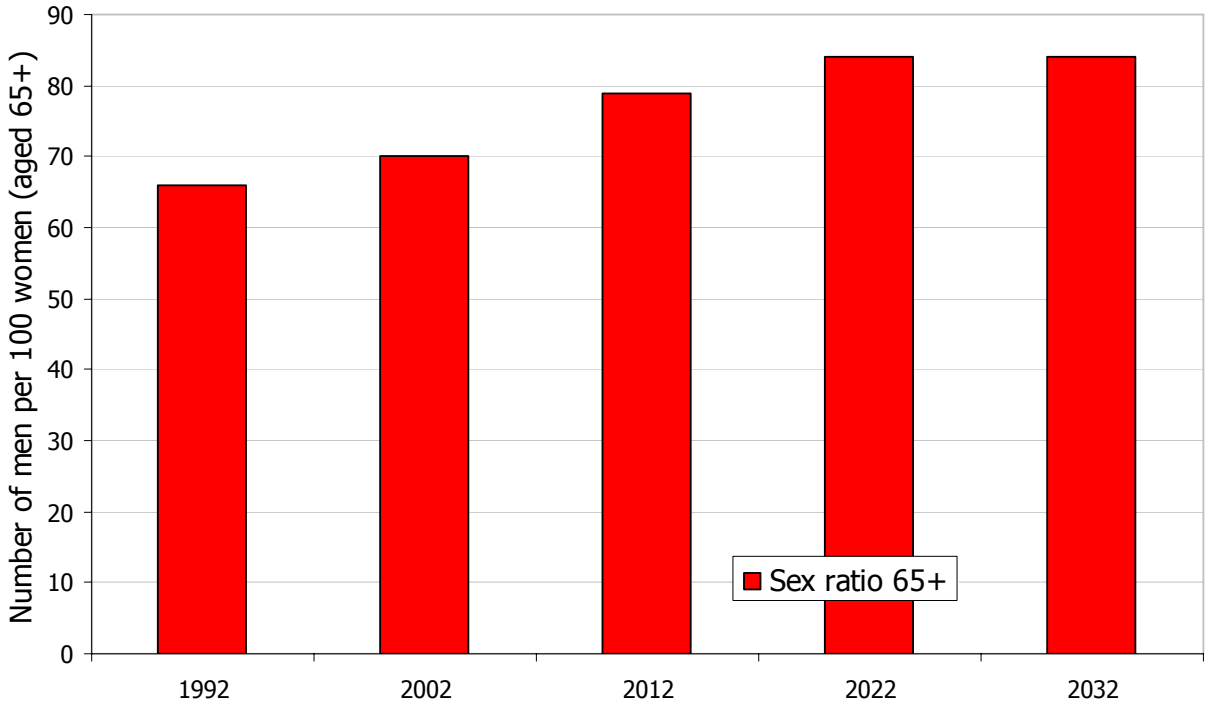
Table 2.1: Estimated Sandwell Ethnicity Population composition Age 65+, 2009

Ethnic Group	People aged 65-74		People aged 75-84		People aged 85+	
	n	% age band	n	% age band	n	% age band
White	21,407	88.2	14,558	90.7	5,693	95.0
Asian or Asian British	1,775	7.3	870	5.4	203	3.4
Black or Black British	970	4.0	570	3.6	79	1.3
Chinese or Other	75	0.3	21	0.1	3	0.05
Mixed Ethnicity	49	0.2	18	0.1	7	0.1
All people	24,276		16,037		5,985	

Source: Office for National Statistics (ONS) Table PEEGC309: LAD 2009 Single Year of Age by Ethnic Group, mid-2009.

2.7 Projections also indicate that the sex ratio will decrease by 2032. This suggests that the gender gap and inequality in life expectancy will decrease over the next two decades.

Figure 2.4: Sandwell Population sex ratio for Age 65+, 1992 - 2032



Living Arrangements

2.8 In terms of living arrangements patterns of marriage and widowhood reflect higher mortality rates in men. In terms of age the data indicate that older men are more likely to be married than older women. This trend continues in old age with men aged 85+ being four times more likely to be married than women.

Table 2.2: Marital Status by age and sex 2001

	Single (never married)	Married (first marriage)	Re-married	Separated (but still legally married)	Divorced	Widowed
Males						
Aged 65 to 69	10%	66%	7%	1%	7%	9%
Aged 70 to 74	9%	63%	6%	1%	5%	15%
Aged 75 to 79	7%	59%	5%	1%	3%	24%
Aged 80 to 84	8%	52%	5%	1%	2%	32%
Aged 85 to 89	6%	40%	5%	1%	2%	47%
Aged 90 and over	7%	24%	4%	1%	2%	62%
Females						
Aged 65 to 69	5%	51%	4%	1%	7%	31%
Aged 70 to 74	6%	42%	3%	1%	5%	43%
Aged 75 to 79	6%	30%	3%	0%	3%	58%
Aged 80 to 84	6%	19%	3%	0%	2%	71%
Aged 85 to 89	6%	10%	2%	0%	1%	81%
Aged 90 and over	8%	4%	1%	0%	2%	85%

Source: 2001 Census, Standard Tables, Table S2, ONS Crown Copyright Reserved, from Nomis

2.9 The proportion of men and women aged 65-74 estimated to be living at home is 20% and 30% respectively (GHS 2007). This proportion increases by age and for men and women aged 75+ the differential is 34% to 61%. This difference is demonstrated in the population prediction over the next decades (Table 2.3). These estimates indicate that the number of men and women living alone will rise with the largest increase in persons aged 75+.

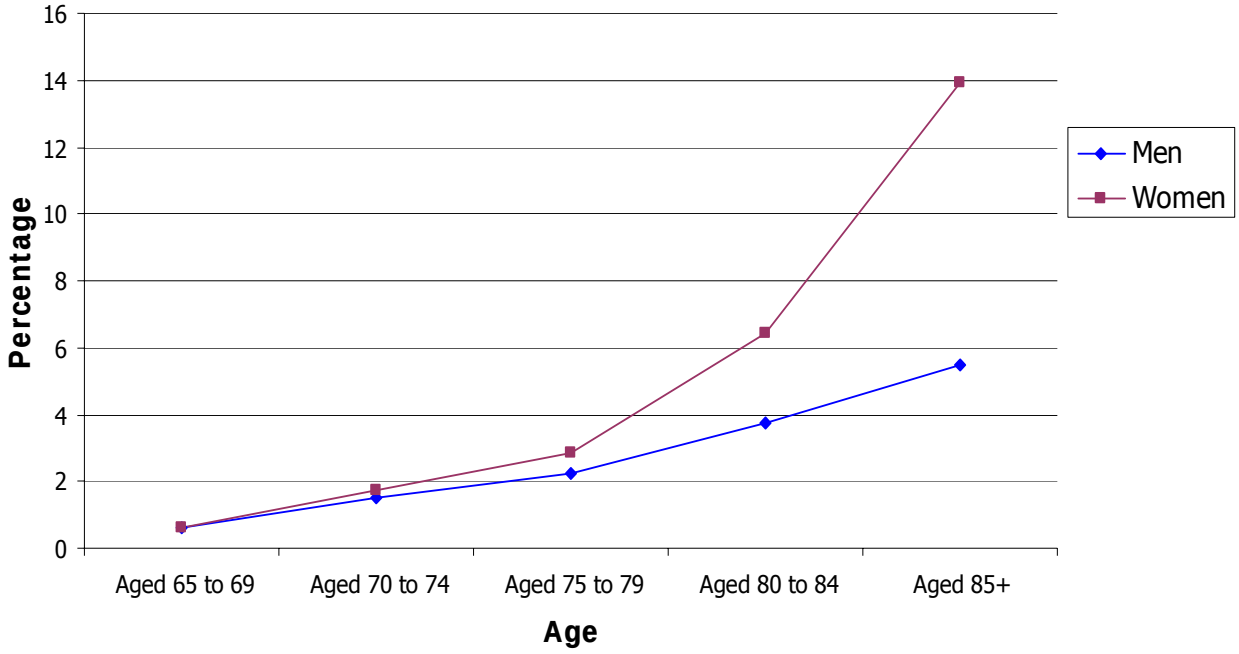
Table 2.3: Population predicted to be living alone by age and sex, 2011-2030

	2011	2015	2020	2025	2030
Males					
Aged 65-74	2,300	2,380	2,380	2,460	2,720
Aged 75 and over	2,958	3,298	3,638	4,148	4,420
Females					
Aged 65-74	3,720	3,900	3,930	4,020	4,620
Aged 75 and over	8,296	8,296	8,784	9,394	10,004
Total population					
Aged 65-74	6,020	6,280	6,310	6,480	7,340
Aged 75 and over	11,254	11,594	12,422	13,542	14,424

Source: www.poppi.org.uk version 6.0

2.10 In Sandwell 3.4% of the population aged 65+ were resident in communal establishments in 2001. The proportion of persons living in communal establishments increases with age and by sex. For persons aged 85+, 5.5% of men and 14% of women of that age were resident compared to less than 1% of men and women aged 65-69 (Figure 2.5).

Figure 2.5: Population living in Communal establishments by age and sex, 2001



Source: 2001 Census, Standard Tables, S1, ONS Crown Copyright, from Nomis

Housing

2.11 The majority of the Housing stock in Sandwell is in the private and rented sector. The provision of council accommodation provided by Sandwell Homes accounts for around a third of housing in the Borough (n≈33,484) (Table 2.4).

Table 2.4: Estimated Housing Tenure all ages, 2007

	n	%
Owner Occupied		
Bought outright	41,502	34
Mortgage	31,601	26
Council rented	33,484	27
Private rented	11,446	9
Social rented	5,365	4
Total	123,398	100

Source: Sandwell Housing Needs and Demands Study 2007

2.12 Sandwell Homes have successfully implemented the national Decent homes programme over the last decade. Table 2.5 indicates that 15% of persons aged 60+ live in the private rented sector.

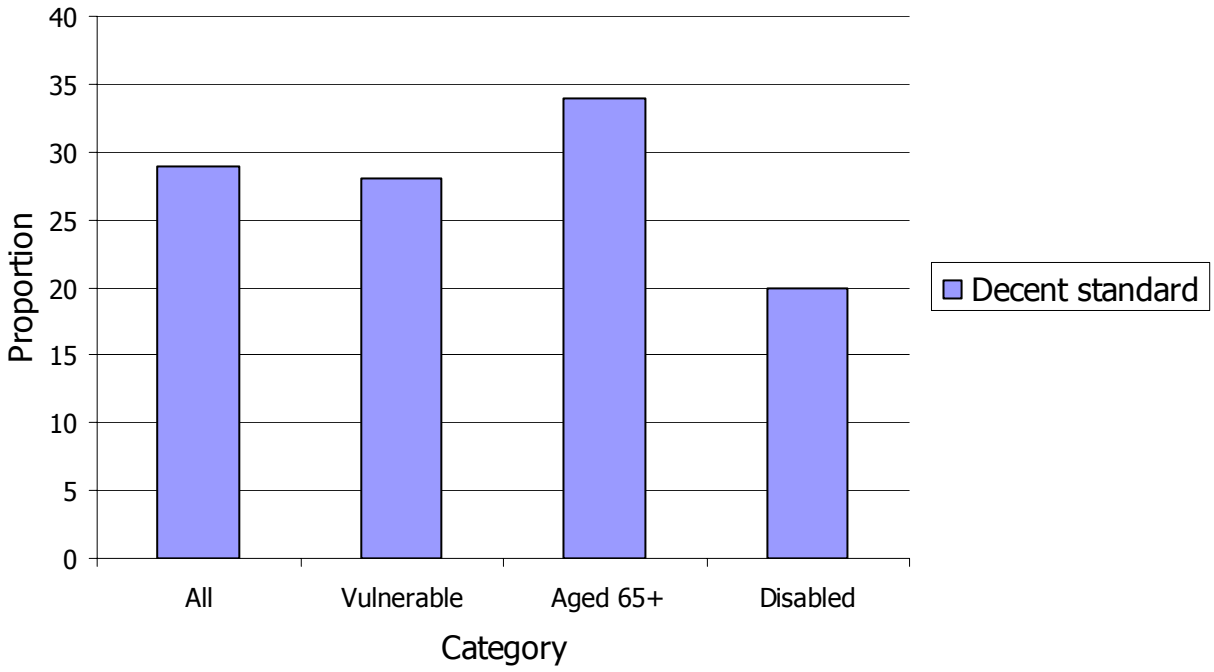
Table 2.5: Housing Tenure: by age of household reference person, 2009

Age	Tenure							
	Owned Mortgage		Owned Outright		Private Rent		All	
	n	%	n	%	n	%	n	%
<34	8,946	21	2,278	7	6,072	41	17,296	19
34-60	27,690	65	7,163	22	6,516	44	41,369	46
60+	5,964	14	23,115	71	2,221	15	31,300	35
All	42,600	100	32,556	100	14,809	100	89,965	100

Source: Private Sector House Condition Survey 2009

2.13 The associated between Housing conditions, poor housing and poor health is well understood (NICE 2005). In the private and rented sector between a quarter and a third of households live in non-decent housing. In terms of old age, over a third persons aged 65+ are likely to live in non-decent homes (Figure 2.6)

Figure 2.6: Private sector Non-Decent Housing by category, 2009



Source: Private Sector House Condition Survey 2009, vulnerable includes children

2.14 Furthermore, the elderly are three times more likely to live in cold housing compared to all households (14% compared 47%, Health and safety rating system).

2.15 In terms of housing support, data from the housing needs and demands study (2007) indicate adaptations to the home had been provided to nearly twenty thousand households. The majority of households had handrails fitted (67%), bathroom adaptations (48%) followed by ground floor toilet (27%), and 14% had wheelchair access.

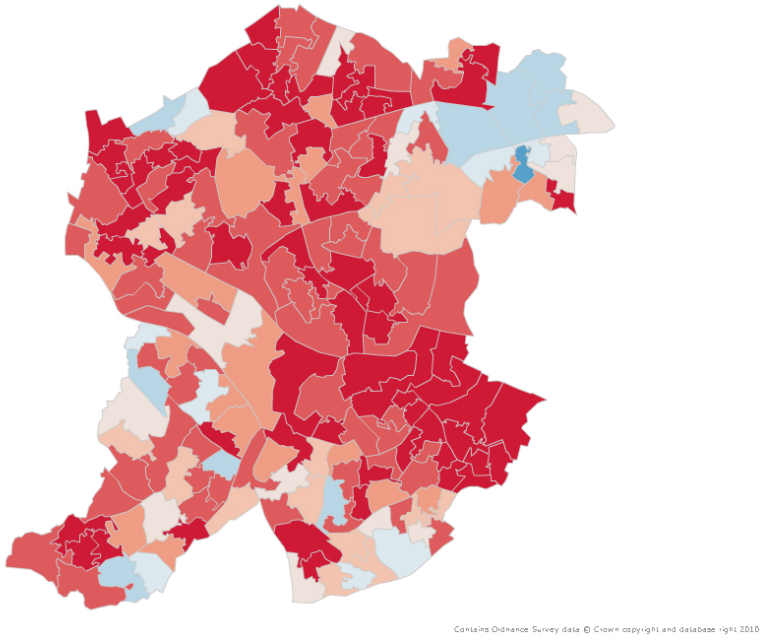
2.16 The housing needs of older people in terms of sheltered housing and extra care accommodation indicate that in 2007 a further two thousand households would require

sheltered housing and a further three hundred extra care units would be required in the short to medium term.

Economic Activity

2.17 Sandwell is the twelfth highest area (PCT) in England in terms of deprivation affecting older persons. The data indicate around a third of adults aged 60+ are entitled to pension credit. Furthermore, the data from the 2001 census indicate that 16% of all households are single pensioner households (n≈18,156).

Figure 2.7: Income deprivation in older persons, 2010



Income Deprivation Affecting Older People Index (IDAOPI). 2010. National deciles. See http://www.sandwelltrends.info/LISV2/navigation/imd.asp?QUERYID=585

3. Health and Wellbeing

Key Findings

- Life expectancy at aged 65+ has been rising over the last decade with men expecting to live for a further seventeen (n≈17) years while women could live for twenty (n≈20) years
- Disability free life expectancy is low with men and women could expecting only nine (n≈9) years of disability free life expectancy in old age.
- The majority of deaths in Sandwell in ranked order are due to disease of the circulatory system (e.g. heart disease, stroke), cancers and then diseases of the respiratory system.
- Compared to similar PCT's Sandwell has a relatively high rate of mortality for the main causes of death with the exception of mortality from fracture of the femur. Sandwell is performing well with a low rate across all age ranges
- Causes associated with age including Excess Winter Deaths indicate Sandwell has a higher than expected number of deaths in the 65-84 age range.
- Deaths at usual place of residence, a key indicator for end of life care, are also low.

Consultation Findings

Sandwell LINk:

When asked if they had a disability and if they had good or bad experiences of support for this one of the participants said:

"Have few good experiences to report on this since 2004"

AgeWell

- Case Study B. Mr S was referred following admission after a fall. Agewell provided a befriending service to MR S to assist him to settle back home. Mr S enjoyed the Agewell befriending service as there was a shared interest with military background. Agewell befriending service was unable to make contact with MR S on one occasion but procedures were in place for us to contact a family member to ensure the safety of MR S. Chatted about a number of interests both of Mr S and Agewell befriending service, Mr S looked forward to the Agewell befriending service visits. Sadly Mr S passes away.
- Older People's Champion Case Study B: A gentlemen in his lat 50 Mr B suffered a heart attach eight months ago. Since this time he called out the emergency services eighteen times, most of these were at night and later found to be false alarms. Mr B was visited and made arrangement s for him to go on an anxiety management course. He also agreed to attend the expert patient programme in order to help him to cope with his health conditions.

Sandwell Council of Voluntary Organisations

- Not enough**:** emphasis on preventative services for frail elderly people which could ensure that they do not require acute care;

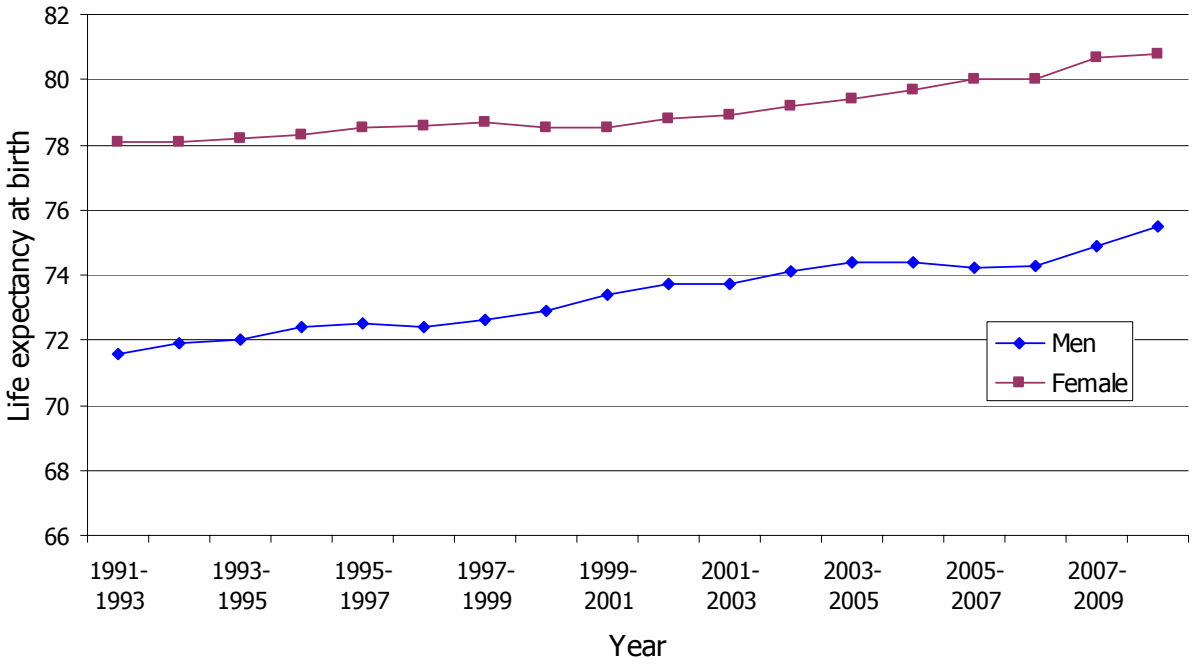
Strategic Actions

- All agencies need to focus attention on not only inequalities in life expectancy and high level of mortality but also inequalities in disability free life expectancy to ensure improved quality of life in old age.

Life Expectancy

3.1 Life expectancy at birth in Sandwell as been rising steadily (Figure 3.1). By the end of the last decade men, on average men could expect to live 76 years and women 81 years.

Figure 3.1: Life expectancy at birth by sex, 1991- 2010



Source: ONS

3.2 In terms of life expectancy at aged 65+, this has been rising over the last decade with men expecting to live for a further seventeen (n≈17) years while women could live for twenty (n≈20) years (Table 3.1).

3.3 There is however inequality in disability-free life expectancy at birth in Sandwell. Disability free life expectancy is the number of years a person could expect to live in a disability free state. In Sandwell the latest data (1999-2003 Marmot indicator) indicate men and women could expect around nine (n≈9) years of disability free life.

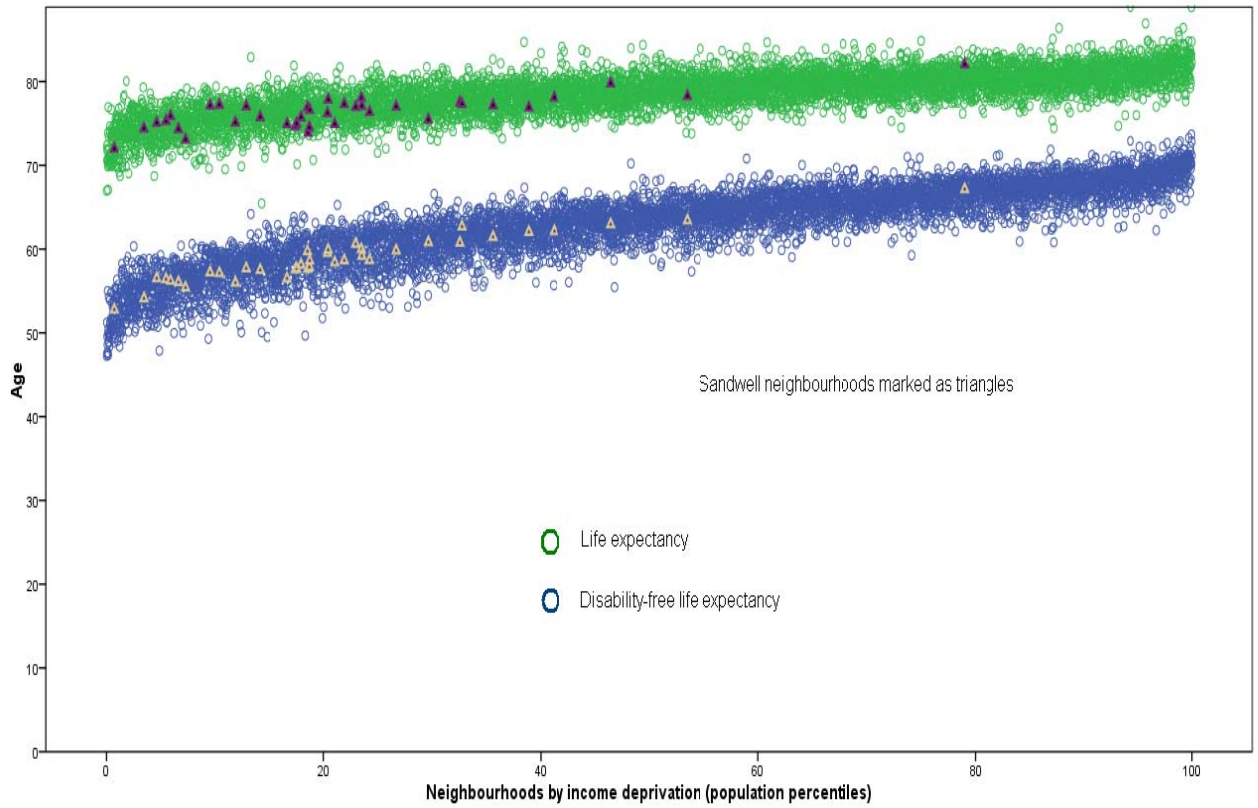
Table 3.1: Life Expectancy at birth and at aged 65+ by sex, 2010

	LE at birth Males	LE at aged 65 males	LE at birth Females	LE at aged 65 Females
South Birmingham	77.7	17.9	81.8	20.5
Birmingham East & North	75.5	17.6	81.6	20.3
Wolverhampton City	76.7	17.6	80.8	20.0
Barking & Dagenham	77.0	17.5	81.1	19.7
Sandwell	75.5	16.7	80.8	19.7
Leicester City	75.4	16.4	80.1	19.3
Nottingham City	75.7	16.3	80.7	19.7
Manchester	74.1	16.1	79.1	18.7

Source: ONS and NCHOD (South Birmingham and Birmingham East and North)

3.4 The data in Figure 3.2 presents the difference in LE and DFLE by ward. The data indicate not only lower LE but lower age related DFLE by deprivation

Figure 3.2: Life expectancy and disability free life expectancy, 2010



Source: Public health information team analysis

Mortality

3.5 The main causes of death for persons aged 65+ are presented in Table 3.2. The majority of deaths are due to disease of the circulatory system (e.g. heart disease, stroke), following by cancers and then diseases of the respiratory system. This general pattern is obverted into older age.

Table 3.2: Mortality by cause and age, 2008 - 2010

	Age Range		
	Aged 65+	**Aged 75+**	**Aged 85+**
	n	**n**	**n**
Diseases of the circulatory system	2,444	1,946	1,034
Neoplasms	1,793	1,172	378
Diseases of the respiratory system	1,241	1,042	559
Diseases of the digestive system	311	218	105
Mental and behavioural disorders	286	274	194
Diseases of the genitourinary system	201	175	96
Endocrine, nutritional and metabolic diseases	188	143	65
Diseases of the nervous system	188	148	64
External causes of morbidity & mortality	110	95	62
Certain infectious and parasitic diseases	89	74	37
Symptoms, signs and abnormal clinical & laboratory findings	85	85	75
Diseases of the musculoskeletal system & connective tissue	47	38	23
Diseases of the skin and subcutaneous tissue	41	39	23
Diseases of the blood	10	6	4
Congenital malformations	1	1	0
3 year total	**7035**	**5456**	**2719**

Source: ONS

3.6 Examining cancer survival in men and women indicates that there is limited difference between men and women but only a small proportion survive who have significant lung disease and around half for bowel cancer.

Table 3.3: 5 year survival rates by gender and site, 2011

5 year survival

	Males			**Females**		
	Lung	**Bowel**	**Prostate**	**Lung**	**Bowel**	**Breast**
60-79	6	51	62	9	55	82
80+	2	40	87	3	40	62

Source: Cancer survival briefing 2011

3.7 Rates of mortality from All Causes, CHD, Stroke and fracture of femur are presented in Tables 3.4, 3.5, 3.6 and 3.7. Compared to similar PCT's Sandwell has a

relatively high rate of mortality for the main causes of death. However, for mortality from fracture of the femur Sandwell is performing well with a low rate across all age ranges.

Table 3.4: Mortality from All Causes, Directly Standardised Rate per 100,000, 65-74 year olds, 2008-2010

PCT	Persons (P)	Male (M)	Female (F)
Manchester	2741.44	3463.83	2096.29
Nottingham City	2260.21	2956.69	1648.78
Leicester City	2251.11	2857.36	1708.78
Barking and Dagenham	2226.47	2690.42	1842.41
Sandwell	2152.74	2693.04	1668.24
Birmingham East and North	1946.37	2365.18	1575.97
Wolverhampton City	1934.55	2445.26	1482.69
South Birmingham	1919.16	2355.20	1529.29

Source: NHS IC Indicator Portal

Table 3.5: Mortality from Coronary Heart Disease, Directly Standardised Rate per 100,000, 65-74 year olds, 2008-2010

PCT	Persons (P)	Male (M)	Female (F)
Leicester City	455.53	623.09	304.78
Manchester	455.22	683.63	252.26
Sandwell	397.41	567.84	243.18
Nottingham City	358.77	528.13	209.50
Birmingham East and North	348.95	488.32	225.52
Barking and Dagenham	312.13	489.17	166.72
South Birmingham	301.63	445.17	173.85
Wolverhampton City	293.21	449.19	154.82

Source: NHS IC Indicator Portal

Table 3.6: Mortality from Stroke, Directly Standardised Rate per 100,000, 65-74 year olds, 2008-2010

PCT	Persons (P)	Male (M)	Female (F)
Manchester	196.06	233.77	162.32
Sandwell	134.89	144.21	126.32
Nottingham City	125.81	158.52	96.03
Leicester City	124.26	149.41	101.29
Wolverhampton City	120.89	175.50	72.51
Birmingham East and North	105.29	106.47	104.68
Barking and Dagenham	98.01	113.78	85.34
South Birmingham	97.95	109.00	88.41

Source: NHS IC Indicator Portal

Table 3.7: Mortality from Fracture of Femur (Neck and Other than Neck), Directly Standardised Rate per 100,000, 65-84 year olds and over 85s, 2008-2010

	Age Group					
	65 - 84			85+		
PCT	**Persons (P)**	**Male (M)**	**Female (F)**	**Persons (P)**	**Male (M)**	**Female (F)**
Manchester	27.22	27.92	25.59	344.18	210.10	407.45
Birmingham East and North	17.83	17.99	18.50	280.51	246.51	297.40
South Birmingham	17.87	14.64	20.17	333.33	303.69	346.95
Barking and Dagenham	14.42	12.21	16.49	213.44	264.87	186.27
Leicester City	16.58	13.36	19.36	198.93	196.99	199.53
Nottingham City	10.85	9.38	12.35	315.86	333.53	307.91
Sandwell	8.65	7.63	9.46	192.68	154.86	210.69
Wolverhampton City	7.89	6.69	9.04	153.68	87.75	189.07

Source: NHS IC Indicator Portal

3.8 Examining mortality from other causes, data on Excess Winter Deaths (a comparison between expected deaths in the winter compared to the rest of the year) indicates that Sandwell has a higher than expected number of deaths in the 65-84 age range. The index is higher for persons aged 85+ but is similar to other PCTs.

Table 3.8: Excess winter deaths index, 2002-2009, aged 65-84, 85+

PCT	Persons %	
	Aged 65-84	**85+**
Sandwell	21.5 *	26.7
Wolverhampton City	21 *	31.1
Leicester City	16.6	24.6
Nottingham City	15.5	27.6
Birmingham #	14.8	27.2
Barking and Dagenham	13.7	28.1
Manchester	13.7	20.6

Source: WMPHO http://www.wmpho.org.uk/excesswinterdeathsinenglandatlas/default.aspx, * Significantly higher than England

3.9 Finally, in terms of end of life care and deaths at home or usual residence, over the last three years (2007/10) there has been an increase in the number of people dying at their usual residence (34%-37%). However, this improvement has consistently been lower than the national data (40%).

4. Risk factors

Key Findings

- In terms of frailty risk factors, in 2011 more than a quarter of the elderly population experienced a fall (n≈12,358), while 9% were suffering from depression.
- For Dementia the risk increases with age, point prevalence within the 65-69 age range is around 1-1.5% but this increases to 20% between the ages 85-89 and for those aged 90+, almost a third will have the condition
- Sandwell for persons aged 65+ report poor general health and an estimated 57% indicate they have a limiting long term illness
- Limited data is available on lifestyle (Physical activity, smoking, alcohol and nutrition) specifically in old age
- Local data indicate that for all persons age 65+ in 2001 n=9% were a victim of crime. The trend from 2009 onwards shows a slight increase from 8% in 2009, 9% in 2010 and 9% in 2001

Consultation Findings

Sandwell LINk:

Responses to the question asking if the participant had fallen were:

"Long way to go in areas of decency, respect, treatment, to all citizens"

"Little help really"

And

"I got mugged when pushing my handicapped son in wheel chair only support from police they took me to hospital when it happened called my home to take statement then only a couple of phone calls no follow up same with victim support"

AgeWell

- Case Study C:"91 years of age Mrs C lives on her own and having difficulty with daily tasks around the house. Agewell provide a befriending service to assist with some of these tasks, they have included forms that need filling in curtains which needed changing. Mrs C was unsure how to use her microwave correctly so spent time explaining and showing. Also assisted with shopping and finally we managed to get her to go out in her wheelchair to the local town centre."
- Case Study D: Mr L, elderly gentleman living on his own and has no access to a washing machine or fridge. Which is waiting to be sorted out by adult services. Agewell befriending service assisted Mr L with numerous tasks within his property. This included emptying rubbish, assisting him to prepare daily meals. Mr L was ill and therefore unable to collect pension and shopping, Agewell befriending Service was able to accompany Mr L to collect pension, shopping as well as taking washing to the launderette,
- Older People's Champion Case Study C: Mrs C lived alone for several years after the death of he husband, Both the Agewell volunteers and I visited Mrs C as here daughter and other family liver in Telford. Agewell volunteer used o visit and

collect Mrs C pension and assist with shopping in getting groceries. We continued to make regular visits, but unfortunately following our last visits we had to contact emergency services. Mrs C was hospitalized and for three weeks and passed away.

Sandwell Council of Voluntary Organisations

- Not enough: community provision: social club/day centre provision cannot meet the demand – a respondent identified the need for "one-stop shops" for service users and their carers;
- Not enough: sitting/befriending provision in service users' own homes: again, demand exceeds supply, denying carers much-needed respite;
- Lack of access: to advocacy and assistance in "navigating" local services, especially where people live alone and are isolated;
- More support: required with maintaining independence especially in terms of "non-medical" factors e.g. money management

Strategic Actions

- All agencies should consider the early identification of the elderly at risk via appropriate assessment of screening tools to identify frailty and pre-frail states and or the possibility of applying the principle of stratified medicine to focus on those who are at heighted risk.
- Further consideration should be given to collective preventative action to reduce the profile of risk factors (e.g. LTC, depression)

Long Term Conditions

4.1 This section is limited due to the lack of routine data sources for age range 65+.

4.2 In terms of frailty Table 4.1 provides estimated numbers and proportions of persons aged 65+ across a range a frailty related indicators. In 2011 more than a quarter of the elderly population experienced a fall (n≈12,358), while 9% were suffering from depression. In terms of Dementia, the risk increases with age, point prevalence within the 65-69 age range is around 1-1.5% but this increases to 20% between the ages 85-89 and for those aged 90+, almost a third will have the condition.

Table 4.1: Estimated population aged 65+ predicted to be living with long term health condition, 2011-2030

	2011		2015		2020		2025		2030	
	n	%	n	%	n	%	n	%	n	%
Depression	4,006	9	4,154	9	4,325	9	4,571	9	5,026	9
Dementia	3,290	7	3,463	7	3,779	8	4,194	8	4,688	8
Fall	12,358	27	12,896	27	13,605	27	14,609	27	16,096	28
Longstanding health condition caused by a heart attack	2,259	5	2,358	5	2,458	5	2,629	5	2,862	5
Longstanding health condition caused by bronchitis & emphysema	773	2	810	2	843	2	901	2	983	2

Source: www.poppi.org.uk version 6.0

4.3 At a population level, observed local data is not available. Table 4.2 provides estimated prevalence of hypertension, CHD and Diabetes by age based on data collected for the Health Survey for England (2006).

Table 4.2: Estimated prevalence of LTC by age, 2006

	Prevalence %		
	Sandwell	England	
Hypertension	**65-74**	**75+**	**All ages**
Men	60	66	31
Women	63	69	28
CHD			
Men	20.8	28.6	6.4
Women	10.0	19.3	4.0
Diabetes (type 1 and type 2 combined)			
Men	15.7	13.5	5.6
Women	10.4	10.6	4.2

Source: Health Survey for England 2006

4.4 The estimated point prevalence of multiple LTC by age is presented in Table 4.3. The data indicate rising prevalence with age, with 20% of men having multiple long terms conditions in late old age.

Table 4.3: Prevalence of people with multiple LTCs in Sandwell by age and gender

Age Group	Men		Women		Persons	
	N	%	N	%	N	%
0-9	86	**0.4**	156	**0.8**	242	**0.6**
10-19	39	**0.2**	50	**0.3**	89	**0.2**
20-29	52	**0.3**	108	**0.5**	160	**0.4**
30-39	93	**0.5**	178	**0.9**	271	**0.7**
40-49	255	**1.2**	333	**1.6**	588	**1.4**
50-59	488	**3.0**	512	**3.2**	1000	**3.1**
60-69	891	**6.6**	830	**6.0**	1721	**6.3**
70-79	1168	**13.0**	1019	**8.9**	2187	**10.7**
80+	920	**20.4**	1101	**13.4**	2021	**15.9**
Total	3992	**2.8**	4287	**2.9**	8280	**2.9**

Multiple LTC include:CHD, Diabetes, Renal disease, COPD, Asthma, Peripheral vascular disease

Wellbeing

4.5 Self reported general health in Sandwell for persons aged 65+ from national surveys indicate a third of person report poor general health and an estimated 57% indicate they have a limiting long term illness (Census 2001).

4.6 A quarter of Sandwell persons aged 60-69 are claiming disability living allowance, and for the persons aged 70+, 17% are claiming. These are higher the the national and in other Local authorities (Work and Pensions Longitudinal Study (WPLS) August 2010)

Lifestyle

4.7 Estimates of smoking in the elderly are not available, the national figure for persons aged 60+ in England suggests the prevalence is men=14%, women=13%.

4.8 Data on other lifestyle factors indicate, 13% of men and 5% of women exceed the weekly recommended limits for alcohol consumption (General Lifestyle survey 2009).

4.9 Level of physical activity also declines in old age (data to follow).

4.10 In terms of nutrition, national estimates indicate that 28% of acute hospital admissions are malnourished, point prevalence estimates for people recently admitted to care homes ranges from 30-42%, and for sheltered housing it is 10-14% of tenants (BAPEN).

Isolation

4.11 In terms of isolation and crime, the elderly may be regarded as being more susceptible to being a victim of crime. Local data indicate that for all persons age 65+ in 2001 n=9% were a victim of crime. The trend from 2009 onwards shows a slight increase from 8% in 2009, 9% in 2010 and 9% in 2001.

5. Health and Social Care Activity

Key Findings

- The proportion of persons registered in General practice aged 75+ ranges from 2% - 17%, median 7%.
- The data indicate a seven fold variation in length of stay for emergency admissions in geriatric medicine by GP.
- Sandwell has higher rates of all admissions for men and women compared to other similar PCT's. Rates of emergency admissions in comparison are relatively low although one fifth of all emergency admissions in the 65-69 age group have Zero length of stay
- Accident and emergency attendance in the elderly has decreased by over 14% in the last three years. The decrease is for both men and women and has resulted in a 20% reduction in healthcare A&E related costs (£1,030,599 in 2009/10 to £827,798 in 2011/12
- The cost of inpatient healthcare has reduced year on year (£22, 838,752, £25,220,393 to £20,794,191), however the average cost per spell has increased from £744 in 2009/10 to £819 in 2011/12
- A significant number of patients with long length of stay (>median) had Renal and Thoracic disorders (e.g. Kidney or Urinary Tract infections, respiratory neoplasm, viral pneumonia).
- The number of persons receiving residential, nursing and community services per 100,000 population declined between 2008/9 to 2010/11 by between 5% and 12%
- The majority of clients aged 65+ in a permanent residential or nursing placement had mental health needs, followed by a physical disability and then learning disability (n=187, n=122 and n=46 respectively
- Self report data from the census 2001 indicates that 11% of persons aged 65+ provide unpaid care and 5% provide unpaid care for more than 50 hours per week. The trend for the numbers of carers looking after clients aged 65+ has increased between 2008/9 to 2010/11, however the current proportion (15%) is lower than similar comparable Local authorities.

Consultation Findings

Sandwell LINk:

In response to the question on accessing social care support one person said that:

"Is a waste of time"

And

For the question on if they had stayed in hospital participants said:

"By large 'bad' because of the system, rather than any 'individual' within that 'system' e.g. at 'City Hospital Trust'!"

"Cant fault anyone"

"Sandwell, Birmingham, Dudley Hospitals 'Good' and 'Awful' in all areas"

And

In answer to the question about health and social care one person said:

"To date many citizens in Sandwell, Birmingham, Dudley areas are treated as second class people in these areas of support"

AgeWell

- Older People's Champion Case Study E: Mr E was a single lower limb amputee and get around by using his wheelchair. He was referred to Agewell older people's champion by a social worker during his stay in hospital. MR E has no contact with any family members. Unfortunately Mr E's health deteriorated and he became double amputee and was very ill for a period of time. During this stay in hospital Mr E decided to make a will. Agewell older peoples champion contacted Citizen Advice Bureau who then referred Mr E's case to a solicitor. Making a will have given Mr E peace of mind and his affairs are in order. Agewell Older Peoples Champions supported and assisted MR E with his discharge from hospital and liaised with agencies to have his property adapted. Mr E became very depressed whilst in hospital but with the support of the older peoples champion he is now getting back to his former self. He appreciated all the help, advice and support he received from the older people's champion and looks forward to her visits.
- Older People's Champion Case Study A: This was referred by Mr's A's daughter who lives in Manchester. She was very concerned for her parents, especially her mother as she was ill with flu and her father was finding it difficult to cope as he suffers from Alzheimer's disease. Following discussions with Mrs A, it was agreed that I should contact Adult Services Fast response Team. They were very helpful and helped Mrs A through the initial crisis. Once she was well again I kept in touch to make sure she is supported.

Sandwell Council of Voluntary Organisations

- Not enough: high-quality, person-centred residential provision (one respondent commented on the "old school" nature of much of the residential support available);
- Service users: caught "in the cracks" between the boundaries of service provision offered by statutory and other agencies;

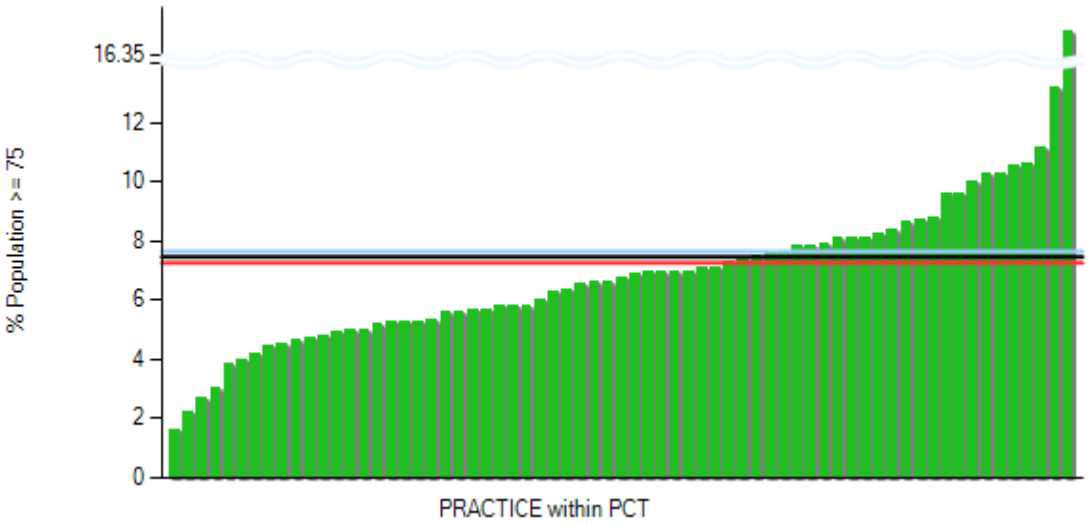
Strategic Actions

- All agencies should consider preventative and diversionary services and commission interventions/services to reduce the possible step up in care and resource use.
- Focus attention on the needs of clients but also on the needs of carers.
- All agencies should consider further social and health care integration and the option for a single agency or board to act as a commissioner to ensure joined up planning of high quality services across health and social care.

Primary Care Activity

5.1 The registered population by General Practice is presented in Figure 5.1. The proportion of persons aged 75+ ranges from 2% - 17%, median 7%, inter-quartile range 5% to 8%. The average proportion in similar to the regional and national figure.

Figure 5.1: Proportion of General Practice registered population aged 75+, 2010/2011

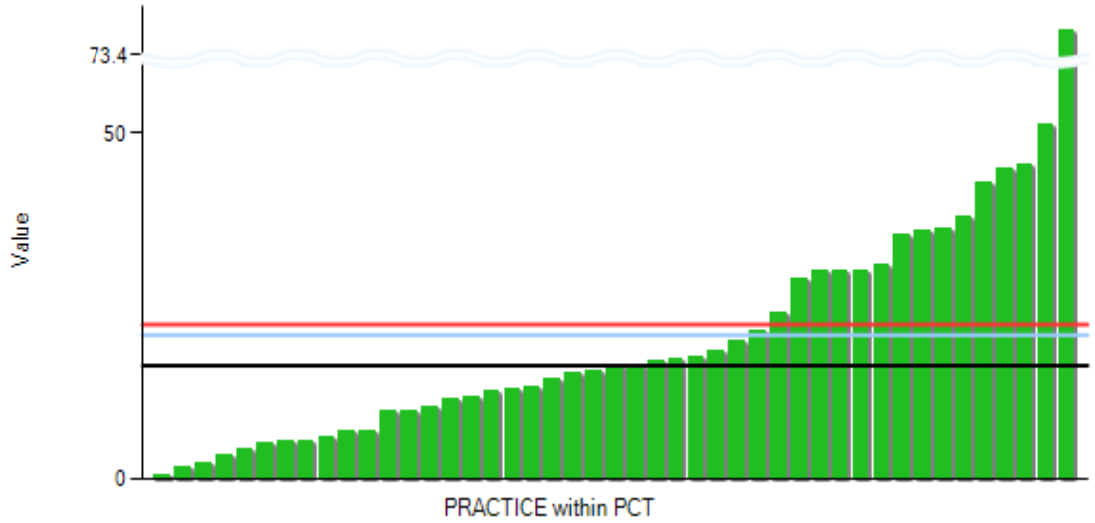


Source: NHS comparators

5.2 The mean length of stay for emergency admissions in geriatric medicine by GP is presented in Figure 5.2. The data indicate a seven fold variation in length of stay. The average Sandwell PCT figure n=22 days, which is a third more bed days that expected given the population.

5.3 The data for emergency admissions for stroke are similar in terms of bed days (n=26 days) and indicate a seven fold variation across GP practice. However, the data show an increase with approaching 50% more bed days observed than expected.

Figure 5.2: Mean length of Stay for Emergency admission, Geriatric Medicine, 2010/2011



Source: NHS comparator

5.4 The pattern of occupied mental health beds is similar in primary care. There is a ten fold variation in general practice and a further 100% more observed activity than expected.

Secondary Care Activity

5.5 The rate of selected admissions to hospital for persons aged 65+ is presented in Table 5.1. The data indicate higher rates of all admissions for men and women compared to other similar PCT's. Rates of emergency admissions in comparison are relatively low. In terms of Frailty risk factors identified early, the number of admissions between 1/1/09 to 31/12/10 included n=264 CHD, n=251 osteoarthritis, n=171 hypertension, n=28 dementia and n=8 admissions for depression. There were no reported admissions for diabetes in that period.

Table 5.1: Directly standardised Admission rate per 100,000 aged 65+, 2008/2009

Cause	Sandwell	Wolverhampton City	Manchester	Leicester City	Birmingham *
All admissions, persons (P)	62,528	59,377	64,031	58,014	56,971
All admissions, male (M)	69,909	67,543	71,373	64,519	62,582
All admissions, female (F)	55,148	51,211	56,690	51,508	51,359
Emergency admissions (P)	23,835	22,446	30,629	29,033	25,580
Emergency admissions (M)	26,611	24,663	33,235	32,013	27,896
Emergency admissions (F)	21,059	20,230	28,024	26,054	23,264
All strokes (F)	780	825	729	588	680

Source: ONS and NCHOD

5.6 Accident and emergency attendance in the elderly has decreased by over 14% in the last three years (Table 5.2). The decrease is for both men and women and has resulted in a 20% reduction in healthcare A&E related costs (£1,030,599 in 2009/10 to £827,798 in 2011/12.

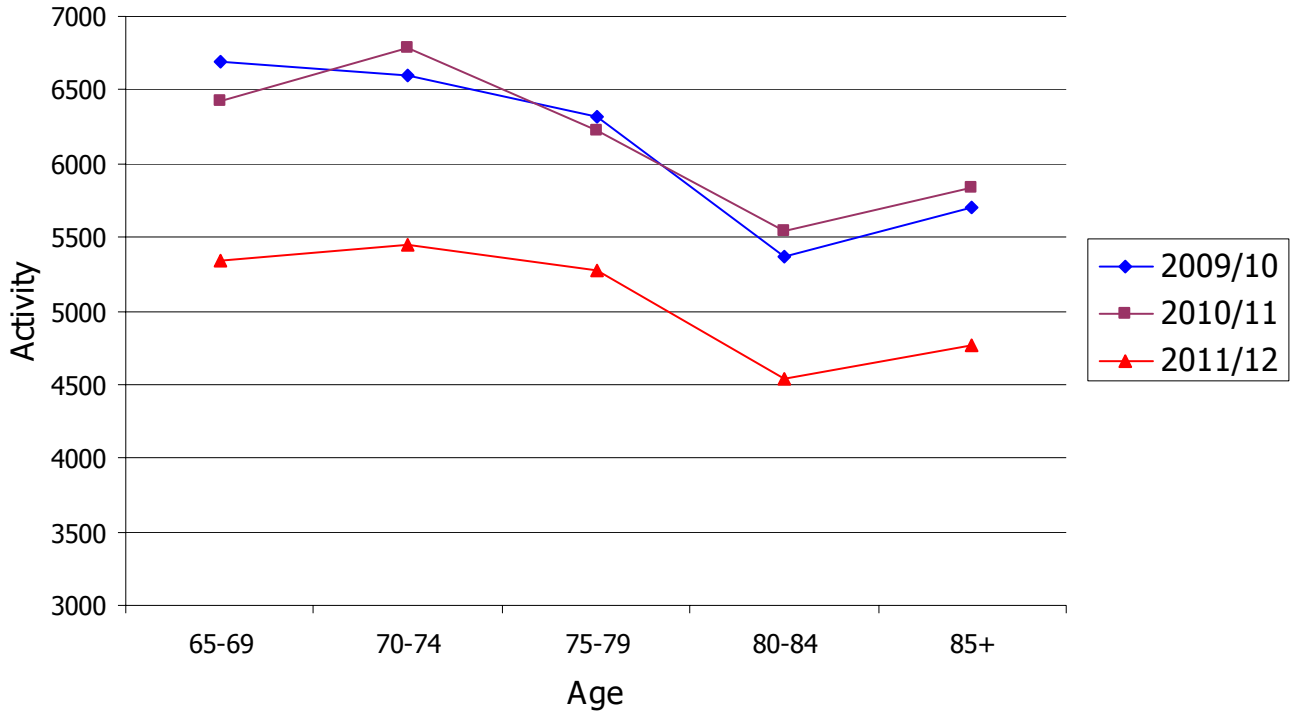
Table 5.2: Accident and Emergency Attendance by age and sex, 2009/10 – 2011/12

		Year			
Men		**09/10**	**10/11**	**11/12**	**Grand Total**
	65-69	2141	2127	1844	6112
	70-74	2115	2050	1736	5901
	75-79	2152	2003	1745	5900
	80-84	1891	1852	1573	5316
	85+	1811	1798	1592	5201
Total		10110	9830	8490	28430
Women					
	65-69	2148	2046	1794	5988
	70-74	2084	2160	1922	6166
	75-79	2226	2154	1838	6218
	80-84	2294	2315	2036	6645
	85+	3282	3502	3002	9786
Total		12035	12179	10592	34806
Grand Total		**22145**	**22009**	**19082**	**63236**

Source: Sandwell PCT information team

5.7 Data on inpatient spells indicate lower patterns of activity across all age ranges in recent years (2011/12) (Figure 5.3). The cost of inpatient healthcare has reduced year on year (£22, 838,752, £25,220,393 to £20,794,191), however the average cost per spell has increased from £744 in 2009/10 to £819 in 2011/12.

Figure 5.3: All inpatient hospital admissions by age, 2009/10 – 2011/12



Source: Sandwell PCT information team

5.8 In terms of emergency hospital admissions in 2011/12, these increase across the elderly age range and also in terms of cost (Table 5.3). One fifth of all emergency

admissions in the 65-69 age group have Zero length of stay. The median and maximum length of stay are also high across all age ranges.

Table 5.3: Emergency admissions by age and cost, 2011/12

Age range	Admissions n	Cost	Zero LOS %	Median LOS days	Max LOS days
65-69	1639	£2,273,254	20	39	344
70-74	1797	£2,660,136	16	44	190
75-79	2134	£3,286,348	14	47	194
80-84	2283	£3,854,097	14	56	216
85+	3261	£6,103,865	11	74	498

Source: Sandwell PCT information team

5.9 The main clinical areas with long length of stay for both emergency and elective inpatient admissions are presented in Table 5.4. A significant number of patients presented with emergency Renal and Thoracic disorders (e.g. Kidney or Urinary Tract infections, respiratory neoplasm, viral pneumonia). All cases are indicative of clinical complications and significant hospital stay. The data on elective admissions also indicate significant hospital stay, particularly for orthopaedic procedures (e.g. Hip, knee or foot procedures).

Table 5.4: Emergency and Elective admissions and LOS by clinical area, 2011/12

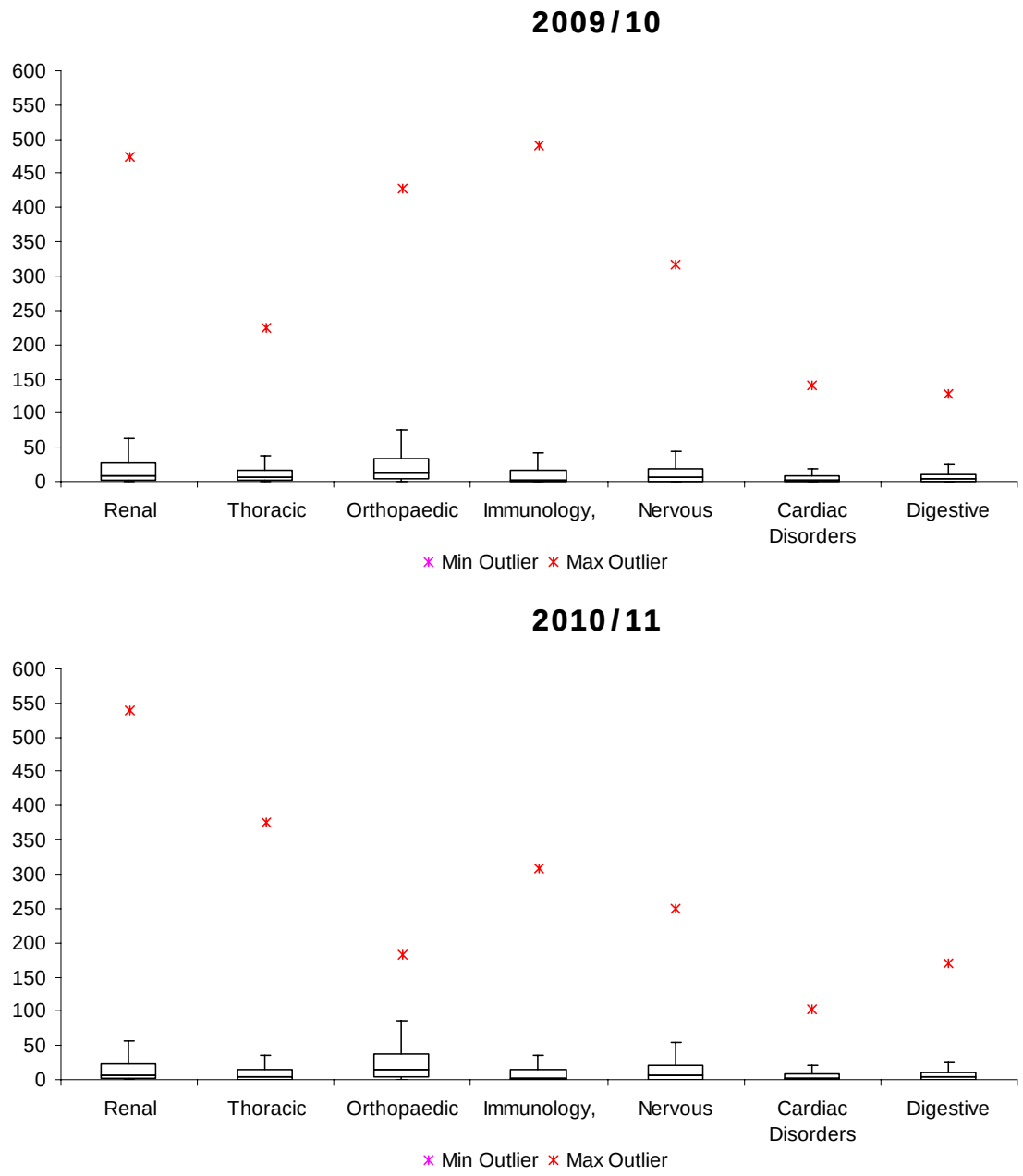
Admissions Type	n	LOS Range
Emergency		
Renal Procedures and Disorders	176	83-498
Thoracic Procedures and Disorders	122	87-217
Orthopaedic Trauma Procedures	75	83-288
Immunology, Infectious Diseases	44	87-198
Nervous System Procedures and Disorders	36	86-344
Cardiac Disorders	26	86-216
Digestive System	20	85-180
Elective		
Orthopaedic Non-Trauma Procedures	195	34-154
Vascular Procedures and Disorders	8	34-97
Orthopaedic Trauma Procedures	2	49-78
Digestive System	2	34-69
Haematological Disorders	2	35-53

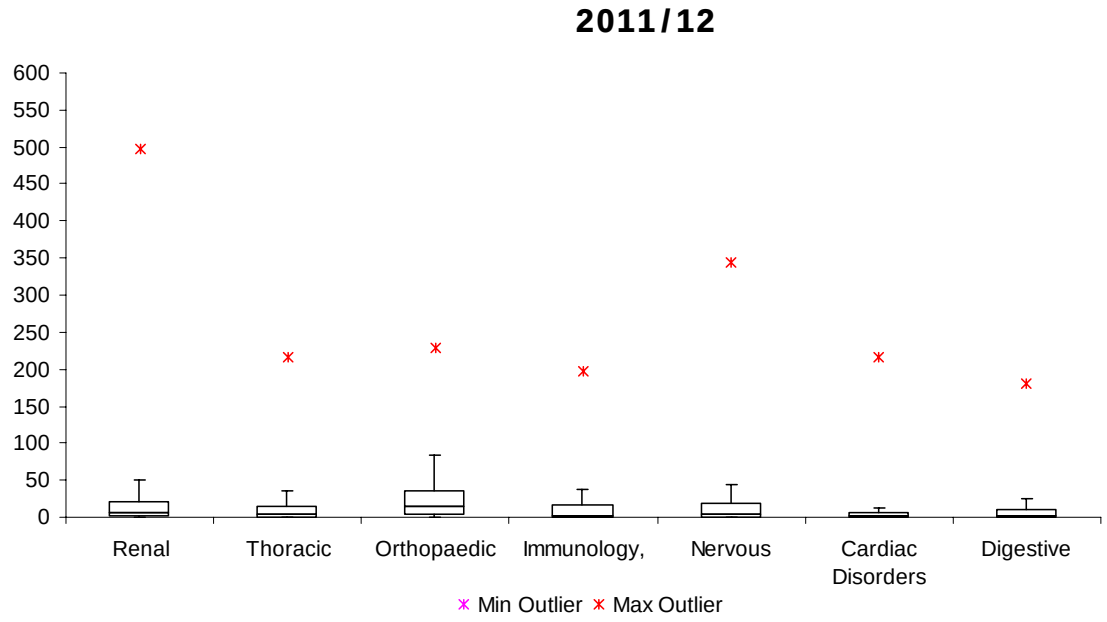
Source: Sandwell PCT information team

5.10 Data on outpatient activity by main speciality for person aged 65+ is given in Table 5.5. As expected, there is considerable variation in ratios across speciality with Rheumatology and Clinical Haematology having the highest ratio.

5.11 Data on emergency admissions and LOS between 2009/10 to 20011/12 is presented in Figure 5.4. The data indicate a similar distribution of LoS between 2009 – 2012. The median LoS in 2011/12 was Renal procedures n=7 days, Thoracic procedures n=5 days, Orthopaedic procedures n=14 days, Immunology n=3 days, Nervous system n=5 days, Cardiac disorders n= 2 days and Digestive system n= 3 days. However, the data also indicate significant LoS for some patients.

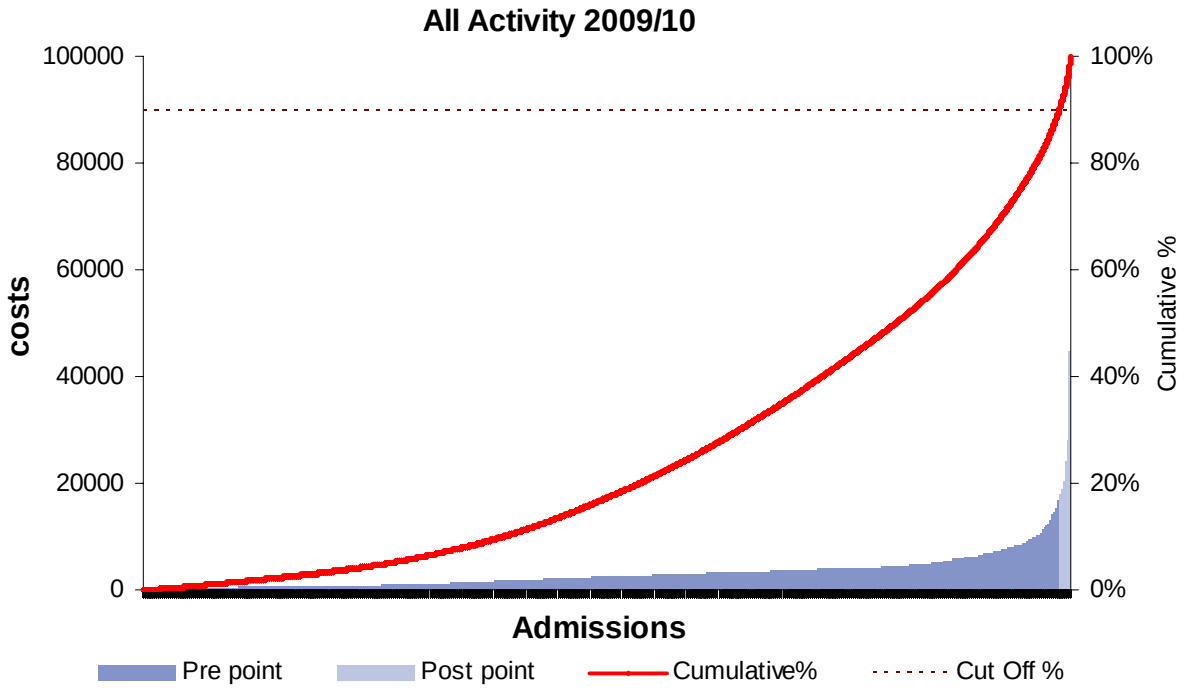
Figure 5.4: Emergency admissions, LOS distribution for selected conditions 2009/10 to 2011/12

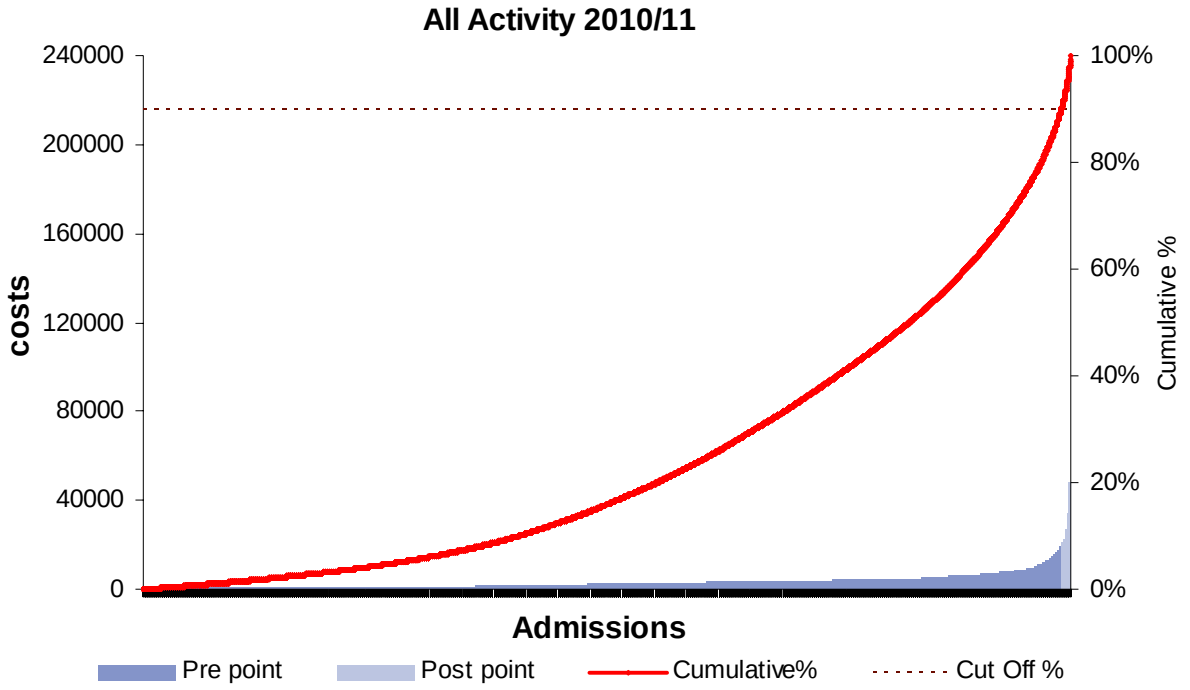


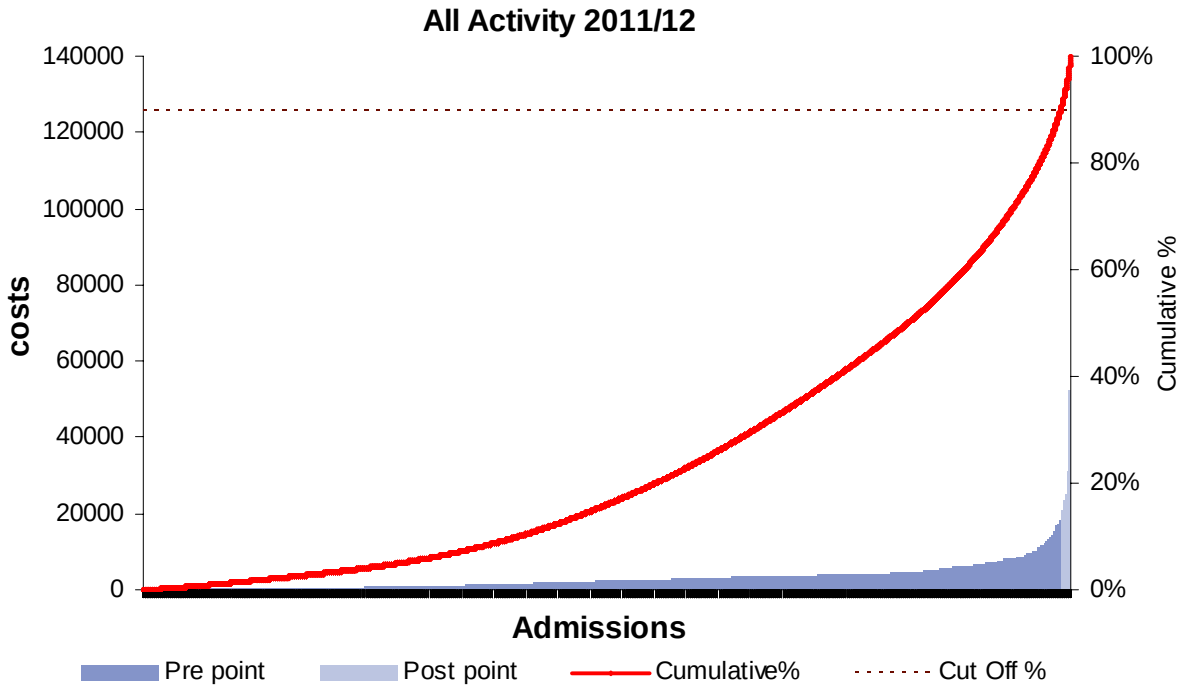


5.12 The data in figure 5.5 examines the cost of all admissions between 2009/10 to 20011/12. The cut off point is marked at 10% of all costs and for each year the data clearly indicates that a small number of patients are accounting for a significant proportion of the total costs.

Figure 5.5: Cumulative cost distribution of all Emergency admissions 2009/10 to 2011/12







Source: Sandwell PCT information team

5.13 In 2011/12 for example, n=87 patients accounted for 10% of total costs (circa £2.7 million). The majority of these cases were discharged back to their usual place of residence (n=54/87), nine clients were care homes (n=5 NHS, n=4 LA), ten patients died and a further fourteen have missing data. An understanding of the complexity of these cases requires clinical audit. Table 5.5 however does provide an indication of primary diagnosis codes for each patient. Further work is required to understand the complexity of these patients and the reasons why they had long stays in hospital.

Table 5.5: Emergency primary diagnosis codes, 2011/12

Primary Diagnosis	n
Urinary tract infection, site not specified	18
Fracture of neck of femur-cl.	10
Lobar pneumonia, unspecified	9
Pneumonia, unspecified	4
Unspecified acute lower respiratory infection	4
Chronic obstruct pulmonary dis with acute lower resp infec	3
Congestive heart failure	3
Parkinson's disease	3
Cellulitis of other parts of limb	2
Cerebral infarction, unspecified	2
Cerebrl infarct due unspec occlusion or stenos cerebrl arts	2
Chest pain, unspecified	2
Oth comps int orthopaedic prosth devs implants & grafts	2
Senility	2
Superficial injury of scalp	2
Acute renal failure, unspecified	1
Agranulocytosis	1
Bronchopneumonia, unspecified	1
Chronic sinusitis, unspecified	1
Disorientation, unspecified	1
Fracture of upper end of tibia-cl.	1
Hypo-osmolality and hyponatraemia	1
Intracerebral haemorrhage in hemisphere, subcortical	1
Left ventricular failure	1
Malaise and fatigue	1
Malignant neoplasm of rectum	1
Melaena	1
Open wound of lower leg, part unspecified	1
Subsequent myocardial infarction of unspecified site	1
Syncope and collapse	1
Toxic effect of other specified gases, fumes and vapours	1
Traumatic subdural haemorrhage-cl.	1
Unspecified fem hernia with obstruct without gangrene	1
Unspecified haematuria	1

Source: Sandwell PCT information team

Table 5.6: Outpatient First/follow-up ratios by specialty and cost, 2011/12

	First	Follow/up	Ratio	Cost
Ophthalmology	3478	12161	3	£1,200,930
Trauma & Orthopaedics	2081	5939	3	£824,384
Cardiology	1453	5331	4	£859,185
Dermatology	1026	2060	2	£270,962
Clinical Haematology	892	6865	8	£1,067,198
Urology	892	3484	4	£509,314
Geriatric Medicine	869	3343	4	£578,674
Gastroenterology	867	1275	1	£363,354
General Surgery	825	2788	3	£459,949
Respiratory Medicine	779	1424	2	£321,872
Rheumatology	289	2264	8	£327,919
	13451	**46934**		**£6,783,740**

Source: Sandwell PCT information team

5.14 Levels of acquired MRSA bacteraemia and C. Difficile continue to decline year on year and across all elderly age ranges in Sandwell. The current data 2011/12 indicate that for all ages there were n=1 case of MRSA Bacteraemia and n=101 cases of C. Difficile (PCT Health protection information team).

Social Care Activity

5.15 Sandwell MBC spends 58% of gross current expenditure of adult social services on persons aged 65+, with the majority of those in receipt of services being women (69%).

5.16 The number of persons receiving residential, nursing and community services per 100,000 population declined between 2008/9 to 2010/11 by between 5% and 12% (Table 5.6).

Table 5.7: Number of persons receiving care and community services per 100,000 population, 2008/9 to 2010/11

	Year		
	2008/9	**2009/10**	**2010/11**
Residential care	1,659	1,671	1,523
Nursing care	1,014	987	966
Community based services	8,906	7,661	7,881

Source: National Adult Social Care Intelligence Service

5.17 Over the last five years the number of persons admitted into residential and nursing care has declined and this mirrored in the number of persons supported in a permanent placement (Table 5.7). During the same period there is an increasing trend in temporary placements.

5.18 In 2011 the majority of clients aged 65+ in a permanent residential or nursing placement had mental health needs, followed by a physical disability and then learning disability (n=187, n=122 and n=46 respectively).

Table 5.8: Number of persons supported and admitted to residential and nursing placements, 2006/7 to 2010/11

Supported	2006/07	2007/08	2008/09	2009/10	2010/11
Permanent					
Residential Care Local Authority Staffed	170	110	95	80	60
Residential Care Independent	725	770	765	820	750
Residential Care Nursing Care	540	535	520	510	485
Adult Placement	5	5	5	5	10
Permanent Total	**1435**	**1425**	**1385**	**1415**	**1305**
Temporary					
Residential Care Local Authority Staffed	55	35	20	20	20
Residential Care Independent	60	70	90	95	105
Residential Care Nursing Care	50	35	25	35	60
Adult Placement	0	0	0	0	0
Temporary Total	**160**	**140**	**140**	**155**	**185**
Admissions					
Permanent					
Residential Care	250	170	180	220	175
Nursing Care	185	170	120	135	120
Adult Placement	0	0	0	0	0
Permanent Total	**435**	**340**	**305**	**355**	**295**

Source: National Adult Social Care Intelligence Service

5.19 Table 5.8 provides data on the type of community services provided to vulnerable clients aged 65+. Approximately 90% of clients are assessed as having a physical disability, frailty or temporary illness. The majority of these clients receive home care and equipment and adaptations. In terms of cost, 41% of gross expenditure is allocated to day care and domiciliary care.

Table 5.9: The number of service users aged 65+ receiving community based services provided or commissioned by the CASSR during 2010-2011

	Home Care	Equipment & adaptations*	Day Care	Meals
Physical disability, frailty and/or temporary illness	2625	1807	393	347
Mental Health (including dementia)	154	75	64	19
Other vulnerable people	61	51	10	5
Visual impairment	65	29	17	9
Learning Disability	47	13	37	1
Hearing impairment	37	26	3	7
Substance Misuse	3	0	1	2
Dual sensory loss	2	0	0	0
Total	**2994 Professional Support**	**2003 Direct Payments**	**525 Short term residential not respite**	**390 Total of clients**
Physical disability, frailty and/or temporary illness	276	189	169	4289
Mental Health (including dementia)	96	22	24	301
Other vulnerable people	8	8	8	120
Visual impairment	8	5	1	90
Learning Disability	4	1	2	61
Hearing impairment	3	2	0	56
Substance Misuse	0	0	1	3
Dual sensory loss	0	0	0	2
Total	**395**	**227**	**205**	**4922**

Source: Statutory return to the department of health: Referrals, Assessments and Packages of Care. P forms page 3 and page 4. March 2011

5.20 The trend for the numbers of carers looking after clients aged 65+ has increased between 2008/9 to 2010/11, however the current proportion (15%) is lower than similar comparable Local authorities. Of those carers looking after clients, around a third receive information from the council while two thirds receive services.

5.21 Self report data from the census 2001 indicates that 11% of persons aged 65+ provide unpaid care and 5% provide unpaid care for more than 50 hours per week

5.22 In 2010/11 85% of persons remained in their home following discharge from hospital through social care services aimed at intermediate and rehabilitation care. This is higher than other comparable local authorities. In the last year 2011/12, n=6395 clients aged 65+ were issued with equipment to support and maintain independent living.

Sandwell Hub Activity

5.23 Evaluation is attached.

Analysis of the HUB system

Sally Lui March 2012

Contents

Introduction

Sandwell HUB is a web-based referral network system that enables partners in the Sandwell Borough to make referrals to different partners in order to provide a variety of services to the residents of Sandwell. The HUB is intended to reduce the number of contacts with individuals and maximise the contacts that are made to ensure those referred get the optimum service.

Aims

- To assess the effectiveness of the Sandwell HUB
- To identify any areas where improvements may be required

Method

- Questionnaires were sent out via email to active HUB users and non-active HUB users at the end of January (see Appendix 1 and 2 respectively)
- Active HUB users were identified as those who have made a referral since June 2010
- Non-active HUB users were identified as those who have remained inactive throughout the time the HUB has been in existence
- Partners were asked to provide the number of HUB and non-HUB referrals received over the past year and the outcomes of the referrals. They were also asked to provide if available the number of referrals received by them before and after they joined the HUB.

Results

170 emails were sent out to active users of the HUB and 41 emails were sent out the non-active users of the HUB.

17/170 questionnaires sent to active HUB users have been returned.

4/41 questionnaires from non-active HUB user were returned.

Some of these questionnaires were returned by the team leaders who represented the opinions of the team and therefore although many emails were sent, not all of them would have replied. Some of the responders did not answer all the questions on the questionnaires.

The active HUB user responders are listed below with the number of replies from each partner and a * to represent replies from team leaders representing the whole department:

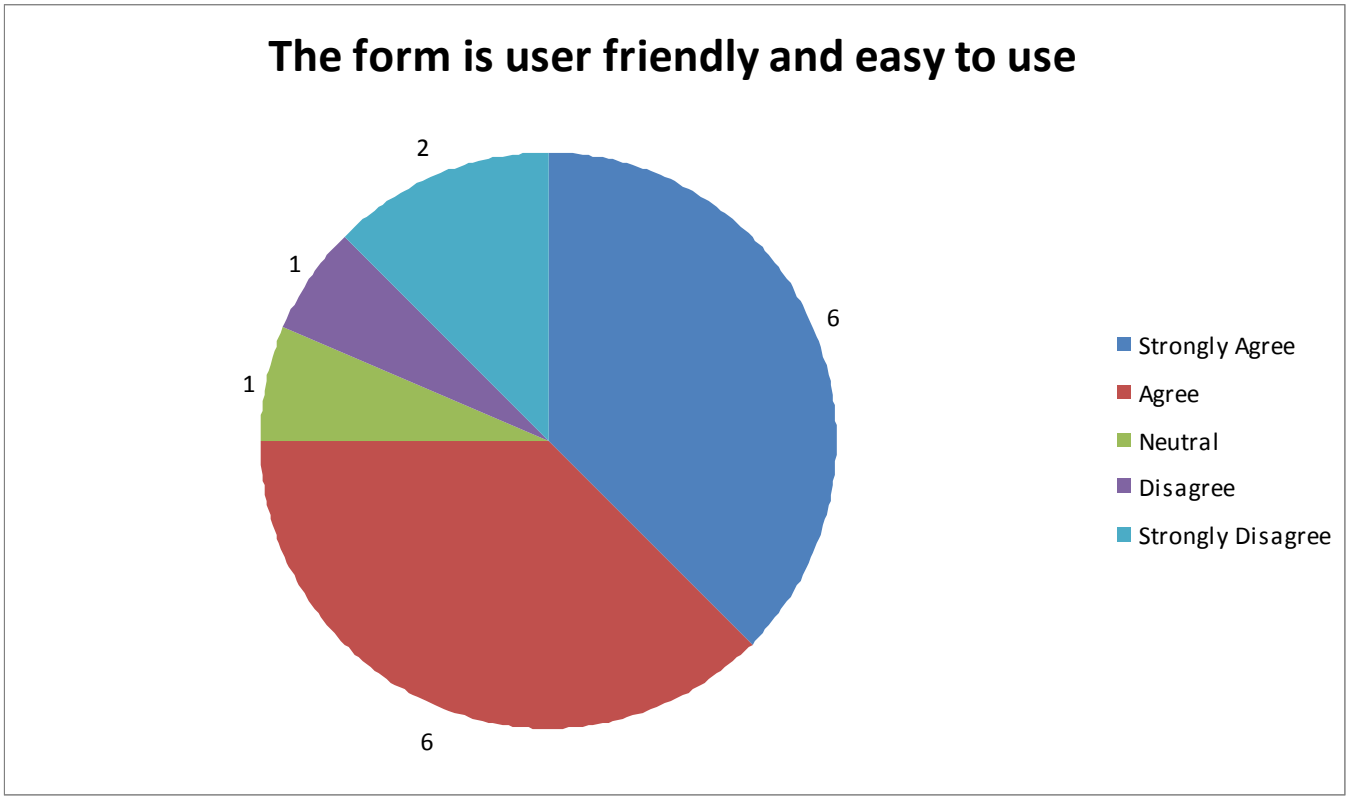
- STAY (1)
- Home Accident Prevention Service (2)
- West Midlands Fire Service (1)
- Healthy Homes Advocate (1)
- Cradley Heath Fire Station (1)*
- Oldbury Fire Station (1)*
- Sandwell Homes (3)
- West Bromwich Purple (1)
- Smethwick White Watch (1)*
- Sandwell Community Continence Service (1)
- Black Country Housing Group (1)
- Community Rehab Team (1)*
- Warmzone (1)*
- Agewell (1)

The non-active HUB user responders were from:

- District Nurse Team (2)
- Anti-social Behavioural Enforcement Team (1)
- Community Tissue Viability Service (1)

Active HUB user questionnaire

Question 1:

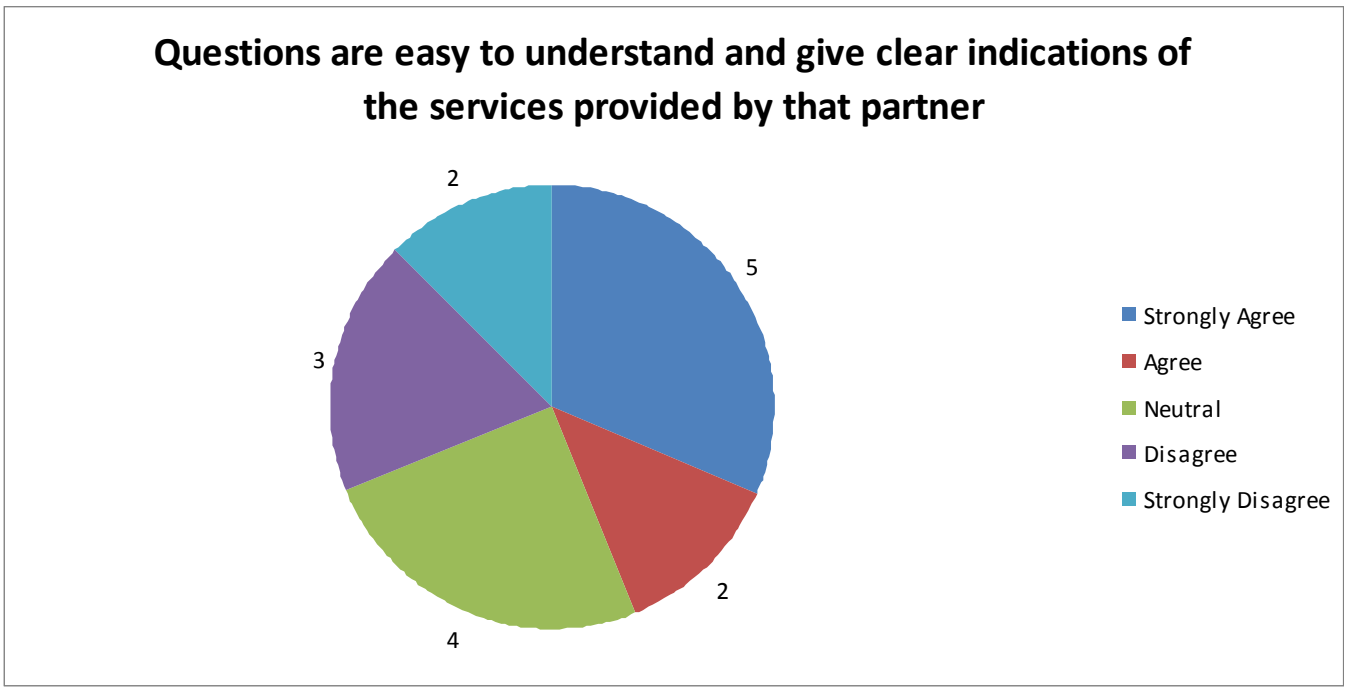


75% have found the form user friend and easy to use. However 19% disagreed because they found that the forms usually did not contain enough information needed to process the referral apart from a tick in a box for someone to go out to visit the client from another service.

For example, they have found that the client's names are sometimes filled in as 'Mrs Unknown Smith' and no age is filled in either. At times the referrals were filled in under the name of the client's spouse and therefore additional work had to be done by the teams who receive the referrals to correct this information.

There needs to be careful consideration of whether increasing the information required on HUB forms will be beneficial, as although issues such as the one mentioned above can resolved, this could add further admin work for users of the system and could potentially deter their use of the HUB.

Question 2:



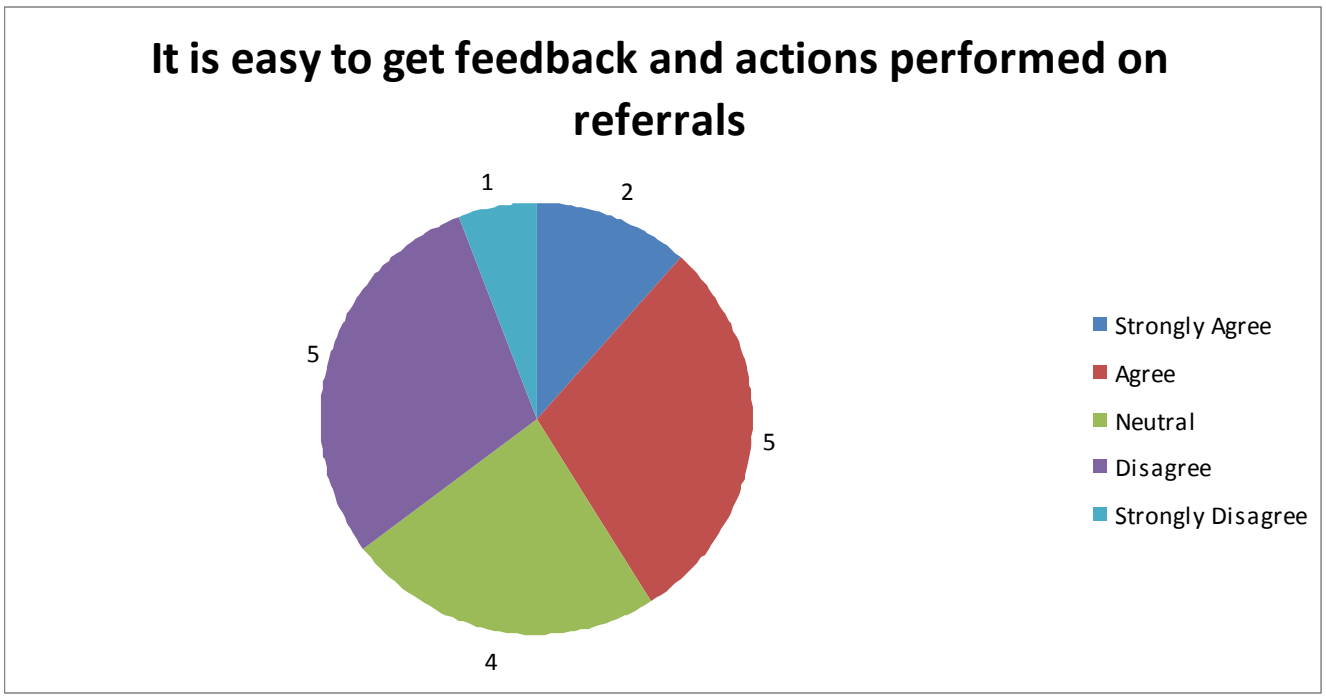
44% respondents have agreed that the questions are appropriate and easily understood, however 31% felt they were not. This was because they found that they did not know from just the questions to which partners they were referring to.

The feedback from STAY was that they found they have been 'accidently' referred clients when it was more suitable for Home Loans or Housing Issues since referrers were just ticking a generic question.

This indicated that there is room for improvement of the wording of some questions in the referral form to improve its efficiency. Also it may be helpful to include the names of the partners at the end of each question which will help referrers identify to whom they will be referring to.

There was a suggestion that the system should allow inappropriate referrals to be forwarded onto more appropriate partners, therefore saving time for referrers to complete another form.

Question 3:



41% have agreed that it is easy to follow up on the actions taken on the clients.

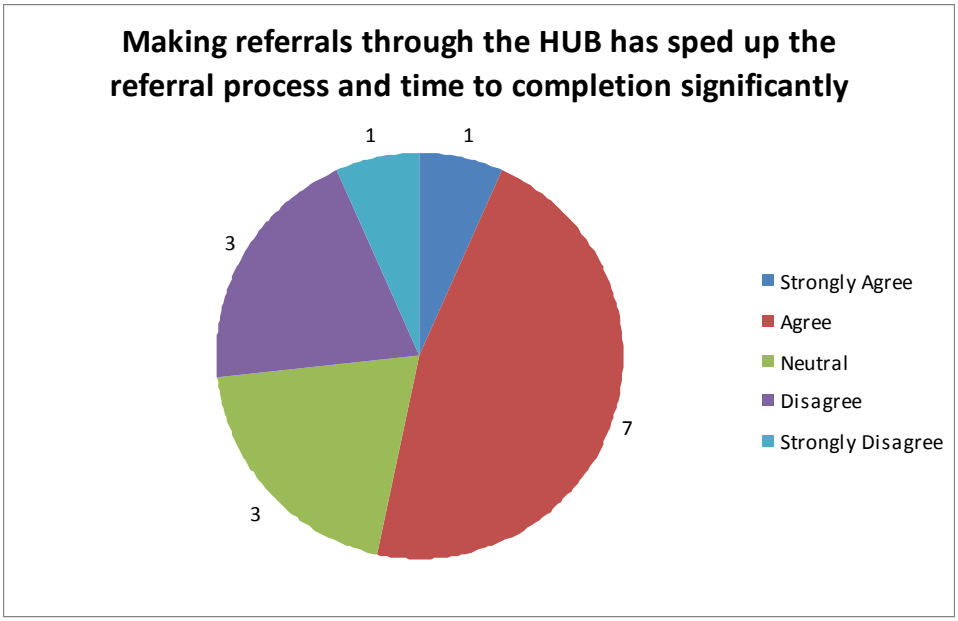
35% have found it difficult as partners were not updating with appropriate comments after acting on the referrals. For example the actions tell you that a client was assessed on a certain date but does not state the outcome of assessment. The opinion to this question is split, the key issues raised are noted below which should be addressed in order to improve the HUB system.

An example provided by a partner was in relation to a client who had been referred to several HUB partners and some had signed off the client as “complete” on the HUB system. However, when this partner contacted the client, they found that the client was in a very vulnerable situation and extremely confused, therefore contacted the safe guarding team and the patient’s GP. In the end, the patient had to be admitted to hospital.

Based on this information, it suggests that there is a lack of communication between partners on actions taken, therefore, the HUB system could be improved by requiring users to complete the “Action Taken” section of the HUB referrals with the outcomes of the assessment and briefly what was done with the client. This would allow all partners involved in that patient’s care to know exactly what has been done which may be valuable in guiding their own service and care for that patient.

Another point raised was that referrals to some partners may be more urgent than to others, however, currently this cannot be differentiated on the referral forms. Therefore some partners may take longer than the allocated time period to complete the referral as they may have assessed it to be less urgent. The HUB system currently only allows priority listing of the whole referral form, but there may be some specific referrals to partners which are more urgent. This may be improved by providing priority options at the end of each question. However this again will need careful consideration as it may make it more of a hassle to complete the form.

Question 4:



53% responders agreed that the HUB had sped up the referral process and time to completion of actions significantly.

27% have disagreed with this as they found that occasionally, incorrect information is filled in on the referral form, such as spouse's name instead of client's and therefore have had to do additional work to correct the referral (as discussed in question 1).

The main problem that most responders pointed out was that there was usually not enough information provided in the form about why the client has been referred. This made it more difficult for the partners to assess the suitability of the referral and therefore needed to chase the referrers or contact clients for more information in order to process it.

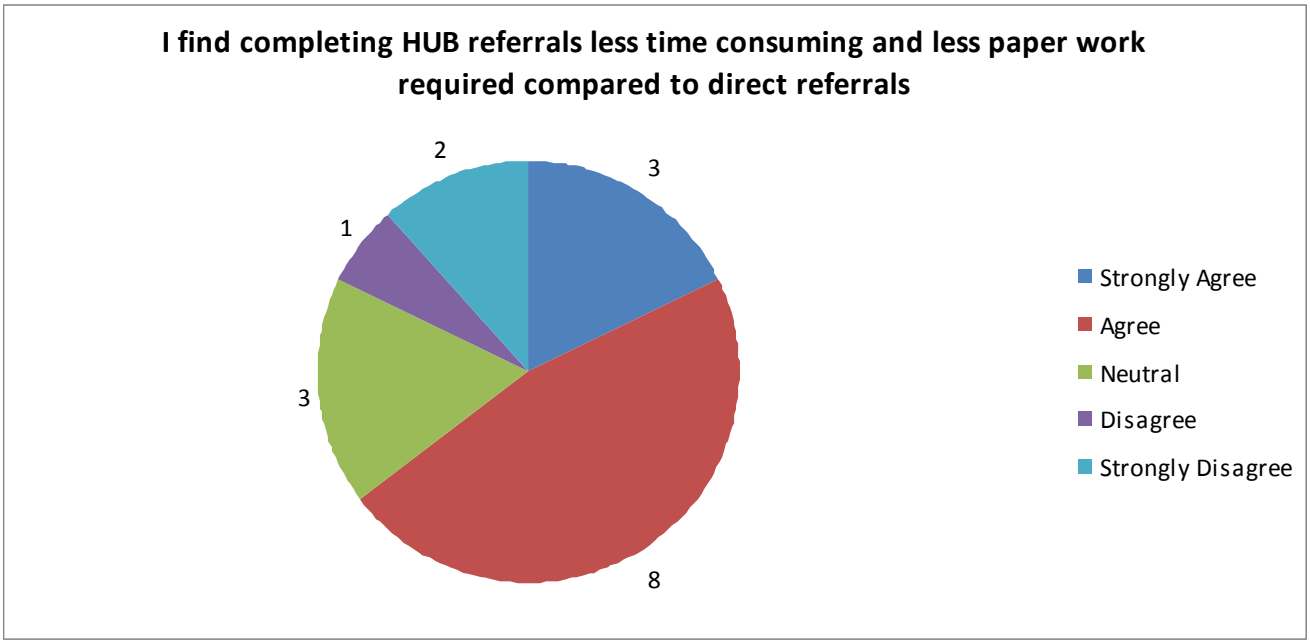
It was suggested that once a box is ticked for a question, a box would automatically pop-up and prompt the referrers to enter relevant information in order to aid the assessment of the referral and therefore reduce the amount of chasing needed and time to process the referral.

Another suggestion was more training for referrers to educate them on making referrals. For example, STAY operates a Trusted Assessor programme.

Partners have stated that both HUB and non-HUB referrals are processed the same way. However, one partner said some HUB referrals they receive arrive 2-3 weeks after the date on the referral form. The most likely reason for this is because after the initial visit from the referrer, it may take a while for the information to pass through their system to get to the person who inputs the referrals onto the HUB system. This issue will need to be resolved by partners inputting information on a timely basis.

There have also been a few cases where the referrals have been duplicated. Between the period Aug and September 2011, there have been 2 cases of duplicate referrals. The first was from West Bromwich Purple, where two referrals were completed for the same client. The other was from Sandwell Homes where there were three referrals completed for the same client. These duplications were likely due to be system issues as the time submitted were within seconds of each other. This issue will need to be investigated by the IT team as to why this has arisen and how to mitigate future duplications.

Question 5:



65% have agreed that HUB referrals are less time consuming and less paper work required compared to making direct referrals.

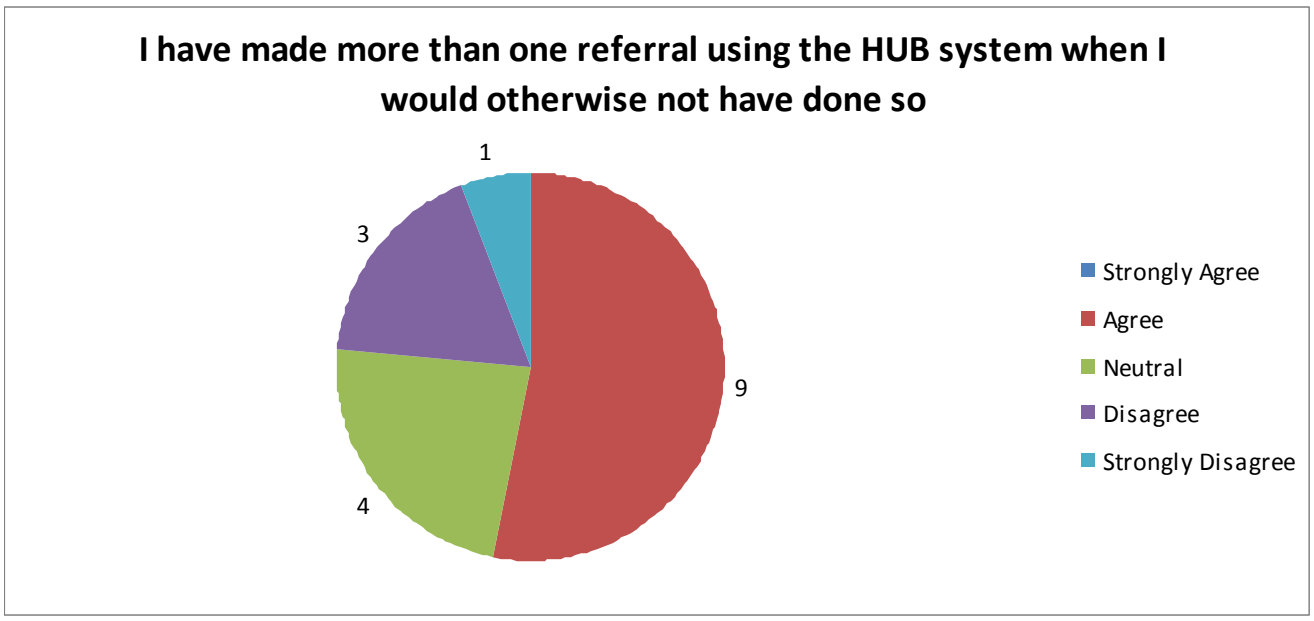
12% have strongly disagreed and the reasons for this is as discussed in Question 4 as they have had to chase referrers for more information.

More than 2/3 of responders found completing referrals via HUB has saved time and required less paper work which indicates that the majority of users of the HUB believe that it is valuable tool in the referral process which has improved efficiency.

As noted above in question 1, there needs to be careful consideration of whether the information required on referral forms should be increased.

The Home Accident Prevention Service has commented that they still prefer to contact the relevant agencies directly and will continue to do so as they find this easier.

Question 6:

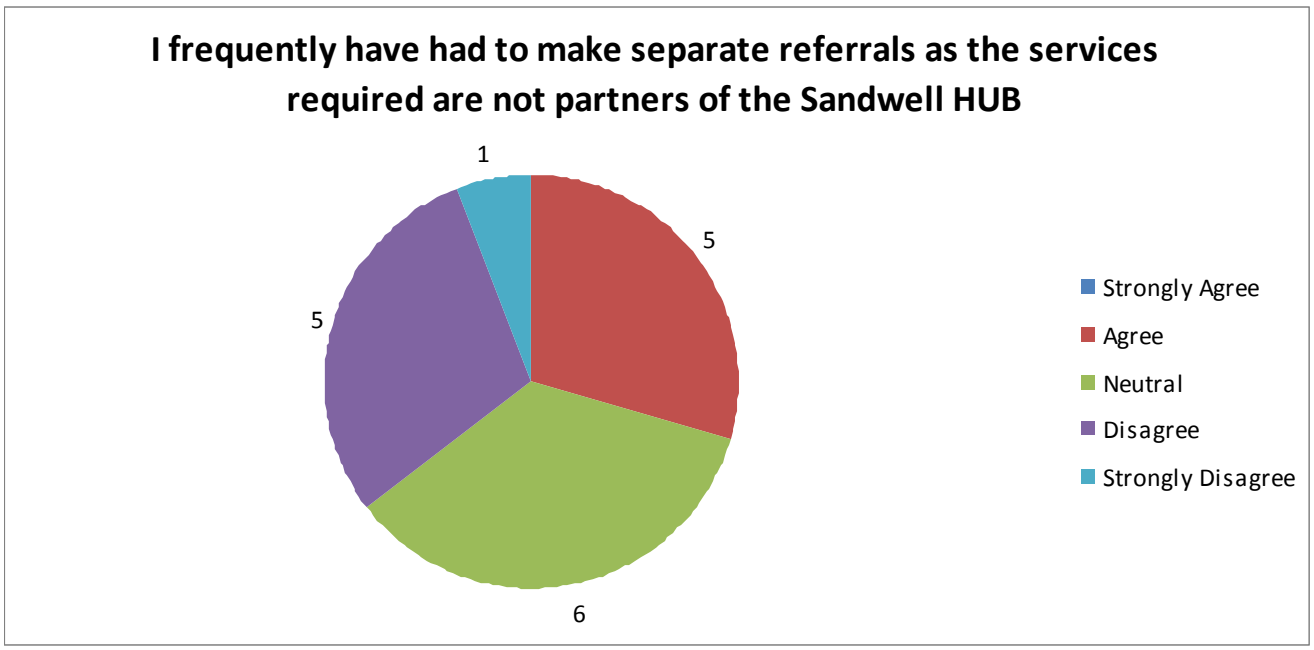


59% of respondents have said they have made more than 1 referral due to using the HUB referral form when they could otherwise not have done so whereas 24% have disagreed to this.

The purpose of this question was to gauge whether users have increased the number of referrals due to the ease of the HUB system as they may have previously been deterred from making a number of referrals due to the number of forms they had to fill in.

The results show that the HUB has generated more referrals by some partners and therefore allowing clients to receive care when they might otherwise not have done so if they were not referred via the HUB. This is beneficial to both the partners who receive the referrals and the clients as the receiving partners will be able to identify clients who were unknown to them and clients can benefit from the services provided by them.

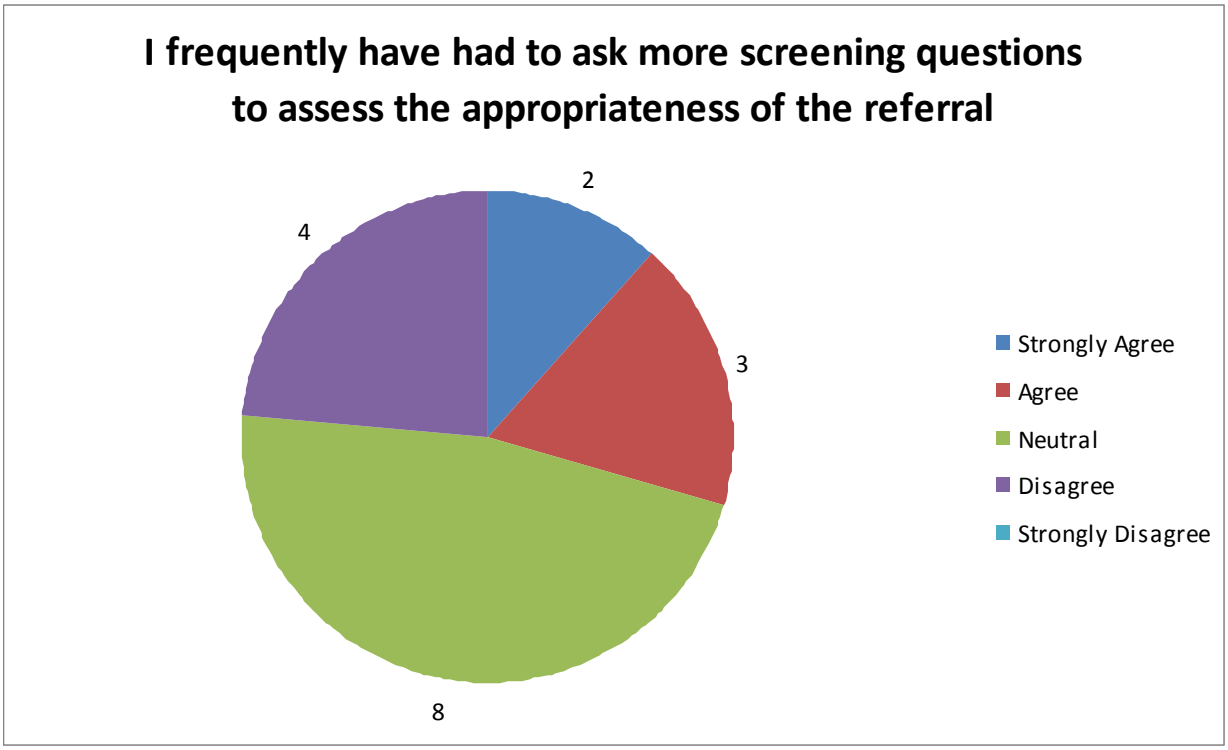
Question 7:



These results show there is no general consensus amongst users of the HUB. Roughly a third find that the current partners are sufficient, a quarter find that additional referrals outside the HUB are required and roughly a third have remained neutral.

This suggests that there could be improvement by adding further partners to the HUB system. However, any new partners added will require additional questions to be added to the referral system, so consideration needs to be taken over balancing relevant partners and time required to complete each referral.

Question 8:



24% of respondents have said that no further information is required after receiving a referral. A further 29% of respondents have said that they frequently need to gather further information on referrals, of which 12% have strongly agreed with the question. The remaining 47% of respondents neither agreed nor disagreed.

Given there is a general split between some partners frequently requiring further information and other partners who do not, this issue may be specific to certain partners, as the information they require is not captured by the HUB system.

Therefore, further analysis is required and it would be good to contact those respondents who felt they frequently had to request additional information to see what kind of information they require. If there were certain information they require for all clients, consideration should be given as to whether additional questions could be incorporated into the system for referrals to these partners, such as in the form of a pop-up box (as discussed in question 4), thereby reducing their need to gather further information.

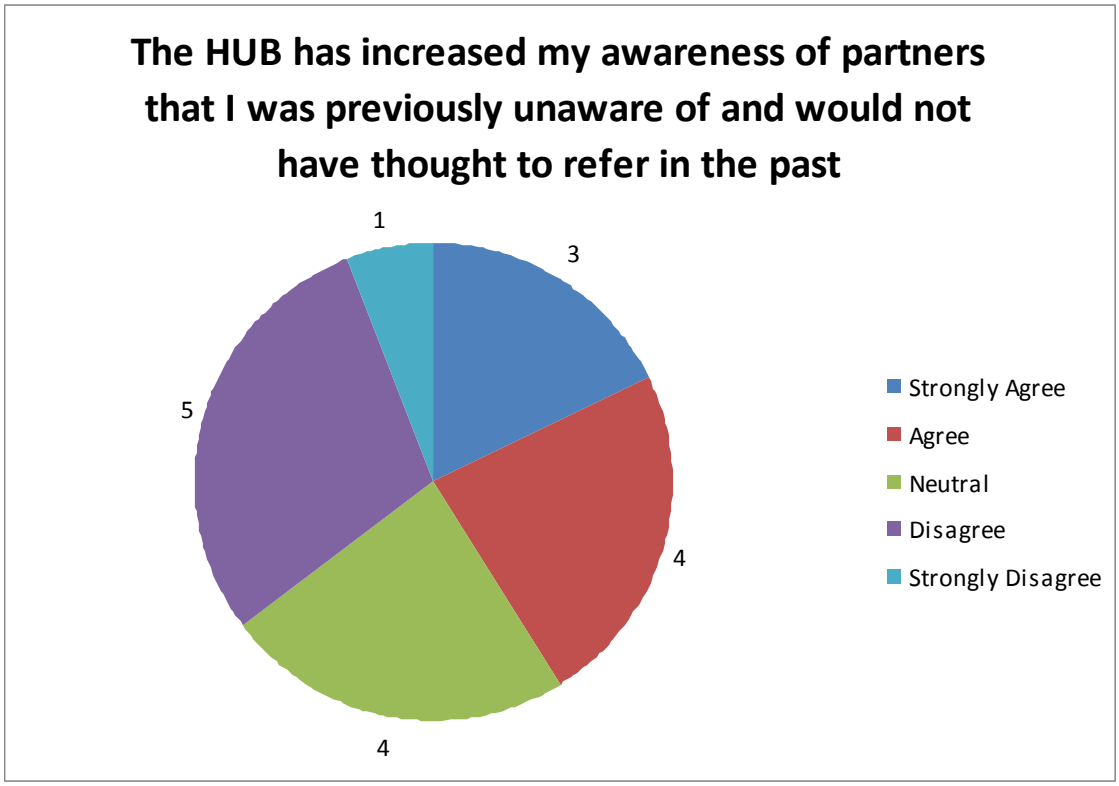
Question 9:

There have been mixed responses to this question, with 40% of users finding it easy to contact the referrer most of the time and have said that they found them very helpful, but 30% of users have found it difficult to contact the referrers and 30% have remained neutral. There were equal numbers of responders who strongly agreed and strongly disagreed.

The HUB system provides the referrers' name and email address, but if a third of respondents found it hard to contact them, this level of detail may not be sufficient. A potential solution is for the referral to include a contact number of the referrer along with alternative contact details e.g. a colleague's details.

It is very important that referrers are easy to contact as several responders have found that there is usually a lack of information (as per question 8) or incorrect information on the referrals (as per question 1) and therefore had to contact the referrer.

Question 10:

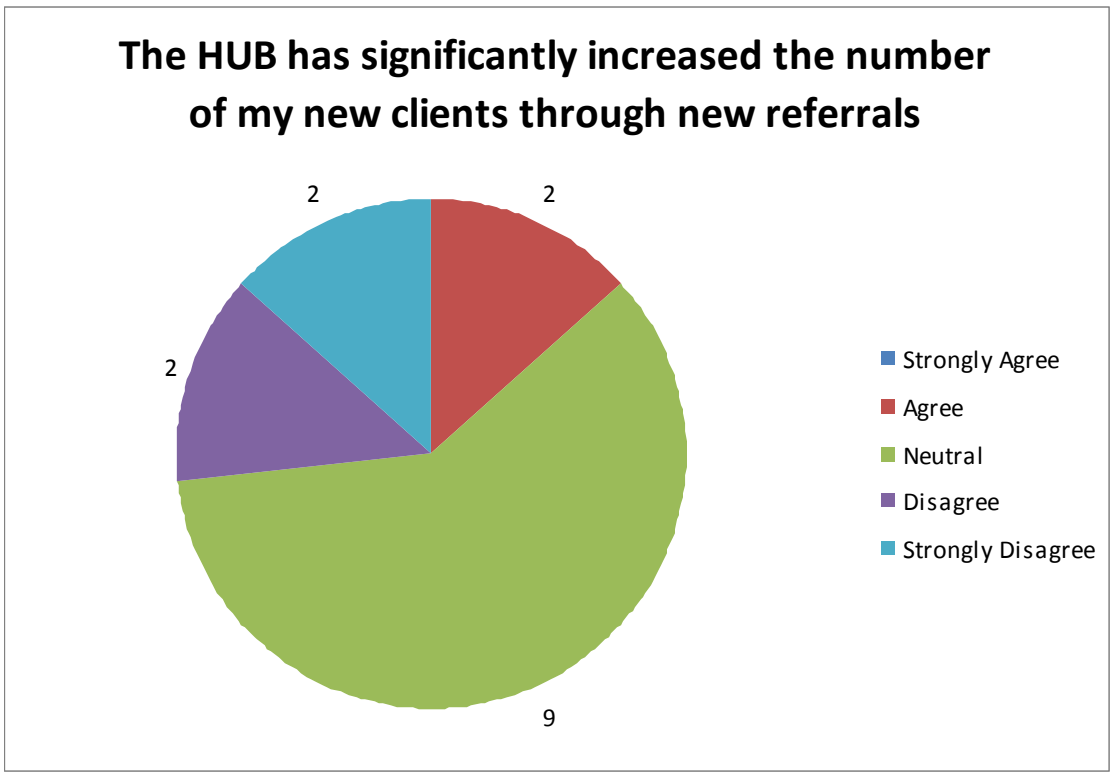


41% have found that the HUB system had increased their awareness of other partners, but 35% of responders disagreed with this.

This shows that the HUB has generated more referrals for some partners and therefore allowing clients to receive care when they might otherwise not have done so if they were not referred via the HUB. This is beneficial to both the partners who receive the referrals and the clients as the receiving partners will be able to identify clients who were unknown to them and clients can benefit from the services provided by them.

This also indicates that some partners were not originally aware of each other and therefore the HUB has provided new contacts to partners. This then leads on to another question regarding whether further detail on each partner is required, which was asked to both users and non-users of the HUB. Please see page16 for more details.

Question 11:



The majority of responses to this question were neutral as to whether the HUB has increased the number of new clients.

It was difficult to assess whether HUB had generated more referrals as many partners did not have this level of information and were unable to provide the number of referrals received before and after they joined the HUB system.

Those partners who thought the HUB had increased their referrals were Cradley Heath Fire Station and Agewell.

The partners who strongly disagreed to this question were Home Accident Prevention Service and Oldbury Fire Station.

Non-active HUB user questionnaire

Due to the lack of responses from non-active HUB users, no graphs have been produced but the results have been summarised as follows:

- 2/4 responders said the majority of referrals they made were not partners of the Sandwell HUB
- 2/4 responders found making written / telephone referrals easier than internet (HUB) system
- 1/4 responders found completing HUB referrals more time consuming and more paper work than making direct referrals
- 3/4 responders thought that more training on the use of Sandwell HUB would be beneficial

Some of the main reasons why some partners do not use the HUB system:

- For the patients these partners provide services for, no further referrals to other partners are required
- Referrals are sometimes already done by other colleagues from different services
- The Trust have stated that due to the nature of the referral system online they were not allowed to use it for confidentiality reasons
- Usually required more information from referrers as not enough on the form
- There are alternative referral methods which they find easier

In summary, the main driver in the lack of activity by these partners is because there is little need for them to use the HUB system and there were no actual issues raised in relation to the HUB system.

Questions asked for both active and non-active HUB users

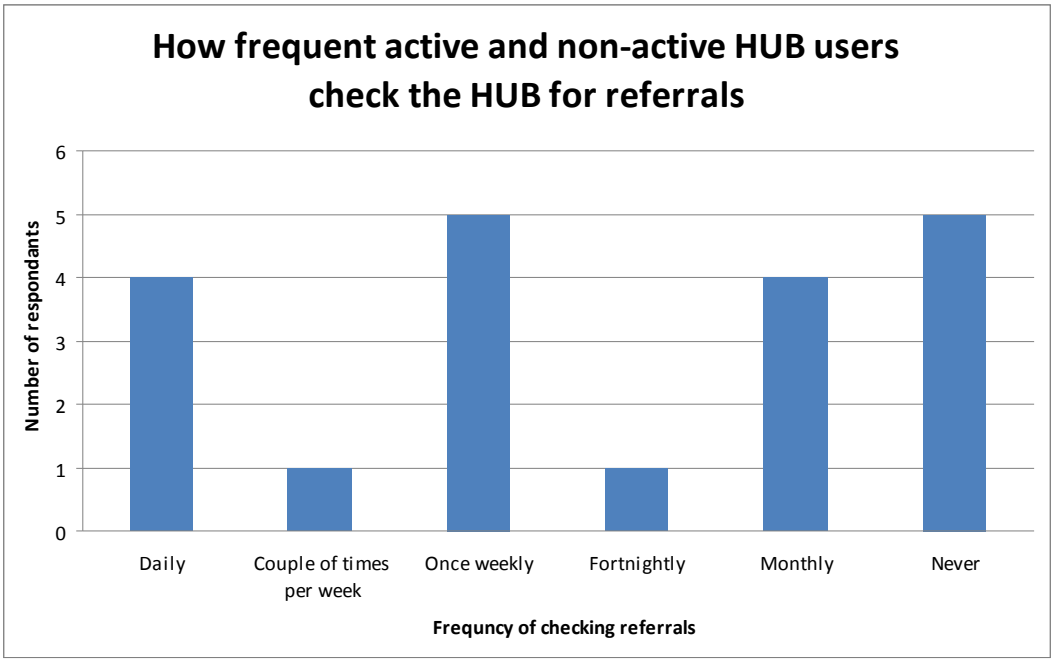
- Do you think it would be useful to have contact details available on the website of all the partners so you can contact them regarding referrals which you are unsure about?

All active and non-active HUB users responded that they thought that this would be useful.

On the Sandwell HUB website, there are currently brief descriptions of services provided by the partners, however all responders thought that having the contact details available on all the partners would be a good idea. This would be more convenient in contacting partners about referrals which referrers are unsure about. It was noted by one of the partners that the brief description of services need to be updated as there have been some changes of services due to cuts. For example, Black Country Housing Group no longer operates the Handyperson Scheme. However they still offer assistance with repairs and have recently become involved with First Stop Advice for older people which is a free service offering advice and guidance in housing, care and financial issues.

It would also be a good idea to have a list at near the top of the webpage of all the partners and a hyperlink to click on which will bring them to the relevant area on the page with brief description instead of having to scroll down and find the relevant partners.

- How often do you check the HUB for referrals?

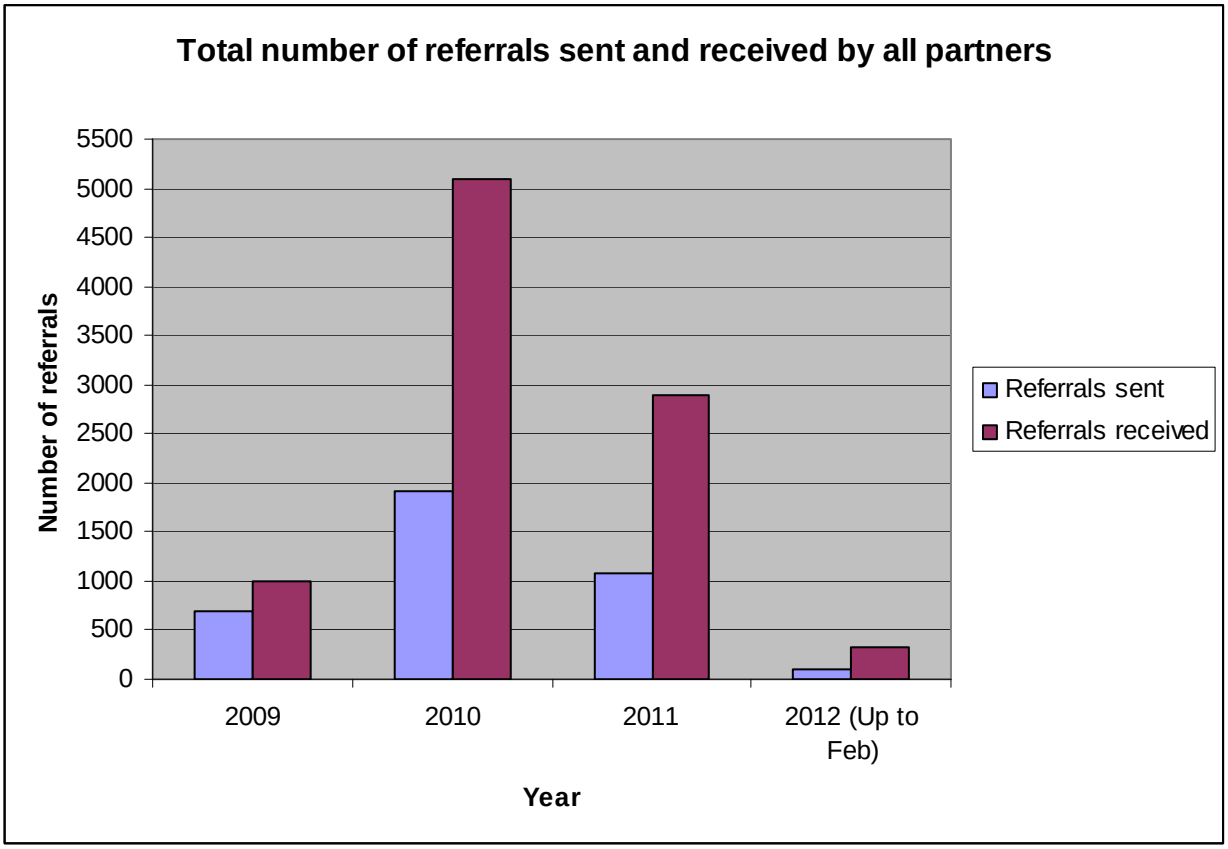


From the results shown above, the majority of users check the HUB for referrals at least on a weekly basis. However, there are 4 active HUB users who said they only check referrals on a monthly basis and 2 who never check for referrals, which should be further investigated as they may miss urgent referrals.

There were 2 active HUB users who never checked the HUB referrals, as this was done by admin staff from their team and the other said they only checked for referrals when notification email comes through.

Outcomes of referrals

The Sandwell HUB system has been active since May 2009. Below is a graph showing the total number of referrals sent and received by all partners between 2009 and Feb 2012. There have been more referrals received compared to referrals sent as some referrals were referred to multiple partners.



1. Agewell

Referrals received by Agewell:

Period	HUB referrals	Non-HUB referrals
Jan – Dec 2011	271	About 50
Jan – Dec 2010	440	84
Jan – Dec 2009	3	74

- Over 3 years, there have been 20/714 inappropriate referrals (2.8%) solely due to the age of the client as Agewell only work with people over 50
- There were 57 completed referrals between September 2011 and March 2012
    - 7 clients were visited
    - 50 information packs were sent out
        - As limited number of staff available to do visits
- There has been a split with people wishing to receive information from Agewell and those who have declined assistance.

The HUB system has generated more referrals for Agewell and had increased the number of new clients through new referrals. For example, a couple who were not known to Agewell until a referral, was contacted by the staff and have started to attend the monthly forums. Agewell have

also been able to provide transport for this lady who is blind and the feedback from the couple was that they both enjoy attending the forum and would not have known about it otherwise.

The number of inappropriate referrals was minimal for Agewell and those that were inappropriate were due to clients being under 50. This could be improved in the future if there was an automatic block on referrals to Agewell if patients were under 50 years old.

2. Sandwell Community Alarms

There have been a total of 617 referrals received by Sandwell Community Alarms between May 2009 and August 2011.

- Sandwell Community Alarms visited 33 clients (5.3%), but only 7 took up the service (1.1%)
- Warden service uptake – 2 service users (0.3%)

There has been a low uptake of their services, mainly due to users:

- Not being aware of charges as they thought it was a free service;
- Thinking the service was provision of a house alarm; and
- Saying they did not ask for an alarm and did not want it

Although the HUB system seemed to have increased the number of referrals for Sandwell Community Alarms, the actual uptake of the services is minimal. This could be due to a misunderstanding of the services by both the referrers and clients. The HUB system does not seem to be very successful for this partner. In order to improve the success, it may be useful to have training sessions for referrers to educate them of the services provided (as suggested in question 4). In addition, the brief explanation on the Sandwell HUB webpage could include more details of the services provided by this service to give a better understanding for the referrers.

3. Row/Tip Community Rehabilitation Team

Due to system limitations, the Row/Tip Community Rehabilitation Team were only able to provide data for referrals between June and December 2011:

	HUB referrals	Non-HUB referrals
Referrals received for Home Accident Prevention Team	Approx 90	Unknown
Referrals received for therapist	Approx 35	Approx 1100

Total number of referrals received 2011 = approx 1700
Total number of referrals received before joining HUB = unknown as all paper records

Inappropriate referrals: ‘Quite a few’

- Falls safety check from a therapist ticked on form but on contacting client, they have not actually had recurrent or recent falls
- Falls safety check for safety assessment at home ticked but no further details given about why client referred
- Incorrect or missing details of client – need to have full name, address, DOB and GP to be able to find client on NHS system

The referrals which were appropriate all had involvement from either the Home Accident Prevention Team in terms of safety of the home environment or physiotherapists from the Row/Tip Community Rehabilitation Team for falls which were all home visits.

The HUB system has not generated many referrals for Row/Tip Community Rehabilitation Team.

In order to improve the usefulness of the HUB system for the Row/Tip Community Rehabilitation Team, the following could be performed:

- Increase the amount of information required when filling in the HUB form for referrals to the Row/Tip Community Rehabilitation Team (as recommended in question 8)
- Require referers to include further details on why they are making the referral
- Consider re-wording of question so referrers are aware that they should only be referring those with recurrent or recent falls

4. STAY

The referrals received from STAY via HUB were 284 between April 2011 and March 2012.

- 85 (30%) were inappropriate referrals and therefore declined any services
    - This number also included duplicated referrals received
- 199 referrals were appropriate where 158 of those (79%) had equipment provided by STAY
- 26 referred clients are currently waiting for equipment to be installed
- 14 (7%) of the referred clients did not take up the service offered to them by STAY
- Of the 158 referrals who received equipment, 125 (80%) were DDA packages installed

The feedback from STAY was that they think that the HUB has hugely aided in their communication with the Fire Service and really kick started the DDA project which formed majority of the referrals.

The few referrals which are inappropriate have been because STAY has identified that there were no specific needs for their services and have been ‘accidently’ referred (as previously discussed in question 2).

Given the information provided by STAY, the uptake of their services has been very high at 92%. The success they have experienced with the communication between Fire Service in starting the DDA project has shown that the HUB has been invaluable.

5. West Midlands Fire Service

Between May 2009 and August 2011, West Midlands Fire Service has received 1,594 referrals from the HUB. Of the 1,594 referrals, 77 referrals have put out a 999 call in that period.

- Fire Damage Report – some fire damage had incurred at the property: 18
- Special service call – cat up a tree, etc: 20
- False alarm equipment – faulty equipment: 21
- False alarm good intent – smoke from cooking actuating the smoke alarm: 13
- False alarm malicious – hoax call: 6

- 7 referrals were entered onto the HUB by one of the partners prior to an incident
- 11 referrals had an incident which occurred before being entered on the HUB system for any referrals

Due to the huge number of referrals received by the West Midlands Fire Service, it has been difficult for them to provide information about outcomes with the number of clients. The outcomes would have been either:

- A smoke alarm was fitted by West Midlands Fire service
- The resident refused a visit
- The equipment already installed was not in need of change

Conclusions

- Majority of responders (75%) agreed that the form is user friendly and easy to use
- Many of the responders (53%) have agreed that making referrals via the HUB has sped up the referral process and completion of referrals
- Many of the respondents felt that there was a lack of or incorrect information on the referral forms and therefore had to chase for the information and therefore increased workload
- More than 2/3 of respondents found that the HUB referral system has saved time and required less paper work compared to making direct referrals
- HUB system has encouraged people to make more referrals than they would otherwise have
- HUB system has increased awareness of some referrers to partners that they were otherwise unaware of
- The main driver for lack of activity in non-active HUB users is due to minimal need for referrals
- All responders thought it would be useful to have contact details of partners on the website so they would be able to contact them regarding referrals they were unsure of
- Regular updating of the brief descriptions on the services of partners on the Sandwell HUB website is required to keep partners informed
- For some partners, the HUB has generated more referrals but many have been inappropriate and therefore not made much difference
- Some questions may need to be re-worded or be made clearer to referrers which partners they are referring to
- Better documentation of outcomes of actions taken on referrals to improve communications between partners
- The HUB has generated more referrals for Agewell, STAY and West Midlands Fire Services

Recommendations

- Consider re-wording of some questions (e.g. STAY, Home Accident Prevention Team)
- Let referrers know who they are referring to by stating the name of the partners at the end of each question
- Encourage partners to update with outcomes of actions on a referral
- Reiterate the importance of filling in the personal details of the client correctly and completely in order for referral to be processed efficiently
- Reiterate the importance of filling in the reason(s) for referral in order to guide receiving partners to provide the optimum care for the client
- Contact respondents who felt they frequently had to request for additional information. If there were certain information that was always missing, consider a pop-up box to prompt referrers to input this regarding client after ticking a question
- Consider automatically blocking referrals, for example blocking referrals to Agewell if patient under 50
- Include contact details of partners on website
- Consider possibility of forwarding on inappropriate referrals to more appropriate partners

Appendix 1

Dear Partners,
I would be grateful if you could answer the questionnaire below about your views on the Sandwell HUB. It should only take about 5 - 10minutes. Please mark the box that represents your views with an 'X'. Please feel free to add any other comments in the space provided. Your help is very much appreciated.

Partner: _____ **Position:** _____

Question		Strongly Agree	Agree	Neutral	Disagree	Strongly disagree
1	The form is user friendly and easy to use					
2	Questions are easy to understand and give clear indications of the services provided by that partner					
3	It is easy to get feedback and actions performed on referrals					
4	Making referrals through the HUB has sped up the referral process and time to completion significantly					
5	I find completing HUB referrals less time consuming and less paper work required compared to direct referrals					
6	I have made more than one referral using the HUB system when I would otherwise not have done so					
7	I frequently have had to make separate referrals as the services required are not partners of the Sandwell HUB					
8	I frequently have had to ask more screening questions to assess the appropriateness of the referral					
9	It has been easy for me to contact the referrer most of the time					
10	The HUB has increased my awareness of partners that I was previously not aware of and would not have thought to refer in the past					
11	The HUB has significantly increased the number of my new clients through new referrals **Approximate number:**					

		Yes	No
12	Do you think it would be useful to have contact details available on the website of all the partners so you can contact them regarding referrals which you are not sure about?		

		Several times a day	Daily	Once weekly	Fortnightly	Monthly	Never
13	How often do you check the HUB for referrals?						

Any other comments:

Appendix 2

Dear Partners,
I would be grateful if you could answer the questionnaire below about your views on the Sandwell HUB. It should only take about 5 - 10minutes. Please mark the box that represents your views with an 'X'. Please feel free to add any other comments in the space provided. Your help is very much appreciated.

Partner: _____ **Position:** _____

Question		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	I frequently forget my username and password					
2	I am not familiar with how to make a referral on the HUB system					
3	I find it difficult to find out the outcomes of referral on the HUB system					
4	I find the questions on the HUB referral form unable to capture my reason(s) for referral					
5	I do not think there is a difference in process time and time to completion between direct referrals and HUB referrals					
6	The majority of referrals I make are not to partners of the Sandwell HUB					
7	I find making written / telephone referrals easier than internet (HUB) referrals					
8	I find completing HUB referrals more time consuming and more paper work than making direct referrals					

		Yes	No
9	Do you think more training on the use of the Sandwell HUB would be beneficial?		
10	Do you think it would be useful to have contact details available on the website of all the partners so you can contact them regarding referrals which you are not sure about?		

		Several times a day	Daily	Once weekly	Fortnightly	Monthly	Never
11	How often do you check for HUB referrals?						

12	Your main reason for not using the HUB is:	

Any other comments