

Islington Council and NHS Islington

Strategy for Older People's Mental Health

FINAL DRAFT FOR CONSULTATION

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1. Introduction

1.1 Scope

Mental ill-health in older age is very common and can have devastating impacts for the people who become ill, as well as the families who care for them.

National estimates of mental ill-health among older people ¹

- Estimates suggest that perhaps 40% of older people attending their GP, 50% of older people in general hospitals and 60% of older residents in care homes have some form of mental health problem.
- It is estimated that around 15% of older people in the community suffer from depression, while dementia affects 5% of people aged over 65 and 20% of people aged over 80.
- Mental health problems, particularly depression and dementia, are more common, and have a worse outcome, in the 60% of older people who suffer from long standing illnesses.
- Up to two-thirds of NHS beds may be occupied by people age 65 or over and up to two-thirds of some in-patient groups either have mental health problems already, or will go on to develop them during their in-patient stay.
- In cost of illness studies, the direct costs of Alzheimer's disease alone exceed the total cost of stroke, cancer and heart disease.

This strategy describes the way we want to improve our services for older people with mental health needs and their carers. It places an emphasis on 'organic' mental health problems - in particular dementia. This is because dementia has especial significance for the way we organise our services and because services for people with dementia are the subject of a major national improvement programme. The strategy is, however, also concerned with 'functional' mental health problems, such as depression, anxiety and psychotic disorders. It also considers the needs of younger people with dementia.

Providing services to meet these needs can be complicated; in part, this is because people may need support from a range of services, including health services, social care services, mainstream services and specialist services. To make sure people's needs are met in a timely, effective and co-ordinated way,

our strategy therefore focuses on ensuring that all these services work together as a 'whole system'.

1.2 Intended outcomes

Our strategy focuses on delivering the following outcomes.

- Helping people to stay as healthy and independent as possible
- Raising awareness about mental ill-health, so that people seek help early on
- Ensuring good quality diagnosis and early intervention, so that people's long term outcomes and quality of life are optimised
- Making sure people have good information and advice and can access appropriate care and support when they need it
- Improving community based support, including support for family carers, so that people can live at home for longer with the best possible quality of life
- Improving intermediate care services so people are supported better in a crisis and are helped to return home if they go into hospital
- Developing sheltered and extra care housing as quality alternatives to care home placements
- Reducing reliance on institutionally based care, while making sure there is
 - An appropriate supply of good quality residential and nursing care
 - Good care in general hospitals
 - Effective specialist in-patient care

To achieve these things, the strategy places particular emphasis on

- Re-focusing our services away from institutional care, towards community based services, early intervention and prevention.
- Making sure there is a more informed and effective workforce
- Making sure that the system of services operates more effectively as a whole

2. The policy context

2.1 The overall policy context

Over recent years, a series of important national policy documents have set a challenging agenda to improve health and social care services.

Key policy documents

- Our Health, Our Care, Our Say.
- Commissioning a Patient led NHS and World Class Commissioning
- Strong and Prosperous Communities
- Putting People First
- Carers' Strategy
- National End of Life Care Strategy

(**Appendix 1** provides further information)

These policies emphasise the need for health and social care services to focus on the following outcomes:

- **Improved health and emotional well-being**
- **Improved quality of life**
- **Full and equal participation in community life**
- **Increased choice and control**
- **Freedom from discrimination**
- **Financial stability and control**
- **Personal dignity and respect**

To achieve this, the Government wishes to reform public services radically, so that services become much more tailored to the needs and preferences of citizens. Currently, there is significant emphasis on 'transforming social care'² through

- **Strengthening communities** to make sure that everyone can experience the friendships, sense of belonging, support and care that can come from families, friends, neighbours and communities.
- **Strengthening universal services**, so people have easier access to – and can benefit to the full from – general support and services such as

transport, leisure, education, housing, community safety, information and advice.

- **Improving early intervention & prevention services** to assist people who need a little more help, at an early stage, to stay independent as well as helping to halt or slow down further deterioration if people become ill or disabled or start to lose their independence
- **Increasing choice and control through developing 'self directed support'**. This means moving from a position where people are recipients of services, to one where they are citizens who can become actively involved in selecting and shaping the services they receive. This is so the services and supports they receive are tailored to their individual needs and preferences.

2.2 The growing emphasis on mental health in older age

There is also a particular emphasis on improving services for older people with mental health needs. A series of important policy documents over recent years have recognised that this has been a neglected area and a real momentum for change is now developing, not least as a result of the recent publication of **a National Dementia Strategy**.

National reports in recent years about older people's mental health

- Forget me not (Audit Commission, 2000)
- National Service Framework for Older People (Department of Health, 2001)
- Everybody's business (CSIP, 2005)
- NICE/SCIE clinical guideline on dementia (2006)
- Promoting mental health and well-being in later life (2006)
- Improving services & support for older people with mental health problems (2007)
- Dementia UK report (2007)
- National Audit Office value for money study (2007)
- Public Accounts Committee report (PAC, 2007)
- Partnerships for Older People Projects (POPPS)
- The Dignity in Care Campaign
- The National Dementia Strategy (2009)
- Equality in later life: A national study of older people's mental health services (2009)

(Appendix 1 provides further information)

These reports have all identified significant deficiencies in health and social care services across the country and drawn together evidence about the effectiveness of different services and interventions. Key themes, which have especially influenced our strategy, are the need to:

- **Improve awareness** about mental health in older age among the public and professionals
- Make sure that **people's needs are diagnosed early on** and that **services intervene promptly and effectively**
- Improve the **quality of care**, so that people
 - Have more choice and control about the support they receive
 - Remain at home, with the best possible quality of life, for as long as possible
 - Experience good care in hospital and in care homes when they need it

2.3 Implications

It is not possible to do justice here to the policy themes that have emerged from central Government over recent years. However the table below summarises the key themes that need to shape the way we develop our services.

Key policy themes
<ul style="list-style-type: none">▪ Promoting social inclusion and well-being▪ Reducing health inequalities and inequalities in provision.▪ Empowering people to look after their own health▪ Promoting prevention and early intervention▪ Ensuring early diagnosis▪ Involving service users & carers when planning & delivering services▪ Ensuring fair and timely access to services▪ Delivering user focussed, holistic and responsive services, which treat service users and carers as individuals▪ Giving people more control and choice about the care they receive, addressing mental health, as well as physical health, needs▪ Delivering care that is as close to people's homes as possible▪ Providing more co-ordinated services, marshalling resources across local authorities, NHS and other agencies

- Providing ***integrated intermediate care services*** to prevent hospital admission, to reduce lengths of stay, to ensure timely discharges and to prevent avoidable re-admissions
- Ensuring ***consistency and value for money***
- ***Raising standards*** and ensuring a ***well-trained workforce***.

The strategy supports – and is supported by - a range of other local policies and strategies, including Islington's overall Commissioning Strategy Plan and its Primary and Community Services Commissioning Strategy.

3. Mental health needs among older people in Islington

3.1 Islington's population

Over the coming ten years the number of people aged between 65 and 84 in Islington will decrease, but there will be an increase in the number of people aged 85 and over. As a result, there are likely to be greater numbers of older residents who are frail, who have long term conditions and who require support. In the subsequent ten years (2019 – 2028), there will then be an increase in all older age groups.

Within this broad picture, there is expected to be an increase in the diversity of people's needs, as the number - and proportion - of older people from different minority ethnic communities increases.

Figure 1: GLA (Low) Population projections for Islington over 65 age groups

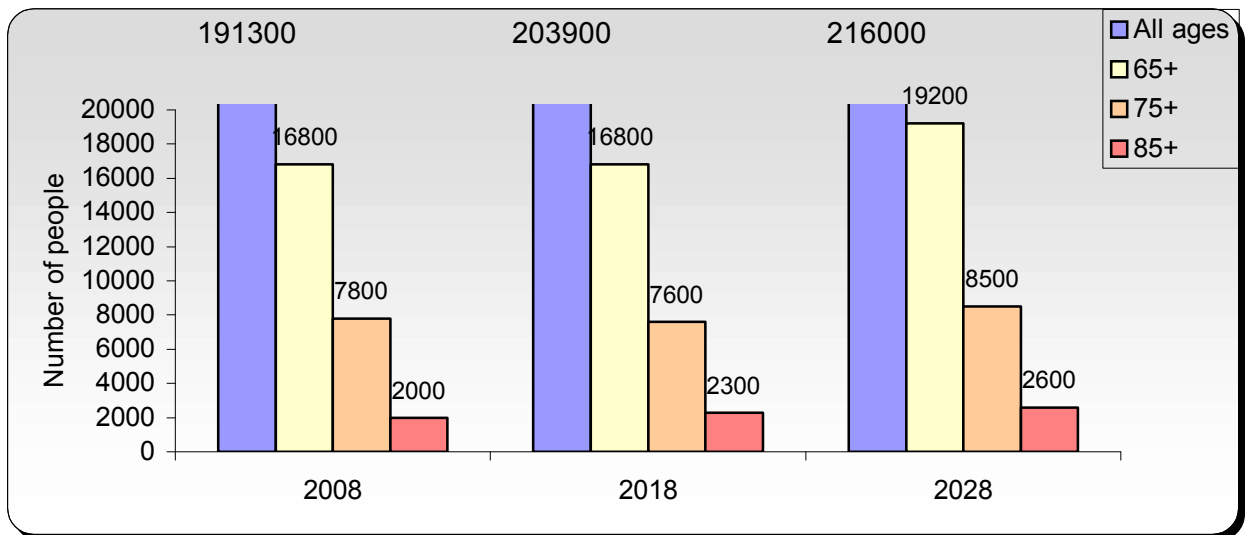
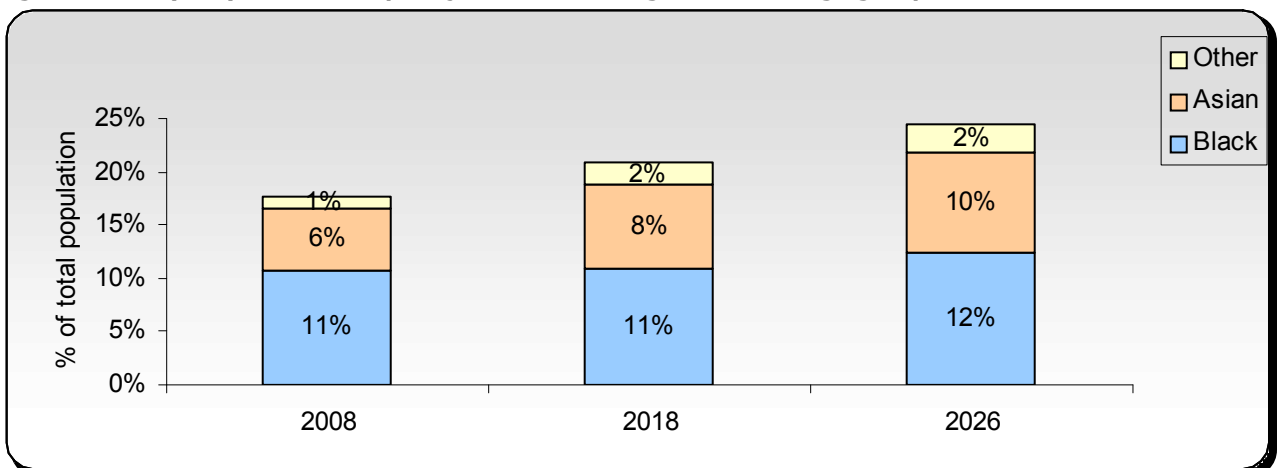


Figure 2: GLA (Low) Ethnic Group Projections for Islington over 65 age group



3.2 Deprivation in Islington

Islington is one of the most deprived boroughs in the country and suffers from significant health inequalities, both within the borough and when compared to many other parts of the country. It has, for example, the lowest life expectancy for men and the third lowest for women out of all London boroughs. Male life expectancy has been calculated as varying from 76.4 years (Clerkenwell ward) to 71.7 years (Tollington ward). For women, life expectancy varies from 82.3 years (St George's) to 77.7 years (Finsbury Park).³

Locally, older people face particular deprivation. For example, the incomes of pensioner households are considerably below the borough average and pensioners make up 25% of social housing households, despite comprising just 9% of the overall population.

This is significant for this strategy, because there are strong links between deprivation on the one hand, and physical and mental ill-health on the other hand. Indeed deprivation among older people and the resultant social exclusion can in itself be a causal factor leading to loss of independence, reduced quality of life and admission to institutional care, causing increased pressure on our services⁴

However, there are also relatively high numbers of more affluent older people in the borough (over one third are owner-occupiers with no mortgage) but this too brings challenges for our services. While many of these people will fund their own support services, there is growing concern⁵ that self funders do not receive adequate information to make informed choices and therefore do not always secure the most appropriate support or best value from services. There is therefore a growing role for the Council to provide more and better information and advice.

3.3 Dementia

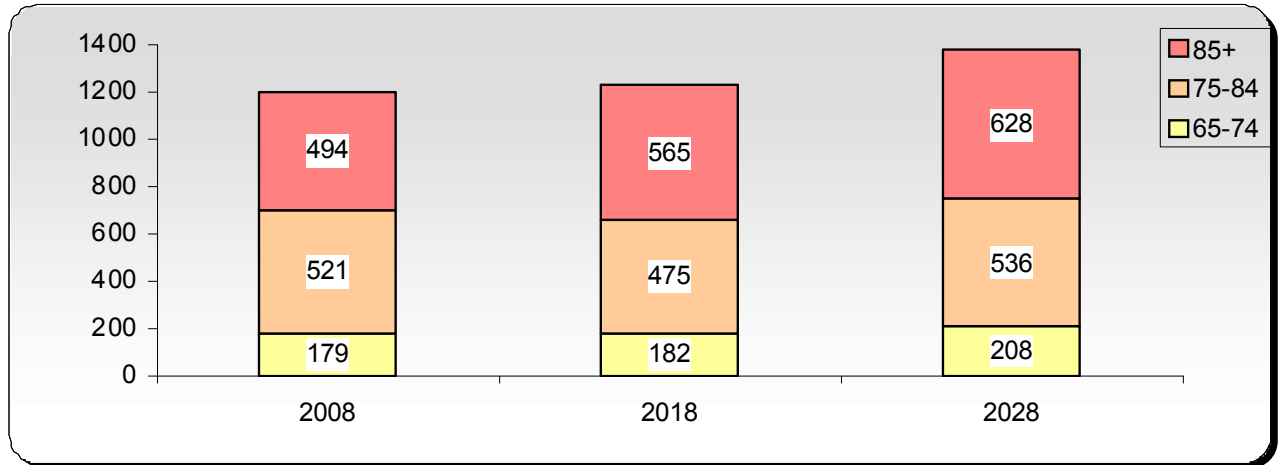
The term 'dementia' is used to describe a syndrome which may be caused by a number of illnesses, in which there is progressive decline in multiple areas of function. This includes decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, people may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which cause problems in themselves, which complicate care, and which can occur at any stage of the illness.

The chart below shows the projected prevalence rates for dementia among people aged over 65 in Islington. This indicates there will be a 2% overall increase between 2008 and 2018, but a 15% increase between 2008 and 2028.

However, the expected rate of increase in the number of people with dementia, who are aged over 85 is faster, increasing by roughly 14% over the next ten years and 27% over the next twenty years. Among people aged 90 or over the increase is expected to be even greater.

Given these rates, the increase in the number of older people with dementia in the Islington population would be 28 more people by 2018, and 150 more people by 2028.⁶

Figure 3: Islington estimates of prevalence of late onset dementia, ages 65+



Source: Dementia UK and POPPI data – adjusted for GLA Low population projections for Islington

These figures may be higher if an allowance is made for higher rates of deprivation.⁷ It is also noted that higher prevalence rates of dementia have been found among African Caribbean older people and this may be linked to untreated hypertension.⁸ Additionally dementia is not necessarily recognised among minority ethnic communities and research has shown that in general minority ethnic groups are at far more risk of misdiagnosis and delayed treatment than other older mental health users.⁹

YOUNGER PEOPLE WITH DEMENTIA

The figures above are for people aged over 65. While dementia is relatively rare among younger people, locally there may be in the region of 140 people aged under 65. However, significantly fewer people have been identified through local primary care registers, or have been referred to specialist neurological services. This is likely to be due to poor diagnosis: there are different patterns of dementia among younger people¹ and a need to recognise unusual dementias and types that may not present with memory loss.

¹ For example Alzheimer's disease only represents one third of dementias among younger people, but is the main form of dementia among older people

IMPLICATIONS

The prevalence of dementia carries significant implications for local services.

- It is one of the most severe and devastating illnesses we face and has profound, negative effects on family carers, who are often old and frail themselves and as a result suffer high levels of care burden, depression, physical illness and loss of quality of life.¹⁰ It is estimated that for every 100 people with dementia, there will be an average of 85 family carers.¹¹
- Alongside this, the costs of supporting people with dementia are high: it has been estimated nationally that these costs are greater than the costs of heart disease, cancer and stroke combined.

3.4 Depression

After the age of 65 there is an increasing risk of major life events associated with depression. These include loss of employment, loss of an intimate person (such as a spouse), changing social environments (such as retirement or a move), increasing risk of social isolation, and changes in health status.

It is estimated that approximately 15% of older adults may be depressed at any one time¹² and there are indications that rates of depression are increasing, so the actual numbers may be much greater¹³. It is also estimated that:

- About one third of older people routinely attending GPs are depressed
- Of depressed older people at home, about one third have moderately severe depression
- About 25% of older people in general hospital are clinically depressed
- 30-40% of older people in residential or nursing care show signs of clinical depression
- Between 26-44% of older people receiving local authority care at home are depressed. ¹⁴

There is contradictory evidence about depression among older people from minority ethnic communities. Some studies show no difference between communities, while other studies have found a slightly higher prevalence among ethnic minority communities. Some research suggests that older people from minority communities may be particularly vulnerable to depression because of risk factors associated with socio-economic deprivation, immigrant status and old age. Research also suggests that many older people from minority ethnic communities feel isolated and that this sometimes leads to high levels of depression.¹⁵

The prevalence of depression carries a wide range of implications, for example

- Depression is more common among people with long-term medical conditions and can worsen outcomes in a range of physical disorders, potentially significantly reducing people's ability to cope with physical ailments ^{16 17}
- The cost of people using health and social care services is almost 1.5 fold higher for older adults with depression, compared with their younger counterparts¹⁸
- There is a high incidence of depression among carers of older people with dementia with up to one third of carers being affected¹⁹ and this together with the related stresses of caring can be a key factor in 'carer breakdown' and subsequent admission of people to care homes
- It is the leading cause of suicide among older people

3.5 Anxiety

Anxiety is closely linked to depression in later life and is an under-researched area. The different types include generalised anxiety disorder, panic, phobias and obsessive-compulsive disorder. Symptoms include worry, apprehension, panic attacks, irritability, restlessness, difficulty concentrating, muscle tension and sleep disturbance.

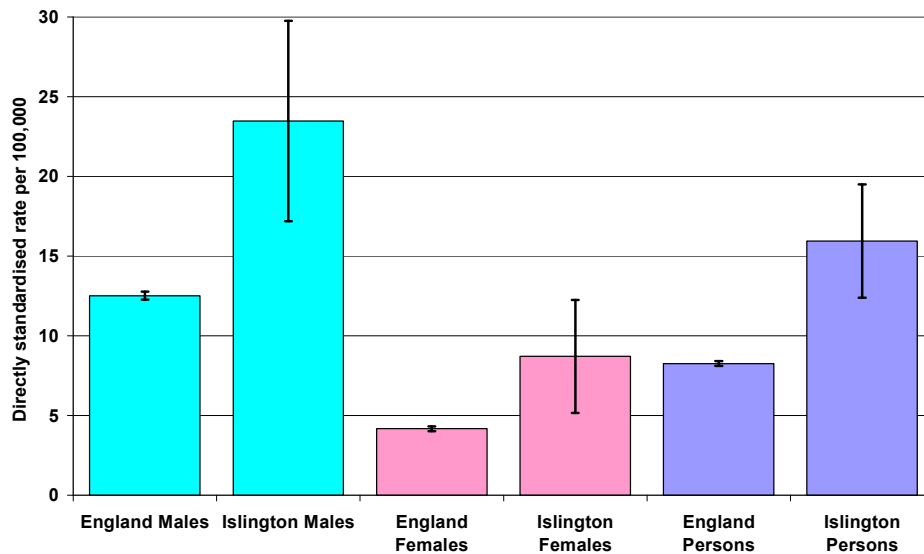
- Between 2% and 4% per cent of older people living in the community meet the clinical criteria for a formal diagnosis of anxiety.²⁰
- Between 10 and 24 per cent of people aged 65 and over living in the community have symptoms.²¹

Anxiety is more common in women than in men. Most older people suffering from anxiety developed it when they were younger and have grown older with it. Few studies have examined the impact of later life anxiety on individuals and their families, the extent of unmet need, or the economic costs.

3.6 Suicide

Nationally in 2006 the suicide rate in England fell to the lowest figure since records began in 1861, with a rate of 7.84 per 100,000. However in the same year, the rate in Islington was much higher – a rate of 14.01 per 100,000 across all age groups.

Figure 4. Deaths due to suicide or undetermined injury, Directly standardised rate per 100,000, 95% confidence intervals, Islington and England, 2004-06.



Local analysis shows that no one group or location can account for the borough's comparatively high suicide rates. However:

- Local audits covering 2000-07 found that men and women from the Irish community are at increased risk of suicide.
- A third of suicides and undetermined injuries were recorded as drug-related during the period 2005-07.
- Depression is a major cause of suicide in older adults²² and nearly half of older people who take their own lives visit their GP in the month before suicide.²³

Suicide in later life is marked by distinct characteristics, in particular

- Older people make fewer suicide attempts than younger people, but are more successful at taking their own lives. One in four attempts by older people results in 'completed suicide', compared with one in 15 attempts for the general population.²⁴
- Older people who take their own lives are more likely than younger people to have seen their GP in the previous six months, and more likely to present symptoms of physical health problems, while younger people were more likely to present symptoms of mental health problems.²⁵

3.7 Delirium (acute confusion)

Delirium, or acute confusion, is marked by sudden onset of confusion, disorientation, memory impairment, agitation and even delusions and hallucinations. The causes are almost always physical in nature, including

infection and dehydration. Prevalence increases rapidly with age. Delirium affects between one and two per cent of people aged 65 and over living in the community and up to 14 per cent of people aged 85 and over.

- Delirium is very common in care settings. Most research has been done on delirium in acute hospitals and half of delirium cases in older people develop after admission to general hospital. The economic costs of delirium are very high. On average it doubles the length of hospital stay and older people who experience delirium are less likely to recover from illness and more likely to enter care homes.²⁶

3.8 Schizophrenia & other severe mental health problems

Schizophrenia, bipolar disorder and other severe mental health problems in later life are an under-researched area. Relatively few older people suffer from these conditions, but those who are affected in later life have very complex needs. People who have grown older with schizophrenia may be 'graduates' of asylums or long-stay mental hospitals, and now living in specialist care homes. They may suffer from side effects of long-term use of anti-psychotic drugs.

- The prevalence of schizophrenia and bipolar disorder does not appear to increase with age. About one per cent of people aged 65 and over in the community have psychotic disorders. About 0.5 per cent have schizophrenia.²⁷

3.9 The relationship between physical and mental health

As indicated above, depression is both more common among people with long-term medical conditions and can worsen outcomes in a range of physical disorders. There is, for example, strong evidence of the link between depression and coronary heart disease and stroke, and increasing evidence pointing to the impact upon immune functioning.²⁸

Studies have also demonstrated the link between mental ill-health and neglect of physical health, as well as the striking difference that can be made to a person's mental health and quality of life by paying closer attention to physical health. This can include steps that are as simple as ensuring people have the right glasses and hearing aids.²⁹

4. The case for change, our strategy and objectives

4.1 The case for change

While Islington has a younger population than many areas of the country and the current rate of growth in the number of older people is lower than most areas of England, we cannot afford to marginalise the needs of older people with mental health problems. There are important reasons for this:

- ***First, mental ill-health in older age can have devastating impacts.*** Dementia, for example, is one of the most severe and devastating illnesses we face and it also has profound and negative effects on the health and well-being of family carers. Carers are often old and frail themselves and as a result suffer high levels of care burden, depression, physical illness and loss of quality of life.
- ***Second, these devastating impacts have very large financial implications for health and social care services.*** National cost of illness studies have shown that the direct costs of Alzheimer's disease alone exceed the total cost of stroke, cancer and heart disease. We need to ensure we meet people's needs in the most cost effective way and national studies and our local analysis of services, which is discussed below, provide growing evidence that this is not currently the case.
- ***Third, it is recognised across the country that mental health in older age has been neglected for too long.*** While we have some excellent services locally, overall we too recognise that there is real room for improvement. There is an opportunity for us to build on the growing national momentum for change to make real and long term improvements locally.
- ***Fourth, while the total number of people aged over 65 in Islington will not increase over the next ten years, there will be an increase in the number of people aged over 85.*** This group is often especially frail and vulnerable, suffering disproportionately from mental ill-health – in particular the incidence of dementia rises dramatically over the age of 80. As the level of need among this group increases, it is therefore especially important to make sure we are able to meet their needs effectively.
- ***Fifth, we have a window of opportunity to strengthen our services before the numbers of older people begin to increase significantly.*** In particular we have an opportunity to develop our preventative and early intervention services to reduce longer term dependence on costly services.

- ***Sixth, the needs of older people with mental health problems directly relate to, and impact on, other local and national priorities.*** For example
 - Older people with mental health problems may be especially vulnerable as a result of admission to general hospital and tend to have significantly longer stays. Difficulties meeting their needs account for a large proportion of delayed transfers of care.
 - Depression among older people accounts for a significant proportion of visits to G.P.s
 - Depression is more common among people with long-term medical conditions and can worsen outcomes in a range of physical disorders, potentially significantly reducing people's ability to cope with physical ailments.
 - The cost of people using health and social care services is almost 1.5 fold higher for older adults with depression.
 - There is a high incidence of depression among carers of older people with dementia with up to one third of carers being affected. Together with the related stresses of caring, this can be a key factor in subsequent admission of people to care homes

Many of the above arguments for change apply to younger people with dementia, but great care needs to be taken not to marginalise their specific needs. The burden of the illness differs, often bringing different problems associated with employment for carers, finances, the impact on children, comparative physical robustness and high levels of behavioural disturbance. There is growing evidence that they are at particular risk of misdiagnosis and delayed treatment and services that have been designed for people who are 30 or 40 years older, often struggle to meet younger people's needs effectively.

4.2 Refocusing our services

People may need to access a wide range of health and social care services. Some are 'mainstream services', which are used by a wide range of older people, others are specialist older people's mental health services. **Appendix 2** describes these in greater detail.

The overall case for change, which has been set out above, is supported by our analysis of these services, which highlights on the one hand the substantial investment – and money tied up - in institutional care, but and on the other hand relatively low levels of investment in community based services.

Investments in care homes, hospital lengths of stay & delayed transfers of care

- There are issues about the way care home placements are classified, but a significant proportion of our overall budget is spent on residential and nursing care.³⁰ However, despite this, there remain real difficulties finding sufficient placements. Work is planned to establish the extent to which money that is spent on residential and nursing care could be spent differently and better on community based services.
- Older people with a primary diagnosis of dementia stay in general hospital on average over 9 times longer than the average for all people aged 65 and over (64.77 days compared to 6.95])
- Older people who are admitted with a secondary diagnosis of mental health stay in general hospital on average over 4.5 times longer than the average for all people aged 65 and over (31.72 days compared to 6.95)
- People with dementia account for a large proportion of delayed transfers of care from general hospital (primarily people awaiting placements in care homes)
- During the first 36 weeks of 2008, there were on average 6 delayed transfers of care each week from 28 specialist mental health in-patient beds for older people. This equates to around 21% of the available beds. Alongside this, there were no significant waiting lists for admission to these wards, which indicate oversupply and opportunities to use some beds differently.

Against these large investments and pressures in some institutionally based services, the scope to develop community based services is widely recognised.

- There are real opportunities to strengthen early diagnosis and early intervention services, which evidence shows can reduce total care expenditure through delaying the time to care home admission and other costly institutionally based outcomes³¹
- People recognise the scope to develop a range of community based and intermediate care services - especially for people with dementia - to prevent admissions and re-admissions to institutional care, to reduce lengths of stay in hospital settings and to help people to return home if they are admitted to care.

4.3 Strategy

Our strategy is therefore to deliver better outcomes through re-focusing our services away from institutional care, towards community based services, early intervention and prevention.

STRATEGY: Re-focusing our services

REDUCING:

- Admissions to residential & nursing care homes and in-patient continuing care beds →
- Admissions to hospital care →
- Lengths of stay in general & specialist hospital care →
- Delayed transfers of care →

(RE)INVESTING IN:

- Prevention and early intervention
- Information, advice and ease of access to services
- Community based support
- Improved and more effective care in hospital and in care homes
- Joining up services and developing the workforce

4.4 Objectives

To achieve this, we need to focus on the following objectives:

4.1.1 PROMOTING PREVENTION AND EARLY INTERVENTION

- **Promoting good mental health**, so that people stay as healthy and as independent as possible
- **Raising awareness among the public and professionals**, so that
 - Stigma, social exclusion and discrimination are minimised
 - There is a greater emphasis on preventing mental ill-health in older age
 - People know about the benefits of timely diagnosis and care and seek help earlier
- **Ensuring good quality early diagnosis and intervention**, so that people receive
 - A rapid and competent specialist assessment
 - An accurate diagnosis, that is sensitively communicated to them and their carers
 - The treatment, care and support they need following diagnosis

4.1.2 IMPROVING INFORMATION ADVICE AND EASE OF ACCESS TO SERVICES

- **Improving information and advice**, so that people receive information about their illness and the services available, at diagnosis and throughout the course of their care
- **Improving access to – and the continuity of - care, support and advice.** For people with dementia and their carers, in time this will include access to
 - A dementia adviser to help them access appropriate care, support and advice
 - Structured peer support and learning networks

4.1.3 STRENGTHENING COMMUNITY BASED SUPPORT

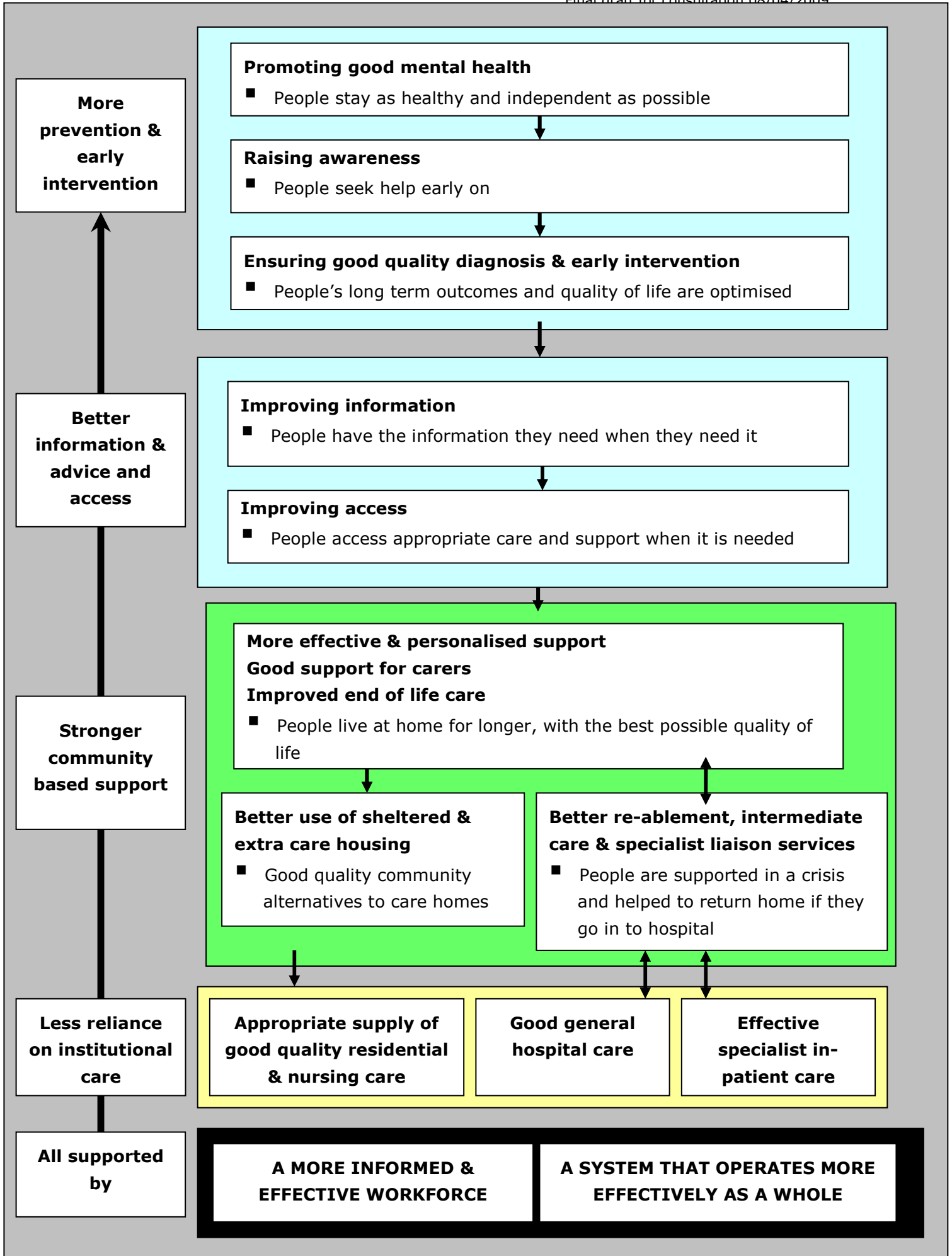
- **Providing more effective and personalised support in the community** so that more people can carry on living at home, for longer, and with the best possible quality of life.
- **Ensuring good support for carers**, including good quality, personalised breaks
- **Improving end of life care**, ensuring it is delivered in a way that involves people and their carers in planning their end of life care and that meets nationally agreed standards
- **Improving intermediate care services** so that people are
 - Better supported in a crisis
 - Helped to return home, whenever possible, if they are admitted to hospital
- **Making better and greater use of sheltered housing & extra care housing** so that people have access to good quality community based alternatives to moving into a care home

4.1.4 IMPROVING INSTITUTIONAL CARE BUT RELYING ON IT LESS

- **Ensuring an appropriate supply of good quality residential & nursing care placements**
- **Improving care in general hospitals and strengthening the pathways both in and out of hospital care**
- **Ensuring effective specialist in-patient care**
- **Strengthening the specialist mental health liaison service**

4.1.5 JOINING UP SERVICES AND DEVELOPING THE WORKFORCE

- **Making sure the system of services operates more effectively as a whole**, so that people's care and support is delivered in a timely, co-ordinated & effective way
- **Developing a more informed and effective workforce**, so that staff across the whole system of services - whether they are specialist mental health professionals or not - are better equipped to support people



5. Making it happen

5.1 Promoting good mental health

Objective 1. To promote good mental health, so that

- People stay as healthy and independent as possible

A range of risk factors are associated with mental ill-health in older age, including increased risk of dementia associated with poor vascular health³², smoking, excessive alcohol consumption, obesity, diabetes, hypertension and raised cholesterol. NHS Islington has put in place a series of strategies to reduce these risks, including for example its strategy for improving cardiovascular health.³³

Islington is also addressing the social determinants of mental health through its strategies to promote good mental health³⁴ and to improve the quality of life among older people.³⁵

The continuing implementation and development of these strategies will play an important part of our longer term approach to improving people's health and quality of life and thereby reducing longer term reliance on more intensive support.

Priorities

- **To continue to implement & develop health promotion strategies** focused on people in middle and older age, making sure in particular that we address the known risk factors associated with dementia, such as vascular health.

As a part of this, we need to place particular emphasis on prevention related work associated with hypertension among African Caribbean older people.

We also need to build prevention related messages into public and professional information campaigns designed to raise awareness (see 5.2 below)
- **To continue to implement & develop health promotion strategies** focused on people in middle and older age, making sure in particular that we address the known risk factors associated with dementia

As a part of this, we also need to also place an emphasis on prevention related work associated with hypertension among African Caribbean older people
- **To develop our quality of life strategy for older people** with an emphasis on reducing social exclusion and social isolation and on optimising older people's health and well-being

5.2 Raising awareness

Objective 2. To raise awareness among the public and professionals, so that

- Stigma, social exclusion and discrimination are minimised
- There is a greater emphasis on preventing mental ill-health in older age
- People know about the benefits of timely diagnosis and care and seek help earlier

We need to raise awareness among the public and professionals about mental health in older age. This is important because lack of awareness in itself can lead to greater dependence and more costly outcomes for health and social care services. For example:

- Despite depression being common among older people, it is often ignored. However, if it is not treated it can lead to a life of misery, cause other illnesses or make other conditions worse and it can create greater dependency on health and social care services. In more extreme cases, it can lead to suicide.
- There is a generally low level of understanding about dementia among the public and non specialist professionals. This causes stigma, a widespread mistaken attribution of the symptoms to old age, and a false belief that little can be done to assist people and their carers. This in turn leads to an unwillingness to seek or offer help, despite – as highlighted below – good evidence that early diagnosis and early intervention can significantly improve people's quality of life and independence.

Priorities

- **To develop a local approach to raising awareness that supports and builds on national awareness raising campaigns,** such as
 - Age Concern's campaign, **'Down, but not out'** which aims to improve the quality of life for older people with depression
 - National campaigns that arise from the **National Dementia Strategy**

Raising awareness about dementia is a priority in the National Dementia Strategy.³⁶ The strategy provides guidance on approaches and content and emphasises, for example, the need for a strong prevention message and the need to encourage people to seek help early (or, in the case of professionals, to offer help early). The guidance in the national strategy will inform our local approach.

We will also firmly embed awareness raising into workforce training programmes (see below)

5.3 Good quality early diagnosis and early intervention

Objective 3. To ensure good quality early diagnosis and intervention, so that people receive

- A rapid and competent specialist assessment
- An accurate diagnosis, that is sensitively communicated to them and their carers
- The treatment, care and support they need following diagnosis

DEMENTIA

Early diagnosis and early intervention of dementia is a national priority³⁷ Although diagnosis rates appear to be higher locally than in many parts of the country, there remains real scope to diagnose people earlier, to intervene earlier and to provide better information, advice, support and care in a way that then promotes people's longer term independence. This includes the need for better diagnosis and early intervention for people with early onset dementia.

This is especially significant because evidence tells us that early diagnosis of dementia and early intervention can significantly help to minimise deterioration in a person's condition and circumstances and to improve their quality of life. In turn this reduces the risks of unnecessary use of hospital beds and care home placements.³⁸ This is because early diagnosis

- Helps people to plan their future, while they are still able to do so
- Means that further help and advice can be offered at a time when people can most benefit from it
- Allows treatment to be provided earlier and support networks to be built up and maintained

Conversely, making a diagnosis at a time of crisis (for example when a person is admitted in an emergency to hospital), or when the disease is more advanced is likely to lead to a potentially false assumption that residential care is the only realistic option.

Camden and Islington NHS Foundation Trust has therefore been allocated further funding by NHS Islington to develop a Memory Assessment Service, which will act as a single point of access for diagnosis, treatment and review. It will focus on making the diagnosis well, breaking the diagnosis well to the person with dementia and their family and on providing directly appropriate treatment, information, care and support after diagnosis. The service will not replace the work currently completed by old age psychiatry, geriatrics, neurology or primary care, but will be complementary to their work

Work is under way to determine how the new service will work with the Cognitive Disorders Service at the National Hospital for Neurology and Neurosurgery (NHNN) in order to diagnose, treat and support people with atypical dementias and people with early onset dementia.

While this service will require initial investment, there is evidence that once established, such services can release substantial funds back into the health and social care system³⁹

Priorities

- **To develop the new Memory Assessment Service**, making sure:
 - Primary care services work closely with the new service so that referrals are made promptly and so that subsequent support and treatment is well co-ordinated.
 - The community mental health team for older people and mainstream care management services have the capacity to respond to the changes in demand for their input that will arise as a result of early diagnosis
 - There is an effective care pathway for people with atypical dementias and people with early onset dementia, through close joint working with the Cognitive Disorders Service at the NHNN.
 - Careful attention is paid by all to diagnosis and treatment among older people from minority ethnic communities and people with learning disabilities, both of whom are groups that research has highlighted face particular problems obtaining diagnosis and treatment.

The Memory Assessment Service needs to have sufficient capacity to see all new cases in Islington and as the new service develops capacity will therefore be kept under review.

The development of the service – and the way it works with others, including primary care, social care and voluntary agencies – will also be informed by planned work to review care pathways (see 5.15 below).

DIAGNOSIS OF DEPRESSION & EARLY INTERVENTION

Improvements are also planned in the early diagnosis and treatment of other forms of mental ill-health, including depression. In particular, NHS Islington is significantly improving the access people have to a range of psychological therapies.

Priorities

- **To continue to improve the way we diagnose and treat depression**, with a particular emphasis on depression among
 - Carers, and especially carers of people with dementia
 - People with long term medical conditions
 - People in hospital, in care homes and receiving local authority care at home
 - People from ethnic minority communities
 - People who are isolated and who suffer from socio-economic deprivation

Part of Islington's wider programme for improving access to psychological therapies, includes a dedicated worker to improve access for older people and the success of this will be monitored and kept under review.

5.4 Information, advice and access to services

Objective 4. To improve information and advice, so that

- People receive information about their illness and the services available, at diagnosis and throughout the course of their care.

Objective 5. To improve access to – and the continuity of - care, support and advice. In time, for people with dementia and their carers, this will include access to

- A dementia adviser to help them access appropriate care, support and advice
- Structured peer support and learning networks

INFORMATION FOR PEOPLE WITH DEMENTIA AND THEIR CARERS

The importance of good-quality information, given in such a way as to be accessible to patients and carers in enabling them to direct their own care, is clear and plays a critical part in promoting well-being and independence.

Information about dementia will be developed nationally as a part of the National Dementia Strategy and will include information on the nature of the condition. This will then be adapted locally to describe the treatment and the support available. Different materials may be needed as the disease progresses and to cover the evolution and management of different symptoms and situations.

Information should also be available on what options exist for planning ahead for those diagnosed with dementia, to ensure that their desires and wishes are

properly considered were they to lose mental capacity. For example, by making a Lasting Power of Attorney and registering it with the Office of the Public Guardian. Versions will also be needed to work across the diverse populations affected by dementia (for example, different language groups, minority ethnic groups, people with learning disabilities and people with early-onset dementia).

Priorities

- **To improve the information and advice people receive** about dementia. This will include
 - Building on nationally produced information, adapting it for local circumstances
 - Ensuring appropriate versions are available for different groups and needs
 - Agreeing arrangements for dissemination across local services and monitoring these
 - Making sure that information is accessible for all, including those who fund their own social care

IMPROVING ACCESS: DEMENTIA ADVISORS

One of the most clear and consistent messages emerging from discussions with people with dementia and their carers has been the desire for there to be someone who they can approach for help and advice at any stage of the illness – 'someone to be with us on the journey'. The National Dementia Strategy has therefore proposed the creation of "dementia advisors"

This is a new role and national demonstrator projects are proposed. Following these, Islington will commission a local dementia adviser service to provide a point of contact for all those with dementia and their carers, who can provide information and advice about dementia, and on an ongoing basis help to signpost people to additional help and support.

Priorities

- **To develop a service model for a local dementia advisor service.**

STRUCTURED PEER SUPPORT AND LEARNING NETWORKS

People with dementia and their carers draw significant benefit from being able to talk to other people living with dementia and their carers, to exchange practical advice and emotional support.

Peer support and learning networks can provide practical and emotional support, reduce social isolation and promote self-care, while also providing a source of information about local needs to inform commissioning decisions. In structured models of peer support, it is also possible to incorporate advice and support from health and social care professionals in an effective and efficient manner.

Structured models of peer support exist in some parts of the country, with examples such as carer support groups and dementia cafés. However, they often cater for only a very small proportion of those who might benefit from them. The National Dementia Strategy proposes a programme to investigate and analyse current practice and from this to develop and evaluate models.

To help patients develop the confidence, skills and knowledge to manage their condition better and be more in control of their lives, we will also look to extend the "expert patient" and "expert carer" programmes

Priorities

- **To develop models for structured peer support networks**

We envisage that the planned improvements in information, the development of a dementia advisor service and the creation of peer support networks will lead to a larger role for the voluntary sector and that this will involve working closely with statutory sector services, including the Memory Assessment Service, Care Managers and the Older People's Community Mental Health Team.

5.5 Personalised community support

Objective 6. To provide more effective and personalised support in the community, so that

- More people can carry on living at home, for longer, and with the best possible quality of life.

A range of developments is planned, or in hand, to improve the quality and responsiveness of community based social care services, and these are being addressed through other related strategies:

- **Home care services** have recently been reviewed and a significant proportion of these services have been re-tendered. There is a clear expectation that these services will - without exception - cater for a broad spectrum of needs, including those of older people with mental health needs

and their carers. Alongside this, Islington's specialist home care service will continue to work with people with especially complex and challenging needs.

- **'Assistive technologies'** can play a significant role in supporting some people at home, ranging from a simple community alarm system like Linkline, to sophisticated monitoring and sensing devices using wireless and electronic technology. The Council and NHS Islington remain committed to developing its role in supporting people at home, in line with the Assistive Technology Strategy.⁴⁰

This will include maintaining a 'watching brief' over the emerging evidence about ways in which assistive technology and telecare support the needs of people with dementia and their carers. This is to enable implementation once effectiveness has been demonstrated.

PERSONALISING SOCIAL CARE SERVICES

Most significantly, however, over the coming years will be the way Islington carries forward work to 'personalise' its social care services. This is as a part of the national "Transforming Social Care" programme, which aims to make services much more tailored to the needs and preferences of citizens, giving people who are eligible for social care services much more choice and control about the support they receive.

This work is at an early stage, but over the coming year we will engage further with service users and their carers to better understand how service can be more responsive. There is likely to be an emphasis on:

- Support in the home that is flexible and not determined by rigid time slots that prevent staff from working alongside people, rather than doing things for them
- Continuity of care from staff who know the person and their carers and who are trained to work with people with dementia and other forms of mental ill-health
- Access to more personalised social activity, short breaks and day services

Community support services need to work with the diverse groups of people and personalisation will allow for greater responsiveness in the way we meet people's specific needs, including, for example, the way we address the needs of people with early onset dementia who may have needs which services designed for people 30 or 40 years older find hard to meet.

In carrying this work forward we will identify the most effective ways to support people who fund their own social care or who are eligible for state support and want to use 'personal budgets' to purchase their own care and support.

This work will also be supported by our planned programme of training for staff (see below).

Priorities

- **To continue to develop community support services with an emphasis on**
 - Developing the responsiveness of home care services
 - Developing the use of assistive technologies as evidence emerges about its effectiveness
 - Personalising social care services, and as a part of this identifying ways of supporting people who fund their own care or want to use 'personal budgets' to purchase their own services

5.6 Supporting carers

Objective 7. To ensure good support for carers, including

- Good quality personalised breaks

Family carers are the most important resource for many people, helping people to remain at home, rather than moving into residential or nursing care. A range of developments highlighted elsewhere are intended to improve the way we support carers in their vital role. These include

- Improvements in information and advice
- The proposed development of a dementia adviser service
- The proposed development of peer support networks and expert patient and carer programmes
- The development of more personalised community based social care services
- Better training for staff

Islington's Strategy for Carers⁴¹ sets out the wider range of support the Council and NHS Islington provide for carers and the way this will be developed over coming years. This includes developments in relation to short breaks following our earlier review of respite care for older people.

It is likely that the personalisation of social care services will, over time, lead to more flexible short breaks that provide valued and enjoyable experiences for people with mental ill-health as well as their family carers

Priorities

- **To continue to improve the way we support carers**, including an emphasis on ensuring people can access good quality personalised breaks

5.7 End of life care

Objective 8. To improve end of life care, ensuring it is delivered in a way that

- Involves people and their carers in planning their end of life care
- Meets nationally agreed standards

The National Dementia strategy emphasises the need for end of life planning needs to take place early, while someone has sufficient mental capacity and where decisions and preferences can be recorded consistent with the principles set out in the Mental Capacity Act. It also emphasises the need for end of life care to be provided across a range of settings, the need for a standards based approach and the need for better pain relief and nursing support.

Islington's End of Life Care Strategy⁴² sets out an improvement programme based on tendering for a community based end of life care service, introducing "the Gold Standards Framework" (which provides a standards based framework for improving services), the development of advanced care plans and specific work to strengthen the quality of end of life care in local care homes. It recognises the particular needs of people with dementia

Priorities

- **To ensure the specific needs of older people with mental health problems – including dementia - are addressed as Islington's end of life Care Strategy is implemented**

5.8 Re-ablement and intermediate care services

Objective 9. To improve intermediate care services so that people are

- Better supported in a crisis
- Helped to return home, whenever possible, if they are admitted to hospital

Particular challenges arise in terms of helping people to remain at home when there is a crisis, or to return home if people are admitted to hospital care. There is, for example, national evidence that pressure to reduce lengths of stay in acute care, combined with risk-averse discharge planning and poor access to intermediate care services can mean that people with dementia are rushed into long-term residential care prematurely.⁴³

There is, however, good clinical evidence⁴⁴ that people with mild or moderate dementia with physical rehabilitation needs do well if given the opportunity. People with severe dementia may need more specialist services geared to meeting their mental health needs as well as those providing general physical rehabilitation. Staff working in intermediate care, like any other staff group, need to have core training in dementia and access to advice and support from specialist mental health personnel to help them ensure that older people with mental health needs are able to benefit from rehabilitation and re-ablement opportunities.

Islington currently has a range of intermediate care services and has developed a new re-ablement service, but these services need to be more accessible and effective for older people with mental health needs. Given the high number of delayed discharges and the high level of expenditure on institutional care locally, this is especially critical to our overall strategy of refocusing services

Options are currently being considered, in particular the way existing services can be made more responsive and the way these services can work more effectively with the existing specialist in-house home care service, the community mental health team for older people and Camden Mews day hospital. This will also be supported by the planned development of a specialist liaison service, which is discussed further below.

Priorities

- **To develop intermediate & interim care services**, with a particular focus on
 - Preventing avoidable admissions to general hospital care and specialist in patient care

- Reducing lengths of stay in hospital settings
- Ensuring timely and successful transfers of care back to people's homes and reducing admissions to care homes

5.9 Sheltered housing and extra care housing

Objective 10. To make better and greater use of sheltered housing & extra care housing, so that

- People have access to good quality community based alternatives to moving into a care home

There is a growing body of evidence about the ways in which sheltered housing and extra care housing can be best used to support older people with mental health needs.⁴⁵ Locally, while there has been a degree of success for the majority of older people with mental health needs who live in extra care sheltered housing, there is a recognised need to improve the capacity and capability of services to meet people's needs. To achieve this a joint approach across health, housing and social care is required.

Locally, a review of supported housing for older people is currently underway. Overall, this has highlighted under occupancy of extra care sheltered housing schemes and a wide range of improvement opportunities. A more strategic approach to meeting the needs of older people with mental health problems is now required, across both sheltered and extra care sheltered housing.

Priorities

- **To complete the current review of supported housing services for older people** to identify ways in which they can better realise their potential for older people with mental health needs

5.10 Residential and nursing care

Objective 11. To ensure an appropriate supply of good quality residential & nursing care placements

As indicated previously, there is considerable investment in residential and nursing care home placements and yet finding sufficient placements remains an

ongoing struggle, which causes significant delays in transfers of care from hospital settings.

Given our overall strategy to reduce admissions to care homes, more sophisticated modelling work is now required to better understand the likely future level of need for these services and related services, including extra care housing and specialist in-patient services.

Priorities
<ul style="list-style-type: none">▪ To carry out further work to better understand the reasons people are admitted to care homes and ways in which we can further reduce admissions. From this we will develop a demand forecast to better inform future commissioning arrangements.

QUALITY OF CARE

In relation to people with dementia, the National Dementia strategy has emphasised a series of characteristics associated with good care. These include

- Clear leadership, staff management and staff training and development
- A focus on person-centred care planning
- Purposeful activities related to individual's preferences, rather than general entertainment
- Active involvement of relatives and friends in the care of residents
- Therapeutic activities, such as art therapy and music therapy
- Strong links with and involvement in local communities
- The quality of staff communication with people with dementia
- A growing interest in life story work, which provides an effective way for care home staff to communicate and develop relationships with residents.

It highlights the need to

- Identify a senior member of staff in homes to lead improvements
- Develop a local improvement strategy
- Make sure anti-psychotic medication is used appropriately
- Commissioning specialist in-reach services from older people's community mental health teams to work in care homes.
- Specify and commission other in-reach services such as primary care, pharmacy, dentistry etc

Locally a range of work in these areas is already happening through the care home groups (including, for example, the commissioning of a reminiscence project). In addition, as discussed below, an extended liaison service is being commissioned. This is likely to play an important part in improving the quality of care in care homes, including an emphasis on minimising the use of anti-psychotic medication.

Priorities

- **To continue to improve the quality of care in care homes, in particular through**
 - The work of the residential and nursing care home provider forums
 - Commissioning specialist in-reach/liaison services

5.11 Hospital care

Objective 12. To improve care in general hospitals and to strengthen the pathways both in and out of hospital care

Objective 13. To ensure effective specialist in-patient care

Older people with mental health problems in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation. A range of factors contribute to this, for example:

- Cluttered ward layouts, poor signage and other hazards make the environment especially challenging
- Patients may not be known to specialist mental health services and their condition remains undiagnosed.
- Poor care can lead to malnutrition and dehydration
- There can be marked deficits in the knowledge and skills of general hospital staff and often insufficient information is sought from relatives and carers. This means that person-centred care is not delivered and it can lead to under-recognition of delirium and dementia.
- There can be a lack of co-ordination between hospitals and care providers at the point of discharge, with delay in access to care packages that might enable successful discharge.

Developments in relation to intermediate care, specialist liaison services and improved pathways - which are discussed elsewhere - will help us to:

- Prevent avoidable admissions to general hospital care and specialist in patient care
- Reduce lengths of stay in hospital settings
- Ensure timely and successful transfers of care back to people's homes and reducing admissions to care homes

To support this we also plan to use some existing acute specialist in-patient beds as re-enablement care beds. These will be used when people no longer need acute specialist beds, but are not quite ready to return home; this will help us to better manage discharges and the associated pressures that can lead to avoidable admissions to care homes.

We also wish to strengthen the quality of care in hospital settings by identifying senior clinicians within general hospitals to take the lead for quality improvement for older people with mental health needs.

Priorities
<ul style="list-style-type: none">■ To re-designate some in-patient beds on specialist mental health acute wards at the Highgate Centre as re-enablement care beds
<ul style="list-style-type: none">■ To identify senior clinicians within general hospitals who will take the lead for improving care in hospitals. As a part of this we will especially involve work with them when<ul style="list-style-type: none">- Designing care pathways in and out of hospital care (see 5.13 below)- Developing re-enablement and intermediate care services (see 5.8 above)- Developing specialist liaison services (see 5.12 below)- Designing and implementing workforce development activities (see 5.14 below)

5.12 Specialist liaison service

Specialist liaison older people's mental health teams can provide rapid high-quality specialist assessment and input into care planning for those with possible mental health needs admitted to general hospitals, including input into ongoing care and discharge planning. They can also play a vital role in build skills and improve care throughout the hospital as well as in other parts of the wider system.

Additional funding has also been allocated to expand the role of specialist liaison nurses locally but there is an initial need to determine the most appropriate service model and to determine how the service will work with other parts of the system

Priorities

- **To expand and develop the role of specialist liaison service** to educate and support staff in general hospital settings, in residential and nursing care homes and in extra care housing so they can better meet people's needs

5.13 Joined up care

Objective 14. To make sure the system of services operates more effectively as a whole, so that

- People's care and support is delivered in a timely, co-ordinated & effective way

While there are excellent examples of services working together and staff co-ordinating complex packages of care, overall our services are too fragmented. This is reflected, for example, in the long lengths of stay many people experience in hospital settings and the related delayed transfers of care. A range of other priorities will support improvements, but this needs to be underpinned by the development of a clearer pathway of care.

There is also a need to improve joint working between specialist mental health services for older people and Islington's drug and alcohol services. NHS Islington commissions a range of Drug and Alcohol services to provide advice, information and treatment and there is a need to make sure that they address the needs of older people and can be accessed easily.

Priorities

- **To establish a clearer and shared pathway of care across all services** that sets out how the system operates, people's roles and responsibilities and the intended outcomes for older people and their carers at different stages
 - This will involve stakeholders from across the system of services, including service users and carers. It will be used to specify the elements of the pathway against which services will be procured and performance managed.

5.14 A more informed & effective workforce

Objective 15. To develop a more informed and effective workforce, so that

- Staff across the whole system of services - whether they are specialist mental health professionals or not - are better equipped to support people

This is critical to our strategy because some staff are insufficiently trained or confident to support older people with mental health needs. This creates a range of problems – for example people may have difficulty accessing or benefiting from certain services; they may be inappropriately moved on to a care home or admitted to hospital; they may be passed unnecessarily from one service to another; their ability to remain at home and quality of life is reduced.

Priorities

- ***To develop and implement a systematic, ongoing and targeted programme of learning and development across the whole system*** so that all services – including G.P.s and primary care services, home care services, intermediate care, general hospital care, and supported housing – play a full role in supporting older people with mental health needs.

As a part of this, as well as improving people's understanding of dementia and depression, we need to make sure people

- Are well informed about delirium, its causes and ways of minimising risks
- Pay close attention to people's physical health, not just their mental health - including steps that are as simple as ensuring people have the right glasses and hearing aids

This needs to mesh with nationally proposed developments in relation to dementia training and may include core competencies to train staff who are not professionally qualified or registered. Options relating to the joint commissioning of training with other PCTs and Councils will be evaluated.

An important first step in this will be to launch the strategy and a series of events are being considered including

- Events for different groups of staff
- Dissemination of information to primary care through PBC commissioning localities

5.15 Governance

Objective 16. To strengthen our governance arrangements and the way we involve older people

An Older People's Partnership Board has been established to oversee the way services develop and a sub group of this will oversee the development of this strategy.

As a part of this, we will improve the way we involve older people and their carers in the planning and review of services and the planned peer support network (see 5.4 above) will enable people with dementia and their carers to take an active role in the development and prioritisation of local services.

We will also significantly strengthen the information that we use to monitor and manage services. This work will be informed by national work to improve information, arising from the recent Healthcare Commission report, 'Equality in Later Life'. This includes work on developing meaningful outcome indicators.

Priorities
<ul style="list-style-type: none">■ <i>To significantly improve the way we involve older people and their carers</i> in the planning and delivery of services■ <i>To improve management information,</i> using it to manage the care pathway we develop

6. First steps

This strategy is the start of a process, not an end in itself: re-focusing our services away from institutional care, towards community based services, early intervention and prevention and transforming their quality is a huge challenge for the whole system. This section outlines our initial priorities and first steps.

1. ESTABLISHING THE DELIVERY GROUP

A small delivery group will be formed to oversee the delivery, review and continuing development of the strategy. It will involve those listed in previous sections as leads for particular aspects of work as well a senior clinical input from Camden and Islington NHS Foundation Trust. It will be chaired by Islington's Assistant Director Joint Commissioning.

2. RAISING AWARENESS, BUILDING ALLIANCES AND CREATING A MOMENTUM FOR CHANGE

This will focus on

- Raising public and professional awareness
- Informing people of the benefits of early diagnosis
- Encouraging behaviour change in terms of appropriate help-seeking and help provision.

It will involve

- Engaging with all core service providers from across the system. This will include acute and specialist trusts, primary care staff, major providers from the independent sector (including providers of home care, care homes, sheltered housing, extra care housing), voluntary agencies
- Building collaboration with clinicians and professionals
- Developing capacity with the voluntary sector to develop information and advice and support services, including peer support networks
- Engaging with older people with mental health problems and their families so they can be engaged in the design and delivery of services
- Developing networks for sharing knowledge and expertise

3. REVIEWING AND DEVELOPING PATHWAYS

This is to establish a clearer shared pathway of care across all services. It will set out how the system currently operates and what needs to change, considering people's roles and responsibilities and the intended outcomes for older people and their carers at different stages. This will help to inform the detail of subsequent priority areas, including in particular

- The design of the ***Specialist Liaison Service***
- The design of ***Dementia Advisor Service***
- Ways of developing ***Intermediate Care Services***
- The continued development of the ***Memory Assessment Service***

4. WORKFORCE DEVELOPMENT

Initial work will relate to the identification of workforce development requirements across the system and the design and costing of a strategy to meet these

5. MODELLING AND FURTHER INVESTMENT PLANNING

This will focus on the following inter-related areas:

- Work to better understand the reasons people are admitted to care homes and hence ways in which we can further reduce admissions
- From the above, work to develop a demand forecast for care home placements to (a) inform future commissioning arrangements (b) identify the scope to re-invest projected savings into community based services
- Work to model the impact of individual budgets in order to identify the level and nature of projected change on community based services.

Appendix 1. Policy Context

NATIONAL POLICY DOCUMENTS RELATING TO OLDER PEOPLE'S MENTAL HEALTH

Forget me not (Audit Commission, 2000)

The key findings included only half of GPs believed it important to look actively for signs of dementia and to make an early diagnosis; less than half of GPs felt they had received sufficient training in how to diagnose dementia; poor assessments and treatment, with little joint health and social care planning and working; insufficient supply of specialist home care and lack of information, counselling, advocacy and support for people with dementia and their family/carers. There was very little improvement when reviewing change two years later (Audit Commission, 2002)

National Service Framework for Older People (Department of Health, 2001)

The chapter on mental health advocated early diagnosis and intervention for dementia and recommended that the NHS and local authorities should review arrangements for health promotion, early detection and diagnosis, assessment, care and treatment planning, and access to specialist services. The strategy report notes that a review of the progress of the NSFOP suggests this has had little positive impact on services for people with dementia and their families.

Everybody's business (CSIP, 2005)

This development guide for integrated mental health services for older adults set out the essentials for a service for older people including memory assessment services to enable early diagnosis of dementia and integrated community mental health teams whose role includes management of people with dementia with complex behavioural and psychological symptoms.

NICE/SCIE clinical guidelines on dementia (2006)

The key recommendations from this joint clinical guideline on the management of dementia included: provision of memory assessment services as a point of referral for diagnosis of dementia; integrated working across all agencies; carers support; assessment and treatment of non-cognitive symptoms and behaviour that challenges; dementia care training for all staff working with older people; and, improved care for people with dementia in general hospitals.

NICE clinical guidelines on depression, anxiety and schizophrenia

published clinical guidelines on the management of conditions in adults in primary, secondary and community care.

Promoting mental health and well-being in later life (2006)

This joint report by Age Concern and the Mental Health Foundation arose from shared concerns that mental health in later life is a much neglected area that is often described as falling into the gaps between policies and services for mental health and those for older people. It presents findings and recommendations on promoting mental health and wellbeing in later life.

Improving services and support for older people with mental health problems (2007)

This report from Age Concern sets out to answer how we can improve services and support for older people with mental health problems. The report offers a vision of a society where the needs of older people with mental health problems and the needs of their carers are understood, taken seriously, given their fair share of attention and resources, and met in a way that enables them to lead meaningful and productive lives. It makes 35 recommendations to support this

Dementia UK report (2007)

One of the main recommendations of this important Alzheimer's Society report was making dementia an explicit national health and social care priority and the need to improve the quality of services provided for people with dementia and their carers.

National Audit Office value for money study (2007)

This report was very critical of the quality of care received by people with dementia and their carers – the size and availability of specialist Community Mental Health Teams was extremely variable and the confidence of GPs in spotting dementia symptoms was poor and lower than it had been in 2000.

The report concluded services were not currently delivering value for money to taxpayers or to people with dementia and their families – too few people were being diagnosed or being diagnosed early enough; early intervention is needed to improve quality of life; and services in the community, care homes and at the end of life are not delivering consistently or cost-effectively against the objective of supporting people to live independently as long as possible in a place of their choosing. The NAO advocated a 'spend to save' approach, with up-front investment in services, for early diagnosis and intervention and improved specialist services, community services and in general hospitals resulting in long-term cost savings from transition into care homes and decreased length of hospital stays.

Public Accounts Committee report (PAC, 2007)

The above NAO report was submitted for consideration by the House of Commons Public Accounts Committee and at the committee's public hearing the NHS Chief Executive and other Department of Health officials were questioned on the NAO's criticisms and recommendations. Following the hearing the PAC published its own report on dementia services in January 2008. The committee's comments and recommendations were consistent with those of the NAO report and further echoed earlier reports on the changes that were needed.

Partnerships for Older People Projects (POPPS)

The 2004 government Spending Review provided ring-fenced funding of £60 million (£20 million in 2006/07 and £40 million in 2007/08) for councils with social services responsibilities to establish locally innovative pilot projects in partnership with PCTs and the voluntary, community and independent sectors. The key purpose of the pilots is to deliver and evaluate approaches aimed at creating a sustainable shift in resources and culture towards early intervention and thereby deliver improved outcomes for older people. Across the country, 29 pilot sites have been established and are delivering a wide range of interventions, including in some pilots older people's mental health services, aimed at addressing the spectrum of need from emerging mental health needs such as anxiety and depression through to dementia and the early stages of Alzheimer's disease.

The Dignity in Care Campaign

This campaign was launched in November 2006. Its aim is to put dignity at the heart of care services, and the role of Dignity Champion has been created to help achieve this. These champions come from many different sectors and professions, including older people themselves and carers, and speak up for dignity, challenging practices that are inadequate and working with health and social care organisations to improve the experience of older people (see www.dignityincare.org.uk).

Equality in later life: A national study of older people's mental health services, Healthcare Commission (2009)

This is a report of a national study of mental health services for older people in England. The study combined an analysis of national data with visits to a representative sample of mental health trusts. The study covered four themes: age discrimination in mental health services; quality of inpatient care; how comprehensive services are; and how organisations work together to provide services. There are 14 recommendations for the Government, the Care Quality Commission, NHS trusts and service providers, to ensure that there is a coordinated approach to improve mental health services for older people.

DOCUMENTS RELATING TO THE WIDER POLICY CONTEXT:

Putting People First. This is a concordat signed by Government departments and organisations. It sets out the Government's vision for public services to enable people to live their own lives as they wish. It is underpinned by a set of values that includes "ensuring older people with chronic conditions, disabled people and people with mental health problems have the best possible quality of life and the equality of independent living". It advocates a personalised adult social care system which will need to work for people with dementia as well as those without cognitive impairment, and sets out the agenda to give more choice and control to service users.

Our Health, Our Care, Our Say. The Government in a 2006 White Paper made the commitment to extend the availability of direct payments, defined as cash in lieu of social services, to people who lack capacity under the Mental Capacity Act 2005 in the Health and Social Care Bill currently going through Parliament (the policy will allow a direct payment to be made to a 'suitable person' who can receive and manage the payment on behalf of the incapacitated person).

Carer's Strategy. This was published in June 2008 and addresses the 500,000 plus family members who care for people with dementia who in turn provide more than £6 billion a year of unpaid care. This strategy implementation will ensure a 10-year plan that builds on the support for carers and enables them to have a life outside caring.

National End of Life Care Strategy. This is currently in preparation and the NAO are due to publish a report on end-of-life care in autumn 2008 (end-of-life care for people with dementia is an underdeveloped area needing specific attention. See Curtice, 2008a for a review of palliative care in people with dementia).

Strong and Prosperous Communities

The Local Government White Paper was published by the Department for Communities and Local Government in 2006 and aims to give local people and local communities more influence and power to improve their lives.

Appendix 2. Current services and investments

OVERVIEW

Older people with mental health needs may access a wide range of health and social care services. Some are 'mainstream services', which are used by a wide range of older people, others are specialist older people's mental health services. They include the following:

Services that assess people's needs & co-ordinate care & treatment

- Primary care services
- Mainstream care management service for older people
- Integrated community mental health team for older people

Services that support people at home

- Primary care services
- Psychological therapies
- Mainstream home care services
- Specialist home care services for people with complex needs
- Mainstream day services
- A specialist day service for older people with mental health needs
- Assistive technology and telecare
- Support for carers
- Home based respite care
- Intermediate care

Housing and support services

- Sheltered housing
- Extra care housing

Hospital & in-patient care services

- General hospital care
- Specialist in patient hospital care
- Specialist in patient respite care

Residential and nursing care service

- Residentially based continuing care
- Residential and nursing care homes

SPECIALIST SERVICES ⁴⁶

Service Name	Service Type	Provider Name	Case load	Bed Nos.	Total Staff
Alzheimer's Society	Carers' Support Service	Alzheimer's Society	50		1
Grace ward	In patient Continuing Care	Camden & Islington NHS Foundation Trust		8	14.94
Garnet Ward	In patient care: Acute Assessment	As above		14	21
Pearl Ward	In patient care: Acute Assessment	As above		14	21
Camden Mews	Day Hospital	As above	64.5		5.76
Community Mental Health Team	Integrated Community Mental Health Team	As above	345		27.37
Memory assessment service	Integrated Community Mental Health Team	As above	Currently being developed		
Psychology Assessment & Treatment Service	Psychological therapy services for older people	As above	18		0.4
Stacey Street Nursing Home	Care Home (with nursing)	Family Mosaic		29	39.9
127 Highbury New Park	Specialist Day/Resource Centres	Care UK	16		11
127 Highbury New Park – residential	Care Home (with nursing)	Care UK		53	56
Carnegie Street	Specialist Day/Resource Centres	Care UK	20		11
Muriel Street	Care Home (with nursing)	Care UK		60	61
Family Mosaic Hornsey Lane	Care Home	Family Mosaic		12	6
Belmore	Extra Care Housing	Islington LA	24	24	15
Islington Assistive Technology	Assistive Technology and Telecare	Islington LA			

Service Name	Service Type	Provider Name	Case load	Bed Nos.	Total Staff
LBI specialist home care	Home Care Service	Islington LA			
Islington Primary Care MH Graduate Workers	Graduate Primary Care Workers - Older Adult	NHS Islington	30		1
20-26 Mildmay Park	Extra Care Housing	Notting Hill Housing Trust		52	41
73 Mildmay Street	Extra Care Housing	Notting Hill Housing Trust		37	26

SUMMARY OVERVIEW OF DIRECT INVESTMENTS IN SPECIALIST SERVICES⁴⁷

SERVICE CATEGORY	TOTAL SPEND £'000	ISLINGTON'S WEIGHTED INVESTMENT PER HEAD	WEIGHTED INVESTMENT PER HEAD – CENTRAL LONDON
Specialist mental health services			
Intermediate care	£4	£0.1	£1.0
Other specialist mental health services	£4,209	£133.9	£110.1
Primary and community care			
Day services	£746	£23.7	£19.4
Home care*	£1,373	£43.7	£7.4
Residential care*	£13,137	£417.9	£92.5

*There are complex issues associated with the way service usage and financial data are classified, especially related to the use of home care and residential care. The difference in weighted investment per head of population for Islington and central London may be due to differences in how this activity is recorded. It is likely that other London boroughs code some or all of this as older people's care rather than mental health care.

Work is planned to establish the extent to which money that is spent on residential and nursing care could be spent differently on community based services.

Appendix 3. Action plan

PRIORITIES	LEAD PERSON	TIMESCALE
<p>Promoting good mental health [Section 5.1]</p> <ul style="list-style-type: none"> ■ Continue to implement & develop our health promotion strategies ■ Develop our quality of life strategy for older people 	<p>Jonathan O'Sullivan: Assistant Director Public Health</p> <p>Clare Henderson: Assistant Director: Independence & Older Adults</p>	
<p>Raising awareness [Section 5.2]</p> <ul style="list-style-type: none"> ■ Develop a local approach to raising awareness that supports and builds on national awareness raising campaigns 	<p>Public Health</p>	
<p>Good quality early diagnosis and early intervention [Section 5.3]</p> <ul style="list-style-type: none"> ■ Develop the new Memory Assessment Service ■ Continue to improve the way we diagnose and treat depression 	<p>Kath McClinton: Assistant Director Joint Commissioning with Doug Wilson: Assistant Director Mental Health Care of Older People.</p> <p>Kath McClinton: Assistant Director Joint Commissioning with NHS Islington Provider Service Lead and IAPT Service Director</p>	
<p>Information, advice and access to services [Section 5.4]</p> <ul style="list-style-type: none"> ■ Improve the information and advice people receive about dementia ■ Pilot a local dementia advisor service ■ Pilot structured peer support networks 	<p>Kath McClinton: Assistant Director Joint Commissioning with NHS Islington Provider Service Lead and Public Health</p>	

PRIORITIES	LEAD PERSON	TIMESCALE
<p>Personalised community support [Section 5.5]</p> <ul style="list-style-type: none"> ■ Develop more personalised community support services <p>Supporting carers [Section 5.6]</p> <ul style="list-style-type: none"> ■ Continue to improve the way we support carers 	<p>Kath McClinton Assistant Director Joint Commissioning</p>	
<p>End of life care [Section 5.7]</p> <ul style="list-style-type: none"> ■ Ensure the specific needs of older people with mental health problems – including dementia - are addressed as Islington's end of life care strategy is implemented 	<p>Kath McClinton Assistant Director Joint Commissioning</p>	
<p>Re-ablement and intermediate care services [Section 5.8]</p> <ul style="list-style-type: none"> ■ Develop intermediate care, interim care services 	<p>Kath McClinton Assistant Director Joint Commissioning</p>	
<p>Sheltered housing and extra care housing [Section 5.9]</p> <ul style="list-style-type: none"> ■ Complete the current review of supported housing services for older people 	<p>Clare Henderson: Assistant Director: Independence & Older Adults</p>	
<p>Residential and nursing care [Section 5.10]</p> <ul style="list-style-type: none"> ■ Better understand the reasons people are admitted to care homes and ways in which we can further reduce admissions. From this develop a demand forecast to better inform future commissioning arrangements. ■ Continue to improve the quality of care in care homes, in particular through the work of the care homes provider forums and through specialist in-reach/liaison services 	<p>Clare Henderson: Assistant Director: Independence & Older Adults</p> <p>Kath McClinton Assistant Director Joint Commissioning</p>	

PRIORITIES	LEAD PERSON	TIMESCALE
<p>Hospital care [Section 5.11]</p> <ul style="list-style-type: none"> ■ Re-designate some in-patient beds on specialist mental health acute wards at the Highgate Centre as re-enablement care beds ■ Identify senior clinicians within general hospitals who will take the lead for improving care in hospitals. 	<p>Kath McClinton Assistant Director Joint Commissioning</p>	
<p>Specialist liaison service [Section 5.12]</p> <ul style="list-style-type: none"> ■ Expand and develop the role of specialist liaison service 	<p>Doug Wilson: Assistant Director Mental Health Care of Older People</p>	
<p>Joined up care [Section 5.13]</p> <ul style="list-style-type: none"> ■ Establish a clearer and shared pathway of care across all services 	<p>Kath McClinton Assistant Director Joint Commissioning</p>	
<p>A more informed & effective workforce [Section 5.14]</p> <ul style="list-style-type: none"> ■ Develop and implement a systematic, ongoing and targeted programme of learning and development across the whole system 	<p>Kath McClinton Assistant Director Joint Commissioning</p>	
<p>Governance [Section 5.15]</p> <ul style="list-style-type: none"> ■ Significantly improve the way we involve older people and their carers ■ To improve management information 	<p>Clare Henderson: Assistant Director: Independence & Older Adults</p>	

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