



Mental Health Strategy for Older People in City & Hackney 2008-2018



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1. PURPOSE OF THE STRATEGY DOCUMENT

- 1.1 This strategy document for the development of Mental Health Services for Older People was initiated by the Older People's Board of Thriving Healthy Communities Board¹ and is a joint statement of intent between City & Hackney Teaching Primary Care Trust, including GP's and other allied health professionals working within Primary Care, the East London NHS Foundation Trust, City of London Corporation, London Borough of Hackney, Homerton University Hospital NHS Foundation Trust, Alzheimer's Society Branch for Hackney & City and City and Hackney Carer's Centre.
- 1.2 The purpose of this paper is to show clearly the key national and local priorities for mental health services for older people and the commissioning tasks that need to be undertaken to implement those priorities. It meets the requirements placed on local health areas of the seven new performance indicators (PI's) introduced in January 2007 by the Health Care Commission.
- 1.3 Amongst others detailed below in section 3.2, three recent documents have particularly influenced the development of this strategy. Firstly, we welcome the vision developed in the National Dementia Strategy consultation document, 'Transforming the Quality of Dementia Care', published on the 19th June 2008. In this document, the government has identified dementia as a national priority and this new draft consultation document concentrates on three key themes:
- Improving awareness of dementia, both among the general public and among health and social care professionals;
 - Ensuring that the condition is diagnosed as early as possible to allow for early intervention, and,
 - Delivery a high quality of care and support for both those with dementia and their carers.

In June 2008, the new government directive 'Carers at the heart of 21st-century families and communities' states that by 2018:

- Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role;
- Carers will be able to have a life of their own alongside their caring role;
- Carers will be supported so that they are not forced into financial hardship by their caring role;
- Carers will be supported to stay mentally and physically well and treated with dignity, and,

¹ Thriving Healthy Communities Board is itself a sub-board of Team Hackney, the local strategic partnership board.

- Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods and to achieve against all the *Every Child Matters* outcomes.

Our local Hackney Carers' Strategy, published in 2007, recognised the crucial role that carers play in supporting people in the community, particularly those with mental ill health and posed a range of improved services for carers. This draft Mental Health Strategy for Older People fully endorses the Hackney Carers' Strategy and proposes new support mechanisms for carers in the community.

- 1.4 The process of commissioning is informed by undertaking a needs analysis of our local population. This in turn, informs the processes of strategic planning, improving existing services, market management, contract setting and contract monitoring. Commissioning seeks to ensure that the right quantity and quality of services are planned to meet the needs of City and Hackney's older people with mental health needs both at the present time and for the next ten years and into the future.
- 1.5 As a principle, we are aiming to ensure that the right services are available to meet people's needs at the right pace and at the right time, in order to promote independence and reduce reliance on institutional forms of care.
- 1.6 This strategy is based on a needs analysis undertaken on our behalf² which shows a number of community services are not available in C&H, against a backdrop of C&H having a greater incidence of need than the majority of comparator sites used as identified by the weighted population. We also have fewer acute assessment beds.³ Their data also showed a rise for those with dementia from 1771 in 2008 to 1903 in 2018. This upward trend will continue dramatically in subsequent years with the increase doubling within the ten year period from 2018 to 2028.
- 1.7 At the heart of this strategy document is a firm commitment to promoting the independence and quality of life for older people with mental health needs within which the needs of City and Hackney's culturally and ethnically diverse communities will be taken into consideration.

² An independent company, Mental Health Strategies.

³ It is unclear, this may be as a result of under-reporting, the data is based on information provided by the MH Trust.

- 1.8 The Needs Analysis highlighted C&H invested less than comparative boroughs and the Inner London average. To enable the development of services, there is a commitment to finding resources beyond the current C&HtPCT's Commissioning Strategic Plan. In addition, although, unclear at this early stage, the draft National Strategy promises extra resources.
- 1.9 This strategy was presented to local strategic partnership structures for ratification, including the Older People's Board of Thriving Healthy Communities, and thereafter went out to public consultation during the months October to December 2008. As a result, the original draft document was amended by comments from a number of local agencies and colleagues working with or promoting the rights of older people and their carers⁴.

⁴ LBH Project Manager for Carers, Hackney & City Alzheimer's Society, Hackney Carers Centre and MH for OP's service.

2. OUR VISION FOR OLDER PEOPLE'S MENTAL HEALTH SERVICES

2.1 Our shared vision and ambition for local services is that, in partnership, we will provide local health, care and community services that meet presented needs in a flexible manner, and promotes and maintains the independence of older people as active citizens irrespective of the diagnosis of their mental ill health. Services will:

- support older people to improve their independence and safety;
- be of high quality and meet required standards;
- be provided in a timely, responsive and flexible way;
- promote dignity, self-respect and individuality in the full range of local settings, eg the community, hospital and our local care homes;
- offer choice, wherever possible;
- promote self directed support and personal budgets;
- be based around the needs of individuals and their families;
- appropriately take account of age, gender, ethnicity, religion and sexuality;
- be published widely and made accessible to all;
- provide opportunities for service users and carers to influence the development and delivery of services.

2.2 The preparation for this strategy was supported by local partners, including GP's and other allied health professionals and voluntary sector representation⁵.

2.3 In the most recent period, City & Hackney Teaching Primary Care Trust's (CHtPCT), London Borough of Hackney (LBH) and the East London NHS Foundation Trust (ELFT) have individually expressed their views through a number of important documents. For C&HtPCT this was their Commissioning Strategic Plan 2008-2010, for LBH this was the Health & Well-Being 5yr Commissioning Strategy for Social Care services for Older People and for ELFT their recent Business Plan.

2.4 All of the above documents will significantly contribute to the improvement in acute and community mental health services delivered to older people based on an understanding of the need to rebalance the range of existing services between hospital, residential or long term placements and community services.

2.5 There is also a clear commitment to increase our research into 'hidden need'. There are many individuals maintaining their independence at home but without presenting to local services. Additionally, we have identified there are those who do access general adult, primary or acute services but do not have their mental health needs identified or

¹. City & Hackney Teaching Primary Care Trust, London Borough of Hackney, City of London, East London NHS Foundation Trust, Homerton University Hospital NHS Foundation Trust, Hackney & City branch of Alzheimer's Society and City and Hackney Carers Centre.

assessed by specialist mental health services. This was clear from two local studies. One undertaken at the Homerton in 2005 where 33% of patients on medical wards had cognitive impairment, and the other, from Hackney Social Services where approximately one quarter of individuals receiving a home care service for their physical needs, have dementia or other mental ill health.

2.6 The broad framework for improved services is a commitment from partner agencies based on:

- **Early intervention**; to promote mental health and provide effective preventative strategies to help those at risk of developing mental health problems, especially severe mental illness
- **A clear pathway of care**; to provide timely access to appropriate services and more consistent pathways through care
- **Promoting recovery and social inclusion**; to improve outcomes and to improve access to evidence-based interventions
- **Local proactive treatment within the community**; to refocus the work of community teams on recovery and support and to reduce dependency away from home care
- **A new strategy for inpatient care**; to rethink the purpose and improve the quality of inpatient care
- **Working with those at most risk**; to reduce stigma and to improve access in primary care.

The impact on outcomes for older people will be:

- Early identification and treatment for those with dementia
- Increased choices when having a dementia assessment
- Identification and improved management of older people with depression in primary care
- Early referral to secondary services
- Improved quality and outcomes in relation to '*Everybody's Business*' and Standard 7 of the NSF for Older People.

2.7 Specifically, the broad strategy is to provide:

- An enhanced Memory Clinic service including improved early diagnosis;
- Continued development of the integrated Community Mental Health team;
- Improved support to Carers and families through better information and community support services;
- Focus on admissions avoidance to both mental health and acute services with faster, safer discharges;

- Conversion of one of the continuing care units to a step-down rehabilitation service;
 - Re-profiling of services in the Mary Seacole continuing care nursing home to manage continuing care patients with dementia
 - Re-modelling of two of the borough's Supported Living Schemes (SLS) to provide housing support, one of which will provide rehabilitation support and one of which will support those with enduring mental ill health;
 - Improved approaches to training on mental health issues for a wide range of health and social care professionals, including OTs, Physios, district nurses, care managers and home carers;
 - Focus on ensuring all local partner contracts include a commitment to the training of allied health professional and care staff to identify and enable support to those with mental ill health.
- 2.8 The East London NHS Foundation Trust, the CHtPCT's commissioned service provider, Service Delivery Plan states in more detail the way in which the provider strategy will be delivered. As part of the contract negotiations in November 2007, the Trust agreed a five-year Service Development Plan (SDP) and associated financial change programme.
- 2.9 The strategy indicates the future need for continuing care beds particularly for those whose behavioural and psychological symptoms of dementia mean they need the support and care of specialist nursing and therapy staff but suggests these needs would best be met by a range of options based on provision of bed space not confined to NHS provision and not confined to any one geographical area. However, for a certain number of service users with increasing physical dependencies, as was the case with those occupying one of the three units at The Lodge, the NHS nursing provision provided at Mary Seacole was recognised as a better option of care.
- 2.10 Service utilisation data suggests the overall requirement for specialist long term in patient beds has declined. As a result the units in the Mental Health Trust (The Lodge) are running at approximately 60% occupancy. At the same time as the decline in the use of beds, the physical frailty of those with dementia has increased with these older people increasingly wishing to stay in the community where a different range of service provision is required.
- 2.11 To best support those whose physical frailty has overtaken their need for specialist mental health nursing and to enable increased choice to service users and their families, the SDP sets out a re-evaluation of the position of the provision at the 45 bed units at The Lodge with the intention to reinvest resources in services to offer people a wider range of choice in the community as well as increased choice of nursing home provision. This proposal will be subject to consultation and the Primary Care Trust is committed to ensuring that resources released are reinvested in older people's mental health. The Older People's

Mental Health sub-group has been working intensively on the model for the new community service and improved dementia assessments.

- 2.12 In addition, as part of the PCT's CSP, significant additional resources have been identified to increase investment in the new community team to improve dementia assessment and community support services. These investments are intended to meet medium to long term increases in the numbers of people with dementia and provide a more flexible service with greater choice. This locally committed investment will be enhanced by any resources made available as a result of the National Dementia Strategy.
- 2.13 Over time, it is anticipated the development of enhanced community services will allow for a reduction in the demand for specialised nursing beds for older people with dementia. This would reconfigure services to provide more residential community placements and new and enhanced community services in partnership with the independent and 3rd sectors. These developments will provide more community based services, including assessment and treatment within the service user's own home and also, potentially, in community settings such as day centres and leisure facilities.
- 2.14 It is the intention of the C&HtPCT to consult separately on the above proposals re continuing care, in line with the requirements of the new national guidelines 'Changing for the Better' issued in May 2008 which laid a responsibility on PCTs to consult with their SHA on any major health provision changes..
- 2.15 We aim to dramatically improve access to dementia assessment and treatment and establish an enhanced Memory Clinic. The aim is to increase diagnosis rates by 5% -8% annually over the next 5 years and provide appropriate interventions and follow-ups. The needs assessment will provide the baseline based on our population projections, it is estimated that there is a need for an additional 100hrs weekly (divided roughly 10 hours for new referrals, 60 hours for brief treatment and 30 hours for follow-up appointments).
- 2.16 The Community Dementia Team (including ELFT CMHT investment) will increase capacity to support 170 clients. The aim is to provide intensive case management in-reaching into hospital, avoiding hospital admission and supporting early discharge.
- 2.17 Currently, approximately one third of referrals to older people's mental health services have functional⁶ mental ill health and we aim to improve services to this group, improving access to psychological therapies and to improving primary care and support in the community. This will contribute to a reduced length of stay from the current 120 days.

⁶ Depression, anxiety, complex/severe mental illness (psychosis, bipolar, affective disorder, personality disorder), schizophrenia.

- 2.18 The publication of 'Our Health, Our Care, Our Say', launched the Improving Access to Psychological Therapies (IAPT) programme in 2006. Following the establishment of two demonstration sites, a further 11 pathfinder sites were launched in July 2007. Particular emphasis has been placed on enabling people with mild to moderate mental health problems (depression and anxiety spectrum disorders) to remain in or return to paid or voluntary work.
- 2.19 In October 2007, the government announced significant funding increases for psychological therapies, through the IAPT programme, spending £170m per year nationally. As a result of this increased funding, an expansion programme commenced and C&HtPCT has been successful in being selected as one of three expansion sites in London. This will result in significant development of the Primary Care Psychology Service. This service had already expanded to 3.6wte⁷ in 2006-07 and will increase to over 50wte in 2008-09. This will greatly improve older people's access to psychological therapies.
- 2.20 'Putting People First', a 2007 government publication, particularly guides local authorities on the approach to developing choice and control to all with a care or support need. It poses a radical shift from the structured way individuals in the care system currently receive their support and moves to introduce personalised budgets. Plans for the introduction of these are at an early stage in both the City and Hackney boroughs and older people with mental ill health will not be excluded from the benefits of this initiative.
- 2.21 LBH has agreed remodelling plans for two of the seven existing Supported Living Schemes (SLS), one of which will deliver the opportunity for slow to medium term rehabilitation for those with functional mental ill health, eight flats, and a separate unit with another eight flats for those with complex and enduring mental ill health. This will be a significant step in promoting their social inclusion within the Hackney community.
- 2.22 The above strategic approach fits with the views of older people themselves. Consultation with Older People for "Well Old, Well Valued 2003", the Best Value Review of Older People's Services 2003, the Best Value Review of Older People's Mental Health Services 2004 and current Supporting People 5 Year Strategy 2005/10 – all of these documents confirmed older people's desire to live for as long as possible in the community in their own homes with support and care services provided as and when required.

⁷ Whole time equivalents.

3. NATIONAL AND LOCAL CONTEXT

3.1 This draft strategy has been developed within the context of the following national policy and legislation:

3.1.1 On 19th June 2008 the consultation document on a National Dementia Strategy was published, 'Transforming the Quality of Dementia Care'. The government has identified dementia as a national priority and this new consultation document concentrates on three key themes:

- Improving awareness of dementia, both among the general public and among health and social care professionals;
- Ensuring that the condition is diagnosed as early as possible to allow for early intervention, and,
- Delivery a high quality of care and support for both those with dementia and their carers.

3.1.2 This local City and Hackney draft strategy wholeheartedly adopts this vision for dementia care in our area.

3.2 A number of other national documents significantly add to our understanding of the need for high quality care for those with mental ill health:

- Mental Capacity Act 2005
- Our Health, Our Care, Our Say
- Independence, Well-Being and Choice
- Everybody's Business 2005
- National Service Framework for Older People 2001 and its follow up, A New Ambition for Old Age 2006
- Securing Better Mental Health for Older Adults
- National Audit Office report on Dementia 2007.

3.3 Performance Indicators

3.3.1 To enable us to track improvement over time of the quality and performance of the new assessment, support and care packages, there will be new performance indicators (PI's):

- 24hour support
- Community respite
- Rapid/crisis response and resolution
- Increased number of community residential placements
- Reduction in admission rates and lengths of stay in hospital
- Greater number of people being supported in the community.

3.4 Supported Housing with Care

- 3.4.1 The 2001 Hackney Census showed people over 65yrs already occupy different kinds of accommodation, ranging from those who own their own home (22.3%), those in council rented tenancies (47.9%), those in housing association tenancies (19.9%) and a small but significant number who privately rent their accommodation (9.9%).
- 3.4.2 In 1993 with the closure of local residential homes, Hackney established seven Supported Living Schemes, which provides 152 tenancies to older people with high levels of support needs. Two-thirds of tenancies are to older people with mental ill health and the Mental Health for Older People team support LBH staff to provide this service.
- 3.4.3 In addition, there are 14 providers of sheltered accommodation in the borough offering 1646 tenancies across 60 different sheltered blocks, including the seven mentioned above. Currently, 311 of the total tenancies are agreed with housing providers as 'Supported Housing with Care'.
- 3.4.4 There are two Extra Care facilities, one specifically for the Orthodox Jewish Charedi community and one in the north of the borough, Barkway Court. The progress towards Supported Housing with Care will develop over the next few years and offer improved support and care to older people.

3.5 Homerton University Hospital NHS Foundation Trust

- 3.5.1 Being admitted to hospital is an unsettling and worrying experience for most people. For patients with a dementia this is significantly magnified; the hospital environment with its frenetic activity, noise and numerous comings and goings is incredibly disorientating. In 2005, a 'Prevalence Study' identified 33% of patients admitted to medical wards had cognitive impairment.
- 3.5.2 Within therapy and rehabilitation services it is fully recognised that early intervention is key in order to maintain skills and abilities and involving carers and family is crucial. A new Carers policy has been launched and the East London Foundation Trust has a Carers Specialist who is able to advise, counsel and signpost carers and families to the most appropriate support.

3.6 Alzheimer's Society (Hackney & City Branch)

- 3.6.1 The Hackney & City branch of the Alzheimer's Society currently has over 250 families on its books and for many individuals and their carers, they are the first point of contact for help and support. They provide a range of high quality information and advice for people living with dementia and their carers. They also run a number of peer support

groups for people living with dementia and carers, including Carers Support Groups as well as a monthly 'Alzheimer's Café'.

4. NEEDS ANALYSIS

4.1 Demography

4.1.1 The City of London and London Borough of Hackney have a total of 19,450 older adults aged 65 years and over. The majority (18,385) live in Hackney with a small number (1,065) living in the City.⁸

Table 1 Population according to age

Borough	Total	65-69yrs	70-74yrs	75-79yrs	80-84yrs	85-89yrs	90yrs+
City of London	1,065	316	225	201	166	93	64
Hackney	18,385	5,277	4,529	3,581	2,645	1,484	869
	19,450	5,593	4,754	3,782	2,811	1,577	933

Source: Mental Health Strategies June 2008

4.1.2 The two boroughs are very different in their demographic makeup. The City has one of the smallest resident populations standing at 9,185 and is unique amongst comparable UK urban locations in that its daytime population far outweighs its residential population. It has a large proportion of single people, a higher proportion of people of working age and a large proportion of those with second homes compared with figures for England and Wales.

4.1.3 Hackney on the other hand is a highly complex and diverse borough with all 19 wards amongst the ten per cent most deprived in the country and a mobile, ethnically diverse population. Deprivation is linked to an increase in the prevalence of some mental health problems.

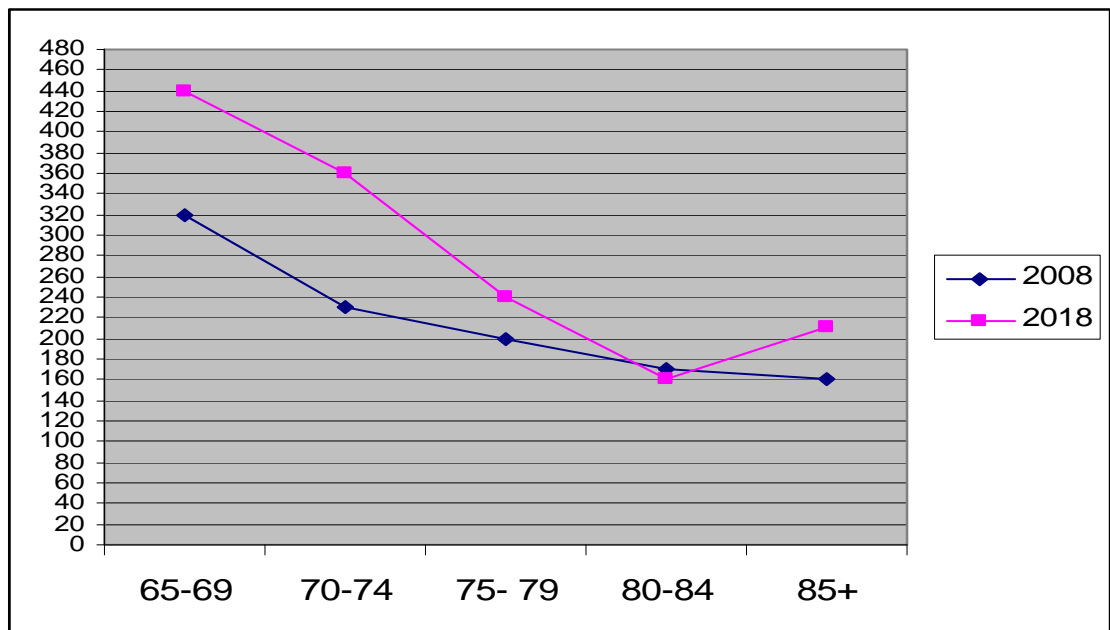
4.1.4 The 2001 Census revealed that Hackney's residents were born in more than sixty countries and speak more than forty different languages, and thus Hackney is an extremely ethnically diverse borough with the majority of those born outside of the United Kingdom coming from Africa, Asia, the Caribbean and Eastern Europe (includes Turkey). There is also a substantial (5.5%) Orthodox Jewish population. Projections indicate that non-white residents will form an increasingly large proportion of the older adult population in Hackney growing from 25% in 2007 to 39% in 2016.

4.1.5 From the following tables/graphs we can see that over the next ten years, the over 65 population within City and Hackney is going to grow by just over 7%, or 1,390 extra people. Within Hackney, this growth will be just 5.6% (a further 1030 people), but in the City of London this will be just over 30% (an extra 330 people), accounting for around a third of the project population growth.

⁸ Note that GLA data has been used throughout for the purposes of this Needs Analysis as it is considered to be more accurate than ONS.

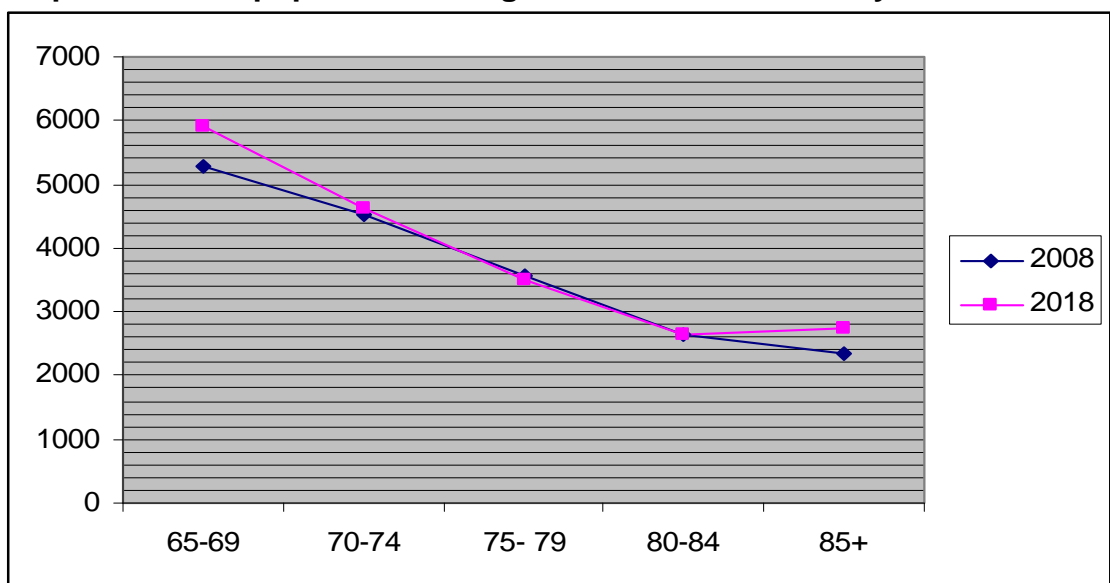
- 4.1.6 Within 5 year age bands, the largest growth will be in the 85yrs+ band (17.13% or 430 more people) followed by the 65-69 age band (13.6% or 760 more people). The age bands 75-79yrs and 8—85yrs will decrease slightly by 0.79% (30 less people and 0.36% (10 less people) respectively. However, within the City of London the age band 70-74yrs will increase the most proportionately, by 56% or a further 130 more people, whilst the 80-84yrs age group will decrease slightly by 10 people. In Hackney, the 75-84yrs age band will reduce by 80 people.
- 4.1.7 These age band changes are significant because the prevalence of dementia increases with age.

Graph 1 Over 65 population change 2008-2018 for the City



Source: Mental Health Strategies June 2008

Graph 2 Over 65 population change 2008-2018 for Hackney

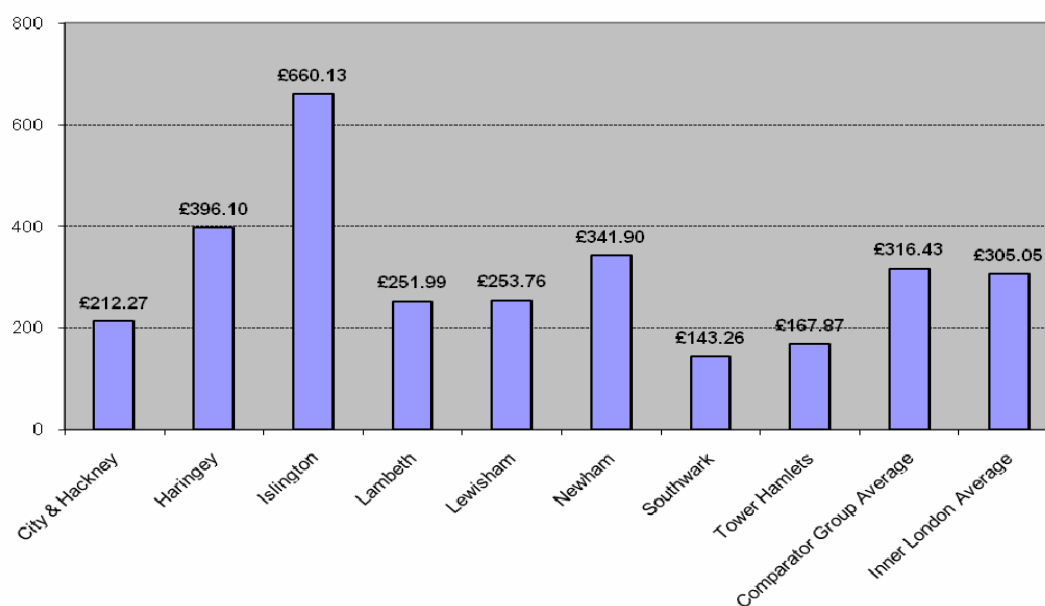


Source: Mental Health Strategies June 2008

4.2 Audit of Investments⁹

4.2.1 Graph 3 below shows that C&H invest more per head of population (£212.27) than Southwark or Tower Hamlets LITS. However, City & Hackney invest considerably less than Islington per head of population, the Inner London average and the comparator group average.

Graph 3: Older Adult MH Investment (£s) per Head – Totals of Older Adult weighted population



* Figures calculated using Finance Mapping 2007-08, Mental Health Strategies and population data (PLP low) published by GLA (2007) for 2008.

4.2.2 From Table 1 below, it should be noted that C&H Primary Care Trust invest comparatively the same proportion of investment in Specialist MH services as the comparator group and Inner London average, but a much lower proportion in Primary and Community Care, residential and day services.

Table 2 PCT service investment comparison (%)

	C&H	Comparator Group Average	Inner London	National Average
Specialist MH services	63.4	63.1	64.6	76
Primary & Community Care - residential	27.3	32.6	27.2	11.5
Primary & Community Care – day services	0	3.9	4.8	7.6

*Figures do not add to 100% due to investment in other service types not counted above.

⁹ Caution should be exercised in drawing strong conclusions from the above data as the variation in investment could be masked by different Commissioners interpretations of older adult MH and local authority investment could be made in the wider older adults services.

4.3 **Types of Mental Illness affecting people over 65yrs**

4.3.1 **Depression**

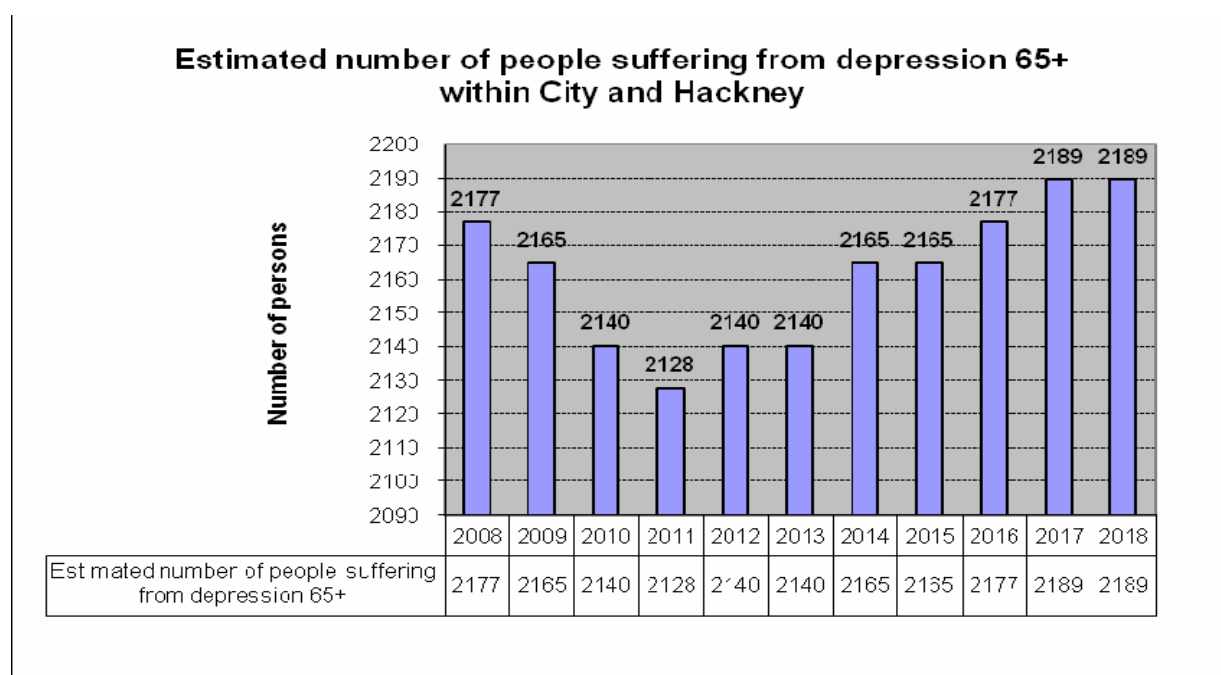
Age Concern in their report entitled 'Improving services and support for older people with mental health problems' discussed the prevalence for depression and gave the following statistics:

- 20% of people aged 65 – 69 will suffer from depression;
- 40% of people 85 + will suffer from depression;
- Older people with depression are three times more likely to be victims of elder abuse;
- Depression is also stated to be the leading cause of suicide in older people. Older people with symptoms of depression are 23 times more likely to take their own lives;
- Depression is more common in care settings;
- Thirty per cent of older people in acute hospitals and 40% of older people in care homes meet the clinical criteria for diagnosis of depression;
- Older people who take their own lives are more likely to have seen their GP in the previous six months and are more likely to present with symptoms of a physical nature;
- 6% of older people with depression receive specialist mental health care;
- The impact on the older person and their family includes increases in risk of physical health problems, slows recovery from illness, increases the risk of readmission to hospital after discharge and increases the risk of premature death.

4.3.2 Here in City and Hackney, as the table below illustrates, because of demographic changes, the overall numbers of older people with depression is not set to rise significantly. In fact, the numbers are expected to fall in the period to 2011, rising thereafter to 2018 and beyond.

4.3.3 This fall in the numbers of older people with depression has to be understood in the context that currently the numbers of older people identified with depression is low with them thus less likely to be receiving the help and support they need.

Table 3 Estimated number 65yrs+ suffering from depression



Source: Mental Health Strategies June 2008

4.3.4 Dementia

Dementia accounts for more years of disability than almost any other condition, including stroke, cardiovascular disease and cancer. It accounts for 10% of deaths in men aged over 65yrs and 15% of deaths in women over 65yrs. Up to half of people with dementia also have depression.

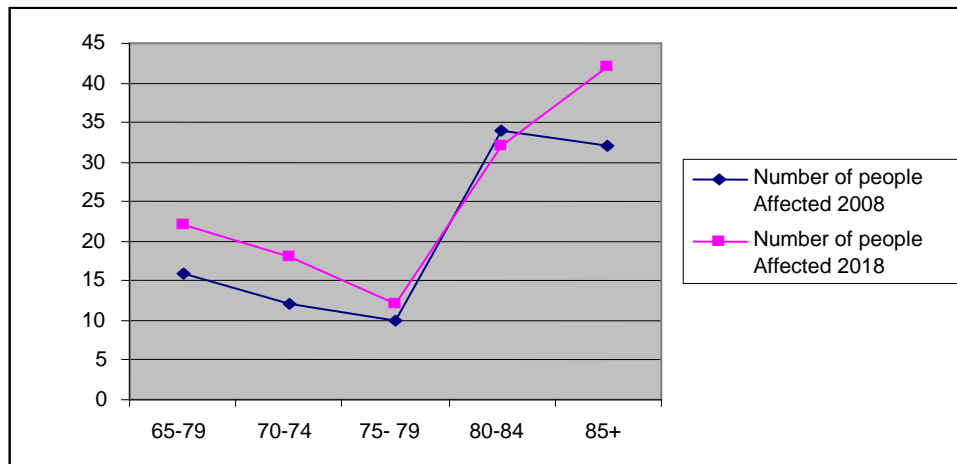
At present, fewer than half of people with dementia will ever receive a diagnosis. For City and Hackney, GP practice QOF data reports only 0.2% practice population with dementia, against an expected third which suggests significant under-diagnosis and need unmet. The prevalence of dementia increases rapidly with age.

Local Pen Picture:

88yr old gentleman presented to A&E over 50 times per year complaining of marital problems – eventually referred to MH for OP team who arranged an in-patient stay and started on anti-dementia drugs – on improvement, deemed to be able to live in the community – attended Memory Clinic, A&E attendances reduced as were his marital disress – follow up support from CPN and community matron.

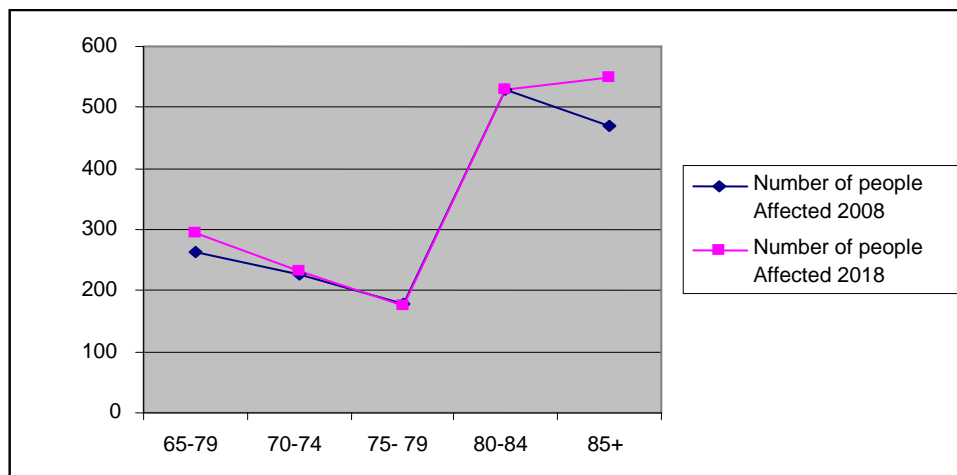
The national rates are expected to double every five years from age 30 onwards but the projected position in City and Hackney is shown separately below:

Graph 4 Prevalence of dementia & predicted increase 2008–2018 for the City



Source: Mental Health Strategies June 2008

Graph 5 Prevalence of dementia & predicted increase 2008–2018 for Hackney



Source: Mental Health Strategies June 2008

As with the dip in the numbers with depression mentioned in the previous section, there is a corresponding fall in the projected numbers with dementia for the years to 2011. Again this is due to demographic changes. However, the above graphs demonstrate an overall increase in the number of people with dementia over the ten year period. For both boroughs there is an increase in the 65-69yrs age group and again in the 85yrs+ age group with the City showing a slightly larger proportionate rise.

Table 4 Types of dementia and prevalence

Form of Dementia	Prevalence	Number of people estimated by 2018
Alzheimer's Disease	62.0%	1086
Vascular Dementia	17.0%	291
Mixed (AD and VaD)	10.0%	171
Parkinsons Disease	2.0%	35
Frontotemporal Dementia	2.0%	35
Dementia with Lewy Bodies	4.0%	70
Other	3.0%	51

Source: Mental Health Strategies June 2008

Further statistical information on the prevalence of dementia shows 2% of people with dementia develop this before the age of 65yrs, people with Downs Syndrome are four times more likely to have dementia and develop it at an early age, 2/3rds of older people with dementia are care for in the community, mostly by unpaid carers. Dementia accounts for more years of disability than almost any other condition, including stroke, cardiovascular disease and cancer. It accounts for 10% of deaths in men aged over 65yrs and 15% of deaths in women over 65yrs.

Up to half of people with dementia also have depression with approximately 20-25% having a major depression and 20-30% having minor or sub threshold depression, and importantly, 1/3rd of people who care for an older person with dementia have depression.

- 4.3.5 Other types of mental illness in people aged over 65yrs include anxiety disorders which are closely linked to depression in later life and which is more common in women. Delirium or acute confusion is prevalent amongst those aged 85yrs plus and is more common in care settings.

Hackney has the highest rate of schizophrenia and the fourth highest incidence of neurosis. Schizophrenia levels are three times the national average and appear to be increasing.

- 4.3.6 The picture in City and Hackney continuing onto the subsequent 10 year period to 2028 continues to show a steady increase in numbers across all the forms of mental ill health, including for dementia. This is different to that of estimates nationally where it is estimated that by 2038 the numbers with dementia will double, a rise from 700,000 to 1.4 million with estimated costs of £50 billion per year. As is shown below,

as we go into the ten year period 2018 to 2028, the biggest increases are in the 80yrs+ age bands.

Table 5 Increases in numbers of Dementia over 20 year period

Age Group	2008	2018	2028
65 - 69	73	82	105
70 - 74	138	145	171
75 – 79	223	221	261
80 - 84	343	342	389
85 - 89	320	335	375
90+	274	381	476
Total	1371	1506	1776

Source: C&HtPCT Health Intelligence Unit June 2008

4.3.7 Black and Minority Ethnic (BME) Communities

Older people from BME groups who experience mental health problems are known to be one of the most socially excluded groups. This form of social exclusion is not only due to the direct impact of mental illness but is a result of the stigma, prejudice and lack of access to services, and poor experiences from the services.

In general, minority ethnic elders are under-represented as users of specialist mental health services, however, there is no evidence that elders from Black and Minority Ethnic groups have reduced mental health needs. There is increasing evidence that mental health problems within this population are poorly detected in Primary Care settings, or that minority elders may be reluctant to report mental health conditions. Mental Health of Migrant Elders – The Islington Study –Livingstone et al 2001 - found that compared with UK born residents, the prevalence of dementia for African Caribbean’s was 17.3 percent and lower for the Irish born 3.6 percent. This study found that “cross-cultural assessment of dementia in older people has specific pitfalls related to language and literacy skills”.

In 2005, the government’s response to the independent enquiry into the death of David Bennett was ‘Delivering Race Equality in Mental Health Care (DRE) 2005–2010: an action plan for reform inside and outside services. This is an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and Minority Ethnic (BME) status, including those of Irish or Mediterranean origin and east European migrants. It sets out a coherent programme of work for achieving equality of access, experience and outcomes for BME mental health service users.

5. GAP ANALYSIS

5.1 Separate gap analysis were undertaken against the following documents:

- The National Service Framework for Older People (2001-2006)
- Everybody's Business (2005)
- The National Institute for Clinical Excellence guidelines (2006).

5.2 As Everybody's Business is considered the significant document to test local services against, this has been used to establish the main gaps identified for further action as below:

- Clear monitoring and review arrangements against strategic recommendations;
- Need for clear monitoring arrangements for service user satisfaction across all mental health service areas;
- Need for clear monitoring arrangements for patient-based output data;
- Across all specialist MH service areas, ensure arrangements established, including allocated dedicated resources, to involve service users in the drawing up of service development plans with arrangements in place for regular feedback to service users and their carers;
- Need mechanisms for raising awareness, tackling public health attitudes and to combat the stigma those with mental ill health sometimes experience;
- Need wider development of culturally appropriate services with better, more focussed information, advice and support for BME older people to access specialist MH services;
- Need for clear monitoring arrangements of mental health training across generic service areas, including Hospital, Housing and other Local Authority services;
- Need to explore more fully opportunities provided by Practice Based Commissioning;
- Need for comprehensive appointment of MH champions across all generic and specialist services;
- Staff training for Secondary and Primary Care staff together with use of assessment tools for depression and dementia;
- Wider range of innovative MH day services;
- Development of targeted intermediate care and rehabilitation services for those with mental ill health;
- Need for clear monitoring arrangements for the various aspects of work of the specialist OPMH teams, including support to carers, training, assuring early intervention and care planning.

5.3 Appendices 1, 2 and 3 show the three GAP analysis mentioned at 5.1 in full.

6. THE CURRENT SERVICE MODEL

Table 6 Current local service provision

	Service	£000s	Activity
	Secondary MH Services		
1.	The Lodge Continuing Care	2051	Previously a 43 bed unit; 2 admissions; 13,985 occupied bed days (now 30 beds are in use)
2.	The Lodge CC – Respite		2 beds; 189 respite; 324 occupied bed days
3.	Gardner Ward at the Homerton	1707	25 bed unit incl OA with enduring functional MH who require NHS CC; 85 inpatients; 7,235 occupied bed days
4.	Assessment		7 beds; now operates at Orchard Lodge
5.	EMI Psychology	165	(info from Ron email 7 Jul 07)
6.	EMI Nursing		5 new placements 06/07
7.	EMI Residential		21 new placements 06/07
	Community MH services		
8.	Integrated MH team for OP	LBH 352k ELFT 720k	(MH data for 2 teams only) 248 caseload; 14 Care Co-ordinators; 158 standard CPA's; 67 enhanced CPA's (need to get data for borough team)
9.	OT/Arts Therapy		169 caseload; 8 Care Co-ordinators; 3,603 contacts
10.	Psychology		90 outpatients seen; 700 appts offered – 453 attended
11.	Memory Clinic		2004/05 – 32 new patients (8 DNA's); 94 appts for year (23 DNA's)
12.	GP Dementia register (register not age related, assume most are OP)		2006/07 – 427 dementia patients registered with 54 GP's
13.	GP Depression register (register not age related, need to decide on approx % for OP)		2006/07 – 17,707 patients with diagnosed depression registered with 54 GP's (2245 new patients in year) (Guestimate for over 65's is 20% of the 17,707)
14.	LBH Supported Living Schemes (SLS)		102 people with mental ill health supported (represents 70% of the 152 OP supported)
15.	LBH Median Road Dementia Day Centre		
16.	LBH Median Road Respite		2006/07 – supported ? individuals
17.	LBH Day Centres (generic)		Marie Lloyd & Sam & Annie Cohen day centres between them support ? OP with mental ill health
18.	LBH Home Care service		2006/07 - ?% of total of ? are people supported with mental ill health
19.	LBH Carer support		2006/07 – included Carers Helpline, support groups, short breaks, emergency respite, Hackney Carers Card
	Voluntary MH services		
14.	Alzheimer's Society	41k	2005-06 new referrals 71; 131 families in service; 2006-07 63 new referrals; 215 families in service (134 female users & 81 male users)
15.	Dementia Link project	45k	
16.	Hackney Carers Centre	180k ¹⁰	
	Pharmacy – Dementia drugs		
16.	Secondary Care	NK	Rivastigmine, Donepezil Hydrochloride, Galantamine, Memantine Hydrochloride – all used, primarily in the Memory Clinic but also at The Lodge
17.	Primary Care	49.6K	9 GP's use Rivastigmine; 28 use Donepezil Hydrochloride; 6 use Galantamine; 9 use Memantine Hydrochloride

¹⁰ Generalist agency providing a wide range of support to Carers, incl those who care for those with mental ill health.

- 6.1 In line with what the needs assessment above tells us, we are seeking to support the modernisation of mental health services for older people through the development of earlier diagnosis pathways, integrated assessment processes and the development of a range of services designed to meet the needs of older people at different levels, rather than continued reliance on latter stage services such as in-patient beds residential and nursing care.
- 6.2 We believe that the vast majority of care should be provided in the community. As part of our aim to develop integrated care pathways, we envisage specialist services not only as in-patient beds, but rather as a range of specialist services meeting different needs and in a variety of settings.
- 6.3 When we map our local services against 'Everybody's Business', a number of gaps are clear:
- There is no local specialist in-patient provision for older adults with enduring functional mental ill-health who require NHS Continuing Care;
 - Early diagnosis and early intervention needs to dramatically improve;
 - The full range of MH treatments, eg psychological therapies, are not easily accessible to those over 65yrs;
 - Improvements in the approach to care of those with mental ill health in non-acute mental health services needs to be improved through increased training opportunities to raise awareness on dealing with those with mental ill health;
 - Innovative approaches to working with older people from BME communities need to be developed;
 - Not all mental health voluntary organisations are organised or funded to work with older adults. The relative level of funding and diversity of organisations working with older people with mental ill health is low compared with adult mental health, eg Hackney MIND, and,
 - We need to improve the way we involve service users and their carers in the planning and delivery of local mental health services.

7. DEVELOPMENTAL PRIORITIES

7.1 Memory Assessment Services

7.1.1 In keeping with a recent report from the National Audit Office (2007) – Improving Service and Support for People with Dementia – the East London Foundation Trust (ELFT) is working with partners to develop a comprehensive memory assessment service that is responsive to local need. In particular, this service will have strong links with primary care and the local acute hospitals with the aim of simplifying referral routes and supporting early identification and diagnosis of memory problems. The service will include a care co-ordination function that will offer ongoing support and advice to service users and their carers at the point of diagnosis and will continue supporting the individual throughout the progress of the condition.

7.2 Proposed Service Model:

7.2.1 The draft National Dementia Strategy states the case for ‘best practice’ mental health care for older people, making twelve recommendations in all for improvements in local areas. Amongst others, these cover the need for good quality early diagnosis and early intervention, continuity of support and advice in the community, improved home, hospital and care home services and improvement in support to families and carers. Our local proposals, detailed below, closely follow these national requirements.

7.2.2 The enhanced Memory Clinic would be complementary to and draw on the resources of the Community Rehabilitation Team for Dementia.

7.2.3 The model of service requires multi-disciplinary and multi-agency working, establishing an agreed pathway for the processing of third party referrals for the assessment of cognitive function.

7.2.4 The service will operate in conjunction with the Community Mental Health Teams, North and South, operated by ELF Trust through a single point of access at the Primrose Resource Centre. Initial assessments will be undertaken within individuals’ own homes within one working week. The Memory Clinic will review complex cases providing a multi-disciplinary approach with review by a physician in Elders Medicine, a Consultant Neurophysiologist and mental health professionals supported by administrative and clerical staff with access to ongoing support from a Community Rehabilitation Team developed as part of service re-provision as outlined in the ELF Trust Business Plan 2008.

7.2.5 It is proposed that the redeveloped Memory Clinic will be sited within the Bryning Assessment Unit at Homerton Hospital. The clinic would have access to specialist support from the Department of Neurology and from professions allied to Medicine and multi-agency provider

teams such as First Response. It will also support holistic assessment of the elderly person through joint working with the hospital elderly care team. The sitting of the clinic within a teaching hospital setting gives ready access to specialist diagnostic equipment such as MRI and CT scanning, with access to a range of laboratory based diagnostic services.

- 7.2.6 The service will provide regular reviews of progress and treatment with defined care pathways leading to engagement with both voluntary and statutory agencies.
- 7.2.7 It is initially envisaged that the clinic will work for a sessional period, 9 am to 1 pm on one day of each week. Appointments will be offered on a (1) a new patient extended appointment system, (2) regular follow-up appointment clinic basis. Assessments will initially require separate review by those in Neuro-psychology and Elders Medicine (it is anticipated that a Community Mental Health Review will already have been undertaken prior to clinic attendance). The medical support to the clinic will be jointly provided both from the Mental Health Trust and Homerton Foundation Trust. A new post of Staff Grade Psychiatrist is envisaged to support the development of a dedicated community focussed Dementia Care Team.
- 7.2.8 Referrals will be sought from GPs and Primary health care teams, the Community Rehabilitation and Homerton In Reach teams, the voluntary/third sector organisations. Self-referral will be considered. The sharing of information with Primary Care and statutory services through the Single Assessment Process (SAP) would be necessary to support this development.

7.3 Primary Care

- 7.3.1 We will continue to develop our primary care support services to ensure they are equally accessible to older people. A key role for primary medical services is to ensure, after assessment, referral to specialised services of older people with mental health problems.
- 7.3.2 Assessment and referral is core primary care practice but we are supporting, in partnership with Practice Based Commissioners, a new Enhanced Service to visit vulnerable & frail elderly (>75years) at home to do assessments and care planning. This will include identifying older people with mental health problems.
- 7.3.3 Another new Enhanced Service will identify people suffering from depression and anxiety and ensure access to counselling and other appropriate treatments. These will be reviewed regularly.
- 7.3.4 In addition, new pharmacy contracts introduced a new service for pharmacists to undertake 'Medicines Use Reviews' and provide assessments of the best way to administer multiple medications for

individual patients and then dispense each month according to needs. Pharmacists are also contracted to manage Compliance Aids which will benefit those with cognitive problems.

7.3.5 Further into the future in 2009-2010, practice based commissioning will promote the use of the 'Map of Medicine' as a tool to review care for older people with mental health problems and ensure care pathways are appropriate.

7.4 **Reduction of Suicide**

7.4.1 Whilst it is true to say that globally:

- Men aged 75yrs+ had the highest suicide rates of all men until 1997;
- Since 1998, men aged 15-44yrs have the highest rate at 19 per 100,000 population;
- Men aged 75yrs+ are now the second highest at 18.4 per 100,000 population;
- Women aged 75yrs+ and 45-74yrs, highest and second highest rates of suicide respectively, for all women 7.0 and 6.9 per 100,000 population;

the local picture is somewhat different. As a result of a suicide audit undertaken in City and Hackney for the years 2004-2006, the number of older people who committed suicide was significantly low.

7.4.2 The characteristics of suicide in later life include:

- Older people are more likely to be frail, live alone and are less likely to have someone intervene;
 - Depression is a leading cause of suicide in older people.
- Consequently, this strategy is looking to ensure home care and other community based services which visit older people in their own homes will help identify those who are expressing suicidal ideation. This would include such services as Community Matrons who support pain management for those with long term conditions.

As mentioned elsewhere, developments in Access to Psychological Therapies will be significantly enhanced for all in order to identify those with depression and other functional mental health problems.

7.5 Urgent Referrals

7.5.1 There are clear guidelines around response to urgent referrals including if a service user is thought to be of high risk of suicide which the Community Mental Health Teams (CMHTs) follow. These referrals will be assessed on the same day and within 4 hours. A management plan is then implemented to optimise patient safety. This team may consider urgent allocation to a CMHT worker, referral to the Home Treatment Team, hospital admission, use of the Mental Health Act, changing the care package to meet the current needs of patient including use of intermediate care.

7.6 Home Care

7.6.1 A review of current arrangements for home care services in both City and Hackney Boroughs has recently been undertaken with a strategy to focus on promoting independence through a broader menu of choice and cost effective services. In this context, both boroughs are exploring the development of personalised budgets (Individualised Budgets) through pilots which use as their base, individuals currently making use of Direct Payments. Provision will need to be made for older people with mental health problems to be supported through this process as they may not always make appropriate choices regarding their care needs.

7.6.2 In Hackney, it is estimated there will be a growth in demand for home care services and that this is likely to persist with increasing numbers of frail older people with complex health needs, including dementia. In re-tendering for services, emphasis has been given to adults with physical and/or learning disabilities and challenging behaviours, people with mental health needs and people who require dementia care.

7.6.3 Emphasis will also be given to adults whose carers have physical or mental health concerns themselves. It is estimated that up to 50% of carers in the UK suffer from clinical levels of stress, chronic depression and anxiety as they can be dealing with erratic or irrational behaviour on the part of the cared-for, heavy lifting and or physical or verbal abuse.

7.6.4 Home care services with a commitment to provide services which are person-centred, treat service users with sensitivity and respect, match needs and are outcome focussed will particularly benefit older people with mental ill health. However, person-centred planning will require a greater amount of support and training for carers to be provided by a range of agencies and colleagues including the newly enhanced dementia service.

7.7 Telecare and Telehealth

- 7.7.1 The Preventive Technology Grant from the government in April 2006 supported the development of Telecare and by March 2008, 700 individuals approximately will have benefited in Hackney, mostly older people. Telecare aims to support people with mental ill health to be able to live independently but to have access to 24hr support through a range of information and communication technological aids, such as the Community Alarm service. It is the continuous, automatic and remote monitoring of real time emergencies and life style changes over time, in order to manage the risks associated with independent living.
- 7.7.2 Telehealth on the other hand, is the remote exchange of physiological data between a patient at home and medical or other clinicians to assist in diagnosis and monitoring. It includes, amongst other things, a home unit to measure and monitor temperature, blood pressure and other vital signs for clinical review at a remote location using phone lines or wireless technology.
- 7.7.3 As yet, the use of these two technological advances has not been significantly developed locally for those with mental ill health. However, nationally, there are a number of Telecare products which have evidenced make a significant difference to the daily lives of those with Dementia and their carers. Progress in 'wiring up' our Median Road Intermediate Care facility and all of the Supported Living Schemes will enhance quality of life for older people in City and Hackney. The joint use of Telecare and Telehealth products can also make a positive contribution to supporting carers and those with dementia in their own homes.

7.8 Supported Housing with Care

- 7.8.1 Supporting People funding contributes significantly to providing housing related support which helps maintain older people in their own home. Existing services are currently being re-modelled to provide a Floating Support service which can be accessed by all older people in the borough, irrespective of their housing accommodation (currently only older people in sheltered accommodation receive this service). The specification for this new service specifically requires providers to provide a service to anyone aged 85yrs or over who wishes or needs it. This will make a significant contribution to supporting older people with mild to moderate mental ill health and those with dementia living in their own homes.
- 7.8.2 The service is currently undergoing re-modelling and in conjunction with their housing partners, LBH have designated two SLS units specifically for adults over 65yrs who have a mental ill-health diagnoses:

- Liz McKeon House (8 flats - ISHA) will provide a recovery service for older people, who will be tenants in their own flats for the duration of their stay. Staff in the scheme will support them to regain their life skills and help them to recover their confidence in their ability to manage independently. We expect that each tenant will stay in the scheme for up to a year. There will be a detailed plan at the outset, both to enable the staff and the service user to have realisable goals and a realistic timeframe, and to ensure that the unit does not simply become another long-stay facility by default;
- Catherine House (8 flats - Newlon Outward) will provide support for service users who have complex and enduring functional mental ill health diagnoses.

7.8.3 The recovery model at Liz McKeon House in particular appears to be unique for older adults and we expect that it will be watched with interest by the wider Health and Social Care community. The ELFT have agreed to support the work in these two SLS establishments by appointing a dedicated CPN to the service.

7.9 Hospital services

7.9.1 Care for people in general hospital (Homerton University Hospital Foundation NHS Trust, St Bartholomew's Hospital and St Joseph's Hospice). Consultation and liaison services are not supported by any formally commissioned services. It is now proposed that an in-reach service be provided by MHCOP services to local hospitals.

7.9.2 Homerton staff are increasingly aware of the specific needs of people with dementia. Where required, a 'one to one nurse' can be booked to supervise and support a patient with dementia to keep them safe; links with psychiatric services in the East Wing are strong and responsive and Homerton geriatricians are able to review patients who may be under the care of other consultants.

7.9.3 Within the Homerton work is ongoing in our Essence of Care programme and the Dignity Code initiative, plus planned work with learning disabilities, all support the philosophy of early assessment and identification of need, good communication and ensuring a safe and comfortable patient experience.

7.10 End of Life Care (EOLC)

7.10.1 End of life care services support those with advanced, progressive, incurable illness to live as well as possible until they die. These are services that enable the supportive and end of life care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement.

7.10.2 The development of EOLC services to support the National End of Life Care Strategy and Healthcare for London will incorporate and support the needs of people with mental health issues and their families.

7.10.3 Although EOLC services in the most recent past have been focussed on cancer patients, as part of the general enhancement and development of new EOLC service in C&H, these will be available for all those approaching end of life including those with enduring mental ill health. Already developed is our 'fast track tool' for ensuring access to palliative care services for those whose condition changes rapidly.

7.10.4 Ensuring that everyone approaching the end of life receives coordinated care, across sectors, and at all times of the day and night will require OP's MH services to play their appropriate part in the provision of developed coordinated services.

7.11 Psychological Therapies

7.11.1 The publication of 'Our Health, Our Care, Our Say' launched the Improving Access to Psychological Therapies (IAPT) programme in 2006. In 2007, the government announced significant funding increases for Psychological Therapies such that the NHS will spend £170m per year, with more than £30m in 2008/09 and more than £100m in 2009/10.

7.11.2 As part of this expansion programme, City and Hackney PCT has been selected as one of three expansion sites in London. This will result in significant development of the Primary Care Psychology Service. This service has already expanded from 3.6 wte¹¹ in 2006/07 and will increase to over 50 wte in 2008/09.

7.11.3 This will improve psychology therapy services to older people as currently they experience difficulty in accessing this type of service. Our aim is to improve the quality of service to older people by:

¹¹ Whole time equivalent.

- Providing waiting times in line with national targets;
- Implementing NICE anxiety and depression guidelines within a stepped model including NICE CBT technical guidance;
- Management by ELFT of the NICE Guidelines with respect to depression and schizophrenia with CBT and more psychodynamic models;
- Providing bereavement counselling which includes dealing with a diagnosis of dementia to people aged 55+ in partnership with Hackney Bereavement Service and East London Foundation NHS Trust. Their counsellors will see people in their own homes and can manage complex cases.

7.12 Under 65's with Dementia

7.12.1 Presently, support to younger people (under 65yrs) with dementia is managed largely through the older adult mental health service. It is estimated that within the City and Hackney locality there is approximately 40 individuals (Dementia UK 2007) with such a condition. However, this is likely to be an underestimate of the true position. While total numbers are relatively small, the impact on the individual and their family is likely to be great and the need for a specialist service is acknowledged. Work in this area is at an early stage and partners across boroughs are giving consideration to scoping the need for a pan-trust or inter-trust service for this group.

7.13 Black and Minority Ethnic communities

7.13.1 Greater emphasis will be placed on ensuring current information and advice services, both statutory and voluntary, are proactively ensuring that Black and Minority Ethnic communities are aware of local services for older people with mental ill health and how to access them. The role of the Community Development Worker with responsibility for older people's mental health has been, and will be, crucial in following through with awareness raising sessions about dementia and older people's mental ill health.

7.14 Alzheimer's Society

7.14.1 This organisation, based on the same site as the statutory acute service, already plays an important role locally and supports individuals, carers and family members of those with dementia. They currently work with over 250 local families where their 'Link' workers support individuals and families they are concerned about and for whom statutory packages are unsuccessful.

7.14.2 Whilst their current support services greatly contribute to the preventative agenda, as a small local branch of the Alzheimer's Society, they are under capacity and operate a 4-week waiting list for new referrals. Statutory colleagues estimate that an average of 15

referrals per month are received by them of people who are diagnosed with dementia but do not meet the criteria for their ongoing support. We plan to commission additional services to enable the Alzheimer's team to pick up on these individuals and to extend their range of services with support to a greater number of people using a 'care management' approach with an automatic referral scheme established direct from the statutory team. This will ensure that all individuals diagnosed with dementia but who do not require acute services, are systematically supported and regularly reviewed, particularly those in the early to moderate stages of their illness. This will help delay or prevent crisis and relieve strain from acute services and will liaise closely with statutory services where they feel individuals require further specialist support.

7.14.3 A further gap identified locally and identified as important in the draft National Dementia Strategy published in June 08 is the need for good quality information and advice and the local Alzheimer's Society will be funded to develop a guide for service users, carers and staff, providing information about all types of dementia and local services which are available to support people with dementia and their carers.

7.15 Dementia Respite

7.15.1 Respite is recognised both locally and nationally as a crucial support mechanism for carers and their families. The objectives of the new draft national strategy are that people with dementia and their carers should have services available at home that are:

- Seamless and continuous;
- Simple to access and use;
- Responsive in a crisis, and,
- Sensitive to the needs and preferences of the person with dementia.

7.15.2 Planned increases in the numbers of people supported in the community, as opposed to NHS continuing care or residential care facilities will likely increase demand for respite. We therefore plan to ensure, working across the local partnership, that there is a significant increase in home-based respite.

7.15.3 Respite care in the community can be provided in a variety of ways – short breaks, through a sitting service, and in some cases the cared for can be taken out to an activity or a club to empower the carer to have time for themselves. Night sitting is also currently available through TLC, a service funded by the PCT.

7.15.4 Median Road has a 6 bedded respite facility with 15 individuals using the service irregularly and 9 people being regular users. Work is being undertaken to identify why there is such a low take up of this emergency service. Median Road also manages the daily Dementia

Day Centre Service. Current mapping and review of these services will provide information on how best to improve future provision.

7.16 Carers

7.16.1 It is not possible to discuss the provision of dementia care without discussing the role of carers and the provision of respite care and advocacy. Carers UK estimate that carers perform £87 billion worth of home care each year – essentially creating a “shadow NHS”. Carers’ views are important in their own right, but may be different from those of the person with the mental health problem.

7.16.2 This Mental Health strategy for Older People wholeheartedly adopts the approach of ‘Carers at the heart of 21st-century families and communities’ where carers are recognised as partners with the right to choose whether to care at all and if so, how much and what tasks they are happy to do. Our approach requires a shift away from the culture of making assumptions about the willingness of carers to care to a position of them working equally with health and social care agencies. In Hackney alone, there are an estimated 16,000 or so carers, of whom only around 2,000 are currently known to the statutory or voluntary services. As part of a package of support measures, ‘The Hackney Carers Card’ was introduced in November 2007 in order to build up the data base of carers known to statutory services.

7.16.3 The ‘Carers at the heart of the 21st-century families and communities’ document also highlights the importance of short breaks and commits new government funding of £150m from the NHS over the next two years to fund more planned breaks for carers.

7.16.4 Young carers are often present in families with mental health issues most commonly a lone parent suffering mental ill health, and, a commonly hidden side of the caring by young carers, their support for their grandparents.

7.16.5 The City and Hackney Carers Centre is a voluntary organisation providing information, counselling, support groups, advice and short breaks to carers in the London Boroughs of City and Hackney. The organisation is currently working in partnership with Hackney Council to implement the Hackney Carers Strategy and smooth the gaps between the statutory and voluntary sectors. A mental health lead and older persons lead have been identified within the centre and will serve as points of contact for older people’s mental health issues.

7.16.6 The new Hackney Carers Strategy & Action Plan 2007-2010 states that “..caring often denies Carers a life of their own”. Supporting older people and their carers at the earliest stages of their dementia will become more of a priority in Hackney. Research has shown that people with dementia whose carers receive support and information – particularly in the form of Cognitive Behavioural Therapy (CBT) or

stress management training have significantly reduced behaviour disturbances.

7.17 Older People with Learning Disabilities

7.17.1 In 2006-2007, there were 512 people with a learning disability who were receiving local authority services, of whom 30 were aged between 60 and 65 years. Increased life expectancy of people with learning disabilities into mid-life and old age increases the likelihood of more complex health and social care needs, as well as a demand for increased housing support. People with mild learning disabilities can expect to live as long as the general population.

7.17.2 People with Downs Syndrome make up 15% of all people with learning disabilities. Life expectancy has improved dramatically from less than 10 years in the early 1900s to the present when more than half will live into their 50s and beyond. The average age of the onset of dementia is 54 years, average life expectancy from diagnosis to death is five years.

7.17.3 Increases in life expectancy of people with learning disabilities will, when combined with the ageing of the general population, lead to increased numbers of older people with learning disabilities whose carers are either deceased or in very old age.

7.18 Older People with mental ill health in Prisons

7.18.1 Arrangements are in place to ensure that all older people in prison requiring assessment and support from City & Hackney mental health services receive the support they require.

7.18.2 The City and Hackney Link worker project working in HMP Pentonville and HMP Holloway has not, as yet, identified any older people requiring their service. Similarly, the Court Diversion Service based at Thames Magistrate Court has not worked with anyone aged over 65 years in the last two years. However, as part of the regular review of these services, particular note will be made as to any change in this position.

7.19 Drugs and Alcohol

7.19.1 Drug and alcohol misuse are linked to the development of mental ill health and vice versa. Older people's drug and alcohol misuse is under researched in City and Hackney. Services are therefore under developed. However, high levels of 65-74yr old admissions to hospital with acute toxic effect of alcohol have been noted, particularly for Caribbean men. Similarly, the overall mortality rate (all ages) is likely to be mirrored for those aged 65yrs plus.

7.19.2 Likewise, there is no local data for drug abuse but Hackney problem drug users aged in the 35-55yr population are significantly older than

the national average (25-35yrs) and likely to present particular problems in the future.

7.19.3 Drugs and alcohol abuse in the older age groups will be the subject of review as part of the Joint Strategic Needs Assessment process.

7.20 **Ongoing Consultation processes**

7.20.1 New mechanisms will be developed for ensuring ongoing stakeholder involvement in the planning and delivery of the proposed new approach and user input and feedback into the quality and delivery of local services for older people with mental ill health.

8. CONCLUSIONS

- 8.1 This Strategy Document for the development of Mental Health Services for Older People is a joint statement of intent between City and Hackney Teaching Primary Care Trust , East London NHS Foundation Trust, City of London Corporation, London Borough of Hackney, Homerton University Hospital NHS Foundation Trust, Alzheimer's Society Branch for Hackney and City and Hackney Carer's Centre.
- 8.2 The purpose of this paper is to show clearly the key national and local strategic developmental priorities for mental health services for older people in City and Hackney. It also identifies the commissioning actions that need to be taken to implement those priorities.
- 8.3 At the heart of this strategy is a firm commitment to promoting the independence and quality of life for older people with mental health needs.
- 8.4 The Strategy Document sets out a shared vision and describes our 3-year rolling investment plans which will be subject to annual update.
- 8.5 The specifics of this strategy will, in the first instance, be presented for ratification to partnership structures and thereafter be out for public consultation in the autumn of 2008 and comments, are welcome. Please comment to:

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