



London Borough
of Hounslow

Hounslow **NHS**
Primary Care Trust

West London Mental Health **NHS**
NHS Trust

Strategy for Older People's Mental Health Services in Hounslow 2006/2010



This strategy is available in Braille by contacting Steve Barnes on 020 8583 4509, and is also available in the following community languages.

Albanian

Ky konsultim eshte lidhur me ndryshimet e mundshme ne sherbimet per shendetin mendor te njerezve te moshuar ne Hounslow. Kjo ka te beje me sherbimet ne te ardhmen te cilat ofrohen ne Brentford Lodge. Si shtese, komentet jane te ftuara ne strategjine skice per sherbimet per semundje mendore te njerezve te moshuar te cilat jane zhvilluar nga agjensionet ligjore ne Hounslow. Nese keni nevojte per te perkthyer ndonje informate mbrenda ketij dokumenti per konsultim ose strategjine skice, ju lutemi kontaktoni lidhjen tone per ndihme me gjuhen ne 020 8583 2299 dhe tregoni referencen OPMH06.

Arabic

تتعلق هذه الإستشارة بتغيير من المحتمل أن يطرأ على خدمات الصحة العقلية الخاصة بالأشخاص المُسنين في بلدية هاونسلو. ويخص هذا التغيير مستقبل الخدمات المُقدّمة بـ "برانتفورد لودج" (*Brentford Lodge*). زيادة على ذلك فإننا نرحب بالأراء المتعلقة بخطة المشروع واسع النطاق الخاص بخدمات الصحة العقلية للأشخاص المسنين الذي تم تطويره من قبل مكاتب قانونية في بلدية هاونسلو. إذا كنت ترغب في ترجمة أي معلومة تتضمنها وثيقة الإستشارة أو خطة المشروع ، فالرجاء الإتصال بخط المساعدة الخاص باللغات على الرقم الهاتفي 020 8583 2299 و اذكر العلامة: OPMH06

Farsi

این مشاورت در باره امکانات تغییراتی در حصه خدمات بهبودی روانی اشخاص مسن در هانزلو میباشد. این اهمیت مهم در قسمت آیندۀ خدماتی که برنت فورد لاج عرضه میکنند دارد. بر علاوه شما را دعوت مینمایم تا پیشنهاد های خود را در مورد طرح ابتدای ایجاد شده توسط کارکنان قانونی هانزلو در قسمت خدمات بهبودی روانی ارایه نمایید. اگر شما به کمک برای ترجمه اطلاعات این سند مشاورت و یا به کاپی ابتدای این طرح نیاز دارید لطفاً با خدمات زبان به شماره 020 8583 2299 تماس گرفته و ریفرنس OPMH06 را یاد آور شوید.

Gujerati

હાઉન્સલોમાં વૃદ્ધ લોકોની માનસિક આરોગ્યની સેવાઓમાં ફેરફાર થવાની શક્યતા છે એ બારામાં આ ચર્ચાવિચારણા થવાની છે. આથી બ્રેન્ટફર્ડ લોજમાં આપવામાં આવતી સેવાઓનું ભાવિ વિષે ચિંતા છે. તે ઉપરાંત, હાઉન્સલોમાં સરકારી એજન્સીઓ તરફથી, વૃદ્ધ લોકોની માનસિક આરોગ્યની સેવાઓ સંબંધી તૈયાર કરેલો વિસ્તૃત કાર્યયોજનાનો મુસદ્દો (ડ્રાફ્ટ)માં તમારા સૂચનો આવકારવામાં આવશે. જો તમને આ ચર્ચાવિચારણાનો દસ્તાવેજમાંથી અથવા કાર્યયોજનાનો મુસદ્દોમાંથી કોઈપણ માહિતી જુજરાનીમાં જાણવામાં મદદ જોઈતી હોય તો, મહેરબાની કરી અમારી લેવેજ હેલ્પલાઇનને આ નંબર પર સંપર્ક સાધો: 020 8583 2299 અને સાથે રેફરન્સ નંબર કહો: OPMH06

Hindi

यह परामर्श वृद्ध लोगों को हंसलो में मेंटल हेल्थ अथवा मानसिक सेवाओं की उपलब्धि के प्रस्ताविक परिवर्तन के विषय में किया जा रहा है। यह ब्रेंटफर्ड लॉज में उपलब्ध सेवाओं के भविष्य के बारे में है। इसके अतिरिक्त हंसलो में वृद्ध लोगों के लिए मानसिक सेवाओं पर सरकारी संस्थाओं द्वारा बनाई गई नीतियों की योजना पर भी विचार प्रकट करने के लिए आमंत्रित किया जाता है। इस प्रलेख के या नीतियों की योजनाओं का अनुवाद करने के लिए यदि आपको सहायता चाहिए तो कृपया हमारी लैंग्वेज हेल्पलाईन को 020 8583 2299 पर संपर्क करें और यह संदर्भ बताएं: OPMH06

Panjabi

ਇਹ ਵਿਚਾਰ-ਚਰਚਾ ਹੰਸਲੋ ਵਿਚ ਵੱਡੀ ਉਮਰ ਦੇ ਲੋਕਾਂ ਦੀਆਂ ਮਾਨਸਿਕ ਸਿਹਤ ਸੰਬੰਧੀ ਸੇਵਾਵਾਂ ਵਿਚ ਸੰਭਾਵੀ ਤਬਦੀਲੀ ਬਾਰੇ ਹੈ। ਇਸ ਦਾ ਬਰੈਂਟਫਰਡ ਲੌਜ ਵਿਖੇ ਭਵਿੱਖ ਵਿਚ ਦਿੱਤੀਆਂ ਜਾਣ ਵਾਲੀਆਂ ਸੇਵਾਵਾਂ 'ਤੇ ਅਸਰ ਹੋਵੇਗਾ। ਇਸ ਤੋਂ ਇਲਾਵਾ, ਹੰਸਲੋ ਵਿਚ ਕਾਨੂੰਨੀ ਜੱਥੇਬੰਦੀਆਂ ਦੁਆਰਾ ਵਿਕਸਤ ਕੀਤੀਆਂ ਜਾਣ ਵਾਲੀਆਂ ਵੱਡੀ ਉਮਰ ਦੇ ਲੋਕਾਂ ਦੀਆਂ ਮਾਨਸਿਕ ਸੇਵਾਵਾਂ ਦੀ ਨੀਤੀ 'ਤੇ ਵਿਸਤ੍ਰਿਤ ਰੂਪ ਵਿਚ ਵਿਚਾਰ ਵੀ ਪੁੱਛੇ ਜਾਣਗੇ। ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਵਿਚਾਰ-ਚਰਚੇ ਦੇ ਪਰਚੇ ਜਾਂ ਨੀਤੀ ਦੇ ਢਾਂਚੇ ਸੰਬੰਧੀ ਕਿਸੇ ਵੀ ਜਾਣਕਾਰੀ ਦਾ ਪੰਜਾਬੀ ਵਿਚ ਤਰਜਮਾ ਚਾਹੀਦਾ ਹੈ, ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ ਲੈਂਗੁਏਜ ਹੇਲਪ-ਲਾਈਨ ਨੂੰ ਇਸ ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ: 0208 583 2297 ਅਤੇ ਇਹ ਰੈਫਰੈਂਸ ਨੰਬਰ ਦੱਸੋ: OPMH06

Polish

Konsultacja ta dotyczy możliwych zmian w usługach w zakresie zdrowia psychicznego dla osób w podeszłym wieku w Hounslow. Dotyczy to przyszłych usług oferowanych przez Brentford Lodge. Prosimy także o sugestie dotyczące projektu przyszłego planu działania naznaczonego przez agencje rządowe w Hounslow w zakresie pomocy dla ludzi w podeszłym wieku wymagających opieki psychiatrycznej. Jeżeli potrzebują Państwo pomocy w przetłumaczeniu informacji zawartych w tym dokumencie lub w planie działania, prosimy skontaktować się z Language Helpline pod numerem 020 8583 2299 i podać referencję: OPMH06.

Somali

Wadatashagani waxa uu ku saabsan yahay is-beddel laga yaabo inuu ku yimaado adeegyada caafimaadka maskaxda dadka waaweyn ee Hounslow. Waxa ay la xiriirtaa mustaqbalka adeegyada laga bixiyo Brentford Lodge. Waxaa taas dheer, iyadoo la soo dhowaynayo wixii aragti ah ee laga dhiibanayo qoraalka qabyada istiraatijiyada guud ee adeegyada caafimaadka maskaxda dadka waaweyn oo ay soo saareen hay'adaha qaanuuniga ee Hounslow. Haddii aad u baahan tahay in lagaa caawiyo tujumaadda dokumentigan ama kan istiraatijiyada, fadlan la xiriir Khadka Luqadaha 020 8583 2299 adigoo soo xiganaya tixraaca: OPMH06

Urdu

یہ مشاورت ہائوسلو میں موجود عمر رسیدہ لوگوں کی دماغی صحت کی سروسز میں امکانی تبدیلی کے متعلق ہے۔ اس کا تعلق برینٹ فورڈ لاج کی طرف سے مہیا کردہ آئندہ کی سروسز سے ہے۔ اس کے ساتھ ساتھ عمر رسیدہ لوگوں کی دماغی صحت کی سروسز کے متعلق وسیع پیمانے پر مسودے کی حکمت عملی کے بارے میں لوگوں کی رائے پوچھنا بھی شامل ہے۔ اگر آپ کو اس دستاویز میں شامل کسی معلومات یا مسودے کی حکمت عملی کے بارے میں اُردو ترجمہ درکار ہو تو براہ کرم ہماری انگلینج، ہیلپ لائن سے اس نمبر 020 8583 2299 پر رابطہ کریں اور اس نمبر OPMH06 کا حوالہ دیں۔

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1 INTRODUCTION

1.1 Purpose of the Strategy

1.1.1 This Strategy for the development of Mental Health Services for Older People is a joint statement of intent between Hounslow Primary Care Trust, West London Mental Health Trust and Hounslow Council's Housing and Community Services Department.

1.1.2 The Strategy was released for consultation on 18th October 2006 and we posed a series of questions on which we particularly sought the views of interested parties. Comments were also welcome on the proposals contained in the document as a whole.

1.1.3 The consultation period ran from 18th October 2006 to 17th January 2007. Comments were received by:

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1.1.4 The purpose of this strategy is to show clearly the key national and local priorities for older people's mental health services and the commissioning actions that need to be taken to implement changes in services to meet those priorities. This document sets out the vision for services for older people with mental health needs in Hounslow.

1.1.5 Effective commissioning of OPMH services requires partners across health and social care economies,

including the independent sector, voluntary sector, users and carers, to have a shared vision for services and a strategy to implement it. This strategy makes reference to other existing documents and aims to provide a single reference point for the Hounslow Integrated Management Board for Older People's Mental Health Services and the Hounslow NSF Standard 7 Subgroup, as the two lead bodies overseeing the development of Older People's Mental Health Services. These bodies both report into the Older People's Partnership Board and the Older People's Executive.

- 1.1.6 The process of commissioning is informed by undertaking 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 Hounslow's older people with mental health needs both at the present time and in the future.
- 1.1.7 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**. Over the next four years, Hounslow Primary Care Trust and Hounslow Council's Housing and Community Services Department will commission services that aim to reach all of our diverse community and that support older people in living with independence in their homes. As a direct consequence of this commitment, all statutory organisations will need to focus on the management of risk. Older people themselves subscribe to the philosophy of living in the community for as long as possible and frequently do not agree with the risk assessment made on their behalf by others. By definition, older people with mental health needs will exhibit behaviour that is unpredictable and could on occasion cause potentially serious risk, usually to

themselves but, at times, also to others. It is nevertheless crucial that where possible these risks are managed in the community with the support of health and social care services. In Hounslow, this will involve developing assessment services, expanding opportunities for treatment, rehabilitation and respite and actively promoting high-quality domiciliary and residential care services.

1.1.8 Fundamental to this shared vision for the care of older people with mental health needs are agreed care pathways, which indicate in principle, the differing responsibilities of health and social care organisations, including those whose primary functions are around the physical health of older people.

1.1.9 The recent Care Services Improvement Partnership (CSIP) service development guide, ***Everybody's Business*** suggests that the success of a strategy depends on all organisations coming together to agree:

- The means and processes required for establishing levels of unmet needs in local populations;
- Credible data on which to base joint / multi-agency service purchasing;
- A common definition of commissioning, and clarity over the roles, functions and governance arrangements of the organisations involved;
- The budgets and resources available for investment;
- Purchasing priorities and plans for achieving them (including agreement on any necessary disinvestment in existing services);
- Methods of review and evaluation to inform future service planning and commissioning; and
- Geographical coherency in service provision.ⁱ

This strategy utilises the framework established in ***Everybody's Business*** as the template for consideration of these key issues.

1.1.10 Key issues pertaining to specific services are highlighted and relevant actions outlined throughout the strategy. In each section in chapter four, topics conclude with a box indicating what the key proposals for action are. In particular, the strategy sets out the intention to:

- Consult on a potential change to the usage of the Brentford Lodge site, whereby the day hospital assessment, rehabilitation and treatment services would potentially be expanded and bed-based respite care relocated to either Dove Ward or residential/nursing care homes dependent on clinical need;
- Implement agreed care protocols (including clarifying the entry and exit criteria for the Older Peoples Community Mental Health Team);
- Implement shadow reimbursement processes (in line with the Community Care (Delayed Discharges Etc.) Act 2003, which introduced liability for local authorities where they are found to be the sole reason for a delay in the discharge process);
- Scope the needs and models of care for people with a dual physical and mental health need; and
- Prioritise the provision of intermediate care services for older people with mental health needs.

1.2 National context

1.2.1 The OPMH commissioning strategy has been developed within the context of national policy and legislation. The following summaries draw particular attention to the issues raised for OPMH needs.

Legislation

- ***Mental Capacity Act 2005***

The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. It is due for implementation in April 2007 and contains five key principles:

- The presumption of capacity – ‘A person must be assumed to have capacity unless it is established that he lacks capacity’;
- Maximising decision-making capacity – ‘A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success’;
- The right for individuals to make what may be seen as eccentric or unwise decisions – ‘A person is not to be treated as unable to make a decision merely because he makes an unwise decision’;
- That anything done on behalf of people without capacity must be in their best interests – ‘An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests’; and
- That anything done on behalf of people without capacity should be the least restrictive of their basic rights and freedoms – ‘Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action’.

The emphasis on the assumption of capacity, unless proven otherwise, and on the rights for individuals to be supported to make their own decisions, are of pivotal importance. Mental vulnerability often increases the likelihood of things being done to the person rather than with or by them. The focus on 'decision specific' assessment of capacity and the principle that no one should be labelled 'incapable' as a result of a particular medical condition such as dementia is also a crucial policy shift.

Recognition of the need to assess an individual's capacity in a systematic way is also positive, as up until now there has been considerable variation both in methods of assessment and in whether capacity is routinely assessed at all. Carers should play a more significant role: their views should be taken account of in the assessment of capacity and they gain a right to be consulted about related care and treatment decisions.

The Act also introduces a new criminal offence of ill treatment or neglect of a person who lacks capacity. As dementia is a known risk factor for abuse, this is to be welcomed. There is however a recognition that where a person is providing care for someone who lacks capacity, they will not incur legal liability in the ordinary course of caring, e.g. for bathing them or giving them prescribed medication, as long as it is in the person's 'best interests'.

The Act introduces the role of Independent Mental Capacity Advocate (IMCA), which will be provided when some one who lacks capacity with no friends or family to support them, is faced with a decision about a serious medical treatment or a change in their long-term accommodation.

- ***Community Care (Delayed Discharges etc) Act 2003***

This Act requires Councils with Social Services Responsibilities to make payments to NHS acute trusts where the discharge of patients is delayed for reasons relating to the provision of community care services or services for carers. The responsible NHS body has to give notice that it considers it unlikely to be safe to discharge a patient unless one or more community care or carer services is made available, and notice of the day on which discharged is proposed. Social services

will make a decision as to which services will be made available. The liability to make delayed discharge payments on a daily basis applies if it has not been possible to discharge the patient because and only because the agreed community care or carer service has not been made available. The Department of Health has consulted in 2005 on extending the reimbursement process to mental health and non-acute care, and this extension remains under consideration.

- ***Mental Health Act 1983***

This Act sets out a legislative framework for the compulsory admission and detention in hospital of people with mental health needs. The Government plans to update the Act, with the amending Bill looking to ensure that legislation reflects the modernisation of services and the move towards more treatment in the community. The aim is to improve safeguards and increase the safety of individual patients, and protect the wider public from harm.

Policy

- ***Our Health, Our Care, Our Say: A new direction for community services - Department of Health – 2006***
- ***Independence, Well-being and Choice: Our vision for the future of social care for adults in England – Department of Health – 2005***

The Green Paper on social care and the subsequent White Paper on community services set out proposals for the future direction of health and social care for all adult care groups. The papers emphasise the importance of increasing control, choice and quality for those who use care services and highlights the necessity for social inclusion. The key proposals in the Green paper to deliver this vision included:

- Increased use of direct payments and the piloting of individual budgets to stimulate the development of modern services;
- A greater focus on preventative services and the use of the local government well-being agenda to promote social inclusion;
- Encouraging the development of new service models and utilising new the opportunities afforded by emerging technologies to deliver the best outcomes for adult social care; and
- A strong strategic and leadership role for local government, working in partnership with other agencies, particularly the NHS, to ensure a wide range of effective provision to meet the needs of diverse communities.

The White Paper sets out four main goals:

- Health and Social Care Services will provide better prevention services with earlier intervention;
 - People will be given more choice and a louder voice, including the development of a risk management framework to enable people using services to take greater control over decisions about the way they want to live their lives;
 - Increased access to community services; and
 - Increased support for people with long-term conditions.
- ***Everybody's Business – Integrated Mental Health Services for Older Adults: A Service Development Guide – Care Services Improvement Partnership – 2005***

This service development guide is committed to:

- Improving people's quality of life;
- Meeting complex needs in a co-ordinated way;
- Providing a person-centred approach; and
- Promoting age equality.

It contains six key messages for commissioners:

- Older people's mental health is everybody's business;
- Improving services for older people with mental health problems will help meet national targets and standards;
- Access to mental health services should be based on need not age;
- Older People need holistic care in mainstream services;
- Workforce development is central to driving service improvement; and
- Whole system commissioning and leadership are vital to deliver a comprehensive service.

- ***Moving On: Key Learning from Rowan Ward – Care Services Improvement Partnership - 2005***

In October 2002 the Greater Manchester Strategic Health Authority contacted the Commission for Health Improvement (CHI) to request an investigation into older age services at Manchester Mental Health & Social Care Trust (the trust). This followed allegations, in August 2002, of physical and emotional abuse of patients by care staff on Rowan ward, an isolated facility housing older people with mental health problems. The report highlighted the following issues:

- Geographical isolation
- Low staffing levels
- Lack of training
- Lack of nursing leadership
- Lack of clinical governance

CHI looked at the systems and processes that existed in the trust and wider health community to maintain the quality of care and ensure the safety of older patients prior to and following the Rowan ward allegations.

In November 2003 a meeting of chief executives of all Strategic Health Authorities (SHAs) agreed to review all services to assess the risk of events similar to those on Rowan Ward occurring in their area.

The Department of Health's Care Services Improvement Partnership (CSIP) highlight a number of lessons from this review in ***Moving On***, these include:

- The importance of user and carer involvement;
- Using and sharing good practice;
- Workforce development – particularly in relation to recruitment and retention;
- Integrated and partnership working;
- The importance of the built environment in promoting independence;
- Clinical governance, including a focus on evidence-based practice;
- Management capacity and leadership; and
- Investment.

Locally, West London Mental Health Trust audited their services to assess the adequacy of approaches to Risk Management, and identified a number of areas in which either action was needed or monitoring arrangements needed to be robust:

- Care settings should be assessed as being suitable to meet the needs of the individual Service User
- The culture and philosophy of care settings should be linked to improving the service user experience
- The continued need to implement policy on culture and diversity
- The continued need to adhere to the multi-agency code of practice to tackle abuse and that there are systems and processes to support its implementation and use
- The continued need to adhere to the Serious Untoward Incident policy, including the sharing, implementation and monitoring of recommendations from internal/external enquiries

- The continued need to adhere to policies, procedures, systems and processes in place to support recording, reporting of incidents, investigation and management action; and
- The continued need to adhere to policies, procedures, systems and processes that identify and meet the needs of staff - particularly around training and development.

West London Mental Health Trust and Hounslow PCT have confidence that this audit and action plan has adequately addressed the majority of the requirements for action stemming from the Rowan Ward Inquiry. However, the concern about geographical isolation remains unaddressed in relation to the respite service at **Brentford Lodge**. The proximity of Brentford Health Centre does not address this issue, as it predominantly relates to the level of medical cover available out-of-hours. The clinical governance issue continues to be a matter of concern for both agencies, as it is difficult to identify a cost effective solution. As the unit offers only ten beds in total, it lacks the economies of scale of larger units and increasing the staffing component to attempt address the issue would only be possible by dis-investing in other services. Further analysis of the financial position of the service is examined in Chapter 3.

- ***Care Services Inquiry – King's Fund – 2005***

The Care Services Inquiry was established to find out:

- Whether the care system operating in 2004 was meeting the needs and preferences of older Londoners who require care and support because of long-term ill health or disability; and
- Whether there will be sufficient care services of the right design and quality to meet the needs of older people in London in 20 years.

The key finding from the Inquiry is that there are major shortcomings in the current care system that disadvantage older people and their carers. They experience:

- Restricted access to care and practical support
- Limited choice and control over care services
- Being put at risk from untrained and unqualified staff
- Hardship caused by inadequate funding and controversy about who pays for long-term care.

The King's Fund calls for three actions to address these shortcomings:

- Investment in market development to strengthen consumer power, support growth and diversity in the market, and create incentives to provide high-quality services;
- Reform of social policies to ensure equality of opportunity for older people and a culture that focuses on their rights as well as their needs; and
- Mobilisation of more public and private resources for the care of older people and creation of greater transparency and certainty around long-term care finances.

- ***Releasing Resources for the Frontline: Independent Review of Public Sector Efficiency (Gershon review) – MH Treasury – 2005***

The public sector efficiency review led by Sir Peter Gershon identified over £20 billion worth of efficiency gains across all of government spending to be achieved by 2007/08. These savings have been directly factored into the 2004 Treasury Spending Review and consequently already form part of the long-term budget settlements for both local government and the NHS. Gershon states that “the Department of Health will realise total annual efficiency gains of around £6.5 billion by 2007-08, of which over half will be cashable, releasing resources for frontline activities”ⁱⁱ.

For local government, six key areas for efficiencies were highlighted. These being:

- Contact Centres;
- Procurement Best Practice;
- Improving and Increasing the use of Block Contracts;
- Better Demand Forecasting and Capacity Planning;
- Effective Home Care Monitoring by the introduction of E-monitoring of time/invoices; and
- Increased uptake of Direct Payments.

The review is, however, not unproblematic for health and social care services aimed at older people, as these tend to be labour intensive and accordingly, procurement efficiencies (aimed mainly at increased efficiency in office costs) are unlikely to form the basis of major savings. Trimming service costs will place pressure on the direct staffing costs and will have an impact on the statutory and independent sector's ability to recruit, retain and train staff.

- ***National Service Framework for Older People - Department of Health – 2001***
- ***Securing Better Mental Health for Older Adults – Department of Health – 2005***
- ***A New Ambition for Old Age - Next Steps in Implementing the National Service Framework for Older People- Department of Health – 2006***

Standard 7 of the NSF for Older People has the aim of promoting “good mental health in older people and to treat and support those older people with dementia and depression”.

It established the associated standard that “Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers.”

The milestones for the standard are:

By April 2004:

- Health Improvement and Modernisation Programmes and other relevant local plans developed with local authority and independent sector partners, should have included the development of an integrated mental health service for older people, including mental health promotion;
- PCG/Ts will have ensured that every general practice is using a protocol agreed with local specialist services, health and social services, to diagnose, treat and care for patients with depression or dementia; and
- Health and social care systems should have agreed protocols in place for the care and management of older people with mental health problems.ⁱⁱⁱ

Nationally, progress against these milestones has been inconsistent and they are revisited in *Securing Better Mental Health for Older Adults & A New Ambition for Old Age*.

Securing Better Mental Health for Older Adults sets out a vision of how mainstream and specialist health and social care services should work together to secure better mental health services for older people. Mainstream services are required to improve skills in detection and assessment of mental illness and equip staff with guidance on initial management and referral pathways. Specialist mental health services are seen as having several key functions – to support mainstream colleagues in developing guidance for the detection and initial management of mental illness; to provide services where there are issues of severity and risk; and to provide diagnoses in the early stages of dementia, where diagnosis is in doubt, where psychotic symptoms are present, for treatments that require their involvement due to national guidance or where the Mental Health Act is being considered.

There should be no automatic transfer from under to over 65 services. If younger adults have multiple, age-related physical co-morbidities, or suspected dementia, their needs may be better met by older adult services. Conversely if older adults are physically fit, or are well known to younger adult services, their needs may be better met by younger adult services.

Mental Health in Old Age is one of the 10 programmes highlighted in the NSF update document and four new aims are set for Older People's Mental Health Services:

- To ensure age equality in the development of mental health care for adults of all ages, with access to services on the basis of need, not age. This will also include the integration of underpinning programmes of work, such as support for service improvement, workforce development, guidelines development, research and development, information systems, performance management, and inspection and audit, across the younger and older adult mental health services.
- To improve the skills and competencies of staff to enhance detection and management of mental illness in all non-specialist settings, so that wherever people are, they are not discriminated against, and have their mental health needs managed well.
- To secure comprehensive specialist mental health services for older adults, with a particular emphasis on community mental health teams, memory assessment clinics, and liaison services.
- To promote mental health as part of active ageing.

1.3 Local Priorities

- 1.3.1 The local framework for the development of services includes the results of the Social Services Best Value Review of Older Peoples Services 2001, local priorities adopted by the Hounslow Partnership Board for Older

People and in the Hounslow Council Executive Business Plan, *“Supporting Vulnerable People”*.

- 1.3.2 In the early part of 2005, West London Mental Health Trust completed a Mental Health Service Model Review across Hounslow, Ealing and Hammersmith & Fulham. The Service Review aimed to:
- Identify a clear vision for the service(s) based upon best practice, National Service Frameworks Standards, Commissioning Intentions and relevant Department of Health guidance;
 - Develop a Service Model that will deliver the vision;
 - Work with key partners in Health and Social Services to facilitate the agreement of the Service Model;
 - Benchmark the current WLMHT services and undertake a gap analysis against the agreed Service Model as well as encouraging key partners to do the same;
 - Lead on developing an action plan in conjunction with key partners, that will include a reinvestment plan to support the current service(s) to achieve full implementation of the new Service Model in order to move forward; and
 - Be aware of, and include as appropriate, any new guidance, requirements or standards pertinent to the Mental Health Services for Older People, which are released during the review process.
- 1.3.3 In July 2004, Social Care services for Older People in Hounslow were inspected by the Commission for Social Care Inspection (CSCI). The Commission found that “the council had made significant progress in implementing plans to improve older people’s services, which were producing better outcomes for older people. Some changes were too recent to have made an impact, but were clearly focused on continued improvement in performance. We concluded that Hounslow was serving most people well, and that the capacity for improvement was promising”^{iv}.

- 1.3.4 Since the creation of Hounslow Primary Care Trust, achieving financial balance has been a major challenge. The PCT inherited serious financial deficits on its creation and fundamental changes are needed to correct this underlying problem. The bulk of the PCT budget is spent on commissioning services from other NHS Trusts, independent practitioners (GPs) or independent sector providers (both private and voluntary). Of this budget, 57% is spent on Acute Hospital activity. The increasing expenditure on commissioning over the last three years has broadly reflected the following factors:
- Increased emergency hospital activity (resulting from more walk-in patients and A&E 4-hour targets affecting admissions);
 - Increased planned hospital activity, as health needs are identified and addressed and Trusts have increased work to reduce waiting times and deliver NHS Plan targets; and
 - Increasing numbers of people with long term care needs living longer.

This has led to increased expenditure on hospital care and on long term care.

- 1.3.5 If Hounslow PCT are to achieve financial balance, two things need to be achieved:
- Matching annual expenditure to income in year, commissioning a reduced portfolio of services to meet local needs within the annual allocation; and
 - Over the next three years find ways, recurrent and non-recurrent, to pay back debts amounting to approximately £10.3m (both inherited and accumulated).

Small-scale efficiency savings cannot achieve reducing expenditure on this scale. It can only be achieved by service review and redesign. Nor can spending simply be turned off, without reference to the needs of the

population, the demand for services, and the rules applied to the commissioning of services within the NHS. Consequently, for 2006/07 Hounslow PCT has looked to reduce its expenditure on mental health services by less than the reduction being sought elsewhere, 3% as opposed to 5% generally.

For 2006/07, the PCT requirement for a 3% reduction equates to £80,000 with regard to older people's services. In order to achieve financial balance, West London Mental Health Trust needs to make a similar saving.

- 1.3.6 Financial pressures are however not unique to the NHS. In 2005/06, Hounslow Housing and Community Services overspent by approximately £1,000,000 on domiciliary care services for older people. All older peoples teams overspent on domiciliary care and there is concern that part of this overspend is attributable to the pressure to maintain older people with mental health needs in community settings.
- 1.3.7 In the past year, Hounslow Council has produced an Older Peoples Housing Strategy. This strategy aims to provide the Council, and its partners from health, community and provider organisations, particularly Hounslow Homes (the Council's Arms Length Management Organisation), with a framework for the future planning of accommodation and related services for older people. The scope of the strategy is wider than the 15% of vulnerable older people who are regular users of health and social care services. It is aimed at all older people in the borough, across tenure and income groups, and across all types of housing provision, both ordinary as well as specialist housing. In order to address the wider aims around quality of life and social inclusion, the strategy also relates to the broader local strategic context as set out in the Hounslow Community Plan. One of the key recommendations from the strategy is to integrate

housing and related care and support services into this Strategy.

- 1.3.8 Hounslow is committed to working in partnership to ensure the safety and effective risk management of adults and children who may be at risk from abuse and/or neglect. Hounslow aims to ensure that people who access services have a right to live a life free from abuse, neglect and discrimination.

A multi agency Safeguarding Adults procedure is in place to ensure there are appropriate procedures to address physical, sexual, psychological, financial or material and discriminatory abuse and acts of neglect or omission.

All providers are expected to adhere to the principles and procedures laid out within this. Whilst this strategy focus's on vulnerable adults the Council and Primary Care Trust expect all providers to be mindful of the risks to children and to forge appropriate links with the Councils Child Protection Team.

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

2.1.1 Hounslow Social Services & Health Partnerships, Hounslow Primary Care Trust, West Middlesex University Hospital and West London Mental Health Trust adopted the following vision for older people's services in 2004. In 2005, one amendment was made in recognising the requirement to take account of older people's sexuality. This recognises that there are both the increasing numbers of older people who are lesbian, gay, bisexual and transgendered (LGBT), and that the older LGBT community is increasingly visible.

2.1.2 Our vision is that, in partnership with local people, we will provide local health and care services that:

- Help you maintain your independence and safety
- Are of high quality and meet required standards
- Are provided in a timely and responsive way
- Promote dignity, self-respect and individuality
- Offer choice, wherever possible
- Meet your unique and individual needs
- Also meet the needs of your carer, if you have one
- Are appropriate and take account of age, gender, ethnicity, religion & sexuality
- Are publicised widely and made accessible to all
- Provide opportunities for you and your carer to influence the development and delivery of services

2.1.3 We will take a shared approach to your care:

- We will actively seek and listen to your views and wishes and we will involve you in decisions.
- We will follow a single, co-ordinated approach to identifying your health and care needs and to arranging your services. With your agreement, we will share information about you to make this happen.

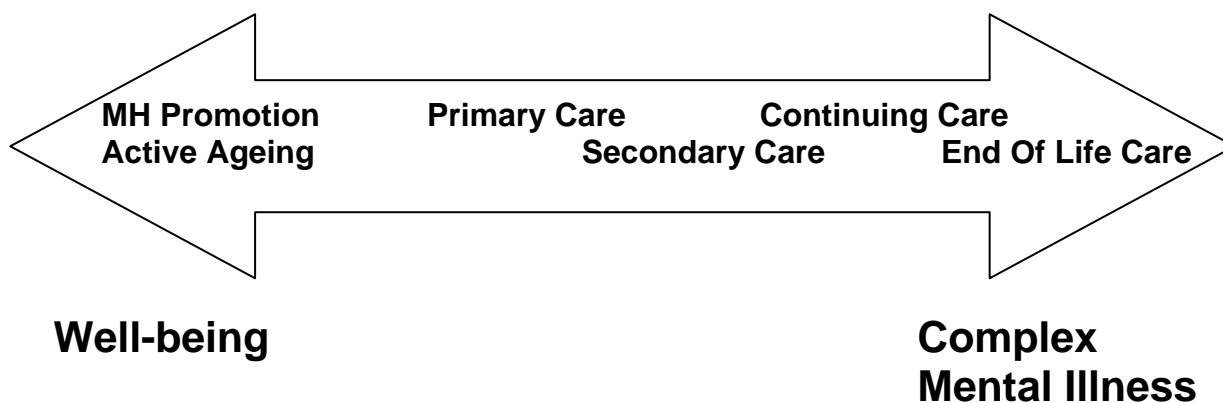
2.1.4 With respect to Older People with Mental Health Needs, the Integrated Management Board for Older People's

Mental Health Services and the Hounslow NSF Standard 7 Subgroup have identified that services should:

- Understand the importance of securing quick and accurate diagnoses at the earliest possible time and that means providing support to strengthen the skills and capacity that exist within primary care;
- Understand that no-one has the power to compel an older person to be accommodated against their expressed wishes on the grounds of a lack of mental capacity, unless action is taken under the auspices of the Mental Health Act 1983 (including the use of Guardianship under s7);
- Actively promote mental well-being to reduce the negative perception of mental health and older age;
- Be commissioned and developed in response to identified needs, delivered according to best practice and based upon evidence;
- Be responsive, sensitive, and as community based as possible;
- Be 'joined up', operating across the whole system and consolidating partnership working at all levels;
- Be designed and developed in partnership with older people with mental health needs and their carers;
- Be provided by organisations with a learning culture and clear governance frameworks; and
- Ensure the same access to the range of services available to Working Age Adults including access to counselling and therapeutic services.

3. THE CURRENT SERVICE MODEL

3.1.1 The service model is designed on the basis of a continuum, that has at one end 'individual well-being', travels through various stages where mental health problems may be encountered and recognises at the other extreme, serious ill health and end of life care. The model recognises that the journey for an individual older person is not likely to be a smooth linear path along the continuum, and enables us to clearly define the input required at each stage, as well as underlining the importance of the multi-agency, multidisciplinary nature of such a service. The service model is represented in simple diagrammatical form below.



3.1.2 Hounslow Primary Care Trust, West London Mental Health Trust and Hounslow Council's Housing And Community Services Department are seeking to support the modernisation of Mental Health Services for Older People through the development of earlier diagnosis, integrated assessment processes and the development of a range of services designed to meet the needs of older people at different points on the criteria rather than continued reliance on either in-patient beds or residential and nursing care. We believe that the vast majority of care should be provided in the community and as part of our aim to develop integrated care pathways, we envisage specialist services not as in-patient beds but more as a collection of a range of specialist services meeting different needs. We will need to continue to

evaluate overall bed capacity in the light of future investment and the development of innovative service models.

- 3.1.3 The current patterns of health provision for older people with mental health problems is largely delivered through discrete services and can be mapped relatively easily. It is more difficult, however, to quantify Council services for this client group, for whilst there is some specialist provision, individuals will also access a range of services available to older people in general.

3.2 Hospital Care

- 3.2.1 **Dove Ward** has 21 in-patient Beds, commissioned by Hounslow PCT and provided by West London Mental Health Trust (further information in chapter 5.15). This equates to 8.8 beds per 10,000 people aged 65 and over in Hounslow. This is slightly lower than Ealing (32 beds, equating to 9.2 beds per 10,000 people aged 65 and over) and substantially higher than Hammersmith & Fulham (12 beds, equating to 7.2 beds per 10,000 people aged 65 and over).
- 3.2.2 The profile of admissions to in-patient care is relatively standard. In the calendar year 2005, there were 75 admissions of older people into in-patient care for Hounslow (31.3 per 10,000 people aged 65 and over), this was higher than in both Ealing (106, equating to 30.5 per 10,000 people aged 65 and over), and Hammersmith & Fulham (46, equating to 27.1 per 10,000 people aged 65 and over).
- 3.2.3 Admissions under the Mental Health Act are substantially higher in Ealing than the other two boroughs. In the last six months of 2005, 53% of admissions in Ealing were formally detained, compared to 20% and 23% for Hounslow and Hammersmith & Fulham.

3.3 Residential & Nursing Care

- 3.3.1 **Charlotte House** has 22 Beds, commissioned on a block contract by Hounslow PCT and provided by Care UK. **Coniston Lodge & Derwent Lodge** have 15 and 8 beds respectively commissioned on block contracts by Hounslow PCT and provided by Lifestyle plc, of these beds 2 and 3 are currently EMI registered. **The Cloisters** has 11 beds commissioned on a block contract by Hounslow PCT and provided by Alpha Health Care, whilst none of these are currently EMI registered, the home has recently applied for a variance to its registration to enable such a service to be offered.
- 3.3.2 Hounslow PCT also supports 46 older people in care homes with nursing with individual 'spot' contracts in place. At present no distinction is made in recording between older people with predominantly mental health needs and older people with needs related to their physical health, and it is therefore not possible to accurately calculate spend on older people with mental health needs.
- 3.3.3 Hounslow Council directly provides three residential care homes (**Sandbanks, Heston House and Clifton Gardens**), which provide 33, 60 and 35 beds respectively. Of these beds 8, 8 and 21 are currently registered for dementia care. Work is currently underway to extend Clifton Gardens to provide 43 beds in total, this has been made possible through the re-investment of a proportion of the proceeds of the sale of Chiswick Lodge.
- 3.3.4 Hounslow Council has block contracts for care homes with nursing with **Dudley House**, which is an independent home (providing 20 beds, all elderly frail), **Norwood Green Care Centre**, provided by Four Season Healthcare (providing 22 beds, of which 7 are EMI

registered) and as above with **Coniston Lodge & Derwent Lodge**, provided by Lifestyle plc (providing 56 beds, of which 20 are EMI registered). The Council also has two care homes, which operate under contract to not for profit organisations with charitable status, these are **Feltham Dene**, operated by Shaw Homes (providing 40 beds, of which 20 are registered for dementia care), and **John Collin House**, operated by Servite Houses (providing 26 beds, all elderly frail).

- 3.3.5 In addition, Hounslow Council is responsible for approximately 250 placements (as at 1st April 2006), which are contracted on a 'spot' basis.
- 3.3.6 The Commission for Social Care Inspection (CSCI) registers, inspects and reports on social care services in England. There are now three different types of inspection for care homes (key inspections, random inspections and thematic inspections). Inspection reports are public domain documents, accessible through the CSCI website, and are used by commissioners and contracts officers in helping to assess the quality of a service.
- 3.3.7 **Key inspections** are a thorough look at how well the service is doing. They take into account detailed information provided by the service's owner or manager, and any complaints or concerns received since the last inspection. Inspectors also ask the views of the people who use those services and their relatives and advocates. Inspectors look at how well the service is meeting the standards set by the government and decide how they will inspect the service in future. These inspections are mainly unannounced.
- 3.3.8 **Random inspections** are short, targeted inspections which focus on specific issues that have come up or check on improvements that should have been made.

Random inspections are also used to investigate complaints. Random inspections are normally unannounced and can take place at any time of the day or night.

3.3.9 **Thematic inspections** focus on a specific issue, such as medication, or a specific area or region so that we can look at trends. The Commission produce reports for government and the public about what is happening in England's care services based on the findings.

3.4 **Extra Care Housing**

3.4.1 Extra care housing provides extra support whilst enabling older people to live as independently as possible and retain a tenancy. This is for older people who are physically or mentally frail and need extra help to manage, and who might otherwise need residential or nursing care. . The aim is to promote independence, while offering an on-site care team to meet needs flexibly 24 hours a day.

3.4.2 There is currently one scheme in Hounslow, which is at **Dashwood Court** (36 flats), with Thames Valley Housing providing housing management and the Council directly providing the care element. It is for older people with both physical health and mild to moderate mental health difficulties, either living on their own or with a partner. A second scheme is under construction in Brentford at present and will provide 43 flats, some of which will be available on a shared ownership basis. This scheme is scheduled to open in early 2008 and will be managed by Housing 21.

3.5 **Day Services (Day Care/Day Hospital)**

3.5.1 Day Services for older people with mental health needs fall into three main categories:

- First Tier – For people with low to moderate needs who can access either mainstream day support services for older people or for older people with mental health problems;
- Second Tier – Specialist day support for people with moderate to severe mental health problems; and
- Third Tier – Day Hospital/Treatment services offering intensive multi-disciplinary assessment and treatment for older people with complex mental health needs, so as to reduce the need for admission to institutionalised care or to aid recovery following an admission.

3.5.2 In Hounslow, this provision is mapped in the table below:

Level	Provision
First Tier	Services provided by Hounslow Housing & Community Services <ul style="list-style-type: none"> • Chiswick Resource Centre • Heston Resource Centre • Sandbanks Resource Centre Services commissioned by Hounslow Housing & Community Services /Hounslow PCT and provided by the Voluntary Sector <ul style="list-style-type: none"> • Age Concern Feltham, Hanworth & Bedfont • Age Concern Hounslow • Centre for Armenian Information & Advice • Heston & Isleworth Older People's Welfare Committee • Southall Day Centre
Second Tier	Services provided by Hounslow Housing & Community Services <ul style="list-style-type: none"> • Chiswick Resource Centre • Sandbanks Resource Centre Services commissioned by Hounslow Housing & Community Services and

	provided by the Voluntary Sector <ul style="list-style-type: none"> • Age Concern Feltham, Hanworth & Bedfont
Third Tier	Services commissioned by Hounslow PCT and provided by West London Mental Health Trust <ul style="list-style-type: none"> • Brentford Lodge Day Hospital (organic and functional)

3.5.3 Third Tier provision is substantially lower in Hounslow than in neighbouring boroughs. Hounslow currently offers 7 places, equating to 2.9 places per 10,000 people aged 65 and over. This is substantially lower than Ealing (45 places, equating to 12.9 places per 10,000 people aged 65 and over) and substantially lower than Hammersmith & Fulham (18 places, equating to 10.8 beds per 10,000 people aged 65 and over)

3.6 Respite Care

3.6.1 The majority of bed-based respite care in Hounslow is provided through **Brentford Lodge** (commissioned by Hounslow PCT and provided by West London Mental Health Trust, 8 beds) and **Clifton Gardens** (as above, directly provided by Hounslow Council, 2 beds), with a small amount of bed-based respite care being provided by Hounslow Housing & Community Services/Hounslow PCT, either by spot purchasing appropriate care or using capacity on block contracts in independent sector residential and nursing homes, as above. Further information is contained in chapter 5.8.

3.6.2 Respite is not available in either Ealing or Hammersmith & Fulham through West London Mental Health Trust. Ealing offered eight beds until September 2005, when Derwent Ward closed.

3.7 Community Services

- 3.7.1 Initial assessment should usually be within the Community Mental Health Team. Patients with complex mental health needs should be treated and supported in the community and wherever practicable at home.

There is one Community Mental Health Team (CMHT) covering the whole borough. The integrated multidisciplinary team includes medical, nursing, psychology, occupational therapy and administrative staff and social workers. It operates a single point of entry and open referral pathway.

All referrals to the psychiatric outpatient service come via the CMHT. New referrals should always be seen by or discussed with a Consultant/Specialist Registrar/Senior Medical Clinician.

Out Patient Services are provided from both West Middlesex and primary care premises by 3 consultants and junior medical staff.

The three Consultant Psychiatrists each provide one session a week to provide specialist advice to older people accommodated in the 22-bedded PCT contract at Charlotte House. Four of these beds have been designated for short-stay (respite/assessment), where beds are used for assessment, the Consultant provides specialist advice throughout the placement to assist the responsible care manager in ascertaining and realising the potential of the assessed person to continue to be supported to live in a community setting. For permanent residents, the nature of contact is regular monitoring and assisting the home in the management of residents.

- 3.7.2 New referrals to the Community Mental Health Team are similar across the Mental Health Trust. In 2005, Hounslow had 418 referrals, equating to 174.5 per 10,000 people aged 65 and over. Comparatively, Ealing had 651 referrals, equating to 187.4 per 10,000 people aged 65

and over, and Hammersmith & Fulham had 253 referrals, equating to 152.2 per 10,000 people aged 65 and over.

3.8 Hospital Liaison

A Community Psychiatric Nurse is employed to provide a liaison service at West Middlesex University Hospital as part of the Integrated Assessment, Rehabilitation & Discharge Service.

3.9 Voluntary Sector

3.9.1 In addition to the first/second tier day support services referred to above, services are commissioned from Alzheimer's Society, Crossroads and Matrix.

The **Alzheimer's Society** are funded to provide the following:

- Operate a daily Helpline supported by the national Alzheimer Society team and provide advice and information locally from 9.00am to 5.00pm by telephone that may operate by recorded message and call-back when staff are not available.
- Provide outreach support on dementia care for an active caseload of 30 clients in their own homes. The outreach service carries out individual assessment of need, identifying problems associated with the experience of dementia. Using a person-centred approach offers advocacy, support, information, education and advice. The service to individuals or families may be of a short term or long term duration.
- Two Carer Support Groups which are run once a month, one day time group for older people and one in the evening for mainly younger people who work.
- Provide carer training and education programmes twice a year for 6 weeks for new carers.

The Branch has identified the need for a meeting place that promotes social inclusion among people with dementia and this is provided by the weekly 50/50 social group. Although this is not a funded service, the Trust accepts that the necessary involvement of the outreach worker and manager in this activity will have some impact on the time available for outreach work.

It is recognised that the Organisation spends time on other areas including work with their national organisation the Alzheimer's Society.

Crossroads provide respite care in the service user's home to leave their Carer free for that time to pursue their own activity according to their own preferences. From April 2003, the number of respite hours was increased from 12,500 to 16,660 annually. This increase enabled the provision of a specialist service (of some 2080 hours each) to those people experiencing mental health problems, and increase the service provision to black and minority ethnic carers, to reflect Hounslow's population and diversity.

Matrix provide one-to-one advocacy in the in-patient setting at Dove Ward on the Lakeside Mental Health Unit, to meet the needs of vulnerable older people with serious mental health problems who require assistance and support in accessing services, in safeguarding their rights and in resolving problems or complaints associated with the mental health services they are receiving.

Throughout its work the service aims to empower service users to take charge of their own lives and to develop the skills, confidence and knowledge to be able to resolve future issues and problems themselves.

3.10 Budget for Older Peoples Mental Health Services

3.10.1 It is difficult to identify the exact spend on mental health services for older people – below is our best estimate of current investment.

3.10.2 As with the Service Profile, Local Authority budget systems do not readily allow analysis of expenditure at sub-specialty level. In Health, specialty costing is not as advanced for Mental Health and Community services as it is for Acute services. In the table below, services for all Older People are given in italics.

3.10.3 Currently the range of services provided to older people with mental health problems represent a largely traditional model, with the emphasis on residential provision, whether this be in hospital or residential / nursing homes. It is the intention of all statutory agencies to shift the balance of investment, with more spending on home based support services and less on long term residential placements.

3.11 **Changes Under Consultation**

3.11.1 The following information is also contained in the Consultation Document:

Brentford Lodge & Dove Ward sites

Brentford Lodge currently offers two services:

- Bed-based respite care (with 8 beds commissioned by Hounslow PCT); and a
- Day Hospital, offering assessment and treatment for older people with mental health needs (7 places).

Option 1 – maintaining the bed-based respite service at Brentford Lodge (8 beds) and either significantly reducing the scope of the Community Mental Health Team for Older People or closing the Day Hospital

This option would be the least disruptive to older people receiving the respite service and their carers, who

undoubtedly value the service provided at Brentford Lodge. Action would need to be taken to address the clinical governance issue referred to as key issue #3, and this would mean needing to significantly invest in additional staff and consequently further disinvest in other services for older people with mental health needs. This has been calculated as requiring an investment of £80,000, increasing investment into Brentford Lodge to £716,000.

When added to the financial implications from key issue #2, Hounslow PCT and West London Mental Health Trust would need to find a saving of approximately £254,000 from other commissioned services. There is no scope to reduce the wider commissioning budget for older peoples services to achieve this, as this has been reviewed to release savings for the PCT's Turnaround Plan and consequently, this saving would need to come from the Older People's Community Mental Health Team or Day Hospital. Such a saving would significantly reduce the service able to be offered. Hounslow PCT, West London Mental Health Trust and Hounslow Council are concerned that any substantial reduction in the Older People's Community Mental Health Team would affect the ability of the statutory partners to meet the high-level commitment to promoting independence for older people with mental health needs expressed in key issue #1, and significantly affect older people and their carers currently receiving service through the Community Mental Health Team for Older People.

Option 2 – ceasing the provision of accommodated respite care at Brentford Lodge, by utilising either Dove Ward or residential/nursing care homes to reprovide the existing service and expanding the Day Hospital & accommodating the Community Mental Health Team for Older People at Brentford Lodge

Under this option, the existing respite service at Brentford Lodge would cease. The regular service users would be offered ongoing respite either on Dove Ward or in residential/nursing care homes, dependent on clinical need and an up-to-date assessment of care needs. All existing respite patterns would be honoured, only on a different site.

There are currently approximately 20 older people who receive regular respite at Brentford Lodge. Initial screening of these indicates that the Consultant Psycho-geriatricians would recommend that 13 of these should be offered ongoing respite at Dove Ward. This is because there is an element of ongoing assessment and treatment that is required in these cases, in addition to the respite offering a break to a carer. The Consultant Psycho-geriatricians have indicated that the remaining 7 older people would be able to offered respite in residential/nursing care homes, as they have relatively stable care needs.

The occupancy patterns of Brentford Lodge, Dove Ward and PCT contracts with care homes in 2005/06 indicate that the Brentford Lodge activity could be reprovided by maximising occupancy on other contracts, without the need for substantial further investment, and this would allow for a saving to be made covering the requirement outlined in key issue #2. Furthermore, the scale of saving would allow for an expansion in day hospital provision outlined in key issue #1.

By bringing those older people who require Consultant Psycho-geriatric supervision of their stay onto Dove Ward, the clinical governance risks outlined in key issue #3 are addressed. For those older people receiving respite in residential and nursing care homes, the supervisory regime established by the Commission for Social Care Inspection addresses this issue.

The revised costing for Brentford Lodge as an expanded Day Hospital is £302,000 per annum. This includes a staffing structure including five nursing posts, two therapy posts and administration. It also includes increased transport costs. The saving achieved of £334,000 would cover the required saving of £174,000 and allow for a further £160,000 to be re-invested in Older People's Mental Health Services. If approved, further discussion as to the priorities for this would form part of the Commissioning Round for 2007/08. It remains a possibility that the PCT will need to make further savings and whilst it is hoped that this will not impact on developing services, the money released should be considered as vulnerable either as a further saving or to address other cost pressures in Older People's Services.

The changes would require some changes to be made to the building at Brentford Lodge. This is not expected to exceed a £50,000 one-off capital allocation within the West London Mental Health Trust budget.

Budgets (2006/07 figures)	Funding Authority	
	Hounslow Council	Hounslow PCT
Type of Provision	£	£
Mental Health Hospital Care	-	£809,700
Residential & Nursing Care:		
• Direct Provision:	£4,968,000	-
• Block Contracts:	£4,331,000	£1,799,000
• Individual Spot Contracts:	£5,841,000	£1,176,000
• Respite Care:	£61,000	-
Day Support Services:		
• Directly Provided:	£2,221,000	-
• Age Concern FHB	£121,300	-
• Age Concern Hounslow:	£64,100	£48,100
• Armenian Centre:	£2,900	-
• Heston & Isleworth OPWC:	£31,000	-
• Southall Day Centre:	£6,600	-
Community Mental Health Team for Older People	-	£482,800

Brentford Lodge	-	£636,000
Psychiatric Team	-	£935,100
Voluntary Sector Contracts:		
• Alzheimer's Society:	£37,100	£42,300
• Crossroads:	£117,600	£118,700
• Matrix:	-	£16,700
Totals	£17,802,600	£5,964,400

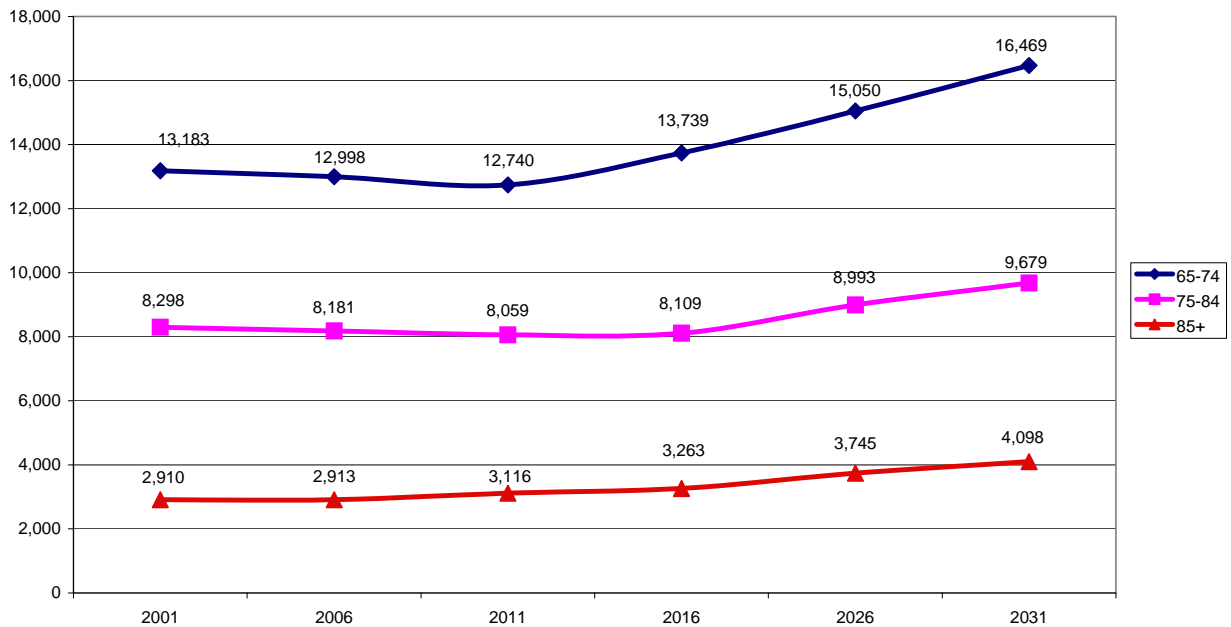
4. NEEDS ASSESSMENT

4.1 Demographic trends – population figures

- 4.1.1 The Greater London Authority 2005 Interim Demographic Projections were published in September 2005. They project forward the mid-year 2004 population estimates to give an indication of future trends in population by age and sex for the next 25 years to 2031. Being trend-based projections, assumptions for future levels of births, deaths and migration are based on observed levels over the previous years.
- 4.1.2 The projections are produced on a consistent basis across all local authorities in England. They do not take into account any future policy changes or local development policies that have not yet occurred.
- 4.1.3 Compared to the population projections used in the Commissioning Strategy for Older People 2004/07, they suggest that there will be a less pronounced reduction in the number of older people in Hounslow and that this will reach a turning point in 2009 after which the population of older people will start to increase. By 2012/13, the numbers of older people resident in Hounslow are projected to have returned to the levels found in the 2001 Census. As ever, the projections need to be treated with a degree of caution as they are subject to a fairly wide margin of error, which increases substantially the further into the future that projections are made.^v
- 4.1.4 For the older population as a whole, this represents a decrease to 2009 from 2001 of approximately 560 people or 2.2%. The decrease in population by age group shows that the 65-74 and 75-84 age groups are projected to decline at 3.7% and 2.8% respectively, whilst for over 85s the population is projected to increase by 5.9%. This increase in the oldest group in the population is in contrast to previous projections.

4.1.5 The rate of growth for all three age groups is projected to be fairly similar after 2009. From 2009-2031, there is a projected increase in the numbers of older people living locally of 27% (approximately 1.2% per year over the period). By 2031, the demands placed on health and social care services by older people will have increased significantly. This is downward revision from the last projection (of approximately 10% by 2028).

Population Projections, Age Groups by total, 2001-2031 (GLA 2005 Round Demographic Projections - Scenario 8.07)



4.2 Black and Minority Ethnic Elders

4.2.1 The population projections referred to above have not updated any of the previous projections with regard to ethnicity, and it continues to be assumed that older people from black and minority ethnic backgrounds will form around a quarter of Hounslow older people by 2011^{vi}.

4.2.2 At the time of the 2001 census, older people BME elders made up over 40% of all older people in two wards (Hounslow Heath and Hounslow West), and over 30% in

a further five wards. All seven wards are located in the central Hounslow Care Community (32.9% of all older people in the area were from BME backgrounds, compared to 9.2% in Chiswick Care Community and 5.2% in Feltham). If rates of population change were consistent with the projections, then it would be likely that by 2008 BME elders would be a majority of older people in at least two wards. Given that census has shown these projections to have under-estimated numbers of BME elders, it is likely that this will happen earlier.

- 4.2.3 Planning services for older people from black and minority ethnic groups, requires a recognition that black and minority ethnic elders face a potential triple jeopardy^{vii}. They may be at risk because of old age, because of social discrimination and because of a lack of access to health and social care services, all of which can lead to a particular vulnerability to mental illness in these groups. Although there have been more studies of older immigrants in recent years, there is a relative lack of research.
- 4.2.4 Livingston and Sembhi found that “cross-cultural assessment of dementia in older people has specific pitfalls related to language and literacy skills. In particular, the use of culturally biased screening instruments that rely on language recognition and familiarity with test situations may be inappropriate or misleading for people with cognitive impairment”^{viii}.
- 4.2.5 In the ONS psychiatric morbidity survey of adults^{ix} (aged 16-to-74 years), it appears statistically significant that functional mental illness appeared higher in Indian, Pakistani and Bangladeshi communities than the average, and Black African and Caribbean communities seemingly lower. Differences in the prevalence rates of common mental health problems in men and women were reported, with women exhibiting higher rates than men overall.

Ethnic group	White	Black	South Asian	Other	All
Any neurotic disorder	%	%	%	%	%
All adults	16.3	14.1	19.2	20.4	16.4
All women	19.2	17.8	22.9	24.9	19.4
All men	13.4	11.7	15.6	16.7	13.5

4.2.6 Locally, it appears that Black and Minority ethnic elders are not significantly under-represented as users of specialist mental health services (information for day hospital and respite services is included in chapter four). However, there is a need to develop and make better use of ethnic monitoring information in service development.

4.2.7 Service development needs to be mindful of the expressed views of Black and Minority ethnic communities. At the annual Jan Pachaan Older People's Consultation event held in early 2005, older Asian residents in Hounslow made it clear that they wished to see the development of more integrated services for all of Hounslow's older people rather than future services being specifically developed for Asian elders. The day involved consultation, training and information aimed at older users from Asian Communities.

We propose that:

- Monitoring of the uptake of services should form part of the quarterly performance audit to be undertaken by the Hounslow Older People's Mental Health Integrated Management Board, with investigation and action required should uptake fall below anticipated levels;
- Ensuring a person-centred approach is taken to assessment and care planning so to avoid stereotyping on the basis of assumed characteristics.

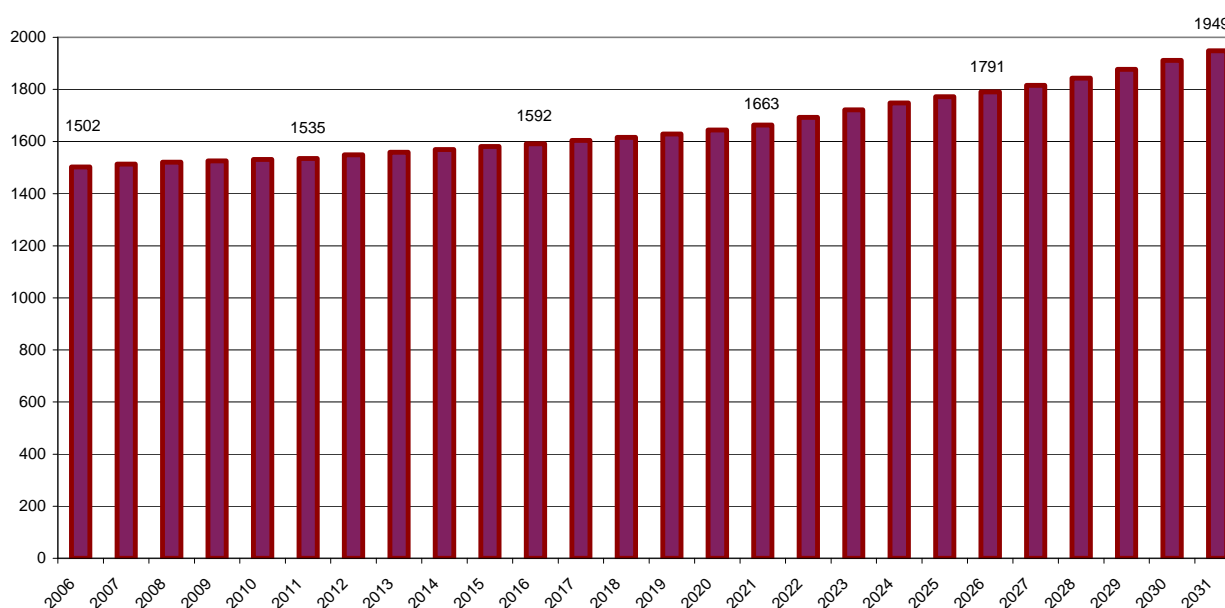
4.3 Epidemiology

- 4.3.1 The level of mental health problems in older people of people is high, increasingly so as people age. Research suggests that depression may affect between 10-15% of people aged 65 and older living at home and approximately 40% of older people who live in care homes, although the incidence of more severe forms of clinical depression are thought to be substantially lower^x. The risk of depression is doubled for older people with ill health and disability^{xi}. Dementia affects 6% of older people, with marked increases in prevalence in people aged 85 and over.
- 4.3.2 In the ONS psychiatric morbidity survey of adults quoted in 4.2.5 above^{xii}, the lowest prevalence rates for any common mental health problem were among those aged 65-to-69 (10.2%) and 70-to-74 (9.4%), compared with 16.4% for all ages). This was most noticeable amongst men aged 65-to-74 (5.7% compared with 13.5% for all ages). Overall, 10% of the sample of people aged 65-to-74 years were thought to have a common mental health problem which equates to approximately 1,300 people aged 65-to-74 living in Hounslow in 2006.
- 4.3.3 Using the model for predicting the prevalence of dementia in local areas developed by the Audit Commission for ***Forget Me Not***, the changes in population projections suggest that there is likely to be a consequent increase in the numbers of older people living with dementia in Hounslow. This model suggests that the prevalence of dementia is approximately 23% in the over 85-year-old group, 7% in the 75-84 year old group and 2% amongst the 65-74 year old group.^{xiii}
- 4.3.4 This would suggest that given the latest Hounslow population projections, the local prevalence for Dementia amongst older people in the borough should increase slightly over the next five years. Thereafter, there is likely

to be an increased rate of change, averaging just over 1% a year, until 2021, when the rate increases in line with the significant changes in population projection.

Year	Projected Numbers of Older People with Dementia	5 Yearly Change	5 Yearly Change %
2006	1502		
2011	1535	33	+2.2%
2016	1592	57	+3.7%
2021	1663	71	+4.5%
2026	1791	128	+7.7%
2031	1949	158	+8.8%

Projected Numbers of Older People Living With Dementia (2006-2031)
(GLA 2005 Round Demographic Projections - Scenario 8.07)



4.4 Conclusions

4.4.1 The change in demographic projections means that it now appears likely that there will be a increase in demand for long-term care services in the future, and that this will pick up speed in the latter part of the next decade. Current commissioning patterns need to be sensitive to these changes and plans made with a view

on ensuring that the short and medium-term plans do not constrain the likely service delivery needs of older people in the long-term.

5. CURRENT SERVICES AND DEVELOPMENTAL PRIORITIES

5.1 Primary Care

5.1.1 Mental health problems are common in primary care, *Everybody's Business* quotes that in a typical GP surgery 40% of people will have a mental health problem and in 20-25% of patients a mental health problem will be the sole reason for attending. Depression is the commonest cause of suicide in older people. Many older people who commit suicide have had recent contact with their general practitioner, one study found that in the week before suicide this was between 20-50% contact and in the month before suicide, 40-70% contact^{xiv}. Suicide prevention is examined in more detail in 5.2 below.

5.1.2 Older people's access to health and social care services often stems from their interactions with primary care. At one level, this can take the form of primary care acting as a signpost to other services. However, as problems become more complex, older people, their families and carers want timely support, advice and onward referral where appropriate. *Everybody's Business* suggests that there are four key tasks for primary care:

- Health promotion, and the advancement of self-care;
- Recognition of mental health problems (including routine screening);
- Formulation of a care plan and ongoing involvement, including support for family carers; and
- Referral to specialist services for the small proportion that have complex needs or pose high levels of risk, with ongoing collaborative care. This is particularly when there are diagnostic issues that need clarification, a lack of response to initial intervention strategies, distress and risk are severe, or where there are legal issues that require the involvement of specialist services (with particular relevance to detention).

- 5.1.3 It needs to be recognised that those caring for older people with mental health problems are usually the first to call for help. The way the initial response is experienced can make all the difference to carers' ability to continue caring, with access to information and help being crucial. Early diagnosis and information regarding how a condition is likely to progress are fundamental in helping to empower carers and enable them to make realistic decisions about their role.
- 5.1.4 Current national arrangements for dementia management have a perverse influence on education about the condition, particularly in primary care. There is no substantial incentive for general practitioners to educate themselves about dementia or the latest treatments for dementia, because of the requirements to initiate and monitor treatment in secondary care. Passmore and Craig argue that "we have a system in place that actively discourages general practitioners from taking an interest in a condition for which the management strategies are community-based"^{xv}.
- 5.1.5 The primary care/secondary care interface in Hounslow requires attention. Shared Care Protocols with Primary Care for the management of depression/dementia have been re-worked with a view to being implemented in the near future. These include a protocol for the detection, initial assessment, initial management and specialist referral of older people with mental health problems, including depression and dementia. Thought needs to be given as to how these protocols relate to other services including, but not exclusive, to the acute hospital, care homes, and supported housing. The protocols should indicate when and how older people with mental health problems should be referred between different services across different agencies, with mechanisms to optimise appropriate information sharing, in line with the information sharing protocol agreed across Hounslow

Primary Care Trust, West London Mental Health Trust, West Middlesex University Hospital and the London Borough of Hounslow.

- 5.1.6 There is also an ongoing need for GPs to be trained and supported, if they are to consistently recognise and appropriately deal with mental health problems in older people. This issue is clearly not unique to Hounslow. Less than one-half of GPs surveyed by the Audit Commission for Forget Me Not felt that they had received sufficient training to help them diagnose and manage dementia. This identified that whilst GPs felt more confident about dealing with depression, they often fail to identify the condition and provide appropriate support and treatment. Fischer et al use a telling phrase in explaining why physicians may be less likely to focus on depression with older patients describing the problem as being the "invisibility of the ordinary"^{xvi}. In this context, Hounslow PCT and West London Mental Health Trust will work together to establish how skills, knowledge and confidence can be increased.
- 5.1.7 The introduction of Practice-Based Commissioning presents an opportunity for primary care to extend into a wide range of services at the interface of primary and secondary care, reduce the demand for secondary care through managing referrals and reducing admissions, and encourage financial stewardship through the regular monitoring of practice budgets.

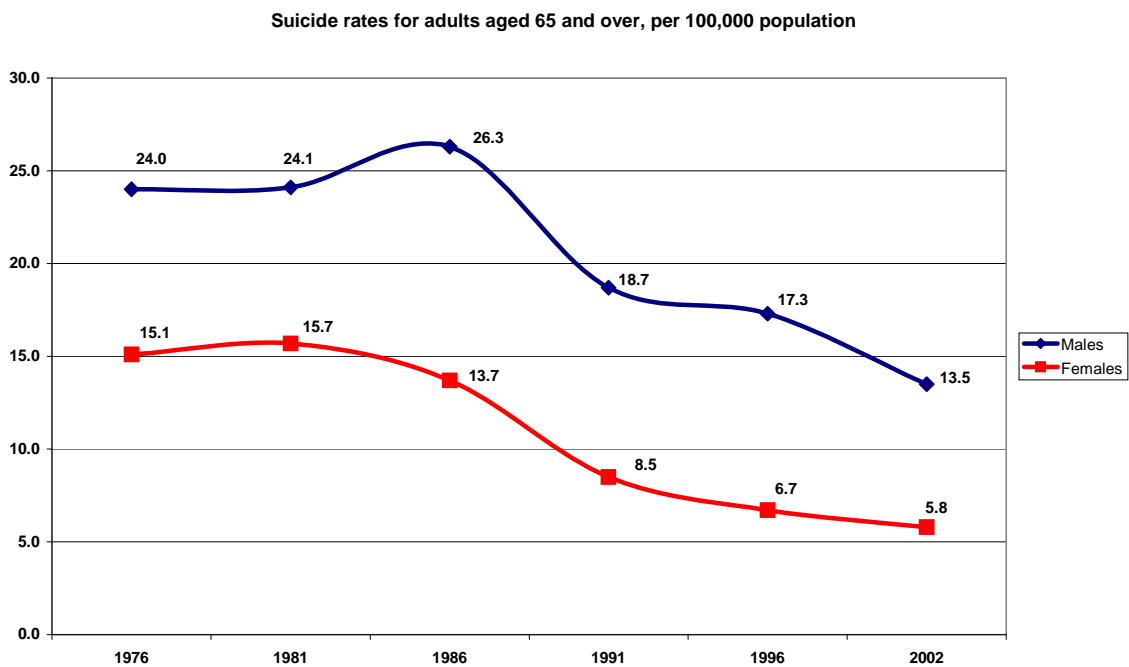
We propose to:

- Review shared care protocols for the management of depression/dementia and support implementation (with particular regard to the co-prescribing of medication);
- Establish greater links between specialist OPMH services and primary care;
- Identify GPs – especially those who make few referrals – and offer support and training (not only around identification, but also in identifying how and when to

- disclose information to users and carers in a way that is supportive and minimises distress);
- Work with local GP's to help them to provide improved services to older people with mental health needs and to their carers (examining the potential of new arrangements under Practice-Based Commissioning);
 - Establish a baseline and uptake monitoring mechanism for 'hard to reach' groups, including a review of service provision to ensure that services are accessible.

5.2 Suicide Prevention

5.2.1 Elderly people have a higher risk of completed suicide than any other age group worldwide. International data published by the World Health Organization^{xvii} shows a steady rise in prevalence of completed suicide with age. Comparatively, in the UK, suicide rates for older people have fallen considerably since 1986, at which time age-standardised suicide rates were higher for both older men and older women than for younger age groups^{xviii}.



5.2.2 Suicide prevention strategies for older people need to focus on the management of individual risk, particularly in

those experiencing severe depression and on wider community strategies to promote health aging.

- 5.2.3 On an individual level, O'Connell et al suggest that opportunistic screening for suicidal ideation, with high risk subgroups defined and targeted, should be practised. High-risk subgroups include those with depressive illnesses, previous suicide attempts, or physical illnesses, and those who are socially isolated. Elderly people with multiple such factors warrant special attention^{xix}. Cattell describes a typical high-risk individual as "an elderly male, living alone following recent bereavement, who may have coexistent painful, chronic health problems. He may have made serious previous suicide attempts and be currently depressed"^{xx}.
- 5.2.4 Older people are less likely to volunteer that they are experiencing suicidal thoughts, and these might not be manifest unless asked about directly. Healthcare professionals should be trained and encouraged to ask such questions directly.
- 5.2.5 Interventions at population level that improve social contact, support, and integration in the community and that promote improved physical and emotional health are also likely to be effective.
- 5.2.6 Furthermore, reducing the availability of the means of suicide as a preventive strategy is likely to have been a major contributory factor to the reduction in completed suicide for older people in the last twenty years. The detoxification of the domestic gas supply in the 1960s is credited with a significant fall in elderly suicide, and more recently the use of catalytic converters, reduced availability of firearms, limitation of paracetamol via over-the-counter sales, and alterations in prescribing habits for older antidepressants have all helped to reduce suicide levels.

We propose to:

- Ensure that specific training is offered to healthcare professionals across all care settings to raise awareness of the risk factors linked to suicide in older people; and
- Ensure that funding decisions about preventative services across health and social care are taken mindful of the need to promote healthy aging as a direct contributing factor in reducing depression and social isolation for older people.

5.3 Home Care

5.3.1 Older people with mental health problems usually wish to continue living in their own home for as long as possible, and are looked after at home by non-specialist services and/or family support. Given the high prevalence of mental health problems in older people, it is inevitable that a high proportion of the recipients of domiciliary care will have mental health problems. It is vital for staff to have an adequate understanding of common mental health problems, the impact of loss and disability, sensory impairments and have good communication skills, particularly with people with cognitive impairment. This is especially important if services are to take on a role in supporting people with mental health problems in crisis.

5.3.2 Home care staff will often work with people who want to live at home despite some risk, and both staff and the service user may need to be supported in pursuing this choice.

5.3.3 Hounslow Housing & Community Services have recently completed a tendering exercise for new domiciliary care block contracts that will run to March 2011. The

approved list of providers has also been re-tendered. These processes have created an expanded pool of providers, and ongoing training in dealing with older people with mental health needs will be co-ordinated by Hounslow Housing & Community Services.

We propose to:

- Work with domiciliary care providers to ensure that there the needs of older people related to mental health are addressed in training; and
- Explore establishing a specialism within the Council's in-house domiciliary care to cater for the needs of older people with mental health needs.

5.4 Day Services (Day Hospital/Day Support)

5.4.1 It is important to be distinct in the roles of day services for older people with mental health needs. Day support services provide an opportunity to combat social isolation in older people with mental health problems, and promote the retention of confidence, self-esteem and social skills. Where an older person with mental health needs is being cared for by an informal carer, such provision also offers valuable respite. Day hospital/treatment services should focus on assessment, treatment and rehabilitation, with people attending on a time-limited basis, and work in close conjunction with home based support/treatment.

5.4.2 For Day Hospitals, interventions will generally end when the older person can be discharged into a day care setting, or be managed in the community under the care of their GP. Such services need to be based around comprehensive multi-disciplinary mental health assessment, which takes account of the risk factors faced by older people with mental health problems. This form of assessment should result in a treatment/maintenance plan for the older person. Education and advice should be provided for carers, and staff should also monitor treatment with mental health medication. A distinction

needs to be made between older people whose mental health needs stem from an organic problem, and those with a functional illness (particularly those in transition from adult mental health services due to age). Distinct specialist responses are required for both groups.

5.4.5 Currently in Hounslow, specialist MH provision at the second tier is provided at Chiswick Resource Centre on 3 days a week offering 25 places and Bedfont Resource Centre on 5 days a week offering 10 places daily (and is currently piloting a 7 day service). Age Concern Feltham, Hanworth & Bedfont offers 1 dedicated day a week offering 12-14 places for people with dementia. It should be recognised that provision at the first tier also includes a number of older people with low to moderate needs related to their mental health, Heston Day Support Service, in particular supports a number of older people living with dementia within their broad service.

5.4.6 The Brentford Lodge Day Hospital has 7 day places for older people who have an organic or functional mental health problem needing assessment and treatment. This service has been recently audited to establish the frequency and rationale for use of the service. The audit covers the year to December 1st 2005. The Day Hospital offered a service to 41 older people. Of these 41 people, the majority presented with depression, followed by dementia. Episode lengths varied substantially, with the majority of cases accessing the facility for less than three months (23, 56.1%), with 6 (14.6%) cases using the service for longer than 6 months. One case received a service for over a year.

The geographic and ethnic profile of service users suggests that the service needs to be careful that there is equity of access, although this warning comes with the caveat that with such small numbers, there can be significant changes to percentages with marginal changes in activity. Whilst the proportion of people

accessing the service from black and minority ethnic backgrounds is in line with the overall community profile, older people from the east of the borough have accessed the service in a far higher proportion than those from the centre.

Diagnosis	Patient Totals
Depression	24 (58.5%)
Dementia	13 (31.7%)
Psychotic Illness	2 (4.8%)
Anxiety	1 (2.4%)
Bipolar Disorder	1 (2.4%)

Locality	Patient Totals
Brentford, Chiswick & Isleworth	22 (53.7%)
Feltham	12 (29.7%)
Hounslow	7 (17.1%)

Ethnicity	Patient Totals
White UK	25 (61.0%)
Asian	7 (17.1%)
White Other	5 (12.2%)
Irish	3 (7.3%)
Black African/Caribbean	1 (2.4%)

5.4.7 Expanding the places available at the Day Hospital would offer the opportunity to increase the numbers of older people with mental health needs receiving detailed assessment and treatment in a community setting. This is of particular importance in helping to maintain older people with mental health needs, especially relevant for older people with cognitive impairment, who have had no formal diagnosis and who are at risk of admission to long-term residential/nursing care in their own homes.

5.4.8 An expansion of the Day Hospital would allow for the development of a mental health intermediate care-type

service, whereby older people who require assessment could be accommodated in either a residential or nursing care setting, whilst receiving a comprehensive mental health assessment. Ideally, such provision should allow for graduated care with older people with mental health needs being accommodated in the least institutional setting appropriate to their needs at the time. This continuum would need to run from care at home (the only current situation available for older people accessing the day hospital), through residential home care and into nursing home care. The extension to the Chiswick Resource Centre would allow for the creation of intermediate care beds, whilst the PCT has recently renegotiated its contract with Care UK for provision at Charlotte House to include up to 4 short-stay admissions at any time.

- 5.4.9 Across statutory partners, this would allow for all potential admissions to long-term care to receive a proportionate assessment of need before a final decision is reached regarding the need for institutional care.
- 5.4.10 *Everybody's Business* suggests that consideration should be given to flexibly combining provision at the second and third tier, as this will enable better joint health and social care planning and a more seamless delivery of the services from the perspective of users and carers. The feasibility of establishing such services locally will need to be reviewed during the life of this strategy.

We propose to:

- **Formally consult on a proposal to expand the Day Hospital from 7 places to provide at least 12 places daily by the end of 2006/07**; with the aim of utilising some of this expansion to create a bed-based mental health intermediate care service (up to 2 beds at the expanded Chiswick Resource Centre & up to 4 beds at Charlotte House);

- Review day support services in line with the Housing & Community Services Resource Centre vision and, in conjunction with statutory and voluntary agencies, establish clear pathways for day services;
- Review and make recommendations to address the day care requirements of older people with functional mental health needs; and
- Examine the feasibility of establishing a Home Treatment Team.

5.5 Respite Care (Bed-Based)

- 5.5.1 Short stay breaks providing respite for carers are key in maintaining well-being and enabling the continuance of the caring role. Respite care should happen as part of an established care plan, and be available on an equitable and transparent basis.
- 5.5.2 Furthermore, bed-based respite care is not emergency care. In the case of an unpredicted change in circumstance, care needs to be taken to ensure the presenting problem is addressed, either through proportionate reassessment of the older person, or through arranging urgent care should the carer of an older person with mental health needs become incapacitated at short notice.
- 5.5.3 At present, the majority of bed-based respite care in Hounslow is provided through Brentford Lodge and the Chiswick Resource Centre, with a small amount of bed-based respite care being provided by Hounslow Housing & Community Services/Hounslow PCT, either by spot purchasing appropriate care or using capacity on block contracts in independent sector residential and nursing homes.
- 5.5.4 The use of respite facility at Brentford Lodge was audited in 2005, with the audit covering 2004/05. The unit has eight beds for Hounslow residents. During this time,

there were 166 admissions, with 43 older people being admitted on one occasion only, and 26 older people being admitted on more than one occasion, of which 14 received bed-based respite frequently. The service has predominantly catered for older people with dementia. The average occupancy was 7.8 beds throughout the period.

- 5.5.5 This is comparable to the West London Mental Health Trust activity report for 2005/06, which showed annual occupancy for Hounslow residents of 2,581 occupied bed nights, equating to an average occupancy of 7.1 beds (with 161 admissions).
- 5.5.6 The geographic and ethnic profile of service recipients suggests that there is approximate equity of access, as above it needs to be remembered that there can be significant changes to percentages with marginal changes in activity.

Number of admissions	Patient Totals
1	43 (55.8%)
2	10 (13.0%)
3	2 (2.6%)
4	0 (0.0%)
5	3 (3.9%)
6	7 (9.1%)
7	4 (5.2%)

Diagnosis	Patient Totals
Dementia	61 (79.2%)
Depression	9 (11.7%)
Bipolar Disorder	3 (3.9%)
Psychotic Illness	2 (2.6%)
Behavioural Problem	1 (1.3%)

Locality	Patient Totals
Brentford, Chiswick & Isleworth	27 (37.5%)

Hounslow	26 (36.1%)
Feltham	19 (26.4%)

Ethnicity	Patient Totals
White UK	45 (64.3%)
Asian	12 (17.1%)
White Other	9 (12.9%)
Irish	2 (2.9%)
Black African/Caribbean	2 (2.9%)

- 5.5.7 The audit found that a significant number of admissions (27.9%) were of a one-off nature, and West London Mental Health Trust has suggested that their primary use was for assessment rather than respite. This activity accounts for approximately 2.1 beds, and could be appropriately re-provided through Dove Ward. In addition, some of more frequent respite includes an element of treatment (predominantly concerned with changes to medication), and as such the formal consultation asks whether this assessment role could be appropriately re-provided as in-patient care on Dove Ward.
- 5.5.8 The remainder of the bed-based respite care currently provided at Brentford Lodge is planned care allowing for a break for a carer. This bed-based respite care should continue to be planned and provided as a part of the overall care plan for the older person with mental health needs, in conjunction with a carer's assessment carried out with the person's carer, regardless of decisions reached as a result of the formal consultation on the future of Brentford Lodge. The consultation seeks to gain views on the proposal that respite care can be appropriately re-provided in residential and nursing care homes identified to meet the needs of the individual older person as identified in the Community Care Assessment (and where appropriate NHS Continuing Care Assessment).

- 5.5.9 The bed-based respite care service provided at Brentford Lodge is of undoubted value to older people with mental health needs and their carers. However, West London Mental Health Trust have highlighted their concerns in the light of the Rowan Ward Enquiry regarding the clinical governance issues of operating a bed-based service on an isolated site, with limited medical cover, particularly out-of-hours. Unfortunately, this problem is exacerbated by the mixed use of the site for respite care and for assessment.
- 5.5.10 Any change to location of bed-based respite services away from Brentford Lodge would need to ensure that:
- All pre-booked respite at Brentford Lodge is honoured;
 - There is equity of access to bed-based respite care (including a defined financial limit for the amount of care available); and
 - Any alternate provision does not replicate, or indeed increase, the clinical governance concerns.
- 5.5.11 The current usage pattern for a number of regular attendees is to receive respite on a two week in, six weeks at home basis. This pattern has largely arisen due to the availability of the service. Whilst any change would honour this existing commitment, new service users are likely to be offered less frequent respite, in line with that offered by other older people's services (the standard being six to eight weeks annual maximum). However, there will be exceptions allowed to this based on individual assessment.
- 5.5.12 As a consequence of these changes in the pattern of provision, it is expected that fewer beds will be needed. If demand increases, this would need to be addressed by the PCT commissioning additional activity either from West London Mental Health Trust or in the independent sector.

We propose to:

- **Formally consult on the withdrawal of the provision of bed-based respite at Brentford Lodge** with a view to utilising up to 5 beds for bed-based respite care on

Dove Ward (with particular regard to first admissions/assessments), and utilising up to 4 beds for bed-based respite care at Charlotte House;

- Continue to utilise 2 beds for bed-based respite care at Chiswick Resource Centre;
- Establish the feasibility of introducing a voucher scheme for bed-based respite care co-ordinated through the Hounslow Older People's Placement Service; and
- Complete a comprehensive assessment of all regular users of bed-based respite care against the prevailing NHS Continuing Care criteria to ensure equity of access (and equity regarding finance).

5.6 Housing

5.6.1 Hounslow Housing and Community Services launched the Older People's Housing Strategy in 2005. The strategy makes a series of recommendations around supporting older people with dementia, which stem from a development workshop held in November 2004. It was identified that progress in supporting older people with dementia in the community was inconsistent. Whilst, there has been a well-developed training programme rolled out across a range of social care services to equip staff to support people with dementia in the community. It also showed that there was not an integrated approach to deliver the outcome aim of keeping people at home or in a supported housing setting for as long as possible. The subsequent formation of the new Housing and Community Services department has created the opportunity to address this and join-up housing, health and social care to improve the health and well-being of people in Hounslow.

5.6.2 The strategy identified a number of practical initiatives that could be put in place to link housing in more closely with the health and social care system. These comprised:

- The inclusion of sheltered housing and other housing management and support staff (across all social housing providers) in the dementia training programme;
- The appointment of a link person in the Community Mental Health Team (CMHT) who housing providers can link with on an individual case basis. This reflects the NSF for older people which specifies the provision of designated link people in the CMHT to provide support for sheltered housing providers;
- Developing the role of housing staff by building on the current skills and knowledge of housing providers in the borough, in particular Hounslow Homes and Housing 21;
- Developing specific floating support for people with dementia as part of the plans for floating support services in the borough;
- Developing practical support services – shopping, cleaning etc – for people who may be outside the care system;
- Developing the role of extra care to support older people with dementia;
- Developing the expertise of the Special Needs panel in relation to allocation of sheltered housing tenancies, support services and care packages for people with dementia;
- Developing further capacity in the local authority owned residential care homes for people with dementia;
- Taking advantage of the forthcoming Department of Health Assistive Technology funding to develop assistive technology services linked to Linkline. This might include automatic connection to Linkline for people with dementia; and
- Training the Care and Repair and handyperson services to work with people with dementia

Progress in addressing these issues will be monitored through the Older People's Accommodation subgroup and reported in addition to the formal requirements to report on the strategy action plan.

We propose to:

- Build capacity in sheltered/extra care housing to enable the provision of independent living in the community for wider groups of vulnerable older people, including people with dementia, mental health and cognitive problems, through training, information, and support;
- Develop the role of the housing sector to support older people with dementia in the community;
- Pilot small group home type housing based models for people with dementia, in particular for BME groups and younger people with dementia, for whom larger residential care settings may not be culturally appropriate.

5.7 Assistive Technology And Telecare

5.7.1 In 2001 the Department of Health produced a health and local authority circular^{xxi} on integrating community equipment services. Reference was made to emerging electronic assistive technology, originally based on the community alarm services that first developed within a sheltered housing unit in 1948. Since publication of this circular there has been a growing interest in the provision of remote technology and increasing government policy directive moving towards the integration of services across the health, social care and housing divide. Focus has been placed upon the need for patient and public involvement, the value of preventative services and holistic care, the role of housing and the importance of choice and independence.

5.7.2 The Department of Health has allocated £80 million for the period 2006-2008 to support the development of telecare services in England. The Preventative Technology Grant aims to increase the numbers of

people benefiting from Telecare via a three-fold approach:

- To provide initial investment;
- To co-ordinate demand to ensure the industry grows as fast as possible; and
- To educate and build knowledge and awareness amongst commissioners and those who will benefit from Telecare services.

5.7.3 A total of £292,785 has been allocated to Hounslow Housing and Community Services over two years commencing April 2006. Funds are not ring fenced but there is explicit reference to the use of such monies being directed towards the care of older people. The main expected outcomes of the grant as stated in the guidance issued in July 2005 is to increase the number of people benefiting from telecare by 160,000 Older People nationally.

5.7.4 Examples of ways in which assistive technologies and telecare can support older people with mental health problems include:

- The use of reminders/voice prompts and/or dispensers to aid medication management for those who need help to keep their mental health stable and prevent a relapse
- A programmed isolation switch to turn off the cooker if it is left on and/or a heat detector to generate an alert if it is overheating
- Sensors set to turn off taps when there is a risk of water overflowing from sinks or baths
- Infra-red sensors programmed with lighting controls to automatically come on or off in the bedroom and in the bathroom when someone gets up at night, to prevent falls or disorientation
- Infra-red movement sensors and/or pressure mats that detect movement in any space, to alert staff when someone is either up or has been inactive for an unusually long period; and

- Timed door sensors that will remotely alert a care service or family member if an external door is opened at night.

We propose to:

- Develop an Assistive Technology Strategy across Hounslow Primary Care Trust, West London Mental Health Trust, West Middlesex University Hospital and the London Borough of Hounslow;
- Develop appropriate pilots utilising telecare to be monitored and evaluated accordingly, focusing on the potential for support older people with mental health needs in the community;
- Develop a demonstration suite/area within the Calen Centre for the promotion and training of telecare equipment; and
- Introduce telecare equipment to the newly commissioned intermediate care assessment flat at Dashwood Court Extra-Care scheme.

5.8 Care In Residential Settings

- 5.8.1 Care in residential settings offers support to a small number of people who are no longer able to live with support in the community. This may be because their mental health needs place them at significant risk to themselves and/or others and consequently they need intensive supervision, which cannot be delivered in a community setting.
- 5.8.2 *Everybody's Business* is explicit in stating that "a move to residential care should enable an improved quality of life for the person with mental health problems and not just be facilitated for the benefit of family carers. The move should maintain dignity and the rights and ability of residents to make decisions about how they live their lives and the care they receive". In order for the latter to be a reality, the significant training needs of care staff will need to be

addressed on an ongoing basis, with particular emphasis given to communication skills training.

5.8.3 Residential care providers need to be mindful of their responsibilities to develop activity programmes, which help in encouraging older people to remain mentally active. *Everybody's Business* highlights a number of areas in which residential and nursing care for older people with mental health needs can be personalised. People should be encouraged to have their own possessions (including furniture and possibly pets) with them, and the staff should seek to know more about their biographies and previous lifestyles so that they can provide personalised care and encourage the maintenance of interests and skills. Relatives and former carers should be encouraged to visit and maintain their relationships, and to participate in their care if they wish to do so. Visitor schemes can reduce social isolation.

5.8.4 The demand for residential and nursing care in Hounslow was reviewed for the Commissioning Strategy for Older People 2004/07, and this has subsequently been further reviewed following the publication of new population projections. These suggest that there will be a less pronounced reduction in the number of older people in Hounslow and that this will reach a turning point in 2008 after which the population of older people will start to increase. By 2012, the number of older people resident in Hounslow is projected to have returned to the levels found in the 2001 Census and there is a projected steady increase thereafter.

We propose to:

- Ensure future commissioned and directly provided residential/nursing home placements reflect the anticipated demand for older people with mental health needs;

- Run sessions in the Residential/Nursing Home provider forum on personalised care planning and activity co-ordination; and
- Work with residential and nursing home providers to ensure that the needs of older people related to mental health are addressed in training.

5.9 Intermediate Care

- 5.9.1 Intermediate care services are currently primarily focussed on physical disorders, and generally had the aim of avoiding unnecessary admission to acute general hospitals. *Securing Better Mental Health for Older Adults* argues strongly that intermediate care services should not exclude people with mental illness, rather they should be able to provide person-centred, needs-based care that holistically manages all of their physical and mental health needs, whether provided by the rehabilitation staff or through input of specialist OPMH service personnel. Similarly people in intermediate care facilities for people with dementia should have their physical needs met by psychiatry staff who are well trained in physical care, or through input from the physical rehabilitation team. There are significant workforce challenges, in particular with regard to training and development, to meet these goals.
- 5.9.2 Two main models have developed nationally in response to these circumstances:
- Developing the skills of staff in mainstream services, with additional specialist support, where the primary need is for physical rehabilitation, but many people have underlying mental health problems; and
 - Developing separate specialist teams or resources where the primary need is the mental health problem.
- 5.9.3 Locally, there has been an significant expansion in mainstream rehabilitation and intermediate care facilities focusing on physical disorders since the London Borough of Hounslow opened the first Community Rehabilitation Unit

(CRU) at Sandbanks in March 2000, providing six rehabilitation beds in a local authority residential home setting. A second CRU at Heston House (six beds) opened in June 2004. Hounslow Primary Care Trust has commissioned rehabilitation beds at Clayponds Hospital and West Middlesex University Hospital. It is imperative that these services do not exclude older people with mental health needs as a matter of routine.

- 5.9.4 The model of care for older people with mental health needs currently lacks the tiered model operating for older people with physical health needs. Consequently, decisions about further assessment and rehabilitation are made in the context of the older person either being able to be maintained in their own home or needing inpatient care. This is unhelpful and is directly leading to decisions about long-term care needs being made without the opportunity for a more proportionate assessment and period of rehabilitation and reflection.

We propose to:

- Develop a tiered model of intermediate care for older people with mental health needs (including the expansion in day hospital assessment, rehabilitation & treatment referred to above);
- Utilise up to 4 beds for assessment, rehabilitation & treatment at Charlotte House;
- Explore the feasibility of utilising 2 beds for assessment, rehabilitation & treatment at Chiswick Resource Centre following its redevelopment in 2007.

5.10 Care for people in the general hospital

- 5.10.1 Physical illness predisposes people to suffer from mental health problems and older people with mental health problems are more likely to be admitted to the general hospital. Older people with mental health problems in the general hospital have the same right to appropriate care as people living at home. This includes a right to dignity, and involvement in decision-making about needs, care and goals of treatment.
- 5.10.2 Cognitive impairment and other mental health problems are not best managed in a general hospital setting and staff (because of their lack of training or experience) are often uncertain of how to best manage them. Local experience suggests that some of the longer lengths of stay in West Middlesex University Hospital in 2005/06 have been for older people with mental health needs who were admitted with minor medical problems. Furthermore, the longer an older person stays in an acute general bed, the more disorientated they are likely to become, and the more independent living skills are lost. Too often, older people previously unknown to statutory services are expected to transfer into long-term residential and nursing care immediately following a general hospital admission.
- 5.10.3 A systematic review of the literature shows that up to 60% of people aged 65 and over have or develop a mental health problem during admission to a general hospital. Given this increased attention needs to be paid to the knowledge and skills base of all mainstream staff in the general hospital on matters that relate to the mental health of older people.
- 5.10.4 *Everybody's business* recommends that preferred model is for specialist mental health teams to work within the general hospital aim to:
- Support and train staff in the detection and initial management of mental health problems in later life;
 - Proactively work with general care teams to avoid unnecessary admission;

- Improve the mental health care of older people while they are inpatients; and
- Link with community organizations to improve follow-up and avoid unnecessary delay in discharge.

However, it also states that most UK services provide a consultation style of service rather than full liaison, and will not be able to provide the full range of support identified above.

5.10.5 In 2005, Hounslow Housing and Community Services expanded the joint Integrated Assessment Rehabilitation and Discharge Service to include a Specialist Liaison Mental Health Nurse. This post works from a general hospital base at West Middlesex University Hospital and has no other clinical responsibilities.

5.10.6 *Everybody's business* also recommends that localities explore the feasibility of establishing a shared care ward, being an inpatient ward on the general hospital site, staffed by general and mental health staff who jointly manage clinical care. Hounslow PCT will investigate the possible benefits and financial implications of commissioning such a service in the context of the introduction of Payment By Results for acute commissioning.

We propose to:

- Cease making placements into long-term care directly from an acute general hospital ward, unless it has been demonstrated that all reasonable options for enabling the person to be maintained in the community have been exhausted;
- Investigate the possible benefits and financial implications of commissioning a Shared Care Ward;
- Work with acute providers to ensure that the needs of older people related to mental health are addressed in training.

5.11 Memory Assessment Services

5.11.1 Memory clinics began to be set up in the UK in the early 1980s, and whilst there is no standard template for services, most offer assessment, investigation, diagnosis, information giving, and the initiation and monitoring of cholinesterase inhibitors.

5.11.2 Memory clinics can play a number of important roles:

- Point of referral
- Specialist assessment and investigation
- Early diagnosis
- Education of patient and carer
- Counselling of patient and carer
- Referral to appropriate agencies
- Initiation and monitoring of symptomatic treatments
- Advice about the behavioural and psychological symptoms of dementia, and their management
- Education of students, postgraduate staff, general practitioners and health planners
- Research into disease aetiology and development of new therapies^{xxii}

5.11.3 In Hounslow, the memory clinic takes patients who have been first seen as out-patients, who could benefit from more detailed neuropsychological assessment (e.g. differential diagnosis for depression or dementia). Patients who may benefit from the prescription of cholinesterase inhibitors have priority. Currently within the memory clinic offered by West London Mental Health Trust, the clinical psychologist conducts a neuropsychological assessment, with assessment of carer strain and activities of daily living also taking place. The patient will also see the psychiatrist, who completes a Neuropsychiatric Inventory Questionnaire (NPI-Q), which evaluates 12 neuropsychiatric disturbances common in dementia: delusions, hallucinations, agitation, dysphoria, anxiety, apathy, irritability, euphoria, disinhibition, aberrant motor behaviour, night-time

behaviour disturbances, and appetite and eating abnormalities^{xxiii}. The full assessment allows for time to discuss issues regarding a possible diagnosis of dementia, and usually takes 2-3 weeks to complete (partially due to logistical differences in arranging for psychological and psychiatric assessments on the same day).

- 5.11.4 In Hounslow, we see the main purpose of the memory clinic in being to aid the early detection and diagnosis of dementia, while identifying treatable causes of cognitive impairment. Critically, this allows early intervention to maximise quality of life and independent functioning and to manage risk for older people with memory difficulties and their carers, and thus supports the central underlying theme of this strategy.

We propose to:

- Expand the opportunities for memory assessment by establishing a specific session (involving psychology, psychiatry and occupational therapy) within the expansion of the Day Hospital, which forms part of the **formal consultation on the future of services at Brentford Lodge.**

5.12 Psychological Therapies

- 5.12.1 Best practice guidelines from the Department of Health state that psychological therapies are part of essential health care and recommend that they should be routinely considered as a treatment option when assessing mental health problems. The guidelines specifically recommend that particular attention be given to the psychotherapeutic needs of older people. It has been demonstrated that the patient's age is generally not an important factor in choice of psychotherapy and should not determine access.
- 5.12.2 The NSF for Older People gives evidence suggesting that the most effective treatments for depression in older people are cognitive behaviour therapy, interpersonal

therapy or brief, focused analytic therapy, offered by a trained person. Counselling in primary care may also be effective for depression at the less severe end of the spectrum.

- 5.12.3 Older People can benefit from specialist care for people suffering from behavioural and psychological symptoms of dementia, including individual and family counselling and support.
- 5.12.4 There is a good evidence for the effectiveness of psychological interventions with older people. It is not acceptable to deny people access to psychological therapy on the basis of age.
- 5.12.5 In early 2006, Hounslow PCT completed a review of counselling services, and produced a new service specification for a range of interventions to be made available on an equitable basis across the borough and available to all adults including older people.

We propose to:

- Monitor referral patterns to the new Counselling providers in primary care to ensure that older people are not under-represented in service receipt, and work with primary care where there is under-representation to address any shortfalls;
- Develop a psychological therapies clinical governance strategy to monitor the quantity and quality of psychological therapies within health organisations

5.13 Inpatient Care

- 5.13.1 Services for older people should be provided as close to a person's home as possible, and it is unusual for older people to require inpatient admission for treatment of their mental health problem. However, admission is essential on occasions for the assessment, treatment and rehabilitation of older people with a range of diagnoses,

who cannot be cared for in the community or other settings due to the intensity and expertise of care required. A proportion of people will be detained under mental health legislation for assessment or treatment. Many will have complex physical and mental health needs. It is also appropriate that short stay beds may be offered for patients whose needs cannot be met in mainstream respite services.

5.13.2 Hounslow PCT commission mental health services from West London Mental Health Trust including inpatient services. Access to inpatient services on Dove Ward will be based on the following criteria, an older person will:

- Present with mental health needs that cannot be assessed or treated in the community or Day Hospital setting;
- Present with difficulties owing to mental illness which place him / herself at risk or of risk to others; and
- Not present with a physical problem, which would receive more appropriate care in a setting other than mental health (i.e. acute medical conditions which may contribute to mental state presentation are treated prior to acceptance to the mental health admissions ward).

5.13.3 It is important to reiterate that these criteria exist as part of a shared vision for the care of older people with mental health needs. Urgent placements in residential and nursing home care are not a substitute for the application of agreed care pathways. Hounslow Housing and Community Services and Hounslow PCT will only provide emergency placement in circumstances where caring arrangements have broken down. Where there is a fundamental change in the underlying behaviour of an older person with mental health needs and physical causes excluded, admission to a mental health ward needs to be given due consideration under the above criteria as the appropriate place for evaluation and review of a treatment plan.

5.13.4 Inpatient care is needed for two main groups:

- Older people who have an 'organic' brain disorder such as dementia; and
- Older people with so-called 'functional' disorders, the most common of which is depressive illness, but also including people with schizophrenia and other psychoses.

5.13.5 The ward environment should reflect the fact that, although this is a clinical area, it is also the patient's home for a variable period of time. Attention needs to be given to all aspects of well-being, with an emphasis on respect and dignity. Practice should be underpinned by a person-centred approach, with services delivered with respect to the patient as an individual and arranged around their needs.

5.13.6 Dove Ward will offer:

- A comprehensive assessment of needs;
- A named nurse responsible for co-ordination and delivery of prescribed care plan;
- A Consultant Psychiatrist and designated Junior Doctor with overall responsibility for treatment and care;
- Access to Occupational Therapy, Physiotherapy, Psychological Therapy, Dietician, Pharmacist, Multi-Faith Team, Medical Team and Other Specialist Services, including Independent Advocacy
- A ward based activity programme providing stimulating and therapeutic groups; and
- Expert advice and information regarding mental health issues and health promotion.

5.13.7 Dove Ward had an average occupancy of 14.2 beds (5200 occupied bed nights) in 2005/06, increasing to 15.7 when periods of short leave from the ward are included (a further 513 occupied bed nights). This latter figure represents 75% occupancy. The year to 31st March 2006 saw 67 admissions. West London Mental Health Trust reported that delayed transfers of care have been high in the last year running at 6 per month (2196 occupied bed nights). These figures have historically been self-reported by the trust and

whilst further work is needed to authenticate them (along the lines of the formal reporting mechanisms for acute hospital trust which requires Council verification), they do suggest that this occupancy figure could be significantly reduced.

5.13.8 In the six months to 31st December 2005, 8 patients were admitted to the ward under the Mental Health Act 1983.

5.13.9 In the year running from January 2005 to December 2005 (Q4 2004/05 to Q3 2005/06), there were 9 (6%) readmissions to Dove Ward within 90 days of discharge compared to a Trust target of 9.19%.

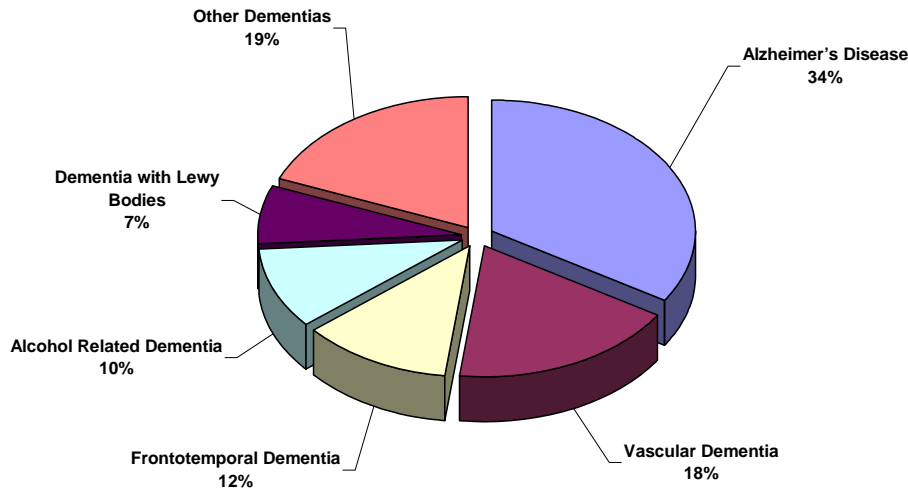
We propose to:

- **Formally consult on the reduction of acute care beds on Dove Ward from 21 to 16;**
- Monitor admission patterns across West London Mental Health Trust to audit practice in use of the Mental Health Act 1983;
- Establish a working group to examine Delayed Transfers of Care from Dove Ward and produce an action plan to reduce these by 50% year-on-year across 2006-2010.

5.14 Younger People With Dementia

5.14.1 Although it is recognised that dementia in people under the age of 65 years is rare, there are however approximately 17,000 people aged under 65 with dementia in the UK. Harvey identified an average prevalence rate of 67.2 people with dementia per 100,000 aged between 30 and 64^{xxiv}. Using this prevalence rate, Hounslow could expect to have 65 people between the ages of 30-64 affected by dementia. Whilst Alzheimer's Disease is the largest single sub-category for this group, vascular dementia, frontotemporal dementia, alcohol related dementia and dementia with lewy bodies are all significant.

Breakdown of Young Onset Dementia in the Harvey (1998) Study, by type of Dementia



- 5.14.2 It is important to recognise that the needs of a younger person with dementia are very different to the needs of an older person who has the same diagnosis. Whilst the symptoms are similar whatever the person's age, they can manifest themselves in different ways. The clinical presentation of dementia may be different in younger people as a result of their better physical health, strength and mobility. Such agility is more enabling of an individual and may exacerbate behavioural symptoms such as aggression, making them become more extreme.
- 5.14.3 The circumstances of the younger person with dementia are also likely to vary from that of older people. Often, impaired ability to perform work related tasks is one of the first signs of young onset dementia. The difficulty with continuing in employment has implications not only for the individual affected by dementia but for their family. Younger people with dementia often have more insight into their condition and are more frustrated by it, particularly as the diagnosis of dementia in younger people is more unexpected than a similar diagnosis in older age. This greater insight into the symptoms and progression of the condition may also extend to an awareness of other people's attitudes. Individuals

affected by young onset dementia and their carers and families find themselves becoming isolated as a result and stigmatised due to a lack of understanding.

- 5.14.4 Harvey reports that 55% of younger people with dementia experience delusions and 44% experience hallucinations. Aggressive behaviour was present in 61% of patients. These symptoms are particularly draining for the carers of people experiencing young onset dementia.
- 5.14.5 Early diagnosis of dementia is vital, regardless of age. Most general practitioners have little experience of young onset dementia and the symptoms can be confused with other conditions. Williams et al found that “in most parts of the country the route to specialist services for younger people with dementia is uncoordinated, with no clear delineation of clinical responsibility”^{xxv}, and during the period after referral many people found themselves to be ‘passed from pillar to post’, between and within psychiatry and neurology.
- 5.14.6 In Hounslow, an initial scoping report was written by Rachael Graham in November 2004, which indicated that there was no clear pathway for individuals diagnosed with young onset dementia. The appropriate skills and knowledge surrounding dementia lies within the older people’s teams however the case management of an individual pre 65 years was seen firmly as a responsibility of the adult teams with mixed views about skills sharing and co case management
- 5.14.7 Expertise and resources have been developed within the field of older people’s services. Those affected by dementia prior to age 65 may be excluded from accessing such services by virtue of age and hence find themselves caught between two service areas with seemingly no clear pathway to assistance and advice and information.
- 5.14.8 Younger people with dementia who are offered access to services are more often than not directed to day centres and

residential settings designed for the over 65's. These serve as inappropriate settings for younger more physically able adults. Activities are geared to the needs and interests of the older person and members may be in the later, more developed stages of their illness. It is important to provide stimulation for the younger person with dementia to prevent social isolation and loneliness. There should be opportunities for members to sustain their previous interests and skills as well as undertake physical exercise and outdoor activities.

5.14.9 Recognition of the needs of the family unit as a whole is essential. Individuals affected by dementia in their younger years are more likely to be part of a family unit. Services, care and treatment should involve the entire family to increase understanding of the developing needs and behaviours, the changing family dynamics and the issues faced by the carer and other family members. The service user should not be considered in isolation.

5.14.10 In 2005, in recognition of the unmet needs of this care group, funding was identified for a social work post within the Community Mental Health Team for Older People to take a lead for young onset dementia. Subsequently, the decision has been made within the manager to aim to skill the whole team to deal with referrals and case management, thus reducing the risk of any specialism being lost by the potential future loss of an individual team member.

We propose to:

- Develop of a project working with adult Community Mental Health Teams to identify service users, consult with them and their carers and seek to develop appropriate services and increase practitioner awareness;
- Establish a co-ordinated referral pathway from early diagnosis through to access of services offered by health, social services and other agencies; and

- Monitor progress through Hounslow's Mental Health Integrated Management Board on a regular basis.

5.15 Older People with Learning Disabilities

- 5.15.1 There are about 210,000 people with severe learning disabilities in England. Approximately 25,000 of these are over 60 years old. Most psychiatric disorders are more common amongst people with learning disabilities than the general population.
- 5.15.2 The incidence of dementia amongst those affected by Down's syndrome is high. In 1995, Prasher found age-specific prevalence rates of 9.4% for age range 40-49 years, 36.1% for 50-59 years and 54.5% for 60-69 years. Findings associated with increasing severity of dementia were gait deterioration, onset of urinary incontinence, increased muscle tone and onset of seizures^{xxvi}. The increased life expectancy of people with Down's syndrome has means dementia is a growing problem.
- 5.15.3 As with young onset dementia, there is a danger that younger adults with learning disabilities and dementia will fall between services, as they are not old enough to be eligible for generic dementia services. Specialist learning disability services may have neither the required resources nor the expertise to manage the specific needs of this group. Again, primary care teams being unaware of how to access appropriate specialist services can compound this problem.
- 5.15.4 Specialist learning disability services need to network effectively with primary care health services and local community social services. They may need to also liaise with secondary care health services such as neurology, gerontology, old-age psychiatry, and palliative care services. It is recognised that the voluntary sector provides invaluable support both in dedicated learning disability groups (e.g.

Mencap, Down's Syndrome Association), and in dementia groups (e.g. the Alzheimer's Society).

5.15.5 Current thinking would indicate that people with Down's syndrome and dementia are tend to be best cared for in services with specific learning disability expertise, particularly in residential settings where someone may have been resident for a number of years. Little has been done in Hounslow, to develop a strategy for service provision for this group and through the course of this strategy; work is required to focus on:

- Residential provision
- Day service provision
- The role of specialist learning disability services
- Transport
- Aids/adaptations
- Medical investigations / pharmacy

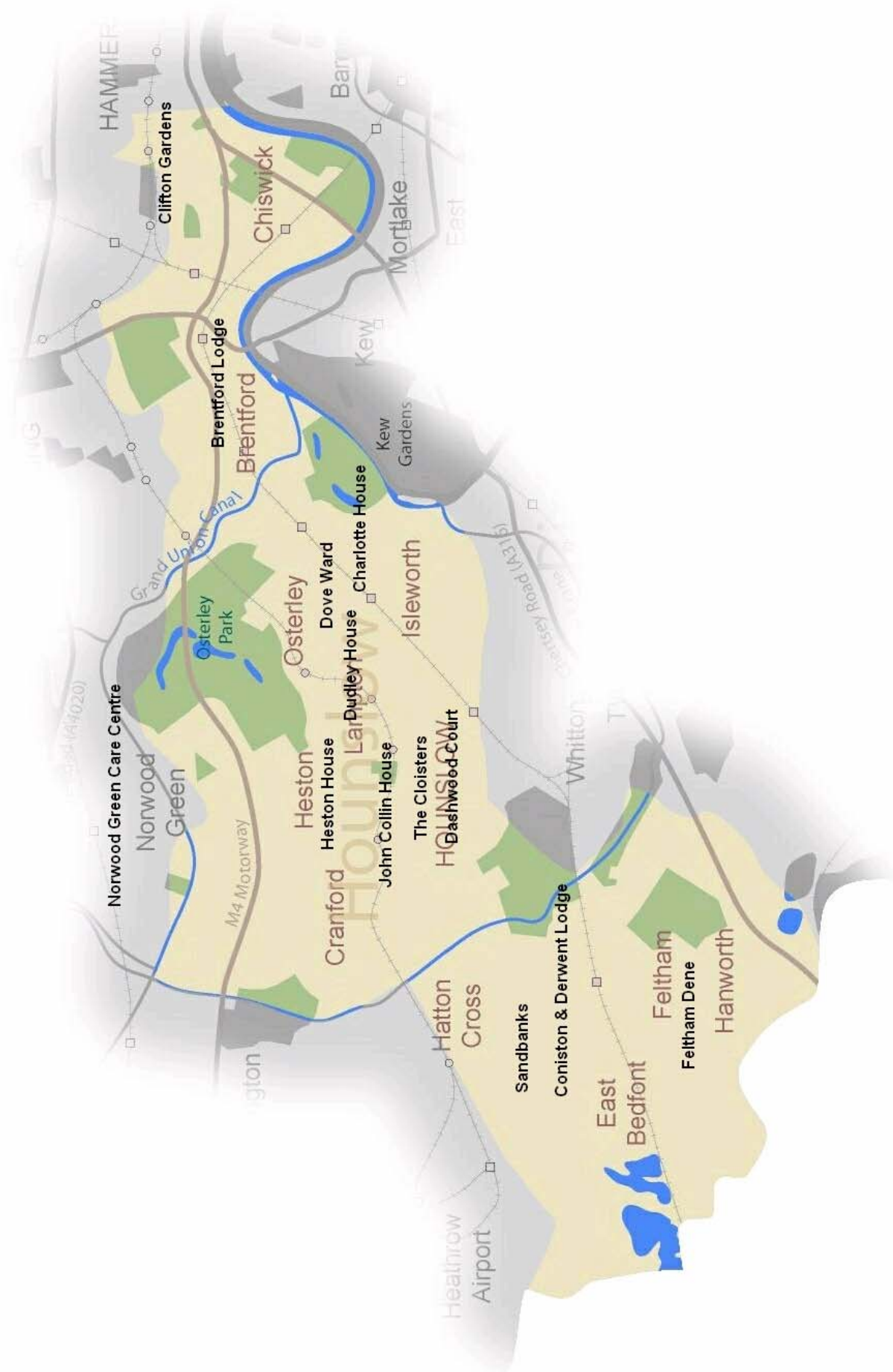
We propose to:

- Develop a register of people with learning disabilities. Minimum data needed for accurate planning of future needs includes the age structure, current accommodation; current levels of independence and staff support; and
- Establish a working party to examine the specific needs of adults with learning disabilities and dementia, tasked with making recommendations about the service development needs of this group.

6. IMPLEMENTING AND MONITORING THE STRATEGY

- 6.1 Following the consultation period, and once a decision is made regarding how to proceed, an action plan will be drawn up and appended to the adopted strategy.
- 6.2 In the interim, a dataset of key indicators will be drawn up for monitoring in the Hounslow Older People's Mental Health Integrated Management Board
- 6.3 This will include:
- Admissions to Dove Ward (informal and formal)
 - Occupancy rate on Dove Ward
 - Delayed Discharges from Dove Ward
 - Council supported admissions to long-term care
 - Uptake of service via the Day Hospital
 - Numbers of people known to OP CMHT

APPENDIX A: MAP OF THE BOROUGH



APPENDIX B: REFERENCES

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