JOINT STRATEGY FOR OLDER PEOPLE’S MENTAL HEALTH

FINAL DRAFT

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Executive Summary

1. The case for change

Islington is committed to improving mental health services for older people. Mental ill-health in older age is very common and can significantly affect people’s quality of life. While the total number of people aged over 65 in Islington will not significantly increase over the next 10 years, there will be an increase in the number of people aged over 85. People in this age group are often especially frail and vulnerable, suffering disproportionately from mental ill-health – in particular the incidence of dementia rises dramatically over the age of 80. As the level of need among this group increases, it is therefore especially important to make sure we are able to meet their needs effectively.

While we have some excellent services locally, overall Islington recognises that this mental health in older age is often a neglected area and that this is an opportunity for Islington to build on the growing national momentum for change to make real and long term improvements in services locally.

2. Our strategy to improve services

The strategy encompasses the needs of people with dementia and functional mental health conditions such as such as anxiety, depression and psychotic disorders. It identifies a clear need to improve value for money and a shift in the way resources are allocated to services. The strategy is intended to be cost neutral, and will be delivered through service shape change.

The strategy outlines the key aims for improving services, which are in line with the Islington Council’s One Islington vision and with the broader strategic aims of the Council, listening to people and building safer and stronger communities.

It supports a range of local work including NHS Islington’s overall commissioning strategy plan and Islington’s strategies on carers, health inequalities, end of life care and transforming primary and community services. The strategy is also closely linked with Islington’s World Class Commissioning goals:

- One: Improve the health of local people, especially targeting those with the worst health outcomes
- Three: Ensure people and services work together to design and deliver the best care pathways

In terms of national policy, the strategy supports recommendations in a number of documents including the National Dementia Strategy and the Healthcare for London Dementia Services Guide.

Currently Islington spends substantial sums of money on institutional forms of care - such as hospital care and residential and nursing home placements – but much less on community based services. Our strategy is to change this balance of expenditure over time and improve community based services. This will deliver better services and better outcomes, while also allowing us to spend money more efficiently and effectively.

3. Key priorities and outcomes:

The strategy has six priorities:

- To promote good mental health and early intervention
- To improve information and advice, making services easier to access
- To strengthen community based services
To improve institutional care, but to rely on it less
To join up services
To develop the workforce

The strategy is the start of a process, not an end in itself: re-focusing our services away from institutional care, towards community based services, early intervention and prevention and transforming their quality is a huge challenge for the whole system. Islington will focus on delivering the following outcomes throughout implementation:

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

4. Implementation

Implementation has already begun in some areas, such as the development of the Islington Memory Assessment Service, increased use of telecare and introduction of dementia liaison nurse posts at the Whittington and UCLH. There are other areas in which implementation has yet to begin. The Strategy’s implementation group will develop a detailed implementation plan.

A small delivery group will be formed to oversee the delivery, review and continuing development of the strategy. It will involve commissioners and providers as leads for particular aspects of work as well a senior clinical input from Camden and Islington NHS Foundation Trust, voluntary sector organisations, users and carers.
2. Introduction

2.1 Scope

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

<table>
<thead>
<tr>
<th>National estimates of mental ill-health among older people</th>
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<tr>
<td>Estimates suggest that perhaps 40% of older people attending their GP, 50% of older people in general hospitals and 60% of older residents in care homes have some form of mental health problem.</td>
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<tr>
<td>It is estimated that around 15% of older people in the community suffer from depression, while dementia affects 5% of people aged over 65 and 20% of people aged over 80.</td>
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<tr>
<td>Mental health problems, particularly depression and dementia, are more common, and have a worse outcome, in the 60% of older people who suffer from long standing illnesses.</td>
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<tr>
<td>Up to two-thirds of NHS beds may be occupied by people age 65 or over and up to two-thirds of some in-patient groups either have mental health problems already, or will go on to develop them during their in-patient stay.</td>
</tr>
<tr>
<td>In cost of illness studies, the direct costs of Alzheimer’s disease alone exceed the total cost of stroke, cancer and heart disease.</td>
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This strategy describes the way we want to improve our services for older people with mental health needs and their carers. It places an emphasis on organic mental health problems; dementia in particular. This is because dementia has especial significance for the way we organise our services and because services for people with dementia are the subject of a major national improvement programme. However, the strategy is also concerned with functional mental health problems, such as depression, anxiety and psychotic disorders. It also considers the needs of younger people with dementia.

Providing services to meet these needs can be complicated. In part, this is because people may need support from a range of services, including health services, social care services, mainstream services and specialist services. To make sure people’s needs are met in a timely, effective and co-ordinated way, our strategy therefore focuses on ensuring that all these services work together as a whole system.

2.2 Intended outcomes

Our strategy focuses on delivering the following outcomes.

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

To achieve these things, the strategy places particular emphasis on
- Re-focusing our services away from institutional care, towards community based services, early intervention and prevention.
- Making sure there is a more informed and effective workforce
- Making sure that the system of services operates more effectively as a whole

3. The policy context

3.1 The overall policy context

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

Key policy documents

- Our Health, Our Care, Our Say.
- Commissioning a Patient led NHS and World Class Commissioning
- Strong and Prosperous Communities
- Putting People First
- Carers’ Strategy
- National End of Life Care Strategy
- Healthcare for London Mental Health Workstream and Dementia Services Guide

(Appendix Two provides further information)

These policies emphasise the need for health and social care services to focus on the following outcomes:
- Improved health and emotional well-being
- Improved quality of life
- Full and equal participation in community life
- Increased choice and control
- Freedom from discrimination
- Financial stability and control
- Personal dignity and respect

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

- **Strengthening communities** to make sure that everyone can experience the friendships, sense of belonging, support and care that can come from families, friends, neighbours and communities.
- **Strengthening universal services**, so people have easier access to – and can benefit to the full from - general support and services such as transport, leisure, education, housing, community safety, information and advice.
- **Improving early intervention & prevention services** to assist people who need a little more help, at an early stage, to stay independent as well as helping to halt or slow down further deterioration if people become ill or disabled or start to lose their independence.
- **Increasing choice and control through developing self directed support**. This means moving from a position where people are recipients of services, to one where they are citizens who can become actively involved in selecting and shaping the services they receive. This is so the services and supports they receive are tailored to their individual needs and preferences.

### 3.2 The growing emphasis on mental health in older age

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

#### Recent national reports on older people’s mental health

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

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

**Improve awareness** about mental health in older age among the public and professionals
Make sure that **people's needs are diagnosed early on** and that **services intervene promptly and effectively**

Improve the **quality of care**, so that people
- Have more choice and control about the support they receive
- Remain at home, with the best possible quality of life, for as long as possible
- Experience good care in hospital and in care homes when they need it.

### 3.3 Implications

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

<table>
<thead>
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<th>Key policy themes</th>
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<td><strong>Promoting social inclusion and well-being</strong></td>
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<td><strong>Reducing health inequalities</strong> and inequalities in provision.</td>
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<td><strong>Empowering people</strong> to look after their own health</td>
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<td><strong>Promoting prevention and early intervention</strong></td>
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<td><strong>Ensuring early diagnosis</strong></td>
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<td><strong>Involving service users &amp; carers</strong> when planning &amp; delivering services</td>
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<td><strong>Ensuring fair and timely access to services</strong></td>
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<td><strong>Delivering user focussed, holistic and responsive services</strong>, which treat service users and carers as individuals</td>
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<tr>
<td><strong>Giving people more control and choice</strong> about the care they receive, addressing mental health, as well as physical health, needs</td>
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<tr>
<td><strong>Delivering care that is as close to people’s homes as possible</strong></td>
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<tr>
<td><strong>Providing more co-ordinated services, marshalling resources</strong> across local authorities, NHS and other agencies</td>
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<tr>
<td><strong>Providing integrated intermediate care services</strong> to prevent hospital admission, to reduce lengths of stay, to ensure timely discharges and to prevent avoidable re-admissions</td>
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<td><strong>Ensuring consistency and value for money</strong></td>
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<td><strong>Raising standards</strong> and ensuring a <strong>well-trained workforce</strong>.</td>
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Islington’s strategy supports, and is supported by, a range of other local policies and strategies, including Islington’s overall Commissioning Strategy Plan and its Primary and Community Services Commissioning Strategy, Transforming Primary Care and the development of polysystems, the Carers Strategy, and strategies for health inequalities and end of life care.
4. Mental health needs among older people in Islington

4.1 Islington’s population

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

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

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

![Chart showing population projections for Islington over 65 age groups]

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

![Chart showing ethnic group projections for Islington over 65 age group]
4.2 Deprivation in Islington

Islington is one of the most deprived boroughs in the country and suffers from significant health inequalities, both within the borough and when compared to many other parts of the country. It has, for example, the lowest life expectancy for men and the third lowest for women out of all London boroughs. Male life expectancy has been calculated as varying from 76.4 years (Clerkenwell ward) to 71.7 years (Tollington ward). For women, life expectancy varies from 82.3 years (St George’s) to 77.7 years (Finsbury Park).²

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

This is significant for this strategy, because there are strong links between deprivation on the one hand, and physical and mental ill-health on the other hand. Indeed deprivation among older people and the resultant social exclusion can in itself be a causal factor leading to loss of independence, reduced quality of life and admission to institutional care, causing increased pressure on our services³.

However, there are also relatively high numbers of more affluent older people in the borough (over one third are owner-occupiers with no mortgage) but this too brings challenges for our services. While many of these people will fund their own support services, there is growing concern⁴ that self funders do not receive adequate information to make informed choices and therefore do not always secure the most appropriate support or best value from services. There is therefore a growing role for the Council to provide more and better information and advice.

4.3 Dementia

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

With 348.7 admitted people per 1,000 people with dementia in 2007/08, Islington had the third highest rate of admission to hospital with any diagnosis of dementia. (Source: HES 2007/08 and dementia prevalence estimates 2007)

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

However, the expected rate of increase in the number of people with dementia, who are aged over 85 is faster, increasing by roughly 14% over the next ten years and 27% over the next twenty years. Among people aged 90 or over the increase is expected to be even greater.
These figures may be higher if an allowance is made for higher rates of deprivation.\textsuperscript{5} It is also noted that higher prevalence rates of dementia have been found among African Caribbean older people and this be may be linked to untreated hypertension.\textsuperscript{6} Additionally dementia is not necessarily recognised among minority ethnic communities and research has shown that in general minority ethnic groups are at far more risk of misdiagnosis and delayed treatment than other older mental health users.\textsuperscript{7}

**Younger People with Dementia**

The figures above are for people aged over 65. While dementia is relatively rare among younger people, locally there may be in the region of 140 people aged under 65. However, significantly fewer people have been identified through local primary care registers, or have been referred to specialist neurological services. This is likely to be due to poor diagnosis: there are different patterns of dementia among younger people\textsuperscript{1} and a need to recognise unusual dementias and types that may not present with memory loss.

**Implications**

The prevalence of dementia carries significant implications for local services.

- It is one of the most severe and devastating illnesses we face and has profound, negative effects on family carers, who are often old and frail themselves and as a result suffer high levels of care burden, depression, physical illness and loss of quality of life.\textsuperscript{8} It is estimated that for every 100 people with dementia, there will be an average of 85 family carers.\textsuperscript{9}
- Alongside this, the costs of supporting people with dementia are high: it has been estimated nationally that these costs are greater than the costs of heart disease, cancer and stroke combined.

**4.4 Depression**

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

\textsuperscript{1} For example Alzheimer’s disease only represents one third of dementias among younger people, but is the main form of dementia among older people
It is estimated that approximately 15% of older adults may be depressed at any one time\textsuperscript{10} and there are indications that rates of depression are increasing, so the actual numbers may be much greater\textsuperscript{11}. It is also estimated that:

- About one third of older people routinely attending GPs are depressed
- Of depressed older people at home, about one third have moderately severe depression
- About 25% of older people in general hospital are clinically depressed
- 30-40% of older people in residential or nursing care show signs of clinical depression
- Between 26-44% of older people receiving local authority care at home are depressed.\textsuperscript{12}

There is contradictory evidence about depression among older people from minority ethnic communities. Some studies show no difference between communities, while other studies have found a slightly higher prevalence among ethnic minority communities. Some research suggests that older people from minority communities may be particularly vulnerable to depression because of risk factors associated with socio-economic deprivation, immigrant status and old age. Research also suggests that many older people from minority ethnic communities feel isolated and that this sometimes leads to high levels of depression.\textsuperscript{13}

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

- Depression is more common among people with long-term medical conditions and can worsen outcomes in a range of physical disorders, potentially significantly reducing people’s ability to cope with physical ailments\textsuperscript{14} \textsuperscript{15}
- The cost of people using health and social care services is almost 1.5 fold higher for older adults with depression, compared with their younger counterparts\textsuperscript{16}
- There is a high incidence of depression among carers of older people with dementia with up to one third of carers being affected\textsuperscript{17} and this together with the related stresses of caring can be a key factor in carer breakdown and subsequent admission of people to care homes
- It is the leading cause of suicide among older people

4.5 Anxiety

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

- Between 2\% and 4\% per cent of older people living in the community meet the clinical criteria for a formal diagnosis of anxiety.\textsuperscript{18}
- Between 10\% and 24\% per cent of people aged 65 and over living in the community have symptoms.\textsuperscript{19}

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

4.6 Suicide

Nationally in 2006 the suicide rate in England fell to the lowest figure since records began in 1861, with a rate of 7.84 per 100,000. However in the same year, the rate in Islington was much higher – a rate of 14.01 per 100,000 across all age groups.
Local analysis shows that no one group or location can account for the borough’s comparatively high suicide rates. However:

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

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

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

4.7 Delirium (acute confusion)

Delirium, or acute confusion, is marked by sudden onset of confusion, disorientation, memory impairment, agitation and even delusions and hallucinations. The causes are almost always physical in nature, including infection and dehydration. Prevalence increases rapidly with age. Delirium affects between one and two per cent of people aged 65 and over living in the community and up to 14 per cent of people aged 85 and over.

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

4.8 Schizophrenia & other severe mental health problems

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

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

4.9 The relationship between physical and mental health

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

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

5. The case for change, our strategy and objectives

5.1 The case for change

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

- **First, mental ill-health in older age can have devastating impacts.** Dementia, for example, is one of the most severe and devastating illnesses we face. It also has profound and negative effects on the health and well-being of family carers. Carers are often old and frail themselves and as a result suffer high levels of care burden, depression, physical illness and loss of quality of life.

- **Second, these devastating impacts have very large financial implications for health and social care services.** National cost of illness studies have shown that the direct costs of Alzheimer’s disease alone exceed the total cost of stroke, cancer and heart disease. We need to ensure we meet people’s needs in the most cost effective way and national studies and our local analysis of services, which is discussed below, provide growing evidence that this is not currently the case.

- **Third, it is recognised across the country that mental health in older age has been neglected for too long.** While we have some excellent services locally, overall we too recognise that there is real room for improvement. There is an opportunity for us to build on the growing national momentum for change to make real and long term improvements locally.

- **Fourth, while the total number of people aged over 65 in Islington will not increase over the next ten years, there will be an increase in the number of people aged over 85.** This group is often especially frail and vulnerable, suffering disproportionately from mental ill-health; in particular the incidence of dementia rises dramatically over the age of 80. As the level of need among this group increases, it is therefore especially important to make sure we are able to meet their needs effectively.

- **Fifth, we have a window of opportunity to strengthen our services before the numbers of older people begin to increase significantly.** In particular we have an opportunity to develop our preventative and early intervention services to reduce longer term dependence on costly services.

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

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

5.2 Refocusing our services

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

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

There are issues about the way care home placements are classified. However, a significant proportion of Islington’s overall budget is spent on residential and nursing care. Against these large investments and pressures in some institutionally based services, the scope to develop community based services is widely recognised.

- There are real opportunities to strengthen early diagnosis and early intervention services.
- There is scope to develop a range of community based and intermediate care services, especially for people with dementia, to prevent admissions and re-admissions to institutional care, to reduce lengths of stay in hospital settings and to help people to return home if they are admitted to care.

Implementation of this strategy will be cost neutral. Excluding additional investment, which was secured in 2008, delivery will be achieved through service redesign.
5.3 Strategy

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

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<th>STRATEGY: Re-focusing our services</th>
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<td><strong>REDDUCING:</strong></td>
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<td>Admissions to residential &amp; nursing care homes and in-patient continuing care beds</td>
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<td>Admissions to hospital care</td>
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<td>Lengths of stay in general &amp; specialist hospital care</td>
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<td>Delayed transfers of care</td>
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5.4 Objectives

To achieve this, we need to focus on the following objectives:
- Promoting prevention and early intervention
- Improving information, advice and ease of access to services
- Strengthening community based support
- Improving institutional care but relying on it less
- Joining up services
- Developing the workforce

The diagram overleaf illustrates this and the following section discusses these.
6. Making it happen

6.1 Promoting good mental health

Objective 1. To promote good mental health, so that
People stay as healthy and independent as possible

A range of risk factors are associated with mental ill-health in older age, including increased risk of
dementia associated with poor vascular health\(^{27}\), smoking, excessive alcohol consumption,
obesity, diabetes, hypertension and raised cholesterol. NHS Islington has put in place a series of
strategies to reduce these risks, including for example its strategy for improving cardiovascular
health.\(^{28}\)

Islington is also addressing the social determinants of mental health through its strategies to
promote good mental health\(^{29}\) and to improve the quality of life among older people.\(^{30}\)

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

<table>
<thead>
<tr>
<th>Priorities</th>
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</thead>
</table>
| **To continue to implement & develop health promotion strategies** focused on people in
middle and older age, making sure in particular that we address the known risk factors
associated with dementia, such as vascular health.

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

We also need to build prevention related messages into public and professional
information campaigns designed to raise awareness |

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

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

| **To develop our quality of life strategy for older people** with an emphasis on reducing
social exclusion and social isolation and on optimising older people’s health and well-being |

6.2 Raising awareness

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

- Stigma, social exclusion and discrimination are minimised
- There is a greater emphasis on preventing mental ill-health in older age
- People know about the benefits of timely diagnosis and care and seek help earlier
We need to raise awareness among the public and professionals about mental health in older age. This is important because lack of awareness in itself can lead to greater dependence and more costly outcomes for health and social care services. For example:

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

## Priorities

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

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

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

### 6.3 Good quality early diagnosis and early intervention

<table>
<thead>
<tr>
<th>Objective 3. To ensure good quality early diagnosis and intervention, so that people receive</th>
</tr>
</thead>
<tbody>
<tr>
<td>- A rapid and competent specialist assessment</td>
</tr>
<tr>
<td>- An accurate diagnosis, that is sensitively communicated to them and their carers</td>
</tr>
<tr>
<td>- The treatment, care and support they need following diagnosis</td>
</tr>
</tbody>
</table>

**Dementia**

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

This is especially significant because evidence tells us that early diagnosis of dementia and early intervention can significantly help to minimise deterioration in a person’s condition and circumstances and to improve their quality of life. In turn this reduces the risks of unnecessary use of hospital beds and care home placements.33 This is because early diagnosis

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

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

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

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

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

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

The development of the service and the way it works with others, including primary care, social care and voluntary agencies will also be informed by planned work to review care pathways.
Diagnosis of Depression & Early Intervention

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

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

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

6.4 Information, advice and access to services

Objective 4. To improve information and advice, so that

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

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

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

Information for People with Dementia and Their Carers

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

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

Information should also be available on what options exist for planning ahead for those diagnosed with dementia, to ensure that their desires and wishes are properly considered were they to lose
mental capacity. For example, by making a Lasting Power of Attorney and registering it with the Office of the Public Guardian. Versions will also be needed to work across the diverse populations affected by dementia (for example, different language groups, minority ethnic groups, people with learning disabilities and people with early-onset dementia).

<table>
<thead>
<tr>
<th>Priorities</th>
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<tbody>
<tr>
<td>- To improve the information and advice people receive about dementia. This will include</td>
</tr>
<tr>
<td>- Building on nationally produced information, adapting it for local circumstances</td>
</tr>
<tr>
<td>- Ensuring appropriate versions are available for different groups and needs</td>
</tr>
<tr>
<td>- Agreeing arrangements for dissemination across local services and monitoring these</td>
</tr>
<tr>
<td>- Making sure that information is accessible for all, including those who fund their own social care</td>
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**Improving Access: Dementia Advisors**

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

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

<table>
<thead>
<tr>
<th>Priorities</th>
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<tbody>
<tr>
<td>- To develop a service model for a local dementia advisor service.</td>
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</tbody>
</table>

**Structured Peer Support and Learning Networks**

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

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

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

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

- To develop models for structured peer support networks

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

6.5 Personalised community support

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

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

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

- **Home care services** have recently been reviewed and a significant proportion of these services have been re-tendered. There is a clear expectation that these services will - without exception - cater for a broad spectrum of needs, including those of older people with mental health needs and their carers. Alongside this, Islington’s specialist home care service will continue to work with people with especially complex and challenging needs.

- **Assistive technologies** can play a significant role in supporting some people at home, ranging from a simple community alarm system like Linkline, to sophisticated monitoring and sensing devices using wireless and electronic technology. The Council and NHS Islington remain committed to developing its role in supporting people at home, in line with the Assistive Technology Strategy. The Foundation Trust and the Council have worked closely together to implement assistive technology for older people with mental health problems and their carers. A range of devices are currently in use in Islington, including gas detectors, wandering alerts, smoke alarms and falls alerts. All devices are electronically linked to social services helpline, who can respond immediately, as necessary. In many cases, appropriate use of assistive technology has facilitated discharge from hospitals, providing support to maintain a level of independence at home.

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

The needs of people with dementia and their carers should be included in the development of assistive technology and telecare. As evidence emerges, Islington will consider the provision of options to prolong independent living and delay and reduce reliance on more intensive services.
Personalising Social Care Services

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

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

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

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

In carrying this work forward we will identify the most effective ways to support people who fund their own social care or who are eligible for state support and want to use individual/ personal budgets to purchase their own care and support. Following a carers needs assessment, carers may also be eligible for an individual budget.

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

<table>
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<tr>
<th>Priorities</th>
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<tbody>
<tr>
<td>To continue to develop community support services with an emphasis on</td>
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<tr>
<td>- Developing the responsiveness of home care services</td>
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<tr>
<td>- Developing the use of assistive technologies as evidence emerges about its effectiveness</td>
</tr>
<tr>
<td>- Personalising social care services, and as a part of this identifying ways of supporting people who fund their own care or want to use ‘personal budgets’ to purchase their own services</td>
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6.6 Supporting carers

<table>
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<tr>
<th>Objective 7. To ensure good support for carers, including</th>
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<tbody>
<tr>
<td>- Appropriate information on the diagnosis of the cared for person and the available services</td>
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<tr>
<td>- Good quality personalised breaks</td>
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</table>
Carers are often the most important source of support and reassurance for older people with mental health problems; helping people to remain at home, rather than moving into residential or nursing care. A range of developments highlighted elsewhere are intended to improve the way Islington supports carers in their vital role. These include

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

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

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

### Priorities

**To continue to improve the way we support carers**, including an emphasis on providing appropriate information on the diagnosis of the cared for person and the available services and ensuring people can access good quality personalised breaks

### 6.7 End of life care

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

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

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

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

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

6.8 Re-ablement and intermediate care services

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

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

Particular challenges arise in terms of helping people to remain at home when there is a crisis, or to return home if people are admitted to hospital care. There is, for example, national evidence that pressure to reduce lengths of stay in acute care, combined with risk-averse discharge planning and poor access to intermediate care services can mean that people with dementia are rushed into long-term residential care prematurely. However, there is good clinical evidence that people with mild or moderate dementia with physical rehabilitation needs do well if given the opportunity. People with severe dementia may need more specialist services geared to meeting their mental health needs as well as those providing general physical rehabilitation. Staff working in intermediate care, like any other staff group, need to have core training in dementia and access to advice and support from specialist mental health personnel to help them ensure that older people with mental health needs are able to benefit from rehabilitation and re-ablement opportunities. Carers should also be involved in planning and re-ablement, where possible.

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

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

Priorities

- To develop intermediate & interim care services, with a particular focus on
  - Preventing avoidable admissions to general hospital care and specialist in patient care
  - Reducing lengths of stay in hospital settings
  - Ensuring timely and successful transfers of care back to people’s homes and reducing admissions to care homes
6.9 Sheltered housing and extra care housing

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

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

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

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

Priorities

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

6.10 Residential and nursing care

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

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

Priorities

To carry out further work to better understand the reasons people are admitted to care homes and ways in which we can further reduce admissions. From this we will develop a demand forecast to better inform future commissioning arrangements.

QUALITY OF CARE

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

It highlights the need to

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

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

### Priorities

<table>
<thead>
<tr>
<th>To continue to improve the quality of care in care homes, in particular through</th>
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<tbody>
<tr>
<td>- The work of the residential and nursing care home provider forums</td>
</tr>
<tr>
<td>- Commissioning specialist in-reach/liaison services</td>
</tr>
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</table>

### 6.11 Hospital care

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

**Objective 13. To ensure effective specialist in-patient care**

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

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

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

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

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

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

### Priorities

<table>
<thead>
<tr>
<th>To identify senior clinicians within general hospitals who will take the lead for improving care in hospitals. As a part of this we will especially involve work with them when</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Designing care pathways in and out of hospital care (see 5.13 below)</td>
</tr>
<tr>
<td>- Developing re-enablement and intermediate care services (see 5.8 above)</td>
</tr>
<tr>
<td>- Developing specialist liaison services (see 5.12 below)</td>
</tr>
<tr>
<td>- Designing and implementing workforce development activities (see 5.14 below)</td>
</tr>
</tbody>
</table>

#### 6.12 Specialist liaison service

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

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

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

6.13 Joined up care

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

- Care and support is delivered in a timely, co-ordinated & effective way

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

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

Priorities

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

6.14 A more informed & effective workforce

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

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

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

### Priorities

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

  As a part of this, as well as improving understanding of dementia and depression, we need to make sure that professionals

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

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

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

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

### 6.15 Governance

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

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

As a part of this, we will improve the way we involve older people and their carers in the planning and review of services and the planned peer support network (see 5.4 above) will enable people with dementia and their carers to take an active role in the development and prioritisation of local services.
We will also significantly strengthen the information that we use to monitor and manage services. This work will be informed by national work to improve information, arising from the recent Healthcare Commission report *Equality in Later Life*. This includes work on developing meaningful outcome indicators.

### Priorities

- **To significantly improve the way we involve older people and their carers** in the planning and delivery of services
- **To improve management information**, using it to manage the care pathway we develop

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### 7. Implementation

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

A small delivery group will be formed to oversee the delivery, review and continuing development of the strategy. It will involve those listed in Appendix Three (Implementation Plan) as leads for particular aspects of work as well a senior clinical input from Camden and Islington NHS Foundation Trust.

Implementation has already begun in some areas, such as the development of the Islington memory assessment service. There are other areas in which implementation has yet to begin. The Strategy’s implementation group, which will be convened by December 2009, will develop a more detailed implementation plan based on the outline implementation plan (Appendix One).
Appendix One. Outline Implementation Plan

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>LEAD PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Promoting good mental health</strong> [Section 5.1]</td>
<td></td>
</tr>
<tr>
<td>• Continue to implement &amp; develop our health promotion strategies</td>
<td>Jonathan O’Sullivan, Assistant Director Public Health</td>
</tr>
<tr>
<td>• Develop our quality of life strategy for older people</td>
<td>Clare Henderson, Assistant Director: Independence &amp; Older Adults</td>
</tr>
<tr>
<td><strong>Raising awareness</strong> [Section 5.2]</td>
<td></td>
</tr>
<tr>
<td>• Develop a local approach to raising awareness that supports and builds on national awareness raising campaigns</td>
<td>Public Health</td>
</tr>
<tr>
<td><strong>Good quality early diagnosis and early intervention</strong> [Section 5.3]</td>
<td></td>
</tr>
<tr>
<td>• Develop the new Memory Assessment Service</td>
<td>Kath McClinton, Assistant Director Joint Commissioning with Doug Wilson: Assistant Director Mental Health Care of Older People.</td>
</tr>
<tr>
<td>• Continue to improve the way we diagnose and treat depression</td>
<td>Kath McClinton, Assistant Director Joint Commissioning with NHS Islington Provider Service Lead and IAPT Service Director</td>
</tr>
<tr>
<td><strong>Information, advice and access to services</strong> [Section 5.4]</td>
<td></td>
</tr>
<tr>
<td>• Improve the information and advice people receive about dementia</td>
<td>Kath McClinton, Assistant Director Joint Commissioning with NHS Islington Provider Service Lead and Public Health</td>
</tr>
<tr>
<td>• Test bed a local dementia advisor service</td>
<td></td>
</tr>
<tr>
<td>• Pilot structured peer support networks</td>
<td></td>
</tr>
<tr>
<td><strong>Personalised community support</strong> [Section 5.5]</td>
<td></td>
</tr>
<tr>
<td>PRIORITIES</td>
<td>LEAD PERSON</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>▪ Develop more personalised community support services</td>
<td>Clare Henderson, Assistant Director: Independence &amp; Older Adults</td>
</tr>
<tr>
<td><strong>Supporting carers [Section 5.6]</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Continue to improve the way we support carers</td>
<td></td>
</tr>
<tr>
<td><strong>End of life care [Section 5.7]</strong></td>
<td>Kath McClinton, Assistant Director Joint Commissioning</td>
</tr>
<tr>
<td>▪ Ensure the specific needs of older people with mental health problems – including dementia - are addressed as Islington's end of life care strategy is implemented</td>
<td></td>
</tr>
<tr>
<td><strong>Re-ablement and intermediate care services [Section 5.8]</strong></td>
<td>Kath McClinton, Assistant Director Joint Commissioning</td>
</tr>
<tr>
<td>▪ Develop intermediate care, interim care services</td>
<td></td>
</tr>
<tr>
<td><strong>Sheltered housing and extra care housing [Section 5.9]</strong></td>
<td>Clare Henderson, Assistant Director: Independence &amp; Older Adults</td>
</tr>
<tr>
<td>▪ Complete the current review of supported housing services for older people</td>
<td></td>
</tr>
<tr>
<td><strong>Residential and nursing care [Section 5.10]</strong></td>
<td>Kath McClinton, Assistant Director Joint Commissioning</td>
</tr>
<tr>
<td>▪ Better understand the reasons people are admitted to care homes and ways in which we can further reduce admissions. From this develop a demand forecast to better inform future commissioning arrangements.</td>
<td></td>
</tr>
<tr>
<td>▪ Continue to improve the quality of care in care homes, in particular through the work of the care homes provider forums and through specialist in-reach/liaison services</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital care [Section 5.11]</strong></td>
<td>Kath McClinton, Assistant Director Joint Commissioning</td>
</tr>
<tr>
<td>▪ Re-designate some in-patient beds on specialist mental health acute wards at the Highgate Centre as re-enablement care beds</td>
<td></td>
</tr>
<tr>
<td>▪ Identify senior clinicians within general hospitals who will take the lead for improving care in hospitals.</td>
<td></td>
</tr>
<tr>
<td>PRIORITIES</td>
<td>LEAD PERSON</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Specialist liaison service [Section 5.12]</strong></td>
<td>Doug Wilson, Assistant Director Mental Health Care of Older People</td>
</tr>
<tr>
<td>▪ Expand and develop the role of specialist</td>
<td></td>
</tr>
<tr>
<td>liaison service</td>
<td></td>
</tr>
<tr>
<td><strong>Joined up care [Section 5.13]</strong></td>
<td>Kath McClinton, Assistant Director Joint Commissioning</td>
</tr>
<tr>
<td>▪ Establish a clearer and shared pathway of</td>
<td></td>
</tr>
<tr>
<td>care across all services</td>
<td></td>
</tr>
<tr>
<td><strong>A more informed &amp; effective workforce [Section 5.14]</strong></td>
<td>Kath McClinton, Assistant Director Joint Commissioning</td>
</tr>
<tr>
<td>▪ Develop and implement a systematic, ongoing</td>
<td></td>
</tr>
<tr>
<td>and targeted programme of learning and</td>
<td></td>
</tr>
<tr>
<td>development across the whole system</td>
<td></td>
</tr>
<tr>
<td><strong>Governance [Section 5.15]</strong></td>
<td>Clare Henderson, Assistant Director: Independence &amp; Older Adults</td>
</tr>
<tr>
<td>▪ Significantly improve the way we involve</td>
<td></td>
</tr>
<tr>
<td>older people and their carers</td>
<td></td>
</tr>
<tr>
<td>▪ To improve management information</td>
<td></td>
</tr>
</tbody>
</table>
Appendix Two. Policy Context

NATIONAL POLICY DOCUMENTS RELATING TO OLDER PEOPLE’S MENTAL HEALTH

Forget me not (Audit Commission, 2000)
The key findings included only half of GPs believed it important to look actively for
signs of dementia and to make an early diagnosis; less than half of GPs felt they had
received sufficient training in how to diagnose dementia; poor assessments and
treatment, with little joint health and social care planning and working; insufficient
supply of specialist home care and lack of information, counselling, advocacy and
support for people with dementia and their family/carers. There was very little
improvement when reviewing change two years later (Audit Commission, 2002)

National Service Framework for Older People (Department of Health, 2001)
The chapter on mental health advocated early diagnosis and intervention for
dementia and recommended that the NHS and local authorities should review
arrangements for health promotion, early detection and diagnosis, assessment, care
and treatment planning, and access to specialist services. The strategy report notes
that a review of the progress of the NSFOP suggests this has had little positive
impact on services for people with dementia and their families.

Everybody’s business (CSIP, 2005)
This development guide for integrated mental health services for older adults set out
the essentials for a service for older people including memory assessment services
to enable early diagnosis of dementia and integrated community mental health teams
whose role includes management of people with dementia with complex behavioural
and psychological symptoms.

NICE/SCIE clinical guidelines on dementia (2006)
The key recommendations from this joint clinical guideline on the management of
dementia included: provision of memory assessment services as a point of referral
for diagnosis of dementia; integrated working across all agencies; carers support;
assessment and treatment of non-cognitive symptoms and behaviour that
challenges; dementia care training for all staff working with older people; and,
improved care for people with dementia in general hospitals.

NICE clinical guidelines on depression, anxiety and schizophrenia
published clinical guidelines on the management of conditions in adults in primary,
secondary and community care.
Promoting mental health and well-being in later life (2006)
This joint report by Age Concern and the Mental Health Foundation arose from shared concerns that mental health in later life is a much neglected area that is often described as falling into the gaps between policies and services for mental health and those for older people. It presents findings and recommendations on promoting mental health and wellbeing in later life.

Improving services and support for older people with mental health problems (2007)
This report from Age Concern sets out to answer how we can improve services and support for older people with mental health problems. The report offers a vision of a society where the needs of older people with mental health problems and the needs of their carers are understood, taken seriously, given their fair share of attention and resources, and met in a way that enables them to lead meaningful and productive lives. It makes 35 recommendations to support this

Dementia UK report (2007)
One of the main recommendations of this important Alzheimer's Society report was making dementia an explicit national health and social care priority and the need to improve the quality of services provided for people with dementia and their carers.

National Audit Office value for money study (2007)
This report was very critical of the quality of care received by people with dementia and their carers – the size and availability of specialist Community Mental Health Teams was extremely variable and the confidence of GPs in spotting dementia symptoms was poor and lower than it had been in 2000.

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

Public Accounts Committee report (PAC, 2007)
The above NAO report was submitted for consideration by the House of Commons Public Accounts Committee and at the committee’s public hearing the NHS Chief Executive and other Department of Health officials were questioned on the NAO’s criticisms and recommendations. Following the hearing the PAC published its own
report on dementia services in January 2008. The committee’s comments and recommendations were consistent with those of the NAO report and further echoed earlier reports on the changes that were needed.

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

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

**The National Dementia Strategy: Living Well with Dementia (2009)** the Strategy outlines three key steps to improve the quality of life for people with dementia and their carers. First, to ensure better knowledge around dementia and remove stigma associated with it. Second, to ensure proper diagnosis of dementia, which takes place as early as possible. Third, to develop a range of services for people with dementia and their carers, which fully meets their changing needs over time.

**Equality in later life: A national study of older people’s mental health services, Healthcare Commission (2009)**
This is a report of a national study of mental health services for older people in England. The study combined an analysis of national data with visits to a representative sample of mental health trusts. The study covered four themes: age discrimination in mental health services; quality of inpatient care; how comprehensive services are; and how organisations work together to provide services. There are 14 recommendations for the Government, the Care Quality Commission, NHS trusts and service providers, to ensure that there is a coordinated approach to improve mental health services for older people.
Healthcare for London Mental Health Workstream and Dementia Services Guide (2009) The Guide will support commissioners and providers in the implementation of the National Dementia Strategy and includes a care pathway for people with dementia who are admitted to a general hospital, to ensure that people with dementia receive high quality physical healthcare within a general hospital. The Guide also aims to advise London commissioners and clinicians how to follow the integrated care pathway to help London commissioners plan services in partnership with Local Authorities, to provide a quality check and performance outcomes for reviewing services.

DOCUMENTS RELATING TO THE WIDER POLICY CONTEXT:

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

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

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

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

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

OVERVIEW

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

Services that assess people’s needs & co-ordinate care & treatment
- Primary care services
- Mainstream care management service for older people
- Integrated community mental health team for older people

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

Housing and support services
- Sheltered housing
- Extra care housing

Hospital & in-patient care services
- General hospital care
- Specialist in patient hospital care
- Specialist in patient respite care

Residential and nursing care service
- Residentially based continuing care
- Residential and nursing care homes
<table>
<thead>
<tr>
<th>Service Name</th>
<th>Service Type</th>
<th>Provider Name</th>
<th>Case load</th>
<th>Bed Nos.</th>
<th>Total Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s Society</td>
<td>Carers’ Support Service</td>
<td>Alzheimer’s Society</td>
<td>50</td>
<td></td>
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<tr>
<td>Grace ward</td>
<td>In patient Continuing Care</td>
<td>Camden &amp; Islington NHS Foundation Trust</td>
<td>8</td>
<td>14.94</td>
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<tr>
<td>Garnet Ward</td>
<td>In patient care: Acute Assessment</td>
<td>As above</td>
<td>14</td>
<td>21</td>
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<td>Pearl Ward</td>
<td>In patient care: Acute Assessment</td>
<td>As above</td>
<td>14</td>
<td>21</td>
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<tr>
<td>Camden Mews</td>
<td>Day Hospital</td>
<td>As above</td>
<td>64.5</td>
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<td>5.76</td>
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<td>Community Mental Health Team</td>
<td>Integrated Community Mental Health Team</td>
<td>As above</td>
<td>345</td>
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<td>27.37</td>
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<tr>
<td>Memory assessment service</td>
<td>Integrated Community Mental Health Team</td>
<td>As above</td>
<td></td>
<td>166 active cases (Nov 08 – Apr 09)</td>
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<tr>
<td>Psychology Assessment &amp; Treatment Service</td>
<td>Psychological therapy services for older people</td>
<td>As above</td>
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<td>0.4</td>
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<tr>
<td>Stacey Street Nursing Home</td>
<td>Care Home (with nursing)</td>
<td>Family Mosaic</td>
<td>30</td>
<td></td>
<td>39.9</td>
</tr>
<tr>
<td>127 Highbury New Park</td>
<td>Specialist Day/Resource Centres</td>
<td>Care UK</td>
<td>16</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>127 Highbury New Park – residential</td>
<td>Care Home (with nursing)</td>
<td>Care UK</td>
<td>53</td>
<td>56</td>
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<td>Carnegie Street</td>
<td>Specialist Day/Resource Centres</td>
<td>Care UK</td>
<td>20</td>
<td>11</td>
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<tr>
<td>Muriel Street</td>
<td>Care Home (with nursing)</td>
<td>Care UK</td>
<td>60</td>
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<td>Family Mosaic Hornsey Lane</td>
<td>Care Home</td>
<td>Family Mosaic</td>
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<tr>
<td>Belmore</td>
<td>Extra Care Housing</td>
<td>Islington LA</td>
<td>24</td>
<td>15</td>
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<tr>
<td>Islington Assistive Technology</td>
<td>Assistive Technology and Telecare</td>
<td>Islington LA</td>
<td>24</td>
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<td></td>
</tr>
<tr>
<td>Service Name</td>
<td>Service Type</td>
<td>Provider Name</td>
<td>Case load</td>
<td>Bed Nos.</td>
<td>Total Staff</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------</td>
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<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>LBI specialist home care</td>
<td>Home Care Service</td>
<td>Islington LA</td>
<td>70</td>
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<td></td>
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<tr>
<td>Islington Primary Care MH Graduate Workers</td>
<td>Graduate Primary Care Workers - Older Adult</td>
<td>NHS Islington</td>
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<tr>
<td>20-26 Mildmay Park</td>
<td>Extra Care Housing</td>
<td>Notting Hill Housing Trust</td>
<td>52</td>
<td>41</td>
<td></td>
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<tr>
<td>73 Mildmay Street</td>
<td>Extra Care Housing</td>
<td>Notting Hill Housing Trust</td>
<td>37</td>
<td>26</td>
<td></td>
</tr>
</tbody>
</table>

**SUMMARY OVERVIEW OF DIRECT INVESTMENTS IN SPECIALIST SERVICES**

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

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

Work is planned to establish the extent to which money that is spent on residential and nursing care could be spent differently on community based services.
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16. As above
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20 Cited in Improving services and support for older people with mental health problems. Age Concern [2007]
21 As above
22 As above
23 As above
24 As above
25 Strategy for promoting mental health and well-being in Islington. Islington PCT [2007]
26 For example
   • Research cited by Alzheimer’s Society relating to older people with mental health problems in residential care [www.alzheimers.org.uk]
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