Contributions

Thank you to everyone who took the time to contribute the development of this strategy, particularly the busy professionals who made time to meet with us, and the residents and carers who also made time, and felt able to share their views and experiences.
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Executive Summary

This strategy has been informed by national policies such as the National Dementia Strategy and the Disability Discrimination Act which aim to promote equity of provision for older people. The strategy has also been developed through consultation with local people, their families and carers and local professionals. They told us what they think our local priorities should be and how best we might address them.

We have also analysed the demographic profile of older people in the borough, based on the Hounslow Joint Strategic Needs Assessment, and what national research tells us about the prevalence of mental health needs among our older people.

The combined spend of the local authority and NHS on older people’s mental health in Hounslow in 2009-10 was approximately £16,500 million. This strategy will be implemented in the context of reduced public funding and the move to GP commissioning. Our strategic aims will need to be delivered within existing and reduced resources, so the focus is on reshaping and reconfiguring existing services to deliver the planned improvements.

The strategy addresses both functional such as depression, anxiety and psychosis, and cognitive mental health problems, such as dementia.

We will commission high quality services for older people and their carers, by:

- Giving them choice and control over personalised care packages and offering a wider range of care options;
- Giving carers access to information, support, and respite breaks based on a thorough assessment of their needs;
- Increasing the availability of supported and extra care housing;
- Making full use of assistive technology, telehealth and telecare and;
- Offering good end of life care.

We will develop the local workforce to have the skills and knowledge to support and care for older people with mental health problems.

There have been a number of significant achievements and improvements to older people’s services over past five years:

- Help in Hounslow - the information, advice and advocacy service
- Primary Care Counselling – which includes provision for people aged 65 and over
- West London Cognitive Impairment Research Unit, now designated a Centre of Excellence
- Dementia Shared Care Protocol
- Reconfiguration of Brentford Lodge into day facility with increased capacity
- Development of Older People’s Resource Centres in Chiswick and a 54 bedded extra care housing facility in Brentford, which includes greater provision for people with dementia.
- Re-development of Sandbanks into an Older People’s Resource centre with a 60 bedded home and day centre, due to open in 2012
This strategy will make the best use of existing resources, maximising capacity by:

- Developing seamless, integrated and efficient care pathways;
- Ensuring specialist mental health expertise is focused on the most appropriate parts of the pathway, and works across professional boundaries to support non-specialist staff;
- Driving up quality standards in assessment, treatment and care;
- Developing the workforce.

We have five key strategic aims:

**Mental Health Promotion and Prevention:** To promote positive mental health and to prevent or delay the decline of an older person’s mental health throughout their later life and in every care setting.

**Early Intervention and Assessment:** To increase early intervention and the capacity to offer an expert assessment of mental health problems at every stage.

**Treatment:** To develop more efficient treatment pathways for cognitive and functional mental health problems, thereby increasing capacity and the ability to outreach to older people in community settings so that care is as local as possible.

**Care and Support:** To increase independent and supported living options for older people with mental health problems, and reduce reliance on bed-based and residential care.

**Ensuring Quality for Older People:** To improve the quality of care and ensure that the right mental health support is available at every stage of a person’s journey by developing:

- A skilled and knowledgeable workforce;
- User-led services that provide equality of access and dignified care for all older people
- Holistic and comprehensive support for carers;
- Choice and control through personalisation of care;
- Good end of life care;
- Continuous improvement of local care pathways;
- Robust procedures for monitoring and reviewing quality standards.

We recognise that older people can be vulnerable, particularly those with mental health problems who depend on care and support from carers and local services. We are committed to ensuring vulnerable older adults are properly safeguarded and will work with our providers to reduce the likelihood of harm or neglect.

This strategy has been approved by NHS Hounslow and the London Borough of Hounslow. Its’ implementation will be overseen by the Adults and Older Person Partnership Board and the Hounslow Integrated Management Board. Work on the strategy will be progressed each year through the annual commissioning intentions and an annual action plan.

Much of the work will be driven forward and the multi agency Older People’s Mental Health Strategy Forum and the Joint Commissioning Team.
1. Demographic Profile and Needs Assessment

1.1 Summary
The information below provides an overview of the demographic profile and anticipated mental health needs for older people living in Hounslow. Appendix One provides a more comprehensive description of these needs.

There is an ageing population in Hounslow, with an increase in older people predicted within the life of this strategy, (up by 6.54% by 2016) and this trend is set to continue up to 2026. This will increase the demand for services most notably within the 85 years and above age group, in particular older males.

The Department of Health estimates suggest mental health problems are present in 40% of older people who attend their GP; in 50% of older people inpatients in general hospitals; and in 60% of residents in care homes. Just over a quarter of admissions to mental health inpatient services involve people over the age of 65.

Mental health problems particularly depression and dementia are more common and have a worse outcome in the 60% of older people who suffer from a long term illness.

1.2 Functional Mental Health
The range of mental health problems experienced by older people is varied, from negative feelings associated with isolation or bereavement, to diagnosed mental health illnesses such as depression, anxiety or more serious illnesses such as schizophrenia. Some will be people who have lived with these problems and are now aged over 65, and others will have acquired them in their older age. We refer to these problems throughout this strategy as ‘functional mental health problems’.

Of the 25% of older people who have symptoms of depression, only half meet the clinical criteria for a diagnosis, these older people do not seek, or struggle to access support and have been identified as a local group with unmet needs.

Deliberate self harm is more closely linked to suicide in older compared to younger people and older people are four times more likely to complete a suicide attempt than their younger counterparts.

The prevalence of schizophrenia and bi-polar disorder does not appear to increase with age, approximately 1% of people aged 65 and over in the community have psychotic disorders and approximately 0.5% have schizophrenia.

1.3 Cognitive Mental Health
Older people are at a much higher risk from cognitive impairment or mental health problems associated with age (i.e. neurodegenerative). The most widely known of these diseases is dementia. The term dementia is used to describe a collection of

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1 London Borough of Hounslow Joint Strategic Needs Assessment 2009
3 Age Concern - Improving Services and Support for Older People with Mental Health Problems - The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, 2007
symptoms, including changes in memory, reasoning and communication skills, with a gradual loss of ability to carry out daily activities.\textsuperscript{4}

There are a number of different types of dementia such as Alzheimer’s; Vascular; Frontotemporal and dementia with Lewy bodies. We refer to these problems throughout this strategy as ‘cognitive mental health problems’.

Approximately 5\% of the total population aged over 65 have dementia, rising to 20\% of the population aged 80 and over. The level of diagnosis and treatment of people with dementia is generally low.\textsuperscript{5} Dementia can also occur before the age of 65 and there are approximately 17,000 people with dementia in younger age groups in the U.K.

In June 2010 there were 719 people listed on the Hounslow GP register as having dementia. Prevalence figures suggest there is at least another 850 with dementia not registered.

Delirium or acute confusion is marked by the sudden onset of confusion, disorientation, memory impairment, agitation and occasionally delusions and hallucinations. Physical causes include infection and dehydration. It is common for symptoms of delirium to be confused with dementia, although there is a link between untreated delirium and dementia but delirium, if appropriately treated is a temporary mental state.\textsuperscript{6}

Delirium is very common in care settings, including hospitals, with half of the cases developing after admission. The cost of treatment is very high and on average, delirium doubles the length of a hospital stay, and older people are more likely to enter care homes afterwards as a result. It is reported that 1-2\% of people aged 65 and over living in the community have suffered from delirium, as compared with up to 14\% of people aged over 85.\textsuperscript{6}

Our ageing population, estimated levels of unmet need and the high numbers of older people using bed based care, suggests that demand from older people with a mental health problem is likely to increase and we will need to find new, more efficient ways of delivering care for them.

\textsuperscript{4} Dementia Services Guide, Healthcare for London p7
\textsuperscript{5} Living Well with Dementia: A National Dementia Strategy 2009, Department of Health
\textsuperscript{6} Age Concern - Improving Services and Support for Older People with Mental Health Problems - The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, 2007
2. Finance and Performance

2.1 Finance

The demographic profile and needs assessment section above indicates that the cost of caring for older people with mental health problems is likely to increase as their numbers and prevalence increases.

In Appendix Four we provide an outline of the cost of older people’s mental health services during 2009-10. Some of these are actual costs and some are estimated. These calculations indicated expenditure of approximately £16,500,000 but this is likely to be a significant underestimate of actual cost. For example, whilst we show that 62% of the expenditure was incurred by the local authority, it is important to note that the NHS expenditure shown does not include the cost of treating older people’s mental health problems in primary care settings or in Accident and Emergency.

In addition, it is difficult to isolate the costs of mental health treatment and care where mental health is not the only reason for receiving the service. There is anecdotal evidence that older people with a mental health problem taken to Accident and Emergency for a physical condition, are more likely to be admitted into an acute bed, than someone without mental health complications. Similarly, anecdotal evidence suggests that people with dementia are likely to have a longer length of stay in a general acute ward.

We know from national sources, local consultation and experience on the ground that older people with mental health problems are at high risk of requiring more expensive treatment and care options. The aims of this strategy have been shaped around the need to prevent hospitalisation and institutional care wherever possible.

Over the course of the strategy commissioners will develop more sophisticated ways of understanding and costing those elements of mental health care that are difficult to quantify financially. There are two major activities that we will undertake to further this aim. Firstly, the introduction of payment by results for mental health services will test out a ‘cost and volume’ approach to treatment and care in the NHS. This will enable us to better understand unit costs and to monitor the patterns of service usage by older people. In addition, the introduction by Local Authorities of personal budgets for the purchase of social care will bring greater clarity to the monetary value of the care provided. Personal budgets may be extended to certain NHS provided services during the life of this strategy.

We will also develop a better understanding of the costs of older people with mental health problems accessing urgent, emergency and in-patient care. This is likely to strengthen the imperative for us to ensure that care pathways are as efficient as possible, and that maximum use is made of existing mental health expertise and resources, in order to, reduce reliance on bed based and other institutional care.
2.2 NHS Performance Indicators for Older People’s Mental Health

Perhaps the most important NHS performance indicators for older people’s mental health are the two Quality and Outcomes Framework (QOF) indicators directly relating to dementia:

- **DEM 1** – A register of patients diagnosed with dementia, produced by GP practices
- **DEM 2** – The percentage of patients diagnosed with dementia whose care has been reviewed within the previous 15 months

As of November 2010, there were 923 local people registered with dementia and 390 had received a care review within the previous 15 months. These indicators enable us to work with GPs to measure progress in the early identification and treatment of dementia.

We will also work with Primary Care Commissioners to maximise screening for risk factors associated with dementia, such as coronary heart disease, stroke and diabetes, during a patient’s annual review.

For associated risk factors we will use the following QOF indicators:

- **CHD 1** – a practice register of patients with coronary heart disease
- **STROKE 1** – a practice register of patients with stroke or TIA
- **BP1** – a practice register of patients with established hypertension

2.3 Local Authority Performance Indicators for Older People’s Mental Health

The local authority does not have any specific performance indicators for older people’s mental health. The following are general indicators which show the quality of care for older people, including older people with mental health problems.

- **NI 130** – Social Care clients receiving Self Directed Support (Direct Payments & Individual Budgets)
  - 2009/10 performance was 6.6% of all adults against a target of 14%
- **NI 132** – Timeliness of Social Care Assessment (all adults)
  - 2009/10 performance for this new indicator was 82.9% against a target of 88%
  - 2009/10 performance for Older People’s Teams was 93.12%
- **NI 133** – Timeliness of Social Care packages following assessment for adults
  - 2009/10 performance for this new indicator was 91.2% against a target of 95%
  - 2009/10 performance for Older People’s Teams was 89.61%
- **NI 135** – Carers receiving a specific carer’s service or advice and information following an assessment or reassessment
  - 2009/10 performance was 21.3% against a target of 21%
  - 2009/10 performance for Older People’s Teams was 35.21%
- **NI 136** – People supported to live independently through social services (65+)
  - 2009/10 performance for this new indicator was 21,252
- C72 – Supported admissions of older people to residential and nursing care per 10,000 population aged 65 and over
  - 2009/10 performance for this new indicator was 40.96% against a target of 43.14%
- Clients ages 65 and over – the average of the percentage where the time from first contact to contact with the client is less than or equal to 48 hours.
  - 2009/10 performance 99.20%

These indicators show the need to make further improvement against these local and national targets. From 2010 local authorities are no longer required to report on national indicators. We will develop local indicators in line with this strategy in order to measure our progress and monitor our performance.
3. Strategic Aim One: Mental Health Promotion and Prevention

‘Give talks to draw older people together, at clubs, church groups etc’

‘Friendly visiting and perhaps talking’

- Quotes from residents who were asked how we could help people before their mental health needs get too bad

3.1 Strategic Aim
To promote positive mental health and to prevent or delay the decline of an older person’s mental health throughout their later life and in every care setting.

3.2 Why is this one of our key priorities?

a) The Department of Health estimates that mental health problems are present in 40% of older people who attend their GP; in 50% of older people inpatients in general hospitals; and in 60% of residents in care homes.

b) Services need to increase their focus on mental health promotion and prevention which should take place both in the community and in all local care settings.7

c) We also need to focus on secondary prevention following an inpatient admission or a residential stay.

d) We need to challenge the assumption that mental health problems are an inevitable part of aging and strengthen social support and community participation so that older people can help themselves and their peers to feel good.8

e) There is a recognition that good physical health and mental health go hand in hand.9

f) Older people and their carers need to be made more aware of mental health issues and be encouraged to seek support early.10

g) The 2010-11 Mental Health and Wellbeing Plan stresses the importance of promoting positive mental health in later life, suggesting that outcomes are worse for people who are less well off and that improving mental health in later life can have a significant impact on chronic disease outcomes and individual independence.11

h) Community safety continues to be of concern to older people; 76% of people aged over 60 felt safe during the day, whilst only 41% felt safe at night.12

i) Fear about crimes such as bogus callers and burglary can be sufficiently distressing to cause some older people to move into residential care. Freedom to travel and socialise can also be curtailed due to fear of crime, this can lead to isolation and impact on physical and mental health.

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7 New Horizons, a shared vision for mental health. HM Government, 2009
8 Age Concern - Improving Services and Support for Older People with Mental Health Problems - The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, 2007
9 Older People and Mental Health, Mind factsheet: http://www.mind.org.uk/help/people_groups_and_communities/older_people_and_mental_health#caregivers
10 Informed by national policy, reports and local consultation
11 A Mental Health and Wellbeing Plan for Hounslow 2010-11
12 Consultation on Community Safety – Community Safety Partnership December 2010
3.3 **What will we do to achieve this aim?**

a) We will work with public health and mental health professionals and community organisations to promote positive mental health via local awareness campaigns. We will reach out to the widest range of communities, including black and minority ethnic communities and other hard to reach groups.

b) We will promote the use of Help in Hounslow, the new advice, information and advocacy service who can sign post to our older residents, and their carers, to preventive activities and networks, and encourage them to take advantage of these.

c) We will develop activities which promote physical and mental health, such as walking groups and exercise programmes, as set out in the NICE Guidance for Mental Health and Wellbeing.\(^{13}\)

d) We will develop opportunities for social participation in the forthcoming health and wellbeing tender, which will seek to commission a range of volunteering, befriending and other group activities.

e) We will ensure the local workforce has the skills to promote positive mental health and prevention, can provide information and signposting to appropriate activities, and to encourage and support participation in these activities;

f) In primary care this would mean promoting good physical health and taking measures to reduce the incidence of functional and cognitive mental health problems by, for example screening and targeting high risk older people.

g) In hospital settings this would mean being aware that older people with physical health problems can also have mental health difficulties or may become less mentally well while in hospital. The environment should promote positive mental health and be sensitive to these needs.

h) For those care settings that have extensive contact with older people, e.g. day centres; hospitals; residential and nursing care homes, staff should create an environment that values and promotes positive mental health, including the provision of meaningful stimulation and activities.

i) We will work with partners in primary, secondary and social care to raise the profile of mental health issues among older people who present with physical health needs. This will include the need for secondary prevention and avoid the exacerbation of pre-existing problems. We will ensure care pathways include access to specialist mental health advice, and a second opinion, to improve the quality of assessment and treatment offered in primary and secondary care settings.

j) We will work with the Community Safety Partnership to build on the successes to date in improving home and community safety. This will include additional uniformed officers on the streets; better information to residents on safety issues by focussing efforts on improving safety for vulnerable groups, such as older people with additional needs.

\(^{13}\) National Institute for Clinical Excellence – Mental Wellbeing and Older People: http://guidance.nice.org.uk/PH16
3.4 What do we want to see changed by 2016?

a) People will have a greater understanding of how to look after their mental health wellbeing, and a larger number of older people will be involved in community activities.

b) A greater proportion of the local workforce will understand the importance of promoting positive mental health and be able to deliver care that reflects this ethos.

c) All treatment, care and support settings will promote positive mental health, and provide activities which prevent, or delay, the onset of mental health problems.

d) Local residents and their families, and the professionals who support them, fully understand the pathways of care available.
4. Strategic Aim Two: Early Intervention and Assessment

‘When we were first told that my wife had dementia some years back, we were pretty much told there was nothing that could be done to help us’
- quote from a carer whose wife is now in a nursing home due to her dementia

‘We want early assessment and diagnosis and regular follow up visits’
- quote from a carer suggesting how we can improve our local services

4.1 Strategic Aim
To increase early intervention and capacity to offer an expert assessment of mental health problems at every stage.

4.2 Why is this one of our key priorities?

a) The economic and social costs of poor mental health include the cost of health and social care, the loss of earnings from the inability to work and contribute to the economy, and the human cost of a poor quality of life. The aggregate cost of mental health in England increased to £105.2 billion in 2009/10, a 36% increase since the first estimates in 2002/3. The analysis shows that health and social care costs specifically have increased by 70%. Clearly mental ill health will continue to be a priority, and there is a strong case for early intervention and meaningful assessment.\(^{14}\)

b) Prevalence data suggests there are 5250 people suffering from depression and anxiety in Hounslow. Five thousand of these will be over 65, many of whom do not meet clinical criteria for treatment but will nevertheless experience distressing symptoms and require support.\(^ {15}\)

c) In 2009/10 there were 795 people who were listed on the Hounslow GP register with dementia and by the end of October 2010 there were 923. However expected prevalence ranges between 1250 and 1574, suggesting there is much work needed to identify people with unmet needs.

d) Some people experience dementia in their 50s, 40s and even 30s and early signs of their dementia should be recognised so they can be given an early assessment and treatment.

e) National policy states that assessment for dementia should be made by specialist clinicians – GPs; psychiatric teams; neurologists or geriatricians. It should be clear locally who is making the diagnosis and the pathways of care.\(^ {16}\) It also recommends the joint commissioning of a simple service focussed on the early diagnosis of intervention in cases of dementia.\(^ {10}\) The service should ensure that patients and their carers are informed of their condition sensitively, and provided with information they need to both manage the condition itself and their expectations.

f) Living Well in Later Life\(^ {17}\) found that different services for adults of working age and older people led to inequity in provision. Examples included out of hours psychiatric advice and crisis management where provision is not as well developed for older people. Consultation with professional stakeholders

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\(^{14}\) The Economic and Social Costs of Mental Health Problems in 2009/10, Centre for Mental Health, October 2010

\(^{15}\) Age Concern - Improving Services and Support for Older People with Mental Health Problems - The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, 2007

\(^{16}\) Living Well with Dementia: A National Dementia Strategy 2009, Department of Health

\(^{17}\) UK Inquiry into Mental Health and Well-Being in Later Life, 2006
suggests this is also an issue in Hounslow. Older people need to be able to access services that are as good and comprehensive as those for people aged under 65.  

There is limited capacity for expert mental health assessment right across the health and social care economy: primary care identification; early specialist community intervention; presentations at A&E; hospital wards; and discharge assessments for mental health inpatients; residential and nursing care homes.

Consultation with local residents and their carers revealed that more, and more frequent, assessments are needed.

Timely, quality assessments which can effectively establish next steps along the care pathway can reduce delayed transfers and reliance on expensive bed based care and result in a more holistic range of support being offered. Expert assessors are better equipped to make informed decisions than non specialist staff for example, an experienced mental health assessor may be more confident in recommending discharge to a community setting, rather than to residential care.

Moving into a care home is a major life transition and this can be a time of increasing risk of mental health problems. Such problems often get overlooked or accepted as the norm. Between 50 and 80% of residents, in care homes, have dementia; 40 per cent have depression; and a high percentage have both. Therefore, it is important to provide a mental health assessment to detect problems early.

Carers input into mental health assessments are vital and they should always be included. They should also have their own needs assessed.

4.3 What will we do to achieve this aim?

We will encourage residents of all ages and their families to seek support for early signs of depression, anxiety and dementia.

We will work with GPs to encourage early assessment and referrals to specialist mental health services. We will measure progress in increasing primary care for dementia using the Quality and Outcomes Framework (QOF):

I. DEM 1 – a register of patients diagnosed with dementia, produced by the general practice

II. CHD1; STROKE1; BP1 – to measure whether opportunities for screening risk factors associated with dementia, such as coronary heart disease, stroke and diabetes, are undertaken during a patient’s annual review:

We will work with our specialist mental health service to reconfigure mental health resources to pilot a Community Liaison Outreach Service for dementia and depression. This will focus on increasing early identification and initial assessments, and would, where possible, offer joint assessment clinics with GPs and social care.

We will work with the boroughs of Ealing and Hammersmith & Fulham as part of the pathway reconfiguration work to refocus local resources so that there is

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18 New Horizons, a shared vision for mental health. HM Government, 2009
19 Findings informed by local stakeholder consultation
20 Age Concern - Improving Services and Support for Older People with Mental Health Problems - The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, 2007
21 QOF is the tool used to assess performance to standards and contractual requirements in General Practice (Primary Care)
always capacity to provide an expert mental health assessment. We will ensure assessments take place at the optimum time, are undertaken by the right clinicians and professionals, and lead to residents being given the most appropriate care. The following are critical points for an expert mental health contribution to assessments:

I. Primary care screening, assessments and referrals for early intervention;

II. Assessment following an emergency presentation at the Urgent Care Centre or Accident and Emergency;

III. Assessment on hospital wards to inform treatment and discharge planning. It is proposed that this assessment could be undertaken by the Community Mental Health Team (rather than acute clinicians) if a patient is already known, as this would be more efficient and reduce duplicate assessments for the patient and carers;

IV. Assessments in the community, undertaken jointly by Seamless assessment between Community Mental Health Teams and social care teams;

V. Early social care assessment on admission to mental health inpatient care to inform treatment and discharge planning;

VI. Early assessment for residents moving into care homes;

VII. Responsive and joined up Continuing Health Care assessments, including fast track decision making as necessary.

4.4 What do we want to see changed by 2016?

a) More initial assessments dementia and depression are undertaken earlier and lead to onward referral to specialist support.

b) More patients known to primary care, and recorded on GP dementia registers.

c) Local residents, their families and the professionals who support them fully understand the pathways of care available.

d) Unnecessary admissions from A&E are avoided because patients are offered a timely mental health assessment.

e) The number of patients at West Middlesex University Hospital with an extended length of hospital stay or delayed discharge is reduced due to timely access to a mental health assessment.

f) Equitable access to hospital based mental health assessment regardless of age.

g) More older people live independently for longer as a result of timely and effective assessments and the use of assistive technology.

h) Care homes understand the mental health needs of their residents and have the skills to meet these needs.

i) Timely access to care packages following a continuing healthcare assessment.
5. Strategic Aim Three: Treatment

‘If I could have these services earlier, and perhaps home help’
- quote from a resident using Brentford Lodge describing how services could be improved

‘I have spent a lot of time on the bus’
- quote from a resident using Brentford Lodge day hospital responding to a question about how services could be improved

‘When my wife went into hospital for an operation, I wanted to be able to stay with her, I still felt responsible for her’
- from a carer whose wife has dementia

5.1 Strategic Aim
To develop more efficient treatment pathways for cognitive and functional mental health problems, thereby increasing capacity and ability to outreach to older people in community settings so that care is as local as possible.

5.2 Why is this one of our key priorities?
   a) Stakeholders and residents have expressed concerns about the equity of access older people currently have to primary care counselling. The current contract does include all adults, however, it is recognised that older people do not necessarily identify with the need for counselling, and are not always able to travel to sessions if they are frail, unwell or for some other reason not able to travel.
   b) A shared care protocol for dementia between primary care and specialist mental health has been introduced and continues to gain support. This provides a foundation for closer working between two key professional groups.
   c) It is recognised that there is a stronger link between deliberate self harm and completed suicides among older people. Therefore, staff who identify an older person harming themselves need to be able to ensure timely and appropriate support is available. It is particularly important that older people who present with physical complaints but have suspected underlying mental health needs are given access to the right treatment and care.\(^{22,23}\)
   d) It was reported that the local depression pathway is slow, with patients waiting for longer than they should for support. In some cases GPs simply require advice or an assessment from mental health professionals to guide them in the treatment of their patients rather than requiring the treatment to be passed on to secondary care.
   e) There are gaps in the provision of assistance with medication administration for older people living at home. Adherence to drug regimes is critical, especially for the early stages of dementia. Yet people without carers or trained support workers to help them, or who are on variable dosages, do not currently receive the same support as those with carers or who get the support via their domiciliary social care package.

\(^{22}\) New Horizons, a shared vision for mental health. HM Government, 2009
\(^{23}\) UK Inquiry into Mental Health and Wellbeing in Later Life, 2006
f) As the number of people being prescribed dementia medication increases there will be associated increasing cost pressures on West London Mental Health Trust's and NHS Hounslow's prescribing budgets. The difference between the number of people registered as having dementia on the GP register and the number we would expect according to prevalence projections is currently approximately 500. This tells us there could be up to a third more people being diagnosed during the life of this strategy. Both organisations will be required to manage their high cost drug budgets to ensure access to dementia medication continues to be made available, and to look for efficiencies and eliminate any wastage.

g) Early referrals to West London Cognitive Disorders Treatment and Research Unit have increased over the last few years with a higher number of young people being referred. At the same time there are also more people being referred with later stages of dementia. This increase is placing pressure on the service to meet the demand.

h) One in seven older people are admitted to hospital each year and older people occupy two thirds of NHS beds, of those admitted, up to 60 per cent will have or develop mental health problems, the three most common being delirium, depression and dementia. Admissions can provide the first opportunity to diagnose a mental health problem, however, many of these mental health needs are not recognised or met at present. Furthermore, staff inexperienced in differentiating between delirium and dementia require training and guidance to ensure timely and appropriate care is provided.

i) Clinical leadership for mental health problems, including dementia, in district general hospitals is required to ensure needs are identified and treated at all stages of admission, including the use of multi disciplinary care and discharge planning. Hospitals should have explicit pathways for the treatment of dementia and delirium. Established pathways and protocols for treatment significantly reduce extended hospital stays and delayed transfer of care.

j) There needs to be more efficient use of our limited specialist treatment services to ensure that those who most need specialist support are able to receive it in a timely manner.

k) The majority of older people in care homes have mental health problems - between 50 and 80 per cent of residents have dementia; 40 per cent have depression; and a high percentage have both. As we have seen these problems can often get overlooked. It is, therefore, important to provide a mental health assessment to detect problems early on and provide psychological therapies where needed.

l) In addition, residents often get depressed when their fellow residents pass away, and are exposed to feelings of loss and bereavement. Thus, the wider issues relating to bereavement need to be addressed by care homes so that older people are supported in dealing with these feelings.

m) National policy recommends that residential and nursing homes should have the benefit of specialist mental health in-reach services, e.g. community mental health teams and liaison psychiatry.

n) There is currently inequitable provision of primary care in-reach into residential and nursing homes across the borough.

24 Living Well with Dementia: A National Dementia Strategy 2009, Department of Health
25 Long Stay Patients in West Middlesex University Hospital: A Review. Mary Godfrey, Leeds University November 2008
26 Age concern
o) Older people’s referrals for alcohol and substance misuse services have historically been low, nationally, despite the dangerous use of alcohol among older people.27

p) Many people who have received hospital treatment or mental health inpatient care will require further care and support afterwards. It is critical that we undertake timely, multi disciplinary discharge planning to offer older people a seamless transition into the next steps in their care.

5.3 What will we do to achieve this aim?

a) We will find ways to increase the number of older people using primary care counselling and look at alternatives to traditional counselling provision. We will also ensure the ‘Increasing Access to Psychological Therapies’ programme takes the needs of older people into account.

b) We will ensure that patients with depression are seen in a timely manner by reviewing the existing pathway and building in advice and liaison to GPs by specialist mental health professionals.

c) We will work to develop a pathway for all older people to receive medication assistance as needed, whether living at home or resident in a care home. We will consider the use of personal budgets for this.

d) West London Mental Health Trust and NHS Hounslow will need to work together proactively to ensure the protocols and systems for prescribing and medication review rule out any opportunities for wasteful use of medications. For example, regular reviews will ensure the right medication is being prescribed at the right time. This can be achieved by adhering to the dementia shared care prescribing protocol.

e) There are also opportunities to ensure prescribing is as efficient as possible by providing medication review to residents in care homes, especially those that have moved in from another Borough. The introduction of this process would also allow us to understand and prevent, where needed, the inappropriate use of antipsychotic medication, and work more generally with homes, to ensure good prescribing practice is being adopted. At present care home medication review is largely a gap in provision, however, it is envisaged that the remodelling of the cognitive impairment pathway will allow consultant led input into the care homes, and a review of how these specialists can best work with GP colleagues.

f) We will work with providers to develop a new, more efficient cognitive impairment pathway which supports older people in the community rather than in bed based care. This is likely to operate at a central location for assessment and will refocus treatment into community settings, including outreaching into people’s homes. A ‘hospital at home’ model of care that reduces the need for older people to be admitted into inpatient mental health care will be investigated. The pathway will provide age sensitive treatment and care.

g) We will also work with West London Mental Health Trust to develop a functional mental health pathway to run in parallel with the cognitive impairment pathway, developing protocols for shared care. In addition, we will explore the option of reconfiguring specialist mental health services into one single adult service.

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27 Age Concern - Improving Services and Support for Older People with Mental Health Problems - The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, 2007
h) We will work to ensure both pathways fully include the range of provision available to older people from primary and community care through to end of life care. We will develop a joint management approach to treatment.

i) We will work with Commissioning Support for London to map existing mental health pathways and current practice, particularly around A&E and general acute care, in order to agree treatment pathways based on best practice.

j) In the context of the reconfiguration of cognitive impairment and functional mental health pathways we will develop better shared working arrangements between health, mental health and social care teams. We will explore the option of developing jointly managed health and social care teams.

k) Staff in primary, community, hospital and mental health settings will be trained to recognise self harm and any underlying mental health needs of older people who present with physical complaints.

l) We aim to ensure the professionals who have day to day contact with older people, i.e. in primary, community and hospital care, are helped to support residents, patients and their carers directly. To do this we will seek to ensure that specialist advice, consultation and liaison resources will be built into each of the care pathways. Alternatives to ‘face to face’ liaison will be considered, for example, email, telephone or a web based forum.

m) We will work with our local acute hospitals to develop clinical leadership for dementia and ensure there are well understood pathways of care that include protocols for admission, discharge and transition to ongoing care.

n) We will ensure hospital staff are trained to look after people with dementia, delirium and other mental health needs. In particular hospital staff will understand the causes of delirium and ways to prevent or reduce its incidence. We will work with the local hospital to ensure a more holistic approach is taken to the treatment and care of older people with mental health problems and support is offered for their carers.

o) We will ensure, through our contracts with residential and nursing homes, that there are established systems and procedures to address older people’s mental health problems during their stay. Homes would be required to be explicit about the clinical and managerial leadership for mental health care in the home, as well as the level of training for staff, to ensure they can recognise and respond to older people’s mental health needs, and have the knowledge and skills to improve the quality of care. We will commission specialist mental health in-reach treatment.

p) We will work with clinicians to ensure pathways of care for alcohol and substance misuse are clear, accessible and increase the number of older people referred for expert support. These referrals are likely to come via community and inpatient mental health and hospital based teams. Assessment and follow up help from the A&E alcohol nurse will be available to older people. We will raise awareness of the harmful effects of alcohol on older people among front line staff and local residents.

5.4 What do we want to see changed by 2016?

a) An increase in the number of older people receiving counselling and psychological support.

b) A comprehensive ‘medication at home’ pathway.

c) Faster access to specialist advice for the management of depression in primary care.

d) An increase in GP confidence in managing patients in the community e.g. through shared care or support from specialist liaison.
e) More efficient treatment pathways for cognitive impairment and functional mental health.
f) An increase in specialist treatment provided in community settings.
g) A greater proportion of older people and carers reporting they have received holistic treatment in hospital that took account of their mental and physical health needs.
h) A hospital pathway for dementia.
i) A greater proportion of patients with delirium (vs dementia) being provided with the appropriate care.
j) An increase in access to psychological and specialist mental health support in residential and nursing homes.
k) An increase in older people benefiting from alcohol and substance misuse provision.
6. Strategic Aim Four: Care and Support

‘Trained staff to help and guide older people with everyday tasks, encouraging them to help themselves as much as possible’
- from a carer responding to a question about how we can help people with mental health problems before their needs get too bad

‘Create opportunities for older people to share memories, sometimes it’s all they have got’
- suggestion from an older person

‘Supportive staff, friendly environment and ability to keep on living in the community’
- an older person’s feedback on extra care housing

6.1 Strategic Aim
To increase independent and supported living for older people with mental health problems, and reduce reliance on bed based and residential care.

6.2 Why is this one of our key priorities?
   a) Social care is central to ensuring that older people with mental health problems are able to maintain quality of life. A large proportion of social care goes to older people; approximately 60% of national expenditure. The cost of services for older people with mental health problems is consistently higher than physically frail older people, however, there are still significant gaps in provision:
      I. Only half of those who need care actually receive it;
      II. Social care is increasingly provided, only in times of crisis, for high levels of need;
      III. 70% of local authorities do not provide help for people with ‘moderate’ difficulties such as mobility problems;
      IV. A third of people receiving home care experience depression but very few receive any treatment;28
   b) The impact of mental health problems in older people is far reaching and can affect the whole family from spouse, to children and grandchildren;
   c) The many improvements and opportunities for development set out in this strategy can be greatly supported by increasing early availability and access to telecare and assistive technology;
   d) There is currently still some bed based respite provision offered to long term service users in the mental health inpatient ward. However, whilst these residents have a history of accessing respite due to a past agreements, there is now a greater need for nursing rather than mental health care for many, and residential and nursing homes are considered more appropriate to meet older people’s respite needs. In addition the Care Quality Commission indicated that it is not appropriate to mix the use of an acute mental health ward.

28 Age concern - Improving Services and Support for Older People with Mental Health Problems - The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, 2007
e) Updated guidance for improving access for people with dementia to intermediate care services, requires that all intermediate care teams have competency in mental health and dementia care, and that teams should consider recruiting mental health professionals. In the past intermediate care has been seen as inappropriate for older people with mental health problems. However, it is possible for people with dementia to benefit from rehabilitation, which if timely, can result in reduced likelihood of a long term residential home.

f) The expected increase in population brings with it extra demand for home and nursing care and we need to develop alternatives to traditional care if we are to meet this demand. Extra care housing is an alternative that helps older people live in the community with the support they need and can help to prevent isolation, and reduce depression among older people. Extra care housing can enable people with dementia to live independently for as long as those without cognitive impairment, and enable friends and relatives to remain part of the informal support network.

g) During the year June 2009 to May 2010 there were 51 care home placements allocated to Hounslow residents with mental health needs. All of the nursing home placements were in the borough but a significant proportion of the residential placements were out of borough. Of all placements 58% were for older people’s mental health (EMI).

h) The LIT Financial Mapping dataset, which is an annual mapping exercise, suggests we spend considerably less on specialist mental health than our comparators (15-20%) and considerably more on Residential (14-20%); we spend a little more on day services (0.6-4%) and a little less on homecare (up to 3%). Whilst the reliability of this data is uncertain, it could indicate that Hounslow’s specialist services are underinvested in (compared to our neighbours) and that as a consequence the costs for intermediate, day and residential care are greater.

i) In order for homes to deliver high quality care for their residents they need to have clearly defined pathways of care which include, for example, management protocols for the appropriate use of anti-psychotic medication and understanding the specific needs and interests of each resident.

j) To support this aim, commissioners need to develop service specifications which value good clinical and managerial leadership, and an ethos that focuses on the way individuals are treated, and these specifications should identify how performance will be assessed.

k) The London Borough of Hounslow is currently undertaking a review of housing and support offered to older people. The aim of the review is to promote a range of housing options which are able to support people with differing levels of need, as near to a home environment as possible. This will include housing options offering care in a secure environment for people with dementia.

l) In the past private developers have independently made planning applications to develop care homes in Hounslow to meet what is perceived to be anticipated future demand. However, London Borough of Hounslow and NHS Hounslow are satisfied that existing provision meets demand and are working on developing community alternatives to long term residential care.

30 LIT Financial Mapping Hounslow 2009/10, Autumn 2009 Monitoring, Mental Health Strategies, Department of Health
6.3 **What will we do to achieve this aim?**

a) We will increase access and efficiency of social care teams by streamlining management, assessment and review functions, including access to resources and packages of care.

b) We will also explore options to augment Link Line, the telephone support service, with a 24 hour emergency response and increase use of assistive technology and telecare which will be provided at an early stage to support people living in their own homes, reduce hospital attendances and facilitate hospital discharges.

c) We want to increase access of older people with mental health problems to rehabilitation and re-ablement. We will commission rehabilitation and re-ablement services to be provided at home or as close to home as possible.

d) The work we will undertake to reconfigure cognitive and functional mental health pathways offers the opportunity to consider joining health and social care community teams under a single management structure. This would enable greater joint working; sharing of information; reduce likelihood of older people being passed between teams unnecessarily; reduce duplication, and increase quality, of assessment and review. We will work with stakeholders to explore the range of possible models.

e) The local authority Older People’s Resource Centre project is now in its third phase, having already developed a resource centre in Chiswick and a 43 unit extra care housing scheme in Brentford. Over the next three years we will develop a centre in Bedfont which will comprise a 60 bedroom home attached to a 40 place day facility together with a housing scheme of 16 units. Subject to consultation and approval of a fourth phase we will also develop a day support facility and an extra care housing scheme in the centre of the borough.

f) We will work with providers to ensure the transition from hospital or mental health bed based care is smooth and offer older people and their carers the use personal budgets for packages of care to support life at home.

g) As legislation becomes clearer we will explore how we will use personal health budgets e.g. to provide prompt assistance to older people who need support at home with their medication regime.

h) We will work to ensure the wider mental health community is connected to the support and care of older people to maximise local resources.

i) We will develop a pathway for respite which will be based on a ruling that the NHS will only pay for bed based respite if the resident is eligible for NHS funded continuing health care.

j) We will work with intermediate care providers to ensure rehabilitation and re-ablement is available to older people who could benefit;

k) We are also committed to making the best use of the existing respite and care home bed stock and will keep this under continual review to ensure supply decreases in line with expected decreases in demand.

l) We will also keep the use of extra care housing and assessment flats under review, to ensure we are gaining maximum benefit from these services in supporting older people to live independently.

m) Respite, residential and nursing care home providers will be required to have designated leads for mental health and clear pathways of care, this will be underpinned by clear commissioning specifications that value the ethos of care provided and hold providers to account for addressing mental health needs. We also expect providers to offer stimulating activities and engage
residents in Life Story work and other evidence based practice to improve wellbeing.

n) The benchmarking anomalies in our expenditure across the health and care economy will require further investigation together with further benchmarking across other London Boroughs to ascertain if there is genuinely better value for money to be obtained from current providers, or if indeed this is simply a data validity issue that is problematic with the LIT financial mapping.

o) We have no explicit intention to commission new residential or nursing home beds from unsolicited sources. There will be separate contracts with providers stipulating any growth, but our first port of call locally is to review existing providers and establish if there are reconfigurations in bed stock over and above commissioning new beds. Our focus will be less on long term residential placements and more community based hospital at home care, older people’s resource centres and also a move to increasing extra care housing, the plans for which are already in development for a unit in Bedfont (Sandbanks).

6.4 What do we want to see changed by 2016?

a) Greater impact of emergency social care response on reducing ambulance call outs and hospital attendances / admissions;
b) More streamlined assessment and review processes;
c) An end to the practice of admitting older residents into mental health inpatient care for social care reasons only;
d) Improved discharge planning that takes account of the wider needs of older people with mental health problems, including rehabilitation and re-ablement, access to respite, domiciliary care and day care;
e) Greater use of assistive technology to support independent living;
f) Reduced length of residential stay across the care pathway;
g) Increase in use of personal budgets to plan care and support for those that wish to manage their own care;
h) Full implementation of the Older People’s Resource Centre Strategy and associated reduction in use of residential beds;
i) Clear pathways of care for older people’s mental health in respite, residential and nursing homes;
j) Value for money from our residential and nursing home providers, compared to appropriate neighbouring boroughs;
k) Review, and where possible, reduction in our bed based provision.
7. Strategic Aim Five: Ensuring Quality for Older People

“Having a respite carer allows me time to just be me”
- quote from a carer

“Involve carers in early assessment, diagnosis and regular follow up and feedback for carers and concerned family members would be very welcome”
- quote from a carer using clinical psychology

‘We have paid taxes all our lives, we just want good services to get us through a difficult old age’
- quote from a carer of a resident with dementia

7.1 Strategic Aim
To strengthen quality of care so that the right mental health support is available at every stage of a person’s journey by developing:

- A skilled and knowledgeable workforce;
- User led services that provide equal access and dignified care for all older people including people with learning disabilities;
- Services that safeguard vulnerable older people;
- Holistic and comprehensive support for carers;
- Choice and control via personalisation;
- End of life care;
- Continuous improvement of local pathways of care;
- Monitoring and review of quality standards.

7.2 Why is this one of our key priorities?

a) Our local workforce is our biggest asset and it is essential that older people with mental health problems can receive support when they come into contact with universal, i.e. available to all, and specialist services alike. The workforce can promote positive mental health; it can detect early problems and make arrangements for more detailed assessment or support; it can provide care that address both physical and mental health needs; and a skilled and experienced workforce can make services accessible and responsive to older people’s needs.31

b) We also believe that residents and carers should be partners in their own care and feel empowered and knowledgeable enough to take care of themselves as much as possible, knowing how to seek, and who to turn to for, support.

c) Unpaid carers are another major resource for older people, enabling many people to live independently and to remain connected to a social network.

d) Carers have told us they value a variety of support mechanisms to help them maintain their caring responsibilities and to look after their own mental health, these include:
   I. Timely access to advice, information and advocacy;
   II. Being included and involved in assessments;

31 National Dementia Strategy; NSF Older People’s Mental Health; Age Concern Inquiry; New Horizons; Local Consultation
III. Flexibility and accessibility of services;
IV. Short breaks and respite;
V. Stimulating and engaging activities, especially in day and residential settings;
VI. To remain with the person they care for should they be admitted into hospital;
VII. Carers believe that older people in particular require holistic and good bedside care;
VIII. Whilst some value being able to co-ordinate the care of the person they care for, others just want to access good quality services without the added responsibility.32

e) Choice and control over care providers is offered to residents and their carers via personal budgets for those meeting the Fair Access to Care criteria of substantial or critical needs. National Personalisation policy has signalled a strategic shift towards promoting wellbeing, prevention and early intervention33, and there are a number of ways that the Personalisation agenda will be implemented locally. These are likely to offer local residents:
   I. Ability to manage personal budgets to buy the care that’s right for them;
   II. Greater partnership with families in agreeing outcomes for care;
   III. Ability to access different forms of care and support, beyond those typically available via local authorities;
   IV. A broader range of community support more closely linked to the individual’s personal interests.

f) We strive to ensure services put dignity and respect at the heart of provision, and for older people this means they receive care that helps maintain their identity; promotes self esteem, personal care, pain management and healthy, nutritious meals; respects privacy and the need to maintain social contact with loved ones and peers; and as needed, offers practical support to maintain their living standards and environment34.

g) Older people who are unable to take care of themselves are vulnerable to poor treatment which can include neglect, physical, sexual or psychological, financial or discriminatory abuse.35

h) Older people who cannot make a decision themselves due to mental ill health e.g. dementia, delirium, stroke etc are protected by the Mental Capacity Act. A person who is aware their mental capacity will diminish should be allowed to make decisions in advance, particularly relating to their medical treatment. They may also decide to confer lasting power of attorney on another person.36

i) There are a growing number of people with learning disabilities who are reaching later life and it is common for these older people to experience mental health problems, however at times eligibility and threshold criteria prevent or delay access to services.37 Early onset dementia is also experienced by this people with learning disabilities and much like their non disabled counterparts, it is often difficult to access age appropriate support.

32 Autumn 2010 Review of Carers Needs in Hounslow; also, consultation with carers about the Older People’s Mental Health Strategy
33 Putting People First Programme
34 Dignity in Care Campaign 2006
35 Hounslow Multi Agency Safeguarding Adults Policy
36 Mental Capacity Act 2005
37 Local consultation with professionals
j) End of life care should be available to all residents, but it is acknowledged that not all professionals are currently equipped to engage residents in end of life care planning. For some older people there is the additional consideration of mental capacity and the need to draw up advanced end of life care plans. Dignity requires that an older person is able to choose their place of death, with regard to their spiritual and cultural needs and have their suffering controlled.

k) Sometimes third sector and community resources get overlooked and are under referred to by statutory service providers. However they tend to be popular with older people and their carers, because they are non stigmatising, more informal and offer more holistic care. They are also able to offer greater flexibility and reduce the sense of isolation some older people experience.

7.3 What will we do to achieve this aim?

a) Local residents, their families and the professionals that support them fully understand the pathways of care available to them.

b) We will develop a comprehensive workforce strategy to provide improved awareness, skills and build the experience needed to ensure Hounslow’s workforce is able to meet the wide range of needs of older people with mental health problems.

c) We want to develop an efficient model of specialist advice, consultation and liaison to support the workforce development strategy, so that providers are empowered to deliver appropriate care to older people with mental health problems.

d) We will continue to develop user led services; promote the use of information, advice and advocacy; increase take up of peer support networks; and provide opportunities to increase knowledge and confidence to help older people and carers to manage their mental health.

e) We will ensure the forthcoming Carers Strategy addresses the issues of concern to carers of older people with mental health problems, including providing advice, support and education about mental health problems; accessible and relevant carers groups, including support for the newly diagnosed; short breaks and respite; involvement in assessments and to have their own needs assessed, including their mental health needs; choice and control over care via direct payments and personalisation, should they wish it; supporting carers through and beyond end of life care; we will also consider ways to involve ex carers in the development and provision of services.

f) We are working to provide better access to information, advice and guidance to enable residents through self assessment, to identify their own needs and desired outcomes, and provide the planning support to meet them. Eligible residents will be provided with a personal budget which can be held by the resident, their carer or the council on their behalf and can be spent on a range of services with a focus on promoting wellbeing; early intervention and secondary prevention to minimise disability or deterioration of problems. We will support the development of non traditional and different care solutions and

38 Ealing and Hounslow (draft health) End of Life Strategy 2009
39 Commissioning Toolkit for NICE End of Life Care for patients with Dementia: http://www.nice.org.uk/usingguidance/commissioningguides/eolforcpeoplewithdementia/eolforcpeoplewithdementia.jsp
support residents and their carers to feel competent and confident in managing their own budget and care.

g) We will work to ensure the rights of vulnerable older people are recognised and respected and organisations providing services have a responsibility to be aware of abuse whether the care takes place in a person’s home or service setting.

h) We will continue to work within the legislation of the Mental Capacity Act to support vulnerable older people. Where there are no family or friends with lasting power of attorney we will appoint a mental capacity advocate.

i) We will work with providers to ensure equitable access for all older people, including those with learning disabilities, and recognise that a flexible and often joint response is required for this group. We will continue to monitoring the implementation of the Green Light Toolkit which provides guidance for a joint forum on how to manage the care of residents who have learning disabilities and mental health problems. We will also support delivery of the aims of the Joint Commissioning Strategy for Learning Disabilities and Autistic Spectrum Conditions which covers the same time period as this strategy. One of the key aims of the strategy is to make mainstream services, including specialist provision, accessible and age appropriate.

j) We will ensure older people’s mental health needs are represented in the forthcoming End of Life strategy with a particular focus on developing professionals to engage in care planning and to ensure issues such as advance care planning and lasting power of attorney are addressed. We will also work to ensure that palliative care providers are able to support the needs of older people with mental health problems, including those with dementia.

k) Throughout the life of this strategy we will continue to develop local pathways of care for older people with mental health problems and their carers. The many areas of opportunity for improvement identified within this strategy will be driven forward by the multi agency Older People’s Mental Health Forum.

l) We will work with all providers to develop greater integration and maximise use of existing resources. We will focus particularly on developing links between statutory and third sector partners, who tend to make up a jigsaw of care. This will allow the wider resource in Hounslow to work to more effect from assessment and care planning through to review.

m) As commissioners of older people’s mental health services we will continue to ensure the range of provision is tailored to suit local needs and demand and will encourage innovation and efficiency from our providers. We will ensure our contracts reflect and value an ethos of high quality, holistic care, recognising that older people have wider needs than the specific issues of mental health in order to stay happy, healthy and well. These principles will be enshrined in outcome focused service specifications and monitored through regular contact, both formal and informal, with our providers.
7.4 What do we want to see changed by 2016?

a) A well developed workforce strategy that puts older people’s mental health at the heart of day to day care settings, via a skilled and experienced workforce;

b) A workable model for specialist advice, consultation and liaison for the workforce to draw on to access support;

c) A local Carers Strategy that fully takes account of the needs of carers of older people with mental health problems;

d) Increase in personal budgets being used to enable residents and their carers to develop a wide range of care solutions;

e) Full use of referral and eligibility protocols to enable older people with learning disabilities access to the most appropriate care to meet their needs at the time;

f) An increase in end of life care planning for older people with mental health problems;

g) Greater integration between the range of providers working across seamless pathways of care.
8. Taking the Strategy Forward

The work to achieve our aims as set out in this commissioning strategy for older people’s mental health in Hounslow has begun. Consultation with residents, their carers and professionals, combined with what we know about local needs and what national policy and good practice is telling us, has provided us with five very clear strategic aims and a number of objectives for each of these.

Our focus for 2011-12 will be on the following key actions:

- Re-commission health and well-being services to promote good physical and mental health, ensuring integration with other education, leisure and health promotion activities;
- Establish efficient cognitive and functional pathways
- Ensure Increasing Access to Psychological Therapies and GP counselling services to address anxiety, depression and other low level psychological conditions faced by many older people;
- Implement Older People’s Resource Centre and Housing and Care Strategies to ensure a range of care options, with staff and carers supported to manage older people with mental health needs.

Each year we will review achievements, outstanding areas of work and set out our priorities for that year in a new action plan. This process will be led by the London Borough of Hounslow and NHS Hounslow Joint Commissioning team, and its successor, and undertaken in partnership with the multi agency Older People’s Mental Health forum.

Overall review will be provided by the Adults and Older People Partnership Board supported by the Integrated Management Board. These groups will oversee progress and improvements in outcomes over the next five years. There will be a formal annual review of this strategy and annual commissioning intentions will be published.

The commissioning organisations will ensure the priorities outlined in this strategy are enshrined in contractual arrangements with providers to make certain high quality care and outcomes for older people with mental health problems are delivered.
Appendix One - Demographic Profile and Needs Assessment

This appendix describes the characteristics of older people living in the London Borough of Hounslow and how we expect the prevalence of mental health problems to feature over the forthcoming five year period, 2011-2016.

Demographic profile

Age
Greater London Authority (GLA) Population Projections published in 2009 provide population estimates for Hounslow at ward level from 2011 to 2026. This ward-level data has been aggregated to show numbers of residents aged 65 years and above within each of the borough’s five committee areas.40

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<td>27,952</td>
<td>29,744</td>
</tr>
</tbody>
</table>

Table 1: Number of residents aged 65 years + in Hounslow’s five areas from 2001 to 2026 (ONS and GLA data)

The GLA predict that the number of residents aged 65 years and above in the borough will increase by 24.5% from 23,899 in 2008, to 29,744 in 2026. By 2026, the number of residents aged 65 years and above will account for 11.9% of the total borough population.

<table>
<thead>
<tr>
<th></th>
<th>Total 65+ (female)</th>
<th>Total 65+ (male)</th>
<th>TOTAL</th>
<th>% + / - on 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Hounslow Area</td>
<td>3,576</td>
<td>2,765</td>
<td>6,341</td>
<td>31.2 +</td>
</tr>
<tr>
<td>Chiswick Area</td>
<td>2,109</td>
<td>1,793</td>
<td>3,902</td>
<td>12 +</td>
</tr>
<tr>
<td>Heston and Cranford Area</td>
<td>3,063</td>
<td>2,643</td>
<td>5,706</td>
<td>25 +</td>
</tr>
<tr>
<td>Isleworth and Brentford Area</td>
<td>3,663</td>
<td>2,643</td>
<td>6,306</td>
<td>28.2 +</td>
</tr>
<tr>
<td>West Area</td>
<td>4,183</td>
<td>3,306</td>
<td>7,489</td>
<td>22.8 +</td>
</tr>
<tr>
<td>Total</td>
<td>16,594</td>
<td>13,150</td>
<td>29,744</td>
<td>24.5 +</td>
</tr>
</tbody>
</table>

Table 2: Number of residents aged 65 years + in Hounslow’s five areas in 2026 (% change since 2008)

40 It should be noted that GLA Population Projections are experimental, and that discrepancies exist between GLA and ONS figures for similar periods; however, GLA Population Projections are the most widely used data detailing population change available to London Boroughs at present.
Central Hounslow Area shows the biggest change with an increase of 1,509 residents (31.2%) from 4,832 in 2008 to 6,341 in 2026. This is followed by Isleworth and Brentford Area and West Area with a 65 years and above population increase of 28.2% and 22.8% respectively. Throughout the 2008 to 2026 period, the number of women aged 65 years and above remains 20-40% higher than the number of men in the same age group. Population trajectories are shown in the graph below.

Figure 1: Increase in residents (male and female) aged 65 years + in Hounslow's five areas

The following maps illustrate the density of people aged 65 years and over and 85 years and over throughout the borough at ward level.
Figure 2: People 65 years and above by ward and in relation to local services
Figure 3: People 85 years and above by ward
Breaking down the figures further, we see the biggest percentage increase occurs in the 85 years and above age bracket. Between 2008 and 2026 the proportion of women in the 85 years and above age group will increase by 37.8% compared with the proportion of women aged 65 to 84 years, which is only set to increase by 23.3%. In the male population, difference between the change in the two age groups is much more stark. Between 2008 and 2026 the proportion of men aged 85 years + is predicted to increase by 78.6%, compared with the proportion of men aged 65 to 84 years which will only increase by 17.8%.

<table>
<thead>
<tr>
<th>2011 (GLA projection)</th>
<th>Total 65+ (female)</th>
<th>Total 65+ (male)</th>
<th>TOTAL</th>
<th>% + / - on 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Hounslow Area</td>
<td>3,006</td>
<td>2,346</td>
<td>5,352</td>
<td>10.8 +</td>
</tr>
<tr>
<td>Chiswick Area</td>
<td>1,884</td>
<td>1,502</td>
<td>3,386</td>
<td>2.8 +</td>
</tr>
<tr>
<td>Heston and Cranford Area</td>
<td>2,557</td>
<td>2,221</td>
<td>4,778</td>
<td>4.7 +</td>
</tr>
<tr>
<td>Isleworth and Brentford Area</td>
<td>3,013</td>
<td>2,152</td>
<td>5,165</td>
<td>5 +</td>
</tr>
<tr>
<td>West Area</td>
<td>3,619</td>
<td>2,693</td>
<td>6,312</td>
<td>3.5 +</td>
</tr>
<tr>
<td>Total</td>
<td>14,079</td>
<td>10,914</td>
<td>24,993</td>
<td>4.6 +</td>
</tr>
</tbody>
</table>

Table 3: Population Change (male and female) 2011

<table>
<thead>
<tr>
<th>2016 (GLA projection)</th>
<th>Total 65+ (female)</th>
<th>Total 65+ (male)</th>
<th>TOTAL</th>
<th>% + / - on 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Hounslow Area</td>
<td>3,258</td>
<td>2,571</td>
<td>5,829</td>
<td>20.6 +</td>
</tr>
<tr>
<td>Chiswick Area</td>
<td>1,973</td>
<td>1,608</td>
<td>3,581</td>
<td>2.8 +</td>
</tr>
<tr>
<td>Heston and Cranford Area</td>
<td>2,665</td>
<td>2,352</td>
<td>5,017</td>
<td>9.9 +</td>
</tr>
<tr>
<td>Isleworth and Brentford Area</td>
<td>3,251</td>
<td>2,316</td>
<td>5,567</td>
<td>13.2 +</td>
</tr>
<tr>
<td>West Area</td>
<td>3,746</td>
<td>2,890</td>
<td>6,636</td>
<td>8.8 +</td>
</tr>
<tr>
<td>Total</td>
<td>14,893</td>
<td>11,737</td>
<td>26,630</td>
<td>11.4 +</td>
</tr>
</tbody>
</table>

Table 4: Population change (male and female) 2016

**Ethnic Profile in Hounslow**

Ethnicity projections for 2010\(^{41}\) suggest that 27.8% of older people living in Hounslow are from Black, Asian and Minority Ethnic populations. This is an increase on the census figure of 2001, reported in the 2006-2010 Older People’s Mental Health Commissioning Strategy to be approximately a quarter of older residents. The 2010 projections are shown in figures 4 and 5 below.

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\(^{41}\) GLA 2009 Round Ethnic Group Projections - SHLAA (revised) 2010
Planning services for older people from Black, Asian and Minority Ethnic (BAME) groups, requires a recognition may be at risk because of old age, because of social discrimination and because of a lack of access to health and social care services, all of which can lead to a particular vulnerability to mental illness in these groups. Although there have been more studies of older immigrants in recent years, there is a relative lack of research.
Livingston and Sembhi\textsuperscript{42} found that “cross-cultural assessment of dementia in older people has specific pitfalls related to language and literacy skills. In particular, the use of culturally biased screening instruments that rely on language recognition and familiarity with test situations may be inappropriate or misleading for people with cognitive impairment”.

In the ONS psychiatric morbidity survey of adults\textsuperscript{43} (aged 16-to-74 years), it appears statistically significant that functional mental illness appeared higher in Indian, Pakistani and Bangladeshi communities than the average, and Black African and Caribbean communities seemingly lower. Differences in the prevalence rates of common mental health problems in men and women were reported, with women exhibiting higher rates than men, overall.

**Key Points for Older People’s Mental Health – Demographic Profile**

There are higher rates of functional mental illness in specific ethnic groups which requires us to find ways to reach out to these groups to reduce any unmet need. There are also cross cultural issues to be considered in ensuring assessment and treatments are tailored to meet the needs and the range of older people in Hounslow requiring provision.

The increase in our older population is likely to lead to a greater demand for universal services such as primary health care; social and community activities; advice, information and advocacy; and housing.

Older people are high intensity users of complex care packages and therefore we are also likely to see an increase in demand for more specialist services such as mental health; social services; hospital care; and residential and nursing care.

**Mental Health in Later Life**

Reaching later life is a time of major transition, most notably people are considering retirement and the changes that brings about. It is also a time of changing physical ability and health and there are inevitable changes in lifestyle, social interests and networks. Taking on the role of an informal (unpaid) carer or being cared for also tends to occur to a greater extent in older age as does coping with bereavement. So perhaps it is not surprising that mental health problems are a concern for our ageing population. Nevertheless, it is important to remember that the majority of older people do have good mental health and that maintaining good physical health, a healthy appetite for physical activity, pursuing interests, learning, and a social life, can all help maintain positive mental health.\textsuperscript{44} The sections below outline some of the risks associated with older people and poor mental health.


\textsuperscript{44} Older People and Mental Health, Mind factsheet: http://www.mind.org.uk/help/people_groups_and_communities/older_people_and_mental_health#caregivers
**Functional Mental Health**
The range of mental health problems experienced by older people is varied, from negative feelings associated with isolation or bereavement, to diagnosed mental health illnesses such as depression, anxiety or more serious illnesses such as schizophrenia. Sometimes these problems grow older with the individual and sometimes they are acquired during older age. We refer to these problems throughout this strategy as ‘functional mental health problems’.

**Cognitive Mental Health**
Older people are also at a much higher risk from cognitive impairment or mental health problems associated with age (i.e. neurodegenerative). The most widely known of these diseases is dementia. The term dementia is used to describe a collection of symptoms, including changes in memory, reasoning and communication skills, with a gradual loss of ability to carry out daily activities. There are a number of different types of dementia such as Alzheimer’s; Vascular; Frontotemporal and dementia with Lewy bodies. We refer to these problems throughout this strategy as ‘cognitive mental health problems’.

**Mental Health and Other Needs**
Older people are particularly at risk from some of the associated issues that come with having a mental health problem, especially self neglect or self harm. This is because they are more likely to be socially isolated and because the impact of this on their physical health can cause additional problems such as malnourishment, dehydration, untreated wounds, sores and infections etc.

Only some older people meet the clinical criteria for specialist treatment in the NHS, although more will be able to benefit from support from primary care i.e. their GP and / or counselling. Others will be able to access social, emotional and practical support from community services offering day to day activities and groups.

Nevertheless, it is felt by local professional stakeholders that there are groups of older people that go unnoticed or perhaps are not having their needs met. For example, those that are socially isolated; the ‘quietly depressed’ who perhaps do not realise they can get help or do not seek it out; and members of minority ethnic groups who have not traditionally accessed mainstream services for mental health support. Sometimes, these older people present in other settings with related needs, such as accident and emergency (A&E) or at health centres, but because their mental health needs are not the primary reason for attendance they can miss out on much needed support. In addition, there are often other issues that can be linked with mental health problems such as harmful drinking; housing problems and sometimes domestic abuse.

**Mental Health and Physical Health**
Depression is more common for people with long term health needs and can worsen outcomes in a range of physical disorders. For example, there is strong evidence for the link between depression and coronary heart disease and stroke. There is also evidence to suggest that mental health can impact on immune functioning and as mentioned above people experiencing mental health problems are more likely to

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45 Dementia Services Guide, Healthcare for London p7
neglect their physical health needs. Ensuring basic health needs are met such as diet, exercise, dental health, eye sight, hearing, and any physical or mobility needs are simple ways to maintain good overall health.

Mental Health and Deprivation

There is a relationship between deprivation and poor mental health for all ages. A national survey in 2000 by the Office for National Statistics found that for older people the likelihood of a common mental disorder increased steadily with decreasing household income. While just one in fifty people (two per cent) with a weekly income of £500 or more had a disorder, the prevalence increased to about one in seven respondents (15 per cent) with an income below £200. In addition, being in receipt of the types of state benefit that are either means tested, or contingent upon disability, was associated with a greatly increased likelihood of having a mental health problem.46

Alcohol and Drug Abuse

There are no firm statistics for alcohol and drug misuse in older people, although estimates suggest that two to 15% of older people living in the community and between four and 23% in clinical settings misuse alcohol. Whilst older people don’t tend to drink as much as younger people, they are more likely to drink more frequently. Added to this is a greater risk from alcohol because they have slower metabolism, and greater potential to experience negative interactions with prescribed medication. Alcohol misuse affects older men more than older women, particularly at risk are older Irish men.

Symptoms of alcohol misuse include: accidents; malnutrition; self neglect; depression; insomnia; confusion.

Alcohol misuse in later life can have grave consequences. It is one of the leading causes of falls in older people. It is closely associated with depression and suicide in older people, and people aged 55 to 74, have the highest rates of alcohol-related deaths in the UK.

Suffering is needless as older people respond just as well to treatment as young people but studies suggest an under referring by psychiatry to alcohol services.

Drug misuse in later life encompasses a range of scenarios including:

- Use of mis-prescribed medication
- Accidental misuse of over-the-counter and prescribed medications such as benzodiazepines or other tranquilisers
- Intentional misuse of over-the-counter and prescribed medications
- Intentional misuse of illicit drugs such as cannabis and cocaine

All of the available evidence asserts that rates of both prescription and illicit drug misuse are under-estimated but there are few definitive statistics.

Mental Health and Learning Disability

There is a close relationship between learning disability and mental health with a greater risk of experiencing mental health problems and associated issues such as deliberate self harm, depression, challenging behaviour and greater reliance on community and residential resources. As more people with learning disability increasingly reach later life it too has become a consideration for older people’s mental health services.

As well as functional mental health problems such as depression, older people with learning disability are also at greater risk from neurodegenerative disorders such as dementia. In Hounslow there are 63 older people with learning disabilities known to services.47 There are also a number of younger adults with learning disabilities who experience early onset dementia, however, the number of these residents is not known at time of publication.

Mental Health of Carers

A Carer is someone who gives help and support to a relative, child, spouse, partner, sibling, parent, neighbour or friend who, due to disability, illness or frailty, is unable to manage living in their own home without help. Carers are unpaid, may be of any age and they may live with, or apart from, the cared for person.

Carers of older people with mental health problems play a particularly important role in supporting them with their mental health and reducing their isolation. Often carers provide older people with a connection to the wider world, as well as, supporting them with day to day life for example reminding them to take medication, taking them to health appointments, help with organising their household and providing any physical care needs. In the 2001 Census 20,000 people reported they were providing informal care, however, only 700 are known to London Borough of Hounslow on the Carers Register.

It is often the case that if the carer was not able to continue to provide care the older person would experience a greater reliance on health and social care professionals. A study by the University of Leeds48 for Carers UK reported that the average carer is saving the nation over £15,260 a year.

Older people often have responsibility for caring for their loved ones who are perhaps unwell or frail. It is important to recognise that informal care can be a full time job for many and can be a source of stress and worry for the wellbeing of the cared for. Older carers can be prone to feeling low in mood, tired and uncertain. Sometimes these feelings can lead to diagnosable mental health problems, but very often, they result in periods when they simply need emotional and practical support with their caring responsibilities. It is important that the emotional and mental health needs of older carers are supported and breaks from caring are provided to help them maintain good mental health.

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47 Learning disability self assessment 2010, CTPLD tracking list
48 Calculating the Cost of Care, Dr Lisa BRUCKNER, and Sue YEANDLE of University of Leeds – September 2007
Estimating mental health problems in the local population
Department of Health estimates suggest mental health problems are present in 40% of older people who attend their GP; in 50% of older people inpatients in general hospitals; and in 60% of residents in care homes and just over a quarter of admissions to mental health inpatient services involve people over the age of 65. Mental health problems particularly depression and dementia are more common and have a worse outcome in the 60% of older people who suffer from a long term illness. These estimates suggest mental health is likely to also be a considerable concern for our local older people.

Key Points for Mental Health in Later Life
We need to support older people to keep physically fit, well and an active mind and social life will to reduce the likelihood of mental health problems in later life. We need to remain mindful that there is a strong link between deprivation and poor mental health when planning services, especially those that target or outreach to communities.

Drinking in older age is reported to be fairly common, we need to ensure we raise awareness of the dangers of drinking in older age to reduce the incidence of accidents, falls and other physical health concerns such as malnutrition and neglect. This work needs to be undertaken with front line services and older people themselves.

More people with learning disabilities are reaching older age therefore we need to ensure that we provide equitable services to this group of older people by ensuring they can access provision that is right for them at every stage. Carers are our greatest asset in helping older people to maintain independent lives. We need to make sure they are able to have their needs assessed, especially their emotional and mental health needs, and to give them the support they need to maintain their caring role.

Prevalence of Functional Mental Health Problems

Depression
Depression is most common in later life and tends to be more chronic with longer episodes and shorter periods of remission compared with earlier life. Depression can be seen as a continuum of symptoms including: low mood; loss of interest or pleasure in things normally enjoyed; sleep and appetite disturbances; loss of self esteem; irritability and difficulty concentrating; sleeplessness; feelings of guilt, sadness and despair; feelings or worthlessness, hopelessness and recurrent thoughts of suicide or death.

Of the 25 per cent of older people who have symptoms of depression, only half (10 to 15 per cent of all older people) meet the clinical criteria for a diagnosis of depression. A diagnosis of major (severe) depression requires that a person has had five of the possible nine specified symptoms for at least two weeks. A diagnosis of minor (mild)

Depression is made when a person has had two of six possible symptoms, and depressed mood, almost every day for at least two years.

Whilst the greater number of older people experiencing depression might not meet clinical thresholds they are able to benefit just as much from intervention. The Age Concern (2007) report suggests that professionals should focus on the experience of symptoms which would allow a more person centred approach to care and treatment of depression.

Based on the 2011 population projections the number of people likely to be experiencing clinical depression are estimated at:

- People aged 65-74: 13,196 with 1,396 - 2,056 older people possibly living with depression
- People aged 75-84: 8,409 with 841 - 1261 older people possibly living with depression
- People aged 85+: 3,485 with 348 - 523 older people possible living with depression

The overall number of older people likely to be experiencing some symptoms, but not necessarily with a diagnosis is approximately 6,200.

**Anxiety**

Anxiety is closely linked with depression, particularly in later life and there are different forms of anxiety: generalised anxiety disorder, phobia, panic, and obsessive compulsive disorder. Symptoms include worry, panic attacks, irritability, restlessness, difficulty concentrating, muscle tension and sleep disturbance. Between 2 – 4 % of the community meet the clinical criteria for anxiety, and 10-24% of people living in the community display symptoms.

Based on the 2011 population projections the number of people likely to be experiencing clinical anxiety is between 500 and 1000.

The overall number of older people likely to be experiencing some symptoms, but not necessarily with a diagnosis is between approximately 2500 and 6000.

**Suicide and Deliberate Self Harm**

Deliberate self harm (DSH) is more closely linked to suicide in older compared to younger people, and the 2007 Age Concern report states that DSH should be considered a failed suicide attempt unless proved otherwise.

Ninety per cent of DSH by older people involves an overdose of medication such as benzodiazepines or other sedatives, paracetemol and antidepressants

Over a third of older people who self-harm have severe depression while 10 per cent are dependent on alcohol

Suicide in later life is marked by distinct characteristics:

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50 Age Concern - Improving Services and Support for Older People with Mental Health Problems - The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, 2007
- Depression is the leading cause of suicide in older people
- Older people make fewer attempts but are more successful; one in four attempts results in a completed suicide, compared with 1 in 15 in the general population
- People who have committed suicide are more likely to have seen their GP in the previous six months and;
- Are more likely to present with physical health symptoms whereas their younger counterparts are more likely to present with mental health symptoms

In London the highest suicide rates for men are in the ages 35-54 years, 75-79 and 85+ years and for women in the ages 35-64, 75-79 and 85+ years. A similar pattern is found nationally except London has higher rates of suicide among men and women aged 75-79 years than England as a whole. In 2003 the national suicide rate per 100,000 was 11.8%, in London in 2005/06/07 it was 7.5%, in Hounslow in 2007/8 it was 10.8%.

It is not possible to identify how many older people committed suicide but there are figures for the average number of suicides per year (1996-2008), compared with two neighbouring boroughs:

- Hounslow - 18 suicides per year
- Ealing - 29 suicides per year
- Hammersmith and Fulham - 16 suicides per year

The number of suicides in Hounslow in 2008 and 2009 was recorded as 26 and 25 respectively\(^{51}\)

### Schizophrenia and Other Severe Mental Health Problems

This is an under researched area, relatively few older people experience severe mental health problems but those that do have very complex needs. People who grow old with schizophrenia may have been in asylums or long stay mental health hospitals in their younger years, they are now likely to be living in specialist care or in supported community environments. The prevalence of schizophrenia and bi-polar disorder does not appear to increase with age, approximately 1% of people aged 65 and over in the community have psychotic disorders, approximately 0.5% have schizophrenia.\(^{52}\)

Three quarters of older people with schizophrenia developed it in their teens or 20s (early onset) and have grown older with it - 15 % developed it between the age of 40 and 64 (late onset);10% developed it for the first time after 65 (very late onset). The majority of older people with schizophrenia are women; men with early onset schizophrenia have very poor outcomes and are less likely to survive into later life


\(^{52}\)
Key Points for Older People’s Mental Health – Functional
Many older people experience depression and anxiety but do not meet eligibility thresholds for specialist mental health care. We need to ensure these older people have their needs met with primary and community care to support their quality of life and to prevent further escalation of these conditions.

We need to ensure front line services are aware of the strong link between self harm and suicide so that they treat each incidence of self harm seriously and access specialist advice to prevent any further harm coming to older people who are harming themselves.

Prevalence of Cognitive Mental Health Problems
Dementia can affect anyone regardless of gender, ethnicity, socio-economic situation and residential status. Nearly two thirds of people with the disorder live in the community, while the other third live in a residential home.53

The prevalence and incidence of dementia increases with age and approximately 700,000 people in the UK have dementia.54 This represents 5% of the total population aged 65 and over, rising to 20% of the population aged 80 and over. Dementia can also occur before the age of 65 and there are about 17,000 people with dementia in younger age groups in the U.K. Of the total number of people with dementia, 154,000 live alone.

The level of UK diagnosis and treatment of people with dementia is generally low, with a 24-fold variation in activity between highest and lowest activity by PCT.

Local Information on Dementia
It is possible to take national prevalence data and apply it to local population projections to help us anticipate the number of people likely to be experiencing dementia locally. The most recent relevant source of UK data can be found in ‘Dementia UK: A report into the prevalence and cost of dementia’ prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King’s College London, for the Alzheimer’s Society, 2007. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2030.

The table below demonstrates expectations for the number of people with dementia between 2011 and 2013.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 65-69</td>
<td>88</td>
<td>94</td>
<td>98</td>
</tr>
<tr>
<td>People aged 70-74</td>
<td>164</td>
<td>161</td>
<td>158</td>
</tr>
<tr>
<td>People aged 75-79</td>
<td>275</td>
<td>281</td>
<td>281</td>
</tr>
<tr>
<td>People aged 80-84</td>
<td>396</td>
<td>396</td>
<td>406</td>
</tr>
<tr>
<td>People aged 85 and over</td>
<td>651</td>
<td>651</td>
<td>625</td>
</tr>
</tbody>
</table>

53 Dementia Services Guide, NHS Health Care for London
54 Living Well with Dementia: A National Dementia Strategy 2009, Department of Health
It is also expected that there will be some gender differences with more women than men experiencing dementia, particularly for the 75 years and above age group.

<table>
<thead>
<tr>
<th>Age range</th>
<th>% males</th>
<th>% females</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>1.5</td>
<td>1</td>
</tr>
<tr>
<td>70-74</td>
<td>3.1</td>
<td>2.4</td>
</tr>
<tr>
<td>75-79</td>
<td>5.1</td>
<td>6.5</td>
</tr>
<tr>
<td>80-84</td>
<td>10.2</td>
<td>13.3</td>
</tr>
<tr>
<td>85+</td>
<td>19.7</td>
<td>25.2</td>
</tr>
</tbody>
</table>

Table 6: Rates for men and women with dementia

We know that there are a number of local people with Dementia under the care of their GP. During 2009/10 there were 7795 people who were listed on the GP register with Dementia. Of the 741 patients who qualified for a review, 590 were had been provided with a review.\(^{56}\)

In 2009/10 there were 600 people being treated for dementia at the West London Cognitive Disorders Treatment and Research Unit. This equates to about 12 referrals per week. Clinicians and managers at the Unit report an increase in the number of people being referred for early signs of Dementia by their GP. A significant minority of these referrals were for people in their 50s and 60s, suggesting concerns about Dementia are manifesting earlier than historical patterns have shown. For example, in 2006 and 2007 there was just one referral for each year, but in 2010 there have already been nine for far.

In line with the findings of the National Dementia Strategy local stakeholders have reported a lower than expected level of people known to be experiencing Dementia. This matches the local discrepancy shown in the tables and paragraphs above between the expected prevalence and actual numbers of people known to primary and secondary care. As awareness about Dementia increases, particularly among referrers in primary care, we should expect to see the number of people known to services increase in the forthcoming five years. According to the expected prevalence, it is very likely that we can expect at least a further 850 people accessing health care and an additional need for other public resources such as social care and housing.

In addition, we know from discussion with local service providers that there are more people with a learning disability experiencing dementia, especially as people now live longer and are reaching old age. There were 63 residents known to services in 2010. Also a small number of people are being diagnosed with Korsakoff’s Dementia which is associated with heavy drinking over long periods of time.\(^{57}\)

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\(^{55}\) Source of Data: Projecting Older People Population Information System - www.poppi.org.uk

\(^{56}\) N.B. 54 were exception reported from Reviews

\(^{57}\) Alzheimer’s Society Factsheet, What is Korsakoff’s Syndrome?: http://alzheimers.org.uk/site/scripts/documents_info.php?categoryID=200137&documentID=98&pageNumber=1
Younger People with Dementia
More working age adults are experiencing early onset dementia, and there are more than 16,000 younger people with dementia in the UK. However, this number is likely to be an under-estimate, and the true figure may be up to three times higher. Data on the numbers of people with early onset dementia are based on referrals to services, but not all those with early onset dementia seek help in an early stage of the disease. It is important to ensure that early identification is considered for this age group and equal access if offered to specialist services.

Dementia and Carers
Healthcare for London have reported in the Dementia Services Guide that that about two thirds of people with dementia are supported by informal carers. Dementia can have devastating effects on carers and the relationship between the carer and cared for. It is also reported that the number of hours care provided per week increases as the severity of the disease progresses. Nevertheless, informal family care, often enables people with dementia to live at home and overall those with informal care are over 20 times less likely to need to be admitted to a residential home.

Local services who work directly with carers have a better idea of the numbers of carers involved in caring for someone with dementia. The Hounslow Alzheimer’s Society tells us that as at June 2010 they are working with 126 carers directly and support approximately 1400 indirectly, for example through newsletters and communications.

End of Life Care and Dementia
A Commissioning toolkit has been published for the NICE End of Life Care guidance for patients with Dementia.

The guidance suggests that the average NHS Primary Care Trust (i.e. borough) would have around 380 people with Dementia needing end of life care services each year while the average practice would encounter around 13 patients requiring these services.

Delirium
Delirium or acute confusion is marked by the sudden onset of confusion, disorientation, memory impairment, agitation and occasionally delusions and hallucinations - physical causes include infection and dehydration. There is a greater incidence with age, 1-2% of people aged 65 and over living in the community have suffered from delirium, as compared with up to 14% of people aged over 85.

In a hospital setting delirium can be confused with dementia so a specialist assessment is very important in providing the right type of care. It should include

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60 Age Concern - Improving Services and Support for Older People with Mental Health Problems - The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, 2007
establishing an individual’s mental health and state of mind prior to hospital admission by talking to carers and those that know the person best. Delirium is very common in care settings, including hospitals, half of the cases develop after admission and costs of treatment are very high. On average delirium doubles the length of a hospital stay and older people are more likely to enter care homes as a result.

With proper care delirium can be prevented in a third of hospital cases but it remains undiagnosed in over half of older hospital patients. One study found that 84 to 95% of cases of delirium in older people went undetected by attending physicians in general medical units. 86

**Key Points for Older People’s Mental Health – Cognitive**

The available data suggests that approximately 1570 people in Hounslow are likely to have dementia, yet only 719 are recorded in primary care on the GP register. This suggests that there are up to 850 people who are unknown to local services or have needs that are currently unmet.

This gap tells us that demand for local dementia care is likely to increase over the period of this strategy.

Whilst we don’t know how many carers of people with dementia there are currently in the borough, we know that it is a significant strain on the carers and family, and that local community services are already working to support a growing number of carers. It is essential that front line staff are able to differentiate between delirium and dementia. This will ensure the proper course of treatment is made available, in a timely manner, to prevent worsening of symptoms, and the risk of delirium becoming dementia, and the associated links with institutional care.
Appendix Two - Outline National Policy

**National Service Framework (NSF) for Older People (DOH 2001)**
The NSF advocates early diagnosis and intervention for dementia. Procedures for early detection and diagnosis should be reviewed together with swift access to specialist services, treatment and care planning.

**Audit Commission 2000- Forget Me Not**
The Forget Me Not report found that only half of GPs grasped the importance of actively looking for symptoms of dementia and less than half thought they were adequately trained in diagnosing dementia.

**Everybody’s Business (CSIP 2005)**
This is a guide to help develop integrated mental health services for older people. The document stresses the importance of memory assessment services for early diagnosis of dementia, and the role of Community Mental Health Teams.

**Dementia UK Report (2007)**
The dementia UK report recommends making dementia an explicit priority for national health and social care services to improve the quality of care for people with dementia and their carers.

**National Audit Office – value for money study (2007)**
This report criticised the quality of care for people with dementia and their carers. It found variable levels of support from Community Mental Health Teams, and noted that GPs lacked confidence in identifying the symptoms of dementia and this situation had deteriorated since 2000. Services did not deliver value for money, and not enough people were receiving an early diagnosis. The conclusions were that early intervention would improve the quality of life, however, services in different settings e.g. care homes, hospitals in the community and at end of life, were not delivered consistently, nor were they cost effective. The objectives of supporting people to live independently were not being met, and improvements to early diagnosis and intervention in community, specialist and hospital services would prove more cost effective in the long term. The Public Accounts Report 2007 echoed these concerns and recommendations.

**Age Concern Reports: Promoting Mental Health and Well Being in Later Life (2007) and Improving Services and Support.**
The first was a joint report with the Mental Health Foundation after concerns from both agencies that mental health in later life was a neglected area. The second report focused on how to improve services for older people with mental health problems. It proposed 35 recommendations to ensure the needs of older people with mental health problems and their carers were taken seriously and resources were directed to meeting them.
Partnerships for Older People Projects
After the Government Spending Review in 2004, 60 million of funding was allocated to local authorities for pilot projects to facilitate a shift in culture and resources towards early intervention and improved outcomes for older people. 29 pilots were set up some to address mental health needs e.g. anxiety, depression and dementia. The results of these pilot projects will be available in 2011.

National Dementia Strategy – Living Well with Dementia (2009)
The strategy identified 3 steps to improve the lives of people with dementia and their carers:

- Increased knowledge of the condition and a reduction of its associated stigma;
- Early diagnosis.
- A range of services to meet their needs across the entire care pathway from raising awareness, early diagnosis, support to live independently, hospital and inpatient care and nursing and residential care homes.

Dignity in Care Campaign
The campaign was launched in November 2006, the aims are to place dignity at the heart of care services. A new role of Dignity Champion was created to help achieve this and Champions come from a wide range of services including older people and carers.

Equality in Later Life – National Study in Older People’s Mental Health Services, Healthcare Commission (2009)
This national study of mental health services for older people was developed around 4 themes:

- Age discrimination in mental health services
- Quality of hospital care
- How comprehensive services are
- How organisations work together to provide services

14 recommendations were developed to achieve co-ordinated services for older people with mental health problems.

This is a guide for commissioners and service providers on how to implement the National Dementia Strategy. It includes how to ensure people in hospital receive high quality healthcare, with a care pathway set out for inpatients. It also advises London Commissioners how to plan services with Local Authorities, following an integrated care pathway, and how to effectively assess performance outcomes.
Quality outcomes for people with dementia: building on the work of the National Dementia Strategy (September 2010)
This Department of Health document presents the revised, outcomes focussed implementation plan for ‘Living with Dementia – A National Dementia Strategy’. It sets out:
- The Department of Health’s role and priorities for 2010/11
- How it fits with the White Paper Equity and Excellence: Liberating the NHS
- A quality outcome framework for dementia

Clinical Guidelines on Dementia (NICE/SCIE)
The NICE Guidelines recommendation is that memory assessment services should be key in identifying dementia. Agencies should offer integrated services to provide:
- improved support services for carers;
- training for staff working with older people on dementia care
- improved dementia care in hospitals

NICE also produced guidelines on depression, anxiety and schizophrenia

NICE End of Life Care guidance for patients with Dementia
A Commissioning toolkit has been published for the NICE End of Life Care guidance for patients with Dementia which sets out the need to:
- Help people with Dementia live with the best possible quality of life until they die
- Offering information at the point of diagnosis to support effective advance care planning
- Providing integrated and coordinated care 24 hours a day
- Supporting carers as the disease progresses through to the point of death
- Providing a quality assured service

Related Publications:

Carers Strategy (2008)
The Carers Strategy details a 10 year plan to support carers, including those caring for people with dementia, to have a life of their own.

National End of Life Care Strategy (2008)
The End of Life Strategy promotes high quality care for all adults at the end of life in all settings, provides a framework for local health and social care services to build on.

Our Health, Our Care, Our Say
This policy document sets out the need to bring care closer to home and addresses direct payments as a way for people to buy in their own care services. For people who are assessed as lacking capacity under the Mental Capacity Act 2005 the payment can be made to a suitable person to manage it on their behalf.
Putting People First
This policy outlines the Government’s plans to provide public services to enable people to achieve self determination. It promotes quality of life and equality of independent living for older people with chronic health problems. It advocates greater choice and control for service users and a personalised adult social care system for people with dementia and those without cognitive impairment.
Appendix Three - Summary of Stakeholder Consultation

Residents and Carers
During the summer and autumn of 2010 we undertook a number of activities to seek out the views of older residents with mental health problems and their carers. A questionnaire was developed to elicit responses about how well services are operating; how we might help at an earlier stage; how we might better help carers and inviting ideas for improvement.

Questionnaires were distributed by local providers to service users and their carers. We also gave out questionnaires at the ‘One Hounslow – Many Voices’ consultation event.

We received 48 questionnaire responses from residents and carers using older people’s mental health service in Hounslow. There were 32 responses from carers and 16 from older residents.

We also attended two carers meetings and held a meeting for residents and carers who access Hounslow Alzheimer’s Society.

In addition, we received a number of telephone calls from carers who wanted to follow up their questionnaire response or who preferred to speak in person with the Senior Joint Commissioning Manger for Older People.

The feedback we have received through this consultation process has enabled us to develop a strategy which is informed by the priorities and concerns of the people using the services we commission. The following provides a summary of the issues that were fed back to us:

Early Diagnosis
It was evident from the responses the importance residents and carers place on early diagnosis and assessment, and the need for information about the mental health problem, what to expect from it and what services are available to provide support.

Carers also felt that there was a long gap between initial diagnosis and access to statutory services. It was suggested by a number of carers that regular assessment, interventions, discussions, support and services are made available during this time. One carer suggested a ‘liaison service’ which could provide support in the time between diagnosis by GP and receipt of statutory services.

This would not only empower carers but enable older people with mental health problems to make informed decisions about their care whilst they were still able to. The following is a summary of issues raised:

- Exploring symptoms with GP for early identification
- More information on first diagnosis
- More information in treatment / what’s available locally
- Receive services earlier
- Regular follow up appointments
• More time from doctors, more frequent appointments

Carers
Carers needs centred on three main themes: access to information; being involved in the person they care for’s care; having breaks and time to themselves. Carers need early access to information, advice and support on diagnosis, treatment and services available to support them in their caring role.

They can also provide insight to professionals and feel more empowered when they are involved in the assessment, treatment and care of the person they are looking after. In order for carers to maintain their role they need breaks to have a sense of their own life. The following are some specific points that were raised:

• Carers benefit from accessing informal support and advice
• Carers benefit from close working with professionals and involvement in care planning
• More support for carers / carers groups (especially condition specific)
• Giving sympathy and answering carers questions
• Support for carers when the cared for is in hospital or mental health inpatient ward
• Alzheimer’s Society able to provide support to whole family
• Appreciated Crossroad and flexible care
• 15 received support from Crossroads in the main for 1 day per week (3 hours) all found the help very good but wanted more hours of support
• 1 described them as a godsend
• Many carers said they needed more than 1 days help
• There was a long waiting time to get a paid carer
• Having the same carer was very important – changes in carers affect the older person and result in repetition of history, needs which carers and older people find frustrating
• Some carers described it as a relief to have break and see to their own needs, lifted some pressure
• Carers want us to listen to them and find out what help they need
• Better publicity of services

Community Support
Both older people and their carers felt that more access to community groups and home visiting / befriending would be beneficial to prevent mental health problems, to support early diagnosis and throughout ongoing care. A central theme to the responses was that more contact and or visits were required.

Respondents wanted to be supported to live independently as long as possible but wanted to have regular support and information. Respondents often alluded to the fact they didn’t always know they needed support or what support was available:

• Promotion and information talks given to older people’s groups, church groups, older people together
• Practical support, e.g. shopping and cleaning
• More regular contact, e.g. by phone to see how people are getting on
• More Home help
• Support with medication
• Close monitoring when it is needed
• De-stigmatising mental ill health – an illness like other illnesses
• Help with travel, especially free travel or access to public transport
• Importance of providing stimulating activities so that older people are able to keep an active mind to help maintain their mental health and prevent decline.
• Importance of providing opportunities for sharing memories
• Clubs for carers and cared for to attend together with older person that are stimulating “bright music and activities”
• Help with benefits and form filling was welcomed and deemed a ‘godsend’ for one respondent who felt she would have given up on the paperwork without the extra help.

Specialist Mental Health Day, Inpatient and Social Care
There was a great deal of positive feedback about specialist mental health services, including praise of psychologists and psychiatrists. However, the major theme (also for all provided services) was the need for more staff:

• Staff are too busy to provide the kind of attention and stimulation older people need to help with their recovery or maintain their sense of mental health. There were also concerns about the length of time between social work visits / assessments.
• Professionals encouraging use of other services on discharge
• More assessments needed by social services or health care professionals
• One older person had had no contact from social care in 3.5 years.
• An older person with depression wanted health workers to “explain my illness in language I can understand” to allay his anxiety
• Regarding the Memory Clinic: described as ‘Getting into its stride but needs more personality - specialists need to remember patients have local history’
• Need to provide stimulating activities, especially opportunities for talk and sharing memories
• Involving carers / briefing carers

Hospital and Respite Care
There was not a great deal of feedback on hospital or respite care, but one response sheds some light on some issues:

• One response detailed mother’s experiences in variety of respite and hospital settings, common themes were:
• Medical care good but nurses too busy to provide adequate care
• All inadequate in feeding and providing food mother wanted
• Locations were: Dove ward; Brentford Lodge; Hammersmith & Fulham A & E; Chiswick Day Centre; Clifton Gardens.

Extra Care Housing
Feedback on extra care housing was very positive both in terms of the safety and security it offers and the fact it enables people to live independently for as long as possible. There were some specific points:
- Modernise the emergency call system
- Build more extra care housing specifically for older people with mental health needs (a common theme was the importance of keeping the disability groups separate)
- More staff as staff are often rushed and busy
- Help and guidance from skilled staff to encourage older people to help themselves

**Professional Stakeholders**
We consulted a number of professionals who work in Hounslow in order to shape and develop this strategy.

<table>
<thead>
<tr>
<th>Name of Professional</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Annabel Crowe</td>
<td>GP</td>
<td>NHS Hounslow</td>
</tr>
<tr>
<td>Dr Parvinder Garcha</td>
<td>GP</td>
<td>NHS Hounslow</td>
</tr>
<tr>
<td>Dr Craig Ritchie</td>
<td>Consultant Psychiatrist</td>
<td>WLMHT</td>
</tr>
<tr>
<td>Hasmita Patel</td>
<td>Chief Pharmacist</td>
<td>NHS Hounslow</td>
</tr>
<tr>
<td>Dr Alice Parshall</td>
<td>Clinical Director</td>
<td>WLMHT</td>
</tr>
<tr>
<td>David Martin</td>
<td>Community Psychiatric Nurse, Liaison to A&amp;E and Wards @ WMUH</td>
<td>WLMHT</td>
</tr>
<tr>
<td>Sarah Ghani</td>
<td>Clinical Lead for Older People’s Mental Health</td>
<td>WLMHT</td>
</tr>
<tr>
<td>Mary Crawford</td>
<td>Associate Director / Head of Joint Commissioning</td>
<td>LBH &amp; NHS Hounslow</td>
</tr>
<tr>
<td>James Hearn</td>
<td>Senior Joint Commissioning Manager Learning Disabilities</td>
<td>LBH &amp; NHS Hounslow</td>
</tr>
<tr>
<td>Anajana Chakraborty</td>
<td>Carers Services Commissioning Manager</td>
<td>LBH</td>
</tr>
<tr>
<td>Clive Churchill</td>
<td>Team Leader Older People’s CMHT</td>
<td>WLMHT</td>
</tr>
<tr>
<td>Jenny Whitford</td>
<td>Chief Executive</td>
<td>Alzheimer’s Society</td>
</tr>
<tr>
<td>Stephen Hawkins</td>
<td>Chief Officer</td>
<td>Age Concern Hounslow</td>
</tr>
<tr>
<td>Sandra Hawke</td>
<td>Manager</td>
<td>Crossroads</td>
</tr>
<tr>
<td>Val Dommett</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martin Elliot</td>
<td>Head of OP care management</td>
<td>LBH</td>
</tr>
<tr>
<td>Jane Walsh</td>
<td>Community Pharmacy Adviser</td>
<td>NHS Hounslow</td>
</tr>
<tr>
<td>Sophie Norton</td>
<td>Older People’s Resource Centre Project Manager / End of Life Strategy Development</td>
<td>LBH &amp; NHS Hounslow</td>
</tr>
<tr>
<td>Munya Nhamo</td>
<td>Senior Joint Commissioning Manager - Continuing Care</td>
<td>LBH &amp; NHS Hounslow</td>
</tr>
<tr>
<td>Ranjit Kooner</td>
<td>Associate Director – Older People</td>
<td>WMUH</td>
</tr>
<tr>
<td>Dr John Platt</td>
<td>Clinical Lead for Dementia and Consultant Geriatrician</td>
<td>WMUH</td>
</tr>
<tr>
<td>Dr Linda Tsams</td>
<td>Consultant Geriatrician</td>
<td>WMUH</td>
</tr>
<tr>
<td>Paula Grahame</td>
<td>Dementia Lead</td>
<td>WMUH</td>
</tr>
<tr>
<td>Doris Briggs</td>
<td>Manager</td>
<td>Charlotte House Nursing Home</td>
</tr>
<tr>
<td>Sharon Brookes</td>
<td>Service Manager - Home Treatment</td>
<td>WLMHT</td>
</tr>
</tbody>
</table>
We also received views from a range of stakeholders who attended a workshop on the development of local dementia services in September 2009.

The strategic aims were also discussed with the Older People’s Mental Health Forum and Adult and Older Person’s Partnership Board.

**Organisation Key:** LBH – London Borough of Hounslow / WLMHT – West London Mental Health Trust / WMUH – West Middlesex University Hospital
## Appendix Four – Expenditure on OPMH 2009-2010

<table>
<thead>
<tr>
<th>Service</th>
<th>PCT Total</th>
<th>LBH (net of user contributions)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>WLMHT</td>
<td>£3,955,940</td>
<td></td>
<td>£3,955,940</td>
</tr>
<tr>
<td>SWL&amp;StG</td>
<td>£336,439</td>
<td></td>
<td>£336,439</td>
</tr>
<tr>
<td>CNWL</td>
<td>£48,850</td>
<td></td>
<td>£48,850</td>
</tr>
<tr>
<td>Alzheimer’s Society</td>
<td>£41,341</td>
<td>£41,341</td>
<td>£82,682</td>
</tr>
<tr>
<td>Crossroads</td>
<td>£24,610</td>
<td>£24,610</td>
<td>£49,220</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>£947,215</td>
<td></td>
<td>£947,215</td>
</tr>
<tr>
<td>Level 2 medication administration (assume 60%)</td>
<td>£90,000</td>
<td></td>
<td>£90,000</td>
</tr>
<tr>
<td>General Acute (excludes A&amp;E)</td>
<td>£692,000</td>
<td></td>
<td>£692,000</td>
</tr>
<tr>
<td>Primary care (Dementia Prescribing)</td>
<td>£109,378</td>
<td></td>
<td>£109,378</td>
</tr>
<tr>
<td>Residential placements (assuming 59% OPMH)</td>
<td>£4,769,560</td>
<td></td>
<td>£4,769,560</td>
</tr>
<tr>
<td>Nursing placements (assuming 47% OPMH)</td>
<td>£51,600</td>
<td>£1,582,020</td>
<td>£1,633,620</td>
</tr>
<tr>
<td>Day care (assuming 40% OPMH)</td>
<td>£1,092,400</td>
<td></td>
<td>£1,092,400</td>
</tr>
<tr>
<td>Homecare (assuming 40% OPMH)</td>
<td>£2,616,800</td>
<td></td>
<td>£2,616,800</td>
</tr>
<tr>
<td>MOW (assuming 40% OPMH)</td>
<td>£146,000</td>
<td></td>
<td>£146,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£6,297,373</strong></td>
<td><strong>£10,272,731</strong></td>
<td><strong>£16,570,104</strong></td>
</tr>
</tbody>
</table>

In addition, other costs are incurred in Primary Care, where approximately 40% of patients have mental health issues and the general acute sector, where approximately 50% patients have MH issues. The prescribing costs shown are for Primary Care only. It was not possible to detail cost for Accident and Emergency.
Appendix Five – Hounslow Older People’s Mental Health Services

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Service Type</th>
<th>Provider Name</th>
<th>Caseload</th>
<th>Bed Nos.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heston Day Centre</td>
<td>Day Centre Monday to Sunday</td>
<td>LBH</td>
<td>15 dementia places (of 40 in total)</td>
<td>n/a</td>
</tr>
<tr>
<td>Roshni Day Centre</td>
<td>Day Centre Monday to Sunday</td>
<td>LBH</td>
<td>2 dementia places (of 10 in total)</td>
<td>n/a</td>
</tr>
<tr>
<td>Sandbanks (temporary Day Centre whilst new Older People’s Resource Centre is being built)</td>
<td>Day Centre</td>
<td>LBH</td>
<td>15 dementia places</td>
<td>n/a</td>
</tr>
<tr>
<td>Chiswick Day Centre</td>
<td>Day Centre</td>
<td>LBH</td>
<td>20 dementia places (of 48 in total)</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dementia Care: 31 Residents on the register</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Main stream: 54 Residents on the register</td>
<td></td>
</tr>
<tr>
<td>Homecare</td>
<td>Homecare social care support</td>
<td>LBH and Private Providers</td>
<td>Approximately 11,000 hours provided to approx 900 people</td>
<td>n/a</td>
</tr>
<tr>
<td>50/50 Social Contact Group Carers' Support Group (day)</td>
<td>Commissioned Voluntary Sector</td>
<td>Alzheimer’s Society Hounslow</td>
<td>120 on active caseload – 1200 receiving newsletters</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Monthly Computer Club Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Telephone Enquiry Line</td>
<td></td>
</tr>
<tr>
<td>Service Name</td>
<td>Service Type</td>
<td>Provider Name</td>
<td>Caseload</td>
<td>Bed Nos.</td>
</tr>
<tr>
<td>--------------</td>
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<td>---------------</td>
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</tr>
<tr>
<td>Branch newsletter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day centre at Feltham Lodge includes one session each week specifically for people with dementia. Carers Support Service Carers Health and Wellbeing activities.</td>
<td>Commissioned Voluntary Sector</td>
<td>Age Concern</td>
<td>40 places per day and is used by about 140 (dementia session for 12 people) Carers support/respite service provides 55 hours a week to approximately 11 carers. The information and advice service runs a number of social groups for approx 92 people.</td>
<td>n/a</td>
</tr>
<tr>
<td>Crossroads</td>
<td>Commissioned Voluntary Sector</td>
<td>Crossroads UK</td>
<td>Approximately 250 home based respite hours per week to 90 carers. Approx 21 of the OP cared for have dementia</td>
<td>n/a</td>
</tr>
<tr>
<td>West London Cognitive Impairment Research Unit Centre of Excellence (based at Brentford Lodge)</td>
<td>NHS</td>
<td>WLMHT61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older People’s Acute/Assessment In-patients</td>
<td>NHS</td>
<td>WLMHT</td>
<td>n/a</td>
<td>16 beds on Dove Ward</td>
</tr>
<tr>
<td>Day Hospital (based at Brentford Lodge)</td>
<td>NHS</td>
<td>WLMHT</td>
<td>15 places per day for people suffering with</td>
<td>n/a</td>
</tr>
</tbody>
</table>

61 West London Mental Health Trust
<table>
<thead>
<tr>
<th>Service Name</th>
<th>Service Type</th>
<th>Provider Name</th>
<th>Caseload</th>
<th>Bed Nos.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older People’s Community Mental Health Teams: The integrated multidisciplinary team includes medical, nursing, psychology, occupational therapy and social workers and administration staff. They operate single point of entry and an open referral pathway.</td>
<td>NHS</td>
<td>WLMHT</td>
<td>either an organic or functional mental health problem</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Liaison and Acute Mental Health Assessment (at West Middlesex University Hospital)</td>
<td>NHS</td>
<td>WLMHT</td>
<td>Based on attendances at A&amp;E and admissions to wards</td>
<td></td>
</tr>
<tr>
<td>Charlotte House</td>
<td>Nursing Home</td>
<td>Care UK</td>
<td>1 session a week of Psychiatric Liaison provided by NHS WLMHT</td>
<td>22 beds (4 beds short stay / respite)</td>
</tr>
<tr>
<td>Clifton Gardens</td>
<td>Residential Home</td>
<td>LBH</td>
<td>n/a</td>
<td>27 permanent and 2 respite places for older people living with the experience of dementia</td>
</tr>
<tr>
<td>Heston House</td>
<td>Residential Home</td>
<td>LBH</td>
<td>n/a</td>
<td>provides 24 hour care</td>
</tr>
<tr>
<td>Service Name</td>
<td>Service Type</td>
<td>Provider Name</td>
<td>Caseload</td>
<td>Bed Nos.</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------</td>
<td>---------------</td>
<td>----------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sandbanks</td>
<td>Residential Home</td>
<td>LBH</td>
<td>Respite</td>
<td>15 dementia places and supervision for older people aged 65 years or over and younger, physically disabled adults</td>
</tr>
<tr>
<td>Private Nursing Care Providers</td>
<td>Private Sector</td>
<td>Various</td>
<td>n/a</td>
<td>184 individuals placed in nursing homes 62</td>
</tr>
<tr>
<td>Private Residential Providers</td>
<td>Private Sector</td>
<td>Various</td>
<td>n/a</td>
<td>0 individuals placed in residential homes 59</td>
</tr>
</tbody>
</table>

Hounslow Joint Commissioning Strategy – Older People’s Mental Health 2011-2016

62 Snapshot from August 2010