Haringey’s Older People’s Mental Health and Dementia - Commissioning Framework 2010-2015

(Updated October 2012)
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1. INTRODUCTION

1.1. Background
This document describes Haringey Council and NHS Haringey’s joint Commissioning Framework for people with dementia of all ages and older people with functional mental health problems. It sets out the way forward for services for the next 5 years (2010/11 to 2015/16) to secure better mental health services for the people of Haringey. This Commissioning Framework should be read in conjunction with Moving Forward – Haringey’s Joint Mental Health Strategy 2010-2013 as much of the content is relevant to people over 65 as well as to those under 65.

The demographic changes in the UK are mirrored in Haringey; the population of older people Haringey is expected to increase over the next few decades and the number of older people in the country will grow significantly. Mental health problems can increase as people age, with needs covering a range of conditions including depression, anxiety, delirium, dementia, severe mental health problems and alcohol and drug misuse. In order to meet the current and predicted levels of demand within the resources available services must be regularly reviewed and where necessary adapt the ways they are delivered. Part of this work will be to ensure that services are aligned and coordinated across the whole system.

The personalisation agenda, the NHS White Paper, Equity and excellence; and Liberating the NHS which will all change the way health and social care services are commissioned make this a good time for developing the Joint Commissioning Framework which is devoted to dementia and older peoples mental health services. This Commissioning Framework is guided by the National Dementia Strategy and New Horizons, the recent cross-government programme in mental health services, which covers a number of areas to better address people’s mental health and well-being.

We have reviewed Haringey’s readiness to deliver the vision contained within these documents and set out the required actions for Haringey to further meet the objectives and goals for service development described.

1.2. What is a Commissioning Framework?
The Audit Commission has defined the commissioning task as:

“The process of specifying, securing and monitoring services to meet individuals' needs at a strategic level....applied to all services, whether they are provided by the local authority, NHS, or by the private or voluntary sectors.”

A commissioning framework is the beginning of a continuous process that will clearly identify gaps in services and set the priorities for future service developments in line with local and national strategies and priorities. It is the driver for change in the organisation and provision of services across the whole system that ensures they meet the changing needs of the people of Haringey. It is led by the Joint Commissioners in health and social care and is best achieved with the full partnership of users, carers and providers of services.
The Haringey Commissioning Framework sets out the foundations that are needed for the development of future services. It also includes a long term overview of commissioning intentions and a clear direction of travel on which more detailed purchasing plans will be based that specify individual service developments, investment, disinvestment and re-investment plans.

The Commissioning Framework outlines the long term overview of the general direction of commissioning rather than detailed purchasing plans which will emerge from the developing joint commissioning partnership between NHS Haringey and Haringey Council. It will also act as a template or guide for the future development of GP Commissioning Consortia as envisaged by the NHS White Paper, Equity and excellence: Liberating the NHS.

1.3. Purpose
**Purpose:** To provide strategic direction for the commissioning of mental health services across health and social care in Haringey.

1.4. Vision, aim and outcomes
**Vision:** To create better mental health services to improve mental health for the people in Haringey.
**Aim:** To identify gaps in services and set the priorities for future service developments.

**Service Outcomes:**
- Understanding and recognising individuals immediate and changing needs.
- Meeting individual need at the centre of commissioning.
- Sharing and using information more effectively to commission services.
- Assuring high quality providers for all mental health services.

**User / Carer Outcomes:**
Work on implementing the NHS White Paper, Equity and excellence: Liberating the NHS includes the development of quality outcomes for people with dementia (Quality Outcomes for people with dementia: Building on the work of the National Dementia Strategy (DH Sept 10). A set of nine key outcomes for people with dementia have been proposed that will feed into future work on outcomes across the NHS. They are:
- I was diagnosed early
- I understand, so I make good decisions and provide for future decision making
- I get the treatment and support which are best for my dementia and my life
- I am treated with dignity and respect
- I know what I can do to help myself and who else can help me
- Those around me and looking after me are well supported
- I can enjoy life
- I feel part of a community and I’m inspired to give something back
- I a confident my end of life wishes will be respected. I can expect a good death
1.5. Equalities and diversity
NHS Haringey and Haringey Council are committed to reflecting the full diversity of the Haringey community and promoting equality of opportunity and access to everyone. This commitment includes active elimination of discrimination on the grounds of:
- Age
- Disability
- Colour, ethnic origin, nationality, national origin or race
- Gender
- HIV status
- Marital status
- Religion or belief
- Responsibility for dependants
- Sexual orientation
- Unrelated criminal convictions

This commitment is central to the Commissioning Framework. Commissioners and providers of services have a responsibility to understand and respect the needs of the whole diverse population in Haringey and to identify and address any inequalities that exist in the mental health service. This will require proactive work with the local community, representative groups and organisations.

2. NATIONAL AND LOCAL POLICIES LEGISLATION & GUIDANCE
2.1. The importance of national and local guidance, and policy
There are numerous publications that influence and direct the development of older people’s mental health and dementia services. Some publications are specific to mental health, others to older people and or to generic services. The Joint Commissioning Framework is underpinned by and designed to deliver on both national and local policies and guidance.

The following sections outline key national and local policies, legislation and guidance that influence and will impact this Framework and the connections between this document and the strategic framework for Haringey.

2.2. National Policy and Guidance
National Service Framework for Older People (NSF): describes eight standards for improvement in services to older people including a specific standard (7) on mental health in older people the aim of which is to promote good mental health and to treat and support those older people with dementia and depression

A new ambition for old age (2006): next steps in implementing the NSF for older people: Next Steps sets out the priorities for the second phase of the government’s ten-year National Service Framework (NSF) for Older People under three themes: Dignity in Care, Joined-up Care and Healthy Ageing.

Our Health, Our Care, Our Say: A New Direction for Community Services (2006): sets out the Government’s vision for more effective community health and social
care services. It promotes a shift from treatment to prevention and from care provided in acute hospitals to care provided in community settings (including general practice), and indicates that there will be specific targets to shift resources in these directions.

_Everybody’s Business (2005):_ is a service development guide building on models described in the NSF for Older People and principles underpinning Securing Better Mental Health for Older Adults. It that sets out the key components of a modern comprehensive older people’s mental health service and focuses on service domains, both specialist and mainstream. It also emphasises the necessity and complexity of using a whole systems approach whilst highlighting how the different parts of the whole system inter-relate.

_Long Term Conditions NSF (2005):_ Is primarily aimed at improving the lives of people with long term neurological conditions its key themes of:

- independent living
- care planned around the needs and choices of the individual
- easier, timely access to services and
- joint working across all agencies and disciplines involved

These should be applied to all other long term conditions including older people with mental health problems and those with early on-set dementia.

_Securing better mental health for older adults (2005):_ marks the start of a Government initiative to combine forces across mental health and older people’s services to ensure that older people with mental illness do not miss out on the improved services that younger adults or those without mental illness have seen. It provides a vision for how all mainstream health and social care services, with the support of specialist services, should work together to secure better mental health for older adults, and describes how the Department of Health is aiming to help deliver this.

_Forget me not:_ An Audit Commission study of 12 local authorities services for older adults with mental health problems that describes how health and social care agencies need to work together to provide:

- help and advice when problems first arise;
- specialist services, especially to people in their own homes;
- co-ordination between the agencies and professions; and
- a comprehensive strategy to ensure all necessary components are in place.

_A sure start to later life – Ending Inequalities for Older People (2006):_ Is aimed at improving the quality of life and increasing, independence, dignity and choice for older people.

_Mental Capacity Act (2005) & Deprivation of Liberty (2008):_ The Act generally only affects people aged 16 or over and provides a statutory framework for working with individuals who may lack capacity to make some decisions for themselves, either as result of a chronic condition or disability affecting the individual’s ability to make decisions or a temporary condition, such as following an accident. The MCA also required statutory bodies to commission an independent mental capacity advocacy (IMCA) service to work with individuals who lacked capacity,
and who do not have a ‘relative or friend in the world’ to assist with making
important life decisions. It also strengthened safeguarding adult arrangements
with a specific requirement to use IMCA services to support the investigation
process where necessary and appropriate.

**Mental Health Act (2007):** Amends the 1983 Act in a number of key ways,
including how mental disorder is defined, the criteria for detention, broadening the
group of practitioners who can deal with the functions of approved social workers,
and responsible medical officers, and makes changes to the definition of ‘nearest
relative’. The 2007 Act also places a duty on statutory bodies to ensure access to
independent mental health advocates and arrangements must be implemented by
April 2009. It introduces:

- a power to require patients in the community who are at high risk to receive
treatment (supervised community treatment).
- removal of the ‘treatability test’ for patients with personality disorders;
these patients can now be treated under the Act if appropriate therapies
are available.
- an explicit requirement for treatment to have a therapeutic purpose.
- a duty on mental health trusts to provide age-appropriate accommodation
for people under 18 who require hospital admission.
- a duty on trusts to provide specialist advocacy support for patients
detained under the Act.

**Mental Health NSF (2004):** This focused on the needs of adults up to the age of 65
and was reviewed in 2004 - *National Service Framework for Mental Health – Five
years On (DH December 2004).* The review document looked at the first five
years of the National Service Framework for Mental Health and set out the
framework and national deliverables for 2005-2010. ‘Five Years On’ shifted the
focus from the needs of those with a severe and enduring mental illness to the
promotion of mental health for the whole community; to primary care provision; to
the provision of psychological therapies; to meeting the needs of carers and of
those with a dual diagnosis. It is now being superseded by New Horizons – see
below.

**Who Cares Wins (2005):** Published by the Royal College of Psychiatrists drawing
attention to the neglected clinical problem of mental disorder affecting older
people admitted to general hospitals. Based on evidence from pilots and the
success of liaison psychiatry for adults under 65 it calls for the development of
specialist liaison mental health services for older people.

**The Future of Mental Health: a Vision for 2015:** The Local Government
Association, the NHS Confederation, the Sainsbury Centre for Mental Health
(SCMH) and the Association of Directors of Social Services produced a vision of
what mental health will be like in 2015. This includes:

- By 2015 mental wellbeing will be a concern of all public services.
- There will still be people who live with debilitating mental health conditions,
but the focus of public services will be on mental wellbeing rather than
mental ill health.
The balance of power will no longer be so much with the system, but instead there will be more of an equal partnership between services and the individuals who have used or even choose them.

*Living Well with Dementia: A National Dementia Strategy (2009)*: This is a five-year plan for improving services for people with dementia and their carers. The strategy will provide a guide for people with dementia and their families about what they can expect from high-quality health and social care and give advice and help on how to plan, develop and monitor services. The strategy has 3 main aims:

- Improve awareness of dementia among both the public and health and social care professionals.
- Make sure that diagnosis is made as early as possible to allow for early intervention.
- Deliver high-quality care and support for people with dementia and their carers.

The strategy is designed to meet the needs of everyone with dementia, no matter what age, ethnic origin or social status they are. Services should be based on the needs and choices of people with dementia and their families, meet recognised quality standards and government recommendations, support people to access a range of services from the NHS, Social Care and charities, ensure that people from all backgrounds and communities can get access to high-quality services and help local health and social care services to respond to local needs.

*Health Act Flexibilities (1999)* – which created S31 partnership agreements - updated by the *NHS Act 2006* – with S31 being replaced by S75 partnership agreements: This act sets out the legal framework and lead arrangements for integration of health and social care services. The flexibilities enable health and local authorities to delegate responsibility to either party. The three flexibilities of integrated provision, pooled budgets, lead commissioning can be used on their own or in combination to integrate services. The flexibilities enable the establishment of clear governance arrangements for integration underpinned through a legally binding agreement. Health and social care will be monitored on their use of Health Act flexibilities.

*Transforming social care – Putting People First and Individualised Budgets: The Green paper Independence, well-being and Choice (2005) and the White Paper Our Health, Our Care Our Say (2006)*: Proposed a vision of social care services that included ‘personalisation’ that signalled a strategic shift towards early intervention and prevention. The ‘Putting People First’ (PPF) concordat and ‘Transforming Social Care’ circular published in early 2008 set out the Government’s intention to make personalisation the cornerstone of public services. Personalisation is

> “the way in which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive.” *Our health, our care, our say: a new direction for community services, Department of Health, 2006*

This means that everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and
community or private sector or by funding it themselves, will have choice and control over how that support is delivered.

It has been recognised that putting personalisation into practice is not just about responding to a more demanding public, it is the key to addressing inequalities. *(A personal approach to public services: shaping services around individual needs, Turning Point and Dr Foster intelligence December 2007)*

It has also been hailed the biggest change to the delivery of social care since the introduction of the NHS and Community Care Act 1990.

*Putting People First* states that the transformation should ensure people, irrespective of illness or disability, are supported to:

- Live independently.
- Stay health and recover quickly from illness.
- Exercise maximum control over their own life and where appropriate the lives of their family members.
- Sustain a family unit which avoids children being required to take on inappropriate caring roles.
- Participate as active and equal citizens, both economically and socially.
- Have the best possible quality of life, irrespective of illness or disability.
- Retain maximum dignity and respect.

There are five elements of the vision for transformation:

- A major shift of resources and practice to prevention, early intervention and re enablement.
- High quality accessible information and advice available to all irrespective of financial means.
- A commitment to treating carers as partners.
- Maximum power, control and choice in the hands of the people who use these services and their carers.

The final element has the potential to be one of the most radical public service reforms for a generation with an active and empowering state rather than one which is paternalistic, reactive and controlling.

*The Report on the Consultation on the Review of the No Secrets* guidance on developing and implementing multi agency policies and procedures to protect vulnerable adults highlighted the need to continue to work on developing an appropriate balance between choice and risk when introducing the personalisation agenda.

*See Me, Not Just the Dementia (CSCI 2008)*: A report on the experiences of older people with mental health needs who are resident in care homes and the quality of care provided. The focus of the study is whether care is personalised and enhances people’s dignity and respect.

*New Horizons Consultation Document (2009) and New Horizons – Shared Vision for Mental Health (2010)*: The New Horizons consultation document set out the importance of improving the well-being and mental health of individuals and the
population and builds on the progress made through the National Service Framework in the last ten years. It used a lifespan approach, encompassing good mental health in childhood, continued well-being into adulthood, and supporting and maintaining resilience in older age. It identified four key guiding values:

- equality and justice.
- reaching our full potential.
- being in control of our lives.
- valuing relationships.

The following themes are emerging for the work:

- **prevention and public mental health** – recognising the need to prevent as well as treat mental health problems and promote mental health and well-being.
- **stigma** – strengthening our focus on social inclusion and tackling stigma and discrimination wherever they occur.
- **early intervention** – expanding the principle of early intervention to improve long-term outcomes.
- **personalised care** – ensuring that care is based on individuals’ needs and wishes, leading to recovery.
- **multi-agency commissioning / collaboration** – working to achieve a joint approach between local authorities, the NHS and others, mirrored by cross government collaboration.
- **innovation** – seeking out new and dynamic ways to achieve our objectives based on research and new technologies.
- **value for money** – delivering cost-effective and innovative services in a period of recession.
- **strengthening transition** – improving the often difficult transition from child and adolescent mental health services to adult services, for those with continuing needs.

Multi-agency commissioning and collaboration and achieving value for money have been highlighted as effective strategies to tackle these themes.

It is expected that this new phase of reform will bring together key areas of policy, increasingly addressing the mental wellbeing of communities as a whole and strengthening the progress made to date across all age groups. Services will need to be more based around models of recovery and seek to promote positive mental health and wellbeing in a broader public health context.

*Healthcare Commission Report: Equality in Later Life: A National Study of OPMH Services (2009):* Focused on the extent to which statutory services in England were addressing the outcomes for service users and carers around four important themes.

- Age discrimination (focusing on the access to, and quality of, services for adults under and over 65 years).
- Quality of inpatient care (looking at issues associated with risk identified in previous investigations).
- How comprehensive are services? (Compared to national guidance).
- Working with other organisations (how specialist services worked with primary care, adult social services and acute hospitals).
The conclusion was that to improve the outcomes experienced by older people with mental health needs, and to raise the quality of mental health services for older people, actions need to be taken to improve the following key areas:

- Improving the quality and relevance of data
- Whole systems working and commissioning
- Leadership
- Discrimination

**The Use of Antipsychotic medication for people with dementia: A Time For Action (2009):** Reviewed the use of anti-psychotic medication for people with dementia who have behavioural and psychological symptoms. The report reviewed the evidence in relation to the risks and benefits of medication and the usage and availability of non-pharmacological approaches. Eleven key recommendations were made covering:

- Clinical governance audit and review of practice
- Widening the research and evidence base
- Staff training and support particularly in non-pharmacological approaches
- Improving the level of support and quality of care and intervention in care homes
- Support for informal carers
- Improving access to psychological therapies for people with dementia and their carers

**Total Place:** A new initiative that looks at how a “whole area” approach to public services can lead to better services at lower cost. Total Place aims to identify and avoid overlap and duplication between organisations, and to seek new ways of working which will deliver better, more efficient public services.

**The NHS White Paper, Equity and excellence: Liberating the NHS,** sets out the Government's long-term vision for the future of the NHS. It sets out how the Government will:

- put patients at the heart of everything the NHS does;
- focus on continuously improving those things that really matter to patients - the outcome of their healthcare; and
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

The Department of Health’s stated priority objectives from the National Dementia Strategy linked to work on Liberating the NHS are:

- Good quality early diagnosis and intervention for all
- Improved quality of care in general hospitals
- Living well with dementia in care homes
- Reduced use of antipsychotic medication

A number of other publications and consultation documents associated with the NHS White Paper are also available on a range of topics. Of most direct relevance to this Commissioning Framework is **Quality Outcomes for people with dementia: Building on the work of the National Dementia Strategy.** This is a set of nine key outcomes for people with dementia have been proposed that will feed into future
work on outcomes across the NHS (see section 1.4 above for details of each outcome).

2.3. Local Haringey Policies and Guidance

1. Sustainable Community Strategy 2007-2016: The vision for Haringey is “a place for diverse communities that people are proud to belong to”. The priorities are:
   - People at the heart of change
   - And, Haringey will:
     - Have an environmentally sustainable future
     - Have economic vitality and prosperity shared by all
     - Be safer for all
     - Have healthier people with a better quality of life
     - Be people and customer focused

2. NHS Haringey - Strategic Plan 2008-2013: The NHS Haringey Strategic Plan sets out how over the next 5 years the PCT will move from assessing the needs of our population to delivering services that will drive improvements in health outcomes.

The Strategy has 5 goals to be achieved of which the most relevant to this Framework is Goal 3:

We will commission mental health and wellbeing services that are timely, effective, culturally appropriate, provided in the least stigmatising environment and as close to home as possible. This will be delivered through the following initiatives:

- Improving Children and Young people’s mental health.
- Increasing access to Psychological Therapies for adults.
- Developing a more effective model of care.

3. NHS Haringey – Developing World Class Primary Care Strategy:

NHS Haringey has developed a strategy to address the issues of quality, accessibility, equity and integration of services in primary care. Included in the proposals are plans to develop Poly-systems to provide GP services, community health services, diagnostic testing and healthy living support services supported by Locality Commissioning Plans. There are implications and opportunities for the delivery of older peoples mental health and dementia services within this strategy.

4. Barnet, Enfield and Haringey Clinical Strategy: Currently in a public consultation period this strategy proposes options for a major re-organisation of emergency care, unplanned and elective care across the acute hospital system within the three boroughs. Whilst largely about district general hospital care, there are potential implications for the commissioning of emergency/liaison mental health services in both A&E and within general hospital inpatient care.

5. Haringey’s Council Plan 2007-2010: The Council Plan outlines how the Council will contribute to Haringey’s Sustainable Community Strategy and further improve its services to meet the needs of Haringey’s residents. The priorities are:
   - A Greener Haringey
• A Better Haringey
• A Thriving Haringey
• A Caring Haringey
• Driving Change, Improving Quality

6. **Haringey's Well-being Strategic Framework, (WBSF):** Was adopted at the Well-being Partnership Board (WBPB) meeting on 22 October 2007. This Well-being Strategic Framework identifies the strategic priorities for improving well-being in Haringey. It identifies priorities for the three-year period from 2007-2010 and lays the foundation for rethinking our approach to promoting well-being in Haringey. It incorporates priorities from existing plans and strategies to bring together the diverse initiatives taking place to improve well-being in the borough.

Based on the seven *Our Health Our Care Our Say* (OHOCOS) outcomes, its objectives, priorities, actions and targets are linked to each OHOCOS outcome to aid strategic direction towards the prevention agenda and delivering local well-being outcomes. The aim of the Framework is: To promote a healthier Haringey by improving well-being and tackling inequalities.

The vision for Haringey by 2010 is that: All people in Haringey have the best possible chance of an enjoyable, long and healthy life.

<table>
<thead>
<tr>
<th>No.</th>
<th>Outcome</th>
<th>Objective</th>
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<tbody>
<tr>
<td>1</td>
<td>Improved health and emotional well-being</td>
<td>To promote healthy living and reduce health inequalities in Haringey</td>
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<tr>
<td>2</td>
<td>Improved quality of life</td>
<td>To promote opportunities for leisure, socialising and life long learning, and to ensure that people are able to get out and about and feel safe and confident inside and outside their homes</td>
</tr>
<tr>
<td>3</td>
<td>Making a positive contribution</td>
<td>To encourage opportunities for active living including getting involved, influencing decisions and volunteering</td>
</tr>
<tr>
<td>4</td>
<td>Increased choice and control</td>
<td>To enable people to live independently, exercising choice and control over their lives</td>
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<tr>
<td>5</td>
<td>Freedom from discrimination or harassment</td>
<td>To ensure equitable access to services and freedom from discrimination or harassment</td>
</tr>
<tr>
<td>6</td>
<td>Economic well-being</td>
<td>To create opportunities for employment and to enable people to maximise their income and secure accommodation which meets their needs</td>
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<tr>
<td>7</td>
<td>Maintaining personal dignity and respect</td>
<td>To ensure good quality, culturally appropriate personal care and prevent abuse of service users occurring wherever possible and to deal with it appropriately and effectively if it does occur</td>
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The strategy covers all aspects of older people’s lives represented by the ten goals set out below. Priorities to achieve each of these goals have been identified for the period 2009-2012.

1. **Being respected:** To ensure that older people are respected and valued.
2. **Keeping informed:** To ensure that older people have accurate information on which to base their decisions.
3. **Staying healthy:** To promote healthy living.
4. **Being active**: To create opportunities for being active including getting involved, volunteering, socialising and life-long learning.

5. **Choosing work**: To create opportunities for employment.

6. **Feeling safer**: To create safer communities.

7. **Having a safe, comfortable and well-maintained home**: To ensure that older people have a safe, comfortable and well-maintained home (and garden) which meets their needs.

8. **Living with support**: To enable older people to live independently with support for as long as possible in their own homes.

9. **Getting out and about**: To ensure that older people are able to get out and about, including being able to use public transport.

10. **Making the most of your income**: To enable older people to maximise their income.

A key priority under Goal 3 (staying healthy – to promote healthy living) is to strengthen mental health services for older people by developing an older peoples mental health strategy.

8. **Haringey Carers Strategy (2009-14)**:

The aims of the Haringey Carers Strategy are:

- to identify and support Haringey’s unpaid carers in their caring role and in their life apart from caring.
- to provide culturally appropriate support for all Haringey’s diverse carers throughout their caring lives.
- to involve Haringey carers in all developments affecting them and the people they care for.
- to ensure that all partners to the strategy work together effectively to support carers.

There are four key outcomes from the National Carers Strategy that Haringey has aligned its objectives to:

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

9. **Moving Forward – Haringey’s Joint Mental Health Strategy 2010-2013**

Describes the specific key priorities and commissioning intentions for the next three years. The Strategies vision is to improve the mental health and wellbeing of the people living in Haringey by ensuring that comprehensive, integrated and personalised services are commissioned which:

- Support people in maintaining and developing good mental health and wellbeing.
- Give people the maximum support to live full, positive lives when they are dealing with mental health problems.
- Help people to recover as quickly as possible from mental illness.

The key themes underpinning this vision are:
- Personalised care, prevention, wellbeing and access.
- Commissioning world class acute mental health services with more community based care.
- Ensuring the right accommodation at the right time.

10. *End of Life Care for People with Dementia (2009)*
This is a report on the assessment of the end of life care for people with dementia in Haringey led by Marie Curie Cancer Care and supported by a strong partnership with NHS Haringey, Haringey Council, Barnet Enfield and Haringey Mental Health Trust (BEH-MHT) and third sector agencies. The report makes a number of key recommendations around the following themes:
- Pathways of care.
- Impact of hospitalisation.
- Financial implications.
- Advanced Care Planning.
- Impact of Carers.
- Staff skills and training.

11. *Barnet Enfield and Haringey Mental Health Trust Draft Dementia Strategy.*
sets out how BEH Mental Health Trust will respond to the challenges set by the National Dementia Strategy (NDS) for our local population. The focus of the strategy is on two of the three themes in the NDS; early diagnosis and support and living well with dementia. The third theme of raising public awareness is being addressed with a national campaign, though there will be local initiatives. As the consultation continues and engagement with other partners in the delivery and commissioning of services grows the draft Strategy will evolve and develop over time.

2.4. Connections to other Haringey strategies
This Commissioning Framework comes under the Haringey Strategic Partnership (HSP) and as such reflects the six key outcomes of the HSP and its *Sustainable Communities Strategy* the priorities are covered on page 13.

As this Commissioning framework is directly related to the health and wellbeing of the community it will also reflect the aims goals and outcomes of the following:

<table>
<thead>
<tr>
<th>Haringey Wellbeing Strategic Framework:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim:</strong> To promote a healthier Haringey by improving well-being and tackling inequalities.</td>
</tr>
<tr>
<td><strong>Vision:</strong> All people in Haringey have the best possible chance of an enjoyable, long and healthy life.</td>
</tr>
<tr>
<td><strong>Outcomes for improving well-being:</strong></td>
</tr>
<tr>
<td>- Improved health and emotional well-being.</td>
</tr>
<tr>
<td>- Improved quality of life.</td>
</tr>
<tr>
<td>- Making a positive contribution.</td>
</tr>
<tr>
<td>- Increased choice and control.</td>
</tr>
<tr>
<td>- Freedom from discrimination or harassment.</td>
</tr>
<tr>
<td>- Economic well-being.</td>
</tr>
</tbody>
</table>
• Maintaining personal dignity and respect.

Haringey Council priorities:

- A Greener Haringey.
- A Better Haringey.
- A Thriving Haringey.
- A Caring Haringey.
- Driving change, improving quality.

NHS Haringey’s Strategic Plan:

<table>
<thead>
<tr>
<th>Strategic objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve the overall health and wellbeing of our population.</td>
</tr>
<tr>
<td>To improve health outcomes for local people.</td>
</tr>
<tr>
<td>To improve life expectancy of our population and to tackle the significant</td>
</tr>
<tr>
<td>health inequalities that exist between communities in Haringey.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Five local goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Communities.</td>
</tr>
<tr>
<td>Safe and healthy starts for children and young people.</td>
</tr>
<tr>
<td>Good mental health and well being for all.</td>
</tr>
<tr>
<td>Preventing and managing Long Term Conditions.</td>
</tr>
<tr>
<td>World Class Primary Care.</td>
</tr>
</tbody>
</table>

2.5. Key Themes of national and local guidance

The key themes of recent policy relevant to the development of this strategy include:

- Promoting social inclusion and well-being.
- Embedding service user and carer involvement into the planning and delivery of services.
- That services provided will reflect the full diversity of the community served in Haringey and will promote equality of access for everyone.
- Empowering people to have greater influence over services through a stronger voice and greater choice and control.
- Developing community resources.
- Responding to people on the basis of need, not age.
- Delivering holistic, person-centred health and care services that address mental as well as physical health needs.
- Developing sustainable preventative services.
- Involving local authorities, NHS and other agencies, including the voluntary sector and independent providers in the provision of resources.
- Developing local leadership.

3. POPULATION DATA AND FUTURE DEMAND

All the population data and future projections in this Commissioning Framework, unless otherwise specified, are taken directly from the Older Peoples Needs
Assessment (Phase One) which forms part of the Joint Strategic Needs Assessment (JSNA). Phase Two of the Older Peoples Needs Assessment, to be published in Spring 2011, will feed directly into this Commissioning Framework as will the work on the Adults Mental Health Needs Assessment. As the JSNA is reviewed and updated the data and projections in this Commissioning Framework must be reviewed to ensure that the most accurate and up to date figures are being used. It is also important to note that different sources of demographic information will give slightly different data (e.g. Office of National Statistics and Greater London Authority), both are referred to ensure that planning future services takes into account the varying projections.

For a detailed analysis of the population of Haringey please refer to the Joint Strategic Needs Assessment.

3.1. Haringey’s demographic profile

**Haringey general demographic data:**

Haringey has a population of 226,200 (2008 Mid year estimates). In 2008, it was estimated there were 20,800 people aged 65+. Approximately 9.2% of the total population in 2006 were over the age of 65, of this number, 43.27% (9,000) were male and 56.25% (11,700) were female (2006 Mid-Year Population Estimates, POPPI).

The population of Haringey is expected to increase in age over the next 25 years (from 2008) to 24,200 people aged 65 and over. According to population projections, the 85+ age group will increase as a percentage of the population of older people in Haringey between 2008 and 2025 rising to 13% of all older people (3,146). Based on the Office of National Statistics sub-national population projections (SNPP) the population of Haringey is expected to increase in age to 28,300 people aged 65 and over (11.4% of total population) in the year 2031. The 85+ age group is also expected to increase as a percentage of the total population from 2,400 (1.06%) in 2008 to 3,600 (1.44%) in 2031. The 85+ age group is expected to increase as a proportion of older people (65+) from 11.4% in 2008 to 12.7% in 2031.

An alternative source of population estimates and projections is the Greater London Authority, which takes into account future developments like housing build. The GLA series has higher overall population estimates and projections for Haringey than the ONS series; however the proportions for the older age groups are smaller.

In 2008, Haringey was estimated to have a population of 234,439 (2009 GLA). There were 19,967 people aged 65+, approximately 8.5% of the total population (2009 GLA). Of this number 56.4% (11,295) were female and 43.6% (8,708) were male.

Based on GLA projections the population of Haringey is expected to increase in age over the next 23 years to 24,557 people aged 65+ (9% of the total population) in the year 2031. The 85+ age group is expected to increase only slightly as a percentage of the total population from 1,524 (0.65%) in 2008 to 2,122 (0.77%) in 2031.
About half of Haringey’s total population is from Black and Minority Ethnic (BME) groups. This includes a high proportion of asylum seekers and refugees. An estimated 193 languages are spoken in the borough. There are a greater number of people who classify themselves as White in the more affluent west of the borough, while Black African and Black Caribbean communities are concentrated in the less affluent east. Residents of Asian origin are concentrated in the middle of the borough. Over 50% of older residents in wards on the eastern perimeter of Haringey are classified as non-British.

Greater London Authority projections estimate the proportion of people aged 50 and over from BME groups in Haringey will grow from 25% in 2001 to approximately 32.2% by 2011. This represents an increase of 19% in the proportion of older people from BME groups. Conversely, the proportion of older people who are of White Ethnic origin is expected to fall from 75% in 2001 to 68.8% in 2011. This represents a fall of 7% in the proportion of older people who are of White Ethnic origin.

Older people can have a much greater need for health services than the young and experience a greater burden of illness than the young. The incidence of many diseases increases with age, particularly chronic diseases such as heart disease, cancers and diabetes. As people age, they have a greater chance of acquiring disabling conditions which will affect their ability to live independently. 39% of adults aged over 55 in Haringey reported a limiting long-term illness (confidence interval 18-59%) compared with 8% of those aged 16-34 and 12% of those aged 35-54 years.

It is predicted that, by 2025, 12,135 residents of Haringey aged 65 and over will be living with a limiting long-term illness; this will be approximately 75% of the 65+ population.

| People aged 65 and over with a limiting long-term illness projected to 2025 |
|-------------------------------------------------|-------|-------|-------|-------|-------|
|                                                 | 2008  | 2010  | 2015  | 2020  | 2025  |
| People aged 65-74 with a limiting long term illness | 5,186 | 5,097 | 5,186 | 5,499 | 5,991 |
| People aged 75 - 84 with a limiting long term illness | 3,794 | 3,849 | 4,123 | 3,959 | 4,178 |
| People aged 85 and over with a limiting long term illness | 1,413 | 1,413 | 1,474 | 1,720 | 1,966 |
| Total population aged 65 and over with a limiting long term illness | 10,393 | 10,359 | 10,783 | 11,178 | 12,135 |

Unpaid Carers:
In terms of the provision of unpaid care, there are no significant differences between older people in Haringey and older people in London and England. Thirteen per cent of older people in Haringey provide unpaid care which is slightly lower than the figures for London (14%) and England (16%).

It is estimated that there are approximately 16,000 unpaid carers in Haringey. All figures given for the number of unpaid carers are likely to be underestimates.
Carers of pensionable age are overwhelmingly White British irrespective of the number of hours of care they provide. They make up 61% of carers providing 1-19 hours of unpaid care. Speculatively, these may be individuals beginning to care for spouses. They make up 57% of carers providing 'heavy end' care (50+ hours per week). In overall terms, White Other make up 16% of the Haringey population and 14% of carers. (White Other is not broken down here; it includes Greek/Cypriot, Turkish/ Cypriot, Turkish, Kurdish as well as White Commonwealth, other European Union and Eastern European). It may be that the increase reflects an ageing population in settled groups and, possibly, spouses caring for spouses. The figure drops back to White Other groups making up 15.5% of carers of pensionable age providing 50+ hours.

**Older Peoples Mental Health in Haringey:**
The prevalence of common mental illness in Haringey may be even higher than some predictions suggest as Haringey is the 18th most deprived borough in England and the 5th most deprived borough in London. Psychiatric morbidity (including anxiety, depression, schizophrenia and psychotic disorders) is known to be associated with social deprivation. Social deprivation is also known to result in longer duration of illness episode, higher risk of relapse, poorer treatment response and clinical outcome.

Housing and homelessness is an important determinant of mental health. Higher prevalence of mental illness has been found in homeless people or in people in insecure accommodation. Haringey has one of the highest rates of people living in temporary accommodation in the country.

There is evidence that refugees are especially vulnerable to psychiatric disorders including depression, suicidality and post-traumatic stress disorder. It is estimated that between 25,000 and 30,000 refugees and asylum seekers live in Haringey. This group also has more complex needs and often have more difficulty accessing health services than the general population.

Patterns of prevalence of mental illness vary across different ethnic communities and evidence is hampered by smaller sample sizes in minority communities. There is evidence that people of Black Caribbean ethnic origin are at higher risk of being admitted to psychiatric hospital than people of white ethnic origin. The Greater London Authority predict that 8.3% of Haringey residents were of Black Caribbean origin in 2005. This proportion is higher than that predicted for London and nationally.

**3.2. Dementia**

*Prevalence projections of levels of dementia in people over 65 in Haringey:*
Nationally, it is accepted that one quarter of people aged 85 and over will develop dementia (Audit Commission’s ‘Forget Me Not’ report). Projected dementia figures are set out in Table 10 below. 6.29% of Haringey’s 65+ population was estimated to suffer from dementia in 2008; of these, 35% are men and 65% women. This compares with an overall male population in 2008 of 43.27%, and, of women aged 65+, 56.25%. It should be noted that one of the strands of the Department of Health’s national strategy Transforming the Quality of Dementia Care is to ensure that the condition is diagnosed as early as possible to allow for
early intervention which will have an impact on levels of need, support and treatment.

<table>
<thead>
<tr>
<th>People aged 65 and over predicted to have a dementia projected to 2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total males aged 65 and over predicted to have dementia</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Total males aged 65 and over predicted to have dementia</td>
</tr>
<tr>
<td>Total females aged 65 and over predicted to have dementia</td>
</tr>
<tr>
<td>Total population aged 65 and over predicted to have dementia</td>
</tr>
</tbody>
</table>

Severity of dementia in older people:
Using the prevalence figures above the table below gives the likely breakdown of people with mild, moderate and severe dementia.

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild (55.4%)</td>
<td>725</td>
<td>899</td>
</tr>
<tr>
<td>Moderate (32.1%)</td>
<td>420</td>
<td>521</td>
</tr>
<tr>
<td>Severe (12.5%)</td>
<td>164</td>
<td>203</td>
</tr>
</tbody>
</table>

Prevalence projections of levels of dementia in people under 65 in Haringey:
Alzheimer’s Disease (30%) is the commonest cause of early onset dementia in the under 65 age group followed by Vascular dementia (15%), Frontal Temporal lobe degeneration (13%) and Alcohol related dementia (12%) iii.

It is estimated that between 67\(^{iv}\) and 81\(^{v}\) people per 100,000 in the 35 to 64 age group will have young onset dementia. This suggests that there will be about 74 people in Haringey with young onset dementia in 2008, based on the best guide available. This is likely to be an underestimation of the numbers as the figures are not adjusted for demographic data such as the increased prevalence of vascular dementia in this age group in Haringey in comparison to the total population of England.

People with learning disabilities and dementia:
About 20 per cent of people with a learning disability have Down’s syndrome; people with Down’s syndrome are at particular risk of developing dementia. Figures from one study suggest that the following percentages of people with Down’s syndrome have dementia:

- 30-39 years 2 per cent
- 40-49 years 9.4 per cent
- 50-59 years 36.1 per cent
- 60-69 years 54.5 per cent

The prevalence of dementia in people with other forms of learning disability is also higher than in the general population. Some studies (according to the Alzheimer’s Society Fact Sheet on learning disabilities and dementia) suggest that the following percentages of people with learning disabilities not due to Down’s syndrome have dementia:

- 50 years and over: 13 per cent
- 65 years and over: 22 per cent
This is about four times higher than in the general population.

*Healthcare for London Needs Assessment Data:*  
The Healthcare for London Dementia Services Guide included a London wide needs assessment; the following are extracts of this work relating to Haringey:

Numbers of places in homes registered in Haringey to take older people with dementia per 100 people aged 65 and over in 2005-06: (Source: Commission for Social Care Inspection data quoted in Dementia UK 2007).
- Number of places in Haringey per 100 aged 65+ = 1.5

Numbers of people with dementia recorded on GP registers compared to estimated prevalence in Haringey, 2007/08 (Source: QoF 2007/08 and prevalence derived from ‘Dementia UK’ rates.)
- Number of people with dementia recorded on QoF 2007-08 = 552
- Estimated total number of people with dementia 2007 = 1330
- QoF recorded dementia as a % of estimated prevalence = 39%

Numbers of people in Haringey with dementia reviewed in primary care in relation to those eligible to be reviewed: (Source: QoF 2007/08)
- Number of people with dementia whose care has been reviewed in the previous 15 months = 404
- Number of people eligible to be reviewed on GP register = 482
- % of people with dementia reviewed against those eligible to be reviewed = 84%
- % of people with dementia reviewed (with exceptions not excluded) = 77%

Numbers of older people (65+) receiving social care for mental health problems compared to estimated prevalence of late onset dementia in Haringey: (2007 Source: DH return RAP P1.1c 2007/08)
- Number of people aged 65+ receiving social care for mental health problems = 410
- Estimated prevalence of late onset dementia = 1289
- Social care users as a % of estimated late onset dementia prevalence = 32%

### 3.3. Demand analysis for personal social care services

The concept of intervals of care offers the opportunity to project the care needs of people with dementia in Haringey. The table below gives the data projections using the estimated number of people over 65 with dementia in Haringey:

<table>
<thead>
<tr>
<th>Care interval description</th>
<th>Requirement</th>
<th>Proportion</th>
<th>Number of people in Haringey (65+) 2008</th>
<th>Number of people in Haringey (65+) 2025</th>
<th>% in Care Home</th>
<th>% Living in own home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical (critical interval)</td>
<td>Constant care or supervision needed</td>
<td>34%</td>
<td>445</td>
<td>552</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Substantial (short interval)</td>
<td>Care needed at regular intervals during the day</td>
<td>48%</td>
<td>628</td>
<td>779</td>
<td>33%</td>
<td>66%</td>
</tr>
<tr>
<td>Moderate (long interval)</td>
<td>Care needed once a week</td>
<td>11%</td>
<td>144</td>
<td>179</td>
<td>26%</td>
<td>74%</td>
</tr>
<tr>
<td>Low (independent)</td>
<td>Care considered</td>
<td>6%</td>
<td>79</td>
<td>97</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Using the care interval projections (based on 2008 mid year data) the following estimates of likely demand for different services can be made:

<table>
<thead>
<tr>
<th>Service required</th>
<th>Method of calculation</th>
<th>Projected maximum number needing service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Homes</td>
<td>Total of each care interval estimated to be in care home</td>
<td>470</td>
</tr>
<tr>
<td>Intensive specialist domiciliary care support up to 3 x daily</td>
<td>Critical + substantial</td>
<td>640</td>
</tr>
<tr>
<td>Home Care packages once a day</td>
<td>Moderate</td>
<td>107</td>
</tr>
<tr>
<td>Day care or day activities</td>
<td>50% of all those living at home in moderate and substantial</td>
<td>263</td>
</tr>
<tr>
<td>Carers support services e.g. carers breaks</td>
<td>50% of all those living at home in all care intervals</td>
<td>413</td>
</tr>
</tbody>
</table>

NOTES:
- All figures and %’s are based on estimates
- The model is intended as a guide only and will need to be refined over time using improved activity data collection.

3.4. Functional Mental Health problems

Depression:
Key facts about depression in older people:
- Depression is three times more common in older people than dementia\(^{viii}\).
- It increases in prevalence in people over 65 especially for those living alone with poor material circumstances\(^x\).
- Co-morbid depression incrementally worsens health status more than depression alone or any combination of chronic diseases without depression in older people\(^x\).
- The World Health Organisation predicts that depression will be the second highest cause of health burden by 2020.
- Depression in later life is a major risk factor in increased suicide, increased levels of natural mortality and impairment of independent function which necessitates need for long term care\(^xi\).
- Treatment of depression in older people has a similar level of efficacy as for younger people\(^xi\).
- Only 1 in 6 older people with depression get treatment vs. 50% of younger people with depression are referred to mental health services\(^xiii\).
- Up to 50% of older people in care homes have clinically severe depression and only 10-15% get treatment\(^xiv\).
- Up to 70% of acute general inpatients beds are occupied by people over 65 and around 30% of these patients also have depression\(^xv\).
- Older people are at greater risk of sudden onset of depressive symptoms after recovery from a manic episode\(^xvi\).

Prevalence projections of levels depression in Haringey in over the 65’s age group:
Haringey has one of the highest mental health admission rates in London, particularly in the east of the borough. Nationally, research has shown that older people are more likely to blame their depression on events or social circumstances, for example, in the years after retirement when people may
struggle to adjust to a new role and routine in life, and later factors which may include chronic illness, frequent loss of peers and friends and increasing restrictions on mobility. Conditions that can lead to depression in older people include heart problems, low thyroid activity (hypothyroidism), vitamin B12 or folic acid deficiency and cancer. Many drugs also cause, aggravate or trigger depression, including beta-blockers, blood pressure drugs, and heart drugs such as digoxin, steroids and sedatives. Depression often occurs after a stroke and effective treatment may be critical to restoring normal abilities. Studies have shown that it can take longer for older people to respond to treatment. Dealing with social isolation is another important part of treating depression and the health benefits of being part of a family or tight community are well-known.

<table>
<thead>
<tr>
<th>People aged 65 and over predicted to have depression, projected to 2025</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>People aged 65 and over predicted to have depression: LOWEST estimated level of prediction</td>
</tr>
<tr>
<td>2008</td>
</tr>
<tr>
<td>2,080</td>
</tr>
<tr>
<td>People aged 65 and over predicted to have depression: HIGHEST estimated level of prediction</td>
</tr>
<tr>
<td>3,120</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People aged 65 and over predicted to have severe depression, projected to 2025</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>People aged 65 and over predicted to have severe depression: LOWEST estimated level of prediction</td>
</tr>
<tr>
<td>2008</td>
</tr>
<tr>
<td>624</td>
</tr>
<tr>
<td>People aged 65 and over predicted to have severe depression: HIGHEST estimated level of prediction</td>
</tr>
<tr>
<td>1,040</td>
</tr>
</tbody>
</table>

**Suicide:**

*Key facts about suicide and self harm in older people:*

- Whilst suicide rates are declining for all age groups the rate for people over 65 is double that in younger people under 25\textsuperscript{xvii}.
- 80% of people over 75 who commit suicide have depression\textsuperscript{xviii}.
- The risk of completed suicide after self harm is much higher in older people\textsuperscript{xix}.
- In 2006 the national prevalence of suicide in over 65’s was 8.14 per 100,000 population\textsuperscript{xx} which is double that of people under 25.

Analysis of suicides in Haringey between 2001 and 2004 shows that an average of 35 Haringey residents commit suicide each year - approximately 50% higher than the national average. Around three-quarters of people who committed suicide in Haringey had no contact with mental health services in the previous 12 months\textsuperscript{xxi}.

**Psychosis:**

*Key facts about psychosis in older people:*

- Psychosis is more common in older than younger people: 20% of over 65’s develop psychotic symptoms by the age of 85, most of which are not precursors to dementia\textsuperscript{xxii}.
- Whist schizophrenia beginning in earlier life is more common, the annual incidence of late onset schizophrenic-like psychosis increases by 11% with each 5 year increase from age 60 and up\textsuperscript{xxii}.
- A study of people aged 95 and above without dementia revealed that 2.4% met the criteria for the diagnosis of schizophrenia, prevalence higher than that in younger people\textsuperscript{xxiv}.

**Alcohol and Substance misuse:**

*Key facts for older people:*
- Alcohol usage generally declines with age but misuse/dependence on alcohol still affects circa 2-4% of older people and there is evidence that older people need different definitions, diagnosis and treatment to younger people\textsuperscript{xxv}.
- Although illicit drug use is predominantly a condition affecting younger people there is a predicted increase in older people needing treatment for substance misuse by virtue of ageing based on figures emerging from America\textsuperscript{xxvi}.

3.5. Data from J SNA Needs Assessment for Mental Health

The Care Services Improvement Partnership developed a tool to estimate common mental illness based on data from the Office of National Statistics Psychiatric Morbidity Survey. The table below describes how these figures relate to the Haringey population:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Estimated Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed anxiety and depressive disorder</td>
<td>15,547</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>7,565</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>4,475</td>
</tr>
<tr>
<td>All phobias</td>
<td>3,173</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>2,022</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>1,202</td>
</tr>
<tr>
<td>Total</td>
<td>28,757</td>
</tr>
</tbody>
</table>

**NOTE:** The figures only relate to people aged 16 – 74 therefore people aged 75 and above are not included in the data. Figures are expected to be even higher due to the demographic mix.

3.6. Dementia Metrics

As part of the National and Regional support for the implementation of the National Dementia Strategy a set of dementia metrics (or measures) has been developed as a way of measuring the progress being made on the implementation of four of the seven priority objectives from the National Dementia Strategy.

**Objective 2:** Good-quality early diagnosis and intervention for all
**Objective 6:** Improved community personal support services
**Objective 8:** Improved quality of care for people with dementia in general hospitals
**Objective 11:** Living well with dementia in care homes
The purpose of the metrics is to create a base line measure for each objective which will be a starting point for discussion about local and national effectiveness and highlight gaps in data sets and services.

3.7. Population and future demand summary and recommendations

It is clear from the data described in the preceding sections that the likely demand for mental health services for older people and people with dementia will grow in the future. Whilst there will be a significant focus on early intervention and prevention work it is vital that commissioners and providers of services have a good understanding of current and future trends and demands for support and services. The work on data collection and gaining a better understanding of the mental health needs of the local population is developing well within Haringey via the Joint Strategic Needs Assessment (JSNA) project. There are however still a number of gaps in our understanding and knowledge of the mental health needs of the local population in this context the following recommendations for future action are made.

**Recommendations for action:**

<table>
<thead>
<tr>
<th>Recommendation 1: Needs assessment and data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R 1.1</strong> Improve the coordination and production of population and needs data across the JSNA projects for Older People and Mental Health services</td>
</tr>
<tr>
<td>The Older Peoples Mental Health Steering Group to ensure that there is a high level of communication and coordination between the Phase Two JSNA projects in Older Peoples and Mental Health services and the Steering Group to ensure i. that there are jointly agreed common data sets (based on NDS Joint Commissioning Framework for dementia) and ii. that priority areas for further data collection in older peoples mental health and dementia services are included in future work including the use of the developing national dementia metrics</td>
</tr>
<tr>
<td><strong>R 1.2</strong> Compare numbers of people with dementia known to services against prevalence data - annually.</td>
</tr>
<tr>
<td>The Older Peoples Mental Health Steering Group will conduct an annual matching exercise across health, social care and third sector services (where appropriate) to establish the number of people, with dementia known to dementia services; and match data collected against the Primary Care Quality Outcomes Framework / GP Dementia Registers and projected prevalence data</td>
</tr>
</tbody>
</table>

4. MARKET ANALYSIS

4.1. Background

The majority of older people with functional mental health problems and people with dementia will receive services from mainstream settings as well as accessing specialist mental health and dementia services. This section on the market will focus primarily on these specialist services creating a map of existing services. There are limitations as the analysis of current services does not assess the quality of service provision or the outcomes for older people with mental health needs. This work will need more detail in the future and will develop from the implementation of the personalisation agenda and the associated market management strategy.
4.2. Integrated health and social care services

**Specialist Community Mental Health Teams for Older People (CMHT’s):**

There are two CMHT’s for older people covering East and West Haringey. The team members are based at St Ann’s Hospital site. Since May 2008 the CMHT’s have been integrated between Barnet Enfield and Haringey Mental Health Trust (BEH-MHT) and Haringey Council’s Adult Care Services, with care managers’ moving into the CMHT offices. The CMHT operates under a joint Operational Policy and has a single point of entry into all services within the Mental Health Service for Older People within BEH-MHT.

4.3. Health services – Barnet Enfield and Haringey MHT

**Inpatient Services:**

There are two older people’s mental health wards on the St Ann’s Hospital site which are accessed via the relevant Consultant Psychiatrist. Cedar Ward is a 16-bed (6 male, 8 female and 2 flexi beds) acute admission ward for patients with functional and organic mental health problems. This ward admits patients from Haringey. Beech Ward is a 17-bed (7 male, 8 female and 1 flexi beds) continuing care facility.

**Day Hospital:**

The Victoria Day Unit (VDU) provides day hospital care for up to 15 patients per day with both functional and organic mental health problems. Patients usually attend 2 or 3 days a week but may be offered up to 5 days per week if needed. It operates between 9am to 5pm, Monday to Friday.

A broad range of individual and group therapy are offered. The VDU has an important intermediate care function in preventing admission and facilitating discharge from hospital.

**Memory Assessment Service:**

Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT) provides a Memory Assessment Service, based within the Older People’s Community Mental Health Teams (CMHT), and a treatment service for people diagnosed with dementia. Referral to the Memory Service follows an initial assessment or referral screen by the CMHT. There is currently a part-time consultant psychiatrist and a nurse who assess people with a diagnosis of dementia in the Memory Service. People continue to attend the Memory Service if they are receiving drug treatment or if their memory problems are being monitored for any reason.

The service works closely with the Admiral Nurse Service and the Alzheimer’s Society and is based at St Ann’s Hospital. Plans are being developed to extend the Memory Assessment Service to operate at Hornsey Central site.

**Older Adults Psychology Service:**

The Psychology department work with individuals, their families and carers. Clinical Psychologist’s also provide clinical input and organisational support (e.g. staff supervision groups) to the CMHT’s, inpatient, day hospital and the Memory Assessment Service. The department operate an open referral system.
**Occupational Therapy:**
The Occupational Therapy team work with older people who have a mental health problem affecting their ability to function in everyday activities. The team work as part of a multidisciplinary team across inpatient, day hospital and community mental health teams providing assessment, advice, training and treatments in individual or group formats.

**Speech and Language Therapy:**
The Speech and Language Therapist (SLT) provides assessment, differential diagnosis, advice and consultative support to older people with dementias and other mental health conditions where there is a related neurological impairment affecting their swallowing or communication. Referrals will also be accepted for those under 65 with mental health disorders where there is a neurologically related swallowing or communication difficulty. The SLT service is provided to the community, inpatient wards and day hospital. Individual and group work is carried out, as well as training to carers and other professionals.

**Physiotherapy:**
The Physiotherapy department provide assessment and treatment to patients across the inpatient wards and the Victoria Day Unit. They lead on exercise groups at the VDU and Cedar Ward and provide individual therapy for treatment of mobility and respiratory problems.

**Music Therapy:**
The practice of music therapy focuses upon unplanned live music making, generally using free improvisation. The process of making music together forms a therapeutic relationship between the therapist and the client. Sessions take place at the same time each week with accessible and culturally appropriate instruments being used. The work mostly takes place within group settings, but referrals for individual work and assessments are welcome. Please contact us to make a referral or to discuss a particular patient’s needs.

4.4. Social care services provided or commissioned by Haringey Council

**Social Care Day Centres:**
There are two established Council-run specialist Day Centres for older people with mental health problems. The Grange provides a service to people with dementia and challenging behaviour (15 places/day and up to 10 each day at weekends). It works with the Alzheimer’s Society since its inception. Woodside Day Centre (24 places/day) provides a service to older people with both functional and organic mental health problems, including early stage dementia. Both centres have service-based transport, with driver/support workers and escorts as part of the local teams.

A further 20 place day centre for people with dementia, the Haynes Centre, has been jointly developed with NHS Haringey and a local voluntary organisation (which has provided significant capital funding) on the Hornsey Central site.
Community Alarm/Telecare services
There are currently some 4,500 users of the Council’s Community Alarm (CA) service. The CA service is a full-response service which operates 24/7, 365 days/year, sending out staff to deal with emergency situations in the community when called. The CA service uses IT systems to provide a platform for a Telecare remote monitoring service to some 200 users – a high proportion of who have a degree of dementia or other mental health problems. In addition the Telecare Service has run a successful pilot for advanced Telecare services for people with dementia using a door sensor linked to the CA service to prevent wandering. A pilot is planned for February 2010 trialling GPS tracking and plans are in hand to pilot a telecare medicines management service in 2010.

Reablement services
The Council’s Reablement service provides specific support to people leaving hospital, to support them with regaining as much independence as possible. This does include working people with dementia where it is appropriate to do so. All staff have basic training in dementia and the majority are trained to NVQ 2 in care level. Long term Personal Care Services are also provided to people with dementia from a range of externally provided agencies.

Nursing Care Home:
There is one in-house nursing care home that provides a specific service for people with dementia – Osborne Grove. This home has 32 beds in total with a mixture of dementia nursing care and standard nursing care provided.

In addition Haringey has a number of external registered residential and nursing care homes that cater for older people with dementia or other mental health issues.

Private Residential care homes:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Capacity</th>
<th>Acceptance Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brownlow House</td>
<td>4 Princes Avenue, London, N10 3LR</td>
<td>24</td>
<td>Care home only ( Dementia - over 65 years of age + Mental health, excluding learning disability or dementia - over 65 years of age + old age, not falling within any other category )</td>
</tr>
<tr>
<td>Ernest Dene Residential Care Home</td>
<td>8-12 Donovan Avenue, Muswell Hill, London, N10 2JX</td>
<td>33</td>
<td>Care home only ( dementia + mental health, excluding learning disability or dementia + old age, not falling within any other category )</td>
</tr>
<tr>
<td>Meadow, The</td>
<td>Meadow Drive, Muswell Hill, London, N10 1PL</td>
<td>40</td>
<td>Care home only ( physical disability + dementia + mental health, excluding learning disability or dementia + old age, not falling within any other category )</td>
</tr>
<tr>
<td>Morriss House</td>
<td>23 Coolhurst Road, London, N8 8EP</td>
<td>25</td>
<td>Care home only ( Physical disability over 65 years of age + Dementia - over 65 years of age + Mental health, excluding learning disability or dementia - over 65 years of age + old age, not falling within any other category )</td>
</tr>
<tr>
<td>Nightingale House</td>
<td>22 Elgin Road, London, N22 7UE</td>
<td>9</td>
<td>Care home only ( old age, not falling within any other category + Physical disability + Physical disability over 65 years of age + Dementia - over 65 years of age + mental health, excluding learning disability or dementia - over 65 years of age + old age, not falling within any other category )</td>
</tr>
</tbody>
</table>
Dementia + Mental health, excluding learning disability or dementia - over 65 years of age

<table>
<thead>
<tr>
<th>Peregrine House, 350 Hermitage Road, South Tottenham, London, N15 5RE - total capacity 35 places</th>
<th>Care home only ( Physical disability over 65 years of age + Mental health, excluding learning disability or dementia - over 65 years of age + old age, not falling within any other category + physical disability )</th>
</tr>
</thead>
</table>

| Spring Lane Care Home, Spring Lane Care Home, 170 Fortis Green, Muswell Hill, London, N10 3PA - total capacity 63 places | Care home only ( Dementia - over 65 years of age + old age, not falling within any other category + physical disability ) |

**Private Nursing care homes:**

<table>
<thead>
<tr>
<th>Newstead Nursing Home, Denewood Road, Highgate, London, N6 4AL - total capacity 36 places</th>
<th>Care home with nursing ( physical disability + terminally ill + dementia + learning disability + old age, not falling within any other category )</th>
</tr>
</thead>
</table>

The Council also has block contracts with registered care providers (mixture of nursing and residential) just outside the borough boundaries providing specialist dementia care provision (over page):

<table>
<thead>
<tr>
<th>Aspray House, 481 Leabridge Road, Leyton, London, E10 7EB - total capacity 64 places</th>
<th>Care home with nursing ( dementia + old age, not falling within any other category )</th>
</tr>
</thead>
</table>

| Stamford Nursing Centre, 21 Watermill Lane, Edmonton, London, N18 1SU - total capacity 90 places | Care home with nursing ( dementia + old age, not falling within any other category + physical disability ) |

**Supported Housing:**

The support service in Council supported housing is funded through Supporting People, but managed within Adult Services, in the wider context of the Community Care Strategy. The housing management function is provided by Homes for Haringey. The criteria for allocation of a tenancy specifically include people over 50 who are socially isolated, feel excluded and/or who have low self-esteem, who are self-neglecting and/or in nutritional deficit, who are vulnerable to abuse by others or who have been so treated, who have mental health or cognition problems, including depression, schizophrenia and dementia, who have personality disorders including obsessive compulsive disorder (hoarding) or whose substance misuse is affecting their ability to cope. The service aims to provide long term support and a home for life, for as long as community services are capable of meeting individual needs. There are currently circa tenants in total receiving this service.

**Floating Support:**

In addition, older people with ‘low level’ mental health problems and their carers are supported in the community through Supporting People funding streams, including 60 Plus. This service provides a support worker who works with the individual in their own home to provide a broad range of support - for example
monitoring health and well-being, dealing with landlords and other services, help with managing finances and benefits, linking up with social activities, and dealing with safety and security in the home.

4.5. Activity data for Haringey Council Services
The following activity data for Haringey Council internally provided and externally commissioned services for older people with mental health problems and dementia is taken from the regular returns the Council makes to the Department of Health (part of the National Social care data collection work):

The number of clients aged 65+ receiving services, provided or commissioned by Haringey Council, by primary client and service type:

<table>
<thead>
<tr>
<th>Year</th>
<th>Primary Client type (over 65)</th>
<th>Total of clients (over 65)</th>
<th>Community based in own home</th>
<th>Residential care</th>
<th>Nursing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full year 2009/10</td>
<td>Mental health (total)</td>
<td>395</td>
<td>211</td>
<td>179</td>
<td>26</td>
</tr>
<tr>
<td>Of which: Dementia</td>
<td></td>
<td>171</td>
<td>89</td>
<td>84</td>
<td>13</td>
</tr>
<tr>
<td>Part 01/04/2009 to 28/01/2010</td>
<td>Mental health (total)</td>
<td>361</td>
<td>214</td>
<td>150</td>
<td>23</td>
</tr>
<tr>
<td>Of which: Dementia</td>
<td></td>
<td>158</td>
<td>86</td>
<td>78</td>
<td>12</td>
</tr>
</tbody>
</table>

Number of clients 65+ receiving community-based services provided or commissioned by Haringey Council, by service and primary client type:

<table>
<thead>
<tr>
<th>DATE</th>
<th>01/04/2009 to 28/01/2010</th>
<th>2008/9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total of clients</td>
<td></td>
<td>Mental health (total)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Of which: Dementia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health (total)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Of which: Dementia</td>
</tr>
<tr>
<td>Home Care</td>
<td>214</td>
<td>211</td>
</tr>
<tr>
<td></td>
<td>66</td>
<td>89</td>
</tr>
<tr>
<td>Day Care</td>
<td>96</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>42</td>
<td>35</td>
</tr>
<tr>
<td>Meals</td>
<td>34</td>
<td>16</td>
</tr>
<tr>
<td>Overnight respite - not home</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>S/term residential - not respite</td>
<td>36</td>
<td>8</td>
</tr>
<tr>
<td>Direct payments</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Professional support</td>
<td>38</td>
<td>30</td>
</tr>
<tr>
<td>Equipment adaptations + adaptations</td>
<td>50</td>
<td>41</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

NOTE: It is likely that these figures may not capture all the people over 65 with mental health problems and/or dementia who are receiving as it is possible that many are either not formally diagnosed or recorded as such.

4.6. Specific services and support for carers of people with dementia
Admiral Nurse Service:
The Haringey Admiral Nurse Team, established in July 2000, are employed by the Haringey Borough of Barnet Enfield and Haringey Mental Health NHS Trust and are supported by a partnership with the charity Dementia UK. The Team is composed of

- 1 x Consultant Admiral Nurse (0.4 wte (whole time equivalent))
- 1 x Senior Admiral Nurse (0.4 wte)
- 3 Admiral Nurses (2.2 wte)

The is specifically designed to meet the needs of those who care for people with dementia. Admiral Nurses are specialist nurses and therefore have expert knowledge of the difficulties facing people who look after a friend or relative with memory problems. The Admiral Nurses in Haringey work alongside the Older peoples CMHT, the Alzheimer’s Society and the Community Matrons in Haringey and carry a caseload of carers. They also provide education and consultancy to various agencies.

Dementia Forum:
Led by the Consultant Admiral Nurse – there is a monthly open forum, with guest speakers, held at St Ann’s Hospital for staff, users and carers across all organisations with an interest in dementia.

Alzheimer’s Society Haringey Branch:
The Alzheimer’s Society offers a range of support services to carers of people with dementia, including a monthly carers’ support group – sitting care service provided, and a monthly drop in Dementia Cafe for people with dementia and their carers. The branch also has an information and support service for dementia-related enquiries (telephone), and publishes a quarterly newsletter.

Asian Carers Support Group:
The majority of Asian carers in Haringey are older people caring for spouses and family members. The Asian Carers Support Group provides information, support and advocacy, in Asian languages. Support is offered via office appointments and home visits. They also undertake delegated carer assessments (on behalf of the Council). In addition they offer twice monthly drop in sessions with complementary therapies and have an activities programme of cultural events, outings, vouchers for meals out. Asian Carers Support Group also publishes a quarterly newsletter

Haringey Carers Hub:
Located in Wood Green Library, the Hub offers a space for carers of people who have needs, and includes access to benefits advice, advocacy, and signposting to appropriate services. It can also be used by carers to hold support groups and meetings

Haringey Council:
Carers support groups run at The Grange and The Haven (day care services for people with dementia).

Barnet, Enfield and Haringey Mental Health Trust:
Carers support groups run at the Victoria Day Hospital and Cedar Ward. In addition a monthly carers support group for people living in the East of Haringey, Tom’s Club based on the Alzheimer’s Cafe approach is run by Admiral Nurses.

4.7. Contracting Mechanisms

Contracts and Service Level Agreements (SLA) are the mechanism by which both the providers of services and the purchasers (commissioners) of services agree upon the type, range, level, means, cost and quality of care.

NHS Haringey has a Standard Contract with BEH-MHT for the specialist mental health services provided. This contract covers both Adult (18-64) and Older People’s (65+) mental health provision; there is no separate specification for older peoples services.

Contract and SLA documentation and specifications are used by Haringey Council with all external providers of social care. The internal provision within Haringey Council is not subject to the same contractual and SLA arrangements as external providers. It should be noted that as the implementation of individualised budgets within the personalisation agenda develops contracting mechanisms in social care will change. This work is being overseen by the Transforming Social Care Programme.

4.8. Finance and Funding

The National Picture:

The Care Services Improvement Partnership (CSIP) 2006/07 National Survey of Investment in Mental Health Services for Older People informs that:

- The total reported overall investment in older people’s mental health services amounted to almost £1.879 billion in 2006/07.
- 68% of services for older people with mental health needs were commissioned by NHS Primary Care Trusts (PCTs) and 32% by Local Authorities.
- The national investment per weighted head of population for 2005/06 was £253.
- Investment within Strategic Health Authorities varied from a low of £142 investment per weighted head to a high of £319.

4.9. Market Analysis and Recommendations

There are specialist health and social care services for people with dementia and older people with mental health needs and dementia available in Haringey. As well as these specialist services, newer services are available such as carers support, Telecare services and floating support services that are preventative in nature, assist people to live at home and help avoid unnecessary admissions to hospital, residential or nursing care.

The development of the personalisation agenda will directly affect the composition and design of the social care market and increasingly there will be a role for commissioners in the development of the market. Additionally the implementation of the personalisation agenda will require adult care commissioners and providers across health and social care to develop their ability
to deliver a personalised service where the user may have difficulty in exercising the choice and control that is central to personalisation.

In evaluating the market it is essential that the future demand on resources is acknowledged in order to ensure that appropriate services are available to meet the needs of the diverse communities of Haringey. Older people are living longer and the numbers of people with mental health problems is projected to rise. A balance in service provision must be sought that reflects the projected increase in the numbers of older people with mental health needs and people with dementia who will require services while at the same time ensuring that adequate investment is made in developing early intervention and prevention services. The future provision of residential and nursing care as well as specialist inpatients services must be developed in line with need and should support the increase in the elderly population while at the same time reflecting the shift towards community based services. Along side this work is required to ensure that the needs of the growing population of black and ethnic minority elders are met in the developing provider markets.

As numbers of people with dementia rise, the numbers of people who will need specific help in making decisions will also increase. The expertise of staff to assess whether the person can make decisions for themselves must be developed along with an understanding of how decisions will be made in users best interests if they are unable to make decision themselves.

At the same time, the residential and nursing care sector must develop expertise in the appropriate and legal use of restraint, including where necessary depriving people of their liberty in their best interests to protect them from harm. Increased expertise across the sector will be needed in the Mental Capacity Act Deprivation of Liberty Safeguards.

Each of these themes and others will be further developed in section 5 - the Gap Analysis (below). The following recommendations for action reflect the information recorded in this section of the Framework on the initial market analysis.

**Recommendations for action:**

<table>
<thead>
<tr>
<th>Recommendation 2: Contract/SLA specifications and metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R 2.1 Ensure services have detailed service specifications</strong></td>
</tr>
<tr>
<td>That the lead commissioners in health and social care for older people’s mental health and dementia services review the specifications for services, identify gaps and priorities and, in conjunction with providers and the market development projects in personalisation, draft detailed specifications for each service area according to the agreed priorities. The new specifications to include specific references to skills and expertise required to implement personalisation agenda in the context of the Mental Capacity Act and Deprivation of Liberty Safeguards and requirements in relation to all equality diversity strands. The use of the Standard Contract for health care services will be an essential tool in this work.</td>
</tr>
</tbody>
</table>
Recommendations for action:

**Recommendation 3: Funding older people’s mental health and dementia services**

<table>
<thead>
<tr>
<th>R 3.1</th>
<th>Identify current spend on specialist dementia services and percentage of generic services used by people with dementia.</th>
</tr>
</thead>
</table>

That the lead commissioners in health and social care for older people’s mental health and dementia services work with providers of services to identify current spend across health and social care on **a.** specialist services for people with dementia and older people with mental health problems and **b.** generic services used by this group of people. The aim of this work will be to inform commissioners about the allocation of existing resources across the whole system.

5. GAP ANALYSIS APPROACH, CONTEXT AND JOINT COMMISSIONING

5.1. Whole system context

It is important to understand the context in which this gap analysis is being undertaken.

There are currently a number of significant changes taking place within the whole system of health and social care that will impact directly and indirectly on the future development of services for people with dementia and older people with mental health problems. A number of these changes have been referred to in other sections of the Framework but it is worth revisiting some of them briefly here at the beginning of this gap analysis. They include:

- The introduction of personalisation and individualised budgets within social care.
- The implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The reorganisation of the Primary Care Trust into commissioning and provider functions.
- The unified approach to commissioning mental health services from BEH-MHT by Barnet, Enfield and Haringey PCT’s.
- The developments within BEH-MHT regarding restructuring provision along service lines.
- Increasing opportunities to develop cross borough services within mental health.
- The introduction of Payment by Results and the Standard Contract in mental health services.
- The drive to use the finite resources available to commissioning the most clinically effective and cost effective services possible using appropriate and available evidence bases.

Each of these factors is likely to influence, over time, the progress and implementation of the recommendations for action made in the document.
5.2. Gap analysis approach
The model of service used to measure Haringey’s dementia services is taken directly from the National Dementia Strategy (NDS) Objectives 1 – 14 and Healthcare For London’s Dementia Services Guide.

The recent report Time for Action on the use of antipsychotic medication for people with dementia (DH 2009) is also used to ensure sufficient coverage of this important issue.

The model of service described in the two publications under the Department of Health’s project on mental health services New Horizons ‘Towards a Shared Vision for Mental health – Consultation document (2009) and A Shared Vision for Mental Health (2010) are used to measure Haringey’s services for older people with mental health problems.

Recommendations will be made in each section that is designed to identify gaps and actions required to meet the gaps.

Services for people with dementia and older people with functional mental health problems will be analysed in separate sections with the exception of Joint Commissioning and the development of integrated care pathways which are dealt jointly in the next two sections.

Links between dementia and functional mental health recommendations are made where it is more efficient or logical for the recommendations to be actioned together.

5.3. Joint commissioning
New Horizons sets out the importance of joint collaboration and commissioning across health and social care in order to ensure required action to make change happen locally can happen. This is supported by themes within the National Dementia Strategy and the associated Joint Commissioning framework for Dementia. The publication of The NHS White Paper, Equity and excellence: Liberating the NHS, sets a new direction for the future of health care commissioning. The plan is for the role and functions of Primary Care Trusts to be transferred to new GP led Commissioning Consortia. The details of how these new Consortia will be established and run is to be locally agreed. It will be essential for this development work to include due consideration as to how complex integrated health and social care services will be commissioned in the future.

Recommendations for action:

<table>
<thead>
<tr>
<th>Recommendation 4: Joint Commissioning leads</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R 4.1</strong> Have named lead commissioners for dementia and older peoples mental health services in health and social care.</td>
</tr>
</tbody>
</table>

In order to progress the development of joint commissioning of services for people with dementia and older people with mental health problems named lead commissioners must be identified who will be responsible for both the strategic direction and direct commissioning tasks in both Haringey Council and NHS Haringey.
The key tasks of the lead commissioners will include:

- Ensure the delivery of service development in National Dementia Strategy and New Horizons project.
- Providing a robust link between strategy, commissioning and contracting functions.
- Influencing other commissioners across service areas.
- Identify opportunities across traditional boundaries and throughout the whole system.
  Coordinate inclusion of other policy themes for example, Dignity, Carers Strategy, Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards.
- Contributing to the development of the new GP Commissioning Consortia and representing dementia and older people mental health within that work.

5.4. Integrated Care Pathways:
The National Service Framework for Older People (Department of Health 2001) defines a care pathway as:

an agreed and explicit route an individual takes through health and social cares services. 
Agreements between the various professional involved will typically cover the type of care and treatment, which professional will be involved and their levels of skills, and where treatment or care will take place (p.152).

The Healthcare Commission (2004) defines an Integrated Care Pathway (ICP) as:

a document that describes a process within health and social care, and that documents variances between planned and actual care. ICPs embed guidelines, protocols and locally agreed, evidence-based, patient-centred best practice, into everyday use for the individual patient. They form all or part of the clinical record for that particular episode of care. Uniquely, they record deviations from planned care in the form of variances (p.1)

Both New Horizons and the National Dementia Strategy emphasise the importance of developing integrated care pathways for dementia and older people’s mental health services.

Recommendations for action:

<table>
<thead>
<tr>
<th>Recommendation 5: Integrated Care Pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R 5.1</strong> To develop a high level integrated care pathway for people with dementia</td>
</tr>
<tr>
<td>The high level integrated care pathway for people with dementia must incorporate indicators for the movement along the pathway and the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards requirements as appropriate.</td>
</tr>
<tr>
<td><strong>R 5.2</strong> To develop a model of service and a high level integrated care pathway for older people with mental health problems</td>
</tr>
<tr>
<td>The high level integrated care pathway for older people with mental health problems must incorporate indicators for the movement along the pathway and the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards requirements as appropriate. Work on the service model will ensure age appropriate services are available.</td>
</tr>
</tbody>
</table>
6. DEMENTIA - GAP ANALYSIS AND RECOMMENDATIONS

6.1. NDS Objective 1: Improving public and professional awareness and understanding of dementia

NOTE: This section also includes a review of, and recommendations relating to, the needs of older people with functional mental health problems.

*From the National Dementia Strategy:*
Public and professional awareness and understanding of dementia to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help-seeking and help provision.

*Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide:*
- P1: Awareness campaign and raising awareness locally.
- P3: Maintaining cognitive and mental health well being.
- P5: Encourage preventative measures.
- ID1: Improved public awareness leading to self identification.
- ID2: Improved awareness of dementia and memory services by health and social care professionals and care home staff.
- ID3: Identification of people from under represented or at risk groups.

*Haringey services:*
Partnership working between NHS Haringey and Haringey Council provide a range of universal services focusing on health promotion and preventative and wellbeing initiatives including Active for Life, Health in Mind – Walk you way to health, smoking cessation and obesity campaigns.

The Third Sector also plays an important role promoting awareness about dementia, the services available and good physical and mental health.

Haringey Alzheimer’s Society is particularly active in dementia services, campaigning and highlighting locally issues related to people with dementia and their carers. They offer information packs and leaflets, advice and signposting as well as promoting good mental health by holding events such as the Haringey Memory Walk. Haringey Age Concern also provides a key role in maintaining good mental health for older people in the borough through a range of different initiatives.

*Gaps:*
There has been significant improvements to public and professional awareness of dementia and mental health services. However, there is no coordinated approach or strategy on dementia or older people with mental health problems.
Opportunities:

NHS Haringey are currently revising and re-drafting its Health Promotion Strategy.

The National Awareness Campaign is being planned as part of the National Dementia Strategy implementation plan.

Recommendations for action:

LINK TO FUNCTIONAL MENTAL HEALTH: See section 9.1.

**Recommendation 6: NDS Objective 1: Improving public and professional awareness and understanding of dementia (and older people’s mental health issues).**

R 6.1 **Develop a whole system Joint Communication Plan to raise awareness and understanding of dementia and older people’s mental health.**

The Communication Plan must take account of the diverse needs and cultural norms within the Haringey population and target traditionally hard to reach groups. Ensure the Plan includes cross referencing and joined up work with other similar strategies and plans in older people and adult mental health services and other health promotion activities (for example: smoking cessation and obesity campaigns making reference to reduced risks of dementia) and develop specific campaigns on e.g. older people and depression.

6.2. NDS Objective 2: Good-quality early diagnosis and intervention for all

*From the National Dementia Strategy:*

All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.

*Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide:*

- The proposed Healthcare for London Memory Assessment Service specification.
- ID1: Improved public awareness leading to self identification.
- AD1 & 2: Assessment process and investigations.
- AD3: If patient diagnosed follow best practice to explain diagnosis to the patient and family.
- AD4: Review everyone in 12 months where people diagnosed with MCI, depression and anxiety.
- T3: Post Diagnostic information support and counselling to person with dementia and their carer.
- A4: Provide and explain information to patients and carers and provide reassurance.
Haringey services:
The diagnosis of dementia is carried out by the Older People’s CMHT. NHS Haringey commission a Memory Treatment Service from BEH-MHT operating from St Ann’s Hospital. The majority of referrals are received from GP’s. The Memory Treatment Service is led by a part-time consultant psychiatrist with support from a Band 6 CPN (currently undergoing Nurse Prescribing training), three sessions a week from the Psychology service. The service is available to people over 65 in Haringey. The service works closely with Admiral Nurses who provide carer support and advice during and after diagnosis.

Gaps:
The current Memory Service is not available to:
- people under 65 with early age onset dementia
- people with learning disabilities
- people with alcohol related brain injury.

It is possible that the current level of service offered by the Memory Service will not meet an anticipated growth in demand as a result of a) demographic changes and b) improved levels of awareness about dementia and the importance of early diagnosis. The NICE Commissioning Guide for Dementia suggests that the indicative benchmark rate for new referrals to a Memory Assessment Service (MAS) is 0.19%, or 190 per 100,000 population, per year. This is based on the following sources of information:
- Epidemiological data on the prevalence/incidence of dementia.
- Current practice to establish the number of existing patients in contact with GP services.
- Published research and local audits on the diagnostic profile of people referred to a memory assessment service.
- Expert clinical opinion of the topic-specific advisory group, based on experience in clinical practice and literature review.

Using the NICE methodology, likely demand for a Memory Assessment Service in Haringey will be 427 people per annum.

Currently the Memory Service offers a comprehensive diagnostic and drug treatment service. People not on the drug treatment pathway, for example people with vascular dementia, will be discharged from the Memory Service once diagnosis is complete. This may create an imbalance in the level of service offered to sections of the community at most risk of vascular disease which includes the Black and minority ethnic community.

Other elements of a Memory Assessment Service designed to meet the full requirements of the NDS and Healthcare for London Guide and extend services to people with all types of dementia that are not currently provided in Haringey, include:
- A well specified pathway for pre and post diagnosis counselling, support and care planning over 4 – 12 week period.
- 6 month follow-up for people with MCI and/or early stage dementia (including those with depression and anxiety) and for people not in touch with other support services.
• Cognitive Stimulation Therapy sessions or similar to promote and maintain cognitive abilities.
• Outreach to Primary Care including liaison, information, raising awareness about dementia.
• Education and training in dementia to specialist and non specialist dementia services.

Some elements of a Memory Assessment Service in the list above need not necessarily be provided by the same agency. Good partnership working across agencies and sectors, will help ensure joined up services and elements provided by the most appropriate provider.

GP’s have a key role in early diagnosis as they are often the service that people worried about their memory access first; their role in early identification and referral for diagnosis is essential. GP’s also have a large role in ensuring that people have good support and health care after they have been diagnosed with dementia.

Opportunities:
The Hornsey Central site has extended the scope of operation of the exiting Memory Service, bringing service closer to where people live in the west.

Operational changes being considered of service within BEH – MHT will create opportunities for cross borough services. Smaller more specialised assessment and diagnostic services for early onset dementia, people with learning disabilities and people with alcohol related brain injury could be commissioned though cross borough cooperation.

Recommendations for action:

<table>
<thead>
<tr>
<th>Recommendation 7: NDS Objective 2: Good-quality early diagnosis and intervention for all.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R 7.1</strong> Agree a model and detailed service specification for the Memory Assessment Service (MAS)</td>
</tr>
<tr>
<td>The Joint Commissioners, in conjunction with users and carers and BEH-MHT, to agree a model and specification for operation and development over time of the MAS service in Haringey, incorporating strategic decisions on:</td>
</tr>
<tr>
<td>• Client groups to be served</td>
</tr>
<tr>
<td>• Which elements of the service will be included and who will provide them</td>
</tr>
<tr>
<td>• Location of MAS</td>
</tr>
<tr>
<td>• Cross borough options for specialist MAS</td>
</tr>
<tr>
<td>• Clear integrated pathway</td>
</tr>
<tr>
<td>• Capacity, data collection and targets for activity and performance (e.g. waiting times, timescales for diagnosis, MMSE score at diagnosis etc)</td>
</tr>
<tr>
<td>• Use of the of Primary Care Quality Outcomes Framework and GP Dementia</td>
</tr>
<tr>
<td>• Registers and dementia matching exercise to monitor the impact of service delivery in relation to early diagnosis.</td>
</tr>
</tbody>
</table>

| **R 7.2** Raise the level of awareness of GP’s (Primary Care) about the importance of early diagnosis of dementia |
| Review the current links between Primary Care and the Memory Clinic and agree a |
programme of actions to increase awareness in primary care and improve joint working.

**R 7.3 Agree an action plan for the development of services for people with learning disabilities and dementia**

Identify a lead for people with learning disabilities and dementia to sit on Older Peoples Mental Health Steering Group and the Learning Disabilities Dementia Working Group. Lead to develop a joint action plan for people with learning disabilities and dementia including the development of the integrated dementia pathway for people with learning disabilities and proposals for future service provision and post diagnostic pathway.

**R 7.4 Agree model of service for people with early age onset dementia**

Identify lead for early age onset dementia to sit on Older Peoples Mental Health Steering Group. Lead to review current services for people of with early age onset dementia, including cross borough services and develop proposals for future service provision and development of post diagnostic pathway.

6.3. NDS Objective 3: Good-quality information for those with diagnosed dementia and their carers.

*From the National Dementia Strategy:*
Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.

*Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide:*
- T3: Post Diagnostic information support and counselling to person with dementia and their carer.
- W2: Carer and family interventions for improving patient care.

*Haringey services:*
Web and paper based information on the dementia illness and support services in Haringey are available from providers across health and social care. There is information that is specific and non-specific to Haringey. All Haringey services have information leaflets about the services. The Third Sector, especially Haringey’s Alzheimer’s Society, and Admiral Nurses are valuable sources for information about dementia.

*Gaps:*
There is no coordination or overview of all the information available, which means that identifying gaps (for example, the availability of information in community languages and alternative formats) is limited.
Recommendations for action:

Recommendation 8: NDS Objective 3: Good-quality information for those with diagnosed dementia and their carers.

R 8.1 **Review existing sources of information on dementia and match against need and publish a dementia services guide/booklet for Haringey.**

Commissioning a full review of the available sources of information for people with dementia and their carers and match against need to identify duplication and gaps. Include in the review a consideration of the needs of people who do not have English as their first language, hard to reach groups, and the places and sources of information preferred by users and carers, this may include extending the scope of existing locations for information to e.g. libraries and community based groups. Seek the views of people with dementia and their carers as part of the review. Use information gathered to publish a dementia services guide/booklet.

6.4. NDS Objective 4: Enabling easy access to care, support and advice following diagnosis

*From the National Dementia Strategy:*  
A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.

*Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide:*  
- A2: Maintain a key contact point who can advocate on behalf of the patient and carer.  
- A4: Provide and explain information to patients and carers and provide reassurance.

*Haringey services:*  
Haringey has an established Admiral Nursing service providing information, advice and support throughout the progress of the illness to families and carers. This function reflects the role of a Dementia Advisor for carers. Everyone receiving an assessment and diagnosis of dementia via the MAS is referred to the Admiral Nursing Service.

*Gaps:*  
There is no equivalent service to the Admiral Nursing service for people with dementia who do not have carers and live alone. Haringey services need to develop its approach to post diagnostic support for people with dementia and their carers. This post diagnostic service should include advice, information, support, counselling and care planning for the future. The service should include assist people with Advanced Care Planning at an early stage. This will enable individuals to maximise choice and control over their lives and extend autonomy and independence for as long as possible.

*Opportunities:*  
The Department of Health is funding 22 Dementia Advisor demonstrator sites throughout the country. The sites will be evaluated to assess the effectiveness of
different models of service, the outcomes for people with dementia and their carers and the impact on the demand for more intensive support services.

Recommendations for action:

<table>
<thead>
<tr>
<th>Recommendation 9: NDS Objective 4: Enabling easy access to care, support and advice following diagnosis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 9.1 Review existing post diagnostic support and advice services and agree model for future provision.</td>
</tr>
<tr>
<td>That the joint commissioners for dementia services: a. await the early messages from the Dementia Advisors Demonstrator sites about effectiveness of different service models; b. explore complementary provision to the Admiral Nursing service for people who live alone without carers including the use of utilising existing community based groups, volunteers and expanding on the social capital model. c. Ensure that Advanced Care Planning is included in future post diagnostic service provision.</td>
</tr>
</tbody>
</table>

6.5. NDS Objective 5: Development of structured peer support and learning networks

From the National Dementia Strategy:
The establishment and maintenance of networks will provide direct local peer support for people with dementia and their carers. It will enable people with dementia and their carers to take active roles in developing and prioritising local services.

Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide
- W2: Carer and Family interventions for improving patient care.

Haringey services:
Haringey has services that offer structured peer support and learning networks for people with dementia and their carers including:
- Alzheimer’s Cafe – Haringey Alzheimer’s Society.
- Haringey Alzheimer’s Society Carers Support Group.
- Toms Club – Admiral Nurses.
- Carers Education and Training Programmes - Admiral Nurses (two held in 2009).

The attendees of the two Carers Education and Training Programmes were invited to evaluate the sessions and were asked what their future support, information and advice needs were and how they would it should be organised. The responses were as follows:
- Practical training in: Managing well, dealing with relatives emotions, dealing with incontinence, how much and how best to communicate with relative.
- Ideas on how to manage relative’s negative feelings.
- An opportunity to continue to meet as a group.
- To be a voice for carers, to support one another and to campaign together.
• More insight into how our relatives are feeling/what they are going through.
• General advice and training on approaches to caring.
• Opportunities for sharing solutions and strategies.
• To get updates on changes in the Law or Benefits.
• Needs to be a facilitator so everyone can speak and there is a structure.
• Needs to be someone who can pick out important issues.
• Someone to help us to think about what to do, e.g. who to write a letter of complaint to.
• Like to have a facilitated forum on a monthly basis.
• Would like it if we could continue to meet here at St Ann’s as it is a good location for all.
• Could staff here continue to facilitate and organise?

Gaps:
Structured and supported peer support and learning networks in Haringey are unlikely to meet potential demand for such services. There were 1,309 people with dementia in the borough in 2008. This need is emphasised by the feedback from participants from the Carers Education and Training Programme (see above).

There are no peer support networks for people with early onset dementia or their carers.

Information on the take up by Black and Minority Ethnic Communities of peer support groups is currently unavailable. Traditional barriers to services for this group indicate a possible gap in peer support to these groups as well.

Opportunities:
The development of the Social Capital model is being discussed in Haringey. Organisations such as Participle – offering low level community networking based services (Get Together model), are considering expanding their operations in North London.

This may be an ideal opportunity to utilise an early intervention and prevention model encouraging and supporting participation in community life for isolated people.

Other opportunities include outreach work to community and faith based groups that people with dementia and their carers may already use. A network of people already involved in these services could be supported by a small number of ‘exerts’ in dementia services to facilitate structured and self supporting peer networks.
Recommendations for action:

**Recommendation 10: NDS Objective 5: Development of structured peer support and learning networks.**

**R 10.1 Review existing peer support mechanisms and agree model for future provision.**

Commissioners and providers to work together to identify alternative ways of supporting the development of structured peer support networks including the use of Social Capital projects, developing a supported network of potential facilitators in existing community based groups and existing volunteer schemes.

6.6. NDS Objective 6: Improved community personal support services

*From the National Dementia Strategy:*  
Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority arranged services.

*Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide*
- W1: Carry out regular reviews of social and health care needs.
- W2: Carer and Family interventions for improving patient care (inc ch behaviour services, talking therapy etc).

*Older people with functional mental health needs*
Older people with functional mental health needs such as psychosis, anxiety, substance misuse or depression may also have complex physical health care needs. The interplay between mental and physical health can result in complex needs in accessing personal social care support. Staff working in personal social care services require a wide range of skills, knowledge and experience.

Additionally staff need access to specialist mental health advice, liaison and support when working with people with such complex needs. The potential number of older people with these needs is quite small. However the impact of not providing appropriate services could be significant in terms of the well being of the individual and the level and cost of alternative services needed (for example, A&E attendance, hospital admissions and care home placements).

The domiciliary care service provided by Haringey Council offers a service to people with complex needs which will include older people with mental health problems.

*Haringey services:*
The personal social care services available in Haringey are outlined in the Market Analysis (section 4).
The implementation of personalisation and individualised budgets will impact the way personal social care services are commissioned and provided. Recognising individual needs of people with dementia and older people, with complex mental health problems is central to the planning and development, in line with personalisation in Haringey. An understanding of the implications of impaired mental capacity and how it impacts on self-directed support is particularly important when considering this client group.

Gaps:
The numerical model in section 4.3 gives projections for the likely demand for personal social care services for people with dementia in Haringey. It suggests a significant short fall in the available provision when measured against the Activity data given in section 5.5. However the number of people with dementia currently receiving social care services is likely to be underestimated. This is due to factors including:

- The high proportion of people in Haringey with undiagnosed dementia.
- People with dementia having another need, for example, physical ill health/fragility that is considered primary for the purposes of recording.
- People developing dementia whilst in receipt of care and this not being recorded as their primary need.

The Haringey ‘In House’ Home Care Service provide a specialist domiciliary care service to people with dementia with complex needs. It does not have strong links with the Older Peoples CMHT and MAS.

It is not possible with the available data for mental health and dementia (as often interchangeable), to extract accurate numbers of older people with functional mental health problems in receipt of services (see Section 5.5 above). There are no specific personal social care services available in the borough for people with early onset dementia.

Recommendations for action:

<table>
<thead>
<tr>
<th>Recommendation 11: NDS Objective 6: Improved community personal support services.</th>
</tr>
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<tbody>
<tr>
<td>R 11.1 That personalisation planning and pilots include people with dementia and older people with mental health problems.</td>
</tr>
<tr>
<td>Robust links to be developed as a priority between the working groups tasked with implementing personalisation (e.g. Market Management &amp; Core Design Groups) with co-opted representatives from dementia services nominated to attend with reporting responsibilities to the Older Peoples Mental Health Steering Group. The aims of the work to include a clear focus on outcome based services rather than time or task based packages of care, seeking the views of potential individualised budget holders and their carers about costs / levels of expertise / specialist versus generic services AND review available publicity and information about personalisation, identify gaps in relation to people with dementia and their carers and take action to cover any gaps identified.</td>
</tr>
<tr>
<td>R11.2 Ensure the personalisation decision making tools and support are developed to support and meet the particular needs of people with dementia and older people with mental health problems.</td>
</tr>
</tbody>
</table>
The Older Peoples Mental Health Steering Group to work closely with personalisation working groups to ensure that particular expertise is developed within Haringey to support people with dementia and older people with mental health problems to make decisions, identify where they lack capacity and ensure appropriate processes are in place and followed in making decisions on behalf of the person concerned.

R 11.3 That the commissioners of social care services regularly update and review the proposed numerical model for demand projection and match against actual activity and service delivery data.

R 11.4 That commissioners consider the development of the Haringey Council ‘In House’ Home Care service to provide a specialist dementia domiciliary care service. Further consideration to be given to the development of this service into a jointly funded Home Treatment Team for people with dementia and /or older people with functional mental health problems.

6.7. NDS Objective 7: Implementing the Carers’ Strategy

NOTE: This section includes a review and recommendations relating to the needs of older people with functional mental health problems

From the National Dementia Strategy:
Family carers are the most important resource available for people with dementia. Additional work is needed to ensure that the provisions of the Carers’ Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs. They can be supported through an agreed plan to support the care they provide the person with dementia. This should include good-quality, personalised breaks. Action should also be taken to strengthen support for children in caring roles, ensuring that their needs as children are protected.

Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide:
- W2: Carer and Family interventions for improving patient care (inc ch behaviour services, talking therapy, for example).
- T5: Carry out carers assessments.

Haringey services:
The specialist dementia based carers support services available in Haringey are outlined in the Market Analysis (section 4).

Opportunities:
Haringey published is Adult Carers Strategy in 2009. All the aims visions and outcomes contained in the Carers Strategy will apply equally to carers of people with dementia and older people with functional mental health problems.
**Recommendations for action:**

<table>
<thead>
<tr>
<th>Recommendation 12: NDS Objective 7: Implementing the Carers’ Strategy</th>
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<tr>
<td><strong>R 12.1 Robust links to be developed as a priority between the Older Peoples Mental Health Steering Group and the Carers Partnership Board</strong></td>
</tr>
<tr>
<td>Co-opted representative(s) from dementia and older peoples mental health services nominated to attend the Carers Partnership Board with reporting responsibilities to the Older Peoples Mental Health Steering Group. The Older Peoples Mental Health Steering Group will be responsible via the carers link representative for ensuring that the Carers Strategy Priority Outcomes and any actions arising are implemented in dementia and older peoples mental health services and that issues of relevance to carers of people with dementia are represented at the Carers Partnership Board.</td>
</tr>
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**6.8. NDS Objective 8: Improved quality of care for people with dementia in general hospitals**

*From the National Dementia Strategy:*
Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people’s mental health teams to work in general hospitals.

*Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide:*
  - H4L: General hospital pathway.

*Haringey services:*
The two main general hospitals servicing Haringey residents are the Whittington and North Middlesex. Both hospitals have identified a lead clinician for dementia and both have a psychiatric liaison service.

*Gaps:*
The main gaps in services identified from both the Whittington and North Middlesex hospitals related to the availability of psychiatric liaison services for Haringey residents.

There are no formal integrated care pathways between the general hospitals and local social care and/or specialist health care services for people with dementia or for the care of people with dementia whilst in hospital.

There needs a high level of confidence and competence in using the Mental Capacity Act within the medical and nursing staff in general hospitals. It is not solely the domain of the psychiatric liaison service. Achieving this level of skill and expertise is fundamental in providing a high quality service to inpatients with dementia whilst maximising their autonomy and dignity.
Recommendations for action:

**Recommendation 13: NDS Objective 8: Improved quality of care for people with dementia in general hospitals.**

R 13.1 To develop a programme of actions designed to improve the joint commissioning and provision of acute general hospital care for people with dementia and older people with mental health problems.

That the Commissioner for health care services for people with dementia (and older people with mental health problems) to work closely with other commissioners of dementia services and of acute hospital services, cross borough, to:

- Evaluate the capacity and demand in older people's psychiatric liaison services in both the Whittington and North Middlesex Hospitals to inform future commissioning of the service
- Research other models of hospital liaison services to inform development
- Work closely with the designated lead senior clinician for dementia to champion older people’s mental health in hospital and to develop a clear care pathway for the management of people with dementia in hospital following the Healthcare for London General Hospital Pathway model.
- Ensure through the provision of appropriate training, service specifications and monitoring, a high level of confidence and competence in using the Mental Capacity Act amongst medical and nursing staff in general hospitals.

R 13.2 That integrated social and health care pathways and protocols are agreed describing the operational interface between the general hospitals (Whittington and North Middlesex) and the local Haringey Social care and Specialist health care services for people with dementia

Including the role of psychiatric liaison service and functioning of the funding panels for continuing care and social care placements and services.

R 13.3 That a pilot teleconference system be established across Older Peoples CMHT, Haring Council assessment and care management service and acute hospital staff (Whittington and North Middlesex) to discuss the support, management and future planning of people with dementia on inpatient wards.

6.9. NDS Objective 9: Improved intermediate care for people with dementia

*From the National Dementia Strategy:*  
Intermediate care which is accessible to people with dementia and which meets their needs.

*Haringey services:*  
Intermediate Care is best described as a function rather than a discreet service. It includes services that contribute to timely supported discharge from hospital, avoidance of admission to hospital and long term care. Intermediate care may be required as a result of a physical health care need or a mental health care need (or a combination of the two); each may require different approaches and interventions.
Services that currently contribute to the intermediate care function for people with physical health care needs in Haringey include:

- Home Treatment Teams for Older People
- Neurological Rehabilitation
- Community Rehab (Integrated Community Therapy Team)
- Rapid Response Service
- Reablement service in Haringey Council.

**Gaps:**
There is no locally agreed intermediate care strategic plan for people with dementia focused on:
1. Developing existing mainstream services to better service people with dementia with physical health care needs.
2. People with dementia at risk of admission to or in need of supported discharge from acute mental health beds.

People with dementia access existing mainstream intermediate care services. However, evidence suggests that some people are excluded from the service because of a lack in knowledge, training skills and experience in dementia care. This leads to the view that a cognitive impairment may reduce the likelihood of a patient's ability to benefit from intermediate care. This effect may be compounded by lack of routine involvement of specialist dementia staff and lack in training in dementia care in mainstream services.

The impact of these factors on intermediate care and acute services is hard to assess. No data is collected on the numbers of people with a primary and secondary diagnosis of dementia in relation to admission rates, length of stay and delayed transfers of care. Consequently, it would be difficult to monitor any improvement in performance resulting from better services for people with dementia.

Improved knowledge of mental capacity and the Mental Capacity Act within intermediate care services would also significantly impact acute hospital services. This will help provide good quality care for people with any form of impaired capacity including dementia.

**Opportunities:**
A major multi-agency Discharge Project with was set up Haringey in 2009 with the following aim:

*To develop and implement a process and pathways that will deliver reduced length of stay and reduced delays in transfer of care for Haringey residents / patients from the NMUHT and Whittington Hospitals.*

The Department of Health has recently revised and re-published its Guidance on Intermediate Care Services, *Halfway Home* to include services for people with dementia.
Recommendations for action:

<table>
<thead>
<tr>
<th>Recommendation 14: NDS Objective 9: Improved intermediate care for people with dementia.</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 14.1 Robust links to be developed as a priority between the Older Peoples Mental Health Steering Group and the Intermediate Care and Rehabilitation Steering Group with co-opted representative(s) from dementia services nominated to attend with reporting responsibilities to the Older Peoples Mental Health Steering Group.</td>
</tr>
<tr>
<td>The role of the dementia services representative(s) will be to ensure the following:</td>
</tr>
<tr>
<td>• That the service specification for intermediate care services meets the needs of people with dementia and promotes more flexible access.</td>
</tr>
<tr>
<td>• Performance monitoring routinely monitors primary and secondary diagnoses of dementia in relation to admission rates, Length of Stay and Delayed Transfers Of Care as well as access to intermediate care for people with dementia.</td>
</tr>
<tr>
<td>• The Steering Group considers the needs of people with dementia when developing interim (step down) beds</td>
</tr>
<tr>
<td>• The Steering Group considers the training needs of intermediate care staff in dementia care and the Mental Capacity Act.</td>
</tr>
<tr>
<td>• The Steering Group reviews the arrangements and options for intermediate care staff to have ready access to the specialist dementia service (including consideration of the feasibility of recruiting mental health professionals as core members of the intermediate care service).</td>
</tr>
<tr>
<td>R 14.2 The Older Peoples Mental Health Steering Group to review and consider appropriate models for the development of:</td>
</tr>
<tr>
<td>• Mental health based services to provide admission avoidance and early supported discharge for people with dementia.</td>
</tr>
<tr>
<td>• Virtual wards in a community setting.</td>
</tr>
<tr>
<td>R 14.3 That BEH-MHT undertake an audit of admissions to the acute mental health beds in Cedar Ward and use as basis for planning admission avoidance services.</td>
</tr>
</tbody>
</table>

6.10. NDS Objective 10: Considering the potential for housing support, housing-related services and Telecare to support people with dementia and their carers

*From the National Dementia Strategy:*

The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider options to prolong independent living and delay reliance on more intensive services.

*Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide*

- W5: Environmental interventions (Housing, Assistive technology, Safety).

*Haringey services:*

Housing: People with dementia and their carers live in a range of different housing and accommodation settings covering all types of tenures. The provision of good
quality housing and housing support services is an essential part of supporting and extending people’s independence. An option that is increasingly considered for people with dementia and their carers is extra care sheltered housing. Evidence shows that the particular housing and support needs of people with dementia may be well met in this type of setting (National Dementia Strategy 2009).

There are two extra care schemes being developed in the west of Haringey in partnership with Housing Associations. These new developments will provide circa 80 units of extra care sheltered accommodation. Plans for increased development of extra care accommodation in the east of the borough is also being considered.

Telecare and assistive technology: Haringey Council offer a full response community alarm system including a Telecare remote monitoring service to circa 200 users, a high proportion of who have a degree of dementia or other mental health problems. The Telecare Service runs a successful pilot for advanced Telecare services for people with dementia using a door sensor linked to the CA service to prevent wandering. A pilot was undertaken in 2010 trialling GPS tracking and plans are in hand to implement the findings of a successful pilot on Telecare medicines management service.

Gaps:
There is no borough-wide strategy for housing and accommodation for people with dementia and their carers. There is need for a clear policy relating to the impact of cognitive impairment on the ability of people to become tenants, in extra care sheltered accommodation for example, or to end their tenancies

Opportunities:
Haringey’s Integrated Housing Board (IHB) has published an over-arching policy document which sets out the approach to and vision for housing over the next ten years in the borough. The vision for housing in Haringey is to create:

Neighbourhoods that people choose to live in with a balance of different types of homes which offer quality, affordability and sustainability for current and future generations.

The Housing Strategy’s five aims are:
1. To meet housing need through mixed communities which provide opportunities for our residents.
2. To ensure housing in the borough is well managed, of high quality, and sustainable.
3. To provide people with the support and advice they need.
4. To make all homes in the borough a part of neighbourhoods of choice.
5. To contribute to creating the Greenest Borough.

Building on the over-arching Housing Strategy work an Older Peoples Housing Strategy was consulted on during 2010 with completion of the Strategy in 2011.
Recommendations for action:

Recommendation 15: NDS Objective 10: Considering the potential for housing support, housing-related services and Telecare to support people with dementia and their carers.

R 15.1 The Older Peoples Mental Health Steering Group to participate fully in the development of the Older Peoples Housing Strategy and ensure that consideration of the following is included:

- The benefits of different types / models of extra care accommodation schemes for people with dementia and their carers, for example, dedicated dementia developments, dementia friendly services, integrated or separate units within a single development (referencing emerging evidence/research).
- The potential for extra care sheltered accommodation to be used as a base for a range of community support services.
- The inclusion of social capital and community resources in the development of extra care and sheltered accommodation.
- The body of knowledge and experience in design and the built environment principles in relation the needs to people with dementia (e.g. use of colour schemes, visual clues, security, Telecare).
- The involvement of people with dementia and older people with mental health problems in the development of the Older Peoples Housing Strategy.
- Review existing housing support services to ensure they are appropriately assessing supporting and managing risk in the community to enable people to live in their own homes more safely and for longer.
- Ensure cross sector working in the implementation of the strategy.
- The legal implications of starting and ending tenancies for people with impaired or lacking capacity due to dementia.

R 15.2 That the Telecare service continues to develop and pilot innovative services to support people living in their own homes.

6.11. NDS Objective 11: Living well with dementia in care homes
NOTE: This section includes a review and recommendations relating to the needs of older people with functional mental health problems.

From the National Dementia Strategy:
Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes.

Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide

- W1: Carry out regular reviews of social and health care needs.
- W4: Physical health care interventions.
- A6: Agree indicators for moving along pathway and implement MC Act as appropriate.
- ID5: Recognition of difference between symptoms of dementia and delirium
- ID2: Improved awareness of dementia and memory services by health and social care professionals and care home staff.
- ID3: Identification of people from under represented or at risk groups.


**Haringey services:**
It is estimated that over two thirds of people over the age of 65 in care will have dementia. It is reasonable to conclude that there are people with dementia who live in every care home for older people in Haringey.

There are 12 registered care homes in Haringey that specifically cater for the needs of people with dementia, including three provided directly by Haringey Council. All 12 ‘dementia’ care homes have a [Care Quality Commission (CQC)](http://www.cqc.org.uk) rating of ‘Good’ or ‘Excellent’; with the three Council run services being rated as Good.

People living in care homes are also at a higher risk of developing depression and other functional mental health problems, for example up to 50% of older people in care homes have clinically severe depression.

The work of the NHS Haringey Community Matron’s team encompasses liaison and joint work with local care homes. This is a highly valued service locally that has focuses on improving the quality of health care for people living in care homes and developing the knowledge, skills and confidence of care home staff.

An integrated Dementia Care Mapping (DCM) project with a DCM ‘hub’ Steering Group was established in Haringey in 2009. Membership is across Health, Adult Social Care and the third sector. DCM is an observation tool which supports the delivery of person centred care by accessing the direct experiences of people with dementia in care settings. In 2008/09 DCM training was commissioned by Haringey Council at the recommendation the Commissioning for Social Care Inspectorate (now Care Quality Commission). Approximately 25 staff attended a four day introductory course. In addition to the Council based DCM ‘mappers’ there are four trained mappers within BEH-MHT and one mapper employed by the local Alzheimer’s Society.

**Opportunities:**
[New Horizons – Shared Vision for Mental Health (2010)](http://www.dcsf.gov.uk/mentalhealth/pdf/new_horizons_shared_vision_for_mental_health_full.pdf) advises commissioners to commission specialist older people’s mental health services to conduct mental health assessments and regular follow-up reviews when residents are newly admitted to care homes. This would also provide a regular forum for discussion between nursing staff, GPs and specialist older people’s mental health teams to identify and manage the mental health problems of care home residents. Joint commissioning of in-reach services from other professionals, such as community pharmacists, community dentists, arts therapists and geriatricians, could also improve support to care homes and enhance their environment.

The social care commissioner’s role of market management and development has been significantly influenced by the implementation of the personalisation agenda. There are new opportunities and approaches available for developing the market in social care. Monitoring services; and informing and supporting people with individualised budgets will help them purchase the best service available. These initiatives will create new ways of working with all providers, including care homes; and increase direct links between individual budget holders purchasing decisions and the quality of care available.
The Mental Capacity Act and Deprivation of Liberty Safeguards are vital tools for Care Home providers. Care homes must be fully aware of legislation, in terms of assessing capacity, making decisions in a person’s best interests, legal use of restraint and the implications of depriving someone of their liberty. Care home managers have a statutory duty to be aware of the Deprivation of Liberty Safeguards, always act in the least restrictive manner with people who lack capacity and make requests for standard [DoLS] authorisations when necessary. Additionally they are under a legal obligation to follow a variety of duties where a resident is deprived of their liberty, such as implementing conditions. Keeping the person’s situation under review and ending deprivation of liberty immediately it is no longer necessary.

Recommendations for action:
NOTE: For other recommendations relating to improving the quality of care in care homes see recommendations in section 7.13 on training and 7.14 on use of anti psychotropic medication.

<table>
<thead>
<tr>
<th>Recommendation 16: NDS Objective 11: Living well with dementia in care homes.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R 16.1</strong> Review the existing care home support services/mechanisms in relation to physical and mental health care; include primary care, community matrons, psychiatric liaison and other external support services.</td>
</tr>
</tbody>
</table>
| **R 16.2** Develop and appraise a range of options for an integrated model for care home support in Haringey with an action plan for future development.  
Include a stand alone mental health service and a joint service incorporating the existing care home support from Community Matrons in model option appraisal |
| **R 16.3** In conjunction with other market development initiatives ensure the development of high quality care home provision for people with dementia and older people with mental health needs  
Establish robust links between the Older Peoples Mental Health Steering Group and the market development and management activities within Haringey Adult Services and Commissioning Business Unit Care. Identify a named lead with reporting responsibilities to the Steering Group on developments to take a lead in supporting the development of high quality care home provision that meets the mental and physical health care needs of older people in Haringey. |
| **R 16.4** Audit Haringey’s care homes’ level of understanding and ability to work within the legal framework of the Mental Capacity Act and feed results into the workforce development and care home support service initiatives. |
6.12. NDS Objective 12: Improved end of life care for people with dementia

From the National Dementia Strategy:
People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy.

Local work on the End of Life Care Strategy to consider dementia.

Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide
- E1: Recognise dementia as a terminal illness.
- E2: Follow guidance outlined in the Department of Health’s End of Life Care Strategy.
- E3: Involve carers and family.
- E4: Exercise the Mental Capacity Act.
- E5: Ensure faith and cultural preferences are taken into account if patient cannot communicate their choice.
- E6: Identify if the person with dementia already has a plan and act on that plan.
- E7: Where possible patients with dementia who are dying should not be moved from their usual place of residence in their last days.

Haringey services:
The care of people at their end of life requires significant cross discipline multi agency work as generic and specialist dementia and palliative care services are involved in supporting people with dementia and their carers. In October 2009 Marie Curie Cancer Care and in partnership with NHS Haringey, Haringey Council, BEH-MHT and third sector agencies published a report on service in Haringey End of Life Care for People with Dementia (2009).

The report acknowledged the good work of Community Matrons in care homes, the Admiral Nurse Service and the Palliative Care Team – all services involved in supporting people with dementia and their carers at the end of life.

Gaps:
The Marie Curie report on End of Life Care for People with Dementia (2009) made a number of recommendations under the following themes
- Pathways of care.
- Impact of hospitalisation.
- Financial implications.
- Advanced Care Planning.
- Impact of Carers.
- Staff skills and training.

The above are all designed to improve the quality of end of life care for people with dementia and their carers.

Opportunities:
The recommendations of the Marie Curie Report form the core of an action plan for development of end of life care services for people with dementia in Haringey and can be used to guide future work.
The Mental Capacity Act provides an essential operating framework for working with people with dementia at the end of life, for example, setting out how best interest decisions should be approached.

**Recommendations for action:**

**Recommendation 17: NDS Objective 12: Improved end of life care for people with dementia.**

**R 17.1 Establish a working group to implement the recommendations of the Marie Curie End of Life and Dementia Report.**

Re-establish the steering group for the Marie Curie End of Life and Dementia project as a formal sub group of the Older Peoples Mental Health Steering Group to i. draft an action plan to implement the recommendations of the Marie Curie End of Life and Dementia report. ii. lead on the implementation of the action plan reporting to the OPMH Steering Group.

Identify of a member of the Community Matrons Team in NHS Haringey to work with the End of Life and Dementia sub group on improving end of life care in care homes for people with dementia and supporting care home staff in the operation of the Mental capacity Act in relation to end of life issues.

**6.13 NDS Objective 13: An informed and effective workforce for people with dementia**

*From the National Dementia Strategy:*

Health and social care staff involved in the care of people who may have dementia to have the necessary skills to provide the best quality of care in the roles and settings where they work. To be achieved by effective basic training and continuous professional and vocational development in dementia.

*Related recommendations, actions and activities from the Healthcare for London Dementia Services Guide:*

- ID4: Use of standard screening tools to identify symptoms that warrant referral to Memory Assessment Services.
- ID5: Recognition of difference between symptoms of dementia and delirium.

*Haringey services:*

BEH-MHT and Haringey Council have both offered training in dementia care for health and social care staff.

The Admiral Nursing service allocates 40% of its time to training and education. Training is delivered in formal and informal settings, to those involved in supporting people with dementia including carers. The Dementia Forum and associated Dementia Interested Group facilitated by the Admiral Nursing service is a key source of education and training on dementia care in Haringey and has a wide membership representing mental health services, primary care, specialist palliative care, social care, acute care and the voluntary and independent sector as well as carers and representatives from learning disability groups.
**Gaps:**
There is no whole joint workforce development and training strategy or coordinated programme of training (which incorporates Mental Capacity Act and Deprivation of Liberty Safeguards) in dementia care in Haringey.

**Opportunities:**
Increased partnership and joint work across health and social care and the principles in the Total Place pilots (see section 3.2 above) can help develop a joint approach workforce development training and education strategy. There are a number of national and London wide work streams and guidance that will support the work including:

- **NICE/SCIE National Clinical Guidance 42 on Dementia** reviews staff training, identifies barriers and provides checklists of what could be included in dementia awareness and challenging behaviour training.
- **Healthcare for London Dementia Services Guide** - Integrated Pathway Workforce Competencies
- The Department of Health review of existing accredited dementia training and education to be published in spring 2010.

**Recommendations for action:**

<table>
<thead>
<tr>
<th>Recommendation 18: NDS Objective 13: An informed and effective workforce for people with dementia.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R 18.1 Establish a multi-agency dementia training working group with training leads and representatives from all agencies to develop a comprehensive training programme and implementation plan</strong></td>
</tr>
<tr>
<td>The Training Working Group to be a sub group of the Older Peoples Mental Health Steering Group and undertake the following tasks:</td>
</tr>
<tr>
<td>• Audit training needs and existing resources.</td>
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<td>• Explore kite mark, passports, e-learning and accreditation.</td>
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<tr>
<td>• Develop training pathways and levels.</td>
</tr>
<tr>
<td>• Investigate joint sources of funding.</td>
</tr>
<tr>
<td>• Produce a joint workforce development and training strategy for dementia.</td>
</tr>
<tr>
<td>• Ensure Mental Capacity Act and Deprivation of Liberty Safeguards are well covered in the training programme on dementia care or elsewhere.</td>
</tr>
<tr>
<td>The proposed priority groups for training are:</td>
</tr>
<tr>
<td>• Care Homes.</td>
</tr>
<tr>
<td>• Domiciliary Care.</td>
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<tr>
<td>• Primary Care / GP’s and practice nurses.</td>
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<tr>
<td>• Carers.</td>
</tr>
<tr>
<td>• Assessment and Care Management / individualised budget brokers.</td>
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<tr>
<td>• General hospital staff.</td>
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</table>

In response to the growing concern about the over-prescription of anti-psychotic drugs to people with dementia who develop behavioural and psychological difficulties (for example: agitation, aggression, wandering, shouting repeated questioning and sleep disturbances) the Department of Health commissioned an independent clinical review.
The review report *The Use of Antipsychotic medication for people with dementia: A Time For Action (2009)* concluded that there is emerging evidence that antipsychotic mediation has a limited positive effect in treating behavioural and psychological difficulties (BPSD) and can cause significant harm to some people.

This conclusion must be viewed in the context of ongoing medical trials in cases where the behaviours are severe and present complex risks as there may be value in the controlled use of the medication – where a careful use of the medication is beneficial.

The overall view of the report is that there is an overuse of antipsychotic medication nationally (circa 180,000 per year nationally) for people with dementia with BPSD. Other non-pharmacological options and interventions should be more readily available to support people with dementia and their carers. There are 11 recommendations in the report on the future use of antipsychotic medication and the support management of people with BPSD and the Department of Health has announced a national action plan:

- A new National Clinical Director for Dementia.
- Measures to ensure people with dementia and their carers have access to psychological therapies to tackle the root of agitation and aggression.
- A national audit to generate data on the prescribing of antipsychotic drugs to people with dementia in each PCT in England.
- Clear local targets to cut antipsychotics use as a result of the audit
- Better regulation of the use of antipsychotic medication.
- Collaboration with the General Medical Council (GMC) and Royal Colleges to ensure all health and social care staff have specialist training in dementia.
- Joint Department and Alzheimer's Society guidance on what to do if a family member is given antipsychotics.

**Recommendations for action:**

<table>
<thead>
<tr>
<th>Recommendation 19: Anti-psychotic medication and behavioural and psychological symptoms in dementia (BPSD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>R19.1 To appoint a senior clinician to lead on the development and implementation of a local action plan to implement the recommendations of the Time for Action report on the use of antipsychotic medication.</td>
</tr>
</tbody>
</table>

Tasks will include an audit, establishment of local targets for reduction in usage, joint work across primary care and dementia care services and link with development of care home support service planning (see section 7.11) and the development of non-pharmacological treatments and pathways.

**7. FUNCTIONAL MENTAL HEALTH - INTRODUCTION**

**7.1. A Service Model for Older Peoples Functional Mental Health**

The Department of Health Consultation document New Horizons builds on the National Service Frameworks for Mental Health and Older People. New Horizons will form a programme of action to advance the twin aims of improving the mental health and well-being of the population and the quality and accessibility of services for people with poor mental health.
Using the New Horizons document as a basis for a model of service for older people with functional mental health problems the following framework can be used to measure Haringey's services

**Well being and promotion of Better Mental Health:**

- Promoting mental well-being and reducing the risk factors for poor mental health.
- Targeting interventions towards those who are at risk of developing mental health problems.
- Promoting recovery and better outcomes for people who have mental health problems.

**i. Better Mental Health Care:**

- Onset and initial phases including: Early Intervention, assessment and information.
- Acute care including: Crisis Resolution/Home Treatment Teams, Acute inpatient care, crisis beds and houses, long term care, alcohol and substance misuse.

The service model must be grounded in the principles of recovery and ensure there is equity and appropriateness of service delivery across all groups including Black and Minority Ethic communities, women and men and older people.

A core message of New Horizons is to ensure that there is no age discrimination in mental health services and that the full range of services available for people aged 18-65 are also available for older people over 65. However, it is widely acknowledged nationally that there is age discrimination in mental health services.

The Royal College of Psychiatrists have published a Compendium of Evidence on The Need to Tackle Age Discrimination in Mental Healthxxviii which lists a range of evidence of age discrimination including:

- The NSF for Mental Health specifically excluding older people by being aimed at 18-65 age group only.
- The NSF for Older people published two years later only having one of the eight standards devoted to mental health which only addressed dementia and depression.
- A number of recent authoritative reports by well respected organisations have demonstrated that there is age discrimination in older peoples mental health services across the countryxxix

Ensuring equity of access and delivery of services is not necessarily about everyone having the same service for all; a one size fits all approach may not be appropriate or achieve equity. A preferable way forward is to ensure a need based approach to the delivery of services.

**7.2. Are older people’s needs different to younger people with MH problems?**

As long as a needs based approach is adopted rather than a strict age related division, the answer is that older peoples mental health needs are often different to those of younger people.
The differences relate to the presentations of mental health problems and the increased incidence of co-morbidities (other illnesses) in older people. Older people often have specific needs relating to medication and poly-pharmacy (the risks associated with the use of multiple medications and over prescription of drugs more common in older people than younger).

Differences in Schizophrenic-like conditions in Older People suggest doubt about the condition being the same in OP as in younger people. There is also evidence that older people’s mental health problems may need different definitions, diagnosis and treatment to younger people. The involvement of family carers with older people is also often different to carer involvement with younger people with mental health problems; this also requires different levels of understanding and experience.

To ensure that older people have equal access to services, the services available should be age appropriate and the staff delivering the care need the right level of skill, knowledge and experience in working with older people with mental health problems.

8. FUNCTIONAL MENTAL HEALTH - GAP ANALYSIS AND RECOMMENDATIONS

8.1. Good mental health promotion and prevention

SEE ALSO LINK TO DEMENTIA: See Section 7.1 and Recommendation 6 above for review of Haringey services, gap analysis and recommendations covering good mental health promotion, awareness and prevention strategies and actions.

Older people with mental health problems can be among the most socially isolated and excluded groups in society. The factors that are important in reducing this isolation and the impact of poor mental health in older people include:

- Reducing stigma and discrimination.
- Increasing participation in meaningful activities and social involvement.
- Promoting physical health, including the ability to carry out everyday tasks.
- Combating poverty.
- Support families and carers.
- Helping to build and maintain relationships and community engagement.
- Reducing isolation and increasing community engagement.

The Third Sector, community and faith groups have a unique and valuable role to play in this task along with arts, sports and leisure based organisations in the Borough. The impact of small scale local community based initiatives significantly contribute to maintaining well being and reducing reliance on more specialist health and social care support services. For example – befriending and volunteering schemes, access to information and advice and signposting, arts and spots based activities and opportunities.
Mental capacity issues in older people with functional mental illness are particularly complex, due to the common co-morbidity of cognitive decline, physical ill health and severe mental illness. Fluctuating capacity poses difficulties for staff working in a personalised manner – attempting to enable dignity, choice and control, as the ability to take choice and control varies widely.

This requires particular skills around assessing capacity, assisting decision making and making best interests decisions within the legal framework of the Mental Capacity Act.

Recommendations for action:

<table>
<thead>
<tr>
<th>Recommendation 20: Good mental health promotion and prevention</th>
</tr>
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<tbody>
<tr>
<td>R 20.1 Commissioners to undertake a review of available community based early intervention and prevention resources across the borough to identify gaps (relating to locality, ethnicity, culture, age, gender etc.) and formulate priorities for further developments and alternative funding opportunities.</td>
</tr>
</tbody>
</table>

8.2. Early Diagnosis and Treatment

Early identification, diagnosis, quick access to services and activities all reduce the impact and development of serious mental health problems. This is essential to a whole system service. Greater awareness of the risk factors and groups particularly at risk has all been shown to reduce the incidence of more severe mental health problems in all age groups. These groups include Black and Minority Ethnic communities, Lesbian and Gay communities, people with long term chronic health problems. There should be regular and appropriate screening and identification and awareness of the range of treatment options available, including referrals to social care and third sector organisations (‘social prescribing’).

A model for early intervention and treatment services is developing within children’s and young peoples’ services. This combines early access to assessment, treatment and intervention, the provision of information, involvement and support of carers and family. It has a strong emphasis on the importance of primary care. The early intervention model combined with the principles of the Recovery Model can be used to inform the development of early diagnosis and treatment services for older people.

The Recovery model is consistent with assisting people to use the planning tools of the Mental Capacity Act, for example Lasting Power of Attorney and statements of wishes. It maximises peoples decision making in the times that they have full capacity, in preparation for times when they may lack capacity to make some or many decisions, as a function of their mental state.
**Recommendations for action:**

**Recommendation 21: Early Diagnosis and Treatment**

<table>
<thead>
<tr>
<th>R 21.1</th>
<th>Establish a sub group of the Older Peoples Mental Health Steering Group to review demand and make recommendations on the development of early diagnosis and treatment models in Haringey for older people with mental health problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>The sub group to:</td>
<td></td>
</tr>
<tr>
<td>• Review existing models of early diagnosis and treatment services for older people with depression and psychosis.</td>
<td></td>
</tr>
<tr>
<td>• Make recommendations about the development of a multi agency pilot project for older people with depression and psychosis focusing on primary care, general hospitals and care homes.</td>
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</table>

**8.3. Crisis Resolution / Home Treatment Teams**

There is a growing body of evidence that older people with mental health problems benefit from a crisis resolution / home treatment team service. The emerging theme from the limited studies available suggests that the best outcomes for older people are attained when there is a specialist home treatment team with a critical mass of workers trained in older people mental and physical health care. They are able to respond rapidly to and treat the broad range of mental health needs.

**Haringey services:**

There is no specialist crisis resolution or home treatment team for older people in Haringey but older people over 65 are able to use the adults (18-65) Home Treatment Team service provided by BEH-MHT. Not all people over 65, particularly those with complex and multiple physical and mental health care needs are able to access this service. The focus of the work is with people with mental health needs that do not have the complications of many people over 65. The service also does not perform any gatekeeping role in relation to admissions to the older people’s acute mental health beds.

**Opportunities:**

The potential development of a specialist domiciliary care service for people with dementia, closely aligned to the integrated team of dementia specialists and Memory Assessment Service hosted by BEH-MHT (see Section 7.2 Recommendation 7.1 above). An option to consider, depending on the outcome of discussions on the application of the Service Line development described above, would be to have a combined older peoples mental health and dementia home treatment team.

**Recommendations for action:**

| Recommendation 22: Crisis Resolution / Home Treatment Teams (Functional MHOP) |
|---|---|
| R 22.1 | Review and appraise evidence and local options for the establishment or extension of an age appropriate crisis resolution / home treatment team with a gatekeeping function for admission to acute MH beds to all people over 65 with functional mental health problems. |
8.4. Care Home liaison and Support

LINK TO DEMENTIA: See Section 7.11 and Recommendation 16 above for review of Haringey services, gap analysis and recommendations covering the development of mental health care home support services. The potential tasks of this sort of service include:
- Strengthening psychiatric input into care homes.
- Facilitating improved standards of care.
- Offering advice, training, systematic reviews and screening (medication / depression / cognitive impairment, for example).
- Provide support to care homes on complex issues of mental capacity, best interests, restraint and deprivation of liberty.

The benefit of this type of service would be an improved quality of life and well being for care home residents. There will be significant cost savings resulting from reduced medication requirements and a reduction in the number of admissions to acute mental health and general hospital beds.

8.5. Access to psychological therapies

Psychological therapies and particularly cognitive behavioural therapy are effective interventions for older people. The delivery of psychosocial interventions requires therapists with specialist knowledge and expertise of ageing to provide age appropriate treatment (Anderson et al (2009) - Royal College Psychiatrists). The DH publication Improving Access to Psychological Treatments (IAPT) - Older People Positive Practice describes the particular needs and issues for commissioning and providing IAPT services to the diverse population of older people covering:
- Understanding the needs of older people
- Removing Barriers to Access
- Engaging older people
- Training and developing the workforce

It offers a number of actions and approaches that would increase the take up and effectiveness of IAPT services for older people. For example:
- Developing a greater understanding of older people’s views attitudes and behaviour in relation of mental health and seeking support.
- Work with GP’s and primary care to raise awareness and support them to identify older people who may benefit from an IAPT service.
- Offering training and education to staff who come into contact with older people, for example in care homes, hospitals, community and faith based groups to help them identify and refer people with mental health problems and refer on to IAPT.

**Haringey Services**
The Increasing Access to Psychological Therapies (IAPT) has dramatically increased the availability of talking therapies in the Borough since its inception in October 2008. It is collaboration between NHS Haringey, BEH-MHT and the Third Sector. The IAPT service model is based on evidence of effective interventions for
people with depression and all anxiety disorders. The service comprises 3 teams aligned to Primary Care Practice Based Commissioning Groups.

The skill mix of the teams includes Cognitive Behavioural Therapists, Counsellors, Psychological Well being Practitioners and Employment Advisors.

From October 2008 to December 2009 IAPT has received 4,536 referrals of which 159 (3.5%) were from people over the age of 65.

**Gaps:**
The lowest estimate of number of people over 65 with depression in Haringey is 2,080; the highest estimate is 3,120 (see above section 3.4). Matching these figures against the numbers of people over 65 suggests that older people are not accessing IAPT services in the same numbers as people under 65.

The IAPT service does not offer a specialist service for older people with staff trained and experienced in the process of ageing and the provision of age appropriate interventions.

**Recommendations for action:**

<table>
<thead>
<tr>
<th>Recommendation 23: Access to psychological therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 23.1 IAPT service to review skill mix of staff and offer specific training to staff to develop expertise in working with older people.</td>
</tr>
<tr>
<td>R 23.2 IAPT service to actively advertise and promote their service to people over the age of 65 and offer additional information and education to staff who come into regular contact with older people e.g. in care homes, hospitals community and faith based groups.</td>
</tr>
</tbody>
</table>

8.6. **Personalised social care services**

LINK TO DEMENTIA: See Section 7.6 and Recommendations 11 above for review of Haringey services, gap analysis and recommendations covering the development of personalised social care services for older people with functional mental health needs.

9. **IMPLEMENTATION AND MONITORING ARRANGEMENTS**

9.1. **Recommendations, timescales and delivery plan**

Each of the recommendations made is linked to either a National Dementia Strategy (NDS) Objective or an identified gap in older people's functional mental health services; several are shared across both service areas. A complete rundown of the recommendations is shown in the Appendix, (10.1).
The NDS Implementation Plan has set timescales for implementation of each objective and, where linked with functional mental health recommendations, these have been given the same target date. The table below sets out over the five year period for the Framework the schedule for the work on each set of recommendations showing when the work on each starts, continues, completes implementation and then development continues.
<table>
<thead>
<tr>
<th>Objective summary / By year end</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDS 1 Public awareness campaign</td>
<td>Complete</td>
<td>Continued</td>
<td>Continued</td>
<td>Continued</td>
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<tr>
<td></td>
<td>implementation</td>
<td>development</td>
<td>development</td>
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<tr>
<td>NDS 2 Memory Assessment Service</td>
<td>Complete</td>
<td>Continued</td>
<td>Continued</td>
<td>Continued</td>
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<td></td>
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<tr>
<td>NDS 3 Information provision</td>
<td>Complete</td>
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<td>Continued</td>
<td>Continued</td>
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<td></td>
<td>implementation</td>
<td>development</td>
<td>development</td>
<td>development</td>
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<tr>
<td>NDS 4 Dementia Advisors</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<td></td>
<td></td>
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<tr>
<td>NDS 5 Peer Support</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<td></td>
<td></td>
<td>implementation</td>
<td></td>
<td>development</td>
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<tr>
<td>NDS 6 Personal social care</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<tr>
<td></td>
<td></td>
<td>implementation</td>
<td></td>
<td>development</td>
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<tr>
<td>NDS 7 Cares Strategy</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<tr>
<td></td>
<td></td>
<td>implementation</td>
<td></td>
<td>development</td>
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<tr>
<td>NDS 8 General Hospitals</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<tr>
<td></td>
<td></td>
<td>development</td>
<td></td>
<td>development</td>
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<tr>
<td>NDS 9 Intermediate care</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<td></td>
<td></td>
<td>development</td>
<td></td>
<td>development</td>
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<tr>
<td>NDS 10 Housing / telecare</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<tr>
<td></td>
<td></td>
<td>development</td>
<td></td>
<td>development</td>
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<tr>
<td>NDS 11 Improve Care homes</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<tr>
<td></td>
<td></td>
<td>development</td>
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<td>development</td>
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<tr>
<td>NDS 12 End of Life care</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<td></td>
<td></td>
<td>development</td>
<td></td>
<td>development</td>
</tr>
<tr>
<td>NDS 13 Training strategy</td>
<td>Start work</td>
<td>Continue</td>
<td>work</td>
<td>Complete</td>
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<td></td>
<td></td>
<td>work</td>
<td></td>
<td>implementation</td>
</tr>
<tr>
<td>Antipsychotic medication</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<tr>
<td></td>
<td></td>
<td>development</td>
<td></td>
<td>development</td>
</tr>
<tr>
<td>FMH Promotion &amp; prevention</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<tr>
<td></td>
<td></td>
<td>development</td>
<td></td>
<td>development</td>
</tr>
<tr>
<td>FMH Early diagnosis &amp; intervention</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<tr>
<td></td>
<td></td>
<td>development</td>
<td></td>
<td>development</td>
</tr>
<tr>
<td>FMH Home Treatment Team</td>
<td>Start work</td>
<td>Complete</td>
<td>implementation</td>
<td>Continued</td>
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<tr>
<td></td>
<td></td>
<td>development</td>
<td></td>
<td>development</td>
</tr>
<tr>
<td>FMH Psychological therapies</td>
<td>Start work</td>
<td>Continue</td>
<td>work</td>
<td>Complete</td>
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<td></td>
<td></td>
<td>work</td>
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<td>implementation</td>
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</tbody>
</table>
9.2. Project Management

The recommendations in this Commissioning Framework will ensure a whole system reorganisation of dementia and older people’s mental health services. The significant organisational change required will be achieved through the adoption of a project management approach. The Older Peoples Mental Health Steering Group will be responsible for leading and driving through the change, operating as the Project Management Board.

The Steering Group will appoint leads for each Recommendation / Action. The leads will be responsible for the delivery of the recommendations on target. Leads may, with the agreement of the Steering Group, establish TIME LIMITED Working Groups to support them in their work. The membership and terms of reference for each Working Group will be agreed by the Steering Group. The diagram below shows how all these groups will work together:

9.3. Involvement of service users and carers

The direct involvement of users and carers will be central to the implementation of this Commissioning Framework. The membership of the Older Peoples Mental Health Steering Group will be reviewed to include users and carers and where possible users and carers will be included in the membership of any time limited Working group established.

Recommendations for action:

**Recommendation 24: Improve user and carer involvement**

R 24.1 Establish and support a carer/user reference group for the Older Peoples Mental Health Steering Group ensuring representation from Haringey’s diverse community.
## 10. APPENDIX

### 10.1. Recommendations

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation 1: Needs assessment and data collection.</td>
<td>R 1.1 Improve the coordination and production of population and needs data across the JSNA projects for Older People and Mental Health services. &lt;br&gt;The Older Peoples Mental Health Steering Group to ensure that there is a high level of communication and coordination between the Phase Two JSNA projects in Older Peoples and Mental Health services and the Steering Group to ensure i. that there are jointly agreed common data sets (based on NDS Joint Commissioning Framework for dementia) and ii. that priority areas for further data collection in older peoples mental health and dementia services are included in future work including the use of the developing national dementia metrics. &lt;br&gt;R 1.2 Compare numbers of people with dementia known to services against prevalence data - annually. &lt;br&gt;The Older Peoples Mental Health Steering Group will conduct an annual matching exercise across health, social care and third sector services (where appropriate) to establish the number of people, with dementia known to dementia services; and match data collected against the Primary Care Quality Outcomes Framework / GP Dementia Registers and projected prevalence data.</td>
</tr>
<tr>
<td>Recommendation 2: Contract/SLA specifications and metrics.</td>
<td>R 2.1 Ensure services have detailed service specifications. &lt;br&gt;That the lead commissioners in health and social care for older people’s mental health and dementia services review the specifications for services, identify gaps and priorities and, in conjunction with providers and the market development projects in personalisation, draft detailed specifications for each service area according to the agreed priorities. The new specifications to include specific references to skills and expertise required to implement personalisation agenda in the context of the Mental Capacity Act and Deprivation of Liberty Safeguards and requirements in relation to all equality diversity strands. The use of the Standard Contract for health care services will be an essential tool in this work.</td>
</tr>
<tr>
<td>Recommendation 3: Funding older people’s mental health and dementia services.</td>
<td>R 3.1 Identify current spend on specialist dementia services and percentage of generic services used by people with dementia. &lt;br&gt;That the lead commissioners in health and social care for older people’s mental health and dementia services work with providers of services to identify current spend across health and social care on a. specialist services for people with dementia and older people with mental health problems and b. generic services used by this group of people. The aim of this work will be to inform commissioners about the allocation of existing resources across the whole system.</td>
</tr>
<tr>
<td>Recommendation 4: Joint Commissioning leads.</td>
<td>R 4.1 Have named lead commissioners for dementia and older peoples mental health services in health and social care. &lt;br&gt;In order to progress the development of joint commissioning of services for people with dementia and older people with mental health problems named lead commissioners must be identified who will be responsible for both the strategic direction and direct commissioning tasks in both</td>
</tr>
</tbody>
</table>
Haringey Council and NHS Haringey.

The key tasks of the lead commissioners will include:

- Ensure the delivery of service development in National Dementia Strategy and New Horizons project
- Providing a robust link between strategy, commissioning and contracting functions
- Influencing other commissioners across service areas
- Identify opportunities across traditional boundaries and throughout the whole system
- Coordinate inclusion of other policy themes for example, Dignity, Carers Strategy, Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards.
- Contributing to the development of the new GP Commissioning Consortia and representing dementia and older people mental health within that work

<table>
<thead>
<tr>
<th>Recommendation 5: Integrated Care Pathways.</th>
<th>R 5.1 To develop a high level integrated care pathway for people with dementia.</th>
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<tbody>
<tr>
<td></td>
<td>The high level integrated care pathway for people with dementia must incorporate indicators for the movement along the pathway and the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards requirements as appropriate.</td>
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</table>

<table>
<thead>
<tr>
<th>Recommendation 6: NDS Objective 1: Improving public and professional awareness and understanding of dementia [and older people’s mental health issues].</th>
<th>R 6.1 Develop a whole system Joint Communication Plan to raise awareness and understanding of dementia and older people’s mental health.</th>
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<tr>
<td></td>
<td>The Communication Plan must take account of the diverse needs and cultural norms within the Haringey population and target traditionally hard to reach groups. Ensure the Plan includes cross referencing and joined up work with other similar strategies and plans in older people and adult mental health services and other health promotion activities (for example: smoking cessation and obesity campaigns making reference to reduced risks of dementia) and develop specific campaigns on e.g. older people and depression.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Recommendation 7: NDS Objective 2: Good-quality early diagnosis and intervention for all.</th>
<th>R 7.1 Agree a model and detailed service specification for the Memory Assessment Service.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Joint Commissioners, in conjunction with users and carers and BEH-MHT, to agree a model and specification for operation and development over time of the MAS service in Haringey, incorporating strategic decisions on:</td>
</tr>
<tr>
<td></td>
<td>• Client groups to be served</td>
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<tr>
<td></td>
<td>• Which elements of the service will be included and who will provide them</td>
</tr>
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<td></td>
<td>• Location of MAS</td>
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<td></td>
<td>• Cross borough options for specialist MAS</td>
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<td></td>
<td>• Clear integrated pathway</td>
</tr>
<tr>
<td></td>
<td>• Capacity, data collection and targets for activity and performance (e.g. waiting times, timescales for diagnosis, MMSE score at diagnosis etc)</td>
</tr>
</tbody>
</table>
• Use of the of Primary Care Quality Outcomes Framework and GP Dementia
  • Registers and dementia matching exercise to monitor the impact of service delivery in relation to early diagnosis.

R 7.2  **Raise the level of awareness of GP’s (Primary Care) about the importance of early diagnosis of dementia**

Review the current links between Primary Care and the Memory Clinic and agree a programme of actions to increase awareness in primary care and improve joint working.

R 7.3  **Agree an action plan for the development of services for people with learning disabilities and dementia**

Identify a lead for people with learning disabilities and dementia to sit on Older Peoples Mental Health Steering Group and the Learning Disabilities Dementia Working Group. Lead to develop a joint action plan for people with learning disabilities and dementia including the development of the integrated dementia pathway for people with learning disabilities and proposals for future service provision and post diagnostic pathway.

R 7.4  **Agree model of service for people with early age onset dementia**

Identify lead for early age onset dementia to sit on Older Peoples Mental Health Steering Group. Lead to review current services for people of with early age onset dementia, including cross borough services and develop proposals for future service provision and development of post diagnostic pathway.
Recommendation 8:
NDS Objective 3: Good-quality information for those with diagnosed dementia and their carers.

R 8.1 Review existing sources of information on dementia and match against need. and publish a dementia services guide/booklet for Haringey.
Commissioning a full review of the available sources of information for people with dementia and their carers and match against need to identify duplication and gaps. Include in the review a consideration of the needs of people who do not have English as their first language hard to reach groups, and the places and sources of information preferred by users and carers. This may include extending the scope of existing locations for information to e.g. libraries and community based groups. Seek the views of people with dementia and their carers as part of the review. Use information gathered to publish a dementia services guide/booklet.

Recommendation 9:
NDS Objective 4: Enabling easy access to care, support and advice following diagnosis.

R 9.1 Review existing post diagnostic support and advice services and agree model for future provision.
That the joint commissioners for dementia services: a. wait the early messages from the Dementia Advisors Demonstrator sites about effectiveness of different service models; b. explore complementary provision to the Admiral Nursing service for people who live alone without carers including the use of utilising existing community based groups, volunteers and expanding on the social capital model. c. Ensure that Advanced Care Planning is included in future post diagnostic service provision.

Recommendation 10:
NDS Objective 5: Development of structured peer support and learning networks.

R 10.1 Review existing peer support mechanisms and agree model for future provision.
Commissioners and providers to work together to identify alternative ways of supporting the development of structured peer support networks including the use of Social Capital projects, developing a supported network of potential facilitators in existing community based groups and existing volunteer schemes.

Recommendation 11:
NDS Objective 6: Improved community personal support services.

R 11.1 That personalisation planning and pilots include people with dementia and older people with mental health problems.
Robust links to be developed as a priority between the working groups tasked with implementing personalisation (e.g. Market Management & Core Design Groups) with co-opted representatives from dementia services nominated to attend with reporting responsibilities to the Older Peoples Mental Health Steering Group. The aims of the work to include a clear focus on outcome based services rather than time or task based packages of care, seeking the views of potential individualised budget holders and their carers about costs / levels of expertise / specialist versus generic services AND review available publicity and information about personalisation, identify gaps in relation to people with dementia and their carers and take action to cover any gaps identified.

R11.2 Ensure the personalisation decision making tools and support are developed to support and meet the particular needs of people with dementia and older people with mental health problems.
The Older Peoples Mental Health Steering Group to work closely with personalisation working groups to ensure that particular expertise is developed within Haringey to support people with dementia and older
people with mental health problems to make decisions, identify where they lack capacity and ensure appropriate processes are in place and followed in making decisions on behalf of the person concerned.

R 11.3 That the commissioners of social care services regularly update and review the proposed numerical model for demand projection and match against actual activity and service delivery data.

R 11.4 That commissioners consider the development of the Haringey Council ‘In House’ Home Care service to provide a specialist dementia domiciliary care service.

Further consideration to be given to the development of this service into a jointly funded Home Treatment Team for people with dementia and/or older people with functional mental health problems.

<table>
<thead>
<tr>
<th>Recommendation 12: NDS Objective 7: Implementing the Carers’ Strategy.</th>
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<tbody>
<tr>
<td><strong>R 12.1</strong> Robust links to be developed as a priority between the Older Peoples Mental Health Steering Group and the Carers Partnership Board.</td>
</tr>
<tr>
<td>Co-opted representative(s) from dementia and older peoples mental health services nominated to attend the Carers Partnership Board with reporting responsibilities to the Older Peoples Mental Health Steering Group. The Older Peoples Mental Health Steering Group will be responsible via the carers link representative for ensuring that the Carers Strategy Priority Outcomes and any actions arising are implemented in dementia and older peoples mental health services and that issues of relevance to carers of people with dementia are represented at the Carers Partnership Board.</td>
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<tr>
<td><strong>R 13.1</strong> To develop a programme of actions designed to improve the joint commissioning and provision of acute general hospital care for people with dementia and older people with mental health problems.</td>
</tr>
<tr>
<td>That the Commissioner for health care services for people with dementia (and older people with mental health problems) to work closely with other commissioners of dementia services and of acute hospital services, cross borough, to:</td>
</tr>
<tr>
<td>- Evaluate the capacity and demand in older people’s psychiatric liaison services in both the Whittington and North Middlesex Hospitals</td>
</tr>
<tr>
<td>- Research other models of hospital liaison services to inform development to inform future commissioning of the service</td>
</tr>
<tr>
<td>- Work closely with the designated lead senior clinician for dementia to champion older people’s mental health in hospital and to develop a clear care pathway for the management of people with dementia in hospital following the Healthcare for London General Hospital Pathway model.</td>
</tr>
<tr>
<td>- Ensure through the provision of appropriate training, service specifications and monitoring, a high level of confidence and competence in using the Mental Capacity Act amongst medical and nursing staff in general hospitals.</td>
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<tr>
<td><strong>R 13.2</strong> That integrated social and health care pathways and protocols are agreed describing the operational interface between the general hospitals (Whittington and North Middlesex) and the local Haringey Social care and Specialist</td>
</tr>
</tbody>
</table>
**Recommendation 14:**

**NDS Objective 9:** Improved intermediate care for people with dementia.

**R 14.1** Robust links to be developed as a priority between the Older Peoples Mental Health Steering Group and the Intermediate Care and Rehabilitation Steering Group with co-opted representative(s) from dementia services nominated to attend with reporting responsibilities to the Older Peoples Mental Health Steering Group.

The role of the dementia services representative(s) will be to ensure the following:

- That the service specification for intermediate care services meets the needs of people with dementia and promotes more flexible access.
- Performance monitoring routinely monitors primary and secondary diagnoses of dementia in relation to admission rates, Length of Stay and Delayed Transfers Of Care as well as access to intermediate care for people with dementia.
- The Steering Group considers the needs of people with dementia when developing interim (step down) beds
- The Steering Group considers the training needs of intermediate care staff in dementia care and the Mental Capacity Act.
- The Steering Group reviews the arrangements and options for intermediate care staff to have ready access to the specialist dementia service (including consideration of the feasibility of recruiting mental health professionals as core members of the intermediate care service).

**R 14.2** The Older Peoples Mental Health Steering Group to review and consider appropriate models for the development of:

- Mental health based services to provide admission avoidance and early supported discharge for people with dementia.
- Virtual wards in a community setting.

**R 14.3** That BEH-MHT undertake an audit of admissions to the acute mental health beds in Cedar Ward and use as basis for planning admission avoidance services.

**Recommendation 15:**

**NDS Objective 10:** Considering the potential for housing support, housing-related services and Telecare to support people with dementia.

**R 15.1** The Older Peoples Mental Health Steering Group to participate fully in the development of the Older Peoples Housing Strategy and ensure that consideration of the following is included (over page):

- The benefits of different types / models of extra care accommodation schemes for people with dementia and their carers, for example, dedicated dementia developments, dementia friendly services,
and their carers. integrated or separate units within a single development (referencing emerging evidence/research).

- The potential for extra care sheltered accommodation to be used as a base for a range of community support services.
- The inclusion of social capital and community resources in the development of extra care and sheltered accommodation.
- The body of knowledge and experience in design and the built environment principles in relation the needs to people with dementia (e.g. use of colour schemes, visual clues, security, Telecare).
- The involvement of people with dementia and older people with mental health problems in the development of the Older Peoples Housing Strategy.
- Review existing housing support services to ensure they are appropriately assessing supporting and managing risk in the community to enable people to live in their own homes more safely and for longer.
- Ensure cross sector working in the implementation of the strategy.
- The legal implications of starting and ending tenancies for people with impaired or lacking capacity due to dementia.

**R 15.2** That the Telecare service continues to develop and pilot innovative services to support people living in their own homes.

| Recommendation 16: NDS Objective 11: Living well with dementia in care homes. | R 16.1 Review the existing care home support services/mechanisms in relation to physical and mental health care; include primary care, community matrons, psychiatric liaison and other external support services.

R 16.2 Develop and appraise a range of options for an integrated model for care home support in Haringey with an action plan for future development.

Include a stand alone mental health service and a joint service incorporating the existing care home support from Community Matrons in model option appraisal.

R 16.3 In conjunction with other market development initiatives ensure the development of high quality care home provision for people with dementia and older people with mental health needs.

Establish robust links between the Older Peoples Mental Health Steering Group and the market development and management activities within Haringey Adult Services and Commissioning Business Unit Care. Identify a named lead with reporting responsibilities to the Steering Group on developments to take a lead in supporting the development of high quality care home provision that meets the mental and physical health care needs of older people in Haringey.

R 16.4 Audit Haringey’s care homes’ level of understanding and ability to work within the legal framework of the Mental Capacity Act and feed results into the workforce development and care home support service initiatives.

| Recommendation 17: NDS Objective 12: Improved end of life care for people with | R 17.1 Establish a working group to implement the recommendations of the Marie Curie End of Life and Dementia Report.

Re-establish the steering group for the Marie Curie End of Life and
Dementia project as a formal sub group of the Older Peoples Mental Health Steering Group to i. draft an action plan to implement the recommendations of the Marie Curie End of Life and Dementia report. ii. lead on the implementation of the action plan reporting to the OPMH Steering Group.
Identify of a member of the Community Matrons Team in NHS Haringey to work with the End of Life and Dementia sub group on improving end of life care in care homes for people with dementia and supporting care home staff in the operation of the Mental capacity Act in relation to end of life issues.

**Recommendation 18:**

NDS Objective 13: An informed and effective workforce for people with dementia.

<table>
<thead>
<tr>
<th>R 18.1 Establish a multi-agency dementia training working group with training leads and representatives from all agencies to develop a comprehensive training programme and implementation plan.</th>
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<tbody>
<tr>
<td>The Training Working Group to be a sub group of the Older Peoples Mental Health Steering Group and undertake the following tasks:</td>
</tr>
<tr>
<td>- Audit training needs and existing resources.</td>
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<tr>
<td>- Explore kite mark, passports, e-learning and accreditation.</td>
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<td>- Develop training pathways and levels.</td>
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<td>- Investigate joint sources of funding.</td>
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<tr>
<td>- Produce a joint workforce development and training strategy for dementia.</td>
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<tr>
<td>- Ensure Mental Capacity Act and Deprivation of Liberty Safeguards are well covered in the training programme on dementia care or elsewhere.</td>
</tr>
<tr>
<td>The proposed priority groups for training are:</td>
</tr>
<tr>
<td>- Care Homes.</td>
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<tr>
<td>- Domiciliary Care.</td>
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<tr>
<td>- Primary Care / GP’s and practice nurses.</td>
</tr>
<tr>
<td>- Carers.</td>
</tr>
<tr>
<td>- Assessment and Care Management / individualised budget brokers.</td>
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<tr>
<td>- General hospital staff.</td>
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</tbody>
</table>

**Recommendation 19:**

Anti-psychotic medication and behavioural and psychological symptoms in dementia (BPSD).

<table>
<thead>
<tr>
<th>R19.1 To appoint a senior clinician to lead on the development and implementation of a local action plan to implement the recommendations of the <em>Time for Action</em> report on the use of antipsychotic medication.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasks will include an audit, establishment of local targets for reduction in usage, joint work across primary care and dementia care services and link with development of care home support service planning (see section 7.11) and the development of non pharmacological treatments and pathways.</td>
</tr>
</tbody>
</table>

**Recommendation 20:**

Good mental health promotion and prevention.

| R 20.1 Commissioners to undertake a review of available community based early intervention and prevention resources across the borough to identify gaps (relating to locality, ethnicity, culture, age, gender etc.) and formulate priorities for further developments and alternative funding opportunities. |

**Recommendation 21:**

Early Diagnosis and Treatment.

<table>
<thead>
<tr>
<th>R 21.1 Establish a sub group of the Older Peoples Mental Health Steering Group to review demand and make recommendations on the development of early diagnosis and treatment models in Haringey for older people with mental health problems.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The sub group to:</td>
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</table>
• Review existing models of early diagnosis and treatment services for older people with depression and psychosis.
• Make recommendations about the development of a multi agency pilot project for older people with depression and psychosis focussing on primary care, general hospitals and care homes.

<table>
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<tr>
<th>Recommendation 22: Crisis Resolution / Home Treatment Teams (Functional MHOP).</th>
<th>R 22.1 Review and appraise evidence and local options for the establishment or extension of an age appropriate crisis resolution / home treatment team with a gate keeping function for admission to acute MH beds to all people over 65 with functional mental health problems.</th>
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</table>
| Recommendation 23: Access to psychological therapies. | R 23.1 IAPT service to review skill mix of staff and offer specific training to staff to develop expertise in working with older people.  
R 23.2 IAPT service to actively advertise and promote their service to people over the age of 65 and offer additional information and education to staff who come into regular contact with older people e.g. in care homes, hospitals community and faith based groups. |
| Recommendation 24 User and carer involvement | R 24.1 Establish and support a carer/user reference group for the Older Peoples Mental Health Steering Group ensuring representation from Haringey’s diverse community. |

The above recommendations have been made in each section designed to identify gaps and actions required to meet the gaps.
**10.2. GLOSSARY**

**Acute care** is generally an inpatient service for a disease or illness with rapid onset, severe symptoms and brief duration.

**Advocates** are people who represent users and carers views and help them to make informed decisions.

**Aims** The changes or benefits that we are trying to achieve

**Alzheimer's disease** is a condition causing loss of memory, intellectual decline, and can cause changes in personality and behaviour.

**Antipsychotics** are drugs that were originally developed for the treatment of people with psychosis. They are often used to treat challenging behaviour (aggression, restlessness and psychiatric symptoms) in people with dementia.

**Assessment** A process which identifies the needs of an individual and evaluates how those needs impact on daily living and quality of life.

**Audit** A review designed to improve an organisation's operations. It helps an organisation reach its objectives by bringing a systematic, disciplined approach to evaluate and improve services.

**Care Package** A collective name for the service(s) a person can expect to receive following assessment.

**Carer** A person providing care who is not employed to do so by an agency or organisation. A carer is often a relative or friend looking after someone at home who is frail or ill; the carer can be of any age.

**Care Management** The process of meeting needs at an individual level, which is sometimes known as micro-commissioning.

**Commissioning** The full set of activities that local authorities and Primary Care Trusts (PCTs) undertake to make sure that services meet the health and social care needs of individuals and communities.

**Community matron** A registered nurse with an additional qualification such as District Nursing or Health Visiting, who works with people with high levels of physical, psychological and social needs. Also can offer clinical care and health promotion activities, co-ordinates the input of other health professionals and teaching and education.

**Community Mental Health Team (CMHT)** supports people with mental health problems in the community. CMHT members include community psychiatric nurses (CPNs), social workers, psychologists, occupational therapists, psychiatrists and support workers.
Community psychiatric nurse (CPN) is a nurse who specialises in mental health and is specially trained to assess and treat people experiencing mental health problems.

Consultation Working with people involved in the service to seek their views and comments on decisions / action plans / recommendations that have been made or proposed

Contract A mutual agreement enforceable by law.

Day Care/Service Day-time care usually provided in a centre away from a person’s home, covering a wide range of services from social and educational activities to training, therapy and personal care.

Dementia is a condition that results in a gradual loss of brain function, cognitive ability and memory.

Depression is one of the most common mental health problems. The main symptoms are feelings of worthlessness, hopelessness, inability to cope, sleep problems, loss of appetite, concentration and energy.

Direct payments Cash payments made in lieu of social service provisions to individuals who have been assessed as needing services. They create more flexibility in the provision of social services. Giving money in place of social care services means people have greater choice and control over their lives, and are able to make their own decisions about how care is delivered.

Equality impact assessment This systematically assesses and records the actual or potential impact of a policy on different groups of people. As far as possible, any negative consequences can be eliminated or minimised and opportunities for ensuring equality can be maximised.

Functional mental health problem A mental health problem that is not due to physical problems in the brain e.g. depression, anxiety, psychosis

Home care/Domiciliary care personal care to enable people to stay at home for as long as possible.

IAPT: “Increasing Access to Psychological Therapies”. A service that offers psychotherapeutic ‘talking’ therapy or counselling.

Individual budgets These are designed to provide individuals who currently receive services with greater choice and control over their support arrangements. The individual budgets pilot project is a cross-government initiative led by the Department of Health working closely with the Department for Work and Pensions and the Department of Communities and Local Government.
Intermediate Care Services Care which bridges hospital and home care and often includes rehabilitation support.

Joint Commissioning The process in which two or more organisations act together to co-ordinate the commissioning of services, taking joint responsibility for the translation of strategy into action.

Joint Strategic Needs Assessment (JSNA) a document that looks in detail at the needs of the population of Haringey.

Local authority/Council Democratically elected local body with responsibility for discharging a range of functions as set out in local government legislation.

Local Involvement Networks (LINKs) LINKs are a way for local people and communities to engage with health and social care organisations. Their aim is to improve communication between people and commissioners and providers, and to make sure that commissioners are more accountable to the public. These networks are able to provide flexible ways for communities to engage with health and social care organisations in ways that best suit the communities and the people in them.

Local Strategic Partnerships (LSPs) LSPs bring together representatives of all the different sectors (public, private, voluntary and community) and thematic partnerships. They have responsibility for developing and delivering the Local Area Agreement (LAA).

Long-term conditions (LTCs) Those conditions (e.g. diabetes, asthma and arthritis) that cannot, at present, be cured but whose progress can be managed and influenced by medication and other therapies.

Mental health services A range of specialist clinical and therapeutic interventions in mental health and social care provision, integrated across organisational boundaries.

Organic mental health problem Problems caused by a physical problem with the brain e.g. dementia / cognitive impairment

Outcomes The difference made as a result of the service provided. A health or social care outcome is the result or effect of an intervention or lack of intervention on a previous health state or condition.

Payment by Results (PbR) A scheme that sets fixed prices (a tariff) for clinical procedures and activity in the NHS, whereby all trusts are paid the same for equivalent work.

Personal social care Personal care is provided to people with a disability, older and frail people, or those with mental health issues. It can be provided by or purchased by social services departments and the NHS to assist people in day-to-day living.
**Personalisation** A government programme which will give people more control over their care and support by giving them Personal Budgets. People can then choose how their Personal Budgets will be spent.

**Primary care** The collective term for all services, which are people’s first point of contact with the NHS, often the GP but not always.

**Primary Care Trust** Primary Care Trusts commonly known as PCTs, are responsible for planning, developing and providing health care services for local people. The local trust is Haringey Teaching Primary Care Trust.

**Provider** Any person, group of people or organisation supplying goods, healthcare or care services. Providers may be in the statutory or non-statutory sectors.

**Quality and Outcomes Framework (QOF)** Part of the contract Primary Care Trusts (PCTs) have with GPs. It is nationally negotiated and rewards best practice and improving quality.

**Respite Care** Help to carers to give them a temporary break from the care they provide, which may be for very short periods of a few hours or for longer periods of time.

**Strategy** is a long term approach, based on a shared vision, to achieve improved outcomes. Strategy does not stay the same; it changes in response to changing needs.

**Telecare** any service that brings health and social care directly to a user, generally in their homes, supported by information and communication technology. It covers social alarms, lifestyle monitoring and telehealth.

**Third sector** The full range of non-public, not-for-profit organisations that are non-governmental and ‘value driven’; that is, motivated by the desire to further social, environmental or cultural objectives rather than to make a profit.

**Voluntary and community sector** An umbrella term referring to registered charities as well as non-charitable, non-profit organisations, associations, self help groups and community groups, for public or community benefit.

**Well-being** The state of being healthy, happy, contented, comfortable and satisfied with one’s quality of life. It includes the physical, material, social, and emotional aspects of life.

**White Paper** Documents produced by the government setting out details of future policy on a particular subject.
10.3. Hyperlinks – website addresses

A new ambition for old age (2006):

A personal approach to public services: shaping services around individual needs:
www.drfosterintelligence.co.uk/newspublications/localdocuments/psrbrochure.pdf

A sure start to later life – Ending Inequalities for Older People (2006):
www.communities.gov.uk/publications/corporate/surestart

Barnet, Enfield and Haringey Clinical Strategy:
www.behfuture.nhs.uk

Care Quality Commission (CQC):
www.cqc.org.uk

Compendium of Evidence on The Need to Tackle Age Discrimination in Mental Health:

Deprivation of Liberty (2008):
www.opsi.gov.uk/si/si2008/uksi_20081858_en_1

Dr Foster intelligence December 2007:
www.drfosterintelligence.co.uk/index.asp

End of Life Care for People with Dementia (2009):
www.mariecurie.org.uk/forhealthcareprofessionals/end-of-life-dementia.htm

Everybody’s Business (2005):

Experience Still Counts (2009 – 2012):
www.haringey.gov.uk/experiencecounts.htm

Forget me not:
www.audit-commission.gov.uk/nationalstudies/health/mentalhealth/Pages/forgetmenot.aspx

Halfway Home:

Haringey Carers Strategy (2009-14):
www.haringey.gov.uk/index/social_care_and_health/carers/carersstrategy.htm

Haringey’s Council Plan 2007-2010:
www.haringey.gov.uk/councilplan.htm

Haringey Teaching Primary Care Trust – Developing World Class Primary Care Strategy:
www.haringey.nhs.uk/listening_to_you/consultations/developing_world_class_primary_care/docs/primary_care_strategy_may_08.pdf

Haringey Teaching Primary Care Trust- Strategic Plan 2008-2013:
www.haringey.nhs.uk/world_class_commissioning/documents/strategies_and_plans/strategic_plan.doc

Haringey’s Well-being Strategic Framework:
www.haringey.gov.uk/index/social_care_and_health/well-being_framework.htm

Health Act Flexibilities (1999):

www.nmhdud.org.uk/our-work/mhep/later-life/later-life-knowledge-base

Healthcare for London Dementia Services Guide:
www.healthcareforlondon.nhs.uk/assets/Mental-health/HealthcareforLondon_Dementia-services-guide.pdf

Improving Access to Psychological Treatments (IAPT) - Older People Positive Practice:

Joint Strategic Needs Assessment:
www.haringey.gov.uk/index/council/hsp/ourplace.htm#sna
Total Place:  
www.localleadership.gov.uk/totalplace

Transforming social care – Putting People First:  
www.puttingpeoplefirst.org.uk

Turning Point:  
www.turning-point.co.uk/Pages/home.aspx

Who Cares Wins (2005):  
www.rcpsych.ac.uk/PDF/WhoCaresWins.pdf

10.4. End notes


ii Dementia UK (2007)


v Alzheimer’s Society Fact-sheet: Learning Disabilities and dementia:  
http://www.alzheimers.org.uk/factsheet/430


x Anderson et al (2009) Royal College Psychiatrists

xi Anderson et al (2009) Royal College Psychiatrists

xii Anderson et al (2009) Royal College Psychiatrists


xv NICE Clinical Guidance 38: Bipolar Disorder

xvi National Confidential Inquiry into Suicide and Homicide in People with Mental Illness (2009) University of Manchester.  


xviii Anderson et al (2009) Royal College Psychiatrists

xix National Confidential Inquiry into Suicide and Homicide in People with Mental Illness (2009) University of Manchester.  

xxii Haringey Mental Health Needs Assessment - J SNA


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Anderson et al (2009) Royal College Psychiatrists

New Horizons a Shared Vision for Mental Health (DH 2010)

Anderson et al (2009) Royal College Psychiatrists


Anderson et al (2009) Royal College Psychiatrists


New Horizons a Shared Vision for Mental Health (DH 2010)