DRAFT

OLDER PEOPLE MENTAL HEALTH STRATEGY

FOR COVENTRY

2005 – 2009

LOGOS

Coventry's older population is ageing. While its size will stay broadly the same, by the end of the next decade the number of people aged 85 and over will have increased by 20%. There is a much higher incidence of illness and disability amongst this age group, leading to a commensurate increase in the amount of care and treatment required.

CONTENTS

1. Executive Summary

This is a **joint strategy agreed between Coventry Primary Care Trust and Coventry Social Services Department** and has been developed in conjunction with the NSF Older People Task Group for Mental Health Older People which includes representation from all key stakeholders.

The strategy sets out **the overall direction for all mental health services for older people with mental health needs** including older people with learning disabilities and people with Young Onset Dementia in Coventry, over the next four years.

Central Government policy is driving forward an agenda of social inclusion, citizenship and community capacity aimed at better outcomes for users and carers, increased development of staff, more open management, public confidence in services and greater efficiency in the use of resources.

From a **carer and service user perspective**, the local priorities have been identified improving the experience of the diagnosis, improving the range and quality of some of the specialist services, improving information about and signposting to these services and enhancing carer support.

Coventry's older population is ageing. While its size will stay broadly the same, by the end of the next decade the number of people aged 85 and over will have increased by 20%. There is a much higher incidence of illness and disability amongst this age group, leading to a commensurate increase in the amount of care and treatment required.

The challenge for Coventry is to change the balance away from institution based towards community based provision and to improve the quality of services whilst at the same time increasing the overall quantity of services to meet the projected demographic needs.

Three priorities emerge from the action plan:

1. **Commissioning the right range of services –** this will include improving community based services such as intensive support at home, day services, care home capacity, carer support services, assistive technology, integrated continence services and culturally sensitive services for people from black and minority ethnic communities. For people with young onset dementia there is also a need to develop a specific strategy and commissioning plan.

2. **Developing systems and pathways to promote access to specialist care -** this will include improvements in the experience of diagnosis, clearer plans for particular services such as primary care, chronic disease management and intermediate care, smoother transitions between services, improved involvement of users and carers and more accessible advocacy

3. **Developing the workforce –** there is a clear need for a workforce development plan for older people with specific reference to the specialist needs of older people with mental health needs. This should address recruitment, retention and learning and development issues across the range of services and sectors.

A project management approach needs to be established to implement the action plan. The PCT and City Council need to make available the right amount of staff time and expertise across the spectrum of health and social care services in all sectors. It is proposed that an OPMH Implementation Project group is established to implement the action plan, with dedicated project management time and that their work is overseen by the Older Peoples Partnership Steering group, chaired by the PCT Chief Executive. The strategy is not cost neutral, and an important component of the action plan will be to produce a Financial Strategy to show what can be done within existing resources, and what additional resource would be required to achieve full implementation.

2. Values and Vision statement for Older Peoples Mental Health Services in Coventry.

The NHS and City Council are committed to the following vision for services and will test out new developments and existing services against these principles.

We believe that older people with mental health needs should be supported to be members of their community and family and to maintain relationships with their partners and friends for as long as they wish.

We will work with older people, their carers and advocates and with representative organisations to develop and improve services which impact on their lives.

The Council and NHS are committed to working in partnership together and with the voluntary and independent sectors and with service users to plan and deliver services.

Our main focus is on promoting the independence and improving the lives of people who need our services. We will organise services to meet this goals rather than for organisational convenience.

Older People and their carers should have good access to Primary Care services where many of their needs can be met. However they should also have timely access to specialist services, which should be able to respond to emergency demand as well as provide planned and timely support.

We are committed to developing our staff to work together for the needs of the service user, to maintain and enhance their skills and knowledge and to have opportunities to develop their practice in Coventry. This also applies to the large numbers of staff working in the Private and Voluntary Sectors in the City and to all the support and administrative staff.

We believe we should aim to provide appropriate services at home or near to more in ways which enable service users and their carers to be supported for longer periods at home.

There is a need for a small number of people at any time to be able to access high quality In-patient services. These services must be able to respond to planned admissions and emergencies and there should be clear pathways for people to return home.

This means that one of our priorities must be to enhance community services, creating greater capacity and a wider choice of services. To this end we will be seeking to invest in services which can respond to people experiencing crisis, people who are in hospital, people whose carers need support and people for whom we can anticipate an imminent problem.

We will work with service providers to enhance the quality of services in the community and to ensure they can access specialist support and training.

We recognise some people will need or wish to live away from home in Housing with Care, Residential Care or Nursing Homes. However, we intend to always ensure that this kind of care is offered only absolutely necessary. Institutional care will only be provided following full assessment and exploration of alternatives.

We are determined to improve the quality of life for those people who do live in care homes and will work with providers to improve standards. The Council and PCT will provide specialist support to these services.

We also recognise that older people with mental health problems should be able to access primary care and specialist acute care

We recognise the role of carers and the need to support them in their role. We want to increase the support we can give to carers, and to ensure that they are involved in planning and developing services.

3. Scope of this Strategy

This strategy has been commissioned by the Older People's Partnership in response to the National Service Frameworks for Older People and Mental Health. The Council, the Primary Care Trust and the University Hospital Coventry and Warwick are focusing on their jointly provided services with the aim of improving service delivery through greater integration.

The strategy encompasses the whole range of mental health conditions experienced by older people including older people with learning disabilities as well as people with young onset dementia:

4. Consultation process

The strategy has been produced in conjunction with the NSF Older People Task Group for Mental Health Older People. This task group reports to the Older People's Partnership. There are three subgroups reporting to the Task Group:

1. Support/Care Services Group
2. Clinical Interface Community Services Planning Group
3. User/Carer Support Group

Through this structure there has been consultation with the Partnership's wider consultation networks. Once this draft strategy has been agreed by the Older People's Partnership there will be a full consultation with service users, staff involved in delivering the service in all organisations and sectors.

5. National Policy Drivers

Central Government policy is driving forward an agenda of:

- social inclusion
- citizenship and community capacity aimed at better outcomes for users and carers
- prevention and early intervention
- community rather than institution based services
- increased development of staff
- closer and more seamless working between health and social care
- public confidence in services and greater efficiency in the use of resources.

The following is a summary of recent, key Government policy documents which have informed this strategy. More detailed information is included in Appendix 1:

- The NHS Plan
- Modernising Social Services, promoting independence, improving protection, raising standards
- The Care Standards Act 2000
- The National Service Framework for Older People (NSF)
- Section 31 of the Health Act 1999
- Integrating Older People's Mental Health Services
- Mental Health Policy Implementation Guide
- Forget me not
- Commission for Health Improvement report into 'Investigations into matters arising from care on Rowan Ward' in the Manchester Mental Health and Social Care Trust
- Avonside Report
- Independent Inquiry into the death of David Bennett

6. Evidence based practice

The DH 2003/4 report on the work of the health and social care Change Agent Team – Changing Times, Improving Services for Older People sets out 'what works' in relation to mental health services for older people.

'Older people with mental health problems can quickly become even more disorientated and distressed in unfamiliar surroundings. The following approaches can help:

- Rapid assessment of the person in their own home to explore alternatives to hospital admission and whether treatment and support can be provided at home
- Patient held records that give a clear picture of how the person is normally supported and how they usually manage
- Early identification of the person's mental health difficulties once they are admitted to hospital and checks on whether the person is already known to specialist mental health services
- Responsive multi-disciplinary liaison services that do not rely solely on consultant-to-consultant referral
- Access to intensive home support services so that the person can be returned home from hospital quickly once their acute illness is under control, and

The majority of research to date has been focussed on dementia rather than functional illness. The following evidence is drawn from:

- Health Care Needs Assessment. The Epidemiologically Based Needs Assessment Reviews 2004, (much of the experimental evidence is fragmentary and drawn from efficacy trials, mostly from the USA)
- The National Service Framework for Older People
- Integrating Older People's Mental Health Services (Jane Lingard and Alison Milne, June 2004.

Before clinical onset:

- no measures are proven to be effective for primary prevention of dementia
- genetic testing is currently only indicated for families where several members have developed early dementia
- general population screening for dementia is not indicated
- clinical recognition of established dementia should be improved, in order to rationalise medication, allow family and patient to make financial and other arrangements, prepare advance directives and avoid inappropriate care.

In mild to moderate dementia:

- much of the diagnostic assessment and management can be carried out by the primary health care team, either alone or in collaboration with specialist services.
- the National Institute for Clinical Excellence (NICE) recommended that the drugs donepezil, rivastigmine and galantamine should be made available in the NHS as one component of the management of those people with mild and moderate Alzheimer's disease under certain specified conditions.
- there has been concern about the prescription of antipsychotic drugs to older adults with dementia, especially those in residential and nursing home care. Such drugs may hasten cognitive decline and may cause increased deaths.
- a number of psychosocial and behavioural therapies have shown promise in managing symptoms of challenging behaviour. Unfortunately, good trials are scarce due to technical difficulties and lack of funding. Reality orientation, behaviour modification, validation therapy and activity groups have all shown promise in at least one study.
- environmental approaches in long-stay settings building on the recommendations contained in two recent, key documents - the NHS Executive 'Safety, Privacy and Dignity in mental Health Units: Guidance on mixed sex accommodation for mental health services' (2000) and 'Put Yourself in my Place: Designing and Managing care homes for people with dementia' (Caroline Cantley and Robert C. Wilson 2002).
- organisational changes such as integration, can improve access and responsiveness to service users and carers as well as ensure care co-ordination, both within and without the team. In the late 1990's Challis and colleagues evaluated an intensive care management scheme for older people with mental health problems in Lewisham which found positive outcomes for older people and their carers in terms of levels of social contact, reduced stress for carers, improvements in levels of overall need and risk and fewer admissions to care homes.
- there is some research evidence that provision of information, counselling and support on an individual or group basis, and some element of ongoing support over time can reduce or delay institutional admission of people with dementia.

In moderate to severe dementia:

- social care ‘case management’ with flexible budget holding and small case loads can be effective in supporting older adults, including many with dementia. Multi-disciplinary community teams with joint health and social care elements can provide a ‘one-stop shop’ for specialist support and management
- the quality of care in institutional settings needs improvement, through meeting physical care needs, rationalising medication, improving recognition and treatment of depression, and bridging gaps to community care. Also provision of hospice-style care in the terminal stages of dementia should be explored. A number of new forms of supported provision have emerged along the spectrum from own home to nursing home, but their effects and relevance are as yet unclear
- standards of care for older people with dementia and milder cognitive impairment admitted to acute hospitals are in great need of improvement.

7. Models of care

a) Dementia

There is insufficient evidence on which to base a quantified model of resources and care for dementia. This is partly due to the many possible substitutions in role (between primary and secondary care, between informal, community and institutional care, etc.), and partly due to the lack of adequate evaluation of many of the elements in the care system. Nevertheless, there are a number of key elements that are needed to address the current problems.

These key elements include:

- a central role for primary care professionals in diagnosis, provision of information, management of medication and coexisting illness, referral and monitoring
- meeting informal caregivers’ needs for information and practical support
- integrated secondary health and social care provision, preferably in multi-disciplinary teams, providing a ‘one-stop shop’ for specialist help
- specialist psychiatry of old age services, providing a hub for the network of required services, and special provision for those with complex problems, including challenging behaviour
- improved services for older adult mental health in acute hospital settings
- active programmes to improve care in institutional settings, monitoring drug use, actively managing coexisting illness and introducing behavioural, environmental and other approaches to improving quality of life
- sufficient and appropriate continuing health care provision for older adults with mental health needs.

b) Depressive illness

Under detection of mental illness in older people is widespread, due to the nature of the symptoms and the fact that many other people live alone. Depressive symptoms in people aged 65 and over is especially under diagnosed and this is particularly true of residents in care homes. Mental and physical problems can also interact in older people making their overall assessment and management more difficult and mental health problems may be perceived by older people and their families, as well as by professionals, as an inevitable consequence of ageing, and not as health problems which will respond to treatment.

Depressive illness may be triggered by a variety of factors such as bereavement and loss, life changes such as unemployment, retirement and social isolation. Other people can also develop depressive symptoms because illness or frailty, or following a stroke or fall.

Early recognition and prompt treatment of depressive illness can reduce distressing and sometime apparently inexplicable symptoms and prevent more serious consequences such as physical illness, adverse effects upon social relationship, self neglect or, in the more serious cases, self harm and suicide.

The diagnosis of depressive illness involves an assessment of psychiatric, psychological and social factors.

Treating any co-existing physical illnesses, and improving the general health of older people who present with symptoms of possible depression, with further improve their quality of life. Strategies for recovery should include enhancing social networks and sources of social support.

The experimental evidence in relation to depressive illness is much more limited for psychological interventions than for pharmacological interventions. Studies have tended to have small sample sizes. The best evidence base is for cognitive therapy, behavioural therapy and cognitive behavioural therapy (CBT) with more limited evidence for problem solving, interpersonal therapy, brief psychodynamic therapy and reminiscence therapy. There is some confusion between the precise boundaries and definitions of therapies. There is no consensus as to which type of therapy is most effective for late life depressive illness. It is also not clear if combination therapy with drugs is superior to drug or psychological treatment alone.

8. Current service arrangements in Coventry

a) Specialist Mental Health Care Services for older people

The Table below shows the specialist mental health care services currently provided directly by the PCT for older people with mental health problems:

	Name of unit	No. of places	Purpose	Base
Services provided directly by the Primary Care Trust	Swanswell	22 beds	In-patient assessment and treatment service focusing on functional capability with aim of facilitating successful transition from hospital to community	Coombe Centre/ Caludon Centre
	Quinton	16 beds	Mixed sex organic assessment ward providing multi-disciplinary assessment for people with suspected dementia	Caludon Centre
	Edgewick	8	Assessment and treatment for people with organic mental illness and challenging behaviour	Caludon Centre
	Cognitive Assessment Treatment Service	N/A	Completes baseline/final assessments and monitors the use of cognitive enhancing drugs available to people suffering from dementia in line with NICE guidelines	Caludon Centre
	Hospital Liaison Team	N/A	Provides multi-disciplinary assessment service to older people within acute in-patient services i.e. Walsgrave and Coventry and Warwick	Caludon Centre
	3 Community Mental Health Teams	N/A	Multi-disciplinary assessment service to include diagnostic, treatment, care and support to older people with a mental health problem	East and West based at Gulson Hospital. North based at Newfield Annexe
	Day Hospital	25 places	Provides assessment, diagnosis, treatment and monitoring for older people with mental health problems (and those with younger onset dementia)	Caludon Centre
	Memory Clinic	N/A	Offers differential diagnosis for people of all ages with memory problems	Tile Hill Clinic
	Young Onset Dementia Team	N/A	Facilitates early diagnosis to provide accessible pathways of care taking onto account complexity of need and cultural background	Caludon Centre

The next table shows specialist mental health care services provided directly by Social Services:

	Name of unit	No. of places	Purpose	Base
Specialist services provided by the SSD	George Rowley	12 places x 5 days per week	Specialist Day Centre for people with dementia	
	Jack Ball House	14 places x 5 days per week	Specialist Day Centre for people with dementia	
	The Spencer Group .	The service has recently increased from 4 days a week to 5 and the hours extended. 12 places per day.	Day care for older people with a functional mental health diagnosis. There is input to the group from Psychology Assistants who are managed by a Clinical Psychologist based at Gulson Hospital. The centre staff offer a range of practical and social activities	Gilbert Richards Centre

The next table shows the specialist mental health care services currently jointly provided by the PCT and Social Services for older people with mental health problems:

	Name of unit	No. of places	Purpose	Base
Services jointly provided by the PCT and the SSD.	Charnwood House.	12	Specialist Dementia Care scheme developed by Methodist Homes for the Aged, includes Intermediate Care places for older people with "dementia or other cognitive deficits", who are currently excluded from other intermediate care services. Patients stay for 8-10 weeks, and receive a therapy led service, primarily from occupational therapists, with input from physiotherapy and psychology, and a GP contract to provide medical input.	Beake Avenue

The following table shows specialist services commissioned from other agencies:

	Name of unit	No. of places	Purpose	Base
Services commissioned from other agencies.	Alzheimer's Society Daycare service	12 places x 4 days per week	Provides a flexible day care service for people with dementia also providing respite for carers.	31 Barras Green
	Alzheimer's Society Dementia Support Service	Contracted to take 15 referrals per quarter	Provides emotional support, information, benefit advice and advocacy to people with dementia and their carers.	
	Alzheimer's Café	Meets once per month	Group for people with dementia, family and carers to provide emotional support, education and social interaction.	
	CACEC	13 places x 5 days a week + 11 places x 2 days a week		
	Alzheimer's Society Younger Persons' Service	8 places one day per week	Day Care Service for adults under 65 with a formal diagnosis of dementia.	31 Barras Green
	Sunshine Club			Methodist Church Hall

There are also proposals, with a successful bid for LIFT (Local Improvement Finance Trust), to develop local integrated services which will "bring benefits to older people with mental health problems through the development of a more localised approach to service provision".

b) The Community Mental Health Teams (Older People).

A specialist multi-disciplinary mental health service for older people was established in 1992, and is provided by three multi-agency multi-disciplinary Community Mental Health Teams – North, East and West, as well as a city wide Hospital Liaison Team: a hospital based service to supplement support for in-patients in the general hospital or people using the wider spectrum of specialist mental health provision. The Teams are managed by the Primary Care Trust.

The teams typically comprise:

1 Team Manager (from a Health background in two teams and from a Social Services background in the third)
2 wte social workers (some, but not all of whom are Approved Social Workers)
2 x G Grade Community Mental Health Nurses
1 x F Grade Nurse
1 x E Grade Nurse

1/0.8 x Senior Occupational Therapist (Teams with 0.8 OT also have a p/t Technical Instructor)
1.5 Administrative staff.

In addition, there are two 0.5 specialist posts based in the North team, who undertake development work city-wide with Asian and Afro-Caribbean communities. Their role is both to develop awareness of the service, and recognition of mental health problems, in response to the historically low uptake of services from these communities.

The remit of the CMHT(OP)s is to provide a short term care management function and a longer term nursing provider service. The care management element of a case is transferred to the Assessment and Care Management Teams (ACMs) for ongoing care management after six weeks, or once stable. Service provision is also available from the CMHT(OP)s to address mental health issues for people who have transferred to the ACMs.
Community mental health nurses (F Grade and above), social workers and occupational therapists all undertake care management responsibilities, applying to Social Services Panel for funding from the community care budget, managed by the Head of Older People's Service, to fund packages of care. Submissions are made to Health to fund health care requirements.

The CMHT (OP) provides a duty service for 5 days a week between 9 am and 5 pm. This is staffed on a rota basis (1 Team Manager and 2 staff) who respond to urgent referrals on older people with mental health problems on a daily basis.

c) Carer Support Groups and Carer Training

The Occupational Therapy Service OAMH runs a city wide Dementia Carer's Training Programme for those with a relative with a dementia illness with one OT who acts as a referral point and co-ordinator; one 6-week recurring group runs for people with dementia and carers together, with a separate group for sons and daughters. The service has recently been evaluated and there has been increased demand for this service which exceeds the amount of OT available. Therefore it has been agreed that the current programme will be developed to be run by the multi-disciplinary team.

The Alzheimer's Society also runs a 6-week carer training programme covering a range of topics associated with dementia care for carers of people with dementia. This service has been evaluated and it is currently under consideration as a joint priority as a future resource, through diverting funding from other sources.

Carer support groups are also run across the city by various agencies including two groups run by the Alzheimer's Society on a monthly basis, one for active carers who need emotional support and a social group for carers and former carers of people with dementia.

The Carer's Centre does not run any groups for carers of older people (though some may be provided by residential care homes). Neither does Coventry MIND operate any groups for carers of older people with functional mental health problems. This type of service is therefore likely to be an identified gap in provision.

d) Consultants

There are four consultant psycho-geriatricians including a medical director for older people, and one consultant for each of the three areas, working with each of the CMHT(OP)s – West, East and North.

e) Psychology service

CMHT(OP)s and Assessment and Care Management Teams can refer clients to the Psychology service (consisting of two qualified psychologists and trainees, - 0.8 funded by Social Services). Referrals are either for an assessment or a service.

f) The Hospital Liaison Team

(Formerly the Hospital Inreach Team) offers mental health assessments for patients aged 65 and over whilst in-patients in the Caludon Centre or Coventry & Warwickshire Hospital. They provide assessment, diagnosis and treatment on the ward, as well as undertaking care management, identifying appropriate services and facilitating discharge.

The Team also now includes an in-reach worker for each of the two MHOP wards at the Walsgrave: a social work post for Quinton Organic Assessment Ward, and a CMHN for Swanswell Acute Functional Ward. The workers facilitate discharge, whether to a Mental Health Unit, residential care, or back home with a care package, as well as working closely with relatives to provide a prompt aftercare service and support. The in-reach workers will also facilitate access to the new intermediate care service.

The Team consists of:

2 WTE G Grade nurses
2 WTE social workers
0.5 staff grade Doctor
2 In-reach workers at the Caludon Centre: a social work post for Quinton, and a CMHN for Swanswell
G grade nurse offering education and training to staff on the basis of 1 session per week.
1 WTE team secretary.

g) Assessment, care management and commissioning arrangements.

There are:

- three Assessment and Care Management Teams for Older People – East, West and North
- a city-wide Reviewing Team

- a Hospital Team based at the Walsgrave Hospital and operating city-wide, responsible for assessment and care management for all adults 18 and over who do not have a social worker prior to admission. The Team commissions and care manages short-term high intensity packages of care aimed at enabling people to return to their former level of independence. Hospital social workers have a remit to manage cases up to the first review at six weeks post discharge, or until they are stable, when they are transferred to an ACM. As

with the transfer of cases from CMHT(OP)s to ACMs, difficulties can arise from the fact that these two factors do not always coincide.

h) Occupational Therapy Team

In the Older Adults Mental Health service Occupational Therapists (OTs) are based within multi-disciplinary teams in a variety of settings (eg inpatient, day hospital, CMHT, intermediate care, YOD). Line management is through the PCT Mental Health OT service. OT staff receive day-to-day management and operational supervision from multi-disciplinary team leaders, and peer supervision and continuing professional development from the Mental Health OT service.

The practice model used by OTs within Older Adults Mental Health is the Model of Human Occupation. The medium used for assessment and therapeutic intervention is meaningful occupational participation. Assessment and treatment may be based within a client's home, a mental health setting, or a variety of community based environments. The OTs use both individual and group based therapeutic interventions.

The Older Adults Mental Health OT staff often work alongside OTs who are based within other health and social care settings eg intermediate care, physical disabilities, assessment and care management teams, Walsgrave General Hospital. There may be an exchange of knowledge and expertise or a need for OTs to co-work with clients who have complex needs. The Older Adults Mental Health OT staff also have access to the Coventry Integrated Community Equipment Store and the Coventry Wheelchair Service.

Generic roles undertaken by the OT staff have an impact on the amount of resources available for the provision of OT therapeutic input within Older Adults Mental Health.

9. Areas already identified for service improvement in Coventry through external audits, internal reviews and development plans.

9a. Audit Commission Review of Mental Health Services for Older People in Coventry

This audit was carried out by Price Waterhouse Coopers in July 2001, based on ‘Forget Me Not’. The following is a summary of the areas requiring action:

- Build on existing good joint working and co-ordination of care at operational level by greater investment to integrate services across the agencies in order to support primary care and improve awareness of needs and available services.
- Develop a specific planning forum for this client group to ensure all the agencies participate in the development and implementation of the proposed strategy.
- The HIMP sets out the priorities for this service and these need to be implemented if the service is to develop
- Implement the action plan following the review of users and carer’s needs

The action plan included the following:

- Detailed needs assessment is required in order to plan and develop services in the most effective way.
- The planning forum for this service needs to be developed to include monitoring of performance against the JIP objectives.

- GPs need to be more involved in the planning and delivery of services.
- Users and carers need to be more involved in planning and delivery of services.
- Investment needs to follow the planning process to retain the commitment of staff towards effective planning in future.
- Agencies should review the provision and use of day services as service users may not be making the best use of current resources.
- Early onset and early intervention dementia services need to be developed
- Need to develop the limited specialist home care provision that currently exists.
- The number of ASW's is falling and this is putting additional pressure on the remaining ASWs ability to meet demand.
- Currently there is a lack of specialist EMI residential provision; however, the new homes for old strategy should rectify this.
- Limited specialist service is available to minority groups.
- Psychology input is limited and this is reflected in the under development of non-drug therapies.

9b. Information from reviews and inspections

The following reviews and reports are relevant to Social Services in relation to older people:

- Social Services Inspectorate inspection of Social Care Services for Older People (August-September 2000)
- Best Value Review of Social Care Services for Adults Aged Over 65 (final report February 2001)
- Social Services Inspectorate follow up review of Social Care Services for Older People (report July 2002)
- Inspection of Best Value Review of Social Care Services for Adults Aged Over 65 (report July 2002)
- Spring and Autumn 2002 Position Statements
- Performance Improvement Plan produced in response to Coventry Social Services 'zero star rating' (August 2002).
- Best Value Review on Promoting Independence in Adults Aged 18 -64 Disability Services in August 2002 (the way that services are organised means that important findings also apply to people aged 65 and over).

9c. A Review of Community Mental Health Services in Coventry.

Coventry Social Services Department, together with Coventry Primary Care Trust, identified a need to review community mental health services, particularly in the light of the National Service Framework for Older People. In early 2004 the independent review found two key issues impeding the effectiveness of the mental health service for older people in Coventry:

- The fact that there are no clear lines of accountability for professional, supervisory and budgetary matters.
- Interface issues between the CMHT(OP)s and the ACMs.

It was recommended that:

- The specialist mental health service for older people be retained, with greater clarity of role and purpose. (Resources and protocols will then need to reflect this.)

- Multiple lines of accountability be addressed by moving to single line of accountability within Social Services, thereby achieving better integration. Clinical supervision will remain with the Trust, while management and professional accountability will all lie with the Social Services Service Manager.
- A greater skill mix be introduced to CMHT(OP)s for more efficient and effective working. Unqualified staff could undertake some of the maintenance of care packages tasks currently undertaken by qualified staff.

As a result it has been agreed by senior managers in Health and Social Services that there will be a single service combining functions currently undertaken by both the CMHT's and the relevant parts of the Social Services ACM teams.

9d. Local Delivery Plan

In 2003/4 the LDP set out the strategic direction for older peoples services in Coventry, highlighting priorities for investment to meet the NSF, building on the following initiatives:

- New Hospital Project
- LIFT
- PFI for New Homes for Old

The shared health/social services strategic aims are:

- Maximising peoples quality of life and levels of independence
- Providing the right services, in the right place, at the right time, by the right staff
- Increasing individuals active participation in the shaping of treatment and care

These strategic aims will be achieved through **targeted investment of resources to achieve a comprehensive rehabilitation and intermediate care service commissioned and provided on a Partnership basis.**

An active programme of development work for older people's services has been in place throughout the last year, building on previous work in the city. The most significant achievement has been to minimise the number of people whose discharge from hospital is delayed. The city consistently achieves some of the best performance nationally in this demanding task.

The main priority for Coventry services in 2005-8 is to build on this achievement, by **continuing to improve support for older people in their own homes, reduce pressure on hospital beds, and ensure timely access to specialist services when required.** Strategic development is based on three important principles: -

1. People **should not have to wait for service**, but should have a prompt and personalised service available to them, regardless of their location.
2. Services should identify people who are vulnerable and are likely to experience a crisis, **should anticipate this and plan actively to prevent it developing too far**, avoiding unnecessary admission to hospital or care homes, and providing the right help at the right time, and

3. People should **not have their longer term care needs assessed** when they are still receiving acute care.

The specific action plan concerning the modernisation of Older Adults Mental Health services is to maximise the benefits of integrating services, review and strengthen community based services, and commission specialist services that meet required quality and cost standards.

The key priorities are to:

- Strengthen integrated teams, clarify links between CMHT and ACM teams
- Improve waiting times through pre-screening involving CMH team members
- Identify commissioning requirements to create a care market fit for purpose for all older people with dementia and functional illnesses within the city
- Complete day services review
- Complete and implement a carers strategy, working with existing groups
- Review policy of usage of inpatient facilities for Young Onset Dementia.
- Ensure the Intermediate Care strategy includes specific policy / facilities for OAMH.
- Develop and maintain a joint data set.

The Coventry PCT Local Delivery Plan Action Plan for Mental Health Services 2005-2006 has set out new objectives/targets for older adult services for the 2005-06 plan period:

- **The development of Clinical Practice/Care Standards**

- **Waiting Time Reduction** (by developing a Primary Care CPN function, that can provide first line triage and treatment of appropriate referrals).

- **Access Booking and Choice**

- **Support to Carers Initiative –** including Admiral Nursing Programme (specifically aimed at supporting carers).

- **Workforce Development** (by developing a localised recruitment and development programme to attract qualified nursing staff).

- **Support to Independent/Voluntary Sector Care Providers** (exploring options to support the Independent /Voluntary Sector Care Providers including the development of a Clinical Nurse Specialists Outreach Team and possibly the provision of qualified nursing staff to providers).

Underpinning strategies for these objectives will include:

- **Capital** (Specific work will need to continue around the options for the delivery of an integrated Community Mental Health Team base, either through the NHS LIFT Programme, or through its associated developments).

- **Patient and Public Involvement** (The development of the Older People's Partnership, and in particular the development of the Older People's Mental Health sub group, which brings together a number of independent and voluntary sector

service providers, provides a new opportunity for expanding and focusing the Public and Patient involvement in the design and delivery of Older Adult Mental Health Services).

9e. The NSF Older People Task Group for Mental Health Older People

The NSF Older People Task Group for Mental Health Older People reports to the Local Implementation Team which in turn reports to the Older People's Partnership.

There are three subgroups:

The Support Services Subgroup made recommendations in October 2004 on what must be done to improve the quality of provision, achieve the 'must dos' within the NSF and to respond to local challenges, for inclusion in to the Autumn LDP and Social Services planning cycle. The key recommendation was not to increase the number of nursing/EMI or residential homes within the City but to concentrate efforts on the homes available currently. This would include a number of initiatives to improve standards and capacity including monitoring, training, increasing support to service providers and consideration of variation in registration where appropriate. The group also recommended the development of specialist domiciliary care services in order to meet complex care packages and the appropriate referral to and use of day care provision. The detailed recommendations and findings are incorporated into this strategy.

The Clinical Interface Community Services Planning Group was established to see how Coventry can deliver the first milestone within Standard 7 of the NSF OP which requires the 'development of an integrated mental health service for older people'. Fifteen key objectives have been established.

The User/carer support subgroup set out with a remit to establish what carers and users of people with either organic or functional mental health illnesses actually want and need, to identify any issues and make recommendations for changes to current service provision. Group members talked to carers and users of their services to identify what services currently existed, whether this was what people wanted, and where the gaps were. Four key areas for improvement were identified:

- **Diagnosis** - improvements in the quality and speed
- **Services**- there is a good range but people are not aware of the choices available to them, the services need to be more flexible and some specific gaps were identified
- **Signposting** – the voluntary sector plays a key role but requires improved information on what is currently available
- **Carer support** – improved choice and flexibility is required

The detailed recommendations and findings are incorporated into this strategy.

10. Local needs

Coventry's older population is ageing. While its size will stay broadly the same, by the end of the next decade the number of aged 85 and over will have increased by 20%. There is a much higher incidence of illness and disability amongst this age group, leading to a commensurate increase in the amount of care and treatment required.

Currently there are 5,233 people aged over 85 in the city and 46,015 aged over 65. A detailed breakdown of local needs and projected needs is attached as Appendix 2. The following table summarises current estimated numbers broken down by types of condition:

Type of condition	**Numbers of people based on estimated numbers of people aged 65+ in Coventry**
Dementia	3395
Depression	6902
Schizophrenia	456 – 912
Anxiety Disorders	1824
Phobias	4560
Heavy dependence on alcohol	456 – 1596
Heavy drinkers	1596
Suicide (male)	3 p.a.
Suicide (female)	2 p.a.
OP with Learning Disability	23 known to specialist services but estimated numbers are higher
Young Onset Dementia	100

Current estimates for Coventry suggest 1017 people with dementia aged 65-85 and 622 aged 85+ are living in the community.

386 people with dementia aged 65 -84 are living in institutional care.

529 aged 85+ are living in institutional care which reflects 85% of the total population aged 85+.

By 2008, the number of older people with dementia is estimated to increase by only 1.7% which reflects the projected ageing of the population in Coventry. Between 2004 and 2008, the number of older people requiring institutional care or intensive care as an alternative to institutional care is expected to rise by 7.1% in Coventry.

There is therefore a need to change the balance from institution based to community based provision. For instance, to increase the proportion of people aged 85+ supported in the community from the current 15% to 30% (in accordance with national targets). This would represent a further 90 people aged 85+ supported in the community.

11. Value Statement

A Value Statement was developed in partnership with service user and carer representatives with National Service Framework for Older Peoples Champions on the 9th July 2004:

Coventry Older Peoples Partnership upholds the values identified in a statement prepared by Hope 2, and approved by the City Council and NHS Trusts in the city. This statement has been prepared to set out the key issues involved in implementing services based on these values.

The Value Statement is as follows:

Service users would like the aim of all staff working with older people across Coventry to consistently value their independence to make decisions about their life and care.

Staff will achieve this by:

- Treating individuals with dignity and respect at all times.
- Informing individuals about all services that may benefit them, acknowledging their rights to choice.
- Working in partnership with individuals to plan care and services.
- Planning care which is determined by an individuals physical, mental and social care needs
- Ensuring the availability of appropriate, reliable and timely services throughout Coventry which are equally accessible to all individuals.

<u>IMPLICATIONS FOR MENTAL HEALTH SERVICES FOR OLDER ADULTS</u>

- The values statement applies to older people using mental health services and their carers in the same way as it does to all other older people, working against stigma.
- When a person temporarily or permanently cannot make their own decisions, these values should apply to people who speak/ make decisions for them, including family carers.

<u>KEY ISSUES INVOVLED IN IMPLEMENTING THESE VALUES IN MENTAL HEALTH SERVICES</u>

The Older Peoples Partnership will work to apply the values as it tackles the following key issues:

1. To promote **earlier intervention** – with all agencies working in partnership to develop:

    - joint provision of information by all providing agencies
    - clearer referral pathways to promote easier access to services;
    - better multidisciplinary teamwork
    - fast track assessments and services

2. To promote **earlier correct identification of needs**, encouraging GPs and front line professionals to: -

    - recognise mental health problems and secure appropriate specialist input at the earliest possible time.
    - avoid inappropriate treatment, including over-medication
    - develop relevant training materials and packages
    - encourage a robust health promotion programme.

3. When planning accommodation with support and care, to develop models based on best practice – aimed **to enable partners to stay together** and not have to be split up to access they care they need.

4. Ensure the development of specific protocols to **manage the transition between Adults and Older Adults mental health services**, where a person's age has changed but their needs have not, avoiding the ill effects of age discrimination.

12. Shaping Mental Health Services for Older People in Coventry

12a. Community Support Services

NSF Older People Standard 7 states that 'Mental Health Services for older people should be community-orientated and provide seamless packages of care and support for older people and their carers'. The care of older people with mental ill health is increasingly provided in the community rather than in institutional care. Recent policy developments focus on promoting and maintaining independence, providing care at home, improving access to services, maintaining dignity and improving quality of life.

(i) Primary Care Services

The current Primary Care Service arrangements in Coventry are detailed in section 8 of this strategy.

Primary Care Services play a key role at the point of entry to the service The National Service Framework (NSF) and "Forget Me Not" both highlight the need for systems of assessment and provision to be in place at the time of diagnosis. These requirements are set out below, alongside the relevant extracts from the Coventry Primary Mental Health Guidelines for depression and dementia in the older adult 2004. This is a Coventry wide consensus on current best practice issued to all GP's, primary care mental health teams and other agencies.

Primary Care Role	Primary Care in Coventry
Explanation of diagnosis and prognosis	Covered in the Primary Mental Health Guidelines for depression and dementia.
Information to service users and carers	Covered in the Primary Mental Health Guidelines for depression and dementia. Provides key information on what carers want to be told, the risks of carers suffering from depression and information about useful organizations and contacts
Multi-disciplinary assessment of overall needs	CPA covered in Primary Mental Health Guidelines. SAP is currently being introduced and work currently underway to integrate SAP and CPA systems.
Advice regarding non-pharmacological management strategies	Primary Mental Health Guidelines outline non-pharmacological management strategies eg expert behavioural/environmental management, counseling, Cognitive Behavioural Therapy etc.
Consideration of the "anti-dementia" drugs (cholinhesterase inhibitors) in accordance with NICE guidelines	Primary Mental Health Guidelines outline NICE criteria. Anti-dementia drugs in Coventry have primarily been delivered since March 2002 by the Cognitive Assessment and Treatment Team (CATS).

The NSF Standard 7 Mental Health Carers and Users Subgroup have identified a need for increased Mental Health support at GP surgeries especially at the time a diagnosis is made. Most people go down the route of going to the General Practitioner for a diagnosis in the first instance then being referred on to the Consultant for a formal diagnosis.

Many of the comments received from carers and users related to the early stages of diagnosis; "if only the G.P. had been able to spot it sooner we would have been able to be treated sooner". It is well known that diagnosing a mental illness can be difficult as it is necessary to rule out other conditions first, it is all very time consuming and can appear to the patient to be a very slow process. Often the G.P.s appear to have limited knowledge about mental illnesses, "label" patients with mental illnesses, they fail to signpost onto other services and forget about the carers' needs.

Even when the G.P. has referred the patient on to the Consultant or "specialist" then there is still a process to go down and a time delay before the diagnosis is given – some people never receive a formal diagnosis.

The key points for action are:

- G.P.s need to be better informed to enable them to make better and earlier diagnoses
- G.P.s need training in mental health issues and have more compassion
- G.P.s need to take the needs of the carers into account
- G.P.s and Consultants need to signpost people on to other services such as support agencies and voluntary agencies

As GP's play an increasing role in early diagnosis of dementia and depression, this will result in increased numbers of service users with identified mental health needs. In response, in keeping with the local strategy of investing in community based services and also the NSF requirements, Coventry are considering the introduction of Primary Care Mental Health Workers (nurses), who would be working in primary care liaising closely with primary care physicians and also with specialist services. They would be assisting in better detection and management of mental health problems in older people, particularly for depression and dementia. They would also ensure base line detailed assessments for each patient and provision of appropriate support using the Single Assessment Process. This would in turn ensure a smooth transfer for further assessment management to specialist services when needed and improve access to appropriate services.

As the Primary Care Mental Health Workers would be focussing on less complex needs with a view to preventing the development of more complex needs; this would result in a change of emphasis of the work undertaken in Community Mental Health Teams (Older People) i.e. on to more complex and specifically focussed work with greater emphasis on psychology and occupational therapy. Also assessment at Primary Care level may highlight areas of need in relation to psychology and occupational therapy services which current CMHT provision may not have the capacity to meet. Therefore this issue should be kept under review.

Currently the Memory Clinic offers differential diagnosis for people of all ages with memory problems. However these are temporarily funded and therefore a potential future gap in provision which must be addressed with a view to achieving permanent funding in the future.

Another area identified for more development is the need to work together with the Acute Trust staff to understand if there is a correlation between older people with dementia illness and long term conditions as the combination of these types of illness can result in repeated referrals and admissions.

(ii) Community Mental Health Teams

Robust integrated Community Mental Health Teams are seen as the "backbone" of the specialist mental health service, providing the framework to:

- improve the experience of service users
- deliver "person centred" care
- provide more seamless patterns of service
- align services provided by all partners with the needs of users
- stimulate creative approach to problems

- deliver co-ordinate packages of service to individuals
- a single point of referral
- a unified health and social care assessment process
- co-ordination of the respective roles and responsibilities of each agency in the system
- access through a simple process for support and resources of both Health and Social Care.

In Coventry there are three multi-agency multi-disciplinary Community Mental Health Teams – North, East and West, as well as a city wide Hospital Liaison Team, which are managed by the Primary Care Trust. (See section 7). An audit is currently taking place of how staff time is being used. There is also further work in progress to ensure appropriately staffed and managed CMHT's with closer joint working.

The NSF Standard 7 Support Services subgroup have recommended the appointment of a community based post to promote access to intermediate care services from the community, to help prevent hospital admission and to provide out of hours cover to support the CMHT's.

It has been agreed by senior managers in Health and Social Services that there will be a single service combining functions currently undertaken by both the CMHT's and the relevant parts of the Social Services ACM teams. A process of detailed planning is now required to achieve the recommended structural change towards integration.

Jayne Lingard and Alisaun Milne define the integrated CMHT for older people as follows:-

The team's role is to assess, treat and support older adults with complex and/or long term mental health problems and their carers in the community.

Initial assessments should take place in the patient's own home and should include family members and where helpful the GP/primary care team. The assessment should result in the formulation of a care plan and follow-up arrangements, which have clear objectives, defined responsibilities for community team members and usually the designation of a key worker. These should include the provision of support, information and advice to carers.

CMHT(OP)s aim to improve access and responsiveness to service users and carers as well as ensure care co-ordination, both within and without the team. The following are the key functions of a CMHT for older people:

- Acting as the focus for referrals from primary care, secondary services, social services and users and carers
- Conducting home-based multi-disciplinary specialist assessments, ASW assessments and carer's assessments
- Using a variety of screening and diagnostic tools
- Care co-ordination up until the first review
- Providing on-going care, support and treatment for older people with more complex mental health problems, and their carers
- Providing outreach support to users of other services with mental health problems e.g. residents in care homes
- Ensuring access to a range of services for users and carers including domiciliary and day care
- Providing support, advice and training to staff in agencies which provide care to older people with mental health problems e.g. care homes, voluntary agencies, carer's organizations)

(iii) Out of Hours Provision

There is little specialist out of hours provision for older people with mental health problems. If a mental health act assessment was required, this would be undertaken by Crisis Resolution Teams, Home Treatment Team or the Emergency Duty Team, but these staff are not old age specialists. Monitoring is currently underway of service users where there are concerns about after 5pm and at weekends. Crisis Resolution Teams have been established but currently there is no comparable service for older adults. The NSF Standard 7 Carers and Users Subgroup have identified a need for this type of service for older people with mental health problems. One solution would be to have a small team of staff who are trained in working with this user group. This type of service small crisis/home treatment team for older people may be helpful in preventing hospital admissions.

The new Intermediate Care Service (Domiciliary Care) will be available 24/7 in order to respond to people who become ill at night, support AEU, A&E, Ambulance Services and to link with Out of Hours Service.

(iv) Day Opportunities

Given the prevalence of mental illness, both functional and organic, in the older population, there are currently few appropriate day service opportunities in Coventry. As more people with dementia are helped to continue living independently longer, through advances in dementia drugs and other support, so there will be a need to provide more day care. There is a bigger gap in day opportunities for people with acute and chronic functional problems.

The key task is to improve the quality and suitability of existing day care rather than simply increase capacity, whilst also stimulating, promoting and supporting change and development in services. The support given to Alzheimer's Society in its launch of an Alzheimer's Café, an opportunity for people with dementia and their carers to get together one evening a month, is a good example of this.

At present, there are four specialist day centres for people with dementia in Coventry. (See section 8).

In addition there are probably a number of people attending other centres who have functional problems or may be in the early stages of dementia, though usually these people would be referred on.

The NSF Standard 7 Support Services Subgroup have identified that there is a need for appropriate day care for older people with a functional mental health diagnosis.

For the future and to maximise the opportunities offered by the Spencer Group, the role should be clarified – either becoming a long-term service for users or offering short-term work with the aim of assisting people to return to the community. Once this has been identified a statement of purpose is required. The following improvements are recommended in order to achieve this:

- Multidisciplinary working between Health and Social Services – involving both managers and day to day co-ordination between ACM and CMHT Teams, in matters of reviews and assessments

- Numbers of referrals from CMHT and Fennel Day Centre and excluding of inappropriate referrals i.e., people with organic dementia who are not able to contribute to or understand the work of the psychologists.
- Access for service users in accessing psychology support in the event of a mental health episode
- Publicity to raise awareness of the service.

A review of day services is underway, which will recommend an increase in day opportunities for older people with organic and functional mental illness and the development of new approaches to providing these opportunities, such as the Alzheimer's Café for people with dementia and their carers.

(v) Domiciliary Care

Domiciliary Services for Older People with Mental Health Needs are currently provided by a two specialist local providers on a spot contract basis. Coventry City Council is in the process of tendering for block contracts for Domiciliary Care. Three blocks of 100 hours for specialist dementia services form part of the tender, one block in each Social Services area of the city. These blocks are small, but are intended to deal with more intensive needs.

A standing list for spot purchasing will continue to operate when block contracts are in place. In addition to block contracting for these specialist services, the generic blocks will also involve work with people who have dementia and their carers.

The Older People's commissioning service has identified the need for appropriate dementia care and mental health related training for many staff in the domiciliary sector.

The NSF Standard 7 Mental Health Carers and Users Subgroup have identified a need for the availability of an agency to help with basic jobs around the home – e.g. cleaning or gardening.

The NSF Older People Task Group for Mental Health Older People have recommended that the PCT/SSD clarify continuing care funding mechanisms to support the payment of complex care packages for domiciliary care agencies and prevent admissions to care homes and hospital.

The Council's in-house Domiciliary Care Service, (known currently as CSS), provides a generic service including services for older people with mental health problems. It is planned that this service will be integrated with the PCTs 'unqualified' workforce to create a new and expanded home support service.

Given the huge level of complexity in managing a dispersed hourly paid care workforce and in maximising hours etc it is proposed to retain a city-wide manager for these services but organise the staff on a locality basis as far as possible. To devolve the staff to local level reduces flexibility and adds to 'down time' costs. Consideration will be given to the registration requirements for such an agency and agreement reached on whether it is a Nursing or a Domiciliary Care agency, or both. The case managers at the hospital should also have access to this service.

(vi) Intermediate care

Intermediate Care has been defined as ‘care and support which is targeted at people who would otherwise be likely to be admitted to hospital or long term care in residential or nursing homes or would otherwise remain in a hospital bed when this is not clinically necessary’. The challenge for Coventry is to make Intermediate Care part of the mainstream services and there should be improved links to mental health services to support people with dementia. (CAT Annual report 2003/4).

Since this report a new specialist Intermediate Care service opened in January 2005 at Charnwood, Beake Avenue. This is a 12-bedded therapy led facility for older people with mental health problems which aims to rehabilitate people and maximise independence.

Intermediate care provision for people over 65 also includes Primrose Hill and Youell Court.

Intermediate care is a key aspect of services delivered jointly by Coventry City Council, Primary Care Trust and Acute Trust. The service has been effective in tackling major issues such as delays in hospital discharge. However a recent review has shown a number of areas requiring further attention, including:

- the lack of a clear 'pathway' between services,
- limited access to speedy assessment when needed, and
- a limited range of service options.

The review also identified potential for better performance in Intermediate Care – particularly in the integration of hospital and community based services, and between health and social care. It is planned to build on the achievements to date, and take a major step forward by integrating the commissioning and provision of the service, under single management, with the City Council Social Services as the lead agency. This will entail preparation of a Partnership Agreement under section 31 of the Health Act 1999.

These plans need to incorporate meeting the needs of people with mild forms of mental illness and dementia as they were designed to propose the integration of the management of the main Intermediate Care service, under a joint arrangement. However the changes indicate issues that require further consideration, particularly in the organisation of Intermediate Care services, for example:

- Where should the Charnwood part of Intermediate Care services be managed? By the Older People Mental Health service or within the proposed Integrated Intermediate Care team?

- If the former, will it be available on a 24/7 basis or less, what should be the referral process, and what resources will it have to prevent unnecessary hospital or care home admission, for example, support workers and domiciliary care etc?

- What would be the policy/ criteria for handing back to mainstream services after intervention?

In terms of resources, a 'holding sum' of £110K for OPMH is in the Local Delivery Plan bids list (the list adds up to three times amount of development cash available), so any resources for strengthening OPMH Intermediate Care provision would need to come from that, unless a separate bid is made.

In addition, the NSF Older People Task Group for Mental Health Older People have recommended:

- Varying the registration of intermediate care facilities at Charnwood or Primrose Hill to include service users with functional mental health needs
- Appointing a community based post to promote access to intermediate services from the Community, with the aim of preventing hospital admission and providing out of hours cover to support CMHT.

As part of the 'New Homes for Old', Second Phase of Developments – Private Finance Initiative (PFI) Project, 3 x 40 place further Housing with Domiciliary Care schemes are planned. 20 Intermediate Care places within two of the new schemes of Housing with Domiciliary Care will offer older people the support that they need, in their desire to continue/resume their independence, and in the long-term, to live at home, rather than in institutional residential care. Specialist staff will adopt a multi-disciplinary approach in caring for older people at risk of admission to long term care, at risk of hospital admission, or those discharged from hospital, helping individuals to feel physically able, and confident enough to return to their home environment. The period of intervention and support will, for the most part, be up to 6 weeks.

The Older People's commissioning service has identified the need for intermediate care facilities for people with functional mental health needs and for people under the age of 65 who have dementia.

The NSF Standard 7 Carers and Users Subgroup have identified a need for more rehabilitation services for this user group.

Agreement should also be reached on the need for more community based intermediate care.

(vii) Continuing Care

It is necessary to be clear where the decision about Continuing Care for older people with mental health problems fits on patient pathway with agreed criteria. All patients should be screened for Continuing Care before receiving Intermediate Care.

The NSF Standard 7 Support Services subgroup has identified that there is currently no in-house, in city NHS Continuing Care provision and that people with both severe organic and functional illness are placed outside the city. It is recommended that a suitable development site is identified.

(viii) Independent Sector Residential and Nursing Home Care

Within Coventry there are currently 57 residential care homes, 9 of which are registered to provide dementia care:

Abberdale (27)
Amber House (formerly Allesley Court) (16)
Beechwood Gardens (20)
Charnwood (45)
Emerald House (9)
Eric Williams (43)
George Rowley (10)
Jack Ball House (12)
Victoria Mews (30)

There are a total of 224 registered dementia care places available within Coventry. The nature and quality of the service inevitably varies between homes in relation to staff training, amenities and links to specialist health services, etc.

The NSF Standard 7 Support Services and Carers and Users subgroups have identified a need for more residential care provision specifically for people over 65 with functional mental health needs. Currently people are placed in EMI residential or ordinary residential homes where staff may not have the appropriate knowledge or skills in meeting these needs.

In addition there are 11 nursing homes in the City. Three offer a total of 120 EMI places:

Brandon House (40)
Evedale (30)
Newfield House (50)

The NSF Standard 7 Support Services subgroup has identified a shortage of nursing provision for people over 65 with functional psychiatric illness. The only provision is outside the city in Leamington and has a long waiting list. Some people are placed in EMI homes but these are not specifically geared to functional mental health needs.

There is some demand for nursing places from outside the City. Social Services sometimes place service users in 'out of City' residential and nursing homes when there is a contract in place and according to individual choice.

The NSF Standard 7 Support Services subgroup has also identified a need for more nursing and residential care provision for people aged under 65 with dementia and for people with mental health needs from Black and Ethnic Minority communities. There is also very limited availability of Adult Placements.

Social Services are devising a new model contract and service specification for residential and nursing homes in 2005. It also plans to produce a market management strategy and plan, to guide service procurement.

The NSF Older People Task Group for Mental Health Older People has made the recommendation not to increase the number of nursing/residential/EMI homes within

Coventry but to concentrate efforts on existing homes. There are a number of initiatives already in place to improve the quality and capacity of existing provision:

- Increased monitoring arrangements for homes within the City to be jointly actioned by SSD/PCT
- Development of the Care Home support team/ encouraging training sessions for managers and care staff
- SSD and PCT to promote professionals feedback on homes to the commissioning team
- The Care homes modernisation project to establish a multi-agency collaborative which aims to promote 'healthy homes' based on the 'essence of care benchmark', including mental health care
- Appointment of a practice facilitator to offer dementia care/mental health awareness training to care homes/nursing homes and domiciliary care agencies who need to increase/refresh knowledge in specific issues. This could also be offered to social work teams as appropriate
- Discussions with providers of care homes the about need for respite care
- PCT and Social Services Training staff should consider standardising training to meet the essence of care benchmarking – this could be jointly delivered to care homes/domiciliary care agencies re mental health
- Exploration of the possibility of using part of Newfield to provide continuing care places for people who have organic or functional health care needs.

(ix) Housing with Domiciliary Care/Extra Care Housing

Extra Care Housing is a style of housing and care for older adults that falls somewhere between established patterns of sheltered housing and the accommodation and care provided in traditional residential care homes. According to Stephen Ladyman MP, Parliamentary Under-Secretary of State for Community (July 2003) 'Extra Care Housing offers another choice to the individual; a choice based on security, rights and control…to reflect the lifestyles that people want and expect. It must be a community solution and to make it work requires the full commitment of housing, health and social care agencies'. Supported Housing can provide a normal living environment for people with dementia, particularly with the added benefits of assistive technology.

A number of years ago, Coventry began to develop strategic plans for the improvement of its services to older people. One of its key strategies was the New Homes for Old project. The project aims to develop better accommodation and a more enabling style of care suited to the needs and expectations of older people.

The aims of the project are to:

- provide a viable alternative to traditional residential care;
- provide "homes for life";
- maximise and maintain independence;
- improve the quality of life for older people needing long term care;
- involve older people and their carers in their services;
- involve the local community;
- promote positive images of old age and of services to older people;
- deliver good quality "seamless" support and enablement services, housing management and health care services;

- continuously improve the quality of services;
- develop sustainable funding of services to meet growing demands.

Extra Care housing schemes offer older people their own flat, comprising a living room, bedroom, kitchen and bathroom. There are also communal facilities to enable tenants, and members of the community, to take part in social and recreational activities and to purchase meals, if they wish. Twenty-four-hour on-site flexible personal care and domiciliary support is provided to meet older people's needs, together with access to the range of health care services required.

In addition, it is anticipated that a number of tenants living in these Schemes will have dementia. The Service Provider responsible for the tenants accommodation and care support will however endeavour to maintain all service users in their own flats, in order to prevent any service user from being moved on to an alternative type of care provision, unless absolutely necessary.

Specialist Dementia Care schemes offer older people with dementia their own private rooms with bathroom facilities. Rooms within the overall scheme will be grouped into small "living units" which will operate on a self-contained basis, having bathing, dining, lounge and kitchen facilities as well as space for social and recreational activities. Homes will adopt a person-centred approach and will offer residents a homely and friendly environment that is safe, reassuring and designed to help orientation. Specialist staff will understand the impact of dementia on individuals and on their families and friends.

An outline of the two phases of developments is attached as Appendix 3.

(x) Continence service

Coventry is committed to developing an integrated continence service. An Action plan has been developed, priorities for have been identified and agreed, assessment documentation is being piloted within acute and community services, resource shortfalls have been identified and proposals are included in the LDP process

(xi) Assistive Technology

Assistive technology is a product or a system that enables independence of people with cognitive, physical or communication difficulties (adapted from the Audit Commission).

Research suggests that Assistive Technology has a number of benefits for people with dementia and their carers. A variety of devices have been developed that can prompt people, remind them how to do things or do things automatically. This can be as simple as a verbal prompt to turn off the gas or close a door triggered by a sensor, to complete instructions visually and spoken on how to cook a meal.

The Audit Commission state that a quarter of those with dementia live alone, often admitted early into institutional care. There is however emerging evidence that AT can open up opportunities for them to maintain their independence and quality of life for an extended period. However as with all AT it is essential that services are provided in a timely fashion in order to anticipate future needs. The ‘crisis management’ approach that typifies many public services simply leads to poorer outcomes and higher cost.

The Occupational Therapy Service in Coventry have funded and recently evaluated an AT project within Older People's Mental Health services. Stand alone equipment has been trialled and it was noted that calendar clocks and diaries were issued more than any other items. The evaluation highlighted the need for equipment to be issued only to meet specific needs and for carers to be fully briefed. It was recommended that the Head OT continue to be involved in the multi-agency Steering Group for Integrated Community Equipment Services and for OT staff to receive appropriate training.

A variety of alarm call systems exist across Coventry, with Registered Social Landlords having their own systems. It is unclear how much take up there is in the private sector, and nearly 80% of older households in Coventry own their own homes.

Coventry are in the process of developing an Assistive Technology Plan. The Coventry AT group will be the vehicle for developing AT services and this should include representation from Social Services, Occupational Therapy, the PCT, the ICES manager and Housing.

(xii) Direct Payments

Direct Payments are cash payments made in lieu of social service provisions, to individuals who have been assessed as needing services. The aim is to support people to live independently in their own homes. A direct payment can give more flexibility in how services are provided to individuals who are assessed as eligible for social services support. Direct Payments can be particularly useful for older adults with mental health needs, where a known and trusted person could provide support, yet the indications are that the numbers nationally are low. There is very little information available on the use of Direct Payments with older adults with mental health needs, because up until the recent regulations that abolished the 'willing and able' criteria, this group of people were generally perceived as being excluded from the scheme.

Currently none of the older people receiving Direct Payments in Coventry have significant mental health issues. However agent and user trust arrangements for direct payments and advance statements for people with fluctuating conditions are about to be launched, subject to legal checks, which should open up availability to older people especially those who are confused or have a dementia and enable them to remain at home. (User trusts – independent living trusts - would be where 3 or more relatives or friends sign a legal trust document agreeing to manage the care money and become legally responsible for it).

The NSF Standard 7 Mental Health Support Services Subgroup has recommended more flexibility in the choice of services which could be helped by wider availability of the direct payment scheme and a better knowledge of how this works.

(xiii) Support to users and carers

About three quarters of people with long term mental health needs living in the community receive support from carers. (Milne et al, 2001). Most are older and the majority are spouses. Most care for sustained periods without any input from services. Entry to a care home of the cared-for person is often triggered by the collapse of the carer. Identification of the need for support before a crisis is reached can delay or even prevent these admissions. Older carers, particularly those providing intensive care, are at high risk of developing mental ill health themselves.

'Improving Support to Carers' development plan, April 2001 – March 2004 supplements the Coventry Carer's Strategy (1999). It sets out the overall aim for Adult Carers –

To recognise, value and support adult carers to continue in their vital role through the provision of services which are responsive to the individual circumstances of carers as well as the person cared for.

The three objectives for the service are:

1. To identify carers of people known to Social Services
2. To raise awareness and recognition of carers within Social Services, Health Services and other key agencies and stakeholders, and
3. To support carers to continue in their caring role through the planning, development and delivery of carer support services.

Coventry Social Services are in the process of producing a new Carers Strategy, across all service user groups. Work will commence on this multi-agency strategy early in 2005 and will be completed by mid-2005. A Strategy Group will be established to steer the work.

The strategy will include information provided through consultation with carers. In the meantime, the NSF Older People Task Group have identified the following areas:

- flexible respite care including sufficient emergency respite for older people with mental health issues, overnight and at weekend
- linking together current support organisations
- improving support to carers - strengthening support to carers to ensure they are skilled and equipped
- developing carer forums for involvement in service development, design and review
- providing information
- training
- night and day sitting (there is some provided via Crossroads but this is an area for development)
- after care for bereaved relatives who have cared for service users which may in turn help prevent future mental health crises
- increasing the amount of respite provision including planned respite, for older people with mental health needs
- exploring with care home providers the need for respite care and reviewing existing block contract arrangements

The NSF Standard 7 Carers and Users Subgroup reported that there is quite a lot of carer support available in the city of Coventry and it takes many forms. However, different carers have different needs according to their circumstances and it can be difficult to provide everything that people want.

Many of the carers' services are offered by the voluntary sector as they often have the time and resources to support the carers as well as the clients. Coventry benefits from having a Carers' Centre. The subgroup found that many of the issues raised specifically about carer support related to the services offered but focussed on choice and flexibility.

In terms of carer support, the key points identified for action are the need for:

- Services that are centrally located and easily accessible, e.g. C.M.H.T.s, Carers Centre, in the city centre not out of town.
- Help with financial matters
- Specific carer support for specific illnesses e.g. functional illnesses, younger people with dementia
- More help for working carers to enable them to continue working
- More respite in various forms – e.g. daycare, domiciliary care, daycare, planned and emergency
- Out of hours support
- Staff that were trained in mental health issues so that the carers can have more confidence in them
- Services geared to help them have as normal as life as possible
- Social activities for active and former carers
- Physical health issues to be taken into account as well as mental health issues
- People to be made aware of equipment loan stores – simple aids can make a lot of difference

The NSF Standard 7 Carers and Users Subgroup reported that there are a variety of services available to help support users and carers and a lot of these are outside of the statutory sector in the voluntary and independent sector. These include the Alzheimer's Society, Carers' Centre, MIND, Crossroads and Age Concern. These agencies rely to a certain extent on the staff working in the statutory sector telling users and carers about the services they provide, although all these agencies also undertake promotional work of their own to raise awareness about the illness and the services they provide.

The important things that these agencies can offer provide are:-
- Time
- Flexibility
- Specialist Information
- Support
- Continuity
- Specialism
- Services free of charge
- Value for money

Staff in the statutory sector confirmed they are happy to signpost clients to these services but sometimes it is just a matter of not knowing what is available. The following were suggestions for improving knowledge about what is available:

- Introduce a regular information bulletin that all agencies can contribute to keep people informed
- Ensure that information about appropriate agencies is available through the statutory services, for example information about MIND is held on Swanswell Ward and on the Alzheimer's Society on Quinton Ward.
- Make better use of the directory produced by CVS but ensure the information in it is current and in a easy to use format
- Ensure that voluntary sector organisations promote the services they provide as widely as possible

- Ensure that the information offered is of high quality and available in a variety of formats such as languages, Braille etc. and also ensure information is available in other forms such as audio for people with literacy problems.
- Ensure availability of Better Care Higher Standards document to everyone

12b. In-patient services

The Older Adult and Adult Mental Health In-Patient services are delivered mainly from The Caludon Centre with the Older Adult Unit consisting of 36 beds, 18 organic assessment beds and 18 functional assessment beds. The Caludon Centre is also the base for Fennell Day Hospital offering 25 places.

A new, purpose-built psychiatric in-patient unit was completed in the Autumn of 2004, providing a total of 52 Older Adult Mental Health beds, including 8 Challenging Behaviour beds and 6 Young Onset Dementia beds (see section 13 below). The wards are multi-disciplinary, based on a broad range of therapeutic interventions, maximising treatment and patient choice and helping people to return home supported by community services where appropriate.

Reimbursement is to be introduced for Mental Health services but there is no firm date set and the decision will go back for a vote in Parliament before it can be implemented. The DH Change Agent Team are advising all sites to prepare for it and they are involved in scoping work to assist policy colleagues both for the mental health beds and for the non acute sector (community hospitals, NHS intermediate care, rehabilitation beds, etc).

12c. General Hospital care

Older people occupy almost two thirds of general hospital beds. Recent results from a survey of old age psychiatry ("Between Two Stools: psychiatric services for older people in general hospitals", 2002) noted that a quarter of all their referrals came from general hospital wards, with these numbers constantly rising. It is already established that psychiatric illness is common in general hospitals and that this psychiatric co-morbidity brings adverse consequences across a range of outcomes, with increases in length of hospital stay, rates of institutionalisation and mortality and reduced quality of life for service users and carers. The ageing population will ensure that these problems and challenges will increase over time. At present, most psychiatric illness in older people in general hospitals is managed by general hospital staff that may receive very little, if any, training. As a result, symptoms of psychiatric distress are not recognised or managed appropriately. This has implications for service users, carers and the services themselves. Psychiatric services may not pick up referrals at the most appropriate time and service managers within the acute sector may be prevented from delivering the targets required by the NHS Plan and the National Service Framework for Older People.

The NSF Standard 7 Carers and Users Subgroup has identified a need for greater awareness of mental health illnesses by general hospital staff with a link to the psychiatric services.

In Coventry the Hospital Liaison Team offers mental health assessments for patients aged 65 and over whilst for in-patients in the Walsgrave or Coventry & Warwickshire Hospital, the Team provides assessment, diagnosis and treatment on the ward, as well as undertaking care management, identifying appropriate services and facilitating discharge.

This also includes an in-reach worker for each of the two MHOP wards at the Walsgrave: a social work post for Quinton Organic Assessment Ward, and a CMHN for Swanswell Acute Functional Ward. The workers facilitate discharge, whether to a Mental Health Unit, residential care, or back home with a care package, as well as working closely with relatives to provide a prompt aftercare service and support.

The team includes 3 CPN's, 4 social workers and a part time Associate Specialist who is overseen by a Consultant.

13. Young onset dementia

In 2004 it is estimated that 91 people aged between 40 and 65 have dementia. This is estimated to increase to 97 in 2010. Though these numbers are small, the needs of those of working age with dementia illness are often of a high degree and complex.

Standard 7 of the NSF gives the Older Adult Mental Health Specialist Service the lead role in developing protocols for those of working age with dementia illness and the Royal College of Psychiatry report (2000) acknowledges that the most appropriate knowledge and skills normally lie within Older Age Psychiatry.

In 2001 Coventry Health Authority made available new funding to address the needs of working age adults who develop dementia. This led to the formation of the citywide community team for Young Onset Dementia (YOD). This team provides a person-centred needs-led long-term and innovative service to this user group and their carers/families.
The service objectives are:

- To facilitate early diagnosis via early investigative processes including access to neuropsychological, neurophysiological and neuroradiological testing.
- To provide readily available and accessible pathways of care across all agencies and take into account complexities of needs and cultural background
- Predominantly community based long term provision to support patients and carers as a unit, with appropriate levels of inpatient/residential/community care available
- Deliver a service that adopts an evidence-based strategy safeguarding the dignity and individuality of the person with dementia.
- Give support to patients and caregivers via groups/networks, information and information systems and genetic counselling.
- Educating other professionals/agencies is an integral component to the success of this service and it will be expected of team members to plan for/ participate in such educational/promotional events.

Target Population for the provision of this service includes degenerative progressive dementias in adults of working age, mostly due to Alzheimer's disease, Vascular dementia, Lewy Body dementia, Frontotemporal dementia and Alcohol dementia (provided that alcohol consumption has ceased for at least six months). The service would accept CJD (variant, sporadic and idiopathic forms).

The service is not intended for patients with Huntington's disease, learning disabilities and traumatic brain damage following a head injury or postoperatively (e.g. after neurosurgery).

The Caludon Centre includes a 6-bed specialist assessment and treatment facility which is not currently operational. It is proposed that neighbouring health and social care partnerships are approached with a view to exploring the feasibility of a shared resource, thereby sharing the cost.

The NSF Standard 7 Carers and Users Subgroup have identified the need for more day care places and long term care options for younger people with dementia.

There is also an identified need for Intermediate Care facilities for this user group.

14. Older people with learning disabilities

People with learning disabilities are prone to the same range of mental illnesses as people from the general population. People with learning disabilities are more likely to suffer from mental ill health (including behavioural disorders, personality disorders, autistic-spectrum disorders and attention-deficit hyperactivity disorder) (Deb et al, 2001). As in the general population, dementia and depression are common psychiatric disorders amongst older people. The presentation of certain symptoms in learning disabled people may vary however - communication difficulties may mean that the individual displays non-verbal symptoms such as psychomotor retardation, adaptive skill loss, apathy and social withdrawal prior to cognitive loss. People with mild learning disabilities and depressive illnesses not may differ greatly in presentation from people without learning disability although often there is a greater loss of confidence and tearfulness (Marston et al., 1997).

Prevalence rates for older people with learning disabilities (aged 65 years+) are much reduced than for the general population, reflecting reduced life expectancy. This reduced life expectancy results from social and genetic causes, physical and mental illnesses (including from side-effects of medication), increased prevalence of sensory impairments, carers' stress, poor self-care skills and inadequate services.

Although there are proportionately fewer people with learning disabilities over the age of 65 years than in the general population, there is a high prevalence of psychiatric disorder among this group that increases with age.

The total needs of the older population should be stressed and not just viewed in terms of dementia. People with learning disabilities often present late to primary health care teams or psychiatric/ psychological services and the challenge is to identify and diagnose early.

The White Paper Valuing People: A New Strategy for Learning Disability for the 21st Century (Department of Health, 2001) acknowledges that specialist services with an understanding of both learning disability and mental health need to exist, but states that people with learning disabilities should be enabled to access general psychiatric services whenever possible. Very often accessing mainstream psychiatric services has been found to be problematic for people with learning disabilities and generic psychiatric services often do not meet the needs of this group.

There are significant methodological challenges to researchers in this area. Prevalence rates for mental illnesses in populations of people with learning disabilities may vary

Dementia 6 – 22% in over 65s
Affective (mood) disorders 2 – 13% in over 60s
Psychotic disorders (schizophrenia) 2 – 13% in over 60s

34% of those with psychiatric diagnosis will show serious challenging behaviours which may include extreme passivity, aggression towards self and/or others and withdrawal.

Cooper (1999) found that “the number of physical disorders, age, level of intellectual disability and smoking status were retained in the logistic regression equation which predicted caseness for dementia in 79.9%. Similar statistical modelling for psychiatric disorders (other than dementia) retained the level of intellectual disability as the only explanatory variable in the equation.”

In Coventry with a population of around 310,000 it is estimated that true population of people with learning disabilities is over 6,800 (about 1500 people are currently known to social services). More than 300 people with learning disabilities in Coventry are assisted by paid carers. Of 642 people with learning disabilities known to specialist psychiatric services 23 people with learning disabilities (13 male, 10 female) were 65 years or more (3.6%). It is highly likely that there is a “hidden” population of people with learning disabilities in Coventry, many of whom would be 65 years or older.

There is emerging evidence which suggests that the course of dementia, whilst highly variable, is usually faster in people with Down’s syndrome.

This issue is already having a significant impact on services and will grow in significance as life expectancy continues to rise and the number of people with Down’s syndrome and dementia increases. Currently most of the people with Down’s syndrome remain at home with family carers, or are in minimally supported living environments without the resources to cope with increased dependency.

At least 36% of people with Downs syndrome aged 50-59 years and 54.5% aged 60-69 are affected by dementia and the prevalence increases significantly with age. The average age of onset is 54 years and the average interval from diagnosis to death is less than 5 years.

Between 15-20% of the learning disabilities population have Down’s syndrome. The life expectancy of people with Down’s syndrome continues to increase (now over 50 years). 96% of people with Downs syndrome have trisomy 21 (they have three chromosomes 21 rather than the usual two). Research into Alzheimers disease has shown that three of the genes implicated in its development are found on chromosome 21.

Further work is required to identify the appropriate care pathways for this service user group, in conjunction with neighbouring Local Authority areas. There are no specific figures for people with Down’s Syndrome in Coventry, but the prevalence is approximately 1:1000 representing 300 people. Dementia is often seen younger and may be more aggressive; however people usually present late to services.

There is evidence that many adults with learning disabilities are living in the community, unknown to psychiatric services but with mental health problems or behaviour suggestive of a mental illness. Roy et al. (1997) found that 42 of 127 (33%) of people with learning disabilities in the community participating in a service development were above the PAS-ADD* threshold (i.e. suggestive of a mental health problem) and of these 18 (44%) were not known to local specialist psychiatric services.

There are no resources in the city specifically for older people with learning disability and dementia who are often cared for in fragile services and many services experience difficulty

coping. A number of people in the later stages of dementia have had to leave the city in recent years.

Delayed transfers at Walsgrave Hospital is of concern and occurs when difficulties arise in finding appropriate accommodation following treatment for physical problems in the later stages of illness. There maybe a role for the hospital liaison team for older people, who currently may feel they need additional skills to work with this user group.

Action is needed to educate carers (whether paid or unpaid) to be better able to detect the early signs of mental illness among adults with learning disabilities. Screening high-risk groups such as those with Down's syndrome over the age of 60 years is suggested. Mainstream health professionals should also receive training and support to skill themselves to meet the needs of People with Learning Disabilities (possibly through Agenda for Change).

Suitable day services are required and a survey of current provision and those older adults attending is essential in order to develop or reorganise existing specialist day provision. Possible improvements would include an increase in flexibility of services and possibly a specialist health day hospital.

Suitable accommodation is a pre-requisite to good health care and again a review of current provision and standards of care is needed. (Older) people with learning disabilities should be taken into account when the health and social services plan new builds and specialist providers could be encouraged into the city. Carers require continuing and ongoing support from the Community Learning Disability Team.

In crisis there is no specialist hospital facility in Coventry to assess elderly PWLD with mental health needs. They are often too frail and vulnerable to be cared for at Whitefriars Lodge (inpatient service for PWLD) and may struggle on the general wards. Those with dementia are also usually less than 65, but need specialist dementia assessment. Consideration should be given to agreed pathways to access care and agreed roles of each service to work jointly.

Further links are required with voluntary and voluntary organisations such as the Alzheimer's Society.

*PAS-ADD is the Psychiatric Assessment Schedule for Adults with a Developmental Disability (Moss et al., 1993)

15. Workforce Development

Workforce Development is one of the key challenges facing the service across both health and social care. In particular there is a shortage of suitably qualified staff in all sectors. There is currently no formal workforce development plan for Mental Health Older People's Services in Coventry, but a post is being created in relation to older people which will encompass older people with mental health problems.

Coventry PCT's Local Delivery Plan has identified that the Trust has a number of vacancies linked to Service Developments within the Older People's Programme, that it has been unable to fill during the year, despite similar extensive, innovative and varied recruitment campaigns.

In the main, the majority of recruitment difficulties within the Older Adult Services relate to qualified nursing staff. To further compound this, the experiences of the Independent and Voluntary Sector Care Providers, also appears to be related to the difficulty in attracting qualified nursing staff.

The Trust propose to look at a newly qualified staff recruitment and development programme during the 2005/06 plan period, as the current level of vacancies suggest it will be difficult to recruit the number of staff needed within traditional means.

This development proposal will be discussed with the Workforce Development Confederation and will run alongside a number of targeted recruitment campaigns, aimed at attracting qualified members of staff that wish to move to Coventry.

Neighbouring service providers face similar issues and there may be scope for the training and development programme for newly qualified staff to be undertaken in conjunction with neighbouring Trusts.

An Audit of Occupational Therapy workloads in Community Mental Health Teams in 2003 found that demand for OT services exceeded supply and that there is a need for a long term plan for the recruitment and development of the current career pathway for OT's. The establishment of Technical Instructor posts would significantly improve the workload capacity of qualified OT staff.

The NSF Standard 7 Carers and Users Subgroup have identified a need for all care agencies providing care to people with mental health problems to be trained appropriately.

The NSF Standard 7 Support Services subgroup has highlighted the need for appropriate dementia care and mental health related training for staff in the residential, nursing and domiciliary sector. It recommended that a practice facilitator be appointed to offer awareness training to these staff who need to increase knowledge and refresh in specific issues. This could also be offered to social work teams as appropriate.

The subgroup also recommended co-ordinated training provision and that PCT training staff and Social Services Employee Development should work together to consider the standardisation of training to meet the essence of care benchmarking which could be jointly delivered to care homes and domiciliary care agencies with reference to mental health. This should include increased training opportunities for care staff and domiciliary care staff on working with relatives of service users who have been diagnosed (possibly involving carers in staff training). Consideration should be given to developing a pool of trainers to offer sessions to staff.

The Audit Commission Review of Mental Health Services for older people in Coventry identified that the number of ASW's was falling and this is putting additional pressure on the remaining ASWs ability to meet demand. There is a need to address recruitment and training issues for ASW's working with older people with mental health problems.

A Review of Community Mental Health Services in Coventry recommended a greater skill mix be introduced to CMHT(OP)s for more efficient and effective working. Unqualified staff could undertake some of the maintenance of care packages tasks currently undertaken by qualified staff.

16. Vulnerable Adult Protection

The Coventry Vulnerable Adult Protection Policy, Procedures and Good Practice Guide was formally launched in November 2003 as the local response to "No Secrets", published in March 2000 by the Department of Health. **This defines a "vulnerable adult" as someone who is or maybe in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation."**

This definition does not therefore automatically include all older people, nor does it automatically include all older people with a mental health problem.

The Coventry Vulnerable Adult Protection Policy, Procedures and Good Practice Guide has been ratified by the Coventry City Council, the Coventry Teaching PCT, the University Hospitals of Coventry & Warwickshire NHS Trust and the West Midlands Police.
The primary purpose of the Vulnerable Adult Protection Policy, Procedures and Good Practice Guide is to enable the vulnerable adult to retain as much control as possible over the decisions affecting their lives.

This primary purpose can be complicated by the issue of the Capacity of the particular older person, Capacity being defined as the ability to understand, retain and process information and communicate a decision made on the basis of this process. At present, the law assumes all adults to have Capacity unless it can be demonstrated that they have not, and Capacity is an all-or nothing concept. If an adult has not got Capacity, no one can be empowered to make decisions re their welfare other than under the Doctrine of Necessity except by applying to the High Court for Declaratory Relief.

The reality for many older people with mental health problems is that they retain Capacity in some areas of their lives but not, and that capacity can vary from day-to-day.

While action can be taken to protect finances and property via Appointeeship, Powers of Attorney, receivership etc, similar protection cannot yet be provided re an individual's care or welfare needs and wishes. This will change when the Mental Capacity Bill becomes an Act.
Vulnerable Adult Protection in general suffers from a low public profile compared to Child Protection, and the position of older people with mental health problems is perhaps poor compared with other adult service user groups due to their lack of a voice and representation.

The Coventry Vulnerable Adult Protection Policy, Procedures and Good Practice Guide is being implemented within the community, including care homes, at a level that appears comparable with other locals authorities in the West Midlands. However, the data masks the fact that the number of referrals relating to in-patients in mental health services is almost zero. It is also the case that very few referrals are received from in-patient mental health facilities.

There was a history of under-reporting and under-recording of adult protection work, as identified in the Benchmarking exercise undertaken in Coventry from April - November 2003. Whilst the level of recording has increased dramatically since November 2003, there remains under-reporting and under-recording within certain client groups - i.e. adult mental health - and the black and ethnic minority communities.

There are certain obvious barriers such as the lack of information for service users and the public in languages other than English or in other formats than the written word. There is also a lack of consistency in referring to the procedures from agencies other than Social Services. There is a similar pattern across other local authorities. This is particularly true of certain client groups, such as adult mental health service users.

The numbers of referrals in Coventry are low (5 older people with mental health issues between 1st April and 30th September 2004). There is a need to increase the level of awareness of what constitutes abuse, especially in health services and in provider services.

However there is a concern in some areas, particularly inpatient services, that the floodgates could open and the service would be inundated with referrals of abuse.

17. Advocacy

The Older People's commissioning service has identified that there is insufficient access to advocacy services in order to meet current demands for older people at home and in residential/nursing care. On occasions this gap in provision can result in financial abuse. Also the need for advocacy far exceeds the resources of Age Concern currently, which has contractual implications. There is a small amount of specialist advocacy for this service user group via Alzheimer's Society and Age Concern.

The NSF Standard 7 Carers and Users subgroup has also identified a need for more advocacy services for service users with both functional and organic mental illnesses and for carers and users to be made more aware of these.

18. Meeting the needs of black and minority ethnic service users

According to the National Service Framework for Older People the proportion of older people from black and minority ethnic communities is small but growing. This is true for Coventry. The following is extracted from the 2001 Census Data:

65-74 by age groups and ethnicity

White	Mixed	Asian	Black	Chinese & Other
21469	48	1619	409	66

75-84 by age groups and ethnicity

White	Mixed	Asian	Black	Chinese & Other
16374	36	552	116	28

85+ by age groups and ethnicity

White	Mixed	Asian	Black	Chinese & Other
5099	15	21	105	9

In Coventry there are two 0.5 specialist posts based in the North team, who undertake development work city-wide with Asian and Afro-Caribbean communities. Their role is both to develop awareness of the service, and recognition of mental health problems, in response to the historically low uptake of services from these communities.

The Asian Mental Health Access Project was initially funded from Coventry's Single Regeneration Budget and was established to meet the mental health needs of South Asian people by providing culturally appropriate services in the two disadvantaged areas of Foleshill and Longford of Coventry and was evaluated by the Department of Sociology at Warwick University. The project is currently financed by Coventry's neighbourhood renewal funding with similar goals and objectives. The project is for all age groups but the carer's worker and outreach worker specifically work with people over 55 years of age (this is considered as elderly or being an 'elder' in the Asian community). The project has:

- Increased awareness of the services which people with mental health problems living or working in Foleshill can access and how to access them.
- Improved partnership working in the care of people with mental health problems between the statutory and voluntary sectors in the Foleshill area.
- Increased benefit to the Asian community from improved access to mental health services.
- Potentially reduced the length of stay whilst in hospital and the number of people needing readmission associated with more effective prevention of mental health crises resulting from improved co-ordination of support.

The NSF Older People Task Group for Mental Health Older People has identified a need for appropriate nursing and residential provision for older people from Black and Minority Ethnic groups. It also recommends:

- Revisiting previous research which supported the view that there is demand for a care home in Coventry specifically for elders from ethnic minority groups
- Reviewing existing homes to assess how well they cater for individual dietary requirements.

An Equality Impact Assessment will be undertaken in relation to this strategy.

19. User and Carer involvement

The Local Delivery plan stresses the importance of ensuring that users and carers' contributions, including those representing minority communities, make a tangible difference to planning.

The Older Peoples Partnership has invited eight representatives of users and carers to be full members. There are also a number of other organisations including PALs and Practice Patient groups which have been established with this goal in mind. Such developments are important but need to ensure the rhetoric of involvement is reflected in tangible influence over the development of services. Over the next period of time the Partnership will:

- Complete the implementation of a User/Carer involvement strategy, based on a consultation exercise recently concluded.
- Launch a Communication strategy to ensure better quality information is produced, and is more available via paper and web-based media.

- Publish an Annual review of its work in July 2005, highlighting changes, reporting on developments influenced by users and carers, and offering users and carers opportunities to comment.
- Promote the role of older people champions, with a brief to enquire about and comment on the way in which the Partnership promotes the views of users and carers.

REFERENCES

Beekman ATF, Copeland JRM and Prince MJ (1999). Review of community prevalence of depression in later life. British Journal of Psychiatry 174: 307 -311.

Between Two Stools: Psychiatric Services for Older People in General Hospitals. Report of a UK survey (2002) Holmes J, Bentley K and Cameron I. University of Leeds: Academic Unit of Psychiatry. University of Leeds.

National Service Framework for Older People (2001) Department of Health. London DOH.

Assistive Technology, Independence and Wellbeing. Audit Commission.

"Services for younger people with Alzheimer's disease and other dementias".
Policy papers prepared by the Faculty of Old Age Psychiatry in conjunction with the Alzheimer's Society. 2000 and 2004

Integrating Older People's Mental Health services, Community Mental Health Teams for Older People, A Commentary and Resource Document. Jayne Lingard and Alisoun Milne, commissioned by the Children, Older People and Social Care Policy Directorate, DH, June 2004

Forget me Not, Mental Health Services for Older People, Audit Commission, 2000

CHI report into 'Investigations into matters arising from care on Rowan Ward' in the Manchester Mental Health and Social Care Trust: September 2003

Avonside Report - report of the Independent Inquiry Team in April 2004 - The Birmingham and Black Country Strategic Health Authority, the Appointments Commission and the Department of Health.

Health Care Needs Assessment. The Epidemiologically Based Needs Assessment Reviews. First Series, Second Edition, Volume 2. Edited by Andrew Stevens, James Raftery, Jonathan Mant and Sue Simpson. 2004

Cooper SA. (1999)
The relationship between psychiatric and physical health in elderly people with intellectual disability.
Journal of Intellectual Disability Research 1999 Feb;43 (Pt1):54-60.

Deb, S. Matthews, T., Holt, G., et al (2001b)
Practice Guidelines for Assessment and Diagnosis of Mental Health Problems in Adults with Intellectual Disability. Brighton: Pavilion Publishing.

Department of Health (2001)
Valuing People: A New Strategy for Learning Disability for the 21st Century. London: Stationery Office.

Marston, G. M., Perry, D. W. & Roy, A. (1997)
Manifestations of depression in people with intellectual disability.
Journal of Intellectual Disability Research, 41, 476– 480.

Moss, S.C., Patel, P., Prosser H., et al (1993) Psychiatric morbidity in older people with moderate and severe learning disability (mental retardation). Part I: Development and reliability of the patient interview (PAS–ADD). British Journal of Psychiatry, 163, 471– 480.

Roy, A., Martin, D.M. and Wells, M.B. (1997)
Health gain through screening -- mental health: developing primary health care services for people with an intellectual disability.
Journal of Intellectual Developmental Disability, 1997 Dec, vol. 22, no. 4, p. 227-39, (20 ref),

Tyrrell, J. and Dodd, (2003)
Psychopathology in Older Age. In: Mental Health, Intellectual Disabilities and the Aging Process (Eds. Davidson, P.W., Prasher, V.P. and Janicki, M.P.) pp.22 – 37.

APPENDIX 1

National Policy Drivers

The NHS Plan: In July 2000 the Government published its vision for the future of the NHS. It is a plan for sustained investment together with a programme for reform and modernisation. The plan is based on ten core principles which state that the NHS will provide a universal service for all, based on clinical need, with services shaped around the needs and preferences of individual patients their families and their carers. There is an emphasis on closing the gap between the health and social divide and ensuring that the workforce is able to deliver services in the modern NHS.

Modernising social services promoting independence, improving protection, raising standards

This White Paper was published in 1998 and presents the government's plans for modernising social services provision. It states the principles underlying the government's 'third way' in relation to social care, which de-emphasises the status of the provider in favour of promoting independence and ensuring the delivery of quality services, and notes the establishment of a Social Services Modernisation Fund. The paper goes on to outline proposals for improving services for adults and for children. It then sets out proposals for general improvements in user protection, the system of regulation, and workforce standards, and notes the intended establishment of a General Social Care Council. The paper's concluding sections explain plans for facilitating partnership with the NHS and non-statutory bodies, and present a framework for cooperation between local authorities and central government in promoting the delivery of efficient, high quality services. In services for adults, the priorities for improvement are: promoting independence, improving consistency, and providing convenient, user-centred services.

The Care Standards Act 2000:

This built on the White Paper Modernising Social Services, and put in place the building blocks of the Government's programme for modernising social care and in particular, for improving quality and protection. The agenda for the modernisation of social care includes the establishment of the following:

- An independent National Care Standards Commission to regulate all care homes, private and voluntary healthcare, and a range of social care services in accordance with national minimum standards
- A General Social Care Council to raise professional and training standards for the million-strong social care workforce
- The Training Organisation for Social Services, to improve both the quality and quantity of practice learning opportunities for social work students
- The Social Care Institute for Excellence, to act as a knowledge base and to promote best practice in social care services.

Other initiatives included strengthening and training the social care workforce and introducing national minimum standards for all aspects of social care services.

The National Service Framework for Older People (NSF) addresses the needs for Older People. It is founded on knowledge-based practice and partnership working between those who use and those who provide services; between different clinicians and practitioners; across different parts of the NHS; between the NHS and local government; between the public, voluntary and private sectors and reaching out to individuals, groups and organisations in the community.

The NSF sets standards for the Care of Older People across health and social services. The four themes in the NSF are:

- Respecting the individual (rooting out age discrimination and person-centred care)
- Intermediate care services
- Providing evidence based specialist care (general hospital care, stroke, falls and mental health)
- Promoting an active and health life

The proportion of Older People from black and minority ethnic communities is small but growing. It is important therefore, that all services reflect the diversity of the population, which they serve. Services need also to be able to respond Older People with learning disabilities, many of whom begin the ageing process at an earlier age than the general population.

The NSF emphasises that carer's needs should be considered as an integral part of the way in which services are provided for Older People.

The aim of Standard 7 is to promote good mental health in older people and to treat and support those older people with dementia and depression. The standard specifically requires that 'older people who have mental health problems have access to integrated mental health services, provided by the NHS and Councils to ensure effective diagnosis, treatment and support, for them and for their carers' These key interventions are required:

- Promoting good mental health
- Early recognition
- Access to specialist care

In particular this standard has a milestone around health and social care systems having agreed protocols for the care and management of older people with mental health problems. Also PCT's will have ensured that every general practice is using a protocol agreed with local specialist services, health and social services, to diagnose, treat and care for patients with depression or dementia.

Standard 8 concerns the promotion of health and active life in older age aims to extend the healthy life expectancy of older people through a co-ordinated programme of action led by the NHS with support from councils. This will involve health promotion activities and wider initiatives involving a multi-sectoral approach to promoting health, independence and wellbeing in old age include exercise services, healthy eating, Keep Warm, Keep Well campaigns etc.

Section 31 of the Health Act 1999 introduced flexibilities in the form of three new possible structures to address the legal barriers to integration of health and social care, lead commissioning, pooled funds and integrated provision.

Integrating Older People's Mental Health Services

This commentary and resource document was commissioned by the Department of Health and produced by Jayne Lingard and Alisoun Milne in 2004. It is a valuable tool which contributes to the development of integration of health and social care processes in the assessment and care management of older people whose mental ill health poses moderate to high levels of risk to themselves or others. It supports the achievement of the first milestone of Standard 7 of the NSF for Older People by focussing on issues of operational integration of service delivery in Community Mental Health Teams for older people.

Mental Health Policy Implementation Guide

This Department of Health guidance supplements the Mental Health Implementation Guide launched in March 2001 which made reference to Community Mental Health Teams. This guidance sets out the functions of a CMHT rather than specifying the precise structure which should be locally developed.

Forget-me-not

Forget me Not, Mental Health Services for Older People, was published by the Audit Commission in 2000. It reported that many older people, especially those over 80, experience mental health needs such as dementia and depression, and government policy recognised that caring for this group should be a priority. Health and local authorities were therefore being encouraged to work more closely together and to submit annual joint plans. The report found:

- A wide variation in practice in the kinds of resources that were available and the balance of community, hospital and residential mental health services
- The need for systems for the identification and initial assessment of mental health needs
- The importance of coordination and joint working between Health and Social Services in service delivery and the arrangements for long term care
- The need for strategic planning arrangements.

The Audit Commission subsequently carried out local audits of these services based on these key issues. A further report in 2002 summarises the main findings from audits in England. It highlights for managers and practitioners where they should concentrate their efforts.

It found that:

- Some areas have good mental health services for older people in place, but many do not.
- Many GPs need more support to diagnose dementia early, to use protocols to help diagnose dementia or depression, to have ready access to specialist advice and to receive sufficient training for dementia.
- Carers of people with dementia need good advice and information on how things would develop and good written information about local services.

- Specialist services need strengthening in some areas in terms of availability and core team membership.
- More day and respite care was needed
- Teamwork and strategy needed further attention with jointly agreed assessment and care management procedures, compatible IT systems and clear goals.

Rowan Report

In October 2002 the Greater Manchester Strategic Health Authority contacted the Commission for Health Improvement (CHI) to request an investigation into older age services at Manchester Mental Health & Social Care Trust. This followed allegations, in August 2002, of physical and emotional abuse of patients by care staff on Rowan Ward, an isolated facility housing older people with mental health needs. The September 2003 CHI report into 'Investigations into matters arising from care on Rowan Ward' in the Manchester Mental Health and Social Care Trust identified key findings:

- Poor and institutionalised environment
- Low staffing levels
- High use of bank/agency staff
- Little staff development
- Poor supervision
- Closed inward looking culture
- Weak management at ward and locality level

Avonside Report

This report of the Independent Inquiry Team in April 2004 was in response to complaints raised by the families of relatives involved in four serious events at the Avonside Unit at the former Northern Birmingham Mental Health NHS Trust. The Birmingham and Black Country Strategic Health Authority together with the Appointments Commission and the Department of Health took responsibility for the inquiry. The findings were similar to the Rowan Report, and could be crystallised into four critical problem areas:

- Lack of consistent leadership
- Lack of embedded clinical governance
- Ineffective operational management
- Lost perspective of core purpose.

Ten major quality and safety recommendations were highlighted at Trust, Directorate and ward level which included communicating a clear shared vision, organisational development, robust clinical governance and reviews of staffing levels and skill mix.

Independent Inquiry into the death of David Bennett

This inquiry was set up by Norfolk, Suffolk and Cambridgeshire Strategic Heath Authority and the report was published in December 2003. Mr Bennett, 38, a Jamaican-born Rastafarian, died in 1998 at the Norvic secure unit in Norwich. The report made 22 separate recommendations to tackle racism within mental health services.

APPENDIX 2

Local Needs

The current population of people aged over 85 in the city is as follows: -

All	5233
Male	1564
Female	3669

Prevalence/incidence of Dementia

Table 1: Prevalence of dementia by age and sex (%) (pooled results from five centres of the Medical Research Council Cognitive Function and Ageing Study)

Age group	Men %	Women %
65-69	1.4	1.5
70-74	3.1	2.2
75-79	5.6	7.1
80-84	10.2	14.1
85+	19.6	27.5

Table 1 shows the best available estimates of the numbers of older people with dementia. The prevalence of dementia increases with age so that over 1 in 5 people aged 85 or over will suffer from dementia. From the age of 75 onwards, the prevalence is markedly higher in women than men.

If we apply the results in table 1 to the age/sex population of Coventry then we can calculate the estimated numbers of people with dementia (table 2).

Table 2: Estimated number of older people with dementia in Coventry based on 2003 ONS base population estimate and MRC CFAS study

Age group	Men	Women	Total
65-69	82	98	181
70-74	160	129	289
75-79	229	380	609
80-84	297	684	981
85+	325	1010	1335
Total	1093	2303	3395

The Medical Research Council's Cognitive Function and Ageing Study (MRC CFAS) results (table 3) can be used to estimate the number of older people with dementia in Coventry by severity of illness and type of residence (table 4). The total numbers shown in table 4 are different to that shown in table 2 as table 4 does not include individuals with minimal cognitive impairment (MMSE >23).

Table 3: Numbers of people with mild to severe dementia or physical disability per 10 000 population in each age group, by type of residence

	Rates per 10,000 population					
	Community		**Institutions**		**All[a]**	
	65-84	85+	65-84	85+	65-84	85+
Dementia						
mild (MMSE[c] 18-23)	116	397	7	92	124	486
Moderate (MMSE 10-17)	98	601	43	360	142	967
severe (MMSE ≤9)	36	168	45	540	82	739
Physical disability only	633	2027	93	804	726	2839
Total	**883**	**3193**	**189**	**1797**	**1074**	**5031**

[a] The numbers in the 'All' columns do not equal the sum of the numbers in the Community and Institutions columns because 0.2% of the original CFAS sample who had missing information on accommodation have been included. Those mentally frail people with missing MMSE scores (1.5%) were distributed in the same proportions as those with scores.

[b] Based on screen, not full AGECAT diagnosis.

[c] Mini Mental State Examination.

Table 4: Numbers of people with mild to severe dementia by type of residence: Coventry based on 2003 ONS population estimate and MRC CFAS study

	Actual numbers					
	Community		**Institutions**		**All[a]**	
	65-84	85+	65-84	85+	65-84	85+
Dementia						
Mild (MMSE 18-23)	472	212	28	49	504	259
Moderate (MMSE 10-17)	399	320	175	192	578	516
Severe (MMSE ≤9)	146	90	183	288	334	394
Total	1017	622	386	529	1416	1169

Projections

Using 2000 based ONS population projections the projected number of people with dementia can be estimated for Coventry as can the number of people with dementia needing institutional care or intensive care as an alternative to institutional care (table 5).

Table 5: Estimated number of people with dementia and numbers requiring institutional care or intensive care as an alternative to institutional care, Coventry 2004 to 2010

Year	2004	2005	2006	2007	2008	2009	2010
Number with dementia	3467	3494	3510	3512	3525	3533	3518
Number with dementia needing institutional /intensive care	953	978	1003	1011	1021	1034	1047

Notes for table 5:

- Numbers with dementia based on prevalence rates shown in table 1 and 2000 based ONS population projections
- Numbers in institutional care based on results shown in table 4 (Rate per 10,000 population requiring institutional care is 348/10,000 for 65-84 year olds and 2192/10,000 for those aged 85+). It is assumed that no one with mild cognitive impairment without physical disability requires institutional care.

By 2008, the number of older people with dementia is estimated to increase by only 1.7% which reflects the projected ageing of the population in Coventry. Between 2004 and 2008, the number of older people requiring institutional care or intensive care as an alternative to institutional care is expected to rise by 7.1% in Coventry.

Prevalence/incidence of Depressive illness

Depressive disorder is common among older people (Beekman et al,1999). Repeated surveys show that around 15% of older people living in the community suffer from pervasive depression, that is, depression considered worth treating. For Coventry this represents …… older people. About 2% of older people suffer from severe depressive disorders. Detection and management of depressive disorders in primary care has been shown to be inadequate. Depression is commoner in women than men. The prevalence of major depressive episodes generally falls with age. In contrast, the prevalence of subsyndromal depressive symptoms and minor depression is highest in those aged over 65.

The prevalence of depressive illness in older people is generally higher in hospital inpatients than in the community. One review found that 5-58% of inpatients suffered from depressive illness. This has been investigated for a number of conditions including myocardial infarction (MI), stroke and cancers.

The prevalence of depressive illness is highest in older nursing home patients. A review of 36 studies found prevalence rates of 43.9% for depressive symptoms, 25.7% for minor depression and 15.5% for major depression in this setting.

Schizophrenia

Surveys suggest that 1-2% of older people suffer from paranoid/schizophrenic syndromes. For Coventry this represents between 456 to 912 older people.

The strategic aim with this longstanding group is to deal with additional problems and reduce the frequency of relapse by the use of effective treatment and close monitoring. In the late onset group the aim is prevention by addressing sensory impairments and social isolation, early detection through screening and effective treatment and monitoring.

Anxiety Disorders

Prevalence of general anxiety among older people in the community is 4% (representing 1824 older people in Coventry) and the prevalence of phobias is 10% (4560 older people in Coventry). Anxiety is often part of a broader depressive illness. A few can be severe and disabling enough to require intensive hospital treatment where both medication and psychological treatments are known to be effective. There are many more who will need psychological treatments in the community.

The strategic aims are early detection and effective intervention to reduce the length of episodes and need for admission as well as reducing the secondary disability which causes great stress to carers.

Substance Misuse

Between 1-3.5% of the older population, (456 to 1596 older people in Coventry) are adversely affected by very heavy dependence on alcohol, with a further 3.5% (1596) who drink heavily. Other substances misused by older people include some prescription drugs, purgatives, cough medicines, analgesics, tranquillisers and sleeping tablets many of which can be bought over the counter.

This can lead to falls, fractures and gastrointestinal problems. Substance misuse, alcohol in particular, may be an important cause of the abuse of older people, either physically, sexually or neglect. Substance use may be caused by psychiatric illness or vice versa.

Suicide

There has been a large fall in the suicide rate for people aged over 65 in the last 30 years. Older people used to be at highest risk of suicide in 1976 (see table) but are now at lower risk than those aged 25 to 64.

Suicide rates[1]: by sex and age

United Kingdom						Rates per 100,000 population
	1976	1981	1986	1991	1996	2002[2]
Males						
15-24	9.8	10.8	12.8	15.8	15.0	13.3
25-44	15.1	19.6	20.4	24.8	23.9	24.1
45-64	20.9	23.0	22.6	20.4	17.3	17.9
65 and over	24.0	24.1	26.3	18.7	17.3	13.5
Females						
15-24	4.6	3.4	3.3	3.9	4.2	3.7
25-44	9.1	7.9	6.6	5.9	6.2	6.4
45-64	14.1	14.9	11.8	8.3	6.4	6.4
65 and over	15.1	15.7	13.7	8.5	6.7	5.8

1 Includes deaths with a verdict of undetermined intent (open verdicts).

2 Rates for 2002 are coded to ICD-10. Rates are age-standardised to the European standard population. See Appendix, Part 7: Standardised rates, and International Classification of Diseases.

Source: Office for National Statistics; General Register Office for Scotland; Northern Ireland Statistics and Research Agency

Factors that predict suicide risk are more numerous in older people and include: previous suicide attempts; increasing age; being male; depression; chronic pain; physical illness; excessive stress; progressive disability; isolation; alcohol abuse. At least two thirds of older people who attempt suicide are suffering from depressive illness and are likely to have a chronic disease of some kind.

Delirium or 'Acute Confusional State'

Delirium is the sudden onset and fluctuating course of disturbance of attention, memory, awareness or surroundings in association with visual hallucinations and disturbed behaviour. Delirium can occur during dementia when brain function seems to deteriorate suddenly. It is usually secondary to a physical cause which may be reversible and it may be more appropriate to refer to general medical services at an early stage where there are better facilities for investigation. The most common causes are infections of the urinary tract, chest, skin or ear, cardiac failure and reaction to medication. Delirium is very common in older people in medical, surgical and orthopaedic wards and the symptoms are often misunderstood.

Young onset dementia

Though it is estimated that there are less than 100 people of working age with dementia illness in Coventry, their needs are often of a high degree and complex.

Appendix 3

New Homes for Old Project.

First Phase of Developments

To date, three Housing with Domiciliary Care schemes have been developed as follows:

Scheme name	Number of Flats	Partner Organisation
Alexandra House	39	Anchor Trust
Bevan Court	41	Focus Housing Group
Poppy Court	48	Focus Housing Group

The first new Specialist Dementia Care scheme, Charnwood House, is located in Beake Avenue in the north of the City, and was developed by Methodist Homes for the Aged. The scheme provides 57 places, inclusive of a 12 Intermediate Care places for older people with mental health problems.

Second Phase of Developments – Private Finance Initiative (PFI) Project

The second phase of the New Homes for Old developments consists of the following:

- Three further Housing with Domiciliary Care schemes. Each of the three schemes of Housing with Care is planned to comprise 40 places. One of these new schemes will have particular emphasis on meeting the specific needs of African/African-Caribbean older people. Due to the fact that 9% of the population are of South Asian origin, it is planned to develop a separate Specialist Scheme in order to address the specific needs of South Asian elders.
- 20 Intermediate Care places within two of the new schemes of Housing with Domiciliary Care will be provided (see (v) above).
- Two new schemes of Specialist Accommodation and Care Support for older people with dementia, planned to comprise 40 places. The proposed New Homes for Old developments of two Specialist Dementia Care Schemes, offering the planned 80 places will help Social Services to address the growing number of over 85 year olds, for whom there is a high prevalence rate for dementia.
- 10 Respite Care places within one of the new specialist residential care schemes are specifically aimed at offering support to older people with dementia and their carers. The places will, as far as possible, be available when carers need a break from their caring role, rather than at designated times. These places will help to avoid a carer reaching a point of crisis leading to an individual being placed unnecessarily in residential or nursing care.

Thus overall, the Council proposals for the second phase of developments, will provide:

- three new schemes of **Housing with Domiciliary Care**, comprising 120 places in total (40 places per scheme), including a total 20 **Intermediate Care** places, and a focus on the specific needs of African-Caribbean elders in one of these; and
- two new schemes of **Specialist Accommodation and Care Support for older people**

with Dementia, comprising 80 places in total (40 places per scheme), including a total 10 **Respite Care** places in one of the schemes**.**

Thus, five new schemes will be provided, comprising a total 200 places, as follows:

Type of care provision	**Future planned number of places**
Housing with Domiciliary Care	40
Housing with Domiciliary Care	40 inc. 10 Intermediate Care places
Housing with Domiciliary Care	40 inc. 10 Intermediate Care places
Specialist Dementia Care	40 inc. 10 Respite Care places
Specialist Dementia Care	40

These developments represent a key stepping stone in Social Services' commitment to modernising services for older people. They form part of a range of services being progressed across the City by various organisations, including the City Council itself.