East London NHS Foundation Trust and NHS Tower Hamlets work together to improve mental health in Tower Hamlets

Older People's Mental Health Needs Assessment

For Depression, Dementia and Severe Mental Illness

October 2009

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ABBREVIATIONS

BLT	Barts and the London
BME	Black and Minority Ethnic
CEG	Clinical Effectiveness Group
CMHT	Community Mental Health Team
CMHTOP	Community Mental Health Team for Older People
ELFT	East London Foundation Trust
EMI	Elderly Mentally Impaired
GLA	Greater London Authority
HfL	Healthcare for London
IAPT	Improving Access to Psychological Therapies
LAP	Local Area Partnership
LBTH	London Borough of Tower Hamlets
LGBT	Lesbian Gay Bisexual and Transgender
MEH	Mile End Hospital
NICE	National Institute for health and Clinical Excellence
NHS TH	NHS Tower Hamlets
N/K	Not Known
POPPI	Projecting Older People Population Index
RLH	Royal London Hospital
SMI	Severe Mental Illness
SOA	Super Output Area

Key documents

National Dementia Strategy, DH, 2009
Joint commissioning framework for dementia, DH, 2009
NICE/ SCIE guidance on dementia, 2006
NICE guidance on depression, 2004
Who Cares Wins, Royal College of Psychiatrists, 2005
Dementia UK, Alzheimer's Society, 2007
Everybody's Business, DH, 2005

EXECUTIVE SUMMARY

This needs assessment provides a summary of the mental health needs of older people in Tower Hamlets. These have been divided into three broad categories: depression, dementia and severe mental illness (SMI).

It also includes a summary of the population profile of older people in Tower Hamlets. With 18,041 older people (8% of total population) in 2008, Tower Hamlets has a smaller than national average proportion of older people. These are not evenly distributed throughout the borough with higher concentrations in the north east. However the health needs of older people in Tower Hamlets are likely to be greater due to local risk factors.

There are varying numbers of recorded mental health conditions on primary care registers, with gaps in expected and recorded prevalence. Moreover national expected prevalence models are likely to underestimate the actual numbers in Tower Hamlets.

Summary of prevalence by mental health condition for 65+

Mental health condition	Recorded in GP registers	Expected numbers
Depression	2,075	1,640-2,460 (POPPI)
Dementia	413	1,532 (McKinsey)
SMI	214	271[1] (Saunders at al)

A third of patients admitted to Barts and the London Trust (BLT) in 2007/08 had diagnosed mental health conditions, which is less than national estimates (50%). Given the risk factors for poor mental health in Tower Hamlets we would expect a higher prevalence than national averages. This might suggest lower detection rates in general hospital settings and a need for awareness raising among professionals.

Cross-analysis of patients with long term conditions shows a high prevalence of depression (14% of people with diabetes have depression). Furthermore a number of patients with depression also have a long term condition (16% of patients with depression have hypertension). This suggests a need to treat both the physical and mental health of patients across the care pathways from initial diagnosis.

For the purpose of this needs assessment mental health surveys were carried out with two main providers, the social work teams and the accommodation providers. This was needed as this information is not currently recorded electronically. 33% of service users were found to have suspected or diagnosed mental health conditions.

Initial public consultation with service users highlighted a gap in mental health awareness and a need to provide mental health promotion to older people to reduce stigma and improve access to services. This consultation also identified a lack of appropriate services for younger people (under 65) with dementia.

The National Dementia Strategy, 2009 sets out 17 objectives for implementation at a local level as part of a five year plan. A joint strategy between NHS Tower Hamlets, East London Foundation Trust, London Borough of Tower Hamlets and partners is essential for ensuring successful delivery of this strategy.

[1] Based on 1.5% prevalence of SMI in TH older people population. Saunders PA, Copeland JRM, Dewey ME, et al. The prevalence of dementia, depression and neurosis in later life: the Liverpool MRC-ALPHA study. *Int J Epidemiol.* 1993;22:838–847

Box 1: Summary of key demographics

- According to GLA estimates, the population of older people (65+) in Tower Hamlets was **18,041** in 2008. This is projected to increase by 7% to **19,287** in 2018.
- The ethnic profile of older people is different from that of the general population, showing a predominantly White population.
- LAP 5 (north east) has the highest concentration of older people.
- There were **2,075** people aged 65 and over on GP depressions registers, **413** on dementia registers and **214** on SMI registers in 2007/08.
- Almost half of all admissions to MHCOP wards at East London Foundation Trust were for dementia.
- 34% of all BLT admissions for patients aged 65+ in 2007/08 had a diagnosed mental health condition.

Older people in Tower Hamlets account for:

- 9% of suicides
- 95% of diagnosed Dementia cases
- 70% of strokes
- 90% of caseloads of community heart failure services
- 79% of people with Parkinson's disease
- 66% of people registered blind or partially sighted

Box 2: Key risk factors for older people in Tower Hamlets

- Between 44% and 54% of older people live alone (43% is the London average), with particularly high rates amongst the older elderly (75+)
- Over 2/3 of lone pensioner households have no access to transport
- Nearly one third of over 65s felt fairly or very unsafe in their local area at night
- Approximately 6% of over 65s live in a poorly heated home
- Older people are heavily represented in the group classed as special needs households. Nearly 38% of this category are in housing deemed 'unsuitable'.
- Older people are heavily represented in the areas of lowest household income with 92% and 83% of older people in Whitechapel and St Dunstan's & Stepney Green wards being income deprived
- 63% of referrals for Adult Protection assessment are for over 65s, where financial abuse, physical abuse and neglect were the greatest areas of concern.[2]

[2] Herne, S., TH Over 65 Needs Assessment, August 2008

Recommendations

Informing Strategy

1. Ensure that there are appropriate services with sufficient skills and knowledge in secondary care mental health services to assess and support younger people with dementia. Further needs assessment work in this area, potentially across the Inner North East London area, may be appropriate.

2. Consider care pathways for older people with functional mental health problems and ensure that they are clear, in line with NICE guidance, and proportionate to the needs of service users and their carers.

3. Ensure that older people with mild to moderate and more severe functional mental health problems are actively referred to talking therapies in line with that available to people of working age, in primary and secondary care as appropriate and consistent with the demographic make up of the population.

4. Agree a service model for Tower Hamlets Memory Services that is in line with the evidence base described in the National Dementia Strategy and which has sufficient capacity to manage predicted activity. This should include a clear pathway into the Tower Hamlets Memory Service which is publicised and incorporated into GP and primary care training.

5. Agree a service model that ensures that people who have a diagnosis of dementia are not lost to services and receive ongoing support that is proportionate to their need. This should include consideration of developing Dementia Adviser posts.

6. Ensure that commissioning arrangements and strategic ownership across NHS Tower Hamlets and the London Borough of Tower Hamlets for people with dementia and older people with mental health problems are clear and unambiguous.

7. Consider the effectiveness of mechanisms currently in place for user and carer involvement in both the strategic planning and day to day monitoring of services.

Prevention and Primary Care

8. Consider the extent to which the current Mental Health Promotion Strategy specifically addresses dementia and mental health problems in older age. The Partnership should ensure that future plans for mental health promotion in these groups are evidence-based and specific to the Tower Hamlets population, e.g. that they adequately address the future age and ethnicity distribution, and cultural needs, of the population.

9. Consider whether specific mental health signposting and information services should be developed in LAP 5.

10. Develop mechanisms to reduce stigma and encourage help-seeking behaviour through increasing public and professional awareness of dementia and mental health problems in older people.

11. Consider the range of preventative services currently in place for older people with mental health problems and their carers, both generic and specific to mental health, and consider whether further services or approaches need to be developed in this area. A focus on the social inclusion of older people with dementia and mental health problems should be

promoted. Evidence suggests that the voluntary sector is best placed to provide preventative services to this client group.

12. Evaluate the impact the NHS Tower Hamlets social marketing campaign targeting alcohol consumption among older people. The campaign is aimed at reducing alcohol consumption in 65+ and encouraging help-seeking behaviour.

13. Consider how to improve data quality regarding dementia in primary care. This should include mechanisms to improve detection of possible symptoms of dementia in primary care, possibly through training specifically targeted at GP's and other primary care professionals.

14. Ensure that there is an appropriate range of mental health services provided by the voluntary sector which are accessible to older people.

Secondary Care and Community Services

15. Consider the extent to which current mainstream services are appropriately geared to the specific needs of older people with co-morbid physical and mental health problems. This should include the capability of mainstream services to recognise, assess and support mental health problems in people with a primary physical health problem, with talking therapies where appropriate. The Partnership should consider the availability of specialist medical, RGN and Professions Allied to Medicine to people with dementia and older people who are in-patients on ELFT provided wards.

16. Consider mechanisms to improve detection of possible symptoms of dementia, and mental health problems in older people, who are patients at BLT and NHS TH, possibly through training specifically targeted at health professionals.

17. Consider the evidence generated by the NHS Tower Hamlets Liaison Psychiatry Needs Assessment regarding the provision of specific liaison services for older people at BLT and MEH.

18. Review the evidence for formally establishing shared care beds for people with very complex co-morbid physical and mental health problems.

19. Review the future demand for specialist Mental Health Care of Older People inpatient beds within ELFT and consider possibilities for re-design to promote quality, strategic fit, and value for money.

20. Develop effective care pathways for older people with functional mental health problems who are in crisis. ELFT should ensure that all patients who are considered for admission to Leadenhall Ward are screened by the Home Treatment Team prior to admission.

21. Review arrangements for the ongoing support of people with diagnosed dementia. This should include arrangements for support in the home and the management of crises for people with dementia or their carers.

22. Scope future demand for, and design of, EMI beds in extra care sheltered, residential and nursing care in-borough.

23. Ensure that in the service model for dementia services is sufficient consideration given to specialist advice and support available regarding dementia and mental health to mainstream social services and residential, nursing and extra care sheltered housing providers.

24. Consider the supply of bed based respite care and ensure that it is commissioned to provide quality, strategic fit and value for money.

25. Review the evidence for, and design of, specialist versus mainstream home care and day care services for people with dementia.

26. Ensure that there is sufficient focus on the needs of carers in the design of future service models.

Next Steps:

If these recommendations are accepted by the Partnership, either wholly or in part, the Partnership should develop a high level action plan including milestones and identified responsible officers in order to deliver them. It may be that some of the recommendations may be deliverable through a commissioning strategy. A senior level project board should have oversight of, and monitoring responsibility for, the action plan.

1. INTRODUCTION

1.1 Background to the Needs Assessment

The planning, provision and evaluation of mental health services should be based on evidence. One way of compiling this evidence is to conduct a health needs assessment. Both the NHS and Local Government share statutory duties to undertake needs assessments. This needs assessment was commissioned to provide up to date information on the mental health needs of older people and people with dementia in Tower Hamlets.

The National Dementia Strategy (NDS) was published in early 2009 and sets out 17 Objectives which should be implemented at a local level as part of a 5 year implementation plan. The NDS brings together evidence on the effectiveness of service models drawn from a variety of sources including the NICE Guidance on Dementia. Tower Hamlets will be monitored on progress towards achieving these objectives. The NDS also supports Tower Hamlets in meeting the World Class Commissioning competencies as outlined in Appendix 3. Standards for services for older people with functional mental health problems are laid out in *Everybody's Business* (DH, 2006) and various NICE publications, for example the NICE Guidance on Depression.

1.2 London Borough of Tower Hamlets

Tower Hamlets is one of London's smallest boroughs, covering an area of just under 20 square kilometres. Bounded by the River Thames and the London Boroughs of Newham, Hackney and the City of London, it is also one of the most densely populated areas of Britain.

The Borough of Tower Hamlets is organised around four geographical localities, each of which contains two Local Area Partnerships (LAPs). These are illustrated in other documents such as the Tower Hamlets Annual Public Health Report. Appendix 1 shows a map of Tower Hamlets with LAPs and GP practices.

1.3 Aims and Objectives of this Report

The overall aim is to provide an assessment of the mental health needs of older people in Tower Hamlets, and some evidence on which to plan services and address health inequalities. Mental health conditions, where appropriate are divided into depression, dementia and severe mental illness.

Objectives

1. To provide demographic and epidemiological information on the prevalence of mental health problems in older people
2. To describe current service activity
3. To give recommendations for improving mental health care for older people based on the needs and current service provision

1.4 Data challenge

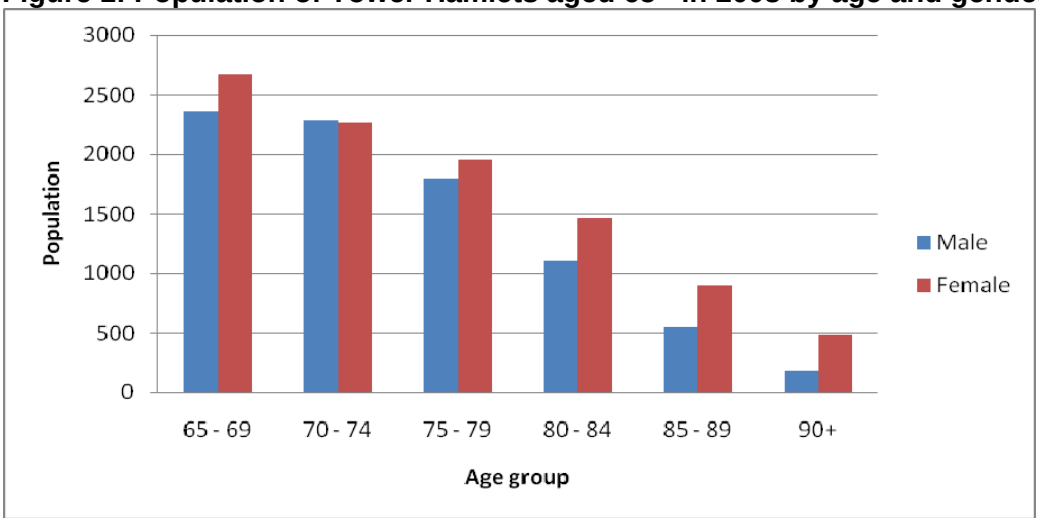
There are a wide variety of information systems used by different services across NHS Tower Hamlets, BLT, ELFT and LBTH including CEG, RiO, EMIS Web and SUS. This causes difficulties in access to data for analytical purposes. A clinical care integrated web system would help enable sharing of key data and understanding the needs of the Tower Hamlets population.

2. DEMOGRAPHY OF TOWER HAMLETS

Older people represent a relatively small percentage of the population of the Borough – approximately one in every thirteen people living in Tower Hamlets is over 65. The profile of the older population also differs from the main body of the population in that it is not evenly distributed across LAP areas and is also predominantly white. Over the next 15 years the make up of the older population will change significantly and become more ethnically representative of the Borough as a whole. As the structure of the population changes there is a question over whether the models of care developed for first generation BME communities is the most appropriate for 2nd and 3rd generation.

Figure 1 shows the population of older people (65+) in Tower Hamlets by age and gender in 2008. The population decreases with age, from 5,041 in the youngest age group to 662 in the 90+. With the exception of the 70 – 74 age group, there are more females than males.

Figure 1: Population of Tower Hamlets aged 65+ in 2008 by age and gender

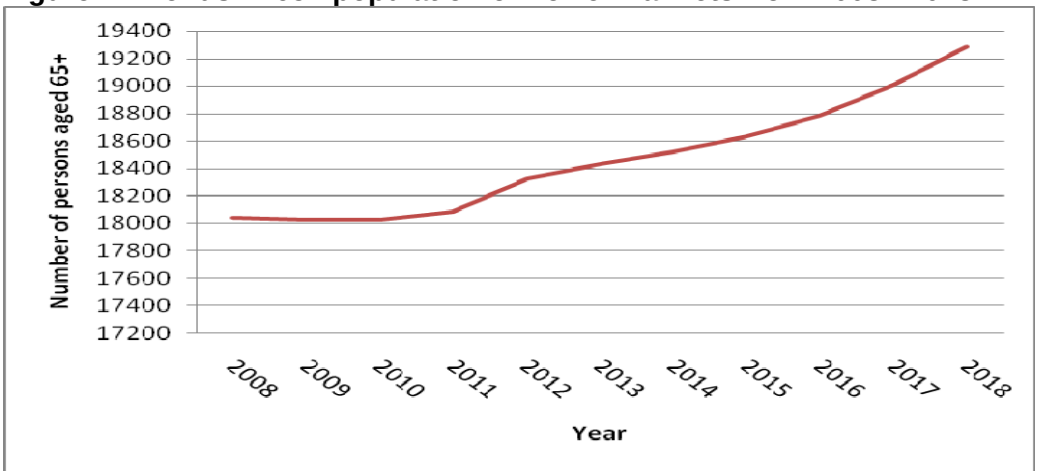


Source: GLA

2.1 Population projection

Figure 2 describes the trend in the population of older persons (65+) in Tower Hamlets over the next ten years, using GLA projections. The population is projected to increase by 7% from 18,041 in 2008 to 19,287 in 2018.

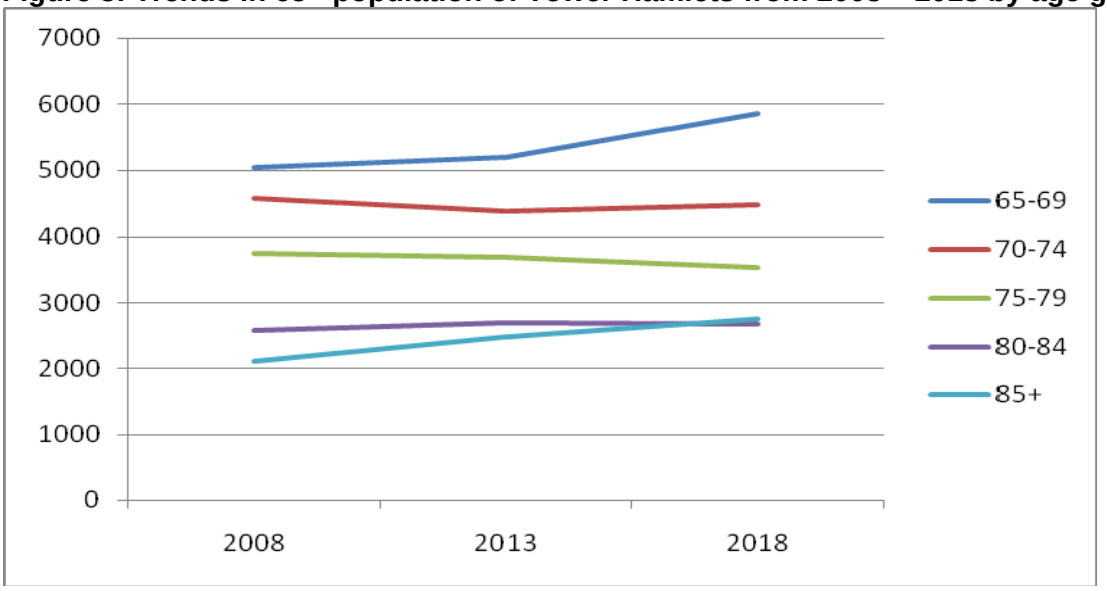
Figure 2: Trends in 65+ population of Tower Hamlets from 2008 - 2018



Source: GLA

Figure 3 below shows how changes in the population of older people over the next ten years will not be uniform across age groups. The largest increases are projected to be in the 65 – 69 age group (14%) and the 85+ age group (23%), with a slight decrease in the 75 – 79 age group.

Figure 3: Trends in 65+ population of Tower Hamlets from 2008 – 2018 by age group



Source: GLA

2.2 Population Distribution

Older people are not evenly distributed across LAPs or practices, with relatively low numbers in the SE Locality (LAPs 7 & 8). Figure 4 describes the number of older people in each LAP with LAP 1 having the highest number.

Figure 4: Number of people aged 65+ by LAP 2008/09

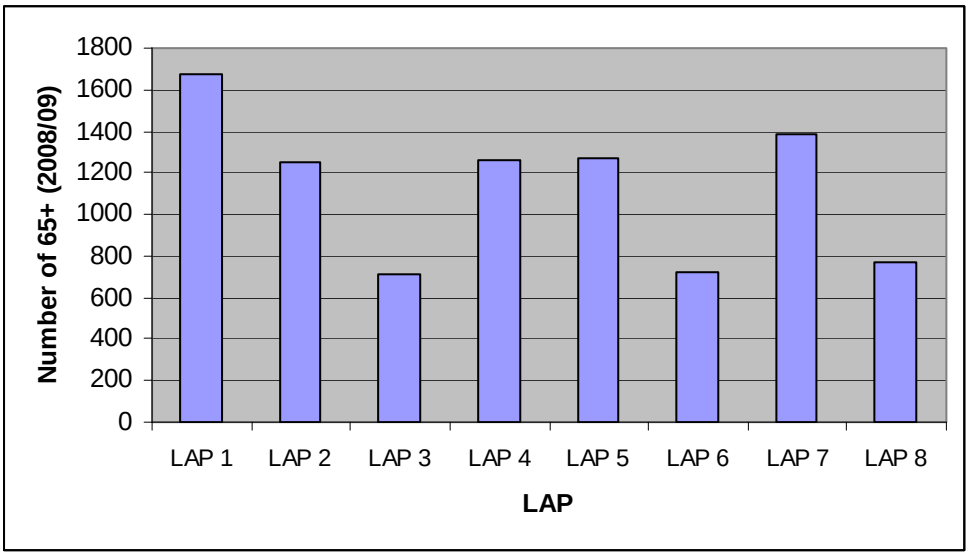
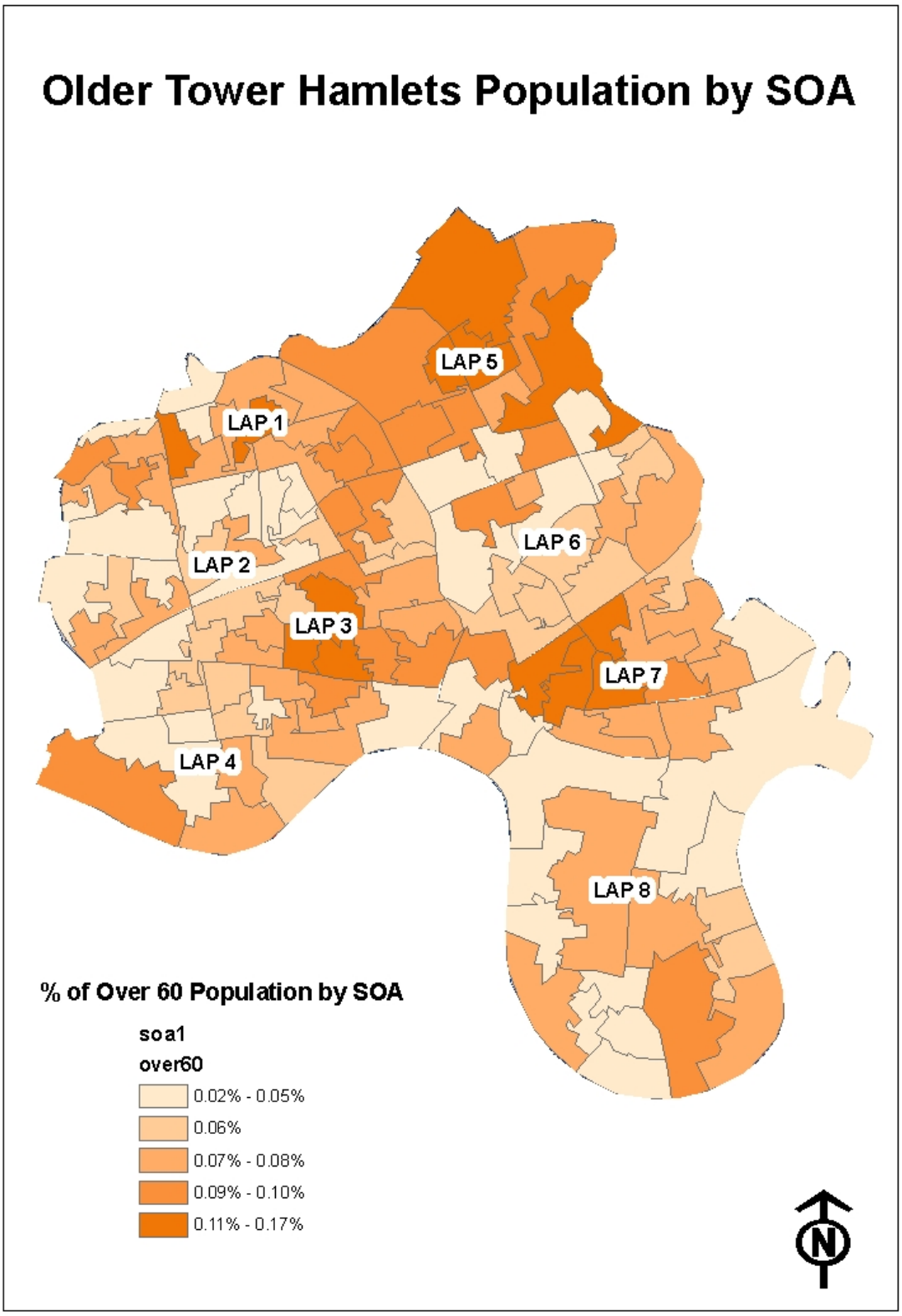


Figure 5 shows the proportion of older people (60+) by super output area (smallest area unit used by the Census) in Tower Hamlets. LAPs 3, 5 and 7 have higher proportions of older people with LAPs 2, 4 and 8 with relatively low proportion of older people.

Figure 5: Proportion of older people (60+) by SOA, Tower Hamlets 2008



Analysis of GP practice populations also shows that a core of practices have particularly high proportions of over 65s on their caseloads (Table 1). All practices in LAP 5 have above average proportions of older people.

About a third of GP practices have above average proportions of older people (highlighted in bold below). This includes a number of the borough's remaining small GP practices. Small practices offer high levels of continuity of care which may be appreciated by older patients. However, they may not be able to provide the same range of services in the practice as large group practices e.g. diagnostics, chronic disease clinics etc. This mapping exercise raises the issue of whether services are distributed appropriately to meet variation in need.

Table 1: GP Practice list sizes with proportion of patients aged 65+

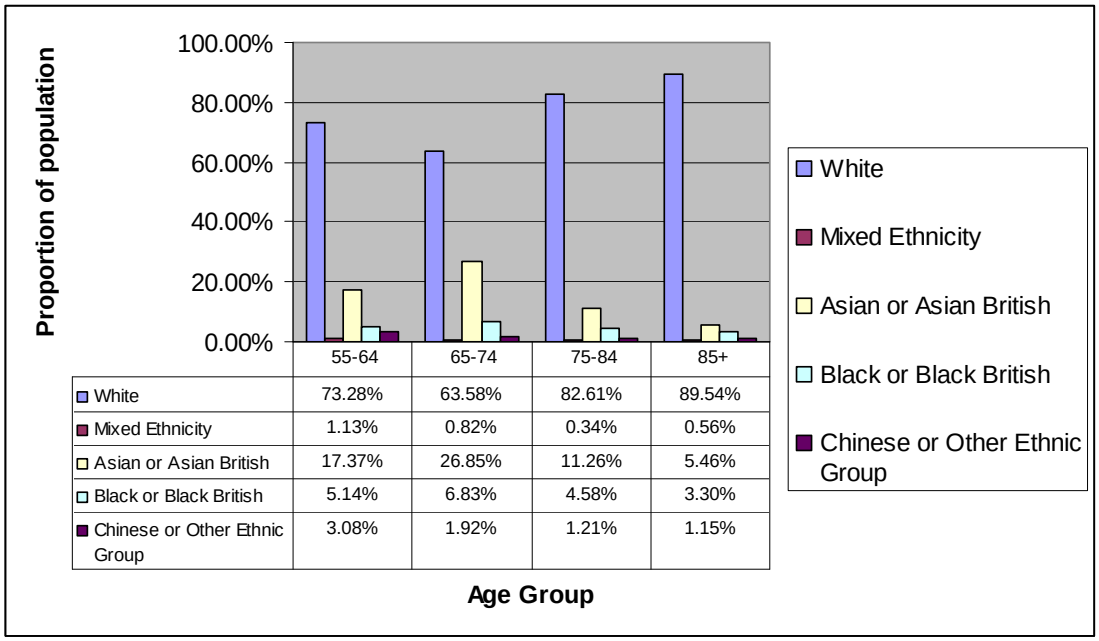
Practice Name	LAP	No aged 65+	Total List Size	% 65+
AMIN NB	**5**	**346**	**2754**	**12.56%**
BETHNAL GREEN HEALTH CENTRE	**1**	**760**	**6485**	**11.72%**
NISCHAL VK	**6**	**316**	**2702**	**11.70%**
SHAH KP	**5**	**371**	**3235**	**11.47%**
SELVAN N	**7**	**334**	**2954**	**11.31%**
JUBILEE STREET PRACTICE	**4**	**1111**	**9911**	**11.21%**
CHRISP STREET HEALTH CENTRE	**7**	**1097**	**11378**	**9.64%**
TREDEGAR PRACTICE	**5**	**295**	**3101**	**9.51%**
MISSION PRACTICE	**1**	**946**	**10014**	**9.45%**
ST STEPHEN'S HEALTH CENTRE	**5**	**903**	**10074**	**8.96%**
STEPNEY GREEN MEDICAL PRACTICE	**3**	**726**	**8944**	**8.12%**
XX PLACE	**2**	**994**	**12255**	**8.11%**
HARLEY GROVE MEDICAL CENTRE	**5**	**383**	**4946**	**7.74%**
ALBION HEALTH CENTRE	2	584	7971	7.33%
ST KATHARINE'S DOCK PRACTICE	4	164	2262	7.25%
EAST ONE HEALTH	4	519	7168	7.24%
BLITHEHALE MEDICAL CENTRE, THE	1	440	6295	6.99%
STROUTS PLACE MEDICAL CENTRE	1	299	4303	6.95%
STROUDLEY WALK PRACTICE	6	264	3811	6.93%
RANA AK	6	276	4009	6.88%
SPITALFIELDS PRACTICE	2	915	13403	6.83%
WAPPING GROUP PRACTICE	4	559	8253	6.77%
ALL SAINTS PRACTICE, THE	7	482	7212	6.68%
SHAH JALAL MEDICAL CENTRE	3	459	6948	6.61%
VARMA, CM	3	189	3010	6.28%
ST PAULS WAY PRACTICE	6	656	10811	6.07%
LIMEHOUSE PRACTICE	7	608	10024	6.07%
ISLAND HEALTH	8	653	10865	6.01%
DOCKLANDS MEDICAL CENTRE	8	308	5438	5.66%
GLOBE TOWN SURGERY	8	534	9609	5.56%
ISLAND MEDICAL CENTRE	8	216	3978	5.43%
TOWER MEDICAL CENTRE	3	259	5272	4.91%
ABERFELDY PRACTICE	7	186	4493	4.14%
POLLARD ROW PRACTICE	3	141	3716	3.79%
BARKANTINE PRACTICE, THE	8	227	7919	2.87%
Health E.1	2	13	1625	0.80%
TOTAL		**17533**	**237148**	**Average 7.39%**

KEY: Bold – GP practices with above average proportions of older people

2.3 Ethnicity

Figure 6 shows that the ethnic make up of older people in Tower Hamlets is different from that of the general population, with a higher proportion of 'White' in the 65+ population (73%) compared to the total population (51%).

Figure 6: Ethnicity of older people in Tower Hamlets

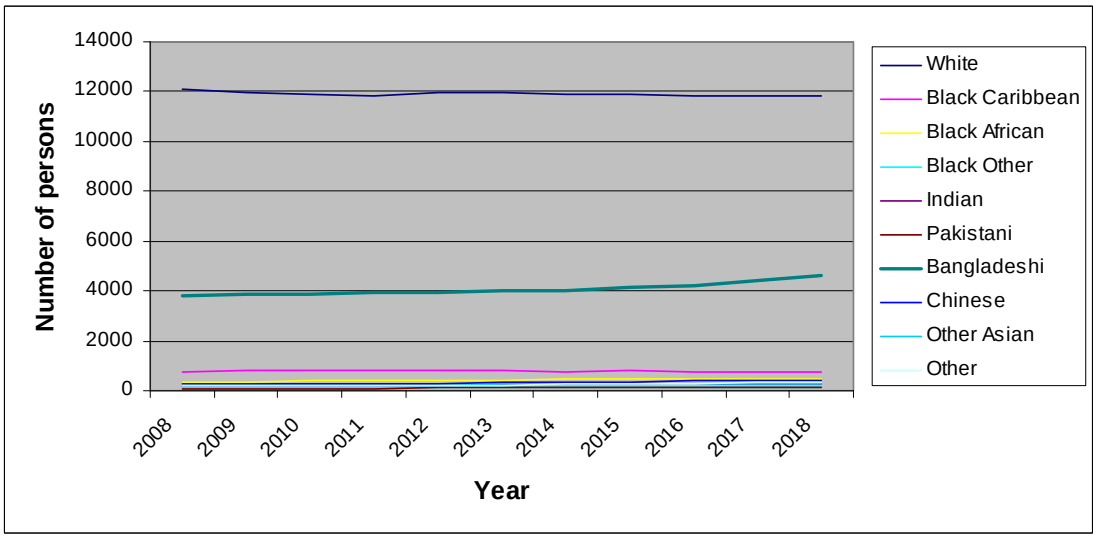


	55-64	65-74	75-84	85+
White	73.28%	63.58%	82.61%	89.54%
Mixed Ethnicity	1.13%	0.82%	0.34%	0.56%
Asian or Asian British	17.37%	26.85%	11.26%	5.46%
Black or Black British	5.14%	6.83%	4.58%	3.30%
Chinese or Other Ethnic Group	3.08%	1.92%	1.21%	1.15%

Source: Projecting Older People Population Information (POPPI) System, year 2006[3]

Population projections for older people for the next 10 years show that the ethnicity profile will remain roughly the same, with the notable exception of the Bangladeshi population, where there will be an estimated 21% increase, approximately 600 people (Figure 7).

Figure 7: Population projection of older people in Tower Hamlets by ethnicity



Source: GLA

[3] www.poppi.org.uk [Accessed April 2009]

Figures from Healthcare for London[4] indicate that in 2001, BME groups in London formed 12% of the population in the 65+ age group, compared to 22% in Tower Hamlets. This is projected to increase to 27% for London in 2021 and 41% for Tower Hamlets.

2.4 Ensuring Equality

In accordance with the Joint Commissioning Framework for dementia[5] there is a need to ensure that services in Tower Hamlets meet the needs of all sections of the community. For example, younger people with dementia, people with learning disabilities and people with alcohol-related dementia.

Anecdotal evidence suggests that there are a number of lesbian, gay, bisexual, trans Older People (OLGBT) in Tower Hamlets. There is currently no data but research carried out on behalf of the London Borough of Tower Hamlets recommends that staff are aware of different sexual orientations and that service provision is sensitive to the needs of the service user[6]. This research recommends a number of actions including looking at current service provision for OLGBT, and developing gay friendly policy and practice.

2.5 Risk factors for poor mental health

Tower Hamlets has many of the risk factors for poor mental health at both individual and community level. These include: high population density, overcrowding, high rates of unemployment and poverty, poor physical health and high rates of substance misuse[7]. This would suggest high levels of mental health problems in Tower Hamlets. In addition isolation and social exclusion are quite common amongst older people and half the older population live alone in Tower Hamlets (see Box 2). This increases the risk of depression and other mental health conditions.

2.6 Physical healthcare for people with mental health conditions

There is also a need to ensure that people with mental health conditions have access to services relating to their physical health in order to ensure improved dignity and quality of life. Some of the key aspects of physical health that can be particularly important are:

- Oral hygiene/Dental Care
- Eye sight and eye care
- Hearing aids
- Foot care/Nails
- Feeding – Speech and Language Therapist (SaLT) assessment
- Dietician support
- Pain management
- Continence
- Infections (especially urinary tract infections/chest infections)
- Constipation (often related to deterioration of behavioural symptoms)
- Falls (e.g. falls assessment at time of admission; prevention; review of medications)[8]

[4] Healthcare for London, Mental health project, Dementia needs assessment, 2009
[5] Joint commissioning framework for dementia, DH, 2009
[6] Cronin, A., King, A., Older LGBT Matters: The experiences of older lesbian, gay, bisexual and transgender adults in Tower Hamlets, 2009
[7] Harrison, J., Barrow, S. and Creed, F. (1998) Mental Health in the North West Region of England: associations with deprivation, *Social Psychiatry and Psychiatric Epidemiology*, 33: 124-128
[8] Healthcare for London, 2009

3. MENTAL HEALTH CONDITIONS IN OLDER PEOPLE

For the purposes of this needs assessment mental health conditions are separated into three broad categories: depression, dementia and severe mental illness.

It is estimated that about 40% of older people attending their GP, 60% of older people admitted to general hospital and 60% of care home residents have mental health problems[9]. The three main mental disorders in older people admitted to acute hospitals are delirium, dementia and depression.[10]

3.1 Tower Hamlets prevalence modelling

Due to the population profile of Tower Hamlets and the unique risk factors including deprivation and atypical ethnicity, national estimates of mental health problems underestimate Tower Hamlets numbers if applied directly. The McKinsey Predictive Model, 2008[11] is a Tower Hamlets specific health tool though it has been argued that the model provides an overestimation of prevalence. With this in mind we need to be cautious when using the estimated prevalence of mental health conditions.

3.2 Depression

There are different estimates for the prevalence of depression in older people depending on the source used. A review of community prevalence of depression in older people estimated that depression is present in around 15% of older people within the general community[12]. The EURODEP study[13] found that 17.3% of the London cohort had symptoms of depression, while the Projecting Older People Population Information (POPPI)[14] System estimates that 10 – 15% of older people in Tower Hamlets would be suffering from depression.

3.2.1 Implications for Tower Hamlets

Using POPPI prevalence estimates, **492** to **820** older adults in Tower Hamlets suffer from a severe form of depression. Table 2 gives estimates of numbers of older people with depression using the different sources given above.

Table 2: Estimates of Depression in Tower Hamlets by source using the GLA 2008 population size estimate (18,041)

Source	Prevalence of depression in population aged 65+	Estimated numbers with depression in population aged 65+
POPPI	10-15%	1,640 – 2,460
Tower Hamlets GP registered population	**11.5%**	**2,075**
Beekman et al. (1999)	15%	2,706
Braam et al., (2005)	17.3%	3,122

[9] Dept of Health (2005) Everybody's Business. Integrated mental health services for older adults
[10] The Royal College of Psychiatrists (2005) Who Cares Wins: improving the outcome for older people admitted to the general hospital
[11] McKinsey predictive model 2008
[12] Beekman et al. Review of community prevalence of depression in later life. British Journal of Psychiatry. (1999).174:307-311.
[13] Braam et al., (2005) Physical health and depression in older Europeans. Results from EURODEP. *The British Journal of Psychiatry*. 187:35-42
[14] http://www.poppi.org.uk/index.php?pageNo=314&areaID=8640&prev=314 [Accessed 08/04/09]

As shown in Table 2, the Tower Hamlets GP registered population aged 65+ with recorded depression is less than prevalence estimates. This could be due to possible recording issues in practices, under-reporting, stigma and under-diagnosis. We would expect to see higher prevalence figures for depression due to risk factors such as deprivation, isolation and poor housing in Tower Hamlets.

Depression can be further categorised into minor and major depression. The predictive prevalence model (McKinsey 2008) for Tower Hamlets estimates 13% prevalence of minor depression and 4.5% for major depression for 65+. Another study found rates for mild (high up to 10% often co-morbid with anxiety stress reaction) and severe (usually at least 3%).[15]

Table 3 gives estimated numbers of people aged 65+ in Tower Hamlets with mild and severe depression. This is useful in terms of considering service capacity.

Table 3: Estimates of mild and severe depression in 65+ in Tower Hamlets

Source	Mild depression		Severe depression	
	Prevalence	Estimated numbers	Prevalence	Estimated numbers
McKinsey	13%	2345	4.5%	811
Saunders et al	10%	1804	3%	541
POPPI	11%	2050	3.4%	611

McKinsey is likely to be nearer to the actual number in Tower Hamlets as it is built on borough specific risk factors for depression.

3.2.2 Primary Care data

There is no breakdown of mild and severe depression recorded in Tower Hamlets primary care registers. Data below is for all types of depression.

Table 4 gives a breakdown of the number of older adults on GP depression registers in Tower Hamlets by ethnicity.

Table 4: Number of persons aged 65+ on GP depression registers, 2007/08

Ethnicity	Number
White	1390
Bangladeshi	307
Black	75
Mixed	16
Other	26
Not stated	1
Incomplete	6
Other Asian	36
Not Recorded	218
Total	**2075**

Source: CEG 2007/08

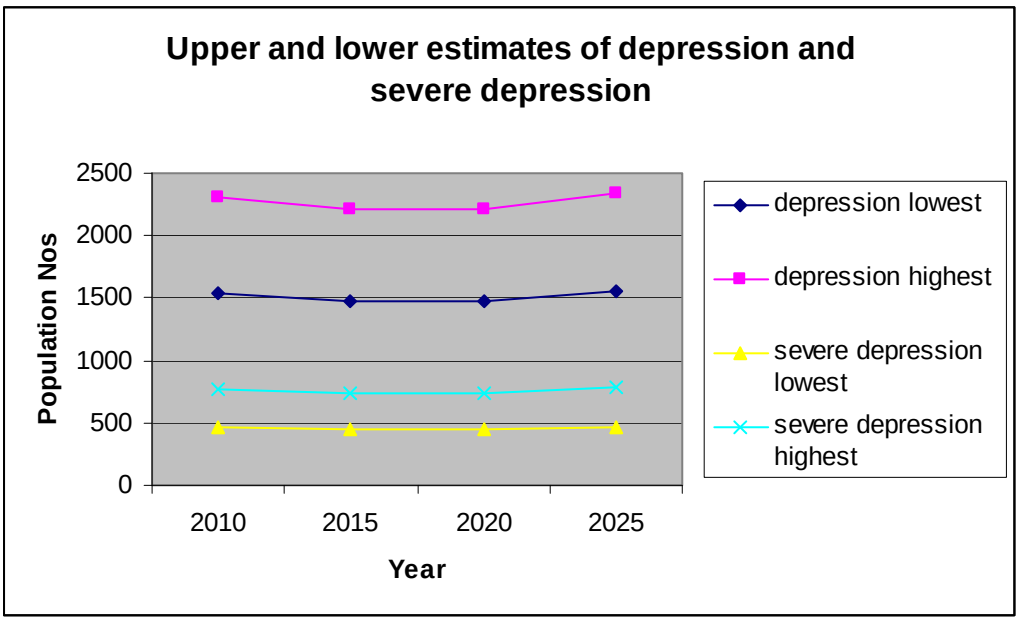
The ethnic profile roughly reflects the current borough ethnic profile of majority white, followed by Bangladeshis. White and Bangladeshi groups account for 67% and 15% of the depression registers respectively. However with the projected increase in the Bangladeshi

[15] Saunders PA, Copeland JRM, Dewey ME, et al. The prevalence of dementia, depression and neurosis in later life: the Liverpool MRC-ALPHA study. *Int J Epidemiol.* 1993;22:838–847

older people we will see an increase in the proportion of Bangladeshi older people in future years. This will have implications for commissioning and service provision.

Projecting depression prevalence is complex and therefore upper and lower estimates have been included in figure 8.

Figure 8: Estimates of depression in older adults in Tower Hamlets, 2010 - 2025



Source: POPPI

3.2.3 Long Term Conditions and Depression

The 2007/08 primary care data (CEG) shows that the most prevalent long term condition in all age groups in Tower Hamlets is hypertension, followed by depression. About a sixth of people with the most common long term conditions also have recorded depression status. Fifteen percent of patients with hypertension also have recorded depression.

Diabetes also has a high prevalence in Tower Hamlets and 14% of people with diabetes also have recorded depression in 2007/08.

Depression data shows that 16.3% of patients with depression also have hypertension and 8.4% have diabetes.

This has implications for mental health and long term conditions strategies. It is important that a cross-partnership approach is taken to address both the physical and mental health needs of patients.

Mental health promotion is needed to increase awareness of depression in the older population. NHS Tower Hamlets commissions Age Concern to provide depression awareness among Bangladeshi Older People. It is worth expanding this to the wider Older People population. Further detail on service provision is in section 4.

3.3 Dementia

3.3.1 The National Dementia Strategy, 2009

The National Dementia Strategy was published in February 2009. The aim of the strategy is to ensure improvements are made to dementia services across three key areas:

- Improved awareness
- Earlier diagnosis
- Intervention and a higher quality of care

The strategy identifies 17 key objectives(see Appendix 2), which when implemented at a local level, should result in significant improvements in the quality of services provided to people with dementia and promote a greater understanding of the causes and consequences of dementia.

In order to achieve the objectives laid out in the National Dementia Strategy there will need to be a close working relationship between the PCT, Local Authority, ELFT and third sector organisations.

A project manager for dementia has been appointed for one year to take forward the NDS and reports to the Local Authority and NHS Tower Hamlets.

3.3.2 Prevalence of dementia

There are about 700,000 people with dementia in the UK. Most people with dementia are over 65 years old, but there are at least 15,000 people under 65 who have the illness. The number of people with dementia in minority ethnic groups is about 15,000 but this figure will rise as populations get older[16].

The prevalence of dementia is not straightforward due to the progressive nature of the illness, increasing exponentially with age[17]. Several meta-analyses give prevalence rates by age group and these rates differ slightly from study to study.

The Institute of psychiatry's data published in Dementia UK showed that 7% of people over 65 have a form of dementia. This rises to 16% over the age of 80[18] (table 5).

Table 5: Dementia estimates in Tower Hamlets

Age group	Prevalence of dementia	GLA estimated population		Number of people expected to have dementia	
		2008	2018	2008	2018
65+	7%	18,041	19,287	1,263	1,350
80+	16%	4,961	5,432	794	869

There is a 9% increase in dementia prevalence from the 65+ to 80+ age group.
These estimates contrast sharply with the numbers currently identified on GP disease registers where Clinical Effectiveness Group (CEG) indicates 413 have been identified (Table 6), of which 394 are aged 65+.

[16] DH (2009) Living well with dementia: A National Dementia Strategy
[17] Jorm, A.F. (2002) Dementia epidemiology: prevalence and incidence. In J. R. M. Copeland, M. T.
[18] Alzheimer's Society UK (2007) Dementia UK: A Report from Alzheimer's Society on the prevalence and economic costs of dementia in the UK. London: Alzheimer's Society

Table 6: Estimates of Dementia in Tower Hamlets by source using the GLA 2008 population size estimate (18,041)

Source	Prevalence of Dementia in population aged 65+	Estimated numbers with Dementia in population aged 65+
Tower Hamlets GP registered population	**2%**	**413**
POPPI	6%	1100
The Institute of psychiatry	7%	1,263
McKinsey Model for Tower Hamlets	8%	1,532

Population prevalence of dementia estimates range from 6-8% whereas Tower Hamlets recorded cases are 2%. The McKinsey Model estimates for Tower Hamlets are in table 7 and figures 9 and 10.

3.3.3 Observed and Expected prevalence of dementia in Tower Hamlets

Expected data has been modelled on a Tower Hamlets population profile according to age, ethnicity and deprivation.[19]

Table 7: Observed and expected numbers of Dementia patients in Tower Hamlets, 2008

	Observed Dementia 2008				Expected Dementia 2008		
Age Band	**M**	**F**	**Grand Total**		**M**	**F**	**Grand Total**
15-39	1	0	1		51	24	75
40-64	7	11	18		140	40	180
65-84	140	129	269		358	444	802
85+	23	102	125		144	330	475
Grand Total	171	242	413		694	838	1532

Source: CEG and McKinsey

Only 33% of expected numbers of dementia patients are on GP registers in Tower Hamlets. Low numbers of recorded dementia is a London-wide issue, with only 25-55% of expected numbers recorded across regional PCTs[20].

Table 7 shows that there is a gender difference in the 40-64 year old age group. There is a 20 fold difference between the observed and the expected in males, compared to a 3 fold difference in females. Possible reasons for this variation need to be investigated.

[19] Long Term Neurological conditions analysis based on SQUID Audit Data 2007/08 and McKinsey model [Analysis Jan 2009]

[20] Healthcare for London, 2009

Figure 9: Observed and expected male dementia numbers in Tower Hamlets 2008

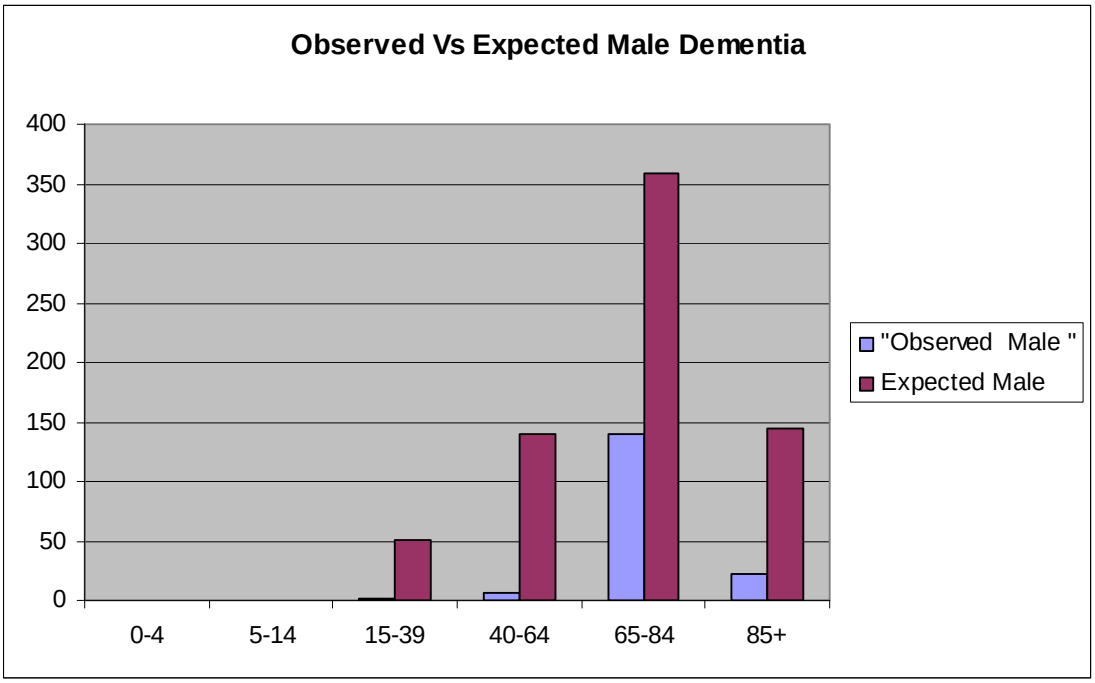
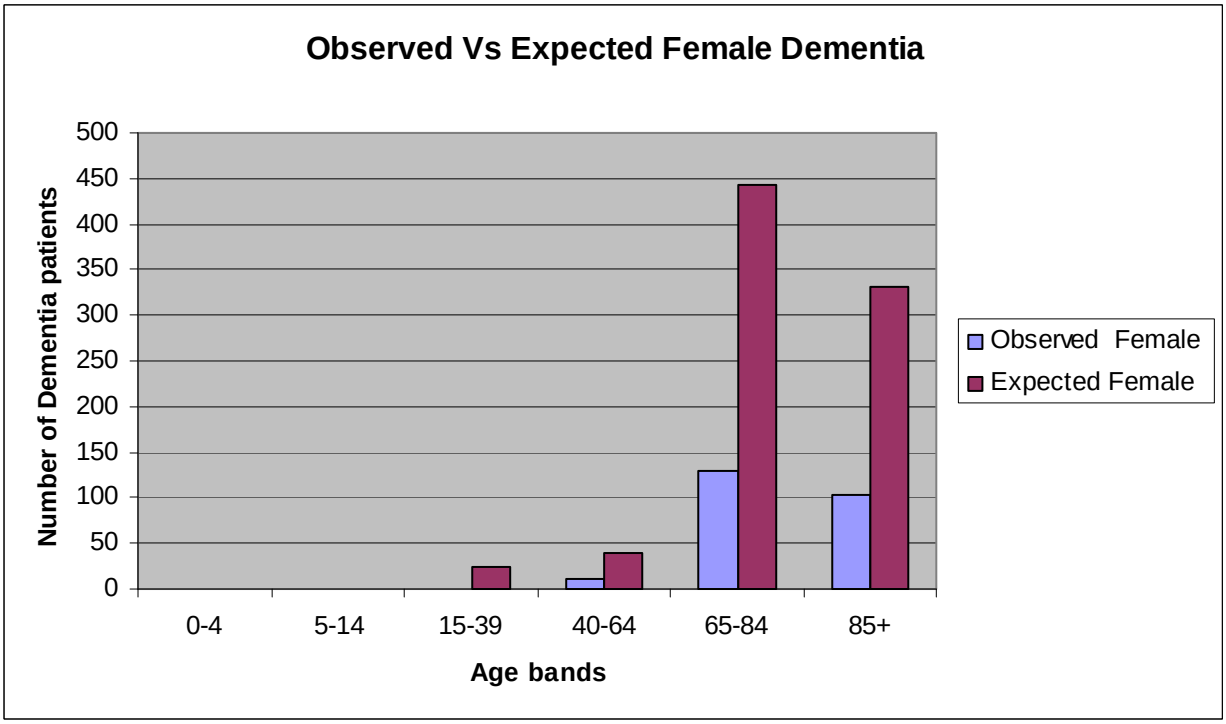


Figure 10: Observed and expected female dementia numbers in Tower Hamlets 2008



3.3.4 Young dementia

There are reports of increasing referral rates to secondary care for young people (under 65) with dementia in Tower Hamlets. This is thought to be attributable to a number of risk factors including vascular conditions, brain injury, young stroke sufferers, and alcohol and drug abuse dementias.

3.3.5 Incidence of dementia

There is a paucity of current literature on incidence of dementia at a local, regional national or international level. Research carried out in 1999 puts incidence within the range of 0.8 to 4.0 per 1000 person years[21] in people aged 60-64 years. This increases to 49.8 to 135.7 per 1000 person years in the 95 plus age group.

Further research carried out in 2005 gave the following incidence at a national level for male and female (table 8).

Table 8: Incidence of dementia in 65+ in England and Wales by age and sex

Age	Incidence per 1000 person years	
	Female	Male
65-69	6.3	6.9
70-74	6.1	14.5
75-79	14.8	14.2
80-84	31.2	17.0
85+	71.7	58.4

Source: Medical Research Council Cognitive Function and Ageing Study, 2005

Applying the above incidence rates to London's population (2007) would suggest that there are about 17,300 new cases of dementia in people aged 65+ in the capital each year[22]. Crude estimates applied to Tower Hamlets suggest approximately 410 new cases of dementia in the borough each year.

3.3.6 Implication for Tower Hamlets

Dementia prevalence is particularly aligned to the number of people aged 85+ within the population. As this is the segment of the older population where Tower Hamlets can expect to see a steady increase, it is unsurprising that overall dementia need will rise and that the greatest need for care will be amongst the oldest (and potentially most complex) constituency.

Table 9 shows the ethnic breakdown of patients on dementia registers in Tower Hamlets. The ethnic breakdown seems to reflect the general Tower Hamlets profile. There is variation in the numbers of male and female dementia patients recorded by ethnicity. There is a similar number recorded for the Bangladeshi population whereas there is a two fold increase in the number of recorded white females compared to white males. Possible reasons for this variation need to be investigated.

[21] Fratigkioni L., De Ronchi, Aguero-Torres, Worldwide Prevalence and Incidence of Dementia, *Drugs & Aging* 1999 Nov; 15 (5): 365-375

[22] Healthcare for London, Dementia needs assessment, 2009

Table 9: Observed count of dementia by ethnicity 2007/08

Ethnicity	Male	Female	Total
Bangladeshi	36	39	**75**
Black	21	13	**34**
Incomplete	1	0	**1**
Mixed	1	1	**2**
Other Total	2	3	**5**
Not stated	0	4	**4**
Other Asian	2	5	**7**
White	94	160	**254**
Not Recorded	14	17	**31**
Grand Total	**171**	**242**	**413**

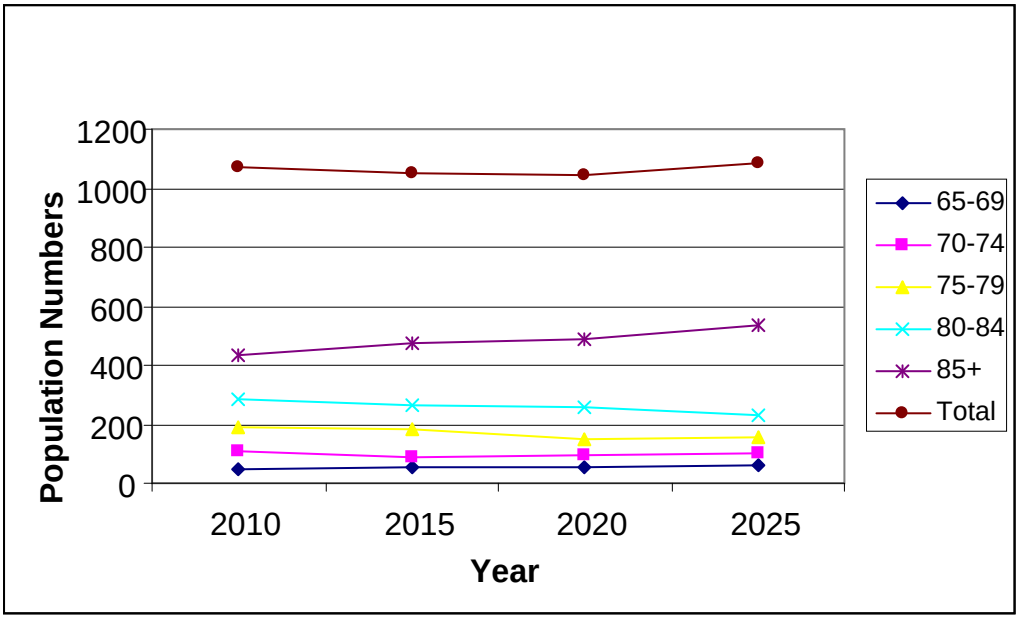
Source: CEG

Low recorded numbers could be due to difficulties in identifying dementia patients due to a variety of factors including language and cultural issues. Discovery interviews undertaken for the 'Time for Health' Vulnerable Older People's project identified cognitive impairment as a significant factor in a number of patients' vulnerability. In some cases the impairment was only picked up part way through the interview which may mean it would not be apparent to practitioners having only brief contacts with the older person.

There is also a variation in the number of recorded dementia patients by GP practice. 57% of all recorded dementia cases are in just 8 practices – Chrisp St, Mission, Stroudley Walk, Jubilee Street, All Saints, Bromley by Bow /XX Place, St Stephens and Limehouse.

Figure 11 gives estimates of dementia in Tower Hamlets over the next fifteen years by age group. The highest numbers and the biggest growth are estimated to be in the oldest age group.

Figure 11: Estimates of dementia in older adults in Tower Hamlets by age groups, 2010 - 2025



Source: POPPI

3.3.7 Prescribing data

Tower Hamlets has the second highest level of prescriptions for dementia related drugs in London (Table 10) with 2369.8 prescriptions per 1000 people with dementia. This is double the London average and 11 times more than the lowest prescribing borough.

Healthcare for London (HfL) suggests that Tower Hamlets had one of the lowest estimated cases of dementia in 2007. This illustrates apparent disparity between numbers of people identified and numbers of prescriptions. This needs further investigation.

Table 10: Range in prescriptions for dementia related drugs per 1000 estimated people with dementia, by PCT 2007/08.

Relative position	PCT	Prescriptions for dementia related drugs per 1000 estimated people with dementia 2007/08
Highest	Lambeth	2769.5
	Tower Hamlets	2369.8
	Lewisham	2146.8
Average	**London**	**1406.9**
	Hammersmith & Fulham	291.5
	Croydon	236.8
Lowest	Ealing	200.0

Source: HfL, drawn from NHS Business Services Authority and EPACT (Prescription Pricing Authority)

3.3.8 Long term conditions and dementia

The Clinical Effectiveness Group (CEG) prevalence data for 2005/06 shows that hypertension and diabetes have the highest prevalence rates among the six most prevalent long term conditions presented in Tower Hamlets, at 11.53% and 6.59% respectively. As diabetes and hypertension both increase the risk of dementia[23] the prevalence of dementia in Tower Hamlets is likely to increase.

Furthermore there is an increased risk of vascular dementia amongst the population in Tower Hamlets as there are higher than national levels of vascular disease in Tower Hamlets. This increased risk is due to a number of risk factors including a high proportion of south Asians and high levels of deprivation[24].

[23] Bruce, D. G., Harrington, N., Davis, W. A. and Davis, T. M. (2001) Dementia and its associations in type 2 diabetes mellitus: the Fremantle Diabetes Study, *Diabetes Research and Clinical Practice,* 53(3): 165 – 72

[24] JSNA 2008

3.4 Severe Mental Illness (SMI)

National estimates of SMI prevalence for 65+ are 1% for schizophrenia and 0.5% for bipolar affective disorder[25]. For the purposes of this needs assessment we have grouped these conditions together as SMI and assumed the prevalence of 1.5%. This would give an estimated number of 271 people aged 65+ in Tower Hamlets with SMI. This is similar to numbers recorded on GP registers.

In 2007/08, there were 214 people on primary care SMI registers in Tower Hamlets aged 65+ (Table 11). East One Health had 21 patients aged 65+ (the highest number) on their register. They also represent the highest proportion of females on the SMI register. Overall there are twice as many females as males on the register. This may be due to shorter male life expectancy or recording issues.

Table 11: Patients aged 65+ on SMI register 2007/08 by practice

Practice Names	Male	Female	Grand Total
Health E1	0	0	0
St Katherine's Dock	0	1	1
Dr Nischal	1	0	1
Ruston Street Clinic	2	2	4
Brayford Square	1	1	2
Dr Selvan	0	0	0
The Grove Road Surgery	0	2	2
Tredegar Practice	6	1	7
Island Medical Centre	0	2	2
Stroudley Walk Centre	4	5	9
Pollard Row PMS Practice	2	1	3
Merchant Street	4	4	8
Strouts Place Medical Centre	1	0	1
Aberfeldy Practice	0	1	1
Tower Medical Centre	1	2	3
Docklands PMS Medical Centre	2	1	3
Harley Grove Medical Centre	1		1
Shah Jalal Health Centre	2	2	4
All Saints Practice	4	5	9
Barkantine Centre	1	4	5
Albion Health Centre	2	2	4
The Wapping Group Practice	1	6	7
Bethnal Green Health Centre	3	4	7
Globe Town Surgery	3	1	4
St. Pauls Way Medical Centre	3	8	11
The Mission Practice	2	8	10
Limehouse Practice	1	3	4
The Jubilee Street Practice	3	7	10
St Stephens Health Centre	3	9	12
Island Health	2	5	7
Chrisp Street Health Centre	4	14	18
The Spitalfields Practice	8	3	11
XX Place	4	9	13

[25] Saunders PA, Copeland JRM, Dewey ME, et al. The prevalence of dementia, depression and neurosis in later life: the Liverpool MRC-ALPHA study. *Int J Epidemiol.* 1993;22:838–847

East One Health	4	17	21
Stepney Health Centre	4	3	7
The Blithehale Medical	0	2	2
Grand Total	**79**	**135**	**214**

The highest proportion of patients over 65 on the SMI register are represented by the Black Caribbean community with nearly 25% of the total number on the over 65s SMI register. This is in line with national figures. The Delivering Race Equality (DRE) in Mental Health care, DH 2005, was set up to address this health inequality.

3.5 Learning disabilities

There are 649 people on the learning disability register (2007/08) in Tower Hamlets. 52 out of the 649 (8%) are aged 65+ which is the same percentage of older people in Tower Hamlets[26]. There are similar numbers of male and females recorded in the 65+ age group (28 and 24).

However in the 65+ age group there are no BME people with learning disabilities recorded on the registers. Given that we have approximately 21% BME represented in the older population further work needs to be done to identify reasons behind the non-representation in the 65+ age group.

A separate joint strategic learning disabilities needs assessment is being carried out with NHS Tower Hamlets and London Borough of Tower Hamlets. Although use of mainstream services must be considered, age and cognitive factors can make it difficult for adults with learning disabilities and dementia to access and benefit from these. It is likely that specialist services will continue to have a central role in appropriate provision.

Interventions recommended are similar to those for the mainstream population but may require some adaptation to be appropriate for individuals with learning disabilities. Interventions and support for families, carers and peers and for staff in day and residential services are also recommended. Ideally people should be supported to continue to live in the same home but this is not always possible. At present there appears to be a lack of suitable accommodation to meet the needs of adults with learning disabilities who are affected by dementia.

3.6 Alcohol

Symptoms of alcohol misuse in older people include anxiety, depression, insomnia, and confusion[27]. These can be hard to distinguish from symptoms of other health problems. Alcohol and drug misuse are also linked to early on-set dementia.[28]

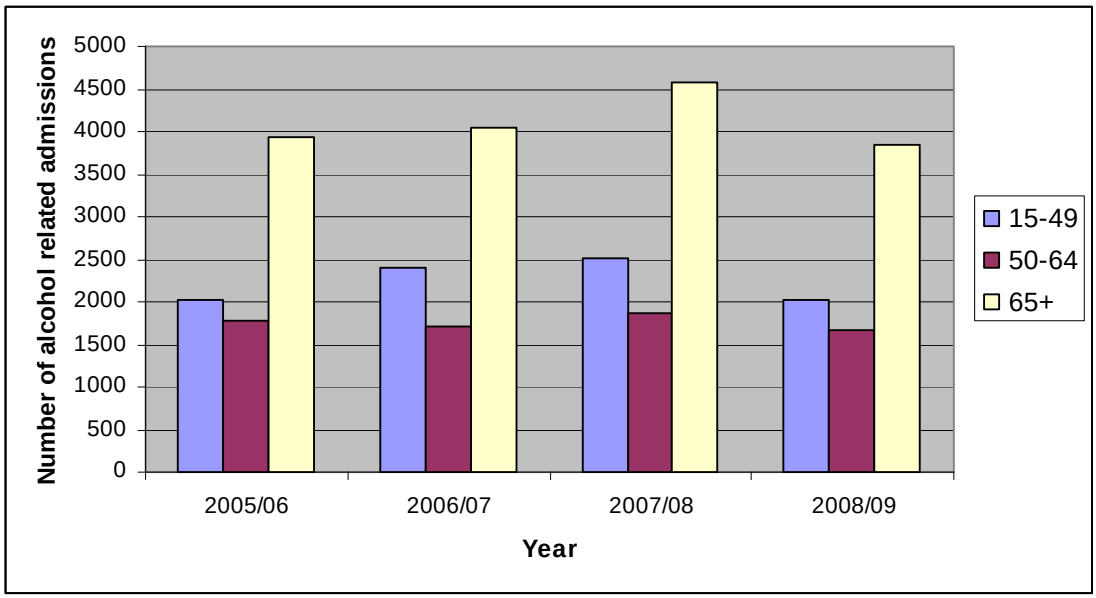
There are no definitive prevalence data on alcohol and drug misuse in later life due to variations in the populations sampled and the methods of detection used. There are also inconsistencies in the terms used, including consumption, use, misuse, overuse, abuse, dependence and addiction. The distinction between intentional and unintentional misuse is also often unclear.

[26] DH return RAP return 2007/08
[27] Karim Dar (2006) Alcohol use disorders in elderly people: fact or fiction?" Advances in Psychiatric Treatment, 12: 173-181. The Royal College of Psychiatrists
[28] Ref

Alcohol misuse is estimated to affect between 2-15% of older people living in the community[29]. For Tower Hamlets this would represent between 360 and 2,706 older people. A study found that the percentage of the over 65 population that exceeded safe drinking guidelines (21 units for men and 14 for women) had increased from 13% in 1988 to 17% in 2000 for men and 4% to 7% for women over the same period[30].

Figure 12 shows the trend of alcohol related admissions over the past 4 years. People aged 65+ are consistently over-represented making up for almost half of all alcohol related admissions.

Figure 12: Numbers of alcohol related admissions in Tower Hamlets by age 2005-9



Source: SUS - ELCIS

Excessive alcohol consumption in older people increases the risk of coronary heart disease, hypertension and stroke[31], which is associated with depression and/or vascular dementia. This has implications for older people's services in terms recognition of alcohol problems and early intervention.

NHS Tower Hamlets has commissioned (2009/10) a piece of social marketing work aimed at reducing alcohol consumption in the 65+ population and encouraging help seeking behaviour in this target group.

[29] Karim Dar (2006) Alcohol use disorders in elderly people: fact or fiction?" Advances in Psychiatric Treatment, 12: 173-181. The Royal College of Psychiatrists

[30] Karim Dar *(2006) Alcohol use disorders in elderly people: fact or fiction?" Advances in Psychiatric Treatment, 12: 173-181. The Royal College of Psychiatrists*

[31] Dept of Health (1995) Sensible Drinking. The Report of an Inter-Departmental Working Group. London: Dept of Health

4 SERVICE PROVISION

4.1 Primary Care Psychology & Counselling Service

This service keeps age related data for first contacts only. In 2008/9 they saw 26 people aged over 65 for a first contact, out of a total of 1,094. Older people therefore represented 2.4% of first contacts in primary care psychology, whereas the population of older people in the borough is roughly 8% of the general population. There is therefore a significant under-representation of older people receiving primary care psychology.

4.2 Specialist old-age psychiatry - East London Foundation Trust (ELFT)

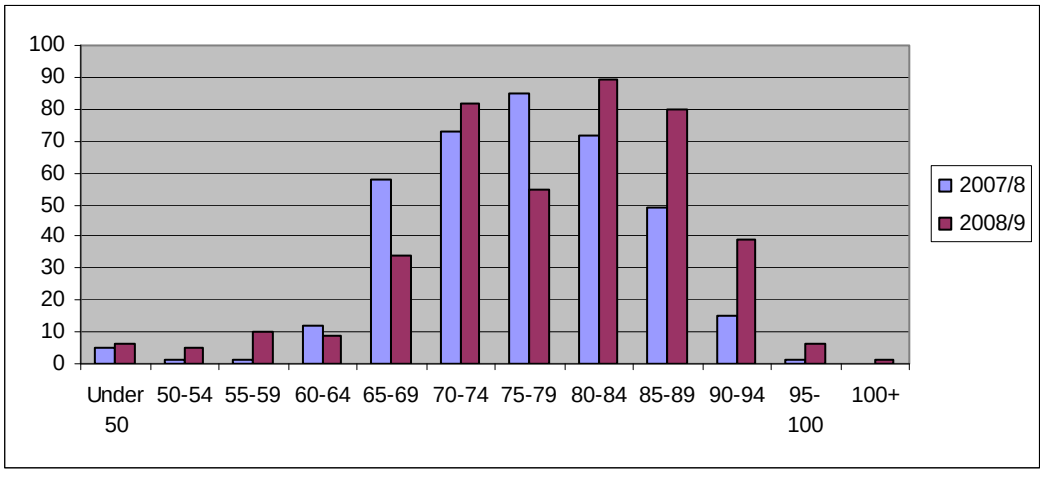
East London Foundation Trust provides a range of secondary care mental health services for older people in Tower Hamlets, covering inpatient and community services.

4.2.1 Community Mental Health Team for Older People (CMHTOP)

The CMHTOP is a multidisciplinary team provided by East London Foundation Trust and the London Borough of Tower Hamlets. The main function of the CMHTOP is to provide assessment, treatment, support and care planning for people with dementia and older people with mental health problems who are registered with a Tower Hamlets GP or for social care for residents of the borough. The team aims to provide the support required to help people to retain their independence at home for as long as possible. Friends, family, GP's, adult Community Mental Health Teams (CMHT) can refer to the service. Self-referrals are also accepted.

The CMHTOP received 372 referrals in 2007/08 and 416 in 2008/09 (although the 2007/8 figure does not include two months of referrals due to a transition to a new referrals management database). 38 of these referrals were for people who were out of borough. In 2008/09 there were 30 referrals for people aged under 65 (18 men and 12 women):

Figure 13: Numbers of referrals to CMHTOP 2007-2009



The ethnic breakdown of referrals roughly mirrors that of older people in the general population (Table 12).

Table 12: CMHTOP referrals by ethnicity 2007-2009

Ethnicity Group	2007/8	2008/9	Total	% of Total
Asian Other	14	17	31	3.9
Bangladeshi	49	46	95	12.1
Black African	7	7	14	1.8
Black Caribbean	17	12	29	3.7
Black Other	1	6	7	0.9
Black Somali	0	3	3	0.4
Mixed	5	5	10	1.3
Not Reported	6	23	29	3.7
Other	16	93	109	13.8
White British	224	179	403	51.1
White Irish	15	9	24	3.0
White Other	18	16	34	4.3
Grand Total	372	416	788	100.0

86% of people referred had English as a first language and 9.5% Syllhetti/Bengali, although only 5.7% were noted as needing an interpreter.

The majority of referrals came from GPs (60%), followed by 'internal' (15%) and 'other' (14%).

Table 13: CMHTOP referral source 2007-2009

Referral Source	2007/8	2008/9	Total	% of Total
Community Health Services	6	0	6	0.8
Family / Friend / Neighbour	5	11	16	2.0
General Hospital	2	3	5	0.6
GP	206	243	449	57.0
Internal	33	81	114	14.5
Local Authority Other	3	3	6	0.8
Local Authority Social Services	19	24	43	5.5
Not known	4	0	4	0.5
Other	80	29	109	13.8
Other Clinical Speciality	13	21	34	4.3
Police	1	0	1	0.1
Self	0	1	1	0.1
Grand Total	372	416	788	100.0

On 1st April 2007 the Team held an open caseload of 309 and as at 31st March 2009 had an open caseload of 222 people who were referred during 2007-2009 and a total open caseload of 355. 133 service users had therefore been open to the team prior to 1st April 2007 and were still open to the team at 31st March 2009.

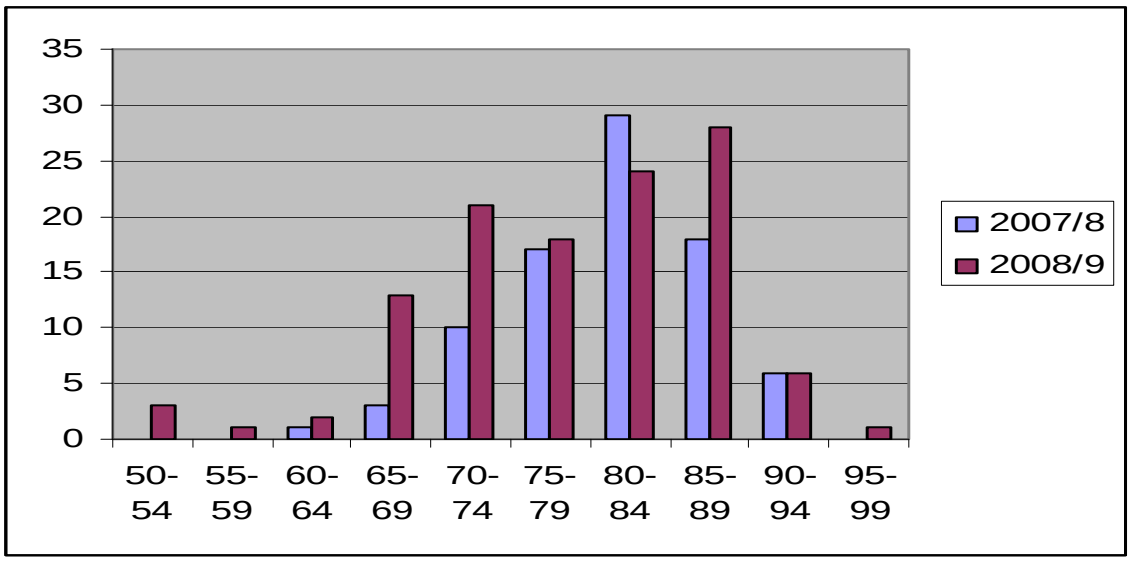
4.2.2 The Tower Hamlets Memory Service

The Tower Hamlets Memory Service is a multi-disciplinary team which has been developed internally within East London Foundation Trust as a pilot project. The Service provides comprehensive assessment of people with early stage memory problems or an undiagnosed memory problem (the Service is currently split into these two separate functions). The team generally provides more intensive follow up for people who receive a diagnosis for three

months post-assessment and is currently also piloting providing more ongoing periodic follow up to people who have been through the Memory Service and received a diagnosis.

The Memory Service received 84 referrals during 2007/8 and 117 during 2008/9 (1 was out of borough), including 7 referrals for people aged under 65 (Figure 14).

Figure 14: Number of referrals to the Memory Service 2007-2009



51.7% of referrals were for people with White British ethnicity and 8% were for people from the Bangladeshi community. 19% of people referred did not speak English as a first language, but only 11% were noted as needing an interpreter (Table 14).

Table 14: Referrals to the Memory Service by ethnicity

Ethnicity	2007/8	2008/9	Total	% of Total
Asian Other	3	7	10	5.0
Bangladeshi	6	10	16	8.0
Black African	2	1	3	1.5
Black Caribbean	1	0	1	0.5
Black Other	0	1	1	0.5
Mixed	2	0	2	1.0
Not Stated	3	5	8	4.0
Other	15	23	38	18.9
White British	45	59	104	51.7
White Irish	2	6	8	4.0
White Other	5	5	10	5.0
Grand Total	84	117	201	100

GP's were by far the largest referrer to the Service (Table 15).

Table 15: Referral source to the Memory Service

Referral Source	2007/8	2008/9	Total	% of Total
Community Health Services	1	0	1	0.5
Family / Friend / Neighbour	1	0	1	0.5
General hospital	2	1	3	1.5
GP	63	72	135	67
Internal	7	38	45	22.5
Local Authority Social Services	1	0	1	0.5
Other	8	3	11	5.5
Other clinical specialty	1	3	4	2
Grand Total	84	117	201	100

On 31st March 2009 the Memory Service had a total caseload of 163 compared to the total caseload of 76 in April 2008. There were 154 cases still open at 31st March 2009, the increase accounted for by the Service piloting a model of keeping patients open to the team for regular follow up post-diagnosis where they may previously have been discharged.

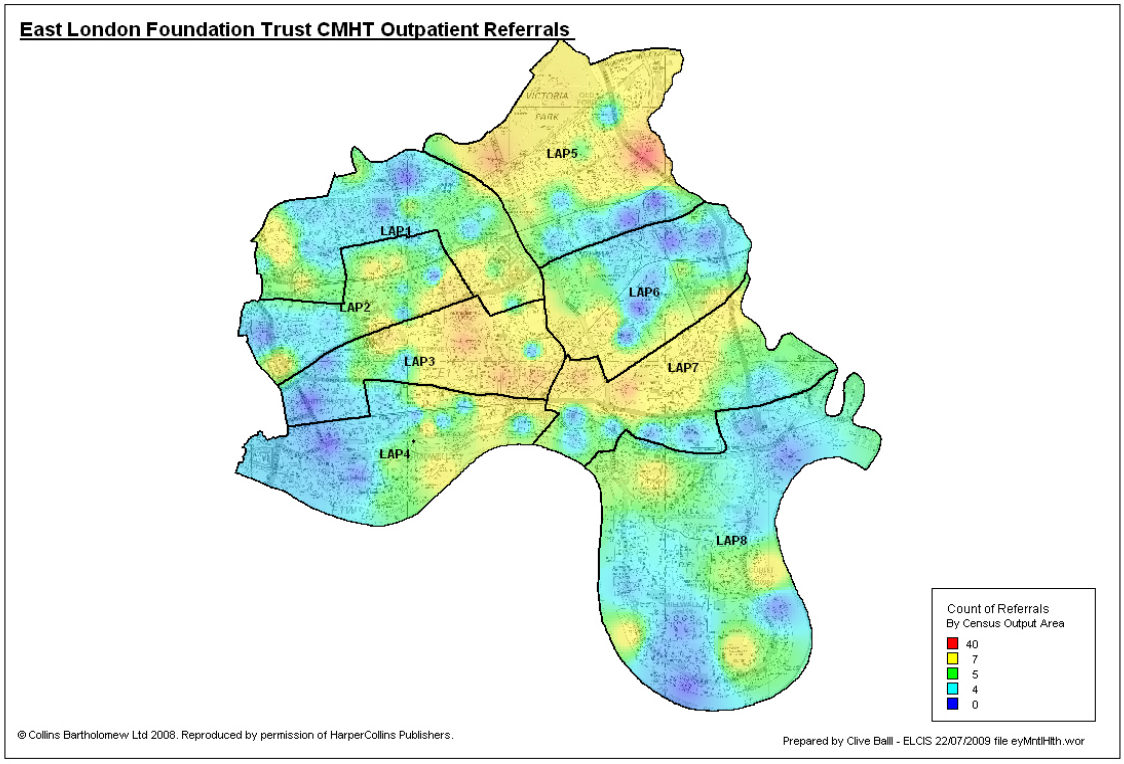
4.2.3 Referrals to CMHTOP and Memory Service

The CMHTOP is the single point of access for all referrals for secondary care mental health assessment for people with dementia or older people with mental health problems. The majority of referrals to secondary care are via this pathway, although some people in emergency need may access (particularly in-patient) services via A&E and some patients may be transferred on to an MHCOP ward from general hospital. Referrals to the Team by GP practice during 2007/8 and 2008/9 are laid out below (Table 16). All referrals to the CMHT and Memory Service are routed through this single point of access and triaged according to presenting need. Table 15 below details referrals by GP Practice during financial years 2007/8 and 2008/9. There is an average of 5.42% of the total practice population of people aged 65+ being referred to secondary care mental health services.

Table 16: Referrals to CMHT and Memory service by GP practice

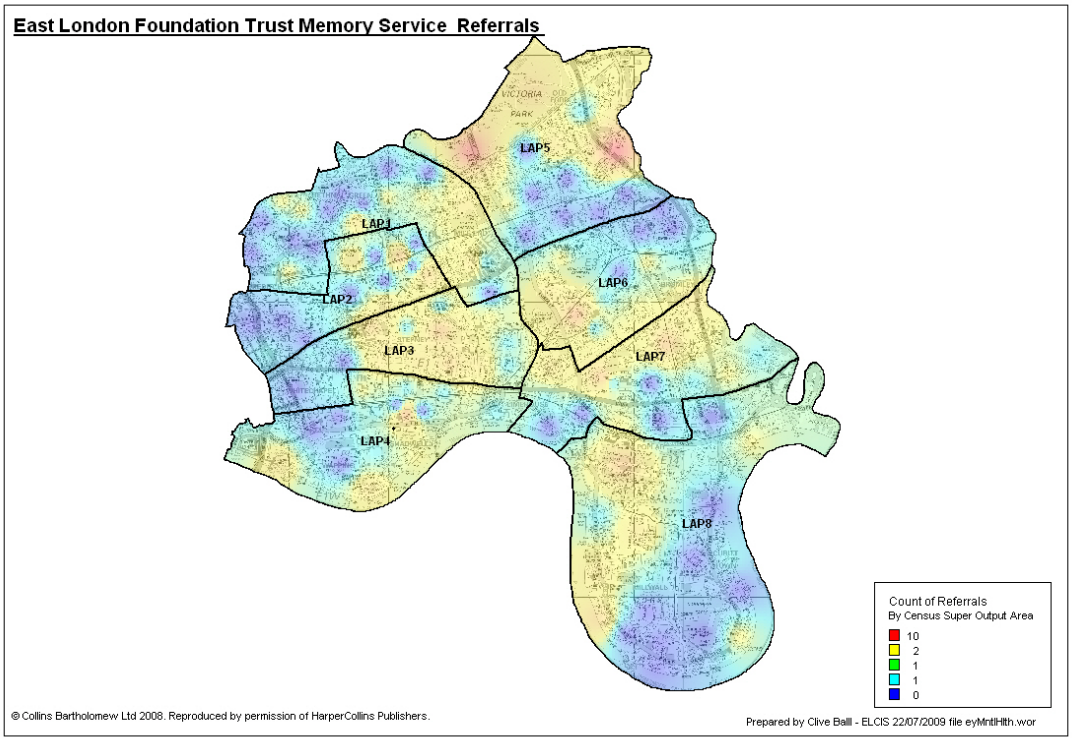
Practice Name	No aged 65+	Referrals to CMHT	Referrals to Memory Service	Total Referrals % to Over 65 Population
Aberfeldy Practice	186	11	2	7.0
Albion Health Centre	584	33	8	7.0
All Saints Practice	482	23	2	5.2
Dr Amin	346	6	1	2.0
Barkantine Practice	227	15	1	7.0
Bethnal Green Health Centre	760	34	6	5.3
Blithedale Medical Centre	440	17	1	4.1
Chrisp Street Health Centre	1097	52	16	6.2
Docklands Medical Centre	308	10	7	5.5
East One Health	519	26	5	6.0
Globe Town Surgery	534	14	10	4.5
Harley Grove Medical Centre	383	22	4	6.8
Health E1	13	2	0	15.4
Island Health	653	26	4	4.6
Island Medical Centre	216	7	2	4.2
Jubilee Street Practice	1111	52	17	6.2
Limehouse Practice	608	37	12	8.1
Mission Practice	946	32	11	4.5
Dr. Nischal	316	6	4	3.2
Pollard Row Practice	141	5	0	3.5
Dr. Rana	276	20	3	8.3
Dr. Selvan	334	7	4	3.3
Shah Jalal Medical Centre	459	9	2	2.4
Dr. Shah	371	7	2	2.4
Spitalfields Practice	915	34	2	3.9
St. Katherine's Dock Practice	164	5	3	4.9
St. Paul's Way Practice	656	36	6	6.4
St. Stephen's Health Centre	903	43	14	6.3
Stepney Green Medical Practice	726	21	3	3.3
Stroudley Walk Practice	264	16	5	8.0
Strouts Place Medical Practice	299	6	2	2.7
Tower Medical Centre	259	4	1	1.9
Tredegar Practice	295	21	5	8.8
Dr. Varma	189	4	4	4.2
Wapping Group Practice	559	19	12	5.5
XX Place	994	68	19	8.8
Total	**17533**	**Total 750**	**Total 200**	**Average 5.42%**

Figure 15: The distribution of referrals by patient's home address to the CMHT for Older People



The highest distribution of referrals is from LAP 5 in the North East sector of the borough, with a high number of referrals also being generated from LAPs 3 and 7. This correlates with the high density of older people living in these areas.

Figure 16: The distribution of referrals by patient's home address to the Tower Hamlets Memory Service



Again, the highest distribution of referrals is in LAP 5 in line with the proportion of older people.

Clinical coding within the CMHTOP is currently being rolled out, clinicians involved in the triage process estimate that roughly three quarters of referrals are for people with dementia or suspected dementia, so that there were roughly 763 referrals for people with dementia during the 2007/8 and 2008/9 period, 201 of which were people with an undiagnosed presentation and 562 for people with a previously diagnosed dementia. This may be an indication of potential need for people who have been given a diagnosis and then discharged from services previously.

The Healthcare for London needs assessment for dementia (2009) estimated incidence of dementia across London. When applied to the McKinney modelled prevalence in Tower Hamlets this results in an anticipated incidence of 410 new cases per year in Tower Hamlets. With a referral rate to the Memory Service of 117 during 2008/9, this suggests that there were in the region of 293 new cases that were not referred to the Memory Service during 2008/9 (although some of these may have received diagnosis in Neurology or a Health Care of the Elderly setting).

4.2.4 Older People's Liaison Service

East London Foundation Trust provides a Liaison Service at the Royal London and Mile End Hospitals based on a historical arrangement between the Trusts. The Service is rudimentary and includes a small number of consultant and junior doctor sessions and a 0.5 WTE Liaison Nurse funded until 30.9.09 internally by ELFT. The team provide mental health assessment and consultation and limited follow-up to inpatients on general wards. During 2008/9 the Service received 329 referrals for people aged 65+ (231 from the Royal London Hospital and 98 from Mile End Hospital).

Table 17: Number of people referred to Older People's Liaison Service 2008/09

Age of person referred	Number of referrals
65-69	25
70-74	46
75-79	73
80-84	88
85-89	52
90-94	27
95-99	14
Not Known	4
Grand Total	329

All of these referrals received an initial assessment visit, and 87 of the referrals from the Royal London and 40 of the referrals from Mile End required subsequent follow up visits.

Table 38 on page 43 shows that during 2007/8 there were 2047 admissions for people aged 65+ who were coded as having a co-morbid mental health problem to the Royal London alone. The referral rate as above to the MHCOP Service Liaison might imply that there are more patients in general hospital who would benefit from the support of Liaison.

4.2.5 Psychiatric In-patient care

Inpatient care for older people with mental health problems is provided by East London Foundation Trust, largely in three specialist in-patient units - Leadenhall ward, Robinson ward and The Green, although older people are at times admitted to wards for people of working age if their care is under an Adult Mental Health CMHT.

4.2.5.1 Leadenhall Ward

Leadenhall Ward provides nineteen acute assessment beds for older people with functional mental health problems within the Tower Hamlets Centre for Mental Health at Mile End Hospital. Referrals are managed via the CMHT for Older People, via A&E (through the MHCOP Modern Matron or Duty Senior Nurse) or via general hospital wards (generally via the MHCOP Liaison Service).

There are roughly 62 admissions per year to Leadenhall Ward, and this has largely remained consistent over recent years:

Table 18: Number of admissions to Leadenhall Ward by year 2005-2009

Financial Year	Number of Admissions
2005-6	59
2006-7	68
2007-8	58
2008-9	62
Grand Total	247

During 2005-2009, there were 114 patients who had a single admission and one patient who had ten (Table 19). Frequent readmission might suggest a need for more care in the community.

Table 19: Number of admissions by patient to Leadenhall Ward 2005-2009

Number of Admissions	Number of Patients
1	114
2	48
3	33
4	20
5	10
6	12
10	1
Grand Total	247

Around 63% of all admissions during 2005-09 were women. During 2007/8 nationally, 56.3% of all admissions to Old Age Psychiatry specialist wards were for women, so Leadenhall receives proportionally more admissions of women than nationally (HES Online). The national average age of admissions to Old Age Psychiatry specialist wards was 77 during 2007/8. In Tower Hamlets the average age is slightly younger at 74.4 (HES Online). 32% of all admissions were women aged 70-79:

Table 20: Admissions to Leadenhall ward by age 2005 -2009

Age	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-95	Grand Total
Female	0	2	30	41	39	25	16	2	155
Male	2	0	22	33	26	7	1	1	92
Total	2	2	52	74	65	32	17	3	247

During this period, admissions were roughly in line with the demographic make up of the local population, although there is a slight over-admission rate of people from the Bangladeshi community.

Table 21: Admissions to Leadenhall ward by ethnicity 2005- 2009

Ethnicity	Number of admissions	% of Total
Asian Other	1	0.4
Bangladeshi	42	17
Black African	1	0.4
Black Caribbean	9	3.6
Black Other	4	1.6
Mixed	5	2
Not Stated	9	3.6
Other	5	2
White British	143	57.9
White Irish	7	2.8
White Other	21	8.5
Grand Total	247	100

Roughly 39% of total admissions were for people with a depressive disorder and 26% of admissions were for women with depressive disorder. 12.6% of total admissions were for women with bipolar disorder.

Table 22: Admissions to Leadenhall by diagnosis 2005-2009

Diagnosis	Number of Patients	% of Total
Alcohol Dependence	2	0.8
Alzheimer's Disease	4	1.6
Anxiety Disorder	10	4
Bipolar Disorder	49	19.8
Depressive Episode	96	38.9
Manic Episode	4	1.6
Not Recorded	24	9.7
Other	8	3.2
Persistent Delusional Disorder	14	5.7
Psychotic Disorder	1	0.4
Schizophrenia	29	11.7
Unspecified Dementia	4	1.6
Vascular Dementia	2	0.8
Grand Total	247	100

During 2005-2009, 69% of people admitted went home to their usual place of residence at discharge:

Table 23: Discharge destination from Leadenhall ward 2005-2009

Discharge destination	Number of patients
Care Home	9
Client Died	1
NHS Other Hospital	26
Not Recorded	34
Temporary place of residence	6
Usual place of residence	171
Grand Total	247

40% of people admitted had a length of stay of 1-3 months during 2005-9:

Table 24: Length of stay on Leadenhall ward 2005-2009

Length of Stay Band	2005-6	2006-7	2007-8	2008-9	Grand Total
0-10 days	5	4	3	7	19
11-28 days	8	6	8	5	27
29-45 days	4	8	5	7	24
46-90 days	19	23	22	11	75
90-180 days	18	12	9	13	52
181-270 days	4	10	5	3	22
271-365 days	1	4	3	1	9
365+days	0	1	1	0	2
Still in hospital at 31/3/09	0	0	2	15	17
Grand Total	59	68	58	62	247

Eight of the nine people who moved into a care home at discharge had a length of stay of more than 90 days, with two between 181 and 270 and two between 271 a

During 2008/9 there was a significant reduction in both length of stay and occupancy (excluding those still in hospital at 31.3.09). In 2007/8, national average length of stay for the Old Age Psychiatry specialism was 92 days (HES Online), so Leadenhall Ward is in line with the national average.

Table 25: Average length of stay on Leadenhall ward 2005-2009

Financial Year	Average Length of Stay	Occupancy (excluding leave)
2005-6	85	N/K
2006-7	108	91%
2007-8	94	96%
2008-9	76	87%

During 2008/9, there were 547 delayed discharge bed days recorded on RiO (although this may be an under-estimate of actual delayed discharge bed days due to recording on RiO beginning mid-year). This means that actual occupancy on the basis of clinical need during 2008/9 was roughly 79%.

During 2009/10, practice has developed to include specific consideration of eligibility for Home Treatment Team support for each person for whom an admission to Leadenhall Ward is being considered. This may have a further impact on occupancy at the 2009/10 year end.

4.2.5.2 The Green

The Green provides circa 14 acute assessments and circa 2 respite beds for people with dementia on a standalone site in Bethnal Green (the actual balance of assessment and respite admissions will fluctuate according to need). Referrals are managed via the CMHT for Older People, via A&E (through the MHCOP Modern Matron or Duty Senior Nurse) or via general hospital wards (generally via the MHCOP Liaison Service).

Admissions to the ward from 2005/6 to 2008/9 are detailed in the table below (Table 25). Admissions for respite have significantly reduced over the period as patients eligible for local authority funded respite are no longer admitted to The Green.

Table 26: Admissions to The Green 2005-09

Financial Year	Assessment	Respite	Total
2005-6	67	62	129
2006-7	40	44	84
2007-8	56	22	78
2008-9	42	16	58
Grand Total	205	144	349

Activity data for people with dementia admitted for respite to local authority funded beds is not currently available, so it is unclear whether the change in admission criteria for respite at The Green has impacted on actual take-up of respite bed days for the totality of people with dementia in the borough. Anecdotal evidence from CMHTOP practitioners suggests that as local authority funded respite is more difficult to access, in terms of process, the actual number of respite bed-days taken up may have fallen.

53.3% of admissions to The Green during 2005-09 were women, which is roughly in line with the national average to Old Age Psychiatry specialist wards at 56.3%. The average age of patients admitted was 78.3, which is again roughly in line with the national average at 77.

Table 27: Admissions to The Green by age and gender 2005-09

Age	Male	Female	Total
50-54	2	0	2
55-59	0	4	4
60-64	8	3	11
65-69	5	11	16
70-74	28	38	66
75-79	34	42	76
80-84	60	54	114
85-89	17	26	43
90-95	9	8	17
Grand Total	163	186	349

During 2005-09, people of a White British ethnicity were slightly over-represented compared to the demographic make up of the local population and the Bangladeshi community slightly under-represented at 6.3% of all admissions:

Table 28: Number of admissions to The Green by ethnicity

Ethnicity	Number of admissions	% of Total
Asian Other	5	1.4
Bangladeshi	22	6.3
Black African	2	0.6
Black Caribbean	10	2.9
Black Other	5	1.4
Mixed	2	0.6
Not Stated	29	8.3
Other	7	2
White British	216	61.9
White Irish	30	8.6
White Other	21	6
Grand Total	349	100

The majority of admissions (68%) to The Green were for Alzheimer's disease or vascular dementia. Given the high prevalence of vascular disease in Tower Hamlets this is likely to increase in the future. There is a need to incorporate vascular conditions as part of the overall dementia strategy.

Table 29: Admissions to The Green by diagnosis 2005-09

Diagnosis	Number of Admissions
Alcohol Related Dementia	3
Alzheimer's Disease	121
Dementia Unspecified	51
Mood Disorder	10
Not Recorded	28
Other	9
Psychotic Disorder	11
Vascular Dementia	116
Grand Total	349

During 2005-9, 10.3% of people admitted were discharged to a care home.

Table 30: Discharge destination from The Green 2005-2009

Discharge destination	Assessment	Respite
Care Home	31	36
Client Died	1	0
NHS Other Hospital	5	8
Not Recorded	24	6
Temporary place of residence	23	8
Usual place of residence	121	86
Grand Total	205	144

During 2005-9, average length of stay excluding respite averaged at 89 days, roughly in line with the national average for the Old Age Psychiatry specialism of 90 days (HES Online). Average length of stay and occupancy were as follows:

Table 31: Average length of stay on The Green 2005-09

Financial Year	Average Length of Stay (inc respite)	Average Length of Stay (exc respite)	Occupancy
2005-6	44	69	N/K
2006-7	59	103	88%
2007-8	94	108	87%
2008-9	67	77	84%

During 2008/9, there were 629 delayed discharge bed days recorded on RiO (ELFT IT system), although this may be an under-estimate of actual delayed discharge bed days due to recording on RiO beginning mid-year. This equates to 10.8% and means that actual occupancy on the basis of clinical need during 2008/09 is roughly 73.2%.

4.2.5.3 Robinson Ward

Robinson ward provides NHS continuing care for people with dementia, primarily when the person has a complex behaviour which is not manageable in any other setting. The ward has 15 beds and is based at Mile End Hospital. Admissions to Robinson Ward are generally via The Green following an in-patient assessment and are subject to a continuing care assessment and the agreement of the Older Person's Continuing Care Panel.

Table 32: Admissions to Robinson Ward during 2005-9

Financial Year	Number of Admissions
2005-6	12
2006-7	15
2007-8	6
2008-9	4
Grand Total	37

The reduction in admissions during the period can be considered as an effect of the introduction of more robust eligibility assessment with the introduction of continuing care eligibility criteria and the National Framework for Continuing Care. It should be noted that in some cases the same patient may be recorded as an admission more than one occasion (for example if they are transferred to the Royal London for an acute medical problem). Admissions by unique patient are detailed in the table below.

Table 33: Numbers of unique people admitted to Robinson ward 2005-09

Financial Year	Unique people admitted
2005-6	7
2006-7	10
2007-8	6
2008-9	4

During 2005-09 there were 15 women and 12 men admitted, the majority of which were over 70 years old. There is a potential issue with admissions of two much younger patients with a majority of significantly older patients. Admissions by ethnicity are roughly in line with the total population:

Table 34: Admissions to Robinson ward by ethnicity

Ethnicity	Number of admissions	% of total admissions
Bangladeshi	3	11.1
Black African	1	3.7
Black Caribbean	2	7.4
Black Other	1	3.7
Not Stated	4	14.8
White British	14	51.9
White Irish	1	3.7
White Other	1	3.7

Occupancy for Robinson Ward is outlined in the table below. The occupancy figures for people who are eligible for continuing care will be lower than stated as Robinson Ward is occasionally used for overspill patients from The Green. In addition there were 119 days recorded as delayed discharge during 2008/9, taking occupancy to 74%.

Table 35: Bed occupancy on Robinson ward 2006-09

Financial Year	Occupancy (excluding leave)
2006-7	72%
2007-8	76%
2008-9	76%

People with primary mental health problems are regularly agreed for NHS continuing care or joint health and social care funding in other settings, for example in their own home or in a care home, via the Older Persons Funding Panel. Activity data is not currently available.

4.2.6 Adult Mental Health Services

East London Foundation Trust operates a needs based transfer protocol which means that only patients who have needs associated with age, or dementia, are transferred to MHCOP services from Adult Mental Health Services. In July 2009 there were 87 people aged over 65 on their case load who are currently open to Adult Mental Health Services.

Table 36: Referrals to Adult Mental Health Services by age as of 17.7.09

Count of Team Referred To	Age									
Team Referred To	**65**	**66**	**67**	**68**	**69**	**70**	**71**	**72**	**73**	**Grand Total**
Assertive Outreach Service			1	1	1					**3**
Bethnal Green CMHT	8	9	5	2	1	1	2	2	2	**32**
Bow & Poplar CMHT	7	2	4		3	2				**18**
Isle of Dogs CMHT	4	6	1		1	3	1			**16**
Community Rehab & Recovery	1	1				1		1	1	**5**
Personality Disorder Service			1							**1**
Stepney/Wapping CMHT	2	3	4	2			1			**12**
Grand Total	**22**	**21**	**16**	**5**	**6**	**7**	**4**	**3**	**3**	**87**

The Tower Hamlets Home Treatment Team is open to referrals of people aged 65 and over where they have a functional mental health problem and otherwise meet the criteria for Home Treatment. During 2008/9, the Team received 45 referrals for people aged 65+ for 26 unique patients from a range of ages from 65 to 83 years old.

4.2.7 Psychiatry & psychology out-patients

Referrals to psychiatry and psychology outpatients are always internal to secondary care, e.g. via the CMHT for Older People or inpatient services. Referrals to psychiatry out-patients are made where a patient needs non-intensive follow up, and psychology activity includes referrals of ward based patients:

Table 37: Referrals to psychiatry and psychology outpatients 2006-09

Year	Psychiatry Referrals	Psychology Referrals
2006-7	75	n/k
2007-8	66	111
2008-9	48	184
Grand Total	189	295

4.3 Acute hospital care

This section describes admissions to Barts and the London Trust (BLT) where a mental health condition has also been identified, either as a primary or other diagnosis.

There were in total 45,403 admissions to Barts and the London NHS Trust hospitals (The Royal London Hospital, London Chest Hospital, Mile End and St Barts) in 2007/2008. Diagnosed mental health conditions in all ages were found in 5808 admissions (12.8%).

In the 65+ admissions 1,962 (34%) had a diagnosed mental health condition. Comparing this figure to the *Who Care Wins*[32] estimates of 50%, we see a gap in recorded prevalence. This might suggest under-detection and a gap in service provision to this population.

Fourteen percent of older people admitted had recorded depression. This is low compared to national prevalence data (*Who Cares Wins*) and suggests that this is not being recorded, or not diagnosed in secondary care. Other mental disorders have been grouped together for ease of analysis, though it should be noted that these range widely from anxiety to substance misuse (Table 38).

There were 114 admissions with recorded schizophrenia for people aged 65+ which is 6% of mental health admissions. It is important that staff have access to the relevant mental health skills to manage these complex patients.

There were 25 admissions for dementia as a primary diagnosis in BLT 2007/08. Analysis by primary diagnosis only shows a small number of mental health admissions. In order to understand prevalence rates in Tower Hamlets we need to expand the analysis to all levels of diagnosis, as patients are generally admitted with a physical condition.

Table 38: Admissions to BLT 2007/08 with recorded mental health conditions

Mental health condition	Under 65	65+	Total	% of all MH admissions in 65+
Dementia	29	1030	1059	52%
Delirium	2	11	13	1%
Depression	454	271	725	14%
Mania/bipolar	78	24	102	1%
Other MH Disorders	3164	597	3761	30%
Schizophrenia	290	114	404	6%
Total	4,017	2,047	6,064	-

(Source: SUS 2007/08)

There are very low rates of delirium recorded. This may be because it is not recognised as a separate diagnostic entity from the primary diagnosed medical condition. Depression is better detected but still low compared to expected figures. This may be due to under-detection of depression and it being viewed as a 'normal' reaction to a medical condition or being admitted to hospital.

More than half (52%) i.e. 1,030 out of 2,047 of the 65+ admissions with recorded mental health conditions had recorded dementia. In comparison, 413 dementia patients (Table 7

[32] The Royal College of Psychiatrists (2005) Who Cares Wins: improving the outcome for older people admitted to the general hospital

on page 21) are recorded on primary care registers. This shows a difference in numbers recorded in primary and secondary care. This may be attributable to a small number of patients being admitted a number of times, or that patients are not being diagnosed in primary care and are then presenting in secondary care. A stronger link with the older people's liaison psychiatry service would enhance the psychological care for general hospital patients.

Table 39: Co-existing physical and mental health conditions

Physical condition	Under 65	65+	Total	% 65+ MH admissions with another LTC
Acute Hypertensive Disease	420	553	973	28%
CHD	406	294	700	15%
COPD	296	326	622	17%
Diabetes	350	391	741	20%
Heart Failure	53	105	158	5%
Stroke	55	153	208	8%
Total	1,580	1,822	3,402	-

BLT recorded 1,822 admissions for people aged 65+ with co-existing physical and mental health problems. More than a quarter (28%) i.e. 553 out of 1,822 of older people admissions with a mental health condition also had acute hypertensive disease and a fifth (20%) had diabetes. This has implications for managing patients and ensuring a holistic approach is used in addressing both physical and mental health needs.

4.3.1 Dementia in acute care

Tower Hamlets has the highest rates of hospital admission with a main diagnosis of dementia in London with 95.7 per 1000 population (Table 40). This is 3 times higher than the London average.

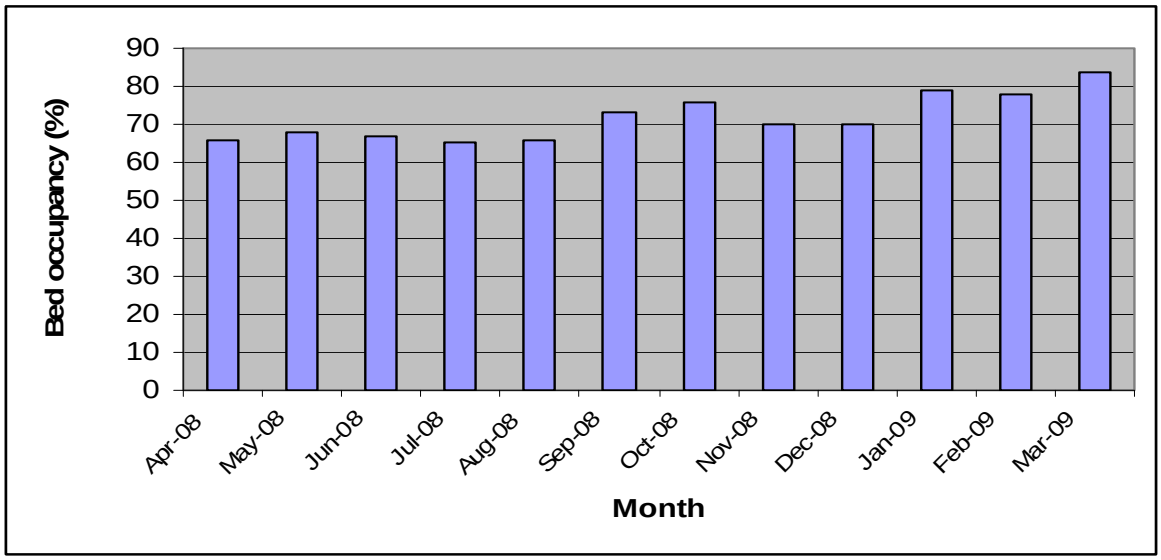
Table 40: Range of admission rates for people admitted to hospital with a main diagnosis of dementia, per 1000 residents estimated to have dementia by PCT, 2007/08.

Relative position	PCT	People admitted to hospital with a main diagnosis of dementia per 1000 population with dementia
Highest	Tower Hamlets	95.7
	Waltham Forest	79.5
	City & Hackney	74.2
Average	**London**	**36.0**
	Enfield	17.0
	Harrow	15.7
Lowest	Barnet	14.8

Source: HES 2007/08 and dementia prevalence estimates 2007.

4.4 Bancroft Unit

Figure 17: Total bed occupancy (%) 2008/09 in the Bancroft Unit



Bed occupancy in the Bancroft unit is consistently below 100% across all the wards with seasonal variation. Further investigation is needed to establish the reasons for this variation.

4.5 Elders social work teams

4.5.1 Social Work Survey

An electronic survey (complete survey and results are in Appendix 5.2) was circulated to all older people social work teams in Tower Hamlets in April - May 09. The aim of the short survey was to establish the mental health needs of people on their caseloads as this information is not centrally collected.

Survey summary

- 471 surveys were returned on individual clients with open cases out of a possible 500 open cases, representing nearly 100% response rate.
- 166 (35%) of returned surveys felt that the service user had some kind of mental health condition
- Results from the survey need to be viewed with some caution as they were not all completed to the same standard. There was also a variation in response rates according to social work team.

The rest of the survey responses were related to service users with either a suspected or diagnosed mental health condition.

Sixty four percent of service users with a mental health condition were aged between 74 and 90 years old. 62% were female and 75% White which reflects the profile of the older people in Tower Hamlets.

The breakdown of type of mental health problem is below (note that there was some co-morbidity reported, hence the total of 176):

Table 41: Numbers of service users with a suspected or diagnosed mental health conditions from Social Work Survey (Appendix 5.2)

Mental health condition	Diagnosed	Suspected	Total
Dementia	110	22	132
Mild Depression	12	12	24
More Significant Depression	5	2	7
Psychotic Illness	13	0	13
Total	140	36	176

Analysis shows that dementia is by far the highest diagnosed and suspected mental health condition (Table 14). Furthermore as many as 22 people had suspected dementia as identified by social workers. This has implications in the detection, referral and diagnosis of dementia.

There are low numbers of suspected and diagnosed depression. This is surprisingly low (1.2%) compared to community prevalence figures which report 15% depression amongst older people in the community, and which could be expected to be higher for this particular client group as a result of the likelihood that they would be experiencing some kind of chronic health problem.[33]

The proportion of people with a mental health problem by accommodation type was as per the table below. This needs to be viewed with caution as representative with the entire Elders social work caseload as it is likely that there would be larger numbers of people in a care home on annual review who would not be included here.

Table 42: Type of accommodation for people with suspected or diagnosed mental health conditions from Social Work Survey (Appendix 5.2)

Type of accommodation	In borough	Out of borough	Total
Own home	56.3%	0.5%	56.8%
Sheltered accommodation	5%	0%	5%
Extra care sheltered	7.6%	0%	7.6%
Residential	1.5%	2%	3.5%
EMI Residential	7.1%	5%	12.1%
Nursing	2.5%	3%	5.5%
EMI Nursing	2%	4%	6%
Continuing Care	0.5%	0%	0.5%
Other	2%	0%	2%

Fifty nine percent of responses in this sample showed that service users with a mental health condition had a carer (Table 43). Tower Hamlets carer's strategy has an action plan to identify and support carer's needs. There is no data available at present to identify how many of these carers have had a carer's assessment. Links need to be developed and maintained between social work team and the local carer's group.

[33] Beekham at al

Table 43: Carer status of service user

Carer	% of service users
Carer	59.3%
No carer	39.2%
Unknown	1.6%

4.5.2 LBTH active caseload review

The London Borough of Tower Hamlets provides four social work teams for older people, based on the four PCT localities. The teams carry a combined caseload of circa 2000 cases at any one time, the large majority of which are older people receiving a package of care which is stable and which is therefore held on "Duty" for a review on the minimum basis of annually. On 20.4.09, the teams carried an active (i.e. currently allocated and receiving either active assessment or follow up under the Single Assessment Process) caseload of 445 and a review caseload of 1448, as follows:

Table 44: Number of people on elder social work team as of 20.4.09

Team	Older People NE	Older People NW	Older People SE	Older People SW	Total
Allocated cases	103	121	83	138	445
Duty cases	357	411	373	307	1448
Total Cases	460	532	456	445	1893

4.6 Accommodation

4.6.1 Accommodation Provider Survey

A survey of care homes and other accommodation providers was carried out as part of this needs assessment (complete survey and results are in Appendix 5.1). Results from the survey need to be viewed with some caution as they were not all completed to the same standard. There was also a variation in response rates according to accommodation provider.

- 1,051 (almost 100%) of possible surveys were returned from 39 accommodation providers
- Response rates varied among providers, ranging from 1 to 86 surveys returned
- The majority of responses were from three types of provider: Sheltered (69%), Extra care sheltered (11.4%) and EMI residential (8.4%)
- Accommodation providers thought that 32% of their service users have some kind of mental health condition (including dementia, depression and/or psychotic illness)
- A third of responses (30%) were for service users known to CMHT for Older People
- 40% of responses did not know / not sure who the responsible care management team was for the service user
- 7% of service responses were for service users under 65
- The majority of service users are aged between 75 and 89 (57%) with a number over 95 (4.5%)
- Two thirds of responses did not indicate the gender of the service user, out of those who responded, 65% of service users were female
- 80% of responses indicated service users were White British or White Other

Analysis of accommodation service users shows that three quarters of mental health conditions are diagnosed and a quarter are suspected (Table 46). It is unlikely that the suspected cases are receiving appropriate care for their condition. It is important to ensure that accommodation providers are aware of referral routes for mental health conditions.

4.6.2 Residential and Nursing Home Placements

There are currently 504 people care managed by the London Borough of Tower Hamlets who are living in care homes. In borough, Tower Hamlets has one of the lowest number of local authority registered care home places for people with dementia in London (0.5 per 100 places for people aged 65+ within a range of 0.3 – 3.6 per 100 places). Beds in in-borough care homes are detailed in the table below:

Table 45: Number of beds available for people with dementia in Tower Hamlets

Provider	Nursing beds	EMI Nursing beds	Residential beds	EMI residential beds
Aspen Court	27	0	21	26
Hawthorne Green	45	45	0	0
Peter Shore Court	0	0	40	0
Pat Shaw Court	0	0	41	0
Silk Court	39	0	0	12
Westport Care	0	0	0	44
Total	111	45	102	82

It is estimated that 52.2% of residents of residential care and 66.9% of residents of nursing care have dementia (Healthcare for London, 2009), roughly 74 people in Tower Hamlets nursing care and 53 in Tower Hamlets residential care. Assuming that all residents of EMI nursing and residential care in the borough have dementia, there are a total of roughly 254 people living with dementia in Tower Hamlets care homes at present, although there is currently no specific mental health related support provided for people with dementia in care homes in the borough at present.

Respondents were asked to comment on the numbers of older people with mental health problems living in their homes and results were as follows:

Table 46: Numbers of people with suspected or diagnosed mental health conditions

Provider	% of residents with a MH problem	Diagnosed Dementia	Suspected Dementia	Diagnosed Depression	Suspected Depression	Diagnosed Psychotic Disorder	Suspected Psychotic Disorder
Aspen Court	80.7%	43	0	9	0	2	0
Hawthorne Green	68.7%	32	0	7	0	5	0
Peter Shore Court	34.4%	6	0	3	0	2	0
Pat Shaw Court	Did not respond						
Silk Court	Incomplete response						
Westport Care	41%	16	0	0	0	0	0

Nationally, the proportion of people with dementia living in care homes (Healthcare for London, 2009), along with anticipated activity in Tower Hamlets, are detailed below:

Table 47: National numbers of expected people with dementia living in care homes

	Expected Dementia 2008		
Age Band	Grand Total	Number living at home	Number living in care home
65-84	802	584 (73%)	218 (27%)
85+	475	233 (49%)	241 (51%)
Grand Total	1277	817	459

It is notable that according to UK wide activity we would expect 459 of the 1277 people with dementia currently resident in Tower Hamlets to be living in a care home whilst there are an estimated 254 people with dementia currently living in care homes in the borough. This figure is not straightforward to interpret directly as an indicator of a potential need for an increase in supply, as although it relates to a snapshot of people with dementia currently in borough, Tower Hamlets traditionally frequently places people out of borough in line with user and family choice.

Total new placements into residential and nursing care are detailed in the table below. It is notable that there has been a 63% increase in all placements for people with dementia (excluding generic residential or nursing care) from 2007 to 2009, with a particular increase in nursing and residential EMI placements from 2007/8 to 2008/9 and that up until 2008/9 the borough has placed significantly more people with dementia out of borough than in. The change in 2008/9 activity may be partially explained by the new registration of existing beds for people with dementia by existing in borough providers:

Table 48: In and Out of borough placements into residential and nursing care 2006-09

		Nursing EMI	Residential EMI	Grand Total
2006-7	**In Borough**	10	16	26
	Out of Borough	22	20	42
2006-7 Total		32	36	68
2007-8	**In Borough**	8	24	32
	Out of Borough	23	28	51
2007-8 Total		31	52	83
2008-9	**In Borough**	25	32	57
	Out of Borough	26	25	51
2008-9 Total		51	57	108
Grand Total		114	145	259

The national average number for placements into residential or nursing care for older people during 2008/9 was 77.24 per 10,000 people aged over 65 were admitted to residential and nursing care[34].

In Tower Hamlets there was a slightly higher rate of admission at 84.27. The age of people placed is detailed below:

Table 49: Age of people admitted to residential and nursing care 2006-09

Age	Number
65-69	10
70-74	9
75-79	36
80-84	60
85-89	81
90-94	45
95-99	18
Grand Total	259

Placements by care team are detailed in the table below. The high level of activity by the CMHTOP can be expected as a result of the nature of their client group. Possible reasons for the variations should be explored.

[34] Tribal Benchmarking 2009

Table 50: Placement type by team 2006-09

Year	Placement Type	CMHTOP	MEH	NE	NW	RLH	SE	SW	Not known	Grand Total
2006-7	Nursing EMI	12	5		5	5		5		32
	Residential EMI	11	2	3	3	5	3	4	5	36
2007-8	Nursing EMI	6	2	6	5	6	2	4		31
	Residential EMI	11	3	5	14	4	7	8		52
2008-9	Nursing EMI	15	10	5	8	7	1	5		51
	Residential EMI	17	3	12	5	7	5	8		57
Grand Total		72	25	31	40	34	18	34	5	259

228 of people with dementia placed from 2006 onwards were still in a placement in 2009. In a study of 238 care home residents with dementia, Hancock et al. (2005) found that the average length of stay in a care home for a person with dementia was 33.5 months. Further exploration of length of stay in residential care may be worthwhile to establish whether placements are being made at an appropriate stage in the person with dementia's illness.

4.6.3 Extra care sheltered

There are currently four extra care sheltered schemes in the borough, as follows:

Table 51: Number of beds available by extra care sheltered scheme

Scheme name	Number of beds
Coopers Court	41
Donnybrook Court	40
Duncan Court	40
Sonali Gardens	32
Total	153

A survey of extra care sheltered and other accommodation providers was carried out as part of this needs assessment. Respondents were asked to comment on the numbers of older people with mental health problems living in their schemes and results were as follows:

Table 52: Numbers of suspected and diagnosed people with mental health conditions by accommodation provider

Provider	% of residents with a MH problem	Diagnosed Dementia	Suspected Dementia	Diagnosed Depression	Suspected Depression	Diagnosed Psychotic Disorder	Suspected Psychotic Disorder
Coopers Court	56.5%	6	7	6	0	10	1
Donnybrook Court	59.4%	10	2	6	2	3	4
Duncan Court	41%	8	15	0	0	0	0
Sonali Gardens	Incomplete response						

There are high numbers of older people with mental health problems living in extra care sheltered in the borough, which may indicate a need to consider the skills and knowledge of providers in delivering mental health care, and the specialist support available to them.

Table 53: Numbers of people with mental health conditions living in extra care sheltered by care team

Team	Coopers Court	Donnybrook Court	Duncan Court	Sonali Gardens
Older People North West	0	1	0	Incomplete response
Older People North East	8	2	0	
Older People South West	0	0	0	
Older People South East	0	0	0	
CMHT for Older People	12	12	0	
Adult CMHT	2	1	0	
Hospital Social Work Team	1	3	0	
None	0	1	19	
Not sure	4	0	0	
Other	0	1	0	

72% of residents of extra care with a mental health problem were women and 85% were of White British ethnic origin.

A recent needs assessment [35] (Dec 2008) notes that there are insufficient extra care sheltered units for older people in the borough to meet demand and recommends doubling the number of units of extra care sheltered housing to 320 units.

4.6.4 Sheltered accommodation

Sheltered Housing schemes in the borough are detailed in the table below.

Table 54: Numbers of people in sheltered housing schemes as returned in Accommodation Provider Survey

Sheltered Housing Scheme	Response Count
Appian Court	25
Bustan Raada	18
Cavell Street	11
Colin Winter House	31
Edith Ramsay House	32
Gawthorne Court	32
Hogarth Lodge	0
Hugh Platt House	20
John Sinclair Crt	24
John Tucker House	10
Jubilee Crescent	27
Lady Mico's Alm Hses	18
Lawrence Close	28
Mandela House	28
Mosque Tower	36
Pebble Centre	29
Peter Shore Court	32
Phoenix Court	27
Regency Court	28
Rochester Court	35

[35] Tribal – Needs Assessment for Extra Care Sheltered Housing, 2008

Ruth Court	26
Shaftesbury Lodge	28
Somali Elders Scheme	16
St John's House	30
St Thomas House	0
Stepney Green	21
Sundial Centre	0
Ted Roberts House	31
Vic Johnson House	29
William Guy Garden	86

The June 2006 Best Value Review of sheltered housing suggested that the number of people requiring sheltered accommodation is likely to increase by 40% over the next 15 years. At the time of writing there were 92 people on the waiting list for sheltered housing.

4.7 Social and community support services

4.7.1 Homecare

Five percent of older people are receiving home care in Tower Hamlets. [36] There are high attendances made each month at various Link Age plus events but it is not clear if this represents individual attendance or the same people attending many times. Over half the older people population in Tower Hamlets have been contacted by Link Age plus since 2006.[37]

The Tower Hamlets in-house service supports **500** people with high care needs. Nursing and Occupational Therapy (OT) staff employed by NHS Tower Hamlets are located within the service to support this work, and a multi-disciplinary re-ablement service, providing intensive time limited rehabilitation input at the point of referral, has recently been launched.

In addition, **983** units of homecare are provided by commissioned services.

4.7.2 Day Services

The Council runs three day centres for older people: Poplar Day Centre, Mayfield House, and Russia Lane. In total these provide up to **95** places a day, and there are currently 159 registered service users. Mayfield House is a centre particularly focused on meeting the needs of Somali older people. Russia Lane provides a specialist service for people with dementia in partnership with the East London NHS Foundation Trust. Poplar Day Centre is based in LAP 7 and the highest density of older people is in LAP 5. Further work needs to be done to ensure that service provision is mapped according to need in Tower Hamlets.

Over 2008/09 there were 33 referrals to Russia Lane, although there is currently no-one on the waiting list. The small number of referrals compared to 413 patients on dementia registers suggests that more publicity is needed to ensure that all potential referrers are aware of this service. There needs to be adequate capacity for this service and other similar services throughout the borough.

[36] Ibid
[37] Ibid

An additional **50** units of day care are provided through commissioned services. Further analysis is needed to establish whether day services are meeting the need in Tower Hamlets.

4.7.3 Telecare

The National Dementia Strategy states that service providers should include assistive technology and telecare as a part of the package of care.[38] This supports independent living and delays reliance on more intensive services.

Tower Hamlets currently provides telecare for **730** people over 65 and **80** people under 65. Further analysis is needed to identify the proportion of telecare provided to people with mental health problems.

4.7.4 Occupational Therapy

The Council's Occupational Therapy (OT) Service is part of an integrated OT Service provided jointly with NHS Tower Hamlets and Barts and the London Trust across health (acute and community services) and social care. As well as the central social care OT service, there are also OTs located in a range of outposted services – the home care service, the Day Opportunities Service, Housing and Homelessness Services, Russia Lane Day Centre, and learning disabilities and mental health services.

There has been a 33% increase in referrals to the OT Service between 2003/4 and 2007/8 – from 1500 to 2000 referrals a year. During 2007/8, major adaptations to property were prescribed for over **400** people. The Service delivered minor adaptations for **1132** people in 2008/9, a 40% increase over 2007/8.[39]

There were suggestions from participants of consultation events (Section 5) that some adaptations may not meet clients' needs; and that waiting times were too long. Further analysis is needed to establish whether there is an unmet need in the OT service for older people.

4.7.5 Integrated Community Equipment Service

There is an integrated LBTH / NHS Tower Hamlets service. It is responsible for the delivery and fitting of community equipment and minor adaptations recommended by approved prescribers.

Last year over **13,500** pieces of equipment were delivered and fitted in service users homes. Further analysis is needed to understand if there is a waiting list and if so how long it is and whether all relevant equipment was delivered and fitted to clients.

Due to the specific neurological problems that arise when a person develops dementia the residential circumstances and physical environment of the person are central to their wellbeing and the degree to which they will need support and interventions. Someone with dementia may develop problems with orientation and mobility early on in the progression of the disease that will be exacerbated by certain environmental features such as an upstairs bedroom and low level of personal and night-time support. Stairs and confusing design features in the home may contribute to unacceptable risks to the safety of the person. Environmental features that do not closely meet a person's needs are also likely to be linked to distress and an increase in challenging behaviour.

[38] The NDS, 2009
[39] Data provided by LBTH, 2009

4.7.6 Additional services

- Range of additional third sector contracts – approximately 35 contracts providing:
    - lunch clubs for over 1500 people
    - befriending services for over 500 people
    - advice and advocacy for over 400 people
- LinkAge Plus - evaluation report July 2008 shows attendances at Linkage Plus events and surgeries running at between 3000 and 4500 a month, and over 850 outreach contacts with isolated and hard to reach older people a month. Over 10,000 people contacted since 2006. Increased integration of mental health promotion into LinkAge Plus contracts would help enhance mental health awareness.

4.8 Voluntary sector

4.8.1 Alzheimer's Society

The Alzheimer's Society provides support both in the community and on the wards for families and carers of people with dementia. After an initial consultation, they provide specialist information on dementia, signpost or refer service users and/or carers to appropriate services and advocacy support.

Specific projects include the

- Younger People with Dementia Project, which employs a half time worker to provide support to younger people with dementia and their carers
- Bangladeshi Dementia Project, which works with the Bangladeshi community to raise awareness of dementia, risk factors and measures to lower their risk of dementia

4.8.2 Age Concern Tower Hamlets

Age Concern runs the Bangladeshi Mental Health Project, which works with the Bangladeshi community to raise awareness of mental health issues with an emphasis on reducing the risk of depression.

4.9 Carers

Research has found that dementia leads to carers spending more time in the undertaking of care giving roles, and that the nature of the care changes to include increased supervision and helping with daily living tasks, increased responding to behavioural problems, increased attention to safety, and dealing with disruptions to daily life patterns, such as night-time wakening.

4.9.1 Carers in Tower Hamlets

There is a Tower Hamlets Carer's Strategy[40] led by the Local Authority. It is essential to ensure that work around the mental health needs of older people is tied in with the Carer's Strategy.

It has not been possible to identify current data at a local level that relates directly to the health needs of carers. The 2001 census indicates that there are in the region of 7,300

[40] London Borough of Tower Hamlets 3 Year - Multi-agency Carers Strategy, 2008-11

people providing more than 20 hours of unpaid care per week to partners, relatives or friends.[41]

In 2007/08 there were 1,700 carer's assessments across all groups. 383 carers' assessments and reviews for older people were carried out for patients with dementia and functional mental health.

Carers of people with dementia are signposted to the Alzheimer's Society and each carer's needs are assessed as part of the Single Assessment Point (SAP). Robinson ward have a support group to provide a support network for families/carers with patients on Robinson ward and for those who are recently bereaved.

4.10 Analysis and conclusion of service provision

4.10.1 Dementia

Approximately 34% of people with dementia in London require constant care or supervision[42]. There are an expected 1532 people in Tower Hamlets with dementia; this means 521 people with dementia would require full-time support. Table 60 shows the number of people with dementia estimated to need different levels of support in Tower Hamlets.

Table 55: Level of support for people with dementia, with figures for Tower Hamlets

Care interval description	Requirement	Proportion of people with dementia	Number in Tower Hamlets[43]
Critical (critical interval)	Constant care or supervision needed	34%	521
Substantial (short interval)	Care needed at regular intervals during the day, for dressing, meals etc	48%	735
Moderate (long interval)	Care needed once a week	11%	169
Low (independent)	Care considered	6%	92
Total		**100%**	**1517***

Source: Adapted from London Centre for Dementia Care 2008 and GLA populations 2007
* 1532 total, 1517 with rounding margin allowing for percentage calculations

The Green has 18 places for full-time support for dementia patients (including 14 acute and 4 respite beds). In addition there were 108 Nursing and residential EMI places in 2008/09. This still leaves a potential shortfall of 376 people with dementia with full-time care needs.

There are a low number of dementia cases recorded in primary care (432) compared to expected (1532). However data from Healthcare for London shows that Tower Hamlets has the highest rates of hospital admissions with dementia as the main diagnosis (95.7 per 1000 population).

[41] JSNA, 2008
[42] Healthcare for London, 2009
[43] Based on 1532 figure of expected number of people with dementia (McKinsey 2008)

This suggests that people with dementia in Tower Hamlets are not being identified or adequately managed in primary care but are possibly making later presentations in secondary care. Work needs to be done to improve identification and management of dementia in primary care in order to reduce unnecessary burden on secondary services.

There is a need for long-term MDT community case management of the rising number of dementia cases through the care pathway that extends out from the 'hub' of the CMHT/Memory service to: patient homes, medical inpatient wards, GP clinics, nursing homes etc from diagnosis to end of life. There is also a need to support the increasing number of chronic treatment resistant anxiety and depression cases in the community where current resources are low.

5. PATIENT AND PUBLIC INVOLVEMENT

Two initial consultation events were organised in order to include the views of older people and their service providers. They were conducted with the Older People's Reference Group and Alzheimer's Society Tower Hamlets.

Box 3: Key issues from the consultation

- Clarification of overall responsibility of older people's mental health – PCT or Local Authority
- Lack of age appropriate services for dementia patients under 65 across the pathway e.g. no residential homes for younger dementia patients in TH
- Limited mental health awareness among older people
- Availability of relevant and culturally appropriate mental health information for older people
- Availability of GPs – time to "listen" to patients
- Difficulty in accessing a range of services without first going through one's GP
- Access to talking therapy
- Stigma associated with mental illness
- Carers' needs
- Delay in diagnosis of dementia
- Lack of clear dementia care pathway
- The mental health needs of people in sheltered accommodation
- More information and clarification on personalised budgets
- There are Bangladeshi services but other ethnic groups not well catered for e.g. Punjabi
- Respite care for people with dementia. Hard for people with dementia to adapt to different environments – it would be ideal to receive respite care in one's own home

Further consultation with service users is planned.

6. PALLIATIVE CARE FOR PEOPLE WITH MENTAL HEALTH CONDITIONS

Only a very small number of patients under the care of the CMHT die at home each year. This appears to be because patients tend to go into care before they reach the end stages of their illness either because they are unsafe living alone or because their family cannot support them despite a care package. In dementia it is often challenging to predict the last year of life therefore patients with dementia in the community are often admitted for treatment for acute infections and subsequently die in hospital.

6.1 Specialist Palliative Care for Inpatient Services

There is an informal arrangement between the Macmillan Palliative Care Team from Barts and the London Trust (BLT) and East London NHS Foundation Trust (ELFT). Inpatients in all three wards requiring specialist palliative care can be referred to BLT Palliative Care team.

6.2 Issues identified as part of the Delivering Choice Programme[44]

6.2.1 Communication between ELF and BLT

The inpatient wards from ELFT outlined several problems in firstly BLT not understanding their remit and secondly having a lack of awareness of the challenges posed by dementia patients.

There have been difficulties in the past of admitting a patient with dementia that for example required hydration. The wards from ELFT are unable to provide invasive physical treatment however BLT does not seem to be aware of this and there are difficulties in admitting dementia patients requiring treatment.

ELFT staff report that when patients return from BLT back to them, there is little or no information sent back with the patient and the nurses spend a lot of time trying to chase the wards for information and discharge summaries.

The challenge to try and keep dementia patients in one environment is a big one considering the limit of what can be provided within the wards. In the past, ELFT had a good working relationship with the Bancroft Unit which is on the same site. Patients requiring treatment for infections could be admitted to Bancroft Unit rather than having to go to A&E. This arrangement no longer exists but it would be in the best interests especially for end of life dementia patients to limit the amount of times moved.

[44] NHS Tower Hamlets, Delivering Choice Programme, March 2009

7. CONCLUSIONS

Box 4: Strategic overview

1. There are reports of an increase in the number of younger people with dementia in the borough.

2. There are significant numbers of older people who have co-morbid chronic physical and mental health problems in Tower Hamlets.

3. There is a lower proportion of older people in Tower Hamlets compared to the national average, but the population has a higher than national average morbidity and service users appear to access services more frequently.

4. The population of over 65's is set to increase over the next ten years, with growth particularly in the 65-69, and 85+ age brackets (for whom there is a greater morbidity of dementia). The proportion of the 65+ population who are from the Bangladeshi community is set to increase significantly over the same period.

5. There are significantly fewer people referred to the Tower Hamlets Memory Service for assessment than anticipated by estimated incidence.

6. There are significant variations in referral rates to the Tower Hamlets Memory Service and the CMHT for Older People by GP Practice.

7. The Tower Hamlets Memory Service appears to have developed in an ad hoc manner and as a result care pathways into and out of the service do not appear to be effectively coordinated. The Service may not have sufficient capacity to meet current and future demand.

8. Tower Hamlets has the second highest rate of prescription for anti-dementia drugs in London.

9. Care pathways across the whole system of care for people with dementia do not appear to be clear and well coordinated.

10. There are significantly fewer people with dementia currently supported by either secondary care mental health services or Social Services than the estimated prevalence would suggest.

11. There appears to be a number of areas where current service provision may fall short of current national guidance.

Box 5: Prevention and Primary Care

1. There are significantly fewer people aged 65+ accessing primary care psychology (2.4%) than the demographic make up of the population (8%).

2. The population of over 65's is largest in LAP 5, from where significantly the greatest number of referrals into secondary care mental health services for older people are also made.

3. Risk factors for older people developing mental health problems in Tower Hamlets (e.g. deprivation, chronic physical illness) are significantly greater than the national average.

4. There is a high prevalence of cardiovascular disease and of alcohol misuse in older people in the borough and this may result in a higher than national prevalence of vascular dementia.

5. There are very low numbers of people with dementia formally identified as such on GP Registers in the borough, i.e. 33% of people expected to have dementia.

Box 6: Secondary Care and Community Services

1. The Tower Hamlets CMHT for Older People has a caseload that is roughly 75% people with dementia. Care pathways and workforce design may not be optimal to meet the consequent need effectively.

2. The number of people aged 65+ with mental health problems accessing voluntary sector support services is unclear. There are several voluntary sector services for people with mental health problems which seem to have an age cut off of 65.

3. People with co-morbid acute physical and mental health problems on in-patient wards (including BLT, ELFT and NHS TH) may not receive sufficiently effectively coordinated mental and physical health care.

4. There is a very significant morbidity of mental health problems in people admitted to BLT and NHS TH beds and some evidence to support reduced length of stay in properly constituted liaison services.

5. Bed occupancy in ELFT is roughly 75% across all three in-patient wards in the borough and this may not represent effective use of financial resources.

6. Delayed discharge days accounted for roughly 3.2 beds from the two assessment units for in-patients during 2008/9.

7. There are a number of people who have had admissions to Leadenhall Ward (acute assessment for older people with functional mental health problems) whose length of stay is significantly in excess of the national average and it is not clear the extent to which all admissions to Leadenhall Ward are considered for support by the Home Treatment Team in the first instance.

8. Tower Hamlets places proportionally more people aged 65+ into residential and nursing care than the national average, but has significantly fewer borough-based beds than the national average.

9. More than 50% of residents of extra care sheltered housing in the borough are identified by providers as having a mental health problem. Around 50% of all placements are made out of borough.

10. The number of people with dementia receiving respite care at The Green has significantly dropped over recent years. It is not clear where and how people are now receiving respite, or if it is to the same level.

11. There is a lack of information on the skills and knowledge of social care commissioned services, for example day care and home care, in providing support to people with dementia. There may be some variance between nationally recognised best practice and local provision.

12. Ensure that there are appropriate services with sufficient skills and knowledge in secondary care mental health services to assess and support younger people with dementia. Further needs assessment work in this area, potentially across the Inner North East London area, may be appropriate.

13. There is a lack of clear information regarding the extent to which carers of people with dementia and older people with mental health problems have been offered and received carer's assessments, and the extent to which carers feel they are offered appropriate support.

8. RECOMMENDATIONS

This section highlights areas that the Partnership may wish to consider in more detail in developing a Tower Hamlets strategy for the development and improvement of services for people with dementia and older people with mental health problems. It details twenty-six high level insights that have arisen as a result of this JSNA, and includes recommendations for future consideration. These have been categorised into three broad areas: Strategy, Prevention and Primary Care and Secondary Care Services.

Strategic overview

1. Ensure that there are appropriate services with sufficient skills and knowledge in secondary care mental health services to assess and support younger people with dementia. Further needs assessment work in this area, potentially across the Inner North East London area, may be appropriate.

2. Consider care pathways for older people with functional mental health problems and ensure that they are clear, in line with NICE guidance, and proportionate to the needs of service users and their carers.

3. Ensure that older people with mild to moderate and more severe functional mental health problems are actively referred to talking therapies in line with that available to people of working age, in primary and secondary care as appropriate and consistent with the demographic make up of the population.

4. Agree a service model for Tower Hamlets Memory Services that is in line with the evidence base described in the National Dementia Strategy and which has sufficient capacity to manage predicted activity. This should include a clear pathway into the Tower Hamlets Memory Service which is publicised and incorporated into GP and primary care training.

5. Agree a service model that ensures that people who have a diagnosis of dementia are not lost to services and receive ongoing support that is proportionate to their need. This should include consideration of developing Dementia Adviser posts.

6. Ensure that commissioning arrangements and strategic ownership across NHS Tower Hamlets and the London Borough of Tower Hamlets for people with dementia and older people with mental health problems are clear and unambiguous.

7. Consider the effectiveness of mechanisms currently in place for user and carer involvement in both the strategic planning and day to day monitoring of services.

Prevention and Primary Care

8. Consider the extent to which the current Mental Health Promotion Strategy specifically addresses dementia and mental health problems in older age. The Partnership should ensure that future plans for mental health promotion in these groups are evidence-based and specific to the Tower Hamlets population, e.g. that they adequately address the future age and ethnicity distribution, and cultural needs, of the population.

9. Consider whether specific mental health signposting and information services should be developed in LAP 5.

10. Develop mechanisms to reduce stigma and encourage help-seeking behaviour through increasing public and professional awareness of dementia and mental health problems in older people.

11. Consider the range of preventative services currently in place for older people with mental health problems and their carers, both generic and specific to mental health, and consider whether further services or approaches need to be developed in this area. A focus on the social inclusion of older people with dementia and mental health problems should be promoted. Evidence suggests that the voluntary sector is best placed to provide preventative services to this client group.

12. Evaluate the impact the NHS Tower Hamlets social marketing campaign targeting alcohol consumption among older people. The campaign is aimed at reducing alcohol consumption in 65+ and encouraging help-seeking behaviour.

13. Consider how to improve data quality regarding dementia in primary care. This should include mechanisms to improve detection of possible symptoms of dementia in primary care, possibly through training specifically targeted at GP's and other primary care professionals.

14. Ensure that there is an appropriate range of mental health services provided by the voluntary sector which are accessible to older people.

Secondary Care and Community Services

15. Consider the extent to which current mainstream services are appropriately geared to the specific needs of older people with co-morbid physical and mental health problems. This should include the capability of mainstream services to recognise, assess and support mental health problems in people with a primary physical health problem, with talking therapies where appropriate. The Partnership should consider the availability of specialist medical, RGN and Professions Allied to Medicine to people with dementia and older people who are in-patients on ELFT provided wards.

16. Consider mechanisms to improve detection of possible symptoms of dementia, and mental health problems in older people, who are patients at BLT and NHS TH, possibly through training specifically targeted at health professionals.

17. Consider the evidence generated by the NHS Tower Hamlets Liaison Psychiatry Needs Assessment regarding the provision of specific liaison services for older people at BLT and MEH.

18. Review the evidence for formally establishing shared care beds for people with very complex co-morbid physical and mental health problems.

19. Review the future demand for specialist Mental Health Care of Older People inpatient beds within ELFT and consider possibilities for re-design to promote quality, strategic fit, and value for money.

20. Develop effective care pathways for older people with functional mental health problems who are in crisis. ELFT should ensure that all patients who are considered for admission to Leadenhall Ward are screened by the Home Treatment Team prior to admission.

21. Review arrangements for the ongoing support of people with diagnosed dementia. This should include arrangements for support in the home and the management of crises for people with dementia or their carers.

22. Scope future demand for, and design of, EMI beds in extra care sheltered, residential and nursing care in-borough.

23. Ensure that in the service model for dementia services is sufficient consideration given to specialist advice and support available regarding dementia and mental health to mainstream social services and residential, nursing and extra care sheltered housing providers.

24. Consider the supply of bed based respite care and ensure that it is commissioned to provide quality, strategic fit and value for money.

25. Review the evidence for, and design of, specialist versus mainstream home care and day care services for people with dementia.

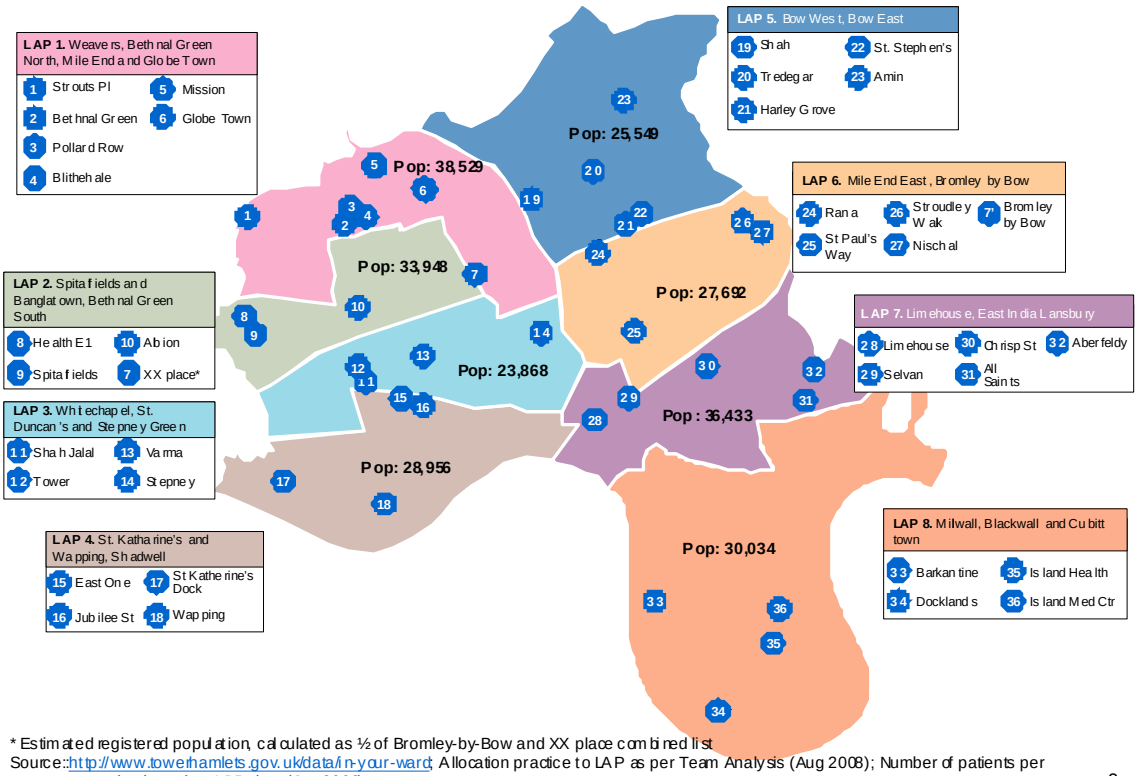
26. Ensure that there is sufficient focus on the needs of carers in the design of future service models.

Next Steps:

If these recommendations are accepted by the Partnership, either wholly or in part, the Partnership should develop a high level action plan including milestones and identified responsible officers in order to deliver them. It may be that some of the recommendations may be deliverable through a commissioning strategy. A senior level project board should have oversight of, and monitoring responsibility for, the action plan.

Appendix 1

Map of Tower Hamlets by LAP and GP practice



* Estimated registered population, calculated as ½ of Bromley-by-Bow and XX place combined list
Source::http://www.towerhamlets.gov.uk/data/in-your-ward; Allocation practice to LAP as per Team Analysis (Aug 2008); Number of patients per * practice based on LDP data (Jan 2009)

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Appendix 2
National Dementia Strategy: 17 Objectives

Objective 1: Improving public and professional awareness and understanding of dementia. Public and professional awareness and understanding of dementia to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help-seeking and help provision.

Objective 2: Good-quality early diagnosis and intervention for all. All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.

Objective 3: Good-quality information for those with diagnosed dementia and their carers. Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.

Objective 4: Enabling easy access to care, support and advice following diagnosis. A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.

Objective 5: Development of structured peer support and learning networks. The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.

Objective 6: Improved community personal support services. Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services.

Objective 7: Implementing the Carers' Strategy. Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia. This will include good-quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected.

Objective 8: Improved quality of care for people with dementia in general hospitals. Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.

Objective 9: Improved intermediate care for people with dementia. Intermediate care which is accessible to people with dementia and which meets their needs.

Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers. The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.

Objective 11: Living well with dementia in care homes. Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes.

Objective 12: Improved end of life care for people with dementia. People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia.

Objective 13: An informed and effective workforce for people with dementia.
Health and social care staff involved in the care of people who may have dementia to have the necessary skills to provide the best quality of care in the roles and settings where they work. To be achieved by effective basic training and continuous professional and vocational development in dementia.

Objective 14: A joint commissioning strategy for dementia. Local commissioning and planning mechanisms to be established to determine the services needed for people with dementia and their carers, and how best to meet these needs. These commissioning plans should be informed by the World Class Commissioning guidance for dementia developed to support this Strategy and set out in Annex 1.

Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers.
Inspection regimes for care homes and other services that better assure the quality of dementia care provided.

Objective 16: A clear picture of research evidence and needs. Evidence to be available on the existing research base on dementia in the UK and gaps that need to be filled.

Objective 17: Effective national and regional support for implementation of the Strategy. Appropriate national and regional support to be available to advise and assist local implementation of the Strategy. Good-quality information to be available on the development of dementia services, including information from evaluations and demonstrator sites.

Appendix 3

World Class Commissioning Competency	Fit with National Dementia Strategy Objectives
1. Locally lead the NHS	1, 2, 3, 4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 17
2. Work with community partners	1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17
3. Engage with public and patients	1, 2, 3, 4, 5, 6, 7, 9, 11, 14, 17
4. Collaborate with clinicians and professionals	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17
5. Manage knowledge and assess needs	1, 2, 3, 4, 5, 7, 11, 13, 14, 15, 16, 17
6. Prioritise investment	1, 2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 17
7. Stimulate the market	1, 2, 4, 5, 6, 8, 9, 10, 11, 13, 14, 17
8. Promote improvement and innovation	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17
9. Secure procurement skills	2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 17
10. Manage the local health system	1, 2, 3, 4, 7, 8, 9, 11, 12, 13, 14, 15, 17
11. Make sound financial investments	1, 2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 16, 17

Source: National Dementia Strategy, DH, 2009

Appendix 4

Effective Service Models

The stepped care model for the management of depression in primary and secondary care (NICE, 2004)

Step	Who is responsible for care?	What is the focus?	What do they do?
Step 1	GP, practice nurse	Recognition of depression	Assessment
Step 2	Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 3	Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 4	Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 5	Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT

How Tower Hamlets compares to the NICE model for the management of depression in primary and secondary care

NICE	Tower Hamlets service provision
Step 1: Recognition of depression in primary care and general hospital settings	Primary Care – Gap in expected and recorded prevalence in GP practice depression registers. Role of Improving Access to Psychological Therapies (IAPT) General Hospital setting – there is some level liaison psychiatry provision at the RLH and MEH
Step 2: Treatment of mild depression in primary care	GP depression registers do not separate depression into mild and severe. Primary Care Psychology and Counselling Service
Step 3: Treatment of moderate to severe depression in primary care	Primary care mental health workers in place
Step 4: Treatment of depression by mental health specialists	CMHTs, Home Treatment Team, Crisis Intervention Service in place
Step 5: Inpatient treatment for depression	In place

Appendix 5 Accommodation provider survey results

Q1 Name of Scheme		
Answer Options	**Response Percent**	**Response Count**
Appian Court	2.4%	25
Aspen Court	5.4%	57
Bustan Raada	1.7%	18
Cavell Street	1.1%	11
Colin Winter Hse	3.0%	31
Coopers Court	4.4%	46
Donnybrook Court	3.1%	32
Duncans Court	3.7%	39
Edith Ramsay Hse	3.1%	32
Gawthorne Court	3.1%	32
Hawthorne Green	6.4%	67
Hogarth Lodge	0.0%	0
Hugh Platt Hse	1.9%	20
John Sinclair Crt	2.3%	24
John Tucker Hse	1.0%	10
Jubilee Crescent	2.6%	27
Lady Mico's Alm Hses	1.7%	18
Lawrence Close	2.7%	28
Mandela House	2.7%	28
Mosque Tower	3.4%	36
Pat Shaw House	0.0%	0
Pebble Centre	2.8%	29
Peter Shore Court	3.1%	32
Pheonix Court	2.6%	27
Regency Court	2.7%	28
Rochester Court	3.3%	35
Ruth Court	2.5%	26
Shaftesbury Lodge	2.7%	28
Silk Court	0.7%	7
Somali Elders Scheme	1.5%	16
Sonali Gardens	0.1%	1
St John's Hse	2.9%	30
St Thomas Hse	0.0%	0
Stephney Green	2.0%	21
Sundial Centre	0.0%	0
Ted Roberts Hse	3.0%	31
Vic Johnson Hse	2.8%	29
Westport Care Centre	3.7%	39
William Guy Garden	8.2%	86
answered question		**1046**

Q2 What type of accommodation does the service user live in?		
Answer Options	**Response Percent**	**Response Count**
Sheltered	69.0%	713
Extra Care Sheltered	11.4%	118

Residential	3.3%	34
EMI Residential	8.4%	87
Nursing	4.0%	41
EMI Nursing	4.0%	41
Other	0.0%	0
answered question		**1034**

Q3 Do you think this service user has any kind of mental health condition? (e.g. dementia, depression and/or psychotic illness)

Answer Options	Response Percent	Response Count
Yes	32.2%	338
No	67.8%	713
answered question		**1051**

Q4 If you have selected 'no' then scroll to the end and click 'Done'. You do not need to continue with the rest of this survey for this service user. If you selected 'yes' please continue. Does the service user have any of the following conditions? (Select as many that are applicable to the service user)

Answer Options	Diagnosed	Suspected	Response Count
Dementia	161	52	213
Depression	86	36	122
Psychotic Illness	49	24	73
	answered question		**346**

Q5 Which is the responsible care management team?

Answer Options	Response Percent	Response Count
Older People North West	5.8%	22
Older People North East	7.4%	28
Older People South West	1.9%	7
Older People South East	2.9%	11
CMHT for Older People	29.7%	112
Adult CMHT	2.9%	11
Hospital Social Work Team	3.7%	14
None	19.6%	74
Not sure	21.2%	80
Other	4.8%	18
answered question		**377**

Q6 Age of service user.

Answer Options	Response Percent	Response Count
Under 50	0.5%	2
50 - 54	0.5%	2
55 - 59	1.5%	6
60 - 64	3.9%	16
65 - 69	10.8%	44
70 - 74	13.4%	55
75 - 79	20.3%	83
80 - 84	17.1%	70
85 - 89	19.6%	80
90 - 94	7.8%	32
95 and over	4.6%	19

	answered question	**409**

Q7 Gender of service user

Answer Options	Response Percent	Response Count
Male	35.0%	135
Female	65.0%	251
	answered question	**386**

Q8 Ethnicity of service user

Answer Options	Response Percent	Response Count
White British	74.4%	303
White Other	6.1%	25
Bangladeshi	3.4%	14
Other Asian	2.9%	12
Somali	5.4%	22
Black African	2.0%	8
Black Other	3.2%	13
Chinese	0.2%	1
Other	2.2%	9
Not Recorded	0.0%	0
	answered question	**407**

Appendix 6 Social Work team survey

Q1 Do you think this service user has any kind of mental health condition? (e.g. dementia, depression and/or psychotic illness)

Answer Options	Response Percent	Response Count
Yes	35.2%	166
No	64.8%	305
answered question		**471**

Q2 If you have selected 'no' then scroll to the end and click 'Done'. You do not need to continue with the rest of this survey for this patient. If you selected 'yes' please continue. Does the service user have any of the following conditions? (Select as many that are applicable to the service user)

Answer Options	Diagnosed	Suspected	Response Count
Dementia	110	22	132
Mild Depression	12	12	24
More Significant Depression	5	2	7
Psychotic Illness	13	0	13
answered question			**168**

Q3 Which is the responsible social work team?

Answer Options	Response Percent	Response Count
North West	37.3%	75
North East	21.4%	43
South West	8.0%	16
South East	33.3%	67
answered question		**201**

Q 4 What is the status of the service user?	**What is the status of the service user?**	**What is the status of the service user?**	**What is the status of the service user?**
Answer Options	**Answer Options**	**Response Percent**	**Response Count**
Actively Care Managed	Actively Care Managed	43.5%	81
Duty	Duty	3.8%	7
Annual Review	Annual Review	52.7%	98
answered question	***answered question***	***186***	**186**

Q5 What type of accommodation does the service user live in?

Answer Options	In Tower Hamlets	Out of Borough	Response Count
Own home	111	1	112
Sheltered	10	0	10
Extra Care Sheltered	15	0	15

Residential	3	5	8
EMI Residential	14	10	24
Nursing	5	6	11
EMI Nursing	4	8	12
Continuing Care	1	0	1
Other	4	0	4
		answered question	**196**

Q6 Does the service user have an identified carer?

Answer Options	**Response Percent**	**Response Count**
Yes	59.3%	112
No	39.2%	74
Unknown	1.6%	3
	answered question	**189**

Q7 If the service user has a carer, does the carer

Answer Options	**Response Percent**	**Response Count**
Live with the patient	34.8%	46
Not live with the patient	53.0%	70
Unknown	12.1%	16
	answered question	**132**

Q8 Age of service user.

Answer Options	**Response Percent**	**Response Count**
Under 50	0.0%	0
50 - 54	0.0%	0
55 - 59	0.0%	0
60 - 64	1.0%	2
65 - 69	5.6%	11
70 - 74	16.2%	32
75 - 79	21.3%	42
80 - 84	21.8%	43
85 - 89	21.3%	42
90 - 94	9.6%	19
95 and over	3.0%	6
	answered question	**197**

Q9 Gender of service user

Answer Options	**Response Percent**	**Response Count**
Male	37.6%	65
Female	62.4%	108
	answered question	**173**

Q10 Ethnicity of service user

Answer Options	**Response Percent**	**Response Count**
White British	68.4%	134
White Other	7.7%	15
Bangladeshi	10.7%	21

Other Asian	1.0%	2
Somali	2.6%	5
Black African	2.0%	4
Black Other	5.6%	11
Chinese	0.5%	1
Other	0.5%	1
Not Recorded	1.0%	2
	answered question	**196**