North Tyneside Council

NHS
North Tyneside
Clinical Commissioning Group

Mental Wellbeing in Later Life
North Tyneside Joint Strategy
2018 - 2023

Contents

Executive Summary

Ageing can bring life changes, including career changes and retirement, bereavement, and physical changes. Many older people also support their families by caring for others.

We recognise the importance of good physical and mental health and that they are essential to the wellbeing of the population of North Tyneside, no matter what age. There is an assumption that mental health problems are a 'normal' aspect of ageing but most older people don't develop mental health problems and if they do they can be helped.

Good mental health is a vital asset for dealing with the different stresses (physical and mental) and problems in life.

The aim of this strategy is to improve mental health and dementia services and support for older people and carers. We also want to ensure that there is targeted prevention for people at risk of mental ill health and early intervention for older people with symptoms of mental illness.

Dementia and/or depression are often associated with getting older but they aren't an inevitable part of ageing. Other mental ill health conditions that may affect any of us include disorders such as, anxiety, schizophrenia, suicidal feelings, personality disorders and substance misuse.

The Department of Health has estimated that 40% of older people seeing their GP, half of older people in general hospitals, and 60% of care home residents, have a mental health problem.

North Tyneside Clinical Commissioning Group (CCG) and North Tyneside Council (NTC) are committed to working together to improve the health, care and the quality of life for older people. The impact of older persons mental health needs is wide ranging, having an effect on not only the person themselves but also their family, friends and carers.

The demand for services is likely to increase given the predictions of demographic changes and higher prevalence of mental health problems. The priorities for older people living in North Tyneside include improving physical health, mental health and emotional wellbeing, reducing mortality and improving healthy life expectancy. Additionally North Tyneside wants to reduce avoidable hospital and care home admissions and also support unpaid carers.

We face the challenge of providing high quality specialised services to a larger number of people but with reducing resources. Existing funding priorities for both health and the local authority will be challenged. We need to consider the potential in terms of effectiveness and efficiency from joined-up, integrated services including developing partnership models that enable older people and their carers to manage long term conditions together, resulting in seamless pathways for those who need assistance.

This Strategy is built upon a number of national and local plans and strategies and sets out our approach to supporting an ageing population in North Tyneside to live well for longer by preparing them for later life and where possible improving their quality of life in later years.

1. National Legal and Policy Context

1.1 Legal Overview

Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS.

Mental Health in England is shaped by a range of laws:

- The Care Act 2014
- Section 47 (2)
- Disabled Persons (Services, Consultation and Representation) Act 1986
- Mental Health Act 2007
- Mental Capacity Act 2005
- Deprivation of Liberty Safeguards (DOLS) 2008
- Equality Act 2010
- Safeguarding Vulnerable Groups Act 2006
- Human Rights Act 1998

1.2 National Policies

There are a wide range of policies which impact upon prevention, frailty, mental health and dementia in a variety of ways.

Mental Health Crisis Care Concordat 2014 describes how we work in partnership with others to improve outcomes for people experiencing mental health crisis. It is a national agreement between services and agencies involved in the care and support of people in crisis. It focuses on four main areas:

- Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

Mental health services: achieving better access by 2020 suggests that people of all ages with mental health problems should receive at least the equivalent level of access to timely, evidence based, clinically effective, recovery focussed, safe and personalised care, as people with a physical health condition.

The **NHS 5 Year Forward View 2015** describes how the NHS must drive towards an equal response to mental and physical health and also towards the two being created together.

The 5 year forward view will form the foundation on which NHS services, including mental health services, will be built over the next 5 years.

The NHS Forward View presents the NHS with three challenges which are expected to be addressed over a 5 year period through the development of a system wide Sustainability and Transformational Plan. Those challenges are:

- The health and wellbeing gap
- The care and quality gap
- The funding and efficiency gap

The **Prevention Concordat for Better Mental Health** was developed as one of the recommendations from the Five Year Forward View for Mental Health. A suite of local support resources have been produced to support local areas across England adopt the Prevention Concordat for Better Mental Health.

Parity of Esteem

The Centre for Mental Health described Parity of Esteem as "the principle by which mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care Act 2012.

Commissioners, including CCGs, Health & Well-Being Boards and Local Authorities are expected to meet their duties to achieve Parity of Esteem, which includes consideration of such areas as reviewing access to services (including waiting times), provision of a range of mental health services and a reduction in premature mortality and variations in inequalities in local communities.

The CCG is monitored by NHS England on its expenditure on mental health to achieve parity of esteem, which is called the Mental Health Investment Standard and it is expected that CCGs will invest in mental health provision at least at the same level as its annual financial uplift.

Closing the Gap – January 2014 sets out 25 priorities for change. It details how changes in local service planning and delivery will make a difference to the lives of people with mental health problems in the next 2 or 3 years.

These priorities are about mental health care and treatment, and work across the entire health and care sector to reduce the damaging impact of mental illness and improve mental wellbeing. In addressing these priorities we will also define our commitment to working with many partners across the voluntary sector – from national charities to local community groups.

The Forward View into Action: Planning for 2015/16 guidance requires CCGs to expand its offer and delivery of personal health budgets where it can be evidenced that people would benefit. CCGs are therefore expected to offer personal health budgets or integrated personal budgets across health and social care by April 2016 for people with learning disabilities and children with special educational needs. CCGs can also offer personal health budgets for other groups.

Personalisation is a social care approach described by the Department of Health as meaning that "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings".

While it is often associated with direct payments and personal budgets, under which service users can choose the services that they receive, personalisation also entails that services are tailored to the needs of every individual, rather than delivered in a one-size-fits-all fashion.

It also encompasses the provision of improved information and advice on care and support for families, investment in preventive services to reduce or delay people's need for care and the promotion of independence and self-reliance among individuals and communities.

As such, personalisation has significant implications for everyone involved in the social care sector.

The Prime Minister's Challenge on Dementia 2020 - the government's vision for England is that it is:

- The best country in the world for dementia care and support and for people with dementia, their carers and families to live; and
- The best place in the world to undertake research into dementia and other neurodegenerative diseases
- This vision is a result of extensive consultation with individuals living with dementia and their carers who described the outcomes they would want in the following statements:
    - I have personal choice and control over the decisions that affect me
    - I know that services are designed around me, my needs and my carer's needs
    - I have support that helps me live my life
    - I have the knowledge to get what I need
    - I live in an enabling and supportive environment where I feel valued and understood
    - I have a sense of belonging and of being a valued part of family, community and civic life
    - I am confident my end of life wishes will be respected. I can expect a good death
    - I know that there is research going on which will deliver a better life for people with dementia, and I know how I can contribute to this

The LGA document **'Developing dementia-friendly communities, Learning and guidance for local authorities'** (2012) defines a dementia friendly community as a place:

- In which it is possible for the greatest number of people with dementia to live a good life
- Where people with dementia are enabled to live as independently as possible and to continue to be part of the community
- Where they are met with understanding and given support where necessary

The Dementia Friendly Communities programme aims to meet the targets outlined by the Prime Minister's Challenge on Dementia 2020 in order to create communities around the UK which make daily living and activities easier and more accessible to people living with dementia.

The Alzheimer's Society report **'Building Dementia Friendly Communities: A priority for everyone'** (2013) states:

"A dementia-friendly community is one in which people with dementia are empowered to have high aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them."

These two definitions provide a useful starting point when we consider how to make North Tyneside a dementia friendly community.

North Tyneside Council working in partnership with Age UKNT began to explore how the borough could become more accessible for people with dementia. Wallsend was identified as a place to test out new approaches and was subsequently successfully registered as working toward becoming dementia friendly with the Alzheimer's Society national scheme.

Mental Capacity Act 2005 (MCA) and **Deprivation of Liberty 2008 (DoLS)** provides a statutory framework for working with individuals who may lack capacity to make decisions for themselves and is part of the Safeguarding agenda. The requirement to have Independent Mental Capacity Advocates is built into the MCA and is particularly relevant for those persons who do not have relatives or families to support them in decision making.

Article 5 of the Human Rights Act states that 'everyone has a right to liberty and security of person. No one shall be deprived of his or her liberty (unless) in accordance with a procedure prescribed in law'. The DoLs is the procedure prescribed in law and the ruling – in the cases of *P v Cheshire West and Chester Council* and *P&Q v Surrey County Council* – threw out previous judgements that had defined deprivation of liberty more restrictively. The judgement saw a surge of referrals for persons being deprived of their liberty in care homes and hospital settings.

Section 117 obliges councils and the NHS to provide aftercare services, including a care home place if that is needed, for people who have been discharged from hospital having been detained for treatment under the Mental Health Act 1983.

The **NHS Health Check** programme is open to residents aged 40-74 years old. The NHS health check can determine whether an individual is at a higher risk of; heart disease, stroke, kidney disease, diabetes and for those aged over 65 years old dementia. The NHS health check also provides advice on stopping smoking, how to increase physical activity, how to loose weight and safe levels of alcohol consumption.

Safeguarding Adults

A priority for both health and social care continues to be that they ensure that the more vulnerable people in our society are able to be safe. Safeguarding is everybody's business and we work with our residents and communities to develop shared safeguarding priorities.

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, whilst at the same time making sure that the adult's wellbeing is promoted, including, where appropriate, having regard to their views wishes, feelings and beliefs in deciding on any action.

Safeguarding duties within the Care Act 2014 apply to an adult who:

- Has needs for care and support;
- Is experiencing, or is at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Both the Local Authority and the CCG work to the principle of "Zero Tolerance" to abuse.

Providers we commission are required to have policy and procedures in line with the Mental Capacity Act and must presume a person has capacity unless assessed otherwise. Consent and Best Interest issues must always be addressed. The policy and procedures are also required to provide for an assessment of risk and the need for an Independent Advocate.

People with Dementia are particularly open to abusive situations, providers are required to put in place a system and training for its staff, which aims to minimise the risks of abuse.

In North Tyneside we have an Adult and Children's Multi Agency Safeguarding Hub (MASH). The purpose of the MASH is to:

- Act as a single point of access for referrals, help partners to define thresholds and manage risk better
- Improve coordination, communication , efficiency and information sharing between partners
- Provide a triage and assessment process which has shown to prevent cases escalating to the safeguarding level , and an integrated Early Support model improves multi-agency responses to cases requiring multi-agency information sharing below the safeguarding level
- Improve information sharing around potential victims and perpetrators of DV and identifying one professional to lead on working with victims/perpetrators to reduce violent offence rates
- Improve outcomes for children and families

Power of Attorney

Many people with dementia will eventually reach a point where they are no longer able to make decisions for themselves – this is known as lacking 'mental capacity'. When this happens, someone else – often a carer or family member – will need to make decisions on their behalf.

A Lasting power of attorney (LPA) is a legal tool that gives another adult the legal authority to make certain decisions for you, if you become unable to make them yourself. The person who is given this authority is known as an 'attorney'. They can manage your finances, or make decisions relating to your health and welfare. This page explains what an LPA is and why you might consider making one. It also provides practical advice and information about how to appoint an attorney, and what powers you can give them.

In addition a person's wishes and directions regarding medical treatment can be recorded in an Advance Health Directive or Living Will. These documents are used to indicate what an individual's wishes are and demonstrate what they would have done if they had capacity to make the decision, this assists friends and family and also to medical professionals when deciding on the course of action to be taken in relation to care and support.

2. Local Policy Context

2.1 North Tyneside Clinical Commissioning Group

2.1.1 Sustainability & Transformation Plans

All areas in the country have been required by NHS England to develop Sustainability and Transformation Plans (STPs). North Tyneside is part of the Northumberland, Tyne and Wear and North Durham STP, and part of the North Tyneside/ Northumberland Local Health Economy.

The STPs are the route map for how the local NHS and its partners, including Local Authorities, can make a reality of the Five Year Forward View, within the Spending Review envelope.

The foundations of our STP are based on the commonalities within our existing Health and Wellbeing Strategies and build on successful partnership working across New Care Models, Better Care Funds and other transformational programmes (e.g. Digital Great North Care Record). We have worked to ensure there is a clear alignment between our STP and the work of the North East Combined Authority Health and Social Care Commission.

We have identified that although we face distinctive challenges within each Local Health Economy, we also share many similar issues and ambitions. Therefore, in developing our operational plans and agreeing contracts we have worked in partnership with CCGs across our STP and the STP Programme Management Office to ensure alignment and reconciliation of each organisation's operational plan.

Our STP has been produced jointly with input and agreement to the assumptions used in all modelling work by all included Commissioners and Providers. It has identified a significant financial shortfall across providers and commissioners driven by an increasing demand for healthcare services and a healthcare budget primarily covering inflationary pressures going forward.

In order to close this gap, the system has developed a range of solutions that will make more efficient use of the resources available and ensure that patients are managed and treated in the right care setting at the right time.

2.1.2 North Tyneside CCG Operational Plan

The CCG is required to produce an Operational Plan which describes how it will meet national requirements, including the annually published national Planning Requirements. Our Operational Plan was submitted to NHS England in December 2016 and covers the period 2017/18 – 2018/19. In the Plan, we describe the NHS North Tyneside CCG Vision as follows:

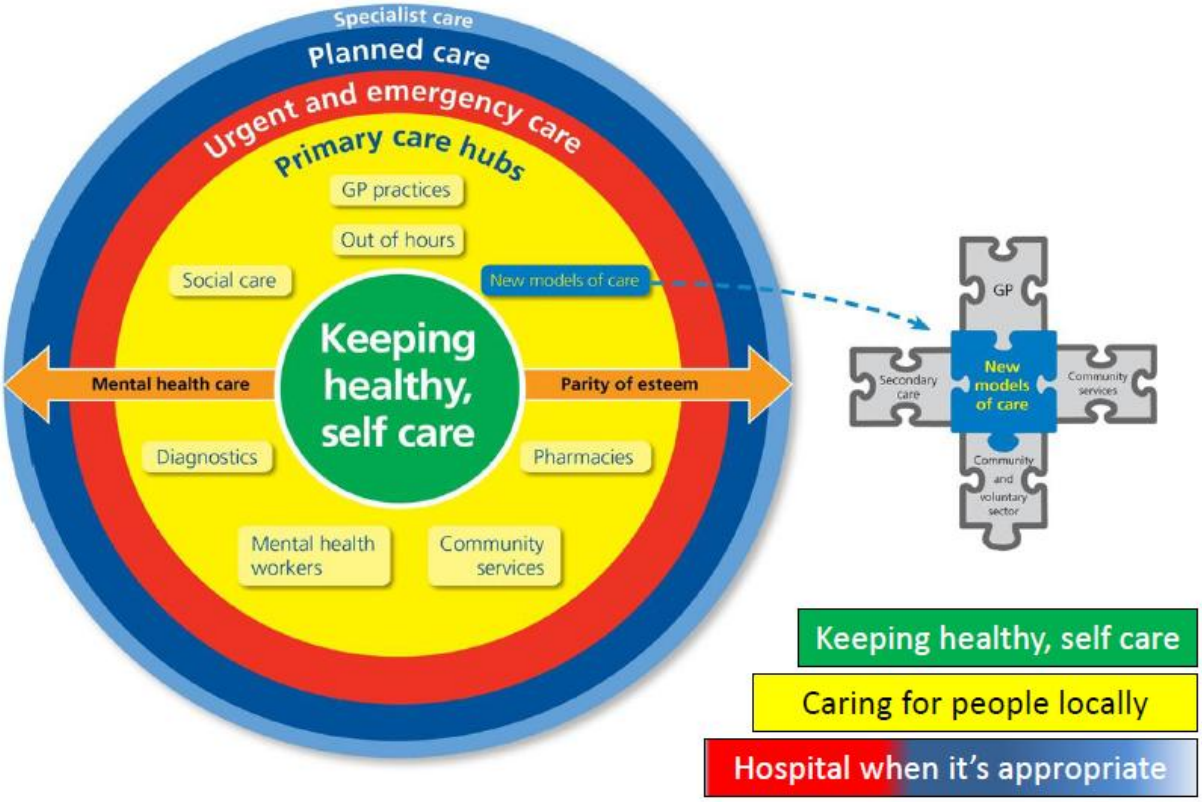
"Working together to maximise the health and wellbeing of North Tyneside communities by making the best possible use of resources"

The CCG's strategic vision is supported by ambitious plans to change the way that care is delivered by 2020/21 with specific focus during 2017-2019 to enable the schemes outlined in the Sustainability & Transformation Plan (STP) for our Local Health economy. The schematic and text below summarises our strategic priority themes for changing the health care system by 2020/21, working together with our partners, as follows:

- Keeping healthy, self care
- Caring for people locally
- Hospital when it is appropriate.

Improving and developing the integration of health and social care is also an important cross cutting priority for both the CCG and Local Authority.

Diagram 1 – NHS North Tyneside CCG Strategic Priority Themes



Our Strategic Principles are:

- High quality care that is safe, effective and focused on patient experience
- Services coordinated around the needs and preferences of our patients, carers and their families
- Transformation in the delivery of health and wellbeing services provided jointly with the local authority, other public sector organisations and the private and voluntary sector
- Best value for taxpayers' money and using resources responsibly and fairly
- Right services in the right place delivering the right outcomes

2.1.3 CCG Commissioning Priorities

In addition to our Operational Plan, the CCG also develops its annual Commissioning Priority Areas. Our Commissioning Priority Areas for 2017/18, will both build on the progress we have made to date in implementation of our previous Five Year Strategic Plan 2014/15 to 2018/19, and also how we will fulfil our commissioning obligations as detailed in the Northumberland Tyne & Wear & North Durham Sustainability and Transformation Plan.

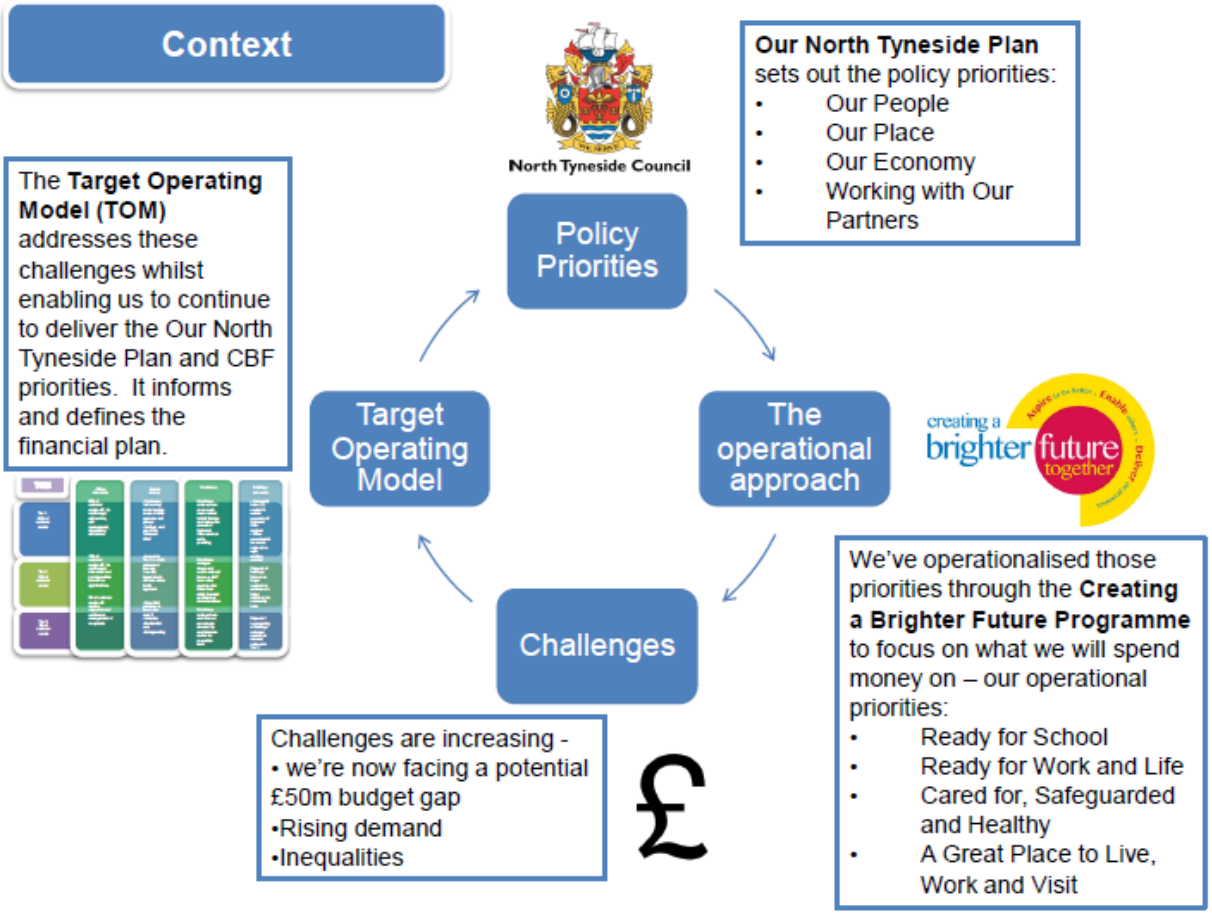
When developing our Commissioning Priority Areas 2017/18, we have taken into account how we will begin to address the 9 nationally identified "must dos" for as well as how we will progress on the national requirements to:

- Close the health and wellbeing gap
- Close the care and quality gap
- Close the finance and efficiency gap

2.2 North Tyneside Council Strategic Plans

2.2.1 Overview

The diagram below represents an overview of the Council's Plan incorporating its key priorities and interface with other plans and priorities.



The Local Authority has duties under the Care Act to assess and meet eligible needs for vulnerable people. New operating models are being developed across its social care services for adults and children which have early intervention and prevention at their heart.

In turn, this will enable people to live more independent lives and reduce the need for more intensive and costly interventions later on. Forging strong links with the NHS and the voluntary and community sector will not only help us offer a seamless, holistic approach to meeting the needs of North Tyneside's most vulnerable, but also prevent those less in need falling into crisis by supporting them to remain living independently in their community.

A joined-up approach across organisations that considers the needs of the whole person, rather than simply treating a particular condition, will help people that fall into crisis to quickly get the help they need so that they are able to return to independent living as soon as possible.

2.2.2 Our North Tyneside Plan 2018-2021

Our North Tyneside Plan sets out our bold ambitions for making North Tyneside an even greater place to live, work and visit by 2021.

It focuses on our three key themes – people, place and economy – and has 16 priorities for delivering positive opportunities for everyone in the borough.

These priorities were formed by listening to residents, businesses and visitors to develop a clear framework for directing the council's resources on the things that matter most to local people.

The plan is also focused on ensuring the council works better for its residents by improving how we do things and offering residents opportunities to volunteer, be more independent and do more for their local communities.

You can read the plan in full on the **council website.**

2.2.3 Creating a Brighter Future

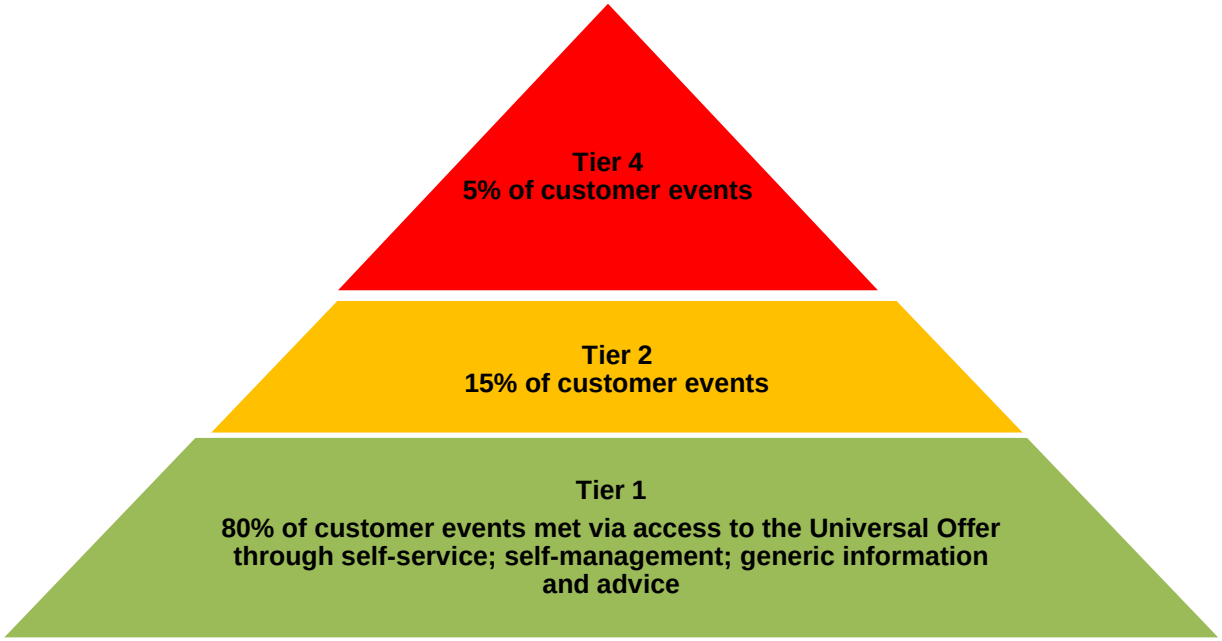
This is the operational programme that puts the Our North Tyneside Plan into place. The Cared For, Safeguarded and Healthy Board oversees the work programme of Adult Social Care, Public Health and part of Children's Services.

2.2.4 Target Operating Model

This is the enabling function to ensure the savings are achieved. We will do this by reviewing what we do and how we spend the money we have on meeting levels of need.

The principles that underpin this include:

- Understand and manage demand
- Enable people to help themselves
- Target resources at those who need it most
- Reduce long term financial cost to the tax payer
- Identify and exploit innovation
- Use technology to enable delivery and reduce long term costs



A major focus of the Council is to identify, at the earliest possible stage, the most vulnerable people in our communities who are at risk of poor health and likely to require social care. The aim is for them to be supported by programmes that promote their capacity to maintain an independent lifestyle.

Prevention and Self Care are two key principles which the local care and support system in North Tyneside will use to promote wellbeing in the borough.

Within Mental Health we have the Mental Health Reablement Service (MHRS)

The Department of Health's definition of Reablement is:

'the use of timely and focused intensive therapy and care in a person's home to improve their choice and quality of life, so that people can maximise their long term independence by enabling them to remain or return to live in their own homes within the community'

This approach focuses on re-enabling people within their home so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing support care.

The focus is on the promotion of independence and the building of resilience and includes:

- Skill acquisition and relearning of 'lost' skills e.g. development of a daily routine, cooking skills, budgeting
- Building confidence on public transport
- The development of social and support networks
- Support to develop self help skills e.g. WRAP (wellness recovery action planning/coping strategies).

Referral Criteria includes:

- Adults - no upper age limit
- Resident of North Tyneside
- Have either mental health or substance misuse issues which have led to a deterioration and is impacting on function
- Does not need a Crisis Response
- Will require the key worker to remain involved for all secondary care referrals & Care Co-ordination Team
- Assessment Information (Interim or Specialist) including the use of a 'Face' Risk Assessment (an assessment tool used following the assessment and/or review of risk, in accordance with local Risk Management Standards).

2.3 North Tyneside Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) informs the planning process of the demand and future need across the borough for different priority areas.

The **North Tyneside JSNA** is aligned to the Local Authority's Creating a Brighter Future Programme and the funding priorities across the Authority for vulnerable people.

2.4 North Tyneside Joint Health and Wellbeing Strategy

The **North Tyneside Joint Health and Wellbeing Strategy 2013-23** sets out how the partners across North Tyneside will come together to meet the identified and agreed priorities.

Improving mental health and emotional wellbeing is an identified priority in the strategy. The task of ensuring that the actions located within the action plan are achieved is the responsibility of The Health and Wellbeing Board.

The health and wellbeing priorities for North Tyneside that are relevant to this strategy are:

- **Improving Mental Health and Emotional Wellbeing**
  Focusing on maximising opportunities to promote positive mental health, wellbeing and recovery through accessible services and community support

- **Addressing Premature Mortality to Reduce the Life Expectancy Gap**
  Focusing on key interventions at a community and primary care level to reduce the difference in life expectancy within the borough

- **Improving Healthy Life Expectancy**
  Focusing on key interventions at a community and primary care level to reduce the difference in life expectancy within the borough

- **Reducing Avoidable Hospital and Care Home Admissions**
  Focusing on interventions in primary care, community and hospital settings to improve self management, personalised support and independence.

3. Demographic Data

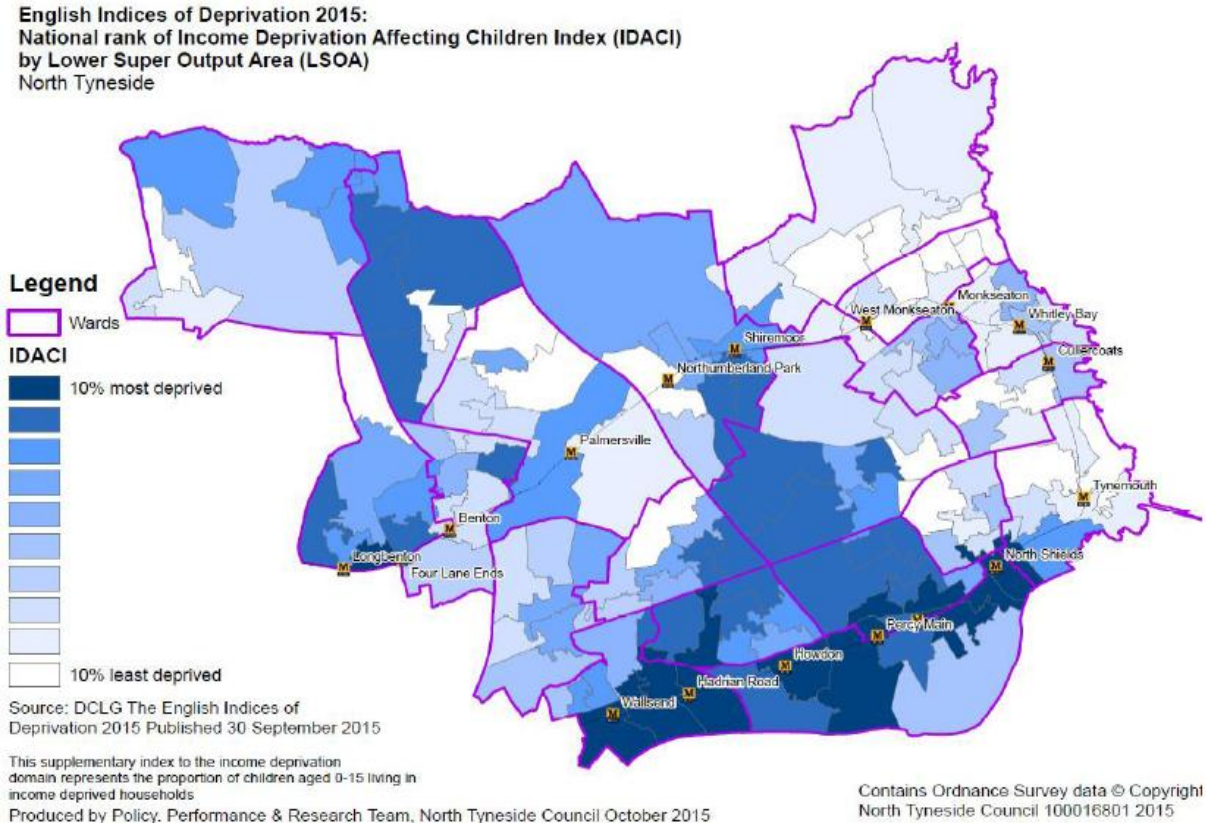
The North Tyneside resident population is around 201,400, which is greater than at any other period since 1981.

Key health indicators show that North Tyneside is in the bottom 20% of local authority areas in the country and rates of improvement are slower.

The most deprived communities generally have the poorest mental and physical health and wellbeing. Those people in lower income groups are less cushioned against risk and hardship. Increasing deprivation means that more people are being exposed to many of the associated factors of mental health problems, including unemployment, poverty and low levels of education achievement.

The map below shows which areas of the Borough are most deprived.

Deprivation



By 2030 it is predicted that the population in North Tyneside will increase by 10% to 221,100, an increase of 19,700 people[1].

The population of North Tyneside is growing year on year with an increasingly ageing population. North Tyneside has a slightly higher proportion of those aged 65 and over than the population of England (18.3% compared to 16.9%). The average life expectancy in North Tyneside is 79 years, which is; 77 years for males and 81 for females. Increasing life expectancy projections indicate an increase in the older population. It is estimated that the number of people aged 65 years and over will increase by 37% from around 39,400 in 2015 to 54,000 by 2030 and the number of people aged 85 years or over will increase by 56% from 5,200 in 2015 to 8,100.[2] These increases will create increased demand for social care, health and housing support and services.

[1] The Office for National Statistics 2012 mid-year population estimate
[2] ONS, sub national population projections, 2014

At 65 years, the disability free life expectancy (DFLE) in North Tyneside is significantly lower compared to England; in addition DFLE is significantly lower in the most deprived populations of North Tyneside. The proportion of people with a disability is also likely to increase with an ageing population creating additional demands for service provision.

Based on prevalence information, we estimate that there are around 2729 people aged 65 years and over who have dementia in North Tyneside, and that this will rise to around 4118 by 2030. One in six people over 80 years have a form of dementia[3]

Many people have multiple long term physical and mental health problems that impact on their quality of life and health. People with serious and complex mental health problems die on average 15 years earlier than people without mental illness. Smoking, diabetes, high blood pressures and obesity are the main factors that cause these early deaths.

People with mental health issues experience higher levels of unemployment and often live in poor quality accommodation. They also experience higher rates of disease, such as cancer and heart disease and also longer term conditions such as diabetes.[4]

4. Local Communication & Engagement

We recognise the importance of engagement to inform future service direction, including the proposals contained in this Strategy and Action Plan. The findings from a wide range of consultation exercises have informed the actions in this strategy.

In developing this Strategy, we have undertaken several communication exercises and used a range of information containing public and service user/patient feedback on service provision.

We reviewed the information obtained by Healthwatch North Tyneside in which they carried out research to gather the views and experiences of people who used Mental Health Services as well as their friends, family and carers. Over 250 responses were received however the focus of this work was not on older people in particular.

The research was followed by a Mental Health Action Day on 1 December 2015. The interactive seminar was attended by service leads, providers, carers, service user representatives, commissioners and board members from the HWBB and Mental Health Integration Board with the aim of debating and planning how all stakeholders could effectively work better together so that more people in North Tyneside can have "good mental health". The event focussed upon broad areas of Mental Health but had some specific focus upon: Prevention; Older Peoples Mental Health Services/Needs; Factors which impact upon individual's levels of Mental Health.

The full report can be accessed here People's experience of Mental Health Services.

[3] https://www.alzheimers.org.uk/download/downloads/id/2323/dementia_uk_update.pdf
[4] Annual report of Chief Medical Officer 2013 - Public Mental Health Priorities: Investing in the Evidence

Consultation on this document was held between 14th December 2017 and 9th February 2018. The comments and suggestions received have been incorporated to strengthen this document and also highlight the key issues that affect older people. This information is contained within Section 5 'Key Issues'.

Day Services Consultation

Additional specific work was undertaken around provision of day services and also dementia care services.

In relation to day service provision, the Community and Health Care Forum (CHCF) were asked to engage with people who currently use day services and their relatives and carers, which were undertaken during 2015. They held group discussions with users of the day services and also distributed questionnaires to unpaid carers.

Overwhelmingly people who use day services appreciate the opportunity to attend. Some of the reasons for using day services include; opportunities to socialise and make new friends; to "get out of the house"; and to give carers a break. There were many positive comments about the staff in the centres, who were considered to be very kind, caring and respectful. Customers were also appreciative of good quality food which is available at some resources.

Relatives and unpaid carers clearly value the opportunity to have a break from their caring role. Many use the time to catch up on housework and shopping, or to support them to continue to remain in employment.

Despite their popularity amongst older people, day services are often seen as an outdated model of service provision that does not reflect what would be wanted by today's older people. There is, however, substantial national and local evidence that many older people in receipt of personal budgets continue to choose to use day services and also satisfaction rates to those who use them are extremely high.

Post Diagnostic Support for people with dementia

In relation to dementia, in August 2016, North Tyneside Council officers met with a number of groups that support people with dementia and their carers to discuss what future support services may be of benefit to both users and carers.

There were many examples of the good practice and how people have benefitted from excellent health and social care services. However, there were also examples given when both health and social care services have failed both people with dementia and their carers. The main themes around areas where improvement could be made focus on inclusion of and support for carers of people with dementia. This particular point echoes feedback received from the Healthwatch research. Training and understanding of dementia for professionals was also highlighted which seems to result in people "bouncing" between services. Support from some statutory services and also from voluntary organisations was highly praised.

Issues that have been highlighted in all the above work have been used to develop the action plan that accompanies this document.

5. Key issues

North Tyneside has an increasing ageing population, some of whom are already in poor health and therefore at increased risk of developing mental health problems.

Many older people experience physical illnesses first and then develop common mental health problems such as depression and anxiety. An older person in good physical health has a relatively low risk of depression.

People who have serious mental illness are at greater risk of a range of medical conditions compared to the general population. They experience physical illnesses more frequently and in some cases also have a considerably shorter life expectancy compared to those without a mental illness.

In the development of this Strategy we feel that it is important to take various lifestyle factors into account, in addition to issues that are particularly relevant for older people. The following is a summary of the key issues that have been identified that are particularly relevant to older people and can have an impact on their mental health and wellbeing.

An **ageing workforce** will need good age management practices to meet the needs of all staff to ensure that they remain fit and healthy and can continue to work for as long as they are willing and able to.

The Advisory, Conciliation and Arbitration Services (ACAS) defines good age management as being 'those measures that combat age barriers and promotes age diversity'. This includes being aware of rights and responsibilities; awareness of team composition and existing issues; the provision of flexible working; good recruitment and retention practices; supporting health, safety and wellbeing; and encouraging informed retirement planning. Age is a protected characteristic under the Equality Act 2010.

Key issues

- Proactive age management is required to ensure older workers can continue to work to the best of their ability in fulfilling and productive ways as they age
- Although not all workers will experience health issues, the Work Foundation has forecast that one in three workers will be experiencing chronic ill health by 2020
- It has been proven that the most effective actions to allow staff to continue working are early intervention, discussion and planning the support they will need
- Flexible working, including different work patterns, will support older workers to work to a higher pension age
- Helping staff to make plans for their future career and retirement at an early stage, including consideration of flexible retirement options, is essential so they can make informed decisions
- Carers aged 60–69 often juggle caring with the demands of work and financial pressures while those aged over 70 may be more likely to find it difficult to cope with the physical demands of caring

There is a strong evidence that **good quality housing** can have a direct impact on health and the use of health and social care services for example; reducing seasonal

deaths and worsening of chronic disease symptoms related to the cold, improving mental health and wellbeing, reducing falls and supporting older people to live independently to reduce residential and nursing home admissions.[5]
A YouGov survey commissioned by Shelter[6] found that a big decision facing older people, particularly if they become less mobile and their care needs increase, is whether to stay in their current home or consider a move to a smaller home better suited to their needs. It found that older people value a safe home, an attractive welcoming area with good facilities, transport links and service, and where they will be close to friends and family.

As people age and remain in mainstream housing, general needs housing can become unsuitable for many. As their health deteriorates they may need support to remain in their homes in the form of aids and adaptations and health and social care services.

Demand for sheltered housing and extra care housing seems likely to grow in demand with an ageing population and it could be a very suitable option for many. However, for a lot of people there remains reluctance to accept that greater support is required; this coupled with upheaval means many prefer to persevere in their own home rather than move into sheltered accommodation or extra care.

The impact of **loneliness and isolation**, in respect of mental and physical health cannot be underestimated. We know that:

- The effect of loneliness and isolation can be as harmful to health as smoking 15 cigarettes a day, and is more damaging than obesity;
- Lonely individuals are at higher risk of the onset of disability; and
- Loneliness puts individuals at greater risk of cognitive decline, and one study concluded that lonely people have a 64 per cent increased chance of developing clinical dementia[7].

Feeling lonely isn't in itself a mental health problem, but the two are strongly linked. Having a mental health problem can increase the chances of feeling lonely, and feeling lonely can have a negative impact on mental health.

The North Tyneside Joint Strategic Needs Assessment highlights that just over 14,000 people, aged over 65, are currently living alone in the borough. The overall number of people who live alone is projected to rise by 13% by 2020 and for those aged over 75, it is projected to increase by 44% by 2030. Of those living alone, there are approximately twice as many women as men aged 65-74 years and three times as many women as men over the age of 75.

Smoking rates in North Tyneside are about twice as high as the general population and alcohol misuse and **obesity** rates are around 50% higher.

[5] Managing Ambulatory Care Sensitive Conditions Kings Fund 2012

[6] YouGov survey commissioned by Shelter 'A better fit?' April 2012

[7] Campaign to end Loneliness – Promising approaches to reducing loneliness and isolation in later life

The reason many older people give for stopping smoking is that they feel the damage has already been done and stopping would not provide any benefits. However the evidence is clear that stopping smoking at any age is of benefit.

Alcohol Consumption - 44% of the total number of hospital admissions related to alcohol were for patients aged between 55 and 74.[8]

For both sexes, rates of alcohol-specific deaths were highest among those aged 55 to 64 years in 2016.

Medication - For some people, medicines are a short-term solution used to help them manage an immediate crisis. For other people, medicines are an ongoing, long-term treatment that enables them to live with severe and enduring mental health problems. Many people do not want to stay on medication for years, but it can help some people to lead the kind of lives they want to lead, without relapses and re-admissions to hospital.

Although it may be quicker and easier to initiate medication rather than initiate other strategies such as talking therapies or exercise programmes,, which can be effective in many mental health problems, all medicines have undesirable side effects that people will experience to a lesser or greater extent and may have problems even when they stop taking the medication. In addition it is recognised abuse of prescribed medication for treating a mental health problem may cause additional problems.

The side effects of prescribed medication may mimic symptoms associated with mental illness in older people, such as confusion, insomnia or hallucinations. Many older people take some kind of medication, and often have multimorbidity (multiple long-term conditions) and take multi medication at the same time. This polypharmacy can increase the risks of suffering adverse side effects as a consequence.

Inactivity - Many adults aged 65 and over spend, on average, 10 hours or more each day sitting or lying down, making them the most sedentary age group.[9] Regular physical activity lowers the risk of a variety of conditions, including Alzheimer's and dementia, heart disease, diabetes, certain cancers, high blood pressure, and obesity.

High blood pressure is a key risk factor for stroke, which usually affects people over the age of 65. Regular activity and healthy eating can reduce blood pressure and also the risk of developing other health conditions such as Type 2 diabetes.

Weight problems affect many older people. The number of people who are overweight or obese is rising.

Taking regular exercise is especially important for older people. Older people have a slower metabolism, and this makes it more likely that they will put on weight which can affect their physical and mental health.

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[8] 2014/15 using a broad measure (where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis) *Statistics on Alcohol, England* - Health and Social Care Information Centre

[9] NHS Choices

The 2014 Health Survey for England showed the following groups as overweight or obese:

- 78% of men aged 65 to 74
- 80% of men aged 75 to 84
- Over 70% of women aged 65 to 84

However conversely, estimates suggest 1.3 million people over 65 suffer from **malnutrition**, and the vast majority (93%) live in the community. [10] Nearly one third of all older people admitted to hospital are at risk of malnutrition. [11]

Depression is the most common mental health problem in later life and affects one in five older people living in the community and 40 per cent of older people living in care homes. It can affect anyone, of any culture, age or background. This is because older people are much more vulnerable to factors that lead to depression, such as:

- being widowed or divorced
- being retired/unemployed
- physical disability or illness
- loneliness and isolation

In England depression affects 22% of men and 28% of women aged 65 or over[12]. The number of people aged 65 and over that are predicted to have depression in North Tyneside is 3,428. 1082 of those people are predicted to have severe depression.

The risk of depression increases with age 70% of cases of depression in over 70s may be caused by disability associated with illness. 40% of those over 85 are affected.

Moderate to severe depression occurs in 3-4% of the older adult population. The highest prevalence is found in those over 75. Worse general health can be associated with depression among older adults.[13]

Diagnosing depressive symptoms can be difficult, and reports indicate that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.

Dementia is a degenerative condition which has a wide reaching effect on the lives of those living with the condition and also the people that care for them. The chance of developing dementia increases significantly with age. One in 14 people over 65 years of age and one in six people over 80, have dementia.

Vascular dementia is the second most common type of dementia, accounting for 20% of dementia. Up to 30% of dementia is preventable through the same modifiable risk factors as for cardiovascular disease. These include; physical activity, healthy diet, reduced alcohol intake and not smoking.

[10] Elia M, Russell C. Combating Malnutrition: Recommendations for Action
[11] C A Russell and M Elia (2014) Nutrition screening surveys in hospitals in the UK
[12] Depression is defined as a high score on the GDS10 (Geriatric Depression Scale)
[13] General health status and vascular disorders as correlates of late-life depressive symptoms in a national survey sample. Stewart, R, & Hirani, V. International Journal of Geriatric Psychiatry, 25(5): 483-488, 2010

Most people living with dementia want to continue to do as much for themselves for as long as they can. People with dementia and those who care for them need access to timely and well-coordinated information, advice and support from diagnosis to end of life, which helps achieve the outcomes that matter to them.

From December 2017 everyone who has an NHS Health Check is made aware that the risk factors for cardiovascular disease are the same as those for dementia, including the message 'what is good for the heart is good for the brain'.

In addition to letting people know the risk factors are the same, everyone aged 65 – 74 will also be made aware of the signs and symptoms of dementia and be signposted to memory services if this is appropriate.

The purpose of the intervention is to raise awareness of:

- how people can reduce their risk of getting dementia and slow its progression
- the availability of memory services that offer further advice and assistance to people who made be experiencing signs and symptoms of dementia

Co-morbidities can complicate older people's access to appropriate services. There is the increased likelihood for those aged 65 and over to present with a number of both physical and mental health conditions. The King's Fund estimates that around 50% of people aged over 50 and 80% of those over 65 live with one or more long-term conditions.[14]

There are significant co-morbidities with a range of physical health needs. For example, 50% of people with Parkinson's disease suffer depression, 25% following stroke, 20% with a coronary heart disease, 24% with a neurological disease and 42% with a chronic lung disease.

It is estimated that approximately half of all in-patients in a hospital setting have a mental health condition which includes depression, dementia or delirium. If those co-morbidities are not addressed, it can result in poorer health outcomes and increased morbidity and mortality rates.

In January 2016 a review of **Intermediate Care Services** was signed off by the Older People's Transformation Board.

The review identified the following gaps in provision:

- Step up beds (for people in the community who are at risk of an inappropriate acute hospital admission)
- 'Discharge to Assess' or 'Time to Think' beds (with appropriate therapy input/ support) which would support the timely discharge of patients from an acute ward into an intermediate care facility, enabling a period of rehabilitation whilst assessments were being carried out or decisions were being made about the appropriateness of permanent placements into residential or nursing homes
- **Specialist intermediate care for people with dementia**

[14] A. Coulter, S. Roberts, A. Dixon, Delivering better services for people with long-term conditions: building the house of care, October 2013

- There were varying access criteria and routes across the system
- There efficiencies that could be made while still improving and delivering an effective service

A project group has been established to implement the new model of intermediate care.

(Older) people with a **learning disability** experience health inequalities, however many of the determinants of health inequalities sit outside health services, and are the result of the interaction of several factors including increased rates of exposure to common 'social determinants' of poorer health (e.g. poverty, poor housing, social exclusion), individual lifestyle factors, barriers to accessing health care and experience of overt discrimination[15]

Many are living with family carers who are themselves ageing and require support.

People with a general learning disability are 3-4 times more likely to get dementia than the general population. People with Down's syndrome are 50% more likely to have dementia when they are aged 60.

Learning Disability practioners report that rather than focussing on the needs of the person, many service providers see the learning disability first; this can result in the person being placed in accommodation that is not suitable or able to meet their needs.

Delirium is estimated to be present in 25-40% of patients presenting to the Emergency Department & in around 50% of those aged over 70 in hospital. It represents the commonest complication of hospitalisation in the elderly, leading to increased length of stay, increased risk of discharge into institutional care and increased mortality. Where delirium is characterised by its acute and transient nature, dementia causes chronic cognitive impairment. However, the two frequently co-exist in an inpatient population.

Vulnerability to delirium is conferred by advancing age, frailty, the effects of poly-pharmacy, hip fracture and high burdens of physical morbidity, including pre-existing cognitive impairment. For this high risk group, the insult can be comparatively minor, yet the consequences far-reaching. The risk of developing dementia following an episode of delirium is increased 3-fold and cognition in an established dementia can be irreversibly worsened.

Rates of recognition are notoriously poor (20-50%) and the precipitants are unknown in up 50% of cases – most often; the causes are multifactorial (including pain, infection, nutrition etc., following the PINCH ME acronym). Prevention is key, with interventions targeted at high risk groups. Person centred care approaches form the linchpin of management.

The number of older carers is growing at a staggering rate; almost one in ten people aged over 85 provide **unpaid care**. There are nearly 1.2 million carers aged 65 and over in England – an increase of 35% in just ten years, compared to an 11% rise in

[15] (Emerson et al, 2012)

the number of all carers, and a 4% rise in the number of carers aged 25-64 in the same time period. The fastest growing group is carers aged 85 and over, whose numbers have more than doubled, growing by a huge 128% in ten years to over 87,000.[16] The number of carers aged over 85 is expected to double over the next 20 years.[17] This group is often invisible, with many older carers providing long hours of vital care and support while their own health and wellbeing deteriorates, resulting in poor physical and mental health, financial strain, and breakdown in their ability to carry on caring.

- 55% of carers aged 85 and over provide 50 or more hours of care a week
- 32% of carers aged 65 to 74 are providing 50 or more hours of unpaid care a week
- Nearly 3 in 5 carers aged 85 and over are male
- 48% of carers aged 85 and over who are providing 20 or more hours a week say that they feel anxious or depressed
- 45% of carers aged 75 and over are looking after someone who has dementia
- 6 in 10 older carers who provide 50 or more hours care a week say their health is not good, rising to 75% of carers aged 85 and over

Specifically in relation to older carers, particular needs to consider are:

- Carers aged 60–69 often juggle caring with the demands of work and financial pressures while those aged over 70 may be more likely to find it difficult to cope with the physical demands of caring.
- Carers will be caring for people with a wide range of health conditions and disabilities, with varied emotional and physical demands and concerns for the future. [18]
- Over 16% of older carers in research in 2011 (The Princess Royal Trust for Carers, 2011) were caring for more than one person. This is more common for the younger age group 60–75 where significant numbers care for a parent as well as an adult son or daughter, grandchild or someone else with a disability or long-term health condition

Deterioration in carer health and wellbeing therefore is likely to increase demand on health and social care services for both the carer and the person with care needs. Preventative interventions to support the carer may therefore reduce the likelihood of increased future health, social care or residential care needs of both parties.

Some of the effects of caring on carers:

Mental health and wellbeing:
• Carers caring for more than one person
• Older carers working and caring

Physical health and wellbeing:
• Carers aged over 75

[16] Carers UK ‘Caring into later life The growing pressure on older carers’ April 2015
[17] HM Government 2014
[18] Carers Trust ‘Caring About Older Carers Providing Support for People Caring Later in Life’ 2015

Both physical and mental health:
• Older carers who need to do physically demanding caring tasks
• Older carers who often need to be up in the night
• Older carers of people with dementia or people with challenging behaviour
• Older carers who have little back-up from other friends or family
• Older carers who feel strongly about coping without outside support, or where the person with care needs is reluctant to accept help from anyone other than the carer

End of life care - It is recognised that people dying from advanced dementia have surprisingly comparable needs to those dying from advanced cancer. Yet people dying from advanced dementia are more likely to:

- die in an acute hospital ward or care home
- have uncomfortable aggressive treatments prior to death

They are also less likely to:

- be prescribed appropriate analgesia
- have spiritual needs addressed
- have an advanced care plan

Non-cancer diagnoses are very under-represented in specialist palliative care services and workload. This could partly be due to the lack of recognition of dementia as a terminal illness and its uncertain prognosis.

Healthcare workers providing palliative care to people with dementia face dilemmas. These can include:

- Differentiating between an aggressive medical approach and a palliative approach
- Assessing and managing pain and other symptoms
- Effective communication about end of life issues
- Families' perceptions
- Resuscitation (DNAR)
- Antibiotic use
- Artificial rehydration
- Admission to acute hospital
- Use of psychoactive drugs

Transitions

We need to ensure that the pathway from adult mental health services to older people's mental health services is as smooth as possible and barriers do not get in the way of enabling older people to access the right level of services at the right time.

Work has been undertaken between the CCG, Northumbria Healthcare trust Older Peoples Mental Health Service and Northumberland Tyne & Wear Service to review the interface between the two teams and to develop a needs lead service as opposed to an age led service.

Issues do still exist between the two trusts in relation to ensuring access to timely crisis support. Work has started to review those pathways but further work is needed.

6. Our Response

Our response to the key issues identified in section five fall into the following main areas:

1. Improving Health and Wellbeing
2. Prevention and Early Intervention
3. Community and Primary Service
4. Secondary Provision
5. Supporting Recovery & Long Term Care

1. Improving Health and Wellbeing	
Where we are now	**Where we want to be/what we will do**
▪ We understand the risk factors for older people; however there is no coordinated plan to address them. ▪ Community Mental Health and Wellbeing Matrons in North Tyneside have been trained to become Stop Smoking Advisors and are able to offer stop smoking medication. ▪ The Director of Public Health (DPH) 2015 Annual Report presented an overview of the health status of the over 50s in North Tyneside. ▪ TyneHealth provides the NHS health check programme to residents aged 40-74 years old. ▪ North Tyneside commissions North Tyneside Recovery Partnership (NTRP) to provide a treatment service for people who misuse alcohol and drugs. There is no upper age limit and NTRP are actively working to encourage older people into treatment and are in discussion with Age UK on how to identify and support older people to enter treatment	▪ Improved use of national and local intelligence to understand the current and future mental health needs of our local population - develop targeted approaches as required. ▪ Older people in North Tyneside have good mental health and resilience through interventions delivered by universal services and also targeted support is provided to those at higher risk of mental ill health. ▪ The DPH made a number of recommendations after reviewing the available data and from conducting interviews with older residents. A priority is to ensure that those who are in the pre-retirement phase are encouraged to plan for older age by being physically active and socially connected, to ensure that older people have a good quality of life and are independent and self-sufficient in older age. ▪ People with mental health problems and their carers will be supported to manage mental health problems and dementia effectively, to ensure that they live a full life and work towards achieving their own goals and aspirations. ▪ There are reduced levels of people that have mental health problems who smoke. ▪ Conduct a review of Active North Tyneside and ensure its contribution to

	mental health wellbeing is documented and core to its service offer. ▪ The North Tyneside Alcohol Partnership will bring the issue of older people and alcohol misuse to the attention of professionals working in the social housing, care and support providers. -The partnership aim to highlight current concerns and the national and local policy context, and to suggest ways in which the social housing, care and support sectors can work in partnership with the North Tyneside Alcohol Partnership to ensure older people have access to appropriate treatment and support; -A nominated team or individual will be established with a specific responsibility for housing and recovery; -Opportunities for joint commissioning and shared outcome frameworks for drug and alcohol and housing services should be explored to incentivise partnership work in support of recovery. -Development of consistent alcohol policies across social housing providers; -Alcohol services and older person's services and accommodation, and social landlords should explore opportunities for specialist housing schemes to support older people with alcohol dependency.
▪ Parity of esteem.	▪ Mental health inequalities across North Tyneside are reduced ▪ Increased interventions to build good wellbeing and resilience, including universal approaches for the general population and targeted wellbeing interventions for those facing particular risk factors. The aim is to improve health, social outcomes, reduce

	prevalence of mental illness and to support recovery. ▪ Targeted public mental health and wellbeing campaign to raise awareness of mental health issues, reduce stigma and also help the public in understanding their role in contributing to their own wellbeing offer to support others with such issues.
▪ 'Making Every Contact Count (MECC)' training programme to frontline staff is being rolled out.	▪ Ensure the 'Making Every Contact Count (MECC)' training programme is effective and making a difference to individuals.
▪ North Tyneside's Safe and Healthy Homes initiative is working to improve housing conditions. ▪ The team will work with residents of North Tyneside regardless of tenure. ▪ The team can fast track referrals for low level equipment and adaptations as well as assistive technology solutions to keep safe and promote independence in a person's own home. ▪ There is an interface between housing and adult social care to ensure that any identified needs are supported and met by the right resource.	▪ Improved living conditions contribute to improved emotional wellbeing for those living within these properties. ▪ Explore opportunities to provide advice, information and support regarding changes to the living environment to support people living with dementia and their families. ▪ The need for specialist Extra Care housing for people with dementia has been identified and will be explored further.
▪ Work has begun to make North Tyneside a Dementia Friendly Community (DFC). ▪ Safe Places have been introduced.	▪ Offer opportunities for local people to understand how they can contribute to the DFC agenda. ▪ Explore the use of contracts to encourage providers to contribute to the DFC agenda. ▪ Continue to roll out Dementia Champions programme. ▪ Need to develop a dementia pathway
▪ We have a North Tyneside's Commitment to Carers and Action Plan which outlines our approach to supporting carers in North Tyneside.	▪ The action plan is due to be updated in 2018. This update should include a review of the needs, identification and support for older carers particularly those over 85.

2. Prevention and Early Intervention	
Where we are now	**Where we want to be/what we will do**
▪ Care and Connect Community Navigators are in place. ▪ A New post has been introduced - Community Navigator Dementia and Memory Loss ▪ Primary Care Navigators have been introduced ▪ Healthy Conversations training is being rolled out for North Tyneside Council staff. This training is comprised of 4 tiers. Suitability for attendance of different tiers is dependent upon the level of contact staff have with residents	▪ Improved promotion of advice and information about self-help/self-care coping strategies. ▪ Support people to access online options to manage their lives in a variety of settings. ▪ Raise awareness of the importance of financial and future planning. ▪ Reduced use of secondary care services and increased use of community and primary care to support people. ▪ Community Dementia Navigator – use the findings to put permanent navigation arrangements in place for people with dementia and memory loss. ▪ Extend training provision to support the introduction of Healthy Conversations within the Community and Voluntary Sector. ▪ Continue to roll out Primary Care Navigator programme across all practices.
▪ A protocol exists between Northumbria Healthcare NHS Foundation Trust and Northumbria Tyne & Wear Mental Health Foundation Trust, to affect a needs led service rather than an age led service between adults and older people. ▪ Further work is needed on developing crisis pathways for older people in North Tyneside who are experiencing a crisis	▪ Work collaboratively across local services to deliver the right support at the right time to help people address the factors which prevent them from leading a full and active life. ▪ Improved identification of those at risk of developing mental health problems or dementia, supporting early intervention to help prevent reaching a 'crisis point'.

▪ Good examples of preventative services provided by Community & Voluntary Sector organisations in North Tyneside can be evidenced. ▪ A Pilot Project with Age UKNT, Tyneside and Northumberland MIND and VODA is testing out a new approach to providing community and voluntary sector preventative services (incorporating Social Prescribing) alongside the new customer pathway in adult social care.	▪ Develop a robust, integrated partnership approach with voluntary organisations to support our preventative and early intervention approach ▪ Evaluate the Pilot Project in line with the Five Ways to Wellbeing framework. Commission new model of preventative support. ▪ Ensure community and voluntary services are adequately resourced to support our approach. ▪ Explore opportunities for the delivery of a Social Prescribing Service.
▪ Active North Tyneside is being delivered through the sport and leisure team at North Tyneside Council. ▪ A range of universal activities are on offer ▪ A range of targeted interventions in communities where people are least active and where health inequalities are stark ▪ A well developed programme of health walks is available led by trained local volunteers. ▪ Community Health Champions (local volunteers who deliver positive health messages in their communities) are in place	▪ North Tyneside Council is working with Age UKNT on the Design in the Public Sector Programme. The focus of this work is enable physically inactive older people to become physically active.
▪ North Tyneside Carers' Centre provides support to all carers and also delivers additional condition specific courses and support groups. ▪ All carers have a statutory right to a Carer's Assessment on the appearance of need. ▪ The Local Authority has developed a Carer's Risk Assessment to identify carers at risk. ▪ A 'Think Family' approach is adopted in North Tyneside	▪ Ensure carers are fully supported to understand the condition of the person they are caring for and also to have a life outside of caring. ▪ Increase the numbers of good quality Carer's Assessments and robust support planning. ▪ A collaborative system wide approach is needed to ensure all carers (including young carers) supporting people over 65 are identified and offered appropriate support. ▪ Health & Social Care staff are fully trained to identify and support carers. ▪ Explore the opportunity to extend the use of the Risk Assessment for Carers as a tool to identify older carers at risk.

▪ Public Health, in partnership with the region's 12 local authorities, commissions the North East's Better Health at Work Award. This is provided by the Northern Regional TUC. To support this award Public Health commissions a service from Northumbria Healthcare NHS Foundation Trust to promote and support health and wellbeing in workplaces in North Tyneside. This Service expires in March, 2018 and will be re-procured with an added focus on positive mental health and reducing stigma.	▪ Increased sign up to the Better Health at Work Programme across North Tyneside to raise awareness of mental health promotion and stress management. ▪ Recognition of the changing landscape of an ageing workforce and define our approaches to support people as they manage work, health issues and caring responsibilities.
	▪ The key message that should be communicated is that 'what's good for your heart is good for your brain' and by adopting a healthier lifestyle people can reduce their risk of developing both cardiovascular disease and dementia.

3. Community & Primary Services	
Where we are now	**Where we want to be/what we will do**
▪ Work to develop improved access routes to community and primary services	▪ Primary care level locality hubs are developed with links to other community primary care services. The mental health needs of older people will be integral to this new service model
▪ The NHS England Improving Access Framework 2016/17 has rated dementia services in North Tyneside in the upper quartile of CCGs, which is very positive.	▪ Continue to work with GPs to maintain and improve the dementia early diagnosis rate ▪ Improve the dementia post diagnostic offer in North Tyneside for both people with dementia and their carers. ▪ Improve health checks in GP Practices for people with dementia
▪ An older peoples liaison psychiatry service operates in North Tyneside, ensuring that older peoples mental health needs are treated and managed alongside their physical health needs	▪ We will review this service to ensure it aligns with the “Core 24” model of liaison psychiatry based at the Northumbria Hospital. Older people will receive appropriate and timely intervention to address their mental health needs both at presentation at A&E and ongoing management if admitted into hospital.
▪ A Street Triage service is in place, which aims to improve access to mental health services and avoid preventable detentions when using section 136 of the Mental Health Act.	▪ Ensure equality of access to the street triage service for the over 65 population when needed.
▪ The North Tyneside Talking Therapies services (including IAPT) already meet the national Access target and waiting time standards and is now meeting the national target for Recovery.	▪ Continue to monitor the Action Plan between the CCG and the provider to ensure that the North Tyneside Talking Therapies service continues to maintain the national Recovery target. ▪ Ensure that the North Tyneside Talking Therapies service has the workforce, capacity and resources to ensure it meets the future national expectations on access.

	▪ Ensure that the older people including those in care homes can access the Talking Therapies Service.
▪ Intermediate Care - The Older Peoples' Partnership Board agreed a new model for the provision of intermediate care. Phase 1 of the new model begun in December 2016 with the development of a new 20 bedded community based Intermediate Care facility and adopting a multi-agency approach to deliver community based rehabilitation.	▪ Phase 2 will seek to further decrease dependency in acute bed usage and utilise and increase resources in community /social care provision. The change would also allow all key partners to strengthen the discharge to assess model, and increase in investment in community / home-care based intermediate care and rehabilitation, funded by a reduction in the capacity and acuity of bed-based provision.
▪ Older People with a Learning Disability – services are in place however additional work is needed in this area.	▪ Need to establish a 'baseline' for a person who has a learning disability, to support dementia diagnosis in later life. ▪ Need to skill up the workforce who support people with a learning disability to ensure that they can indentify and support people with a learning disability who may have dementia.
▪ Age UK are the main provider of post diagnostic support for people with dementia and their carers. The Service includes provision of Admiral Nurses ▪ The CCG has invested funding with Age UK for provision of an Admiral Nurse to provide post diagnostic support for people with dementia and their carers in North Tyneside.	▪ The CCG will regularly review the impact of this service. ▪ The Local Authority and the CCG will work with Age UK and other voluntary organisations to maximise potential funding opportunities.
▪ "Care Plus" is a "new models of care" programme targeted to frail elderly patients, commissioned by the CCG It aims to deliver high quality, cost effective care where inpatient hospital care is by exception. The Care Plus team is in place now comprising GPs, geriatricians, nurses, social workers, and admin support, serving the Whitley Bay locality of North Tyneside. The service has four key components:	▪ The CCG will roll out the Care Plus model of care across the other locality areas in North Tyneside.

1. Coordination of Care – to ensure patients actually receive the care they need when they need it and to eliminate waste and duplication. 2. Standardised Care - to drive consistency and high quality while leveraging systems that encourage clinicians to find the most cost effective solutions to meet patient needs. 3. Matching patients need with an appropriate care delivery model – patients with complex chronic diseases need a different kind of care than patients with injuries or simple episodic diseases and therefore the philosophy of directing patients into the right care model or delivery channel applies to clinicians as well. 4. Facilitate the development of health literacy- which will ensure that patients are supported to develop the confidence and knowledge to manage their own conditions ▪ The Care Plus Team has access to the older peoples liaison psychiatry team to ensure that mental health and dementia related needs are addressed	
▪ S117 ensures that councils and the NHS provide aftercare services, including a care home place if that is needed, for people who have been discharged from hospital having been detained for treatment under the Mental Health Act 1983.	▪ Ensure those people subject to a Section 117 receive an annual review.
▪ Extensive range of residential and nursing care provision is available for those unable to live independently in North Tyneside. ▪ An Enhanced Primary Care in Care Home scheme is in place to ensure all eligible patients are registered with an aligned GP practice in North Tyneside.	▪ Ensure that people in residential care are appropriately supported through continued joint quality monitoring processes. ▪ Where cognitive impairment exists ensure appropriate referrals to clinicians are made (not dependent on behavioural change). ▪ Expand the Medicines Optimisation in Care Home project through the Enhanced Primary Care scheme.
	▪ Improved early identification of older people who are released from prison is needed

4. Secondary Provision	
Where we are now	**Where we want to be/what we will do**
▪ Progress has been made with the two hospital mental health providers in North Tyneside, the CCG and the Council working together and forming a Mental Health Integration Board. We will expand on the foundations that this Partnership has laid to develop further integrated services and to continue to take an integrated approach to commissioning mental health services.	▪ Inclusion of mental health will be an integral part of the local Sustainability and Transformational Plan and will be a major contribution to parity of esteem with integrated leadership and collective accountability across the public sector. ▪ Review commissioning arrangements between the Local Authority and Clinical Commissioning Group, consider best practice and areas for joint / lead commissioning. ▪ Improve information sharing between mental health trust/acute trust and community psych services.
▪ We have developed an operational framework for transition arrangements between adult mental health services and older people's services.	▪ Transition arrangements and roles / responsibilities are defined and understood by relevant agencies and individuals. ▪ Review and update arrangements for access to crisis services between adult mental health and older peoples services
▪ A mental health reablement service is in place with specialist staff who have the skills and knowledge to prevent escalation to secondary mental health services. ▪ Advice and information is available for those that need outreach.	▪ Provide a proactive response to people with chaotic lifestyles. ▪ Continue to measure / monitor outcomes in relation to the services currently provided including the use of service user feedback.
▪ Personal social care budgets in place ▪ Direct Payments are in place for social care services but low take up by older people ▪ Personal health budgets are available but have previously been limited to people with learning disabilities and children with special education needs	▪ People have increased choice and control ▪ Increased numbers of people in receipt of a person health budget. ▪ Increased numbers of people in receipt of a Direct Payment ▪ Joint personal budgets (health and social care) are available and accessible ▪ Explore if the Alzheimer's Society Dementia Friendly Personal Budget Charter can be used to support us.
▪ NICE Guidance is available on the treatment of patients with delirium.	▪ Review policy and procedures to ensure NICE Guidance is being implemented

▪ Currently no Northumbria Healthcare NHS Foundation Trust policy on the management of delirium.	and achieved. ▪ Develop a policy on the management of delirium which includes referral for further assessment following resolution of an episode of delirium. ▪ Introduce the newly designed series of flowcharts which focus upon key areas (depression, anxiety, delirium, behaviour that challenges) to both nursing and medical staff. ▪ Develop a mental health champion scheme on the wards; the champions disseminate good practice within the clinical team – essentially principles of person centred care. ▪ The CCG will review current policies and pathways with the Northumbria Healthcare NHS Foundation Trust.
▪ Liaison Psychiatry services are in place. ▪ Dementia and delirium training including the challenges of nutrition is provided to all staff groups. ▪ Focused training to specific groups (i.e. portering staff) is provided which includes a session on delirium. ▪ NHCT participates in the Dementia Accreditation Process within care of the elderly wards across the trust.	▪ Need to improve general care of patients with dementia and delirium (including the environment, relative's access and support, nutrition etc) across acute services. ▪ Ensure adequate resources are in place to support people with dementia including the use of the third sector, families and carers.

5. Supporting Recovery & Long Term Care	
Where we are now	**Where we want to be/what we will do**
▪ Plans have been developed to improve community mental health services for adults in North Tyneside, reducing inpatient services and increasing community support services.	▪ GP's to support people in managing and maintaining their mental health when stable ▪ Work with Northumberland, Tyne & Wear Mental Health Trust to manage and implement the new recovery focussed model which will meet the principles and expectations identified by service users, carers and practitioners
▪ Crisis Care Concordat is in place	▪ Ensure that people are only treated in hospital settings when this is the best place for them to be, using a multi-agency approach to support people with mental health needs. We will review and update Crisis Care Concordat to ensure it remains pertinent and identifies key areas for improvement and development
▪ Suicide prevention action plan in place	▪ Review suicide action plan in line with the Mental Health Five year Forward View in relation to local suicide audit, trends, benchmark against other areas.
▪ Non-elective alcohol admissions in North Tyneside are falling but remain higher than the England average, which places a financial burden on the system	▪ Reduction of non-elective admissions for alcohol related conditions to below the England average for both activity and expenditure by reviewing how existing services can develop more effective joint working systems and pathways.
▪ Mental health services will also need to be effectively integrated with physical health care at both primary and secondary care levels to ensure that people with long term conditions and other physical healthcare problems are effectively supported.	▪ In relation to primary care provision, the talking therapies service in North Tyneside is a pilot area for expansion into long term conditions. The service is working with secondary care clinics to offer mental health support to people who have specific long term conditions. ▪ The Liaison Psychiatry service ensures that the mental health needs of older people who attend A&E or are admitted onto wards are addressed at the same time as their physical health needs ▪ In both examples, primary care and secondary care clinician's work alongside one another and further

	opportunities for such integration need to be explored.
▪ We have a growing population of people with ADHD and/or Autism and/or Learning Disabilities and need to ensure that mental health provision is appropriate to meet mental health and/or dementia needs as they also grow older	▪ Work with providers to ensure that staff have the skills, knowledge and experience to appropriately manage and treat the mental health needs of people with ADHD and/or autism and/or learning disabilities. ▪ Need to identify providers who can offer a mix of skills i.e. not solely learning disability or only dementia support ▪ Define our approach to support - understand that the staff team may need to change to support the person to continue to live in their own home – rather than residential care alternatives.
▪ During 2016/17, North Tyneside CCG worked with Northumbria Healthcare, who is working with Marie Curie, to deliver a range of expert care and support for people with complex, advanced terminal illness, and their families. The recently commissioned RAPID service aims to deliver a more responsive in hours and out of hours at home service.	▪ Continued improvement of responsive and expert support and care for people with complex, advanced terminal illness and their families ▪ North Tyneside CCG will develop a plan to implement the recommendations set out within North Tyneside CCG End of Life Strategy Achievements report (Feb 2016). This includes: - Working with GPs and support practices to increase percentage of North Tyneside Practice patients on the palliative care register to meet the national target. This will be achieved by proactive communications with GPs and users of the register evidencing how it is being used within practices. To undertake further Patient Voice/Unbiased User Surveys. - Maximizing our community assets moving more beyond the medicalised forms of delivery engaging the community. - Working with stakeholders to embed the principles and messages around End of Life education. - Reviewing Bereavement Services across all settings in North Tyneside

	ensuring that CCG managers cross reference current and future projects with regard to end of life. - Reviewing any projects relating to vulnerable and minority groups to ensure these people have equal access to services that support a 'Good Death'. - Establishing a target for an increase in the reported 15.23% of palliative care patients who have an emergency health care plan (EHCP).

7. Governance

This Strategy has been developed by a sub-group of the Mental Health Integration Board involving officers from the CCG and the Council.

The Strategy will be delivered through an implementation plan which will contain detail about what will be done, by whom and by when. It will be refreshed annually. The Mental Health Integration Board will monitor progress against the implementation plan and will also provide regular feedback to the Health & Wellbeing Board.

A number of other Boards exist which support decision making in North Tyneside. These Boards also have interfaces into mental health services. Collaboration with these boards will be required to ensure that the mental health needs of older people are being fully addressed. Relevant actions from our action plan may also need to be incorporated into the work plans of these other boards.

The following boards of specific note in relation to this Strategy are:

- Learning Disabilities Integration Board
- *Children and Families Integration Board*
- Carers Partnership Board

Appendix 1 – Current Services and Support

There is currently a wide range of mental health services and support available for older people in North Tyneside. Some of these services are specific for older people while a number are more generic but can also be accessed by older people with mental health problems and dementia.

The Local Authority provides and commissions a range of services which includes both social care services as well as support for older people in other areas such as housing and other accommodation.

A key feature of provision in North Tyneside is the co-located health and social care teams which offers the benefits of collaborative working and ensuring individuals social and health care needs are addressed at the same time, as far as possible.

At present North Tyneside CCG commissions older people's mental health services in North Tyneside from two different healthcare providers: Northumbria Healthcare NHS Foundation Trust (NHCT) through the Mental Health Services for Older People Service and Northumberland, Tyne & Wear NHS Foundation Trust (NTW). NHCT provides services to most of the borough except for the North West area which, instead, is covered by NTW Trust. Both Trusts were inspected by the Care Quality Commission in 2016, and both were rated as outstanding. The links to the full inspection reports can be accessed here:

NTW

Northumbria

As well as hospital services, there is a range of community and primary care level health services.

For the purposes of this Strategy we have provided a summary of the various services which are available. Some services are provided as a result of national requirements while others have grown organically to meet specific need.

The purpose of including this information is twofold. Firstly, it provides a comprehensive source of existing services. Secondly, it helps identify the gaps in current service provision and therefore will ensure that future commissioning is undertaken with a more strategic influence.

This will help us to be able to respond to the current and future challenges in North Tyneside with the aim of transforming mental health services for older people across the borough and will ensure we focus on improving outcomes for all and ensuring best value for money.

Improving Health & Wellbeing

Healthy Conversations

Healthy Conversations training is being rolled out for North Tyneside Council staff. This training is comprised of 4 tiers. Suitability for attendance of different tiers is dependent upon the level of contact staff have with residents.

Level 1 is an e-learning module

Level 2 delivered face to face.

Both courses enable staff to deliver basic healthy lifestyle messages, encourage people to change their behaviour and to signpost to local services for support.

Level 3 is comprised of individual workshops, covering Alcohol Brief Interventions, Healthy Eating and Physical Activity, Personal Resilience and Stop Smoking Brief Interventions.

Level 4 includes Blue Light training; Impact and Approaches to working with Treatment resistant drinkers.

Safe & Healthy Homes

North Tyneside's Safe and Healthy Homes initiative gives advice and guidance to help residents to solve health related housing issues and improve physical/mental health through referrals to relevant services and organisations.

The service targets vulnerable people who own or privately rent their property and can help with the following:

- heating issues, energy bills and fuel poverty
- damp and mould
- home safety - hazards and clutter
- outstanding repairs
- fire safety

Sheltered Housing

Sheltered housing is housing built for groups with varying needs. Accommodation is self-contained, but there are communal areas, such as the lounge, laundry room and garden. Sheltered Housing Officers support the schemes including the group dwellings in North Tyneside. The Care Call Community Alarm and Crisis Support Team are available 24/7 through an alarm system.

North Tyneside Council has undertaken a huge transformation programme of sheltered accommodation to provide modern, attractive housing that offers a quality lifestyle for older people. There are currently 922 new or refurbished 1 and 2-bedroom apartments and some bungalows over 26 schemes.

Due to the standard of accommodation and the partnership integration between Housing, Health and Social Care the residents are supported to remain in their homes for as long as possible with little to no need for adaptations. The CARE Point team are accessible to the schemes for minor injuries and prevention of admission to hospital initiatives. A falls prevention awareness programme has taken place in most of the schemes.

Smoking Cessation

For people with mental illness who smoke, stopping smoking will have the greatest impact on their health.

Mental health inpatient and community staff have a critical window of opportunity to identify people who smoke, advise on the most effective way of stopping smoking and either provide, or refer people for, specialist support. Community Mental Health and Wellbeing Matrons in North Tyneside have been trained to become Stop Smoking Advisors and are able to offer stop smoking medication. All NTW sites are now smoke free and some staff have also been trained to be stop smoking advisors.

Dementia Friendly Communities and Dementia Friends

Dementia Friends Information Sessions are run by volunteer Dementia Friends Champions, who are trained and supported by Alzheimer's Society.

Dementia Friends have some understanding about dementia and how they can help people living with the condition.

There are a number of Dementia Friends Champions in North Tyneside who have been delivering sessions locally to encourage others to make a positive difference to people living with dementia in their community. They do this by giving them information about the personal impact of dementia, and what they can do to help.

A Dementia Friendly Community (DFC) is a place where:

- It is possible for the greatest number of people with dementia to live a good life
- People with dementia are enabled to live as independently as possible and to continue to be part of the community
- People are met with understanding and given support where necessary

Age UK North Tyneside and North Tyneside Council worked in partnership to test out how this concept could be developed locally. Wallsend is currently formally registered with Alzheimer's Society as a DFC.

Prevention & Early Intervention

There are a range of additional initiatives, services and support currently being provided in North Tyneside which supports older people to maintain good mental health, prevent loneliness and isolation and continue to be linked into their communities. Many of these services are provided by the community and voluntary sector using a variety of funding sources and some receive statutory funding.

Information Advice and Self Help

The care and support advice and information offer within North Tyneside covers all conditions and support needs and aims to be as accessible as possible.

The main source of advice and information can be found on the North Tyneside Council website in **My Care**

My Care provides useful advice and information about the care and support offer locally, including;

- The adult social care offer
- Community living
- Disability information
- Health and wellbeing, and much more.

Care and Connect

Care and Connect provides advice and support to help people to stay independent. Support is provided by telephone or face to face in community settings.

The Service offers tailored and detailed knowledge of the local care and support system and information and access to the Council's adult social care system, where needed.

Signposting Information Guidance Network (SIGN) North Tyneside

SIGN North Tyneside (**S**ignposting, **I**nformation, **G**uidance **N**etwork) is a network of Council and community and voluntary sector providers of free, independent and confidential information on adult health and wellbeing services locally. The organisations work together to put people in need of practical or emotional help and guidance, in touch with those local organisations best able to provide it. Members can direct, signpost and support people to access groups, activities and resources in their area.

The SIGN Directory is available through My care. The online directory brings together information about activities, events and services for residents living within North Tyneside. It can help you find out what's happening in the local area. You can also find out about support and equipment for your home, activities and events within your community, and services to meet your care and support needs.

North Tyneside Carers' Centre

North Tyneside Carers' Centre provides support to both young and adult carers. They are a network member of Carers Trust.

They have specialist Carer Support Workers who support carers to recognise the impact of their caring responsibilities on their own health and wellbeing. They can provide individually tailored advice, information and support and also carry out carers assessments on behalf of North Tyneside Council.

They provide a range of peer support groups and training for carers free of charge, which are designed to give carers the skills and knowledge to cope confidently in their caring role.

Safe Place Scheme

The Safe Place Scheme is supported by North Tyneside Council and Northumbria Police. A Safe Place is a public building, like a shop, a bank, a community centre or a church, where the staff have been trained to help members of the Safe Place scheme. It is for people who may be vulnerable as a result of their physical or mental health, because they have a learning disability or have been subjected to some form of verbal or physical abuse whilst out in public. The scheme supports members to get out into their communities and feel safer knowing that support is available.

Active North Tyneside

Evidence demonstrates that an active life is essential for physical and mental health. In addition regular physical activity can protect against conditions like depression, obesity, hypertension, cancer and diabetes. Active North Tyneside is a programme funded through public health and delivered through the sport and leisure team at North Tyneside Council. Active North Tyneside aims to improve the health and wellbeing of residents in the borough by increasing participation in healthy lifestyle interventions and more specifically increase participation in physical activity.

There are a whole range of universal activities offered by North Tyneside Sport and Leisure services with a range of targeted interventions via the Active North Tyneside programme in communities where people are least active and where health inequalities are stark.

In addition many of the Active North Tyneside programmes contribute to improving mental health and wellbeing by promoting inclusion and participation e.g. encouraging and supporting young men who are not in education, employment or training to increase participation in physical activity and enhance mental wellbeing. Another programme supports young women.

The borough also has a well developed programme of health walks, which are led by trained local volunteers. Community Health Champions are local volunteers who deliver positive health messages in their communities.

Prevention Services Pilot

Adult Social Care is working in partnership with a number of organisations in the Community and Voluntary Sector to pilot a new preventative 'offer' to residents in North Tyneside, many of whom have low to moderate mental health problems.

Organisations involved in the pilot include:

- Age UKNT (Befriending; Social Prescribing; and One to One Service)
- Tyneside and Northumberland MIND (Social Prescribing)
- VODA (Good Neighbours Project)

The following is a brief description of the services involved in the pilot:

Befriending - Age UKNT – this service is open to older people 50+ who are extremely socially isolated and unable to access their communities. They are matched up with a volunteer befriender who will visit them for around an hour or two a week for a chat in their own house. This service has no time limit and is expected to be permanent.

Social Prescribing - Age UKNT & Tyneside & Northumberland Mind

Social prescribing involves empowering individuals to improve their health and wellbeing and social welfare by connecting them to non-medical and community support services.

North Tyneside Social Prescribing Service aims to link people in with activities in their community to improve their wellbeing. People are supported to access a variety of physical, social and creative activities, and the person has the involvement of a Coordinator throughout their time in service, which is expected to be around 3 – 6 months.

Age UK North Tyneside and Tyneside & Northumberland Mind use their specialist knowledge and work in partnership to deliver the service to anyone over the age of 18 who lives in North Tyneside who has a genuine need for improvement in wellbeing. People who are being referred in must be at the stage where they would like to participate in activity outside of their home.

Good Neighbours - provided by VODA (Voluntary Organisations Development Agency) - involves volunteer good neighbours to support vulnerable, isolated North Tyneside residents with practical, household tasks, errands, shopping and informal social contact.

North Tyneside Recovery College

VODA is working in partnership with NTW NHS Trust to develop a recovery college which will offer free courses related to mental health and well-being. Courses are open to all and the first prospectus will run between September and December 2017

Mental Health Reablement Service (MHRS)

The Mental Health Reablement Service offers short term timely and intensive community intervention, free of charge, for approximately six weeks. The MHRS may be extended for up to 12 weeks following a review and includes:

- Pre and post discharge from an inpatient setting
- Relapse prevention
- A recovery goal/outcome focused approach
- Whole family approach

Input varies from two to seven sessions a week, with the average length of each session being 1.5 - 2 hours. Support can be provided at evenings and weekends. Input can be flexible and can be more intensive at first and gradually reduced over time.

The focus is on the promotion of independence and the building of resilience and includes:

- Skill acquisition and relearning of 'lost' skills e.g. development of a daily routine, cooking skills, budgeting
- Building confidence on public transport
- The development of social and support networks
- Troubled Families Champions
- The identification of activities specific to the person that support a Recovery approach, use of Recovery Star
- Support to develop self help skills e.g. WRAP (wellness recovery action planning/coping strategies).

Technology

There are a range of products and services available that can improve the functionality of the home to create a place of safety, promote independent living and ensure a good quality of life for the person cared for and also their carer.

Equipment is available to support people with many daily living tasks. There is a large range of equipment available; this can include equipment to help people feel safe, help with communication and social isolation, helping people to be independent and less reliant on others to complete daily tasks.

Equipment can be provided to give people and their families piece of mind that things are going well, however if there are problems, sensors and pendants are provided to allow help to be called, this can be an automatic call for help or by pressing a pendant.

North Tyneside Council have a dedicated tele-care team who will support you to look at all area's of daily living, they will also recommend or signpost you to equipment that will support you to feel safe and to be more independent.

Extra Care

Extra Care housing provides more independence than a care home. Extra care schemes are purpose built or an adapted building that is age and disability friendly in design and decor and accommodation is self-contained. One key fundamental feature of an extra care scheme is that there is a care team on site 24-7.

Extra care schemes in North Tyneside are targeted at those who are 55 or over and have a care need, as assessed by Adult Social Care.

The costs e.g. rent and service charges, to live in extra care are determined by the landlord of the scheme. The costs for care are set by the Council. The Council has a contract with the care provider on site.

There are nine extra care schemes across the borough which support around 350 people. There are a mix of accommodation options with bedsits, 1 and 2 bedroom flats. There is a mix of tenure options where a person can either opt in to shared ownership or tenancy.

One of sheltered schemes has been convereted to extra care and rehabilitation.This has been a huge success for the residents who live there or who access the rehabilitation flats. A team of care staff are based on site along with two rehabilitation officers.

Making Every Adult (MEAM)

We have operated Making Every Adult (MEAM) in North Tyneside for four years. It is a multi-agency panel that discuss referrals for people with multiple and complex needs who would often in the past have fallen through the gaps. The panel includes representation from the Police, Probation, Drug and Alcohol Treatment Services, Housing and Mental Health. We also invite other agencies if relevant to particular clients. Our supported housing contracts have been changed to reflect the needs of this group of people and to ensure access whenever possible. The supported housing providers are key partners as without somewhere to live it is difficult to scaffold other services, such as treatment services around the person. The panel also are flexible wherever they can be, in the way they deliver services to this often difficult to engage group.

Primary & Community Services

Community and Voluntary Sector

Many innovative services are provided by our voluntary sector colleagues and play an essential role in mental health promotion and supporting people to self–care, stay well

and out of hospital. These services are community based and often provide preventative support to individuals to promote inclusion; reduce isolation; retain housing; or manage finances. It is important that these services are promoted and professionals are aware of them.

GP Offer

GPs, practices, and the extended primary care team (community matrons, nurses, physiotherapists, pharmacists, mental health workers, occupational therapists, and dieticians) are all available to support mental wellbeing in later life. Practices offer a range of appointments; routine, review, same day, telephone; with a wide range of professionals.

Everyone with a Long Term Condition (LTC), such as dementia/diabetes/asthma; is offered a routine checkup every year, which includes a brief assessment of mental health.

Everyone on repeat medication has regular medication reviews, which includes any medications for mental health. Pharmacists, both in the community and in practices are involved in keeping medications safe and effective.

If people become housebound, then care is offered at home. This is particularly relevant to end of life care, and includes measures to maintain mental health and wellbeing.

People often stay with the same GP practice for the long term, so there is continuity of care, and the reassurance of familiarity.

GP's refer into various services to support people to remain well: social prescribing, exercise on referral, self–help leaflets and groups.

NHS Health Check

The NHS Health Check programme aims to promote and improve the early identification and management of individual behavioral and physiological risk factors for vascular disease and the other associated conditions. It also supports individuals to manage and reduce behavioral risks and associated conditions through information and evidence-based clinical interventions.

Under the Health and Social Care Act 2012, responsibility for commissioning and monitoring the programme passed to local authorities. Therefore, there is a legal responsibility for local authorities to offer a NHS Health Check to 100% of their eligible population every 5 years. They must also demonstrate year-on-year improvement in uptake.

Public Health commissions TyneHeath to provide the NHS Health Check.

Post Diagnostic Support for People with Dementia

A Community Navigator for Dementia and Memory Loss post has been established as part of the Care and Connect Team in Adult Social Care. The Navigator provides dedicated support to people with dementia, memory loss and their carers.

The aim is for this person to develop expertise in this area; map out the current provision to ensure we have an accurate picture of what is available; and also to provide time limited support to people with dementia and their carers to access appropriate community services. We hope that this will strengthen the current offer of support for people with dementia and memory problems.

The role includes the following key aspects:

- Work into the community to support developments and build community capacity for people with dementia or memory loss and their carers;
- Offer unbiased advice and information;
- Provide assisted signposting;
- Reduce loneliness and isolation by empowering local communities to develop their own solutions; and
- Care and support planning for adults if needed.

The role includes actively encouraging the person living with dementia or memory loss and their families/carers to develop 'circles of support' in their community and so enhance their quality of life.

Age UKNT Dementia Services

Age UKNT is the main provider of post diagnostic support for people with dementia and their carers in North Tyneside.

Their specialist Admiral Nurse Team provides expert practical, clinical and emotional support to families living with dementia.

North Tyneside CCG has commissioned an Admiral Nurse from Age UKNT and there are two additional Admiral Nurses which Age UKNT has acquired funding for. The service operates from Cedar Grove Wellbeing Centre in Wallsend; people can self refer or be referred through a health or social care professional, who feel they will benefit from the service.

The service provides one-to-one practical, clinical and emotional support and expert advice for people living with dementia and their families and carers, dealing with more complex issues including loss and bereavement.

The Lead Admiral Nurse also provides consultancy, liaison and specialist dementia education to professionals to improve dementia care in a variety of settings.

The Dementia Service also offers one to one support through additional dementia workers, offering advice and support to people with dementia and their carers to help

them navigate services and put practical measures in place to help them cope with the disease.

Improving Access to Psychological Therapies (IAPT)

North Tyneside IAPT Service provides psychological therapies (sometimes known as talking therapies) to patients who are registered with a North Tyneside GP. It is part of a national government programme to Improve Access to Psychological Therapies (IAPT) offering free, confidential services.

The service provides a single point of access and self-referral process for counselling, psychological education groups and courses, computerised CBT (Cognitive Behavioural Therapy) telephone and face to face guided self-help, individual psychological therapy and group psychological therapy.

People can self-refer into the service and some evening and weekend appointments are available.

The service also offers an Employment Advice Service which is part of IAPT initiative. Employment Advisers can work with clients who are currently employed and working but at risk; currently employed; and not working or currently unemployed; and looking to re-enter the workplace.

Street Triage

In June 2015, a street triage system was introduced in North Tyneside. This means that a mental health nurse will accompany police to an incident where it appears that someone is experiencing a mental health crisis in a public place. By being able to provide direct intervention and signposting, the number of detentions that the police had been making using their s136 Mental Health Act powers has reduced significantly and, crucially improved outcomes for the person experiencing the crisis. Also people detained under the Mental Health Act are not being held in police cells and instead are being taken to an appropriate place of safety to be assessed and treated.

Day Services

An Older People's Day Services Framework is in place.

The Framework consists of five providers who deliver services across seven sites:

- Age UK North Tyneside
- Dementia Care
- St. Anthony's of Padua
- St. John Ambulance
- Tynemouth Village

Between them, these organisations offer a range of building based day services including specialist provision for people with dementia. All services provide a range of stimulating activities; some services provide specialist equipment and are able to support people with a range of disabilities; some offer daily trips out to local places of interest and provide additional opportunities for older people to make links with the wider community that might not otherwise be possible.

Home Care

Home care is one of several services that can be offered to people assessed as needing social care support. The range and type of services classed as home care vary but may include support with personal care, activities of daily living and essential household tasks. This support can help people to stay independent and to take part in social and other activities. Home care is primarily funded by local authorities or the person themselves, but can also be funded by healthcare commissioners. Home care services are provided by independent home care agencies, local authorities and personal assistants.

Older people are now living longer and are being supported to live at home independently. However as people are living longer they are becoming frailer and have more complex needs. The support older people require relates to both health and social care and includes strokes; dementia; falls; medication support; physical difficulties; transition from hospital to home; support for those with no family or friends and for those who are socially isolated.

There is currently a joint contract in place with the North Tyneside CCG for a Framework of Home Care Providers, who deliver care to approximately 1000 people at any one time. 50 people are classified as requiring Continuing Health Care.

Approximately 11,000 hours of care are delivered per week and people receive on average approximately eleven hours of care per week.

The current framework contract is due to expire on 3st March 2019 and a procurement exercise is planned for the autumn of 2018.

North Tyneside Care Plus

Care Plus is a partnership between health services (hospitals, community and GP Practices), Social Care and Age UK who will work together to provide:

- Coordinated proactive and reactive care for a stratified population defined as severe or moderate on the frailty index.
- Core General Medical Service sub contracted services for patients whilst registered within the service.
- Promoting independence guided conversations and support via Age UK Promoting Independence Coordinators and volunteers.

North Tyneside Care Plus is aligned to local and national strategy and builds on local existing service developments and locality working in North Tyneside.

Aims

1. To ensure health and social care work more effectively together to deliver person centred seamless care delivery – ensuring patients tell their story once and care is coordinated regardless of provider.
2. Deliver early interventions so that older and disabled people can stay healthy and independent at home – avoiding unnecessary hospital admissions and reduce A&E visits.
3. Deliver care that is centred on the individual needs; rather than what the system wants to provide.
4. Provide integrated support to carers.
5. Improved outcomes for both patients and the health economy.

Residential and Nursing Care

Care homes offer accommodation and personal care for people who may not be able to live independently. Some people may need nursing care which is provided by qualified nurses, some homes may specialise in caring for particular conditions.

Many people with dementia move into a care home when their dementia progresses to a certain stage. Some people with dementia have other illnesses or disabilities that make it difficult for them to remain at home. Good quality care that preserves dignity, treats people with respect and promotes independence.

Care Homes are required to register with the Care Quality Commission (CQC) who use registration to check whether care providers can meet a number of legal requirements. These include fundamental standards of quality and safety. Once a service has registered, CQC monitor them to ensure standards are maintained.

North Tyneside Council conducts Quality Monitoring visits at least annually to ensure that homes provide good quality services that safeguard those who use them.

Care home places can be funded publicly but many people pay for their own care.

A specialist nursing service is in place for end of life patients who live in North Tyneside nursing and residential homes. The objectives of the service are to:

- Support people to die in their usual place of residence
- Increase the quality of healthcare through a nursing home training programme
- Implement advance care plans and emergency healthcare plans for anticipated emergencies and exacerbations
- Reduce inappropriate hospital admissions at the end of life or palliative phase
- Reduce A&E attendances

Hospice at home (rapid response end of life service)

The aim of this service is to ensure all patients in non-palliative settings receive emergency palliative care, trying to keep people in their place of choice, offering

emotional and practical support for carers and family members as well as specialist input where needed. Emergencies may arise from changes in condition, symptom problems, anxiety, distress or social crisis.

The CCG worked in collaboration with Northumbria Healthcare NHS Foundation Trust and Marie Curie, to develop three teams across the patch, backed up by a consultant for the whole area. This allows for economies of scale and also ensures sufficient back up with each other where there are pressure points.

The service model consists of two components. The first being a band 5 palliative care nurse and a band 3 Health Care Assistant providing a dedicated rapid response service. The second component will require a band 7 specialist nurse practitioner backed up by a consultant to deliver specialist palliative care input. This is designed to build upon existing work e.g. GPs and District Nurses in the community, nursing home staff and hospital ward teams to enhance the urgent and emergency palliative care delivery.

The new service has included some internal reconfiguration with the current specialist palliative care team and matched funding with Marie Curie will allow for a comprehensive multi-disciplinary palliative care team which can respond to patients needs urgently and allowing care to be delivered at home. This will prevent avoidable admissions and facilitate admission to and discharge from the palliative care unit where appropriate.

Secondary Care

Memory Clinics

Northumbria Healthcare NHS Foundation Trust provides Memory Clinic 3 days a week, located within the Priory Day Hospital in North Shields. A full assessment is undertaken by a consultant psychiatrist and the team to develop a plan of treatment. A thorough assessment of memory is undertaken with referral for further investigations if needed.

The Trust also runs a six week course called the Carers Information Group which is delivered one evening a week, and runs twice a year. Also on offer is a Memory Strategy Group which is a six week course, one afternoon a week for carers and people with dementia. This is repeated throughout the year with new starters every six weeks.

Northumberland Tyne & Wear NHS Foundation Trust offers a Memory Assessment Management Service (MAMS) which provides a memory assessment and diagnosis of people with dementia to people who live in the North West area of North Tyneside and is based at the Campus for Ageing and Vitality.

Liaison Psychiatry Services for Older People

The Older People's Liaison Psychiatry Team works into the older people's wards and rehabilitation wards at North Tyneside General Hospital. The team aims to provide timely assessment, effective intervention and appropriate input into the care of older

people who present/are admitted and who have a mental health need. It is expected that this will improve the quality of care provided to older people who attend North Tyneside General Hospital who are thought to be suffering from mental illness while being treated as an inpatient for physical health problems.

Another remit of the team is to provide education and training to all hospital staff on older people's mental health. Evidence shows that considerable improvements can be made to older people's mental health by non-direct liaison psychiatry staff, if they have received appropriate training and therefore have an understanding of older peoples mental health needs.

The team are involved in multi-disciplinary team meetings therefore older peoples mental health needs are being addressed at the same time as their physical health needs. As a consequence of the team's involvement, there has been a reduction in length of stay and a reduction in readmissions of this cohort of people.

Intermediate Care and Rehabilitation Services

Intermediate Care is a range of integrated services which promote faster recovery from illness. A range of services provided by North Tyneside Council, Northumbria Healthcare NHS Foundation Trust and the Independent Sector are available which together form part of a range of health and social care support enabling patients who are most vulnerable to admission to hospital or long term care to remain living as independently as possible for as long as possible in their own homes and to support discharge and transition in to care facilities where their own home is no longer appropriate.

These services are overseen by a core multi-disciplinary intermediate care team led by a senior clinician and is closely linked with rehabilitation and reablement services in social care.

In-Patient Services

A range of inpatient services is provided by Northumbria Healthcare NHS Foundation Trust, for both older people with dementia and older people with other mental health needs such as depression and anxiety and other complex conditions. These are provided mainly at North Tyneside General Hospital.

A range of therapies are provided, depending on the needs of the patient for example medication, participation in talking therapies or group work. The aim is to ensure that a plan of care is developed to reduce the effects of patient's symptoms on the quality of their lives.

Forensic Services

Northumberland, Tyne & Wear NHS Foundation Trust is the provider of in-patient forensic services.

Supporting Recovery & Long Term Care

Mental Health Reablement Service (MHRS)

See previous entry Mental Health Reablement Service (MHRS)

Intermediate Care

The new Intermediate Care model in North Tyneside is a 'Home First' model and is comprised of a Community Rehabilitation Team, a Primary Care led community based 20 bedded unit at the Royal Quays Intermediate Care Centre and in-hospital beds at North Tyneside General Hospital (acute intermediate care provision and a transition unit) all of whom work in partnership with CARE Point for full access to a range of services to support the wider intermediate care pathway. The service aims to facilitate a safe discharge home from hospital and can provide rehabilitation at home or people can access bed based provision if they are unable to be discharged directly home.

The Royal Quays Intermediate Care Centre (RQICC) is delivered in partnership with Akari, North Tyneside Local Authority, Northumbria Healthcare NHS Foundation Trust and Primary Care, commissioned by North Tyneside CCG. Its aim is to deliver intermediate care bed based provision in a care home facility with appropriate care and nursing support. It is:

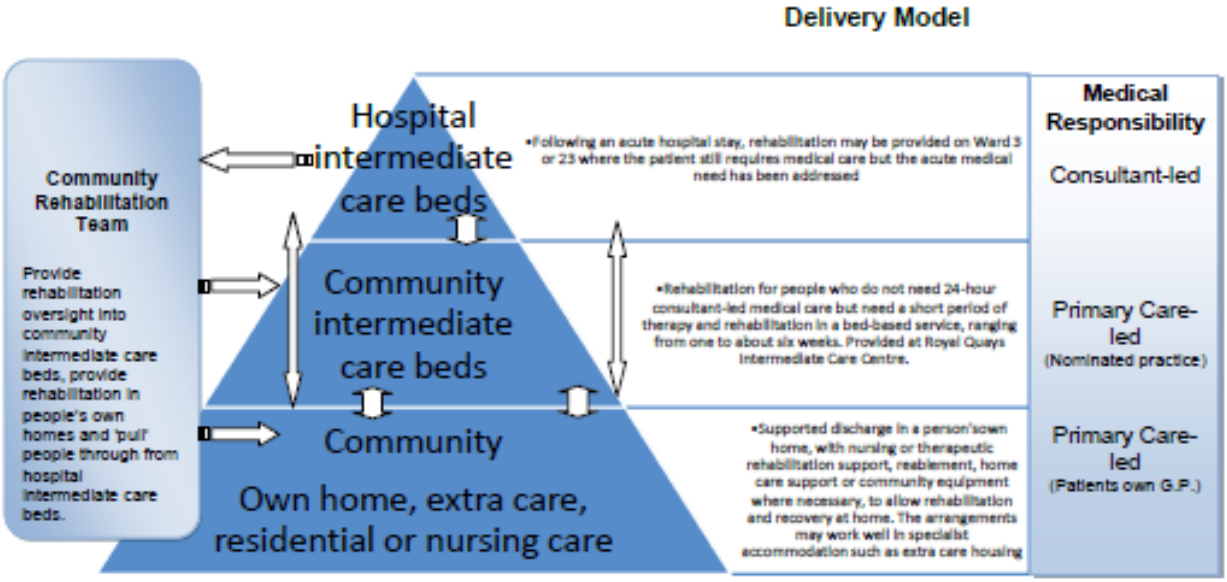
- Targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential and nursing care, or continuing NHS in-patient care;
- Provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
- Has a planned evidence based outcome of maximising best achievable function and maximal attainable physical, psychological, social function and independence; enabling the client to resume living at home wherever possible;
- Facilitates an effective flow through the intermediate care pathway, ensuring people receive proactive care and are only admitted to a bed-based service when they are unable to be rehabilitated at home;
- Is time-limited, normally no longer than 2 to 4 weeks but a maximum of 6 weeks dependent on need.

The RQICC involves multi-agency working as part of the wider model of intermediate care, working with G.P.s, community healthcare staff (such as physiotherapists and occupational therapists) and community rehabilitation workers.

The Community Rehabilitation Team work to 'pull people' out of hospital and can provide rehabilitation in people's own homes, they can work into the RQICC to facilitate a smooth discharge home and they can also work with people in the community to help prevent an unnecessary hospital discharge. This is done in partnership with other CARE Point services such as the Reablement Team, Hospital to Home Team and the Admission Avoidance Team.

The Transition Unit at North Tyneside General Hospital provides an appropriate environment for people recovering from an acute in-patient stay who might be considering a move to permanent care.

The diagram below describes the new model, phase one. It is due to be reviewed in 2017.



Community Services provided by Northumbria Healthcare NHS Foundation Trust, provide home based assessment and treatment of older people with mental health problems. The service endeavours to raise the profile of mental illness in older people, to provide education and support to carers, and to help improve the detection of mental health problems in older people. There is also a Care Home team that supports residents in care homes.

Crisis Resolution and Home Treatment Service is provided by NTW and operates 24 hours a day, 7 days a week. A treatment plan will be developed which could provide a range of support to help patients manage their situation and prevent them from being admitted into hospital.

Patients need to be referred by their GP to access the service and the service also offers support to families and carers.