



Devon Older People's Strategic Partnership

FUTURE DEVELOPMENT OF MENTAL HEALTH SERVICES FOR OLDER PEOPLE

Final Report: April 2005

Key Proposals and Recommendations

- Centrality of Primary Health and Social Care as the Initial Access Point for Assessment and Support.
- Development of Fully Integrated Specialist Community Mental Health Teams
- Access to Dedicated Organic and Functional Mental Illness Beds
- Rationalisation of Inpatient Units to Support Critical Mass and Dedicated Provision
- Review of Inpatient Bed Numbers in Light of Community Developments and Benchmarking
- Development of Specialist Home Support Services
- Needs based Access to Adult Mental Health Services such as Crisis Resolution Home Treatment.
- Development of Community Services that Supports Recovery and Social Inclusion
- Information and Communication Strategy To Support Service User and Carer Empowerment
- Development of and Sustained Support to an Older Person's Mental Health User and Carer Network
- Leadership Across all Partner Organisations at PCT Area and Pan PCT Area Level
- Commissioning Expertise and Capacity at a PCT and Pan PCT Level

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**This Report accompanies the Executive Summary December 2004
which includes the Key Proposals and Recommendations**

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Section One

Project Background

Devon Older People's Strategic Partnership together with Torbay PCT and Local Authority have commissioned the Sainsbury Centre for Mental Health to facilitate a process for arriving at locally owned set of proposals and recommendations for the development of older people's mental health services.

The project has been funded by Devon County Council, Torbay Borough Council, Devon Partnership Trust and Torbay, North Devon, East Devon, Mid Devon, South Hams and West Devon, Teignbridge and Exeter Primary Care Trusts (PCTs).

The broad scope and specific outcomes expected of the project are:

Scope and Overall Aim of the Project

Propose a Service Commissioning and Provider Framework for Older People's Mental Health across Devon and Torbay.

To engage with all stakeholders including service commissioners, providers, local organizations and service users and carers.

To address issues of:

- Equity of access
- Consistency of outcome
- Implementation and achievability across short medium and long term time scales

Specific Outcomes

- Ensure service users and carers experience a quality services.
- Sustainable service user & carer involvement.
- Sustainable Staff involvement.
- Define essential components for a comprehensive Older People's Mental Health Service.
- Service improvements meet national policy and local needs.
- Make most effective use of all resources available.
- Map/analyse current service, organisational and management arrangements.
- Describe current and possible future integration arrangements.
- Benchmark services across Devon and Torbay
- Workforce planning, learning and development.
- Recommendations for evaluation framework for implementation.
- Seamless service across care pathways inc. transitions and boundaries.

The project aimed to evaluate the effectiveness of all current older people's mental health services, including organic mental illness for under and over 65 years and

functional mental illness for over 65 years, identifying strengths to be built upon and areas for further development. It considered the range and type of services required, how individual services worked as a whole system to provide clear care pathways, and how future developments could be planned for and implemented effectively. In addition the project considered how older people's mental health services link with primary care, acute hospital services and adult mental health services and how there could be improved integration between health and social care.

Comprehensive Approach

A comprehensive approach with three clear phases was adopted. The initially proposed six-month period was extended to incorporate further data analysis and to allow sufficient time for boards' sign off.

These three phases followed local launch events, which were designed to ensure all stakeholders were informed about the project in advance and thus able to contribute fully during the process.

Phase One

- Undertook one to one and group interviews with all key stakeholders in order to scope out the issues, establish a baseline for current services and identify initial ideas on proposals for future development.
- Undertook specific and dedicated engagement with service user and carer groups and representatives to establish a process for involving service users and carers throughout the project and beyond.
- Initiated a local data collection process with information to be available for analysis during phase two and three.
- Information from stakeholder interviews and data collection was analyzed against existing local reviews, audits and national policy and good practice, to provide an interim report that will help direct phase two.

Phase Two

- Development of full proposals and recommendations informed by a series of themed workshops that related to the issues and needs generated out of the above analysis. These workshops involved a cross section of all stakeholders and focused on designing whole systems solutions and specific service initiatives. These were also to be supplemented by some targeted sessions with local service user and carer networks and groups.

Phase Three

- Detailed data analysis to support production of final proposals and recommendations.
- Final report production bringing together information from above together with national evidence and policy.
- Presentation of initial findings with outline proposals and recommendations to the Devon Older People's Strategic Partnership Group and a Torbay health, social care and wider stakeholder workshop.

- Sign off from partner organisation boards of executive summary
- Dissemination of agreed proposals and recommendations to all stakeholders throughout February.

Section Two

National Context

In developing a new vision for older people's mental health services in Devon and Torbay it is important that the widest possible view is taken of how local communities and services should respond and plan. This wide view is underpinned by national policy, guidance and research, key aspects of which are summarised below:

National standards

- National Service Framework (NSF) for Mental Health (1999)¹
- National Service Framework for Older People (2001)² -(see *summary standards from combined NSFs below*)
- National Standards, Local Action – Health and Social Care Standards and Planning Framework 2005-08 – the core standards here are not optional. All the standards can only be achieved when they apply equally to all groups within a community regardless of age, disability or ethnic origin.³

National Guidance on Treatment and Support

- NICE Guidelines for treatment of dementia; depression; schizophrenia
- Supporting people with long-term conditions – an NHS and social care model to support local innovation and integration. The aim of this new model of care is to improve the health and quality of life of people with long-term conditions, prevent premature death and reduce emergency admissions.⁴
- The Rowan Report. This report, published by CHI in 2003, concerned allegations of physical and emotional abuse of vulnerable older people by staff on Rowan Ward (Manchester) and made several recommendations. The Royal College of Psychiatrists has issued guidance on recognising and addressing institutional abuse risk factors. It highlights in particular the risks associated with units that are physically, clinically, educationally and managerially isolated from the community.⁵

Support and promote independence and social inclusion; reduce inequalities

- Mental Health and Social Exclusion (2004).⁶ The social inclusion agenda recognises that loneliness, social isolation and poverty constitute major problems for older people and also seeks to build 'community capacity' so that individuals and families have options other than professional public services.

¹ Department of Health (1999) *National Service Framework for Mental Health* DH London

² Department of Health (2001) *National Service Framework for Older People* DH London

³ Department of Health (2004) *National Standards, Local Action – Health and Social Care Standards and Planning Framework 2005-08* DH London

⁴ Department of Health (2004) *Supporting People with Long Term Conditions* DH London

⁵ Royal College of Psychiatrists Faculty for the Psychiatry of Old Age (2004) *The Rowan Report: Implications and Advice*

⁶ Social Exclusion Unit (2004) *Mental Health and Social Exclusion*. Office of the Deputy Prime Minister

- Choosing Health (2004) – national agenda for public health and health promotion⁷
- Delivering Race Equality in Mental Health Care (2005) – an action plan for reform inside and outside services⁸

Recovery orientated, aspirational service provision

- *The Journey to Recovery* (2001) sets out the government's vision for modernised mental health services within the context of an optimistic, positive approach to people who have mental health problems, where recovery is based on service user and carer aspirations⁹
- The NHS Choice agenda together with the introduction of direct payments by local authorities should support this vision

Promoting active citizenship

- *All Our Tomorrows* (2003). This discussion paper published by the Association for Directors of Social Services and the Local Government Association sets out an approach towards supporting older people and their carers based around focusing on strengths and contributions, adopting community development approaches to the development of health and social care provision, looking beyond health and social care services to the broad range of support options and opportunities that exist for all citizens.¹⁰
- The recently published Green Paper on adult social care endorses this community development approach and seeks to foster an approach to social care that enables vulnerable adults to take greater control of their lives, within the context of a debate on balance in risk management.¹¹

Support for carers

- The Carers' Act (1995), subsequent legislation, guidance and the carers' grant have emphasised the importance of support to informal carers.

Balance in favour of home based provision

- Forget me not – Audit commission (2000 updated in 2002). This report on older people's mental health services in England and Wales recommended a shift in the balance of care in favour of home based services. It found that whilst most people prefer to be supported in their own home, most of the expenditure in older people's care still goes on hospital, nursing home and residential care.¹²
- The NHS Plan (2000) sets out a vision of a patient centred health service and requirements relating to the development of intermediate care.¹³

⁷ Department of Health (2004) *Choosing Health – Making Healthy Choices Easier*. DH London

⁸ Department of Health (2005) *Delivering Race Equality in Mental Health Care* DH London

⁹ Department of Health (2001) *The Journey to Recovery*, DH London

¹⁰ Association of Directors of Social Services, Local Government Association (2003) *All our Tomorrows – Inverting the Triangle of Care*

¹¹ Department of Health (2005) *Independence, Well Being and Choice: Our Vision for the Future of Social Care for Adults in England: Social Care Green Paper*. DH London

¹² Audit Commission (2000 and 2002) *Forget me Not – Mental Health Services for Older People*

¹³ Department of Health (2000) *NHS Plan* DH London

Shift in provision from secondary to primary care

- Primary mental health care is increasingly seen as central to the provision of both mental health and primary care services. Introducing details of the new graduate primary care mental health worker posts and additional community mental health staff (gateway workers) proposed for primary care, the NHS Plan says:

'Most mental health problems are managed in primary care. One in Four GP consultations are with people with mental health problems. So improving these services will have a major impact on the health and wellbeing of the population.'

- The primary care policy agenda provides opportunities to develop local enhanced services, GPs with a special interest and practice based commissioning, all of which could facilitate an increased capacity within primary care to support people with mental health problems across the age spectrum.

Improved partnership working

- Local Government Act (2000) led to the development of Local Strategic Partnerships. These bring together public, private, voluntary and community sectors with the aim of reducing health inequalities and social deprivation by better local coordination.
- Health Acts 1999 and 2001 have provided opportunities to pool budgets between health and local authorities.
- At the service level there is now a plethora of policy and guidance on the establishment of integrated, multi agency teams to facilitate seamless service delivery.

Outline standards for commissioning mental health services for older people

The Older People's NSF identifies older people with depression and dementia as two priority groups for care improvement. However, commissioning and service development plans in mental health services for older people need to recognise that older people have as wide a range of mental health difficulties as working age adults. The increasing proportion of the national population living longer makes this recognition vital. On this basis, the Older People's sub group of the National Mental Health Partnership has proposed a standards based framework for commissioning mental health services for older people which is derived from joint consideration of the Working Age Mental Health NSF and the Older People's NSF¹⁴.

Whilst these standards require a useful reference for mental health provision across the adult spectrum, it is important from a commissioning perspective to remain aware that both the relevant National Service Frameworks are very focused on health care provision. The challenge is to find ways of commissioning universal services on a joined up community wide basis and specialist services on a system wide joint agency basis.

¹⁴ National Mental Health Partnership – Older People's Sub Group (2005) Briefing No 2

NPMH Standards

Standard One – Health promotion

Older people and their carers should be able to access general and mental health promotion and education services and information from community access points, through primary to acute in-patient and continuing care. All should work to promote the social inclusion of and independence of older people with mental health difficulties.

Standard two – Primary care

Older people and their carers should be able to receive effective assessment, recognition and treatment for common mental health problems and for signs of severe mental health difficulties, including depression, psychotic problems and dementia, in primary care.

Standard three – Crisis

Older people with mental health difficulties and their carers should have access 24 hours a day, 365 days a year, to advice, support and crisis intervention services.

Standard four – Community Teams and Care coordination

Older people identified as requiring assessment and/or treatment for severe mental health problems, including dementia, and their carers, should have timely access to integrated health and social care community mental health teams, and through coordinated care under the SAP or CPA to the full range of physical and mental health and social care and treatment resources required, supported by evidence.

Standard five – Intermediate and In-patient care

Older people in need of mental health assessment or intervention should have access to intermediate and in-patient services, with a full range of evidence based psychological, social, medical and personal care delivered in a culturally sensitive manner and aiming to support the individual into the most independent living circumstances possible.

Standard six – Liaison across the care system

Where older people in sheltered housing, generic day or residential care, or acute hospital care suffer from, or require assessment for, mental health difficulties, they will receive sensitive and effective care from the staff in such units and have timely and effective access to primary and specialist mental health care.

Standard seven – Specialist placements

Where an older person's mental health difficulties are complex and severe, and require longer term care in a residential setting, specialist placements will be available, supported by specialist older people's community mental health services and primary care.

Standard eight – Suicide prevention

An element of each locality suicide prevention strategy will involve special attention to the evidence relating to, the risk factors relevant to and action to prevent suicide in older people.

Standard nine – Carers

Carers of older people with mental health difficulties should be supported with information, advice and breaks as key partners in care, and as people requiring assessment, and often care, themselves.

Section Three

Phase One Feedback

This part of the project was designed to ensure all stakeholders had an opportunity to share their views on the problems facing older people's mental health services, identify positive aspects to be built upon and express initial ideas on how the service might be developed. The information from that first phase is reported here and elements incorporated into the proposals and recommendations made.

The main issues identified were used to set the topics for the second phase workshops. These workshops were a very important part of the process in that they afford an opportunity for stakeholders to come together and develop local solutions to some of the difficulties identified in the first part of the project. The workshops facilitated by SCMh and the ideas developed form the basis of the proposals and recommendations made. Nonetheless a brief summary of the main points that emerged from phase one is provided.

Main Issues Raised

Commissioning and Planning Framework

Perhaps one of the most commonly identified issues was the lack of clarity about how older people's mental health services were planned. Issues involved lack of understanding about the process, lack of transparency about how decisions were made, lack of financial transparency between commissioners and providers and lack of an obvious champion to fight the corner for older people's mental health against other competing priorities. This for many had led to a history of ad hoc service development, lack of equity in provision and consistency in outcome and difficulties in agreeing or communicating a shared vision for the future.

The outcome was a 'postcode lottery' for service users & carers based on historic differences in service infrastructures and resource base perpetuated by seven different NHS commissioning arrangements.

Partnership Working

Linked to the issues around planning and commissioning and perhaps one of the causes for not establishing effective planning and commissioning arrangements was the belief that there is a very complex set of partnership working arrangements across Torbay and Devon. The first and most obvious point was that Torbay and Devon is a huge geographic area with different local needs, histories and priorities. The area covered by the project includes two Local Authorities, seven Primary Care Trusts, one Mental Health Trust and three Acute Hospital Trusts. All have a desire to see services improved but have had different views on how this might be achieved and the priority areas for development. One ambition for the project that many supported was the development of a shared vision of the future across all the partner organisations supported by clear planning and commissioning arrangements and strong leadership. Coupled with this however was the need to ensure local sensitivity in responding to local need and circumstances.

Resources and Gaps in Service Provision

Not surprisingly the issue of resource shortfalls was extensively raised. There was also added concern given recent consultation on the Devon Partnership Trust financial recovery plan.

The specific nature of the issues varied across different Primary Care Trust areas as some had more developed services than others did. However, there were common concerns about staffing levels within community teams and especially inpatient and residential care units. This impacted upon service availability, response times and quality of care provided and the physical environment in which it was delivered. In addition, all areas fell short of having a comprehensive spectrum of care. Not all areas have community multi-disciplinary teams, most have gaps in terms of the range of residential care and nursing care environments required including intermediate care and there are significant shortfalls in both rapid and intensive community support services. Other areas needing development included extra care housing initiatives, advocacy services, out of hours provision, early interventions, services for younger people with dementia and services for people with more complex needs and challenging behaviour.

Despite these concerns many people recognised that the overall resource available, much of which was either locked up in historic service patterns or not linked across the partner organisations, could probably be used differently. Therefore, there was some optimism that these resource difficulties could be significantly addressed.

However, what was seen as vital to achieve this was:

- Clarity and ownership of a comprehensive shared model.
- A planning and commissioning structure empowered to refocus existing resources.
- Better value from pooled resources and better use of targeted new resources.

New Service Model

The variance of service availability and outcomes across Devon and Torbay did provoke significant concern. This concern manifested itself in different ways; however, there were some common elements. There was felt to be little current consensus on what the range of services might look like and the proportionate amount of individual service to make up a comprehensive system. There were also concerns about what the relationship of those service elements would be to each other and how they might support clear and accessible care pathways for service users and carers. Some saw potential tensions that revolved around the degree to which services were bed and building orientated compared with being community based. Others focused on the linkages and interfaces between: primary and secondary care; health and social care; mental health services and wider community services such as housing; and older people and adult mental health services.

Finally there were issues about the value base of the service, with potentially conflicting ideals about how service provision might be more needs based, locally determined and provided, socially inclusive and holistically orientated.

What did become clear from these comments was that there was a desire to achieve some clarity over the service model that delivered on maximum ownership but which also moved the service forward.

Integration

The need to consider issues of integration between the partner organisations emerged across a number of themes including future planning and commissioning arrangements, resource allocation and the development of specialist multi-disciplinary teams. Most notable was the need to consider how the workforce of the health and social care organisations and the resources they commanded might be deployed and managed in a more joined up way. For many, this meant that there was a need for unified specialist teams, single line management, integrated policy and procedures and pooled or aligned budgets.

Geography

Large parts of Devon are rural with dispersed and sometimes isolated populations. Providing a comprehensive service model across such geography was for many people interviewed a significant challenge. Potentially issues of geography would impact upon the design of a new service model however there was a clear desire to explore innovative ideas around transportation and linkages with wider community services to off set that impact as much as possible.

Stigma and Discrimination

There was significant consensus across all stakeholder groups that issues of stigma and discrimination have adversely affected the development of older people's mental health services. In addition to the general impact stigma has on mental health, many believed that service users and carers within older people's mental health have suffered additional discrimination by virtue of it not having the national priority afforded to adult mental health. Consequently there is a marked difference in the range of mental health services available to people under sixty-five as opposed to those over that age. In addition, the linkage with older people's services has not improved access to generic provision as many of those services have little detailed understanding of mental health needs and in some cases are fearful of providing care for people with complex functional illness or dementia. It was common to hear views that expressed concern about older people's mental health being lost: neither owned nor prioritised within mental health or generic older people's services.

Workforce

There was a general recognition that making any significant improvements in older people's mental health would not just impact on the workforce but was reliant upon its development. Issues of recruitment and retention as well as skills development were obviously seen as crucial. However, issues of support and involvement in future service development were also seen as essential if long establish working arrangements and cultures were to be challenged and modernised. Finally, it was also acknowledged that the skills mix and professional profile of the workforce might also have to be reviewed if service capacity was to be increased and community alternatives developed.

Service User and Carer Needs and Involvement

A multitude of issues were identified in terms of services being more responsive to needs and service users and carers feeling properly engaged both on an individual care planning basis as well as a service development basis. Key areas for consideration included:

- Availability and communication of information about diagnosis, prognosis, treatment options and detailed care plans including crisis response.
- Clear description of the full range of available services and their access arrangements
- Greater choice in treatment and support options linked with communication and information to enable empowered decision making
- Greater clarity and simplicity about how the system works especially in regards to issues of charging and care pathways
- Improving the complex and little understood process of engagement in respect of assessment of need, care planning and health and social care services
- Involvement in planning and service review.

Positive Areas to be Built Upon

As illustrated above, a significant range of issues was identified during the first phase consultation. However, all stakeholders felt there were some real positive areas upon which future service developments could be built around. Key amongst these was an acknowledgement of the need to change and an enthusiasm to explore new partnership opportunities and service responses. There was a general recognition of the need to strengthen community alternatives and a realisation that a range of innovative local developments across different parts of Devon and Torbay offered learning opportunities for agreeing what some of these developments might look like. Finally and perhaps most importantly there was awareness and an appreciation of the dedication, enthusiasm and skill within the workforce. It is this strength of workforce coupled with a genuine commitment to work in partnership and explore innovative change that provides a solid foundation for future service development.

Section Four

Outcome of Phase Two Workshops

Programme of Workshops

First phase engagement identified a range of issues and partner organisation aspirations which SCMh detail in section two. These issues were used to set the agenda for phase two workshops. Workshops were organised around the central issues and themes with the expectation that they would develop locally owned solutions that all stakeholders could sign up to. The workshops facilitated by SCMh were:

- Service User and Carer Involvement (4 days across Devon of direct consultation with service users and carers)
- Role and Function of Primary Health and Social Care
- The Range of Older Peoples Mental Health Services
- Role and Function of Inpatient and Intermediate Care
- Whole Systems Working
- Integration
- Workforce Development
- Planning and Commissioning
- Strategic Sign Up

The outcomes of these workshops are summarised and built upon within the four sections below

- Key principles, which describes the value base of the model.
- Key service model elements which details role and function of core services.
- Whole systems working which details how the service elements work together including access, referral and care pathways.
- Planning and commissioning which details how partner organisations wish to work together in implementing any accepted proposals and recommendation.

The model is very much the product of local ideas and as was required of SCMh one that enjoys wide ownership. It is specifically built upon:

- Good practice initiatives across Devon and Torbay
- Service user and carer expression of need.
- Political and strategic sign up from senior managers within the partner organisations

Much of what is described exists in some form within various parts of Devon and Torbay. The various components at present do not come together as a whole in any one particular area, although some are much nearer than others. However, what makes SCMh confident about the overall potential ownership of the model is the level of networking that occurred within the second stage workshops and degree of interest expressed across PCT areas as to what each was developing. There are challenges for all in taking forward the proposed model and SCMh are aware that, as with any

such process, there are some people across the whole system who find ideas of integration, and a refocus away from building based services difficult to acknowledge. SCMH return to this within the implementation planning section.

Principles and Value Base

The service model proposed is built around a number of core principles and values.

- ✓ Needs led and Person Centred
- ✓ Community focused / promoting independence
- ✓ Socially inclusive
- ✓ Age appropriate not age-defined
- ✓ Managed risk
- ✓ Primary health and social care orientated
- ✓ Integrated
- ✓ Whole systems working
- ✓ Older People's mental health promotion
- ✓ Involving service users & carers

These principles and values were locally identified during phase two workshops and in many instances are already embraced and operated across Devon and Torbay. SCMH emphasise them in order to ensure that they are more consistently applied and to formally recognise their impact on the development of the proposed new service model. A shared principle and value base should provide a common platform for partnership working and a mechanism for checking and supporting decisions about service delivery and development. This can be especially helpful when working across agencies as means of remaining focused on desired outcomes and the purpose of service change and delivery

Needs Led and Person Centred

The model is service user and carer focused and person centred with developments based on meeting people's needs rather than being driven by existing or new service structures. This means a number of priority service user and carer issues must be addressed within the basic construction of the service. These are described more fully below but can be summarised as:

- Assessment and treatment is as close to home as possible.
- Ease and swiftness of access supported by clear and readily available information.
- Access to a comprehensive range of health and social care through a single system and process.
- Greater recognition of and support to the role of carers and caring.

Improving access to specialist assessment/care management and specialist community support packages will be crucial if greater choice for people with more complex needs is to be afforded. The model specifically requires specialist capacity both at assessment and care delivery ends of the spectrum working in order to enable this difficult process to be consistently applied.

Community Focused/Promoting Independence

A key feature of modern mental health services is the provision of treatment and support close to home¹⁵. In this spirit, services should be provided as part of a person's natural community. The model promotes the development of greater opportunities to be supported within the community and which for most people will be within their own home. This requires less reliance on residential, nursing and acute hospital care and greater investment in community support services. Within the treatment options there should be an emphasis on minimising change of environment, which recognises that frequent or numerous changes and or introduction to new environments is often detrimental.

Socially Inclusive

The model supports people to use ordinary services and facilities where possible with the aim of retaining or regaining a place in local community life. The aim of service assessment and intervention should be about promoting and maximising opportunities to recover and or maintain independence. Access to mainstream services should be increased and where specialist interventions are required they must look to promote recovery and retain abilities rather than signal an inevitable decline into more institutionally supportive care.

Age Appropriate not Age Defined

Needs and lifestyles for many aged 65 or over are no different from under 65. Yet access to services are in many instances governed by artificial age limits. Continuity of care is often disrupted and access to more innovative service developments within adult mental health is denied. The model supports a needs rather than age based approach and advocates that traditional age boundaries are much more flexibly operated.

Managed Risk

Greater access to community support requires an extended capacity to assess and manage risk across the whole system. Early detection and diagnosis of a problem reduces risk. Access to specialist assessment and care management should be related to the degree of risk to the health or safety of the service user or others – including carers. For the older service user group, issues of risk are best addressed in emerging service models as issues relating to need for intensity of input/care/treatment rather than as prompts for the development of new service models.

Determining thresholds of acceptable risk and appropriateness of moving someone to more supportive environments must also be person centred. For example, consideration of a move to a new environment needs to balance the risks of the current environment against the disruption of a move to a new environment with all its institutional features, which most people recognise as damaging to maintaining independence and maximising quality of life.

¹⁵ Department of Health (2001) *The National Service Framework for Mental Health Policy Implementation Guide*,:DH London

Primary Health and Social Care Orientated

Whilst access to a specialist mental health service is central it is important that it operates within primary care services. Local feedback emphasised the importance of developing access to both health and social care functions at the primary care level. The access points to service and the majority of mental health need are provided within primary health and social care. Specialist mental health services are there to support primary health and social care in performing those functions and only become more involved with assessment and care provision as needs become more complex. Managing this transition point is crucial to the provision of a seamless service and relies on specialist services not being distant but actively engaged with primary health and social care services.

Integrated

Mental health needs of older people require the combined and joined up working of health and social care organisations. Indeed within specialist mental health services integration between these agencies is a requirement.¹⁶ It will be important that in addition to integration within the specialist services, the widest possible approach is taken to developing integrated, holistic responses to need.

Different statutory responsibilities and funding streams are often cited as reasons for the different organisations to support separate policy, procedures and management structures. However the statutory framework is there as well as the needs and potential benefits to support working in a more integrated way. Implementation of the service model and greatest effectiveness of the model can only be realised by greater integration. This is a central tenet of the proposals made.

In older people's services, there are also issues of integration to be addressed across other dimensions:

- Integrated commissioning of older people's services
- Integration across the care system, from primary care through to acute care, and involving the independent sector, of generic services for older people through the development of whole systems care pathways
- Integration of disciplines and specialisms in specific services developed to deliver these generic older people's pathways. Such services might include case management services in primary care; community older people's teams; intermediate care and rehabilitation services; acute hospital care coordination and discharge teams, etc.
- Integration of response to older people's needs into previously age discriminatory working age adult services, allied with clear care pathways for joint work with and referral through to specialist older people's mental health services
- Integration of commissioning and purchasing budgets at service or individual care purchasing levels

¹⁶ Department of Health (2001) *National Service Framework for Older People* – Standard 7

Whole Systems Working

The model below sets out the essential elements of a whole system service model for older people's mental health. It is an integrated health and social care commissioned service but one that needs to be delivered in partnership through a mix of specialist and non-specialist service providers within the independent, voluntary, NHS and local authority sector.

Older People's Mental Health Promotion and Prioritisation

Both the approaches adopted in developing the proposals and recommendations and the actual model described below aim to increase awareness of older people's mental health and raise its priority. Specifically it aims to:

- Raise awareness of older people's mental health needs.
- Promote positive older people's mental health.
- Target support to help prevent mental illness and reduce impact of mental illness.
- Provide effective communication and useful information on health needs and service availability.
- 'Empower' service users and carers through expert welfare rights and independent advocacy.

Service User and Carer Empowerment

Empowering service users and carers to have greater influence over their care arrangements must be a primary goal. This can be more regularly achieved by explicitly promoting and auditing key elements of good care management:

- Assessment of need being needs focused and identified through active dialogue with service users and carers.
- Routine carer assessments that specifically identify carer support requirements.
- Good provision of information on diagnosis, prognosis, treatment options, support availability, crisis management and financial impact.
- Education that helps service users and carers adopt caring and coping strategies and which meet holistic needs in a sustainable way.
- Routinely providing full copies of assessments and care plans unless there are specific that requires some form of interpretation.

Supporting the development of sustainable service user and carer networks is also essential. This will improve the flow of appropriate and useful information and help translate individual service user and carer experience into powerful service development drivers for change. The involvement and empowerment of service users and carers needs to be facilitated not only at the operational, service level but also throughout planning, audit and policy development processes.

Care Pathways and Comprehensive Spectrum of Care

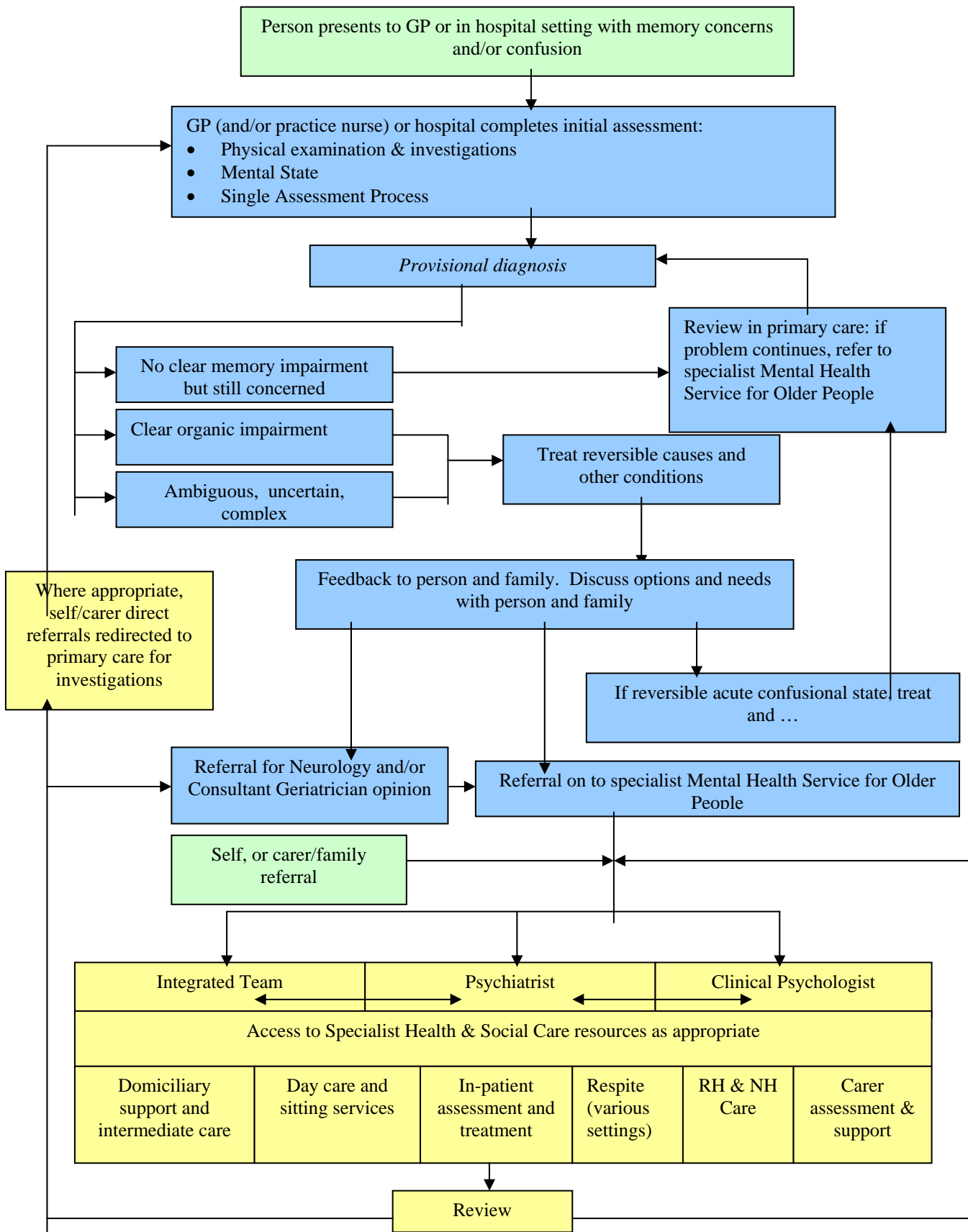
In describing a comprehensive spectrum of care SCMh, building on the innovative work undertaken in the phase two workshops and local service development, seeks to emphasise the importance of care pathways.

The development of clear care pathways holds the key to realising needs led services, to embedding a universal shift to whole systems working and thereby to facilitating a cultural shift for service users and carers in the provision of more appropriate service interventions.

The care of people with organic conditions such as dementia and that of people with functional mental health difficulties such as anxiety, depression, affective disorders or schizophrenia should be seen as requiring separate specialist care pathways, models of care and arguably treatment settings. Such pathways need to be able to cope with co-morbidity of organic and functional difficulties and diagnostic uncertainty. They must also be able to respond to variations in complexity and need, both in mental health and in other co-existing health problems and, accordingly, require careful mapping through mental health services and through the wider primary, intermediate and acute sectors.

The model below sets out a dementia care pathway developed through local work undertaken in Exeter and East Devon.

Dementia Care Pathway: East Devon (Draft)



Building this approach to delivering care pathways the role and function of its core, the East Devon model builds on the outline care pathway presented in the NSF for Older

People and provides a useful reference for similar work across Devon and Torbay. However – on the basis of national evidence and feedback from the local Phase two workshops, SCMHS suggest that the following points are additionally considered in the further development of care pathways:

- Primary health care must be seen as part of a wider network of universal services including, for example, housing organisations and leisure services, within which the function of promoting mental health, participation and independence is as important as that of facilitating access to specialist assessment and treatment when necessary.
- Primary care must include access to social care and practical support – provided either by community based voluntary sector organisations or statutory services – to ensure that people with complex social needs who could otherwise be supported in primary care do not have to be referred into specialist services for access to social support.
- Primary care should include access to a range of psychological and psychosocial therapies for service users and their carers
- Referral and assessment processes should be multi disciplinary team focused rather than profession specific. Thus an initial presentation in primary care may be to any primary care practitioner – not just GPs. Referrals into the CMHT (OP) will be to the team, not to an individual professional.
- Relationships between the service elements in care pathways will need to be supported by properly resourced flows of advice, consultation and training to enable non-specialist elements to deliver effective holistic care to their service users – thinking particularly of their mental health
- Mental health care pathways are multi-agency and require corresponding joint planning and attention to the interfaces between organisations if they are to be seamless for service users

The core components of a comprehensive care pathway have been identified:

- Information in public domain
- Primary health & social care
- CMHT (OP)
- Day treatment
- Day care
- Respite
- Specialist & generic domiciliary care
- Crisis Resolution and Rapid Response
- Intermediate Care
- Inpatient units
- Residential and Nursing Homes

Information and Health Promotion

Pivotal to delivering the above care pathway and responding to the most basic need consistently highlighted by service users and carers, is access to information. Information has to be provided against a number of headings including:

- Health promotion linked to increasing awareness of mental health for older people and addressing stigma.
- Information on how to get advice and more detailed information on issues of older peoples mental health.
- Information on how to access help from both statutory and non-statutory agencies including service user and carer forums and networks.

In addition there needs to be a clear and coherent strategy for providing accessible information. Important developments include:

- Statutory support for developing and sustaining service user and carer networks. Consideration is required as to how this is encompassed within general older people's networks already in existence and how more specifically related mental health networks can be consistently supported across natural communities.
- A locally developed and managed process for advertising information availability in prominent public places such as Libraries, Public Offices, GP surgeries as well as in generic older people's and specialist mental health services.
- A pro-active approach to ensuring GP surgeries routinely support carer registration and how this correlates to identifying potential mental health needs and initial contact for improving awareness of mental health information.

Shared Care Diaries

Linda Durrant, a CPN from Bideford, North Devon, has explored use of a 'Shared Care Diary', with information kept in people's homes, to improve information giving and facilitate communication between service users/carers and staff. Experience shows this can be useful when applied appropriately: where people are interested and where someone involved is committed and comfortable with having things written in the diary and kept at home. Simple information is often appreciated, i.e., a system that informs of staff visits and contact details. This project poses interesting questions for health and social care organisations' emerging recording systems: the Single Assessment Process (SAP) and Care Programme Approach (CPA). The Shared Care Diary presents information in an informal and acceptable form. At a time when we are moving towards more consistency and avoiding duplication, how can we provide choice in methods of recording and sharing information to suit different preferences and needs?

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Developing Mental Health Competence in the Whole System of Care

1 Primary Health and Social Care

The development of PCTs and greater integration with social services both at a commissioning and provision level, has nationally and locally increased the interest, capability and capacity to provide high quality general and increasingly more specialist care within primary care. The 'Forget Me Not Report', NSF for Older People and NICE guidelines all see primary care, with support from specialist mental health services, as the foundation for assessment, diagnosis and treatment.

GPs and some primary care nurses, including practice and district nurses, have skills and may have training to detect signs and symptoms of mental illness and are well placed to provide a range of effective support and treatment, often in conjunction with other health and social care needs.

Throughout the consultation process in this project, much weight and significance was given by delegates as to the potential for primary care to be the vehicle for managing a significant degree of mental health need. Particularly significant was the recognition that primary care must include social as well as health care. The presentation of mental health problems is often not straightforward. Professionals need help to interpret the problems and signpost people to solutions which may often be practical. It is vital not to medicalise 'problems of living' at this stage in the system. It is equally vital that escalating mental ill health is detected and treated as early as possible. There needs to be an improved capacity for signposting, identification, assessment and appropriate treatment, including access to psychological and psychosocial therapies. If support can be provided earlier in people's experience of distress or illness, this will not only be beneficial to individuals and the community but also cost effective to the system as a whole.

Consistent with the recognition that social factors are inextricably linked with mental health issues, a shift in approach is taking place. Rather than the traditional NHS focused, problem based model that attempts to diagnose and treat all presentations, primary care is developing an outward looking, participative, solution focused approach that seeks to empower individuals and works in partnership with community based organizations as well as specialist mental health service provision.

With support from specialist mental health services and a much closer day-to-day working relationship, a greater role for primary health and social care was envisaged. Core functions and objectives included

- Mental health promotion an integral function of routine consultations with older people
- Proactive detection of mental health needs with 'over 75s checks' having great potential for early detection and diagnosis of both organic and functional mental illness.
- Proactive detection should be based on routine full assessment of physical and mental health needs with specific attention to excluding physical health issues from early signs and symptoms.
- Shared care in early stages of dementia especially with primary care follow up to secondary care prescription of specific drugs.
- Equal access as for adults of working age, to counselling and talking evidence based psychological therapies for common mental illnesses.
- Access to information and advice about mental illness and service availability
- Access to practical help for example in relation to housing, finances, transport
- Proactive support for carers in registering as carers.
- Promoting primary health and social care surgeries and buildings as access centres to local voluntary sector and wider community support information and services.
- Long Term Conditions management for severe and enduring stable mental health needs.

- Medicine management support for functional mental illnesses and dementia drug treatment. There are significant concordance issues for older people especially around poly-pharmacy.
- Dietetics advice and support where dementia and severe mental illness is compromising their nutrition.
- Improved access also to Physiotherapy and Speech & Language Therapy for older people with primary mental health needs.

A number of factors will facilitate provision of these functions. These include:

- Improving information for primary care practitioners about voluntary sector and other community based provision
- Improving knowledge and information amongst primary care practitioners about functions of and access to specialist services
- Increased visibility of specialist CMHT staff within primary care
- Effective liaison between primary care and specialist mental health services, with clear joint care pathways, identifying roles and responsibilities of each sector
- Integration of mental health skills with more generic healthcare training for all primary care practitioners
- Engagement of primary care clinicians by PCTs in commissioning and planning services
- Primary care mental health workers – e.g. graduate MH workers – specialising in or trained in older people's needs.
- Gateway workers (as in NSF for MH) equipped to respond to older people's needs.
- Mental health expertise in generic older people's teams and allied health professionals

2 Secondary General Physical Health

It will be important that general health care services have the ability to support people with mental health needs. There will inevitably be presentations of people with primary physical needs but also with mental health needs and vice versa. A joint policy statement issued by the British Geriatrics Society and Royal College of Psychiatry (1997) provided guidelines on collaboration between 'physicians of geriatric medicine and psychiatrists of old age' indicating that there was an increasing need for clear criteria and greater shared care arrangements underpinned with more active engagement.

The current system, particularly when there are issues of bed availability, leads to very real barriers preventing transfer of care and or greater shared care arrangements. In many cases there is confusion as to the reasons for admission with the likely cause being that the person's dual needs are not being met within community settings and admission appears the only immediately available solution. These issues are often compounded by the physical health care workforce being apprehensive about providing for mental health needs and vice versa. Such stuckness increases the vulnerability of service users and carers and more often than not leads to missed opportunities in providing community alternatives and raises the likelihood of earlier access to residential or nursing care.

The Forget Me Not Report suggests that regardless of the location of mental health beds for older people in relation to general hospital beds, far more important is

effective communication, advice and support between the staff of mental health and physical care services.

The process to date has not been able to facilitate any substantive dialogue between mental health and physical health clinicians and senior managers. A mechanism to allow for such discussions will be important to establish. SCMH return to this within the implementation and planning and commissioning sections. However in terms of service principles and availability the NHS Modernisation Change Agent Team Annual Report 2003/4 provides useful guidelines.¹⁷

- Mental Health services will need to be able to access rapid physical health assessment in the persons own home to explore alternatives to hospital admission.
- Service user and carer held records providing a clear picture of mental health needs and normal management approaches to facilitate appropriate care and treatment if admission to a general acute ward is required.
- Early detection of mental health needs once admitted to general acute ward.
- Access to responsive multi-disciplinary liaison service that does not rely on consultant to consultant referrals.
- Access to intensive home support in respect of dual needs, facilitating swift return home once acute illness is under control.
- Access to mainstream intermediate care services for people with mental health needs whose primary need at that point is for physical health problems.

In addition to access to liaison psychiatry services, it will be important that acute physical health services address training needs in mental health in order that shared care is more feasible. Older people's mental health services will have a key role in supporting that training and responding to shared care opportunities.

This work will be supported by a new resource being sent to acute hospital trusts that is based on research by Dr Rachel Norman into the experiences of people with dementia in general hospital settings. The resource is being designed to inform nursing practice and offers concrete examples of three key themes: the need to consider the social, individual and medical models of dementia; the importance of seeing action in terms of communication and ways to maximise interaction with people with dementia¹⁸

3 Older People's Assessment and Care Management

The model proposed sees the development of multi-disciplinary specialist older people's community mental health teams {CMHT(OP)}. However this does not and should not preclude the generic older people's assessment and care management team from also providing for mental health needs. Generic older people's service should be able to accurately assess mild mental health needs and provide or arrange provision of appropriate support. They should have access to advice and support from specialist mental health services to enable them to undertake that assessment and care management function. Likewise specialist mental health teams will need to assess and manage physical health care needs and where necessary access advice and guidance to support this function. Managing the interface between specialist

¹⁷ NHS Modernisation Change Agent Team Annual Report 2003/4

¹⁸ <http://www.news.bbc.co.uk/1/hi/england/bristol/4292487.stm>

CMHT(OP)s and generic care management services will be crucial. Developing clear agreements on respective responsibility supported by effective management links and dialogue will be essential.

Specialist Community Mental Health Team for Older People {CMHT(OP)}

The core of the proposed service model is the establishment of specialist CMHT(OP)s. The team must be multi-disciplinary, have its own community office base and have as core members:

- Consultant Psychiatrist
- Single Line Team Manager
- Community Psychiatric Nurses
- Social Workers
- Occupational Therapists
- Community Support Workers/Nursing Assistants

The team will also need to access psychological therapies and contracting/care management brokering services. A clear decision is required as to whether these services are integral to the team or accessed through explicit service level agreements. SCMH, working on the principles highlighted above - especially in respect of tackling ageism and discrimination, and promoting older people's mental health - would advocate integral provision. However there are strongly held beliefs within the current psychology service that do not support this approach. When this factor is linked with limited resources and with the fact that universal establishment of CMHT(OP)s will be a challenging task anyway, it may be prudent to opt for improving access arrangements and/or to look at strengthening provision of some psychological therapies, for example cognitive behavioural therapy, through additional training of other team members. In part this will depend on issues of team size and capacity which are discussed more fully in appendix one.

National policy requires the CMHT(OP) to be fully integrated across professional disciplines and across health and social care. At a minimum this means developing joint, team focussed referral, assessment and case management processes, with co-located staff working to a team manager with delegated authority to sign off care packages up to a jointly agreed maximum limit.

SCMH's experience is that higher levels of integration, including single line management, single and shared assessments and aligned dedicated OPMH budgets increase the effectiveness and cost efficiencies of multi agency teams. This is essential in meeting service user and carer expectation of having a single health and social care assessment that unlocks both health and social care services. Care will need to be taken to ensure that the social care element of such teams is adequate. In many areas, significant inputs from generic older people's social care services are part of the care offered by mental health services. It will not be good enough merely to integrate what is already "ring-fenced" as social care for older people with mental health difficulties into newly integrated CMHTs. It is important to recognize that, apart from bringing skills in carrying out statutory assessment and care management functions into the CMHT, the social worker and other social care staff such as

community support workers are important to the team to promote social inclusion, intensive case management and a range of person-centred care skills.¹⁹

It will be important that this integration is not translated merely into better co-ordination of traditional roles and responsibilities of the professional groups making the CMHT. SCMHT would advocate that there is considerable emphasis on team building and skills development to support core competency that will enable all team members to make comprehensive needs assessment and access/care manage complex care packages.

The main functions for the CMHT(OP) will be:

- Specialist assessment and care management of people with complex functional and organic mental health needs.
- Comprehensive and routine carer needs assessment.
- Implement Care Programme Approach (CPA) with effective interfaces with the Single Assessment Process (SAP)
- Risk assessment and management.
- Rapid response duty system for in house hours.
- Specialist treatment and care interventions.
- Primary Care liaison
 - Provide a direct link between primary and specialist care through a visible presence in primary care settings.
 - Support primary health and social care staff to make mental health assessments and undertake shared assessments.
 - Undertake initial screening of potential referrals to the full CMHT.
 - Support primary care to manage people with stable severe, long-term or enduring mental illnesses.
 - Provide assessment and short-term direct intervention especially for complex common mental health needs and early-detected dementia with a view to the long-term management being within primary care.
 - Provide support, liaison and training to primary care staff to enable support and treatment to be delivered through primary care wherever possible.
 - Facilitate swift access into full CMHT(OP) where appropriate and facilitate discharge back to primary care for people with stable severe mental illness.
 - Facilitate optimum transfer of early-detected dementia when complexity of need increases and more specialist and or intensive support is required to maintain maximum independent and community living.
 - Support development of expertise in early detection.
- Secondary Care Liaison involving sustainable links with general acute hospitals and generic older people's services and residential care homes to support:
 - Mental health training and assessment skills, including early detection.
 - Provision of mental health care.
 - Shared care for significant dual needs.
 - Appropriate transfers of lead care management and access to more specialist support services and appropriate physical environments.
- Liaison with OPMH inpatient units to actively support individual discharge planning from the point of admission. This will be a significant feature in

¹⁹ National Mental Health Partnership – Older People's Sub Group (2005) Briefing No 2

improving the linkage between inpatient and community services and maximise opportunities for a return home or timely access to other resources.

- Early onset dementia expertise and support. The younger age and early life-stage of this small group of people means that they do not necessarily fit well within adult or older people's services. The specialist older person's CMHT is recognised as the best suited team to provide for this client group but it does require more specialist assessment skills and complex care planning arrangements. It may well be that each CMHT(OP) across Devon and Torbay could identify a lead person with a caseload weighting arrangement that allows for a virtual assessment and care management team.

Transitions to Integrated CMHT(OP)s

The Teignbridge CMHT for Older People, while waiting formal integration, has created interim joint-management arrangements with Devon Partnership Trust and Social Services. There is now a full multi-disciplinary team with Consultant Psychiatrist, Staff Grade Doctor, Clinical Psychologist, Occupational Therapist, Community Psychiatric Nurses, Approved Social Workers, Social Workers, Community Support Workers and Social Services Referrals Co-ordinator/Community Care Worker who acts as a broker for health staff to fast track referrals for social care needs. Access for service users and carers benefits from the Team being co-located with the Day Hospital and Memory and Medication Clinics.

The Exeter Integrated Team has a single manager for a Team comprising Practice managers, Lead Nurse, CPNs and Assistants, Approved Social Workers, Social Workers, Community Care Workers, Occupational Therapists and Referrals Co-ordinator. This Team is also located with a Community Support Team (providing specialist domiciliary care for dementia) and a Functional Support Team.

Both Teams provide specialist assessment of health and social care needs, integrated care planning, treatments, monitoring and reviewing and commissioning of local services as well as opportunities for sharing challenges and team development. Teignbridge have weekly allocation meetings. Exeter is trialing allocation of referrals with clinicians linked to primary care.

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Acute OPMH Inpatient Care

National guidance and local engagement both support a move away from mixed ward environments. SCMH are aware that this has been achieved in certain parts of Devon but is not universal. Despite the national guidance, there remains a debate amongst clinicians nationally about the benefits of developing separate units for treatment of functional and organic conditions. It is worth noting that there are a number of arguments against separating units along these lines which include:

- Loss of flexibility in admissions
- Reduced opportunities for transfer of skills
- Risk of losing access to key therapies/services for [people with dementia – for example psychological therapies

- Fragmentation of already constrained resources through need to separate provision by gender as well as diagnosis means loss of economies of scale and increased risk of developing small isolated units with all the associated risks identified in the Rowan Report.
- In areas of dispersed population these factors are all more pertinent

It may be more appropriate to consider a split in provision that is more needs based than diagnosis based.²⁰

Acute inpatient care forms a small but important part of the service. It affords an opportunity to undertake detailed assessment and explore new treatment plans. It also supports the effective management of risk especially for those who present a danger to themselves or to others.

Key to any conclusion on the level and deployment of acute beds is clarity about their role and function. The workshops gave a consistent message as to role and function, which essentially requires this element of service provision to become more specific and focused and to be the last rather than first option for providing for need. Acute care needs to provide:

- A short-term intervention for very acute and serious mental illness.
- Stabilisation and safety.
- Comprehensive and detailed assessment especially following significant and/or sudden deterioration in health or social functioning.
- Specialist treatment following assessment.
- Effective discharge planning to promote swift return to home or other care environments.

But of equal importance are the ways this function is to be provided and the environment that it is provided in. Of particular importance are:

- Its accessibility and sustainable linkages with local communities and local community resources.
- A person centred care approach
- That on admission people should be greeted personally and have their individual needs both medical and wider holistic needs assessed.
- Good information and clear explanations about what is happening for patients and/ or their relatives.
- Attitudes and culture amongst staff that demonstrate empathy for the things people are experiencing and that provide an environment where people are offered safety, dignity and respect.
- An environment that provides space and enabled safety and an ability to provide for diversity of need.
- An environment and nursing ratios that allowed for intense therapeutic input thereby supporting more rapid discharge and better utilising workforce skills
- Staffing ratios, or access to shared staff or well managed bank staff systems that enable inpatient staff to fully participate in training and governance activities. It should also accommodate for staff sickness, emergency situations

²⁰ Dr Chris Ball – personal communication

and annual leave without recourse to expensive agency staff or putting inpatient staff under unacceptable levels of pressure.

- Length of stay to be monitored closely. There is real danger that any prolonged stay will very quickly erode the potential for the service user to return home and increase the likelihood of premature admission to residential or nursing care.

Further dimensions relating to acute care provision that were raised in the second phase workshops included:

- Specialist in-patient services for frail older people with functional conditions
- Psychological therapies open to over 65s, with sufficient specialists in old age and dementia
- Joint care pathways with OT, physiotherapy, dietetics, speech therapy, neuropsychology
- Effective liaison arrangements with general hospital and intermediate care services

There was also significant debate about inclusion of a respite function specifically for people with very challenging needs. It is SCMH's view that a respite function does not sit easily alongside the core functions of acute care and that the new model must focus on the core functions if acute inpatient admissions are to be managed more effectively and efficiently. If a respite function were to be provided it would need to be very strictly managed.

Whilst there was general consensus within the second phase workshops as to the role and function of acute care, there was less agreement as to implications that potentially flow. In particular there was not necessarily agreement as to the size or siting of inpatient units or a shared understanding of issues of critical mass and linkage with community services. Essentially the options identified were :

1. units concentrate on core functions described above
2. units operate more as a resource centre providing additional intermediate care and outreach services.

As emphasised above, SCMH believe it is important that acute care focuses on the core functions and that resource centre provision should be community based.

SCMH return to this within discussions on intermediate care, whole systems working and implementation. Issues of size, bed numbers and critical mass are discussed in appendix one.

Intermediate Care (IC)

If the use of inpatient beds is to be kept to a minimum, then access to intermediate care will, in some circumstances, be important.

The essential function is to provide an alternative to admission or provide rehabilitation following admission. This should be on a short-term basis and combined with a rehabilitation/recovery element with any admission having a clear expectation that it will maximise independence and lead to a return home.

There are several considerations in the use of intermediate care for older people's mental health. Some of these were identified within stage two workshops and others raised here from recent NIMHE conferences. The most relevant are:

- Intermediate care is an emerging concept, with much variation in definition and implementation, both locally and on a national stage.
- Intermediate care is a concept largely driven by policy for physical care (NHS Plan, NSF for Older People) in which intermediate care was supported and given financial incentive – hence many service developments try to 'label' the services as 'IC'. Its objectives therefore look to address issues relevant to general older people's services of which their relevance to local mental health services needs to be analysed. Objectives include:
 - Reduce transfers into general and mental health acute care
 - Reduce care home placements
 - Reduce lengths of stay (LOS) in hospital
 - Reduce pressure on rehab beds
 - Provide more appropriate care
- Intermediate care in mental health may include access to crisis/intensive home treatment and/or assertive outreach services, particularly specialist home treatment for older people with dementia, or with functional mental health problems and other problems associated with age.
- Some schemes for older people with mental health problems have been developed building on IC services for physical health and bringing in mental health capability, while some (seemingly fewer) have tried to be a specific mental health service. Both are seen to have pros and cons
 - Building on physical health services gives access to people with mental health problems in a less stigmatising way, but many physical health IC schemes have excluded people with mental health problems.
 - Developing specific OPMH IC services enables a stronger capability in mental health but possibly makes for a less integrated 'whole person' care, which is often seen to be important for older people. Most of these examples target people with mental health needs who also have additional physical health issues.

The risk then is that older people with mental health needs will be discriminated against in terms of access to intermediate care facilities.

These issues have led to the development of different service models for older people whose need primarily relates to mental rather than physical health, with a different attention to two key aspects.

- Intensive community support,
- Availability of specific IC beds providing short-term care to ease transitions. Transitions might be movement from in-patient care to home or may be other changes involved in a person going through a crisis or from one level of dependency to another

It could be argued that community based mental health teams are already offering intermediate care in so far as they prevent admissions, reduce length of stay and offer intensive home support. A recent report on intermediate care for older people with mental health needs suggests that rather than developing new services, the key to

applying this model to mental health is a conceptual shift that facilitates improved flexibility, better integration and more coordinated responses than are currently available in many localities.²¹ To this end, leadership that actively encourages better partnerships and working together is seen to be just as important as hands on support in developing new approaches and processes.

The deterioration caused by repeated moves is well recognised in care of older people with mental health problems, along with the associated increased risk of institutional admission. The concept therefore of moving someone from an acute ward to an intermediate care bed does not transfer easily to mental health care. Far more effective may be the provision of very intensive home care support on a flexible, needs led basis, together with flexible use of day care and well defined access to crisis and home treatment services for working age adults. The latter is supported in some areas elsewhere in the country by an on call rota from old age psychiatrists.

Any bed based provision is most likely to be useful for people with co-morbidity – that is physical and mental health problems.

The important issue in the development of intermediate care capacity for mental health is that IC bed requirements are determined within the context of a system of truly supportive community based care to avoid the risk that they are used simply as additional bed capacity. There is a danger that over provision of acute beds in some areas might be addressed by re-labelling some beds as IC within the same unit. This not only sustains high costs but is clearly not consistent with a community orientated approach to IC provision.

Finally there are issues of who is best placed to provide the service. There are examples of both bed based and intensive community models being delivered by NHS, local authority, and independent/voluntary sector providers. Some are even provided in partnership between health and social care and or statutory and independent/voluntary care.

²¹ Nuffield Institute for Health supported by the Joseph Rowntree Foundation (2002) *Exclusivity or Exclusion: Meeting Mental Health Needs in Intermediate Care*

Developments in Intermediate Care

In two separate rural areas local NHS and Social Services have had to meet the challenges of distance from, or loss of, acute hospital beds. Service developments have created innovative collaborations to bridge the gap between hospital and home. Social Service Residential Homes have changed focus to become intermediate care services, specialising in the rehabilitation for older people with mental health needs. The units are run by Social Services staff while specialist staff from Devon Partnership Trust provide ongoing support and education. As further innovation, in South Hams & West Devon there are now shared specialist Occupational Therapy and Physiotherapy posts between the intermediate care site and the CMHT.

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Whole Systems Working

Devon County Council, in collaboration with Dementia Voice and staff and stakeholders from a range of agencies have produced a Template for Intermediate Care for Dementia to support the extension of intermediate care services for older people with mental health needs. This project included consultations with carers and with people with dementia. A Framework and Key elements for intermediate care services were identified.

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Residential and Nursing Care

Whilst the emphasis of the service model is about providing home based care there will be a need for residential and nursing care provision. The degree of provision may change in time as community services are developed and the spectrum of support may also narrow over time as the ability to support ever more complex needs at home increases.

The crucial factor is that this profile of need and provision is understood and proactively commissioned. At present most areas lack comprehensive local provision and within that provision standards vary, which with fair access and choice further compromises availability.

Other factors such as the degree of local authority provision and the strategic direction of that provision in relation to wider developments, such as intermediate care, skew the current and potential future spectrum of provision.

Relevant recommendations from the Forget Me Not report on this area of care include:

- Agencies should ensure there is sufficient residential and nursing home care of good quality available for older people with mental health problems including some specialist provision
- Agencies should provide advice, support and training to the staff of residential and nursing homes
- Agencies should make every effort to reach a continuing care agreement where they have not already done so.

SCMH return to this within implementation and planning and commissioning.

Specialist Home Care Support

The primary goal for services is to maximize opportunities for people to remain at home as long as possible. Home care and community support are key features in providing intensive and practically orientated care within the home environment. However - generic older person's services are not necessarily able to deliver such support effectively for someone with more advanced dementia or complex functional illness. There is growing evidence that the lack of specialist knowledge and inflexibility of the service, particularly around time spent with the person and lack of continuity of personnel, makes any input ineffective. Not only is this detrimental to the service user and carer it also wastes a valuable resource, as expected outcomes are not being achieved.

'Health and social care agencies should...develop home care – out of hours where necessary – with home care workers trained in mental health.'²²

There is thus a strong evidence base to support the development of some specialist home care capacity either within generic home care providers or as a specialist stand alone service.

Day Services

In considering day services it is helpful to distinguish the different functions that make up a continuum of care. It is also necessary to consider the different service responses for functional and organic mental health needs. Key functions within this continuum include:

- Specialist short-term interventions such as memory assessment and evidence based psychological and psychosocial therapies.
- Intensive day assessment and treatment to support alternatives to hospital based services.
- Longer-term care management of complex mental health needs necessary to support independent living, including rehabilitation and behavior management interventions.
- Educational and social inclusion/recovery opportunities – including occupation/employment where appropriate.
- Day care providing social and emotional support as well as respite care.

Providing this continuum will require a mixture of specialist mental health provision and access to generic older person's services and ordinary community services. There will also be a mix of providers including those from the voluntary and independent sectors. There will be a need to balance issues of capacity and skills base within existing services to provide additional specialist interventions against the accessibility of specialist provision that is potentially further afield and more difficult to travel to. The key to determining this balance will be clarity about function. For example, if the function is primarily to provide respite and social support together with targeted short term interventions, the core staff team may not need to be highly trained provided there is access to on call professional support and specialist interventions provided by 'peripatetic' professional staff.

²² Audit Commission (2002) Forget me Not Report - update

Other support issues to be addressed, in making a spectrum of day services a reality and maximizing its impact include:

- Developing capacity and ability of specialist mental health services to provide input into and support people accessing day care.
- Siting and transportation infrastructure especially in rural areas.
- Clarity of purpose in attending day care that strikes a balance between therapeutic input and respite potential afforded.
- Distinguishing between focused intensive and time limited therapy and maintenance day care
- Improving access to under 65 provision especially for functional mental health needs.
- Workforce development to ensure skill and capacity for time limited evidence-based therapeutic interventions, e.g. CBT, IPT.
- Building in explicit health promotion functions within all settings
- Access to extended hours provision utilising opportunities across the entire health and social care system.

Promoting Social Inclusion

Exeter PCT & Social Services have a long tradition of commissioning to develop a comprehensive care pathway. **Exeter Age Concern** now provide a range of services for older people with mental health needs:

- **Neighborhood Day Care** where people with functional mental health, physical or sensory needs attend in small groups in someone's home
- **Dementia Day Care** with separate bases to provide continuity for people with a range of cognitive impairments
- **Linking Lives Project** promoting links into normal community and social activities for older people with functional mental health needs
- Creative use of **Sitting & Escort Services** to provide small tailored groups to meet specific needs and promote social inclusion (i.e., pub visits, walking groups)
- Once engaged, people with mental health needs can also be actively linked into a wide range of advice and support services and a choice of purposeful activities, appropriate to all older people.

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Respite

Access to respite both on a planned and more rapid emergency basis was one of the most important service elements identified by carers. There is huge frustration caused by the confusion as to its availability both in terms of local accessibility, types of environments it is offered in and the charging arrangements attached. As with other service components the ability to provide a spectrum of respite environments and capacity to respond to planned and emergency need is vital.

Respite should include:

- Home based provision through sitting services
- Day based provision in terms of access to meaningful day care that offers more than just carer respite

- Residential based provision within a range and choice of environments that afford for different levels of complexity and challenging need.

SCMH understand that the more successful the service becomes in maintaining people within their own home for a longer period, the more potential there is for respite outside the home to be more challenging both for the respite provider and service user. Potentially there will be an increasing need for such provision though not necessarily within NHS acute hospital beds. There is further debate to be had about function, location and provision of respite care.

Respite capacity with the range of community developments discussed above affords an appropriate way forward. However SCMH specifically regard the provision of respite care within acute inpatient and intermediate care services to be inappropriate except in exceptional cases where behaviour is particularly challenging. It should not be seen as an opportunity to provide respite outside the normal social service charging arrangements. There will obviously be cost pressures and in some cases carer/advocacy pressure to pull against this principle. There will also be professional traditional practice that sees inpatient settings as appropriate for complex needs respite. However, if there is to be a rebalance between inpatient and community service, then this will be an important priority to address. SCMH return to this debate within the implementation section and resource analysis section in appendix one.

Whole Systems Model

The above section describes the component parts of a comprehensive care pathway and service spectrum, together with their role and function. This section begins to describe how the individual services work as a whole systems service model. It concentrates on four areas:

- √ Access arrangements and referral patterns to support care pathways
- √ Assessment, care management and care coordination arrangements
- √ Management arrangements
- √ Service and care group interface arrangements - partnership working

1. Access arrangements and referral patterns to support care pathways.

Primary health and social care, in conjunction with the CMHT(OP) primary care liaison function will operate a single point of access. This single point of entry has a critical role in ensuring that older people with mental health needs are not admitted to specialist services, including inpatient care, inappropriately. It will be important that joint care pathways and protocols including information, liaison arrangements and clear systems of referral and access into specialist mental health services for older people are operational in related settings including:

- Primary care
- Community health and social care services
- Intermediate care
- Acute care (and discharge) services
- Independent sector older people's services
- Working age mental health services

Primary health and social care with active CMHT(OP) support, including advice, training and shared care arrangements, will provide initial assessment and early detection and diagnosis. Additional specialist assessment inputs can also be provided by for example:

- Psychiatry for more specific diagnosis and prescribing dementia medication.
- Psychology
- Occupational Therapy for functional assessment of risk and need
- Memory Clinic

Where ever possible care will be managed within primary health and social care settings. Active liaison and engagement by CMHT(OP)s, together with access to early detection/diagnosis records will facilitate identification of optimum transfer point to the CMHT(OP) for more comprehensive specialist assessment and care management. For some this will be a long term transfer of care but for others there should be an expectation that achievement of greater stability and set up of community support such as day care, can lead to a transfer back to primary health and social care services.

OLDER PEOPLE'S MENTAL HEALTH SERVICES

SPECTRUM OF SERVICES

Community Involvement
Self Help Groups, Volunteering, Adult Education, Mental Health Promotion, Community Safety, Community Based Social & Interest Groups, Mental Health Information: Care & NHS Direct, Libraries, etc

TIER 1

Primary Health & Social Care

TIER 2

**Day Treatment and Day Care
Intermediate Care and Respite Care
Specialist Domiciliary Centre**

TIER 3

CMHT(OP)S

TIER 4

Inpatient Units

**Care
Pathway**

**Generic
Older
People's
Services**

**Specialist
OPMH Services**

Working with Primary Care

CPN links to primary care are working well in South & West Devon. CPNS are based in five CMHTs from Teignbridge and Torbay to rural West Devon and each CPN covers their own geographical area. CPNs are linked to specific GP surgeries where they attend practice meetings. This enables effective liaison and close working with primary care staff. CPNs are also linked to local community hospitals in their area and attend the multidisciplinary meetings to support safe and effective hospital discharges.

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2 Assessment, care management and care coordination arrangements

Service users and carers experiencing complex mental health needs will require both health and social care support and do not want to have to go through separate processes to access it. A complex system of service elements is potentially fragmented and uncoordinated for service users. What makes it work for user and carers is care management and care coordination under the guidance of a key worker role. To this end SCMH propose that a single assessment and care management process be operated. The vehicle for this should be the Care Programme Approach with additional assessment areas incorporated to ensure it reflects a health and social care needs assessment and provides evidence of eligibility for accessing social care resources. CPA must interface and link with the generic Single Assessment Process (SAP). It will be important to agree on terminology and function of key worker/care coordinator roles across agencies

It is easier to provide coordinated care where health and social services staff have easy access to each others resources. The development and implementation of agreed care pathways can help coordinate efficient use of the available resources.

The combined CPA Care Management assessment should avoid prescribed boxes and encourage free text and clear analysis that covers core information areas relevant to both health and social care organisational requirements. In addition, the assessment should be translated into clear care plans that provide for comprehensive care packages as appropriate to need, recognizing that potentially they will require health and social care services and interventions provided across statutory, voluntary and independent providers utilizing aligned health and social care budgets. In addition assessment and care management will need to emphasis effective risk assessment and management which will be crucial in supporting a service shift away from buildings based residential, nursing and inpatient care, to community and home support/treatment.

A critically important process issue in retaining maximum capacity in services is regular reviews of people's needs so that they do not receive higher levels of care than they need. This will be a key role for the CMHT(OP)s. If this task is not sufficiently

resourced the consequence will be continued and additional mismatches of care needs and services.

3 Management arrangements

3.1. CMHT(OP) Manager

The specialist integrated CMHT(OP) should be supported by single line management having access and responsibility for aligned dedicated budgets across health and social care. Single line CMHT(OP) managers will be supported by senior professional leads within the team, who will be responsible for clinical supervision and professional development. Senior professional leads can in part be resourced through realising a single line manager, however there will be resource implications and it may be necessary to explore the possibility of professional leads covering several teams.

The single line CMHT(OP) manager will be responsible for

- Processing team referrals.
- Allocating assessments and care management tasks.
- Deployment of team resources using core workforce competency skill arrangements, to allow for all team members to undertake single assessment and care management duties. This will be supported by preserving and nurturing specialist skills and training that can be utilized in either supporting case allocation and or supplementing core competency assessment skills within specific team referral
- Monitoring team performance to expected outcomes and standards.
- Micro community development and commissioning.
- Managing team interfaces and promoting whole systems working.
- Aligned budget management.
- Team building and development.

CMHT(OP) single line managers would report to a specialist older people's mental health service manager. This builds upon the joint agency manager post recently established within the East PCT area.

3.1. Joint Agency Service Manager

This management post would be an integrated and joint appointment across the local NHS and Social Services at PCT level, having both a service development and operational responsibility and accountability.

The significance of this development is that it would for the first time give dedicated and specialist senior management capacity to the older people's mental health system. This is a central recommendation from SCMh, as it will provide crucial support, both in respect of dedicated time but also skill and experience, for a number of far reaching changes. SCMh believes the need for this across Devon and Torbay has been evident during the course of this development project. Difficulties in communication, stakeholder engagement, information collation have all impacted on the much evident enthusiasm for prioritising older people's mental health.

Key roles and responsibilities include:

- Supporting a PCT based joint health and social care commissioning arrangement, tasked with overseeing reduction and rationalisation of beds and significant community development using aligned dedicated budgets potentially from limited new development funds or even a cost neutral position.
- Supporting CMHT(OP) single line managers in delivering a more seamless health and social care service, which operates to jointly agree outcome measures, focused on community based integrated working that supports maximising independence and reduced reliance on institutional based care options.
- Supporting prudent financial management from aligned provision budgets and enabling effective risk assessment and management decisions that must underpin a move to more community orientated care.
- Supporting local community development in particular service user and carer networks and primary health and social care/specialist care interfaces.
- Supporting local needs assessment and planning forums that directly impact upon commissioning decisions and future service development.

Accountability arrangements will be a factor in determining the effectiveness of the post. Clearly there will be accountabilities to PCTs and Local authorities for planning and commissioning functions and to the Trust and Local Authority for operational functions. SCMH see the post supporting commissioning rather than doing commissioning and therefore the main line of accountability is likely to be to the Trust and Local Authority. However the partnership working requirements of such a post and complex and sometimes conflicting responsibilities and aspirations of local partner organisations make this difficult to resolve within this report. SCMH believe further discussion will be required and it may be that different arrangements apply in different areas. SCMH return to this within the implementation section.

4 Service and care group interface arrangements – partnership working.

It will be the responsibility of the CMHT(OP) single line manager and the older people's mental health joint agency service manager to manage the interface issues with:

- Primary Care.
- General Older People's Assessment and Care Management.
- Secondary acute general physical health care services.
- Generic and specialist health and social care community services.
- Older people's mental health acute inpatient services.
- Working Age Mental Health Services

There are two main responsibilities involved in managing these interfaces.

1 Providing and sustaining the liaison function with primary health and social care, older people's assessment and care management, secondary acute physical health care services and adult mental health services. The CMHT(OP)s have, as a core function, the need to pro-actively work within primary health and social care to support shared care arrangements and develop close working relationships with secondary

health and social care services. This will enable the effective flow of specialist and complex mental health referrals to CMHT(OP)s and support capacity and skill development within general services to meet mental health needs.

2 Effective management and appropriate utilization of limited health and social care support services. The CMHT(OP) should effectively gatekeep access to limited inpatient, nursing and residential care and resource manage access to specialist and generic health and social community support such as day support, domiciliary support, respite care etc.

Improving Access

Bideford OPMH services (day hospital, community and inpatient services) have undertaken a range of service improvements that have been appreciated by GPs and significantly reduced waiting times for Consultant Psychiatry. Process mapping by the multi-disciplinary team identified key areas for improvement and developments have led to a Memory Clinic, single point of access, central allocation system and functional mental health recovery groups.

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Transitions from Adult to Older People's Services

Devon Partnership Trust's Transitions Policy was introduced in 2003 to prevent age discrimination in mental health services and help meet individual needs rather than fit people into a different category on their 65th birthday. Now people who reach 65 and who already receive Younger Adult Mental Health Services, are not automatically transferred to Older People's Services simply because of their age. Older People's Services take new referrals over 65 and also see people aged under 65 whose needs will be best met there. The Policy includes a range of considerations to be made before any transfer, including taking access to suitable resources into account.

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Local Partnerships

Honiton OPMH Team (multi-disciplinary community, inpatient and day services) won a Trust 2004 Staff Achievement Award for their tradition of crossing boundaries for local partnership working. Engaging in modernization projects (Pursuing Perfection) with other local organizations has had tangible benefits, demonstrated by fewer Mental Health Act sections and lowest locality length of inpatient stays, with emphasis on discharge planning from the point of admission. A local GP contributes sessions to the OPMH inpatient unit and close partnerships and reciprocal support have been developed with adjacent Honiton Community Hospital, Reablement Team, Rapid Response Team and District Nurses. Social Service 'Link Workers' liaise with inpatient and community staff. The Team organises a Carers' Group with an ongoing rolling programme of events. Carers are involved and are supportive to services (eg., funding specialist moving and handling equipment). East Devon Alzheimer's Society help the team support carers and provide extra resources

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Planning and Commissioning

Definition and Principles/Responsibilities

Commissioning is an approach to planning strategy implementation and performance managing service outcomes. It will be an essential capability if ideas generated within this project and within any subsequent local needs assessment work are to be translated into service reality. Within this skilled commissioning capability there will be technical aspects of contracting and performance monitoring that will have to be factored in.

In respect of older people's mental health services, the National Mental Health Partnership suggests that the underpinning principle should be commissioning for person centred care pathways for older people, not fragments of service or organizations.

Given the service development proposals and recommendations made within this report and the potentially challenging nature of implementation in relation to aspects of cultural shift and resource identification/prioritization, SCMh make detailed proposals on a commissioning framework.

Commissioning will need to:

- Work with and stimulate a variety of provider organizations maximizing choice quality and innovation.
- Bring together the statutory responsibilities and combined potential of health and social care agencies.
- Identify, access and deploy new resources as well as dis-invest and reinvest existing resources.

- Prioritize and specialize in older people's mental health whilst pro-actively managing interface and access to wider older people's health and social care resources.
- Assess and understand local need and respond at most local level possible.
- Understand and respond to national policy and partner organizations statutory and strategic priorities.
- Assess and understand best practice service developments.
- Support partnership working both in terms of a mental health commissioning and provider relationship and mental health and non-mental health commissioning/provider relationship.
- Support performance management through more robust commissioning/contracting arrangements and service level agreements.
- Access to detailed resource mapping and utilization.
- Facilitate development of local OPMH local implementation groups (LIGs) and develop service user and carer networks to feed into these.
- Map out planning forums and spell out relationship between forums.
- Support communication and information giving strategies.

Commissioning

East Devon PCT, with Social Services, have produced an OPMH Commissioning Strategy (2004) based on a comprehensive care pathway with spectrum of services at different levels across health and social care and the independent sector. This work was informed by a number of local consultations and by a carers' survey, reinforcing the need to develop community-based services. Action plans will be informed by the Devon Development Project. Implementation is led by the new Joint Agency OPMH Manager. This post crosses the specialist mental health Trust, local PCT and Social Services and integrates the functions of commissioning and providing to streamline service developments and make the best use of resources. Guidance and support are provided by the multi-agency OPMH Local Implementation Group, which includes representatives from older people's forums and works actively to improve service user and carer experiences

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East Devon PCT Commissioning Strategy: www.eastdevon-pct.nhs.uk

Section Five

Priorities and Implementation

Introduction

The degree to which care pathways, service elements and whole systems working, described above, are provided across PCT areas varies significantly. For some areas the proposals represent a huge development agenda, whilst for others, some of the core infrastructure is in place. SCMH have therefore identified priority development areas to assist localities in making some key early decisions on where to start with implementation. Further areas for development are also identified.

Implementation will require dedicated supporting structures and processes that span the commissioning and provision spectrum across the whole system of services for older people. Proposals relating to these structures and processes are set out in this section under the heading ' Making it happen'.

Priority Service Developments and Action

There are four priority service areas for development:

- √ Primary health and social care
- √ Community Mental Health Teams for Older People
- √ Inpatient bed/unit rationalisation
- √ Specialist home support

Primary Health and Social Care

The model specifies the centrality of primary health and social care as the initial access point for assessment and support. Specialist CMHT(OP)s will need to support primary health and social care services undertake this function. SCMH believe that, in common with most other areas of the country, there is a very significant development agenda for primary mental health care in Devon and Torbay which includes:

- Communication and promotion of the model for older people's mental health by PCTs and local authorities in partnership with specialist services
- Increasing capacity in primary health and social care through, for example, joint training and skills development in older people's mental health needs, inreach from specialist services, specialist designation of graduate and/or gateway workers for older people, improved links with local voluntary sector advice, guidance and support organisations
- Development of primary care based care pathways and protocols to support assessment, signposting and decision making by primary care practitioners
- Routine information giving to service users and carers.
- Engagement points for CMHTs to develop effective liaison.

The primary care policy agenda currently offers opportunities to develop greater levels of specialism within mental health (as in other areas of health care) - for example through local enhanced services, GPs with a special interest. In practices or practice clusters that choose to develop these specialisms, some of the identified functions of specialist services may move toward primary care. Additionally, the development of practice based commissioning may enable practices or groups of practices to commission more locally sensitive services in the future. Whilst the introduction of practice based commissioning for all mental health services currently would be premature because as yet there is no national tariff or IT infrastructure appropriate to mental health, there is now freedom for practices to commission evidence based talking therapies for some people with common mental health problems.²³

This development agenda will be fundamental to successful implementation of the model for older people's mental health services. Moving it forward will require a joint approach between PCTs, local authorities, practice/clinical representatives, local community services and specialist services to agree priorities and action plans. In other areas, PCT based Local Implementation Teams (equivalent to Devon OPMH LIGs) have proved a useful vehicle for this joint work, supported by the identification of local champions for example through the Local medical committee, Non-Executive Directors on PCT Boards, Patient and Public Involvement Forums.

Community Mental Health Teams for Older People

The central plank of the model, the thing that creates the expertise and capacity to fundamentally provide and manage community alternatives, is the development of CMHT(OP)s. Without this, the task of shifting from the current very significant variance in bed usage practices across Devon and Torbay, to a model of greater equity of service user and carer choice and quality of outcome, may prove insurmountable.

If psychologists continue to work both within and outside of CMHT(OP)s there will be a need for clarity about commitment and CPA responsibility.

Implementation tasks for the CMHT(OP)s will include:

- A number of areas need to start from scratch with development of teams. This will require work on identifying where staff may be pulled out of generic services.
- Review optimum staffing levels and skills mix. (See appendix 1)
- Identify skills development requirement to support core competencies around comprehensive needs assessment and care management.
- Review of operational policies to include additional role of primary care liaison and access to working age adult services including CMHTs, community facilities, assertive outreach, crisis services on the basis of need.
- Joint agreement on care coordination model through CPA and/or SAP
- Development of joint care pathways with community and acute health care services
- Pathways to access therapies including OT, physiotherapy, speech therapy, dietetics etc

²³ Cohen, A (2004) *Practice Based Commissioning in the NHS: The implications for mental health* Sainsbury Centre for Mental Health

- Rota arrangements for any extended hours working.
- Staff recruitment and training issues regarding additional roles of primary care liaison.
- Linkages with other teams.

Inpatient Bed/Unit Rationalisation

There is significant variance in acute inpatient provision. This variance relates to:

- Level of provision
- Staffing level
- Utilisation
- Quality of physical environment
- Model of care
- Role and function
- Separation of functional and organic as opposed to mixed units

SCMH support the refocusing of acute inpatient care in line with the role and functions described in Section 4 above including a reduction in overall beds and number of units. This reduction is dependent upon the full development of CMHT(OP)s, including primary care liaison.

SCMH propose that this be achieved within a two-phase timescale. Phase one would involve an initial reduction in line with existing outline proposals and this should be completed within a twelve-month period.

Phase two would involve detailed planning across PCT areas in respect of identifying optimum bed numbers and future siting of either dedicated functional and organic or other needs defined units operating to an optimum critical mass size. SCMH envisage this process being a medium term planning and development project.

SCMH see this refocus as an immediate priority because of lead in times for consultation, and because there are some very real concerns about staffing ratios in certain areas (see appendix one). There are urgent issues of equity to be addressed in terms of access to separate organic and functional mental illness environments that have sufficient critical mass to afford greater therapeutic input. This is currently only available in some areas.

It is important to clarify that SCMH are not necessarily recommending hospital rebuild schemes to accommodate specific separate units. Much will be achievable in each PCT area and where necessary combined PCT areas to utilise space within units to create separate environments supported by the right skills mix and staffing ratio. This will support more flexible use of space which can both create separate environments and specialist skills development for organic and functional mental illness, whilst allowing some flexibility in terms of how individual needs are met and more effective resource utilisation achieved. There will also be opportunities like in North Devon, where there are two units relatively close to each other, to have one taking a lead for functional mental illness and the other leading on organic mental illness – if that is the model agreed locally.

Listening to Service Users and Carers

In North Devon feedback and comments from services users and carers are informing the process to review two OPMH acute inpatient units. The David Barlow Unit in Barnstaple and the Abbotsvale Unit in Bideford, have traditionally been mixed units, admitting older people with both functional and organic mental health needs (dementias). The views of local service users and carers, in line with national guidance and consultations from the Development Project, are advocating a move to units which specialise in either functional or organic needs.

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The development of a remodelled acute inpatient service that maximises opportunities for economies of scale and community development will require a much more joined up and cooperative approach to commissioning across PCT areas. SCMH return to this issue in the commissioning section below.

Such development may also provide greater clarity of model and level of need for intermediate care.

Specialist Home Support

Perhaps the most commonly supported development expressed by both service users and carers and the older people's mental health workforce, was specialist domiciliary care. In realising the principles of maintaining independence, CMHT(OP)s will have to have access to specialist domiciliary support service to provide intensive but skilled practical support. There will undoubtedly be cost and recruitment implications to establishing such a service. However it is perhaps the most important and effective community support development in terms of impacting on inpatient and residential/nursing care use. Consideration of how this will be provided will be important. It could be an intrinsic part of a more community orientated intermediate care service, a stand-alone service or a specialist function within generic home support services.

Further Developments

Providing a comprehensive range of services should be a priority. A number of additional developments will be beneficial.

Day Services:

Ensuring a continuum of day services from intensive day treatment to day care support, including memory clinic functions, will be important. In particular they will offer therapeutic interventions that promote recovery and enable maximum independence, as well as meeting social and recreational needs and also affording some carer respite.

Potentially this area of development can be taken forward by using current provision in a more co-ordinated way that reduces duplication and which can be supplemented with community service inputs. In particular SCMH advocate commissioning that promotes the opening up of ordinary community services to older people with mental health needs, supported by targeted interventions from mental health specialists. This

should start with generic older people's day centres where an emphasis on training and skills development could support greater access. However there will also be a need to consider how community centres, leisure facilities, further education and even supported employment schemes could be made more accessible. If the principle of recovery is to be genuinely adopted then this is an area of development that will need some prioritisation. Creating capacity within CMHT(OP) and working in partnership with voluntary organisations and general social inclusion programmes will be important.

Dementia Cafes

In East and Mid Devon specialist mental health staff, including nurses, Occupational Therapists and Social Care Workers, have developed three Dementia Cafes over recent years. These provide venues, open weekly or monthly, where carers and people with dementia can attend together in informal settings, for support and advice, to share their experiences and develop social contacts. The Axminster Dementia Drop In Centre has received national recognition in the Alzheimers Society report "Let It Happen". The model of the longstanding Crediton Dementia Café, run by specialist staff in an Age Concern venue, is soon to be rolled out across Mid Devon, with a dementia Café in Tiverton opening soon. The Courtney Dementia Café opened in Exmouth six months ago, set up by the Alzheimer's Society in collaboration with the CMHT(OP).

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Intermediate care

Intermediate care is in principle supported by local stakeholders and SCMh believe it to be an important addition to the spectrum of care. However, its potential benefit is intrinsically linked to clarity about the model and its fit within local service provision, especially as to its role in either replacing other forms of bed provision or augmenting current services. Wider strategic planning about development of generic intermediate care and access to this by people with mental health needs will also be critical in determining the significance of any specialist provision.

Development action in this area is likely to include:

- Mapping of existing IC arrangements
- Design and redesign of role functions
- Strengthening of the home care function for older people with mental health problems
- Linkages with existing services ie NHS inpatient units/Social Services residential homes, community teams and IC.
- Use of day services as satellite bases and effective coverage of a widespread geographic area.
- Information sharing procedures and IT requirements.
- Learning from existing services in some areas
- Visits to a range of similar services across the UK, as there are a number of variations in operational arrangements.
- Identifying a lead clinician and manager at an early stage to provide leadership in improving partnership and coordinated approaches to intermediate type care.

- Consideration of a range of practical issues such as operational policies, rota and on call arrangements across a 24 hour period, and staff recruitment and training issues

Residential & Nursing Homes:

Ensuring a spectrum of locally accessible and equitable standard residential and nursing home provision will be important. With significant levels of closure local availability is patchy with specific gaps around more specialised care environments that can manage more challenging behaviour needs.

Recommended actions are as follows:

- Undertake a comprehensive audit of all resources available and identify gaps in provision.
- Review service level agreements.
- Review operational policies.
- Ensure clear separate strategies and consider separate facilities for dementia and functional needs
- Identify potential for refocusing and aligning current services to offer a more comprehensive spectrum of provision.
- Engage with housing officials regarding development of supported accommodation, Supporting People initiatives and access to more appropriate housing.
- Pro-active commissioning and engagement with the voluntary and independent sector about filling gaps in range of residential and nursing home provision.
- Be more proactive in monitoring performance across sectors including the volume of placements
- Explore options for day care in the residential sector to reduce the number of changes experienced in the course of an organic illness
- Establish effective arrangements for liaison, consultation, care coordination and review by CMHT(OP)s.

Extra Care Housing:

This also affords greater choice and availability of community alternatives. Development is likely to be a lengthy process and the level of overall impact, unless significant numbers are developed, will be small. However it is still worth further exploration.

Crisis Resolution and 24hour provision:

This may also be an important function. SCMh would advocate that for functional mental illness access to adult mental health service provision would be the more appropriate approach. This will need to be done with an understanding that access to other adult services could follow, especially inpatient care given the gate keeping role and early discharge planning arrangements that will have been established. This may need to be achieved through a re-negotiation of the age transfer into older people's services, such as 70 as opposed to 65. However whatever age limit is agreed, there should still be flexibility in order to make services more needs orientated.

For organic mental health a greater capability to pro-actively assess for and manage crisis points within day time services supplemented by a more community outreach intermediate care service would meet the majority of need. A number of areas have usefully made links with generic Rapid Response services to meet the crisis needs of people with dementias.

These two approaches are likely to be as effective and significantly less resource intensive than replicating an adult mental health model Crisis Response and Home Treatment Team for older people or Rapid Response Teams for older people with mental health needs.

Black and minority ethnic service users

The issue of specific needs of black and minority ethnic service users and carers across Devon and Torbay was not raised in any of the workshops in phase one or two. SCMh is aware that a programme of work is being planned in Exeter, based on the 'Question of Fairness' project, looking at the needs of local Muslim communities. At a national level, Professor Louis Appleby, national director for mental health, has identified the needs of black and minority ethnic communities as the area of mental health care where there is the greatest need and yet the least has been done.²⁴

The Department of Health's recently published 'Delivering Race Equality' is clear that improving responses to black and minority ethnic communities is not about developing separate mental health services but about taking action based on three building blocks:

- More appropriate and responsive services
- Increased community engagement; and
- Better quality information, more intelligently used.

This national programme of action is intended to support all those from minority ethnic communities who may experience discrimination and disadvantage including those of Irish origin, those of Mediterranean origin and East European migrants.

The risk of experiencing discrimination and disadvantage can be higher for people from minority ethnic groups in areas where their numbers are small. It is therefore particularly important in these areas to be proactive in countering these risks. Delivering Race Equality describes the action that needs to be taken around the three key building blocks above both at national and local levels. It also indicates where support for local action may be available from national bodies, in particular the National Institute for Mental Health in England (NIMHE) and the National Primary Care Development Team. Reference to and action upon these recommendations will be critical in developing older people's mental health services in Devon and Torbay that reduce inequalities and are genuinely responsive to individual needs.

Telemedicine and IT infrastructure

There is an increasing body of evidence to suggest that telemedicine can be a helpful tool in mental health care, even for people with quite severe dementia – particularly in

²⁴ Forrest E (2005) *Must Try Harder* Health Service Journal 31.3.05 Mental health supplement pp 2-4

dispersed or rural areas.^{25 26} Possible applications include cognitive assessments, links between primary and secondary care, running memory clinics and video conferencing for a range of consultation purposes. It can improve access to services and reduce travel time and costs for service users, carers and staff.

It is axiomatic that delivery of the new model of mental health care will require systematic developments in the IT infrastructure to facilitate access to information and support for users and carers and access to electronic patient records for staff across the system of care – as appropriate. The Department of Health is clear that the National Programme for IT must not only deliver new IT systems but also new approaches to designing care processes and services to ensure that staff and service users know how to get the best from the system and that it is kept up to date.²⁷

Implementation – making it happen

This section specifically relates to the priorities identified above and outlines the structures and processes that will be needed to support implementation. Some specific working group activity could be done at an individual PCT level, especially when the commissioning and planning framework is fully implemented. However at this initial stage of the project, much would be usefully done on a wider Devon and Torbay level.

Key Decisions and Sign off from Strategic Partnership Groups

The key service development areas present some significant challenges.

It will be important that sign off is reflected in financial planning and that a clear time frame is set that sustains the momentum for change already established by this project. There does appear to be a need to communicate some certainty that the agreement reached will be performance managed in respect of PCT area based commissioning.

Communication Strategy

There is huge expectation of this project leading to some fundamental change in the service profile.

Despite initial scepticism, the workforce is excited about taking forward some of the ideas generated within the workshops which are reflected within the proposals made in this report.

Critically important will be maintaining opportunities for two-way communication with the workforce about the decision making process and implementation strategy.

A communication strategy will need to be developed that supports this process from here on.

²⁵ Doze et al (1999) Evaluation of a tele-psychiatry pilot project. *Journal of Tele Medicine and Tele Care* vol 5 no 1 RSM press

²⁶ Simpson et al (2001) Telepsychiatry as a routine service – the perspective of the patient. *Journal of Tele Medicine and Tele Care* vol 7 no 3 RSM press

²⁷ Department of Health (2005) *Creating a Patient led NHS: Delivering the NHS Improvement Plan*

There will also need to be an active process of engagement in terms of developing detailed operational arrangements for new service developments.

Project Management/Business Lead

Effective project management of community service development is vital given the dependency of their implementation to reduce use of inpatient, nursing and residential care.

Each development area, including rationalisation of inpatient beds, will require dedicated planning. However SCMH propose that there is an overarching structure in place to ensure important linkages between each development are facilitated and that a whole systems operating model is maintained. This could involve the appointment of a project manager or business lead with links into joint commissioning arrangements, service provider organisations (statutory and voluntary) and service user and carer networks.

The project manager would have overall responsibility for pulling together the different workstreams that are likely to use a variety of approaches. These approaches may include dedicated working groups, work by the OPMH DIG, single workshops and mapping templates. SCMH acknowledge that some of this work will already have been done and that any previous reviews may still be relevant.

The Project Manager post would also create capacity to ensure localised commissioning structures work together as a whole as and when appropriate in order to afford great co-ordination, avoid duplication and ensure big picture development are not lost.

A further key task for this post would be the development of an evaluation framework to assess the impact of implementation of core elements of the service model.

Integration

SCMH note that there are clearly established multi disciplinary teams in many areas with joint management arrangements. However, in terms of maximising capacity within CMHTs, managing risk in relation to lower bed levels and providing greater consistency in psychosocial assessment and combined health and social care packages, greater integration is required.

SCMH are aware that there is a working group looking at integrated CPA and SAP. Membership of this should be extended and linked into wider CMHT/ integration. This enlarged working group will need to map out detailed proposals around:

- Job redesign and job descriptions. There are templates already developed for jobs in other care group areas and some OPMH posts in Exeter and East Devon that could potentially be used as a starting point for a Devon County and Torbay wide approach. These options may also apply for issues below and will need to be mapped and considered.
- Employment organisation and terms and conditions

- Accountability arrangements
- Recruitment arrangements
- Budget identification and aligned budget management
- Workforce development
- Policy and procedures
- IT systems
- Support services
- Core Team Competencies
- Professional supervisions and development v line management

This work will need to be particularly mindful of the implications of proposals for the future direction of social care contained in the recent Green Paper on Adult Social Care.

The following factors will strengthen strategic approaches to integration ²⁸:

- Shared vision: specifying what is to be achieved in terms of user centred goals; clarifying the purpose of integration as a mechanism for achieving such goals, and mobilising commitment around goals, outcomes and mechanisms
- Clarity of roles and responsibilities around concept of core competencies for effective comprehensive assessment and care management
- Appropriate incentives and rewards: promoting organisational behaviour consistent with agreed goals and responsibilities, and harnessing organisational self interest to collective goals
- Accountability to joint working
- Commissioning driven process with clarity about outcomes, partnership, models and workforce shape
- Legal agreements which capture the strength of relationships and the importance of outcomes as well as protecting the parties
- Encouraging innovation through bringing in a mixed economy of care

Workforce Development

The workforce and organisational development plan should be a priority consideration and this should include key voluntary and independent sector inputs.

This should support the full integration within teams and provide joint access and joint delivered core competency training with a specific emphasis on assessment and management of risk.

A shift to a more community based model will require some concomitant changes to the roles of staff across the system. Key amongst those roles requiring change is that of psychiatrists. Consultant psychiatrists have increasingly become involved with every aspect of service activity for every patient. They have been vested with ultimate clinical responsibility, power, leadership and management roles in teams or services. These trends benefit neither psychiatrists nor users of the service. There is increasing recognition nationally that in order to remain or become more attractive and viable, the

²⁸ Joannides, D and Gilbert, P (2003) *Positive Approaches to the Integration of Health and Social Care in Mental Health Services* – briefing for directors of Social Services on the integration of mental health services. NIMHE/ADSS

role of psychiatrists must be redefined to reflect their specialist skills.²⁹ If Trusts are to gain the maximum benefit from employing consultants within their services they must develop flexible and imaginative approaches to both immediate job planning but also the long-term career development of their work force.³⁰ Accompanying developments will be required across the multi disciplinary team to ensure competencies appropriate to the work.

Workforce development packages should also concentrate on whole systems working both in terms of communication and interface management skills but also cultural change in respect of professional and team isolation working practices. The Department of Health's 10 essential capabilities (see below) provide a useful framework for this development.

A number of national reports, including the independent inquiry into the death of David Bennett, have highlighted the need for improvements in the ability of mental health staff to respond appropriately to different racial and cultural groups. Delivering Race Equality recommends that local cultural capability frameworks should complement the 10 essential capabilities for mental health practice launched in 2004 by the Department of Health³¹. These capabilities, which strike a balance between values based practice and evidence based practice, are:

- Working in partnership
- Understanding and respecting diversity
- Practising ethically
- Challenging inequality
- Promoting recovery
- Identifying people's needs and strengths
- Providing service user-centred care
- Making a difference
- Promoting safety and positive risk taking
- Personal development and learning

Future workforce requirements in terms of numbers and types of qualified and non-qualified staff mapped out against service model quantification, current workforce retirement and known local training outputs, will be important. This will need to be explicit about those tasks and processes that can be undertaken at a generic level and those that require specialist skills. The aim should be to increase competence across the generic level to ensure that specialist resources and skills are effectively and efficiently targeted. The essential capabilities could provide a framework to skill development at the generic level. A business case setting out these requirements will be important in terms of securing any statutory corporate workforce planning inputs to the process.

Service User and Carer Empowerment

Ongoing engagement with service users and carers must be a priority within any implementation plan, both in terms of maintaining effective communication as well as

²⁹ Department of Health, RCP, NIMHE, BMA (2004) *New Roles for Psychiatrists*

³⁰ Ball, C. (2005) *Developing Consultant Roles in Older Adult Mental Health Services*. National Mental Health Partnership – older people's sub-group briefing No 2

³¹ Hope R (2004) *The 10 Essential Shared Capabilities – A Framework for the Whole of the Mental Health Workforce*. DH London

contributing information and knowledge in work around operational policy, procedures, and workforce development. SCMH would strongly advocate that service user and carer networks are fully supported in their development and engaged with regarding any evaluation and performance management of implementation and improved service outcome.

SCMH would support the establishment of specific user and carer networks focusing on older people's mental health as opposed to generic older people's needs. To this end it will be necessary to work in partnership with the voluntary sector to ensure that there is a lead organisation in each local area to undertake the necessary development work regarding sustainable networks. These networks should also be supported through that lead agency to link into local commissioning and planning frameworks and especially improved information and communication systems.

Service User Involvement

An Exeter Service User Involvement Group for people with functional mental health needs has contributed to developments on Rougemont Ward and in day services. Service users now participate in staff recruitment. Rougemont Ward has regular patients' meetings, with user involvement in Essence of Care projects leading to improvements in privacy & dignity. At the ARC Project, service users participate in roles at a day resource, in planning activities and groups (ranging from CBT, relaxation, crafts, physical and mental aerobics). ARC service evaluations have used interviews, focus groups and questionnaires and have shaped commissioning priorities. **Senior Voice Project** visits at regular intervals to ensure that views of people whom may be hard to reach are included in their citizenship projects **South Hams & West Devon Rural CMHT are** launching a service user satisfaction survey, which will be ongoing. **In Sidmouth in East Devon**, day services for older people with functional mental health needs have been actively developed with service users involved therapeutic activities suitable for their needs

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Carer Involvement

An East Devon OPMH Local Implementation Group sub-group investigated carers' perception of their needs. The resulting survey and report "Your Life is Not Your Own", informed the PCT's recent commissioning strategy. Focusing on dementia, a questionnaire to carers was distributed by staff. Results highlighted details of the extensive commitments given by carers, loss of personal freedom, isolation and value placed on specialist Community Mental Health Nurses. Carers preferred to see improvements in service integration, 24hour help and advice, a telephone help line, day care in the home, a central bank of carers (especially other older people) and better general health care for carers. Only a few carers preferred respite care in hospital and the majority asked for respite in more non-hospital settings.

Contact: Robert.Hallett@DevonPtnrs.nhs.uk

Leadership

The changes required to bring about a significant shift in the resource profile and radical rethink in the use of acute inpatient beds, will require transformation of existing services and not just an incremental increase in current services. Changes will affect service configurations, team working, the philosophy of care, budgets, and will challenge staff and management.

We strongly believe that delivering this degree of organisational and cultural change will require strong, visionary, and innovative leadership. The proposal advocates strengthening of leadership at an integrated health and social care level and which can span all partner organisations across each PCT area.

Commissioning

Undertaking this level of service development, being able to evaluate and monitor impact at key stages, and fully understand the sequencing that supports disinvestment and reinvestment is a complex task. SCMh make the strongest recommendation that effective joint commissioning arrangements are put in place to support this process.

SCMH propose an integrated PCT/ Local Authority commissioning structure built around PCT areas and designed to support care pathways. It will fall under a generic older people's heading but have sufficient capacity and expertise to give required attention to OPMH.

It will operate with aligned health and social care budgets and be responsible for local implementation of agreed service outcome priorities set by a Devon OPMH Implementation Group (DIG), responsible to the Devon Older People's Strategic Partnership - and a separate Forum in Torbay.

The commissioning structure and OPMH DIG should be supported and linked to fully established OPMH Local Implementation Groups (LIGs) in each PCT area. SCMh understand that these exist in some areas but are not universally established and in some cases have not been sustained. SCMh make a strong recommendation that these groups are established and supported by the commissioning structure. They should be instrumental in:

- Maintaining momentum of strategy implementation
- Organising ongoing assessment of need
- Refinement of strategy to reflect need
- Supporting the flow of information between stakeholders including service user and carer networks and the voluntary and independent sector
- Providing a conduit between recipients of service and statutory commissioners and providers

In developing joint commissioning arrangements to support a range of care groups SCMh strongly recommend that there is sufficient time built into job descriptions to give sustainable input into older people's mental health. This together with establishment of joint agency older people's service managers should enable the ambition of effective PCT area based commissioning to become a reality.

Establishment of a pan PCT Implementation Group and possible project manager/business lead provides some planning capacity and the forum in which to undertake effective partnership working. It will be of central importance in terms of co-ordinating the inputs from the partner organisations and linking implementation with the wider workforce and service user and carer networks.

Change of this scale requires effective commissioning. This will be essential in undertaking more detailed financial breakdowns of savings from disinvestment in beds that in turn could offset additional new investment. Baseline information will need to be established about existing service and operating costs. Important resourcing decisions will need to be made across both PCT and Local Authorities and performance management outcomes and targets set and monitored.

There is therefore a need to ensure there is sufficient capacity and expertise available to support this commissioning process within each joint PCT/ Local authority building block. In addition, mapping out in advance the areas of development that require targeted joined up work across PCT areas to support their development will be important. This should be driven by thinking that cannot be done solely within one PCT area, because of the more specialist nature of that development which is unlikely to be sustainable within single PCTs. Also there would be wasted duplication of work across PCTs especially relating to technical planning and or outcomes or ways of working that must apply equally across all of say Devon County Council.

The initial service development requirements that will arise from adoption of proposals and recommendations in this project will help to identify initial planning that must cut across single PCT areas. As time moves on there should be routine mechanisms that enable identification of these shared planning opportunities. Maintaining the project steering group is perhaps one approach whilst establishing a fixed point in time for PCT based commissioning and planning personnel to come together as a wider forum is another.

Appendix One

Data Analysis and Capacity Modelling

Introduction

SCMH have completed a data collection and analysis exercise. The data collected includes the level and utilisation of inpatient and community resource and has been analysed to make observation and recommendation against four key areas.

- Future inpatient bed requirements
- Current impact and resourcing of community teams
- Supporting community services
- Practice development targets

Supporting Principles

The use of data analysis for purposes of making observations on current and future need, practice and service level is fraught with difficulties.

- Benchmarking within OPMH to identify service resource base is not recommended.
- Deprivation indices for weighting demography are not necessarily appropriate for understanding need or making like for like comparisons
- In general the information systems and data available from them is limited and there are questions of accuracy given inconsistent input of data across the services.
- Acute bed provision analysed against use of residential/nursing care is likely to be relevant but requires further clarification.

Having identified these limitations it is still possible to make some conclusions from the data to support legitimate proposals and recommendations.

- Bed utilisation including admissions, lengths of stay and occupancy levels should be more uniform. SCMh use this to make observations on current practice and potential capacity projections.
- Capacity within CMHT should be influenced around team critical mass, with reference to referral rates and demography and internal (Devon and Torbay wide) benchmarking. What is important is that a benchmark average of current provision is not used in isolation given that OPMH service nationally and locally are probably under resourced.

Headline Findings Health Data

Inpatient Bed Provision and Usage

There are a number of significant issues that emerge from the data analysis.

1. Levels of bed provision per 10k population.

There are considerable differences in the number of beds provided per 10,000 PCT population across Devon and Torbay. East Devon, Exeter and Mid Devon have twice the provision of Teignbridge and Torbay* and between 10 and 29 beds per 100,000 higher than North Devon and South and West Devon.

As discussed above it is difficult to equate need with deprivation scores and therefore difficult to calculate this apparent over provision with an understanding of need. Nonetheless whilst it is likely that Exeter has additional factors that might support a significant difference in provision it is difficult to understand why East and Mid Devon might require such an additional level of provision.

*Torbay beds calculate against provision since suspension of Briseham Unit

2. Bed occupancy.

Generally units are operating at national target levels of 85% or under. There are three units with occupancy over this Rougemont at 96.1% Westleigh at 91.7% and Abbotsvale at 87.4 %

Two units which have since been suspended Stowford Lodge and Briseham were both operating at just over 50% occupancy.

There are two units operating below 70% occupancy Redvers and Harbourne and a further three operating under 80% occupancy Fernwothy, St Johns court and Melrose.

With an overall occupancy of 77.7% together with other factors of admission rates there is likely to be an issue of over capacity to which SCMH comment on below.

3. Admissions per 10K population.

There are some stark difference between the numbers of people admitted to inpatient care with East Devon PCT having three and half times the level of admissions than South and West Devon. In general East Devon, Mid Devon and Torbay are making significantly more admissions over 30% more than other areas.

Again SCMH would question why there is such a significant difference in certain areas and return to this in later in making proposals around future inpatient provision.

4. Lengths of stay.

Lengths of stay tend to be useful information in terms of understanding how inpatient beds are being used and what some of the pressures may be in respect to bed blocking. The data supplied together with occupancy levels would suggest there are no particular difficulties with bed blocking. Whilst there is no national bench mark information the figures look low compared with other areas SCMH has studied. There is an exception for Exeter, which as discussed earlier may well reflect the different demographic makeup compared with other areas. The other area of interest is North Devon, which is notably higher than other areas. SCMH believe that this may be associated with three specific factors, low staffing ratios compared with other units, low community resources and lack of integrated CMHT which could affect access to social

care assessments. Leaving aside Exeter there is a general correlation between higher lengths of stay and lower inpatient and community resources.

5. Conclusion

Leaving aside Exeter, due to its unique demographic issues and Torbay, given its suspension of Briseham Unit, there is evidence to suggest there is an over provision of inpatient beds. SCMH does not make specific recommendations on the number of beds that can be reduced in each area as this should be worked out as part of each PCT areas detailed implementation commissioning strategy. However SCMH make reference to some of the main differences between PCT areas that should be influential in developing commissioning strategies.

East Devon

For East Devon there should be an expectancy that admission levels and bed provision be more closely matched with other areas across Devon. With current average occupancy levels at only 79% it should be an achievable task. In addition East Devon has been pro-active in planning an integrated CMHT(OP) and made an innovative move in appointing a service manager specifically for older people's mental health with both operational and commissioning responsibilities and accountabilities. The newness of these developments mean their impact will not have been evident in the data set analysed, which is from 2003/4.

Mid Devon

In respect of Mid Devon it has the highest level of bed provision and the second highest admission rate. In addition it has only an 81% occupancy level and uses four different sites two of which are small six bedded units. SCMH would suggest that with a reduction in admission levels comparable with other areas and a rationalisation of sites it should be possible to reduce bed numbers and reinvest in building up the limited community infrastructure.

North Devon

For North Devon, admission levels are lower than comparable areas, bed provision is at the Devon and Torbay wide average and occupancy is marginally below the 85% national target. There is little scope for any significant bed reduction and it is unlikely that any level of reduction possible would fund the development of CMHTs. It is however possible with two mixed units of 15 and 23 beds, to explore some slight reduction to improve staffing ratios and to move to specialist functional and organic mental illness units. This would also facilitate an ability to provide more therapeutic input and help tackle the higher than average lengths of stay.

SCMH are aware that this is under discussion at present and would be supportive of such a development.

South and West Devon

In respect of South and West Devon bed provision is above the Devon and Torbay average yet admissions per 10k population, lengths of stay, and occupancy levels are

the lowest across Devon. With occupancy levels at 67% and inpatient/community staffing ratios above average there is likely to be scope for a reduction in bed provision.

Staffing Levels Inpatient Units

There are some notable difference in the staffing ratios for inpatient units and some correlation between these and the average lengths of stay per patient.

SCMH have undertaken considerable work through its 'Search for Acute Solutions' project in trying to understand what factors contribute to providing a more therapeutic inpatient environment. Whilst there are a wide range of influential factors and the study focuses on adult mental health, there is an issue about staffing ratios and degree of specialism available that are equally applicable to older peoples mental health. The lower the staff ratio and greater range of needs having to be provided for did significantly impact on a wards ability to consistently undertake good quality need assessments and effective discharge planning.

What is notable is that in general the units with the lower staff ratios such as David Barlow, Westliegh and Rougemount Wards had much higher lengths of stay whilst units with higher staff ratios such as Harbourne, Fernworthy and Rowan tended to have much lower lengths of stay. Clearly there are many other factors to consider in looking at reasons for longer lengths of stay such as community service availability, community clinical practice, and wider service linkages.

In terms of improving patient and staff experience SCMh would therefore be supportive of a minimum of ratio of 1 qualified nurse and 1.5 qualified nurse and care assistant being applied to all units. This would fit with a Devon and Torbay wide benchmark and match the UK benchmark for qualified nurse per bed ratio for adult mental health. This should be an achievable target given the potential for bed numbers to be reduced across the system. However this would impact on any ability to reinvest savings from bed reduction in supporting development of community services. It may be that bed reduction and rationalisation would as a result release less money than hoped and this will need to be carefully quantified within individual PCT area commissioning strategies.

Medical and Community Staffing Levels

1. Medical Staff

Data analysis does show some significant difference in the level of medical staffing available across PCT areas. The benchmark average is 1.4 per 10k population bur there are some exceptions that are significant enough for SCMh to make specific observations.

The first is the higher level of provision for Torbay and South and West Devon and the second, the lower level of provision in Mid and East Devon and especially Exeter.

2. Community Health Staffing

As with medical staffing there is significant difference in the level of community staffing available across some PCT areas. Most notable, is the low level of community nursing provision in Torbay, Mid and especially North Devon. Again community nurse staffing for North Devon is worryingly low compared with other areas especially as it also has the lowest level of provision for community care assistants, occupational therapists, psychologists, managers, and administrative staff.

Headline Findings Social Care Data

Residential and Nursing Home Placements

A similar pattern has emerged for residential and nursing home placements as for hospital admissions. Torbay and Mid Devon are above average in respect of numbers of people cared for in residential and nursing home accommodation, per 10,000 older adult population. North, Teignbridge and South and West are well below average. Exeter, however is unlike its hospital admissions pattern, with residential and nursing home placements well above average.

Community Resources

A pattern begins to emerge when considering the relationship of community resources with hospital, residential and nursing home admissions/placements.

Generally areas with higher levels of community resources are making lower demands on residential and nursing care. For example Teignbridge, North Devon and South and West Devon have higher social work, community support worker, referral co-ordinators and practice managers and for Teignbridge and South and West Devon this together with establishing dedicated mental health staff is likely to have greater impact. For Exeter despite having the largest dedicated mental health resource are in general low in overall level of resource.

There are exceptions however, such as Mid Devon, where residential and nursing home placements are higher yet community resources are also comparatively high. This may be explained when health resources are factored into the equation. For Mid Devon community health resources are comparatively low which potentially cancels out any high social care provision.

What does appear consistent is where there are both higher levels of health and social care resources and where these are organised as integrated health and social care community mental health teams there is both a combined lower level of hospital admission and residential/nursing home placement. The two clearest examples of this are Teignbridge and South and West Devon. The only notable exception is North Devon where both hospital admissions and residential/nursing home placements are relatively low yet overall resourcing levels are not high and there are no integrated CMHTs(OP).

4. Conclusion

As discussed above there are difficulties in using benchmarking information to determine future service capacity. However, internal benchmarking across Devon and Torbay, particularly when matched with activity data does provide an opportunity to consider what is an appropriate staffing complement for the establishment of community mental health teams across Devon and Torbay.

SCMH have specifically looked to see if there are norms for provision and resulting activity, that a majority of areas are close to. In addition we have looked for extreme over and under provision and considered its impact on activity. In doing so SCMHT try to construct a model for CMHT provision that can inform future implementation and commissioning activity.

The modelling is described below however underpinning assumptions from staffing and admission patterns are discussed here.

- The medical staffing levels for Devon are relatively low with some areas significantly lower than others. Therefore SCMHT are advocating areas modelling up to the higher levels of provision for each service and/or discipline including medical staffing.
- There are some anomalies that need further investigation. Exeter has higher resources, an integrated CMHT structure and smaller population yet whilst making fewer hospital admissions is making higher residential and nursing home placements. North Devon has relatively low health resources and slightly higher but generic social care resources and yet both hospital admissions and in particular residential and nursing home placements are low.
- Areas with lower community provision such as, nursing, care management, domiciliary support and day care tend to have higher than average admissions to hospital and residential/nursing care (see SSD data) and Health data.
- Areas with CMHTs tend to have the best-combined results in terms of both reduced hospital admissions and residential/nursing home placements.

SCMH make the following proposals for CMHT modelling.

- Teams must be multi disciplinary and ideally include Psychologists, Occupational Therapists (mixed health and social care) and Support Workers (mixed nursing assistant and social service community support workers) in addition to a Consultant Psychiatrist, Social Workers and Community Psychiatric Nurses.
- There should be single line management. Where the manager is from a health background it will be important to have a senior social work practitioner to give a professional social care lead. Where the manager is from a social care background there should be an H Grade professional nursing lead.

- It is difficult to make hard and fast recommendations regarding CMHT(OP) as there will be different needs and inevitably be different historical patterns of provision across a range of health and social care services. However taking into consideration areas of higher provision as a benchmark and issues of critical mass SCMH make the following recommendation Per 25,000 older adult population.

Team Composition: -

Consultant Psychiatrist	x 2fte
Team Manager	x 1fte
SSWP/Grade	x 1fte (included in CPN & SW numbers)
Social Worker	x 5fte
CPN	x 6fte
Referral Co-ordinator	x 1fte
Support Workers	x 5fte
OT	x 1fte
Psychologist	x 1fte

NB there will also be a need to consider other medical staffing grades as well as CPN and Social Work grades within the over staffing compliment.

Data Analysis for Older People's Mental Health Services
Data for 12 months from 1st August 2004 until 31st July 2004

Socio-economic deprivation, as measured by the Jarman under-privileged area (UPA) score (Jarman, 1983) and other measures, is associated with a high prevalence of disease, including severe mental illness (Thornicroft et al, 1992; Acheson, 1998). A more recent measure of social deprivation linked specifically to the prevalence of mental health problems in working age adult is the MINI 2K compiled by Centre for Public Mental Health, Durham University. Deprivation scores such as the MINI 2K are used to enable like for like comparisons, when the areas being compared have different levels of affluence, employment, housing etc.

Unfortunately there are, as yet, no indicators of deprivation that specifically cover the needs of older people. It was felt that an overall index of deprivation may give some insight into relative need across the Devon and Torbay. The Index of Multiple Deprivation 2004 ('IMD 2004') (DETR) provides an overall picture of multiple deprivation based on a number of indices including:

- Income;
- employment;
- health deprivation and disability;
- education, skills and training;
- housing;
- geographical access to services.

Indicators are calculated at electoral ward level. These are then aggregated to local authority and ranked. As there are 354 Local Authorities, the most deprived is ranked first or 1 and the least deprived 354. Ranking and scores for all the LAs in the Devon and Torbay area are shown in the table below.

When IMD 2004 scores are further aggregated to county level, they range from 1 to 149 as there are 149 counties in England. Devon County ranks 100, whereas Torbay County ranks 66.

Table 1. PCT Populations and deprivation scores

PCT	PCT Pops over 65yrs	%age difference bet. GP and PCT pop	LA Name	Rank of Average Score
East Devon	33,034	5%	East Devon	246
Exeter	21,753	4%	Exeter	115
Mid Devon	18,087	-13%	Mid Devon	175
North Devon	31,005	-2%	North Devon	133
			Torridge	119
S Hams & W Devon	23,848	9%	South Hams	227
			West Devon	187
Teignbridge	24,449	5%	Teignbridge	177
Torbay	29,360	-4%	Torbay	94

The table above illustrates that Torbay is the most deprived of the areas being compared, while East Devon is the least deprived. As can be seen differences between the PCT and GP populations range from 2% to 13%.

Bed Provision

A breakdown of bed provision is presented in Table 2 below. At the time of analysis, only four of the seven PCTs had beds dedicated to older people with functional mental health problems. In the other PCTs, beds are used on a needs basis and there are no beds separately dedicated to functional or organic problems.

Please note that:

Stowford Lodge, a 16 bedded unit providing inpatient and day services in the East Devon PCT area had its inpatient service suspended on the 9th Sept. 2003 and has not been included in the calculations below.

The 14 beds provided by Plymouth PCT to South Hams and West Devon are by 'gentleman's agreement' and may not always be available.

Table 2. Bed Provision by PCT

PCT	Ward	Beds	Dedicated Anxiety/ Depression/ Psychosis Beds	Total Beds	Beds per 10,000 PCT Pop over 65 yrs
East Devon	Conybeare*	4		45	14
	Rowan	6			
	St Johns Court	14			
	The Bungalow	14			
	Rougemont **	7	12%		
Exeter	Rougemont	11	33%	33	15
	Westleigh	22			
Mid Devon	Boniface	6		28	15
	Melrose	12			
	Redvers	6			
	Rougemont	4	14%		
North Devon	Abbotsvale	15		38	12
	David Barlow	23			
South Hams & West Devon	Harbourne	16		30	13
	Pinewood in Plymouth	7			
	Cotehele in Plymouth	7	23%		
Teignbridge Devon	Brunel Lodge	16		16	7
			14%	190	12
Torbay	Briseham ***	19		38	13
	Fernworthy	19			

* Although Conybeare unit has 9 beds, 5 are contracted for Dorset patients and 4 are available for East Devon patients

** Rougemont Ward is based in Exeter and takes people with functional mental health needs from Exeter and Mid Devon and East Devon

*** The inpatient service at Briseham has since been suspended from end Dec 2004

Teignbridge has the least beds dedicated to older people, however there is anecdotal evidence that on average there are two patients from Teignbridge on the Fernworthy ward in Torbay.

Analysis of Hospital Episode Statistics (HES)

In order to study specialist mental health NHS inpatient service usage, inpatient stays for patients who had been discharged between August 2003 and July 2004 were analysed. As there is currently no national comparative data available, all tables have an average figure for Devon and Torbay. Please note that the data contains records for patients in Stowford Lodge during the months of August and September 2003.

TABLE 3 – Inpatient Stays per 10,000 population over 65yrs split by diagnosis

PCT	All diagnoses PCT pop over 65yrs	Anxiety, depression & psychoses PCT pop over 65yrs	Dementia & confusion PCT pop over 65yrs
East Devon	117	30	87
Exeter	58	24	34
Mid Devon	98	22	76
North Devon	42	13	30
S Hams & W Devon	34	7	26
Teignbridge	63	17	47
Torbay	90	26	65
Devon and Torbay	73	20	53

As can be seen from the breakdown of inpatient stays by diagnosis (Table 3), the number of people being admitted with functional mental health needs (anxiety, depression, psychoses) is slightly higher than the number of beds dedicated for these problems (in those PCTs where there are beds dedicated to functional problems). However, if we compare the occupied bed days (OBDs) that were used by patients with these problems, the number is higher than expected for the number of beds available.

Table 4. Inpatient stays split by diagnosis as percentage of total

PCT	Anxiety/depression & psychoses	Dementia & confusion
East Devon	26%	74%
Exeter	41%	59%
Mid Devon	22%	78%
North Devon	30%	70%
S Hams & W Devon	21%	79%
Teignbridge	26%	74%
Torbay	28%	72%
Devon and Torbay	27%	73%

Table 5. Inpatient stays split by diagnosis and bed days

	All diagnoses	Anxiety, depression & psychoses		Dementia & confusion	
PCT	Bed days	Bed days		Bed days	
East Devon	12709	5460	43%	7249	57%
Exeter	10706	4513	42%	6193	58%
Mid Devon	7549	2197	29%	5352	71%
North Devon	7166	2898	40%	4268	60%
S Hams & W Devon	2170	563	26%	1607	74%
Teignbridge	5434	1472	27%	3962	73%
Torbay	10299	3247	32%	7052	68%
Devon and Torbay	56033	20350	36%	35683	64%

Diagram 1.

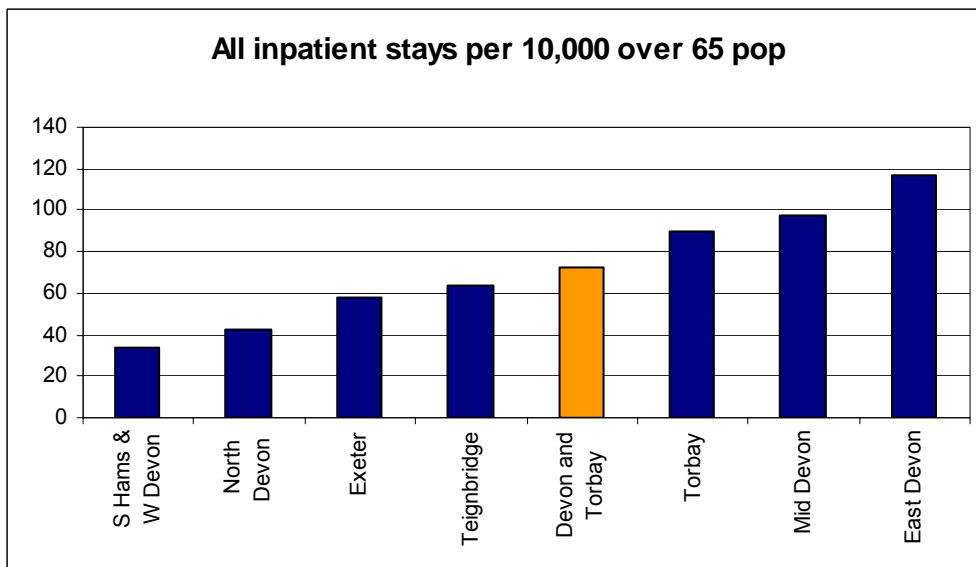


Diagram 2.

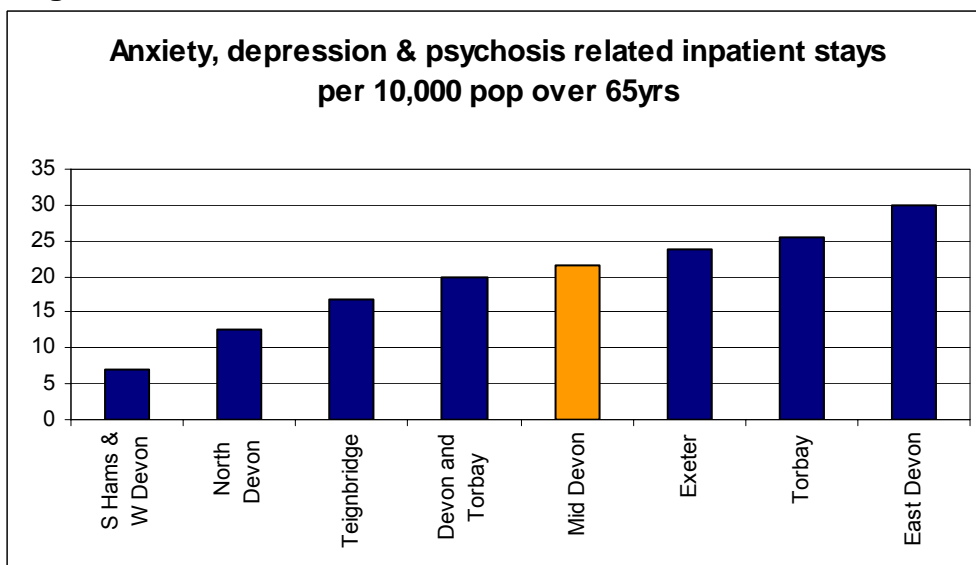
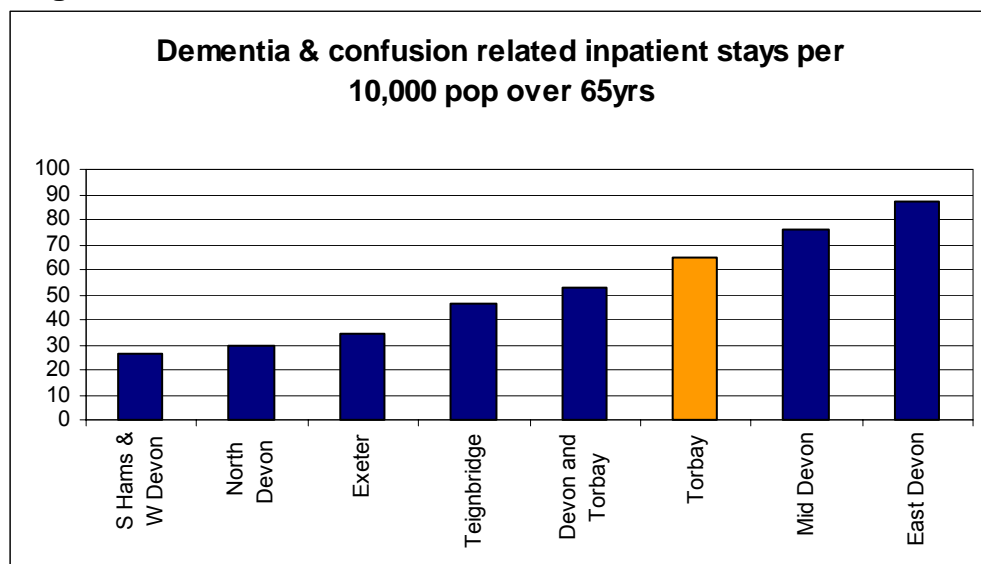


Diagram 3.



The average length of stay for older people in Devon and Torbay is 42 days. Length of stay is highest for patients with functional problems at 56 days. Patients with organic problems tend to spend an average of 39 days in hospital. The average age of patients ranges from 75 to 87.

Table 6. Average length of stay (LOS) and age broken down by diagnosis

Av LOS days	All		Anxiety/depression & psychoses		Dementia & confusion	
	Av LOS days	Av Age	Av LOS days	Av Age	Av LOS days	Av Age
East Devon	33	82	55	78	26	83
Exeter	84	80	87	76	71	82
Mid Devon	43	78	56	76	38	79
North Devon	55	78	74	77	47	78
S Hams & W Devon	27	80	33	78	22	80
Teignbridge	35	80	36	77	31	81
Torbay	39	80	43	78	36	81
Devon and Torbay	42	80	56	77	35	81

Diagram 4.

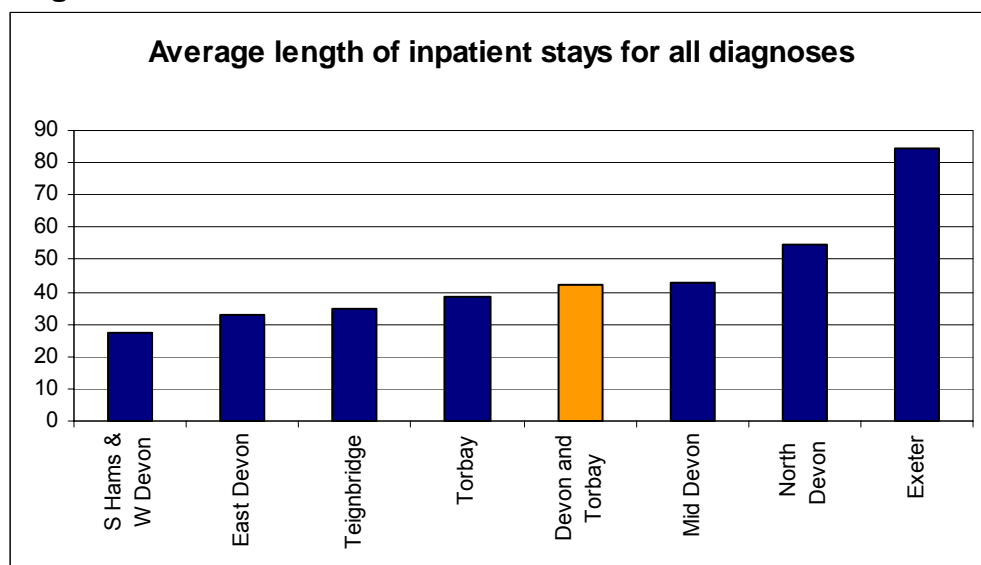


Diagram 5.

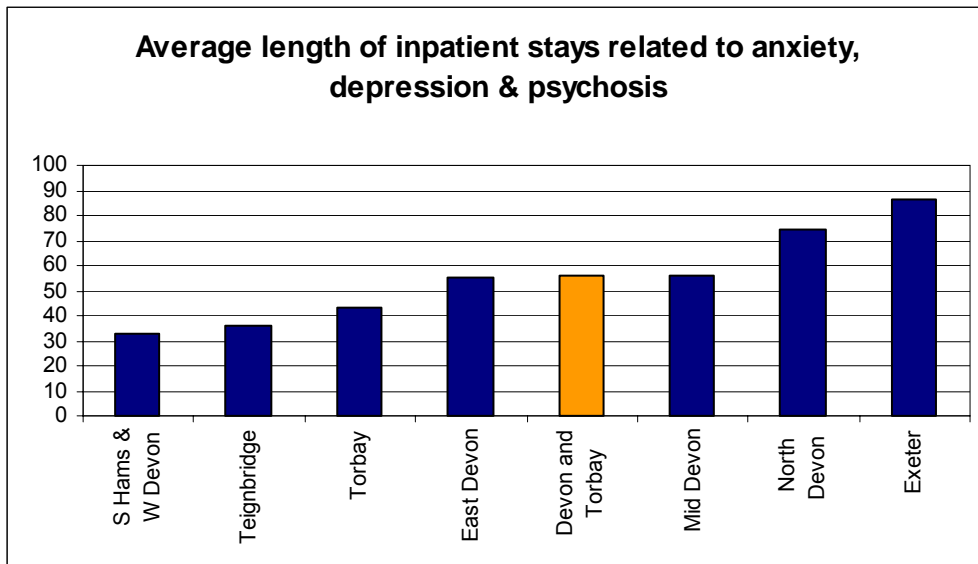
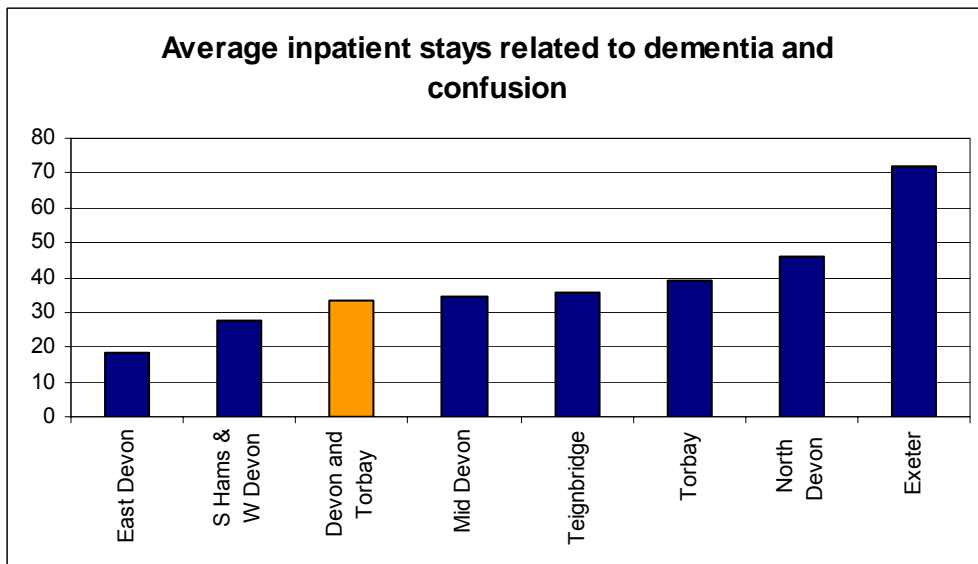


Diagram 6.



Transfers and Multiple Admissions

An analysis of single and multiple admissions was carried out on the hospital episode statistics. A study of the data showed that transfers from one hospital to another (e.g. from a PCT community hospital or acute trust hospital to a specialist mental health unit, or from a private to an NHS hospital) were being picked up as multiple admissions. Even though the data contains this anomaly it was felt that it would be useful information for commissioners/providers given that this would be one way of identifying breaks in the continuity of care. In addition to this, transfers can be experienced as quite traumatic by some clients, especially for people with dementia where continuity in surroundings and staff are important.

To be better able to calculate multiple admissions in the future, it would be useful if there some way of identifying whether an inpatient stay was a transfer or a new admission.

Table 7. Inpatient stays as single admissions, transfers and multiple admissions per 10,000 PCT pop over 65yrs

PCT	Single admissions PCT pop over 65yrs		Transfers and multiple admissions PCT pop over 65yrs	
	Count	Percentage	Count	Percentage
East Devon	50	71%	21	29%
Exeter	35	80%	9	20%
Mid Devon	44	73%	16	27%
North Devon	24	79%	6	21%
S Hams & W Devon	14	72%	5	28%
Teignbridge	27	69%	12	31%
Torbay	41	69%	19	31%
Devon and Torbay	33	72%	13	28%

Diagram 7.

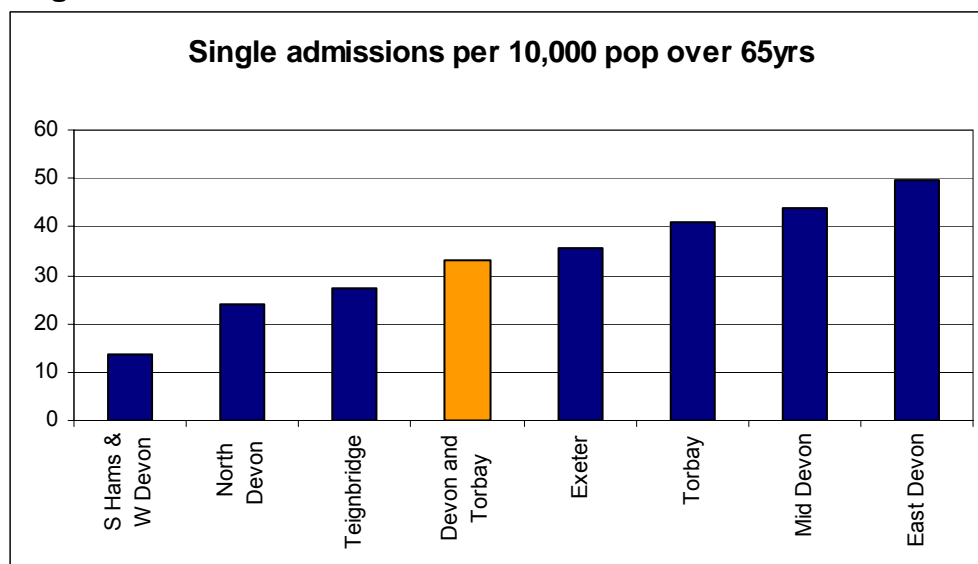
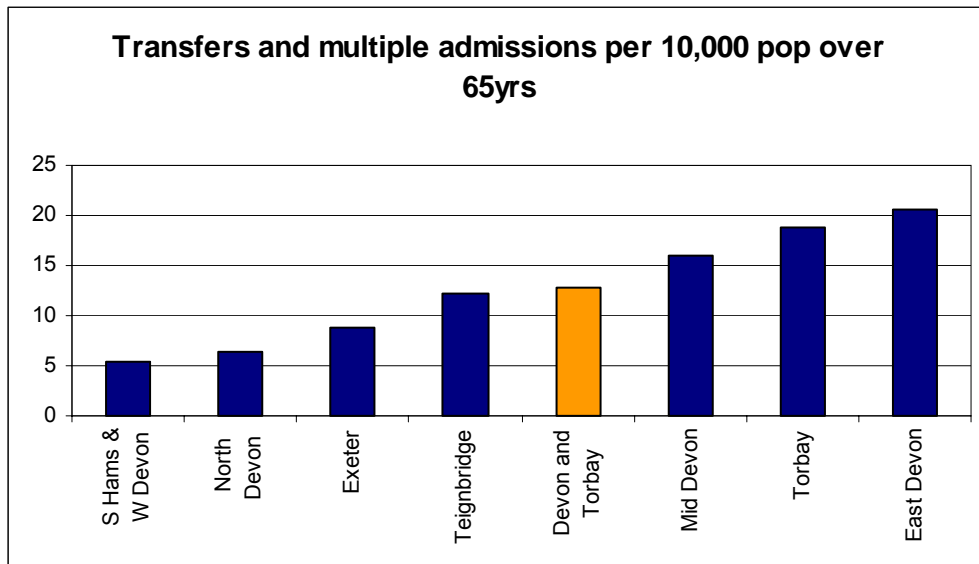


Diagram 8.



Bed Occupancy

Bed occupancy was initially calculated using hospital episode statistics(HES), the results of which are presented in table 8.

Table 8. Breakdown of inpatient stays by ward, average length of stay and bed occupancy rate

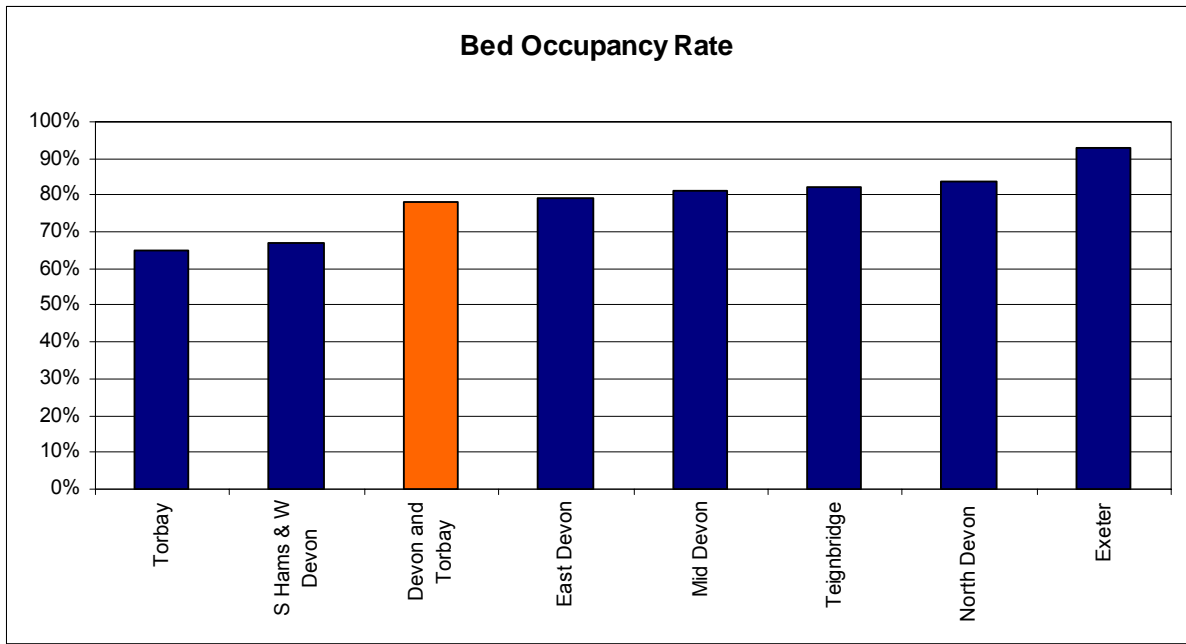
PCT	Unit Name	All inpatient stays	Average length of stay	Bed occupancy rate
East Devon	The Bungalow	113	33	79%
	Rowan Ward	89	17	70%
	St. John's Court	73	44	66%
	Conybeare Ward	57	21	36%
	Rougemount Ward	35	60	86%
	Stowford Lodge	12	45	55%
	Westleigh Ward	4	66	95%
	Fernworthy Unit	2	8	79%
	David Barlow Unit	1	154	48%
	Total / Average	386	33	68%
Exeter	Westleigh Ward	74	97	95%
	Rougemount Ward	40	78	86%
	St. John's Court	6	23	66%
	The Bungalow	3	29	79%
	Boniface Ward	2	44	88%
	Melrose Unit	1	66	64%
	Rowan Ward	1	48	70%
	Total / Average	127	84	78%
Mid Devon	Melrose Unit	72	38	64%
	Redvers Ward	36	32	54%
	Boniface Ward	33	48	88%
	Rougemount Ward	26	66	86%
	The Bungalow	4	49	79%
	Conybeare Ward	2	7	36%
	St. John's Court	2	5	66%
	Fernworthy Unit	1	49	79%
	Westleigh Ward	1	113	95%
	Total / Average	177	43	72%
North Devon	David Barlow Unit	80	48	48%
	Harbourne Unit	71	27	67%
	Abbotsvale	36	84	56%
	Total / Average	131	55	82%
South Hams & West Devon	Boniface Ward	15	18	88%
	Fernworthy Unit	7	13	79%
	Briseham Unit	2	84	59%
	Total / Average	80	27	75%
Teignbridge	Brunel Lodge	120	36	74%
	Fernworthy Unit	28	32	79%
	Harbourne Unit	4	28	67%
	Abbotsvale	1	27	56%
	Westleigh Ward	1	77	95%
	Redvers Ward	1	28	54%
	Total / Average	155	35	71%
Torbay	Fernworthy Unit	102	43	79%
	Briseham Unit	94	42	59%
	Harbourne Unit	68	28	67%
	Brunel Lodge	1	42	74%
	Total / Average	265	39	70%
Devon and Torbay		1321	42.4	69%

However, it was felt that this data did not correctly reflect occupancy on the wards. Further data was sent which had been collected via the Patient Administration System (PAS) and was felt to be more accurate than that collected via HES. An analysis of this data for the same time period August 2003 to July 2004 is presented in table 9.

Table 9. Bed occupancy rate by ward and PCT

PCT	Ward	Bed occupancy rate
East Devon	Conybeare*	88.3%
	Rougemont **	96.1%
	Rowan	80.5%
	St Johns Court	76.4%
	Stowford Lodge	50.9%
	The Bungalow	82.8%
	Average BOR	79.2%
Exeter	Rougemont	96.1%
	Westleigh	91.7%
	Average BOR	93.9%
Mid Devon	Boniface	84.9%
	Melrose	76.3%
	Redvers	66.6%
	Rougemont	96.1%
	Average BOR	81.0%
North Devon	Abbotsvale	87.4%
	David Barlow	81.1%
	Average BOR	84.2%
South Hams & West Devon	Harbourne	67.4%
	Pinewood in Plymouth	---
	Cotehele in Plymouth	---
	Average BOR	67.4%
Teignbridge	Brunel Lodge	82.3%
Torbay	Briseham ***	52.9%
	Fernworthy	77.8%
	Average BOR	65.4%
Devon & Torbay	Total Average BOR	77.7%

Diagram 9. Bed occupancy rate based on patient admin. system data



Inpatient and Community Staffing Levels

The below staffing figures are based on established staffing figures as at August '04.

Table 10. Staff establishments to bed ratio for inpatient wards

PCT	Ward name	Beds	Qualified nursing staff to bed ratio	Assistant care staff to bed ratio
East Devon	Conybeare	9	0.49	1.02
	St. John's Court	14	0.49	0.69
	The Bungalow	14	0.49	0.69
	Rowan	6	0.63	0.83
Exeter	Rougemt	22	0.47	0.75
	Westleigh	22	0.46	0.55
Mid Devon	Boniface	6	0.40	0.17
	Melrose	12	0.48	0.00
	Redvers	6	0.45	0.00
North Devon	Abbotsvle	15	0.60	0.57
	David Barlow Unit	23	0.30	0.52
South Hams West Devon	Harbourne	16	0.91	1.07
Teignbridge	Brunel	16	0.73	0.92
Torbay	Fernwrthy	19	0.71	0.63
	Briseham	19	0.59	0.92

Nursing and care assistant to bed ratio are based on established staff rather than staff per shift. The housekeepers on the wards in Mid Devon have not been included in the calculations, neither have the USA staff in Torbay and Teignbridge.

Diagram 10.

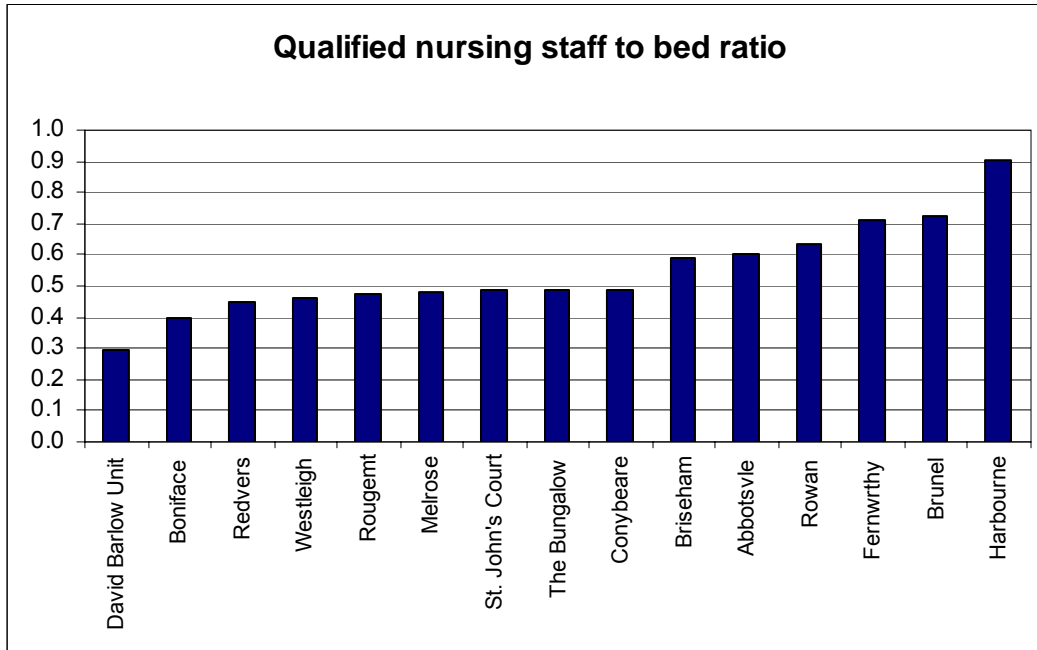


Diagram 11.

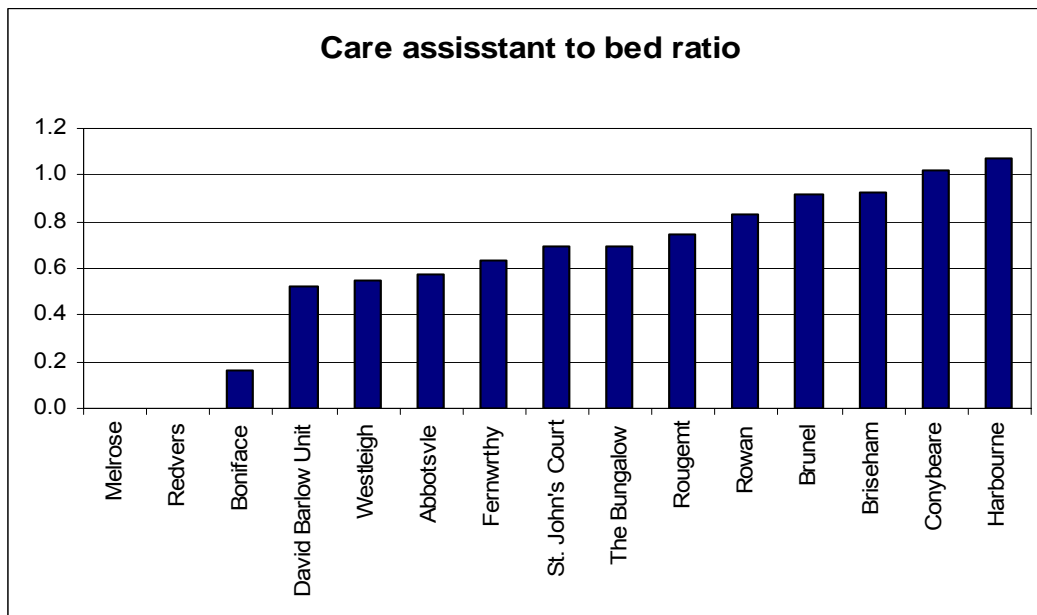


Table 11. Medical Staffing as whole time equivalents

PCT	Consultant Psychiatrist	Associate Specialist	Staff Grade Doctor	Senior House Officer	Clinical Assistant	Hospital Practitioner	Other Grade	Total
East Devon	1.36	1			1.27	0.27		3.9
Exeter	0.8		1	1				2.8
Mid Devon	1 (unfunded)*				0.8*			1.8
North Devon	1.4			? **	0.5**			1.9
S Hams & W Devon	2			0.67				2.67
Teignbridge	1		1	0.67			1	3.67
Torbay	2			0.67				2.67

* Mid Devon:

- The 1.0 wte Consultant Psychiatrist is an unfunded post, with longstanding locum arrangements
- The 0.8 Clinical Assistant is a PCT SLA for out-of-hours cover of inpatient units

** North Devon:

- At the David Barlow Unit (Barnstaple) there is Senior House Officer rotation cover, which cannot be quantified
- The 0.5 Clinical Assistant cover is provided on a regular locum basis

In order to differentiate between community and inpatient medical staffing, total medical staffing figures were treated as spending 70% time in inpatient settings and 30% in the community. Please note the Exeter nursing staff include ALL Rougemont staff, even though Rougemont staff also serve the 7+4 east and mid devon beds on Rougemont ward – therefore serving more than the Exeter 65+ population.

Table 12. Inpatient Staffing per 10,000 over 65 pop

PCT	Qualified Nurses	Care Assistants	OTs*	Medical Staff	Admin. Staff
East Devon	8.0	13.2	0.7	0.87	0.8
Exeter	9.8	2.7	0.5	0.94	1.1
Mid Devon	5.3	0.5	0.5	0.61	0.7
North Devon	5.0	6.5	0.9	0.42	0.5
S Hams & W Devon	6.6	7.8	0.5	0.86	1.0
Teignbridge	5.0	8.5	0.0	1.10	0.4
Torbay	8.1	12.6	0.0	0.61	1.0
Devon & Torbay	6.8	8.0	0.5	0.75	0.8

* In some cases OTs who are based in community teams provide inreach to inpatient units

Diagram 12.

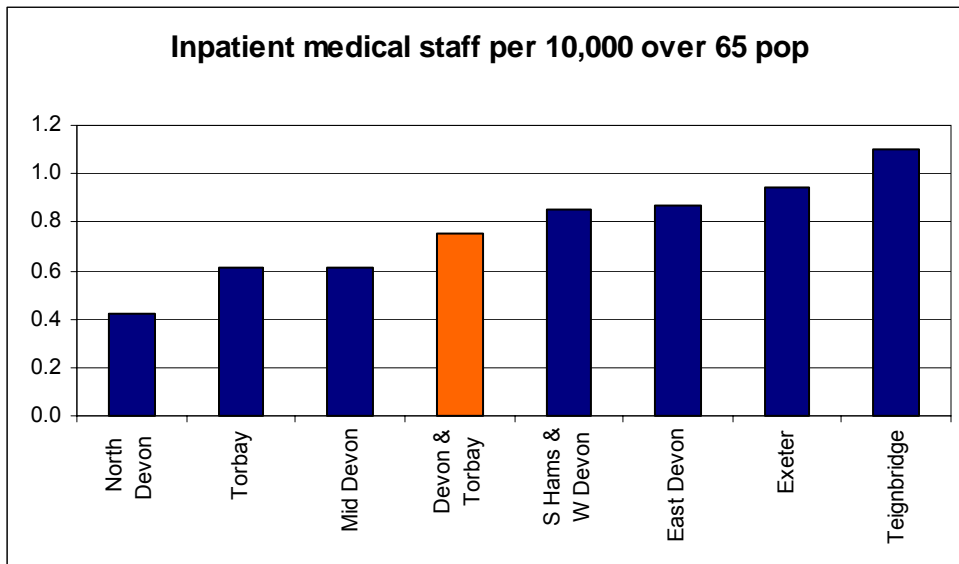


Diagram 13.

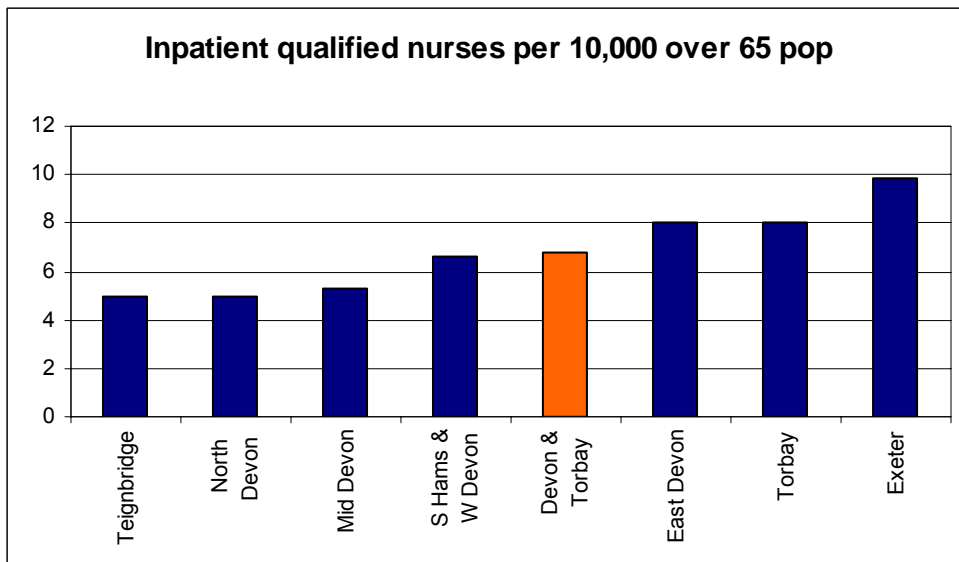


Diagram 14.

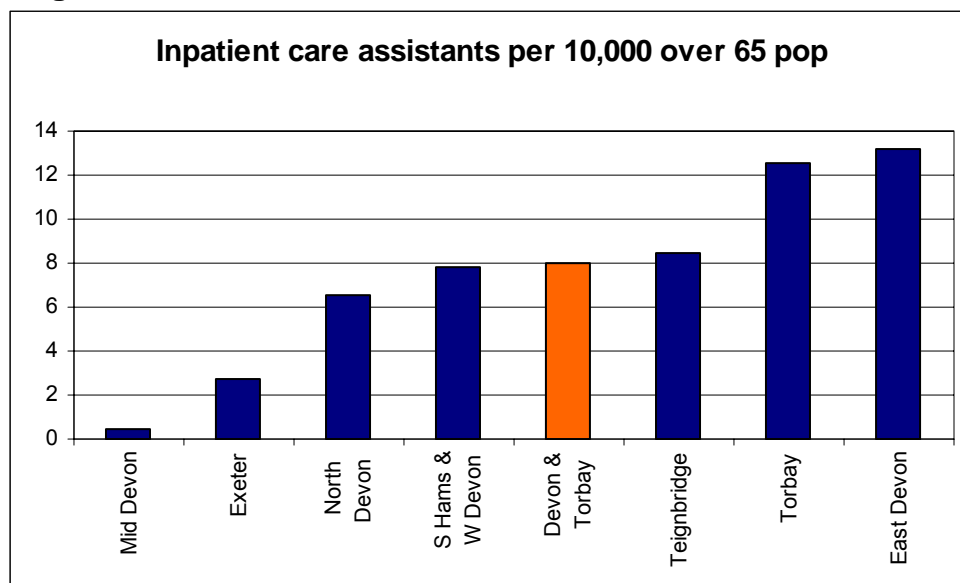


Table 13. Community Staffing per 10,000 over 65 pop

PCT	Qualified Nurses	Care Assistants	OTs	Medical Staff	Managerial Staff	Admin. Staff	Psychologists
East Devon	3.5	1.9	0.2	0.37	0.2	0.3	0.6
Exeter	6.0	0.8	1.3	0.40	0.5	0.2	1.0
Mid Devon	2.1	1.0	0.2	0.26	0.2	0.0	0.5
North Devon	1.8	0.0	0.2	0.18	0.0	0.2	0.3
S Hams & W Devon	4.6	1.3	0.9	0.37	0.2	0.8	0.2
Teignbridge	4.0	1.0	0.5	0.47	0.4	0.9	0.4
Torbay	2.2	1.3	0.7	0.26	0.3	1.0	0.2
Devon & Torbay	3.3	1.0	0.5	0.32	0.2	0.5	0.4

Please note the Arc project in Exeter has been included in the above figures. In addition to this the specialist OPMH community services in Exeter receive the extra support of dedicated Social Service Intermediate Care Teams for Functional and Community Support Team for dementia. In all the areas some OTs and all Psychologists included in the above table do inreach into inpatient units.

Diagram 15.

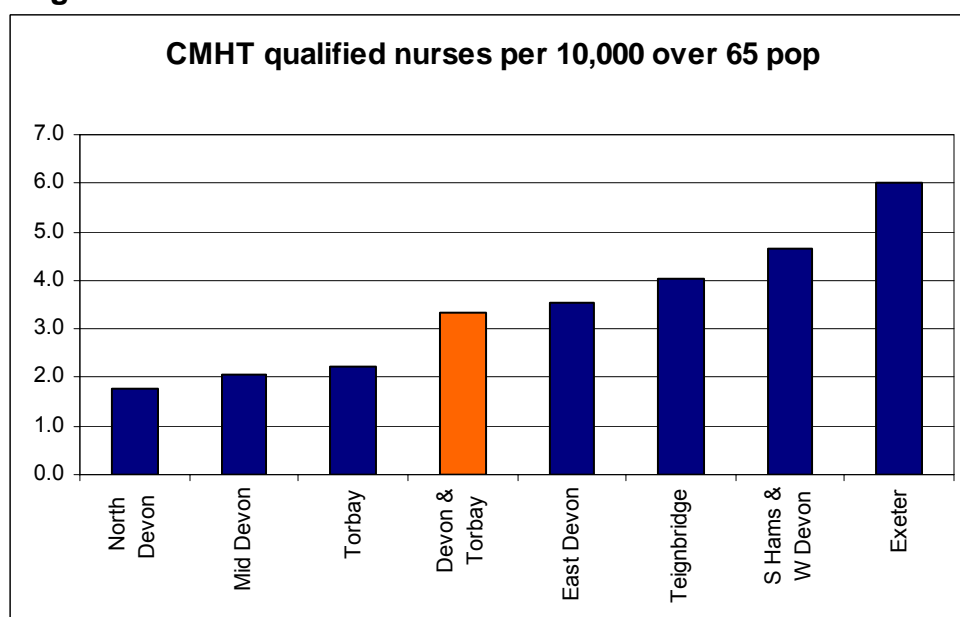


Diagram 16.

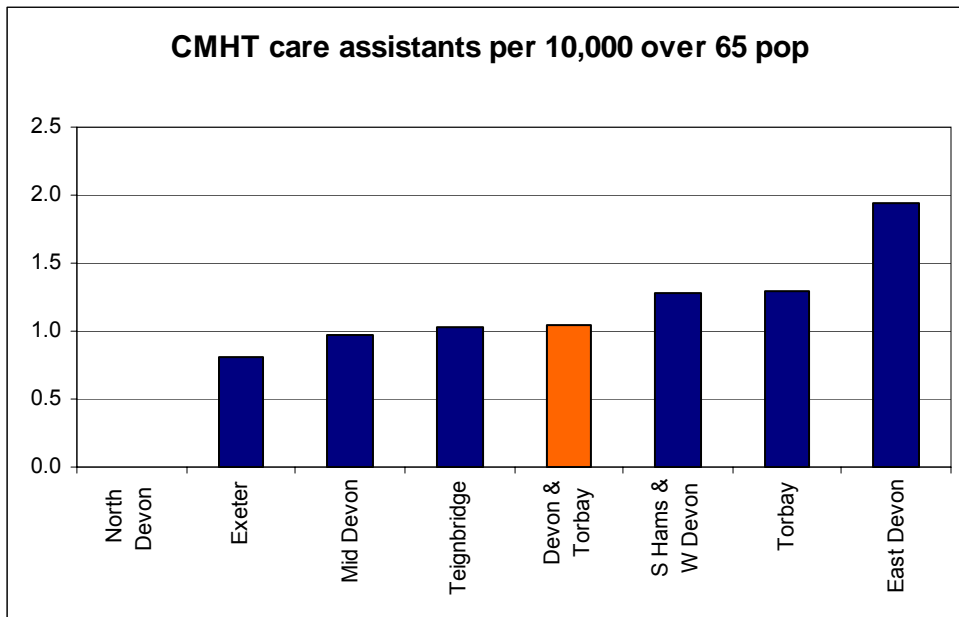


Diagram 17.

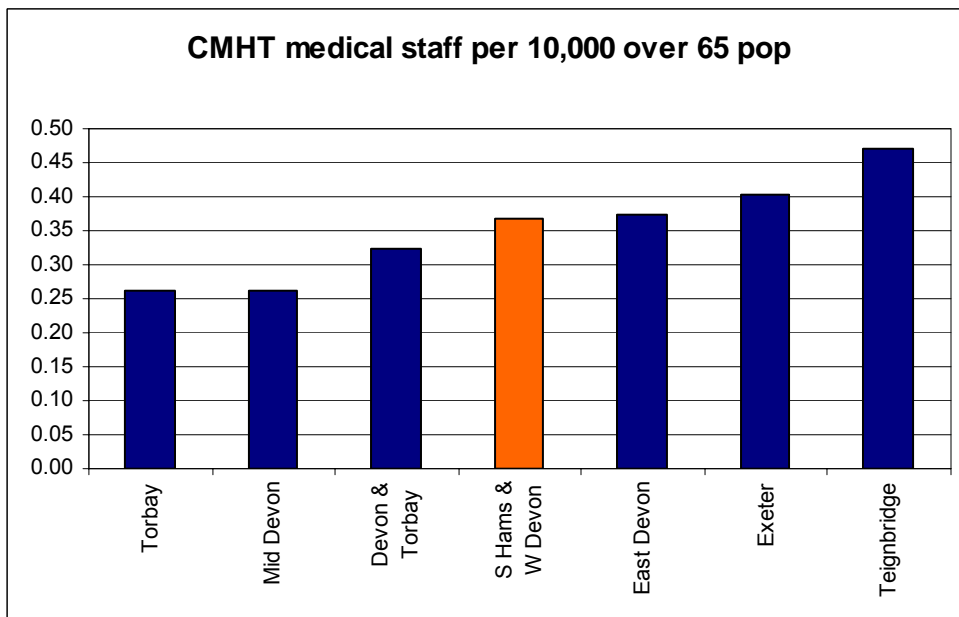


Table 14. Mental Health Assessments carried out between Aug. '03 and July '04

Primary Care Trust Name	MHA	MHA's per 10,000 over 65 GP pop.
PCT not recorded	4	
East Devon	52	16.57
Exeter	63	30.25
Mid Devon	22	10.64
North Devon	22	6.95
S Hams & W Devon	1	0.46
Grand Total	164	12.98

Table 15. A further breakdown of the data shows the outcome of MHAs.

Area	Section	No of people sectioned
(Blank)	Section 117	1
	Section 2	1
	Section 3	1
	Section 37/41	1
	Section 4	1
	Total	5
East Devon PCT	Section 117	28
	Section 2	26
	Section 25(A) (Annl Rnwl)	2
	Section 3	13
	Section 3 (2nd 6 Months)	2
	Section 4	1
	Section 5 (2)	7
	Section 5 (4)	1
Total	80	
Exeter PCT	Section 117	37
	Section 2	25
	Section 25(A)	2
	Section 25(A) (Annl Rnwl)	2
	Section 3	18
	Section 3(Annual Renewal)	3
	Section 4	2
	Section 5 (2)	9
	Section 5 (4)	2
Total	100	
Mid Devon PCT	Section 117	11
	Section 2	12
	Section 3	8
	Section 3 (2nd 6 Months)	2
	Total	33
North Devon PCT	Section 2	9
	Section 25(A) (Annl Rnwl)	2
	Section 3	6
	Section 3(Annual Renewal)	1
	Section 5 (2)	3
	Section 5 (4)	1
Total	22	
South Hams & West Devon PCT	Section 117	1
	Total	1
Devon	Total	241

Data for referrals to community mental health teams for older people was collected via the EPEX system. Where this data was not available a manual count of referrals between Aug '03 and Jul. '04 was carried out to complete the data.

Table 16. Referral Data for Community Services from 1.08.03 to 31.07.04

PCT	No. of Referrals	Referrals per 10,000 over 65 GP pop.
East Devon	1123	358
Exeter	1262	606
Mid Devon	436	211
North Devon	702	222
S Hams & W Devon	1357	621
Teignbridge	849	364
Torbay	614	200
Devon & Torbay	7806	433

Local Authority Service Provision

Table 17. Social services staffing by profession per 10,000 over 65 pop

Social services generic older adult team staffing by type per 10,000 older adult pop.						
PCT	Social Worker	Occupational Therapist	Community Care Worker	Referral Co-Ordinator	Practice Manager	Total
East Devon	1.7	3.7	6.5	1.9	1.2	14.9
Exeter	1.6	3.5	5.3	0.0	1.1	11.6
Mid Devon	3.3	3.2	6.2	1.9	2.0	16.6
North Devon	3.7	3.9	7.5	2.6	1.6	19.4
S Hams & W Devon	1.7	2.5	8.7	2.4	1.7	17.0
Teignbridge	3.4	4.2	8.3	3.5	1.6	21.1
Torbay	2.0	3.1	6.3	2.7	3.0	17.2

Social services dedicated older adults mental health team staffing per 10,000 older adult pop.						
PCT	Social Worker	Occupational Therapist	Community Care Worker	Referral Co-Ordinator	Practice Manager	Total
East Devon	0.3	0.0	0.4	0.0	0.0	0.7
Exeter	2.2	0.0	1.8	0.5	0.7	5.2
Mid Devon	1.0	0.0	1.3	0.0	0.0	2.3
North Devon	0.0	0.0	0.0	0.0	0.0	0.0
S Hams & W Devon	0.8	0.0	1.7	0.0	0.0	2.5
Teignbridge	1.1	0.0	1.0	0.2	0.2	2.5
Torbay	2.0	0.3	1.9	0.3	1.0	5.6

Diagram 18

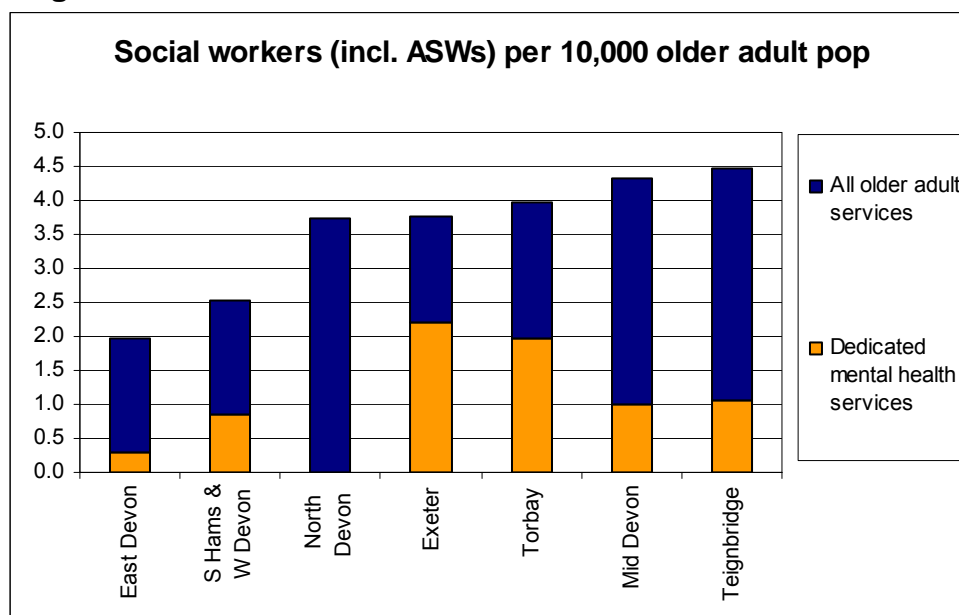


Diagram 19

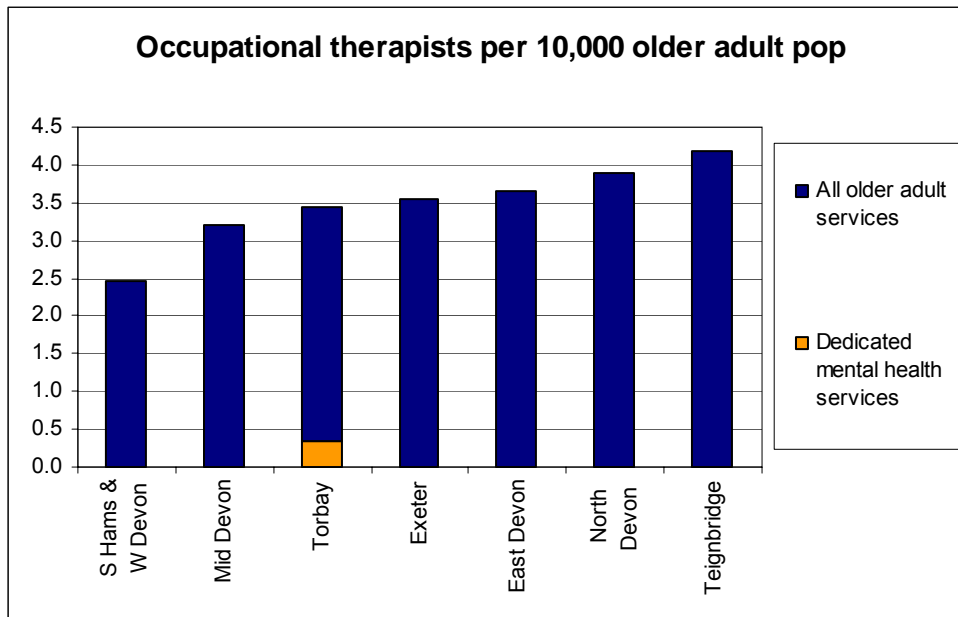


Diagram 20

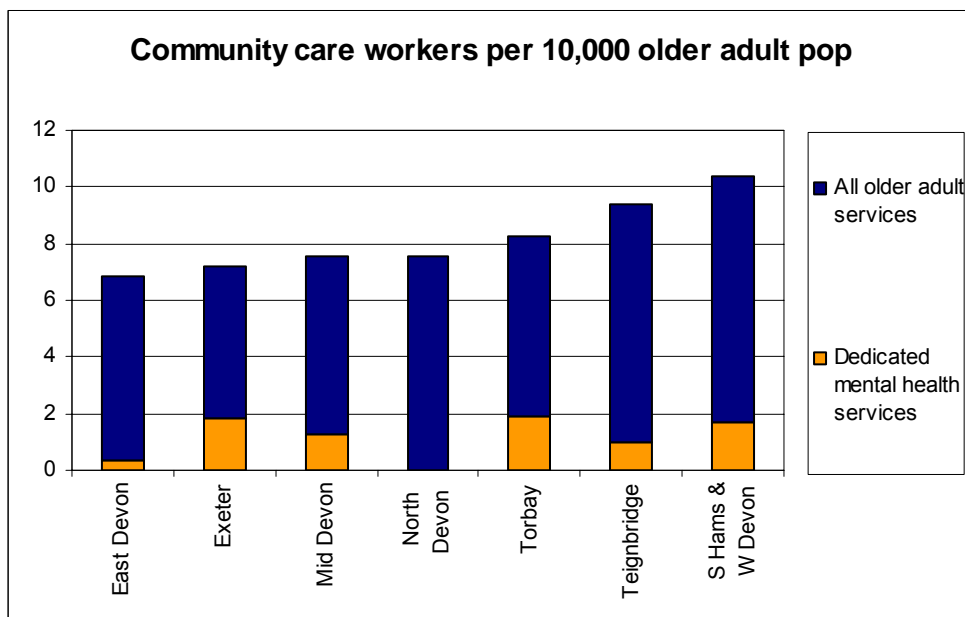


Diagram 21

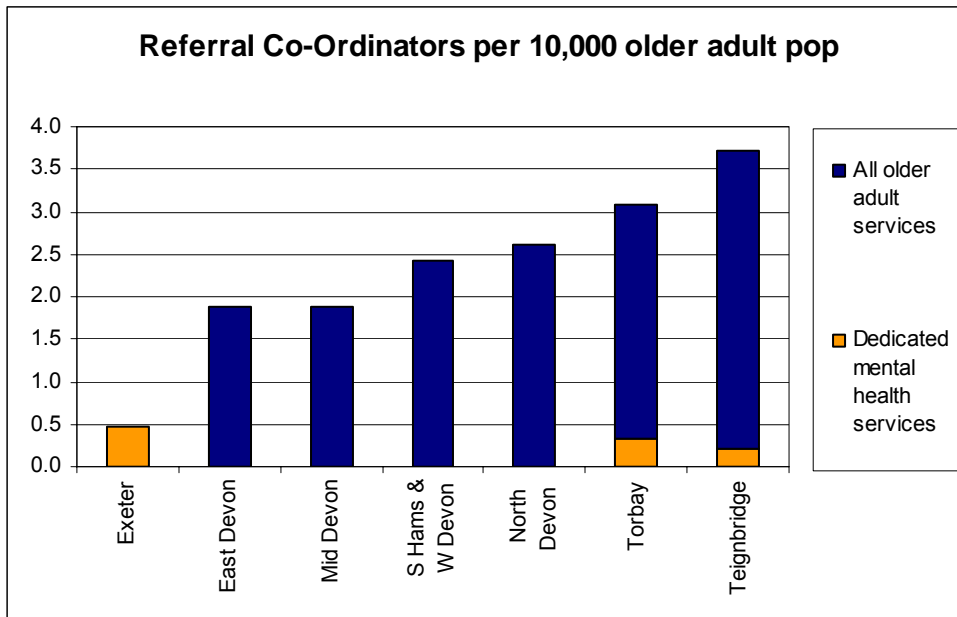


Diagram 22

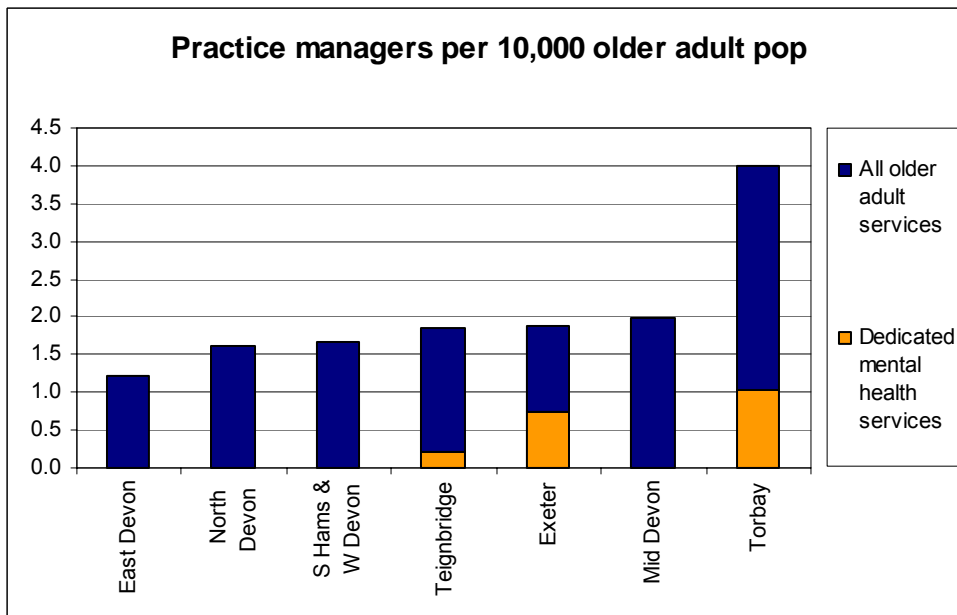


Diagram 23

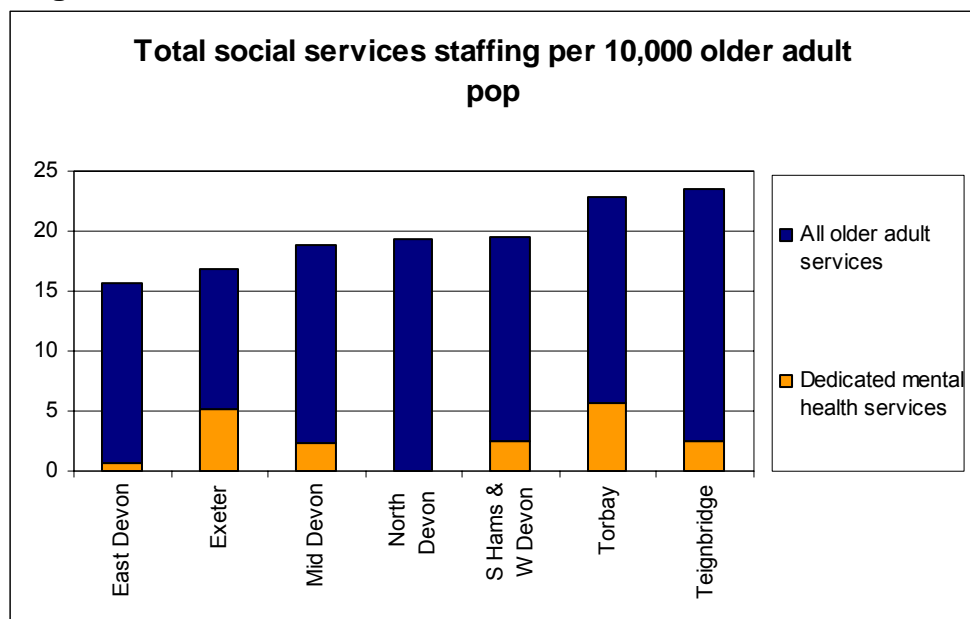


Table 18 Breakdown of services provided to older adults

Number of clients with mental health problems served per 10,000 older adult pop.						
	Domiciliary Care		Day Care		Community Meals	
	Independent Sector	Social Services In House	Independent Sector	Social Services In House	Hot Meals	Frozen Meals
East Devon	5115	2462	843	79		
Exeter	6263	9759	2163	0	5050	4930
Mid Devon	8290		91	608		663
North Devon	2074	621	0	597		
S Hams & W Devon	2576	1270	74	894	806	1678
Teignbridge	2460	1088	1036	249	2048	3352
Torbay	No stats	No stats	No stats	No stats	No stats	No stats

Table 19 Number of clients supported by sector

Number of clients supported per 10,000 older adult pop.				
	Residential (independent sector)	Residential (Devon County Council)	Nursing (independent sector)	Total
East Devon	48	10	17	75
Exeter	58	11	31	100
Mid Devon	43	20	48	111
North Devon	30	4	24	58
S Hams & W Devon	37	2	26	66
Teignbridge	50	7	16	73
Torbay	No stats	No stats	No stats	No stats

Table 20 Bed losses

Bed losses per 10,000 older adult pop.						
	Residential			Nursing		
	Jan 01–Dec 02	2003	2004	Jan 01–Dec 02	2003	2004
East Devon	28	5	5	21		
Exeter	8	9	5	0	0	0
Mid Devon	4	0	0	0		0
North Devon	6	9	13	19		
S Hams & W Devon	No stats	No stats	No stats	No stats	No stats	No stats
Teignbridge	No stats	31	37	13	23	No stats
Torbay	No stats	No stats	No stats	No stats	No stats	No stats

Table 21 Average vacancies

DCC residential average vacancy for 2004	
East Devon	26%
Exeter	2%
Mid Devon	32%
North Devon	13%
S Hams & W Devon	27%
Teignbridge	20%
Torbay	no data

Table 22 Monthly average number of clients provided services

Average monthly figures of older adults in residential / nursing homes (Apr to Nov. 2004) per 10,000 older adult population			
	Nursing	Residential	Total
East Devon	16.6	53.6	70.1
Exeter	32.2	71.5	103.7
Mid Devon	34.9	47.2	82.1
North Devon	21.8	34.6	56.5
South Hams & West Devon	24.5	40.7	65.2
Teignbridge	15.5	52.7	68.2
Devon County	23.1	49.4	72.5
Torbay	36.5	100.4	136.9

Diagram 24

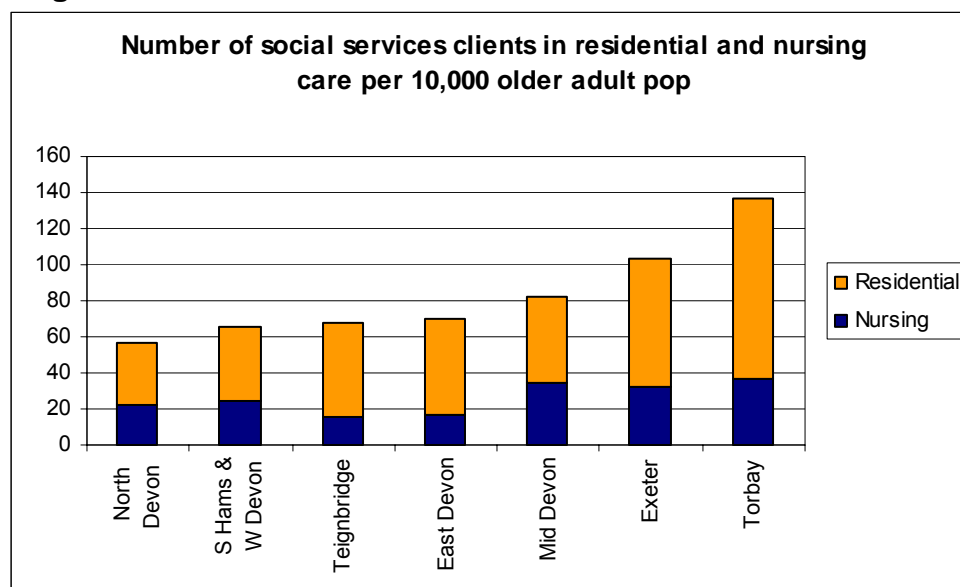


Table 23. Number of referrals to older adult services

Referrals to Social Services per 10,000 older adult pop				
PCT	Referrals (GP pops)		Referrals (PCT pops)	
	18-65	65+	18-65	65+
East Devon	9	64	8	61
Exeter	12	114	12	109
Mid Devon	9	75	10	86
North Devon	6	61	6	62
S Hams & W Devon	5	70	5	65
Teignbridge	6	64	5	61
Devon	8	74	8	72
Torbay	9	64	8	61

Diagram 25

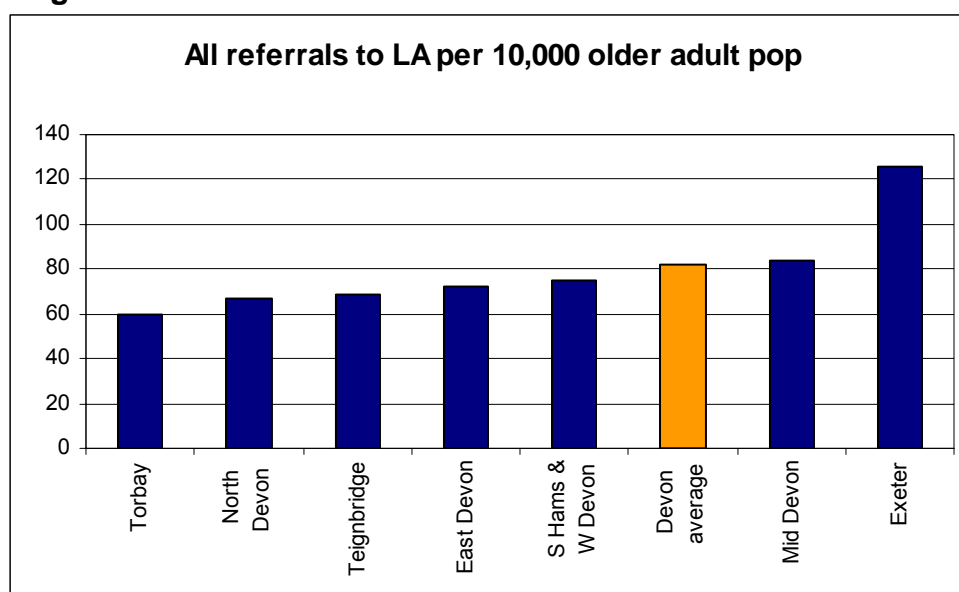


Table 24 Assessment carried out by social services

Assessments per 10,000 older adult pop		
PCT	Assessments (GP pops)	Assessments (PCT pops)
East Devon	145	138
Exeter	363	348
Mid Devon	135	155
North Devon	126	128
S Hams & W Devon	112	103
Teignbridge	86	82
Devon	163	161
Torbay	110	116

Diagram 26

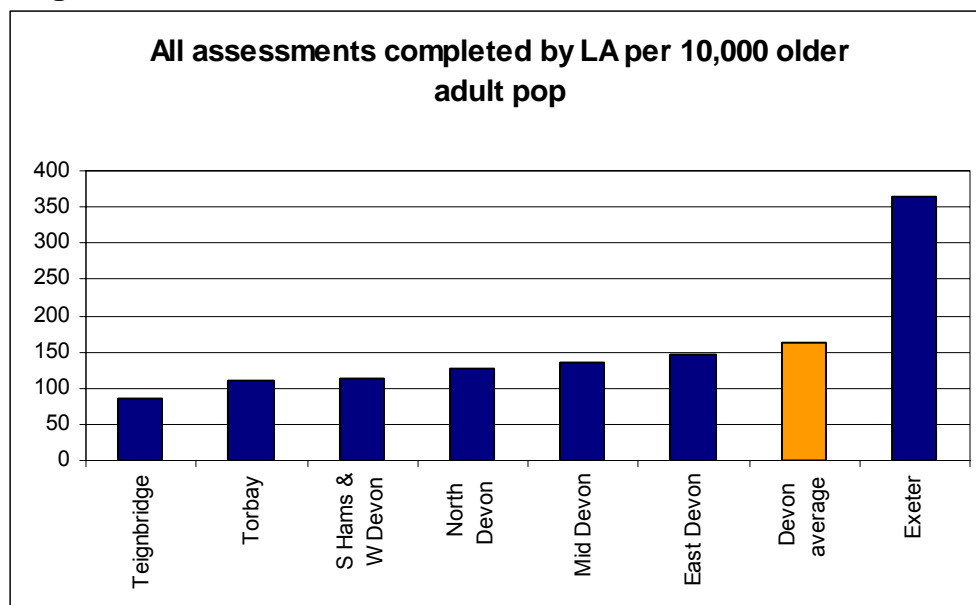


Table 25 Standard Assessments carried out by social services

Standard Assessments per 10,000 older adult pop						
PCT	Dementia Assessment			MH Assessment		
	18-64	65+	All	18-64	65+	All
East Devon	0.3	19	20	2	43	46
Exeter	0.5	12	13	7	93	99
Mid Devon	1.5	28	30	1	36	37
North Devon	2.2	31	33	3	22	26
S Hams & W Devon	0	22	22	1	27	28
Teignbridge	0.4	15	16	2	32	34
Devon	0.9	22	23	3	41	44

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