DEVON & TORBAY DEVELOPMENT PROJECT FOR OLDER PEOPLE'S MENTAL HEALTH

Dissemination Events February 2005 – Questions & Answers

Event Venue:	North & Mid (N) (Barnstaple)	South & West (S) (Newton Abbott)	Exeter, East & Mid (E) (Exeter)	DEVON
Number of People Present:	40	57	56	153

PRESENTATION:
David Seward, Sainsbury Centre for Mental Health (SCMH), the Project Consultants, presented from the Executive Summary of the Final Report, together with emerging themes from the data analysis

Q&A PANELS: David Seward, Project Steering Group representatives & local managers

RECORDING: This report based on notes taken at events by Paula Seal, Project Administrator

THEMES

Themes raised by participants have been prioritised based on:
(1) The number of events at which they were raised, and then
(2) The number of separate questions relating to each theme

Themes raised at all 3 events :

- **Implementation of Recommendations**
- **Inpatient Units**
- **Carers' Needs**
- **Report - Data**
- **Independent Sector**
- **Communication & Information**

Themes raised at 2 events :

- **Community Mental Health Teams for Older People**
- **Respite Care**
- **Age Discrimination in Mental Health Services**

Themes raised at 1 event :

- **North Devon Resources**
- **Primary Care**
- **Housing**
- **Health Promotion**
- **Sensory Needs**

(Participants' questions and comments are in bold, panel responses in regular font, with separate contributions bulleted. Themes from different venues are amalgamated where appropriate and venue identifications (N) (S) (E) shown)

IMPLEMENTATION OF RECOMMENDATIONS

What are proposals and timescales for implementation process? Is there commitment to these proposals? (N)
Will each PCT be considering statistics/needs in each area? (E)

- It has taken a long time to get to this point and what has been lost in time has been gained by having sign up from 10 organisations. We now have the Devon Older People's Strategic Partnership (DOPSP), with wide representation on it, led by Chief Executive of Exeter PCT and Deputy Director of Social Services, a good solid body
- There will be a Devon-wide implementation Group for the project recommendations, monitored by the DOPSP. This Group will comprise commissioners as well as managers. PCTs will still have local implementation, and will now have an overall group to be accountable to. There will also be

communication plans and service user and carer networks. It still is up to individual PCTs to commit to these arrangements.
- The means of taking this forward is with a project management approach
- The profile of OPMH has been raised
- In each area recommendations are for a Joint Agency Service Manager, responsible for overseeing implementation. This is where we are at moment.
- I am not pretending this isn't a challenge. This will be going once a month to a senior level meeting and to the DOPSG

Where is the funding coming from? (E)
- This is coming from all the organisations. There is only one new post to take these recommendations forward

I Just worry about raising expectations and nothing happening (N)
- (North PCT Officer) The PCT is well aware and waiting final report. We do now have an Older People's Local Implementation Group (LIG) and a subgroup of that will take the project recommendations and interpret for North Devon

Where will OPMH sit in future? We feel we are second best. I think that a directorate would be best (E)
- Sainsbury have not had this within the terms of reference, but is important factor. Leadership is recommended. I genuinely believe this is the best opportunity to take things forward.

We have to look at equity of funding from the different organisations. Is the Strategic Health Authority (SHA) involved?
- The SHA they have been informed of Project and they are very interested. They are looking at working with OPMH on specific issues. Everyone has inherited these inequitable budgets, which we have to accept at present. For the first time we shall be able to look at the NHS and Social Service budgets together

Disparity of numbers raises interesting questions. We start with a poor base, with serious areas of deprivation, and we must start serious thinking of allocation of resources. It is going to be a very interesting – is there going to be any quick work done to make changes? (S)
- We are not operating in vacuum, we know one unit is suspended and we know there was under occupation within one of units. There are things that can be done immediately but commissioning proposals can look at what needs to be done over time
- It can be seen that small units are operating – and we shall be looking at changing of function of these units as they are very expensive to run. There are opportunities with local and more global co-operation

These graphs have implications re disparity in number of staff and expertise. Given PCT locality based funding and that DCC are looking at council tax etc, do we have undertaking in DCC about resources shifting across the county? (S)
- The Social Service perspective is to identify situation in each locality – there would be concern, I understand the needs of locality would be taken into account. We have to work together to ensure that we plan and identify gaps

What might we expect over next 6 or 12 moths forward – what changes? (S)
- Quick wins are important – A new driver is the forthcoming national target for Trusts for integrated CMHT(OP)s, about which we are waiting details from the Department of Health. There will be a bigger incentive to get on with that quickly. Some PCTs are showing support for a Joint Agency Manager to take this work forward.
- Some areas are moving to look at specialist in house domicilliary services. We need to look at intermediate care services (generic) and how we can improve specialist provision. North Devon heard clear messages about basic staffing and key areas of risk. There are cultural issues and themes about risk assessments.
- We shall be sitting down in April and May and looking at recommendations and what is short, medium and long.
- (Torbay) By the end of March we are coming up with a model. A project group will soon be working and hopefully looking for quick wins, including looking at CMHT(OP) integration.. Then after that more detailed work will look at inpatient provision
- There does need to be dedicated work teams set up swiftly – how to access mental health services, to understand what the budgets are, how to map out. You should expect a roll out of CMHT(OP)s fairly swiftly. Best opportunity for a long time to see change in services
- However, the report is not just for the here and now but to work on throughout the years. The implementation group will need to take time to prioritise and consider proposals

INPATIENT UNITS

Questions on bed data – concerns about how figures arrived at. What does critical mass mean? (N)

- Lots of work still needs to be done, – reluctant to draw conclusions from data at present, but can give an idea
- Critical mass means the number of beds needed for an effective service that is going to need sufficient numbers of dedicated staff. It is more difficult to provide acute inpatient provision in small units

In the drive towards critical mass. will small units be consumed by big, then transport issues will arise? (E)

- Provision locally is keen recommendation. Community teams would have sufficient capacity to cover bigger areas. Respite would be more of a local service. It is never feasible to have unit next to everyone's village – community services closer to home as possible will lead to fewer acute inpatient units

Bed occupancy differs and there are higher and lower occupancies in identical types of units. Wisdom seems to be from staff and service users that it is the attitudes of Consultant Psychiatrists and their willingness to take risks and plan that makes a difference. Can you factor that in? (E)

- The Report will not highlight specific work of Consultant Psychiatrists. We are aiming to make less variance between units. We are keen to highlight risk assessments. All proposals are trying to get an integrated team approach and this will make managing risks easier and supportive

On EMI inpatient units' length of stay, is it because there are no residential nursing homes to transfer these people to? (E)

- Without data on residential sector there are no automatic assumptions – the Report will need to factor in availability of other resources. Emerging data for placements shows that East and Exeter is higher at moment, but no final figure. If there are longer lengths of stay because of lack of residential care – you may need to look at other alternatives

If you can't exert power over Consultant Psychiatrists you can't achieve (E)

- This Report is trying to create a team, with the Consultant as part of that team. The team has the responsibility of thinking about the care of individuals

As an operational manager, I think this is a useful platform – it gives me more power and permission to address some of the issues (E)

Need to consider therapy on inpatient units, not just nursing and medical staff (E)

I don't have a problem with recommendations except access to dedicated functional beds. If you are building a new unit, I don't see a problem, but using existing resources, I think this is difficult (S)

- I think it will be a challenge to achieve that and we shall need to be creative. There are other ways than to look at existing buildings and structure. In the Harbourne Unit, using the lounge area solely for functional inpatients has improved quality and we can look at other units in this way
- Also need to look at age discrimination and se how Adult Mental Health inpatient units are being used

  It is trying to create the space and staffing ratios and expertise and a comfortable place

Torbay have only Haytor Unit and there are staffing issues there(S)

- It is also about how you manage. Interesting comments have been made to me about how you only admit people with functional needs when they are older and frailer and more suited to the environment on existing units
- Bear in mind that we were asked for mid and longer term strategies

(Carer) Briseham was an excellent unit (S)

- I would hope that the skills of the staff that worked there will continue to be used. The needs would have to be carefully looked at.
- It might be that would have intermediate care in respite home but supported by the new specialist team. It would have extra support. It would be that Respite in the right place
- What is the care pathway for the patient and how can those needs be met is what we should be thinking

CARERS' NEEDS

(Carer)For gods sake get it started – what we have experienced is a shambles! I am a carer of a mother with Alzheimer's – she spent six weeks in hospital, causing bed blocking, and contradictory diagnoses were given. Please, please have action (N)

- What we haven't had in place are the networks to support service users and carers – we hope for better connections in future.
- I personally would like to say to you that the fact that we have commissioned this Report shows how committed we are and we will be held to account if it is not followed through

Is there any information on unpaid carers? (N) Difficult to separate into one area, there is some information available

There is no importance given to the role of carer – how can you build this model without knowing about carers? Caring is a role affecting all agencies (N)

- (Carers Network)There are some statistics available – more importantly under the new GP contract system, GPs have to identify and register which carers they have got. The two together should produce figures (in future). North Devon now has the highest over 65 population and this is not reflected in the levels of finance given.
- Social Services point of view is to look at carers as a whole, and not just OPMH. We need to respond to all needs. We need to articulate more clearly about needs and support.
- A section in the Report will focus on carers and give some perspective on a carers' network. There are some unique needs that OPMH carers will require and these will be featured. There is also need for specific support services but there is a long way to go.

I see excellent work in this area every day which is given to meeting the needs of carers and this is against a backdrop of limited resources (N)

I worked as a Carer Support Worker in Adult Mental Health Services. Seeing the experience of a carer of an older person, I didn't feel that there was the same impact from that side (OPMH). Carers are alone and unsupported and there isn't (in OPMH) a critical mass of activity to generate services. Is there going to be specific support for OPMH carers? (E)

- We are aware of need for good carer support. OPMH has access to generic older people's carer support services. With this system, there has been good work in some areas. However, there is a disconnection of specialist OPMH planning for carers' needs with structures for generic services. We have opportunity to make better links through this Project. There is an enhanced carers' network now. I think we have to link this Project into generic carers' networks across the county. We are aware that we do need stronger links.

We need to make distinction between engagement and support. The support there is now is stretched and there is an agenda to look at the needs for specific support.(E)

(Carer) You cannot do that to carers (close respite facilities as well as inpatient units), they need that local support (S)

- You need to increase resources in the local environment and I certainly wouldn't suggest in the Report to cut respite

(see also respite)

REPORT – DATA

Is there a recommended number for nurses and psychologists per population? (N)

- (Sainsbury) may put a line in to indicate the national guidance in the Report if that would be helpful

Very worrying that we haven't defined what equity is? (N)

- Difficulty in what it actually does mean and without all data to make final conclusions but hopefully in Report will give indication of what to strive for. An outstanding high priority of work to do.

Have you reflected in your report the differing needs of people at home in all areas – rural and local? (E)

- We are looking at this when we have collated data and want to include rurality figures. There is only so much we can do in global report. Thinking of that will have to be done locally and put in implementation plan.

Any data requested from General Practices? (E)

- We haven't requested that

Figures don't tell about efficacy of decisions (E)

- Any benchmarking data at this level won't tell us all need to know but a starting point

Where is the data we were hoping to get? Concerns re robustness of Report, doesn't reference what is going on in other areas of the country. Will the Report have a national picture? (S)

- It will have a national picture and what is going on with national trends. Nothing suggested so far that is out of step nationally. If you are looking for exact reference – there will be references to help support.
- We did agree Exec Summary will be a simple fit and the full report a more academic report.
- What we have agreed is areas of excellence in Devon & Torbay and where these link in other parts of the UK. (to put in Report).

Nothing in report on demographic changes ad projections? (S)

We are going to factor a part on demographic change in Report

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INDEPENDENT SECTOR

What about inclusion of the private sector? (N)

We are talking about OPMH as a specific subject, but it is also connected with physical disability and we have heard nothing about the private sector as one of the main OPMH providers (E)

- Never underestimate the importance of their role in providing services. They will be included in Implementation Plan in some form
- Not specifically mentioned today, however the Project will look at what resources available. Some independent sectors (in Devon) provide quite vibrant opportunities and there is an opening to share experiences with other localities.
- The Report is going to be describing functions of an OPMH system. We will not say who should provide what, but we shall suggest getting a good balance of all sectors. How the model is realised will come down to local areas. The private sector should not be excluded. They have had input into the Report and into workshops.
- It is clear there is need for ongoing work with that sector. Two helpful ways forward: with regards to the independent sector, there is a new contract for whole of Devon. The Best Value Review of help at home has encouraged an in-house service targeted at specialist (OPMH) needs and Exeter and East are moving towards this.

I am disturbed about not getting into residential homes. We ask the public to pay for that and I am not happy with quality of homes accredited. It is a closed world. I think we should be in there. Where is your responsibility? (E)

- I have mentioned little about expectations and about standards and responsibility of monitoring – I will give consideration to that and take it to the Steering Group. The emphasis on our Report is placing reliance on that.

I am very clear NHS should provide acute care treatment. We are very dependent on Private Sector – and I worry about quality (S)

(Home owner) we are looking at remodelling homes in conjunctions with PCTs and we are looking at extending resources and range of services supported by the NHS (S)

The rates that we get to look after people – we have to pay a decent wage for our staff. In the past we could change on assessment and on people's needs and negotiate. Chadwell Centre operates a good system that provides help and support and has cut our admissions to NHS acute units (S)

- There is greater potential to utilise the independent sector and a dedicated budget around mental health capacity as well as at Service Manager level

(see also Respite Care and Age Discrimination)

COMMUNICATION & INFORMATION

How are you going to communicate what you are doing? People do need information – and make that clear (E)

- We need different ways but have used a newsletter and website. For service users and carers we need to develop a cascade system to reach them

How widely will report be circulated? (E)

- Public document will be put on website and made available to all groups who will filter down

How are you going to address the stigma of mental health to promote social inclusion, this is difficult and evident from our work in (voluntary sector)? (E)

- While, we've had success in social inclusion projects in older people's mental health in Exeter, stigma is an important and real issue

Massive publicity will be needed – are there more ways of publicising this? people need to know (S)

- First and often said thing. There are at present complicated ways to get information. Complete re-think needed of how to communicate about mental health needs and how to access services. This has to come out of local planning and commissioning.

No one is arguing for OPMH, someone needs to stand up & shout loud (N)
The Alzheimer's society is developing in this area (N)

COMMUNITY MENTAL HEALTH TEAMS FOR OLDER PEOPLE (CMHT(OP)s)

I think there is some CMHT staffing model available – maybe it could be looked at? (N)

- A lot of benchmarking data is available for AMH CMHT staffing – but I wasn't aware that there was anything relevant and up to date available for OPMH staffing

Can see advantages of CMHT but a lot of clients have low level need so who comes into this specialised service ? –there is a fear of generic services being "swamped" (N)

- There is nothing about this project to undermine the importance of primary care services the recommendation is that they will remain as they are. The specialist CMHT(OP) will concentrate on the cases of challenging and complex needs. It is a liaison function to link into primary care services and support them to carry on working in the way they are, but with good access to specialist mental health services. CMHT(OP) eligibility criteria will be an implementation task that has to be done. Sainsbury will not design but recommend engagement with workforce to reshape and design locally.
- Trusts will have a new national performance rating - integrated CMHT(OP)s. We are waiting for information on criteria for how this rating will be monitored. We have different types of resource and need across Devon, rural and urban, and will be looking at a gradual plan and for longer term development
- There is experience already where teams are in place and we can build on operational experience – it is fundamental to involve yourselves, to form the protocols
- A word of caution about eligibility criteria, there are always boundaries and individuals cross one service and back again. There needs to be firm intent to ensure that people who don't fit do get a service. We must use this specialist team to support mainstream. We need to make sure boundaries are fluid to maximise potential.

Older people have combinations of physical and mental health problems and adult Social Services usually deal with these. How do you apply Fair Access to Care? Wen would the Adult Team pick up on something and when would the new CMHT(OP) pick it up? Why would Social Services pick up on lower mental health needs? (N)

- I am not sure they would. What I was proposing was how mental health needs would be addressed to make sure they were not missed

Talking with Social Workers, they have lost the ability to commission and feel that everything is health led (N)

- This a very real and pertinent point. There is great need to train up staff. The need to integrate properly is important and crucial and this will come down to robustness in implementation.

I work with Torbay Social Services and we have only six social workers – there is a lot of focus on inpatient activity (S)

- A lot of work has been done on this area and we are expanding community services and now looking at how to work effectively. However there is an issue here, it is about having it (CMHT) properly resourced
- We need to ensure teams are well resourced and mixed to cover these problems

Different organisational cultures not spoken about and how to share different views of culture? (S)

- As you move towards greater integration – some guidance in Report will be given but management, leadership and philosophy needs a health and social care perspective. Report will help but it will come down to local implementation.

RESPITE CARE

What about acute units and respite? (E)

- Respite should be maximised, but not using acute units to provide this. There should be Increased access to respite, but doing it in a different way. We need to resolve the equity issue

I understand the acute and respite but some of those people have great needs of specialist care and we need to get this right (E)

- We agree – and we need to educate and understand the needs

(carer)I feel people should go to acute units as they have day centres – my husband has accepted this (E)

- In some areas it is looking at how many acute units are needed and whether they can be devised locally to needs, such as respite and intermediate care, when 24 hours acute inpatient resources are not viable
- There is something about equity needing to be built in. In some areas you have to pay and in others you don't. This issue will be included in an implementation plan.
- There is a large stock of social services in house beds and we need to think flexibility over all our resources

The Report does shift towards Social Service and domicilliary care especially for those requiring respite. They would benefit from a unit environment – is there any provision for a specialised respite unit? (S)

- We haven't been that specific on that issue
- We need to look at that and the discrepancy where some people have to pay and others not

You cannot do that to carers (close respite) – they need that support (S)

- We need to increase support in home environments and certainly wouldn't suggest in Report to cut respite
- We need to ensure that we are careful with assessment and meet present needs. I am aware that carers build a trust with a unit and when we look at change we need to take that into consideration

On respite services – I represent independent sector and there is wealth of experience and expertise out there and we do a lot rehabilitation work. The funding is a problem and there is great inequity over paying. It is a big issue with service users and carers. There is an investment in respite provision and we do have a commitment to work with external providers so that we get a full range of service within localities. Previous experience shows that home owners are keen to develop rehabilitation units (S)

AGE DISCRIMINATION IN MENTAL HEALTH SERVICES

What about clients with functional mental health needs. How can they access Adult Mental Health (AMH) Crisis Intervention? If we are expecting this specialist team to do it – how are we going to resource that? (E)

- Sainsbury strongly advocates greater access to adult services, especially for 65-70 year olds. When we have looked at resources, we shall match with investment commitment. Would like to maintain existing services, and we wouldn't want monies being taken out. It is about someone having ownership of all pan-Devon mental health – and making message heard.

(Service user) If you are 65 and over you are put in a geriatric (mental health) ward – is that going to change? (E)

Lot of ageism in this service and it can be difficult to get older adults into (AMH) psychiatric beds. I think there are major problems to take on this work (E)

- We are trying to look at the person's needs and get away from age defined services
- The issue is to see whether people can be cared for more at home. Some over 65s go into adult wards – however for people new to mental health services at the moment the change is at 65. We are using this Project to look at this.
- No need for separate units for "functionally mentally ill" over 65 years – if we base inpatient mental health services on all clinical needs from 18+
- Make units of 12-15 – to provide a better staff ratio, with amount of resource to provide for that extra care and development of local protocol. We need to hang on to NSF values as this will be difficult to take forward

(see also inpatient units)

Where you compare costs, AMH with OPMH, younger adults can access placements at £500 (more than OPMH funding). Is there scope at looking at discrepancies? (S)

- There is a huge overspend in AMH services and we have to look at strategy to cope with demand. How we can meet the needs of greatest number of people in the most effective way.
- A point well made and we shall keep raising it, with the strength of collaborative working
- We don't operate on flexible fees with the independent sector. We are working towards block rather than spot contracts. We need to look at how we commission from the independent sector

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NORTH DEVON ISSUES

North Devon does appear to be under-resourced. How are changes going to be achieved? (N)

- Sainsbury (SCMH) are reluctant to make statements until all the data has been ratified. SCMH is saying capacity is an important factor, but we shouldn't just rely on improving resource base. Higher resource bases in other places do not necessarily show achievement. It is about making current resources work in different ways with different styles of management working with robust commissioning
- One of the key principles is equity. As we move forward we shall get more clarity on equity. If it demands redistribution will there be a will to achieve this?. I feel this area does need reinvestment here and especially in the next 3 years. If investment comes, resource distribution will need to take place. The difficulty is how to make that happen.

We've had service developments in North Devon that have had detrimental impact

- This takes into a difficult area – it is more about looking at equity and commitment to take that forward

There is an anxiety in North Devon about being left behind. It does "boil down" to resources but don't let North and Mid Devon get behind. We need leadership to get things moving

- The Change Agent Team is working towards this. There is also need to get Devon-wide commitment

As things stand North Devon doesn't have the money – we are doing a reasonable job – are we ever going to get more money? We are weary with empty promises

- (N D PCT) It is impossible to say – only to reiterate that for N D PCT this is a high priority, and with limited resources this is till a high priority. Lots of things happening and I feel optimistic about this

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PRIMARY CARE

As a carer – there is need for early diagnosis – this links with your recommendation but it still needs GP knowledge and involvement (E)

- It will be a core part of final report. The proposals for dedicate mental health teams is so that they can work alongside primary care in order that GPs are in a better place to know what they can manage and what they can appropriately refer to the specialist team. This will increase knowledge and skills. There is emphasis on planning and commissioning to audit the level of resources needed

Re early identification – commitment to training is that general or specialist? I just wonder at ability of field work staff to recognise early signs? (E)

- It is aimed at primary care and generic social services and the voluntary and private sector providing frontline services. Carers want to access this training too. Initially it will be for people who have not had access before to recognise early signs

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HOUSING

If we are talking rehabilitation and changing health and social care, please put in Report Recommendations that local councils have to be involved. The missing part is Housing. They need to be involved on the LIGS as older people with mental health needs are neglected in housing (S)

- It is clearly part of the commissioning and planning process to involving housing organisations. Mental health organisations are going to have to have the debate with organisations with responsibility for housing to address this

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HEALTH PROMOTION

Disappointed that not much talk about preventative work. If you get in early you save money – I didn't hear you talk much about that. I wanted leadership about that. There seems to have been a reduction in the last few years of how much we (voluntary sector) can help (E)

- PCTs have responsibility for universal care. Health promotion and wellbeing are all embedded in that primary care function
- We can only make conclusions from data we have got but it is only a starting point to global proposals. This report gives an indication of where we want to start

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SENSORY NEEDS

This report tells us what the gaps are. I want to emphasise that older people have sensory problems and there are specialist sensory disability services that can contribute to meeting those needs in older people's mental health (E)