

BEST VALUE REVIEW OF MENTAL HEALTH SERVICES FOR OLDER PEOPLE **INTEGRATED SERVICE**

IMPLEMENTATION PLAN TO ESTABLISH SPECIALIST MENTAL HEALTH TEAMS FOR OLDER PEOPLE

Ref.	Recommendation	Rationale	Costs and Savings	Benefits for Users/Carers	Performance Indicators	Timescale to achieve
1.	ACS should seek to ensure that NHS providers of Mental Health Services for Older People at the boundaries of the county are signed up to the Best Value Recommendations and Implementation Plan.	<ul style="list-style-type: none"> • Parts of the county are not served by HPT i.e. Cheshunt. • Ensuring Best Value is rolled out across the whole county. • Equity. 	Within existing resources.	<ul style="list-style-type: none"> • All parts of the county receive improved service. 	<ul style="list-style-type: none"> • Agreement between ACS and other specialist Health providers of the overall Implementation Plan. 	July 2002.
2.	Service Commissioners, Health, ACS and all relevant agencies should work towards an agreed overall service strategy for provision of Mental Health services for Older People across Hertfordshire.	<ul style="list-style-type: none"> • To ensure co-ordinated service planning. • Accurate targeting of resources and highlighting of gaps. • Joined-up approaches to service provision. • Innovation will be promoted and encouraged. • Forget-me-not. 	Within existing resources.	<ul style="list-style-type: none"> • A clear and equitable vision of services for the county. • An opportunity to shape the agenda. • A requirement for agencies to work together leading to a joined-up service. 	<ul style="list-style-type: none"> • The availability of a service strategy signed up to by all key players. 	September 2002.
3.	Health and ACS to draw up with the voluntary sector, users and carers shared values and objectives for Specialist Mental Health Teams for Older People.	<ul style="list-style-type: none"> • There needs to be involvement of all key players. • A shared vision of what we're trying to provide. • Demonstrable improved/ outcomes for users/carers. 	Within existing resources.	<ul style="list-style-type: none"> • Users/Carers input into agreeing objectives and priorities. • Partnership working with voluntary agencies. • A clear vision. 	<ul style="list-style-type: none"> • Availability of integrated operational plans for provision of service. 	September 2002.

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4.	Establishment of multi-agency locality forums to identify local issues and agree solutions to improve joint working.	<ul style="list-style-type: none"> Improves local communication and information. Brings agencies together. Sensitive to local demography and resourcing. 	Within existing resources.	<ul style="list-style-type: none"> Improves everyone's knowledge of local services. Professionals will have a better understanding of User/Carer needs. A means to influence services. 	<ul style="list-style-type: none"> Each PCT locality will have a forum in existence. 	September 2002.
5.	Health and ACS should collaborate to provide joint training to staff, which should be extended to include other relevant agencies working with this client group.	<ul style="list-style-type: none"> Develops shared knowledge, understanding and expertise. Provides good networking. Promotes understanding of different professionals' perspectives. 	Within existing resources. May be some economies of scale between Health/ACS.	<ul style="list-style-type: none"> Better informed staff. More expertise within service. 	<ul style="list-style-type: none"> Training attendance records indicate presence of at least 4 different professional groups/agencies. 	September 2002.
6.	Health and ACS to begin to have joint selection panels for appointments of staff.	<ul style="list-style-type: none"> Increases understanding. Nurtures concept of joint working. Sends out a clear message. 	Within existing resources.	<ul style="list-style-type: none"> New staff immediately aware of joint working principles. More suitable staff appointed. 	<ul style="list-style-type: none"> 50% of recruitment selection panels in Health/ACS to have at least one member from other agency. Increasing to 100% compliance by January 2003. 	September 2002.
7.	There should be a county-wide protocol agreed between Adult Mental Health Services and the specialist Mental Health team for Older People for managing transition between services which places high priority on meeting user needs.	<ul style="list-style-type: none"> It would assist clarity and consistency. A single approach for the county. User needs are considered a priority. 	Within existing resources.	<ul style="list-style-type: none"> Equity across county. Seamless transition based on what's best for user. Non-discriminatory on age basis. 	<ul style="list-style-type: none"> Monitoring of implementation of protocol. Audit of randomly selected cases transferred after September 2002 to show 75% compliance with protocol. To increase to 100% compliance within further six months. 	September 2002.

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8.	There should be identification of named professionals within EPD teams (ACS) to provide specialist support to older people with mental health needs.	<ul style="list-style-type: none"> • Forge-me-not. • ACS resources requirement for EMI can be combined with specialist health workers to form multi-disciplinary teams. • Specialist training requirements can be met. • More stable footing for CMHT foundations. • Ring-fencing of resources for mentally ill. • Presents opportunity for formal secondment of staff. 	Dissaggregation may cause knock on effect for remaining staff in EPD and increase remaining overheads.	<ul style="list-style-type: none"> • Identified ACS staff specialising in mental health. • Staff will be better trained and more informed. • Better continuity. 	<ul style="list-style-type: none"> • Pro rata funding for EMI services identified for each ACS team based on 2001/2 activity out - turn for:- <ul style="list-style-type: none"> • Social Workers • Prof. Assistants • OTs 	50% disaggregation by December 2002. 100% disaggregation by December 2003. (Phased to minimise disruption and to make manageable.)
9.	A specialist Mental Health team for Older People will allow professions/agencies to cross-refer within the same team without complex referral systems or recourse to third parties.	<ul style="list-style-type: none"> • Quicker and less bureaucratic. • Needs of user are central to care. • Breaks down professional barriers. • Frees up time for more direct user services. 	Will release professional time from current cross-referral requirements, thus making more hours available for direct care.	<ul style="list-style-type: none"> • Quicker, more responsive service. • More hours of direct care time made available • Seamless care will emerge. 	<ul style="list-style-type: none"> • Reduction in formal referrals within a team demonstrated as less than 10% of random audit sample of caseload. 	December 2002.

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10.	Health and ACS members of specialist Mental Health teams for Older People should design and agree care pathways within the specialist service.	<ul style="list-style-type: none"> • A care pathway allows the team to anticipate a course of treatment and measure variances. • The team can consider improvements to services based on outcomes. • The care pathway requires commitment of all disciplines. • NSF requirement. 	<p>Within existing resources.</p>	<ul style="list-style-type: none"> • Better information on likely course of treatment can be shared. • Shows input of all agencies on single document. • Brings together professionals skills for focus on user needs. 	<ul style="list-style-type: none"> • Agreement and availability of care pathways for: <ul style="list-style-type: none"> • Dementia. • Depression. 	April 2003.
11.	ACS/Health members of a specialist Mental Health Team for Older People should share office accommodation (single base).	<ul style="list-style-type: none"> • Improved communication between team members. • Broader knowledge/skill base. • Informal advice readily available. • Minimises duplication. 	<p>Rationalisation of current expenditure by Health/ACS. Economies of scale around office accommodation costs.</p> <p>Some additional capital may be required as resources become available.</p>	<ul style="list-style-type: none"> • Single point of contact for staff of either agency – less confusing for users/carers. Less staff to have to deal with. 	<ul style="list-style-type: none"> • 50% of identified specialist ACS staff are co-located with Health. • Plans/strategies for co-location of remaining staff are agreed within further 12 months. 	
12.	There should be a single assessment process for staff of Health and ACS in a specialist Mental Health team for Older People.	<ul style="list-style-type: none"> • NSF requirement. • More holistic assessment carried out. • More integrated assessment and commissioning processes. • Reduction in number of separate pieces of documentation. 	<p>Within exiting resources, however:</p> <ul style="list-style-type: none"> • Training may need to be re-profiled to support move to single assessment. • New documentation required. 	<ul style="list-style-type: none"> • Less duplication. • Information only required to be given once. 	<ul style="list-style-type: none"> • 100% of assessments completed are in agreed single assessment format. • Introduction of Single Assessment overseen through HOPSG. 	April 2003.

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13.	Agreed single referral route to all members of specialist Mental Health team for Older People.	<ul style="list-style-type: none"> • Reduce confusion for referrer as to most appropriate referral source. • Speed up referral process. • Less likelihood of duplication. 	Within existing resources.	<ul style="list-style-type: none"> • Less duplication. • Single contact point for queries. • Users/Carers won't be bounced between agencies. • Faster response to enquiries. 	<ul style="list-style-type: none"> • 50% of total number of team referrals through single referral route. Increasing to 100% within 12 months. 	April 2003.
14.	There should be a joint clinical allocation forum (Health/ACS) to consider referrals to the Specialist Mental Health Team for Older People.	<ul style="list-style-type: none"> • Prompt allocation of appropriate worker to case based on needs. • Pool of expertise is broader. • More co-ordinated response. • Prioritisation of cases carried out jointly. 	Within existing resources.	<ul style="list-style-type: none"> • Quicker and more appropriate response. • Needs considered by all agencies / disciplines. • No re-referral to other statutory agency thereby reducing bureaucracy. 	<ul style="list-style-type: none"> • 75% of cases being assigned to staff are through this forum. • 100% target of cases in further 6 months. 	April 2003.
15.	Health/ACS members of specialist Mental Health team for Older People should agree a single integrated approach to providing care which has users/carers needs at its centre i.e. CPA.	<ul style="list-style-type: none"> • Forget-me-not. • Currently separate systems for Health/ACS. • Single approach would streamline and simplify management of care. • Common terminology can be adopted. • Reflective of user sensitive service. 	<p>Within existing resources, however:</p> <ul style="list-style-type: none"> • New training will be required to support introduction. 	<ul style="list-style-type: none"> • More straightforward and simple to understand. • A single responsible care co-ordinator for all aspects of care. • Users/Carers can be placed at centre of care planning with a single care plan. 	<ul style="list-style-type: none"> • An agreed policy between agencies to outline organisation of care. • Compliance with requirements of policy. 	<p>April 2004.</p> <p>(May require secondment of staff to single organisation.)</p>

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16.	There should be single line management of all staff (Health/ACS) within a specialist Mental Health team for Older People (aim to second staff to a single organisation).	<ul style="list-style-type: none"> • The teams actions and responses can be managed by a single individual. • Ensures there is a person with decision making capability within team. • Streamlines management of team. • Speeds up decision making process whilst retaining it locally. • Local autonomy and responsiveness. • Favoured model in Adult Mental Health. 	Potential additional cost of appropriately graded manager and/or disaggregation of some posts from EPD services. Ensuring adequate professional supervision is maintained.	Will unify policies/procedures of 2 agencies. Single complaints process. No "passing the buck". Will ensure delivery of all recommendations.	<ul style="list-style-type: none"> • Number of teams managed by single line manager. 	April 2004.

THESE RECOMMENDATIONS REQUIRE FURTHER CONSULTATION WITH STAFF AND UNIONS.