BEST VALUE REVIEW OF MENTAL HEALTH SERVICES FOR OLDER PEOPLE

1. Current Arrangements for Providing Services for Older People with Mental Health Problems

Services for older people with mental health problems are provided by Adult Care Services, and by Health Trusts, in particular the Hertfordshire Partnership Trust (HPT). Currently the clients using these services are over 65 and suffer from long-term functional illnesses such as schizophrenia or depression, or they have dementia which is organic. Younger people with dementia also, normally, fall into this group, as this is where staff have specialist skills for diagnosis and assessment.

Adult Care Services provides care management to this client group from within its seven Area Teams for Elderly and Physical Disability. Currently this is not ring-fenced time and is part of the overall service provided by Area Teams to all older people and people with physical disabilities.

The Health services are provided separately by HPT and other out-county Trusts. The range of services provided by Health varies considerably and is more community based in West Hertfordshire than in other parts of the county. Within HPT and out-county Trusts there are clearly identified staff who work with this client group – Psychiatrists, Community Psychiatric Nurses, Psychologists, Therapists and Support Workers. The HPT calls these Teams, Community Mental Health Teams for Older People, although they contain only HPT staff.

A range of services is commissioned for this client group by either ACS or the Trusts.

ACS Area Teams commission:

- Community Support.
- Day Care.
- Residential care/respite and long-term nursing home care.
- Support for carers mainly provided by voluntary organisations (Carers in Herts, Age Concern, Alzheimer's Society.

Health Trusts provide or commission:

- Psychiatric assessment and treatment.
- In-patient services.
- Day Hospitals
- Community Psychiatric Nurses.
- Psychology.
- Continuing Care.
- Carers Support

A map of current provision is attached as Appendix A. From this it can be seen that the provision of services is patchy and inconsistent.

2. Objectives of Service

These are identified as:

- Consistent, integrated services with clear networks and protocols.
- Easy / quick access for users or carers.
- Flexible, responsive, cost effective services that maintain independence.
- Joint planning and commissioning to make best use of resources of all agencies.
- Maintaining quality services.
- Response according to needs not age.

3. Legal and Policy Framework

Entitlement to and eligibility for services fall within the following framework:

3.1 Rights to Assessment

There are five key pieces of legislation, which underpin the rights of an older person with mental health problem, and their carer, to access an assessment of their needs:

NHS and Community Care Act 1990

Section 47 states: "Where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of such services the authority shall:
a) carry out an assessment of his needs for those services; and
b) having regard to the results of that assessment, shall decide whether his needs call for the provision by them of any such services."

1983 Mental Health Act

A person may receive an assessment under Section 2 of this Act if it appears that they are suffering from a mental disorder and may need admission to hospital either in the interests of their own health or safety or for the protection of other people. Their nearest relative also has the right to request the local authority initiate such an assessment, and an Approved Social Worker is then required to 'consider' the person's case, and decide whether an application for admission may be necessary.

Disabled Persons (Services, Consultation and Representation) Act 1986; Carers (Recognition and Services) Act 1995; and the Carers and Disabled Children's Act 2000.

Provisions in these three acts, taken together, establish rights for carers to be involved in the assessment process, to have their own needs assessed if they are providing 'substantial and regular' care to someone, even if the person who receives their care is rejecting an assessment or formal care services.

3.2 The Provision of Services

Once the needs of an older person with mental health problems have been assessed, the provision of the appropriate health and community care services is likely to be made under one or more of the following Acts.

1948 National Assistance Act

The Local Authority has a duty to provide residential accommodation for people aged 18 or over who because of 'age, illness, disability or any other circumstances are in need of care and attention that is not otherwise available to them'. (Section 21)

1970 Chronically Sick and Disabled Person Act

The Local Authority duty to provide specified range of community-based services to individuals covered by Section 29 of 1948 Act 'where the Authority is satisfied that it is necessary to do so in order to meet the needs of that person'.

1983 Mental Health Act

Following an initial assessment under this Act, a person may be admitted to hospital for a further period of assessment or treatment. This may be on an informal (voluntary) basis, or if certain legal criteria are met, they may be compulsorily detained in hospital, or received into guardianship. Section 117 of the Act establishes the right of anyone who has been formally detained to receive appropriate after-care services from Health and Social Services for as long as they need it.

National Health Services Act 1977

This is the principal statute governing the Health Service. It refers to the wide ranging and general duty of Government to promote a Health Service designed to secure improvements in people's physical and mental health, and to prevent, diagnose and treat illness.

Health Act 1999

This has particular relevance to this group as it strengthens the legal requirement for Health and Social Services to work together in partnership in order to deliver the integrated services that are essential to people who have both health and social care needs. It removed some of the legal barriers, which had previously prevented more flexible working arrangements between the two services.

Human Rights Act 1998

This Act seeks to ensure that all our laws, practices and procedures comply with the European Convention on Human Rights. Many aspects of the Act could be relevant to the provision of services to this group, but especially Article 2 which places a positive obligation on the State to protect life; Article 3 which prohibits inhuman or

degrading treatment; Article 5 which prohibits a person from being detained against their will unless this is done in accordance with a 'procedure prescribed by law' and Article 8 which protects people's right to respect for their private and family life.

Carers and Disabled Children's Act (2000)

Carers may now receive services in their own right to help support them in their caring role.

3.3 National Policy Framework

Better Services for Vulnerable People 1997 requires Health and Local Authorities to work together to develop and produce an annual Joint Investment Plan for older people.

Making Decisions (1999). Although not yet law, this is an important document, which contains the Government's proposals for changes in the law in relation to those who lack capacity to make their own decisions. It makes proposals, which seek to address the widely acknowledged problems and gaps in existing law.

Effective Care Co-ordination in Mental Health Services (1999) contains the current Government guidance on implementing the Care Programme Approach (CPA) in respect of people in contact with the specialist mental health services.

'No Secrets' (1999) is the first national policy guidance on developing and implementing local multi-agency policies and procedures to protect vulnerable adults from abuse.

'Forget Me Not' (2000 and 2002) Audit Commission Report and update on mental health services for older people describes how health and social care services need to work together to provide prompt, effective and co-ordinated help to older people with mental health problems and their carers. It focuses particularly on two largest groups affected: those suffering from dementia and from depression.

National Service Framework for Older People (2000) includes highly relevant sections on mental health in older people; person-centred planning; a single assessment process and challenging age discrimination in service provision. Standard 7 states "that by 2004 there must be agreed protocols in relation to mental health services for older people, as well as development of integrated services".

SSI 'Improving Older People's Services (2001) reported on progress in 21 Authorities towards the goals for better services identified in the Government's plans in **Modernising Social Services**, drawing attention again to what constitutes good quality services for older people.

The Single Assessment Process for Older People (2002). This Department of Health circular to both Health and Local Authorities contains guidance and implementation dates for the new Single Assessment Process, which is aimed at ensuring older people receive a timely and properly integrated assessment of both their health and social care needs.

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Fair Access to Care Services (due out in 2002) is the new national guidance for Social Services eligibility criteria for adults. No longer will Social Services authorities be allowed to apply different eligibility criteria based on a person's age or type of disability. It will also ensure that such criteria in future focus on addressing threats to a person's independence.

National Care Standards Commission (from April 2002). This important new body will have wide ranging responsibilities for setting national minimum standards for care services, inspection and regulating care homes, domiciliary care and nursing agencies, and private and voluntary hospitals and clinics.

3.4 Local Policies, Procedures and Initiatives

There are also many local policies, procedures and multi-agency initiatives in Hertfordshire all designed to deliver services, which are in line with legislation and the policy framework outlined above. The most relevant of these are:

A Guide to Assessment and Care Management in Hertfordshire for staff with social care responsibilities.

Policy on Integration of CPA and Care Management for clients of the mental health services.

Eligibility criteria for social care (currently under revision in light of new Government guidance).

HCC Charging Policy sets out what people in receipt of certain social care services need to pay towards their care.

Care practice and service standards which set out the Department's quality standards for all branches of social care services.

'Putting People First' is Hertfordshire County Council's corporate policy on equal opportunities, and is implemented in Adult Care Services through the Department's **Equalities Action Plan**.

Policy on Intermediate Care which focuses on joint working at PCT level to develop services to prevent inappropriate admissions to hospital and facilitate timely discharges.

Carer's Strategy – a multi-agency strategy to improve the quality of support offered to carers in Hertfordshire across all statutory agencies in line with the National Carers Strategy and the 2000 Carers and Disabled Children's Act.

District Audit Report in 2001 on Mental Health Services for Older People. Implementation of its recommendations are awaiting the outcome of this Best Value Review. This relates to a need to develop a single, multi-disciplinary assessment tool, and to address inconsistencies in service provision across Hertfordshire.

Adults at Risk Inter-Agency Response to Allegations of Abuse of Vulnerable Adults Hertfordshire's multi-agency policy and procedures for the protection of vulnerable adults from abuse or exploitation.

Multi-agency Steering Group overseeing the local implementation of the National Service Framework for Older People.

4. Summary of Investment in Mental Health Services for Older People.

An initial analysis indicates that within ACS about £2.5m is spent on staffing for this client group. This includes social work, occupational therapy, professional assistant, administrative and management time.

The equivalent cost for HPT staffing in their community teams is £2.4m, but in addition they spend £8.3m on in-patient and day hospitals.

ACS purchases about 760 specialist residential and nursing home beds for this client group, or 18% of the total beds, purchased at a cost of £9.6m (at 2002/3 prices disregarding the changes in residential care allowances). An estimated £7m is spent on home care for this client group, which is 32% of the total home care budget for Elderly and Physical Disability. An extra £900,000 is spent by ACS on day care, equipment and grants to voluntary organisations.

Provider	Type of Cost	Cost (£)
ACS	Staff	2,500,000
ACS	Specialist and Nursing Home Beds	9,600,000
ACS	Home Care	7,000,000
ACS	Day Care, Equipment, Grants to Voluntary Organisations	900,000
Total ACS		***20,000,000***
HPT	Staff	2,400,000
HPT	In-Patient and Day Hospitals	8,300,000
Total HPT		***10,700,000***
Total ACS and HPT		***30,700,000***

It has not been possible to obtain from the Health Authority a full breakdown of the additional amounts spent on purchasing services from Health Trusts outside the County.

This Review considers:

- **How resources could be more cost effective by integrating ACS and Health staffing?**

- **How service improvements could be made by shifting the balance from residential to domiciliary services to improve quality of life for our clients.**

5. The Best Value Review Process

The Review focussed on improvements in services and providing best value, from the perspective of users of services and their carers. It has been undertaken jointly with representatives of HPT and Primary Care Trusts (PCTs), and has included consultation with a very wide group of stakeholders, including users, carers, voluntary organisations, independent providers, staff and national experts. It has drawn on examples of best practice identified nation-wide.

The 'Scoping Workshop' added to a vast amount of information gained from sending out questionnaires to stakeholders. From this, two main hypotheses were developed and tested at a 'Challenge Workshop'. In addition a smaller group of external challengers helped to shape the final hypotheses to be tested. At this stage professional challenge was also commissioned from Professor Andrew Kerslake and Maria Parsons from the Oxford Dementia Centre and the Institute of Public Care. This same rigorous challenge process of Workshop, meetings with external and professional challengers helped to determine the final recommendations. Further consultation and investigation of best practice in other Authorities informed the final outcomes.

Throughout the process a best value framework of comparison, consultation, challenge and competition has been adopted.

6. Work Undertaken

6.1 Hypothesis One

Hypothesis One states: ***If we establish an integrated mental health service, it would improve the service to older people and their carers by being more co-ordinated, more flexible and cost effective.*** *Focus was given to a need to address age discrimination.*

Methods used to test this have included:

6.1.1 Comparison

A number of Authorities were identified who were known to have already integrated services. These included Northumbria, Dorset and Wolverhampton. Written and verbal information was collated and this informed the model of integrated service envisaged. It was also concluded that no one Authority had fully implemented our proposed model.

The ideal model of service proposed include the following; and it is our intention to call this A Specialist Mental Health Team for Older People:

- Co-location.
- Identified team leader/manager.
- All team members employed by one organisation.
- Single line management structure.
- Ensuring professional supervision structure is robust and supportive.
- Referrals into team as whole – multi-disciplinary meeting to allocate referrals.
- Single documentation for all professionals within team.
- Open access – referral accepted from wide variety of sources.
- Team to take both organic and functionally ill.
- Specialist mental health Social Workers as part of team.
- All team members to be able to be Care Programme Approach Care co-ordinators.

6.1.2 Consultation

There had been a considerable amount of feedback from previous consultations and Workshops. This indicated overwhelming support for an integrated service.

Further consultation was undertaken with 7of the existing 9 Community Mental Health Teams for Older People (Hertfordshire Partnership Trust) and included discussions with Psychiatrists and Community Psychiatric Nurses.

Consultation with these staff teams indicated:

- Positive joint work in many areas.
- Considerable variation in how service is organised across county – some co-location, membership of community mental health team varies.
- Complicated and lengthy referral pathways – particularly between ACS and Health.
- Some attached Social Workers are not able to be Care Programme Approach Care Co-ordinators.
- Assessments not always joint or shared.
- Separate documentation and files.
- Case allocation and processes vary.
- Links to Primary Care variable.
- Links to Voluntary Sector under-developed.

In three CMHTs for Older People, Welwyn/Hatfield, Watford and Hertsmere there are Social Workers located with HPT staff but continuing to be employed by, and accountable, to ACS. There was positive feedback on these, albeit limited, arrangements.

In order to test out the transitional arrangements for people over the age of 65, particularly those who have a long standing functional illness, 4 CMHT for Adults were visited. Discussions confirmed that clients are transferred inconsistently according to age or to locality, sometimes at age 65 and sometimes 70 or later. Occasionally a Psychiatrist for Adults would retain clinical responsibility, but care

management responsibility would transfer to an ACS Elderly and Physical Disability Team. Usually services, such as therapeutic day care, available to adults under 65 years of age, would no longer be available once that age was reached. Feedback from this consultation and from previous wider consultations indicates that people over the age of 65 have access to a more limited and less appropriate service.

This informed our conclusion that in order to address age discrimination much greater flexibility is required around transitional arrangements so that people receive a service appropriate to their needs and not according to their age.

6.1.3 Challenge

Further discussions with Maria Parsons and Professor Andrew Kerslake from Oxford Dementia Centre and the Institute of Public Care suggested a need to start by focusing on outcomes, objectives, pathways and protocols and lead on to structural change. It also highlighted the need to take account of demographic change. For example, currently 11% of over 75 year olds have dementia. Over the next ten years, this will be 14% of over 75 year olds. The number of people with dementia aged over 85 years will be 21% by 2012. Primary care will need to take a more active role in the delivery of services to older people with mental health problems. This will affect the final models of integrated working.

The 'Challenge' Workshop on 13 February was a further opportunity to test out proposals. The feedback again indicated a need to involve Primary Care Trusts and voluntary organisations, empower users and carers, rationalise and speed up access and referral routes, encourage flexibility and agree joint protocols and care pathways and promote joint training.

6.1.4 Competition

Work is still ongoing which will inform the cost effectiveness of the recent structural integration of Adult Mental Health Services within the Hertfordshire Partnership Trust.

However integration would avoid duplication and quicker, easier, access to other professionals would be time and cost effective. Where social workers are based with Health staff currently there is evidence of improved service delivery, better communication and time saving, allowing quicker response to referrals.

6.1.5 Conclusion

An integrated service will be more efficient and add value to the current working arrangements. Initial responses indicate wide support, but further consultation with staff and Union is required before progressing this model.

6.2 Hypothesis Two

Hypothesis Two states: ***If we shifted the balance towards community based services from institutional care, it would promote independence by supporting clients to live in their own homes longer, and appropriately support carers.*** Methods used to test this have included:

6.2.1 Comparison

Work was undertaken to identify services and initiatives in other parts of the country that are particularly creative and might be appropriate to Hertfordshire. These included specialist Domiciliary Care/Support Services, Admiral Nursing Schemes to support Carers, schemes offered by voluntary organisations, extra care housing and the use of technology.

6.2.2 Consultation

A significant amount of the previous consultation gave feedback on services, particularly day care and home care and support for carers. Feedback was also obtained from Quality Monitoring Officers; visits to users, from a Listening to Carers day, and from a Department of Health User Satisfaction Survey in Hertfordshire of the views of minority ethnic groups.

The feedback and comparisons of good practice have informed the Recommendations, especially in relation to service gaps and requirements and future service developments.

6.2.3 Challenge

There was a further meeting with the External Challenge group who questioned the robustness of initial assessment and diagnosis. There is also a perceived gap in alternatives, for example, in day care, night care and support for carers. Training for staff and carers is essential. The voluntary sector is sometimes more acceptable to users and carers than the statutory sector. To achieve this transport is essential.

The final Workshop highlighted other issues not previously prioritised. In particular these were around:

- Firstly, the need to determine Intermediate Care for this client group.
- Secondly, hospital admission is a major life crisis from which clients in this group might never return home. Emphasis on a rapid/crisis response to prevent avoidable admissions is a priority.
- Thirdly, the administration of medication is a major factor in maintaining people independently and a means must be found for this to be achieved when it is the only care task required.

6.2.4 Competition

This has been a major component in testing this Hypothesis. An in-depth study of 35 case files of clients with mental health needs being admitted to specialist residential care beds for life, has identified both the triggers and alternatives. It is considered that 40% of these admissions to residential care could have been delayed and people could have been supported to maintain their independence at home longer if a wider range of more specialist domiciliary support is made available to them and their carers. Hypothetical care packages have been costed, based on alternative services being established and available.

6.2.5 Conclusion

Some of the key issues arising from testing this Hypothesis and making recommendations are:

- It is essential to avoid hospital admission wherever possible.
- This client group, in particular, benefit from receiving services in their own home as far as possible.
- Carers should be well supported, as this in turn helps them to continue their caring role.
- People can only be supported at home with a greater range of specialist services e.g., better diagnosis, medication and flexible home care/support, extended day care, possibly 7 days a week, and/or overnight, ring fenced support to informal carers, and appropriate provision of transport.

7. Recommendations

7.1 Hypothesis One – Integrated Working

The detailed Implementation Plan is attached as Appendix C. It is a national requirement to have made significant progress by 2004. It is, therefore, suggested that we implement the recommendations incrementally. We recommend that we should achieve a fully integrated Specialist Mental Health Team for Older People within HPT by April 2004. Meanwhile, there are significant issues that can be progressed immediately and within current resources such as developing care pathways and protocols, setting up local forums to include all stakeholders, providing better information for users and carers.

It is also suggested that Adult Care Services should identify dedicated time from within its Area Teams, and that opportunities to co-locate staff in existing CMHTs within HPT should be taken. This is likely to be achieved in West Hertfordshire without extra cost, except for equipment such as laptops and mobile phones. In other parts of the County this may be achievable in ACS premises, e.g., in North Herts. Some capital funding might be required in some parts of the County before moves could be completed as and when resources become available within the capital programme.

Further attention needs to be given to the shape of future integrated services where current specialist Health services are provided by Trusts outside the County. This is a particular issue in some parts of North and East Hertfordshire.

Whilst there are significant service improvements achieved by integrated working, there are complications for ACS in retaining the remaining services within Area teams. Disaggregation of staff must not adversely affect services to physically frail older people or younger people with a disability, and this will need to be managed carefully. Judgements will also need to be made by ACS, HPT and PCTs as to what services will be provided within primary care and what services will be provided by Specialist Mental Health Teams. This will affect the levels of staffing required in

each. Working towards integration on an incremental basis will allow time to work through these issues.

7.2 Hypothesis Two – Service Delivery

The detailed Implementation Plan is attached as Appendix D. It is again recommended that we proceed incrementally. Whilst it is identified that significant service improvements can be achieved by shifting resources from residential to community / domiciliary care, this can only happen over time.

It is therefore recommended that the following would be initial priorities:

7.2.1 Services For Carers

Identifying funds from specific grants as available to provide carers support services across the County, extending existing Agreements with voluntary sector organisations; and using Carers Breaks money to fund respite.

7.2.2 Technology

Piloting the use of technology and equipment and linking this with the current work on establishing a joint equipment service with Health, and on the outcome of the previous Best Value Review of Services for Adults with Physical Disabilities or Sensory Loss. Examples of equipment that could be provided are pressure mats and sensors which can alert carers to someone getting out of bed, going downstairs, turning on the gas, opening the front door.

7.2.3 Establishing A Specialist Home Support Service

This needs to offer a different service from the domiciliary care currently commissioned. For this care group, staff require specialist training and must be able to provide a responsive, flexible service that can vary on a day-to-day basis according to need. Specialist workers need to have close contact with professional staff to monitor the welfare and safety of clients, as well as providing their personal care. Such a service is likely to be more expensive than our current service and further work will be required to determine how such support could be best provided. Contact with independent providers indicates that there would be interest in developing this. Alternatively, further work might indicate that a service, similar to the Community Support Service provided within CMHTs for Adults, might be most appropriate. Independent agencies have indicated that it would cost appropriately £2.50 per hour more than current domiciliary care to provide this specialist service.

7.2.4 Day Care

Consultation indicated that additional, more consistent and better quality day care is required. Day care is provided not only by ACS, but includes a range of voluntary sector provision and day hospitals run by HPT. More work is needed to establish the full picture and to identify gaps. These might be then met by reconfiguring existing services. 7 day availability will need to be considered. Any additional resourcing could be met from shifting the balance of service from residential to domiciliary care.

It is recommended that this is not pursued until year two, by which time it will have been possible to evaluate the impact of improved home support, technology and support to carers.

8. Financial Implications of the recommendations

Over time a decrease in the use of specialist mental health beds in the residential establishments would release funds to provide alternative domiciliary care.

Based on research and investigation, it has been calculated that admission to residential care could be delayed for 40% of clients. An assumption has been made that this delay would be, an average, 30 weeks. The research indicates an average saving of £43.09 per week per client, but is dependent on additional services being available to support these clients at home. Over a 3-year period, it is estimated that £307,000 can be realigned from residential to domiciliary care. This would support the 240 people who it is estimated could stay at home longer, and also provide additional services for carers and clients which would offset some of the demographic increases and reduce the need for additional resourcing.

Extra staff time of social workers or community psychiatric nurses has not been included. This may need to be added but it is anticipated that this could be cost neutral as a result of:

- Greater efficiency of integrated working.
- Better crisis management because clients and carers receiving more appropriate packages/support.
- Home Care/Home Support being better integrated.

Funds released from residential care for realignment to domiciliary care over, 3 years £307,000

Proposals to reinvest funds	Year 1 (£)	Year 2 (£)	Year 3 (£)
Grants to voluntary organisations to support carers	40,000	80,000	80,000
One-off expenditure on technology equipment say 50 clients at £250 each	12,000	12,000	12,000
Additional domiciliary care to include specialist home support/home care packages at estimated £14.50 per hour and increased day care (including transport)	68,000	148,000	215,000
Total proposed reinvested funds	***120,000***	***240,000***	***307,000***

As stated previously some capital funding might be required in the future to achieve co-located integrated teams. This would need to go through the normal capital and revenue budgeting process.

The issue of charging for services requires further consideration. Currently the Charging Policy excludes those who have “a severe and enduring mental illness”. An exception is made for those with dementia. As this group is mainly made up of older people, the fact that they continue to be charged by the County Council for social care services, which are free to younger people, appears to be discriminatory. This should be reviewed in line with the requirements of the National Service Framework for older people.

9. Quick Wins

A number of quick wins have been identified as Appendix F. These focus on initiatives that require little or no extra resourcing, could be achieved quickly and could have a major impact on service improvements.

The Quick Wins address the following issues:

- Creating networks and disseminating information.
- Joint training and recruitment.
- Identifying ring-fenced staff time.
- Agreeing referral routes and protocols.
- Ensuring clients have a psychiatric assessment before being admitted to long-term residential or nursing care.
- Train staff to prevent avoidable admissions to hospital for this client group.

10. Next Steps

- Complete work on identification of expenditure by Health on this client group.

- Consider joint commissioning arrangements through the Joint Commissioning Partnership Board.

- Build on meetings already held within PCT Executives to maintain sound communication and retain their support and commitment to the Review.

- Begin to implement Quick Wins.

- Implement Recommendations when agreed.

In order to achieve all this, dedicated ACS staff time is required with a clearly identified lead officer. Continued work will be undertaken in partnership with HPT and PCTs. Partnerships with out-county Trusts will need to be developed.