City of Bradford Metropolitan District Council, Bradford & Airedale Teaching Primary Care Trust & Primary Care Alliances

“Emerging From the Shadows”

PART 1: A strategic commissioning framework for services for older people with mental health difficulties

[2008-11]

May 2008
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1 Introduction

1.1 Background

Older people’s mental health is an increasingly important area of public policy that “does not get the attention it deserves” ([Age Concern). Three million older people in the UK experience symptoms of mental health difficulties that significantly impact on their quality of life and this number is set to grow by a third over the next fifteen years.

This represents an enormous cost to society and the economy in direct costs to public services and indirect costs in lost contributions from older people, who contribute to the economy each year as workers, volunteers, unpaid carers and grandparents.

The range of mental health problems experienced in later life is very wide. It includes depression, anxiety, delirium, dementia, schizophrenia, and other severe mental health problems, including alcohol misuse.

- One in four older people living with mental health have symptoms which serve enough to warrant intervention.
- Only a third of older people with depression discuss it with a GP. Only half of them are diagnosed and treated, primarily with anti-depressants.
- Depression is a leading risk factor for suicide. Older men and women have some of the highest suicide rates of all ages in the UK.
- Dementia costs the health and social care economy more than cancer, heart disease and stroke combined.
- Fewer than half of older people with dementia ever receive a diagnosis.
- A third of people who provide unpaid care for an older person with dementia have depression.
- Delirium or acute confusion effects up to 50% of older people who have operations.
- There are 70,000 older people with schizophrenia in the UK.
- People aged between 54 and 74 have the highest rate of alcohol related deaths in the UK.

1.2 Purpose of the review

This review of older peoples mental health services, culminating in the document “A Commissioning Framework: model of services for those older persons experiencing mental health difficulties”, was commissioned by the City of Bradford Metropolitan District Council and Bradford & Airedale Teaching Primary Care Trust. It was undertaken in partnership with Bradford District Care Trust, the third sector and independent sector through an inclusive and participative process.
The origin of this review is two-fold, namely:

- Arising from a joint agreement by the DASS and PCT that significant reviews of learning disability, adult mental health, and older persons mental health needed to be undertaken to run on a convergent track with the application for Foundation Trust status being taken by Bradford District Care Trust, the specialist provider of a range of the above service elements;
- The development and implementation of ‘Health in Mind’ through POPPs funding, which has sought to put in place a community and preventative approach, and has acted as a stimulant to the realignment and determination of a model of service. It remains to now to develop and implement a managed network approach to this model of service.

The review outcome is described as a “Commissioning Framework, developing a model of service”. It sets out:

- A strategic direction for the next three years ['08-'11]. It does not identify the operational detail as this remains an important local dialogue although much work has been undertaken on this through the process and prior to it;
- A model of service which reflects local ambition and aspiration, and which is evidence and best practice based;
- The rational for such an approach;
- The priorities for implementing such an approach together with the ceiling costs for differing elements;
- Ongoing work that is required at a local level to clarify design and content of specific elements for the future (09/10 onwards).

It is a brief document written to be practically useful during implementation. Separately a ‘Part II’ has been developed which captures outputs of the process, including contextual polices and influences, carers stories, workshop inputs/outputs, people seen and a bibliography. This may well be helpful as a reference point during the process of implementation.

1.3 Project brief and assurance processes

The brief for the review is set out below together with the governance and assurance process that has been in place:

- An appraisal of national policy, best practice, and evidence in this policy area;
- Mapping of the local service profile, performance and demography;
- The development of a gap analysis to reflect the current profile for the service in Bradford, against which the development of the commissioning framework and model of service would be undertaken;
- The identification of a model of service for older people with mental health needs which would give the strategic direction for joint and integrated commissioning [PCT, Alliances & DASS];
- The identification of priorities for the development of the commissioning framework and model pathways, providing clarity for the appropriate business case development.
The governance assurance process for the review consisted of:

i. A Steering Group comprising the DASS, PCT, Alliances, Health in Mind and Bradford District Care Trust, supported by the project management team to the work (Gemma Dunn, WSP and Karen Flowers, Bradford District Care Trust). The Group was tasked to:
   a. Provide local leadership to the development and implementation of recommendations emerging from the review;
   b. To ensure clinical engagement in the local development of commissioning perspectives and delivery mechanisms to further the model of service.
   c. To discuss and sign off the implementation plan as it is developed and ensure the integration of it in the wider health programme.

ii. An engine room group comprising of Alliance representatives and the Project Team, together with the ‘Health in Mind’ Lead.

iii. A workshop methodology that involved a range of stakeholders including commissioners and providers together with carers.

1.4 Process adopted

The outline process adopted for the review is set out below:

- Individual and/or group discussions using a consistent and structured approach to gather outputs. The profile of these is provided at Appendix 7, Part II.
- Mapping the current levels of spend, resource availability (location and function) and performance. These are set out in Appendix 2, Part II.
- Identifying the needs profile including demographic trends, see Appendix 2 in Part II and the separate compendium of presentation material.
- A series of three workshops; details of the objectives, the inputs and outputs are set out at Appendices 3, 4 and 5, Part II. These workshops worked through a process of:
  a. Analysing the current service model (SWOT);
  b. Undertaking issue-specific redesign arising from the above.
  c. Developing a model of service.
- Developing ‘real experience’ stories from the perspective of service users and carers.
- Working with the steering group to develop the final report.

Much of the output above is contained in a series of appendices (Part II) whilst this report focuses on the specific commissioning framework and model of service.
2 Context

2.1 National context

2.1.1 National Dementia Strategy

The first national dementia strategy was announced in August 2007. The strategy will focus on the following three key areas:

- Improved awareness;
- Early diagnosis and intervention;
- Improving the quality of care for dementia.

**Improved awareness** will involve:

- Developing a better understanding of dementia by public and professionals alike;
- Ensuring that better information is provided on how to seek help and what help and treatment is available; and
- Tackling the stigma and misunderstandings that currently exist.

**Early diagnosis and intervention:** the programme in this area will concentrate on ensuring that effective services for early diagnosis and intervention are available in future on a nationwide basis.

**Improving the quality of care for dementia:** this area of the programme will focus on improving liaison services that can enable effective management in hospital and intermediate care. It will also focus on building better skills and understanding of dementia in the health and social care workforce so that all those working with older people develop core skills in this area.

Early products for the strategy have included ‘Strengthening the Involvement of People with Dementia Toolkit’, published in November 2007, which was the first document produced as part of this work and builds on and strengthens the section on *Involving service users and their carers in Everybody’s Business*. Its key messages are:

**For people with dementia:** as a person using a service you have a right to be involved:

- You have a personal perspective about dementia that no-one else can provide;
- Involvement can increase confidence and self esteem;
- It can provide a role and occupation and contribute to a better quality of life;
- You can provide positive examples of living with dementia encouraging others to get involved;
- You will contribute to removing the stigma associated with dementia as with mental health in general.

**For commissioners:** involving people who use a service is a policy requirement:

- It can evidence where services are no longer required and how new services should be shaped optimising the value of available resources;
Feedback through involvement gathers data for audit and evaluation purposes and feeds into performance assessment frameworks;
- It ensures fair access to public services and benefits;
- It ensures equality of treatment and protection;
- Involvement improves standards and responsiveness;
- Involvement generates new ideas.

**For practitioners:** people who are involved, whether practitioners or those receiving services, feel empowered:
- Information gathered and acted upon ensures the most relevant services are provided.
- It meets the personal and social needs of people using services
- It can assist people with dementia and practitioners to develop their potential
- It illustrates respect for individuals and their communities
- It promotes dignity, individuality, rights, responsibilities, identity and personal preferences
- Involvement promotes trust in services and may guard against abuse

A further paper has been produced, *Creative models of short breaks (respite care) for people with dementia* (CSIP). The aim of this fact sheet is to provide commissioners, providers and planners with information on a variety of innovative models of short breaks.

### 2.1.2 Public Accounts Committee - Sixth Report (January 2008)

On 24 January 2008, the House of Commons Public Accounts Committee (PAC) published a report (Sixth report: improving services and support for people with dementia (HC 228)). Its recommendations included:
- The appointment of a Senior Responsible Officer to drive through the national dementia strategy, learning from the model used for cancer services;
- That diagnosis should always be made, regardless of whether interventions are available;
- That the Department should commission a dementia awareness campaign to address poor awareness amongst the public and some professionals of dementia, to increase understanding of the symptoms, interventions and treatments;
- That on diagnosis, people with dementia and their carers should be given a single health or social care professional contact point to improve the co-ordination of care between the various services and professionals;
- That the Department should emphasise to local health and social care organisations that they need to develop an action plan which gives priority to assessing and meeting the needs of carers;
- CSCI should assess staff qualifications and training as part of its review of the quality of care for people with dementia, and local mental health services should use the findings when allocating resources to community psychiatric teams so they can provide adequate out-reach services to support care homes;
That, finding that hospital care for people with dementia is often not well managed, and to improve the cost effectiveness of acute care, families or carers of people with dementia should hold a copy of the care record so that paramedics will be able to make an informed decision whether the person needs to be taken into hospital or can be treated at home.

2.1.3 Improved services and support for people with dementia - The National Audit Office, July 2007

This study examined what health and social care services are available for people with dementia and their unpaid carers in England and whether they are providing effective and good quality support.

2.1.4 Inquiry into Mental Health and Well-Being in Later (Life, Age Concern and Mental Health Foundation)

The Inquiry has worked in two stages:

- **Stage 1** focused on the promotion of good mental health and well-being in later life.
- **Stage 2** examined services and support for older people with mental health problems.

The first report, published in 2006, recommends action to remove the barriers that prevent older people from participating in society; and encourages local authorities to take a lead role in partnership with the NHS, voluntary organisations, business representatives, community groups and individuals to develop programmes that promote positive mental health and well-being in later life. The second report, Improving services and support for older people with mental health problems, was published in 2007.

The Inquiry has identified five main priorities for action:

- Ending discrimination: older people with mental health problems face discrimination in policy, practice and research;
- Prioritising prevention: many mental health problems in later life can be prevented;
- Enabling older people to help themselves and each other: only a small percentage of older people with mental health problems receive help through formal services so support for self-help and peer support is necessary;
- Improving current services: although only a minority of older people with mental health problems access them, housing, health and social care services can play an important role;
- Facilitating change – through, for example:
  - Policy emphasis on age equality and self-directed support;
  - Improved education, training and support for those who work with older people;
  - Stronger professional, managerial and political leadership;
  - Effective targeting of investment.
2.1.5 **Dementia UK - 2007**

This report established an accurate estimate of the numbers of people in the UK who currently have dementia and estimates for the numbers of people who will have dementia up to 2051. It also included a review of current evidence on the services and treatments currently provided to support people with dementia and estimated the current costs of dementia.

In brief its recommendations for future dementia care were:

- Make dementia a national priority;
- Increase funding for dementia research;
- Improve dementia care skills;
- Develop community support to provide improved home care support packages, including low-level support to enable people to retain their independence and dignity;
- Guarantee carer support packages;
- Hold a national debate on who pays for care;
- Develop an integrated, comprehensive range of care models for people with dementia to bridge the gap between care at home and care in a care home.

2.1.6 **Putting People First (December 2007)**

This concordat sets out the way in which the adult social care system will undergo a radical transformation, giving people more control over the services they need and supporting independent living. A LA-led partnership of stakeholders and the wider local community will create a personalised, high quality care system which is responsive to the individual needs of those who use services and their carers.

There will be a major shift of resources and practice to prevention, early intervention and re-enablement. The aim will be to provide quality care that promotes dignity, and is safe, effective and available when and where people need it. Personal advocates are to be available in the absence of a carer or in circumstances where people require support to articulate their needs and/or use their personal budgets.

2.1.7 **NHS Operating Framework**

The Operating Framework sets out a brief overview of the priorities for the NHS next year. It identifies a number of enabling strategies, which help organisations to improve services for patients, including empowering patients through choice, information and personalisation. In redesigning care pathways, PCTs should aim to create a more personalised service that provides:

- Choice and control;
- Health and wellbeing outcomes that are as good as possible for the individual and their carers;
- Joined-up services;
- Access and convenience – including care closer to home;
- A good user experience, where service users feel that their dignity is respected;
• Support for carers by (among other things) taking on board their views about the people they care for, and recognising their need for breaks from caring.

2.1.8 **NHS Next Stage Review, Interim Report: October 2007 (DARZI)**

In his interim report Lord Darzi sets out a vision of an NHS that provides care that is personalised to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice. Practice-based commissioners will be encouraged to use NHS funds more flexibly to secure alternatives to traditional NHS provision where this would provide a better response to an individual's needs.

Lord Darzi highlights the issues of dignity and a focus on the patient as a person from his experience of his own patients, particularly older people, when treated in hospital who are concerned about feeling neglected or ignored while receiving care; and being treated more as an object than a person.

2.1.9 **Creative Partnerships: Improving Quality of Life at the End of Life for People with Dementia - A Compendium (January 2008)**

The overarching theme of this publication from the National Council for Palliative Care is collaboration. It outlines where barriers can occur and provides practical solutions to facilitate effective partnership working to benefit people with dementia at the end of life.

2.1.10 **Supporting people with dementia and their carers in health and social care (NICE/SCIE) - NICE clinical guideline 42, Nov ‘06**

The guide is for health and social care staff who work with people with dementia and their carers, and those who work with older people and people with learning disabilities. It also includes recommendations relevant to commissioners, managers and coordinators of health and social care. It sets out the identification, treatment and care of people with dementia and the support that should be provided for carers within primary and secondary healthcare, and social care.

The following recommendations were identified as priorities for implementation:

- People with dementia should not be excluded from any services because of their diagnosis, age or coexisting learning disabilities.
- Health and social care professionals should always seek valid consent from people with dementia.
- Health and social care managers should:
  - Uphold the rights of carers to receive an assessment of needs;
  - Coordinate and integrate working across all agencies involved in the treatment and care of people with dementia and their carers; and
  - Ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia-care training that is consistent with their roles and responsibilities.
- Care managers and care coordinators should ensure the coordinated delivery of health and social care services for people with dementia.
• Memory assessment services should be the single point of referral for all people with a possible diagnosis of dementia.
• People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop challenging behaviour should be offered an assessment at an early opportunity.
• Acute and general hospital trusts should plan and provide services that address the specific personal and social care needs and the mental and physical health of people with dementia who use acute hospital facilities for any reason.

2.1.11 Commissioning for Health and Well-being

The Commissioning Framework for Health and Well-being is part of the White Paper Our health our care our say implementation. It is designed to enable commissioners to shift investment patterns to earlier targeted interventions that promote health, independence and well-being. The framework sets out eight steps that health and social care should take in partnership to commission more effectively.

These include:

• Putting people at the centre of commissioning - so that services are personal, sensitive to individual need and maintain independence and dignity;
• Understanding the needs of populations and individuals – (through the Joint Strategic Needs Assessment); and
• Assuring high quality providers for all services.
• The framework’s vision for the future includes:
• A focus on enabling people to do things for themselves (e.g. homecare, re-enablement);
• A greater focus on prevention, early intervention and support for self-care;
• Making support more convenient and closer to home;
• Seamless transition, with services configured around a person’s needs.

2.1.12 Everybody’s Business: Integrated mental health services for older people - a service development guide (2005)

This service development guide sets out the key components of a modern older people’s mental health (OPMH) service. It builds on the service models outlined in the National Service Framework for Older People and the principles promoted in Securing Better Mental Health for Older Adults, in describing the foundations and key elements of a comprehensive older adult mental health service.

Its aim is to ensure that older adults with mental health problems and their carers have their needs met wherever they are in the system, without encountering discrimination or barriers to access. The complex nature of older people’s mental health requires a whole systems response that cuts across health and social care, physical and mental health, and mainstream and specialist services.
2.1.13 National Service Framework for Older People (Standard Seven)

The aim of this standard was to promote good mental health in older people and to treat and support those older people with dementia and depression. A comprehensive service model should involve:

- Promoting good mental health in older people;
- Early detection and diagnosis;
- An integrated approach to assessment, care planning and treatment planning;
- Support to carers; and
- Providing a specialist mental health service for older people.

2.2 Local context

Based on an analysis of individual and group discussions with further analysis at Workshop 1, and subsequent refinements, a full and comprehensive statement of strengths and weaknesses, opportunities and threats has been complied and is available in Part 2, Appendix 6 of this report.

Set out below is a visual summary of the threads that emerged from that analysis. The commissioning framework seeks to address that analysis through both its objectives, strategy and model of service, and anticipate the national requirements that are currently emerging and documented in 2.1.11 and 2.1.12.

Opportunities

Key aspects of the opportunities can be summarised as:

- Placing service delivery and its commissioning as close to communities and systems as possible;
- Acknowledge and implement individual budgets to reshape the care model;
- Developing community involvement and delivery strategies.
Threats

Key aspects of the threats can be summarised as:
- Must ensure a core comprehensive profile of services is available to all;
- Unless benefits realisation is developed and measured no common purpose will be achieved;
- Need to establish primary care leadership as this is essential to delivery.

Strengths

Key aspects of the local strengths can be summarised as:
- The current professional and clinical group with their skills and knowledge;
- The capability and commitment of the third sector;
- Emerging POPPS infrastructure vis prevention, knowledge transfer and commissioning development.
Weaknesses

Key aspects of the local weaknesses can be summarised as:

- The balance in the model of care that is currently too ‘bed’ focussed;
- Lack of an information strategy targeted appropriately;
- Primary care access to an all ages stepped model of care (talking and psychological therapies).

3 Mapping and performance appraisal

A full analysis of the local needs and service profile is provided in Appendix 2 in Part II of this report and the associated compendium of presentation material. Key findings from a review of this information include:

- **Differences in boundaries** - Bradford District Care Trust, Bradford and Airedale Teaching PCT, and Bradford District Care Trust each have different ways of splitting the overall area into smaller patches. This is likely to lead to difficulties in both commissioning, and service provision, unless this issue is explicitly considered.

- **High prevalence rates** – mental health difficulties are common amongst 65 and overs. A national survey showed 1 in 10 having common mental disorder, 1 in 6 impaired memory and concentration, 1 in 5 having signs of cognitive disorder.

- **Links with physical disability and household income** – a national survey showed that people with mental health difficulties were more likely to have difficulties with activities of daily living, and to have lower household incomes.

- **Frequent contact with GPs** – there was evidence that older people with mental health difficulties have frequent contact with general practices. Therefore this provides a good opportunity for early intervention and support. However, data on GP registration showed that City Alliance has less of its population registered with GP than other alliances, so it may be important for this Alliance to consider different ways to ensure awareness of, and access to services.

- **Prevalence amongst Ethnic Minorities** – A study showed higher prevalence of common mental health disorders amongst older people.
from Indian and Pakistani background, than amongst those from White, Irish and Caribbean backgrounds. This is interesting when considering that approximately 20% of the population in Bradford and Airedale is from South Asian background.

- **Differences between Alliances** – there are considerable differences between the alliances. Most obvious is in the size of population, with South and West having almost a third of the over 65’s within its Alliance. However work needs to be undertaken to look at other differences, eg looking at ethnicity, social deprivation, housing etc.

- **High projected population growth** - Bradford’s population is projected to increase by around a quarter over the next 25 years. This is considerably higher than the average increase expected across England, and the number of over 65’s is projected to increase by 46%. This will have considerable implications for Older People’s Mental Health services and places extra emphasis on the importance of putting in place a structure that can respond effectively to changing needs.

- **Differences in levels of identification** – the Quality and Outcomes Framework highlighted considerable differences in the percentages identified as having mental health difficulties across practices and alliances, and therefore it is important to ensure all practices are identifying and offering support to older people with mental health difficulties. Applying published prevalence estimates to local population projections enabled an estimate for the number of people with dementia and depression. A broad comparison with the numbers identified at GP’s as having suggests that only half of those with Dementia may be receiving help via their GP.

- **Low inpatient bed occupancy rates** - bed occupancy appears low for the BDCT inpatient services, suggesting that the number of beds needs to be looked at to ensure this is optimal.

- **Potential gaps in day services** - activity data showed 50% of attendances were at one day service in Bradford North. This raises questions around access to day services in other areas. The financial information also showed that spending was significantly less on day services than the SHA and English averages.

- **Overall spend of £23.5 million** - the overall recorded spend on older people’s mental health services is £23.5 million (source: LIT Financial Mapping Report Autumn 2007). However it must be recognised that this doesn’t include the money spent on voluntary / community services, or recognise the contribution and support that non-specialist services provide for older people with mental health difficulties.

- **Investment picture skewed by high investment in residential care** - the financial information suggested overall higher levels of investment than in Bradford ONS cluster group (although slightly below the average for the SHA). However this is skewed by significant imbalance in spend, in particular with high levels of spend in residential care. **The spend on specialist services in Bradford represents 30% of total compared to 40% across the SHA and 50% in their ONS cluster.** There was an absence of financial mapping returns / evidence for the wide range of community services / support and non-statutory sector provision.
• **High proportion of specialist spend on inpatient services** - spend on specialist services is heavily weighted towards inpatient services.

• **Imbalance in the spend across Community Mental Health Teams** - with Airedale receiving a much larger proportion of the finances than other teams.

• **Funding and activity doesn’t appear to match “need”** - a broad comparison of CMHT population, funding and activity highlighted considerable differences between areas, with the area with the highest number of over 65’s apparently receiving the least amount of funding and vice versa. This highlights the need for a thorough local needs assessment to determine the level of need for older mental health services within each locality, taking into account a wide range of factors, and subsequently the levelling up of response profiles.

4 Commissioning framework

4.1 Introduction

The commissioning framework and associated service model have been informed by both local and national drivers (see section 2), both recent and emergent. These indicate some fundamental and radical changes that are required in the service in respect of style and delivery associated with the emotional health of older people, as well as the ability of services to respond to the expectations of service users and carers and engage with them.

Running in parallel to these initiatives are critical policies that will dramatically challenge the way in which the commissioning of these services will be undertaken in the future. The most significant of these are ‘Putting People First’ and Practice based Commissioning. These relocate the decision making about need and response very close to the individual, and allow personal control to be exercised. It will have significant impact on the relationships for the commissioning of services for older people with mental health needs and the need to establish an overall framework for commissioners, which can both ensure fairness of access and flexibility in the response to the local needs profile. Significant demographic drivers are also in force in Bradford, in particular:

- An increase in the number of ‘very old’ (i.e. over 85) of two thirds by 2021;
- A rise in the percentage of older people who are from a Pakistani background from 3% to 7.6% (i.e. more than doubling in percentage times) and a corresponding reduction in the number of older people from an Eastern European background;
- In the City locality there is a comparative percentage increase in the percentage of older people from a Pakistani background but from a higher baseline, i.e. from 14.7% to 31.4%.

Prevalence rates for dementia rise from 1% to 34.4% with age, with early onset dementia in people from BME populations being significantly higher than in the white population, 6.1% compared to 2.2%. Whilst two thirds of people with dementia live at home this population already accounts for 80% of people in a registered EMI home, 67% of people in a non-EMI nursing home and 52% of people in a non-EMI residential care home (further detailed estimates of prevalence amongst the Bradford population for mental ill-health in older age
can be found in Part II, Appendix 8 and in the accompanying compendium of presentation material).

4.2 The Vision

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Figure 1 The vision

Central to the vision is:

- The locus of integrated, local, multi-disciplinary community mental health teams for older people. These will provide a service to those (where it is appropriate and after a joint decision) with a functional mental illness such as depression, and to those with dementia. They will work with primary care and community services to ensure early diagnosis and an efficient, person centred care pathway through the service map;

- Individuals who are case managed by this team will offer an integrated comprehensive assessment of need including that of the carer, and a personal care plan and access to personal budgets where requested. Individuals will receive information, verbal and in other forms, of their diagnosis and available support services in ways which are accessible to them. Staff will always demonstrate respect, understanding and care for patients, service users and their carers;

- A well informed primary care sector committed to early diagnosis and intervention, providing access to a range of services, and which acknowledges and responds to the needs of carers;

- Ensuring that older persons with mental health difficulty will stay in their homes as long as possible. Carers will have access to services at short notice during a crisis through the service being
available 24/7. This will include specialist, and if necessary, intensive home support available to be provided in a responsive and timely manner. A range of flexible and responsive respite services will offer a menu of support to carers both in the home and through transition beds. Where a more long term care solution becomes necessary this will be to more dementia style living environments set in the context of a comprehensive quality framework;

- Through increased staff development a choice of psychological therapies and other talking therapies will be available, based on need. Non specialist staff will be encouraged and required to have their development needs met in both dementia and functional illnesses;

- Where older people are in general hospital setting and have a mental health difficulty, access to a mental health liaison will help ensure appropriate care. This will reduce lengths of stay, and increase the chances of people returning to their own homes. The use of a Resource Centre will enable outreach support to be provided to peoples own homes, including extra care housing;

- The development of a comprehensive range of community services will reduce the requirement for inpatient admissions. Where admission does occur this will be a specialist facility reflecting contemporary accommodation standards;

- Younger people with dementia will have age appropriate services including access to specialist staff for younger persons with dementia. These staff will ensure that the needs are assessed and detailed in a comprehensive person centred plan;

- A set of services which promote the well being and health of all individuals, physical and mental, and which seeks to promote the highest level of independence and civic engagement for all through imaginative use of available resources.

This is the vision. Developing and delivering it will be a challenge. The services described in the model are, however, no less than that each of us would want for our families and ourselves. Whilst it will require additional resources, of equal importance is the will to change and to work in equal partnerships (and creatively) with service users, their carers and staff.

### 4.3 Commissioning objectives ('08-'11)

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- Developing community capacity and capability through increased localisation, improved access, integrated delivery, the development of education programmes & skill transfer together with service enhancement to ensure a 7/24 model of delivery.
• Initiating workforce development that is integrated (health and social care), enhances the skills mix through community support worker roles and provides flexibility across increased continuity of care functions, so providing broader professional career opportunities and increased continuity of care.

• Increasing the understanding of variance and diversity in the agreed footprints through comprehensive needs analysis at this level, informing the resource allocation process, identifying and modelling future demand and being pro-active in the commissioning process.

• Enabling the further development of a third sector as a key partner in delivery through appropriate provider roles, allied to active community development strategies.

• Significantly enhancing the support for, and of, carers through the development of carer network arrangements, appropriate information availability and partnerships in the development of services.

• Developing integrated ‘operational’ commissioning (PbC/social care) to better reflect the footprint, linked to joint and integrated strategic population-wide planning approaches and the mainstreaming of service user and carer influence in the full range of commissioning functions.

• Agreeing the practical application of the concept of managed care networks at a footprint level, together with its implementation linked to the strategic operational commissioning processes.

4.4 Commissioning Strategies

<table>
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<tr>
<th>Vision</th>
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<tbody>
<tr>
<td>Commissioning Objectives</td>
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<tr>
<td>Commissioning Strategies</td>
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</table>

**Generic Commissioning Approaches**

• Developing needs led and more accessible services by extending the availability of psychological therapies to all individuals regardless of age and with a range of mental health conditions, through a stepped model of care.

• Developing an intermediate level of services that seek to support the commissioning infrastructure, respond to a range of Tier 2 needs and link to specialist skills and advice.

• Building up the mental health workforce by putting in place more strategic approaches to workforce planning and seeking relatively untapped sources of community resources and future staff.

• Pursuing race equality by full implementation of the Delivering Race Equality Action Plan.

• Supporting carers by implementing the Carers (Equal Opportunities) Act 2004 through which carers assessments must now include a consideration of whether the carer works or wishes to work or participate in any education, training or leisure activity.

• Implementing individual budgets by developing mediated advocacy and support workers to allow for greater access to direct payments and individualised budgets.
• Better care planning by ensuring quality outputs of CPA and SAP processes, prior to the introduction of the Common Assessment Framework (Adults).

• Investing in service user groups by the PCT and LA ensuring there is investment in developing and sustaining networks of people who use services and their carers at a local level to both inform commissioning and the quality framework.

• Investing further in housing support by sustained investment in Supporting People and imaginative use of the voluntary and independent sectors and the development of extra care housing supported by innovative technology.

• Tackling the physical health of mental health service users particularly those most vulnerable, complex and at risk by actively pursuing a high quality of health engagement in personal health care planning at a primary level, early intervention and support.

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**Commissioning Strategies**

1. Promoting and sustaining commissioning approaches that support positive mental health, user led approaches, social inclusion and the development of self managed mental health care.

2. Demonstrating improved outcomes in providing more care and support in the community in order to reduce needs for hospitalisation and to encourage care at home.

3. Encouraging investment in preventative approaches that promote health, well-being and independence for all.

4. Provide the means whereby person centred, integrated care for all individuals experiencing mental health difficulties through early diagnosis and intervention, and goal focused support.

5. Promoting effective partnerships that acknowledge the wider systemic approach to provision and the treatment of mental health.

6. Providing a distinctly more primary and community focused range of responses organised on the basis of four footprints with designated primary care accountabilities.

7. Ensuring cost efficient management is applied to integrated mental health services that both acknowledges the footprint and strategic specialty.

8. A non-ageist, needs driven approach to the organisation and delivery of primary care mental health services with integrated pathways to a range of available and developing therapeutic interventions.

9. The locus of primary health care in the organisation and delivery of mental health services and the development of a wide range of treatment options available to individuals, accessible through general practice.

10. The development of an integrated health and social care model for both functional and dementia services (all ages) that promotes community solutions, rehabilitation and crisis responses in line with developing practice in this area of work. This should be underpinned by the assessment and treatment function being provided in a range of settings and be underpinned by an
intermediate tier of services designed to integrate physical and mental health needs of all older persons.

11. The location of an integrated multifunctional CMHT in each footprint, accountable for an agreed range of tasks and roles.

12. Ensuring the use of referral to the intermediate services from primary and community professionals that facilitates responses at footprint level.

13. Increased roles and opportunities for the third sector in the provision of service responses.

14. Ensuring that those individuals in long-term care have access to high standards of provision and access to the full range of responses to those living at home.

The implications for any model of service for older people who experience mental health difficulties therefore are reflected below. It must be able to sustain a:

- Close relationship between physical and mental ill health, and provide the means whereby this relationship can be integrated in the individuals assessment and personalised response;

- That an older person is part of the community in which they live, possibly work, have friends and undertake local activities, and it is this context that services need to be delivered - locally and integrated;

- That the organisation of the CMHTs and Alliances (reflecting mainstream and specialist, physical and mental health) should, as far as practically possible, reflect the footprint for the organisation of the core model of service;

- That the presence of an intermediate tier of specialist service, community based and which offers depth and breadth in services to those most vulnerable and for those at the highest risk, is a fundamental requirement. This should be close to home, accessible, be integrated and have flexibility;

- That the adoption of the development of footprint managed networks of care, which reflect the nature of the plurality of provision and the need for a system co-ordination to effect smart pathways for service users;

- That standards for access for all, response times, emergency (0-4 hrs), urgent (0-12 hrs) and standard (12-30 hrs) be consistent;

- That the model of core service elements be flexible to the footprint populations reflecting the demographic mix and profile and that the footprint plan reflects improved access and the full integration of health and social care support workers to ensure conformity;

- Enhancing and facilitating carer benefit at all points of delivery with greater appraisal of both the needs and the impacts upon carers and team building;

- That third sector development should always be sustainable in its implementation;
That personal representation and advocacy is fundamental to both fairness and access for all, but a fundamental informant of the relevance, appropriateness and quality of services; And finally it is important that early intervention and case finding and the stratification of need within a practice footprint are seen as building blocks of the framework and model of service, reducing inequalities in both access and response through sizing the core elements of the model appropriately and in the development of community solutions customised to the footprint.

5 The model of service

5.1 Overview and key characteristics

The locality approach is based on four localities defined by the agreed footprint of the four community mental health teams are illustrated below.

Figure 2 Illustrative service model

These reflect:

- Footprints that have differences in levels of need, demography, and current levels of resource; and
- Different relationships between partners and systems dependant on the history of resource allocation and the style of practice.

The characteristics of this locality model are that:
It enables greater sensitivity to general practice, either individually or collectively through linked CHMT workers in their roles as both providers and commissioners. This is therefore cognisant of PbC and PbR;

It, as a result of the above, provides the basis for pro-active case finding based on practice lists, and effective co-working, sharing of information and a preventative approach;

It recognises the systemic nature of communities, and that local community development opportunities can contribute both to well-being and recovery dependant on their presence or not – the model provides the basis on which these initiatives can be developed close to individuals lives and daily functioning, in other words a social model of disability;

It recognises that what happens at the primary and secondary prevention levels impacts positively or adversely on specialist services and therefore seeks to identify the concurrent approaches that need to be actioned;

It is sensitive, once local health needs assessment is available and it’s analysis agreed, to the flexing of resources to better reflect the priorities for commissioners;

It seeks to enhance an integrated systemic set of relationships for those with an interest or contribution to make in meeting the needs of a particular individual in much the same way as the palliative model of care;

It recognises that physical and mental health are two sides of the same coin, and that accentuated and integrated health care planning is required for those with severe and enduring mental health in order to promote their mental well being;

It moves towards the need to deliver an approach to both functional and organic conditions at a locality level footprint through open access to a range of primary care provision through a stepped care model, with the availability of psychological talking therapies;

It establishes consultants as ‘footprint focussed’ promoting their more general role in the coordination and development of others and in their consultative and facilitative capacities; in addition it has the ability to promote consultants in their wider strategic role as specialists, as envisaged by 'new ways of working';

Each footprint has a primary care focused CMHT ensuring the appropriate ability to promote and seek alternatives to hospitalisation and I/t care;

The basis for the development and agreement to pathways which promote diversion from specialist services if appropriate, whilst speeding access to those specialist services if necessary;

The development of locality relationships across a wide range of service providers who have a significant contribution to aid recovery, e.g. housing support workers, welfare rights advice, pharmacy…;

It anticipates specialist staff operating to a significantly greater degree in a supportive and developmental role (advice, training and development, governance, co-working ….)
5.2 The core model and functionality – strategic building blocks

Whilst the locus of the model of service is the CMHT footprint there remain Bradford and Airedale-wide service functions that are the building blocks of the commissioning framework, namely:

i. **Acute assessment** – the inpatient function as in Fig 3. This service function requires a Bradford/Airedale wide plan for its future provision, in order to accommodate the contemporary requirements to address:

   a. Dignity and respect through personalised accommodation and single sex accommodation;

   b. The distinct needs of functional and organic patients recognising both age, complexities and vulnerability;

   c. The impact over the next three years of the comprehensive development of a range of community responses alleviating the need for inpatient admissions and promoting earlier and safer discharge.

   The current arrangements require urgent review and long term planning to:

   - Anticipate reducing demand arising from the model of service;
   - To take account of the contemporary debate about functional/organic differential needs;
   - Age and need rather than 'labels', and to be undertaken safely;
   - This review needs to address accommodating a single model across Bradford and Airedale.

ii. **An older persons mental health liaison team within the acute sector**, which would provide:

   a. Education and training to hospital based staff;

   b. Complex case management in those situations where active case planning is complex and risk orientated;

   c. Linking the physical and mental health care;

   d. Linking hospital and community care through the liaison function ascribed to the footprint CMHTs;

   e. A vehicle to quality improvement – it needs to be multi disciplinary, integrated and commissioned for outcomes.

   “**Better management of these (mental) disorders improves the outcome and this has major implications for the lives of older people, the efficiency of acute hospitals and the utilisation of health and social care resources. We believe that any strategy to improve the performance of acute hospitals is seriously deficient if it ignores the mental health needs of older people** (Dr Dave Anderson, Consultant Psychiatrist)."
If not actioned the likelihood is of increased mortality, increased length of stay, loss of independent function and increased institutionalisation.

iii. **A primary care stepped care model**, as illustrated in Figure 4 accessible to all, dependent on need, with the ability to respond in a timely manner. Steps 1-4 of the model have access by primary care professionals based on knowledge of the appropriateness of intervention.

These strategic building blocks would then be supported by a model of service based on the CMHT footprint which was specifically orientated to those older persons whose mental health needs requires intervention in a service specific way.

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**Figure 3 Layered commissioning**

Described in section 5.3 are the ‘footprint’ service elements core to each but potentially sized appropriately and sensitive to the relevant needs analysis.
Referral pathways

<table>
<thead>
<tr>
<th>FACS</th>
<th>Presentation</th>
<th>Considerations</th>
<th>Psychological intervention</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical</td>
<td>Severe &amp; complex problems, e.g. psychosis, bipolar &amp; PD</td>
<td>• Needs multi-professional care and range of resources</td>
<td>STEP 5 Psychological assessment, formulation and intervention integrated with wider care plan for individual and carers</td>
<td>Acute interventions – specialist staff, psychiatry/psychology</td>
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<tr>
<td></td>
<td>• High risk</td>
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<tr>
<td></td>
<td></td>
<td>• High risk needs multi-professional care</td>
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<tr>
<td></td>
<td>• Entrenched/complex problematic behaviours</td>
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</tr>
<tr>
<td></td>
<td>• Coping poorly with everyday life</td>
<td></td>
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<td></td>
<td></td>
<td>• Disengaged from support</td>
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<td>• High level of impact on life</td>
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<td>Substantial</td>
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<td>Low</td>
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5.3 A footprint profile of service elements

5.3.1 Summary (Model of Service)

Figure 5 provides an illustration of the service model, reflecting a ‘footprint’ approach that links a core ‘Intermediate Resource Centre’ with local networks of support. These networks and the links to specialist services rely on a series of local partnerships.
of building blocks such as the community involvement project and a series of resource persons, as detailed in the rest of this section. It is a model that:

- Is built into communities and extends normal networks
- Develops an approach which seeks to keep individuals as independent as possible and in their own homes as long as possible (intensive home support, intermediate tier, alternatives to hospital);
- Reduces the reliance on specialist services through providing capacity and capability and building the community infrastructure (cafes, carer support, engagement, information);
- Adds further quality to primary care, perhaps in respect of a depression and a dementia pathway;
- Develops a centre of excellence as a focal point for each footprint, from which outreach support to the network and other systems of care can be supported and also offers a base for advice, drop-in etc.
- Promotes the notion that crisis and recovery/rehabilitation can be provided locally (transitional beds), offers opportunities for respite.

5.3.2 Community involvement project/Dementia café's

Whilst this development has clearly contributed to an emerging community infrastructure, the limitations of the opening hours can, if allowed to continue, inhibit their significant potential to play a wider role in community engagement and access. The next stage in their development would be to see them fully integrated into a wider network and open more frequently, which would enable them to mature further. One distinct potential element is to build in community navigation which would enhance and enable access from one part of a network to another (addressing a significant perceived weakness), and be an access point for information and group work.

5.3.3 Resource persons

1. **Carer Development Worker (1wte):** the functions of this role would be:
   
   a. To develop a network of care support ranging from the individual, to specific groups and community systems;
   
   b. To gather intelligence of need and support systems preferred and required by carers;
   
   c. To be involved in the design of pathways and services, including their qualitative elements;
   
   d. To facilitate the development of the required information by carers, which enables improved access, and awareness.

2. **Community Development and Engagement Worker (1wte):** the functions of this role would be to:
   
   a. Promote the community infrastructure necessary to support a systemic community model;
   
   b. Engage actively with community members in the commissioning function and to act as an influential voice in the promotion of need;
c. To actively encourage community models of response;

d. Develop the range of advocacy systems to support individuals and community access appropriately.

3. **Advanced Practitioner (1wte) – Long Term Care:** the functions of their role would be to:

a. Work with the long-term care sector to define, promote and implement an outcomes and quality framework;

b. To act as adviser and facilitator to the development and promotion of training programmes to be adopted in this sector;

c. To advise on the management of individuals as required and facilitate their continuity of care within the placement, preventing inappropriate and avoidable moves;

d. To undertake medication reviews as appropriate and to act as a conduit for the CMHT and primary care should that be necessary;

e. To advise on the commissioning of this sector and input into service specifications.

4. **Peer Educators (POPPS initiative):** the spread of skills, knowledge and awareness within the full range of organisations (mainstream, independent and third sector) complements pathways that seek to maintain individuals’ at the most appropriate, non-stigmatising part of a continuum of care, and thereby ensure quality at each of these points. This programme needs to be sustained. It would be advantageous if Commissioners in their wider set of requirements (the general list) of contractual obligations by providers sought to commit organisations to this programme, as it offers direct benefit to quality, safety and performance. Current difficulties of commitment and lack of promotion of these opportunities reflect a lack of awareness of its value. Commissioners need to assert these obligations. Unless this is embedded and developed as the knowledge resource there is a consequent lack and loss of capacity in the wider network of care.

5. **GPSi (3 sessions):** the functions of this role would be (at a footprint level) to:

a. Offer clinical leadership in conjunction with the footprint consultant(s);

b. Promote high standards of practice through ensuring active programmes of training and development being undertaken and adopted;

c. To facilitate the development and implementation of the local enhanced services for depression and dementia in each footprint and to undertake the audit and effectiveness of these in conjunction with others;

d. To offer advice to the CMHT where appropriate on the clinical/community management of individuals.

6. **Community Pharmacy:** Older people take more medicines than any other age group, and they account for about 50% of the NHS
drug bill mainly by repeat prescriptions. Of the over 75s 36% take four or more different medicines regularly. Changes associated with ageing have significant effects on how medicines are handled in older people, making them more generally sensitive and prone to adverse drug reactions, particularly prone to falls, confusion, delirium and other reactions.

However, not all older people are at the same level of risk and other medication problems. It is helpful to consider who these high risk groups are. The risks are related to a number of factors including drugs (number and type), the patient (multiple co-morbidities, physical and mental health, socio-economic status and environmental factors including being institutionalised, housebound and having poor access to care).

**Older people in higher risk categories should be actively targeted by pharmacists to ensure they gain maximum benefits to minimise any risk to them from the medicines taken. Other studies and service models have pro-actively targeted and identified those at a higher risk of medicine related problems and focused the time and resources of a pharmacist on those individuals alongside community matrons and the management of long term conditions. This approach of identification and subsequent management (carrying out further assessment and interventions) can help promote independence, prevent deterioration and reduce demand for services.**

7. **Advocates – citizen based:** the functions covered through this approach would be undertaken in conjunction with the engagement worker and would entail:

a. The availability of individual advocates for service users, where appropriate;

b. The potential for navigators to undertake a facilitative role in pathway access and movement, linked to the dementia cafes.

c. Promoting the individuals opportunities for choice, direct payment/individual budgets.

5.3.4 Extra Care Housing

Each footprint, based on the emerging needs analysis, should be able to identify the potential for the provision of a range of extra care housing support to alleviate inappropriate long-term care placements, so shifting the model towards independent living, complemented by the support of new technologies.

5.3.5 Day Support

Whilst the Intermediate Resource Centre will offer various therapeutic interventions, opportunities for group meetings and group work, there remains a need for a range of community based day resources, linked to support mechanisms provided from the Intermediate Resource Centre. These would be part of the development strategy for the community engagement and development workers and need to take account of existing resources. Opportunities for community ownership need to be explored.
5.3.6 **Intermediate Resource Centre (Centre of Excellence)**

Key elements of this service element would be:

- Base for CHMT/consultant;
- Optional location for outpatient appointments;
- Optional location for therapeutic interventions;
- Transitional beds (circa 6) linked to a single workforce construct, an intensive home support team offering clear alternatives to hospital admissions and optimal discharges (step up/step down). The intensive home support function would include the HIMIS function integrated into a single team approach, and offering a broader skills mix for home based support;
- Resource facility for information and advice both through new knowledge, advice line, leaflets and group approaches.

It is an outreach and in-reach model of service.

5.3.7 **Locally enhanced services for dementia**

Improving the access to mental health services and Mental Health well-being is an emerging national priority supported by Government, particularly through Our health, our care, our say (2006) and the QOF. Dementia presents multiple challenges for primary care; approximately 1 in 5 over the age of 80 has some form of dementia. Guidelines produced jointly by NICE and the SCIE is in part a response to the needs of primary care. The guidelines indicate recommendations on:

1. The components of the diagnostic process that can be carried out in general practice;
2. Advice on medication and review;
3. Requirements for review and evaluation of care plans;
4. The availability of memory assessment services;
5. The promotion of independence and maintenance of function for those with dementia;
6. The steps required when assessing and individual’s capacity to make decisions.

In the guidelines there is also a need for formal agreements on joint working between health, social care, and housing. Primary care is the point of first medical contact and, as such, is the cornerstone of the management, ensuring early detection, timely intervention, and effective ongoing care.

To prevent people being referred and retained inappropriately in secondary care specialist services it is suggested that a locally enhanced service be developed for dementia screening, which aims to provide:

- A holistic package of care to enable more individuals to be managed in primary care where appropriate, and to reduce the number of individuals referred to specialist care;
- Provide care closer to home;
- Reduce the waiting time for patients by making this service available in primary care;
• Enhance the physical care of all patients with mental health problems;
• Reduce the stigma attached to receiving mental health care from secondary care and attending mental health facilitates;
• Focus specialist secondary service on those most complex and at risk;
• Enhance communication between primary care and social care to better meet the social care needs of older people rather than just those in secondary care. The services must provide an enhanced level of care beyond the scope of essential and additional services.

**Commissioners would need to ensure incorporation of pathways to the necessary memory assessment services and the all ages stepped care model of therapeutic intervention.**

### 5.3.8 Locally enhanced services for depression – an age inclusive approach at primary care

Evidence shows that psychological distress is one of the top three causes of disability and that one in four individuals presenting to their GPs have depression, which is set to rise to the second most preventable diagnosis in the next ten years, rivalled only by heart disease.

It is increasingly important that there is an integrated approach for the treatment and management of individuals presenting with psychological distress in primary care. The objectives of the locally enhanced services would be:

• To implement a standardised screening tool;
• To implement a standardised multi agency care pathway across Bradford & Airedale;
• To develop individual choice;
• To minimise stigmatisation;
• To support early intervention and so promote the early recovery of individuals with this illness in primary care;
• To promote access to mental health promotion resources, to carers and individuals who are vulnerable to the development of mental health difficulties including those with chronic physical illness;
• To reduce the number of anti-depressants prescribed where appropriate;
• To enhance cost effectiveness strategies;
• To provide standardised training to primary care staff for mental health and well being;
• To support the development of PbC.

### 5.3.9 Memory assessment service

Memory assessment services offer a responsive service to aid the early identification of dementia, which includes a full range of assessment, diagnostic, therapeutic and rehabilitation service. Memory assessment services ensure an integrated approach to the care of individuals with dementia and the support of their carers in partnership with mainstream healthcare,
social care and voluntary organisations. They have been shown to significantly improve the quality of life of carers and individuals with dementia.

In current practise the diagnosis of dementia is often delayed for several years after the initial onset of symptoms. Experts agree that the early diagnosis and intervention in dementia is cost effective, yet there is a significant diagnosis gap, and only a third and a half of individuals receive a formal diagnosis. The early recognition and detection enables individuals with dementia, their families, and others to plan more effectively for the future, and can significantly improve their quality of life.

The benefits include:

- Providing a cost effective way of significantly increasing the number of people seen for early diagnosis, and intervention;
- Reducing (delaying) total care expenditure;
- Breaking down the stigma of dementia and potential barriers to recognition and diagnosis;
- Reducing refused referrals;
- Improving quality of life for individuals and carers;
- Improving performance and person centred care (NICE guidelines);
- Reducing inequalities;
- Increasing choice.

However, to methodology adopted needs to undertake holistic needs assessment of the individual and their carer, addressing their comprehensive requirements. To this end the approach should accommodate a partnership between the statutory and third sector providers.

5.3.10 CMHT

The core functionality should be as described in the DoH report Everybody’s Business. These core footprint functions would be supported by a:

- Footprint needs analysis;
- Quality outcomes framework for long-term care facilities linked to commissioning incentives;
- Protocol agreement, for ‘no long term care placements, other than by exception, direct form hospital’;
- The development of a managed care network to support the concept of a systemic model;
- A named member of the CMHT for developing the specific practice relationships necessary to support the case finding approach.

5.3.11 Summary

The increasing shifts in the demographic balance together with the ageing population places a responsibility on commissioners to plan and design models of care that both reflect those demographic changes and fit with an increasingly articulate and independently minded citizen/service user for locally accountable, timely, responsive and supportive well-being services.

The unstoppable moves towards both personal control over resources and the self acquisition of services together with a more developed view about community difference and diversity (i.e. one size does not fit all) inevitably
mean that commissioners will need to establish an understanding about local footprints, core provision (to ensure equity and accessibility) and local difference whilst maintaining a clear framework of desired outcomes. This will be challenging.

However, this commissioning framework will establish both a fixed (core) and flexible approach to these tensions. This model is illustrated below in Figure 4. Developing the concept of a managed network of care, which addresses the need to ensure a mixed economy, which can be collaborative, mutual and non-competitive (and retaining a person centred focus) will now be an important next stage in this process.

6 Priorities

Workshop 3 sought to develop a consensus about the priorities. These are reflected below and capture the consensus achieved.

<table>
<thead>
<tr>
<th>Year one:</th>
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<tbody>
<tr>
<td>1. Developing intensive home support teams, transitional beds, 7/24 coverage on a multidisciplinary integrated workforce basis, including the absorption of HIMIS teams (each footprint). Part of Intermediate Resource Centre – a centre of excellence.</td>
</tr>
<tr>
<td>2. Intermediate Resource Centre manager</td>
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<tr>
<td>3. Establish fit for purpose CMHT baseline establishment to include liaison function.</td>
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<tr>
<td>4. Expand CMHT to undertake memory assessment function and expand third sector capacity to ensure community infrastructure and support to carers is established.</td>
</tr>
<tr>
<td>5. Establish resource persons in each footprint, including Carer Development Worker, Engagement Worker and Advanced Practitioner (LTC).</td>
</tr>
<tr>
<td>6. Therapeutic interventions as part of stepped care and intermediate response (4 x 2 staff)</td>
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<tr>
<td>7. Advocacy service (citizens/third sector)</td>
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<tr>
<td>8. Community pharmacy</td>
</tr>
<tr>
<td>9. Liaison service (see notes)</td>
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</tbody>
</table>

**TOTAL YEAR 1:**

<table>
<thead>
<tr>
<th>Year two:</th>
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</thead>
<tbody>
<tr>
<td>1. Young onset service (see notes)</td>
</tr>
<tr>
<td>2. Locally Enhanced Service (LES)</td>
</tr>
<tr>
<td>3. Brokerage/Third Sector (individual budgets)</td>
</tr>
</tbody>
</table>

**TOTAL YEAR 2:**

Notes:
1. Liaison service – Acute Trust cost.
2. During the course of 08/09 further work needs to be undertaken on the Young Onset Strategy, the Locally Enhanced Services and the Individualised Budget Resource Allocation model.
7 Recommendations

1. Develop a comprehensive stepped care model in primary care which reflects an all ages approach, access to psychological therapies, and is in line with NICE recommendations.

2. The development of locally enhanced service(s) to increase capacity and capability at a primary care level for two pathways:
   - Depression;
   - Dementia as described in the model of service.

3. To reinstate the mental health liaison team in the acute sector to undertake:
   - Education and training;
   - Complex case management;
   - To link physical and mental health care;
   - To link hospital and community care;
   - As a vehicle for quality and governance improvement.

   This team should be multi-disciplinary including OT and Social Work and be integrated into single management. This should be funded by the Acute Foundation Trust with support from the PCT.

4. Initiate the development of a memory assessment service in each footprint with an agreed model that embraces the holistic continual assessment of need, including carers, at the point of access. This should be linked to the dementia pathway for the LES (recommendation 2).

5. Seeking and seizing opportunities in each footprint to develop extra care housing strategies that compliment the flexibility of the model, and that are sensitive to new technologies and could be linked to the Resource Centre for specialist support.

6. Undertake as a matter of urgency a needs-driven analysis of each footprint including information on housing needs, levels of benefit uptake, crime together with other factors.

7. The development of education and training packs for mainstream staff built into practice and community team training sessions – these to be developed through the use of a small working group of specialist clinical, professional and mainstream staff (utilise knowledge of work previously undertaken from the liaison team).

8. Develop an Intermediate Resource Centre as a centre of excellence in each footprint for older people with mental health needs which offers the following functions:
   - A small number of transitional beds (4-6) for crisis, assessment and rehabilitation;
   - A base for the footprint CMHT and consultant psychiatrist(s);
• Space (rooms) for the provision, if appropriate, for therapeutic interventions and counselling;
• Locus for the availability of information, 'hot-line' advice and carer development worker;
• The hub of a systemic support approach and outreach to the community infrastructure supporting older persons with mental health needs.
• Move the CMHTs out of Daisy Hill as soon as possible, temporarily if necessary, into their footprint.

The commissioners should secure and ensure, through contractual obligations, the commitment of stakeholder organisations to the peer educator programme thus development and sustaining the necessary knowledge and capacity in other service elements.

9. Develop an intensive home support team for each footprint which integrates HIMIS (POPPS) into a single team which has an integrated community support worker workforce approach. This should operate 7/24 and be part of a whole service with the transitional beds and a single workforce.

10. Develop Resource Persons in each of the footprints including:
  • A Carer Development Worker (WTE).
  • An advanced practitioner to support long term care homes in the footprint (WTE).
  • Local citizen advocates supported through the third sector.
  • Lead community pharmacist.
  • Liaison function CMHT worker (individual and named) accountable to link to the Acute Liaison function.
  • Engagement and Development worker (WTE).

11. Explore the possibilities to operate the dementia cafes with increased opening and functionality, and use as base for the development of navigator advocacy.

12. Appoint a ‘footprint’ GPSi for OPMH with the functionality described at paragraph 5.3.3.

13. Set target reduction year on year for three years for the contraction of long term care placements re-allocating the funding into service developments (Intensive Home Support, Extra Care Housing etc).

14. From April 09 introduce a policy which requires all but the obvious long term care placements from either the acute or mental health acute facilitates to be first subject to community assessment and not placed directly into long term care.

15. Acknowledge and address the need for increased availability and access to specialist skills and staff through increased resources for the specialist services (applies equally to learning disability and working aged adults). The commissioning model will require high levels of specialist skills focussed on
ensuring that individuals can remain in community settings with the necessary support to carers.

16. Establish an outcomes and quality framework for long-term care placements and consider ways in which it can be incentivised and linked to an accreditation system.

17. Use the period April 08 to March 09 to design with the purpose of implementing at April 09, a model for individualised budgets for OPMH together with the utilisation of third sector brokerage schemes.

18. Develop a strategic view of the commissioning and planning of an overall information approach and the ways in which OPMH developments fit in with this.

19. Ensure end of life care for older people with mental health needs is incorporated in the Primary Care Trust review of this policy area.

20. Further work during 08-09 to design and implement plans for a Young Onset Service including an analysis of the evidence base for its delivery (critical mass etc).

21. Urgently develop a short term, medium term and long term approach to the management of acute illness admissions for both organic and functional mental illness (older persons) which addresses:
   - The need to reconcile age, frailty and safety;
   - The different needs of both organic and functional illness which recognises a needs-driven model for provision;
   - The whole patch use of resources;
   - The potential of the community infrastructure to provide alternatives and improved home/community based solutions.