

Care Services Improvement Partnership **CSIP**

National Institute for  
**Mental Health in England**

National Older People's Mental Health  
Programme

## **10 High Impact Changes** for Mental Health Services

# **Supplementary guidance for Older Peoples Mental Health Services**



## DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Performance
<b>Management</b>	IM & T
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<b>Description</b>	This guide has been created to support Older Peoples Mental Health services in implementing the 10 High Impact Changes for Mental Health Services. It advises what each High Impact Change might mean for Older Peoples Mental Health Services, and additional resources to support each of the High Impact Changes.
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<b>For Recipient's Use</b>	

## **Introduction**

This guide has been created to support Older Peoples Mental Health services in implementing the 10 High Impact Changes for Mental Health Services. It advises what each High Impact Change might mean for Older Peoples Mental Health Services, and additional resources to support each of the High Impact Changes.

It also identifies some of the benefits and measures of process or service redesign (relating to the 10 High Impact Changes).

This supplementary guide should be utilised in conjunction with the main publications.

## What each High Impact Change might mean for Older Peoples Mental Health Services

### High Impact Change 1 Treat home based care & support as the norm for the delivery of mental health services

It may be helpful to consider the following:

- Do your protocols account for the possible disorientation and distress when moving older people from home to hospital?
- Do your systems recognize that up to 60% of people aged 65+ have, or develop, mental health problems when they are admitted to hospital?
- Do your protocols recognize that hospital environments may foster dependency and lead to loss of self-help skills?
- Do your protocols recognize the needs of carers/relatives? E.g. in some circumstances, carers may feel more stressed at the prospect of the service user being at home
- **How do** you ensure that a valued lifestyle is maintained?
- Do your OPMH services include the use of assistive technologies and supported housing services
- **How** you promote a person centred model of care?
- Do you use both the Care Programme Approach and Single Assessment Process, with a clear understanding of the role and value of each?
- Do you have models of Respite Care at Home?
- Do you have Intermediate Care (which need not necessarily be bed based) that includes older people with mental health problems?
- Do your protocols take account of the impact of Mental Health Legislation (e.g. Mental Capacity Act and Bournewood)?

### High Impact Change 2 Improve flow of service users and carers across health and social care by improving access to screening and assessment

It may be helpful to consider the following:

- Do you use the single assessment process to enable identification of potentially vulnerable older people, linking in with adult protection and long term conditions management?
- Do you have clear pathways/protocols/guidelines that clarify responsibility for management of older peoples' mental health?
- Do your systems enable an earlier diagnosis to increase opportunity for choice of future care (advanced directives/individualised budgets)

- Do you have efficient ‘memory services’? (There are various types of service, both ‘virtual’ clinics and those located in GP and hospital buildings).
- Do you have joint assessment processes across health and social care boundaries?
- How do you ensure equity of access to ‘talking therapies’ for both service users and carers?

**High Impact Change 3**  
**Manage variation in service users discharge processes**

It may be helpful to consider the following:

- Are carers involved in the discharge planning process?
- Would a pooled/devolved budget facilitate discharge process?
- Is self-directed support (Individual Budgets/Direct Payments) an option for this person?
- Do you have an old age psychiatric liaison service in the acute general hospital? This can lead to major improvements in discharge and outcome.
- Do older people with mental health needs have access to intermediate care services in order to facilitate discharge?
- Is there an agreed single care plan and has a copy been issued to the service user?
- Are statistics collated that show the scale of delayed discharges?
- Are you monitoring readmissions?

**High Impact Change 4**  
**Manage variation in access to all mental health services**

It may be helpful to consider the following:

- Are your clinical pathways designed to meet the needs of the people who use them, based on individual need not age?
- Do your systems enable older people to move between mainstream services and access to specialist advice and support, according to need?
- Does your staff have the right skills to care for people of different ages and with different physical and mental health needs?
- Do you make full use of “Everybody’s Business, Integrated mental health services for older adults: a service development guide”?
- Are you working with health promotion to reduce stigma and discrimination around older people with mental health problems and the early recognition of dementia?

## High Impact Change 5

### **Avoid unnecessary contact and provide necessary contact in the right care setting**

Older people often have complex needs and present with co-morbidity, which may require care from a wide range of services and professionals. It is therefore important that agencies work together to ensure care is delivered in the right place and at the right time

It may be helpful to consider the following: -

- Is there an effective use of SAP and appropriate sharing of information to reduce duplication of assessments?
- Do you have staff working to extended roles such as supplementary prescribing or with additional skills such as phlebotomy?
- Do you have any nurse-led or therapy led services?
- Are patients seen close to home either at a local facility or within their own home?
- Do older people with mental health needs have access to a range of services such as intermediate care and psychiatric liaison?
- Do you need to re-visit care pathways?

## High Impact Change 6

### **Increase the reliability of interventions by designing care based on what is known to work & that service users & carers inform & influence**

We should **NEVER** consider the re-design of services without the integral involvement of users and carers at all levels of service design.

It may be helpful to consider the following:

- **In what way** do you involve users and carers in care planning, service improvement and systems (staff recruitment and training)?
- Do you systematically collect feedback, using mechanisms like PALS and LINKS?
- Do you link this to Clinical Governance pathways?
- Do you listen to the individual voice of the "user" and "carer", distinct one from the other?
- Do you always seek to find ways to involve people who you think may lack capacity i.e. people with dementia, those who lack verbal communication?

### High Impact Change 7

#### **Apply a systematic approach to enable the recovery of people with long-term conditions**

It may be helpful to consider the following:

- Do you have an individualized approach to recovery that means that each person reaches their own best and fullest potential within the boundaries of their long-term condition?
- Do you have a holistic approach to older people which recognizes that people have better mental health when they: feel included; have social supports, networks and groups to belong to; are able to participate; have a sense of purpose; and, experience economic security?
- Do your systems take a positive approach to ageing so that they do not assume that as people get older they want to do less?
- Do your staff find out what people feel is "meaningful activity" for them?
- Beyond the Recovery model, do you have systems in place to support end-of-life care?

### High Impact Change 8

#### **Improve service user flow by removing queues**

Since many illnesses become more common with increasing age, older people frequently present with complex problems for diagnosis and management. In addition they have greater sensitivity to the adverse effects of drug treatments and rehabilitation may be more difficult due to multiple disabilities and increased frailty. (Who Cares Wins 2005) An untreated mental disorder can further disable an older person and complicate physical health care and it is therefore essential that mental health services respond quickly.

It may be helpful to consider the following:

- What are your waiting times for memory services and diagnostic services i.e. CT scans, CMHT services. Can you reduce them?
- Is access to your service based on need or age?
- Is SAP/ CPA integrated into the Care Pathway?
- Do you have an effective Single point of access?
- Is there joint working between Primary Care, Social Care and Mental Health services?
- Are you making the best use of technology e.g. telecare, choose and book?

High Impact Change 9  
**Optimise service user and carer flow through an integrated care pathway approach**

It may be helpful to consider the following:

- What should an integrated care pathway look like for: -
  - older people with functional mental ill health?
  - older people with organic mental ill health?
  - carers?
- Which services need to be involved in providing a whole systems care pathway? E.g., health, social services, housing, domiciliary care, mainstream OP services, voluntary sector
- Are you making best use of data sources e.g. OPMH finance and service mapping to identify efficiency gains and service needs to improve outcomes?

High Impact Change 10  
**Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce**

It may be helpful to consider the following: -

- Do you promote OPMH as a valued high profile service within your organisation?
- What is your organization doing to raise the positive profile of working with OPMH?
- Do you have a clear understanding of the specialist roles required to provide an excellent OPMH service?
- Do you promote effective educational links with admiral nurses, Alzheimer's society and other organizations to help staff develop new practices and share learning?
- Have all staff a basic training to understand how to communicate and interact with older people with mental health needs?
- Do you have some bespoke introductory preparatory training to offer all staff that matches your service user and carer profile?

## Benefits and measures of process or service redesign relating to High Impact Changes in Older Peoples Mental Health Services

<p><b>IMPACT ON SERVICE DELIVERY</b></p> <p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>• Earlier diagnosis leading to less crisis management</li> <li>• Increased use of the Quality and Outcomes Framework in primary care</li> <li>• Implementation of Everybody's Business Guidance</li> <li>• Meets complex needs of older person in a coordinated way</li> <li>• Provide effective services for older people with learning disability and MH problems</li> <li>• Provide effective services for younger people with dementia</li> <li>• Increased access for older people and their carers to psychological therapies</li> <li>• Reduced emergency bed days</li> <li>• More older people helped to live at home</li> <li>• Increased numbers of older people on end-of-life care pathways</li> </ul> <p><b>Measures:</b></p> <ul style="list-style-type: none"> <li>• <i>OPMH Mapping information</i></li> <li>• <i>Everybody's Business commissioning audit</i></li> <li>• <i>Reduction of emergency bed days (PSA target)</i></li> <li>• <i>Quality &amp; Outcomes Framework</i></li> <li>• <i>National Service Framework for Older People milestones</i></li> <li>• <i>CSCI and Healthcare Commission reviews</i></li> <li>• <i>Priorities and Planning Framework targets on the care and management of older people with mental health problems</i></li> <li>• <i>LDP returns on target for access to psychological therapies</i></li> </ul>	<p><b>IMPACT ON SERVICE USERS &amp; CARERS</b></p> <p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>• Reduced levels of suicide in older people</li> <li>• Access to advance directives and advocates (including Independent Mental Capacity Advocates) when making decisions about later life care.</li> <li>• Improved quality of life and independence for vulnerable older people</li> <li>• Empowering older people to live in their own homes for longer</li> <li>• Receiving equivalent services to younger adults with MH problems</li> <li>• No artificial age barriers to service access</li> <li>• Potential for less confusion leading to institutionalisation</li> <li>• Improved carer assessments</li> </ul> <p><b>Measures:</b></p> <ul style="list-style-type: none"> <li>• <i>D55 acceptable waiting time for assessment</i></li> <li>• <i>D56 acceptable waiting time for care management</i></li> <li>• <i>Audit of consultation with users and carers.</i></li> <li>• <i>PSA target on reduced mortality from suicide</i></li> <li>• <i>Increased use of direct payments and individual budgets</i></li> <li>• <i>Increased numbers of carer assessments</i></li> <li>• <i>Quality of life outcome measures</i></li> </ul>
<p><b>IMPACT ON OUTCOMES</b></p> <p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>• Reduced hospital acquired infection</li> </ul>	<p><b>IMPACT ON STAFF &amp; ORGANISATIONS</b></p> <p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>• Role developments for those working</li> </ul>

<ul style="list-style-type: none"> <li>• Better outcomes following treatment in terms of returning to usual place of residence</li> <li>• Improved take-up of intermediate care for older people with mental health problems</li> <li>• Improved take-up of Direct Payments and Individual Budgets</li> <li>• More older people involved in their local community</li> </ul> <p><b>Measures:</b></p> <ul style="list-style-type: none"> <li>• <i>Reduced hospital acquired infection</i></li> <li>• <i>Reduced numbers of people being cared for in Care/Nursing Homes/ long stay wards.</i></li> <li>• <i>PAF C32 – increased proportion of older people enabled to live in own home</i></li> <li>• <i>PAF C28 - the number of households receiving intensive home care (10+ hours per week)</i></li> <li>• <i>LAA – older people involved in the community</i></li> <li>• <i>LAA – community safety targets</i></li> <li>• <i>SITREP data</i></li> <li>• <i>PSA target on Direct Payments</i></li> </ul>	<p style="text-align: center;">with older people</p> <p><b>Measures:</b></p> <ul style="list-style-type: none"> <li>• <i>Staff surveys</i></li> <li>• <i>Recruitment and retention figures</i></li> </ul>
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## **Resources to support High Impact Change service improvements in Older Peoples Mental Health Services**

### **Documents**

Everybody's Business. Integrated mental health services for older adults; a service development guide (Department of Health, 2005)

<http://www.olderpeoplesmentalhealth.csip.org.uk/everybodys-business.html>

Securing Better Mental Health for Older Adults (Department of Health, 2005)

[http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Olderpeopleservices/Browsable/DH\\_4113714](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Olderpeopleservices/Browsable/DH_4113714)

National Service Framework for Older People (Department of Health, 2001)

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4003066&chk=wq3bg0](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003066&chk=wq3bg0)

Our Health, Our Care, Our Say (Department of Health, 2006)

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/OurHealthOurCareOurSay/fs/en>

Recipe for Care – not a Single Ingredient (Department of Health, 2007)

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4142425&chk=8v8oMf](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4142425&chk=8v8oMf)

A sure start to later life – ending inequalities for older people (Social Exclusion Unit, 2006)

<http://archive.cabinetoffice.gov.uk/seu/downloaddoc7b5f.pdf?id=797>

Dementia: Supporting people with dementia and their carers in health and social care (NICE/SCIE, 2006)

<http://www.nice.org.uk/guidance/cg42>

All Our Tomorrows: Inverting the Triangle of Care (A joint discussion document by the ADSS and the LGA on the future of services for older people, 2003)

<http://www.adss.org.uk/publications/other/alltomtext.pdf>

Forget-Me-Not (Audit Commission, 2000)

<http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=4EEC12F0-AA9A-4CB0-90AE-7FC5CB6584CE>

Forget-Me-Not 2002 (Audit Commission, 2002)

<http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=3DFEF403-038C-464f-8518-441477E92B15>

Between two stools (University of Leeds, 2002)

<http://www.leeds.ac.uk/lpop/documents/betweentwostools.pdf>

Who cares wins (Royal College of Psychiatrists, 2005)

[http://www.alzheimers.org.uk/Working\\_with\\_people\\_with\\_dementia/PDF/WhoCaresWins.pdf](http://www.alzheimers.org.uk/Working_with_people_with_dementia/PDF/WhoCaresWins.pdf)

Moving out of the Shadows (Bowers, H., Eastman, M., Harris, J. and Macadam, A., 2005)

<http://www.changeagentteam.org.uk/library/mootsreport.pdf>

Raising the Standard (Royal College of Psychiatrists, 2006)

<http://www.rcpsych.ac.uk/PDF/RaisingtheStandardOAPwebsite.pdf>

The UK Inquiry into Mental Health and Well-Being in Later Life

<http://www.mhilli.org>

## **Websites**

Everybody's Business

<http://www.olderpeoplesmentalhealth.csip.org.uk/everybodys-business.html>

Let's Respect

<http://www.olderpeoplesmentalhealth.csip.org.uk/lets-respect.html>

Managed Learning Networks

<http://www.olderpeoplesmentalhealth.csip.org.uk/managed-learning-networks.html>

CSIP Housing Learning and Improvement Network

<http://www.changeagentteam.org.uk/housing>

CSIP Telecare Learning and Improvement Network

<http://www.changeagentteam.org.uk/telecare>

Change Agent Team OPMH

<http://www.changeagentteam.org.uk/index.cfm?pid=12>

Dignity in care

[http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/DignityInCare/DignityInCareArticle/fs/en?CONTENT\\_ID=4134922&chk=zkuAla](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/DignityInCare/DignityInCareArticle/fs/en?CONTENT_ID=4134922&chk=zkuAla)

Mental Capacity Act

<http://www.dca.gov.uk/menincap/legis.htm>

Commission for Social Care Inspection  
<http://www.csci.org.uk>

Alzheimer's Society  
<http://www.alzheimers.org.uk>

Mind  
<http://www.mind.org.uk>

Partnerships for Older People Projects  
[http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Olderpeopleservices/DH\\_4099198](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Olderpeopleservices/DH_4099198)

Building Capacity, and Partnership in Care  
[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4006241&chk=BPcEi1](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4006241&chk=BPcEi1)

## **Resources to support specific High Impact Changes service improvements in Older Peoples Mental Health Services**

### **High Impact Change 1**

Building telecare services in England

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4115303&chk=AZNQjz](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4115303&chk=AZNQjz)

Time to Care? CSCI Review of Home Care 2006

[http://www.csci.org.uk/PDF/time\\_care\\_full.pdf](http://www.csci.org.uk/PDF/time_care_full.pdf)

Home Improvement Agencies

<http://www.foundations.uk.com>

### **High Impact Change 2**

Single Assessment Process guidance

[www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/SingleAssessmentProcess/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/SingleAssessmentProcess/fs/en)

### **High Impact Change 3**

Intermediate care and older people with mental health problems

<http://www.changeagentteam.org.uk/index.cfm?pid=11>

<http://www.changeagentteam.org.uk/index.cfm?pid=266>

### **High Impact Change 4**

**Breaking down the walls of silence: an integrated care pathway for dementia.**

(Naidoo, M. and Bullock, R. 2001)

Time for Action – The report of the Health and Adult Social Care Overview and Scrutiny Committee's Care Pathways Steering Group

[http://www.cornwall.gov.uk/media/pdf/r/3/dementia\\_report.pdf](http://www.cornwall.gov.uk/media/pdf/r/3/dementia_report.pdf)

### **High Impact Change 5**

Single Assessment Process- Centre for Policy on Ageing

[http://www.cpa.org.uk/sap/sap\\_lists.html](http://www.cpa.org.uk/sap/sap_lists.html)

National Institute for Health and Clinical Excellence Dementia Guideline

<http://www.nice.org.uk/guidance/cg42/guidance/pdf/English/download.dsp>

### **High Impact Change 6**

Dementia Advocacy and Support Network

<http://www.dasninternational.org/>

'Hear what I say' – developing dementia advocacy services (Dementia North, 2003)

<http://www.dementianorth.org.uk/advocacy/Hear%20what%20I%20say.pdf>

Listen to Us (Dementia North, 2005)

<http://www.dementianorth.org.uk/PDFs/IPWD%20report.pdf>

### **High Impact Change 7**

Suicide in elders

<http://www.westmidlands.csip.org.uk/mental-health/suicide-in-elders-introduction.html>

End of Life Care

<http://www.endoflifecare.nhs.uk/eolc>

### **High Impact Change 8**

Integrating Older People's Mental Health Services: Community Mental Health Teams for Older People (Lingard and Milne 2004)

[http://kc.nimhe.org.uk/upload/CMHT\\_OPs\\_July%20042004JL.pdf](http://kc.nimhe.org.uk/upload/CMHT_OPs_July%20042004JL.pdf)

### **High Impact Change 9**

Care pathways

[http://www.alzheimers.org.uk/Working\\_with\\_people\\_with\\_dementia/carepathways.htm](http://www.alzheimers.org.uk/Working_with_people_with_dementia/carepathways.htm)

Services for younger people with dementia

[http://www.alzheimers.org.uk/Younger\\_people\\_with\\_dementia/PDF/Ready\\_or\\_not\\_report\\_2006.pdf](http://www.alzheimers.org.uk/Younger_people_with_dementia/PDF/Ready_or_not_report_2006.pdf)

[http://www.alzheimers.org.uk/Younger\\_people\\_with\\_dementia/PDF/YOD%20Regional%20Pathway.pdf](http://www.alzheimers.org.uk/Younger_people_with_dementia/PDF/YOD%20Regional%20Pathway.pdf)

Integrated Care Network (ICN)

<http://www.integratedcarenetwork.gov.uk>

South Tyneside Matrix model pathway of care and supporting letter

<http://www.changeagentteam.org.uk/library/tyneside%202.doc>

<http://www.changeagentteam.org.uk/library/tyneside%201.doc>

### **High Impact Change 10**

New ways of working in mental health

<http://www.skillsforhealth.org.uk/mentalhealth/nwp.php>

Connect with Us (Dementia North, 2006)

<http://www.cat.csip.org.uk/library/Connect%20With%20Us.pdf>

## Glossary of terms

CSCI	Commission for Social Care Inspection
CMHT	Community Mental Health Team
CPA	Care Programme Approach
LAA	Local Area Agreement
LDP	Local Delivery Plans
LINKS	Local Involvement Networks
OPMH	Older Peoples Mental Health
PAF	Performance Assessment Framework
PALS	Patient Advice and Liaison Service
PSA	Public Service Agreement
SAP	Single Assessment Process
SITREP	Situation Report