



HASCAS

**Health and Social Care Advisory
Service (HASCAS)**

**Individual Standards
for Intermediate Care for Older
People with Mental Health
Difficulties**

**A DEPARTMENT OF HEALTH FUNDED
NATIONAL PROJECT**

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Making a positive difference



Health and Social Care Advisory Service - HASCAS

Intermediate Care for Older People with Mental Health Difficulties Project

Department of Health Section 64 Grant

Early findings paper

This paper presents the standards and the early findings from our Department of Health funded national project on Intermediate Care for Older People with Mental Health difficulties. The project benchmarked the intermediate care service provision in seven sites across England during March and April 2006 against best practice standards developed by HASCAS.

An overarching view is that there is often poor integration and understanding between mainstream older peoples intermediate care services and older peoples mental health services and that this results in sub optimal care and treatment. This is presented against a back drop where mental health problems in older adults are common: present in perhaps 40% of GP attendees, 50% of general hospital patients, and 60% of care home residents. In the next 10 years, the population of over 65s will increase by 15%, and the population of over 85s by 27%. Approximately 10% of people aged 60 – 74 have a common mental health disorder such as anxiety, depression or phobia. About 37% of people in this age group have difficulty with one or more of the seven common activities of daily living such as personal care, household work and getting out and about. The likelihood of reporting difficulties rises with increasing severity of symptoms of common disorders of mental health. Difficulties with common activities of daily living are also increased with long standing physical health problems. Prevalence rates for dementia indicate that 10% of the over 65s and 35% of the over 80s will have some significant cognitive impairment. This suggests that there is a high likelihood that those requiring physical and frail intermediate care services will also have an underlying common disorder of mental health.

Intermediate Care (IC) refers to a configuration of care that provide short-term intervention to promote independence by maximising functional skills in relation to an individuals physical and mental health needs. Care and support should provide person-centred, needs-based care that holistically manages all of their physical and mental health needs. Care and support are based on comprehensive assessment, which lead to person centred, goal orientated interventions in the clients own home, a day care setting or a bed-based unit for example. Assessments and interventions are provided by a range of professionals working within a shared framework (Single Assessment Process) of assessment, goal setting and documentation. IC services are time limited (usually up to six weeks according to individual need), although they may be provided sequentially with other services such as in-patient facilities or home care services, the aim is to prevent prolonged hospital stays or inappropriate admissions to the acute sector or care home.

Older People with Mental Health Difficulties traditionally refers to people over the age of 65 years, pre and post formal diagnoses of either functional mental health difficulties (such as depression) or organic mental health difficulties (such as dementia). However, following the publication of "Everybody's Business" (2005) this view is being challenged through placing the emphasis of care on what individuals need rather than their age. Consequently all services should be considering the mental health needs of their patients/service users, even those services whose focus is predominantly on physical health care. It is known that hearing impairment, neurological disease, vision impairment, and lung and heart disease have particularly strong associations with psychological distress, and are more prevalent with advancing years therefore, increasing the susceptibility of older people to mental health difficulties. Where there are recognised or suspected co-morbidities the right services need to work together to provide the best outcome for the patient regardless of their age and this includes intermediate care services.

Individual Standards for Intermediate Care for Older People with Mental Health Difficulties

I. Strategy, management and information

1. Local principles and strategy - There are local comprehensive and associated specific strategies, with provision for user involvement and action planning.

- 1.1. The four principles of the NSF for Older People are apparent in strategy documents:
 - Person-centred care and continuity of care
 - Whole system working
 - Timely access to specialist care
 - Promoting health and active life
- 1.2. There is a local comprehensive strategy for the overall co ordination of intermediate care services.
- 1.3. There is the local comprehensive strategy for services for older people with mental health needs.
- 1.4. Housing agencies are seen as equal partners with health and social care, with encouragement of housing associations to offer supported housing and of the formation of home improvement agencies.
- 1.5. These two strategies relate to each other and are mutually consistent.
- 1.6. There is effective co-ordination at a strategic level to make the appropriate organisational link and to maximise joint working with other services.
- 1.7. Users and carers are involved in developing local strategies and in planning local services.
- 1.8. The needs of members of ethnic minorities and other under-served groups (such as people with learning disabilities) or localities are considered in all aspects of service planning.

Early findings

- Integrated care strategies should be developed across all partnership agencies including representation from services users and carers, the voluntary sector and Black and Minority Ethnic groups to address the primary and secondary mental health needs of the older population and drive integrated service development.
- Mapping exercises should be undertaken of voluntary organisations to establish their potential to support the development of intermediate care services for older people with mental health difficulties.

2. Commissioning, management and co-ordination - There are clear agreements on all aspects of managing and co-ordinating all elements of local services.

- 2.1. The process of commissioning intermediate care for older people is clearly identified within the overall commissioning procedure and there is an identified lead commissioner.
- 2.2. There is a clear overall management structure which has been agreed between all partner agencies.
- 2.3. The overall management structure is known to the managers of each element of IC.
- 2.4. There are locally agreed shared financial arrangements that may include flexible joint funding or pooled budgets.
- 2.5. Arrangements are in place for regular effective liaison and co-ordination across all agencies and elements of the service, including co-location of staff.
- 2.6. There is evidence that partnership and joint working includes a full range of partners, including housing, other local authority services, voluntary sector and other agencies.
- 2.7. There are clear locally agreed eligibility criteria for the acceptance, exclusion and inclusion of service users, based on individual needs, that take account of any functional mental health problems and dementia.

Early findings

- Awareness and understanding of mental health difficulties in mainstream older peoples services is variable.
- Commissioning of fully integrated intermediate care services needs improving.
- Section 31 partnership agreements need to be considered to support the development of intermediate care for mental health.
- There is a lack of consistency across agencies of the use and meaning of step up and step down beds as well as transition, short stay and assessment beds.

3. The role of the intermediate care (IC) coordinator / lead - The IC coordinator/lead function is clearly established with authority to carry out key tasks.

- 3.1. An IC coordinator/lead post is established with a clear job description (whether the post holder performs all these functions depends often upon the complexity of the organisation, its size and other factors).
- 3.2. The primary function of the post is to co-ordinate multi-agency, multi-team services at an operational level to achieve seamless care.
- 3.3. The IC coordinator has delegated authority to make decisions to ensure smooth running of the service.
- 3.4. The IC coordinator is involved in the further development of established intermediate care services and in the planning of new related services e.g. the provision of support to residential care to prevent hospital admission.
- 3.5. If the IC coordinator manages any element of the service, they have clear working relationships with other managers.
- 3.6. The IC coordinator is empowered to report any monitoring information to senior managers, to prevent inappropriate admissions and improve the flow of emergency admissions.

Early findings

- In some areas, there is a need to review the management arrangements of the intermediate care service to bring all services together under an overarching integrated management structure.
- In some areas, further clarity of the role of the intermediate care co coordinator is required giving consideration to the strategic and operational elements of these positions.

4. Population Needs Assessment - The needs of the local population for IC services are known and are taken into account in planning services.

- 4.1. The population structure of the locality, particularly for older people with mental health difficulties, is known to service managers, including localities of potential high need and significant under-served groups.
- 4.2. Current patterns of service activity related to IC are known, and patterns of under-provision and of any over-provision are known.
- 4.3. A sample population has been assessed to identify the needs of the members of the local population using or likely to use IC services; this would include the identification of any gaps.
- 4.4. Patterns of local population need are taken into account by commissioners in commissioning IC services.

Early findings

- The incorporation of population needs assessment and the use of prevalence data in the strategic development of intermediate care services for older people with dementia is variable.
- In some areas, a broad population needs assessment should be commissioned to identify the most appropriate model for service delivery ie community and bed based services.

5. Information and communication - Users, carers and providers are all informed about access to and use of the service.

- 5.1. It is clear who has the responsibility to prepare and revise core information about the IC service.
- 5.2. General information about local IC services is available to users and carers in a range of formats and languages appropriate to their needs and impairments.
- 5.3. Up to date and accurate information is available to users and carers about the specific services they use, to cover all stages of their care pathway/provision.
- 5.4. Users and carers experience effective communication that is sensitive to their individual needs and takes account of any communication difficulties they may have.
- 5.5. Effective communication networks exist between all service providers.
- 5.6. Information about user and carers satisfaction is included along with service activity data and other performance indicators, in any local service evaluation.
- 5.7. Information is available to other service providers who might identify people appropriate for IC to assist routing.

Early findings

- Up to date, accurate and accessible information in a variety of languages and mediums is not always available to users and carers about the specific services they use or services that may be available to them.
- Effective communication networks do not always exist between mainstream older peoples services and specialist older peoples mental health services.

II. Single Assessment Process (SAP)

6. Referral Procedures

- 6.1. The documented referral process is consistent with SAP/ ICPA.
- 6.2. The referral clearly states the purpose of admission/care.
- 6.3. Referral and initial response systems are timely and appropriate for service users and carers.
- 6.4. Referral procedures include all possible transitions from one service to another, including return to a person's own home (there is a documented care pathway for entry and exit to and from IC).
- 6.5. Appropriate consent procedures to share information have been followed including provision for those who lack capacity.
- 6.6. Contact and overview assessments have been completed by the referrer (if not already completed)
- 6.7. A protocol exists for sharing information on a need to know basis for those who lack mental capacity that is consistent with Caldecott principles.

Early findings

- There is inconsistent and sporadic implementation of the Single Assessment Process often due to the leadership style of the organisation and the level of partnership working.
- Care pathways should be developed in line with strategy development to include mental health service users who require physical care.

7. Individual Needs Assessment

- 7.1. There are systems for individual needs assessment that are consistent with the local use of SAP/ICPA (covering all 8 domains).
- 7.2. The appropriate physical health screening has occurred to exclude underlying physical causes symptomatic of poor mental health.
- 7.3. The service user and carer perception and expectations are clearly recorded.
- 7.4. Needs assessment includes assessment of cognitive functioning including orientation and memory.
- 7.5. Needs assessment includes assessment of general mental health including mood, emotional difficulties, coping mechanisms, anxiety levels.
- 7.6. A specific evidenced based assessment is used for depression in all older people.
- 7.7. Drug and alcohol use are recorded as part of the assessment.
- 7.8. Needs assessment includes comprehensive risk assessment (using defined risk screening tools) and adult protection where appropriate.
- 7.9. Needs assessment includes needs for social and recreational activity.
- 7.10. Specialist service practitioners e.g. physiotherapy, psychology, occupational therapy, speech and language therapy complete the specialist assessment documentation.

Early findings

- The focus of intermediate care is often towards physical health and well being to the exclusion of primary mental health needs.
- There needs to be an early assessment of mental health needs of service users in main stream older peoples services. An approach could be to screen all admissions to step down units for depression and develop or adopt practice guidelines for intervention and treatment.
- Where services are integrated, the care of service users physical health, mental health and social care is well advanced.

8. Assessment and Support for Carers

- 8.1. Staff recognise the pivotal role and contribution of carers offering involvement, time and advice in a flexible manner, e.g. visiting times, appointment times.
- 8.2. Carers are informed of their legal right to request and assessment in all cases.
- 8.3. The physical and mental health needs of carers is included in their assessment.
- 8.4. Information and support is offered to carers about support services for them, by staff e.g. PALs information, local carers organisations etc in a written format.
- 8.5. Clinical information is shared with the carer with the service users consent based on Caldecott principles.
- 8.6. Assessment and care plans are given to service users and carers where appropriate and possible.
- 8.7. Carers are offered advice and support to facilitate attainment of the user's goals (helping the person do things for themselves). Where appropriate, they are offered training to support them as carers e.g. moving and handling.
- 8.8. Carers consent is sought to share carers assessment information with the service user.

Early findings

- Organisations need to raise the awareness of their staff of the statutory requirement to offer a carers assessment.
- Information is not always available for families and carers about all support services and facilities that are available including those for mental health service users.
- Where appropriate, consideration should be given to the use of independent mediation to support families who are highly anxious about the family member they are caring for.

9. Care Planning

- 9.1. There is evidence that needs assessment guides care planning.
- 9.2. Service users and carers are involved in care planning.
- 9.3. Service users have access to their care plans (user held records) where possible.
- 9.4. Care plans include provision for addressing identified mental health needs including referral to, counselling, memory clinic, psychology, psychiatry, bereavement services etc where appropriate.
- 9.5. Care plans consider the use of facilities in the community including primary mental health care services and community mental health teams, and other mainstream services for older people.
- 9.6. Care plans are reviewed systematically to record progress and set new goals (at least once during their admission episode).

Early findings

- There needs to be a greater awareness of what community services and facilities are available, including mental health support through closer liaison with voluntary organisations to improve the social, pleasure and leisure aspects of service users lives.
- Senior staff in intermediate care should have direct referral systems to specialist staff such as speech and language therapy, dietitians, psychiatrists, chiropodists and community physiotherapists without having to access these services via the general practitioner to reduce waiting times.

10. Discharge, transfer and rehabilitation procedures

- 10.1. Care packages and plans to facilitate discharge from IC services are discussed with potential contributors and providers as early as.
- 10.2. Carers are involved in the discharge planning process [these may take the form of meetings - likely in the context of residential based rehabilitation; but may assume a more informal character where the person is receiving home based rehabilitation/support].
- 10.3. Information about discharge arrangements is shared with involved people as soon as possible.
- 10.4. There are multi disciplinary meeting to plan for discharge involving service users and their carers where possible.
- 10.5. Provision of equipment and adaptations in the home is to the same standard as younger adults.
- 10.6. Where ongoing rehabilitation and maintenance support is identified as a need this is incorporated into the discharge plan.
- 10.7. The discharge plan is the next consecutive care plan in the SAP process.
- 10.8. Where there is a complex package of care a named care coordinator/ care manager/ community matron is identified to provide continuity of care to the service user and carer.
- 10.9. The service user has a written copy of the discharge plan which includes information about key contacts and follow up arrangements.

Early findings

- Discharge, transfers and rehabilitation procedures work well where Mental Health and physical frailty intermediate care services are integrated.
- There is little understanding about the relationship between SAP and CPA and they are regarded as separate processes.

III. Service delivery

11. Dementia and other mental health difficulties

- 11.1. Intermediate care staff are aware of and liaise with other specialist services for older people with mental health difficulties to help prevent unnecessary acute admission or admission to long term care facilities and facilitate timely and appropriate discharge.
- 11.2. Where intermediate care services are provided staff are trained and supported to provide appropriate mental health care for patients.
 - Dementia
 - Psychosis
 - Depression
 - Other difficulties
 - Challenging behaviour
- 11.3. Service delivery offers a physical environment that, reduces confusion and offers freedom to move about in an unrestricted space. This could include the home setting.
- 11.4. Consideration has been given to communication difficulties specifically related to mental health e.g. expressive and receptive dysphasia.
- 11.5. Consideration has been given to commissioning a specific short course or project work in mental health awareness in older people.

Early findings

- Liaison and communication between Mental Health and main stream older peoples intermediate care services needs improving.
- There are some generic support workers in intermediate care services who have attended Mental Health training modules that focus on dementia and depression but few address challenging behaviours or other functional mental health interventions.
- Most organisations offer basic training around mental health awareness and dementia care however this does not appear to have impacted on a predominantly negative attitude to mental health service users.

12. Clinical and social interventions

- 12.1. Interventions are provided by people from a range of disciplines and agencies, informed by staff with specialist skills in mental health care for older people including:
- General practitioner services
 - Specialist physicians and psychiatrists
 - Community nursing
 - Community psychiatric nursing
 - Social work
 - Clinical psychology
 - Occupational Therapy
 - Physiotherapy
 - Podiatry
 - Speech and Language Therapy
 - Dietetics
 - Home care/ community support workers/ HCAs
- 12.2. Interventions are provided flexibly according to identified needs and choices in terms of location and times of availability, and in terms of who provides the intervention, and supportive of informal arrangements.
- 12.3. Interventions are provided in ways to maintain the dignity of service users and their families.
- 12.4. An appropriate range of individual evidence based interventions is available for both users and carers: the following are some of the main categories of intervention that should be available:
- Medication
 - Day hospital/care facilities
 - Memory Clinic
 - Psychological therapies, including cognitive therapy
 - Physical therapies, including physiotherapy
 - Meaningful creative and recreational activity
 - Meaningful educational and occupational activity
 - Anxiety management
 - Management of challenging behaviour
- 12.5. There is awareness of assistive technology and it is available where appropriate.
- 12.6. There is a joint equipment store that has the capacity to respond service users requirements in a timely manner facilitating prompt discharge and preventing admission.

Early findings

- There is little recognition of primary mental health problems e.g. anxiety, depression, changes in cognitive function or the development of interventions to help service users.
- Main stream older peoples intermediate care services are not equipped or trained to treat people presenting with mental health problems and vice versa.

13. Clinical and service outcomes

- 13.1. Service providers regularly monitor their services to ensure that they are of good quality, responsive to need and promote independence.
- 13.2. Service users and carers are encouraged to comment on the quality of the services they receive, with the support of advocates where necessary.
- 13.3. The service has appropriate clinical and service governance mechanisms.
- 13.4. There is a framework for regular audit of the services to ensure quality and efficiency.
- 13.5. Users and carers are actively involved in evaluation procedures.
- 13.6. Relevant local standard outcome measures are used where applicable.

Early findings

- Where they exist, service outcomes are systems based i.e. bed occupancy and length of stay rather than service user outcome focused measure of performance.

IV. Resources

14. Staffing

- 14.1. There are sufficient numbers of staff who are knowledgeable and deemed competent in assessing older people's mental health.
- 14.2. There is provision for ongoing training of staff including older people's mental health and dementia care.
- 14.3. The approach to care is active multi disciplinary team working with close liaison with, and active engagement of specialist clinical and mental health professionals and services where necessary (e.g. geriatrician, community mental health teams, social work, specialist clinician, liaison psychiatry, dementia care specialist).
- 14.4. There is evidence of good human resources practice, including appraisal (at least once a year) leading to professional development plans.
- 14.5. There is a regular review procedure to ensure there are sufficient places and resources to respond to local education/ development needs.
- 14.6. There is a strategy for recruitment and retention of staff, including contingency planning for staff shortfalls.
- 14.7. There is a supervision policy that is fully implemented and regular audited including elements of reflective practice.

Early findings

- Some specialist Mental Health service posts remain unfilled for more than one year and in some under resourced services, there are long waiting times for psychiatric outpatient appointments and excessive waits for memory clinics.
- Appraisals are occurring but there are weak links to training and service development.
- Supervision is strong in social services but weaker in health services.

15. Finance and governance

- 15.1. There are clearly defined and transparent processes in place to enable macro and micro purchasing where managers are accountable for budgetary decision.
- 15.2. Services know the unit costs of all its services (whether provided in-house or contracted out to the voluntary or private sector).
- 15.3. There is an open, effective, transparent process for tendering for service provision.
- 15.4. The services have in place the key elements for:
 - Commissioning needs analysis
 - Strategic planning
 - Contract setting and monitoring
 - Market management
 - Contract monitoring
 - Performance management.
- 15.5. The review of these services has a clear way of determining service quality which includes comparison with others and challenges the status quo.
- 15.6. Service users and carers benefit from the improvements in quality, cost and efficiency that result from the above performance management framework.

Early findings

- There is evidence of integrated working between health and social services with parallel services in mental health with little or no clearly defined strategic direction leading to poorly thought through service development. However, where there is strong integration within teams, there is efficient commissioning of appropriate packages of care.