Inspecting Informing Improving

Healthcare Commission

Equality in later life

A national study of older people's mental health services

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The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.
- Be independent, fair and open in our decision making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission's work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.

Summary

The importance of older people's mental health services

Conservative estimates from the Department of Health suggest that, in the UK, mental health problems are present in 40% of older people who attend their GP, in 50% of older adult inpatients in general hospitals, and in 60% of residents in care homes. Just over a quarter of admissions to mental health inpatient services involve people over the age of 65. In the next 10 years, the number of people aged over 65 will increase by 15%, and the number aged over 85 by 27%. Mental health problems, particularly depression and dementia, are more common and have a worse outcome in the 60% of older people who suffer from a long-term illness.

As a result of the ageing population, the number of people with dementia in the UK is set to increase significantly. At present, there are approximately 700,000 people with dementia and it is estimated that there will be over a million people with dementia by 2025. The financial cost of dementia to the UK each year is over £17 billion and is set to increase.

Despite the significant achievements of the National Service Frameworks (NSFs) for Mental Health and for Older People, there has been less emphasis on mental health services for older people than on those for younger adults (the framework for mental health only addresses the mental health needs of working age adults up to 65). An example of this is seen when comparing the number of pages in national service frameworks: the framework for mental health is 149 pages long, whereas in the framework for older people, the chapter on mental health is only 17 pages long. National directors have reviewed how these two NSFs have been implemented and these reviews, together with national inspection reports, generally agree that there have been particular challenges in delivering better mental health services for older people. These challenges include lack of awareness of the mental health needs of older people and proper diagnosis in primary care and in acute hospitals, as well as variable quality and availability of the full range of services. Preliminary research commissioned by the Department of Health estimated that eliminating age discrimination in adult mental health services in England could require an additional £2 billion, against a current spend of £8.4 billion (a 24% increase in funding).

Older adults with mental health needs have not benefited from some of the developments in services experienced by younger adults and any developments in services for older people do not always fully meet their mental health needs.

In July 2005, the Department of Health published *Securing Better Mental Health for Older Adults* to mark the start of a new programme to bring together the policies for mental health and older people. However, the joint programme board set up to oversee this programme is no longer meeting.

Background to this study

The final report of the NHS Next Stage Review, *High Quality Care For All*, places quality at the heart of the NHS. This is defined as services that are clinically effective, personal and safe, with an increased focus on health outcomes, including patients' views and clinical outcomes. The report emphasises the

importance of making services fit for everyone's needs, not just those who make the loudest demands. It states that people with long-term conditions should have personalised care plans, and be treated with compassion, dignity and respect. It also highlights the importance of involving clinicians in making decisions at every level of the NHS and in leading change. This links well with the conclusions drawn from this study, and further emphasises the need to keep the focus firmly on older people's mental health services.

The work looking at older people's mental health described in this study commenced in 2006, following the publication of *Living Well in Later Life*. This was the report of a joint review of older peoples' services carried out by the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission. The intention at that time was to carry out a joint review of older people's mental health services. However, several factors combined to redirect our work, including the Department of Health's dementia strategy and the forthcoming Equality Bill. To enable a more up-to-date view, we carried out a national study of older people's mental health services, which involved assessing the available national data and visiting specialist mental health trusts.

While we recognise the limitations of this study, we hope that that the findings will help us to highlight some of the strengths and weaknesses of these services, and ensure that they receive the same focus as others. The findings from the study will also help to focus commissioners and providers on the areas that require ongoing improvement, and to inform the future methodology of the new regulator of health and adult social care in registering NHS trusts and assessing their performance.

The focus of the study

We aimed to focus on the extent to which statutory services in England were addressing the outcomes for service users and carers around four important themes. These were derived from existing policy guidance, previous national reports and the contribution of an expert reference group. The themes selected for this study were:

1. Age discrimination (focusing on the access to, and quality of, services for adults under and over 65 years).
2. Quality of inpatient care (looking at issues associated with risk identified in previous investigations).
3. How comprehensive are services? (compared to national guidance).
4. Working with other organisations (how specialist services worked with primary care, adult social services and acute hospitals).

Using data from our screening of trusts, we identified and visited six specialist mental health trusts that were expected to be at the high, mid and low end of performance, and were from different geographic regions. Many of these trusts crossed the boundaries of different local authorities and commissioners, enabling us to consider a wider variety of models of service. We also examined national datasets in an attempt to understand how feasible it is to assess these important areas of older people's mental health through routinely collected data.

Key findings

The most significant finding from this study was that there was limited availability of good quality national data in relation to the quality of specialist older people's mental health services. Where data was found to be reliable, it did not shed light on the most important themes identified for the study. Nationally available data does not provide a robust basis on which to compare the performance of different areas in meeting older people's mental health needs, or to provide the boards of trusts with sufficient information to be confident about the extent to which they are providing good quality non-discriminatory care.

Age discrimination

In the six trusts we visited, we found two that had made concerted efforts to address the age discrimination encountered by older people when accessing services, and who were delivering services based on need, not age. They had approached the issue differently, but both had required strong senior clinical and managerial leadership. Both continued to provide specialist old age psychiatry services for those people who required them, and staff were proud of the services they delivered.

However, most trusts were struggling to make progress, and older people were denied access to the full range of mental health services that are available to younger adults. In particular, there was poor access to out-of-hours and crisis services, psychological therapies and alcohol services. Services for younger adults indirectly discriminated against older adults, even when, in theory, there was no obstruction to their access (for example, by providing services that are open to older people, but are not sensitive to their age-related needs).

Quality of inpatient care

We were generally encouraged by the level of involvement by service users and carers, though this was not universal. Factors that appeared to have a beneficial effect were having access to advocates working in inpatient areas, and a good physical environment that is conducive to care, with meaningful activities provided that meet the needs of the patients.

Clinical governance systems were in place, although they varied in the degree to which they were an integral means of running the trust and in their apparent effectiveness. In the trusts where we found evidence of high quality care, with staff who felt involved, there was a sense of strong clinical and managerial leadership. These trusts tended to have psychiatrists specialising in old age in managerial roles at senior levels, who were able to provide leadership and bring older people's issues directly to the trust's board.

How comprehensive are services?

Trusts generally used their clinical governance structures to identify best practice, to examine their services and to develop new services as required. The trusts that appeared to have a more robust and cohesive development plan for their older people's mental health service, and evidence of progress, were characterised by two aspects. Firstly, they had senior clinical leadership with both internal and external stakeholder involvement and, secondly, they had strong central governance structures.

Most trusts had been through a major reorganisation over the past year or so, usually due to mergers. For some, this represented investment in older people's

services in time and focus, though many staff referred to chronic under-funding compared to services for people under 65. Patient groups were given priority where they were seen to be a higher risk to the public, or where more Government targets were applicable, leaving older people's services lagging behind with insufficient resources or interest to promote new initiatives.

Models of service varied markedly between trusts and between localities within trusts. Many had additional specialist functions added on to the core community mental health team. Access to out-of-hours and crisis services, psychological therapies, alcohol services and liaison services into acute hospitals were poorly provided in some trusts.

Working with other organisations

The most notable issue regarding the development of a joint commissioning strategy was the number of different organisations involved and the complexity that this added to developing a unified vision. Most trusts worked with several different PCTs and local authorities. Although this presented challenges, we found evidence of some good practice in working across health and social care. However, commissioners struggled with the boundary that separates people over 65 and people under 65 in mental health services, and were unsure about the different models of service required. Where commissioners had made progress with this, it was generally due to having one manager who was responsible for commissioning all mental health services.

Strategies for older people's mental health were largely in place, but they were not always being implemented convincingly.

Care planning appeared to be generally carried out well, but trusts used a variety of approaches to integrating the care programme approach used in mental health care with the single assessment process used by social care services. We found that incompatible IT systems and data requirements remain a considerable obstacle to joint working. Protocols introduced as part of the National Service Framework for Older People were being used as the basis for pathways of care between organisations.

Community mental health teams for older people were less well integrated than those in mental health services for younger adults, with different levels of integration between localities within trusts themselves. Where health and social care services were integrated at both team level and management level, and where staff from social care were managed within the community teams, services were more likely to offer a higher standard of care and a greater range of services. The level of integration between organisations had a significant impact on how patients and their carers could get the help they needed and on their satisfaction with the services offered.

The patchy integration across trusts was surprising given that, in their self-assessment of performance in the annual health check, mental health trusts declared high levels of integration for their community mental health teams. We explored this further using our internal data and aligning it, on an anonymous basis, with responses from community mental

health teams in the Dementia Study undertaken by the National Audit Office (NAO). The data from the annual health check focused on the trusts who had declared all their teams to have the highest level of integration in their self-assessment. In the NAO's study, only 48% of these trust's community mental health teams considered themselves to be integrated, with only 52% reporting that they had a joint management structure and 17% reporting that they had some form of joint health and social care funding arrangement in place. This may suggest that community mental health teams themselves felt that they were less well integrated than their trust's self declaration would imply, or that there are issues regarding the interpretation of the guidance provided, which therefore requires greater clarity.

Conclusion

The visits to a sample of six representative trusts demonstrated the importance of clinical leadership, the involvement of skilled management, and integrated working across organisational boundaries. We found a number of areas of good practice, including a comprehensive network of modern matrons who champion good practice in older people's services, a care home liaison service, a longstanding and effective crisis resolution service that works well for older people and their carers, and an innovative adult safeguarding project. However, the visits also also emphasised the lack of implementation of a standard model of care and how older people's mental health services are falling behind services for younger adults in terms of priority. In addition, it showed some clear evidence of age discrimination in access to services, age-appropriateness and lack of specialist input to services.

These visits were not 'assessment visits', therefore we did not increase the burden of inspection by requesting additional data from trusts. However, the findings were in keeping with the published views of other national bodies.

The mental health standard from the National Service Framework for Older people has yet to be delivered, yet the framework comes to the end of its 10-year lifespan in 2011. In such a complex area, where data is difficult to obtain and interpret, simple answers do not materialise and required actions are difficult to implement. The ways in which we divide organisations and services in policy, planning, implementation and regulation can potentially de-prioritise an area such as older people's mental health. Past experience has taught us that, to secure better mental health for older people, there needs to be a coordinated and sustained response at all levels and organisations in the network of health and social care agencies that work with them. Concerted action is required now. The forthcoming Equality Bill and the National Dementia Strategy provide a focus, and this needs to be reinforced by the planned new vision for mental health, which must be age inclusive. World Class Commissioning, strong leadership and a greater national priority are required to deliver results.

Key priorities for action

To improve the outcomes experienced by older people with mental health needs, and to raise the quality of mental health services for older people, actions need to be taken to improve the following key areas:

- Improving the quality and relevance of data.
- Whole systems working and commissioning.
- Leadership.
- Discrimination.

We have developed detailed recommendations to address these areas, which are summarised below.

Recommendations

1. Effective leadership to develop older people's mental health services, with senior clinical leadership and strong central governance structures, is required across all health and social care organisations that work with older people, as well as all policy-making organisations.

   Commissioners' and providers' leaders should work together using the World Class Commissioning approach to deliver improved whole system outcomes. Commissioners and providers should have clearly identified actions for older people's mental health services in the National Dementia Strategy and the Equality Bill.

2. The 'New Horizons' project led by the Department of Health, is working on the successor to the existing National Service Framework for mental health, which expires in 2009. We recommend that this project steers the strategic direction for mental health services towards including adults of all ages and tackles age discrimination in mental health services.

3. The Department of Health should develop an equalities impact assessment to ensure that its own policies, as well as those of regulatory bodies, health and social care commissioners and providers, reflect the aspirations of holistic care in mainstream settings and age equality in mental health services.

4. The Department of Health, the Information Centre for Health and Social Care, regulatory bodies and providers should:

   - Review the quality and focus of national datasets and regulatory assessments to identify gaps and duplication.
   - Develop a range of meaningful outcome indicators, in particular around the themes covered in this report, building on our monitoring and assessment of local and national progress and to support the commissioning of older people's mental health services.
   - Develop an effective data source that captures the experiences of those who use older people's mental health services and their carers.

5. As part of the Department of Health's approach to monitoring the compliance of health and social care organisations with the Equality Bill, we recommend that a data project be established to look at the detail required.
6. The Department of Health should ensure that the payment by results system in mental health can be used to drive forward age equality and to monitor progress against this objective.
7. Unless other similar data streams are forthcoming, the Care Quality Commission should consider how it might use data from the annual service and financial mapping exercises to inform its work, and how it can encourage services to reliably collect the data required.
8. The Care Quality Commission should adopt, at an early stage, the topics for further review that identify joint working between primary and secondary care, physical and mental health, and health and social care issues, from the viewpoint of older peoples' mental health. Relevant topics for review might include the care of older people in residential settings, and discharge of older people from acute hospitals. The Care Quality Commission should also investigate methodologies to assess cross-cutting themes in delivering services and make older people's mental health services a priority in this, and consider making use of the information it gathers when reviewing trusts in its new registration process.
9. Strategic health authorities should ensure that a national network of strategic leads with special interest is maintained, with a focus on commissioning and providing older people's mental health services.
10. The Royal College of Psychiatrists should lead a collaborative approach, with other relevant organisations, to develop models of service in specialist services, based on needs not age. This should include a self-assessment toolkit.
11. In preparation for the forthcoming Equality Bill, and while awaiting the work of the Royal College of Psychiatrists on age-appropriate services, commissioners and providers should assess their services for evidence of discrimination in access to services and start planning on how to address this. Plans should consider how to equitably meet the needs of older people with mental health problems, and not simply provide access to services designed for younger adults.
12. Commissioners and providers of services should work together to implement fully the National Dementia Strategy and agree the measures by which the outcomes will be assessed and monitored.
13. Trusts' quality accounts* should include data items that relate to older people's mental health.
14. The boards of PCTs, mental health trusts and local authorities with responsibility for social services should review the quality and appropriateness of their older people's mental health services.

* From April 2010, the boards of NHS trusts will be required to publish quality accounts in the same way that they publish financial accounts. These will be reports to the public on the quality of services they provide, looking at safety, experience and outcomes.

Introduction

Background

Conservative estimates suggest that 40% of older people who visit their GP, 50% of older adult inpatients in acute hospitals, and 60% of residents in care homes have mental health problems.[1] Just over a quarter of admissions to mental health inpatient services are for people over the age of 65. In the UK, dementia is a steadily increasing challenge; there are currently approximately 700,000 people suffering from dementia* and it is estimated that this figure will rise to over a million by 2025. The financial cost of dementia to the UK each year is over £17 billion, and is increasing.[2]

In the next 10 years, the number of people over 65 will increase by 15%, and those over 85 by 27%.[3] Mental health problems, particularly depression and dementia, are more common and have a worse outcome in the 60% of older people who suffer from long-term illnesses.[1] Clearly, services for this group of people need to be robust enough to cope with this increase.

Strategies to improve services

There have been many policy initiatives that have highlighted issues concerned with mental health services, but fewer that have concentrated dedicated resources on services for older people. The publication of the National Service Framework for Mental Health was a landmark in the development of mental health services for adults in England.[4] It introduced new national standards and models of service, a significant level of new funding[5] and guidelines for effective performance management. However, its focus was limited to adults below the age of 65. The comparable service framework for the mental health care for older adults appeared as a chapter (Standard 7) in the National Service Framework for Older People.[6] This chapter is just 17 pages long, compared with the 149 pages of the National Service Framework for Mental Health. When compared with the framework for adults below the age of 65, the chapter on the care of older people contained less prescriptive models of service, no dedicated resources, and less robust mechanisms to manage performance.

In 2003, a report from the Commission for Health Improvement on the abuse of older people with mental health problems noted a lack of priority for mental health services for older people generally within the health community, and "confused and ineffective" implementation and monitoring of the relevant national service frameworks.[7] The Commission for Health Improvement also noted that "the focus of policy, local priorities and the national performance indicators remain centred around adult mental health services" as opposed to older people's services. In the same year, the Social Services Inspectorate found that services for older people with mental health difficulties needed urgent attention.[8]

The national directors' reviews of the national service frameworks for both older people and mental health, carried out in 2004, recognised that mental health services for older people had fallen behind those for adults of working age.[9, 10] Their joint statement in 2005, *Securing*

* Dementia is a condition characterised by deterioration in brain function. It is almost always due to Alzheimer's disease or to cerebrovascular disease, including strokes. The main symptoms of dementia are progressive memory loss, disorientation and confusion.

Better Mental Health for Older Adults[11], announced the start of a joint strategic approach, and a new Programme Board for adult mental health services for older people was set up, although this did not continue.

In 2005, the Department of Health, through the Care Services Improvement Partnership, published the good practice guide *Everybody's Business, Integrated mental health services for older adults: a service development guide*.[1] It set out the foundations and key elements of a comprehensive mental health service for older adults, and described how health and social care services should work together around the needs of older people with mental health problems.

Although *Everybody's Business* was felt to be helpful in setting out the key components of such a comprehensive service, there was no additional investment or incentives to implement developments such as performance indicators or targets.

In parallel with the publication of *Everybody's Business*, the Healthcare Commission, the Audit Commission and the Commission for Social Care Inspection carried out a collaborative in-depth review of older peoples' services. The report *Living well in later life: A review of progress against the National Service Framework for Older People* was published in March 2006. It found that all aspects of mental health services for older people needed to improve, and that most areas were struggling to provide a full range of integrated, good quality services to older people with mental health needs.[12] It also found that services for older people were not integrated, and that out-of-hours and crisis management services were less well developed than for other adults. The review found explicit age discrimination in services for older people with mental health problems, and some service users who had transferred to services for older adults reported poorer quality, fewer services and less support.

Following on from the review, the three commissions made a commitment to develop improvement activities that were targeted at issues identified in the review, including a joint review of mental health services for older people by the Commission for Social Care Inspection and the Healthcare Commission. However, several factors combined to redirect this work, including the Department of Health's national dementia strategy[13] and the forthcoming Equality Bill.[14]

In addition, the final report of the UK Inquiry into Mental Health and Well-Being in Later Life highlighted a lack of awareness and proper diagnosis in primary care and acute hospitals, as well as variable quality and availability of the full range of services.[15]

Forthcoming changes to improve services

From 1 April 2009, the Care Quality Commission (CQC) will be the new regulator for both health and adult social care, taking over the work of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. It will join up disciplines that have many links, common themes, work plans and delivery streams, and will address the lack of integrated social care and health services that the earlier review highlighted. The initial manifesto of the Care Quality Commission states that it will use a range of regulatory approaches for different services, and prioritise these on the basis of risk.[16]

In February 2009, the Department of Health published the National Dementia Strategy, which addressed three key themes: raising awareness, early diagnosis and intervention, and improving the quality of care. The strategy also made reference to the non-dementia parts of specialist older people's mental health services, including the need for specialist community mental health teams for older people, which will continue to look after those with the most complex and severe problems in dementia as well as those with schizophrenia, depression, mania and other mental disorders in later life.[13]

Although new strategies and regulation are welcome, they come at a high financial cost. The Queen's Speech of December 2008 included the Equality Bill[14], which will consolidate the various existing pieces of legislation on discrimination into one Act, and will introduce further responsibilities in a bid to outlaw all forms of discrimination. The Equality Bill (under the Age Goods, Facilities and Services (GFS) provisions) will make it unlawful to discriminate against adults aged 18 and over because of their age when providing goods, facilities and services and carrying out public functions. This means that public bodies will need to demonstrate that they are tackling discrimination and promoting equality.

In preparation for this, the Department of Health commissioned research to explore the extent of age discrimination in mental health services.[17] This preliminary analysis estimated that eliminating age discrimination in mental health services in England could require an additional £2 billion, against a current spend of £8.4 billion (an increase in funding of 24%).

Why we conducted this study

We wanted to find out how the collection of data supports the planning and development of older people's mental health services and improves the outcomes for older people who use the services, by giving a picture about how well services were performing. We also wanted to talk to service users and carers, as well as people working in these services, to understand what was working well, what needed to improve, and to find out if there was any learning that could be shared. It will be important to use information from service users and their carers, as well as national data and the results of studies to determine what type of services are needed and how they should be provided.

How we conducted the study

Our study of mental health services for older people combined an analysis of available national data with visits to a representative sample of mental health trusts. The four key themes for the study were derived from existing literature and the advice of an expert reference group:

1. Ageism/age discrimination.
2. Quality of inpatient care.
3. How comprehensive are the services provided?
4. Working with other organisations.

Analysis of data

We found that some potential sources of data were unsuitable for a number of reasons. Often the data was not broken down into that for people aged 65 and over and, for people under 65. In some cases (for example in service mapping), reports from the data sources could not distinguish between health and social care. This meant that there was no reliable way of finding out the number of people for each specific age range, and therefore no way of comparing data for the two age groups. In other cases, the data was not available or had not been collected, making any analysis or interpretation impossible. Data from national sources was not robust enough to comment in detail on the four key themes outlined above. The main quantitative data used in this report is from the Healthcare Commission and the National Audit Office (data on integration of community mental health trusts), which highlights some important conclusions about the insufficiency of data on mental health services for older people.

Visits to trusts

To select a representative mix of mental health trusts to visit, we were guided by the initial risk matrix rankings that were used when this study was originally a review, and we chose trusts that were in the high, mid and low range of likelihood of risk of poor performance. From these, we chose a number of trusts from each of our regional areas (see page 37).

The trusts invited to take part in the study helped us to build a more complete picture of older people's mental health services nationally. We visited six trusts, representing approximately 10% of all mental health trusts in England between February and March 2008. The majority of these trusts spanned more than one local authority boundary and many had recently merged, enabling us to consider a wide variety of models of service.

The interview tool that we used was comprehensive and covered all areas of the four key themes. The questions related to several of the core standards that the Healthcare Commission uses to assess trusts' performance in the annual health check. The mapping into the core standards forms part of the interview guide, which is available on our website (www.healthcarecommission.org.uk).

The visits were carried out by two assessors from the Healthcare Commission and most also had a member of the project team from the strategy department for consistency across the visits. The teams were on site for two days and met with groups representing service users and carers, members of staff at the trusts, social care staff from the corresponding local authorities, and commissioners of services.

Key findings

Theme 1: Age discrimination

Overcoming age discrimination

Two of the six trusts we visited appeared to have a service that was led by the needs of service users, with non-ageist policies embedded throughout the organisation and no restrictions to services on the basis of age. Both had made a concerted effort to address this issue, which had involved structural change, but both had retained specialist older people's mental health services.

Interestingly, these two trusts approached the structural change differently. One trust had merged the adult mental health and older people's mental directorates into one, with a single director of mental health services, just 18 months before our visit. A multi-agency mental health strategy was in operation covering both younger and older adults. The trust had reviewed operational and clinical policies and procedures to ensure that they were non-ageist and the medical director of the trust is a psychiatrist specialising in the needs of older people.

The other trust started to consider ageism as an issue approximately 10 years ago, and carried out a review of all policies when the National Service Framework for Older People was published. Rather than merging directorates, it maintained separate directorates for people under 65 and those 65 and over, though working very closely with a joint commissioning group and management board for mental health across all age groups. This allowed the trust to oversee and further develop non-age and age-appropriate services. The trust also carries out an impact assessment for every new policy, which includes ageism.

These two trusts felt that there was a clear role for specialist older people's mental health skills. In particular, many of their older patients had a mix of physical and mental health needs and often required more intensive support from social services. Staff showed pride in their non-ageist services and felt strongly that their services were seen as being equal to others, and that their skills and experience were valued. Some staff expressed difficulties with their professional identity because the specific directorate for older people's mental health had been dissolved. However, in general, staff mostly felt that there had been progress and development over the last few years, and they were positive about their level of involvement in shaping developments in services.

Feedback from patients and carers supported the idea of having separate facilities for older people with age-related needs and behavioural issues. The first trust had specific intensive care units within the older people's mental health directorate, while the second trust used the skills of staff in older people's mental health in the general intensive care unit, though there was wide support for developing a separate intensive care unit for older people with mental health needs.

Existing age discrimination

Four of the trusts that we visited had made progress in identifying the issues of age discrimination and had taken some action towards making their services accessible on the basis of need. However, services struggled with the funding implications of a needs-based service, not only in terms of the allocation of cases and resources to individual teams, but also with regard to funding packages of care from social services. These were referred to as sometimes having an explicit division at the age

of 65. In all trusts, people with dementia of all ages were seen in the service for older adults.

Three of these four trusts had a transition protocol in place for patients transferring between services for people under 65 to those for people aged 65 and over. These were generally felt to work fairly well, respecting needs rather than age in deciding when patients should be transferred. In one trust, the services for people under 65 were said to be so much better resourced than those for older patients, that the older people's community mental health team would sometimes not accept a transfer on the basis that the patient would be disadvantaged and lose services on transfer.

Out-of-hours services and crisis services were often not open to older people and these took referrals only for people under the age of 65, or for conditions other than dementia. Even when there was no explicit policy about discrimination on the basis of age, staff often reported that although the rules did not prevent referring older people, in actual practice accessing the full range of services for older people was often not possible. There appeared to be a reluctance to refer and a reluctance to accept referrals, partly due to workload capacity and the age-appropriateness of the service being offered. There was no clear justification for this and, in each case, the way services were offered seemed to be based on organisational, historic and/or cost reasons. Even when it was possible for people to access services, there was a lack of specialist input at times to ensure that older people's needs were fully addressed.

Staff from several trusts referred to difficulties in gaining access to services for alcohol and substance misuse, because even when they were theoretically available, they were either not offered in an age-appropriate way or were not available when staff attempted to refer to them. Many were geared towards younger people, usually males, and were felt not to be appropriate for older people, who could feel vulnerable in the atmosphere.

One service that was particularly poorly provided for was psychological therapies. This was noted in most of the trusts we visited. One trust reported a waiting list of six months for an assessment. Another reported that, in an audit of 1,300 referrals to psychological therapies from GPs, only 49 were for people over the age of 65. Many carers also told us that they could not get any help as resources were too stretched and, when services were provided, they often felt that they were too difficult to access physically as they tended to be centralised and were unavailable in many parts of the community.

Example of good practice from Dorset Healthcare NHS Foundation Trust

- The trust has a well-established crisis resolution/home treatment service, which was developed following the publication of the National Service Framework for Mental Health.
- In developing the service, the trust was proactive in ensuring that it was not age-limited and was also available to older people with mental health problems. The service also provides support to A&E departments at the two local acute hospitals for both adult and older people.

Although service users and carers expressed some concerns about the deterioration of the quality of services as people moved from those for people under 65 to services for those over 65, there were also cases where the care had improved due to a greater awareness of issues for older people.

Equality, dignity and respect

Training on ageism was usually incorporated into the training provided on discrimination awareness and equality. In general, staff have ongoing training on equality issues, and some trusts also incorporate training on the Human Rights Act into training on the Mental Capacity Act. Training on the care of people with dementia included privacy and dignity.

One trust had two black and minority ethnic (BME) community development workers, who were working with the PCT and elders from the BME community to review and plan services. One inner city trust (East London NHS Foundation Trust) carried out a survey of older Asian people regarding their knowledge of mental health issues and the availability of services. It is carrying out ongoing work jointly with Age Concern and the Alzheimer's Society to work on actions arising from this survey.

The trusts mainly used standards from the Department of Health's *Essence of Care*[18] to assess how they address issues relating to privacy and dignity. There were some issues regarding single sex accommodation, with some male female bedrooms on the same corridor and a female-only lounge being used as a walkway by male patients to get to the garden. These services would be unlikely to meet guidelines from the Department of Health on single sex accommodation.

In one area, chaplaincy services had been adapted and delivered based on the needs of service users, and multi-faith prayer facilities had been made available. However, there was little evidence of sexual safety issues being given any prominence.

Theme 2: Quality of inpatient care

Involvement of service users and carers

In all the visits to trusts, we met with groups of service users and carers to help us form a fuller picture about the outcomes of the services. Service users and carers were very positive in some areas about the support they received and told us about groups for carers that offered mutual support, about training courses where carers could learn about the conditions their loved ones faced, and about how services were better at involving them in the decisions about the person they cared for. Two trusts with a high proportion of people from BME groups had fostered partnerships with groups from the local BME community, so that they could understand better what services to provide and how to provide them.

However, there were still lessons to be learned on involving service users and carers, and some groups told us about examples when they were not included, were given no help or understanding, were not consulted on plans, and were not given basic information about how they could access services when necessary – either in an emergency or for routine help. These comments arose most often when staff teams were isolated from each other and from the communities they served, leaving people feeling that they were being pushed 'from pillar to post' in their attempts to contact someone.

In three trusts, evidence both from staff and service users and carers suggested that there was genuine and meaningful involvement in getting feedback on current services and developing services, though some of the service users and carers said that, although their views were sought, they were doubtful how much real influence they had. Most trusts reported that they had worked hard to change the way they worked with service users and carers, and this had improved how they felt about the services. Some trusts were involving service users and carers in more formal settings, for example in user/carer councils or forums that regularly meet with members of the trust's board (including the chief or deputy chief executive and chair). One user/carer forum was a sub-committee to the trust's board. Some trusts routinely involve service users and carers on staff interview panels and when training is provided for carers and service users, and their costs are reimbursed.

In general, service users and carers had a positive regard for staff, and recognised that they were, at times, working under difficult circumstances due to the environment or the demanding nature of caring for patients. However, carers sometimes felt excluded from decisions involving the care and care planning of their loved ones.

Adult protection

All trusts were involved in local safeguarding boards, and training in adult protection was largely mandatory for all staff. While the lead for adult protection generally lay with social services, South West Yorkshire Mental Health Trust employed a specialist adviser for vulnerable adults. We found that staff were conversant with practice and procedures and knew when and how to make referrals.

Example of good practice from South West Yorkshire Mental Health NHS Trust

- The trust is signed up to three safeguarding boards and takes an active role in developing positive working relationships in these three local authorities.
- There is a protocol supporting the multi-agency safeguarding boards. The boards look at training and development issues through serious case reviews. The trust's assistant directors now attend the safeguarding boards.
- The trust employs a specialist adviser for vulnerable adults.
- Staff confirmed that they receive training in safeguarding issues and that this is mandatory.

Clinical governance

All six trusts had clinical governance systems in place, and had policies for whistle-blowing and complaints, which staff appeared to be aware of. At the trusts that appeared to have embedded clinical governance as an integral part of their services, senior staff attended directorate meetings. At one trust, the clinical governance group was attended by all consultants in older people's mental health, with senior managers designated as leads on each of the core standard domains. In a second trust, their lead consultant is the associate medical director and clinical governance lead for the trust.

Safety

All six trusts addressed issues of safety through their clinical governance systems, and

policies for incident reporting, complaint handling, whistle-blowing, risk management and training were integral to delivering safer services. The trusts with a more robust approach to improving safety routinely used root cause analysis to investigate serious untoward incidents. We found examples of best practice in those trusts that could demonstrate a culture of positive support around managing incidents. This included routinely using debriefing and weekly audits of serious untoward incidents, IT systems to help collate and identify issues, as well as regular auditing of prescribing practice.

Management and leadership

In the trusts where we found evidence of high quality care and staff who felt involved, there was a sense of strong clinical and managerial leadership. These trusts tended to have old age psychiatrists with managerial roles at senior levels (medical director, assistant medical director and head of clinical governance), who were able to provide leadership and bring issues relating to the care of older people directly into the trust's board. In the trusts with divided or joint clinical leadership, or with no overall responsibility for older people's services, there appeared to be a lack of robust progress in service improvements. One trust was proud to have a nurse consultant in older people's mental health, though others either lacked the funding or had been unable to appoint such a position.

The care environment and procedures

Most inpatient areas used the standards in *Essence of Care* as a way of guiding good practice. We found evidence in some areas of auditing against these standards, and we saw evidence of action taken to improve care and improvement on re-auditing. Other examples of good practice included: involving carers in care planning; involving carers in PEAT inspections[19]; an independent advocate carrying out weekly visits to inpatient wards (at South West London and St George's Trust); advocates visiting wards without notice; and representatives of service users visiting patients a week before discharge to give feedback to the trust. Staff were generally aware of the importance of maintaining the environment and the need for therapeutic activities, and they had some concerns about the lack of single sex accommodation and private en-suite facilities. However, staff reported that they felt they were making progress in this area.

Staff generally reported an improvement in staffing levels on inpatient wards, though recruitment difficulties in some cases meant there was still an over-reliance on agency support workers, which is potentially detrimental to care. Staff in one trust noted an improvement in care because nutritional staff and continence nurses were working as part of the older people's mental health services. One trust (East London NHS Foundation Trust) had a particularly strong network of modern matrons who had a rolling programme of improvements under the banner of *Essence of Care*. This had improved the environment and the nursing expertise.

Example of good practice from East London NHS Foundation Trust

The trust has restructured its inpatient workforce to increase the number of matrons to 25. This has delivered a tier of strong clinical managers who have a close focus on standards and clinical interventions.

The role of the modern matron is to:

- Set and promote the highest standards of care across the service, with particular emphasis on the ward setting.
- Ensure that the objectives of staff reflect these standards and form the basis of interactions with patients.
- Ensure that the clinical environment supports the delivery of these objectives.

Among other things, this involves benchmarking against the best clinical services and employing a systematic audit regime to ensure that standards are maintained.

As ambassadors for the older adult service, the modern matrons promote the ambitions of the service, both corporately and with partner agencies such as the PCT, social services and third sector organisations.

Workforce development and training

All trusts reported good compliance with policies for essential and mandatory training. We did not hear of any obstacles to training or personal development. Difficulties with recruitment had been helped by giving more attention to the career pathways of support workers and registered nurses, and ward managers at one trust had been trained in counselling staff on their work-life balance as part of their leadership training. Dorset Healthcare NHS Foundation Trust also reported that its services had been accredited as practice development units with the local university, while South West Yorkshire Mental Health Trust provided staff with the opportunity to give anonymous feedback about their supervision. However, there was some evidence of a lack of training in clinical governance activities.

Theme 3: How comprehensive are services?

Identifying and delivering best practice

All the trusts we visited had strategies for older people's mental health that directed developments in services. Some trusts reported benchmarking their service specifically against *Everybody's Business* and some commissioners used a needs assessment based on the needs of their population. All trusts also had clinical governance structures and showed evidence of involving clinicians when considering good practice.

The structure of the directorate in five out of the six trusts we visited allowed a focus on older people's mental health, and allowed clinical governance and developments in practice to be shared across the whole organisation.

One trust had moved to providing locality-based services rather than a directorate-based structure. Staff told us that the advantages of this were less travel, easier communication, and being better able to work in an integrated

way with partner organisations and services, including services for younger adults, to confront ageist patterns of service delivery. However, they felt that this resulted in a loss of leadership, sharing of best practice and consistency of approach. There were also markedly different levels of integration with social services across these localities, with inconsistent service models and differences in the age range of services. These differences were apparently due to historical reasons from the merger of trusts. The same group of staff told us that there were pockets of good practice that needed to be spread across all areas. Staff said that it was harder to argue for resources when services were part of a geographical model, because they lacked the power and weight of the larger organisation.

The trusts that appeared to have a more robust and cohesive development plan for their mental health services for older people, and those that showed evidence of progress, were characterised by two aspects: firstly, they had senior clinical leadership and both internal and external stakeholder involvement, and, secondly, they had strong central governance structures. Interestingly, the trusts with a stronger central management structure appeared to have a greater sense of staff ownership and involvement (as expressed by staff themselves). Good leadership existed in all the trusts that were seen to be offering good services. Services were successful in trusts whose senior team was dedicated to improving services for older people, where there was board level concern and focus, and where there was a passion for building the best service they could offer.

Staff made reference to using direct professional support and paper-based toolkits, such as those provided by the Care Services Improvement Partnership and the Royal College of Psychiatrists, to externally validate their services and assist with developing them.

Evidence of delivering comprehensive specialist services

Most trusts had been through a major reorganisation over the past year or so, usually due to a merger of trusts. For some, this represented an investment in older people's services in both time and focus, though many staff referred to chronic underfunding compared to the services for those aged under 65. Patient groups were felt to be prioritised where they were seen to be of a higher risk to the public, or where more Government targets were applicable, leaving older people's services lagging behind with insufficient resources or interest to promote new initiatives.

Interviews with groups of patients raised concerns about local closures of day hospitals or inpatient units. Other concerns related to a lack of awareness, among some GPs, of the mental health needs of older people and the needs of their carers, which delayed referral to specialist services, and to patients with dementia receiving medical treatment in a general hospital.

Community mental health teams

All trusts appeared to have staff groups as recommended in the National Service Framework for Older People.

There were three areas that community mental health teams appeared to be lacking in: psychological therapies, drug and alcohol services and access to social workers. (Integration with social services is referred to

in the next theme on working with other organisations on page 22.) Psychological therapies and drug and alcohol services are referred to in the earlier section on age discrimination.

One trust had a dedicated community mental health team for dementia that worked with other agencies, including stroke services, elderly care day hospitals and intermediate care. Other specialist teams were often provided as part of an extended community mental health team, including a care home intervention team, a rapid response team, care home liaison, acute services liaison (general hospital) and memory services. Some concern was expressed about psychology services being provided outside of the community mental health team.

Example of good practice from Cumbria Partnership NHS Foundation Trust

The award winning Carlisle CHESS (Care Home Education and Support Service) has developed a 20-week rolling programme of education and support for staff in care homes. Its evaluation shows that, where people are cared for in their existing environment, their care has improved and admissions to hospitals have reduced significantly.

This has resulted in a better experience for service users.

Inpatient services

There was wide variation in how these services were delivered. Some trusts separated their beds for people with functional disorders from those with organic disorders*, while others assessed and treated people with functional and organic disorders in the same inpatient area. The style of providing organic beds included having sections for assessment, intermediate care and intensive care, and a non-age-specific acute assessment unit with a separate ward for older people's mental health for longer stays.

Carers and staff said that it was difficult to find appropriate activities for everyone in the mixed dementia/functional mental illness wards, and staff also reported difficulties in getting age-appropriate activities for younger adults with dementia.

One trust was unique in still having three continuing care wards, though there is emerging consensus from the five locality commissioners that these should be provided outside of the specialist and mental health services.

Other aspects of inpatient care are covered in the second theme on the quality of inpatient care (page 16).

Care received on general wards in acute hospitals

Carers expressed general dissatisfaction with the care their relatives received on the general wards in acute hospitals. In particular, they referred to staff in hospitals not being trained or equipped to deal with patients with mental health problems, especially dementia. Four of the six trusts said they had liaison services of some sort, that were normally based on specialist nurses providing assessments,

* A functional disorder is one that shows symptoms for which no physiological or anatomical cause can be identified. An organic disorder is caused by a detectable physiological or structural change in an organ. Dementia, including Alzheimer's Disease, is an organic mental illness.

education, training and support to staff in hospitals. The mental health nurse at one trust taught new nurses on the induction course at the local hospital, and had introduced a leaflet on easy recognition indicators for mental health problems. Training provided by some of the consultant psychiatrists was rather ad hoc, although all trusts appeared to be aware of the relevance of advice from psychiatrists in hospitals. However, they had generally struggled with obtaining the necessary funding.

Day services

The six trusts varied markedly with regard to the provision of day services. Some did not provide any day care services, with therapeutic activities being provided for people in their own homes. Other trusts provided services differently in each of their localities, with different views on whether day hospital services should be developed or abandoned. One area within a trust had day services that were jointly funded by the local authority and the NHS. It delivered integrated day services for people with dementia, having separate health-provided locality day units for dementia sufferers with challenging behaviour that could be managed in mainstream day settings.

Special groups

Integration with learning disability services was described as being on the basis of need, though in practice learning disability services generally continued to manage people with dementia, with input from older people's mental health services as necessary. None of the trusts provided any specific mental health services for older people in prisons. These were generally provided by the PCTs or through a generic mental health in-reach service provided by the mental health trust.

South West Yorkshire Mental Health NHS Trust was the only trust that felt it had good support for older people with alcohol problems.

Theme 4: Working with other organisations

Commissioning strategy

The most notable issue regarding the development of a joint commissioning strategy was the number of organisations involved and the complexity that this added to the development of a unified vision. Most trusts worked with several PCTs and local authorities, and only one trust worked with one local authority and PCT. While most trusts have aligned at least some of their services to be based on the same boundaries as those of local authorities, the result is multiple models of service and degrees of integration across one organisation. Although all areas had a strategy for older people's mental health and a joint strategic needs assessment, this was not necessarily being implemented convincingly and there was variable engagement between commissioners. However, in one mental health trust that worked with three PCTs and three local authorities, the strategy has been signed off by all health and social care commissioners. They also intend to integrate the health and social care budgets for older people's mental health to allow better integration across the whole geographical area.

Another common issue was the difficulty experienced in commissioning services across the boundary between under 65s and over 65s. The division between services for people under 65 and those for people over 65 was said to be based on reporting and funding mechanisms, as well as differences in performance assessment.

There was also uncertainty about the different models of service required. Where commissioners had made progress with this, it was generally where one manager was responsible for commissioning all mental health services. This allowed seeing across the age boundary to ensure that older people's mental health services received appropriate attention, and acted as a mechanism to assist working in a non-ageist way. Examples included a 'depression pathway' in primary care across all age groups, crisis services that did not stop at 65 years, and a tenancy-supported living service that was not restricted on the basis of age.

The general trend for commissioning appeared to be towards multi-organisational strategies, aligning strategies across boundaries of health and social care and across boundaries for under 65s and over 65s, with the appointment of commissioning leads who were able to span more than one division.

Assessment and planning of care

We were particularly interested to see how trusts were working across organisational boundaries through common assessment and care planning methodologies. There are two assessment and care planning systems in use: the care programme approach (CPA) used by mental health services and the single assessment process (SAP) used by older people's services. This could lead to poor communication between agencies if not managed effectively. In the trusts where this was working best, the CPA and the SAP appeared to be integrated, with the CPA becoming a specialist module of the SAP. One common theme that obstructed trusts' progress with this was the lack of integrated IT systems between health and social services. Where social workers were attached to community mental health teams for older people, they often had to enter data twice, once into the IT system for health and once into the system used by the local authority. Where electronic CPA/risk assessments were in use, they did not integrate into the SAP. Only one area had recently completed work to facilitate sharing data electronically between the trust's and local authority's systems.

Protocols for the care and management of older people with mental health needs

Protocols were in evidence in all six trusts that we visited. Where they were being most usefully implemented, they had been drawn up with multi-agency involvement, and were seen as pathways describing initial assessment, referral processes and inter-agency working. Several trusts found them most useful for managing the interface between mental health services and the acute hospital. One GP, a lead adviser, described using the protocols, or pathways, as the basis of a fluid mechanism for transferring the care of people with mental health needs back to primary care. It was felt that this had a significant impact on reducing waiting times for specialist advice.

The protocols or pathways acted as a focus for educational interventions with primary care, the acute hospital and care homes.

Integration with community mental health teams

Integration between mental health trusts and social services was variable both between and within trusts. The most integrated working teams have been in place for many years, though often the level of integration still varied between localities within the same trust. One trust that had no formal integrated

working across health and social care did have community teams co-located with social services, and this was felt to promote close working. Another trust described integrated working across health and social care in all community mental health teams, and in two localities having formal joint management and delegated independent sector budgets. Here, a governance framework allows the manager of the community mental health team to have responsibility for staff from both organisations and for the budget for purchasing a package of care. This was the only evidence of pooling of budgets across the six trusts. The division between services for under 65s and over 65s was evident in most trusts, with integration for the under 65s service being further advanced.

Where health and social care services were integrated at both team level and management level, and where staff from social care services were managed within the community teams, it was more likely that services offered a higher standard of care and a greater range of services. Services with 'joined up' teams reported that they could build on the knowledge and expertise of each of the disciplines and consequently felt better equipped as professionals. The level of integration had a significant effect on how patients and their carers could access the help they needed and the satisfaction they felt with the services offered. Carers in less integrated services reported that they could often spend a great deal of time and energy trying to find out who they needed to go to for what problem.

Comparative analysis of trusts' self-assessment returns for the annual health check with responses from community mental health teams to the NAO's study of dementia

The patchy integration across trusts was surprising, given that in the Healthcare Commission's annual health check of the performance of mental health trusts, their self-assessment reported high levels of integration of community mental health teams. The integration of community mental health teams has been used as an indicator of performance in the annual health check from 2004/05 to 2007/08. It is a measure of how well specialist older people's mental health services are integrated with social services. The indicator is in two parts, the second part being an assessment of the completeness of a trust's returns to the Older People's Service Mapping. Criteria used to assess integration were produced by an expert working group, with a hierarchy of importance ranging from 1 to 6.

Criteria used to assess integration of community mental health teams

1. The community mental health team has at least two different disciplines from health and a social care worker who is suitably experienced to carry out initial assessment on behalf of the team, meeting at least weekly (face-to-face or by electronic means).
2. Referrals to all members of the community mental health team can be made through a single point of access.
3. Individuals within this team produce and share a current summary record (single assessment process).
4. Individuals within this team use a common assessment process.
5. Individuals within this team carry out a common care planning methodology.
6. Individuals within this team carry out integrated care.

The highest level of integration (6 – integrated care coordination) means that no additional assessment is required to access health or social care resources beyond the usual resource gate-keeping processes, for example financial assessment. The care coordinator, whether employed by health or social care agencies, should be able to access all mental health and social care services without the service user having to undergo any further assessment for eligibility. The expert working group considered this to be an exceedingly demanding level of integration, as there are significant complications in accessing services from another organisation for which you are not financially or managerially responsible, and because social care services are often means-tested. This level was thought only likely to be achieved by organisations with joint funding and management arrangements.

If a service reported itself as having "achieved" this level, it would not only have to satisfy all six integration criteria, but its chief executive would also confirm that the data was complete and correct for every team.

In 2007/08, of the 69 trusts whose performance was assessed, 53 trusts were scored as "achieved" (77%), and 14 trusts were scored as either "underachieved" or "failed" (20%).

In 2006, the National Audit Office (NAO) carried out a study on dementia *Improving services and support for people with dementia*.[20] We compared our own data on the trusts who had declared all their teams to have the highest level of integration on an anonymous basis with the results from a survey of the integration of community mental health teams carried out by the NAO as part of their study.

This included a self-assessment survey of community mental health teams which, among other topics, asked older people's community mental health teams about their integration with social services. Out of 66 trusts, 371 teams took part in this survey, a response rate of 75% of all teams listed in the service mapping database.

In their responses to the NAO survey, only 48% of these trust's teams considered themselves to be integrated, with only 52% reporting that they had a joint management structure and only 17% reporting that some form of joint health and social care funding arrangement was in place. This suggests that teams themselves felt that they were less well integrated than their trust's self declaration would suggest.

When asked what they considered to be barriers to delivering effective care for people with dementia, a lack of joint working between health and social care services was rated as the highest (with 57.5% of teams giving it a rating of 6 or 7 out of 7, with 1 being lowest and 7 being highest importance). The key theme that was considered low on achievement was the lack of joint funding between health and social services.

Key priorities for improvement

To improve the outcomes experienced by older people with mental health needs, and to raise the quality of mental health services for older people, actions need to be taken to improve the following key areas:

- Improving the quality and relevance of data.
- Whole systems working and commissioning.
- Leadership.
- Discrimination.

Improving the quality and relevance of data

We found little robust, easily available national data that could inform the key themes for older people's mental health services identified for this project. We would have been unable to provide any significant analysis on the care given to older people with mental health needs in both primary care and acute hospitals due to the lack of data. The lack of robust data is of particular concern for commissioners and providers of care, in ensuring that they are meeting local health needs, providing good quality care and delivering value for money. It is also a concern for the regulator of services in identifying areas where people may be at greater risk of poor outcomes, and in providing meaningful assessments of performance. What data there is requires analysts who have experience and expertise in working with mental health datasets, and it is still not possible to provide any meaningful analysis if the data is not broken down by age or type of organisation delivering services.

We believe it is vital to improve the availability and robustness of data to enable monitoring and evaluation of older people's mental health services.

Recommendation: The Department of Health, the Information Centre for Health and Social Care and regulatory bodies should:

- Review the quality and focus of national datasets and regulatory assessments to identify gaps and duplication.
- Develop a range of meaningful outcome indicators that build on our monitoring and assessing of local and national progress and support the commissioning of older people's mental health services.
- Develop an effective data source that captures the experiences of those who use older people's mental health services and their carers.

If commissioners and providers of services, the Department of Health and the Care Quality Commission are to be able to assess discrimination in health and social care services on the basis of mental health and age, existing data streams will require additional detail to allow this data to be extracted.

Recommendation: As part of the Department of Health's approach to monitoring the compliance of health and social care organisations with the Equality Bill, a data project should be established to look at the detail required.

Effective services for older people with mental health needs often involve pathways of care across health and social care providers. In developing the approach to registration and performance assessment in the future, it

would be of great benefit to have an approach that allowed a focus on service lines within trusts or pathways of care across organisations.

Recommendation: The Care Quality Commission should investigate methodologies to assess cross-cutting themes in service delivery, and make older people's mental health services a priority in this.

The issue of integration between health and social care services, and the discrimination between older and younger adults in access to specialist social care, requires further focus. The integration indicator for community mental health teams has not been included in the 2008/09 set of indicators for new national targets. This has meant that the indicator assessing completion of the service mapping dataset has also been withdrawn. While this dataset does not currently provide data on outcomes, when combined with the financial mapping exercise it is potentially a very rich source of data on services and comparison with services for younger adults.

Recommendation: Unless other similar data streams are forthcoming, the Care Quality Commission should consider how it might use data from the annual service and financial mapping exercises to inform its work, and how it can encourage services to reliably collect the data required.

The service and financial mapping frameworks provide a potentially rich source of benchmarking performance. This is especially important given the lack of other sources. However, services need to be able to easily extract data by the type of organisation as well as by locality. The Department of Health and the data collating organisation for the service and financial mapping exercises (currently Mental Health Strategies) should ensure that the web portal allows for data extraction by organisation as well as by locality.

Whole systems working and commissioning

Our study was originally intended to be a whole systems review, and it is perhaps illustrative of the difficulty organisations have in maintaining a focus on an issue that crosses organisational barriers, that our study had to gradually narrow its focus in looking largely at mental health trusts. Bringing together the regulation of health and adult social care services in the Care Quality Commission brings some very great potential for driving up standards in older people's mental health, since the issue crosses all organisational boundaries. The Care Quality Commission's consultation proposals for special reviews and studies in 2009/10 include a number that would have direct relevance for older people with mental health problems and their carers. They include:

- Meeting the healthcare needs of people (adults of all ages) in care homes.
- Meeting the physical health needs of people with mental health problems and learning disabilities in hospital and residential settings.
- Assessing how well the health and social care pathway is working for people who have stroke and their carers, and people with dementia.
- Assessing how well health and social care services are addressing equality and

human rights, focusing on commissioning in two or three service areas.

- The value for money covering both quality and cost of care in the areas of diagnostic services in acute hospitals, commissioning and services for older people.

Recommendation: The Care Quality Commission should adopt, at an early stage, topics for further review that identify joint working between primary and secondary care, physical and mental health, and health and social care issues from the viewpoint of older peoples' mental health. Relevant topics for review might include the care of older people in residential settings, and the discharge of older people from acute hospitals.

The latter topic could also examine how well services are meeting the physical health needs of older people, which might involve looking at the care provided in residential and nursing homes or on discharge from acute hospital, as the majority of people in care homes are older people.

The variation in how services are provided between trusts, and even between localities within trusts that we saw during our visits, was striking. Services differed largely on the basis of historical considerations rather than the differing geographical patterns of need. The trusts that we visited varied markedly in their integration with social services, and groups representing patients and staff emphasised difficulties in accessing care for older people with mental health problems within primary care and acute hospitals. Standard 7 in the National Service Framework for Older People, which states that: "Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers", has not yet been achieved.

Holding commissioners and providers to account for good quality care requires a multi-faceted approach, involving assurance from the trust's board, the views of people using services and carers, an analysis of available information (including getting better information on outcomes) and inspection. The NHS Next Stage Review highlights the importance of quality at the centre of everything the NHS does.

Recommendation: Trusts' quality accounts* should include data items that relate to older people's mental health.

The proposed future method of payment by results for mental health[21] has great potential to end age discrimination and bring reality to the aspiration to have services delivered on the basis of need not age, as packages of care will be determined by a common assessment of need.

Recommendation: The Department of Health should ensure that the payment by results system in mental health can be used to drive forward age equality and to monitor progress against this objective.

Given the lack of available data on older people's mental health services, the findings of inspections by past regulators, the concern

* From April 2010, the boards of NHS trusts will be required to publish quality accounts in the same way that they publish financial accounts. These will be reports to the public on the quality of services they provide, looking at safety, experience and outcomes.

raised in this report about trusts' self-assessment, and the shift to ensuring that quality is at the heart of all the NHS does:

Recommendation: The boards of PCTs and mental health trusts should review the quality and appropriateness of their older people's mental health services. The Care Quality Commission should consider making use of this information in the new registration process for NHS trusts.

Leadership

We found clear evidence of the importance of leadership, both clinically at a senior level within trusts, and also in collaborative working across organisations, particularly between commissioners. We found some good evidence of joint working with social services, and of services that did not discriminate on the basis of age despite maintaining a specialist old age psychiatry service. All these organisations had overcome issues that are seen by some as insurmountable obstacles. We also found some good practice with regard to training in care homes and general hospitals.

However, although most areas had a joint health and social care strategy, there seemed to be slow progress in developing a comprehensive model of service from either the commissioner's or the provider's side. The Department of Health's World Class Commissioning programme is designed to deliver a more strategic and long-term approach to commissioning health and social care services, with a clear focus on delivering improved health outcomes.[22] The NHS Next Stage Review also emphasises the importance of clinical involvement and leadership. The Department of Health's service development guide *Everybody's Business*[1] and the Royal College of Psychiatrists' *Raising the Standard*[23] provides descriptions of styles of service and practice.

The National Dementia Strategy, the health and social care community's response to the Equality Bill, and the new vision for mental health (which will provide strategic direction following the NSF for mental health) all hold great potential for older people's mental health services, though they will not deliver change without concerted effort, focus and leadership.

Recommendation: Effective leadership to develop older people's mental health services, with senior clinical leadership and strong central governance structures, is needed across all health and social care organisations that work with older people, as well as all policy-making organisations.

Recommendation: Commissioners' and providers' leaders should work together using the World Class Commissioning approach to deliver improved whole system outcomes. Commissioners and providers should have clearly identified actions for older people's mental health services in the National Dementia Strategy and the Equality Bill.

The National Dementia Strategy recommends senior clinical leadership, a joint commissioning strategy, memory clinics and better care and treatment in all settings.

Recommendation: Commissioners and providers should work together to implement fully the National Dementia Strategy and agree the measures by which its outcomes will be assessed and monitored.

Services have found the older people's mental health programme from the Care Service Improvement Partnership[24] to be a significant resource in disseminating good practice and in supporting change. This could have a major influence on improving the quality of commissioning in older people's mental health services. With the redistribution of central resources to strategic health authorities, there is an ongoing need for a network of strategic leads with a focus on older people's mental health services spanning the SHAs.

Recommendation: Strategic health authorities should ensure that a special interest national network of strategic leads is maintained, with a focus on commissioning and providing older people's mental health services.

Discrimination

Our study is in keeping with other literature which shows that age discrimination exists within adult mental health services, and that some of the attempts to address this are, in themselves, discriminatory and not meeting people's needs. However, we also found evidence of services that had developed approaches to combating ageism, that respected the different needs of some older people and that maintained a specialist focus for particular needs. Groups of staff that we spoke to were proud of working in these services. However, patients and carers also told us that the mental health needs of older people are not being adequately met in primary care and in acute hospitals.

The Department of Health's *Securing Better Mental Health for Older Adults*[11] focuses on a dual approach of providing holistic care in mainstream settings and age equality in mental health services. It provides a vision for how all mainstream health and social care services, with the support of specialist services, should work together to secure better mental health for older adults. We agree that this seems to be right way to ensure equal access to services based on age and mental health.

Recommendation: The Department of Health should develop and introduce an equalities impact assessment to ensure that its own policies, as well as those of regulatory bodies, and health and social care commissioners and providers, reflect the aspirations of holistic care in mainstream settings and age equality in mental health services.

The Scottish Government's equality and diversity impact assessment tool may provide a useful interim solution for organisations wishing to make quicker progress on this. The New Horizons project, led by the Department of Health, is working on the replacement for the existing National Service Framework for Mental Health, which expires in 2009.[25]

Recommendation: The New Horizons Project should ensure that the strategic direction for mental health services includes adults of all ages and tackles age discrimination in mental health services.

One contentious aspect of the guidance in *Everybody's Business* was the perception by some trusts that services 'based on need, not age' meant that specialist services for older people's mental health were no longer required. This led to a clarification note by the Department of Health and the Care Service Improvement Partnership on the meaning of

age equality.[26] The Royal College of Psychiatrists issued a statement in 2007 in response to concerns that reorganisations of services were neglecting the need for specialist services for older people with mental health problems and potentially eroding the specialist skill base.[27] They also released a consensus statement on ageing and mental health, jointly with the Royal College of General Practitioners, the Royal College of Nursing, Age Concern and others. This highlighted the lack of attention being paid to mental health problems in later life and the detrimental organisational changes being made, against professional judgement.[28] The second report of the UK Inquiry into Mental Health and Well-Being in Later Life found that older people with mental health problems face discrimination in policy, practice and research, and reported that some mental health trusts were tackling age discrimination "by decimating older people's mental health services". [15]

However, we also recognise the difficulty for commissioners and providers of services in understanding what a mental health service that respects age equality should look like in practice. We also note the observation of the UK Inquiry into Mental Health and Well-Being in Later Life, that specialists themselves have a responsibility to be clear about what the specialities for general adults and old age can each contribute to the wellbeing of older adults with mental health problems.

Recommendation: The Royal College of Psychiatrists should lead a collaborative approach, with other relevant organisations, to develop models of service for specialist services based on needs, not age. This should include a self-assessment toolkit.

Ageist practices in delivering services may take many forms[15], including direct discrimination (unjustifiably unequal treatment on the basis of age) and indirect discrimination (where an apparently neutral practice disadvantages older people), as well as more subtle ageist negative attitudes based on stereotypes and prejudice. It is a simplistic and flawed approach that considers age discrimination to be removed by giving all adults the same service, or dismantling services purely in the name of equality. Indeed, this would be likely to be discriminatory in itself. Guidance is available from the Department of Health on addressing age discrimination in mental health services while maintaining cohesive specialist expertise in older people's mental health services[26], and discussions on the nature of ageism are available to inform this.[15]

Recommendation: In preparation for the forthcoming Equality Bill, and while awaiting the work of the Royal College of Psychiatrists on age-appropriate services, commissioners and providers of services should assess their services for evidence of discrimination in access to services and start planning on how to address this. Plans should consider how to equitably meet the needs of older people with mental health problems, and not simply provide access to services designed for younger adults.

Conclusions

Although we found that services are still some way from delivering the mental health standard from the National Service Framework for Older People, it would be wrong to give an entirely negative view of the priority given to older people's mental health services nationally or the progress that has been made locally. We found many examples of excellent practice and a committed workforce during our visits to trusts.

There have also been some very clear advances in policy and support for service development over the last few years. Among these we include:

- The publication of *Everybody's Business*.
- The Care Services Improvement Partnership's older people's mental health programme.
- The Mental Capacity Act.
- The inclusion of the dementia register and depression screening in physical illness in the Quality and Outcomes Framework.
- The inclusion of older people's mental health services in the annual service and financial mapping exercise.
- The Dementia Guideline from the National Institute for Health and Clinical Excellence and the Social Care Institute for Excellence.

The Healthcare Commission has also supported the National Audit of Violence that looked at inpatient services for older people with mental health needs alongside those of working age adults,[29] and we are supporting the National Audit of Dementia that will, for the first time, shine a light on at least one aspect of older people's mental health in acute hospitals.

In such a complex area, where data is difficult to obtain and interpret, simple answers do not materialise and required actions are difficult to implement. The way we divide organisations and services in policy, planning, implementation and regulation can potentially de-prioritise an area such as older people's mental health. Past experience has taught us that in order to secure better mental health for older people, there needs to be a coordinated and sustained response at all levels and organisations in the network of health and social care agencies that work with older people. Concerted action is required now. The forthcoming Equality Bill, the National Dementia Strategy and the new vision for mental health services provide a focus, but World Class Commissioning and strong leadership is required to deliver results.

Recommendations

1. Effective leadership to develop older people's mental health services, with senior clinical leadership and strong central governance structures, is required across all health and social care organisations that work with older people, as well as all policy-making organisations.

   Commissioners' and providers' leaders should work together using the World Class Commissioning approach to deliver improved whole system outcomes. Commissioners and providers should have clearly identified actions for older people's mental health services in the National Dementia Strategy and the Equality Bill.

2. The 'New Horizons' project led by the Department of Health, is working on the successor to the existing National Service Framework for mental health, which expires in 2009. We recommend that this project steers the strategic direction for mental health services towards including adults of all ages and tackles age discrimination in mental health services.
3. The Department of Health should develop an equalities impact assessment to ensure that its own policies, as well as those of regulatory bodies, health and social care commissioners and providers, reflect the aspirations of holistic care in mainstream settings and age equality in mental health services.
4. The Department of Health, the Information Centre for Health and Social Care, regulatory bodies and providers should:
    - Review the quality and focus of national datasets and regulatory assessments to identify gaps and duplication.
    - Develop a range of meaningful outcome indicators, in particular around the themes covered in this report, building on our monitoring and assessment of local and national progress and to support the commissioning of older people's mental health services.
    - Develop an effective data source that captures the experiences of those who use older people's mental health services and their carers.
5. As part of the Department of Health's approach to monitoring the compliance of health and social care organisations with the Equality Bill, we recommend that a data project be established to look at the detail required.
6. The Department of Health should ensure that the payment by results system in mental health can be used to drive forward age equality and to monitor progress against this objective.
7. Unless other similar data streams are forthcoming, the Care Quality Commission should consider how it might use data from the annual service and financial mapping exercises to inform its work, and how it can encourage services to reliably collect the data required.
8. The Care Quality Commission should adopt, at an early stage, the topics for further review that identify joint working between primary and secondary care, physical and mental health, and health and social care issues, from the viewpoint of older peoples' mental health. Relevant topics for review might include the care of older people in residential settings, and discharge of older people from acute hospitals. The Care Quality Commission should also investigate methodologies to assess cross-cutting themes in delivering services and make older people's mental health services a priority in this, and consider making use of the information it gathers when reviewing trusts in its new registration process.

9. Strategic health authorities should ensure that a national network of strategic leads with special interest is maintained, with a focus on commissioning and providing older people's mental health services.
10. The Royal College of Psychiatrists should lead a collaborative approach, with other relevant organisations, to develop models of service in specialist services, based on needs not age. This should include a self-assessment toolkit.
11. In preparation for the forthcoming Equality Bill, and while awaiting the work of the Royal College of Psychiatrists on age-appropriate services, commissioners and providers should assess their services for evidence of discrimination in access to services and start planning on how to address this. Plans should consider how to equitably meet the needs of older people with mental health problems, and not simply provide access to services designed for younger adults.
12. Commissioners and providers of services should work together to implement fully the National Dementia Strategy and agree the measures by which the outcomes will be assessed and monitored.
13. Trusts' quality accounts* should include data items that relate to older people's mental health.
14. The boards of PCTs, mental health trusts and local authorities with responsibility for social services should review the quality and appropriateness of their older people's mental health services.

* From April 2010, the boards of NHS trusts will be required to publish quality accounts in the same way that they publish financial accounts. These will be reports to the public on the quality of services they provide, looking at safety, experience and outcomes.

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