Haringey Council

Adults and Health Scrutiny Panel – MENTAL HEALTH AND PHYSICAL HEALTH EVIDENCE SESSION

MONDAY, 13TH JANUARY, 2014 at 18:00 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, LONDON N22 8LE.

MEMBERS: Councillors Adamou (Chair), Bull, Erskine, Stennett and Winskill

Co-Optees: Helena Kania (HFOP)

AGENDA

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. URGENT ITEMS

The Chair will consider the admission of any late items of urgent business. Late items will be dealt with under the agenda item where they appear. New items will be dealt with at the end of the agenda.

3. DEPUTATIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's Constitution.

4. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) Must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) May not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Members' Register of Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

5. CABINET MEMBER INPUT

An opportunity for the Cabinet Member to input into the project.

Attending: Cllr Vanier, Cabinet Member for Health and Adult Services

6. OLDER PEOPLE - SPECIALIST MENTAL HEALTH NEEDS OF PHYSICALLY FRAIL AND OFTEN OLDER PEOPLE WITH LONG TERM CONDITIONS. (PAGES 1 - 36)

To receive a report from Adult services and a presentation by BEH MHT followed by a discussion on the specialist mental health needs of physically frail and often physical and mental health care needs of older and / or frail people with functional mental health problems.

Attendees:

- Dr Therese Shaw (Consultant Psychiatrist for older people), BEH MHT
- Dr Ken Courtenay (Clinical Director), BEH MHT
- Charlotte Pomery, Head of Joint Commissioning, Haringey Council
- Liz Evans, Interim Commissioning Manager, Haringey Council
- Jill Shattock - Director Commissioning, Haringey CCG

7. HARINGEY CCG - DR MUHAMMED AKUNJEE MENTAL HEALTH LEAD

Dr Muhammed Akunjee MBBS, MRCGP (distc.) Lead GP & Clinical Director for SE Haringey, Haringey CCG Board Member, Mental Health Lead Haringey CCG will be attending to talk about the work being done by Haringey CCG and the GP role in mental and physical health.

8. MENTAL HEALTH AND PHYSICAL HEALTH SURVEY (PAGES 37 - 44)

To update the Panel on the mental and physical health survey which is currently live.

The survey can be found at:

http://www.haringey.gov.uk/scrutiny_consultation.htm

9. DISCUSSION

To discuss:

- Any further information needed for the project.
- Draft conclusions.
- Draft recommendations.

Paper to follow

10. MINUTES FROM PREVIOUS MEETINGS (PAGES 45 - 60)

To note and agree the minutes from previous meetings:
17th October 2013
28th October 2013
28th November 2013 (To Follow)

11. NEW ITEMS OF URGENT BUSINESS

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and Member Services
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Tuesday, 07 January 2014

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Agenda Item 6

Mental and physical health care
Briefing for consideration for Overview and Scrutiny agenda:

The specialist mental health needs of physically frail and often older people with long term conditions and severe and enduring functional mental health problems (e.g. psychotic illness, severe depression) are currently met by BEH MHT via the Older Peoples Mental Health Team (who also work with people with people with cognitive impairment and dementia of all ages). Broadly speaking this means that the specialist knowledge and expertise required to effectively support older and / or frail people with functional mental health problems is currently concentrated in the Older Peoples Mental Health Team whilst the other community based mental health services have more expertise in working with younger less frail people.

The future direction for commissioning mental health services is based on whole life course planning; this raises a question about the best service model for the specialist community based mental health support for frail and/or older people: Should services remain as they are currently configured or should there be a move to all age functional mental health services incorporating the needs of older and / or frail people alongside a separate all age cognitive impatient and dementia service. Different commissioners and mental health trusts have opted for different models and there are pros and cons for each option. This question has not been considered in Haringey for several years, it is now timely to consider it again particularly in the context of the Overview and Scrutiny Committee investigation into mental and physical health care and the emerging integration of health and social care commissioning and provision in the future.

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Report for:	**EVIDENCE SESSION, Adults and Health Scrutiny Panel**	**Item Number:**	

Title:	**Physical and Mental health care for older and or frailer people with functional mental health problems.**

Report Authorised by:	**Beverley Tarka - Acting Deputy Director, Haringey Council** **Jill Shattock - Director Commissioning Haringey CCG**

Lead Officer:	**Liz Evans**

Ward(s) affected: **All**	**Report for Key/Non Key Decisions:** **NA**

1. Describe the issue under consideration

1.1. The purpose of this paper is to provide evidence to the Adult and Health Overview and Scrutiny Panel on the physical and mental health care needs of older and / or frail people with functional mental health problems. Many older frailer people will also have multiple long term conditions (LTC's). The term "functional mental health" encompasses depression, anxiety, schizophrenia, suicidal feelings, and personality disorder and substance misuse. It includes those with severe and enduring mental health problems as well as those with more common mental health problems such as mild to moderate anxiety and depression.

1.2. Two related issues are considered in this report; the needs of older, frailer people with LTC's who:

a. have severe and enduring functional mental health problem, and
b. develop common mental health problems often related to the ageing process e.g. bereavement, loneliness, loss of independence, illness and disability.

1.3. This paper does not specifically deal with dementia and cognitive impairment services. It should, however, be noted that older frailer people may have both a

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cognitive impairment and a functional mental health need that also needs to be taken into account.

2. Cabinet Member introduction

NA

3. Recommendations

3.1. That the Adult and Health Overview and Scrutiny Panel include in its investigation into mental and physical health care consideration of the needs of older frail people with a functional mental health problem, many of whom also have multiple long term conditions (LTC's) and their carers.

4. Alternative options considered

NA

5. Background information

5.1. ***The National Policy context***

5.1.1. A key standard in the *National Service Framework (NSF) for Older People* is that older people who have mental health problems should have access to specialist integrated older peoples mental health services. This will help to ensure effective diagnosis, treatment and support.

5.1.2. *Everybody's Business* (Care Services Improvement Partnership 2005) re-asserted that older people's mental health spans both physical and mental health. This is the responsibility of specialist as well as mainstream or generalist services.

5.1.3. *Improving Access to Psychological Treatments (IAPT) – Older People Positive Practice* (Dept of Health 2009) describes the particular needs and issues for commissioning and providing talking therapies to the diverse population of older people experiencing common mental health problems.

5.1.4. *No Health without Mental Health (*Dept of Health 2011) explicitly states that all mental health services should be age-appropriate and non-discriminatory. The six objectives of the strategy are:

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- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

5.1.5. *Guidance for Commissioners of Older Peoples Mental Health* (Joint Commissioning Panel for Mental Health May 2013) asserts that older people should not be prevented from using adult (working age) mental health services where they can meet their needs. At the same time it raises the question and expresses a concern that merging older peoples and adult (working age) mental health services potentially risks causing indirect discrimination against older people. It also states that it is "essential that services sensitive to different needs continue to be provided".

5.1.6. *The Francis Report (The Final Report of the Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust 2013)* found that many of the issues investigated related to the care and treatment of older people and issues of discrimination in relation to their care.

5.1.7. *A Call to Action – No Health without Mental Health:* Thirty leading health and social care organisations (including Directors of Adult Social Services, MIND, Department of Health, The Royal College of Psychiatrists, Rethink and the MH Network of the NHS Confederation) have signed a Call to Action. All recognise the urgent need for co-ordinated action to improve mental health and wellbeing and the life chances and recovery rates of people who experience mental health problems. The organisations signing the Call to Action have committed to work together to ensure a co-ordinated approach to deliver the six objectives of the *No Health without Mental Health* National Strategy.

5.2. ***Prevalence and impact of functional mental health needs on older and frailer people:***

Depression:

5.2.1. Depression is three times more common in older people than dementia. It increases in prevalence in people over 65, especially for those living alone

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with poor material circumstances. Co-morbid depression incrementally worsens older people's health more than either depression alone or any combination of chronic diseases without depression. Depression in later life is a major risk factor in increased suicide, increased levels of natural mortality, and impairment of independent function which necessitates the need for long term care.

5.2.2. Treatment of depression in older people has a similar level of efficacy as for younger people. Recognition rates are lower for older people than for younger people. Only 1 in 6 older people with depression get treatment and only one third of older people are likely to discuss their depression with their GP's. Less than half of these will receive adequate treatment.

5.2.3. Up to 50% of older people in care homes have clinically severe depression and only 10-15% gets treatment. Up to 70% of acute general inpatients beds are occupied by people over 65 and around 30% of these patients also have depression.

5.2.4. The Audit Commission estimated that between 10 – 16% of older people living in cities had depression (Forget Me Not: 2000). Using these figures Table 1 below shows the estimated number of older people in Haringey who suffer from depression (based on the 2011 ONS Interim Sub National Population Projections for Haringeys 65+ population):

Table 1: Number of Haringey residents over 65, predicted to have depression.

	2011	**2021**
Lowest estimate of prevalence - 10%	2,246	2,692
Highest estimate of prevalence - 16%	3,594	4,308

Suicide and self harm:

5.2.5. Whilst suicide rates are declining for all age groups the rate for people over 65 is double that in younger people under 25. 80% of people over 75 who commit suicide have depression and the risk of completed suicide after self harm is much higher in older people.

5.2.6. Haringeys Mental Health JSNA estimates that around 26 Haringey residents commit suicide each year 11% of whom were retired.

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Psychosis:

5.2.7. Psychosis is proportionately more common in older people than younger people. 20% of older people develop psychotic symptoms by the age of 85, most of which are not precursors to dementia. The ONS 2011 census gave a figure of 19,948 Haringey residents aged between 65 and 84. This suggests that there were approximately 3,989 people aged 65 to 84 experiencing some form of psychotic symptoms in the borough in 2011.

5.2.8. Whist schizophrenia beginning in earlier life is more common, the annual incidence of late onset schizophrenic-like psychosis increases by 11% with each 5 year increase from age 60 and up. Older people with schizophrenia include those who have grown old with the condition and those who have developed the illness later in life.

Alcohol and Substance misuse:

5.2.9. Alcohol usage generally declines with age but misuse/dependence on alcohol still affects circa 2-4% of older people. Table 2 below shows the estimated number of older people in Haringey who have problems with alcohol (based on the 2011 ONS Interim Sub National Population Projections for Haringeys 65+ population). There is evidence that there is a hidden group of older people with caring responsibilities who have drinking problems so these figures may be an under estimate. It is also suggested by some that older people who have substance misuse problems need different definitions, diagnosis and treatment to younger people.

Table 2: Number of Haringey residents over 65, predicted to have problems with alcohol.

	2011	**2021**
Lowest estimate of prevalence - 2%	449	538
Highest estimate of prevalence - 4%	899	1,077

5.2.10. Although illicit drug use is predominantly a condition affecting younger people, there is a predicted increase in older people needing treatment for substance misuse by virtue of ageing. This is based on figures emerging from America.

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Black and Minority Ethnic and refuge communities

5.2.11. Different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments.

5.2.12. Patterns of prevalence of mental illness vary across different ethnic communities and evidence is hampered by smaller sample sizes in minority communities. The Mental Health Foundation found that in general, people from black and minority ethnic groups living in the UK are:

- more likely to be diagnosed with mental health problems
- more likely to be diagnosed and admitted to hospital
- more likely to experience a poor outcome from treatment
- more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health.

5.2.13. There is evidence that refugees are especially vulnerable to psychiatric disorders including depression, suicidality and post-traumatic stress disorder. This group also has more complex needs and often have more difficulty accessing health services than the general population. It is estimated that between 25,000 and 30,000 refugees and asylum seekers live in Haringey.

5.3. ***Are older peoples functional mental health needs different to younger peoples?***

5.3.1. Using a needs based approach rather than a strict age related division, the evidence is that older peoples mental health needs are often different to those of younger people. The differences relate to the presentations of mental health problems, and the increased incidence physical illnesses and LTC's in older people. Poly-pharmacy, the risks associated with the use of multiple medications and over prescription of drugs, is more common in older than younger people. Older people often have specific needs relating to medication for both physical and mental health illness.

5.3.2. Differences in schizophrenic-like conditions in older people suggest doubt for some about the condition being the same in older people as in younger people. There is also evidence that older peoples functional mental health problems may need different definitions, diagnosis and treatment to younger people. The involvement of family carers with older people is also often different to carer involvement with younger people; this also requires different levels of understanding and experience.

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5.3.3. The additional stresses and strains experienced by some older people as a result of aging, bereavement, isolation, and caring responsibilities may also impact more negatively on older than younger older people.

5.4. ***The key elements of a good mental and physical health care for older frail people:***

5.4.1. The Guidance for Commissioners of Older Peoples Mental Health (Joint Commissioning Panel for Mental Health May 2013) sets out some key principles that should underpin the commissioning and delivery of services for older frailer people with mental health problems. These are summarised below:

5.4.2. Mental health and emotional wellbeing are as important for older and or frailer people with LTC's as for any other person. Services need to be age appropriate and delivered on the basis of need rather than age. Older people's services should be of the same high standard as for people of working age. All services must be delivered in a culturally sensitive manner, recognising different risk factors and needs across communities.

5.4.3. Staff delivering the care need the right level of skill, knowledge and experience of working with older frailer people. Health and social care services should be aligned and able to work together to meet complex needs. The specific physical and mental health needs of carers must also be catered for.

5.4.4. Clear pathways joining up physical and mental health needs are required to stop people falling through service criteria and boundary gaps. This applies equally to both:

- ~ people with severe and enduring mental health needs getting appropriate physical health care and
- ~ older frailer people having their mental health needs recognised, diagnosed and treated.

5.4.5. Staff across all health and social care organisations working with older frailer people should be able to recognise and care for peoples mental health needs. In the same way staff in specialist mental health services must be able to recognise and care for peoples physical health needs.

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5.4.6. The majority of mental and physical health care for older frailer people is delivered in primary care and community based settings by mainstream or generalist services. Partnership work between specialist teams, expert in supporting older frailer people with mental health problems and generalist mainstream services, is essential. This will help staff in generalist services develop skills in recognition, diagnosis and treatment of mental health problems and vice versa.

5.4.7. Older people with mental health problems can be among the most socially isolated and excluded groups in society. The factors that are important in reducing this isolation and the impact of poor mental health in older people include:

- ~ Reducing stigma and discrimination.
- ~ Increasing participation in meaningful activities and social involvement.
- ~ Promoting physical health, including the ability to carry out everyday tasks.
- ~ Combating poverty.
- ~ Supporting families and carers.
- ~ Helping to build and maintain relationships and community engagement.
- ~ Reducing isolation and increasing community engagement.

5.4.8. The Third Sector, community and faith groups have a unique and valuable role to play in this task along with arts, sports and leisure based organisations. The impact of small scale local community based initiatives significantly contribute to maintaining well being and reducing reliance on more specialist health and social care support services.

5.5. ***Specialist mental health services for older frailer people in Haringey:***

The Older People's Community Mental Health Team

5.5.1. The specialist mental health needs of frailer older people with LTC's and severe and enduring functional mental health problems are currently met by Barnet Enfield and Haringey Mental Health Trust (BEH MHT). BEH MHT provides an Older Peoples Community Mental Health Team that also works with people with people with cognitive impairment and dementia of all ages. Broadly speaking, this means that the specialist knowledge and expertise required to effectively support older frailer people with functional mental health problems is currently concentrated in the older people's team. The

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other community based mental health services provided by BEH MHT have more expertise in working with younger less frail people of working age.

Inpatients services

5.5.2. Bed based inpatient mental health care for people over 65 who cannot be treated or supported at home or in another setting is provided by BEH MHT at Chase Farm Hospital. This inpatient service combines care for both people with functional and cognitive impairment.

The Rapid Assessment, Interface and Discharge service

5.5.3. Haringey CCG has recently commissioned a new enhanced psychiatric liaison service from BEH MHT at North Middlesex University Hospital (NMUH). The Rapid Assessment, Interface and Discharge (RAID) model provides an innovative liaison psychiatry service which will improve quality of care, drive down lengths of stay and reduce readmission rates across the whole spectrum of mental health need in the acute hospital. This service will include older and or frail people with functional mental health problems. The model was developed and implemented at Birmingham City Hospital, and has been thoroughly evaluated and accepted nationally as a benchmark platform for acute hospital liaison services.

5.5.4. The new RAID service is Consultant-Led and made up of a mix of Consultant Psychiatrists, Consultant Psychologist, Social Workers, specialist Psychiatric Nurses and Graduate Mental Health Workers. It provides:

- ~ A 24 hour nurse delivered on-site service to A&E, mainly focusing on adults of all ages with mental health presentations;
- ~ A 9am to 9pm dementia focused service to the wards;
- ~ Support for other non-dementia clinical area's such as Substance misuse and Self Harm;
- ~ An on-going programme of education and mentoring to the acute trust staff which also provides them with on-site mental health expertise to assist with any difficult decisions.

Haringey IAPT *service*

5.5.5. The Haringey Increasing Access to Psychological Therapies service (IAPT) is provided through a collaboration between Whittington Health and BEH MHT. The IAPT service provides high quality psychological therapies to help people manage and overcome anxiety and depression through the provision of:

- ~ guided self-help, stress management skills, computerised cognitive behavioural therapy and psycho-education groups;

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- individual and group cognitive behavioural therapy;
- counseling.

5.5.6. The IAPT service offers support to all age groups but only about 3% of the Haringey users are over 65.

*5.6. **Future commissioning of services to support older and or frailer people with mental health problems:***

5.6.1. People are living longer and older people are disproportionally high users of health and social care services. The impact of older, frailer people's poor mental health is significant, not only for the person themselves but also their carers and society as a whole. Demand is likely to increase unless we can improve people's physical and mental health and wellbeing.

5.6.2. The way CCG's and Local Authorities commission health and social care is changing. In the future there will be more integrated services with pooled budgets offering joined up support and care to people with complex health (physical and mental) and social care needs. The changes will be delivered jointly by the CCG and Local Authority working together on the Department of Health driven initiatives including the allocation of the new Better Care Fund.

5.6.3. The future direction for commissioning of mental health services is based on "whole life course" planning. Ensuring that the particular needs of older and or frailer people are included within this life planning approach is essential.

5.6.4. Commissioners will continue to face the double challenge of providing specialist mental health services for older frailer people with severe and enduring mental health problems, at the same time as ensuring older frailer people with LTC's have access to high quality mental health services. These services include prevention services to support people to maintain good mental health and wellbeing. The range of services commissioners can consider commissioning include:

- preventive public health awareness campaigns and early interventions targeted at older frailer people;
- support and engagement with families and carers to help them maintain their mental wellbeing as well as physical health;
- provision of psychological therapies (IAPT) that is equitable with those for working age adults and which meet the needs of frailer people with multiple LTC's and their carers;

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- ~ provision of acute hospital liaison services that include expertise in older peoples mental health;
- ~ services that are delivered in both community and inpatient settings;
- ~ specialist mental health assessment, diagnosis and intervention services for older and of frailer people that are distinct from those for working age adults.

5.6.5. Careful consideration also needs to be given to the best model for strategic planning, commissioning and provision of specialist mental health support for frail and/or older people in Haringey. Should these functions and services remain as they are currently configured or should there be a move to all age functional mental health commissioning and service provision incorporating the needs of older frailer people alongside a separate all age cognitive impatient and dementia service. This question has not been considered in Haringey for several years and it may now be timely to consider it again particularly in the context of the emerging integration of health and social care commissioning and provision in the future.

6. Comments of the Chief Finance Officer and financial implications

NA

7. Head of Legal Services and legal implications

NA

8. Equalities and Community Cohesion Comments

NA

9. Head of Procurement Comments

NA

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10. Policy Implication

NA

11. Reasons for Decision

NA

12. Use of Appendices

NA

13. Local Government (Access to Information) Act 1985

What is the best service model for the specialist community based mental health support for frail and/or older people

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Presentation to Haringey Overview and Scrutiny Committee.
January 2014.
BEHMHT - Dr Therese Shaw (Consultant Psychiatrist for older people)
Dr Ken Courtenay (Clinical Director).

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Executive Summary - Guidance from the Royal College of Psychiatrists 2011

- From April 2012, unjustifiable age discrimination will be banned in the UK and health and social care services will be legally required to promote age equality in their adult mental health services.
- Of all health and social care services, older people's mental healthcare has been highlighted as one of the worst examples of discrimination. This has been described in a number of high-level national reports.
- There is a danger that commissioners and providers of mental health services, in an attempt to meet the need for equality and to save money, might attempt to merge adult and older people's services into 'age-blind' services.
- This does not recognise age-appropriateness, is against the policies of the government and the Royal College of Psychiatrists, and will result in indirect age discrimination.
- As the population is ageing there will need to be more expertise available for older people, and specialist older people's mental health services will be essential to train future generations to acquire that expertise.

Advantages of ageless services

- Equality of access to acute mental health services
- No discrimination on the basis of age
- Wider range of staff to work with older people
- Utilise resources efficiently

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Disadvantages of ageless services

- Knowledge of impact of physical health and medication on mental health
- Different/subtle presentations of mental illness in older people
- Expert knowledge on ageing
- Co-operative links with older people's medicine and community services
- Competition with aggressive / violent younger adults
- Vulnerability of older people on acute in-patient wards
- Capacity of staff to meet the needs of older people when occupied by managing dangerous patients in the community
- Potential for over-use of medication because of little capacity to manage difficulties of ageing

Mental health risks for **older** people

- Falls
- Suicide
- Multiple medications
- Co-morbid physical health problems
- Self-neglect and weight loss
- Abuse
- Safety in the house, outside and driving
- Hidden substance abuse
- Social isolation
- Having their voice heard

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Current Haringey position:

- Most new patients 65+ are referred to MHSOP
- The majority of functional and complex organic patients are initially seen at home
- Recent review of 87 consecutive referrals to the CMHT showed 12 were under 70 - 14%. (NB some of these patients would be complex dementia).
- Average age 77 and 4 month. This compared to 77 and 6 months in the memory clinic. Age range 61 – 92
- The CMHT is comprised of psychologists, psychiatrists, social workers, nurses and OTs who have specific older adult training and also work with carers.
- The team members have made a choice to work with older adults
- Work with the integrated teleconference project with strong links to LBH, acute hospitals, voluntary sector and community services.
- The CMHT is highly regarded by patients, carers and GPs
- MHSOP does not accept transfer of patients from CMHTs on the basis of age.
- All age groups have access to IAPT, HAGA, DASH, CRHT and RAID

Conclusion

- Haringey MHSOP currently offer a comprehensive, community-based mental health service to older people in conjunction with other Trust teams
- This is replicated across Barnet and Enfield
- It is vital that specialist older peoples mental health services are maintained for a vulnerable patient group but there could be useful discussion about how this should be done

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Thank you

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OP82

The Equality Act 2010 and adult mental health services: achieving non-discriminatory age-appropriate services

Joint guidance from the Royal College of Psychiatrists' Faculties of Old Age and General and Community Psychiatry

December 2011

OCCASIONAL PAPER

The Equality Act 2010 and adult mental health services: achieving non-discriminatory age-appropriate services

Joint guidance from the Royal College of Psychiatrists' Faculties of Old Age and General and Community Psychiatry

Occasional Paper OP82
December 2011

Royal College of Psychiatrists
London

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Contents

Executive summary

From April 2012, unjustifiable age discrimination will be banned in the UK and health and social care services will be legally required to promote age equality in their adult mental health services.

Of all health and social care services, older people's mental healthcare has been highlighted as one of the worst examples of discrimination. This has been described in a number of high-level national reports.

There is a danger that commissioners and providers of mental health services, in an attempt to meet the need for equality and to save money, might attempt to merge adult and older people's services into 'age-blind' services. This does not recognise age-appropriateness, is against the policies of the government and the Royal College of Psychiatrists, and will result in indirect age discrimination.

As the population is ageing there will need to be more expertise available for older people, and specialist older people's mental health services will be essential to train future generations to acquire that expertise.

This document:

- explains what age discrimination is
- gives examples of age discrimination in action
- describes the requirements under the Equality Act 2010, and
- provides guidance on responding to the equality challenge in a non-discriminatory age-appropriate manner.

Non-discriminatory age-appropriate services

What is age discrimination?

Direct age discrimination occurs when a person receives a less favourable service or intervention because of their age alone. Examples of direct discrimination include services developed as part of the National Service Framework for Mental Health (Department of Health, 1999), such as crisis intervention and assertive outreach, which deny access to people 65 and older.

Indirect age discrimination occurs when a service or intervention is provided, often unintentionally, in a manner that puts a person of a particular age group at a disadvantage. This might happen when a service designed for the needs of younger adults is opened up to older people without tailoring the service to the specific needs of many in this age group. Examples include all-age admission wards, and crisis services with staff who have little experience, training and ongoing supervision in old age psychiatry.

What evidence is there that it is happening?

Age discrimination has been recognised as a problem by the Royal College of Psychiatrists (2009*a*), the Healthcare Commission (2009), the Care Quality Commission (2010) and the Department of Health, which even commissioned a report (Beecham *et al*, 2008) that quantified a £2 billion gap in the funding of mental health services for older and for younger adults.

The Equality Act 2010

The Equality Act 2010 created, for the first time, a duty on public sector bodies in the UK to have regard to the need to eliminate age discrimination. From April 2012 there will be a legal requirement to apply this duty to health and social care services.

In some circumstances, however, it may be beneficial to provide services specifically targeting older adults, for example in screening programmes for age-related disorders. Therefore, the Equality Act allows age discrimination if it passes the 'objective justification' test: if it is a

proportionate means of achieving a legitimate aim. It also allows 'positive action' to improve the situation of a group that is discriminated against. In a report on age equality to the Secretary of State, Carruthers & Ormondroyd (2009) cite older people's mental healthcare as an example of a service targeted at older adults that is not discriminatory and could be an example of positive action.

Dangers of merging

Members of the Royal College of Psychiatrists have raised concerns to their Faculty Executive about how commissioners and mental health providers might respond to the need to demonstrate non-discriminatory services. In an attempt to meet this need while coping with current stringent financial curbs there may be an inclination to cut overheads and merge adult and older people's services into 'age-blind' services. This does not recognise age-appropriateness, is against the policy of the government and the Royal College of Psychiatrists and will result in indirect age discrimination.

What national policy says

The policy of the government is clear. Its *National Dementia Strategy* (Department of Health, 2009: p. 73) states:

> 'The nature of risk and need in older people with mental disorders means that, in order to provide services that are of equivalent quality to those available to adults of working age, specific provision needs to be made in terms of specialist community mental health teams and inpatient services for older people with mental disorder. The separation of 'organic' and 'functional' disorders in terms of service provision is essentially a false dichotomy, and one that is likely to disadvantage people with dementia with complex needs and their family carers. Specialist mental health services are needed that can deliver good-quality care that is attuned to the specific needs of older people.'

The government's mental health strategy *No Health without Mental Health* (HM Government & Department of Health, 2011*a*: p. 16) refers to the 'clear evidence that mental health services do not always meet the needs of certain groups, particularly black and minority ethnic communities and older people'. Its companion document, on delivering the strategy (HM Government & Department of Health, 2011*b*: p. 68), states that the government 'is fully committed to ending age discrimination in health and social care by 2012, with no exemptions to the Equality Act 2010 requirements'. This document suggests various current and future measures to assess age discrimination, and references an age equality resource pack and audit tool (Department of Health, 2010) that was at that time being piloted.

The Royal College of Psychiatrists set out its position in 2009 in two statements: *Links Not Boundaries: Service Transitions for People Growing Older with Enduring or Relapsing Mental Illness* (Royal College of Psychiatrists, 2009*b*) and *Age Discrimination in Mental Health Services: Making Equality a Reality* (Royal College of Psychiatrists, 2009*a*). The College believes that all services should be available to people on the basis of need,

not age, and that comprehensive specialist mental health services for older people are essential to appropriately meet need in later life. For people already receiving mental health services, there is no justifiable reason for transferring them to older people's services simply by virtue of their age, but only if their needs have changed and would be better met by those services.

These principles recognise an individual's different needs, the requirement to address those needs in an equal way and not to treat all people the same when their needs are different. Addressing needs in an unequal way, or treating all people the same when their needs are different, would be discriminatory. Discrimination will also exist when inequitable distribution of resources prevents services meeting needs fairly, when older people are required to attend services not designed to meet their needs, or when older people are denied access to services available to younger people that could meet their needs.

Meeting the needs of older adults with mental health problems

As people get older, certain needs become more common. This is due not only to the differences in mental health problems that arise in later life, but also to increasing comorbidity with physical ill health and the psychosocial context in which these problems develop. Although not universally true, older people's mental health services will generally be best placed to assess and meet the needs of people who develop mental health problems in later life. Failure to recognise the changing needs of people as they grow older, so that all people attend exactly the same service regardless of need, will serve people badly and amounts to indirect discrimination.

It is informative to consider how old age psychiatry became differentiated from general adult psychiatry. Old age psychiatry became a recognised specialty within the National Health Service in 1989, having emerged from age-inclusive general psychiatry because the needs of older people were being neglected in these services. The fact that older people's mental health services have since been seen to fare worse than services for younger adults does not mean that they have failed. Indeed, where evidence exists, old age psychiatry services produce better outcomes for older people (Anderson *et al*, 2009). What it does mean is that the continuing age discrimination in mental health policy, commissioning and provision has been recognised. Without the differentiation of old age psychiatry, such indirect age discrimination would have been more difficult to establish. A lesson worth remembering for those services considering reverting to an age-blind approach is that it is age-blind, not age-equal.

The Royal College of Psychiatrists' position statement on age discrimination, endorsed by the Royal College of General Practitioners, the Royal College of Nursing, the British Geriatrics Society, Age Concern and Help the Aged, suggests a list of needs that should be the basis for access to specialist older people's services (Royal College of Psychiatrists, 2009*a*: p. 4):

- mental health problems developing in later life, as these are often of a different nature and require a different approach to treatment than those occurring earlier in life; this applies to a range of conditions, including cognitive disorders, mood disorders and psychoses

- multi-morbidity of both physical and mental health conditions
- cognitive disorder or dementia
- problems related to being at a later point in the life cycle, which include psychological and social difficulties and lifestyle
- frailty
- where other services required are more directed to the needs of older people, for example, particular types of social care needs or care homes.

If older people, regardless of their condition or circumstances, are unable to access specialist older people's mental health services or these services cannot meet the needs of their population because of inequitable distribution of resources, then discrimination will exist.

Competencies required

Competently trained psychiatrists are required to meet the increasing need for psychiatric services for the growing elderly population. The competencies required include not only specialist clinical skills but also knowledge of effective service delivery models. Future trainees will need good-quality specialist old age psychiatry services and well-trained consultant old age psychiatrists from which to gain experience.

The Royal College of Psychiatrists produces competency based curricula for the different psychiatric specialties, based on the General Medical Council's (2009) *Good Medical Practice* and the College's *Good Psychiatric Practice* (Royal College of Psychiatrists, 2009*c*). The College's curriculum (Royal College of Psychiatrists, 2010) outlines the competencies needed to complete core and specialist training for the award of the certificate of completion of training (CCT) required to become a consultant in old age psychiatry. Maintaining competency will be necessary for relicensing and recertification.

Organising non-discriminatory age-appropriate services

The Royal College of Psychiatrists believes that specialist older people's mental health services, with unique expertise in meeting a particular set of needs characteristic of later life, should be provided comprehensively in all commissioning areas. This appears to be in agreement with Department of Health policy. Failure to provide these services would deny older people access to services specifically designed to meet their needs.

However, there may be more than one way to structure an organisation and services to meet the age-equality challenge. For example, in the Healthcare Commission's (2009) national study of older people's mental health, *Equality in Later Life*, two of six trusts visited appeared to have good-quality age-equal services. One trust had merged the adult mental health and older people's mental health directorates into one, with a multi-agency mental health strategy covering both younger and older adults. The other had maintained separate directorates for older and younger adults,

although these worked very closely, with a joint commissioning group and management board for mental health across all age groups. Both had restructured and had made a concerted effort to address age inequality, scrutinising all existing and new policies. Critically, however, both had retained specialist older people's mental health services.

No matter how services are organised and managed, they will need to be set up to meet the needs of older adults in an age-appropriate non-discriminatory way. In addition, to maintain the skills necessary for old age psychiatry, there will need to be a sufficient and ongoing core of specialist knowledge, peer support, supervision and training.

Delivering non-discriminatory age-appropriate services

One challenge for the delivery of age-equal services is having a common understanding of what this means. A National Learning Network, established to inform the development of age-equal mental health services, has generated a working definition (National Development Team for Inclusion, 2011: pp. 14–17). This includes four components:

1 a shared vision of age equality in relation to mental health and well-being, which is essential for establishing the future direction and development of local mental health services, securing a clear commitment to eradicating age discrimination at all levels of policy and practice development and implementation;

2 better outcomes and service experiences for older people, achieved as a result of equal access to and guaranteed quality of services, and support designed to respond to the needs and circumstances of the individual;

3 positive attitudes and mindsets in relation to ageing, older people and mental health that are evident and actively promoted within and across all services;

4 a comprehensive range of responsive, personalised services based on individual needs and circumstances, with particular attention given to:
   - a a clear, strategic approach to planning, commissioning and delivering age-equal services, based on a shared understanding and underpinning principle that people accessing and using local services are defined by their needs and not by their age;
   - b a focus on early intervention and preventive approaches for people of all ages, regardless of their condition/diagnosis, their level of support needs or their eligibility for state-funded support;
   - c making the promotion of well-being, recovery and inclusion the key aim of all services, interventions and treatment;
   - d ensuring that people of all ages can and do access the full range of services, treatments, interventions and therapies available to local communities, and that equality of access is monitored on a regular basis;
   - e ensuring that developments aimed at shifting power and control to those using/needing services and support are equally applied and experienced across all age groups.

Age, in itself, is clearly unsatisfactory as the single criterion for access to services in later life. No person should be required to attend older people's mental health services by virtue of their age alone. Nor should they be prevented, because of their age, from attending alternative services that better meet their needs.

No one already receiving mental health services should be transferred to older people's services simply because of their age. The only justification for such a transfer is if their needs have changed and would be better met by those services. This principle is already set out in the College's report on service transition as people move into old age (Royal College of Psychiatrists, 2009*b*).

There may be younger people for whom older people's mental health services would be appropriate. These include people with young-onset dementia, as described in *Services for Younger People with Alzheimer's Disease and Other Dementias* (Royal College of Psychiatrists, 2006).

There will be people whose needs could equally be met by more than one service – a person should be able to choose, with advice from professionals, the service they prefer.

There will be people who have complex needs who require more than one service. In these cases, there must be close collaboration between services and a clear agreement that one service will take the lead role to ensure clear clinical and managerial accountability and properly coordinated care.

It is essential that all mental health services collaborate, whenever necessary, to make decisions based on a person's needs and that accountability remains clear at all times.

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Understanding barriers to staying healthy and ways to overcome them

The Adults and Health Scrutiny Panel of Haringey Council is looking at the physical health of people with mental health needs; the barriers people face in trying to stay healthy and finding ways in which these can be overcome.

This survey will help the panel understand the physical health of local people with mental health needs in order to develop recommendations that can help to improve local services. Recommendations will be presented to local organisations that provide services for people with mental health needs including the Barnet, Enfield & Haringey Mental Health Trust, Haringey Council and Haringey Clinical Commissioning Group.

As a local mental health service user or carer of someone with mental health needs, I invite you to complete this short survey. It is anonymous (you don't have to give your name) and it should take no longer than 10 minutes to complete. I would be grateful if you could complete this survey before Monday 3rd February 2014.

Cllr Gina Adamou, Chair of the Adults of Health Scrutiny Panel

Please note, the survey needs session cookies enabled on your browser, otherwise you may experience problems filling in the survey. We use session cookies to allow you to page through the survey without losing any information. No personal information is stored or obtained from your computer. If you're unsure how to enable session cookies, please visit www.haringey.gov.uk/cookies

1. **I am completing this survey as a:**

- ○ Mental health service user
- ○ A carer of someone with mental health needs

2. **How would you describe your current physical health? (Please tick ONE box only)?**

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

3. **How would you describe your current mental health? (Please tick ONE box only)?**

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

4. **When was the last time you met with a Mental Health worker? (Please tick ONE box only)**

- ○ Less than 1 month
- ○ 1-2 months
- ○ 3-5 months
- ○ 6 months or more

5. Are you registered with a local doctor (GP)?

- ○ Yes
- ○ No

6. If yes, when was the last time you visited your doctor (GP)? (Please tick ONE box only)

- ○ in the past 3 months
- ○ between 4 and 6 months ago
- ○ between 7 and 11 months ago
- ○ between 1 and 2 years ago
- ○ more than 2 years ago

7. When was the last time you had a physical health check up? (Please tick ONE box only)?

- ○ in the past 3 months
- ○ between 4 and 6 months ago
- ○ between 7 and 11 months ago
- ○ between 1 and 2 years ago
- ○ more than 2 years ago

8. Do you think that any of the following may be affecting your health? (Tick as many boxes as apply)?

- ☐ Smoking
- ☐ Eating unhealthily
- ☐ Weight
- ☐ Alcohol
- ☐ Tooth ache
- ☐ Eye sight
- ☐ Stress/anxiety
- ☐ Problems at work / unemployment
- ☐ mental health
- ☐ Feeling depressed
- ☐ Lack of exercise
- ☐ Sexual Health
- ☐ Medications
- ☐ Drug use
- ☐ Feeling lonely
- ☐ None of these issues are affecting my health
- ☐ Other physical health problems

Please describe:

9. Have you felt physically unwell in the last 12 months?

- ○ Yes
- ○ No

10. When you have felt physically unwell have you experienced any of the following problems in getting the help that you needed?

- ☐ I didn't know where to go to get help in the NHS
- ☐ There were problems getting an appointment with my GP (doctor)
- ☐ I felt embarrassed talking about personal health issues
- ☐ I hoped the problem would go away so didn't seek help at first
- ☐ I was anxious that I wouldn't be listened to due to my mental health needs
- ☐ There are other things that have stopped me from seeking advice when I was physically unwell

Please tell us what these were:

11. Have you taken any steps over the past 12 months to improve your physical health?

- ○ Yes
- ○ No

If yes, please describe what this was

12. If you wanted to maintain or improve your health (for example lose weight, do more exercise or stop smoking) would any of the following issues stop you?

- ☐ I don't know who to talk to about this
- ☐ I don't have enough time
- ☐ This is not a priority for me at the moment I need to focus on my mental health
- ☐ I don't feel that I would be taken seriously because of my mental health
- ☐ I don't feel unwell
- ☐ Health workers do not understand mental health
- ☐ I don't like the preaching attitude of health workers
- ☐ I already know what to do to keep healthy

13. What other reasons might stop you from seeking advice about how to improve your health?

14. If you wanted support to stay healthy, which of the following things be helpful?

	Yes	*No*
Face-to-face advice from a health professional	○	○
A local group to discuss health issues	○	○
A booklet with information about local health services	○	○
Health information/ tips to your mobile	○	○
A website of local health information	○	○
Discounted health and fitness membership	○	○

15. Is there any other support that you need that could help you stay healthy?

16. Please us the space below to describe services which work well to support you, could do more to help, or have any suggestions that could help local people with mental health issues improve their physical health?

About You

Asking questions about you can help us improve the services we deliver to the community, monitor what different groups of people think about a particular service or issue and influence decisions that affect them.

17. What is the first part of your post code? (For example, N22)

18. What is your age group?

- ○ *Under 20*
- ○ *21-24*
- ○ *25-29*
- ○ *30-44*
- ○ *45-59*
- ○ *60-64*
- ○ *65-74*
- ○ *75-84*
- ○ *85-89*
- ○ *90+*

19. Which ethnic group best describes you?

- ○ *White category*
- ○ *Mixed category*
- ○ *Asian or Asian British*
- ○ *Black or Black British*
- ○ *Chinese or any other ethnic group*

20. Are you?

- ○ *Male*
- ○ *Female*

21. Do you have a religion or belief that you would like to mention? If so, please tick the appropriate box

- ○ *Christian*
- ○ *Muslim*
- ○ *Jewish*
- ○ *Buddhist*
- ○ *Other*
- ○ *Hindu*
- ○ *Sikh*
- ○ *Rastafarian*
- ○ *No religion*
- ○ *Prefer not to say*

Any other religion, please specify

22. Please tick the box that best describes your sexual orientation?

- ○ *Heterosexual*
- ○ *Bisexual*
- ○ *Gay*
- ○ *Lesbian*
- ○ *Prefer not to say*

23. Are you

- ○ *Single*
- ○ *Married*
- ○ *Co-habiting*
- ○ *Separated*
- ○ *Divorced*
- ○ *Widowed*
- ○ *In a same sex civil partnership*

24. Are you

- ○ *A Refugee*
- ○ *An Asylum Seeker*

25. What country or region are you a refugee/asylum seeker from?

26. Please tick the box which best describes your language?

- ○ *Albanian*
- ○ *Arabic*
- ○ *English*
- ○ *French*
- ○ *Lingala*
- ○ *Somali*
- ○ *Turkish*
- ○ *Other*

Any other religion, please specify

Thank you for completing this survey. The information that you have provided may help to improve physical health services and support available to people with mental health concerns.

MINUTES OF THE ADULTS AND HEALTH SCRUTINY PANEL
THURSDAY, 17 OCTOBER 2013

Councillors Adamou (Chair), Erskine, Stennett and Winskill

LC35. APOLOGIES FOR ABSENCE

Pam Moffatt, HFOP
Mabel Kong-Rawlinson, Healthwatch
Mike Wilson, Healthwatch
Sarah White, MHSA
Cllr Bull

LC36. DECLARATIONS OF INTEREST

None received.

LC37. URGENT ITEMS

None received.

LC38. MENTAL HEALTH AND ACCOMMODATION

The Panel heard from BEH MHT with the following points noted:

- The average length of stay on a mental health ward is 20 days.
- There are currently 158 acute beds across the Trust (49 in Haringey), 31 recovery house beds and 18 beds being used in bed and breakfast accommodation.
- Approximately 40% of the beds in recovery houses are 'blocked' – where they are being used by people who are well enough to leave the recovery house.
- There can be 7 or 8 people a day waiting for a bed to become available on a Ward.
- The day prior to the meeting there was:
    - 11 people waiting for a bed;
    - 16 patients ready to leave but with nowhere to go.
- There is a desire to look at a person's accommodation issues earlier in the process, whether this is day one of admission or when a person begins to break down.
- BEH MHT is a hospital service and people should not be on the Wards for longer than necessary and at a cost of £285 per day.
- There is a desire to work in a constructive way and raise the profile of the mental health client group.

- There is a proportion of people on the wards and in recovery houses every day who should not be there and it is not good for these people to be there when they do not need to be.
- BEH MHT is working with Re-Think to employ a dedicated Accommodation Case worker who will solely focus on people's accommodation needs for leaving the MHT.
- People with mental health needs can find it difficult to concentrate for long periods of time, manage their finances etc – all of which need to be considered when looking at a person's accommodation needs.
- Mental health pressures across the country have increased over the past 6 months, including in Haringey. This is believed to be due to the economic situation.
- The nearest bed available for a Haringey resident recently was in Pontefract. To avoid the person having to go to Pontefract they stayed in the S136 suite overnight until a bed became available.
- There is one Recovery House in Haringey, this is situated in Fortis Green and has only 7 beds. This is not enough for Haringey. Ideally there should be more Recovery House beds and they should be situated where the need is e.g. in St Ann's Ward.
- The issues around moving people on from Ward/Recovery Houses include a person not wanting to move on as they feel secure, are being fed and kept warm etc. It can also take 4-5 weeks for electricity to be re-connected to a property.

In response to questions from the Panel:

- Every person known to the MHT has a Care Coordinator assigned to them.
    - It was acknowledged that there may be issues around the work loads of Care Coordinators and that there is a need for an increased focus to get the service overall back on track.
- Approximately 95% of patients across the 3 borough have the right to abode in the UK.
- There is a need to be more creative about the use of pooled budgets.
- People attending mental health panels are not always as prepared as they should be.

- Sometimes a person does not have any accommodation to go to and sometimes there is accommodation but it is in a dreadful state.
- There are clearly issues about the process involved and time taken in ensuring someone has accommodation. The Re-Think enablement Officer should help a lot with these issues.
- There is a need to have more vigour in the process right from the start.
- There are approximately ten people today on mental health wards who could be deemed as homeless. The MHT questioned whether the Council would have places for these people should they be deemed as in priority need and was informed that the Council has a statutory duty to house these people and they would therefore find places.
- There is a 'Top Delays' meeting every Monday which is attended by the Vulnerable Adults Team. An issue which has been raised at these meetings is that there is a lack of places to discharge people to.
- Within the first 72 hours of a person's admission their housing need is identified.
- The Head of Housing Support and Options informed the Panel that they had previously offered a surgery at St Ann's Hospital to try and address some issues and it was noted that the proposed Reablement Officer may provide this link.
- Housing Support and Options need to be informed earlier than is currently happening so that they can address any problems with a person's accommodation for example, if a front door needs to be replaced or the accommodation needs a deep clean.
- There is a need to remember that not everyone wants to return to their previous accommodation and that there are a variety of reasons for this.
- There is a need to build a closer working relationship across the organisations earlier and as an ongoing part of the process in settling someone into accommodation.
- There are some people who will never be able to live alone, and whilst they may not need hospital care they may need some sort of supported or sheltered living arrangements.
- Approximately 50% of people of people lose their Housing Benefit whilst in hospital, this means that they therefore lose their tenancy.

- **It was agreed that BEH MHT would look at whether it would be cost effective for BEH MHT to pay a person's rent whilst they are in hospital, therefore avoiding a loss of tenancy and a person therefore being in hospital longer than necessary**.
- The cost of running a Ward over a year is approximately £1.5 million.
- Private sector beds cost £800 per night.
- BEH MHT is currently running at a 105% bed occupancy rate. The optimum bed occupancy rate is 85%.
- Due to the increased demand there is no flexibility in the system at present.
- Rod Wells noted that there are not enough beds at St Ann's Hospital at present and asked how another Ward could be included in the St Ann's redevelopment. BEH MHT responded by noting that the whole process needs to be strengthened in order to free up the beds where people do not need to be in hospital and therefore make room available for someone who does need to be in hospital. It was also noted that the BEH MHT is moving towards more community based services, however there had been plans to close a Ward approximately 12 months ago. Due to the increased demand over the last 6 months this had not been possible.
- The St Ann's redevelopment application will include space for extra beds, however the question is how many beds will the Commissioners commission and therefore fund?
- The Haringey Clinical Commissioning Group (CCG) welcomes the scrutiny focus on accommodation and is keen to move towards a recovery model. The CCG would also welcome focus on S117 cases (aftercare).
- BEH MHT are currently running three Wards which are not commissioned – these include a private Ward and Somerset Ward.
- BEH MHT can not see demand getting better any time soon, however if the system can be unblocked this would help.
- Occupancy, funding and bed numbers have been benchmarked and BEH MHT do well against statistical neighbours. Haringey is below the London average on number of beds per population, length of stay and funding. **It was agreed that this information would be made available to the Panel**.
- There are only 7 recovery house beds in Haringey, rather than the 12 which BEH MHT had wanted.

- BEH MHT are funding ten places at the Pavillion on a trial basis – these places will be a structured place for people to go and there will opportunities for cooking, CVs etc.

The Panel then heard from Claire Drummond, Commissioning Manager, Housing Related Support.

- Housing Related Support offers accommodation based and floating support for a range of needs, including mental health.
- Floating support includes training, well-being and employment.
- The service is in the process of commissioning a new pathway for drugs and mental health which will extend the availability of accommodation by 36 units. This new pathway should be in place by 2015, with some units commissioned for 2015 and some for 2016. The pathway coordinator role is currently being recruited into.
- Some people come into the service at the higher need support end and move to lower support or come into the service at a lower support end.
- There is an issue with a number of the units at present, where it is no longer appropriate for a person to be in them. This is being worked through with the Community Mental Health Team (CMHT).
- Supporting Housing units should be for 18 months to 2 years. However, approximately 50% of the units have people in them who have been there for over 2 years. The 50% are being looked at on a case by case basis with Adults Services and the Community Mental Health Rehabilitation Team in order to move them on. As part of this project a needs analysis will be undertaken and any gaps in provision found will form part of future commissioning plans.

In response to questions from the Panel:

- After the 18 month to 2 years a person is in supporting housing a Pathway co-ordinator and a member of the Vulnerable Adults Team sits down and discusses options. This can include finding housing through mainstream routes e.g. private renting or thorough housing options.
- The Panel raised concerns about a person being placed in private accommodation with no support and noted that in these cases a person's

mental health can deteriorate very quickly and was informed that floating support is still available at this stage.

- 24 hour supported living is commissioned by Adult Services.
- A supported living arrangement for 6 mental health service users at Truro Road is being developed and should be ready for March 2014. Following this there are plans for further developments.
- The delays in move on are historic. A number of the cases where issues have been identified are due to the care element for example where the care coordinator does not believe a person is ready to be moved on.
- There are people in housing related support who have higher needs than can be delivered by the service.
- There is a need for joint commissioning for care and support.
- There is a need for stepping stones along the whole pathway as opposed to silos of working.
- Public Health raised a query as to how many of the 195 people in housing related support were from out of borough placements which then place a demand on services in Haringey and whether there is any data on this. **It was agreed that BEH MHT would have a look to provide this data to the Panel**.
- The Chair asked attendees to each highlight three issues/actions:
    - Process links need to be developed. This could include a short pact/protocol with accountability and which is signed up to by all parties.
    - Greater impetus behind move-on.
    - Future joint commissioning throughout the pathway.
    - More work on the preventative side e.g. housing benefit payments not stopping, more communication about where people are.
    - S177 unblocking.
- **It was agreed that further thoughts would be emailed to Melanie Ponomarenko.**

- **It was agreed that a glossary of terms would be compiled.**

LC39. MENTAL HEALTH AND PHYSICAL HEALTH

The Panel received a presentation from Dr Tamara Djuretic and Dr Fiona Wright.

Key points noted:

- Map showing where there are a greater proportion of people with schizophrenia is also the same areas where there is increased deprivation.
- Haringey is in the top 3 in London for the number of suicides, within this men are more likely to commit suicide and those in the East of the borough are more likely to commit suicide.
- 48% of people who claim benefits have a mental health need.
- Not enough dementia or depression cases are being detected.
- There are 3,000 people living with psychosis in Haringey – much higher than the expected number of 1,000.
- The GP data shown in the presentation is not Quality Outcomes Framework data. It is data extracted from the database.
- Haringey has started recording whether someone has a mental health problem or is taking medication for a mental health problem at smoking cessation services.
- There are issues around mental health and smoking cessation for example a person may not want to access the services. There is also a need to consider the reasons why a person started smoking in the first place.
- There is a two way relationship between mental health and physical health.

In response to questions:

- More GP data is available, but this data needs to be validated before it can be shared. **It was agreed that once the data is validated it will be shared with the Panel**.
- **It was agreed that Public Health will look at data for hospital admissions and see whether data on the number of people with an underlying mental health need can be extracted**.
- The Panel asked for the reasons behind: “Of those who have coronary heart disease (CHD) and diabetes, 91% were screened for depression and of those who have other LTCs, only 10% were screened for depression” and was informed that it could be reasons such as whether one screening was incentivised for example through QOF or it could be that there is a greater awareness of the link between CHD and depression.

- A report by Re-Think (Lethal Discrimination) noted that physical problems are sometimes seen as psychosomatic and are therefore not investigated and treated properly.
- The focus on mental health needs can often be detrimental to physical health needs.
- There seems to be a split between physical health and mental health whereby a person is seen to have either physical or mental health needs and not both.
- The majority of people which come under the scope of this project are already in contact with NHS services.

Discussion points:

- It was noted that BEH MHT are training all GPs in mental health at present (Mental Health Academy).
- IT systems between BEH MHT and other Trusts are not joining up so the information across a person's health is not marrying up.
- Men present later and there is a higher proportion of men with mental health needs.
- Social determinants have a significant impact on a person's mental health e.g. social isolation.
- The government has released £3.8 billion for integration between health and social care services (Integration Transformation Fund).
- There needs to be a greater utilisation of the voluntary and community sector.
- The Mind in Haringey representative noted that people with mental health needs who have visited their GP to discuss issues have often been referred to their consultants rather that the GP deal with issues. It was also noted that dentistry and optometry are key areas of a person's physical health and that these are often also ignored in people with mental health needs.
- Mental Health is only touched on in GP training.
- Attendees were asked for three areas of focus for mental and physical health:
    - Coordination and leadership – with clear lines of responsibility for who leads on what.
    - Training issues, especially for primary care.
    - Annual physical health checks for people with mental health needs.
    - Whole system approach – get rid of silo working.

- Prevention – can BEH MHT refer people to stop smoking services. The training for doing this is just ½ a day.
- Need to remember that people with mental health needs often have multiple needs and issues.

LC40. NEW ITEMS OF URGENT BUSINESS

None received.

LC41. FUTURE PROJECT MEETING DATES

Mental Health and accommodation

15th November, 10-12.30

Aim: To gain an understanding of the care pathway and how different agencies work together and fit into the care pathway.

17th December, 6.30-9pm

Aim: To gain an insight into patient experiences.

9th January 6.30-9.30pm

Aim: To discuss and agree conclusions and recommendations

(*Joint with physical health project*)

Mental health and physical health

28th October, 6.30-9pm

Aim: To gain an overview of what services are currently provided to improve the physical health of people with mental health needs

28th November, 7-9.30pm

Aim: To gain an insight into patient experiences.

9th January 6.30-9.30pm

Aim: To discuss and agree conclusions and recommendations

(*Joint with accommodation project*)

MINUTES OF THE ADULTS AND HEALTH SCRUTINY PANEL
THURSDAY, 17 OCTOBER 2013

Chair

MINUTES OF THE ADULTS AND HEALTH SCRUTINY PANEL
MONDAY, 28 OCTOBER 2013

Councillors Adamou (Chair), Bull, Erskine, Stennett, Winskill and Moffat

LC42. APOLOGIES FOR ABSENCE

Cllr Stennett
Dr Tamara Djuretic

LC43. DECLARATIONS OF INTEREST

None received

LC44. URGENT ITEMS

None received

LC45. PUBLIC HEALTH

The Panel heard from Dr Fiona Wright, Assistant Director, Public Health.

The following points were noted:

- Mental health is covered in two outcomes of the Health and Wellbeing Strategy – Outcome 2, A reduced gap in life expectancy and Outcome 3, Improved Mental Health and Wellbeing.
- Public Health tries to target or make accessible all programmes to people with mental health needs. An example of this is in reducing smoking prevalence where the stop smoking service has Key Performance Indicators to target people with mental health needs and to work with BEH MHT. However, the target is currently low yet not being met. A possible reason for this would be the discomfort people have in asking about mental health needs, and therefore information is not recorded.
- Acknowledge that more work is needed on recording information about mental health needs – specialised clinics are enforcing data collection but more work is needed to ensure that GPs and Pharmacists are also collecting the data.
    - The data is needed to monitor and assess what is working and what isn't working.
- **Physical Activity** - Active for Life is a large physical activity programme. It is a GP referral scheme targeted to the East of the borough and on people with long term conditions.

  - Last year there were 800 referrals – 11% of which was people with mental health needs.
  - 54% of those referred to the scheme are still active 6 months after the programme ends.
- **Alcohol** - Public Health have a contract with BEH MHT to provide a dual diagnosis service. The challenge is people completing the course as people can come out of hospital before it has finished. There is a need to better link with GPs in order to complete these.
- **Cardio Vascular Disease and Cancer** – Under the Health and Social Care Act it is mandatory for Councils to provide Health Checks for those between the ages of 40-74 years of age.
  - Health Checks are mainly commissioned through GPs.
  - A programme has been commissioned to focus on those with mental health needs. So far 62 people have had a health check through this.
  - Health Checks are aimed at people who haven't yet got an illness – it is a preventative programme. If you already have, for example, diabetes then you should already be being treated and have an annual review of your health.
- **Health Trainers and Champions** – historically the focus has just been on physical health, however they have now had Mental Health First Aid training.
  - Anyone can refer to a health trainer, including in the West of the borough, however, services are located in the East.
  - Over 1000 people were seen by Health Trainers last year:
    - 80% were from deprived areas
    - 85% were from BME communities
    - 80% achieved their goals.

Discussion points noted:

- How do leisure centres gear themselves up for those with mental health needs?
- Mind in Haringey runs sessions in Tottenham Green Leisure Centre – this includes Yoga and Thai Chi.
- There is a need to systematically roll programmes out across all GPs as the practices who are more engaged generally are more like to be engaged with their patients.

- 70% of those who go through the drug and alcohol services have mental health needs.
- There is no local data on the cancer survival rate of people with mental health needs.
- There is a need to get messages out to people about the benefits of exercise etc on mental well being. This is likely to be done by GPs, but possibly not every GP.

LC46. BEH MENTAL HEALTH TRUST

The Panel heard from Dr Ken Courtenay, BEH MHT. Key points noted:

- BEH MHT has had a physical healthcare policy since 2006. This is due to be revised in 2015.
- There has been a big push around physical health over the past few years. This has in part been due to the CQUIN (Commissioning for Quality and Innovation – a contract between the CCG and the MHT which means that if a target is met the MHT get a reward), however work was ongoing beforehand.
- The MHT is very aware of the impact that medication has on weight.
- When a person is referred to the MHT an assessment of their needs is done. This includes whether they smoke, what medication they are on and a lifestyle questionnaire.
- There are boundaries between primary and secondary care – the MHT work on the basis that physical health is everyone's business.
- If a person is in the community they enlist a person's GP and ask them to deal with a person's physical health.
- If the person is within the MHT then they work with Junior Doctors and inform the person's GP.
- Smoking is a huge problem. As well as the physical health effects of smoking it has a direct effect on medication – for example a person can need a higher dose of medication when they are smoking.
- Acknowledge that there is more than can be done for example actively motivating people in a non-judgmental way rather than just referring on to another service.
- Hospitals are smoke free, however there are issues around enforcement.

In response to questions the following points were noted:

- Weight is a problem when a person stops smoking. This is not focused on as a big issue at the outset as actually stopping smoking is such a big deal. Weight issues can be managed afterwards.
- People with mental health needs are eligible for a health check and this is covered on the Quality Outcomes Framework.
- A carer noted that her son gone from 12 stone to 19 stone over ten years and since being on medication. There is a feeling that people are not told about the weight impact of medication in order to ensure that the person takes the medication. There should be an intervention earlier around weight as putting on weight can have side effects such as low self esteem. It is also very difficult for people to motivate themselves to lose weight.
- The carer also noted that exercise classes use to be run by the MHT at Tottenham Green Leisure Centre but that these no longer take place.
- There was a feeling that a weight management/loss class for people with mental health needs would be beneficial.
- Dr Courtenay informed the Panel that there is a Well-being clinic and that at the clinic a person's BMI and waist circumference is taken. However a carer noted that whilst this is the case, nothing is done with the information.
- Dr Courtenay noted that a dietetic input is missing and that there needs to be a better link between community dieticians and the MHT.
- There is a need to look at how often medicines are reviewed and within this a look at whether they can be reduced.
- People may not always been informed at the outset of the side effects of medication due to what they are going through at the time.
- Dr Wright asked Dr Courtenay whether MHT staff are trained in brief interventions and motivational interviewing as it can often be a difficult subject for people to broach. Dr Courtenay responded that most do not have this training, but some do. The training is being rolled out further but not as systematically as it could be.
- There is a Mental Health Stop Smoking CQUIN which is currently in it's second year.
- Blood tests on admission to check for certain health conditions would not be possible as there needs to be a clinical indication/reason in order to do this.

- Care Plans incorporate physical health and are shared with GPs. The GP would be primarily responsible to deliver this as GPs need to have a full picture of all of a person's health needs. If a person is on a Care Programme Approach then it would be the responsibility of the Care Coordinator liaising with the GP.
- The Panel are how responsive GPs are in actively managing Care Plans and was informed that in Dr Courtenay's experience they are relatively good.
- There could be more partnership working between BEH MHT and Whittington Health on the ground, for example liaising and sharing information.
- There is regular communication between senior pharmacists and community pharmacists. However, the Panel were interested to hear more about this and agreed that this would be followed up by the scrutiny officer with the Local Pharmaceutical Committee.
- GPs are not expected to attend CPA, but they are invited.
- Any recommendations of the Panel around the CPA would need to go to NHS England.
- In response to a question about what can be done to improve the following ideas were given:
    - Communication within 48hrs with GP's – faxes are sent by practitioners to services. Primary Care needs to be able to handle all of the information which is sent to them. If a fax is sent to a GP surgery, what happens to the information?
    - CPA – areas where there is shared responsibility need to be laid out clearly and there needs to be good communication between the parties.
    - CPA meetings could take place in the GP practice to try and encourage GPs to be attend. GP attendance is beneficial as it improves relationships, for example between GPs and local psychiatrists.
    - A CQUIN around discharge data being passed on within 48hrs. Currently failing in this area. (A CQUIN was put in place 6 months ago in order to encourage improvements around communication).
    - CQUINS are a good lever to get improvements made.
    - Primary care should be more involved in the acute setting.
    - More training needed.

- A gym/out door gym on the redeveloped St Ann's site would be beneficial.

AGREED:

- BEH MHT would send the Physical Healthcare policy to the Scrutiny Officer
- CCG would send data on the Mental Health Stop Smoking CQUINN
- QOF data on MH health checks – Scrutiny Officer to look at.
- Scrutiny Officer to make contact with the Local Pharmaceutical Committee.

LC47. HARINGEY CLINICAL COMMISSIONING GROUP

Deferred

LC48. NEXT STEPS AND FUTURE MEETINGS

Evidence session 3 – 28th November – service user/carer/voluntary and community sector session

LC49. MINUTES FROM LAST EVIDENCE SESSION

Agreed

LC50. NEW ITEMS OF URGENT BUSINESS

None

LC51. DATES OF FUTURE MEETINGS

As above.