

Faculty of Psychiatry for Old Age
Notes from Strategy Meeting
held on Wednesday 23rd November 2011
in Council Room



Overview

Peter Connelly, Chair, outlined the progress of the Faculty over the past year (see Appendix).

Working Groups

Peter, Andy and Krish introduced the three themes for the Strategy day:

- A. Recruitment and retention
- B. Cost-effective services
- C. Links with Primary Care

Small groups discussed these themes, checked their preliminary work with the whole group after lunch, and then continued the discussion in the afternoon, with some participants changing groups. The following are the main outputs of the three groups.

A. RECRUITMENT AND RETENTION

Discussion group: Rob Stewart (chair), Stuart Ritchie, Peter Connelly, Rafi Arif, Vicky Osman-Hicks, Deborah Girling, Martin Brown, Laurie Beed.

Background and remit

Although it is accepted that Old Age Psychiatry Consultant Staffing in the UK requires to increase in response to demographic and other pressures there is considerable anxiety amongst trainees and consultants that the future of Old Age Psychiatry as a specialty is under threat. The primary reason cited for this is the creation of "age inclusive" services for people over 18 who have functional illness. In turn this is considered by some groups to be the most appropriate solution to problems faced under Age Equality Legislation. In addition, however, the drop out rate amongst core trainees is much higher than anticipated under MMC. Consequently at a time when consultant expansion needs to be planned there is a potential shortage of high quality trainees coming into the pool.

This affects both clinical and academic arms of the service. The work of the subgroup is to consider strategies to ensure that potential recruitment and retention of Old Age Psychiatrists is maximised.

Issues raised and actions arising

1. The first set of issues were grouped approximately under a category of 'avoiding shooting ourselves in the foot'. Specifically, it was felt that there is a real danger that recruitment and retention will be adversely affected by low morale amongst consultants and lack of drive in the specialty as a whole, compounded by rumours (whether true or not) of job shortages and service reductions. It is important for consultants to remember the importance for us as juniors of the pioneering generation before us who often faced more stark pressures and yet inspired both recruitment and retention through their belief in Old Age Psychiatry as a noble and worthy career choice. It is also important not to forget the extent to which we have demographic changes on our side.

Action: Clearly these are issues held by the specialty as a body – further consideration is needed as to how they might be addressed by the Faculty and its activities.

2. Some concerns were raised about previous Faculty residential meetings in relation to their accessibility and helpfulness for trainees – specifically the price (too high), bursaries (lack of) and lack of academic content compared to other College meetings. There was a concern that they were primarily a social event for an inward-looking senior consultant group and not particularly encouraging both socially and intellectually for trainees. An instance was also cited where negative comments about trainees were raised and left unchallenged. However, the training day attached to the residential meeting received much better feedback.

Action: Raise the issue at the Executive meeting and with the Academic Secretary. The impact of balancing a service development vs. academic focus in Faculty meetings needs to be considered.

3. A number of issues were raised around being competitive and pro-active as a specialty about advertising, recruiting and retaining. Particular examples included the following:
 - a) Promoting a level playing field regarding opportunities for dual vs. single CCT (either one or the other but not the current situation where training schemes differ and there is seen to be

unfairness in opportunity). Deanery liaison would have to be considered. How much influence can the Faculty have over this?

- b) Avoiding the loss of potential trainees to General Practice at the FY-CT transition (e.g. better advertising of Psychiatry, better information regarding location of placements in training schemes). This may be more of an issue for the College as a whole, but the Faculty may wish to assist with this.
 - c) The importance of maximising our exposure in general hospitals where many medical students and FYs are making up their minds about career choices. This includes standard actions such as ensuring a good presence at grand rounds but also some consideration about the staffing of older adults liaison services – if these are predominantly provided by nursing colleagues, as is commonly the case, then generations of FYs will be given the idea that mental healthcare does not really need medical input.
 - d) Considering potential opportunities for attracting CT2/3s from other specialties. Traditionally Old Age Psychiatry has benefited, for example, from General Practice trainees who try it out and find that they like it. There may be a reasonably sized pool of late-stage trainees who might be attracted this way. Again, this may be primarily for the College as a whole to consider but our Faculty might be a particular beneficiary – hence worth some promotion.
 - e) Streamlining work experience placements. Early exposure prior to medical school is potentially important in shaping career intentions. However, placements are often highly bureaucratic in terms of honorary contracts etc. An example was cited from Newcastle where streamlining had been achieved with good effect and would be worth wider dissemination.
4. Achieving a positive CT experience: it was suggested that CT1 was too early for a positive experience in Old Age Psychiatry, being too often restricted to outpatient clinic and inpatient work because of the inexperience of the trainees at this level. CT2-3 placements would allow more of a community focus. Other specialties insist on trainees being at a certain level of experience and Old Age Psychiatry might do the same.
- Action:** This might have wider unforeseen ramifications and needs further discussion; a request has been made for it to be included as an item for the next Faculty Executive meeting.

5. Scoping good practice and experiences: it was felt that a survey for trainees might be helpful in further identification of good ideas for recruitment and retention.

Action: RS to pursue this issue with the trainees group.

6. It was felt that involvement of interested charities might possibly be of some use given their skills in marketing and engagement. There might be a broader issue of encouraging people into career paths involving care of older people and our specialty could benefit as a by-product.

Action: RS to explore this issue.

B. COST EFFECTIVENESS

Discussion group: Andy Barker (chair) et al

Background and remit

The government announcement of the need for the NHS to save £20 billion has major implications for all services. The All Party Parliamentary Group on Dementia has produced a report in which the potential to make the service more cost effective was examined. Colleagues wishing to attend this subgroup should be familiar with this report prior to the Strategy Day. The work of the subgroup will be to extract key points from the APPG report to combine these where appropriate with any novel developments and to consider how service re-organisation make the cost effectiveness more attractive with the possible additional effect of attracting new consultants.

Actions

This strategy day working group developed a project plan for the production of a document on the effectiveness and hopefully cost effectiveness of specialist older people's mental health services, intended to be of benefit for the faculty membership, though also to influence GP commissioners and others. We aim to search for evidence of cost effectiveness in the areas of memory services, community mental health teams (encompassing other specialist community services such as care home in-reach, intensive support / crisis services, psychological therapies), general hospital liaison, and psychiatric in-patient care.

We will be approaching members of the faculty membership for examples of innovative service models and evidence of effectiveness/cost effectiveness. Where this is lacking we also need models of good practice, which would appear to be likely to provide a cost effective means of intervention. We aim to have a draft document available for the faculty residential meeting, and to complete the document before the summer break. We will be approaching the faculty membership soon, but would be grateful if people could keep an eye out for evidence of good services, audits of interventions or research on cost effectiveness.

C. IMPROVING LINKS WITH PRIMARY CARE.

Discussion Group: Anand Ramakrishnan (Chair), Peter Connelly, Pradeep Arya, Anthea Livingston, Deborah Girling, Sean Lennon, Trevor Jarvis, Ann Jarvis, Aparna Mordekar.

Background and remit

Although the Faculty has had official links with primary care via the RCGP for many years in reality there is little direct interaction. There is concern that despite various initiatives dementia in the community remains under-diagnosed, depression is under-diagnosed and under-treated and guidance on the use of antipsychotics is not well understood. Additionally in England GPs will have a more prominent role in the commissioning of Old Age Psychiatric Services. The task of this group is to examine how we can influence primary care in the clinical and commissioning field.

Issues raised and actions arising

The main points discussed were-

- How to link with primary care
- How to support GPs in effective clinical service for older people
- How to support the faculty members
- What is the cost involved
 - Diagnosis (PBR)
 - What cost if MH disorders are not diagnosed early? (Business model)
- What are the advantages of improved links with primary care?
- What are the disadvantages of these links?
- What are the barriers?
- Form an action plan

1. Link with GPs and other Primary Care agencies:

It is essential to have good relationship with Primary care to ensure better patient care. It is all the more important in the current political and social climate with the introduction of GP commissioning and CCGs.

- to improve the diagnosis of people with mental health problems especially dementia and depression, how to help early identification
- if there are no efficient links with GPs many changes will happen without involving old age psychiatrists. eg: a medication review in care homes at a London PCT did not involve old age

psychiatrists. This kind of situation is likely to increase in a rapidly changing NHS.

- Increased awareness and early management of mental illness leads to-
 - reduced cost,
 - improved quality of care
 - reduced admissions to hospitals
 - delayed admissions to long term care
 - increased access to psychological therapies as current access and uptake is poor
 - impact on quality of service by not referring to secondary care
 - Open access to services improves the quality and increases acceptance and access, eg: worried well? Increased utilisation of resources? (not much evidence to support this)
 - Referral to Older people's mental health services (OPMH) leading to high-quality mental health assessment.
 - May result in crisis response teams for OPMH to be agreed with CCG.
- Unrecognised mental health problems in the community can lead to
 - Poor recognition of mental illness leading to late diagnosis and delayed referral resulting in high morbidity, increase complexity, worsens carer's stress and considerably increases risk.

2. Advantages:

- Improve quality and early diagnosis through primary care protocols and defining patient care pathways. This could be enhanced through helping with training needs of GPs and making them aware of better quality of service for depression/anxiety
- Improve liaison with primary care
- Make GPs aware of changes in psychiatric services, structure and function of CMHTs
- Improve their liaison with the GPSIs
- Enlist help of patients and carers to make GPs aware of what old age psychiatrists do.

3. Disadvantages:

- Old age psychiatrists see only see one-third of patients with dementia. Improved liaison means increased workload for psychiatrists. One has to be mindful about capacity issues for taking on additional referrals. Transfer of responsibility to GPs may become difficult as GPs may not think it is their business to do the assessment of people with dementia, eg: physical care.

- Non-QOF related responsibility could be shifted to the psychiatrists, eg: general medical examination and physical care of patients with dementia or other chronic mental health conditions.

4. Barriers:

- Lack of enthusiasm of both primary and secondary care to engage in discussions and improve their understanding of each other.
- CCG groups are not fully familiar with working of old age psychiatrists and not sure how to seek help and advice from them.
- Training of old age psychiatrists may need more emphasis on primary care to understand the working of GPs.
- How to use their language to improve communication.
- Some GPs carry negative assumptions about psychiatric illness and that of older people.
- QOF related issues (recent reduction in depression related QOF points).
- Locally Enhanced Services (LES) – wrong priorities linked to shared care.
- Reluctance to utilise CBI accredited carers in training, confidentiality used as an excuse in effective sharing of patient related information.
- Increased paper work and bureaucracy.

5. Good practice examples suggested improving knowledge of GPs to deal with older people's mental illness...

- Annual review of patients with complex needs with GPs
- OP Clinics in GP practices or where and when to see patients, to be decided with GPs
- When and where to discharge patients - to have locally agreed protocols with GPs (CCGs)
- Better liaison diminishes variability in GP practice
- Local targeted initiatives with GPs
- Have clear understanding or protocols with GPs to make them aware what happens when patients relapse, what other systems available to facilitate access to specialised services including psychological therapies and what to do how and when systems breakdown.

6. Good Practice examples:

- ❖ Gnosal – Dr. David Jolly helping GPs to run memory clinics

7. Action Points:

- a) Faculty to establish Links with RCGP:
 - Education and training initiatives for GP registrars.
 - Link with RCGP in palliative care of dementia
 - GPs to be involved in Faculty's annual conference
 - Establish formal links through Mental Health Forum (a joint RCGP-RCPsych initiative)
 - Campaign against Sigma of mental illness in older people among professionals

- b) Local level- Links with CCGs:
 - Introduce model shared care with CCGs and discuss any resource issues.
 - Highlight educational and training roles for improving diagnosis, confidence to diagnose and to improve awareness.
 - Age equality to be used to commission services locally and not age inclusive services that do not take into consideration of special needs of older people with mental illness.
 - Healthy discussion about the reluctance of some GP practices to access MHSOP and lack of confidence in diagnosing illnesses like dementia.
 - Advocacy for eliminating stigma of mental illness and accept disability associated with mental illness.

- c) Enlist help of local involvement team (users and carers) and voluntary agencies as appropriate.

Action Plan

1. Make a full report available before Faculty AGM in March 2012.
2. Make links with RCGP- to be arranged by Faculty Executive committee.
3. Local:
 - a. Improve practice by improved training and quality – by all old age psychiatrists.
 - b. Make links with CCGs and GPs – all, especially those who have assigned roles/links with Commissioners.
4. **Gain Support of Faculty members:**

Members are asked to **inform** Faculty chair and executive committee about:

- **Examples of GOOD practice of links with primary care and innovative services**

- Members who have received accolade or recognition for links with primary care
- **Evidence for increased awareness leading to improved services as mentioned in section 1 of this report.**
- Local service changes due to “age inclusivity”
- Questions or concerns needing support from Faculty.
- What is happening in this area in devolved nations, especially Wales and N. Ireland.

5. Links with devolved nations.

- Scotland: Same issues as in England except that there is no PBR, no directive commissioning rights for GPs.
- Wales:
- N. Ireland:

Final Report: Anand Ramakrishnan, Sean Lennon, Deborah Girling, Anthea Livingston.

Appendix: Progress since last year

a) Outcome measure

Subgroup was led by Andy Barker. This group produced documentation on a variety of potential clinical and service outcome measures. Within the College there is still a drive towards generating a series of measures which can be helpful in the evaluation of patients to assist payment by results. As far as I know, however, Council have not yet produced the final document.

a) Conjoint Management

This subgroup was led by Sandra Evans. A report is available and can be circulated. The College Council were due to debate the issue of transitions between services in February of this year but the session was cancelled at fairly short notice. The session has been rescheduled for the 2 December. Meantime the Joint Commissioning Panel has commissioned a subgroup to look at issues around transition between services which has so far met on one occasion with Andy and I both in attendance. It is hoped that guidance will be produced by spring next year.

b) Ideal Services

I lead this subgroup. Work has stalled over the summer due to my personal circumstances. However we have obtained some examples of different styles of services from published literature and invited a variety of colleagues across the country to submit brief descriptions of novel aspects of services which they run. My anticipation is that a draft of this document will be available for the November meeting but that it will not be finished.