What’s hot in old age psychiatry?

A summary of four contemporary documents:
- A report outlining progress with David Cameron’s challenge on dementia
- A Royal College of Psychiatrists guide to consultant job planning
- An updated Department of Health suicide prevention strategy
- A toolkit to aid suicide prevention from the Centre for Suicide Prevention

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THE PRIME MINISTER’S CHALLENGE ON DEMENTIA – Delivering major improvements in dementia care and research by 2015: A report on progress

At the Alzheimer’s Society (AS) Dementia Conference in March 2012, David Cameron launched his challenge on dementia with the aim of making dementia a globally recognised issue and placing the UK at the forefront of developments in dementia care and research. This report published in November 2012 gives an update on the first 7 months of progress.

A key aspect of the challenge was to create 3 ‘Champion Groups’ to focus on the following areas;
- Creating dementia friendly communities that understand how to help
- Driving improvements in health and care
- Better research

The dementia friendly communities champion group chaired by Jeremy Hughes (Chief Executive of the AS) and Angela Rippon (former newsreader
and AS Ambassador) generated significant press attention with the launch of a £2.4m Dementia Friends Programme, led by the AS with the aim of providing dementia awareness educational sessions to 1m UK citizens by 2015. Alongside this a dementia awareness symbol (a forget-me-knot) has been designed to be worn by these newly trained Dementia Friends and displayed by dementia friendly organisations. The goal of this group over the coming years is to work with various organisations and companies such as emergency services, retailers and financial institutions to increase awareness and educate those in frequent contact with people with dementia to improve their quality of life.

The health and care champion group chaired by Sir Ian Carruthers (Chief Executive of the South West Strategic Health Authority) and Sarah Pickup (President of the Association of Directors of Adult Social Services) have signed up 42 separate organisations such as care homes (encompassing 500,000 people with dementia) to a Dementia Care and Support Compact, committing them to standards of care and treatment for those with dementia. Furthermore, £50m of funding has been secured to specifically adapt wards and care home settings to better meet the needs of those with dementia. Finally the group are working with the NHS Institute on a Call to Action for hospitals to sign up to becoming dementia friendly care environments by 31 March 2013.

The final research champion group chaired by the Chief Medical Officer (Dame Sally Davis) and Sir Mark Walport (Director of the Wellcome Trust) has showcased its main achievements thus far, which include securing funding for a new pilot project to translate UK imaging and cognitive testing technology, used in clinical trials, into a digital health care platform for early dementia diagnosis. Funding in dementia research (by the National Institute for Health Research (NIHR) and Medical Research Council (MRC)) is expected to double over the lifespan of the current government from £26.6m per annum in 2009/10 to £66.3m in 2014/15.

It is pleasing to witness dementia care being thrust to the forefront of the political agenda, epitomised by David Cameron’s speech to the Dementia 2012 conference. However, it is crucial that these bold ambitions (many of which make for appealing political sound-bites that risk oversimplifying the challenges faced) translate into increasing diagnosis rates and better care and support for patients with dementia, their friends and families. Whilst increased funding for research into dementia is clearly welcome, this will
not equate to short term improvements in patient care. One fears that despite
the admirable intentions of the prime minister’s challenge, the necessary
increases in provision of health and social care resources show few signs of
materialising – a situation exacerbated by the current economic context
within which the NHS exists.

COLLEGE REPORT (CR174) SAFE PATIENTS AND HIGH
QUALITY SERVICES: a guide to job descriptions and job plans for
consultant psychiatrists

This college report published in November 2012 has been produced to
reflect the ever evolving role of the consultant psychiatrist in light of
changes in areas such as resource availability, patient and societal
expectations, and the developing roles of other professions. The guidance is
designed to enhance innovation and service development, with a focus on
patient safety and delivery of high quality care. At the same time the
document reiterates the advantages of consultant-delivered services, namely
by improving clinical care, leadership and education, as outlined in a recent
report by the Academy of Royal Colleges (2012).

The document emphasises the importance of adequate job planning and the
role of the Royal College of Psychiatrists in reviewing new job descriptions
to ensure high standards are met by employers. Readers are also signposted
to the British Medical Association and NHS Employers guide to consultant
job planning (2011). The report also offers recommendations in relation to
minimum supporting professional activities (SPAs) deemed necessary to
meet the demands of revalidation.

With regards to Old Age Psychiatry, key clinical and leadership roles are
outlined and reference is made to the wide variety of service models adopted
within the specialty. The impact of community based care (and associated
travelling) is acknowledged. The document suggests minimum time allocation for assessment of new and follow up cases, both in clinic (60 mins new, 30 mins follow up) and in the community (90 mins new, 60 mins follow up) and also suggests minimum programmed activities (PAs) for mental health and mental capacity legislation work (0.5 PA), multidisciplinary meetings/supervision (1 PA) and emergency work (1 PA). For full-time inpatient consultants, guidance is offered in relation to appropriate maximum numbers of ward-based patients under their care, distinguishing between functional (15-20 beds) and organic (20 beds) roles. Model job plans are included in the report.

Whilst patient safety and quality of care is paramount, one must be careful that a service maintains productivity and this document has certainly sparked debate locally, in relation to time allocations suggested for clinical assessments. Despite this, overall the document provides a useful tool for both the recently appointed consultant to negotiate their newly acquired role and also for experienced consultants to review their practice against established guidance.

References:


PREVENTING SUICIDE IN ENGLAND – A cross-government outcomes strategy to save lives

Launched by Care Services Minister Norman Lamb, on World Suicide Prevention Day, this report acts to build on the successes of the 2002 strategy, aiming to further reduce suicide rates and better support families bereaved or affected by suicide. The strategy is backed by a Call to Action led by the Samaritans and up to £1.5m in funding for suicide prevention research.
The strategy is supported by a Statistical Update on Suicide from the Department of Health (2012). This highlights that over the past 10 years, the general trend has seen a decrease in suicide rates to 7.9 suicides per 100,000 general population for the 3 year period 2008-10, down 17.9% from 1998-2000. Men are more likely to take their own lives and this remains noticeable in those aged 75+. Although relatively few suicides occur in this group, the low population makes the rate per 100,000 relatively high, especially for men. However the suicide rate for males over 75 years has continued to decline in recent years. Middle aged men are now the group with the highest rates of suicide.

6 key areas of action to deliver the above objectives were identified;

- **Reduce the risk of suicide in key high risk groups** such as young and middle aged men, people in the care of mental health services (including inpatients), people in contact with the criminal justice system, people with a history of self-harm and certain occupational groups (such as healthcare workers, veterinary workers and farmers).
- **Tailor approaches to improve mental health in specific groups** such as survivors of abuse, military veterans, black and minority ethnic groups/asylum seekers, those who misuse drugs, lesbian/gay/bisexual/transgender groups, people with chronic physical illnesses and those who are socially and economically vulnerable.
- **Reduce access to the means of suicide** such as hanging/strangulation in psychiatric inpatient and criminal justice settings, self-poisoning, those in high risk locations and those in rail/underground settings.
- **Provide better information and support to those bereaved or affected by suicide** via healthcare professionals and voluntary organisations in schools, workplaces, health and care settings.
- **Support the media in delivering sensitive approaches to suicide and suicidal behaviour** via the internet, newspapers and other media outlets.
- **Support research, data collection and monitoring** by ensuring ongoing capture of timely and reliable statistics and continued research work via groups such as the NIHR.

**SAFER MENTAL HEALTH SERVICES: a toolkit**

The work of the suicide prevention strategy is also complimented by the November 2012 launch of a toolkit, entitled Safer Mental Health Services.
This document enables mental health practitioners to self-assess their local services and individual practice against key findings from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

Both of these key documents make for clear reading, identifying areas of concern and providing straightforward, evidence-based solutions centred upon extensive research over many years. A must read for all mental health practitioners.

References:
Department of Health (2012) Statistical Update on Suicide. Department of Health