"How Does Your Team Work?" A National Survey of Community Mental Health Teams for Older People in England.

NHS National Institute for Health Research

Research and Policy Update

PSSRU
Personal Social Services Research Unit at the University of Manchester

Issue 9 February 2010

EDITORIAL

The number of people reaching old age in the UK is increasing, and increasing fast. In the 25 years up to 2007 the number of people aged over 65 rose by 15 per cent. However, across the next 25 years a further 64 per cent increase is projected. Whilst many older people will lead healthy and fulfilling lives, with old age comes an increased risk of a range of illnesses and disabilities, including mental health problems such as dementia.

Community Mental Health Teams for older people (CMHTsOP) form the cornerstone of specialist services aiming to diagnose, treat and care for older people with all forms of mental health problems in their own homes. There are now over 400 teams across England, with an estimated 6,000 (wte) staff. Their importance has been highlighted in a range of government policies over the last decade, from the National Service Framework (NSF) for Older People to the more recent National Dementia Strategy. The government recommends that these teams draw on a wide range of professional disciplines across both health and social care services, and that they should provide "seamless packages of care and support for older people and their carers" (DH, 2001: p91).

The PSSRU has been commissioned by the National Institute of Health Research to investigate the national variation in CMHTOP composition and structure, as the first part of a wider programme of research assessing the relative merits of different team approaches. This Research and Policy Update reports on a national survey of all CMHTsOP, entitled "How Does Your Team Work?", which was completed by 88 per cent of all teams in late 2008 / early 2009.

MENTAL HEALTH SERVICES IN LATER LIFE AND THE PSSRU

The PSSRU has a long history researching the provision of services for older people with mental health problems. Recent examples include surveys of consultant old age psychiatrists working in CMHTsOP in 1999 / 2000, and again in 2004 (Challis et al, 2002; Tucker et al, 2007). These studies found that many teams were unable to access the range of specialisms expected by government: for example, in 2004 over a third of teams lacked any dedicated social work input, whilst the proportion of teams with social workers as core team members actually fell between the two surveys.

These studies also investigated certain key aspects of team practice, and the 2004 survey found that progress in implementing NSF standards was patchy. Whilst the majority of teams reported using single care coordinators and single care plans, the use of multi-disciplinary assessment documentation was found in only a third of teams, and the availability of electronic case files was the exception rather than the rule. PSSRU's research forms part of an emerging evidence base on the work of CMHTsOP, which includes other important studies such as those by the National Audit Office (eg NAO, 2007).

Aims and Objectives

Against this background, the PSSRU was commissioned to conduct a national survey of CMHTsOP with the primary purpose of 'describing national trends and variations in CMHTOP structures and processes'. In meeting this overarching aim, the survey would also address the following objectives:

- to describe progress against national standards of good practice;
- to compare changes in team structure and process with earlier studies;
- to investigate wider aspects of a CMHT's remit, such as liaison and outreach work, and;
- to more closely examine the degree of joint working across professional disciplines and agencies.

THE RESEARCH TEAM

The research staff conducting this study are David Challis, Michele Abendstern, Christian Brand, Val Harrington, Sue Tucker, David Jolley, Mark Wilberforce (PSSRU The University of Manchester), Bob Baldwin and Sean Lennon (the Manchester Mental Health and Social Care Trust). The research is funded by the National Institute for Health Research, and hosted in partnership with the Manchester Mental Health and Social Care Trust. For further information please contact Mark Wilberforce (mark.wilberforce@manchester.ac.uk / 0161 275 5391).

"HOW DOES YOUR TEAM WORK?"

PSSRU researchers designed a bespoke postal questionnaire, which was piloted with six teams from three Trusts, to collect information on:

- general team characteristics;
- staff composition and responsibilities;
- key team processes; and
- outreach and liaison work.

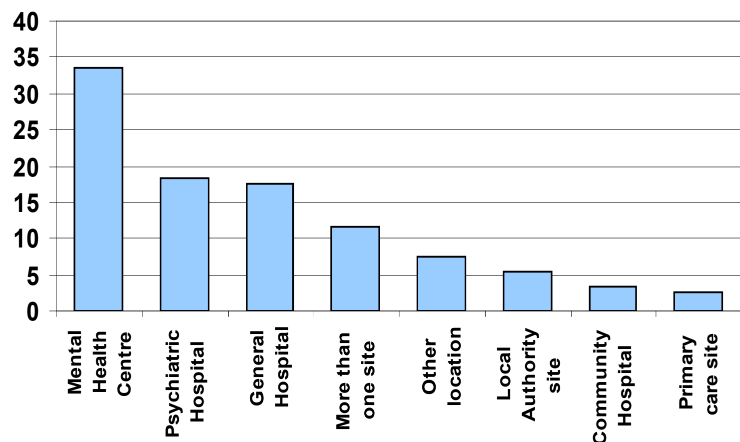
The questionnaire was sent to the team managers of all CMHTsOP in England in November 2008. Although a total of 457 CMHTsOP were identified in the 2008 national "mapping" study (commissioned annually by the Department of Health), by the time of the survey a number of teams had merged or undergone other organisational change. This reduced the overall number of available teams to 429, of which a total of 376 (88%) had responded by the end of fieldwork in March 2009.

The information collected on CMHT characteristics revealed some variation in what, exactly, constituted "a team". Whilst the majority of respondents reported that their CMHT was a single and distinct team, just under 10 per cent reported that the team was amalgamated with a memory clinic, home treatment team, or other broader service.

Just over a half of teams (56%) organised their staff around geographical patches or GP practices. Just a handful (11 teams) divided their team according to type of illness. Most teams (71%) worked with just one local authority (LA); 17 per cent worked with two LAs; and 12 per cent operated across three or more LA boundaries. Just under half (47%) of teams described the community they served as "mixed urban / rural", with 38 per cent being mainly urban and the remainder (15%) being rural. Most CMHTs (72%) had been in operation for more than five years with just nine per cent being new teams (operating for under two years). However this is not to suggest that CMHTs operated in a static environment: almost two-thirds (63%) of teams reported major changes to the structure and organisation of the team within the preceding year.

Teams were located in a wide variety of locations (Figure 1). Whilst a third of teams were in community mental health centres, and 19 per cent and 18 per cent of teams were based in psychiatric and general hospitals respectively, the remaining teams were situated in a particularly diverse range of locations. These included GP surgeries; LA settings (ranging from social services offices to day centres); community hospitals and other buildings such as high street offices and business parks. Just over 10 per cent of teams had more than one office-base.

Figure 1: Location of CMHT base



Team staffing and composition

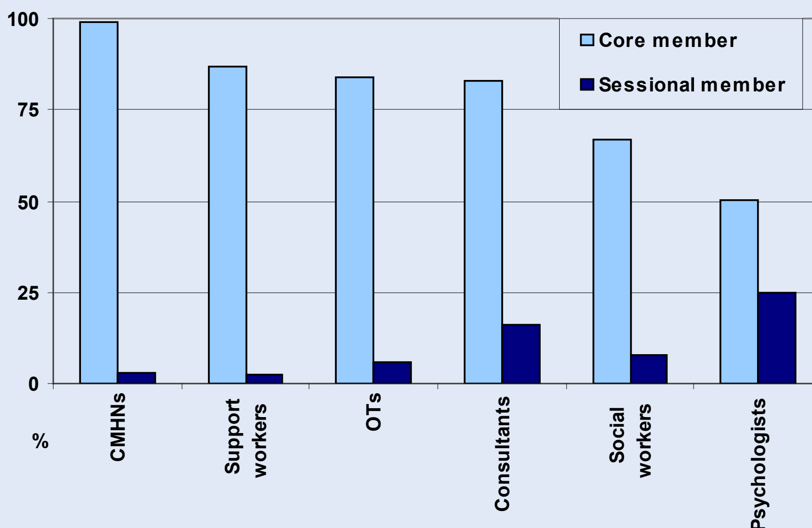
The questionnaire collected information on CMHT staffing, including data on "core" and "sessional" team members: the former defined as devoting a substantial proportion of their working week to the team's work, with the latter contributing a regular (but smaller) part of their time. The 'average' team had 16 core members, but, reflecting diversity in team size, almost a quarter of teams had fewer than 10 core members, and a similar proportion again had more than 20.

Team composition

Figure 2 shows team membership amongst those professional disciplines that are regarded as central to a successful CMHTOP. As expected, almost every team had core community mental health nurses (CMHNs), and over 80 per cent of teams had core support workers, OTs and consultants.

Social workers and psychologists were core members in two-thirds and a half of teams respectively: This represents a significant increase on PSSRU's 2004 survey (Tucker et al, 2007), where these professions were core members of just half and one-third of teams. 'Sessional' membership was more likely for psychologists than for other staff groups, although 10 per cent of teams reported that they had no access at all to a psychology service in their area. Most teams (72%) were managed by a nurse, with 18 per cent managed by a social worker.

Figure 2: Team membership by professional discipline



Team processes and outreach

Access and referral

Whilst CMHTs received, on average, 36 new referrals per month, the data again revealed significant variation between teams. In part, but not entirely, this was due to differences in team size. Almost all teams used a single point of access, and 80 per cent of teams had formal referral criteria. As expected, GPs were the primary source of referrals, although social workers and care homes provided a 'large proportion' of referrals for 15 per cent and 13 per cent of teams respectively. Self-referrals were accepted by about half the teams, though they formed a relatively small number in almost all cases.

Assessment

Just under two-thirds (63%) of teams made their first contact with service users within 2 weeks of the date of referral (for routine cases), on average. For just under a third (31%) of teams this took up to a month, and for six per cent it took even longer. For almost all teams (93%), the initial assessment was conducted in the service user's home. Consultants and CMHNs conducted assessments in almost all teams, but in addition OTs conducted assessments in 81 per cent of teams (that had an OT); social workers in 79 per cent of teams; and psychologists in 62 per cent of teams.

Key workers

All teams used some form of a key worker / case coordinator system, though only 60 per cent used this for all / most clients, and for coordinating care between agencies. CMHNs, OTs and social workers were the most common professional disciplines acting as key workers. In addition, in 69 per cent of teams the consultant acted as a key worker; and in 58 per cent of teams psychologists performed this task.

Liaison and outreach work

Almost all teams (97%) reported being involved in at least some liaison and outreach work in their community. A third of teams (34%) reported having a link worker system in care homes, and just under two-thirds (61%) reported that they provided education or training to care home workers. Just under a quarter of teams reported that they had a link worker system in GP surgeries and in general hospitals, whilst 18 per cent conducted education and training in these settings. Other forms of outreach work, such as open clinics and case finding / screening, were rare.

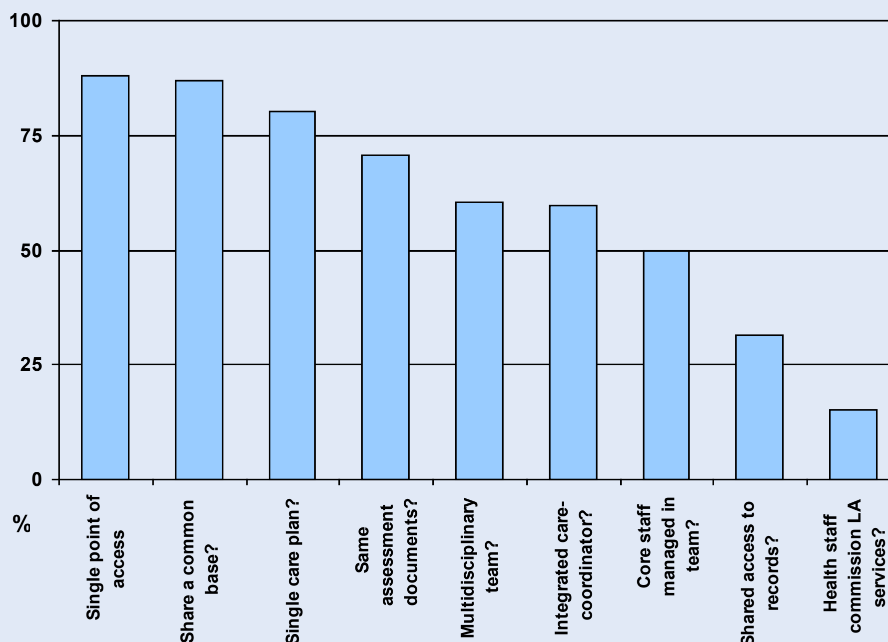
Team integration and joint working

The questionnaire also collected information that enabled a closer look at team integration, a theme that has attracted considerable policy attention in recent years. Figure 3 shows the proportion of teams achieving each of nine indicators of joint working, all of which have been recommended in key policy documentation, in service development guides, in publications of professional standards, and in influential audit reports.

The chart shows that over 80 per cent of all teams had (and used) a single point of access, shared a common office base, and used single joint care plans that detail the input from each team member and any social care services in place. Over two-thirds of teams also used the same assessment documentation between all professional disciplines, which is an increase from a little over a third of teams in 2004 (Tucker et al, 2007). Sixty per cent of teams were multidisciplinary (defined as having at least a social worker and two health workers as core team members) and the same proportion used a single key worker for coordinating the care across different agencies, as noted above. A half of CMHTs reported that all core members were directly line managed within the team.

However fewer than a third of teams (32%) reported that their CMHT and social services teams shared service user records where appropriate, and even those that did often noted that this was not a simple process. Finally, just 57 teams across the country (15%) stated that health staff within the team were able to commission social care services directly.

Figure 3: Teams attaining nine indicators of joint working



Conclusions

This study has highlighted a significant diversity in CMHTOP structure and practice across England. Teams range in style from small CMHTs with just a few core members, to those with 30 or more staff, sometimes incorporating a wider range of services such as a memory clinic. Access to key staff groups appears to have increased since an earlier PSSRU study in 2004, though the availability of psychology services remains low in some Trusts. Indicators of team integration and joint working also show some signs of increasing, though not in all aspects.

This wide variety of team structures and processes raises the question: does it matter? Do some CMHT structures and approaches lead to better service user care than others? How important is the degree of joint working and integration? This survey cannot answer these questions, but it forms the platform on which the next phase of this research programme will be built. Beginning in 2010, PSSRU will conduct new exploratory research with selected CMHTsOP to investigate how certain team approaches impact on service user outcomes.

Acknowledgements

We are grateful to the CMHT staff that took the time to complete this survey, and also to those that assisted in the testing and development of the questionnaire. This paper outlines independent research commissioned by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

References

Challis DJ, Reilly S, Hughes J, Burns A, Gilchrist H and Wilson K. (2002). Policy, organisation and practice of specialist old age psychiatry in England. International Journal of Geriatric Psychiatry, 17: 1018-26.

Department of Health (2001). National Service Framework for Older People. London: Department of Health.

National Audit Office (2007). Improving services and support for people with dementia. London: The Stationery Office.

Tucker S, Baldwin R, Hughes J, Benbow S, Barker A, Burns A and Challis DJ. (2007). Old age mental health services in England: implementing the National Service Framework for Older People. International Journal of Geriatric Psychiatry, 22: 211–17.

NEW PROJECTS

Specialist Healthcare Support to Older Residents of Care Homes: Models and Costs:
PSSRU at the University of Manchester has been funded by BUPA Giving to investigate the provision of specialist healthcare support for the physical healthcare needs of older people resident in care home. This project aims to identify the range of different models of providing such care and their costs.

Improving Health Services for European Citizens with Dementia:
This project involves eight European countries and aims to identify best practice strategies in dementia care with a particular interest in the transition between home support and long-term care facilities. This project involves Professor Alistair Burns National Clinical Director for Dementia as well as PSSRU staff.

Community Support Services for People with Dementia: the Relative Costs and Benefits of Specialist and Generic Domiciliary Care Services:
This project aims to identify the relative costs and benefits of specialist and generic home care services in supporting people with dementia. It is also designed to identify the different types and models of specialist home care provision. The findings will feed into the implementation of Objective 6 of the National Dementia Strategy.

RECENT PUBLICATIONS

Abell J, Hughes J, Reilly S, Berzins K and Challis DJ. (2010). Case Management for Long Term Conditions: The Role of Networks in Health and Social Care Services. Journal of Integrated Care, 18(1), 45-52.

Clarkson P, Challis DJ, Davies S, Donnelly M, Beech R and Hirano T. (2010). Comparing how to compare: an evaluation of alternative performance measurement systems in the field of social care. Evaluation, 16(1), 59-79.

Abendstern M, Hughes J, Clarkson P, Sutcliffe C, Wilson K and Challis DJ. (2010). 'We need to talk': communication between primary care trusts and other health and social care agencies following the introduction of the Single Assessment Process for older people in England. Primary Health Care Research and Development, 11, 61-71.

Reilly S, Hughes J and Challis DJ. (2010). Case management for long-term conditions: implementation and processes. Ageing and Society, 30, 125-155.

Berzins K, Reilly S, Abell J, Hughes J and Challis DJ. (2009). UK self-care support initiatives for older patients with long-term conditions: a review. Chronic Illness, 5, 56-72.

The PERSONAL SOCIAL SERVICES RESEARCH UNIT was established in 1974, and from 1996 it has operated from three branches:
University of Kent at Canterbury, Cornwallis Building, Canterbury, Kent, CT2 7NF
London School of Economics, Houghton Street, London, WC2A 2AE
University of Manchester, First Floor, Dover Street Building, Oxford Road, Manchester, M13 9PL

Email: PSSRU@manchester.ac.uk Website: www.PSSRU.ac.uk