



National Audit Office

Improving Dementia Services in England – an Interim Report

Consultant Old Age Psychiatrist Survey Results

JANUARY 2010

Contents

National Audit Office Survey
of Consultant Old Age
Psychiatrists **2**

General Information **3**

1 The Department of Health's
National Dementia Strategy **4**

2 Services **10**

3 Commissioning and
Funding **17**

4 Other Professionals **19**

National Audit Office Survey of Consultant Old Age Psychiatrists

As part of the fieldwork for our 2010 interim report on dementia services, the National Audit Office (NAO) developed an online survey of Consultant Old Age Psychiatrists and asked the Royal College of Psychiatrists to inform and encourage its members to complete the survey for us. The survey was completed over July and August 2009.

The survey included a range of questions covering availability of specialist services for people with dementia in the consultants' local general hospital, changes implemented since the Strategy's publication and the consultants' involvement in, familiarity with and opinions on the National Dementia Strategy.

The aim of the survey was to identify:

- consultants' views on the clarity and vision of the Strategy;
- the extent of consultants' involvement in and familiarity with the Strategy;
- the extent of any changes which have been implemented in general hospitals following the publication of the Strategy;
- the extent to which specialist services are available for people with dementia; and
- the main challenges and barriers consultants anticipate in terms of implementing the Strategy.

The results of the survey are used, where appropriate, in the 2010 National Audit Office report *Improving Dementia Services in England – an Interim Report*.

All percentages shown are the "valid percentages" i.e. they exclude blank and not applicable responses. Where we have provided data for individual Strategic Health Authority regions, it should be noted that sample sizes are small on a regional basis but they are in line with the Royal College of Psychiatrists' regional membership populations.

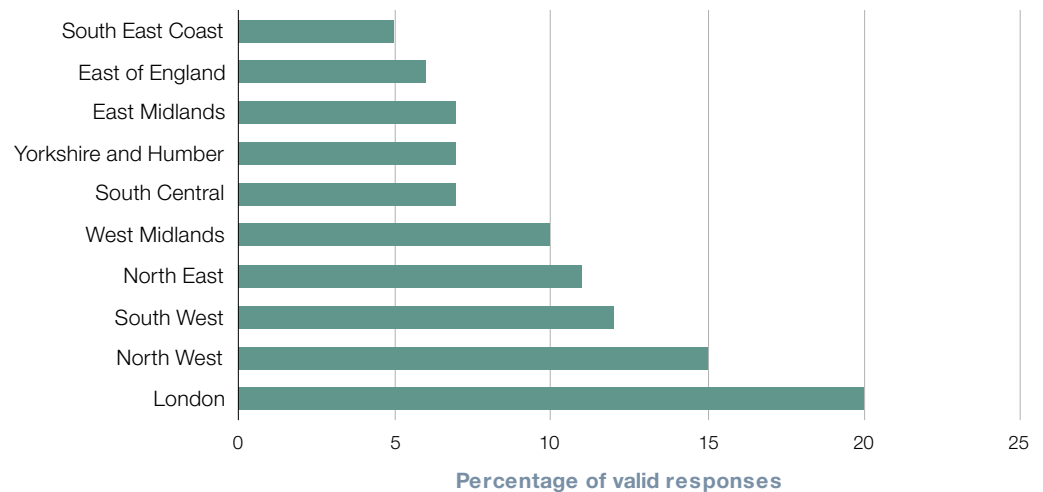
General Information

There are 816 practising Consultant Old Age Psychiatrists (“consultants”) in England and we received a total of 218 valid responses (27 per cent), with at least five per cent of the total from each of the ten English Strategic Health Authority (SHA) regions (**Figure 1**).

Figure 1

Breakdown of regions where respondents practise

English SHA region



As **Figure 2** shows, the majority of respondents qualified after 1980.

Figure 2

Breakdown of respondents' year of qualification

Year of qualification	Percentage of respondents	Number of respondents
Pre 1960	0.5	1
1960-1969	1	3
1970-1979	16	35
1980-1989	47	102
1990-1999	35	76
2000+	0.5	1
Total	100	218

1 The Department of Health’s National Dementia Strategy

Respondents were asked a number of questions relating to the newly launched (3 February 2009) National Dementia Strategy (the “Strategy”).

1.1 Involvement in the National Dementia Strategy Consultation

Sixty-four per cent of respondents had no involvement in the consultation for the Strategy. Respondents in Yorkshire and the Humber SHA were the least involved (seven per cent), and respondents in East Midlands SHA were the most involved (53 per cent).

As **Figure 3** shows, of the 36 per cent who were involved in the consultation, the majority did so at an organisational level (48 per cent) or by participating in a listening or other event (40 per cent).

Figure 3
Method of involvement in the Strategy consultation

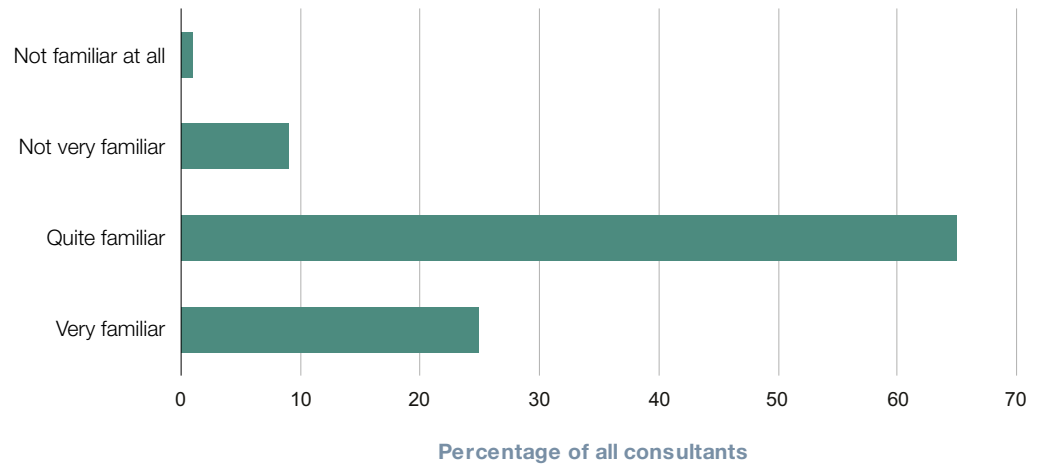


1.2 Familiarity with the National Dementia Strategy

All respondents were asked to state how familiar they were with the Strategy (regardless of their involvement in the consultation). The vast majority of consultants responding to our survey (90 per cent) were familiar with the Strategy (**Figure 4**). Respondents in North East SHA were the most familiar (100 per cent), and respondents in East of England SHA were the least familiar (77 per cent).

Figure 4

Familiarity of consultants with the National Dementia Strategy

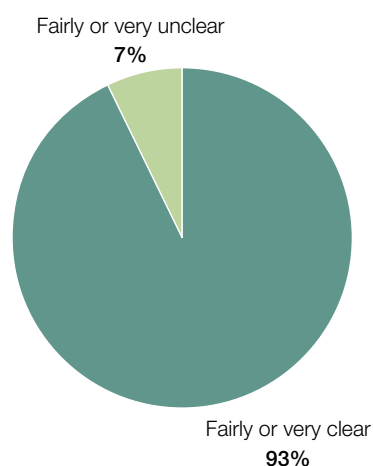


1.3 Clarity of the National Dementia Strategy's vision and likelihood of its successful implementation within 5 years

Of the respondents who were familiar with the Strategy, the vast majority (93 per cent) felt that the Strategy's vision was fairly or very clear (**Figure 5**).

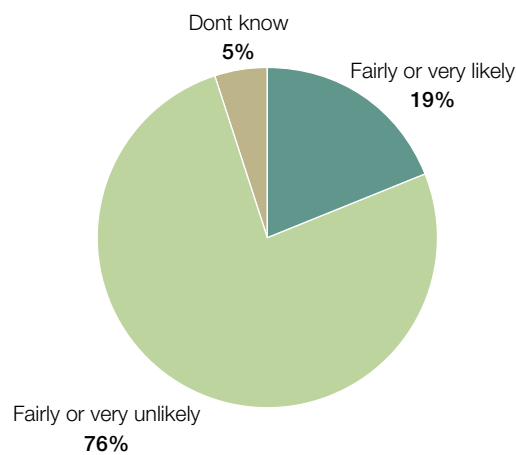
Figure 5

Clarity of the Strategy's vision for those familiar with the Strategy



Of the respondents who were familiar with the Strategy, less than two-fifths (19 per cent) believed that the Strategy would be successfully implemented within the five year time-period specified (Figure 6).

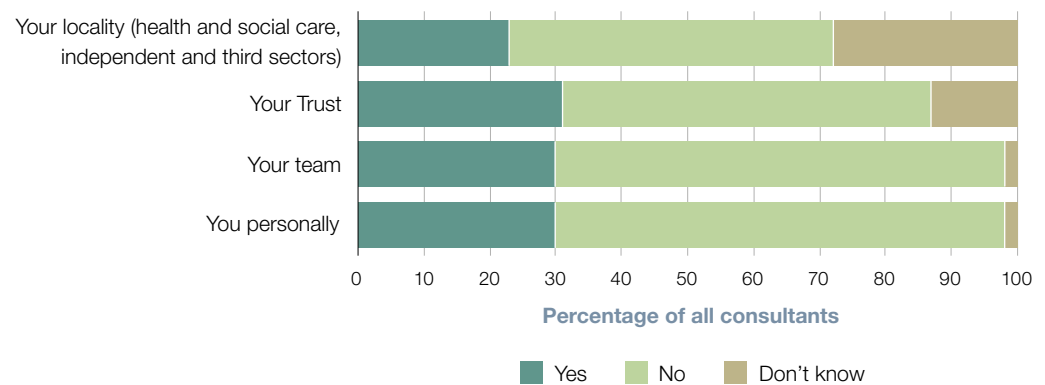
Figure 6
Likelihood of the Strategy’s successful implementation within 5 years according to those familiar with the Strategy



1.4 Changes implemented to date following the National Dementia Strategy’s launch

At a local level there is poorer understanding of whether changes have been implemented or not, with over a quarter (28 per cent) of respondents selecting ‘don’t know’ when thinking about their locality (Figure 7).

Figure 7
Changes implemented as a result of the Strategy

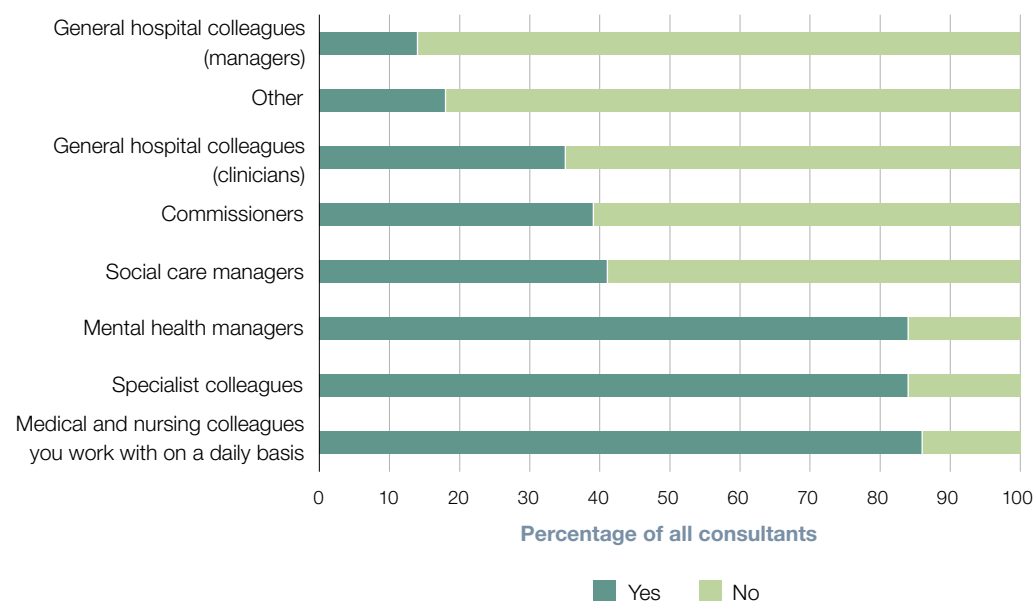


Over half of consultants (56 per cent) said that no changes had been implemented at a Trust level as a result of the National Dementia Strategy. Thirty-one per cent said changes had been made and 13 per cent did not know. Almost a third of consultants said that they personally and their teams had implemented changes since the Strategy, but over two-thirds had not.

Respondents in London SHA had implemented the most changes personally (42 per cent), and respondents in Yorkshire and Humber SHA the least (13 per cent). The highest proportion of respondents saying their Trust had implemented changes was in North East SHA (53 per cent), whilst no respondents in East of England SHA said their Trust had done so (zero per cent).

The National Dementia Strategy has provoked the most discussion between consultants and the medical and nursing colleagues they work with on a daily basis (86 per cent), specialist colleagues (84 per cent) and mental health managers (84 per cent). There has been less discussion with general hospital colleagues (both clinicians and managers) (Figure 8).

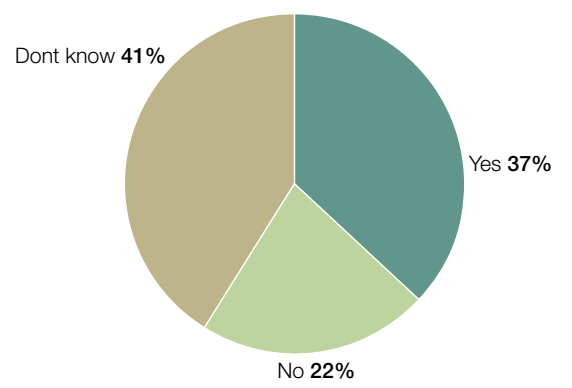
Figure 8
Discussions taken place with colleagues following the Strategy



Over a third of consultants stated that a local multi-agency group has been formed in their area to plan local implementation of the Strategy, though almost two-thirds said one hadn't or they didn't know (**Figure 9**). There was little regional variation around this question.

Figure 9

Formation of local multi-agency groups to plan local implementation of the Strategy



1.5 Importance of different areas to the success of the Strategy's implementation

Respondents were asked to rate, firstly, the importance of certain factors to the success of the Strategy's implementation and, secondly, to what extent these factors are in place. Each aspect was rated on a scale of 1-10, where 1 means the area in question is not at all important/does not exist at all and 10 means it is extremely important/well established. **Figure 10** provides a summary analysis of the scores.

The majority of factors were rated as of high importance to the successful implementation of the Strategy (none were rated lower than 6). This might have been expected since the NAO chose the factors based on an informed view of the issues. Adequate funding was rated as the most important and performance measures of the least relative importance (however they were still of medium importance).

Achievement in each of the areas deemed important was poor – indeed, as the graph shows, there was a general trend whereby the more important a particular aspect was deemed to be, the lower it scored in terms of achievement. Correspondingly, whilst adequate funding was deemed the most important issue, it scored lowest in terms of the extent to which it is in place.

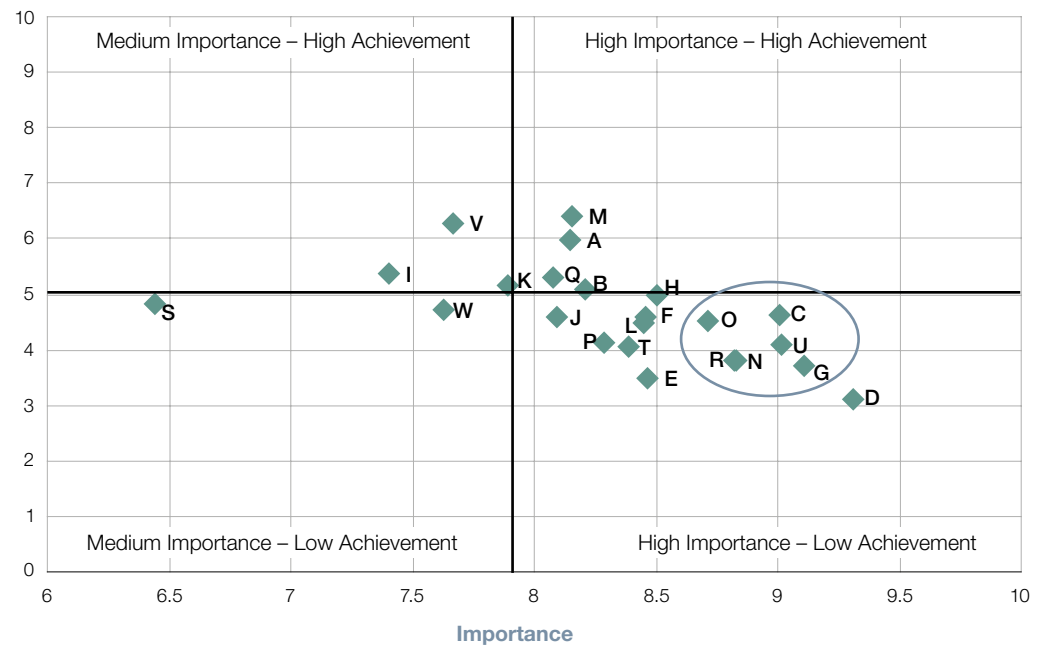
No aspect scored particularly highly on achievement; the best established factor was the quality training/capability of mental health staff, such as those completing the survey.

The factors that require particular attention i.e. those which have high importance and low achievement are circled in Figure 10. They are (excluding funding which is already mentioned above): sufficient capacity (number of staff); joint working across the whole system; quality training/capability of staff in general hospitals, care homes and social care; and strong local leadership (PCT / Local Authority).

Figure 10

Areas deemed important by consultants to the successful implementation of the National Dementia Strategy mapped against their achievement

Achievement



Areas important to successful implementation

A Strong national leadership (Department of Health/Programme Board)	M Quality training/capability of staff – mental health
B Strong regional leadership (SHA/DRD)	N Quality training/capability of staff – general hospitals
C Strong local leadership (PCT/Local Authority)	O Quality training/capability of staff – social care
D Adequate funding	P Quality training/capability of staff – intermediate care
E Flexible funding (i.e. the ability to reallocate funding)	Q Quality training/capability of staff – voluntary sector
F Sufficient capacity (number of beds/places)	R Quality training/capability of staff – care homes
G Sufficient capacity (number of staff)	S Performance measures/targets
H Effective processes/pathways	T Clear allocation of responsibility
I Change in staff culture	U Joint working across the whole system
J Change in management culture	V User demand
K Change in public attitudes	W Evidence of benefits from exemplars
L Quality training/capability of staff – General Practice	

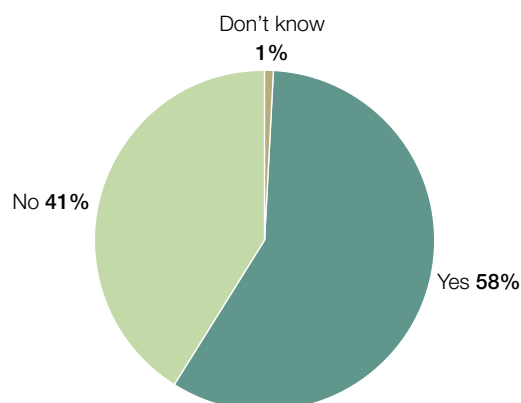
2 Services

2.1 Availability of hospital mental health liaison services

Over half of consultants questioned (58 per cent) confirmed that their local general hospital had a specialist older people’s mental health liaison team (**Figure 11**). Respondents in the South East Coast SHA had the highest proportion of people saying they had one (91%) whilst the East Midlands SHA had the lowest proportion (20 per cent).

Figure 11

Is there a specialist older people’s mental health liaison team at the local general hospital?

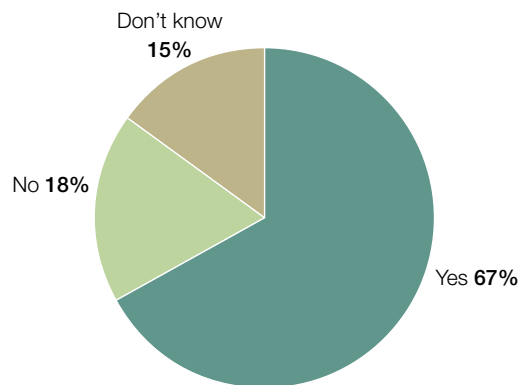


Of the respondents who answered no, less than a third (32 per cent) could confirm that a specialist older people’s mental health liaison team was on the commissioners’ agenda. Forty-two per cent said no and 26 per cent did not know. One hundred per cent of those South East Coast respondents answering no believed a liaison service was on the agenda. East of England had the highest proportion of negative responses at 80 per cent.

Generally consultants felt that their general hospital Trust was supportive of mental health liaison with two-thirds (67 per cent) responding to this question positively (**Figure 12**).

Figure 12

Consultants' perception of whether or not their general hospital Trust is supportive of mental health liaison

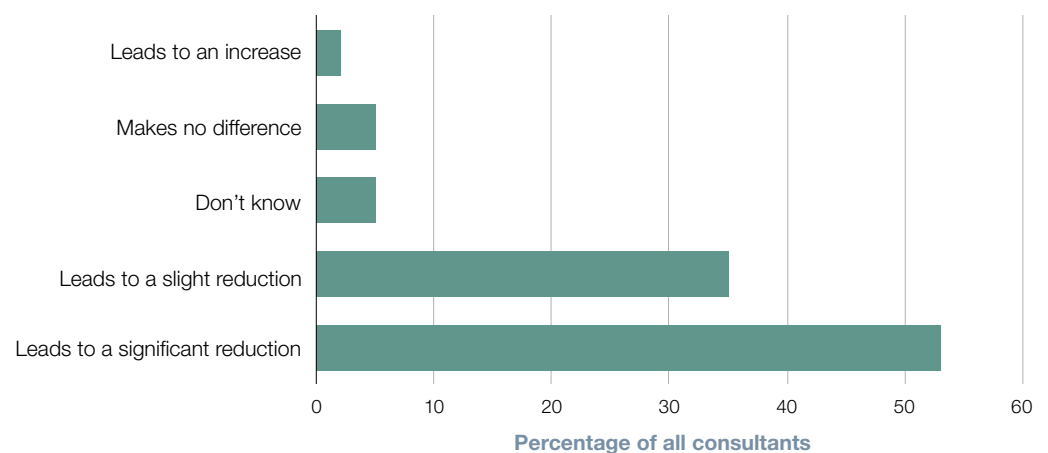


2.2 Impact of hospital mental health liaison services

Consultants were asked their opinions on the impact they felt the use of a multidisciplinary mental health liaison team has on a patient's length of stay in general hospital. The vast majority (88 per cent) believed it leads to a significant (53 per cent) or slight (35 per cent) reduction (**Figure 13**). Respondents in the South East Coast were the most positive about the impact (100 per cent saying it leads to a reduction) whereas those in East of England SHA were more sceptical (69 per cent).

Figure 13

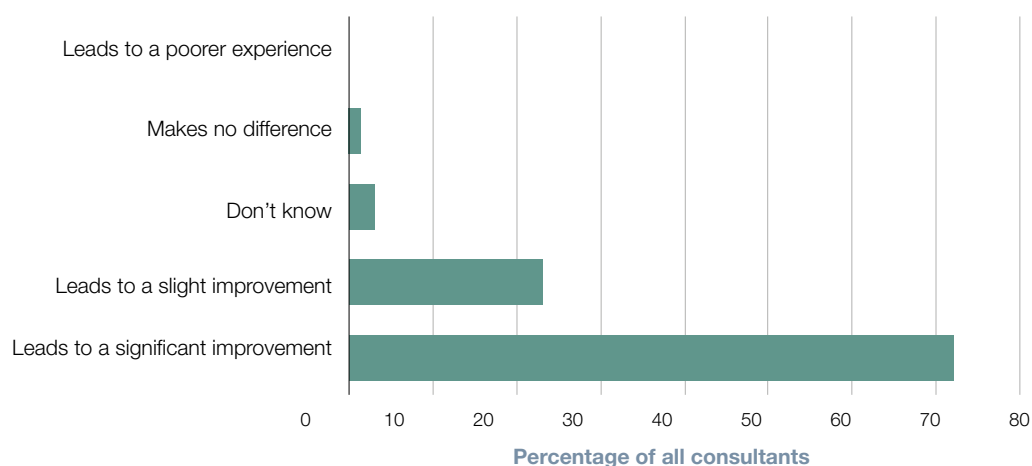
The impact the use of a multidisciplinary mental health liaison team has on a patient's length of stay in general hospital



Almost all respondents (95 per cent) felt that the use of a multidisciplinary mental health liaison team improves a patient's experience of their stay in general hospital, with almost three-quarters (72 per cent) believing it leads to a significant improvement. No respondents felt that it leads to a poorer experience (**Figure 14**). There was little regional variation with agreement ranging from 93 per cent to 100 per cent with the exception of East of England SHA, where agreement was at 77 per cent (23 per cent did not know).

Figure 14

The impact the use of a multidisciplinary mental health liaison team has on a patient's experience of stay in general hospital

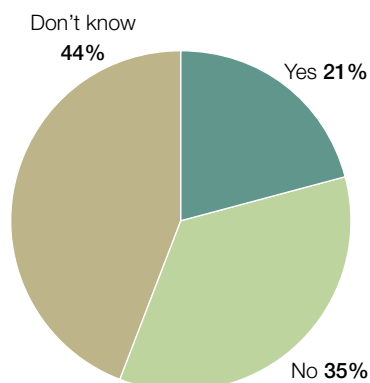


2.3 Local hospital care pathways

Respondents were asked whether a senior clinician has been identified to take the lead for quality improvement in dementia care in their local general hospital; only one fifth (21 per cent) said yes (**Figure 15**). Of those who said yes, 17 per cent said they themselves had been identified to take the lead whilst 83 per cent said another senior clinician had been identified to take the lead. South East Coast SHA had the highest proportion of respondents saying either they or someone else had been identified (36 per cent) whilst East of England had the lowest (eight per cent).

Figure 15

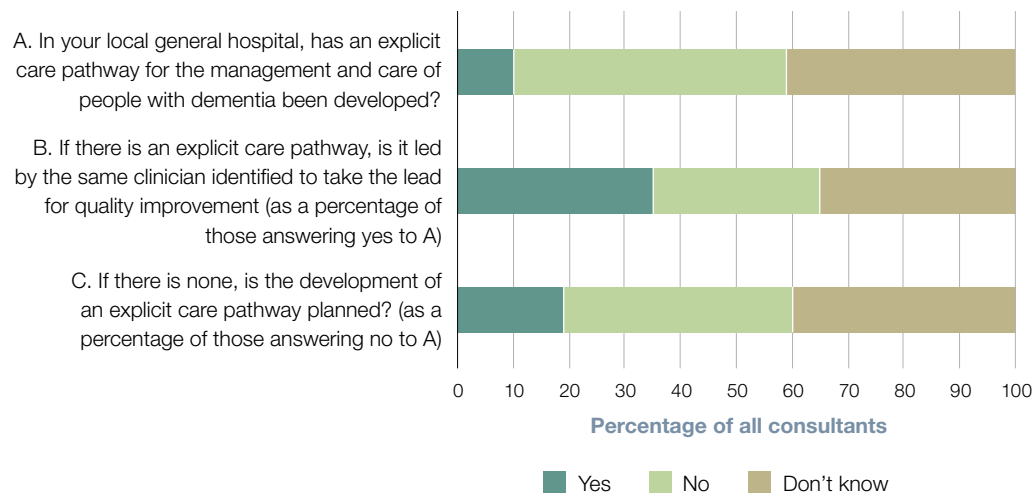
Has a senior clinician been identified to take the lead for quality improvement in dementia care in the local general hospital?



Almost half (49 per cent) of respondents stated that an explicit care pathway for the management and care of people with dementia has not been developed in their local general hospital and, of these, less than one-fifth (19 per cent) could confirm that a pathway was planned. Where one is in place, over a third of respondents (35 per cent) do not know who it is being led by (Figure 16). One fifth of respondents in the East Midlands and South West SHAs confirmed their local general hospital had an explicit care pathway whilst no respondents in Yorkshire and Humber, South East Coast and East of England SHAs said there was a pathway (zero per cent).

Figure 16

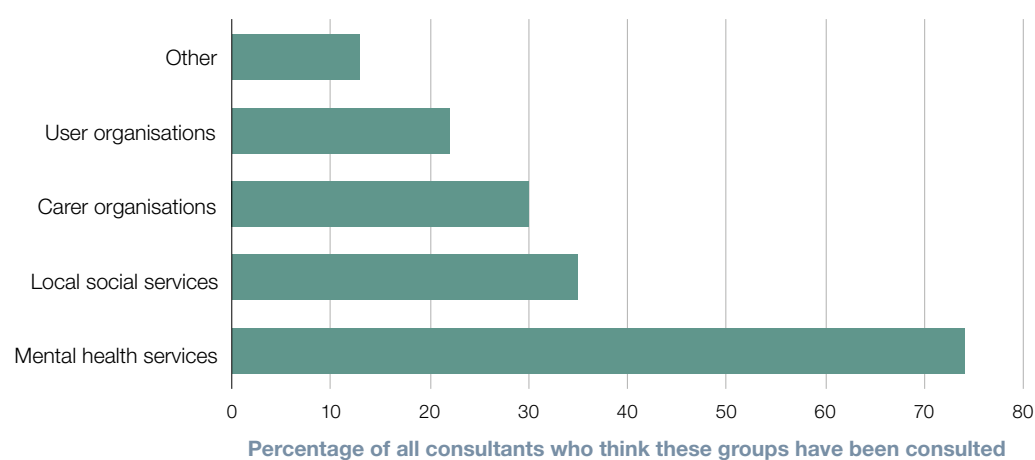
Existence and leadership of an explicit care pathway for dementia in the local general hospital



Almost three-quarters (74 per cent) of explicit care pathways that exist, have been developed in consultation with mental health services. Just over a third (35 per cent) have been developed in consultation with local social services and fewer in consultation with carer (30 per cent) and user (22 per cent) organisations (Figure 17).

Figure 17

Extent of consultation with different groups in the development of explicit care pathways



2.4 Availability of rehabilitation and intermediate care services for people with dementia

Respondents were asked about the availability of rehabilitation and intermediate care services in their local general hospital and how accessible these were for people with dementia.

Whilst almost two-fifths (38 per cent) of respondents reported that physical rehabilitation services were available for people with dementia, a third (33 per cent) said that physical rehabilitation services exist, but were not open to people with dementia (Figure 18).

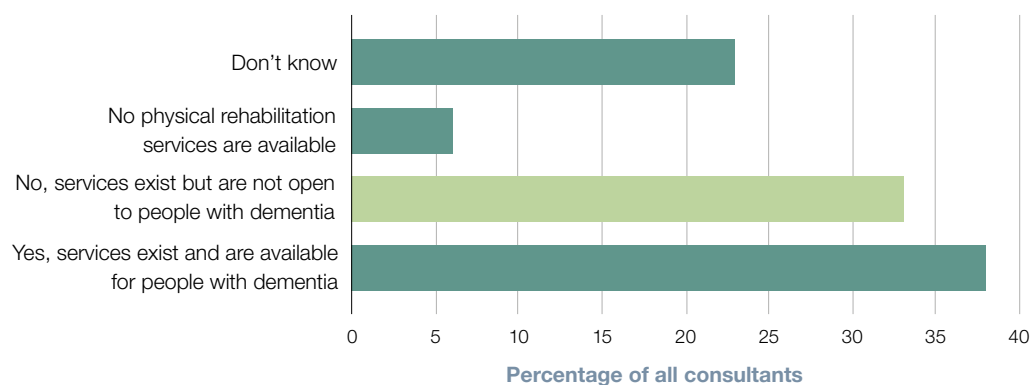
Over half of respondents in the East Midlands (53 per cent) and the North East (52 per cent) SHAs said physical rehabilitation services existed and were open to people with dementia, whilst eight per cent said so in East of England SHA.

Mental health rehabilitation services are less widely available with over half of respondents (51 per cent) saying no such services are in place at their local general hospital. Where services do exist, almost two-thirds of these (63 per cent) are not open to people with dementia (Figure 19).

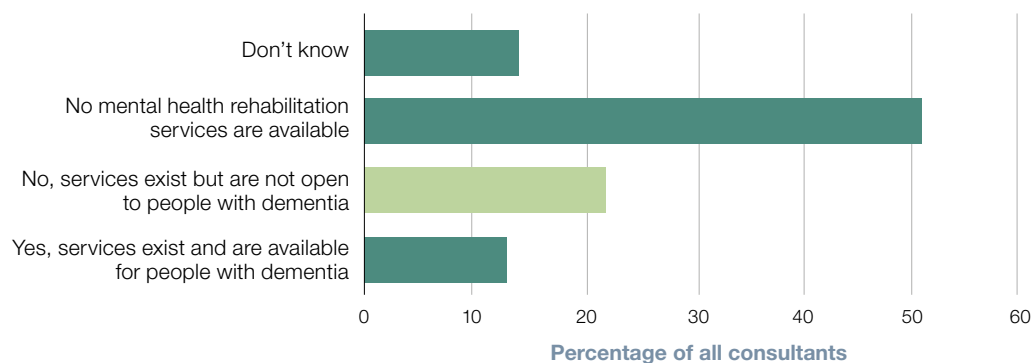
Almost a fifth of respondents in the London (19 per cent) and the South East Coast (18 per cent) SHAs said mental health rehabilitation services existed and were open to people with dementia, whilst five per cent said so in the West Midlands SHA and no respondents answered positively in the South Central SHA (zero per cent).

Figure 18

Availability of physical rehabilitation services for people with dementia

**Figure 19**

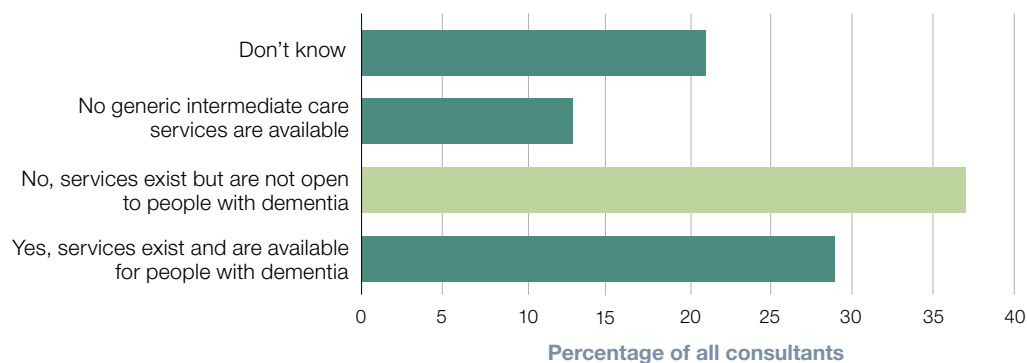
Availability of mental health rehabilitation services for people with dementia



Generic intermediate care services were available in the local general hospital of two-thirds (66 per cent) of respondents. Of these, over half (56 per cent) were not open to people with dementia (**Figure 20** overleaf).

Over two-fifths (44 per cent) of respondents in the North East SHA said generic intermediate care services existed and were open to people with dementia, whilst nine per cent of respondents in the West Midlands said so.

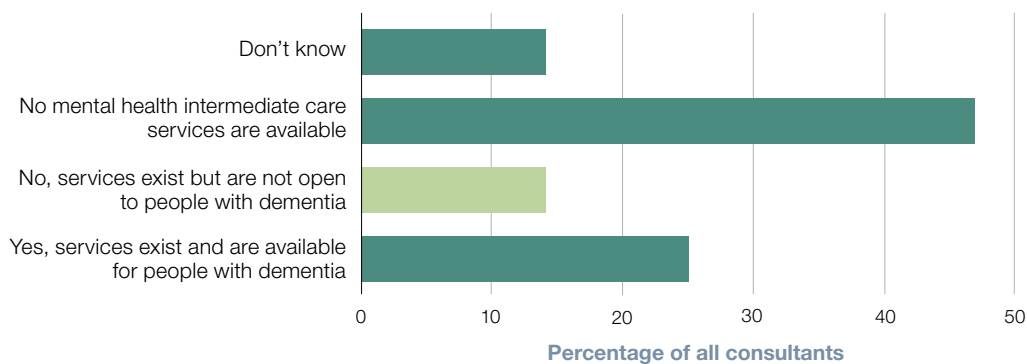
Figure 20
Availability of generic intermediate care services for people with dementia



Mental health intermediate care services are less widely available with almost half of respondents (47 per cent) saying no such services are in place at their local general hospital. Where services do exist, almost two-thirds of these (64 per cent) are open to people with dementia (Figure 21).

Almost half (47 per cent) of respondents in the Yorkshire and Humber SHA said mental health intermediate care services existed and were open to people with dementia, whilst nine per cent of respondents in the West Midlands and South East Coast SHAs said so.

Figure 21
Availability of mental health intermediate care services for people with dementia



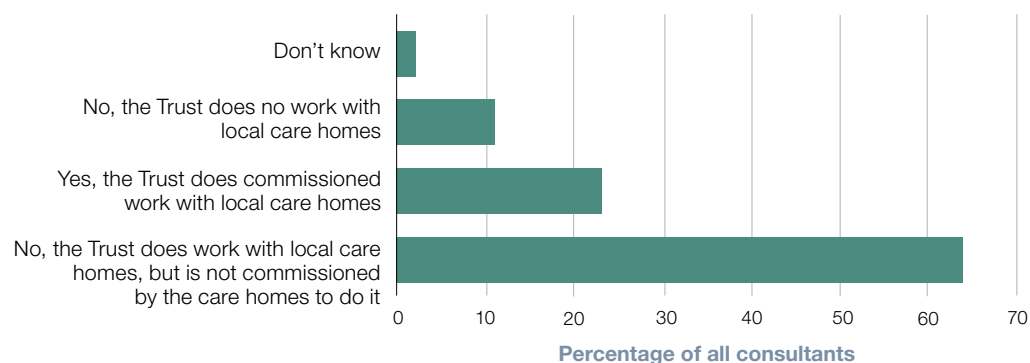
3 Commissioning and Funding

3.1 Commissioned work with local care homes

Respondents were asked whether their Trust did any work with local care homes and, if so, whether they were formally commissioned by the care homes to do it. Eighty-seven per cent of respondents stated that their Trust did work with local care homes, but almost two-thirds (64 per cent) of all respondents did so without being commissioned by the care homes (**Figure 22**).

Figure 22

Work undertaken by Trusts for local care homes



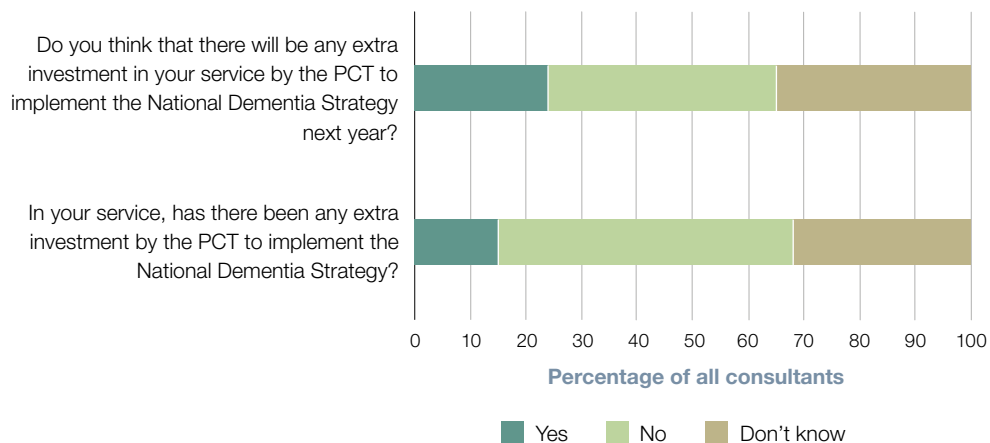
3.2 Extra investment by Primary Care Trusts to implement the National Dementia Strategy

When asked if there had been any extra investment by their Primary Care Trust to implement the Strategy, over half (53 per cent) of respondents said no. Almost a third (32 per cent) did not know. Almost a quarter of respondents thought that the PCT would make extra investment in their service next year (**Figure 23** overleaf).

The West Midlands had the highest proportion saying yes (32 per cent), while in the East of England, Yorkshire and Humber, and the South East Coast, zero per cent said yes.

Figure 23

Current and future investment by the PCT to implement the Strategy



4 Other Professionals

4.1 Other professionals' knowledge of dementia

Respondents were asked how well-informed they felt other professionals are about dementia (**Figure 24** overleaf). Specialists, as would be expected, were generally considered to be better informed than generalists. The groups considered to be the most well-informed about dementia are doctors on mental health wards (93 per cent), doctors on elderly care wards (86 per cent) and nurses on mental health wards (85 per cent). The groups considered to be the most poorly-informed are nurses on surgical wards (93 per cent), doctors on surgical wards (89 per cent) and nurses on general wards (89 per cent).

4.2 Opportunities to network and share learning and good practice

Respondents generally were satisfied (62 per cent) with their opportunity to network and share learning and good practice with other Consultant Old Age Psychiatrists. However, a significant minority (19 per cent) were fairly or very dissatisfied. There was greater dissatisfaction with the opportunities to network and share learning with other professionals, with almost a third (31 per cent) stating they were fairly or very dissatisfied (**Figure 25** on page 21).

Figure 24

Consultants' views on how well-informed their colleagues are about dementia

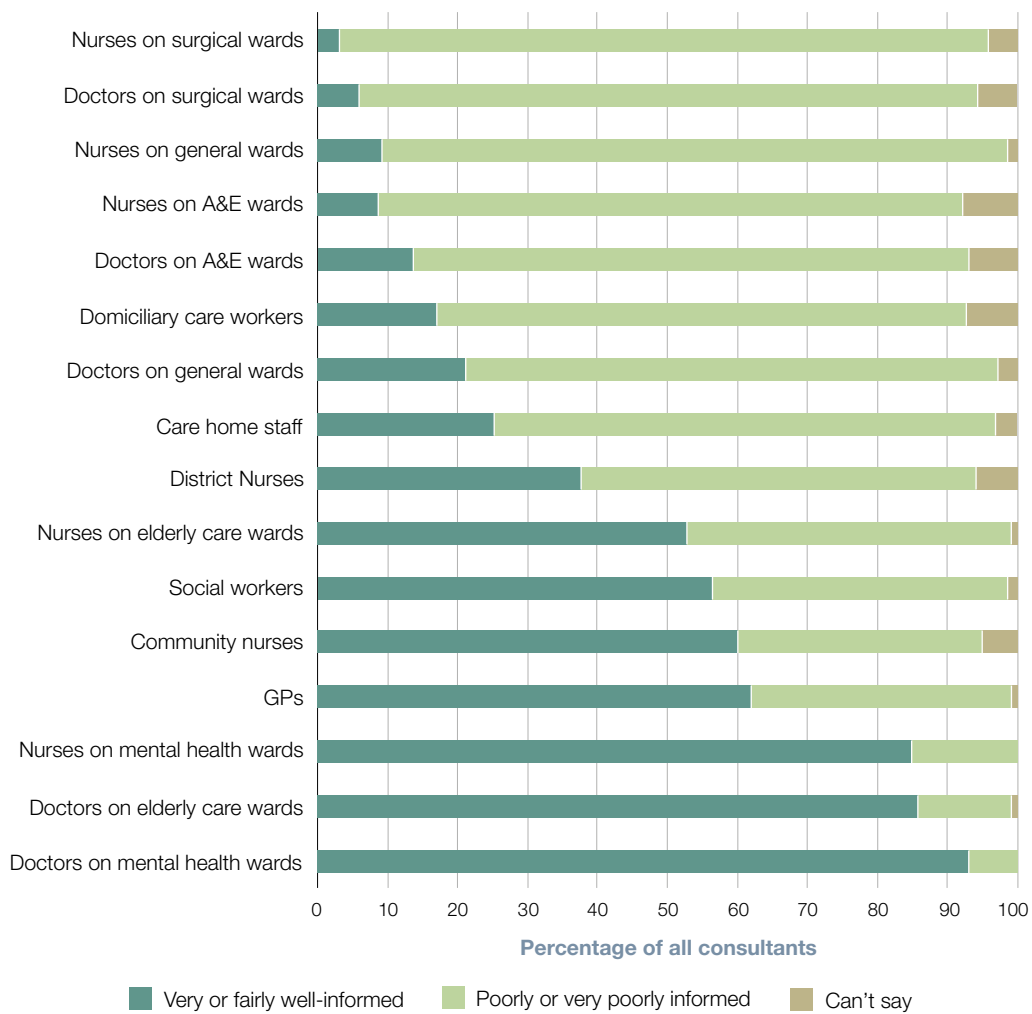


Figure 25

Consultants' levels of satisfaction with opportunities to network and share learning and good practice with colleagues

