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ROYAL COLLEGE OF PSYCHIATRISTS

OP105

BGS
British Geriatrics Society
Improving healthcare for older people

Collaborative approaches to treatment

Depression among older people living in care homes

Foreword

The British Geriatrics Society and the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists have worked together to produce this short report.

We are working to overcome the barriers that sometimes prevent psychiatrists and geriatricians working more closely together. Addressing the divide between mental and physical healthcare is essential if we are to provide the best care for older people living with frailty. Achieving this at a time when levels of need are increasing and resources are constrained is challenging, and organisational structures can be a barrier. It is encouraging that some of the examples in our report show the benefits that can be realised when multidisciplinary teams include both geriatricians and psychiatrists, and an integrated model of healthcare is delivered.

A further barrier to providing excellent care in relation to depression is that the scale of depression among older adults in care homes is probably not adequately recognised. As shown in the literature review summary, there has been a paucity of research in this area, and what studies there have been on the prevalence of depression show hugely varying results. What we do know is that people in care homes have multiple risk factors for depression, and that the mental and physical health input from specialist services to address depression appears to remain limited. This perhaps suggests that little has changed since 2011 when the BGS Quest for Quality Inquiry into Healthcare Support for Older People in Care Homes found that over 70% of geriatricians believed that depression and dementia affecting residents of care homes were not optimally managed.

However, rather than focusing on the barriers that exist, our report focuses instead on the creative ways that specialist practitioners have found to collaborate effectively to provide integrated care. The report sets out examples of good collaborative practice in treating depression in older people living in care homes.

Our key findings and analysis provide an indication of the need that all our members are aware of; the need for accelerated system reform in the journey towards a fully integrated healthcare system for older people, which addresses both physical and mental ill health, grounded in a commitment to holistic patient-centred care.

We will be using our report to promote further discussion and debate on how we can work together to achieve better outcomes for some of the most vulnerable people in our society; older people living in care homes.

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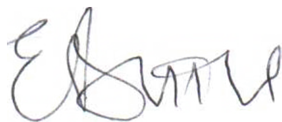

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1 Introduction, background and context

Introduction

Members of the British Geriatrics Society and the Faculty of Old Age Psychiatry at the Royal College of Psychiatry both have expertise in providing high quality treatment and care for older people.

Geriatricians and old age psychiatrists work with older people with depression on a daily basis, and share a concern about the significant levels of depression among those older people who live in care homes.

In 2017 we decided to carry out a joint project to collate and showcase examples of the best practice that flows from effective interdisciplinary collaboration and practice in treating depression in older people living in care homes.

Our aim was to promote awareness and understanding of the key features of best practice among practitioners, commissioners and policy-makers. Our objective was to explore the ways in which geriatricians and allied health professionals, and psychiatrists specialising in the care of older people, are working together to overcome the specific challenges that arise when treating depression in older people living in this community. We wanted to focus on those people whose physical and mental health needs are severe enough to require input from psychiatrists and from geriatricians, while fully recognising the key role GPs play in diagnosis and treatment.

With that objective in mind, we put out a call to members of the BGS and to members of the Old Age Faculty at the Royal College of Psychiatry, asking them to submit good practice examples.

Our short report tells you about our research journey, presents the examples received, and offers some reflections and analysis of the issues that it raises.

We are publishing the report now because we want to engage others in discussion and debate about current practice and encourage people to reflect with us on the experience that is shared in this report.

Background and wider context

People are living longer and demand from older people for health and social care services is increasing rapidly, and will continue to increase in the coming decades. The statistics are telling: the number of older people aged eighty five and over in the UK has increased by over a third in the last decade and is predicted to more than double in the next 23 years to over 3.4million[1]. At present 14.8% of people aged 85 and over live in care homes[2]. Recent evidence shows that four in ten older people living in nursing homes in England are depressed[3]. At the same time, the prevalence of multi-morbidity is estimated to increase by 17% by 2035, and two thirds of people with four or more diseases will have mental ill-health[4].

While people are living longer there is recent evidence to show that the number of disability-free years of life is actually decreasing[5]. The significant increase in the size of the older population, combined with other changes in the way society is structured, is a key factor in the rapidly increasing and urgent need for greater investment in health and care services in the UK and long term solutions for ensuring that everyone gets the right care at the right time and in the right place.

At the time of writing there is intense pressure on health and care services. Some of this pressure is attributed to older people experiencing delayed discharge from hospital as a result of lack of capacity in social care. A Government Green Paper on Care of Older People is due to be published in Autumn 2018; the extent to which it will include proposals that represent a long term solution to the provision of social care remains to be seen; in the meantime, the pressure on social care continues.

Alongside increased demands on services the workforce census for 2017 published by the Royal College of Psychiatrists shows an ongoing rise in the reported number of vacant or unfilled consultant psychiatrist posts across the UK, up from 5% in 2013 to 9% in 2017, and that old age psychiatry is one of the specialties where vacancies are most severe. While the most recent RCP census shows that geriatrics now has the largest number of trainees, the demand for consultant geriatricians is unprecedented.

So, given the current pressures on the care of older people, what response did we get to our call to clinicians for good practice examples of collaborative treatment of older people who are living in care homes and experiencing depression?

1 National population projections for the UK, 2014, Office for National Statistics, 2015
2 Care of Older People, UK Market Report, Laing and Buisson, 2017
3 Five Year Forward View for Mental Health https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
4 Age and Ageing, Volume 47, Issue 3, 1 May 2018, Pages 374–380, https://doi.org/10.1093/ageing/afx201
5 Marmot health indicators, Institute of Health Equity, 2017 http://www.instituteofhealthequity.org/about-our-work/marmot-indicators-release-2017

2 Key findings, themes and messages

Person-centred care

Person-centred care[6] is the central focus of the examples received. Full involvement of patients, and their families and friends in significant decisions is a key feature of the collaborative working that we present in this report.

The case study from Gateshead is a strong example of how someone's mental and physical health can improve dramatically when they are encouraged and supported to express their feelings, are really listened to, and practical solutions found that are tailored to the patient; in this case the person had a number of long term conditions and was severely depressed. After seeing both a psychiatrist and a geriatrician it was noted that the patient had a love of dogs and a referral was made for pet therapy. The outcome of basing a treatment plan on an understanding of the person rather than only their clinical symptoms was a significant improvement in mood, decrease in pain and reduction in medication.

The example from South Manchester demonstrates the value of proactively involving patients' families, especially in developing advanced care plans[7] when patients are approaching the end of life. The physical burden of treatment on overall well-being is assessed which means patients are appropriately treated for depression, and are looked after in their preferred place of care and place of death.

Use of Comprehensive Geriatric Assessment and multidisciplinary working

In Camden and Islington the Care Home Liaison Service works with the Integrated Community Ageing Team. This team is led by a consultant geriatrician and specialises in Comprehensive Geriatric Assessments. The multidisciplinary meetings are held in each care home covered by the Service and have been instrumental in changing practice, for example by exploring new strategies which resulted in the commissioning of additional psychology resources and more care home Activities Coordinators. The result has been a significant reduction in admissions to acute hospitals and in the number of bed days for those people who are admitted to hospital.

The example from Manchester shows the benefits of multidisciplinary team meetings being attended by both geriatricians and psychiatrists. In all our examples the role played by Advanced Nurse Practitioners and Community Psychiatric Nurses, and Occupational Therapists and other allied health professionals, is shown to be at the heart of successful treatment of depression.

In Poole, Dorset, the benefits of an integrated mental and physical health service are striking. The development of a 'liaison model' has brought together expertise from the community mental health team, primary care, social workers, and the community physical health team which includes GPs, practice and district nurses, a speech and language therapist and care home staff. The sharing of expertise in managing complex physical and psychiatric co-morbidities has led to reductions in admissions to psychiatric and acute hospitals, and reductions in use of medication.

Professional development, training and support

One of the benefits of collaboration that shines through in our examples is the increase in opportunities for shared learning and for professional development.

At Nazareth House in West London experienced mental health nurses are providing training for senior care home staff in identifying mental health issues among the residents. In Gateshead a holistic approach to healthcare means that all healthcare staff in the care home are able to develop skills that help to identify depression in the older people they are working with. This has led to an increased awareness and ability to challenge the idea that low mood might be something to be expected in people living in care homes. In Camden and Islington clinical psychology-led support groups for care workers have been established with 1.5 hours of support available every four to six weeks.

Also in Camden and Islington, one of the outcomes from conducting a research study alongside clinical practice has included the development and delivery of a training programme for care home staff in managing agitation in people with dementia.

6 Person-centred care means people are treated as equal partners. It involves putting patients and their families at the heart of all decisions. Glossary - NHS England https://www.england.nhs.uk/wp-content/uploads/2014/06/tp-res-7-glossary.doc

7 Advance care planning describes the conversation between people, their families and cares and those looking after them about future wishes and priorities for care. The gold standards framework 2013 http://www.goldstandardsframework.org.uk/advance-care-planning

Voluntary and community sector involvement

A key feature of our examples is the role played by the voluntary sector. The benefits of building relationships with voluntary organisations are clearly demonstrated in the example from the Community Mental Health Team for older people in Rydale, North Yorkshire. Here a carers' support organisation provides a befriending service to anyone living in a care home who needs additional one-to-one support in order to engage in purposeful activity, resulting in positive feedback from patients and their families. The importance of working with arts charities to help support older people and people with dementia to engage in creative activities is highlighted in the Gateshead example.

Funding and investment

Most of the services described in this report are funded from standard funding sources; the majority receive funding from the Clinical Commissioning Group in their local area.

Two of the services, in Gateshead, and Cheshire, were successful in accessing funding from the Care Homes 'Vanguard'[8]. This enabled those leading the initiative in Gateshead to introduce new approaches in managing depression in care homes, for example the development of an education framework for everyone working in 24 hour care settings. In Cheshire initial funding from the Vanguard helped the Liaison Team to develop and apply a quality improvement methodology which led to positive changes in care staff's ways of working, with increased empowerment and a more proactive approach to meeting people's needs.

A strong example of what can be achieved without any additional funding is shown in Poole, Dorset. The liaison model which resulted in increased patient contact and decreased waiting time for psychiatric services was developed with no extra funding.

Outcomes and impact

Our examples show a range of positive outcomes in the treatment of depression in older people living in care homes although in some cases it wasn't clear how impact was being measured. In other examples the use of a depression scale, and clear statistics about the number of people who are admitted to an acute hospital ward showed the positive impact of collaborative, person-centred practice. In Manchester, where geriatricians and psychiatrists are working together as part of a multidisciplinary team, there has been a reduction in the need for detaining people under the Mental Health Act, and the number of admissions for acute in-patient psychiatric assessment has also reduced.

Geographical spread of examples

The examples we received are from a range of locations across England and include work in cities, suburban and rural areas. However we have not been able to include any examples from the devolved nations. Both the British Geriatrics Society and the Royal College of Psychiatry are UK-wide membership organisations whose members work across England, Scotland, Wales and Northern Ireland. We were unsuccessful in eliciting examples and will be reflecting with locally based members on how best to generate further evidence of the issues and experiences across the UK.

8 Care Home Vanguards provide new models of care. Across England there are six enhanced health in care home vanguards working to improve quality of life, healthcare and health planning for people living in care homes

3 Analysis and reflections/conclusions

It is difficult to draw any firm conclusions from the small number of examples in this report. Instead we are left with some tentative conclusions and some questions requiring further study.

We began our project with an anticipation of receiving a significant number of examples to select from for publication. Instead the response was slow and small. We are grateful to all who responded, including those clinicians who got in touch to say that they had seen the call for examples but were unable to send in a submission because of the barriers that exist; especially the different ways in which mental and physical health services are commissioned and funded.

The examples we received show a diverse mix of practice across a wide range of settings and offer just a very small snapshot of an extensive area of clinical practice. The amount of resource available, both clinical time and funding was very variable in the examples we present. What they consistently demonstrate, however, is the value of a person-centred approach to treating depression in older people who live in care homes, and the benefits of multidisciplinary team working and sharing of expertise.

What our examples do not provide is insight into the challenges and barriers that exist in developing and delivering collaborative practice between the specialties of psychiatry and geriatrics in providing treatment in care homes. A question we are left with which would require research on a larger scale, is the extent to which unmet needs exist that go untreated.

A further question is whether there is a lot more excellent innovative practice that we failed to identify, perhaps because the pressure that health care professionals are working under means they find it difficult to make the time to engage with projects such as this one.

Notwithstanding these issues, analysis of the examples presented in our report show that:

- collaboration across disciplines to treat people with depression in care homes requires a holistic and person-centred approach which takes account of the patient's full range of health conditions; this can result in significant improvements in health and quality of life as well as reductions in detentions under the mental Health Act and admissions for in-patient psychiatric assessment
- collaboration between geriatricians and old age psychiatrists benefits not only patients and their families but also the staff who work in care homes, who gain increased skills and knowledge which enables them to be more proactive in recognising depression in the people they work with.

Next steps

The British Geriatrics Society and the Old Age Faculty at the Royal College of Psychiatry plan to hold a roundtable meeting later this year to discuss the issues in this report and to consider next steps. Our view is that treatment of depression among older people living in care homes is an under resourced and under researched issue. We will be seeking to encourage government bodies and research organisations to engage further with the issues.

4 Good practice examples

Gateshead Care Home Initiative

Background

There are 32 care homes for older people across the borough of Gateshead, Tyne and Wear, with approximately 1600 beds. The homes vary in size. 17 of them have nursing beds; these include 8 with dementia nursing beds. The remaining homes are residential. The majority are registered for dementia care. Only one home would describe itself as having special skills in older people with mental illnesses other than dementia.

Who are the patients?

The health of people in Gateshead is generally worse than the average for England. Deprivation is higher than average and life expectancy is 9.9 years lower for men and 8.7 years lower for women in the most deprived areas of Gateshead than in the least deprived areas[9]. Healthy life expectancy at birth in Gateshead is 57 years for men and 59 years for women. With regards to the care home population the average age of those living in care aged 65+ is 84 years old. The average number of long-term conditions is four. In the North East of England only 18% of care home residents are self-funding. Currently 26% of all care home residents are recorded as having depression.

Nature of the intervention/s

All homes in the Gateshead Care Home Initiative (GCHI) are linked to a GP practice with a named GP who conducts weekly ward rounds. Since 2013, all homes with nursing and some of the residential homes have Older Person's Specialist Nurses (OPSNs) attached to them who cover between one and three homes each, working in primary care alongside the GPs. The aim is to provide proactive care with Comprehensive Geriatric Assessments (CGA) forming the basis for that. CGA also informs the development of emergency health care plans for all residents.

All of the specialist nurses attend a multidisciplinary, virtual ward meeting held every Wednesday afternoon, along with Consultant Community Geriatricians and a Consultant Old Age Psychiatrist. Everyone participating in the meeting can bring patients to discuss, get advice and updates and arrange further visits.

This aids holistic care and enables co-working between primary and secondary care staff, and physical and mental health staff. The involvement of relatives and carers in all aspects of care and care planning as appropriate has increased and is now the norm.

The benefits of this approach to managing depression in older people are that it:

- skills up all members of the care home healthcare team to consider and treat depression
- enables quick access to specialist advice and support
- helps identification and management of depression in the context of multi-morbidity and polypharmacy
- helps promote non-pharmacological management strategies alongside medication.

Due to this approach already being in place in Gateshead the GCHI was designated one of the Care Home Vanguard programme sites in 2015. This has enabled the team to consider the wider system and ways to improve care in care homes across many themes. The developments which have most helped in the management of depression among older people living in care homes in Gateshead are:

- development of a competency-based education framework for all those working in 24 hour care settings, part of which is about mental health conditions (aside from dementia)
- promotion of the value of meaningful activities and interactions: this is particularly so for people with dementia but it is beneficial to everyone, especially those with mood disorders, with or without dementia. Linking this to the evidence base, for example, the Wellbeing and Health for People with Dementia (WHELD)study found that exercise-based activities in care homes showed significant improvements in mood
- inclusion of depression as a specific strand in their North East Frailty Summit in December 2016

Time spent treating older people with depression

It is difficult to quantify the time because treatment is holistic and person- centred; usually depression will be one of several long-term conditions being managed.

9 Gateshead unitary authority, health profile 2017, Public Health England http://fingertipsreports.phe.org.uk/health-profiles/2017/e08000037.pdf

The consultant psychiatrist has four programmed activities: four half days a week, for this work. Approximately one third of the people that the Psychiatrist visits in the care homes have a predominant depressive component of their health issues. At virtual ward meetings, the proportion is also approximately a third of all patients.

Funding

The Clinical Commissioning Group provides funding for the Gateshead Care Home Initiative. The Vanguard programme funding has been in place from March 2015 for three years and has allowed staff to study the system and develop different approaches. It has not been used to provide clinical care. For example, exploring acute admissions to hospital for urinary tract infections highlighted numerous areas where a difference could potentially be made. This has led to work on promoting hydration in care homes, improving carers' recognition of deteriorating health at early stages and better pathways to access clinical support in a timely manner.

Community

A range of activities is provided as in-reach into the care homes. These include engagement with Equal Arts, a creative charity working in Gateshead and Newcastle which supports older people and those living with dementia to engage with musical, visual and movement-based creative activities.

Results and impact

While there are lots of data on reduced unplanned acute admissions to hospital across the care homes the GCHI has not collected any depression-specific data. However, it is the view of the clinicians involved that there is much greater awareness and much less acceptance of low mood being 'the norm' or 'to be expected'.

When asked to reflect on the difference the care home initiative has made some of the responses were:

"People get recognised better as we're making a more holistic assessment of their physical and mental health"
Older person's specialist nurse

"We've got more awareness of how depression may present in other ways like lethargy, agitation or pain"
Older person's specialist nurse

"As a group we can think about a wider array of interventions rather than just an antidepressant"
Geriatrician

"The health staff listen when I say that someone's not been right for a while, they take notice of that" *Carer.*

"The regular contact with patients by GP's on a week by week basis combined with the increased co-working with the nursing home staff through the GP link homes initiative, and the increased contact and communication between GP's and Old Age Psychiatrists goes a long way to improving recognition and management of depression in this group of patients. Their overall care is more coherent and streamlined and the management of mental health problems in particular more joined up." *GP*

Case study

Ida* is 81 years old. She has lived in her care home for 6 months having previously lived at home with her husband. Her health conditions include vascular dementia, diverticular disease, osteoporosis, hiatus hernia and poor vision. She currently takes 9 different medications. She frequently presents on the care home GP round with complaints of abdominal pain. The OPSN brought Ida for discussion at the virtual ward regarding her abdominal pain, but both she and the GP had also wondered about low mood being a component of Ida's presentation.

Following discussion Ida was visited separately by the consultant geriatrician and the consultant psychiatrist. As well as depressive symptoms, she expressed a wish to die although denied any thoughts of self-harm. A collaborative management plan was then agreed at the next weekly virtual ward meeting. Ida's bone protection was altered to further limit gastric irritation and she was prescribed an antidepressant. The geriatrician noted that the only topic of conversation that sparked her interest was about her previous pet dog. A referral to the Pets as Therapy (PAT) dogs was therefore arranged. The team also liaised with the home regarding a potential move of floors to improve Ida's social opportunities. Her progress was monitored by the OPSN and fed back through the virtual ward. By the psychiatrist's next regular visit to the home, Ida had significantly improved in mood and her complaints of abdominal pain had ceased. She had made a friend on her new floor of the care home and was enjoying her weekly visits from the PAT dog.

*name changed

Camden and Islington NHS Foundation Trust's Care Home Liaison Service

Background

Islington is one of the most ethnically diverse areas of the UK, according to the 2011 census, with only 60% of the local population describing their ethnicity as White British. Areas in Islington are in the top 10% of most deprived areas in the UK, according to the indices of deprivation published by the Department for Communities and Local Government. Islington is an ethnically diverse borough and this is reflected in the care home population.

Camden and Islington NHS Foundation Trust's Care Home Liaison Service aims to support care homes in Islington to provide effective care for the mental health needs of their residents. Eight of the care homes are privately run, and one is run by Camden and Islington NHS Foundation Trust.

The Care Home Liaison Service works closely with the Integrated Community Ageing Team (ICAT). ICAT is a multidisciplinary team led by a consultant geriatrician specialising in Comprehensive Geriatric Assessments for patients who are registered with an Islington GP. As part of the ICAT Geriatricians and specialist pharmacists provide visits and support to patients who live in care homes in the borough.

Who are the patients?

One of the eight care homes is a nursing home which specialises in supporting people with severe mental illness. The other homes provide either nursing or residential care, or both. Approximately four fifths of people living in care homes have dementia. Depression is often present alongside dementia and physical frailty in older people living in all of the care homes in Islington. Data from the MARQUE care home study[10], in which several of the care homes participated, indicate that around 86% of English care home residents have dementia; their mean age was 86 years and 70% were female. Around 40% of care home residents with dementia have clinically significant levels of agitation (1).

Nature of the intervention/s

Multidisciplinary meetings take place regularly in each care home, either once or twice a month, depending on the nature of the home. The meetings are coordinated by the Ageing Team and chaired by the lead General Practitioner for the care home. They are attended by care home staff, the ICAT staff, a consultant geriatrician, a pharmacist, a specialist palliative care nurse, a speech and language therapist and a Liaison Service professional. The Service currently comprises 1.4 FTE mental health nurses and 0.2 FTE Consultant Old Age Psychiatrist. These meetings have helped to ensure that there is a joined-up and coordinated approach to managing depression among older people living in care homes in Islington.

In developing the liaison service the team has responded to the emerging evidence base which shows that psychological treatments are effective in reducing symptoms of depression and anxiety for people with dementia (2), while benefits of antidepressants are less clear than for people without dementia (3).

Between January and April 2016 the liaison service trialled provision of clinical psychology-led support groups for care workers in five of the care homes. They ran 1.5 hour groups every four to six weeks. These were co-facilitated by a clinical psychologist and mental health nurse. Staff were invited to discuss challenges they were experiencing, and to explore together new strategies to try. The groups were so successful that they led to a business case being made for the commissioning of additional psychology resources for Camden and Islington NHS Foundation Trust services. The liaison service is currently recruiting for a Clinical Psychologist to join the team to support a continuation of this work.

ICAT and the liaison service both identified an unmet need for more support for care home Activities Coordinators, in order to increase the quality and reach of structured activities. It was seen as especially important for the Activities Coordinators to be supported to engage people with more severe dementia, as they are often least able to access the activities programme but at high risk of depression; a risk increased by under-stimulation and isolation. In February 2017 bi-monthly groups were set up in collaboration with Whittington Health. An Occupational Therapist (OT) employed by the NHS Foundation Trust works with the Activity Coordinators in the care homes.

10 MARQUE is a study by University College London which aims to improve the quality of life for people with dementia

The support the OT has provided has resulted in the Activity Coordinators developing and delivering training sessions for other care home staff to explain their role and encourage others to follow their example.

All nine care homes are encouraged to take part in research. Six of the care homes in Islington have participated in the MARQUE (Managing Agitation and Raising Quality of life) research study that aims to increase knowledge about managing agitation, other neuropsychiatric symptoms and personhood in care home residents with dementia.

Time spent treating older people with depression

The liaison service spends approximately 50% of its time treating older people with depression. Much of that time is spent treating agitation in people with severe dementia, whose low mood is often an important contributor to their referral to the Service.

Funding

Camden and Islington NHS Foundation Trust fund the Care Home Liaison Service. The Whittington Health funds the Integrated Community Ageing Team. The forum for Activities Coordinators is coordinated by Whittington Health NHS. The groups are run by staff from the Liaison Service staff. They are supported by expert input from the Occupational Therapist from Camden and Islington NHS Foundation Trust. The MARQUE study is a programme grant funded by National Institute for Health Research and the Economic and Social Research Council (£3.5m over 5 years).

Impact and results

Since the service provided by the Ageing Team was introduced admissions to acute hospitals have reduced significantly, thereby avoiding the mental and physical distress that often accompanies hospital admission for frail, care home residents.

In the three years that the Care Home Multidisciplinary Teams have been established, the ICAT's data shows that:

- acute admissions to the Whittington Hospital have fallen from 32.5 to 24.2 per month
- there has been an 18% reduction in bed days, despite an 8% rise in length of stay.

These reflect improvements in coordination of care, as well as the advance care planning from the MDTs that has been enabled by this approach. The psychology-led staff support groups have been well received. Staff reported back on the new strategies they were using for managing depression in residents. Where these worked well they were continued.

Examples that the groups shared included:

- spending more time outside
- talking to relatives about what residents might enjoy, for example, providing a tape of the Koran greatly improved agitation in one resident.

Introduction of these groups coincided with a decreased use of antipsychotics to treat agitation in the homes.

Tri-borough in-reach service for care homes in South London

Background

The teams work across three boroughs to provide an in-reach service into care homes (residential, nursing, specialist dementia) within the specified borough/s of the team: Lambeth, Southwark, Lewisham and Croydon. The residents of the care homes reflect the ethnically and economically diverse populations of these London boroughs.

Who are the patients?

The majority of older people referred to the team have a diagnosis of dementia. Referrals are also made to the team when the symptoms and behaviour of other mental illnesses present as challenging to care staff, for example, depression, anxiety disorders, schizophrenia type disorders, and personality disorders. The number of people referred to the team with depression and dementia is at a rate lower than might be expected, possibly indicating the ongoing challenge of enabling care staff to identify signs and symptoms of depression and request input.

The team prioritises family involvement and where possible family are invited to attend an information-sharing formulation session along with care staff to develop a collaborative, person-centred care plan.

Nature of the intervention/s

The multi-disciplinary teams include clinical psychology, community psychiatric nurses psychiatry, occupational therapy. Pharmacy sessions are included in one team. Teams provide evidenced-based assessment and interventions, underpinned by high quality research and agreed best practice standards. These are measurable at each stage of the patient journey, as described on the Mental Health Older Adults and Dementia Maudsley care pathways[11].

NICE guidelines are followed which specify that where there are behavioural and psychological symptoms of dementia, a holistic assessment is required including physical, psychological, environmental and biographical factors that might impact on the person's behaviour.

A 'stepped care' approach is used to identify the appropriate assessment and treatment at different levels and the nature of the training and expertise necessary to undertake these tasks. Innovative approaches such as multidisciplinary 'ward rounds' involving a team representative, GP, care staff and pharmacist are in pilot to facilitate effective practice at Step 1 which involves the assessment and treatment of common physical and psychiatric causes. The team can face organisational barriers to the implementation of psychosocial care plans in care homes, for example, in care homes where person-centred care is not fully embedded.

Depression in dementia is assessed using the Cornell Scale for Depression in Dementia[12]. The Hospital Anxiety and Depression Scale[13] is used for patients treated on the depression and anxiety care pathway.

Funding

Teams are funded via contracts with the local Clinical Commissioning Group.

Community

The teams work in partnership with other services, including the local palliative care team.

Results and impact

Outcome measures are included in all care pathways. In order to ensure that the treatment and care provided is effective, the services uses disorder specific outcomes tools. These make it possible to assess the extent to which a person has changed during the time they have been receiving a service. The team routinely collects the Neuropsychiatric Inventory (NPI) analysis[14] which demonstrates a statistically significant reduction in symptoms pre to post treatment with the team, in line with similar services nationally.

11 (further information is available at: http://mhoad.slam.nhs.uk/).

12 The Cornell Scale for Depression in Dementia is a scale designed as a screening tool to assess depression in people with dementia; it is not diagnostic.

13 The Hospital Anxiety and Depression Scale is a self-assessment tool commonly used by doctors to determine a person's levels of anxiety and depression

14 The Neuro-psychiatric inventory is used to assess psychopathology in the person with dementia and to help distinguish between the difference causes of dementia https://www.cgakit.com/p-3-npi

Case study

An anonymised case study from the Lewisham team is provided to further demonstrate the difference made by the service.

Lewisham Mental Health Care Home Intervention Team, South London and Maudsley NHS Foundation Trust and their work with Agnes

Background and presenting mental health problem. Agnes* is a lady in her 80s. She had been living in a nursing home for three years at referral to the team. She had a long history from the 1950s of serious mental health difficulties and reluctance to engage with services. She had received treatment on inpatient wards with medication and electroconvulsive therapy and had a diagnosis of recurrent depression. She was referred to the team as staff had found it challenging to manage her recurrent urine infections caused by a benign cyst in her bladder. At these times her mood would deteriorate and she would experience hallucinations. The most recent referral was due to her increased tearfulness and spending increasing amounts of time in bed. She could also be demanding of staff, especially if she felt that she was not being assisted correctly and promptly.

Agnes reported severe levels of anxiety and depression at assessment (18 for Anxiety and 17 for Depression on the Hospital Anxiety and Depression Scale (HADS)). She was worried about her eyesight deteriorating as she had bilateral cataracts and feared becoming a burden on her family and staff.

Intervention. Agnes received intervention from three members of the team with close involvement of her daughter:

- A consultant psychiatrist optimised her psychiatric medication regime which included paroxetine and lithium and recommended a reduction of clonazepam.
- A community psychiatric nurse focused on coordinating her physical health treatment working alongside other services (for example, specialist continence team) monitoring psychotropic medication and engaging a volunteer to visit Agnes on discharge from the MHCHIT
- An assistant psychologist worked with Agnes and staff using CBT interventions, for example psycho-education, graded exposure and progressive muscle relaxation

Outcomes. At discharge from the team Agnes scored 1 for anxiety and 2 for depression on the Hospital Anxiety and Depression Scale (both in non-clinical range). She was engaging with activities that she previously enjoyed, both with other residents and in her room. She had also started to read books again. Agnes reported an increase in confidence in mental health services and in managing her mental health including writing her own care plan with the assistant psychologist and understanding her medication regime. This plan was shared with the care home staff. Agnes also reported more confidence in the care home staff and worked with them to manage her physical health conditions with the result that no urine infections were reported in the latter half of the team intervention.

*The patient's name has been changed to protect her anonymity

Multidisciplinary care home and community liaison model - Poole, Dorset

Background

Poole has a population of approximately 35,000 older residents. There are pockets of affluence in the suburbs and on the Sandbanks peninsula. There are also areas of social deprivation, especially in and around the town centre where many people live on low incomes. The population is fairly static and includes a high proportion of retired people. A lot of older people in Poole move into supported housing, residential and nursing homes in the town.

A liaison model of care and treatment in residential and nursing homes for patients with dementia and depression has been developed as part of a consultant psychiatrist and multidisciplinary team hub. This means that there are good working relationships between the psychiatrist, the managers of the specialist care homes for dementia and the wider multi-disciplinary team (MDT). This has helped to ensure swift and effective treatment for their residents, either in community or residential settings.

Who are the patients?

The patient population consists of older patients, mostly aged 65 and above. They all have complex psychiatric and physical co-morbidities, including long-term conditions such as dementia, heart disease, COPD, diabetes, and depression. Approximately 30% of patients are aged 85 and above.

Nature of the intervention

Together the multidisciplinary team and psychiatrist have developed a model of working that incorporates an MDT within the community setting (including care homes), with improved referrals and joint working pathways.

The combination of community multidisciplinary teams using psychotherapy for the older patient is at the heart of the model, which has been developed to ensure that a lot of interventions that were previously based in hospital are now coordinated through 'hub and spoke' models within the community. The NHS Trust has a lot of community-based expertise in managing psychiatric and physical co-morbidities among older people in care homes.

There are strong working relationships in place to support this model of working. A MDT approach is used to deliver a comprehensive integrated mental and physical health service. It includes the community mental health team, primary care, social workers, and the community physical health team: this comprises community matrons, the physical intensive care service (PICs), GPs, practice nurses, district nurses, speech and language therapists, and the staff of residential care homes. The consultant psychiatrist contributes to the MDT meetings by providing educational and clinical expertise.

The psychiatrist oversees the work of link workers and care coordinators who are based in the Community Mental Health Team, and are affiliated to the primary care MDT. The care coordinators serve as link workers to larger primary care hubs where they work closely with a MDT which includes a geriatrician. Together they plan care strategies for, treat and manage patients with complex mental health conditions within a virtual ward by facilitating and working to improve communication across the team.

The consultant psychiatrist led on the introduction of Cognitive Analytical Therapy (CAT) for use by members of the community mental health team. CAT is felt to be a useful intervention for treating older people with depression, focusing particularly on relationships. The aim of the therapy is to help improve relationships, and find more adaptive ways of coping with difficult emotions and mental health problems.

How much team time is spent treating older patients with depression in care homes?

About 50% of the psychiatrist's time and 50% of the MDT's time is spent treating patients with dementia and depression either in care homes or supported living settings. The psychiatrist has medical support from an associate specialist and part time junior doctor.

Funding

There has been no additional money for this project. The overall service funding is from the NHS Trust (Dorset Healthcare University Foundation Trust).

Community

In Poole there are many examples of excellent outcomes being achieved through joint working between statutory and non-statutory organisations. The multidisciplinary team and psychiatrist have focused on working to improve community networks for isolated individuals with depression, both in residential settings and more widely in the community.

15 Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services https://www.kingsfund.org.uk/publications/social-prescribing

Joint partners from voluntary organisations include the Social Prescriptions Society, Mementos project, and some local sailing projects.

Joint working with respect to ‘social prescriptions’[15] has included collaborative working with the Community Mental Health Trust with elderly isolated patients who are experiencing either a combination of mental health difficulties and/or physical restrictions which would preclude them from living independently in the wider community. Social prescriptions offers an additional service for taking patients out of their home environment and introducing them to a wider range of social activities which could include clubs, singing and exercise groups.

Mementos is a charitable organisation part funded by the local authority that helps patients and carers with dementia. They have run dementia-friendly events which include disabled access to cinema events, and locally run day centre activities with the core emphasis on reminiscence and sensory activities. Because of the invaluable non-statutory service they provide it is heavily subscribed to and they often hold special events such as local integrated arts and heritage symposia.

Impact and results

Quotes and comments from older people and their families:

“I had given up on all my normal activities - very good to relax with understanding people. We couldn’t have coped without helpers”

“doing craft with my mum which we both enjoy”

“It was all much better than we could have hoped”

“Getting some patience back which has been going down and down for the last 2/3 years”

"It’s been a really enjoyable experience"

"Doing this together is really nice"

"We’ve enjoyed the social side of the group"

"Doing something enjoyable together"

"It’s brought back memories"

"Pictures and cards that we’d forgotten about"

"Things we’ve done in the past"

"We’ve reminisced about all sorts of things: some really happy days spent together"

The results have been significant. Outcomes have improved; these include reduced admissions to psychiatric hospitals, and acute hospitals, and also significant cost reductions in medicines reconciliation. This has reduced unnecessary duplication of prescriptions and reduced polypharmacy. There has been a more thoughtful process to prescribing medication with a greater awareness of the potential interactions of various medications. Because of the shared expertise in managing complex physical and psychiatric co-morbidities, the psychiatrist has not had to prescribe ECT. This is because interventions are delivered in a prompt way within the residential setting with a focus on improving relationships as well as working psychotherapeutically with staff and residents. In effect the residential setting often takes the place of the ward with the community MDT working as in-reach staff to treat patients effectively and where possible avoid admission.

The team’s work has resulted in reduced caseloads for care coordinators, and improvements in frequency of contact. This has led to all patients being seen within a four-week waiting period, and often within five working days of initial referral.

This model has improved the skills set, both of the staff in the community mental health team and staff in residential settings, and improved their confidence in being able to deliver therapeutic interventions. This includes looking at losses and how to reduce isolation and work therapeutically with the older person. The psychiatrist has used this model for other conditions, including atypical eating disorders in the older person, atypical grief and somatisation/conversion disorders.

Next steps

There is an appetite to develop the model further and to work with non-health settings, for example with managers and teams in service line industries that could face conflict as part of day to day work, such as residential homes, the police, Patient Advice and Liaison Service (PALs). The current challenges faced by the psychiatrist and her team would need to be overcome. These include access to adequate time, money and therapists to deliver the interventions and develop further links within community and voluntary organisations.

University Hospital of South Manchester Nursing Home Service

Background

The University Hospital South Manchester Nursing Home Service has been in existence since 2004. It provides all the medical care to the South Manchester Nursing Home population of about 300 people, as well as carrying out proactive reviews of nursing home residents. The services provide a reactive, same-day service for emergencies, as well as proactive clinical and nurse reviews.

The nursing home population is based in mixed specialist dementia and general nursing home environments in suburban locations.

Who are the patients?

The patients have a range of nursing needs, with a small proportion of patients living in residential care homes. There is a high prevalence of psychiatric disease, including depression, behavioural and psychological symptoms of dementia (BPSD), and delirium, and patients with learning difficulties and other primary psychiatric diagnoses. Frailty, Parkinson's, and cerebrovascular disease are common physical health diagnoses in many of the patients.

Key features of the service

The core team is made up of three advanced nurse practitioners, three geriatricians (0.7 whole time equivalent), a case manager and administrative support. A multidisciplinary team meeting is held on a weekly basis which is attended by a psychiatrist. At the meetings patients with challenging needs are discussed, and debriefings are held on deaths and admissions to hospital. Interdisciplinary teaching regularly occurs.

The team liaises very closely with relatives, with the consent of the patient, or in their best interests if the patient is unable to give consent. Advanced care decision-making is discussed with relatives and or carers, and the existence of any Health and Welfare Lasting Power of Attorney or Advance Directives is identified.

This proactive work with patients, or their family or friends if they lack capacity, enables the team to discuss patient's goals and preferences for place of care and decisions about resuscitation. Depression is common in this population, as is the prescription of antidepressants. As part of a holistic assessment, proactively and on a regular basis, the medical burden of any diagnosis of depression is always considered: whether the depression might be being under or over-treated, and its effects on a person's physical health and overall well-being.

Funding

The Service is funded by South Manchester Clinical Commissioning Group, and the team members are employed directly by the Acute Trust (University Hospital of South Manchester).

Community

Regular liaison takes place with Activity Coordinators and Health Care Support Workers in the nursing homes. Their positive contribution to well-being is fully recognised.

Impact and results

A high proportion of patients are looked after in their preferred place of care and preferred place of death. The number of people who are admitted as acute general unplanned admissions is low - typically about 15 a month. Psychiatric acute admissions are minimal; there have been only two in the past five years. By working very closely with the Nursing Home Service nurses and managers, support is provided to ensure that placement breakdown is minimised. Early intervention from the Service, working together with the Old Age Psychiatry team, minimises the need either for sectioning under the Mental Health Act, or admission for acute in-patient psychiatric assessment.

Nazareth House, West London Mental Health Trust

INTEGRATED CARE PILOT

Background

Nazareth House is located in the London Borough of Hammersmith and Fulham. This is an inner city borough where 12% of the population are aged between 50 and 64, and 9% are aged 65 and above. This means that the population in the borough aged 50 and above is smaller than the average for England.

Nazareth House provides a full range of care services. Its focus is on providing holistic care that promotes health and wellbeing, and supporting older people to maintain quality of life.

Who are the patients?

The majority of people living in the home have multiple long-term medical conditions which need monitoring and treatment. The aims of treatment are to improve health outcomes where possible, maintain function, minimise discomfort and provide end-of-life palliation. Ensuring that people's dignity is maintained is paramount.

Nazareth House provide 24-hour care for up to 95 people aged 65 and above, who require nursing and personal care. There are three floors in the building. The first and second floors are home to people with nursing needs and some people with palliative care needs. The third floor is residential and is home to older people, some of whom have early onset dementia.

Nature of the intervention/s

The multidisciplinary team.
The integrated care project was first established as a pilot. A key aspect was the monthly meeting of a specialist multidisciplinary team to discuss the needs of clients presenting with complex physical and mental health needs. The collective expertise of the team informed planning, treatment and management of the older person's needs. The team comprised:

- general practitioner to the care home
- senior manager of the care home, and unit manager
- consultant geriatrician
- consultant psychiatrist
- mental health community liaison nurse
- community pharmacist
- social worker
- palliative care staff

A relative would usually be present to advocate on behalf of the older person if they were unable to attend the meeting. The needs of the patient would be assessed by either, or both, the geriatrician and member of the mental health team (nurse or psychiatrist) before the meeting. This provided the multidisciplinary team with first-hand knowledge of the older person's needs. The agreed care plan and interventions were reviewed by the specialist team at each monthly follow-up.

The focus of the model was on ensuring that care plans were detailed and specific enough to promote physical health and psychological wellbeing, and to recognise underlying cognitive and mood related problems. It allowed for the integrated and focused intervention of an experienced band 6/7 mental health nurse to provide:

- **training** of nursing home unit/floor managers that manage the care provision on each nursing care unit, who cascaded the training to frontline staff. It helped to ensure consistent induction to new staff which was a significant benefit, given the high turnover of frontline staff in care homes

- **upskilling** in the delineation of care plans to address psychological, cognitive and mental health disorders

- **consultation** on the management of challenging behaviours as a result of cognitive and mental disorders with the aim of ensuring a consistency of care model approach adopted for all clients.

A weekly review by geriatrician and psychiatric trainee.
As well as the multidisciplinary team meeting, the consultant geriatrician and a core psychiatric trainee jointly carry out a weekly review of residents' physical and mental health concerns. Where there are mental health issues that need an in-depth review this is carried out under clinical supervision by the consultant psychiatrist.

The geriatrician and general practitioner hold additional clinics during the week and review any other mental health concerns of the patients they see. They will escalate to the mental health team for further assessment and management advice, for example if a patient's features are atypical, resistant to interventions already tried or need further review by a mental health specialist.

This is done either through an initial consultation with the mental health practitioner, or by raising it with the core psychiatric trainee for an initial triage assessment of the patient's mental health. If needed, a formal referral is made for more specialist diagnosis and management, with the aim of ensuring that treatment interventions are timely, prevent crises and avoid acute hospital bed admission.

A monthly review meeting.
Once a month, relatives, designated carers, the consultant psychiatrist and general practitioner together with the home's manager hold a review meeting to discuss cases of greater complexity where first-tiered management interventions have had limited success. Input from patient's family members is invaluable in gaining insight about the patient's history and past aspects of behaviour that may not have been formally diagnosed by a mental health service.

Time spent treating older people with depression

It is difficult to provide an accurate assessment; time spent varies according to the current level of patient need and other demands on team members.

Funding

Nazareth House, together with three other nursing homes and three residential homes in the borough, benefitted from funding from the Integrated Care Pilot of North West London (ICP NWL) for a two-year innovation project until its termination in April 2016.

When the pilot funding came to an end the cost-neutral elements of the project continued. The multidisciplinary team is now smaller, and is made up of the general practitioner, mental health liaison nurse, senior manager and unit manager. The unit manager still presents the case and issues of concern. Interventions are discussed and agreed with the patient and/or relative depending on the patient's capacity to make an informed decision.

Results and impact

The pilot project resulted in the reduction of non-elective admissions to acute hospitals by almost 70% during the first 12-15 months.

Key benefits of the model are:

- The joint assessment by the geriatrician and core trainee psychiatrist allows a mutual upskilling in the management of depression and co-morbid physical conditions. This enhances the skill-base of the core trainee and supports the treatment and management of adverse physical health effects for patients with mental illness
- The weekly input of half a session of a psychiatric core trainee offers both a medical consultation and supports the mental health nurse in differential diagnoses and advice on behaviour management both on behaviour, and pharmaceutical drugs for depression
- Where patients require pharmaceutical treatment, the input of a core trainee or consultant psychiatrist helps identify delineate functional mood disorders and atypical presentations of depression or other mental disorders where suspected
- The key components of this model can be essentially cost-neutral as it involves a new way of working within existing resources
- Awareness and experience of the mental health aspects of care and treatment by the general practitioner and geriatrician further enhances the detection of underlying mental health problems
- The mental health nurse and core trainee inputting into the service has the benefit of added clinical supervision provided by the consultant psychiatrist within the hub of the mental health team.

High turnover of staff and the reliance on senior nursing home staff to provide consistency of approach in screening for mental health issues remain a challenge.

While the core operational policy of the team is the assessment and management of cognitive disorders, the consultative and supportive role of the team enables a holistic approach to be maintained in identifying, managing and treating all aspects of mental health.

Next steps

The multidisciplinary team will continue to deliver and build on the approach which is now well established.

16 Life story work is an activity in which a person with dementia is supported by staff and family to gather and review their past life events and build a personal biography to help the person understand their past experiences. https://www.dementiauk.org/for-professionals/free-resources/life-story-work/

Ryedale, North Yorkshire - community mental health team for older people

Background

Ryedale is a district of North Yorkshire covering 575 square miles with a population of around 53,000 people. It is largely rural with four market towns serving its community and several villages and hamlets in the surrounding area. There are eleven care homes within Ryedale. These are mainly located within the market towns of Malton and Pickering. They include nine residential care homes specialising in dementia care, two nursing care homes, one of which provides specialist dementia nursing. There is also one additional care housing facility run and managed by the local authority, specifically designed to offer people, over the age of 55, independent living with access to care and support which is tailored to meet the needs of the individual.

Who are the patients?

The patients are people with dementia but some with co-morbid depression. There are patients with severe and enduring mental illness.

Key features

i. Staffing. The Community Mental Health Team for Older People is located in Malton and the Team comprises one Team Manager, one Consultant Old Age Psychiatrist, one part-time locum Old Age Consultant Psychiatrist, one Junior Doctor, three Community Mental Health Nurses, two Community Staff Nurses, two part-time Occupational Therapists (providing a service to the Teams across Scarborough, Whitby and Ryedale) and one Community Support Worker. There is also a part time advanced nurse practitioner.

The team has positive working relationships with GP practices in the area. Strong links have been developed by attending practice meetings and other practice forums. The team has involved the practices in the development of their service improvement plans, and all the care homes in the area have an identified GP who[16] is responsible for the residents in their care.

There is regular psychiatric input by a dedicated community psychiatric nurse with medical back-up where necessary. The team also has a part-time Occupational Therapist (OT) with a special interest in care home provision who supports patients and staff in any of the care homes to explore non-pharmacological interventions, including occupational and recreational activity, use of Life Books and education for the care team within the home. Such educational interventions include: developing understanding of the condition and the impact upon functioning and behaviour, which includes person-centred strategies for management and maximising engagement. The Community Psychiatric Nurse identifies individuals who are likely to benefit from the additional support of the OT. The OT's involvement includes an assessment and a time-limited number of therapy sessions.

The team's Support Worker provides time-limited interventions identified by any of the Team's CPN's, OT's or Doctors. The Support Worker is skilled in developing a therapeutic relationship with the residents and works with the Care Home team to identify ways of improving their residents' health and wellbeing. The NHS Trust Chaplain can be accessed by any resident who has a spiritual need. The Chaplain will visit the individual in the care home to provide support.

ii. Interventions. The team and NHS Trust are committed to the principles of recovery and the promotion of personal wellbeing, in line with CHIME factors:

- Connectedness, Hope, Identity, Meaning and Empowerment (CHIME).

Patients with a primary diagnosis of depression receive care that is evidence-based, and follows the Trust's Functional Disorders Pathway (FDP). The FDP principles, which cover treatment and structured interventions to address mood, are also applied and/or adapted in order to treat patients experiencing symptoms of depression and anxiety, and whose symptoms of dementia are the primary identified need.

As part of the Pathway all patients are discussed by the team within seven days of Initial Assessment. This allows the team to identify the patient's needs and risk factors using the 5P approach:

- Presenting problems, and Precipitating, Predisposing, Perpetuating and Protective factors.

The details of this meeting are shared with the patient and, if agreed, their family and/or carers. The patient's personal recovery goals are identified and plans are agreed for the appropriate structured interventions needed to support the patient's recovery journey. Functional Disorder Pathway multidisciplinary team meetings take place twice a week. These provide an enhanced clinical supervision session for staff, with the aim of ensuring high quality, value-added care for the patient.

Patients have their needs and risk factors objectively assessed by the Assessing Clinician in line with the Mental Health Clustering Tool. Cluster allocation is based on the person's identified needs rather than on their diagnosis, although the tool does provide guidance regarding the likely and unlikely diagnosis that patients assigned to each Cluster would be expected to receive. Like the SWEMWBS (Short Warwick-Edinburgh Mental Wellbeing Scale), the Cluster Tool is reviewed at every Comprehensive Psychiatric Assessment (CPA) Review and finally on discharge. Needs identified by the Clinician in the patient's cluster are aligned to those identified by the patient and together the information supports the care planning process.

One of the main challenges for the team is supporting the care homes in avoiding admission to hospital or a move to an alternative care provider if possible. This is managed by providing timely responses to concerns and encouraging care home staff to be aware of any physical cause for changes in mental health, and by completing behaviour charts. This approach has been the result of proactive development of good working relationships, and timely communication between the CMHT, GPs and care home staff.

Family involvement is encouraged by the team. They are invited to attend initial assessments, Comprehensive Psychiatric Assessment and Discharge Reviews/Transfers of Care and the care homes themselves strive to engage the family in the care of their residents. In general the care homes encourage the family to visit. They also organise social outings and all homes have activity workers who provide a stimulating environment and structured activity programmes.

Time spent treating older people with depression

Approximately 10% of the team's total caseload is currently spent on treatment and intervention for the specific purpose of reducing and/or improving the symptoms of depression and/or anxiety. The percentage of their patients living in care homes is low for a community based team; this is due to a lot of patients having to move out of the area to be supported in care homes that are more affordable for them.

Funding

The funding of the CMHT is from the two Clinical Commissioning Groups (Scarborough & Ryedale CCG and the Vale of York CCG) that cover the Ryedale area.

The team is commissioned to provide mental health care for older people only in this area. Team meetings are held once a week to review progress in meeting expected key performance targets; these include waiting timescales, timely Cluster and CPA Review, training and appraisal, data quality, and other indicators.

Community

The team is fortunate in having excellent voluntary sector resources in Ryedale. Ryedale Carers Support provide a befriending service to any resident living in a care home who needs the additional support to engage in purposeful activity on a one-to-one basis. This enables individuals who may have no other visitors to go on social outings or just enjoy being able to talk to someone. Pet therapy is used in all the care homes and most of the homes have pets that live within the care homes. The care homes all invite musical motivation workers to provide music as a therapy to improve wellbeing, one home has employed a music therapist and others engage in arts, zumba and dance.

Results and impact

The team uses feedback from Friends and Family teams for patients and carers to measure patient satisfaction and personally reported experiences of the service. Feedback collected in this way is used to celebrate team and individual staff successes, and to learn from any concerns identified. All patients are encouraged to complete the SWEMWBS patient reported outcome measure (where it is assessed to be clinically appropriate) - this is an evaluation tool where a baseline position is obtained at the point of Initial Assessment and is repeated in order to measure perceived therapeutic impact of treatment and intervention at CPA Reviews and at discharge. The patient's responses to the SWEMWBS questions are used by staff as a starting point for Assessment and Review and are incorporated during collaborative Care Planning.

The team receive consistently positive feedback via Friends and Family Teams, and have performed highly on audits completed by the Trust's Patient and Carer Experience Team. One of the Team's CPN's was recently shortlisted in the Trust's "Making a Difference" Awards for her commitment to involving patients and carers and encouraging feedback. The team have also been commended as an example of 'Best Practice' for its action plans, based on monthly Friends and Family Team feedback, and for its Patient and Carer Feedback display, which is held in the reception area of the team base.

Care Home Liaison Team – mental health services for care homes in Chester and Thornton-le-Moores, Cheshire

Background

The Care Home Liaison Service provides mental health services in three care homes in Cheshire:

- Orchard Manor is a 90-bed care home with registration of residential and nursing beds that provide specialist dementia care in the city of Chester
- Thornton Manor is a 47-bed care home with registration of residential and nursing beds that provide specialist dementia care in the town of Thornton-le- Moores (rural)
- The Willows is a 70-bed care home with registration of residential and nursing beds that provide specialist dementia care in the city of Chester.

Who are the patients?

The majority of residents are aged 65 and above. All residents are included in the scope of the team's work; it is not limited to those who are already using mental health services.

Key features of the service

The Care Home Liaison team works collaboratively with care homes to introduce the use of quality improvement methodology. This approach uses a proactive approach to introducing systematic improvements, which empowers care staff to change their systems of working, developing safe, comfortable and caring environments that meet residents' needs. This has encouraged the development of new ways of delivering care to all residents.

The liaison team's approach has involved the provision of mental health education sessions, role modelling, case discussions which include education and learning opportunities linked to actual resident care, and observations in collaboration with their own clinical leaders and coaching. This has allowed upskilling of the care home's own staff, improved communication with other professionals including GPs, community geriatricians and nurses which has led to earlier identification and improved treatment for residents.

Time spent treating older people with depression

30% of the team's time is spent providing a mixture of face-to-face, discussion and support for older people living in the care homes in Chester and Thornton-le-Moores, Cheshire.

Funding

The team's funding initially came from the Care Homes Vanguard programme, and has now been incorporated into the CCG budget for Mental Health.

Community

Involvement of community organisations has been limited. One care home has now actively sought to bring in voluntary sector organisations to create more purposeful activities.

Results

The team's work in care homes has resulted in:

- increased awareness of depression and mental health conditions as a whole among staff members
- improvements in Care Quality Commission ratings
- positive comments from CCG inspections
- greater staff confidence and higher morale via staff comments
- reduction in number of referrals to mental health team.

5 Summary of literature

Prevalence

The population of older adults in Long-term Care (LTC) is expected to increase considerably in the near future [1]. Prevalence of depression diagnoses in nursing home residents range from 11% to as high as 78% [2].

A survey conducted in South East London (Lambeth, Southwark, Lewisham and Croydon) across 113 care homes [3] showed that the prevalence of dementia was 55.8% in residential homes, 91.0% in residential elderly mentally infirm care and 77.0% in nursing homes (overall prevalence of 75.1%). Whilst the prevalence rates for depression were 26.5, 22.0 and 29.6%, respectively. Residential homes with what was previously called Elderly Mentally Infirm (EMI) status had the highest prevalence of dementia and highest proportions with severe dementia and behavioural problems [2].

Depression remains the most common psychiatric diagnosis in patients with Alzheimer's disease and other progressive dementias (4).

Risk factors

Nursing Home Studies have reported that patients with cardiovascular diseases, stroke, visual impairment, loss, and pain are at a higher risk of depression (5; 6; 7; 8; 9; 10; 11 12,13).

Worse general medical health was the strongest factor associated with depression, followed by degree of cognitive impairment [14].

Outcome of having depression

Late Life Depression continues to have detrimental consequences, despite progress in identification, advances in antidepressant therapy, and newer service care delivery approaches [15, 16].

Even presence of a relatively `minor` degree of depression can significantly decrease the quality of life of elderly persons [17]. Depression is associated with disability [18], a reduction in active life expectancy [19], and correlates with worsening of outcomes of comorbid chronic medical conditions [20].

Depression has been recognised as an important predictor of adverse outcomes in care homes in UK [21].

Identification

Depression is identified within the spectrum of behavioural symptoms of dementia [22] and is a consistent risk factor for development of `resistiveness to care that may escalate to verbal and physical aggression. [23]. Behaviours like withdrawal and agitation could be interpreted as part of the dementia syndrome, but also as depressive symptoms; a fact that represents a challenge in diagnosing and measuring depression in nursing home patients with dementia [24]. The close relationship of depression and agitation is not surprising because agitated depression is one of the clinical forms even in cognitively intact individuals [25]. Major overlap between symptoms of depression and symptoms of dementia however complicate an accurate diagnosis, as also a diversity in population with dementia, stage of illness, ethnicity and variation in the diagnostic instruments used to assess depressive symptoms [26]

In nursing home residents with dementia, depression is often underdiagnosed and undertreated [27, 24]. Reviews have noted that depression is often overlooked by nursing and social work staff [28], and social workers and activity staff are likely to view depression as a normal [29].

Diagnosing depression can pose significant challenges in patients with advanced dementia given the limited or inconsistent verbalisation and variable scores on commonly used depression scales. An inability to rely on self-report scales makes clinical diagnosis difficult. Studies have found that the use of the Cornell Scale for Depression in Dementia failed to significantly discriminate depressed residents when compared to a gold standard of psychiatric diagnosis [30] and another study found that 22% of nursing home residents could not be diagnosed by this scale as some items could not be rated [14]. However, it still remains a useful instrument [31].

Treatment

Studies have suggested that nonpharmacological treatment options like environmental initiatives and psychotherapy are seldom used in nursing homes [32]. Symptoms of depression may be improved by involvement in meaningful activities. [33, 34]. However the effect of structured physical exercise has been proved negative. [35]. If these interventions fail, antidepressants may be required.

Studies acknowledge that many nursing home residents who are clinically diagnosed as depressed are not effectively treated for depression [24] and that such treatment is especially lacking as age of the residents increases.

Staff training

Based on the evidence gathered so far, this review will not be complete without an evaluation of available evidence relating to staff training to identify depression in care homes. Initial search showed there has been some work done around this with variable results.

A number of studies have explored the relevance of training staff to improve identification of depressive symptoms in care home settings [36, 37, 38]. One feasibility study [36] demonstrated that untrained care home staff are unable to reliably identify clients who were presenting with depression. The study suggested that a routine screening tool with minimal staff training could prove vital.

There have been several models for depression training explored [38, 39, 40] and they have been shown to be relevant and effective. The training of staff to identify depression would however be futile if it does not bring about actual change in treatment and patient outcomes. Care home staff have many responsibilities as part of their routine and it is important to consider how they can practically apply new knowledge and skills seamlessly. A few studies [37, 38, 39, 41] have looked at the benefits and impact of staff training. Two of them [37, 41] also concluded that training staff with use of a screening tool can improve referrals and pathways to care. However, they highlighted the importance of monitoring and measuring training-related outcomes such as changes to treatment including medical and psychological interventions. The treatments identified in both studies however did not include behavioural interventions.

Whilst there is evidence to suggest that patients with dementia are also quite prone to depression [36]. A lot of the studies reviewed have invariably excluded patients with moderate to severe dementia partly or wholly due to the non-specific signs and symptoms of depression in this group which make it difficult to assess them with routine standardized screening tools. There is very little work done exploring the impact of training staff to identify and manage depression in patients with dementia within the care home setting. One clinical trial [42] explored the benefits of behavioural interventions in the management of depressive symptoms in dementia patients and concluded there were significant benefits with improvements noted in patients.

In summary, depression training for care staff can help to identify Late Life Depression in care home settings. It can also lead to prompt and appropriate referrals, initiation of treatment and better patient outcomes. Training further boosts confidence of care staff.

It is also essential to implement systems to measure training related outcomes to ensure the benefits of the training appropriately influences practice and translates to health benefits for service users.

In conclusion

Further research is needed about the incidence and prevalence of depression in care homes and what treatment approaches are most effective. More work also is needed to develop and identify universally acceptable depression training models which can be easily applied in practice to improve care of patients suffering from Late Life Depression. The high levels of mortality, psychiatric morbidity, and chronicity of depressed mood among residents requires care homes to have access to specialist resources such as geriatric consultation, old-age psychiatry, occupational therapy, and physiotherapy [19].

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Summary of literature

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