Old age psychiatry and integration: what does it mean and which road do we choose?

Helen McCormack, Consultant, Older Peoples Mental Health, Hampshire, helenmccormack@nhs.net

Introduction

One of my reasons for becoming a member of the executive of the Old Age Faculty is my interest in the integration agenda and what it means for the patients we serve, for us as practitioners and for our future as a speciality.

Integration is a term that has become commonplace, although it is clear that it means very different things to different people. I come across old age psychiatrists who show great enthusiasm for integration, and equally those who are uneasy about what it might mean for us and the work we do for our patients. I come across widely varying definitions and descriptions of what integration means, ranging from pockets of innovative practice, some structured evidence based service changes, through to a fear that we have no real confidence that what we are being asked to do will really deliver better quality, experience and value for money.

It would seem that changes towards an integrated care model are inevitable, and we, as a group of highly committed and skilled practitioners, need to be encouraged to drive this agenda, with as much evidence, shared experience and collective engagement as we can muster. Hence, I have begun a piece of work for the Faculty, to gain a greater understanding of what is already being done, how well it is working, what evidence we have, what the pitfalls might be, and subsequently, to identify ways we can share our rich knowledge in these challenging times.

Current models of care

As a starting point, I have asked members of the Faculty to share with me integrated practice in their areas. There are a number of different models in place, not mutually exclusive, but demonstrating a range of approaches:

- **Working with primary care.** This includes formal arrangements in which old age psychiatry is provided within primary care, or psychiatrists are seconded to primary care working with community geriatricians, alongside informal working arrangements. These involve psychiatrists working with general practitioners (GPs), running memory clinics, early onset dementia services, screening services and services for people with functional illness. People are happy to be seen at their GP’s surgery, and there is good access to GP records, up to date medication lists, and letters from other professionals. GPs can discuss cases and are happier to take patients back because of the close working relationship.

- **Whole system approach.** Many people use this term for services in which community based teams incorporate local authority, geriatric medicine, primary care and old age psychiatry services. These teams aim to provide comprehensive community based services for physical and mental health needs. The schemes are likely to be initiated or supported by Clinical Commissioning Groups (CCG), and
there are examples where acute trusts, community trusts and mental health trusts are jointly commissioned to tackle the problem of chronic disease. In some areas this is being driven by the Better Care Fund (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/) and the desire to achieve parity of esteem.

- **Care home liaison.** Care home initiatives are a high priority in many areas, supported by some CCGs. The model often comprises a named GP visiting regularly, identified older people’s specialist nurses, and weekly multi-professional meetings which include an old age psychiatrist, geriatrician, GP, pharmacist, physiotherapist and social worker. Teams support care homes, enabling a proactive approach to patient identification, teaching, influencing culture and practice, medication reviews and regulatory processes.

- **Integration in inpatient care.** There are areas in which mental health services sit within an acute trust. This is a less common model for old age psychiatry, but can provide good links with physical health services, including dual-care inpatient wards with elderly people’s medicine. There are also informal arrangements where specialist units are run by physicians with mental health nurse and psychiatrist input. There is demonstrated benefit in terms of clinical quality, experience and value for money. In addition, recruitment and retention have improved, and staff who have been through the unit retain their skills and are able to transfer what they have learnt to other settings.

There are also examples where the model implemented for working age adults with mental health problems, comprising a single acute admission ward supported by enhanced crisis assessment and home treatment teams, is being extended to older adults. The ultimate goal is to have locality teams that deal with all ages over 18 but which are needs-led rather than ‘ageless’. An essential element is to preserve specific expertise in older adult care while blurring the service boundaries at the transition into older adulthood.

- **Liaison psychiatry.** Implementation of the RAID (Rapid Assessment, Interface and Discharge) model of liaison service in some places has brought with it effective integrated care between acute hospital staff, hospital social workers and old age psychiatry teams. There are also proactive models of liaison psychiatry services that don’t await referrals, but have mental health nurses and mental health physiotherapists based permanently within the key medical and orthopaedic wards of the acute trust. There is evidence that this model is highly effective.

**Potential pitfalls**

I have been struck by the diversity of initiatives alongside the varying extent to which commissioners are involved. Overwhelmingly, I have been encouraged by the enthusiasm that exists among old age psychiatrists. However, the stories have not been universally positive, and people have told me of their concerns and reservations. There are those who think we need to change to survive and those who feel integration will lead to disintegration. There are challenges of trying to work in a joined-up way when we work in different buildings, have separate IT systems, different admin staff and employers with different agendas and budgetary constraints. A number of issues have been expressed about staff in integrated teams becoming deskilled, and that we may be moving towards loss of specialisation and expertise. Coupled with this, there is a concern about whether we are planning and training our workforce effectively for this style of working. Issues related to
commissioners understanding the complexity of the field in which we work, and the danger of fragmentation as a consequence of competition, also feature.

The most significant area of concern, however, is the demographic change and the lack of a coherent, well-resourced approach to this at a national and local level. There is anxiety that the model of care of reducing inpatient beds in order to enhance community services is flawed, and that we need more of both in the future. There is concern that changes should be evidence based, properly piloted and evaluated. It needs to be demonstrated that enhanced community based services can reduce acute admissions, and we need a more planned approach to find out what resources are needed for a defined population in order for this to succeed. One person pointed out that we need to get this right for our patients and population now, and for ourselves in the future.

What next?

In this initial exploration of what we are doing around the country, I have heard some great examples of integrated care. I hope this brief summary gives a flavour of the diversity of initiatives, the enthusiasm and some of the potential pitfalls. The anxiety about whether we have a sound evidence base for what we are doing has led me to wonder whether this evolution of different ways of working across our countries will succeed in enabling the best coming to surface. Or, are we potentially doing our patients, our budgets, and our profession a disservice by the lack of coordination, evidence and planning? Different solutions are always going to be needed in different places, but we don’t have time to wait and see what happens elsewhere before proceeding in our own areas. However, we do have a long history of a skilled, adaptable and tenacious profession, and I believe that, by sharing experience and with camaraderie, we have the potential to lead this agenda in the right direction.

My current thinking is that we must bring together what we have in terms of experience and evidence to steer integration in the most effective way. My plan is to test further whether what people have told me so far is representative, to visit some services who have had success with integration, and to explore whether we can create a way of sharing this and supporting one another. I have already had some offers to visit services which I hope to follow up during the summer, and I will be sending out a brief questionnaire in the next few weeks.

Your comments, support and challenge are most welcome.