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Delivering the NHS Long-Term Plan's ambition of ageing well: Old age psychiatry as a vital resource

October 2019

FACULTY REPORT

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Foreword

This report has been prepared by the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists. It incorporates views from older people, service users, carers and a wide range of health and social care professionals. Its purpose is:

- to provide insight into the essential role played by old-age psychiatrists, and the Older People's Mental Health (OPMH) services to whom they provide leadership, in delivering high-quality outcomes for the health and wellbeing of the UK's ageing population

- to support decision-makers responsible for implementing the NHS Long-Term Plan (LTP) as it affects older people in providing a clear case for the need for high-quality, well-led mental health support (especially through input into rapid community response teams) with a focus on:
 - older people with health issues before they need hospital treatment

 - older people with health issues leaving hospital to return and recover at home; and

 - those who look after family members, partners or friends because of their illness, frailty or disability.

This report also provides a summary of good-practice examples of collaboration and innovations involving old-age psychiatrists across different health and social care settings, and especially in care homes.

Although the LTP sets out a vision for health services in England only, this report is also relevant for those involved in the development and commissioning of integrated health and social care services for older people across the devolved UK nations.

Older people with mental illnesses have specialist and often complex needs related to medical co-morbidity and long-term conditions, frailty, cognitive impairment and social needs. Chapter 3 of the LTP specifically outlines plans for improved adult mental healthcare and older adult mental health provision; OPMH services may be thought of as a 'silver thread' running through these plans. Effectively supporting older people's mental health is also integral to each of the ambitions of Chapter 1 of the LTP (Ageing Well). This will help people with complex health and care needs to stay healthy and functionally able and living in a community setting for as long as possible. Key ways of achieving this include having an intense focus on anticipatory

care, urgent care and enhanced care within care homes. Implementing this will require support by integrated teams as part of primary-care networks. Specialist OPMH expertise is vital for developing teams and services that work across specialties, reduce barriers, and provide high-quality joined-up care to meet the needs of older people.

A multidisciplinary approach is in the DNA of OPMH services. Such services provide collaborative care across a wide range of health and social-care settings. These include care in the community, in inpatient mental health units, acute general hospitals, care homes and prisons.

The successful delivery of the welcome ambitions of the LTP for older people depends on the recognition that specialist OPMH services provide essential expertise, and that access to these specialist services must be incorporated at every stage of planning and implementation in all areas that meet the needs of older people.

The report provides examples that demonstrate the willingness and ability of old-age psychiatrists and the OPMH services to adapt to new and integrated ways of working.

I certainly feel that this report will be valuable and provide guidance to anybody who is interested in improving services to some of our most vulnerable patients and their carers.

Dr Amanda Thompsell
Chair, Faculty of Old Age Psychiatry
Royal College of Psychiatry

“ As a 70-year-old, I had no previous contact with mental health services until having a head injury following an accident. It changed my life, causing both physical and behavioural problems, resulting in a non-voluntary admission to a mental health ward.

The help I received from both the Home Treatment Team and the hospital was invaluable. I really don't think I would have recovered without such a speedy intervention, and one year later I have returned to work part time and feel my life is back on track.

”

– *An older patient*

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Working group

This report was written by members of the Royal College of Psychiatrists Faculty of Old Age Psychiatry.

Chair

Dr Amanda Thompsell
Chair, Faculty of Old Age Psychiatry

Editor

Dr Mohan Bhat
Executive Member, Faculty of Old Age Psychiatry

Members

Dr Alex Bailey
Chair, Specialty Advisory Committee, Faculty of Old Age Psychiatry

Dr Jonathan Richardson
Executive Member, Faculty of Old Age Psychiatry

Dr Joanne Rodda
Executive Member, Faculty of Old Age Psychiatry

Amy McGregor
Policy Analyst and Commentary Manager, the Royal College of Psychiatrists

Abbreviations

CGA	comprehensive geriatric assessment
CHAT	Care Home Assessment Team
CQC	Care Quality Commission
CRHTT	crisis and home treatment teams
DIS	Dementia and Intensive Support
DoLS	Deprivation of Liberty Safeguards
EAHSN	Eastern Academic Health Science Network
EHCH	Enhanced Health in Care Homes
EMIS	Egton Medical Information Systems
GDS	Geriatric Depression Scale
HEE	Health Education England
IAPT	Improving Access to Psychological Therapy
ICS	integrated care systems
ICS	integrated care systems
LTC	long-term conditions
LTP	NHS Long-Term Plan
MDT	multidisciplinary team
MIU	minor injury unit
MOP	medicine for older people
NHSE	National Health Service England
OMPH	Older People's Mental Health
OPAC	Older People's and Adult Community
STP	sustainability and transformation partnerships
WTE	whole-time equivalent

Introduction

This paper considers the needs of older people, focusing in particular on the role of old-age psychiatrists in the context of the NHS Long-Term Plan (LTP) in delivering high-quality outcomes for the health and wellbeing of older people.

It examines the demographic and epidemiological imperatives within health and social care and sets out the clear case for a focus on addressing the mental health needs of older people within emerging integrated systems as specified in the NHS LTP.

The paper highlights some innovative service examples, along with views from older people, carers, health and social-care professionals on the value of this input.

It also sets out next steps for those developing and implementing policy, strategy and service changes within the context of the LTP.

1. Current context

1.1 An ageing and frailer population

The UK population is ageing, with the number of people aged over 85 expected to double in the next 23 years to 3.4 million.¹ By 2046, one in four people will be aged over 65 (Table 1).

With the prevalence of mental health disorders in older people at 20–25%,² this demographic expansion will represent a very substantial increase in the absolute number of older adults developing mental health difficulties. The effect will be felt keenly in acute hospitals – at least 50% of older adults in acute hospitals will have a mental health disorder. It will be felt even more keenly in care home settings, as 60% of the residents will have a mental health disorder.³

Mental health problems in older adults present with higher levels of complexity and associated health and social care costs; the cost in the UK of dementia alone was at least £26 billion in 2015.⁴

An increased focus on frailty reveals that cognitive and psychological factors play a complex role in the development and outcomes of this syndrome,^{5,6} yet current models for identifying and diagnosing frailty do not pay sufficient attention to these factors.⁷ One third of people with a long-term health condition also have a mental health disorder.⁸

There is, therefore, a clear humanitarian, social and economic case for ensuring that services are developed to meet this urgent growing need.

Table 1: Population growth projections by 2046 in the UK.¹

Year	0–15 years	16–64 years	65+ years	UK population
2016	18.9%	63.1%	18.0%	65,648,054
2026	18.8%	60.7%	20.5%	69,843,515
2036	18.0%	58.2%	23.9%	73,360,907
2046	17.7%	57.7%	24.7%	76,342,235

1.2 How old-age psychiatrists help to meet the needs of older people

As has been recognised within the LTP, old-age psychiatrists are central to the delivery of truly integrated community care for older people with mental health problems. Their particular expertise is in the synthesis and coordination of complex care in older people with complex mental illness, one of the most vulnerable groups in society. They are clinical leaders with advanced skills in communication, the education of others, legislative issues and understanding complex health and social care systems. They are experienced in working in a variety of settings in collaboration with health and social-care staff with a wide range of knowledge and expertise.

The profession recognises the need to engage with new models of care in order to thrive. With workforce challenges in terms of recruitment and retention, the specialty is ready to adapt to deliver care across multiple systems and away from traditional siloed models. This includes engaging heavily with emerging integrated care systems, as well as using their expertise to train and support other healthcare professionals working with older adults.

Situations in which the expertise of old-age psychiatrists is particularly valuable to older people.

Clinical assessment and management

Old-age psychiatrists are involved in:

- expert assessment, management and coordination of care in people with mental illness, complicated by physical health comorbidity and frailty
- provision of direct specialist support to GPs regarding clinical decision-making for older people experiencing complex mental health problems; early discussion of medication issues and other options for therapeutic intervention.
- assessment and diagnosis of dementia where there are complex presentations (e.g. atypical and young-onset dementias), situations associated with high risk, severe behavioural and psychological symptoms, social complexity, and cases where there is overlap of mood, anxiety or psychotic symptoms; this may be in inpatient mental health units, or community and liaison psychiatry settings
- management of delirium and other mental health conditions in older people in an acute general hospital setting and the community

- advising on management of substance misuse often complicated by mental illness in older people (an area of growing importance as a new generation ages)⁹
- advising on end-of-life care.

Leadership

As clinical leaders, old-age psychiatrists are involved in:

- overseeing and coordinating care for older people with mental health conditions and complex comorbid conditions to reduce the need for moving them from their place of care
- assessment of and decision-making on complex capacity issues
- providing expertise on the use of the Mental Health Act 2007, Mental Capacity Act 2005, and other relevant legislation
- supporting social care and the wider system with older adult safeguarding issues
- providing expert advice on risk reduction and prevention (including risks around self-harming behaviours)
- supporting structured medication reviews, in which mental-health input is highly relevant, especially in care homes (this includes expert knowledge of both prescribing and de-prescribing psychiatric medications).

Education

Old-age psychiatrists provide education and training to professionals across the health and social care system, including in primary care, community services, local authorities and acute hospital settings, to help services better meet the needs of older people. Examples include:

- training and education for other health and social-care professionals in the assessment, diagnosis and management of dementia and other mental health conditions in all settings
- education and support for carers and older people living with mental illness
- educational initiatives focusing on the management of behavioural and psychological symptoms of dementia in the community, or acute hospital or care-home settings

- addressing (often unrecognised) mental health issues in care-home residents that impact on overall health and wellbeing.¹⁰
- training in the recognition and management of delirium and other mental health conditions in older people in acute hospital settings
- education and training in the use of the Mental Health Act 2007 and Mental Capacity Act 2005
- advising on risk reduction in at risk populations.

Research

In the area of research, old-age psychiatrists:

- support older people and their families to become involved in advising on and participating in research
- encourage early adoption of research developments and advances in technology in practice which improve care for older people
- continue to find ways to understand and prevent older people developing a mental illness
- study the efficacy and safety of various management options (biological, psychological, social) in older people with mental-health problems
- develop and clarify what components of care are most effective and evidence based
- engage in and lead on quality-improvement processes to improve delivery of the care provided by services that meet the needs of older people.

Advocacy

The nature of the work that old-age psychiatrists are involved in, as clinician, leader, educator and researcher, puts them in a unique position to act as an advocate and ambassador for older people to:

- ensure that older people's needs are included in plans for strategic direction for services at all levels (local and regional to devolved assembly and government level) as well as working to reduce stigma and age discrimination
- be the voice for older people to ensure that their views are heard, and thus address inequality.

1.3 Where do old-age psychiatrists work?

Old-age psychiatrists work across a wide range of services. They not only work in older people's mental health services (which include community mental health teams, memory services, primary care, general hospitals, care homes, hospices and prisons) but also in integrated care teams in the community and in hospitals with physical health services for older people.

Older people's mental health services are generally delivered by multi-disciplinary teams that include nurses, social workers, pharmacists, psychologists and occupational therapists. Within these teams both delivery and leadership are provided by old-age psychiatrists.

Old-age psychiatrists also provide mental health expertise to other health and social-care teams, such as care-home support teams, frailty services, social care and the voluntary sector. There is an increased focus on the importance of older-adult mental health expertise in crisis resolution and home treatment teams, although the provision of these across the UK is still patchy.

2. How the Long-Term Plan (LTP) will take things forward

2.1 The Long-Term Plan and integrated care systems

The LTP has set out an imperative for all geographic regions of England to develop integrated care systems by April 2021.

These systems will be responsible for the local delivery of service transformation as specified in the LTP, and will consist of collaborations between commissioning, provider and local authority partners.

The LTP sets out clear goals for the development of both mental health and community health services, supported by significant transformation and baseline-uplift funding.

There are multiple areas specified within the LTP that have direct relevance to the mental health of older people. Old-age psychiatry input will be fundamental in realising these goals.

2.2 Older people's mental health within the LTP

The mental health of older adults is specified in the LTP Mental Health Implementation Plan as a 'silver thread' across all of the adult mental health ambitions outlined in Chapter 3 of the LTP.¹¹

There are also clear synergies with the ambitions described in Chapter 1 of the LTP (Ageing Well), which specifies the development of community multidisciplinary teams to work with the older and frail population.

The focus of Chapter 1 is on anticipatory care and urgent care for complex patients at risk of unwarranted health outcomes, and on helping them stay healthy, able and functioning, using collaborative models of care in the community that are centred around primary-care networks.

It also focuses on enhancing healthcare in care homes where many older residents have mental health needs (e.g. secondary to their underlying depression, psychosis or dementia).

To ensure that Chapters 1 and 3 work together effectively, and that there are no gaps or duplication of services for patients, it is critical for old-age psychiatrists to have a central role.

Mental health services for older adults are currently provided in a heterogenous way across multiple service areas. As a result when local and regional transformation is undertaken, the risks of overlooking the specific mental health needs of older adults are greatly increased

Section 3.1 (overpage) outlines the commitments related to older people's mental health within the LTP and provides service examples of the role of old-age psychiatry in delivering these ambitions; it also recommends how national and regional bodies can ensure that the mental health of older adults is specified within transformation plans.

Some service examples (not an exhaustive list) are given in [Appendix 1](#).

2.3 Adapted from Chapter 1 (Ageing Well) of the NHS Long-Term Plan (published January 2019).

Note that at the time of writing, the implementation Plan for Ageing Well had not been published.

Table 2			
LTP ambition (section 1): Urgent community response: to meet the national standards' two-hour response time for urgent care and a two-day response time for access to intermediate care/re-ablement			
Role of old-age psychiatry	Case examples	Recommendations	Service examples
<p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> has the expertise necessary to identify and manage comorbidities, liaising with and coordinating care across relevant health and social care teams has a pivotal role in upskilling the workforce to recognise mental health problems in frail adults in crisis. 	<p><i>A person with advanced dementia presents with acute confusion.</i></p> <p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> assesses for the presence of delirium or behavioural symptoms of dementia and identifies associated needs and risks advises on appropriate investigations collaborates with and provides leadership to colleagues across health and social care teams and institutes a management plan to avoid hospital admission. 	<ol style="list-style-type: none"> Ensure access to specialists in older adult mental health for the management of complex behaviours that are challenging, to reduce risk of inappropriate management decisions (e.g. excessive antipsychotic prescribing). Improve recognition of depression and delirium (especially in those with pre-existing dementia) via training, specialist support and collaborative working to improve outcomes and reduce lengths of stay. Ensure specialist expertise of an old-age psychiatrist is included in 'ageing well' in the accelerator site bids (these are early adopter sites). 	<p>See examples 2, 7 and 11 in Appendix 1</p>
LTP ambition (section 2): Roll-out of the Enhancing Health in Care Homes (EHCH) model			
Role of old-age psychiatry	Case examples	Recommendations	Service examples
<p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> has well-established expertise in providing in-reach to care homes provides holistic overview of care, particularly in residents presenting with behaviours that challenge offers expertise in medicines optimisation, non-pharmacological interventions, and providing training and support to care-home staff has expertise in legislative frameworks and complex-capacity and best-interest decisions to ensure residents are appropriately safeguarded and treated. advises on end-of-life care and support for older people, carers and care staff. 	<p><i>A resident with dementia, complex medical history and polypharmacy has become confused and agitated.</i></p> <p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> provides expertise on formulation (understanding what factors lead to and maintain behaviours), support and management strategies to the GP and care-home staff optimises medicines to decrease risk of confusion and adverse effects (often in conjunction with the pharmacist) to prevent unnecessary acute admission and the need for one-to-one care/support trains staff to recognise and appropriately respond to a range of mental health issues resulting in improved staff wellbeing and retention. 	<p>Older people's mental health teams must be a central component in the planning of EHCH to:</p> <ol style="list-style-type: none"> Provide specialist expertise to support care-home staff, primary care and community health colleagues with assessment, diagnosis and management of complex mental illness (including depression, delirium and behaviour that is challenging). Train the workforce in mental health, so as to better equip them and ensure the safety and wellbeing of care-home residents. Collaboratively develop EHCH requirements for community healthcare providers and primary care networks for implementation from 2020–21. 	<p>See examples 2, 7, 9, 10, 11 and 13 in Appendix 1</p>

LTP ambition (section 3):
Expanded community MDTs delivering ‘anticipatory care’: focused on people living with complex health and care needs to help them stay as healthy and functionally able as possible, for as long as possible

Role of old-age psychiatry	Case examples	Recommendations	Service examples
<p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> has expertise in managing MDTs, taking a truly holistic approach to care and identifying unmet needs works collaboratively with primary-care networks to meet the most complex of patients’ needs. <p>Old-age psychiatrists are already system leaders in identifying ‘hard to reach’ isolated populations (e.g. in the prison sector and within minority groups).</p>	<p><i>An older person with multiple comorbidities, presents with low mood and memory loss.</i></p> <p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> takes a psychobiosocial approach, formulating current difficulties in the context of all aspects of the person’s life to aid understanding and management leading to improvements in mood and in memory. looks beyond the immediate problems to anticipate and prevent further deterioration has a shared care/joint management approach with their health, social and voluntary sector colleagues, resulting in joint learning opportunities for all concerned. 	<ol style="list-style-type: none"> Ensure old-age psychiatry input into community multidisciplinary teams. Management of comorbid physical and mental health problems requires specialist expertise from old-age psychiatrists in partnership with primary-care networks, social care and voluntary sectors to avoid misdiagnosis and suboptimal management. Provide better support for health and social-care staff to deal with complex cases by having opportunities for shared learning with the old-age psychiatrist. Use the expertise of the old-age psychiatrist to develop systems to recognise depression and substance abuse and treat them early. 	<p>See examples 1, 4, 6, 8, 11 and 13 in Appendix 1</p>

LTP ambition (section 4):
Increased recognition and support for carers

Role of old-age psychiatry	Case examples	Recommendations	Service examples
<p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> has well-established expertise in recognising and working with carers; the holistic nature of practice in old-age psychiatry ensures that carers’ needs are central to supporting patients provides psychoeducation and therapeutic support, as well as educating the wider MDT to disseminate expertise provides advanced knowledge of legal and ethical frameworks to help carers plan care for the future and safeguard finances, etc. offers expertise in recognising stress and adjustment-related mental health conditions among carers themselves. 	<p><i>An older adult with advanced dementia living with a frail spouse.</i></p> <p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> provides carer education around diagnosis and management strategies involves other suitable services such as Admiral nursing gives advice to social care on carer needs provides capacity assessment for application to the Court of Protection. 	<ol style="list-style-type: none"> Ensure that specialist older-adult mental health support is available to support carer needs and improve outcomes for carers and, indirectly, for patients. 	<p>See examples 4, 6 and 8 in Appendix 1</p>

LTP ambition (section 5): Improved care for dementia and delirium			
Role of old-age psychiatry	Case examples	Recommendations	Service examples
<p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> provides expertise and leadership in diagnosis and management of delirium and dementia, and advises on complex cases has expertise in safely reducing the use of antipsychotics in dementia has expertise in post-diagnostic support in dementia plays a key role in advancing and implementing dementia-related research offers expertise in training the wider workforce, including the voluntary sector (e.g. Dementia Connect). leads and works collaboratively across all settings with health and social care teams and voluntary organisations to optimise diagnosis and care pathways for people with dementia and delirium. 	<p><i>Old-age psychiatrists working within primary care to upskill GPs and other social and healthcare professionals to screen and assess dementia and delirium.</i></p> <p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> manages diagnostic uncertainty and complex psychobiosocial aspects of dementia and delirium (including drug and non-drug treatments) is used to working across all settings that include acute hospitals and community and with the voluntary sector. advises on management and risk reduction for both dementia and delirium develops delirium services in the community develops delirium-awareness training. 	<ol style="list-style-type: none"> LTP planning guidance for delirium and dementia must include OPMH and old-age psychiatrists as a key component to ensure optimal assessment and care at every stage. This will include direct work with patients as well as consultative and educational roles across all healthcare settings. 	<p>See examples 1, 2, 3, 4, 5, 6, 8, 12 and 13 in Appendix 1</p>
LTP ambition (section 6): Improved care for those who are frail			
Role of old-age psychiatry	Case examples	Recommendations	Service examples
<p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> identifies frail people as part of their everyday clinical work along with the MDT, detects undiagnosed mental health issues (e.g. alcohol/substance misuse, anxiety, and depression) which can be the result of comorbid physical health problems works collaboratively within Frailty MDTs to devise management plans for the most complex cases. 	<p><i>An older person who is frail and repeatedly attends the Emergency department.</i></p> <p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> identifies undiagnosed mental health issues (e.g. alcohol/substance misuse or anxiety). provides advice in collaboration with the Frailty MDT on the management, treatment and risk-reduction plan for those individuals who are frail provides advice on complex capacity issues and relevant legislation. 	<ol style="list-style-type: none"> Old-age psychiatrists should be an essential part of any integrated multidisciplinary service caring for frail older people in acute hospitals and within ‘anticipatory care’ models. OPMH input should be a core requirement for community healthcare providers and primary-care networks taking forward the Ageing Well agenda. Alcohol and substance misuse should be considered by those undertaking frailty assessments. Research bodies should, as a matter of urgency, ensure there is more research into the impact of mental health issues on frailty, and into the impact of serious mental illness has on the development of frailty. (The College’s Psychiatrists Position Paper on Frailty is due to be published at the end of 2019.) 	<p>See examples 1, 4, 5, and 12 in Appendix 1</p>

LTP ambition (section 7): Reduced inappropriate stays in hospital			
Role of old-age psychiatry	Case examples	Recommendations	Service examples
<p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> • has the necessary expertise to support hospital discharges by providing advice to healthcare and social care colleagues • gives advice in relation to falls prevention and optimising medications to reduce adverse side effects • supports suicide prevention by promoting health, specialised risk assessments and early intervention and management • increases recognition of mental health issues by other health and social-care professional through integrated working and education. 	<p><i>Older person admitted to hospital following a fall, who has depression and expresses suicidal ideation.</i></p> <p>The old-age psychiatrist:</p> <ul style="list-style-type: none"> • assesses the patient as part of the older-adult liaison team • puts in place a care plan that includes medication, support of ward staff in caring for the person, and provision of community care for the patient on discharge. 	<ol style="list-style-type: none"> 1. Guidance regarding implementation of the LTP should specify that coordinated older-adult mental health services are commissioned across different settings in both a direct-care and advisory capacity. 2. To implement the LTP, this service should include: <ul style="list-style-type: none"> • liaison teams with access to adequate old-age psychiatry input to reduce inappropriate admissions and delayed discharges • parallel access to old-age specific crisis support in the community to avoid A&E attendances, provide an alternative to admission and to support early discharge by providing clear guidance regarding crisis and contingency planning in people with dementia and other mental illness. 	<p>See examples 2, 3, 5, 7, 9, 12 and 13 in Appendix 1</p>

2.4 Adapted from Chapter 3 (Mental Health) of the NHS Long-Term Plan (published January 2019).

The NHS Mental Health Implementation Plan 2019/20–2023/24 was published in July 2019.

Table 3		
LTP ambition (section 1): Adult common mental illness (IAPT)		
Role of old-age psychiatry	Recommendations	Service examples
<ul style="list-style-type: none"> • Old-age psychiatrists can and should provide much-needed educational interventions to IAPT therapists, to ensure familiarity with presentations of mental health disorders in older people. • They have expertise in case-finding within the community, particularly with hard-to-reach and isolated individuals. • They have a key and clear role in development of expertise for IAPT for LTCs. 	<ol style="list-style-type: none"> 1. Involve expertise and leadership from OPMH in the expansion of IAPT services to ensure it can continue to improve its recognition and treatment of older people with common mental illnesses. 2. Consider appropriate skill-mixing, including dedicated older-adult psychological expertise to improve case-finding and recovery rates. 	<p>See examples 1, 4, 7, 8 and 11 in Appendix 1</p>
LTP ambition (section 2): Adult severe mental illness (SMI) community care		
Role of old-age psychiatry	Recommendations	Service examples
<ul style="list-style-type: none"> • Old-age psychiatrists are system-leaders in the prevention, assessment and management of mental health problems in older people which present in complex and different ways to younger adults with severe mental illness. • Old-age psychiatrists work collaboratively with primary care services in the community to ensure good outcomes for older people with severe mental illness • Old-age psychiatrists provide expertise and leadership in service development, legislative frameworks and understanding the wider health and social-care landscape. • They are a vital educational resource for GPs and other health and social-care professionals, enabling them to manage the increasing prevalence of mental health disorders in older people. 	<ol style="list-style-type: none"> 1. Service commissioners must ensure they do not overlook older adults' specific mental health needs in service transformation. 2. Community transformation plans must specify how OPMH will be commissioned and provided within each ICS/STP and link with primary-care networks and frailty services. 3. It is essential that older adults living with severe mental illness in the community have access to age-appropriate specialist care delivered by OPMH professionals and led by old-age psychiatrists. 4. Commissioners must be aware of how local OPMH services are currently delivered, e.g. in OPMH-specific services, 'all-age' adult mental health services or as part of frailty and physical health services, and ensure that the service configuration provides specific expertise for the mental health of older people. 	<p>See examples 1, 4, 7 and 11 in Appendix 1</p>

LTP ambition (section 3): Mental health crisis care		
Role of old-age psychiatry	Recommendations	Service examples
<ul style="list-style-type: none"> • Old-age psychiatrists and OPMH teams are experts in the provision of mental health care to older adults in crisis, with suicide reduction being one of its main focuses. • They are experts in complex risk assessment and management for older people. • They have advanced knowledge of legislation, including the interplay between the Mental Health Act and Mental Capacity Act, along with DoLS/Liberty Protection Safeguards. 	<ol style="list-style-type: none"> 1. Local transformation plans must provide age-specific expertise to deliver the ambition for 100% coverage of age-appropriate crisis care. 2. There is a need for greater mapping of current service provision for older adults' mental health crisis. OPMH crisis services are currently patchy, with insufficient national data to understand the nature and level of current provision. 3. Transformation plans should specify that crisis services for older people may be provided in different parts of the service (i.e. within acute mental health care or community frailty-based hubs). 	<p>See examples 2, 7 and 11 in Appendix 1</p>
LTP ambition (section 4): Mental health liaison		
Role of old-age psychiatry	Recommendations	Service examples
<ul style="list-style-type: none"> • The proportion of older adults within acute hospitals is over 40%¹²; people diagnosed with dementia account for at least 25% of all admissions; they have longer lengths of stay and are often admitted in an unplanned way with preventable causes. Almost 40% are discharged to a higher level of care than they had on admission.¹³ • Old-age liaison services, managed by old-age psychiatrists, are expert at managing these complex patients, including recognising and advising on delirium. They have a key role in complex discharge planning into the community, as well as liaising with community colleagues regarding patients at risk of admission. • Studies have shown that old-age liaison services yield cost benefits above and beyond working-age adult services.¹⁴ 	<ul style="list-style-type: none"> • It is essential that old-age expertise is built into liaison services to reduce bed utilisation and lengths of stay, and to improve outcomes. 	<p>See examples 3, 5, 9, 10 and 12 in Appendix 1</p>

3. Next steps and recommendations

The wide range of services and the variation in service models through which older people with mental health problems are currently supported puts this growing group at risk of having their mental health and wellbeing overlooked unless clear specification is provided. To this end we make the following recommendations.

3.1 Improved understanding of need and the current provision to meet these needs

The Faculty Executive recommends that local demographic data is used to assess the extent of the needs of older people along with a local mapping exercise of the current older-adult mental health provision to meet these needs. This will help inform greater understanding of regional variation and service gaps and future planning.

In particular, the current understanding of crisis support for older adults with mental health problems is unsatisfactory. With the expansion and mandating of crisis and home treatment teams (CRHTT) support nationally, it is now pressing that there is understanding of where service gaps are likely to arise.

3.2 Local five-year plans must include explicit reference to OPMH

Regional and local systems must be fully aware of the need for the mental health care of older adults to be explicitly addressed throughout their plans for integrated system redesign. The Faculty Executive recommends that all ICS/STP (integrated care systems/sustainability and transformation partnerships) five-year plans for delivering the LTP should include explicit reference to how systems will support people with dementia and other mental health disorders in older age and include old-age psychiatrists in these discussions.

Local systems at the primary care network level should follow planning guidance when developing their plans, and ensure that the mental health needs of older people are met; systems must be aligned to ensure that older people's mental health is recognised within general mental health transformation and is also specified within community transformation through redesign of Ageing Well, particularly around 'anticipatory care'. In this regard, the old-age psychiatrist representation will be key at primary-care networks level.

3.3 Planning of EHCH (Enhanced Health in Care Homes) models

The current EHCH framework does not include mental health expertise as part of its core multidisciplinary team. This report has clearly outlined the mental health needs in care homes. The Faculty Executive recommends that future planning for EHCH services includes the provision of older peoples' mental health input as a central part of such services.

3.4 Workforce

There is a growing demand for older-people's mental health services which is not matched by recruitment and retention trends. Workforce planning must therefore be a key factor in transformation plans.

To make the most of limited resources, and in keeping with the goals of the Long Term Plan, there must be a move away from siloed working of old-age psychiatrists to integrated working across primary care, community health and hospital inpatient settings.

3.5 Research

There are several key areas in older people's mental health where further research data is needed to better inform and drive service design and practice in lines with the priorities of LTP. These include frailty in older people with mental illness, and the efficacy of different models of care in terms of positive outcomes for older people with mental illness and their caregivers.

Research is also needed to clarify which particular models of shared care/joint management with older people's mental health services and their health, social and voluntary sector colleagues work best across different settings in the community and hospital.

Appendix 1:

Service examples

This section outlines a few examples of the role old-age psychiatrists have played in the development and delivery of transformational services for older people that have been driven by various local needs.

1. Cambridgeshire physical and mental health services for older people (Cambridgeshire and Peterborough Foundation Trust)

In Cambridgeshire, physical and mental health services for older people are now fully integrated in the community following the transfer of physical health services to the mental health trust in 2016.

This has resulted in a large service responsible for a caseload of 40,000–50,000 at any one time, and more than 800,000 contacts per year in general services, more than 40,000 MIU (minor injury unit) attendances, and 50,000 occupied bed days.

The quality of the service is high, with only 68 complaints last year (one for every 12,000 contacts), 22 SIs (serious incidents) (one for every 37,000 contacts), a friends and family test of 97%, and it was rated 'good' by the Care Quality Commission (CQC). The service also finished the last financial year in financial balance.

This service is led by old-age psychiatry. Part of its success lies in the integration of physical and mental health at an individual patient level, but also in terms of the staff learning from each other in terms of service structure and delivery.

For example, an emergency response team has been created for those in a physical health crisis, modelled on our psychiatric crisis teams. This is effective in reducing the need for admission to acute trusts.

Old-age psychiatry is at something of a crossroads. In many areas, to make savings, it is merging with adult psychiatry. This example shows that old-age psychiatry can merge successfully with physical healthcare for older people and can lead those services, bringing benefits for patients and the healthcare system more generally.

For more information, contact Benjamin Underwood, Clinical director, Older People's and Adult Community (OPAC), Cambridgeshire and Peterborough NHS Foundation Trust, or see www.cpft.nhs.uk/services/older-peoples-and-adult-community-services.html/

2. Dementia Crisis Team, North East London Foundation Trust

The Dementia Crisis Support Team was set up to support and manage crises in people with dementia in the community, to avoid admissions to hospital. The service is based in Brentwood Community Hospital, covering the catchment areas of Basildon, Brentwood and Thurrock in Essex.

The service started as a pilot project in Jan 2014 and due to its huge success it received permanent funding a year later. It was set up with active engagement with local GPs, Commissioners and service users (mostly carers of people with dementia, but also people in the early stages of dementia).

The team has one WTE (whole-time equivalent) consultant, one WTE speciality doctor and one FY2 trainee.

The team receives an average of 100 referrals per month of people with dementia or memory loss in a state of crisis that might be triggered by a physical, health or mental health disorder or social factors.

The team works in a crisis model with RAG rating of cases and offers a holistic, multidisciplinary package of care, including support for carers.

As part of the core work, the team also offers training sessions to care-home staff in the catchment area to enable and empower them to manage people with dementia in their homes.

The team offers placements to medical students and nursing students and recently has started to support the Anglia Ruskin University with a physician-assistant training programme.

Significant savings have been made, including closure of a twenty-bed mental health ward for people with dementia, as the team has drastically reduced admissions for people with dementia.

The length of stay in acute hospitals for dementia patients has also been reduced, which translates into savings on excess bed costs. The reduction in admissions has been sustained year on year.

In 2014, the team won an EAHSN (Eastern Academic Health Science Network) health innovation award, and in 2016 it won the Health Service Journal (HSJ) award.

For more information, contact Dr Afifa Qazi, Associate Medical Director, North East London Foundation Trust, or see: <https://www.nelft.nhs.uk/services-bsbwtk-dementia-crisis-support/>

3. Enhanced dementia care ward (University Hospital Southampton NHS Trust)

A re-purposed fourteen-bed medical ward has been developed in the acute hospital within Medicine for Older People (Geriatrics), with integrated OPMH consultant input.

Admissions are accepted from the emergency department, acute medical unit and other wards from 8 am to 8 pm, seven days a week, for people with an acute medical problem requiring hospital admission, with high cognitive needs and high dependency.

The ward has an OPMH consultant-led MDT meeting twice a week. The OPMH consultant is employed directly by the acute trust and integrated within Medicine for Older People.

The average length of stay is 18 days, with approximately 250 patients seen per annum, amounting to 5% of MOP (medicine for older people) patients per year.

Evaluation demonstrates that a length-of-stay cost saving has been achieved across the Medicine for Older People department, both before and after opening of the ward, versus an investment of 0.2 Pas (programmed activity) consultant OPMH time.

There has also been a significant reduction in the length of stay across medicine for older people (with a bed base of 150). There have been reductions in use of the Mental Health Act for people with dementia and transfer to organic OPMH wards.

For more information, contact Dr Vicki Osman-Hicks, OPMH Consultant/Ward Link Consultant (Victoria.osman-hicks@uhs.nhs.uk), or see www.uhs.nhs.uk/OurServices/Medicineforolderpeople/Services/Dementia/G7-Enhanced-dementia-care-ward/G7-Enhanced-dementia-care-ward.aspx

4 The Camden Frailty Hub

Weekly frailty MDT (multidisciplinary team) meetings are held in four local 'neighbourhood' groups of five to eight GP surgeries.

They are chaired by a GP representative, and membership usually includes a senior social worker, a consultant geriatrician from the local acute hospital (either the Royal Free Hospital, Hampstead, or University College Hospital London, Euston), a senior nurse from the local memory service (Camden & Islington Foundation Trust), an Age UK community navigator, and a complex-care nurse from local community health services.

There is also periodic attendance of a local consultant old-age psychiatrist, who rotates each week through these meetings. The MDT's focus is on providing collaborative care planning, whereby they devise a care plan for inclusion in the EMIS (Egton Medical Information Systems) GP electronic patient record (to which partners also have access).

The patients discussed at these meetings are considered to have moderate frailty as well as complexity, which cannot be managed in GP practices alone.

Patients can be referred to these meetings from a variety of sources, but generally from health or social-care sources. GPs are the primary-case identifiers, however a significant proportion of patients considered in the borough Frailty Hub are identified by local acute trusts, reflecting the high rates of frequent admission among this patient group.

A study of the impact of the model has shown an increase of 7% in the number of days that moderate and severely frail patients were able to spend at home during the six months after receiving support.

In this population, there has been a 51.8% reduction in emergency-bed days, and a 47.7% reduction in A&E attendances. Additionally, there has been a 32.2% reduction in first and follow-up outpatient appointments.

For more information, see <https://gps.camdenccg.nhs.uk/service/frailty-mdt-hub/>

5. Outpatient older-adult liaison psychiatry services and frailty (South London & Maudsley NHS Trust and King's College Hospital)

Since 2016, a pilot outpatient mental health liaison clinic has been in operation, embedded within the outpatient geriatric medicine service. The outpatient geriatric team conducts comprehensive geriatric assessments (CGAs) for older adults who are referred to the geriatric multidisciplinary medical team.

As part of this process, patients are screened for depression using the Geriatric Depression Scale (GDS) and they undergo assessments for cognition (e.g. with the Mini Mental State Examination). Those identified as having a mental health need through these assessments may trigger a referral to the service.

Referrals to the outpatient liaison service are also received from junior medical staff, other hospital consultants, nursing staff and professions allied to medicine when a suspicion of a mental health need arises during routine assessments (e.g. through the falls clinic) in older adults.

The referral process is enhanced by the regular presence of an old-age psychiatrist in the weekly MDT meetings, as well as through the informal discussion of referrals. The clinic does not accept people for whom primary concerns relate to memory problems (who are referred to memory services) or who are under the care of CMHTs.

The clinics are currently operated by one senior clinician (a consultant old-age psychiatrist) who also attends the MDT meetings in the Geriatric Medicine service. The clinics operate as a one-off assessment and treatment service, with all patients being referred on to other services as appropriate, or discharged back to the referrer.

Patient feedback has been collected as part of our outpatient service evaluation, which indicates that all patients surveyed would be 'extremely likely' or 'likely' to recommend the service to their friends or family if they needed similar treatment.

The clinics also have an educational function, with the regular presence of nursing students, medical students and other members of staff.

For more information, see:

<https://www.kch.nhs.uk/service/a-z/clinical-gerontology>

6. The Bristol Dementia Wellbeing Service (Alzheimer's Society and Devon Partnership NHS Trust)

This service brings together the Alzheimer's Society and Devon Partnership NHS Trust and is responsible for delivering dementia services in Bristol.

Its aims are to improve access to early diagnosis, to co-develop personalised wellbeing plans to support those living with dementia to remain well and active, and to provide training and support to other services by raising awareness and understanding across the city.

The service includes all aspects of living well with dementia – early diagnosis, treatment and post-diagnostic support, work in care homes and at the end of life, and support of carers. It actively fosters links across all services that a person living with dementia may encounter.

Initiatives across the city and in schools aim to raise awareness and access to services, particularly in communities with historically low rates of engagement.

A community development co-ordinator leading on dementia education in Bristol's primary and secondary schools has delivered age-appropriate assemblies and an age-appropriate toolkit to support young people of all ages living in families affected by dementia

They seconded three practitioners into local hospital trusts to support people with dementia in hospital, and to improve proactive and safe discharge planning, as well as facilitating communication between the acute trusts and community support.

For more information, see www.bristoldementiawellbeing.org/

7. Crisis and home treatment for older people (Cambridge and Peterborough Foundation Trust)

Since June 2016, the trust has established two CRHTTs for older people, with a full-time consultant embedded in both the North and South of the county in a multidisciplinary team, who work shifts from 8 am to 8 pm.

The two CRHTTs have a Dementia and Intensive Support (DIS) 'arm' and staff work across both functional and dementia domains.

We evaluated the efficacy of the DIS service in preventing admissions to both psychiatric and general hospitals. It contributed to admission avoidance in 70% of patients referred in the South team and in 50% of patients in the North team over a two-month period.

Having DIS teams in both parts of the county is an effective way to prevent admissions to general and psychiatric hospital.

For more information, contact Judy Rubinsztein (Judy.rubinsztein@cpft.nhs.uk) or see <https://www.cpft.nhs.uk/services/Crisis%20Resolution%20Home%20Treatment%20Teams%20for%20Older%20People/>

8. Downshall Intergenerational Provision (North East London foundation Trust)

Redbridge Older Adults Mental Health Team, in North East London, have partnered with a local primary school, Downshall Primary, as well as the London Borough of Redbridge and the charity Age UK to provide the UK's first older-adults day provision embedded within a school.

It was set up to provide a low-cost solution to a steady reduction in opportunities for older adults within the borough, coupled with growing class sizes and reduced resources at the school.

The Downshall Intergenerational Provision (Bringing Together, Learning Together, Growing Together) has been running since November 2017 and provides space for nine older adults per day on three days a week in a custom-furnished, dementia-friendly environment.

The staffing costs are minimal and include administrative time from school admin, one support worker from the local authority for three sessions a week, and three Age UK volunteers per day.

Leadership is provided by a consultant old-age psychiatrist, the head-teacher and the head of early years. The consultant time needed formally is one afternoon every two months for the referral meeting and steering group.

All of the participants are referred from Redbridge Older Adults Mental Health Team, Redbridge Memory Service or Age UK. They are referred on the basis of concerns that they may be lonely or socially isolated and may be suffering from, or recently treated for, depression, anxiety disorders or mild dementia.

The North East London Intergenerational Strategic Alliance (NELISA) aims to bring together stakeholders across North East London to replicate this provision in neighbouring boroughs. We aim to further expand this across London.

For more information, contact David Hinchcliffe (David.Hinchcliffe@nelft.nhs.uk) or see www.theguardian.com/education/2017/dec/11/primary-school-elderly-people-work-with-young-pupils-essex/

9. Care Home Liaison Service (NHS Lanarkshire)

Due to service changes and budgetary pressures we were asked to redesign our care-home liaison team. This previously consisted of nine nursing staff who were locality based, with no dedicated medical input.

We determined to reduce the service to six nursing staff covering the entire health board area, and to add 0.5 sessions of old-age psychiatry medical time per week.

This system has allowed us to operate with fewer staff, while providing a higher-quality service that is able to work as a multidisciplinary team. Early indications are that the service effect is to increase the proportion of people we can manage in the community, as opposed to admitting them to inpatient wards.

For more information, see www.nhslanarkshire.scot.nhs.uk/services/care-home-liaison/

10. Gateshead virtual ward (Newcastle Gateshead Clinical Commissioning Group)

As part of the enhanced healthcare in care homes vanguard, Gateshead have instigated a weekly care-home MDT virtual ward, with associated clinical input, with visits outside of the meeting that focus on frail older people.

The attendees at the meetings are a consultant old-age psychiatrist (four sessions), GPs, a consultant geriatrician (six sessions) and band-7 older-people's specialist nurses.

Currently this service covers 70% of care-home residents in Gateshead (a total of 1360). The weekly MDT caseload is approximately 30.

This model provides the ability for shared decision making in complex frail people in the most holistic manner encompassing their physical, mental health plus social, family and emotional factors.

The results show reduced bed days and emergency admissions and significant economic value to the health and social-care system, with a calculated cost saving of £3.3 million across NGCCG for the duration of the Care Homes Vanguard.

For more information, see <http://old.ahsn-nenc.org.uk/wp-content/uploads/2015/04/Gateshead-Care-home-initiative-slides.pdf> and <https://www.necsu.nhs.uk/wp-content/uploads/2019/02/2018-01-NG-CCG-Reviewof-GatesheadVirtualWard.pdf>

11. Camden and Islington's Home Treatment Team and Enfield's Care Home Assessment Team (CHAT)

Camden and Islington's Home-Treatment Team at the Camden and Islington foundation trust is a unique emergency mental-health crisis response and short-term treatment team for older people with either functional (e.g. depression or anxiety) or organic (i.e. dementia and delirium) mental health needs.

Achievements for their Home Treatment Team include a 55% reduction in the average number of treatment days (from 20 days in 2015 to nine days in 2018); 63% of older adults who received crisis mental health support were discharged to their normal place of residence.

The Care Home Assessment Team (CHAT) located in Enfield at the BEH Trust is an integrated multidisciplinary mental and physical health care-home support team with strong links to primary care. It is underpinned by seamless support from local geriatricians and a consultant psychiatrist.

The team's approach is particularly ground-breaking in that it promotes an integrated response across physical and mental healthcare.

Achievements since 2013 include a 35% reduction in the number of A&E attendances and non-elective admissions. Furthermore, 8,409 hospital attendances and 8,109 GP call-outs have been avoided).

For more information, see www.candi.nhs.uk/services/home-treatment-team/ and <http://www.beh-mht.nhs.uk/services/care-home-assessment-team-chat.htm>

12. Saffron Ward: An innovative service for people with delirium

Saffron Ward is a 20-bed 'step-down' from Stepping Hill Hospital for patients suffering predominately from delirium, dementia and depression. It optimises older people's health, wellbeing and independence through medical, nursing and therapy interventions.

The primary admission route for step-down referrals is from the medical wards at Stepping Hill Hospital, referred by the inpatient liaison team and five 'step-up' patients via the crisis team for patients who it is felt might benefit from admission from their own home, thus preventing general hospital admission. It provides comprehensive assessments and structured individual care plans that involve active therapy and an opportunity for recovery.

A range of nursing assessments is carried out on the ward. The ward provides rehabilitation for people with comorbid physical and mental health conditions who are considered unsafe to remain in (or return to) their own homes, but who could have the ability to live at home if provided with suitable rehabilitation services.

The ward adopts a biopsychosocial model to deliver holistic care to patients with complex presentations who are cared for by a multi-disciplinary team. An old-age psychiatrist has a weekly ward round. The ward is also visited by a GP every day.

Due to the complexity of the cases, the average length of stay is currently five weeks.

Discharge is achieved with the involvement of a mental health social work team. The team consists of social workers, an assistant practitioner, a physiotherapist and an occupational therapist, who work closely with the team. The consultant psychiatrist provides continuity of care post-discharge for patients requiring further psychiatric input.

For more information, contact Joanne Cole (joanne.cole6@nhs.net) or see www.penninecare.nhs.uk/saffronward/

Example 13: Medichec: A tool to make prescribing safer for people with dementia

Medichec was developed in collaboration with Mindwave Ventures and the support of the Mental Health of Older Adults and Dementia Clinical Academic Group at SLaM.

In 2017, Medichec was launched as an online tool to help clinicians identify medicines that could cause memory and cognitive problems in older people, and to improve the safety and quality of prescribing. Medichec allows clinicians to easily identify which medicines have an effect on cognition, along with the size of the effect for different medicines individually and in combination. This helps to inform the choice of medicines and any changes required.

Since its launch, Medichec has been integrated into Older Adult Mental Health assessments at SLaM and is being used across a number of other NHS Trusts. Over the last 12 months, it has been used to check medication almost 13,000 times across the UK and internationally, including the USA, Canada, South America and Europe. The availability of the Android and Apple apps will widen its usefulness.

For more information, see www.medichec.com.

Appendix 2:

Views of patients, carers, health and social care professionals and commissioners about the role of old-age psychiatrists

Patients and carers

An older patient:

“ I am 84 years old and I have bipolar. I always tried so hard to hide my illness because I thought my children would be taken from me. Over the years I have made appointments with doctors, but could never tell them what I really needed to say. When I had a breakdown later on, all the years of controlling my feelings came crashing down. My GP referred me to a psychiatrist who dealt with older people. He listened, he made me laugh, he taught me to go easy on myself. When my husband and my sister died eighteen months later, he really was my saviour. What I really feel is that the day I met my psychiatrist my life changed. I no longer think of ending my life and look forward to my telegraph from the Queen. ”

Carer of someone with early-onset dementia (now advanced):

“ Since 2009 we, as a family, have been receiving not only professional help but also total support and encouragement from the resident psychiatrist. He ensures and tries very hard to address our concerns, worries about future, and treats patients with dignity and respect. His invaluable support when the family were going through a very bad phase of my sister’s challenging behaviour is very much commendable. Even though the clinic is facing staff shortages and additional pressure due to more dementia awareness, his leadership and commitment to the community is beyond doubt very excellent. The NHS should try and maintain consistency and retain professionals in order that patients and their families feel comfortable and relaxed when dealing with known professionals with whom they have established a rapport and understanding. ”

Educationalists and researchers

Professor Wendy Burn, President, Royal College of Psychiatrists:

“ The skills of old-age psychiatrists will be essential to deliver the ambitions of the NHS Long-Term Plan. We already know how to deliver integrated care and how to support older people to live well in their communities. ”

Dr Sanjeev Ahluwalia, Regional Postgraduate Dean, Health Education England working across London:

“ As people live longer, there is a strong emphasis on supporting individuals to remain independent and in their own environment. The Long-Term Plan emphasises the importance of parity of mental with physical health, as well as secondary and primary care, health and social. Old-age psychiatrists are uniquely placed in their roles to lead and support new models of care that emphasise the importance of integration of services, research into cutting-edge treatments and new ways of delivering care, and offering leadership to place-based healthcare systems. Old-age psychiatrists, with their whole-person and family-orientated approach, are also well-placed to emulate and role-model the values of generalist practice called for by educational and regulatory bodies. ”

Professor Martin Orrell, Director of the Institute of Mental Health, University of Nottingham:

“ Specialist expertise in the assessment and management of older adults is vital if a liaison psychiatry service is to meet the needs of patients of all ages. This is recognised in a recent College Position Statement on liaison psychiatry across the lifespan, and in the current national standards for the provision of a robust (Core 24) liaison psychiatry service. ”

Dr Jim Bolton, Consultant Liaison Psychiatrist, Chair, Faculty of Liaison Psychiatry:

“ Old-age psychiatrists should provide clinical and academic leadership to innovative projects and research studies which can help people with dementia remain at home for longer, and avoid unnecessary hospital admissions. ”

Primary care (GPs, commissioners)

Dr Serena Foo, GP Partner, West Seven GP, Mental Health Lead for Ealing Clinical Commissioning Group:

“ Old-age psychiatrists are likely to continue to have a significant role in the care of the population in the future. As the population continues to grow older, living with chronic medical conditions that are being managed more effectively, it will be even more important for clinicians to work in an integrated manner, combining all their skills. I believe the model of care developing around primary care homes and primary care networks will continue to grow, and we need old-age psychiatrists to be a part of this. We will need their expertise to help manage the various mental health issues that may already be prevalent or arise anew – not just around cognitive impairment that we commonly associate with older age. We will want to continue to work with them especially in managing complex cases where mental and physical health needs are all intertwined. Henceforth they will need to be jointly designing the future, helping to innovate, lead, educate and inspire. ”

Dr Andy Goodstone, Primary Care Network Clinical Director, Marylebone Health Centre, London:

“ Working as a GP I have become increasingly aware over the years of the differing physical and mental health needs of the elderly and working-age adults. With the ageing population and advances in medical care, more of our patients have complex physical and mental health symptomatology requiring input from specialist services. As a primary-care network clinical director, I believe that old-age psychiatrists are integral to the development and delivery of future integrated-care organisations. Locally I have always felt confident in the skills of my current local old-age psychiatrist. I can think of several occasions when he promptly and efficiently managed a complex matter. ”

Dr G Winder, GP Partner, Oakwood Lane Medical Centre, Leeds:

“ Old-age psychiatrists are so important in our future integrated-care systems. Our local old-age psychiatrist is based with us once a week, and this has made a tremendous difference in assessing and managing complex cases of mental health and those with comorbid physical health. Their expert knowledge in legal aspects, such as the Mental Capacity Act, expedites and simplifies complex capacity decisions and end-of-life decisions in primary care. As the population ages, expanding work in an integrated manner will not only benefit patient and carers, but enable education and efficiencies for frontline staff. ”

NHS managers

Melody Williams, Integrated Care Director, North East London Foundation Trust:

“ From an operational leadership perspective, the role of the old-age psychiatrist in service development is pivotal in ensuring that we continue to focus on the intergenerational aspects of the services we deliver. The need to account for the whole family system surrounding the older person who has mental health difficulties is key to ensuring the best outcomes, not only for the individual but also those who love and support them. Poor care in the later years of life leaves an unacceptable and unforgettable footprint in the memories of those surrounding them, which can impact on their perception of health and care services, their proactive approach to health and wellbeing, and any future access of services. The old-age psychiatrist has both a clinical and multifaceted engagement role that gives them unique insight into this intergenerational view, which means they are well placed to challenge thinking, planning and direction for services in the community. By getting these right, then successful and insightful ageing will be something we can all look forward too. ”

Dr Neville Pursell, Chair, NHS Central London Clinical Commissioning Group:

“ The challenge for GPs is getting harder and more complex as we try to manage an increasingly elderly population with problems of multimorbidity, so often with social isolation and cognitive, mood and behavioural issues. Having access to expert advice and quick assessment for these patients is essential, so they can be looked after better in their own homes. Discussions around capacity, and advice on behaviour management, medication and treatment are frequent; I have no doubt we have avoided many admissions to an acute hospital, which are usually very disruptive to the individual patient and their wellbeing. ”

Dr Jeremy Isaacs, Clinical Director of the NHS E&I London Dementia Clinical Network:

“ As a cognitive neurologist, old-age psychiatrists are essential partners in the management of people with dementia. We rely on the expertise of old-age psychiatrists in managing behavioural and psychological complications of dementia. Old-age psychiatrists bring to dementia a broader understanding of the psychosocial effects of cognitive decline and personality change on the individual, their family and the wider community, and how some of these can be mitigated. The increasing complexity of the dementia field requires that the professions involved in 'brain medicine' (e.g. psychiatry, neurology, psychology, radiology, nursing, occupational therapy) work collaboratively and share expertise. Unfortunately, the current NHS structures, specifically the organisational split between physical and mental health, make this very difficult. We almost need to start again, conceptualising services around a new discipline of 'cognitive medicine'. But in whatever way we provide care for people with dementia in the future, old-age psychiatry will be one of the key anchoring specialties in service provision, quality improvement and research. ”

Care-home staff

Mrs Karleen Carole Taylor-Williams, registered mental health nurse, Balmoral Care Home:

“ I have been a home manager for the past eight years and have always managed severely challenging behaviour units, which brings me into contact with psychiatrists from a number of local authorities. In my opinion, the assistance of old-age psychiatrists when people are admitted to the home is invaluable. If the old-age psychiatrist continues to follow-up these patients, it assists in ending the revolving door of constant hospital admissions, as people can be reviewed and medication changes made while they are still in the care home. When I worked in the Gateshead area, the availability of the old-age psychiatrists was second to none, and all issues could be resolved on an immediate level, and crisis management avoided. Whilst working in a different area, the assistance from psychiatry was extremely lacking, and therefore crisis management of such patients led to hospital admission through A&E, which is extremely draining on resources and further anxiety-provoking for patients. This has increased ambulance time, A&E resources, and bed-blocking of patients that could have been easily treated within their care home, which has a huge resource of experienced, medically trained staff to manage these emergencies under the guidance of an old-age psychiatrist. ”

Wendy Reid, Home Manager, Philips Court Care Home:

“ As a care home manager, the input of the old-age psychiatrist within the care home is invaluable. Within social care, too often residents once discharged by a hospital may not have the consistency that they require. This may be in terms of long-term antipsychotic treatment that requires regular reviews, or in instances when advice and support is required in urgent situations. Having a positive working relationship with the old-age psychiatrist not only benefits the residents in the home with ever-changing mental health presentations, but also offers helpful support and guidance to staff in terms of distraction and or de-escalation skills. Of paramount importance is that the consistent approach ensures that the residents' care is optimised, and that staff feel part of an extended MDT within the community. Within social care this is often lacking with some NHS providers, where the care-home facility is seen as second class. The input of the old-age psychiatrist brings knowledge and understanding, working in partnership that can only benefit the resident. ”

Professional colleagues

Elizabeth Bond, Head of Pharmacy in Mental Health and Learning Disabilities:

“ Older people have specific needs that old-age psychiatric consultants are skilled and experienced in understanding and communicating effectively when discussing diagnosis and treatment to patients. During my independent prescribing and advanced practice training, I benefit greatly from the input and expertise of various old-age psychiatric consultants who have mentored and supervised me. Without their specialist input, I do not think that older patients will get the best treatment for their mental health. ”

Social worker, Tees Esk and Wear Valleys NHS Foundation Trust:

“ Being co-located with an old-age psychiatrist is a valuable resource with many benefits to both staff and service-users alike. Being part of a wider team allows a more responsive joined-up approach for meeting the needs of service-users. We regularly work together, undertaking joint visits and responding to crisis calls. As we have a longstanding good working relationship, there is a mutual understanding of roles and responsibilities. The service-user/patient hugely benefits from this approach, as they receive a timely response to reduce mental distress and we offer support to them and their family in the community. ”

Appendix 3:

Key points from the 2016 literature review on integration and older adults' mental health

The Faculty of Old Age Psychiatry produced a report in 2016^{15} that reviewed the evidence relating to integrated care in the context of older people's mental health. The report, endorsed by the British Geriatrics Society, made some stark observations.

- Older people's care cannot be integrated unless it addresses mental health needs.
- Older people's integrated-care services need to include qualified mental health professionals, including consultant old-age psychiatrists.
- The success of integration depends on the establishment of effective collaborative working relationships.
- A consultant old-age psychiatrist must be involved in service redesign and development.
- The workforce for physical and mental health services needs to be fit for purpose and have appropriate skills to deliver integrated care.
- The process of becoming integrated involves significant investment of time and workforce.

Additionally, prerequisites for effective integration that are often quoted in the literature include:

- co-location
- integrated record-keeping systems
- shared governance structures
- a single care coordinator for each patient wherever possible
- a single care plan for each patient wherever possible.

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