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# Integration of care and its impact on older people's mental health

Report to the Old Age Faculty of the Royal  
College of Psychiatrists

FACULTY REPORT



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I would like to acknowledge the time spent with me by the services I have visited around the UK, and the reference group, which convened at the end of the work to review the findings and formulate the recommendations.

# Background

The government's recently published Five Year Forward View for Mental Health (Mental Health Taskforce, 2016) points to their commitment to improve mental health services for everyone and highlights the challenges that this poses. There are high expectations of integrated care, both in terms of achieving the best outcomes for people with complex health needs, and also in making best use of resources, particularly in times of austerity. Although treatment of some previously chronic diseases has improved enormously – for example, cataract treatment for impaired vision – there are other diseases, such as diabetes, depression, dementia and Parkinson's disease, for which prevalence is rising and the focus is on prevention, maintenance, and management of comorbidity rather than cure.

Although assessment and management of health problems is rightly a function for primary care (Boeckxstaens & De Graaf, 2011), for people with complex needs, input from professionals with specialist knowledge is of proven value. Having access to multidisciplinary teams has long been known to assist with diagnosis and treatment, and to lead to improved outcomes (Warren, 1943). Furthermore, the pioneering of old age psychiatry as a specialism in the 1970s by Tom Arie, and its integration with old age medical services, has demonstrated improved outcomes for patients (Arie, 1973).

This work was commissioned by the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists to explore the following questions. For older adults with mental illness:

- what is there in the published literature about integrated care?
- is there an agreed definition of integrated care?
- what evidence is there of improved quality of care for patients and their carers?
- what evidence is there of improved cost-effectiveness?
- is the evidence available applicable to the current health and social care system in the UK?
- can this published information be supplemented by informal reports of best practice around the UK?
- what recommendations can be made to inform local and national approaches to integrated care?

# Methodology

## Literature search

A literature search was undertaken, covering both UK and international journals, using the PubMed, Embase, Medline and PsycINFO databases. The search was for articles related to integrated care, specifically with reference to mental illness and older adults. The time period for the search was initially 2010 to the present, on the basis that publications from further back would be less likely to be relevant to current practice in the UK. However, it transpired that much of the research undertaken earlier than 2010 is still relevant. The search words used were 'integrated health care system' or 'integrated care', 'psychiatry', 'mental health', 'mental well-being', 'dementia', 'ageing' or 'later life', 'quality of life', 'aged', 'frail' and 'elderly'. The search only included journals written in or translated into English. In addition to the literature search, a number of services across the UK were visited and semi-structured interviews were conducted. Services were identified by individuals reporting that they had implemented integrated care in their area, although this had often been done without adherence to standard research methodology or accompanying publication. Information from these interviews is included in this report to supplement the intelligence available from the published literature.

The findings are presented here by describing the context in which integrated care is promulgated, together with definitions and a review of identified models of integration. For all of the papers reviewed, the inclusion of mental health and the methodology used is noted, alongside an evaluation of the benefits in terms of clinical quality and cost. The findings from the semi-structured interviews are also summarised. Common themes are drawn from the literature, and services are reviewed and summarised in the discussion. A reference group, comprising representatives from old age psychiatry, elderly medicine, general practice, the voluntary sector, local authorities and commissioning groups was convened to review the findings and propose a set of recommendations.

## Definitions of integrated care

At its most fundamental, integration is concerned with the coordination of care for individual patients and their carers, described by the King's Fund as 'micro-level' integration (Ham & Curry, 2010). The description proposed by Leutz is much fuller and refers to the need for whole systems to work effectively together: 'the search to

connect the health care system (acute, primary medical, and skilled) with other human service systems (e.g., long-term care, education, and vocational and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency)' (Leutz, 1999). This is described by the King's Fund as 'macro-level' integration. Systems in between the micro- and macro-levels, in which organisations collaborate to coordinate care around a particular group of people, are classified as 'meso-level' integration (Ham & Curry, 2010). Within the literature identified, we found no consistent agreement as to a definition of integration, with descriptions ranging between those described above. In most of the papers reviewed, there is reference to multiple agencies working together in a coordinated manner to provide high-quality seamless care for individuals.

## Limitations of the literature

The literature is equally varied in terms of the level of integration described, and the extent to which studies have included psychiatry for older adults. There is no agreement as to which agencies are essential, although many have cited the central importance of primary care. The situation is compounded by the fact that in many countries there is no dedicated mental health service for older adults, as there is in the UK. The work of old age psychiatrists is variously carried out by general practitioners (GPs), neurologists, geriatricians and general adult psychiatrists, making it difficult to interpret the literature and its relevance to services in the UK.

Evaluation of the published literature is further complicated by difficulties in accurately measuring the impact of integration. In an international review of integrated models of care (Béland & Hollander, 2011), the aims of the studies, and therefore the criteria against which success was measured, were found to vary widely. Even when intentions were clear and consistent, the target populations, size of intervention groups and context differed, and therefore the results were difficult to compare. In addition, some of the intended outcomes of integration were not easily measurable. A systematic review of different models of home and community care services for older people, including those with dementia (Low *et al*, 2011), highlighted the benefits of case management in improving function, use of medications, use of community services and reduction in nursing home admission. However, the studies were described as heterogeneous in methodology, and the results were therefore not properly comparable.

A further review focusing on integrated working between care homes and healthcare services (Davies *et al*, 2011) described heterogeneity of topic, interventions, methodology and outcomes across the studies reviewed. Most quantitative studies reported limited clinical effects of interventions, and insufficient information to evaluate cost. Furthermore, it was not possible to clearly describe factors that inhibited or facilitated effective integrated working.

# Models of integrated care

In systematically reviewing the literature for this report, we analysed different models of integration. Here, we start with large-scale initiatives providing for whole populations, followed by joint working across organisations that serve specific groups of people. Studies which have centred on coordination of care around the individual are then reviewed. Finally, we explore the evidence about implementation of integrated care. The applicability of the models considered for the UK population is highlighted throughout.

## Whole-system integrated care

Kaiser Permanente is recognised as one of the top-performing health systems in the USA, and there is evidence from a study in 2002 that Kaiser performs better in comparison with the National Health Service (NHS), with about one-third of the bed use for the same cost (Feachem *et al*, 2002). The Veterans Association and Geisinger health system demonstrate similar outcomes, although all of these health systems focus primarily on physical healthcare, without specific inclusion of mental health. The underpinning principles are multispeciality medical groups, aligned financial incentives, information technology that supports the delivery of integrated care, the use of guidelines, accountability for performance, defined populations, effective leadership and a collaborative culture (Ham & Curry, 2010). Although there may be significant advantages to a whole-system approach, even those that have been implemented have focused on physical healthcare in the main, and have operated alongside rather than being integrated with psychiatric services. They also depend on national policy and legislative change. In our review of the literature, we did not identify any description of a healthcare system, anywhere in the world, that provides integrated care for both mental and physical health across the population it serves.

## Disease-specific management programmes

Disease-specific management programmes, in contrast to initiatives aimed at people with multiple coexistent conditions, focus on individual long-term conditions – for example, diabetes, coronary heart disease, depression and chronic obstructive pulmonary disease (COPD). These programmes are underpinned by evidence-based

guidelines and employ various strategies, including multidisciplinary team input and patient and provider education. The impact of these programmes is difficult to ascertain, not least because there is no common understanding of what constitutes disease management compared with usual care, and programmes for different conditions may not be comparable.

In Sweden, from the late 1990s, 'chains of care' have been developed to coordinate and integrate care for patients and populations with specific conditions (Åhgren, 2003). Defined as 'coordinated activities within health care, linked together to achieve a qualitative final result for the patient', the chains of care cover conditions including diabetes, dementia and rheumatism. A chain of care often involves several responsible authorities and medical providers, and central to their success is a form of contractual integration across organisational and professional boundaries. However, they have proved difficult to implement; reasons cited include the complex interplay between the overriding goals of the chain of care and individual factors relating to the patient and the professionals involved.

In the UK, the Scottish Cardiac Network was set up at the same time to develop appropriate pathways and associated protocols, unconstrained by existing professional and health board boundaries. It was ultimately successful in bringing together clinicians, patients and managers to redesign services, although it proved difficult to implement because no single agency owned the network. In addition, integration did not save money in this case, as setup was expensive and costs for treatment remained steady (Woods, 2001).

The CADET (clinical effectiveness of collaborative care for depression in UK primary care) study was conducted in three districts in England (Richards *et al*, 2013). Adults with a depressive episode were treated with collaborative care, compared with usual care. Mental health outcomes were found to be significantly better for those receiving collaborative care, with significantly higher patient satisfaction in that group. Physical healthcare was not affected by the intervention, and, as the study was conducted in younger adults, it is not clear whether the findings are applicable to frail older adults. Similar findings were demonstrated in a further study by the same group in the north-west of England (Coventry *et al*, 2015). In this study, collaborative care was found to reduce depression and improve self-management of chronic disease. In addition, the experience of care was more patient centred.

Although a disease-based model is potentially useful, a study in Norway demonstrated how cultural differences between specialist care and primary care may affect the implementation of an integrated care model (Røsstad *et al*, 2013). The initial objective had been to develop pathways for patients diagnosed with heart failure, COPD and stroke. The findings highlighted disjointed collaboration across primary and secondary care, but also within primary care, and there was significant variance in the understanding of professional groups as to the objective they were trying to achieve. Some individuals were

focused on a single disease from a medical perspective, emphasising diagnosis, short-term interventions and advanced technology, whereas others had a more long-term, holistic perspective with a focus on functional ability, patient preferences and self-management. During the course of the project, the disease-based model was abandoned in favour of the patient-centred model, and a holistic approach was favoured over a disease-specific approach when considering frail older adults.

## Frailty-based programmes

There are publications from around the world describing initiatives that have been implemented to provide better coordinated services for frail older adults, incorporating – to a varying extent – evaluation of clinical and cost-effectiveness. Some of these programmes have encompassed specific mental illnesses such as depression or dementia, although there is limited evidence of mental health professionals integrated within clinical teams.

The USA-based Program of All-inclusive Care for the Elderly (PACE), created in the 1990s, was an integrated provider model aimed at maintaining frail older people in the community. Care was organised around adult health day centres, with services from with specialist physicians, acute hospitals and skilled nursing facilities where required. At the heart of PACE was the multidisciplinary team. The programme resulted in a reduction in hospital usage, reduction in admission to nursing homes and higher patient satisfaction (Lee *et al*, 1998). In a further study in the USA, a variant of PACE, Elder Partnerships for All-inclusive Care (Elder-PAC) was evaluated over a 5-year period (Kinosian *et al*, 2010). Integrated services, with structures adhering to PACE principles, achieved comparable outcomes at nearly 30% lower cost. However, it was concluded that there is not a single organisational blueprint for integrated services, but that provision needs to be individualised to the local area and the population living there.

In Washington, a randomised controlled trial compared multi-condition collaborative care with usual care, for depression and for poorly controlled diabetes with risk factors for coronary heart disease. The study entailed a targeted programme for diabetes and coronary heart disease, with collaborative care for depression. Modest improvements were noted on levels of disability and quality of life, and there was a trend towards improved activities of daily living (Von Korff *et al*, 2011).

The System of Integrated Services for Aged Persons (SIPA), a Canadian variant of the American PACE model, was introduced to overcome the fragmented health and social care system. It provided comprehensive, long-term, acute medical and social services, including some respite housing. Reduction in the use of institution-based services, of accident and emergency department attendances, and

of permanent nursing home placements was demonstrated. However, the increased access to home- and community-based services meant that the average cost for these services was higher per patient, and there was overall no difference in the cost per patient within the new system (Béland *et al*, 2006).

The Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) was another Canadian model of care delivery for frail older people (Hébert *et al*, 2003). PRISMA involved integrated community care for older persons and was an attempt at both vertical and horizontal integration. The programme worked alongside existing care and aimed to integrate service delivery and to ensure functional autonomy of older people living in the community. Benefit was demonstrated through reduction in functional decline and handicap levels, and improvement in feelings of empowerment and satisfaction with the care provided. There was more appropriate use of emergency rooms and decreased consultations with medical specialists.

A review of all published literature on PRISMA identified the importance of designing programmes with an eye to local context, and of building in flexibility to allow the programme to be adapted to changing circumstances (Stewart *et al*, 2013). Creating partnerships between policy designers, project implementers and academic teams was an important element of achieving the goals. The review also demonstrates that, despite a shared electronic health record being key, there was an under-investigation of the impact that this technology could have on facilitating and enabling integration and the outcomes achieved.

The PRISM-E study in the USA, published in 2009, evaluated the cost-effectiveness of integrated care for depressed older people, compared with the usual system of enhanced specialty referral (Wiley-Exley *et al*, 2009). The study showed unclear benefits of integrated care, both in terms of clinical improvement and cost-effectiveness, independent of the setting in which the patients were living.

In Toronto Central, the Integrated Care for Complex Populations (ICCP) project, launched in 2011, was a collaborative local health integration network that aimed to develop a practical, cost-effective model of integrated care for older adults with complex needs (Goldhar *et al*, 2014). The framework for the ICCP was designed after undertaking a review of best practice from successful integrations, including PACE, Geriatric Resources for Assessment Care of Elders (GRACE), Comprehensive Home Option for Integrated Care of the Elderly (CHOICE) and PRISMA.

From this work, six key innovations were postulated as foundational for informing future practice (Box 1). Care coordination in particular was highly valued by patients, caregivers, care providers and the coordinators themselves.

In a variant of the multidisciplinary team approach, the BRIGHTEN (Bridging Resources of Inter-Disciplinary Geriatric Health Team via Electronic Network) programme was a virtual interdisciplinary team

**Box 1 Key innovations demonstrating significant value and driving sustainable solutions**

- **Care coordinators providing intensive case management**
- **Partnership with primary care entailing weekly case conferences and home visits for home-bound patients**
- **Emergency medical services**
- **Acute care**
- **Pharmacy**
- **Caregiver support**

(Goldhar *et al*, 2014)

intervention for assessing and treating older adults for depression in out-patient primary and specialty medical clinics (Emery *et al*, 2012). The programme, from the USA, integrated the primary care collaboration concepts of studies, including the ‘impact study’ and the ‘prospect study’, in which primary care patients treated for depression with integrated care had a lower mortality than those without such intervention (Gallo *et al*, 2007). The BRIGHTEN virtual team provided treatment recommendations based on the results of assessment. From baseline to 6 months, significant improvements were found in depression and general mental health, and the study concluded that an interdisciplinary virtual team can be an effective, non-threatening and seamless approach to enable older adults to access treatment for depression. However, detailed analysis of programme costs and potential overall cost savings were not identified.

The Prevention of Care (POC) approach was developed in The Netherlands, in which frail older people received multi-dimensional assessment and interdisciplinary care. In a study published in 2013, the primary outcome, disability, was assessed alongside depressive symptomatology, social support interactions, fear of falling and social participation (Metzelthin *et al*, 2013). Patients were followed up for 24 months; however, no evidence for the effectiveness of the POC approach was found with regard to any of these outcomes.

In Rotterdam, the short-term value of the Walcheren Integrated Care Model (WICM) for frail older people was evaluated for its effects on health, quality of life, healthcare use and satisfaction with care (Looman *et al*, 2014). The study entailed provision of enhanced primary care, supported by secondary care elderly medicine services. In the short term, patients were better able to attain love and friendship. However, there were no significant changes in health and little effect on health-care usage and satisfaction with care. The investigators assumed that 3 months as too short a period for integrated care models to have an influence on health. The WICM was found to improve the satisfaction of caregivers with the care the individual received, but the degree to which they knew which professional to call should there be a problem diminished (Janse *et al*, 2014).

Evidence of cost-effectiveness in these Dutch trials is still not clear. A further study of an integrated care model, ACT (frail older adults: care in transition), is underway in The Netherlands with the intention

of evaluating clinical effectiveness, cost-effectiveness and implementation processes (Muntinga *et al*, 2012). The impact of nurse-led multidisciplinary intervention programmes, described as U-Care and U-Profit, are also being studied (Bleijenberg *et al*, 2012). Outcomes including activities of daily living, quality of life, mortality, nursing home admission, emergency department and out-of-hours attendance, GP surgery visits and caregiver burden are being investigated.

In France, a model of integrated services, COPA (coordination of professional care for the elderly) was developed in the early 2000s. This model set out to design processes in which health professionals, including GPs and managers, participated actively. COPA targeted older people living at home with functional and/or cognitive impairment identified by their GP (Somme & de Stampa, 2011). The implementation of this bottom-up and pragmatic strategy relied on establishing a collaborative dynamic among health and social care stakeholders.

Under another programme in France, Maison pour l'Autonomie Integration Alzheimers (MAIA), a qualitative study of multidisciplinary case management teams was conducted in 2009 (de Stampa *et al*, 2014). Integrative units were based on the six components of integration in the PRISMA established in Quebec. The study identified that success depends on a strong sense of belonging to a team, a comprehensive understanding of integration concepts within a practical application, obtaining a comprehensive clinical vision in order to meet the complex needs of elderly people, and changes in practice under an interdisciplinary approach.

The Reverso and Vittorio Veneto models developed in Italy in the 1990s were similar to SIPA and PACE, and the results were largely positive, reporting a decrease in the use of community services alongside both institutional care and hospital admission. There were also improvements on several functional measures on a pre- and post-intervention questionnaire for patients (Johri *et al*, 2003).

In the UK, research has not been conducted on the scale of that described in the USA, Canada and elsewhere in Europe. However, there is more literature on the effectiveness of psychiatric multidisciplinary teams for older adults, interdisciplinary working, and collaboration with secondary and primary care. Here, we review that literature, supplemented by examples of best practice from around the UK where integrated care initiatives are being implemented. These service summaries do not represent a comprehensive review of the work that is underway, but they do showcase changes in clinical practice which – although not necessarily fulfilling the criteria for research, or having been published – may be a valuable source of intelligence.

# Team-focused integrated care

In the UK, care coordination has long been established in mental health, with the formalised care programme approach (CPA) being developed in the early 1990s. The four elements of the CPA are well established: a systematic needs assessment; the creation of a care plan to address the identified needs; the appointment of a care coordinator; and regular review. The impact of the CPA has been demonstrated through patient surveys showing satisfaction with care. Furthermore, the importance of the care coordinator has been clearly demonstrated (Goodwin & Lawton-Smith, 2010).

An analysis of integrated assessment between specialist clinicians and social services care managers was conducted in 2011 to evaluate the costs and benefits of integration (Clarkson *et al*, 2011). The participants in the trial, who were being assessed for substantial levels of care, were very frail, and few significant differences were found across the domains evaluated. The original research, published in 2004, was re-examined for changes in physical and social functioning, as well as in costs, both formal and informal. All indices, with the exception of depression, deteriorated. However, those receiving integrated assessment experienced a less marked deterioration in their physical functioning, and more appropriate care home admissions. NHS expenditure for the most frail increased without any overall shift of the cost burden to social services.

## Characteristics of integrated care

A study in Manchester in 2011 described the characteristics of well-integrated teams for older adults with mental illness. The study cited the variation in degree of integration across England and the need for further research to clarify the benefits of integrated care to patient outcomes and cost (Wilberforce *et al*, 2011). The same team conducted a further study across England (Wilberforce *et al*, 2016). Associations between the degree of integration in community mental health teams (CMHTs) for older adults, the cost of service provision, and the rates of mental health in-patient treatment and care home admission were evaluated. Teams were chosen to represent high or low levels of integrated working practice, using nine identified features of an integrated team (Box 2).

The study found that integrated teams facilitate greater access to community care services. However, patients supported by high-integration

### Box 2 Features of an integrated older people's mental health team

- A multi-disciplinary core team, including health and social care professionals
- Members directly line-managed within the team
- A single point of access
- All professionals using the same structured assessment documentation
- All or most patients having a single care coordinator
- All or most patients having a single care plan
- At least one health professional within the team able to authorise services funded by the local authority
- The team and local social services having access each other's patient records
- All core team members sharing the same office base

(Wilberforce *et al*, 2016)

teams received services costing an estimated 44% more than comparable patients in low-integration teams. No significant differences were found in the likelihood of admission to mental health in-patient wards or care homes between team types. The study concluded that integrated teams, through facilitation of more intensive community support, address additional needs that would otherwise have gone unmet. However, no positive link between integrated old age mental healthcare and good patient outcomes was identified in this study, nor was a link with improved cost-effectiveness.

## Examples of best practice

### Integrated community mental health team (Doncaster)

In Doncaster, an intensive style of CMHT working has been developed to respond to variations in service delivery, resulting in improved access, greater team capacity and high patient satisfaction.

Dr John Bottomley and nurse consultant Jayne Wallace describe an intensive integrated older people's mental health (OPMH) team in a relatively deprived area with high psychiatric morbidity. The integration work was initiated because of variations in waiting times for appointments and time to diagnosis, and variation in care pathways. There were high levels of non-attendance and high patient transport costs. Research was commissioned by the clinical commissioning group (CCG) to evaluate the issues and develop a new service model.

The service is based around a CMHT meeting for up to 2 hours every morning to review new referrals and other urgent matters, coupled with a late afternoon meeting to review the day's work, undertake formulation and plan case management. All teams are located in the same building, providing cohesive working and cross-cover. Adult services, secondary care records and GP records can all be accessed, although there is no shared IT system. An important aspect of the

team's functioning is supervision – both weekly formal supervision for the team and informal supervision on a daily basis – supplemented by monthly education meetings.

The success of the referral system is predicated on primary care assessment first, for both physical and mental health. Upon receipt of the referral information, supplementary information is sought from the local authority, GP, patient and carer, before a decision is made about acceptance or otherwise. The work is largely community based, and consultants regularly go into the surgery to see patients or meet with the GP.

Three key positive measures of success are a reduction in access times (waiting times for an appointment) from 4 months to under 2 weeks, an increase in capacity and volume of patients seen each year despite reduced team size, and positive patient feedback ('Your Opinion Counts' forms are sent to every patient).

### Success factors

- High-quality patient care with a more timely and purposeful pathway (primary driver)
- Formal and informal supervision for the team, supplemented by monthly education meetings and coupled with co-location of professionals

### Adopting the Trieste model (Carmarthen)

In Carmarthen, South Wales, the response to variation in quality and access has been to redesign services across the trust, in line with a model from Trieste in Italy. The benefits cited include confidence in a model that has proved successful elsewhere, joint commitment to it, and high levels of patient and public involvement.

Dr Graham O'Conner describes a pre-existing old-fashioned service model with geographical variation in provision, the challenges of a diverse population across South Wales, and a lack of identity and clarity of purpose for OPMH.

Although Wales has integrated health trusts covering acute care, the ambulance service and mental health, this in itself has not resulted in integrated services. There is still a recognised need for modernisation, improved consistency across the area, and greater responsiveness to the needs of the population, alongside preservation of financial resources.

The trust has engaged in a formal twinning agreement with Trieste in Italy, where there is a 40-year history of community-based psychiatric services. There is a strong desire to consider service models inspired by Trieste, where services are rehabilitation-focused and open access.

Plans include centralisation of in-patient services, including an OPMH high-dependency unit, in-patient care shared with geriatricians in the acute hospital, and clear pathways of care developed with GPs.

The initiative is underpinned by a partnership board, which includes mental health professionals, GPs, and representatives from the local authority, from the fire, police and ambulance services, and from the third sector, alongside patient and carer representatives. Service user groups, who are in liaison with the Trieste family association groups, are critical; through membership of the partnership board they give a voice to service users in West Wales.

### Success factors

- The voice of people who use services is seen as crucial
- The formation of strong interprofessional relationships with a common goal is a priority

### Improving the flow of older people (Sheffield)

There are a number of initiatives around the UK focusing on providing improved care for older people in acute hospitals. In Sheffield, an acute hospital study described an initiative to improve the flow of older emergency patients (Silvester *et al*, 2014). A diagnostic patient flow analysis, followed by a series of 'plan, do, study, act' cycles, was employed to test and implement changes by a multidisciplinary team. Changes designed to improve patient flow, reduce waste and improve quality of care were put in place. Redesigning the system of care for older emergency patients led to reduction of bed occupancy, with a 37% increase in patients discharged on the day of admission or the following day and a 15% reduction of in-hospital mortality, without affecting readmission rates or requiring additional resources. The ongoing need to improve communication across departmental silos and external links was identified as a critical factor for the work to reach its full potential.

Dr Tom Downes, Consultant in Elderly Medicine, stresses the importance of identifying at the outset what needs to change, rather than setting out with a service specification. He had spent a year studying at the Institute for Healthcare Improvement to understand quality improvement methodology. He and colleagues spent a year mapping the problems for older people in an acute hospital setting, including patients remaining in hospital for too long, delays in discharge and concerns about institutionalisation.

Having identified the difficulties, they gained the support of the executive team by demonstrating their findings and taking them physically around the hospital to see the issues at first hand. They also took a very rigorous approach to engaging stakeholders across the city by using patients' stories to illustrate what needed to change.

The team used plan, do, study, act cycles, and a 'Big Room' initiative, with weekly meetings involving a range of stakeholders. Data demonstrating a range of parameters were shown on boards and graphs around the room. The process is seen as one of continuous improvement, rather than a project with a beginning and an end.

Overall, the focus was on using quality improvement methodology to drive change in practice within elderly medicine. There are also service developments, centred on the provision of in-patient wards jointly between elderly medicine and OPMH, with the purpose of providing better care for people with mental illness in acute hospitals.

### Success factors

- The importance of quality improvement methodology is recognised
- If staff are enabled to improve patient experience, then the efficiency and safety improvements will follow

### Team Trial (Nottingham)

In Nottingham, the success of a joint in-patient unit for older people with physical and mental illness was thought to be due to the benefit of supernumerary registered mental health nurses (RMNs) working alongside registered general nurses (RGNs) on the ward.

Dr Jonathan Waite describes a combined elderly medicine and OPMH ward in the acute hospital. This is a medical ward supporting older people who have primarily physical health problems with additional mental illness. In addition to the usual number of RGNs on the ward, there are three RMNs who are supernumerary. The ward is overseen by a consultant in elderly medicine, with a half-day input from an OPMH consultant. The benefit of this has been sharing of expertise and clinical management. The initiative was written up as a research project called 'Team Trial', and demonstrated a slight benefit in favour of the specialist unit. This benefit was improved quality of care and reduced levels of disturbance for people with psychiatric problems on the ward. Alongside provision of better care for people in the unit, the service was able to provide education for staff working on other wards, both in terms of managing people with dementia and in making appropriate referrals.

RGNs had been provided with training at the outset, but this did not equip them well to provide good care for people with mental health problems, and the real benefit has been having RMNs working alongside them in the ward. Dr Waite believes that this informal education and modelling has been of significant importance.

The service is well supported by commissioners, as it has been particularly successful in supporting seasonal pressures on in-patient services, and it is also attractive to patients and carers. However, because the ward has better staffing levels, it is more expensive. There is close liaison with the local authority to facilitate early discharge, although delayed transfers of care are higher than the average in the hospital, which is thought to be related to the complexity of patients' needs. Strong medical leadership is important, with consultants taking ownership of and responsibility for the services they deliver, rather than having working patterns imposed on them.

## Success factors

- Informal education and modelling has been of significant importance
- There has been strong medical leadership in both initiation and development of the service

## Home from Home (Grimsby)

In the Home from Home initiative in Grimsby, a joint in-patient ward was created in the acute hospital, run under elderly medicine but with OPMH nursing and medical input. The success of the unit was its provision of high-quality nursing care, with a single nursing team both working in the hospital and providing outreach for patients on discharge. The extent to which families were able to remain involved in patients' care during their stay was also central to the philosophy.

Home from Home was implemented by NAViGO, a social enterprise providing mental health and social care in Grimsby. Relationships between staff and service users are key; a high proportion of the staff have been service users in the past, and the trust's membership includes staff, users of the service, carers and local people.

Its chief executive, Kevin Bond, describes the Home from Home scheme as providing individualised care for people with mental health and physical health problems in an acute hospital environment. The service was prompted by concern about the consequences of individuals with complex health problems being moved from service to service, and from ward to ward. The intention is to provide personalised care, in a small unit, where relatives can stay if they wish to and where staff include a mix of mental health and physical health professionals. He stresses the importance of valuing individuals, and of a philosophy of supporting change in people's lives – alongside treating illness – while they are in hospital, to enable them to manage again at home. The affordability of the unit is underpinned by providing not only in-patient care, but also 'in-reach', outreach and crisis services using the same pool of staff. This creates greater efficiency, and also continuity of care for patients and their families. Key to success of the initiative has been the commitment of the chief executive and the consultants, and the relationship with the acute trust.

## Success factors

- High-quality individualised nursing care supporting people in hospital, and through discharge and at home
- High-quality leadership and relationship development with the acute trust

## Combined OPMH and elderly medicine unit (Stoke-on-Trent)

In Stoke-on-Trent, a combined OPMH and elderly medicine unit was created, this time in the psychiatric hospital, run by OPMH and supported by elderly medicine. Its success is described as both the priority of a service led by the needs of the individual, alongside a model that is able to help the acute hospital manage the pressures it experiences on beds, particularly in the winter. Dr Buki Adeyemo described how the ward had become available after the creation of a 7-days-a-week outreach team working alongside the CMHT, and was financed by the closure of in-patient beds.

The idea of a joint ward was mooted in discussions about supporting the acute trust in managing winter pressures. Dr Adeyemo had been advocating this for 3 years previously and had become discouraged because of lack of interest, until failure to reach targets in the acute hospital led to its consideration as a way to reduce length of stay and improve patient experience. In commissioning the service, there was collaboration between the acute trust, the mental health trust, GPs and the local authority. The initiative was successful through clear articulation of patient-centred care, and collaboration between organisations. The ward is situated on the site of a mental health trust, but next door to the acute trust. Medical input on the ward is primarily from the mental health trust, with regular additional input from geriatricians. The nurses on the ward are mainly RMNs, with two RGNs and one nurse practitioner. Patients on the ward have a higher level of physical dependency and physical interventions, and the focus of the work is to encourage mobility and independence. There is also input from occupational therapy and physiotherapy, and there is an application for speech and language therapy.

There are clear admission criteria – in this case, a diagnosis of dementia with a physical need – and a clear view of the anticipated benefits. Prior to admission, the ward manager and nurse practitioner visit acute wards and review admissions. Alongside this they are able to educate ward staff as to their criteria and how to manage patients with psychiatric conditions including delirium.

The ward is funded by the CCG on a bed-by-bed basis. NHS England commissioned an evaluation of all the initiatives to manage winter pressures; this is one of only two that demonstrated delivery.

The 15-bed ward runs at 90–100% occupancy, and length of stay has been demonstrated to be reduced. Compared with staying in the acute trust, it was found to be cost-effective. Patient and carer experience is extremely good, and outcomes for patients in terms of their discharge destinations have improved.

### Success factors

- Clear articulation of a patient-centred approach to care
- Alignment of incentives

## Community liaison (Epsom)

All of the hospital initiatives have described cost savings, although it is not clear whether there has been a consequent shift of costs from secondary care to community health and social care. Evidence of cost saving for out-of-hospital care is difficult to quantify because of the complexity of people's needs and the care they receive. In an initiative in Epsom which began in an acute hospital setting, the development of community liaison care for older people with mental illness has begun to address a previously unmet need, and to introduce a mental health dimension to risk prediction models in primary care. This initiative depended on intensive work to help commissioners understand the need, as well as employment of staff who had expertise in both physical and mental health.

Dr Lia Ali describes developing an integrated model of community liaison care, based on an existing virtual ward with three community hubs, each with their own mental health nurse. The new integrated team focuses on supporting people with multiple physical conditions and mental health problems.

While working in Guildford, Dr Ali had implemented an integrated model for patients living in the community with complex physical needs, in addition to the same mental health needs as an acute liaison hospital population. Referrals were received from primary care, and the service provided mental health input with nursing, physiotherapy and occupational therapy in the context of long-term physical health conditions.

The service was funded by the CCG through the Better Care Fund. In order to gain CCG commitment, it was necessary for commissioners first to understand the need for liaison in the acute hospital, and then to understand how this translated to community liaison. It was also important to have the right people working in the liaison posts, with expertise in management of both physical and mental health problems. The liaison team currently includes mental health nursing, with a psychiatrist providing supervision and service development. Support from the chief executives of both the acute trust and the mental health trust has been critical to the success of the initiative.

The service model is still only partly implemented, and was prompted by the identification of a population with an unmet need. The general practice risk prediction model focuses mainly on physical problems, and there is an identified need to join up pathways of physical health and mental health in the community. The population served by this new service will not be the same as a CMHT population, but will consist of people whose needs are not currently identified or met. The aim is to intervene early, to improve physical outcomes, prevent dependency and improve mental health outcomes.

## Success factors

- A good understanding by commissioners of what is being proposed
- The development of a risk prediction model that has a mental health dimension

## Gateshead Care Homes Initiative

A similar approach in providing out-of-hospital liaison has been developed in Gateshead. The drive to modernise services had created an opportunity to introduce an intensive service for people in residential and nursing homes. It was dependent upon motivated individuals who identified a need, coupled with good cross-organisational collaboration. The initiative has demonstrated year-on-year reductions in hospital admissions.

Dr Karen Franks describes a service in which OPMH is provided within an acute trust, as part of older people's medicine. The service had been quite old-fashioned, geographically organised ('patch-based') and medically led, with dwindling resources. There was a need to look at providing services differently.

One particular dynamic GP worked with Dr Franks, supported by commissioners, to tackle health inequalities for people in 24-hour care. Initially, a specific surgery was set up for people in nursing homes, providing both physical and mental healthcare. The aim was a proactive approach to patient management, thereby reducing emergency hospital admissions. This specific surgery did not continue, but the learning from it informed the development of the Gateshead Care Homes Initiative. In all care homes across the borough, GPs conducted a weekly ward round, developing a high level of knowledge of the residents and staff. The community multidisciplinary team included older people's physical nurses, a community geriatrician, and pharmacy, physiotherapy and occupational therapy services working alongside the OPMH consultant. An older people's nurse specialist provided support and training to care home staff alongside undertaking clinical work.

The initiative has improved clinical decision-making and information sharing. Since the creation of the model 3 years ago, there has been a 14% year-on-year reduction in admissions to acute hospital beds. There has also been a reduction in antipsychotic use.

The service has recently been identified as one of six national care home 'vanguard' sites, with plans to develop what is currently in existence and explore opportunities for greater access to GP records. There is an intention to identify more detailed measures of success, including 'I statements' (assertions about the feelings, beliefs and values of the person speaking), clinical outcome measures, and carer support, diagnosis rates, antipsychotic use, medication reviews and out-of-hours activity.

### Success factors

- Good working relationships among professionals from different organisations
- Commissioner support, with clearly demonstrated benefits

### Memory Assessment Service (Brent)

Dr Lawrence Woo has been involved in developing integrated memory services in Brent since 2008. The service was developed partly because of an internal drive within the trust to improve efficiency and modernise services, and partly to change in line with the priorities of the commissioners. There was a need for improved consistency in service delivery across an area that had significant health challenges, a highly diverse population and historical variation in provision. There were concerns that for many people there was no service. There was a huge financial uplift in 2012, prompted by the CCG undertaking a broad review of dementia service provision across primary care, mental health, public health and the voluntary sector. A strong GP voice was also important in gaining agreement for the financial investment.

New money funded three nursing posts, in addition to psychology, occupational therapy and a half-time consultant. There was also significant additional money for the voluntary sector. These service changes were supported and monitored by a dementia steering group, chaired by the commissioners and attended by relevant stakeholders.

Time to diagnosis is now within recommended guidelines, and there has been a reduction in referrals to the CMHT. There has also been an increase in dementia diagnosis rates to 70%, and there is now a focus on improving quality.

The service still experiences challenges with communication between the primary care dementia nurses and GPs, both in terms of access to physical space for clinics and of access to GP records or connection between IT systems. There is also need for better post-diagnostic signposting and counselling.

### Success factors

- Commissioner commitment to address health inequalities in the local area
- A clear shared vision of an optimal service supported by the Dementia Strategy

### The Memory Protection Service (Sunderland)

Commissioners in Sunderland had taken a different approach to variation in consistency of service, by tendering memory assessment services. The success of the memory protection service in Sunderland is partly related to its commissioning, but also to the use of improvement methodology in facilitating continuous improvement

Dr Anthea Livingstone and Diane Jackson, Clinical Team Lead, work within the Memory Protection Service in Sunderland and also cover Gateshead and South Tyneside. The Memory Protection Service is a primary care service hosted by secondary care.

A decision had been taken by commissioners to tender memory assessment services, to improve both dementia diagnosis rates and consistency of the service patients received across a wide area. The model is rooted in primary care, with close liaison with GPs and the third sector. The service, which has been running for 4 years, is similar in many ways to a standard memory clinic, but with a significant focus on early identification and psychosocial interventions.

Patients are seen initially by a band 6 nurse, with a medical review by either an OPMH consultant or a GP with specialist interest working within the Memory Protection Service. It had been anticipated that the GPs would run the service with minimal psychiatric supervision; however, this has not been possible owing to the complicated nature of accurate diagnosis in the earliest stages of dementia.

Regular multidisciplinary meetings are conducted, with occupational therapy and psychology input to ensure the right pathway of care for the patient and to enable education for team members. The service works alongside CMHTs and is effective through good partnership working. In order to facilitate multidisciplinary working, there has also been recent access for the Memory Protection Service to GP records in some surgeries. The service holds Royal College of Psychiatrists Memory Service National Accreditation Programme (MSNAP) accreditation and has been commended for its work with local research teams.

One of the underlying principles in this and other community services within the trust is the use of lean methodology, which was adopted in a community pathway review 2 years ago. This enables the service to both embrace innovation and standardise its delivery across the geographical area.

Collaboration with local radiology teams has minimised reporting time for neuroimaging, reducing the time to diagnosis. Close working with associated teams such as neurology and GPs has reduced the number of referrals sent back to referrer, and waiting times for appointments have been reduced. The service is monitored through patient-reported outcome measures and patient and carer satisfaction questionnaires.

### Success factors

- Commissioner support in designing a new service model
- Use of lean methodology to enable continuous improvement

## Primary care collaboration (West Bromwich)

Although the commissioning of a new service has clear advantages, there are also examples of innovative initiatives, on a small scale without additional resources, implemented by individuals seeing a need and an opportunity. The service changes in West Bromwich are illustrative of what can be done through good interpersonal working, with clear benefits for patients and professionals.

Dr Lisa Blissitt and Dr Kate Lowe, working for the same trust, have developed two different models of partnership working, both embedded in primary care. In Dr Blissitt's case, an individual GP expressed an interest in developing a dementia care pathway. The practice already had a geriatrician and other acute specialties providing clinics. This new service entailed a memory nurse undertaking screening, review by a consultant or GP, and signposting for patients after assessment. Subsequently, the service was expanded to include all referrals from that practice, not just people with memory problems.

Dr Lowe similarly developed a dementia care pathway jointly with a GP, who had also introduced specialist clinics into the surgery. The surgery employed a dementia lead practice nurse who undertook cognitive tests before referral to consultants. A cognitive stimulation therapy group for patients diagnosed with dementia was also introduced at the surgery. There is no direct interface between IT systems, but consultants have been able to log into patients' records at the surgery, which has been very beneficial.

The new services were felt to be effective in terms of more fluid processes of referral and discharge, the satisfaction of working in primary care, earlier discharge of patients back to their GP, and dovetailing the clinic with the geriatrician.

Failure-to-attend rates were low, as receptionists checked patients were coming, and the prescription of medication was more easily achieved through the on-site pharmacy. Patients and carers were interviewed as a result of the initiatives and high levels of satisfaction were demonstrated.

A second initiative was in a particular geographical location where there was a large Asian population, but with relatively low referral rates. Work was undertaken to enhance awareness within Black and minority ethnic populations for dementia awareness week. There were three events held in the local temples and gurdwaras, which were very successful and resulted in an increase in referrals. There was a specific clinic for Asian patients, where an Asian consultant carried out assessments and local voluntary services were involved. Cognitive screening was adjusted to be culturally appropriate, and a Punjabi cognitive stimulation therapy group was also created. This work was all done within existing resources and won the national care integration award for dementia in 2013. Feedback from GPs and families has been excellent.

## Success factors

- Collaboration between individuals without organisational change or investment
- Change has been driven by the desire to improve patient experience and quality of care

The new services described have been, to some extent, driven by an imperative to tackle a specific problem – for example, pressure on acute hospital in-patient beds – but they have also highlighted that there is often an unmet need which can be addressed through the initiative. A number of services have highlighted improvements in quality of care, and in patient and carer experience, although this has sometimes been associated with an increase in workload. To overcome fragmentation of care for older people in the community, and to better coordinate services outside of hospital, Torbay Care Trust, created in 2005, established five integrated health and social care teams organised in localities aligned with general practices (details available from the author on request). The teams targeted their efforts at very high-risk patients, proactively managing care through intensive support from integrated teams in partnership with GPs. A single assessment process and patient-held records helped to coordinate care across settings. Bringing together responsibility for commissioning and provision of health and social care, this pilot scheme demonstrated a reduction in non-elective admissions, reduction in emergency department attendances, reduction in the number of people attending a community hospital, and a modest increase in out-patient appointments. This integrated care programme is now being extended to other locations in the UK through collaboration among Age UK, the NHS and local authorities (O'Dowd, 2015).

## Challenges in implementing integrated care

Although it is accepted that multidisciplinary cooperation between professionals is a prerequisite to providing integrated care, a number of the published papers and services studied have highlighted the challenges in implementing agreed integrated care models. In order to better understand the experiences of professionals who implement integrated care, a case study of multidisciplinary geriatric teams was performed in Sweden (Janssen *et al*, 2015). The data collection included observations of meetings, in-depth interviews and focus groups with professionals. Within organisations, mutual trust and clarity about working routines were found to be important, whereas between organisations, the quality of communication and insight into each other's priorities were central to success. The study recommended that policy-makers should not determine the nature of professional cooperation in advance, but should leave that to the local context and the judgement of the professionals involved.

A separate review of integrated care across Europe (Leichsenring, 2012) postulated the need to treat long-term care as a system in its own right, with a discernible identity; specific policies, structures, processes and pathways; and appropriate leadership and resources. Progress in developing long-term care systems can be identified today in all European countries, and Leichsenring describes how these have been achieved, partly by means of (slow) political reforms, partly as a response to market-oriented governance, and in many cases through pioneering community and civil society initiatives.

A study in England in 2005 highlighted the importance of attitudes towards integrated care (Parker *et al*, 2005). The attitudes of health-care professionals towards integrated care pathways in one acute NHS trust demonstrated unhappiness across all professional groups (doctors, nurses, professions allied to medicine) with the idea of integrated care pathways, rather than with the evidence they are based on or the quality of the documentation itself. The study highlights the importance of investing time and effort in winning the hearts and minds of those expected to use the pathways.

# | Conclusions

There are high expectations of integrated care, both in terms of providing better coordinated support for people who increasingly experience multiple health conditions as they grow older, but also in using financial resources to the greatest effect. Integration describes coordination of care for individual patients and their carers, with the intention of providing better outcomes. Multidisciplinary cooperation between professionals is an agreed prerequisite to providing integrated care.

Internationally, there is a paucity of research that focuses specifically on mental health, and the published literature is difficult to interpret because not all countries have old age psychiatry as a specialism. In addition, there is variation in the populations studied and the outcomes measured, and the methodology used is not consistent.

## Large-scale population-based integration

There is no evidence in the literature for large-scale, population-based integration encompassing mental health, although the evidence from the USA suggests that such models can be successful for managing physical illness. Although there is evidence that large-scale systems are more difficult to implement, as they require changes to existing legislation and policy, there may still be benefits of a single administrative structure and single funding envelope to ensure seamless care and good communication systems.

## Integration for specific groups of people

There is some evidence of success for single-disease management programmes – particularly for depression – in terms of clinical outcomes and experience, but not cost. Demonstration of benefit for physical disease management has similarly demonstrated clinical improvement, but not cost benefit. A number of studies have highlighted that pursuing a disease-specific approach for people with multiple conditions is likely to fragment rather than integrate care. Therefore, for older adults with multiple conditions, a holistic approach is to be favoured over a disease-specific approach.

There is a large body of evidence from the international literature evaluating integrated care for frail older adults. Some of these programmes have encompassed specific mental illnesses such as depression or dementia, although there is inconsistent evidence of mental health professionals being integrated within teams. While these initiatives do not necessarily include mental illness or mental health professionals, as they relate to older adults with multiple health conditions, the findings may well be relevant to people who experience mental illness alongside physical disease.

## Multidisciplinary team working

In the UK, research has been undertaken to evaluate treatment programmes for specific conditions, such as depression, but there has also been qualitative research evaluating the features and benefits of multidisciplinary team working. There is no clear difference in demonstrated outcomes between larger-scale initiatives across organisations in an area and those that focus on small-scale change within an individual service. There is not a single definition of an integrated multidisciplinary team, but a set of principles are identified as valuable. These encompass a philosophical belief regarding the benefits of a coordinated continuum of care, care planning and coordination across a range of services, and a reasonably wide range of home- and community-based services. A single point of entry into the system, independent case management, and an integrated information system support coordinated working, alongside system-level policies and procedures.

## Cost-effectiveness

Review of the literature does not provide a consistent body of evidence for the cost-effectiveness of integration. Although there are some studies that demonstrate cost savings, others do not evaluate it. There are studies in which a cost saving has been demonstrated in one area, without investigation of whether that cost is shifted to another part of the system. There are programmes which identify a clear increase in costs, in part because of the cost of the programmes being implemented, but also because of the costs associated with previously unmet need in the population. There is little evidence that community-based integration saves costs, and a focus on cost-effectiveness rather than cost saving may be more valuable in planning services.

## Quality of care

There is evidence in the literature of improvements in clinical outcomes, although the results are not consistent. Some of this is attributed to the complexity of people's health problems and therefore the difficulty in studying them, the duration of the study period, and the likelihood that health will deteriorate over time irrespective of any intervention. Improvements in patient experience are much more consistent, with most studies demonstrating that patients and their carers feel better supported and better informed as a result of more integrated care. Care coordination is highly valued by patients, caregivers, care providers and the coordinators themselves.

## Implementation of integrated care

A number of studies identify the importance of tailoring integrated care to the needs of the local population. Designing programmes in the local context and building in flexibility to allow the programme to be adapted to changing circumstances is critical to success. This is borne out in the semi-structured interviews describing initiatives implemented in the UK. There is also evidence that structural integration of services is less important than attention to developing effective working relationships across services. Success in implementing effective integrated care is also found to depend heavily on interpersonal relationships, with some studies highlighting the issues that arise in implementing an agreed plan. The literature highlights that as much attention needs to be paid to the way organisations and individuals collaborate as to the service design or strategy.

This is similarly reinforced by the semi-structured interviews, which indicate that understanding the priorities and incentives for partner organisations is key to success. The literature also highlights the value and importance of engagement with patients, their carers and the public in developing integrated services.

A number of studies and initiatives also highlight the benefits of adopting a particular method of quality improvement, in order to better identify the issues that need to be changed and to monitor progress. However, it is stressed that improvement techniques require expertise and sound knowledge of improvement methodology to be successful. Interviews with services around the UK also highlight the benefits of informal education through professionals from different backgrounds working alongside one another.

## Recommendations for future research

- 1 There is a need for research focused on younger people with dementia and older people with mental health problems without multiple physical comorbidity, whose needs are likely to be different from those of frail older adults.
- 2 There is a need for more detailed research focusing on the interface between end of life care and mental health.
- 3 Development of older person-specific outcomes, alongside further research on cost-effectiveness, will help to better identify successful strategies for integrating services for older adults.
- 4 Further research to clarify effective factors in multidisciplinary team working would help with future planning.
- 5 There is a need to better evaluate the role of IT in providing effective integrated care.

# Recommendations

On the basis of the findings of this report, I make the following recommendations.

- 1 The Old Age Faculty of the Royal College of Psychiatrists accepts this report and creates a reference group to implement the agreed recommendations, to identify timescales and to report progress to the Executive.
- 2 The Faculty adopts the following position statements:
  - 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.
  - Integrated older people's services need to be patient-centred and involve collaboration across professions, including care of the elderly and social care.
  - The success of integration depends on the establishment of effective 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.
- 3 The Faculty shares this report widely: to its members, to professional groups who are providing or planning integrated care services, and through publication.
- 4 The Faculty develops and hosts a web-based platform, with the purpose of sharing best practice.
- 5 The Faculty supports old age psychiatrists to understand their leadership role and to become proactive in the development of services with commissioners, and encourages them to identify and work with local individuals in primary care, elderly medicine and the voluntary sector who are similarly interested and motivated.
- 6 The Faculty develops a one-page document to explain the role of an old age psychiatrist in an integrated care model. This document will stand alongside the personal interactions psychiatrists will make in engaging with a range of stakeholders, and will

support greater understanding of the importance and relevance of mental health in integrated services.

- 7 The Faculty reviews the curriculum for psychiatric training to include integrated care training.

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