NHS Wales Awards 2013

For ‘Improving quality through better use of resources.’

Storyboard Title
"A step change in mental health care" - establishing a care home in reach team in Bridgend

Outline of Context
Based in the Princess of Wales hospital in Bridgend, the local mental health service for older adults provides advice and support for residents living in Bridgend County Borough. The care home 'estate' in Bridgend is around 900 beds and in November 2009 a multi professional care home in reach team was established to target care home residents as a vulnerable group and offer support and advice more directly tailored to their specific mental health needs.

Outline of Problem
Census data shows a progressive incremental increase in the number of adults over 65 years of age, which in turn has been associated with a progressive increase in the number of care home residents with significant mental health problems. At the same time, frail older adults especially those from care home settings have found attendance at out patient hospital clinics impractical and at times unnecessarily distressing.

A major report from the Department of Health in 2009 (the Banerjee report) strongly encouraged all mental health services to reduce antipsychotic prescribing in older adults suffering from dementia, restricting these drugs to episodes of psychosis and severe distress. The care home in reach team also wanted to address this issue directly by placing more emphasis upon non-pharmacological approaches and interventions.

Assessment of Problem / Analysis of the Causes.

The orthodox pattern of service delivery to residents in care home settings typically involves individual professional visits either on request or by statutory requirement. Opportunities to arrange regular joint visits or make routine assessments together as a team are often not achievable. As a consequence, assessment of many care home residents remains limited and the potential benefits of a wider, more collaborative mental health assessment are missed.

In Bridgend, over a period of almost ten years, the Dementia Care Training
team has delivered wide ranging high quality teaching to care home staff across the Bridgend County Borough area. The teaching places considerable emphasis upon non-pharmacological approaches and interventions but in order to further advance the impact of the training on a daily basis in care, implementation of a systematic and repetitive process of care home support and encouragement was required.

Strategy for Change
In late 2009 and early 2010, the mental health service for older adults in Bridgend was reconfigured from two geographically based Consultant led teams by developing a third Consultant led team (including mental health nursing, social work, occupational therapy, psychology and trainee medical staff along with secretarial support) concentrating upon hospital liaison psychiatry and care home in reach.

The initial strategic direction was dictated by a need to contain and where appropriate suppress the continuing health care (CHC) budget for older adults with mental health problems within the Bridgend County Borough. Analysis of trends within this group of patients revealed that a need for CHC funding was usually preceded by the breakdown of one or two earlier placements in a care home setting.

A system of regular routine visits to all the care homes in Bridgend County Borough was established using spreadsheets as a checklist and a focus upon drugs of particular psychiatric interest (antipsychotics, lithium and the drugs for dementia). Visits were initially made monthly and subsequently relaxed to a more sustainable six weekly cycle allowing residents to be seen sufficiently often to address the mental health need collaboratively as a team.

This produced a step change in service from consultation (where staff in the care home or in primary care teams tend to request the mental health input) to a multi professional liaison model taking a more direct role, actively seeking to identify problems and to intervene at an early stage.

Measurement of Improvement
From a baseline figure of three mental health admissions per month from care home settings in 2009 (for a population of adults over 65 years of around 25 000), little impact was observed during the next year but a sustained reduction of over 30% was identified from the second year onwards (down from an average of three admissions a month to two).

Clinical audit activity now informs a strategy of safe reduction of
antipsychotic prescribing. Over a period of three years, the rate of antipsychotic prescribing within the care home sector has been contained and the current rate is around 30% of all care home residents.

Increased activity within the care home settings has essentially removed the need for mental health out patient clinic attendance for care home residents, allowing two of the established weekly out patient clinics to be dissolved.

All these changes have been strongly supported by local care home managers.

Effects of Change
In addition to the points above, the care home in reach team also provides a valuable and well structured educational and training experience for newly qualified medical staff on the Foundation Programme and for mental health professionals more widely. It is likely that the presence of the care home in reach team has raised the levels of confidence and competence of staff within the care home sector which in turn has contributed to the lower rates of mental health admission and also a reduced need for CHC funding. The care home in reach team consistently emphasised person centred care and the system of care home visits have almost eliminated the need for routine out patient attendance for mental health care for this group.

Lessons Learnt
The raised expectations in terms of the availability of a rapid mental health response can be logistically challenging and the initial four weekly cycle of visiting twenty five care homes was relaxed after two years to a more sustainable six weekly cycle.

It is important to recognise that the rate of mental health admission from care home settings cannot be reduced to zero and it is also important to allocate sufficient time to maintain close collaboration with ward based mental health staff for all patients in transition between domiciliary, hospital and care home settings.

Similarly, clear lines of responsibility and accountability are required for all care home placements supported by CHC funding.

Message for Others
Implementation of the care home in reach team has been well received by
care home staff, especially care home managers. Overlap and joint working with colleagues in primary care has steadily improved, especially where general practitioners hold primary care clinics within the various care home settings, representing a viable model for future collaboration and development.

The key element remains prompt (timely) access to adequately senior mental health advice. When this is consistently achieved (as demonstrated by this new care home in reach team), the positive impact upon medicines management and also upon episodes of unscheduled care can be substantial.

This work has recently been published as:


Dr Robert Colgate
17 January 2013