



Mental Health of Older Adults and Dementia

Clinical Academic Group

King's Health Partners has

- three of the UK's leading NHS Foundation Trusts
- a university ranked 16th in the world which achieved outstanding scores across its health faculties in the 2014 Research Excellence Framework. In the world university rankings for clinical, pre-clinical and health, King's College London is 11th
- 4.2m patient contacts each year
- over 36,000 staff
- more than 25,000 students
- a combined annual turnover of £3.2bn
- clinical services provided across central and south London and beyond, including seven mental health and physical healthcare hospitals and many community sites
- a comprehensive portfolio of excellent quality clinical services with international recognition in cancer, diabetes, mental health, regenerative medicine, transplantation, cardiac and clinical neurosciences
- a major trauma centre and two hyper-acute stroke units

About King's Health Partners

King's Health Partners Academic Health Sciences Centre brings together one of the world's top research-led universities, King's College London, and three of London's most prestigious and highly regarded NHS Foundation Trusts – Guy's and St Thomas', King's College Hospital and South London and Maudsley.

The partnership provides a powerful combination of complex clinical specialties that cover a wide range of physical and mental health conditions and a breadth of research expertise that spans disciplines from medicine and biomedical sciences to the social sciences and humanities.

There are three parts to our mission: excellence in research, education and clinical care.

To support our mission, we are delivering programmes of work to:

- join up mental and physical healthcare so that we treat the whole person, mind and body
- increase the value of the care we provide and the outcomes we achieve for our patients and service users
- integrate care across local primary, secondary and social care services to make it easier for people to get the care and support they need
- improve the public health of our local community by tackling inequalities and supporting people to live healthy lives

We are structured to deliver our mission for excellence. Our 21 Clinical Academic Groups (CAGs) bring together all the clinical services and staff from the three trusts with the relevant academic departments of King's College London.

Foreword



Professor John Moxham, Director of Clinical Strategy

At King's Health Partners we are committed to improving outcomes for our patients and service users. We believe that being open and transparent about the care and outcomes we deliver results in a culture of improvement across our partnership. This in turn leads to better outcomes for the people we serve and better value for the money we spend. This is why we are publishing a series of outcomes books that will help patients, service users, carers, referring clinicians and commissioners to make better informed decisions, and our staff to drive up the quality of the care we provide. The books report key outcomes for treatments provided by our 21 Clinical Academic Groups (CAGs). CAGs form the building blocks of our Academic Health Sciences Centre. We believe that by bringing together our clinicians and academics across teaching, training and research, we can use their combined expertise to achieve better outcomes for our patients and service users.

Our books are designed for a clinical and lay audience and contain a summary of patient volumes and measures (e.g. length of stay, re-admissions, patient experience), clinical outcomes, educational activities, technological and research innovations and publications. They also focus on other important measures, such as staff satisfaction and wellbeing.

The primary purpose of King's Health Partners is to improve health and wellbeing locally and globally. We must deliver this goal against a challenging economic environment, with rising demand for, and costs of, healthcare. We will only achieve sustainable health improvement if we strive always to increase value. We define value in terms of outcomes that matter to patients, over the full cycle of care, divided by the cost of producing those outcomes. By publishing outcomes books we have more information to support us measuring the value of the healthcare we provide.

Our goal is to increase the depth and breadth of reporting each year. Books will be updated regularly to demonstrate progress against our mission to achieve world-class research, education and clinical care. We hope you find these data valuable. Please send comments and suggestions to us at kingshealthpartners@kcl.ac.uk. For more information please visit our website at www.kingshealthpartners.org.

Professor John Moxham, Director of Clinical Strategy, King's Health Partners

June 2015

A handwritten signature in black ink that reads "John Moxham". The signature is written in a cursive, flowing style.

Foreword from Mental Health of Older Adults and Dementia CAG

The Mental Health of Older Adults and Dementia CAG was one of the earliest CAGs in King's Health Partners to form. Our existing strong relationship between the clinical service and the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) has gone on to develop our vision to be a pre-eminent service in the provision of high quality and effective clinical care nationally. This book highlights the impressive array of clinical and academic activity across the CAG and the dedication of those working for the benefit of our service users and their carers.

Providing high quality care and measuring our performance is integral to our services, and this publication demonstrates the ongoing importance of specialist mental health services for the older adult population.

We hope our outcomes book illustrates not only what we have achieved but also our ambitious

vision for how our services will continue to develop. We have the opportunity to lead the development of the next phase of integrated services for older people with mental health needs and new approaches in treating and supporting people with dementia. The CAG is well placed within King's Health Partners to work with clinical partners and our other stakeholders to develop and implement a dementia strategy for King's Health Partners. This will support the creation of effective integrated models of care for older people in south London, working with and learning from our service users, carers and staff.

**Professor Robert Howard,
CAG Lead and Academic Director**

Dr Daniel Harwood, Clinical Director









David Norman, Service Director

June 2015

Home treatment team's service user and carer event



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Integrating mental and physical healthcare within King's Health Partners

Mental and physical integrated healthcare

King's Health Partners aims to create a centre where world-class research, education and clinical practice (the 'tripartite mission') are brought together for the benefit of patients.

We want to make sure the lessons from research are used more swiftly, effectively and sympathetically to improve healthcare services for people with physical and/or mental health problems.

We will achieve this transformation of healthcare for the whole person, through our commitment

to integrated mental and physical healthcare, research, education and clinical delivery, across our breadth of services and from conception to the last days of life.

We aim to:

- transform outcomes for patients with both mental and physical health conditions, to ensure that care in all healthcare settings addresses the whole person, and is patient centred
- expand our internationally recognised programme of mental health research and provide comprehensive innovative staff education programmes

- develop and evaluate novel and integrated mental and physical healthcare pathways in collaboration with commissioners, patients and primary care colleagues

More specifically, we will:

- address underlying physical health risk factors which contribute to the excess mortality and morbidity experienced by patients with enduring mental health problems
- reduce the adverse impact of mental health disorders on outcomes of long-term conditions and medically unexplained symptoms
- integrate service provision for the whole person throughout all of our specialties

Academic integrated care system

We are committed to working with our partners across local boroughs to integrate services at a local level to improve patient care. To this end we will use 2014/2015 to test the provider offer of new models of care to enable a more integrated academic healthcare system.

We are a founder member of Southwark and Lambeth Integrated Care (SLIC), a movement for change aiming to genuinely transform how care services are delivered so they are coordinated

around the needs of people, treating mental health, physical health and social care needs holistically.

This programme is vital to address the crisis within our healthcare economy and quality must improve significantly so people receive effective care and experience it positively.

A lot has already been achieved. Work to date has built an ever deepening shared understanding of the issues, a commitment to action, and an understanding of the options to reduce avoidable emergency admissions, speed up delays in discharge, improve mental and physical health liaison and reduce admission to residential care.

Public health integrated care system

Public health has been identified as a priority for King's Health Partners and is one of our biggest challenges. We have developed a strategy approved by our Board – over the next five years we aim to be recognised internationally for our academic and service innovation in urban public health in addressing local and international issues, with a focus on inequalities in health and healthcare delivery, particularly with regard to ethnicity and deprivation.

Our Clinical Academic Groups (CAGs) and the south east London sector will be an innovative test bed to develop and trial solutions in prevention

and management of long term conditions of public health importance, thereby achieving academic, training and service delivery to improve public health advances.

In order to reduce morbidity and premature mortality whilst reducing health inequalities in south east London, all CAGs are responding to the call for increased action on smoking and harmful drinking. We are implementing both an alcohol and tobacco strategy.

Alcohol strategy

- developing appropriate resources for clinical staff and patients
- developing and implementing training for all staff on alcohol early identification and intervention
- establishing ourselves as a centre of excellence for integrated research, training and practice in the management and prevention of alcohol misuse
- attracting funding for future alcohol clinical, training and research initiatives
- monitoring the impact of the strategy on indicators of alcohol related harm

Tobacco strategy

- supporting all clinical sites to be smoke-free
- developing an informatics structure for routinely and systematically recording smoking status
- support, referrals and treatment uptake for smoking cessation across the partnership
- co-producing clinical care pathway for nicotine dependence treatment
- developing and implementing training packages for smoking cessation interventions for all our healthcare professionals
- monitoring the impact of our smoking cessation strategy in relation to knowledge and uptake of skills by staff, uptake of smoking interventions, outcomes of interventions, user satisfaction, prevalence of smoking, cost-effectiveness of interventions

Introduction

This outcomes book will tell you about some of our services, research and developments over the last three years and what difference they have made. It is designed to be viewed by a wide audience and contains many voices from service users, carers and staff contributions, to detailed contributions from some of our researchers. We hope there is something for everyone but we would be pleased to hear from any readers who might like more information.

The services now covered by South London and Maudsley NHS Foundation Trust have played an important role in the historical development of the specialty of Mental Health Care for Older People in the UK. Dr Felix Post was appointed as the first Consultant Psychiatrist in the UK to work exclusively with older people (over the age of 60), in Gresham Ward at the Royal Bethlem Hospital in 1947. In 1948 the medical school gained independent status within the University of London as the Institute of Psychiatry. Its first director was Professor Aubrey Lewis, who played a key role in establishing psychiatry as an academic discipline, and who our inpatient older adult ward at the Maudsley is named after. Professor Elaine Murphy was the first person

appointed to a chair in Psychogeriatrics in 1983 as part of Guy's Medical School, followed the next year by Raymond Levy as Professor of Old Age Psychiatry at the Institute of Psychiatry, confirming the importance of services for older people as a specialism within mental health.

The Institute of Psychiatry became a school of King's College London in 1997 and in 2014 the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) was formed. South London and Maudsley NHS Foundation Trust (SLaM) was formed following the reconfiguration of community and mental health services in south east London.

New models of mental health care were pioneered by these services. The community based multi-disciplinary team approach, and Domus Home care for people with advanced dementia and complex needs were both developed by the Guy's and Lewisham Services. This service also developed the first electronic clinical information system within Mental Health of Older Adults and Dementia (MHOAD) presaging the collection and reporting of routine outcome data. A unified inpatient, day hospital and community team approach was

developed at the Bethlem and Maudsley's Felix Post Unit and one of the first memory clinics for the early diagnosis and treatment of dementia was established in the 1980's. This preceded the broader model of memory services which were pioneered in Croydon and subsequently recommended in the National Dementia Strategy.

In 2012 South London and Maudsley's first dedicated Clinical Academic Group (CAG) for older adults was created, aiming to deliver high quality specialist mental health care to people aged 65 years and over with severe and complex mental health needs and to anyone who developed dementia. The CAG recognises the impact of the ageing process on physical and mental wellbeing and the additional complexity this might bring. Our specialist services are directed towards:

- finding the right therapeutic environment – especially for those who are more frail
- ensuring that staff have the skills, expertise and understanding of mental and physical changes and how this can affect the experience of illness and wellness

- understanding how treatment options may need to be modified to optimise therapeutic outcomes for older people
- combating the dual stigma of ageing and mental illness by promoting wellbeing and belief that meaningful life is as possible in one's 90s and 100s as it was in one's 40s and 50s
- the promotion of translational research, especially relating to dementia, as part of the CAG tripartite agenda in collaboration with the National Institute of Health Research funded Biomedical Research Centre based within King's College London

The CAG has redesigned clinical services to provide more clinically appropriate and cost-effective models of care, including development of integrated memory services and crisis services in the community. At the heart of the CAG is the practical involvement and engagement of our service users and carers at all levels of our work.

Who uses our services?

The table below provides information of how many people use each of our services, based on a cross section of data from 2014/15

Service Line	Patients	Percentage of our total caseload
Community Mental Health Teams	1,853	40%
Home Treatment Teams	21	<1%
Specialist Mental Health/Care Home Intervention Teams	81	2%
Memory Services	2,155	46%
Liaison Services	85	2%
Psychology and Psychotherapy	320	7%
Inpatient Units	62	1%
Specialist Care Units	48	1%
Total number of service users to date	4,625	100%

The four boroughs have a diverse population in terms of ethnicity, religion, gender and other differences. We monitor this information to ensure our services are available and accessible to all communities.

Referrals to our community services have increased by 18% in the past two years (Figure 1). We believe this is through a combination of factors including earlier referral to services for people with cognitive difficulties and less stigma around mental illness more generally. Our inpatient

services have low four week re-admission rates, which remain at around 1% (Figure 2).

Figure 1 | Number of community referrals over the last three years

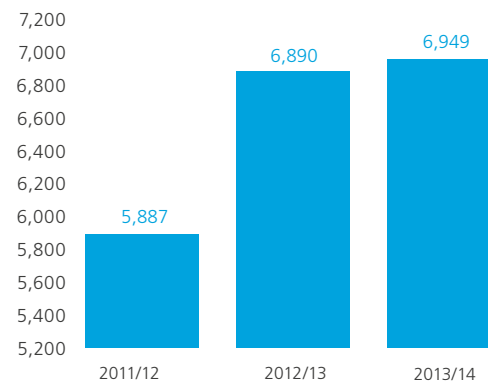
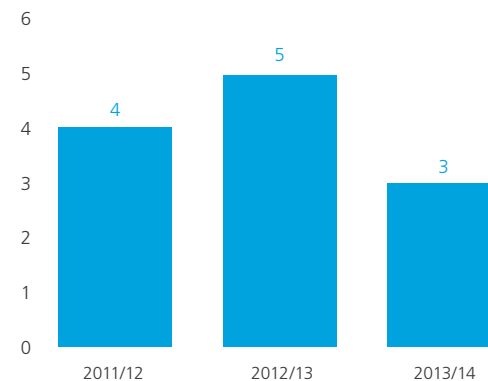


Figure 2 | Total number of re-admissions within 28 days over three years



Our aims and ambitions

The work of the CAG involves clinical service delivery, research and training coming together in a collaboration that drives up quality and effectiveness in each area. The divide between academic and clinical activity should be invisible, with practice based on current evidence. Our aim is that the quality of teaching and training we provide supports and accelerates the development of evidence-based health care. Where there is no robust evidence for service change, we aim to lead in generating it.

Our CAG commitments were developed with our Service User and Carer Advisory Group, (SUCAG).

We aim to transform the quality of our clinical services, research and education for older people with mental health illness or dementia and their carers until we are confident that we set an example of quality and effectiveness.

Our co-produced vision for the MHOAD CAG is to:

- **organise our specialist older adults mental health services in the right way**

This includes:

- ensuring high quality services and demonstrating their worth to our service users, carers, local communities and commissioners
- making sure the right services are available and accessible when they are needed
- ensuring safe services which address restrictive practices such as the use of physical restraint, making sure medication is not overused and, as far as possible, people can move about freely in our inpatient services
- getting service users and carers involved at every level to help design, shape and monitor the quality of our services

- **have compassionate, hardworking, committed and competent staff who act as local and national champions**
 - tackling both age discrimination and the stigma of mental illness
 - offering hope of improved wellbeing in older age
 - educating the public, staff, service users, carers and key partners such as emergency services
 - promoting the diversity of our communities
 - promoting dementia friendly communities by working with local partners and service providers
- **provide access to the very best information leading to evidenced-based treatment and support**
 - ensuring that all clinical and non-clinical practice is based on evidence through being the leader in research in older adults mental health
 - promoting the wellbeing and recovery of the whole person through service integration and joint working with partners and services
 - championing partnerships with local authority and voluntary sector partner agencies across our four boroughs

Our philosophy of service users and carers as partners

Service User and Carer Group – SUCAG

Kelvin Wheelan, SUCAG member presents to our staff conference.



Close working with our SUCAG members is part of the way we do things in the CAG. Whether being involved in staff recruitment, conducting mock Care Quality Commission audits or helping to develop new services, this partnership is vital. The group have developed a support group for carers of people living with dementia and took part in the BAFTA and National Broadcast Award winning TV documentary "Bedlam".

» **Copy the link below to see a short film about SUCAG and our work**

video214.com/play/cC6gTQUkUoQv6N0dDrLWZg/s/dark

Here is a perspective from one of the long standing members of the group, Doreen

“About four and a half years ago SLaM, ever-forward looking, enlisted the aid of a small group of service users (SU) and carers to work on the Social Inclusion and Recovery Project. The aims being:

- improvement to the delivery of services
- involvement of the SU in his/her recovery
- education of the staff to this new way of thinking

As demand for our services grew, so did our numbers and SUCAG was born. This is an active group of SUs, ex SUs, carers and ex carers which oversees the many projects undertaken by members. From the beginning we have been supported, encouraged and trained by the Involvement Team, always professional but considerate and aware of our needs too.

Our remit is wide. We have different aptitudes but are able to find a place for our particular expertise. Consequently, our activities are many and varied and include:

- policy and procedure reviews
- representing carer/user voices
- the Power of Story project

We are a happy group, we like each other, we enjoy our work. We have made a difference. Perhaps the obvious one is the change in the relationship between us, the users, and the providers. We are consulted and our opinions considered and respected. On our part we have gained insight into the inner workings of SLaM and the day-to-day difficulties faced by the providers. This two-way communication can only be good. ”

Doreen Bryant, SUCAG Member

Sylvia Honeyman (left), who is a volunteer on one of our inpatient wards and a SUCAG member, was recognised in the SLaM celebration for Bedlam. This four-part documentary series about SLaM services scooped a BAFTA television award. The pioneering series which SLaM made with Channel 4 and Garden Productions was declared the winner of the 'best factual series' category at a prestigious ceremony at the Theatre Royal, Drury Lane, London on 18 May 2014.



OT Garden

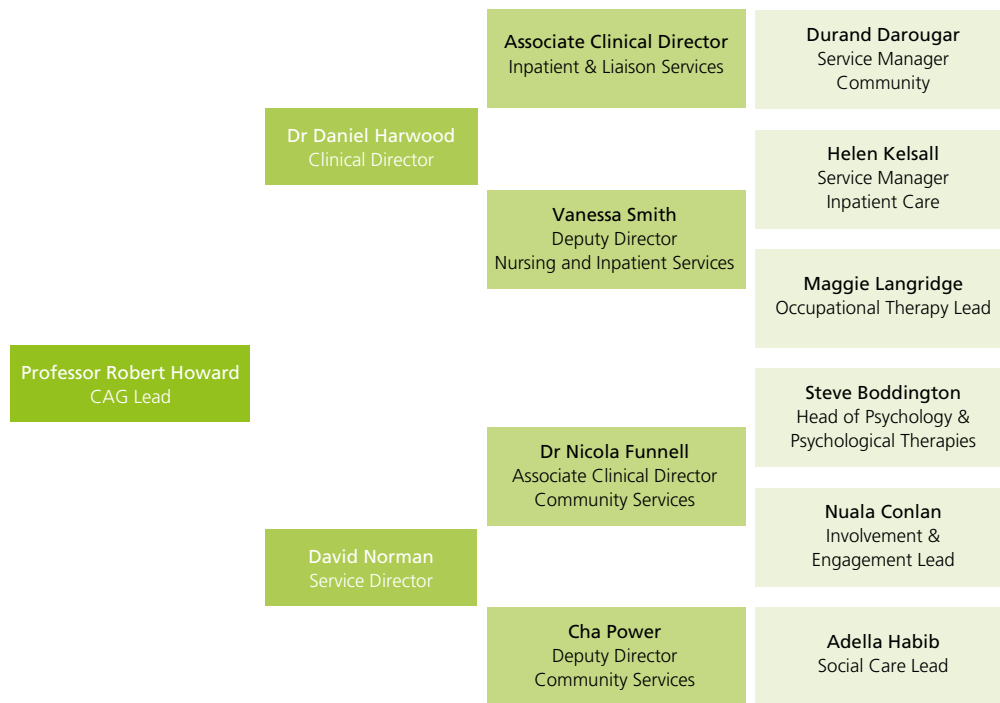
Way Out to

- Chelsham House*
- Monks Orchard House*
- River House*
- Wickham Park House*

- Fitzmary House*
- Gresham House*

Team structure

Figure 3 | Our CAG management structure (as at March 2015)



Our services

We offer a range of community and hospital based mental health services covering the London boroughs of Croydon, Lambeth, Lewisham and Southwark.

Community services

- Community mental health teams: Lambeth, Southwark, Lewisham and Croydon
- Care home intervention teams: Lambeth, Southwark, Lewisham and Croydon
- Memory services: Lambeth, Southwark, Lewisham and Croydon
- Psychology and Psychotherapy services: Lambeth, Southwark, Lewisham and Croydon
- Home treatment teams in Lambeth, Southwark and Lewisham

Inpatient services

- Aubrey Lewis 1, Acute Admission (The Maudsley Hospital)
- Chelsham House, Acute Admission (Bethlem Royal Hospital)

- Hayworth, Acute Admission (University Hospital Lewisham)
- Ann Moss, Specialist Care Unit (Rotherhithe)
- Greenvale, Specialist Care Unit (Streatham)
- Inglemere, Specialist Care Unit (Forest Hill)

Liaison services

- Liaison services at Croydon University Hospital, Guy's and St Thomas' Hospital for Lambeth, Lewisham University Hospital and King's College Hospital in Southwark

National and specialist

- Early intervention memory service
- Visual perception disorder clinic

Our services and pathways

Community mental health teams (CMHTs)

We have four community mental health teams providing specialist assessment, diagnosis and treatment, across south east London. Each team is made up of psychiatrists, community psychiatric nurses (CPNs), occupational therapists, social workers, psychologists, mental health support workers and administration staff. We work closely with other social care staff, voluntary and statutory organisations to make sure everyone receives a level of treatment and care that is appropriate and effectively coordinated to help maintain health and independence wherever possible. The contact that staff from these teams have with service users, their carers and relatives may vary greatly, depending on an individual's level of need and treatment plan. We deliver care in:

- people's own homes, including residential and nursing homes
- outpatient clinics
- community hospitals
- GP surgeries
- community mental health teams also work with carers and relatives

The other thing that helped were the people at the community mental health team, they were a helpful bunch. An OT (occupational therapy) student anticipated our needs and said *you don't need these things now but they take ages to order* and she ordered things like bath aids and just got it all sorted.

Doreen Bryant



Care home intervention service

This specialist team supports service users who have behaviour which is challenging in the context of mental health problems or dementia living in a residential or nursing home. The team provides training and support for care staff to develop their skills and knowledge to improve the quality of care. There is an emphasis on non-drug treatments in line with national guidance and person centred care.

Memory services

The CAG has three memory services which provide specialist assessment, investigation, diagnosis and treatment for anyone where dementia is suspected, whatever their age. Our teams are made up of psychologists, nurses, occupational therapists, psychiatrists, social workers and administrative staff.

Those referred to the memory service are seen either at home or in a local clinic. Using the latest diagnostic tools to detect dementia in its earliest stages, staff carry out an initial assessment and follow this up by talking to service users and their carers about the results. A diagnosis of the problem will be made along with a referral for treatment which might be needed.

Psychology and psychotherapy services

We have two psychology and psychotherapy teams made up of registered psychologists and psychotherapists who are experienced in working with older people who have moderate or severe mental health difficulties. Our psychologists and psychotherapists work closely with other professionals across our services and offer a range of therapies including cognitive behavioural therapy (CBT), couple and family therapy (FT) and psychodynamic psychotherapies. We run

groups for people experiencing memory problems and for carers who may be struggling with the demands of their role. People who are experiencing cognitive or memory difficulties may be offered a more detailed neuropsychological assessment. The service is one of eight specialist psychology and psychotherapy services for older people to have been scrutinised by the Royal College of Psychiatry's National Audit of Psychological Therapies. This showed a high level of performance when compared to national benchmarks, for more details on this see the outcomes section on page 37.

The psychology and psychotherapy service provides highly valued teaching and training placements to a range of professional training programmes and to postgraduate academic courses in specialist mental health care of the elderly.

Clinical research trials include two investigations, one of the feasibility of transdiagnostic CBT for older people, which addresses psychological features that are common to both depression and anxiety disorders, and one which examines the benefits of staff supervision groups using transference focused psychotherapy, which applies a psychodynamic model to inform the care of older people with complex mental illnesses such as personality disorder.

Kenneth's story

In late February 2013, I was admitted to the Bethlem Hospital with suicidal thoughts and a lost will to live. Years of sleep deprivation, drinking and a persistent depression had finally caught up with me. Like so many others in a similar situation, it was a series of major changes in my life that was the root cause to my depression.

By the end of January 2014, I was in such a bad state that I seriously considered taking my own life. Fortunately for me I was then staying with my wife and daughter who realised the gravity of my situation. They contacted the community mental health team at Croydon Integrated Mental Health of Older Adults Services. The consultant psychiatrist visited

me directly and by the 4th of February 2014, I was admitted to Chelsham House, Bethlem Royal Hospital in Beckenham, Kent. I spent the following three weeks at Chelsham House and that was the best thing that could possibly happen to me. I recovered very quickly, managed to sleep and get my depression under control. I was fortunate to also receive help from the resident psychologist with treatment at the hospital as well as after-care in the community. I cannot describe in words what this help meant to me, but the result was that I became a much better, healthier and positive person than I've been for years. I'm not kidding myself into believing I am suddenly, by some miracle, cured of all the problems that have affected me, but with a bit of awareness and care with my lifestyle, I should not have any future problems.

Home treatment team

Most people prefer to be treated at home with the support of family and carers, especially when facing a crisis, rather than going into hospital. The home treatment team offers intensive short term treatment for those who are experiencing a severe episode of mental illness, in Lambeth, Lewisham and Southwark. The team can make

an early discharge from an inpatient ward easier. We work every day of the year and our team consists of an administrator, nurses, support workers, occupational therapists and psychiatrists. We are currently setting up a home treatment team in Croydon.

Inpatient care

We provide acute care, including assessments and treatments for anyone with a diagnosis of dementia and for adults aged 65 and over with mental health problems such as depression or psychosis. The majority of people receive treatment on our inpatient wards via a voluntary admission in the same way that people who are physically ill are admitted to hospital. For some service users this may be a brief stay for intensive

treatment and support. Others who suffer from severe mental illness may need a longer stay or multiple admissions. We also assess and treat service users who are subject to the Mental Health Act 2007 and the Mental Capacity Act 2005.

One of our home treatment team colleagues told us a bit about her story and why she wanted to work in the older adults mental health service:

A little story from inside the CAG

Sue Andrews-Bligh tells us about her inspirations in her career

How did I get here?

When I was 24 I started in home care. I was inspired by my grandad really. I could see my Nan really struggling and he had told the home help he had been offered to 'go away' (but not so politely). It wasn't that they weren't trying to help, it was the way they approached him; he just wanted someone to show him how to cope in a different way. Then I went to work in the home care team, where I was working alongside a team from SLaM. I also worked in a care home and was struck by how task focused they were. I began introducing some small changes like different breakfast times and joint mealtimes with families. But I realised working in community settings was what I really enjoyed, helping people

to regain and keep their independence as long as they possibly could.

What 'moments' have stuck with you throughout your career?

I once worked with a lady who was very isolated. She had breast cancer and found most tasks a challenge to do. She had been in a prisoner of war (POW) camp with her mother before she came to England. She told me of how in the POW camp she recalled the feeling of terrible hunger and how they would unravel barbed wire to knit and keep themselves occupied. Further on in her life tragedy struck twice, once when she was trapped in a train crash and later she was diagnosed with dementia. Despite this she always had a smile on her face, she was such an inspiration, always positive, always saw the good in people and in everything. It was a pleasure working with her and she was a true inspiration to me. And that's what I've found about this job, it has to be in your heart.



Felicia's talks about her experience in one of our inpatient services

At first it was very disturbing hearing that I was in a mental hospital, it really made me panic, I was worried. After a while I could see my whereabouts and it was then I realised how beautiful the hospital was. The complete medical team are so good. We had so many classes, psychology classes, cookery and art classes, a prayer room, a library and a beautiful dining room.

» Copy this link into your web browser to watch Felicia's story

www.youtube.com/watch?v=kkSfDcxaeaw



In our inpatient services our health professionals (psychiatrists, mental health nurses, health care assistants, occupational therapists, drama therapists, psychologists, speech and language therapists, physiotherapists and volunteers) work together with the service user and their families and carers to assess and treat the individual needs of each service user and support them through their recovery.

Service users are encouraged to take part in therapeutic activities such as psychology, physiotherapy, occupational therapy, speech and language and drama therapy, informal activities such as music, relaxation, reading and board games, as well as receiving medical treatment for their illness. All wards have access to a garden with sections dedicated to gardening activities for service users.

Carers, relatives and community volunteers are encouraged to support the work we do by getting involved in some of the activities, talking with service users or helping at meal times. Some of our volunteers provide hairdressing, massage and aromatherapy treatments.

Specialist care

Some older adults with dementia also experience complex problems which need a different approach. We provide this highly specialist care for people who may develop behaviours that challenge their carers such as being agitated, restlessness or who are very dependent on others for support with eating, dressing, bathing and other daily living tasks. We also assess and treat service users who are subject to the Mental Health Act 2007 and the Mental Capacity Act 2005.

Liaison services

Service users who are admitted to general hospital may also have mental health needs. In older inpatients delirium, dementia and depression are common and often poorly recognised. Our liaison services consist of specialist mental health doctors and nurses who provide help and advice across a total of over 3,300 inpatient beds in hospitals at four large hospital sites in south London.

We assess service users and speak to families and the staff who have been working with them to make our assessment. We make sure this is done before making any recommendations for

medication or treatment. The liaison team may also recommend care and support for service users when they are discharged from hospital, including referrals to our community mental health teams.

Tom is 82 and has Alzheimer's. He took part in our Croydon community mental health team's men's group and is seen here continuing to do what he loves; gardening on his allotment.



Clinical care pathways for older people

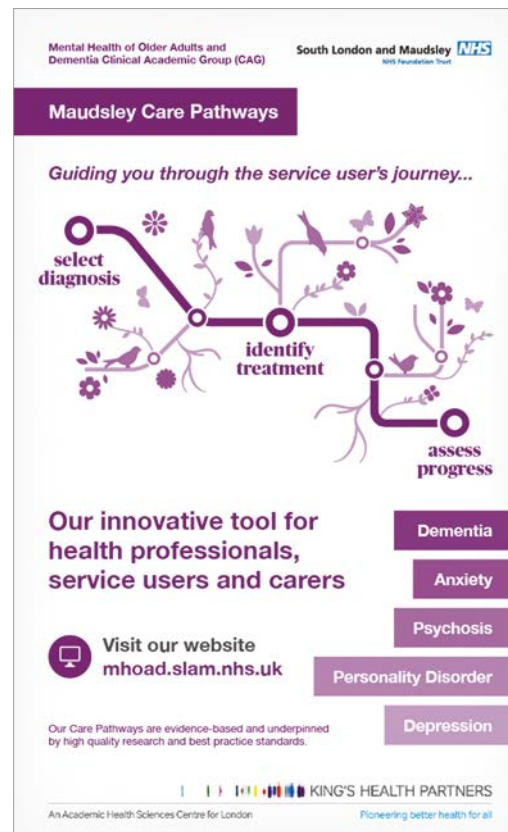
Over the past two years we have developed a series of care pathways which provide guidance, based on the best available evidence for the treatment of the range of clinical conditions for which we offer a service.

The primary purpose of the care pathways is to assist us in:

- designing care processes
- implementing clinical governance
- improving quality of care
- guiding evidence based practice

There are clinical pathways based on clinical presentation and diagnosis, for:

- dementia
- depression
- anxiety
- psychosis
- personality disorder



The poster is titled 'Maudsley Care Pathways' and features a central graphic of a tree with a path leading through it. The path starts at 'select diagnosis', goes to 'identify treatment', and ends at 'assess progress'. The tree is decorated with flowers and birds. At the top, it says 'Mental Health of Older Adults and Dementia Clinical Academic Group (CAG)' and 'South London and Maudsley NHS Foundation Trust'. Below the path, it says 'Guiding you through the service user's journey...'. At the bottom, it says 'Our innovative tool for health professionals, service users and carers' and lists conditions: Dementia, Anxiety, Psychosis, Personality Disorder, and Depression. It also includes the website 'mhead.slam.nhs.uk' and the King's Health Partners logo.

Mental Health of Older Adults and Dementia Clinical Academic Group (CAG) South London and Maudsley NHS Foundation Trust

Maudsley Care Pathways

Guiding you through the service user's journey...

select diagnosis identify treatment assess progress

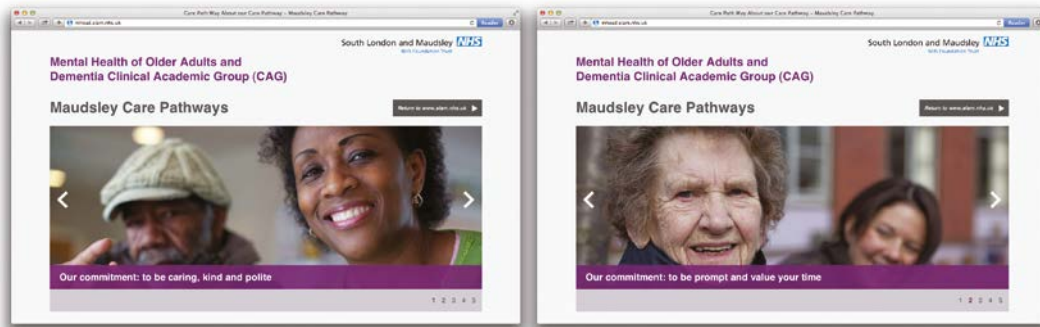
Our innovative tool for health professionals, service users and carers

- Dementia
- Anxiety
- Psychosis
- Personality Disorder
- Depression

Visit our website mhead.slam.nhs.uk

Our Care Pathways are evidence-based and underpinned by high quality research and best practice standards.

KING'S HEALTH PARTNERS
An Academic Health Sciences Centre for London Pioneering better health for all



These are available publicly via our website, (mhead.slam.nhs.uk), and function as a tool to guide clinical practice. They are being embedded within our staff practice together with a range of routine clinical outcome measures which are linked to each of the specific pathways.

The care pathways were developed by a wide range of staff in the CAG, from different professional and service perspectives. They help us to ensure that we offer assessment and intervention that is of the highest quality and consistent across our services. The content of the care pathways tool will be updated regularly to ensure that it is relevant to current evidence and practice.

Clinical outcome measures as an integral part of our care pathways

As part of our commitment to using the best evidence to direct our services for older people, we are introducing a new range of outcome measures to assist us in assessment and the evaluation of the efficacy of interventions.

The specific measure/s used will depend on the pathway being followed, and the clinical needs of the service user. There is a combination of service user rated measures, carer rated, and professional rated scales. The full range of outcome measures include:

- the Standardised Mini Mental State Examination (SMMSE)
- the Addenbrooke's Cognitive Examination (ACE-III)

- the Bristol Activities of Daily Living Scale (BADLS)
- Neuropsychiatric Inventory (NPI)
- Cornell Scale for Depression in Dementia (CSDD)
- the Adult Carer Quality of Life Scale (AC-QoL)
- the Hospital Anxiety and Depression Scale (HADS)
- the Brief Psychiatric Rating Scale (BPRS)

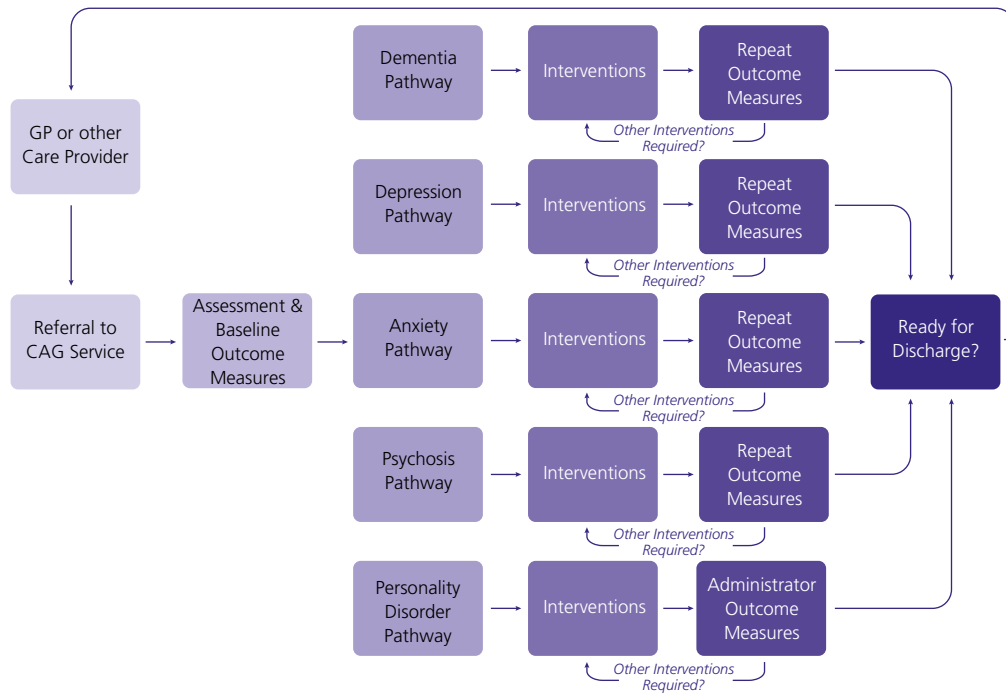
- the Clinical Outcomes in Routine Evaluation (CORE)

These will be used in conjunction with the Health of the Nation Outcomes Score (HoNOS). You can find out more about these on page 37.

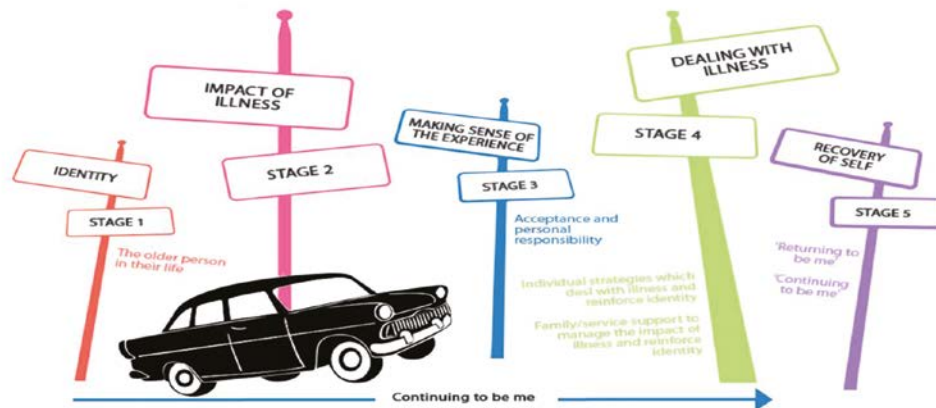
» **The pathways are accessible via this link**
mhead.slam.nhs.uk

We hope they will be of considerable benefit to our staff, service users and carers.

Figure 4 | Maudsley Care Pathways Overview



Recovery and support



The CAG is committed to the development of recovery based practice for older people (Daley et al 2013) and the development of simulation models for evaluating and developing the clinical skills amongst staff.

Key implications for our staff in supporting the recovery of our service users involves:

- supporting service users to maintain a positive self-identity
- enhancing resilience by focusing on service user goals, wellbeing, strengths and existing expertise, and relapse prevention
- supporting service users to re-engage and maintain existing social networks, activities and valued social roles
- working with carers to support the recovery of service users with dementia
- signposting service users and their carers towards local resources and services which best meet their needs, as opposed to building dependence on our services

A key objective of all nursing and OT clinical leadership roles across the CAG includes the embedding of recovery-oriented and inclusive practice at an individual and team level. We will support service users to develop their skills in self-management by implementing the use of the recovery and support (wellbeing) plans across all clinical services.

Further, we have developed a number of educational programmes, as part of the Trust Recovery College (a virtual college) www.slamrecoverycollege.co.uk including

a "Living with Memory Problems" workshop which has been developed with service users, and was co-run with the "Wellbeing" programme for older people.

Paper

Daley S, Newton D, Slade M, Murray J, and Banerjee S (2013) Development of a framework for recovery in older people with mental disorder *International Journal of Geriatric Psychiatry* 28: 522–529.

Innovations

Journeys of Appreciation (JOAP) gets national attention

This exciting CAG project enables service users to experience the creative environment of museums and galleries. It has received national interest with an article published in Community Care magazine and a keynote presentation at a conference in Oxford. In partnership with Tate Modern, Tate Britain, The Cinema Museum, Dulwich Picture Gallery and Horniman Museum, adults from our inpatient units have been able to reconnect with art, history and culture in a truly inspiring way. Through the visits to the galleries and museums, service users reconnect with the world and experience things that they may have done before their illness. These visits and the follow up creative sessions are a way of encouraging life story work, capturing the positive experiences and important recollections of creative aspects of their lives.

The service users and staff who have taken part are beginning to report the benefits including; a real sense of freedom by going out and getting

off the ward; the joint experience of learning together which is proving to have a positive impact on how the ward 'feels' and works on a daily basis.



If only I'd known

'If Only I'd Known' is a series of six workshops devised by a group of carers and ex-carers of people with dementia who want to share their experiences and to support other carers, who are coping with their relatives' dementia, by preventing them from having to fight battles in lonely isolation, as most of them have done. There is support available in the local community but exhausted carers have difficulty in sorting out the maze of services and benefits that are available. The six workshops cover:

Figure 5 | Carers workshop



1. signs to look for if you think someone may have dementia
2. how to get a diagnosis if you are worried someone may have dementia
3. dealing with social care
4. health of the person with dementia – physical and emotional
5. care for the carer
6. the money side of things

The group is piloting the workshops in different locations in the four boroughs before transferring to the Recovery College, which is a series of jointly produced workshops and learning events with SLaM and some of our users and carers of services.

Namaste care

Namaste Care is a structured seven days a week programme that integrates compassionate nursing care with individualised, meaningful activities for people with advanced dementia. Engaging people with dementia, through the use of sensory input such as touch, has been found to enrich the quality of life for this group of individuals. Our Greenvale Specialist Care Unit has embraced the Namaste Care philosophy. The programme has not only enhanced care but also attracted ministerial and research interest from Japan and Hong Kong. As part of the Department of Health's Connecting Programme, civil service staff wishing to introduce Namaste Care in other hospital

trusts have all had the opportunity to attend our Namaste sessions.

Our consultant old age psychiatrist at Greenvale has presented research promoting the merits of the Namaste Care programme at many conferences, along with one of our research nurses.

Namaste care – publications

Thompson A, Stacpoole M, Hockley J. (2014). Namaste Care: the benefits and challenges. *Journal of Dementia Care*; Vol 2, No 2, 28–30.

Hockley J, Stacpoole M. (2014). The use of action research as a methodology in healthcare research. *European Journal of Palliative Care*; 21(3), 110–114.

Stacpoole M, Hockley J, Thompson A, Simard J, Volicer L. (2014) The Namaste Care programme can reduce behavioural symptoms in care home residents with advanced dementia. *Int J Geriatric Psychiatry* DOI: 10.1002/gps.4211.

Recovery enablers: 'recovery in action'

The Lewisham recovery enabler (RE) project came about when it was noticed that there was a steady flow of requests by psychology graduates who wanted clinical experience acting in a voluntary capacity. The recovery enablers are supervised by qualified staff in the Lewisham CMHT, to assist service users on their recovery journeys. For many

older people, this may be as simple as 'continuing to be me', or 'living well' with dementia or other mental health problems. In return they receive training, supervision and opportunities to take part in other projects relating to service evaluation or development. They also get a reference, subject to satisfactory completion of the role.

Figure 6 | Group discussion



What have been the main successes?

So far feedback from service users, carers and staff has been very positive, though there is a complaint that we do not have enough recovery enablers to go round! Projects have included the development of two support groups for people with dementia living in extra-care sheltered housing which has been done in conjunction with the Mental Health Foundation.

The recovery enabler projects were an amazing opportunity for me in my gap year. It greatly enhanced my reapplication to medical school. I wrote about my experiences as an RE in my personal statement and was able to talk about it in my interviews. I was able to secure three offers at different medical schools. As an RE I had the chance to interact with mental health service users in their homes and on a group basis, which I feel has given me skills I will continue to use when I do patient visits on my course.

Edward, RE

Service users and carers in partnership with the Department of Health Connecting Programme

In February 2015 our Service User and Carer Advisory group visited the Department of Health to hear about the future direction for the Prime Minister's Dementia Challenge launched on 21 February. The group had an open discussion forum with senior civil servants covering a wide range of topics and lunch with Rt Hon Norman Lamb MP.

www.gov.uk/government/publications/prime-ministers-challenge-on-dementia

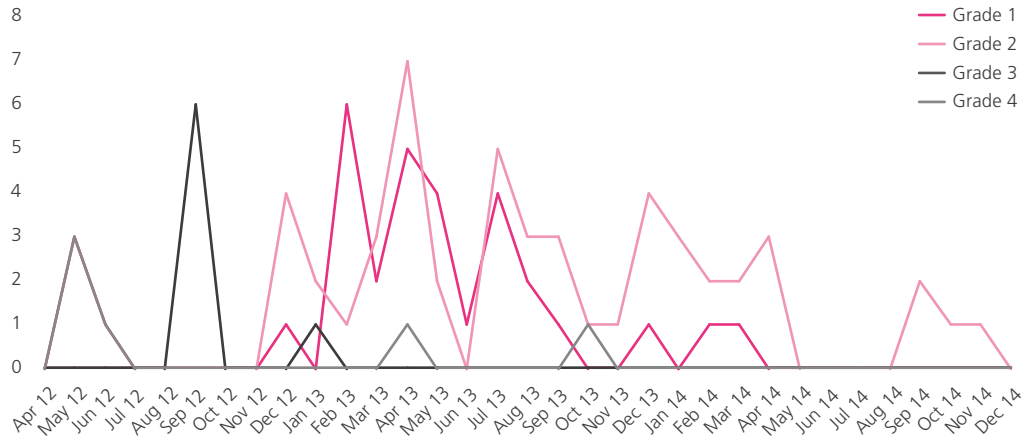


Wound care

In April 2012 a number of patients in our specialist care units were assessed as having grade 3 or 4 pressure ulcers. We realised that nurses in some of our isolated specialist care units were trying to give care supported by GPs but there was no system to escalate the need for support either to our MHOAD senior nurses or to a specialist tissue viability service. In addition, nurses on the acute wards did not know how to access specialist care for people. They were all trying their best but their ignorance about physical healthcare meant that people got poor and inadequate care.

Our specialist mental health nurses did not have the knowledge and skills to identify and understand the importance of reporting tissue viability issues to prevent pressure ulcers. This led us to complete a major piece of work that led to a Commissioning for Quality and Innovation (CQUIN) target on preventing and managing pressure ulcers in our CAG and in the Trust.

Figure 8 | MHOAD: All New Pressure Ulcer Incidence by Grade by Month April 2012–December 2014



Community engagement

Figure 9 | John Goodrum, SUCAG member and Signe Fogg, volunteer supporting and celebrating World Mental Health Day



Service outcomes

Clinical outcomes

Clinical outcomes are measurable changes in the health or quality of life of service users and carers that result from the care they have received. These clinical outcomes are collated to establish standards against which we can improve our clinical practice.

Quality of care outcomes

We aim to ensure that all service users get the most effective care in a timely and efficient manner. 'Quality of care' is a guiding principle in assessing how well the health system is performing in its mission to improve the health of service users.

The Trust Clinical Outcomes Team is a UK market leader influencing the implementation of clinical outcomes measurement in secondary mental health services across England. The team make recommendations to the Department of Health on outcomes and payment by results policy developments and assists other mental health Trusts with their outcomes implementation programmes. The SLaM Trust possesses

an extensive outcomes dataset, developed over many years, which provides practice-based evidence of the clinical effectiveness of MHOAD CAG services.

The Health of the Nation Outcomes Scale (HoNOS)

There are 12 HoNOS scales which cover a wide range of health and social domains:

1	Overactive, aggressive, disruptive or agitated behaviour
2	Non accidental self-injury
3	Problem drinking or drug taking
4	Cognitive problems
5	Physical illness or disability problems
6	Problems associated with hallucinations and delusions
7	Problems with depressed mood
8	Other mental and behavioural problems
9	Problems with relationships
10	Problems with activities of daily living
11	Problems with living conditions
12	Problems with occupation and activities

How they are scored:

0	No problem
1	Minor problem requiring no action
2	Mild problem but definitely present
3	Moderately severe problem
4	Severe to very severe problem

Our CAG outcomes

To measure the impact of our services, we collect HoNOS data at the initial assessment and repeat this again following our treatment and interventions. This is known as a paired rating. (In this report we present data collected 2011–2014).

Percentage of people we have completed HoNOS ratings for according to their diagnosis

Dementia	44.6%
Psychosis	43.5%
Mood	45.2%
Anxiety	38.2%
Personality	33.6%

Percentage of people we have collected HoNOS ratings for by service

Community Mental Health Teams	41%
Memory	30%
Liaison	38.8%
Home Treatment Team	52.1%
Inpatient	40.8%
Specialist care	51.8%

The nature of our memory and liaison services makes it difficult to collect the data. We know that we cannot show meaningful outcomes in memory services using HoNOS as these measures do not really assess the impact of the work we do around assessment and diagnosis. We are currently developing alternative ways of showing the impact for memory services in the future.

The diagrams that appear below show the changes in HoNOS ratings of those we have collected for each service area across the twelve domains. The yellow lines indicate initial severity and the black lines indicate the rating after treatment. The wider the gap between the yellow and black, the greater the positive impact of the treatment.

The largest changes can be seen in acute (inpatient) and crisis (home treatment) services. Little change would be expected in specialist care due to the complex physical and cognitive needs of this group of service users. In our community and liaison services, changes are more subtle reflecting the diversity of diagnoses and condition of the people the teams work with.

Figure 10 | Change in HoNOS rating for community service (CMHT)

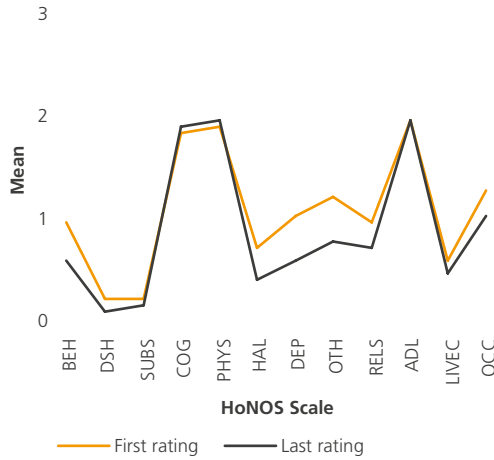


Figure 12 | Change in HoNOS score for home treatment team

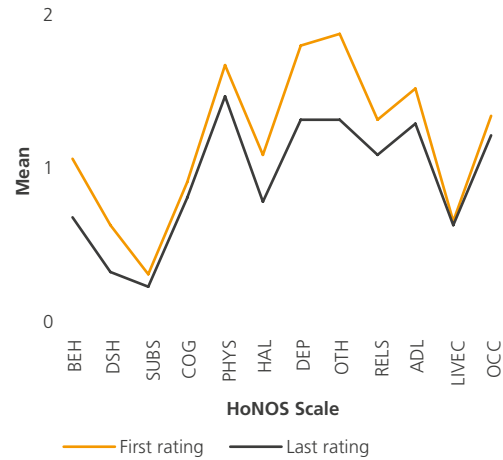


Figure 11 | Change in HoNOS rating for liaison services

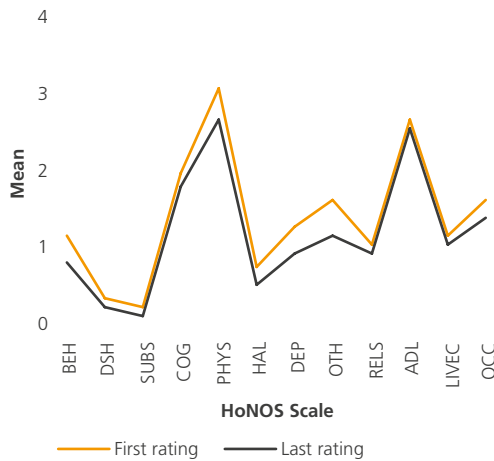


Figure 13 | Change in HoNOS score for inpatient services

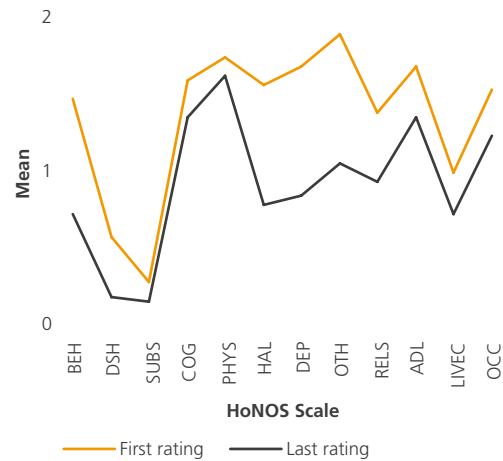
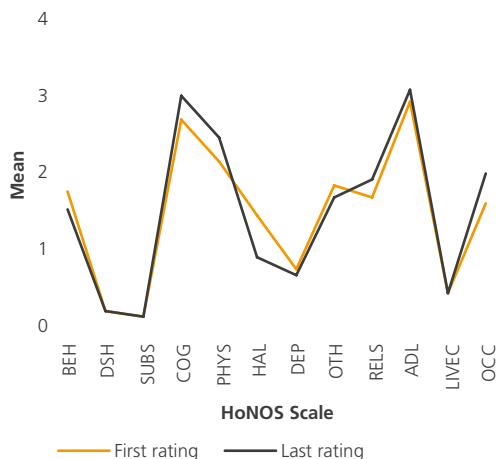


Figure 14 | Change in HoNOS score for specialist care



Mental health care home intervention

Behavioural and psychological symptoms of dementia (BPSD) are common and the needs of people that move to live in residential or nursing care are more likely to be complex, as efforts have increased to enable people to live in their own homes for as long as possible.

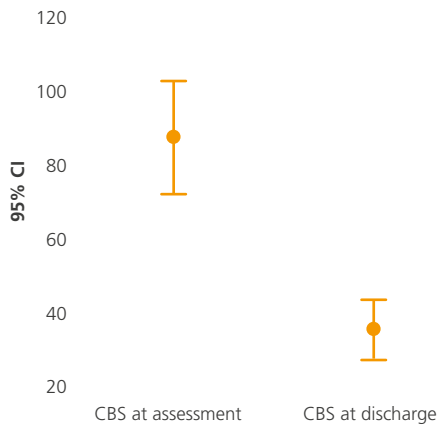
The Lewisham MHCHIT works with a model that considers BPSD as understood best in the context of an individual's current and previous experience, and can often be seen as a communication

of need. The approach prioritises appropriate psychosocial interventions to meet the specific needs. Medication is only prescribed as 'the last resort' and as recommended in NICE guidelines. The team works to develop the skills of carers in care homes and build relationships across primary and acute care and social services to improve the quality of care for people living in residential and nursing settings. Similar teams are currently in development in Lambeth, Southwark and Croydon.

Care home intervention outcomes

During the first year of the Lewisham Mental Health Care Home Intervention Service, the Challenging Behaviour Scale (Moniz-Cook et al., 2001) was completed by a member of the care home staff at initial assessment and discharge from the service. This 25 item scale was developed within care home settings to assess those behaviours occurring in dementia that challenge staff in both residential and nursing settings. Each behaviour is rated according to frequency 1–4 (occasional, to daily, or more). A total 'challenge' score is calculated as a combination of the frequency of the behaviour and the degree of difficulty each case causes staff 1–4 (no problem–lots of problems). The scale has a maximum score of 400.

Figure 15 | Using a paired-samples t-test, statistically significant decreases in BPSD were demonstrated between the start (M=87.75, SD=55.69) and end of treatment with MHCHIT Lewisham (M=35.45, SD=30.0; $t=7.38$ (52), $p<.001$). These outcomes closely resemble those of other successful service models that have been reported.



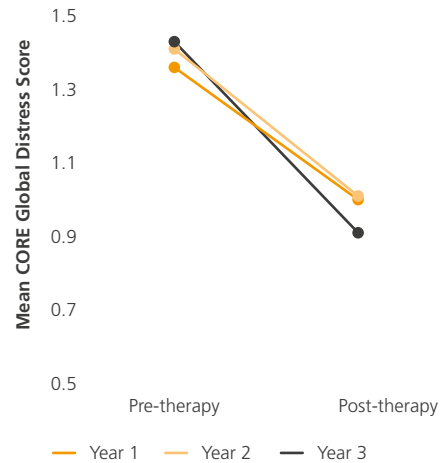
Moniz-Cook, E.D., Woods, R.T., Gardiner, E., Silver, M. & Agar, S (2001). 'The Challenging Behaviour Scale (CBS): Development of a Scale for Staff Caring for Older People in Residential and Nursing Homes'. *British Journal of Clinical Psychology*. 40 (3): 309–322.

CORE outcomes for psychology and psychotherapy

In line with Trust policy, outcomes of formal psychological therapies are evaluated using the 34 item Centre for Outcome, Research and Evaluation Outcome Measure (CORE-OM) or the briefer ten item version (CORE-10). The CORE scales measure 'Global Distress' and not particular psychological difficulties. Service users are asked to complete outcome measures before and after therapy (as a minimum) to measure the impact of therapy on their levels of emotional distress.

Effectiveness is investigated by examining group and individual data. The latter involves identifying whether change in CORE scores indicates clinically significant and/or reliable change has taken place.

Figure 16 | Global Distress Scores



- *Clinically significant change* is when service users' severity of psychological distress improves from pre therapy scores above the cut off of a clinical condition to below the cut off and therefore in the 'normal' range.
- *Reliable change* is when service users' scores change to a degree that is unlikely to have occurred by chance. For the purposes of these analyses, reliable change is a change ≥ 0.50 in Global Distress score.

In the three years from November 2011 to end of October 2014, 828 referrals to the CAG's Psychology and Psychotherapy service were eligible to have had a pair of COREs. Of these, 371 had a pair of COREs that could be used for data analysis, representing 44.8% of the total. This group was found to be representative of

the whole group of service users in terms of age, gender and level of emotional distress at the start of therapy. However, service users registered as white British or Irish were more likely to have completed outcome measures both before and after treatment compared to other ethnic groups. Also, people with a primary diagnosis of depression or anxiety showed a higher completion of the outcome measure than those with a primary diagnosis of dementia.

Primary outcome for the service

Global Distress scores decreased significantly over the period of therapy, showing a moderate effect size (Figure 17) and a year on year improvement in overall improvement (Figure 16).

Figure 17 | Pre-and post-therapy mean and effect size

	Pre-Therapy Global Distress Score	Post-therapy Global Distress Score	Effect Size ¹
P&P teams (n=371)	1.40 (SD 0.71)	0.98 (SD 0.68)	0.60 (M)
	$t(370)=12.624, p<.001$		

1 Effect size is a standard way of reporting significant treatment effects, taking into account the natural variability within the population. In this report the effect size reported is Cohen's

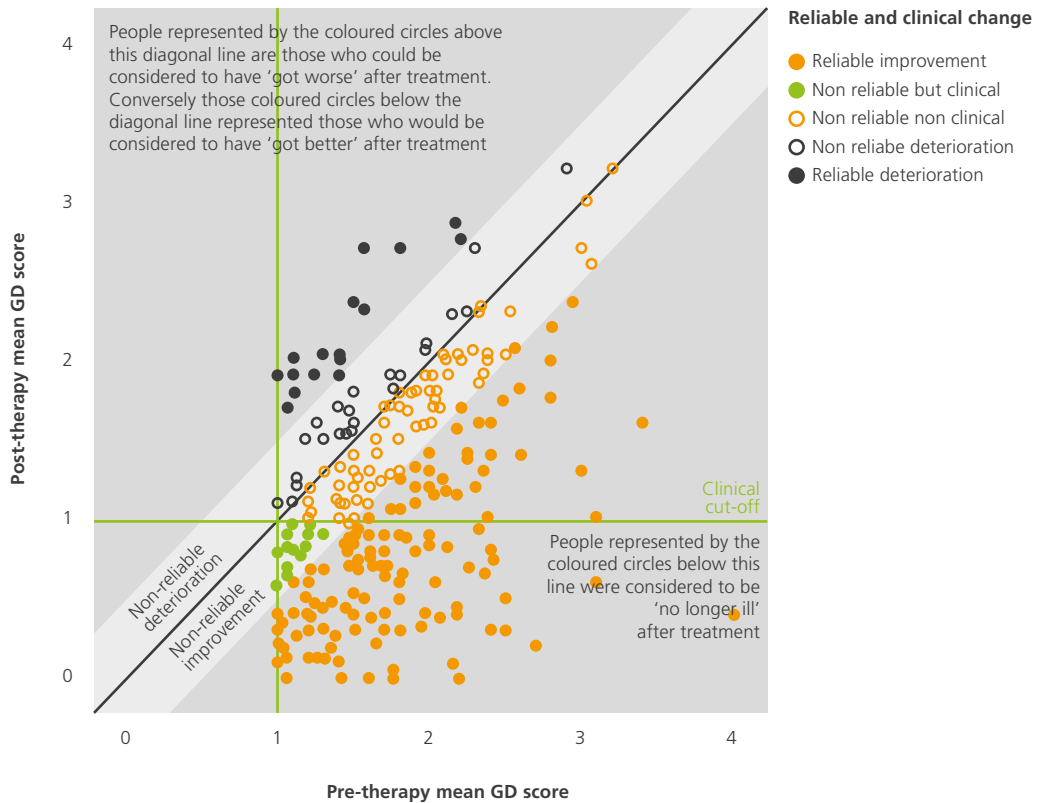
d (Cohen 1992), for which a value of 0.2–0.49 is deemed to indicate a 'small' (S), 0.5–0.79 a 'medium' (M) and 0.8 or above a 'large' (L) effect.

Outcomes for individual service users

262 service users with a pair of outcome measures had pre therapy scores that were above the clinical cut off. Of these 84% showed improved CORE scores during therapy and 52% showed a reliable

improvement in emotional distress by the end of therapy. Almost 43% reached a point of clinical recovery and 58% of service users either 'reliably' or 'clinically' improved.

Figure 18 | This scatter-graph displays the reliable/clinical change for those service users whose initial scores were above the clinical cut-off. We have included some non-clinical and non-academic descriptions in the boxes to help readers of this booklet



Service User and Carer Advisory Group (SUCAG) Christmas carols with the Mind and Soul Choir at the Cinema Museum, London



Service performance measures

We collect wider information about our performance to identify how and where we can improve services. Psychology and psychotherapy (P&P) teams exceeded their projected referrals target over the first three years (since 2011) with 2,325 referrals made to the service. Almost two thirds of referrals are received from the community mental health teams and a quarter from the memory services. Smaller numbers are received from liaison and inpatient services, reflecting the service model of embedding a specialist psychology and psychological therapy resource within these bed-based services.

Forty percent of referrals receive a CBT intervention and about 20% are seen in group therapy treatments. Others will receive family therapies (12%), psychodynamic therapies (8%), neuropsychological assessments or support in the

management of behaviours that challenge those who provide care. Referrers report an 86% overall satisfaction with the service and service users report a 90% satisfaction.

National audit of psychological therapies

Our MHOAD psychology and psychological therapy service took part in the 2012 National Audit of Psychological Therapies coordinated by the Royal College of Psychiatry and commissioned by the Healthcare Quality Improvement Partnership (HQIP). This audit encompassed 220 primary and secondary care psychological therapy services for adults presenting primarily with anxiety/depression, and aimed to evaluate the quality of treatment and care provided across four areas: access, appropriateness, acceptability, effectiveness/outcomes.

Area	Results
Access	Our waiting times for assessment (3 weeks) and treatment (4 weeks) all fell within the national targets and were markedly shorter than the mean waiting times for secondary care services as a whole
Appropriateness	83% of our service users received NICE recommended treatment for anxiety and depression (national sample = 79%) 43% received treatment for the NICE recommended number of sessions (or reached recovery) (national sample = 57%) 96% of our staff have completed appropriate training or are currently in formal training and working under supervision (national sample = 93%)
Acceptability	There were very high satisfaction ratings for the promptness of treatment, the convenience of time and location of appointments and for the quality of experience of therapy from our service when compared to the national sample Rates of attrition were lower for our service (11%) than the national sample (24%)
Effectiveness/ outcomes	43% of the our service users showed 'recovery' and 'reliable improvement' on routine standardised outcome measures (national secondary care sample = 33%)

Service user experience data collected in our community and inpatient services (Figures 19 and 20) indicates that in general, service users have a high level of hope in the treatment they receive. They also report that they are generally treated with dignity and respect. Key areas for improvement include:

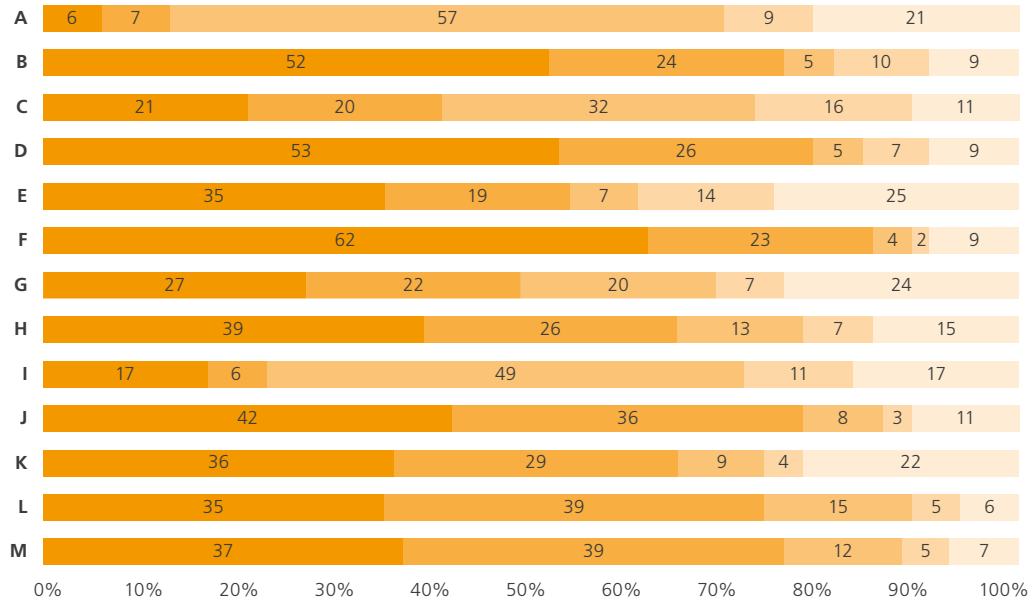
- ensuring that service users get and understand care and recovery plans

- developing crisis plans for our services users in community services
- explaining medication and its side effects more clearly
- provide better information and a simpler process to make and respond to complaints

We will monitor and report a change in service user feedback as a result of ongoing improvements to the services we offer.

Service User Experience Data

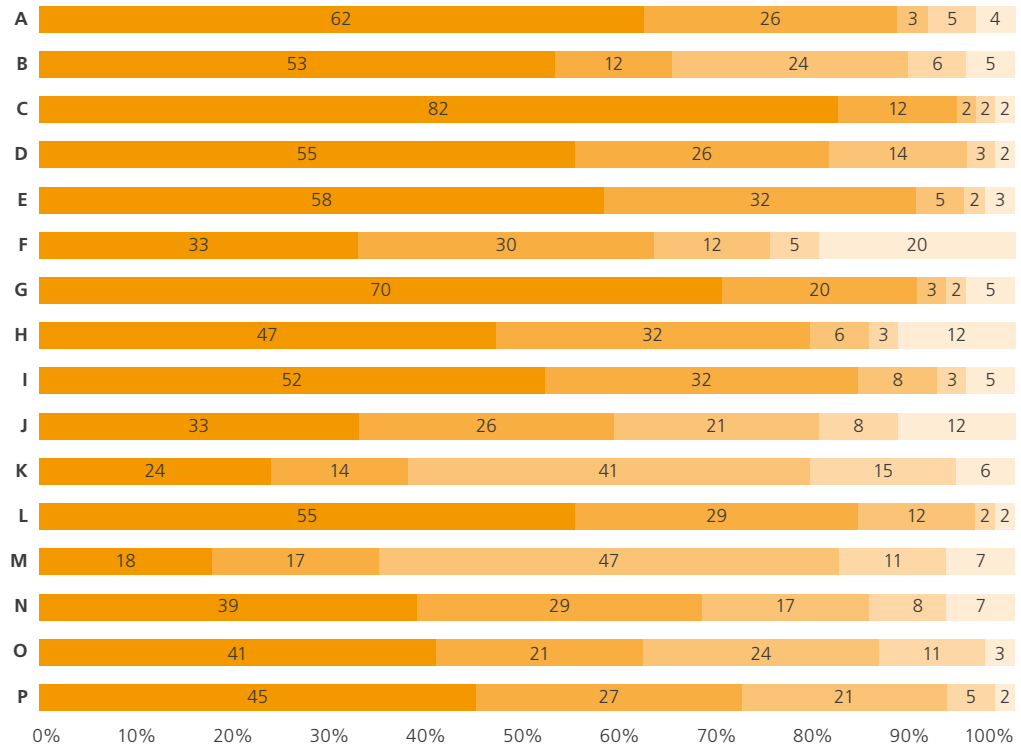
Figure 19 | Community service user experience 2012/13



- A** Have you been offered a crisis plan for emergency mental health situations?
- B** Do you have hope that the care you are having from this team will help you?
- C** Do you know how to make a complaint?
- D** Do you trust the staff team with your care?
- E** Do you feel your individual needs (cultural, spiritual, faith) are taken into consideration?
- F** Do you feel you are being treated with dignity, empathy and respect?
- G** Do you receive emotional support from the staff team when you need it?
- H** Do you feel the staff team continually supports you?
- I** Have you received a copy of your care/recovery plan?
- J** Do you feel supported in maintaining your well-being?
- K** Has the purpose of the medication been explained to you?
- L** Do you understand your diagnosis?
- M** Do you feel actively involved in making decisions about your care?

■ Yes definitely
 ■ Yes to some extent
 ■ No
 ■ Don't know
 ■ Not applicable/not answered

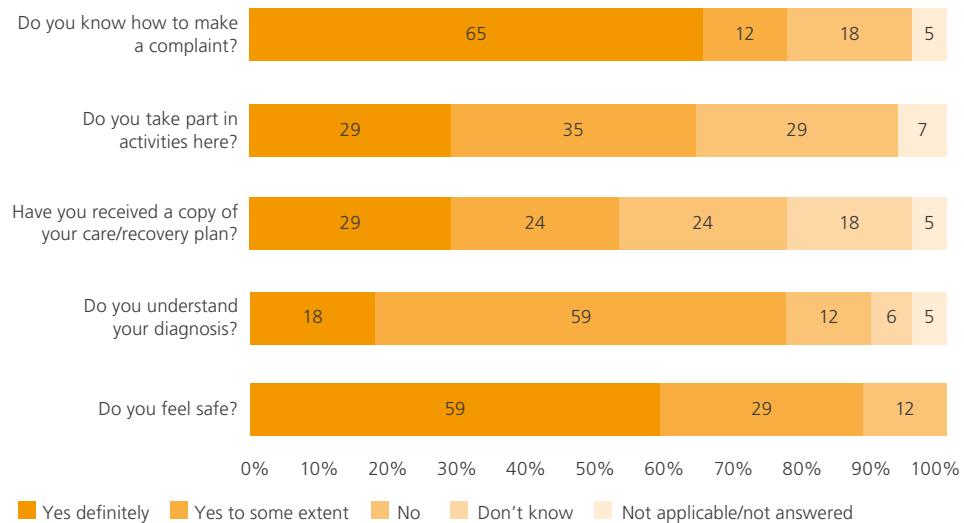
Figure 20 | Inpatient experience 2012/13



- A Do you have hope that the care you are having from this team will help you?
- B Do you know how to make a complaint?
- C Do you feel the ward is clean?
- D Do you feel safe on the ward?
- E Do you trust the staff team with your care?
- F Do you feel your individual needs (cultural, spiritual, faith) are taken into consideration?
- G Do you feel you are being treated with dignity, empathy and respect?
- H Do you receive emotional support from the staff team when you need it?
- I During your inpatient stay, do you feel the same staff team continually supports you?
- J Can you access a range of activities, 7 days a week, to help you stay active and occupied?
- K Have you received a copy of your care/recovery plan?
- L Do you feel supported in maintaining your well-being?
- M Has the possible side effects of the medication been explained to you?
- N Has the purpose of the medication been explained to you?
- O Do you understand your diagnosis?
- P Do you feel actively involved in making decisions about your care?

■ Yes definitely
 ■ Yes to some extent
 ■ No
 ■ Don't know
 ■ Not applicable/not answered

Figure 21 | Specialist care service user experience 2012/13



Medication management

The CAG has a consultant pharmacist in Older Adults Mental Health and Dementia who focusses on specialist clinical advice, research, education and training. A key part of this role is to also act as a lead nationally, showing how research and evidenced based practice can be implemented. An example of this is our work identifying medications which can worsen the symptoms of dementia, such as confusion, or interfere with the other medical treatment people are receiving. We aim to provide the evidence to inform GPs and memory clinics as to which medications they

should be alerted to review for those people they support who are living with dementia. Our consultant pharmacist also delivers specialist training to ensure that knowledge shared with colleagues, services users and carers is up to date and evidence based.

The following data is taken from the Prescribing Observatory for Mental Health UK (POMH-UK) audit – Prescribing anti-dementia drugs – March 2014. Overall, the Trust performed very well on this audit.

The CAG submitted data for 268 service users in SLaM (100% of inpatients and specialist care units and 10% of CMHTs). The prevalence of anti-dementia drug prescribing in the total national sample (TNS) was about 68% and the prevalence in SLaM was just under 60%.

- 45% of SLaM service users with dementia were prescribed anticholinesterase inhibitors (AChEIs)
- 15% were prescribed memantine
- 40% were not prescribed an anti-dementia drug

Figure 22 | With regards to the audit standards for prescribing of anti-dementia drugs, SLaM performed better than the total national sample (TNS) for the majority of standards audited including the following standards

	SLaM	The national sample
Proportion of service users for whom a cognitive assessment was conducted prior to initiation of anti-dementia drug	94%	89%
Proportion of service users for whom existing medication was reviewed prior to initiation of anti-dementia drug	92%	78%
Documentation of pulse rate and blood pressure prior to initiation of drug	81%	68%
Documentation of blood pressure prior to initiation of drug	62%	43%
Documentation of ECG prior to initiation of drug	78%	55%
Carer's view sought for medication review prior to initiation of drugs	78%	74%
Family carer or care worker consulted at medication review within 6 months of starting medication	80%	75%
Adverse effect assessed at medication review for service users prescribed anti-dementia drugs for >12 months	72%	74%
Carer's view recorded at medication review for service users prescribed anti-dementia drugs for >12 months	79%	84%
Evidence of formal global (SLaM 65%; TNS 20%), functional (SLaM 40%; TNS 26%), behavioural (SLaM 30%; TNS 18%) and cognitive (SLaM 65%; TNS 62%) assessments within 6 months of starting dementia medication		

Papers

Bishara D, Taylor D (2014) – Adverse effects of clozapine in older patients: epidemiology, prevention and management. *Drugs and Aging*.
 Bishara Delia, Sauer Justin (June 2014) – Prescribing drugs for Alzheimer's disease in primary care – managing cognitive symptoms. *Drugs and Therapeutic Bulletin*.

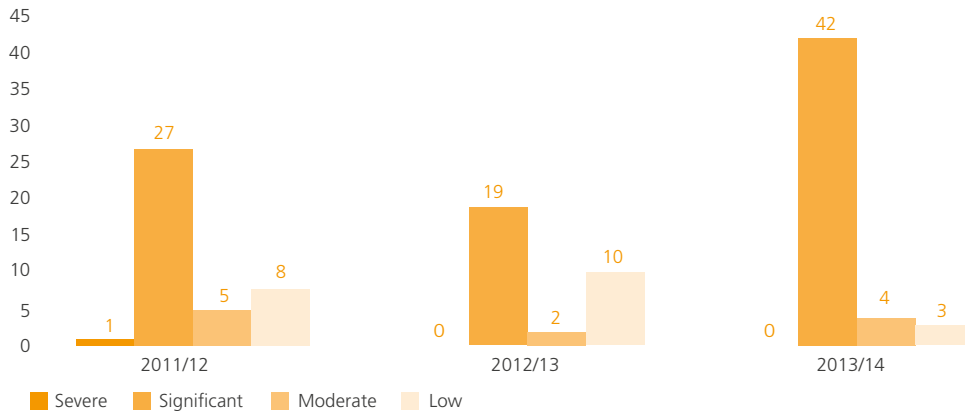
Bishara Delia, Harwood Daniel (2014) – Safe Prescribing of physical health medication in patients with Dementia. *International Journal of Geriatric Psychiatry*.
 Bishara Delia, Sauer Justin (October 2014) – Managing Behavioural symptoms associated with dementia in primary care. *Drugs and Therapeutic Bulletin*.

Medication, falls and violent incidents

We collect data on medication incidents and track these to be addressed through our staff training and our practice assurance measures. The graph below indicates that we have seen an increase in the reporting of medication incidents but

no severe incidents over the last two years. All medication incidents are now reviewed by a senior nurse and an action plan put in place designed to prevent further errors occurring.

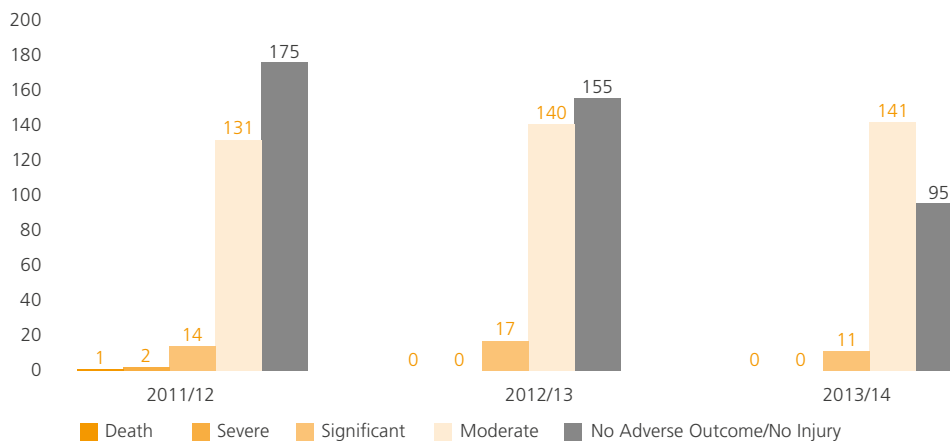
Figure 23 | Medication incidents by severity across MHOAD services over a three year period April 11–March 14



This graph shows data collected on falls recorded in our services. It is positive that we have seen a year-on-year reduction on both the number and severity of falls occurring. We have implemented

a new falls protocol to identify earlier those people who are at greater risk of falling and make sure we refer them to get the right support, for example physiotherapy.

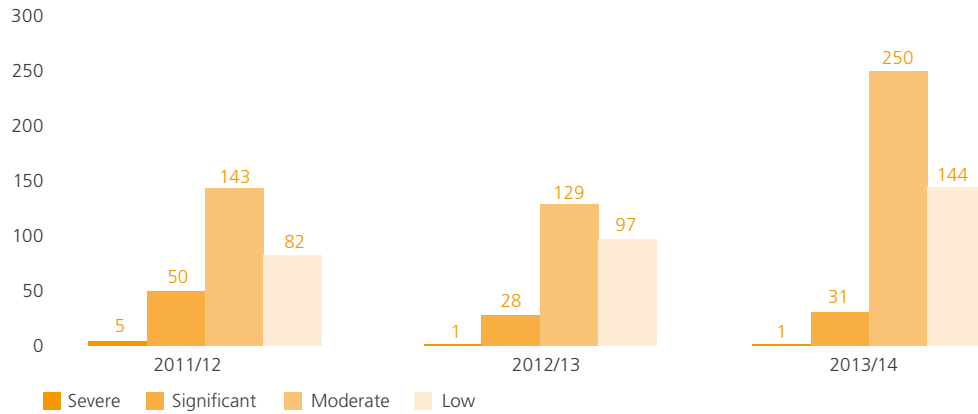
Figure 24 | Falls incidents by severity across MHOAD services



This final graph illustrates the increase of moderate and low instances of violence and aggression occurring on our units over the last three years, although the severe incidents are limited to one recorded per year. All staff receive

regular mandatory training in Promoting Safe and Therapeutic Services (PSTS) training, which has been specifically adapted for older adults with age related frailties, such as mobility problems.

Figure 25 | Incidents of violence and aggression by severity across MHOAD services over a three year period



Claire Jospeh, SUCAG Member at the Department of Health
reading about the new public health campaign for carers
[campaigns.dh.gov.uk/2014/12/30/
care-support-public-information-campaign-materials](http://campaigns.dh.gov.uk/2014/12/30/care-support-public-information-campaign-materials)



Education and training

As well as providing training placements for a wide range of professions, the CAG has developed an online training platform with materials to support the dissemination of good practice in dementia and psychosis in later life: The Dementia Training Centre (DTC).

This is an online resource that provides high quality education and training about dementia and aspects of old age mental health for health and social care professionals, care home managers and their care staff and voluntary sector organisations. The centre currently offers three e-learning packages that are accessible in the 'LearnZone' and through the King's College London Learning Hub. These are:

- working with non-cognitive symptoms of dementia
- pharmacological interventions for non-cognitive symptoms of dementia
- recovery focused practice in older people's services

The CAG is developing an e-learning package to improve the knowledge, skills and attitude of health care assistants providing evidence-based

direct care to people with dementia. The DTC also delivers face-to-face training on dementia care to care homes and in acute health care settings.

MSc and higher education

CAG staff have enrolled on, or completed, the MSc In Advanced Care in Dementia and the CAG has commissioned a number of profession-specific CPD events, including assessment of mobility process skills (AMPS) and dementia for Occupational Therapists.

Our Psychological and Psychotherapy leads deliver a range of teaching including a Clinical Psychology module to the D.Clin.Psych programme at the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) on psychological work with older peoples and workshops at the University of Sussex and IoPPN as part of the postgraduate diploma in Cognitive Behavioural Therapy.

Band 7 development programme

The CAG provides an intensive training programme for Band 7 team leaders The course

focuses on quality improvement techniques, the role of supervision and coaching to ensure that clinical staff provide safe and effective care. Participants are required to demonstrate an understanding and appropriate response to issues of performance and conduct with a special focus on 'difficult conversations'.

Care pathways

The CAG care pathways provide a publicly available benchmark which enables clinicians to be clear about the evidence based treatment and care. The transparency for service users and carers will help drive expectations regarding treatment plans. A supporting training programme for the associated outcome measures will promote routine evaluation of the pathways.

Dementia Care Mapping (DCM)

Dementia Care Mapping is an internationally recognised observational tool for assessing the quality of care in services for people with dementia. Over twenty senior staff members and clinicians have trained as Dementia Care Mappers by the University of Bradford. Three mappers are undertaking the Advanced Dementia Care Mapping course. DCM is now being embedded into our wards and units to drive service improvement.

Joint learning events with South West London and St George's Mental Health Trust

The CAG has established a joint learning forum with a neighbouring mental health Trust. The events provide an opportunity to share both organisations' knowledge and expertise in the mental health of older people. To date we have run seven events that have focussed on challenging behaviour, psychological care in the inpatient setting, recovery and involvement, falls management and the development of the Academic Health Science Network (AHSN) forum which is open to all senior clinicians and managers and adopts an interprofessional education approach.

King's Health Partners learning event for higher medical trainees

In partnership with the Medicine CAG, higher medical trainees learn about old age mental health and dementia. The content of the day is delivered by senior psychiatrists and geriatricians and aims to increase awareness about the interface between physical and mental health.

Medication management

Our CAG provides medication management training for inpatient, specialist care and community staff. This training promotes improved completion of electronic patient records and improves core standards for commencing and monitoring psychotropic medication.

Simulation training

As a CAG we recognise the value of simulation training in the translation of knowledge into direct clinical care. We have been working in partnership with the SLaM Simulation Team to develop and deliver a programme for specialist care to manage behavioural and psychological symptoms of dementia.

Samuel Akinton (right) completes a health check at a Black History Month celebration.



Sid Morris (SUCAG Member) and Sean Persaud (volunteer) reminiscing at the Cinema Museum



Valuing our staff

Effects on service user care

Studies have shown that satisfaction levels among hospital staff are closely linked to the quality of health care it provides. A study carried out at Imperial College London found that hospitals in England with lower mortality rates were more likely to have members of staff satisfied with the quality of care they provide. They demonstrated that staff satisfaction is correlated with organisational performance and the logical next question is about establishing whether happier staff provides better care or if better care creates happier staff.

Associations between various aspects of staff wellbeing and service user experience have been reported, mostly at whole-hospital or systems level. For example, the national staff and service user surveys have been compared with various service user outcomes. Research suggests situating staff experience (as well as service user experience) centre stage may be one of the best actions senior leaders can take. Analysis of the staff and service user experience surveys indicate seven staff

variables that are linked to good staff-reported experience. These are:

- a good local team/work group climate
- high levels of co-worker support
- good job satisfaction
- a good organisational climate
- perceived organisational support
- low emotional exhaustion
- supervisor support

Below are some of the key findings, in relation to the above seven variables, from the National Staff Survey from 2013. The Picker Institute was commissioned by 12 mental health trusts and the report presents our Trust's results in comparison to the average for the other mental health trusts. By listening to the feedback from this survey, we have been able to improve how we demonstrate that we value our staff, have improved communication and developed significantly our engagement with service users and carers.

Figure 26 | Staff satisfaction results compared to 11 other MHOAD services



Locally, we have developed a monthly email bulletin to keep staff informed of any changes, developments or events in the CAG. Over the last 12 months, we have developed the Leadership Council to which we have attempted to attract a wide group of managers, who have direct clinical responsibilities to be involved in decision making in the CAG.

The Leadership Council

Our Leadership Council provides consultation and advice on clinical, managerial and professional issues to the MHOAD CAG management executive to support, inform and influence decision making relating to clinical service delivery. This is delivered through short term work groups aligned to CAG

strategic objectives and operational work streams. The Council's aim is to empower our managerial and clinical leaders to be fully involved in the decision making of the CAG. We do this by driving the CAG to achieve the overall vision of being a leading provider of high quality clinical services for older people in south London. In doing so our mission is to support the tripartite strategy of King's Health Partners in the following ways:

- to be a local and national champion against age discrimination
- to improve the quality of our services
- to increase research activity
- to develop additional educational and training opportunities
- to work inclusively with other CAGs

The Nursing Council

Nurses are the largest professional group in the CAG delivering direct care to service users and their families who use our services. The CAG recognises the unique contribution of nurses who work in all of the wide range of services it provides. Nurses provide direct care to service users and we know that these relationships shape the person's experience of our services. Quality services rely on empowered nurses who have the knowledge and skills to deliver safe, effective and compassionate care.

The CAG's Nursing Council is a system of shared governance that provides a forum for nurses at all levels to influence and shape decisions to support excellent practice and compassionate care. Shared governance is simply a system of leadership that involves direct care nurses in the decision making process.

Traditionally, decisions that affect the way nurses practice in our CAG and our organisation, have followed a 'top down' approach. These decisions were made either in the formal Trust nurse executive meeting or in the formal CAG executive and related meetings and then fed back and actioned by the Head of Nursing, modern matrons and clinical service managers. This meant that nurses had little understanding of the rationale for the decisions that had a direct impact on them, and therefore their service users, as well as limited knowledge of the evidence that underpinned those decisions. As a result the nurses felt that the guidance around practice was constantly changing but had no real idea as to why this was happening.

The Council has worked hard as a group to think about how we can influence the way we practice to meet some of the nursing outcomes. We have worked on a number of things but wanted to try and do something that has a direct impact on our service users. As an example the Council has produced depot guidelines for the community psychiatric nurses working in our community mental health teams.



Our Nursing Council is more than a meeting that works to targets or work streams. It is a forum for nurses who work in different services, on different sites, in different boroughs to come together and share their passion for nursing. When we started we envisaged a fairly straightforward process of thinking about the outcomes and working towards meeting these. Our journey has brought nurses together to find their voices, start to hear each other's and to realise that they have the ability to influence and shape practice so that they are really empowered to deliver compassionate care to service users and their families. It has helped nurses redefine their worth, feel valued, appreciated and supported. Nurses have begun thinking about developing their practice and building an evidence base that will help sustain and move their profession forward to meet a challenging mental health and integrated

service agenda, including an all graduate profession, doing and achieving more for less and lastly, but most importantly, that enables nurses to deliver compassionate care that really makes a difference to service users' lives.

In the last year we also began capturing staff stories as seen through a film project with our Nursing Council and started our own CAG newsletter to share up to date information with our colleagues across the CAG, spread the good practice and research we are working on and help everyone feel more connected. The stories are in film and written format.

» To view one of our specialist care nurses stories online please copy and paste the following link into your web browser

www.patientvoices.org.uk/flw/0837pv384.htm



Qualitative research with our nurses



What our student nurses say about working in the CAG (an interview)

Why did you become a nurse?

Freya: I enjoyed the placements in different areas and with the Lambeth community mental health team, I felt like 'a proper nurse'. So much of my positive experience there was due to my mentor. When I moved over into older adults I realised the added complexity of physical and mental health problems, so you have to develop the skills to work in both areas. I loved the stories – there is so much to learn from older people.

Pat: My first placement was on AL1 (home treatment team) and now it feels like I don't want to be anywhere else. I had to go on my first assessment with my mentor who explained to the service users that I was a student. She said she felt

so comfortable with me and it is such an honour when people feel safe and comfortable in your company when they are unwell.

What about the skills you are learning?

Freya: You have to learn expert communication skills. I have never been so aware of the impact of not only what I say but how I say it. Everything you say has to have a well thought out purpose.

Pat: I am learning things I never would have from my ethnic background. Talking freely about one's mental health issues good or bad, is still very new to me. In the Black African community we don't often talk about things like mental health problems, so I have almost become a community advocate for doing just that.

I've nursed some amazing people whose life stories are beyond belief. One of my patients was a gentleman who helped set up the NHS, his story was just fantastic.

Claire Flanagan, Care Home Intervention Manager



My Dad always used to tell me "age is just a number, age is how you feel and how you live."

Geoff Ward, Ward Manager



Admin Council

Across all industries, administrative staff are often the 'face/voice' at the frontline of services. Within SLaM we are generally the first point of contact for service users, carers, external organisations and colleagues. The CAG recognises the importance of the administrative role in representing our services. The CAG also recognises the pivotal role and contribution of administrators which ensures business systems are in place to enable the smooth running of our services and its delivery.

The Admin Council is in the beginning stages of a journey towards shared governance based on the CAG Nursing Council model. Like the Nursing Council it provides a forum for administrators at all levels to influence and shape decisions to support best administrative, business and service delivery practices.

The very heart of mental health nursing is the 'therapeutic use of self'. It's about nurses' communication skills which are absolutely key in older adults services.

Vanessa Smith, Deputy Director Nursing & Inpatients



- providing professional supervision and oversight to our CAG's social work staff

In addition to this, an important part of the role is to develop our working relationships with local authority partners to ensure that these are as efficient and effective as possible.

If you're going to be a good nurse, you need to be able to look after the whole person.

Delores Williams, Modern Matron



Social care leadership

This year we were delighted to have appointed a social care lead within the CAG. This diverse role ensures that we have expert in-house guidance on:

- safeguarding adults and children
- the legal implications of the Mental Capacity, Mental Health and Care Acts
- Southwark and Lambeth Integrated Care (SLiC) programmes
- making sure that service users and carers are empowered to be part of our quality assurance, including preparation for Care Quality Commission (CQC) inspections

I chose Psychiatry because it had a bit more of an edge to it.

Liz Cort, Clinical Research Nurse





Academic research and innovations

In terms of research we have:

- increased our research capacity in basic science and clinical trials
- increased research funding through NIHR grants
- supported the development of a Biomedical Research Unit in dementia
- delivered high impact early phase trails in first-in-main therapies through delivering trials in minicycline
- made sure we have research being done by all the disciplines in the CAG

In the last two years the CAG has developed new services for older people with mental health needs, including a crisis service operating in the community, a specialist psychology and psychological therapy services, and a new service model in the provision of continuing care.

Dementia research covers the translational pathway from basic science discovery of therapeutic targets and potential agents through

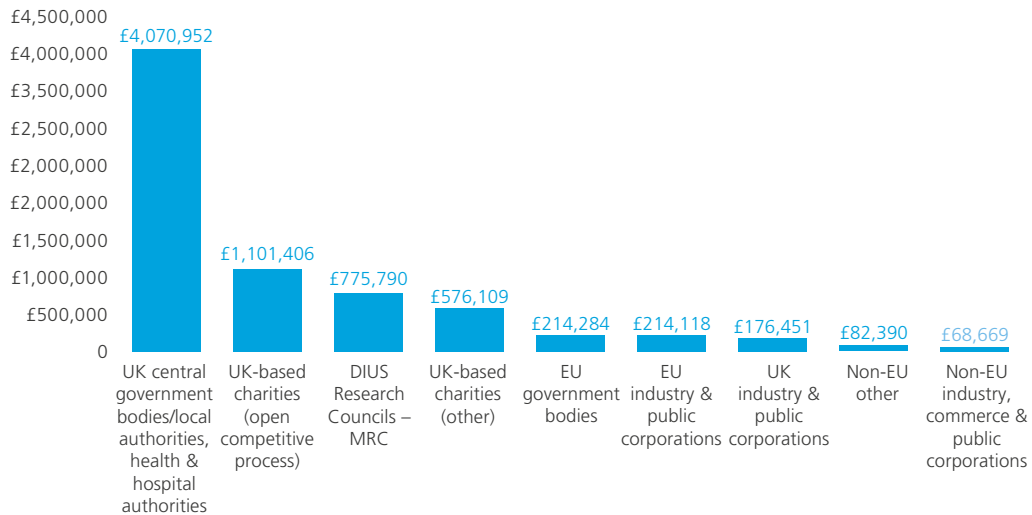
early stage first-in-man trials to leadership of multicentre Phase III clinical trials. We have world-leading researchers in dementia and in older people's psychosis, mood, anxiety and personality disorders research.

Our work in dementia identifies novel biomarkers to aid diagnosis and progression monitoring, new treatments in collaboration with industry partners and independent definitive efficacy and effectiveness trials, e.g. developing new MRI markers based on the shape of the hippocampus to help confirm the diagnosis of Alzheimer's disease at the earliest stage, and trialling potential course-modifying drugs in service users within our memory services.

About 50% of our service users have mental health diagnoses other than dementia and we are developing better evidence based drug and psychological treatments. For example, in service users who develop psychosis after the age of 60, we evaluate the advantages of antipsychotic drug treatment and using PET imaging to optimise drug dosing based on brain receptor occupancy.

Research income

Figure 27 | Shows the total research income for the last three years 2010/11–2012/13



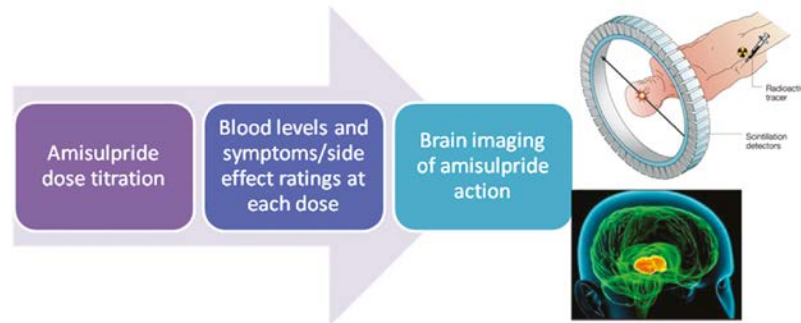
Some of our research projects

Optimising antipsychotic drug use in people with dementia

People with dementia are extremely susceptible to developing side effects when antipsychotic medication is prescribed for the treatment of psychosis and agitation. The 'Optimisation of Amisulpride Prescribing in Older People' study utilises a brain imaging technique which measures the action of the antipsychotic drug amisulpride in the brain, and combines this with information

on clinical outcome and blood levels to explore the underlying reasons for this sensitivity. We have been recruiting to the study for the past two years and have already established the minimum clinically effective dose required in people with Alzheimer's disease to reduce symptoms with minimal side effects. Once recruitment to the study ends (April 2015), dose-response relationships will be published in a definitive paper, to inform and guide prescribing.

Figure 28 | Optimisation of Amisulpride Prescribing in Older People study – brain imaging technique



Pilot paper

Clark-Papasavas C, Dunn JT, Greaves S, Mogg A, Brownings S, Nwosu B, Liu K, Marsden P, Joemon J, Cleij M, Kessler R, Howard R, Reeves SJ. (2014) Towards a therapeutic window of D2/3 occupancy for treatment of psychosis in Alzheimer's disease, with [¹⁸F] Fallypride PET imaging. *International Journal of Geriatric Psychiatry* 29(10):1001–1009.

Supporting grants: Guy's and St Thomas' Charity. 'Establishing the Reliability and Feasibility of [¹⁸F] Fallypride Imaging in Healthy Older Adults and Patients with Alzheimer's Disease'. 2010–2012.; National Institute for Health Research. 'Rationalisation of antipsychotic drug use in older people, using [¹⁸F]-Fallypride PET'. 2011–2016.

Change in cognition and activities of daily living during 12 months of trial treatment

In the DOMINO trial (Donepezil and Memantine in Moderate to Severe Alzheimer's Disease) we investigated the effects of stopping dementia drug treatment when service users had declined to the moderate to severe point as recommended by the National Institute of Clinical Excellence guidance. During a year of double blind treatment, service

users who were randomised to receive placebo instead of donepezil showed much greater cognitive and functional decline and were more likely to be admitted permanently to a nursing home. As a result of the trial, clinical practice with regard to continuing to prescribe dementia medication in severe dementia has changed. In our CAG services we now offer cholinesterase inhibitor treatment to all service users with Alzheimer's disease, regardless of dementia severity.

The graph in Figure 29 shows that cognitive ability (measured by the sMMSE) deteriorates fastest in service users whose dementia medication is stopped. Service users deteriorate less rapidly if their treatment is either continued, or changed

to a different medication (memantine), but they do best if both medicines are taken together. The second graph (Figure 30), shows a similar result when looking at a measure of activities of daily living (BADLS).

Figure 29 | sMMSE

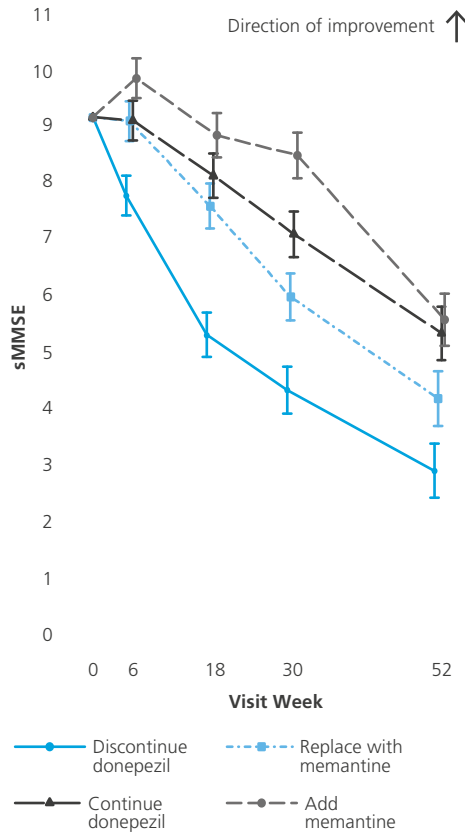


Figure 30 | BADLS

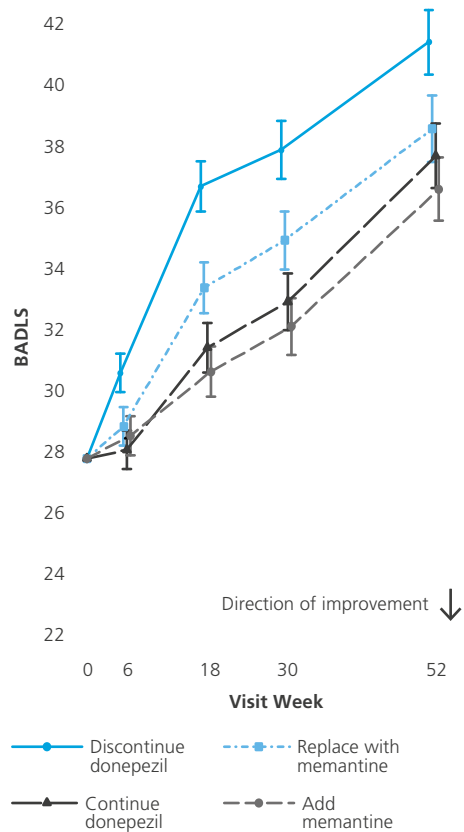
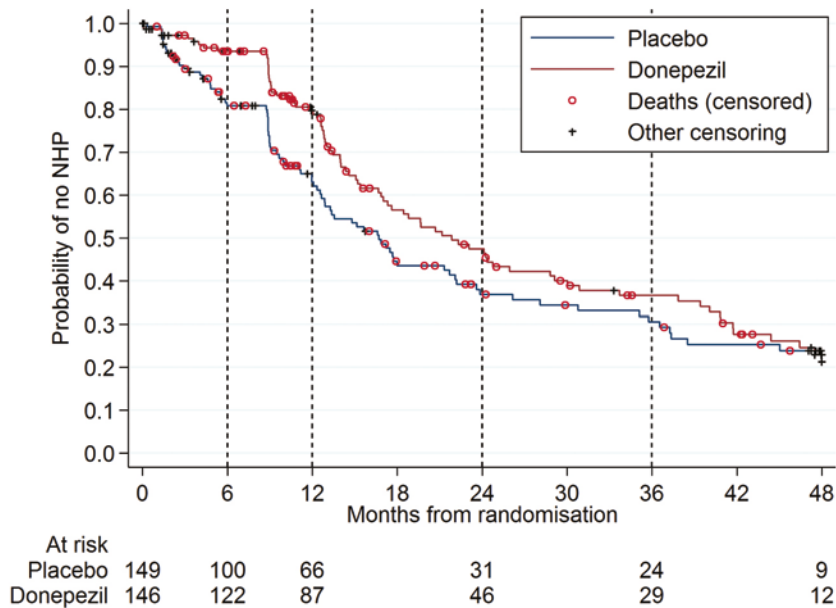


Figure 31 shows data on rates of admission to nursing home care collected over two years for people with dementia who receive medication

or placebo treatment. Medication delayed admission by about six months.

Figure 31 | Probability of independent living during four years of follow-up post-randomisation



Main paper

Howard R, McShane R, Lindsay J, Ritchie C, Baldwin A, Barber R, Burns A, Denning T, Finlay D, Holmes C, Hughes A, Jacoby R, Jones R, Jones RW, O'Brien JT, Passmore P, Sheehan B, Juszczak E, Katona C, Hills R, Knapp M, Ballard C, Brown R, Banerjee S, Onions C, Griffin M, Adams J, Gray R, Johnson T, Bentham P, Phillips P (2012) Donepezil

and memantine in moderate to severe Alzheimer's disease. *New England Journal of Medicine* 366 893–903.

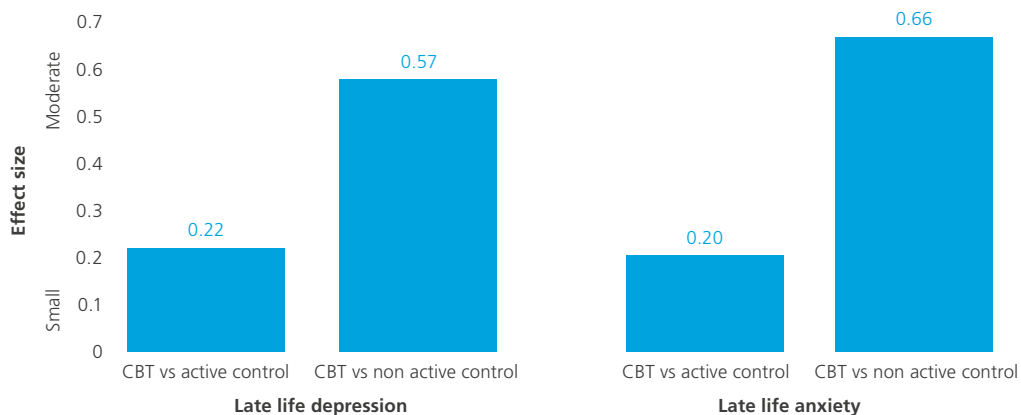
Supporting grant Medical Research Council. Donepezil and memantine in moderate to severe Alzheimer's disease: The DOMINO Trial.

Efficacy of psychological therapies with older people experiencing depression and anxiety

In a series of systematic reviews and meta-analyses, we investigated how helpful a form of talking therapy called Cognitive Behavioural Therapy (CBT) is for reducing anxiety and depression in older people. We found that CBT is helpful for reducing anxiety and depression if you compare it to receiving usual care or being on a waiting list (also called no-active controls; see Figure 32). The effect sizes were moderate in magnitude and were significantly in favour of CBT ($p < 0.0001$). However, there was no evidence that it was helpful when you compare it to placebo or other forms of treatments (also called active controls; see Figure 32). These effect sizes were

small in magnitude and were not significantly in favour of CBT ($p = 0.39$ and $p = 0.06$, respectively). In addition, we found that CBT for anxiety tends to be less helpful for older people than it is for younger people (based on the magnitude of the effect sizes found in these different populations). As a result of these studies, we have started to explore alternative forms of talking therapy for reducing anxiety and depression in older people. For example, in our CAG services we are currently exploring transdiagnostic CBT for co-occurring anxiety and depression, and mindfulness-based therapy for anxiety.

Figure 32 | Results of the systematic reviews and meta-analyses of CBT for depression and anxiety in older people



References

Gould, R.L., Coulson, M.C. & Howard, R.J. (2012). Cognitive Behavioural Therapy for depression in older people: A meta-analysis and meta-regression of randomized controlled trials. *Journal of American Geriatrics Society*, 60(10), 1817–1830.

Gould, R.L., Coulson, M.C. & Howard, R.J. (2012). Efficacy of Cognitive Behavioural Therapy for anxiety disorders in older people: A meta-analysis and meta-regression of randomized controlled trials. *Journal of American Geriatrics Society*, 60(2), 218–229.

Discussed in

Critical commentaries of both studies were included in the National Institute for Health Research's database of systematic reviews:

www.crd.york.ac.uk/CRDWeb/HomePage.asp

The CBT for anxiety study was included in a National Institute for Health and Care Excellence clinical guideline update:

www.evidence.nhs.uk/evidence-update-22

Understanding immune susceptibility and developing treatments for Alzheimer's disease

Recent work by our group and others has shown for the first time that 1–3% of people with late onset Alzheimer's disease have a change in their DNA in a gene called TREM2 or CSF1R, making them more vulnerable to developing the disease. Understanding how changes in DNA lead these genes to go wrong will help direct our efforts to find a treatment and may help us properly advise people on what it means if they or their families have the faulty gene.

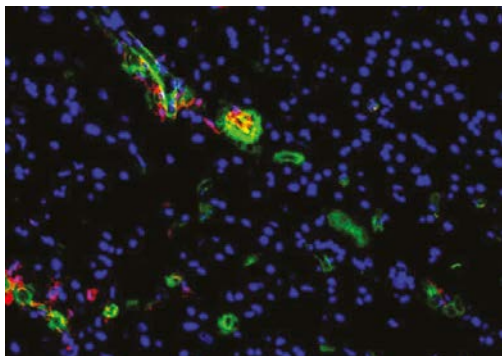
We know TREM2 and CSF1R are involved in controlling the activity of brain cells called microglia, which are part of the brain's immune system. These cells defend the brain against pathogens and are essential for controlling the healthy clearance of damaged cells as part of normal healthy ageing and during disease (Figure 33). This fits with growing evidence that the immune system is not only compromised in Alzheimer's disease but may even be contributing to the steady progression of disease.

We have started recreating these changes in cells in the laboratory to look for compounds which can overcome the problems these faulty genes cause. We then compare these laboratory tests with human tissue from the very rare but valuable

group of people we have already identified with these DNA changes.

We are also scanning the DNA of a further 100 immune genes in large numbers of people as we believe there may be other similar genes which function together in microglia and are involved in the same disease pathway. This work will further refine our choice of compounds to test.

Figure 33 | Microscope image of brain tissue from person who died of Alzheimer's disease. Note the characteristic plaques associated with disease (green) and the reduced number of microglial cells which are important for 'removing' plaques (red)



Main paper

Proitsi, P., L. Sang Hyuck, K. Lunnon, A. Keohane, C. Troakes, S. Al-Sarraj, S. Furney, H. Soininen, I. Kłoszewska, P. Mecocci, M. Tsolaki, B. Vellas, S. Lovestone on behalf of the AddNeuroMed Consortium and A. Hodges (2014) Alzheimer's disease susceptibility variants in the MS4A6A gene

are associated with altered levels of MS4A6A expression in blood.

Neurobiology of Aging 35(2): 279–290.

Supporting grants

Lilly Research Awards Program (LRAP), application entitled: An integrated systems view of disease in Alzheimer's disease patients harbouring rare risk variants in TREM2 (2014–2016).

Alzheimer's Society PhD studentship, application entitled: Functional characterisation of rare risk variants in immune genes associated with Alzheimer's disease (2014–2017). ARUK Pilot Grant, application entitled: Rare variants in inflammatory pathways in Alzheimer's Disease (2013–2015).

Understanding reduced life expectancy in people with severe mental illness

The Clinical Record Interactive Search (CRIS) was set up in 2008 with funding from the National Institute for Health Research. CRIS is a groundbreaking database of anonymised information on service user care in SLaM. Research using CRIS information has focused particularly on the physical health of people with mental disorders, highlighting for example the substantial loss of life expectancy in people with disorders such as schizophrenia and bipolar disorder, which is now

a major national priority in mental health policy. More recent work has focused on particular health issues, including cancer – demonstrating that people with mental disorders do not appear to receive delayed diagnosis, but do still have worse survival after the cancer is detected.

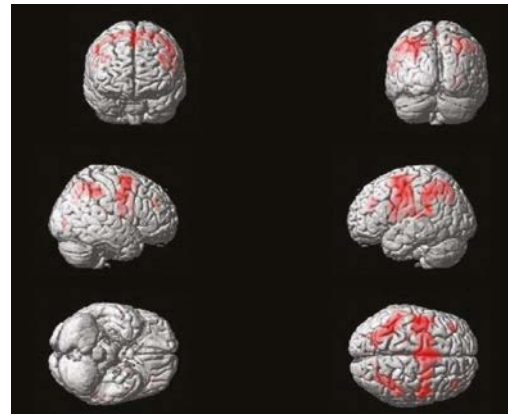
Key references

Stewart R, Soremekun M, Perera G, Broadbent M, Callard F, Denis M, Hotopf M, Thornicroft G, Lovestone S. The South London and Maudsley NHS Foundation Trust Biomedical Research Centre (SLaM BRC) Case Register: development and descriptive data. *BMC Psychiatry* 2009; 9: 51.

Chang C-K, Hayes RD, Perera G, Broadbent MTM, Fernandes AC, Lee WE, Hotopf M, Stewart R. Life expectancy at birth for people with serious mental illness, substance use disorders, and depressive disorders from a secondary mental health care case register in London, UK. *PLOS One* 2011; 6(5): e19590.

Chang C-K, Hayes RD, Broadbent MTM, Hotopf M, Davies E, Møller H, Stewart R. Mental disorders, stage of cancer at diagnosis and subsequent survival. *BMJ Open* 2014; 4: e004295.

The impact of memory training in early stage dementia



This research involves assessing the clinical efficacy of memory training, as well as designing and conducting clinical trials of cognitive training tools in early Alzheimer's disease. Initial pilot data demonstrated that service users with early Alzheimer's disease remained able to use mnemonic strategies to improve their working memory. Subsequently, we conducted a small randomised controlled trial to show that a novel, simple and effective strategy based memory training intervention based on 'chunking', leads to improvements in both trained and untrained clinical measures of cognitive function. Moreover, fMRI brain scans reveal a significant reduction in activation in the executive cortical

network, indicating increased neural efficiency following training.

Based on these promising results larger trials of computerised cognitive training are planned, with the aim of integrating cognitive training into clinical practice as an affordable, scalable and non-invasive method for improving cognition in Alzheimer's disease.

Key references

Huntley, J.D, Bor, D., Hampshire, A., Owen, A. & Howard, R.J. Working memory task performance and chunking in early Alzheimer's disease. *Br J Psychiatry* 198, 398–403 (2011).

Huntley J.D., Gould R.L., Liu K, Smith M, Howard R.J. Do Cognitive Interventions improve general cognition in Dementia? – A Meta-analysis and Meta-regression. Huntley JD, et al. *BMJ Open* 2015;5:e005247. DOI:10.1136/bmjopen-2014-005247 3.

Funding

Dr Huntley has been supported by an MRC Clinical Research Training Fellowship (Grant number G0901982) and an NIHR Academic Clinical Lectureship.

Mind before matter: do negative thoughts increase risk of Alzheimer's disease?

Researchers from the Institute of Psychiatry, Psychology & Neuroscience (IoPPN) at King's College London have proposed that repetitive negative thinking (RNT), a common symptom of many psychological disorders, may increase the risk of developing Alzheimer's disease.

Until recently, research into Alzheimer's disease has focused on how physical factors are linked to the onset of symptoms. However, scientists at the IoPPN suggest that there are psychological factors that make a person more vulnerable to Alzheimer's disease and that these factors occur *before* any physical indicators of the disease emerge.

In an article published in the *Journal of Alzheimer's Disease*, the researchers argue that a habit of negative thinking over a prolonged period of time (RNT) can have a harmful effect on the brain's capacity to think, reason and form memories. RNT is a common behaviour in people suffering from depression, anxiety, sleep disorders, post-traumatic stress disorder, and life stress, which are themselves associated with increased risk of Alzheimer's. RNT can occur without us being consciously aware of it and consumes our finite capacity of brain resources. Importantly, RNT also

triggers a physical stress response in the brain, which over a prolonged period of time may cause damage and reduce the brain's resilience to Alzheimer's disease.

Robert Howard, Professor of Old Age Psychiatry and Psychopathology at the IoPPN, says: "Treatments that reduce RNT exist, and we believe that they may reduce the risk of Alzheimer's disease. Further research is needed to verify this concept however our new proposal offers a promising line of scientific investigation to reduce the heavy societal burden posed by Alzheimer's disease."

Dr Natalie Marchant, Lecturer in Old Age Psychiatry at the IoPPN, King's College London, says: "We propose that the way that we think may impact our risk for developing Alzheimer's disease. If future research supports this hypothesis this would have implications for the treatment of the disease through psychological interventions."

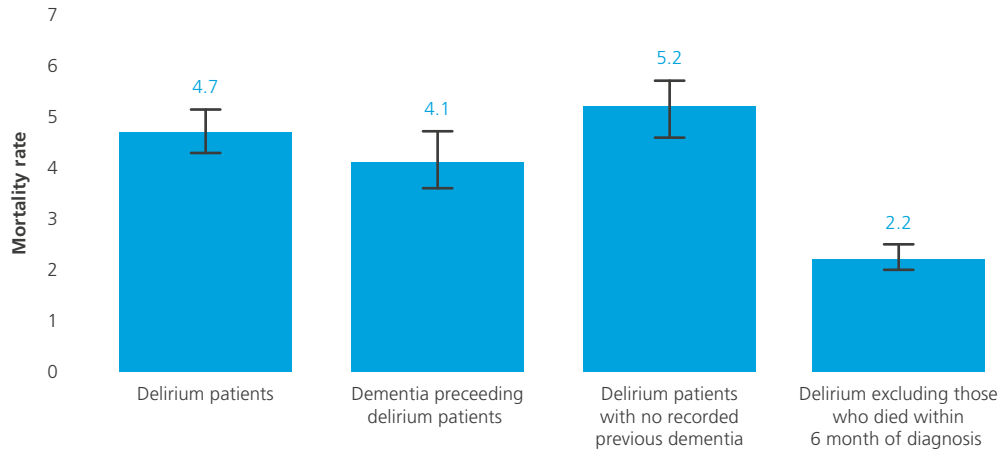
Paper reference: Natalie L. Marchant and Robert J. Howard "Cognitive Debt and Alzheimer's Disease" published in *Journal of Alzheimer's Disease*. DOI: 10.3233/JAD-141515.

Predictors of mortality for people aged over 65 years receiving mental health care for delirium: a retrospective survival analysis

Using SLaMs anonymised Clinical Record Interactive Search (CRIS) facility we investigated mortality rates and predictors of mortality following delirium in older patients. Standardised mortality rates (SMRs) were calculated, and predictors of survival were investigated including demographic factors, health, cognitive function and a diagnosis of dementia.

Older people with delirium were found to have a mortality rate that was 4.7 times higher than the general population (95% CI: 4.3–5.1). Mortality rates were highest (5.2 times higher than the general population: 95% CI: 4.6–5.7) for patients with delirium without prior dementia, and 4.1 times more likely: 95% CI: 3.6–4.7) for patients with a history of dementia which precedes delirium.

Figure 34 | Comparison of Standardised Mortality Rates for different cohorts of delirium patients compared with the general population (ONS, 2011)



Significant predictors of mortality included older age, male gender, white (compared with non-white) ethnicity, and physical ill-health and functional impairment as measured by the Health of the Nation Outcome Scale (HoNOS). No mortality associations were found with cognitive function, dementia, or psychological symptoms. When people who died within six months of a delirium diagnosis were excluded, the mortality rates reduced to 2.2 (95% CI: 2.0–2.5) which may indicate that people with delirium often die within the acute phase of their physical illness.

Conclusions: mortality risk is high in people diagnosed with delirium, especially where the patient does not have a prior history of dementia and should also consider additional demographic risk factors.

Paper

Ward G, Perera G and Stewart R. (2014). Predictors of mortality for people aged over 65 years receiving mental health care for delirium in a South London Mental Health Trust, UK: a retrospective survival analysis. *International Journal of geriatric Psychiatry*. Oct 2014; Epub ahead of print.



Our local and global influence

Dr Lia Ali	National Association of Primary Care Council BBC Academy for their Black, Minority, Ethnic Talent programme	Consultant in the Psychiatric Liaison Service for Older Adults #ExpertVoices – a blogger for The Mental Elf and is engaged in work for eHealthInsider, a leading industry digital health media outlet
Delia Bishara	Alzheimer's Society	Consultant Pharmacist for Older Adults – advisor for the Alzheimer's Society factsheets on medication: Use of Donepezil, Galantamine, Rivastigmine and Memantine in Alzheimer's Disease www.lambethccg.nhs.uk/news-and-publications/meeting-papers/south-east-london-area-prescribing-committee/Documents/Shared%20Care%20Protocols/Dementia%20Medication%20Guidelines%20APC%20Oct%202013.pdf
Steve Boddington	Department of Health	Expert Reference Group for Improving Access to Psychological Therapies for Older People Past chair of the Faculty of Psychology for Older People (within the British Psychological Society's Division of Clinical Psychology)
Dr Daniel Harwood	NHS England	Dementia Ambassador for the London Region working with CCGs to improve rates of diagnosis and post diagnostic support services for people with dementia Also sits on the Royal College of Old Age Psychiatry Executive Committee
Professor Robert Howard	National Institute for Health Research (NIHR)	Health Technology Assessment Commissioning Board

Dr Tony Rao	All Party Parliamentary Group on Alcohol Misuse, Alcohol Concern, Drugscope and the Institute of Alcohol Studies	National Advisor on older people and alcohol misuse/ dual diagnosis advisor to AddAction on monitoring the implementation of national projects being delivered by the voluntary sector
Dr Justin Sauer	Clinical Commissioning	Use of Donepezil, Galantamine, Rivastigmine and Memantine in Alzheimer's Disease www.lambethccg.nhs.uk/news-and-publications/meeting-papers/south-east-london-area-prescribing-committee/Documents/Shared%20Care%20Protocols/Dementia%20Medication%20Guidelines%20APC%20Oct%202013.pdf
Vanessa Smith	Department of Health NHS Protect	Making a Difference In Dementia: Nursing Vision and Strategy Clinically related challenging behaviour – prevention and management
Dr Amanda Thompsell	NICE	Acted as Vice Chair for the NICE Guidance Development Group on medication in care homes Also sits on the Royal College of Psychiatry's Executive Committee

Acknowledgement and thanks

And none of the exciting and vital work we have covered in this booklet could be achieved without our staff, service users and carers. Their tireless commitment to continually learning, developing and improving our services, is what makes our CAG such an important part of SLaM.

We also want to thank all of our many valued partners who have and continue to support our specialist work with older adults and those experiencing dementia.

From our Local Authority partners in Croydon, Lambeth, Lewisham and Southwark Council's and Clinical Commissioning groups to our agency friends in the voluntary sector, this year we have received unprecedented backing to achieve some great results. We have a whole series of

partnership events planned for 2015 to further develop our existing work and be part of building stronger and more supportive communities for all older adults, people with dementia, their carers, friends and families across our four boroughs.

A special thanks to

Patient Voices, for work on our stories and to the cartoonist Kipper Williams for his images reproduced from the Community Links excellent report "Looking forward to Later Life".

www.community-links.org/our-national-work/publications/looking-forward-to-later-life

CAG Editorial Team: Cha Power, Steve Boddington, Cathi Francis, Dan Harwood and Helena Taylor-Knox.

Front page image: Nicola Chanot and Winifred Blackie at a Black History Month Celebration at the Copleston Centre, Southwark

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