The National Audit Office undertook a self-assessment census of Community Mental Health Teams for Older People (CMHTs) between September and December 2006. The overall findings are presented in the National Audit Office report *Improving Services and Support for People with Dementia*. Summary findings, including locally benchmarked results by individual team, will be sent to those teams that responded to our survey within a few weeks of our report's publication.

The National Audit Office received 371 responses to its census of CMHTs, a response rate of 75 per cent of all teams as listed in the Department of Health's older people's mental health mapping exercise.[1] The deadline for the survey was 22 December 2006.

1 Barnes D and Lombardo C (2006) *A Profile of Older People's Mental Health Services: Report of Service Mapping 2006*, Durham University.

Key findings

Section 1: General information

- Fifty-six per cent of CMHTs considered themselves to be integrated and 47 per cent had a joint management structure.[2] 29 per cent had some form of joint health and social care funding arrangements in place.
- The number of people aged 65 and over in the population area covered by the teams ranged from 1,000 to 235,000 with a mean number of 21,822. The number of people with dementia under the care of CMHTs as at 1 November 2006 ranged from 5 to 1500 with a mean of 275.
- Contrary to good practice guidance[3] some CMHTs had no access to the skills of key health and social care staff. See Table A.

A A number of CMHTs could not access skills of key recommended health and social care professionals

Health/Social Care Professional	% of CMHTs with no access to their skills
Community support or Support Time & Recovery (STaR) worker	51
Team leader/administrator/manager	36
Clinical psychologist	29
Social Worker	25
Occupational Therapist	5

- Seventy-six per cent of CMHTs worked closely with a memory clinic, and 83 per cent worked closely with a day hospital.
- The mean total budget for CMHTs was £512,000 (however only 182 teams responded to this question).
- Forty-two per cent of CMHTs estimated that they spent between 41 per cent and 60 per cent of their budget on dementia care. Thirty-two per cent estimated this at between 61 per cent and 80 per cent of their budget.

Section 2: Information and advice to people with dementia and carers

- On communicating a diagnosis of dementia see Table B.

B CMHTs do not always tell the person with suspected/confirmed dementia their diagnosis

Approach to communicating diagnosis of dementia	% of CMHTs
Always tell service user as soon as dementia is suspected	11
Always tell service user, but only when diagnosis is definitely confirmed	29
It varies – in some cases, may decide not to tell the service user	60

- Where a service user was informed of their diagnosis, 70 per cent of CMHTs did not send the service user a letter about the diagnosis, or they only did so in a minority of cases.
- Ninety-eight per cent of CMHTs had an identified key worker or care manager for each person with dementia under their care and 66 per cent of CMHTs had done work to raise public awareness of dementia.
- Many CMHTs did not have a policy on the sort of advice and information they should be giving to people with dementia and their carers. See Table C.

C Many CMHTs had no policies on the information or advice to give to people with dementia and their carers

Information/advice on the following areas	% of CMHTs with NO policy on this area
Understanding the likely progression of the disease	53
Understanding the options available for ongoing care in the community	49
Understanding what support networks are available	48
Understanding what financial entitlements or benefits there are	47
Preparing for losing mental capacity (for example, making living wills)	44
How to get a review of a care package	38
Information about how to apply for continuing NHS care	36
Who to contact if they need help	28

2 Joint management structure means someone managing a team of both social care and health professionals.
3 The Royal College of Psychiatry (2004) *Raising the Standard. Specialist services for older people with mental illness* Report of the Faculty of Old Age Psychiatry

Section 3: The provision of dementia services

- Seventy-eight per cent of CMHTs had a defined care pathway for people with dementia and 87 per cent had a protocol for the diagnosis, treatment and care of people with dementia; however half of CMHTs said these protocols were not always adhered to.
- Forty-six per cent of CMHTs were using the Single Assessment Process (SAP) documentation for people with dementia; 91 per cent were using the Care Programme Approach (CPA) documentation and 18 per cent were using the Effective Care Coordination (ECC) documentation.
- CMHTs were presented with a range of identified barriers or bottlenecks to delivering effective care for people with dementia. They were asked to assign each barrier/bottleneck a score between one (lowest) and seven (highest) in terms of how important a barrier they felt is was and how well they were achieving against it in their local area. Average scores are presented in Table D.

D Importance of and achievement against barriers faced by CMHTs in delivering effective care for people with dementia

Barrier/bottleneck	Average rating by CMHTs (1-7)	
	Importance as a barrier	Achievement in your area
Lack of care home beds/places	5.75	3.37
Lack of social services respite places	5.53	3.49
Lack of rehabilitation services	5.44	3.05
Difficulty discharging from acute psychiatric wards	5.42	3.93
No services for young onset dementia	5.40	3.14
Lack of joint funding between health and social services	5.35	2.87
Lack of joint working between health and social care agencies	5.29	4.44
Poor understanding by GPs	5.05	4.10
Poor understanding by social services	5.04	4.32
Lack of joint working between other organisations	4.77	4.14
Difficulty discharging from acute physical wards	4.74	3.66
Lack of joint working between management of acute and mental health trusts	4.62	3.31
Lack of joint working between geriatric and mental health specialties	4.54	3.90
Lack of a day hospital/outreach services	4.59	4.20
Lack of access to geriatric healthcare services	4.43	3.91
Waiting time to obtain an MRI/CT scan (or other barriers to early diagnosis)	4.32	3.98
Inappropriate admissions to acute physical wards	4.20	3.74
Inappropriate admissions to acute psychiatric wards	4.21	4.41
No memory clinic	3.89	4.93

- There was a general consensus on what would generate financial savings and what would lead to no savings/ increased costs for the NHS and social care in the provision of dementia services, see Tables E and F.
- CMHT coordination was deemed to be good or excellent with local authority social services in 83 per cent of cases, 74 per cent with primary care and 72 per cent with voluntary sector organisations. 64 per cent had little or no coordination with ambulance services, 50 per cent with younger adult psychiatry services and 49 per cent with elderly care medicine.
- Twenty-nine per cent of CMHTs had formal outreach arrangements with nursing/residential care homes (59 per cent had informal arrangements). Nineteen per cent had formal outreach arrangements with A&E departments (25 per cent had informal arrangements).
- Fifty-eight per cent of CMHTs worked with acute trusts to manage discharge arrangements; 61 per cent were aware of a discharge coordinator in each acute trust with which they work.
- The majority of CMHTs felt joint working between different agencies would bring major benefits in terms of improving dementia care. See Table G.
- CMHTs had a mixed response to what the impact of better identification and diagnosis of dementia would have on the costs incurred by different groups. See Table H.

E Main factors which CMHTs believe would generate savings in dementia care to the NHS and social services

Factor	% of CMHTs agreeing
Improved discharge procedures from acute psychiatric wards	81
Improved discharge procedures from acute physical wards	79
Better joint working	77
More support for people in their own homes	75
Home treatment teams	75

F Main factors which CMHTs believe would generate no savings/increase costs in dementia care to the NHS and social services

Factor	% of CMHTs agreeing
Improved memory clinic provision	41
Earlier diagnosis and intervention	33
Identifying dementia in people with other illnesses and finding suitable facilities for them	33
More local authority beds/places	30
Joint funding between health and social services	25

G The extent to which CMHTs believe joint working between different agencies can bring benefits in terms of improving dementia care

Area	% of CMHTs believing joint working would bring major benefit here	% of CMHTs believing joint working would bring some benefit here
General support and well-being for people with dementia	86	13
Avoiding unnecessary acute bed use	79	17
Staff morale	73	24
Early interventions for people recently diagnosed with dementia	72	23

H The impact that CMHTs believe better identification and diagnosis of dementia will have on costs to different groups

Group	% of CMHTs believing costs will increase	% of CMHTs believing costs will decrease
Memory clinics	65	12
Old age psychiatrists/CMHT	62	14
Social services	46	19
GPs	43	21
Nursing/residential care homes	27	32
People with dementia/carers	23	36

- CMHTs were asked to state the number of individual places they had for people with dementia in various care settings. Average numbers of places are shown in Table I.

I The average number of individual places available locally for people with dementia

Care setting	Average number of places
Nursing/residential care homes	120
Day centres	34
Long stay mental health wards	19
Acute trusts (specialist dementia services only)	17
Dementia assessment/admission wards	16
Rehabilitation services	7
Intermediate care	7

- The average waiting time for a CT scan for patients with suspected dementia was 7.36 weeks, for an MRI scan it was 10 weeks.

Section 4: Therapies and interventions

- In terms of prevention, less than half of CMHTs regularly offer any intervention to prevent dementia. See Table J below.
- CMHTs have a clear preference for particular interventions in screening, diagnosis and assessment of dementia, with MMSE the most popular. See Table K opposite.
- The majority of CMHTs regularly use cholinesterase inhibitors to treat early and mid stage Alzheimer's disease but not other forms of dementia. See Table L opposite.
- The majority of CMHTs do not use memantine to treat dementia. See Table M opposite.
- Structured group cognitive stimulation for dementia was used regularly by 36 per cent of CMHTs in early stage dementia, by 33 per cent in mid stage and by 20 per cent in late stage.
- Around one fifth to one third of CMHTs used anti-psychotic drugs regularly for people with dementia and mild behavioural disturbances or mild psychotic symptoms. This increased to between two thirds to three quarters for people with dementia and severe behavioural disturbances or psychotic symptoms.

J Interventions offered by CMHTs to people in all care settings in their area to prevent dementia

Intervention	Yes, used regularly %	Only used occasionally %	No %	Don't know %
Advice or treatment for hypertension or other vascular risk factors	46	16	7	32
Statins	32	16	12	40
Non-steroidal anti-inflammatory drugs	6	17	26	51
General population screening	6	14	36	44
Hormone replacement therapy	4	14	28	54
Genetic counselling	1	32	27	41
Vitamin E	1	18	27	55

K Interventions offered by CMHTs to people in all care settings in their area for the screening, diagnosis and assessment of dementia

Intervention	Yes, used regularly %	Only used occasionally %	No %	Don't know %
Mini Mental State Examination or MMSE	97	2	0	1
Physical assessment	78	16	3	3
Memory clinic assessment for those with mild cognitive impairment	67	14	16	4
Occupational therapy assessment of functional ability	67	27	6	1
CT scan	66	30	1	3
GP assessment of cognition	37	39	9	15
Abbreviated Mental Test Score (AMTS)	28	41	21	10
MRI scan	26	64	5	6
Cambridge Cognitive Examination (CAMCOG)	21	37	24	17
6 item Cognitive Impairment Test (CIT)	17	34	32	16
Alzheimer's Disease Assessment Scale (ADAScog)	8	33	38	21
7 minute screen	4	19	37	40

L Use of cholinesterase inhibitors by CMHTs to treat dementia

Cholinesterase inhibitor for:	Yes, used regularly %	Only used occasionally %	No %	Don't know %
Alzheimer's disease in early stage	65	24	6	5
Alzheimer's disease in mid stage	88	8	0	4
Alzheimer's disease in late stage	34	52	11	3
Other forms of dementia in early stage	21	53	18	9
Other forms of dementia in mid stage	32	49	12	7
Other forms of dementia in late stage	12	49	28	10

M Use of memantine by CMHTs to treat dementia

Cholinesterase inhibitor for:	Yes, used regularly %	Only used occasionally %	No %	Don't know %
Alzheimer's disease in early stage	7	22	58	14
Alzheimer's disease in mid stage	8	34	45	13
Alzheimer's disease in late stage	13	40	34	14
Other forms of dementia in early stage	4	18	58	20
Other forms of dementia in mid stage	4	23	53	20
Other forms of dementia in late stage	5	24	51	20

- CMHTs use a wide range of treatments for non-cognitive symptoms. See Table N.

N CMHTs use a wide range of treatments for non-cognitive symptoms

Treatment	Yes, used regularly %	Only used occasionally %	No %	Don't know %
Cholinesterase inhibitors for Alzheimer's disease	69	19	6	6
Antidepressants	68	29	1	2
Behavioural therapy	38	51	10	2
Cholinesterase inhibitors for other dementias	29	48	14	9
Therapeutic use of music and/or dancing	26	43	27	4
Palliative treatments	16	45	22	17
Multi-sensory stimulation	12	42	40	6
Massage	6	39	46	9
Aromatherapy	5	36	54	5
Pet-assisted therapy	5	37	51	7

- When it comes to supporting people with dementia to stay at home, insufficient funding prevents 23 per cent of CMHTs from providing respite care, 20 per cent from providing extra care housing and 19 per cent from providing day care. See Table O.

O Interventions provided by CMHTs to support people with dementia to stay at home

Intervention	Yes %	No, service is not available %	No, service is available but insufficient funding to provide it %
Community psychiatric/mental health nurse	97	0	3
Meals of Wheels	83	11	4
Occupational Therapy	83	4	12
Regular needs assessment	79	8	5
District nurse	76	7	4
Day care	74	3	19
Community support workers	72	14	11
Respite care	67	6	23
Specific home care provision from a dedicated team	45	42	12
Telecare	34	31	11
Extra care housing	33	22	20

Section 5: Training and human resources

- Most CMHTs provide training in dementia care (largely informal with some formal) to healthcare staff, carers and people with dementia. See Table P.

P Most CMHTs provide some sort of training in dementia care

Training provided by CMHT to:	% of CMHTs providing informal training	% of CMHTs providing formal training
Self-care	75	14
Informal/family carers	62	36
Nursing or residential care home staff	57	39
Primary care staff, such as GPs and practice nurses	56	22
Community based nursing	54	27
General hospital staff	38	26

- Training to general hospital staff is less common, with 36 per cent of CMHTs providing no training at all to these staff.
- Domiciliary care staff receive less training from CMHTs. See Table Q.

Q Domiciliary care staff receive less training from CMHTs than healthcare staff, carers and people with dementia

Training provided by CMHT to:	% of CMHTs providing informal training	% of CMHTs providing formal training
Local authority staff	47	26
Voluntary sector staff	43	34
Agency staff	39	15

- Some 90 per cent of CMHTs make us of the specialist knowledge and skills of Alzheimer's Society staff and other voluntary bodies such as Age Concern.
- Almost half of CMHTs feel that nursing staff in acute secondary care are inadequately trained regarding the treatment, care and support for people with dementia. Over a third felt the same about medical staff in acute secondary care and homes care social services workers. See Table R.

R CMHTs generally believe that workers in their local area are adequately trained regarding the treatment, care and support of people with dementia

Training provided by CMHT to:	Training is adequate or better %	Training is inadequate %
Community based nursing staff: Community psychiatric/ mental health nurses	98	2
Staff in nursing/residential care homes	97	3
Community based nursing staff: District nurses	96	17
Primary care staff, such as GPs and practice nurses	70	26
Home care social services workers	61	36
Medical staff in acute secondary care	59	36
Nursing staff in acute secondary care	47	49