CAMBRIDGE LOCAL HEALTH PARTNERSHIP

Date: Thursday, 23 October 2014
Time: 12.00 pm
Venue: Committee Room 1 - Guildhall
Contact: Graham Saint **Direct Dial:** 01223 457013

AGENDA

1 APOLOGIES

2 PUBLIC QUESTIONS

This is an opportunity for members of the public to ask a question or make a statement to the Partnership. Please refer to the Public Participation section at the end of this agenda.

3 MINUTES AND MATTERS ARISING *(Pages 5 - 8)*

To approve the minutes of the meeting held on 3rd July 2014.

4 PRESENTATION *(Pages 9 - 24)*

Wendy Quarry, Joint Strategic Needs Assessment (JSNAs) lead for Cambridgeshire Public Health will outline the main findings from recent JSNA reports that include:
Final JSNA Report - Carers 2014
Final JSNA Report - Older People's Mental Health 2014
Final JSNA Report - Primary Prevention of Ill Health in Older People 2014
And will seek the views of members about issues for future JSNAs.

A paper showing the findings of the above reports, for background, is attached.

5 REVIEW OF SELECTED PUBLIC HEALTH OUTCOME FRAMEWORK INDICATORS *(Pages 25 - 34)*

Jill Eastment, Public Health Analyst at Cambridgeshire County Council, will provide some additional information to the Public Health Outcomes

Framework indicators, households that experience fuel poverty and hip fractures in people aged 65 and over, that members asked for at the last meeting.

A background paper is attached.

6 UPDATES

Health and Wellbeing Board
The last meetings of the Health and Wellbeing Board were on:

- **11 September 2014** where progress with a Better Care Fund was discussed. New guidance recently issued by Central Government requests that plans be resubmitted by 19th September 2014. These are to be signed off by Board Members. Papers can be found here - http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=10274

- **2 October 2014**. Papers can be found here – http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/Meeting.aspx?meetingID=940

  The agenda includes:

  i. Domestic Abuse Strategy Report
  ii. Children Safeguarding Board Annual Report
  iii. NHS England Strategy item
  iv. CCG Commissioning Intentions
  v. JSNA Transport & Health Briefing Paper

7 DEVELOPING LOCAL ACTIONS

Jo Dicks, Cambridge City Council lead officer for action on energy, will provide a view on the extent of fuel poverty in Cambridge and outline some of the local schemes being delivered through partnerships that are looking to improve energy efficiency. Jo will also discuss with members opportunities for the health sector to assist this work.

In particular the presentation will cover:

- Who are our target groups and communities
- How we can assist our target groups

- What is our current and potential future funding streams
- What will the shape of our future partnerships and engagement be like

8 PROGRESS ON OUTSTANDING ACTIONS

i. Update on discussion at the last meeting about how local advice services can contribute an improvement in well-being locally. A proposal is being prepared for piloting an outreach CAB advice session at East Barnwell practice. Rachel Talbot, Chief Executive of Cambridge CAB will be in attendance to discuss this developing project and to seek the views of members.

9 DATE OF NEXT MEETING

29 January 2015 at 12 noon in the Guildhall.

Information for the public

Public attendance
You are welcome to attend this meeting as an observer, although it will be necessary to ask you to leave the room during the discussion of matters which are described as confidential.

Public Speaking
You can ask questions on an issue included on either agenda above, or on an issue which is within this committee's powers. Questions can only be asked during the slot on the agenda for this at the beginning of the meeting, not later on when an issue is under discussion by the committee.

Fire Alarm
In the event of the fire alarm sounding please follow the instructions of the Chair.

CAMBRIDGE LOCAL HEALTH PARTNERSHIP 3 July 2014
12.00 - 1.40 pm

Present:

Attendance
Cllr. Peter Roberts
Cllr. Kevin Price
Cllr. Lucy Nethsingha
Graham Saint: Strategy Officer, Cambridge City Council;
Jas Lally: Head of Refuse and Environment, Cambridge City Council;
Kate Parker: Cambridgeshire County Council, Public Health
Liz Robin: Director of Public Health, Cambridgeshire County Council
Mark Freeman: Cambridge Council for Voluntary Services
Frances Swann, Housing Support Manager, Cambridge City Council (Guest Speaker).

FOR THE INFORMATION OF THE COUNCIL

14/18/CLHP Election of Chair and Vice-Chair

Councillor Peter Roberts was elected as Chair and Councillor Kevin Price was elected as Vice Chair for the ensuing year.

14/19/CLHP Apologies

Apologies were received from Councillor Joan Whitehead and Antoinette Jackson.

14/20/CLHP Minutes and Matters Arising

The minutes of the meeting held on 27 March 2014 were approved as a correct record.

14/21/CLHP Public Questions

No public questions were received.

14/22/CLHP Presentation

Frances Swann, Housing Support Manager at the City Council, gave a short presentation about the newly commissioned Housing Related Support Service for Older People Service in Cambridge providing details about what is available and how to access it. Frances said this is a needs based service that will be available to all residents in the city and not just those living in the City's sheltered accommodation. The starting point will be a reassessment of local need, which will be taking place over the next 6 months, with emphasis on more targeted and preventative work.

Some of the issues discussed by the Partnership were:

- Older people seem to like living in sheltered accommodation and there is a big demand for this type of housing – additional investment is required
- Older people with assets should be encouraged to spend more of their money on looking after themselves, such as purchasing community alarms.
- More older people should be involved in social events to help combat isolation – sheltered accommodation events were now open to local people.
- There was probably more room for people to begin to manage their own health and care – so approaches like tele-care were being investigated.
- Continuing need for better dialogue for hospital discharges – some recent problems had arisen that could have been avoided.
- Referral routes to the services came from a variety of sources, mostly from GPs and Social Care professionals but early assessments seemed to offer the best way forward.
- The contract is for 3 years and then will be subject to renegotiation, so budgets were secure over the next few years.

14/23/CLHP Updates

Health and Wellbeing Board
Liz Robin, Director of Public Health gave an update on the work of the Board, including discussions at its last meeting on 11June 2014.

NHS Cambridgeshire and Peterborough CCG had succeeded in achieving most of the local quality premium indicators for 2013/14 it had previously negotiated. It should be eligible to the reward attached to this success but had been told this could not be drawn down because the CCG was presently running a deficit. The HWB felt that this was unfair and was lobbying to have this reward was released.

In the HWB's discussions about the local health economy and the CCG's new 5 year strategic plan the pressures across the health care system were noted. The CCG was having difficulty in matching the increased activity in the local NHS hospitals and consequently was running up a deficit. The CCG had been recognised as being a challenged commissioning group and was working with national bodies to create a more stable health care system. A "blue-print" for change had been developed by PWC and a concordat agreed with providers.

Liz said that the HWB would be lobbying NHS England and others to alter the present payment by results arrangements as it felt these were preventing sufficient investment in community services to break the cycle of crisis management.

Liz outlined the main messages from her Annual Public Health report and members discussed the PHOF indicators for Cambridge that had got worse over the past year. It was felt that reducing falls and reducing fuel poverty were the areas where the Partnership should focus, although members in the meeting did not think they had sufficient knowledge of the reasons why these were high, such as the location of the falls or why fuel poverty occurred, or existing activity to reduce them.

Liz was asked to look into providing additional statistics that might provide additional insight into the reasons why the indicators had worsened.

Liz also set out the main conclusions of the summary report on the findings of the Joint Strategic Needs Assessment (JSNA) on autism, personality disorders and dual diagnosis. Liz said that the report showed high rates of diagnosis for autism in Cambridge. Members thought that dual diagnosis presented some of the bigger challenges, especially around personality disorders, drugs and alcohol.

14/24/CLHP Looking Forward

Members said that they wanted to focus on two areas, derived from the PHOF indicators, at the next CLHP meeting. These were: reducing the number of falls, and; reducing fuel poverty. It was felt the biggest gains could be made from partnership work in these areas.

Partners will be asked to consider their contributions in advance of the meeting, particularly how low income (and inequalities), poor mental health, homelessness and lack of physical activity, influenced these indicators. These

are issues that the Partnership has previously identified as being important to good health and wellbeing in the city.

14/25/CLHP Progress on Outstanding Actions from the Last Meeting

1. The proposal to hold a workshop to help explore how local advice services can contribute an improvement in well-being locally, based on the evidence provided by the CAB Health Outreach Service in Sefton, was agreed. This will take place on 30 July 2014.
2. A Housing Officer from the Council would be attending a CamHealth GP committee on 10 July to help improve the local links between housing and health and social care services.

14/26/CLHP Date of Next Meeting

12.00 Noon on the 23rd October 2014

The meeting ended at 1.40 pm

CHAIR

Cambridge Local Health Partnership

23 October 2014

ITEM 5: Summary of recent JSNA findings

This paper is in support of the presentation and shows the summaries of the recent JSNA reports.

A. Carers 2014
B. Older People's Mental Health 2014
C. Primary Prevention of Ill Health in Older People 2014

A. Carers 2014

Definition and Scope

A carer is a person of any age - adult or child - who provides unpaid support to a partner, child, relative or friend who could not manage to live independently or whose health or wellbeing would deteriorate without this help. Those receiving this care may need help due to frailty, disability or a serious health condition, mental ill-health or substance misuse.

Carers are a valuable asset within our communities, providing not just voluntary, unpaid care to assist the person they care for to remain independent, but also love, friendship, reassurance and connection. Carers have good knowledge of the person they care for and their health issues, often co-ordinating and managing their care. Nationally the 1.25 million carers who provide care for more than 50 hours per week are a full-time workforce greater than the entire NHS!

Young carers are children and young people who assume inappropriate responsibilities to look after someone who has an illness, a disability, or is affected by mental ill-health or substance misuse. Young carers often take on practical and/or emotional caring responsibilities that would normally be expected of an adult.

The main question for the JSNA was ‘What can we do to support carers to stay healthy and well?’ In addition, to support the work around the Better Care Fund, the JSNA has also looked at the evidence for whether supporting carers reduces health and social care service use. The scope of the JSNA is carers across the whole lifecourse.

9.2.2 Detailed Summary taken from JSNA

A systematic review of the effectiveness and cost-effectiveness of different models of community-based respite care for frail older people and their carers (Mason A. , et al., 2007) found some evidence of a small positive effect upon carers in terms of

burden and mental or physical health. Many studies reported high levels of carer satisfaction. The review found no reliable evidence that respite delays entry to residential care. Some of the included studies had methodological problems. The best quality studies were from outside of the UK and it may be difficult to generalise the findings. Cost effectiveness evidence was only available for day care. Economic evidence suggests that day care is at least as costly as, and may be more expensive than, usual care (only one economic evaluation was UK based). The authors concluded that the current evidence base is insufficient to inform policy and that better quality research is needed.

A systematic review and meta-analysis of cognitive re-framing for carers of people with dementia (Vernooij-Dansen, Draskovic, McCleery, & Downs, 2011)showed beneficial effects over usual care for carer mental health. Only one study included institutionalisation and did not demonstrate any delay in this outcome. No benefit was found in terms of carer burden.

A systematic review of respite for people with dementia and their carers (Lee & Cameron, 2004) found a lack of high quality research in this area. The three randomised controlled trials included in the study varied widely in the intervention, duration and outcomes studied. There was insufficient evidence on rate of institutionalisation.

A focused review of the UK literature by the Audit commission (Pickard, 2004) looked at the effectiveness and cost effectiveness of respite care of older adults (60+ or 65+) and included cost effectiveness studies from the US literature. For findings on cost effectiveness, the review drew largely on one UK study from 1994/05 which was concerned with the effects of the community care reforms on outcomes for the general population of frail elderly people using community services. Daycare, home help/care, institutional respite care and social work/counselling were found to be effective and/or cost-effective for carers in terms of one or more of the outcomes - in improving carer welfare and delaying admission to institutional care.

A report for the Princess Royal Trust for Carers and Crossroads Care (2011) states that investing in respite care results in savings resulting from reduced costs to health and social care: spending more on breaks, training, information, advice and emotional support for carers reduces overall spending on care by more than £1bn per annum, as a result of reductions in unwanted (re)admissions, delayed discharges and residential care stays". In making this statement, the document cites a randomised controlled trial of family support to families of stroke patient, reporting that this trial found a shorter length of hospital stays (and resulting costs) in the treatment arm. A case study of case coordinators for carers of people with end-stage heart failure in Tower Hamlets (which is reported as reducing hospital admission) is also presented. Similarly support pre-discharge at a hospital trust in Bristol is reported as reducing bed days. With regard to reducing admission to residential care, three non-UK studies are cited, but there is no discussion of whether the

findings of these studies are generalizable to the UK. The document is not presented as a systematic review (eg does not state inclusion criteria, does not discuss methodological rigour of included studies). Savings for individual councils are given in an appendix; these are modelled based on assumptions in reductions in residential care.

A pilot project in Scotland (Kelly, Watson, West, & Plunkett, 2010) aimed to prevent crises for carers through early identification and support to carers (including carers assessment) when in contact with services and the promotion of integrated joint working between sectors. The project promoted certain core outputs (eg supporting carers and improving access to carers' assessments using dedicated project workers) which were then applied slightly differently across four pilot sites. The evaluation reported benefits eg an increase in the number of carers identified as such during a hospital admission, but did not result in a reduction in readmissions during the course of the project.

B. Older People's Mental Health 2014

Executive Summary

This joint strategic needs assessment reviews the mental health needs of older people in Cambridgeshire, with a particular focus on dementia and depression. It is important to be clear about the differences between mental wellbeing (or general mental health), and mental illness. In the document we refer to both using the definitions below:

Mental wellbeing (or mental health): There are many different definitions of mental wellbeing but they generally include factors known to promote mental health such as: life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support. Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against the development of many such problems.

Mental illness or disorder: Mental illness or disorder refers to a diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities eg dementia, depression, anxiety, and schizophrenia.

Over a third of older people in the UK are likely to experience mental health problems. Depression and anxiety are the most common conditions, followed by dementia. Other less common conditions include delirium (acute confusion), schizophrenia, bipolar disorder, personality disorder and autism, alcohol and drug (including prescription drug) misuse; this needs assessment focuses primarily on depression and dementia.

Dementia is a group of related symptoms associated with an ongoing decline of the brain and its abilities. This includes problems with memory loss, thinking speed, mental agility, language, understanding and judgement. People with dementia can become apathetic or uninterested in their usual activities, and have problems controlling their emotions. They may also find social situations challenging, lose interest in socialising, and aspects of their personality may change. A person with dementia may lose empathy (understanding and compassion), they may see or hear things that other people do not (hallucinations), or they may make false claims or statements. As dementia affects a person's mental abilities, they may find planning and organising difficult. Maintaining their independence may also become a problem. A person with dementia will therefore usually need help from friends or relatives, including help with decision making.

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. It affects how one feels, thinks and behaves. It may make it difficult to carry out normal day-to-day activities and make one feel that life is not worth living. Depression and dementia can co-exist and can be difficult to distinguish.

Both conditions, especially when moderate or severe, can reduce markedly the quality of life of those living with the condition. They also affect the family and friends who care for their loved ones. Depression is highly treatable, but the progressive nature of dementia can cause extensive physical, psychological, emotional and financial stresses to those with the condition, their family, carers and the wider community.

This report starts by describing the population of Cambridgeshire, with particular emphasis on the older population and the factors which contribute to mental health problems in that population. It goes on to estimate how many people in Cambridgeshire have depression and dementia, both now and in the future. The report then describes the present pattern of services available in Cambridgeshire for older people with mental health problems, and summarises relevant NICE guidance and reports findings from research about the interventions which, if used early in the course of illness, may reduce its severity. The report then summarises the results of engagement with service users, carers and providers, before setting out some conclusions and key findings.

The difficulties with securing data on NHS activity meant that the report has adopted a qualitative approach. There are also other sources of information which were not available or accessible during this project, and these mean there are limits to the conclusions we are able to draw. These include details of where people with mental health problems live, the exact nature of all clinical and social care services provided locally and the outcomes of service interventions. It has not been possible therefore to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards.

Key Facts

1.The population of Cambridgeshire will age substantially by 2026: the number of people aged over 90 years will more than double, and the number of people in their 80s rise by more than 50%. This will lead to steep rises in the number of older people with dementia and, to a lesser extent, depression.

2.Cambridgeshire's population is more affluent and less ethnically diverse than that of England, but social isolation is no less common. Most risk factors for poor mental health show similar patterns of prevalence across Cambridgeshire, though in some cases the Cambridgeshire population shows a lower risk profile. There are also areas within the county where risk factors are concentrated, such as Fenland.

3.Assuming prevalence rates remain the same as current rates, between 2012 and 2026, the number of older people with depression in Cambridgeshire is expected to rise by 12%, from approx. 11,900 to 13,360. The number of people over 65 years with dementia is expected to rise from 7,400 to 12,100, an increase of 64%. There is forecast to be a 43% increase in the number of older people with learning disability. Increases of this size over a short period will put severe strain on existing services.

4.In Cambridgeshire, many people with depression and most of those with dementia have not been diagnosed and recorded by their primary care teams, which reflects a national trend. This means they cannot receive the treatment and support they need. This suggests that there is unmet mental health need within the population.

5.Cambridgeshire apparently devotes less health service spending per head to mental health than average for England. The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is relatively under-funded and faces a challenging financial future.

Key findings

1.Increasing older population

•Due to an increasing population there is forecast to be an increase in the number of older people with dementia and, to a lesser extent, depression, within a few years.

•However, the resources available from statutory agencies, for health services given the current financial restraints, will at best remain the same, requiring the development of new service models to meet need. A holistic approach is vital.

2.Risk factors for depression and dementia

•Older people's mental health needs are complex. They cause substantial impact on wellbeing and the ability to lead a normal life. They have wider impacts on the family and other carers.

•Mental health needs interact in complex ways with long-term physical health problems. Adults with severe mental illness have a substantially reduced life expectancy due to both mental and physical ill health. There is often inequality of access to health services for physical illness for people who use mental health services. Physical health and mental health are inseparable and demand a holistic approach to the care of all patients with mental health problems.

•Evidence-based guidelines from NICE recommend reviewing and treating vascular and other risk factors for dementia in middle-aged and older people. These include smoking, excessive alcohol use, obesity, diabetes, hypertension and raised cholesterol levels.

•NICE are also currently developing two relevant pieces of public health guidance: the first, due to be published in February 2015, focuses on mid-life approaches to prevent or delay the onset of disability, dementia and frailty in later; the second, due for publication in November 2015, considers independence and mental wellbeing (including social and emotional wellbeing) for older people.

3.Diagnosis and assessment

•There is apparent widespread under-diagnosis of depression in primary care. Rates of diagnosis also vary between practices for unexplained reasons. Depression is a distressing, but highly treatable condition, so improvement in rates of diagnosis is important.

•Dementia is also under-diagnosed in primary care, with unexplained variation in rates of diagnosis and prescribing. Early diagnosis means that patients and carers can receive appropriate information and support, so ensuring the condition is recognised promptly is beneficial.

•Improving diagnosis in primary care is a priority, as part of an integrated approach and partnership working, to improve awareness of mental health needs in the community.

4.Current spending

•The NHS in Cambridgeshire apparently spends 18% less per head on mental health services than the average for England. It is, however, less well funded than average. This information is based on programme budgets, and differences in budgetary definitions and coding behaviour may underlie these findings. More analysis of the reasons for the differences would be of value.

5.Current service provision

•The JSNA full report describes acute and community mental health services available for older people and details three local clinical pathways for ‘Functional mental illness’ (includes depression, anxiety, bipolar affective disorder, psychosis,

personality disorder); ‘Memory assessment’; and ‘Complex dementia’. Training programmes to raise awareness of dementia are in place across primary care, community and acute settings. Local support services are also provided by the Alzheimer’s Society and Mind. These are jointly commissioned by the CCG and Cambridgeshire County Council (CCC) and are also described in more detail in the full report.

•There is substantial variation in the rate of referrals to the older people’s mental health service, with lower rates seen in South Cambridgeshire, and higher rates in Cambridge City, Fenland and East Cambridgeshire. The reasons for this variation are unclear, and may relate to data quality problems, but it would merit further investigation.

•No information on activity levels and expenditure patterns, by the main NHS mental health service provider in Cambridgeshire, was available within the timescale of this report. This impedes service planning and evaluation by commissioners and limits the extent to which patterns of service delivery can be reported and analysed. The routinely collected anonymised national minimum dataset should be available in a timely and accessible format to providers and commissioners of mental health services.

•There are other sources of information which were not available or accessible during this project, and these limited the conclusions we are able to draw. These include details of where people with mental health problems live, the exact nature of all clinical and social care services provided locally and the outcomes of service interventions. It has not been possible, therefore, to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards.

•The current re-procurement of older people’s services is expected to lead to improvements in mental health services for older people. The re-procurement process will involve clarifying what mental health services for older people are available, where and to whom.

6.National guidance and evidence on provision of services and standards

•National guidance in the form of Clinical Guidelines and Quality Standards published by NICE describe, in detail, what patients should receive from the NHS and social services.

•A review of the evidence did not find any reliably evaluated early interventions for mental health disorders in older people that were not included in existing NICE guidance.

•Existing service specifications from commissioners describe what should be available from NHS mental health services. The extent, to which national guidance

and local service specifications are followed, in practice, was not reviewed as part of this JSNA. This could form part of a future work programme.

7.Stakeholder feedback

•The main concerns of service users and carers reported to us were:

•Service delivery

•Organisational challenges

•Coordination of services

•Safeguarding of vulnerable people

•Access to services

•Transition between services

•Continuity of relationships

•Culture and equity

•Physical health and mental health

•Carers' needs.

•Service improvement ideas from service users and carers, included more help with practical things, such as maintaining relationships, applying for benefits, and a focus on the positives rather than the diagnosis. Community support, and signposting for where to go for help, ideas or friendship were also considered important. Information and training for families and carers as well as those with mental health disorders, and seeing the same health professional consistently were also suggested.

8.Further information

Building on the findings of this JSNA, further work may be useful to:

•Establish the activity and cost levels at the main NHS mental health provider;

•Review the validity of the apparent low levels of NHS spending on mental health in Cambridgeshire;

•Audit the extent to which NICE guidance is followed and understand gaps in mental health service provision for older people;

•Investigate the apparent variation in referral rates to the older people's mental health service.

C. Primary Prevention of Ill Health in Older People 2014

Executive Summary

1. Introduction – context and scope

Cambridgeshire has an ageing population, and there are opportunities to maximise the potential for residents to enjoy good health and wellbeing throughout their lives, and ensure that local communities benefit from the vast assets of the older people population. This JSNA focusses on modifiable lifestyle behaviours, for which there are clear associations with poor health outcomes and opportunities to take a preventative approach: active ageing and physical activity, maintaining a healthy diet (including preventing malnutrition), and stopping smoking.

2. Primary Prevention for Older People

The underlying principle to primary prevention is that modification of risk factors in later life is still beneficial for health: chronic degenerative disease and ill health are not inevitable concomitants of ageing. A lifecourse approach recognises the impact of earlier exposures to risk factors for health, on-going behavioural choices, and the opportunities for change and support through life-stages. There is significant variety in the way individuals experience and respond to their senior years, and a range of cultural differences, preferences and perspectives on what healthy ageing means for each person which could inform effective preventative work locally.

Evidence suggests that interventions which focus on encouraging healthy behaviours in 55-75 year olds may be more effective as they may be more ready, interested and intend to change than individuals in older age groups. Older adults with negative health behaviours are less worried about the effect of the things they do on their health, and have less intention to change than those with positive health behaviours; this may reflect some of the complexities linked to health inequalities. Much of the societal emphasis on retirement is about winding down, and carers may, with good intention, also express care and concern in ways that discourage independence. Supporting primary prevention in older people may therefore require much broader discussions around ageing and society, as well as recognising the significant crossover between physical health, mental health and emotional wellbeing, as important influencers of health behaviours.

3. Wider Determinants of Health

The underlying social, economic and environmental conditions that influence the health and wellbeing of individuals and populations are recognised to be ‘wider determinants of health’. These determine the context of daily life for older adults. One in five pensioners lives in a household receiving Housing Benefit or Council Tax Benefit. The distribution of the benefit population follows similar patterns to the distribution of poor educational attainment and poor health status. In measurements for the Income Deprivation Affecting Older People Index, deprivation

is more widely spread across Cambridgeshire. There are some pensioners who are not receiving benefits, but who may be experiencing income poverty, particularly in areas with a high proportion of owner-occupied households.

The adequacy of housing for older people in Cambridgeshire is crucial; changes in both the population of older people resident in the county, their needs, and their preferences about the sort of housing they wish to occupy, require ongoing consideration. The sufficiency of housing for older people in Cambridgeshire has been recently assessed in Chapter 9 of the Prevention of Ill Health in Older People JSNA, and in the Housing and Health JSNA, both published in 2013.

Cambridgeshire is by and large a rural county and the availability and access to means of transport is an important factor which influences healthy behaviours. An approach to facilitate active ageing requires consideration of how to ensure the mobility of older people so that they are able to participate in society and the community around them, maintain social networks, access services, and benefit from leisure, social and volunteering opportunities. Access to local shops and food sources is also important in maintaining a healthy diet. A Transport and Health JSNA is being prepared for 2015 which will consider the local situation, evidence base, and implications for health and wellbeing in detail, and inform local policy and decision making.

Social and emotional wellbeing is impacted by participation and engagement with family, friends, civic organisations, and services in the neighbourhood and further afield. Societal change including geographic dispersion and fragmentation of extended family networks may mean other local social networks are increasingly important. Primary prevention work offers an opportunity to support the role of communities in meeting the needs of older people and set health behaviours in the context of the social norms of the communities which older people relate to. Loneliness has detrimental impacts on physical and mental health, and increases the likelihood of multiple unhealthy behaviours. Effective interventions to tackle isolation and loneliness may be those with a theoretical basis, where older people are active participants, and which address the vicious cycle of loneliness. Isolation may also be addressed through provision of services in rural areas, and through embedding social elements within other public health interventions.

4. Physical Activity

Physical inactivity is the fourth leading risk factor for death worldwide; the positive impacts of physical activity and the negative impacts of physical inactivity on the health of older adults are well known.

‘How active?’ guidelines for older adults have been produced by Chief Medical Officer (CMO) which describe ideal levels of activity that are beneficial to health and wellbeing. In terms of how many older adults meet these guidelines, there is data for England available and an indication of participation for Cambridgeshire. Older adults

are not a homogenous group; an interpretation of the CMO guidelines for three groups of older adults ('actives', in 'transition' and 'frail') is available.

There is some evidence of what works; volume of activity is more important that engaging in specific types of activity. There is evidence of the cost effectiveness of interventions and indication of the cost of physical inactivity.

Cambridgeshire is not a blank page; assets in the community exist. These may not be available to all, and sustained funding is not assured. The local assets include older adults who are trained volunteers.

5. Diet

Dietary factors contribute significantly to the global burden of disease. Dietary improvements made in older age significantly reduce the risk of chronic diseases.

There is very limited information about the healthiness of the food consumed in Cambridgeshire; new Public Health Outcomes Framework indicators on fruit and vegetable consumption will provide a snapshot in future. Nationally, older adults consume low levels of fruit and vegetables, fibre, oily fish, and high levels of salt relative to recommendations.

The evidence on primary prevention of cancer, cardiovascular disease, and diabetes draws from the all adult population; research for older adults focusses on bone health and preventing cognitive decline. Population approaches to improving nutritional status include taking opportunities at all ages to prevent the development of chronic disease, and supporting behaviour change for healthier diet and healthy ageing. Weight management interventions (12 weeks with $\geq$1kg lost and maintained for life) can be more cost effective for older adults because older people gain health benefits sooner.

Daily vitamin D supplementation is recommended by the Department of Health for all adults aged 65 years and over. It is not known how far this is practiced locally; NICE guidance on the implementation of vitamin D recommendations is due November 2014.

Local assets include lifestyle support services accessed by older adults, and practical advice and support through social care and voluntary sector organisations. There may be opportunities to look at enhancing messaging about a healthy balanced diet for older adults through local services, stakeholders, health and social care professionals, and to consider the healthiness of the food offered in residential and social settings.

6. Malnutrition

Malnutrition is measured as a Body Mass Index (BMI) lower than 18.5kg/m^2 or unintentional 10% weight loss. NICE identified malnutrition as the sixth largest

source for potential NHS savings. The annual health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient spells, more primary care consultations and the greater long-term care needs of malnourished individuals.

About two thirds of cases of malnutrition are not recognised; the impacts are increased burden of disease and treatment costs. It is estimated 10,000 to 14,000 older residents in Cambridgeshire are malnourished, many more are at risk. Social networks have a preventive role, as interest groups and shopping clubs support motivation and the means for good nutrition.

Regular screening for malnutrition is recommended by NICE; early intervention screening and appropriate treatment is cost-effective. Those at risk should have a 'food first' approach, including dietary advice to optimise their intake, and support with practicalities. NICE estimates that the overall resource impact of increased screening, early intervention and appropriate treatment could lead to a saving of £71,800 per 100,000 people.

Awareness of malnutrition needs to be improved by both healthcare workers and the wider public. Efforts to prevent malnutrition should be integrated with other care to prevent ill-health, and between healthcare workers, carers, social workers, and the voluntary sector. There is much good practice in place at Addenbrooke's Hospital, and developing plans for Hinchingbrooke Hospital. A clear pathway for post-discharge support for those at risk, particularly for older adults who live independently could help to prevent or reduce malnutrition. Community dietitians provide training for care home staff to screen residents for malnutrition; care homes should use a validated screening tool and should audit to ensure CQC compliance.

The majority of individuals at risk of malnutrition live in the community; preventative resources include home help schemes, community navigators, lunch clubs, day care centres, shopping services and the support offered by voluntary organisations. Coverage is not even across the county e.g. there are fewer lunch clubs in rural areas, where social isolation may be a greater problem. Lack of awareness of the problem and services or support available can hinder engagement and access to support. This might be improved by raising awareness amongst older adults, their families and GPs about the services available in the community.

7. Smoking

Smoking is the primary cause of preventable and premature death in the UK, responsible for approximately 100,000 deaths/year. Nearly a fifth of the population of England smokes (19.5%); prevalence is lowest among the 60 and over age group (12%) and is probably the result of many factors including death before age 60 from both smoking and other causes of death, and higher cessation rates amongst older people. A recent systematic review of the evidence on smoking cessation in the 60+

age category concludes that smoking cessation significantly improves health and reduces mortality for all ages.

In Cambridgeshire, there are estimated to be 112,210 smokers and 17,461 of these are over the age of 60 years (16%). Prevalence is significantly higher in Fenland when compared to the national average.

There are no specific recommendations for reaching or delivering services specifically to older populations; smoking cessation interventions known to be effective in the general population have been found to be effective with older smokers across a variety of treatment methods.

9% of CAMQUIT (the local stop smoking service) clients are aged 65 and older. In Cambridgeshire the quit rate for all service users is 47%, and is 5% higher among those aged 65 and older (52%). Also, fewer older smokers are lost to follow-up than other age groups. Older adults are more likely to access the CAMQUIT service via their GP, and less likely to access support via core or pharmacy services. They appear to be less sensitive to some national smoking cessation campaigns; local tailored advertising is used. Increasing access to stop smoking services should be encouraged for older smokers. Local feedback suggests it might be important to emphasise the continued health benefits of quitting at older ages and that it is 'never too late to quit'. There are significant opportunities to encourage referral or signpost older adults to stop smoking services from a broad range of settings including primary care, social care, community and acute health care, housing, and community interest groups.

8. Conclusions

There are health and wellbeing benefits to be experienced by older adults in Cambridgeshire through modifying their health behaviours and lifestyle risk. This can be supported by interventions and enabling societal and environmental structures. There is a key message to disseminate that it is never too late to make changes, and this could be personalised to individuals to emphasise the specific benefits for their own quality of life. There are opportunities for local health and social care professionals to make every contact count towards this. A positive view of healthy ageing and an increased awareness of the available local assets will enable tailored support for older adults to access appropriate services, with potential advantages in overcoming social isolation and in strengthening local communities.

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PUBLIC HEALTH intelligence

Briefing for Cambridge City Local Health Partnership
On three Public Health Outcomes Framework indicators
October 2014

Background

The Cambridgeshire Annual Public Health Report 2013/14[1] focussed on the new national Public Health Outcomes Framework (PHOF) which provides detailed information on how well Cambridgeshire and districts is doing compared with other areas for a range of health outcomes, as well as the lifestyle and environmental factors which influence health. The PHOF is available on an interactive website which is updated quarterly, and is designed to be accessible and understandable for the general public as well as specialist staff: **www.phoutcomes.info.** Local information is also available at http://www.cambridgeshireinsight.org.uk/health/phof.

This report provides background to three indicators where Cambridge City has statistically significantly high rates compared with England as a whole:

- Fuel poverty
- Injuries due to falls in people aged 65 and over
- Hip fractures in people aged 65 and over

Further information will be presented to the meeting on October 23rd.

Fuel poverty

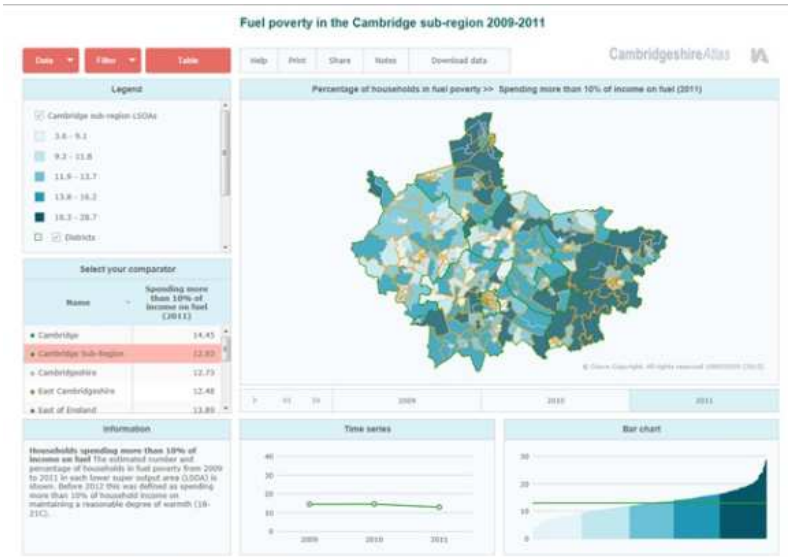
An understanding of fuel poverty is important because it can have negative effects on health and well-being; the 2012 Hills Review[2] suggested around 2,700 excess winter deaths caused by fuel poverty. It is strongly linked to general income poverty and deprivation, with households on below average incomes having to sometimes choose between heating their homes and other essentials such as food or accommodation costs, especially if they live in older, less well-insulated stock which uses more fuel to heat and increases carbon emissions.

Whether a household is in fuel poverty is determined by the interplay across three factors:

- The energy efficiency of the property;
- Energy costs;
- Household income.

Research about households in fuel poverty across the Cambridge housing sub-region is shown in the Cambridgeshire Atlas™ | Fuel Poverty[3] This Atlas shows local data about fuel poverty. It looks at the number and percentage of households in fuel poverty at a detailed level (known as lower super output area or LSOA level). It compares these small areas with district, sub-region and country-wide data.

[1] http://www.cambridgeshire.gov.uk/download/downloads/id/2944/annual_public_health_report
[2] https://www.gov.uk/government/publications/final-report-of-the-fuel-poverty-review
[3] http://atlas.cambridgeshire.gov.uk/Housing/FuelPoverty/atlas.html



What is fuel poverty?

The Atlas considers two definitions of fuel poverty. The 2009 to 2011 estimates are based on a household spending more than 10% of income on maintaining a reasonable degree of warmth (in England, between 18 and 21 degrees C). Based on this definition there were an estimated 7,493 households in Cambridge City (15.8%) in fuel poverty.

In 2012, the indicator for fuel poverty is based on a revised methodology (Low Income High Costs (LIHC)) based on households with below average incomes paying above average costs for fuel. This definition combines information on household income and energy costs to work out whether a household is fuel poor. Nationally the change in definition means around 800,000 fewer households estimated to be in fuel poverty; the previous definition possibly included some high income households with high (but affordable for them) fuel bills. This new definition emphasises urban fuel poverty whereas the previous definition tended to highlight fuel poverty in rural areas. In the Cambridge sub-region, the new definition shows more fuel poverty in areas such as Cambridge City and some of the market towns and less fuel poverty in more rural areas.

Fuel poverty in Cambridge City

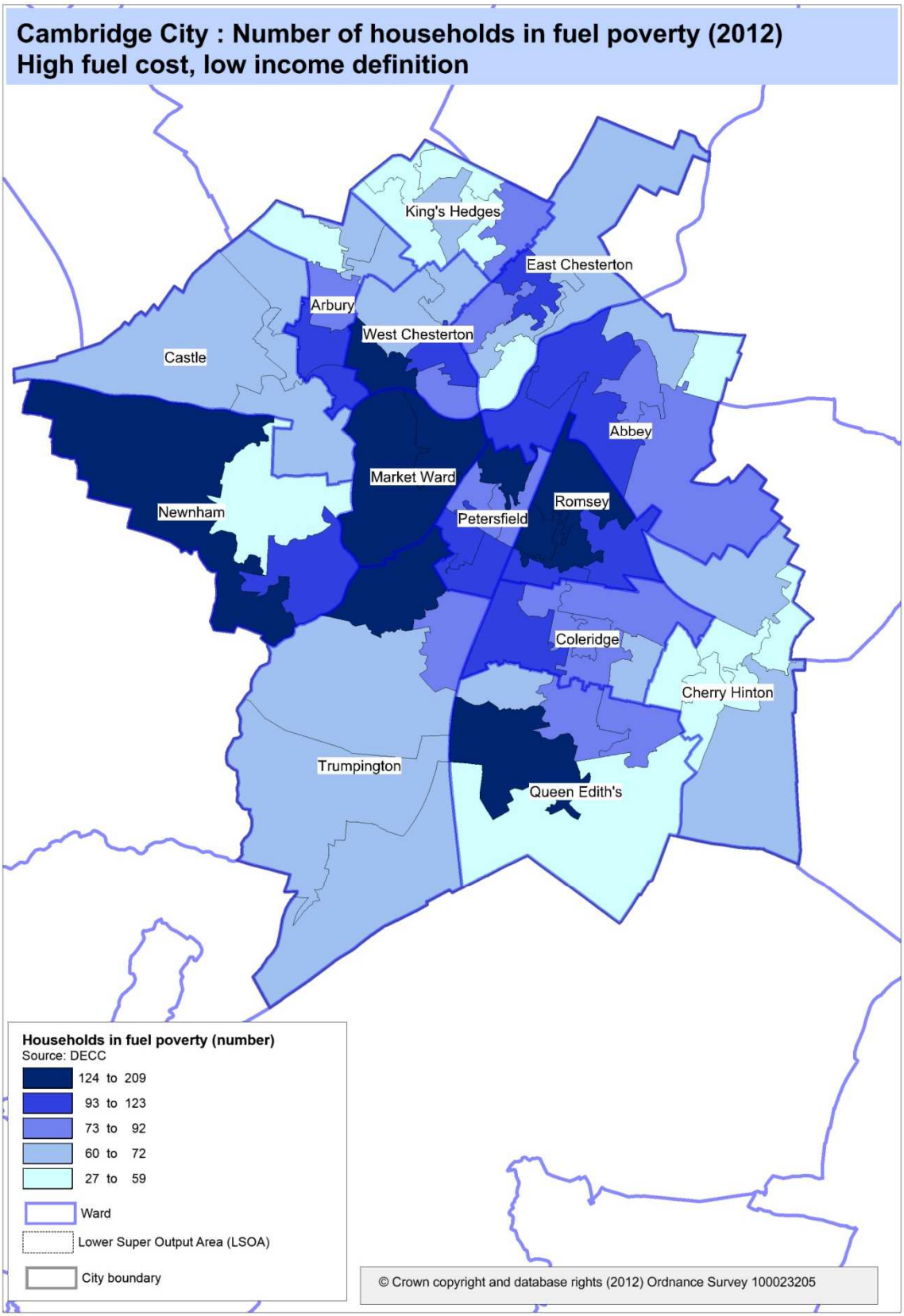
Cambridge City has a statistically significantly higher proportion of households in fuel poverty than England. In 2012, this equates to 6,087 households in Cambridge City, 13.5% of the total (95% Confidence Interval (CI) 12.9% to 13.5%). The value for England is 10.4%.[4]

The maps overleaf show the number (Map 1) and proportion (Map 2) of households in Cambridge City estimated to be in fuel poverty in 2012. Data are mapped to LSOAs within electoral wards and show the variation within the City.[5]

[4] Estimates of households who are fuel poor are produced by the Department for Energy and Climate Change (DECC) and the full data spreadsheet for the country as a whole can be accessed at https://www.gov.uk/government/collections/fuel-poverty-sub-regional-statistics.

[5] Fuel poverty data specifically for Cambridge City from the PHOF tool are available at: http://www.phoutcomes.info/search/fuel%20poverty#gid/1/pat/6/ati/101/page/4/par/E12000006/are/E07000008

Map 1


Cambridge City : Number of households in fuel poverty (2012)
High fuel cost, low income definition
King's Hedges
East Chesterton
Arbury
West Chesterton
Castle
Abbey
Market Ward
Romsey
Newnham
Petersfield
Coleridge
Cherry Hinton
Trumpington
Queen Edith's
Households in fuel poverty (number)
Source: DECC
124 to 209
93 to 123
73 to 92
60 to 72
27 to 59
Ward
Lower Super Output Area (LSOA)
City boundary
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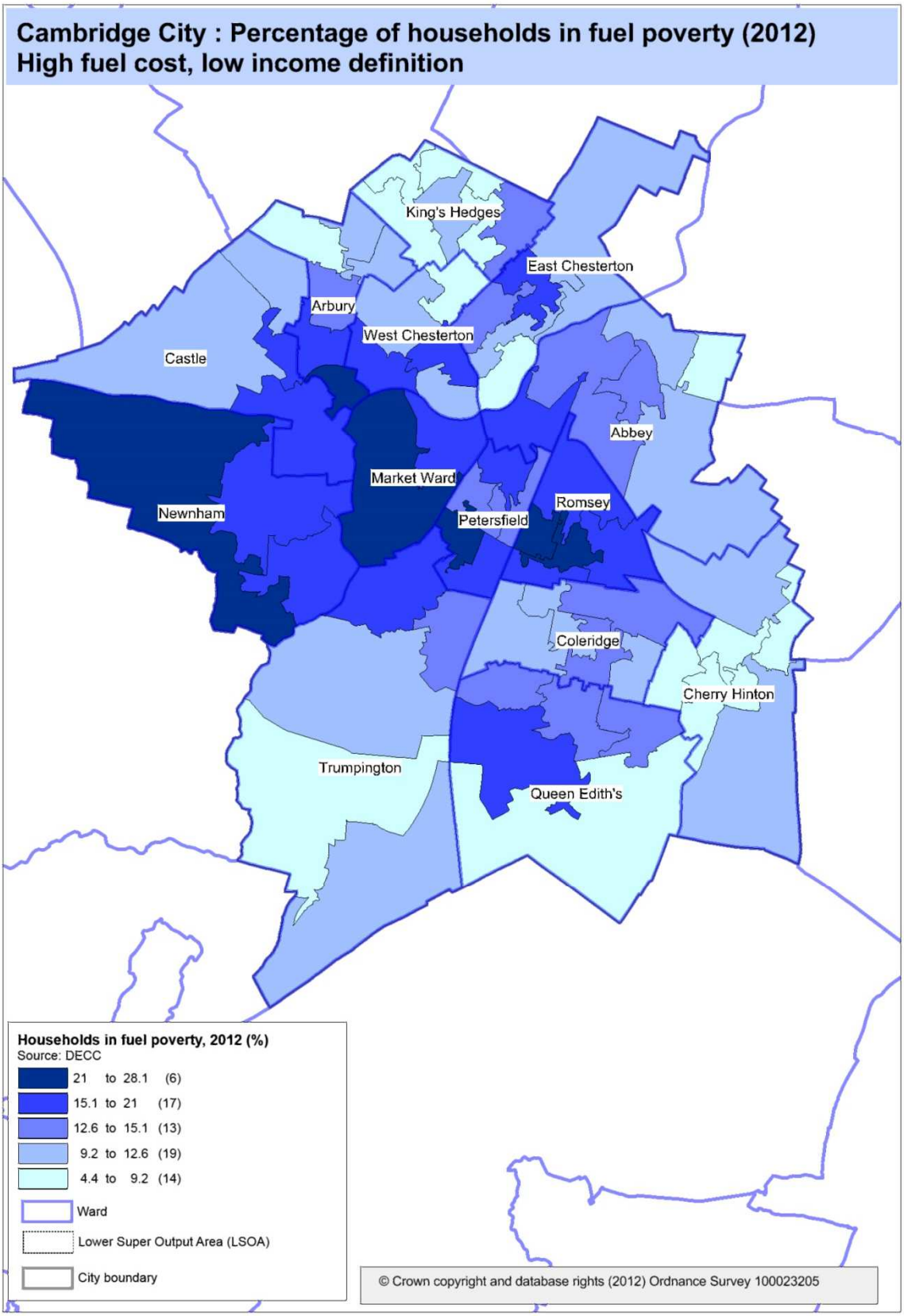
Map 2


Cambridge City : Percentage of households in fuel poverty (2012)
High fuel cost, low income definition
King's Hedges
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Castle
Abbey
Market Ward
Romsey
Newnham
Petersfield
Coleridge
Cherry Hinton
Trumpington
Queen Edith's
Households in fuel poverty, 2012 (%)
Source: DECC
21 to 28.1 (6)
15.1 to 21 (17)
12.6 to 15.1 (13)
9.2 to 12.6 (19)
4.4 to 9.2 (14)
Ward
Lower Super Output Area (LSOA)
City boundary
© Crown copyright and database rights (2012) Ordnance Survey 100023205

See also Cambridgeshire Joint Strategic Needs Assessments (JSNA)

Housing and Health JSNA 2013 – Chapter 8 Improve standards in existing homes and encourage best use of all housing stock. Available at: http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/housing-and-health-2013

Further resources:

FUEL POVERTY: HOW TO IMPROVE HEALTH AND WELLBEING THROUGH ACTION ON AFFORDABLE WARMTH. A guide to delivering action on fuel poverty for public health professionals, health and wellbeing boards, and local authorities in England. UK Health Forum, April 2014. Available at: http://www.fph.org.uk/uploads/UKHF-HP_fuel%20poverty_report.pdf

Evidence review 7: fuel poverty and cold home-related health problems

Ref: PHE publications gateway number: 2014334
PDF, 641KB, 40 pages

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Evidence review 7: fuel poverty and cold home related health problems. UCL Institute of Health Equity. September 2014. Available at: https://www.instituteofhealthequity.org/projects/fuel-poverty-and-cold-home-related-health-problems

Briefing 7: fuel poverty and cold home related health problems. UCL Institute of Health Equity. September 2014. Available at: https://www.instituteofhealthequity.org/projects/fuel-poverty-and-cold-home-related-health-problems

Barnes M, McKnight A. Understanding the behaviours of households in fuel poverty: a review of research evidence. DECC. July 2014.

The Health Impacts of Cold Homes and Fuel Poverty. Available at: http://www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty Marmot review team. 2011.

Fall related Injuries in Older People

Falls are the leading cause of injury-related hospitalisation in older people and are a common reason for older people requiring long-term care in their home or a residential facility. Falls often lead to reduced functional ability and thus increased dependency on families, carers and services. They can often be a turning point or trigger for a deterioration in health or wellbeing, reducing independence and mobility and may lead to increased needs for both formal and informal support. Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures.[6] The prevention of falls can be categorised as primary (preventing a fall in those who have not yet had a fall) or secondary (reducing the likelihood of subsequent falls). Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures.[6]

The average age of a person with hip fracture is 84 years for men and 83 for women, with 76% of fractures occurring in women. There is emerging evidence that people with dementia and neurological disorders have an increased risk of falling.[7] Only one in three sufferers of hip fracture return to their previous levels of independence and one in three move into long-term care.

Public Health Outcomes Framework indicators

Two indicators in the Public Health Outcomes Framework relate to falls and injury: the age and sex standardised rate of hospital admission for injury due to falls and the age and sex standardised rate of hip fractures[8]. Both indicators are for people aged 65 and over and have further sub-indicators broken down to those aged 65 to 79 years and those aged 80 years and over. This is because interventions for recently retired and active older people are likely to be different in provision and uptake to those for frailer older people.[9]

When a fall results in a hospital admission, the hospital codes the fall as a contributory factor to the reason for admission. The coding of falls is known to be variable between hospital Trusts but the new indicator improves upon this by restricting to where the primary reason for admission is an Injury code (International Classification of Disease (ICD 10).

Note that both indicators are calculated nationally based on the resident population.

Cambridge City

The rate in Cambridge City for both PHOF indicators related to falls injuries in older people aged 65 and over is significantly higher than the national average although for hip fracture this has varied from year to year. The rate of injury due to falls is higher in women than in men and in 2012/13, the rate was statistically significantly higher than England in both men and women though this has varied over time. (Figure 1) The average annual number of admissions over the period is 446, 130 in men and 300 in women.

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6 Royal College of Physicians.(2011) 'Falling standards, broken promises. Report of the national audit of falls and bone health in older people 2010'. Available at: http://www.rcplondon.ac.uk/sites/default/files/national_report.pdf

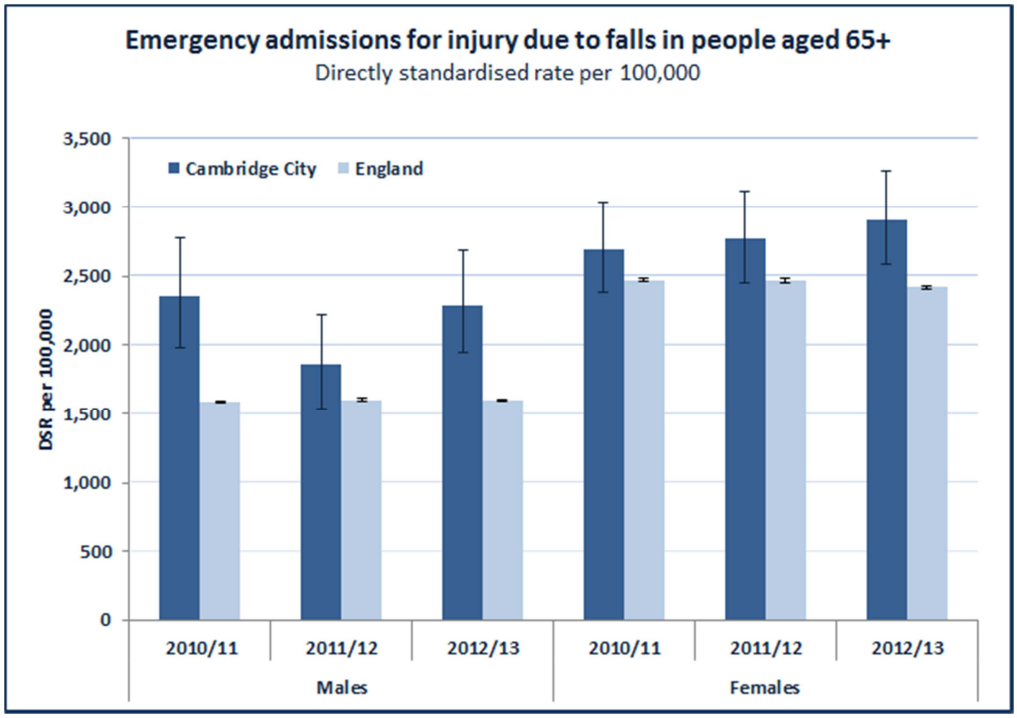
7 Allan LM, Ballard CG, Rowan EN, Kenny RA (2009) Incidence and Prediction of Falls in Dementia: A Prospective Study in Older People. *PLoS ONE* 4(5): e5521. doi:10.1371/journal.pone.0005521.

8 The standardisation method takes account of differing age and sex structures in the population.

9 Department of Health (2012).
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

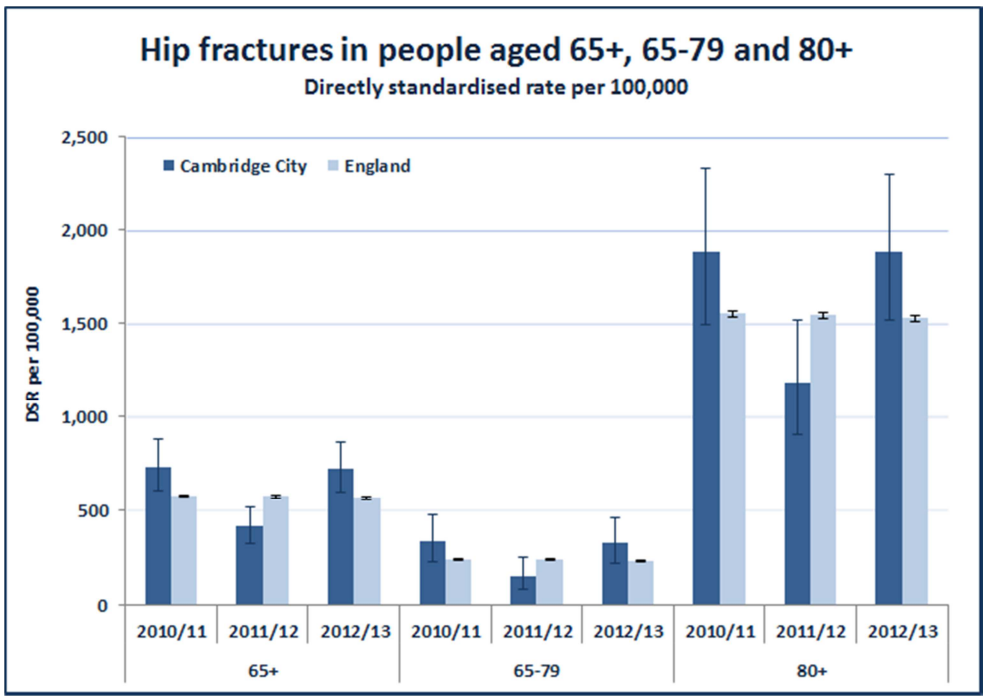
The rate of hip fracture in older people is highest in those aged 80 and above with over 75% of hip fractures occurring in that agegroup. (Figure 2) In 2012/13 there were 104 hip fractures in people aged 80 and over and 32 in those aged 65-79 years.

Figure 1



Source: Public Health England (PHE). Primary diagnosis code for Injury (ICD 10 S00-T19) with falls code (WOO-W18) anywhere in diagnostic string.

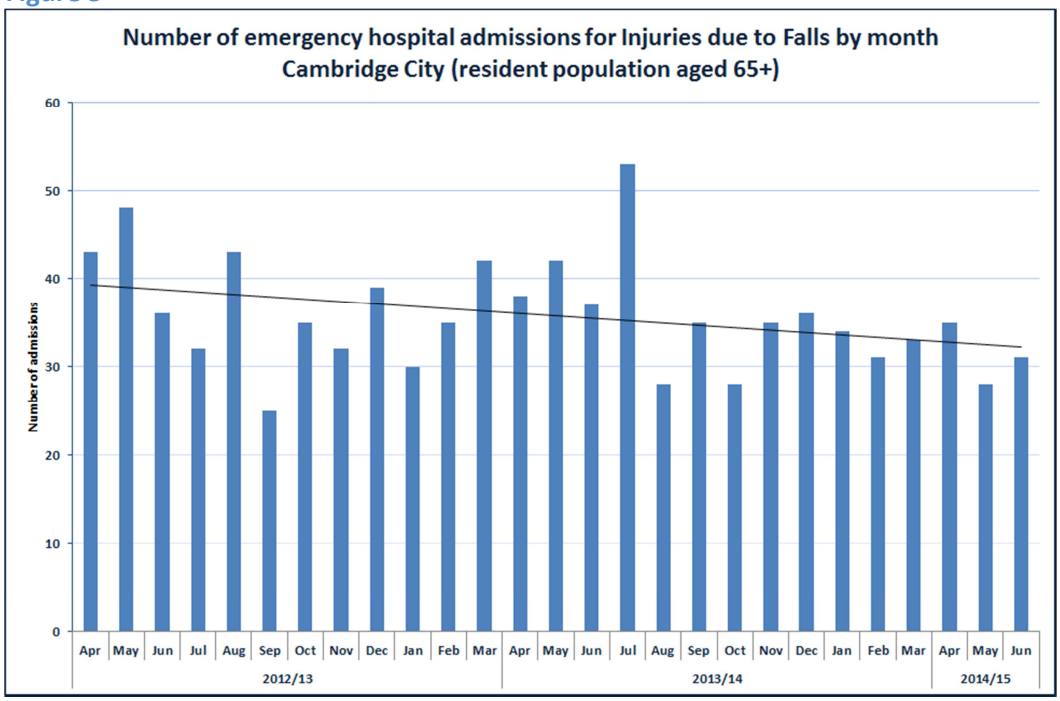
Figure 2



Source: Public Health England (PHE) Primary diagnosis ICD 10 S71.0, S71.1, S71.2.

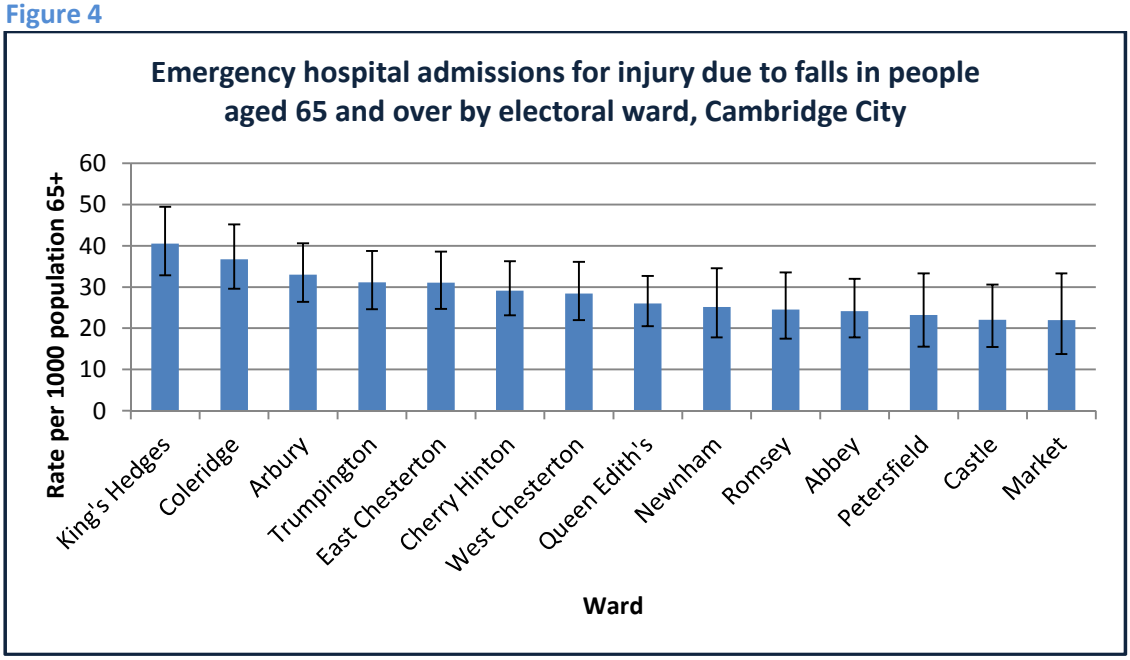
The following figures show the variation within Cambridge City over time (Figure 3) and by electoral ward (Figure 4).

Figure 3



Source: Inpatient Commissioning Data Set (CDS). Primary diagnosis code for Injury (ICD 10 S00-T19) with falls code (WOO-W18) anywhere in diagnostic string. Note that there is little evidence of seasonal variation in these data although the trend over time appears to be downward.

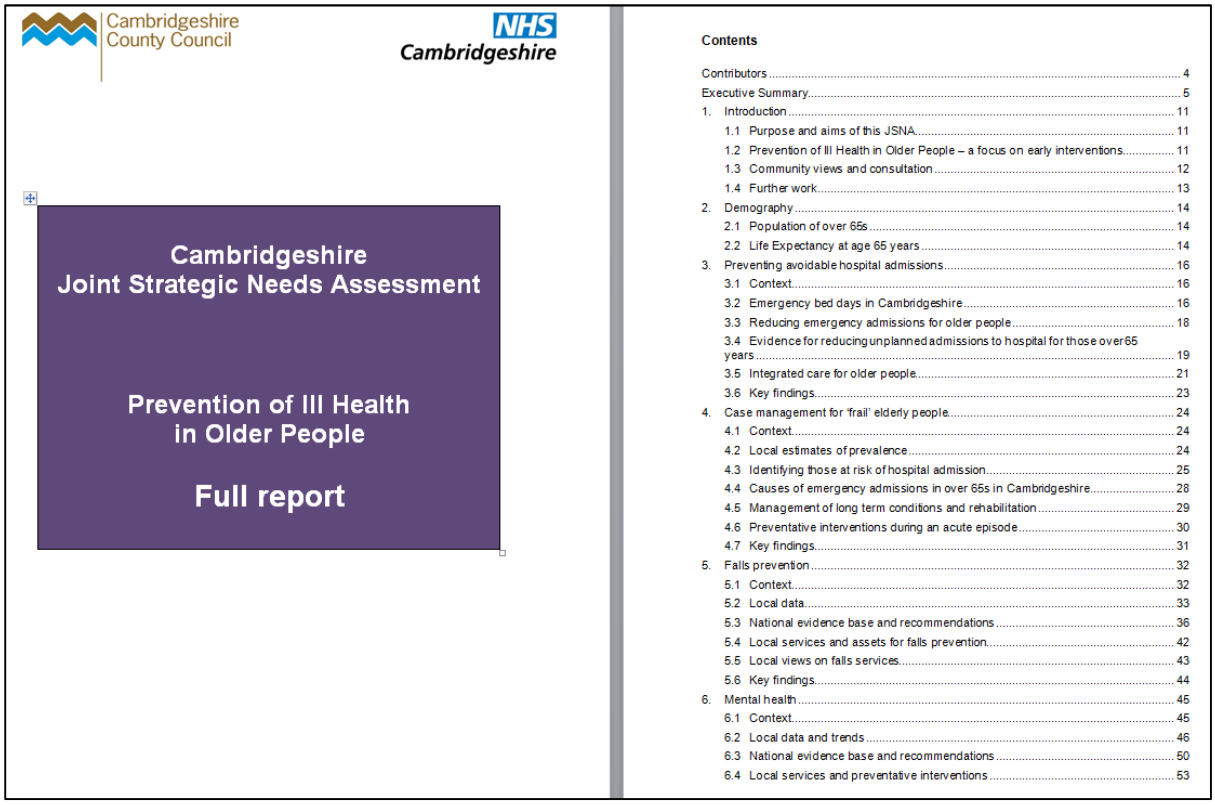
Figure 4



Source: Inpatient Commissioning Data Set (CDS). Primary diagnosis code for Injury (ICD 10 S00-T19) with falls code (WOO-W18) anywhere in diagnostic string. Error bars represent 95% confidence intervals (CI). Note that although there is variation between areas, the difference between electoral wards is not statistically significant.

See also Cambridgeshire Joint Strategic Needs Assessments (JSNA)

Older People and Prevention JSNA 2013 – Chapter 5: Falls Prevention.



Cambridgeshire County Council

NHS Cambridgeshire

Cambridgeshire
Joint Strategic Needs Assessment

Prevention of Ill Health
in Older People

Full report

Contents

Available at:

http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/prevention-ill-health-older-people-2013

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