

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.

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 than 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 ≥ 1 kg 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 Hinchingsbrooke 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.

