Cambridgeshire County Council

NHS Cambridgeshire

Cambridgeshire Joint Strategic Needs Assessment

Prevention of Ill Health in Older People

Full report

Contents

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Executive Summary

Purpose and process

The purpose of this JSNA is to bring together information to inform how cross-sector partners and local communities can best work together to prevent ill health and achieve priority two of the Cambridgeshire Health and Wellbeing Strategy, 2012-2017: 'support our older people to be independent, safe and well'.

In Cambridgeshire in 2011, there were 101,400 people aged 65 or over. People in Cambridgeshire are living longer and the number of people over 65 is set to grow by approximately 19% in the next four years and 33% in the next nine years. Preventative approaches are important to ensure older people remain healthy and independent in the community for longer, and to reduce the unsustainable cost of health and social care services for this growing population. This report aims to inform local discussions to help shape the planning and commissioning of preventative services.

The Prevention of Ill Health in Older People JSNA has been developed to complement and build on the JSNAs for Older People produced in 2008 and 2010 and the Older People Financial Services Review (2012), as well as specific JSNAs on prevention, housing, physical impairments and long term conditions. The Older People JSNA steering group agreed this JSNA would initially focus on secondary and tertiary prevention approaches for older people with a view to updating information on primary prevention approaches in future JSNA phases.

This report therefore reviews early interventions which can enable older people to remain well and live independently at home, or in a community setting where appropriate, and prevent or reduce unnecessary hospital admissions. The group identified five priority areas to review which are important for the prevention of ill health in older people of Cambridgeshire:

- Integrated care and joined-up working to provide person-centred care and sharing of information.
- Identification of frail older people and those at risk of avoidable hospitalisation, and targeted multi-disciplinary interventions to provide support and prevent crisis eg active case management, rehabilitation and falls prevention.
- Early interventions to prevent or treat mental health problems in older people and initiatives to support and enhance mental wellbeing, including tackling social isolation and loneliness.
- Housing and social care support services tailored to the individual needs of older people.
- Community support and information, including the supportive roles of voluntary organisations and informal carers.

This JSNA has been produced in collaboration with key stakeholders, local voluntary organisations and the Older People's Partnership Board. The report presents views from our local communities collected from the Ageing Well Consultation (2011) and the draft Cambridgeshire Health and Wellbeing Strategy consultation (2012). It also informs the future planning of a number of key community engagement events including focus groups, to seek the views of local older people and community groups to ensure our assessments, services and interventions are responsive to local needs.

Early interventions to support older people to be independent, safe and well

a) Preventing hospital admissions and developing integrated care models

Preventing avoidable hospital admissions for those over the age of 65 through early interventions to prevent ill health and deterioration is desirable for both older people and their families or carers, and to reduce the use of expensive acute hospital care.

A national study by the King's Fund reported significant variation in the number and rate of emergency bed days used by people over 65 years of age (per weighted population) between Primary Care Trusts (PCTs) in England in 2010/2011. Where the top ranking (1st) has the lowest emergency bed days and admissions, Cambridgeshire ranked 98th out of 151 PCTs nationally. Factoring in population growth, there has been a 10.6% reduction in the rate of emergency bed day usage by people aged over 65 in Cambridgeshire between 2009/10 and 2011/2012. However, even continuing this progress will not be sufficient to achieve the same performance of the top quartile of PCTs in England. In Cambridgeshire in 2011/12, nearly 70% of all emergency occupied bed days were for people aged 65 or over.

The top 10 PCTs with lowest emergency bed day rates use different models of integrated primary and community care. Nationally, integrating care for older people is proposed as an approach to meet the funding challenges of financial austerity, rising acute healthcare costs and an ageing population with an increasing demand on acute services.

- Local commissioners are currently working together through the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Older People Programme Board to develop models of joint working to promote early intervention for better health and wellbeing, to deliver high quality care for older people and their carers, and reduce avoidable emergency admissions.
- There is limited evidence available to support specific interventions or models of care which can be demonstrated to reduce emergency admissions. Key to the success of a variety of reported case studies is developing integrated, co-ordinated systems which are responsive to local needs and have support from local stakeholders.

There are significant benefits to be realised by greater joint working within health and social care both at an operational and strategic level. However, at present integrated working remains a challenge, which is under review at the local level.

The following sections review a number of cross-sector interventions across health, social care, the voluntary sector and in local communities that can help to prevent ill health or dependency in older people in Cambridgeshire.

b) Case management by multi-disciplinary teams for 'frail' elderly people

Some older people are often referred to as 'frail', a non-specific term which is used to describe someone with a number of physical or mental disabilities or a cumulative loss of function, which makes an older person more vulnerable to an acute health or social crisis. Applying national estimates of frailty to the local population suggests that nearly 17,000 people over 65 (16.8%) are likely to be 'frail' in Cambridgeshire.

A fundamental element of intervening early requires identification of those who are most at risk. The Department of Health supported the development of a national risk stratification tool which uses data from primary and secondary health care to predict the patient's risk of future emergency admission.

- A modified version of this national tool is being piloted in Cambridgeshire to identify older people from GP surgery lists at higher risk of hospitalisation, for active case management and early intervention by multi-disciplinary teams.
- Evaluations are being conducted for a number of active case management approaches by multi-disciplinary teams throughout Cambridgeshire and Peterborough which will generate learning to share across the counties.
- Stakeholders have also emphasised that the development of information sharing across health, social care and the voluntary sector would facilitate more co-ordinated, cross-sector early interventions.

There are inter-collegiate guidelines for preventing avoidable hospital admissions during an acute episode and improving early recognition and interpretation of non-specific syndromes in older people which can be markers of poor outcomes.

- These recommendations are being used locally as a guide to audit, evaluate and improve the local response for an older person with an acute health crisis in the urgent care system.

Primary preventative approaches are important in reducing the risk of respiratory and circulatory diseases which are the main causes of mortality and morbidity and the top two causes of hospital admissions in Cambridgeshire for people over 65. There is also strong evidence base for secondary and tertiary prevention to reduce the impact of a stroke or heart attack, with national standards for cardiac and stroke rehabilitation.

- Coping with multiple morbidities and illnesses are significant challenges for older people and 'upstream' interventions should include optimising management of long term conditions and ensuring appropriate rehabilitation after stroke or cardiac events.

c) Falls prevention

Falls are a major cause of disability and the leading cause of mortality due to injury in older people over 75 in the UK. In each of the three 2012 falls related indicators in the Older People's Health and Well-Being Atlas (in those over 65: hospital admissions for falls, hospital admission injuries due to a fall, hip fractures) Cambridge City is significantly worse than the England average. In Cambridgeshire, there were 2,650 emergency admissions (and 17,890 bed days) in 2011/12 for injury due to falls in the over 65s, which accounts for 7.7% of emergency admissions in the over 65s.

- There are a range of falls prevention and falls services available across Cambridgeshire, but little data available on the outcomes or quality of these services. An audit of falls prevention strategies and interventions throughout Cambridgeshire could offer insight into local models, highlight gaps in service provision, identify areas of inequality and examples of good practice.
- A strong evidence base exists with national recommendations for commissioners to underpin the development of an integrated falls service across Cambridgeshire, building on assets and good practice already in place.
- There are also local opportunities to collaborate with research colleagues to strengthen and expand the evidence base into effective interventions for reducing falls in specific population groups, such as people with dementia.

d) Mental health

Over a third of older people in the UK are likely to experience mental health problems. The mental health needs of older people are often complex due to co-morbidities with mental health and/or physical health conditions or frailty being present at the same time.

In Cambridgeshire in 2013 there were estimated to be 7,240 people with dementia, and this number is likely to grow. This increase will lead to increasing demands on social services, primary care and families, as well as increasing pressure on acute hospitals and specialist mental health services. The prevalence of depression in older people is almost three times more common than dementia (and increases with age), particularly in those living alone with poor material circumstances. Although 20% to 40% of older people in the community show symptoms of depression, only 4% to 8% will consult their GP about this problem.

Mental health problems are under-identified by professionals and older people themselves, and older people are often reluctant to seek help, both of which can result in a delay before individuals and their carers are offered support.

- Increasing awareness of possible mental health problems affecting older people (including cognitive impairment) and access to advice and support could help to improve early diagnosis and access to effective help. This is important both for those caring for older people in all care settings including own home/community, care homes and hospitals.

A joint commissioning strategy for the mental health and well-being of older people (2013 – 2016) has been drafted by Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire County Council and Peterborough City Council and is due to be finalised in April 2013. This focuses on:

- early diagnosis and improving access to effective help, in particular, increasing awareness of mental health problems amongst those caring for older people;
- developing integrated services for mental health which facilitate early intervention and support older people and their carers in the community.
- advice and support for carers of older people with mental health problems including cognitive impairment;
- improved commissioning processes to promote joint working across health, social care and voluntary organisations.

- There is a need to further investigate local needs and service provision to support and evaluate the commissioning of mental health services and early interventions for older people. Specifically, further information would be helpful on the needs of older people in vulnerable groups, and alcohol and drug misuse.
- There is a need to ensure equity of access and services and sufficient capacity to meet the increasing mental health needs of older people. Improved joint-commissioning and better integration of services with joined-up working could enhance patient and carer experience, deliver better health outcomes and facilitate timely intervention.
- National case studies have shown that liaison psychiatry services in the acute hospital can generate improved mental health outcomes for older people as well as potential savings through an integrated approach to physical and mental health, reducing length of stay and readmissions.

e) Reducing social isolation and loneliness

Loneliness and isolation amongst older people is a key issue which impacts on their health and wellbeing. Nationally it is estimated that between 6% and 13% of people over 60 often or always feel lonely. In Cambridgeshire, approximately 29,000 people over 65 live alone.

Reducing loneliness can contribute to achieving a number of health and wellbeing board priorities and addressing it should result in stronger communities in which older

people play a greater role. Reducing loneliness and isolation can also help to address health inequalities.

- The issue of loneliness and social isolation is multi-faceted and the design of services needs to be informed by the complexity and inter-relationship of the causes of loneliness. Several local initiatives are described which help to promote social interaction and engage older people in meaningful activity.
- The evolving evidence base and sharing of effective local interventions to tackle social isolation and loneliness is a key priority for further analysis and consideration.
- There is a need to strengthen social capital through initiatives such as time banking and peer-group support models to drive wider health and wellbeing initiatives in local communities. It is recognised that local authorities may particularly need to stimulate community activity in areas where social networks are poorly developed because of deprivation or rural geography.

f) Social care and support in the community

There are a number of local interventions and examples of good practice which help to support older people and their carers, as well as prevent or delay the need for health and social care, including hospital admissions.

- Encouraging systematic evaluations of the impact of these interventions could help to promote, enhance and share best practice.

Re-ablement services are now widely available and proven to be effective in helping older people regain their independence through assisting with re-learning everyday tasks.

- The development of this approach needs to continue, to benefit more people.

The Ageing Well asset-based approach sees older people as community assets and demonstrates the benefits of engaging with them.

- This underlines the need to continue working in partnership and involving older people in service design, delivery and review.

Progress has been made in responding to older people's views about needing better information, through 'Community Navigators' and 'Information@GPs' and embedding 'Your Life, Your Choice' and 'Ask SARA' in other services. There is considerable potential to improve the way in which information and advice is offered across the whole health and social care sector. GPs are a key point of contact with 'at risk' older people and provide an opportunity to signpost to preventative and community support services.

- Raising awareness of local databases and sources of information about local support groups in the community could help to prevent ill health or crises and enhance the health and wellbeing of older people and their families or carers.

g) Housing

Supporting older people to remain in their own homes meets their aspirations and generates significant financial savings. This JSNA highlights key interventions delivered by local Home Improvement Agencies (HIA) or the Housing Related Support Team including grant and loan funding for adaptations and essential property repairs, low level housing-related support relating to security, personal safety, personal budgeting and minor repairs. More information is available in the Housing JSNA and Cambridgeshire Strategic Housing Market Assessment (2011).

- The challenges for housing support services are to ensure the continuation and co-ordination of interventions to support an increasing older population to remain in their own homes.
- The Health and Wellbeing Board and Local Health Partnerships offer new opportunities for joint working to ensure services, support and information to make informed choices are accessible for older people in need, particularly those in rural areas.

Fuel poverty is a growing problem, with the percentage of households in fuel poverty increasing from 11.5% to 14.5% in Cambridgeshire between 2008 and 2010. There were 211 excess deaths in winter in Cambridgeshire in 2009/10. The Winter Warmth programme supports older people by providing a fast, responsive system to provide advice on benefits and access to other services such as for insulation.

- The evaluation of this project highlights key learning which could be embedded into existing services to address the needs of vulnerable groups during the winter months.

h) Supporting carers

Carers provide a crucial role in supporting older people to be independent and live in the community, preventing unnecessary hospital admissions and reducing the need for health and social support. Better recognition of a caring role would help older people identify themselves as a carer at an earlier stage, and potentially be more likely to access appropriate support services before the point of crisis. Many carers are older people themselves and have specific health and wellbeing needs, as well as needs relating to their caring role. Nationally 65% of older carers (aged 60 to 94) have long-term health problems or a disability themselves and 69% say that being a carer has an adverse effect on their mental health.

- This group have been identified as a specific client group for whom a JSNA would be useful to further investigate their needs.

There are 60,000 informal carers in Cambridgeshire, but fewer than 5% are 'known' to GPs. In the 2012 Carers Survey, local carers identified a need for local and accessible information to enable informed decisions and choice, isolation and carer breaks and easily accessible advice on financial benefits.

- There is a need to widen the range of information and advice to ensure that all carers can access support appropriate to their need through a range of communication channels and across all sectors, particularly those in rural or deprived areas and hard to reach groups.
- Reaching carers who do not meet the Social Care eligibility criteria for services is also a priority, as they could benefit from accessing information and free low level/ preventative services that would support them to continue in their caring role.

Next Steps

The findings of this JSNA will be fed into commissioning plans for health and adult social care and support plans to develop local models of integrated teams working to support and deliver person-centred care tailored to the needs of individuals and their families or carers. There is a need to continue robust evaluation of local pilot interventions and to share good practice between all agencies and across the county where appropriate.

There is also a need to update the evidence base and local information about a primary prevention approach including active ageing, a healthy diet and nutrition, smoking and alcohol use, and oral and dental health.

Introduction

1.1 Purpose and aims of this JSNA

The purpose of this JSNA is to bring together information to inform how we can best work together to prevent ill health in older people. It has been developed to complement and build on the JSNAs for Older People (2010) and the Older People Financial Services Review (2012)[1], as well as specific JSNAs on prevention, housing, physical impairments and long term conditions. Key areas for focussing preventative efforts have been identified and this is a snapshot in the middle of a process of assessing and responding to local needs, to improve health and wellbeing and "support our older people to be independent, safe and well" (Cambridgeshire Health and Wellbeing Strategy, 2012-2017). This report will inform local discussions to help shape the planning and commissioning of preventative services.

This JSNA aims to provide analyses of local data, community views and local service provision data to assess the needs of older people. Information has been brought together from local partners and stakeholders about services and programmes of work in Cambridgeshire designed to prevent ill health in older people, and where there are gaps or inequalities to address. Opportunities are identified for early interventions and prevention programmes, and where available this report presents the evidence base for their effectiveness and cost-effectiveness.

Included are analyses of the range of factors important for the prevention of ill health in older people. The analyses recognise and emphasise that while health services make a contribution to the prevention of ill health, most of the key determinants of health such as education, employment, housing, and environment, lie outside the direct influence of healthcare. This is reflected in sections looking at the integration of services, local community support and information, preventing loneliness and social isolation, housing aids and adaptations and the needs of carers in the community.

Each section makes reference to external reports and to more detailed information and includes publicly accessible web links to these sources where possible.

1.2 Prevention of Ill Health in Older People – a focus on early interventions

Preventative services are often thought about in three levels:[2]

- Primary prevention – universal services that are aimed at people who have no or no particular health or social care needs or symptoms of illness (but including those who are at risk of needing social care support).
- Secondary prevention (early intervention) – services that aim to halt or slow down deterioration for people who have some health or social care need or illness.

[1] Cambridgeshire JSNA Older People Services and Financial Review. Available at: http://www.cambridgeshirejsna.org.uk/search/node/phase%206.
[2] Department of Health 'Putting People First: a shared vision and commitment to the transformation of social care'. 2007. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118.

- Tertiary prevention (specialist support) – services that are aimed at minimising disability or deterioration from established health conditions or complex social care needs.

The Older People JSNA steering group agreed this JSNA would initially focus on secondary and tertiary prevention approaches for older people with a view to updating information on primary prevention approaches in future JSNA phases. The group identified five priority areas to review which are important for early interventions to prevent ill health in older people in Cambridgeshire:

- Integrated care and joined-up working to provide person-centred care and sharing of information.
- Identification of frail older people and those at risk of avoidable hospitalisation, and targeted multi-disciplinary interventions to provide support and prevent crisis eg active case management, rehabilitation and falls prevention.
- Early interventions to prevent or treat mental health problems in older people and initiatives to support and enhance mental wellbeing, including tackling social isolation and loneliness.
- Housing and social care support services tailored to the individual needs of older people.
- Community support and information, including the supportive roles of voluntary organisations and informal carers.

Section 5 of the JSNA Older People (including Dementia) describes primary preventative approaches to promoting healthy lifestyles and behaviours for older people, a key tenet in Priority 3 of the Health and Wellbeing Strategy. Many of the key issues for primary prevention are similar to those described in the Prevention for Adults of Working Age and a JSNA update on oral and dental health relevant to older people is also available. These include: a healthy diet and nutrition, the importance of physical activity and active ageing, smoking, alcohol and drug use, and oral and dental health. This is an area for future work to update local information on primary prevention.

A vertical theme throughout the Health and Wellbeing Strategy is a call for more joined-up working, more effective partnerships and person-centred care. Key to this is improving the sharing of information; both raising awareness of what services and support are available throughout Cambridgeshire and sharing information about individual patients to facilitate more joined-up care. It is hoped that this JSNA contributes to this agenda by describing some of the local interventions and programmes which can be accessed by older people and help to support them and their carers. The section on information and advice (see section 8.4) also details a number of web-based directories for local GPs or health care staff in primary and secondary care where they can signpost local support to their patients, their families or carers.

1.3 Community views and consultation

The report presents views from our local communities collected from the Ageing Well Consultation and the draft Cambridgeshire Health and Wellbeing Strategy consultation (2012). Also included is information and selected case studies contributed by some of our voluntary sector colleagues.

A key aim of the Cambridgeshire Health and Wellbeing Strategy 2012-2017 is to recognise the importance of the voluntary and community sector and their valuable contribution to implementing the strategy. In particular, the voluntary and community sector in Cambridgeshire plays an important and significant role in supporting and delivering services to people aged 65 years and over. Care Network, Age UK, Alzheimer's Society and Crossroads have been involved in developing this JSNA and contributing local data and information about local interventions and services. Feedback from these organisations, as well as from the Cambridgeshire Older Persons Partnership Board, has been incorporated into this report.

As part of the on-going process of joint strategic needs assessment, the JSNA and Health and Wellbeing for Older People Action Plan Steering Group is planning a number of focus groups and events to engage with our local communities of older people and community groups. This on-going work aims to engage older people in the planning of services and policies so that they reflect local need and help to target services where they will have greatest impact and take into account future needs.

1.4 Further work

This report should be regarded as work in progress which can be built on further and which has, and will, raise a number of questions for future work. The group welcome comments, additional information and questions on this JSNA from all stakeholders and local communities to continually update our local knowledge.

In particular, the steering group has recognised a need to continue robust evaluation of local pilot interventions and to share good practice between all agencies and across the county where appropriate. This forms part of the Cambridgeshire Health and Wellbeing Strategy Action plan[3] for Priority 2.

As noted above, there is also a need to update the evidence base and local information about a primary prevention approach including: active ageing, a healthy diet and nutrition, smoking and alcohol use, and oral and dental health.

[3] Most recent action plans available from the Cambridgeshire Health and Wellbeing Board meeting minutes:
http://www.cambridgeshire.gov.uk/CMSWebsite/Apps/Committees/Committee.aspx?committeeID=55

Demography

2.1 Population of over 65s

This JSNA focuses upon the population of older people aged 65 years and over. In Cambridgeshire in 2011, there were 101,400 people aged 65 or over (16% of all residents), 47,600 people aged 75 or over (8% residents), and 14,100 people aged 85 and over (2% residents). The number of people in each age group are shown in Table 1.

Table 1: Number and proportion of people age 65 years and over, Cambridgeshire, mid 2011 population estimates

Population	65-69	70-74	75-79	80-84	85-89	90+	Total (aged 65+)
Number	30,700	23,100	18,900	14,600	9,100	5,000	101,400
Proportion	30.3%	22.8%	18.6%	14.4%	9.0%	4.9%	100%

Source: ONS mid 2011 population estimates

People in Cambridgeshire are living longer and it is estimated that by 2021 there will be 33,000 more people aged 65 and over in Cambridgeshire (a 33% increase). The largest proportional increases will be in the older age bands, especially the very elderly (see Table 2).

Table 2: Population projections, mid 2011 based, number and estimated % change, people aged 65 years and over

Age band	2011	2016	2021	% change 2011 to 2016	% change 2011 to 2021
65-69	30,700	36,900	33,900	20%	10%
70-74	23,100	29,300	35,200	27%	53%
75-79	18,900	21,000	26,800	11%	42%
80-84	14,600	15,800	17,900	8%	22%
85-89	9,100	10,500	11,900	15%	31%
90+	5,000	6,800	8,800	37%	77%
Total 65+	101,400	120,100	134,500	19%	33%

Source: ONS mid 2011 interim population projections

For more detailed demographic information, please refer to the Cambridgeshire JSNA Demographic District reports.[4]

2.2 Life Expectancy at age 65 years

Life expectancy at age 65 is the number of additional years males and females at age 65 can expect to live when current mortality rates are applied based on mid 2006-2008 population estimates and mortality data. Life expectancy at age 65 is described by district in Table 3.

[4]Cambridgeshire JSNA Demographic District reports. Available at: http://www.cambridgeshirejsna.org.uk/supportingdata/cambridgeshire-district-demographic-reports.

Table 3: Life expectancy at age 65 in Cambridgeshire, 2006-2008

	Males		Females	
	Additional years of life after 65	95% Confidence Intervals	Additional years of life after 65	95% Confidence Intervals
Cambridge City	17.5	(17.1 - 18.0)	20.6	(20.1 - 21.0)
East Cambridgeshire	18.7	(18.2 - 19.2)	21.7	(21.2 - 22.1)
Fenland	17.4	(17.0 - 17.8)	20.0	(19.6 - 20.4)
Huntingdonshire	18.2	(17.8 - 18.5)	20.9	(20.6 - 21.3)
South Cambridgeshire	19.6	(19.2 - 20.0)	21.9	(21.6 - 22.3)
England	17.7		20.4	

Source: Older People's Health and Wellbeing Atlas produced by the West Midlands Public Heath Observatory on behalf of the Public Health Observatories in England. http://www.wmpho.org.uk/olderpeopleatlas/atlas/atlas.html

For both males and females in Cambridgeshire, life expectancy at age 65 is generally above the national average, and this figure is significantly better than the national average in East Cambridgeshire, Huntingdonshire and South Cambridgeshire. In Fenland and Cambridge City the figure is lower but this is not statistically significant.

Preventing avoidable hospital admissions

3.1 Context

Emergency admissions to hospital are often undesirable from the patient's perspective, expensive for the health system and take resources away from elective admissions. More than 70% of hospital bed days are occupied by emergency admissions.[5] Whilst the majority of hospital admissions are for elective patients (55% in 2009/10) they occupy less than 30% of bed days. In Cambridgeshire in 2011/12, nearly 70% of all emergency occupied bed days were for people aged 65 or over.

In 2012, a King's Fund report[6] explored the variation in the number of emergency bed days used by people over 65 years of age, as reported by each hospital in England using hospital episode statistics (HES) data. Significant variation was noted between Primary Care Trusts (PCTs), although extrapolating the drivers of this variation is complex. The number of bed days used depends on the rate of admissions as well as length of stay. However, the King's Fund analysis suggests that for the PCTs with the highest and lowest bed use, the dominant driver of bed days used is the rate of admission.

The headline finding of the report was a nearly fourfold variation between PCTs nationally and it was suggested that PCTs should strive to reduce emergency admissions to the rate of the best performing 10 PCTs. Torbay remains the leading PCT for lowest emergency bed days, followed by Herefordshire, Devon and Cornwall.

This analysis was replicated locally to produce a needs weighted bed day rate based on local data using a modified method to calculate the needs index. This adjusted the Health and Community Health Service (HCHS) for the needs of older people rather than the whole population.

3.2 Emergency bed days in Cambridgeshire

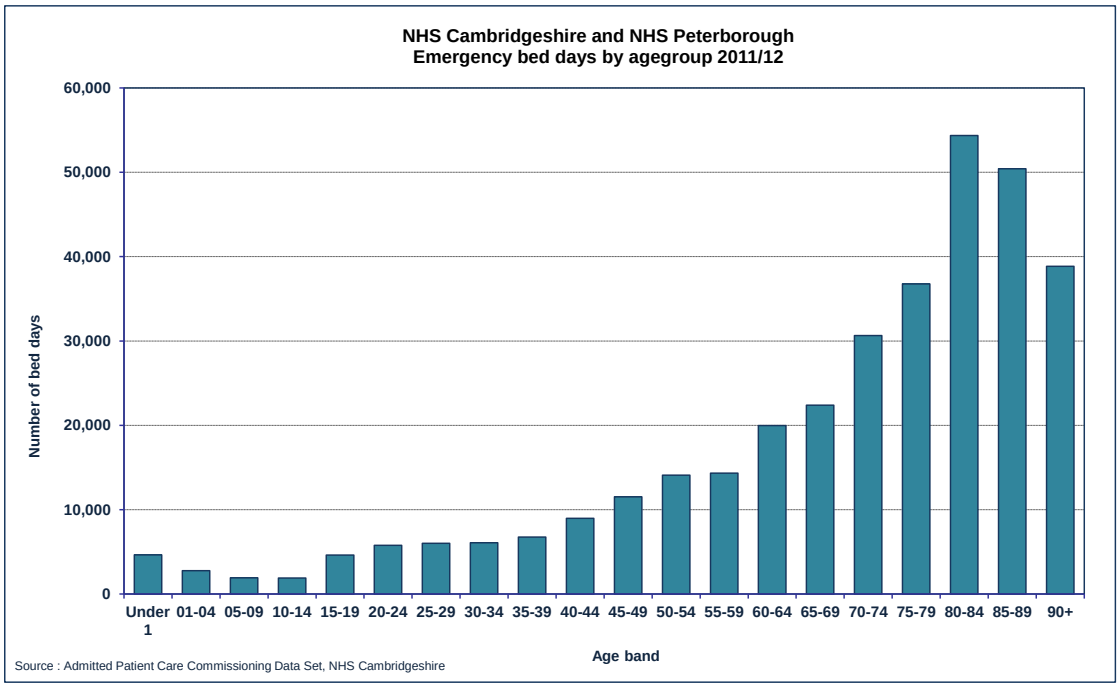
A detailed analysis of activity and resource use for the care of people aged over 65 was produced and is available in the Cambridgeshire JSNA Older People Services and Financial Review.[7] Data in this report demonstrated that almost half of total hospital spend (45%) was for people aged over 65, who make up about one in six of the Cambridgeshire population.

With the exception of the early years, hospital usage increases rapidly with increasing age (see

[5] Poteliakhoff E, Thompson J. Emergency bed use: what the numbers tell us. King's Fund, December 2011.
[6] Imison C, Thompson, J. Older people and emergency bed use: exploring variation. King's Fund, 2012.
[7] Cambridgeshire JSNA Older People Services and Financial Review. Available at: http://www.cambridgeshirejsna.org.uk/search/node/phase%206.

Figure 1). A significant proportion of resource use for emergency bed days is amongst the very elderly population.

Figure 1: NHS Cambridgeshire and NHS Peterborough Emergency bed days by age group 2011/2012



Source: APC CDS Serco and quarterly Exeter downloads, Serco. Acute hospitals only.

Data from the King's Fund research for financial year 2009/10 found that out of 151 PCTs in England, where the top ranking (1st) has the lowest emergency bed days and admissions, Cambridgeshire ranked:

- 98th for emergency bed days per weighted population aged 65+;
- 59th for emergency admission rate per weighted population aged 65+;
- 126th for average length of stay for emergency admissions for people aged 65+.

The Public Health Intelligence analysis (applying a revised methodology on the King's Fund data) shows the revised emergency bed day rates for different age groups against comparators including the England average, top quartile and top 10 performing PCTs and our ONS cluster comparator, 'Prospering Southern England PCTs' (see Table 4). Cambridgeshire and Peterborough have a higher rate of bed days than the top 10 PCTs in the country, although they do not differ significantly from the comparison group of Prospering Southern England PCTs.

Table 4: Emergency weighted bed day rate (per 1,000) 2010/11

HES 2010/11	Needs Weighted rates							
	Crude rate				Directly age standardised rate			
	65+	75+	80+	85+	65+	75+	80+	85+
NHS Cambridgeshire	2.02	3.19	4.34	5.86	2.04	3.32	4.35	5.86
NHS Peterborough	1.83	3.08	3.95	5.38	1.88	3.08	4.04	5.38
Top 10 PCTs	1.57	2.39	3.00	3.61	1.55	2.43	2.99	3.61
Top quartile	1.77	2.74	3.55	4.48	1.76	2.80	3.54	4.48
Prospering Southern England	2.05	3.13	4.36	5.85	2.03	3.32	4.38	5.85
New and Growing Towns	2.28	3.70	4.93	6.58	2.30	3.78	4.99	6.58
England	2.17	3.47	4.47	5.71	2.17	3.47	4.47	5.71

Source : HES 2010/11 (provided by Capita) and mid 2010 population estimates. Revised HCHS index of need by age band (calculated by Public Health).

Table 5 shows the number of emergency bed days for people aged over 65 years in Cambridgeshire and Peterborough in 2011/12, by Local Commissioning Group (LCG) and age group. Of note, columns 2-5 show absolute numbers of emergency bed days used by older people, not adjusted according to population age structure. The right hand columns calculate the bed day rate weighted according to age structure and health care needs for over 65s and over 75s age groups.

Table 5: Emergency bed days in people aged 65 and over, 2011/12 and emergency bed day rate by LCG and age group

LCG	Bed days 2011/12			Bed days 2011/12		Bed Day Rate 2011/12*	
	65-74	75-84	85+	65+	75+	65+	75+
Borderline	5,979	9,268	7,286	22,533	16,554	1.79	2.85
CATCH - Cambridge City	2,090	3,858	4,792	10,740	8,650	1.82	2.93
CATCH - City Suburb	2,024	3,854	4,645	10,523	8,499	2.13	3.32
CATCH - Granta	1,307	2,071	2,176	5,554	4,247	2.39	3.94
CATCH - North Villages	922	1,876	1,836	4,634	3,712	1.92	3.53
CATCH - South Villages	3,308	6,231	6,916	16,455	13,147	1.79	3.01
CATCH - Total	9,651	17,890	20,365	47,906	38,255	1.93	3.18
CamHealth Integrated Care	4,846	8,758	10,342	23,946	19,100	2.21	3.31
Hunts Care Partnership	7,995	14,787	13,535	36,317	28,322	1.94	3.39
Hunts Health	5,413	8,278	7,930	21,621	16,208	1.97	3.36
Isle of Ely	6,450	10,441	11,100	27,991	21,541	1.92	3.18
Peterborough	7,664	13,475	11,778	32,917	25,253	1.93	2.97
Wisbech	4,508	7,335	5,967	17,810	13,302	1.91	3.04
Cambridgeshire and Peterborough	52,506	90,232	88,303	231,041	178,535	1.94	3.16

Source: APC CDS Serco and quarterly Exeter downloads, Serco. *Rates calculated using revised HCHS index of need by age band (calculated by Public Health).

Analysis of trends between 2009/10 and 2011/12 show that Cambridgeshire and Peterborough are making progress in reducing emergency bed day usage for older people, despite the overall growth in the older population. As described in section 0 the population of older people in Cambridgeshire is projected to increase significantly from the 2011 baseline, by 18.5% by 2016. Factoring in population growth, there has been a 10.6% reduction in the rate of emergency bed day usage by people aged 65+ in Cambridgeshire and a 7.2% reduction in Peterborough between 2009/10 and 2011/12 (see Table 6). However, even continuing this trend, this is not sufficient for Cambridgeshire to achieve the performance of the top quartile PCTs in England for the emergency bed day rate.

Table 6: Change in emergency bed day usage for people aged 65+ in Cambridgeshire and Peterborough between 2009/10 and 2011/12

Change over two year period from 2009/10 to 2011/12	Cambridgeshire		Peterborough	
	Number	%	Number	%
Increase in registered population aged 65+	5,592	5.9%	578	2.6%
Change in emergency bed days for people aged 65+	-10,529	-5.3%	-2,217	-4.8%
Change in emergency bed day rate for people aged 65+		-10.6%		-7.2%
Change in emergency admissions for people aged 65+	1,180	6.1%	482	9.7%
Change in emergency admission rate for people aged 65+		0.0%		7.0%
Change in average emergency length of stay people aged 65+	-1.1 day	-10.8%	-1.2 days	-13.2%

Source: APC CDS Serco and quarterly Exeter downloads, Serco

3.3 Reducing emergency admissions for older people

According to the NHS Institute's 'Better Care Better Value', reducing length of stay (LOS) by one day saves the NHS £215.[4] For example, a 5% reduction in bed days for patients aged 85 years or above who stay in hospital for more than two weeks

would mean that the NHS Cambridgeshire and NHS Peterborough saved 2,670 bed days, with a theoretical saving of £574,050.

Public Health Intelligence calculations using the King's Fund data indicate that Cambridgeshire could theoretically have reduced its overall acute bed requirement by 225 beds by moving to the performance of the 'top ten' PCTs, with the lowest emergency bed day use for people aged over 65 years.

It is worth noting however that interventions which reduce admissions and length of stay do not necessarily reduce system costs due to:

- The additional cost of community intervention, which needs to be balanced against the savings from admission and length of stay reductions.
- The potential for hospital beds to be occupied by patients who would not otherwise have been admitted, reducing the net hospital saving.
- The continuation of hospital fixed costs.

The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)'s commissioning intention is to "improve out of hospital care for frail older people, and reduce 'emergency bed days' in terms of both admissions and the amount of time spent in hospital as a result of unplanned admissions."[8] This would deliver improved patient experience, better community care, and reduced unplanned admissions to hospital, where these can be safely avoided.

The aim is to deliver this by following best practice in treatment such as the use of assistive technology embedded within pathways, re-ablement/rehabilitation, improved information sharing and communication between professionals / organisations, effective management of the discharge process, reducing variation, reducing unnecessary admissions and avoiding unplanned re-admissions. The aim is to redesign services for care to be provided in an integrated way with services organised around the patient.[9]

The CCG is working closely with Cambridgeshire County Council and local stakeholders to develop models and systems, which respond to local needs and deliver an integrated system of care and support, which emphasises early and preventative interventions. A Consultation on the Older People programme proposals will be held from April 2013.

3.4 Evidence for reducing unplanned admissions to hospital for those over 65 years

In trying to reduce emergency admissions, it is important to be clear which admissions are potentially avoidable and which interventions are likely to be effective. In 2012, the University of Bristol conducted a series of systematic reviews of interventions to reduce unplanned hospital admissions (UHA)[10] which updated a review of the available evidence (by the same lead author) published by the King's Fund in 2010.

[8] Cambridge and Peterborough Clinical Commissioning Group (CCG) Commissioning Intentions. Available at: www.cambridgeshire.nhs.uk

[9] Cambridgeshire and Peterborough CCG Older People's Programme Board Stakeholder Update (2013). Available at: http://www.cambridgeshire.nhs.uk/downloads/CCG/Older%20Peoples%20Programme%20Stakeholder%20Update%201.pdf.

[10] Purdy, S. et al. (2012) 'Interventions to reduce unplanned hospital admissions: a series of systematic reviews' University of Bristol (funded by NIHR). Available at: http://www.bristol.ac.uk/primaryhealthcare/docs/projects/unplannedadmissions.pdf.

There was some evidence that education/self-management, exercise/rehabilitation and telemedicine in selected patient populations, and specialist heart failure interventions can help reduce UHAs. Evidence on specific interventions included:

- **Integrating health and social care**: Integrating primary and secondary care can be effective in reducing admissions. In primary care, higher continuity of care with a GP is associated with lower risk of admission.
- **Telemedicine:** This seems to be effective for patients with heart failure, but there is little evidence available at present that it is effective for other conditions.
- **Hospital at home:** This produces similar outcomes to inpatient care, at a similar cost. There was insufficient evidence (a lack of studies) found to make any conclusions on the role of finance schemes, emergency department interventions and continuity of care for the reduction of unplanned UHAs.
- **Case management**: In the community and in hospital this was not found to be effective in reducing generic admissions. There is limited evidence to suggest that it may be effective for patients with heart failure. Assertive case management is beneficial for patients with mental health problems.
- **Specialist clinics:** Overall specialist clinics for heart failure patients, which included clinic appointments and monitoring over a 12 month period reduced UHAs. There was no evidence to suggest that specialist clinics reduced UHAs in asthma patients or in older people.
- **Care pathways:** Systematic reviews have been conducted across conditions as well as for specific diseases such as gastrointestinal surgery, stroke and asthma. Guidelines have been reviewed similarly across conditions. There is no convincing evidence to make any firm conclusions regarding the effect of these approaches on UHA, although it is important to point out that data are limited for most conditions.
- **Senior review:** Early review by a senior clinician in the emergency department is effective. Acute assessment units may reduce avoidable admissions, but the overall impact on number of admissions should be considered. GPs working in the emergency department are probably effective in reducing admissions, but may not be cost-effective.
- **Education and self-management:** Patient self-management seems to be beneficial. The Cochrane reviews concluded that education with self-management reduced UHAs in adults with asthma, and in chronic obstructive pulmonary disease COPD patients but not in children with asthma. There is weak evidence for the role of education in reducing UHAs in heart failure patients.
- **Community interventions:** Overall, the evidence is too limited to make definitive conclusions. A small number of randomised controlled trials (RCTs) based on home visits were found by the searches and covered older people, mother and child health and heart disease.

The most striking finding from this comprehensive review is the limited evidence available which convincingly demonstrates reductiona in unplanned hospital admissions from individual intervention programmes. There is also a lack of evidence on the effectiveness of combinations of interventions. However, the review noted the importance of the impact of various interventions across the system and the difficulty in isolating a single factor in the prevention of admissions. The authors also

emphasise the need for robust evaluation of interventions as they are introduced into health and social care systems.

Given the limited evidence available to support various models of care, there is no recognised national best practice in terms of specific interventions. Key to the success of a variety of reported case studies seems to be using best practice but developing systems which are responsive to local needs and investment by local stakeholders. What appears to be important is a system wide approach, and a degree of integration of care, as reviewed in the next section.

3.5 Integrated care for older people

The King's Fund analysis found that areas with lower rates of hospital bed use had well-developed, integrated services for older people, and achieved lower readmission rates and reported better patient experiences.[11] Given the complex interactions and inter-related influences on emergency admissions and length of stay, it is difficult to extrapolate which factors play a significant role in, and could be modified to, reduce the use of emergency bed days. Factors which were found to correlate with variation in emergency bed use were availability of community services, access to hospital services, and the way services and staff relate to each other. However, it is notable that these outcomes were correlated rather than being demonstrated as cause and effect.

Integrated care provides "a framework for co-ordinated multidisciplinary working, enabling professionals across several organisations to provide better and more efficient health care to patients."[12] It aims to bring together previously fragmented services to improve the quality, experience and coordination of care across the patient pathway. Integrated care and support should be, by definition, patient centred and aim to support shared decision-making and self-management between patients and providers.[13] A key objective of integrated care and support is to view an unplanned admission to hospital as a 'system failure'.[14] The number of hospital emergency bed days used by patients over 65 can therefore be used as an outcome indicator of successful integrated care.

International models such as Kaiser Permanente and Geisinger Health in the USA and Alzira in Spain illustrate some effective models of integration at the organisational level. However, change at this macro-scale is not necessary to deliver the benefits of integrated care[15] and effective integrated care can be achieved without the need for formal (real) integration of organisations. The key element appears to be clinical and service level integration with joined-up working between different professionals and organisations.[16]

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[11] Imison C, Thompson, J. Older people and emergency bed use: exploring variation. King's Fund, 2012

[12] Policy Exchange (2012) All Together Now: Competitive integration in the NHS Policy Exchange, London. Available at: http://www.policyexchange.org.uk/publications/category/item/all-together-now-competitive-integration-in-the-nhs.

[13] Goodwin, N. And Smith, J. (2012) 'Presentation: The evidence base for integrated care' Presentation from the King's fund and Nuffield Trust. Available at: http://www.King'sfund.org.uk/audio-video/evidence-base-integrated-care.

[14] Policy Exchange (2012) 'All Together Now: Competitive integration in the NHS' Policy Exchange, London.

[15] Goodwin, N. And Smith, J. (2012) 'Presentation: The evidence base for integrated care' Presentation from the King's fund and Nuffield Trust.

[16] Ham, C. & Curry, N. (2011) 'Integrated care: What is it? Does it work? What does it mean for the NHS?' The King's Fund, London. Available at:

There are a number of common features in the international and Torbay models to which the success of implementing an integrated model is attributed by the case study authors:

- **Multiple local strategies to meet local needs**: The evidence suggests that "the cumulative impact of multiple strategies for care integration is more likely to be successful in meeting the demands and improving the experiences of patients, service users and carers".[17] Common to each example is the importance of tailoring an approach to the local situation and keeping the needs and perspectives of the individual at the heart of any discussion about integrated care.
- **Clinical and service integration:** The support of local professionals across all disciplines was necessary to facilitate effective communication and multi-specialty or cross-organisational working, including establishing clear protocols and processes for managing patient care.[18]
- **Staff and patient engagement**: Involvement and engagement of staff and patients was vital. This often required a meaningful consultation to listen and share views of staff and a powerful narrative at the local level about how services could and should be delivered for frail older people including a clear articulation of the benefits to patients, service users and carers
- **Information sharing:** A significant factor in achieving effective integrated care is the close coordination and sharing of information, which requires a suitable IT mechanism for storing and sharing information. Although a single or integrated model of IT seems unfeasible at present, the crucial aspect of this is interconnectivity between primary care, secondary care, community and social care information systems. Patient access to health records as a means of involving the patient in their own care is also recommended in the literature as a long-term priority.
- **Clear, achievable outcomes:** In the Torbay model for example, these were:
    a. Improve access to services.
    b. Reduce the time from identification of need to delivery of community service.
    c. Simplify the decision-making processes or pathway with a unified management system.
    d. Improve communication, including sharing of information to facilitate more co-ordinated care and reduce duplication of services or assessment.

Each of these factors also present potential barriers to integration. A number of these which are important to address in developing a local system, are noted in the policy and research literature:[19,20, 21]

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http://www.Kingsfund.org.uk/sites/files/kf/field/field_publication_file/integrated-care-summary-chris-ham-sep11.pdf

[17] Powell-Davies, G. et al. (2008) 'Co-ordinating primary health care: an analysis of the outcome of a systematic review' *Medical Journal of Australia*, 188: 8: S65-68.

[18] Policy Exchange (2012) 'All Together Now: Competitive integration in the NHS' Policy Exchange, London.

[19] Thistlethwaite P. (2011) 'Integrating health and social care in Torbay: improving care for Mr Smith' The King's fund, London.

[20] Goodwin N. And Smith, J. (2012) 'Presentation: The evidence base for integrated care)' Presentation from the King's fund and Nuffield Trust.

[21] Steventon A. (2011) 'An evaluation of the impact of an independent inquiry commissioned by the King's Fund' The King's Fund, London.

- organisational divisions between primary and secondary care in the NHS, and between health and social care;
- cultural differences and different accountabilities between professionals;
- a limited basis of information sharing and incompatible IT systems with access limited to professional groups, and the absence of a robust shared electronic patient record;
- risk averse culture in the NHS;
- a potential restriction of integrated care to short-term pilot projects which may fail to demonstrate desired goals;
- real clinical engagement and leadership;
- a payment by results approach to funding hospital activity, plus increasing financial pressures to accommodate both a capitated model of service integration and acute care costs until the service is fully functional.

There are significant potential savings and benefits from earlier identification and support for older people. Cambridgeshire has some good examples of support by health and social care and Voluntary Sector, although was criticised for working in silos in the very recent ECIST review.[22] Integrated working remains a challenge locally, but is the subject of the current review of Older People's Services as part of the health commissioning process.

3.6 Key findings

- Nationally, integrating care for older people is proposed as an approach to meet the funding challenges of financial austerity, rising acute healthcare costs and an ageing population with an increasing demand on acute services. The top 10 PCTs with lowest emergency bed day rates use different models of integrated primary and community care.[6]
- Local commissioners are currently working together to develop models of joint working to promote early intervention for better health and wellbeing, to deliver high quality care for older people and their carers, and reduce avoidable emergency admissions.
- There is limited evidence available to support specific interventions or models of care which can be demonstrated to reduce emergency admissions. Key to the success of a variety of reported case studies is developing integrated, co-ordinated systems which are responsive to local needs and have support from local stakeholders.
- The following sections review a number of cross-sector interventions currently in place or under development across health, social care, the voluntary sector and in local communities that can help to prevent ill health or dependency in older people in Cambridgeshire.

[22] Cambridgeshire Whole System Review (2012) Diane Fuller, Emergency Care Intensive Support Team (ECIST) NHS IMAS.

Case management for 'frail' elderly people

4.1 Context

For many older people, advancing age is associated with 'frailty', a term that describes the state of 'limited functional reserve' or 'failure to integrate responses in the face of stress".[23] In frail individuals, a 'small insult can result in catastrophic loss of function'.[24] Common co-morbidities can contribute to frailty such as: cardiovascular disease (high blood pressure, or previous heart attack or stroke), physical disability, diabetes, respiratory problems, osteoporosis, previous falls, malnutrition or sensory loss.

Developing a universal definition of 'frailty' is challenging and a number of different models exist. Several instruments for the identification of frailty can be found in the literature.[25] Some, such as the Fried frailty criteria,[26] focus on frailty as a physical syndrome whereas others use a broader definition in which psychological and social aspects are incorporated, such as the Frailty Index by Rockwood[27] and the Tilburg Frailty Indicator.[28] This broader definition proposes a deficit model, summarising frailty by counting the number of problems people have experienced or protective functions they have lost: the number of deficits is consistently related to a risk of adverse outcome.[29]

The aim of defining frailty is to provide both population level estimates of those in need of support for commissioning and needs assessment, and to identify 'frail' individuals at a local operational level, who may be most at risk of ill health or require emergency interventions or support.

4.2 Local estimates of prevalence

Frailty estimates in the population are useful as they indicate whether the population is becoming more or less frail. Forecasting the proportion of people likely to be frail necessitates an understanding of changes to the population and the likelihood of any individual becoming frail. The Medical Research Council's Cognitive Function and Ageing Study[30] (CFAS) provides estimates of the prevalence of frailty among older people, where frailty is defined as either physical disability, mental disability or both. Physical frailty is measured using an activity of daily living scale and mental frailty using standard assessment scales. Applying these rates to the local population

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[23] Cirnwell, J. (King's Fund) 'The care of frail older people with complex needs: time for a revolution' (2012) Available at: http://www.King'sfund.org.uk/sites/files/kf/field/field_publication_file/the-care-of-frail-older-people-with-complex-needs-mar-2012.pdf

[24] Rockwood K, Hubbard R (2004). 'Frailty and the geriatrician'.*Age and Ageing*, vol 33, pp 429–30.

[25] van Kempen JAL. et al. 'Development of an instrument for the identification of frail older people as a target population for integrated care' B*ritish Journal of General Practice*, March 2013.

[26] Fried LP, et al. Frailty in older adults: evidence for a phenotype. J Gerontol A BiolSci Med Sci 2001; 56(3): M146–156.

[27] Theou O, Rockwood MRH. Et al. 'Disability and co-morbidity in relation to frailty: how much do they overlap?" Archoves of Gerontology & Geriatrics 2012; 55: e1-8

[28] Gobbens RJ, et al. **'**The Tilburg Frailty Indicator: psychometric properties'*J Am Med Dir Assoc.* 2010 Jun; 11(5):344-55.

[29] Rockwood K. et al. 'Long-term Risks of Death and Institutionalization of Elderly People in Relation to Deficit Accumulation at Age 70' *Journal of the American Geriatrics Society* 2006; 54:975-979

[30] Melzer D. *et al.* Medical Research Council Cognitive Function and Ageing Study (MRC CFAS) and Resource Implications Study (RIS MRC CFAS): Profile of disability in elderly people: estimates from a longitudinal population study. *BMJ* 1999; 318:1108-1111.

provides a forecast of the likely number of frail people in the future. This methodology assumes that the prevalence of frailty will remain constant into the future. While medical and technical advances mean that this may not be the case, we equally have no robust conceptual base on which to base any alternative assumptions.

Table 7 below shows how the prevalence of frailty varies by age, sex and type of frailty. Among all men aged over 65, 11% are likely to be frail, of whom just over half will be physically frail, just over a quarter will have a cognitive impairment and the remaining 19% will be physically and cognitively frail. Among women, a higher proportion is likely to be physically frail, and a lower proportion to be cognitively impaired. The prevalence of frailty rises with age, such that among women aged over 85, over half would be expected to be frail.

Table 7: Prevalence of physical and mental frailty in men and women aged 65+,

Prevalence	65-74		75-84		85+	
	Men	Women	Men	Women	Men	Women
% frail	**6%**	**7%**	**14%**	**21%**	**36%**	**54%**
Of whom,						
Physically frail	59%	75%	53%	69%	48%	59%
Mentally frail	28%	18%	29%	15%	22%	16%
Combined mental and physical frailty	13%	7%	17%	15%	30%	25%

Source: MRC CFAS Study[30]

Applying estimates of frailty to the local population suggests that nearly 17,000 people over 65 (5,600 men and 11,200 women) are likely to be 'frail' in Cambridgeshire (see Table 8). This is approximately 16.8% of older people in Cambridgeshire over the age of 65. Of these, 17,000 people, 10,300 are likely to be physically frail, 3,150 cognitively frail and a further 3,100 combined mental and physical frailty.

Table 8: Estimated number of frail older people (65+) in Cambridgeshire, 2012-2020

Age band	2012	2016	2021	% change 2012 to 2016	% change 2012 to 2021
Physically frail	10,300	11,610	13,060	13%	27%
Mentally frail	3,280	3,720	4,210	13%	28%
Combined mental and physical frailty	3,150	3,600	4,120	14%	31%
Total frail	16,790	19,000	21,470	13%	28%

Source: MRC CFAS[30] estimates applied to ONS mid 2011 interim projections

4.3 Identifying those at risk of hospital admission

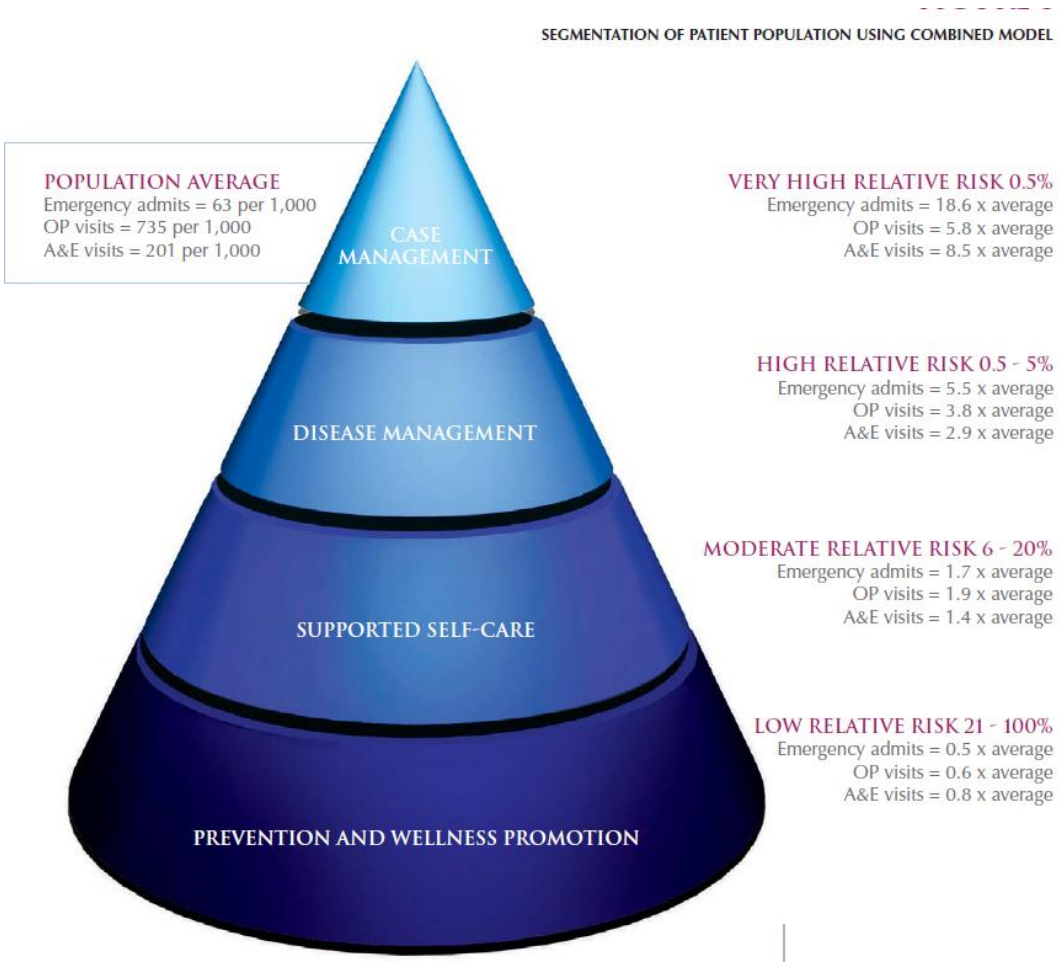
In order to change care from being reactive and disease oriented to proactive and patient oriented (integrated care) those who are frail must be identified. Key to developing effective interventions to support older people is establishing a robust mechanism to identify patients who are at risk (case finding). The assumption is that better upstream care (or case management) will improve health such that the risk of admission (and cost) 'downstream' will be reduced.[31]

[31] The King's Fund.'Predictive Risk Project Literature review' (2005). Available at: http://www.Kingsfund.org.uk/sites/files/kf/field/field_document/predictive-risk-literature-review-june2005.pdf

The accurate identification of those at risk is also crucial to ensure that care, and resources, are targeted at the correct people and do not exclude any vulnerable individuals. It is also important to conduct a health impact assessment to assess the potential for widening health and wellbeing inequalities through new models of care and support.

In the UK, the focus has been on identifying those at risk of hospitalisation. It has been proposed that the best available technique to identify patients at risk is using predictive modelling[32] where current data are used from health and social care to predict the patient's risk of future emergency admission. A national risk stratification tool called the Combined Predictive Model was developed in 2005, supported by the Department of Health. Using data from two PCTs and a population of 560,000, this model divided the population into four risk categories (see Figure 2).

Figure 2: Segmentation of population using Combined Predictive Model[33]



Key to reducing hospital admissions is identifying those with high or moderate relative risk (second and third tier) who are not yet in need of urgent care and developing

[32] Ibid.
[33] The King's Fund "Combined Predictive Model: Final report (2006) Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_document/PARR-combined-predictive-model-final-report-dec06.pdf

effective interventions to improve their health and wellbeing and reduce their risk of emergency admission. It is proposed that these techniques can be used to identify patients for an appropriate intervention in order to improve health outcomes, efficiently allocate resources, and reduce future costs and to facilitate better planning.[34]

Across parts of Cambridgeshire, NHS Cambridgeshire (now the Cambridgeshire and Peterborough Clinical Commissioning Group) are evaluating pilot programmes of Multi-disciplinary teams (MDTs) managing patients with complex needs, commonly those over the age of 65. Patients are identified using a predictive modelling tool, a modified version of the national risk stratification tool 'Patients at risk for Re-hospitalisation (PARR)++', which has been developed locally by SERCO. At present, this uses secondary care data and is being modified to also take into account primary care data. Once fully established this will also offer a resource for assessing the size of the local population in each of these risk categories.

Two current projects in Peterborough and Borderline Local Commissioning Groups (LCGs) illustrate the approach being taken.

Case study 1: Borderline Multi-disciplinary Team (MDT) and Administrative Hub

The Borderline MDT with an Administrative Support Hub is a community service based on changing the way current organisations work together to support patients with complex care needs. The hub acts as an important lynchpin in planning and communication in an area where the commissioning and delivery of care is complex due to the amount of borders/boundaries it covers. The MDT Hub is open 8 am to 6 pm giving patients and professionals one place to call and ensure important updates are circulated.

The Hub staff aim to ensure that, wherever possible, busy professionals remain free of the administrative burden and remain on the front line delivering care and support. The administrative Hub staff co-ordinate and facilitate MDT meetings which provide a single point of co-ordinated care to improve the outcomes for vulnerable adults and those with long term conditions. Through the use of a risk stratification tool and professional judgement vulnerable people are identified as having potential to benefit from a proactive review of their care. The person is contacted for their consent and to share their priorities and perspectives.

MDT teams include GP/community matron/social worker/mental health input. Specialist nurses and other allied health professional are invited when appropriate. Outside the meeting all the professionals work as the service user/patient's team with the support of the Hub who provide system knowledge and facilitate and support professionals with the actions they have undertaken to improve client care.

An evaluation is on-going to ascertain the impact of this new service.

[34]The King's Fund. 'Predictive risk project Literature review' (2005). Available at: http://www.King'sfund.org.uk/sites/files/kf/field/field_document/predictive-risk-literature-review-june2005.pdf

Case study 2: 'The Firm' in Peterborough and Borderline

The Firm is a community service, based on changing the way current staff operate, with the collective aim of avoiding inappropriate admissions and supporting early discharge. Existing provider staff from primary care and the Acute Trust in the Peterborough and Borderline area have come together to create a service with the following characteristics:

- **Focused on the patient:** irrespective of whether they needed medical, nursing or care interventions.
- **Strong clinical leadership**: coordinating care provision for patients.
- **Reactive**: able to see referred patients within hours and sort out issues mostly on a 'same day' basis.
- **Proactive**: eg enabling people to leave hospital as they are ready for discharge.
- **Quality**: ensuring experienced clinical staff are the first to assess patients.
- **Quantity**: capacity available to deliver management plans.
- **Integrated:** service made up of leaders from the key partner organisations, working together, but also working with their own organisations to make this truly integrated.
- **Community based**: aiming to support people in their homes or in the community.

An evaluation is on-going to ascertain the impact of this new service.

4.4 Causes of emergency admissions in over 65s in Cambridgeshire

Table 9 breaks down the number of overall emergency bed days for over 65s into broad categories of disease according to how the admission was coded (ICD-10[35] code chapter headings). The total spend on these headings is detailed in the JSNA Older People Financial review data supplement.[36]

Table 9: Number of emergency bed days for over 65s (2010/11 and 2011/12) by ICD 10 Chapter Heading

ICD Chapter	Number of emergency bed days		
	2010/11	2011/12	% of total (2011/12)
Diseases of the circulatory system	42,683	43,462	19%
Injury poisioning and certain other consequences of external injury	37,689	38,722	17%
Diseases of the respiratory system	35,576	38,493	17%
Diseases of the digestive system	23,015	22,784	10%
Diseases of genitourinary system	18,278	18,895	8%
Symptoms, signs and abnormal findings, not elsewhere classified	19,175	16,503	7%
Neoplasms	15,923	15,055	7%
Diseases of muskuloskeletal and connective tissue	8,561	7,729	3%
Infectious & Parasitic Diseases	7,503	7,429	3%
Other	23,285	21,732	9%
Total Bed Days	231,688	230,804	100%

[35] International Classification of Diseases (ICD) v10.
[36] Available at: http://www.cambridgeshirejsna.org.uk/older-peoples-service-financial-review-data

It is evident that a large proportion of emergency admissions for older people are recorded as due to diseases of the circulatory system (19%) and respiratory system (17%). This is as expected as stroke, heart attack and chronic obstructive pulmonary disease (COPD) are significant causes of mortality and morbidity in the older population. A further 17% of admissions are due to injury, and 11% of admissions are additionally coded as due to falls (see section 5.2).

4.5 Management of long term conditions and rehabilitation

The majority of admissions for circulatory and respiratory system problems relate to long term conditions or risk factors for major causes of mortality and morbidity: stroke and heart attack. Effective management and early intervention to reduce the impact of long term conditions including diabetes, heart disease, stroke, heart attack and COPD is key to improving the health and wellbeing of older people. Coping with multiple morbidities and illnesses are significant challenges for older people.

Further information about long term conditions and their management is detailed in the Older People JSNA (2010)[37] and much of the information and evidence in the JSNA on the Prevention of Ill Health in Adults of Working Age[38] is also relevant to older people, particularly the section on long-term conditions.[39] Primary prevention approaches to reduce obesity, encourage physical activity and promote smoking cessation are key factors in reducing the burden of cardiovascular and respiratory disease and diabetes for our population, as emphasised in the recent Cardiovascular Disease Outcomes Strategy published in March 2013.[40]

There are National Service Frameworks and National Institute for Clinical Excellence (NICE) guidance[41] covering most long term conditions including coronary heart disease, cancer, mental health, diabetes, long term neurological conditions, renal services, chronic obstructive pulmonary disease and stroke. In particular, there is a strong evidence base for the impact of cardiac and stroke rehabilitation for improving functioning and minimising disability.

Cardiac rehabilitation is a structured set of services that enables people with coronary heart disease (CHD) to have the best possible help (physical, psychological and social) to preserve or resume their optimal functioning in society. Cardiac rehabilitation is recommended in NICE clinical guideline 48 on myocardial infarction (MI): secondary prevention[42] as an appropriate intervention for people following a hospital admission for a heart attack (MI). There is evidence that exercise-based cardiac rehabilitation:

- is effective in reducing total and cardiovascular mortality and hospital admissions in people with coronary heart disease;[43]
- reduces all-cause and cardiovascular mortality rates in patients after a heart attack when compared with usual care provided when it includes an exercise component[44]; and

[37] Available at: http://www.cambridgeshirejsna.org.uk/currentreports/older-people-including-dementia
[38] Available at: http://www.cambridgeshirejsna.org.uk/currentreports/jsna-prevention-ill-health-adults-working-age-2.
[39] Available at: http://www.cambridgeshirejsna.org.uk/LTC.
[40] Department of Health. 'Cardiovascular Disease Outcomes Strategy ' (2013). Available at: https://www.wp.dh.gov.uk/publications/files/2013/03/9387-2900853-CVD-Outcomes_web1.pdf.
[41] http://www.nice.org.uk.
[42] Available at: http://www.nice.org.uk/CG48.
[43] Heran BS, Chen JM, Ebrahim S et al. (2011) Exercise-based cardiac rehabilitation for coronary heart disease. Cochrane Database of Systematic Reviews Issue 7: CD001800.

- significantly reduces hospitalisation for chronic heart failure and significantly improves quality of life and exercise tolerance for people with heart failure.[45]

The National Service Framework for Coronary Heart Disease[46] established a goal that every hospital should ensure that more than 85% of people discharged from hospital with a primary diagnosis of acute MI or after coronary revascularisation are offered cardiac rehabilitation.

The National Stroke Strategy 2007[47] aimed to improve awareness, prevention, pathways, treatment, and on-going support for people having a stroke. It contained 20 Quality Markers for Health and Social Care such as raising awareness on the symptoms of stroke, prompt access to a stroke unit, specialist rehabilitation, appropriate long term care, assistance to return to work and to participate in community life etc.

Specialist co-ordinated rehabilitation, started early after stroke and provided with sufficient intensity, reduces mortality and long term disability.[47] There is evidence that co-ordinated community stroke teams prevent patients from deteriorating once they return home[48] and increase the chances of patients being independent in the long term. A strong evidence base supports the implementation of 'Early Supported Discharge' for stroke patients with mild to moderate disability (approximately 40% of patients) to a comprehensive stroke specialist and multidisciplinary team in the community, with a similar level of intensity to stroke unit care.[49] Early Supported Discharge can reduce long-term mortality and institutionalisation rates for up to 50% of patients, as well as lower overall costs.

A fundamental part of the Cambridgeshire response to the National Stroke Strategy (2007) was to part fund the pilot post of a Stroke Care Coordinator to facilitate early discharge from hospital and to offer timely information and advice to those newly discharged. Additionally the team works with partners to develop localised self-sustaining peer support groups across the county for stroke survivors and develop exercise for stroke facilities/classes across the county.

4.6 Preventative interventions during an acute episode

The 'Silver Book'[50] is a guidance document for care for frail older people during the first 24 hours of an urgent care episode, developed by an intercollegiate working

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[44] National Collaborating Centre for Primary Care (2007) Post myocardial infarction: secondary prevention in primary and secondary care for patients following a myocardial infarction (full guideline). London: Royal College of General Practitioners.

[45] National Clinical Guideline Centre for Acute and Chronic Conditions (2010) Chronic heart failure: national clinical guideline for diagnosis and management in primary and secondary care. London: Royal College of Physicians.

[46] National Service Framework for Coronary Heart Disease. Department of Health. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094275

[47] National Stroke Strategy. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062

[48] National Service Framework for Long Term Conditions. Department of Health. Available at: http://www.nhs.uk/NHSEngland/NSF/Pages/Longtermconditions.aspx

[49] Langhorne P et al. 'Early Supported Discharge Trialists: Services for reducing duration of hospital care for acute stroke patients'. Cochrane Database of Systematic reviews Issue 2; 2005.

[50] Banerjee, J & Conroy, S. 'The Silver Book' - Quality Care for Older People with Urgent & Emergency Care Needs. 2012. Available at: http://www.bgs.org.uk/index.php?option=com_content&view=category&layout=blog&id=207&Itemid=888

party led by the National Clinical Directors for Urgent Care, Older People and Dementia.

A key recommendation in the ‘Silver Book’ is the need for health and social care in primary, secondary and community care to understand a combination of risk factors and issues which may precipitate the need for urgent care, labelled as 'frailty syndrome'. This approach recognises that multiple comorbidities, disability and communication barriers can result in older people requiring urgent care due to non-specific problems, part of a bigger picture, which require a multi-disciplinary approach.

The recommendations for preventing avoidable hospital admissions during an acute episode include:

- a timely primary care response and ready access to general practitioners;
- more community based services with a rapid response time;
- referral by ambulance services to urgent care, community and primary care services, including falls services.

The report details clinical guidance for a variety of urgent care settings and information for training and development of staff. This includes appropriate assessment, recognition and interpretation of non-specific syndromes relating to frailty and risk of adverse outcomes and person-centred care with a positive attitude towards older people.

Section 6.3.3 also describes psychiatric liaison services in the acute setting which can help to identify and provide support for older people with mental health problems who may be admitted, which can help to facilitate an earlier successful discharge.

4.7 Key findings

- Evaluations are being conducted for a number of active case management approaches by multi-disciplinary teams throughout the Cambridgeshire and Peterborough which will generate learning to share across the county. Stakeholders have also emphasised that the development of information sharing across health, social care and the voluntary sector would facilitate more coordinated, cross-sector early interventions.
- There is a strong evidence base for secondary and tertiary prevention to reduce the impact of a stroke or heart attack, with national standards for cardiac and stroke rehabilitation.
- There are inter-collegiate guidelines (‘The Silver Book’) for preventing avoidable hospital admissions during an acute episode and early recognition and interpretation of non-specific syndromes in older people which can be markers of poor outcomes. These recommendations are being used locally as a guide to audit, evaluate and improve the local response to an older person with an acute health crisis in the urgent care system.

Falls prevention

This section builds on information about falls in Cambridgeshire published in the JSNA Older People (2010).[51] Data are updated and a review of the evidence base for falls prevention is included. Both lead to a strengthening of recommendations for reducing falls, falls related injuries and concomitant NHS costs.

5.1 Context

Falls are not an inevitable result of ageing but if they occur, can be a significant event which can have a knock-on effect on health, wellbeing and independence. Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK. About 10% of people with a hip fracture die within one month and about one-third within 12 months.[52] Death certificates do not reliably record these data and published mortality rates are a gross underestimate. Most of the deaths are due to associated conditions and not to the fracture itself, reflecting the high prevalence of comorbidity in this older group of people.[53] There is emerging evidence that people with dementia and neurological disorders have an increased risk of falling.[54]

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. Up to 90% of older patients who fracture their neck of femur (hip) fail to recover their previous level of mobility or independence.[55] Only 46% of older people with a fractured neck of femur return to their usual residence on discharge from hospital.

There is also evidence that fear of falling has an impact on quality of life for both people who fall and their carers. For example, a recent study identified that fear of falling was common in people following a hip fracture and significantly associated with activity avoidance, disability and affected the lives of those recovering. Some patients were physically incapacitated by fear of falling.[56]

There are a large number of risk factors which increase the likelihood of a fall and awareness and interventions can help to minimise these risks. Risk factors can be intrinsic (related to the individual), or extrinsic (related to the environment in which they live which can be addressed0.

Falls are therefore a significant preventable cause of ill health, and of hospitalisation in older people. 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

[51] Available at:http://www.cambridgeshirejsna.org.uk/currentreports/older-people-including-dementia
[52] Available at: http://www.wmpho.org.uk/resources/APHO_OP.pdf.
[53] National Institute of Health and Clinical Excellence. Cited in Clinical Guideline 124: Hip Fractures – The Management of Hip Fractures in Adults (2011).
[54] 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.
[55] Murray GR, Cameron ID, Cumming RG.The consequences of falls in acute and subacute hospitals in Australia that result in proximal femoral fracture.Journal of the American Geriatrics Society. 2007;55(4):577-82.
[56] Jellesmark A et al. Fear of falling and changed functional ability following hip fracture among community dwelling elderly people. Disability & Rehabilitation (2012).

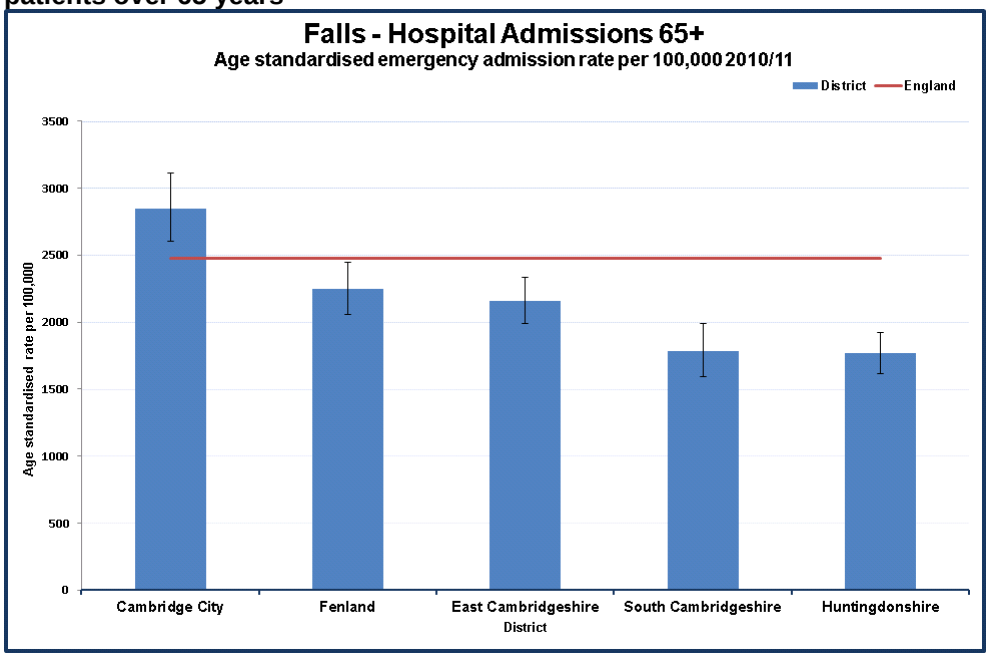
subsequent falls). Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures.[57]

5.2 Local data

There are three broad indicators in the Public Health Outcomes Framework which relate to falls: the number of admissions in over 65s due to falls; the number of admissions in over 65s classified as 'injury due to falls'; and the number of hip fractures in the over 65s. Of note, the rate in Cambridge City for all three indicators is significantly higher than the national average.

Figure 3 shows the rate of emergency admission, standardised for age and sex to take account of the different population structures, where a fall is coded anywhere in the string of codes which describe the underlying reason for the hospital admission. Cambridge City has a rate that is statistically significantly higher than the national average, and all other districts in Cambridgeshire. South Cambridgeshire and Huntingdonshire have rates that are statistically significantly lower.

Figure 3: Age standardised rate of Falls emergency admissions in Cambridgeshire patients over 65 years[58]



Source: Older People's Health and Wellbeing Atlas produced by the West Midlands Public Heath Observatory on behalf of the Public Health Observatories in England (Public Health Outcomes Framework)

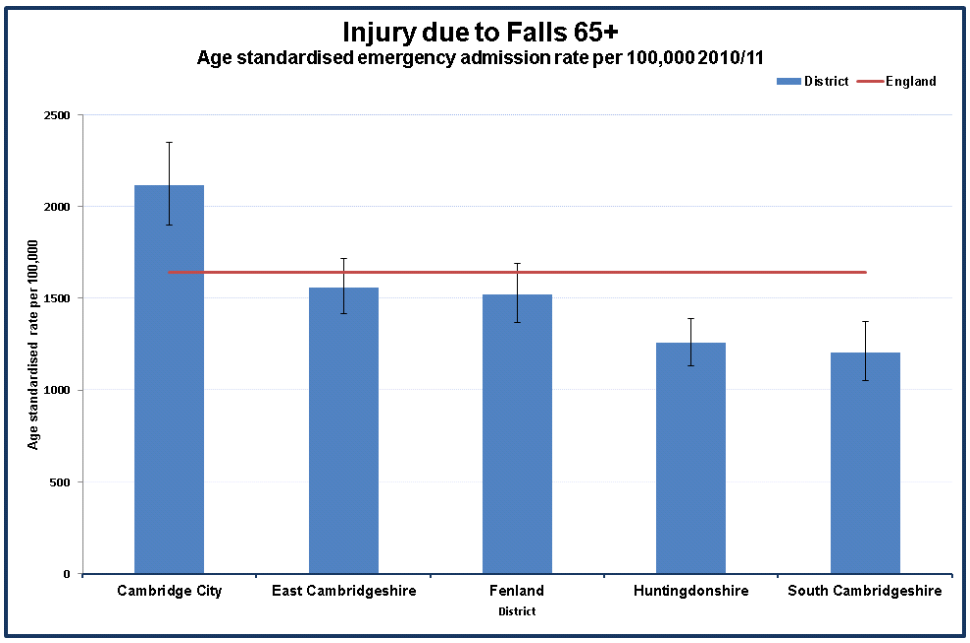
Figure 4 shows the rate of emergency admission where a fall was coded as having occurred and the primary diagnosis – the main reason for the hospital admission – as a code related to an Injury (using the International Classification of Disease (ICD

[57] Royal College of Physicians.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.

[58] Rate of emergency hospital admissions for falls, in persons aged 65 and over, per 100,000.Rates are directly standardised for age and sex by the European standard population.

v10) chapter heading). Again, Cambridge City has a statistically significantly high rate compared to England and to other districts and South Cambridgeshire and Huntingdonshire have rates that are statistically significantly lower.

Figure 4: Age standardised rate of Injury due to falls in Cambridgeshire patients over 65 years[59]

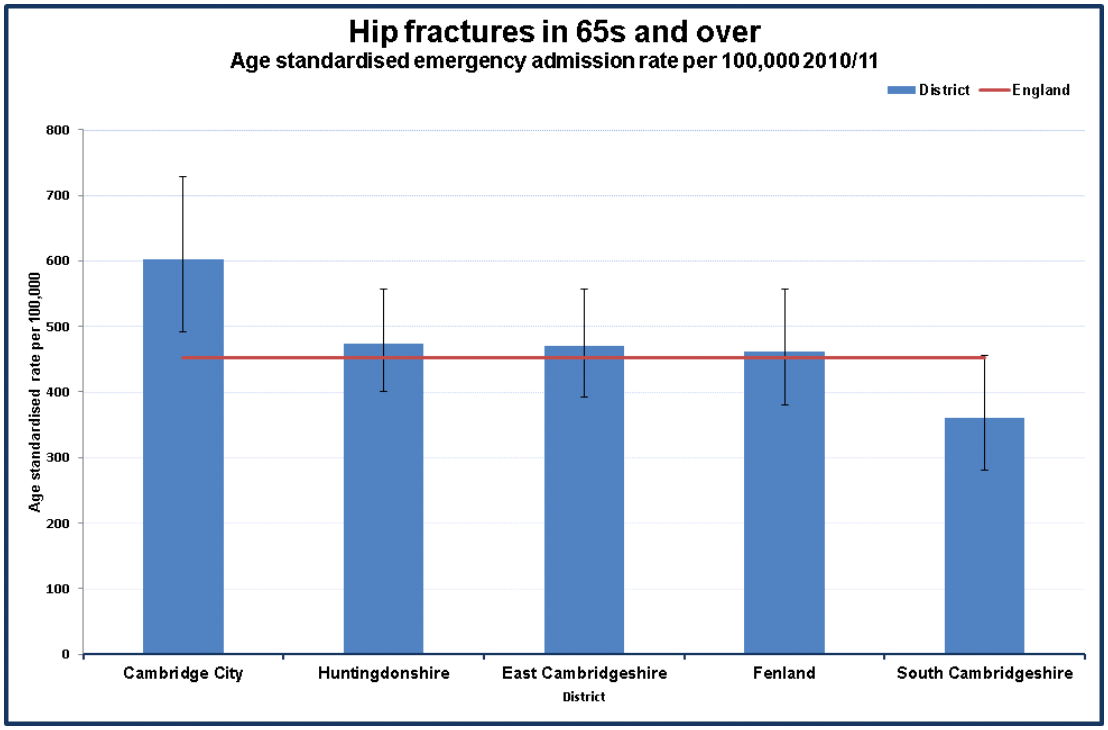


Source: Older People's Health and Wellbeing Atlas produced by the West Midlands Public Heath Observatory on behalf of the Public Health Observatories in England (Public Health Outcomes Framework)

Figure 5 shows the age standardised emergency admission rate per 100,000 for hip fractures (fractured neck of femur). Cambridge City has a rate that is statistically significantly higher than the national average.

[59] Rate of emergency hospital admissions for falls, in persons aged 65 and over, per 100,000. Accidental injury defined by the primary diagnosis codes ICD10 S00 -T98 and where caused by accidental falls defined by the external cause codes ICD10 W00-W19 . Rates are directly standardised for age and sex by the European standard population.

Figure 5: Age standardised rate of Hip Fractures in Cambridgeshire patients over 65 years[60]



Source: Older People's Health and Wellbeing Atlas produced by the West Midlands Public Heath Observatory on behalf of the Public Health Observatories in England (Public Health Outcomes Framework)

The data shown in the preceding figures have been calculated nationally and are on a 'resident' basis. Local data for all people registered with Cambridgeshire and Peterborough GPs are shown in Table 10.

In 2011/12 there were 3,770 emergency hospital admissions where a fall was recorded as having contributed to the hospital admission in the Cambridgeshire and Peterborough CCG area (see

Table 10). All falls admissions resulted in over 26,000 emergency bed days which represented 11.5% of the total number of bed days in the over 65s.

Of these 3,770 admissions, 2,650 (70%) had an Injury code recorded as being the 'primary diagnosis' or reason for admission. Injuries due to falls accounted for nearly 8% of total occupied bed days in 2011/12.

[60].Rate of emergency hospital admissions for hip fractures, in persons aged 65 and over, per 100,000. ICD10 codes used for hip fracture: S72.0, S72.1, S72.2. Rates are directly standardised for age and sex by the european standard population.

Table 10: Falls Emergency Admissions and Bed Days 2011/12, Persons 65+[61]

LCG	Admissions			Bed days		% of Total Bed Days 65+	
	Falls	Injury due to Falls	%	Falls	Injury due to Falls	Falls	Injury due to Falls
Borderline	478	314	66%	2,999	1,389	13.3%	6.2%
CATCH - Cambridge City	193	152	79%	1,653	1,356	15.4%	12.6%
CATCH - City Suburb	159	124	78%	1,229	970	11.7%	9.2%
CATCH - Granta	80	61	76%	744	617	13.4%	11.1%
CATCH - North Villages	66	53	80%	822	672	17.7%	14.5%
CATCH - South Villages	237	186	78%	1,766	1,473	10.7%	9.0%
CATCH - Total	735	576	78%	6,214	5,088	13.0%	10.6%
CamHealth Integrated Care	371	299	81%	2,438	1,983	10.2%	8.3%
Hunts Care Partnership	512	351	69%	4,200	3,001	11.6%	8.3%
Hunts Health	296	204	69%	2,795	1,914	12.9%	8.9%
Isle of Ely	381	281	74%	2,552	1,712	9.1%	6.1%
Peterborough	693	446	64%	3,816	1,958	11.6%	5.9%
Wisbech	304	179	59%	1,457	845	8.2%	4.7%
Cambridgeshire and Peterborough	3,770	2,650	70%	26,471	17,890	11.5%	7.7%

Source: APC CDS Serco and quarterly Exeter downloads, Serco. Bed days – Acute Hospital only.

The healthcare cost associated with fragility fractures nationally is estimated to be £2billion a year. In Cambridgeshire, the JSNA Older People's Services and Financial Review (2012) describes the top ten diagnoses for emergency admissions for people in the 85-89 year old and over 90 year old age groups (see Tables 9 and 10[62]). This clearly demonstrates the importance of falls as leading to fractured neck of femur (hip fracture) as a cause of emergency admissions, accounting for 8.3% of the emergency admissions total spend in the 85-89 age band and 13.9% for those aged over 90 years.

5.3 National evidence base and recommendations

5.3.1 NICE Guidance

In 2004, NICE published a Clinical Guideline (CG 21)[63] for the assessment and prevention of falls in older people for the community setting. A subsequent NICE review of this guideline in 2010 found that there was not enough evidence to change the current recommendations but NICE has agreed to expand the scope and include inpatient safety.[64]

The key recommendations include:

[61] See references 41 and 42 for codes used.
[62] Available at: http://www.cambridgeshirejsna.org.uk/webfm_send/232
[63] National Institute for Health and Clinical Excellence (NICE): Clinical Guidance (CG146) Falls: the assessment and prevention of falls in older people (Nov 2004). Available at: http://publications.nice.org.uk/falls-cg21
[64] National Institute for Health and Clinical Excellence (NICE): Falls Guidance. NICE (updates 2010) Available at: http://guidance.nice.org.uk/CG21/Guidance/pdf/English

- ***Case or risk identification***: Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s. Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.
- ***Multifactorial risk assessment:*** All older people with recurrent falls, or assessed as being at increased risk of falling, should be considered for an individualised multifactorial intervention assessment by a multi-disciplinary team. This assessment should identify and address future risk, and offer individualised intervention aimed at promoting independence and improving physical and psychological function.
- ***Multifactorial intervention programmes:*** All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. In successful programmes the following specific components are common:
    - strength and balance training;
    - home hazard assessment and intervention;
    - vision assessment and referral;
    - medication review with modification/withdrawal.
- ***Information and education:*** Older people should be encouraged to participate in falls prevention programmes including education and information giving about how to prevent further falls.
- ***Professional education:*** All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

A review of the clinical guideline is underway which extends and replaces CG21, to provide recommendations on the assessment and prevention of falls in older people in both inpatient and community settings. The new inpatient recommendations are out for consultation and due to be published in July 2013. Although not yet ratified, the consultation guideline proposes regarding all inpatients over the age of 65 as at risk of falling and recommends they undergo a multifactorial assessment and offer interventions tailored to their individual risk factors to reduce their risk of falling during their hospital stay.[65]

In addition, NICE guidance on osteoporosis is relevant to reducing the risk of fractures from falls. Osteoporosis is a disease characterised by low bone mass and structural deterioration of bone tissue, with a consequent increase in bone fragility and susceptibility to fracture. Osteoporosis leads to nearly 9 million fractures annually worldwide,[66] and over 300,000 patients present with fragility fractures to hospitals in the UK each year.[67] The short clinical guideline (CG 146) on osteoporosis[68] aims to provide guidance on the selection and use of risk assessment tools in the care of people who may be at risk of fragility fractures in all settings in which NHS care is received.

[65] Available at: http://guidance.nice.org.uk/CG/Wave0/611.

[66] Johnell O, Kanis JA (2006) An estimate of the worldwide prevalence and disability associated with osteoporotic fractures. Osteoporosis International 17: 1726–33.

[67] British Orthopaedic Association.The care of patients with fragility fracture (2007).

[68] National Institute for Health and Clinical Excellence (NICE): Clinical Guidance (CG146) Osteoporosis: assessing the risk of fragility fracture (Aug 2012). Available at: http://publications.nice.org.uk/osteoporosis-assessing-the-risk-of-fragility-fracture-cg146

5.3.2 Cochrane reviews

The Cochrane Collaboration has produced a series of reviews relating to falls prevention: a review of the evidence underpinning falls prevention and balance in older people (2011);[69] interventions to reduce the incidence of falls in older people living in nursing care facilities and hospitals (2010);[69] and interventions to reduce the incidence of falls in older people living in the community (2009).[70] In summary, these provide additional evidence on the following interventions:

a) Exercise for preventing falls

- Group and home-based exercise programmes, and home safety interventions reduce rate of falls and risk of falling.
- Exercise in sub-acute hospital settings appeared effective but its effectiveness in care facilities remains uncertain due to conflicting results, possibly associated with differences in interventions and levels of dependency.
- Multi-factorial assessment and intervention programmes reduce rate of falls but not risk of falling.
- Tai Chi reduces risk of falling.

b) Exercise for improving balance and physical functioning in older people

- Progressive Resistance Strength Training is an effective intervention for improving physical functioning in older people, including improving strength and the performance of some simple and complex activities. However, some caution is needed with transferring these exercises for use with clinical populations because adverse events are not adequately reported.[71]
- There is weak evidence that some types of exercise (gait, balance, co-ordination and functional tasks; strengthening exercise; 3D exercise and multiple exercise types) are moderately effective, immediately post intervention, in improving clinical balance outcomes in older people. Such interventions are probably safe.
- There is either no or insufficient evidence to draw any conclusions for general physical activity (walking or cycling) and exercise involving computerised balance programmes or vibration plates. Further high methodological quality research using core outcome measures and adequate surveillance is required.

c) Medications and medical devices

- Gradual withdrawal of psychotropic medication reduced the rate of, but not risk of falling. A prescribing modification programme for primary care physicians significantly reduced risk of falling.[Error! Bookmark not defined.]
- Thiazides appear to reduce the risk of hip fracture based on observational studies. Randomised controlled trials are needed to confirm these findings.
- Pacemakers reduced the rate of falls in people with carotid sinus hypersensitivity.[Error! Bookmark not defined.]
- Overall, vitamin D supplementation does not appear to reduce falls but may be effective in people who have lower vitamin D levels before treatment.

[69] The Cochrane Library. Falls Prevention and Balance in Older People. Available at: 2011.http://www.thecochranelibrary.com/details/browseReviews/579145/Falls-prevention--balance-in-older-people.html.

[70] Gillespie LD, Robertson MC, Gillespie WJ, Lamb SE, Gates S, Cumming RG, Rowe BH. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD007146. DOI: 10.1002/14651858.CD007146.pub2.

[71] The Cochrane Library. Falls Prevention and Balance in Older People. Available at: 2011.http://www.thecochranelibrary.com/details/browseReviews/579145/Falls-prevention--balance-in-older-people.html.

- The effectiveness of the provision of hip protectors in reducing the incidence of hip fracture in older people is still not clearly established. Poor acceptance and adherence by older people offered hip protectors have been key factors contributing to the continuing uncertainty.[72]

5.3.3 National Audit of Falls and Bone Health

The 2010 Royal College of Physicians National Audit of Falls and Bone Health[73] in older people showed that across the UK older people with fractures do not routinely receive key aspects of care for falls prevention or bone health, needlessly exposing them to greater risk of further falls or fractures. The audit found that:

- Many patients do not receive adequate pre-operative assessment and care.
- Even if older people attend hospital with serious injuries they are not being properly assessed in order to prevent further injuries. Patients with non-hip fragility fractures are only half as likely to receive assessment or treatment for secondary prevention as patients with hip fractures.
- Few local healthcare organisations provide adequate falls prevention services that are attended by a majority of older people who have already sustained a fracture following a fall.
- Many providers are failing in their responsibility to provide expertise to reduce falls in the high risk care home population.

The National Audit recommended that "Primary care and acute services must work together on the falls and fracture patient pathway, providing a better integrated service in the face of increased disintegration in parts of the NHS. In particular, falls and fracture services must be able to identify older people at high risk of further falls and fractures and to ensure the availability of appropriate secondary prevention measures, notably therapeutic exercise and treatment for osteoporosis."[74] In particular, commissioners were encouraged to use the Department of Health Prevention package to inform the commissioning of effective falls and fracture services, described in the following section.

5.3.4 Department of Health – Prevention Package for Effective Interventions

Published in 2009, this 'Prevention Package for Older People Resources'[75] includes resources for falls and fractures in three areas:

1. Effective interventions in health and social care;
2. Exercise training to prevent falls;
3. Developing a local JSNA.

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[72] Gillespie WJ, Gillespie LD, Parker MJ. Hip protectors for preventing hip fractures in older people. Cochrane Database of Systematic Reviews 2010, Issue 10. Art. No.: CD001255. DOI: 10.1002/14651858.CD001255.pub4.

[73] Royal College of Physicians.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.

[74] Royal College of Physicians.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.

[75] Department of Health. Prevention Package for Older People Resources.DOH (2009). http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103146.

The guide for effective interventions provides a model for the development of an integrated falls service, with interventions listed in priority order in terms of the impact and evidence base, although they each have a role for different risk groups (see Figure 6).

Table 11 describes the outcomes with some of the recommendations relevant to prevention for commissioners from the 2010 National Audit report.

Figure 6: Effective Interventions in Health and Social Care - Prevention of falls and fractures (Department of Health, 2009)

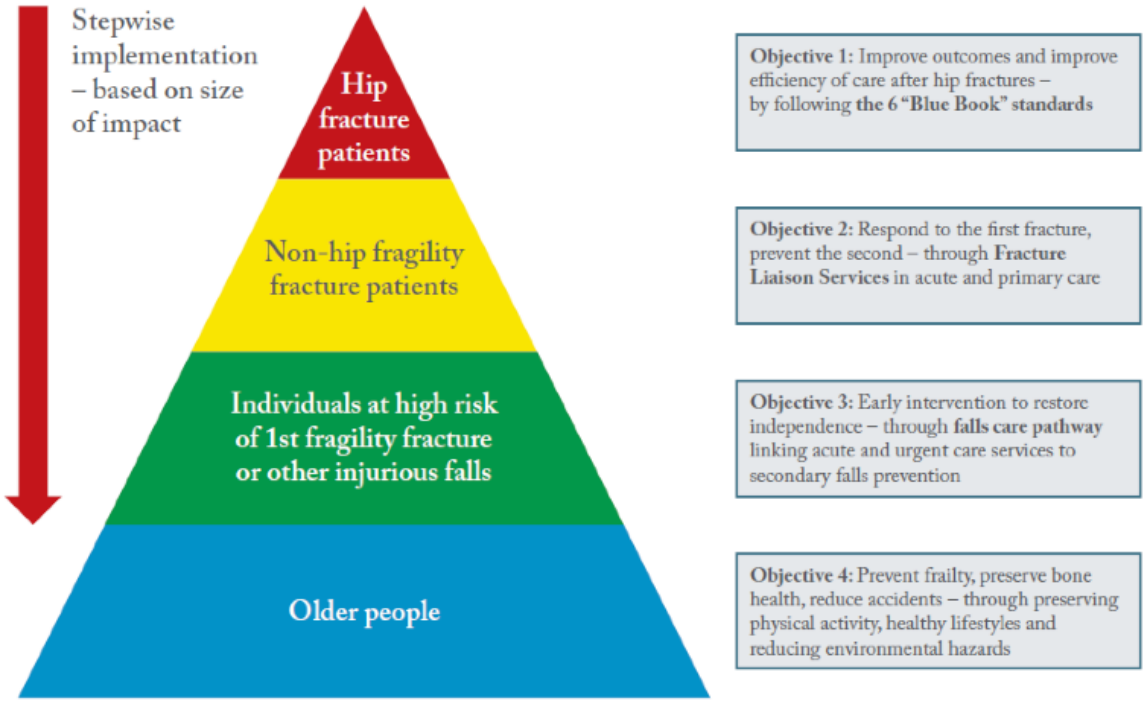


Table 11: Selected recommendations from the National Audit of Falls and Bone Health in Older People mapped against the DoH objectives for health and social care interventions prevention package for Older People

	Intervention	National Audit recommendations
Objective 1:	Improve patient outcomes and improve efficiency of care after hip fractures through compliance with core standards	• We *recommend* that acute providers review and improve their procedures for rapid admission and early surgery of hip fracture patients.
Objective 2:	Respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings	• We *recommend* that all localities commission a fracture liaison service following the best-evidenced models either for acute-based services (eg Glasgow) or primary care-based services (eg West Sussex). This will require the commissioning of an adequate volume of DEXA[76] bone density scans for the local population. • We *recommend* that all acute care providers introduce routine screening of older people, presenting to emergency departments or Minor Injury Units (MIUs), for falls and fractures and that this is audited at least annually.
Objective 3:	Early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries	• We *recommend* joint commissioning between health and local authorities to ensure the provision of therapeutic (Otago and/or FaME) exercise programmes, particularly for those older people who have fallen and fractured or who are at risk of fracture. • We *recommend* that commissioners ensure adequate local provision of falls clinics, or similar, particularly for those older people who have fallen and fractured or who are at risk of fracture. In many localities, this could require a ten-fold expansion in falls service capacity.
Objective 4:	Prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards	• We *recommend* that commissioners specifically include care homes in contracts with services for falls and fracture prevention. In particular, commissioners should ensure that care home residents receive regular medication reviews, including treatment of osteoporosis, and, where appropriate, have access to therapeutic exercise for falls prevention. • We also *recommend* that care homes record and report falls to the relevant commissioners and that commissioners use these reports to inform and monitor local falls service provision. • We *recommend* that all providers of inpatient services ensure that their falls policies and procedures include specific regard to the recommendations of the National Patient Safety Agency (NPSA) in the use of bed rails, reporting and monitoring of falls, and the aftercare of fallers in hospital.

[76] A DEXA scan is a special type of x-ray that measures bone density. DEXA stands for dual energy X-ray absorptiometry.

5.3.5 Local research opportunities

Recent evidence has identified that falls are a major cause of morbidity and mortality in dementia,[77] but there have been no prospective studies of risk factors for falling specific to this patient population, and no successful falls intervention/prevention trials.[77]

The Institute of Public Health, Cambridge (Collaboration for Leadership in Applied Health Research and Care) is conducting a research project to assess the impact of an exercise programme for people living with dementia and carers, which involves local stakeholders including public health.

5.4 Local services and assets for falls prevention

Evidence-based Falls Services are available across Cambridgeshire currently provided by Cambridgeshire Community Services (CCS). Some Local Commissioning Groups across Cambridgeshire are in the process of developing an Integrated Falls Service for their population. Service specifications for NHS Falls Services may not currently include outcome metrics, although metrics are available in the Public Health Outcomes Framework (2012)[78] and Department of Health Guidance on Falls and Fractures: effective interventions in Health and Social Care.[79] There is currently no agreed Cambridgeshire model or service specification which might ensure consistency and reduce the potential for increasing inequality of access throughout the county.

Community-based falls prevention classes are embedded within physical activity programmes to promote active ageing in some areas of Cambridgeshire. These are funded and delivered by local authorities, working in partnership with the CCS Falls Services. Programmes are delivered by qualified exercise instructors and local people can self-refer. Examples are:

- the 'Forever Active' programme delivered across Cambridge and South Cambridgeshire; and
- the 'Right Start' programme delivered in Huntingdonshire.

However, access to community based falls prevention classes may be limited in some areas of Cambridgeshire, perpetuating health inequalities.

Opportunities are developing to offer falls prevention training to staff attached to Adult and Social Care Services provided by Cambridgeshire County Council. These could include staff working in care homes, in the voluntary sector, domiciliary care providers, personal assistants etc. Housing associations, such as Sanctuary House in East Cambridgeshire, are also offering falls prevention training to staff.

A Falls Response Vehicle has recently been piloted in Cambridge and Southern Cambridgeshire. This intervention has recently received an NHS Innovation Award and has reduced costs (see case study 3).

[77] Allan LM, et al. (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.
[78] Department of Health. Improving Outcomes and Supporting Transparency. DOH (2012).http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf.
[79] Department of Health. Falls and Fractures: effective interventions in health and social care. DOH (2009).http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_109122.pdf.

Case study 3: Cambridge and South Cambridgeshire Falls Response Vehicle

A Falls Response Vehicle was piloted in Cambridge City and South Cambridgeshire starting in 2012. The pilot costs were approximately £136k for one year.

A community consultant geriatrician has validated all interventions to assess whether, in the absence of the Falls Response Vehicle, the outcome would have been transportation to A and E and consequent admission. This assessment identified that eight transportations/admissions have been avoided each month, 96 per year.

In the first few months of the pilot, a value was placed on those avoided admissions of just under £1,572, which would suggest avoided admission costs of around £150,912. However, the Falls Response Vehicle provided the primary response in around 16 calls per month, for which there was an additional saving of the normal £250 charge for a 999 vehicle response, which is another £48,000.

This suggests around £200,000 costs avoided each year for an investment of £136,000. More recently, the PCT Informatics team have reassessed the cost of the avoided admissions, based on actual costs for patients within these HRGs,[80] and suggest that a significantly higher figure of £3,689 should replace the figure of £1572. On that basis, the costs avoided would become £354,144 plus £48,000, giving £402,144 avoided for that investment.[81]

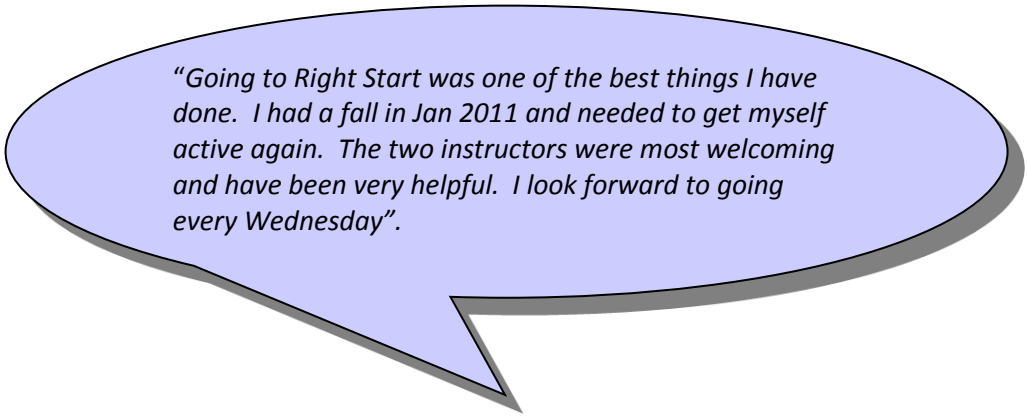
5.5 Local views on falls services

- A report commissioned by the Healthcare Quality Improvement Partnership in 2010 on the 'Older People's Experience of Falls Prevention Services' identified that the majority of people were positive about their experiences of local Falls Prevention Services.[82] The Cambridgeshire Falls and Bone Health Service contributed to this report. Recommendations in communication and exercise interventions are made.
- The Falls Prevention and Bone Health Service provided by Cambridgeshire Community Services does not routinely undertake service user surveys. The service did contribute to the report listed above, and the audit of 'Older People's Experiences of Therapeutic Exercise as part of a Falls Prevention Service' undertaken by the Royal College of Physicians.[83]
- Surveys of users of falls prevention classes provided by local authorities across Cambridgeshire are embedded into more general physical activity programme surveys. Individual responses to general questions have elicited responses such as:

[80] HRG – Healthcare Resource Group. HRG is a combination of procedure (operation) codes and diagnostic codes with some indication of complexity of case and often including agegroup. HRGs are used as the basis for calculating costs based on national tariff costs.

[82] Royal College of Physicians. 'Older People's Experience of Falls Prevention Services'. Healthcare Quality Improvement Partnership, 2010.

[83] Royal College of Physicians. 'Older People's Experiences of Therapeutic Exercise as part of a Falls Prevention Service'. RCP, 2012.



- Responses to questions about the effectiveness of the Falls Response Vehicle from users and their families indicate that 95.8% of respondents were either satisfied or very satisfied with the service they received.

5.6 Key findings

- There are a range of falls prevention and falls services available across Cambridgeshire, but there is little data available on the outcomes or quality of these services. An audit of falls prevention strategies throughout Cambridgeshire could offer insight into local models, highlight gaps in service provision, identify areas of inequality and examples of good practice such as the Falls Response Vehicle and local training.
- An evidence base exists with national recommendations for commissioners to underpin the development of an integrated falls service across Cambridgeshire, building on assets and good practice already in place.
- There are also local opportunities to collaborate with research colleagues to strengthen the evidence base by supporting research into effective interventions for reducing falls in specific population groups, such as people with dementia.

Mental health

The mental health of the population of Cambridgeshire is described in the JSNA on Mental Health in Adults of working age (2010)[84] much of which is relevant to older people. The JSNA on Older People (including Dementia) 2010[85] also includes a specific section relating to the mental health of older people which describes basic local information about rates of dementia and depression.

Information on the use of specialist mental health services by older people in Cambridgeshire and associated costs is collected by age group and presented in the Older People Services and Financial Review.[86]

A joint commissioning strategy for the Mental Health and Well-being of Older People (2013 – 2016) has been drafted by Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire County Council and Peterborough City Council. This is under consultation and is due to be finalised in April 2013. This local strategy details national policy and an analysis of current service provision and future needs, plus a mapping exercise for local implementation of the National Dementia strategy.[87]

Key points from the draft strategy and previous needs assessments are described in the following sections with updated information where it is available.

6.1 Context

The population of older people over 65 is growing and while poor mental health is not an inevitable part of ageing, a number of mental health conditions are more common in old age, such as depression and dementia. Nationally it has been acknowledged that current patterns of mental health need and service provision for older people are unsustainable when modelled on future population projections.[88]

Mental wellbeing encompasses life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support.[89] Mental illness refers to a diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities.[89] Mental health and wellbeing are important parts of overall health, and can be affected by different factors.

The mental health needs of older people are often complex due to co-morbidities with mental health and/or physical health conditions or frailty being present at the same time. Rates of psychiatric disorders are increased at least twofold amongst individuals with chronic medical problems. There is increasing evidence that depression may also be a risk factor in the development of some chronic diseases,

[84] Available at: http://www.cambridgeshirejsna.org.uk/currentreports/mental-health-adults-working-age.
[85] Available at: http://www.cambridgeshirejsna.org.uk/currentreports/older-people-including-dementia.
[86] Available at: http://www.cambridgeshirejsna.org.uk/currentreports/jsna-older-peoples-services-and-financial-review.
[87] Department of Health.National Dementia Strategy. (2009) Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058.
[88] Audit Commission, Under Pressure: Tackling the financial challenge for councils of an ageing population, 2010.
[89] NHS Scotland, Mental Health Improvement: Background and Policy Context. Accessed 2013 http://www.healthscotland.com/mental-health-background.aspx.

especially those related to lifestyle, such as type 2 diabetes and cardiovascular disease and may influence their prognosis.[90]

The Department of Health 'No Health without Mental Health' report stated that untreated or poorly managed mental disorder in older people is an independent predictor of poor outcome, including increased mortality, greater length of stay in hospital, loss of independent function and higher rates of institutionalisation.[91] For example, one UK study has shown that where dementia, delirium or depression is present after hip fracture, length of stay is increased by an average of 11 days.[92]

Depression and other mental health illnesses may lead to social exclusion or arise through social exclusion. Compared to the general population, older people are more at risk of social exclusion for reasons of income, transport and disability (see the Older People JSNA). Section 7 describes further information on the impact of social isolation and loneliness and the importance of social contact and participation in meaningful activity.

One of the most important issues for older people's mental health is the delay that regularly occurs before they are offered support. This can happen either because of people's reluctance to seek help or under recognition on the part of professionals.[93]

6.2 Local data and trends

- 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, alcohol and drug (including prescription drug) misuse.
- It is estimated that 40% of older people seeing their GP, 50% of older people in general hospitals, and 60% of care home residents, have a mental health problem.[94]

Although the majority of older people with mental health problems are treated by their GP, unfortunately there is little primary care data available for analysis. The available data relies heavily on Hospital Episode Statistics (HES) data on admission with mental health disorders as primary diagnosis.[95] Furthermore, there is limited information available regarding common mental health problems due to under reporting, low diagnosis and identification rates.

The Community Mental Health Profile for Cambridgeshire (2012)[96] indicated that:

[90] National Collaborating Centre for Mental Health, Depression in Adults with a Chronic Physical Health Problem (The NICE Guideline on Treatment and Management), 2010.
[91] Department of Health. 'No health without mental health: a cross-government mental health outcomes strategy for people of all ages' (2011). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf
[92] Department of health, National Service Framework for Older People, 2000.
[93] Social Care Workforce Research Unit, Update for SCIE best practice guide on assessing the mental health needs of older people, 2005.
[94] Healthcare Commission, Equality in later life: a national study of older peoples mental health services, 2009.
[95] Indications of Public Health in the English Regions: 7 Mental Health. APHO 2007. Available at: http://www.apho.org.uk/resource/item.aspx?RID=39375.
[96] Community Mental Health Profile for Cambridgeshire. Available at: http://www.nepho.org.uk/cmhp/index.php?pdf=E10000003.

- The number of people using NHS secondary mental health services for older people, and the number of total contacts with mental health services is significantly lower than the average figure for England.
- Emergency hospital admissions for mental health and for Alzheimer's disease and other related dementias are significantly lower than the England average in Cambridgeshire.

6.2.1 Dementia

Dementia is the name given to a group of diseases that affect the normal working of the brain. This can lead to a decline of mental ability, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities.[97]

- Dementia affects 7% of people aged over 65 and 17% of those aged over 80,[97] although only around 43% of dementia cases are currently ever diagnosed.[98] The prevalence of dementia increases with age.
- Dementia affects men and women in all social and ethnic groups.
- The Cognitive Function and Aging Studies (CFAS) reported the following risk factors associated with dementia: female sex, increasing age, fewer years of education, poor self-perceived health, stroke event, and Parkinson's disease.[99]

The report 'Dementia UK' (2007) produced for the Alzheimer's Society gave accurate estimates of the prevalence of early and late onset dementia using an expert panel to produce consensus estimates. The consensus prevalence estimates are shown for late onset dementia in
Table **12**.

Table 12: The consensus estimates of the population prevalence of late onset dementia

Agegroup	Female (%)	Male (%)	Total (%)
65-69	1.0	1.5	1.3
70-74	2.4	3.1	2.9
75-79	6.5	5.1	5.9
80-84	13.3	10.2	12.2
85-89	22.2	16.7	20.3
90-94	29.6	27.5	28.6
95+	34.4	30.0	32.5

Source: Alzheimer's Society[97]

Applying these prevalence estimates to the population of Cambridgeshire gives estimated numbers of people with dementia which are slightly more conservative than

[97] Dementia UK (2007). A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society. Project directors: Professor Martin Knapp and Professor Martin Prince. Available at: http://alzheimers.org.uk/site/scripts/download_info.php?fileID=2.

[98] Improving dementia services in England – an interim report.(2010). National Audit Office. Available at: http://www.nao.org.uk/report/improving-dementia-services-in-england-an-interim-report/.

[99] Agustin G. Yip, Carol Brayne, and Fiona E. Matthews. Risk factors for incident dementia in England and Wale: The Medical Research Council Cognitive Function and Ageing Study. A population-based nested case-control study, 2006.

previously published in earlier JSNAs. However, the consensus prevalence estimates are considered to be the best currently available.
Table **14** shows that there were estimated to be 7,240 people with dementia in 2011 in Cambridgeshire. This number is likely to grow (see Figure 7).

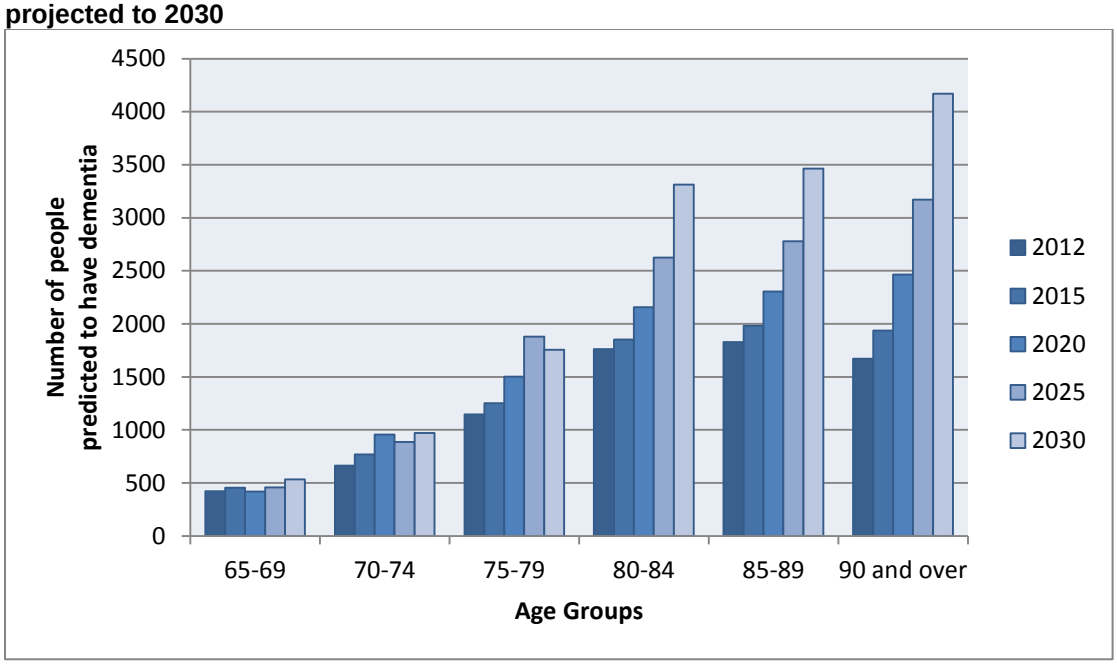
Table 13: Estimates of the number of people with dementia in Cambridgeshire, 2011 by gender

Agegroup	Male	Female	Persons
65-69	230	150	380
70-74	350	290	630
75-79	450	650	1,100
80-84	620	1,130	1,750
85-89	550	1,270	1,820
90+	400	1,150	1,550
Total	2,600	4,640	7,240

Source: Dementia UK (2007) consensus prevalence estimates applied to Census 2011 mid year population estimate (Cambridgeshire County). Office of National Statistics.

Figure 7 shows the expected number of older people in Cambridgeshire predicted to have dementia from 2012 to 2030. This shows that, as expected, the biggest increase in the prevalence of dementia will be in the older age groups. This increase will lead to increasing demands on social services, primary care and families, as well as increasing pressure on acute hospitals and specialist mental health services.

Figure 7: Number of people (by age) in Cambridgeshire predicted to have dementia, projected to 2030



Source: Projecting Older People Population Information System (POPPI) [100]

The Older People's JSNA (2010)[101] presented forecast numbers of dementia cases (prevalence) and new dementia cases (incidence) by local authority. District level

[100] Available at: www.poppi.org.uk . Data sources: Prevalence estimates from Dementia UK (2007) Alzheimers's Society. Population ONS 2011 (interim) projections.
[101] Available at: http://www.cambridgeshirejsna.org.uk/currentreports/older-people-including-dementia

estimates will be updated once population forecasts based on the 2011 Census data are available from Cambridgeshire County Council Research and Performance team.

Nationally it is reported that only 43% of dementia cases are formally diagnosed, which is determined by comparing prevalence estimates with the number of people on dementia registers in the Quality and Outcomes Framework (QoF).
Table 14 shows this information by Local Commissioning Groups (LCGs) in the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and demonstrates the potential 'gap' between diagnosis and prevalence.

Table 14: Estimated number of dementia cases (2011) compared with dementia register (2011/12) by LCG in Cambridgeshire and Peterborough

LCG	Dementia 2011		
	Estimated number of Dementia cases	QoF Register 2011/12	Register as % of estimated total ('diagnosis rate')
Borderline	1,122	593	53%
CATCH - Cambridge City	443	166	37%
CATCH - City Suburb	430	167	39%
CATCH - Granta	184	76	41%
CATCH - North Villages	219	78	36%
CATCH - South Villages	707	261	37%
CATCH - Total	1,983	748	38%
CamHealth Integrated Care	939	606	65%
Hunts Care Partnership	1,352	523	39%
Hunts Health	772	416	54%
Isle of Ely	1,073	435	41%
Peterborough	1,187	507	43%
Wisbech	622	246	40%
Cambridgeshire and Peterborough	11,032	4,822	44%

Source:http://www.dementiapartnerships.org.uk/diagnosis/dementia-prevalence-calculator/

It has been estimated that 75% of all those people with moderate to severe dementia living in the community have a family carer.[102] Caring for a person with dementia is widely evidenced as highly physically and emotionally stressful, and for some it results in the development of mental ill-health, particularly depression.[103] Further information on the supportive role of carers, and their own health needs, is described in section 0.

6.2.2 Alcohol misuse

Alcohol misuse is a problem for people of all ages, yet it is less likely to be recognised among older people. The Mental Health Foundation estimates that one in six older men and one in 15 older women are drinking alcohol at levels that could harm their health.[104] About one in three older people with alcohol problems only start drinking excessively in later life.

[102] Policy on Carers, Social Care Institute for Excellence. Available at: http://www.scie.org.uk/publications/guides/guide03/law/policy.asp.
[103] Cooper et al, The prevalence of depression in the carers of dementia sufferers. International Journal of Geriatric Psychiatry, 1995.
[104] Available at: http://www.mentalhealth.org.uk/help-information/mental-health-a-z/O/older-people/

The Mental Health Foundation have also identified reasons for alcohol abuse in older age, including bereavement and other losses, loneliness, physical ill health, disability and pain, loss of independence, boredom and depression (which is also linked to the other factors). Excess alcohol use can also be associated with other mental health problems including anxiety, depression, and dementia. Approximately 10–30% of older people who abuse alcohol become depressed. They are also at greater risk of suicide.

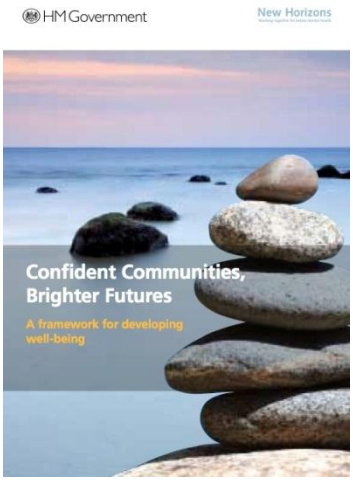
In Cambridgeshire, CATCH reported from local hospital episode data that at least 24% of predicted spend in 2012/13 on alcohol related hospital admissions and A&E activity in CUHFT will be for people aged over 65.

6.3 National evidence base and recommendations

6.3.1 Improving health and wellbeing in the community

The Department of Health New Horizons 'Confident Communities, Brighter Futures'[105] strategy identified the following evidence-based interventions for older people:

- *To promote the wellbeing of older people:*
  Psychosocial interventions, high social support before and during adversity, prevention of social isolation (see also chapter 0), multi-agency response to prevent elder abuse, walking and physical activity programmes, learning and volunteering.
- *Prevention and early intervention for depression:*
  - early intervention;
  - target prevention in high risk groups.
- *Prevention of dementia:*
  - Exercise;
  - anti-hypertensive treatment.



NICE guidance is available on:

- interventions that promote the mental wellbeing of older people;[106]
- supporting people with dementia and their carers in health and social care;[107]
- managing depression in primary and secondary care;[108] and
- behaviour change and community engagement.[109]

Research on different models of care management has highlighted that the most effective case management interventions are those targeted at a highly specific client

[105] Department of Health.'Confident communities, brighter futures: a framework for developing well-being' (2010). Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114774.
[106] Mental wellbeing and older people. NICE 2008. Available at: http://guidance.nice.org.uk/PH16
[107] Dementia: Supporting people with dementia and their carers. NICE 2006 updated 2007. Available at: http://guidance.nice.org.uk/CG42.
[108] Managing depression in primary and secondary care. NICE Available at: http://www.nice.org.uk/nicemedia/pdf/CG023fullguideline.pdf.
[109] Behaviour change.The most appropriate means of generic and specific intervention to support attitude and behaviour change at population and community levels. NICE 2007. Available at: http://www.nice.org.uk/PH6.

group.[110] One study showed older people with depression who received support from an old age psychiatry service had much better recovery rates from depression than those who were supported by their general practitioner alone.[111] An evaluation of an intensive care management scheme for people with dementia in a community mental health team compared with people receiving the 'standard' service from a similar team showed that there were fewer admissions to long term care, increases in social and physical functioning and reductions in risk and in carer stress among those receiving the care management service.[112]

NICE also published 'Quality Standards for Dementia' (2011)[113] developed in collaboration with both health and social care professionals, which act as markers of high-quality, cost-effective patient care covering treatment and prevention. One of the national CQUIN (Commissioning for Quality and Innovation) objectives for 2012/13 is to improve awareness of dementia in acute hospital settings.

6.3.2 National Dementia Strategy

The National Dementia Strategy (2009) identified seventeen objectives to improve the quality of dementia care.[114] Eight of these specifically relate to early interventions:

- Improving public and professional awareness and understanding of dementia.
- Good-quality early diagnosis and intervention for all.
- Good-quality information for those with diagnosed dementia and their carers.
- Enabling easy access to care, support and advice following diagnosis.
- Development of structured peer support and learning networks.
- Improved community personal support services.
- Implementing the Carers' Strategy.
- Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.

In 2012 the Department of Health issued a requirement that all PCTs must have a strategy including a local action plan for local implementation of the National Dementia Strategy. NHS Cambridgeshire and NHS Peterborough mapped current local provision against each of the 17 objectives and identified major gaps and prioritised actions to address these. These are available in Appendices A and B of

[110] Social Care Workforce Research Unit, Update for SCIE best practice guide on assessing the mental health needs of older people, 2005.
[111] Randomised controlled trial of effect of intervention by psychogeriatric team on depression in frail elderly people at home, 1996.
[112] Davies B et al, Resources, Needs and Outcomes in Community Based Care, 1990.
[113] Quality standards for dementia. NICE 2010. Available at: http://guidance.nice.org.uk/QS1
[114] Department of Health.National Dementia Strategy. (2009) Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058.

the Commissioning strategy.[115] The eight strategy objectives relating specifically to early interventions outlined above are rated as 'amber', where some progress has been made locally. Action plans are in place for the strategy group to work alongside the Voluntary sector including the Alzheimer's Society and Cambridgeshire's Older People Enterprise Forum (COPE) to further develop local initiatives to address these objectives.

6.3.3 Liaison psychiatry services

The prevalence of psychiatric and psychological disorders amongst acute hospital patients is significantly higher than in the general population. While the mental health needs of general hospital patients are sometimes independent of physical health, most are intimately related to the presenting physical illness and its treatment.

25% of medical in-patients have clinically significant depressive or anxiety symptoms. This increases to 30% in certain high risk groups such as patients with cancer, neurological disorders, chronic pain syndromes or long term conditions (eg COPD, diabetes, ischaemic heart disease). This co-morbidity increases admissions and health care costs and decreases patients' ability to adhere to medical treatments. Untreated or poorly managed mental disorder in older people is an independent predictor of poor outcome, including increased mortality, greater length of stay, loss of independent function and higher rates of institutionalisation.

Liaison Psychiatry Services (LPS) work at the interface of physical and mental health, addressing the psychiatric and psychological needs of people with physical health problems who are being treated in physical healthcare settings. The development of these services, traditionally based within general hospitals, is a relatively recent phenomenon in the UK and may be seen as part of a wider response to an accumulating body of evidence which shows that:

- Very high proportions of people with physical health conditions also have co-morbid mental health problems (including 30% - 65% of medical inpatients).
- This co-morbidity is associated with a number of adverse consequences including poorer quality of care for the physical condition, reduced adherence to treatment, increased health service and other costs, and poorer health outcomes.
- The economic and financial impact of co-morbidity can be very significant. For example, a US study has shown that physical healthcare costs for people with diabetes and co-morbid depression are almost twice as high as for people with diabetes alone.

6.3.4 The RAID (Rapid Assessment, Interface and Discharge) model in Birmingham.

A mental health trust in Birmingham has developed a new model for patient assessment and discharge that aims to address the full spectrum of patient needs in one assessment. RAID is an award-winning service which offers comprehensive mental health support, available 24/7, to all people aged over 16 within the hospital.. A notable feature of the RAID evaluation is that elderly people represent only about a third of the patient samples but account for around 90 per cent of total benefits in terms of reduced bed use.

[115] Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire County Council and Peterborough County Council. A joint commissioning strategy for the Mental Health and Well-being of Older People (2013 – 2016).

The RAID project provides a model of liaison psychiatry that can improve care whilst delivering significant cost savings. For an initial investment of £0.8m in the RAID model in Birmingham, cost savings were estimated to be in the region of £3.4 - £9.5 million/year.[116] These savings were generated from a combination of admission avoidance, reduced length of stay (LOS) and reduced readmissions, with a significant contribution to overall cost savings coming from reduced bed use amongst elderly patients.

The analysis of cost savings in the internal review of RAID focused on the ability of the service to promote quicker discharge from hospital and fewer re-admissions, resulting in reduced numbers of in-patient bed-days. Based on a comparison of lengths of stay and rates of re-admission in similar groups of patients before and after RAID was introduced in December 2009, in place of a previous, smaller liaison service, the internal review estimated that cost savings are in the range of £3.4 - £9.5 million a year. Most of these savings come from reduced bed use among elderly patients.

RAID's provision of a formal training and education programme for acute trust staff focussing on common mental health problems was also identified as generating significant cost savings, mediated through changes in staff behaviour even if the patient had not been seen by the RAID team – the RAID influence (detection, management and referral of mental health problems).

6.4 Local services and preventative interventions

There is strong clinical leadership locally with GP mental health lead representation covering the majority of local commissioning groups and a CCG Older People's Mental Health Strategy Group with responsibility for commissioning mental health services on behalf of the CCG. This is a multi-agency group working collaboratively for a joined-up approach. In consultation with a range of local stakeholders, this group has developed the Cambridgeshire and Peterborough CCG 'Joint Commissioning Strategy for Mental Health and Well-Being of Older People' 2013-2016.

The strategy identifies five priorities:

- **Increasing awareness** amongst those caring for older people of possible mental health problems, including cognitive impairment, affecting older people in all care settings including own home/community, care homes and hospital.
- **Early diagnosis and improving access to effective help**.
- The inter-relationship between **physical and mental health** and the need for multi-disciplinary working to better address the often complex health needs of older people in a more seamless and integrated way.
- Increasing access to advice and support for the **carers** of older people with mental health problems including cognitive impairment.
- Improved **commissioning processes** to promote joint working across health and social care and voluntary organisations, and better use of available resources.

[116] Parsonage M. & Fossey, M. 'Economic evaluation of a liasison psychiatry service'. (2011) Mental Health Network NHS Confederation.

The strategy also further details current local service provision. Some key programmes or initiatives are described below:

- The Primary Care Older People's Mental Health (OPMH) service has been rolled out across Cambridgeshire to provide advice and support for patients with mild to moderate functional and cognitive mental health problems and to increase access to psychological therapy for older people. This service is fully integrated into the Community Mental Health Teams to provide a seamless service for patients and single point of access. The service is provided by the Mental Health Trust (CPFT) in partnership with the Alzheimer's Society.
- A CQUIN (Commissioning for Quality and Innovation) contractual mechanism was introduced in 2012 for dementia screening to take place in all local hospitals and community services in Cambridgeshire.
- An Older People's Mental Health Liaison Service at Addenbrooke's and Hinchingbrooke hospitals provides assessment and advice on treatment for patients aged over 65 currently in hospital presenting with acute mental health problems requiring immediate specialist mental health advice. Patients under the age of 65 years are also assessed by the liaison team if those patients have a confirmed diagnosis of dementia.
- The Cambridgeshire Training, Education and Development - Older People (CAMTED-OP) is a countywide specialist multi-disciplinary training team provided by the Older People's Mental Health Division within CPFT. Training and practice development is offered to a range of providers in the areas of dementia care and functional mental health. Providers to receive input include care homes, home care providers and acute hospitals.
- The Dementia Carers' Support Service (DCSS) is a multi-award-winning service that provides support for carers of people with dementia throughout the journey of their caring role. This is achieved by linking current carers of people with dementia with those who already have first-hand carer experience. These experienced carers are a befriender or buddy and become a Dementia Carers' Support Volunteer (DCSV).
- The Dementia Adviser Service (DA) is a Cambridgeshire wide service provided by the Alzheimer's Society for those that have been recently diagnosed with dementia. Dementia Advisers provide personalised information, advice and signposting services to people in the process of getting a diagnosis or from diagnosis of dementia onwards.
- The CrisP programme is an educational programme for carers of patients with dementia. There are two different programmes focussing on carers of patients with early dementia and late stage dementia respectively.
- There are also close commissioning links with research organisations (CLAHRC old age theme, Dendron and Mental Health Research Network) facilitating the evaluation of initiatives eg the Dementia CQUIN.

For more information on services commissioned from or provided by the Voluntary sector see section 8.5.

6.5 Community and stakeholder views

Recurrent themes from local consultation for the Older People Mental Health Commissioning Strategy (2013 – 2016)[117] identified the need for:

[117]Cambridgeshire and Peterborough Clinical Commissioning Group draft Older People's Mental Health Strategy, 2013.

- Earlier diagnosis and timely guiding towards sources of support which should result in improved outcomes for both service users and their carers.
- Staff training in a range of settings (acute and community) to raise awareness and increase the identification of patients with mental health issues.
- Partnership and multi-disciplinary working at all levels.
- Services to support independent, self-determination and recovery through integrated services.
- Specialist provision of accommodation for people with all types of mental health needs.

The UK enquiry into Mental Health and Well-being in Later Life[118] identified five themes which older people said were important to their mental health and well-being. When these five themes are congruent, they enable people to stay well, independent and experience fulfilment in their lives. These five factors were:

1. discrimination (eg by age or culture),
2. participation in meaningful activity,
3. relationships,
4. physical health (including physical capability to undertake everyday tasks) and
5. poverty

Factors which were most frequently mentioned by older people as important to their mental well-being include social activities, social networks, keeping busy and 'getting out and about', good physical health and family contact.[119] The impact of social networks and meaningful activity, and the detriment of social isolation, is reviewed in the next section.

6.6 Key findings

- More local data and analysis is needed to better understand the mental health needs and inequalities experienced by older people. There is a lack of available local information particularly in the following areas:

    - Analysis of older people demographics who present and use services compared to expected need;
    - Older people mental health needs of vulnerable groups (eg Gypsy and Travellers, ethnic minorities, homeless and learning disabilities) and those in deprived areas;
    - Older people alcohol and drug misuse (including prescription drugs);
    - The impact of older people's mental health issues upon the local health and social care system.

- Early diagnosis and improving access to effective help could be improved through increasing awareness of possible mental health problems affecting older people (including cognitive impairment), access to advice and support. This is important both for those caring for older people in all care settings including own home/community, care homes and hospitals.

[118] Age Concern England and the Mental Health Foundation, Promoting Mental Health and Well-being in Later Life, 2006

[119] Age Concern England. 'Third Sector First: 'Things to do, places to go'. Promoting mental health and wellbeing in later life – a report for the UK inquiry into mental health and well-being in later life'. (2005).

- There is a lack of integrated care between health, social and housing services for older people with mental health needs. It has been reported by local health and social care staff that failure to share patient information between services and across organisations can often lead to delays in diagnosis and treatment.
- There is a need to ensure equity of access and services and sufficient capacity to meet local mental health needs of older people. Improved joint-commissioning and better integration of services with joined-up working could enhance patient and carer experience, deliver better health outcomes and facilitate timely intervention.
- National case studies have shown that liaison psychiatry services in the acute hospital can generate improved mental health outcomes for older people as well as potential savings through an integrated approach to physical and mental health, reducing length of stay and readmissions.

Social isolation and loneliness

7.1 Context

The terms isolation and loneliness are often used together but are not synonymous and may not occur together. Isolation can be described as "separation from social or familial contact, community involvement, or access to services."[120] Loneliness can be understood as "an individual's personal, subjective sense of lacking these things to the extent that they are wanted or needed."[121]

Loneliness and isolation amongst older people is a key issue which impacts on their health and wellbeing. There is strong evidence of the link between loneliness and isolation and poor physical and mental health and wellbeing[122] including impacts on physical risk factors such as high blood pressure and obesity. Lonely individuals are more prone to depression, and loneliness has been linked to cognitive decline, dementia, fatigue and low energy levels.[123]

Various factors have been found to increase older people's risk of experiencing loneliness and isolation. These include:[124]

- Personal circumstances: eg loneliness and isolation are more common among people who are widowed or have no children.
- Life events: eg sudden occurrences such as bereavement, or having to move into residential care; or gradual developments that give rise to a perception of having become lonelier over time.
- Poor physical health and mental health can also exacerbate isolation and loneliness eg physical disability or impaired mobility, sensory loss, depression and cognitive decline.

7.2 Estimating loneliness and isolation in older people

A measure of social isolation is included in the 2013/14 Adult Social Care Outcomes Framework (ASCOF). This will draw on self-reported levels of social contact as an indicator of social isolation. Initially this indicator will focus on social care users and carers rather than the broader population. However there is a commitment to develop a population based measure of loneliness with a view to including in both Adult Social Care and Public Health outcomes frameworks in future years.

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[120] Age UK. Loneliness & Isolation evidence review. (2011) Available at: http://www.ageuk.org.uk/documents/en-gb/forprofessionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true.

[121] Age UK. Loneliness & Isolation evidence review. (2011) Available at: http://www.ageuk.org.uk/documents/en-gb/forprofessionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true.

[122] http://campaigntoendloneliness.org/toolkit/wp-content/uploads/Evidence-on-mortality-and-morbidity1.pdf.

[123] Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA (2006) Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analyses. Psychol Aging 21(1) Available at: http://www.ncbi.nlm.nih.gov/pubmed/16594799.

6 Cacioppo JT, Hawkley LC, Berntson GG, Ernst JM, Gibbs AC, Stickgold R, et al. (2002) Do lonely days invade the nights?

[124] Age UK. "Loneliness & Isolation evidence review". (2011) Available at: http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true.

An Age UK evidence review on loneliness and social isolation reports[125]:

- It is estimated that about 20% the older population are mildly lonely and another eight to 10% are intensely lonely.
- 36% of people aged 65 and over in the UK feel out of touch with the pace of modern life and 9% say they feel cut off from society.
- Nearly 600,000 older people in the UK leave their house only once a week or less.

The national loneliness and isolation Health and Wellbeing Board toolkit[126] suggests the prevalence of lonely or isolated older people should be based on an estimate of six to 13% of people aged over 60 who often or always feel lonely.[127] It suggests that older people at particular risk include:

- Lone pensioners;
- Older carers;
- Recently bereaved older people;
- People over 75;
- People over 65 living in a materially deprived area;
- Older people with sensory impairment including dual sensory impairment.

The number of older people living alone offers a proxy estimate of the number of people who may potentially feel socially isolated by living arrangements. It is predicted nationally that between 2008 and 2031 the increase in the number of 65 to 74 years olds living alone will be 44% and the increase in those aged 75 plus living alone will be 38%.[128]

7.2.1 Local figures - older people living alone in Cambridgeshire

At the 2011 Census, there were nearly 29,500 households in Cambridgeshire occupied by one person aged 65 and over (see Table **15**).This corresponds to 29% of older people over 65 in Cambridgeshire.

This was 11.7% of all households in Cambridgeshire, a lower proportion than in England (12.4%). This varied however by district with 14.3% of households (6,000) in Fenland being one person households (65+). The largest absolute number of one person households (65+) was in Huntingdonshire with over 7,000 such households.

[125] de Jong Giervald J, Fokkema T, Van Tilberg T. Alleviating loneliness among older adults: possibilities and constraints of interventions. Safeguarding the Convoy: a call to action from the Campaign to End Loneliness, Oxfordshire: Age UK Oxfordshire (2011). http://campaigntoendloneliness.org.uk/wp-content/ uploads/downloads/2011/07/safeguarding-the-convey _- _a-call-to-action-from-the-campaign-to-end-loneliness.pdf.

[126] http://campaigntoendloneliness.org/toolkit/wp-content/uploads/Building-a-basic-picture-for-JSNAs-and-JHWSs.pdf.

[127] Cann P and Joplin K. Safeguarding the Convoy – a call to action from the Campaign to End Loneliness, Age UK Oxfordshire (2011) http://campaigntoendloneliness.org.uk/wp-content/ uploads/downloads/2011/07/safeguarding-the-convey _- _a-call-to-action-from-the-campaign-to-end-loneliness.pdf.

[128] Department for Communities and Local Government Household Projections to 2031, England, 2009 Available at: http://www.communities.gov.uk/documents/statistics/pdf/1780763.pdf.

Table 15: Number of one person households aged 65+ and % of all households by District, 2011

District	All households	One person households aged 65+	%
Cambridge	46,714	5,194	11.1%
East Cambridgeshire	34,614	4,117	11.9%
Fenland	40,620	5,809	14.3%
Huntingdonshire	69,333	7,389	10.7%
South Cambridgeshire	59,960	6,899	11.5%
Cambridgeshire	251,241	29,408	11.7%
England	22,063,368	2,725,596	12.4%

Source: 2011 Census, Office for National Statistics

7.3 Community engagement and participation

As our older population grows in the coming years, the problem of loneliness and isolation amongst older people is likely to increase. The issue of loneliness and social isolation is multi-faceted and the design of services needs to be informed by the complexity and inter-relationship of the causes of loneliness.[129] Tackling this issue requires interventions and locally derived solutions to enable older people to contribute to and participate in their local communities.

Services that help to diminish loneliness and isolation provide a way back in to the community for many older people and enable them to start to contribute again. Many befriending schemes also provide an opportunity for volunteering which is highly valued by volunteers and also promotes good mental health and well-being.[130]

The following sections describe a 'Timebanking' community scheme and a number of local programmes run by the libraries service in Cambridgeshire which engage older people in the community and help to reduce social isolation, often through both supporting and engaging older people and encouraging older people to participate in their community in volunteering and supportive roles for others.

7.3.1 Timebanks

Timebanks are an innovative form of 'volunteering' based on mutual support that can be a highly effective system for promoting active citizenship, the growth of social capital, community empowerment and community skills. It involves building on peoples' strengths and recognising that everyone in a community has something to offer, including those often defined as disadvantaged or vulnerable.

Timebanking is a way of linking local people who can then share their time and skills. Participants 'deposit' their time by giving practical help and support to others, and are able to 'withdraw' their time when they need something done themselves. Working

[129] Age UK. "Loneliness & Isolation evidence review". (2011) Available at: http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true.

[130] Age UK. 'Promoting Mental Health and Well-being in Later Life: A guide for commissioners of older people's services'. Available at: http://www.ageuk.org.uk/documents/en-gb/for-professionals/care/mental%20health%20and%20wellbeing%20in%20later%20life_pro.pdf?dtrk=true.

on the assumption that everyone's time is valued equally, one hour of time given earns one time credit and an exchange takes place without the need for money.

As research suggests, the Timebank model can help build social networks of people who give and receive support from each other, enabling people from different backgrounds, who may not otherwise meet, to come together and form connections and friendships and build and harness their skills. It is a highly effective community development tool, empowering individuals and groups to bring about change, make choices and take control of their own lives and neighbourhoods.

As a result of a highly successful pilot project in the parish of Somersham a network of Timebanks are evolving across the county of Cambridgeshire.[131] A wide range of organisations were involved in setting up the original pilot and now, are helping establish this network. Currently there is at least one Timebank in each district of the county. A multi-agency Steering Group, which includes voluntary organisations, district and county councils and registered social landlords, is offering advice and developing resources, such as a Start-Up handbook and software, to assist interested groups, organisations and parish councils to widen the network.

7.3.2 The role of public libraries in health and wellbeing

Around 40% of the population use public libraries. Recent mapping research shows that libraries offer key services which support the work of health and social care partners and deliver public benefit; including health information, health promotion, therapeutic reading and social reading activities. Nationally there are at least 10,000 library-linked reading groups reaching people of all ages and some of our most vulnerable communities.[132]

Engagement with cultural activity increases older people's happiness.[133] In addition to facilitating social interactions in linking to local communities and people through

[131] http://www.cambridgeshire.gov.uk/community/localism/timebanks.htm.

[132] Taking Part Statistical Release, 2011–12; Public Library Activity in the Areas of Health and Well Being, MLA, 2012; Reading Groups in Libraries Mapping Survey, TRA, 2008.

[133] Frieswijk N, Steverink N, Buunk BP, Slaets JP. The Effectiveness of Bibliotherapy in increasing the Self-Management Ability of Slightly to Moderately Frail Older People, Patient Education and Counselling. Patient Educ Couns. 2006; 61(2):218-27. Available at: www.ncbi.nlm.nih.gov/pubmed/15939567.

libraries and groups, reading can reduce stress levels by up to 67%.[134] Evidence also suggests that reading can reduce the risk of dementia by 35%.[135] Bibliotherapy increases the self-management ability, mental agility and health literacy of older people.[136]

Cambridgeshire County Council Library, Archive and Information Service provide a wide range of services that assist older people to remain safely independent at home, help keep them socially engaged through learning and have an extensive stock of books on health and related topics. 'Books on Prescription' is a nationally accredited scheme whereby GPs in Cambridgeshire are able to recommend books available in their local library to people who need information about their condition to help them learn about their condition and so work towards self-management of their own health.

Smoking cessation information at a local library

"I came to the library to borrow a book and then joined an exercise class in the library and made new friends"

Linked to mental health, the library 'Reading Well' and poetry reading groups offer support specifically for people living with and/or recovering from mental health conditions. Regular promotions such as 'Mood boosting books' help to promote the value of reading as therapy and enjoyment.

The 'Library at Home' service (previously the 'Doorstep Delivery' service) offers more than 400 housebound people a personal book and audio book delivery service, access to the library e-reading, e-audio and e-information services and the 'Postal Tape Service' for people with a visual impairment (300 customers). 'Reading Aloud' volunteers visit and read to people in both residential care settings and their own home and promote and support reading to the most vulnerable.

"As I am housebound this service is a lifeline for me"

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[134] Galaxy Research, Mindlab International, 2009.

[135] Leisure Activities and the Risk of Dementia in the Elderly, New England Journal of Medicine, 2003, 348:2508-2516, , 61, 2006, Taking Part Statistical Release. *www.ncbi.nlm.nih.gov/pubmed/15939567*

[136] Verghese MD, Lipton RB, Mindy JK et al. Leisure Activities and the Risk of Dementia in the Elderly. New England Journal of Medicine, 2003,348:2508-2516.

'EngAGE Groups' for the over-50s take place in 16 libraries across the county and offer a range of activities that keep people active and socially engaged. Older people can also access the 'Computer Buddy' scheme whereby 26 peer mentors in libraries can help build confidence in use of the library computers for banking, shopping, information, email, family history and for learning and hobbies. 'Knit and Knatter' groups and 'Creative writing' groups also take place in libraries as well as over 400 'Reading Groups', many meeting in the library. The Library Service has a created a collection of individually designed 'Reminiscence boxes' that are loaned to residential homes or used in libraries.

"I just moved to Histon to be near my family and I didn't know anyone, now after coming to the 'Engage Group' I have three new friends"

7.4 Key findings

- Reducing loneliness can contribute to achieving a number of health and wellbeing board priorities and addressing it should result in stronger communities in which older people play a greater role.[137]
- Tackling this issue requires interventions and locally derived solutions to enable older people to contribute to and participate in their local communities.The problem of loneliness and social isolation is multi-faceted and the design of services needs to be informed by the complexity and inter-relationship of the causes of loneliness.[138]
- Voluntary and community organisations, activities and services are essential in reducing isolation. There are a wide range of these; the grassroots nature of community support means that there will be different availability in different formats and locations, varying from small local groups with no paid staff to larger voluntary organisations. These are commissioned and funded in various ways by different organisations.
- The evolving evidence base and sharing of effective local interventions to tackle social isolation and loneliness is a key priority for further analysis and consideration. There is a need to strengthen social capital through initiatives such as timebanking and peer group support models to drive wider health and wellbeing initiatives in local communities.
- Reducing loneliness and isolation can also help to address health inequalities but it is recognised that local authorities may particularly need to stimulate community activity in areas where social networks are poorly developed because of deprivation or rural geography.[139]

[137] Loneliness toolkit for health and wellbeing boards. Available at: http://www.campaigntoendloneliness.org.uk/toolkit/.
[138] Age UK. "Loneliness & Isolation evidence review". (2011) Available at: http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true.
[139] Age UK. "Loneliness & Isolation evidence review. (2011) Available at: http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true.

Social care and support in the community

8.1 Context

A focus on preventing problems and early interventions to prevent or reduce social care needs is beneficial both for the individual to remain independent, safe and well, and to reduce the demand for services, easing the pressure on resources allocated to adult social care.

The shift towards prevention and early intervention is a key theme of Cambridgeshire County Council's vision for transforming adult social care through personalisation; 'Shaping our Future'.[140] In 2011 the Council produced a Prevention and Early Intervention Strategic Plan which developed ways in which this strategic shift could be achieved. Working and commissioning effectively with partners, particularly NHS Cambridgeshire, District Councils and other health providers, a continued aim is to ensure the shift of investment from reactive provision towards preventative and enabling/rehabilitative interventions.

The strategic plan examined the way in which social care and support was delivered and what the County Council are already doing that is preventative in nature. This mapping identified a range of in-house and commissioned interventions, including:

- Carers Support team carers
- Housing-related support services
- Assistive technology, Telecare and Telehealth
- Library 'Engage' groups
- Doorstep Library Service
- Citizen's Advice Bureau
- Cambridgeshire Mind
- Sensory services, such a Camsight and Camtad
- A range of Age UK advocacy, information, visiting and other services
- Care Network Good Neighbour, Info@GPs and Help at Home schemes

As a result of understanding this landscape and investigating the evidence and national examples of good practice, a number of key themes were identified:

- Community networks
- Skills, work and volunteering
- Information and advice (see section 8.4)
- Re-ablement (see section 8.3.4)
- Housing-related support (see section 0)
- Equipment and assistive technology (see section 9.3.5)

Voluntary sector colleagues report that people not in receipt of social care including self-funders can often be poorly served by information and support and remain "hidden" and unsupported for years. Many Older People live in co-dependency, neither recognising their frailty as a disability nor their roles as carers of each other. These people can often be 'off the radar' of social services until care needs reach a substantial level; and are registered with Primary Care but may not receive preventative solutions or support until a crisis occurs. Adult Social Care services are

[140] Cambridgeshire County Council, 'Shaping *our* Future': Transforming Adult Social Care through personalisation, 2009.
http://www.cambridgeshire.gov.uk/council/depts/adultsocialcare/transformation.htm

geared to support people meeting eligibility criteria and are means tested, unlike the NHS.

8.2 Identifying causes of social care need among older people

Older people that receive support from adult social care services may do so for a variety of reasons. These reasons may be personal factors relating to personal care and health, or circumstantial factors associated with social isolation, housing, finances and availability of care; often these are present in combination.

Assessments of social care need often focus on personal factors, but it is thought that changes in circumstantial factors may be the common triggers for needing social care support. For example, an older person may have a long-standing health problem or disability and not be receiving social care support, but bereavement results in the loss of a usual caregiver, prompting a requirement for support from the local authority. Knowledge of the most common triggers, personal or circumstantial, could help to inform and target preventive interventions to reduce or delay a need for significant adult social care support.

A review of the literature revealed a range of common risk factors for adult social care need (Figure 8). A pilot study is underway in Cambridgeshire County Council to review a random sample of adult social care assessment records, aiming to identify which of these, and other, risk factors are the most prevalent among clients in Cambridgeshire and which risk factors are the most common triggers of need.

Figure 8: Common causes of social care need among older people[141]

Personal risk factors		
Physical conditions	Personal care/lifestyle/mobility	Mental health
Arthritis Cancer Cardiovascular disease Cerebrovascular disease Diabetes Hypertension Impaired motor function Parkinson's disease Sensory impairment Stroke	Difficulty bathing/dressing Falls Incontinence Low levels of activity Malnutrition/low BMI/frailty Obesity Unsteadiness/difficulty walking	Cognitive impairment Confusion Dementia Depression Disorientation Low self-esteem Psychosis Other Communication difficulties Low level of education
Circumstantial risk factors		
Housing and accessibility	Social isolation	Finances
Difficulty doing own shopping Need to use assistive device Rural living Unsuitable housing conditions	Bereavement - family member Bereavement - pet Divorced Few family members Few household members	Low income No savings Not a home owner Poverty
Carer breakdown	Living alone	Other
Bereavement - carer Old age of carer	Unmarried	Length of stay in hospital Male spouse Prior stay in a care home

[141] Common risk factors for adult social care need summarised from a number of sources:
Avlund K. Disability in old age.Longitudinal population-based studies of the disablement process. Dan Med Bull. 2004 Nov;51(4):315-49.
Cahn-Weiner DA, Malloy PF, Boyle PA, Marran M, Salloway S.Prediction of functional status from neuropsychological tests in community-dwelling elderly individuals.ClinNeuropsychol. 2000 May;14(2):187-95.
Friedman SM, Mendelson DA, Bingham KW, McCann RM. Hazards of hospitalization: residence prior to admission predicts outcomes. Gerontologist. 2008 Aug;48(4):537-41.
Gaugler JE, Duval S, Anderson KA, Kane RL.Predicting nursing home admission in the U.S: a meta-analysis.BMC Geriatr. 2007 Jun 19;7:13.
Lewis G. Predicting who will need costly care – How best to target preventive health, housing and social programmes. 2007.
King's Fund. McCann M, Donnelly M, O'Reilly D. Gender differences in care home admission risk: partner's age explains the higher risk for women.
Age Ageing. 2012 May;41(3):416-9. doi: 10.1093/ageing/afs022. Epub 2012 Apr 17.
McCann M, Grundy E, O'Reilly D. Why is housing tenure associated with a lower risk of admission to a nursing or residential home? Wealth, health and the incentive to keep 'my home'.J Epidemiol Community Health. 2012 Feb;66(2):166-9. doi: 10.1136/jech-2011-200315. Epub 2011 Oct 19.
Quadri P, Tettamanti M, Bernasconi S, Trento F, Loew F.Lower limb function as predictor of falls and loss of mobility with social repercussions one year after discharge among elderly inpatients.Aging ClinExp Res. 2005 Apr;17(2):82-9.
Taekema DG, Gussekloo J, Maier AB, Westendorp RG, de Craen AJ.Handgrip strength as a predictor of functional, psychological and social health.A prospective population-based study among the oldest old.Age Ageing. 2010 May;39(3):331-7. doi: 10.1093/ageing/afq022. Epub 2010 Mar 10.
Vass M, Avlund K, Parner ET, Hendriksen C. Preventive home visits to older home-dwelling people and different functional decline patterns. European Journal of Ageing. 2007 Sept;4(3):107-113
Wanless D.Securing good care for older people – Taking a long-term view. 2006. King's Fund.

8.3 Services to support older people

8.3.1 Adult Safeguarding Board

'Adult safeguarding' is the term that describes the function of protecting adults from abuse or neglect. This is an important shared priority of many public services and a key responsibility of local authorities. It is important to note that the safeguarding of vulnerable older people is a key priority which runs through all of the aspects of care, support and services described in this JSNA.

In Cambridgeshire the Adult Safeguarding Board and Adult Safeguarding Team are working closely with partners to protect vulnerable people from abuse. The Cambridgeshire Adult Safeguarding Board Annual Report 2011-2012[142] provides an informative insight into the work of the Board and partners and describes key achievements. Some of the notable achievements in 2011-2012 were:

- increased awareness of safeguarding adult issues as illustrated by a 22.3% increase in the number of safeguarding adult referrals;
- review and revision of the adult safeguarding policy guidance and procedures and the development of a range of complementary practice guidance;
- alignment of adult safeguarding and serious incident processes.

8.3.2 Day services

The increasing number of older people in our population requires services to focus on maximising independence, dignity and well-being. Older people are not a homogeneous group. The population of Cambridgeshire in the age range from 65 to over 100 includes huge differences in terms of health, fitness, interests, culture and faiths.

A broad spectrum of high quality day services are an essential part of a strategy to support the majority of older people in their wish to remain in their own homes pursuing active and fulfilling lives for as long as is possible. 'Day services' is an umbrella term that covers both day activities and day care:

- 'Day activities' are those that happen in the community and support older people who have lower level needs. These may include formal and informal settings; centres run by voluntary organisations, drop-in centres, lunch clubs, social clubs and keep fit activities and may or may not include staff and volunteers.
- 'Day care' implies a specific need that would not be met by day activities. It suggests a greater degree of dependency by the person using the service, and a care plan would be in place to document the individual's need and how it will be met.

It is also clear that a growth in both the amount and variety of day activities will be required to ensure service accessibility is maintained and improved. The benefits realised by the provision of high quality day services are felt not only by older people themselves but by the statutory services as well. For the older people these include:

- Maintaining independence.
- Improved sense of well-being – social contact is one of the key factors. contributing to a sense of well-being in later life.
- Access to advice services and support.

[142] Cambridgeshire County Council. Cambridgeshire Adult Safeguarding Board Annual Report 2011-2012. Available at: http://www.cambridgeshire.gov.uk/social/adultprot/schapannualreps.htm

- Personal development – both physical and mental stimulation.
- Support for carers.
- Promoting social engagement and helping to tackle social isolation, which can contribute to depression.

For the statutory services, the benefits include:

- Promoting effective use of inpatient services including preventing unnecessary hospital admission and supporting early and successful discharge, including reducing the risk of readmission;
- Offering the opportunity to identify changes in the physical, social and psychological state of the users.

Currently in Cambridgeshire day services are funded, commissioned and provided by a range of organisations, including the County Council, Parish Councils, housing providers, Age UK and other voluntary and community organisations.

In 2011, Cambridgeshire County Council's Older People's Partnership Board undertook a review of Cambridgeshire's Day Services.[143] This included a mapping and analysis provision for older people across the county. As a result of the review the County Council revised its commissioning intentions, to:

- Ensure more effective use of finite resources by addressing under-usage and reducing the block funding accordingly;
- Amalgamate some services with other specialist resources;
- Provide specialist day services at identified locations across the county;
- Provide wider day services and meaningful opportunities across the county aligned to libraries, the new communities and housing developments and better use of local services;
- Support greater choice and control through Self-Directed Support and Personal Budgets, moving away from block funding arrangements.

8.3.3 Rehabilitation and risk management

Day services are not solely about providing socialisation and support for the isolated and respite for unpaid carers. They also provide a service:

(a) As part of a rehabilitative, recovery and preventative programme of care for people at risk of, with, or recovering from clinical depression, severe anxiety states or psychosis, some of whom are within the care of the Mental Health Service;
(b) As part of risk management for people who may be at risk of self-neglect or abuse;
(c) To help manage the risk for some people who are mainly at home for large parts of the day and, for example, may have dementia and be at risk of wandering; or
(d) People may attend a day service because they have been advised that this is in their best interest or to provide their carer with some respite.

[143] Cambridgeshire Older People's Partnership Board, The Future of Day Services and better opportunities for Older People in Cambridgeshire: A vision statement 2011/12. 2011 http://www.cambridgeshire.gov.uk/council/depts/adultsocialcare/olderpeople/Getting+involved.htm

8.3.4 Re-ablement

Re-ablement is short-term support to help people regain their independence. It could be support with personal care, to prepare a meal, manage medication or other daily living activities. It is about helping people to 'do things for themselves' rather than 'having things done for them', and supports people to live in their own homes. Many people who participate in a re-ablement programme find that afterwards they can cope very well on their own without the need for further support.[144]

The benefits of re-ablement include:[145]

- Maintaining or regaining independence;
- Improved health and wellbeing;
- Improved significant and sustained social care outcomes;
- A positive impact on health-related quality of life;
- Reduced expenditure on future demand for intensive social care services and support.

In 2010, the Council together with its NHS partners successfully introduced a re-ablement service across the county. The service was delivered by Cambridgeshire Community Services NHS Trust who provided short-term, intensive support to enable older people to live independently at home following illness or accident.

- Between 2010 and May 2012 nearly 3,000 people completed a re-ablement package.
- In 2010/11 55% of people completing a re-ablement package required no further support at the end of their programme.

A range of information, for staff, service users, families, carers and GPs, has been produced explaining the concept of re-ablement and how it works.[146]

scie social care institute for excellence

The Social Care Institute for Excellence has produced a number of resources, including films on SCIE TV,[147], which show how re-ablement works and in particular the role that families and carers can play.

Following on from the initial success in Cambridgeshire with adults with a physical disability, re-ablement services were then introduced to include new service users requiring an occupational therapy service and older people who already have a care package and now require additional support. At the beginning of 2013 re-ablement

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[144] Le Mesurier, N. and Cumella, S. 'Enhancing independence: the effectiveness of re-ablement provision in South Worcestershire Journal of Integrated Care1999 7- 4 pp 27−32.

[145] **Francis, J., Fisher, M. and Rutter, D. SCIE, Research briefing 36: Reablement: a cost-effective route to better outcomes SCIE 2011.**

[146] http://www.cambridgeshire.gov.uk/social/re-ablement.

[147] http://www.scie.org.uk/socialcaretv/topic.asp?t=reablement.

services are now being made available to all adults discharged from hospital. This phase will take all referrals from hospital, not just new people in to the service.

Ready and easy access to equipment and assistive technology plays a key role in re-abling people and improving independence (see section 9.3.5).

8.3.5 Help at Home (Incorporating Welcome Home from Hospital)

This Cambridgeshire service run by Care Network offers short term practical and emotional support in someone's home at a difficult time such as an illness or injury, or following a hospital stay. Police checked and trained volunteers visit people to offer help with shopping, calling in to check someone is okay, collecting prescriptions, helping people to access other services – whatever practical help is needed.

The service has had over 1,267 referrals in the last calendar year. 649 referrals for 'Admission Avoidance', 499 'Welcome Home from Hospital' referrals and 119 referrals to help people remain 'Independent at Home'.

Case study 4: An example of 'Help at Home'

"A patient was referred to 'Help at Home' who had emphysema and is normally quite independent. He had developed a chest infection and had become housebound and was on oxygen. He couldn't get out to collect his prescription or to shop, and had no neighbours or relatives who could help. The Care Network volunteer was able to help with these practical tasks and provide reassurance by calling in to check he was ok, until he recovered and was able to get out and about again."

8.4 Information and Advice

Cambridgeshire Age UK report that key questions from residents in the community relate to:

- benefits – particularly benefit checks and claiming Attendance Allowance;
- health issues – often around equipment, aids and adaptations;
- non residential care – often finding daytime activities;
- finding help at home – often finding help with little job;
- housing and property – often how to get repairs done.

8.4.1 'Your Life, Your Choice'

Your Life, Your Choice
Information about Adult Social Care

Easily accessible and accurate information and advice is a pre-requisite for good decision-making, and so is at the heart of the personalisation of adult social care. In

2010, Cambridgeshire County Council worked with a range of partner organisations to develop a strategic plan which explored experiences at the time and how these could be improved.[148] This work explicitly included people who fund their own care and support and recognised the major role information also plays in preventative services.

The plan identified the wealth of digital and written information about adult social care, and often that this can be difficult to find, out of date or sometimes duplicated or presented in such a way as to confuse more than inform. The plan highlighted that it is not the creation of new sources that is needed but ensuring that existing sources are coherent, comprehensive and accurate. In practice this means making sure information content is owned and kept up to date and there are comprehensive links to national and local sources of information.

The strategic plan delivers a universal information and advice system branded as 'Your Life, Your Choice', with a new adult social care website as the central focus, supported by a streamlined leaflet set, a number of new delivery points, including libraries and the County Council Contact Centre, and an extensive and on-going marketing plan.

The key sites that have been linked are:

- http://www.yourlifeyourchoice.org.uk - General information regarding adult social care and keeping well, independent and safe.
- http://www.asksara.org.uk/?auth=cambridgeshire - Self-help guide for accessing equipment and assistive technology
- http://www.cambridgeshire.gov.uk/social/ - Provider and partner information about workforce development, commissioning and safeguarding
- http://www.cambridgeshire.net/ - Local directory of activities, groups and organisations.

Mapping the wide range of grassroots community activity of this kind is very difficult. As described in the Older People JSNA (2010)[149] Cambridgeshire.net (www.cambridgeshire.net) is a large database of community activity in Cambridgeshire. It is as close as possible to a definitive list of community activity, having been actively promoted to voluntary and community groups and statutory agencies for a number of years. The database shows that there are approximately 4,500 services and activities provided by grassroots, voluntary and independent sector organisations that could help to reduce social isolation. A significant proportion of these provide leisure activities, but there is also evidence that whether they are based on hobbies, sports or promoting health there is a strong focus on supporting the community with people coming together in social groups. Older people and disabled people are key target groups for these services.

[148] Cambridgeshire County Council, Shaping *our* Future: Universal Information and Advice services, 2010. Available at: http://www.cambridgeshire.gov.uk/council/depts/adultsocialcare/transformation.htm

[149] Available at: http://www.cambridgeshirejsna.org.uk/currentreports/older-people-including-dementia.

8.4.2 'Community Navigators' Pilot programme

Community Navigators

Routes to activities and services

To progress the evident need for community networks and effective information and signposting, Cambridgeshire County Council have commissioned Care Network to develop and deliver a 'Community Navigator' scheme that will address the core themes of the adult social care prevention agenda; promoting independence; preventing or delaying the deterioration of wellbeing resulting from ageing, illness or disability and delaying the need for more costly and intensive services.

This model delivers a localised bespoke support related service that acknowledges and addresses the multiple and often complex needs of individuals. The Navigator infrastructure focuses on people's whole needs by supporting them to find their way through the often complicated systems and access integrated, personalised information and services.

The Navigator concept has been implemented and reviewed under different names in a wide range of places and countries. Despite varying objectives and intervention designs, the Navigators are characterised by the fact that they are rooted in the community. They have been trained in reaching out to older and vulnerable people in order to provide them with practical, social support and skills and to help them identify the services and service providers that can assist them to stay healthy and independent.

An important part of their role is to inform members of the community about locally available services and resources and to signpost and refer to those. They typically act at the interface between the community and public and voluntary sector services to provide support. The aim of the Community Navigators model is to help people move from social isolation to regains a sense of contribution and social capital. The Navigators use 'Your Life, Your Choice' as their primary information source.

A key element of this pilot programmer is a rigorous evaluation which aims to identify key elements of success, sharing of good practice and areas for improvement.

8.4.3 'Information@GPs' pilot programme

An important part of joint working between health and social care requires that GPs and primary care or community staff are aware of the social services and local community support available for individuals and their families or carers. Being aware of what local support exists and which is most appropriate for an individual, family or carer is a challenge which has been identified by a number of local GPs in the Older People Programme Board local stakeholder events.

'Information@GPs' is a pilot project run by Care Network which has been running in Ely GP consortium in the past year. Information Officers offer sessions once a week in each practice providing information and help to patients in the surgery or a home visit.

The service has had 361 referrals and helped people to access 923 organisations between April 2012 and February 2013.

Case study 5: An example of 'Information@GPs'

A patient referred to the service by their GP had cancelled important heart surgery twice due to extreme anxiety coupled with some learning difficulties. The Information Officer signposted him to the Help at Home service who arranged for a volunteer to meet with him to gain his confidence and to go to hospital with him. After gaining the patient's consent, the Information Officer liaised with the hospital and the Consultant's secretary who agreed that he could have his pre-op appointment at the same time as the operation. The Information Officer also contacted the hospital social worker and the ward to ensure they knew the situation. The warden of the sheltered accommodation where the patient lived was also contacted to remind him not to take certain medication before the operation. The operation went ahead as scheduled and the Help at Home service offered a volunteer to visit during his recovery. The patient's GP emailed Care Network with the following comment:

"*I wanted to say particular thanks for the effort put in last month to get my patient to Papworth Hospital for his admission. He would not have had this important surgery without you*."

8.5 Summary of commissioned Voluntary services

The voluntary and community sector provide a wide range of activities and services that offer support and care to older people, their families and carers. These activities and services are provided by a large number of groups and organisations, differing hugely in size, nature and purpose. These range from the smallest community group with no paid staff, to larger organisations providing a range of services, many of which are commissioned by statutory health and social care organisations.

This section sets out the services offered by four of the largest voluntary providers in the County.

8.5.1 Age UK

Age UK provide a range of services to people aged 50 and over throughout Cambridgeshire. Key services include:

- Information, Advice and Advocacy service - which takes over 6,500 information calls per year. The accuracy and range of subjects which can be advised upon is backed up by AgeUK England's up to date knowledge and advice standards in order that correct information is given to older individuals, their families and carers. The advocacy service deals with the more in-depth queries and helps older people have their rights, choices and wishes heard and acted upon.
- Visiting Scheme - to provide lonely isolated people over 60 with a weekly visit of an hour to reduce the feeling of isolation and loneliness.
- Community Warden Schemes - Age UK Cambridgeshire manages seven warden schemes in the county.
- Safer Homes - The scheme is for people aged 60 or over and is aimed at the prevention of falls and accidents in the home.
- Day Centres - Age UK Cambridgeshire run six day centres in the county in several different geographical areas, the day services support older people to remain independent and continue living at home.

- Fenland Healthy Homes - supports older people to live as comfortably, safely and independently as possible by providing free minor modifications, equipment and adaptations within their homes.
- Home Help Service - covers areas Cambridge, East Cambridgeshire, Fenland and Huntingdon.

8.5.2 Alzheimer's Society

The Alzheimer's Society provides specialist services and information on all forms of dementia. The Alzheimer's Society provides services that are both practical providing support and information - an essential point of contact for those affected by dementia or worried about their memory.

These include:

- Peer Support Groups, cognitive stimulation groups and Dementia Advisers for those living with dementia.
- Carers Information and Support Programmes and a befriending service aim to help partners and families cope with the demands of caring.
- Dementia Café's and innovative 'Singing for the Brain' sessions provides support and information in social environments.
- Home visits are available for those dealing with complex situations, with the Dementia Information Points providing a point of access for the public to receive information and support without appointments.

8.5.3 Care Network

Care Network Cambridgeshire's mission is "To help older, isolated and vulnerable people living in Cambridgeshire to stay independent and maintain social contact with friends and the community." The organisation has a small staff team supported by approximately 140 volunteers who they recruit, support and train. They also support older people by raising issues which affect older people, and older people's support or social groups, with statutory or other bodies.

Their main work is delivered by three teams:

- The Direct Services team provides a 'Help at Home' service in which volunteers offer short term practical help to people during a difficult time such as illness or following a hospital stay. They also provide the 'Information@GPs' service where information officers inform patients of services which can assist with non-medical problems. Both these services help to reduce attendance at GPs and hospital admissions.
- The Community Development team help to start up and support local community groups that offer practical help and social contact for older and vulnerable people. By keeping people engaged in their community this aims to reduce the need for medical and social care interventions.
- The Community Navigator volunteers provide information and help so that older people can get to activities and services which they would enjoy or find useful. By signposting to pre-medical services such as lunch clubs they aim to reduce attendance at primary care settings.

8.5.4 Crossroads Care Cambridgeshire

Crossroads Care Cambridgeshire works across Cambridgeshire and Peterborough to support informal, unpaid, family carers and people with care needs, many of whom are older people. They are funded by the Local Authorities, NHS and charitable grants and donations and winners of The Charity Awards 2012.

They provide a range of solutions for carers and people with care needs of any age with any condition including:

- Care in the home for adults;
- Social outings and flexible breaks;
- ICER Carers Emergency Service;
- Carer Services Prescription from GPs;
- Day Care and Carers Groups;
- Carers advocacy ('Have your say').

8.6 Community views and engagement

The 'Ageing Well' initiative was funded by the Department for Work and Pensions (DWP) programme, and promoted by the Local Government Association (LGA). The programme sought to provide advice and assistance to local authorities in improving their older people's services. It was launched in July 2010 and formed a key part of the government drive to shift power to communities by promoting learning from research and empowering local people to devise local solutions to local needs. The objectives of Ageing Well were to:

- help local authorities to use their resources effectively;
- promote well-being in later life;
- ensure that older people can live independently for longer;
- engage older people in civic life;
- tackle social isolation by recognising older people's potential.

The LGA are now supporting the legacy of Ageing Well by promoting the learning from the programme. The evaluation report[150] sets out how tailored support was taken up by some Local Authorities and included such activities as engagement workshops and best practice reviews, and how the programme assisted in developing strategic agendas to address age-related issues.

In Cambridgeshire the Ageing Well Programme was progressed by local authority, health organisations and the housing and the voluntary sector working together on local programmes of engagement and action. Older people's representative organisations, such as Cambridgeshire Older People's Reference Group (COPRG) and Cambridgeshire Older People's Enterprise (COPE), were central to the work which explore age-related issues in their area through holding 'conversations' about health, wellbeing and local support networks.

The engagement workshops held in various locations across the county during 2011 and 2012 identified the following themes as of prime importance to older people:

- Information;
- Transport;

[150] Harkness, V., Cameron, D., Latter, J., Ravat, M. and Bridges, L. Preparing for an Ageing Society: Evaluating the Ageing Well programme Parts 1 and 2, Department of Work and Pensions, 2012. http://www.local.gov.uk/web/guest/ageing-well/how-to-know/-/journal_content/56/10171/3491587/ARTICLE-TEMPLATE

- Supporting and developing village warden services;
- Improved operational liaison between local authorities, health and the voluntary sector;
- Developing a programme of work to tackle rural health inequalities.

Best practice responses identified in Cambridgeshire include:

- The Community Navigator project (see section 8.4.2);
- A county-wide network of Timebanks (see section 7.3.1);
- Local 'Mature and Active' programmes.

Local responses to these engagement exercises are being progressed by district-level Health and Wellbeing Partnerships, thereby complementing local arrangements and community activity, whilst at the same time supporting the strategic agenda of the Health and Wellbeing Board.

The Office for Public Management have produced a handbook based upon the good practice identified by the Ageing Well programme, *Ageing Well: An asset based approach.*[151] This booklet highlights the benefits of co-production and seeing older people as assets rather than problems. Whilst this approach is central to elements of the positive ageing work happening within Cambridgeshire a wider awareness could assist in developing meaningful discussion and maximising the potential for change.

8.7 Key findings

- There are significant benefits to be realised by greater joint working within health and social care both at an operational and strategic level. However, at present integrated support remains a challenge.
- There are a number of local interventions and examples of good practice which help to support older people and their carers, as well as prevent or delay the need for health and social care, including hospital admissions. Encouraging systematic evaluations of the impact of these interventions could help to promote, enhance and share best practice.
- Re-ablement services are now widely available and proven to be effective in helping older people regain their independence through assisting with re-learning everyday tasks. The development of this approach needs to continue, to benefit more people.
- Progress has been made in responding to older people's views about needing better information, through Community Navigators and Information at GPs and embedding Your Life, Your Choice and Ask SARA in other services. There is considerable potential to improve the way in which information and advice is offered across the whole health and social care sector.
- GPs are a key point of contact with 'at risk' older people and provide an opportunity to signpost to preventative and community support services. Raising awareness of local databases and sources of information about local

[151] Office of Public Management & Local Government Association, Ageing Well: An asset based approach, 2012. http://www.local.gov.uk/c/document_library/get_file?uuid=b009f17c-5b0f-4b7c-a661-1f2f06140934&groupId=10171

support groups in the community could help to prevent ill health or crises and enhance the health and wellbeing of older people and their families or carers.

- The Ageing Well asset-based approach, seeing older people as community assets, demonstrates the benefits of engaging with older people. This underlines the need to continue working in partnership and involving older people in service design, delivery and review.

Housing

9.1 Context

The provision of appropriate housing is clearly important for Cambridgeshire's growing population of older people. Most older people live in the community: nationally only 5% of older people live in supported sheltered schemes; 95% of older people live in the wider community.[152] From a prevention perspective it is essential to ensure that the majority of older people in their own home are supported or have easy access to support where required. This section briefly summarises aspects of housing support and local initiatives which are particularly pertinent to the prevention of ill health and poor well-being of older people.

Further information on housing can be found in the JSNA on Housing and Health (2013), JSNA Older People (including dementia) (2010)[153] and the Strategic Housing Market Assessment for the Cambridge sub-region updated in 2011.[154]

9.2 The role of housing in health and wellbeing

The Housing Learning and Improvement Network (LIN) briefing paper 'Health, Wellbeing, and the Older People Housing Agenda'[155] describes 26 health-related indicators where housing may be a contributory factor to poor health. Table 16 summarises eight of these indicators which are particularly relevant to preventing hospital admission for older people and emphasises the importance of housing in supporting them to be independent, safe and well.

Table 16: Indicators where housing may contribute to older people's ill health and avoidable admission to hospital or residential care

Performance measure	Indicators of where housing may be a contributory factor
Numbers of older people moving into residential care from hospital	• Poor housing quality (condition and/or design) means more difficult to move back home. • No access to equipment and adaptations to provide support to moving home. • Restricted choice of housing options. • Poor information and assistance to help older people make decisions about housing and support options.
Numbers of older people admitted to hospital following falls	• Poor housing quality (condition and/or design). • No access to equipment and adaptations, or handyperson service. • Accessibility of the local neighbourhood.

[152] National Housing Federation. Breaking the Mould, NHF, 2011. Available at: http://www.housing.org.uk/publications/find_a_publication/care_and_support/breaking_the_mould_re-vision.aspx.
[153] Available at: http://www.cambridgeshirejsna.org.uk/currentreports/older-people-including-dementia
[154] Strategic Housing Market Assessment for the Cambridge sub-region. 2011. Available at: http://www.cambridgeshireinsight.org.uk/housing/current-version.
[155] Institute of Public Care, Oxford Brookes University. Health, Wellbeing, and the Older People Housing Agenda, Housing Learning & Improvement Network, 2012 http://www.housinglin.org.uk/Topics/browse/HousingOlderPeople/HousingandHealth/?parent=977&child=8661

Numbers of older people with repeat admissions following falls	• Delays in appropriate adaptations or improvements to the home increasing dependency. • Reablement services or hospital discharge planning poorly integrated with housing.
High numbers of older people with COPD[156] admitted to hospital	• Poorly ventilated housing. • Thermally inefficient housing. • No access to equipment and adaptations.
Numbers of older people entering residential care following stroke	• Thermally inefficient housing. • Fuel poverty.
High numbers of older people in residential care	• Poor housing quality (condition and/or design) • Poor choice of housing options. • Poor information and assistance to help older people make decisions about housing and support options. • Poor community based services to reduce social isolation.
Levels of older people diagnosed with depression	• High levels of anti-social behaviour. • Poor housing quality (condition and/or design). • Poor choice of housing options. • Geographic isolation. • Poor social and physical infrastructure. • Older people experiencing bereavement.
Numbers of older people admitted to hospital with respiratory infections	• Poorly ventilated housing. • Exposure to damp, mould or dust mites.

Source: Housing LIN, Health, Wellbeing, and the Older People Housing Agenda, Dec 2012

9.3 Local services and housing support

9.3.1 Housing Related Support Team (previously 'Supporting People')

The Supporting People programme began in 2003 and worked through local authorities with social care responsibility holding a ring-fence pot of money from the Government to provide housing related support. The money is no longer ring-fenced and will shortly be integrated into the commissioning budgets for the respective client groups. In Cambridgeshire the team is known as the Housing Related Support Team.

Housing Related Support[157] is provided through a range of organisations including housing associations and voluntary and community organisations. It includes assistance with such things as security, personal safety, neighbour disputes and personal budgeting along with minor repairs, often through Health Improvement Agencies. It does not support care in the home.

[156] COPD stands for chronic obstructive pulmonary disease. It is the name used to describe a number of conditions, including chronic bronchitis and emphysema, where people have difficulty breathing because of long-term damage to their lungs.

[157] Housing Related Support team structure chart: http://www.cambridgeshire.gov.uk/social/supportingpeople

9.3.2 Sheltered housing and extra care

There are a considerable number of households living in sheltered and extracare housing (5,541 households) (see Table 17). Most of these will be in sheltered housing. The JSNA Older People (including dementia) (2010)[158] mapped sheltered, extracare and residential provision against the population of older people over 75.

Table 17: Funding by sheltered and extracare schemes

District	Number of schemes	Approximate number of household units	Population 2011 aged 65+	Annual value (£000)
Cambridge City	26	897	15,200	£301.60
East Cambridgeshire	33	953	14,600	£307.40
Fenland	28	873	19,000	£298.00
Huntingdonshire	36	1,173	27,200	£316.20
South Cambridgeshire	48	1,645	27,000	£473.30
Total	**171**	**5,541**	**103,000**	**£1,696.50**

Source: Cambridgeshire Supporting People

The Housing Related Support funding is moving from being invested in sheltered schemes in the social rented sector to being extended to the wider community through a 'Community' or 'Village' warden scheme. As noted in the introduction to this chapter, 5% of older people live in supported sheltered schemes. Ideally, the Community Wardens scheme would eventually be open to all tenures.

The organisations currently funded by Housing Related Support to provide housing and support are:[159]

- Accent Nene
- Anchor Trust
- Axiom Housing Association
- Cambridge City Council
- Cambridge Housing Society
- Hanover
- Housing 21
- Luminus
- Metropolitan
- Minster
- Muir
- Park Lodge
- Raglan Housing
- Roddons
- Sanctuary
- South Cambridgeshire District Council
- St Pancras and Humanist

There is a move away from the traditional model of sheltered housing to various forms of 'retirement housing' including forms of sheltered housing, retirement villages and others. There appears to be little evidence directly from older people who do not live in sheltered housing but who are of the age where they might consider sheltered

[158] Available at: http://www.cambridgeshirejsna.org.uk/currentreports/older-people-including-dementia.
[159] Cambridgeshire Supporting people, December 2012.

or retirement housing about whether they would consider moving into retirement housing and what models they require.

There are mixed views as to what the future of sheltered housing will be. It may be that little or no sheltered housing is developed, though some organisations argue that more sheltered housing should be developed taking into account there is a future for the tenure if the model of sheltered housing can meet older people's aspirations. The term 'retirement housing' is increasingly being used alongside the term 'sheltered'. Age UK recommend:[160]

- 'There should be a comprehensive policy review of future models and funding of sheltered and retirement housing.'
- 'More must be done to promote the benefits of retirement housing to future generations, by offering well-designed and affordable housing options.'

Hanover Housing Association also argue for an increase in retirement housing and plan to build 1,000 new retirement homes across England, though they are looking at new models of retirement housing. Their report 'Is there a future for retirement Housing?'[161] includes a map of demand for retirement housing compared to supply. Low demand is shown on the map for Cambridgeshire and for the Cambridge housing sub-region.

The Cambridgeshire Commissioning Strategy for Extra Care Sheltered Housing in Cambridgeshire 2011-15[162] identified development areas based on the mapping exercise covered in the JSNA Older People in Cambridgeshire 2010 and noted:

> 'An additional exercise to calculate the capacity within the county to develop new schemes established that one new scheme of approximately 40 units could be developed each year for the next ten years until April 2020. These, approximately 400, units will replace the need for additional residential care places that are forecast to be required due to population growth in the next ten years. As the cost of social care in extra care schemes is around half that in residential care this provides a considerable saving as well as providing older people with new homes and helping them maintain their independence. Demand and supply of extra care housing will be kept under review and the priorities for developments adjusted accordingly.'

The Cambridgeshire Commissioning Strategy for Extra Care Sheltered Housing is currently under review.

Secondary research undertaken for the Hanover report explored the key motivators for older people moving to retirement housing:[163]

- Needing some help but wanting to stay independent;
- Wanting to downsize (for financial and/or 'hassle' reasons);
- Seeking a more fulfilling/stimulating social life;

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[160] Age UK. Making it Work for Us - A residents' inquiry into sheltered and retirement housing, Age UK, 2012: Available at: http://www.ageuk.org.uk/professional-resources-home/policy/housing/inquiry-into-retirement-housing/

[161] Hanover Housing Association, Is there a future for retirement Housing?, Hanover Insights, Spring 2010: Available at: http://www.hanover.org.uk/public-affairs/Is%20there%20a%20future%20for%20retirement%20housing%20-%20Insights%20Report.pdf

[162] Commissioning Strategy for Extra Care Sheltered Housing in Cambridgeshire 2011-15, March 2011: http://www.cambridgeshire.gov.uk/NR/rdonlyres/48541DEC-6A2D-43E1-8A3E-E5EC62D9833B/0/DeliveryStrategyforExtraCareShelteredHousinginCambridgeshirefinal.pdf

[163] Hanover Housing Association, Is there a future for retirement Housing?, Spring 2010: http://www.hanover.org.uk/publicaffairs/Is%20there%20a%20future%20for%20retirement%20housing%20-%20Insights%20Report.pdf

- Wanting to move nearer to family and friends;
- Wanting a property that is more accessible;
- Wanting to feel safe (with worries about crime and anti-social behaviour);
- Not wanting the burden of large garden upkeep.

9.3.3 Property condition, equipment and adaptations

Home Improvement Agencies (HIA) assist vulnerable homeowners and private sector tenants who are older, disabled or on a low income, to repair, improve or maintain or adapt their homes. They are local, not-for-profit organisations.[164]

Following a review of the five HIAs in Cambridgeshire in 2010, there are now three separate organisations which cover Cambridgeshire districts:

- 'Cambs HIA' is a single HIA set up in spring 2012, which covers Cambridge City, Huntingdonshire and South Cambridgeshire.
- Care and Repair East Cambridgeshire.
- Care and Repair West Norfolk, which covers King's Lynn and West Norfolk and Fenland.

The HIA services in five districts are a considerable asset in the community, providing around £4.5 m of funding in 2011/12 to enable older and disabled people to remain in their own home. Funding for adaptations is provided through Disabled Facilities Grants (DFG), mandatory grants which local authorities must make available to disabled people. DFG are targeted at maintaining disabled people in their own home and can be up to £30,000. Referrals for DFG are usually through an Occupational Therapist.

Funding for repairs is through home-improvement grants and loans which are discretionary and available to vulnerable people who may or may not be disabled. Non-secured grants of up to £1,000, repair grants of up to £5,000 and secured loans of up to £20,000 are available subject to conditions such as having less than £20,000 in savings and having owned the property for more than three years, though these conditions vary between HIAs in different authorities. Secured loans are against the property. Some HIAs offer other funding options.

The level of spend on DFGs demonstrates that a considerable number of disabled and older people require adaptations to live independently. The level of spend on the buildings structure combined with spend on services improvement such as heating, plumbing and wiring demonstrates that older, vulnerable and disabled people may find it difficult to maintain their housing, either for financial reasons, or other reasons such as difficulty in finding builders.

Most older people live in their own homes and the HIA services cover all five districts in Cambridgeshire. However some older people, particularly in rural areas, may not be aware of Home Improvement Agencies/Care and Repair which may perpetuate some inequalities in access.

[164] http://www.foundations.uk.com/about-home-improvement-agencies/

9.3.4 Safe and Secure Homes and the Handyperson Scheme

These services deliver low level interventions such as repairs and maintenance services, hospital discharge service, checks around the home (such as energy, fire and security checks), first-contact and referral services and other housing maintenance related services to older individuals at a very low cost to mainly owner occupiers or private sector tenants.

The Shadow Health and Wellbeing Board (HWB) received a report on the Safe and Secure Homes and the Handyperson Scheme across the County in October 2012:[165]

Key findings were:

- The Handyperson schemes across Cambridgeshire carried out 2,031 jobs in 2010/11 and 1,538 jobs in 2011/12.
- Between 30% to 50% of Handyperson clients were aged over 80.
- Key financial benefits of HIA works:
    - postponing entry into residential care by a year saves on average £28,080 per person;
    - preventing a fall leading to a hip fracture saves the state £28,665 per person on average;
    - housing adaptations reduce the costs of home care (saving £1,200 to £29,000 a year);
    - hospital discharge services speed up patient release, saving at least £120 a day.
- Age UK Cambridgeshire is a partner to the Handyperson scheme.
- Satisfaction with the Handyperson scheme runs at 96% - 100% depending on district and year, with positive feedback being received from clients about their experience of the scheme.

9.3.5 Assistive technology

The use and importance of Assistive Technology (AT) for older people was highlighted by The Royal Commission on Long Term Care, 1999[166] and following this in the National Service Framework for Older People, 2001[167] and National Service Framework for Long-term Conditions, 2005.[168]

The Cambridgeshire Assistive Technology Strategy 2012-2014[169] was adopted in July 2012. It sets out the commissioning intentions for 2012 to 2014 in relation to the development and provision of all aspects of AT to residents of Cambridgeshire.

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[165] http://www.cambridgeshire.gov.uk/CMSWebsite/Apps/Committees/Meeting.aspx?meetingID=547.

[166] The Royal Commission on Long Term Care, The Stationery Office, 1999 http://collections.europarchive.org/tna/20081023125241/http://www.archive.official-documents.co.uk/document/cm41/4192/4192.htm.

[167] National Service Framework for Older People, Department of Health, 2001 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066.

[168] National Service Framework for Long-term Conditions, Department of Health, 2005. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4105361.

[169] Cambridgeshire Assistive Technology Strategy 2012 – 2014 committee report: http://www.cambridgeshire.gov.uk/CMSWebsite/Apps/Committees/AgendaItem.aspx?agendaItemID=5658. Cambridgeshire Assistive Technology Strategy 2012 – 2014: http://camweb2/Document%20Library/CAS/ass/disserv/Draft%20Assistive%20Technology%20Strategy%202012.pdf.

Within the Cambridgeshire Health and Social Care system, AT encompasses a range of health and social care equipment, devices and systems that are available to people to support them to remain as independent as possible in the community. These are listed in Table 18. AT excludes specialist medical and nursing equipment, for example, continence products, syringe drivers, oxygen equipment and any other equipment that requires a prescription. The full table including who commissions the services and notes is available in the Assistive Technology Strategy (p21).

An important local impetus for developing the Cambridgeshire Assistive Technology Strategy was the JSNA 2009 which notes that 'many people live in unsuitable accommodation' and that there are gaps in provision regarding maintenance of 'access to adaptations and AT assistive technology to maintain and develop independence'.[170] The JSNA supported the development of assistive technology through commissioning that would deliver a greater range of technological options in a more flexible way.

Table 18: Assistive Technology Assets as at 2012

AT Strategy classification	Type	Provided by
Telecare and telehealth equipment	Personal Community Alarm Systems (often known as Lifelines)	District Councils
	Telecare	CCS
	Telehealth	CCS
Wheelchairs and specialist seating	Wheelchairs and specialist seating	Central Essex Community Services
	Health and social care equipment	NRS
Housing adaptations	Major housing adaptations	District Councils/HIAs
	Minor housing adaptations	NRS (ICES) Districts RSLs Handy Persons schemes
Equipment for people with visual and hearing impairment	Equipment for visual impairment	CCC Sensory Services Team
	Equipment for hearing impairment	CCC Sensory Services Team)
Communication aids	Electronic Communication aids	CCS but for children only.
Environmental Control Systems	Environmental Control Systems	Assessed by CCS - provided by range of suppliers
	NeuroPage	Oliver Zangwill Unit
Orthotics and Prosthetics	Orthotics and prosthetics	Acute sector
Daily living equipment	Equipment for NHS Continuing Care	Via ICES or spot purchases

Source: Cambridgeshire Assistive Technology Strategy 2012 - 2014

[170] Available at: http://www.cambridgeshire.gov.uk/business/research/Joint+Strategic+Needs+Assessment.htm.

In addition, the Strategy Action Plan has put in place the following assets to October 2012:

- An Assistive Technology Practitioner is employed by the Learning Disability Partnership (LDP).
- A Cambridgeshire and Peterborough Wheelchair Service contract in is place and monitored through contract monitoring group.
- Making AT available in new housing developments. A process has been established and proactive links made with developers and planners.
- Access to retail facilities. A Community Equipment Service provider has established a mobile unit which is in use at events across Cambridgeshire.
- AT skills across frontline staff are being improved. The routine training of frontline staff is now in place and will remain on-going.

Most older people live in their own homes and many may not be aware of Home Improvement Agencies/Care and Repair. Assistive Technology is more easily provided to older people who live in sheltered housing, extra care or are tenants of housing associations or local councils, along with older people who have had an Occupational Therapy (OT) or social care assessment. The reasons for this inequality might include knowledge of what is available, either by the older person themselves or by a professional such as an OT, or housing staff. This may mean that some older owner occupiers and private tenants, particularly in rural areas, are likely to be disadvantaged. The Strategy places considerable emphasis on communication, which should minimise this inequality.

9.4 Cost effectiveness of housing related support

Equipment and adaptations, and repairs are often necessary to support older people to live in their own home. Although not all older people having work done through HIA would require visiting support, providing these adaptations can also reduce the amount of health or social care support required and therefore offer a preventative approach which generates cost savings overall in the long term.

As well as providing support to enable older people to be independent, safe and well, providing a visiting support service to keep people in their own home can offer considerable cost savings through preventing the need for admission to residential or extra care services. Research into the financial benefits of the Supporting People (SP) programme by the CLG (2009),[171] reported considerable savings from using SP funding to provide visiting support (also known as 'floating support') to older people compared to the cost of them moving to residential care or extra care.

The calculation in the CLG report showed that funding the same number of people who were living in residential care to live at home through the SP programme at an annual cost of £97.3m for England would save a total of £628m when compared to the cost of residential care for the same number of people. This calculation took into account other costs and savings such as housing, health and social care costs for people living in their own home. When a similar calculation was run for extra care, £32.4m of SP funding saved £123.4m annually. Both these net savings figures are after subtracting the cost of SP funding.

[171] Capgemini.Research into the financial benefits of the Supporting People programme.CLG, 2009. Available at: https://www.gov.uk/government/publications/research-into-the-financial-benefits-of-the-supporting-people-programme-2009.

9.5 Local Views

This section presents some key results from the 'Living Independently in Cambridgeshire' survey run by Cambridgeshire County Council Adult Social Care Services in October 2012. The survey was completed by 786 older people across the County living in their own homers or in sheltered accommodation. Of these:

- 515 (85%) lived alone;
- 450 (65%) lived in sheltered housing;
- 92% of respondents considered 'living where I do now' to be important or very important;
- 98% considered 'knowing my health needs will be addressed' to be important or very important;
- 91% hoped to remain in their present home, whereas only 9% would 'like to move to a community of people your own age'.

There was a comparatively high level of use of services available to support people in their own home:

- 79% of respondents used Telecare eg lifeline, community alarm.
- 71% used equipment or home adaptations such as bath aids or grab rails.
- 31% had had home improvements, such as from Care and Repair. A further 9% said they would like to access this service.
- 39% received practical help at home services such as cleaning.
- 30% received personal care at home.
- 56% had received some form of safety assessment or work.
- 53% had received some form of insulation or energy efficiency measures.
- 62% had received help with minor repairs or general maintenance
- 55% had used the handyperson service.

9.6 Fuel poverty

Fuel poverty, where more than 10% of income is spent on heating, is linked to general poverty but is also affected by energy prices and energy efficiency. Fuel poverty is increasing locally and nationally, with the national economic situation and increasing fuel costs posing significant challenges.

- The National Fuel Poverty indicator shows that fuel poverty was generally more significant in the north of the country than in the south and East Anglia.[172]
- Cambridgeshire had the 13th lowest per cent of households experiencing fuel poverty out of 47 counties (range: 9.6% - 27.1%). The percentage of Cambridgeshire households in fuel poverty increased from 11.5% in 2008 to 14.5% (46,357 households) in 2010 (see Table 19). This compares to a national average of 16.4%.
- However, this county-wide figure masks significant inequalities in fuel poverty throughout Cambridgeshire. In 2008, 22 Lower Super Output Areas (LSOAs)[173] in Cambridgeshire had fuel poverty levels above 20%. This had increased to 30% by 2010. Fenland and Cambridge City have the highest levels of fuel poverty while Huntingdonshire had the lowest (11.3%).

[172] Centre for Sustainable Energy, University of Bristol. National Fuel Poverty Indicator, 2013:http://www.fuelpovertyindicator.org.uk/newfpi.php?mopt=1&pid=welcome.
[173] A geographical area of around 1,500 households used since 2001 Census for small area statistics.

Cambridge City had the largest increase in the percentage of households in fuel poverty - 4.5% between 2008 and 2010 to almost 7,500 households.

Table 19: Percentage of All Households in Fuel Poverty 2010 and 2008 comparator[174]

District	2010			2008
	All Households	Fuel Poor Households	Percent Fuel Poor	Percent Fuel Poor
Cambridge City	46,387	7,497	16.2%	11.7%
East Cambridgeshire	34,701	4,764	13.7%	12.9%
Fenland	39,922	7,680	19.2%	15.3%
Huntingdonshire	67,730	7,637	11.3%	9.6%
South Cambridgeshire	58,781	7,523	12.8%	10.7%
Cambridgeshire	319,515	46,357	14.5%	11.5%
England	21,599,926	3,535,932	16.4%	15.6%

Source: Department of Energy and Climate Change, 2010

Energy efficiency is one element contributing to fuel poverty. Levels of energy efficiency are lowest in older private sector homes. Figures for Cambridgeshire are shown in Table 20, which updates 2008 data in the JSNA Prevention of ill health in adults of working age (2011).[175]

Table 20: Energy Efficiency in Private Sector (non RSL) Housing, April 2011

District	Average SAP rating of the private sector (non HA) dwellings (using SAP 2005 measure)	Percentage of private sector (non HA) dwellings with a SAP rating below 35% (using SAP 2005)	
	2010	2010	2008
Cambridge	51	12%	12%
East Cambridgeshire	-	-	18%
Fenland	53	14%	14%
Huntingdonshire	54	5%	6%
South Cambridgeshire	54	14%	14%

Source: HSSA 2011, published November 2012, 2010.[176]

Note: Standard Assessment Procedure (SAP) is the methodology to assess and compare the energy and environmental performance of dwellings. Essentially the higher the SAP rating, the less energy consumed and CO^2 emitted by the dwelling.[177]

9.6.1 Preventing excess winter deaths

Inefficient heating and insulation are factors driving the high level of winter deaths in Britain: there are 30,000 to 40,000 more deaths in winter than summer months, and

[174] https://www.gov.uk/government/organisations/department-of-energy-climate-change/series/fuel-poverty-sub-regional-statistics.
[175] Available at: http://www.cambridgeshirejsna.org.uk/currentreports/jsna-prevention-ill-health-adults-working-age-2.
[176] https://www.gov.uk/government/statistical-data-sets/housing-strategy-statistical-appendix-hssa-data-returns-for-2010-11.
[177] https://www.gov.uk/standard-assessment-procedure.

old people make up the vast majority of that excess.[178] Reducing excess winter mortality is one of the outlined outcomes for the Public Health Outcomes Framework in the 'Healthcare public health and preventing premature mortality' domain. Excess winter deaths are measured as the ratio of extra deaths from all causes that occur in the winter months compared to the average of the number of non-winter deaths of the same period. Table 21 shows the average excess winter deaths in Cambridgeshire over the period 2007-2010, broken down by district. On average, there were 239 excess winter deaths recorded in Cambridgeshire.[179]

Table 21: **Excess Winter Deaths and Excess Winter Deaths Index (2007-2010)**

District	Average annual Excess Winter Deaths (2007-2010)	EWD Index (%)	95% Confidence Intervals
Cambridge City	19	12.4%	(3.6% - 22.0%)
East Cambridgeshire	24	15.6%	(5.5% - 22.7%)
Fenland	51	17.4%	(9.1% - 26.3%)
Huntingdonshire	76	16.2%	(8.6% - 24.3%)
South Cambridgeshire	42	16.6%	(8.5% - 25.3%)
Cambridgeshire	239	15.8%	(14.0% - 17.7%)
England	24,046	18.7%	(18.3% - 19.1%)

Source: Health Profiles 2012, Public Health Observatory

Lowering the living room temperature by 1°C is associated with a 1.3mmHg rise in blood pressure in older people. Increases in blood pressure increase the risk of strokes and heart attacks.[180] Cold air can affect the functioning of the respiratory system, and can trigger breathing difficulties particularly for people with Asthma and COPD. A cold damp house is more likely to have mould growth which increases the risk of infections.[181] Cold houses affect mobility and increase falls. Cold housing can be associated with mental health problems; some people become more socially isolated during the winter months. Cold winter weather is also associated with an increased demand for services with an increase in the numbers of people admitted to hospital. The demographic shift that is leading to increasing numbers of older people in the population exacerbates the demand on services during these episodes of poor weather.

While it may be difficult for local authorities to reverse the trend of increasing fuel poverty, it is possible to mitigate the effects to some extent. Excess deaths in winter (EWD) continue to be an important public health issue potentially amenable to effective intervention.[182]

[178] Wilkinson P, Armstrong B, Landon M, et al. Cold comfort: The social and environmental determinants of excess winter deaths in England, 1986-1996. Joseph Rowntree Foundation. 2001. Available at: http://www.jrf.org.uk/publications/cold-comfort-social-and-environmental-determinants-excess-winter-deaths-england-1986-19.

[179] Excess Winter Death in England Atlas URL: http://www.wmpho.org.uk/excesswinterdeathsinenglandatlas/default.aspx Source: Atlas produced by the West Midlands Public Heath Observatory on behalf of the Public Health Observatories in England Publication date: 25th January 2013.

[180] Woodhouse PR et al (1993) Seasonal variation of blood pressure and its relationship to ambient temperature in an elderly population' Journal of Hypertension 11(11): 1267-74.

[181] Somerville M et al (2000) 'Housing and health: does installing heating in their homes improve the health of children with asthma?' Public Health: 114 (434-39).

[182] http://www.wmpho.org.uk/excesswinterdeathsinEnglandatlas/.

Housing improvements, particularly warmth improvements can generate health improvements.[183] A Health Impact Evaluation of the Warm Front Study indicated that insulation and health improvements are associated with increase in both living room and bedroom temperatures.[184] A randomised control study carried out in New Zealand which provided family homes in low income communities with new insulation, reported significant increases in indoor temperatures. Residents also reported significant improvements in quality of life, decreased wheezing, fewer GP visits and sick days from school and work.[185]

There are examples of effective interventions available at www.warmerhealthyhomes.org.uk. However generally more successful interventions involve establishing effective referral pathways to support services and educating front line professionals on how to identify the most vulnerable people and how to make those referrals. Additionally, promotional campaigns for winter warmth work best when linked with other relevant health messages, for example the seasonal flu campaign.

9.6.2 The Cambridgeshire winter warmth campaign

In 2011/12 a countywide partnership came together to deliver the Cambridgeshire Warm Homes Healthy People Project. Funded by the Department of Health, the project's overarching aims were to reduce deaths and disease from cold housing. This would be done through the provision of responsive services, establishing a rapid referral system, and increasing the range and level of practical support such as advice on benefits, insulation and heating interventions, shopping services and emergency heating repairs. In practice this meant increasing the access by vulnerable groups to support and services that would enable them to keep their homes warm and have a healthy lifestyle in winter.

Ten local organisations were funded to provide a wide variety of services ranging from the provision of new boilers to information sessions to help in crisis situations. Those in need could be identified and referred by an organisation or professional or an individual could self-refer. A referral could be made directly between organisations or to a central referral management centre to be allocated to the most suitable organisation. In 2012/13 this project has again been awarded funding from the Department of Health.

As part of the evaluation framework, feedback was obtained in 2011/12 from referrers, stakeholders and clients.

- Overall the referral management system was effective and organisations were able to access those in need. The project benefitted 1,123 individuals and a total of 784 wide ranging service interventions were provided.
  The demographic data indicates that the intervention services were provided to targeted vulnerable older age groups and the remainder to other vulnerable groups. The greatest number of beneficiaries appears to be from the most deprived sections of the population.

[183] Thompson et al (2009) The Health Impacts of Housing Improvement: A Systematic Review of Intervention Studies From 1887 to 2007. American Journal of public health 99(S3): S681–S692.
[184] Warm front study group, 'Health impact evaluation of Warm Front – Summary results' Web resource http://www.warmerhealthyhomes.org.uk/media/PDF/Warm_fron_summary%20results.pdf.
[185] Howden-Chapman et al (2007) 'Effect of insulating existing houses on health inequality: cluster randomised study in the community' BMJ 334:460.

- The total spend was £205,750. It is difficult to estimate an average cost per intervention as overall the data indicate 1,123 people benefited from the data. However lack of detailed data and the underdeveloped data recording and collection system means that only 784 service interventions were recorded in detail which using this figure gives an average cost per intervention of £262, a very crude indicator.
- Unfortunately it was not possible to measure if the programme had any discernible effect on the excess winter deaths. The winter of 2011/12 was exceptionally mild with only the occasional short cold spell making it difficult to make comparisons with mortality and morbidity data from previous years. Furthermore NHS numbers were to be used to track hospital admissions. These numbers were only available if the referrals originated form the NHS professionals. However due to a very low number of referrals from the NHS, this analysis could not be undertaken.

As a result of this evaluation, improvements have been made to the referral processes, data collection systems and communication about the project.

9.7 Key findings

- The challenges for housing support services are to ensure the continuation and co-ordination of the strands of support for an increasing older population.
- The Health and Wellbeing Board and Local Health Partnerships offer new opportunities for District and County councils to work closer with health and social care and health partners to share information and ensure services and support are accessed by older people in need. It will be increasingly important to ensure that older people in rural areas have access to the support they need to remain in their own homes.
- Under the Assistive Technology Strategy Action Plan there is further scope to improve the quality of information available to people to enable them to self help and make informed choices regarding equipment provision. There are also a number of outstanding actions relating to telecare and telehealth development.
- There was robust partnership working to develop the Cambridgeshire Warm, Healthy People Project which was instrumental in enabling a substantial number of vulnerable people accessing support. Further development and refinement of the project based on the learning could be embedded into existing services to address the needs of vulnerable groups during the winter months.
- Planning for adverse weather conditions needs to be undertaken well in advance. This is an advantage not only for implementation but essential to ensure that communication and engagement of all stakeholders and the public is fully secured. The learning from the Winter Warmth evaluation could be used by partners over the summer months to ensure that there is a plan in place and that organisations are fully prepared for the winter months.

Support for Carers

10.1 Context

Currently there are an estimated six million Carers in the UK and the Department of Health have projected that this number is set to rise to approximately nine million by 2040 (an increase of nearly 50%) as the UK general population sees the ratio of retired people actually increasing from one in four to one in three.[186]

- Every day another 6,000 people take on a caring responsibility - that equals over two million people each year.
- 58% of carers are women and 42% are men.
- Over one million people care for more than one person.
- One-third of carers are new to caring every year and carers take on average two years to recognise they are carers.
- People over 65 account for a third of all carers providing more than 50 hours of care a week.

The role of carers is particularly important in preventing ill health and poor wellbeing of older people, and supporting their independence. They provide a crucial role in supporting older people to be independent and live in the community, preventing unnecessary hospital admissions and reducing the need for health and social support.

- Carers save the economy £119 billion per year, an average of £18,473 per carer.[187]
- Over three million people juggle care with work, however the significant demands of caring mean that one in five carers are forced to give up work altogether. The Struggling to Recover Report (2012) identified that 27% reported that changes to benefits had impacted on their personal finances, which in turn, affected their recovery and led to their carer having to give up work.[188]
- The main carer's benefit is £58.45 for a minimum of 35 hours, equivalent to £1.67 per hour - below the national minimum wage of £6.08 per hour (2012-2013 figures).[189]

Of note, many carers are older people themselves and have specific health and wellbeing needs, as well as needs relating to their caring role.

- People providing high levels of care are twice as likely to be permanently sick or disabled.
- 65% of older carers (aged 60 to 94) have long-term health problems or a disability themselves.
- 69% of older carers say that being a carer has an adverse effect on their mental health.
- 625,000 people nationally suffer mental and physical ill health as a direct consequence of the stress and physical demands of caring.
- Research indicates that the physical health of carers is more likely to decline after the first year of caring.[190]

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[186] Department of Health, Review of Support Provision for Carers, 2009.

[187] Valuing Carers (2011) Buckner & Yeandle, Leeds University/Carers UK. Available at: http://www.carersuk.org/professionals/resources/research-library/item/2123-valuing-carers-2011

[188] https//www.carersuk.org/newsroom/stats-and-facts.

[189] HM Government https://www.gov.uk/carers-allowance/overview.

[190] Carers UK policy briefing 2009. Valuing carers - Calculating the value of unpaid care. (2007) Carers UK, London.

- One third of older carers say they have cancelled treatment or an operation for themselves because of their caring responsibilities.[191]

10.2 Carer Assessments

By identifying carers at an early stage their situation can be assessed and, where appropriate and eligibility is established, assistance and support provided to enable them to continue in their role. For assessment purposes, Carers Assessments are available to any carer *who is or appears to be* informally caring ie not paid but caring for an individual on a regular and substantial basis.

An assessment gathers information about the extent of the caring duties and considers the carers ability to continue in that role, and the risk and impact to their own health and wellbeing. A Carer Assessment allows carers to increase their own awareness, and to make continued informed choices about how they wish to be supported in this caring role.

Table 22 describes the number of assessments conducted by Cambridgeshire Adult Social Care services up until the end of March 2012 including Older Peoples Services and Cambridgeshire and Peterborough Mental Health Trust. This data represents a small proportion of the numbers of self-reported carers in Cambridgeshire as compared to the recent results of the 2011 Census. Table 23 describes the outcome of the assessments in terms of services offered or information or advice given.

Table 22: Number of carer assessments delivered (Adult Social Care) April 2011-March 2012

Age group of carer	Number of carers assessed or reviewed separately	Number of carers declining an assessment
Under 18	10	1
18 - 64	1,597	62
65 - 74	683	7
75 and over	714	14
Age Not Recorded	6	8
All ages	3,010	92

Source: Cambridgeshire County Council Adult Social Care

Table 23: Number of carers receiving different types of services provided as an outcome of an assessment or review, by age group of carer, April 2011-March 2012

Age group of carer	Services including breaks for the carer and/or other carers' specific services	Information and advice only
Under 18	10	0
18 - 64	1,411	186
65 - 74	650	33
75 and over	687	27
Age Not Recorded	6	0
All ages	2,764	246

Source: Cambridgeshire County Council, Adult Social Care

[191] Carers Trust www.carers.org.

Assessment of carers needs is essential in order to identify the help that they need. Yet many carers are reluctant to ask for help and may only approach services once they are experiencing difficulties. Carers have reported that needs assessments have been worthwhile when they have resulted in:[192]

- access to information;
- a new or additional service;
- an opportunity to discuss their position in an objective way with an experienced professional.

Where carers are looking after someone with a long term condition or one that deteriorates (such as dementia), they may find it increasingly difficult to provide care as time goes on. This means that assessments should not be a one off process and that reviews should take place regularly.[192]

Assessment and support for carers is provided through Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) for those who care for someone receiving a service through the Trust. For carers of people with a mental health problem who are not receiving a service through CPFT, assessment and support for carers is provided via the third sector organisation 'Making Space'. Performance on supporting Carers is part of this monitoring. Measures will include Care Programme Approach audits (CPFT's assessment forms) and satisfaction surveys. CPFT also have a responsibility to ensure that the Care Programme Approach involves carers.

10.3 Local data and community views

There are 60,000 informal carers in Cambridgeshire – one in eight adults, but fewer than 5% are 'known' to health and social care (see Table 24).

Table 24: Number of people and percentage of population providing unpaid care, Cambridgeshire, 2001 and 2011[193]

District	2001			2011		
	Number of people providing unpaid care	% of total population	Total population (all ages)	Number of people providing unpaid care	% of total population	Total population (all ages)
Cambridge	8,901	8.2%	108,863	9,777	7.9%	123,867
East Cambridgeshire	7,026	9.6%	73,214	8,289	9.9%	83,818
Fenland	8,159	9.8%	83,519	10,594	11.1%	95,262
Huntingdonshire	13,750	8.8%	156,954	16,525	9.7%	169,508
South Cambridgeshire	12,837	9.9%	130,108	14,991	10.1%	148,755
Cambridgeshire	50,673	9.2%	552,658	60,176	9.7%	621,210

Source: Census 2011, Office of National Statistics

The Cambridgeshire County Council's Carers Survey is distributed on a bi-annual basis and the responses are used locally to feedback on satisfaction and standards of

[192] Social Care Workforce Research Unit, Update for SCIE best practice guide on assessing the mental health needs of older people, 2005.

[193] Office for National Statistics © Crown Copyright 2012.
2011 Census, Key Statistics for Local Authorities in England and Wales: Table KS301EW Health and provision of unpaid care, local authorities in England and Wales.
http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/index.html.

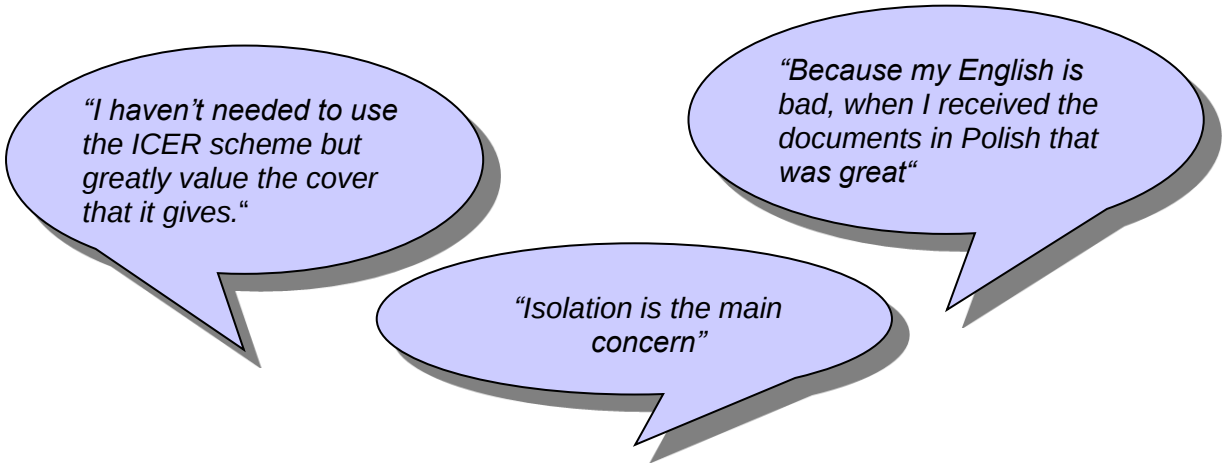
delivery. This survey contributes several measures to the Adult Social Care Outcomes Framework (ASCOF) including:

- carer reported quality of life;
- the overall satisfaction of carers with social services;
- the proportion of carers who report that they have been included or consulted in discussion about the person they care for; and
- the proportion of people who use services and carers who find it easy to find information.

Locally, this information is used as an improvement and information tool and feeds into the strategic development of carers support for the next three to five years. The 2012 survey was sent to 991 randomly selected carers from the social care database, and 647 carers responded (69.4%).

Key themes from the survey responses include:

- Information and Advice – the need for local and accessible information to enable informed decisions and choice.
- Financial – easily accessible benefits advice.
- Isolation and carer breaks.



Feedback and decisions for action have already been incorporated into the strategic action plan for carers.

10.4 Evidence and local strategy

In their report, 'Recognised, valued and supported: next steps for the Carers Strategy'[194] the Standing Commission for Carers highlighted key priorities:

- to support carers to identify themselves early on;
- to offer guidance and assistance with employment and education so that carers are not disadvantaged;
- to personalise support;
- to provide advice and information and other support mechanisms to ensure that Carers themselves remain physically and mentally well.

[194] HM Government. 'Recognised, valued and supported: next steps for the Carers Strategy' 2010. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135632/dh_122393.pdf.pdf

The Cambridgeshire Carers Strategy Refresh: Caring in Partnership 2012-2016, is currently in development and will set out how carers will be supported by the County Council and its partners. The model adopted and approach taken will reflect closely the 'Transformation' model which has recently been adopted for Adult Social Care. This approach acknowledges the good practice in early intervention and prevention work, community work and building social capital that reflects a wider caring society. It also aims to offer choice and control to individuals who use the services themselves.

Carer support will be highlighted and integrated in all commissioning strategies across health and social care with carer views being represented and responded to, throughout planning, the decision making, and the commissioning processes.

10.5 Preventative interventions to support carers

Interventions for carers include carer respite and carer education. It has been recognised that a single service is unlikely to meet carers' on-going needs fully and a wide range of services needs to be provided in order to meet the diverse preferences of carers and those for whom they care.[192]

There are a number of local interventions described below which illustrate good practice and can help to support older people and their carers, as well as prevent or delay the need for health and social care, including hospital admissions. Encouraging systematic evaluations of the impact of these interventions could help to promote, enhance and share best practice.

The County Council Carers Support Team are facilitating local Carer Assessment Clinics and offer training for professionals in carer awareness and good practice in supporting carers. In partnership with the workforce development team sessions for carers to support and increase carer confidence levels are scheduled in localities across the County. Good feedback has been received from carers. Work is underway to ensure that this type of support continues to be available to all carers on an equitable basis with ease of accessibility.

10.5.1 Information and advice

In every consultation carers say that timely, easily accessible, and appropriate information and advice is the most valuable support mechanism. Information is a key priority and it is recognised that a range of mediums and channels are needed to engage with different access requirements. In Cambridgeshire, these include:

- 'Your Life, Your Choice' website;
- Cambridgeshire Carers Network – Facebook page;
- @CambsCarersNetwork – Twitter feed;
- Leaflets specific to Caring and Assessment;
- Carers Quarterly Magazine distribution over 7,000 copies to Carers, GP Surgeries and other organisations that work in partnership;
- Streamlined self-assessment form;
- Carers directory of services published bi-annually and updated insert annually
- Voluntary Organisations Newsletters eg Care Network, Crossroads, Alzheimer's Society, Age UK, etc.

Cambridgeshire County Council, together with partner health organisations, commission a range of training for Carers and Carers' specific support services. These include:

- Age UK
- Alzheimer's Society
- Care Network
- Crossroads
- FACET
- Making Space
- Opportunities without Limit
- Sense

In Cambridgeshire Age UK are commissioned by Cambridgeshire County Council to offer all carers of older people an advice and information service and link them into local community activities and services.

10.5.2 Outreach model

To support the strategic transformation of Adult Social Care Services, resources for Carer support will be focussed on providing increasingly local support in local communities. A number of new outreach initiatives are underway to deliver appropriate and easily accessible information to enable carers to make informed choices.

One example is the'Carers Café' and 'Drop In' sessions. These will use local community hubs and village amenities to offer a range of cost effective flexible options to provide information, advice and support through a one stop shop model. Built on a peer support group model and harnessing volunteer wisdom and capabilities, these aim to enhance and increase professional carer support. Information will be available from a range of other support organisations together with the NHS and Cambridgeshire County Council. Co-ordinated as a county-wide scheme the Carer Support Team will be utilising and working with the growing local community Navigator scheme to establish the network.

10.5.3 Support for Carers of Adults in Acute and Mental Health Services

In 2012, Crossroads started a pilot with a Carer Support Officer in Cambridge University Hospital Foundation Trust (CUHFT, Addenbrooke's). They have provided training to Case Managers and staff and support to carers. Carer identification and recognition has been introduced on CUHFT admission forms through the recent 'Transformation' project.

To date, 323 carers have been helped, with 44% using a drop-in service for information. The service is working well and has helped to reduce hospital and residential admissions.[195]

- Most people were of high level need/high risk of further interaction with services and several people were in hospital as a result of a fall.
- Carers identified within Addenbrooke's are those at higher risk of breakdown – ie significant caring responsibilities, stressed and interrupted sleep.

[195] Crossroads feedback

- Three quarters of the carers identified were not accessing any statutory support services which could prevent hospital admissions.

Although carers will benefit from all support for carers, there are also some specific sources of support relating to carers of people with mental health problems. Some of these initiatives include:

- Cambridgeshire Crossroads Voluntary organisation support more than 25 carers and partners with dementia to meet fortnightly at the David Raynor centre and are moving this group to be self-managing.
- They also provide four 'Home from Home' home shares across Cambridgeshire, where each member of staff opens their home to a small group of two to four people with dementia who have similar interests. Outcomes have been very good, with carers accepting of more support and receiving a long break, whilst knowing their cared-for enjoys the day. People with dementia are engaged in many activities and develop friendships.
- Specialist mental health organisations such as the Alzheimer's Society are also commissioned to offer flexible groups, training and peer support for carers of people living with dementia.
- A new service has been commissioned from the Alzheimer's Society to provide a Countywide coverage to train Carers whose cared have recently been diagnosed with some form of dementia. The CrISP training programme aims to bring added confidence to the Carer to assist them provide ongoing long term support

10.5.4 Respite services

Offering respite or breaks for carers is important for long-term support. Research shows that Carers not receiving a break were twice as likely to suffer from mental health problems, 36% compared to 17% of those carers getting a break.[196]

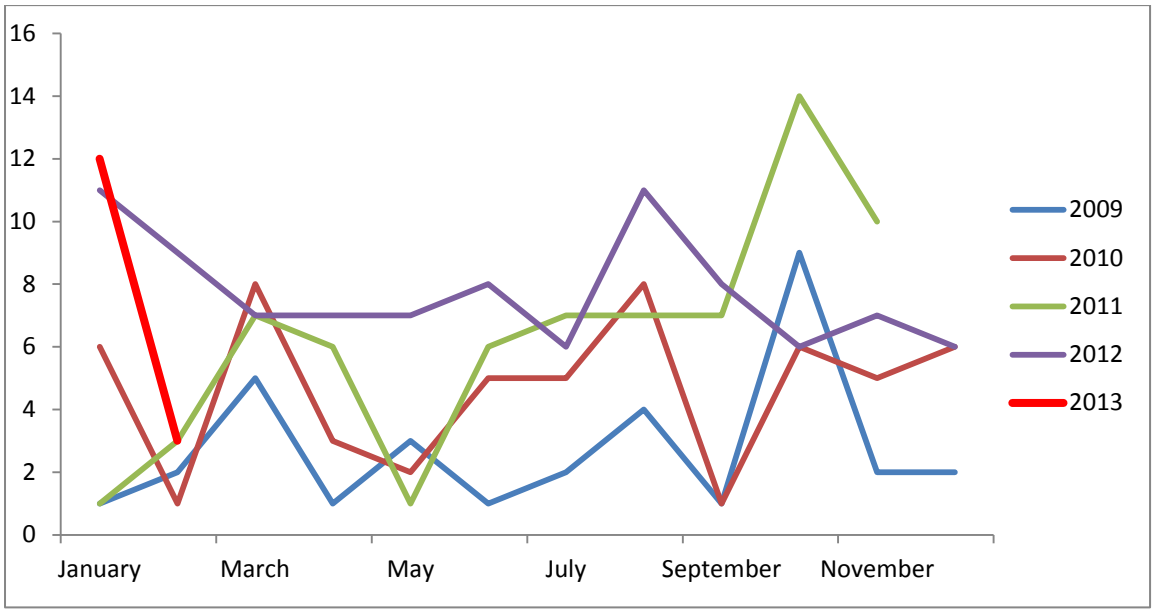
10.5.4.1 Individual Carers Emergency Respite (ICER) service

This is a pre-planned service commissioned by Cambridgeshire County Council and provided by Crossroads Care to support people with care needs to remain supported at home in the event of their informal, unpaid or family carer being suddenly (maximum of 48 hours prior notice) unable to sustain their care. ICER support is for 48-72 hours until the emergency is over or a handover to statutory services.

The service has increased in capacity year on year since 2009 and currently 2,338 people are registered or in the process of being risk assessed, of which 59 have high risk medical needs. Figure 9 shows the trends in numbers of carers activating ICERs from 2009 to 2013. These are small numbers to establish trends from but this information broadly highlights peaks in winter.

[196] Carers UK policy briefing 2009 / Hirst M. (2004) Hearts and Minds: the Health Effects of Caring., Carers UK, London.

Figure 9: Numbers of ICER activation per month – trends (2009-2013)



Source: Data from Crossroads Care Cambridgeshire, 2013.

Most activations are due to hospital admission of the carer or their illness, as detailed in Table 25.

Table 25: Reasons for activation of ICERs 2009-2012

Reason for activation of ICERs	% of Activations			
	2009	2010	2011	2012
Carer has Illness/health needs	46%	23%	34%	32%
Hospital admission	30%	61%	55%	42%
Job at risk	6%	0%	1%	0%
Other emergency	18%	16%	9%	26%

Source: Crossroads Care Cambridgeshire, 2013

- In 2012, there were 93 ICER emergencies. By providing carer respite it is believed that admission to hospital or residential respite care was prevented in a large proportion of these cases.
- In 2009, carers were given a choice to register a plan involving family and friends or use Crossroads Care Cambridgeshire. Overwhelmingly they opted for professional support and now everyone is referred to Crossroads Care, who contact and work alongside any family or friends wherever possible. Surveys show a high level of customer satisfaction.
- In 2009, 13% of carers activated an ICER more than once. Increasing home assessments for older people and all people over the age of 75 has reduced this to 10%. This is thought to be due to better understanding of their situations, risk assessments of their homes and provision of appropriate support towards a more robust situation. However, this is a significant resource (90 assessments per month) and so more phone assessments are being used, with home visits if greater risks are identified.

10.5.4.2 Carer Services Prescription service

This is a service funded by NHS Cambridgeshire to:

- improve awareness within professionals in primary care of the value of supporting carers;
- identify carers earlier in order to provide preventative support services; and
- offer carers information and a break.

The pilot service enabled Crossroads Care to win The Charity Awards 2012 for Effectiveness. It is only currently available to support people with health needs who have a carer needing support.

- To date, this programme has supported almost 800 prescriptions, of which older people were the largest group.
- All prescriptions were analysed by a GP in the pilot report and 32% were recorded as preventing hospital admissions. A significant number went on to plan for emergencies, including registering the ICER service.
- The study also showed that carers under-assess their own health needs. Many (40%) rated their health as good, but 80% disclosed health conditions at assessment. GPs do not universally offer carers an annual health assessment.
- There is substantial demand for this from carers: 89% of carers reported that it was helpful to access carers services via their GP because of ease of access; people know how to get there; they visit for other reasons; they feel that the GP knows them and their circumstances and thus is better placed to offer advice and signposting.

10.5.4.3 Adult Short Breaks

This service is funded by Cambridgeshire County Council and was changed to support new carers and carers meeting eligibility criteria who do not receive breaks through a social care allocation to the person with care needs. Regular contact with people, particularly co-dependent older people, enabled Crossroads Care to identify escalating needs and refer to voluntary and statutory colleagues for reviews.

- In 2013 to date, 224 people benefitted of which 78% were new or 'hidden' carers. By District area, these were: Cambridge City = 37, East Cambridgeshire = 37, Fenland = 36, Huntingdonshire = 78, South Cambridgeshire = 36, reflecting a higher legacy of awareness and support pathways particularly in Huntingdonshire.
- People access 10 (universal offer to provide info and recommend a carers assessment), 50 or 75 hours per annum.

During these breaks, volunteers' step into a carers shoes' and do what is agreed between the carer and cared for. This might include supporting the cared-for towards independence, taking them out for a walk, discussing memory books, or enabling a couple to go out together with support. Surveys show that 40% receive personal care and a third use the social mileage option.

10.5.4.4 Service Level Agreement funded carers breaks ('grant')

This service is funded by Cambridgeshire County Council to support eligible people with care needs and their carers also receive a break. Currently it is still open referral from all Voluntary organisations. On average, carers receive about 2.5 hours per week.

10.6 Key findings

- There is a need to further assess the needs of carers and how their caring role impacts on their own health and wellbeing, and how a multi-agency approach can be developed to best support them. Carers have been identified as a specific client group for whom a JSNA would be useful to further investigate their needs. This has been welcomed by our Voluntary sector colleagues.
- Better recognition of a caring role would help older people identify themselves as a carer at an earlier stage, and so more likely to access appropriate support services before the point of crisis.
- There is a need to widen the range of information and advice to ensure that all carers can access support appropriate to their need through a range of communication channels and across all sectors. To reduce health inequalities, this should particularly be focussed on targeting rural and hard to reach groups through outreach initiatives.
- Given the increasing number of carers, many of whom do not seek support, a key priority is to provide good quality appropriate and available information to Carers who do not meet the Social Care eligibility criteria for services, but could benefit from accessing information and free low level/ preventative services that would support them to continue in their caring role.

Conclusions

The functions of the Cambridgeshire Health and Wellbeing Board and Network include jointly assessing health and wellbeing needs of the population of older people in Cambridgeshire, developing a strategy to meet those needs (priority 2 of the Cambridgeshire Health and Wellbeing Strategy 2012-1017), and joining up the commissioning of services across organisations to deliver the strategy.

The information in this report is designed to support the implementation of the action plan for priority 2 in the strategy, by:

- describing local data on the prevention needs of older people and current service provision and pilot initiatives;
- identifying gaps and inequalities;
- identifying evidence and best practice to support effective early interventions to support older people to be independent, safe and well and preventing avoidable admissions to hospital or institutional care.

The findings of this JSNA will be fed into commissioning plans for health and adult social care. It will support the Cambridgeshire and Peterborough Clinical Commissioning Group and Cambridgeshire County Council with plans to develop local models of integrated teams working to support and deliver person-centred care tailored to the needs of individuals and their families or carers. There is a need to continue robust evaluation of local pilot interventions and to share good practice between all agencies and across the county where appropriate.

This JSNA focuses on secondary and tertiary prevention. There is also a need to update the evidence base and local information about a primary prevention approach including active ageing, a healthy diet and nutrition, smoking and alcohol use and oral and dental health.