Oxfordshire NHS
Primary Care Trust

Mental Health Needs Assessment of Older People in Oxfordshire

October 2007
Drat Version 2.0

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Specialist Registrar in Public Health

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Dr Uy Hoang
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Foreword

Executive Summary

Introduction

Mental health is an important component of overall health and well-being in older people. Whilst much progress has been made towards improving general health service provision for older people and mental health service provision for people of working age against the National Service Framework (NSF) standards, mental health services for older adults has remained a relatively neglected subject. This mental health needs assessment seeks to address this subject and provide the rational basis for Oxfordshire PCT's older peoples mental and physical health commissioning strategy that incorporates the views of all our commissioning partners.

Methods

The mental health needs assessment was carried out between June and October 2007 and conducted in five steps as suggested by the Health Needs Assessment (HNA) Toolkit written by the Health Development Agency. Normative, epidemiological and corporate needs were assessed using a wide range of methodologies including focus groups, face-to-face/ telephone interviews with key informants, surveys, analysis of routine data and key reports. A steering committee consisting of representatives from key stakeholder organisations within health and social services, as well as the voluntary sector and patient advocacy groups was convened to advise the lead researcher, Dr Hoang, to ensure that needs were comprehensively surveyed, to agree priorities for action, and to drive forward the project, including the recommendations from this report.

Results

The results showed that the older people make up just less than 15% of the total population covered by the PCT, which is slightly less than the national average. Women form 56% of this group. Older people are distributed unevenly across the county, with most concentrated around the urban conurbations and the southern half of the county. The older population of Oxfordshire is expected to increase by 20% over the next 10 years, with some sub-populations such as older people from the black and minority ethnic communities set to increase at a greater rate. However the increase is the elderly population will fall unevenly across the county, with the southern half of the county expected to show the largest increases.

Measures of chronic stress such as deprivation, social exclusion, and long-term limiting illness have been found to be more important in the pathogenesis and maintenance of mental illness in the elderly than discrete adverse life events. These risk factors for mental illness also show an uneven distribution across the county, although not necessarily reflecting the current distribution of older people in Oxfordshire or the areas where the elderly population is expected to increase the most. Deprivation as measured by the IMD (index of multiple deprivation score shows that the majority of wards in Oxfordshire are above the median levels of deprivation for England, however there are pockets of deprivation concentrated in the towns of Oxford and Banbury, specifically the wards of Cowley and Grimsby. Those older people who were most likely to complain that their health was 'Not good' or that they

had a long-term limiting illness were most likely to reside in the West or Northern parts of the county in contrast to the general distribution of older people.

The most common conditions associated with mental ill-health in older people are depression and dementia, in fact these two conditions are the 2nd and 6th most important contributors to acute inpatient bed days in Oxfordshire, despite lower admission rates for these conditions than the national average. Recently discharged patients with dementia also manage more poorly in the community and are more commonly readmitted than patients discharged with any other condition. With the advent of anti-dementia drugs these conditions are also increasingly impacting upon prescribing costs for the PCT.

For some other conditions such as acute psychosis the rate of admission amongst older adults in Oxfordshire is higher than the national average.

Although there is a considerable range of statutory and voluntary services provided for older people with mental health problems, there are notable gaps in the current provision of mental health services for older people, including the absence of any mental health promotion programs for older people across the county, and the lack of psychological services for those over the age of 65 suffering with mild to moderate mental illness in primary care. Specialist mental health services for the elderly, including Community Mental Health Treatment services, day hospital, and nursing home beds are currently evenly distributed across the county. An analysis of current and projected service use suggests that the majority of the burden of increasing mental illness, especially amongst the very frail will fall on geriatric medical services and psychiatric community services rather than old age psychiatry services.

Discussion and recommendations

A total of 46 needs were identified. These needs were grouped under into thirteen themes and ranked according to their impact, and the possibility of successfully addressing the need (i.e. the changeability of the need). 5 priority areas were identified for further action, namely;

1. *There is a need to work with local providers to agree care pathways for older people with mental health problems*

The results showed that there was no agreed care pathways for older patients with the most common mental health diagnoses, but instead patients with similar symptoms often progressed along different treatment trajectories. This results in delayed diagnosis, missed opportunities for early intervention, prolonged time spent in inappropriate care settings such as A&E and disparities in treatment. These findings points to the need to look at the pathway of care for older people with mental illness to ensure that;

a) older people have access to a wide choice of high quality care, including community based services, that are appropriate to their level of need
b) whilst the increasing burden of mental illness amongst older people does not fall too unevenly upon local providers

Development of acute mental health services will be especially important in the southern parts of the county where the largest increase in the older population is expected and mental health services are likely to be most impacted.

2. *There is a need to develop, and strengthen the health, and social care workforce locally, particularly to increase expertise in older peoples mental health issues*

The projected increase burden of mental illness amongst the older population in Oxfordshire will mean that the PCT must look to improve the skills and competencies of all staff to enhance detection and management of mental illness in all non-specialist settings. It is recommended that the PCT in conjunction with social service partners undertakes a review of mental health training of its staff, starting with an audit of the training received by health and social care staff working in residential/ nursing homes in Oxfordshire

3. *There is a need to ensure a wide range of health and social care services that offer timely, appropriate and high quality care closer to home for older people with mental illness*

Having their loved ones at home was very important to many carers, some of whom had been married for 40 to 60 years to their spouse before mental illness had suddenly snatched them from what they were used to. Therefore the objective of the PCT should be to provide timely, appropriate and high quality care closer to home for older people where it is appropriate.
Practice based commissioning (PBC) offers great opportunities to develop more person-centred and integrated community based services and it is recommended that the PCT should work with PBC consortia using this needs assessment to identify and develop local commissioning strategies that ensure the provision of a wide range of timely, appropriate mental healthcare services for older people closer to their homes.

4. *Services also need to acknowledge the needs of carers and the supportive unit around older people with mental health problems*

Social support from friends, family, neighbours and other carers can help older people with mental health problems to recover from stressful life events and maintain 'life as usual'. However, the views and needs of carers, and the wider supportive unit around older people, especially the family are often overlooked in planning care for patients, assessing needs for services or drafting policies for service development. It is recommended that the PCT acknowledges the needs of carers, through the formal assessment of their needs, but also looks at practical steps that could be taken more immediately to address the needs of carers identified in this document, particularly the need for emergency respite care. This would be most pertinent in Cherwell and West Oxfordshire where there is the highest proportion of carers reporting that they provide greater than 50 hours of unpaid care per week.

5. *There is a need to implement strategies to prevent mental illness in older people by promoting and supporting healthy ageing and active citizenship*

Mental health problems are not an inevitable part of growing older, and it is possible to prevent problems, or at least reduce their risk of occurring, in later life. However, this report identified that there are currently no programs to promote mental health and well-being amongst older people in Oxfordshire. In addition few other health promotion programs that address risk factors for mental illness, such as physical exercise programs, are specifically designed to evaluate their impact on mental well-being.
Thus it is recommended that the PCT works with local health and social care partners to draw together a mental health promotion strategy for older people, that would work alongside current programs to promote physical health, but ensure that risk factors that are more specific to mental health such as bereavement are also addressed.

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Background

Mental health is an important component of overall health and well-being in older people. According to the WHO and the Mental Health Foundation, good mental health is defined as the ability to enjoy life and cope with difficulties[1, 2]. It is a resource that enables people to[2];

- face problems, resolve them and learn from them
- be confident and assertive
- be aware of others and empathise with them
- develop emotionally, creatively, intellectually and spiritually
- initiate, develop and sustain mutually satisfying personal relationships
- laugh, both at ourselves and the world
- use and enjoy solitude
- enjoy life and have fun

These traits are essential for an older person to continue to live an independent, fulfilling and productive life.

Why is mental health an important public health issue?

In addition to the effects that a deterioration in mental health can have on the individual, mental illness amongst older people can also have wider social, economic and public health consequences.

1. Mental health problems and mental illness amongst older people is common

Within the UK, two national surveys suggest that at any one time approximately 23% of the population have psychological symptoms[3] and 14-18% suffer from a mental disorder[4, 5]. In a typical GP surgery 40 % of people attending for any reason will have a mental health problem and in 20-25% of people a mental health problem will be the sole reason for attending[4, 6].
Amongst older people, recent estimates in the UK suggest that over a third of older people experience symptoms of mental health problems such as depression, anxiety, delirium (acute confusion), dementia, schizophrenia, bipolar disorder, and alcohol and drug (including prescription drugs) misuse[7].
This number is set to increase substantially within the next decade as the population ages and the proportion of older people, especially the frail elderly (>85 years) increases[8, 9].

2. Mental illness amongst older people is an important determinant of social exclusion and inequality in health

Research undertaken by Scharf and colleagues found that older people with mental health problems were prone to several different types of social exclusion, including[10];

- increased risk of poverty
- increased risk of social isolation and loneliness

- more liable to be excluded from neighbourhood/ civic activities such as community meetings
- more liable to have poor access to basic amenities and social services

Unfortunately the stigma and discrimination associated with mental illness are still substantial barriers to older people accessing formal mental health services[7, 11, 12]. Additionally studies also suggest that there remain significant ethnic and racial inequalities in the burden of mental illness, and the provision of mental healthcare across the country[13].

3. Mental illness amongst older people has a substantial impact on health and social services

Older people with mental health problems are found throughout the health and social care systems. The burden within primary care has been illustrated above, whilst conservative estimates suggest that 60-70% of residents in care homes have dementia and 40% have depression.
Two-thirds of NHS beds are occupied by people age 65 or over, and up to two-thirds of some inpatient groups either have mental health problems already, or will go on to develop them during their inpatient stay[7, 14].
Recently detailed economic analysis has been undertaken by the National Audit Office around the cost of dementia with the annual direct costs to the NHS in England of caring for people with Alzheimer's disease estimated at over £1 billion. Taking into account the cost of informal care, and the costs to all statutory agencies, the total cost of caring increases to around £6 billion[15, 16].

4. Mental illness is not inevitable in old age[2]

The majority of older people are healthy, happy and making valuable contributions to society and the economy as workers, volunteers, carers and parents/ grandparents. As our population ages it is important to ensure that good mental health and well-being is promoted and maintained to ensure that these contributions are maximised to everyone's benefit[2, 17-19]. The recent report from the UK inquiry into health and well-being in later life reiterated the need to challenge the widespread defeatism that leads people to believe that mental health problems are an inevitable part of growing older[7].

5. There is a significant interaction between mental, physical and social health and well-being

Mental illness increases the risk of poor physical health and premature death, including the risk of heart disease, diabetes, respiratory disease and infections[4]. Conversely, Evans and colleagues estimated that 70% of all new cases of depression in older people were associated with poor physical health[20]. Poor mental health is also associated with behaviours that are detrimental to health including poor diet, smoking, decreased exercise and substance misuse[4].

Thus the challenge for healthcare systems and their partners in commissioning mental health services for older people, fit for the future, is to ensure a balance between the delivery of a comprehensive, high quality mental healthcare service for the elderly,

with the need to address the wider effects of mental illness, in the context of a growing burden of morbidity. This was reiterated in the recent Oxfordshire Mental Health Strategy 2007 – 2012, which spoke of the continued need to operate within a national framework of legislation and quality standards whilst seeking to develop flexible mental health services designed to support recovery and sustain independent living for people of any age[21].

Why undertake a mental health needs assessment for older people?

This mental health needs assessment aims to form the rational basis for Oxfordshire PCT's older peoples physical and mental health commissioning strategy. Thus it is important that the process is thorough, transparent and inclusive, and is clearly linked to an implementation plan[22]. The assessment will include the following information;

1. An outline of the current population of older people in Oxfordshire
2. An examination of the current burden of illness from mental health problems, and the mental healthcare needs of older people in Oxfordshire
3. A map of the current provision of statutory and non-statutory services for older people with mental health problems in Oxfordshire
4. Predictions regarding the burden of mental illness over the next decade

The needs assessment will follow the 5 step template suggested within the Health Needs Assessment Toolkit, written by the Health Development Agency (HDA)[23]. Further information about Health Needs Assessment is included in Appendix 1.

Table 1: Steps in Health Needs Assessment

Step 1 – getting started	• What population is being assessed? • What are you trying to achieve? • Who needs to be involved? • What resources are required? • What are the risks?
Step 2 – identifying health priorities	• Population profiling • Gathering data • Perceptions of need • Identifying and assessing health conditions and determinant factors • Identifying current service provision • Gap analysis
Step 3 – assessing a health priority for action	• Choosing health conditions and determinant factors with the most significant size and severity impact • Determining effective and acceptable interventions and actions
Step 4 – planning for change	• Clarifying aims of intervention • Action planning • Monitoring and evaluation of strategy • Risk-management strategy • Forecasting predicted needs in 10 years
Step 5 – moving on/ review	• Learning from the project • Measuring impact • Choosing the next priority

Source: Health Needs Assessment Toolkit, Health Development Agency[23]

The policy background

In developing a new vision for the provision of mental health services for older people within Oxfordshire, a review of national policies, regional and local guidance and research relevant to this area of health services was conducted to allow us to formulate a picture of normative needs, i.e. needs deduced from comparing the present provision of services with best practice (see Appendix 1). The policies reviewed are outlined here and summarised in Appendix 2.

Table 2: Reports, policies and guidance used to assess normative needs

National Service Frameworks
A new ambition for old age: next steps in implementing the NSF for older people (2006)[12]
National Service Framework for Long-term conditions (2005)[24]
National Service Framework for Older People (2001)[19]
National Service Framework for Mental Health (1999)[18]
Department of Health White papers and consultations
Commissioning framework for health and well-being (2007)[25]
Securing better mental health for older people (2005)[26]
Everybody's business (2005)[14]
Delivering race equality in mental health (2005)[27]
Choosing health (2004)[28]
Supporting people with long term conditions (2004)[29]
Developing services for carers and families of people with mental illness (2002)[30]
The journey to recovery (2002)[31]
The NHS plan: A plan for investment, a plan for reform (2000)[32]
Other governmental white papers, consultations, and policy documents
2nd report of the UK inquiry into Mental Health and Well-Being in Later Life (2007)[7]
Improving services and support for people with dementia (2007)[16]
Dementia UK (2007)[15]
Indicators of Public Health in the English Regions – No 7. Mental Health (2007)[33]
1st report of the UK inquiry into Mental Health and Well-Being in Later Life (2006)[2]
Raising the Standard. Specialist services for older people with mental illness (2006)[34]
Supporting people – promoting independence (2006)[35]
Living well in later life, a review of progress against the NSF for older people (2006)[36]
Securing good long-term care for older people: taking a long-term view (2006)[37]
The state of social care in England 2004 – 2005 (2005)[38]
Who cares wins (2005)[39]
Opportunity Age (2005)[17]
Mental health and social exclusion (2004)[13]
Organising and delivering psychological therapies (2004)[40]
All our tomorrows (2003)[41]
Forget me not (2000)[42]
Previous legislation
Carers Act (1995)
Health Act (1999, 2001)
National guidance on treatment and support
NICE guidelines for treatment of dementia[43], depression[44] and schizophrenia[45]
National commissioning guidance
Commissioning framework for health and well-being (2007)[25]
Local guidance
Oxfordshire Primary Care Trust Draft Strategy 2007 – 2012 [46]
Oxfordshire mental health strategy 2007 – 2012 [21]
Oxfordshire County Council social & community service commissioning strategy for older people 2007 – 2010 [47]
Mental health and well-being in the South-East (2006) [48]
Annual report of the Director of Public Health, Oxfordshire Health Authority (1999)

Method

Setting & Investigator

The mental health needs assessment was carried out between June and October 2007. The principal investigator was Dr Uy Hoang, Specialist Registrar in Public Health for Oxfordshire PCT, who was advised and assisted by a steering committee composed of the following people (see Appendix 3);

Table 3: Members of the Older Peoples Mental Health Needs Assessment Steering Committee

Member	Organisation
Susanne Jones (SL)	Service Development Manager-older people, Oxfordshire PCT
Juliet Long (JL)	Service Development Manager-mental health, Oxfordshire PCT
Lester Lee (LL)	Age Concern Oxfordshire City & County, Director of Services
Daphne Marsden (DM)	Service Development Manager-adults, OBMHT
Carol Bannister (CB)	Clinical Director and Consultant Psychiatrist – Older Adults
Uy Hoang (UH)	Lead researcher, SpR in Public Health, Oxfordshire PCT
Moira Gilroy (MG)	Unit Manager for Provider services, Oxfordshire PCT
Varsha Raja (VR)	Strategic Commissioning for older people, Oxfordshire County Council
Adam Darowski (AD)	Consultant Geratology, Oxford Radcliffe Hospitals Trust
Joyce Ruiz (JR)	Alzheimer's Society, Oxon
Patrick Taylor (PT)	Director, MIND Oxfordshire
Gordon Wilcock (GW)	Professor of Clinical Geratology, Oxford Radcliffe Hospitals Trust

Structure of the investigation

Three different types of needs were assessed using the methods defined below in table 17. These needs were as follows[22];

Epidemiological Needs Assessment, is a method of identifying needs by examining shortfalls in current practices using routinely collected data. The needs identified using this method are likely to be representative of the average older person within Oxfordshire as this method uses data collected from the entire older population of Oxfordshire or alternatively a representative sample of older people

Normative Needs Assessment, is a method of identifying needs by comparing current practices to improve health with recommended best practices from national/ international guidelines. The needs identified by this method are stipulations by local and national organisations, and may not be representative of the views and needs of all older people within Oxfordshire

Corporate Needs Assessment, is a method of identifying needs by interviewing interested parties (stakeholders) including service users and carers for subjective opinions on where services could be improved. These needs are perceived by the older people, carers and service providers interviewed and may not be representative of the mental health needs of the general population of older people within Oxfordshire, as the methodology used in this study deliberately sampled the views of representatives from communities that are difficult to reach and have not traditionally been included in needs assessments undertaken by the PCT in the past.

Given the stipulation from the Healthcare Commission that the provision of mental health services for older people from all PCTs should be based upon current best

practice standards as well as the latest assessment of mental healthcare needs[14, 26, 49], it was felt that an assessment of comparative needs, namely identifying healthcare needs by comparing the services provided by the PCT with comparable PCTs, would be unhelpful at this stage.

Table 4: Types of need and methods used to assess needs

	Method						
Need	**Formal Interviews**	**Informal/ group Interviews**	**Email correspondence**	**Formal journal and book search**	**Data from individuals**	**Internet search**	**Attendance at meetings**
Normative		X	X	X		X	
Epidemiological			X	X	X	X	
Corporate	X	X	X				X

The health needs assessment was conducted in five steps as suggested by the HNA Toolkit written by the Health Development Agency[23].

Table 5: Stage of needs assessment and method used

	Method						
Step	**Formal face-to-face or telephone interviews**	**Informal/ group Interviews**	**Email correspondence**	**Formal journal and book search**	**Data from individuals**	**Internet search**	**Attendance at meetings**
Step 1 – defining boundaries and getting started			X	X		X	X
Step 2 – population profiling & identifying health priorities	X	X	X	X	X	X	X
Step 3 – assessing a health priority for action		X	X	X			X
Step 4 – planning for change		X	X				X
Step 5 – moving on/ review		X			X		X

During **STEP 1**, in order to reach an informed and agreed consensus on the scope and boundaries for this work, relevant documents relating to the process of health needs assessment, especially its application to assessing older peoples mental health needs were sought by searching the internet, liaising with colleagues at the Oxfordshire PCT department of public health and the Health Development Agency. Relevant documentation outlining the statutory boundaries for this mental health needs assessment as well as the local and national policy context within which this needs assessment will sit were sought in consultation with colleagues at the department of public health and from a formal book and reference search. The documents which informed this normative needs assessment are indicated in Appendix 2.

During **STEP 2**, a demographic profile of the older population in Oxfordshire, a comprehensive epidemiological assessment of the burden of mental illness within the community and at all levels of the healthcare system was formulated using the following methods;

- recent local strategy documents and needs assessments were sought and hand searched
- in consultation with the decision support team at Oxfordshire PCT, *demographic data* from the Office of National Statistics Census 2001 (2006 mid-year update) and the Oxfordshire County Council's ethnic projections 2006 were used to construct a demographic profile of the older population
- an internet search and formal search of the literature was conducted to construct a profile of the *risk factors* for mental illness within the local population
- given that no recent local mental health surveys have been conducted on the *prevalence of symptoms of mental distress or mental illness* within the older population of Oxfordshire, the Ovid web interface was used to search the Medline database (1996-present), PsychLit for relevant articles and community surveys of mental illness in the UK. These national prevalence figures were then overlaid onto the local elderly population of Oxfordshire to give an indication of the burden of symptoms and mental illness within the community
- in consultation with the decision support team at Oxfordshire PCT, Dr A'Court, (Clinical Audit Advisor for Oxfordshire PCT and local GP) and Julie Dandridge (Head of Prescribing at Oxfordshire PCT) a general practice computer extract was constructed (see Appendix 5) to collect data about the *burden of mental illness amongst older people in general practice*.
- burden of mental health morbidity amongst older adults in primary care was also extrapolated from national data collected by the Royal College of General Practitioners weekly returns database. This was overlaid onto the local elderly population of Oxfordshire to give an indication of the *prevalence of mental illness in general practice and the incidence of new cases*
- Hospital Episode Statistics (HES) data were used to study the *burden of mental illness within community hospitals, secondary care and mental health specialist services*
- data was also sourced from local statutory and voluntary providers to develop a better picture of local mental health service use and provision

- corporate needs - a steering committee consisting of representatives from *key stakeholder organisations* within health and social services, as well as the voluntary sector and patient advocacy groups was convened to advise the lead researcher, Dr Hoang, to ensure that needs were comprehensively surveyed, to agree priorities for action, and to drive forward the project, including the recommendations from this report (see Appendix 3).
- Other *key informants* including health advocates from the minority ethnic communities in Oxfordshire and carers representatives were interviewed face-to-face or over the telephone to obtain information on the mental health needs of older people. A list of interviewees is given in Appendix 3.
- focus groups were convened with *mental health service users and carers* from across the county to canvass views on mental health needs and current service

provision. An example of the letters sent to service users and carers inviting them to contribute their views is included in Appendix 6.

- presentations outlining this work were made by Suzanne Jones, Commissioner for older people to the Oxfordshire PCT public-patient participation panel and by Uy Hoang to the Oxfordshire County Council Health Overview and Scrutiny Committee. Further comments on mental health needs were sought through these forums.

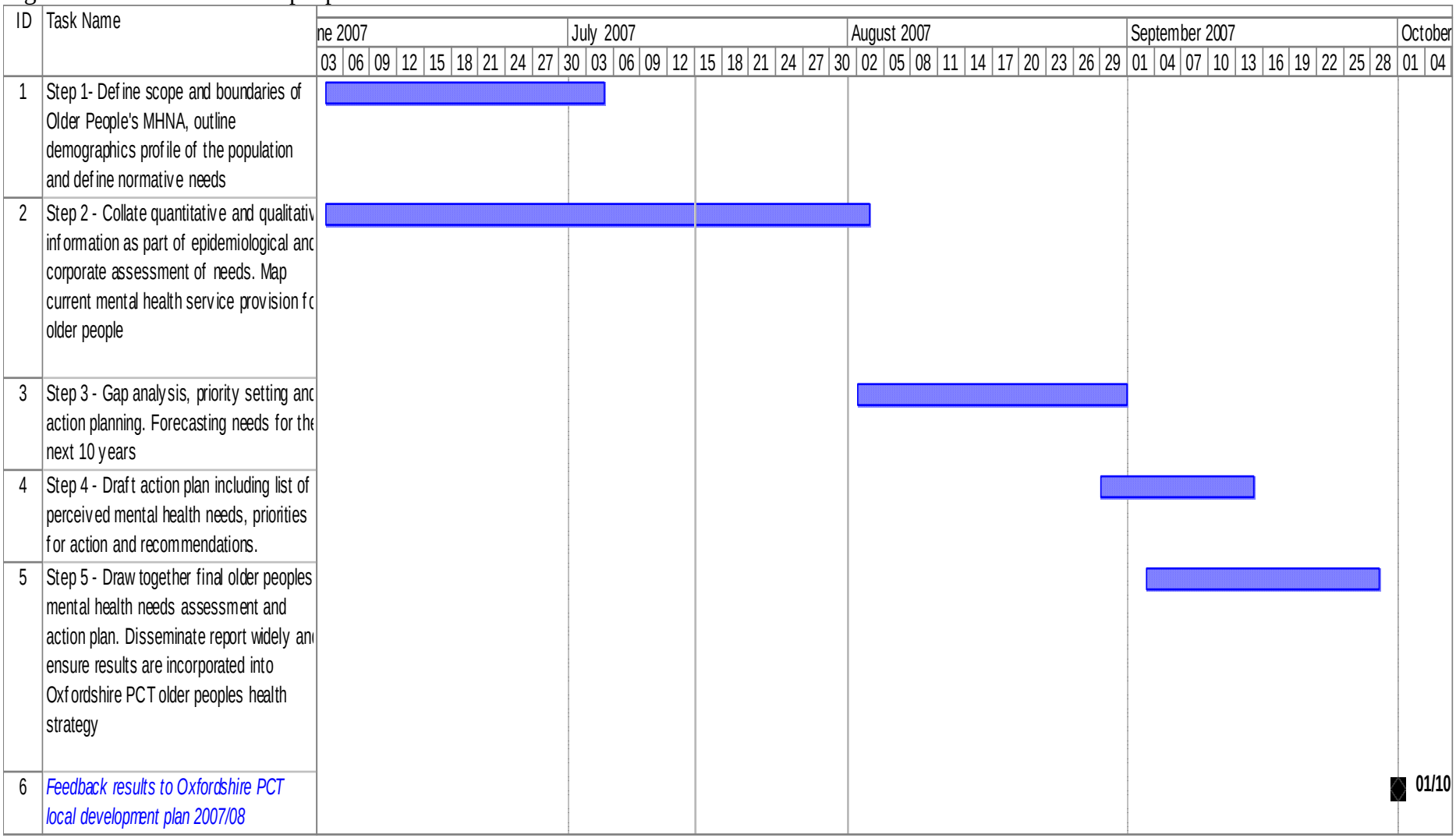
- A *map of the current provision of mental health services* was constructed from the information collected as part of the combined mental health service mapping framework for 2006/ 2007 undertaken by the Care Services Improvement Partnership and Mental Health Strategies (http://www.mhcombinedmap.org)
- Local statutory and voluntary sector providers and commissioners were also consulted to clarify the information received from the combined MH service mapping and to identify other important statutory and voluntary sectors services that were provided for older people with mental health problems (see Appendix 8)

During **STEP 3**, a list of mental health needs was drawn up from the information collected as part of step 2 (see Appendix 7). This list of mental health needs and a list of the current services provided for older people with mental health problems was presented to the steering committee (see Appendix 8), with a view to identifying gaps in the current services provided, and prioritising needs for action. A list of priorities was agreed based upon a consensus within the committee on the impact of the need identified and possibility of successfully addressing the need (i.e. the changeability of the need).

During **STEP 4**, the agreed list of priorities and actions were summarised in a draft report and sent to a wider list of stakeholders and other interested parties for consultation (see Appendix 3). The final needs assessment and action plan was presented to the steering committee for comment. Agreement was sought on the final recommendations and suggestions were sought regarding a suitable monitoring and evaluation strategy to ensure that the actions are met and risks are minimised. This work will be taken forward by Oxfordshire PCT in the formulation of an organisational commissioning strategy for older peoples' physical and mental health and local development plans for mental health services for older people in 2008. Subsequently Dr Hoang worked with the decision support team at Oxfordshire PCT to model the prevalence of mental illness in older people over the next ten years with a view to estimating the level of mental healthcare need and impact on mental health services over the next decade. These predictive models along with the needs assessment were used as part of step 5 to contribute to the longer term Joint Strategic Health Commissioning work lead by Oxfordshire County Council.

During **STEP 5**, the results from the final report were widely disseminated and put forward for incorporation into the Oxfordshire PCT 2007/ 08 commissioning agenda and the local development plans. In addition the report will feed into the wider older peoples health commissioning strategy for the PCT, and the Joint Strategic Health Commissioning Strategy led by the Oxfordshire County Council.

Figure 1: Timeline for older peoples mental health needs assessment



Results

The demographic and geographic boundaries of this needs assessment were agreed as follows;

- To include individuals aged 65 years and over
- Residing within the geographical boundaries of Oxfordshire PCT (excluding residents of Thame and Shrivenham)

Given these boundaries on the needs assessment, I have omitted to include the needs of approximately 27,000 residents of Thame and Shrivenham. The wards excluded are Aston Rowant, Chinnor, Thame North and Thame South in South Oxfordshire, and Shrivenham in the Vale of White Horse. The needs of older people within these towns will need to be assessed separately by West Berkshire PCT. Additionally, the age limit on this needs assessment restricts my ability to look at the needs of those with pre-senile dementia such as those individuals with learning difficulties who typically develop symptoms of dementia from the age of 55. The needs of those with learning difficulties are however catered for by learning difficulties service, however the health and social care needs of other people with pre-senile dementia should be investigated, as their mental health care may be better served by the geriatric service than by general adult services.

The older population in Oxfordshire

Some 88,000 people over the age of 65 live in Oxfordshire, excluding the residents of Thame and Shrivenham. Older people currently make up approximately 15% of the population in Oxfordshire, which is slightly below the national average (Table 6)[8, 9]. More than half (56%) are women, with the proportion of women increasing after the age of 85 (Table 7).

Currently older people are distributed unevenly across the county. As one would expect the population density for this age group is highest in wards around the main towns. However there are some rural wards, especially in the south of the county with a high population density of older people (see Figure 2) [50].

Table 6: Population of England and Oxfordshire aged 65 and over, 2004

	England	Oxfordshire PCT
All ages	50,093,100	595,200
65-69	2,236,400	24,300
70-74	1,944,200	20,900
75-79	1,615,300	17,600
80-84	1,263,700	14,200
>85	942,700	11,000
Total >65	8,002,300	88,000
% >65	15.97%	14.8%
% >85	1.88%	1.8%

Source: Office of National Statistics (ONS) Mid 2004 Estimates for Primary Care Organisations

Table 7: Gender distribution of older people in Oxfordshire, 2004

	Male	Female	M/ F ratio
All ages	295,500	299,700	49.65/ 50.35
65-69	12,100	12,200	49.8/ 50.2
70-74	10,000	10,900	47.8/ 52.2
75-79	7,800	9,800	44.3/ 55.7
80-84	5,500	8,700	38.7/ 61.3
>85	3,200	7,800	29.1/ 70.9
Total >65	38,600	49,400	43.9/ 56.1
% >65	13.1%	16.5%	
% >85	1.1%	2.6%	

Source: ONS Mid 2004 Estimates for Primary Care Organisations

The demographic shift

The UK is undergoing profound demographic change. Population growth is slowing down, the number of children and young people is falling, and the proportion of older people is growing, especially the most frail, namely those over the age of 85[7]. Demographic projections from the Office of National Statistics indicate that within the next ten years the number of people over 65 is expected to increase nationally by 18%, and those over 85 by 22% (Table 8)[8]. Within Oxfordshire the rate of increase in the population is expected to be slightly higher than the national average with those over 65 expected to increase by 20%, and those over the age of 85 by 25%[9].
The underlying prevalence of mental illness is also expected to change, which has important implications for our predictive models of mental illness in older people over the next ten years[7], although there is no precise data on these trends.

Table 8: Population change within England and Oxfordshire, 2006 to 2016[8]

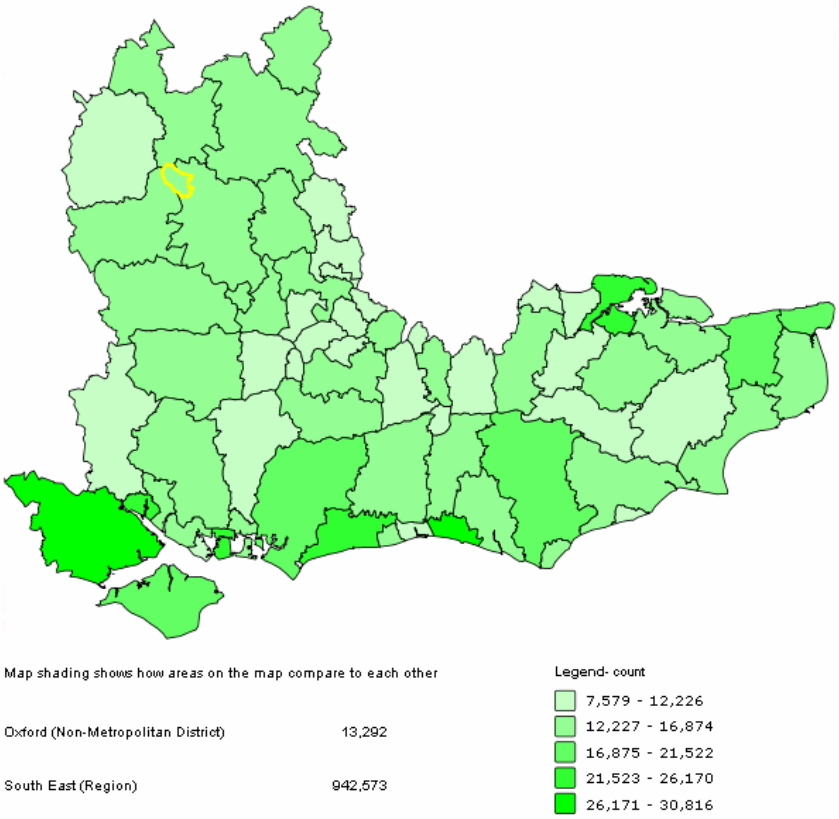
	England			Oxfordshire		
	2006	**2016**	**% change**	**2006**	**2016**	**% change**
All ages	50,714,000	53,276,000	4.81	630,200	666,600	5.46
65-74	4,191,000	5,332,600	21.41	47,500	62,000	23.39
75-84	2,863,800	3,165,900	9.54	33,100	37,400	11.50
85+	1,047,000	1,335,700	21.61	12,800	17,100	25.15
Total >65	8,101,800	9,834,200	17.62	93,400	116,500	19.83
% >65	16.0%	18.5%		14.8%	17.5%	
% >85	2.1%	2.5%		2.0%	2.6%	

Source: ONS, 2004 based sub national population projections for Oxfordshire County Council (including Thame & Shrivenham)

Distribution of older people in Oxfordshire - ageing by ward

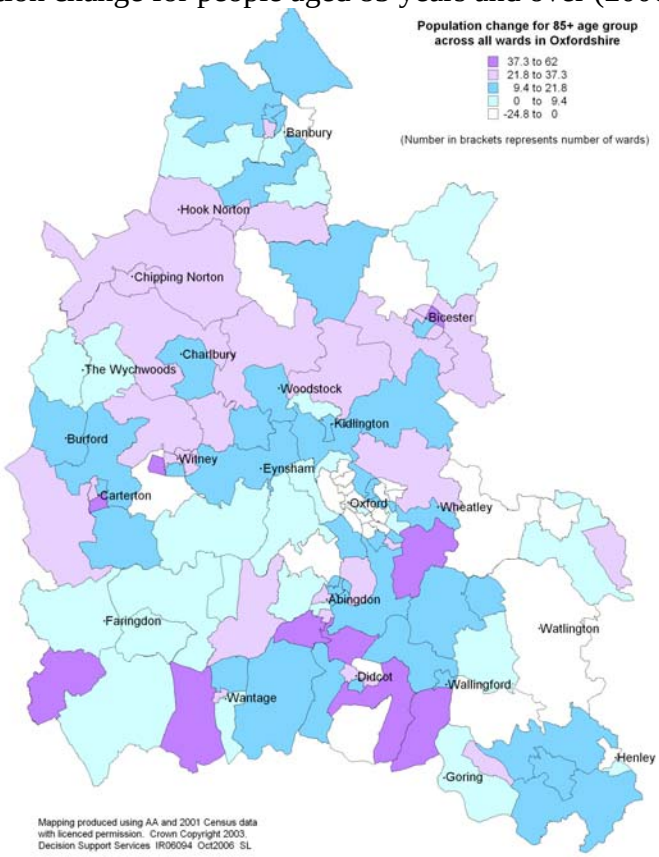
The expected increase in the older population within Oxfordshire will fall unevenly across the county[9, 50]. Wards in the southern part of the county are expected to see the largest percentage increase in their older populations, especially around the towns of Didcot, Wantage, Abingdon and Wheatley, although rural wards in the northern part of the county are also expected to see significant increases in their elderly populations.
Wards in and around Oxford will show little if any increase in their older populations (see Figure 3).

Figure 2: Households where Household Reference Person is of pensionable age in SE England



Source: ONS Census Neighbourhood Statistics, 2001

Figure 3: Population change for people aged 85 years and over (2006-11)



Source: GLA ward population projections based on 2001 census

Ethnic composition of older people in Oxfordshire

Census data show that the British White population within Oxfordshire form the majority of older people within the county. There are scattered populations of people from the BME community in Oxfordshire, especially within the urban conurbations, although they are generally young, except for an elderly Eastern European population in Bicester (personal communication). Ethnicity projections undertaken by Oxfordshire County Council show that the growth rates within black and minority ethnic populations are predicted to outstrip those of the white population, particularly within urban conurbations in the next ten years, however absolute numbers remain small (see Table 9 & Figure 4).

Although we can expect there to be an increase in the number of older people from black and ethnic minority (BME) communities requiring mental health services, the recent report by the Association of Public Health Observatories shows that there is no clear relationship between the size of the ethnic minority population and the use of mental health services by BME communities[33].

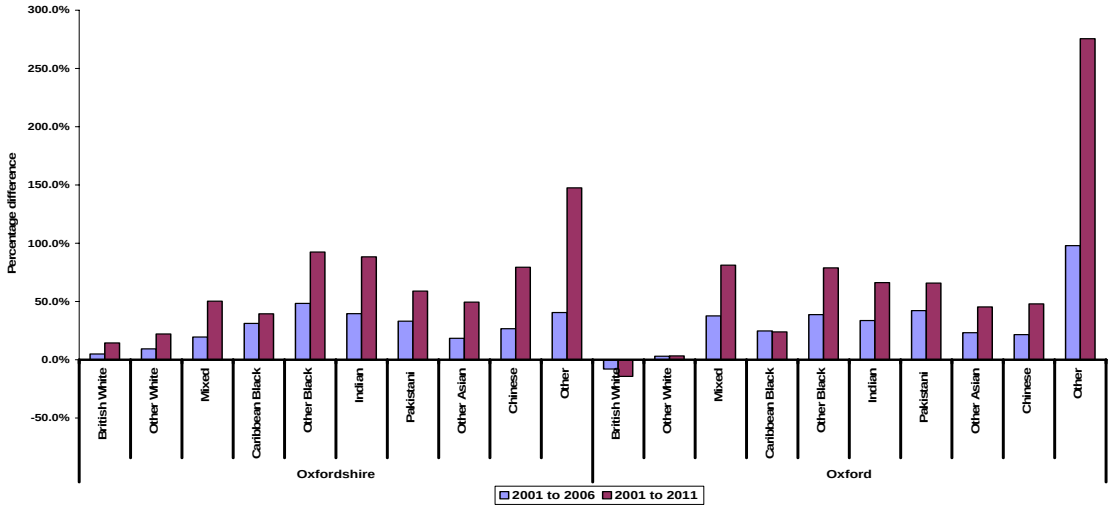
This may be related to variations in the completeness of coding practices, diagnostic and treatment variations or the provision and access to culturally competent mental health services[27].

Table 9: Ethnicity Projections for Older People aged 65 and over in Oxfordshire

Ethnicity	2001	2006	2011
British White	83,126	87,246	95,074
Other White	3,630	3,969	4,433
Mixed	179	214	269
Caribbean Black	264	346	368
Other Black	70	104	135
Indian	171	239	322
Pakistani	164	218	261
Other Asian	103	122	154
Chinese	135	171	242
Other	58	82	144

Source: Oxfordshire County Council, experimental projection statistics, Nov 2006

Figure 4: population differences between 2001 and 2006, 2001 and 2011 for older people (aged 65 and over) by ethnic group in Oxfordshire and Oxford



Source: Oxfordshire County Council, experimental projection statistics, Nov 2006

These demographic changes pose a considerable challenge to providing mental health services for older people within Oxfordshire and will require that all stakeholders including health services, social services, voluntary services, patient/ carer advocates and service users are fully engaged in planning, prioritising and delivering a vision for the future provision of older peoples mental health services[9, 21].

Risk and protective factors for mental illness

As mentioned in the introduction, mental health problems are not an inevitable part of growing old, and it is possible to prevent problems or at least to minimise their impact in later life[7, 11, 51]. The recent report by the UK Inquiry into health and well-being in later life reviewed the risk factors for mental illness in older age[7], and the Association of Public Health Observatories suggested several routine indicators that could be used to gauge these risks for mental illness[20, 33]. In this needs assessment I have outlined the distribution of these risk factors amongst the local older population to allow us to better estimate the level of need for mental healthcare services, although it must be stressed that many of the indicators do not capture the entire totality of the concepts that are identified as risk factor, and additionally the identification of risk factors for mental ill-health at an individual level does not necessarily imply that the high prevalence of the indicator at a population level translates into an increased prevalence of mental illness. There is a need for more research on the most appropriate use of routine indicators to measure risk for mental illness amongst older people.

Table 10: Risk and protective factors for mental illness in old age include[7]

Condition	Risk factor	Protective Factor
Depression	Physical disability, sensory impairment, long-term illness, social isolation, bereavement, unpaid carer, moving into a nursing home, poverty and social exclusion, discrimination	Physical activity, healthy diet, well developed supportive social networks, policies to encourage social inclusion and end discrimination
Suicide	Depression, previous episode of deliberate self-harm, insomnia, alcoholism	Policies to limit the availability of lethal devices, well developed supportive social networks
Delirium	Acute illness, infection, recent surgery, physical frailty, multiple medications, dementia, frequent environmental changes	
Dementia – Alzheimer's	Old age (>85), gender, genetic factors, Down's Syndrome and some other medical conditions	
Dementia – Vascular	Old age, high blood pressure, obesity, diabetes	Physical activity, healthy diet, smoking cessation

Deprivation and social exclusion

Stressful recent life events such as bereavement or job loss have been shown to predict the onset of mental illness in the young and people of working age. However,

older populations differ from the young in that chronic difficulties are more prevalent, and discrete adverse life events carry relatively little threat. In old age, chronic poverty, isolation, social exclusion and long-term limiting health problems are an important source of adversity and useful predictors of the burden of mental illness [20].

Evidence from work done in adults and children shows that measures of deprivation can identify areas where the need for mental health services are likely to be the greatest [4].

The Index of Multiple Deprivation (IMD2004) is a measure of multiple deprivation for small geographical areas, known as Super Output Areas (SOA) covering the whole of England. These individual small area IMD2004 scores are grouped into quintiles representing the most through to the least deprived areas of England, allowing the each area to be compared as well as the proportions of SOAs to be compared between regions of England [52].

Figure 5 shows that the majority of wards in Oxfordshire are above the median levels of deprivation for England, however there are pockets of deprivation particularly within the wards of Northfield Brook, Oxford and Banbury Ruscote in Cherwell.

There is an extensive research literature which indicates that social relationships can have powerful effects on physical and mental health. The frequency of interaction with friends, especially confiding relationships, is positively associated with emotional well-being. Martin Prince and colleagues demonstrated in their longitudinal study of depression in the UK, that frequent contact with friends was the only social support variable prospectively associated with the onset of depression[53, 54]. They also found that a wider lack of social support and social participation, which was measured by the proportion of older people who lived alone or had few contacts with neighbours, was responsible for the maintenance of depressive illness.

Table 11: Older People living alone in Oxfordshire

Area	All households	Lone pensioner household	Percentage of lone pensioner households
England	**-**	**-**	**14.4**
Oxfordshire	**241,218**	**31,140**	**12.91**
Cherwell	53225	6118	11.49
Oxford	51732	7415	14.33
South Oxfordshire	52105	6728	12.91
Vale of White Horse	45759	5738	12.54
West Oxfordshire	38397	5141	13.39

Source: ONS Census 2001

Figure 6 shows that within the South East (SE) region people over the age of 50 on the whole reported that they were regularly in contact with neighbours, friends and family, with over 50% of the sample in the General Household Survey (GHS) 2001 reporting that they regularly spoke with their neighbours more than 3 times-a-week, and greater than 30% saying that they see their friends more than 3 times-a-week, which is approximately equal to the national average. Contact with relatives was less frequent in this age group. People over the age of 50 in SE England were also more likely to be engage in civic activities within their local communities as illustrated in

Figure 7, which shows that almost a third had reported being involved in a local voluntary organisation. When unwell, greater than 60% of older people within the SE reported that they had 2 or more sources of help to call upon, whereas a third were only able to call upon the assistance of more then 1 person, although very few reported that they had no source of help (Figure 8). Data specifically for Oxfordshire, also shows that the proportion of older people living alone is lower than would be expected from national figures (Table 11). However, more detailed analysis of the data and comparison with the distribution of older people shows that there is a considerable difference in this indicator between different areas in Oxfordshire, with the city of Oxford having the highest proportion of lone pensioners.

Figure 5: Income deprivation affecting older people across Oxfordshire

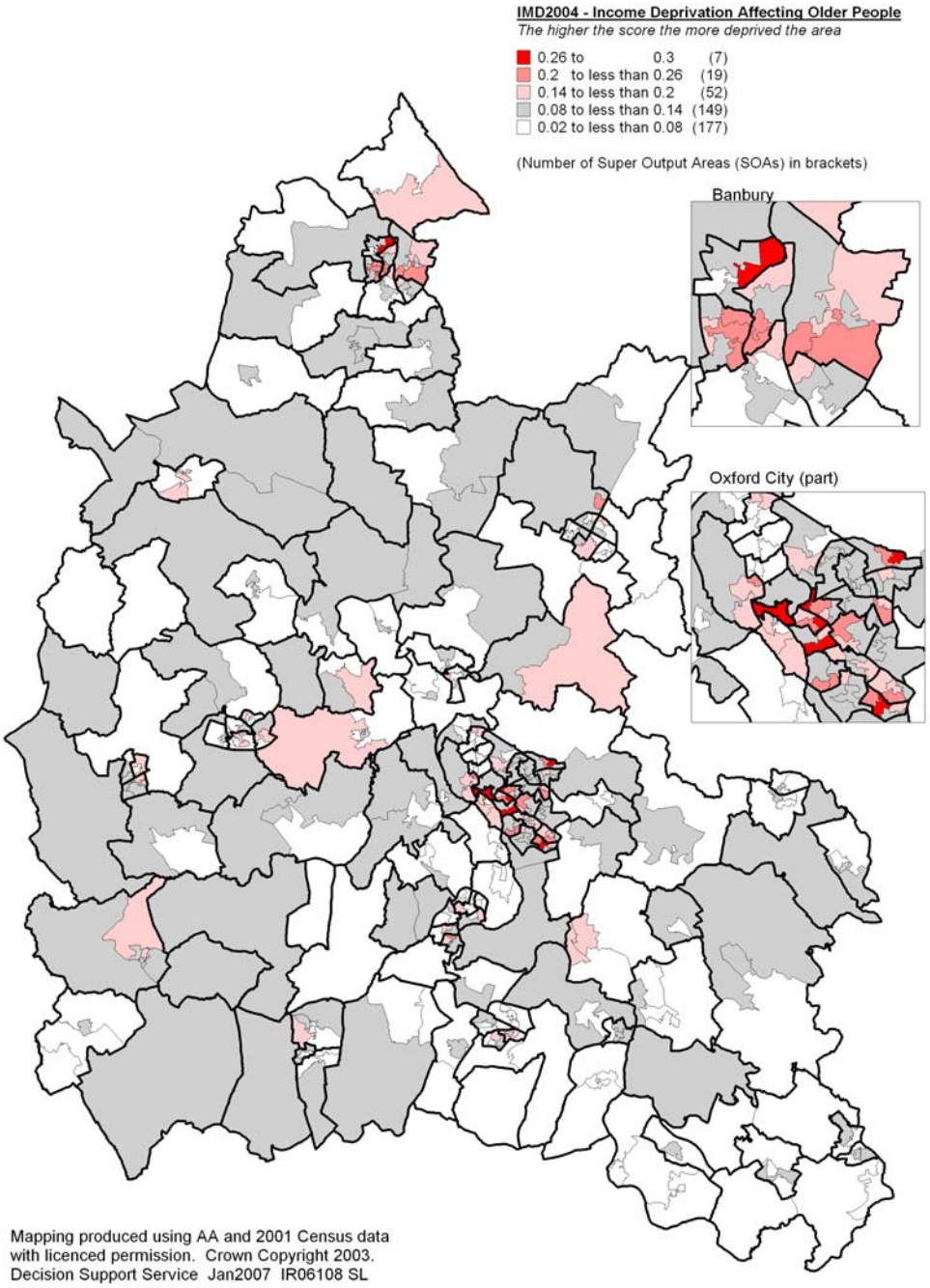
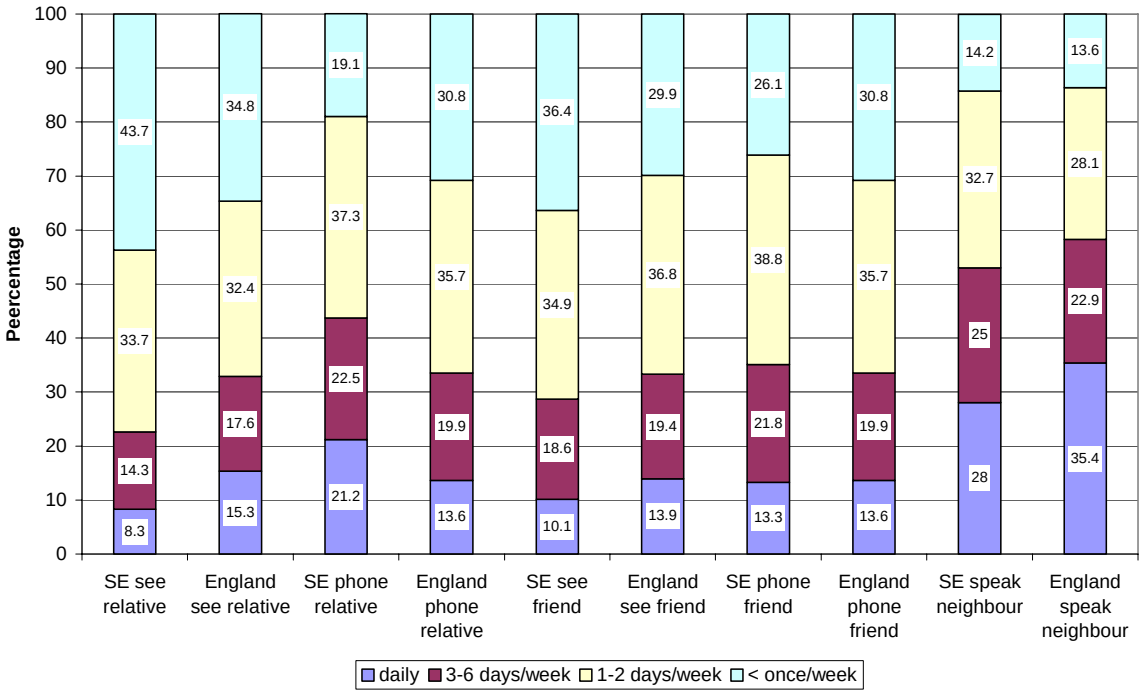
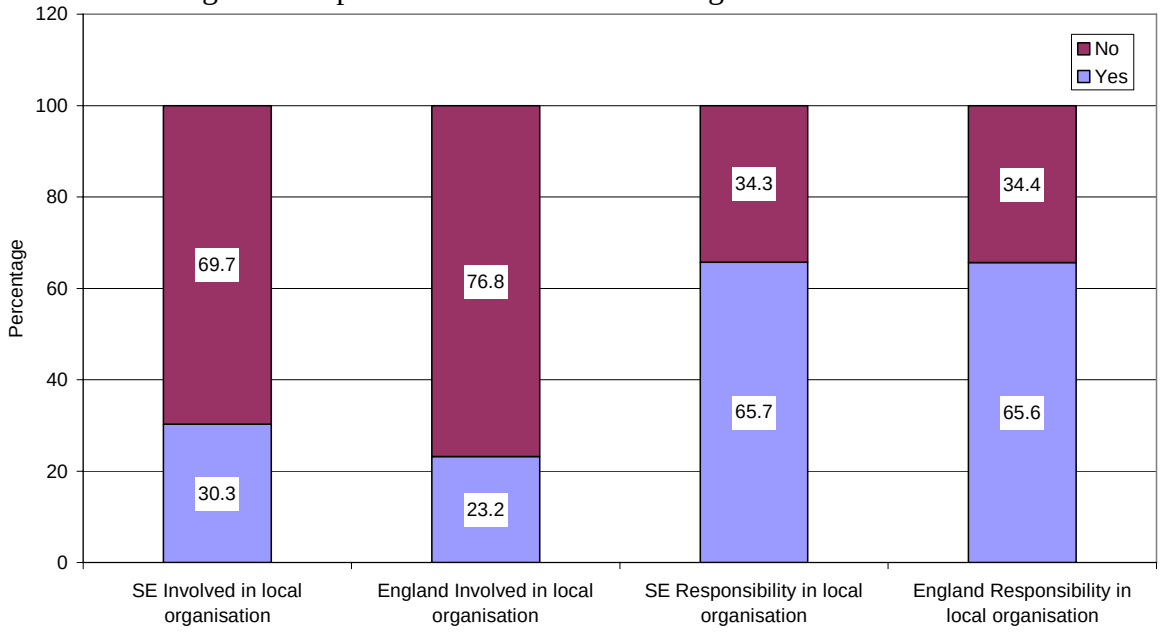


Figure 6: Frequency of contact with relatives, friends or neighbours for people over 50 yrs in South East England compared with the national average



Source: General Household Survey, Social Capital Module 2001

Figure 7: Involvement in local organisations in the last 3 years by people over 50 yrs in South East England compared with the national average



Source: General Household Survey, Social Capital Module 2001

Figure 8: Sources of help when ill for people over 50 yrs in South East England compared with the national average

Source: General Household Survey, Social Capital Module 2001

Physical illness and disability in older age

Long-term limiting illness is a cause of chronic adversity and an important determinant of emotional wellbeing for older people[20, 54]. Table 12 shows that there is a strong positive correlation between age and long-term illness or disability that limits an individual's daily activities and the work that they are able to undertake. The 2006 report on long term illness by the South East Public Health Observatory found that the rate of long-term limiting illness in the South East is significantly lower than the national average, and is in fact the lowest of the nine English government office regions [55]. However, this masked considerable variation at the local level, where it was observed that the West Oxfordshire and Oxford City had considerably more residents with long-term limiting illness as a percentage of their total population than other local authorities (see Figure 6). Residents in these councils as well as those in Cherwell District Council were also more likely to describe their health as 'Not good' (see Figure 7).

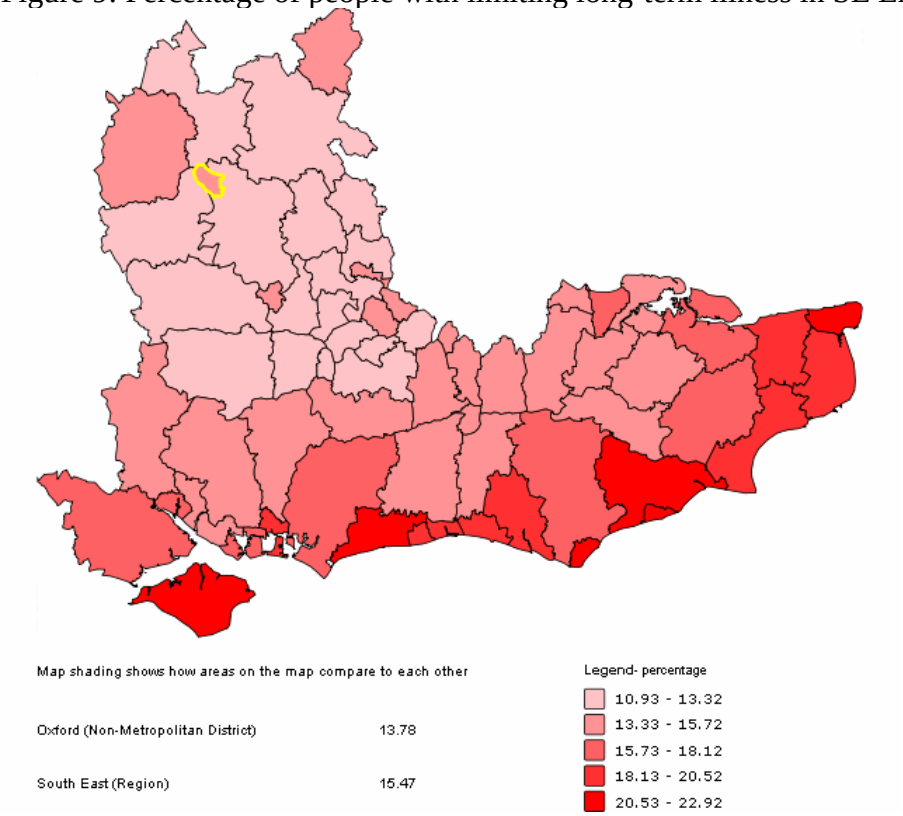
Table 12: Older people with limiting long term illness in Oxfordshire

	Total – all people	Limiting long-term illness – all people	% with limiting long-term illness in age group
65-74	45,343	14,685	32.4
75-84	29,961	15,362	51.3
>85	9,465	6,587	69.6

Source: ONS Census 2001

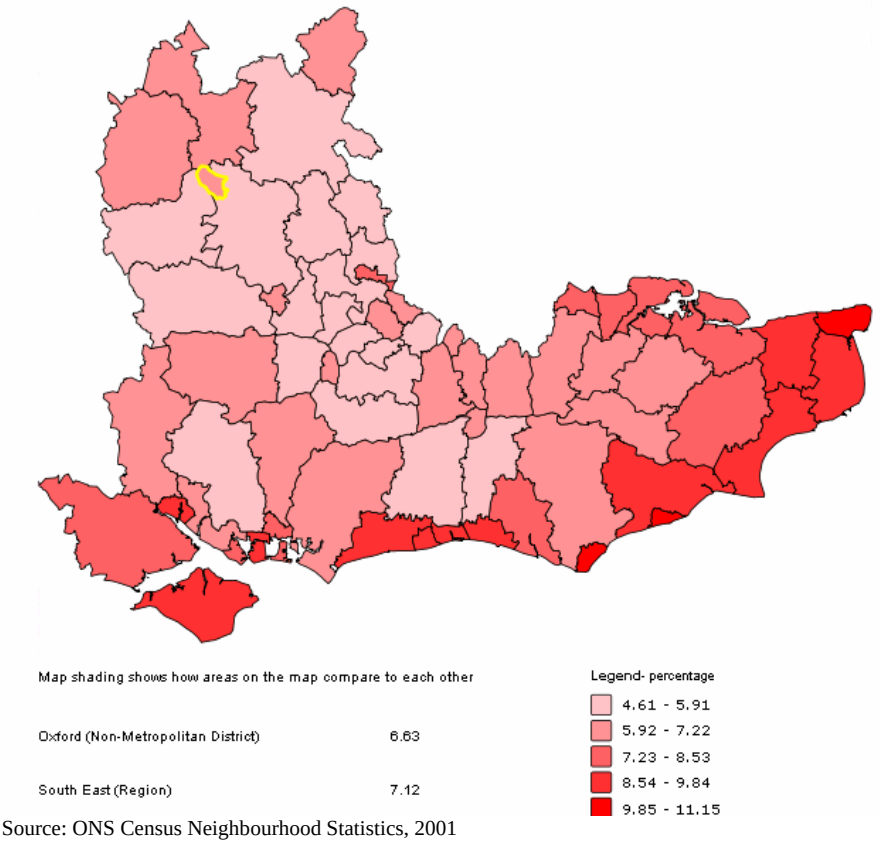
The distribution of patients seen for episodes of cerebrovascular disease (strokes) (see Figure 8), which is associated with the incidence of vascular dementia, unsurprisingly reflects the current distribution older people within the county (compare with Figure 2).

Figure 9: Percentage of people with limiting long-term illness in SE England



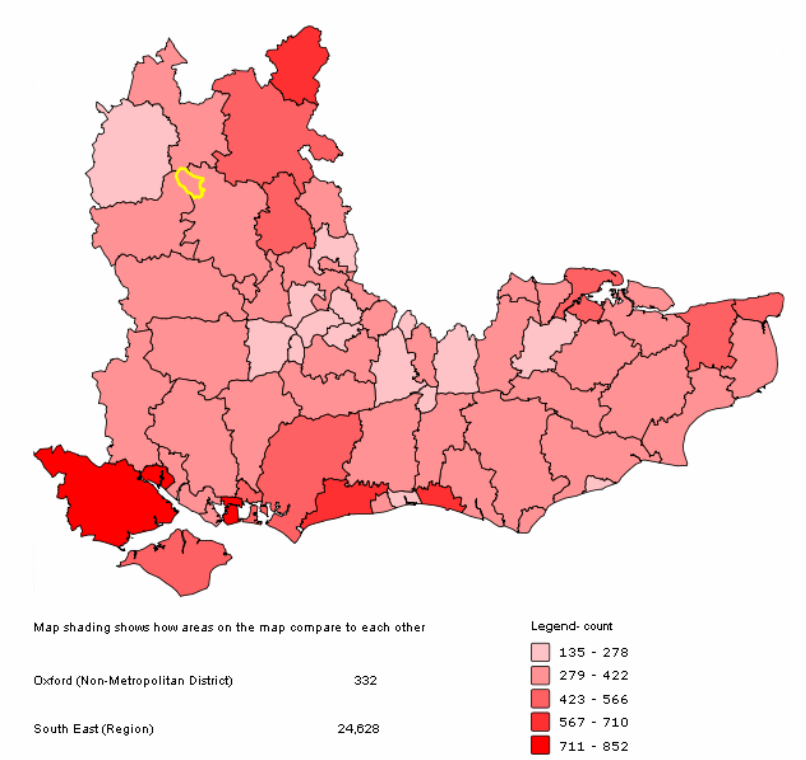
Source: ONS Census Neighbourhood Statistics, 2001

Figure 10: Percentage of people who described their health as 'Not good' in SE England



Source: ONS Census Neighbourhood Statistics, 2001

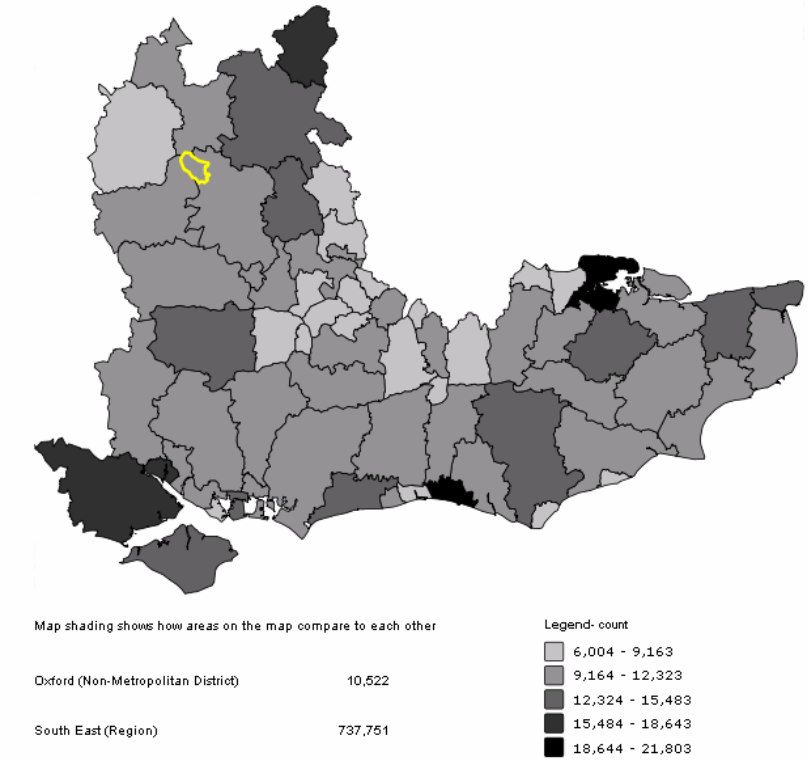
Figure 11: Number of FCEs for cerebrovascular disease, Apr 2005 – Mar 2006



Source: ONS Census Neighbourhood Statistics

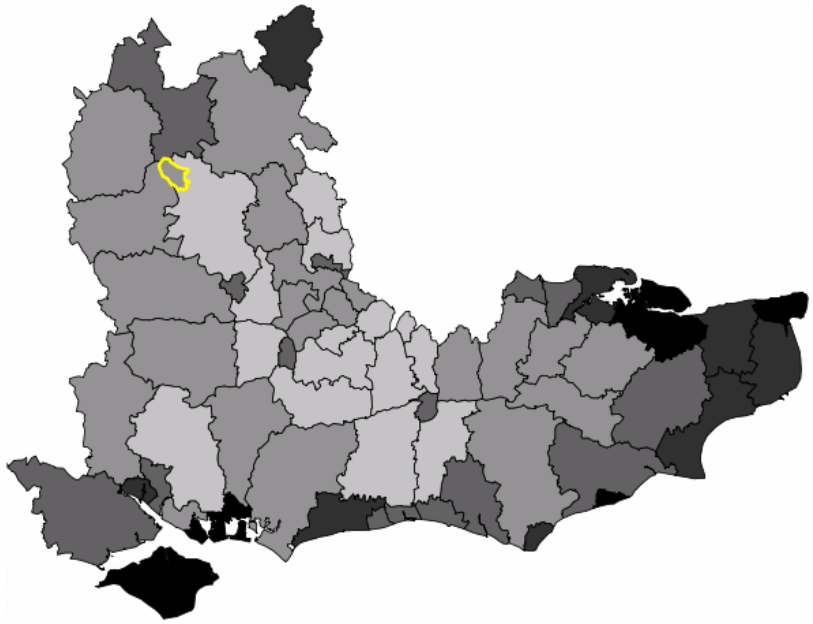
Carers

Figure 12: Number of people who provide unpaid care in SE England



Source: ONS Census Neighbourhood Statistics, 2001

Figure 13: Percentage of people who provide 50+ hours of unpaid care per week in SE England



Source: ONS Census Neighbourhood Statistics, 2001

The impact of looking after another person, particularly when that person requires very substantial help, may have a negative effect on carers' lives. Although it is difficult to show that it leads directly to poor psychological health, there is strong evidence that some carers are in poorer psychological health than people of a similar age and gender without any caring responsibilities in the general population[56].

Carers frequently report that they feel social isolation and loneliness, either because they no longer have the time to meet up with family members and friends, or pursue hobbies or other interests, or because their relationship with the person from whom they care has altered. Practical help and interventions aimed at helping carers to cope with day-to-day situations that they find difficult can make a positive difference to carers' lives and to the lives of those whom they care for.

Locally a recent report by the Oxfordshire Data Observatory found that the proportion of people in rural Oxfordshire providing unpaid care is above the rate in urban areas. 9.8% (23,300) of people in rural areas were providing unpaid care - above the Oxfordshire average (8.8%) according to the 2001 Census survey. Seven areas of rural Oxfordshire are ranked in the top 10% nationally on % of people providing unpaid care, namely[57];

1. Kidlington North (Cherwell)
2. Faringdon and The Coxwells (Vale of White Horse)
3. Sunningwell and Wootton (Vale of White Horse)
4. Chiltern Woods (South Oxfordshire)
5. Sonning Common (South Oxfordshire)
6. Chinnor (South Oxfordshire)

7. Sonning Common (South Oxfordshire)

Figures 9 and 10 also indicates that most carers are distributed within the south of the county, however those carers who report the greatest burden of care (>50 hours per week), and thus are most vulnerable to psychological distress themselves are located within the Cherwell district council area. Thus any strategy to support carers should ensure that the needs of these full-time carers within Cherwell and the west of the county are addressed.

Healthy eating and physical activity

Maintaining good physical health through regular exercise and balanced nutrition into old age is an important determinant of healthy ageing. Prospective studies have shown that people with high cholesterol levels and other risk factors for cardiovascular disease in their thirties are at risk of coronary heart disease, stroke and diabetes, as well as mental health problems such as dementia, both vascular dementia and Alzheimer's Disease [58, 59], and depression in their old age [2]. Although there has a lack of recent statistics on exercise and food intake in the elderly population of Oxfordshire, previous survey work undertaken in 2005 has shown that there is still some work to do to encourage healthier lifestyles in Oxfordshire, especially amongst the over 65s (see Tables 13 and 14).

Table 13: Proportions eating less than one or more than five fruits per day

	% eating less than one fruit per day	% eating more than five fruits per day
35-44	5.8%	21.6%
45-54	4.7%	24.7%
55-64	2.6%	34.9%
65-74	4.7%	38.5%

Source: Healthy Lifestyle Survey for Oxfordshire Primary Care Trusts, 2005 [60]

Table 14: Proportions of people aged 18-74 who reporting eating more than five fruits per day within the former PCTs

Former PCTs	% eating more than five fruits per day
North East Oxford	25.1%
Cherwell	27.2%
Oxford City	27.9%
South East Oxford	29.9%
South West Oxfordshire	27.6%

Source: Healthy Lifestyle Survey for Oxfordshire Primary Care Trusts, 2005 [60]

Table 15: Exercise undertaken by older people in Oxfordshire

	None	At least once per week of moderate exercise	At least 3 days per week of moderate exercise
65-74	64.1%	28.4%	12.9%
75-84	86.1%	13.2%	5.0%
85+	90.7%	6.9%	1.7%

Source: Active People Survey for Oxfordshire Primary Care Trusts, 2006

Table 16: Exercise undertaken by working age population in Oxfordshire

	At least 3 days per week of moderate leisure time exercise
35-44	14.1%
45-54	16.7%
55-64	9.3%

Source: Healthy Lifestyle Survey for Oxfordshire Primary Care Trusts, 2005 [60]

Table 17: Proportions of people aged 18-74 who report undertaking regular exercise by former PCT

Former PCTs	Vigorous exercise at least 3 days a week	Any moderate exercise for 30 minutes, at least five times-a-week
North East Oxford	14%	19.9%
Cherwell	18.1%	20.8%
Oxford City	12.8%	22.3%
South East Oxford	13.8%	18.8%
South West Oxfordshire	11.9%	21.8%

Source: Healthy Lifestyle Survey for Oxfordshire Primary Care Trusts, 2005 [60]

Table 18: Proportion of people who smoke in Oxfordshire, by age group

	Yes
35-44	19.7%
45-54	22%
55-64	25.1%
65-74	18.2%

Source: Active People Survey for Oxfordshire Primary Care Trusts, 2006

Table 19: Location of smokers aged 18-74 by former PCT

Former PCTs	Smoke at least once-a-day
North East Oxford	15%
Cherwell	17%%
Oxford City	16%
South East Oxford	14%
South West Oxfordshire	15%

Source: Active People Survey for Oxfordshire Primary Care Trusts, 2006

Thus in summary whilst the data on risk factors for mental illness in Oxfordshire generally shows that older people within the county have good resources to buffer them against the risk of mental illness, and ensure that those affected are able to overcome their illness quickly, this masks some variation in the risk factors that are both antecedent to mental illness within the elderly, such as indicators of chronic stress (e.g. long-term limiting illness and deprivation) and factors that help to maintain mental distress (e.g. living alone or having restricted social networks). This may indicate areas where a mental health promotion strategy may best be targeted, such as programs to address social isolation and poverty in the wards of Northfield Brook and Ruscote in Banbury, or carers support in the north and west of the county.

Mental illness in the older population

A wide range of mental health problems may affect people in later life, although the most common diagnosed conditions are depression, dementia and anxiety disorders. Many people develop mental health problems for the first time in later life, whilst a few others will grow older with severe enduring mental illness[7].
As pointed out earlier, older people with mental health problems are found at all levels of the health and social care systems. The table below shows the prevalence of different mental health problems for older people in three settings, namely; the community (usually private households, but also including sheltered and extra-care housing), acute hospitals and residential/ nursing care homes. However, at present there are significant gaps in our knowledge of the prevalence rates with many estimates based on small studies.

Table 20: Percentage of older people with different mental health problems in different settings

Condition	Community (symptomatic)	Community (diagnostic)	Acute hospitals	Care homes
Depression	19 - 43	2 - 15	29	40
Dementia	Unknown	1.4 - 21.6	31	50-80
Anxiety	10-24	2 - 15	8	6-30
Delirium	Unknown	1-2	20	'very common'
Schizophrenia	2-5	0.5	0.4	Unknown
Alcohol misuse	Unknown	2-15	3	Unknown
Drug misuse				
- prescription	Unknown	11	Unknown	Unknown
- illicit	Unknown	0.1	Unknown	Unknown

Source: The second report from the UK inquiry into mental health and well-being in later life[7]

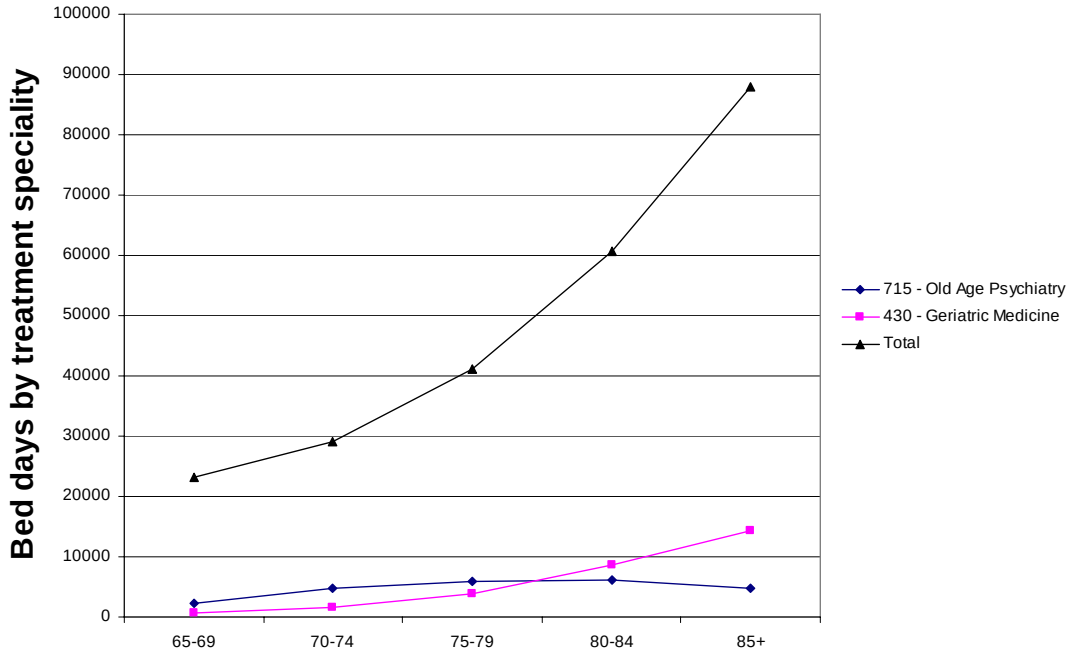
Whilst no recent local surveys have been conducted on the prevalence of mental illness amongst older people, extrapolation of national rates onto local population figures demonstrates how these prevalence figures may translate into the expected burden of mental illness amongst the elderly within Oxfordshire (see Appendix 9).

Thus from this information on the burden of morbidity in primary care, intermediate care and specialist services the following points are highlighted;

- 'unspecified dementia' and 'depressive episodes' remained leading reasons for consumption of acute bed days within the local health economy (Table 51)
- whilst the patients admitted to community hospitals in Oxfordshire for mental illness had decreased, the length of stay for each patient had increased (Tables 45 and 46)
- patients at age 75 are less likely to consume bed days in geriatric medical wards than patients over the age of 85 (Figure 20)
- However patients at age 75 are more likely to consume bed days in old age psychiatry than patients over the age of 85 (Figure 21)
- the rate of admission for patients with 'cognitive impairment/ senility and other organic mental health problems' was lower than expected from national figures, conversely the rate of admission for 'other psychosis' was higher than expected (Table 49)

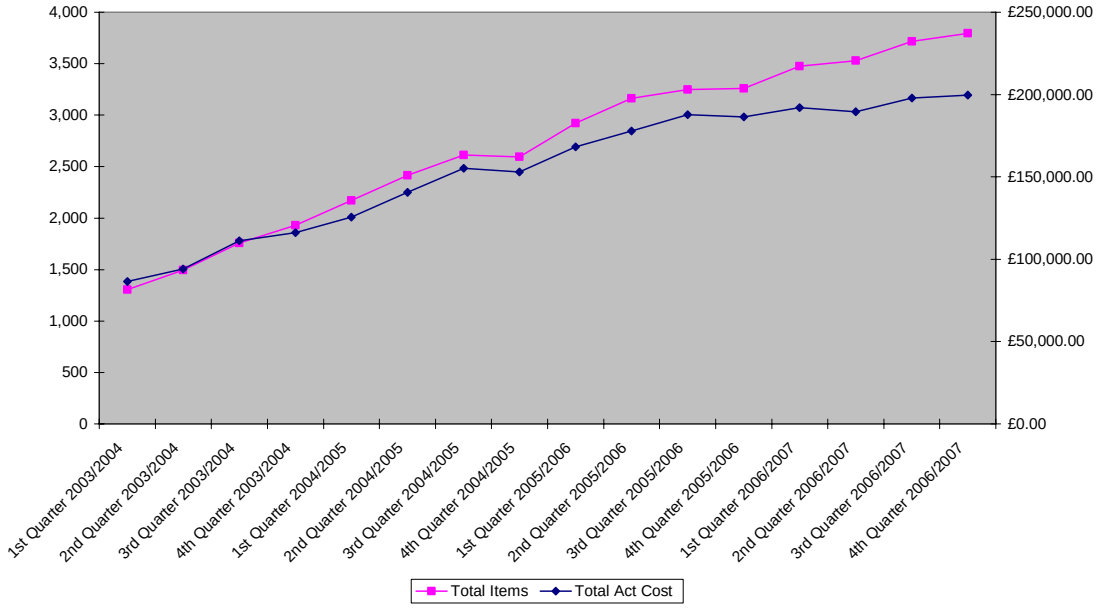
- the rate of re-admission was highest for those older people who had a diagnosis of dementia compared to any other mental health problem (Tables 52 and 53)
- the cost of prescribing for Alzheimer's disease in primary care recently has also significantly increased (Figures 14 and 15)

Figure 14: Admitted patient activity (bed days per annum) for people registered with Oxfordshire PCT by treatment speciality, 2006



Source: Decision Support Team, Oxfordshire PCT

Figure 15: Cost and use of Alzheimer's drugs in primary care



Source: epact data from the Prescribing Team, Oxfordshire PCT

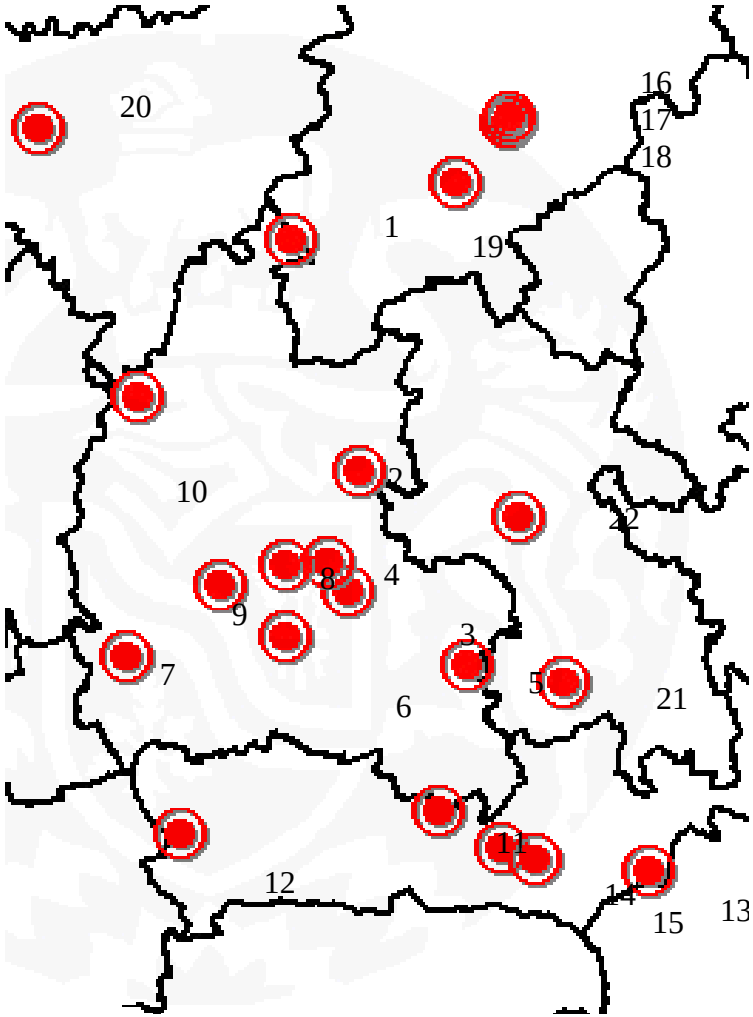
Mental healthcare services for older people in Oxfordshire

Currently financial data for Oxfordshire PCT does not disaggregate mental health program budgets by age and thus spending by the PCT specifically on older peoples mental health services is difficult to capture. However data shows that OBMH is budgeted to spend £13.5m on older adult services in 2005/ 06 and Oxfordshire County Council plans to spend £5.8 m on mental health services for older adults in 2006/ 07[21].

Appendix 8 shows the range and location of mental health services for older people provided across the county. This information highlights that;

- there is no older peoples mental health promotion program in Oxfordshire
- psychology services for older people within primary care is currently only available for people of working age, under 65 years
- day care and CMHT provision is predominantly focused on the southern half of the county (Figure 18)
- specialist dementia bed provision is distributed across the county (Figure 16)
- the current provision of dementia beds within the county equates to approximately half the number of new mild or greater cases of dementia expected per year (Figure 16 and Table 33)
- the majority of new dementia beds are expected to be developed within the south of the county, where the largest increases in the elderly population are expected (Figure 17)

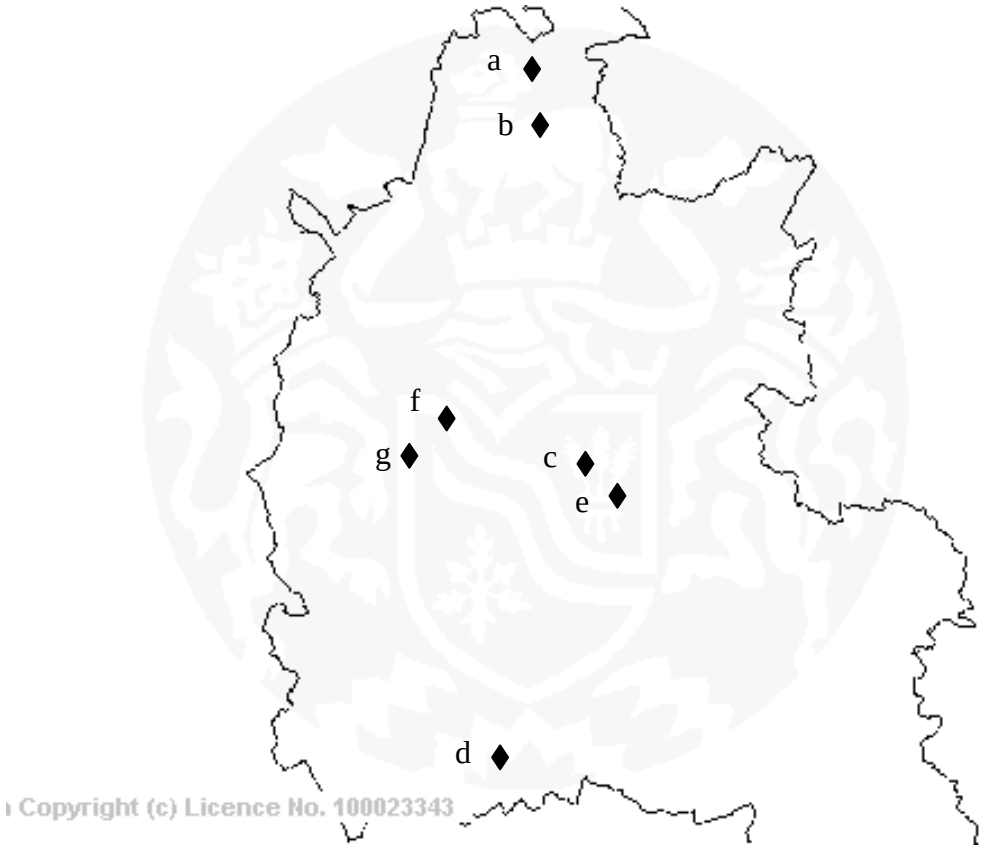
Figure 16: Existing specialist dementia beds in and around Oxfordshire



Source: Oxfordshire County Council, 2007

	Name of home	Address	No of beds	No of nursing de beds
1	Wardington	Wardington	60	60
2	Manor House	Merton	102	102
3	Brookfields	Oxford	66	33
4	Headington CH	Oxford	30	30
5	Watlington	Watlington	60	30
6	Abingdon Court	Abingdon	64	64
7	Coxwell Mews	Faringdon	68	37
8	Vale House	Botley, Oxford	20	20
9	Meadow View	Standlake	42	23
10	Southerndown	Chipping Norton	87	87
11	River View	Reading	137	137
12	Hungerford Home	Hungerford	59	21
13	Lynwood House	Maidenhead	87	12
14	Austen House	Reading	79	58
15	West Oak	Wokingham	55	55
16	St Matthews	Northampton	58	38
17	Goldcare Ltd	Northampton	19	19
18	Parkside House	Northampton	20	20
19	Westgate House	Northants	41	41
20	Arden Valley NH	Solihull, Warks	48	24
21	Catherine Court	High Wycombe	60	30
22	Chiltern View NH	Aylesbury	31	31
		Total bed numbers	**1293**	**972**

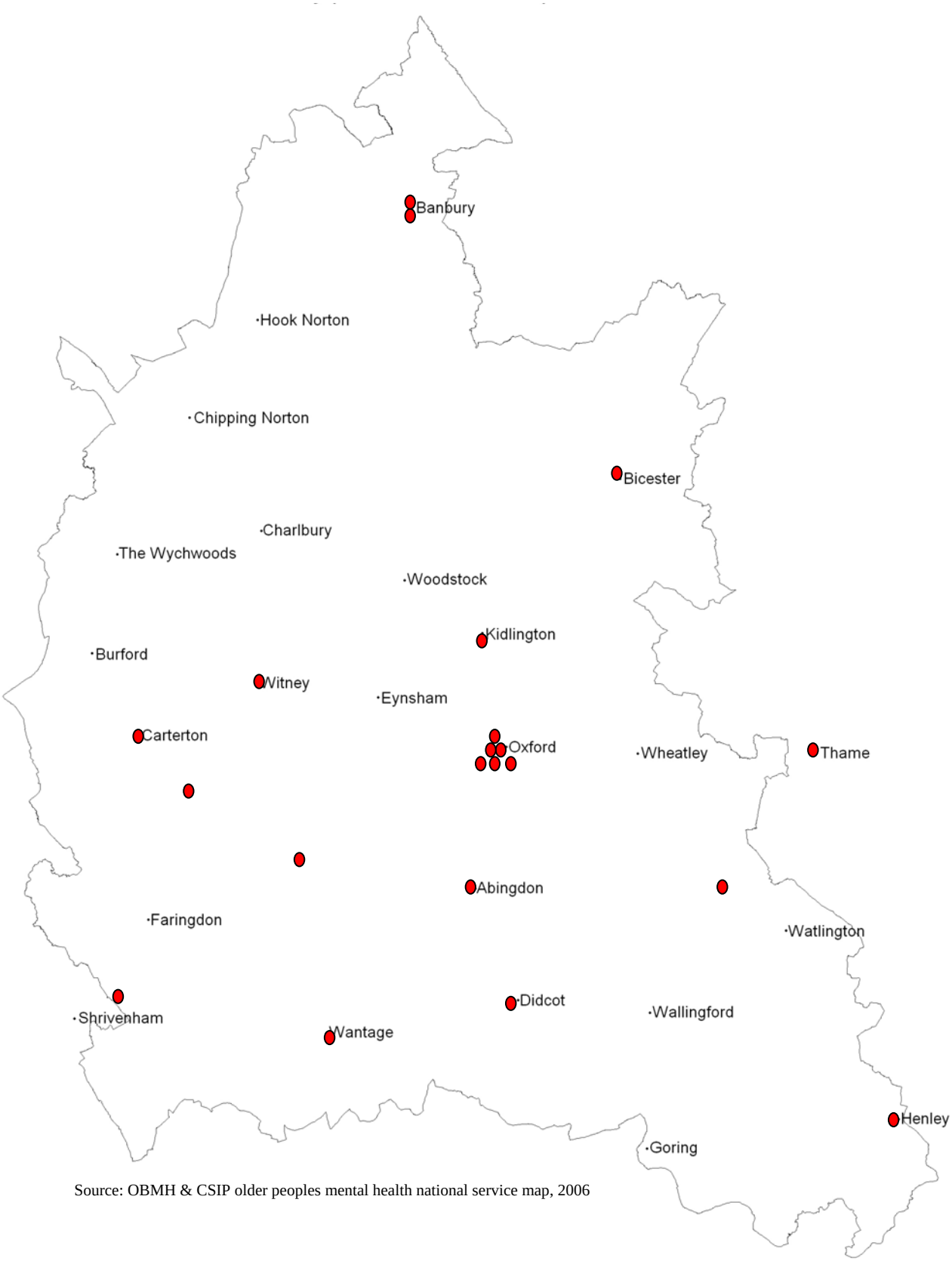
Figure 17: Known developments of specialist dementia beds in Oxfordshire



	Name of home	Address	Number of beds planned for nursing dementia	Estimated date of completion
a	Brooklands Nursing Home	Banbury	40	
b	Glebefields Nursing Home	Drayton, Banbury	9	Autumn 07
c	Headington Care Home	Headington, Oxford	20	
d	Sanctuary Home	Wantage	20	March 08
e	Orchard House	Sandford	40	
f	Middletown Grange	Hailey, nr Witney	May 07	33
g	Methodist Homes	Carterton	40	May 08

Source: Oxfordshire County Council, 2007

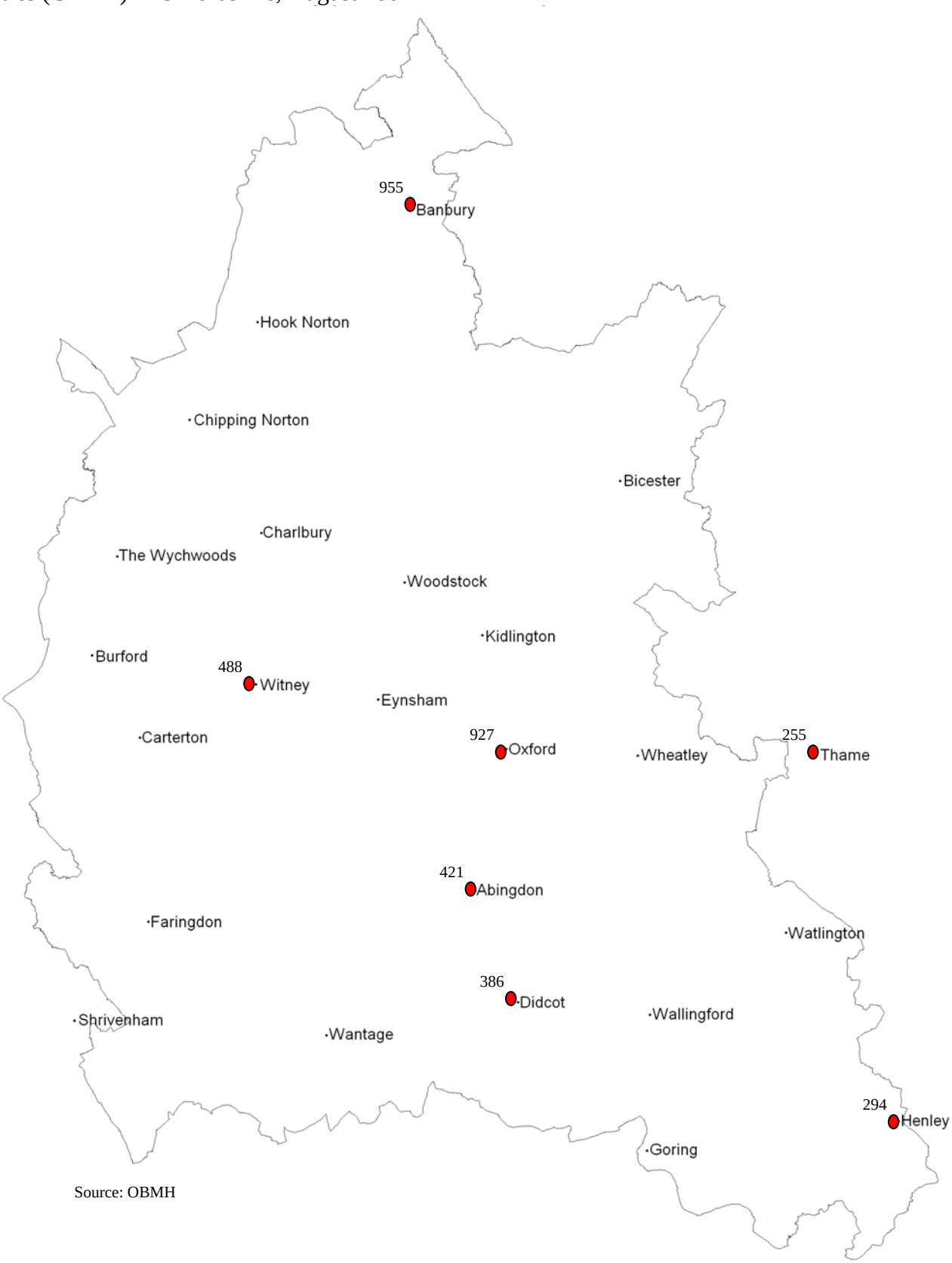
Figure 18: Day hospital and centres for older people with mental health problems in Oxfordshire



Source: OBMH & CSIP older peoples mental health national service map, 2006

Mapping produced using AA and Ordnance Survey data with licenced permission. Crown Copyright 2003. Decision Support & Performance Aug2007 SL

Figure 19: Caseload of older people seen within Community Mental Health Treatment Centres (CMHT) in Oxfordshire, August 2007



Source: OBMH

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Projected future burden of mental illness in the elderly

As mentioned earlier, the prevalence of mental illness is expected to change over the coming decade, which will have important implications for our predictive models of mental illness and mental health service needs amongst older people over the next ten years[7], although there is no precise data on these trends.

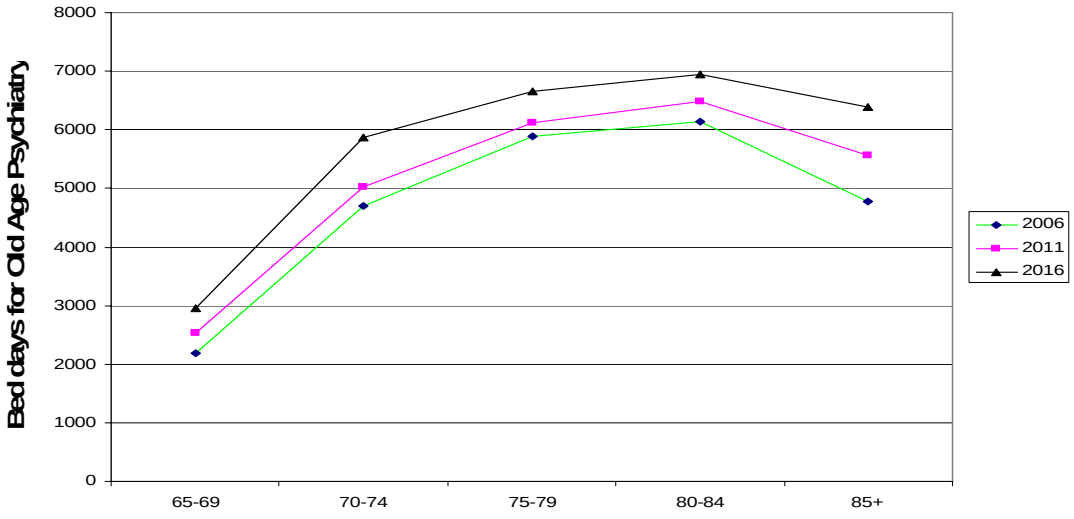
With the assistance of the Decision Support Team at Oxfordshire PCT, the projected demographic shift in the population of Oxfordshire was modelled against the current pattern of acute health services commissioned by the PCT.

Table 21: Estimated future admissions (spells per annum) for older people with mental health problems in Oxfordshire PCT, assuming the current levels of service use are maintained

Health Treatment Group (HRG)	Age groups	2006	2011	2016
T – Mental Health	65-69	33	38	45
	70-74	21	22	26
	75 – 79	26	27	29
	80-84	45	48	51
	85+	59	69	79
	Total >65	184	204	230
	% change from 2006	-	+11%	+25%

Source: Decision Support Team, Oxfordshire PCT

Figure 20: Estimated future bed days required by older people admitted under old age psychiatry (bed days per annum), 2006 – 2016, assuming the current levels of service use are maintained



Source: Decision Support Team, Oxfordshire PCT

Table 22: Estimated future bed days required by older people admitted under old age psychiatry (bed days per annum), 2006 – 2016, assuming the current levels of service use are maintained

Treatment function speciality	Age groups	2006	2011	2016
715 – Old Age Psych	65-69	2190	2534	2954
	70-74	4700	5020	5875
	75 – 79	5895	6116	6649
	80-84	6143	6484	6954
	85+	4777	5561	6382
	Total >65	23705	25715	28814
	% change from 2006	-	+8%	+22%

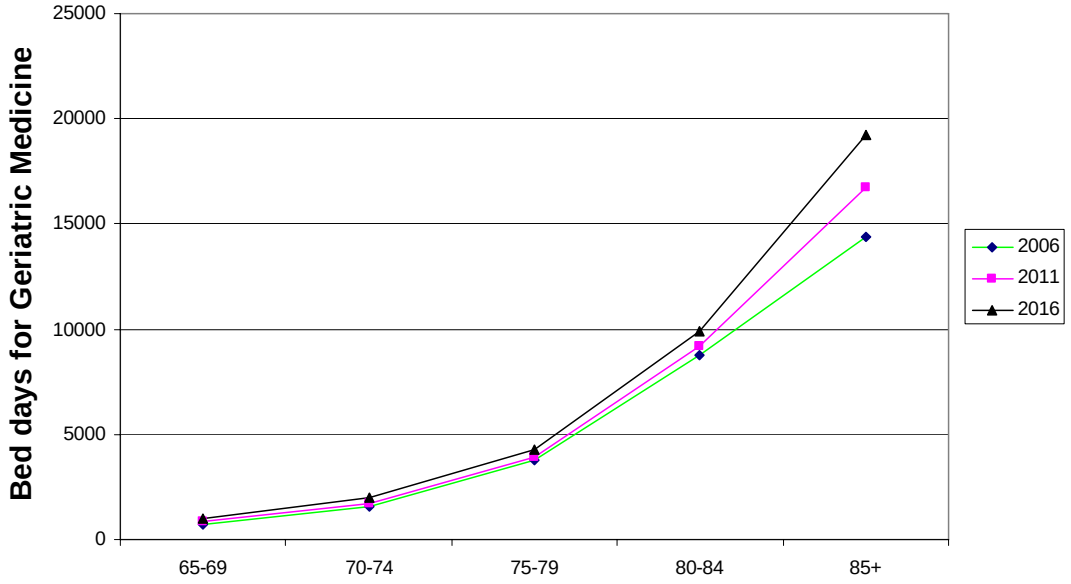
Source: Decision Support Team, Oxfordshire PCT

Table 23: Estimated future bed days required by older people admitted under geriatric medicine (bed days per annum), 2006 – 2016, assuming the current levels of service use are maintained

Treatment function speciality	Age groups	2006	2011	2016
430 – Geriatric Medicine	65-69	735	850	992
	70-74	1585	1693	1981
	75 – 79	3792	3933	4276
	80-84	8728	9213	9880
	85+	14409	16773	19250
	Total >65	29249	32462	36379
	% change from 2006	-	+11%	+25%

Source: Decision Support Team, Oxfordshire PCT

Figure 21: Estimated future bed days required by older people admitted under geriatric medicine (bed days per annum), 2006 – 2016, assuming the current levels of service use are maintained



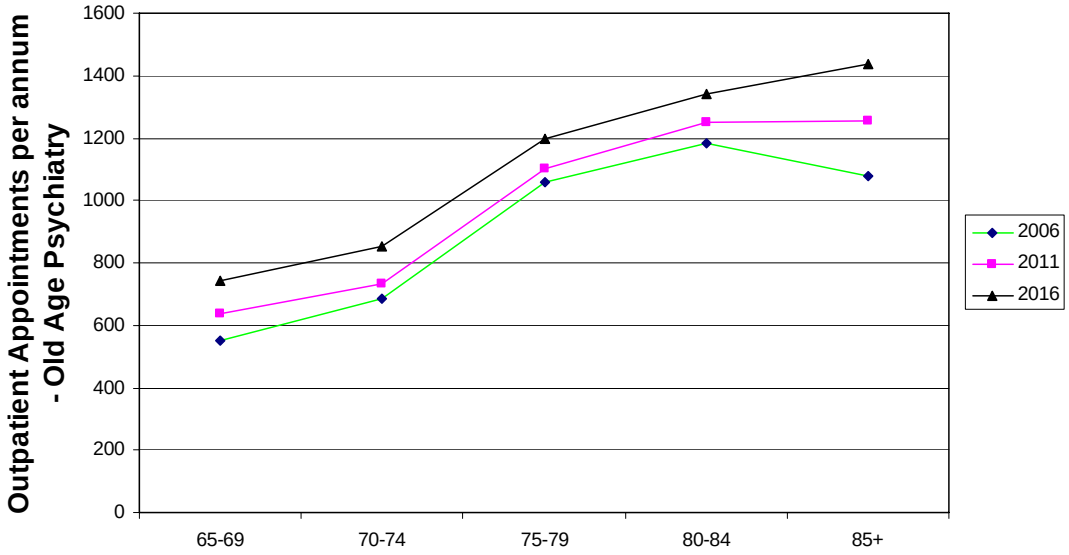
Source: Decision Support Team, Oxfordshire PCT

Table 24: Estimated future outpatient activity (appointments per annum) for old age psychiatry in Oxfordshire, 2006 – 2016, assuming the current levels of service use are maintained

Treatment function speciality	Age groups	2006	2011	2016
715 – Old Age Psych	65-69	550	636	742
	70-74	684	731	855
	75 – 79	1061	1101	1196
	80-84	1184	1250	1340
	85+	1076	1253	1437
	Total >65	4555	4971	5570
	% change from 2006	-	+ 9%	+22%

Source: Decision Support Team, Oxfordshire PCT

Figure 22: Estimated future outpatient activity (appointments per annum) for old age psychiatry in Oxfordshire, 2006 – 2016, assuming the current levels of service use are maintained



Source: Decision Support Team, Oxfordshire PCT

This information highlights that;

- the increase use of acute old age psychiatry services is expected to mirror the increase in use of mental health services over the next decade
- if the current levels of service use are maintained and without a change in the treatment pathways for older people with mental health problems then we should expect a substantial increase in the use of geriatric medicine services and psychiatric outpatient services, especially for the most frail patients over the age of 85

Discussion and Recommendations

Oxfordshire PCT's new strategy for 2007 -2012 lays out ambitious targets for the new organisation. It envisages that by 2012,

- local people will be healthier, particularly those in the most deprived communities
- that they will be actively engaged with the PCT in activities to promote their health and prevent illness
- that they will be actively supported to manage their own health and care needs at home, when this is appropriate, and
- that they will have access to a choice of high quality, safe and appropriate health services should they need it

The challenge to promote mental well-being and ensure the delivery of mental health services of the highest calibre for local residents will be crucial to the success of this strategy.

However, this needs assessment identifies that significant work around older people's mental health will be needed to ensure that the PCT's vision can be brought to fruition.

This report identifies five priority areas for further work, namely;

1. There is a need to work with local providers to agree care pathways for older people with mental health problems

The results of this needs assessments shows that mental illness in older people, especially dementia and depressive illness are leading causes of acute admission to local hospital, and that whilst the numbers of acute admissions may have decreased locally in some areas, the length of stay and the bed days consumed for each older patient with mental illness have increased. Mental illness amongst older people is also a leading cause of readmissions to hospital. This is projected to increase further as the population ages. Evidence from local service users, carers and providers also showed that the course of care for older people with mental illness from the first presentation of symptoms, to formal diagnosis and subsequent management was often long and arduous. Patients with similar symptoms often progressed along different treatment trajectories. This results in delayed diagnosis, missed opportunities for early intervention, prolonged time spent in inappropriate care settings such as A&E and disparities in treatment.
In addition, the progression illness within old age varies greatly and the increased burden of mental illness within the older population is expected to have an impact at all levels of the health economy. For example, early symptoms of dementia which consists of loss of short-term memory, minor anxiety and confusion may be managed appropriately at home, whilst older people with increasingly severe symptoms of dementia such as severe memory impairment, physical and behavioural problems will require more intensive support[16].
These findings points to the need to look at the pathway of care for older people with mental illness to ensure that;

   a. older people have access to a wide choice of high quality care, including community based services, that are appropriate to their level of need

b. whilst the increasing burden of mental illness amongst older people does not fall too unevenly upon local providers

Development of acute mental health services will be especially important in the southern parts of the county where the largest increase in the older population is expected and mental health services are likely to be most impacted.

2. There is a need to develop, and strengthen the health, and social care workforce locally, particularly to increase expertise in older peoples mental health issues

The projected increase burden of mental illness amongst the older population in Oxfordshire will mean that the PCT must look to improve the skills and competencies of all staff to enhance detection and management of mental illness in all non-specialist settings, so that wherever people are, they are not discriminated against, and have their mental health needs managed well. This process may begin with an audit of the training received by health and social care staff providing care within areas of the health economy which currently receive the greatest percentage of older people with mental health problems, namely nursing and residential homes. The results from this audit could then form the basis of a training needs review and mental health training strategy for health and social care staff across the county.

3. There is a need to ensure a wide range of health and social care services that offer timely, appropriate and high quality care closer to home for older people with mental illness

Mental illness in older people encompasses a broad range of conditions of varying severity, which have an impact at each level of the local health economy. This report illustrates the burden of mental illness within primary, intermediate and specialist care in Oxfordshire and shows that mental illness in old age is common in all settings. Interviews with local carers and advocates made it clear that having their loved ones at home was very important to many carers, some of whom had been married for 40 to 60 years to their spouse before mental illness had suddenly snatched them from what they were used to.
Therefore the objective of the PCT should be to provide timely, appropriate and high quality care closer to home for older people where it is appropriate. However there are significant challenges to this achieving this objective as pointed out above, the burden of mental health morbidity amongst older people is substantial and varied in nature, and in addition older people, particularly the most frail are often also afflicted by multiple problems both mental and physical illness.

This highlights the need for a holistic approach to commissioning mental health services for older people that incorporates community-based services (where the majority of older people with mental health problems receive their health and social care) and services provided by voluntary organisations such as Age Concern and the Alzheimer’s Society who have a crucial role not only in advocating for people with mental health problems but also in providing a wide range of mental health services.

Practice based commissioning (PBC) offers great opportunities to develop more person-centred and integrated community based services. With this in mind the PCT

should use this needs assessment to identify a core range of mental health services for older people that should be provided across the county, and look for opportunities to work with PBC consortia to develop local commissioning strategies that ensure the provision of a wide range of timely, appropriate mental healthcare services for older people closer to their homes.

This new direction links with developments in the White Paper on improving primary and community health and care services, 'Independence Well-being and Choice', and the management of long term conditions.

4. Services also need to acknowledge the needs of carers and the supportive unit around older people with mental health problems

Social support from friends, family, neighbours and other carers can help older people with mental health problems to recover from stressful life events and maintain 'life as usual' Many older people do not seek help from formal services when they are feeling distressed; two-thirds of older people with depression have never discussed it with their GP. Friends and family are often the first and only port of call. They play an important role in preventing problems from developing or getting worse, however evidence from local carers, providers and policy documents shows that the views and needs of carers, and the wider supportive unit around older people, especially the family are often overlooked in planning care for patients, assessing needs for services or drafting policies for service development.

However, carers themselves are also at increased risk of mental illness and thus it is essential that the PCT recognises the need to support unpaid carers in order to protect and improve their own mental health (e.g. identify their needs, esp. respite care).

Thus it is recommended that the PCT acknowledges the important role of carers in the support of older people with mental illness and quantifies the specific needs of carers including the mental healthcare needs, through the formal assessment of their needs, but also looks at practical steps that could be taken more immediately to address the needs of carers identified in this document, particularly the need for emergency respite care. This would be most pertinent in Cherwell and West Oxfordshire where there is the highest proportion of carers reporting that they provide greater than 50 hours of unpaid care per week.

In addition, any mental health prevention strategy for older people should incorporate the needs of carers.

5. There is a need to implement strategies to prevent mental illness in older people by promoting and supporting healthy ageing and active citizenship

As mentioned earlier, mental health problems are not an inevitable part of growing older, and it is possible to prevent problems, or at least reduce their risk of occurring, in later life. The second report from the UK Inquiry into Health and Well-being in later life recently collected the evidence for preventative interventions in old age, and suggested that more could be done by healthcare providers and commissioners to reduce the incidence of the most common mental health problems in old age. However, this report identified that there are currently no programs to promote mental

health and well-being amongst older people in Oxfordshire. In addition few other health promotion programs that address risk factors for mental illness, such as physical exercise programs, are specifically designed to evaluate their impact on mental well-being.

Thus it is recommended that the PCT works with local health and social care partners to draw together a mental health promotion strategy for older people that would work alongside current programs to promote physical health, but ensure that risk factors that are more specific to mental health such as bereavement, social isolation and stigma are also addressed.

This may include mental health promotion programs to address social isolation and poverty in the wards of Northfield Brook and Ruscote in Banbury, or carers support in the north and west of the county as mentioned above.

Appendix 1

What is health needs assessment

Health Needs Assessment is a systematic and explicit process that reviews the health issues facing a population leading to agreed priorities and resource allocation that will improve health and reduce inequalities[23].

There are three main reasons for carrying out a health needs assessment including;
- to help decide what services should be provided
- to inform how a service may need to change what is does or what is provided
- to aid the planning of a new service

As indicated in table 4, there are four types of needs that may be assessed.

Table 25: Types of Need

Need	Method of assessing need
Normative	By comparing current practices to improve health with recommended best practices from national/ international guidelines
Corporate	By interviewing interested parties (stakeholders) for subjective opinions on where services could be improved
Comparative	By comparing current practices with practices in similar populations
Epidemiological	By identifying shortfalls in current practices using routinely collected data

Source: A health needs assessment at Huntercombe Young Offenders Institution, March 2005 By T Porter, 2005[61]

The process of assessing health needs involves engaging with members of the population, and other stakeholders involved in commissioning and providing healthcare for that population to identify gaps in provision, agree priorities and plan actions needed to maximise benefit to health and reduces health inequalities. The HNA guide written by the Health Development Agency sets out five steps to Health Needs Assessment[23], namely;

Appendix 2

Table 26: Summary of national policies relevant to older people's mental health

Date	National Documents	Summary
1999	National Service Framework for Mental Health; modern standards and service models, Department of Health [18]	Building on the principles outlined in modernising mental health services (1998), for the first time it sets out national standards, service models and priorities for improvement. Aimed at the adult population up to age 65, the framework covers five areas; - mental health promotion - primary care - access to services - effective care for those with severe mental illness, and prevention of suicide - support for carers
2000	Forget me not; developing mental health services for older people in England, Audit Commission [42]	Reviewed older peoples mental health services across England and Wales. Looked specifically at the; - nature of mental health problems in old age - how older people get access to services and how to support carers and service providers - the range of services available in the community - the range of services available in hospital and residential care - the need for good communication and coordination between the agencies using the Care Program Approach - the need for strategic planning They found most people prefer to be supported in their homes, but most expenditure on older peoples care still goes on hospitals, nursing homes and residential care. There was also wide variation in practice and resources with specialist help patchy and uncoordinated. The report recommended the following measures to promote the independence of older people; - improvements to home-based services, day care and respite care. Shift in the balance of care in favour of home based services - a shared vision and better coordination of health and social care services locally - early diagnosis and active management of mental health problems by GPs with support from specialists - information and help for carers - better support for staff in care homes
2000	NHS Plan: a plan for investment, a plan for reform, Department of Health [32]	Sets out a vision of patient centred health services with a ten-year plan promising financial investment for reforms, including; - Contracts that commit consultants to working up to seven years for the NHS with reward for further commitment - Faster access to care - Nurses to gain greater prescribing powers as well as powers to admit and discharge patients - A new level of PCT to commission total health and social care packages - Commitment to the development of intermediate care services - Community health councils to be replaced by patient advocacy services and patient forums - Appointment of modern matrons with authority to intervene to sort out discharge delays and poor hospital hygiene - Commitments to improve services for patients with mental illness and older people
2001	National Service Framework for Older People, Department of Health [19]	Following on from A First Class Service; quality in the new NHS (1998) this paper launched a ten year program of improvement for older peoples services set against eight standards. The eight standards cover; - age discrimination - person-centred care - intermediate care: bridging the gap between acute and primary care - general hospital care - stroke

		- falls - mental health – explicitly mentions the need for early diagnosis and treatment of dementia - health promotion
2002	Developing services for carers and families of people with mental illness, Department of Health [30]	Aimed at local mental health services to be read alongside standard six of the National Service Framework for Mental Health: caring for carers. The report focuses on carers of people with severe mental illness and who are on the Care Program Approach. Support is vital, for the impact of mental illness on the carer can be similar in terms of affecting work, education, finances and social life as well as their own physical and emotional health. Carers are also vital as the first point of contact at the onset of illness. Service providers should recognise the valuable role of carers and the stress they are under, provide timely support or help if they can no longer carry on and involve carers in planning and developing future services Support should include information and advice, including advocacy, breaks and access to interventions such as family therapy. Services should be based on four principles; - positive and inclusive - flexible and needs led - accessible and responsive - integrated and coordinated
2002	The Journey to Recovery; the government's vision for mental health care, Department of Health [31]	Sets out the government's vision for modernised mental health services within the context of an optimistic, positive approach to people who have mental health problems, where recovery is based on service users and carers aspirations. Plans included; - closer working with social services and the criminal justice system - new services tailored to meet local needs, paying particular attention to women's mental health, support for carers and personality disorders - National Institute of Mental Health to support research, and improve and disseminate the evidence base for effective treatments and therapies - Emphasis on staff recruitment, retention and training. Staff should be employed to reflect the communities they serve - Services to consider basic human needs, the need for social networks and friends, and removing the stigma of mental illness by changing society's attitudes to it
2003	All our Tomorrows; inverting the triangle of care, Association of Directors of Social Services, Local Government Association [41]	Discussion paper that sets out an approach towards supporting older people and their carers based around focusing on their strengths and contributions, adopting community development approaches to the development of health and social care provision, looking beyond health and social services to the broad range of support options and opportunities that exist for all citizens
2004	Organising and delivering psychological therapies, National Institute of Mental Health [40]	Found that the provision of psychological services was patchy and inadequate in spite of convincing evidence of their effectiveness in treating mild to moderate mental health problems. Recommended that there should be; - more information about what therapies are available and how they may be accessed - development of care pathways for different problems and diseases - address the needs of specific groups especially the elderly and ethnic minorities
2004	Choosing Health; making healthier life choices, Department of Health [28]	Public health white paper setting out priority areas for new funding, including; - smoking cessation - tackling obesity and increasing exercise - sexual health - alcohol - address mental health issues including extending the sure start programs and tackling mild to moderate mental health problems in the workplace - public health research

2004	Mental health and social exclusion: a social exclusion unit report, Office of the Deputy Prime Minister [13]	Recognises that loneliness, social isolation and poverty constitute major problems for older people as both a precursor and precipitant of mental health problems. It recommends actions to build community capacity so that individuals and families have options other than professional services for their symptoms of distress, including; - a program to dispel to negative attitudes about mental illness - supporting families and communities - addressing access to basics such as housing, transport, money advice, etc. - target-setting to increase the employment rates of people with disabilities, reduce child poverty and reduce deaths from suicide
2005	National Service Framework for long term conditions, Department of Health [24]	Sets eleven quality requirements for services to support people with long term conditions including; - person centred care - early recognition and diagnosis - appropriate emergency management - community support - attention to special needs in hospital - palliative care - support for carers
2005	Securing better mental health for older adults, National Directors of Older Peoples Services and Mental Health [26]	Position statement, launching a new initiative to join forces across mental health and older peoples services to tackle older peoples mental health
2005	Everybody's business; integrated mental health services for older adults; a service development guide, Department of Health and Care Services Improvement Partnership [14]	Guide describing the key elements of a comprehensive older peoples mental health service, designed to inform local discussion on commissioning. Laid out the components of an ideal older peoples mental health service and included specifications on the regarding; - assessment - home care and primary care - day services - housing - telecare - intermediate services - general acute hospital services - liaison services - Community Mental Health Services - Specialist services including memory assessment services, psychology services, services for prisoners and older adults with learning difficulties
2005	The state of social care in England 2004-2005, Commission for Social Care Inspection [38]	First comprehensive overview of social care in England. Suggested that more work needs to be done by councils working closely with partners to avoid unnecessary admissions to hospital and drive up the quality of services
2005	Who cares wins, British Geriatric Society & the Royal College of Psychiatry [39]	Drew attention to the problem of mental illness in older adults admitted to general hospitals. Called for the development of specialist liaison mental health services for older people
2006	Securing good long-term care for older people: taking a Long-term view, King's Fund [37]	Review of social care commissioned by the Kings Fund from Sir Derek Wanless. Sought to determine how much should be spent on social care for older people in England over the next 20 years and what funding needs to be in place to secure high quality outcomes. On dementia, it highlighted the need for better information on costs, service and numbers affected, need for increases in trained staff and good quality care in care homes.
2006	Living well in later life, a review of progress against the NSF for older people, Healthcare Commission, Audit Commission and Commission for Social Care Inspection [36]	Found progress in some areas but found that still further work to do. For example there was still evidence of explicit discrimination in mental health services for older people
2006	A new ambition for old age: Next steps in implementing the National Service Framework for Older People, Department of Health and Care Services Improvement Partnership [12]	Sets out priorities for the second half of the 10 year National Service Framework for Older People under three themes: Dignity in Care, Joined-Up Care and Healthy Ageing. Consists of ten programmes driven nationally (one of which is mental health in old age)
2006	Supporting people – promoting independence, Commission for Social	Reviewed the impact that the Government's Supporting People programme had had on the lives of social care service users

	Care Inspection [35]	in terms of allowing more to live independently. Found that many people had benefited where high performing councils had used the programme to improve joint working with housing and health services. But older people had received the least amount of grant despite making up the largest group in the programme. Development of "extra-care" housing for older people had generally excluded those with mental health needs. Step-down support was not sufficiently developed. More information about the programme needed to be provided to users and advocacy services that assist people.
2006	Raising the Standard. Specialist services for older people with mental illness, The Royal College of Psychiatry: Report of the Faculty of Old Age Psychiatry [34]	Made a wide range of recommendations to improve services for older people's mental health including the need for a higher priority to be given to the topic by the Department of Health. Also addressed training in older people's mental health issues, mental health liaison services in acute hospitals, community services and the development of fully comprehensive old age psychiatry services in all localities. Its recommendation on incentivisation of GPs to record and monitor patients with dementia
2006	Promoting mental health and well-being in later life. The first report from the UK inquiry into mental health and well-being in later life, Age Concern and Mental Health Foundation [2]	The first report from an independent inquiry into mental health and well-being in later life. Recommends action to remove the barriers that prevent older people from participating in society. Encourages local authorities to take a lead role in partnership with the NHS, voluntary organisations, business representatives, community groups and individuals to develop programmes that promote positive mental health and well-being in later life.
2007	Indicators of Public Health in the English Regions – No 7. Mental Health, Association of Public Health Observatories [33]	Part of a series of reports looking at indicators on a major health policy area that would help to present information on the relative positions of the English Regions and inform the implementation of national and regional priorities. Selected over 70 indicators to help inform commissioning, local specialist providers, GPs, service users and carers.
2007	Dementia UK, Alzheimer's society with King's College London and London School of Economics [15]	An overview of the prevalence and cost of dementia in the UK. Establishes an estimate of the numbers of people in the UK who currently have dementia, and trends expected to 2051. Estimates Current and future costs of dementia and makes recommendations for future dementia care.
2007	Improving services and support for people with dementia, National Audit Office [16]	Similar report to that of the Alzheimer's society. Made recommendations on; - improving diagnosis and early intervention - improving support in the community - gearing up the mental health system as a whole to respond to the challenges of dementia in the future
2007	Commissioning framework for Health and well-being, Department of Health [25]	Document is to help commissioners to negotiate personalised services, promote health and well-being, proactively prevent ill health, and work in partnership to reduce health inequalities by focusing on outcomes for children and adults. The framework identifies nine steps to more effective commissioning: - Putting people at the centre of commissioning by giving people greater choice and control over services and treatments (including self-care), and access to good information and advice to support these choices. - Understanding the needs of populations and individuals through joint strategic needs assessments - Sharing and using information more effectively - Assuring high quality providers for all services - Recognising the interdependence between work, health and - well-being - Developing incentives for commissioning for health and well-being - Local accountability - Addressing capability and leadership
2007	Improving services and support for older people with mental health problems, The second report from the UK inquiry into mental health and well-being in later life, Age Concern[7]	Second report from the independent inquiry into mental health in older people. The report again reiterates the high prevalence of mental illness amongst older people and reviews the current provision of mental health services for older people. It recommends five main areas for action; 1. ending discrimination, including removing age barriers to accessing services 2. prioritising prevention 3. enabling older people to help themselves and help each other 4. improving current services 5. facilitating change and new service models

Table 27: Summary of local policies relevant to older people's mental health

Date	Local Documents	Summary
1999	Annual report of the Director of Public Health; Mental Health in Oxfordshire, Oxfordshire Health Authority [62]	Oxfordshire Health Authority DPH Annual Report focused on mental health in the county and highlighted 31 specific needs that should be considered in the development of the Oxfordshire Health Improvement Programs (HImP)
2006	Mental Health and Well-being in the South East, Department of Health and Care Services Improvement Partnership [48]	Reviewed mental illness and mental health service provision across the South East region. Only included working age population. Recommended; the need for a greater emphasis on promoting well-being in children exploit opportunities for earlier prevention to tackle alcohol related violence an integrated approach balancing tackling risk factors with an emphasis on promoting protective factors for mental, physical and social well-being in a comprehensive way challenge stigma and discrimination
2007	Oxfordshire social and community services commissioning strategy for older people, 2007 -2010, Oxfordshire County Council [47]	Sets out a strategy for the development and delivery of a broad range of services for older people in Oxfordshire. Based on the following values of ; person centred care focus on prevention and promoting independence applying best value principles being jointly commissioned taking a whole systems view of the impact upon other parts of the service
2007	Oxfordshire Mental Health Strategy 2007 – 2012 [21]	County-wide strategy looking at a shared vision for the development of mental health services, especially focusing on; access to services choice and flexibility of treatment and care partnership working social inclusion of service users support for carers quality of services Suggests that the priorities for development include; Need for health and social care commissioners and providers to work together to develop detailed strategy for the development of services for older people in Oxfordshire. Need to establish services for older people with mental illness including mental health promotion Need for early assessment and diagnosis Need to address issues of access to specialist services Need to address the presentation of social care performance data so that a proper analysis of how well older adults mental health social care target are being met Need to develop links with learning disabilities services for older people with learning difficulties Need for a 'whole system commissioning strategy'
2007	Oxfordshire Primary Care Trust Draft Strategy 2007 – 2012 [46]	Outlines the PCT's vision, aims and strategic commissioning priorities for the next five years (2007 – 2012), aiming to move from a reactive 'sickness' service towards a pro-active health and well-being service for the county. Includes the aim to provide 'a better deal' for older people by focusing on older peoples physical and mental health services, particularly; Tackling avoidable admissions to hospital by developing single referral pathways and intermediate care services for older people with mental health problems. Preventing people from becoming unwell. Providing more services in the community. Improving our understanding of the economic impact of the growing population and of how we might get a better return for older people on the investment we make in services for them.

Appendix 3

Table 28: List of interviewees, key informants and individuals consulted

Name	Organisation	Method
Susanne Jones	Service Development Manager-older people, Oxfordshire PCT	Steering Committee
Juliet Long	Service Development Manager-mental health, Oxfordshire PCT	Steering Committee
Lester Lee	Director of Services, Age Concern Oxfordshire City and County	Steering Committee
Daphne Marsden	Service Development Manager-adults, OBMHT	Steering Committee
Carol Bannister	Clinical Director and Consultant Psychiatrist – Older Adults, OBMHT	Steering Committee
Moira Gilroy	Unit Manager for Provider services, Oxfordshire PCT	Steering Committee
Varsha Raja	Strategic Commissioning for older people, Oxfordshire County Council	Steering Committee
Patrick Taylor	Director, MIND Oxfordshire	Steering Committee
Joyce Ruiz	Alzheimer's Society Oxon	Steering Committee
Adam Darowski	Consultant Geratology, Oxford Radcliffe Hospitals NHS Trust	Steering Committee
Professor Gordon Wilcock	Professor of Geratology, Oxford Radcliffe Hospitals NHS Trust	Steering Committee
David Janes	Coordinator, Manzil Dementia Carers group, Cowley, Oxford	Face-to-face interview
Carers and older people with dementia patients in Oxfordshire	ISIS Dementia Carers group, Henley Carers Group	Face-to-face interviews
Carers and older people with dementia patients in Oxfordshire	The Manor Nursing Home, Merton, Oxon	Face-to-face interviews
Dina Rodriguez	Nurse Manager, The Manor Nursing Home, Merton, Oxon	Face-to-face interview
Carers and older people with dementia patients in Oxfordshire	Wardington House Nursing Home, North Banbury, Oxon	Telephone interviews
Pauline Turner	Care Manager, Greenwood Day Centre for older people with LD, Banbury, Oxon	Face-to-face interview
Carers and older people with LD in Oxfordshire	Greenwood Day Centre for older people with LD	Focus group
Health advocates for minority ethnic population	Jennifer Siu (Chinese Community in Oxfordshire)	Telephone interviews
Dennis Hambridge	Management Committee Member, Gay Oxford LBGT	Telephone interview

Table 29: List of individuals and organisations consulted on the draft

Name	Title and Organisation
Steering Committee Members	
Sue Lygo	Decision Support, Oxfordshire PCT
Angela Baker	Health Improvement Principal – Adults, Oxfordshire PCT
Kate King	Health Improvement Practitioner – Adults, Oxfordshire PCT
Bryony Brown	Health Improvement Practitioner – Carers, Oxfordshire PCT
Rupert McShane	Consultant in Old Age Psychiatry, OBMH
Health Overview and Scrutiny Committee	Oxfordshire County Council
Val Messenger	Public Health Consultant, Oxfordshire PCT
Jonathan McWilliam	Director of Public Health, Oxfordshire PCT
David Janes	Patient Advocate, OBMH and Manzil Carers Group
Sarah Gibson	CPN and organiser of dementia carers groups across South Oxfordshire, OBMH
Tom Birmingham	CPN and organiser of dementia carers groups across South Oxfordshire, OBMH
Anne Ambler	Health Improvement Practitioner – Public Health in Practice Based Commissioning, Oxfordshire PCT
Julie Dandridge	Head of Medicines Management, Oxfordshire PCT
Meg Barbour	ISIS carers group, Oxfordshire
Dina Rodriguez	Nursing Manager, The Manor Nursing Home for patients with dementia, Merton, Oxon
Nurse Manager	Wardington Nursing Home for patients with dementia, North Banbury, Oxon

Appendix 4

Appendix 5

Specifications for the GP data extract (July2007)

Target Population

Currently registered patients aged 65 and over. The output will show patients NHS number, age and sex.

	Item Collected	Outcome
APOP	Currently registered Practice population aged 65 and over Broken down into 5 year age bands: **65-69, 70-74, 75-79, 80-84, 85+**	Number and % of the older practice population *(require age sex breakdowns for age sex standardisation)*

A. Prevalence of mental health problems in older people

	Indicator Description	Outcome	Read Codes
A1.	Older people with diagnosis of Schizophrenia & related psychoses recorded at any time, *excluding those with schizophrenia resolved codes*	Number and % of APOP	**Eu2%, E10% E11z, E11z0, E11zz, E1124, E1134, E12% E13%(excluding E135) E2122 Exclude those with codes: 212T. 212W. 212X.**
A2.	Older people with diagnosis of Bipolar affective disorder recorded at any time, *excluding those with Bipolar resolved codes*	Number and % of APOP	**Eu30%, Eu31%, E110%, E11y%(excluding E11y2) E111, E114-E117z. Exclude those with codes 212T. 212V.**
A3.	Older people with diagnosis of Dementia recorded at any time	Number and % of APOP	**Use Contract codes**
A4.	Older people with diagnosis either of Depressive disorder or Anxiety disorder recorded within the last 12 months	Number and % of APOP	**Eu32%, Eu33%, Eu34%, Eu3y%, Eu3z%, Eu 4%, E11y2, E11z2,E112% E113% E118, E135, E2B%, E20%, E26%, E27%, E28%, E29%.**
A5.	Older people with diagnosis of Alcohol abuse recorded within the last 12 months	Number and % of APOP	**Eu10%, E01%, E23% E250% E23-2**
A6.	Older people with diagnosis of Drug abuse recorded within the last 12 months	Number and % of APOP	**Eu11%, Eu12%, Eu13%, Eu14%, Eu16%, Eu18%, Eu19% Eu1A% E24% E25%(excluding E250, E251)**

B. Review of older people with Severe Mental Illness (SMI)

	Indicator Description	Outcome	Read Codes
SMIPOP	Older people with SMI (combination of A1 and A2 and anyone over 65 prescribed lithium within last 12 months)	Number and % of APOP	**Read codes for A1, A2 & Contract codes for on lithium (d6% excluding patients with 665B. lithium stopped)**
B1.	Number of SMIPOP with a mental health review recorded within the last 15 months	Number and % of SMIPOP	**6A6.. Mental health review 8BM0. Mental health medication review**
B2.	Number of SMIPOP with a medication review recorded within the last 15 months	Number and % of SMIPOP	**8BM0. Mental health medication review 8B3S. Medication review 8B3V. Medication review done 8BIH. Medication review done by doctor**

			8BIy. Medication review done by nurse **8BIC. Medication review done by pharmacist** **8BMH. Medication review done by pharmacy technician** **8B3x. Medication review with patient** **8B314 Medication review**
B3.	Number of SMIPOP with an assessment of suicide risk recorded within the last 15 months	Number and % of SMIPOP	**38B0. Suicide risk assessment** **1BD% Harmful thoughts**
B4.	Number of SMIPOP with a blood pressure recorded within the last 5 years	Number and % of SMIPOP	**Contract codes**
B5.	Number of SMIPOP with On Care Programme Approach ever recorded	Number and % of SMIPOP	**8CG% Care programme approach level**
B6.	Number of SMIPOP with Key worker ever recorded	Number and % of SMIPOP	**918B. CPA key worker**
B7.	Number of SMIPOP with a Carer ever recorded	Number and % of SMIPOP	**918F. Has a carer**

C. Mental health prescribing for older patients

	Indicator Description	Outcome	Read Codes
C1.	Number of APOP with antipsychotic prescription issued in last 6 months	Number and % of APOP	**Use relevant BNF codes**
C2.	Number of APOP with antidepressant prescription issued in last 6 months	Number and % of APOP	**Use relevant BNF codes**
C3.	Number of APOP with anxiolytic/ hypnotic prescription issued in last 6 months	Number and % of APOP	**Use relevant BNF codes**

D. Assessment & Prescribing for Dementia

	Indicator Description	Outcome	Read Codes
D1.	Number of A3 with annual review for dementia recorded	Number and % of A3	**6AB.. Dementia annual review**
D2.	Number of A3 with MMSE score within the last 12 months	Number and % of A3	**388m. MMSE score**
D3.	Number of A3 with ADL assessment within the last 12 months	Number and % of A3	**39F.. Barthel ADL index**
D4.	Number of A3 with prescription for anti-cholinergic medication within the last 36 months (earliest)	Number and % of A3	Drugs from BNF heading 4.11, especially: Donepezil Galantamine Rivastigmine Memantine hydrochloride
D5.	Number of D4 with medication review recorded within 6 months of first prescription for anti-cholinergic medication	Number and % of D4	**Codes as for B2**
D6	Number of D4 on anti-cholinergic medication for longer than 18 months	Number and % of D4	**As in D4**
D6	Number of D4 on anti-cholinergic medication for 36 months	Number and % of D4	**As in D4**

E. Prevalence of Chronic Disease in Older people

Cancer

	Indicator Description	Outcome	Read Codes
E1.	Number of APOP with Cancer diagnosed within the previous 18 months	Number and % of APOP	**Use Contract codes**

CHD

	Indicator Description	Outcome	Read Codes
E2.	Number of APOP with Heart Failure ever	Number and % of APOP	**Use Contract codes**
E3.	Number of APOP who have had an MI ever	Number and % of APOP	**Use Contract codes**
E4.	Number of APOP with Angina ever	Number and % of APOP	**Use Contract codes**

Diabetes

	Indicator Description	Outcome	Read Codes
E5.	Number of APOP with Type 1 Diabetes ever	Number and % of APOP	**Use Contract codes**
E6.	Number of E5 with one or more of these complications: *amputees* *diabetic retinopathy* *foot ulcers*	Number and % of E5 Show total number with 1 or more complication then by each complication ie number with amputation, number with foot ulcer etc	**Amputees** 7L06% Amputation of leg 7L07% Amputation of foot 7L08% Amputation of toe 2G42. - 2G47. 2G56. O/E - Amputated right forefoot 2G57. O/E - Amputated left forefoot 2G61. O/E - Amputated right toe 2G62. O/E - Amputated left toe **Retinopathy** F420% Diabetic retinopathy 2BBP. - 2BBV. **2BBo. O/E sight threatening diabetic retinopathy** **C10E7 Type 1 diabetes mellitus with retinopathy** **C1087 Insulin dependent DM with retinopathy** **C1096 Non-insulin-dependent DM with retinopathy** **Foot Ulcer** M2710 Ischaemic ulcer diabetic foot M2711 Neuropathic diabetic ulcer - foot M2712 Mixed diabetic ulcer – foot C10E5 Type 1 diabetes mellitus with ulcer 2G54. O/E - Right foot ulcer 2G55. O/E - Left foot ulcer 2G5H. O/E - Right diabetic foot – ulcerated 2G5L. O/E - Left diabetic foot – ulcerated 2G5S. O/E - right healed foot ulcer 2G5T. O/E - left healed foot ulcer

			2G5V. O/E - right chronic diabetic foot ulcer 2G5W. O/E - left chronic diabetic foot ulcer C10E3 Type 1 diabetes mellitus with multiple complications
E7.	Number of APOP with Type 2 Diabetes ever	Number and % of APOP	**Use Contract codes**
E8.	Number of E7with one or more of these complications: *amputees* *diabetic retinopathy* *foot ulcers*	Number and % of E7	**Codes as for E6 apart from:** **Replace C10E7 with C10F6 (T2 with retinopathy)** **Replace C10E5 with C10F4 (T2 with Ulcer)** **Replace C10E3 with C10F3 (T2 multiple complications)**

Muscular Skeletal conditions

	Indicator Description	Outcome	Read Codes
E9.	Number of APOP with Osteoporosis ever	Number and % of APOP	**N330% Osteoporosis, N3312 - N331B N331H- N331M**
E10.	Number of APOP with Osteoarthritis ever	Number and % of APOP	**N05% Osteoarthritis, N05z%Osteoarthritis NOS**
E11.	Number of APOP with Rheumatoid Arthritis ever	Number and % of APOP	**N040% Rheumatoid arthritis, F3964 Myopathy due to rheumatoid arthritis F3712 Polyneuropathy in rheumatoid arthritis N04X. Seropositive rheumatoid arthritis NOS**
E12.	Number of APOP with Hip Fracture ever	Number and % of APOP	**S30% Hip fracture S30y Hip fracture NOS S4E% Fracture-dislocation or subluxation hip 7K1L4 Closed reduction of fracture of hip**

Neurological conditions (not inc stroke)

	Indicator Description	Outcome	Read Codes
E13.	Number of APOP with Parkinson's ever	Number and % of APOP	**F12% Parkinson's disease**
E14.	Number of APOP with other neurological conditions ever (count of how many)	Number and % of APOP	**F2% Other central nervous system disorders (excluding F25% and F26%)**

Palliative Care

	Indicator Description	Outcome	Read Codes
E15.	Number of APOP receiving palliative care (latest)	Number and % of APOP	**8CM1. On GSF palliative care 8BA2. Terminal care 8BAN. Community specialist palliative care 8BAP. Specialist palliative care 8BAR. Specialist PC treatment - inpatient 8BAS. Specialist PC treatment - daycare 8BAT. Specialist PC treatment - outpatient 8BJ1. Palliative treatment 8HH6. Referral to Macmillan nurse**

			8H7g. Referral to palliative care service **8HH7. Referred community specialist PC team** **8H7L. Refer for terminal care** **8HY.. Referral to hospice** **8HX% Admission to hospice** **66S3. Full care by hospice** **66S4. Shared care - hospice / GP** **9Nh0. Under care of community PC team**

Pulmonary

	Indicator Description	Outcome	Read Codes
E16.	Number of APOP with COPD ever	Number and % of APOP	**Use Contract codes**
E17.	Number of APOP with active asthma ever	Number and % of APOP	**Use Contract codes and rules ie exclude those with diagnosis who have <u>not</u> been prescribed asthma related drugs in the previous 12 months.**

Stroke

	Indicator Description	Outcome	Read Codes
E18.	Number of APOP who have had a TIA ever	Number and % of APOP	**Use Contract codes**
E19.	Number of APOP who have had a Stroke ever	Number and % of APOP	**Use Contract codes**

F. Recording of Lifestyle data

	Indicator Description	Outcome	Read Codes
F1.	Number of APOP whose latest smoking record shows current smoker.	Number and % of APOP	**137,1372-1376,137C-137D,137G-137H,137J,137M,137P-137R,137V,137X-137h**
F2.	Number of APOP with **BMI of 25–29.9** (latest record in last 5 years)	Number and % of APOP	**22K + value**
F3	Number of APOP with **BMI of 30–34.9**(latest record in last 5 years)	Number and % of APOP	**22K + value**
F4	Number of APOP with **BMI of 35–39.9** (latest record in last 5 years)	Number and % of APOP	**22K + value**
F5	Number of APOP with **BMI of 40 or more** (latest record in last 5 years)		**22K + value**
F6.	Number of F2 and F3 with waist circumference measured (latest record in last 5 years)	Number and % of F2 and F3	**22N0. Waist circumference** **22N8. Abdominal circumference**
F7.	Number of APOP with high BP defined as **>/=160mmHg systolic <u>or</u> >/=100mmHg diastolic** (latest record in last 5 years)	Number and % of APOP	**246%**
F8.	Number of APOP with high cholesterol >5mmol (latest record in last 5 years)	Number and % of APOP	**Use contract codes**
F9.	Number of APOP with statins prescribed in the last 6 months	Number and % of APOP	**8B6A. Statin prophylaxis** **bxi.. ATORVASTATIN**

			bxk.. ROSUVASTATIN **bxg.. FLUVASTATIN SODIUM** **bxe.. PRAVASTATIN SODIUM** **bxd.. SIMVASTATIN**
F10.	Number of APOP with exception code for statins ever *This question needs to be asked of Older patients who are NOT on statins ie excluding F9*	Number and % of APOP excluding F9	**8I27. Statins contraindicated** **8I3C. Statin declined** **8I63. Statin not indicated** **U60CA [X]Statin causing adverse effect in therapeutic use** **TJC24 Adverse reaction to simvastatin** **TJC25 Adverse reaction to pravastatin** **8I76. Statin not tolerated**
F11.	Number of APOP with Pneumococcal vaccination (latest)	Number and % of APOP	**6572%**
F12.	Number of APOP with contraindication for Pneumococcal vaccination ever	Number and % of APOP Excluding F11	**8I2E, 8I3Q, 68NX**

G. Other

	Indicator Description	**Outcome**	**Read Codes**
G1.	Number of APOP with poor vision ever	Number and % of APOP	**F49% Blindness and low vision** **F46%Cataract (excluding F460)** **F41% Retinal detachments and defects** **F42% Other retinal disorders** **F45% Glaucoma** **F4B% Corneal opacity & other cornea disorders** **F43% Chorioretinal inflammations scars and other disorders of choroid** **P33%Congenital cataract and lens anomalies** **6688. Registered partially sighted** **668B. Poor visual acuity**
G2.	Number of APOP registered blind ever	Number and % of APOP	**6689. Registered blind**
G3.	Number of APOP with hearing problems ever	Number and % of APOP	**F59%Hearing loss** **F582. Unspecified sudden hearing loss** **F5801 Presbyacusis** **2DG Hearing aid worn** **1C12 Hearing difficulty** **1C13% Deafness** **1C16 Deteriorating hearing** **1C17 Hearing aid problem**
G4.	Number of APOP with continence problems ever	Number and % of APOP	**16F Double incontinence** **1A23 Incontinence of urine** **1A24. Stress incontinence** **1A26. Urge incontinence of urine**

			R076% [D]Incontinence of faeces **3930 Bowels: incontinent** **3940 Bladder: incontinent** **19E2. Soiling - encopresis**
G5.	Number of APOP with continence problems in last 5 years	Number and % of APOP	**Codes as for G4**
G6.	Number of APOP disabled or with disability status ever	Number and % of APOP	**13VC2 Disability – severe** **13VC3 Chronic physical disability** **13VC4 Poor adaptation to disability** **13VC5 Registered disabled** **13VCZ Disability NOS** **13VL Sensory disability** **13VM Physical disability**
G7.	Number of APOP with falls recorded (latest)	Number and % of APOP	**16D% Falls** **U10% [X]Falls** **TC% Accidental falls**
G8.	Number of APOP with Mobility problems (latest)	Number and % of APOP	**13CE. Mobility poor** **13CD. Mobility very poor** **3980. Immobile** **13C5. Confined to chair** **13C6. Bed-ridden** **13CA. Housebound** **13CP. Impaired mobility** **13C4. Needs walking aid in home** **39B2. Tripod/quadrupod: walking** **39B3. Uses zimmer frame** **39BZ. Other walking aid** **N097% Difficulty in walking** **3981. Independent in wheelchair** **3982. Minimal help in wheelchair** **398A. Dependent on helper pushing wheelchair**

H. Multiple Problems

	Indicator Description	Outcome	Read Codes
H1.	Number of APOP with 4 or more chronic disease conditions	Number and % of APOP	**4 or more of the following:** **A1 to A7, E1 to E5, E7, E9 to E18, G1 to G6**
H2.	Number of APOP on 4 or more medications within the last 6 months	Number and % of APOP	

NB The target population for this last query is the adult practice population i.e. currently registered patients aged 16+ with a record of being a carer.

I. Carers

	Indicator Description	Outcome	Read Codes
I1.	Practice population recorded as Carers (latest)	Number and % of practice population	**918A. Carer**

Appendix 6

Questionnaire sent to key informants requesting their views on the mental health needs of older people

Which section of the community can you describe?
What age group/ gender?
Any specific ethnic/ religious groups?
People who live in a specific area?
Are there any other defining characteristics of the group?
What mental health disorders/ conditions do you feel have a significant impact on this group?
Which other things do you feel have a significant impact on the mental health of the older population in Oxfordshire? These could be about; • People's behaviours (e.g. smoking, exercise, diet, use of drugs, etc.) • The local community and social networks • People's living and working conditions (including income, employment, education, housing, transport and food)
From the things that you have already mentioned, which do you feel are the five most important bearing in mind; • How many people does the issue affect? • How much does the issue affect their health?
Are there any of those five issues that cannot be changed? Changes could be made by; • Individuals themselves • Statutory or voluntary groups in the area or local authority district

Example of letter sent to service users and carers requesting their participation in this consultation

Do you feel that your mental health needs of your relative and yourself are being addressed?

Tell us your views on mental health services

Date

Dear Relative/ Carer,

Oxfordshire Primary Care Trust is currently looking at the mental health services currently provided and also the mental health needs of older people living in Oxfordshire.

We feel that carers like yourself play an essential part in ensuring the well-being of your relatives.

We are keen to talk to you about mental health services, and any needs that you or your relative have or may have had.

If you would like to contribute to our consultation then please contact the telephone number below.

Kind regards,

Dr Hoang

Oxfordshire PCT
Dept of Public Health
Jubilee House
Oxford Business Park South
OX4 2LH

Tel: 01865-336892
Email: uytrong.hoang@nhs.net

Oxfordshire Primary Care Trust

Older peoples Mental Health Needs Assessment

	Please tick
I am happy to talk about the provision of mental health services and the mental health needs of myself or my relative	☐
I am *NOT* happy to talk about the provision of mental health services and the mental health needs of myself or my relative	☐

Signed……..

Print Name…….

Please return to;

Dr Hoang

Oxfordshire PCT
Dept of Public Health
Jubilee House
Oxford Business Park South
OX4 2LH

Tel: 01865-336892
Email: uytrong.hoang@nhs.net

Appendix 7

Epi = **Epidemiological Needs Assessment**, method of identifying needs by examining shortfalls in current practices using routinely collected data. The needs identified using this method are likely to be representative of the average older person within Oxfordshire as this method uses data collected from the entire older population of Oxfordshire or alternatively a representative sample of older people

Norm = **Normative Needs Assessment**, method of identifying needs by comparing current practices to improve health with recommended best practices from national/ international guidelines. The needs identified by this method are stipulations by local and national organisations, and may not be representative of the views and needs of all older people within Oxfordshire

Corp = **Corporate Needs Assessment**, method of identifying needs by interviewing interested parties (stakeholders) including service users and carers for subjective opinions on where services could be improved. These needs are perceived by the older people, carers and service providers interviewed and may not be representative of the mental health needs of the general population of older people within Oxfordshire, as the methodology used in this study deliberately sampled the views of representatives from communities that are difficult to reach and have not traditionally been included in needs assessments undertaken by the PCT in the past.

Impact = the relative extent of the need with the population

Chang = changeability, the likelihood that measures can be taken to successfully address the need

Table 30: List of Needs

Need	*Epi*	*Norm*	*Corp*	Impact	Chang	Rank
1. Need for agreed care pathways for older people with mental health problems						***1***
a) Need for clear pathways of care for the detection, initial assessment (incorporating contact and overview assessment within the Single Assessment Process), initial management and specialist referral of older people with mental illness, including depression and dementia and symptoms of mental distress, which is developed for the Oxfordshire community across organisations, and covers the whole intervention from diagnosis to terminal care.		X	X			
b) Need to acknowledge that older people with mental illness can often present as acute medical/ surgical emergencies, and to ensure that there are a range of suitable and expedient alternatives to in-patient admission			X			
c) Need for earlier diagnosis of dementia, including appropriate early referral for assessment and management		X	X			
d) Need for appropriate and timely information on the health and social services available to patients and carers following diagnosis			X			
e) The diagnosis of dementia or other mental illness needs to be conducted in a setting that allows the			X			

Need	*Epi*	*Norm*	*Corp*	Impact	Chang	Rank
diagnosis to be conveyed to the patient and carer with sensitivity and in confidence						
f) Need for regular review of dementia patients who are currently prescribed anti-dementia medications as per NICE guidance and priorities forum protocol	X	X				
g) Need to investigate the higher rates of inpatient admission for patients with psychosis than the national average within Oxfordshire	X					
h) Need to investigate the lower rates of inpatient admission for patients with dementia than the national average within Oxfordshire	X					
2. *Developing the health and social care workforce, and increasing expertise in mental health*						***2***
a) need to raise awareness of symptoms of mental distress and mental illness in older people amongst general health and social care staff. This work should be led by the liaison psychiatry service		X	X			
b) need to raise awareness of mental illness amongst GPs and other care staff responsible for older people			X			
c) need to map the current level of training and skills mix within the social and healthcare workforce to assess the capacity to deliver an appropriate, timely and high quality service for older clients with mental illness in line with NICE and other national guidance			X			
d) need for workforce development strategy to increase the knowledge, skills and capacity of the health and social services workforce to handle older people with mental illness			X			
e) need for better information and support to nursing and other healthcare staff about mental health issues involved in the care of older patients in residential and nursing homes		X	X			
f) need for on-going training of health and social care staff on mental health issues to ensure that skills and knowledge are maintained and updated			X			
3. *Ensuring a range of health and social care services that offer timely, appropriate and high quality care closer to home for older people with mental illness*						**3**
a) need to look at different ways of working to enable the provision of timely, appropriate and high quality mental health services to older people			X			
b) need for development of care outside the acute phase of older people with mental illness, including day care opportunities			X			
c) Need to develop a range of services closer to patient's homes including 'step-down' support for those returning home after discharge from acute care and intermediate care services for those who need more support on a temporary basis and specialist care for those clients with both physical/ mental health needs or intensive mental health needs		X	X			
d) Need for more care home beds which can cater to the older population with dementia in Oxfordshire, ensuring that dementia patients can be cared for closer to their families			X			
4. *Focus on carers and the supportive unit around individuals*						***4***
a) need for better data about carers, including the number of carers and distribution across Oxfordshire and their needs			X			
b) need for the provision of more respite care services across Oxfordshire which is flexible enough to fit around the lives of patients and carers			X			
c) need to keep carers informed of any treatment changes for their loved ones			X			
d) need for service providers to recognise the valuable role of carers and the stress they are under, provide		X	X			

Need	*Epi*	*Norm*	*Corp*	Impact	Chang	Rank
timely support or help if they can no longer carry on						
e) need for clinicians to be sensitive to the distress that stopping anti-dementia medication may cause			X			
5. *Preventing mental illness by promoting and supporting healthy ageing and active citizenship*						***5***
a) need to ensure mental health prevention strategies for older people that are properly resourced and well integrated with other health promotion programs to encourage healthy aging and social inclusion		X	X			
b) need for mental health programs to be sustained in the long-term			X			
c) need to emphasise general well-being and good health in later life as a prerequisite for good mental health		X	X			
d) need to address the problems of social isolation and loneliness amongst older people, especially the elderly living within Oxford City and isolated BME communities living within the rural districts	X	X	X			
e) Need to incorporate carers into mental health promotion programs both as recipients and active participants			X			
f) need to address the wider determinants of mental health including the provision of adequate housing and accommodation, ensuring safe communities and equipping older people with practical 'skills for life'		X	X			
6. *Raising awareness of mental illness and mental health services amongst older people, and decreasing the stigma of mental illness*						
a) need to increase awareness of the features of the most common mental illness amongst older people and how older people may access help for their problems, especially amongst members of the BME (Black and minority ethnic) communities in Oxfordshire		X	X			
7. *Building stronger, more resilience individuals, families and communities*						
a) need to address the dual problems of age discrimination and the stigma of mental illness amongst older people suffering from mental health problems		X	X			
b) need to promote dignity-in-care and to ensure that older people with mental illness are treated with respect especially by healthcare providers		X	X			
8. *Joined-up services*						
a) need for more joined up planning and provision of services by health, social services and other key stakeholders for older people with mental illness, including ensuring that any newly commissioned care pathways effectively link with existing physical and mental healthcare initiatives such as the falls service where			X			
b) need to develop a shared vision of the future mental health services for older people living in Oxfordshire that is agreed between health services, social services and other key stakeholders		X				
c) Need to improve communication and liaison between the many different social and healthcare service providers who care for older clients with mental illness to ensure that clients receive a seamless service			X			
9. *Addressing the divide between adult and older peoples services*						
a) need to address the artificial divide between adult and older peoples mental health services, especially for individuals with severe enduring mental illness where there is a risk that they may 'fall through the net' and for people with learning difficulties who may have develop psychological and functional symptoms of old age prior to the age of 65			X			
b) need to raise the awareness of younger onset (pre-senile) dementia in individuals under 65 years who do not fit the stereotype of the patient with dementia			X			

Need	*Epi*	*Norm*	*Corp*	Impact	Chang	Rank
10. *Addressing the divide between physical and mental health services*						
a) Need to address the perceived inequality in the funding and provision of mental health services versus physical health services			X			
b) Need to ensure that mental health issues are assessed and appropriately managed when older patients are admitted with a physical health compliant			X			
11. *Acknowledging and addressing the issues behind the demographic changes*						
a) need to raise awareness amongst all the main providers and commissioners of mental healthcare of the substantial expected growth in the older population within Oxfordshire, especially amongst the most frail elderly over the age of 85 years	X	X	X			
b) commissioning plans also need to take into account the expected increase in the incidence of dementia and depression across Oxfordshire within the next few decades	X	X				
c) need to raise awareness of older peoples active contribution to families, communities, and the economy and to encourage their continued support		X				
12. *Finances*						
a) need for service providers to recognise the financial impact of mental illness on the individual, their carers and families			X			
b) need for individuals and their carers to be given better information about the cost of nursing and residential care, and the sources of further information and financial support that are available locally			X			
c) need for privately funded patients to be offered SW assessments to see if they are applicable for any assistance with the cost of their care			X			
13. *Research*						
a) need to increase the evidence base about what works in older peoples mental health, including what preventative interventions are effective in decreasing the incidence of mental illness and what treatment modalities are most effective for the major causes of mental health morbidity in older people		X				

Appendix 8

Table 31: List of services provided for older people with mental health problems in Oxfordshire

Name of Service Provider / Organisation	Summary of Functions Provided	Area of County	Type of Service/Base	Client Group	Days Open	Operational Time
Voluntary Day Services for people with mental health needs 2006 - 7						
Abingdon Alzheimers Club (Ref:26 VSC)		Vale	Day Centre	Mon, Wed-Fri. severe EMI People/Tues for M/Confused	MTWF	9.30 - 3.30pm
Age Concern Oxfordshire City and County		County wide	Flexible Community Support for Carers	Carers of Adults with Dementia	7 days as required	as required
Age Concern Oxfordshire City and County		Vale	Day Centre	Older People, Older People with MH needs	M W F	10.00 - 3.00pm
Age Concern Oxfordshire City and County		South	Day Centre	Older People with MH needs	M W Th F	9.30 - 3.30pm
Age Concern Oxfordshire City and County		South	Day Centre	Older People with MH needs	W Th	10.00 - 3.00pm
Age Concern Oxfordshire City and County		Vale	Day Centre	Older People with MH needs	TWF	10.00 - 3.00pm
Age Concern Oxfordshire City and County		County wide	Client Support Service	OP (MH)		9.00am to 5.00pm
Anchor Trust		Cherwell	Day Centre	Frail Older People who may have moderate dementia	M TO F	10.00 - 3.30pm
Agnes Smith		Blackbird Leys	Information centre	frail OP and OP with MH needs	Tues (OP MH)	
Bampton Bush Day Centre		West	Day Centre	OP, OP(MH), PD	Wed	10am-2.30pm
British Red Cross		County wide	Transport	OP, OP(MH), PD		Varies
Chalgrove Day Centre		South	Day Centre	Tues/Frail Older People, Friday OP MH needs	T F	10.00 - 2.00pm
Clive Project		County wide	Carers Support as per care plan	Adults under 65 with Dementia	weekly service	as and when required

Name of Service Provider / Organisation	Summary of Functions Provided	Area of County	Type of Service/Base	Client Group	Days Open	Operational Time
Daybreak Oxford (Ref. 25VSC		Cherwell	Day Centre	Older People with MH needs	M W F	9.30 - 3.30pm
Daybreak Oxford (Ref. 25VSC		City	Day Centre	Older People with MH needs	M T	9.30 - 3.30pm
Dialability Helpline and Disability Living Centre		County wide	Advice and Information Service and Disability Living Centre	OP, OP(MH), PD		10am-4pm
Elms Day Centre, The(Ref:31VSC		West	Day Centre	OP, OP(MH)	M to F	10.00 - 4.00pm
October Club (Ref:34VSC)		Vale	Day Centre	Older People with MH problems inc. Dementia	M W F	9.00 - 3.00pm
Oxfordshire Advocacy Development Group			Advocacy	People with Mental Health and Learning Disabilities who cannot advocate for themselves	M to F	9.00am to 5.00pm
The Salvation Army		Hart Day Centre		Frail OP, OP MH		
LIP Carers Service						
Carers Grant projects						
S&CS Relief to Care service to support carers	by provision of replacement care	Oxfordshire	In the Home and community	18+ including 65+MH	All	
S&CS Support for carers of Older persons	by provision of breaks	Oxfordshire	Residential and community	65+	All	
Carers Centres Direct Access Support for carers	Breaks, services, support, advocacy, information, training, & carer support workers	Oxfordshire	3 Carers Centres - Oxford, N&W, S&V, Community and in the home	All ages including 65+ MH	Weekdays	
S&CS Carers Services	One off Direct Payments to carers for services to support that particular carer such as housework, gardening, holiday, wellbeing services	Oxfordshire	Community and in the home	All ages including 65+ MH	All	
Age Concern Flexible Care Services	Flexible care to support carers and person cared for	Oxfordshire	Age Concern, Abingdon office, Community	? 60 or 65+	?	

Name of Service Provider / Organisation	Summary of Functions Provided	Area of County	Type of Service/Base	Client Group	Days Open	Operational Time
Range of projects for carers from Black and Minority ethnic groups S&CS and Carers Centre Oxford	Support and services for carers across BME groups	Oxfordshire and projects at Oxford City Carers Centre	Community and Carers Centre Oxford	All ages including 65+ MH	Weekdays	
All ages including 65+MH	Advocacy/consultation for carers	Oxfordshire	Whitney Office, represents views across Community & to Statutory sector	All ages including 65+MH	Weekdays	
Shotover Resource Centre	Day care breaks and support services	Primarily Oxford City	Centre in Headington	Adults with PD and Older People who are mentally or physically frail	Weekdays & Saturday for carers breaks	
Willow Day Centre	Day Care Breaks	Oxford City	Centre in Cowley?	65+ Dementia	Weekdays	
Volunteer Befriending Service North & West Oxfordshire Carers Centre	Befriending service to give carers breaks using volunteers trained and coordinated by the NW Carers Centre	N&W Oxfordshire	Community and in the home	Adults including OP 65+ with MH needs	Weekdays	
Clive Project	One to one and group support for younger people with dementia and their family and friends	Oxfordshire	Community and in the home	Younger people with dementia	Weekdays + (not certain)	
Carers in Oxfordshire Website	www.oxoncarers.org.uk Information to support carers and professionals	Oxfordshire	Hosted by Oxfordshire County Council in partnership with Oxford Carers Centre Information Project	All care groups including OPMH	24-Jul	
Alzheimer's Society Carer Support Workers	Carer support workers	Oxfordshire	Community	Carers of Adults with Alzheimer's	Weekdays?	
Service Mapping across Oxon Local Implementation Team LIT						
Service Mapping across Oxon Local Implementation Team LIT						
Psychiatric Liaison Nursing within the Single Point of Access to Rehabilitation and Care	Psychiatric Liaison Service for Older Adults	Oxfordshire	John Radcliffe Hospital, Horton Hospital	65-100	Weekdays	
Emergency Duty Team (EDT)	EDT provides a social work response out of office hours	Oxfordshire	County Hall, Oxford	16-100	Evenings and W/E	

Name of Service Provider / Organisation	Summary of Functions Provided	Area of County	Type of Service/Base	Client Group	Days Open	Operational Time
Inpatient care - Cherwell Ward, Fulbrook Centre	17 bedded inpatient unit	Oxfordshire	Headington	65+	All	
Inpatient care - Sandford Ward, Fulbrook Centre	17 bedded inpatient unit	Oxfordshire	Headington	65+	All	
Inpatient care - Windrush Ward, Fulbrook Centre	20 bedded inpatient unit	Oxfordshire	Headington	65+	All	
Inpatient care - Fiennes Ward, Banbury	17 bedded inpatient unit	Oxfordshire	Banbury	65+	All	
Abingdon CMHT	Multi-disciplinary mental health team providing community, memory clinic and out patient services to older people Snap shot caseload Aug 2007 - 421 people	Abingdon and Wallingford	Abingdon	65+	Weekdays	
Oxford CMHT	as above. Snapshot caseload Aug 2007 – 927 people	Oxford City	Manzil Centre, Oxford	65+		
Didcot and Farringdon CMHT	as above. Snapshot caseload Aug 2007 - 386 people	Didcot and Farringdon area	Ridgeway Day Hospital, Didcot	65+		
Henley and Goring CMHT	as above. Snapshot caseload Aug 2007 - 294 people	Henley and Goring	Townlands Hospital, Henley	65+		
North Oxfordshire CMHT	as above. Snapshot caseload Aug 2007 – 955 people	North Oxfordshire	Fiennes Centre, Horton Hospital	65+		
West Oxfordshire CMHT	as above. Snapshot caseload Aug 2007 – 488 people	West Oxfordshire	Nuffield Health Centre, Witney	65+		
Thame CMHT	as above. Snapshot caseload Aug 2007 – 255 people	Thame and Wheatley	Wykeham Park Thame			
Outpatients and memory clinics and carers support	Provided as an integral service with the CMHTs	Oxfordshire		65+		
Day services - Oxford City Day services	Providing a range of therapuetic groups in the community and groups and individual support to clients attending day centres, Aug 2007 - 59 people on caseload	Oxford City	Manzil way	65+	Weekdays	
Day services - North Day services	as above. Aug 2007 caseload – 196 people	North Oxfordshire	Fiennes Centre, Horton Hospital	65+	Weekdays	
Day hospitals/treatments services - South East Day services	Aug 2007 - 56 people on caseload	Abingdon	Abingdon	65+	Weekdays	

Name of Service Provider / Organisation	Summary of Functions Provided	Area of County	Type of Service/Base	Client Group	Days Open	Operational Time
Day hospitals/treatments services - South West Day services	Aug 2007 - 140 patients on caseload	South West and West Oxfordshire	Nuffield Health Centre, Whitney	65+	Weekdays	
Day centre (voluntary) - the Archway Foundation	Day Centres/Resource Centre/Drop-in	Oxfordshire	Headington, Oxford	18-99	Weekdays	
Day centre (voluntary) - Oxfordshire Chinese Community and Advice Centre	Day Centres/Resource Centre/Drop-in	Oxfordshire	Oxford	18-85	some weekdays	
Day centre (voluntary) - Railway Lane Club Littlemore	Day Centres/Resource Centre/Drop-in	Oxfordshire	Littlemore Village Hall	18-99	some weekdays	
Day centre (voluntary) - Springboard Family Project	Day Centres/Resource Centre/Drop-in	Oxfordshire	Carterton	up to 99	some weekdays	
Day Care at home						
Assistive technology and telecare						
GPs with specialist interest in mental illness in older adults						
Graduate primary care workers - older adults						
Residential Care - residential	Morrell Crescent supported housing (response) - 33 beds		Oxford	18-95	All	
Residential Care - residential	St Gabriels supported housing (response) - 33 beds		Oxford	18-95	All	
Residential Care - nursing						
Extra Care Housing						
Sheltered housing						
Intermediate care						
Learning disabilities services for older people						
services for pre-senile dementia						
Employment services - Bridewell Organic Gardens						

Name of Service Provider / Organisation	Summary of Functions Provided	Area of County	Type of Service/Base	Client Group	Days Open	Operational Time
Employment services - Root and Branch	Therapeutic horticulture and craft activities	Oxfordshire	Wilcote	18-99	some weekdays	
Advice and information services for older people	Therapeutic gardening and craft project	Oxfordshire	Watchfield	18-99	some weekdays	
Advocacy services for older people	Oxfordshire MIND Crisis Line	Oxfordshire				
Befriending and voluntary schemes	Age Concern helpline	Oxfordshire				
Lunch clubs						
Self-help and mutual aid groups						
Carers support groups/service-Connection Floating Support	Floating support to enable people to maintain accommodation and access services and engage with life.	Oxfordshire	Oxford	16-99	Weekdays	
Sitting services						
Care and repair schemes						

Appendix 9

Mental illness amongst older people in the Community

Table 32: Estimated annual prevalence of older people with dementia in Oxfordshire

Age group	Prevalence %	2004 population (thousands)	Annual prevalence (thousands)
65-69	1.4	24.3	0.3
70-74	4.1	20.9	0.9
75-79	5.7	17.6	1.0
80-84	13	14.2	1.8
85+	21.6	11	2.4
Total 65+	-	88	Total = 5.5

Source for prevalence figures: Hofman et al, 1991[63]

Table 33: New cases of dementia over 75 years using 2004 as the baseline

AGE GROUP	Annual incidence of mild or greater dementia%	2004 population (thousands)	Annual incidence (thousands)
75-79	2.3	17.6	0.4
80-84	4.6	14.2	0.65
85+	8.35	11	0.92
Total 75+	-	42.8	1.97

Source for incidence figures: Paykel et al, 1998[64]

Table 34: Estimated annual prevalence of older people with significant depressive symptoms (GDS score >3) in Oxfordshire

Gender	Age group	% GDS10 score >3	2004 population (thousands)	GDS10>3 prevalence (thousands)
MALE	65-69	19	12.1	2.3
	70-74	18	10	1.8
	75-79	22	7.8	1.7
	80-84	31	5.5	1.7
	85+	40	3.2	1.3
FEMALE	65-69	20	12.2	2.4
	70-74	24	10.9	2.6
	75-79	27	9.8	2.6
	80-84	39	8.7	3.4
	85+	43	7.8	3.4
Total	65+	-	88	23.2

Source for prevalence figures: Health Survey for England, 2005[3]

Table 35: Estimated annual prevalence of older people with depressive illness (GDS score >3) in Oxfordshire

Age group	Prevalence %	2004 population (thousands)	Annual prevalence (thousands)
65+	lower limit 10	88.8	8.8
	upper limit 15		13.3
	severe 2		1.8

Source for prevalence figures: Anderson et al, 2001[65], Beekman et al, 1999[66]

Table 36: Estimated annual prevalence of older people with anxiety disorder in Oxfordshire

Age group	Prevalence %	2004 population (thousands)	Annual prevalence (thousands)
65+	15	88.8	13.3

Source: Manela et al, 1996[67]

Table 37: Estimated annual prevalence of alcohol misuse (>21 units in men and >14 units in women) amongst older people within Oxfordshire

Gender	Age group	Prevalence %	2004 population (thousands)	Annual prevalence (thousands)
MALE	65+	5	38.6	1.9
FEMALE	65+	2.5	49.4	1.2
Total	-	-	88	3.1

Source: Hajat et al, 2004[68]

Mental illness amongst older people seen within primary care

Table 38: Estimated annual number of older people consulting for all mental disorders in general practice within Oxfordshire (ICD 290-319)

Age group	2004 population (thousands)	Annual consulting rates per 10k	Annual number of patients consulting in general practice
65-74	45.2	918.0	4149
75+	42.8	1260.0	5393
Total	88	-	9542

Source for prevalence figures: weekly returns database, from the Birmingham research unit of the RCP, 2004

Table 39: Estimated annual number of older people consulting for organic psychotic conditions in general practice within Oxfordshire (ICD 290-294)

Age group	2004 population (thousands)	Annual consulting rates per 10k	Annual number of patients consulting in general practice
65-74	45.2	38.0	172
75+	42.8	287.0	1228
Total	88	-	1400

Source for prevalence figures: weekly returns database, from the Birmingham research unit of the RCP, 2004

Table 40: Estimated annual number of older people consulting for senile/ pre-senile organic psychosis in general practice within Oxfordshire (ICD 290)

Age group	2004 population (thousands)	Annual consulting rates per 10k	Annual number of patients consulting in general practice
65-74	45.2	23.0	104
75+	42.8	221.0	946
Total	88	-	1050

Source for prevalence figures: weekly returns database, from the Birmingham research unit of the RCP, 2004

Table 41: Estimated annual number of older people consulting for psychosis in general practice within Oxfordshire (ICD 295 - 299)

Age group	2004 population (thousands)	Annual consulting rates per 10k	Annual number of patients consulting in general practice
65-74	45.2	106.0	479
75+	42.8	120.0	514
Total	88	-	993

Source for prevalence figures: weekly returns database, from the Birmingham research unit of the RCP, 2004

Table 42: Estimated annual number of older people consulting for affective psychosis in general practice within Oxfordshire (ICD 296)

Age group	2004 population (thousands)	annual consulting rates per 10k	Annual number of patients consulting in general practice
65-74	45.2	76.0	344
75+	42.8	88.0	377
Total	88	-	721

Source for prevalence figures: weekly returns database, from the Birmingham research unit of the RCP, 2004

Table 43: Estimated annual number of older people consulting for neurotic personality and other mental disorders in general practice within Oxfordshire (ICD 300 - 316)

Age group	2004 population (thousands)	annual consulting rates per 10k	Annual number of patients consulting in general practice
65-74	45.2	698.0	3155
75+	42.8	734.0	3142
Total	88	-	6297

Source for prevalence figures: weekly returns database, from the Birmingham research unit of the RCP, 2004

Table 44: Estimated annual number of older people consulting for neurotic disorders in general practice within Oxfordshire (ICD 300)

Age group	2004 population (thousands)	annual consulting rates per 10k	Annual number of patients consulting in general practice
65-74	45.2	340.0	1537
75+	42.8	395.0	1691
Total	88	-	3228

Source for prevalence figures: weekly returns database, from the Birmingham research unit of the RCP, 2004

Mental illness amongst older people seen within intermediate care

Table 45: Number of episodes for each diagnosis code

Community hospital site	ICD10 code	Financial Year		% change	Grand Total
		2005-06	2006-07		
ABINGDON HOSPITAL	F01	4	3		7
	F20		1		1
	F32		1		1
	F41	2			2
ABINGDON HOSPITAL Total		**6**	**5**	**-17%**	**11**
BICESTER HOSPITAL	F01		2		2
	F32	1			1
BICESTER HOSPITAL Total		**1**	**2**	**+50%**	**3**
CHIPPING NORTON HOSPITAL	F01	1			1
	F32	1			1
	F41	1	1		2
CHIPPING NORTON HOSPITAL Total		**3**	**1**		**4**
DIDCOT HOSPITAL	F01	3	5		8
	F10		1		1
	F41	2			2
DIDCOT HOSPITAL Total		**5**	**6**	**+17%**	**11**
OXFORD COMMUNITY HOSPITAL	F32		1		1
ST MICHAELS HOSPITAL (WARWICK)	F33	1			1

WITNEY COMMUNITY HOSPITAL	F01	6	5		11
	F03		1		1
	F10		1		1
	F32	1			1
	F41	1			1
	F50	1			1
WITNEY COMMUNITY HOSPITAL Total		**9**	**7**		**16**
Grand Total		**25**	**22**	**-12%**	**47**

Source: Decision Support Team, Oxfordshire PCT

Table 46: Average length of stay for each diagnosis code

Site	ICD 10 code	Financial Year		% change	Grand Total
		2005-06	2006-07		
ABINGDON HOSPITAL	F01	42.25	62.33		50.86
	F20		101.00		101.00
	F32		4.00		4.00
	F41	16.00			16.00
ABINGDON HOSPITAL Total		**33.50**	**58.40**	**+74%**	**44.82**
BICESTER HOSPITAL	F01		26.00		26.00
	F32	32.00			32.00
BICESTER HOSPITAL Total		**32.00**	**26.00**	**-19%**	**28.00**
CHIPPING NORTON HOSPITAL	F01	44.00			44.00
	F32	48.00			48.00
	F41	13.00	5.00		9.00
CHIPPING NORTON HOSPITAL Total		**35.00**	**5.00**	**-86%**	**27.50**
DIDCOT HOSPITAL	F01	47.00	81.00		68.25
	F10		7.00		7.00
	F41	7.50			7.50
DIDCOT HOSPITAL Total		**31.20**	**68.67**	**+120%**	**51.64**
OXFORD COMMUNITY HOSPITAL	F32		138.00		138.00
ST MICHAELS HOSPITAL (WARWICK)	F33	31.00			31.00
WITNEY COMMUNITY HOSPITAL	F01	61.83	75.60		68.09
	F03		16.00		16.00
	F10		9.00		9.00
	F32	60.00			60.00
	F41	25.00			25.00
	F50	60.00			60.00
WITNEY COMMUNITY HOSPITAL Total		**57.33**	**57.57**		**57.44**
Average LOS overall for all community hospitals		**41.64**	**59.18**	**+42%**	**49.85**

Source: Decision Support Team, Oxfordshire PCT

Mental illness amongst older people seen within secondary care

Table 47: Inpatient admissions for elderly residents at Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust by the number of completed consultant episodes

	2004/ 05	2005/ 06
>65	339	263
>85	65	71

Source: Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust

Table 48: Top 10 main diagnoses for completed consultant episodes for Oxfordshire residents aged over 65 admitted to Oxfordshire & Buckinghamshire Mental Health NHS Trust, 2004/05 to 2005/06

2004/2005		2005/2006	
Unspecified dementia	113	Depressive episode, unspecified	94
Depressive episode, unspecified	92	Unspecified dementia	77
Other/ non-specific symptoms & signs involving cognitive function and awareness	12	Bipolar affective disorder, unspecified	16
Bipolar affective disorder, unspecified	11	Other/ non-specific symptoms & signs involving cognitive function and awareness	14
Schizophrenia	9	Schizophrenia	12
Alzheimer's disease, unspecified	9	Depressive episode, severe depressive episode with psychotic symptoms	12
Dementia in Alzheimer's disease, unspecified	7	Depressive episode, severe depressive episode without psychotic symptoms	9
Persistent delusional disorders, delusional disorder	7	Dementia in Alzheimer's disease with late onset	6
Depressive episode, severe depressive episode with psychotic symptoms	7	Other anxiety disorders, unspecified	6
Depressive episode, severe depressive episode without psychotic symptoms	7	Persistent delusional disorders, delusional disorder	5

Source: Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust

Table 49: All in-patients admissions related to mental health (all providers) - April 2003 to March 2007

				Not adjusted for deprivation				
Group	**Adm.**	**Pop.**	**Rate/k**	**Exp.**	**Rate/k**	**SAR**	**Low**	**High**
ALL	4155	91566	11.34	4168	11.38	99.7	96.7	102.8
Senility and organic mental disorders	2431	91566	6.64	2552.9	6.97	**95.2**	91.5	99.1
Other psychoses	781	91566	2.13	592.7	1.62	**131.8**	122.7	141.3
Affective disorders	589	91566	1.61	555.8	1.52	106	97.6	114.9
Alcohol-related mental disorders	129	91566	0.35	121.7	0.33	106	88.5	126
Anxiety somatoform dissociative and personality disorders	111	91566	0.3	137.5	0.38	**80.7**	66.4	97.2
Schizophrenia and related disorders	64	91566	0.17	98.7	0.27	**64.8**	49.9	82.8
Other mental conditions	40	91566	0.11	97.3	0.27	**41.1**	29.4	56
Preadult disorders	5	91566	0.01	1.4	0	**362.5**	116.8	845.9
Substance-related mental disorders	4	91566	0.01	4.9	0.01	81.9	22	209.8
Mental retardation	1	91566	0	5.1	0.01	19.5	0.3	108.5

Source: Extracts from Dr Foster (2007)

Table 50: Length of stay (LoS) for all in-patients admission related to mental health (all providers)

	2005/06				2006/07			
Age groups	Inpatients	Average LOS	Expected LoS	Diff	Inpatients	Average LOS	Expected LoS	Diff
ALL	3240	32.1	44.2	-12.1	2687	45.4	44.6	0.7
0-64	2103	29.7	48.4	-18.7	1646	50.7	51.4	-0.7
65-69	104	44.5	50.4	**-5.9**	100	45.4	38.4	**7**
70-74	125	47.9	45.8	**2**	95	48.6	44	**4.6**
75-79	153	38.1	39.5	**-1.3**	154	48.5	46.7	**1.8**
80-84	267	39.5	38.3	**1.2**	263	40	35.3	**4.8**
85-89	262	33.7	33.6	**0.1**	245	30.3	27.4	**2.9**
90-94	177	26.7	24.3	**2.3**	127	25.8	23.7	**2.1**
95+	49	19.6	23.6	**-4**	57	11.6	21.4	**-9.8**

Source: Extracts from Dr Foster

Table 51: Top 10 main diagnoses consuming the most hospital bed days for Oxfordshire residents aged 65 and over

2004/2005		2005/2006	
Fracture of femur	13494	Fracture of femur	12597
Unspecified dementia	11852	Unspecified dementia	10149
Pneumonia organism unspecified	8892	Other disorders of the urinary system	8833
Stroke not specified as haemorrhage or infarction	8341	Cerebral infarction	8426
Other disorders of urinary system	7936	Pneumonia organism unspecified	7657
Depressive episode	6538	Depressive episode	7427
Other COPD	6398	Stroke not specified as haemorrhage or infarction	7073
Heart failure	5890	Other COPD	6962
Syncope and collapse	5785	Unspecified acute lower respiratory tract infection	5776
Schizophrenia	4978	Senility	5720

Source: Hospital Episode Statistics

Table 52: Readmissions for ICD10 codes F0, F1, F3, F4 in 2006/07 that had a previous discharge within the preceding 28 days with the same ICD10 code (includes >65 years, for Oxfordshire PCT only, matched by NHS number)

Original admission code	Readmission admission code	ICD10 Code	ICD10	Readmissions
Elective	Elective	F019	Vascular dementia, unspecified	2
		F323	Severe depressive episode with psychotic symptoms	1
	Transfer	F03X	Unspecified dementia	2
Emergency	Emergency	F011	Multi-infarct dementia	1
		F019	Vascular dementia, unspecified	3
		F03X	Unspecified dementia	11
		F100	Mental & behavioural disorders due to use of alcohol: acute intoxication	8
		F106	Mental and behavioural disorders due to use of alcohol: amnesic syndrome	1
		F109	Mental & behavioural disorders due use alcohol: unspecified mental & behavioural disorders	1
		F410	Panic disorder [episodic paroxysmal anxiety]	3
		F419	Anxiety disorder, unspecified	2
	Transfer	F03X	Unspecified dementia	4
		F319	Bipolar affective disorder, unspecified	1
Transfer	Transfer	F011	Multi-infarct dementia	4
		F03X	Unspecified dementia	2
		F329	Depressive episode, unspecified	5
Grand Total				**51**

Source: Decision Support Team, Oxfordshire PCT

Table 53: Readmissions for ICD10 codes F0, F1, F2, F3, F4 by gender, age and ICD10 code, within the preceding 28 days with the same ICD10 code, 2006/07 (includes >65 years, for Oxfordshire PCT only, matched by NHS number)

Gender	Age	ICD10 Code	ICD10	Readmissions
Female	65	F319	Bipolar affective disorder, unspecified	1
	69	F410	Panic disorder [episodic paroxysmal anxiety]	2
	72	F419	Anxiety disorder, unspecified	1
	76	F323	Severe depressive episode with psychotic symptoms	1
	80	F03X	Unspecified dementia	2
		F100	Mental & behavioural disorders due to use of alcohol: acute intoxication	1
	81	F019	Vascular dementia, unspecified	1
	84	F011	Multi-infarct dementia	1
		F03X	Unspecified dementia	2
		F410	Panic disorder [episodic paroxysmal anxiety]	1
	86	F03X	Unspecified dementia	1
	87	F03X	Unspecified dementia	2
	88	F03X	Unspecified dementia	2
	92	F03X	Unspecified dementia	2
	96	F03X	Unspecified dementia	1
Male	66	F419	Anxiety disorder, unspecified	1
	67	F100	Mental & behavioural disorders due to use of alcohol: acute intoxication	1
	68	F100	Mental & behavioural disorders due to use of alcohol: acute intoxication	3
		F106	Mental and behavioural disorders due to use of alcohol: amnesic syndrome	1
	69	F100	Mental & behavioural disorders due to use of alcohol: acute intoxication	1
	71	F329	Depressive episode, unspecified	5
	73	F019	Vascular dementia, unspecified	1
	78	F019	Vascular dementia, unspecified	1
		F109	Mental & behavioural disorders due use alcohol: unspecified mental & behavioural disorders	1
	79	F011	Multi-infarct dementia	3
		F03X	Unspecified dementia	2
		F100	Mental & behavioural disorders due to use of alcohol: acute intoxication	1
	80	F011	Multi-infarct dementia	1
		F03X	Unspecified dementia	2
	81	F03X	Unspecified dementia	1
	82	F03X	Unspecified dementia	1
	83	F03X	Unspecified dementia	1
		F100	Mental & behavioural disorders due to use of alcohol: acute intoxication	1
	84	F019	Vascular dementia, unspecified	2
Grand Total				**51**

Source: Decision Support Team, Oxfordshire PCT

Appendix 10

Table 54: List of Faculty of Public Health learning contract competencies claimed

Competencies	Explanation	Phase of training
1.2	Undertake a brief health needs assessment for a defined population for a specific purpose using appropriate qualitative or quantitative methods and make recommendations for action	2
1.3	Use a range of methods of assessing morbidity and burden of disease within and between populations, both as ad hoc analysis and as part of systematic health surveillance	3
1.4	Analyse data of populations in specific geographical areas and in particular groups of people in order to assess health status, health inequalities, determinants and different needs to support prioritisation of action	3
1.5	Use a range of routine information sources and surveillance systems including, as a minimum, mortality, hospital admission, census, primary care, communicable disease, cancer registry, reproductive and sexual health data, and government surveys to support public health activity	3
1.7	Undertake a health needs assessment for a defined population for a specific purpose and demonstrate that this work has been considered at a high level in a relevant organisation	3
2.1	Generate an appropriate question in order to assess the evidence	1,2,3
2.3	Make use of others in finding and retrieving evidence (e.g. librarians, information specialists)	1,2,3
2.4	Define a literature search strategy with appropriate inclusion and exclusion criteria to find relevant evidence to answer a question	1,2,3
2.7	Use an appropriate framework to critically appraise evidence	1,2,3
2.8	Formulate a balanced, evidence-based recommendation explaining key public health concepts using appropriate reasoning, judgement and analytic skills in a public health setting	1,2,3
2.10	Communicate recommendations orally and in writing in order to influence decisions	1,2,3
2.14	Use an appropriate framework to critically appraise each of the following types of study: ecological, qualitative, aetiological, interventional, and economic	1
3.4	Propose evidence-based policy options for solving problems and develop appropriate strategy	1,2,3
4.8	Manage a project to successful completion within available resources and timescales	3
4.18	Identify and engage relevant stakeholders for a project to improve public health	2
8.1	Formulate and articulate problems so they can be addressed by using public health intelligence	1

Glossary

BME	Black and minority ethnic
CMHT	Community Mental Health Treatment Centres
CSIP	Care Services Improvement Partnership
EDT	Emergency Duty Team
FCE	Finished Consultant Episode
FPH	Faculty of Public Health
HDA	Health Development Agency
HNA	Health Needs Assessment
HRG	Health Resource Group
ICD10	International Classification of Disease, Version 10
LOS	Length of stay
NHS	National Health Service
NSF	National Service Framework
OBMH	Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust
ONS	Office of National Statistics
OP	Older people
OP (MH)	Older people (mental health)
ORH	Oxford Radcliffe Hospitals NHS Trust
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PD	Parkinson Disease
RITA	Record of In-Training Assessment
SE	South East
SOA	Super Output Area
SpR	Specialist Registrar
WHO	World Health Organisation

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