Mental Health and Old Age

Martin McShane
Domain Director
Long Term Conditions
Content

- Context
- Follow the money
- New approach
Parity – it isn't new!

*orandum est ut sit mens sana in corpore sano*

*Juvenal: Satire 10: 356*
Life expectancy at birth

Source: Social Trends 40: 2010 edition, ONS
Common mental health disorders

Source data: Adult Psychiatric Morbidity in England, 2007: Results of a household survey\(^6\). Copyright © 2011, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.
Dementia: a major challenge

![Bar chart showing percentage of men and women with dementia by age group. The chart indicates a higher percentage of women than men in each age group, with the exception of the 65-69 age group, where the percentage is lower for women.](image-url)

Years lost to disability

Loneliness – a risk factor

![Bar chart showing percentage of people who feel isolated or lonely by age group](chart.png)

Source data: ELSA 2009

Figure 24: Percentage of people aged 50+ years not living with a partner/spouse, who replied ‘Often’ as opposed to ‘Sometimes’ or ‘Hardly ever’ when asked if they felt isolated or lonely, England, 2009
Hidden and masked problem?

Figure 40: Adjusted odds ratios for those consulting a GP in the last year for a mental health problem: Comparison of older age groups with those aged 16-34 years, England, 2007

Source data: Cooper et al., 2010

16-34 (Reference)  35-54  55-74  75+

Adjusted odds ratio

1.0  0.9  0.7  0.3
Follow the money
People over 65 years of age account for:

- 70% of bed days within hospitals.
- 60% of hospital admissions/re-admissions
- 80% of delayed transfers
- 70% deaths in hospital
- 37% of primary care spending
- 60% of adult social care spending
- 46% of acute spending.\(^1\)

Year of Care Costs

Average costs by age group

<table>
<thead>
<tr>
<th>Age bands in years</th>
<th>Average cost per patient (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>569</td>
</tr>
<tr>
<td>25-29</td>
<td>652</td>
</tr>
<tr>
<td>30-34</td>
<td>615</td>
</tr>
<tr>
<td>35-39</td>
<td>581</td>
</tr>
<tr>
<td>40-44</td>
<td>647</td>
</tr>
<tr>
<td>45-49</td>
<td>592</td>
</tr>
<tr>
<td>50-54</td>
<td>655</td>
</tr>
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<td>55-59</td>
<td>739</td>
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<tr>
<td>60-64</td>
<td>953</td>
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<tr>
<td>65-69</td>
<td>1,066</td>
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<td>70-74</td>
<td>1,587</td>
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<tr>
<td>75-79</td>
<td>1,930</td>
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<tr>
<td>80-84</td>
<td>3,697</td>
</tr>
<tr>
<td>85+</td>
<td>4,665</td>
</tr>
</tbody>
</table>
Gearing of investment across the system

Primary Care
£200

Comm/MH
£500

Specialised
£300

Acute
£1000

£2000/head of population

Public Health
Social Care
(H&WB Board)

NHS England

CCGs
New system approach to care?
Newark and Sherwood Integrated Model of Care for Long Term Conditions

Workforce Development, Training and Education

1. **Level**
   - Public Health
   - Population wide Prevention
   - Disease awareness campaigns
   - Social marketing
   - Education
   - Health promotion
   - Schools

2. **Level**
   - **Low RISK / Complexity**
     - 21% - 100%
       - Proactive Self Care Support and Management in Primary Care
       - Risk score recorded and reviewed annually
     - Active Case Finding
     - Disease Register
     - Accurate diagnosis
     - Information Prescriptions
     - Care Planning
     - Education relevant to patients needs
     - Disease prevention and Health promotion

3. **Level**
   - **6-20%**
     - Proactive Disease Management by General Practice supported by specialist community services and teams
     - Care Planning and individualised Care plan
     - Support to Self Manage
     - Education Programmes
     - Annual Review
     - Specialist Medication reviews
     - Anticipatory Care
     - Remote monitoring via tele health where appropriate

4. **Level**
   - **0.6-5%**
     - Intensive disease / case management by specialist teams as part of the MDT
     - Telehealth / Telecare
     - Community Specialist Services and clinics with MDT support
     - Care Planning and individual personalised care plan
     - Planned Hospital Admission for those who need it and facilitated discharge via intermediate care to reduce LOS

5. **Level**
   - **Top 0.5%**
     - Community Matron / Virtual Ward as part of Multidisciplinary Team (Community Geriatrician, GP, Social Care, Therapists, Rehab, Domiciliary)
     - Care Planning and individual personalised care plan
     - Disease Specialist Input where required from specialist community teams (COPD, Diabetes)
     - Telehealth and Telecare
     - Baptheological
     - Planned hospital admission, proactive in reach and facilitated discharge via specialist support

**Co-ordinated Social Care**
- Personal Care Navigator / Named Lead
- Special Patient Notes / 24/7 Access to specialist support
- Admissions Avoidance

**Smoking Cessation, Health Promotion and Self Care**
- **LOW RISK / Complexity**
  - Smoking Cessation, Health Promotion and Self Care in Primary Care
  - Risk score recorded and reviewed annually
  - Active Case Finding
  - Disease Register
  - Accurate diagnosis
  - Information Prescriptions
  - Care Planning
  - Education relevant to patients needs
  - Disease prevention and Health promotion

**HIGH RISK / Complexity**
- Top 0.5%
  - Community Matron / Virtual Ward as part of Multidisciplinary Team (Community Geriatrician, GP, Social Care, Therapists, Rehab, Domiciliary)
- Care Planning and individual personalised care plan
- Disease Specialist Input where required from specialist community teams (COPD, Diabetes)
- Telehealth and Telecare
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**Public Health**
- Population wide Prevention
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- Schools

**Population wide Prevention**
- Disease prevention and Health promotion

**Disease awareness campaigns**
- Information Prescriptions
- Education relevant to patients needs

**Social marketing**
- Education relevant to patients needs

**Education**
- Information Prescriptions
- Education relevant to patients needs

**Health promotion**
- Health promotion
- Disease prevention and Health promotion

**Schools**
- Education relevant to patients needs

**Disease prevention and Health promotion**
- Information Prescriptions
- Education relevant to patients needs

**Personal Care Navigator / Named Lead**
- Special Patient Notes / 24/7 Access to specialist support

**Admissions Avoidance**
- Special Patient Notes / 24/7 Access to specialist support
Bridging the gap

INTEGRATED CARE
- Self-management
- Risk profiling
- Long Term Condition Management incl Cancer
- Locality teams
- Third sector provision
- Primary Care

SHIFT LEFT

COMPLEX CARE PRACTICE

ACUTE CARE
- Specialty Clinic
- Planned procedures
- ICU

Quality of life

Cost of Care per Day

0% - 100%
Person centred coordinated care

“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes”
The House of Care

Organisational and supporting processes

Engaged, informed individuals and carers

Person-centred coordinated care

Health and care professionals committed to partnership working

Commissioning
The House of Care in value to NHS:

£0.4-0.6bn: Avoidance of drug errors e.g. through electronic records/e-prescribing (7)

£1.2bn: Avoid ambulatory care sensitive admissions though e.g. following NICE guidelines (1)

£0.8bn: Reduction of hospital admissions for common LTCs through integrated care esp frailty, comorbid (2)

£0.2-0.4bn: Empower people in supportive self-management (4)

£5.5bn: Incentivised wellness programmes in healthy pop & early stage LTCs inc. smoking cessation, salt ↓, exercise ↑(6)

£0.8-1.2bn: Reduce use of low value drugs, devices and elective procedures using commissioning analytics and clinician education (3)

£1-1.6bn: Shift activity to cost effective settings e.g. pharmacy minor ailments (5)

£0.2-0.4bn: Avoidance of drug errors e.g. through electronic records/e-prescribing (7)
The House of Care in value to people/patients: The House supports National Voices ‘I’ statements

My goals/outcomes.
• All my needs as a person were assessed and taken into account.

Communication.
• I always knew who was the main person in charge of my care.

Emergencies.
• I had systems in place so that I could get help at an early stage to avoid a crisis.

Information.
• I could see my health and care records at any time to check what was going on.

Transitions.
• When I went to a new service, they knew who I was, and about my own views, preferences and circumstances.

Decision-making.
• I was as involved in discussions and decisions about my care and treatment as I wanted to be.

Care planning.
• I had regular reviews of my care and treatment, and of my care plan.
Commissioning better value mental health

- Intelligence
- Commissioning Development
- Service Improvement
- Physical health
- Crisis Concordat
Providers

• Better quality information
• Use it.....
Does the NHS measure what matters to patients?

<table>
<thead>
<tr>
<th>Classic NHS measure</th>
<th>Outcomes that matter to patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>Quality of life</td>
</tr>
<tr>
<td>Process measures/waiting times</td>
<td>Being supported to stay well</td>
</tr>
<tr>
<td>Clinical information</td>
<td>Being treated with dignity and respect</td>
</tr>
<tr>
<td>Patient safety data</td>
<td>Seamless and coordinated care</td>
</tr>
<tr>
<td></td>
<td>Being supported to make decisions</td>
</tr>
<tr>
<td></td>
<td>Services that listen to feedback and improve</td>
</tr>
</tbody>
</table>
Growing Old isn’t a bad thing!

Finally we should remember that the majority of older people report being fairly or very happy, and this changes little with advancing age.

• health status in later life is not fixed and immutable.

• With greater access to good quality prevention and treatment there remains substantial scope to enable older people to remain physically active, socially engaged and happy for longer.

• Perhaps the key to improving care is to recognise this opportunity and to move beyond the media stereotypes of later life being a largely unhappy and negative experience.

http://www.exeter.ac.uk/media/universityofexeter/medicalschool/pdfs/Health_Care_Quality_for_an_Active_Later_Life_2012.pdf
Chart 50: Happiness in later life - age makes little difference

Source data: Cooper et al (2010)\textsuperscript{131}

*Figure 50: Level of happiness reported by age group, England, 2007*
The good physician treats the disease; the great physician treats the patient who has the disease.

*William Osler*
Thank you.