Equality Impact Assessment

Name of project/proposal: Refresh of Joint Hampshire Commissioning Strategy for Older People’s Mental Health

Contact name: Catherine Pascoe

Department: Adult Services

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Purpose for project/proposal:

The Joint Hampshire Commissioning Strategy for Older People’s Mental Health (OPMH) set a direction of travel for 2008 – 2013 for all organisations and individuals involved in older people’s mental health services that reflected national good practice guidance and that we believed would improve outcomes for older people with mental health needs and their carer's.

The scale of the challenges facing Hampshire County Council Adult Services and NHS Hampshire Primary Care Trust, as was, in terms of population changes, growing demand for older people's mental health services and pressure on resources, meant that we had to do things differently.

By developing the strategy, we believed:

• There would be improvements to the quality of life for both the older person with mental health needs and their carer
• Effective interventions would promote independence and inclusion in society.
• Early diagnosis and treatment and no artificial barriers to access services in a mainstream or specialist mental health setting would enable:
  - a coordinated response to complex needs
  - planning to avoid crises and unnecessary admissions to hospital that can lead to increased dependency
  - access to effective specialist mental health services.

Much has changed since the strategy was first agreed and we have made significant progress in addressing some of the issues highlighted. However, population changes, growing demand for older people's mental health services and pressure on resources continue to challenge and if there is no further change to the way we currently deliver services, we will not be able to effectively manage this growing demand.


The new document is an update and refresh of the 2008-13 joint OPMH strategy and should be viewed alongside the original documentation, which can be found at: http://www3.hants.gov.uk/adult-services/bettertime/publications-strategies.htm.

The key commissioning priorities remain current. The refreshed document summarises the achievements to date and identifies the further key areas for action to enable us to meet the significant challenges ahead.

Consultation

Has a consultation been carried out? Yes

The original OPMH strategy was developed with wide engagement from statutory and voluntary agencies and carers, plus support from the Care Services Improvement Partnership. A Steering Group with membership from Hampshire County Council Adult Services, Hampshire Primary Care Trust, Hampshire Partnership NHS Trust, Surrey and Borders Partnership NHS Trust and the Alzheimer's Society oversaw developments. The Alzheimer's Society undertook a consultation exercise to find out what matters to people who use older people's mental health services across Hampshire, including meeting service users and their families/carers from gay, black, minority and ethnic groups.

There was also a full 3 month consultation period before the final version of the strategy was produced and signed off in 2008. Significant effort went into achieving cohesion with other Hampshire strategies, e.g. Older People's Wellbeing, Carers, Sheltered Care Extra Housing, Day Opportunities and Mental Health for Working Age Adults Strategies. Implementation of the strategy was overseen by a Partnership Board with representation from key stakeholders.

The refreshed document should be viewed alongside the original documentation. It is believed that the key headline commissioning priorities remain current. In order to support feedback on progress on implementation of the original strategy the refreshed document summarises the achievements to date, it then identifies the further key areas for action to enable us to meet the significant challenges ahead.

The refresh is also underpinned by the Development Vision for Improving Services for Older People in Hampshire, Commissioning Outline 2013-18, which was co-produced with the Older People’s Vision Development Group and the wider Older People’s Reference Group

A further 5 week engagement period aimed to check back that progress had been adequately captured and that stakeholders were happy with the proposed headline actions to be further progressed.
We now have 5 Clinical Commissioning Groups, (CCGs) in Hampshire. The implementation of the refreshed strategy will be taken forward at organisational and Clinical Commissioning Group level. Local Implementation Groups will be developed at CCG level and will involve a range of key stakeholders including people with dementia and their carers. Each local group will also ensure that there is two way engagement and involvement with local service user and carer groups to ensure wide representation as implementation progresses.

Statutory considerations

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<td>Age</td>
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Other policy considerations

Poverty: Medium
Rurality: Low
Other factors: Low
If other please describe:

Geographical impact: All Hampshire
Have you identified any medium or high impact?* Yes No

Equality statement

Much has changed since the original OPMH strategy was first agreed and we have made significant progress in addressing some of the issues highlighted. However, population changes, growing demand for older people’s mental health services and pressure on resources continue to challenge and if there is no further change to the way we currently deliver services, we will not be able to effectively manage this growing demand.

The joint commissioning strategy was produced to provide a framework to underpin development of services and support over the coming years. Working together across health and social care services and wider communities will provide a much more effective and coordinated response to complex needs and promote independence and inclusion in society.

The scope of the strategy is broad and reflects the care pathways for dementia and functional mental health from the promotion of health and well-being right through to end of life care. It not only covers health and social care services but also encompasses support from communities and universal services that can be accessed by the broader population. The strategy seeks to ensure that older people with mental health needs are actively considered in other linked key strategic developments such as Ageing Well in Hampshire: Older People’s Well-being Strategy, Extra care Housing Strategy, Carer’s Strategy, CCG Commissioning plans, Better Care Fund projects etc and provides a cohesive framework for considering needs.

The strategy specifically targets a relatively disadvantaged group with a view to promoting social inclusion and addressing barriers to accessing services and support that could potentially meet the needs of this group. Therefore, impacts around age and disability should be particularly high and should be largely positive.

The refreshed strategy is a high level document outlining the vision for services and the priorities and direction of travel up to 2017. It does not give detailed implementation plans. These will be completed at organisational and local CCG level. Any projects taken forward as part of the strategy implementation will be subject to individual Equalities Impact Assessments to ensure any specific negative equality impacts and most effective ways to tackle any inequalities are identified.

The following paragraphs highlight the protected characteristics where it is felt that the refreshed strategy could have a medium or high impact for people in these categories and proposes any actions required to mitigate against any negative impacts.

Age (High Impact):

Hampshire

Hampshire has an ageing population. There are currently 274,600 people aged 65 and over in Hampshire (POPPI, 2014) and this figure is predicted to increase to 396,500 by 2030, a rise of 44%
New Forest has the highest proportion of older people (aged 65 and over), 48,800, 17.8% of the Hampshire total.

The 85 and over population group is likely to be where the largest proportionate change will be seen. The risk of developing dementia increases with age, thus there will be a disproportionate increase in the numbers of people with dementia given the patterns of demographic change.

**Single households**

People are more likely to live alone than they were in the past. The 2011 Census found that 100,000 people over 65 in Hampshire live alone. The highest levels of single person households are found in New Forest (18,100) and Havant (10,300), and lowest in Gosport (5,800). Rising numbers of older and vulnerable people living alone raises concerns over their health and the impact on access to care and support for these groups.

**Younger onset dementia**

One of the misapprehensions of both the public and professionals alike is that dementia is a natural part of ageing. Although dementia is primarily an illness associated with older people, there are also a significant numbers of people, currently estimated to be around 348 (PANSI, 2014) people in Hampshire, who have developed dementia earlier in life and services for dementia should reflect this fact. Early-onset dementia can start at 30 years of age. Younger people with dementia are usually supported by services largely provided for older people, ie OPMH specialist services and older people's services in social care.

Clinicians may not easily recognise early-onset dementia and therefore may under-diagnose. Younger people with undiagnosed early-onset dementia can find themselves lost between services with no one taking responsibility for their care i.e. going between neurologists, psychiatrists or an old age psychiatrist. Obtaining an accurate diagnosis can be a difficult and prolonged process.

Younger people with early-onset dementia are more likely to have dependent children, heavy financial commitments and a partner who works. They themselves are more likely to be in employment at the time of diagnosis and will require their employers/HR professionals to be supportive and protect their employment rights.

**Specific issues:**

- The increasingly ageing population of the county as a whole, and in particular within the New Forest district, will put increasing pressure on health and social care services and budgets
- The rising number of older and vulnerable people living alone has an impact on access to care and support for these groups.
- Demographic changes will lead to a significant increase in the numbers of people with dementia in Hampshire who will require health and social care services.
- The needs of younger people who develop dementia must also be taken into account when developing OPMH services.

**Actions:**

- It is anticipated that implementation of the OPMH strategy should help to address the issues highlighted above and should have a positive impact on managing increasing demand.
- It is recommended that further more detailed local needs analysis is carried out at CCG level to support priority setting and implementation planning for the refreshed strategy.
- It is recommended that implementation projects falling under the refreshed OPMH strategy are subject to detailed equality impact assessment/equality analysis as plans are developed.
- It is recommended that specific focus is given in local implementation plans to improving support for younger people with dementia.

**Disability (High Impact):**

In Hampshire, 24% of the population over 65 years of age say they are 'limited a little' as a result of a long term condition and 18% are 'limited a lot' by their illness. The proportion of Hampshire’s population who are 'limited a lot' is below the level in both the South East and England and Wales. Across the county people are living with a range of disabilities and long term health conditions:

**Learning disability**

Figures relating to the number of people with a learning disability and dementia can be found at: Learning disability and dementia

Source: Dementia and People with Learning Disabilities: Guidance on the assessment, diagnosis, treatment and support of people with learning disabilities who develop dementia, Royal College of Psychiatry, 2009

It is acknowledged that the prevalence of dementia is higher in the population of people with learning disabilities than
in the general population, with an increased risk of developing dementia for those with Down Syndrome.

Implementation planning needs to take account of the particular needs of this group

**Chronic disease**

The number of people with long term conditions such as heart disease, diabetes and lung disease is increasing. This is partly due to the ageing population and the decreasing death rate at all ages, but also partly due to the increase in illnesses caused by unhealthy lifestyles and unequal life opportunities.

**Cardiovascular disease (CVD)**

In 2011 28% of deaths in Hampshire were attributable to CVD. The worst CVD outcomes are seen for Hampshire's least affluent residents. There also seem to be inequalities between the sexes. Women seem particularly at risk from strokes and are less likely to have access to planned hospital care.

The National Dementia Strategy tells us the current evidence base suggests that up to 50% of dementia cases may have a vascular component (ie vascular dementia or mixed dementia). This holds out the possibility of preventing or minimising dementia by means of promoting better cerebrovascular health.

Current health promotion messages on diet and lifestyle and actions such as health checks are therefore likely to have a positive effect on dementia rates. Providing public education that such changes may decrease the likelihood of developing dementia as well as heart disease can only help the impact of the campaigns overall. The message that what is good for the heart is good for the head is critical.

**Submission to engagement exercise from Stroke Association, Fareham and Gosport**

Whilst it is accepted not every condition can be included within this strategy, the Stroke Association would like to see acknowledgement of the implications on mental health for stroke survivors.

Their campaign 'The emotional impact of stroke' in 2013 surveyed 2700 people and found the following:

- Only two in ten stroke survivors were given information, advice and support on coping with the emotional impact of stroke.
- Almost two-thirds of stroke survivors agreed or strongly agreed that their emotional needs were not looked after as well as their physical needs.
- Although 67% of stroke survivors had experienced anxiety and 59% felt depressed, over half of those who responded to our survey did not receive information, advice or support to help with anxiety or depression.
- Two-thirds of carers had experienced difficulties in their personal relationships with a husband, wife or partner as a result of stroke. Of these, one in ten had broken up with their partner, or considered doing so.
- Caring gets harder as time goes by. For those who have been caring for up to three years 48% said they were stressed by caring, but when they had been caring for seven years or more 69% of carers said this was the case.

The Association felt that many mental health services are currently inaccessible for stroke survivors, particularly those with physical, communication or cognitive disability. They welcome a focus on this in the strategy going forward.

They recognise that not every individual condition can be named in the strategy, they support the emphasis on partnership which ensures open access and enabling services for those with combined health needs...i.e. making sure that people don't fall through the net because of diagnostic labelling (e.g. enabling people and carers of those with vascular dementia being able to access support even though diagnosis has given them a diagnostic label of "stroke"; e.g. enabling those with depression and mood changes consequent to stroke or impact of stroke – being able to access support even though diagnostic label is "stroke")

They also recognise that with age comes multiple pathology and support enablement for those with combined health needs and making support inclusive rather than exclusive to a single diagnosis/pathology.

They would like to see specific acknowledgement to the need for aphasia accessible information, especially enabling involvement of those without a personal advocate under the strategic aim of improving communication.

Re aphasia friendly information –this has knock on benefits for people with cognitive issues and people for whom English is not their first language.

On physical accessibility they note that available suitable transport and/or the cost of suitable transport can often prevent stroke survivors being able to take advantage of services on offer.
They identify that lack of suitable transport is without doubt the biggest obstacle faced by stroke survivors in accessing services and in having the kind of social contact which often protects against mental health problems.

**Diabetes**

The number of people with diabetes in Hampshire is increasing in line with the national trend. There were 57,092 people of all ages in Hampshire with known diabetes during 2011/12 and a further 13,000 people are estimated to have diabetes but have yet to be diagnosed. By 2020, there may be nearly 39,000 older people in Hampshire with diabetes. Diabetes is very strongly related to deprivation. The most deprived fifth of people living in Hampshire are more likely to have diabetes and three to five times more likely to develop serious complications and be admitted to hospital because of their diabetes, than the least deprived fifth. (Source: Hampshire Better Care Fund Equalities Impact Assessment)

**Mental health**

In general mental health appears to be better in Hampshire than England as a whole, but there are areas and groups that experience poorer mental health, often associated with deprivation and the wider determinants of health.

Within Hampshire it is estimated that 19,357 or 7% of the over 65 population are living with dementia (POPPI, 2014). By 2030 this number is predicted to have increased by 74% to 33,780. Within the 85 and over population the increase will be over 123%, at 9,686. Yet currently, only around half of those expected to have dementia seem to be receiving a diagnosis, though significant efforts are underway to improve this figure.

We also know that depression significant enough to warrant intervention, affects one in four older people living in the community, yet only one in three of these will discuss their condition with their GP and only half of those are diagnosed and treated. (Everybody’s Business). In 2014 it is estimated that in Hampshire there are around 7,500 older people with severe depression.

More than 2% of people aged 65 or over have had suicidal thoughts in the past year.


Older People with a mental health need account for a significant proportion of those who use health and social care services. (Everybody’s Business)

A conservative estimate is that around:

- 40% of people attending their GP
- 50% of all general hospital inpatients and
- 60% of care home residents have a mental health problem.

One third of people who care for an older person with dementia have depression.

The direct costs of dementia exceed the total costs of stroke, cancer and heart disease in cost of illness studies.

**Figures received from the National Development Team for Inclusion**

**Treatment for depression and anxiety (1.).**:

- Less than 0.5% of people aged 65 and over get referred to IAPT services for treatment of depression or anxiety
- Less than 0.2% of people aged 85 or over get referred to IAPT services for treatment of depression or anxiety

**Other mental health problems:**

- 1% of people aged 65 and over experience post traumatic stress disorder (6)
- 0.1% of people aged 65-74 have psychosis (including schizophrenia and bi-polar) (7)

**Alcohol misuse:**

- 2% of people aged 65 to 74 are dependent on alcohol (8)
- People aged 55 to 74 have the highest rate of alcohol related deaths of all age groups (9)
• The number of alcohol-related deaths among people aged 75 and over has increased to their highest level since records began. (10)

References


Specific issues:

• There are increasing numbers of people with a learning disability who are developing dementia and their particular needs will need consideration in implementation planning
• The number of people with long term conditions such as heart disease and diabetes is increasing.
• There is increasing evidence showing that the risk of developing dementia can be reduced by living a healthier lifestyle. In essence, what is good for the heart, is good for the head
• The prevalence of a number of long term conditions is strongly related to deprivation. In response, any focus on prevention as part of the implementation of the OPMH strategy should include a focus on neighbourhoods with the most concentrated deprivation: Leigh Park and Wecock Farm in Havant; Rowner and Town in Gosport; and pockets of localised deprivation in Aldershot, Andover, Basingstoke, and Blackfield and Holbury in New Forest. There needs to be a focus on the diagnosis of disease and supporting self-management and lifestyle changes
• People with mental health problems have significantly higher rates of mortality and morbidity from illnesses such as heart disease, stroke, diabetes, respiratory disease and infections. Projects included as part of implementation of the OPMH strategy should increase opportunities for physical health checks for people with mental health problems
• A significant amount of mental health need in older people is unrecognised and untreated.
• Due to the high level of comorbidities in older people, implementation planning for the OPMH strategy should also consider screening for dementia and other mental health needs as part of any other projects focussing on health checks for physical health needs.

Actions:

• It is anticipated that implementation of the OPMH strategy should help to address the issues highlighted above and should have a positive impact on managing demand and supporting those with a range of comorbidities
• The scope of the strategy is very broad, which presents us with significant challenges in terms of implementation. Alongside delivery of some specific OPMH projects that can be actioned by members of OPMH groups it will be necessary to use other change agendas to support deliver, such as the Care at Home Project, Extra-care Housing project, Integration project, etc, requiring shared broad understanding of the OPMH strategy and evidence based knowledge of what works regarding OPMH in the context of these other change agendas. Organisational ownership and commitment to implementation of the refreshed OPMH strategy and achieving synergy across workstreams will need to be clearly in place. The Hampshire OPMH Delivery Group and the Integrated Delivery Executive Group should support this.
• It is recommended that further more detailed local needs analysis is carried out at CCG level to support priority setting and implementation planning at local level for the refreshed strategy.
• It is recommended that implementation projects falling under the refreshed OPMH strategy are subject to detailed equality impact assessment/ equality analysis as plans are developed.
• It is recommended that specific focus is given in local implementation plans to improving support for people with learning disabilities and dementia
• It is recommended that priority is given to promoting the message that the risk of developing dementia can be reduced by living a healthier lifestyle. What’s good for the heart is good for the head.

Race (Medium impact)

Dementia is recognised as a worldwide health priority but research on dementia in general is poorly funded. Little is known about its relative prevalence in black and minority ethnic populations, although there is a growing body of evidence that the Black African-Caribbean community in the UK has a higher prevalence of vascular dementia than other communities. African-Caribbean elders have the highest incidence of high blood pressure compared to other BME groups. African-Caribbean and South Asian elders also have a high incidence of diabetes.
Black and minority ethnic older people with mental health problems and their carers need to have access to appropriate and responsive services.

**Specific issues**

Older people with mental health needs from black and minority ethnic communities face a number of potential barriers to effective assessment of their needs:


- There may be little awareness of older people's mental health issues within black and minority ethnic communities, for instance, Asian languages do not have an equivalent word for dementia. Symptoms may therefore be unrecognised or misunderstood.
- In some communities a lack of understanding and the stigma attached to mental illness may prevent families from seeking help. This may particularly be the case where the community culture places great emphasis on self-reliance.
- Language barriers may prevent people from receiving information about what is available and how to access help. Even where printed information in minority languages is available, this may not help those older people who have a limited level of literacy in their own language.
- Unfamiliarity with social care services, which may not exist in minority cultures, may prevent people from requesting services or lead to misunderstandings about their role. Medical services, which are better understood, and free from stigma, are often considered more acceptable than social care services. Low uptake of social care services by older people from minority ethnic communities may lead to demand being overlooked or underestimated by commissioners.
- The lack of a professional interpreting service may make it difficult for assessors who do not speak the older person's preferred language to conduct an effective assessment. The use of friends or family members as interpreters may compromise confidentiality or influence the assessment. Older people affected by dementia, who were once able to speak English as a second language, may lose the skill as their memory deteriorates. Even with good language skills, cultural differences may result in meaning and nuance being lost.
- Standard diagnostic tests for dementia, or depression, may not be culturally appropriate and may lead to inaccurate diagnosis.
- Assessors may not be able to offer a sensitive and effective assessment because they are not sufficiently familiar with the lifestyles, health, religious and cultural needs of older people and their carers from minority ethnic communities.
- No suitable services may be available where the older person's language is spoken and their cultural, religious and dietary needs met.
- Conversely, assessors may make assumptions about the lack of acceptability of mainstream services to older people and their families, and not offer them.

**Actions**

There is a need to ensure that the actions highlighted in the refreshed strategy are implemented taking into account the information and support needs of black and minority ethnic communities.

**Poverty (Medium Impact)**

See above re links with deprivation and illhealth.

**Potential Mitigating Actions**

**Strategic**

- It is anticipated that implementation of the OPMH strategy should help to address the issues highlighted above and should have a positive impact on improving access to services and support for older people with mental health needs, managing demand and supporting those with a range of comorbidities
- It is recommended that further more detailed local needs analysis is carried out at CCG level to support priority setting and implementation planning for the refreshed strategy
- The scope of the strategy is very broad, which presents us with significant challenges in terms of implementation. Alongside delivery of some specific OPMH projects that can be actioned by members of OPMH groups it will be necessary to use other change agendas to support deliver, such as the Care at Home Project, Extra-care Housing project, Integration project, etc., requiring shared broad understanding of the OPMH strategy and evidence based knowledge of what works regarding OPMH in the context of these other change agendas. Organisational ownership and commitment to implementation of the refreshed OPMH strategy and achieving synergy across work streams will need to be clearly in place. The Hampshire OPMH Delivery Group
and the Integrated Delivery Executive Group should support this.

**Tactical**

- It is recommended that priority is given to promoting the message that the risk of developing dementia can be reduced by living a healthier lifestyle. What’s good for the heart is good for the head.
- It is recommended that any focus on prevention as part of the implementation of the OPMH strategy should include a focus on neighbourhoods with the most concentrated deprivation: Leigh Park and Wecock Farm in Havant; Rowner and Town in Gosport; pockets of localised deprivation in Aldershot, Andover, Basingstoke, and Blackfield and Holbury in New Forest. There needs to be a focus on the diagnosis of disease and supporting self management and lifestyle changes.

**Operational**

- It is recommended that implementation projects falling under the refreshed OPMH strategy are subject to detailed equality impact assessment/ equality analysis as plans are developed.
- It is recommended that specific focus is given in local implementation plans to improving support for younger people with dementia.
- It is recommended that specific focus is given in local implementation plans to improving support for people with learning disabilities and dementia.
- There is a need to ensure that the actions highlighted in the refreshed strategy are implemented taking into account the information and support needs of black and minority ethnic communities.

Date to review actions: 01 Sep 2015

**Final decision date**

Final decision date due: 28 Aug 2014
Decision to be made by: DMT