

Leicestershire Joint Strategic Needs Assessment 2015

Chapter 5: **Issues specific to ageing**



Version 1.4

30th November 2015

For more information please contact:

Public Health Department

Leicestershire County Council

0116 3050705

phi@leics.gov.uk

CONTENTS

CONTENTS	2
CHAPTER 5 - ISSUES SPECIFIC TO AGEING	3
1. Ageing well.....	5
2. Older people with care needs.....	12
3. Falls	17
4. Excess winter deaths.....	19
5. Frail older people	21
6. End of life care	26
REFERENCES.....	29

List of Tables

Table 1: POPPI data on long-term conditions in older people, Leicestershire, 2014, 2020 and 2030 ¹⁸	13
Table 2: People aged 65 and over living alone, by age and gender, Leicestershire projected to 2030	15
Table 3: Place of death - Number and percentage of deaths for Leicestershire residents 2012-14	27

List of Figures

Figure 1: Estimates of frailty in people aged 65 years and over in Leicestershire, 2012-2037	23
Figure 2: Estimates of frailty in people aged 85 years and over in Leicestershire, 2012-2037	23

CHAPTER 5 - ISSUES SPECIFIC TO AGEING

Healthy ageing is a concept promoted by WHO, that considers the ability of people of all ages to live a healthy, safe and socially inclusive lifestyle. It recognises the factors beyond health and social care that have a major effect on health and wellbeing, and the contribution that must be made by all sectors with an influence on the determinants of health. It also embraces a life course approach to health that recognises the impact that early life experiences have on the way in which population groups age.

Age is the single most significant driver of health need. The prevalence of the common long-term conditions such as heart disease, hypertension, stroke, respiratory disease, and diabetes, all increase with age. The rise of other health issues such as visual impairment, mental ill health and physical disabilities also increase with age and all have a significant impact on people's independence and need for care and support.

1 in 5 people are over 65 and this is set to rise to 1 in 3 by 2033. The number of "oldest old" (over 85) has doubled in the past decade and the percentage of people dying before 65 has remained constant for the past 20 years. Older people are the biggest and costliest users of health and social care - those with complex needs, long-term conditions, functional, sensory or cognitive impairment are the highest cost and volume group of service users.¹

Today's 65-year-olds are more active and well than ever before. Maintaining social networks, being part of a community and staying active all benefit health and wellbeing in later life. Older people want to enjoy good health and remain independent for as long as possible. The effects of ageing begin to manifest themselves after the age of 50 and these effects are influenced in part by people's earlier lifestyles. Ageing well is about helping older people to live active, healthy lifestyles and about limiting deterioration and illness. As people get older, remaining independent often depends on health and social care services being effective enough to support them.

Central to the health and wellbeing partnerships plans to support the ageing population is the Better Care Together 5 Year Strategy.² This sets out the partnerships commitment to address the nine components of care identified in the Kings Fund research:³

- Healthy, active ageing and supporting independence;
- Living well with simple or stable long-term conditions ;
- Living well with complex co-morbidities, dementia and frailty;
- Rapid support close to home in times of crisis;
- Good acute hospital care when needed;
- Good discharge planning and post-discharge support;
- Good rehabilitation and re-ablement after acute illness or injury;
- High-quality nursing and residential care for those who need it; and
- Choice, control and support towards the end of life.

It is important to prevent or delay the onset of illness, disability and of long-term conditions; and then when such conditions do arise, to try and minimise their impact so that people can remain in their own homes and independent for as long as possible and avoid the need for acute treatment or social care. For this reason, the service provision sections are focused on the themes set out in the Care Act 2014 of “prevent, reduce, delay”.⁴ This structure is based on the principle that the care and support system works to actively promote wellbeing and independence and does not wait for a person to meet a crisis before identifying and responding to their needs.

Prevent – this is primary prevention of ill health and disability in people who do not currently have care or support needs. This is providing universal services to ensure that people have access to good information and advice, are able to live healthy and active lives, live in safe neighbourhoods and have good social networks to help to support them.

Reduce – this is a tier of secondary prevention or early interventions. Providing targeted interventions to individuals with increased risk of developing a need for services and where service provision may prevent people from deteriorating and needing to use services.

Delay – this is a tier of tertiary prevention, which is aimed at minimising the effect of disability or deterioration for people with established health conditions.

Provision of long-term care - as well as people that fall into the categories of need

where interventions can prevent, reduce or delay the need for services or treatment, there will also be a cohort of patients where these strategies will not be effective who will need long-term services and support. This cohort of people may still benefit from preventative approaches including universal services, and opportunities to minimise use of long-term services and support should continue to be utilised.

There are a number of other JSNA chapters that address issues specific to ageing:

- Mental health covers dementia;
- Physical and sensory disabilities covers disabilities that are related to age;
- The adult section includes issues that affect all adults, including older people, and the sections on issues such as long-term conditions will be particularly relevant to older people; and
- Carers and the increasing older population of carers.

1. **Ageing well**

Within this section the population and demography of all older people in Leicestershire is the primary focus. The primary prevention of health and social care needs is linked to providing universal services to the whole population to help to maintain good health and wellbeing and will prevent them from needing services longer term and minimise their use if they do.

Much of the support that will enable people to live healthy and active lives in old age will happen much earlier in their lives – working with children and adults to promote healthy lifestyles and to reduce the risks associated with, for example, tobacco, substance misuse and obesity. As well as the direct effects of lifestyle choices on people's health and wellbeing, there are many external factors that will influence this - things such as good housing, a good education, being in employment, and having strong social networks – and these are all key to having a long and healthy life.

The JSNA has already considered many of these issues in the following chapters:

- Giving children the best start in life
- The health and wellbeing of adults

The 2014 Director of Public Health's Annual Report focused on the Wider

Determinants of Health and looked at the wider role of the council and partners in supporting the local population to live long and healthy lives.⁵

1.1. Evidence of Need

- In 2013, it was estimated that 661,600 people were living in Leicestershire. 126,100 people (19.1%) were aged 65 years and over and 16,200 people (2.4%) were aged 85 years and over.⁶
- Life expectancy for the people of Leicestershire was 80.1 years for males and 84.0 years for females in 2010-12.¹ However, for the same time period, healthy life expectancy was much lower, at 64.9 years for males and 66.7 years for females.¹ Healthy life expectancy estimates the average lifespan spent in very good or good health based on self-assessed general health.
- The population of Leicestershire is growing, and it is growing more quickly in the older population than in the overall population. By 2015, the population aged 65 years and over is projected to grow to 134,000, an increase of 6%. By 2020, this population is projected to grow to 149,500 people, an increase of 18%. By 2030, this population is projected to grow to 186,900, an increase of 48%.⁷
- The population is growing even more quickly in the population aged 85 years and over. By 2015, this population is projected to grow to 17,700, an increase of 8%. By 2020, this population is projected to grow to 21,200 people, an increase of 29%. By 2030, this population is projected to grow to 31,300, an increase of 102%.⁷
- By 2030, the proportion of the population that is aged 65 years and older will account for over 25% of the total Leicestershire population.⁷
- In 2010, 12.8% of people aged 60 years and over were classed as living in income-deprived households (19,844 people). This is significantly lower than the England average but still represents a large number of older people who are affected by income poverty. Income-deprived households are defined as households receiving income support or income-based jobseeker's allowance or pension credit.⁸
- Usage of social care service by client group demonstrates the high usage/high proportion of budget spend on older people.

1.2. Key service issues and developments

There is strong and growing evidence that social networks and social capital increase people's resilience to and recovery from illness.⁹ This includes evidence on some of the individual components of a local strategic approach to building and utilising community assets.¹⁰ For example, every £1 spent on health volunteering programmes returns between £4 and £10, shared between service users, volunteers and the wider community.⁹

A brisk walk every day is thought to have the potential to reduce the risk of heart attacks, strokes and diabetes by 50%; fracture of the femur, colon and breast cancer by 30%, and Alzheimer's by 25%.¹¹

Poor quality housing is thought to cost the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes.¹² Among the over-65s, falls and fractures account for 4 million hospital bed days each year in England, costing £2 billion.¹³

The services within this section are strongly linked to the "prevent" part of the cycle of care and locally include:

Prevention

A strategic review of preventative services was conducted in 2014 and a model for secondary prevention was developed. This model covers the four main areas of identification, supporting independence, maximising and enhancing resources, and community development. It focuses on identifying and supporting individuals at risk, on the assets available to them and maximising community resources. Formal consultation during summer 2014 elicited broad support for the approach to prevention with 69% of questionnaire respondents agreeing (strongly or tending to) with the proposed secondary prevention model.

Consultation responses from people over the age of 65 years clarified the most important elements of prevention support for older people by popularity as being:

- help establishing personal safety and security;
- developing domestic/life skills;
- supervision and monitoring of health and wellbeing;
- help gaining access to other services; and
- help in establishing social contacts and activities.

The key principles underpinning prevention are focused on developing assets, co-production, outcomes focused, cost effectiveness, evidence based, working in partnership and being more integrated in our approach.

The aims for individuals are enhanced control, increased resilience, more participation and feeling more included in their community and the decisions that affect them.

Local Area Coordination (LAC) is a key enabler to the prevention model and aims to support people who are vulnerable through age, frailty, disability or mental health issues achieve their vision for a good life through early support. LAC is a key component of the Better Care Fund and the Council's Communities Strategy which both aim to reduce demand on public services and to build resilience in communities to manage the health and wellbeing of their most vulnerable residents. Local Area Coordinators will be based in their communities and will use informal networks as well as using existing tools to identify those who are most vulnerable in their local communities. They will support these individuals and their families to achieve their idea of a happy and independent life – LACs may support individuals along a journey that ranges from low level support, to intensive multi-disciplinary and service support.

The LAC project will help build community resilience by working with existing community and voluntary groups to map existing assets and then work alongside the council, partners and communities to improve capacity and coordination between groups and services.

The Lightbulb Programme which is piloted in the Blaby area from July 2015 (with a second district to be piloted around autumn 2015 and countywide roll out by April 2016) aims to enable people to live as independently as possible, to become socially included in their community and provide practical housing support. Three key changes to the frontline offer are:

- A single point of contact or referral;
- A single, broader assessment process which will be accompanied by a case management service; and
- A broader offer of housing support and advice with access to handyperson services, cost effective recycled furniture, affordable warmth advice and practical support including housing based assessment services and minor and major adaptations.

First Contact – Health and Wellbeing Hub

Over the last 12 months, the First Contact referral management scheme has continued to grow its capacity (number of referrals and partners, including GP

practices) and capability (monitoring of outcomes and service evaluation). The contribution of First Contact to the Council's shift to early intervention and prevention was recognised by the inclusion of the scheme in the Better Care Fund (BCF) plan for health and social care integration. Following the end of national funding for local welfare provision on 31 March 2015, First Contact extended its role to provide signposting to community support for people in financial and material crises. To support the BCF's 'unified prevention offer for communities', First Contact transferred from the department of Adults and Communities to Public Health on 1 May 2015. In doing so, First Contact came together with public health preventative services and ambitions to develop a lifestyle information and advice hub. The resultant model in development is a fully integrated health and wellbeing hub that supports frontline identification, brief advice and referral, provides triage assessment, advice and motivational support and facilitates access to appropriate support, including self-help resources, community services and specialist provision. Further opportunities to integrate with related projects, including LAC, Lightbulb and Healthy Housing, are being explored.

Re-ablement

Re-ablement is short term support given in a person's own home after an illness or hospital stay in order to build confidence and/or regain independent living skills with the aim of preventing longer term need.

Re-ablement data for Leicestershire shows that in 2014/15 87.6 % (3,363) of people using re-ablement were over 64 years of age. Re-ablement referrals were recorded for 53.3% of people as a result of hospital discharge and for 46.6% of people at home.

The intention is that the period of re-ablement results in no long-term need. Only 792 (23.6%) of older people accessing re-ablement require longer term support after the period of re-ablement, with the majority (730) requiring support in their own home and/ or community. The remaining 62 older people required residential or nursing care. There is no comparable data for earlier periods due to the changes associated with statutory reporting requirements.

Housing

The development of specialist housing has reduced over time whilst the population of over 65s has increased. The development of new accommodation-based schemes currently occurs at the rate of 15% of the actual demand. Increasingly the emphasis is on enabling older people to continue to live at home by adapting their physical environments and providing additional services to assist them to "stay put". This principle places a particular focus on social landlords given the concentration of this and wider social need within social housing stock of all types.¹⁴

A significant number of the older population in Leicestershire are affected by disability and need additional help to continue to live safely in their own homes. Demand for Disabled Facilities Grants (DFG) is growing at twice the rate that councils are able to meet applications have risen by 6% since 2011/12 but the amount of adaptations funded in the same period has risen by only 3%.¹⁵ Thousands of disabled people wait for years in homes which are damaging to their health while they wait for adaptations to their homes.¹⁵ A survey of GPs found that a lack of disabled-friendly homes places intolerable pressures on health and care services:¹⁶

Integrated Housing Solutions

Housing professionals and the Health and Wellbeing Board recognise the potential that housing services have to deliver better health and social care outcomes. Everyone is fully engaged in shaping and delivering different ways of working in Leicestershire to achieve this, including a range of housing providers. An improved housing offer to health could be better targeted – e.g. in support of hospital discharge, avoiding admissions, and keeping people well and independent at home and this has been prioritised in the BCF, with the support of all District Councils. Key work areas include:

- Housing expertise within the acute sector to ensure accommodation matters are prioritised as early as possible to promote discharge.
- Using First Contact and Local Area Coordination to reduce demand on other services such as GPs and hospital care by effectively signposting to practical housing advice and interventions across multiple agencies, using one referral form. This will pick up important interventions such as Keeping Warm and Well at Home, and providing a range of practical support to older and vulnerable people.

The aim is to reduce emergency admissions and prevent delayed hospital discharge through primary prevention focused on housing support.

1.3. Gap Analysis

The gaps for this population are driven by the changing healthcare needs linked to our ageing population rather than gaps in our current service provision.

Commissioners need to consider the longer term care needs for our populations. With our ageing population, we need to consider the plans that need to be put in place to manage future health and care needs and demands in the longer term, with a focus on reducing preventable ill health, particularly in working age adults.

Health needs increase with age. The 2011 Census data for Leicestershire shows us that for people aged 85 years and over, only 15% of the population do not have their

activities of daily living limited (ADL) by a long term health problem or disability. Nearly a third of this age group have their ADL limited a little and over a half have their ADL limited a lot. There is a clear correlation with age and as people become older their care needs linked to ADL increase. In terms of absolute numbers, the population with the highest number of people with ADL limited either a little or a lot is the population aged 55-64 years, affecting over 23,000 people. Understanding the population that have health and care needs linked to ADL is a useful way to target our preventative services to reduce longer term dependency on services.

The focus for this population has to be increasing healthy life expectancy and planning for this population must be linked to prevention earlier in the life course, particularly targeting working age adults.

It is important to note that a significant number of older people in Leicestershire are identified as living in poverty.

1.4. Recommendations

It is recommended that:

- Commissioners prioritise effective early identification and preventative support for older people who are at risk of developing health and social care needs, particularly in light of the increasing older population in Leicestershire.
- There is further development of the local evidence base on what works in preventing future need in older people.
- Through the development of the Better Care Fund and Better Care Together, commissioners work together to further integrate health and social care to improve outcomes for the population.
- There is a further increase in re-ablement provision in order to reduce likelihood of requiring ongoing support.
- There is a focus on helping people to plan for the future, including making healthy lifestyle choices, making appropriate housing choices and contingency planning for sudden changes in situation.
- Support for carers is an integrated part of all strategy development for older people.
- The health and social care partnership is more involved in planning decisions – to provide opportunities for more integrated planning and delivery of housing, for example through developing bespoke housing alongside new health centres, or through the use of 'hub and spoke' models (services based

in local extra care or retirement schemes extended out to residents of retirement or general housing in the local area) as part of a wider community resource.

2. Older people with care needs

Within this section we are looking at the older population that are starting to have care needs, who, with the right interventions, will be able to manage their care needs at home.

This section of the report is concerned with understanding the number of people that have increased needs, through their health status or through decreased independence, where providing additional support will improve their quality of life and reduce their future needs.

A central aspect of the Care Act 2014 is to help people maintain their independence in their own homes for as long as possible. Adult Social Care services are key to helping people to do this. In 2013, the Health Survey for England focussed on social care needs of people aged 65 years and over and found that:¹⁷

- 23% of men and 33% of women aged 65 and over needed help with at least one Activity of Daily Living (ADL); and
- overall, 11% of men and 14% of women aged 65 and over had received help with at least one ADL in the last month, with most people receiving this from informal carers.

2.1. Evidence of Need

- The number of older people (65 years and over) that require help with activities of daily living is estimated for people of Leicestershire in 2014 by the POPPI system:¹⁸
 - It is estimated that 52,281 people are unable to manage at least one domestic task unaided.
 - It is estimated that 23,517 people are unable to manage at least one mobility task unaided.
 - It is estimated that 43,001 people are unable to manage at least one self-care task unaided.
- POPPI estimates that, in 2014, 21,340 people aged 65 years and over in

Leicestershire were providing unpaid care.¹⁸

- Furthermore, POPPI estimates that in 2014 in Leicestershire the number of older adults (65 years and over) with the following conditions was: ¹⁸
 - 60,326 people predicted to have a limiting long-term condition.
 - 16,268 people predicted to have diabetes
 - 11,214 people predicted to have depression.

A number of other conditions are included in Table 1 which shows the projected levels in the population to 2030. Heart attacks, stroke, bronchitis and emphysema, and severe depression affect a smaller number of people but will have a significant and enduring impact on people's lives. A number of disabilities are directly related to ageing, and these are covered in detail in the chapter on sensory and physical disabilities. This includes the prevalence of hearing loss and sight loss that is linked to age.

Table 1: POPPI data on long-term conditions in older people, Leicestershire, 2014, 2020 and 2030¹⁸

	2014	2020	2030	% Change 2012-2020	% change 2012-2030
Older adults with a limiting long-term illness	60,326	70,382	91,499	17%	52%
Older adults predicted to have a longstanding health condition caused by a heart attack	6,376	7,347	9,272	15%	45%
Older adults predicted to have a longstanding health condition caused by a stroke	3,006	3,494	4,467	16%	49%
Older adults predicted to have a longstanding health condition caused by bronchitis and emphysema	2,204	2,535	3,175	15%	44%
Older adults predicted to have Type 1 or Type 2 diabetes	16,268	18,623	23,182	14%	43%
Older adults predicted to have depression	11,214	12,819	16,048	14%	43%

	2014	2020	2030	% Change 2012-2020	% change 2012-2030
Older adults predicted to have severe depression	4,217	4,900	6,574	16%	56%

- The increase in the number of people aged 65 years and over in Leicestershire will see a corresponding increase in the number of people that need care and support. The POPPI system indicates the rate that we can expect these needs to grow based on population projections. The figures below indicate the anticipated growth between 2014 and 2020:¹⁸
 - An increase of 18% in the number of people that are unable to manage at least one domestic task unaided (61,656 by 2020)
 - An increase of 19% in the number of people that are unable to manage at least one mobility task unaided (27,901 by 2020),
 - An increase of 17% in the number of people that are unable to manage at least one self-care task unaided (50,479 by 2020).
- By 2020 there is predicted to be an increase of 39% in the number of people aged 65 years and over providing unpaid care (29,721 carers by 2020).¹⁸
- The number of people aged 65 and over in Leicestershire predicted to have a limiting long-term condition is expected to increase by 17% to 70,382 people by 2020 and by 52% to 91,499 people by 2030. (Table 1).¹⁸
- There are a significant number of older people living alone in Leicestershire and this is projected to increase. This has implications for social care in relation to those people living alone being less likely to benefit from informal support of someone they live with and more likely to require support from social care. The percentage of females living alone is higher for older people and the percentage of both males a females living alone increases with age. The major consequence of these changes is that, in the near future, a larger group than ever will enter old age living on their own (Table 2).¹⁸

Table 2: People aged 65 and over living alone, by age and gender, Leicestershire projected to 2030

	2014	2020	2030
Males aged 65-74 predicted to live alone	7,040	7,700	8,540
Males aged 75 and over predicted to live alone	8,364	10,506	15,164
Females aged 65-74 predicted to live alone	11,040	12,090	13,440
Females aged 75 and over predicted to live alone	20,679	24,339	33,367
Total population aged 65-74 predicted to live alone	18,080	19,790	21,980
Total population aged 75 and over predicted to live alone	29,043	34,845	48,531

2.2. Service Review

The Adults and Communities budget for service provision in 2011/12 was £131,226,120, 57.3% of which was spent on services for older people. 33.7% of spend on older peoples services was on residential care (actual £21,417,342). Comparatively £15,547,113 was spent on homecare and £2,153,549 on day care for older people.

Expenditure on Older People continues to be the highest proportion of spend on adult services at 47%, compared to 32% on Learning Disability, 14% on physical disabilities and 7% on mental health, and the demographic trends suggest this will continue to be the case. These figures include council run services and those commissioned through either independent providers, or the voluntary sector, but excludes services that are purchased via an individual's Personal Budget (Figure 1).¹⁹

In 2014/15, 72% (13,828) of people accessing long-term social care support were older adults (over 64). The number of older people accessing long-term social care support has increased from the previous year (11,722) but reduced as a percentage (73.5%).

National statutory reporting for Adult Social Care Outcomes Framework (ASCOF) include measures that relate to delaying and reducing need for support, as follows:⁸

- The number of older people in Leicestershire in residential accommodation in

Leicestershire is higher than the England average for 2013/14 at 756.2 per 100,000 population. This figure is a reduction on the previous year but higher than in 2011/12.

- Of older people being discharged from hospital 3% access re-ablement services. This is a slight increase from the previous two years which remained constant at 2.9%.
- Of older people who were discharged from hospital to re-ablement services 78.6% were at home ninety-one days later. This is the same picture as the previous year and a slight increase from 2011/12 which was 77.9% however this is lower than the national average.

Extra Care Housing

Extra care housing schemes give people the support they need to stay independent and continue living in their own home by its purpose built design or adaptation, and enables access to care and support 24 hours per day.

Leicestershire County Council works with providers to deliver care and support services in extra care housing with a total of 188 units across the County. Although actual data on utilisation and throughput is not available, voids tend to be minimal and temporary. An additional 62 units are planned to be in place in Charnwood by October 2016.

2.3. Gap Analysis

The growth in the older population will increase the need for services for this cohort of the population – as indicated by the anticipated growth in older people who are affected by ill-health and disability. There will be increasing pressure on services and an increase in the level of need on the overall population.

The projected increase in older people living alone and the implications on this for services when there is a lack of informal care and support is also a significant issue of concern when planning for the future.

Services across health and social care need to be integrated more effectively so that there is a more holistic approach to identifying and meeting people's care needs.

2.4. Recommendations

It is recommended that:

- Through the development of the Better Care Fund and Better Care Together, commissioners work together to further integrate health and social care to improve outcomes for the older population.
- There is further development of integrated proactive care for people with long term conditions to help people to manage their conditions for longer in their own homes.
- Commissioners regularly review their progress to ensure that the system is working as effectively as possible and making the most of public money.
- All partners work together to manage risks and make sensible decisions which provide benefits for the whole population that can be evaluated.

3. Falls

Each year one in three people over 65, and almost half of people over 85 years, experience one or more falls, many of which are preventable.²⁰ The long-term implications of falling can include physical disability, entry into long-term care, and psychological problems.

Hip fracture is the most serious consequence of falls among older people, with a mortality rate of 10% at one month after a fall, 20% at four months and 30% at one year. Many of those who recover suffer a loss in mobility and independence.²¹

More than 95% of hip fractures in adults aged 65 and older are caused by a fall. For many older people it is the event that forces them to leave their homes and move into residential care. There is reliable research evidence that between a quarter and one third of falls can be prevented in older people.²²

3.1. Evidence of Need

- The Projecting Older People Population Information (POPPI) System predicted that in 2014, 4,793 older people would be admitted to hospital as a result of a fall. This is predicted to rise to 7,929 admissions by 2030, an increase of 68%.¹⁸
- In 2012/13, in Leicestershire, there were 1,875 emergency hospital admissions due to falls in people aged 65 years and over. The rate of 1,504 admissions per 100,000 population is significantly lower than the England rate

of 2,011 per 100,000. However, whilst the rate is lower, it is still a significant issue affecting a high number of people.¹

- In 2012/13, in Leicestershire, there were 646 hospital admissions for fractured neck of femur in people aged 65 and over.¹ The rate of 512 admissions per 100,000 population is significantly lower than the England rate of 568 per 100,000.¹
- It is estimated that approximately 15,000 people in Leicestershire call East Midlands Ambulance Service (EMAS) as a result of a fall each year.²³ Approximately 7,000 of these calls result in a patient being conveyed to hospital and approximately 2,000 are admitted as result of an injury due to a fall.²³

3.2. Service Review

The Better Care Fund is developing an integrated, seamless pathway across all settings of care, for people who are at risk of a fall, or who have experienced one or more falls. With the older population increasing, there is a need to develop alternative ways of delivering a service for frail older people which includes a variety of elements such as rapid access to clinical intervention, and access to community services or equipment that improves quality of life and allows people to remain independent/living at home. By working with EMAS and Leicestershire Partnership Trust the pathway of care for people who fall in Leicestershire has been changed to offer rapid response in the community. This assesses the need for hospitalisation, and if this is not required, offer any treatment or follow up support that may be needed in their usual place of residence instead.

The project has two main elements:

- end to end review of the falls pathway; and
- prevention pathway and early intervention.

The urgent response for falls is only one part of the falls prevention pathways which will be supported by a medium term falls prevention approach which is being addressed through the unified prevention schemes in the BCF.

3.3. Gap Analysis

The BCF will identify and improve pathways for people who are at risk of falls and for people who have already fallen in the medium term. However, there is a need to look at the longer term demographic trend and to ensure that these plans will be sustainable in the longer term and will meet the needs of the population beyond the next five years.

3.4. Recommendations

It is recommended that:

- The BCF falls schemes are further developed across the wider health and wellbeing partnership.
- The impact of the BCF schemes is properly evaluated and the findings are used to inform future developments.
- There is a longer term view developed around primary prevention to help to ensure that there is a long term sustainable response to falls across the partnership in response to the longer term demographic change.

4. Excess winter deaths

Excess deaths in winter is an important public health issue in the UK, and is potentially amenable to effective intervention. More people die in the winter months than in the summer months in the UK and these deaths are linked to cold weather, and in particular, to cold homes. This excess death in winter is greatest in elderly people and for certain disease groups. Housing support, particularly energy efficiency and fuel poverty, are both important issues in tackling excess winter deaths.

Most excess winter deaths and illnesses are not caused by hypothermia or extremes of cold. Rather, they are usually caused by respiratory and cardiovascular problems during normal winter temperatures – when the average outdoor temperature drops below 5–8°C. The risk of death and illness increases as the temperature falls further. However, because there are many more relatively 'warm' winter days than days of extreme cold, most cold-related ill health and death occurs during these milder periods.²⁴

A household that cannot afford to heat its home is likely to be under stress, for instance, from being forced to live in the only heated room. Or it may need to choose between heating and food or other commodities or risk falling into debt.²⁴

4.1. Evidence of Need

- Between August 2009 and July 2012 there were 1,073 excess winter deaths for people in Leicestershire. This gives an excess winter deaths index of 20.6 which is significantly worse than the England average of 16.9.¹
- On average, there are a total of 358 excess winter deaths per year in Leicestershire.

- Between August 2009 and July 2012, there were 509 excess winter deaths for people aged 85 years and over in Leicestershire. This gives an excess winter deaths index of 26.2 which is similar to the England average of 22.6.¹
- On average, for people 85 years and over there are 170 excess winter deaths per year in Leicestershire. The over 85 year olds account for nearly 50% of all excess winter deaths.
- In 2012/13, 72.7% of people aged 65 years and over in Leicestershire were vaccinated against flu, this is significantly lower than the England average of 73.4%.¹
- In 2012, almost 31,000 households (12%) in Leicestershire experienced fuel poverty. This is significantly higher than the England average of 10%.²⁵
- The 2011 census showed that 224,800 (84%) of homes in Leicestershire were under occupied.²⁶

4.2. **Service Review**

Housing conditions are a very important factor affecting excess winter deaths. The death rate rises about 2.8% for every degree Celsius drop in the external temperature for those in the coldest 10% of homes.²⁴ The Marmot review, 'The health impacts of cold homes and fuel poverty', estimated that 'excess winter deaths in the colder quarter of housing were almost 3 times as high as in the warmest quarter'.²⁷

Several factors also influence whether someone finds themselves living in a cold home and how ill they may become as a result. These include:²⁴

- how efficient the heating system is;
- how well insulated the home is;
- whether the person can afford to heat their home (factors here include their income, the cost of fuel, the temperature needed to make the home feel warm enough and how long the heating needs to be on); and
- the person's vulnerability to the effects of cold due to age or a medical condition.

4.3. **Gap Analysis**

The excess winter deaths index for Leicestershire is consistently higher than the

England average and this needs to be reviewed and addressed. Additionally, the proportion of older people in Leicestershire affected by fuel poverty is significantly higher than the average for England.

4.4. Recommendations

It is recommended that:

- Commissioners develop an affordable warmth/ healthy housing project to ensure continued support for people to keep warm in their homes and support residents most in need to access energy advice and warm home funding and related schemes. The Better Care Fund continues to develop the unified prevention offer to address the needs of people affected by fuel poverty and to identify early opportunities to provide integrated advice and support.

5. Frail older people

Independence and wellbeing come under particular threat when older people become frail or ill. The likelihood of frailty and illness increases as people age. This, combined with a lack of the right kind of support, can limit an older person's ability to continue enjoying life to the full.

Older people who are frail, or who have long-term illnesses, need support to manage their health conditions so that they can maintain the parts of their lives that they most value. Support needs to go beyond clinical and care issues to include the whole range of factors and concerns that older people see as most important. Such approaches need to be sensitive to the older person's need to retain control over their life.

Frail individuals are more likely to have an emergency admission to hospital which has additional hazards, such as cross-infection, noise and disorientation, worsening the situation for them. Falls, reduced mobility, loss of confidence, malnutrition, continence problems and increased dependency are other very important problems that can be caused by hospital admission.

Frailty, rather than age, is an important indicator for poorer outcomes in older people, as well as an increased need for social care and health services. If we use the definition of 65 years and over as being 'old', most of these people are usually fit and living full lives, with only 7% being classed as 'frail'.²⁸ The prevalence of frailty increases up to 40% in persons aged 80 and over, and given the dramatic increase of the oldest-old population (those 80 and over), frailty is becoming increasingly common.

An estimated 10-11% of people over 65 years, and 25-50% of those over 85 years, have frailty.²⁹

5.1. Evidence of Need

It is difficult to predict the number of older people in Leicestershire who are frail or at risk of deterioration in their condition or crises. Because of the difficulty in predicting this, the data used within this section is focused on looking at the numbers of people that are receiving services.

- Using the mid points of the estimates for frailty of 10-11% of people aged over 65 years and 25-50% of people aged over 85 years, we can model the number of people that are likely to be frail:
 - In 2012, the number of people aged 85 years and over that are estimated to be frail is 6,000. This is projected to rise to 17,100 by 2037, an increase of 185%.^{30, 29}
 - In 2012, the number of people aged 65 years and over (including people aged 85 years and over) that are estimated to be frail is 12,800. This is projected to rise to 22,100 by 2037, an increase of 78%.^{30, 29}

The increasing numbers of people in Leicestershire in the older age groups (65 years and over), particularly in the very old age groups (85 years and over) will mean that there will be an increasing number of people with long-term health and social care needs. Managing needs and demands within the most vulnerable cohort of older people will be linked increasingly to managing needs earlier in the pathway and earlier in a person's life. The adults chapter focuses on the lifestyle factors that will impact on people's health later in life. However, there is a significant need to work with people already in old age to prevent, reduce and delay their need for services.

Figure 1 and Figure 2 illustrate a simple model projecting the potential growth in the number of people aged 65 years and over and 85 years and over that are classed as frail. The two models provide a lower and upper estimate of the numbers of people in each age group projected to be frail and illustrates the rapid growth in the numbers of people this will affect. It is essential that our commissioning strategies are developed to support not just the current level of need in the population, but are robust enough to deal with the anticipated growth in need in this population.

Figure 1: Estimates of frailty in people aged 65 years and over in Leicestershire, 2012-2037

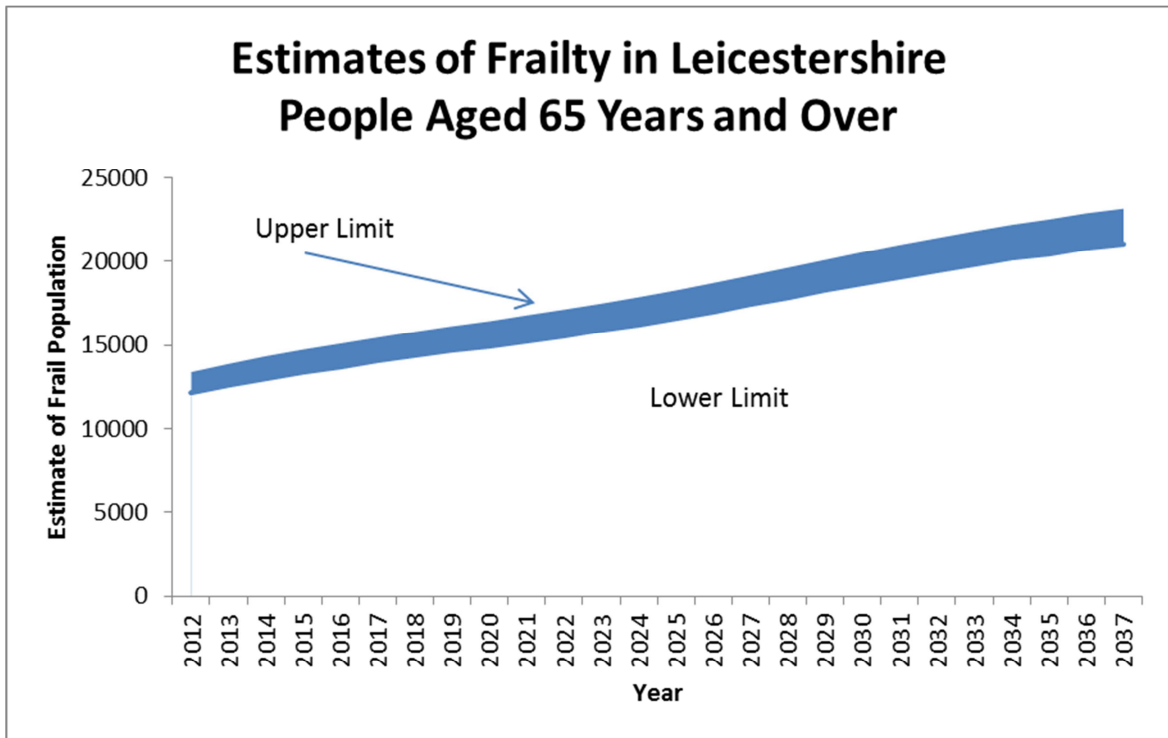
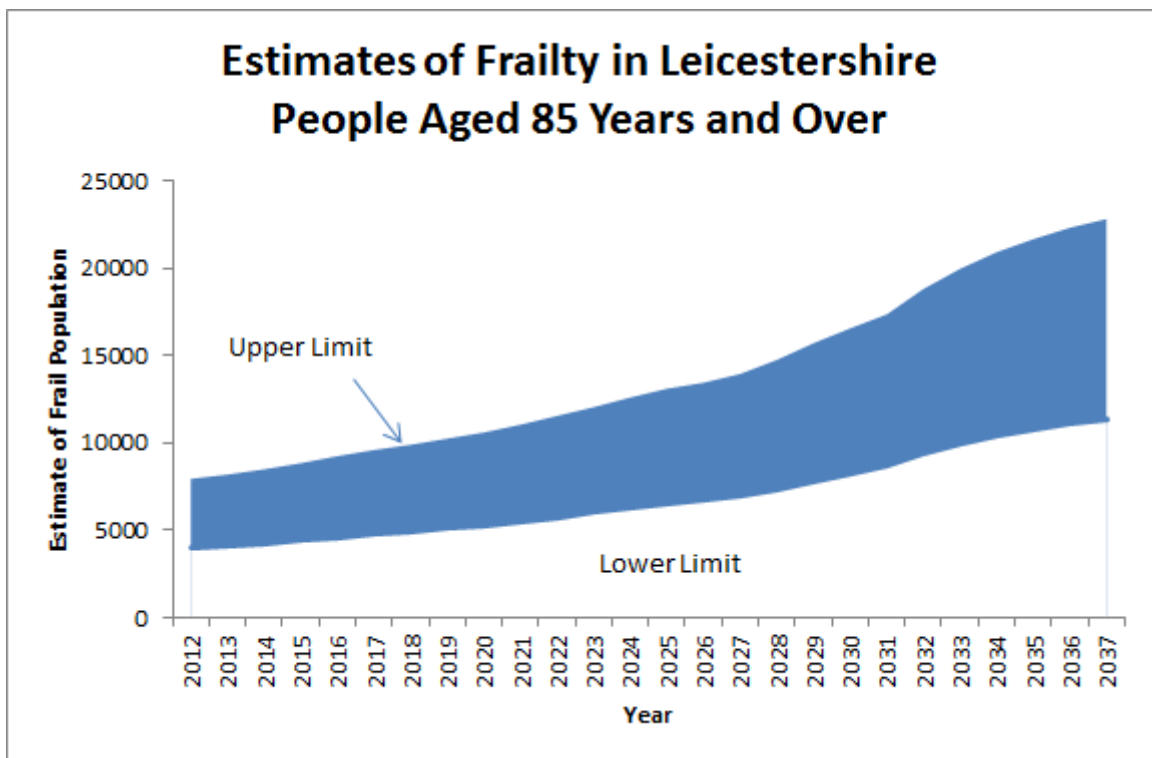


Figure 2: Estimates of frailty in people aged 85 years and over in Leicestershire, 2012-2037



With respect to meeting older people's care needs, these services are changing both nationally and locally. Between 2010/11 and 2012/13 in Leicestershire there has been:⁸

- A reduction in the proportion of people age 65 years and over supported through the year from 10,864 per 100,000 population to 8,107 per 100,000.
- An increase in permanent admissions to residential and nursing care from 681 per 100,000 population to 763 per 100,000.
- An increase in the proportion of patients offered re-ablement services, from 2.4% to 2.9%.
- A significant increase in the proportion of clients receiving self directed support, from 8% to 73%.

5.2. Service Review

- In 2012/13, 9,885 older people in Leicestershire were supported throughout the year, by receiving community and residential and nursing home care. This is a rate of 8,107 people per 100,000 population which is significantly higher than the England average of 7,859 per 100,000 population.⁸
- In 2012/13, 930 older adults were permanently admitted to nursing and residential care homes (where this was at least partly funded by the local authority). This gives a rate of 763 per 100,000 which is significantly higher than the England average of 697 per 100,000 population.⁸
- In 2012/13, the Adult Social Care Outcomes Framework (ASCOF) reported that:⁸
 - Out of 17,390 people discharged from hospital, 505 people were offered re-ablement services. This is 2.9% of all hospital discharges which was significantly lower than the England average of 3.2%.
 - Of the 505 patients offered re-ablement services, 395 people were still at home after 3 months, this is 79% of people receiving re-ablement services. This proportion is similar to the England average of 81%.

Local Area Coordination (LAC)

LAC aims to support people who are vulnerable through age, frailty, disability or mental health issues achieve their vision for a good life, to support people to contribute to their communities and to strengthen the capacity of communities to welcome and include people. The main principles are:

- Supporting people to stay strong and building welcoming, inclusive and mutually supportive communities.
- Thinking and acting differently, with a greater focus on strengths, individual and family leadership, personal and community resilience.
- Supporting people, irrespective of service labels, to build and pursue their vision for a good life as active and valued citizens in their local communities.
- Social justice, inclusion and citizenship for all.
- Positive assumptions and opportunities for all citizens in our society, including those who are labelled, isolated or excluded in our communities.

Subject to an evaluation, LAC will extend its coverage across the whole of Leicestershire by 2017.

Better Care Together

Better Care Together has prioritised frail older people, with aims to:

- Meet the changing levels of need driven by the ageing population;
- Support people outside of hospital, either in their own homes or within their local area;
- Support people to remain independent for as long as possible, and, where possible, keeping them out of residential care; and
- Provide services that are joined up to support both mental and physical wellbeing.

5.3. Gap Analysis

The growing ageing population will lead to an increase in the number of people that are frail in Leicestershire.

Frailty is a key strategic theme on the Better Care Together strategy and there is a whole system response planned to address the issues for people affected by frailty. There are a number of gaps in identifying people who are frail or are at risk of becoming frail and this is being addressed through the plans around pro-active care.

Maintaining independence is a key issue for this population that requires a whole system response.

5.4. Recommendations

It is recommended that:

- The health and wellbeing partnership works together to identify frail older people and works together to meet their needs.
- The partnership progresses plans that are set out by BCT collaboratively and evaluates the progress that is being made.
- More is done to identify people that are at risk of becoming frail so that their needs can be identified early.

6. End of life care

Approximately 500,000 people die in England each year. When asked, most people say they would prefer to die at home. However, mortality statistics show that place of death is most commonly in hospital.³¹

The Department of Health published its ten year End of Life Care Strategy for England in July 2008. The aim of this strategy was to promote high quality care for all adults at the end of life.³² In 2014, NHS England published “NHS England's Actions for End of Life Care: 2014-16”²⁹ to set out plans to build on the 2008 strategy.³²

A proportion of people that die will not need end of life care before death because the cause of death is sudden, either through unpredictable onset of disease or an external cause. Recent analysis of all deaths in England by the National End of Life Care Intelligence Network estimate that at least 25% of all deaths in England are unexpected deaths from sudden causes.³³ This is in line with the palliative care funding review,³⁴ which estimated that between 70% and 80% of all deaths are likely to need end of life care.

All people whose deaths are not sudden or unexpected (approximately 75% of all deaths) should have their end of life care needs recognised and provided for in the last year of life.³⁵

Population-based studies of preferences for place of death indicate that over 60% of people (including those who were not facing life-threatening illness at the time) would prefer to die at home.^{36 37} It is also clear from research, that place of death is not the most important factor for people needing end of life care – support from family and friends, access to information and having control over who makes decisions about their care have all been ranked as very significant factors.^{32 36}

6.1. Evidence of Need

- Between 2010 and 2012, there were 16,882 deaths of residents of Leicestershire, an average of 5,630 deaths every year.³⁸
- If 75% of deaths are predictable and therefore eligible for end of life care, 4,220 people in Leicestershire will be eligible for end of life care every year.^{38, 35}
- In 2013/14, there were 3,219 people on GP palliative care registers (patients registered with Leicestershire GPs).³⁹

6.2. Service Review

The NICE Quality Standard for End of Life Care for Adults (2011) provides a comprehensive picture of what high quality end of life care should look like.⁴⁰ Delivered collectively, this should contribute to improving the effectiveness, safety and experience of care for adults approaching the end of life and the experience of their families and carers.³² This is described through the 16 quality statements set out on the NICE guidance.

- Table 3 indicates the number and proportion of deaths for residents of Leicestershire between 2012 and 2014.⁴¹ This illustrates that in 2012 in Leicestershire 49% of all deaths occurred in hospitals. By 2014, this had reduced to 45%. There has been an increase in the proportion of deaths at home from 24% in 2012 to 26% in 2014. There has also been an increase in the proportion of deaths taking place in nursing and residential homes.

Table 3: Place of death - Number and percentage of deaths for Leicestershire residents 2012-14

	2012	2013	2014	2012	2013	2014
Home	1305	1408	1436	24%	25%	26%
Hospital	2700	2594	2439	49%	46%	45%
Hospice	223	236	235	4%	4%	4%
Nursing Home	652	672	684	12%	12%	13%
Residential Care Home	566	579	573	10%	10%	11%
Other	85	100	74	2%	2%	1%
Total	5531	5589	5441			

6.3. Gap Analysis

- 1,000 people that are potentially eligible for end of life care are not being added to GP end of life care registers, representing a potentially significant level of unmet need.

6.4. **Recommendations**

It is recommended that:

- Commissioners work together to improve the identification of people who are at the end of their life and developing end of life care plans that reflect their wishes.
- Commissioners will work together to improve the provision of end of life care and support for people who wish to die at home and support for their carers.

REFERENCES

1. Public Health England. Public Health Outcomes Framework. (2014). at <<http://www.phoutcomes.info/>>
2. Better Care Together. A Partnership of Leicester Leicestershire and Rutland Health and Social Care. Better Care Together Plan 2014. (2014). at <<http://www.bettercareleicester.nhs.uk/the-bct-plan/>>
3. The Kings Fund. *Making our health and care systems fit for an ageing population*. (2014). at <<http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population>>
4. Department of Health. *Care and Support Statutory Guidance. Issued under the Care Act 2014*. (2014). at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf>
5. Leicestershire County Council & Director of Public Health. *The 2014 Annual Report of the Director of Public Health The wider determinants of health*. 56 (2014). at <<http://www.lsr-online.org/uploads/n0499-public-health-annual-report-2014.pdf>>
6. Office of National Statistics (C) Crown Copyright. ONS Mid-2013 Population Estimates. (2014). at <www.statistics.gov.uk>
7. Office for National Statistics Population Projections Unit. *2012-based sub-national population projections*. (2014).
8. The Health and Social Care Information Centre. Adult Social Care Outcomes Framework. (2014). at <<http://ascof.hscic.gov.uk/>>
9. Buck, D., Gregory, S. & The Kings Fund. *Improving the public's health, a resource for Local Authorities*. (2013).
10. Knapp, M., McDaid, D. & Parsonage, M. *Mental Health Promotion and Prevention: The economic case*. (2011). at <www.lse.ac.uk/businessAndConsultancy/>
11. GreenLink. *Blue Sky Green Space. Understanding the contribution parks and green spaces can make to improving people's lives*. (2010). at <<http://www.green-space.org.uk/resources/>>
12. Friedman, D. *Social impact of poor housing*. (2010). at <http://www.hlg.org.uk/images/stories/hlg_files/Social-20impact-20of-20poor-20housing.pdf>
13. Royal College of Physicians. *National Audit of Falls and Bone Health in Older People*. (2011).

14. Support Solutions UK. *The Silver Surge Wellbeing & Prevention in Services for Older People*. (2015).
15. Leonard Cheshire Disability. *The Long Wait for a Home*. (2015). at <<https://www.leonardcheshire.org/sites/default/files/Leonard-Cheshire-Disability-The-Long-Wait-for-a-Home.pdf>>
16. Leonard Cheshire Disability. *The real cost of the lack of disabled-friendly homes*. (2014). at <<https://www.leonardcheshire.org/who-we-are/publications/latest-publications-download#.VXg2xU3bLIU>>
17. Health and Social Care Information Centre. *Health Survey for England 2013*. (2014). at <<http://www.hscic.gov.uk/article/2021/Website-Search?productid=16571&q=health+survey+for+england&sort=Relevance&size=10&page=1&area=both#top>>
18. Institute of Public Care, Oxford Brookes University & Extra Care Charitable Trufts. *Projecting Older People Population Information System*. (2014). at <<http://www.poppi.org.uk/>>
19. Leicestershire County Council. *2012/13, Adults and Communities Business Plan 2012/13, Leicestershire*. (2013).
20. National Institute for Health and Care Excellence. *Clinical Practice Guidelines for the Assessment and Prevention of Falls in Older People*. (2004). at <www.nice.org.uk/CG21>
21. NHS Institute for Innovation and Improvement. *Delivering Quality and Value Focus on: Fractured Neck of Femur*. (2006). at <http://www.institute.nhs.uk/images/documents/Quality_and_value/Focus_On/DVQ_path_fracturefemurPROOF_Nov.pdf>
22. Gillespie, L. *et al. Interventions for preventing falls in elderly people (Cochrane Review)*. *The Cochrane Library* (2002).
23. Leicestershire County Council, West Leicestershire CCG & East Leicestershire and Rutland CCG. *Final Draft of the Leicestershire Better Care Fund*. (2014). at <[http://politics.leics.gov.uk/Published/C00001038/M00004131/AI00037775/\\$B CFcoversheetApril120143.docA.ps.pdf](http://politics.leics.gov.uk/Published/C00001038/M00004131/AI00037775/$B CFcoversheetApril120143.docA.ps.pdf)>
24. National Institute for Health and Care Excellence. *Excess winter deaths and morbidity and the health risks associated with cold homes. NICE guidelines [NG6]* (2015). at <<https://www.nice.org.uk/guidance/ng6>>
25. Public Health England. *Public Health Outcomes Framework*. (2014).
26. Office of National Statistics. *Census 2011 - Nomis. Crown Copyright* (2013). at <<http://www.nomisweb.co.uk/census/2011>>

27. Marmot Review Team. *The Health Impacts of Cold Homes and Fuel Poverty*. (2011).
28. Fried, L., Furrucci, L., Darer, J., Williamson, J. & Anderson, G. Untangling the concepts of disability, frailty and co-morbidity: implications for improved targeting and care. *Journals Gerontol. Series A* , 255–263 (2004).
29. NHS England. *NHS England's Actions for End of Life Care: 2014-16*. (2014). at <<http://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf>>
30. Office for National Statistics (C) Crown Copyright. ONS Mid-2012 Population Estimates. at <www.statistics.gov.uk>
31. The Health and Social Care Information Centre. *Health Survey for England 2013*. (2014). at <<http://www.hscic.gov.uk/catalogue/PUB16076/HSE2013-Sum-bklet.pdf>>
32. Department of Health. *End of Life Care Strategy: Promoting high quality care for all adults at the end of life*. (2008).
33. Blackmore, S., Pring, A. & Verne, J. *Predicting death: estimating the proportion of deaths that are 'unexpected'*. (2011).
34. Hughes-Hallet, T., Craft, A. & Davies, C. *Palliative Care Funding Review; Funding the Right Care and Support for Everyone*. (2011).
35. National Institute for Health and Care Excellence. Assessing service levels for adults needing end of life care services. *NICE commissioning guides CMG 44* (2011). at <http://www.nice.org.uk/guidance/cm42/chapter/3-assessing-service-levels-for-adults-needing-end-of-life-care-services#ftn.footnote_12>
36. NatCen Social Research. *British Social Attitudes Survey*. at <<http://www.bsa.natcen.ac.uk/>>
37. Gomes, B., Calanzani, N. & Higginson, I. *Local preferences and place of death in regions within England 2010*. (2011).
38. Health and Social Care Information Centre. The indicator portal.
39. Health and Social Care Information Centre. *Quality and Outcomes (QoF) Data*. (2014).
40. National Institute for Health and Care Excellence. *NICE Quality Standard for End of Life Care*. (2011). at <<https://www.nice.org.uk/guidance/qs13>>
41. Public Health & Leicestershire County Council. *Local analysis of ONS Mortality Data using the Primary Care Mortality Database*. (2015).