



Director of Public Health Annual Report 2012

Health through the life cycle: Report 2 - Older People



Rutland County Council



Leicestershire
County Council



Foreword

Welcome to my third annual report as Director of Public Health for Leicestershire and Rutland. Last year my annual report focused on the health and wellbeing of children and the actions that we need to take to give every child the best start in life. It was the first in a series that will cover the life course and focus on key health issues at different stages of our lives.

This report now focusses on the health and wellbeing challenges that are facing the older population.

Older people live longer, are financially better off and own more property than ever before. An increasing number of people aged 65 and over remain in work, and despite the recession full-time employment rates for this group have continued to rise. Older people also play a key role in society. They do more volunteering, charitable giving and other forms of civil engagements than other age groups. It has been estimated that, rather than being a burden, they make a valuable financial contribution. Many older people act as carers, both of their partners and of their grandchildren. They are also more likely to vote in elections than any other age group.

However, age is the most significant factor when it comes to health need. As the older population grows it is essential that we develop services that will ensure older people will have the maximum opportunity for independence and good health. It is important that all parts of the health and social care system work together to meet the needs of the older population, and that this is done alongside the voluntary sector. It is clear through the case studies presented in this report that there has been excellent progress made in meeting the needs of the older population. However, the challenge that is facing the health and social care system is significant. The predicted increase in the number of older people, alongside a reduction in the resources available across the public sector, means that the system needs to be working together to improve care across the whole care pathway for older people.

I would like to express my sincere thanks to all those who have contributed to this report, both within and outside the Public Health Directorate in Leicestershire and Rutland, it has been very much a team effort. In particular, I would like to acknowledge the contributions from the Clinical Commissioning Groups, Health Protection Agency, East Midlands South, staff from Adults and Communities Services at Leicestershire County Council, staff from the People Directorate at Rutland County Council and staff from University Hospitals Leicester and Leicestershire Partnership Trust.

I hope the recommendations in this report are taken forward so that we can make even greater strides in improving the health of the people of Leicestershire and Rutland.

A handwritten signature in black ink, appearing to read 'Peter Marks', written in a cursive style with a large, sweeping flourish at the end.

Dr Peter Marks

Joint Director of Public Health Leicestershire and Rutland

Contents

EXECUTIVE SUMMARY	7
RECOMMENDATIONS	12
INTRODUCTION	17
1. Background	17
2. Key policy drivers	18
3. The assets of an ageing population	20
4. Leicestershire Ageing Well Strategy	20
5. Rutland Ageing Well Strategy	21
6. Integrated commissioning in Leicestershire	22
HEALTH AND INEQUALITIES IN OLDER PEOPLE	23
1. Demography	23
2. Health Inequalities	24
3. Older people and health inequalities	28
4. Inequalities in health and social care	28
5. Tackling health inequalities	29
FRAIL OLDER PEOPLE	31
1. Frail Older People	31
2. Primary Care, Prevention and Proactive Care	40
3. Reablement, intermediate care and joint care planning	45
4. Enhanced Home Support	51
5. Crises – the acute care pathway	57
6. End of Life Care	63

OLDER PEOPLE'S MENTAL HEALTH INCLUDING DEMENTIA	67
DIGNITY	73
SAFEGUARDING OLDER PEOPLE	76
PROTECTING THE HEALTH OF OLDER PEOPLE	80
FEEDBACK FROM ACTIONS FOR 2011	84
APPENDIX A: DATA TABLES	89
APPENDIX B: FRAILTY CLASSIFICATIONS	90
REFERENCES	92



List of Tables

Table 1:	Population numbers and percentages for Leicestershire, Rutland and England, Census 2011	23
Table 2:	Population projections 2015 and 2020	24
Table 3:	Recorded and Estimated Number of People living with long-term conditions	33
Table 4:	Estimated number of people aged 65 years and over living with long-term conditions, 2010 and 2015	34
Table 5:	Continuum of Supported Housing	53
Table 6:	Leicestershire County and Rutland Reported Cases to Health Protection Unit East Midlands South between 01/04/2011 and 31/03/2012. 65 years and over	80
Table 7:	Uptake of seasonal influenza vaccination between 2009 and 2012, NHS Leicestershire County and Rutland	83

List of Figures

Figure 1:	Achieving the case for tomorrow	19
Figure 2:	Income Deprivation Affecting Older People	26
Figure 3:	Geographical Barriers to Housing and Services	27
Figure 4:	NHS Hospital Activity 2011/12	32
Figure 5:	Frail Older People Pathway	36
Figure 6:	Pathway for frail older people in Leicester, Leicestershire and Rutland	38
Figure 7:	The continuum of intermediate care (adapted from Brody 2008)	46
Figure 8:	Frailty Syndromes	58
Figure 9:	Hospital Admissions for Falls, People aged 65 years and over, 2010/11	61
Figure 10:	Leicester, Leicestershire and Rutland End of Life Care Pathway	65

EXECUTIVE SUMMARY

This report focusses on the health and wellbeing of older people in Leicestershire County and Rutland. It builds on the evidence presented in the Leicestershire and Rutland Joint Strategic Needs Assessments, which led to both County Councils identifying the health and wellbeing of older people as a key priority. It reviews the health needs of older people, the services that we should be providing and the services that we are providing locally. This information has been used to inform a series of recommendations that will lead to improved care of older people in the future.

In Leicestershire and Rutland 18% of people are aged over 65 years - an older population profile compared to England. It is predicted that the number and proportion of older people will increase. The 2011 Census reported locally 123,000 people aged 65 years and over. This is

predicted to increase to 145,600 by 2015 and 162,300 by 2020. This will lead to an increase in the number of people that are affected by illness and disability that is associated with ageing.

Overall, people in Leicestershire County and Rutland enjoy better health than the average for England, as demonstrated by their higher life expectancy of 79.7 years for males and 83.4 years for females. Life expectancy at age 65 is 18.7 years for males and 21.4 years for females, which is significantly higher than the England averages.

Generally, older people are significant users of health and social care services. However, the overall contribution that our ageing population makes to society far outweighs the use of resources, both financially and through wider contributions. It is imperative that we challenge any negative views of our ageing society.

The key challenge facing health and social care services is that the services that are currently in place will not support the ageing population of the future. With shrinking resources across health and social care this means there is a need to redesign the way that services are delivered to ensure that these resources will meet the future healthcare needs of the population. This will only be achievable by changing the culture of services from treatment services to prevention services. By promoting health in our populations we can delay and/ or prevent their need for treatment services. This will also support people in their desire to remain independent and to lead full and active lives in older age.





1. Frail Older People

Age is the single most significant driver of health need. The prevalence of the common long term conditions (e.g. heart disease, hypertension, stroke, respiratory disease, 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.

People aged 65 years and over in Leicestershire County and Rutland account for less than 20% of the population, but count for over a third of hospital admissions, over half of hospital bed days and almost half of all the spend on hospital care.

Most people who are older will be physically fit

and live full lives. Independence and wellbeing come under threat when older people become frail or ill. It is essential that services are in place across the frail older people's pathway to ensure that people have equitable access to appropriate services when they need them.

The person and their needs must be the central point of their care with all sectors of the health and social care community working together to meet their needs. There are five key stages to the frail older people's pathway and these are summarised below.

1.1. Primary care, prevention and proactive care.

Preventing people from becoming ill needs to underpin everything that we do across health and social care. This will support long term planning for health and social care services and offers the best opportunity for people to enjoy independence and good health in older age.

Older people live longer, are financially better off and own more property than ever before. The majority of our older population are not frail and are living independently of health and social care services. It is essential that we develop services that support people to remain independent, as well as provide easy access to effective services as soon as they are needed.

Supporting people with illness and/ or disability to manage their conditions effectively in the community through proactive care has been demonstrated to improve health outcomes for older people and to reduce long-term costs for health care. Proactive care is based on supporting patients to manage their own conditions more effectively. This support will mean that patients are better able to manage their own health and reduces their risk of having a health crises. Working in partnership across primary care, secondary care and social care will ensure that all agencies understand the issues that can lead a person into crises when their need for interventions and services will increase.

1.2. Reablement, intermediate care and joint care planning

This is the care that is needed by patients that require extra support in managing their health and social care needs, either as an early intervention to prevent a person's health from deteriorating or providing

appropriate support after an acute crisis. The fundamental aim of reablement and integrated care services is to provide care earlier in the frail older person's pathway to reduce the risk of older people needing hospital or residential care and becoming dependant on services.

Central to this is joint care planning across health and social care, and the provision of integrated services through intermediate care. Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to residential care, support timely discharge from hospital and maximise independent living.

Reablement is the support that is given to a client in their own home to help them to get back on their feet and be independent. This includes providing preventative support to people who may be at risk of admission to hospital or residential care.

Both integrated care and reablement services need to ensure that they make the most effective use of the new technologies that are available to support people to remain independent in their own homes. This includes making best use of telehealth and telecare technologies.

1.3. Enhanced home support

Enhanced home support is the support that we need to make available to older people to support them in retaining their independence. This includes supporting people in their homes by ensuring that they have access to appropriate adaptations, ensuring that there is a choice in the range and availability of supported accommodation, from sheltered housing, extra-care housing and residential care to the provision of nursing care for those with the highest level of needs.

Carers provide essential support to older people with support needs who want to retain their independence. In 2011 it was estimated that 14,604 people aged 65 years and over were providing unpaid care to a partner, family member or other person in Leicestershire County and Rutland. The number of people aged over 85 is set to double over the next 20 years, affecting many more families, and potentially increasing the number of people that will be providing family members with care. It is essential that both health and social care work together to identify and support carers in their caring role, and to ensure that we are doing this effectively there is a comprehensive carers' strategy for Leicester, Leicestershire and Rutland.

1.4. Crises – the acute care pathway

Crises occur when the interventions and care that have been put in place for older people break down and their care needs increase resulting in them needing more intensive care. Most older people who are admitted to hospital come via the emergency department and this is where there is the greatest opportunity to work with the patient and their carer to ensure that they get the care that they need.

The oldest patients attending hospital are often physically, cognitively or socially frail. Frailty contributes to patients having longest lengths of stay, highest readmission rates and highest use of long term care after discharge. The most effective way to manage frail older patients presenting in hospitals as an emergency is through a **comprehensive geriatric assessment, integrated within a multidisciplinary team**, to ensure that patients' needs are identified and care is co-ordinated with the aim of returning patients to a community setting.

Prevention measures can also reduce the risk of need for acute care or improve care outcomes for older people. For example:

- » **Falls prevention** - every year, 1 in 3 people over 65 and almost 1 in 2 people over 85 will experience one or more falls. Between a quarter and a third of falls in older people can be prevented and it is essential that we contrive to improve and develop our falls prevention services.

- » **Stroke risk reduction** - stroke is the single largest cause of adult disability. In Leicestershire County and Rutland it is estimated that over 13,000 have had a stroke. Promoting healthy living is very important to preventing strokes – reducing high blood pressure, managing irregular heart beats, smoking cessation and wider statin use.

1.5. End of Life Care

End of life care is the care and support given to both the patient and their carers in the place of their choice during the last year of life and after bereavement.

High quality services for end of life care should ensure dignity, choice and support to achieve the patients' (and their carers') preferred priorities for care in the last year of their life. More than 50% of people express a wish to die at home although currently only about 20% are actually supported to do this.

Leicester, Leicestershire and Rutland have an agreed 'end of life care' pathway, setting out six steps for end of life care taking patients and their carers from discussions as the end of life approaches to care and support after death for the carer and family members.

2. Older People's Mental Health

It is estimated that mental health problems in older people occur in 40% of people visiting their GP, 50% of general hospital inpatients and 60% of people who live in care homes. Depression is the most common mental health problem in older people, affecting 10-16% of people over 65 years of age.

Dementia affects one in 20 aged 65 and over and one in 5 people aged 80+. The ageing profile of Leicestershire County and Rutland's population means that the number of people suffering from dementia is expected to almost double by 2030 from 8,678 in 2011 to 16,845 in 2030.

Leicester, Leicestershire and Rutland have agreed a joint dementia strategy for 2011-2014 to improve the lives of people affected by dementia.

Promoting mental health and wellbeing in later life benefits the whole of society by maintaining older people's social and economic contributions, minimising the cost of care and improving the quality of life. Mental health is a cross cutting condition and many people with long term physical health conditions will also have psychological and emotional needs resulting from the burden of physical illness. Planning to support patients holistically will help long term outcomes both in terms of their mental health and their physical health issues.

3. Dignity

Dignity and respect must be at the heart of care services. It is essential that we change the culture of care services and place a greater emphasis on improving the quality of care and the experience of people using services across health and social care.

4. Safeguarding Older People

Safeguarding is the protection of vulnerable adults from harm. Safeguarding locally is overseen by the Leicestershire and Rutland Safeguarding Adult Partnership.

Forms of abuse include: physical abuse, financial or material abuse, neglect, discriminatory abuse and institutional abuse. There has been an increase in levels of financial abuse, linked to the current economic climate.

In 2010/11, there were over 1,000 referrals linked to adult safeguarding, so it is clear that this is a significant priority for Leicestershire and Rutland. It is essential that all partners work together to promote and further develop the safeguarding agenda and to minimise the risk of harm to vulnerable populations.

5. Infectious Disease in Older People

Older people can be more susceptible to infectious diseases, and the consequences can be more serious, often because of other long term conditions that may be present such as diabetes or chronic lung disease.

Certain infectious diseases are notifiable and as a result we have quite good information about them. Of these, there were 190 infections reported in older people to the Health Protection Agency (April 2011 to March 2012). The most common infection was campylobacter, a food borne pathogen which causes gastroenteritis, and can have more serious health implications for older people.

Older people are more susceptible to health care acquired infections, particularly *Clostridium difficile*. Those living in care homes are also susceptible to winter vomiting disease (*Norovirus*) and scabies. In order to minimise the incidence of hospital or institute acquired infections it is essential that infection control training and procedures remain rigorous.

Influenza can be a serious risk for older people and to address this there is a seasonal flu vaccination programme. Over 73% of people aged 65 years or more in Leicestershire and Rutland were vaccinated against seasonal flu in 2011/12. Work continues to try to get this level to at least 75% for 2012/13 in line with Department of Health targets.

The pneumococcal bacterium is the cause of a serious pneumonia in older people. In 2003 a pneumococcal polysaccharide vaccine was recommended for all people aged 65 and over. Unlike the flu vaccine which needs to be repeated every year, pneumococcal vaccination only needs to be done once for those over 65 years. In 2011/12 almost 92,000 adults had received the vaccination at some time since their 65th birthday. This equates to 66% of the eligible population.



RECOMMENDATIONS

It is proposed that the following strategic recommendations are incorporated into our future planning to ensure that older people maintain their quality of life and have the best health outcomes.

The recommendations within this report link strongly to the recommendations in the Joint Strategic Needs Assessments (JSNA) of Leicestershire and Rutland, and the JSNA has formed the main evidence base that has been used in putting this report together. It is essential that commissioners and providers refer back to the JSNA reports when developing their plans to address the recommendations within this report.

1. Frail Older People

The health needs of frail older people are complex and dynamic. Older people need to be able to access services across the whole of the pathway, accessing the appropriate care for their own health needs, from a range of services and professionals. To achieve this, services:

- must be planned across the pathway and across agencies to ensure that they work together to provide the right level of care, in the right place and at the right time;
- need to be provided in a seamless way that is easy for the patient and their carers to access;
- must be designed in a way that allows equitable access and continually seeks to remove barriers to access and reduces inequalities in health across communities.

It is clear from the evidence that the key risk for frail older people is that they receive a number of separate medical and social care services at different stages in their care. To prevent this:

- there should be an overall plan of care for each frail older person which reflects all of the person's needs (health, social care, housing, economic, etc.);
- commissioners and providers should work together to further develop early access to geriatric assessment. This is proving effective with respect to both patient outcomes and the cost of their care;
- for the most frail there is a need to keep a focus on continuity and unity of purpose in care across sectors and services and on ensuring that information is communicated promptly by each service to all other stakeholders.

The significant challenges in controlling costs and in improving the clinical outcomes, quality of care and experience for older people can be overcome by:

- developing an integrated pathway which involves health and social care partners in all elements of care, from early identification and intervention to end of life care. This should be our aim as this offers the best possibility of meeting these challenges;
- recognising the complexity of the care that is needed by frail older people and ensuring that all staff involved in their care are properly supported to do this.

There is a significant projected growth in the number of people that are over the age of 65 and, in particular, over 85 years. To cope with this change:

- services for this increasing number must be planned now. This is to ensure long-term sustainability of services that are essential for the continued health and wellbeing of our populations.

If the population continues to access healthcare at current rates, hospital use will grow much quicker than the population is growing. This is unsustainable for future service provision and the demand on hospitals cannot be met by future NHS funding. The significant increases in activity and hospital bed days are driven by the ageing population and their increased health needs. To address this:

- there must be a whole system change in the way that health services are planned, commissioned, provided, accessed and used. Without this, the financial challenges faced by the health and social care system in the future will mean that services will not keep pace with the demands that are placed on them;
- challenges need to be faced by a joined-up service, working together across health and social care services and across primary, secondary and community care.

The case studies that have been presented within this report demonstrate the levels of progress that have been made in all parts of the health and social care system, both in improving the services and providing the access to services for older people. However, the whole system change that is needed for a sustainable future health and social care economy has not yet been achieved. To deliver this change:

- it is essential that all providers and commissioners of health and social care work together, alongside the voluntary sector, to address future challenges together.

2. Primary care, prevention and proactive care

The key recommendations for primary care, prevention and proactive care focus on primary prevention and working with people to ensure that they are in full control of their own health and wellbeing. To achieve this:

- public health must work in partnership with county council colleagues to lead effective and targeted early intervention and prevention services across health and social care. This must be driven by a comprehensive strategy, developed through the early intervention and prevention programme;
- primary care must work in partnership with patients to ensure that they are able to manage their long-term conditions;
- primary care must increase the number of people with long-term conditions on their disease registers, with a focus on identifying patients with undiagnosed conditions;
- both Clinical Commissioning Groups (West Leicestershire CCG and East Leicestershire and Rutland CCG) must have a clear and consistent approach to medicines management in older people across Leicestershire County and Rutland. This approach needs to consider policies to target polypharmacy in older patients, as well as targeted campaigns to reduce variations with respect to prescribing in general practice;
- older people must have good access to dental services, ophthalmology services and audiology services.

3. Reablement, intermediate care and joint care planning

The aim of this second stage of the care pathway for older people is early intervention in order to prevent further health problems, or providing appropriate support after an acute crisis, and ensuring that patients have the greatest chance for independence. This can be achieved through:

- good co-ordination of care through a single point of access, with a professional responsible for co-ordinating their care across agencies;
- care planning which must take place across health and social care and across primary, community and secondary care;
- improved integration between primary care and social care offering the best opportunities for early intervention to support older people to be independent;
- commissioning services that are integrated across health and social care. This is essential to the joining up of services and will support focussing services into areas of greatest need;
- building on the success of existing projects like the pathway to 'integrate' health intermediate care services and social care reablement services in Leicestershire;
- increasing access to assistive technologies to bring care into people's homes.

4. Enhanced home support

It is essential to develop affordable housing solutions that support older people to retain independence for as long as they are able. Of particular importance is ensuring that informal care arrangements are recognised and the appropriate support is in place to support carers to continue to care. For this to be achieved the following developments are important:

- the transfer of responsibility of public health to local government is an opportunity to strengthen the relationship between housing, health and care services;
- the existing strategies of Leicestershire County Council and Rutland County Council for future housing provision and support, for example, Leicestershire's extra care strategy, must be developed. The action plans within these need to be realised to ensure that housing provision in the future meets the needs of the population;
- all agencies that have a role with carers must work together in partnership to implement the Leicester, Leicestershire and Rutland carers strategy. CCGs must improve their understanding of the health and wellbeing needs of carers and develop services within primary care to ensure that carers have access to appropriate services across health and social care.

5. Crises – the acute care pathway

To ensure the best possible care, response and health outcomes for older people in crisis, the following steps are recommended:

- health and social care commissioners, and those responsible for commissioning support for older people, must always reflect a joint approach which takes account of the multi-disciplinary nature of care of older people;
- commissioners should ensure that all providers of acute or emergency care for older people conduct an audit against the standards set out in the Silver Book⁵⁰, as well as participating fully in all relevant national audits (e.g. stroke, hip fracture, dementia, fall and bone health, continence);

- clinicians referring patients to urgent care should have access to a simple referral system with an agreed policy provided by local geriatric, emergency medicine, acute medicine and social services;
- older people being admitted to community hospitals, whether for 'step-up' or 'step-down' care, should be assessed and managed in the same way as patients accessing urgent care in any other part of the health system;
- all urgent and emergency care units should have accessible patient information about local social services, falls services, healthy eating, staying warm and benefits, as well as information for carers of frail older people;
- people having an exacerbation of a long-term condition should be treated according to a plan already agreed by their GP and potential acute or out of hours providers, which is realistic and appropriate;
- commissioners need to continue to prioritise falls and stroke prevention services;
- it is essential that all patients have access to acute care when they need it. However this care must be targeted at returning the patient to independence as quickly as is practical, with clear pathways to early supported discharge and access to high quality intermediate care services.



6. End of Life Care

There has been excellent progress in developing the end of life care pathway. However, there is still significant progress that needs to be made in terms of ensuring that all patients at the end of their lives are supported to die in the place of their choice. Key recommendations are:

- improve the early identification of patients across all diagnoses with end of life care needs, allowing timely access to advance care planning;
- shift the focus from specialist palliative care services to causes of deaths with more complex end of life trajectories;
- support the continued development of a single point of access service, to improve the co-ordination of end of life services;
- commission an end of life care pathway that recognises and addresses the challenges and complexities in delivering end of life care on a 24/7 basis. Effective handover care arrangements are essential and services need to be streamlined across all providers;
- all clinical commissioning groups should involve a dedicated end-of-life care lead, as recommended by the National Council for Palliative Care.

7. Mental Health

Any public health approach to mental health in older people needs to be population based and targeted at mental health and wellbeing across the lifespan. It is also important to recognise that mental health and physical health are inextricably linked. Mental health services should focus on primary prevention and early and effective treatment of older people.

Primary Prevention

- Tackle the risk factors for depression, anxiety, suicide, delirium and dementia at all levels, from the individual to the broader policy by:
 - » strengthening social inclusion and participation in meaningful activity;
 - » promoting peer support and older people community development initiatives;
 - » facilitating the fostering of secure, supportive relationships e.g. with family or friends;
 - » maintaining physical exercise levels - 30 minutes a day of at least moderate physical activity on five or more days of the week where appropriate;
 - » tackling poverty in old age including support to maximise benefit uptake.
- Tackle discrimination/stigma on the basis of age by:
 - » promoting older people as independent, respected members of the community;
 - » working with the media to improve perceptions of older people;
 - » promoting intergenerational activities to strengthen understanding and respect between younger and older people.

Early and effective treatment

The early and effective treatment of mental illness in older people should be achieved by:

- raising public awareness about recognising the early signs of depression and dementia;
- further developing the role of primary care in the early identification, diagnosis and support of older people with mental health needs in the community;
- providing information and advice about services that will promote the wellbeing of those affected and their carers;
- strengthening support for unpaid carers and review the information, advice and support provided to carers, especially immediately after the diagnosis of a mental illness is made;
- improving the capacity of local care homes' staff to meet the needs of older people with complex mental health needs and challenging behaviour;
- increasing the involvement of older people in evaluating, monitoring and planning services targeted at mental health and mental illness in older people;
- implementing the recommendations in the LLR Dementia Strategy;
- reviewing the availability and accessibility of services and support for older people with substance misuse needs;
- addressing the underlying mental health needs of people with long-term physical health problems.

INTRODUCTION

1. Background

This is the second in a series of reports reviewing health across the life cycle. This report focuses on the health and wellbeing of older people.

Leicestershire and Rutland's population, like the rest of the UK, is ageing rapidly, because people are living longer and staying fitter for longer. By 2024, an estimated 50% of the UK population will be over the age of 50, due to a combination of increased life expectancy and low birth rates¹.

It is important to celebrate the increase in life expectancy that is driving our ageing population. Older people contribute far more to the community than they consume in terms of resources, and our ageing population is dominated by home owners and people who continue to pay taxes. In addition, our older people have a key role to play as assets to our local communities.

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. As people get older, remaining independent often depends on health and social care services being effective enough to support them.

Older people are not a uniform group and they have a wide range of needs. They may be broadly seen as three groups:

- **Entering old age** - these are people who have completed their career in paid employment and/or bringing up children. This is a socially-constructed definition of old age, which, according to different interpretations, includes people as young as 50, or identifies people that have retired using official retirement ages. These people are active and independent and many remain so into late old age.
- **Transitional phase** - this group of older people are in transition between healthy, active life and frailty. This transition often occurs in the seventh or eighth decades but can occur at any stage of older age.
- **Frail Older People** - these people are vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both. Frailty is often experienced only in late old age, so services for older people should be designed with their needs in mind.





This report is supported by the Joint Strategic Needs Assessment (JSNA) for Leicestershire² and Rutland³ which both contain detailed information on the health and wellbeing needs of the population. Both County Councils have identified the ageing population, in particular the frail older population, as a key strategic priority from their JSNAs.

2. Key policy drivers

“The next ten years will see unprecedented demands on health and social care services as more people reach old age and its associated disability. Epidemiological research and modelling are finding that old age is the overwhelming risk factor for disability, with health status the second most important factor.” (A strategy for the care of frail older people).⁴

The Operating Framework for the NHS in England 2012/13⁵ sets out a number of key challenges for improving the health and wellbeing of older people. This includes requirements on clinical audit in key areas of basic care, a further programme of inspections by the Care Quality Commission, a renewed push on implementation of the national dementia strategy and increased support for carers.

Healthy Lives, Healthy People⁶ is the public health white paper, published in November 2010. At its core is the need to reduce inequalities and improve health at key stages of people’s lives. It sets out a vision to design communities for active ageing and sustainability. It plans to make active ageing the norm rather than the exception, for example, by building more lifetime homes, protecting green spaces and launching physical activity initiatives.

Our Health and Wellbeing Today⁷ provides the evidence for the public health white paper, “Healthy Lives, Healthy People”. This report emphasises the fact that health and wellbeing needs evolve throughout our lives and the need to consider the influences on health at all stages of the life cycle. It demonstrates how the influences on health change at different stages in our life. Of particular importance, it highlights the long-term impacts of our health and wellbeing in early years and the long-term impact this can have on our health in later life.

Caring for Our Future: Reforming Care and Support⁸ is the white paper for social care, published in July 2012. It sets out a vision for a reformed care and support system. This system will:

- focus on people’s wellbeing and support them to stay independent for as long as possible;
- introduce greater national consistency in access to care and support;
- provide better information to help people make choices about their care;
- give people more control over their care;
- improve support for carers;
- improve the quality of care and support;
- improve integration of different services.

This builds on **A Vision for Adult Social Care: Capable Communities and Active Citizens**⁹, which was published in 2010 and sets out seven principles for adult social care. These are prevention, personalisation, partnership, plurality, protection, productivity and people.

The Case for Tomorrow:¹⁰ Facing the Beyond is a policy statement, published in 2012, by the Association of Directors of Adult Social Services (ADASS). This report sets out the challenges for the care of older people in terms of demand, expectations, resources and the services that are currently provided. The report states the case for a fundamental rethink about the role of older people, and the services which are there to help them to lead healthy independent lives into great old age. The report identifies eight key areas that need to be addressed across the full range of health and wellbeing services (Figure 1).

Figure 1: Achieving the case for tomorrow

Effective prevention in supportive communities which promote good health, wellbeing and involvement.	Community health and care services working together to aid recovery and provide ongoing support to reduce the need for acute care.	A range of different types of housing which allows people to remain at home as long as they wish.
Good quality information and advice and straightforward access to health, care and support services.	THE CASE FOR TOMORROW	Better recognition and support for carers, particularly for older carers.
Safe, good quality services from reliable and skilled people.	Real choice and control over services which are fairly priced and affordable.	Services which are effective, efficient and accessible when and where needed.

Source: ADASS

The Marmot Review, Fair Society, Healthy Lives – A Strategic Review of Health Inequalities in England post 2010¹¹ highlights that social inequalities result in many lives being cut short and many people not living life to the full and enjoying opportunities open to them. The review reinforced the message that disadvantage starts before birth and accumulates throughout life. Therefore, the adoption of a life course approach is recommended to break the link between early disadvantage and poor health outcomes.

Marmot states: “Services that promote the health, wellbeing and independence of older people and, in so doing, prevent or delay the need for more intensive or institutional care, make a significant contribution to ameliorating health inequalities.”

The National Service Framework for Older People¹² was launched in 2001. It sets out eight standards that cover the full range of care older people might need. This care is based on clinical need, not age, and services that treat older people as individuals, promoting their quality of life, independence, dignity and their right to make choices about their own care.

3. The assets of an ageing population

Older people contribute to our society in many ways. Financially, through spending and taxation, through caring for friends and family and volunteering. They are also active members of the places in which they live, providing leadership, community cohesion and wisdom and expertise which enriches our society. The Women's Royal Voluntary Service (WRVS) takes a positive look at this in their recent publication "Gold Age Pensioners valuing the socio-economic contribution of older people in the UK" (2011).¹³ The key message from this report is that older people contributed £40 billion positive net contribution to the UK economy in 2010 and will make a projected £77 million net contribution in paid and non-paid work by 2030.

The analysis was based on the costs of providing pension, welfare and health services to older people. The contribution was calculated from tax revenue (with projections linked to increasing retirement age), and the hidden value of the contributions that older people make to society. This includes:

- spending power of over 65s;
- provision of social care by older people;
- hidden value of older people's volunteering;
- donations to charity.

In addition to these financial contributions, older people make other contributions to their communities and neighbourhoods by being active members of the places in which they live. Examples of this kind of social glue include:

- pillars of the community through, for example their role in local clubs, societies, faith groups and other community-based organisations;
- leadership and high levels of membership of local organisations, groups and societies;
- contributing to community safety through, for example, neighbourhood watch;
- active neighbours, looking out for vulnerable neighbours and helping them to stay independent for longer;
- skills and experience, helping to address the national shortages in a number of craft and technical skills to volunteering groups;
- providing advocacy and guidance to people in their communities;
- active users of services in their local area, making these more viable.

4. Leicestershire Ageing Well Strategy

Leicestershire County Council has a strategy for ageing well, "Strategy for Ageing Well in Leicestershire 2008-2011"¹⁴ and a refresh of this strategy, "Ageing Well in Leicestershire (2008-2011) A Strategy Refresh 2010".¹⁵ A new strategy will be developed setting out the priorities of community partners for 2012 and onwards.

The strategy was drawn up in partnership with the Older Person's network and the County Integrated Partnership for Older People (CIPOP). It outlines the high level objectives for the ageing population in Leicestershire, to ensure that older people are not excluded from participating fully in the community in which they live. By highlighting the issues facing older residents the aim is to make Leicestershire a good place to live as people get older.

The key issues identified in this strategy were:

- ensuring that older people feel part of their neighbourhood;
- ensuring that older people are able to access a full range of facilities in their local communities;
- supporting more older people to live healthier lives with care closer to home;
- supporting independence of older people and carers;
- ensuring that older people get appropriate housing support services.

The refresh of the strategy acknowledged the progress that had been made through the 2008-11 strategy and identified the following key objectives for future progress:

- ensuring that older people feel part of their neighbourhood;
- supporting older people to maximise income and use money more effectively;
- supporting more older people to live healthier lives with care closer to home.

5. Rutland Ageing Well Strategy

Rutland County Council has an Ageing Well Strategy that hopes to achieve three broad aims (key outcomes) for older people in Rutland. These are:

- to ensure that older people are able to live at home for as long as they can;
- to ensure that older people who need to receive specialist care in hospital are able to leave in a supported way, having gained the maximum benefit from their stay;
- to ensure that older people have access to accommodation that is appropriate to their needs.

Rutland County Council aims to provide a range of services that will enable people to choose the support that is most appropriate for them. Furthermore the Council is committed to making planning processes more transparent and procedures more inclusive.

These are ambitious aims that will involve all partner agencies in the statutory, voluntary and independent sectors working in partnership and, crucially, with service users and their carers, to achieve them.



6. Integrated commissioning in Leicestershire

The integrated commissioning board is part of the local accountability structures for the Leicestershire health and wellbeing agenda and is key to the modernisation of the NHS. The integrated commissioning board has been established as a sub-committee of the shadow health and wellbeing board to:

- oversee the management of relevant areas of existing joint NHS and local government investment;
- manage a targeted programme of activity that exploits new opportunities. Greater alignment between health and social care expenditure could lead to improved outcomes, greater resource efficiency and potential decommissioning plans.

This is a key board for directing initiatives across health and social care targeted at care for older people. In 2012/13 the board has agreed to focus on the following priority areas:

- Proactive care/frail older people (integrated community teams)
- Dementia
- Continuing Health Care
- Care Homes
- Carers
- Transitions

HEALTH AND INEQUALITIES IN OLDER PEOPLE

1. Demography

The population of England is ageing rapidly and, by 2035, over a fifth of the population will be over 65. Leicestershire and Rutland has an older population profile than England and is predicted to have over a quarter (26%) of the population aged over 65 by 2035.¹⁶

The public health challenges for older people are different to those of working-age adults. Smoking and drinking prevalence are low compared with the rest of the population (although many people are affected by diseases partly caused by sustained risky behaviour through adulthood), and dealing with disability and frailty, falls, dementia and depression are the significant public health challenges. The prevalence of poor diets and malnutrition is high in those who are very old.¹⁷



In 2011 there were an estimated 687,900 people in Leicestershire County and Rutland (650,500 people in Leicestershire, 37,400 people in Rutland).¹⁸ 123,300 people (18%) were aged over 65 years and 16,300 (2.3%) were over 85 years.

Table 1: Population numbers and percentages for Leicestershire, Rutland and England, Census 2011

	Population	Population 65+	Population 75+	Population 85+
England	53,012,500	8,660,500 (16.3%)	4,108,200 (7.7%)	1,180,200 (2.2%)
LCR	687,900	123,300 (17.9%)	57,300 (8.3%)	16,300 (2.4%)
Rutland	37,400	7,800 (20.9%)	3,600 (9.6%)	1,100 (2.9%)
Leicestershire	650,500	115,500 (17.8%)	53,700 (8.3%)	15,200 (2.3%)

Significantly higher than England average

Similar to England average

Significantly lower than England average

Source: 2011 Census, Office of National Statistics © Crown Copyright

Table 2: Population projections 2015 and 2020

	2015			2015		
	Total	65+	85+	Total	65+	85+
England	54,468,200	9,742,400	1,374,300	56,606,600	10,581,900	1,604,900
LCR	722,300	145,600	19,500	755,100	162,300	23,900
Rutland	38,700	9,600	1,400	40,800	10,800	1,800
Leicestershire	683,600	136,000	18,100	714,300	151,500	22,100

Source: 2010 based sub national population projections, Office of National Statistics, © Crown Copyright

The population aged 65 years and over is predicted to increase to 145,600 by 2015 and 162,300 by 2020. This will lead to an increase in the number of people that are affected by illness and disability that is associated with ageing.

In Leicestershire County and Rutland, around 9% of the population are from a black and minority ethnic (BME) group (9% Leicestershire, 4.5% Rutland). In the retired age group (over 60 for women, over 65 for men), this falls to less than 3% from BME groups.¹⁹

Around 45% of people in Leicestershire County and Rutland live in rural communities compared with 27% in England.¹²⁰ Rural communities tend to have an older age profile, with the average age in rural communities generally six years older than in urban areas. This could present issues in terms of older people living within rural communities being able to access services.

In 2005, the Health Survey for England focussed on the health of older people.²¹ This survey reported:

- more than half of both men and women aged 65 and over said their health was 'good' or 'very good';
- among both men and women aged 65 and over, 71% reported longstanding illness. 43% of men and 46% of women reported that their illness limited their activities in some way;
- 22% of older people had visited their GP in the two weeks prior to the study;
- 53% of men and 49% of women had attended hospital as an outpatient in the past 12 months;
- 15% of both men and women had been admitted to hospital in the preceding 12 months;
- the likelihood of outpatient attendance and inpatient admission increased with age.

2. Health Inequalities

Health inequalities are "differences in health status or in the distribution of health determinants between different population groups".²² Health inequalities arise from inequalities in society; that is from the type of houses people live in, the environment and community in which they exist, the nature of the job they do (or the lack of one), and their level of education. These factors which influence health, but lie outside the traditional remit of healthcare, are known as the wider social determinants of health.¹¹ These inequalities in society can be expressed in terms of deprivation, whereby those with poorer health, lower incomes, lower levels of education, poorer quality housing and so on are considered deprived compared with more affluent people living in good quality housing, with higher levels of education.

There are several markers of health inequalities, which include measures of morbidity, self-reported health and mortality. The most straightforward marker for health inequalities is life expectancy. This

considers how long someone can expect to live at the point of birth. There is a gap of seven years between those with the greatest and shortest life expectancies; this is the case for both men and women.²³

Another important measure of health inequalities is 'disability-free life expectancy' (DFLE). This combines information on limiting long-term illnesses and mortality and gives an average number of years that a person can expect to live free of a limiting, long-term condition or disability.²⁴ DFLE is closely linked to the wider social determinants and deprivation.

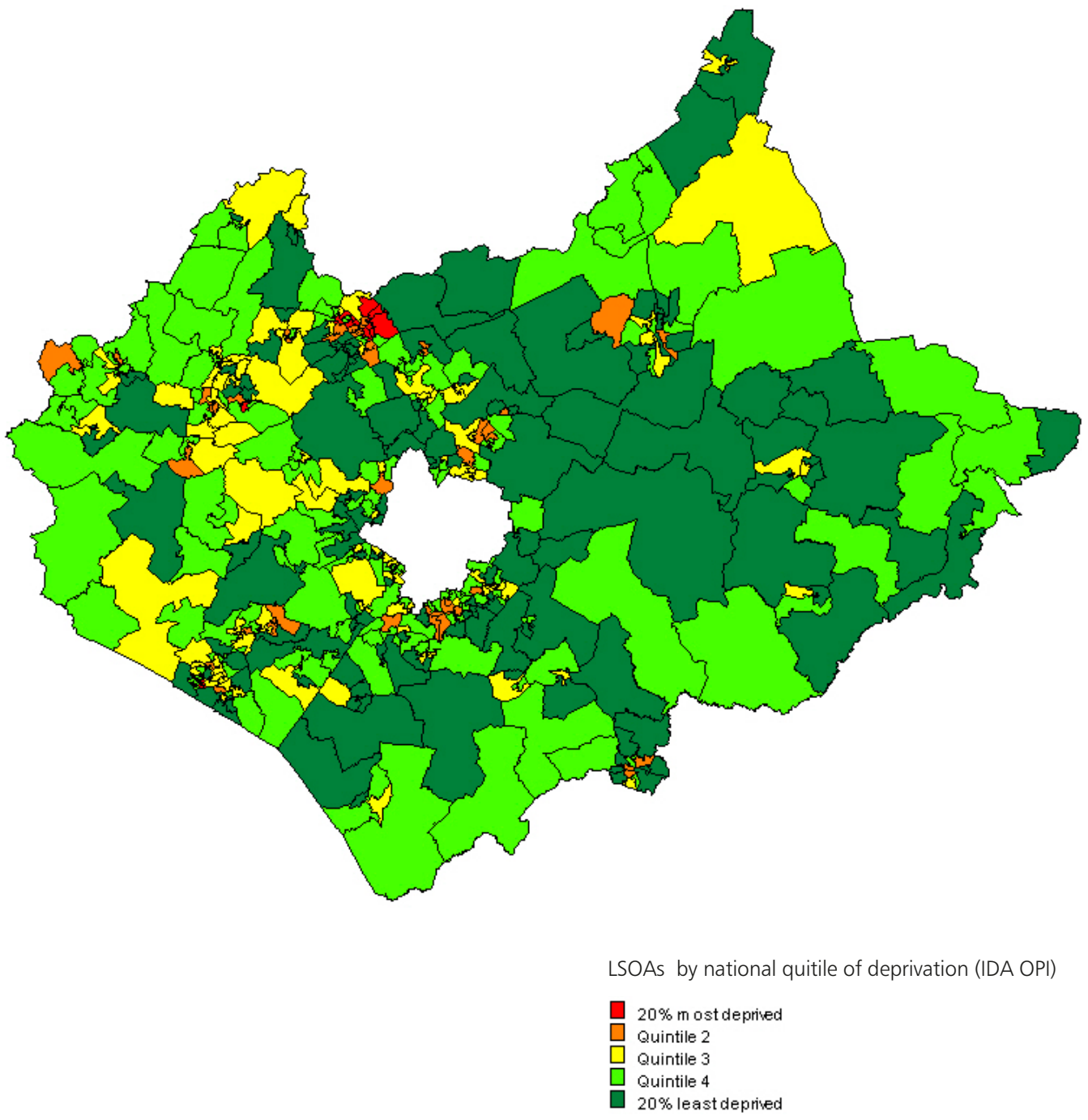
On average in England, the most deprived can only expect about 53 years of disability-free life expectancy, whereas the least deprived can expect about 70 years of life free of limiting long-term conditions. This means that there is an alarming gap of 17 years between the best and worst off; many people are unlikely to get to enjoy retirement free of long-term illnesses.

Health inequalities in Leicestershire and Rutland (combined):

- life expectancy is 79.8 years for males and 83.5 years for females (2008-10). These are both significantly higher than the England averages of 78.6 and 82.6 for males and females respectively;²³
- life expectancy at 65 is 18.8 years for males and 21.5 years for females (2008-10). These are both significantly higher than the England averages of 17.7 years and 20.3 years for males and females respectively;²³
- two thirds of all deaths occur after 75 years and just over one third are in those over the age of 85. This means almost a third of deaths are regarded as premature i.e. they occur before a person reaches 75 years of age. The highest proportion of deaths was in women over the age of 85 (23% of all deaths);²⁵
- the gap in life expectancy between the most and least deprived groups is estimated to be 6.1 years for males and 5.5 years for females;²⁶
- around a third of all deaths are caused by circulatory diseases, a further third are caused by cancer and around 1 in 8 are caused by respiratory diseases;²⁵
- the Excess Winter Mortality Index is the excess winter deaths expressed as a percentage of the expected deaths. In most districts of Leicestershire this index is similar to the England average of 18.7%. It varies from 14.6% Hinckley and Bosworth to 30.1% in Blaby which is significantly higher than the England average. In Rutland it is 22.2%, which is also similar to the England average.²⁷

The **income deprivation affecting older people index** (IDAOPI) is a domain of the English Indices of Multiple Deprivation (IMD), and is a measure of the proportion of older people aged 60 and over living in income deprived households. It is based on the number of older adults living in households claiming Income Support, Income-based Job Seekers Allowance (JSA) or Pension Credit (Guarantee). Comparatively, the IMD allows areas to compare their relative deprivation across the whole country. 68% of the population of Leicestershire County and Rutland live in areas that fall in the 40% least deprived in the country for the IDAOPI, only 10% of the population live in areas that fall in the 40% most deprived. Looking at just this sub-domain, Leicestershire and Rutland is a mostly prosperous area with some pockets of deprivation.²⁸

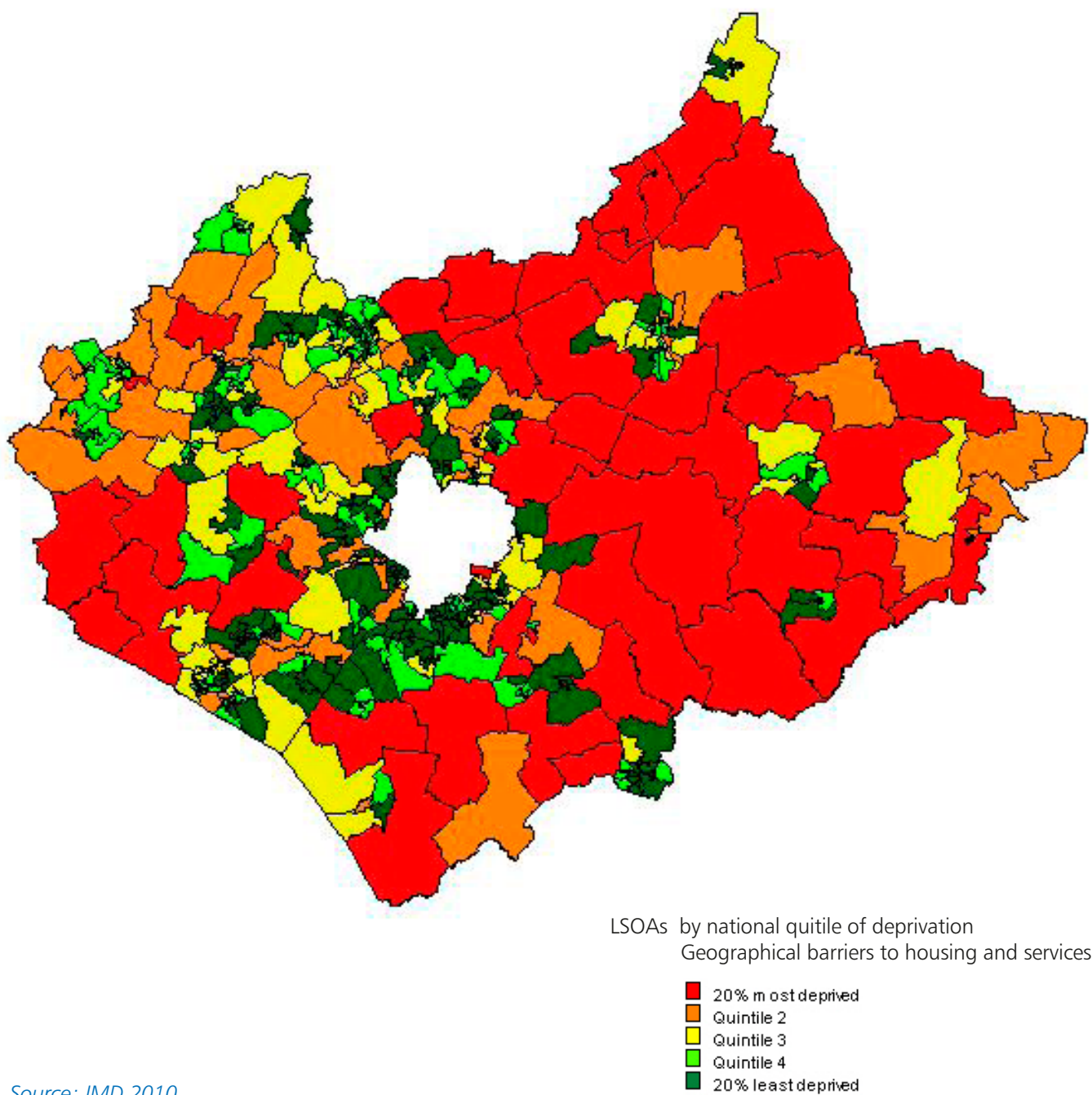
Figure 2: Income Deprivation Affecting Older People



Source: IMD 2010

Access to services is often an issue for the older population. One of the domains of the English Indices of Deprivation is geographical access to housing and services. This includes indicators such as road distance to the nearest GP surgery, shop and post office. 40% of the population of Leicestershire County and Rutland live in areas that fall in the 40% least deprived in the country for access to services, 44% of the population live in areas that fall in the 40% most deprived.²⁹ The higher levels of deprivation in this sub-domain reflect the rural nature of the area.

Figure 3: Geographical barriers to housing and services



Source: IMD 2010

3. Older people and health inequalities

Our population is ageing, due to a combination of increasing life expectancy, a low birth rate, and changes in age distribution within the population. Older people with protected characteristics will face further challenges in terms of social and health inequalities. Such characteristics include: black and minority ethnic people, people with mental health problems, gypsies and travellers, and the homeless. People in these and other disadvantaged groups will need extra support if health inequalities are to be reduced.³⁰

Older people are disadvantaged by the current UK tax system.³¹ Whilst older people often benefit from lower direct taxation, they can spend a disproportionate amount of their income on indirect taxation (for example, duty on clothing and motor fuel), which will cancel out any benefits.³¹

This current system contributes to a gradient of inequalities as, apart from the very wealthiest, all are disadvantaged by this system, but the heaviest burden falls to those who can least afford it. Marmot recommends an overhaul of the tax and benefit system to create a more progressive tax system that takes into account indirect taxes and their impact on the more deprived.

Our population in Leicestershire and Rutland resides in towns or in rural areas. Those with the highest incomes tend to live in the more rural areas of our counties.³⁰ However, this masks issues with social and health inequalities in rural areas. Health inequalities are affected by the higher proportion of older people who are living in rural areas; the average age of someone living in a rural area is almost 6 years greater than the average age of an urban resident.⁶

Living in rural areas poses unique problems in terms of transport, accessing health and social care services, and social exclusion and isolation.³¹ Car ownership is often used in calculating measures of deprivation. This can be misleading, as car ownership is higher in all income groups in rural residents compared with urban residents; the difference is particularly noticeable in those in the poorest 40% of the population.³¹ The problems associated with living in a rural area are compounded by the older age profile of these people.

Inequalities in the health of older people are rooted in inequalities in the wider social determinants of health, which have an impact even before a child's birth. These societal and health inequalities then continue to accumulate throughout the life course. It is for this reason that health inequalities in older people are most effectively addressed by tackling social inequalities at the other end of the lifespan. The Marmot Review identified 'Give every child the best start in life' as the main priority for reducing health inequalities in England. By focussing on this area, social and health inequalities in later life can be reduced.

4. Inequalities in health and social care

Health inequalities can be seen in areas of health and social care, particularly with regards to access to services. In 2009 several major reports on ageism and age discrimination in health and social care in the United Kingdom were written by the Centre for Policy on Ageing on behalf of the Department of Health. These reviews considered the evidence for the presence or absence of ageism in a wide range of areas in healthcare.

The report into ageism in secondary care³² found that older people are less likely to be investigated and treated for cancer, heart disease and stroke than younger people. This was found to be the case even though outcomes for planned, elective surgery in those over 75 years old are good, with rates of adverse events during and after surgery being at similar levels to younger patients. This is important, as emergency surgery in older people is higher risk compared with younger people.³² Early access to planned surgical operations for older people could play a key role in reducing health inequalities in this group.



The quality and access to mental health services for older people vary by location, with compulsory transfer into ‘older people’s services’ at age 65 in some places. The report into ageism in mental health services³² claims that direct age discrimination results from mental health services being divided into separate ‘adult’ and ‘older people’ services. People with chronic mental health problems can find that they do not have access to the same care and treatment options in older people mental health services as they had in adult services. There is also evidence that older people under use mental health services relative to need; the reason for this is unclear, but is probably based on a number of factors.³²

A report into ageism in social care found that “concepts of independence and social care are often interpreted differently and more restrictively for older people than for other adult client groups”.³² Younger people were supported to achieve greater independence than older people, with compulsory transfer from adult services to older people services based on age (65 years) rather than need.³²

Age is a protected characteristic under The Equality Act 2010.³³ This means that under the Act people are not allowed to discriminate on the basis of age; a policy must not have a worse impact on one age/age-group than another (where this cannot be objectively justified). It is crucial that age discrimination does not occur in access to and provision of health and social care, as this may contribute to health inequalities.

5. Tackling health inequalities

The accumulation of health inequalities throughout a lifetime begins even before conception. The housing that a mother-to-be lives in, whether she has a job, and whether she smokes, are just a few of the influences on the future of her children. These social inequalities continue through pregnancy and into the early years of the child.

These early influences are thought to have a major impact on health inequalities even at this early stage, with the impact on health increasing over a lifetime. The Marmot Review recommends concentrating on giving every child the best start in life, through ensuring access to high quality maternity services, childcare, parenting support, and early years education.³¹

Whilst concentrating on the early years is the key to reducing health inequalities throughout the life course, action can be taken to reduce health inequalities at each stage of life, including during

older age. It is important to provide health promotion services to support health and wellbeing and independent living in older people. Services that delay or prevent the need for community or acute hospital stays, or residential and nursing home care, contribute considerably to reducing health inequalities in older people. An example of an initiative that is considered to have achieved improved outcomes for older people is the 'Partnership for Older People'. This pilot project consisted of smaller scale services providing physical and emotional support to older people which improved their health and wellbeing, as well as large scale services to reduce the need for hospital stays.³⁴

FRAIL OLDER PEOPLE

1. 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.

Whilst there is no clear consensus on the definition of frailty, the term is used loosely to describe people that have a reduced ability to cope with minor stresses, such as minor infections or injuries. Only a subset of older people are at risk of becoming frail; those who are vulnerable, prone to dependency and have reduced life expectancy.³⁵

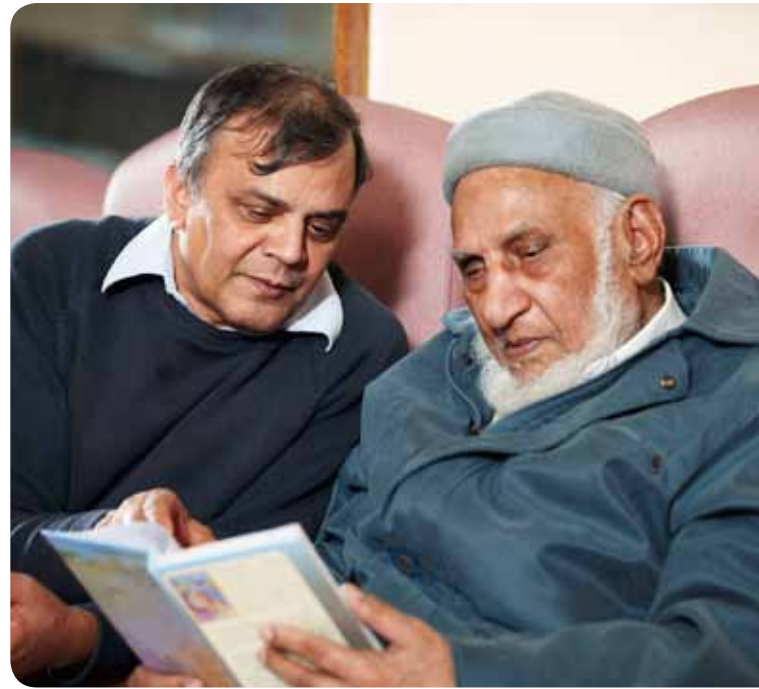
Frail individuals are more likely to have an emergency admission to hospital which has additional hazards, such as cross-infection, noise and disorientation, worsening the situation for them. Falls, reduced mobility, loss of confidence, malnutrition, continence problems and increased dependency are other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

It is important to recognise the rights of frail older people as citizens and the diversity of the group. Many have a wide range of interests and concerns, with a contribution to make and with aspirations for the future. Most still want to lead an active and fulfilling life, even if their health begins to fail.

The factors that older people see as crucial to maintaining independence, such as housing, income and social networks, continue to play a key role for frail older people. Having choices and control over what happens, how and when, remains central to frail older people's sense of wellbeing.

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.

Services for older people have traditionally focused on the most vulnerable in times of crisis, and only rarely reach beyond the immediate health issues to look at the whole person. There is now a growing acknowledgment that a more proactive approach, focused on all the older person's concerns, can promote independence and wellbeing more effectively.



1.1. NHS Hospital Care and older people

The older population uses a significant proportion of hospital activity. As shown in Figure 4 (2011/12) the Leicestershire and Rutland population aged 65 years and over:

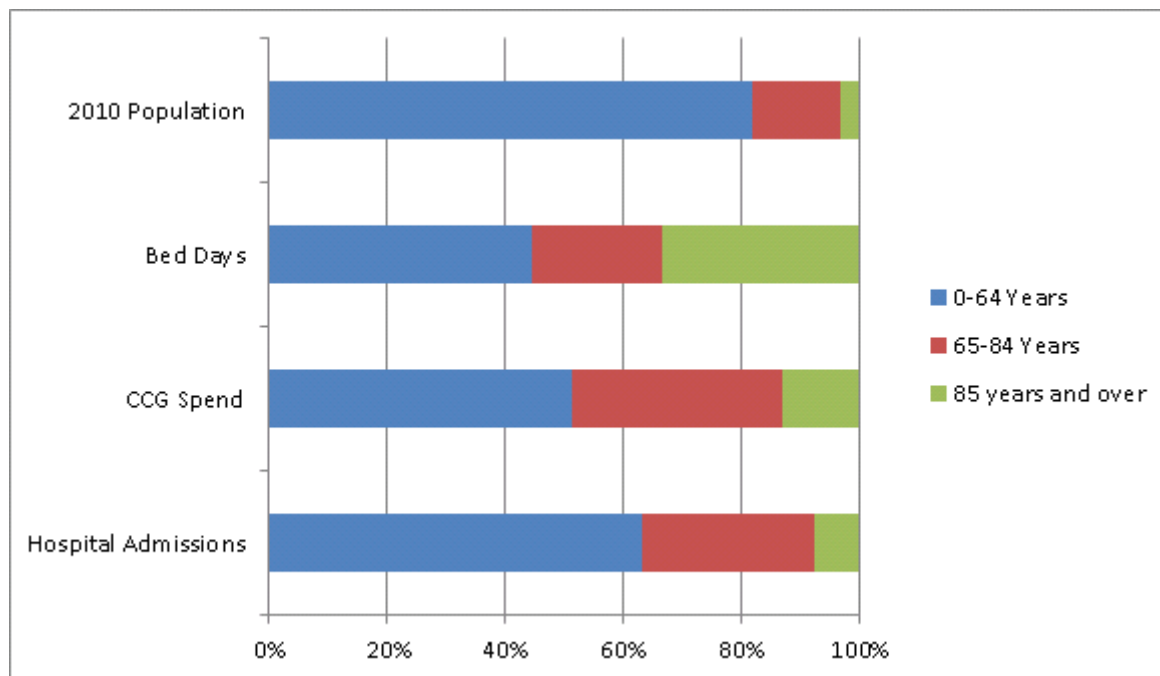
- accounts for less than 20% of the total population;
- accounts for over a third of hospital admissions;
- uses over 50% of hospital bed days;
- drives almost 50% of the spend on inpatient hospital activity.

The main reasons for the hospital stays in the older population are cancer (17%), diseases of the circulatory system (11%) and diseases of the respiratory system (11%).³⁶ However, these medical issues are often concurrent (which leads to polypharmacy), often there are added mental health problems (delirium and dementia) and physical disability.

Fifty five per cent of patients are treated within medical specialties (18% in general medicine, 9% in respiratory medicine, 8% in gastroenterology); 38% are treated within surgical specialties (10% in urology, 8% in ophthalmology, 7% in trauma and orthopaedics).⁸

Fifty five per cent of hospital admissions in the over 65 year olds were planned in 2010/11. Forty Five per cent were unplanned or emergency admissions.⁸

Figure 4: NHS Hospital Activity 2011/12



Source: HERA Health, Evidence, Reporting, Analysis, NHS Leicester, Leicestershire and Rutland, extracted 12-6-12

1.2. Disability

The Projecting Older People Population Information System (POPPI) provides estimates of the level of need in local populations using national prevalence data and applying these to local populations. This data provides us with an estimated level of need and also projections of future need, linked to population growth.

Across Leicestershire County and Rutland it is estimated that in 2011:

- 11,039 people aged 65 and over have moderate/ severe visual impairment (10,328 Leicestershire, 711 Rutland);³⁷
- 3,738 people aged 75 and over have registrable eye conditions (3,501 Leicestershire, 237 Rutland);³⁷
- 22,884 people aged 65 and over are unable to manage at least one activity on their own (21,405 Leicestershire, 1,479 Rutland);³⁷
- 55,605 people aged 65 and over have a limiting long-term illness (52,401 Leicestershire, 3,204 Rutland).³⁷

1.3. Long-term conditions

The increase in the ageing population will drive an increase in the number of people living with long-term conditions. The data in Table 3 illustrates the recorded and estimated prevalence of key long-term conditions. It is evident that we are not identifying all of the people affected by long-term conditions across Leicestershire County and Rutland and there are significant levels of unmet needs in our populations.

Table 3: Recorded and Estimated Number of People living with long-term conditions 2010

Condition	Recorded prevalence	Estimated prevalence	Estimated Number undiagnosed
Hypertension	96,265	169,259	72,994
Coronary heart disease	22,576	29,492	6,916
Stroke or TIA	11,447	13,850	2,403
Diabetes	29,884	39,609	9,125
Chronic Obstructive Pulmonary Disease	9,974	15,079	5,105

Source: GP QOF Data (2010-11) and ERPHO disease prevalence models (2010)

Table 4 illustrates the expected growth in the number of people living with long-term conditions, over a comparatively short period of time. In 5 years time we anticipate a growth of 15-20% in the number of people affected by the four long-term conditions presented.

Table 4: Estimated number of people aged 65 years and over living with long-term conditions, 2010 and 2015

Condition	2010	2015	% change
Hypertension	79,000	93,000	18%
Coronary heart disease	19,500	23,000	18%
Stroke	9,800	11,500	17%
Chronic Obstructive Pulmonary Disease	7,400	8,800	19%

Source: *ERPHO Disease Models and Projections*

1.4. Future care needs

The proportion of the population of Leicestershire County and Rutland that is aged 65 years and over is significantly higher than the average for England and this is expected to increase in the future.

Between 2010 and 2015 the:^{37,a}

- overall population of Leicestershire County and Rutland will increase from 691,600 to 722,300, an increase of 4.4%.
- population aged 65 years and over will increase from 123,100 to 145,600, an increase of 18%
- population aged 85 years and over will increase from 16,100 to 19,500, an increase of 21%.
- overall proportion of the population aged 65 years and over will increase from 18% to 20%.

This unprecedented rise in the older population affects areas such as Leicestershire and Rutland disproportionately due to the older age profile of the population compared to the England average. Older people generally place greater demands on health and social care systems and creating sustainable, affordable, effective and efficient services for the future is a major challenge.

Between 2010 and 2015 it is anticipated that, amongst the population aged 65 and over across Leicestershire County and Rutland, there will be an additional:

- 3,400 people with coronary heart disease (18% increase);³⁹
- 1,400 people with chronic obstructive pulmonary disease (18% increase);³⁹
- 14,000 people with hypertension (18% increase);³⁹
- 1,700 people with stroke (17% increase);³⁹
- 1,800 people with moderate or severe visual impairment (17% increase);³⁷
- 3,200 people unable to manage at least one activity on their own (18% increase);³⁷
- 9,500 people with a limiting long-term illness (18% increase).³⁷

This will drive an increase in the need and demand for health and social care services. This growth should be planned for now to ensure the provision of a sustainable health and social care economy in the future.

^a Note: the data in this section of the report is 2010 to 2015 to ensure that all projections cover the same time period.

Local analysis of current activity for Leicester, Leicestershire and Rutland, applied to projections of the future population,⁴⁰ demonstrate that by 2025:

- the population across Leicester, Leicestershire and Rutland will increase by 12%;
- total hospital inpatient spells will increase by 19%;
- hospital bed days will increase by 32%.

1.5. What is frailty?

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'.⁴¹ 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.

The definition of frailty that is being used in this report is older people (aged 65 and over) who need help with the basic activities of daily living (washing, dressing, feeding, toileting). This section of the report focuses on the impact of medical crises on frail older people. Clearly, the older people's pathway across health and social care will impact directly on frail older people and this is covered throughout the report as a whole.

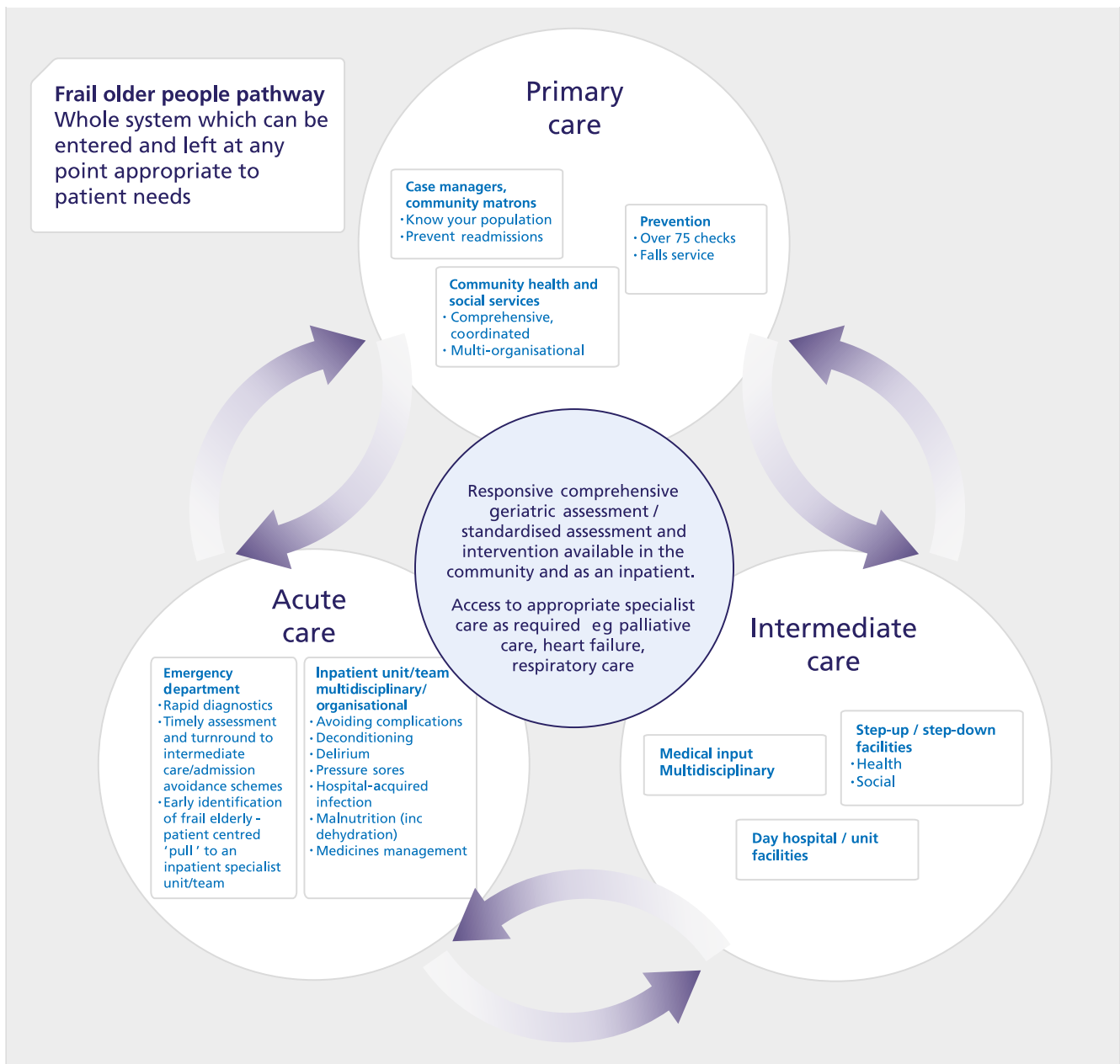
Currently, the best estimate for the prevalence of frailty comes from a European study, which indicated that the proportion of people aged 65 and over in Northern Europe likely to be frail is about 12%.⁴³ On this basis, it can be predicted that, in Leicestershire, there were about 13,800 frail older people in 2010, increasing to 18,200 by 2020 and 22,600 by 2030.

There are a number of tools that are available for classifying frailty. Two of the current tools for measuring frailty are included in Appendix A, the World Health Organisation's International Classification of Functioning, Disability and Health (ICF) and the Canadian Study of Health and Ageing Clinical Frailty Scale. These tools help the people that are involved in the care of frail older people to understand the challenges that their frail older clients will face and will support them in determining the levels of support and intervention patients will need.

1.6. Managing the health of frail older people

The health needs of frail older people are complex and dynamic and therefore the pathway of care frail older people is complex. The NHS Institute for Innovation and Improvement have developed a frail older person's pathway (Figure 5) for the delivery of the best outcomes and achieving the best value for money for care.⁴⁴ People will move up and down the pathway in terms of their healthcare needs and the challenge across health and social care is to improve the care for and management of frail older people so that their care needs are met before patients reach crises. Older people need the skills and knowledge necessary to enable them to access extra support when it is needed and services need to be flexible and responsive to meeting their needs.

Figure 5: Frail Older People Pathway



Source: NHS Institute for Innovation and Improvement

Older people need to be able to access the appropriate care for their healthcare needs by being able to access services across the whole of the pathway. The "Acute care toolkit 3"⁴⁵ is a toolkit for developing acute medical care for frail older people. It proposes a system that is integrated across primary and secondary care and health and social care.

The toolkit presents a holistic pathway for frail older people, which shows how people can move through the system from primary care through to an acute hospital stay. For each stage in the pathway it also sets out key actions for improving a patient's health and their access to appropriate care.

The key challenge for services is to design a system that enables the early identification of those people that can safely be managed outside of hospital, as well as intensive support for patients who have a medical crisis, and provides a framework for managing patients across the whole pathway.⁴⁶

Unwell frail older people ideally need more than just a medical assessment. They require assessment and support from other services, such as physiotherapy, occupational therapy, nursing and social care, in order to deliver a holistic overview and arrange on-going treatment, whether in hospital or in the community. Social care and health services in the community should have a co-ordinated approach to identifying frail older people. They need to put support measures in place to help maintain them in their home rather than in hospital with the increased risk of long lengths of stay, high readmission rates and subsequent long-term care.^{48,49}

The Silver Book⁵⁰ sets the standards for quality care for older people with urgent and emergency care needs. The Silver Book⁵⁰ is a collaboration between Age UK, National Ambulance Service Medical Directors, Association of Directors of Adult Social Services, British Geriatrics Society, Chartered Society of Physiotherapy, College of Emergency Medicine, College of Occupational Therapists, Society for Acute Medicine, Royal College of General Practitioners, Royal College of Nursing, Royal College of Physicians, Royal College of Psychiatrists, Emergency Nurse Consultants Association and the Community Hospitals Association. The standards were developed with the following underpinning principles:

- respect for the autonomy and dignity of the older person must underpin our approach and practice at all times. All older people have the right to a health and social care assessment and should have access to treatments and care based on need, without an age defined restriction to services;
- a whole systems approach with integrated health and social care services strategically aligned within a joint regulatory and governance framework, delivered by interdisciplinary working with a person centred approach, provides the only means to achieve the best outcomes for frail older people with health and social crises.

The report sets out standards for older people with emergency and urgent care needs and it is important that these are used by commissioners when developing their plans for the future.

1.7. Care for frail older people in Leicestershire County and Rutland

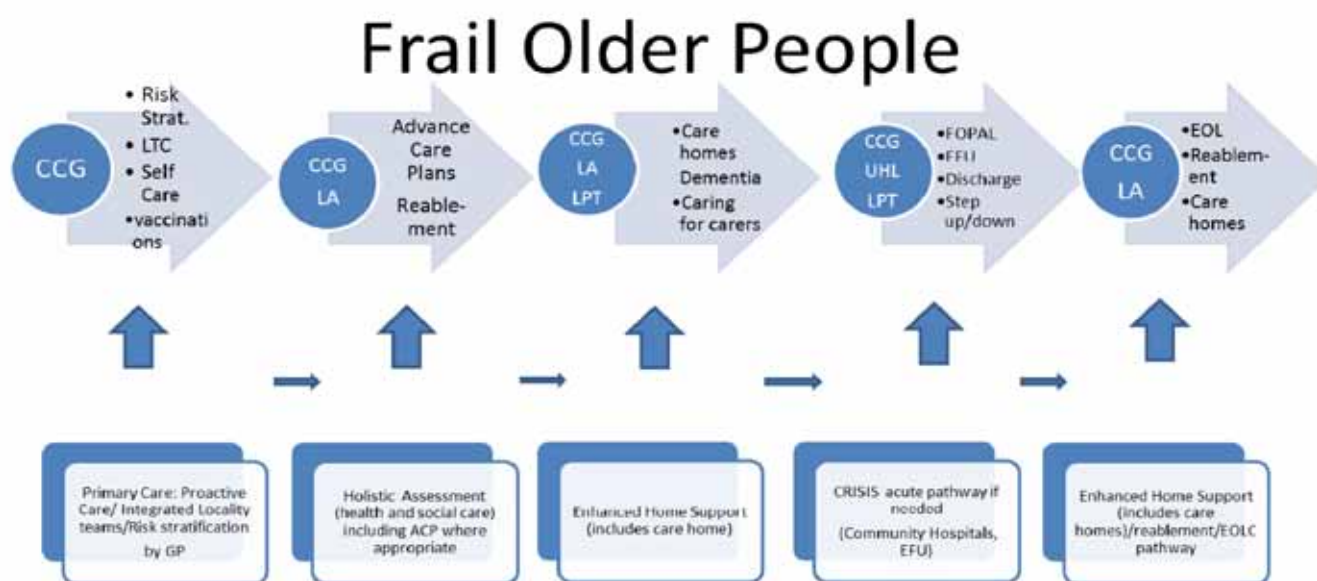
Across Leicestershire County and Rutland the current patterns of care for older people are unsustainable. Both primary care, secondary care and social care services are facing stringent cuts in the face of the economic downturn. The ageing population and the increasing complexity of patients requiring urgent care are a major challenge for the healthcare system. Local analysis has shown⁵¹:

- between 2011 and 2033 the total population is projected to grow by 16%,
- between 2011 and 2033 total hospital spells are projected to grow by 32%.

This section of the report reviews some of the initiatives that have been developed across Leicestershire County and Rutland in the planning for service redesign to support our future populations across primary and secondary care. The case studies presented in this section cannot be viewed in isolation as a whole system response is required to adequately address the future health needs of our population. The success of the service redesign is dependant on the initiatives outlined in other areas of this report around issues such as integrated care, reablement and end of life care.

Across Leicester, Leicestershire and Rutland (LLR) there is an agreed local pathway for the care of frail older people that has been agreed across health and social care.

Figure 6: Pathway for frail older people in Leicester, Leicestershire and Rutland



To co-ordinate and improve the delivery of care for frail older people across this pathway, a number of groups and projects have been established to address the issues of ageing and frailty.

- **LLR wide Frail Older People's Network**, chaired by the clinical lead from West Leicestershire CCG. This group includes representation from the three CCG older people's leads, and clinical and managerial representation from a range of stakeholders as well as from patients. The terms of reference for this group include setting the strategic framework for developments in frail older people services, sharing good practice, and providing leadership across the region to ensure delivery on LLR wide initiatives such as falls, dementia and risk stratification.
- **Care Homes Advisory Group**, chaired by the PCT Cluster Assistant Director of Quality, brings together stakeholders from the three CCGs, University Hospitals of Leicester, Leicestershire Partnership Trust, East Midlands Ambulance Service, and Care Homes providers to drive forward an agenda which allows sharing of good practice and work to address quality issues.
- **End of Life Steering Group**, chaired by the clinical lead from West Leicestershire CCG. This LLR wide group has been recently formed with a focus on collaboration on best practice linked to commissioning and service development.

1.8. Recommendations

The health needs of frail older people are complex and dynamic. Older people need to be able to access services across the whole of the pathway, accessing the appropriate care for their own health needs, from a range of services and professionals. To achieve this, services:

- must be planned across the pathway and across agencies to ensure that they work together to provide the right level of care, in the right place and at the right time;
- need to be provided in a seamless way that is easy for the patient and their carers to access;
- must be designed in a way that allows equitable access and continually seeks to remove barriers to access and reduces inequalities in health across communities.

It is clear from the evidence that the key risk for frail older people is that they receive a number of separate medical and social care services at different stages in their care. To prevent this:

- there should be an overall plan of care for each frail older person which reflects all of the person's needs (health, social care, housing, economic, etc.);
- commissioners and providers should work together to further develop early access to geriatric assessment. This is proving effective with respect to both patient outcomes and the cost of their care;
- for the most frail there is a need to keep a focus on continuity and unity of purpose in care across sectors and services and on ensuring that information is communicated promptly by each service to all other stakeholders.



The significant challenges in controlling costs and in improving the clinical outcomes, quality of care and experience for older people can be overcome by:

- developing an integrated pathway which involves health and social care partners in all elements of care, from early identification and intervention to end of life care. This should be our aim as this offers the best possibility of meeting these challenges'
- recognising the complexity of the care that is needed by frail older people and ensuring that all staff involved in their care are properly supported to do this.

There is a significant projected growth in the number of people that are over the age of 65 and, in particular, over 85 years. To cope with this change:

- services for this increasing number must be planned now. This is to ensure long-term sustainability of services that are essential for the continued health and wellbeing of our populations.

If the population continues to access healthcare at current rates, hospital use will grow much quicker than the population is growing. This is unsustainable for future service provision and the demand on hospitals cannot be met by future NHS funding. The significant increases in activity and hospital bed days are driven by the ageing population and their increased health needs. To address this:

- there must be a whole system change in the way that health services are planned, commissioned, provided, accessed and used. Without this, the financial challenges faced by the health and social care system in the future will mean that services will not keep pace with the demands that are placed on them;
- challenges need to be faced by a joined-up service, working together across health and social care services and across primary, secondary and community care.

The case studies that have been presented within this report demonstrate the levels of progress that have been made in all parts of the health and social care system, both in improving the services and providing the access to services for older people. However, the whole system change that is needed for

a sustainable future health and social care economy has not yet been achieved. To deliver this change:

- it is essential that all providers and commissioners of health and social care work together, alongside the voluntary sector, to address future challenges together.

2. Primary Care, Prevention and Proactive Care

The first stage of the care pathway for frail older people is primary care, prevention and proactive care. This stage of the pathway is concerned with keeping people well and independent for as long as possible.

2.1. Early Intervention and prevention services

Early intervention is aimed at halting the development of a problem which may already be evident, whilst prevention is about stopping a problem arising in the first place. There is strong evidence that older people benefit from early intervention and primary prevention initiatives such as:

- physical activity: for example, adapting exercise, even for the very frail older people can help strength, mobility and balance, and reduce the risk of falling;
- improved diet and nutrition: for example, being either overweight or underweight can have a detrimental effect on an older person's health and wellbeing. Being overweight is related to a higher risk of developing diabetes, and a higher prevalence of osteoarthritis of the knees;
- immunisations management programmes: it is estimated that, if all older people were immunised against influenza, almost 5,000 additional lives might be saved each year in England.

In addition to specific health initiatives, local initiatives to reduce poverty and improve housing and local amenities, including transport, also promote good health and support independence.

Early intervention and prevention services should include the following tiers:

- **Primary prevention/promoting wellbeing** services or interventions are aimed at people who typically have no assessed care needs or symptoms of illness. The focus is therefore on changing risky lifestyle behaviours or maintaining healthy ones, maintaining independence and promoting wellbeing. Stopping a problem developing in the general population is the key objective.
- **Secondary prevention/early intervention** services or interventions seek to identify people at risk and to halt or slow down any deterioration, and actively seek to improve their situation. Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those who have existing low level care needs. Identifying those at risk and preventing problems occurring in the at risk population is key.
- **Tertiary prevention** services are aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus here is on maximising people's functioning and independence through interventions such as rehabilitation and enablement services. Stopping a problem getting worse is the key objective here.

The transfer of public health to local government will improve integration of public health with these services and presents an opportunity to improve the integration of care. This service integration is particularly important in an area like Leicestershire and Rutland which covers large rural areas. Sparse older rural populations may have more limited social networks, transport issues and restricted access to services.

Leicestershire Early Intervention and Prevention Project Board

This board has been established to develop a strategy for early intervention and prevention across children's, adults' and public health services'.

The integrated early intervention and prevention project board is developing a comprehensive strategy for primary and secondary prevention. This strategy will present a shared understanding across public health, children's and adults' services within Leicestershire of:

1. at risk groups within the community where investment in primary prevention and early intervention will help people to maintain a good quality of life, good health and the ability to live independently;
2. the risk factors across these groups which ultimately lead to increased need for services such as long-term residential care, hospital admission or a requirement for expensive packages of care;
3. effective services and interventions which address these risks/ "tipping" points and which represent good value for money;
4. current investment by Leicestershire County Council in early intervention and prevention, who it is targeted at, how much it costs and its effectiveness;
5. currently available universal services across Leicestershire which contribute positively to early intervention and prevention;
6. the synergies and gaps between current services.

2.2. Management of long-term conditions through proactive care

Long-term conditions refers to a group of illnesses that, at present, cannot be cured but can be controlled by medication and other therapies. Once a person has a long-term condition their life is forever altered. However, by supporting patients with a long-term condition to manage their condition and their risk factors, the NHS and social care can support the patient to attain better health outcomes and quality of life, slow disease progression and reduce disability.

The prevalence of many long-term conditions increases with age and an ageing population will have an increasing number of people living with long-term conditions. These patients will be largely managed within primary care.

In 2007, the Department of Health published "Supporting People with Long-Term Conditions". This report sets out the vision for long-term conditions, for a joint approach across health and social care, providing patients with access to high quality personalised care, with reduced reliance on secondary care and effective management of care in a primary, community or home environment.

"Supporting people with long-term conditions" ⁵³ reported that:

- seventeen and a half million people in this country report a long-term condition (such as diabetes, asthma or arthritis);
- for some people, especially older people and those with more than one condition, discomfort and stress is an everyday reality;
- the impact on the NHS and social care for supporting people with long-term conditions is significant;

- care for many people with long-term conditions has traditionally been reactive, unplanned and episodic. This has resulted in heavy use of secondary care services;
- just 5% of inpatients, many with a long-term condition, account for 42% of all acute bed days;
- only about 50% of medicines are taken as prescribed.

The report sets out a strategic vision of ensuring that health and social care has an effective and systematic approach to the care and management of patients with a long-term condition. This would increase the provision of care services available in a primary, community or home environment, reducing the reliance on secondary care services. Care for patients would be high quality and personalised to their individual needs. Central to the strategy is the need to identify all patients in the community with long-term conditions and to stratify these patients according to their needs. The report proposed a model of care for long-term conditions:

- **Level 3: Case management:** Identify the most vulnerable people, those with highly complex multiple long-term conditions, and use a case management approach, to anticipate, co-ordinate and join up health and social care.
- **Level 2: Disease-specific care management:** This involves providing people who have a complex single need or multiple conditions with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways, such as the National Service Frameworks and Quality and Outcomes Framework.
- **Level 1: Supported self-care:** collaboratively help individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively

This is the basis of the proactive care model that has been developed for frail older people in West Leicestershire CCG. The model is using risk stratification to identify the patients that would benefit from primary and secondary prevention and referring these patients to integrated neighbourhood care teams who will support the patients and their carers to manage their conditions. The principle behind the model is that effective self-care will provide patients with greater control over their condition, which will mean that they are better able to manage their own health and are less likely to move through the pathway towards a crises state.



West Leicestershire CCG Proactive Care Strategy

Proactive care is a strategic approach to managing frail older people and those with long-term conditions. The approach places the patient and their general practice at the centre with teams working in an integrated geographical basis to support their care.

Central to the proactive care model is the vision of virtual wards. The patient is the central point of the ward and their care is co-ordinated across the integrated team by a team of clinical co-ordinators.

The model proposes the provision of effective community services alongside a robust means of identifying which individuals are most at risk of unscheduled hospital admissions. The philosophy model moves away from condition-based approaches which can create silos and fragmentation in patient care to a fully integrated service across health and social care.

The approach has three key objectives:

1. Develop a strategic approach to risk stratification
2. Define and implement the commissioning model for integrated neighbourhood care teams through virtual wards
3. Develop the approach to supported self-management/ shared decision-making with the patient and their carers

A multi-agency project group was established, chaired by the GP lead for Proactive Care, with representatives from each locality, a patient representative and clinical and managerial colleagues from secondary, community and social care. The group is an active participant in Sir John Oldham's National Long-Term Conditions programme and was recently praised for the progress made to date.

2.3. Management of medicines in the older population

As people get older, the number of medicines they take tends to increase – 80% of people over 75 take at least one prescribed medicine, with 36% taking four or more medicines (polypharmacy). This means that for many older people, particularly those with chronic illness, medication forms a part of their daily routine and contributes significantly to their health and wellbeing.⁵⁴

Poor medication management, allowing adverse drug reactions or non-compliance to go unchecked, can contribute to a breakdown in independent living and unnecessary waste of money and resources. The National Service Framework (NSF) for Older People outlines a whole range of ways that things can go wrong and can affect the ability of older people to manage their own medication safely and effectively. Examples include under and over use of medicines, inadequate or misleading dosage instructions, poor follow-up and lack of medication review.⁵⁵

Across Leicestershire County and Rutland the key themes that are being addressed with respect to medicines management and older people are polypharmacy and the prescribing of antipsychotic drugs for patients with dementia.⁵⁶

The East Midlands Strategic Health Authority (SHA) has produced guidance for the use of antipsychotic drugs in patients with dementia. Antipsychotic drugs are used for the management of behavioural and psychological symptoms in dementia. The development of such symptoms is a core part of the

syndrome of dementia. They can cause major problems for people with dementia and their carers and are a legitimate focus for intervention to decrease distress and harm, and increase quality of life.

However, the assessment and management of such behaviours in dementia can be complicated. The systems that we have for dementia treatment and care have grown by chance rather than by active planning or commissioning, and there are important gaps in services and skills. The consequence of this is that, while some people with dementia receive excellent care, for the large majority it appears that current systems deliver a largely antipsychotic-based response. Good practice guidelines are readily available but they do not appear to have been translated into clinical practice.

These guidelines have been adopted across Leicestershire County and Rutland and form part of a national work stream for improving Quality, Innovation, Productivity and Prevention (QIPP). Across practices in LCR, this has been identified as a target area and practices with high rates of prescribing of antipsychotics have been selected to audit their prescribing and will develop an action plan to address any issues that this identifies.

The polypharmacy agenda, where patients are on four or more prescribed drugs, is an area that is under development. In April 2012, three care homes were selected for medication reviews and this project is currently being developed. The recommendations from this evaluation will be used to develop a strategy around polypharmacy and care homes. The medicines management team have applied for transformation money to support medicines reviews in care homes.

Other areas of concern for prescribing in older people are medicines related falls, the prescribing of antihypnotics and prescriptions of sip feeds.

2.4. Recommendations

The key recommendations for primary care, prevention and proactive care focus on primary prevention and working with people to ensure that they are in full control of their own health and wellbeing. To achieve this:

- public health must work in partnership with county council colleagues to lead effective and targeted early intervention and prevention services across health and social care. This must be driven by a comprehensive strategy, developed through the early intervention and prevention programme;
- primary care must work in partnership with patients to ensure that they are able to manage their long-term conditions;
- primary care must increase the number of people with long-term conditions on their disease registers, with a focus on identifying patients with undiagnosed conditions;
- both Clinical Commissioning Groups (West Leicestershire CCG and East Leicestershire and Rutland CCG) must have a clear and consistent approach to medicines management in older people across Leicestershire County and Rutland. This approach needs to consider policies to target polypharmacy in older patients, as well as targeted campaigns to reduce variations with respect to prescribing in general practice;
- older people must have good access to dental services, ophthalmology services and audiology services.

3. Reablement, intermediate care and joint care planning

The second stage of the care pathway for older people is concerned with patients that require additional support in managing their health and social care needs. The aim of this part of the pathway is early intervention, preventing exacerbation of health problems, or providing appropriate support after an acute crisis, ensuring that patients have the greatest opportunity for independence. This includes developing joint care plans across health and social care, making the best use of new technologies in patients' care and ensuring that patients have access to effective community based care.

3.1. Intermediate Care

Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

Intermediate care has an important function in meeting the health and social care needs of individuals to prevent unnecessary admission, expedite appropriate hospital discharge and avoid premature admission to care homes.

Older people are particularly vulnerable at transition points in care, so services need to work together and share responsibility for meeting older people's needs through access to appropriate care, in the right place and at the right time.

Properly developed and implemented, the intermediate care function will enhance the appropriateness and quality of care for individuals and help older people realise their full potential as well as regaining their health. Intermediate care should also have a significant impact on the health and social care system as a whole by making more effective use of capacity and establishing new ways of working. It is an important element of recent policy development, such as care closer to home, the transformation of social care,⁵⁷ the NHS Next Stage Review,⁵⁸ carers' and national dementia strategies⁵⁹ and compliance with the Mental Capacity Act.⁶⁰

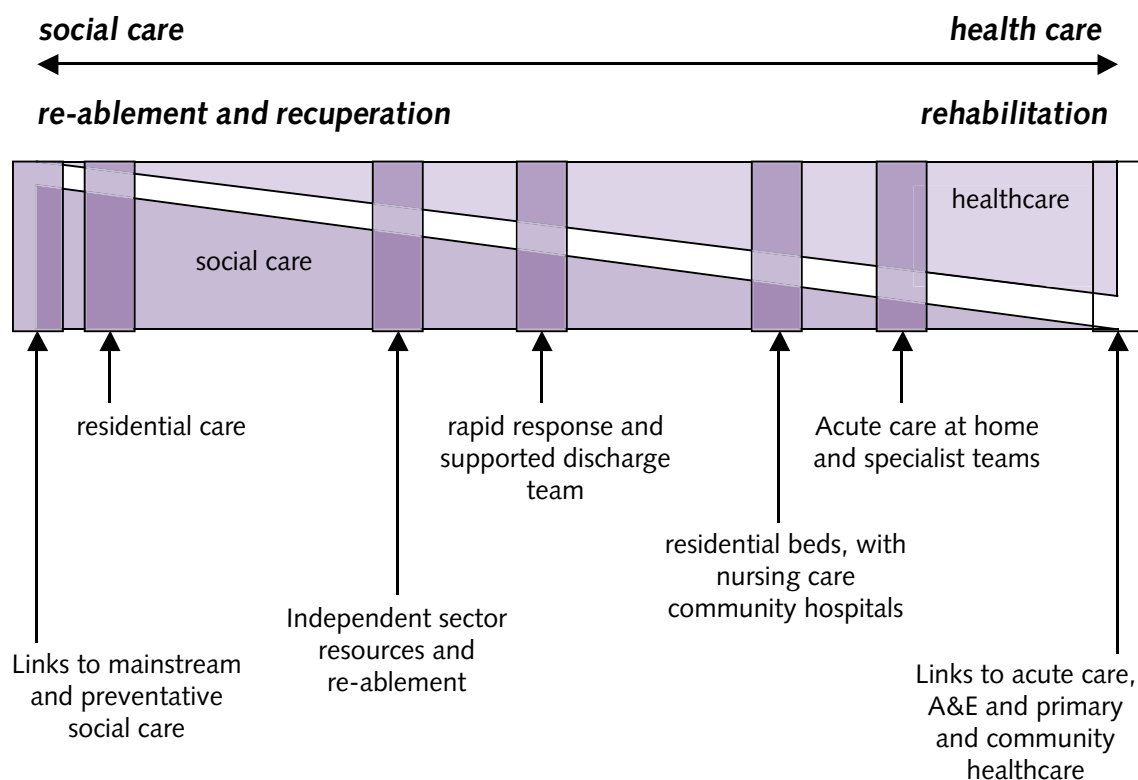
Intermediate care services meet the following criteria:⁶¹

- targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long-term residential care or continuing NHS inpatient care;
- provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
- planned outcome of maximising independence and typically enabling patients and service users to resume living at home;
- time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less;
- involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

Types of intermediate care provision

Intermediate care is a function rather than a discrete service, so it can incorporate a wide range of different services, depending on the local context of needs and other facilities available. It should support anyone with a health-related need through periods of transition, operating between other service units, so will need to adapt in response to any changes in the surrounding services. It is part of a continuum, spanning acute and long-term care, linking with social care reablement. This is illustrated in Figure 7.

Figure 7: The continuum of intermediate care (adapted from Brody 2008)



Single Point of Access:

There is a single point of access (SPA) for adult community health services in Leicestershire Partnership NHS Trust (LPT). This is designed to ensure that patients get the most appropriate care, quickly, and help to make better use of resources. Health professionals, patients, carers, relatives, care agencies and organisations will call one number to access services.

The SPA operates 24-hours a day and is manned by nurses and other healthcare professionals who can:

- refer patients to appropriate services;
- give patients and carers advice on managing conditions;
- help clinicians to make choices about care options for their patients, so that they don't get admitted to hospital unnecessarily;
- help make sure care is in place in the community so that patients aren't in hospital longer than they need to be.

Having a single number to call to access services is much less confusing for patients and referrers, and managing referrals centrally ensures that patients get the right care in an efficient way.

East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG): Additional Care Home Beds Pilot

The pilot was designed to reduce emergency hospital admissions during the very busy winter period. Instead of admitting their patient to hospital as an emergency, GPs were able to offer them the option of being admitted to a local care home.

Patients would generally be frail and old, the length of stay would be a maximum of two weeks, the patient would be capable of being discharged home again or to another easily available long-term placement at the end of this time. The advantages of the scheme for the patient and their family are:

- continuity of care – the patient's own GP would be able to continue caring for them, but in a safer environment than the patient's own home;
- ease of access – the patient would be cared for closer to home than the University Hospital Leicester (UHL). This promotes ease of visiting for the older patient's spouse, relatives and friends;
- homely environment - there is much less risk of hospital acquired infections;
- better liaison with local social services to aid quick and appropriate discharge homecare support packages.

The original pilot was undertaken by two practices. It has evaluated well and ELR CCG has secured transformation funding to extend the pilot from August 2012 to the end of March 2013. The intention is to increase the number of practices and care homes participating across the whole ELR CCG area. The extended pilot will then be more fully evaluated.

3.2. Reablement

Reablement is the name for support given to a client in their own home and is designed to help them to get back on their feet and be independent. For example, this might be after a period of illness or a stay in hospital. Reablement services are seen as key preventative support to people who may be at risk of admission to hospital or residential care.

Reablement is designed to help people learn or re-learn the skills necessary for daily living which may have been lost through deterioration in health and/or increased support needs. Reablement improves outcomes, particularly in terms of restoring people's ability to perform usual activities and improving their quality of life. From a social care perspective, there is a high probability that reablement is cost effective, through reducing or removing the need for on-going support via traditional home care. However, there is currently little evidence to suggest that it reduces health care costs.⁶²

Leicestershire Homecare Assessment and Reablement Team (HART)

In Leicestershire, reablement and promoting independence services are a key priority and are provided by the Home Care Assessment and Reablement Team (HART), the Community Enablement and Reablement Team (CERT) and the Mental Health Inclusion Support Service. The use of short-term reablement has been provided in Leicestershire for over 10 years and has a proven track record of maintaining independence and value for money. All of the services work with individual service users to achieve greater independence as well as facilitating access to community services. Assistive technology and telecare services have received significant investment in Leicestershire. This is linked to the HART team which ensures that the equipment and response services are fully considered to help support people to continue to live in their own homes. Further use of telehealth and telemedicine are being considered.

The HART reablement service has been integrated with the work of health intermediate care teams, focusing on adults who have been discharged from hospital or are at risk of an unnecessary admission / readmission to hospital.

The County Council is working collaboratively with the Clinical Commissioning Groups (CCGs) to enhance and integrate community services for frail older people. One of the significant aims of the joint working is the identification of those that are most in need to support the identification and provision of appropriate services in a timely and effective way across different agencies.

Rutland Enablement Team – Case Study

Mrs C, a 91 year old lady discharged home following a major operation, initially required four calls a day to support her with personal care and meal preparation. Goals were agreed with Mrs C to work towards regaining her independence with daily living tasks. A commode was initially needed in the lounge as Mrs C was not confident to use the bathroom alone. Calls were gradually reduced as her independence increased. At the end of the reablement period (of only a few weeks), just one call a day was needed as an on-going care package. Mrs C's strength and stamina had increased, her mobility had improved through joint working with social services and the health intermediate care team physiotherapist and the commode were no longer needed as she had regained her confidence in using all areas of her house.

3.3. Assistive Technology

Assistive technology is the generic term for telecare and telehealth. These interventions include community alarms linked to an emergency response service, electronic motion monitoring equipment and remote monitoring of key diagnostic symptoms for people with long-term health conditions.

Assistive Technology has been shown to be an effective way of enabling people with a wide range of conditions to stay in their own homes as well as offering support to their carers and reducing and/or delaying admissions to hospital, residential or nursing care.

Several councils have identified cost savings attached to the implementation of assistive technology. For instance, North Yorkshire County Council found a 38% reduction in care costs through the use of telecare as an element of packages of support.

The NHS Operating Plan for 2012/13⁵ emphasised the role of assistive technology in modernising the NHS and delivering more effective and efficient care. Telehealth and telecare are two technologies that offer opportunities for delivering care differently but also more efficiently. The Whole System Demonstrator programme⁶³ is developing the evidence base to support further integration of these technologies in the care that is available to patients.



Leicestershire Assistive Technology Project

In Leicestershire, the assistive technology project team was established in September 2011. This team has supported a considerable increase in the number of customers receiving support through assisted technologies. In July 2011, six units of assistive technology were issued through Leicestershire County Council. In November 2011, this had increased to 48 units issued in the month. The most common types of standalone equipment are flip clocks, Grayson clocks and wireless pressure mats, and medication dispensers. The majority of equipment has been allocated to people with dementia and cognitive impairment or for falls prevention.

Significant developments in relation to the delivery of a countywide telecare service are nearing completion. The full service, including community alarms, will be in place from early 2012, also providing an emergency responder service, critical to the needs of service users across the county.

Rutland County Council Assistive Technology

Rutland County Council is partnered with Spire Housing to provide advice and support to people who wish to find out more about how assistive technology can help them remain in their homes for as long as possible and enable them to have more independence.

3.4. Reductions in funding of social care

Local councils are facing severe cuts to their funding at a time when the older population is growing and care needs are predicted to rise. In July 2011, the Commission on Funding of Care and Support published "Fairer Care Funding", the report of the commission on funding of care and support.⁶⁴ This report found that the current adult social care funding system in England is not fit for purpose and needs urgent and lasting reform. It found that the current system is confusing, unfair and unsustainable, with people unable to plan ahead to meet their future care needs. The report made a series of recommendations linked to achieving an affordable and sustainable funding system for care and support for all adults in England, both in the home and in other settings. The white paper for adult social care, "Caring for our future: reforming care and support"⁸ sets the financial context for the reforms of social care that are proposed in the white paper, this includes making better use of social financing (for example social impact bonds) and improving efficiency in social care.

The relationship between individual wealth and state funding is a complex issue. Older people contribute more to the overall economy than they use. As the pressure increases on social care to reduce their overall spending it is anticipated that the number of people that will have to fund their own care will rise. The drivers that will influence the numbers of people that are self funding are:

- changes to the eligibility criteria;
- increased charging;
- reduction of state funding;
- increase in direct payment uptake.

In the longer term, pensions and the housing equity held by many older people will mean that many are ineligible for public funded social care support in the future. By 2030, 25% of Leicestershire's population will be 65 or over, of which 77% are likely to be home owners.

It is also anticipated that an increasing number of people who currently self-fund their care home placements, may cross over to being council funded. This is because people are living longer and their assets are not sustaining them throughout their old age.

People entering the social care market need access to good quality information, advice and a broad range of flexible services. People will access this through a range of agencies, of which the council is one. No more than around one in five people aged 75 or over in a particular council area make contact with the council, and only around one in six receive council funded support⁶⁵.

There is an expectation that both the number and the proportion of self-funders is likely to increase in the coming years. The precise numbers of self-funders is an inexact science for a variety of reasons, and figures produced should only be seen as indicators.

Even with increases in the wealth of the older population, Forder⁶⁵ estimates the call on public funding will increase by over 3.5% per annum in real terms over the next 10 years. If available resources do not keep pace, then a smaller proportion of people can be supported. Levels of unmet need are therefore likely to increase.

3.5. Recommendations

The aim of this second stage of the care pathway for older people is early intervention in order to prevent further health problems, or providing appropriate support after an acute crisis, and ensuring that patients have the greatest chance for independence. This can be achieved through:

- good co-ordination of care through a single point of access, with a professional responsible for co-ordinating their care across agencies;
- care planning which must take place across health and social care and across primary, community and secondary care;
- improved integration between primary care and social care offering the best opportunities for early intervention to support older people to be independent;
- commissioning services that are integrated across health and social care. This is essential to the joining up of services and will support focussing services into areas of greatest need;
- building on the success of existing projects like the pathway to 'integrate' health intermediate care services and social care reablement services in Leicestershire;
- increasing access to assistive technologies to bring care into people's homes.

4. Enhanced Home Support

For a large proportion of the older population, independence depends on a decent income, comfortable housing, being able to get around in the community and having good social networks. For a minority (although increasingly for older ages), being independent may require more support.⁶⁶

Work undertaken by the Audit Commission has identified seven key dimensions in enabling independence among older people:⁶⁷

- housing and the home;
- the neighbourhood;
- social activities, social networks;
- getting out and about;
- income;
- information;
- health and healthy living.

Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society⁶⁸ was published in 2008 and sets out the following vision:

"...everyone should be able to make a choice that mirrors their lifestyle and circumstances; above all, to remain safely in their own home, near friends and family, as long as they would wish to; that good housing is essential for good health and wellbeing, and should be valued and planned as such; and that, as years go by there will be a choice of desirable housing with support and care to match changing capabilities."

Older people are twice as likely to be unable to afford fuel in winter, and thermally inefficient housing has been linked to the increase in deaths during the colder months.⁶⁸ Older people are also at highest risk of dying in a dwelling fire. Poor housing conditions can exacerbate existing medical conditions. Forty per cent of those aged 80 and over report a long-term illness or disability and there are currently 1.5 million people with a medical condition or disability requiring specially adapted accommodation.

Most older people would much prefer to stay put rather than move home. However, as health and mobility declines many need 'that bit of help' to remain living in their home in safety and comfort. This needs to be supported through access to adaptations and rapid repairs services.

Specialised housing needs to be available to people who are no longer able or no longer want to live in their own homes. Specialised housing refers to housing with care services and includes care homes and supported housing.

Leicestershire Housing and Support for Older People

The Housing and Support for Older People project was created as a partnership between Leicestershire County Council Older People's Services, strategic housing representatives from the seven district councils, the Primary Care Trust and the voluntary sector. The project's vision is:

To develop a county-wide continuum of supported housing options for older people that addresses support as well as housing need, is flexible to the changing needs of older people, maximises independence, and is provided in properties and places where people choose to live.

The health and wellbeing needs driving this project have been identified as:

- the increase in the ageing population, particularly those aged 85 years and over;
- the profile of the BME population, with a different age profile and concentrations of south-Asian people in Loughborough and Oadby and Wigston Districts;
- the wide variation in terms of wealth and deprivation across the county, with a shift from urban to suburban, or rural living, as people age and become more affluent;
- owner-occupiers account for 79% of all older people's housing tenure;
- most old people living in owner occupied properties are mortgage free;
- owner occupiers are often capital rich, but sometimes income poor;
- many older people are unsuitably housed, especially in the private sector;
- many older people under-occupy their properties, especially in the private sector;
- property maintenance, especially in the private sector, is a very important issue for older people;
- the highest levels of unmet support needs are in the private sector;
- there are considerable numbers of older people in receipt of informal care and support;
- there is a poor fit between housing needs and the available provision of housing designated for older people;
- there are issues around meeting the decent homes standard in some sheltered accommodation;
- the two groups with the highest unmet needs are people with physical disabilities and frail older people.

Housing options should be understood in its widest sense, to include all forms of accommodation for older people. This ranges from general purpose housing with no formal links to support services through to 24-hour staffed supported accommodation, and all points in between. This is what is meant by a continuum of supported housing.

Table 5: Continuum of Supported Housing

Unsupported Housing		Supported Housing			Intensive Supported Housing
General Needs	Adapted General Needs	Ordinary Sheltered	Extra Care	Residential Home	Nursing
Low		Level of Need			High

4.1. Extra Care Housing

In recent years there has been a change in the needs and aspirations of people as they get older, with a dislike of traditional models of residential care and housing support services. As the numbers of older people increase, the housing market, care and support services need to adapt to individual requirements.

Designing more accessible and easily adaptable 'lifetime housing' has been promoted as a long-term cost-effective way of improving older (and disabled) people's independence and quality of life.

Extra care is a form of housing provision that allows people in need of care and support to remain independent, or age in one place without having to move, in particular to residential care or nursing homes. This provides a range of tenure options, and allows more flexibility in terms of lifestyle choice.

The basis of extra care is:

- Choice and control for older people, by offering individuals a wider range of modern, flexible and innovative care and support options, which will:
 - » put older people at the centre of services
 - » give individuals better and improved services that are joined up and seamless
- Promoting independence for older people, by the provision of self-contained accommodation with access to on-site care and support, which will:
 - » enable individuals to live independently in the community
 - » promote their wellbeing and help alleviate social isolation
- Empowering older people, by the provision of health, care and support services coming to the individual, as and when they need it, which will:
 - » enable individuals to stay in their own homes and not be required to change their accommodation
 - » allow individuals to receive services that can and should be available in the community
- Accessible services for older people, by designing or adapting where individuals live to facilitate the delivery of personal social care, support and health services.

Leicestershire Extra Care Housing Strategy for Older People

Leicestershire Adult Social Care Service has agreed an "Extra Care Housing Strategy for Older People 2010-2015".⁶⁹ The strategy offers a structured approach to developing extra care in the county and helps to create balanced communities and provide choice to older people in Leicestershire. The strategy will allow older people in Leicestershire to have the choice and control over their daily lives with care and support delivered as and when they need it.

There are currently 166 units of extra care housing across the County. The strategy sets out an ambitious target of 500 places by 2015. The economic climate makes this target incredibly challenging and the department is considering all viable opportunities for developing this approach in the coming years.

4.2. Care homes

Residential care is either provided by independent sector providers, often private businesses or voluntary sector providers, or by local authorities in their own homes.

There are 125 care homes across Leicestershire, but these are not located evenly across the County with 23% of independent sector homes being in Charnwood. Eighty five per cent of the care provided is through independent sector providers.

Care homes in Rutland County Council

Rutland County Council has developed a best practice checklist to assist contract monitoring within care homes. The contracts section regularly liaises with the Care Quality Commission regarding any concerns about care homes as well as noting good practice. Safeguarding training is provided to the homes by the Council and regular provider forums are held for care providers to keep up to date with developments and share good practice.

4.3. Community Alarm Services

Community alarms allow vulnerable people to live at home with the reassurance that if something happens they are able to call for help through a control centre using their alarm. The housing and support for older people project is reviewing the existing provision of community alarms and will identify and make recommendations on the types of assistive technology to be promoted and supported through control centres, to assist people who have a tendency to fall or are becoming confused.

4.4. Property Related Services

The housing and support for older people project is reviewing the range of property related support services (repairs and maintenance, aids and adaptations, and handyman services) across the county. They will carry out a feasibility study into rationalising services to achieve a better strategic fit to the needs of older people, whilst ensuring equitable access from anywhere in the county, and enabling older people to access properties and services appropriate to their needs.

4.5. Carers

There are almost six million carers in the UK - that is one in ten people. Over the next 30 years, the number of carers will increase by 3.4 million (around 60%). Carers are estimated to save the Government between £67 billion and £87 billion a year. More than 80% of carers say that their caring role has damaged their health.⁷⁰

- In 2011 it is estimated that 14,604 people aged 65 years and over are providing unpaid care to a partner, family member or other person in Leicestershire County and Rutland.³⁷
- This is expected to rise to 16,815 in 2015 and 21,864 by 2030.³⁷
- This is an increase of 15% in Leicestershire and Rutland by 2015 and 50% by 2030.³⁷

The number of people aged over 85 is set to double over the next 20 years, affecting many more families, and potentially increasing the number of people that will be providing family members with care.

Carers help and support the people they care for to deal with and manage problems caused by illness or disability, or substance or alcohol misuse, by giving physical, practical and emotional support to the cared for person. Caring responsibilities may be for short periods of time or, in many cases, for a lifetime. Anyone can become a carer as a result of an accident or sudden illness or it may be a gradual process with a slow deterioration in the health of the cared for person. The condition of the cared for person may change on a daily basis making it difficult to predict the demands on the carer and their own need for support

There is no fixed group that needs care. Support might be needed by relatives, friends, children, older people, people with disabilities or those who are ill.



Carers Strategy

In June 2012 a refreshed carer's strategy for Leicester, Leicestershire and Rutland was launched (Supporting the Health and Wellbeing of Carers in Leicester, Leicestershire and Rutland – Strategy and Delivery Action Plan, 2012-2015). The strategy is a joint strategy between Leicester City Council, Leicestershire County Council, Rutland County Council and Leicester City, Leicestershire County and Rutland NHS Cluster. It has been developed in collaboration with carers and carer organisations from across Leicester, Leicestershire and Rutland.

The vision of the LLR Strategy is taken from the national strategy which states::

“Our vision is that by 2018, carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals' needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, while enabling the person they support to be a full and equal citizen.”

The strategy, and work detailed in the delivery action plans (each Council has its own delivery action plan) will lead to implementation of the strategy and reconfirm the commitment of all partners to see carers universally recognised and valued as being fundamental to strong families and stable communities. Throughout the next three years our goal is to demonstrate that the successful delivery of the actions within the plan will both lessen and support the impact that caring has on a carer's life, thus enabling carers to maintain a balance between their caring responsibilities and a life outside of caring.

The strategy and delivery action plans focus on the following areas:

- Identification and recognition
- Realising and releasing potential
- A life outside caring
- Supporting carers to stay healthy
- Early intervention and prevention, particularly high quality provision of information and advice (especially at the beginning of the caring role)
- Ensuring fair access to marginalised groups

Within these priority areas it is recognised that older carers represent a growing group of people. Continuing investment in carer support is critical, including timely and accessible breaks for carers and Leicestershire County Council will continue to increase funding for the carers support grant using health transfer money. Another vital element of support is the provision of high quality information and advice, especially at the beginning of the caring role. By providing these key areas of support we are helping carers to continue to be independent. It is also recognised nationally that the health needs of carers significantly increase with the number of hours that they care for an individual. In 2012/13 the increase in NHS Transfer Money for Leicestershire is also being used to specifically implement health checks for carers and to provide information about the condition of their cared for person early on in their caring role, thus leading to significant improvements in the health of carers by adopting these preventative approaches.

The Leicester, Leicestershire and Rutland Carers Strategy in Rutland

Rutland County Council consulted with carers concerning the overarching LLR carer strategy. A good response was received to this from carers as well as a commitment to involvement in developing the action plan arising from this. Key issues were breaks for carers, information and advice and support when it is needed.

4.6. Recommendations

It is essential to develop affordable housing solutions that support older people to retain independence for as long as they are able. Of particular importance is ensuring that informal care arrangements are recognised and the appropriate support is in place to support carers to continue to care. For this to be achieved the following developments are important:

- the transfer of responsibility of public health to local government is an opportunity to strengthen the relationship between housing, health and care services;
- the existing strategies of Leicestershire County Council and Rutland County Council for future housing provision and support, for example, Leicestershire's extra care strategy, must be developed. The action plans within these need to be realised to ensure that housing provision in the future meets the needs of the population;
- all agencies that have a role with carers must work together in partnership to implement the Leicester, Leicestershire and Rutland carers strategy. CCGs must improve their understanding of the health and wellbeing needs of carers and develop services within primary care to ensure that carers have access to appropriate services across health and social care.



5. Crises – the acute care pathway

A substantial proportion of hospital care concerns older people. The oldest old (aged 85+) accounted for 5% of first attendances to emergency departments in 2008/9, and 62% were admitted to hospital. People aged 85 years and over are nearly 10 times more likely to have an emergency admission than those aged 20-40. If admitted for inpatient hospital care, the oldest old have the highest readmission rates and highest rate of long-term care use after discharge.⁷²

There will always be events that occur where the interventions and care that have been put in place to support older people break down and their care needs will increase, resulting in the older person requiring more intensive care, such as a hospital stay. Most older people who are admitted to hospital come via the emergency department. This is a key interface in the health and social care system where older people with crises can be assessed. The oldest patients attending hospitals are often physically, cognitively or socially frail (i.e. prone to significant deterioration after apparently minor stressors). Frailty contributes to the oldest patients having the longest lengths of stay, highest readmission rates,

and highest rate of use of long-term care after discharge. Admission to hospital also adds the specific hazards of, for example, cross-infection, noise and disorientation.

It is essential that older patients are properly assessed when they move into a crises. Getting the assessment of older people right has the potential to improve outcomes, reduce inappropriate hospitalisation, and potentially reduce the need for long-term care. The assessment should review the patient for one or more frailty syndromes (Figure 8). If present, this should prompt consideration of the need for a fuller assessment. In addition to the medical assessment, many older people will require assessment and support from professionals within other disciplines (physiotherapy, occupational therapy, nursing, social care and others) in order to deliver a holistic overview and arrange on-going treatment, either in hospital or in the community.

Figure 8: Frailty Syndromes

<p>Falls Distinguish between syncopal (eg cardiac, polypharmacy), or non-syncopal (strength, balance, vision, proprioception, vestibular and environmental hazards all to be assessed).</p>	<p>Incontinence This is an unusual acute presentation, but a marker of frailty and a risk factor for adverse outcomes. More common is the misuse of urine dipstick testing, leading to erroneous diagnosis of infection, inappropriate antibiotics and increased risk of complications such as clostridial diarrhoea. Dipstick tests are frequently positive for leucocytes due to the high prevalence of asymptomatic bacteriuria. A dipstick positive for leucocytes and nitrites has a disappointingly low positive predictive value for infection – only 44% – and should only be considered in a patient with unexplained systemic sepsis.</p>
<p>Delirium and dementia These are closely interrelated but each requires clinically distinct management. Collateral history is key to detect a recent change in cognition; it is common for delirium to be superimposed on pre-existing dementia. Delirium can be hyperactive, hypoactive or mixed. Delirium in the AMU is usually caused by sepsis, metabolic disturbance or polypharmacy; by contrast dementia is a long-term condition.</p>	<p>Immobility 'Off legs' can hide many diagnoses ranging from cord compression to end-stage dementia. A comprehensive assessment is needed to focus on the urgent and important issues to be addressed.</p>
<p>Polypharmacy Adverse drug events lead to increased hospital stay, morbidity and mortality. Consider a medication review focusing on identifying inappropriate prescribing, as well as drug omissions (eg STOPP/START). Medicines reconciliation should also be considered.</p>	<p>End-of-life care Mortality rates for frail older people in the year following discharge from AMUs are high (26% in one series); attendance at the AMU is therefore an ideal opportunity to consider advance care planning.</p>

Geriatric medicine does not deal with a single organ system or type of disease process. The key patient group for geriatric medicine is frail older patients who often have multiple chronic diseases and may also have cognitive and social problems. Geriatricians work within a team to deliver comprehensive geriatric assessment to undertake a holistic assessment of the older person. The most important aspect of treatment is to identify reversible or treatable medical conditions. The key is working as part of a multidisciplinary team with nurses, therapists, and colleagues from social services to rehabilitate, support, and finally help our patients to return to a community setting.

The service model for geriatric medicine in University Hospitals Leicester has been driven by "Transforming Community Services, A Strategy for Frail Older People".⁴ This strategy was proposed by Leicestershire County and Rutland, NHS Leicester City and University Hospitals of Leicester (UHL) NHS Trust in 2010. It sets the context for the care for frail older people, with a drive towards the integration of health and social care for older people to provide the most effective care to sustain older people in the community. The strategy also set out options for the management of older people in a crises, using comprehensive geriatric assessment by a multi-disciplinary team working across all sectors of care.

Older people's services in University Hospitals Leicester

The Department of Geriatric Medicine in Leicester is one of the leading services in the country delivering interface geriatrics - a fusion of community geriatrics and acute geriatrics.

There are two main services, the Emergency Frailty Unit (EFU) and the Frail Older Person's Advice and Liaison Service (FOPAL). The development of EFU and FOPAL services at the Leicester Royal Infirmary make up the strategy at UHL for creating a 'frail friendly front door'. The aim of these services is to try to improve the care received by frail older people in hospital and reduce unnecessary hospital admissions, lengths of stay and readmissions. Each of the services works to deliver comprehensive geriatric assessment for each identified frail older person, joining together doctors, nurses, physiotherapists, occupational therapists, primary care co-ordinators, physician assistants and discharge specialists to provide an integrated response. The services provide an assessment covering not only medical aspects, but psychological social, environmental and functional assessment. This assessment therefore does not only identify, treat and manage the patient's initial reason for coming to hospital but also works to reduce readmission rates by looking at the patient holistically.

Emergency Frailty Unit (EFU):

The EFU is a central area within the emergency decisions unit (EDU) designed to improve the quality of care and decision making for frail older people in the emergency department (ED). It delivers multidisciplinary assessment from nurses, primary care co-ordinators, therapists and geriatricians at the front door enabling patients to have comprehensive geriatric assessment on arrival to facilitate an appropriate patient pathway. These patients are transferred to EFU rather than admitted to acute medical unit (AMU) for assessment. There is a multidisciplinary ward round of these patients every morning focussed on determining a frail older person's medical, psychological and functional capability in order to develop a co-ordinated and integrated plan for treatment and follow-up. The length of stay for patients aged 85 and over on EFU is 0.4 days, and the overall discharge rate for that age group has increased by 20% comparing 2011-12 to 2010, with readmissions down by 25%. The Geriatricians work closely with ED and provide in reach into ED throughout the day - supporting the ED staff with the assessment of older people. We are currently developing an EFU outreach service. This involves a primary care co-ordinator from the EFU working jointly with community teams to case manage selected high risk frail older people who have recently been discharged from EFU, to ensure they receive the right care, at the right time, in the right place.

Frail Older Persons' Advice and Liaison (FOPAL)

The FOPAL service provides in-patient support only for older people with psychiatric or geriatric syndromes. It runs Monday to Friday, 9am to 5pm and supports mainly the Leicester Royal Infirmary and the Glenfield Hospital with ad-hoc support to the Leicester General Hospital. FOPAL offers support to the base wards and the acute medical unit for frail older people, including problems such as:

- Confusion
- Immobility
- Parkinson's disease
- Falls
- Continence
- Capacity/refusing treatment

In conjunction with EFU, the number of patients being admitted to hospital for in-patient care has reduced by around 25%.

5.1. 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.⁷⁴ The long-term implications of falling include possible physical disability, entry into long-term care, and psychological problems.

Hip fracture is the most common injury related to falls in older people, and is the most serious complication of a fall in an older person. More than 95% of hip fractures in adults aged 65 and older are caused by a fall. Hip fractures can lead to loss of mobility and loss of independence. For many older people it is the event that forces them to leave their homes and move into residential care. Mortality after hip fracture is high: around 30% at one year.⁷⁵

Falls are the commonest cause of serious injury in older people and the commonest reason for hospital attendance. There is reliable research evidence that between a quarter and one third of falls can be prevented in older people.⁷⁶ The National Service Framework for Older People has described the appropriate service response based on an integrated falls prevention service¹² and the National Institute for Health and Clinical Excellence (NICE) has produced guidance on important components of such a service.⁷⁷

Evidence-based guidance is available from NICE on falls and fall prevention.⁷⁴ This guidance was published in 2004 and is currently being updated. According to the current guidance, all health professionals should routinely ask older people if they have fallen in the last year and how frequently falls occur and the context of the falls. Patients considered at risk should be evaluated for gait and balance deficits. A patient's ability to benefit from strength and balance interventions should also be considered. The NICE guidance (2004) also provides some information on how best to manage older people who seek medical attention due to a fall, those who fall multiple times in a year, and/or have abnormal gait or balance.

- Over 4,000 hospital admissions were due to falls in Leicestershire County and Rutland for people aged 65 years and over in 2010/11.⁷⁸ This equates to 6% of total inpatient activity in this age group and 15% of all emergency activity.³⁶
- The hospitalisation rate for falls in Leicestershire is significantly higher than in England or the East Midlands.
- There were 730 hospital admissions for fractured neck of femur in Leicestershire County and Rutland in 2009/10. This is 18% of the hospital admission rates linked to falls.⁷⁸

Figure 9: Hospital Admissions for Falls, People aged 65 years and over, 2010/11

Indicator	Number of Falls	DSR per 100000 Population	England Range
1 England	281250	2475	
2 East Midlands	24589	2471	
3 Leicestershire CC	3828	2567	
4 Rutland UA	243	2209	
5 Blaby CD	605	2730	
6 Charnwood CD	940	2716	
7 Harborough CD	428	2109	
8 Hinckley and Bosworth CD	580	2366	
9 Melton CD	268	2202	
10 North West Leicestershire CD	580	2934	
11 Oadby and Wigston CD	427	2750	

Source: *Injury Profiles*

Falls Clinics in Leicestershire County and Rutland

There are six sites providing falls clinics across Leicestershire. These clinics operate in line with NICE 'Clinical Guidelines for Falls; the assessment and prevention of falls in older people'.⁷⁷ The programme consists of a consultant led multifactorial medical assessment clinic, with a follow-up weekly prevention and management programme over a period of six weeks. A functional assessment is carried out using an accredited assessment tool, i.e. Berg balance test, together with a functional reach test and timed walk assessment, at the beginning and end of the programme.

The multifactorial assessment includes:

- identification of falls history;
- assessment of gait, balance and mobility, and muscle weakness;
- assessment of osteoporosis risk;
- assessment of the individual's perceived functional ability and fear related to falling;
- assessment of visual impairment and referral;
- assessment of cognitive impairment and neurological examination;
- assessment of urinary incontinence;
- assessment of home hazards;
- cardiovascular examination and medication review with modification/ withdrawal.

The prevention and management programme includes:

- strength and balance training;
- relaxation and memory techniques;
- skills of problem solving and confidence techniques;
- what to do if they have a fall;
- home hazard assessment and intervention.

All programmes have some involvement from social services.

5.2. Stroke

Stroke is caused by a disturbance of blood supply to the brain. A number of conditions predispose to stroke - most importantly a previous stroke, a transient ischaemic attack, high blood pressure, atrial fibrillation (a form of irregular heart beat) or carotid stenosis (a narrowing of the carotid artery). A third of people who experience a stroke recover, but most live with long-term health and care consequences for the rest of the lives.

About 110,000 people in England have a stroke each year.⁷⁹ 20 to 30% of people who have a stroke die within a month. Stroke is the single largest cause of adult disability, 300,000 people in England live with moderate to severe disability as a result of stroke. A substantial proportion of health and social care resources are devoted to the immediate and continuing care of people who have had a stroke.

In Leicestershire County and Rutland:

- 1 in 50 (or 2% of) adults have been diagnosed with stroke (11,447 people);⁸⁰
- modelled estimates of stroke suggest that 13,850 people have stroke suggesting 2,403 undiagnosed stroke cases.⁸¹

Promoting healthy living is very important in helping to prevent stroke. It is estimated that 20,000 strokes a year could be avoided through preventive work on high blood pressure, irregular heartbeats, smoking cessation, and wider statin use.

Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke. Prevention work is particularly important in deprived communities who are at a disproportionately greater risk of stroke due to poor lifestyle factors. Preventing strokes can, not only reduce the associated suffering, morbidity and mortality caused by strokes, it may also lead to NHS savings, as each stroke costs approximately £15,000 to treat over five years.⁷⁹

The National Stroke Strategy was published in 2007.⁸² This report aims to improve the quality of services, support the commissioning of effective services and inform the expectations of those affected by stroke and their families.

Health Checks in NHS Leicestershire County and Rutland

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk.

This programme is being rolled out across Leicestershire County and Rutland.

5.3. Recommendations

To ensure the best possible care, response and health outcomes for older people in crisis, the following steps are recommended:

- health and social care commissioners, and those responsible for commissioning support for older people, must always reflect a joint approach which takes account of the multi-disciplinary nature of care of older people;
- commissioners should ensure that all providers of acute or emergency care for older people conduct an audit against the standards set out in the Silver Book⁵⁰, as well as participating fully in all relevant national audits (e.g. stroke, hip fracture, dementia, fall and bone health, continence);
- clinicians referring patients to urgent care should have access to a simple referral system with an agreed policy provided by local geriatric, emergency medicine, acute medicine and social services;
- older people being admitted to community hospitals, whether for 'step-up' or 'step-down' care, should be assessed and managed in the same way as patients accessing urgent care in any other part of the health system;
- all urgent and emergency care units should have accessible patient information about local social services, falls services, healthy eating, staying warm and benefits, as well as information for carers of frail older people;
- people having an exacerbation of a long-term condition should be treated according to a plan already agreed by their GP and potential acute or out of hours providers, which is realistic and appropriate;
- commissioners need to continue to prioritise falls and stroke prevention services;
- it is essential that all patients have access to acute care when they need it. However this care must be targeted at returning the patient to independence as quickly as is practical, with clear pathways to early supported discharge and access to high quality intermediate care services.

6. End of Life Care

The first national end of life care strategy was published in 2008. Its aim was to promote high quality care for all adults with advanced progressive, incurable illnesses at the end of their life⁸³ and to enable choice about where people would like to live or die.

End of life care is, "the holistic assessment and management of physical care, pain and other symptoms including the provision of; psychological, social, financial, spiritual and practical support for both the patient and their family/carers in their place of choice, during the last year of life."⁸³ It also includes care given after bereavement.



High quality services for end of life care should ensure dignity, choice and support to achieve the patient's (and their carers) preferred priorities for care in the last year of their life. More than 50% of people express a wish to die at home although currently only about 20% are actually supported to do this.

The strategy proposes that, for many people, a 'good death', would involve being:

- treated as an individual, with dignity and respect;
- without pain and other symptoms;
- in familiar surroundings;
- in the company of close family and/or friends.

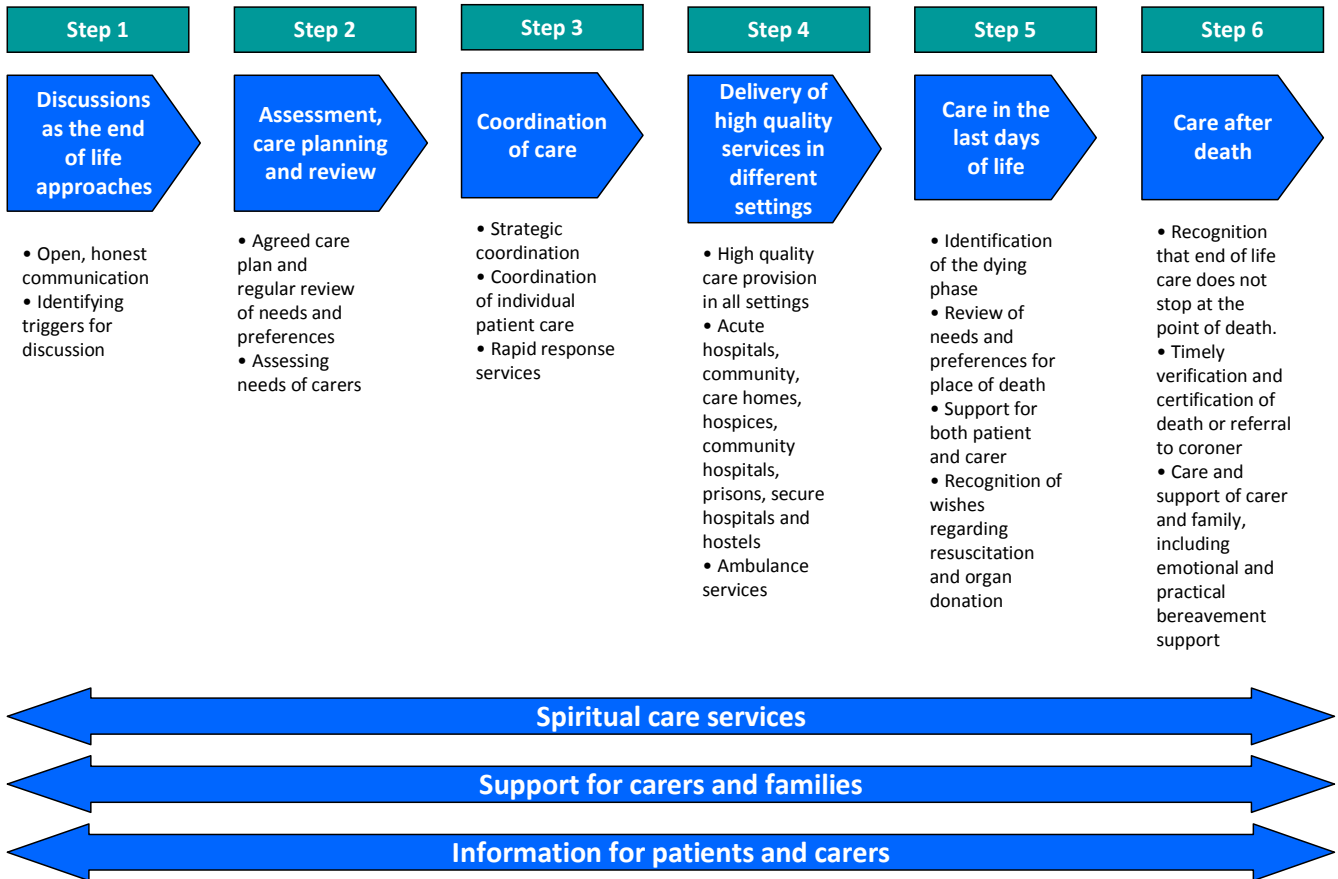
The Leicester, Leicestershire and Rutland (LLR) End of life care strategy 2010-2014⁸⁴ states that the overall aim for LLR is: to enable people in LLR at end of life to die in their preferred place of care. The LLR strategy states that end of life care should encompass:

- people with advanced, progressive, incurable illness (e.g. advanced cancer, heart failure, Chronic Obstructive Pulmonary Disease (COPD), stroke, chronic neurological conditions and dementia);
- care given in all settings (e.g. home, acute hospital, ambulance, residential/care home, nursing home, hospice, community hospital, prison or other institution). Proportionately deaths in hospital at end of life for care home residents are more preventable than for non-care home residents;
- care given in the last year of life;
- patients, carers and family members (including bereavement care).

Leicester, Leicestershire and Rutland have agreed an end of life care pathway. This sets out six steps for end of life care. This starts with discussions as the end of life approaches to care and support after death for the carer and family members.

Figure 10: Leicester, Leicestershire and Rutland End of Life Care Pathway

The End of Life Care Pathway



West Leicestershire Clinical Commissioning Group: End of life – Improving outcomes and patient experience

West Leicestershire Clinical Commissioning Group (WL CCG) has developed a Locally Enhanced Service (LES) to incentivise GPs to improve the care that is given to their patients at the end of their lives. The LES included 10 standards to support the improvement in care. These included improved identification of patients at end of life, co-ordination of care through a multi-disciplinary team, advanced care planning and information exchange with other agencies involved in the patient's care. In addition, the scheme included training around end of life care and bereavement support.

The scheme was implemented on 1 September 2011 with 96% of practices interested in taking part in the scheme. The scheme has been running for six months and in this time the number of patients on practice end of life registers has increased by 429 patients, from 393 (March 2011) to 822 (March 2012)

400 patients who died had an after death audit submitted, and from these:

- » 47% of patients on the registers had a non-cancer diagnosis, illustrating improved access to the end of life care pathway for these patients;
- » 85% of patients with an after death audit and a recorded preferred place of death, died in their preferred place of death;
- » 65% of patients who died were cared for by a carer who had a documented needs assessment;
- » bereavement support was offered to 64% of carers where the patient had an after death audit.

6.1. Recommendations

There has been excellent progress in developing the end of life care pathway. However, there is still significant progress that needs to be made in terms of ensuring that all patients at the end of their lives are supported to die in the place of their choice. Key recommendations are:

- improve the early identification of patients across all diagnoses with end of life care needs, allowing timely access to advance care planning;
- shift the focus from specialist palliative care services to causes of deaths with more complex end of life trajectories;
- support the continued development of a single point of access service, to improve the co-ordination of end of life services;
- commission an end of life care pathway that recognises and addresses the challenges and complexities in delivering end of life care on a 24/7 basis. Effective handover care arrangements are essential and services need to be streamlined across all providers;
- all clinical commissioning groups should involve a dedicated end-of-life care lead, as recommended by the National Council for Palliative Care.

OLDER PEOPLE'S MENTAL HEALTH

1. Mental health problems in older people

The World Health Organisation defines mental health as “A state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community”.

In this positive sense, mental health is the foundation for individual wellbeing and the effective functioning of a community. According to NICE, five key factors that affect the mental health and wellbeing of older people are:

- » discrimination (for example, by age or culture);
- » participation in meaningful activity;
- » relationships (e.g. bereavement);
- » physical health (including physical capability to undertake everyday tasks);
- » poverty.



Conservative estimates suggest that mental health problems in older people are widespread, occurring in about 40% of people visiting their GP, 50% of general hospital inpatients and 60% of people who live in care homes. Mental health illnesses that affect older people range from depression to dementia, schizophrenia or other conditions.⁸⁵

Depression is the most common mental health problem in older people. An estimated 10–16% of people over 65 have depression and 2–4% have severe depression.⁸⁶

Depression is associated with social isolation, long-term physical health problems, caring roles, and living in residential care.⁸⁷ Prevalence rises with age and women are more often diagnosed with depression than men. A third of people who provide unpaid care for an older person with dementia have depression.

Studies show that only one out of six older people with depression discuss their symptoms with their GP and less than half of these receive adequate treatment.⁸⁸ Depression is more common in people with long-term medical conditions and can worsen outcomes in a range of physical disorders. It is the

leading risk factor for suicide. Older men and women have some of the highest suicide rates of all ages in the UK.

Dementia affects one person in 20 aged over 65 and one person in five over 80. Due to the ageing profile of Leicestershire and Rutlands population, the number of people suffering from dementia (aged 65 and over) is expected to almost double by 2030.

Nationally, GP dementia disease registers (i.e. Quality Outcomes Framework) significantly under-reports the prevalence of the condition. In 2009 a local review concluded that only 30% of possible cases were reported at GP practice level.⁸⁹ Currently, fewer than half of older people with dementia ever receive a diagnosis.

Early diagnosis is essential to ensure that any identified care and support plan is based on individual need and can facilitate choice and control. If the majority of people are unknown to adult primary care and/or social care services, care is often sub-optimal as it is unplanned, frequently resulting in a crisis intervention. Older patients are also more likely to experience delayed discharge from hospital and that lack of joint working and care home capacity were key factors.⁹⁰

There are a number of other and rarer mental health diseases that affect older people, including delirium, anxiety and late-onset schizophrenia. For example:

- there are approximately 70,000 older people with schizophrenia in the UK;
- people aged between 55 to 74 years have the highest rates of alcohol-related deaths in the UK;
- it is agreed that rates of both prescription and illicit drug misuse in later life are under-estimated for older people.

2. Mental health in older people in Leicestershire County and Rutland

Mental health has been identified as a cross cutting theme in both the Leicestershire and Rutland JSNAs.

The number of people aged 65 and over in Leicestershire who have depression is expected to increase from an estimated 10,163 in 2011 to 12,892 in 2020 and 15,966 in 2030. This is an increase of 57% from 2011 to 2030.³⁷

The number of people aged 65 and over in Rutland who have depression is expected to increase from an estimated 704 in 2010 to 934 in 2020 and 1,198 in 2030. This is an increase of 70% from 2011 to 2030.³⁷

Combining these figures means that the total number is expected to increase from an estimated 10,867 in 2011 to 13,826 in 2020 and 17,164 in 2030. This is an increase of 58% from 2011 to 2030.³⁷

Research concerned with national suicide trends indicates that suicide rates tend to be higher for people aged over 65 years than for those aged under 65. For example, twice as many people aged over 65 commit suicide than those aged under 25 years.⁹¹

Dementia is a terminal illness but people may live with dementia for between seven and twelve years after their diagnosis.⁹² Nationally one in four females and one in five males over the age of 85 have dementia³⁷. The higher prevalence in females is to some degree, due to a longer life expectancy.⁹³ In terms of mortality, 10% of deaths in men over 65 years and 15% of deaths in women have been found to be attributable to dementia in a UK study (this equates to 59,685 deaths annually).⁹⁴

It is currently estimated (2011) that there are 8,678 people aged 65 and over, living in Leicestershire and Rutland with dementia (Leicestershire 8,115, Rutland 563).³⁷ Using national prevalence statistics, due to the ageing profile of Leicestershire and Rutland's population, the number of people suffering from dementia (aged 65 and over) is expected to almost double by 2030.⁹⁴

3. Improving mental health and wellbeing in older people

Mental health and wellbeing in older people are influenced by a range of factors including life events, physical wellbeing and opportunities for social and economic engagement. In later life individuals are more likely to be exposed to the negative side of these factors through issues such as retirement, bereavement, caring responsibilities and declining physical health.

Mental resilience and access to opportunities for improving wellbeing are therefore essential to living well in later life.

A decline in mental wellbeing should not be viewed as a natural and inevitable part of ageing and there is a need to raise both older people's and society's expectations for mental wellbeing in later life.⁹⁵ Mental health problems are therefore not a 'normal' and inevitable part of the ageing process.

Promoting mental health and wellbeing in later life will benefit the whole of society by maintaining older people's social and economic contributions, minimising the costs of care and improving the quality of life. Good mental health and wellbeing in later life benefit society by maximising the contributions that older people can make.⁹⁶

Wellbeing and emotional and physical resilience are inextricably linked. Effective population mental health strategies and mental health promotion will improve wellbeing, resilience to mental illness and other adversities, including physical illness. Resilience is the ability of individuals or communities to cope positively with change, challenge, adversity and shock, and can reduce the impact of risk factors in the external environment, such as the recent recession.

In rural areas, older people's ability to access essential services, health, shops, employment, culture and leisure, is affected by a variety of factors. These include poor infrastructure provision (lack of a network of accessible buses, low or no services), cost, low car ownership and death of a spouse leaving a non-driver isolated. The rural nature of much of Leicestershire and Rutland compounds the situation. Isolation is a particular risk factor for older people from minority ethnic groups, those in rural areas and for people older than 75 who may be widowed or live alone.⁹⁷



The Leicester, Leicestershire and Rutland Joint Dementia Commissioning Strategy 2011-2014⁹⁸ has been developed by a group of lead commissioners across Health and Adult Social Care, working with providers, patients, carers and other stakeholders across health and social care. It aims to:

- » improve early diagnosis and access to treatment for people living with dementia;
- » ensure that patients and their carers have access to a co-ordinated health and social care pathway.

The Leicester, Leicestershire and Rutland dementia strategy identified four key priority areas which fall into the following work streams:

LLR Joint Commissioning Dementia Strategy (2011) work streams

Work stream 1 led by NHS LCR:

Increased awareness, early diagnosis and access to care and support services

Work stream 2 led by UHL and PCT Cluster commissioners:

Improved experience of general hospital care and the management of physical health needs of people living with dementia.

Work stream 3 led by Leicestershire County Council Adults and Communities:

Improved quality of care in residential/ care homes.

Work stream 4 led by Leicester City Council:

Personalisation of care and living well with dementia in the community.

4. Investing in emotional and psychological wellbeing for patients with long-term conditions

People with long-term physical health conditions will often have psychological and emotional needs resulting from the burden of illness-related symptoms, the disability associated with the physical illness, and the impact of living with more than one physical condition at any time.

For some, a mental health disorder will also be present. In the face of such multi-morbidity, personalised planning of care, including a collaborative care approach, is required to facilitate meaningful management plans.

To ensure meaningful access to effective services, and to maximise the efficiency of those services, a well co-ordinated and collaborative patient journey between physical, psychological and mental health components of disease specific pathways is required, as well as cross-cutting pathways where common co-morbidities exist.

There is a growing body of clinical and economic evidence to support investment in clinical services which address both mental health conditions and physical health long-term conditions simultaneously.

5. People with learning disabilities

There is a small but significant growth in the number of people with learning disabilities who are living beyond the age of 65 and who subsequently develop a mental health condition associated with old age. People with Down's Syndrome over the age of 30 are at a greater risk of developing the symptoms

of dementia. By their fifties, approximately 50% will show evidence of memory loss and other conditions associated with having Alzheimer's disease. This issue needs to be addressed by services for people with learning disabilities.

6. Recommendations

Any public health approach to mental health in older people needs to be population based and targeted at mental health and wellbeing across the lifespan. It is also important to recognise that mental health and physical health are inextricably linked. Mental health services should focus on primary prevention and early and effective treatment of older people.

Primary Prevention

- Tackle the risk factors for depression, anxiety, suicide, delirium and dementia at all levels, from the individual to the broader policy by:
 - » strengthening social inclusion and participation in meaningful activity;
 - » promoting peer support and older people community development initiatives;
 - » facilitating the fostering of secure, supportive relationships e.g. with family or friends;
 - » maintaining physical exercise levels - 30 minutes a day of at least moderate physical activity on five or more days of the week where appropriate;
 - » tackling poverty in old age including support to maximise benefit uptake.
- Tackle discrimination/ stigma on the basis of age by:
 - » promoting older people as independent, respected members of the community;
 - » working with the media to improve perceptions of older people;
 - » promoting intergenerational activities to strengthen understanding and respect between younger and older people.



Early and effective treatment

The early and effective treatment of mental illness in older people should be achieved by:

- raising public awareness about recognising the early signs of depression and dementia;
- further developing the role of primary care in the early identification, diagnosis and support of older people with mental health needs in the community;
- providing information and advice about services that will promote the wellbeing of those affected and their carers;
- strengthening support for unpaid carers and review the information, advice and support provided to carers, especially immediately after the diagnosis of a mental illness is made;
- improving the capacity of local care homes staff to meet the needs of older people with complex mental health needs and challenging behaviour;
- increasing the involvement of older people in evaluating, monitoring and planning services targeted at mental health and mental illness in older people;
- implementing the recommendations in the LLR Dementia strategy;
- reviewing the availability and accessibility of services and support for older people with substance misuse needs;
- addressing the underlying mental health needs of people with long-term physical health problems.

DIGNITY

The Dignity in Care Campaign⁹⁹ was launched nationally in 2006 and aims to put dignity and respect at the heart of care services. The campaign is about having dignity in our hearts, minds and actions, changing the culture of care services and placing a greater emphasis on improving the quality of care and the experience of citizens, using services including NHS hospitals, community services, care homes and home support services. The objectives of the dignity in care campaign are to:

- **raise awareness** of dignity in care;
- **inspire** local people to take action;
- **share** good practice and give impetus to positive innovation;
- **transform** services by supporting people and organisations in providing dignified services;
- **reward** and recognise those people who make a difference and go that extra mile.

The Commission on Dignity in Care for Older People was established in 2011, following the publication of “Care and Compassion?”¹⁰⁰ the report by the Parliamentary and Health Service Ombudsman, Ann Abraham, which exposed shocking failures in the care of older people.

Addressing the outcomes from the above, the Commission has published a draft report, Delivering Dignity: Securing dignity in care for older people in hospitals and care homes currently out to consultation (2012).¹⁰¹ It proposes ten key recommendations for hospitals and ten key recommendations for care homes.

The **key recommendations for hospitals** include:

- ensuring that hospital staff are personally responsible for putting the person receiving the care first;
- ensuring that staff are equipped with the right skills to carry out their roles;
- that hospital leaders recognise and value dignity;
- older people receive a comprehensive geriatric assessment on admission to hospital;
- recognition of older people’s families, friends and carers as partners in their care;
- the importance of maintaining older people’s independence.



The **key recommendations for care homes** include:

- the development of a rating scheme for care homes based on nationally agreed standards and benchmarks;
- ensuring that residents of care homes have access to fulfilling lives, building links with the wider community;
- greater use of technology to encourage residents' independence;
- all staff and leaders in care homes are responsible for putting the person receiving the care first;
- providing end of life care tailored to the wishes and needs of each individual.

Dignity in Care Consultation in Leicestershire

In January 2010 a Dignity in Care consultation took place in Leicestershire, and 1,200 responses were received. Positively 94% of respondents said that they were happy with the service they receive.¹⁰²

From the survey it appeared that both residents and relatives were satisfied and relatives were satisfied with the approach of staff with regards to dignity and respect. Whilst the overall responses were very positive, some consistent themes emerged where services can be improved by:

- improving the activities that are provided, particularly in homes for older people;
- improving staffing issues such as high staff turnover, inconsistencies in quality of care and staff shortages.



Dignity in Social Care in Leicestershire

Despite the reduction in Department of Health funding for dignity, Leicestershire County Council has continued to promote and embed dignity as integral to their working practices. The county has identified the importance of delivering dignified services as central to the provision of effective services. The key projects that support this are:

- the council's Dignity Award – aimed primarily at residential and nursing care providers. This award supports the training of care staff across older people's, learning disability and mental health service providers. The scheme encourages providers to appoint dignity champions to promote and establish best practice. The number of providers that have achieved the dignity award continues to increase;
- the longer term objectives of the adult social care team include promoting dignity in other areas of care and support. This includes domiciliary care and non-regulated services such as community life choices;
- the Quality Assessment Framework (QAF), introduced in January 2011, is a framework for providers of residential and nursing care for older people. It is used to assess the quality of services that are provided and includes enhanced payments for services that are able to evidence that quality standards have been met. It is a mandatory requirement of the QAF for a provider to be working towards the dignity award. Providers are expected to sign up to the dignity charter, identify champions and focus practices on the 10 dignity challenges;
- a dignity 'train the trainers' programme is being developed in consultation with care providers. This is planned for implementation in autumn 2012. In addition to training other support networks are being developed.

Dignity in Social Care in Rutland

Rutland County Council is focusing on dignity in care as part of regular reviews and contract monitoring inspections of residential and nursing homes. Staff are trained to identify where there may be a lack of dignity in care.

Case Study - Rutland County Council carried out a contract monitoring visit to a care home. Whilst the contract officer was present she witnessed a staff member entering someone's room without knocking and also carrying out personal care for the resident without closing the door. This meant that the resident could clearly be seen by others passing by in the corridor. The contracts officer politely pointed this out to the carer and proceeded to close the resident's door.

SAFEGUARDING OLDER PEOPLE



Safeguarding adults is the term that we use to describe protecting vulnerable adults from harm.

A vulnerable adult is a person aged 18 years or over who may be unable to take care of themselves, or protect themselves from harm or from being exploited. This may be because they have a mental health problem, a disability, a sensory impairment, are old and frail, or have some form of illness including misuse of drugs and alcohol.

Abuse is mistreatment by any other person or persons that violates a person's human and civil rights. The abuse can vary from treating someone with disrespect in a way which significantly affects the person's quality of life, to causing actual physical suffering. Abuse can happen anywhere - in a

residential or nursing home, a hospital, in the workplace, at a day centre or educational establishment, in supported housing, in the street or in their own home.

There are different forms of abuse, including: physical abuse, sexual abuse, psychological or emotional abuse, financial or material abuse, neglect, discriminatory abuse and institutional abuse. Any of these forms of abuse can be either deliberate or be the result of ignorance, or lack of training, knowledge or understanding. Often if a person is being abused in one way they are also being abused in other ways.

The person who is responsible for the abuse is very often well known to the person abused and could be:

- a paid carer or volunteer;
- a health worker, social care or other worker;
- a relative, friend or neighbour;
- another resident or service user;
- an occasional visitor or someone who is providing a service;
- people who deliberately exploit vulnerable people.

If the abuse is also a crime such as assault, racial harassment, rape or theft it should also be reported to the police.

Across Leicestershire County and Rutland, the safeguarding of adults is overseen by the “Leicestershire and Rutland Safeguarding Adults Board”.¹⁰³ This is a multi-agency partnership that leads the strategic development of safeguarding adults work. The board was established to co-ordinate multi-agency working across the safeguarding agenda, including developing policies with regard to safeguarding and monitoring progress.¹⁰⁴

Leicestershire County and Rutland are committed to “Safeguarding Adults: Multi-Agency Policy and Procedures, Policy and Procedure for the Prevention of Abuse of Adults in Need of Safeguarding”.¹⁰⁵ The policy sets out 11 service standards as the multi-agency framework within which planning, implementation and monitoring of safeguarding adults work should take place. These standards have been developed to:

- ensure that there is a multi-agency framework within which planning, implementation and monitoring of safeguarding adults will take place;
- set out the commitment and engagement of each of the partner agencies;
- prevent abuse and neglect in the community and through service delivery and through overseeing training across the partnership;
- set out the duties of (public) agencies under the Human Rights Act (1998) to intervene proportionately to protect the rights of citizens to live free from violence and abuse;
- ensure that there is equality of access to safeguarding services.

The quality of Social Care commissioned/ provided services is regularly monitored and reviewed, ensuring that our customers have a positive experience when accessing services. Perhaps the most important role of all is to ensure the safety of those individuals accessing services and to investigate all incidents appropriately.

In 2010-11 there were 1,006 referrals linked to adult safeguarding across Leicestershire County and Rutland (927 from Leicestershire County Council, 66 from Rutland County Council and 13 from health organisations).¹⁰⁶ 748 of these referrals were for older people (aged 65 years and over). 59% of referrals were from care homes. The most frequent reasons for referral were physical abuse (31%) and neglect (27%).

Leicestershire County Council’s forecast for 2011-12 is 1,125 referrals, which represents a 21% increase (based on activity for April – October 2011). Although this is a trend which requires careful monitoring, there are several contributory factors which could account for the increase. It is likely that the reporting and recording of safeguarding concerns has improved, alongside a greater awareness of safeguarding issues through the implementation of the Dignity in Care programme amongst other local initiatives. The contribution of these factors to the rising proportion of safeguarding referrals needs to be investigated further so that an accurate picture of the incidence of safeguarding can be obtained.

As may be expected in the current economic climate there appears to be a rise in the number of cases of financial abuse. Although this requires further examination, this does reflect trends reported by the Police Vulnerable Persons Unit that show an increase in the number of referrals relating to financial abuse.

Safeguarding is also taken into account as part of the Leicestershire County Council ‘Quality Assessment Framework for Older People’ (QAF). The QAF is used as part of the assessment process undertaken by the Adults and Communities Department and the outcome of safeguarding investigations are taken into account when assessing providers against the QAF and awarding QAF-related payments.

Safeguarding is used to make a judgment on the need for reactive monitoring of contractual compliance for providers who deliver services under contract for the Adults and Communities Department.

It is essential that the Clinical Commissioning Groups play an active role in the future safeguarding agenda, through membership of the Leicestershire and Rutland Safeguarding Adults Partnership.

Leicestershire and Rutland Safeguarding Adults Board¹⁰⁶

NHS Leicestershire County and Rutland is an active member of the local Safeguarding Adults Board for Leicestershire and Rutland and works closely with partner agencies to ensure that the safety and welfare of all vulnerable people in the area is considered within the working arrangements for all local healthcare providers.

During 2010, the organisation has been working with partner agencies to make sure that safeguarding arrangements are more closely aligned with the reporting of Serious Untoward Incidents, so that we can strengthen arrangements for ensuring that lessons are learnt by all agencies.

Another significant area of work for us over the last year has been in developing the quality monitoring role of the organisation. A particular element of this work has involved working with providers of nursing home services to assess the quality of nursing care provision in nursing homes and to support the homes owners and staff to achieve the highest quality of care. We will further develop the quality assurance role of NHS Leicestershire County and Rutland and develop arrangements with partner providers to ensure that there is a multi-agency approach to quality audits.

We have developed sound partnership arrangements in order that the organisation discharges its duty in accordance with the Deprivation of Liberty Safeguards. This ensures the safety and wellbeing of those vulnerable people where it is in their best interests to remain in therapeutic environments in order to provide services that they require and to protect them from harm. We are working hard to ensure that adequate assessments of mental capacity are conducted across all health services and this will be developed further in the coming year.



Rutland Case Study

Mrs D is a 94 year old lady with dementia who lives in a residential care home. One lunch time Mrs D was given some food by her support worker that was too hot and resulted in severe burns to her mouth and lips. The care home contacted the emergency services and Mrs D was taken to hospital for treatment. The home also contacted Rutland County Council and made a safeguarding adults referral regarding the incident.

A safeguarding adults meeting involving adult social care, the hospital and Care Quality Commission was convened and an investigation was undertaken. This found that the thermometer used for measuring the temperature of Mrs D's food was not working properly and had not been tested before use. As a result of the safeguarding adults investigation the residential care home invested in new thermometers, developed a procedure ensuring regular testing and maintenance and ensured all staff received appropriate training. Mrs D was discharged back to the residential care home after a couple of days in hospital with no long term effects as a result of her injuries and continued her recovery with support from her GP and district nursing service.

PROTECTING THE HEALTH OF OLDER PEOPLE



1. Infections in older people

Table 1 shows infections in older people (65 years and over) that were notified to the Health Protection Agency. Of the infections reported to the Health Protection Agency, the majority which affect older people are no different from those which affect adults of all ages. The data in table show the commonest infection is that of the food borne pathogen, *Campylobacter*, which causes gastroenteritis. Older people are no more likely to develop infection from *Campylobacter* than younger adults although the illness may be more severe if they become infected.

Table 6: Leicestershire County and Rutland Reported Cases to Health Protection Unit East Midlands South between 01/04/2011 and 31/03/2012. 65 years and over

Disease Type	Number of Reported Cases
<i>Campylobacter</i>	144
<i>Cryptosporidium</i>	1
<i>E.Coli</i> 0157	2
<i>Giardia</i>	6
Legionnaires Disease	3
Measles	0
Meningococcal Disease Probable and Confirmed only	1
Mumps	2
Pertussis (Whooping Cough)	6
Rubella	0
Salmonella	14
Shigella	0
TB	11

Source: Health protection unit

Older people are more susceptible to health care associated infections particularly *Clostridium difficile*, and those living in Care Homes are susceptible to *Norovirus* infections, commonly known as Winter Vomiting Disease.

***Clostridium difficile* (C-difficile)**

C-difficile is a relatively common Health Care Associated Infection (HCAI). Whilst it is not reportable, hospitals have to record diagnosed cases as part of mandatory surveillance of HCAI. Leicestershire County and Rutland has a high rate of cases of *C-difficile*, the rate being 148 per 100,000 person years.

Clostridium difficile (*C-difficile*) is a bacterium that causes mild to severe diarrhea and intestinal conditions. *C-difficile* bacteria and their spores are found in faeces. People can get infected if they touch surfaces contaminated with faeces, and then touch their mouths. Healthcare workers can spread the bacteria to their patients if their hands are contaminated. For healthy people, *C-difficile* does not pose a health risk. The elderly and those with other illnesses or who are taking antibiotics, are at a greater risk of infection. In addition, patients taking stomach ulcer drugs, known as proton pump inhibitors, are at increased risk for contracting *C-difficile* infection.

Using antibiotics increases the chance of developing a *C-difficile* infection. Antibiotics alter the normal levels of good bacteria found in the intestines and colon. When there are fewer of these good bacteria in our intestines and colon *C-difficile* bacteria have the chance to thrive and produce toxins. These toxins can damage the bowel and cause diarrhoea. The presence of *C-difficile* bacteria, together with a large number of patients receiving antibiotics in healthcare settings, can lead to frequent *C-difficile* outbreaks.

Control measures for *C-difficile* include:

- good hand hygiene for all care staff;
- antibiotic prescribing should follow local guidance to ensure that the most appropriate antibiotics are used only when necessary;
- prescription of proton pump inhibitors should be reviewed to ensure that no older patients are taking these tablets when they do not need to.

Winter Vomiting

The symptoms of *Norovirus* illness include nausea, vomiting, diarrhoea and stomach cramps and this is often called winter vomiting. Sometimes, people may have a low-grade fever, chills, headache, muscle aches and fatigue. The illness often begins suddenly, about 24 to 48 hours after exposure and the infected person may become very sick with frequent vomiting and/or diarrhoea.

Norovirus infection often causes serious problems in care homes. During 2011/12 there were 11 outbreaks of *Norovirus* reported to the health protection agency. It is essential that infection control procedure remain rigorous to ensure that the impact of these events is minimised. Basic control measures for winter vomiting include ensuring that:

- all care staff have received basic training in infection control;
- all care providers have infection control policies.

Scabies

Scabies infections are relatively common in older people who are unable to adequately care for themselves. These older people often end up being admitted to care homes where they then go on to infect care staff and other residents. Five care homes reported outbreaks of scabies to the HPA during 2011/ 12.

It is essential that care staff are aware of the symptoms and signs of scabies and that new residents are assessed for scabies, especially those who through older age have sadly neglected their own care.

2. Influenza

Influenza is an acute viral infection that spreads easily from person to person. The virus circulates worldwide and can affect anybody in any age group. Influenza is a serious public health problem that causes illnesses and deaths for higher risk populations. The risk of serious illness from influenza is higher amongst older people when compared to other non-risk groups in the population.

Influenza peaks during the winter. Seasonal flu vaccinations are usually given between September and December so that people have immunity before influenza viruses begin circulating. A new vaccine is produced each year as the viruses changes, therefore it is important for people in risk groups to have the vaccination every year.

It is very important that those aged over 65 years and other at risk groups (such as, pregnant women and carers) receive the vaccination every year.

Vaccination:

Vaccination is the most effective way to prevent infection. The benefits to receiving the vaccination are:

- to protect the most vulnerable people in society;
- to reduce severe illness, hospitalisation and occasionally, death;
- doctors, nurses and frontline staff can protect their patients, colleagues, family and friends by receiving the vaccination;
- to protect pregnant women and their babies in the first few months of life.

Doctors, nurses and frontline staff can protect their patients, colleagues, family and friends by receiving the vaccination. Good uptake of influenza vaccination reduces hospitalisation and mortality in older people in healthcare settings¹⁰⁷

Each year the World Health Organisation makes recommendations to pharmaceutical companies about the viruses to enable them to produce a vaccine. The vaccine gives immunity for up to a year.

The influenza vaccination has been recommended in the UK since the mid-1960s. The Department of Health Chief Medical Officer writes to Primary Care Trusts offering guidance and indicating targets to be achieved. During 2011/12 the targets were set nationally as 75% uptake for over 65 year olds and 60% for the under 65 at risk groups and pregnant women. This target increases to 70% during 2012/13 and 75% in 2013/14.

Table 7: Percentage uptake of seasonal influenza vaccination between 2009 and 2012, NHS Leicestershire County and Rutland

	2009/10		2010/11		2011/12	
	PCT	England	PCT	England	PCT	England
Over 65s	71.6%	72.4%	72.2%	72.8%	73.2%	74%
Under 65 at risk (excluding pregnant women)	49.4%	51.6%	47.8%	50.4%	48.4%	51.6%

Work continues to try to get this level to at least 75% for 2012/13 in line with Department of Health targets. Approaches include ensuring that every older person receives a reminder about flu immunisation, focussing on those who live in nursing or residential homes and utilising the media and other forms of publicity for the programme. It is also important that staff looking after vulnerable older people are also immunised to avoid them passing on the virus to their patients.

What are we doing to increase uptake in older people locally?

- Media communications: public health is working closely with communications colleagues in the local authority and health service to ensure that media releases, articles for newspapers and other communications happen at the right time in line with the start of the seasonal flu campaign
- Collaborative working: with general practices to assist them in increasing their uptake by sharing information on vaccine production, sharing best practice and providing them with regular reports and data indicating achievements
- Occupational Health Departments: are contacted to encourage vaccinations for frontline healthcare staff
- Surveillance: providing monthly monitoring data to the Department of Health

1.3. Pneumococcal bacterium

The pneumococcal bacterium is the cause of a serious pneumonia in older people. There is a seasonal variation in pneumococcal disease with peak levels in the winter months. In 2003 a pneumococcal polysaccharide vaccine was recommended for all people aged 65 and over. It was also added to the routine childhood immunisation programme for under 2 year olds in 2006 as it also affects the very young.

Unlike the flu vaccine which needs to be repeated every year, pneumococcal vaccination only needs to be done once for those over 65 years. Across Leicestershire and Rutland over 65 year olds will be invited to their general practice for the vaccination. In 2011/12 almost 92,000 adults had received the vaccination at some time since their 65th birthday. This equates to 66.2% of the eligible population.

FEEDBACK FROM ACTIONS FOR 2011



The 2011 Director of Public Health annual report focused on health through the lifecycle: Report 1 Children and made a series of recommendations highlighting achievable actions to address children and young people's health and wellbeing. The recommendations were grouped under four headings and progress over the last 12 months is captured below.

- **Shifting resources into early years support**

It has been demonstrated that shifting resources into early years support will yield the greatest benefits, both for individuals throughout their lives and for the population as a whole. This shift in resource is being embedded into our planning for the health and wellbeing of our population.

- **Starting well, through early intervention and prevention**

It is essential that we develop strong universal public health and early education. This needs to be accompanied by targeted interventions for disadvantaged families and children at risk of poor health outcomes. We have made progress on the following recommendations:

- We are on track to increase the number of Health Visitors available to universally deliver the healthy child programme by 2013 through the new service model 'Call to Action' set out by the Department of Health. We have been identified as an early implementer site for Call to Action. The healthy child programme is a core programme of evidence based preventative health care with additional care and support for those that need it.
- Good working relationships are being maintained within the changing school landscape and the development of academies to ensure that schools continue to support the delivery of key public health programmes and to ensure that health and wellbeing is embedded into their everyday work.
- Pregnant women continue to have access to high quality care. The Maternity Services Liaison Committee ensures that there is full compliance with National Institute of Health and Clinical Excellence (NICE) guidelines for the maternity pathway.
- There is improving liaison between GPs, midwifery, health visitors and the wider children's workforce including the children centre programmes, to deliver high quality antenatal support in partnership to ensure the best possible start for babies.

- Services are in place through midwifery services, stop smoking services, health visitors and the children centre programmes to support pregnant mothers to make healthy choices with regards to smoking, healthy eating, physical activity and substance misuse (including alcohol).
- Tobacco-free Leicestershire and Rutland (TLR) continues to develop. This is an alliance of partners involved in the tobacco agenda with a remit to reduce tobacco use across our community. Projects include a Young People's Smoking Prevention Project and 'Step Right Out' a Smoke Free Homes and Cars campaign
- Access to our Stop Smoking Services has increased by increasing the number of public sector employees trained in brief advice and interventions.
- The Smoking in Pregnancy Service has continued to develop to support pregnant mothers to stop smoking or to reduce their tobacco use.
- The Baby Friendly Initiative (BFI) accreditation is progressing ensuring that women are supported to make informed choices about feeding their baby. We shall be applying for stage 2 BFI accreditation in August 2012 to be assessed for accreditation in November 2012.
- Breast feeding peer support programmes have continued under the La Leche League branding in order to sustain the uptake and continuation of breastfeeding across LCR.
- We have continued to deliver the childhood immunisation programme and improve uptake. Specifically we have:
 - » Continued the implementation of the NICE public health guidance to improve uptake of immunisations across LCR.
 - » Continued to increase uptake of immunisations and public health supply monthly reports to general practices showing their achievements and providing a list of unimmunised children for them to target.
 - » Delivered a rolling programme of immunisation and vaccination training for practice professionals.
 - » Delivered immunisation and vaccinations sessions to support staff in general practice.
 - » Delivered the seasonal flu vaccination to children and staff in special schools

- **Developing well**

We have continued our public health efforts to improve the health and wellbeing of school age children and aid their transition into healthy adulthood. We have continued to strive to reduce health inequalities within this group.

- We have continued to work in partnership through the healthy child programme, making full use of the Sure Start children's centres, and the Leicestershire Healthy Schools programme.
- We have continued our programme of work to reduce childhood obesity. Specifically we have:
 - » Continued to develop the National Childhood Measurement Programme to increase early identification of children who are overweight or obese. When children become overweight, we offer high quality, easily accessible NHS support services to support families and children to change lifestyle behaviour in a positive and sustainable way.

- » We are continuing to work with schools, through the Healthy Schools programme, to promote a 'positive food and physical activity culture' within schools, where eating a healthy balanced diet and participating in physical activity becomes the 'social norm'.
- » We are continuing to support schools to achieve measurable health and wellbeing outcomes for children and young people with regards to healthy weight through the implementation of the Healthy Schools enhancement programme.
- » We are routinely promoting physical activity, including unstructured play at home, in school, in childcare settings and throughout the community, to ensure the children's living environment encourages and facilitates these choices. Foundation Stage and Key Stage 1 primary school staff have received physical literacy training.
- We continue to improve the identification, treatment and prevention of mental health problems by:
 - » Ensuring that, as services are combined across specialist Children and Adolescent Mental Health Services (CAMHS) and community children's services, we maximise service quality and capacity. This includes the development of pathways to ensure that services are working together and are clearly specified (including attention deficit hyperactivity disorder (ADHD), autism, self-harm, behaviour).
 - » Providing support to schools to promote positive mental health and to capitalise on the legacy of the Targeted Mental Health in Schools Project (TaMHS). This has been achieved by disseminating the learning from nine Leicestershire County schools who participated in the project.
 - Maximising the mental health of vulnerable young people, including those who offend or are at risk of offending, are looked after, are homeless, or have a physical illness.
 - Ensuring that good links with adult services are maintained in relation to transition from children to adult services and taking the whole family approach work forwards.
 - Ensuring that interventions are developed at the earliest possible opportunity, maximising on the links between preventative infant mental health and post natal depression services through to school related services.



- **Addressing risk taking behaviour in teenagers**

As teenagers go through their transition from childhood to adulthood the potential exists for the development of risk taking behaviours that may impact negatively on health.

- We are continuing to address this through the Healthy Schools programme, supporting children to make informed choices with regards to smoking, physical activity, healthy eating, sexual health and substance misuse.
- We are continuing to work with teenagers to ensure that they are able to make informed choices with respect to smoking including:
 - » Rolling out the comprehensive school-based tobacco control programme. This focuses on using social norming techniques and incorporates prevention and awareness education, and accessible stop smoking support and youth advocacy.
 - » There has been improved engagement with youth oriented agencies and voluntary organisations to increase access to harder to reach young people as well as more traditional school based programming, including the Youth Offending Service, Young People in Alternative Education Provision and Looked After Children.
 - » The evaluation of test purchasing data since 2003 has shown significantly improved compliance by retailers associated with increased resources for Trading Standards from the start of Local Area Agreement (LAA) funding and beyond. The evaluation also revealed a small increase in 'failed' test purchases (and therefore an apparent reduction in compliance) during the latter stages of LAA funding; this is because better intelligence has enabled better targeting. As a consequence the emphasis in the last 12 months has been on establishing effective communication pathways to encourage and facilitate the passing on of information and intelligence from the public via partners about problem areas and businesses, and the use of the media for similar purposes.
 - » Intelligence has also been used to target advice and education to retailers. This has enabled them to devise effective procedures and systems to avoid selling to children. This improved targeting and a merging of alcohol and tobacco related work has improved effectiveness and provided better value for money
 - » Partners and the public have also been encouraged to report sales of illicit tobacco, and there are links in place with HMRC to enable a quick response when intelligence is received.
- We have continued to work with schools, youth services and families to raise awareness of the risks associated with alcohol and illicit drugs. The Strategic Substance Misuse Team (SSMT) (Adult Services) are working more closely with the Children and Young People Service and Tobacco Free Leicestershire and Rutland to deliver an integrated children and young people and adult programme regarding identification, brief interventions and referral
- Specific interventions that target groups of young people at greater risk of problematic substance misuse, particularly children in care, young offenders and children not attending school are being developed. A comprehensive approach is being developed where a range of social and health risk behaviours are being 'clustered' together and integrated services are provided.
- There are specific substance misuse related posts in the Youth Offending Service working with young people at risk but also with young people who have parents who have substance misuse problems. There are similar posts in the Children and Young People Service that provide support to looked after children and young people in alternative education provision.

- The Youth Service provide a targeted service to young people at risk or at an early stage of a substance misuse problem to facilitate access to treatment
- The tier 2 school substance misuse network continues to be expanded with trained school staff, the aim of which is to increase the number of young people receiving timely, appropriate high quality support and treatment in relation to their substance misuse problems.
- We have continued to improve young people's access to integrated sexual health services, with particular emphasis on improving access to the range of contraceptive options, including long-acting reversible contraception.
- We have continued to increase chlamydia screening for 15-24 year olds in LCR and improve detection and treatment of the infection with the aim of reducing the prevalence of chlamydia.
- We are continually looking for ways to improve access to sexual health information for young people and those who provide information and support for young people.
- **Safeguarding:** the children at risk of harm are safeguarded through the Leicestershire and Rutland Local Safeguarding Children Board.



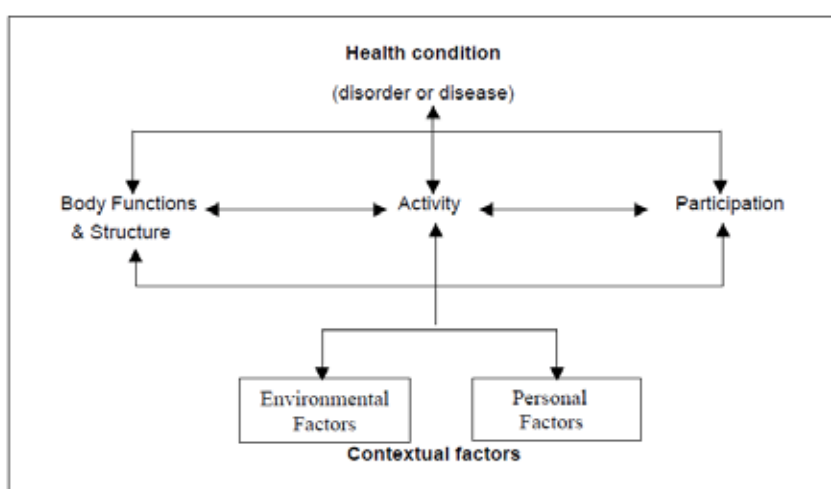
APPENDIX A: DATA TABLES

The full set of data appendices are included with the web based version of this report. The data tables included are listed below.

1. Population based on 2011 census estimates
2. 2010 mid year population estimates
3. Population projections – 2015 and 2025
4. Life expectancy and life expectancy at 65
5. Mortality Data
6. Indices of Multiple Deprivation 2010 – Income Deprivation Affecting Older People Index; Geographical Barriers to Housing and Services
7. GP Disease Prevalence (Quality and Outcomes Framework)
8. Disease Estimates from the Association of Public Health Observatories
9. Projecting Older People Population Information data
10. Health Outcomes – excess winter deaths, falls and fractured femurs, emergency admissions for stroke

APPENDIX B: FRAILTY CLASSIFICATIONS

World Health Organisation, International Classification of Functioning, Disability and Health



Body Functions are physiological functions of body systems (including psychological functions).

Body Structures are anatomical parts of the body such as organs, limbs and their components.

Impairments are problems in body function or structure such as a significant deviation or loss.

Activity is the execution of a task or action by an individual.

Participation is involvement in a life situation.

Activity Limitations are difficulties an individual may have in executing activities.

Participation Restrictions are problems an individual may experience in involvement in life situations.

Environmental Factors make up the physical, social and attitudinal environment in which people live and conduct their lives.

Source: World Health Organisation: <http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf>

The Canadian Study of Health and Ageing (CSHA) Clinical Frailty Scale¹¹⁰

1. *Very fit* – robust, active, energetic, well motivated and fit; these people commonly exercise regularly and are in the most fit group for their age
2. *Well* – without active disease, but less fit than people in category 1
3. *Well, with treated comorbid disease* – disease symptoms are well controlled compared with those in category 4
4. *Apparently vulnerable* – although not frankly dependent, these people commonly complain of being ‘slowed up’ or have disease symptoms
5. *Mildly frail* – with limited dependence on others for instrumental activities of daily living
6. *Moderately frail* – help is needed with both instrumental and non –instrumental activities of daily living
7. *Severely frail* – completely dependent on others for the activities of daily living, or terminally ill

Source: Rockwood K et al. *CMAJ* 2005; 173:489-495, ©2005 by Canadian Medical Association

REFERENCES

- ¹ Social Exclusion Task Force (2009) *Working Together for Older People in Rural Areas*, www.cabinetoffice.gov.uk/media/226170/working-together-older-people-ruralareas-july09.pdf
- ² Leicestershire County Council, (2012) *Leicestershire Joint Strategic Needs Assessment* http://www.lsr-on-line.org/reports/leicestershire_joint_strategic_needs_assessment_jsna1
- ³ Rutland County Council, (2012) *Rutland Joint Strategic Needs Assessment* <http://www.lcr.nhs.uk/Library/RutlandJSNA2009.pdf>
- ⁴ Hsu, R., Conroy, S., (2010), *Transforming Community Services, A Strategy for Frail Older People*, NHS Leicestershire County and Rutland, NHS Leicester City, University Hospitals of Leicester NHS Trust.
- ⁵ Department of Health (2011), *The Operating Framework for the NHS in England 2012/13*; Department of Health; © Crown Copyright; November; http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf
- ⁶ Department of Health, (2010) *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, 30 November, © Crown Copyright www.dh.gov.uk
- ⁷ Department of Health, (2010) *Our Health and Wellbeing Today*, 30 November, © Crown Copyright www.dh.gov.uk
- ⁸ Department of Health; (2010); *Caring for our future: reforming care and support*; © Crown Copyright; <http://www.dh.gov.uk/health/files/2012/07/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf>
- ⁹ Department of Health (2010) *A Vision for Adult Social Care: Capable Communities and Active Citizens*, Social Care Policy © Crown Copyright, 16 November
- ¹⁰ Directors of Adult Social Services; (2012) *The Case for Tomorrow: Facing the Beyond*; ADASS; <http://www.adass.org.uk/images/stories/Policy%20Networks/Older%20People/Key%20Documents/TheCaseForTomorrow080312.pdf>
- ¹¹ Marmot, M. (2009), *Strategic Review of Health Inequalities in England post-2010 Marmot Review* <http://www.marmotreview.org/>
- ¹² Department of Health; (2001); *National Service Framework for Older People*; © Crown Copyright; http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4071283.pdf
- ¹³ Womens Royal Voluntary Service, (March 2011), *Gold Age Pensioners valuing the socio-economic contribution of older people in the UK*; http://www.sqw.co.uk/file_download/332
- ¹⁴ Leicestershire County Council, (2008) *Strategy for Ageing Well in Leicestershire (2008 – 2011)*, Produced in collaboration with County Integrated Partnerships for Older People and LAA Older People's Steering Group,
- ¹⁵ Leicestershire County Council (2010) *Ageing well in Leicestershire (2008-2011) A Strategy Refresh - Produced in collaboration with County Integrated Partnerships for Older People and LAA Older People's Steering Group*, 2010

- ¹⁶ Office of National Statistics (2011) *2010 Based Sub National Population Projections*, © Crown Copyright March 2012
- ¹⁷ Department of Health (1998) *National Diet and Nutrition Survey: People Aged 65 Years and Over*.
- ¹⁸ Office for National Statistics (2012) *2011 Census Results*; © Crown Copyright 2012
- ¹⁹ Office of National Statistics (2011) *Experimental Population Estimates by Ethnic Group for local authority districts 2009*, published May. © Crown Copyright 2011
- ²⁰ DEFRA, *Local authority rural-urban classification*, <http://www.defra.gov.uk/statistics/rural/what-is-rural/rural-urban-classification/> - accessed 11/06/12
- ²¹ Craig, R. and Mindell J (2007); *The Health of Older People, Summary of Key Findings*; © The NHS Information Centre
- ²² World Health Organisation Glossary of terms used. *World Health Organisation*. [Online] 2012. [Cited: 15 June 2012.] <http://www.who.int/hia/about/glos/en/index1.html>
- ²³ Office for National Statistics (2012) *Life Expectancy at Birth and at Age 65 by Local Areas in the United Kingdom, 2008–10*; © Crown Copyright
- ²⁴ Office for National Statistics. Topic Guide to Disability and Self-Reported Health. *UK National Statistics*. [Online] [Cited: 15 June 2012.] <http://www.statistics.gov.uk/hub/health-social-care/health-of-the-population/disability-and-self-reported-health>
- ²⁵ Office of National Statistics: *Public Health Mortality File, analysed by Leicestershire County and Rutland Public Health Intelligence Team Mortality Data*; Unpublished
- ²⁶ McHugh, Mike and Bellamy, Verity. (2012) *Leicestershire Joint Strategic Needs Assessment. Health Inequalities*. s.l. : NHS Leicestershire County and Rutland, Public Health Directorate.
- ²⁷ Association of Public Health Observatories; *Data Tables for 2012 Health Profiles*
- ²⁸ Indices of deprivation 2010 <http://www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10/>
- ²⁹ Indices of deprivation 2010 <http://www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10/>
- ³⁰ Dellar, Janine, et al., et al. (2012) *Leicestershire Joint Strategic Needs Assessment. Key findings and recommendations*. s.l. : NHS Leicestershire County and Rutland, Public Health Directorate,.
- ³¹ Cabinet Office Social Exclusion Task Force (2009) *Working together for older people in rural areas*.
- ³² Centre for Policy on Ageing. (2009) *Ageism and age discrimination in secondary health care in the United Kingdom*.
- ³³ Equality and Human Rights Commission. EHRC - *Ten key questions about the Act*. Equality and Human Rights Commission. [Online] ND. [Cited: 25 June 2012.] <http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/ten-key-questions-about-the-act/>
- ³⁴ Personal Social Services Research Unit. *National Evaluation of Partnerships for Older People*. s.l. : Personal Social Services Research Unit, 2009.
- ³⁵ Lally, F., Crome, P (2007) *Understanding Frailty*, *Postgrad Medical Journal* Vol.83:pp16-20 doi:10.1136/pgmj.2006.048587

- ³⁶ HERA: Health, Evidence, Reporting, Analysis, NHS Leicester, Leicestershire and Rutland, extracted 12/06/2012
- ³⁷ Projecting Older People Population Information <http://www.poppi.org/uk>
- ³⁸ 2008-based Subnational Population Projections by sex and quinary age; Primary care organisations and strategic health authorities in England; Office of National Statistics © Crown Copyright May 2010
- ³⁹ Davies, Tim, Augustine, Glenda and Bellamy, Verity. (2012) Leicestershire Joint Strategic Needs Assessment. Long Term Conditions Factsheet. : NHS Leicestershire County and Rutland, Public Health Directorate
- ⁴⁰ NHS Leicestershire County and Rutland Public Health Intelligence, June 2012, Capacity modelling analysis for better care together board, Unpublished Analysis
- ⁴¹ Fried L, Ferrucci L, Darer J, Williamson J, and Anderson G. (2004) Untangling the concepts of disability, frailty and co-morbidity: implications for improved targeting and care. *The Journals of Gerontology: Series A: Biological sciences and medical sciences*. 59A 255-263
- ⁴² Ferrucci L, Guralnik JM, Studenski S, Fried LP, Cutler GB Jr, Walston JD; The Interventions on Frailty Working Group. Designing randomized, controlled trials aimed at preventing or delaying functional decline and disability in frail, older persons: A consensus report. *J. Am. Geriatr. Soc.* 52(4): 625-634, 2004
- ⁴³ Santos-Eggimann, B., Cuenoud, P., Spagnoli, J., Junod, J., (2009) Prevalence of frailty in middle-aged and older community-dwelling Europeans living in 10 countries. *Journals of Gerontology - Series A Biological Sciences and Medical Sciences*, 64A(6), pp. 675-681.
- ⁴⁴ NHS Institute for Innovation and Improvement (2012) Delivering Quality and Value, Focus on Frail Older People; http://www.institute.nhs.uk/index.php?option=com_joomcartandmain_page=document_product_infoandproducts_id=189andcPath=71
- ⁴⁵ Royal College of Physicians: (2012); Acute Care Toolkit 3 Acute medical care for frail older people © Royal College of Physicians
- ⁴⁶ Ellis G, Whitehead M, O'Neill D, Robinson D, Langhorne P. Comprehensive geriatric assessment for older adults admitted to hospital. *Cochrane Database Syst Rev* 2011(7):CD006211
- ⁴⁷ Beswick, A.D., Rees, K., Dieppe, P., Ayis, S., Gooberman-Hill, R., Horwood, J., et al, (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *The Lancet*, 371(9614), pp. 725-735.
- ⁴⁸ Sager, M.A., Franke, T., Inouye, S.K., Landefeld, C.S., Morgan, T.M., Rudberg, M.A., et al, 1996. Functional Outcomes of Acute Medical Illness and Hospitalization in Older Persons. *Arch Intern Med*, 156(6), pp. 645-652.
- ⁴⁹ Woodard, J., Gladman, J., Conroy, S., 2010. Frail older people at the interface. *Age Ageing*, 39(S1), p. i36.
- ⁵⁰ Leicester University; *THE SILVER BOOK - QUALITY STANDARDS FOR THE CARE OF OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS*; Unpublished; <http://www2.le.ac.uk/departments/cardiovascular-sciences/people/conroy/silver-book-1>
- ⁵¹ NHS Leicestershire County and Rutland Public Health Intelligence Team; Local Analysis; \\Lakeside3\data\Public Health\PHI\Health Care Commissioning Projects\Capacity Planning\Activity Modelling\2011-12\Cap_Model_201112_Master_CP_ActivityAndFinanceOutput.xls

- ⁵² Lakhani, Mayur; Frail Older People Strategy; West Leicestershire Clinical Commissioning Group
- ⁵³ Department of Health; (2007 Feb); Supporting People with Long Term Conditions; © Crown Copyright http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4100317
- ⁵⁴ The Audit Commission (2004) Supporting Frail Older People Independence and Wellbeing 3; http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/OlderPeople_3_Report.pdf
- ⁵⁵ Department of Health, (2001) *Medicines and Older People, National Service Framework: Implementing medicines-related aspects of the NSF for Older People*, Department of Health, 2001
- ⁵⁶ Jillian Guild; (2011); *People living well with Dementia in the East Midlands: The Use of Anti-psychotic Medication*; Strategic Health Authority East Midlands
- ⁵⁷ Department of Health, (2007) *Putting People First: a shared vision and commitment to the transformation of adult social care*, DH, © Crown Copyright, December 2007
- ⁵⁸ Department of Health, (2008) *High Quality Care for All, NHS Next Stage review: final report*, Prof. Lord Darzi of Denham, DH, © Crown Copyright, June 2008.
- ⁵⁹ Department of Health, (2009) *Living well with dementia: a National Dementia Strategy*, DH, © Crown Copyright, February 2009
- ⁶⁰ Department of Health and Department for Constitutional Affairs, (2005) *Mental Capacity Act, TSO*, © Crown Copyright, 2005
- ⁶¹ Department of Health, (2009) *Intermediate Care – Halfway Home: Updated Guidance for the NHS and Local Authorities*, DH © Crown Copyright, July 2009
- ⁶² Social Care Institute for Excellence (2011) Research briefing 36: 'Reablement: A cost effective Route to better outcomes', April.
- ⁶³ Department of Health, (2009) *Whole Systems Demonstrators: an overview of telecare and telehealth*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_100946
- ⁶⁴ Commission on Funding of Care and Support; 2011 July; *Fairer Care Funding*; © Crown copyright 2011; <https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf>
- ⁶⁵ Forder J (2007) *Self-funded social care for older people: an analysis of eligibility, variations and future projections*, PSSRU Discussion Paper 2505, PSSRU and CSCI.
- ⁶⁶ Department of Work and Pensions (2005) *Opportunity Age – Opportunity and security throughout life* <http://webarchive.nationalarchives.gov.uk/20100210072046/dwp.gov.uk/policy/ageing-society/strategy-and-publications/opportunity-age-first-report/>
- ⁶⁷ Audit Commission and Better Government for Older People (2004) *Older People – a Changing Approach*
- ⁶⁸ Department for Communities and Local Government, Department of Health, Department for Work and Pensions; (2008 February) *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society*; © Crown Copyright 2008 <http://www.communities.gov.uk/documents/housing/pdf/lifetimehomes.pdf>

⁶⁹ Leicestershire Adult Social Care Service, *Leicestershire Extra Care Housing Strategy for Older People 2010-2015*, Leicestershire County Council.

http://www.leics.gov.uk/index/social_services/asc_support/asc_general_info/sc_plans_policies/extra_care_housing_strat.htm

⁷⁰ The Carers Organisation, *Key Facts about Carers: The Princess Royal Trust for Carers*

<http://www.carers.org/key-facts-about-carers>

⁷¹ Supporting the Health and Wellbeing of Carers in Leicester, Leicestershire and Rutland. Leicestershire County Council, Rutland County Council, Leicester City Council

⁷² Department of Health (2005) Older peoples mental health: six key messages for commissioners,

<http://www.nmhdu.org.uk/silo/files/six-key-messages.pdf>

⁷³ University Hospitals of Leicester NHS Trust; 2012 Apr; *GP Referrers Guide 2012/13*

⁷⁴ National Institute for Health and Clinical Excellence (2004) *Clinical Practice Guidelines for the Assessment and Prevention of Falls in Older People*, www.nice.org.uk/CG21

⁷⁵ Compendium of Clinical Indicators http://www.erpho.org.uk/topics/NCHOD_Compendium/

⁷⁶ Gillespie LD, Gillespie WJ, Robertson MC, Lamb SE, Cumming RG, Rowe BH. Interventions for preventing falls in elderly people (*Cochrane Review*). In: *The Cochrane Library*, Issue 4, 2002. Oxford: Update Software.

⁷⁷ National Institute for Health and Clinical Excellence (2004) *Falls: the assessment and prevention of falls in older people*. Clinical Guidance No. 21, November

⁷⁸ South West Public Health Observatory; March 2012; 65s and over hospital admissions due to falls, 2010/11; Directly age-sex standardised rate per 100,000 population; Association of Public Health Observatories; www.injuryprofiles.org.uk

⁷⁹ National Audit Office (2005) *Reducing Brain Damage: Faster access to better stroke care*, London, NAO

⁸⁰ Quality Outcome Framework data www.ic.nhs.uk

⁸¹ Association of Public Health Observatories (APHO) Models - www.apho.org.uk/

⁸² Department of Health; 2007; National Stroke Strategy; © Crown Copyright

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_081059.pdf

⁸³ End of Life Care Strategy – promoting high quality care for all adults at the end of life; Department of Health; © Crown copyright 2008;

http://www.endoflifecareforadults.nhs.uk/assets/downloads/pubs_EoLC_Strategy_1.pdf

⁸⁴ Leicester, Leicestershire and Rutland End of Life Care Strategy 2010-2014 - www.lcr.nhs.uk/Library/FinalEoLCStrategyv19141010.doc

⁸⁵ UK Inquiry into Mental Health and Well-being in Later Life (2006) *Promoting mental health and wellbeing in later life*. London: Age Concern /Mental Health Foundation.

⁸⁶ <http://www.mentalhealth.org.uk/help-information/mental-health-a-z/O/older-people/References>

⁸⁷ Health and Social Care Information Centre (2009) *Adult psychiatric morbidity in England, 2007: Results of a household survey*,

- ⁸⁸ Chew-Graham C, Baldwin R and Burns A (2004) Treating depression in later life. *British Medical Journal* 329: 181
- ⁸⁹ Report prepared for Leicestershire and Rutland County NHS Primary Care Trust Review of Health Care for Older People with Dementia Analysis of current pattern of commissioning and scope for efficiency and transportation, January 2009.
- ⁹⁰ National Audit Office report, Ensuring the effective discharge of older patients from NHS acute hospitals in 2003
- ⁹¹ National Development Team for Inclusion, A long time coming part 2 – Achieving age equality in local mental health services. London: National Development Team for Inclusion, 2011.
- ⁹² Department of Health, Living well with dementia: A National Dementia Strategy, 2009
- ⁹³ Alzheimers Association, (2011) *Alzheimers Disease; Facts and figures*, Volume 7, Issue 2
- ⁹⁴ Knapp, M. and Prince M. (2007) *Dementia UK - A report into the prevalence and cost of dementia* prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society. THE FULL REPORT. London: The Alzheimer's Society; 2007.
- ⁹⁵ Mental Health and Older People Forum 2008
- ⁹⁶ Promoting mental health and well-being in later life: A first report from the UK Inquiry into Mental Health and Well-Being in Later Life, Age Concern and Mental Health Foundation
- ⁹⁷ Office of the Deputy Prime Minister 2006
- ⁹⁸ The Leicester, Leicestershire and Rutland Joint Dementia Commissioning Strategy 2011-2014; http://www.lcr.nhs.uk/Library/DementiaJointStrategy201114_FINAL.pdf
- ⁹⁹ Social Care Institute for Excellence; Dignity in Care Campaign; November 2006; <http://www.dignityincare.org.uk/DignityCareCampaign/>
- ¹⁰⁰ Ann Abraham, Parliamentary and Health Service Ombudsman; Care and Compassion?; February 2011; <http://www.ombudsman.org.uk/care-and-compassion/home>
- ¹⁰¹ NHS Confederation, Local Government Association, Age UK; Delivering Dignity: Securing dignity in care for older people in hospitals and care homes. A report for consultation; February 2012; <http://www.nhsconfed.org/Documents/Delivering%20Dignity.pdf>
- ¹⁰² Leicestershire County Council, Leicestershire Joint Strategic Needs Assessment: Service Usage, Assessment and Development in Social Care; March 2012; http://www.lsr-online.org/reports/leicestershire_joint_strategic_needs_assessment_jsna_2012_key_documents
- ¹⁰³ Safeguarding Adults Partnership, Leicestershire County Council http://www.leics.gov.uk/print/index/social_services/asc_support/asc_keeping_people_safe/asc_suspected_abuse/adult_protection_procedures/safeguarding_adults_partnership.htm
- ¹⁰⁴ Leicestershire and Rutland Safeguarding Adults Board Constitution Revised 8.7.2010: Available from: http://www.leics.gov.uk/print/index/social_services/asc_support/asc_keeping_people_safe/asc_suspected_abuse/adult_protection_procedures/safeguarding_adults_partnership.htm

¹⁰⁵ Safeguarding Adults: Multi-Agency Policy and Procedures: Policy and Procedure for the Prevention of Abuse of Adults in Need of Safeguarding: Adult Social Care Services, Health and Police in Partnership with the CQC and the Voluntary and Independent Sector in Leicester, Leicestershire and Rutland: Revised 2010: http://www.leics.gov.uk/safeguarding_no_secrets.pdf

¹⁰⁶ Leicestershire and Rutland Safeguarding Adults Board: Annual Report 2010-2011 http://www.leics.gov.uk/print/leicestershire_and_rutland_safeguarding_adults_board_annual_report_2010_to_2011.pdf

¹⁰⁷ Department of Health, Chief Medical Officers Letter 03.05.12. Gateway reference 17488 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133963.pdf

¹⁰⁸ NHS Choices: Flu and Flu Vaccine. <http://www.nhs.uk/livewell/winterhealth/pages/fluandthefluvaccine.aspx>

¹⁰⁹ World Health Organisation; International Classification of Functioning, Disability and Health (ICF), <http://www.who.int/classifications/icf/en/>

¹¹⁰ Kenneth Rockwood, Xiaowei Song, Chris MacKnight, Howard Bergman, David B. Hogan, Ian McDowell, Arnold Mitnitski, (2005), *A global clinical measure of fitness and frailty in elderly people*, CMAJ August 30, 2005 vol. 173 no. 5 doi: 10.1503/cmaj.050051, © 2012 Canadian Medical Association or its licensors, <http://www.ecmaj.ca/content/173/5/489.full>

