

commissioning brief healthy living

Gloucestershire's ageing
population

Commissioning Series
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NHS

Gloucestershire



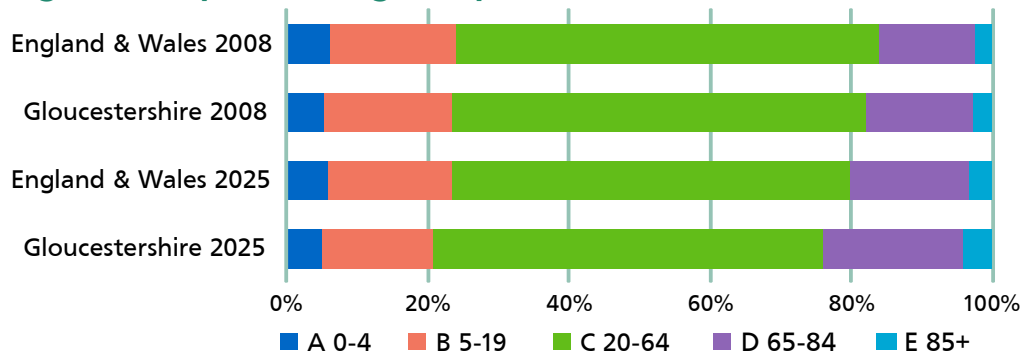
Gloucestershire
Conference



1 What is the issue?

Gloucestershire already has a greater proportion of people aged 65 and over than England and Wales. Based on 2005 mid-year estimates, this age group makes up 18.2% of the total population compared with 16.1% nationally¹.

Figure 1: Population Age Proportions



Source: eJSNA

The total population of Gloucestershire is expected to increase to 660,000 by 2025 – an extra 92,000 people. The majority of this increase is in the 65 and over age group, which is forecast to rise from 106,800 to over 158,000. This is an increase of approximately 48% compared to an increase of 12% for all ages.



¹ Office for National Statistics (ONS)

Figure 2: Gloucestershire long-range population projections for persons ages 65+, 75+ and 85+



Source: eJSNA

These changes are likely to have a huge impact on levels of morbidity, the numbers of older people who are no longer able to live independently (measured by their levels of mobility and their ability to carry out simple domestic tasks) and unpaid care.

Morbidity

- In 2008 there were an estimated 2,800 people aged 65 and over with a longstanding health condition caused by a stroke and this number is predicted to rise to 4,200 by 2025, an increase of 50%.
- In 2008 there were nearly 7,500 people aged 65 and over in Gloucestershire with a longstanding health condition as a result of a heart attack and this is expected to rise to nearly 10,800 by 2025, and increase of 44%.
- In 2008 there were an estimated 2,300 people with a longstanding health condition caused by bronchitis and emphysema and this is expected to rise to just below 3,400 by 2025, an increase of 48%.
- Estimates suggest that in 2006 there were just under 8,000 people aged 65 and over living in Gloucestershire with dementia. This is likely to rise to nearly 12,000 by 2025, an increase of nearly 50%.
- In 2008 there were an estimated 10,560 people aged 75 and over registered blind or partially sighted in Gloucestershire and this is expected to rise to 16,300 by 2025, an increase of 59%.

Independent living

- In 2008, just under 17,000 people aged 65 and over in Gloucestershire were estimated to be unable to manage at least one mobility activity on their own (such as going out of doors and walking down the road, getting up and down stairs, getting in and out of bed, going to the toilet etc) and this is expected to rise to over 25,000 by 2025, an increase of 47%.
- Estimates suggest that in 2008 in Gloucestershire just over 38,000 people aged 65 and over 36% were unable to complete at least one of a list of simple domestic tasks, such as using a vacuum cleaner, or washing and drying the dishes. This is expected to increase by 54% to over 58,500 by 2025.
- From a study carried out by the Department of Health, it was estimated that in Gloucestershire in 2008, 35,000 people in the 65 and over age group were unable to perform even one basic self-care activity, such as washing themselves, and that this is likely to rise to more than 51,000 people by 2025, an increase of 34%.

Carers

- Approximately 12,000 carers (over 30% of the total number of carers in Gloucestershire) are aged 65 and over and provide unpaid care to family, friends and neighbours.
- According to the 2001 census, just under ten per cent of these carers considered their own health status to be 'poor' and four per cent provide care for more than 50 hours a week.

Service utilisation

- There are 6,835 people aged 65 and over in Gloucestershire who receive help to live at home. This level of care can prevent or postpone someone from needing a more intensive care package or residential care. This is estimated to rise by approximately 48% by 2025 to 10,125.
- In Gloucestershire, there are 854 people aged 65 and over who are currently receiving intensive home care (ten hours or more, six visits or more per week). This service helps many people to remain in their home or return home after a period in hospital. This figure is expected to rise by approximately 48% by 2025 to 1,266. However, the total number of people aged 65 and over who receive community based services (a

referral, assessment, or package of care from the community and adult care directorate of Gloucestershire County Council) is 13,942. This figure is expected to rise to 20,652 by 2025, a rise of approximately 48%.

- There are currently 7,588 people aged 65 and over receiving equipment for independent living in Gloucestershire as a result of an assessment. This figure is expected to rise to 10,834 by 2025, a rise of approximately 43%.
- There are 1,857 people aged 65 and over receiving meals in Gloucestershire. This figure is expected to rise to 2,902 by 2025, an increase of approximately 56%.
- There are currently 3,598 people aged 65 and over who are supported in residential or nursing care in Gloucestershire. This figure is expected to rise to 5,345 by 2025, an increase of 49%.
- There were almost 142,000 consultant-led outpatient appointments in 2007-08 for the 65 and over age group, approximately 34% of all consultant-led outpatient appointments for Gloucestershire.
- There were nearly 43,000 hospital admissions in the 65 and over age group (34% of all admissions), which utilised 35,000 bed days (66% of total bed days) in 2007-08.
- There were approximately 18,500 emergency admissions in the 65 and over age group, and 13,500 in the 75 and over age group in 2007-08.

Predictions of future service levels have been modelled in the eJSNA based on population changes and with the assumption that services will be maintained at current levels. Examples for some specific conditions are given below.

Table 1: Number of emergency admissions for specific conditions

Condition	Number of emergency admissions in 2008	Predicted number of emergency admissions in 2025	Percentage increase
CHD (all ages)	3,566	5,036	41
Stroke (all ages)	967	1,317	36
COPD (all ages)	911	1,278	40
Falls (65 and over)	2,300	3,500	52

Source: PHIU



Dementia

Although there is no cure, if dementia is diagnosed early, a considerable amount can be done to help manage the symptoms of the illness and support people and carers to cope with the condition. Key facts about dementia are that:

- over the next 20 years, projections suggest that the overall number of people with dementia in Gloucestershire will increase by 49%
- dementia affects one person in five over the age of 80
- older people typically have other forms of ill health at the same time as dementia
- nationally, up to 70% of acute hospital bed days are occupied by older people and up to half of these are patients with cognitive impairment, including dementia
- estimates suggest that in 2006 there were just under 8,000 people aged 65 and over living in Gloucestershire with dementia: this is likely to rise to nearly 12,000 by 2025, an increase of nearly 50%
- carers play an important part in supporting people with dementia – it is important that we understand and support carers' needs
- currently dementia care is mostly provided within a care-home setting
- carers say it is important to have access to skilled and knowledgeable staff, especially at time of diagnosis, and to have flexible services e.g. short breaks, timely information, training and support.

Modifiable risk factors for dementia include smoking, excessive alcohol consumption, obesity, diabetes, hypertension and raised cholesterol.

The Department of Health published a national dementia strategy in February 2009. This strategy is driving local service developments and implementation plans which are monitored by the Strategic Health Authority.

2 What works?

The National Institute for Clinical Excellence (NICE) provides guidance on evidence based interventions. The following are examples relating specifically to older people.

Promoting People's mental wellbeing

The following are the NICE recommendations on the best ways to promote people's health and wellbeing:

- Offer regular sessions that encourage older people to construct daily routines to help maintain or improve their mental wellbeing. The sessions should also increase their knowledge of a range of issues, from nutrition and how to stay active to personal care.
- Offer tailored, community-based physical activity programmes. These should include moderate-intensity activities (such as swimming, walking, dancing), strength and resistance training, and toning and stretching exercises.
- Advise older people and their carers how to exercise safely for 30 minutes a day on 5 or more days a week, using examples of everyday activities such as shopping, housework and gardening. (The 30 minutes can be broken down into 10-minute sessions.)
- Promote regular participation in local walking schemes as a way of improving mental wellbeing. Help and support older people to participate fully in these schemes, taking into account their health, mobility and personal preferences.
- Involve occupational therapists in the design of training offered to practitioners.

Dementia

NICE has provided guidance on the following aspects of managing dementia:

Structural imaging for diagnosis

Structural imaging should be used in the assessment of people with suspected dementia to confirm the diagnosis and to determine the sub-type of the disease. A magnetic resonance imaging (MRI) scan is the



preferred option to assist with early diagnosis and to detect subcortical vascular changes, although computed tomography (CT) scanning could be used. Specialist advice should be taken when interpreting scans in people with learning disabilities.

Behaviour that challenges

People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an assessment at an early opportunity to establish the likely factors that may generate, aggravate or improve such behaviour. The assessment should be comprehensive and include:

- the person's physical health
- depression
- possible undetected pain or discomfort
- side effects of medication
- individual biography, including religious beliefs and spiritual and cultural identity

- psychosocial factors
- physical environmental factors
- behavioural and functional analysis conducted by professionals with specific skills, in conjunction with carers and care workers.

Individually tailored care plans that help carers and staff address the behaviour that challenges should be developed, recorded in the notes and reviewed regularly. The frequency of the review should be agreed by the carers and staff involved and written in the notes.

Training

Health and social care managers should ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia-care training (skills development) that is consistent with their roles and responsibilities.



Mental health needs in acute hospitals

Acute and general hospital trusts should plan and provide services that address the specific personal and social care needs and the mental and physical health of people with dementia who use acute hospital facilities for any reason.

Falls

The following provides a summary of the guidance on aspects of falls prevention:

Case/risk identification

- Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall(s).
- Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. Tests of balance and gait commonly used in the UK are detailed in the full guideline.

Multifactorial falls risk assessment

- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by healthcare professionals with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention.

Multifactorial interventions

- All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention.
- In successful multifactorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):
 - strength and balance training



- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal.
- Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk, and individualised intervention aimed at promoting independence and improving physical and psychological function.
- Encouraging the participation of older people in falls prevention programmes including education and information giving.
- Individuals at risk of falling, and their carers, should be offered information orally and in writing about what measures they can take to prevent further falls.

Professional education

- All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

3 What are we doing about some of these now?

The figures above are based purely on population estimates and current service utilisation. However, some conditions listed are amenable to prevention and/or early intervention, which may either reduce the incidence, or the severity, of the condition. Two examples of these are provided here.

Preventing Falls

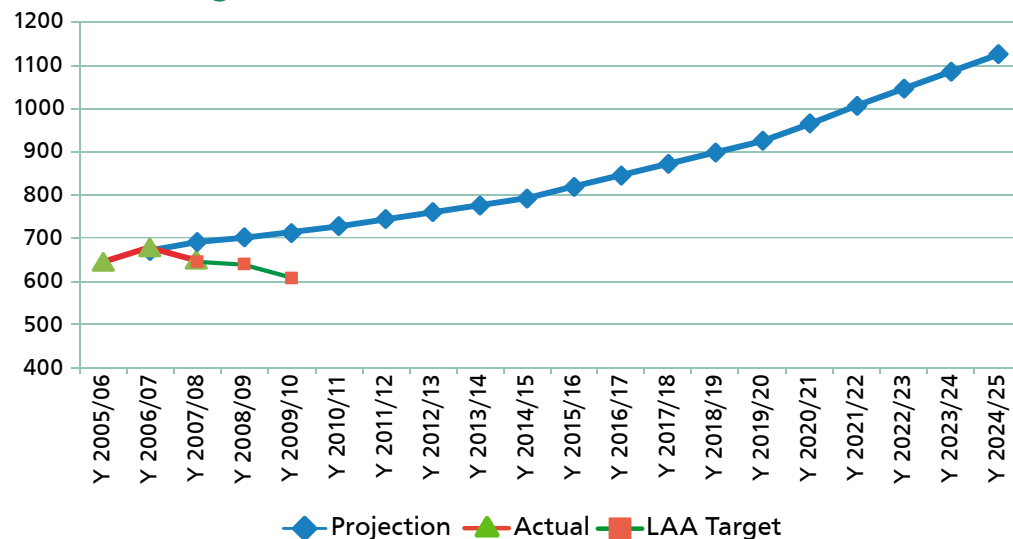
Falls are a common occurrence in older people. In Gloucestershire, hospital admissions for falls account for 11.6% of all emergency admissions in the 65 and over age group which increases to 13.3% in the 75 and over age group. Due to the significant burden of falls, they were chosen as one of the stretch targets for the Local Area Agreement (LAA). As a result, partners have worked together to develop services across the whole spectrum of prevention and early intervention, with the aim of reducing the number of older people who fall and fracture their femur. These include:

- Developing the falls prevention pathway to ensure, not only that older people at risk of falls are identified and provided for, but also that it extends across the local community providing opportunities for older people to remain physically active.
- Establishing a Bone Health Service to identify and treat people over 75 who are at high risk of osteoporosis and falls. This service identifies those at high risk, ensures they receive assessment and treatment and links them into the falls prevention pathway.
- Developing services in partnership with the Local Ambulance Trust and Telecare Service to enable health and social care community staff to respond to fallers more effectively. It also ensures that older people are more easily able to have a home assessment, advice and any equipment that might help them avoid a fall

- Establishing evidence-based falls exercise services across the county. This means that whether people attend a health-based *Active Balance Group* or an exercise class in their local community, they will be equally effective in keeping individuals physically active and helping to reduce the risk of falling.
- A programme of educational events on falls prevention and healthy lifestyles across the county, where NHS staff give talks to local groups, or attend appropriate events with information.

The graph below shows the likely number of people who suffer a fractured femur based on population projections (blue line). It also shows the LAA target (green line) and actual figures (red line). This shows that in 2007-08 we managed to start to 'turn the curve' and meet the target. However, as shown in the graph, year 2 and year 3 LAA targets are even more challenging.

Figure 3: Fractured femurs in the 75 and over age group (LAA target)



Source: PHIU

Stroke and coronary heart disease (CHD)

In 2006/07, there were 1,534 emergency CHD admissions and 932 emergency admissions for strokes.

There are a number of factors which affect the prevalence of stroke and CHD, including smoking, hypertension (high blood pressure), high cholesterol, obesity and lack of physical activity.

Prevention is better than cure and to tackle these risk factors we are:

- Rolling out the national NHS Health Check (formerly known as the Vascular Risk Assessment Programme) in Gloucestershire for residents aged 40-74. This programme aims to assess an individual's risk of cardiovascular disease and manage this risk by providing lifestyle advice and prevention/early intervention treatment locally. As most cardiovascular 'events' happen in our more mature members of the community this will have the greatest benefit in the 65+ population. The NHS Health Check programme is expected to also address health inequalities by reducing premature deaths and illness in populations at highest risk. We will target geographical areas and specific populations which are at highest risk in the first instance.
- Continually looking for novel ways to increase access to smoking cessation services which include the opening of a shop on Gloucester High Street, to enable easy access for those who might want advice on how to quit smoking.
- Developing a weight management care pathway to help people who are obese reduce their risk and improve their fitness and sense of wellbeing.
- Ensuring that all those with high blood pressure or high cholesterol are treated appropriately. Through this we estimate that we could avoid 33 cases of angina, 54 strokes, 55 mini strokes and 80 heart attacks every year.

A new stroke care pathway is being developed to ensure that timely services are available to all who need them - from the provision of clot-busting drugs at the very beginning of a stroke, to improved community rehabilitation services and support for carers.

4 What do we need to do next?

- Prioritise older people's services for service redesign in order to deliver appropriate and timely services to meet the needs and wishes of older people. This needs to take into account people's preferences, support people to stay in their own homes for as long as possible and to receive services close to home.
- Provide services which will support carers, thus reducing pressures on statutory services.
- Continue to develop pathways of care which put emphasis on prevention and early intervention.
- Use modelling techniques to help develop alternative care pathways and fully integrated packages of care.
- Develop and implement comprehensive countywide action plans for stroke and dementia, to meet the needs of patients and carers in line with national strategies.





5 Next Steps

This briefing will be shared with the Joint Commissioners for Older People and the Countywide Older People's Steering Group to consider and act on the findings and recommendations.

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