Cheshire West and Chester

NHS

INTEGRATED STRATEGIC NEEDS ASSESSMENT:
OLDER PEOPLE AGED OVER 85
SUMMARY

KEY ISSUES

- Many older people are assets within their communities that can help build more resilient and sustainable communities
- People with complex multiple conditions need holistic assessment and integrated care
- People with complex multiple needs want personalised care wrapped around their individual needs
- High use of acute hospital care in an emergency in West Cheshire CCG
- High use of nursing home care with increasing complexity and length of time spent in care homes
- Increasing demand on most intensive type of care may indicate 'system gaps' in lower intensity type of care
- The number of over 85s will increase by 44% between 2011/12 and 2021/22 – the current service model is unsustainable in the face of rising demand, reducing resources and high use of high-intensity care

Level of need

In 2012, 8,222 patients aged over 85 were registered with the two CCGs practices. Chester locality has the greatest number of over 85s registered with their practices whilst the Rural locality has the highest proportion. Most people aged 85 and over are living at home. We however estimate that 14% of our over 85s are living in a care setting. Chester and Vale Royal have the highest number of people living in a residential or nursing home setting whilst Vale Royal has the highest proportion (16.8%).

Most older people aged over 85 have multiple long-term conditions which means they have a combination of physical, social, mental and emotional wellbeing needs. A recent multi-morbidity study found that 82% of over 85 year olds had multi-morbidity (2 or more conditions) and 31% had physical and mental co-morbidity. The prevalence of multi-morbidity did not vary by deprivation in this age group.

Nationally we estimate that 6-13% of older people feel lonely. Local surveys have found that although our older people have a strong sense of belonging to their immediate neighbourhood, they are likely to feel less useful and go on

fewer social outings than younger people. Poor physical health, bereavement, retirement, illness of a close partner and taking on a caring role can affect mental wellbeing but personal resilience, adopting the ‘5 Ways to Health and Wellbeing’ and good support networks in the community can mitigate the effect of these life events on our wellbeing.

Quality of people’s experience

The adult social care survey in 2011-12 reported positive satisfaction levels amongst service users aged over 85. Key issues identified however include that 15% do not feel they had enough social contact, a third didn’t spend enough time or don’t do anything they value or enjoy and many are experiencing difficulties getting to places in the local area that they want to.

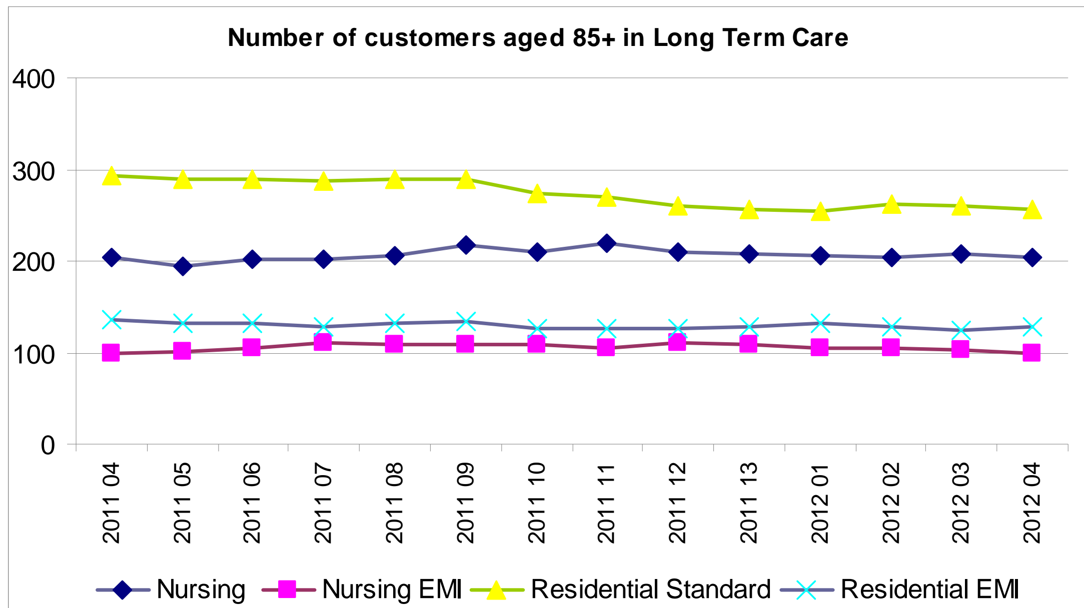
Although the majority of older people are reporting satisfaction with individual services, they report difficulties navigating the complexity of the whole system; whilst individual customer contacts may be customer-focussed, the system as a whole is not. There is concern at the fragmentation of care and limited choice and control and service users reported they would value a ‘personal and comprehensive’ single assessment process which would mean that a range of services could respond to their individual needs in a flexible way. They valued intermediate type and reablement services and felt there were more opportunities to keep people out of hospital. They valued getting sufficient information to make decisions and continuity of communication with care givers and felt that the quality of care was really important.

Stakeholders felt that there was a potential role for social enterprises that could develop to meet the unique needs of different communities. They felt that communities and service users should be at the heart of these enterprises and that these could be a way of working with volunteers on the prevention agenda particularly in reducing loneliness and social isolation or to respond to peoples low level needs to reduce future dependency.

Use of services

Adult Social Care currently commission/provide services to approximately 1,600 customers aged 85+. 40% of these customers are in permanent long term care and 60% are receiving services in the community. The community service for which there is most demand from customers aged 85+ is home care. The overall number of people aged 85+ receiving social care services has been reducing but there is evidence that the remaining customers have more complex needs, for example EMI and nursing compared to standard residential care needs, and are staying for a longer period in a long term care setting. The number of customers in residential care per 100,000 population was low whereas for nursing care it was high compared regionally and with CIPFA comparator group in 2011/12.

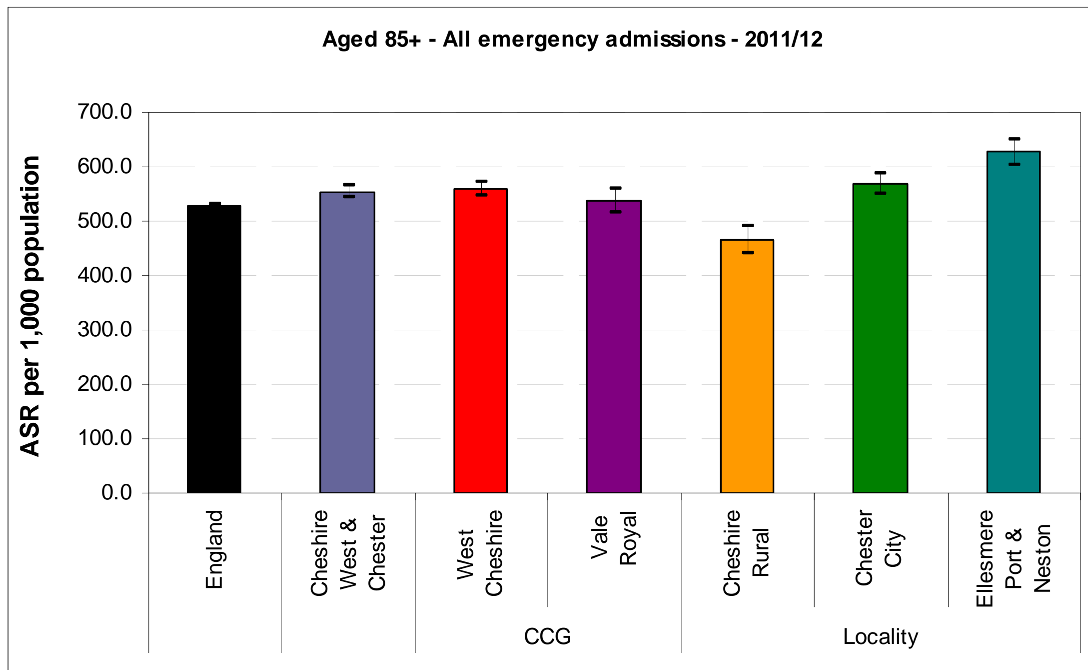
Trend in the number of customers in long-term care aged 85+



Source: Cheshire West and Chester Council. Adult Social Care and Health

In 2011/12, there were 4,326 emergency admissions in people aged over 85. This is 12.6% of all emergency admissions for all ages. The most common reason for emergency admission is general symptoms and signs. Overall emergency rates of admissions in the over 85s are high compared nationally. This hides a different picture between the two CCGs with rates in West Cheshire particularly in Ellesmere Port and to a lesser extent Chester being high compared to being average in Vale Royal. Two key causes for high emergency rates in West Cheshire CCG were in relation to general symptoms and signs; circulatory and respiratory conditions, head injuries and symptoms & signs with cognition/perception problems. Vale Royal CCG had high rates of admission for general symptoms and signs.

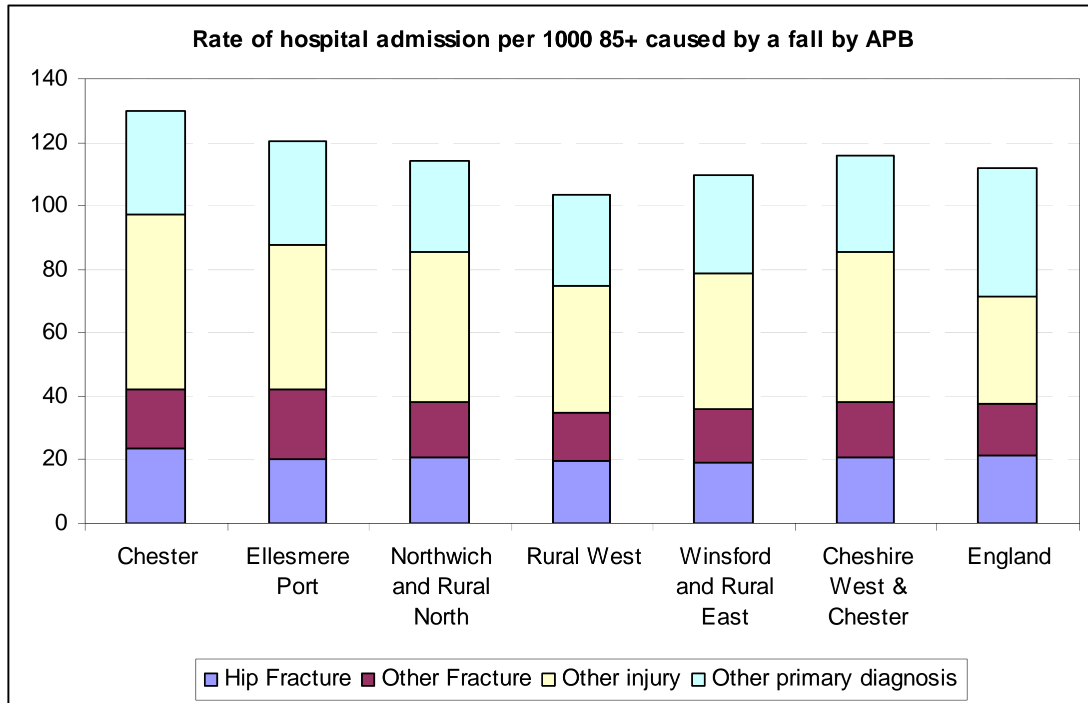
Figure Emergency admission rates in the over 85s national and local comparisons 2011/12



Source: NHS Information Centre HES Online

20% of non-elective admissions in the over 85s are due entirely or partly to a fall. Hospital admission rates for falls in the over 85s are high (but not statistically) compared with England. This is because hospital admission rates for falls due to non-fracture injuries are much higher and have been increasing over recent years. This is apparent across all localities. In addition, Chester has a high rate of admission due to hip fracture and Ellesmere Port has a high rate of admission for other fractures.

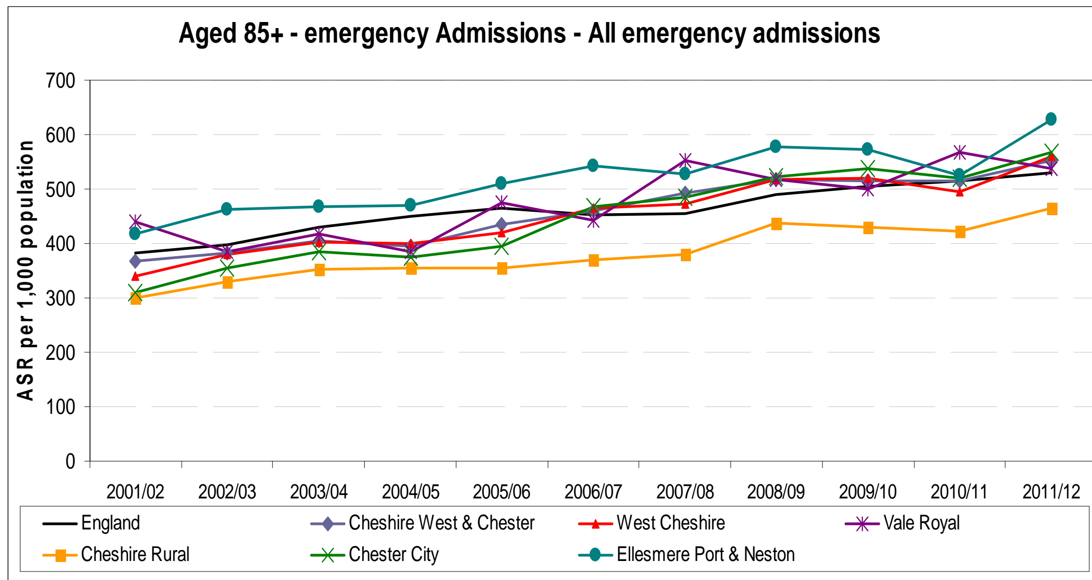
Rate of hospital admission per 1,000 population aged 85+ caused by a fall by Area Partnership Board 2009/10 – 2010/11



Source: NHS Information Centre HES Online

Emergency admissions have been increasing faster than demographic growth in the over 85s. Rates of emergency admission have been increasing recently, particularly in Ellesmere Port. Conditions that have increased include heart failure, pneumonia and influenza in particular.

Trends in rates of emergency admission by CCG geographical locality



Source: NHS Information Centre HES Online

On average people aged over 85 stay in hospital 12.5 days after a non-elective admission. This has fallen over the last 10 years but less so locally compared to the regional and national average. The average LOS was slightly higher in West Cheshire and Vale Royal compared nationally in 2011/12.

In 2008-10, half of our over 85s died in hospital compared to a third in a care home and 11% at home. The proportion of deaths in the over 85s that occurred in hospital was highest in Ellesmere Port. The percentage of people aged over 85 dying in hospital fell over the last 3 years, particularly in Chester and Northwich. Deaths from respiratory disease (as a primary cause or contributory cause) are most likely to occur in hospital.

The number of over 85s is predicted to increase by 1,100 people or 14% by 2015/16 and by a further 30% by 2021/22. The use of hospital services by the over 85s has increased at a faster rate than demographic growth over the last 10 years – if services are to be sustainable over the longer term the current service model will need to change to a more community-based model.

RECOMMENDATIONS FOR COMMISSIONERS

Older people with multiple needs require holistic assessment, multi-disciplinary care planning, advance planning to avoid predictable emergencies, care co-ordination and excellent care and communication and collaborative relationships between staff, patients and carers.

1. Develop and encourage communities to build resilient support networks and offer practical support for older family/neighbours or friends. Consider developing 'community navigator' or 'local co-ordinator' roles and encourage the development of small social enterprises.
2. Ensure carers are supported and have their own needs assessed.
3. Encourage all to adopt the '5 Ways to Health and Wellbeing'.
4. Create the environment to develop an integrated care system where care is co-ordinated around the needs of an individual.
5. Develop more effective systems and teams within the community to prevent avoidable hospital admissions and reduce hospital stays to the minimum period. This may require more alternative step-up and step-down provision.
6. Ensure that people have adequate time for recovery and reablement to maximise their independence.
7. Develop more alternatives to residential care for people and their carers to consider such as extra care housing.
8. Continue to work on 'end of life' care pathways.
9. Continue to work with the care home sector to ensure resident's needs are being met by high quality care and predictable emergencies are avoided as much as possible.

INTEGRATED STRATEGIC NEEDS ASSESSMENT: FRAIL OLDER PEOPLE

MAIN REPORT

INTRODUCTION

Most older people are healthy and happy and are making valuable contributions to society and to the economy. Older adults have a variety of skills, abilities and energy they can use for the benefit of their communities but they also have a wide range of needs. However, older people are not a uniform group within the population.

As people grow older their risk of ill health or disability increases, the rate at which physiological functions change with age and hence the occurrence of ill health and disability varies greatly among different people in different circumstances: ageing is a process that involves social and behavioural influences as well as biological change. However, although no two individuals will age in the same way, at a population level, a greater number of older people will mean more ill health and disability.

In 2001, the DoH Older Peoples National Service Framework described three broad groups of 'older people'.

These were those:

• **entering old age** These are people who have largely completed their child rearing career and are perhaps coming to the end of their working lives and are in their 50s.These people are active and independent and many remain so into late old age and the key issue is promoting and extending healthy active life.

• **in 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. The key issue is to identify emerging problems ahead of crisis, and ensure effective responses which will prevent crisis and reduce long-term dependency.

• **who are 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 and the key issue is for the whole system to anticipate and respond to problems, recognising the complex interaction of physical, mental and social care factors, which can compromise independence and quality of life.

This ISNA focuses on the latter group – frail older people. For the purposes of analysis we will use the over 85s as a proxy measure for frail older people but

recognise that this is an arbitrary definition and does not mean that all over 85 year olds are ‘frail’ and that no one younger than this age is not frail.

CURRENT NEED IN THE POPULATION

How many people aged over 85 live in Cheshire West and Chester?

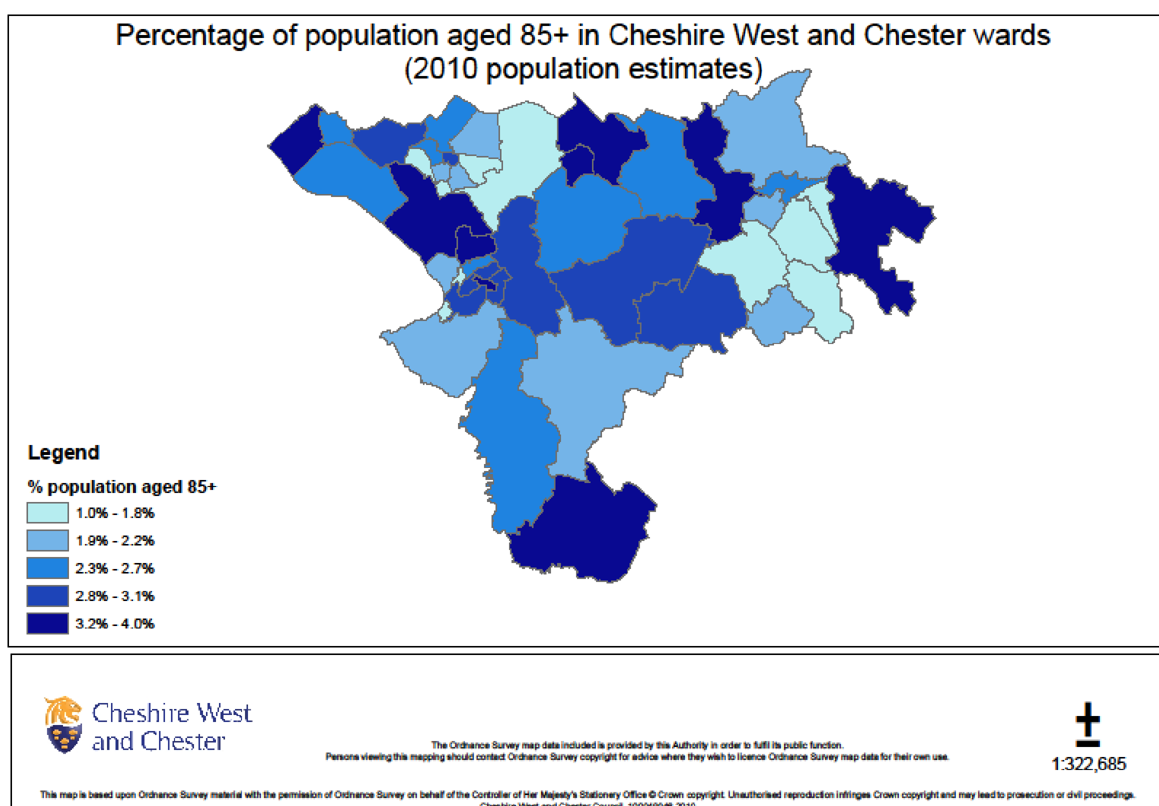
In 2011 according to the national census, there were 7,900 residents in Cheshire West and Chester who were aged 85 years and over. In 2012, Western Cheshire CCG and Vale Royal CCG had 8,222 patients registered aged over 85 with their practices. Chester locality has the greatest number of over 85s registered with their practices whilst the Rural locality has the highest proportion (table 1). The breakdown in the number of over 85s by ward and practice is given in an appendix. The proportion of over 85s varied by practice from 5.5% (Hoole Road, Chester) to 0.8% (Launceston Close and Willow Wood, Winsford) and from 4% in Malpas and Shakerley wards, Rural and Northwich respectively to 1% in Winsford and Over (figure 1).

Table 1 Registered Population aged 85 and over by CCG locality 2012

Locality	Females	Males	Persons
Chester	1641	823	2464
Ellesmere Port	1243	622	1865
Rural	1172	594	1766
Vale Royal	1453	674	2127
Cheshire West & Chester	5509	2713	8222

Source : NHAIS (Exeter) Register, June 2012

Figure 1 Percentage of population aged 85+ by ward (2010)



Most people aged 85 and over are living at home. Using information from the Exeter patient registration system we estimate that 1,167 people were living in a residential or nursing care setting in June 2012. This is approximately 14% of our over 85s. Chester and Vale Royal have the highest number of people living in a residential or nursing home setting (table 2). Vale Royal has the highest proportion of people aged over 85 living in a care setting (16.8%).

Table 2 People in Residential or Nursing Homes aged 85 and over by CCG locality 2012

Locality	Females	Males	Persons
Chester	262	69	331
Ellesmere Port	176	42	218
Rural	204	52	256
Vale Royal	300	62	362
Cheshire West & Chester	942	225	1167

Source : NHAIS (Exeter) Register, June 2012

The 2011 Census will give us more knowledge about how many of our over 85s are living alone.

Mental Wellbeing

Many older people enjoy life but a significant proportion struggle with loneliness, isolation and low-level mental health problems. Research over decades has found a fairly constant proportion (6 – 13%) of older people feeling lonely often or always[1]. Certain groups of older people are at more risk of poor emotional wellbeing than others. Key risk factors include being in later old age (over 80 years), on a low income, in poor physical or mental health, living alone or in isolated rural areas or deprived urban communities and not having an active social or community life [2.]

We asked about mental wellbeing in the Cheshire West and Chester "Our Community Survey" 2012. We used the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS), a set of validated questions aimed at measuring mental wellbeing in the local population. The following table shows the percentage of respondents who said they had experienced the following feelings and thoughts **none** of the time or **rarely** during the last 2 weeks. It shows nearly a third of respondents aged 85 and over had not or rarely felt useful or optimistic in the previous two weeks but only 12% had not felt relaxed. This is in contrast with younger age groups who felt more optimistic and useful but less relaxed (table 3).

Table 3 Proportion of respondents who said they had experienced the following feelings and thoughts NONE of the time or RARELY during the last 2 weeks by age

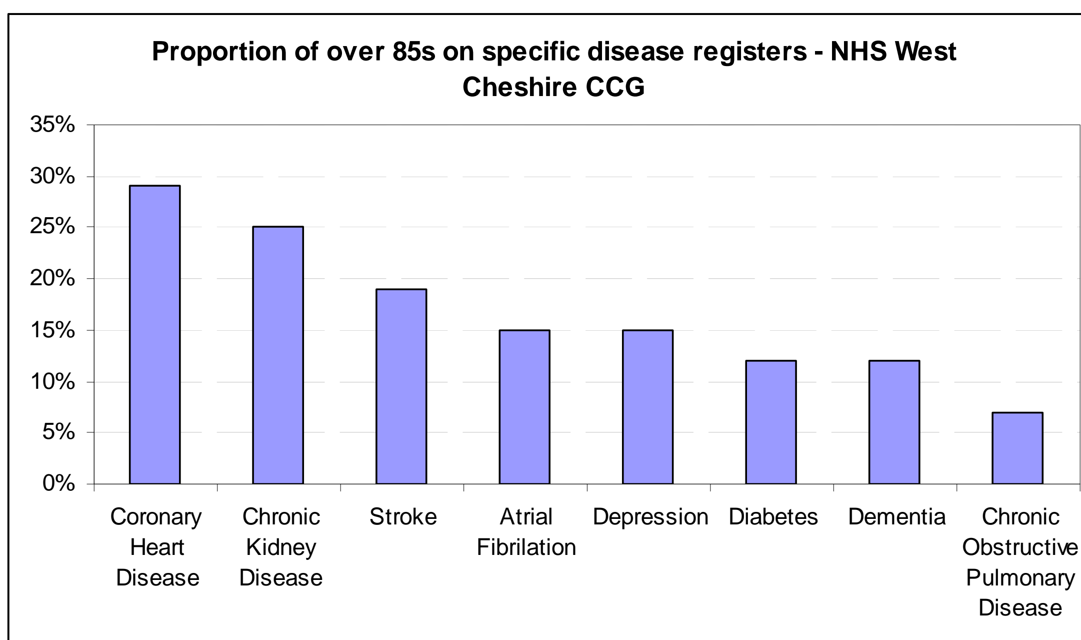
I've been...	18-34 (base for % 591-595)	35-54 (base for % 2014-2024)	55-64 (base for % 1412-1438)	65-74 (base for % 1249-1304)	75-84 (base for % 655-725)	85+ (base for % 185-210)
Feeling optimistic about the future	16%	20%	22%	21%	26%	30%
Feeling useful	12%	10%	10%	10%	15%	31%
Feeling relaxed	27%	22%	15%	11%	9%	12%
Dealing with with problems well	11%	7%	5%	5%	6%	5%
Thinking clearly	9%	5%	4%	2%	3%	4%
Feeling close to other people	9%	9%	9%	8%	10%	10%
Able to make my own mind up about things	4%	3%	2%	3%	3%	4%

Source: Cheshire West and Chester, Research, Intelligence & Consultation Team 2012
Please note: Figures in bold indicate that the result is significantly higher than for other age groups

What long-term conditions do our over 85s have?

People aged over 85 have a wide range of long term conditions. Using local evidence from Western Cheshire CCG we found the following proportion of over 85s were on specific QOF disease registers (figure 2).

Figure 2 Proportion of over 85s on specific disease registers 2011



Source: Primary Care Database (Graphnet), 2011

Most older people aged over 85, however, have multiple long-term conditions. This means that many have a combination of mental, physical, social and emotional needs. People with multimorbidity – those with two or more chronic morbidities – need a broader approach rather than disease specific health care delivery. Use of many services to manage individual diseases can become duplicative and inefficient and is burdensome and unsafe for patients because of poor co-ordination and integration. Multi morbidity becomes progressively more common with age and is associated with high mortality, reduced functional status and increased use of both inpatient and ambulatory health care. In a cross-sectional study in Scotland that included information for 40 morbidities from over 300 general practices they found that 82% of over 85 year olds had multimorbidity (2 or more conditions) and 31% had physical and mental co-morbidity. Although they found that people living in deprived areas were more likely to be multimorbid than those living in affluent areas – this finding did not apply to those aged 85 years and older[4].

We have applied these findings to our population and estimated that 6,701 people aged 85 and over have two or more conditions and 2,532 have both a physical and mental health co-morbidity (table 4).

Table 4 Estimated registered population aged 85 and over with 2 or more chronic conditions by locality

CCG Locality	Number of people with 2 or more chronic conditions	Number of people with physical/mental health co-morbidity
Chester	2008	759
Ellesmere Port	1520	574
Rural	1439	544
Vale Royal	1734	655
Cheshire West & Chester	6701	2532

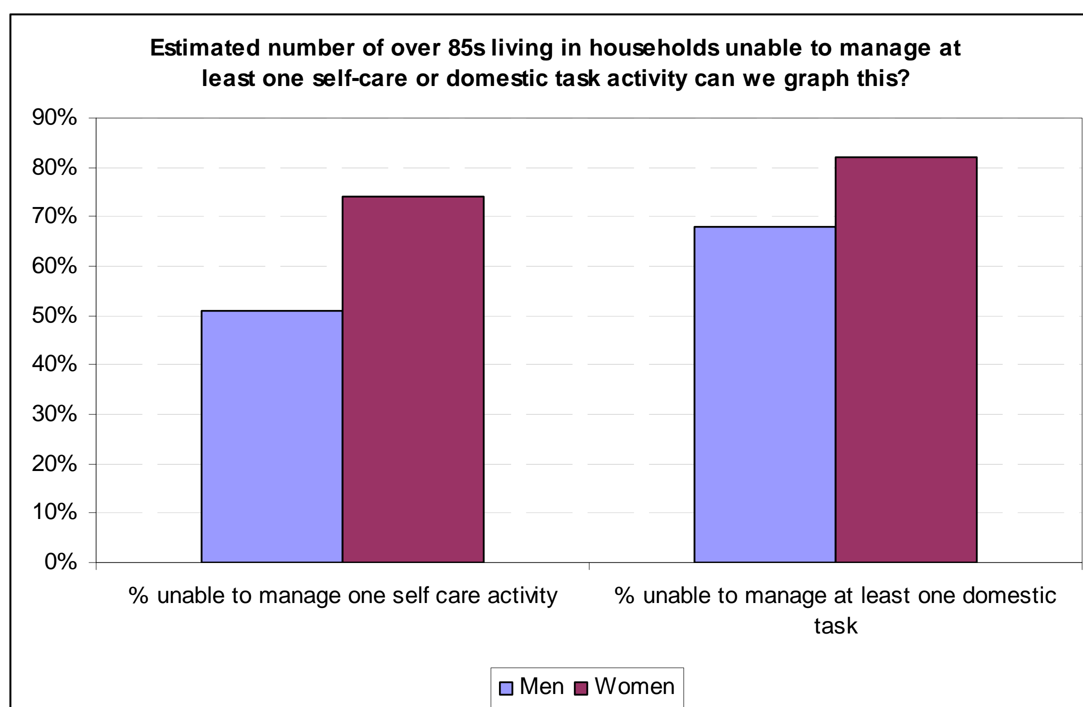
Source : Population – NHAIS (Exeter) Population Register, June 2012. Estimates based on : Epidemiology of multimorbidity and implications for health care, research and medical education : a cross-sectional study. Barnett et al. 2012

How many over 85s may have difficulties looking after themselves?

The National Living in Britain survey in 2001 found that 51% of men and 74% of women aged over 85 living in private households were unable to manage on their own at least one self-care activity (activities include: bathe, shower or wash all over, dress and undress, wash their face and hands, feed, cut their toenails, take medicines). This survey also found that 68% of men and 82% of women aged over 85 were unable to manage at least one domestic task (tasks include: household shopping, wash and dry dishes, clean windows inside, jobs involving climbing, use a vacuum cleaner to clean floors, wash clothing by hand, open screw tops, deal with personal affairs, do practical activities).

In the absence of more up to date data we have applied these findings to our current population aged 85 and over (Figure 3).

Figure 3 Estimated number of over 85s living in households unable to manage at least one self-care or domestic task activity



Source: Living in Britain 2001

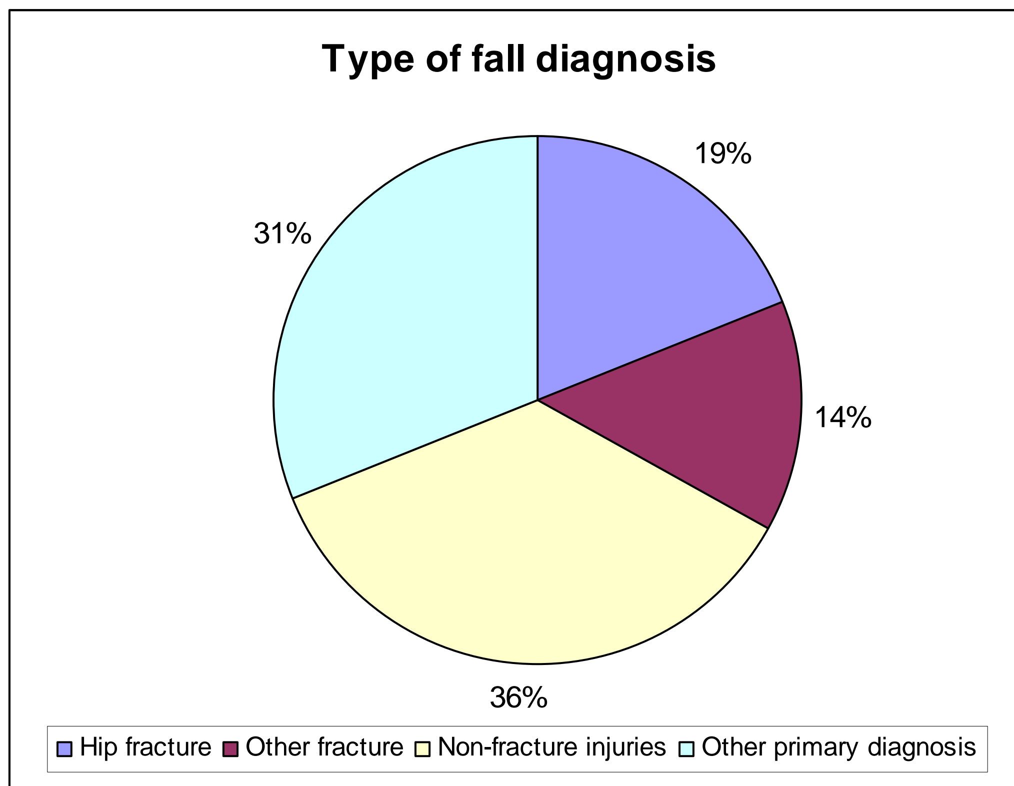
How many over 85s fall?

Falling is more common in older people but is not an inevitable consequence of old age. Common risk factors include occurrence of a previous fall, gait and balance problems, muscle weakness, cognitive impairment – for example from dementia, multiple medications, visual impairment and acute medical illness. Recurrent falls are often a manifestation of impaired postural stability. This can result from a combination of factors, such as conditions like arthritis, stroke or Parkinson's disease, age-related frailty and long-term cardio respiratory conditions leading to loss of strength, balance and concentration.

External factors can contribute to falls, such as poor or cold housing or behavioural issues such as excessive alcohol consumption. Underlying many of the risk factors is a common disease known as osteoporosis. This is a progressive skeletal disease that increases susceptibility to fracture. 25% of women who are over 80 will have some form of osteoporosis.

There were 960 hospital admission due to falls in the over 85s in 2011/12. Not everyone who falls are however admitted to hospital and not all falls admissions are due to fractures. The different types of falls admission are given below (Figure 4).

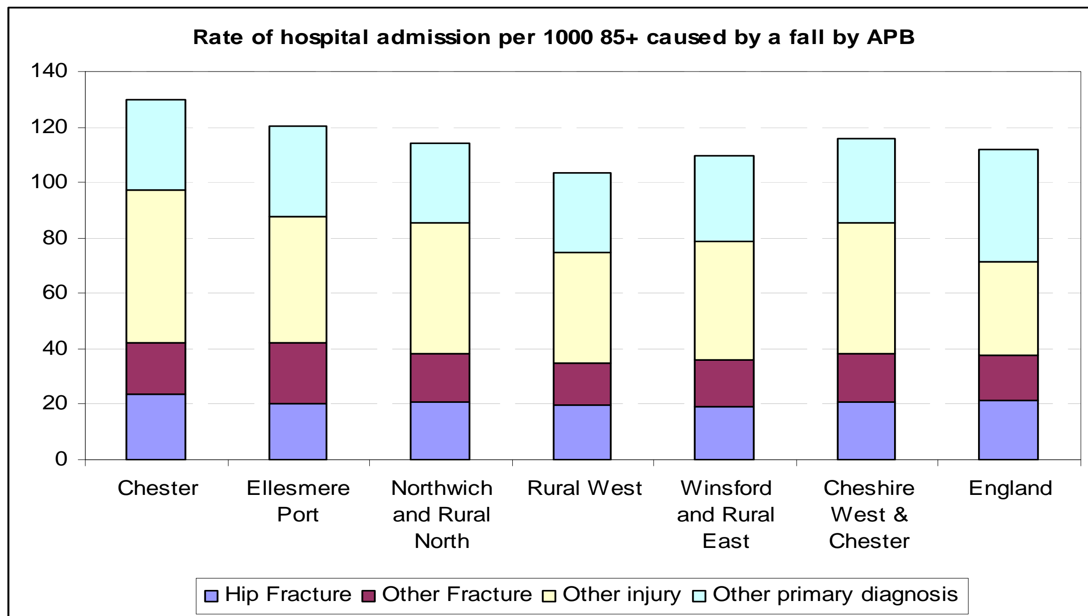
Figure 4 Types of fall admissions 2011/12



Source: NHS Information Centre HES Online

Hospital admission rates for falls in the over 85s are higher (but not statistically) compared with England during 2009/10-2011/12. This is because hospital admission rates for falls due to non-fracture injuries are much higher than the national average, this is apparent across all localities. In addition, Chester has a high rate of admission due to hip fracture and Ellesmere Port has a high rate of admission for other fractures (figure 5).

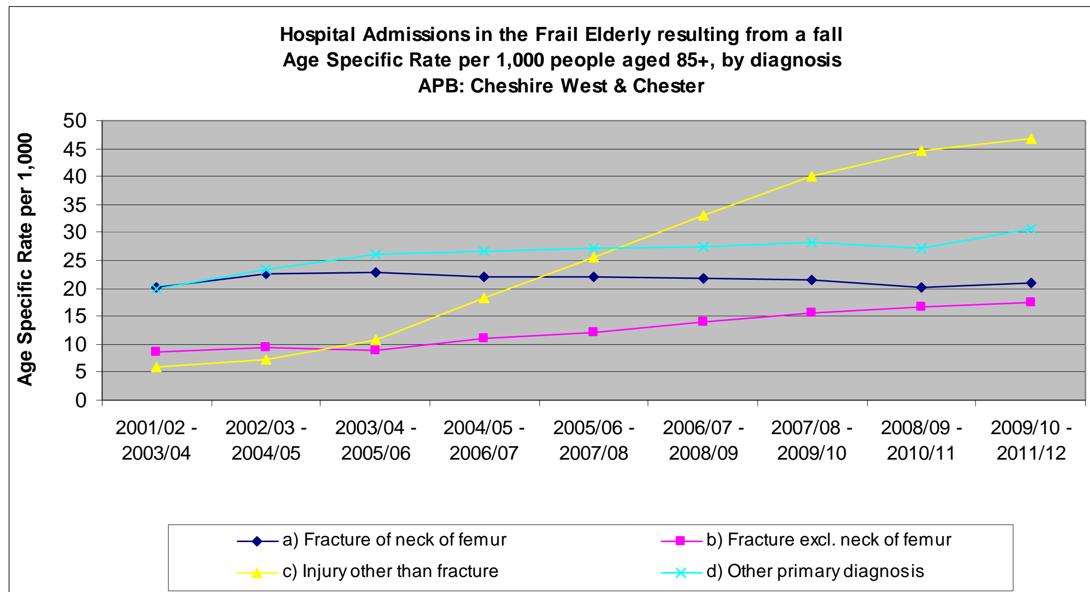
Figure 5 Rate of hospital admission per 1,000 population aged 85+ caused by a fall by Area Partnership Board 2009/10 – 2010/11



Source: NHS Information Centre HES Online

Hospital admissions for falls have been increasing since 2001/02 although the rate of increase has slowed slightly in recent years. Chester and Ellesmere Port has had the highest rate of increase in recent years (since 2007/08).This recent upward trend has been highest in falls due to non-fracture injuries. This is apparent across all localities but particularly Chester (figure 6).

Figure 6 Trend in rates of admission by each type of fall admission Cheshire West and Chester

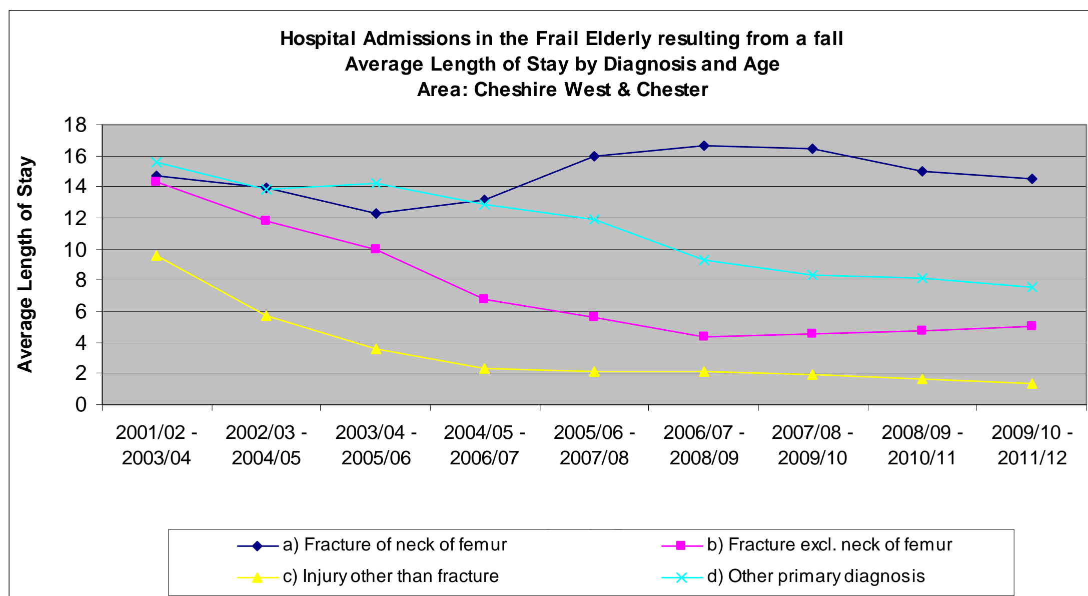


Source: NHS Information Centre HES Online

The length of time people aged over 85 are staying in hospital after a fall has been decreasing – the actual length of time does vary according to the underlying cause and locality. For example, people from Rural West stayed in hospital longest after a hip fracture. This may indicate that they were less likely to be transferred to step down facilities or that facilities are not available in the rural area to support early discharge.

Over the last few years the average length of stay for non-fracture injuries is short – only 1.5 days and is much lower than 10 years ago (figure 7). This is the group of fall admissions that have increased the most and may indicate that the increase has been in less severe types of fall or that the threshold for admission has changed.

Figure 7 Trend in Average Length of Stay by type of fall admission Cheshire West and Chester



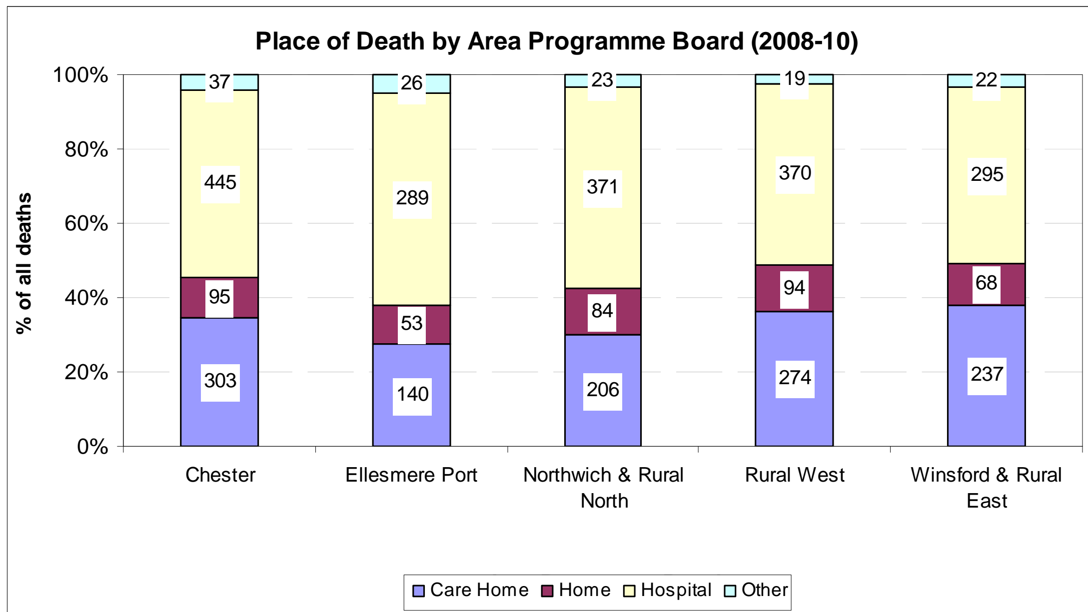
Source: Hospital Episode Statistics (HESOnline)

End of Life

With improvements in life expectancy many people are now reaching their 80s and are dying at an older age. Locally, around 1,150 people aged over 85 die each year. This represents about a third of all deaths each year.

Most of us die within our 'old age' from a disease that in it's advanced stages, is incurable and progressive; for example, heart failure, stroke, cancer, respiratory disease, neurological diseases and dementia. We however wish to live as well as possible before we die and most of us would like a choice in how we are cared for and would prefer to die at home. In a national survey 56% of people said that they would prefer to die at home, 24% in a hospice and 11% in a hospital. In 2008-10 51% of our over 85s died in hospital compared to 34% in a care home and 11% at home. The proportion of deaths in the over 85s that occurred in hospital was highest in Ellesmere Port and lowest in Rural West but the difference is not significant (figure 8).
The percentage of people aged over 85 dying in hospital fell over the last 3 years, particularly in Chester and Northwich.

Figure 8 Place of death in the over 85s by Locality 2008- 10



Source: Annual District Death Extracts

Nearly 40% of deaths are caused primarily by heart disease and stroke with 18% and 16% caused by respiratory conditions and cancer respectively. People aged over 85 who die from respiratory causes are most likely to die in hospital (63%) (and account for 22% of all deaths in hospital). Many of these deaths have other contributory causes including in particular dementia and respiratory conditions. About 20% of all deaths in this age group have dementia mentioned on the death certificate – about two-thirds of these occur in care homes but a fifth occur in hospital. A further 40% have respiratory conditions as a contributory cause. These occur most frequently in hospital and account for half of all deaths that occur in hospital in the over 85s (table 5).

Table 5 Number deaths by principal and underlying cause and place of death 2008-10 combined

	All Causes	Underlying cause of death			Causes mentioned on death certificate			
		Cancer	Cardiovascular disease	Respiratory disease	Alzheimer's, Dementia or Senility	Liver disease	Renal disease	Respiratory disease
Home	394	91	155	45	62	*	15	86
Care Home	1171	140	373	191	470	*	26	418
Hospital	1801	233	704	399	145	22	100	854
Hospice	73	63	5	*	*	*	*	10
Total	3439	538	1291	635	697	28	146	1385

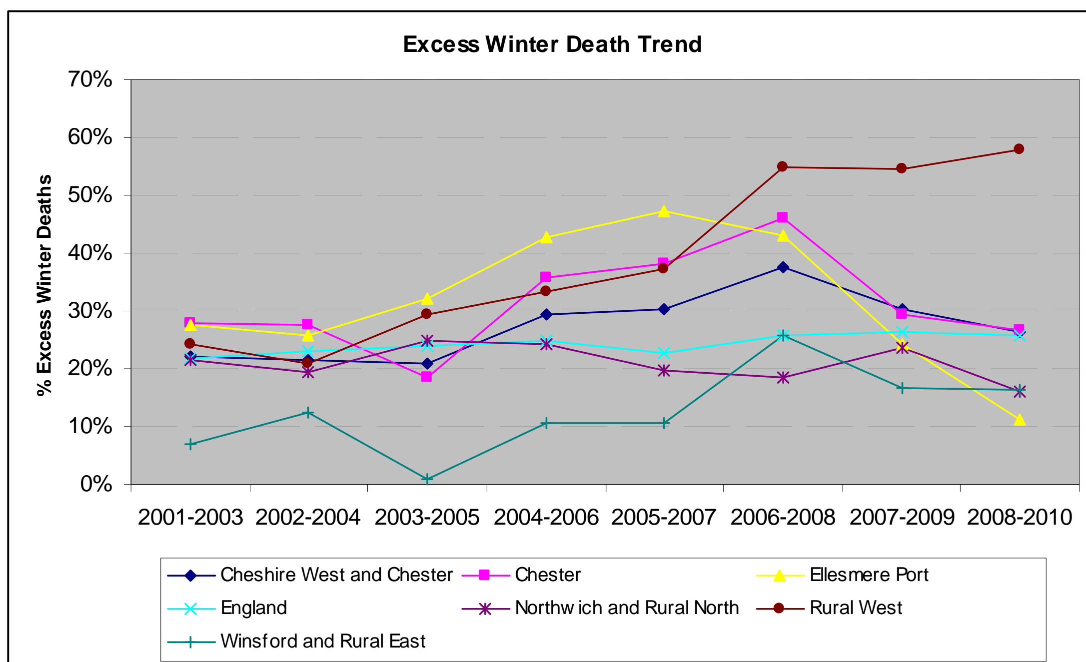
Source: Annual District Death Extracts

Care at the end of life makes up a significant proportion of health and social care expenditure. A recent study by the Nuffield Trust examining records of 16,500 people who died in 2007 showed that use of local authority-funded social care increased gradually in the last year of life, whereas NHS-funded inpatient hospital care increased sharply, particularly in the final two months. The use of social care also differed according to the presence of some long-term conditions. For example people with mental health problems, falls and injury, stroke, diabetes and asthma tended to use more; those with cancer appeared to use less. The balance of total hospital inpatient and social care costs shifted dramatically with increasing age. After age 60, hospital costs in the final year of life declined, while social care costs increased. A crossover occurs in people aged 90 and over, when estimated social care costs in the last year of life exceed the hospital inpatient costs. There is some evidence across all age groups that higher social care costs at the end of life tend to be associated with lower inpatient costs. The study concluded that while a direct causal link between high social care use and lower hospital use cannot be confirmed, it does suggest that any reductions in the availability of local authority-funded social care might increase demand for hospital services[4].

Excess Winter Deaths

There are usually around 26% (92) more deaths in the over 85s in the winter compared to the rest of the year. Nearly half of all excess winter deaths over the last 3 years (2008/09-2009/10) were in the over 85s although there has been a reduction in the last few years (figure 9). This is apparent in most localities except Rural West. Over a longer-term period Cheshire West and Chester is an outlier for excess winter deaths in the over 85s compared to other similar authorities.

Figure 9 Trend in percentage excess winter deaths in the over 85s by Area Partnership Board



Source: Annual District Death Extracts

CURRENT SERVICE PROVISION

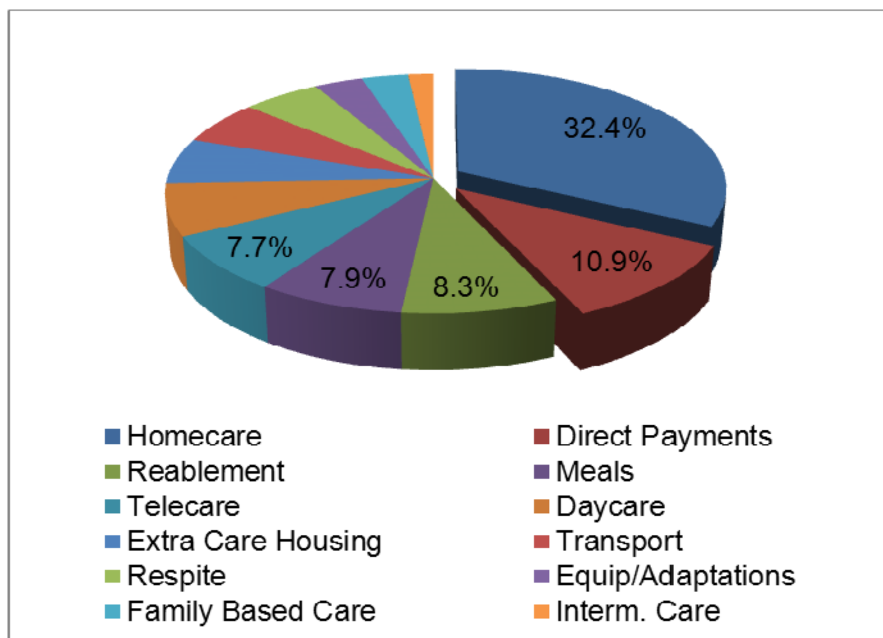
Complexity of need and care response

Many frail older people and their families have multiple needs, which can be identified, assessed and addressed by more than one agency or sector. In particular they may receive support from both or either of the health and social care systems. Differences between the finance arrangements and responsibilities, eligibility and ways of accessing health and social care services can be a source of both confusion and distress. An added complication is that the support and care needed by some people and their families could be delivered by government, private or voluntary organisations. However, **most support and care is not provided through structured organisations but by individuals**, whether unpaid family members, other unpaid caregivers or, increasingly, by individuals employed under direct payment or individual budget arrangements. The need to support family and other unpaid carers, and the opportunities to increase choice and control through devolution of responsibility for commissioning services are important aspects of current provision for frail older people.

Social Care Funded Care

Adult Social Care are currently providing services to approximately 1,600 customers aged 85+. As at July 2012, 40% of these customers are in permanent long term care and 60% are receiving services in the community. The community service for which there is most demand from customers aged 85+ is home care (approx. 30%) followed by Direct Payments (10%) and reablement (8%) (figure 10).

Figure 10 Types of community services used by customers aged 85+



Source: Cheshire West and Chester Council – Adult Social Care and Health

The following information compares activity in July 2011 to July 2012.

Reducing numbers, increasing complexity

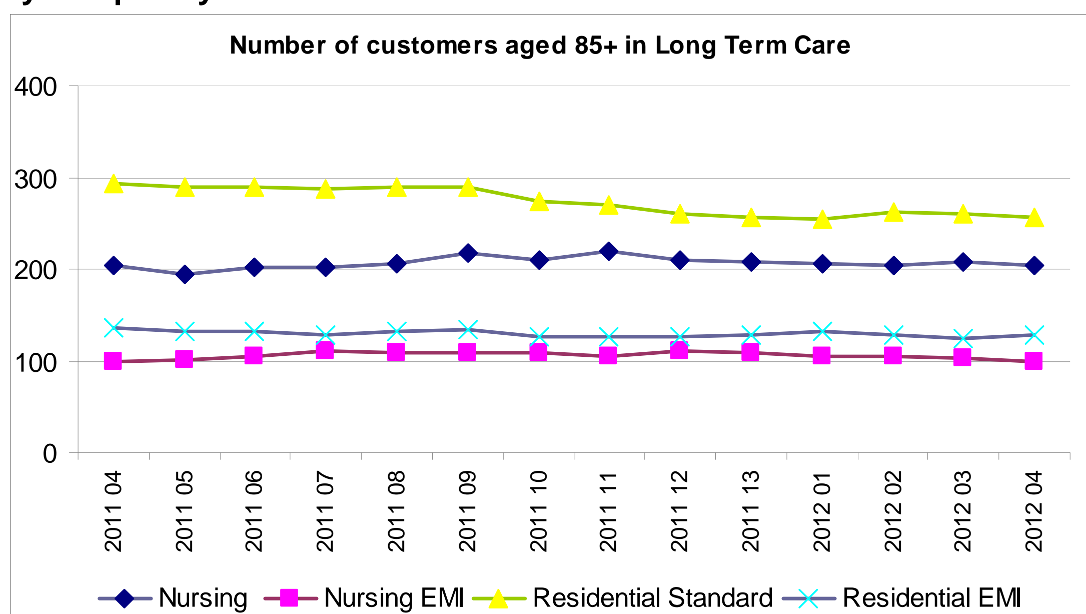
The number of people aged 85+ receiving social care services has reduced by 13% compared to 4% for people aged 65+. The number of people aged 85+ receiving community services reduced by 206 (18%).

The biggest specific decrease has been in home care – the number of customers has reduced by 186 (28% over 12 months). The number of customers receiving Direct Payments (DPs) has increased – however this has been affected by the change to the home care contract in April 2012, where customers wishing to remain with their existing provider (if no longer under contract) could do so by moving to a DP.

Overall there are 6% less people aged 85+ in long term care. The number of customers in standard residential care has reduced by 37, however the remaining long term care bands (Residential EMI, Nursing, Nursing EMI) which care for people with more complex needs only reduced by 7 in total (figure 11).

Although the number of customers is reducing, customers are staying for longer in the long term care setting. In 2010 the most common length of time for customers aged 85+ to remain in long term care was 1 – 1.5 years, by 2012 this had changed to 3 – 3.5 years. The distribution of long term care attrition is now more evenly spread over a longer timescale which has implications for the authority and the NHS (for those receiving continuous healthcare) both in terms of financial planning for customers entering care and the management of social care caseloads.

Figure 11 Trend in the number of customers aged 85+ in long term care by complexity



Source: Cheshire West and Chester Council. Adult Social Care and Health

The council benchmarks itself against both other local authorities in the North West and its CIPFA comparator group. Using these comparators in 2011/12, the number of customers in residential care per 100,000 population was low whereas for nursing care it was high.

Reablement and rehabilitation

For the 12 months to June there were 598 cases of reablement for customers aged 85+, involving 541 customers. 27% of these customers completed reablement and had no on-going need and 46% had on-going needs. 13% of customers entering reablement did not complete and 14% were admitted or readmitted to hospital.

The council's rehabilitation measure target is to ensure that 86% of customers discharged into a rehabilitation service are still living at home 91 days later. Performance over the past two years of people aged 65+ is 84%; for people aged 85+ it is 77%. Of the customers in receipt of rehabilitation, 45% are aged 85+.

Geographical variance in service demand

As at July 2012, Ellesmere Port Patch team had the highest number of 85+ customers in long term care, however Rural, Northwich and Chester patch teams has greater community service caseloads for customers aged 85+.

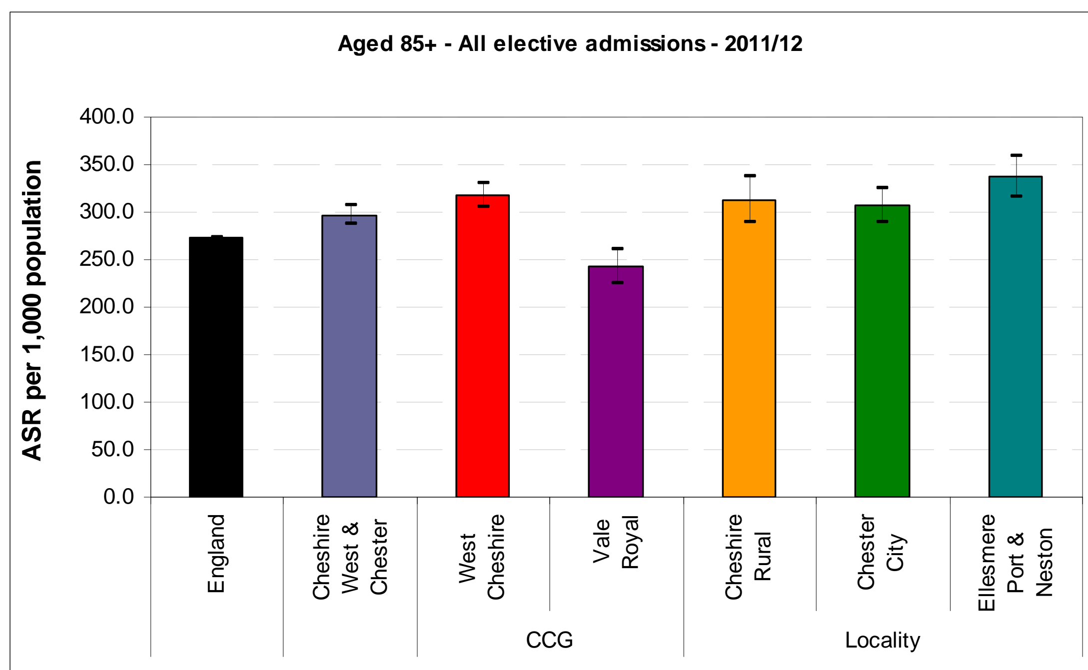
More information related to these findings is contained in a separate report.

In-patient hospital care

Elective Care

In 2011/12, there were 2,320 elective admissions in the over 85s. This is 4.5% of all elective admissions for all ages. The most common elective procedure is cataracts. Overall elective rates of admissions in the over 85s is high compared nationally. This hides a different picture between the two CCG with rates in West Cheshire high but low in Vale Royal (figure 12). Two key causes for high elective rates in West Cheshire CCG were in relation to procedures for skin cancer and investigations for benign cancers.

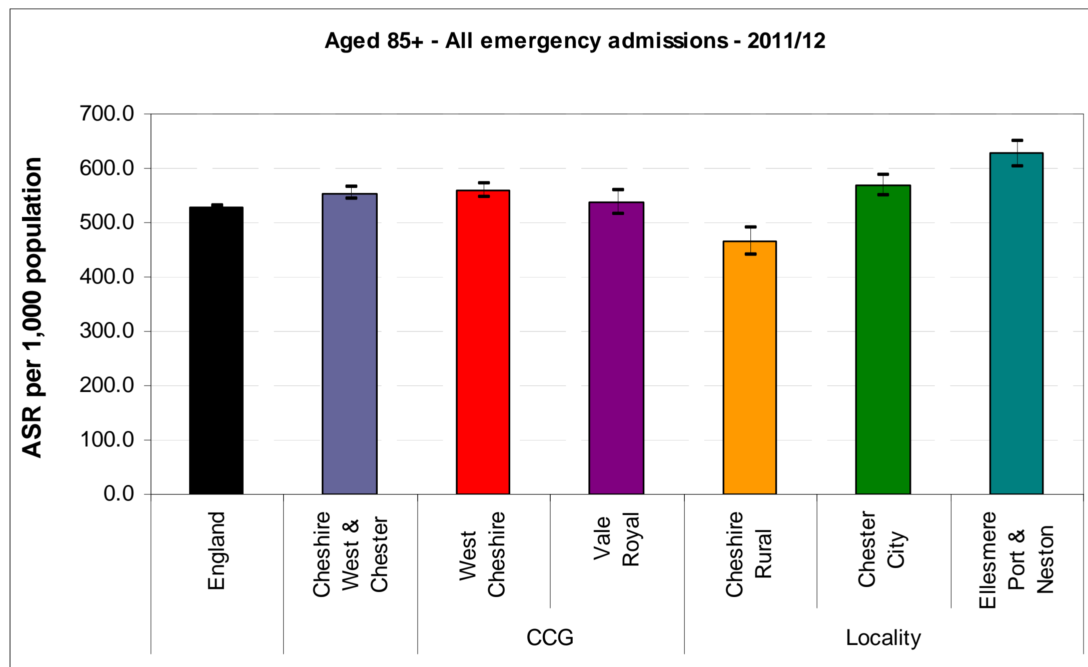
Figure 12 Elective admission rates in the over 85s by locality 2011/12



Source: NHS Information Centre HES Online

In 2011/12, there were 4,326 emergency admissions in people aged over 85. This is 12.6% of all emergency admissions for all ages. The most common reason for emergency admission is general symptoms and signs (480 admissions). Overall emergency rates of admissions in the over 85s is high compared nationally. This hides a different picture between the two CCGs with rates in West Cheshire high and average in Vale Royal (figure 13). Two key causes for high emergency rates in West Cheshire CCG were in relation to general symptoms and signs, in relation to circulatory and respiratory conditions, head injuries and symptoms & signs with cognition/perception problems. Vale Royal CCG had high rates of admission for general symptoms and signs. Of note also is the high admission rate for hip and thigh fractures in the Chester locality.

Figure 13 Emergency admission rates in the over 85s by locality 2011/12

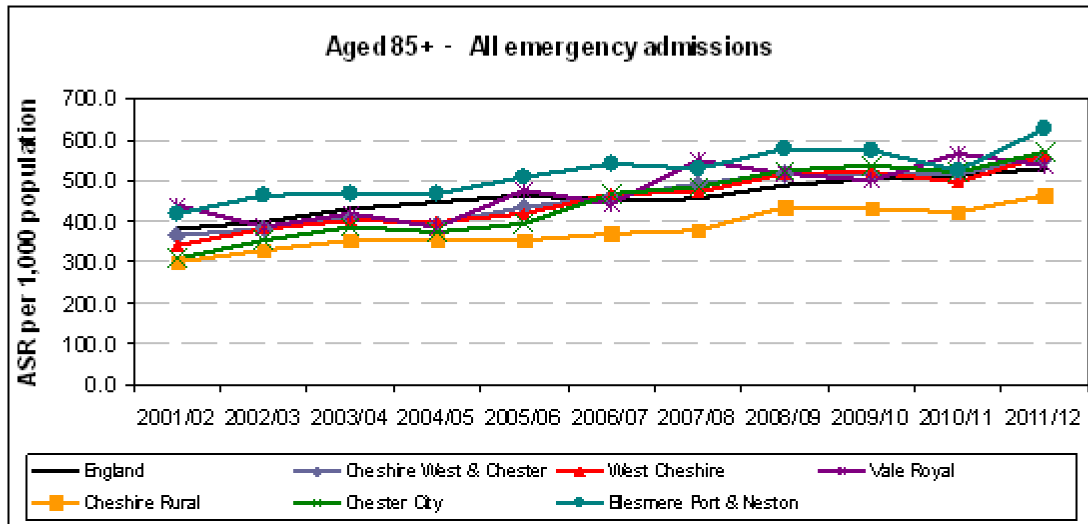


Source: NHS Information Centre HES Online

Emergency admissions have been increasing at a faster rate than demographic growth (figure 14). Between 2010/11 and 2011/12 rates of emergency admission in the over 85s increased by 7%. Rates increased particularly for admissions due to other forms of heart disease (heart failure) and pneumonia and influenza. The highest rate of increase was in admissions from the Ellesmere Port locality (20% rise) particularly for general symptoms and signs and influenza and pneumonia.

Summary charts with locality emergency admission rates are contained in an appendix.

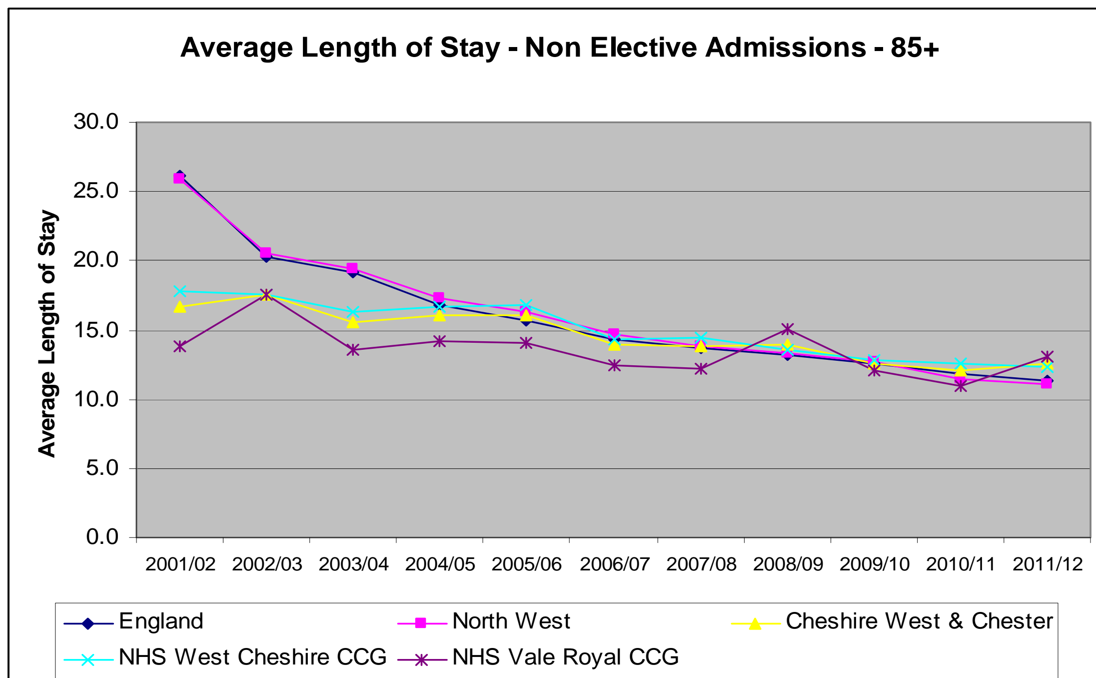
Figure 14 Trend in emergency admission rates in the over 85s 2001/02 to 2011/12 by locality



Source: NHS Information Centre HES Online

On average people aged over 85 stay in hospital 12.5 days after a non-elective admission. This has fallen over the last 10 years but less so locally compared to the regional and national average. The average LOS was around 1.5 days higher in West Cheshire and Vale Royal compared nationally in 2011/12 (figure 15).

Figure 15 Long-term trends in Average Length of Stay for non-elective admissions in the over 85s



Source: NHS Information Centre HES Online

Community Health Services

Many older people particularly those aged over 85 are supported by community health services such as district nurses and community matrons. An analysis by one local NHS community services provider suggests that people aged over 85 account for nearly 40% of district nursing and community matron caseloads.

Table 6 Community Services activity in the over 65s in West Cheshire CCG April 2011 – April 2012

Age	District Nursing	Community Matrons	COPD	Heart Failure	Parkinsons
85+	38%	39%	21%	18%	17%
75 - 84	31%	33%	43%	35%	46%
65 - 74	13%	17%	26%	25%	26%
TOTAL	82%	89%	89%	78%	89%

Source: Cheshire & Wirral Partnership Trust – Oracle community services data May 2012

PROJECTED SERVICE USE IN 3-5 YEARS AND 5-10 YEARS

The number of over 85s is predicted to increase by 1,100 people or 14% by 2015/16 and by a further 30% by 2021/22. These are locally produced CWAC predictions that we have crudely applied to CCG registered populations.

The use of hospital services by the over 85s has increased a faster rate than demographic growth over the last 10 years – if services are to be sustainable over the longer term the current service model will need to change to a more community-based model.

Table 7 Cheshire West and Chester: Resident Population Forecasts

	Resident Population						
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2021/22
65-74	33,100	34,500	35,900	36,800	37,400	38,200	39,500
75-84	20,800	21,200	21,700	22,300	22,700	23,200	26,900
85+	8,000	8,300	8,500	8,800	9,100	9,500	11,500
65+	61,900	64,000	66,100	67,900	69,200	70,900	77,900

Source: Cheshire West and Chester's Research, Intelligence and Consultation Team's Population Forecasts (Locally calculated)

Table 8 West Cheshire Clinical Commissioning Group: Registered Population Forecasts

	Registered Population						
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2021/22
65-74	24,730	25,770	26,800	27,470	27,930	28,520	29,490
75-84	15,680	15,980	16,340	16,780	17,100	17,460	20,240
85+	5,980	6,200	6,350	6,570	6,790	7,080	8,570
65+	46,390	47,950	49,490	50,820	51,820	53,070	58,300

Table 9 Vale Royal Clinical Commissioning Group: Registered Population Forecasts

	Registered Population						
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2021/22
65-74	8,940	9,310	9,680	9,930	10,100	10,310	10,660
75-84	5,140	5,240	5,360	5,500	5,600	5,720	6,630
85+	2,010	2,080	2,140	2,210	2,280	2,380	2,880
65+	16,090	16,630	17,180	17,640	17,980	18,410	20,170

Source: Open Exeter/GP Mortality Database List Sizes, April 2011.
Population forecasts calculated by applying percentage increases derived from Cheshire West and Chester forecasts

EVIDENCE OF WHAT WORKS

It is not possible to review the evidence base for this wide ranging topic – frail older people given the complexity and range of conditions of interest. However we can say something about the evidence about a number of approaches to promoting health and caring for frail older people in a holistic way.

Reducing social isolation

Social Care Institute for Excellence (SCIE) reviewed the evidence around social isolation and found that older people are particularly vulnerable to social isolation or loneliness owing to loss of friends and family, mobility or income. Social isolation and loneliness impact upon individual's quality of life and wellbeing and increases their use of health and social care services, for example, evidence suggests that lonely and socially isolated individuals are more likely to have early admission to residential or nursing care. The report found that community navigator interventions have been shown to be effective in identifying those individuals who are socially isolated and befriending services can be effective in reducing depression. They recommended that when planning services to reduce social isolation or loneliness strong

partnership arrangements need to be in place between organisations to ensure developed services can be sustained [5].

Integrated care

The Kings Fund has reviewed the evidence around integration focusing on the needs of particular groups of patients and populations, such as older people and patients with one or more long-term conditions. Evidence from North America and Europe shows that integrated health and social care systems for older people demonstrate positive results on many indicators [6].

There has been much written about integration between health and social care in recent years both nationally and internationally, and whilst the evidence indicates that integration of services leads to improved customer experience and outcomes; improved efficiencies and reduction in duplication as well as improved staff satisfaction, the evidence base remains mixed particularly with respect to overall resource use. In Torbay, experience of integration between health and social care has been developed over a number of years. They found an improvement in patient experience, a reduction in use of hospital beds and residential and nursing home placements and minimal delayed transfers of care and increased uptake of direct payments in social care[8].

The Department of Health have evaluated 16 sites that explored different ways of providing integrated care to help drive improvements in care and well being. They found no evidence that the number of emergency admissions were reduced but there was some reductions in planned admissions and OPD appointments. They concluded that there were no overall significant changes in costs to secondary care utilisation; but where case management is in place, there was a net reduction in combined inpatient and outpatient costs. They concluded that any cost savings are likely to be longer term. The evaluation also suggested that quality of care can improve but not necessarily in the short-term[8].

Adaptive technologies

For some dependent adults, equipment and adaptions play a vital role by allowing people to live independently in their own home. Interventions vary from simple devices such as grab rails, to major adaptions such as stair lifts and bespoke bath and shower rooms. A review conducted by PSSRU in the London School of Economics and Political Science in 2012 suggest that equipment and adaptions can lead to reductions in demand for health and social care services worth on average £579 per recipient per year (including both state and private costs). In addition, the services lead to improvements in the quality of life of the dependent person worth £1,522 per year. By comparison the cost of providing the adaptions is estimated to be approximately £1,000 per individual per year, taking into account the likely life expectancy of the equipment. Overall the review concludes that adaptive

technologies generate net social benefits and this is despite the fact that, due to the lack of appropriate evidence for use in the quantitative model, the analysis could not factor in other likely benefits such as those for care givers [9].

Reablement

Evidence shows that reablement is significantly associated with better health-related quality of life and social care-related outcomes compared with conventional home care. The evidence demonstrates that reablement improves independence, prolongs people's ability to live at home and removes or reduces the need for commissioned care hours (in comparison with standard home care). The best results show that up to 62% of reablement users no longer need a service after 6-12 week (compared to 5% of the control group) and that 26% had a reduced requirement for home care hours (compared to 13% of the control group). In terms of cost-effectiveness, reablement requires substantial up-front investment but there is a moderate reduction in the cost of community packages that will be required in the future [10].

Extra care housing

Extra care housing is an important innovation in the care and support of older people, and is a housing model that has considerable potential to support older people in leading active, independent lives. A 2011 study on the cost – effectiveness study found that costs were lower when comparing equivalent people who moved into publicly-funded residential care homes in 1995, and similar to the more dependent type of person moving into care homes in 2005. The study concluded that similar or lower costs combined with better outcomes mean that although extra care housing does not appear to provide a direct alternative, it can support some older people at risk of moving into a residential care homes in a cost-effective way[11].

STAKEHOLDER VIEWS

Quality of Life – Our Community Survey

The following is some of the findings of the 'Our Community Survey' that relates to older people. The survey is a quality of life survey that aimed to capture residents' views of their local area and monitor and benchmark key indicators for a number of partnership organisations covering Cheshire West and Chester and is carried out by Cheshire West and Chester Council on behalf of the Local Strategic Partnership (LSP). The most recent survey was carried out during October 2011. The survey found:

- Generally, respondents aged 65 and over were significantly more likely to be satisfied with their home as a place to live compared to younger age groups.

- The proportion of respondents who stated that they strongly belonged to their immediate neighbourhood increased as age increased. Older age groups were significantly more likely to say they strongly belonged to their local area compared to younger age groups, with those aged 85 and over reporting the highest levels of belonging.

- Generally, the proportion of respondents who felt that older people in their local area get the services and support they need to live at home for as long as they want to increased as age increased, with nearly half (49%) of those aged 75 to 84 and 59% of respondents aged 85 and over answering ‘yes’.

- A higher proportion of participants aged 75 and over said that they participated in activities like eating out, going on social outings, attending live performances, visiting museums, galleries and heritage attractions **less** than once a year or never.

- Those aged 85 and over were the age group with the highest proportion of respondents who had taken part in the following **less** than once a year or never:
  - Attend a sports event
  - Attend a day or evening class
  - Take part in sports or physical activities
  - Take part in arts or creative activity.

Adult Social Care – Users experience

The Adult Social Care Survey for 2011-12 has recently been published for Cheshire West and Chester. This is a national survey conducted annually and is designed to provide user experience information for how services are affecting people’s lives. The survey was sent to a variety of service users but we have analysed the results for those aged over 85 years. Overall the results are positive with the results for those in residential care generally more favourable. Key issues identified however include that 15% do not feel they had enough social contact, a third don’t spend enough time or don’t do anything they value or enjoy and many experiencing difficulties getting to places in the local area that they want to. These highlight the importance of building stronger mutual support networks within communities. The headlines are that:

- 93% of service users were satisfied with 2% dissatisfied
- 67% felt they had a good quality of life with 4% saying they had a bad quality of life
- 86% felt they had as much control or adequate control over their daily life
- 98% felt clean and able to present themselves
- 82% feel as safe as they want
- Whilst 85% had adequate or as much social contact as they would like, 10% had some but not enough and 5% had very little and felt socially isolated
- Whilst 67% of service users are able to spend their time doing things they value and enjoy, 33% do some things but not enough or don't do anything they value or enjoy
- 40% of service users felt their health was good with 10% feeling their health was bad in general
- Only 19% felt they can get to all the places in the local area that they want while 28% are unable to get to these places and 43% do not leave their home.

Both these reports can be found at:

http://www.cheshirewestandchester.gov.uk/your_council/key_statistics_and_data/research_publications.aspx

Wider stakeholder views

A recent engagement event was held with the older people's network concerning the adult social care provider services review. Nearly 50 older people attended the workshop and gave their views. They felt they sometimes had difficulty navigating the system which seemed fragmented between different providers. They would value a 'personal and comprehensive' single assessment process that would mean that a range of services could respond to their individual needs in a flexible way. They valued intermediate type and reablement services and felt there were more opportunities to keep people out of hospital. They valued getting sufficient information to make decisions and continuity of communication with care givers. They felt that the quality of care was really important and how the quality of service provision needed careful assessment. They discussed the potential role of social enterprises that could develop to meet the unique needs of different communities. They felt that communities and service users should be at the heart of these enterprises and that these could be a way of working with volunteers on the prevention agenda particularly in reducing loneliness and social isolation or to respond to peoples low level needs to reduce future dependency.

UNMET NEED AND SERVICE GAPS

Key issues

- Many older people are assets within their communities that can help build more resilient and sustainable communities
- People with complex multiple conditions need holistic assessment and integrated care
- People with complex multiple needs want personalised care wrapped around their individual needs
- High use of acute hospital care in an emergency in West Cheshire CCG
- High use of nursing home care with increasing complexity and length of time spent in care homes
- Increasing demand on most intensive type of care may indicate 'system gaps' in lower intensity type of care
- The number of over 85s will increase by 44% between 2011/12 and 2021/22 – the current service model is unsustainable in the face of rising demand, reducing resources and high use of high-intensity care.

RECOMMENDATIONS FOR COMMISSIONERS AND POLICY MAKERS

Older people with multiple needs require holistic assessment, multi-disciplinary care planning, advance planning to avoid predictable emergencies, care co-ordination and excellent care and communication and collaborative relationships between staff, patients and carers.

1. Develop and encourage communities to build resilient support networks and offer practical support for older family/neighbours or friends. Consider developing 'community navigator' or 'local co-ordinator' roles and encourage the development of small social enterprises
2. Ensure carers are supported and have their own needs assessed
3. Encourage all to adopt the '5 Ways to Health and Wellbeing'
4. Create the environment to develop an integrated care system where care is co-ordinated around the needs of an individual
5. Develop more effective systems and teams within the community to prevent avoidable hospital admissions and reduce hospital stays to the minimum period. This may require more alternative step-up and step-down provision
6. Ensure that people have adequate time for recovery and reablement to maximise their independence
7. Develop more alternatives to residential care for people and their carers to consider such as extra care housing
8. Continue to work on 'end of life' care pathways
9. Continue to work with the care home sector to ensure resident's needs are being met by high quality care and predictable emergencies are avoided as much as possible.

KEY CONTACTS
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Helen Pickin-Jones, Research and Intelligence - Research Officer

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Appendix

The number and percentage of people aged 85 and over on GP Practice lists 2012

Code	Practice	Aged 85 and over	% of total list size aged 85 and over
N81005	Helsby	249	2.82
N81006	Bunbury	96	1.92
N81009	Heath Lane	194	2.75
N81017	Frodsham	149	2.71
N81018	Park Road	237	3.07
N81023	Whitby (Wall)	98	1.94
N81024	Swanlow	173	1.73
N81025	Firdale	168	2.13
N81030	The Knoll	338	2.83
N81031	Tarporley	179	3.21
N81034	Boughton	303	2.61
N81038	Malpas	185	2.97
N81040	High Street	80	1.56
N81046	Park Medical	206	2.40
N81050	Great Sutton (Wearne)	130	1.75
N81051	Weaverham	242	3.09
N81055	Watling Medical	183	2.42
N81060	Neston Surgery	279	3.32
N81061	Witton Street	180	2.55
N81063	York Road	225	1.89
N81067	Oakwood	145	1.79
N81074	Launceston Close	37	0.82
N81079	The Elms	214	2.20
N81080	Northgate Medical	160	2.64
N81081	Garden Lane	220	1.78
N81082	City Walls	404	2.31
N81087	Danebridge	618	2.59
N81091	Whitby (Warren)	81	1.82
N81092	Hope Farm	253	2.10
N81093	Whitby (Stringer)	115	1.87
N81094	Great Sutton (Wood)	115	1.83
N81095	Great Sutton (Mcalavey)	142	2.47
N81100	Upton	197	3.22
N81101	Handbridge	166	2.47
N81102	Hoole Road	117	5.46
N81104	Willaston	91	2.15
N81113	Middlewich Road	94	1.44
N81115	Lache	85	1.41
N81117	Old Hall	95	1.79

N81120	Kelsall	108	2.45
N81121	Northgate Village	161	2.59
N81123	Willow Wood	48	0.83
N81125	Neston Medical	213	2.83
N81126	Farndon	131	3.04
N81127	Weaver Vale	159	1.98
N81607	Westminster	28	1.17
N81624	Tattenhall	94	2.76
N81626	Western Avenue	37	0.95
N81655	St Werburghs	0	0.00
	Cheshire West and Chester	8,222	2.31

Source : NHAIS/ Open Exeter GP Mortality Database, April 2012

The number and percentage of people aged 85 and over by electoral ward 2010

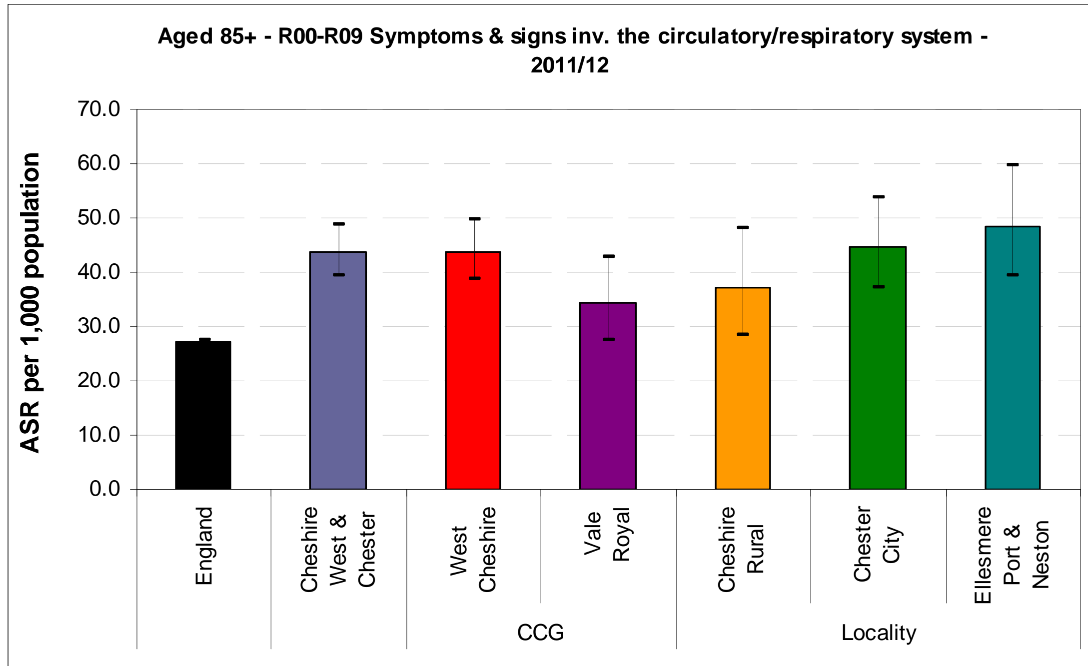
Ward	Aged 85 and over	% of total list size aged 85 and over
Blacon	250	1.85
Boughton	160	3.22
Chester City	100	2.87
Chester Villages	250	2.98
Davenham & Moulton	230	1.69
Dodleston & Huntington	80	2.19
Ellesmere Port Town	160	1.73
Elton	60	1.34
Farndon	100	2.59
Frodsham	320	3.45
Garden Quarter	60	1.23
Gowy	90	2.29
Grange	140	2.84
Great Boughton	260	2.97
Handbridge Park	280	3.18
Hartford and Greenbank	180	2.21
Helsby	150	3.04
Hoole	250	2.90
Kingsley	110	2.58
Lache	60	1.12
Ledsham and Manor	110	1.38
Little Neston and Burton	210	2.47
Malpas	150	4.04
Marbury	240	1.98
Neston	120	2.94
Netherpool	90	2.63
Newton	230	2.47
Parkgate	140	3.76

Rossmore	70	1.85
Saughall & Mollington	160	3.58
Shakerley	180	4.04
St Paul’s	200	2.25
Strawberry	60	1.19
Sutton	180	1.96
Tarporley	140	3.08
Tarvin and Kelsall	230	2.89
Tattenhall	90	2.09
Upton	320	3.43
Weaver & Cuddington	470	3.65
Whitby	170	2.09
Willaston & Thornton	120	3.00
Winnington & Castle	230	2.51
Winsford Over & Verdin	140	1.01
Winsford Swanlow & Dene	210	2.20
Winsford Wharton	170	1.76
Witton & Rudheath	140	1.72
Cheshire West and Chester	7,860	2.40

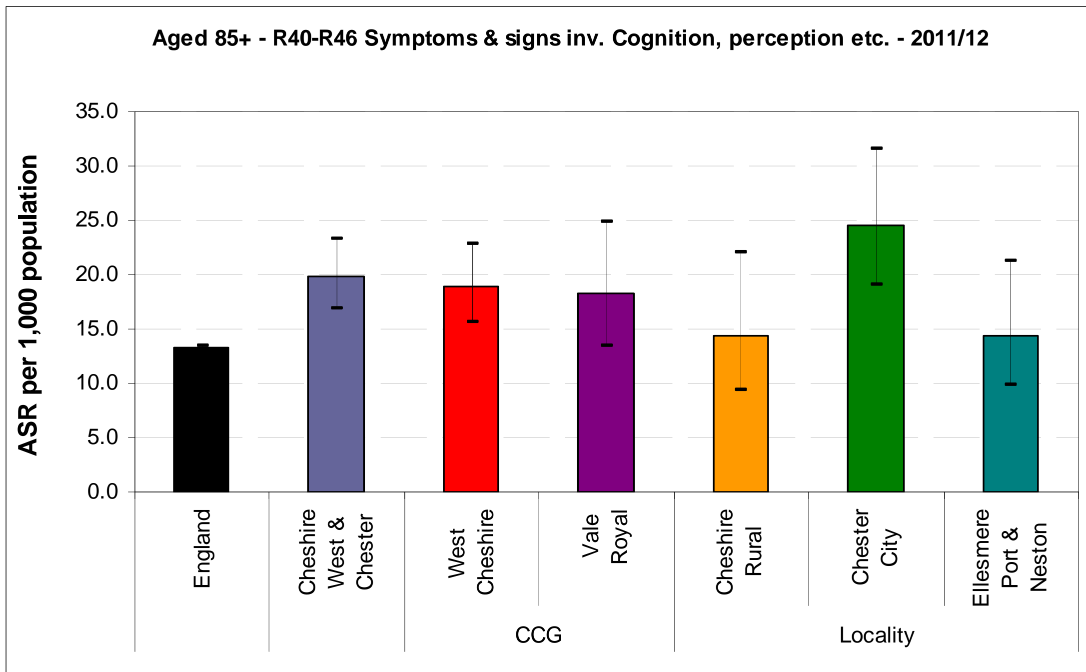
Source: Cheshire West and Chester: Research, Intelligence and Consultation Team (Locally calculated population estimates) 2010

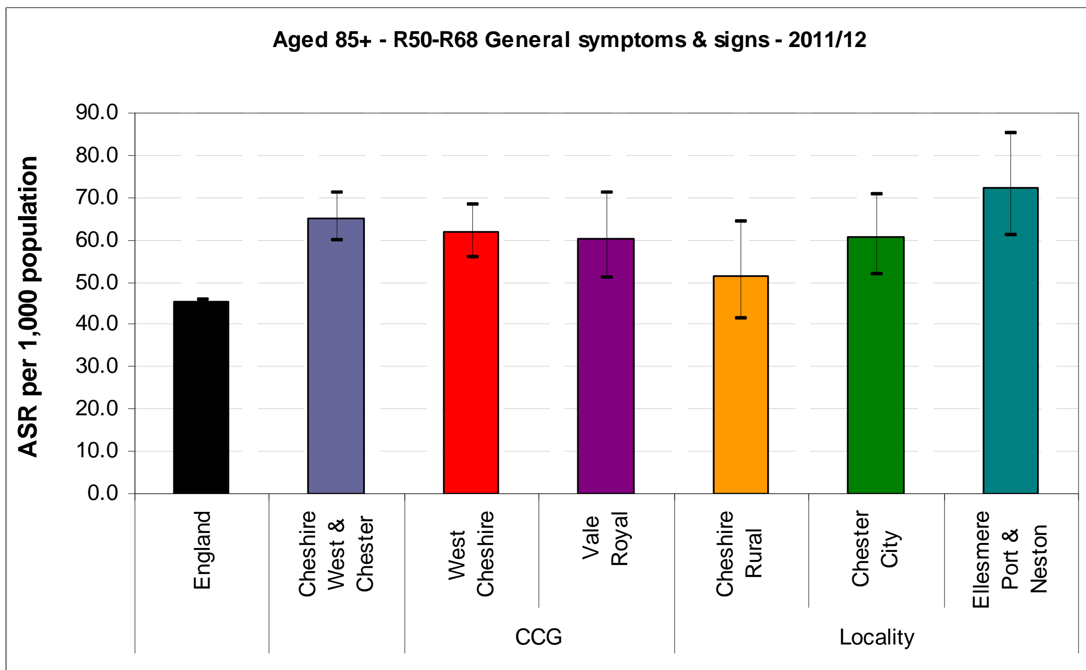
Appendix

Comparative rates of emergency admissions in the over 85s by diagnosis 2011/12

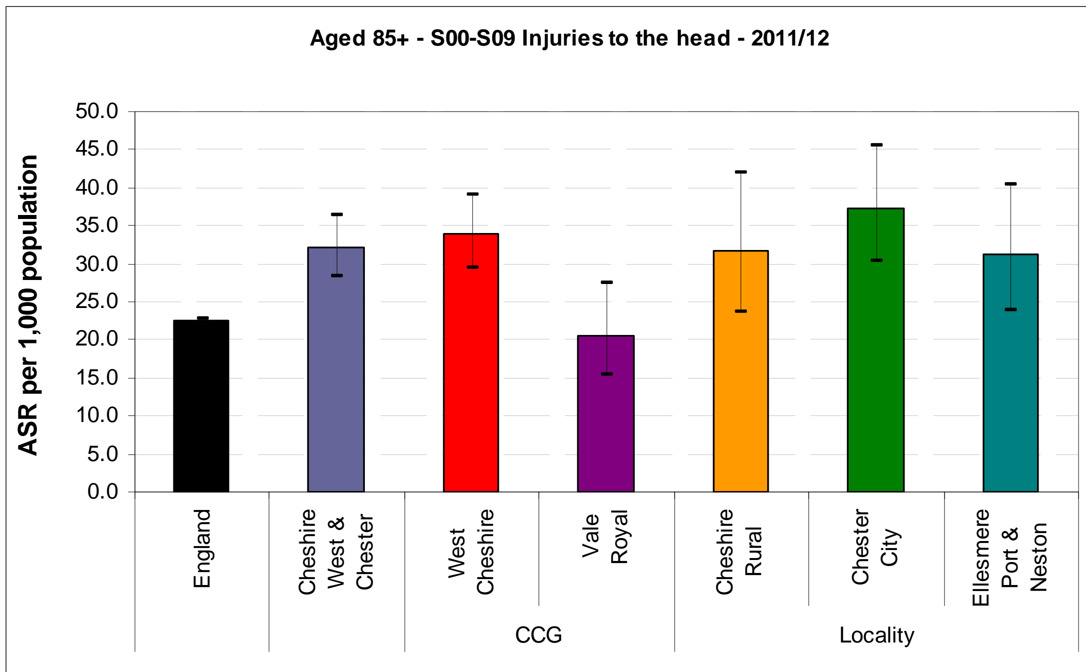


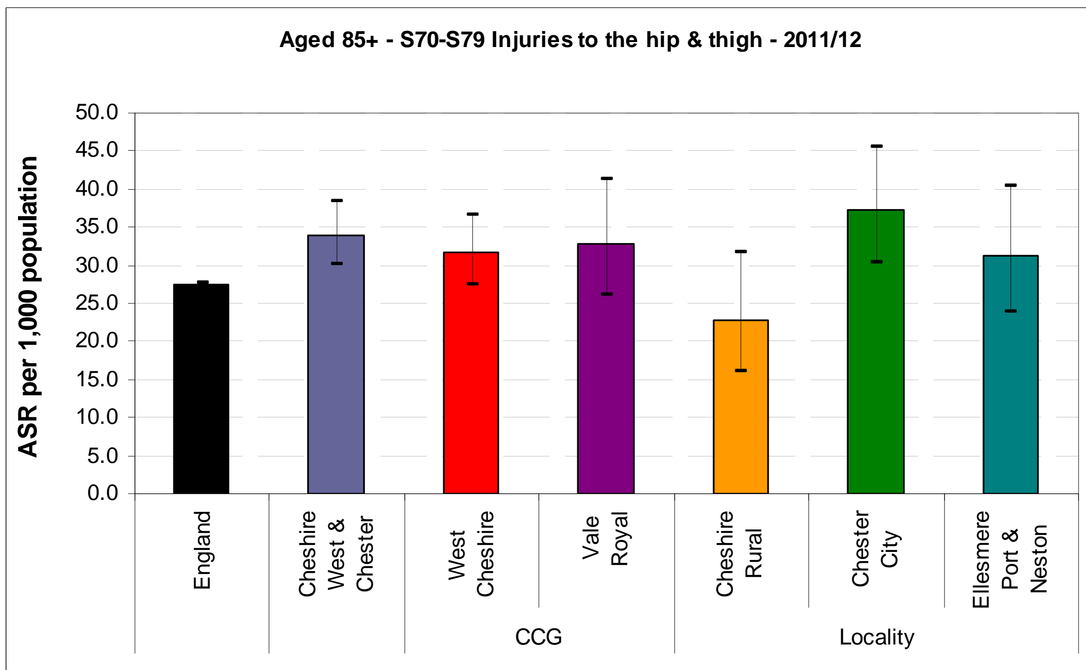
Source: NHS Information Centre HES Online





Source: NHS Information Centre HES Online





Source: NHS Information Centre HES Online