RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

AGEING WELL – 65 YEARS AND OVER

DECEMBER 2018

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FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

The JSNA has reviewed the population health needs for the people of Rutland in respective of a person's later life. This has involved looking at the determinants of health, the health needs of this population in Rutland, the impact of services, the policy and guidance supporting the older population, the existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

The JSNA offers an opportunity for the Local Authority, CCG and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

- The rate of emergency hospital admissions for injuries due to falls in persons aged 80 and above has declined year on year for the last four years, at a faster rate than nationally. In 2016/16, the rate of emergency hospital admissions due to falls for adults aged 80 and over was 4,329 per 100,000 population, better than the England average value of 5,363 per 100,000 population.

- The rate of emergency hospital admissions for hip fractures in persons aged 65 and above and in persons aged 80 and above (separately) has increased each year between 2014/15 to 2016/17. In both age bands the national rate has declined slightly year on year.

- The ratio of excess winter deaths for all ages and in persons aged 85 and above in Rutland (over 3 years) has remained similar to the national ratio since August 2001 – July 2004.

- In 2016/17, there were 26 new certifications of visual impairment in Rutland. This relates to completions of Certificate of Visual Impairment by a consultant ophthalmologist and initiates the process of registration with a local authority. The rate in Rutland is 67.3 per 100,000 population, significantly worse (higher) than the England rate of 42.4 per 100,000 population.

- The prevalence of dementia as recorded on GP registers in Rutland has increased significantly over the last seven years, following the national trend. Through this time, the prevalence in Rutland has remained significantly higher than the national prevalence. In 2016/17, 1.0% of the practice population in Rutland were recorded on GP registers with dementia, significantly higher than the national percentage of 0.8%. This equates to 362 patients in Rutland with this diagnosis. Although prevalence of dementia is higher it is estimated that there are more people living with undiagnosed dementia in Rutland and in 2018, 56.5% of those patients estimated to have dementia had been diagnosed. This is significantly worse (lower) than the national average of 67.5% and means people are not able to access suitable support.

- In Rutland, the directly age standardised rate of emergency inpatient hospital admissions for people with a mention of dementia for Rutland's over 65 population has remained significantly lower than the national rate during the last five years.

- In 2016 in Rutland, 84.5% of all deaths of people with a recorded mention of dementia were in their usual place of residence (DiUPR). This is significantly higher than the national percentage of 67.9%. Almost three-quarters (70.4%) of all deaths of people with a recorded mention of dementia in Rutland in 2016 were in a care home, followed by in hospital

(15.5%) and in the home (14.1%). This pattern of place of death is reflected nationally. The latest data shows Rutland has a significantly lower proportion of deaths occurring in hospital and a significantly higher proportion of deaths of people with a recorded mention of dementia in care homes compared to nationally.

- In Rutland, 10.1% of all deaths in 2015 were in those aged under 65. This is significantly lower than the national percentage of 14.8% and has decreased year on year from 13.2% in 2012. Of all deaths in Rutland, 46.6% were from those aged 85 and above. This proportion, which has increased over time, is now significantly higher than the national percentage of 40.4%, indicative of a growing proportion of people living to over 85.

- Two-thirds (66.1%) of all deaths from those aged 85 and above in Rutland were in the usual place of residence, this is significantly higher than the national percentage of 54.1%. The percentage of deaths in usual place of residence in this age group has increased significantly over time.

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1. Introduction

This chapter presents a comprehensive overview of the ageing population in Rutland. The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. We appreciate that this document uses technical language. This is due to the nature of the JSNA, which is intended for use by commissioning organisations such as local authorities and the NHS in developing their commissioning plans. One example is the use of statistical significance. A statistical significant result ensures the result is not likely to be caused by chance, for a given statistical significance level. Using these statistical tests improves the reliability of our evidence base which will help strengthen our commissioning based decisions.

2. Who is at risk?

There are many factors that influence the health of a person during their older adult years.

2.1. Income deprivation

A person is classed as income deprived if they receive income support, income based job seekers allowance, pension credit or child tax credit. In Rutland, in 2015, 7.9% of people aged 60 years and over were classed as income-deprived households. This is in the lowest quintile nationally and less than half the England average value of 16.2%.[1]

2.2. Community and residential care

Since 2013/14 the number of permanent admissions to nursing and residential care homes has fallen significantly: during 2016/17 11 older adults were admitted. This equates to 0.2% of the over 65 population per year in the three years from 2014-15, although with variation year on year with variation in cohorts.

Data from 2013/14 has been examined to allow comparison to the national average. In 2013/14 in Rutland, the rate of older adults who were supported throughout the year by receiving community and residential care was 10,709 per 100,000 population (915 older adults). This is higher than the England average value of 9,781 per 100,000 population.

In 2013/14 in Rutland, the rate of older adults who were permanently admitted to nursing and residential care homes was 527 per 100,000 population (45 older adults). This is

statistically similar to the England average value of 651 per 100,000 population.

2.3. Minimising unnecessary time in hospital

Delayed Transfers of Care (DToC) are the additional days that a person may stay in hospital, once medically fit for discharge, because they are unable to move on to their onward destination, e.g. because there is a lack of capacity in non-acute hospital for convalescence, or a package of care is not yet in place for them. Where DToCs can be avoided, as well as freeing up hospital capacity, this reduces the risk to individuals of hospital-contracted infections and of deconditioning due to prolonged inactivity, which can then impede recovery and independence.

DToC rates in Rutland have been reducing over time, and now match those of some of the best performing parts of the country: Rutland was ranked 19th out of 152 Health and Wellbeing Board areas in England in 2017-18 for its DToC rate, at 5.5 delays per day per 100,000 adult population. This was the lowest rate in the East Midlands, where rates ranged between 5.5 and 24.2.

2.4. Regaining the ability to manage at home after a hospital stay

Reablement helps people to learn new ways to accomplish day to day tasks that they can no longer manage as well as they used to, prolonging their ability to manage independently.

In Rutland, in 2016-17, 3.1% of people aged 65 years and over who were discharged from hospital were offered reablement services, which was similar to the England average. This is an improvement on previous patterns: in 2013-14 the rate was 2.8%, 0.5% below the then England average of 3.3%. The 2016-17 rate equals the rate of reablement being offered in Leicester and is 0.7% higher than that in Leicestershire.

Rutland has achieved very high rates of success with reablement services. In 2016-17 and 2017-18, more than 95% of individuals who received reablement services were still at home 91 days after being discharged from hospital. The 2016-17 rate of 97.2% was the best in the country.

2.5. Living alone

According to the 2011 census, 6.25% of households in Rutland were occupied by a single person aged 65 and over living alone (2,142 households). This is higher than the England value of 5.24%.[2]

2.6. Quality of life

The health related quality of life index for people 65 years and over in Rutland in 2016/17 was 0.761. This is similar to the England value of 0.735.[9]

2.7. Carers

Family carers play a key role in supporting the health and wellbeing of those they care for. The Care Act 2014 requires that carers are supported in their role by social services. The number of carers supported by Rutland County Council during 2017/18 increased by 25%, from 143 to 194 (503 per 100,000 population). In 2016/17, 62.1% reported that they were satisfied with the support they had received, relative to an English average of just 39%, and 79.5% said that they found it easy to find information about services, relative to an English average of 70.6%.

In 2017, the total number of people aged 65 and over providing unpaid care to a partner, family member or other person in Rutland was estimated to be 1,385. This is expected to increase by 33.9% to 1,855 carers by 2035.[3]

It can be difficult for carers to maintain their own connection to what is important to them while fulfilling their caring role. According to the Personal Social Services Carers survey, the latest data from 2016/17 shows carer reported quality of life in 2016/17 was rated as 7.9 in Rutland, similar to the English average of 7.7. In the same survey less than a third (31.1%) of adult carers who use support services in Rutland and felt they have as much social contact as they would like. This is lower than the national percentage of 35.5%.[9]

3. Level of need in Rutland

In 2016, 4.6% of the population was aged 0-4 (1,766 people), 18.0% was aged 5-19 (6,859 people), 53.4% was working age (20,320 people aged 20-64) and 23.9% was older than 65, this includes 3.3% of the total population that was aged 85 and over (1,249 people). Compared to nationally, Rutland has a higher proportion of the population aged over 65 and 85 respectively.[4]

Nationally the over 65 population is predicted to grow by 53.5% and the over 85 population by 127.1% between 2016 and 2039. In Rutland, the over 65 population is predicted to grow at a slower rate than nationally, by 48.9% from 9,400 to 14,000 people, whilst the 85 and over population is predicted to grow at a faster rate than nationally, by 142.9%. The largest change in population is the age band 90 years and over, an increase of 1,200.[5]

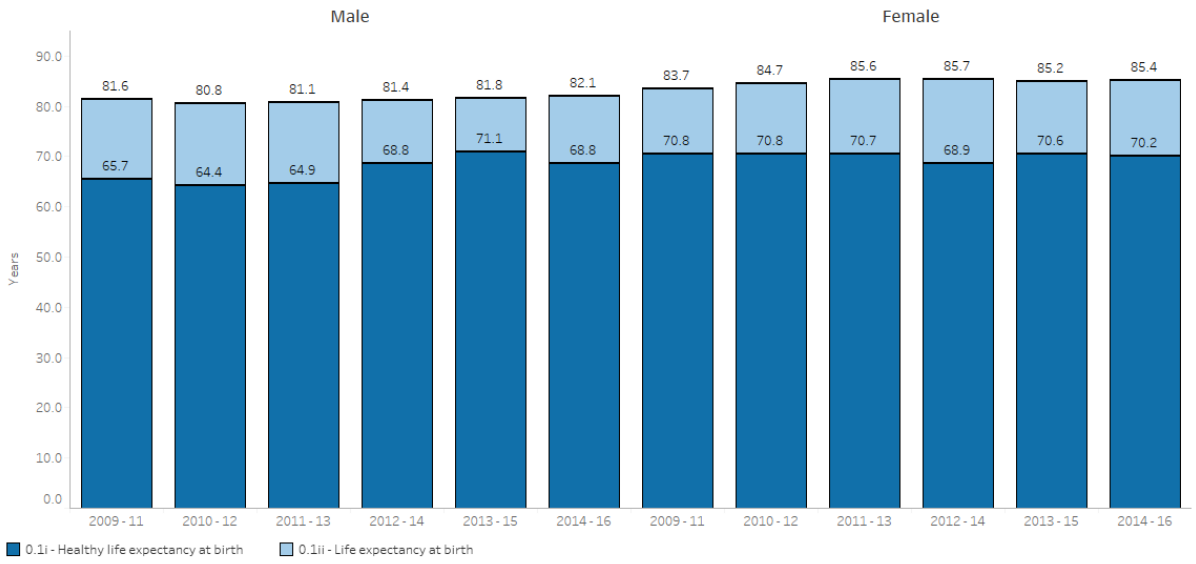
3.1. Gap in healthy life expectancy at birth and life expectancy at birth

Nationally, life expectancy at birth has remained constant for males over the last two time periods and in females over the last three periods, at 79.5 and 83.1 years respectively. In Rutland, life expectancy at birth for males has shown a year on year increase from 80.8 years in 2010-12 to 82.1 years in 2014-16, whereas life expectancy for females has fluctuated, residing at 85.4 years in 2014-16.[9]

Nationally, healthy life expectancy at birth has fallen for males and females compared to the previous time period, from 63.4 years to 63.3 years in males and from 64.1 years to 63.9 years in females. In Rutland, healthy life expectancy at birth in males has decreased from 71.1 years in 2013-15 to 68.8 years in 2014-16. In females, healthy life expectancy at birth has also decreased compared to the previous time period from 70.6 years in 2013-15 to 70.2 years in 2014-16.[9]

The gap in life expectancy at birth and healthy life expectancy at birth infers the number of years a person is likely to live in poor health. As shown by the graph, females, on average, live more years in poor health than males. The latest data from 2014-16 shows in Rutland males spend 13.4 years in poor health compared to 15.2 years in females. This is lower than the national average of 16.2 and 19.3 years respectively.[9]

Figure 1: Gap in Healthy Life Expectancy at Birth and Life Expectancy at Birth in Rutland

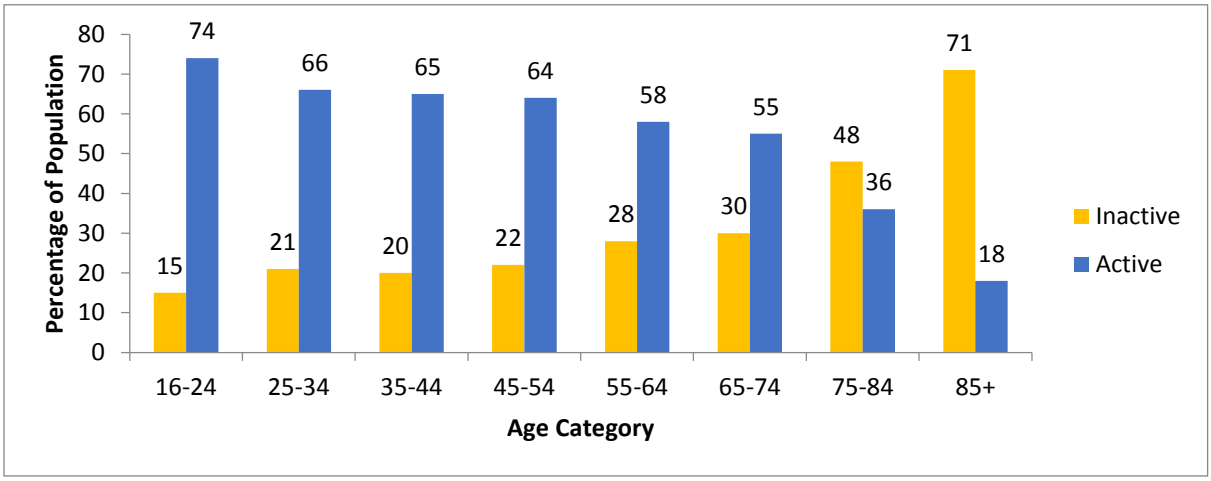


3.2. Physical activity

Nationally, as the population ages, the percentage of the population classified as physically

active (150+ moderate intensity equivalent minutes per week) decreases. The percentage of the population classified as physically inactive (<30 moderate intensity equivalent minutes per week) increases with each age-band from 30 years and above. Local activity data for Rutland is not available segmented by age.[6]

Figure 2: Percentage of the national population who are physically active and inactive, 2016/17



Data from 2015/16 showed the favourite sports in Rutland are swimming (12.5% of the adult Rutland population), gym sessions (11.8%), cycling (11.4%) and fitness classes (7.7%). Participation rates in all of these sports are greater than East Midlands and England values.

The Exercise Referral Scheme is a programme for adults (16+) with health conditions, who could benefit from increased physical activity. This prevention programme has become increasingly popular with numbers referred to the scheme increasing steadily over the last few years. See table below. Evaluation shows that participants are very positive about the scheme and a high proportion report continuing into mainstream activity programmes.

Table 1: Rutland Numbers of People accessing the Exercise Referral programme

2015	2016	2017	2018 Jan- Oct
315	350	479	465

There is considerable evidence of the benefits of physical activity in preventing ill health including reducing the likelihood of falls. Steady Steps and its predecessor FAME provide a 24-week programme tailored to those who have previously fallen or worry about falling and

it is designed to help improve balance and stability. The programme evaluates well, numbers referred have increased (see table below) and many individuals report having joined mainstream activities such as bowls, gym and other classes.

Table 2: Rutland participants in FAME/Steady Steps

2016	2017	2018
28	32	52

3.3. Loss of hearing

A person who is not able to hear as well as someone with normal hearing, hearing thresholds of 25 decibels (dB) or better in both ears, is said to have hearing loss. Unaddressed Hearing Loss can have a serious impact on health and wellbeing:

- People with hearing loss are more likely to experience emotional distress and loneliness.
- Hearing loss doubles the risk of developing depression.
- People with hearing loss are at least twice as likely to develop dementia.

Action on Hearing Loss have estimated the number of people with hearing loss of at least 25 dB in each Local Authority area in the UK, using mid-2014 ONS population estimates. In 2014, approximately 8,000 people in Rutland were estimated to be affected by hearing loss, over a fifth (21.0%) of the total population.[7]

3.4. Loss of sight

Over two million people in the UK live with sight loss. That's around one person in 30. It is predicted that by 2020 the number of people with sight loss will rise to over 2,250,000. And by 2050, the numbers of people with sight loss in the UK will double to nearly four million.[8] This is because:

- the UK population is ageing and as we get older we are increasingly likely to experience sight loss
- there is a growing incidence in key underlying causes of sight loss, such as obesity and diabetes

Prevention of sight loss will help people maintain independent lives as far as possible and reduce needs for social care support, which would be necessary if sight was lost permanently. The counts of new completions of Certifications of Visual Impairment (all causes - preventable and non-preventable) by a consultant ophthalmologist as a rate of the resident population in the county have been examined. In Rutland the rate of sight loss certifications per 100,000 population has fluctuated to perform significantly worse (higher) and similar to the national average since 2010/11. The latest data shows in 2016/17 there were 26 new certifications in the county, which equates to a rate of 67.3 per 100,000 population. This is significantly worse (higher) than the national rate of 42.4 per 100,000 population.[9] Whilst a higher level of sight certifications is deemed to be worse, completing the sight loss certification initiates the process of registration with a local authority and leads to access to services. This may well indicate that people with sight loss in Rutland are being proactively identified and therefore able to access the help and support they require. However sight loss can develop for a number of preventable reasons, for example related to diabetes or smoking, and therefore it is worth considering whether some of these sight loss certifications could be avoided through better diabetic control, or through improving smoking cessation rates.

Where the cause of sight loss is Age-related Macular Degeneration (AMD) or Glaucoma, the rate of new completions of Certifications of Visual Impairment due to these disorders have been examined separately. For the last six years, the rate of sight loss due to AMD in those aged 65 years and above has remained similar to the national average. The rate of sight loss due to glaucoma in those aged 40 years and above performs similar to the national average in 2016/17 with 6 new certifications.[9]

3.5. Mental health

3.5.1. Common mental health conditions

Common mental health conditions, also known as common mental disorders (CMDs) or neurotic disorders, encompass different types of depression and anxiety, including generalised anxiety disorder, phobias, OCD and panic disorder. While they do not affect cognition, they do cause emotional distress and can interfere with a person's day to day life. Many of these conditions are known to overlap; for example someone who is experiencing anxiety and depression may also have OCD symptoms. It is further recognised that not all CMDs are diagnosed. For this reason, data relies on estimates, with the understanding that those in service and receiving treatment do not account for all those with CMDs.

Table 3 shows the national prevalence of CMDs from the Adult Psychiatric Morbidity Survey (APMS) 2014[10] applied to Rutland's population across age bands[11]. Despite the prevalence of CMDs decreasing as age increases, it must be recognised that a substantial proportion of the older population, one in ten females and one in twenty males over the age of 75 years, will continue to be affected by these disorders. With the population in Rutland predicted to age, this demand is also set to increase by 48% in males (from 290 individuals in 2017 to 430 in 2040) and 45% in females (from 597 individuals in 2017 to 867 in 2040) aged over 65 years.[5]

Table 3: Estimated prevalence of common mental health disorders in Rutland mid-2017 population based on APMS (2014)

Age	Males			Females		
	APMS Prevalence (%)	Rutland Pop	Rutland Est. Counts	APMS Prevalence (%)	Rutland Pop	Rutland Est. Counts
16-24	9.1	2,162	197	26.0	1,766	459
25-34	15.3	2,315	354	19.1	1,642	314
35-44	15.1	2,355	356	20.6	2,042	421
45-54	13.2	2,851	376	22.7	2,867	651
55-64	14.9	2,575	384	19.1	2,628	502
65-74	7.3	2,583	189	12.9	2,719	351
75+	5.3	1,919	102	10.0	2,463	246
All	12.2	16,760	2,045	19.1	16,127	3,080

3.5.2. **Dementia**

With the introduction of the new General Medical Services (GMS) contract in April 2004, a quality framework of indicators (QOF) was developed for general practice, the QOF. An integral part of the QOF is the collection of prevalence data to allow practices to identify those patients that require specific management. Prevalence data within the QOF are collected in the form of practice registers. Please note, while many patients are likely to suffer from multi-morbidity, i.e. are diagnosed with more than one of the clinical conditions included in the QOF clinical domain, robust analysis of multi-morbidity is not possible. Identifying these patients may rely on finding those that are on more than one chronic disease (or long term condition) register.

The recorded dementia QOF prevalence examines the number of people with dementia recorded on GP practice registers as a proportion of the people (all ages) registered at each

GP practice. In Rutland the dementia QOF prevalence has significantly increased over time from 0.6% in 2011/12 to 1.0% in 2016/17. Throughout this time, the prevalence in Rutland has remained significantly higher than the national average. The latest data reflects 362 patients have been diagnosed with dementia in Rutland.[12]

Increasing the number of people living with dementia who have a formal diagnosis enables patients, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes. In 2018 in Rutland, 56.5% of those patients estimated to have dementia had been diagnosed; this is significantly worse (lower) than the national average of 67.5% and significantly lower than the national benchmark of 66.7%.[9]

Examining the trend in the directly age standardised rate of emergency inpatient hospital admissions for people with a mention of dementia in any of the diagnosis code positions (aged 65 years and above) per 100,000 population is useful to understand the variation in the provision of care of people with dementia. Over the last five years in Rutland the rate has remained significantly better (lower) than the national average and has declined compared to the previous year. The latest data shows there were 214 emergency admissions with a mention of dementia in the population aged 65 years and above in Rutland in 2016/17.[13]

In 2016 in Rutland, 84.5% of all deaths of people with a recorded mention of dementia were in their usual place of residence (DiUPR). This is significantly higher than the national percentage of 67.9%. Almost three-quarters (70.4%) of all deaths of people with a recorded mention of dementia in Rutland in 2016 were in a care home, followed by in hospital (15.5%) and in the home (14.1%). This pattern of place of death is reflected nationally. The latest data shows Rutland has a significantly lower proportion of deaths occurring in hospital and a significantly higher proportion of deaths of people with a recorded mention of dementia in care homes compared to nationally.[12]

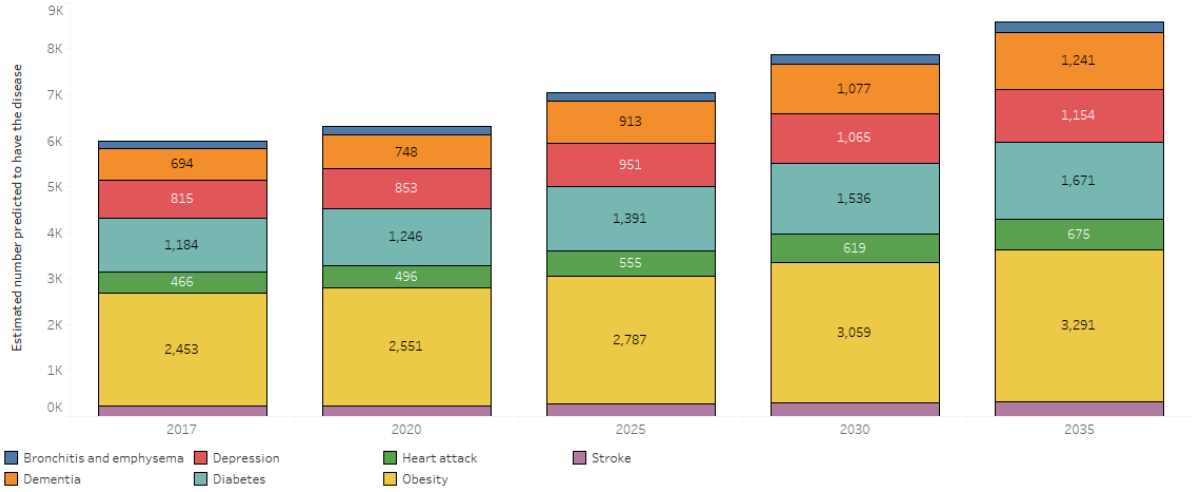
3.5.3. **Suicide**

In Rutland between 2011-15 there was one male death from suicide and injury of undetermined intent in the 65 and over age range. The crude mortality rate from suicide and injury of undetermined intent in males aged 65 and over was 5.1 per 100,000 population during 2011-15, this is statistically similar to the England rate of 12.6 per 100,000 population.[14]

3.6. Forecasted prevalence of long term conditions in people aged 65 years and above

The projected number of people over the age of 65 years with a long term condition between 2017 and 2035 in Rutland have been examined in the chart below. The numbers are based on the current prevalence rates applied to projected populations. Please note, the numbers refer to people on individual registers i.e. people with multi-morbidities will be counted on each register, therefore the totals will be greater than projected populations for the over 65s.

Figure 3: Forecasted prevalence of specified Long Term Conditions in people aged 65 years and above, Rutland



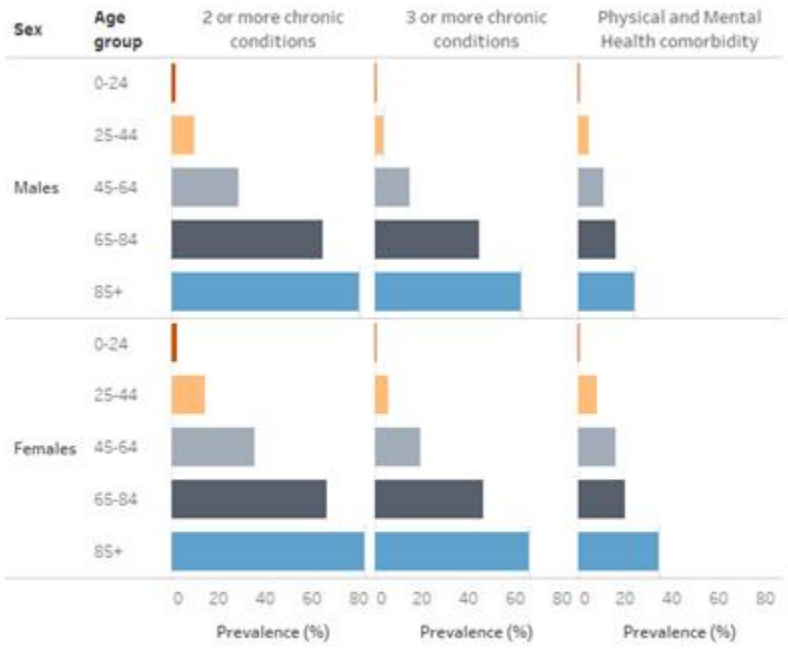
The projected increase in number of people with the following conditions between 2017 and 2035 in Rutland is: Dementia (78.8%), Stroke (47.5%), Heart attack (44.8%), Bronchitis and emphysema (42.9%), Depression (41.6%), Diabetes (41.1%), Obesity (34.2%).[3]

3.7. Prevalence estimates of multi-morbidity

Although multi-morbidity (presence of multiple chronic (long-term) conditions) has been researched extensively, there is currently no consensus on its precise definition. The number, type (physical or mental health) and selection criteria for conditions included in multi-morbidity indices vary from one author to another. The differences in definitions and measurement tools give rise to non-comparable information on the prevalence of multi-morbidity across various studies. Barnett et al.[15] defined multi-morbidity as the presence of 2 or more chronic conditions from 40 specified conditions, and reported prevalence by sex, age group and area deprivation decile. The data reported here are based on 2 or more, 3 or more, and physical and mental health comorbidity only.

Prevalence estimates of multi-morbidity are only available at a regional level. Data for the East Midlands shows, regardless of gender, as we age the prevalence of multi-morbidity increases. In each age group, the prevalence of 2 or more chronic conditions was the highest, followed by 3 or more chronic conditions and the physical and mental health comorbidity.

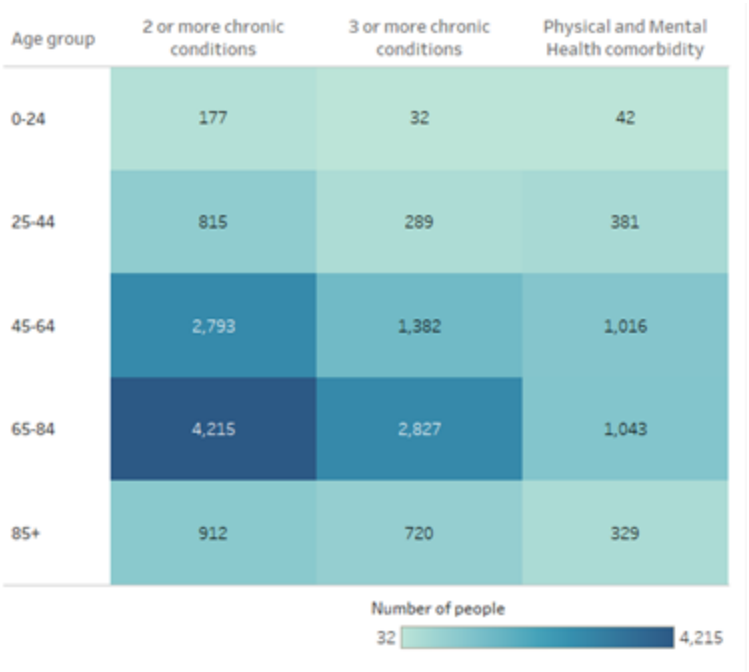
Figure 4: Estimated prevalence of multi-morbidity in the East Midlands



Expected prevalence estimates are based on observed prevalence estimates provided by Barnett and colleagues and mid-2011 population estimates. Source: Public Health England

In Rutland, the highest count of people (4,215) with multi-morbidity was in the 65-84 years age group with 2 or more conditions respectively. This was followed by the 65-84 years age group with 3 or more conditions (2,827) and 45-64 years age group with 2 or more conditions (2,793).[16]

Figure 5: Estimated counts of residents with multi-morbidity in Rutland



3.8. Hospital admissions

3.8.1. Emergency Admissions

Good management of long term conditions requires effective collaboration across the health and care system to support people in managing conditions and to promote swift recovery and reablement after acute illness. There should be shared responsibility across the system so that all parts of the health and care system improve the quality of care and reduce the frequency and necessity for emergency admissions.

Against a strong national trend of rising emergency admissions, the rate of emergency admissions has been maintained at a steady level in Rutland, with the 2017/18 rate only 0.5% higher than the rate in 2014-15. Non elective admissions rose by 9% in England over the same period according to national hospital activity data.[17]

In 2017/18, the crude rate of emergency admissions for patients aged 65 years and above in Rutland is 18,815 per 100,000 population aged 65 years and above. This equates to 1,822 emergency admissions in the population aged 65 years and above in Rutland. This is the 2nd lowest rate out of the 16 CIPFA nearest neighbours to Rutland.[18]

3.8.2. **Falls**

Nationally falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. they are a major precipitant of people moving from their own home to long-term nursing or residential care. The highest risk of falls are in those aged 65 years and above and it is estimated that about 30% people aged 65 years and above living at home and about 50% of people aged 80 years and above living at home or in residential care will experience an episode of fall at least once a year.

The local data for Rutland shows the rate of emergency admissions for falls increases with age, with the rate of admissions for those aged 80 years and above being six times higher than those aged 65 to 79 years. The rate of emergency admissions for falls for those aged 80 years and above has decreased year on year since 2012/13. The data from the most recent two years now perform significantly better (lower) than the national average, the previous three years performed similar to the national average.[9]

3.8.3. **Fractured neck of femur**

Only one in three people that suffer a hip fracture return to their former levels of independence. The condition is so debilitating that one in three sufferers end up moving into long-term care facilities.

The rate of emergency hospital admissions for hip fractures in persons aged 65 and above and in persons aged 80 and above (separately) has increased each year between 2014/15 to 2016/17. In both age bands the national rate has declined slightly year on year.

Emergency hospital admissions for hip fractures in persons aged 65 and above per 100,000 population has increased (worsened) from 532 per 100,000 population in 2015/16 to 558 per 100,000 population in 2016/17, representing an increase of 4 admissions. The latest rate performs similar to the national average. In 2016/17, the rate of emergency hospital admissions for hip fractures in males aged 65 and above per 100,000 population is significantly worse than the national average, whereas the rate in females is significantly better than the national average.[9]

Meanwhile in 2016/17, the rate of emergency hospital admissions due to fractured neck of femur for adults aged 80 and over was 1,432 per 100,000 population, this is similar to the England average value of 1,545 per 100,000 population. The counts of emergency hospital admissions for hip fractures in persons aged 80 and above has increased by 5 admissions compared to the previous year, from 31 in 2015/16 to 36 in 2016/17.[9]

3.9. Excess winter deaths

In common with other countries, more people die in the winter than in the summer in England and Wales. The Excess Winter Deaths (EWD) Index is defined as the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths. Between August 2013 to July 2016 there were an estimated 38 excess winter deaths in Rutland. This represents a EWD Index of 10.9%, which means that 10.9% more deaths occurred in the winter months compared with the non-winter months.[9] As it is common to observe large fluctuations in EWDs for which trends over time are often not smooth, we have presented a three-year moving average to smooth out any short-term fluctuations and make the trend over time clearer in the graphs presented.

Nationally, EWDs are generally higher in females and the elderly. In Rutland, for all but one data point in August 2006 to July 2009, the EWD Index for those aged 85 years and above has been consistently higher than those of all ages since recordings began. When examining by gender, on a national level, the EWD Index for females aged 85 and above has been higher than males (although not always significantly) for the last 12 time periods. In Rutland, the EWD Index for females aged 85 and above has been higher (although not significantly) than males in the same age group for the last three time periods.[9]

3.10. Mortality

The directly age standardised mortality rate (ASMR) is calculated to take into account the age structures of the population. Since 2004, the ASMR for all ages in Rutland has remained significantly lower than the national average. The latest data in 2015 shows when the ASMR is broken down into age groups, those under 65, between 65 and 74, between 75 and 84 and above 85 years all have a similar rate to the national average.[12]

In Rutland, 10.1% of all deaths in 2015 were in those aged under 65. This is significantly lower than the national percentage of 14.8% and has decreased year on year from 13.2% in 2012. Of all deaths in Rutland, 46.6% were from those aged 85 and above, this is significantly higher than the national percentage of 40.4%. The percentage of deaths in this age group has increased significantly over time, likely due to the ageing population.[12]

3.10.1. Place of death

Over a third (38.9%) of all deaths in Rutland in 2016 were in hospital, followed by: in the home (27.7%), in care homes (27.7%), hospices (3.2%) and other places (2.4%). This pattern

of place of death is reflected nationally. The latest data shows Rutland has a significantly lower proportion of deaths occurring in hospital and a significantly higher proportion of deaths in care homes compared to nationally. In Rutland the trend is significantly decreasing over time for in-hospital deaths and significantly increasing over time for deaths in care homes.[12]

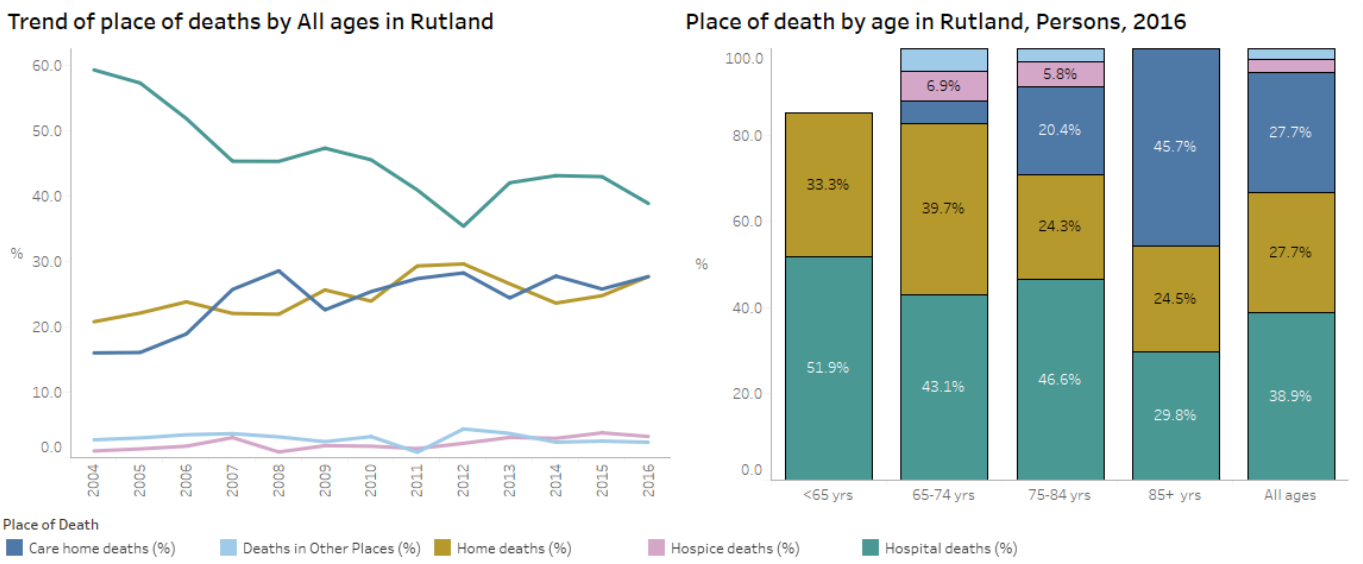
In Rutland, over half (51.9%) of deaths in the under 65 years age group occurred in hospital in 2016, this is the highest percentage out of all age groups. The lowest percentage of in-hospital deaths occurred in those aged over 85 years. In 2016, less than a third of deaths (29.8%) in this age group were in hospital, significantly lower than the national percentage of 43.8%. The trend of in-hospital deaths has been significantly decreasing across the 65-74 age band and 85 and above age band over time.[12]

As age increases, the percentage of deaths in care homes increases. Almost half (45.7%) of all deaths in the 85 and above age bands occurred in care homes, a significantly higher percentage to the national average (36.7%). The trend of care home deaths has been significantly increasing in the county across the 85 and above age band over time.[12]

Nationally the percentage of deaths at home decreases with age. In 2016 in Rutland, over a third (39.7%) of deaths in those aged 65-74 years died at home, similar to the national percentage of 30.3%. This was the highest percentage out of all age bands in Rutland residents. In those aged 85 and above, a quarter (24.5%) of all deaths were in the home. This is a significantly higher percentage compared to the national average (16.4%).[12]

In 2016, hospice deaths accounted for 3.2% of all deaths in Rutland. This is similar to the national percentage of 5.7%. In Rutland the trend is significantly increasing over time for deaths in hospices.[12]

Figure 6: Place of death in Rutland



3.10.1.1. Deaths in Usual Place of Residence

In Rutland, over half (52.4%) of all deaths were in usual place of residence (DiUPR) in 2015, this is significantly higher than the national percentage of 46.0%. The trend has increased significantly in Rutland over time and the percentage of DiUPR has continued to have a significantly higher percentage than nationally since 2006. Two-thirds (66.1%) of all deaths from those aged 85 and above in Rutland were in the usual place of residence, this is significantly higher than the national percentage of 54.1%. The percentage of DiUPR in this age group has increased significantly over time.[12]

When examining DiUPR by cause of death in 2015, this showed Dementia and Alzheimer's disease had the highest percentage of DiUPR (87.3%), followed by Circulatory disease (49.0%), Cancer (48.0%) and Respiratory disease (32.5%). Trend analysis for Rutland shows that the percentage of deaths in usual place of residence for Cancer has shown a significant increase over time whereas Dementia and Alzheimer's disease, Circulatory disease and Respiratory disease have all shown no significant change in the percentage of DiUPR.[12]

4. How does this impact?

The last few years have seen a steady increase in the prevalence of a range of long term conditions in Rutland, many of which are largely preventable and closely associated with lifestyle factors including increased levels of obesity, lack of exercise and smoking. Supporting people to stay healthy for longer is therefore a key area for action.

The number of complex cases is increasing, as more people are living with more than one long term condition. In light of the challenges of frailty and multimorbidity, the longer term challenge for the health and care system is a shift towards treating the person, not the individual conditions, and using this to move towards a holistic approach to Healthy Ageing. The 'system' should be about prevention, early identification and management of conditions, ideally within primary care, to prevent the onset of ill health.

Being housebound is a risk factor for loneliness, and that loneliness is itself a risk factor for depression, poor sleep, impaired thinking skills, higher use of health care with more GP visits, higher use of medication, and higher incidence of falls. Linked to prevention and social prescribing, tackling loneliness and supporting people in their own communities will help mitigate the increasing numbers of frail people.

Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being. The earlier this support can be offered, the better, and preferably it should be available in that individual's own communities.

Informal carers, friends and family, often provide considerable support to people with multimorbidity. It is important to take an integrated approach to identifying and assessing carer health and wellbeing. Carers have worse health outcomes than people who are not carers and they might need support too. 70% of carers come into contact with health professionals with only around 10% being identified as carers.

5. Policy and Guidance

5.1. NICE (National Institute for Health and Care Excellence) Guidance

There is an extensive range of guidance relating to ageing well and health and care of older people. This includes NICE (National Institute for Health and Care Excellence) guidance ranging from mental wellbeing in the over 65's (PH16) to Older people with social care needs and multiple long-term conditions (NG22) to Falls in older people: assessing risk and prevention (CG161). NHS guidance includes Frail Older People – Safe Compassionate Care. This is a practical guide outlining responsibilities and approaches for commissioners, providers and nursing, medical and allied health professional leaders.

5.2. The Care Act 2014

A major piece of legislation that has shaped care in recent years stems from The Care Act 2014. This sets out the primary statutory duties of adult social care. People have a right to a free needs assessment from the council regardless of finances or presenting needs or are too low to qualify for help. All councils must use national eligibility criteria to decide whether someone can get help from them.

If people get social care support, they now have a right to request a personal budget enabling people to commission their own care. If the needs assessment shows they do not qualify for help from the council, they must advise people how the care system works and how to pay for their own care. Carers too have a legal right to a care assessment from the local council and can also get support services if they qualify for them.

If people find it difficult to communicate or to understand the issues being discussed, the council must provide an advocate to help when discussing their care. They will represent people's interests if they do not have a friend or relative who can help.

The council is the lead agency in preventing abuse to vulnerable adults and now has powers under section 42 of the Care Act to cause enquiry. This means the council can ask providers of health and domiciliary services to investigate concerns and present the findings to the council for scrutiny. The council works closely with the Police and other statutory agencies at these times, always keeping in contact with and supporting the alleged victim.

5.3. Realising Realistic Medicine

In 2017, the Chief Medical Officer published a report titled 'Realising Realistic Medicine'. Realistic medicine puts the person receiving health and social care services at the centre of decisions about their care. It recommends a holistic approach, along with aiming to treat the person as an individual rather than treating the conditions that they may have.[19]

5.4. The Better Care Fund (BCF)

The Better Care Fund (BCF) programme was set up in 2014, spanning both the NHS and local authorities, to join-up health and care services, in order that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. Rutland's Better Care Fund programme aims to shape more integrated, efficient and effective health and care services which work well for the people of Rutland. This is so that people receive the right care and support at the right time to maintain their health and

wellbeing, staying well for as long as possible, thus preventing, delaying or reducing their need for care. The programme is run jointly by Rutland County Council and East Leicestershire and Rutland Clinical Commissioning Group, and overseen by the Rutland Health and Wellbeing Board.

5.5. A connected society: a strategy for tackling loneliness

Most recently, in recognition of the impact loneliness can have a person's wellbeing, the government published 'A connected society: a strategy for tackling loneliness' in October 2018. This strategy provides an assessment of the existing evidence and outlines actions to embed loneliness as a consideration across government policy, recognising the wide range of factors that can exacerbate feelings of loneliness and ways to support people's social wellbeing and resilience. It also aims to build a national conversation on loneliness, to raise awareness of its impacts and to help tackle stigma.

5.6. Carer's Strategy (2018 -2021)

Additionally, at a local level across Leicestershire, Leicester and Rutland (LLR) a number of cross agency strategies have been developed. This includes the recently adopted Carer's Strategy (2018 -2021) which seeks to improve services and support for carers through the work that is carried out by NHS, social care and voluntary sector organisations for unpaid carers who are caring for someone that lives in LLR. It outlines eight key priorities to support carers in their caring role and to maintain their own health and wellbeing. It covers all carers: adults, parent carers, young carers and life-long carers. The draft LLR Living Well with Dementia Strategy 2019-2022 is out for consultation. This outlines actions to create a health and social care system that works together so that every person with dementia, their carers and families have access to and receive compassionate care and support not only before diagnosis but after diagnosis and through to end of life.

6. Current Services

6.1. The Rutland Information Service

The Rutland Information Service website is designed to support people to access a wide range of information, advice and support enabling them to help themselves. It also offers a directory for signposting organisations who are working with the public, enabling the public to obtain more consistent referrals information**,** wherever they go to ask for support.

6.2. The Rutland Community Wellbeing Service

The Rutland Community Wellbeing Service (RCWS) offers support and signposting to help residents of Rutland with a range of health and wellbeing needs. This includes self-help tools, and onwards referral to a variety of community support, through an interactive website (https://www.rutlandwellbeing.org.uk/), single telephone number and drop-in services. They provide a wide range of assistance to help people to overcome some of the factors which may have a negative impact on their health and wellbeing, such as poor housing and debt. This includes help to access specialist military/veteran support. RCWS also provides support to help people around a range of lifestyle issues such as stopping smoking, and basic dietary and weight management advice and referral.

6.3. Active Rutland

Active Rutland provides details of all the physical activities and sports available within the county, including those aimed at specific groups such as older people, young people with disabilities and those recovering from injury.

The Exercise Referral Scheme is a programme for adults (16+) with health conditions, who could benefit from increased physical activity. It is a partnership between Public Health, Leicester-Shire and Rutland Sport, local authorities, GP practices and other healthcare professionals. It offers an opportunity for these individuals to exercise in a safe, supervised and structured environment.

Rutland operates a Passport to Leisure scheme which allows specific groups the opportunity to access daytime services and facilities at the local sports centre at a discounted rate, including low income families, students and individuals with a disability or impairment.

6.4. Rutland County Council's Adult Social Care Service

Rutland County Council's Adult Social Care (ASC) Service has a number of specialist teams

covering all aspects of adult social care from both a commissioning and a provider perspective.

The teams are divided into three multi-disciplinary service areas: Prevention and Safeguarding, Long-term Support, and Hospital Discharge and Reablement. All of the teams work on an outcome-focused ethos with the person at the centre, involving and empowering them to take decisions over their own lives at often very difficult times for them and their families. The Hospital Discharge team is a fully integrated team which includes health professionals from the community health provider (Leicestershire Partnership Trust) as well as local authority employed staff. The teams work closely with other professional agencies, GPs and appropriate third sector partners to ensure the best possible outcome for the person concerned and their families.

In addition, Adult Social Care have a reablement team which specialises in helping people back to being independent such as after a hospital stay. The service will support and encourage people in their own homes, facilitating them to stay there as long as possible.

Rutland is one of only two local authorities within the UK to directly employ an Admiral Nurse to support people following a diagnosis of dementia. Services are being restructured to increase provision and support available for dementia.

The local authority commissions services from other sources to assist it with its statutory duties. This includes advocacy services for those who lack capacity and equipment services for occupational therapy and home adaptions.

In addition to adult social care, the local authority commission a number of external providers to deliver residential and nursing care, homecare (domiciliary care), and wider support services, including specific older people's support from Age UK Leicester-Shire and Rutland, via Rutland Access Partnership (a VSCE consortium).

The Council funds a well-established Assistive Technology service provided by Spire Homes and complemented this from October 2017 with a Housing MOT service which offers users a more holistic assessment of their home environment, including for falls prevention, fire safety, energy efficiency and security. The scheme, delivered by Spire Homes, provides an integrated response to housing-related issues that could impact on wellbeing. In its first ten months, 193 visits were undertaken, advising clients, two thirds of whom were aged 75 or over. This contact generated 476 onward referrals to a wide variety of largely preventative services (2.2 referrals per service user visited). Where users have a disability and would benefit from more significant home adaptations costing under £10k e.g. stair-lift, level

access shower, the Housing MOT service can also recommend assessment for a Housing and Prevention grant for home adaptations. This streamlined grant funding approach delivers small-scale adaptations rapidly using DFG funding, increasing the preventative impact of this budget. In the first half of 2018-19, 17 DFG projects were completed including 15 level access showers, 11 stairlifts and 4 access improvements. Anticipated benefits are improved carer sustainability, prolonged independent living in the community and falls prevention.

6.5. Mental health services

Most common mental health problems are appropriately managed in primary care. Mental health services provide support to those 65 and over as well as those under 65. The Let's Talk-Wellbeing (IAPT service) service provides psychological assessment and treatment for mild to moderate common mental health problems. Specialised skilled and accredited practitioners provide psychological therapies (talking therapies) for people experiencing common difficulties including depression, anxiety, panic, phobias, obsessive compulsive disorder (OCD), trauma and stress.

For specialist input for severe mental illness and for those with dementia age 65 and over, referral can be made to 'old age psychiatry' services. Inpatient and community mental health services are provided by Leicestershire Partnership Trust. Further details can be found in the Adult Mental Health chapter of the JSNA.

7. Unmet needs/Gaps

In Rutland, carers who are supported by Rutland County Council are substantially more satisfied with the support they received than the English average. However the proportion of carers accessing support from the Council is about 14% of the estimated total number of people aged 65 and over that are providing unpaid care to a partner, family member or other person in Rutland. This means that there are a large number of older carers who could be accessing alternative sources of support, or who are not accessing or receiving any form or support. This could mean a lack of resilience in that carer's arrangements which could have a substantial impact on the person cared for if the carer became unwell or otherwise unable to continue in their carer role.

Those aged 75-84 and 85+ in Rutland are more likely to be inactive than active, whereas in all other age groups people are more likely to be active than not. It may be that there are people in these older age groups who would wish to, and are able to, be more physically active but who do not have access to appropriate physical activity and exercise opportunities.

In 2018 in Rutland, 56.5% of those patients estimated to have dementia have been diagnosed, which is significantly lower than the national average and the national benchmark. There is room to improve this figure. Doing so will mean that patients, carers, the multidisciplinary healthcare team, as well as healthcare commissioners, are able to plan, deliver and access individual and population level care and services. This in turn could improve the health and care outcomes, including quality of life, of patients with dementia.

8. Recommendations

- Support Rutland residents to remain well, active and connected, and therefore to stay healthy for longer.
- Encouraging and enabling individuals to take a greater role in their own care.
- Promote and develop a social prescribing model, to help address social isolation and loneliness, and to support mental and physical wellbeing.
- Health and care services to work together to develop a holistic approach to Healthy Ageing that treats the patient rather than the separate conditions, reviewing commissioned pathways where relevant and appropriate.
- Health and care services to consider how the system may need to adapt in its processing and use of data to focus on the patient, particularly those with multimorbidities, rather than on separate medical conditions.
- Develop the dementia pathway to increase the proportion of those with living with dementia who have a formal diagnosis, enabling them to access services and support.
- Consider ways to proactively identify carers aged 65 and older, and those caring for people aged 65 and over, in order to provide appropriate support to increase carer resilience.

GLOSSARY OF TERMS

ASC	Adult Social Care
AMD	Age-related Macular Degeneration
CCG	Clinical Commissioning Group
CMDs	Common Mental Health Disorders
DiUPR	Deaths in Usual Place of Residence
DToC	Delayed Transfer of Care
EWD	Excess Winter Deaths
GMS	General Medical Services
JSNA	Joint Strategic Needs Assessment
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
QOF	Quality Outcomes Framework
PHE	Public Health England
RCWS	Rutland Community Wellbeing Service

REFERENCES

[1] Public Health England. Wider Determinants of Health Profiles (2018). At https://fingertips.phe.org.uk/profile/wider-determinants

[2] Public Health England. Mental Health and Wellbeing JSNA (2018). At https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna

[3] Institute of Public Care (2018). Projecting Older People Population Information. Available at: http://www.poppi.org.uk/

[4] Office for National Statistics, Revised population estimates for England and Wales: mid-2012 to mid-2016 (2018). At https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2012tomid2016

[5] Office of National Statistics. Subnational population projections for England: 2014-based (2016). At: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2014basedprojections

[6] Sport England (2017). Active Lives Adult Survey 2016/17. Available at: www.sportengland.org/media/12458/active-lives-adult-may-16-17-report.pdf

[7] Action on Hearing Loss. Hearing Matters (2015). At: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/hearing-matters-report/

[8] RNIB (2018). How many people in the UK have sight loss? Available at: https://help.rnib.org.uk/help/newly-diagnosed-registration/registering-sight-loss/statistics

[9] Public Health England (2018) Public Health Outcomes Framework. Available at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

[10] McManus S, Bebbington P, Jenkins R, Brugha T. (2016). Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014. Leeds: NHS digital.

[11] Office of National Statistics (2018) Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2017. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2017

[12] Public Health England (2018) End of Life Care Profile. Available at: https://fingertips.phe.org.uk/profile/end-of-life

[13] Public Health England (2018) Dementia Profile. Available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia

[14] Public Health England. Suicide Prevention Profile (2018) At https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

[15] Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie, Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. The Lancet, Volume 380, Issue 9836, 2012, Pages 37-43, ISSN 0140-6736, https://doi.org/10.1016/S0140-6736(12)60240-2. (http://www.sciencedirect.com/science/article/pii/S0140673612602402)

[16] Public Health England (2018) PHE prevalence estimates of multi-morbidity (region and local authority)

[17] NHS England (2018) Monthy Hospital Activity Data. At. https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/

[18] Department of Health and Social Care (2018) Local area performance measures: NHS social care interface dashboard. Available at: https://www.gov.uk/government/publications/local-area-performance-metrics-and-ambitions

[19] NHS Scotland. Realising Realistic Medicine. Chief Medical Officer's Annual Report 2015-16. Available at: https://www.gov.scot/binaries/content/documents/govscot/publications/report/2017/02/chief-medical-officer-scotland-annual-report-2015-16-realising-realistic-9781786526731/documents/00514513-pdf/00514513-pdf/govscot%3Adocument