

Older People's Integrated Needs Assessment

Version 1.00

Herefordshire Council Intelligence Unit

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INTRODUCTION

ABOUT THIS REPORT

Jointly commissioned by Herefordshire Council and Herefordshire Clinical Commissioning Group, Herefordshire's Older People's Integrated Needs Assessment provides an overview of health and wellbeing issues affecting older people (those aged 65 and over) living in Herefordshire.

The Older People's Integrated Needs Assessment will be of interest to:

- health and social care commissioners, managers and professionals,
- voluntary organisations,
- local businesses,
- members of the public.

HOW TO USE THIS REPORT

This report can be read as a whole, or browsed by topic using the table of contents to assist with navigation.

Those interested in best practice, such as commissioners, managers and professionals are directed to the Best practice section on page [191](#), which contains a list of documents that detail best practice in the provision of health and social care for older people.

NATIONAL CONTEXT

With an ageing population structure, comes the challenges of meeting increased demand for health care and social care services. Older people accessing these services often have multiple conditions, making the provision of appropriate care more challenging to deliver. In their 2016/17 report summarising the state of health and adult social care in England(1), the Care Quality Commission (CQC) warned that the NHS and adult social care services "are at full stretch". Furthermore, work undertaken by the National Audit Office has highlighted that key indicators of health and social care performance (such as delayed transfers of care and emergency admissions to hospital) are worsening(2). These findings reflect the challenges of improving service delivery to an ageing population with increasingly complex needs, in a climate of financial constraint.

There is a general consensus that the response to the challenges facing the health care and social care systems should be that of closer collaboration and integrated working; and by placing a person's needs at the centre of every interaction. This approach is perhaps best exemplified by the Better Care Fund, a programme spanning both the NHS and local government aimed at joining-up health and care services, supporting people to manage their own health and wellbeing, and to live independently in their communities for as long as possible. Across the country, through the Better Care Fund, steps are being taken to deepen collaborative working and to provide seamless health and social care services that rise to the challenge of providing good quality care.

At a local level, effective collaboration is underpinned by partner organisations having a shared understanding of the wider health and social care system, enabling key issues to be identified and prioritised, followed by the drawing up and implementation of strategic solutions that are co-ordinated and reduce duplication. This report is intended to support such activities by presenting an integrated and holistic overview of key issues affecting the health and wellbeing of older people living in Herefordshire.

EXECUTIVE SUMMARY

A larger proportion of Herefordshire's population is aged 65 and over (24 per cent) compared to England and Wales (18 per cent). Locally, between 2016 and 2039 there is expected to be a 34 per cent increase in the number of people aged between 65 and 84 years of age, and a 140 per cent increase among those aged 85 and over.

Nationally, an ageing population is forecast to place considerable strain on the health and social care system. As Herefordshire's population structure is already older, it is anticipated that such strains will be more pronounced. However, anticipatory action can be taken at a local level to ensure that Herefordshire's health and social care services are able to provide good quality care, appropriate to the needs of older people living in the county.

A number of issues have been highlighted as affecting the health and wellbeing of older people living in Herefordshire, with evidence of action being taken, or strategies being drawn up to address the vast majority of the challenges identified. In most cases the responses being planned or implemented were holistic and multi-agency in their approach, evidencing a clear commitment to improving integrated partnership working to achieve improvements the health and wellbeing.

Some of the key issues affecting the health and wellbeing of older people living in Herefordshire identified in this report are:

➤ Fuel poverty

A larger proportion of homes in Herefordshire (16.6 per cent) are in fuel poverty than in the West Midlands (13.5 per cent) and England (11.0 per cent). Older people are more susceptible to ill health (including the risk of death in the winter) as a result of residing in cold homes. In Herefordshire, an estimated 60 per cent of people aged 65 and over live in rural parts of Herefordshire, where access to mains gas may not be possible, and properties with poor thermal efficiency are more common, both of which increase the risk of fuel poverty. The detrimental effects of fuel poverty pose a considerable threat to the health and wellbeing of older people living in Herefordshire.

Recognising that fuel poverty is a particular challenge locally, Herefordshire's Health and Wellbeing Board have made it a priority area. The [Herefordshire Affordable Warmth Strategy 2016-19](#) contains a detailed local action plan to address fuel poverty.

➤ Loneliness

Data from the 2011 census indicated that 14.3 per cent of Herefordshire's households were occupied by a single person aged 65 and over, compared to the England figure of 12.4 per cent. Living alone increases the risk of loneliness and associated poor health and wellbeing. In 2012, the [Herefordshire Quality of Life Survey](#) findings indicated that approximately 5 per cent of residents reported having contact with family, friends or neighbours once a month or less, and a

similar proportion reported feeling lonely most or all the time. Feeling lonely becomes more common with age and is associated with increased risk of a number of health conditions, including dementia.

➤ Frailty

Frailty is “a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves”(3). Frailty is not an inevitable part of ageing, but an under recognised health state. Older people with frailty are more vulnerable to minor illnesses and are at an increased risk of hospitalisation, admission to a care home and death.

It is estimated that in 2016 there were 4,600 people aged 65 and over with frailty living in the community in Herefordshire. However, this does not take into account the number of people with frailty living in care homes. By 2035, the number of people aged 65 and over with frailty living in the community in Herefordshire is estimated to rise by approximately 67 per cent to approximately 7,700 people.

Fragmented health and social care services are known to cause poor outcomes for older people with frailty. Benchmarking results presented in this report provide a snapshot of how the care provided to older people with frailty in Herefordshire compares with best practice. Results indicate that there is room for improvement, particularly in the provision of rapid crisis support and discharge planning. Those who participated in the benchmarking exercise spoke of the commitment to improvement that exists among those who work within the health and social care system. Actions are currently being taken to put in place a local integrated care pathway for the management of people with frailty, resultant improvements should be evident were this benchmarking exercise to be repeated in the future.

➤ Dementia

It is estimated that there are approximately 3,200 people aged 65 and over with dementia living in Herefordshire, and in 2017, local dementia related costs among this age group were estimated to be in the region of £104 million.

A number of health behaviours and long-term health conditions are associated with an increased risk of developing dementia. In Herefordshire the proportion of people with hypertension (high blood pressure), coronary heart disease and stroke (all known dementia risk factors) is higher than nationally, suggesting a need to prioritise preventative action and treatment for these conditions.

Locally, the dementia diagnosis rate is lower than the national and regional figures, and has not yet reached the 2015 diagnosis rate target set by NHS England. Timely diagnosis can lead to people living with dementia and their carers receiving appropriate support and advice when it is likely to be of greatest benefit. Campaigns to improve public awareness of dementia and diagnosis case finding activities all form part of a local diagnosis rate improvement plan.

Informal carers make a significant contribution to the wellbeing of people living with dementia, with informal care accounting for an estimated 44 per cent of dementia related health and social care costs(4). Providing informal care for someone living with dementia can be challenging and can have negative effects on the psychological wellbeing of caregivers. Timely and appropriate support can reduce carer stress and prevent people living with dementia being prematurely admitted to care homes. There are some good examples of local community support available to people living with dementia and their carers, some named examples being the Dementia Adviser Service and the Leominster Dementia Meeting Centre. While self-reported quality of life data indicates that Herefordshire Council is supporting carers of people living with dementia better than the average local authority, there is still room for improvement.

Herefordshire's Health and Wellbeing Board has named dementia as a priority area. A partnership dementia strategy is in place to ensure a coordinated local response to support people living with dementia and their carers.

➤ Falls and fractures

It is estimated that in 2017 nearly 12,200 people aged 65 and over living in Herefordshire will experience a fall, with the number expected to rise to over 18,100 by 2035. Falling can result in fracture, admission to hospital, disability, and admission to residential or nursing home, or in some cases death.

Evidence from a recent benchmarking exercise indicates that in Herefordshire, people have acceptable access to falls prevention interventions. The Falls Prevention Service has seen considerable growth in the number of referrals it receives (300 per cent increase between 2012 and 2016), indicating that it is well utilised. The Falls Responder Service in Herefordshire has been in operation since 2014, providing 24/7 non-medical support and referral (if required) for falls at home that do not result in an injury. There is evidence that the service could be better utilised, with an indication that some of the callouts made by West Midlands Ambulance Service could be attended by a falls responder instead; actions are being taken to address this missed opportunity.

Falls are common in residential and nursing home settings. Systematic recording of falls occurring in these settings would be helpful in order to develop more effective prevention strategies.

NHS RightCare identified that in Herefordshire, a considerably smaller proportion of people aged 75 and over presenting with fragility fractures are treated with a bone sparing agent (a treatment for osteoporosis) compared to other clinical commissioning groups, suggesting that there is an opportunity to improve outcomes for people with osteoporosis by enhancing treatment coverage.

➤ Physical activity

Physical activity levels among those aged 65 and over living in Herefordshire are higher than regional and national levels. However, physical activity levels in over half of this age group are below what is recommended in order to realise health benefits which include a reduced risk of

coronary heart disease, stroke, diabetes, obesity, osteoporosis, colon and breast cancer, and poor mental health. In addition, older adults who engage in physical activity are more likely to maintain their functional capacity, which is vital to living independently.

➤ Informal carers

It is estimated that just over 14 per cent of people aged 65 and over living in Herefordshire provide some degree of informal care. As a result of their responsibilities many informal carers:

- are time poor, making it difficult for them to access services,
- are at increased risk of social isolation,
- find that their quality of life deteriorates, having less time to socialise and pursue activities that they enjoy.

Locally, GP surgeries are being encouraged to identify carers and document carer status on patient medical records in order to ensure that carers receive appropriate support from primary care services. However, evidence suggests that carers are still not being routinely identified and recorded as having caring responsibilities by their GP surgeries. Carer self-reported quality of life in Herefordshire is trailing national and regional figures, but this issue is being addressed as part of Herefordshire's carers strategy, [A Joint Carers Strategy for Herefordshire: 2017 – 2021](#).

➤ Adult social care

In Herefordshire, the majority of council funded residential and nursing home placements are for people aged 65 and over. The ageing population structure and the associated increase in age related disability is expected to lead to increased demand for adult social care locally and nationally. Locally, care is being taken to ensure that support is directed toward those with the greatest need. In addition, volunteers and support networks within the community and preventative interventions (such as intermediate care services) are being maximised, to enable people to live independently at home for as long as possible.

Nationally adult social care providers are facing challenges in recruiting and retaining staff. Estimates from Skills for Care suggest that the adult social care workforce will need to increase by between 21 to 44 per cent between 2016 and 2030 in order to meet demand. With an older population structure than that of England as a whole, Herefordshire is likely to be particularly affected by workforce challenges. Herefordshire Council has launched the "Care Heroes" project to support the local adult social care sector in building a resilient workforce fit for the challenges that lie ahead.

Evidence suggests that people who covered the full cost of their social care needs themselves (self-funders) can find it difficult to understand their care and support needs, and navigate the social care provider market. Under The Care Act 2014, local authorities have a responsibility to provide a care needs assessment to self-funders free of charge, in order to help them understand their needs, and identify suitable services to meet them. Given Herefordshire's ageing

demographic and relative levels of wealth among those aged 65 and over, there are likely to be a considerable number of self-funders in the county. Although Herefordshire Council provides advice regarding care choices to all who want it, not all receive this advice and this can result in self-funders making choices not best suited to their needs. Current understanding of the number of self-funders, or what proportion of self-funders eventually need local authority funded care, is limited. Increasing the availability of data in this area has been highlighted as a priority for Adult's Social Care Commissioning.

➤ Digital exclusion

Digital exclusion refers to the inability to access online products or services or to use simple forms of digital technology (such as smart phones and tablets). Digital exclusion has been linked to loneliness and social isolation and also presents obvious barriers to accessing information and support that is located online. Data indicates that digital exclusion affects adults in Herefordshire more than England as a whole, and that older people are more likely to be digitally excluded. As part of their objective to bring faster broadband to Gloucestershire and Herefordshire, Fastershire have undertaken two initiatives aimed at addressing digital exclusion. Commissioners and service providers should give consideration to the impact that moving services to online-only platforms will have on accessibility for older people, taking action to mitigate this impact wherever possible.

RECOMMENDATIONS

Recommendations are dispersed throughout this report, but for ease of reference are presented in the table below by topic area.

Topic Area	Recommendation	Page number(s) where relevant content appears
Fuel Poverty	Consider undertaking research activities to identify and deliver targeted interventions to individuals at risk of experiencing poor health outcomes as a result of living in cold homes. Specifically, giving consideration to how best to utilise available health data and the capacity for existing services (public, private and voluntary sector) to facilitate identification of at risk individuals and to disseminate interventions.	35
Fuel Poverty	Implement actions outlined in the Herefordshire Affordable Warmth Strategy 2016-19 (5).	35
Health Behaviours	Continue to take action to ensure that health, social care and voluntary organisation workers who come in contact with older people take every opportunity to support them to make healthy lifestyle choices such as consuming alcohol at safe limits, engaging in physical activity, and quitting smoking.	49
Dementia	Prioritise preventative action and treatment for hypertension, coronary heart disease and stroke, as prevalence rates for these three dementia risk factors are particularly high among Herefordshire residents.	73
Dementia	Continue to take action to improve dementia diagnosis rates.	75

Topic Area	Recommendation	Page number(s) where relevant content appears
Dementia	Investigate the underlying reasons for the observation that in Herefordshire a statistically significantly smaller proportion of people with a diagnosis of dementia receive hospital inpatient care compared to nationally, and if required, implement quality improvements	81
Frailty	Ensure that health and social care professionals have appropriate training in the recognition and assessment of frailty; and screen all older people for the presence of frailty during every encounter.	97
Frailty	Take action to reduce the number of emergency admissions among people living in residential and nursing homes, including reviewing the health care provision on offer for people living in residential and nursing homes and the extent to which it is easily accessible.	101
Frailty	Continue to take action to improve the integrated management of people with frailty across the whole health and social care system. Areas warranting particular attention are rapid crisis support, hospital discharge planning, and optimising access to the frailty specialist Gilwern Assessment Unit (GAU) at Herefordshire County Hospital.	98,104
Falls and Fractures	Increase awareness of the need for health and social care professionals to ask older people if they have experienced a fall in the past twelve months.	126

Topic Area	Recommendation	Page number(s) where relevant content appears
Falls and Fractures	Continue to take actions to optimise utilisation of the Falls Responder Service, specifically the appropriate onward referral of non-injurious falls received by West Midlands Ambulance Service and NHS 111.	115
Falls and Fractures	Encourage appropriate data sharing related to falls which take place in residential and nursing homes, and consider whether targeted interventions to reduce incidence are warranted.	123
Falls and Fractures	Identify and implement methods to increase the proportion of people aged 75 and over who have experienced a fragility fracture treated with bone sparing agents.	130
Mortality	Explore whether there are opportunities to improve the diagnosis and management of cardiovascular disease in Herefordshire with a view to a lowering premature mortality attributable to the condition. This may include improving the proportion of eligible people who receive a Health Check.	135,137
Mortality	Explore the underlying causes of premature mortality attributable to injuries and consider whether local health and safety campaigns and/or targeted interventions are warranted.	138
Informal Carers	Continue to take action to improve self-identification of informal carers, and identification of informal carers by health and social care professionals.	142

Topic Area	Recommendation	Page number(s) where relevant content appears
Informal Carers	Support informal carers to engage in meaningful social interaction and seek to improve the quality of life for carers, as outlined in Herefordshire's carers strategy (A Joint Carers Strategy for Herefordshire: 2017 – 2021).	144,150,151
Adult Social Care	Seek to better understand the key factors associated with the variation observed in the local permanent residential and nursing home placement rates among people aged 65 and over.	171
Adult Social Care	Continue to monitor: i) the proportion of older people who are discharged from hospital and go on to receive rehabilitation and re-ablement, and ii) the proportion of those who have received rehabilitation or re-ablement who return home within 91 days of their hospital discharge date, to ensure that ongoing improvements to intermediate care services (through the launch of the Home First service) are delivering greater capacity while maintaining good quality outcomes.	163
Adult Social Care	Continue to work collaboratively across organisations to reduce delayed transfers of care.	171
Adult Social Care	Consider undertaking intelligence gathering exercises to better understand the number and experiences of care home and domiciliary care self-funders in Herefordshire.	174
Adult Social Care	Continue to support the adult social care sector in recruiting and retaining suitable staff.	175
Safeguarding	Explore whether people who lack capacity and are involved in section 42 safeguarding enquiries and are well supported, and take action if required.	180

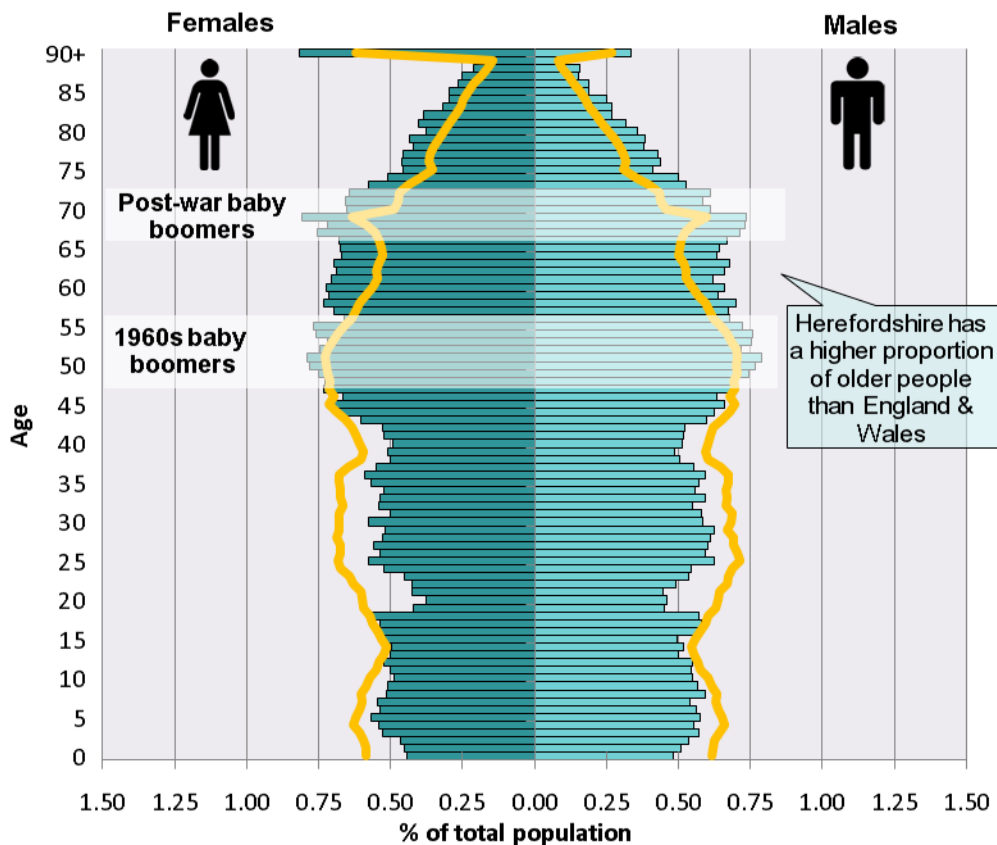
Topic Area	Recommendation	Page number(s) where relevant content appears
Vulnerable Groups / Digital Exclusion	Service providers and those commissioning services should give consideration to the needs of vulnerable groups and the barriers they are likely to face in accessing services. If services intend to move to an online only delivery model, specific consideration should be given to how this may affect accessibility for older people, and what actions they might take to mitigate this.	183

Key Facts

- There are an estimated 44,800 people age 65 and over living in Herefordshire in 2016.
- Twenty-four per cent of Herefordshire's population is aged 65 and over, compared to 18 per cent in England and Wales.
- Between 2016 and 2039 the number of people aged 65-84 is expected to increase by 34 per cent, and by 140 per cent among those aged 85 and over.
- In Herefordshire, 60 per cent of those aged 65 and over and 53 per cent of those aged 85 and over live in rural areas.

According to the Office for National Statistics 2016 mid-year population estimates, there are 189,300 people living in Herefordshire, with 44,800 being 65 years of age or older. Herefordshire has a greater proportion of older people than England and Wales with people aged 65 and over accounting for 24 per cent of Herefordshire's total population, compared to only 18 per cent of the total population of England and Wales (Figure 1).

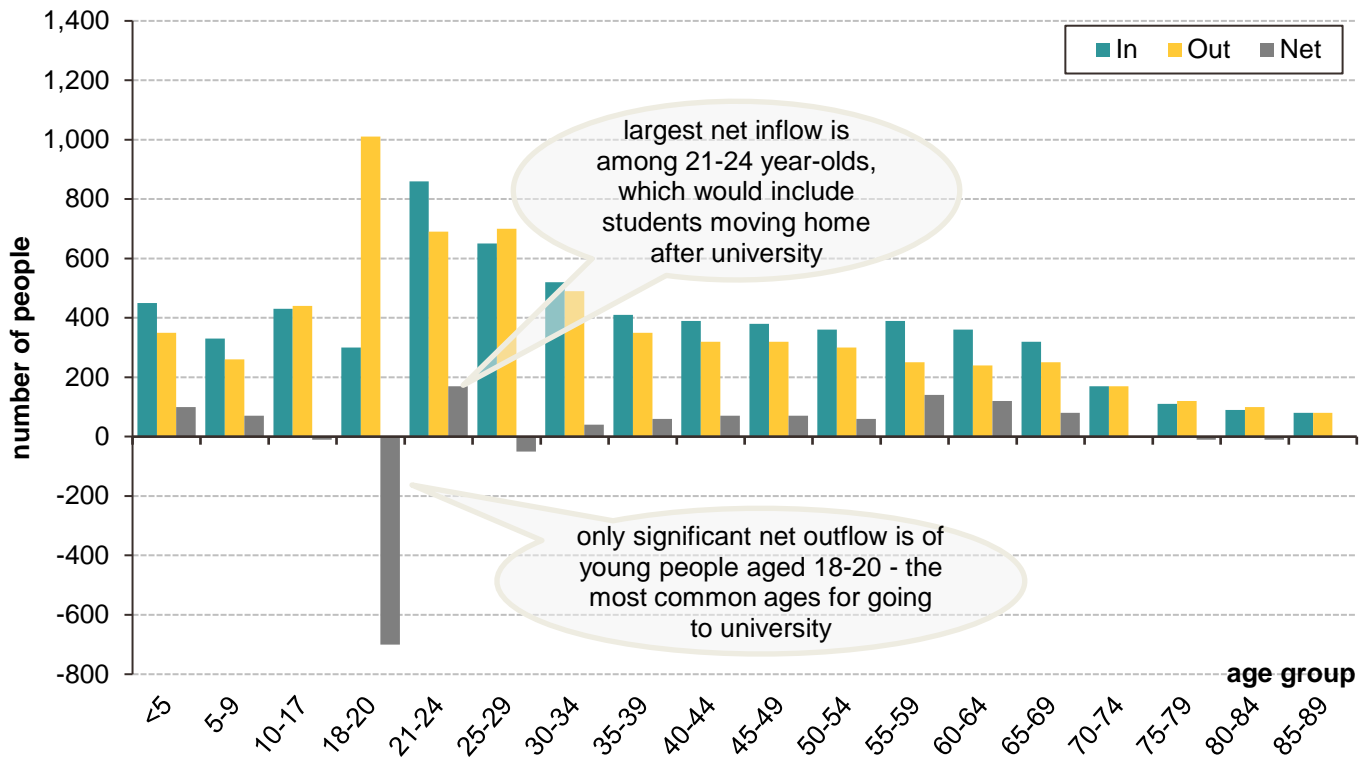
Figure 1 2016 Population Pyramid: Herefordshire (bars) and England and Wales (lines)



Data Source: Office for National Statistics 2016 mid-year estimates © Crown copyright.

While Herefordshire has a reputation for being an attractive place to retire, migration into the county by people aged of 65 over has typically been low, as illustrated in Figure 2 and Figure 3.

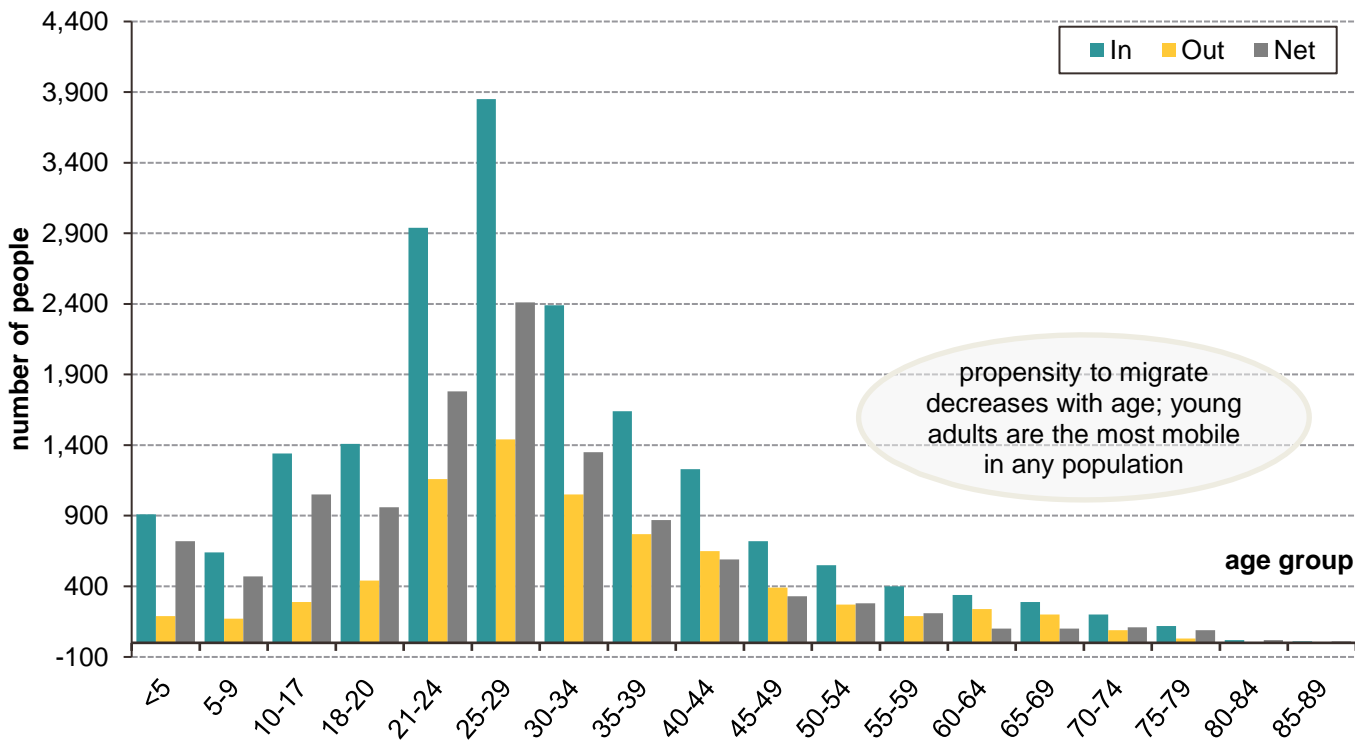
Figure 2 Migration flows between Herefordshire and the rest of the UK (average 2008/09 to 2015/16 inclusive)



Source: The Population of Herefordshire, 2018.

Data sources: Office for National Statistics 2009 to 2016 mid-year estimates © Crown copyright.

Figure 3 International migration flows into and out of Herefordshire (total migration flows 2004 to 2016 inclusive)



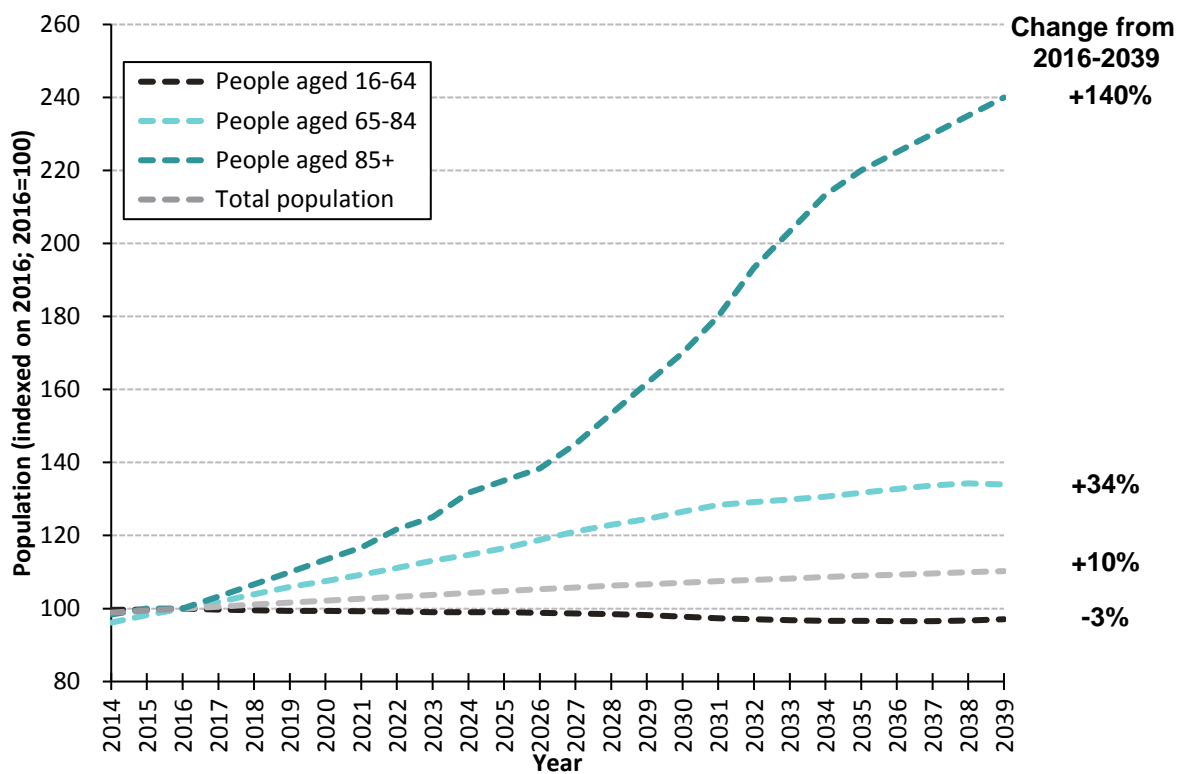
Source: The Population of Herefordshire, 2018.

Data sources: Office for National Statistics 2004 to 2016 mid-year estimates © Crown copyright.

Based on projections produced by the Office for National Statistics, the number of people aged 65-84 is projected to grow by 34 per cent (from 38,800 to 52,000 people) between 2016 and 2039. However, it is estimated that the number of people aged 85 and over will rise even more rapidly, increasing by 140 per cent (from 6,000 to 14,400 people). Over the same time period, as the proportion of older people is rising, the proportion of those aged 16-64 is expected to decrease slightly (Figure 4). While a similar shift in the population age structure is expected to affect the United Kingdom as a whole, Herefordshire's population structure is expected to age to a greater degree (Figure 5).

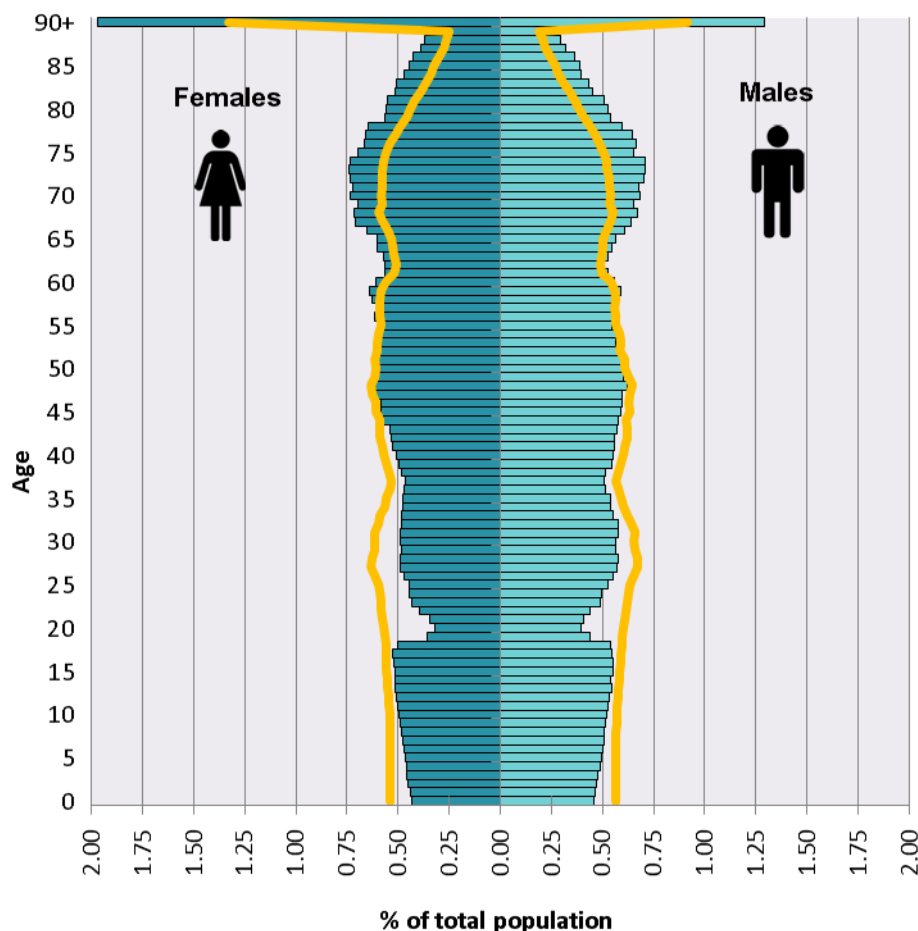
For further information on the population of Herefordshire see the [Population overview](#) page on the Facts and Figures about Herefordshire website.

Figure 4 Observed and predicted population change in Herefordshire among those of working age (16-64), people aged 65-84 and 85+



Data Sources: Office for National Statistics 2014 to 2016 mid-year estimates © Crown copyright and Projections – Office for National Statistics sub-national population projections (2014-based demographic scenario) © Crown copyright.

Figure 5 2039 Population Pyramid: Herefordshire (bars) and United Kingdom (lines)

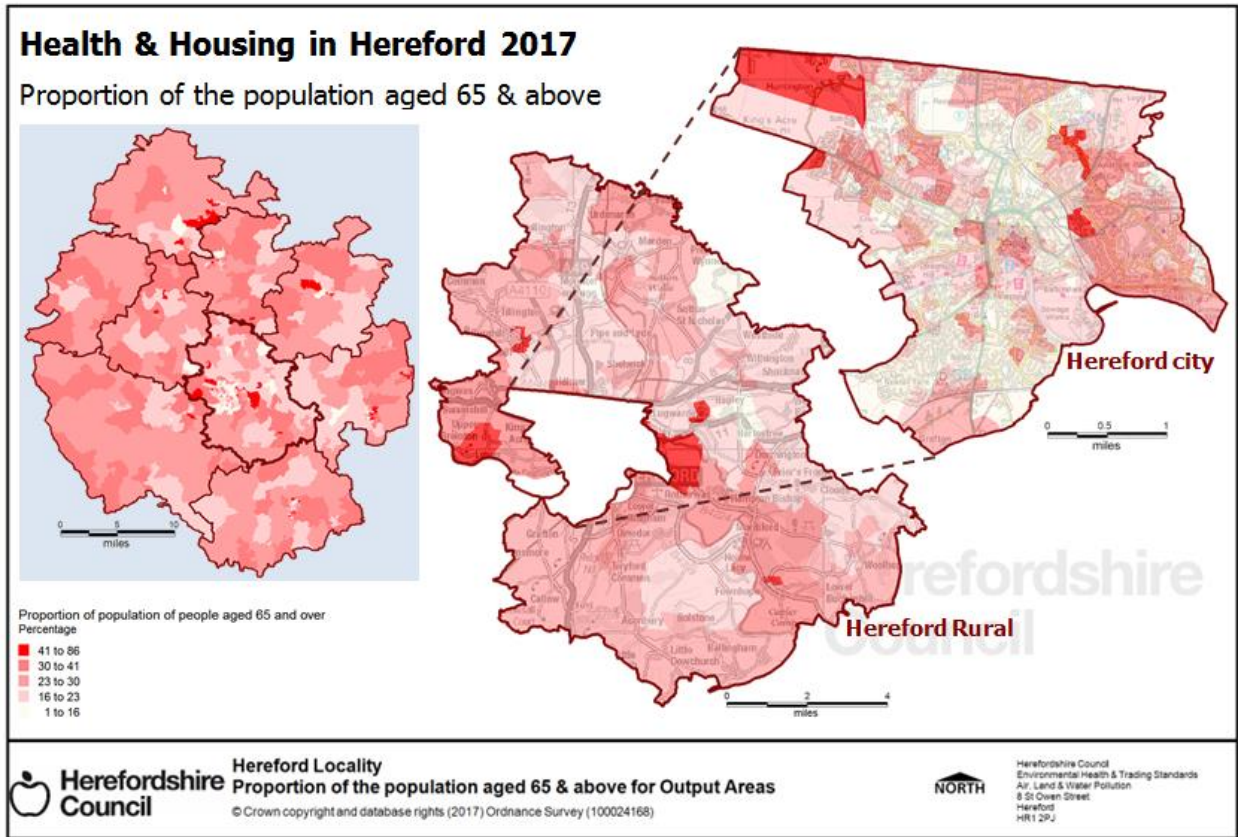


Data Sources: Office for National Statistics sub-national population projections (2014-based demographic scenario) © Crown copyright and Office for National Statistics 2014-based National Population Projections © Crown copyright.

An analysis of the Office for National Statistics 2016 annual small area population estimates indicates that in Herefordshire, 60 per cent of those aged 65 and over and 53 per cent of those aged 85 and over live in rural areas. Figure 6 is a heat map which illustrates the proportion of the population of each of Herefordshire’s output areas¹ who are aged 65 and over. As can be seen, larger proportions of people aged 65 and over are clustered in the western and eastern outskirts of Hereford City, north of Leominster, Bromyard, Ledbury, and north and south of Ross-on-Wye.

¹ An output area is a statistical geography which is based on postcodes. There are between 40 and 129 households within an output area.

Figure 6 Proportion of people age 65 and over in Herefordshire by output area



Data Source: Office for National Statistics-Annual Small Area Population Estimates © Crown Copyright 2016

Key Facts

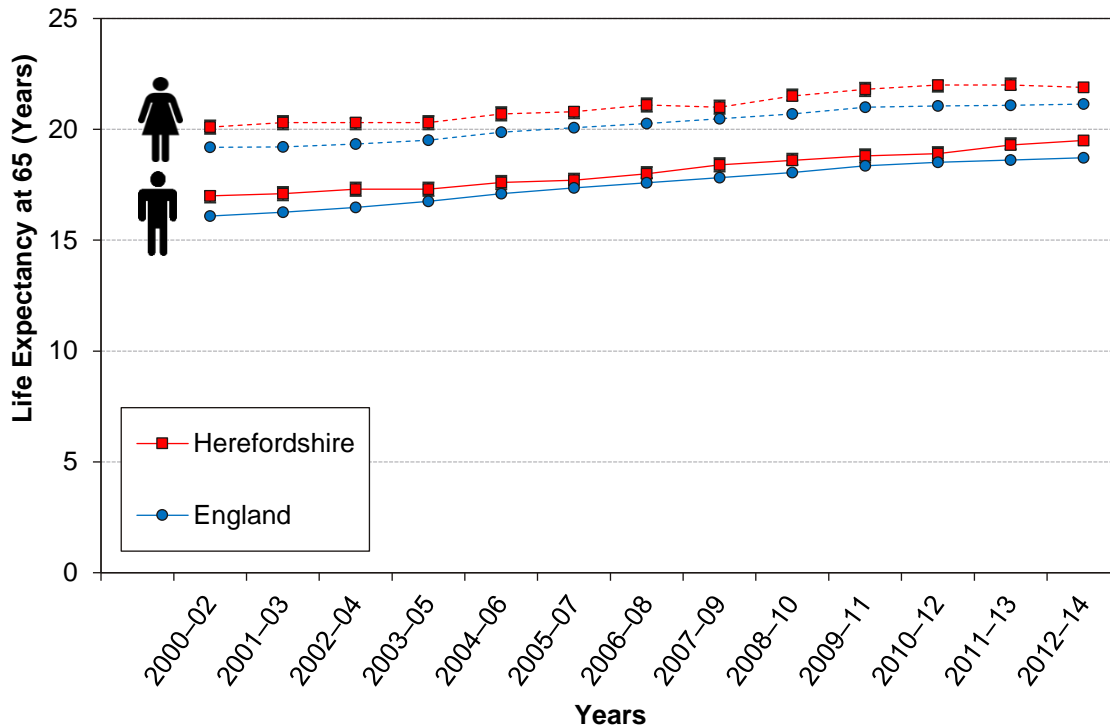
- Nationally and locally, life expectancy at the age of 65 has been increasing for both males and females. However, healthy life expectancy has not kept pace - meaning that older adults are living longer in poor health.
- On average men and women aged 65 years in Herefordshire are both expected to live 0.6 years longer than the national averages.
- In Herefordshire, men and women aged 65 years are expected to spend a smaller proportion of their remaining years in poor health (7.0 per cent and 6.2 per cent respectively) compared to the national averages.
- In Herefordshire, men and women 65 aged years are expected to spend a smaller proportion of their remaining years in poor health compared to the national averages.

LIFE EXPECTANCY AT AGE 65

In Herefordshire, between 2000-02 and 2013-15 male life expectancy at 65 years has seen a general increase from 17.0 years to 19.3 years (an increase of 13.5 per cent). A similar pattern was observed nationally, however the proportional increase over this time period was higher at 16.1 per cent. Between 2000-02 and 2013-15 inclusive male life expectancy at age 65 has been statistically significantly higher for those living in Herefordshire compared to the national average (Figure 7).

Locally, female life expectancy at age 65 has increased from 20.1 years in 2000-02 to 22.0 years in 2011-13; in 2013-15 the figure was 21.7 years. While the national average followed a similar trajectory, the Herefordshire figure remained statistically significantly higher over the time period (Figure 7).

Figure 7 Life expectancy at age 65 for females and males in Herefordshire and England between 2000-2002 and 2013-2015



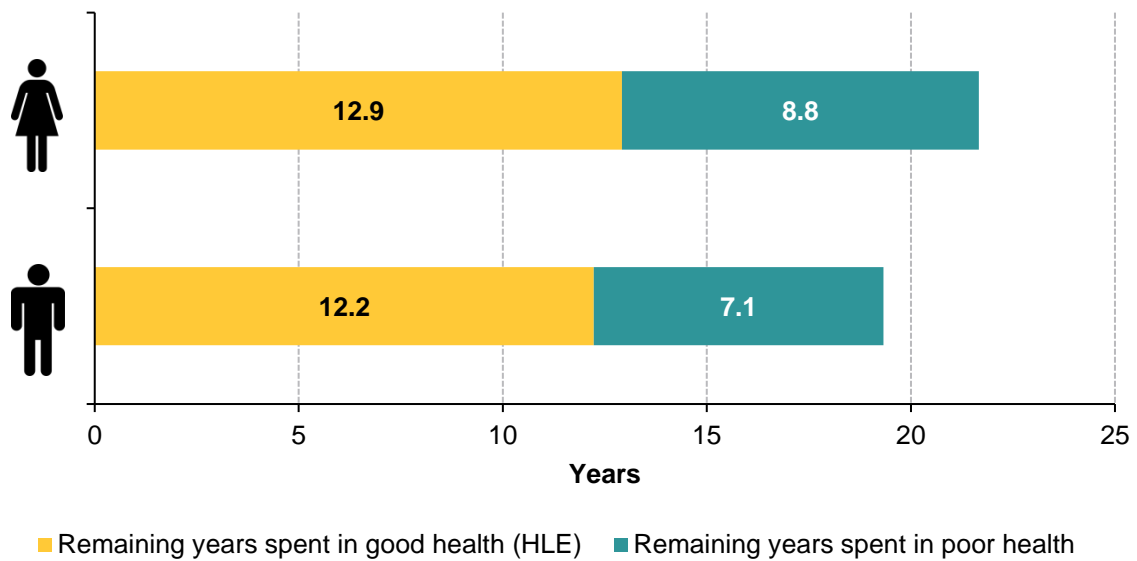
Data Source: Office for National Statistics

HEALTHY LIFE EXPECTANCY

Nationally and regionally, for both males and females at age 65, the absolute increases in life expectancy have been greater than the absolute increase in the number of years a person aged 65 can expect to live in good or fairly good self-perceived general health (healthy life expectancy). Therefore, the number of years older people are living in poor health has increased(6).

According to 2013-15 data, at age 65 males and females will on average live for a further 19.3 and 21.7 years respectively; for males 12.2, and females 12.9 of these remaining years will be spent living in good health (Figure 8). However, as females are expected to live for longer, they will spend a larger proportion of their remaining years in poor health than men (40.6 and 36.8 per cent respectively) (Table 1).

Figure 8 Life expectancy at age 65 for females and males in Herefordshire broken down by number of remaining years spent in good health (healthy life expectancy) and poor health, based on 2013-15 data



Source: Office for National Statistics

When compared to the England figure, at the age of 65 men and women in Herefordshire are expected to live for longer, and spend a smaller proportion of their remaining life in poor health (Table 1).

Table 1 Average life expectancy and healthy life expectancy at age 65, number of remaining years spent in poor health and proportion of remaining years spent in poor health for England and Herefordshire, based on 2013-15 data

	England		Herefordshire	
	Male	Female	Male	Female
Life expectancy at age 65 (years)	18.7	21.1	19.3	21.7
Healthy life expectancy at age 65 (years)	10.5	11.2	12.2	12.9
Years of remaining life spent in poor health (years)	8.2	9.9	7.1	8.8
Proportion of remaining life spent in poor health	43.8%	46.8%	36.8%	40.6%

Source: Office for National Statistics

Key Facts

- According to the English Indices of Deprivation 2015, in Herefordshire, 13 per cent of people aged 60 and over are living in income deprivation (approximately 7,100 people). The areas with the highest proportion of people aged 60 and over living in income deprivation are located in Hereford city (both north and south) and north Leominster.
- There is an indication that poverty among older people living in Herefordshire is decreasing, evidenced by the fact that the proportion of people aged 65 and over claiming attendance allowance is decreasing.
- However, fuel poverty is estimated to affect 16.6 per cent of households in Herefordshire, a higher percentage than nationally (11 per cent) and regionally (13.5 per cent).

For the purposes of this report, deprivation refers to unfulfilled need in any aspects of economic or social well-being caused by a lack of resources.

The English Indices of Deprivation provide a means of identifying the most and least deprived areas in England and to compare whether one area is more deprived than another. At the local level the indices are most commonly used for the effective targeting of resources. However, it is important to note that not everyone who lives in an area of high deprivation will be deprived and not all deprived people live in areas of deprivation.

The Indices of Deprivation 2015 is the most recent release. [The Indices of Deprivation 2015: Findings for Herefordshire](#) is a comprehensive report providing analysis of the Indices of Deprivation 2015 data for Herefordshire. Relevant sections of this report are summarised in brief below.

The Indices of Deprivation are applied to small geographies called Lower Super Output Areas (LSOAs), of which there are 32,844 in England. Each LSOA is given a score that is used to rank

them in order from one (the most deprived) to 32,844 (the least deprived) for seven different domains of deprivation:

- income,
- employment,
- education,
- skills & training,
- health & disability,
- crime,
- barriers to housing and services and,
- living environment.

The seven domains are combined, using appropriate weights, to produce an overall measure of relative deprivation - the index of multiple deprivation (IMD).

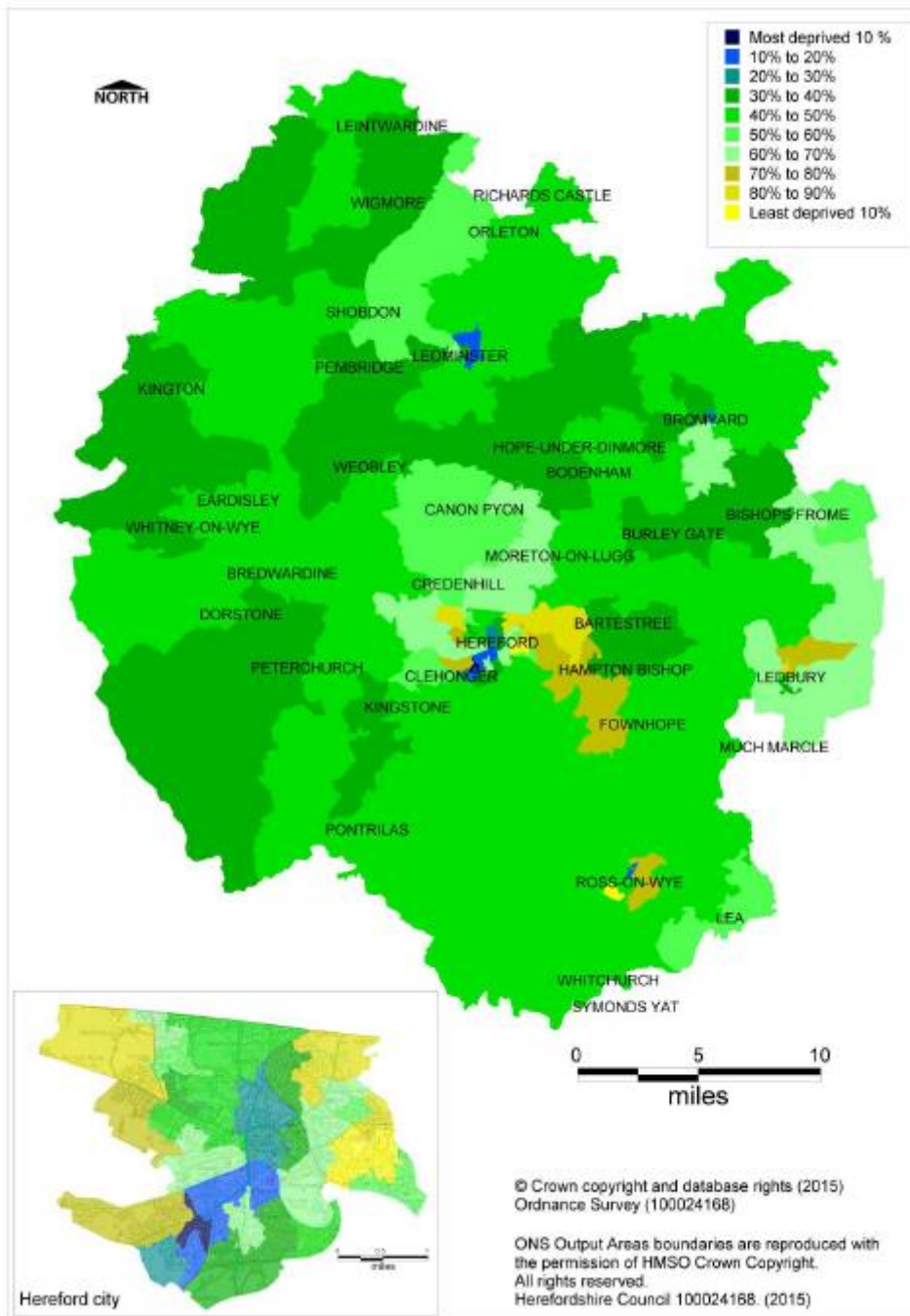
OVERALL INDEX OF MULTIPLE DEPRIVATION

Figure 9 is a heat map illustrating the IMD decile for each of Herefordshire's 116 LSOAs.

Out of Herefordshire's 116 LSOAs, twelve were among the 25 per cent most deprived nationally (Table 2). Five of these areas are in south Hereford, two in north Hereford, three in Leominster, one in Ross-on-Wye and one in Bromyard. 'Golden Post - Newton Farm' remains the most deprived area in the county – the only LSOA to be in the 10 per cent most deprived nationally. Figure 10 provides a spatial representation of the twelve most deprived LSOAs in Herefordshire.

Nine of Herefordshire's LSOAs are among the 25 per cent *least* deprived nationally. These areas include parts of Tupsley, Aylestone and Kings Acre in the north of Hereford city, the rural area around Bartestree and Lugwardine to the east of the city, and parts of Ross-on-Wye and Ledbury.

Figure 9 Distribution of the IMD 2015 by national decile for Herefordshire LSOAs



Source: *The Indices of Deprivation 2015: Findings for Herefordshire, 2016.*

https://factsandfigures.herefordshire.gov.uk/media/45872/the-indices-of-deprivation-2015-summary-report_10.pdf

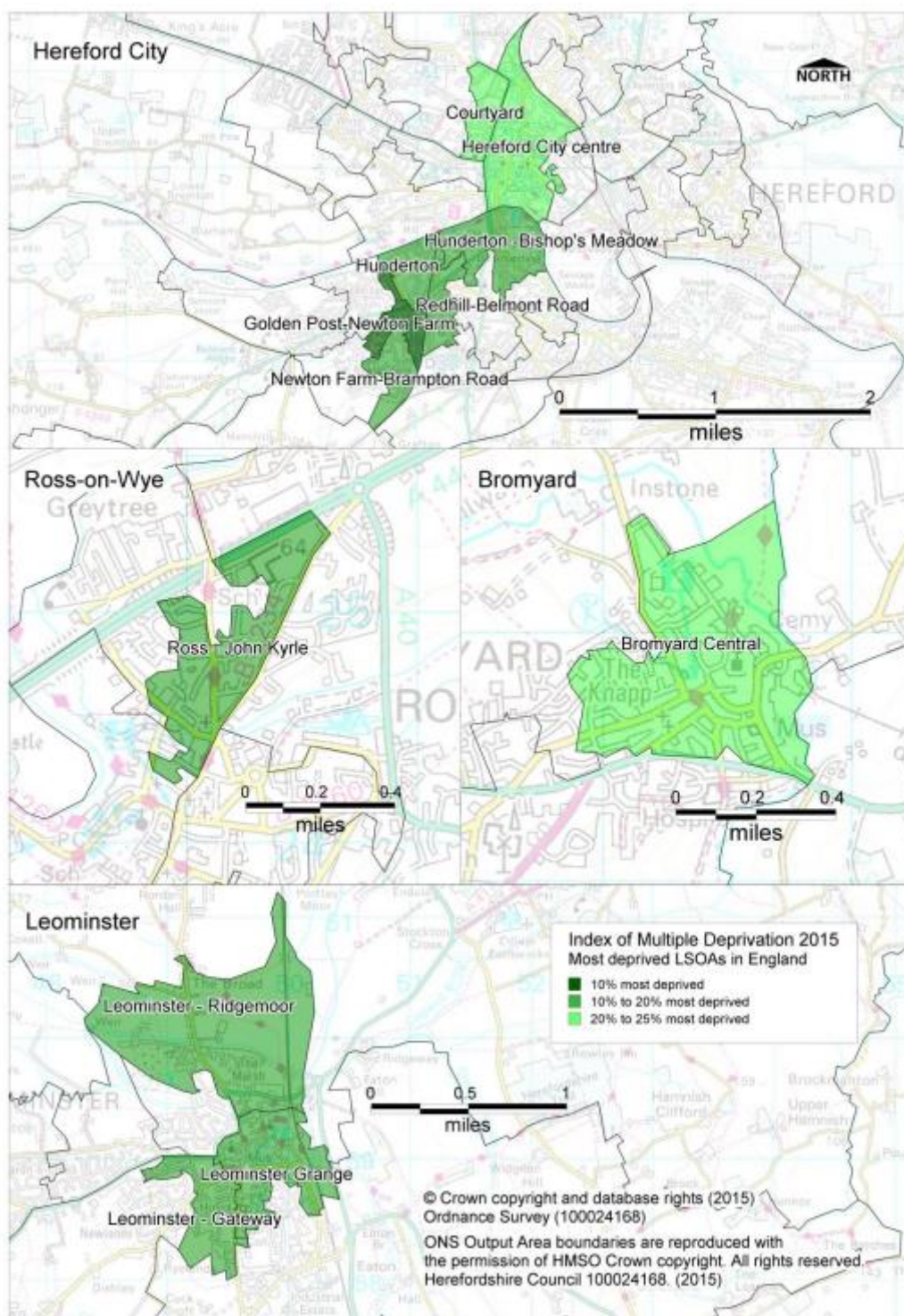
Table 2 Lower super output areas in Herefordshire among the most deprived nationally according to the 2015 index of multiple deprivation (IMD)

LSOA name	2015 Ward(s)	Sub-locality	ID 2015 percentile - most deprived out of all LSOAs in England (ID 2010 percentile)
Golden Post - Newton Farm	Hinton & Hunderton; Newton Farm	South Hereford	Top 10% (Top 10%)
Leominster - Ridgemoor	Leominster North & Rural	Leominster town	Top 20% (Top 20%)
Redhill - Belmont Road	Hinton & Hunderton; Red Hill	South Hereford	Top 20% (Top 20%)
Hunderton	Hinton & Hunderton; Newton Farm	South Hereford	Top 20% (Top 20%)
Leominster Grange	Leominster East; Leominster South	Leominster town	Top 20% (Top 20%)
Bishop's Meadow - Hunderton	Hinton & Hunderton; Red Hill; Saxon Gate	South Hereford	Top 20% (Top 20%)
Newton Farm - Brampton Road	Newton Farm	South Hereford	Top 20% (Top 20%)
Leominster - Gateway	Leominster East; Leominster South	Leominster town	Top 20% (less deprived)
Ross - John Kyrle	Ross North; Ross West	Ross town	Top 20% (Top 25%)
Hereford City centre	Central; Widemarsh	North Hereford	Top 25% (less deprived)
Courtyard	Widemarsh	North Hereford	Top 25% (less deprived)
Bromyard Central	Bromyard Bringsty; Bromyard West	Bromyard town	Top 25% (less deprived)

Source: *The Indices of Deprivation 2015: Findings for Herefordshire, 2016.*

https://factsandfigures.herefordshire.gov.uk/media/45872/the-indices-of-deprivation-2015-summary-report_10.pdf

Figure 10 Maps showing the areas of Herefordshire that are among the most deprived nationally according to the IMD 2015.



Source: *The Indices of Deprivation 2015: Findings for Herefordshire, 2016.*

https://factsandfigures.herefordshire.gov.uk/media/45872/the-indices-of-deprivation-2015-summary-report_10.pdf

INCOME DEPRIVATION AFFECTING OLDER PEOPLE

Income deprivation among older people is a sub-domain of the income domain. The score for the income deprivation affecting older people supplementary index indicates the proportion of adults aged 60 or over living in income deprived households.

According to the Indices of Deprivation 2015, there were approximately 7,100 older people living in income deprivation, 13 per cent of all people aged 60 or over. Fifteen LSOAs are among the 25 per cent most deprived in England (Table 3 and Figure 11). Of these, eight areas fall within the 20 per cent most deprived (the majority of which are in either north or south Hereford, one is in Leominster); a further seven are in the 25 per cent most deprived. 'Leominster – Ridgemoor' and Hereford city's 'Hunderton' and 'College Estate' had the greatest proportions of older people living in income deprivation at 34 per cent each.

There are 23 LSOAs that are among the 25 per cent least deprived in England, with nine per cent or fewer of those aged 60 and over living in income deprived households within these LSOAs. Just under two thirds of these LSOAs are scattered around the rural areas of the county. Of the remainder, the greatest number (six LSOAs) are in the north of Hereford city, including 'Ledbury Road East', 'Kings Acre', 'Huntington', 'Broomy Hill', 'Kings Acre-Green Lane', 'Old Eign Hill' and 'St Paul's'.

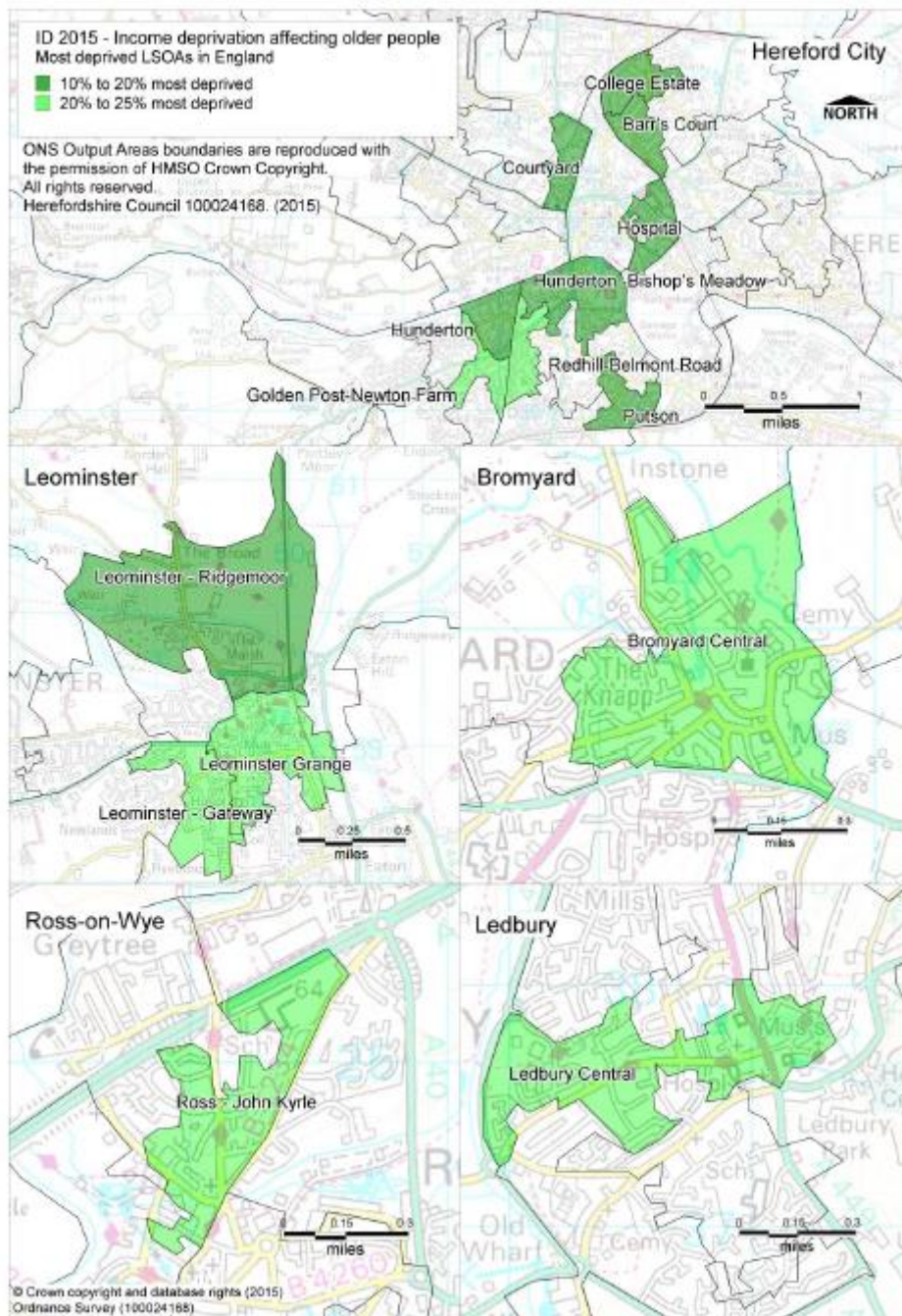
Table 3 Lower super output areas in Herefordshire that are among the most deprived in England according to the income deprivation affecting older people index

Lower Super Output Area name	2015 Ward(s)	Sub-locality	% living in income deprived households	ID 2015 percentile - most deprived out of all LSOAs in England (ID 2010 percentile)
Leominster - Ridgemoor	Leominster North & Rural	Leominster town	34%	Top 20% (Top 20%)
Hunderton	Hinton & Hunderton; Newton Farm	South Hereford	34%	Top 20% (Top 20%)
College Estate	College; Holmer	North Hereford	34%	Top 20% (Top 20%)
Bishop's Meadow - Hunderton	Hinton & Hunderton; Red Hill; Saxon Gate	South Hereford	33%	Top 20% (Top 20%)
Courtyard	Widemarsh	North Hereford	31%	Top 20% (Top 20%)
Putson	Hinton & Hunderton; Saxon Gate	South Hereford	31%	Top 20% (Top 20%)
Hospital	Central	North Hereford	30%	Top 20% (less deprived)
Barr's Court	College	North Hereford	29%	Top 20% (Top 25%)
Leominster - Gateway	Leominster East; Leominster South	Leominster town	28%	Top 25% (less deprived)
Golden Post - Newton Farm	Hinton & Hunderton; Newton Farm	South Hereford	28%	Top 25% (Top 25%)
Leominster Grange	Leominster East; Leominster South	Leominster town	28%	Top 25% (Top 20%)
Redhill - Belmont Road	Hinton & Hunderton; Red Hill	South Hereford	28%	Top 25% (Top 20%)
Bromyard Central	Bromyard Bringsty; Bromyard West	Bromyard town	27%	Top 25% (Top 20%)
Ross - John Kyrle	Ross North; Ross West	Ross town	27%	Top 25% (Top 20%)
Ledbury Central	Ledbury North; Ledbury West	Ledbury town	26%	Top 25% (less deprived)

Source: *The Indices of Deprivation 2015: Findings for Herefordshire, 2016.*

https://factsandfigures.herefordshire.gov.uk/media/45872/the-indices-of-deprivation-2015-summary-report_10.pdf

Figure 11 Maps showing the areas of Herefordshire that are among the most deprived in England according to the income deprivation affecting older people index



Source: *The Indices of Deprivation 2015: Findings for Herefordshire, 2016.*

https://factsandfigures.herefordshire.gov.uk/media/45872/the-indices-of-deprivation-2015-summary-report_10.pdf

ATTENDANCE ALLOWANCE

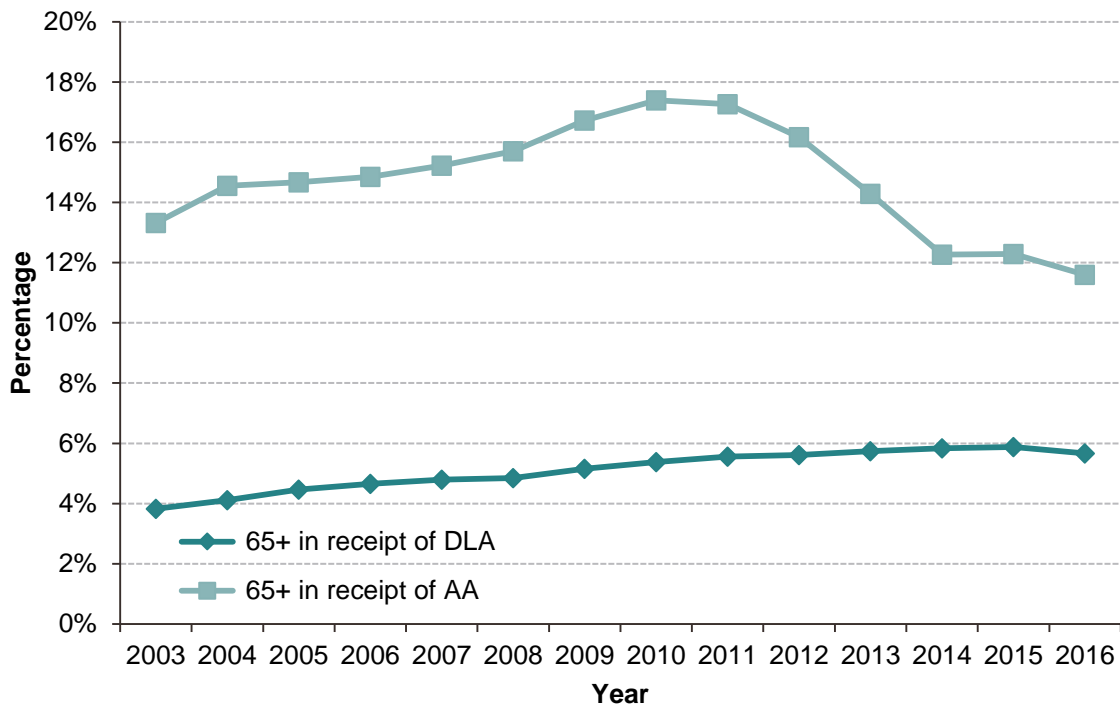
Attendance allowance is a tax-free benefit paid to people aged 65 and over who need help to look after themselves because of physical or mental disability. The purpose of the benefit is to provide financial support to help older people with the financial costs associated with living with disability. Attendance allowance is paid at two rates, as of October 2017 these are £55.65 per week for people who require assistance in the day and £83.10 per week for those who require assistance in the day and at night.

Research undertaken by the Department of Work and Pensions (DWP) indicates that older people in receipt of attendance allowance are more likely to be female (65.0 per cent), aged over 80 (69.5 per cent), receive the benefit for five years or more (47.3 per cent), report arthritis as their main disabling condition (31.5 per cent)(7).

While attendance allowance is not a means tested benefit, research indicates that claimants have lower incomes than their non-claimant counterparts(7). Therefore, claim rates may be used as a proxy indicator of the health and dependency among people aged 65 and over who have a low income. The proportion of people aged 65 and over in receipt of attendance allowance forms part of the deprivation top-up in the relative needs formula for Adult Social Care(8).

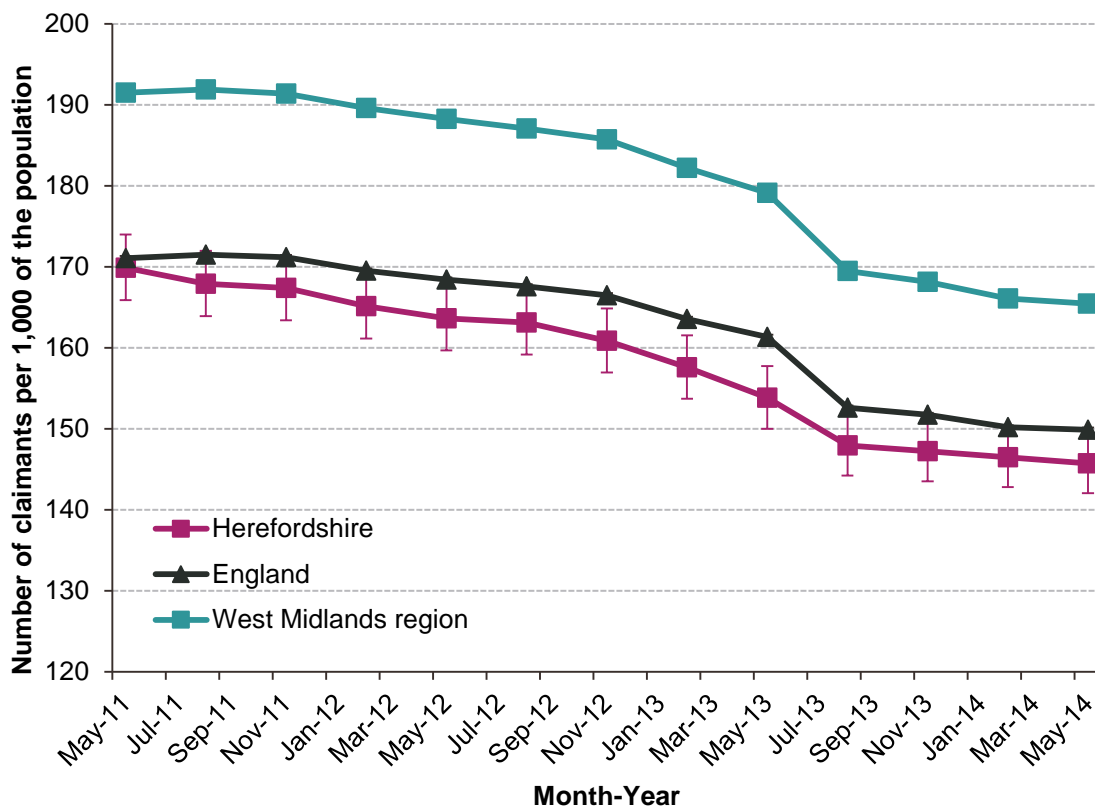
In Herefordshire, in February 2017 there were 5,300 people aged 65 and over receiving attendance allowance, with the total number of attendance allowance recipients remaining relatively static since 2014. However, the rate of claiming has been in decline since 2010 when 17.3 per cent of those aged 65 and over were claiming attendance allowance, in 2016 the figure was 11.6 per cent (Figure 12). Overall claimant rate (number of claimants per 1,000 of the population) has also been decreasing over this period, mirroring the national and regional trend. Across all regions, a noteworthy decrease in the attendance allowance claimant rate was observed in 2013. The Herefordshire rate has remained similar to the figure for England but significantly lower than that for the West Midlands (Figure 13).

Figure 12 The percentage of people aged 65 and over in receipt of disability living allowance (DLA) and attendance allowance (AA) in Herefordshire, 2003-2016



Data Source: Department for Work and Pensions, 2017 and ONS, 2017.

Figure 13 Number of people aged 65 and over receiving attendance allowance per 1,000 of the population in Herefordshire, the West Midlands, and England, 2011-2014



Data Source: Public Health England, 2017.

DISABILITY LIVING ALLOWANCE/ PERSONAL INDEPENDENCE PAYMENT

Disability living allowance (DLA), also known as Personal Independence Payment (PIP), is a tax-free benefit paid to people aged 16-64 who need help to look after themselves because of physical or mental disability. People in receipt of DLA are entitled to continue to claim DLA beyond the age of 64. However, people who receive DLA are not eligible for attendance allowance. In Herefordshire, between 2003 and 2016, there has been a steady increase in the percentage of people aged 65 and over receiving DLA (from 3.8 to 5.8 per cent). However, there is no indication that this explains the decrease in the percentage of attendance allowance claimants observed between 2011 and 2016 (Figure 12).

PENSION CREDIT

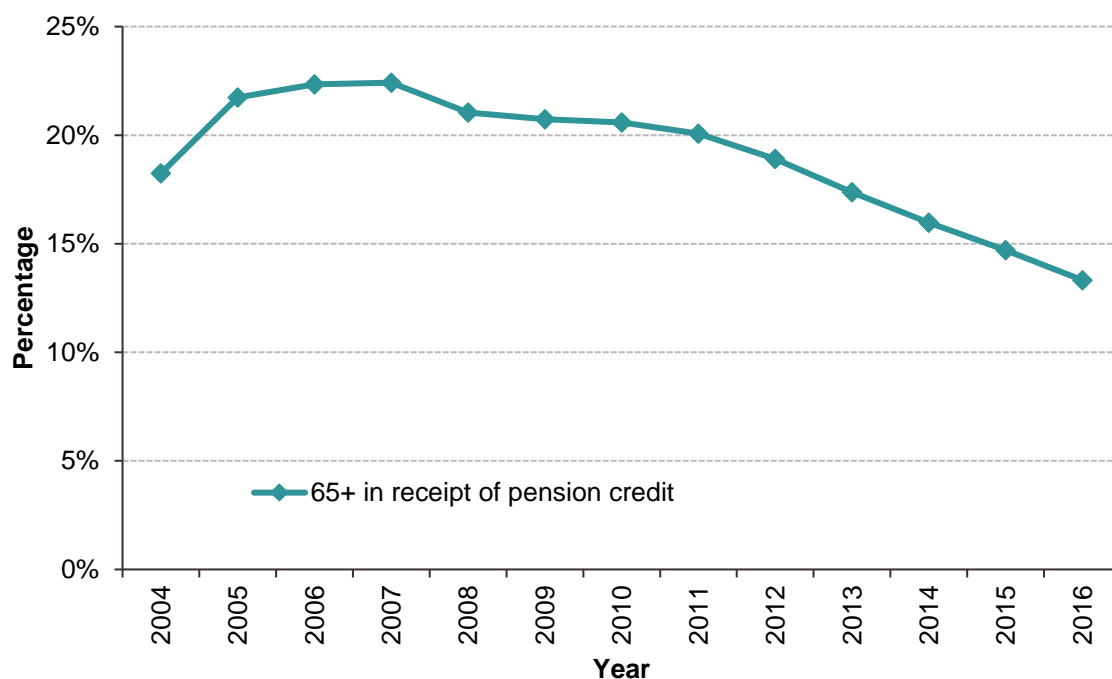
Pension credit is a tax-free income related benefit which is intended to provide financial support to people of state pension age with low-income. Similar to attendance allowance, pension credit claimant rates are a proxy indicator of deprivation among older people and form part of the deprivation top-up in the relative needs formula for Adult Social Care(8).

There are two parts to the pension credit:

1. Guarantee Credit- which tops up weekly income to a guaranteed level, £159.35 (for single people) or £243.25 (for couples).
2. Savings Credit- an extra payment for people who saved some money towards their retirement, for example a pension. People who turned 65 after the 6th of April 2016 are not eligible for this credit payment. Savings credit payments are a maximum of £13.20 per week (for single people) or £14.90 per week (for couples).

In February 2017 there were 5,460 people in Herefordshire in receipt of one or more pension credit payment. In Herefordshire, between 2008 and 2016 there has been a steady decline in the percentage of people aged 65 and over in receipt of one or more pension credit payment (Figure 14). This suggests that the overall level of poverty among pensioners living in Herefordshire is reducing.

Figure 14 The percentage of people aged 65 and over in receipt of pension credit in Herefordshire, 2003-2016



Data Source: Department for Work and Pensions, 2017 and ONS, 2017.

FUEL POVERTY

Fuel poverty is defined as a household that has required fuel costs that are above average, and after spending that amount, are left with an income that is below the official poverty line(9). This definition is based on the Low Income, High Cost (LIHC) methodology which became the official fuel poverty indicator in 2013.

Whether a household is in fuel poverty is determined by the interplay of three key factors:

1. the energy efficiency of the property
2. the household income
3. fuel/energy prices(9)

WHO IS AFFECTED BY FUEL POVERTY?

National analysis of fuel poverty data indicates that households in fuel poverty are more likely to be large, older, owner occupied, and occupied by families(10).

Herefordshire, like other rural counties, has a considerable number of households without access to the mains gas grid. [The Healthy Housing Survey](#) (2011)(11) identified that mains gas was available to only 69 per cent of properties in Herefordshire, compared to 87 per cent nationally. Being off the mains gas grid increases the risk of a household being in fuel poverty considerably as the fuel options for off-grid homes are often more expensive and less energy efficient than gas(12). Furthermore, in addition to rural households being more likely to be off the mains gas

grid, they are also more likely to be living in older and less thermally efficient dwellings, and to have a lower than average household income(12).

WHAT ARE THE EFFECTS OF FUEL POVERTY?

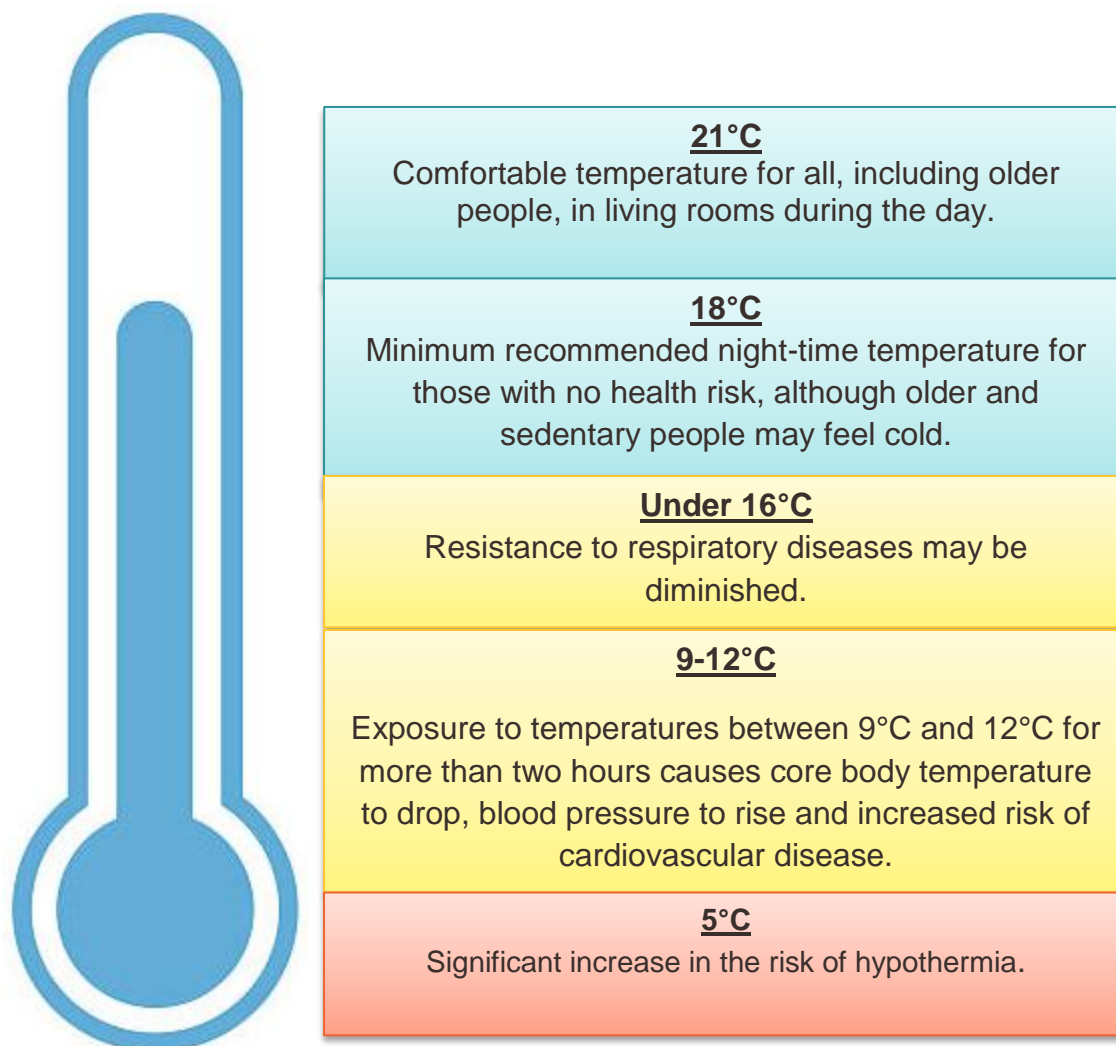
Fuel poverty adversely impacts upon health and wellbeing through:

1. associated financial hardship,
2. health conditions such as increased risk of respiratory illness, increased blood pressure, and hypothermia, all of which can result in mortality.

The physiological effects of exposure to cold room temperatures are well documented and temperature dependent (Figure 15). Cold homes are known to contribute to excess winter deaths(13). Further information on excess winter deaths is available in the Excess winter deaths section (page[139](#)) of this report.

Older people, children and people with disabilities and long-term illnesses are particularly vulnerable to the adverse effects of fuel poverty. Many older people spend a lot of time in their homes. Therefore, low room temperatures can have a substantial impact upon their health. Fuel poverty can also exacerbate the social isolation felt by many older households, making it more difficult for them to afford to go out, or fearful of going out knowing they will come in, already feeling cold, to a cold home; or reluctant to invite friends into a cold house. In addition cold causes other discomfort for older people, for example worsening arthritic pains or contributing to a general feeling of illness(14).

Figure 15 The impact of various room temperatures upon health

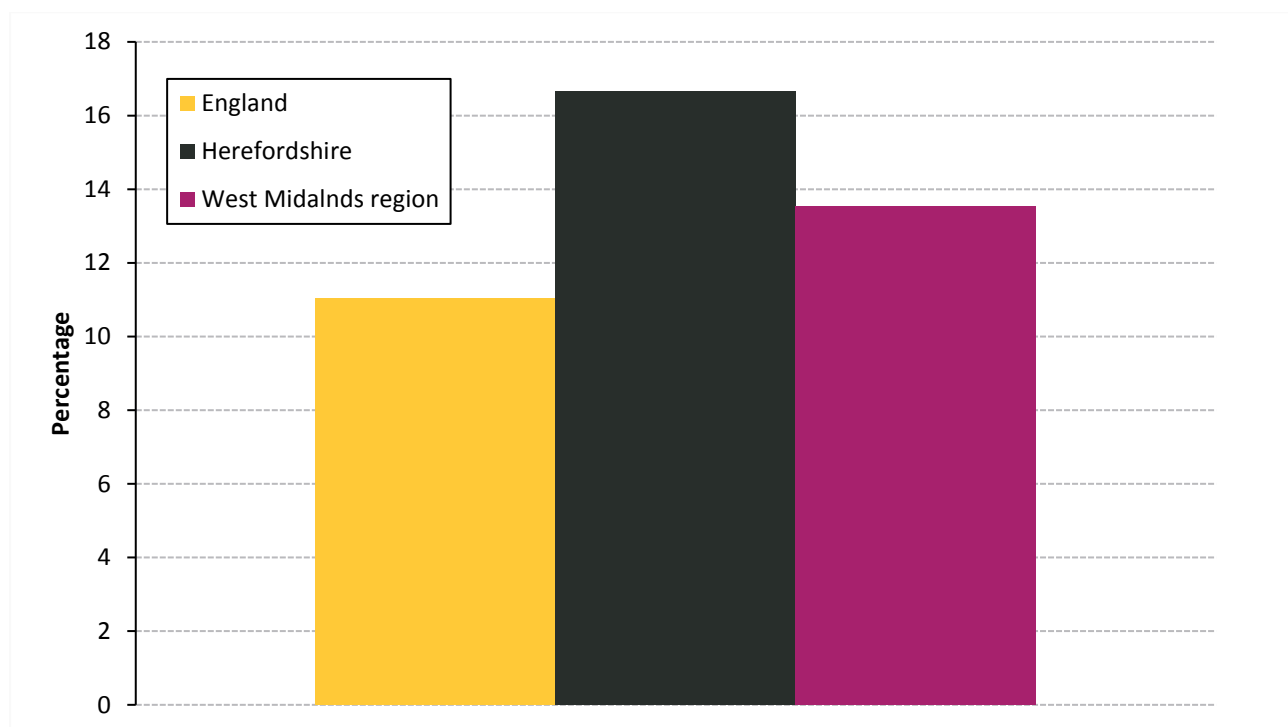


Data Sources: Fuel Poverty and Health – A Guide for Primary Care Organisations, and Public Health and Primary Care Professionals. (2003) London: National Heart Forum.

LOCAL DATA

In 2015, there were an estimated 79,800 households in Herefordshire, 16.6 per cent of which were in fuel poverty (13,300), which is a higher proportion than in the West Midlands (13.5 per cent) and England (11.0 per cent) (Figure 16). The majority of households affected by fuel poverty are located in rural areas.

Figure 16 Percentage of homes in fuel poverty (low Income, high cost methodology) in Herefordshire, the West Midlands and England, 2015



Data Sources: Public Health England, 2017 and Department for Business, Energy and Industrial Strategy, 2017.

LOCAL ACTION

In 2016, Herefordshire Council published the [Herefordshire Affordable Warmth Strategy 2016-19](#)(5). The strategy provides further insight into fuel poverty in Herefordshire, and details the actions being taken to tackle the issue.

DISCUSSION POINTS

- Attendance allowance claimant rates are a proxy-indicator of wealth among people aged 65 and over, with higher claimant rates signifying higher levels of deprivation(8). Local claimant rates for attendance allowance have declined suggesting that on average, poverty among people aged 65 and over living in Herefordshire is in decline. Attendance allowance claimant rates are lower locally than regionally and nationally. In addition, home ownership among those aged 65 and over is higher in Herefordshire than the West Midlands and England². Taken together, this suggests that on average older people in Herefordshire are relatively well-off.

² However, a considerable number of home owners may be asset rich, yet cash poor, making it difficult for them to afford to look after or heat their homes.

- While on average, older people living in Herefordshire are relatively well-off, there are specific pockets of the county that are identified as having high levels of income deprivation affecting people 60 years of age and over. A total of 15 out of 166 lower super output areas in Herefordshire are among the 25 per cent most deprived in England in terms of income deprivation affecting people aged 60 and over (Table 3, page [30](#) and Figure 11, page [31](#)). It is estimated that in Herefordshire, some 7,100 people (13 per cent of people aged 60 and over) are living in income deprivation.
- A larger proportion of homes in Herefordshire (16.6 per cent) are in fuel poverty than in the West Midlands (13.5 per cent) and England (11.0 per cent). Older people are more susceptible to ill health (including the risk of death in the winter) as a result of fuel poverty. In Herefordshire, an estimated 60 per cent of people aged 65 and over live in rural parts of the county, where access to the mains gas grid may not be possible, and properties with poor thermal efficiency are more common, both of which increase the risk of fuel poverty. Therefore, the detrimental effects of fuel poverty pose a considerable threat to the health and wellbeing of older people living in Herefordshire.

RECOMMENDATIONS

- Consider undertaking research activities to identify and deliver targeted interventions to individuals at risk of experiencing poor health outcomes as a result of living in cold homes, giving consideration to how best to utilise available health data and the capacity for existing services (public, private and voluntary sector) to facilitate identification of at risk individuals and to disseminate interventions.
- Implement actions outlined in the [Herefordshire Affordable Warmth Strategy 2016-19](#)(5).

Key Facts

- In Herefordshire, a larger proportion of people aged 65 and over own their own homes compared to nationally, suggesting relative levels of wealth among older people in the county.
- Data from the 2011 census indicated that 14.3 per cent of Herefordshire's households were occupied by a single person aged 65 and over, compared to the England figure of 12.4 per cent.
- Living alone increases the risk of loneliness and associated poor health and wellbeing. Feeling lonely becomes more common with age and is associated with increased risk of a number of health conditions.

In 2012, Herefordshire Council commissioned a piece of research to provide a comprehensive overview of the housing and support needs of older people living in the county. Readers are referred to this [report](#) for in depth analysis and commentary on the housing needs of older people.

HOUSING TENURE

Housing tenure refers to the legal and financial arrangements through which an individual has the right to occupy a dwelling. In the United Kingdom, housing tenure is often used as an indicator of social standing, with house ownership indicating relative wealth and public sector rental being associated with higher levels of deprivation, worse self-reported health and higher mortality rates(15).

In the United Kingdom, since the 1990s owner occupancy has seen a gradual decline among those aged 16 to 44 years of age. However, it has remained relatively high and stable among those aged 65 and over(16). According to the 2011 Census, there are a higher proportion of households that are owner occupied in Herefordshire (68 per cent) compared to England and Wales overall (64 per cent).

In Herefordshire, among people aged 65 and over, a smaller proportion are living in social rented accommodation compared to nationally, and a higher proportion of people live in their own homes, and private rented or rent free accommodation (Table 4). The proportion of people owning their own home in Herefordshire was found to vary with age, with 80.7 per cent of those aged 65 to 74, 79.2 percent of those aged 75-84 and 72.7 per cent of those 85 and over being owner occupiers (Figure 17).

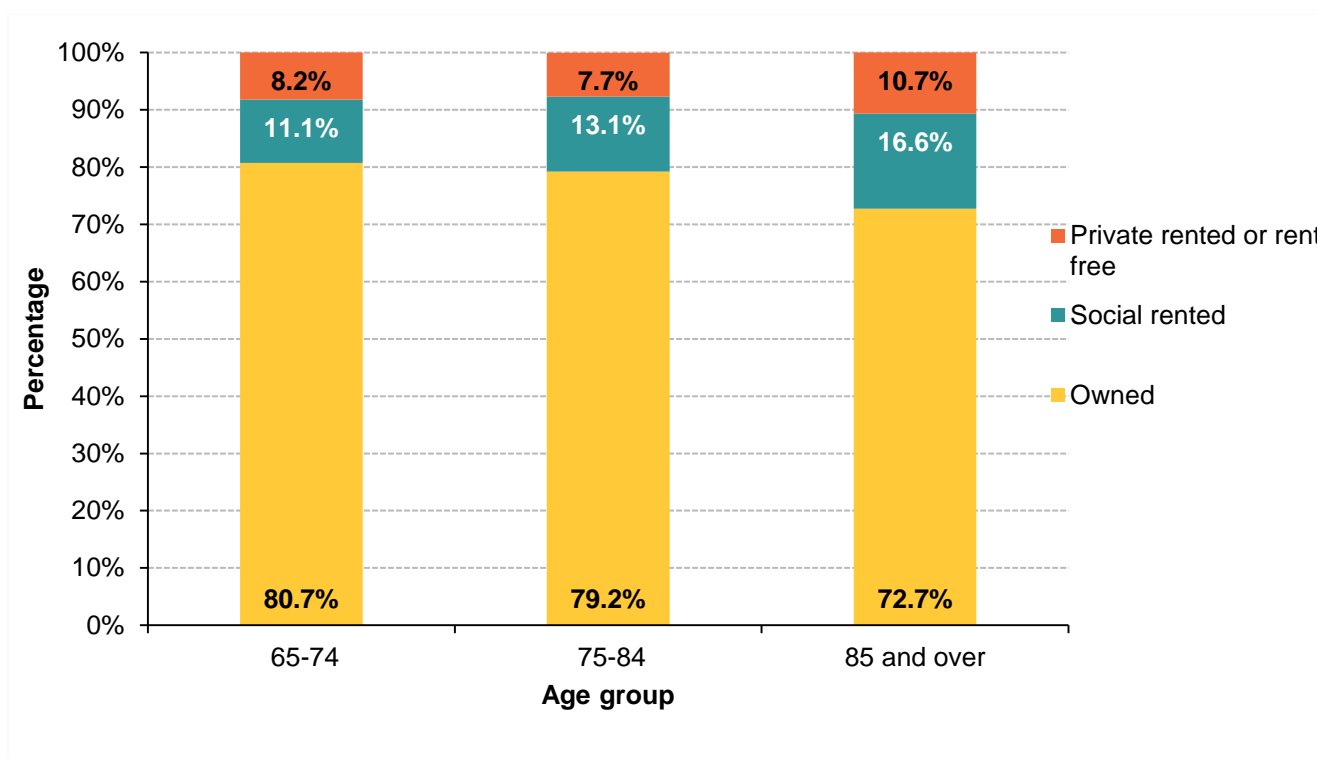
Table 4 Proportion of people aged 65-74, 75-84 and 85 and over by tenure type in Herefordshire and England

Tenure Type	People aged 65-74		People aged 75-84		People aged 85 and over	
	Herefordshire	England	Herefordshire	England	Herefordshire	England
Owned	80.7%	76.3%	79.2%	74.8%	72.7%	68.2%
Social rented	11.1%	17.3%	13.1%	19.2%	16.6%	23.7%
Private rented or living rent free	8.2%	6.4%	7.7%	6.0%	10.7%	8.2%

Data Source: Office for National Statistics, Census 2011.

Numbers in the table may not total to 100 per cent due to rounding.

Figure 17 Proportion of people aged 65 and over by housing tenure in Herefordshire



Data Source: Office for National Statistics, Census 2011.

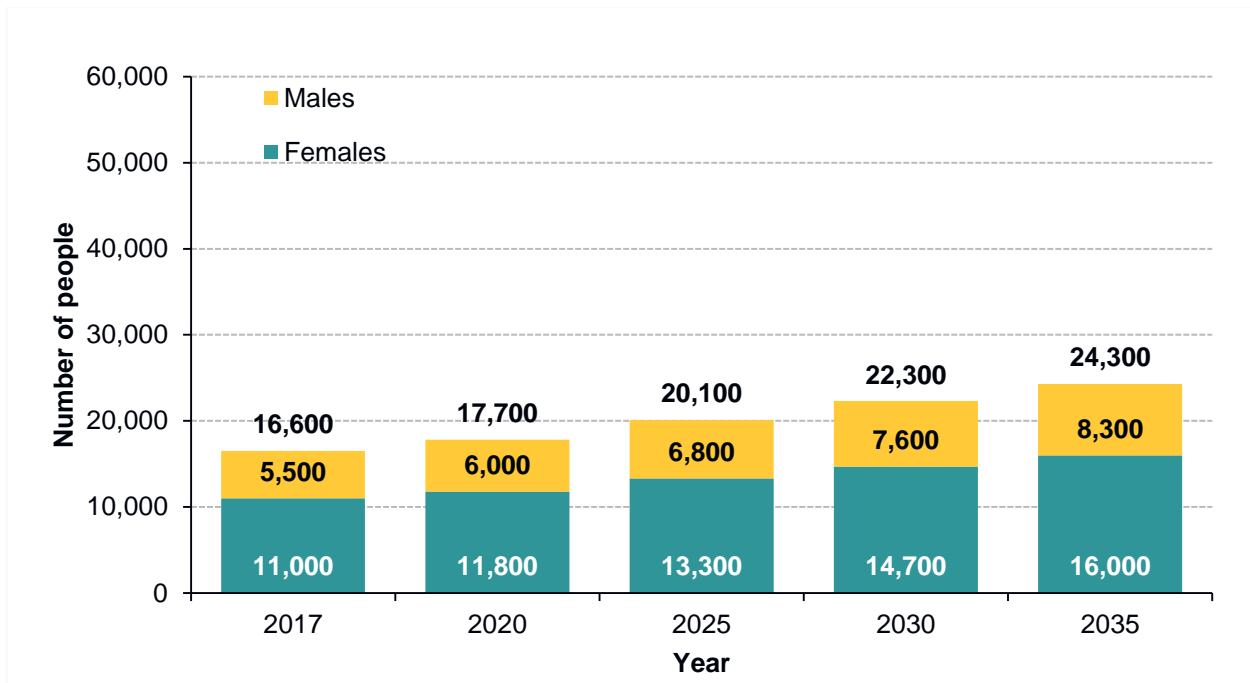
LIVING ALONE

After controlling for the effect of other factors researchers have found that living alone is associated with multiple falls, functional impairment, poor diet, smoking, risk of social isolation, and three self-reported chronic conditions; arthritis and/or rheumatism, glaucoma, and cataracts(17).

According to the 2011 Census, in Herefordshire there were 11,209 households with a single occupant who was aged 65 and over, 14.3 per cent of all of Herefordshire’s households, compared to 12.4 per cent of households in England and Wales.

Estimates produced by The Institute of Public Care(18) suggest that in 2017 there were 16,600 older people living alone in Herefordshire, with a greater proportion (67 per cent) being female. Estimates suggest that the number of older people living alone in Herefordshire will increase by approximately 47per cent to 24,300 people by 2035 (Figure 18).

Figure 18 Number* of people aged 65 and over predicted to live alone in Herefordshire by gender, 2017-2035



Data Source: INSTITUTE OF PUBLIC CARE. Projecting Older People Population Information System, 2017.

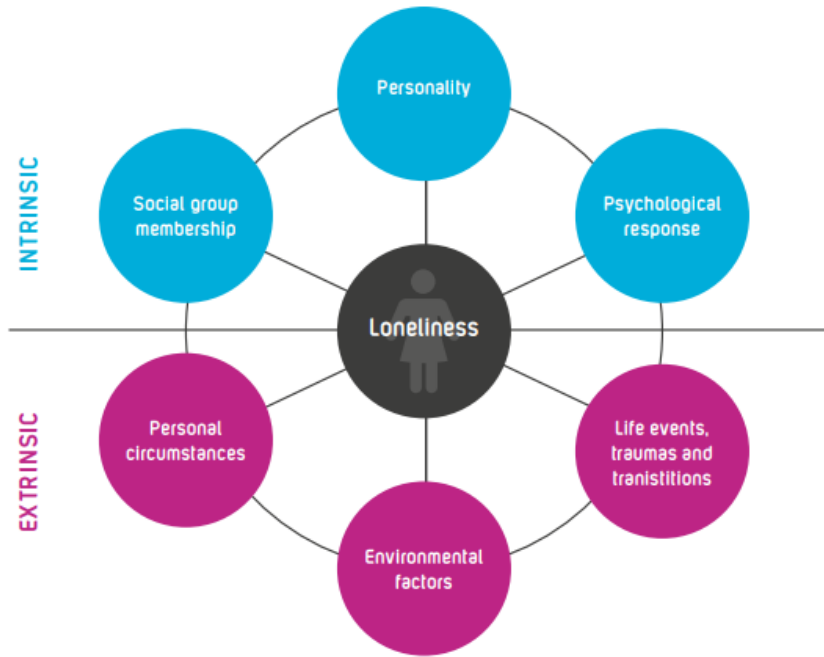
*Numbers in figure may not total due to rounding.

LONELINESS

“Loneliness is a subjective, negative feeling experienced where there is a discrepancy between the amount and quality of social contacts one has, and the amount and quality one would like to have. It is related to, but distinct from, social isolation which is an objective state where there is an absence of social contacts and social connectedness(19).”

Loneliness is caused by a number of intrinsic and extrinsic factors (Figure 19). While loneliness can occur at any age, it can be exacerbated by major life events that typically correspond with ageing such as bereavement, loss of mobility and declining physical health.

Figure 19 Factors which can precipitate loneliness



Source: <https://www.campaigntoendloneliness.org/wp-content/uploads/CEL-Hidden-People-Exec-Summary-final.pdf>

The English Longitudinal Study of Ageing (ELSA) asked participants about their feelings regarding social interactions and feeling lonely(20). Analysis of the ELSA data revealed that the proportion of people who feel lonely “some of the time” or “often” increased with age.

Emerging evidence indicates that loneliness is associated with poor health and wellbeing outcomes including:

- High blood pressure(21),
- Coronary heart disease(21),
- Stroke(21),
- Depression(22),
- Mortality(23).

LOCAL DATA

In 2012, the [Herefordshire Quality of Life Survey](#) gathered information on residents’ views about living in Herefordshire. Approximately 1,300 people responded to the survey. Among the questions asked were a number about the amount of social contact received and perceptions of loneliness.

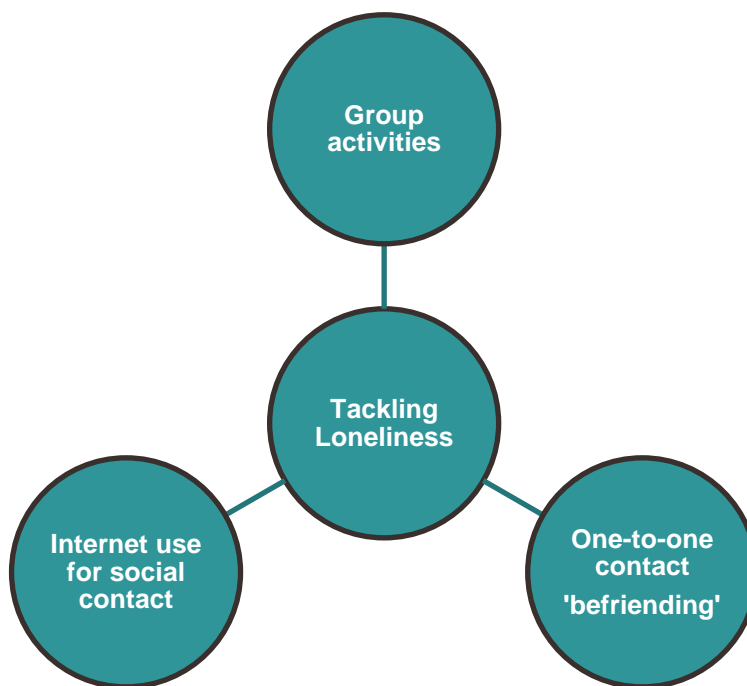
While most people in Herefordshire (60 per cent) had contact with family, friends or neighbours most days of the week, for five per cent of people, the contact was once a month or less, and a similar proportion felt lonely most or all the time (regardless of age or where they lived in the county). Those who lived alone were most likely to experience this kind of isolation.

TACKLING LONELINESS

Early intervention provides an opportunity to reduce associated health risks, with some researchers suggesting that doing so may be cost effective, by improving longer-term health outcomes and reducing the number of healthcare interventions(24).

Recognising the impact loneliness can have on older people, Age UK undertook an evidence review to identify interventions that are effective in tackling loneliness(25). These interventions are outlined in Figure 20.

Figure 20 Effective interventions for tackling loneliness



Data Source: Age UK, Loneliness in later life evidence review, 2015.

In response to their findings, Age UK has taken action to ensure that interventions to tackle loneliness are among the various types of support it offers to older people.

LOCAL ACTION

In various locations across Herefordshire Age UK provide activities and events for older people. Two services which are particularly focussed on tackling loneliness are the Care call service and the Computer Café. Care call is a free telephone befriending service for people who are living in the Herefordshire area (excluding Ross) and experiencing loneliness. Through the Care call service volunteers make weekly telephone calls to clients to have a friendly chat. Computer Café provide a social environment alongside the opportunity to learn digital skills and meet new people. In addition to these two services, Age UK regularly host a number of activities including lunch clubs, day centres and coffee mornings which provide opportunities for social interaction.

For up to date information about the activities on offer in the Ross-on-Wye area visit the Herefordshire and Worcestershire Age UK [website](#), for details about the activities on offer in the rest of Herefordshire visit the Herefordshire and Localities Age UK [website](#).

As part of their objective to bring faster broadband to Gloucestershire and Herefordshire, Fastershire have undertaken two initiatives aimed at improving IT literacy and use of the internet among all age groups. Further information about the support on offer can be found on page [184](#) of this report.

Key Facts

- In 2011, five per cent of employees in Herefordshire were aged between 65 and 74.
- Nationally, the number of people aged 65 and over in the workforce almost doubled between 1992 (when records first began) and 2016.

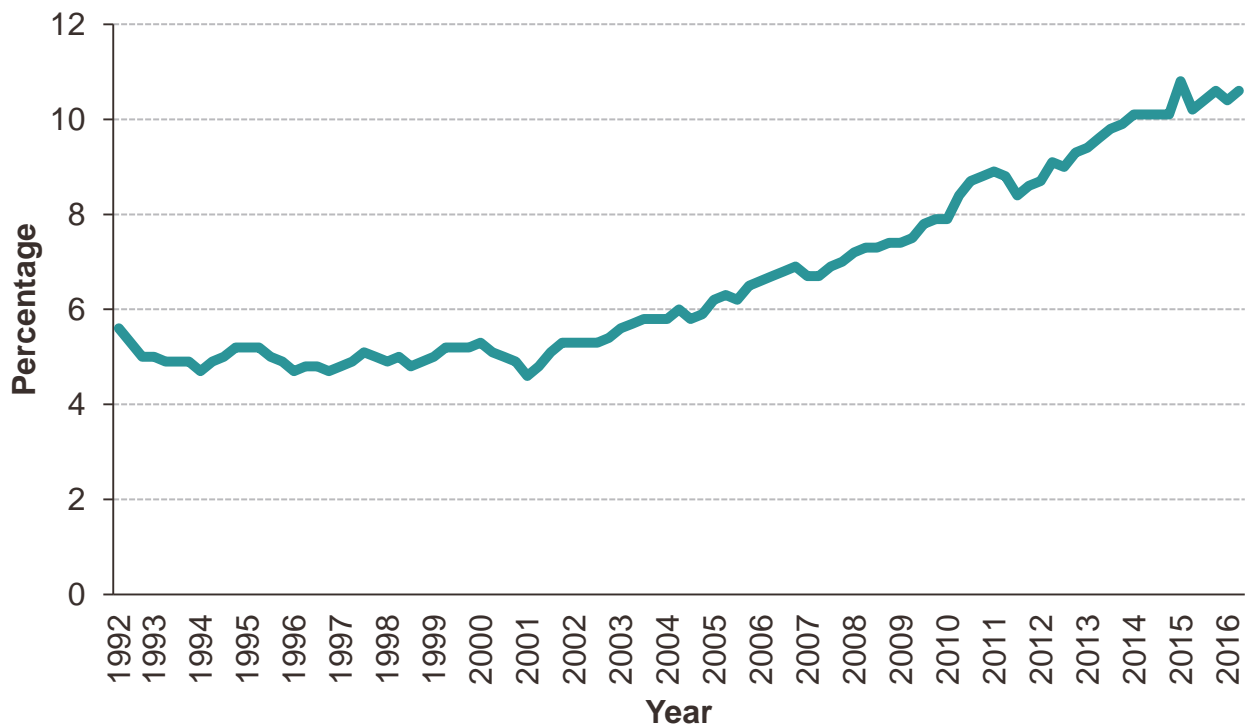
HOW MANY OLDER PEOPLE ARE IN THE WORKFORCE?

THE NATIONAL PICTURE

In the UK, the percentage of those aged 65 and over in the workforce nearly doubled between 1992 (5.6 per cent) and 2016 (10.6 per cent) (Figure 21). Some of the key drivers for this are the increase in life expectancy, the passing of legislation abolishing mandatory retirement at the age of 65 in the UK, and the phasing in of increases to the state pension age.

2017 estimates indicate that there are approximately 1.2 million people aged 65 and older in the UK workforce, which represents 11 per cent of all those aged 65 and over, and 3.6 per cent of the national workforce. Almost two thirds of employees over the age of 65 are men(26, 27).

Figure 21 Percentage of the UK population aged 65 and over in the workforce 1992-2016



Data Source: Office for National Statistics, 2016. <http://visual.ons.gov.uk/five-facts-about-older-people-at-work/>

THE LOCAL PICTURE

The 2011 census is the source of the most recent data on the number of people aged 65 and over in employment in Herefordshire. However, the data is only captured for those aged 16 to 74, with no data available for those aged 75 and over.

In 2011, census data indicates that there were 4,393 people aged between 65 and 74 in the workforce, sixty-two per cent of whom were between the ages of 65 and 68. In Herefordshire workers between the ages of 65 and 74 accounted for five per cent of the workforce aged between 16 and 74 years. In comparison, in both the West Midlands and England as a whole, three per cent of the workforces were between 65 and 74 years of age.

It is reasonable to assume that the increase in the proportion of older people in the workforce observed nationally (Figure 21) will be mirrored locally.

THE ECONOMIC CONTRIBUTION MADE BY OLDER WORKERS

The Old Age Dependency Ratio (OADR) refers to the number of people of pensionable age (State Pension Age (SPA)) for every thousand people of working age (16 years to SPA). In the UK, the

OADR has remained relatively stable between 1980 and 2006 (28). However, due to the ageing population structure the OADR has since increased and this trend is forecast to continue. This means there will be proportionally fewer people of working age to finance the health and social services for an increasingly aged population.

Planned changes to the state pension age will go some way to help manage imbalances in the OADR, however, people working beyond the state pensionable age will also assist in addressing the financial challenges associated with OADR increases (28).

According to a research published by the older people's charity Women's Royal Voluntary Service (WRVS), the total net contribution of older people in 2010 was estimated to be worth nearly £40 billion, and by 2030 the overall value of the net contribution is anticipated to grow to nearly £75 billion an increase of 89 per cent(29).

Key Facts

- Smoking prevalence is lower locally than nationally and regionally. However, in Herefordshire smoking attributable hospital admissions are rising, with a greater proportion of smoking related hospital admissions observed among those living in and around Bromyard and Ross-on-Wye.
- Herefordshire's smoking attributable mortality rate is lower than national and regional rates, and is in decline.
- Experts are concerned that excessive drinking among over 65s is a significant national public health concern. In Herefordshire alcohol related hospital admission rates are highest among those aged 40-64 and in 2014/15 the rate increased among those aged 65 and over.
- National trends suggest that physical activity levels among those aged 65 and over are increasing. Levels in Herefordshire are higher than regionally and nationally. However, over half of this age group are not engaging in the recommended amount of physical activity.

A number of health behaviours are known to have an impact upon an individual's health and wellbeing. Some of these behaviours have a damaging effect (for example: smoking and excessive alcohol consumption), and others have a protective effect (for example: engaging in physical activity). By engaging in and abstaining from certain behaviours individuals can help to reduce their risk of ill health and premature mortality caused by conditions such as coronary heart disease, stroke, type 2 diabetes, chronic obstructive pulmonary disease, cancer, dementia, and frailty.

Evidence indicates that it is never too late to change health behaviours, with resultant improvements in health and quality of life being realised relatively quickly, even in later life(30, 31). Therefore, in Herefordshire, health, social care, and voluntary sector workers are encouraged to promote healthy lifestyle choices through the "Making Every Contact Count" programme (Figure 22).

Figure 22 Making every contact count in Herefordshire

Making Every Contact Count

Making every contact count (MECC) is an approach to health promotion that was developed by the NHS and local government.

MECC is a behaviour change approach aiming to use the day to day interactions that organisations and individuals have with people to promote positive lifestyle choices. The aim is to deliver consistent and concise healthy lifestyle information and enable healthy lifestyle conversations across the population. Healthcare, social care and voluntary sector staff working with the public can all have an impact through MECC.

MECC delivery includes providing information and signposting to a wide range of services on lifestyle issues such as stopping smoking, drinking alcohol within the recommended limits, healthy eating, being physically active, and mental wellbeing and sexual health.

Effective implementation of MECC can lead to improvements in people's health and well-being, reduce avoidable premature mortality caused by poor health behaviours, and help people better manage long term conditions.

Expertise, confidence and knowledge are required in order to effectively tackle sensitive issues such as weight loss, smoking cessation or alcohol abuse. In recognition of this, MECC has produced e-learning materials to support people in developing the skills required. For MECC in Herefordshire please contact:

Kristan.Pritchard@herefordshire.gov.uk

Older people respect and are responsive to the advice of healthcare professionals, particularly their GPs, making all healthcare contacts important opportunities to support older people to optimise their health behaviours.

Smoking, alcohol consumption and physical activity levels among the residents of in Herefordshire are detailed below. In most instances it was not possible to summarise local data specific to those aged 65 and over.

The data presented below is a summary of relevant content from the [Smoking in Herefordshire Overview](#) report. Readers are referred to this report for a comprehensive account of smoking prevalence and the impact it has on the health and wellbeing of the residents of Herefordshire.

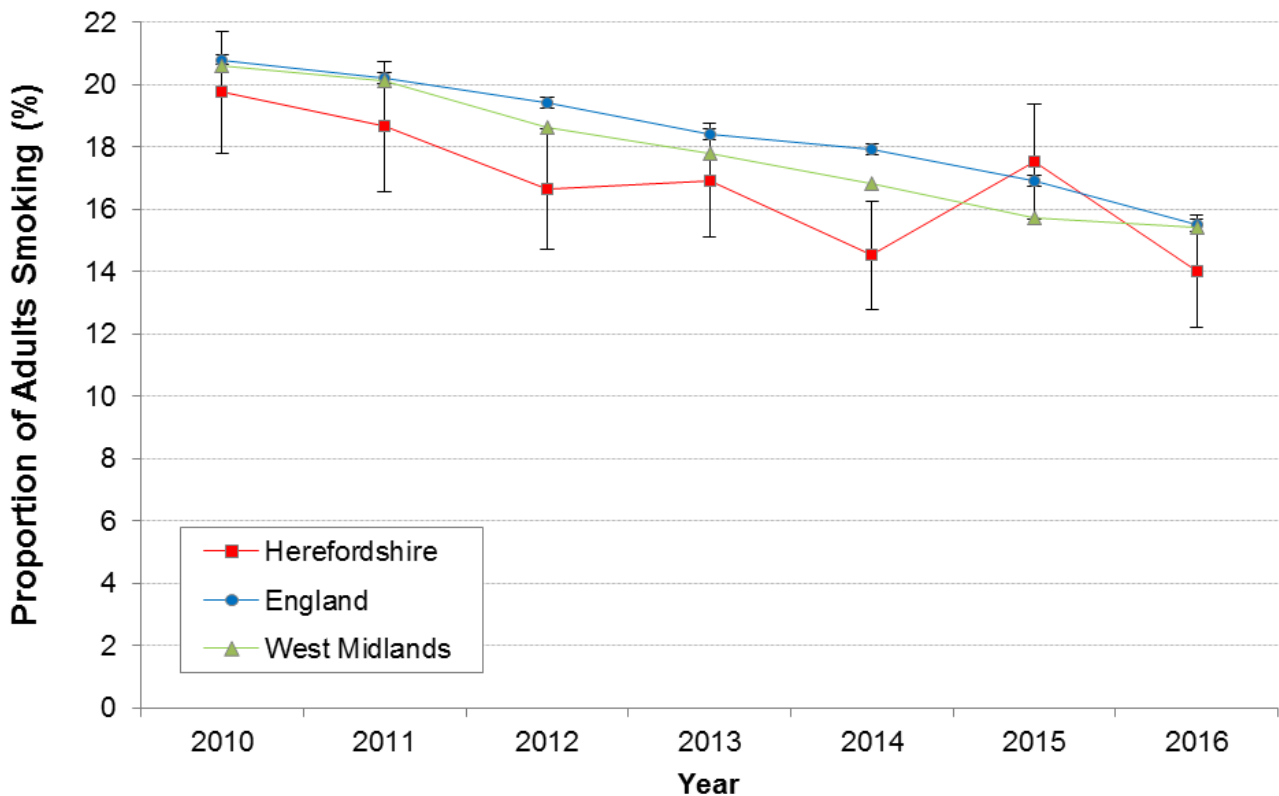
SMOKING AMONG OLDER PEOPLE

A recent report from the Office for National Statistics indicates that those aged 60 years and over are more likely to have quit smoking than their younger counterparts(32). However, among older male smokers average consumption is high at 15.5 cigarettes per day, compared to an average consumption of 12 cigarettes per day across all age groups(33). In addition, older smokers are likely to have smoked for many years, resulting in greater exposure to the harmful substances within cigarettes, putting them at high risk of smoking related ill-health.

SMOKING PREVALENCE

Figure 23 presents smoking prevalence data for Herefordshire, the West Midlands and England as captured by the Integrated Household Survey (IHS) and the Annual Population Survey (APS) from 2010 to 2016. In Herefordshire, the proportion of adults who were self-reported smokers has declined from 19.8 per cent in 2010 to 14.0 per cent in 2016; this trend was mirrored in both England and the West Midlands. Over this time period the local prevalence was below those recorded nationally and regionally, except in 2015 when the local figure was higher, although not significantly so.

Figure 23 Prevalence of adult self-reported smokers in Herefordshire, the West Midlands and England, 2012-2015



Data Source: PHE – Local Tobacco Control Profiles for England/APS/HIS.

Results of the Herefordshire Health and Well-being survey undertaken in 2011 indicated that males were more likely to smoke than females with almost 60 per cent of males being either current or ex-smokers compared to 44 per cent of females, of which two fifths were current smokers for both genders(34). This trend is mirrored nationally(35).

According to the Quality and Outcomes Framework (QOF)³ in 2015/16 there were 27,000 smokers aged 15 and over across Herefordshire (17.3 per cent of the total population aged 15 and over), statistically significantly lower than the proportion of people aged 15 and over who smoke in the West Midlands (18.3 per cent) and England (18.1 per cent).

Similar to the rest of the UK, in Herefordshire there is evidence of a correlation between the index of multiple deprivation score (IMD 2015) and smoking prevalence, with higher prevalence of smoking observed with greater levels of deprivation.

³ It has been demonstrated that the proportion of patients recorded as smokers correlates well with IHS smoking prevalence and is a good estimate of the actual smoking prevalence in GP practice lists.

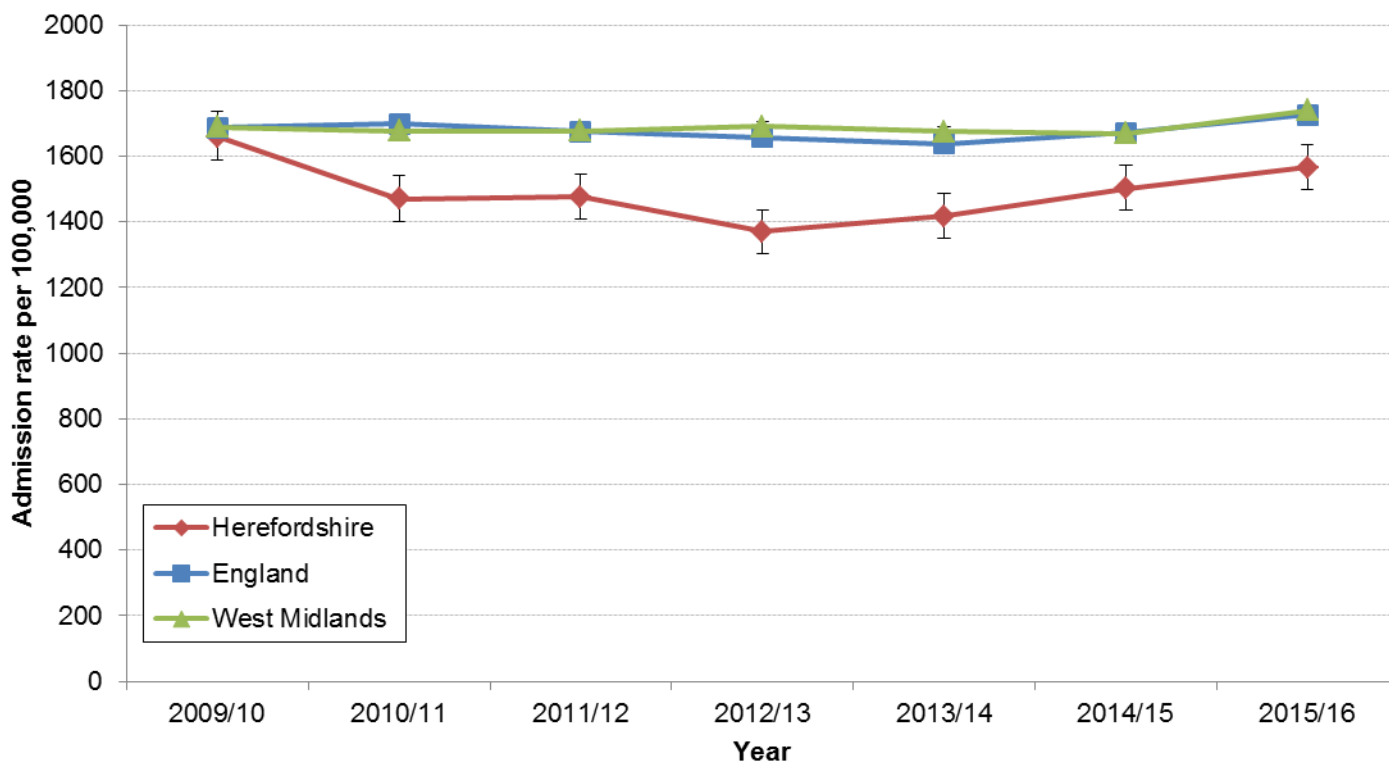
SMOKING RELATED ILL-HEALTH

SMOKING ATTRIBUTABLE HOSPITAL ADMISSIONS

In 2015/16, in Herefordshire 2,015 hospital admissions were attributed to smoking, 58 per cent of those admitted were males and 42 per cent females. The major causes of all smoking attributable admissions were lung cancer which represented 19.4 per cent of admissions, chronic airway obstruction (12.8 per cent) and ischaemic heart disease (11.0 per cent).

Between 2009/10 and 2012/13 the local smoking attributable admission rate for those aged 35 and over showed a decreasing trend, falling from 1,660 to 1,370 per 100,000 of the population over the three year period (Figure 24). However, between 2012/13 and 2015/16 the rate increased to 1,567 per 100,000. Over this seven year period both the national and regional rates remained relatively consistent with both figures being significantly higher than in Herefordshire, with the exception of 2009/10 when no appreciable differences were evident between the three figures.

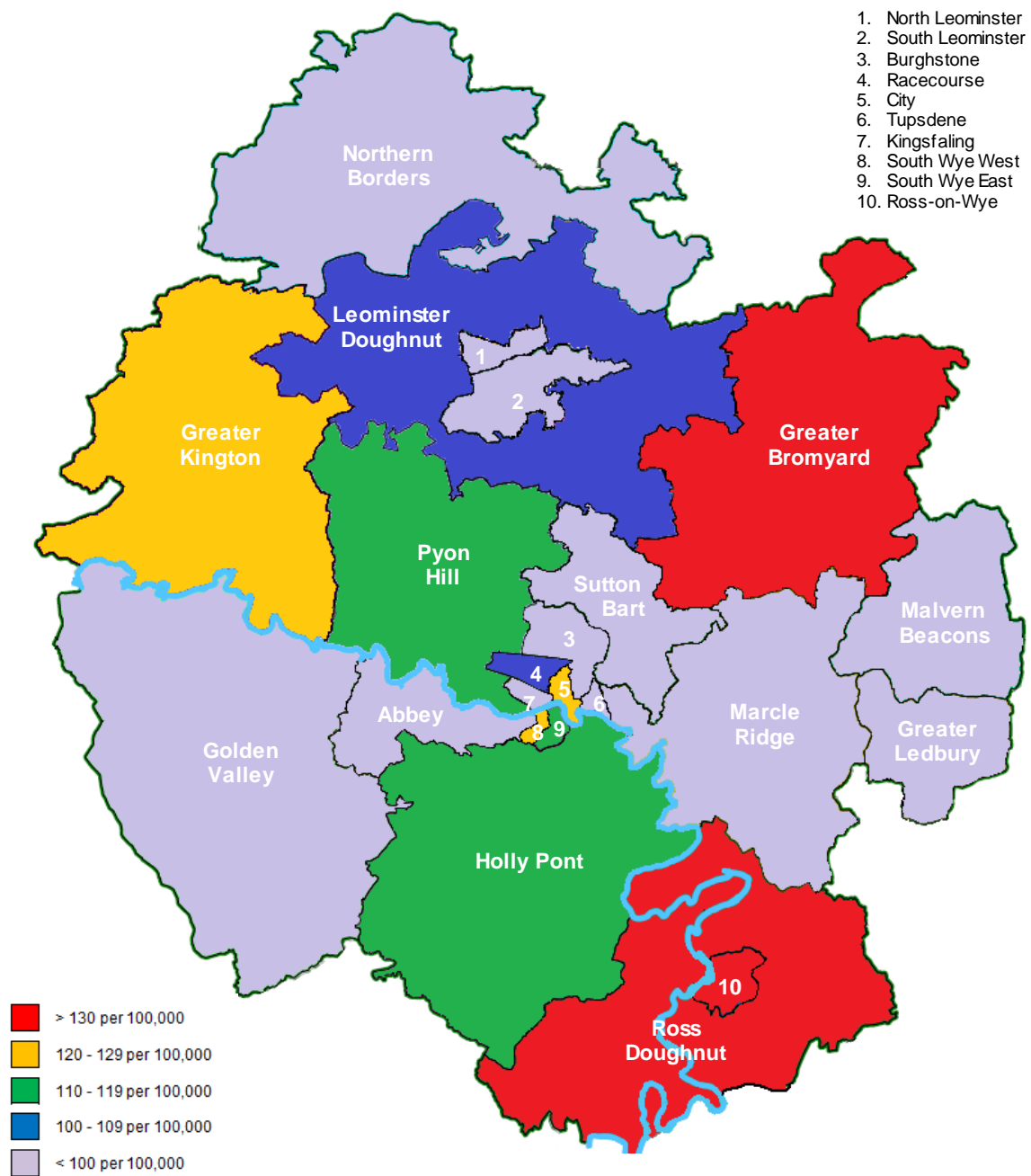
Figure 24 Directly standardised smoking attributable hospital admission rates in those aged 35 and over for Herefordshire, the West Midlands and England, 2009/10 -2015/16



Data Source: Public Health England – Local Tobacco Control Profiles for England.

The highest smoking attributable hospital admission rates were evident in and around Ross-on-Wye and Bromyard, parts of which are among the most deprived areas in Herefordshire (Figure 25 2015/16 Crude smoking attributable admission rates by Middle Super Output Area (MSOA) Figure 25). However, the trend was inconsistent, with relatively low admission rates being observed in other deprived areas such as Leominster, where the rates were lower than the county rate.

Figure 25 2015/16 Crude smoking attributable admission rates by Middle Super Output Area (MSOA)



Source: Herefordshire Council Intelligence Unit.
Data Source: Hospital Episode Statistics.

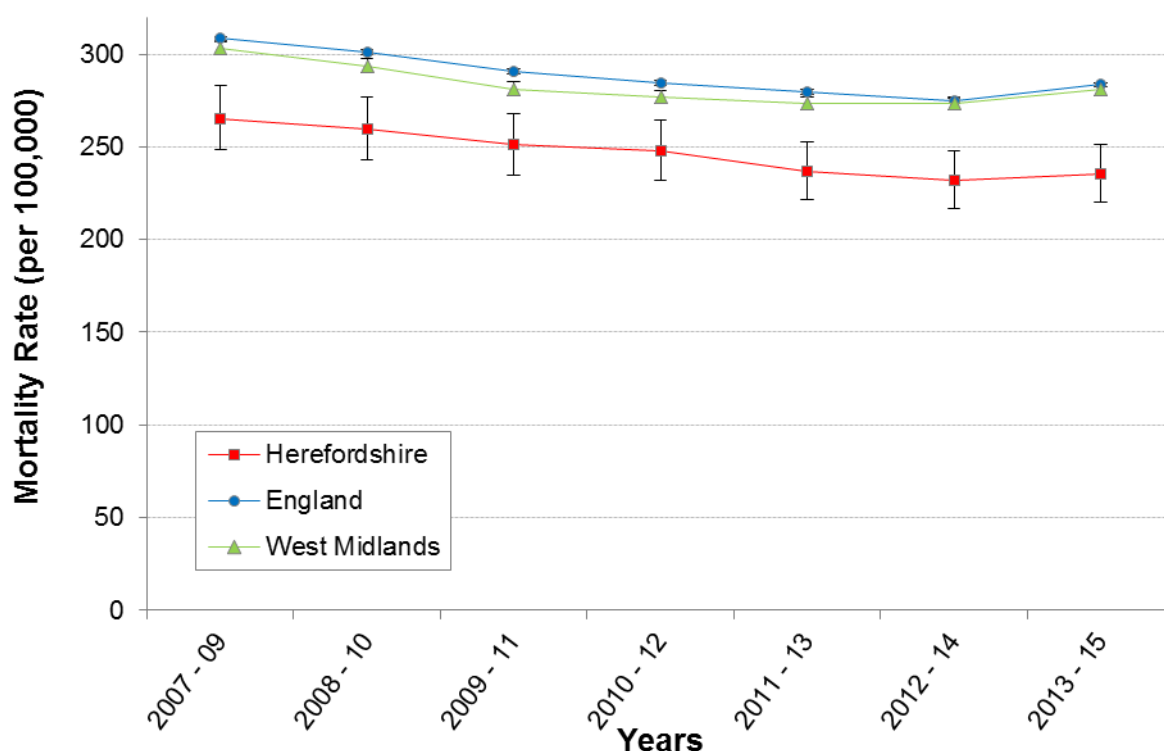
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Ordnance Survey (100024168)

SMOKING-ATTRIBUTABLE DEATHS

Smoking is one of the leading causes of preventable mortality and morbidity in the world(36). Between 2013 and 2015 there were 925 smoking attributable deaths in Herefordshire among those aged 35 and over, approximately two thirds of which were among men, a pattern which is also observed regionally and nationally(37).

Between 2007 and 2015 there has been a decline in the local smoking attributable mortality rates, falling from 265 to 235 per 100,000 population. Throughout this time period, the local smoking attributable mortality rate has been consistently lower than the national and regional rates (Figure 26).

Figure 26 Directly standardised smoking attributable mortality rates in those aged 35 and over for Herefordshire, the West Midlands and England, 2007/09-2013/15



Data Source: Public Health England – Local Tobacco Control Profiles for England.

ALCOHOL CONSUMPTION

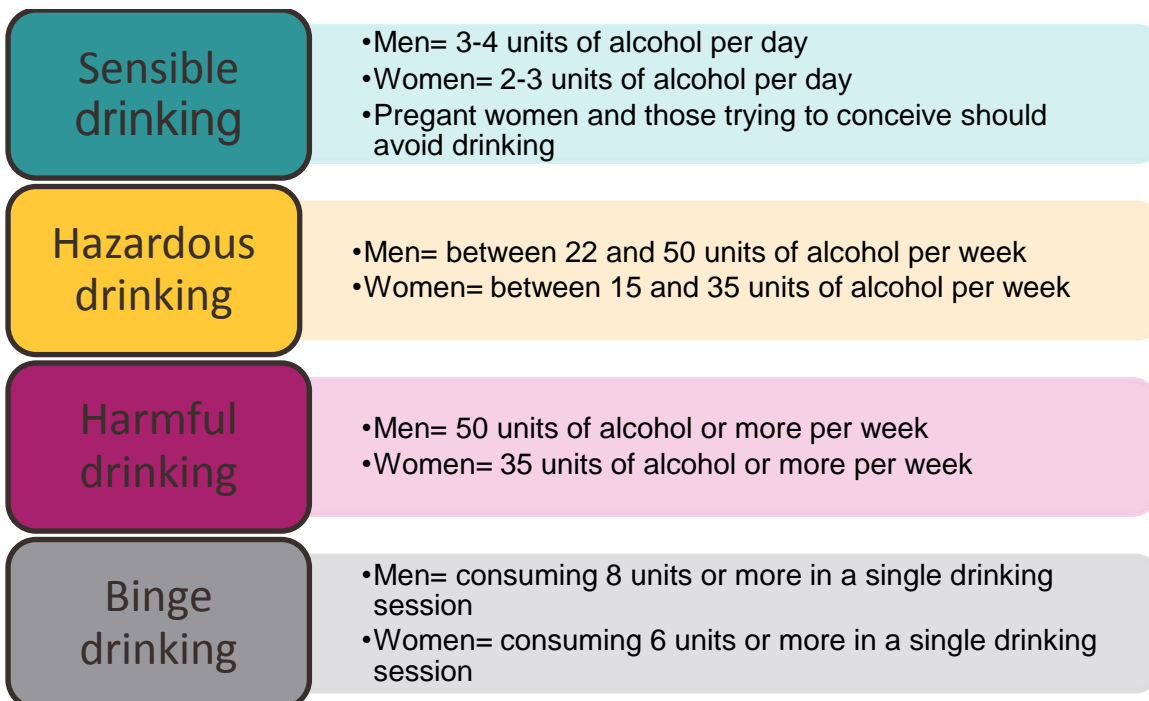
The data presented below is a summary of relevant content from a detailed report on alcohol published in 2017. Readers are referred to this [report](#) for further information about alcohol consumption and the impact it has on the health and wellbeing of the residents of Herefordshire.

RECOMMENDED CONSUMPTION LIMITS

The Department of Health has classified levels of drinking according to amounts consumed(38)(Figure 27). Recommendations from the UK Chief Medical Officer state that in order to reduce the health risks associated with alcohol consumption an individual should not to drink more than 14 units of alcohol per week on a regular basis(39).

However, the Royal College of Psychiatrists warn that the recommended 'safe limit' for alcohol consumption is based on research conducted on younger adults, and because of physiological and metabolic changes associated with ageing, the 'safe limit' is too high for older people. Therefore, they **recommend that older people do not exceed more than 1.5 units of alcohol on any one day, or more than 11 units per week**(40).

Figure 27 Department of health alcohol consumption limits and classification levels



Data Source: Department of Health, *Safe. Sensible. Social. The next steps in the National Alcohol Strategy.*

ALCOHOL CONSUMPTION AMONG OLDER PEOPLE

About a third of older people who misuse alcohol do so for the first time in later life (40). Bereavement, physical ill-health, difficulty getting around and social isolation can lead to boredom and depression, which can trigger excessive alcohol consumption(40).

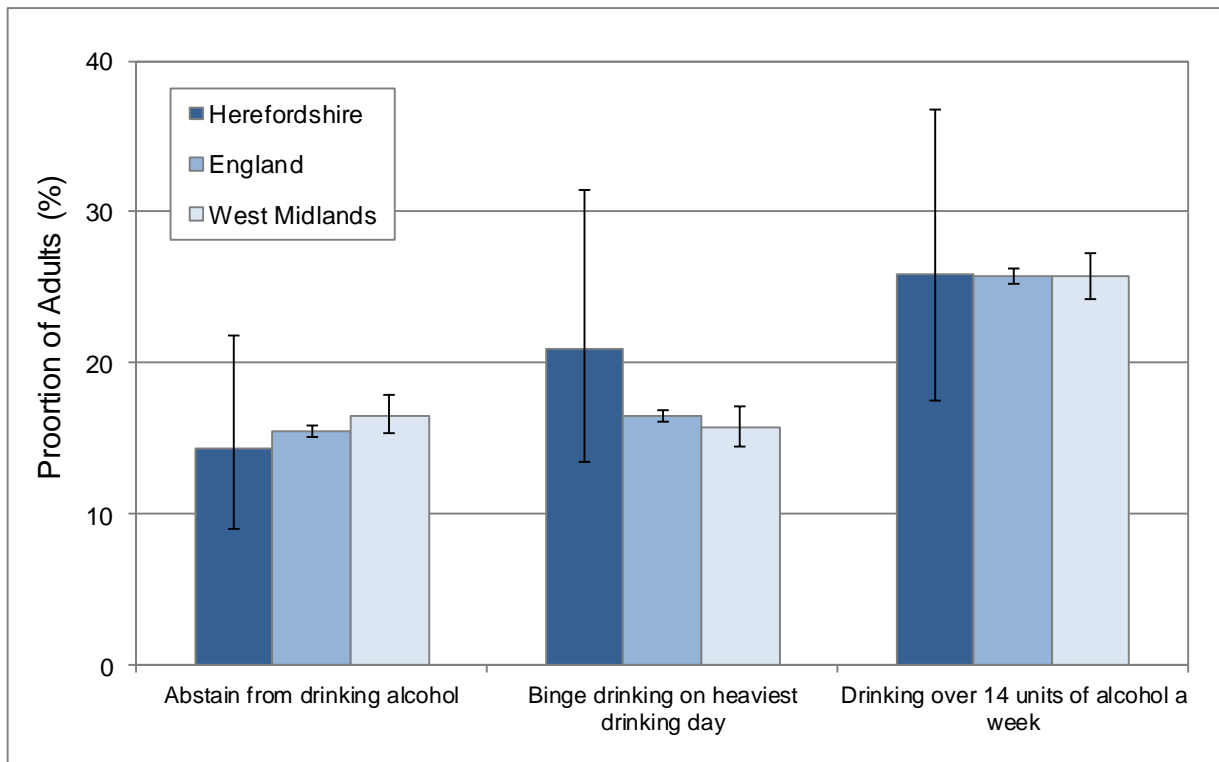
Negative health effects associated with alcohol misuse include increased risk of morbidity and mortality due to liver diseases, oropharyngeal cancer, oesophageal cancer and pancreatitis. Excessive drinking puts older people at greater risk of age-related harms such as falls (41), social isolation and elder abuse(42). In addition, alcohol is known to interact with a number of medications commonly prescribed to older adults and can result in serious medical consequences(43).

Older people who drink alcohol, drink more than their counterparts from previous generations, and are more likely to drink at home and alone(44). According to Wadd *et al.*(44), “evidence suggests that the UK may be on the cusp of an epidemic of alcohol related harm among older people.” This is evidenced in part by the national phenomenon of increasing alcohol related hospital admissions among over 65s.

CONSUMPTION RATES

Data for the period between 2011 and 2014 indicate that in Herefordshire 25.9 per cent of adults consumed more than the recommended safe drinking limits of 14 units per week, a figure similar to that recorded both nationally and regionally (Figure 28). Over the same period 21.0 per cent of adults in Herefordshire reported binge drinking on their heaviest drinking day in the week compared to 16.5 per cent across England and 15.8 per cent in the West Midlands. Locally the proportion of adults abstaining from alcohol was 14.4 per cent, a figure marginally lower than those recorded nationally (15.5 per cent) and regionally (16.6 per cent). While there are some differences observed in the drinking habits of adults in Herefordshire, the West Midlands, and England, none are statistically significant.

Figure 28 Proportion of adults abstaining from alcohol and those drinking above guidelines in Herefordshire, the West Midlands and England, 2011-2014



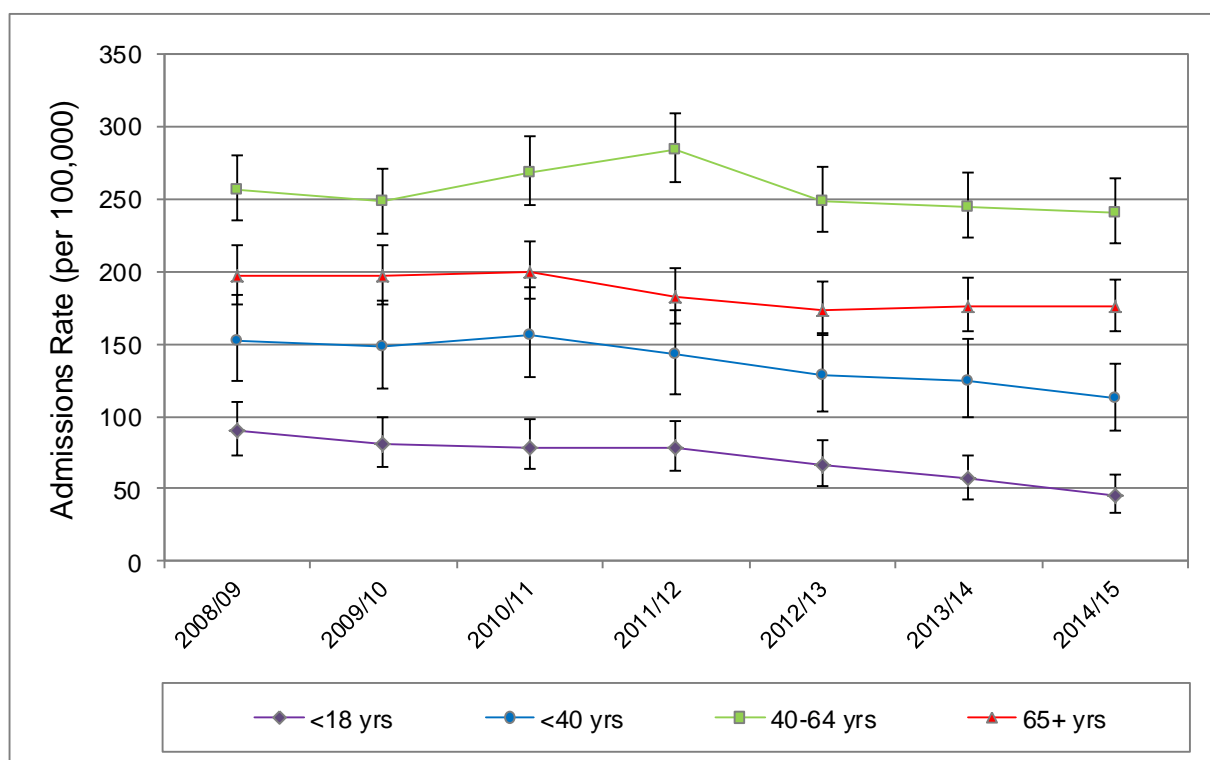
Data Source: Public Health England – Local Alcohol Profiles for England.

HOSPITAL ADMISSIONS

Alcohol related conditions are a significant cause of hospital admissions nationally. In 2014/15 they accounted for over 3,020 admissions in Herefordshire, of which 63 per cent were male and 36 per cent female.

In Herefordshire, from 2008/09 and 2014/15 inclusive, the directly age standardised alcohol admission rates have been highest among those between 40 and 64 years of age. In 2014/15 the number of hospital admissions decreased among those under the age of 64, but rose among those aged 65 and over. However, none of these observations are statistically significant (Figure 29).

Figure 29 Alcohol related directly age standardised hospital admissions rate by age group for Herefordshire, 2008/09 - 2014/15 – measure for >18 is for alcohol specific conditions. (Narrow measure)



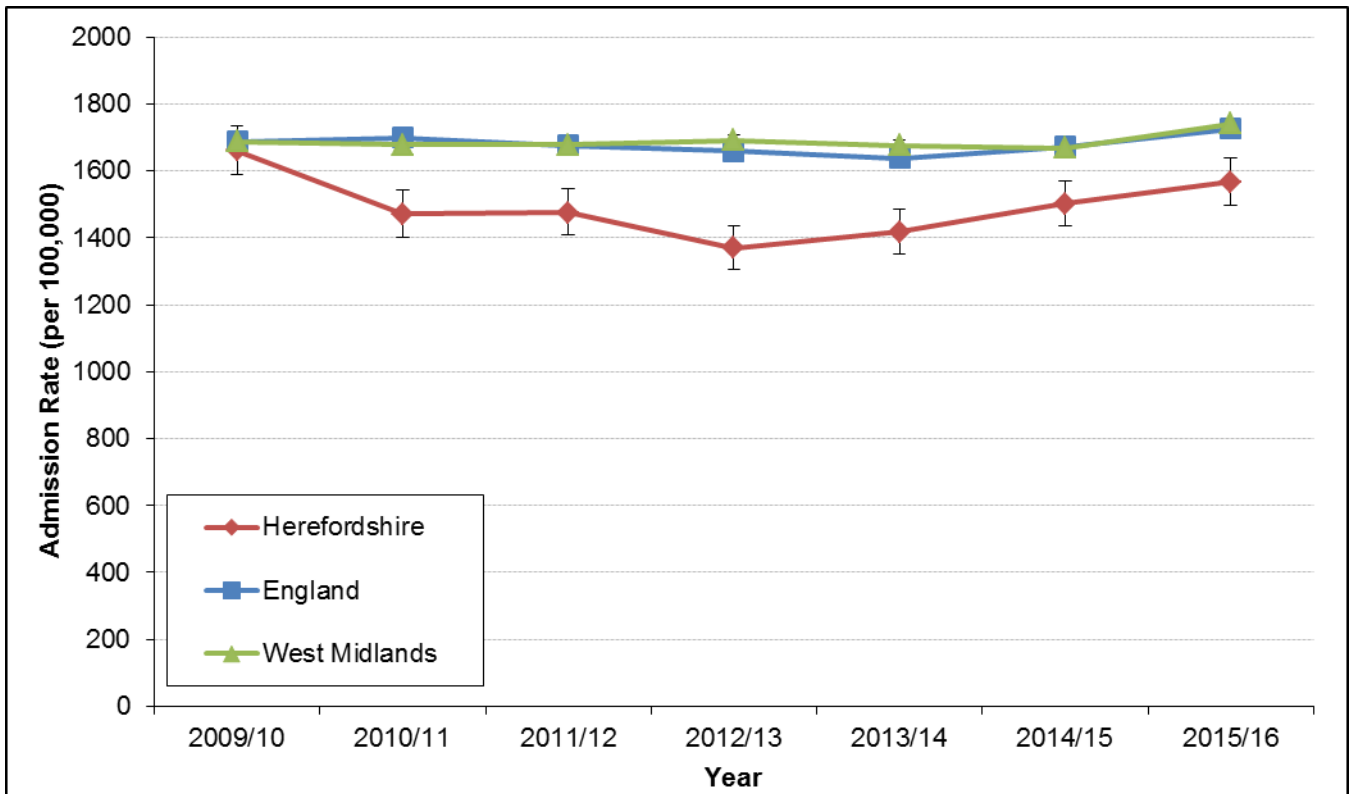
Data Source: Public Health England – Local Alcohol Profiles for England.

MORTALITY

Alcohol misuse can be directly related to deaths from certain types of disease, such as cirrhosis of the liver, and in some cases, may be associated with other causes of death, such as strokes. Public Health England (PHE) produces estimates on the number of alcohol-related deaths which include conditions which are alcohol specific and also partially caused by alcohol which are then converted to alcohol related mortality rates.

Since 2008, the Herefordshire alcohol related mortality rate has varied, although up to 2014 a general downward trend was evident (Figure 30). Of note is the 2015 figure of 46.1 per 100,000, an increase on the previous year, though 8 per cent lower than that recorded in 2008. Between 2008 and 2015 inclusive, the alcohol related mortality rate for Herefordshire has been consistently lower than the rate for the West Midlands, though not significantly so.

Figure 30 Directly age standardised alcohol related mortality rate alcohol for Herefordshire, the West Midlands and England, 2008 – 2015



Data Source: Public Health England – Local Alcohol Profiles for England

PHYSICAL ACTIVITY

Physical activity refers to any bodily movement that is produced by skeletal muscle and requires energy expenditure. Regular physical activity is associated with a reduced risk of coronary heart disease, stroke, diabetes, obesity, osteoporosis, colon and breast cancer, and poor mental health.

In contrast, physical inactivity is the fourth leading risk factor for mortality, accounting for 6 per cent of deaths globally. The estimated direct cost of physical inactivity to the NHS across the UK is currently over £0.9 billion per year.

While it is generally accepted that doing some physical activity is better than nothing, evidence suggests that the benefits of physical activity are dose dependent, meaning that a certain level of physical activity is required in order for health benefits to be realised. In recognition of this, the Department of Health physical activity guidelines recommend that adults engage in at least 150 minutes of moderate physical activity per week, in bouts lasting 10 minutes or more. Moderate activity can be achieved through brisk walking, cycling, gardening and housework. Alternately, an adequate level of activity can be achieved by undertaking 75 minutes of vigorous intensity (for example: running, or playing an active sport) per week. All adults should also aim to minimise sedentary activities and improve muscle strength and balance on at least two days a week (Figure 31).

Figure 31 Physical activity recommendations for adults and older people



Source: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541233/Physical_activity_infographic.PDF

BENEFITS OF PHYSICAL ACTIVITY IN OLDER PEOPLE

As we age, our physiology changes with an overall decline in muscle mass and bone density, and a lowering of basal metabolic rate. Low muscle mass and bone density are linked to frailty, reduced functional capacity and poor health outcomes. In addition, the tendency to become more sedentary with age, in combination with a lower basal metabolic rate can result in excessive weight gain.

Physical activity can improve bone density, maintain muscle mass, increase energy expenditure, and assist in the maintenance of a healthy weight. Research findings indicate that older adults who engage in physical activity are more likely to maintain their functional capacity(45), which is vital to living independently.

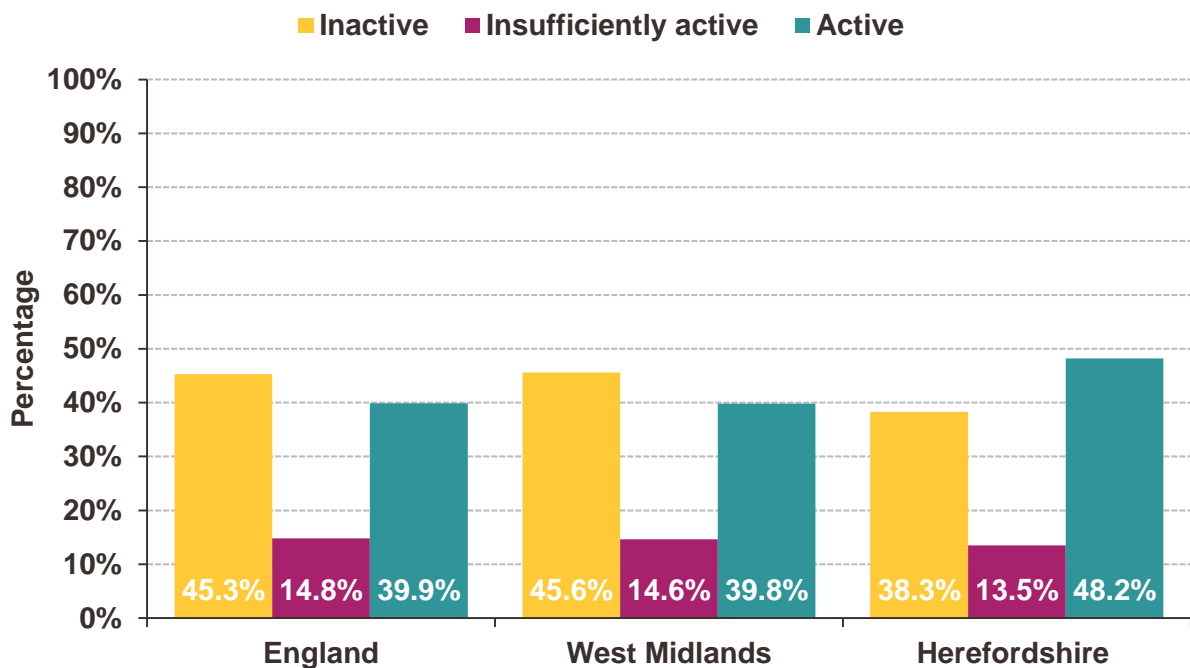
ACTIVITY LEVELS

Sport England commissions the Active People Survey (APS), which is an annual survey that provides a comprehensive measure of participation in sport and physical activity in England. The APS asks survey participants about their physical activity levels in the last 28 days, and based on their responses, assigns them to one of three categories:

1. **Active**-those who engaged in the recommended 150 minutes or more of moderate intensity physical activity per week
2. **Insufficiently active**- those who engaged in more than 30 and fewer than 150 minutes of moderate intensity physical activity per week
3. **Inactive**- those who engaged in less than 30 minutes of moderate intensity physical activity per week

According to the APS, in England between 2012/13 and 2014/15 the level of activity among adults aged 65 and over has increased. Over this time period the number of adults categorised as inactive and insufficiently active has decreased year on year, conversely, the number judged as active has increased year on year. In 2014/15, older adults living in Herefordshire had slightly higher activity levels than regionally and nationally, with a greater proportion being classified as active and lower proportions being classified as insufficiently active and inactive in comparison (Figure 32).

Figure 32 Physical activity profiles among people age 65 and over in Herefordshire, the West Midlands and England, based on 2014/15 data



Data Source: Active People Survey, Sport England.

While levels of physical activity among older adults are higher in Herefordshire than regionally and nationally, locally, 51.8 per cent of older adults do not regularly engage in the recommended 150 minutes of moderate intensity physical activity each week. Therefore, over half of this group are not reaping the health and wellbeing benefits associated with being physically active.

DISCUSSION POINTS

- Even in later life, engaging in positive health behaviours can lead to improvements in health and wellbeing.
- Smoking prevalence is lower locally than nationally and regionally, as is Herefordshire's smoking attributable mortality rate, which is in decline. However, in Herefordshire smoking attributable hospital admissions are rising, with a greater proportion of smoking related hospital admissions observed among those living around Bromyard and Ross-on-Wye.
- Experts are concerned that excessive drinking among over 65s is a significant national public health concern. In Herefordshire alcohol related hospital admission rates are highest among those aged 40-64 and in 2014/15 the rate increased among those aged 65 and over.
- National trends suggest that physical activity levels among those aged 65 and over are increasing. Physical activity levels in Herefordshire are higher than regionally and nationally. However, over half of this age group are not engaging in the recommended amount of physical activity.

RECOMMENDATIONS

- Take action to ensure that health, social care and voluntary organisation workers who come in contact with older people take every opportunity to support them to make healthy lifestyle choices such as consuming alcohol at safe limits, engaging in physical activity, and quitting smoking.

Key Facts

- By 2035 it is estimated that there will be 5,500 older people living with dementia in Herefordshire.
- In 2017, dementia related costs among over 65s in Herefordshire were estimated to be in the region of £104 million, with the highest proportion of the cost (£46 million, 44 per cent) being attributed to the provision of informal care.
- As of 2017, Herefordshire has not met the 2015 national dementia diagnosis rate target of 66.7 per cent of people having a formal diagnosis.
- In 2015/16, the percentage of people diagnosed with dementia accessing inpatient hospital care was significantly lower in Herefordshire (46.4 per cent) compared to the West Midlands (58.5 per cent) and England (53.8 per cent).
- In 2016/17, the average self-reported quality of life score among informal carers who provide care for a person living with dementia was 7.6 out of 12, the same as it was in 2014/15 and similar to the average scores for England (7.5) and the West Midlands (7.7).

WHAT IS DEMENTIA?

Dementia is an umbrella term for a progressive neurological disorder that affects how the brain functions. There are over 200 different types of dementia, with Alzheimer's disease being the most common, accounting for 62 per cent of dementia cases(4). Symptoms vary depending upon the part of the brain affected, and can include difficulties with memory, communication, decision making, planning, and orientation to place and time, all of which impact upon a person's ability to carry out activities of daily living.

Dementia prevalence increases with age and is more common among women(4). Dementia among people aged 65 and older is called "late-onset dementia". People with learning disabilities are at increased risk of developing dementia.

WHAT ARE THE EFFECTS OF DEMENTIA?

Dementia is classified as mild, moderate or severe, with more challenging symptoms emerging with increasing disease severity. The rate of progression of the disease varies from person to person and is affected by type of dementia as well as genetic and environmental factors.

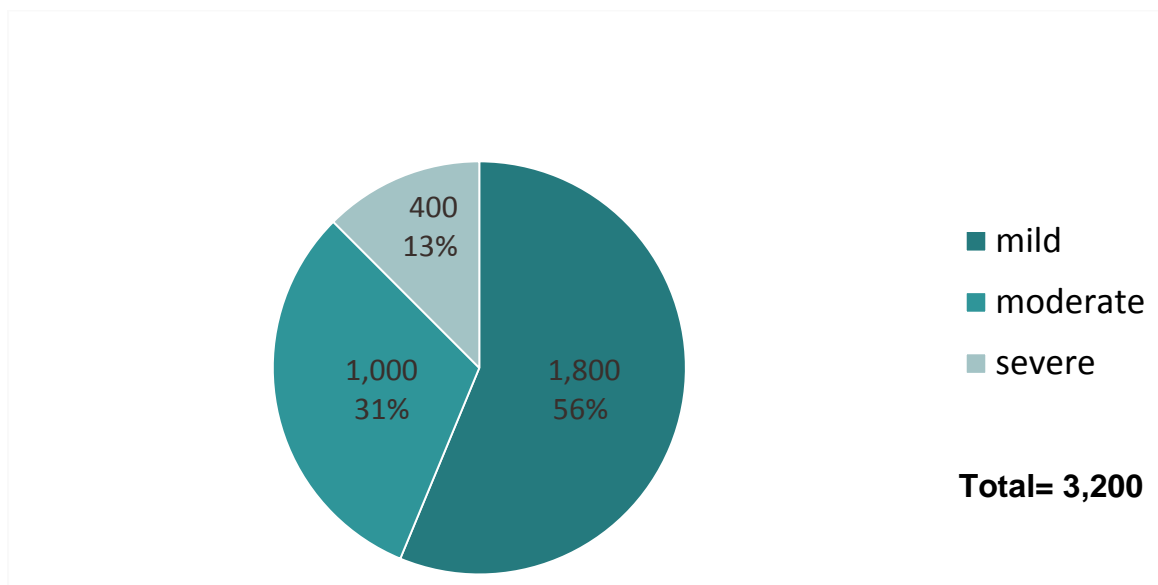
In the early stages, when dementia is mild, most people are able to carry out their usual activities either independently or with a low level of support. However, as the condition progresses people living with dementia require more assistance and support. Many people living with dementia will continue to be cared for by their family and friends in their own home. However, as their condition progresses some people living with dementia will require more intensive support and may move into a residential or nursing home to have their needs met.

PREVALENCE

In 2014, research undertaken by leading clinicians and academics on behalf of the Alzheimer’s Society estimated that dementia prevalence in the United Kingdom was approximately seven per cent among those aged 65 and over(4). However, there is some disagreement and uncertainty around dementia prevalence, with more recent evidence suggesting that this figure may be an overestimate(46).

Analysis undertaken by the Institute of Public Care(18) estimates that in 2017, approximately 702,000 people over the age of 65 in England will have dementia. It is estimated that there are currently 3,200 people over the age of 65 with dementia in Herefordshire(18), 400 (13 per cent) of whom are estimated to have severe dementia(4) (Figure 33).

Figure 33 Estimated proportion of people aged 65 and over with mild, moderate and severe dementia in Herefordshire in 2017

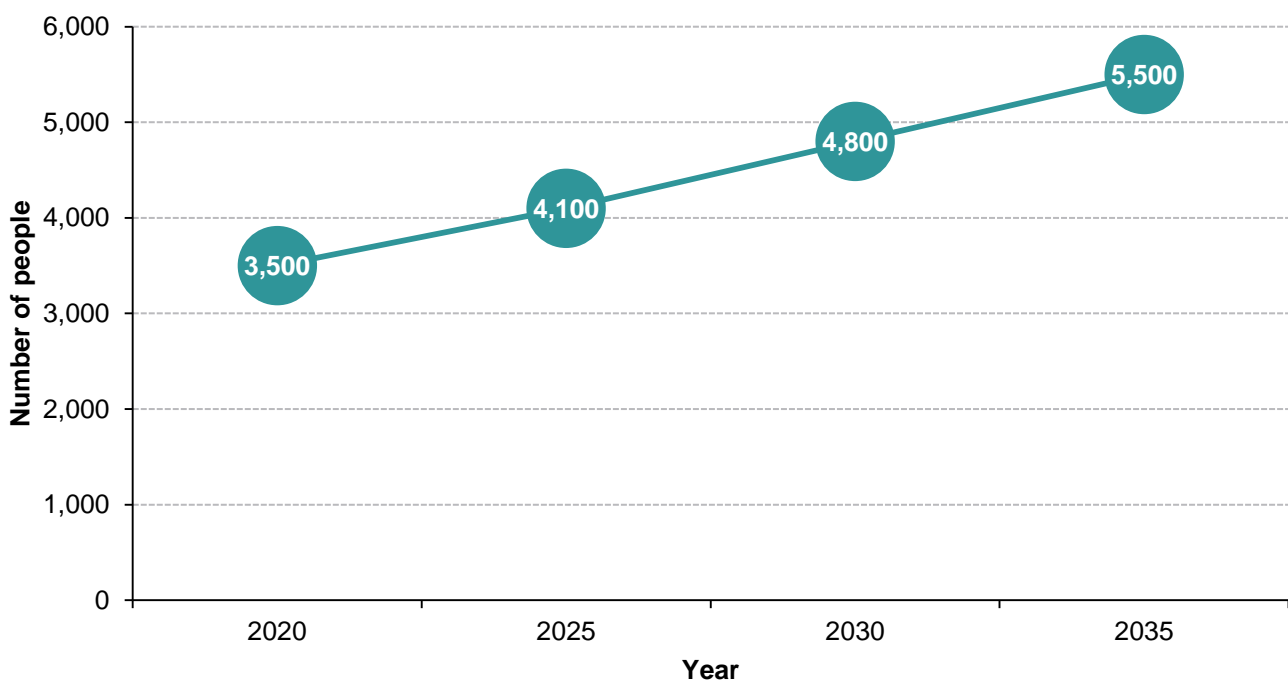


Data Sources: INSTITUTE OF PUBLIC CARE. Projecting Older People Population Information System, 2017 and ALZHEIMER'S SOCIETY. Dementia UK: Update 2014.

Locally, recorded dementia prevalence⁴ among those aged 65 and over is lower than what might be expected, with 3.81 per cent of over 65s having a formal diagnosis of dementia as of April 2017. This is a lower rate than regionally (4.13 per cent) and nationally (4.29 per cent). This finding reflects Herefordshire’s lower diagnosis rates (see page 75 for further information).

As Herefordshire’s population ages, the number of people with late onset dementia is expected to increase. By 2035, the number of older people with dementia in Herefordshire is estimated to be in the region of 5,500(18) (Figure 34).

Figure 34 Estimated number of people aged 65 and over with dementia in Herefordshire 2020-2035



Data Source: INSTITUTE OF PUBLIC CARE. *Projecting Older People Population Information System, 2017.*

RESIDENTIAL STATUS

The Alzheimer’s Society has estimated that 63.5 per cent of people living with dementia are in their own homes, with 36.5 per cent living in a care home(47). The proportion of older people living in the community versus a care home varies considerably with age, with the likelihood of residing in a care home increasing with age (Table 5). This trend is explained by the prevalence of severe dementia increasing with age, combined with the depletion of informal care and support systems due to the loss of a spouse, friends, and family members through bereavement.

⁴ Dementia recorded prevalence refers to the prevalence of dementia being recorded in GP medical records.

Table 5 Estimated percentage of people with dementia aged 65 and over living in a care homes and in the community

Age Group	Percentage living in the community	Percentage living in a care home
65-74	73.4	26.6
75-84	72.2	27.8
85-89	59.1	40.9
90+	39.2	60.8

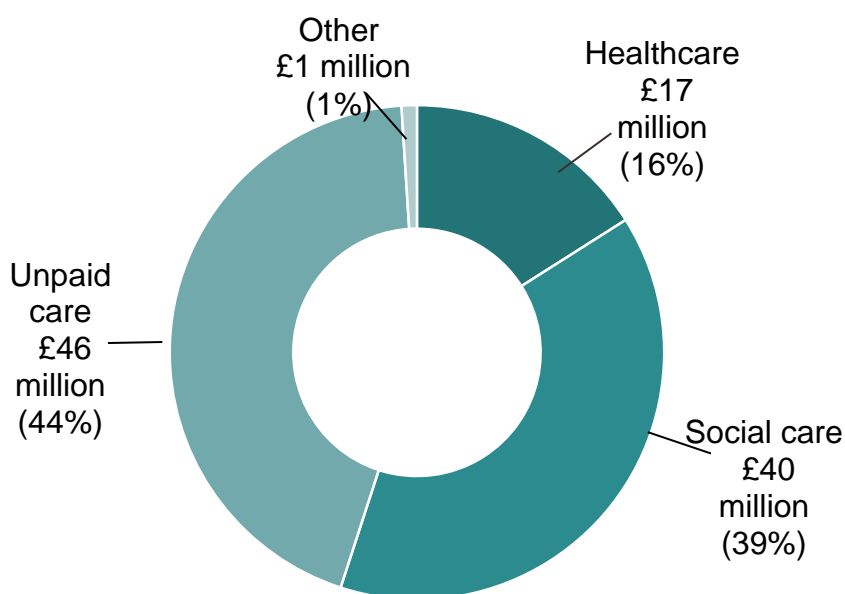
Data Source: ALZHEIMER'S SOCIETY. Dementia UK. 2007.

WHAT IS THE FINANCIAL IMPACT OF DEMENTIA?

In 2014, giving consideration to the cost of providing health, social, and unpaid care to people living with dementia, the Alzheimer's Society estimated the overall financial impact of dementia on the United Kingdom to be £26.3 billion per year, an annual cost of roughly £32,250 per person with dementia(4).

Applying the estimated cost per person with dementia to local dementia prevalence estimates for over 65s suggests that in Herefordshire, dementia related costs for people aged 65 and over were in the region of £104 million in 2017. It is estimated that £46 million was spent on provision of informal care, £40 million on social care (£17 million being local authority funded and £23 being individually/self-funded), and £17 million on healthcare for people with dementia over the age of 65 locally (Figure 35). Though only rough estimates, these figures provide an indication of the financial impact of dementia in Herefordshire.

Figure 35 Estimated breakdown of dementia related costs among people aged 65 and over in Herefordshire in 2017



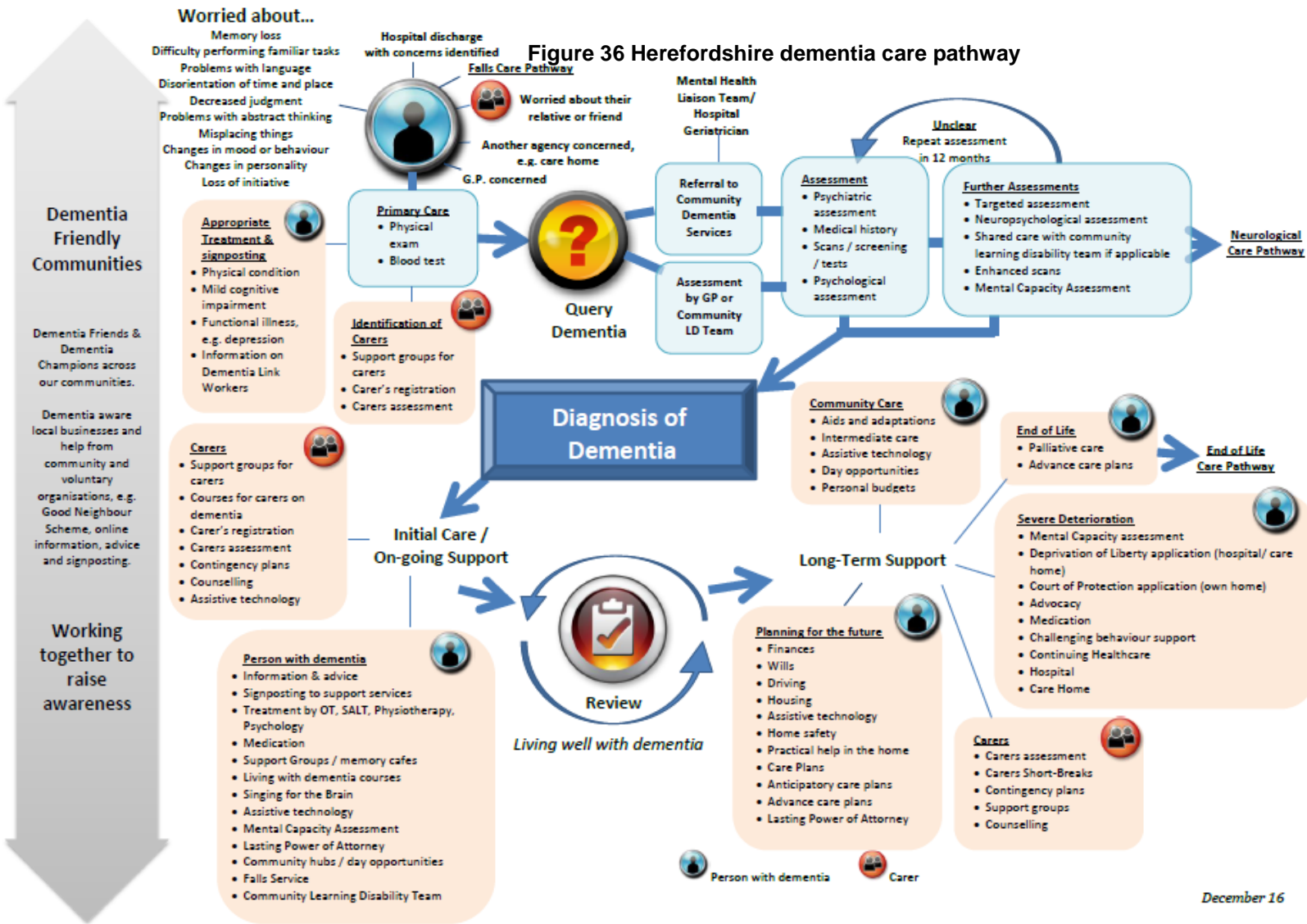
Data Sources: INSTITUTE OF PUBLIC CARE. Projecting Older People Population Information System, 2017 and ALZHEIMER'S SOCIETY. Dementia UK: Update 2014.

A PARTNERSHIP RESPONSE TO DEMENTIA IN HEREFORDSHIRE

In late 2017, Herefordshire Health and Wellbeing Board named dementia as a priority issue, recognising that as a common long-term condition it has a considerable impact on the health and wellbeing of local residents.

Locally, the Living Well with Dementia Partnership Board oversees the implementation of the “People with Dementia and their Carers: Strategy and Implementation Plan 2018-2019”, a partnership document reflecting the activities (ongoing and planned) of local communities, Herefordshire Council, providers of voluntary and private sector services, and statutory providers of health services who are all committed to enabling people with dementia and their carers to enjoy good quality, active, healthy and fulfilling lives in Herefordshire. The Herefordshire dementia strategy was refreshed in late 2017 into 2018, and is rooted in the local dementia care pathways (Figure 36) and focused around three key outcomes:

1. Driving a Herefordshire wide culture change through raising awareness and understanding,
2. Increasing availability of early diagnosis of Dementia and support,
3. Supporting people with dementia, carers and families to live well with dementia.



BUILDING DEMENTIA FRIENDLY COMMUNITIES

Research undertaken by the Alzheimer's Society indicates that only 35 per cent of people living with dementia leave the house each week and 10 per cent only venture out once a month.

People with a dementia can live independently for longer, and make an important contribution to society if environments and communities are dementia friendly. The creation of a dementia friendly community centres around members of the community understanding what dementia is, how it might affect someone in their day to day lives, and taking practical actions to support people living with dementia to overcome any challenges they may face. The Alzheimer's Society has published a range of documents⁵ detailing how local governments, businesses and individuals can act to create dementia friendly communities.

LOCAL ACTION

Herefordshire is making great strides in developing dementia friendly communities through engagement in the Alzheimer's Society's Dementia Friends and Dementia Action Alliance initiatives.

Dementia Friends

The Alzheimer's Society's Dementia Friends initiative is helping to tackle the stigma that often results in people with dementia being socially isolated by taking action to transform the way people act, think and talk about the condition in Herefordshire. Dementia Friends is about giving people an understanding of dementia and the small things they can do that can make a real and meaningful difference to people living with dementia. There has been considerable growth in the number of dementia friends in Herefordshire, as of the 10th of November 2017 Herefordshire had 3,813 dementia friends.

Dementia Action Alliance

The Dementia Action Alliance initiative is a social movement with one simple aim; to bring about a society-wide response to dementia. It encourages and supports local communities and organisations to take practical action to enable people to live well with dementia. Across Herefordshire, membership to the Dementia Action Alliance continues to grow, with approximately 40 members including local businesses, community groups, faith groups, schools, libraries, museums, shopping centres and charities as well as health and social care providers.

The Voice of People Living with Dementia

⁵ https://www.alzheimers.org.uk/info/20079/dementia_friendly_communities

Service User Review Panels (SURPs) are small groups of up to 8 people with dementia who are involved in influencing issues beyond their own care, both for society as a whole and for external organisations.

A local SURP was established in January 2017. The group meets monthly to discuss and review a range of topics, discussions from past meeting have focussed on:

- Helping The Clinical Research Network, by reviewing their approach to promoting the “Join Dementia Research” register to individuals with dementia,
- The local Wellbeing Information and Signposting Herefordshire (WISH) service,
- Alzheimer’s society “Helpcards”,
- Helping the Alzheimer’s Society and the Department of Transport to understand the challenges people living with dementia face in arranging and accessing everyday travel,
- How the Government can create a more dementia friendly social care system.

PREVENTION

A major study(48) estimated that approximately a third of cases of Alzheimer’s disease (the most common cause of dementia) might be attributable to modifiable risk factors, indicating that incidence could be reduced by improving vascular risk factors through supporting people to:

- stop smoking,
- be more active,
- reduce their alcohol consumption,
- improve their diet,
- lose weight (if necessary) or to maintain a healthy weight.

Risk factors for dementia include; smoking, excessive alcohol consumption, obesity, diabetes, hypertension, coronary heart disease, and stroke(49). Addressing these risk factors can act to prevent the onset of dementia or slow down disease progression in those who are living with dementia (secondary prevention).

Table 6 provides an overview of the prevalence of the above risk factors among Herefordshire residents. In 2015/16 the prevalence of hypertension, coronary heart disease and stroke were all statistically significantly higher locally than nationally. These findings suggest that local dementia prevention could be improved by optimising prevention and treatment for these conditions.

Table 6 Dementia prevention indicators for England and Herefordshire

Key

- ≈ Herefordshire value not statistically significantly different to England value
- ↓ Herefordshire value is statistically significantly lower than England value
- ↑ Herefordshire value is statistically significantly higher than England value
- Herefordshire's performance on this indicator is better than the England's overall performance
- Herefordshire's performance on this indicator is worse than the England's overall performance

Indicator	Time point	England	Herefordshire
Smoking prevalence- percentage of people aged 18 and over who are self-reported smokers.	2016	15.5	14.0 ≈
Hospital admissions for alcohol-related conditions (Narrow) among those aged 40-64 years old, directly age standardised rate per 100,000 population.	2015/16	904	810 ↓
Prevalence of physical inactivity- percentage of people aged 19 and over who self-report engaging in less than 30 minutes of moderate intensity physical activity each week.	2015/16	22.3	21.2 ≈
Prevalence of excess weight- percentage of people aged 18 and over who are overweight and obese based on self-reported height and weight.	2015/16	61.3	63.2 ≈
Diabetes recorded prevalence- percentage of GP registered population age 17 and over with a diagnosis of diabetes in their medical notes.	2015/16	6.5	6.6 ≈
Hypertension recorded prevalence- percentage of GP registered population with a diagnosis of hypertension in their medical notes.	2015/16	13.8	16.0 ↑
Coronary heart disease (CHD) recorded prevalence- percentage of GP registered population with a diagnosis of CHD in their medical notes.	2015/16	3.2	3.5 ↑
Stroke recorded prevalence- percentage of GP registered population whose medical notes identify that they have had a stroke.	2015/16	1.7	2.3 ↑

Data source: Public Health England-Dementia Profile, 2018.

MANAGEMENT

BEST PRACTICE

As with other long-term conditions, person-centred care is regarded as best practice in the management of dementia. Tom Kitwood developed the underpinning concepts of person-centred care for people living with dementia, central to which is accepting the 'personhood' of people living with dementia. According to Kitwood(50) personhood is 'a standing or status that is bestowed upon one human being, by others, it implies recognition, respect and trust'. Through this recognition, respect and trust, the personhood of an individual will be enhanced, as will their wellbeing. If the opposite occurs, then personhood will diminish, leading to 'illbeing'.

More recently, the Dementia Action Alliance in conjunction with people living with dementia and their carers developed the "I statements" (Figure 37). The "I statements" bring to life what best practice management of dementia looks like from the perspective of a person living with dementia.

Figure 37 Dementia "I statements"

"I was diagnosed in a timely way."

"I am able to make decisions, and I know what to do to help myself and who else can help."

"I am treated with dignity and respect."

"I get treatment and support which are best for my dementia and my life."

"Those around me and looking after me are supported."

"I feel included as part of society."

"I am confident my end-of-life wishes will be respected and I can expect a good death."

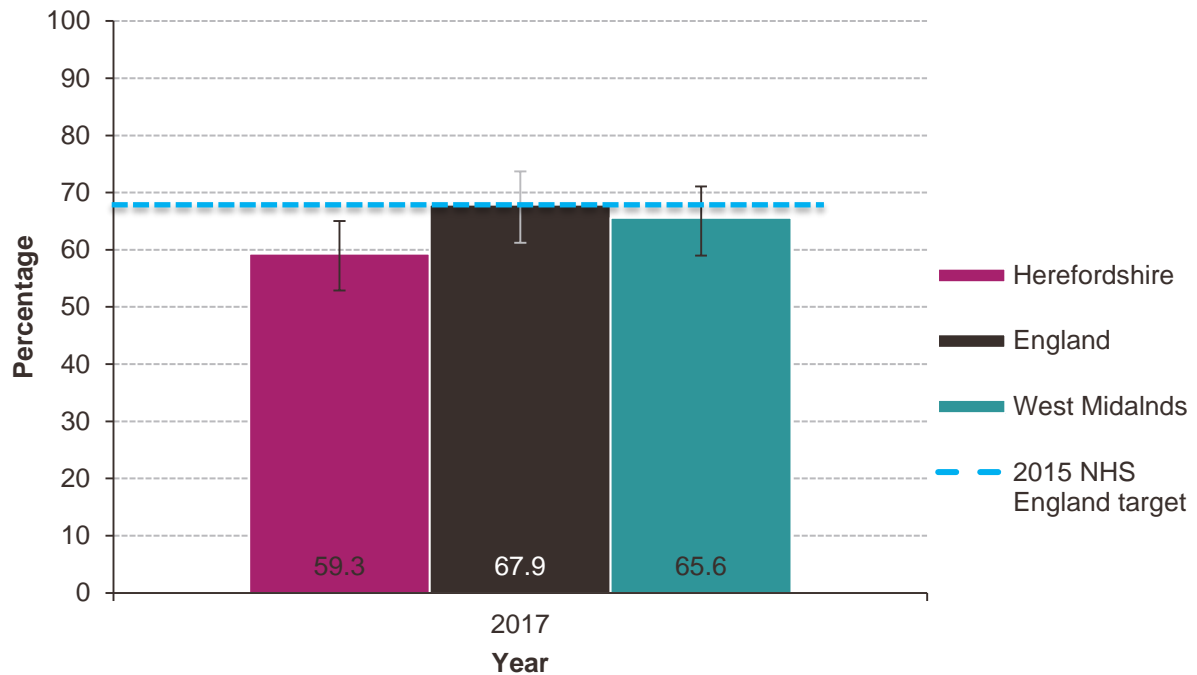
The National Institute of Health and Care Excellence Clinical Guideline 42(49) is a comprehensive guideline detailing best practice provision of health and social care for people living with dementia and their carers, and can be used as benchmark against which to compare local provision.

DIAGNOSIS

Early diagnosis leads to appropriate management and support for people living with dementia and their carers. The Prime Minister's Challenge set a target to increase the number of people living with dementia who have a formal diagnosis. In response, in 2013 NHS England set a target of 66.7 percent of people with dementia having a diagnosis by 2015(51). At the beginning of 2017 in Herefordshire, only 59.3 per cent of the estimated number of people with dementia aged 65 and

over had a formal diagnosis⁶, lower than the NHS England target and the rates reported nationally (67.9 per cent) and regionally (65.6 per cent) (Figure 38). Among our five most similar statistical neighbours⁷ Herefordshire’s dementia diagnosis rate ranks joint lowest.

Figure 38 Estimated dementia diagnosis rate among people aged 65 and over in Herefordshire, the West Midlands and England in 2017 compared to the 2015 national target



Data Source: NHS Digital, 2017.

In autumn 2017, the NHS England Intensive Support Team visited Herefordshire to take an in depth look at the local management of dementia. Interim findings from the visit suggest that on average people living with dementia in Herefordshire are presenting for diagnostic assessment at a relatively late stage, evidenced by the fact that a lower than expected proportion of people assessed by the local Memory Assessment Service (MAS) receive a diagnosis of mild cognitive impairment⁸. The NHS England Intensive Support Team took the view that lack of awareness of

⁶ <https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/4/gid/1938133052/pat/6/par/E12000005/ati/102/are/E06000019/iid/92949/age/27/sx/4>

⁷ Our five most similar statistical neighbours are Shropshire, Cheshire East, Bath and North East Somerset, Wiltshire, and Rutland.

⁸ Mild cognitive impairment is a term used to describe a state where an individual's cognitive ability is mildly impaired, but not to the extent that it is among those with dementia. In some cases mild cognitive impairment represents a transitional phase into dementia.

dementia and the stigma around it are two of the key issues preventing people from getting a diagnosis.

Local Action

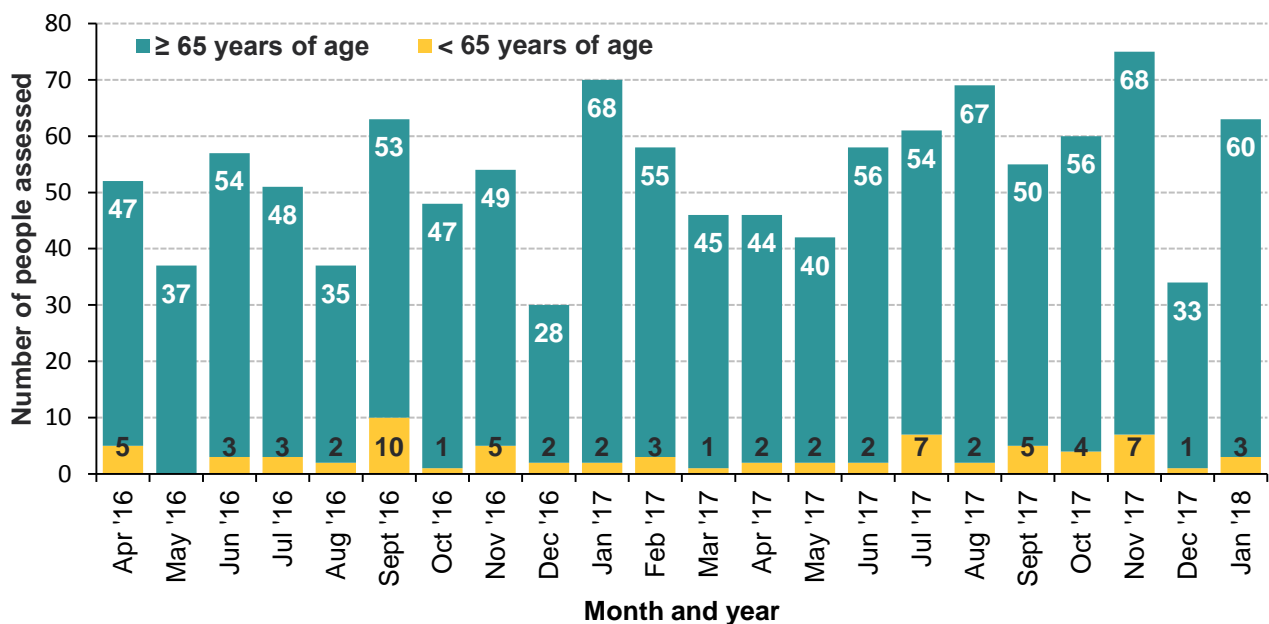
Plans have been drawn up and actions continue to be taken to improve local dementia diagnosis rates by improving public awareness of dementia, providing education for front-line care workers, and engaging in dementia case finding activities.

MEMORY ASSESSMENT SERVICE

Memory Assessment Services are specialist services which provide cognitive assessment to support the diagnosis and initial management of dementia. The National Institute for Health and Care Excellence recommends that a specialist service such as a Memory Assessment Service is the single point of referral for people with suspected dementia(52). Herefordshire’s Memory Assessment Service is run by 2gether NHS Foundation Trust.

Between April 2016 and January 2018 the Memory Assessment Service provided cognitive assessment for 1,166 people, approximately 94 per cent of whom were aged 65 or over. The number of people assessed on a monthly basis has varied with the lowest number (30 people) being assessed in December 2016 and the largest number (75 people) in November 2017 (Figure 39).

Figure 39 Number of people assessed by the Herefordshire Memory Assessment Service each month (April 2016 to January 2018 inclusive)



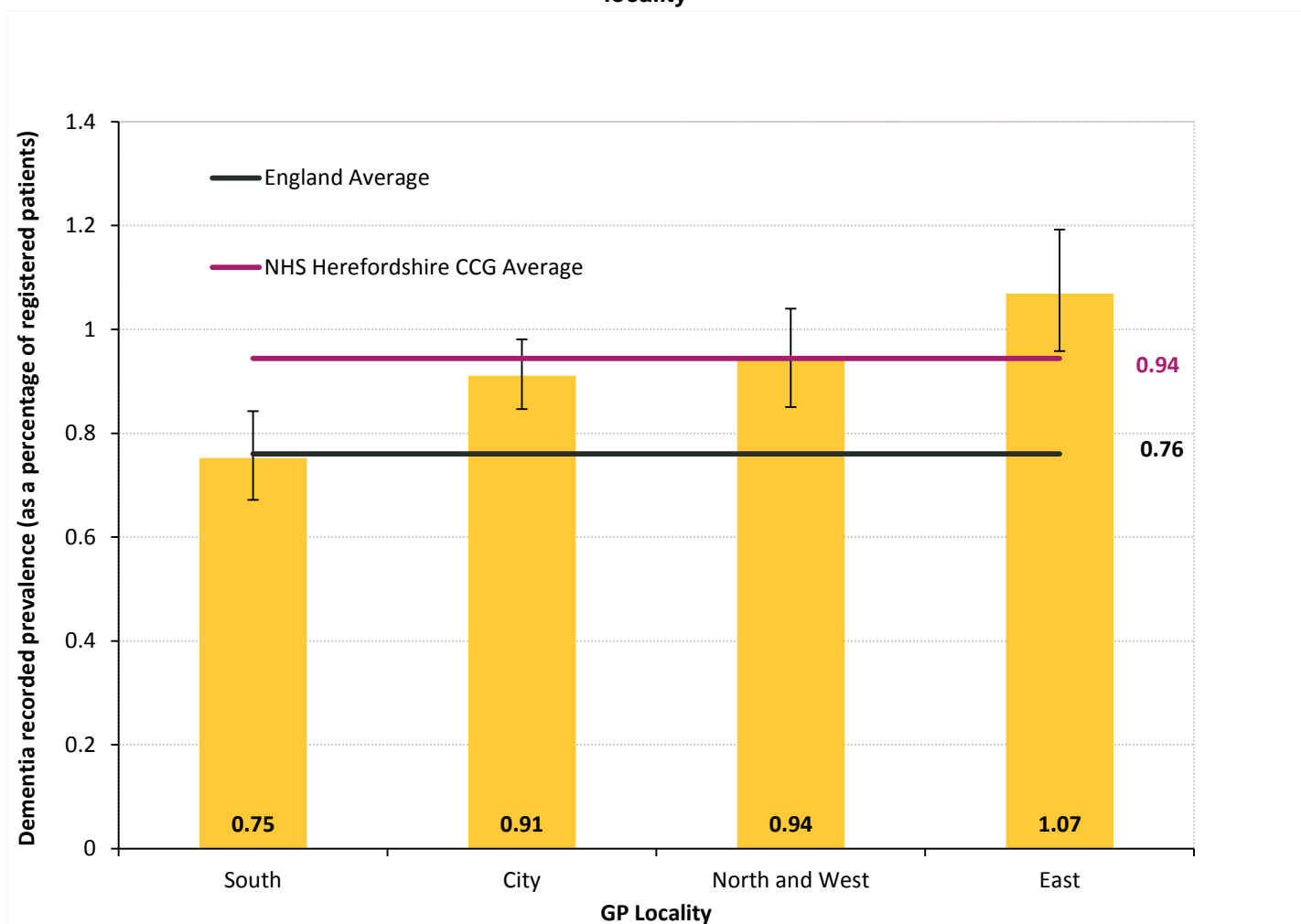
Data Source: Herefordshire Memory Assessment Service activity data.

DEMENTIA DIAGNOSIS RECORDED IN GP MEDICAL RECORDS

The figures in this section refer to the proportion of registered GP patients with a dementia diagnosis recorded in their medical records (dementia recorded prevalence), and therefore do not reflect the true prevalence of dementia; as not all people with dementia have a formal diagnosis. In particular, dementia recorded prevalence under-reports prevalence for groups who are less likely to be registered with a GP, such as ethnic minority populations, homeless people, migrants and travellers.

Dementia recorded prevalence is highest in the East locality and lowest in the South locality. The difference in recorded prevalence between these two localities is statistically significant (Figure 40).

Figure 40 2016/17 dementia recorded prevalence among registered patients of all ages by Herefordshire GP locality

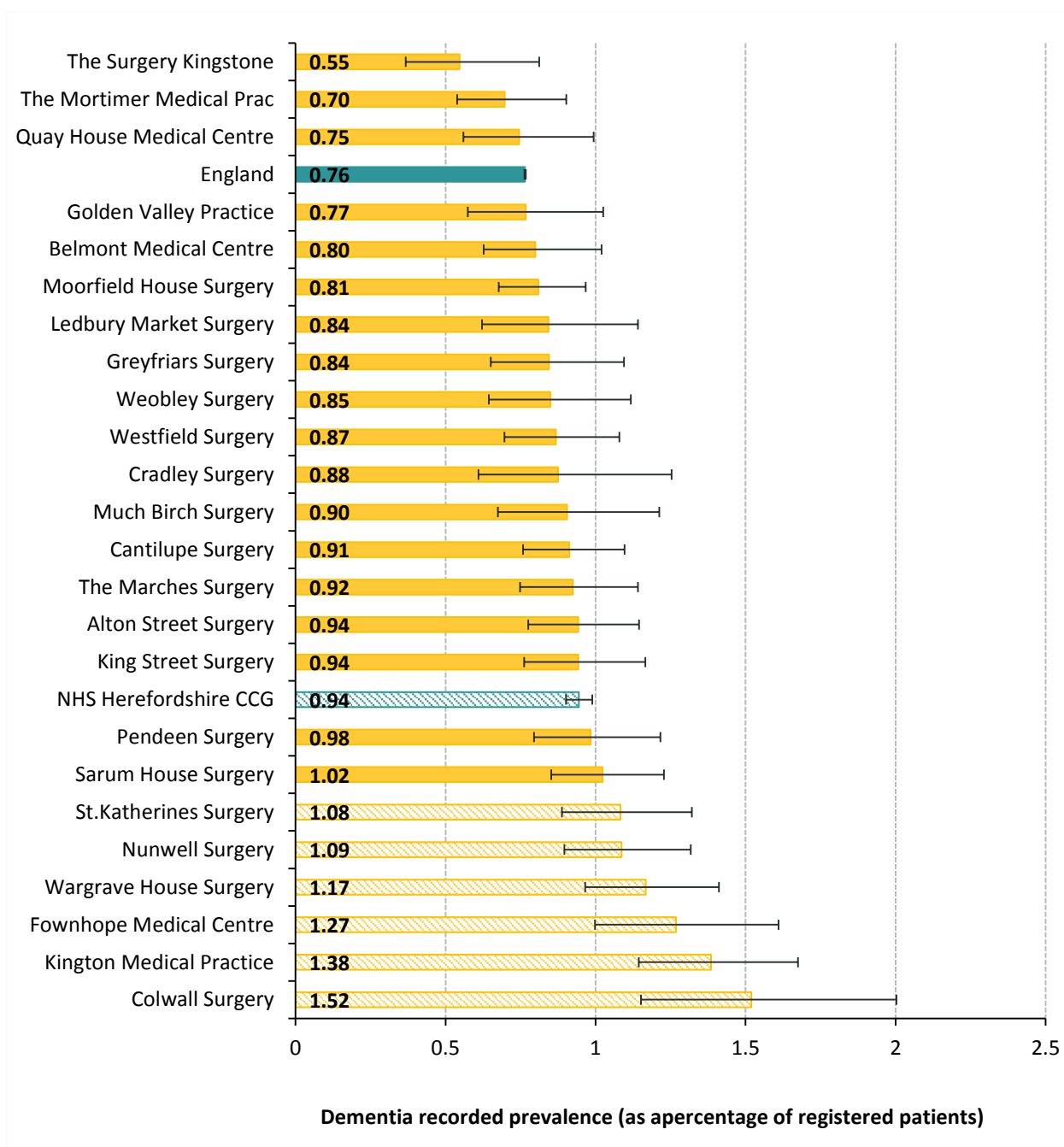


Data Sources: Quality Outcomes Framework via Public Health England-National General Practice Profiles, 2018.

The prevalence of dementia in Herefordshire GP practices varies between 0.55 per cent at The Surgery, Kington to 1.52 per cent at Colwall Surgery. Twenty-one practices across the county reported dementia recorded prevalence above the national rate of 0.76 per cent. The proportion of people with a recorded diagnosis of dementia is significantly higher than the national figure for

six practices, the county figure of 0.94 per cent is also significantly higher than the national figure (Figure 41).

Figure 41 2016/17 dementia recorded prevalence among registered patients of all ages by Herefordshire GP practice (striped bars indicate that values are statistically significantly different to the England value)



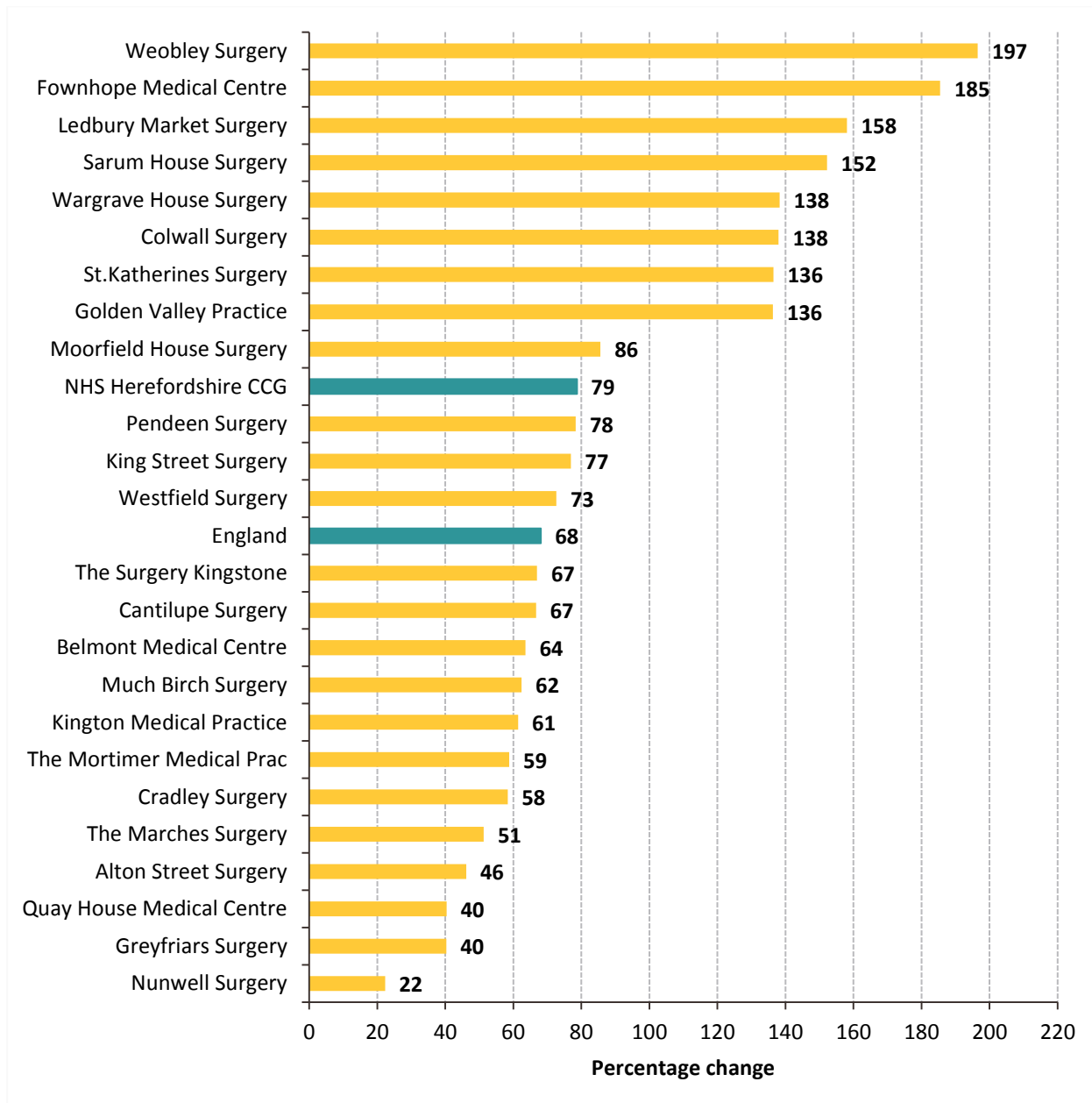
Data Sources: Quality Outcomes Framework via Public Health England-National General Practice Profiles, 2018.

Between 2009/10 and 2016/17 the recorded prevalence of dementia increased at all Herefordshire GP practices. The proportional increases ranged from 22 per cent at Nunwell Surgery to 197 per cent at Weobley Surgery, with eight practices indicating an increase of 100 per cent or more. This

increase is in line with the national trend of 68 per cent, while the proportional change for Herefordshire GP practices as a whole was 79 per cent (Figure 42).

The increases in dementia recorded prevalence observed among all local GP practices, and in England as a whole is likely a reflection of the ageing of the local and national population profiles, enhanced public awareness of dementia, and local and national efforts to improve diagnosis rates.

Figure 42 Percentage change in dementia recorded prevalence between 2009/10 and 2016/17 among registered patients of all ages by Herefordshire GP practice



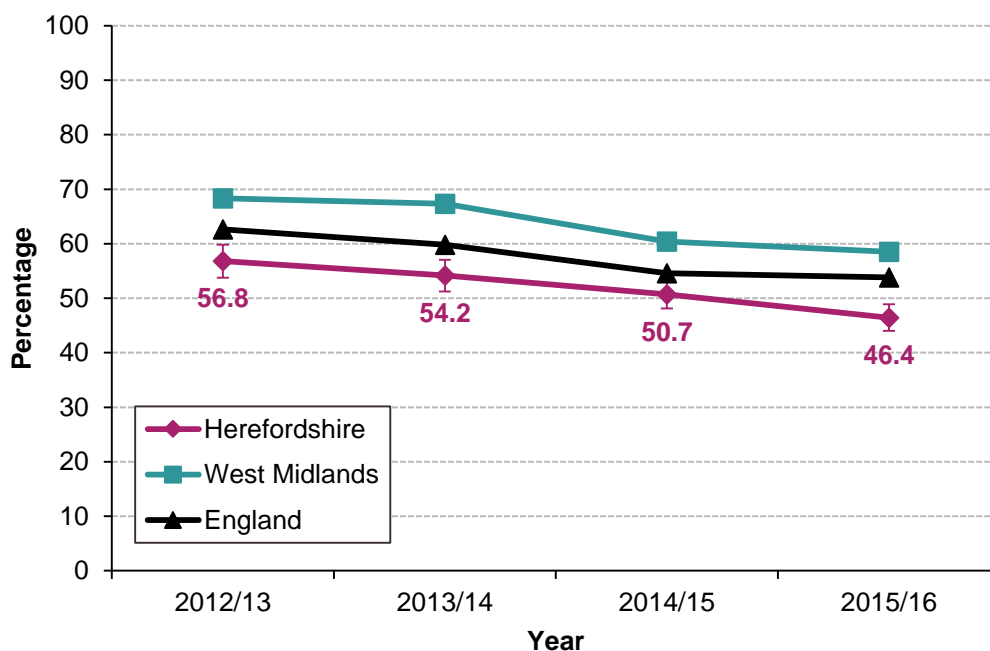
Data Sources: Quality Outcomes Framework via Public Health England-National General Practice Profiles, 2018.

GENERAL HOSPITAL ADMISSIONS

It is estimated that 66 per cent of beds in an NHS general hospital are occupied by older people at any given time (53), approximately a third of whom will have dementia(54). Among hospital inpatients, dementia is an independent predictor for loss of independence, longer lengths of stay, being discharged to a care home, and dying(55). In addition to being at risk of poor outcomes once hospitalised, people with dementia can be easily distressed by changes to their surroundings, therefore, where appropriate, medical care should be provided in the community. Delays in hospital discharge can be particularly detrimental to people living with dementia(49).

In Herefordshire, in 2015/16 approximately 46 per cent of people with a diagnosis of dementia were admitted to hospital to receive either emergency or planned inpatient care, approximately four percentage points fewer than in 2014/15, and ten percentage points fewer than in 2012/13. This decreasing trend is mirrored regionally and nationally. In 2015/16, the percentage of people diagnosed with dementia accessing inpatient care was significantly lower in Herefordshire (46.4 per cent) compared to the West Midlands (58.5 per cent) and England (53.8 per cent) (Figure 43). The reason for this is unclear, and could be explained by numerous factors; for example, it could be the product of excellent community care, or conversely, poor access to secondary care among people living with dementia in Herefordshire. Therefore, this observation warrants further investigation.

Figure 43 People with dementia using inpatient hospital services as a percentage of recorded diagnosis of dementia in Herefordshire, the West Midlands and England between 2012/13 and 2015/16



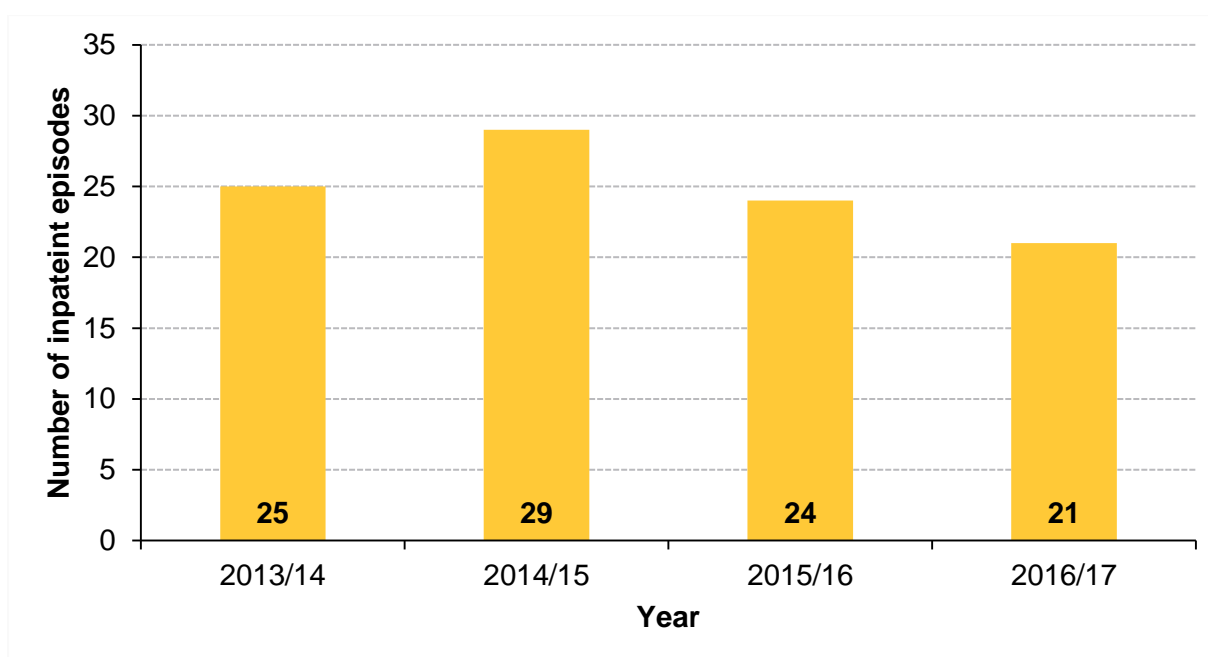
Data Source: Public Health England, 2017.

MENTAL HEALTH HOSPITAL ADMISSIONS

In patient admission to a mental health hospital is warranted when a person living with dementia experiences psychiatric and behavioural symptoms that cannot be appropriately managed in another setting(56). In Herefordshire, specialist inpatient mental health services are provided by 2gether NHS Foundation Trust from the Stonebow Unit.

Over the four year period between 2013/14 and 2016/17 the Stonebow Unit provided an average of 25 episodes of inpatient care each year to people with an active diagnosis of dementia (Figure 44).

Figure 44 Number of inpatient episodes at the Stonebow Unit where the patient had an active diagnosis of dementia (financial years 2013/14 to 2016/17)

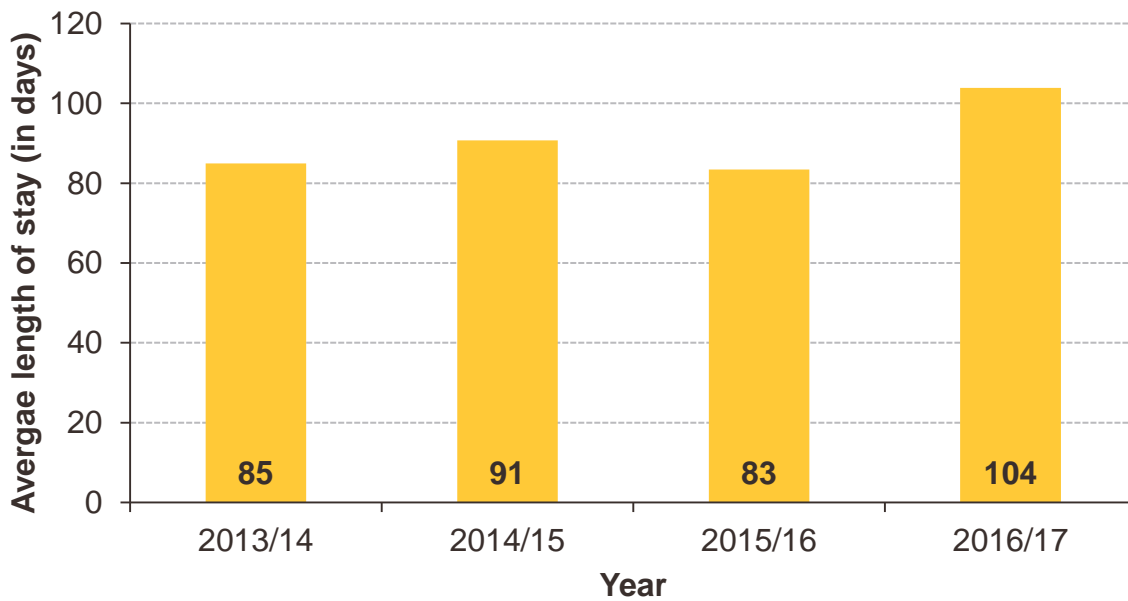


Data Source: 2gether NHS Foundation Trust service activity data

The negative impact of prolonged mental health in-patient admissions is widely recognised(56). Historically, a considerable proportion of mental health beds have been occupied by people whose discharge has been delayed(57), the main delay being patients waiting to move into a care home. More recently, case studies from the National Audit Office(58) have highlighted concerns over bed capacity in residential and nursing homes, with the availability of specialist care beds for people living with dementia with behaviour that challenges (often referred to as elderly mentally infirm beds) being highlighted as a particular issue. Therefore, unless these capacity issues are addressed, it is expected that delayed transfers of care among people living with dementia will become more common-place.

At the Stonebow Unit, between 2013/14 and 2016/17 inclusive the average length of inpatient stay among people with an active diagnosis of dementia was 91 days, with some variability on average length of stay noted from year to year (Figure 45).

Figure 45 Average length of inpatient stay at the Stonebow Unit among people with an active diagnosis of dementia (financial years 2013/14 to 2016/17)



Data Source: 2gether NHS Foundation Trust service activity data.

As of the 28th of February 2018, in the 2017/18 financial year the Stonebow Unit provided 19 episodes of inpatient care to people with an active diagnosis of dementia. Their average length of stay was 77 days, lower than the average for the 2016/17 financial year, and the lower than in the previous four years.

USE OF ANTIPSYCHOTIC DRUGS

Some people living with dementia experience behavioural and psychological symptoms such as delusions, hallucinations, agitation, and aggression. Antipsychotic drugs are sometimes prescribed to help manage these symptoms. While antipsychotic drugs may represent appropriate management for some people, they are not suitable for all, and have the potential to cause serious side-effects. NICE Guideline 42(49) recommends that antipsychotic drug prescription be avoided unless the person living with dementia is severely distressed by their symptoms or their behaviour puts themselves or others at immediate risk of harm. Historically, the over prescription of antipsychotic drugs among people living with dementia in the NHS was commonplace(59), however between 2008 and 2011 national prescribing levels were halved(60).

In December 2017, NHS Digital published data on the prescribing of antipsychotic drugs to dementia patients(61). As at 30th November 2017, 9.4 per cent of people with a diagnosis of dementia in England had a prescription of antipsychotic medication within the last 6 weeks, with considerable variation observed across Clinical Commissioning Group areas. In Herefordshire, over the same time period 8.9 per cent of people with a diagnosis of dementia had a prescription of antipsychotic medication.

SUPPORTING CARERS

The majority of older people living with dementia are cared for in the community by friends and family. This is referred to as “informal care”. Remaining in the community supported by friends and family is the preference for most people living with dementia. However, caring for a person living with dementia can be very challenging, especially if they have behavioural and psychological symptoms⁹. Carer stress is one of the main factors which predicts care home admission among people living with dementia(62). However, it has been evidenced that interventions to support carers (such as those aimed at improving carers’ psychological health and knowledge and understanding of dementia) can improve their quality of life and delay care home admission for the person they care for(63, 64).

ADULT SOCIAL CARE DATA

Carer self-reported quality of life is an indicator which forms part of the Adult Social Care Outcome Framework (ASCOF), and provides insight into how well supported carers feel by local authorities. This data is collected via the biennial Personal Social Service Survey of Adult Carers in England (PSS SACE) which is administered to carers who have had a carer’s assessment or review by the local authority in the previous 12 months. Carers are asked to rate the degree to which they feel their needs are met in the following six domains: occupation, control, personal care, safety, social participation and encouragement and support. Twelve is the highest possible score, and zero the lowest, with the highest scores indicating that all of a carers needs are being met, and the lowest score signifying that a carers needs are not being met.

In 2016/17, 125 respondents in Herefordshire were caring for a person living with dementia. Their average score was 7.6 out of 12, the same as in 2014/15 and similar to the scores for England (7.5) and the West Midlands (7.7). These scores indicated that Herefordshire Council is supporting carers of people living with dementia as well as other local authorities regionally and nationally, however the survey results suggest there is still room for improvement.

POST-DIAGNOSTIC SUPPORT FOR PEOPLE LIVING WITH DEMENTIA AND THEIR CARERS

The Government’s mandate to the NHS for 2016/17 included a number of specific objectives on dementia, one being to improve the quality of post-diagnosis treatment and support for people with dementia and their carers.

Care Planning

Care planning is a person-centred activity that supports planning for the present and future health and social care needs of an individual through setting goals, identifying needs, and developing and

⁹ Behavioural and psychological symptoms are caused by changes in the way a person with dementia thinks perceives the world around them, and they ways they feel. Examples include: agitation, anxiety, elation, irritability, depression, apathy, disinhibition, delusions, hallucinations, and sleep or appetite changes.

implementing action plans. Care planning is commonly undertaken for people with long-term conditions, and is frequently conducted by a GP.

NHS England has recognised care planning as an important element in delivering improved post-diagnostic care and support for people living with dementia, their families and carers(65). It is recommended that care planning take place soon after a diagnosis of dementia, and be renewed at least annually.

According to the Quality Outcomes Framework Database, in 2017 there were 1,656 patients on the Herefordshire Clinical Commissioning Group dementia register, 1,426 (86.1 per cent) of whom received a face-to-face care plan or review of their care plan within the last 12 months. This figure compares favourably to the figures for NHS England, and NHS Midlands and East (West Midlands) which were 83.7 and 85.2 per cent respectively.

COMMUNITY BASED SUPPORT

In Herefordshire, a number of services are available to people living with dementia and their families, some of those on offer are highlighted in the section below.

Dementia Adviser Service

Dementia advisers offer one-to-one personalised support to people living with dementia, their family and carers by providing a single point of contact from which to receive:

- specialist dementia advice and support,
- assistance in navigating the health and social care system and voluntary sector to access appropriate support and input,
- advice on how to remain independent and live well in the community.

Dementia advisers are seen as key to providing integrated post-diagnostic support.

Alzheimer's Society commissioned an evaluation of the dementia adviser role(66). The social cost benefit analysis identified the following key outcomes as creating the greatest value:

- a reduction in the cost of mental health services to the state, by avoiding carer breakdown,
- an increase in information and knowledge for carers as evidenced by their awareness of support services available in the community, knowledge of strategies that help them to cope with caring for someone with dementia, and their ability to keep the person they care for safe from harm,
- an increase in building peer support for both people with dementia and carers from having more contact with other people with dementia or carers.

The overall findings of the social cost benefit analysis indicate a return on investment, with every £1 invested in dementia adviser post-diagnosis support resulting in nearly £4 worth of benefits (Figure 46).

Figure 46 Return on investment: dementia post-diagnostic support

For every **£1** invested in post-diagnosis support...



...nearly **£4** worth of benefits are created

Source: https://www.alzheimers.org.uk/download/downloads/id/3429/dementia_advisers_a_cost_effective_approach_to_delivering_integrated_dementia_care.pdf

In the 12 months from the 1st of November 2016 to the 31st of October 2017 the Herefordshire Dementia Adviser service received 384 referrals, 301 of which came from the NHS 2gether Foundation Trust. A total of 1,345 people were reviewed or supported in this 12 month period. On average there were 4.25 interventions per person, with interventions constituting a phone call, email, home visit, or meeting in a clinic.

Feedback from service users, health care professionals and other stakeholders has been positive, with many commenting on the positive impact and added value the Dementia Adviser service is having at both the individual and health and social care system level.

Leominster Dementia Meeting Centre

In 2016, a dementia meeting centre opened at The Multi-Agency Offices on Coningsby Road in Leominster. The purpose of the meeting centre is to provide post-diagnostic support for people living with dementia and their families through the implementation of an evidenced based model for meeting centres established in The Netherlands. Evaluation of meeting centres in The Netherlands revealed that they were effective in improving outcomes for both family carers and people living with dementia, including reduced nursing home admissions (67-69):

Family carers benefited from:

- improved feelings of competence in providing care,
- reduced feelings of burden.

People living with dementia benefited from:

- increased happiness,

- increased physical activity levels,
- the development of new friendships.

The Leominster meeting centre was set up and supported by the Alzheimer's Society, Herefordshire Council and the University of Worcester as part of the European MEETINGDEM research project¹⁰ to evaluate whether the benefits observed in The Netherlands can be replicated in the UK.

The centre is run by a small team of staff and volunteers trained in the ethos of person centred dementia care and the Adjusting to Change Model. The centre staff deliver the Meeting Centres Support Programme, which is comprised of evidence-based interventions targeted to the needs of the people living with dementia (members) and their families. Carer support is provided under the same roof and by the same people as the support on offer for people living with dementia.

Between the 1st of April 2016 and the 30th of June 2017 there were 2,040 individual attendances by people living with dementia and 1,150 attendances by family carers. In total, 71 people with dementia and 51 carers accessed the Meeting Centre, although not all became full members.

Evaluation of the impact of the meeting centre is in progress; however the earlier indicators suggest that the meeting centres have had a positive impact on the quality of life for people living with dementia(70). The Leominster Meeting Centre was so well received that in March 2017 another was set up in Ross-on-Wye.

Memory Cafés

Memory Cafés are run by The Alzheimer's Society and provide people living with dementia and their carers with an opportunity to:

- discuss their own dementia diagnosis, or someone else's, and think about what it means for the future,
- get answers from health professionals and meet and learn from other people in similar situations.

A recently published qualitative study found that Memory Cafés are particularly valuable to carers, offering them valuable social opportunities and respite from their caring roles(71).

Memory Cafés are run in Hereford, Ross-on-Wye and Leominster. Between the 1st of April and the 10th of October 2017 there were 290 individual attendances made to Herefordshire's Memory Cafés by people affected by dementia, 156 attendances were made by people living with dementia and 134 by carers.

Singing for the Brain

¹⁰ <https://www.meetingdem.eu/links/united-kingdom/>

Singing for the Brain is an activity developed by The Alzheimer's Society. Singing for the Brain uses music for the therapeutic benefits of enhancing mood, relieving stress and improving sense of wellbeing, as well as creating an opportunity to socialise. Singers of all abilities are welcome. Familiar songs are sung to allow people to access old memories and new ones are introduced to provide a challenge, with songs from different genres and eras sung to offer variety and interest.

A recent research evaluation found that Singing for the Brain participants reported benefitting from the social inclusiveness of the groups, and felt that improvements in relationships, memory, mood, and a greater acceptance of their dementia diagnosis were all facilitated by their participation(72).

Singing for the brain is available in Hereford, Ledbury and Leominster. Between the 1st of April and the 10th of October 2017 there were 609 individual attendances made to Herefordshire's Singing for the brain groups by people affected by dementia, 376 attendances were made by people living with dementia and 609 by carers.

Further details about the Memory Café and Singing for the Brain meeting venues and times can be found via the online [Dementia Connect](#) search tool.

END OF LIFE CARE

End of life care planning is important for anyone with a life-limiting condition, but for people living with dementia, this planning may need to take place earlier than with other conditions, in order to ensure that the person living with dementia is able to carefully consider and articulate their wishes while they still have the mental capacity to do so. Every effort should be made to support a person with dementia to die with dignity in a place of their choosing.

PLACE OF DEATH

When nearing the end of their life, most people with dementia wish to die at home, or in a well-supported care setting that is familiar to them, surrounded by family and friends. When supporting someone with dementia to die at home, timely access to equipment, and health and social care professionals is essential. Therefore, it is crucial to communicate that the person wishes to die at home to relevant health and social care professionals in a timely fashion, so that all necessary arrangement can be made.

While most people would not choose to die in a hospital setting, for those who require urgent medical care this might be unavoidable. However, some people with dementia nearing the end of their lives are admitted to hospital unnecessarily. Avoiding such admissions requires recognition that a person is nearing the end of their life. Common indicators are limited speech (use of single words or phrases that may not make sense), needing help with most everyday activities, eating less and having difficulties swallowing, bowel and bladder incontinence, becoming bed-bound(73).

In 2017, in Herefordshire, 22.3 per cent of deaths among older people with dementia were in hospital, 66.0 per cent in a care home and 9.5 per cent in the community. Data on place of death was missing for 0.2 per cent. Overall, 76.0 per cent died in their usual place of residence, compared with 64.0 per cent in the West Midlands and 69.0 per cent in England.

DISCUSSION POINTS

- Herefordshire's Health and Wellbeing Board has named dementia as a priority area, acknowledging that as a long-term condition it has a considerable impact upon the health and wellbeing of the local community. A partnership dementia strategy is in place to ensure a coordinated local response is in place to support people living with dementia, their carers, and families to live fulfilled lives.
- A number of health behaviours and long-term health conditions are associated with an increased risk of developing dementia. In 2015/16 hypertension, coronary heart disease and stroke (all known dementia risk factors) were all statistically significantly higher locally than nationally. These findings suggest a need to prioritise preventative action and treatment for these conditions, with resulting benefits having a direct impact on the long term conditions in question, as well as acting to reduce dementia incidence.
- Locally, the dementia diagnosis rate has not yet reached the government's 2015 target of having 66.7 per cent of people with dementia formally diagnosed. Herefordshire's diagnosis rate (59.3 per cent) is lower than the West Midlands and England rates (65.6 per cent and 67.9 per cent respectively), though not significantly so. Timely diagnosis can lead to people living with dementia and their carers receiving appropriate support and advice when it is likely to be of greatest benefit. However, it is important to note, that not all people will want to seek a dementia diagnosis, and this choice must be respected. Campaigns to improve public awareness of dementia and diagnosis case finding activities all form part of a local diagnosis rate improvement plan.
- In Herefordshire, the proportion of people with dementia receiving inpatient hospital care (either emergency or planned care) is statistically significantly lower than nationally. However, the reasons for this are not known, and could be indicative of good quality community care, or could signify poor access to secondary care among people living with dementia.
- Informal carers make a significant contribution to the wellbeing of people living with dementia, with informal care accounting for an estimated 44 per cent of dementia related health and social care costs(4). Providing informal care for someone living with dementia can be challenging and can have negative effects on the psychological wellbeing of caregivers. Timely and appropriate support can reduce carer stress and prevent people living with dementia being prematurely admitted to care homes. There are some good examples of local community support available to people living with dementia and their carers, some named examples being the Dementia Adviser Service and the Leominster Dementia Meeting Centre. While self-reported quality of life data indicates that Herefordshire Council is supporting carers of people living with dementia better than the average local authority, there is still room for improvement.

RECOMMENDATIONS

- Prioritise preventative action and treatment for hypertension, coronary heart disease and stroke, as prevalence rates for these three dementia risk factors are particularly high among Herefordshire residents.
- Continue to take action to improve dementia diagnosis rates.
- Investigate the underlying reasons for the observation that in Herefordshire a statistically significantly smaller proportion of people with a diagnosis of dementia receive hospital inpatient care compared to nationally, and if required, implement quality improvements.

Key Points

- It is estimated that in 2016 there were 4,600 people aged 65 and over with frailty living in the community in Herefordshire. However, this does not take into account the number of people with frailty living in care homes. By 2035, the number of people aged 65 and over with frailty living in the community in Herefordshire is estimated to rise by approximately 67 per cent to 7,700 people.
- Between April 2016 and March 2017, 5,029 patients who were admitted to Herefordshire County Hospital Accident and Emergency department were identified as having frailty.
- Locally, the number of emergency hospital admissions from care homes is on the rise.

WHAT IS FRAILITY?

Frailty is “a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves”(3). Frailty more commonly affects older people, but can occur at any age. Frailty is distinct from multiple long term conditions (multi-morbidity) and disability; however, these health states often co-exist.

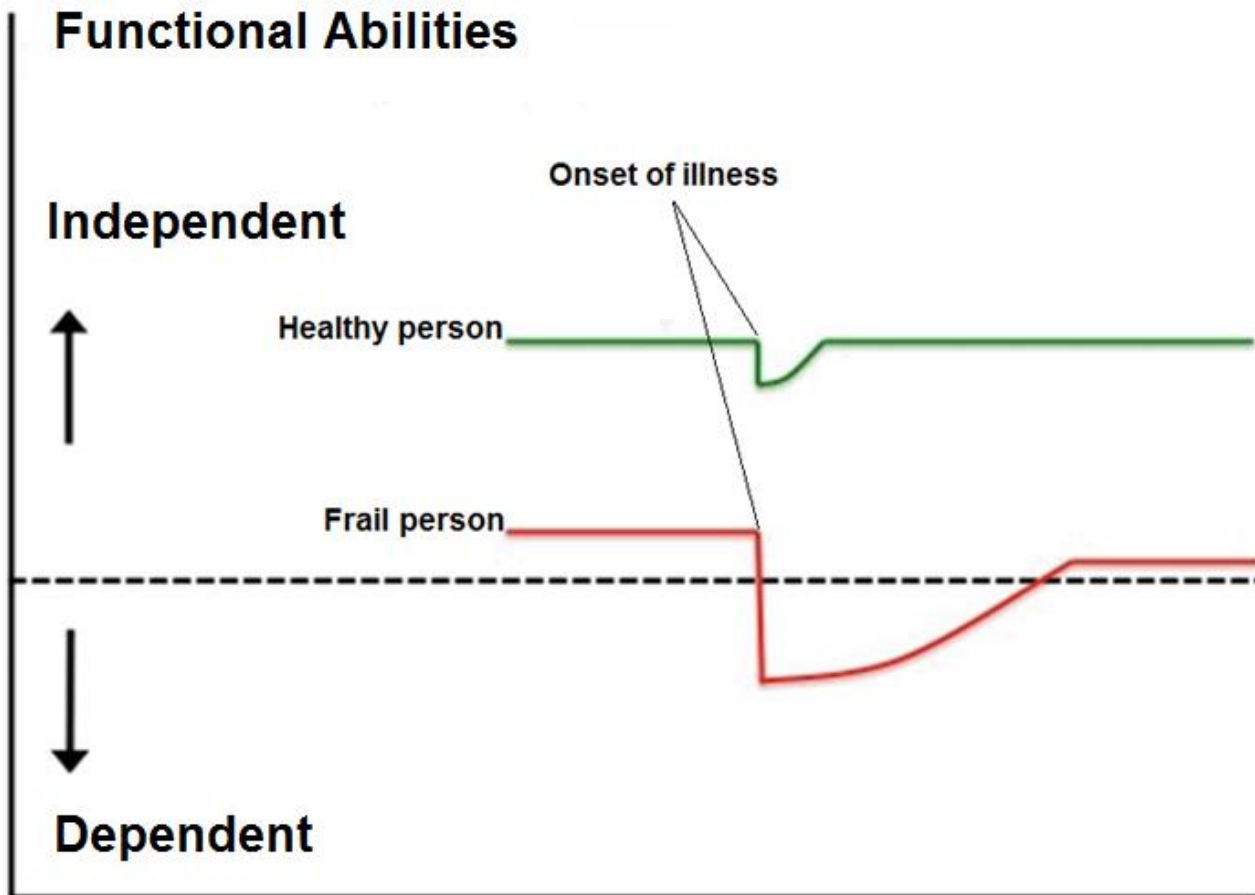
Frailty can be identified by the presence of three or more of the following: unintentional weight loss, reduced muscle strength, reduced gait speed, self-reported exhaustion, and low energy expenditure. People with one or two of the above symptoms are considered to have prefrailty(74).

Frailty is not a fixed state, and in some cases it is possible to reverse frailty(75).

WHAT ARE THE EFFECTS OF FRAILITY AND PREFRAILITY?

People who have frailty are more vulnerable to minor illnesses and less able to recover to their previous health state and level of function (Figure 47). As a result, frailty is associated with an increased risk of falls, disability, admission to a care home, and death(76).

Figure 47 Illustration of how older people with frailty are more vulnerable to minor illnesses



Source: Clegg et al. 2013 <https://www.ncbi.nlm.nih.gov/pubmed/23395245>

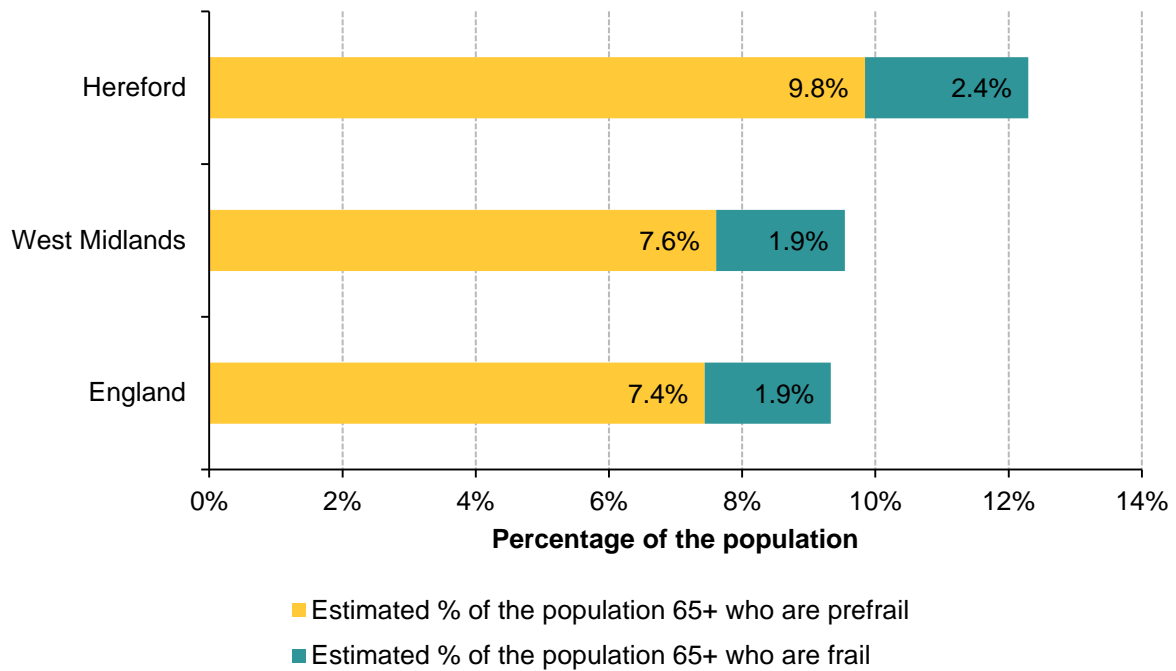
Prefrailty is a transitional state where a person is less robust than a healthy individual, and is at an increased risk of developing frailty. A person who has prefrailty is at an increased risk of experiencing falls, disability, admission to a care home, and death, though to a lesser degree than someone who has frailty(74).

PREVALENCE OF PREFRAILTY AND FRAILTY

It is estimated that in 2016 there were 4,600 people aged 65 and over with frailty, and 18,600 with prefrailty living in the community in Herefordshire. The prevalence of frailty increases with age with 4 per cent of those aged 65-69 estimated to be frail, rising to 26 per cent among those aged 85 and over(77).

There are a higher percentage of over 65s who are estimated to have prefrailty or frailty in Herefordshire compared to the West Midlands and England as a whole (Figure 48). This is explained by the fact that a larger proportion of the population in Herefordshire is over the age of 75 compared to the West Midlands and England.

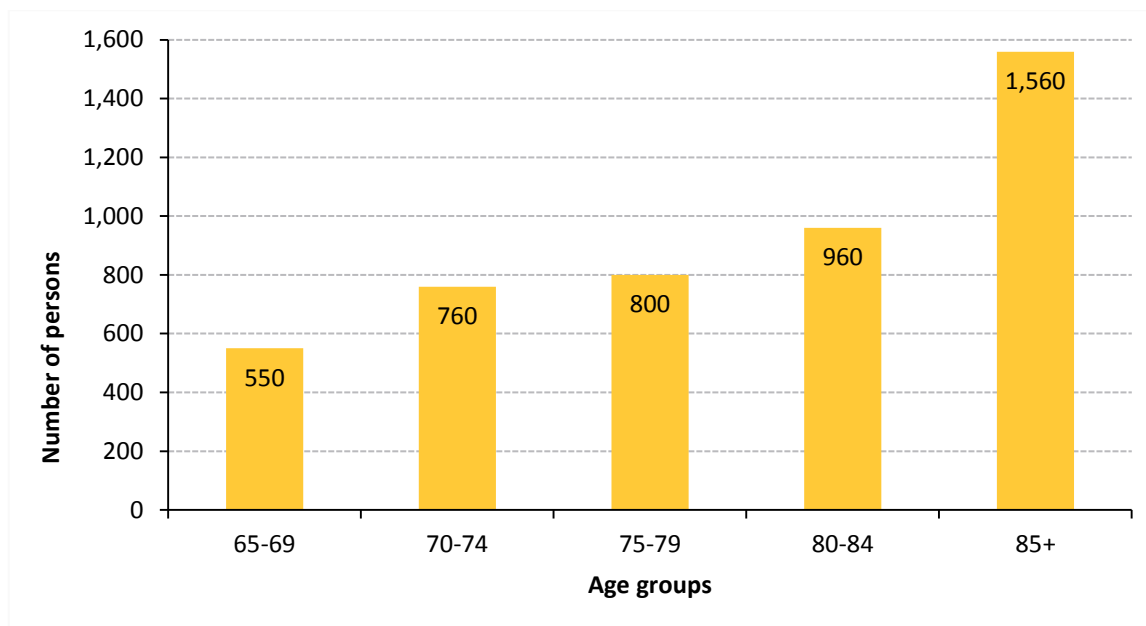
Figure 48 Estimated percentage of the population aged 65 and over who were prefrailty and frailty in 2016



Data Source: ONS mid-2016 population estimates and prevalence rates published by Collard et al.

Figure 49 presents the number of people living in the community over the age of 65 estimated to have frailty in Herefordshire by age group. Table 7 presents the estimated number of over 65s with frailty and prefrailty in 2016 by Herefordshire GP practice. The estimated percentage of each GP practice population aged over 65 with frailty or prefrailty is presented in Figure 50.

Figure 49 Estimated number* of community dwelling older persons with frailty in Herefordshire in 2016 by age group



Data Source: ONS mid-2016 population estimates for Herefordshire and prevalence rates published by Collard et al.(77).

*Numbers in figure may not total to values in the text due to rounding.

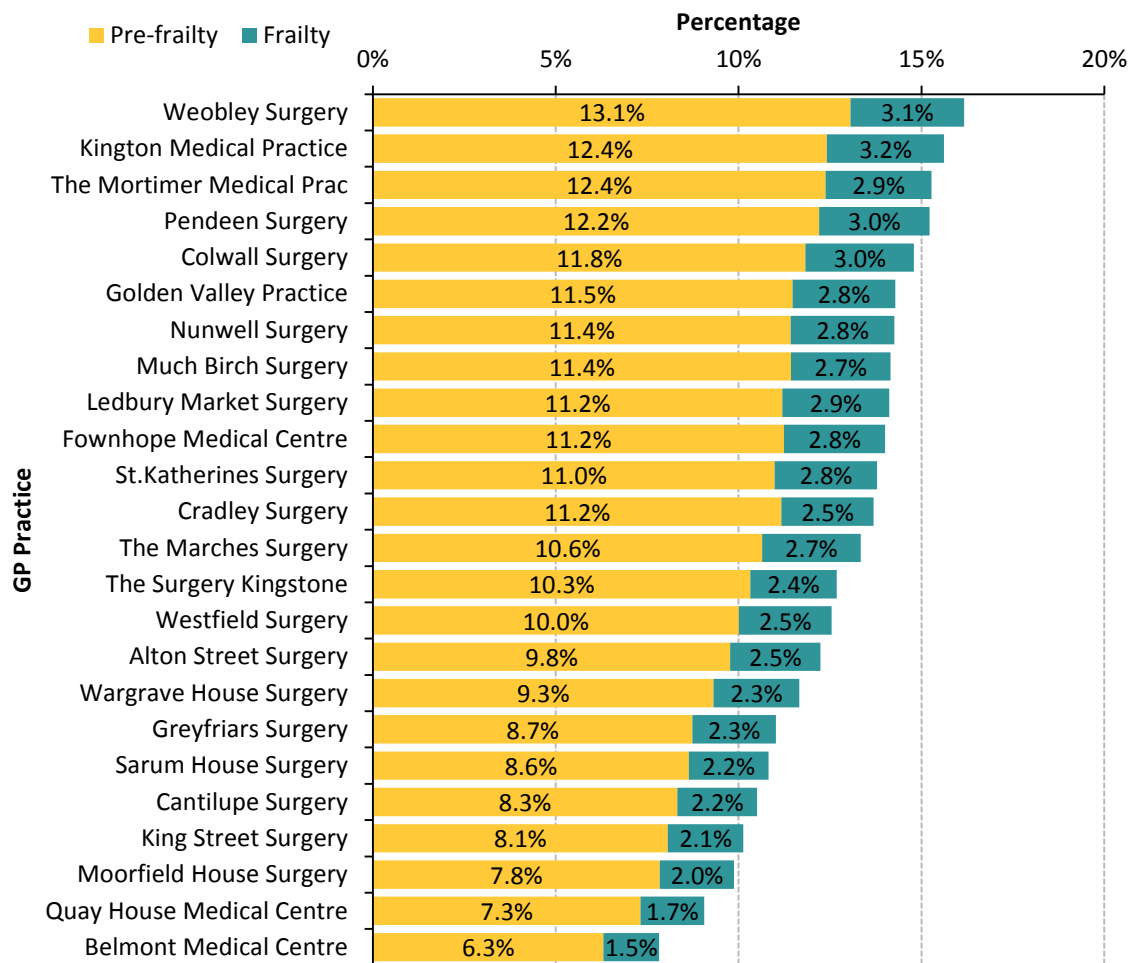
Table 7 Estimated number* of people aged 65 and over with prefrailty and frailty in 2016 by GP practice

Practice name	Total practice population	Estimated number with frailty	Estimated number with prefrailty
Alton Street Surgery	10,557	260	1,030
Belmont Medical Centre	7,964	120	500
Cantilupe Surgery	12,150	270	1,010
Colwall Surgery	3,151	90	370
Cradley Surgery	3,299	80	370
Fownhope Medical Centre	5,071	140	570
Golden Valley Practice	5,859	170	670
Greyfriars Surgery	6,394	150	560
King Street Surgery	8,874	180	720
Kington Medical Practice	7,716	250	960
Ledbury Market Surgery	4,763	140	530
Moorfield House Surgery	14,950	300	1,170
Much Birch Surgery	4,812	130	550
Nunwell Surgery	9,372	270	1,070
Pendeen Surgery	8,342	250	1,020
Quay House Medical Centre	6,199	110	450
Sarum House Surgery	11,054	240	960
St.Katherines Surgery	8,854	250	970
The Marches Surgery	9,056	240	960
The Mortimer Medical Prac	8,079	230	1,000
The Surgery Kingstone	4,282	100	440
Wargrave House Surgery	9,035	210	840
Weobley Surgery	5,716	180	750
Westfield Surgery	9,167	230	920

Data Source: Public Health England National General Practice Profiles and prevalence rates published by Collard et al.(77).

*Numbers in table may not total to values in the text due to rounding.

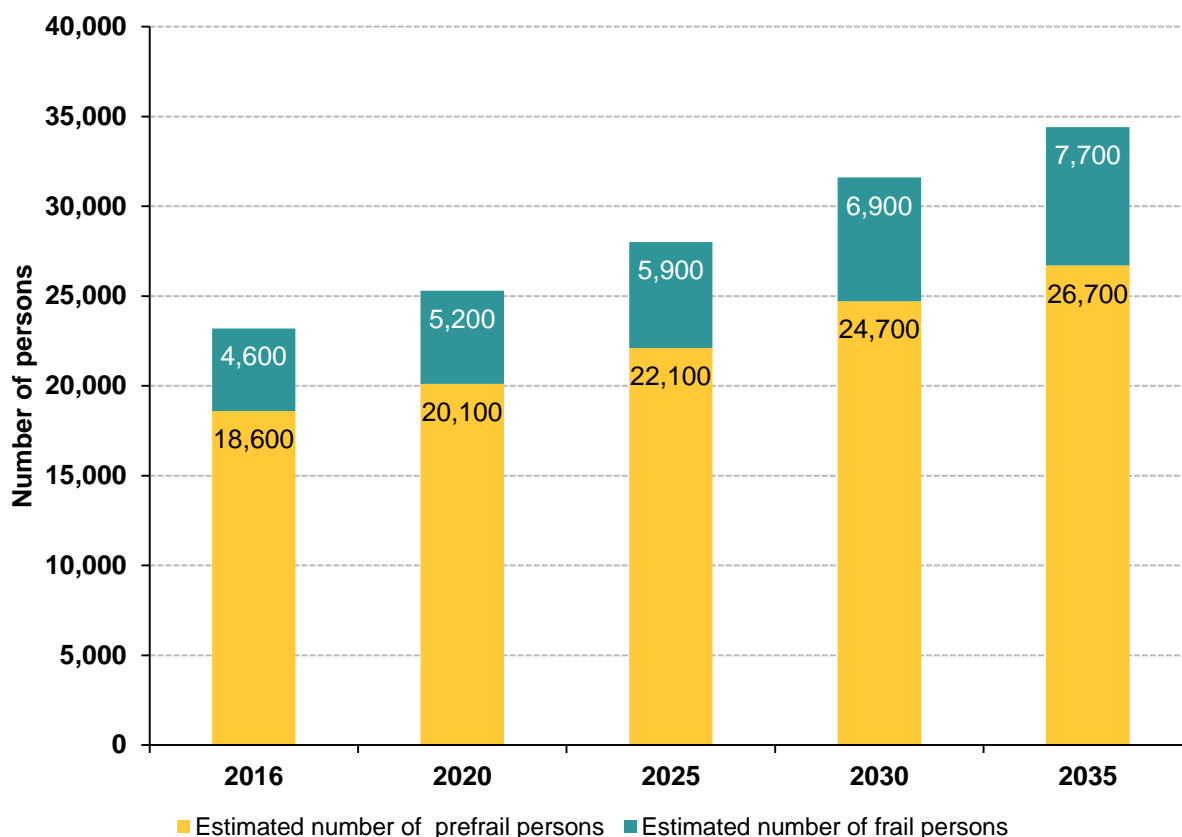
Figure 50 Estimated percentage of GP practice population aged 65 and over with prefrailty and frailty for each GP practice in Herefordshire in 2016



Data Source: ONS mid-2016 population estimates for Herefordshire and prevalence rates published by Collard *et al.*(77)

As the number of people over the age of 65 increases, so too will the number of people living in a frail and prefrail state. It is estimated that the number of over 65s living with frailty in Herefordshire will increase by approximately 67 per cent between 2016 and 2035, and the number who are prefrail by approximately 44 per cent (Figure 51).

Figure 51 Estimated number* of community dwelling over 65s who will be prefrail or frail in Herefordshire in 2016 and 2020-2035



Data Source: ONS mid-2016 population estimates for Herefordshire, ONS 2014 population projections for Herefordshire and prevalence rates published by Collard et al.(77).

*Numbers in figure may not total to values in the text due to rounding.

The prevalence of prefrailty and frailty in the care home setting is not well understood. However, it is estimated that up to 40 per cent of older people living in care homes have prefrailty and that up to 50 per cent have frailty(78).

BEST PRACTICE MANAGEMENT

PREVENTION

Findings indicate that health behaviours at mid-life contribute to frailty risk in later life(79). Being physically active has been found to be protective against frailty, while smoking, poor nutrition and alcohol consumption have been found to put people at greater risk of frailty, and related adverse health outcomes as they age(79). Therefore, from a population health perspective, it is important to take every opportunity to promote health and wellbeing at all ages. In Herefordshire, health, social care, and voluntary sector workers are encouraged to promote healthy lifestyle choices through the “Making Every Contact Count” programme (see page 16 for further details).

Exercise and nutritional interventions are recommended for both the prevention and the treatment of frailty(3). Strength and balance training are common components of effective exercise

programmes, aimed at targeting muscle loss and reducing falls risk respectively. Nutritional interventions are targeted at combating muscle loss, and include protein and vitamin D supplementation.

Older people with prefrailty are an ideal cohort to target with interventions aimed at preventing frailty(80). While currently limited(81), there is some evidence indicating that engaging in exercise can stave off the development of frailty in older people who are prefrail(82).

IDENTIFICATION

While there is evidence that it is possible to reverse the effects of frailty, the ability to do so decreases over time(75). Therefore, timely identification and diagnosis of frailty is of great importance.

Routine health and social care interventions have the potential to cause harm to older people who are frail, and among people with frailty, decisions to commence or discontinue an intervention must be given careful consideration(3). For this reason, health and social care professionals should assess all older people for the presence of frailty during every encounter. To support this practice, the health and social care workforce are likely to require training on the recognition and assessment of frailty(3).

Validated frailty assessments are recommended for a variety of settings in NICE Guideline 56(83).

MANAGEMENT

A comprehensive geriatric assessment (CGA) is a multidimensional assessment for older people, and is considered the gold standard approach for managing older people with frailty(84). CGA is an assessment involving multiple health care professionals and is structured in such a way as to help plan and coordinate long-term care. CGAs can reduce the risk of falls, functional dependence and hospital and nursing home admission in frail older people(85).

A CGA is not necessary and/or recommended for all people with frailty(3). However, all people with frailty should have a holistic medical review which should include:

- identification and optimisation of medical conditions, including onward specialist referral where appropriate,
- individualised goal setting,
- medication review,
- and anticipatory care planning(86).

Polypharmacy and medication review

It is estimated that 40 per cent of adults over the age of 65 use four or more medications (polypharmacy). In contrast, 85 per cent of older adults with frailty have been observed to have polypharmacy(87). In some circumstances, polypharmacy constitutes appropriate medical

management of multiple complex conditions. However, polypharmacy can also be inappropriate, and potentially dangerous due to the risk of interaction between medications.

Frailty can make people more susceptible to the side effects of medication. Older people with frailty and polypharmacy have more health problems, longer hospital stays, and are more likely to be readmitted to hospital and discharged to a nursing home(87).

A medication review is recommended for all older people identified as being frail, in order to optimise their medication intake and reduce the risk of unwanted side effects and harmful interactions(3).

Anticipatory care planning

The aim of care planning is to anticipate future care needs and avoid reactive care, which can often involve unwanted and unnecessary tests and admissions to hospital. Avoiding unnecessary hospital admissions is of particular importance to frail older people, as there is evidence that they can cause harm(88). Wherever possible, frail older people are supported in their own home, with appropriate support mechanisms in place(3).

For frail older people, the outcome of anticipatory care planning is an individualised care and support plan which:

- identifies a lead clinician to coordinate care,
- outlines a goal focused maintenance plan to help manage health and social care needs,
- details what will happen if a person's health and social care needs to escalate,
- outlines what will happen if emergency services were required,
- covers end of life care (if appropriate)(3).

Care and support plans should be made available to all health and social care professionals.

MANAGEMENT OF PATIENTS WITH FRAILITY AT HEREFORDSHIRE COUNTY HOSPITAL

As part of a quality improvement exercise, mapping was undertaken to track the hospital journeys of patients who were identified as having frailty in the Herefordshire County Hospital Accident and Emergency Department (A and E) between April 2016 and March 2017.

At Herefordshire County Hospital, all patients admitted to A and E are screened for frailty using the frailty screening tool recommended by "Think Frailty", NHS Scotland(89). Between April 2016 and March 2017 5,029 patient attendances at Herefordshire County Hospital A and E were identified as being for people with frailty. A total of 3,882 of the 5,029 patient attendances (77 per cent)

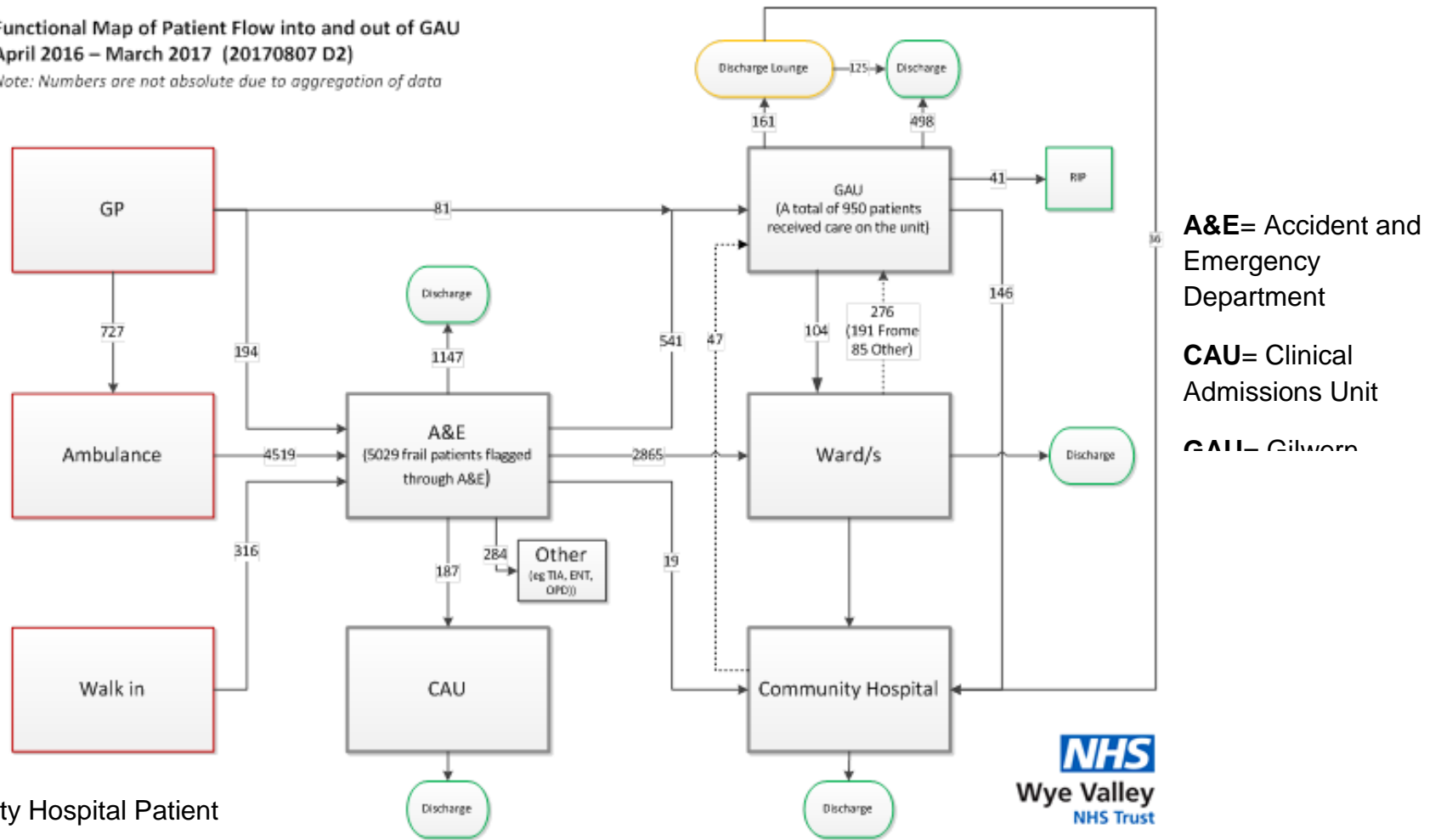
resulted in admission to the hospital for inpatient care. Of those admissions, 541 (14 per cent) were admitted directly to the Gilwern Assessment Unit (GAU)¹¹(Figure 52).

¹¹ The Gilwern Assessment Unit is a 16 bedded specialist frailty assessment unit. The intention is that patients should not remain on the unit for longer than 72 hours. After which point, they should be discharged or transferred onto another hospital ward for ongoing medical input.

Figure 52 Map detailing the hospital journeys for patients identified as having frailty in the Accident and Emergency Department at Herefordshire County Hospital between April 2016 and March 2017

**Functional Map of Patient Flow into and out of GAU
April 2016 – March 2017 (20170807 D2)**

Note: Numbers are not absolute due to aggregation of data



Data Source: Hereford County Hospital Patient

Between April 2016 and March 2017 the GAU had a total of 950 patient attendances, of these 81 (8.5 per cent) accessed the GAU directly through their GP, 541 (56.9 per cent) were admitted to the GAU via A and E, and 323 (34.0 per cent) were admitted as “backflow” from the community hospitals (47) or other wards in Herefordshire County Hospital (276). The route of access could not be confirmed for five patient attendances (0.5 per cent) (Figure 52).

The mapping exercise illustrated in Figure 52 highlighted some important points about how patients with frailty are managed in Herefordshire County Hospital. These are summarised in brief below:

1. The GAU provided care for a smaller number of patient attendances than would be expected, despite bed occupancy remaining high over this period, suggesting that patients are frequently spending longer than 72 hours on the unit. Enhancing the turnover of the GAU would enable a greater number of patients to benefit from specialist frailty input.

Please note: If the GAU were to operate at full capacity, with 85 per cent bed occupancy on every day of the year, and with all patients discharged within 72 hours of their admission, it could provide a total of 1,654 instances of patient care per year.

2. A substantial number of patients are being received as “backflow” from other wards within the hospital. Anecdotal evidence suggests that this is tending to happen prior to discharge, enabling patients to access the multidisciplinary discharge arrangements in place within the GAU.
3. A considerable number of patients are received as “backflow” from community hospitals. This raises the question as to whether community hospitals are the best place for patients with frailty.
4. A total of 808 patient attendances were referred to Herefordshire County Hospital by their GP, 10 per cent accessed the GAU directly, with the majority (727) being sent to A and E. The ambition would be for more patients to have direct access to the GAU. However, in order for this to happen GAU must have beds available when required.

LOCAL ACTION

In Herefordshire County Hospital, actions are being taken to improve the hospital journeys of patients with frailty, an example being “Silver Week” engagement events where geriatric consultants are temporarily based in A and E to enhance early identification of frailty and support appropriate management.

USE OF SECONDARY CARE AMONG CARE HOME RESIDENTS

Older people living in care homes are more likely to be frail and to have multiple health care conditions, making timely access to appropriate healthcare input of great importance. However, there is evidence indicating that care home residents face significant barriers to accessing health care services(90, 91).

In 2015 QualityWatch undertook a national analysis of secondary care¹² use among care home residents (92), their research highlighted that when compared to their community dwelling counterparts, older people in care homes receive more emergency secondary care than planned secondary care.

QualityWatch concluded that high levels of emergency hospital admissions among care home residents are a likely reflection of poor quality care. However, they acknowledged that care homes are part of a wider system, and that emergency hospital admission rates among care home residents are inextricably linked to how well the system functions as a whole, stating that:

“High rates of emergency admissions may reflect quality issues in, among other things, local primary care, community care, GP support and dispensing practices in pharmacy chains, as much as the quality of care in the homes themselves. The responsibility of care still predominantly rests with the GP and the care in the home will at least partly be influenced by the quality of the GP services its residents receive and often a single home will be dealing with a number of GP practices. So while care homes do need to look to their own systems, they may have little influence over other surrounding systems.”

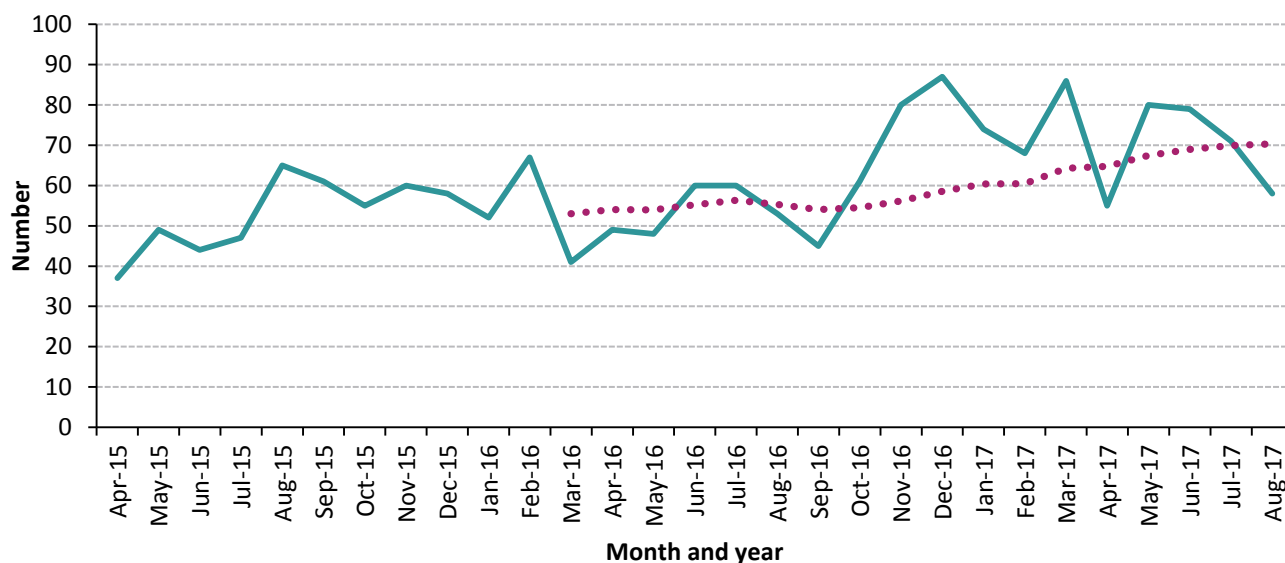
Local data

Between April 2015 and August 2017 there were 2,302 people aged 65 and over admitted to Wye Valley NHS Trust from a care home¹³, 1,750 (76 per cent) of which were emergency admissions. Over this time period, though there was considerable variability in the number of older people admitted for emergency care to Wye Valley NHS Trust from a care home, an increase was observed (Figure 53). Anecdotal evidence suggests that ease of access to primary care may be an important contributing factor to emergency hospital admission rates among care home residents in Herefordshire. However, as there are likely to be many contributing factors further investigation is warranted in order to build a comprehensive understanding of the underlying issues.

¹² Secondary care refers to hospital based care.

¹³ Please note, data records are not sufficiently detailed to allow the precise identification of care home residents' hospital admissions. Therefore, the method used for counting these is a proxy measure, based on the residential post code of the patient and therefore is subject to granulation errors, the likelihood of which will increase the more densely populated the area.

Figure 53 Number of patients aged 65 and over admitted to Wye Valley NHS Trust for emergency care from a care home* per month, April 2015 to August 2017(solid line= observed number, dotted line= 12 month rolling average)



*Please note, data records are not sufficiently detailed to allow the precise identification of care home residents' hospital admissions. Therefore, the method used for counting these is a proxy measure, based on the residential post code of the patient and therefore is subject to granulation errors, the likelihood of which will increase the more densely populated the area.

Source: Admissions from a care home, Midlands and Lancashire Commissioning Support Unit, October 2017.

Interventions to reduce unplanned hospital admissions from care home settings

The University of York Centre for Reviews and Dissemination undertook a review of the evidence to identify interventions to reduce emergency hospital admissions from care home settings(93). Due to a lack of good quality comparative evidence, their recommendations were largely based on case studies. The review found the following interventions to show promise:

- promotion of closer working between healthcare and care home staff through dedicated GP or community geriatric services,
- protection of training for care home staff,
- implementation of processes for stated end-of-life care preferences,
- implementation of multifaceted interventions to prevent delirium in long-term care, as recommended by the National Institute for health and Care Excellence (NICE).

FRAILTY INTEGRATED CARE PATHWAY BENCHMARKING EXERCISE

In 2014, NHS England published a document detailing best practice for the provision of health and social care for frail older people(94). The document draws together best practice criteria from the Silver Book(95) and a report produced by the King's Fund on developing integrated care for people with frailty(96). The criteria are intended to support commissioners, providers, managers and clinicians to ensure that services are commissioned along the whole health and social care pathway, and are fit for purpose. There are a total of 59 benchmarking statements, covering nine health and social care service areas:

- Healthy active ageing (prevention),
- Living well with long-term conditions,
- Living well with comorbidities,
- Rapid crisis support,
- Acute hospital care,
- Discharge planning and support,
- Rehabilitation and re-ablement,
- Nursing and residential care,
- End of life care.

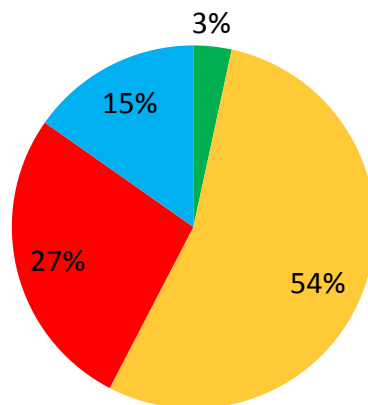
In October 2017 a benchmarking exercise was undertaken, where members from the Herefordshire Frailty Forum and Dementia Steering Group were invited to rate how they felt health and social care services in Herefordshire compared with the best practice statements in NHS England's 2014 publication(94). A total of 17 individuals took part¹⁴, by selecting one of four rating options for each statement; these are detailed in Figure 54.

BENCHMARKING RESULTS

A summary of the results of the benchmarking exercise are presented in Figure 54. The results for each of the 59 benchmarking statements are presented in Appendix 1 (page [211](#)).

¹⁴ Please note that the one participant had other commitments, and therefore only provided a response to one of the benchmarking statements.

Figure 54 Summary of results of the frailty integrated care pathway benchmarking exercise, October 2017



- "Green" -This is happening/in place in Herefordshire and working well.
- "Amber"- This is happening/in place in Herefordshire, but improvements are required.
OR Efforts are ongoing to make this happen/ put this in place in Herefordshire.
- "Red" -This isn't happening/ in place in Herefordshire.
- "Blue" -Unable to make a judgement.

There were only two statements where the majority of those who took part in the benchmarking exercise felt that the activities detailed were in place and working well in Herefordshire. These two statements related to the provision of influenza and pneumococcal vaccinations and whether people with frailty had access to a falls prevention service. Thirty-two statements (54 per cent) were categorised as amber, indicating that the majority of those who took part in the exercise felt that the activities or services detailed within the statements were either in place in Herefordshire, but required improvement or that actions were being taken to put the activities or services in place. A total of 16 statements (27 per cent) were categorised as red, with the majority of those who took part in the exercise feeling that the activities or services detailed in these statements were not taking place in Herefordshire. For nine statements (15 per cent), the majority of participants felt unable to judge Herefordshire's performance, with most indicating that this was because they didn't have knowledge about this part of the health and social care system.

Results by health and social care service area

When the results of the benchmarking exercise were considered by the nine health and social care service areas, it can be seen that a considerable number of criteria relating to the provision of

“rapid crisis support” and “discharge planning and support” were assessed as being red, suggesting that these may be priority areas for improvement activities (Appendix 1, page [211](#)).

Disagreement

There was some disagreement among participants with regard to their rating of Herefordshire’s performance against the benchmarking statements. This is not surprising, as both the Frailty Forum and Dementia Strategy Group consist of representatives from across the health and social care system, each with a specific “system view”.

For eight statements, there were responses for both the green and red categories. The degree of agreement for each benchmarking outcome is indicated in the final column in Appendix 1 (page [211](#)).

END OF LIFE CARE

National findings indicate that end of life care has typically been focused on providing support to people with a diagnosis of cancer(97). A recent report found that Herefordshire’s end of life care provision mirrors this trend(98). However, people with a diagnosis other than cancer can and should benefit from specialist end of life care planning and support(99).

Older people with frailty are at an increased risk of dying; but it is often difficult to identify when a person with frailty is reaching the end of their life. Healthcare professionals are encouraged to consider carefully whether an older person with frailty is likely to be nearing the end of their life, and if appropriate, to initiate end of life care planning(3). Palliative care planning should seek to establish a ceiling of care in order to prevent unwanted medical interventions as a person nears the end of their life(100). Frail older people approaching the end of their life should also be considered for inclusion on the palliative care register(101).

DISCUSSION POINTS

- Frailty is not an inevitable part of ageing, but an under recognised health state. Older people with frailty are more vulnerable to minor illnesses and are at an increased risk of hospitalisation, admission to a care home and death(76). However, early identification and intervention can prevent or reverse frailty and associated adverse health outcomes(75). Furthermore, adopting positive health behaviours such as exercising, not smoking and eating healthily in mid-life can decrease the risk of developing frailty in older age(79).
- There is evidence that hospital admissions among frail older people can cause harm(88). Therefore, avoiding unnecessary hospital admissions is of particular importance to frail older people. It is estimated that approximately half of all care home residents have some degree of frailty(78). Locally, emergency hospital admissions among those who live in care homes have been increasing. This may reflect increases in the number of over 65s living in care homes, or it could signify that this population are facing barriers to accessing health care.

- Fragmented health and social care services are known to cause poor outcomes for older people with frailty(94). The benchmarking results presented in this report provide a snapshot of how the management of older people with frailty in Herefordshire compares with best practice. Results indicate that there is room for improvement, particularly in the provision of rapid crisis support and discharge planning. Those who participated in the benchmarking exercise spoke of the commitment to improvement that exists among those who work within the health and social care system. Actions are currently being taken to put in place a local integrated care pathway for the management of people with frailty, resultant improvements should be evident were this benchmarking exercise to be repeated in the future.

RECOMMENDATIONS

- Ensure that health and social care professionals have appropriate training in the recognition and assessment of frailty; and screen all older people for the presence of frailty during every encounter.
- Take action to reduce the number of emergency admissions among people living in residential and nursing homes, including reviewing the health care provision on offer for people living in residential and nursing homes and the extent to which it is easily accessible.
- Continue to take action to improve the integrated management of people with frailty across the whole health and social care system. Areas warranting particular attention are rapid crisis support, hospital discharge planning, and optimising access to the frailty specialist Gilwern Assessment Unit (GAU) at Herefordshire County Hospital.

Key Facts

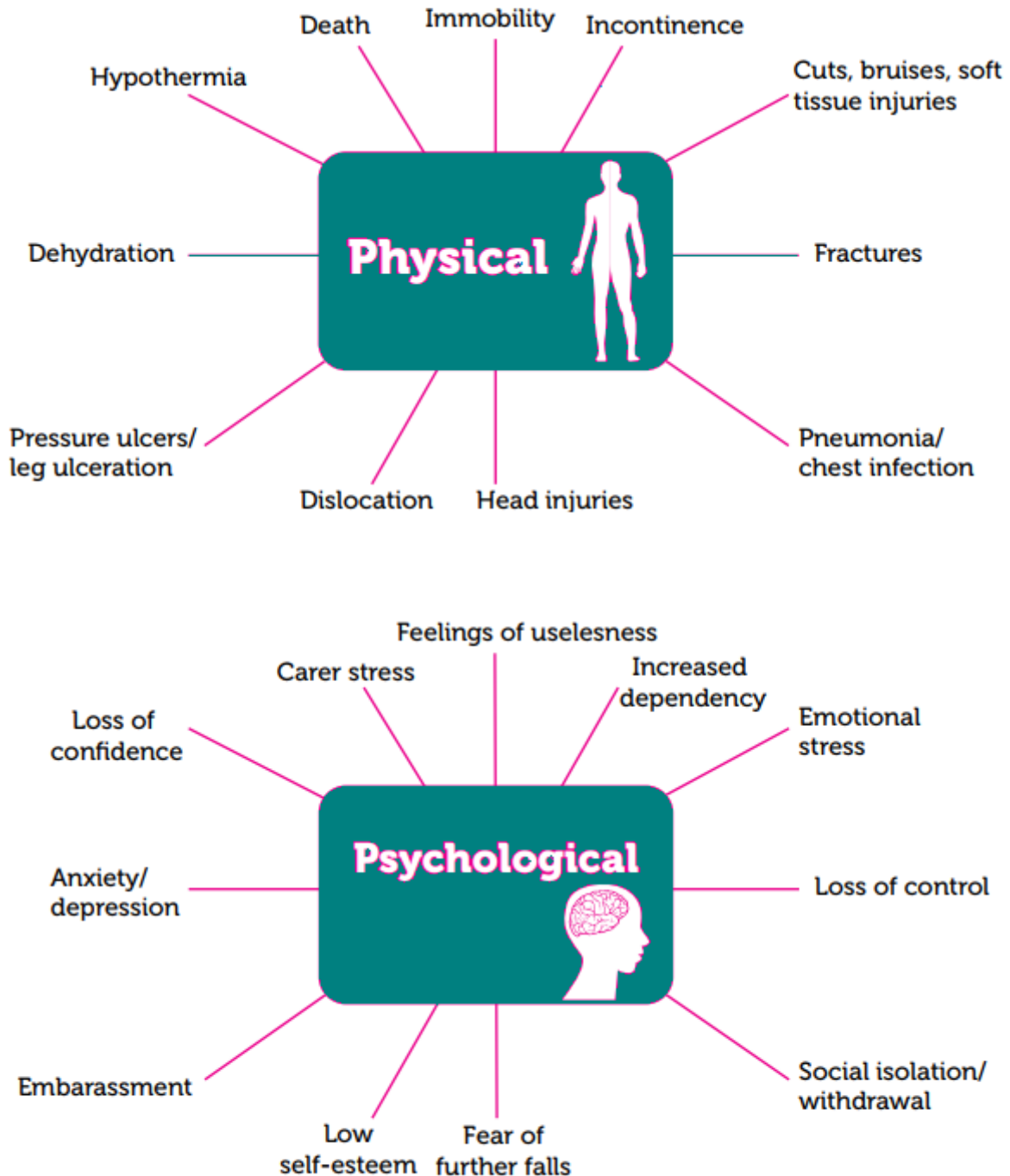
- It is estimated that in 2017 nearly 12,200 people aged 65 and over living in Herefordshire will have experienced a fall, with the number expected to rise to over 18,100 by 2035.
- Between 2013 and 2016 the West Midlands Ambulance Service made 10,676 falls related callouts to Herefordshire residents aged 65 and over, approximately 32 per cent of which resulted in the patient being conveyed to hospital.
- In 2015/16 there were 689 hospital admissions for falls injuries among those aged 65 and over living in Herefordshire, a slight increase from 2014/15.
- Between 2010/11 and 2015/16 Herefordshire's age standardised falls related hospital admissions rate has been statistically significantly lower than the national and regional figures.
- In 2016, there were 19 falls related deaths among people aged 65 and over living in Herefordshire, representing one per cent of deaths among this age group.
- Between 2010/11 and 2015/16 Herefordshire's age standardised emergency hip fractures hospital admissions rate has been similar to those observed regionally and nationally.
- In 2015/16, there were 247 hip fractures managed at Herefordshire County Hospital.

A fall is ... “an event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness”(102).

CONSEQUENCES OF A FALL

Falling can have serious consequences, especially among those aged 65 and over. Falling can result in a fracture, admission to hospital, disability, and admission to residential or nursing home. The physical and psychological consequences of a fall are outlined in Figure 55.

Figure 55 Physical and psychological consequences of a fall

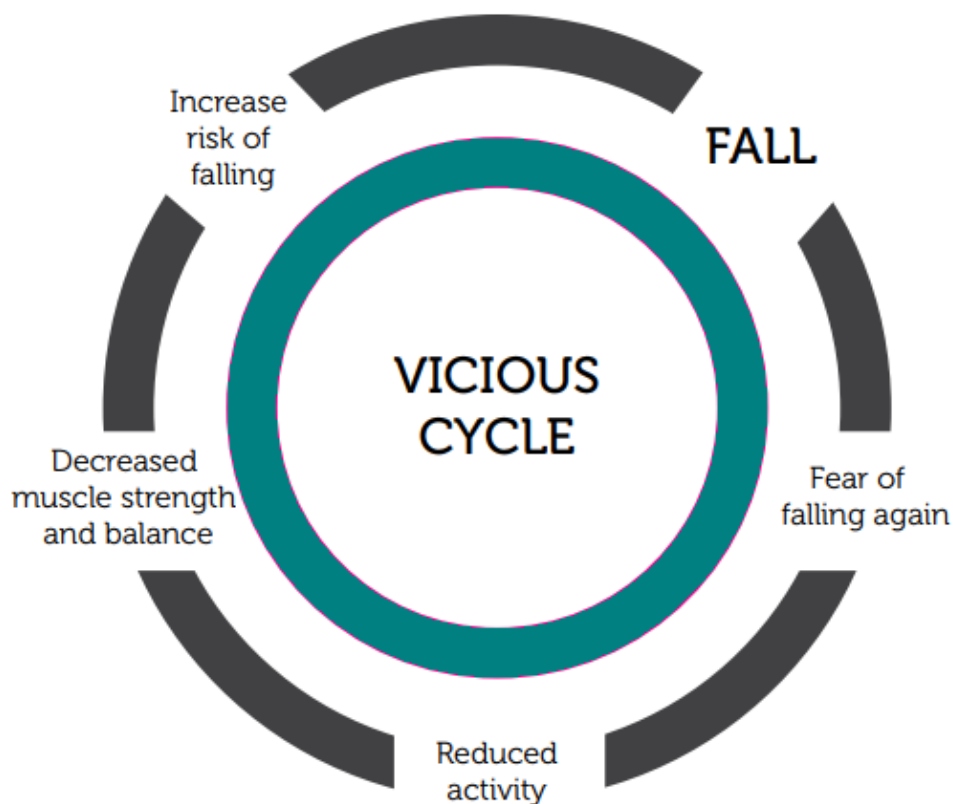


Source: NHS SCOTLAND; CARE INSPECTORATE. Managing Falls and Fractures in Care Homes for Older People – good practice resource: Revised edition. 2016.

Approximately 5 per cent of falls among over 65s result in a fracture or other injury requiring hospital admission (103). Fall related fractures are more common among women than men. This is thought to be due to an increased occurrence of falls related fragility fractures¹⁵ among women, as a result of osteoporosis.

Fear of falling is a psychological consequence of a fall which is often overlooked, but it can have a considerable impact. Fear of falling can lead to the avoidance of activity, social isolation and frailty, having a negative impact upon mental health, as well as acting to increase the risk of further falls (Figure 56).

Figure 56 The vicious cycle of falls



Source: NHS SCOTLAND; CARE INSPECTORATE. Managing Falls and Fractures in Care Homes for Older People – good practice resource: Revised edition. 2016.

¹⁵ A fragility fracture is a fracture that is sustained from an injury that would not normally result in a fracture. This has been defined by the World Health Organisation as forces equivalent to falling from a standing height or less.

RISK FACTORS

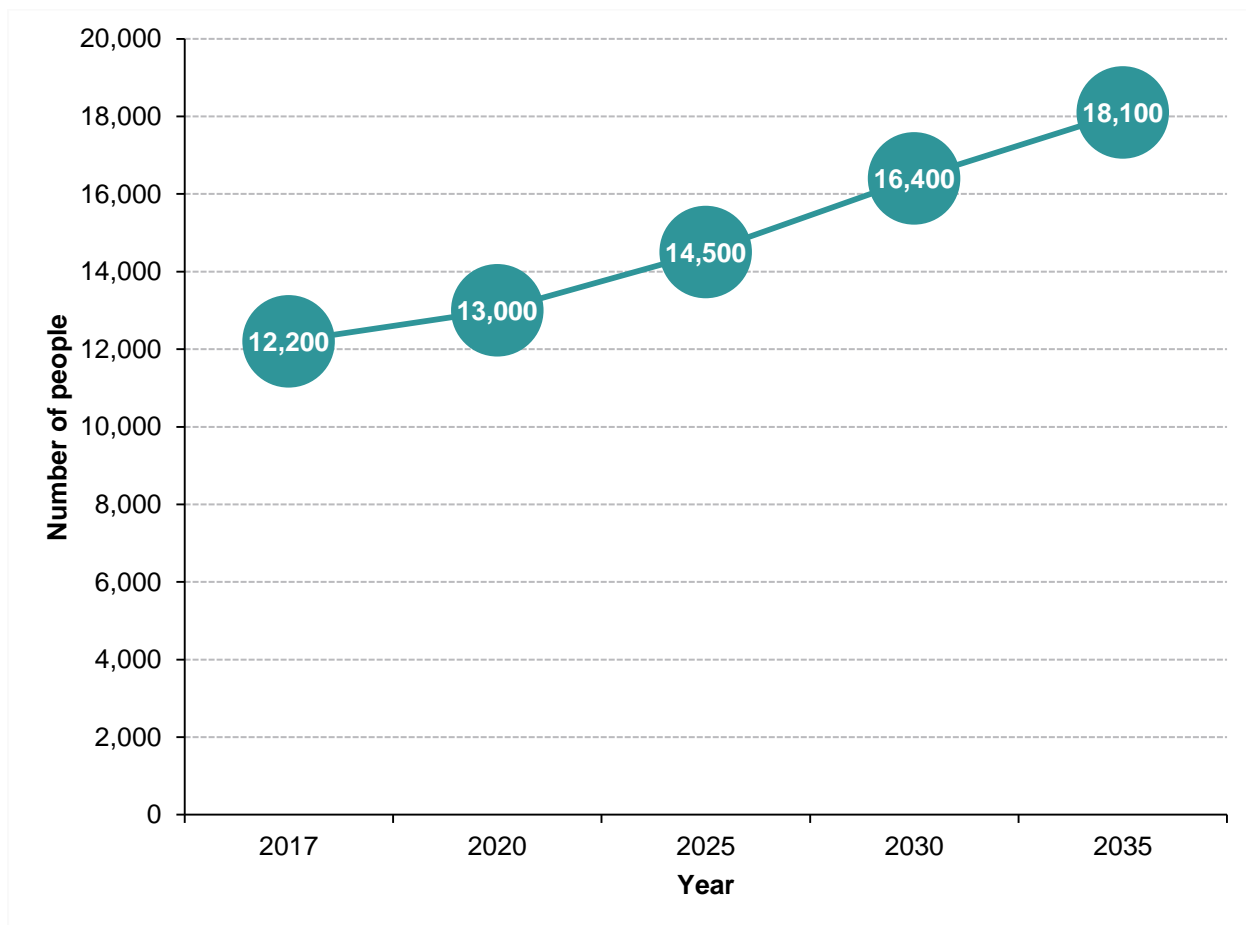
There are over 200 risk factors associated with falls. These can be broadly categorised into individual and environmental factors. Risk factors relating to an individual include older age, severe pain, diagnosis of a long term condition, frailty, previous falls, depressive symptoms, incontinence and poor balance(104). Risk factors relating to the environment include poor lighting, uneven flooring, poorly maintained staircases, and clutter(105). In addition to the presence or one or more individual or environmental risk factor, falls can be precipitated by engaging in risk taking behaviours, where an individual performs an action which is outside of their physical capabilities(106).

People living with dementia and care home residents are at particular risk of falling.

LOCAL DATA

The Institute of Public Care estimates the prevalence of falls among over 65s living in the community for all of the local authorities in England. It is estimated that in 2017, approximately 12,200 people over the age of 65 will experience a fall in Herefordshire. As the population of Herefordshire ages, the number is expected to increase by approximately 48 per cent (to 18,100 people) by 2035(18) (Figure 57).

Figure 57 Estimated number of people aged 65 and over predicted to have a fall in Herefordshire by year 2017-2035



Due to poor reporting and the absence of a comprehensive dataset it is challenging to develop a sound understanding of the nature and incidence of falls in Herefordshire. It is estimated that only 5 per cent of falls among older people living in the community result in a hospital admission (103, 107), the location where cases are most easily identified; many more people seek treatment in primary care, or not at all, especially in instances where the fall resulted in a minor injury or no injury. To provide insight into the scale of the issue, local data on falls has been gathered from the West Midlands Ambulance Service, the Falls Responder Service, and Hospital Episode Statistics.

WEST MIDLANDS AMBULANCE SERVICE DATA

Falls are a common reason for people calling for an ambulance, accounting for between eight to 10 per cent of all 999 calls(108). Data regarding falls related ambulance call-outs to Herefordshire residents aged 65 and over between the 1st of December 2012 and the 31st of August 2017 was obtained from West Midlands Ambulance Service.

The method used for categorising ambulance call-outs for falls related injuries changed in October 2015, limiting meaningful long-term trend analysis. The impact of this change is apparent in Figure 58, where a drastic change in the number of falls related call-outs can be seen from 2015 onwards.

Figure 58 Total number of WMAS falls related call-outs to Herefordshire residents aged 65 and over between the 1st of January 2013 and the 31st of December 2016



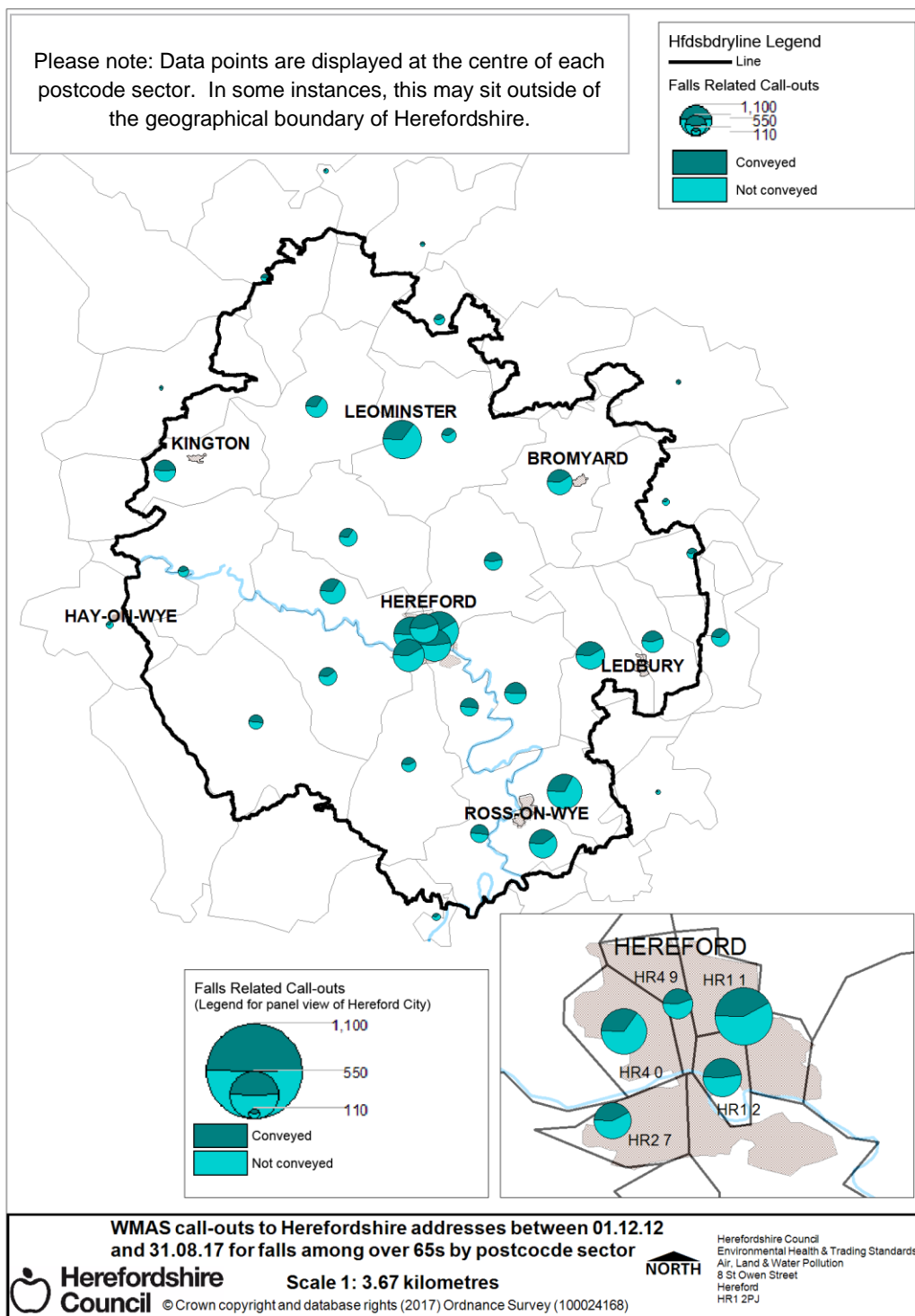
Data source: West Midlands Ambulance Service data

Between the 1st of January 2013 and 31st of December 2016 a total of 10,676 ambulance callouts were made to Herefordshire residents aged 65 and over. Ten per cent of falls related call-outs

were flagged on the WMAS system as being to a residential or nursing home. It is worth noting that this is likely an underestimate of the percentage of call-outs made to residential or nursing homes, as not all will be flagged on the system. Sixty per cent of falls related ambulance call-outs were to attend to women.

Figure 59 provides a spatial representation of the location and number of ambulance call-outs, and percentage that were conveyed to hospital in Herefordshire between the 1st of December 2012 and the 31st of August 2017 by postcode sector. A greater number of call-outs were made to post code sectors for Hereford City and the market towns, where the population density of older people is greater. A noticeably large percentage of call-outs in Hereford City post code sector HR4 0 and Ross-on Wye and Leominster's main postcode sectors were not conveyed to hospital. On average, only 32 per cent of falls related ambulance call-outs were conveyed to hospital. Some of these call-outs will have been to non-injured older people, who could have been tended to by Herefordshire's Falls Responder Service.

Figure 59 Spatial representation of the number of West Midlands Ambulance Service falls related call-outs among Herefordshire residents aged 65 and over between the 1st of December 2012 and the 31st of August 2017 by postcode sector



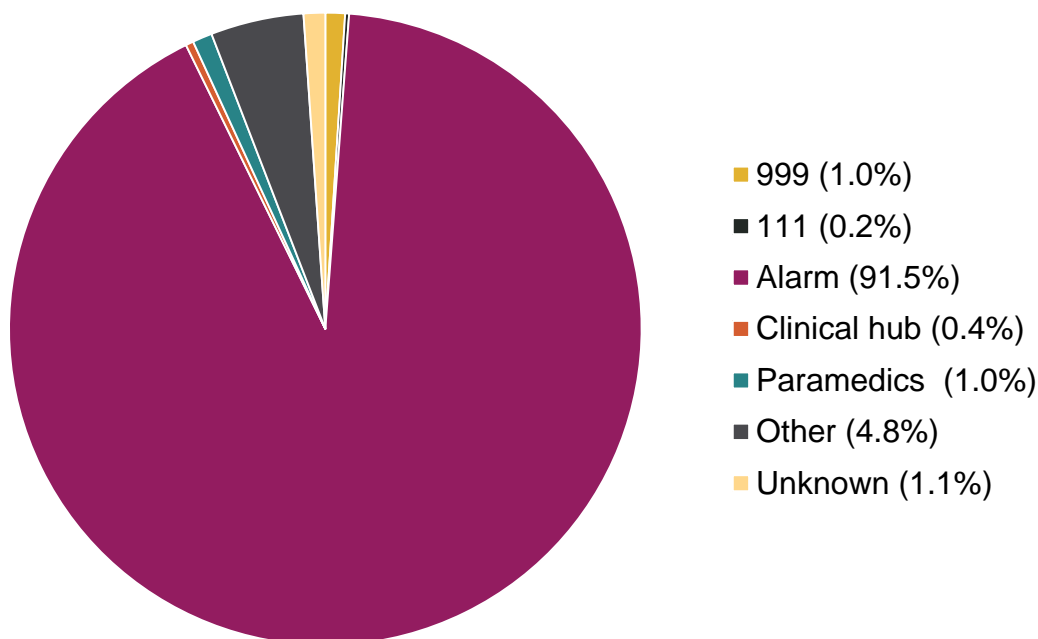
Data Source: West Midlands Ambulance Service data

FALLS RESPONDER SERVICE

The Herefordshire Falls Responder Service provides a 24/7 call-out service to adults aged 18 and over who have had a non-injurious fall in a place of residence. The falls responder will attend the residence and carry out a basic assessment and where required, will assist a person in getting up off of the floor. While the service does not provide clinical assistance, information is forwarded to clinical teams at the scene of the incident and, where appropriate referrals are made to other services and professionals such as the Falls Prevention Service and the person's GP. The service is accessed directly by Herefordshire Housing Ltd. telecare pendant wearers or through a referral from a healthcare professional, WMAS or NHS 111 for non-pendant wearers.

The service began in November 2014 and has seen considerable growth in the number of call-outs received. As of July 2017, the service was receiving an average of 90 call-outs per month, with an average response time of 25 minutes. Approximately 80 per cent of call-outs are to people age 65 years and over. Between November 2015 and March 2017 the Falls Responder Service attended 1,996 call-outs. Alarms were the source of the majority of call-outs (91.5 per cent) (Figure 60).

Figure 60 Percentage of Falls Responder Service call-outs by source between November 2015 and March 2017



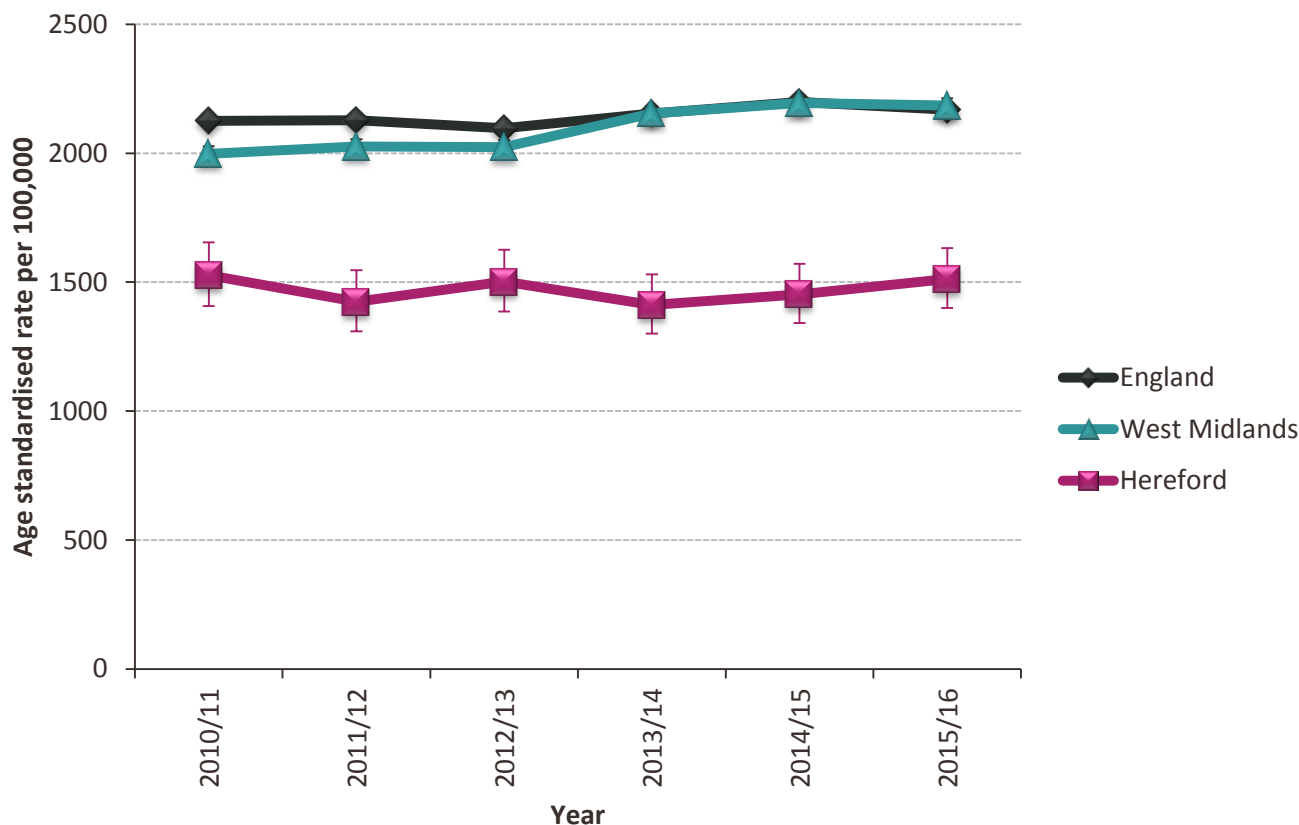
Data Source: Falls Responder Service data

It could be assumed that the majority of the Falls Responder Service call-outs prevent a WMAS attendance. However, the data suggests that opportunities are being missed to divert calls involving non-injurious falls received by the WMAS and NHS 111 into the Falls Responder Service. Actions are being taken to improve system response processes to ensure that all appropriate calls are diverted to the Falls Responder Service.

FALLS RELATED HOSPITAL ADMISSIONS

Between 2010/11 and 2015/16 the age standardised rate of emergency hospital admissions for falls injuries in Herefordshire has remained significantly lower than the rate for England and the West Midlands region (Figure 61). The reason for this is not clear; while it is generally accepted that local falls prevention services are well utilised, anecdotal evidence indicates that clinical coding may also be implicated, suggesting that further investigation may be warranted.

Figure 61 Age standardised rate of emergency hospital admissions for falls injuries in people aged 65 and over, 2010/11-2015/16



Data Source: Public Health England, 2016, ©Crown Copyright

ANALYSIS OF HOSPITAL ADMISSIONS FOR FALLS INJURIES IN 2015/16

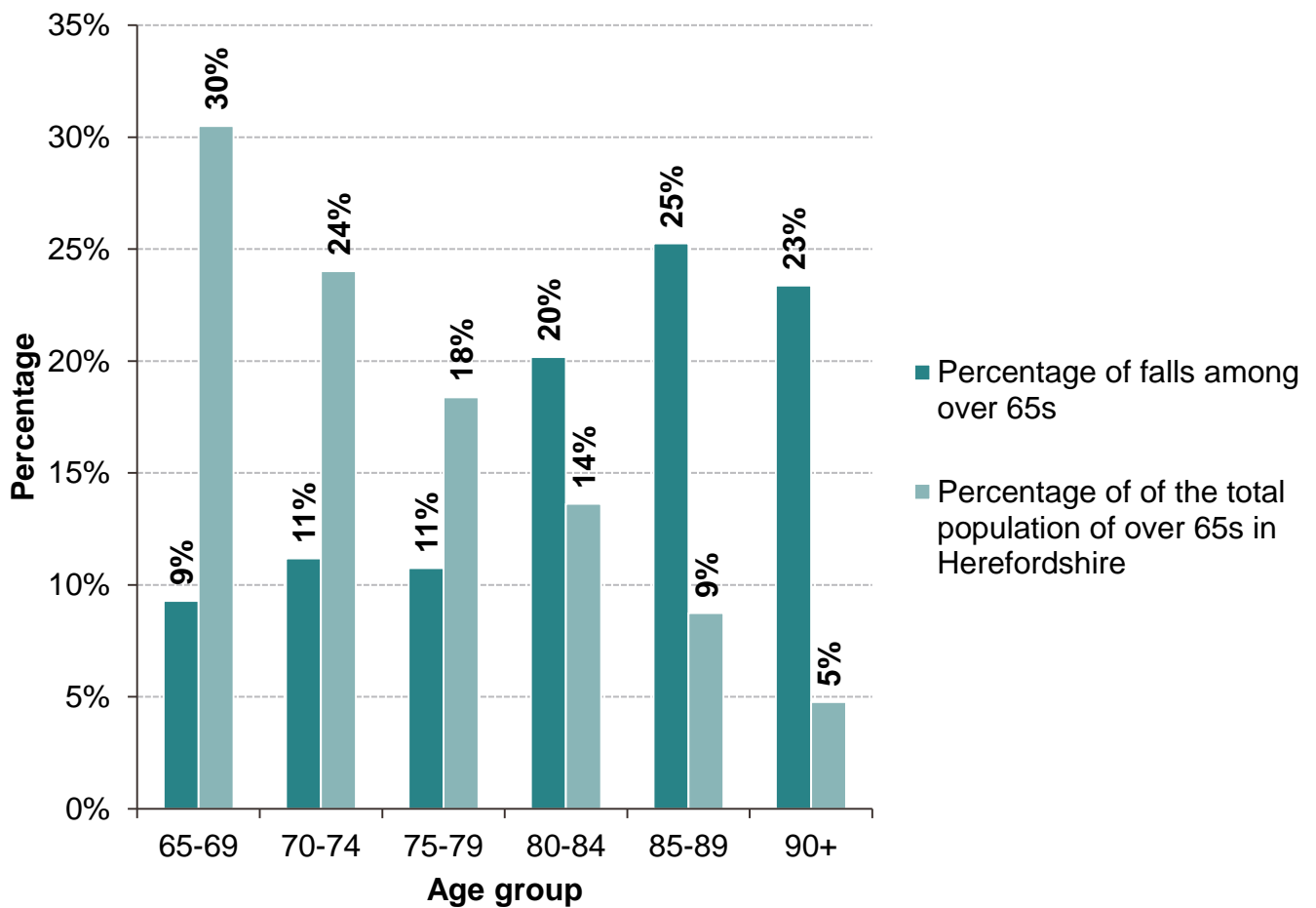
Hospital Episode Statistics were used to undertake a detailed analysis of hospital admissions in 2015/16 for falls related injuries among people aged 65 living in Herefordshire. Using the method advocated by Public Health England, falls were defined as hospital admissions where the ICD-10 cause of injury was between W00 and W19, and where the ICD-10 primary diagnosis was between S00-T98.

In 2015/16 there were 689 hospital admissions for falls injuries among those aged 65 and over living in Herefordshire, a slight increase from 2014/15. More women (31 per cent) than men (69

per cent) were admitted to hospital with falls related injuries. This finding mirrors the national trend, and is thought to be explained by a greater proportion of over 65s being female, and a greater incidence of fall related fractures among older women due to osteoporosis.

Falls resulting in hospital admissions were more common among those aged 85-89 years of age, with falls among this age group accounting for 25 per cent of all falls among over 65s, despite this age group only comprising nine per cent of the total population of over 65s in Herefordshire (Figure 62).

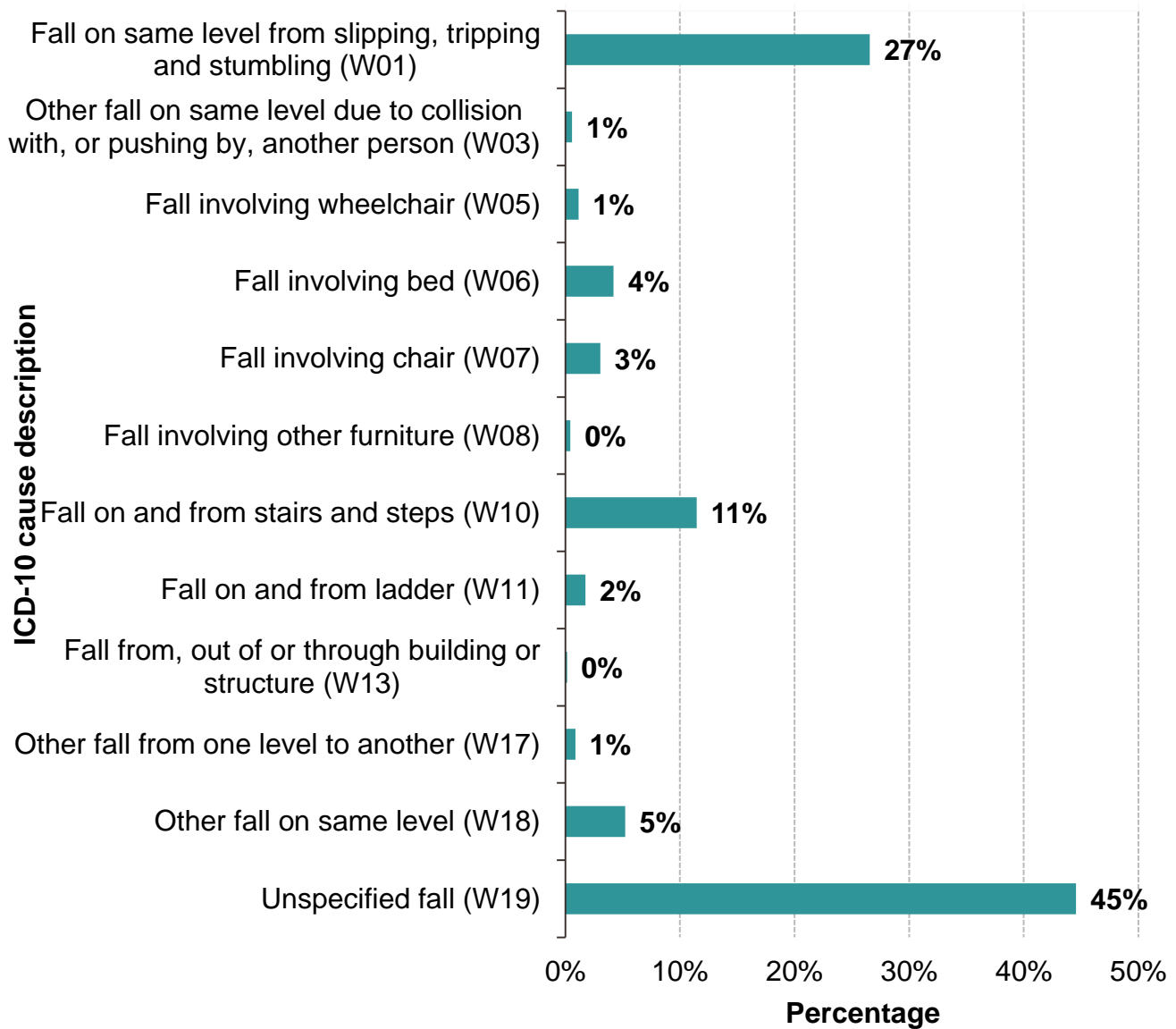
Figure 62 Percentage of 2015/16 hospital admissions due to falls injuries by age group among over 65s living in Herefordshire



Data Sources: Hospital Episode Statistics, ONS 2015 mid-year estimates © Crown copyright.

A slip, trip or stumble was the most commonly documented cause of falls injuries resulting in a hospital admission (27 per cent). Thirteen per cent of falls involved steps, stairs (11 per cent) or ladders (two per cent), and seven per cent involved household furniture. The cause was not specified for the majority of falls injuries (45 per cent) (Figure 63).

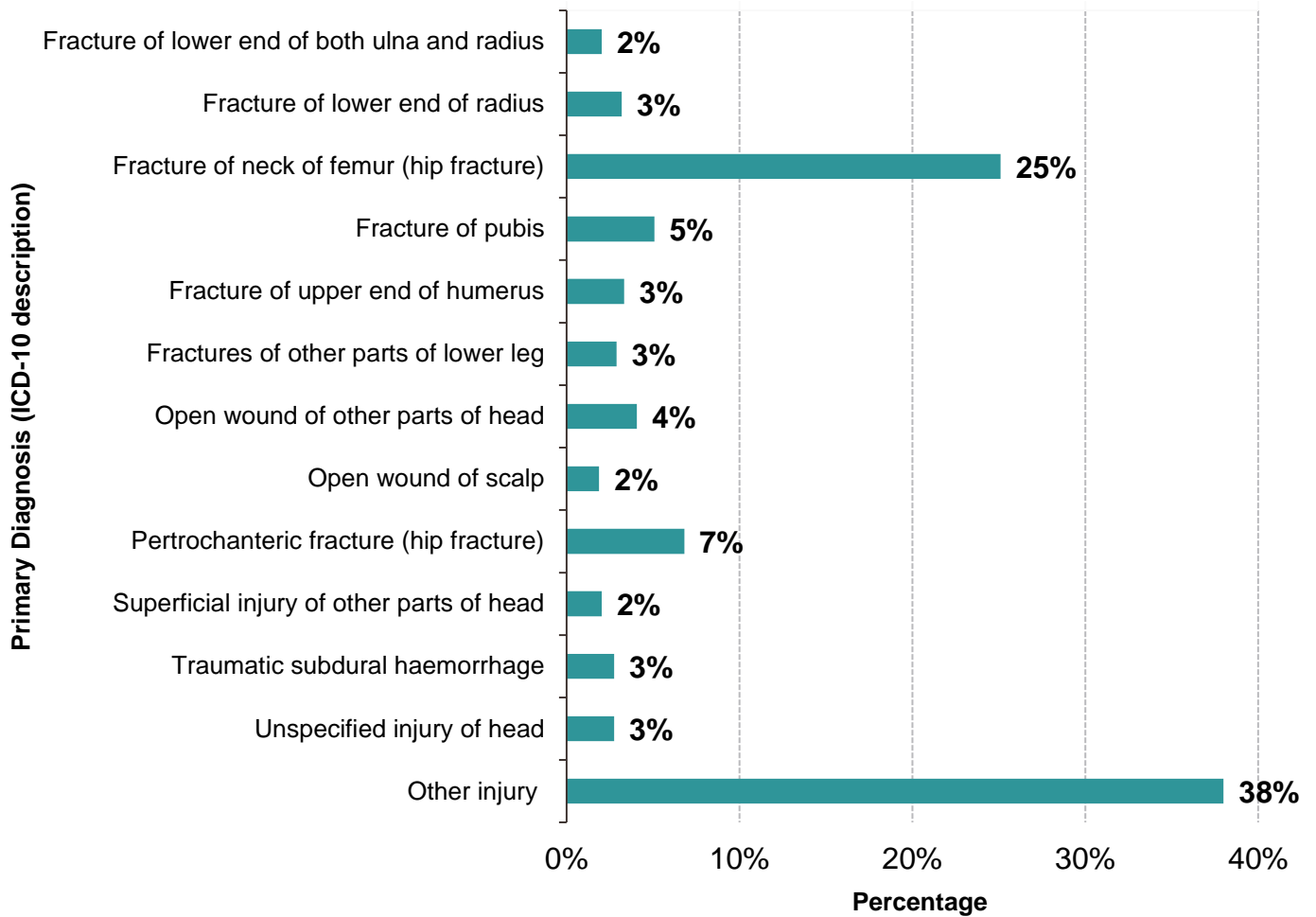
Figure 63 Cause of hospital admissions for falls injuries in 2015/16 among people aged 65 and over living in Herefordshire



Data Source: Hospital Episode Statistics

The most common falls related injury was a hip fracture (32 per cent, 25 per cent neck of femur and 7 per cent pertrochanteric), followed by a fractured pubis (5 per cent), and an open wound to the head (4 per cent) (Figure 64).

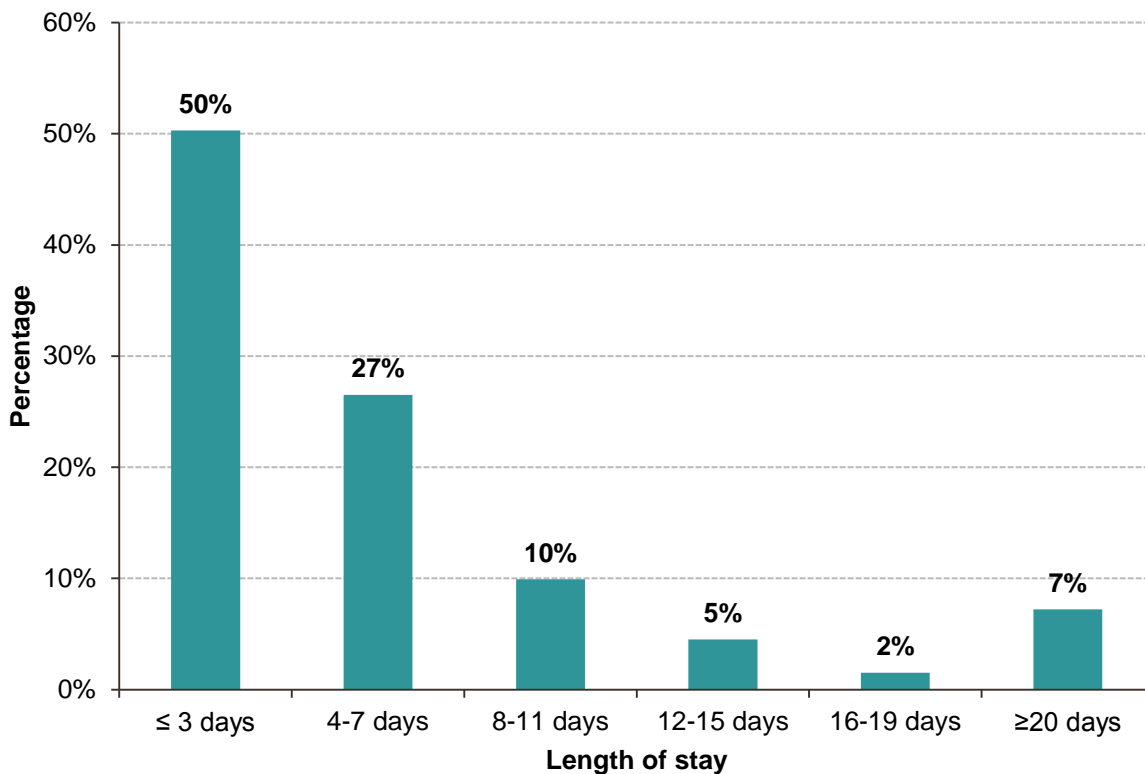
Figure 64 Primary diagnoses for falls injuries in 2015/16 among people aged 65 and over living in Herefordshire



Data Source: Hospital Episode Statistics

Fifty per cent of older people admitted for a falls related injury remained in hospital for between zero to three days. However, length of stay ranged from zero to 88 days (Figure 65). The majority of patients who stayed in hospital for 20 days or more were being treated for a fractured neck of femur.

Figure 65 Length of stay for people aged 65 and over admitted to hospital for a falls related injury and discharged in 2015/16



Data Source: Hospital Episode Statistics

FALLS IN HOSPITAL

Falls are the most commonly reported safety incident in National Health Service (NHS) hospitals, and up to half are avoidable (109). Falls in hospital cause injury, extend patient stays and are costly. It is estimated that the cost of falls in hospitals is around £15 million a year (107).

In 2015, the Royal College of Physicians published their nationwide review into inpatient falls (109), disseminating the results of a clinical audit focussing on the inpatient management of seven patient related falls risk factors. The report also published falls rates for each NHS hospital in England. Relevant findings are outlined below.

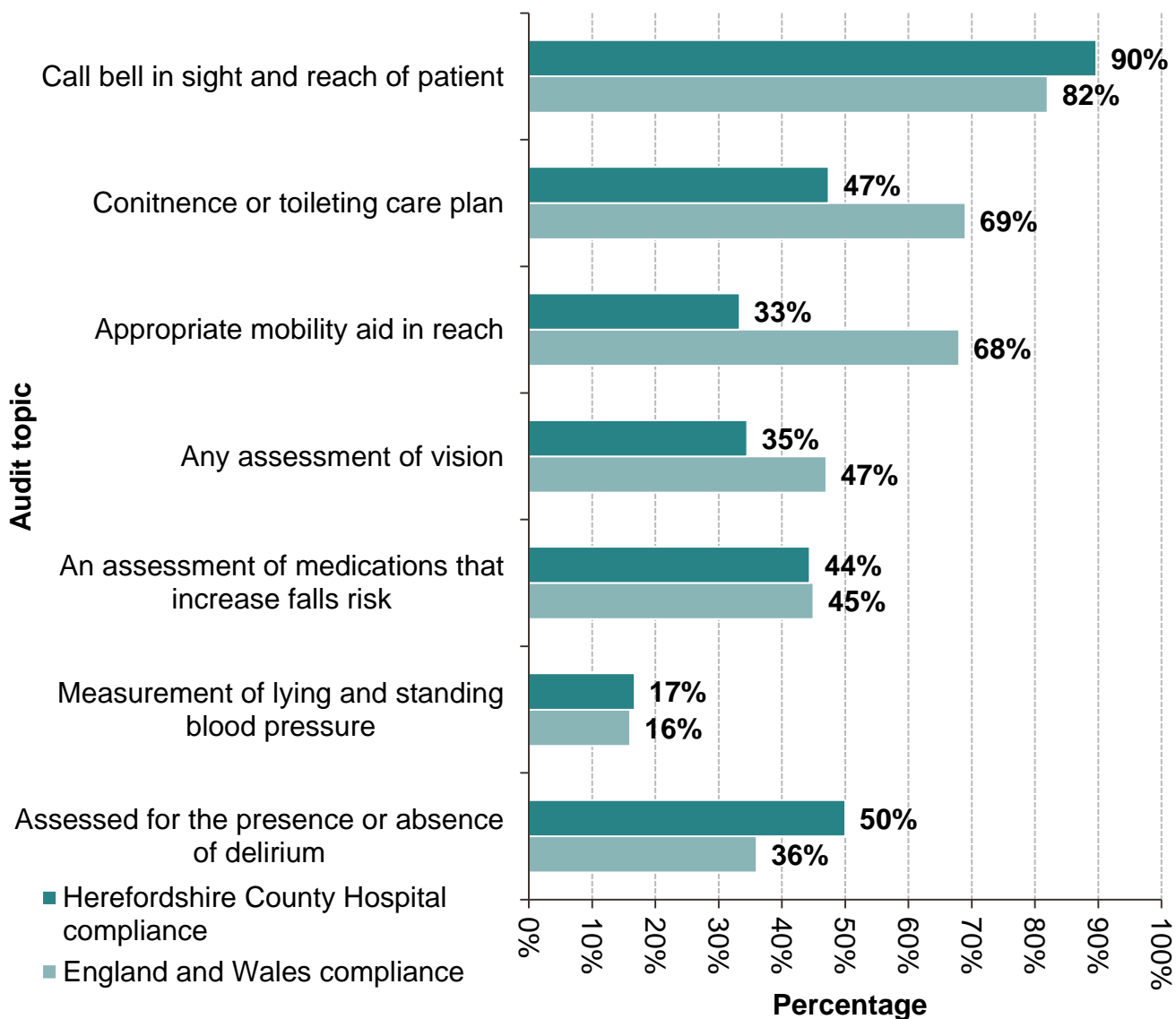
Clinical audit

At a national level, the audit results indicated that hospitals could take additional action to prevent falls, with evidence of room for improvement for all seven risk factors. However, on average, hospitals performed particularly poorly for assessment for the presence of delirium, measurement of lying and standing blood pressure, assessment of medications that increase falls risk, and assessment of vision.

Herefordshire County Hospital performed better than the national average for the proportion of patients who had been assessed for the presence of delirium and who were within sight and reach of their call bell. The hospital performed worse than the national average with regards to the

proportion of patients whose; vision had been assessed, mobility aid was within reach and had a continence and toileting plan in place. While the proportion of patients who had been assessed for medications that increase falls risk, and had their lying and standing blood pressure had been taken were low; these two indicators were in line with national findings (Figure 66).

Figure 66 Results of the Royal College of Physicians clinical falls audit for Herefordshire County Hospital and the average for all participating NHS hospitals in England and Wales



Data Source: ROYAL COLLEGE OF PHYSICIANS. National audit of inpatient falls: audit report 2015.

Falls rates

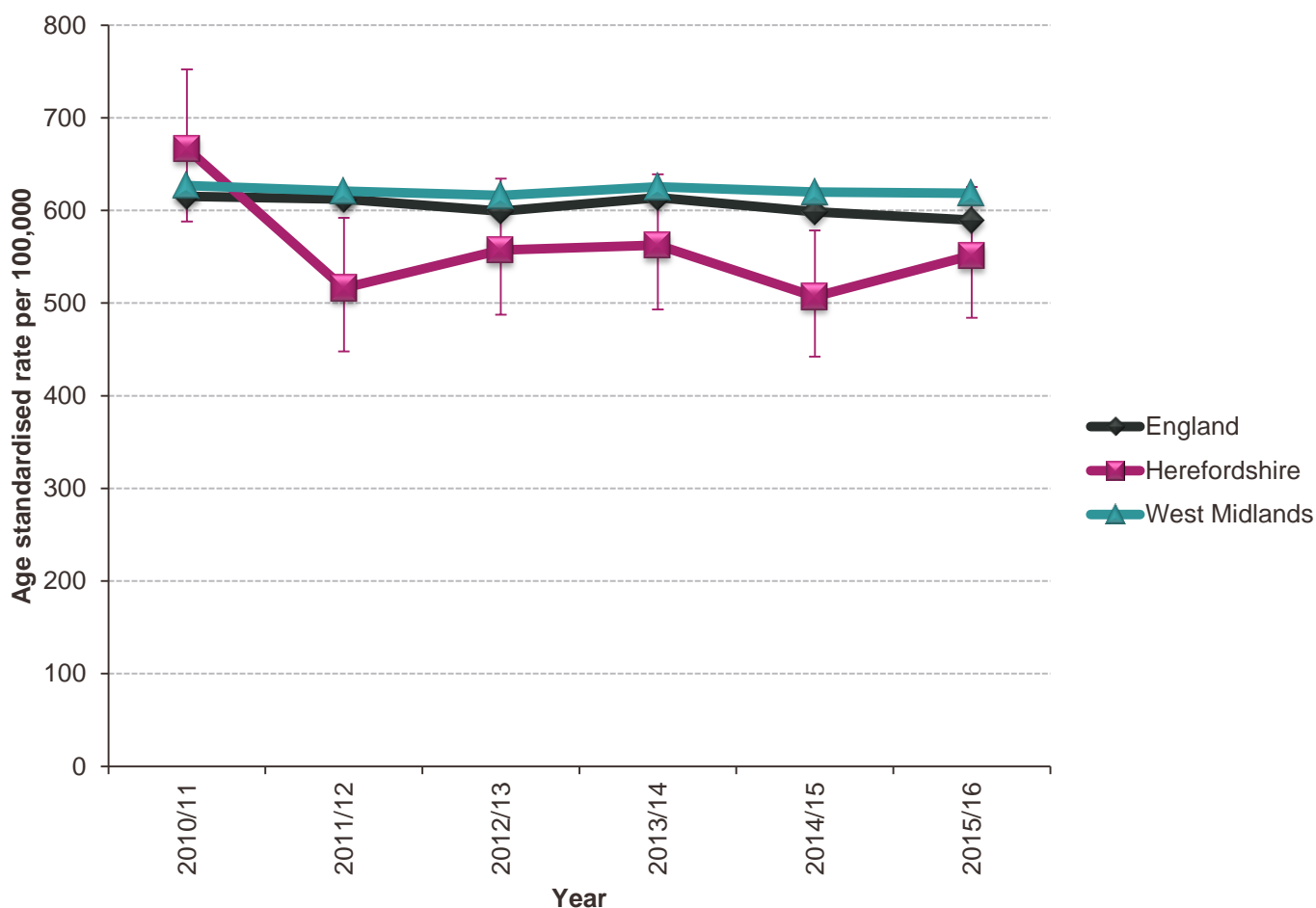
In 2015, there were 6.63 falls per 1,000 occupied bed days, with 0.19 falls per 1,000 occupied bed days resulting in moderate harm, serious harm or death among NHS hospitals in England and Wales. The falls rate for Wye Valley Trust is slightly lower at 5.35 falls per 1,000 occupied bed days, with 0.18 falls per 1,000 occupied bed days resulting in moderate harm, serious harm or death (109). In 2015/16, four per cent of hip fractures (10 cases) managed at Herefordshire County Hospital were sustained as an inpatient, with the majority being caused by a fall(110).

HIP FRACTURES

Hip fractures are the most common serious injury among those aged 65 and over, with approximately 95 per cent caused by a fall. There were 64,864 hip fractures in The UK in 2015/16 (110). Following a hip fracture patients may remain in hospital for a number of weeks, leading to one and a half million bed days being used each year, which equates with the continuous occupation of over 4,000 NHS beds(110). Only a minority of older people who have sustained a hip fracture will completely regain their previous abilities, with approximately 20 per cent being admitted to long term care within a year of their fracture. As a result, hip fracture is associated with a total cost to health and social services of over £1 billion per year (110).

In Herefordshire, the age standardised hip fracture rates among people over the age of 65 have remained relatively constant between 2010/11 and 2015/16, and have been roughly in line with the rates for England and the West Midlands, apart from in 2011/12 and 2014/15 when they were significantly lower than the regional and national rates (Figure 67).

Figure 67 Age standardised rate of emergency hospital admissions for hip fractures in people aged 65 and over, 2010/11-2015/16



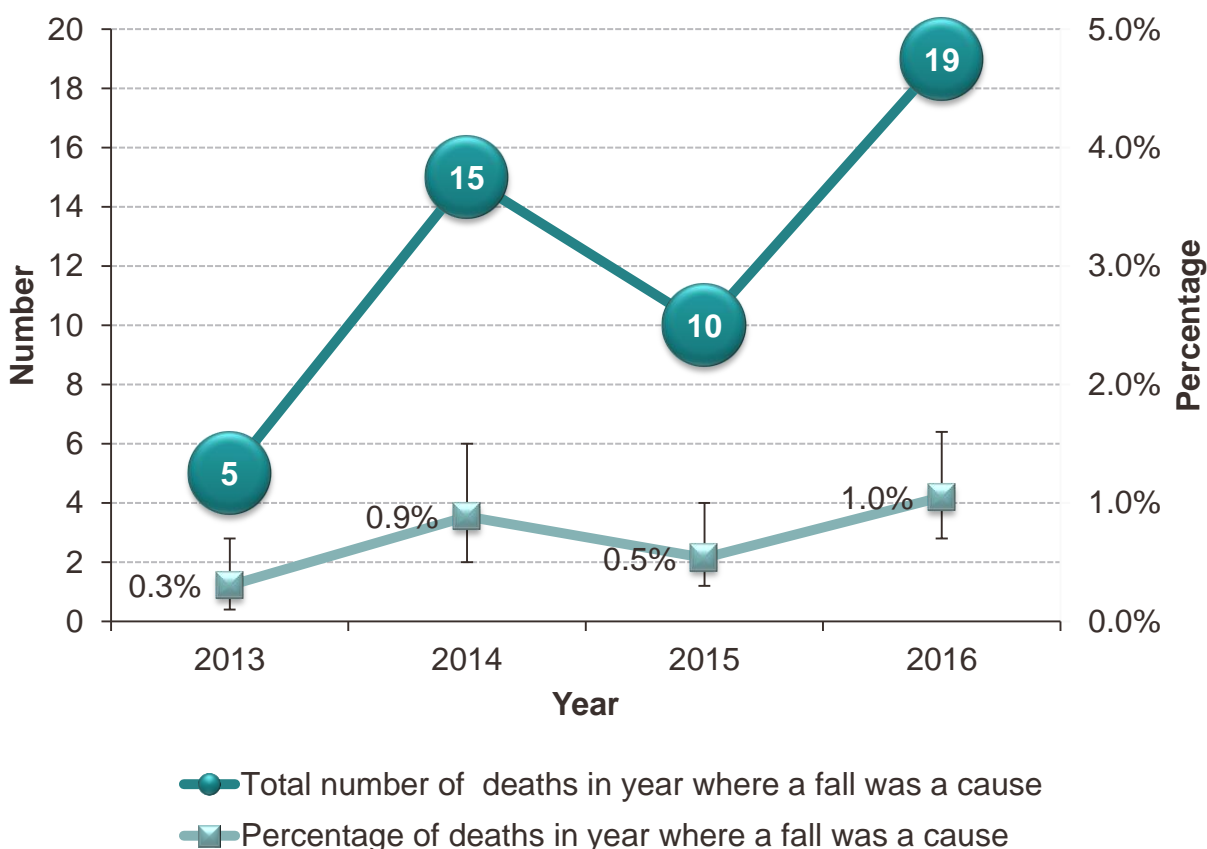
Data Source: Public Health England 2016, ©Crown Copyright

FALLS RELATED DEATHS

Data from the Primary Care Mortality Database (PCMD) was analysed for all people aged 65 and over living in Herefordshire. Falls related deaths were defined as those where the one or more of the ICD-10 codes W00-W19 were listed as a cause of death in any position.

Between the 1st of January 2016 and the 31st of December 2016, there were 19 falls related deaths among people aged 65 and over living in Herefordshire, accounting for one per cent of deaths among this age group. Between 2013 and 2016, the percentage of deaths where a fall was a cause has varied, however the difference in values has not been statistically significant (Figure 68).

Figure 68 Total number and percentage of deaths where a fall was a cause among people aged 65 and over and resident in Herefordshire 2013-2016



Data Source: Primary Care Mortality Database

FALLS IN CARE HOMES

Older people living in care homes are at a greater risk of falling than their community dwelling counterparts. Estimates suggest that approximately 60 per cent of older people living in a care home will fall each year, with up to 40 per cent falling more than once a year(111).

It is considered best practice for care homes to keep a falls register, to support better falls management and prevention for individual residents and the care home as a whole(112). A detailed guide on best practice falls prevention and management in the care home setting was jointly published by NHS Scotland and the Care Inspectorate(112).

Approximately ten per cent (1,183) of the 11,860 falls related WMAS call-outs made to Herefordshire residents aged 65 and over between the 1st of December 2012 and the 31st of August 2017 were flagged on the WMAS system as being to a residential or nursing home. It is worth noting that this is likely an underestimate of the percentage of call-outs made to residential or nursing homes, as not all will be flagged on the system.

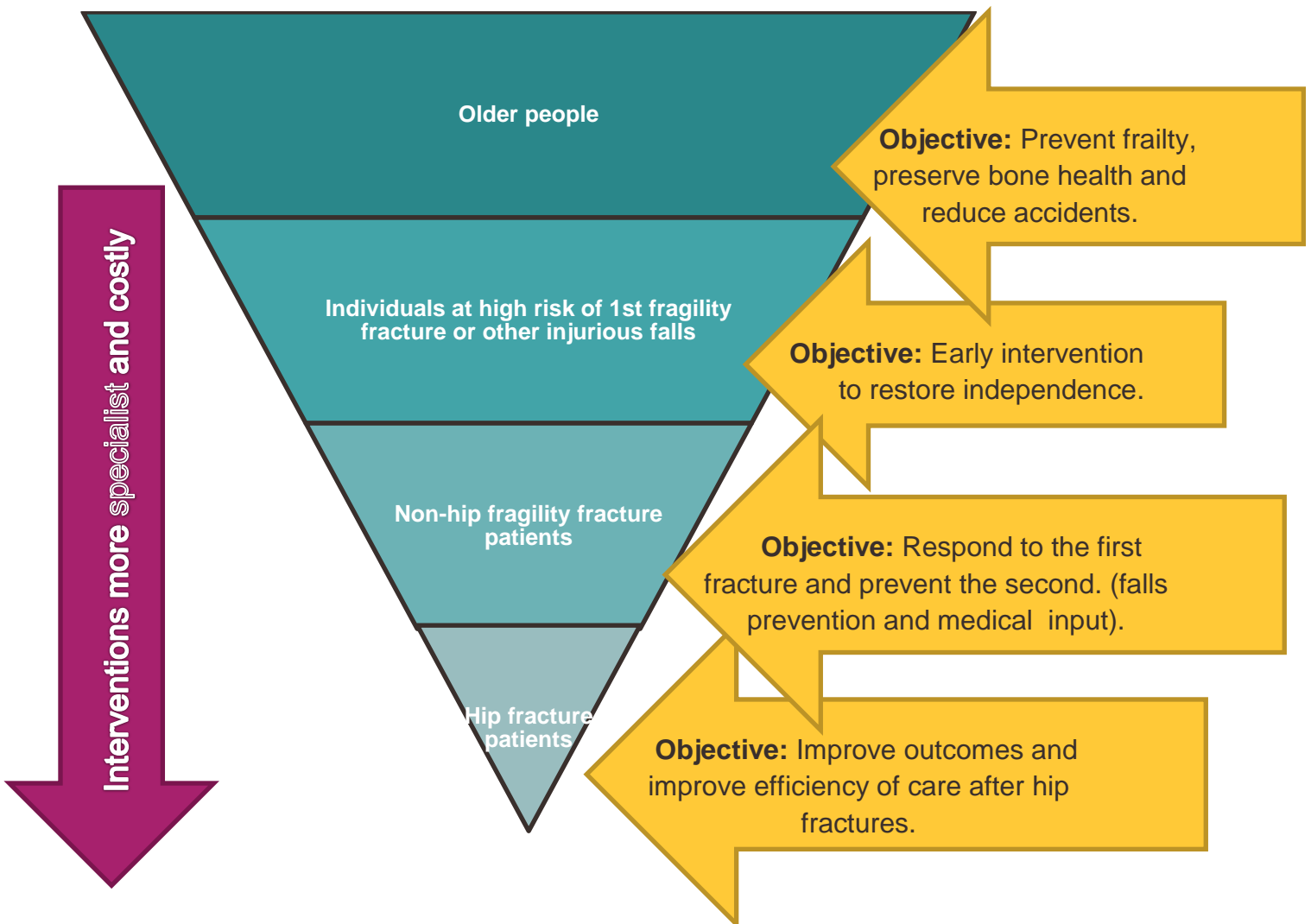
Locally, there is no requirement for residential and nursing homes to report falls figures. Therefore, it is difficult to draw an accurate picture of the incidence and nature of falls among this population. However, this information could be helpful in identifying whether additional support and training might improve falls prevention and management in care home settings.

PREVENTION AND MANAGEMENT

The National Institute of Health and Care Excellence (NICE) has produced a clinical guideline detailing best practice in the prevention and assessment of falls in older people(113). The management of hip fractures is covered by a separate NICE clinical guideline(114). In addition, Public Health England has recently published two falls and fracture consensus statements papers(115, 116) to support the commissioning of falls prevention services.

Prevention and management strategies are best targeted at populations most likely to benefit. The Department of Health has identified four distinct groups of older people who are at risk of falls and fractures, and has set out objectives for managing risk in each group(111). This information is presented in Figure 69. The prevention and management of these different groups is outlined in brief below.

Figure 69 Groups of people at risk of falls and fractures



Source: DEPARTMENT OF HEALTH. Falls and fractures: Developing a local joint strategic needs assessment. 2009.

SELF-CARE AND ADVICE FOR OLDER PEOPLE

NICE(113) recommends that health and social care professionals offer advice to individuals at risk of falling, and their carers. A comprehensive, yet easy to read guide [Get up and Go](#) has been jointly produced by the Chartered Society of Physiotherapy, Saga, and Public Health England(117). The booklet is evidence based and covers the following topics:

- how to identify if you are at risk of a fall,
- how to prevent a fall through exercise, addressing falls hazards in the home, identifying and addressing personal falls risks (such as osteoporosis, incontinence and polypharmacy),
- how to get up from a fall,
- how to help someone if they have fallen.

TARGETED FALLS PREVENTION

Identification

NICE(113) recommends that all older people coming into contact with healthcare professionals are asked if they have fallen in the past year.

Having previously fallen is a strong risk factor for experiencing further falls. Each contact with a healthcare or social care professional is an opportunity to identify that risk and to intervene, with the aim of preventing an injurious fall in the future. [Don't mention the "f" word](#) is a brief guide designed to support health and social care professionals to communicate falls prevention messages to older people.

Assessment and intervention

Older people with obvious gait or balance abnormalities, or who present for medical treatment following a fall should be offered a multifactorial falls assessment by a suitably qualified healthcare professional(113). The components of a multifactorial falls assessment are presented in Figure 70.

Figure 70 Components of a multifactorial falls assessment



Based on the findings of their multifactorial assessment, an individual can expect to be offered a multifactorial intervention which might encompass:

- home hazards intervention
- individually prescribed strength and balance exercises
- medication modification or withdrawal
- vision assessment and referral

In Herefordshire, multifactorial falls assessments and interventions are carried out by the Falls Prevention Service.

Exercise

NICE guidelines (113) recommend that older people living in the community who have experienced recurrent falls are offered strength and balance exercise training. However, there is evidence that older people with low to moderate risk of falling can also benefit(115). Strength and balance exercise programmes should be individually prescribed, incorporating progressive strength training and challenging postural stability exercises monitored by a qualified professional. Otago exercise programme(118) and the Falls Management Exercise (FaME) programme(119) are two examples of evidence based strength and balance training programmes. Locally, the FaME programme is delivered by the Falls Prevention Service and as part of a [pilot scheme](#) delivered by Sports Partnership Herefordshire and Worcestershire.

FALLS PREVENTION SERVICE

The Falls Prevention Service consists of Specialist Physiotherapists, an Occupational Therapist, Support Workers and an administration assistant. The Falls Prevention Service is a specialist service that aims to:

- reduce individual's risk factors for falling,
- reduce the number of falls and injuries from falling ,
- prevent ambulance call outs and attendance at A&E,
- prevent hospital admissions, premature admission into Care Homes and increased dependence on carers,
- reduce fear of falling, maximise independent living and quality of life,
- help individuals cope in the event of a fall including how to get up from the floor,
- advise and educate on falls prevention and bone health.

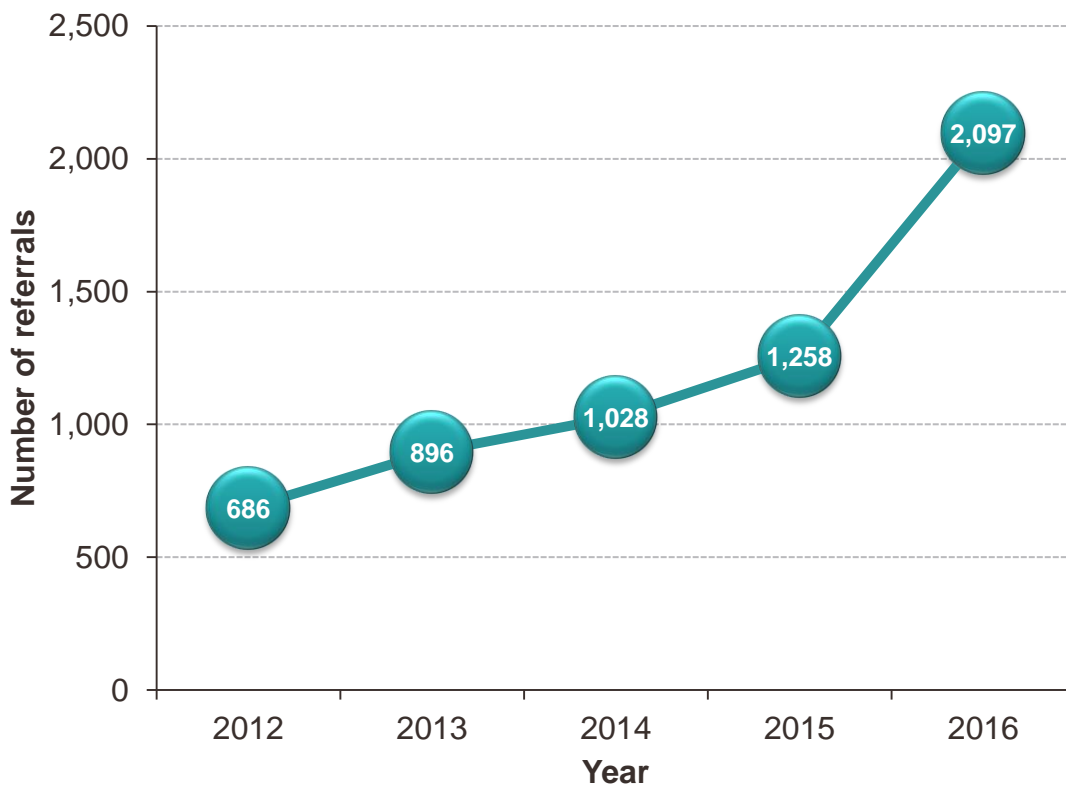
Criteria for referral into the Falls Prevention Service include:

- anyone with risk factors for falling or who is fearful about falling (can be a pre-faller, single faller or recurrent faller),
- balance, strength or gait deficits,
- general unsteadiness and dizziness,
- low activity levels,
- osteoporosis/osteopenia,

- difficulty getting up from the floor or coping in the event of a fall,
- fear or falling and loss of confidence,
- need for a walking aid,
- potential home hazards.

Approximately 70 per cent of patients referred to the service are aged 75 or over. Between 2012 and 2016 referrals to the Falls Prevention Service have increased by over 300 per cent (Figure 71).

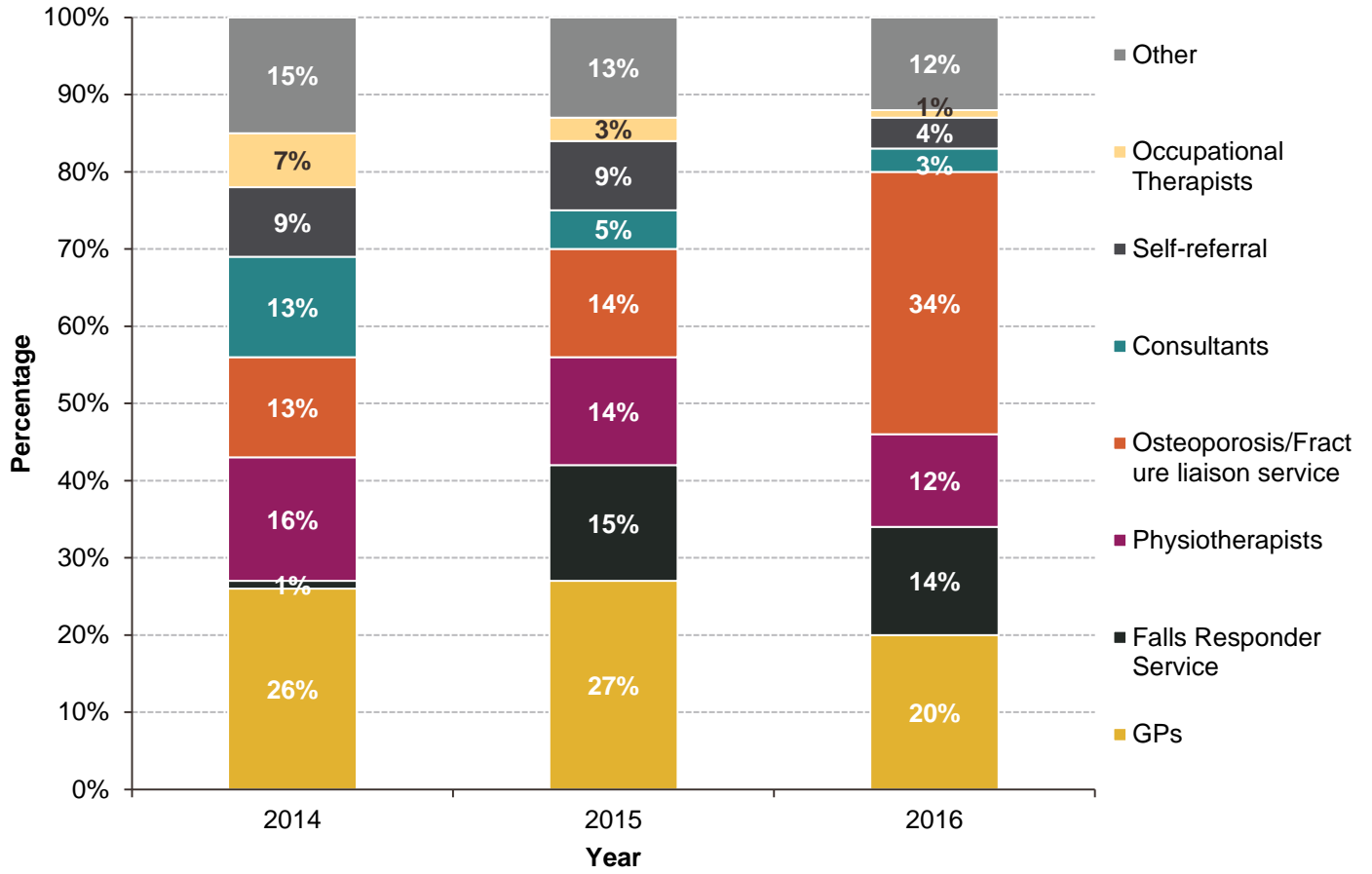
Figure 71 Number of referrals to the Falls Prevention Service, 2012-2016



Data Source: Falls Prevention Service data

In 2016, the largest proportion of referrals into the Falls Responder Service came from the Osteoporosis and Fracture Liaison Service. Referral numbers from this service have grown between 2014 and 2016, overtaking GP referrals as the most common referral source. The proportion of referrals made by the Falls Responder Service has also increased between 2014 and 2016. The proportion of consultant, GP, occupational therapist and self-referrals has decreased over the same time period (Figure 72). Considering the number of contacts the WMAS has with people who fall, the number of referrals made to the Falls Prevention Service are relatively few.

Figure 72 Proportion of referrals to the Falls Prevention Service by source, 2014-2016



Data Source: Falls Prevention Service data

MANAGING FRAGILITY FRACTURES

Osteoporosis is a condition where bone density is decreased, increasing the risk of a fragility fracture¹⁶. Fragility fractures are relatively common, affecting one in three women and one in five men over the age of 50(120). They cost NHS approximately £1.9 billion per year(121), and can lead to permanent disability.

People who have fallen and sustained a fragility fracture are at high risk of experiencing further fractures. To help prevent future fragility fractures the National Osteoporosis Society recommends that people over the age of 50 who have experienced a fragility fracture receive targeted medical input from a specialist fracture liaison team. In Herefordshire, this is managed by the Osteoporosis Fracture Liaison Service.

The National Osteoporosis Society recommend that secondary prevention of fragility fractures be managed in five distinct steps(121). These are presented in Table 8.

NHS RightCare undertakes analysis of key healthcare indicators, and produces recommendations for areas of improvement for each clinical commissioning group. Recently, NHS RightCare identified that a considerably smaller proportion of people aged 75 and over, who have experienced a fragility fracture are receiving treatment with a bone sparing agent (a treatment for osteoporosis) in Herefordshire as compared to other clinical commissioning groups, recommending that this might represent an opportunity to improve both clinical and cost effectiveness outcomes in relation to the secondary prevention of fragility fractures(122).

¹⁶ A fragility fracture is a fracture that is sustained from an injury that would not normally result in a fracture. This has been defined by the World Health Organisation as forces equivalent to falling from a standing height or less.

Table 8 Five steps in the secondary prevention of fragility fractures

Clinical steps in the management of secondary fragility fractures	Criteria	Rationale
1. Identification	All patients aged 50 years and over with a new fragility fracture or a newly reported vertebral fracture will be systematically and proactively identified.	Patients who have sustained a fracture are at higher relative risk of fracture than those who have not. Targeted interventions in this population will have most impact on reducing the future fracture burden.
2. Investigation	Patients will have a bone health assessment and their need for a comprehensive falls risk assessment will be evaluated within 3 months of the incident fracture.	Assessments need to be conducted promptly as the risk of having a further fracture is increased in the first year.
3. Information	All patients identified will be offered written information about bone health, lifestyle, nutrition and bone-protection treatments.	Anyone aged over 50 years who has had a fracture needs to be aware of the steps they can take to maintain healthy bones and prevent further fractures.
4. Intervention	Patients at increased risk of further fracture will be offered appropriate bone-protection treatments.	Appropriately targeted interventions reduce future risk of fracture.
	Patients at increased risk of further falls will be referred for appropriate assessment or interventions to reduce future falls.	Evidence-based falls interventions are effective at reducing risk of falls.
5. Integration	Management plans will be patient-centred and integrated between primary and secondary care.	Effective communication is essential to ensure that long-term management is achieved and that patients are supported to engage with recommended interventions.
	Patients who are recommended drug therapy to reduce risk of fracture will be reviewed within 4 months of initiation to ensure appropriate treatment has been started, and every 12 months to monitor adherence with the treatment plan.	Treatments must be taken consistently and appropriately over many years to be effective. Follow-up allows early identification of issues (side effects, compliance) with prescribed medications, reinforces need to take treatments and supports long-term concordance.

Source: National Osteoporosis Society. *Effective Secondary Prevention of Fragility Fractures: Clinical Standards for Fracture Liaison Services, 2014.*

HIP FRACTURE MANAGEMENT

Prompt, best practice medical management is important for improving outcomes among older people who have sustained a hip fracture, where poor outcomes are frequent and associated with significant personal (loss of mobility and independence), health care (extended stays in hospital) and social care (provision of long term social care) costs.





The National Institute of Health and Care Excellence (NICE) has produced a clinical guideline(114) and an accompanying quality standard(123) for the management of hip fractures. The National Hip Fracture Database (NHFD) collects hip fracture data and benchmarks hip fracture performance against the NICE quality standard for every NHS hospital in the UK in its annual report(110).

LOCAL MANAGEMENT OF HIP FRACTURES

In 2015/16 NHFD audit data indicates that there were 247 hip fractures managed at Herefordshire County Hospital. Herefordshire County Hospital was among the top 25% of UK hospitals in relation to its performance in the proportion of arthroplasties that were cemented, the number of days patients stayed in hospital for the acute management of their fractured hip, the proportion of patients who returned to their place of residence within 30 days and the proportion of patients for whom the final discharge destination was recorded. However, the hospital was among the bottom 25% of UK hospitals in relation to the proportion of patients who had their mental test score recorded upon admission, the proportion of patients who received a perioperative assessment, the proportion of patients for whom the best practice tariff criteria were met, the proportion of patients who received a spinal and nerve block, and the proportion of subtrochanteric fractures that were treated with an intramedullary nail. Herefordshire County Hospital's compliance with NICE quality standards relating to the management of hip fracture is outlined in Table 9.

Table 9 Local and national performance against NICE Quality Standard QS16 in 2015/16

NICE Quality Standard	Herefordshire County Hospital	All hospitals in the United Kingdom
Admitted to orthopaedic ward within 4 hours (%)	40.4	43.9
Mental test score recorded on admission (%)	90.7	94.9
Perioperative medical assessment (%)	64.8	87.5
Mobilised out of bed on the day after surgery (%)	79.4	76.1
Met the criteria for best practice tariff (%)	42.0	65.6
Surgery on day, or day after admission (%)	69.9	71.5
General anaesthetic and nerve block (%)	45.5	58.1
Spinal and nerve block (%)	10.9	32.5
Proportion of arthroplasties which are cemented (%)	100	83.6
Eligible displaced intracapsular fractures treated with a total hip replacement (%)	27.4	26.3
Intertrochanteric fractures treated with sliding hip screw (%)	79.1	72.8
Subtrochanteric fractures treated with an intramedullary nail (%)	50.0	79.2
Acute length of stay (days)	10.1	15.6
Overall hospital length of stay (days)	22.7	21.1
Return to original residence within 30 days (%)	63.5	50.5
Documented to have developed a pressure ulcer (%)	3.1*	94.9
Documented final discharge destination (%)	94.7	82.2

Quartile (national)	Colour grading
Top 25%	
2nd quartile	
3rd quartile	
Lowest 25%	

Colour coding and grading allows readers to see how their hospital is performing – in quartiles compared with national performance.

Tables are colour coded when performance figures can be set against clear definitions of best clinical practice or NICE quality standards.

We highlight units in the 'top performing quarter of hospitals' (dark green) and in the 'worst performing quarter of hospitals' (dark red).

Data Source: ROYAL COLLEGE OF PHYSICIANS. National Hip Fracture Database (NHFD):

DICUSSION POINTS

- Falls are a major health risk for older people. While local falls related hospital admission rates are lower than national and regional rates, local hip fracture rates are similar. Therefore, in Herefordshire, there are still a considerable number of older people are experiencing serious injury as the result of a fall. In 2016 there were 19 falls related fatalities among Herefordshire residents aged 65 and over.
- Since 2014 there has been a 24/7 Falls Responder Service in Herefordshire providing non-medical support and referral (if required) for non-injurious falls that occur in a place of residence. There is evidence that the service could be better utilised, with an indication that some of the callouts made by West Midlands Ambulance Service could be attended by a falls responder, with action being taken to support appropriate onward referral from the ambulance service to the Falls Responder Service.
- Falls are not an inevitable part of ageing, and actions can be taken to prevent them. The results of the frailty integrated care pathway benchmarking exercise (see page [98](#)), indicate that in Herefordshire, people with frailty have acceptable access to falls prevention interventions. The Falls Prevention Service has seen considerable growth in the number of referrals it receives (300 per cent increase between 2012 and 2016), indicating that it is well utilised.
- Falls are common in residential and nursing home settings and an understanding of the incidence and nature of falls which take place could be helpful in identifying whether additional support and training might improve falls prevention and management in these settings. Locally, there is little information about the number and nature of falls which take place in residential and nursing homes.
- NHS RightCare have identified that in Herefordshire, a considerably smaller proportion of people aged 75 and over presenting with fragility fractures are treated with a bone sparing agent (a treatment for osteoporosis) compared to other clinical commissioning groups, suggesting that there is an opportunity to improve outcomes for people with osteoporosis by enhancing treatment coverage.

RECOMMENDATIONS

- Increase awareness of the need for health and social care professionals to ask older people if they have experienced a fall in the past twelve months.
- Continue to take actions to optimise utilisation of the Falls Responder Service, specifically the appropriate onward referral of non-injurious falls received by West Midlands Ambulance Service and NHS 111.
- Encourage appropriate data sharing related to falls which take place in residential and nursing homes, and consider whether targeted interventions to reduce incidence are warranted.
- Identify and implement methods to increase the proportion of people aged 75 and over who have experienced a fragility fracture treated with bone sparing agents.

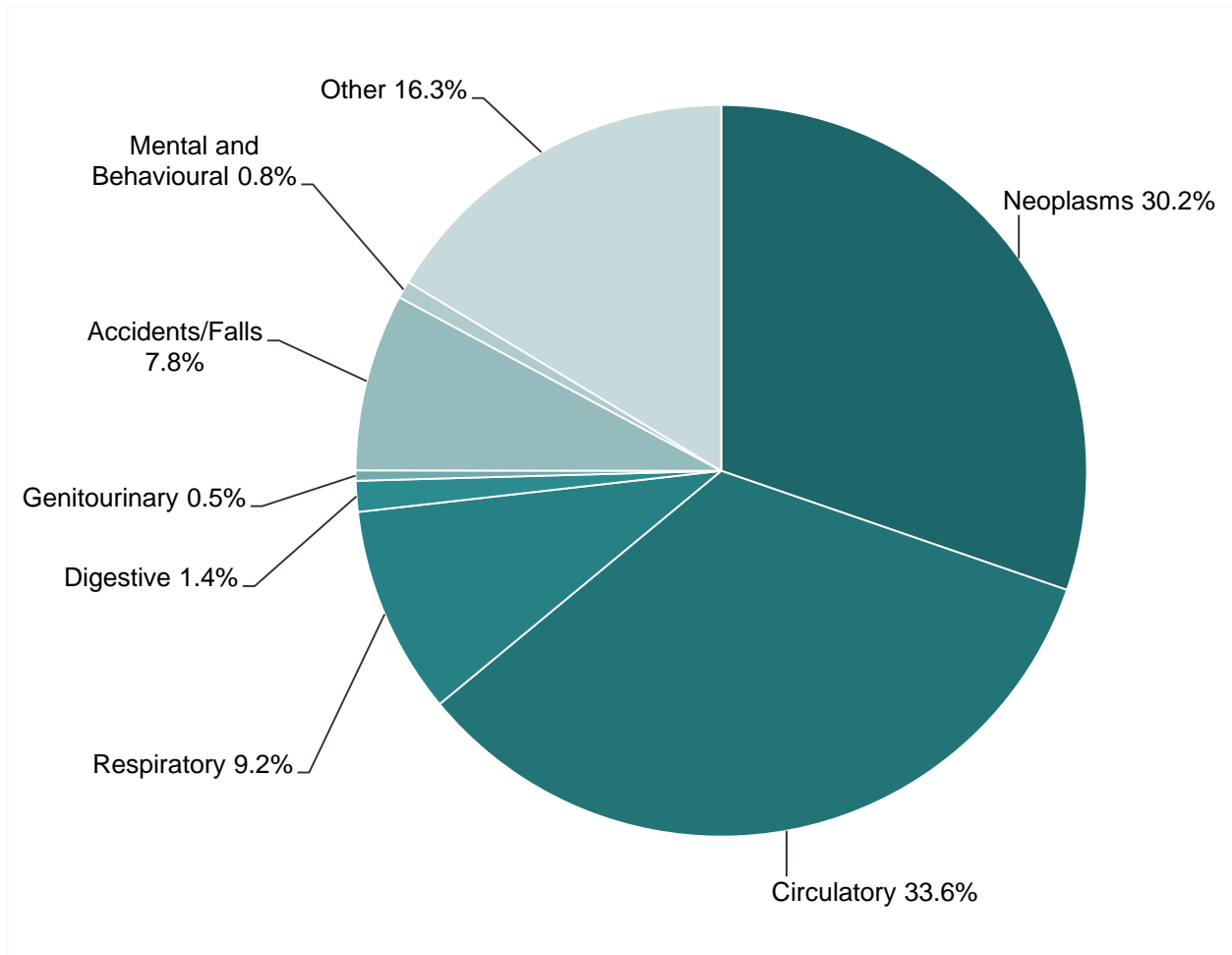
Key Facts

- The cardiovascular disease mortality rate among people aged 65 and over is worse in Herefordshire compared to England. The difference in rates is statically significant, and has been since 2007.
- In Herefordshire, the injury related mortality rates among those aged 75 and under are worse than those reported for England as a whole.
- Excess winter death rates in Herefordshire are similar to those observed nationally.
- There was a sharp increase in the number of excess winter deaths across England in 2014/15, a trend also observed in Herefordshire. Moderate levels of influenza in the community are believed to be the underlying cause.

MORTALITY BY MAJOR CAUSE

Between 2012 and 2014 the most common underlying causes of death in Herefordshire were diseases of the circulatory system (33.6 per cent) neoplasms (cancer) (30.2 per cent), and respiratory disease (9.2 per cent) (Figure 73).

Figure 73 Percentage of all mortalities associated with underlying cause in Herefordshire 2012 – 14



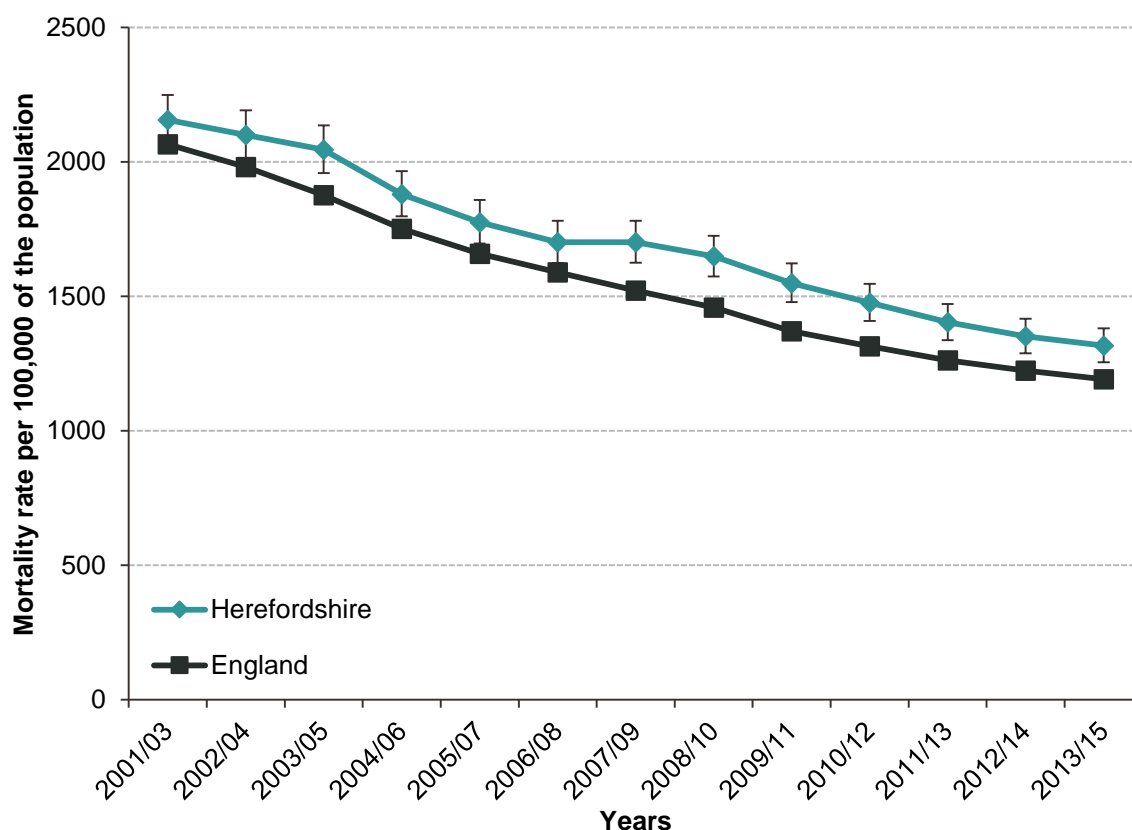
Source: MORTALITY AND PREMATURE MORTALITY, Herefordshire Council Strategic Intelligence Team. 2016.

Data Source: NHS Digital Indicator Portal

MORTALITY AMONG PEOPLE AGED 65 AND OVER

In Herefordshire respiratory disease mortality rates and cancer mortality among people aged 65 and over have been statistically significantly lower than the England figure. However, cardiovascular disease mortality rates among this population are worse than the rate for England. The difference in rates is statically significant, and has been since 2007/09 (Figure 74).

Figure 74 Cardiovascular mortality rate per 100,000 of the population aged 65 and over for Herefordshire and England



Source: MORTALITY AND PREMATURE MORTALITY, Herefordshire Council Strategic Intelligence Team. 2016.

Data Source: Public Health England, 2017.

CARDIOVASCULAR DISEASE

Cardiovascular disease refers to a group of diseases which affect the heart and blood vessels, and can lead to heart failure, heart attacks and strokes(124). It is the number one cause of death in the world. Physiological indicators of poor cardiovascular health include raised blood pressure, raised blood lipids (cholesterol) and raised body mass index (BMI)(124). Early detection of these physiological indicators is possible through quick, routine medical tests.

NHS Health Checks, is a national health screening programme aimed at detecting physiological indicators of poor cardiovascular and metabolic health among those 40 to 74 years of age, with the aim of improving these physiological markers and decreasing individuals' risk of associated adverse health outcomes.

In Herefordshire, between 2013/14 and 2017/18, despite 93.6 per cent of people aged 40-74 eligible for a GP Health Check being offered one, only 47.3 per cent actually received a GP Health Check, less than nationally (48.9 per cent). This difference is

statistically significant(125). Better uptake of GP Health Checks could help to reduce local cardiovascular mortality rates(126).

PREMATURE MORTALITY

Premature mortality is defined as death occurring in individuals aged less than 75 years. In 2015, one in three deaths in England were premature(127). Premature mortality rates are greater among men than women. The most common causes of premature mortality are cancer, heart disease, stroke, lung disease and liver disease which between them account for 79 per cent of all premature deaths in England. Of these deaths it is estimated that two thirds could be avoided either through prevention, earlier diagnosis and access to the highest quality treatment and care(128). Therefore, analysis of premature mortality statistics can assist in identifying areas for improving local health care provision.

Between 2014 and 2016 there were 1,716 premature deaths in Herefordshire. Herefordshire’s directly age standardised premature mortality rate was 299 per 100,000 of the population, ranking 38th out of 150 English local authorities (among the best)(127). Herefordshire’s premature mortality rates were ranked as being among the “best” or “better than average” for eight of the nine major causes of premature mortality, with the local premature mortality rate for injuries judged as being “worse than average” (Table 10).

Table 10 Herefordshire's rank and outcome based on analysis of premature mortality rates for the nine major causes (based on 2014-2016 data)

Major cause of premature mortality	Rank (1 to 150, with 1 being the best)	Outcome (Best, Better than average, Worse than average, Worst)
Breast cancer	55	Better than average
Cancer	22	Best
Colorectal cancer	36	Better than average
Heart disease	44	Better than average
Injuries	114	Worse than average
Liver disease	35	Better than average
Lung cancer (all ages)	4	Best
Lung disease	55	Better than average
Stroke	23	Better than average

Data Source: Public Health England. *Longer Lives: Premature Mortality*, 2017.

<http://healthierlives.phe.org.uk/topic/mortality/#are//par/E92000001/ati/102/pat/102>.

EXCESS WINTER DEATHS

It is a well-established observation that more people die in the winter than in the summer in the UK, as well as in other countries(129). This trend is referred to as excess winter deaths.

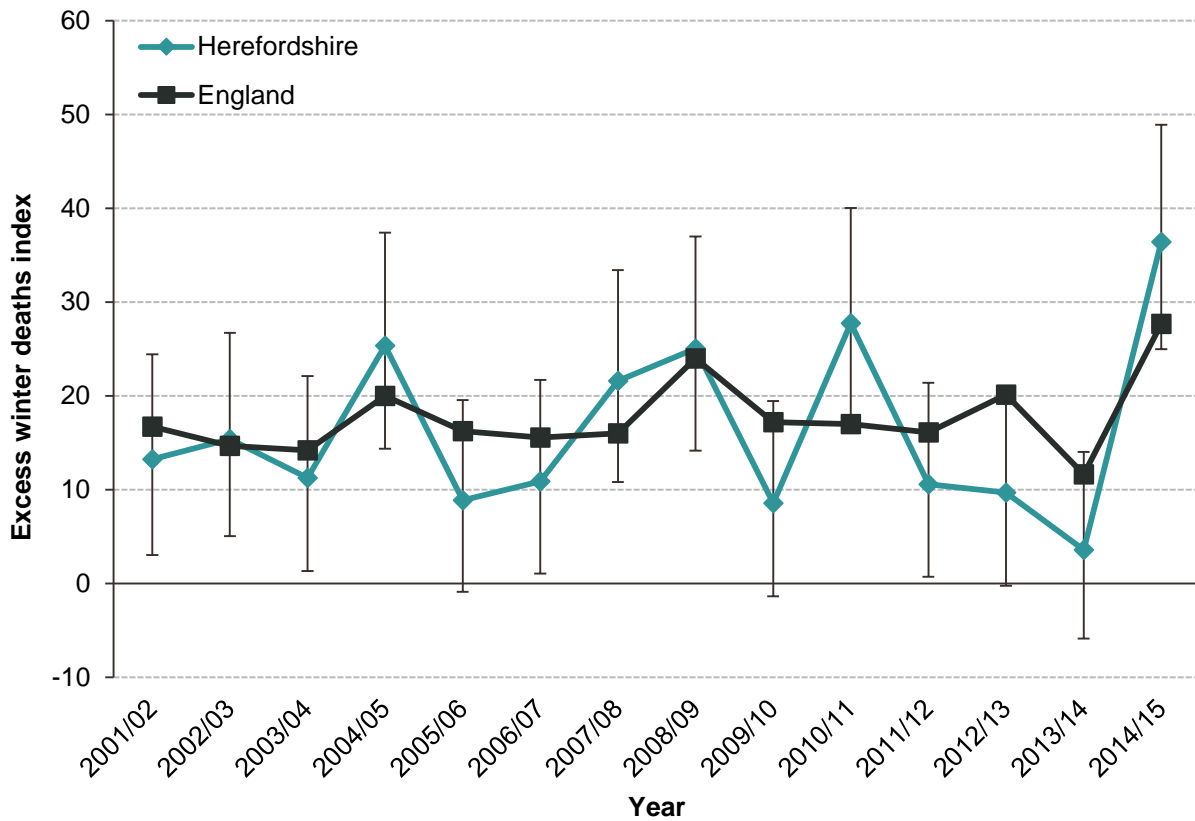
The most common causes of excess winter deaths are cerebrovascular diseases, ischaemic heart disease and respiratory disease, with the majority of excess winter deaths occurring among older people(129). In England there is evidence that colder homes are associated with higher levels of excess winter deaths from cardiovascular disease(13), physiological evidence indicates that colder home temperatures cause high blood pressure among older people(130), increasing the risk of a cardiovascular event. Poor thermal efficiency is a particular issue among Herefordshire's housing stock, and so is fuel poverty (see page [35](#)).

The excess winter deaths index is calculated as a ratio of deaths occurring over the four month winter period (December to March) compared with the expected number of deaths, based on the average number of deaths observed in the non-winter period(129).

Between 2001/02 and 2014/15 there has been considerable variability in the number of excess winter deaths in Herefordshire. The lowest number being 22 deaths in 2012/13 and the highest being 225 deaths in 2014/15. Herefordshire's single year excess winter deaths index has been similar to England's index from 2001/02 to 2014/15 inclusive (Figure 75).

In 2014/15 Herefordshire's excess winter deaths index was significantly higher than that observed in the previous three years. This trend was in line with what was observed nationally (Figure 75). Following statistical investigation(129), the Office for National Statistics concluded that the observed spike in excess winter deaths in the UK in 2014/15 was largely due to moderate levels of influenza in the community caused by low influenza vaccination effectiveness (34 per cent effectiveness) and the dominant flu strain being influenza A(H3N2), a strain which is particularly virulent in older people. Provisional data for 2015/16 suggests that the national and regional excess winter deaths index were lower, and back in line with average trends (131).

Figure 75 Excess winter deaths index (single year) for Herefordshire and England, 2001/02-2014/15



Data Source: Public Health England, 2017.

RECOMMENDATIONS

- Explore the diagnosis and management of cardiovascular disease in Herefordshire in order to make system improvements that lead to a lowering of premature mortality attributable to the condition. This may include improving the proportion of eligible people who receive a Health Check.
- Explore the underlying causes of premature mortality attributable to injuries and consider whether local health and safety campaigns are warranted.

Key Facts

- People who provide informal care, often do not recognise themselves as “a carer”. This can result in informal carers missing out on relevant information, support and advice.
- It is estimated that there are 21,300 informal carers living in Herefordshire.
- Just over 14 per cent of people aged 65 and over living in Herefordshire provide some degree of informal care, a figure similar to that observed nationally.
- The number of people providing informal care is forecast to rise, with the number of people aged 65 and over providing informal care set to increase by approximately 36 per cent between 2017 and 2035 from 6,600 to 9,000 people.
- Women aged between 55 and 64 are the group most likely to provide informal care. However, from the age of 75 and over, a higher percentage of men provide care.
- In Herefordshire, carer reported quality of life is improving, but is statistically significantly lower than the figure for England.

An informal carer is a person who provides a considerable amount of care, unpaid (excluding volunteers who work for a voluntary organisation), on a regular basis for a partner, family member or friend(132).

THE VALUE OF INFORMAL CARE

In 2014, the Office for National Statistics estimated that informal carers in the UK provided £56.9 billion worth of care(133). However, in 2015, using a more holistic model, Carers UK estimated that informal carers contributions equated to £132 billion worth of savings(132). In contrast, for the 2015-16 reporting period the gross expenditure of all councils with Adult Social Service Responsibilities (CASSRs) was £16.97 billion(134). In 2015, it was estimated that informal carers living in Herefordshire cumulatively provided care and support worth approximately £385 million(132).

WHO PROVIDES INFORMAL CARE?

Identification

People who provide informal care often don't identify themselves as being carers. Health and social care professionals also often fail to identify informal carers, missing opportunities to provide appropriate information, support and advice, including making them aware of their entitlements.

It is not possible to determine the exact number of informal carers in Herefordshire. The usual method for estimating informal carer numbers involves applying the prevalence estimates from the most recent National Census to current population estimates. The 2011 Census estimated the prevalence of unpaid care in Herefordshire to be approximately 11 per cent of the population, Office for National Statistics 2016 mid-year population estimates indicate there are 189,300 people living in Herefordshire. Therefore, it is estimated that there are approximately 21,300 informal carers in Herefordshire.

The Family Resources Survey (FRS) is a household survey which collects information on a representative sample of private households in the United Kingdom. Detailed information is recorded on respondents' income from all sources: housing tenure, caring needs and responsibilities, disability, expenditure on housing, education, pension scheme participation, childcare, family circumstances, and child maintenance. In the 2015/16 over 19,000 households were interviewed, a summary of relevant carer data is presented below(135).

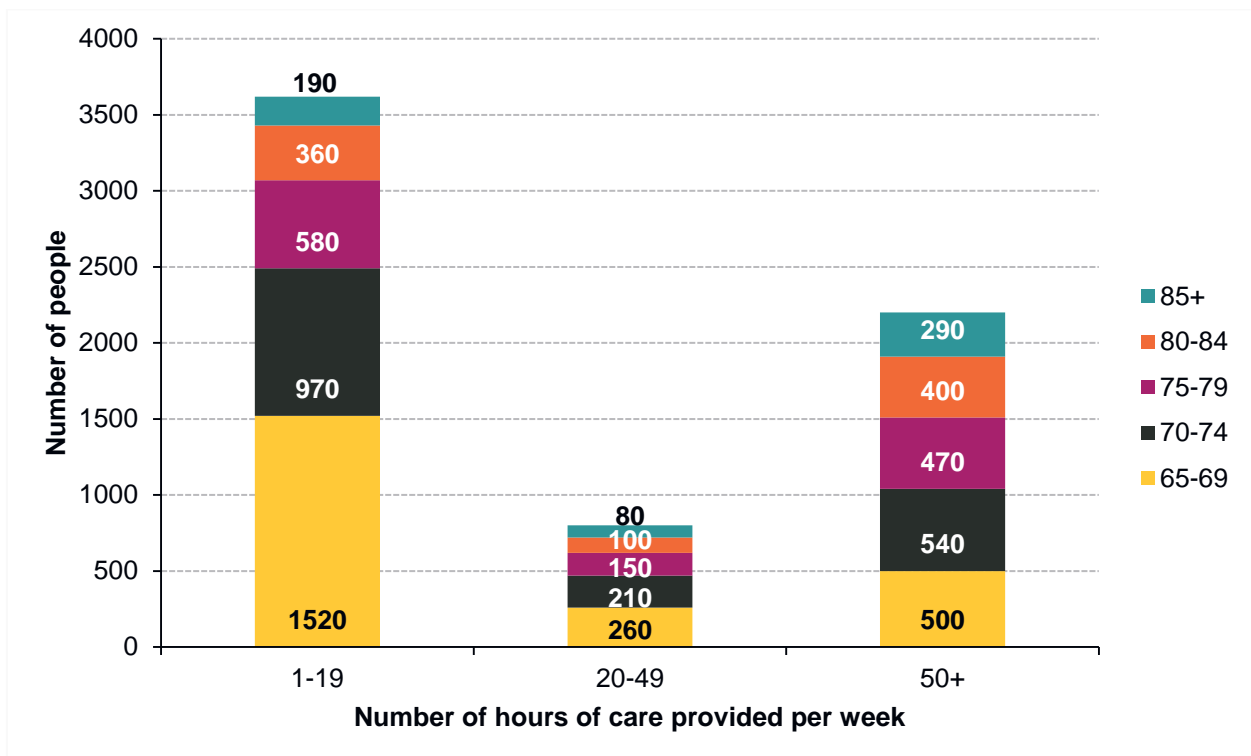
The percentage of adults providing informal care was found to vary by age and gender. Men and women aged between 55 and 64 were most likely to provide care. Women were more likely to provide informal care than men up to the age of 74. However, over the age of 75, there was a higher percentage of men providing informal care. Of those aged 85 or over, 11 per cent of men provided informal care compared to 2 per cent of women. The age and gender profile of informal carers is of particular importance when seeking to understand their needs, and considering how best to provide support.

In 2015/16, 44 per cent of all informal carers provided care to someone living within their household and 58 per cent provided care to somebody living outside their household, with some providing care to more than one person (accounting for the figures equating to more than 100 per cent). Thirty-five per cent of informal carers cared for parents living outside of their household. The majority of informal carers providing care for someone within the household did so for a person who was either their spouse, partner or cohabitee.

OLDER CARERS

It is estimated that there are 6,600 people aged 65 and over providing informal care in Herefordshire in 2017(18), approximately 14.5 per cent of Herefordshire’s population aged 65 and over. This is similar to England, where approximately 1.4 million of people aged 65 and over (14.2 per cent) provide some degree of informal care(18). The largest proportion of older informal carers (23.0 per cent) are thought to be between 65 and 69 years of age, and provide between one and 19 hours of care per week (Figure 76).

Figure 76 Estimated number of informal carers in Herefordshire in 2017 by age group and hours of carer provided per week

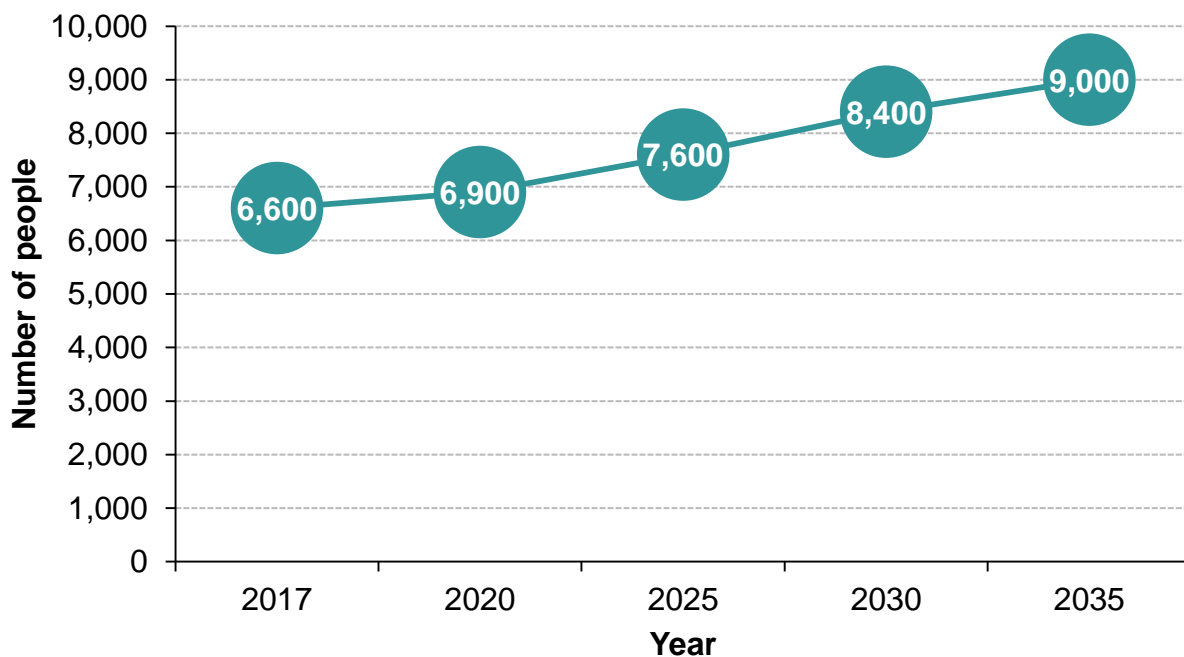


Data Source: Projecting Older People Population Information System , 2017.

**Numbers in figure may not total to values in the text due to rounding.*

The number of people aged 65 and over providing informal care in Herefordshire is forecast to rise to 9,000 by 2035, a 36 per cent increase from 2017 (Figure 77).

Figure 77 Estimated number of informal carers aged 65 and over in Herefordshire 2017-2015



Data Source: Projecting Older People Population Information System , 2017.

CARERS' NEEDS AND EXPERIENCES

Seeing to their own health concerns and social isolation and loneliness are concerns which are universal to informal carers(136).

SOCIAL ISOLATION

In 2015, Carers UK published the findings of their research into the impact of loneliness on informal carers(137). Social isolation¹⁷ and loneliness¹⁸ were found to be common among carers, with approximately 8 out of 10 carers reporting that they feel lonely or socially isolated. Fifty-seven per cent of carers reported that they have lost touch with friends and family members, and 49 per cent have experienced additional stress in their relationship with their partner as a result of the demands of their caring role.

When asked, carers identified the following factors as the main cause of their loneliness:

- not having time to participate in social activities,
- not being able to get out of the house much,

¹⁷ Social isolation refers to the number of social contacts a person has.

¹⁸ Loneliness refers to the feeling of a lack of companionship, and is something that can come and go.

- not being able to afford to participate in social activities,
- not being comfortable talking to friends about caring.

Loneliness and isolation are linked to numerous adverse health and wellbeing outcomes such as increased blood pressure, abnormal stress response, heart disease, and poor sleep(138). There is also a strong link between loneliness and depression(139), in addition older people who are lonely have an increased risk of developing dementia compared to their socially fulfilled counterparts(140, 141).

HEALTH AND WELLBEING

Findings from the 2016 GP patient survey indicate that three in five carers have a long-term health condition, compared to half of non-carers(142). In addition, people providing informal care are at increased risk of psychological stress, and associated mental health issues(143). Carers providing a greater number of hours of care are more likely to suffer from poor health(144).

Many carers find it difficult to fit their own medical appointments around their caring responsibilities, and often delay seeking out medical support and advice. Some carers find that caring itself has a detrimental impact upon their physical health, especially when their caring role involves frequent moving and handling activities.

Carers UK administer an annual “State of Caring” survey(136). Between March and May 2017, a total of 7,286 carers and former carers responded. A portion of the survey covers health and wellbeing, the results of which are summarised below.

Sixty-one per cent of informal carers report that their physical health has worsened as a result of caring, and 70 per cent report having suffered from mental ill health, with 46 per cent experiencing a bout of depression which they attributed to their caring role. Caring can even impact upon health behaviours, with 54 per cent of informal carers having to reduce the amount of exercise they engage in and 45 per cent finding it more challenging to eat a healthy and balanced diet since taking on their caring responsibilities.

Support from GPs

Of those surveyed, 15 per cent reported that their GP is not aware that they are a carer. Eighty-five per cent reported that their GP is aware of their caring responsibilities, and of those, 68 per cent said that their GP does not provide specific additional support or advice; and eight per cent said they felt their GP offered some carers specific support but that they could offer more. Only nine per cent reported that their GP knew that they were an informal carer and felt that they were offered the appropriate level of tailored support and advice.

Local Action

Herefordshire Carers Support has launched a campaign to improve the awareness of carers among Herefordshire GP practices. Carers are being encouraged to inform their GPs of their role and GPs are being urged to ask patients if they are a carer, and to document carer status in their medical records. Once carers have registered their carer status with their GP they can expect to benefit from annual invitations for a free flu jab and access to more flexible GP appointment slots (and possibly the offer of a home visit).

As of October 2017, the GP surgery of 4,047 carers registered with Herefordshire Carers Support was known (Table 11), with the GP surgery of approximately 1,500 carers being unknown.

Table 11 Number of carers registered with Herefordshire Carers Support by GP surgery, valid as of October 2017

GP surgery	Number of carers
Alton Street Surgery	159
Belmont Medical Centre	225
Cantilupe Surgery	297
Colwall Surgery	61
Cradley Surgery	75
Fownhope Medical Centre	131
Golden Valley Practice	74
Greyfriars Surgery	161
King Street Surgery	251
Kingstone Surgery	140
Kington Medical Practice (the Meads)	62
Ledbury Market Surgery	102
Marches Surgery The	78
Moorfield House Surgery	369
Mortimer Medical Centre	39
Much Birch Surgery	140
Nunwell Surgery	223
Pendeen Surgery	226
Quay House Medical Centre	143
Sarum House Surgery	284
St Katherine's Surgery	49
Wargrave House Surgery	262
Weobley Surgery	172
Westfield Surgery	324
Grand Total	4047

Data Source: Herefordshire Carers Support

SUBGROUPS OF CARERS

The experiences and needs of carers are diverse, and it is important to explore these on an individual, person centred basis. However, there are specific groups of carers who have similar experiences and needs (Figure 78). A basic summary of the needs and experiences of three sub-types of carer most relevant to this review, namely working carers, older carers and former carers, is presented below. A more comprehensive overview of the experiences of carers is detailed in full in [A Joint Carers Strategy for Herefordshire: 2017 – 2021](#)(145).

Figure 78 Sub-groups of informal carers



Source: A Joint Carers Strategy for Herefordshire: 2017 – 2021.

https://www.herefordshire.gov.uk/downloads/file/3784/carers_strategy

WORKING CARERS

According to the 2011 National Census, three million people (approximately 1 in 9 people in the workforce) work while providing informal care. Many informal carers are forced to give up work, reduce their hours, or have taken a lower paid role or turned down a promotion in order to ensure they are able to manage their caring responsibilities(136).

The number of people remaining in work beyond the age of 65 is increasing, and this trend is set to continue following the passing of legislation abolishing mandatory retirement in 2011, and rises in the state pension age. Given that people aged 65-69 are

most likely to provide informal care, a significant overlap between providing informal care while working in older age is expected. Older working women will be greatest affected as they are group more likely to take on a caring role.

Carers in paid work are the least likely to have a GP who is aware that they are a carer(136). This, combined with the fact that this group of carers are extremely time poor, suggests that working age carers are likely to have unmet health and wellbeing needs. Evidence from analysis of the 2011 National Census data has revealed that carers working full-time and providing 50 or more hours of unpaid care per week are between two and three times more likely to report poor health than their non-caring counterparts(144).

Research undertaken by Carers UK in 2017 indicates that the majority of working carers (73 per cent) do not feel that their status as a working carer is given sufficient consideration in their carer's assessment, and therefore is not reflected in the formal support they receive from local authorities(136).

Engagement activities with working carers in Herefordshire revealed the following:

- They try to keep working and meeting the needs of the person they care for but something has to give.
- Experiences vary dependent on how flexible their employer is.
- Skills become out of date the longer they are caring, making it difficult to get back into work.
- New skills gained as carers aren't recognised as useful to potential employers.
- Being self-employed is exceptionally difficult due to conflicting demands.

Data Source: A Joint Carers Strategy for Herefordshire: 2017 – 2021.

https://www.herefordshire.gov.uk/downloads/file/3784/carers_strategy

OLDER CARERS

The younger old (those aged 65 to 69 years) are more likely to be children caring for their elderly parents, whereas, the older old (those age 85 and over) are more likely to be providing care for a spouse. Therefore, there is a considerable amount of diversity among the carers within this sub-group, facing different challenges and with differing needs.

Health issues among older carers are common and many are forced to continue providing care while ill, or put off seeking medical input due to the time pressures associated with their caring roles(146). If unaddressed, the risk of older carers reaching breaking point is great. When a carer reaches breaking point, one in nine of those they

care for are rushed into hospital or supported by social services on an emergency basis(146).

Older carers are particularly vulnerable to isolation, in the social sense as well as the geographical sense. Older carers may find it difficult to keep in touch with family and friends, and to access vital services (for example shops and pharmacies). The issue of access to services and amenities is a particular issue in Herefordshire, where, according to the English Indices of Deprivation 2015, 55 of the 116 LSOAs in the county (almost half) are among the 10 per cent most deprived in England regarding geographical barriers to services(147).

Older carers in Herefordshire said that:

- They are most likely to go to their GP as a starting point for advice, with mixed outcomes.
- Their own health has a huge impact on their ability to fulfil their caring role and they have concerns about who would continue in their absence.
- Poor mobility caused by their own illness or disability, combined with limited transport options, mean it is difficult to access services.
- Universal services don't recognise when a carer's health is failing and no one checks if they are okay.

Data Source: A Joint Carers Strategy for Herefordshire: 2017 – 2021.

https://www.herefordshire.gov.uk/downloads/file/3784/carers_strategy

FORMER CARERS

With approximately 80 per cent of carers reporting that they feel lonely or socially isolated(137), former carers are often left to deal with the bereavement of the person they cared for with a reduced social support network to fall back on.

Former carers who wish to return to work face significant barriers. Many will struggle to return to work and suffer loss of earnings that can have a long-term impact.

Former carers in Herefordshire have said that:

- No one checks up on them after their loved one moves on or passes away.
- There is a huge sense of loss and no sense of purpose or direction.
- Where the person cared for has moved on (for example: into a nursing home), the carer still has a role within their ongoing care. It is important that the new care provider uses the carer's wealth of knowledge to adopt a team approach.
- They have built up skills which could be used for a new career, but they don't know where to start.

Data Source: A Joint Carers Strategy for Herefordshire: 2017 – 2021.

https://www.herefordshire.gov.uk/downloads/file/3784/carers_strategy

CARER SPECIFIC INDICATORS

Carer-reported quality of life, and whether carers are receiving as much social contact as they would like are indicators within the Adult Social Care Outcome Framework (ASCOF) which are specific to informal carers. The data for these indicators is collected every other year via the Personal Social Service Survey of Adult Carers in England (PSS SACE) which is administered by each Local Authority.

CARER-REPORTED QUALITY OF LIFE

Adult carers who provide informal care are asked to rate the degree to which they feel their needs are met in the following six domains: occupation, control, personal care, safety, social participation and encouragement and support. Twelve is the highest possible score, and zero the lowest, with the highest scores indicating that all of a carers needs are being met, and the lowest score signifying that a carers needs are not being met.

In 2014/15, the average quality of life score among Herefordshire carers was 7.6 out of 12, and while this represents a slight improvement on the average score observed in 2012-13 (7.4), it is statistically significantly lower than the figure for England (7.9) (Figure 79). Provisional data for 2016/17 suggest that the local quality of life score for carers (7.0) continues to trail national and regional figures (7.7 and 7.7 respectively). Locally, regionally and nationally, there is room for improving the quality of life of informal carers.

Figure 79 Average carer quality of life score for England and the local authorities within the West Midlands, 2014/15

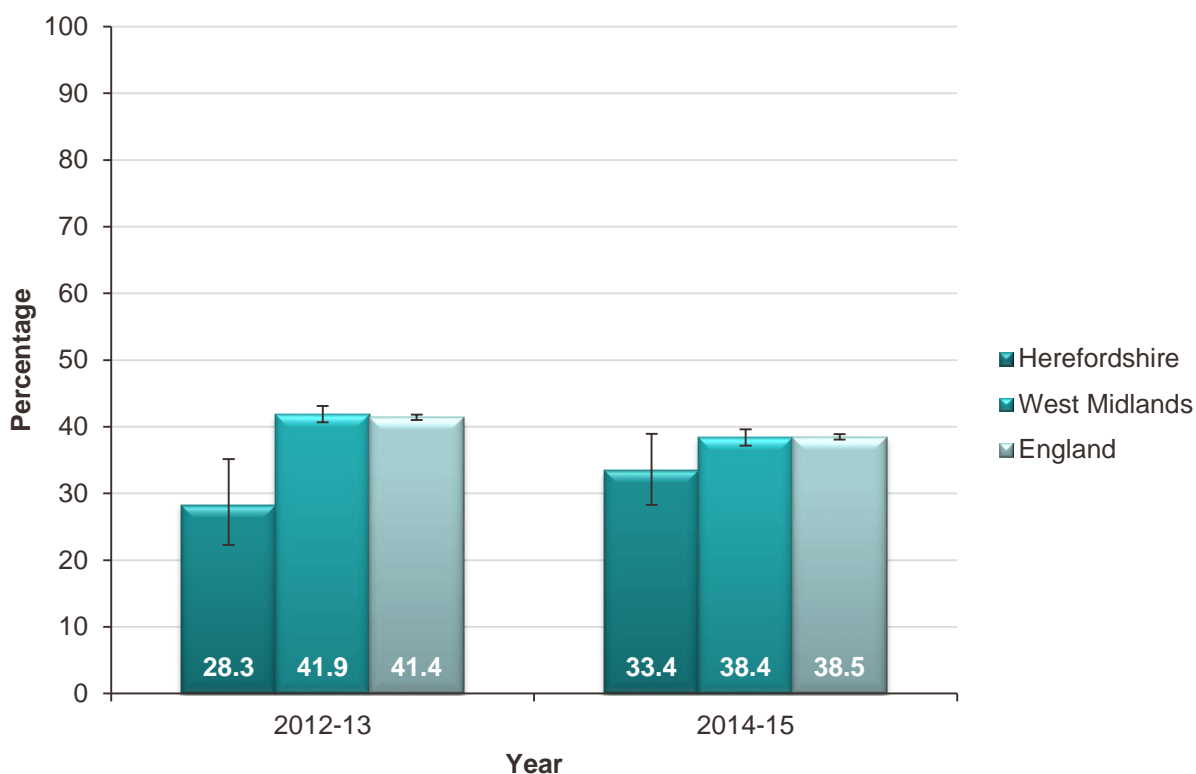
Area	Value	Lower CI	Upper CI
England	7.9	7.9	7.9
West Midlands region	7.8	7.7	7.9
Birmingham	7.1	6.8	7.4
Coventry	7.8	7.5	8.1
Dudley	7.9	7.7	8.1
Herefordshire	7.6	7.4	7.8
Sandwell	7.9	7.6	8.2
Shropshire	8.1	7.8	8.4
Solihull	7.7	7.5	7.9
Staffordshire	8.1	7.9	8.3
Stoke-on-Trent	8.4	8.1	8.7
Telford and Wrekin	7.5	7.3	7.7
Walsall	7.3	7.1	7.5
Warwickshire	7.7	7.4	8.0
Wolverhampton	7.4	7.2	7.6
Worcestershire	7.7	7.5	7.9

Source: NHS digital, ASCOF

CARER SOCIAL INTERACTION

In 2012-13, 28.3 per cent of Herefordshire respondents reported that they received as much social contact as they would have liked, statistically significantly fewer than in the West Midlands region (41.9 per cent) and England (41.4 per cent). In 2014-15, 33.4 per cent of Herefordshire respondents reported that they received as much social contact as they would have liked, a 5.1 per cent improvement on the previous survey results. Notably, there was a deterioration in both West Midlands' and England's performance on this indicator between 2012-13 and 2014-15. Though Herefordshire's performance on this indicator was lower when compared to the West Midlands (38.4 per cent) and England (38.5 per cent) in 2014-15, it was not statistically significantly different (Figure 80).

Figure 80 Percentage of carers who reported having as much social contact as they would like in Herefordshire, the West Midlands and England in 2012-13 and 2014-15



Data Source: Measures from the Adult Social Care Outcomes Framework (ASCOF), England, 2010-11 to 2015-16. <http://digital.nhs.uk/pubs/aduscoccareof1516fin>

Evidence from carer survey responses indicate that more can be done to improve the amount of social interaction informal carers are receiving, locally, regionally and nationally. Plans for preventing social isolation among informal carers in Herefordshire have been developed and documented in [A Joint Carers Strategy for Herefordshire: 2017 – 2021](#), these are summarised in the box below.

A Joint Carers Strategy for Herefordshire, 2017 – 2021

Key outcome:

Fewer carers experience social isolation through improved access to technology and mutual support.

What needs to happen?

- Promotion of ideas and opportunities for mutual support and social networks through information and signposting.
- Identify and promote best practice in forming and sustaining mutual support networks.
- Identify carers with poor access to broadband and seek improvements via the Fastershire programme.
- Establish new places online for carers to interact, share information and support each other.
- Professional support to connect carers and initial development of new groups and networks.
- Identifying young carers and others who are particularly vulnerable to social isolation and providing support.
- Provide support to leaders of groups and networks. Value the experience and knowledge of groups and help publicise them and their achievements through WISH and other means.

Data Source: A Joint Carers Strategy for Herefordshire: 2017 – 2021.

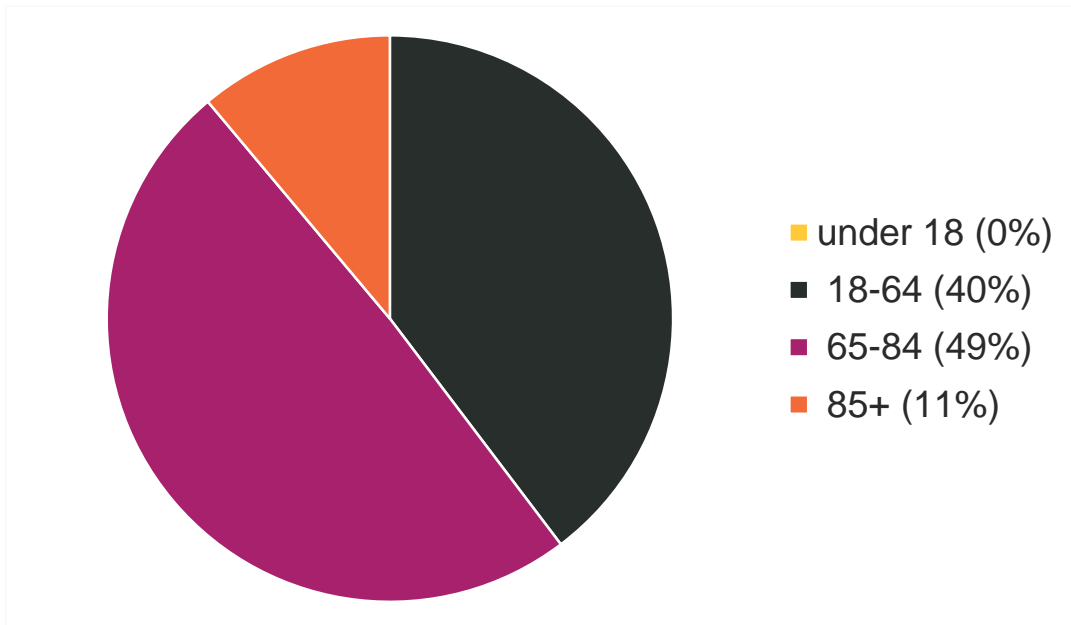
https://www.herefordshire.gov.uk/downloads/file/3784/carers_strategy

FORMAL CARER SUPPORT

In 2015/16 there were 915 carers in contact with Herefordshire Council, 630 (69 per cent) of whom received direct support within the year. There were 285 instances of support (for example: respite) provided directly to the cared for person.

All direct support provided by Herefordshire Council to informal carers was to those aged 18 and over, with older people accounting for over half of those receiving formal support. Forty per cent were aged 18 to 64 years, 49 per cent were aged 65 to 84 years, and 11 per cent were aged 85 and over (Figure 81).

Figure 81 Age breakdown of carers receiving formal support from Herefordshire Council in 2015/16



Data Source: Community Care Statistics, Social Services Activity, England - 2015-16.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/557849/comm-care-stat-act-eng-2015-16-exce-data.xlsx

DISCUSSION POINTS

- Informal carers often put their health and wellbeing needs second to those of the person they care for. Many informal carers are time poor, and can find it difficult to access healthcare. When carers do access healthcare, many don't have their caring role identified, which can result in them missing out on important advice, support and services. Locally, GP surgeries are being encouraged to identify carers and document carer status on patient medical records in order to ensure that carers receive appropriate support from primary care services. However, evidence suggests that a considerable number of carers are still not identified as having caring responsibilities by their GP surgeries.
- Social isolation has numerous adverse effects upon health and wellbeing and is more common among carers than their non-caring counterparts. Historically, a smaller proportion of carers in Herefordshire have reported having as much social interaction as they would like, compared to England as a whole. In acknowledgment of this, plans for preventing social isolation among informal carers have been developed and documented in in [A Joint Carers Strategy for Herefordshire: 2017 – 2021](#).
- As a result of fulfilling their role, many carers find that their quality of life deteriorates. This is often as result of the challenging nature of their caring role, and having less time for themselves. In 2014/15, the average quality of life score among Herefordshire carers was 7.6 out of 12, which is statistically significantly lower than the England figure (7.9). Research indicates that there are numerous factors which affect carers' quality of life. Key issues impacting on carers' quality of life include the quality of social care support directed at carers and at those they

care for, ease of access to services, the experience of stigma in communities, social exclusion and the extent to which individual needs and preferences are considered when making decisions about care(148).

RECOMMENDATIONS

- Continue to take action to improve self-identification of informal carers, and identification of informal carers by health and social care professionals.
- Support informal carers to engage in meaningful social interaction and seek to improve the quality of life for carers, as outlined in Herefordshire's carers strategy ([A Joint Carers Strategy for Herefordshire: 2017 – 2021](#)).

Key Facts

- In Herefordshire, the demand for social care is forecast to rise; the main driver for this is the ageing population structure.
- In 2016/17 in Herefordshire, 69 per cent of local authority funded residential home placements and 93 per cent of nursing home placements were for people aged 65 and over.
- Between 2013/14 and 2015/16, a smaller proportion of people aged 65 and over who were discharged from hospital received re-ablement and rehabilitation in Herefordshire compared to regionally and nationally.
- Between 2012/13 and 2015/16 the number of delayed transfers of care per 100,000 of the population were lower in Herefordshire (7.7) than those observed regionally and nationally (15.4 and 12.1 respectively).
- Locally, delayed discharges from hospital were most commonly due to patients awaiting a nursing home placement (25 per cent), awaiting a care package in their home (24 per cent) or awaiting completion of an assessment (17 per cent).

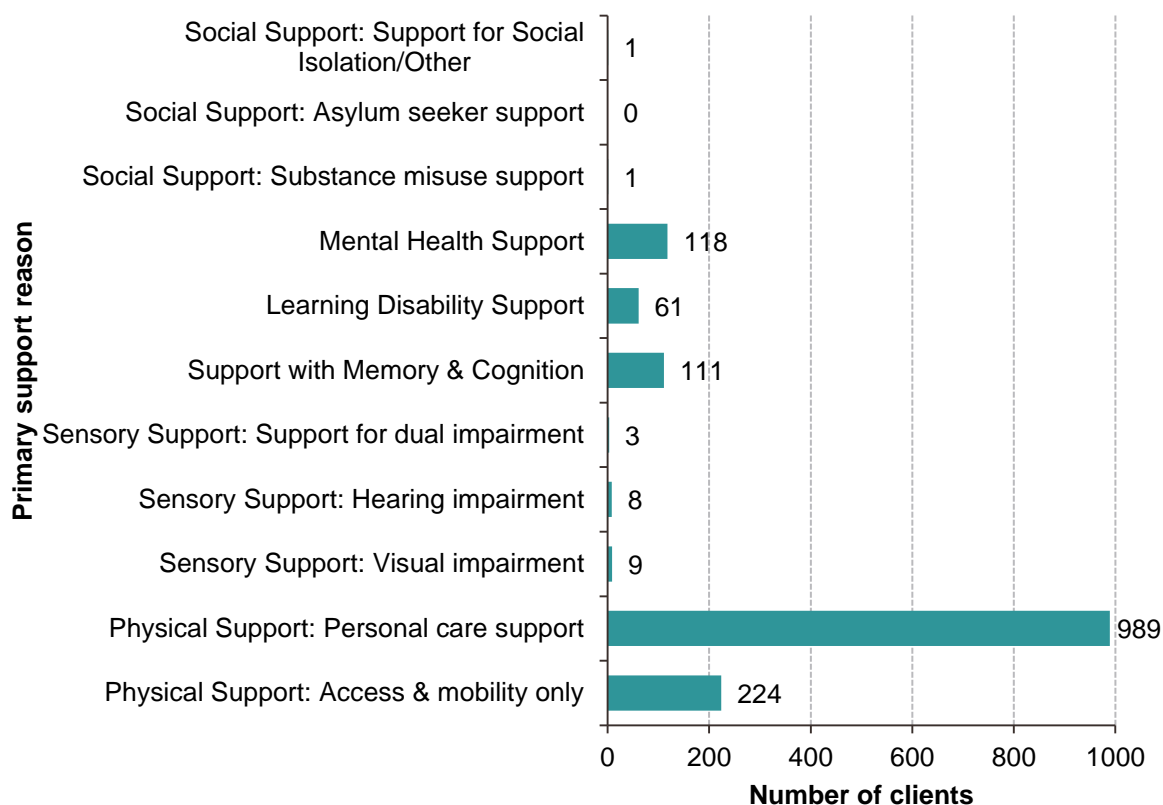
SOCIAL CARE USE AMONG OLDER PEOPLE

Due to the increased prevalence of disability, the need for and use of social services increases with age. In Herefordshire, at the end of the 2016/17 financial year, 1,525 of the 2,471 long term care clients¹⁹ (62 per cent) were aged 65 and over. Of these, 628 (41 per cent) were receiving support in a residential or nursing home. Sixty-nine per cent of all local authority funded clients in a residential home placement, and 93 per cent in a nursing home placement are aged 65 and over.

¹⁹ Long-term clients are those who receive a local authority funded service that is provided with the intention of maintaining quality of life for an individual on an ongoing basis.

At the end of the 2016/17 financial year the majority of older people who were receiving local authority funded social care required support for their personal care (65 per cent). Other common reasons for requiring support were for mobility (15 per cent), mental health (8 per cent), and memory and cognition (7 per cent) (Figure 82). The most commonly reported health conditions among clients aged 65 and over were long term physical health conditions and dementia.

Figure 82 Primary support reason for people aged 65 and over receiving local authority funded long-term social care at the end of the 2016/17 financial year in Herefordshire



Data Source: Short and Long Term (SALT) Data Return 2016/17, Herefordshire

FACTORS AFFECTING DEMAND FOR ADULT SOCIAL CARE

There are a number of factors which impact upon demand for social care. Key factors which can increase demand for social care in a defined geography include the:

- proportion of people aged 90 years and over,
- number of older people living alone,
- levels of disability within the population,
- proportion of people with a low income(149).

DEMAND: THE LOCAL PICTURE

Like the rest of England, Herefordshire has an ageing population structure. However, a larger proportion of Herefordshire's population is aged 90 and over compared to England; a trend which is expected to strengthen over the next decade. Locally, levels of disability among people aged 65 and over are predicted to rise (Figure 83). In addition, Herefordshire has a greater proportion of older people living alone than England (see page 41). At the same time, there is an indication that older people living in Herefordshire are relatively wealthy, with lower attendance allowance claimant rates and higher home owner occupancy rates compared to nationally (see page 38).

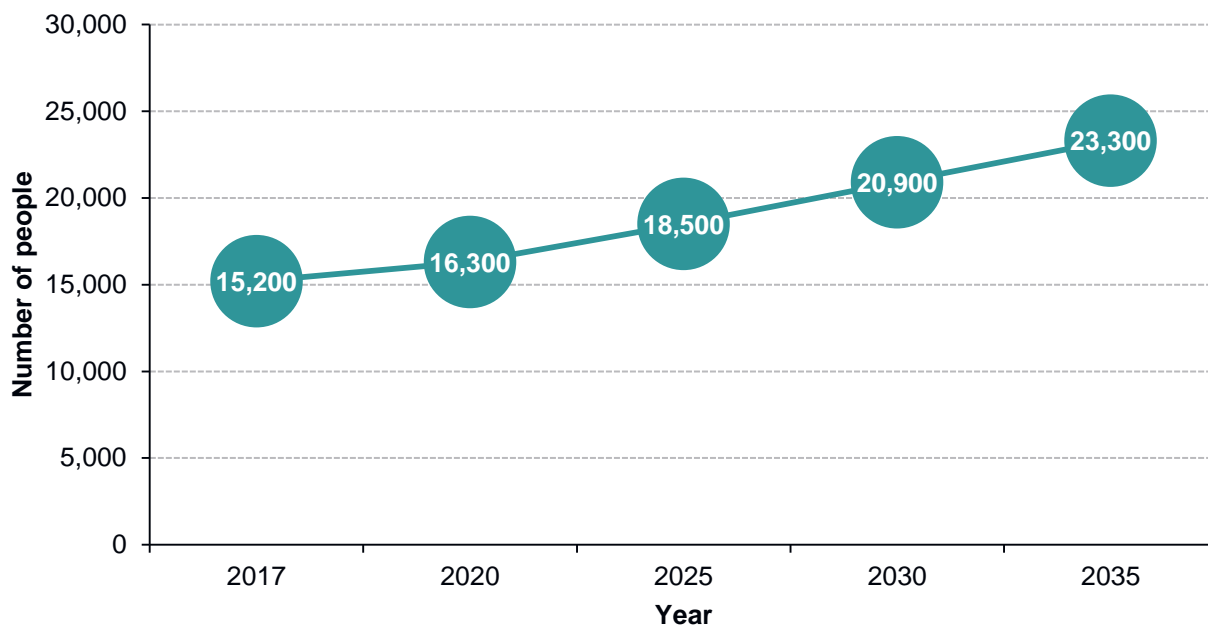
While the relative wealth among older people living in Herefordshire should act to temper the demand for adult social care to some degree(150), the ageing population structure and increasing levels of disability are expected to result in increased demand for adult social care.

Disability

People aged 65 and over who require assistance with one or more self-care activity (for example: dressing, bathing or toileting) are more likely to require support from adult social care(150, 151). This population is estimated by applying the prevalence rates derived from Table 35 of the Living in Britain General Household Survey (2001/2)(152) to the Office of National Statistics (ONS) population estimates and projections. These figures are published by the Projecting Older People Population Information system(18).

In Herefordshire, the number of older people requiring assistance with one or more self-care activity is predicted to rise to by approximately 53 per cent between 2017 and 2035 to 23,300 people (Figure 83).

Figure 83 Estimated number of people aged 65 and over unable to complete one or more self-care activities independently

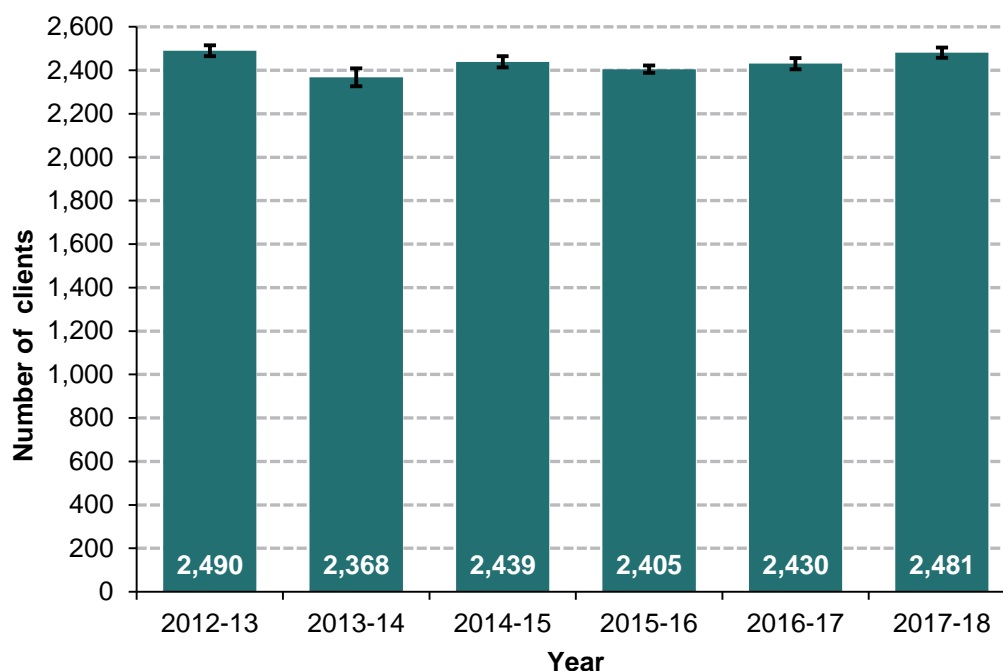


Data Source: Projecting Older People Population Information System, 2017

Figure 84 presents the annual average number of long term clients²⁰ in Herefordshire between 2012/13 and 2017/18. There was a statistically significant decrease in client numbers between 2012/13 and 2013/14 in Herefordshire. While the underlying cause of this decrease is unclear, it coincided with the transfer of adult social care commissioning from Herefordshire Primary Care Trust to Herefordshire Council. However, in the four proceeding years the numbers have been higher, with the numbers showing year-on-year increases in the last three years, and the number of clients in 2017/18 returning to the levels observed in 2012/13.

²⁰ Long-term clients are those who receive a local authority funded service that is provided with the intention of maintaining quality of life for an individual on an ongoing basis.

Figure 84 Average number of observed long term social care clients in Herefordshire by year, 2012/13 to 2017/18



Data Source: Herefordshire Council MOSAIC

As demand for social care is rising, local authority social care budgets are reducing. By 2020, the grants paid to local government will be minimal, with local authorities being required to raise funds from local residents and businesses. Herefordshire, like other local authorities has responded by focussing its' reduced resources on providing effective support to those who are the most vulnerable.

CHANGING OUR APPROACH

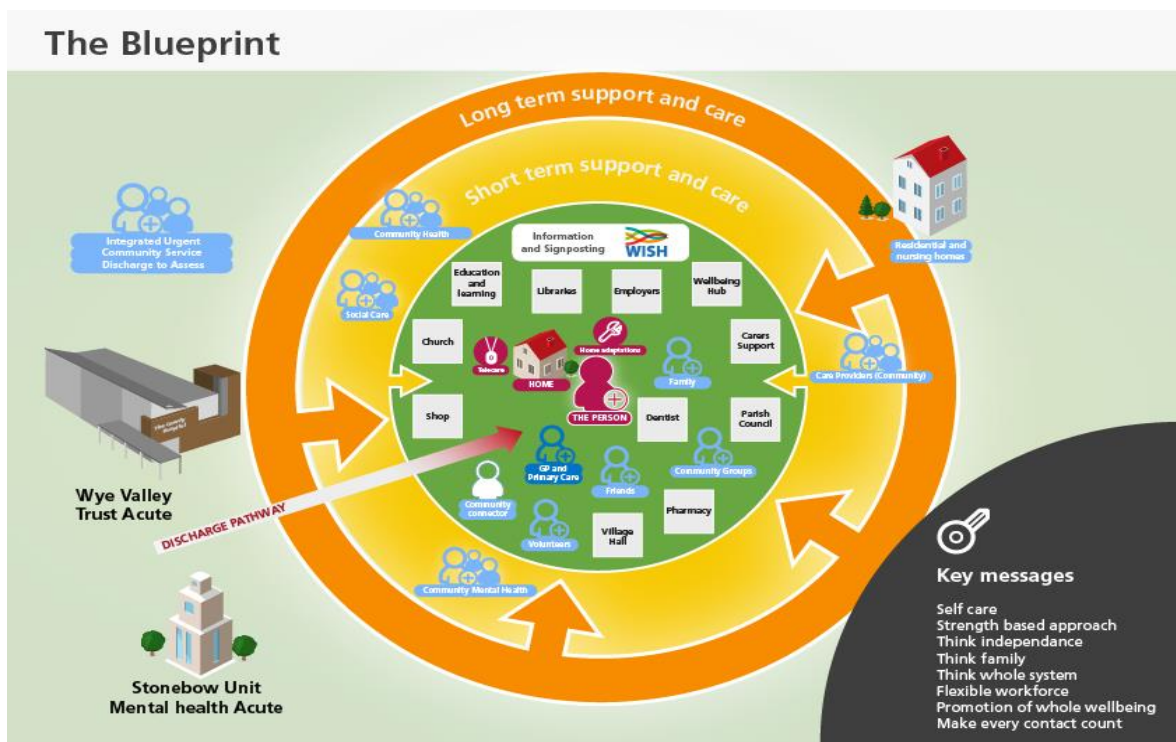
While the need for adult social care is forecast to increase, it is generally accepted that proactive actions which focus on helping people to continue to live independently can help to curtail the demand for social care. These actions have been highlighted by Professor John Bolton(150), and include:

- communicating the importance of and supporting people to engage in self-care,²¹
- enhancing and making effective use of support in the community (including support offered by voluntary sector organisations),
- ensuring effective short-term preventative interventions are available to enhance independence.

²¹ Self-care refers to the actions that individuals take for themselves, on behalf of and with others in order to develop, protect, maintain and improve their health, wellbeing or wellness.

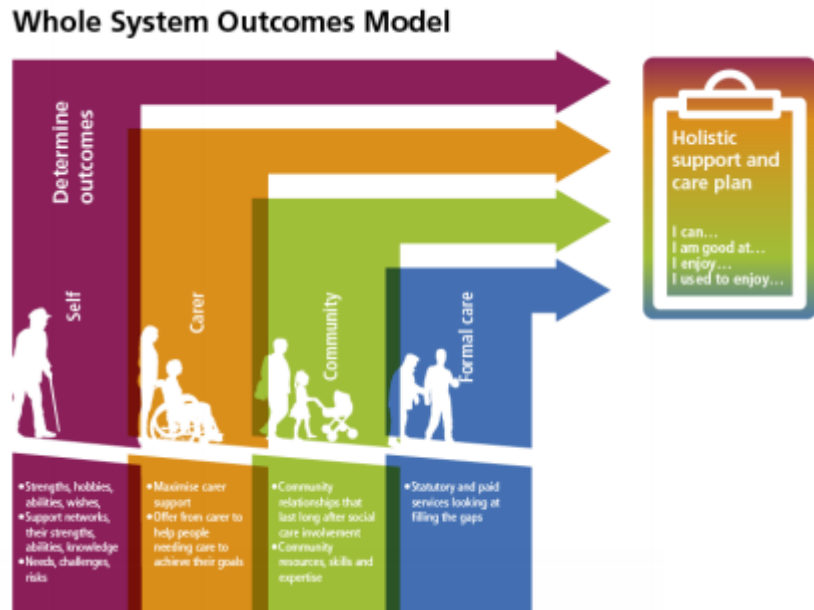
By recognising people’s capabilities when delivering adult social care, and providing timely support to prevent decline in health and wellbeing, Herefordshire Council will be able to effectively focus its resources on those with the greatest need. This approach is reflected in The Blueprint (Figure 85) and Whole System Model (Figure 86), where emphasis is placed on the actions that individuals can take to lead independent and fulfilled lives, and the ways in which the communities around them can step in and provide support alongside more formalised health and social care services. Delivery of this new model requires close working with other organisations, and members of the community to provide holistic, whole system support. Further information on The Blue Print and the Whole System Model can be found in [Herefordshire’s Adults Wellbeing Plan 2017-2020](#)(153).

Figure 85 The Blueprint: a model illustrating Herefordshire Council's approach to the provision of adult social care



Source: Herefordshire’s Adults Wellbeing Plan 2017-2020.

Figure 86 The Whole Systems Outcomes Model: an illustration of how Herefordshire Council draws on the strengths of individuals and the wider community to provide holistic support for clients



Source: Herefordshire’s Adults Wellbeing Plan 2017-2020.

At present it is too early to determine the impact implementing The Blueprint and Whole System Outcomes Model will have. However, it is anticipated that the approach it will enable Herefordshire residents to remain well and independent within their communities for longer.

SELF-CARE: ACCESSING INFORMATION

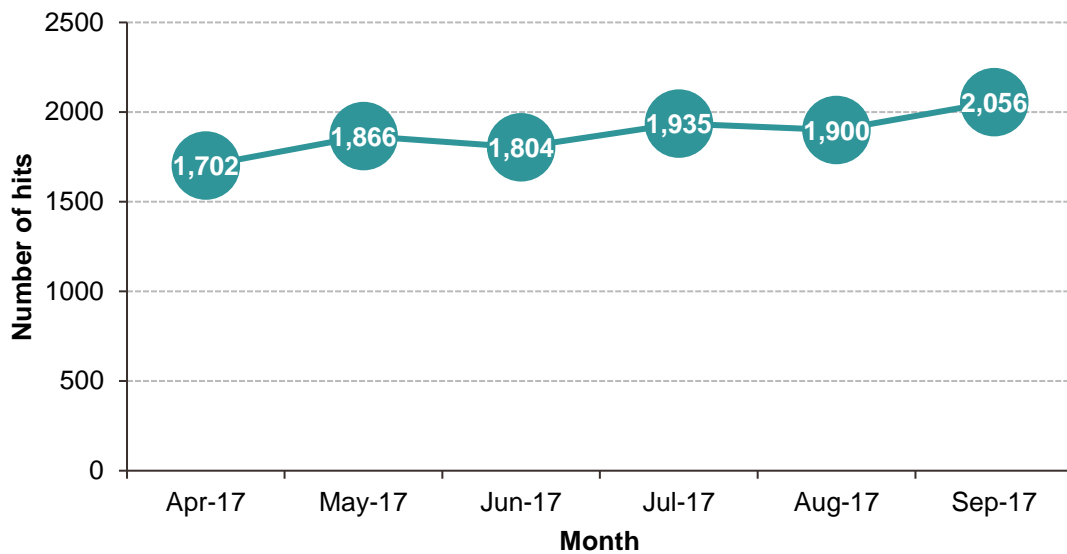
Wellbeing Information and Signposting for Herefordshire (WISH)

Wellbeing Information and Signposting for Herefordshire (WISH) is a service provided by Herefordshire Council in partnership with Services for Independent Living (SIL). WISH plays an integral part in enabling self-care by providing information to support the wellbeing of adults, children, young people and families across Herefordshire.

The WISH website provides a wide range of information and guidance alongside a comprehensive directory of services and activities. As of September 2017 there were 562 approved providers on the WISH directory.

Performance data gathered between April and September 2017 indicates that WISH is being well utilised. There were 13,090 hits on the WISH website, with an increase in the number of hits observed over this time period (Figure 87).

Figure 87 Monthly Wellbeing Information and Signposting for Herefordshire (WISH) website hits, April to September 2017



Data Source: WISH Performance Monitoring Data, 2017/18.

PREVENTATIVE INTERVENTION: INTERMEDIATE CARE

“Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital”(154). Intermediate care services seek to:

- prevent unnecessary hospital admissions,
- improve independence following a hospital admission,
- prevent premature admission into residential and nursing homes.

Intermediate care can be split into four distinct service areas: crisis response, home based rehabilitation, bed based rehabilitation and re-ablement. These four areas are summarised in Table 12.

The National Institute for Health and Care Excellence (NICE) has recently published guidelines on the provision of intermediate care. While the guidelines acknowledge the strengths of each of the four types of intermediate care, they recommend that home based intermediate care be offered wherever practical(155).

Table 12 Summary of the four types of intermediate care

Type of intermediate care	Setting	Aim
Crisis response	Community based services provided to service users in their own home/care home	Assessment and short term interventions to avoid hospital admission
Home based intermediate care	Community based services provided to service users in their own home/care home	Intermediate care assessment and Interventions supporting Admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living
Bed based intermediate care	Service is provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, independent sector facility, local authority facility or other bed based setting	Prevention of unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital
Re-ablement	Community based services provided to service users in their own home/ care home	Helping people recover skills and confidence to live at home, maximising their level of independence so that their need for on-going homecare support can be appropriately minimised

Data Source: National Audit of Intermediate Care: Summary Report 2014.

Experts in intermediate care services suggest that intermediate care could provide a suitable alternative to hospital based in-patient care for approximately 30 per cent of older people who present to A and E, however, at a national level there is currently insufficient intermediate care capacity to address growing demand(156).

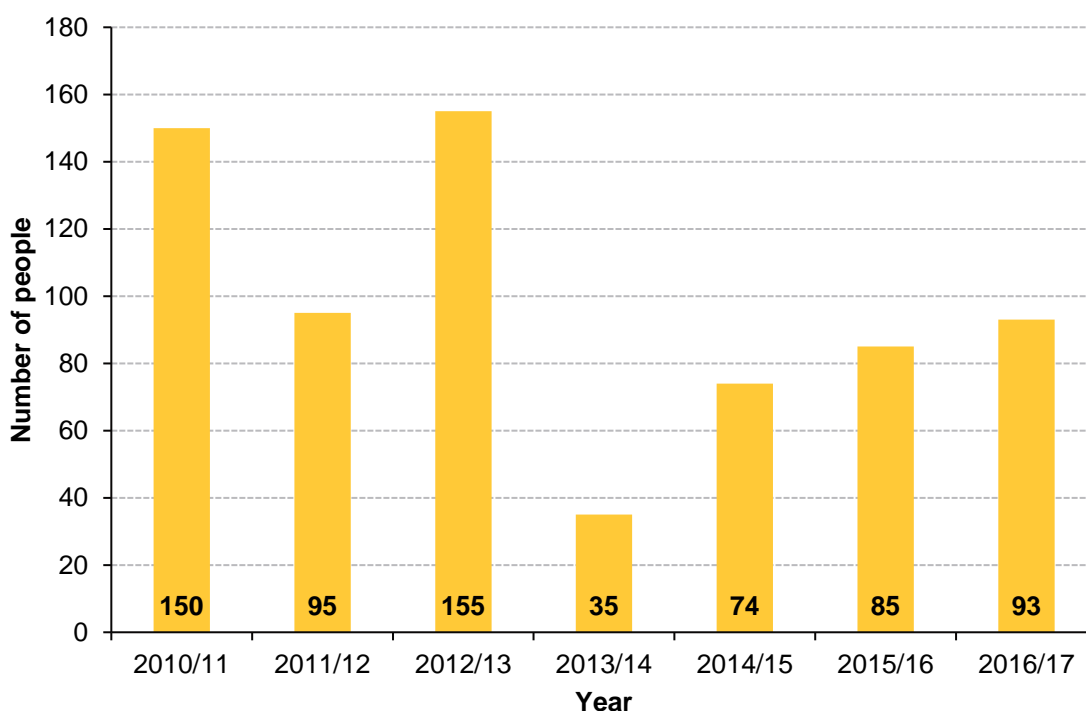
The findings of the National Audit of Intermediate Care 2015 indicate that intermediate care is effective at improving and maintaining dependency levels and enabling people to return to their usual place of residence(157).

Local Data

Data within the Adult Social Care Outcomes Framework provides an overview of the activity and effectiveness of re-ablement and rehabilitation services for each local authority. Several years of this data are summarised below.

Between 2010/11 and 2015/16 the number of people aged 65 and over who received re-ablement or rehabilitation in Herefordshire has varied considerably: with a sharp, statistically significant drop in numbers observed in 2013/14 (Figure 88). This decrease was the result of the service provider at the time having limited capacity, with demand for the service remaining high throughout this period.

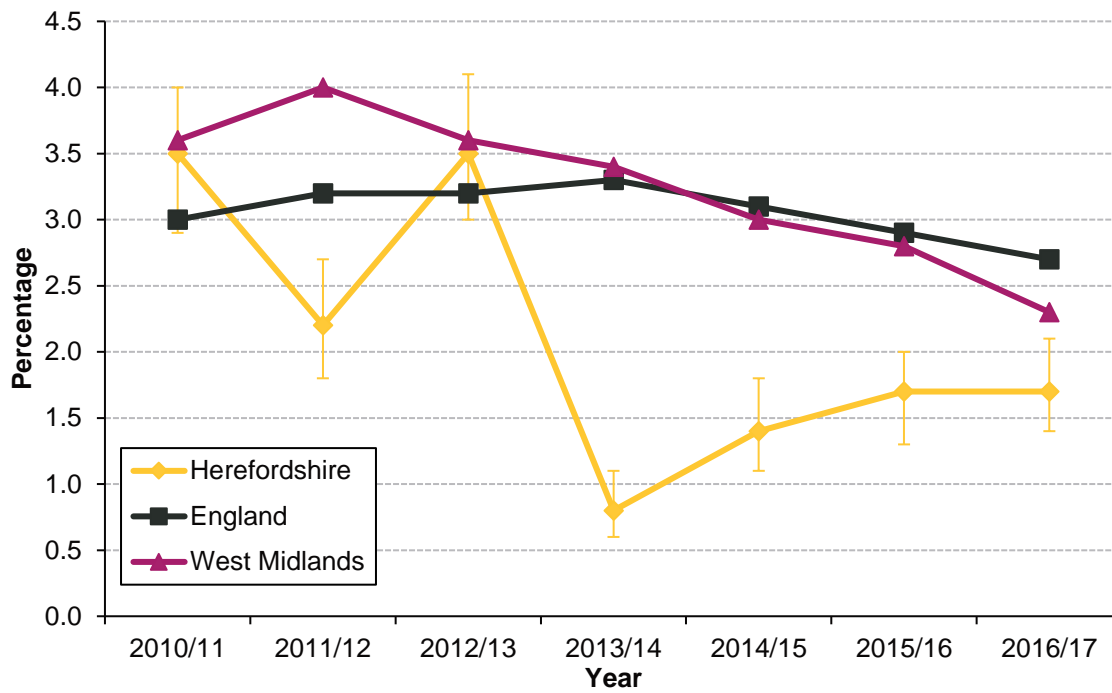
Figure 88 Number of people aged 65 and over receiving re-ablement or rehabilitation following a hospital admission who were expected to return to their home, 2010/11 to 2016/17



Data Source: ASCOF: Time series of aggregated measures, 2010-11 to 2015-17, 25th October 2017.

From 2013/14 onwards the number of people aged 65 and over who were discharged from hospital and went on to receive re-ablement or rehabilitation has decreased in England and the West Midlands (Figure 89). This is not surprising given that on average, national investment in intermediate care services has decreased in real terms over this time period, despite evidence of unmet demand(157). From 2013/14 through to 2016/17 a significantly smaller proportion of eligible older people received re-ablement or rehabilitation in Herefordshire compared to the national and regional figures.

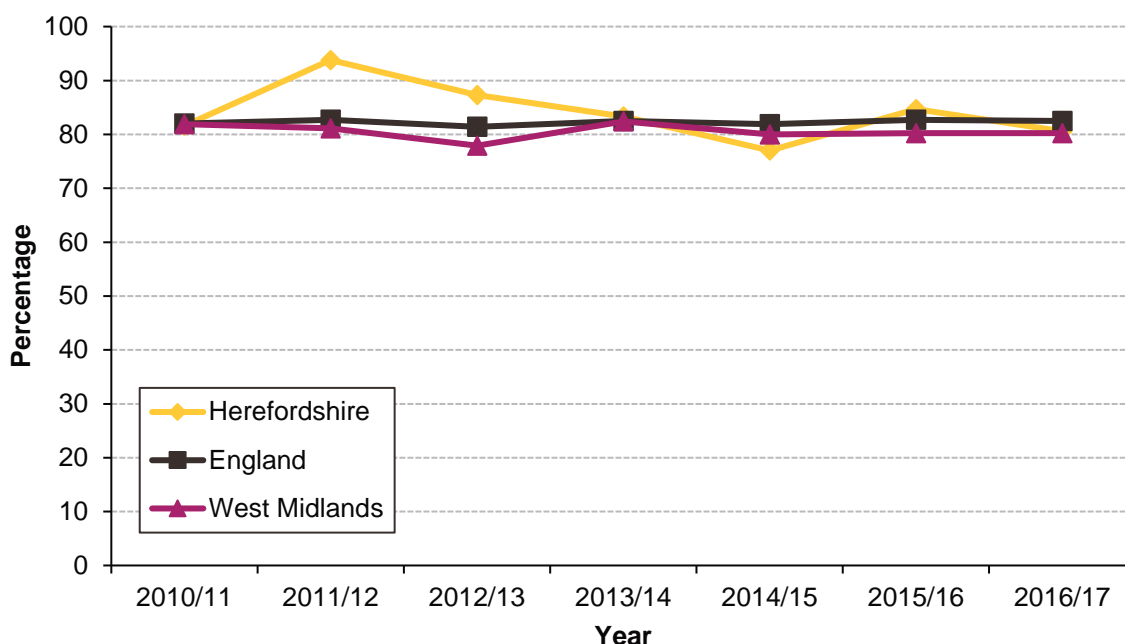
Figure 89 People aged 65 and over who were expected to return home and received re-ablement or rehabilitation following discharge from hospital as a proportion of all people aged 65 and over discharged from hospital, 2010/11-2016/17



Data Source: ASCOF: Time series of aggregated measures, 2010-11 to 2015-17, 25th October 2017.

Successful re-ablement or rehabilitation for people age 65 and over is defined as returning home, to extra care housing or to an adult placement scheme within 91 days of discharge from hospital. Between 2010/11 and 2015/16 Herefordshire's figures have been in line with the national figures, except in 2011/12 when performance was statistically significantly better (Figure 90).

Figure 90 Percentage of people aged 65 and over whom received re-ablement or rehabilitation following a hospital admission and were at home or in extra care housing or an adult placement scheme 91 days after the date of their discharge from hospital, 2010/11-2016/17



Data Source: ASCOF: Time series of aggregated measures, 2010-11 to 2015-17, 25th October 2017.

Local Action

In recognition that re-ablement and rehabilitation services have not been available for all of those who might benefit, a new intermediate care service has been developed for Herefordshire; “Home First”, which will begin operating in late 2017. The ambition is that 100 per cent of people requiring social support following discharge from hospital, and who have rehabilitation potential will be referred to the service, benefiting from a tailored re-ablement package focussed on person-centred goals which are aimed at maximising independence.

LONG TERM SUPPORT

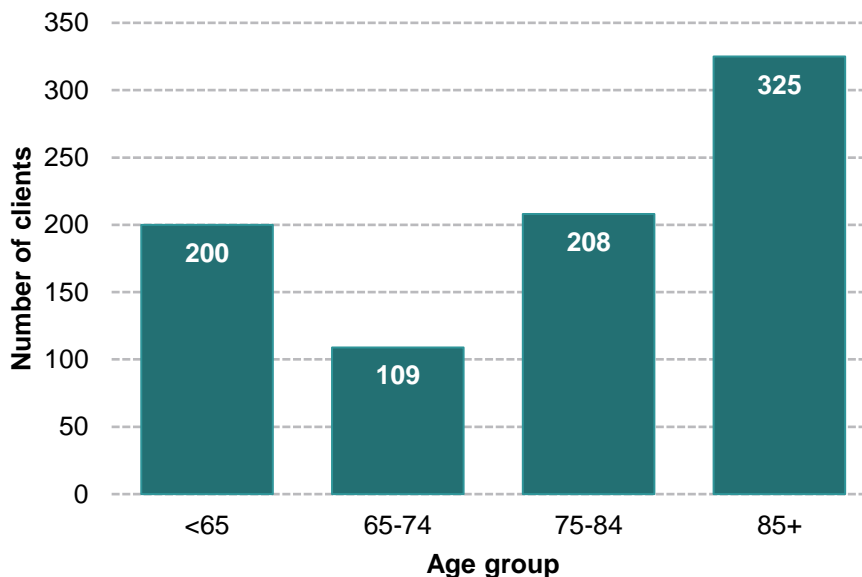
DOMICILIARY CARE

As of September 2017, there were 50 Care Quality Commission registered domiciliary care providers in Herefordshire. Of these, one was rated as “Outstanding”, 38 “Good”, and one as “Requires improvement” by the Care Quality Commission (CQC). Eleven providers were awaiting inspection.

In Herefordshire, as of September 2017, there were 842 people in receipt of local authority funded domiciliary care, 642 (76 per cent) of whom were aged 65 and over (Figure 91). Use of council funded domiciliary care was more prevalent among those

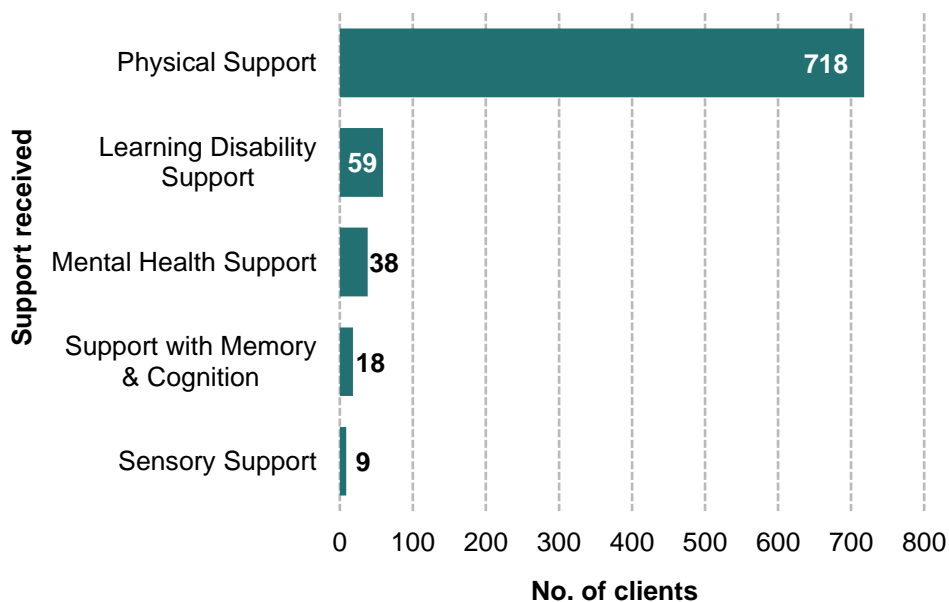
aged 90 and over. Clients were most commonly in receipt of domiciliary care for physical support (718 clients, 85 per cent) (Figure 92).

Figure 91 Age profile of clients in receipt of Herefordshire Council funded domiciliary care (as of September 2017)



Source: Herefordshire Council Domiciliary Care Dashboard, September 2017.

Figure 92 Number of clients in receipt of domiciliary care by support type (as of September 2017)

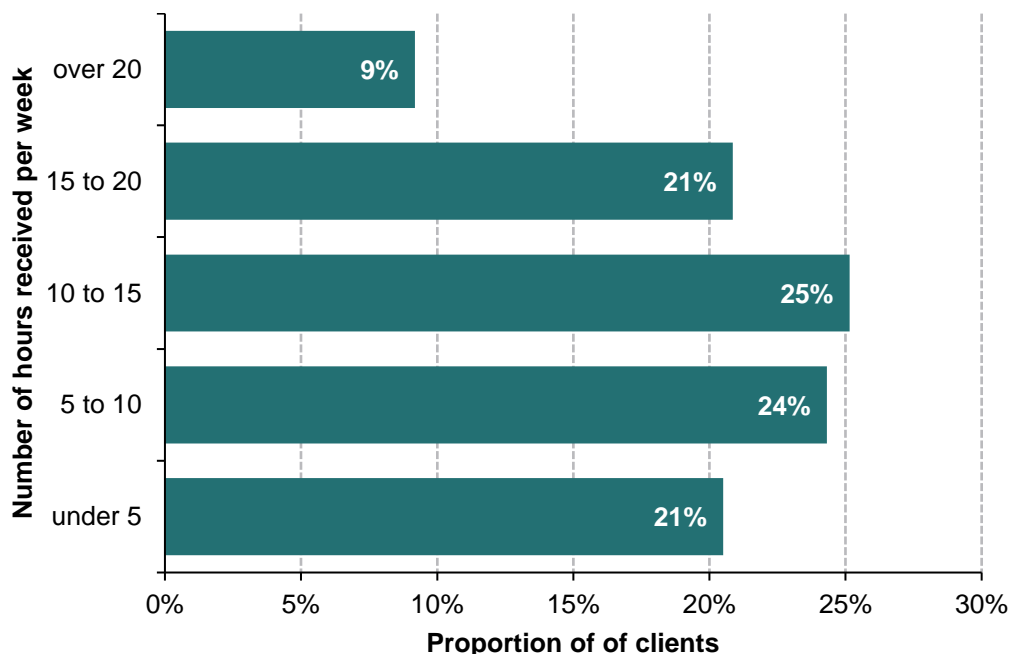


Source: Herefordshire Council Domiciliary Care Dashboard, September 2017.

A quarter of all clients received 10 to 15 hours of domiciliary care per week, 24 per cent received five to 10 hours, 21 per cent received less than five hours and 15 to 20 hours, and the smallest proportion (9 per cent) received in excess of 20 hours per week (Figure

93). Approximately 12 per cent of clients (98 people) received domiciliary care packages from two members of care staff.

Figure 93 Proportion of Herefordshire Council funded domiciliary care clients by number of hours of care received per week (as of Spetemebr 2017)



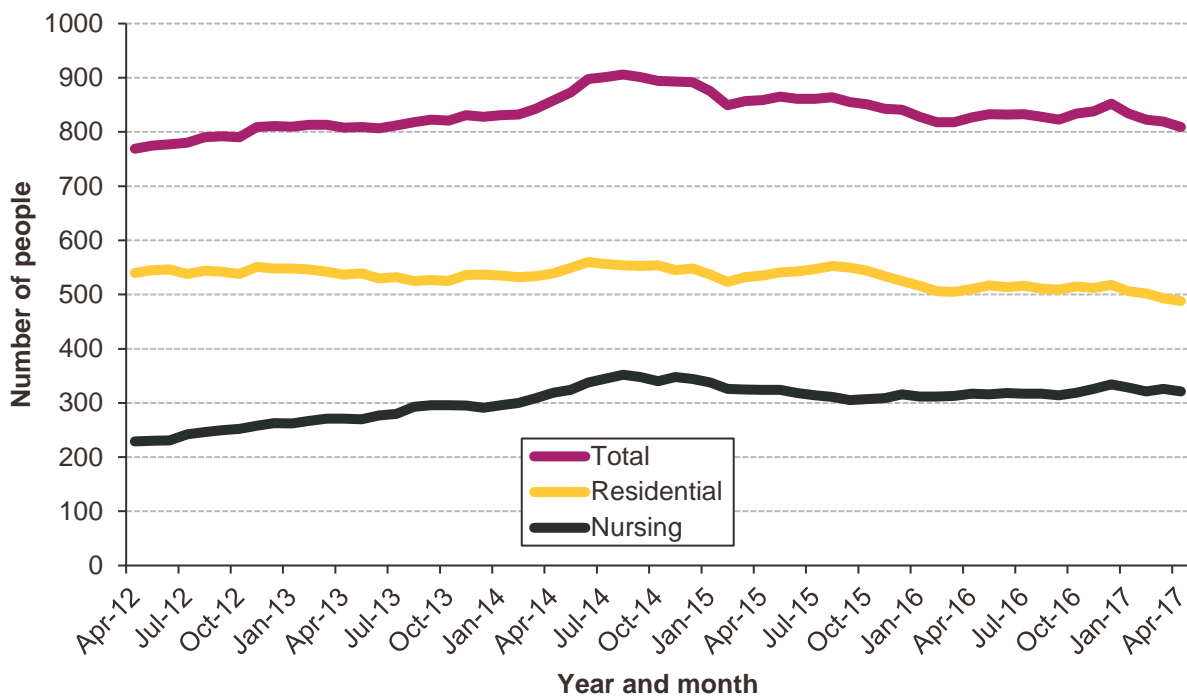
Source: Herefordshire Council Domiciliary Care Dashboard, September 2017.

RESIDENTIAL AND NURSING HOMES

As of September 2017, there were 54 nursing homes and 23 residential homes in Herefordshire. Of these, two (3 per cent) had a Care Quality Commission (CQC) rating of “Outstanding”, 69 (90 per cent) had a rating of “Good”, 6 (7 per cent) were rated as “Requires Improvement”. None of the care homes in Herefordshire were rated as “Inadequate”. The CQC ratings for Herefordshire’s residential and nursing homes are roughly in line with what has been observed nationally(1).

In April 2017 there were a total of 809 people living in residential and nursing homes were funded by Herefordshire Council. Between April 2012 and April 2017 there has been a considerable amount of variability in this number, the lowest number being 769 people in April 2012 and the highest number being 906 in August 2014 (Figure 94). Over this five year time period there have consistently been more people supported by the local authority living in residential homes than in nursing homes.

Figure 94 Number of people living in residential and nursing home accommodation supported by Herefordshire Council, April 2010-2017



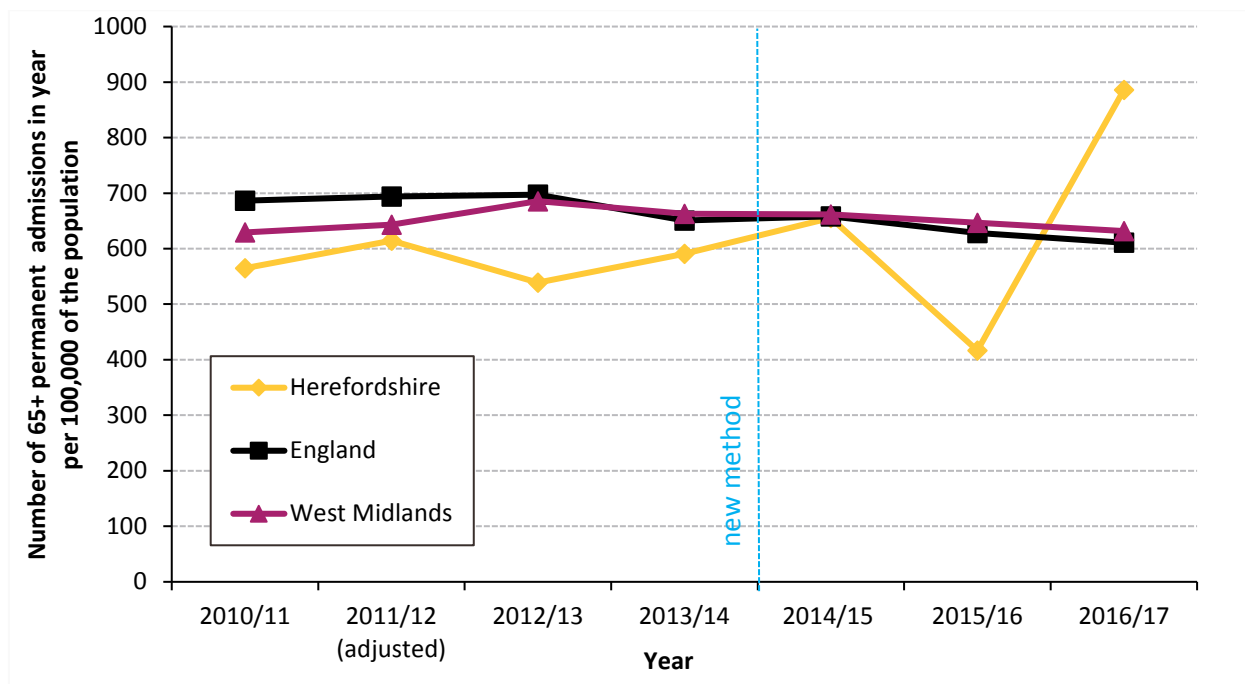
Data Source: Herefordshire Council Residential and Nursing Home Dashboard, September 2017.

Figure 95 presents local authority supported residential and nursing home admission rates among people aged 65 and over in Herefordshire, the West Midlands, and England between 2010/11 and 2016/17 inclusive. In 2014/15 there was a national change to adult social care data returns with a transition from Adult Social Care Combined Activity Return (ASC-CAR) to the Short and Long-term Support (SALT) return. This transition resulted in a change in the way admissions were captured and defined, hindering meaningful comparison of the data pre and post 2014/15.

A slight decline in the number of admissions was observed in the national and regional rates in 2015/16. In Herefordshire, a noteworthy decrease in admission rates was observed in 2015/16, the reasons for which are uncertain. In 2016/17 the national and regional rates continued to decline, however a noteworthy spike in rates was observed locally. The extreme variation observed in local rates has not been mirrored among Herefordshire’s five most similar statistical neighbours²², and while small numbers may account for some of the observed local variation, it is unlikely to explain all of it.

²² For older adult social care clients, Herefordshire’s statistical neighbours in order of similarity are Somerset, Shropshire, Suffolk, North Yorkshire, and Norfolk.

Figure 95 Permanent residential and nursing home admissions rates among people aged 65 and over for Herefordshire, the West Midlands and England, 2010/11 to 2016/17



Data Source: ASCOF: Time series of aggregated measures, 2010-11 to 2016-17, 25th October 2017.

DELAYED TRANSFERS OF CARE

The majority of patients are discharged from hospital as soon as they are medically fit. However, in some cases a delay occurs. This is often because the necessary care support, accommodation or funding is not readily accessible. These delays are referred to as delayed transfers of care (DTC). DTC are an important indicator, providing insight into how well ASC and inpatient NHS services are working together.

Delayed transfers of care can have adverse effects on people's health by increasing the risk of hospital acquired infection(158) and increasing muscle wasting and associated functional decline such as immobility(154), both of which can have a significant impact upon the long term health and independence of older people. Delayed transfers of care also lead to wasted public funds, and can prevent the timely treatment of other patients presenting to hospital(158).

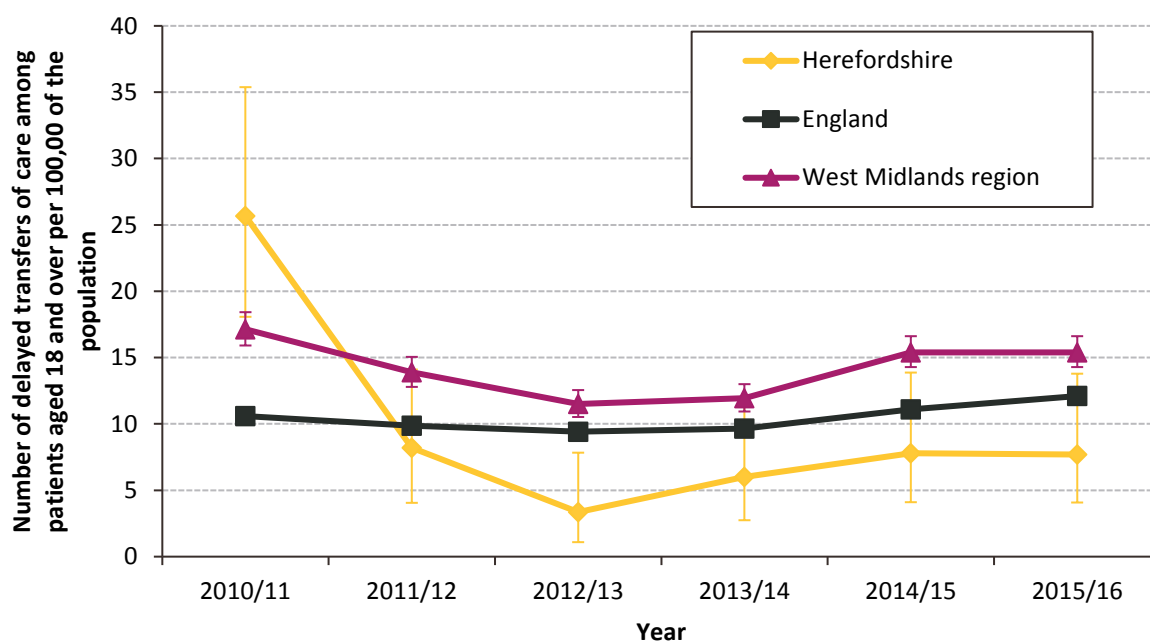
Local data

Between 2010/11 and 2012/13 there was an observed decrease in the average number of delayed transfers of care in Herefordshire, with a slight year on year increase observed between 2012/13 and 2015/16. This trend is mirrored in the regional and national data. Herefordshire's average numbers of delayed transfers of care have been similar to the England figures except in 2010/11 when they were statistically significantly higher, and in 2012/13 when they were statistically significantly lower. Herefordshire's average numbers of delayed transfers of care were statistically significantly lower than the West Midlands figures between 2012/13 to 2015/16 inclusive (Figure 96). Provisional data

indicates that in 2016/17 the average number of delayed transfers have increased, locally (14.9), regionally (19.3) and nationally (15.0)(159).

Delayed transfers of care are used as an indicator of the effectiveness of hospitals and community based care (including social care) in facilitating timely and appropriate transfers from hospital. Considerable variation has been observed between local authorities(158), suggesting that local action can have an impact on this metric. However, the broad trend has been similar nationally and regionally, which suggests that wider factors are also be impacting on delayed transfer rates.

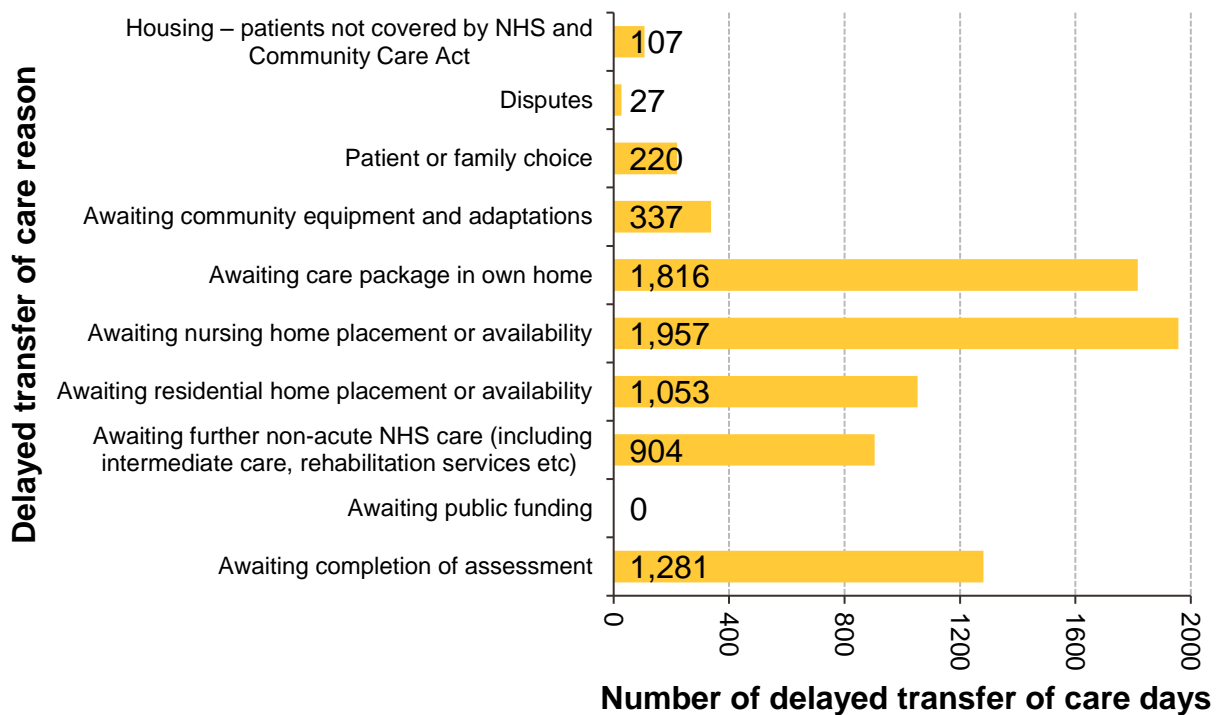
Figure 96 Average number of delayed transfers of care among patients aged 18 and over on a particular day taken over the year per 100,000 of the population for Herefordshire, the West Midlands, and England, 2010/11-2015/16



Data Source: Public Health England, 2017.

In the 2016/17 financial year there were 7,702 delayed transfers of care days affecting adults in Herefordshire. The most common causes of delayed discharges were awaiting a nursing home placement or availability (25 per cent), awaiting a care package in their home (24 per cent), and awaiting completion of an assessment (17 per cent) (Figure 97).

Figure 97 Total number of delayed transfer of care days by delay reason for people aged 18 and over living in Herefordshire (sum of all delays attributable to the NHS, social care, or both), 2016/17



Data Source: Delayed Transfers of Care Data 206-17, NHS England, 2017

Recent internal data indicates that between March and July 2017, approximately 200 discharges from Hereford County Hospital and local community hospitals were delayed by at least one day. During this time period, more than 90 per cent of patients experiencing a delayed transfer of care were aged 65 and over (with 66 per cent being aged 80 and over, and 29 per cent aged 90 and over). This finding is in line with the national picture, and indicates that older people are the greatest affected by problems with care co-ordination and transitions between services(160).

Local action

Through the Better Care Fund programme, action is being taken to enhance the integration of Herefordshire’s health and social care systems. Through better integration the system will be better equipped to assess and meet a wide range of care needs and improve continuity of care for the increasingly older population profile of Herefordshire.

Among other planned areas of investment, the Better Care Fund will enhance local intermediate care services to: i) provide rehabilitation and support for people who are medically fit for discharge, and ii) prevent the need for hospital admission. The intended impact of this investment is to enhance the efficiency of hospital discharges, and prevent unnecessary hospital admissions through the timely offer of rehabilitation and support, and should therefore have a positive impact upon local delayed transfers of care rates.

EMERGENCY HOSPITAL ADMISSIONS FROM CARE HOMES

Emergency hospital admissions from care homes are often used as a proxy indicator of both the quality of care provided within a care home as well as the accessibility and effectiveness of in reach support offered by community healthcare services.

In line with the national trend, there has been an increase in the number of emergency hospital admissions from care homes in Herefordshire. Further information is available on page [101](#) of this report.

SELF-FUNDERS

WHAT ARE SELF-FUNDERS?

People who use social care and support services and fund the full cost themselves are referred to as self-funders. People come to self-fund their own social care because they have either:

- not approached the council for help,
- approached the council for help but have chosen not to be financially assessed,
- received a care needs assessment but are not eligible for social care,
- received a care needs assessment which found them to be eligible for social care, but they did not meet the eligibility criteria for financial support.

SUPPORTING SELF-FUNDERS TO MAKE INFORMED DECISIONS

The cost of social care can vary greatly depending on the type, intensity, specialisation, location and duration, with decisions about care having considerable financial implications. Research carried out by the Institute of Public Care(161) found that many self-funders made decisions about purchasing social care at a time of crisis. Self-funders reported struggling to find information and advice to help them in deciding what social care to purchase, with many choosing not to or not thinking to approach local authorities for assistance.

There is evidence that people who self-fund their care are not always aware of the various types of care available, resulting in some self-funders purchasing care and support above their level of need(150, 161). While the reasons for this are complex, findings from research undertaken by Henwood and Hudson(162) implicate the following drivers:

- self-funders associating nursing homes with enhanced service and luxury,
- care home owners seeking to maximise occupancy,
- hospitals desiring to free up beds,
- GPs looking for solutions to complex cases.

The findings above outline the importance of ensuring that self-funders receive appropriate and timely advice about the nature of their needs and the care options

available to meet them. Under The Care Act 2014, local authorities have a responsibility to provide a care needs assessment to self-funders free of charge, in order to help them understand their needs, and identify suitable services to meet them.

HOW MANY PEOPLE SELF-FUND THEIR CARE?

In 2011 the Institute of Public Care estimated the number of self-funders in England(161). They concluded that approximately 45 per cent of care home places were occupied by self-funders (170,000 of the then 378,053 Care Quality Commission registered beds), with an estimated 40 per cent of residential home and 48 per cent of nursing home places being self-funded. It was estimated that 168,701 people aged 65 and over self-funded domiciliary care to support activities of daily living (such as bathing and toileting), with the number rising to 271,536 if instrumental activities of daily living (such as laundry and cooking) were included.

However, the number of people who self-fund their social care is expected to rise, and the proportion of self-funders is expected to vary between local authorities. Therefore, it is recommended that local authorities take steps to quantify the number of self-funders in their area(161).

Given Herefordshire's ageing demographic and relative levels of wealth among those aged 65 and over, it is likely that there are a considerable number of self-funders in Herefordshire. Current intelligence on this cohort of social care user are based on crude estimates. However, it is hoped that close collaboration with care providers will assist in refining estimates.

ADULT SOCIAL CARE WORKFORCE

The adult social care workforce is comprised of a large number of roles including:

- front line workers such as senior care workers, care workers and support and outreach staff,
- professionals such as social workers, occupational therapists, and registered nurses,
- managerial and supervisory roles such as senior management, and registered managers.

The adult social care workforce play a vital role in supporting the most vulnerable in society, by either directly providing face to face support and care, or supporting those who do.

In Herefordshire it is estimated that there are 6,100 people in social care jobs, approximately 4,600 of whom are directly involved in providing care.

INCREASE IN DEMAND FOR ADULT SOCIAL CARE WORKFORCE

Skills for Care has produced adult social care workforce projections using Office for National Statistics population projection data and data from the National Minimum Dataset for Social Care (NMDS-SC). The projections only account for demographic and population change over the period, and do not account for any political, economic, technological or social factors that could have an impact on the future size of the workforce, however provide some guide as to the scale of workforce growth which may be required. Three different projections have been produced, suggesting that between 2016 and 2030, in order to meet expected demand for social care England's adult social care workforce will need between 350,000 and 700,000 new workers, representing growth of between 21 and 44 per cent (163).

RECRUITMENT AND RETENTION CHALLENGES

In their 2017 report(163), Skills for Care have highlighted that recruitment and retention challenges are a major concern for the social care sector. Data gathered in the NMDS-SC indicates that in 2016/17 the turnover rate among staff working in adult social care was 27.8 per cent, with the highest turnover rates observed among health care assistant roles. Data suggests that the issue is worsening with a 4.7 per cent increase in staff turnover rate observed between 2012/13 and 2016/17. The sector has reported particular issues with retention of young staff, and a high proportion of staff leaving the workforce within their first year. Approximately two thirds of new starters are recruited from within the social care sector, indicating that employers are struggling to attract new recruits into the social care workforce.

Local feedback from care providers indicates that recruitment and retention issues reported nationally are reflected locally, with challenges being greatest among health care assistant roles.

The projected increased demand for adult social care workers combined with the recruitment challenges currently affecting the sector suggest that actions need to be taken imminently to ensure that the workforce is resilient enough to continue to provide much needed social care services.

LOCAL ACTION

The Care Workforce Development Project has been set up by Herefordshire Council to support the social care sector, to promote the professionalism of the care workforce as 'Heroes', in order to increase the number of people choosing care as a career and remaining in the profession. Support will be specifically targeted at independent care providers. The aim objectives of the project are to:

- Change the perception of roles in the social care sector, reinforcing the professionalism required to deliver good quality support and its value to the supported people and wider society,

- Attract more people to come and work within the sector and so increase staff resilience, wellbeing and stability across the market, reducing turnover and improving retention,
- Map and describe a career path that is referenced with equivalent roles in the healthcare sector to improve awareness of progression options,
- Identify areas that could improve efficiency, consistency and quality and reduce the workforce running costs for the sector,
- Improve the consistency and quality of care and support delivered across the sector through developing the workforce competence and confidence.

DISCUSSION POINTS

- The ageing population structure and the associated increase in age related disability is expected to lead to increased demand for adult social care locally and nationally. The anticipated increase in client numbers is expected to have a significant financial impact on Herefordshire Council, at a time when, like other local authorities, the council is losing central government revenue and taking steps towards financial self-sufficiency. Locally, care is being taken to ensure that support and funding are focussed on those with the greatest need. In addition, assets and networks within the community and preventative interventions (such as intermediate care services) are being maximised, enabling people to live independently in the community.
- Intermediate care services act to prevent unnecessary hospital admission, maximise independence following discharge from hospital and prevent premature hospital admissions. Locally, intermediate care services have been reasonably effective in assisting older people to return home following hospital discharge. However, between 2013/14 and 2015/16 a statistically significantly smaller proportion of older people have had access to intermediate care locally compared to nationally. "Home First", a new intermediate care service will commence in November 2017, with the long-term ambition of providing rehabilitation and reablement for all people with rehabilitation potential who require ongoing social care input following a hospital admission. In addition, the Home First service should assist in reducing delayed transfers of care, and will serve to prevent decisions about ongoing social care packages being made in hospital, at a crisis point, and before a person's longer term functional dependency levels are apparent.
- In recent years there has been noteworthy and unexplained variation observed in Herefordshire Council funded permanent residential and nursing home placement rates for people aged 65 and over. Under The Care Act 2014 local authorities have a duty to ensure that sufficient and appropriate social care support is available for the community, which requires having an understanding of the current and future needs of the population. Enhancing understanding of the underlying factors associated with the observed variation would help the local authority to fulfil its duty to support and shape the local social care market.
- Delayed transfers of care from hospital are detrimental to the health and wellbeing of older people, disrupt the flow of incoming patients, and are costly.

Herefordshire's delayed transfers of care rates have been lower than the rates for the West Midlands and England. Locally, the majority of delayed transfers of care are caused by patients awaiting a nursing home placement or availability (25 per cent), awaiting a care package in their home (24 per cent), and awaiting completion of an assessment (17 per cent).

- Self-funders are a relatively hidden group of social care user(162). Given Herefordshire's ageing demographic and the relative levels of wealth among those aged 65 and over in the county, it is likely that there are a considerable number of self-funders in Herefordshire. Evidence suggests that self-funders can find it difficult to understand their care and support needs, and navigate the social care provider market. Although Herefordshire Council provides advice regarding care choices to all who want it, not all receive such advice. Current understanding of the number of self-funders, or what proportion of self-funders eventually need local authority funded care, is limited. Increasing the availability of data in this area has been highlighted as a priority for Adult's Social Care Commissioning.
- Adult social care workers are involved in ensuring much needed care and support is provided to some of the most vulnerable people in our society. Locally and nationally adult social care providers are facing challenges in recruiting and retaining staff. An additional pressure being faced by the sector is the anticipated increase in demand for adult social care in the coming years. Estimates from Skills for Care suggest that the adult social care workforce will need to increase by between 21 to 44 per cent between 2016 and 2030 in order to meet demand. With an older population structure than that of England as a whole Herefordshire is likely to be particularly affected by workforce challenges. Herefordshire Council has launched the "Care Heroes" project to support the local adult social care sector in building a resilient workforce fit for the challenges that lay ahead.

RECOMMENDATIONS

- Seek to better understand the key factors associated with the variation observed in the local permanent residential and nursing home placement rates among people aged 65 and over.
- Continue to monitor: i) the proportion of older people who are discharged from hospital and go on to receive rehabilitation and re-ablement, and ii) the proportion of those who have received rehabilitation or re-ablement who return home within 91 days of their hospital discharge date, to ensure that ongoing improvements to intermediate care services (through the launch of the Home First service) are delivering greater capacity while maintaining good quality outcomes.
- Continue to work collaboratively across organisations to reduce delayed transfers of care.
- Consider undertaking intelligence gathering exercises to better understand the number and experiences of care home and domiciliary care self-funders in Herefordshire.
- Continue to support the adult social care sector in recruiting and retaining suitable staff.

Key Facts

- In 2015/16 there were 253 safeguarding enquiries per 100,000 of the population, higher than the figure for Herefordshire's local authority comparator group (202 per 100,000 of the population), and the national figure (239 per 100,000 of the population).
- There were 885 safeguarding concerns involving individuals aged 65 and over raised in Herefordshire in 2015/16, 250 of which resulted in a section 42 safeguarding enquiry.

Safeguarding is the term used to cover all work undertaken to support individuals with care and support in order to maintain their safety and wellbeing. It describes the preventative and responsive actions undertaken to support those who are experiencing, or at risk of experiencing abuse or neglect.

Safeguarding Adults is now a statutory duty under Section 42 of the Care Act 2014²³, and applies to incidences where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect,
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

In these situations the local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken on the adult's behalf and, if so, what and by whom.

The Herefordshire Safeguarding Adults Board (HSAB) was established by Herefordshire Council, health commissioners and West Mercia Police in 2009 with the aim of co-ordinating the effectiveness of safeguarding services provided to Adults at Risk in the county and became a statutory function under the Care Act 2014 on 1st April 2015. The main statutory objective of a Safeguarding Adults Board is to assure that local safeguarding arrangements and partners act to help and protect Adults at Risk.

²³ <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

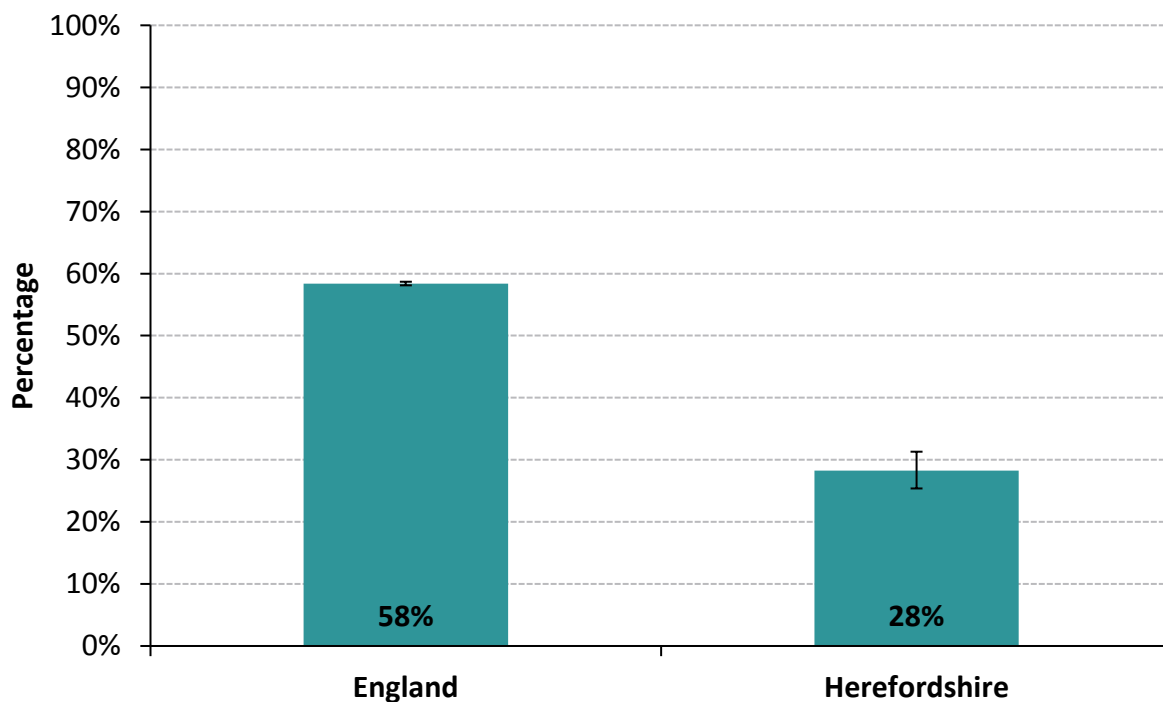
LOCAL DATA

A safeguarding concern is a sign of suspected abuse or neglect that is reported to the council or identified by the council. A safeguarding enquiry is the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult to a more formal multi-agency response.

In Herefordshire, in 2015/16 there were 253 safeguarding enquiries per 100,000 of the population, higher than the rate observed in Herefordshire's local authority comparator group (202 per 100,000 of the population), and the national rate (239 per 100,000 of the population).

There were 885 safeguarding concerns involving individuals aged 65 and over raised in Herefordshire in 2015/16, 250 of which resulted in a section 42 safeguarding enquiry representing a conversion rate of 28 per cent. In England 58 per cent of all safeguarding concerns involving individuals aged 65 and over progressed to a section 42 safeguarding enquiry in 2015/16, a statistically significantly higher proportion than was observed locally (Figure 98). This difference is likely explained by the fact that local authorities have different standard operating procedures for the management of safeguarding concerns, with some local authorities employing pre-screening at the point at which safeguarding concerns are reported, which can result in higher safeguarding concern to section 42 enquiry conversion rates.

Figure 98 The proportion of safeguarding concerns involving individuals aged 65 and over that resulted in a section 42 enquiry for England and Herefordshire in 2015/16

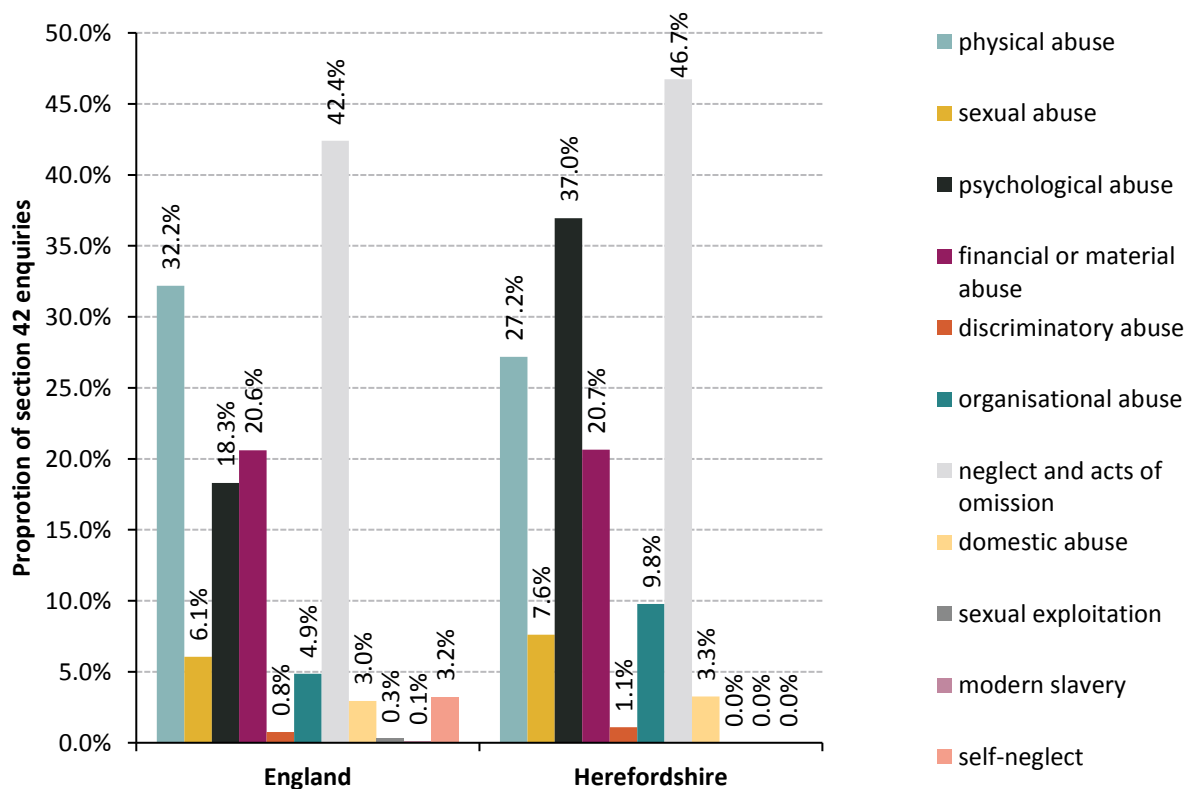


Data Source: Safeguarding Adults Collection (SAC), England 2015 – 2016, NHS Digital.

A total of 460 safeguarding enquiries were concluded in Herefordshire in 2015/16. Among these closed cases, the most frequently documented types of risk were neglect and acts of omission (46.7 per cent), psychological abuse (37.0 per cent), and physical abuse (27.2 per cent) (Figure 99). Please note that an enquiry may involve more than one type of risk, and multiple selections are permitted. Therefore, the totals will not sum to 100 per cent.

Figure 99 presents the profile of types of risk involved in section 42 enquiries that were closed in 2015/16 for Herefordshire and England. In general the profiles are quite similar, however in Herefordshire there appear to be a greater proportion of enquiries which involve psychological abuse, and a smaller proportion of enquiries involving self-neglect²⁴.

Figure 99 Proportion of section 42 enquiries concluded in 2015/16 involving various types of risk for England and Herefordshire



Data Source: Safeguarding Adults Collection (SAC), England 2015 – 2016, NHS Digital.

Locally, in 46 per cent of section 42 safeguarding enquiries concluded in 2015/16 the individual concerned was assessed as lacking capacity. This is higher than the figure for Herefordshire’s local authority comparator group and the England figure (36 and 27 per cent respectively). This finding is corroborated by the fact that there are a considerable

²⁴ Please note, sexual exploitation, modern slavery, and self-neglect are new categories of abuse and this could explain why there was no local data for these abuse categories in 2015/16.

number of Deprivation of Liberty Safeguards authorised in Herefordshire. Forty-seven per cent of individuals who were found to lack capacity were supported by an advocate, a smaller proportion compared to that observed in Herefordshire's local authority comparator group (66 per cent) and England as a whole (62 per cent). This suggests that locally, further action may need to be taken to ensure that those who lack capacity and are the subject of a section 42 safeguarding enquiry are provided with appropriate support.

RECOMMENDATION

- Consider whether people who are involved in a section 42 safeguarding enquiries and lack capacity are well supported, and take action if required.

VULNERABLE GROUPS: HEALTH NEEDS AND ACCESS TO SERVICES

It is recognised that there are sub-groups of the population who may have specific health and social care needs and/or face additional challenges in accessing health and social care services. These sub-groups are often referred to as vulnerable groups.

Though there is considerable variation among the individuals who fall within a vulnerable group, as a whole these sub-groups share characteristics which may warrant special consideration in the planning and provision of health and social care services.

BARRIERS TO ACCESSING SERVICES

Equitable access to services is important in order to ensure the health and wellbeing of communities. Vital to ensuring equitable access is an understanding of the nature of the barriers individuals may face. Barriers to accessing services can largely be categorised into those that relate to service structure, and those that relate to individual characteristics. Common types of barriers to accessing services are presented in Table 13.

Table 13 Examples of service and individual level characteristics that can act as barriers to accessing services

Service Characteristics	Individual Characteristics
<ul style="list-style-type: none">the structure, organisation and delivery of servicesservice characteristics such as location and opening times.	<ul style="list-style-type: none">demographic characteristics, for example being an asylum seeker, being homeless, having a learning difficulty, or living in a rural areacultural characteristics, for example if the person does not speak English as their first language or lives in a Gypsy or Traveller communitybehavioural characteristics, for example illicit drug use or commercial sex work, that people may want to actively concealattitudinal characteristics, for example being suspicious of the services offered or being unaware of the health benefits that might be gainedlifestyle characteristics, for example being a carer.

Source: National Institute for Health and Care Excellence Local Government Briefing 14, 2014.
<https://www.nice.org.uk/advice/lgb14/chapter/Introduction>

The barriers to accessing services and the specific health and social care needs of older people are summarised below, as are those of: 1) migrants, refugee and asylum seekers, 2) residential and nursing home residents, 3) the homeless, 4) gypsies and travellers and 5) informal carers. Not all of these groups are mutually exclusive, with potential for an individual to belong to more than one.

OLDER PEOPLE

Needs

The physiological effects of ageing lead to increased prevalence of long-term health conditions and loss of functional ability, resulting in increased need for health and social care input.

Access to services

Accessing services requires the coordination of a range of resources, such as social support, information and transport. Dixon-Woods *et al.*(164) highlight that older people are more likely to be deficient in one or more of these resources than other age groups.

DIGITAL EXCLUSION

Digital exclusion refers to the inability to access online products or services or to use simple forms of digital technology. Digital exclusion frequently results from having a lack of access to or not having the skills to access and engage with content on the internet. Older people, those from low-income backgrounds and people with learning disabilities are at particular at risk of being digitally excluded.

Findings from the 2017 Labour Force Survey (Quarter 1)(165) suggest that 10.9 per cent of adults in the UK were digitally excluded, having not used the internet within the last three months, or having never used the internet (a proxy measure for digital exclusion). The same survey indicated that in Herefordshire a statistically significantly greater proportion adults were digitally excluded (20.6 per cent), highlighting that digital exclusion is an issue which affects more adults in Herefordshire than in the UK as a whole.

The impact of digital exclusion can be considerable, as many services opt to move their operations online, access to information and delivery of services is increasingly happening via the internet. While the majority of the population will find this shift towards digitally accessed services more convenient, it makes getting information and services difficult or impossible for those who are not online.

LOCAL ACTION

Fastershire is a partnership between Gloucestershire County Council and Herefordshire Council to bring faster broadband to the two counties. To assist in achieving this objective

the Fastershire project is facilitating digital inclusion by supporting the development of digital skills in the community through their Faster Communities and Go-online@Fastershire initiatives.

Faster Communities

Fastershire's Faster Communities project offers free beginner's 'Introduction to the Internet' computer training to organisations, groups and clubs at community venues in Herefordshire. The training provided ranges from one-off workshops on specific subjects such as social media, online shopping or staying safe online, to a 5-week course covering all these and more. Through this initiative regular [workshops](#) are also offered at Herefordshire Libraries.

In addition to offering training, Faster Communities collates details of computer training opportunities for beginners that are provided by other organisations in order to signpost people who have expressed an interest.

Go-online@Fastershire

The Go-online@Fastershire grant programme supports community groups, parish councils and other not-for-profit organisations in Herefordshire to raise awareness of the benefits of using the internet and help people develop the skills to use it effectively. This is a rolling programme with applications considered within 6 weeks of receipt.

The grant has provided funding for the Royal National College for the Blind's student-run Tech Novice Café offering drop-in sessions for people who want to learn how to use the internet. This primarily supports those with visual impairments and older people although all interested members of the community are encouraged to attend.

Further information about these initiatives is available on the Fastershire [website](#).

MIGRANTS, REFUGEES AND ASYLUM SEEKERS

In the context of this section of the report, migrants refer to all people who were born outside of the United Kingdom, including economic migrants, refugees and asylum seekers. While there is considerable diversity among migrant population categories, they have been considered in tandem due to some of the common barriers they face in relation to accessing services.

According to the 2011 Census Herefordshire had 12,250 residents who were born outside the UK, 11.4 per cent (1,400) of whom were aged 65 and over. The majority of international migrants were from EU member countries with, 53 per cent of the county's international migrants having arrived since 2004, following expansion of EU membership. Over 5,000 residents were born in the new member states (Estonia, Czech Republic, Hungary, Lithuania, Latvia, Poland, Slovakia and Slovenia joined in 2004; Romania and Bulgaria in 2007).

Refugees are people fleeing armed conflicts or persecution. Refugees are protected by international law, through the 1951 Refugee Convention. Sixty Syrian refugees (14 households) are settled in Hereford under the Syrian Vulnerable Person's Resettlement Scheme, their ages range from zero to over 70 years.

An asylum seeker is someone who claims to be a refugee but whose claim hasn't been evaluated. People apply for asylum on the grounds that returning to his or her country would lead to persecution on account of their race, religion, nationality or political beliefs. While Herefordshire does not currently host asylum seekers, it has been agreed in principle that up to forty asylum seekers will be hosted in the county under the General Asylum Dispersal scheme.

Needs

There is considerable variation in health status among migrant categories, with research indicating that asylum seekers and refugees are more likely than economic migrants to suffer poor physical and mental health. This is largely attributed to their exposure to conflict and war; trauma associated with migration and settlement processes including isolation, loss of social status, poverty and insecure legal immigration status; and impact of government policies such as detention and dispersal in the receiving society. UK based and European studies indicate that higher rates of depression and anxiety are common among asylum seekers and refugees compared to the national population or other migrant categories (166).

Access to services

The extent to which migrants and asylum seekers will be eligible to receive free health and social care is dependent upon their immigration status.

Migrants, refugees and asylum seekers may face challenges in accessing health and social care services due to language barriers, cultural differences which impact upon help seeking behaviour, lack of familiarity with health and social care service structures and provision, lack of access to reliable transportation, and confusion around entitlement both on behalf of the migrant and service providers(167-169).

RESIDENTIAL AND NURSING HOME RESIDENTS

According to the Care Quality Commission there are approximately 2,000 registered residential and nursing home beds in Herefordshire, assuming an 80 per cent occupancy rate an estimated 1,600 people live in a residential or nursing home in the county, the majority of whom are aged 65 or over.

Needs

By definition, older people in residential and nursing home settings have more complex health and social care needs than their community dwelling counterparts. The prevalence of dementia is particularly high among this population.

Access to services

A recent national study undertaken by QualityWatch(92) found evidence that people living in residential and nursing home settings can face particular barriers in accessing timely community based healthcare, with access to specialist geriatric services identified as a particular concern. The inability to access timely community based healthcare was found to be linked to a rise in emergency hospital admissions. Locally, an increasing trend in emergency hospital admissions from residential and nursing homes has been observed. See p.103 of this report for further details.

THE HOMELESS

A person is referred to as homeless if they lack a permanent dwelling, and the term encompasses people in a variety of living situations from those in insecure accommodation such as those living in temporary accommodation or squatting, to the most vulnerable who sleep rough.

As many people who are homeless are not visible, obtaining an accurate count of the number of people who are homeless is not possible. However, local authorities have a duty to prevent and relieve homelessness and report figures on these activities on an annual basis. In 2015/16 financial year there were a total of 41 cases of statutory homelessness in Herefordshire a rate of 0.5 per 1,000 households. This compares favourably to regional and national rates of statutory homelessness which were 3.5 and 2.5 per 1,000 households respectively.

Needs

Rough sleepers and people in insecure accommodation have significantly higher levels of mental and physical ill health, substance abuse problems and higher rates of mortality than the general population. The average age of death for those who are homeless is 47 years, compared to 77 years of age for the general population(170).

In 2016, Herefordshire Council commenced a Homeless Link Health Needs Audit to identify the health needs of the local homeless population. As of October 2017, 81 homeless people aged between 17 and 74 years of age had taken part in the audit. Interim findings from the audit highlighted that 65 per cent of participants reported having a long-standing illness, higher than the overall national prevalence of 36 per cent. In addition the participants who smoked consumed five times more tobacco than the national population, putting them at higher risk of smoking related illness such as chronic obstructive pulmonary disease, stroke, heart disease and lung cancer.

Access to services

Interim findings from the recent Homeless Link Health Needs Audit found that participants made significantly fewer visits to the GP, despite evidence indicating that on average homeless people suffer from poorer health than the general population. Among those who participated in the local audit exercise 21 per cent reported that they were not registered with a GP. National evidence suggests that people who sleep rough are more

likely not be registered with a GP than those in insecure accommodation(171). In addition to having reduced access to a GP, 69 per cent of participants were not registered with a dentist.

GYPSIES AND TRAVELLERS

Gypsies and Travellers have long been resident in Herefordshire. Gypsy Travellers were traditionally a nomadic community, making an important contribution to the local agricultural workforce. In Herefordshire, the majority Gypsies and Travellers now live in conventional housing, but as a community retain a distinct ethnic and cultural identity. The 2011 Census was the first to include a Gypsy or Irish Traveller ethnic group. A total of 363 Herefordshire residents identified themselves as being a Gypsy or Traveller, representing 0.2 per cent of the local population. However, it is thought that the Census data does not accurately reflect the size of the local community, with locally derived estimates suggesting that the actual population of the Gypsy Traveller community (including Showmen and New Travellers) is nearer to double this (between 550 and 800. According to the 2011 Census approximately seven per cent of the local Gypsy or Irish Traveller community were aged 65 and over.

Needs

Analysis of the 2011 Census found that in England and Wales, Gypsy or Irish Travellers had the lowest proportion of people rating their general health as 'good' or 'very good' (70 per cent compared to 81 per cent of the total population of England and Wales)(172).

In their 2004 investigation into the health needs of Gypsies and Travellers Parry *et al.*(173) found poorer health outcomes compared to non-Gypsy Traveller peers, including high infant mortality rates, high maternal mortality rates, low child immunisation levels, substance misuse issues and high rates of diabetes. Self-reported anxiety, chest pain, respiratory problems, and arthritis were also more prevalent among Gypsy Travellers.

Access to services

Parry *et al.*(173) found that despite Gypsy Travellers reporting poorer health, they were less likely to access services than the general public. Their findings suggest that attitudes and beliefs play a large role in help seeking behaviour, with a cultural pride in self-reliance, low faith in the benefits and effectiveness of medical intervention, diminished trust in professionals, and fear of receiving a life threatening diagnosis all acting as barriers to accessing services.

INFORMAL CARERS

An informal carer is a person who provides a considerable amount of care, unpaid (excluding volunteer work), on a regular basis for a partner, family member or friend(132). There are an estimated 21,300 informal carers in Herefordshire.

Needs

Research findings indicate that informal carers are at increased risk of experiencing social isolation and mental health problems. Some carers find that caring itself has a detrimental impact upon their physical health, especially when their caring role involves frequent moving and handling activities.

Further information on the needs of informal carers can be found from p. 144 to p.150 of this report.

Access to services

Many carers find it difficult to fit their own medical appointments around their caring responsibilities, and often delay seeking out medical support and advice. Finding the time to access services is a particular challenge for working age carers.

OTHER CONSIDERATIONS

Veterans

A veteran is a person who has served in the Armed Forces for at least one day. In 2016, the Annual Population Survey(174) estimated that there were 14,000 veterans resident in Herefordshire; 1 per cent of the United Kingdom's veteran population. Veterans aged 65 and over are referred to as retired veterans. Information on the age profile of Herefordshire's veterans is not readily available. However, nationally the age profile of the veteran population is older than that of the general population with veterans being significantly more likely to be aged 75 years and over compared to their peers(175).

The provision of veterans' healthcare is primarily the responsibility of the NHS. Veterans in England, Scotland and Wales receive priority access to NHS secondary care for service-related conditions, as outlined in the Armed Forces Covenant(176).

Compared to younger veterans who generally have poorer health than their civilian counterparts, older veterans are more likely to report better or equivalent health. Like their civilian counterparts, among retired veterans prevalence of self-reported difficulties in self-care and mobility is high, reflecting age related changes in functional capacity(177).

In conclusion, while evidence indicates that working age veterans represent a vulnerable group with specific health needs, the needs of retired veterans do not appear to differ greatly from those of their civilian peers.

DISCUSSION POINTS

- Older people may find it difficult to access health and social care services at a time in their life when their need is likely to increase. Older people may face particular difficulties in accessing information and support that is located online. As part of their objective to bring faster broadband to Gloucestershire and Herefordshire, Fastershire have two initiatives aimed at addressing digital exclusion in Herefordshire. The initiatives provide and support local information technology training opportunities in order to promote and enhance information technology skills in the community.
- Subgroups of the population may have specific needs and/or face additional barriers in accessing services. Understanding these specific needs and barriers can help commissioners to identify what actions might be taken in order to better meet the needs of particular vulnerable groups, and to ensure that services are structured and delivered in a way which facilitates access.

RECOMMENDATIONS

- Service providers and those commissioning services should give consideration to the needs of vulnerable groups and the barriers they are likely to face in accessing services. If services intend to move to an online only delivery model specific consideration should be given to how this may affect accessibility for older people, and what actions they might take to mitigate this.

BEST PRACTICE

The National Institute for Health and Care Excellence (NICE) is the independent organisation responsible for providing guidance and quality standards for health and social care in England.

NICE do this by producing evidence-based guidelines which are recommendations for health and care provision in England. The guidelines provide an indication what constitutes best practice, having regard for clinical and cost-effectiveness. NICE guidelines set out the care and services suitable for groups of people (for example: those with a specific condition or need and people in particular circumstances or settings).

In addition to producing guidelines, NICE produce quality standards, which are statements with accompanying metrics aimed at supporting audit and quality improvement activities. NICE quality standards are produced for priority areas, and often accompany NICE guidelines.

NICE guidelines and quality standards are developed for anyone who wants to improve health and social care services, examples of interested groups include:

- **Commissioners** –who may use quality standards to ensure that high-quality care or services are being commissioned.
- **Service providers** –who may use quality standards to monitor service improvements, to show that high-quality care or services are being provided and highlight areas for improvements.
- **Health, public health and social care practitioners** –who may use audit and governance reports to demonstrate the quality of care, as described in a quality standard, or in professional development and validation.
- **Regulators**-the Care Quality Commission and Ofsted endorse the use of quality standards to help identify and define good quality care.

NICE guidelines and quality standards which are relevant to the provision of health and social care to older people²⁵ are listed below under the following three topic categories:

- Adult social care
- Health conditions
- Wider health and wellbeing issues

²⁵ In October 2017, the NICE website was searched to identify NICE guidelines and quality standards relevant to health and social care services for older people. Please note that new and updated NICE guidelines are published on a regular basis. Therefore, some of the guidelines listed here may have been superseded and that further relevant guidelines will have been produced. Readers are directed to the [NICE website](#).

Some guidelines and standards appear under more than one heading. Quality standards have the reference “(QS#)” at the end of their title, and guidelines have the reference “(CG#)”, “(NG#)” or “(PH#)”.

ADULT SOCIAL CARE

[End of life care for adults \(QS13\)](#)

[Excess winter deaths and illness and the health risks associated with cold homes \(NG6\)](#)

[Faecal incontinence in adults \(QS54\)](#)

[Faecal incontinence in adults: management \(CG49\)](#)

[Home care for older people \(QS123\)](#)

[Home care: delivering personal care and practical support to older people living in their own homes \(NG21\)](#)

[Intermediate care including re-ablement \(NG74\)](#)

[Managing medicines for adults receiving social care in the community \(NG67\)](#)

[Managing medicines in care homes \(SC1\)](#)

[Medicines management in care homes \(QS85\)](#)

[Mental wellbeing of older people in care homes \(QS50\)](#)

[Older people with social care needs and multiple long-term conditions \(NG22\)](#)

[Oral health for adults in care homes \(NG48\)](#)

[Social care for older people with multiple long-term conditions \(QS132\)](#)

[Transition between inpatient hospital settings and community or care home settings for adults with social care needs \(NG27\)](#)

[Transition between inpatient hospital settings and community or care home settings for adults with social care needs \(QS136\)](#)

[Transition between inpatient mental health settings and community or care home settings \(NG53\)](#)

HEALTH CONDITIONS

[Acute heart failure \(QS103\)](#)

[Acute heart failure: diagnosis and management \(CG187\)](#)

[Anxiety disorders \(QS53\)](#)

[Atrial fibrillation \(QS93\)](#)

[Atrial fibrillation: management \(CG180\)](#)

[Cardiovascular disease: identifying and supporting people most at risk of dying early \(PH15\)](#)

[Cardiovascular disease: risk assessment and reduction, including lipid modification \(CG181\)](#)

[Cardiovascular risk assessment and lipid modification \(QS100\)](#)

[Cataracts in adults: management \(NG77\)](#)

[Chronic heart failure in adults \(QS9\)](#)

[Chronic heart failure in adults: management \(CG108\)](#)

[Chronic obstructive pulmonary disease in adults \(QS10\)](#)

[Chronic obstructive pulmonary disease in over 16s: diagnosis and management \(CG101\)](#)

[Colorectal cancer \(QS20\)](#)

[Delirium in adults \(QS63\)](#)

[Delirium: prevention, diagnosis and management \(CG103\)](#)

[Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset \(NG16\)](#)

[Dementia: independence and wellbeing \(QS30\)](#)

[Dementia: support in health and social care \(QS1\)](#)

[Dementia: supporting people with dementia and their carers in health and social care \(CG42\)](#)

[Depression in adults with a chronic physical health problem: recognition and management \(CG91\)](#)

[Depression in adults: recognition and management \(CG90\)](#)

[Diabetes in adults \(QS6\)](#)
[Generalised anxiety disorder and panic disorder in adults: management \(CG113\)](#)
[Glaucoma in adults \(QS7\)](#)
[Hip fracture in adults \(QS16\)](#)
[Hip fracture: management \(CG124\)](#)
[Hypertension in adults \(QS28\)](#)
[Hypertension in adults: diagnosis and management \(CG127\)](#)
[Lower urinary tract symptoms in men \(QS45\)](#)
[Multimorbidity \(QS153\)](#)
[Multimorbidity: clinical assessment and management \(NG56\)](#)
[Myocardial infarction with ST-segment elevation: acute management \(CG167\)](#)
[Myocardial infarction: cardiac rehabilitation and prevention of further cardiovascular disease \(CG172\)](#)
[Osteoarthritis \(QS87\)](#)
[Osteoarthritis: care and management \(CG177\)](#)
[Osteoporosis \(QS149\)](#)
[Parkinson's disease in adults \(NG71\)](#)
[Peripheral arterial disease: diagnosis and management \(CG147\)](#)
[Pneumonia in adults \(QS110\)](#)
[Pneumonia in adults: diagnosis and management \(CG191\)](#)
[Pressure ulcers \(QS89\)](#)
[Pressure ulcers: prevention and management \(CG179\)](#)
[Secondary prevention after a myocardial infarction \(QS99\)](#)
[Stable angina \(QS21\)](#)
[Stroke in adults \(QS2\)](#)
[Stroke rehabilitation in adults \(CG162\)](#)
[Type 1 diabetes in adults: diagnosis and management \(NG17\)](#)
[Type 2 diabetes in adults: management \(NG28\)](#)
[Type 2 diabetes prevention: population and community-level interventions \(PH35\)](#)
[Type 2 diabetes: prevention in people at high risk \(PH38\)](#)
[Urinary incontinence in women \(QS77\)](#)
[Urinary incontinence in women: management \(CG171\)](#)
[Urinary tract infections in adults \(QS90\)](#)

WIDER HEALTH AND WELLBEING

[Alcohol: preventing harmful use in the community \(QS83\)](#)

[Alcohol-use disorders: diagnosis and management of physical complications \(CG100\)](#)

[Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence \(CG115\)](#)

[Alcohol-use disorders: prevention \(PH24\)](#)

[Behaviour change: general approaches \(PH6\)](#)

[Cardiovascular disease prevention \(PH25\)](#)

[Coexisting severe mental illness and substance misuse: community health and social care services \(NG58\)](#)

[Common mental health problems: identification and pathways to care \(CG123\)](#)

[Domestic violence and abuse: multi-agency working \(PH50\)](#)

[End of life care for adults \(QS13\)](#)

[Excess winter deaths and illness and the health risks associated with cold homes \(NG6\)](#)

[Faecal incontinence in adults \(QS54\)](#)

[Faecal incontinence in adults: management \(CG49\)](#)

[Falls in older people \(QS86\)](#)

[Falls in older people: assessing risk and prevention \(CG161\)](#)

[Falls: the assessment and prevention of falls in older people \(CG21\)](#)

[Medicines optimisation \(QS120\)](#)

[Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes \(NG5\)](#)

[Mental wellbeing and independence for older people \(QS137\)](#)

[Mental wellbeing in over 65s: occupational therapy and physical activity interventions \(PH16\)](#)

[Mental wellbeing of older people in care homes \(QS50\)](#)

[Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition \(CG32\)](#)

[Nutrition support in adults \(QS24\)](#)

[Obesity in adults: prevention and lifestyle weight management programmes \(QS111\)](#)

[Obesity: clinical assessment and management \(QS127\)](#)

[Obesity: working with local communities \(PH42\)](#)

[Older people: independence and mental wellbeing \(NG32\)](#)

[Physical activity: brief advice for adults in primary care \(PH44\)](#)

[Physical activity: exercise referral schemes \(PH54\)](#)

[Physical activity: walking and cycling \(PH41\)](#)

[Preventing excess weight gain \(NG7\)](#)

[Preventing excess winter deaths and illness associated with cold homes \(QS117\)](#)

[Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services \(CG136\)](#)

[Smoking: brief interventions and referrals \(PH1\)](#)

[Smoking: supporting people to stop \(QS43\)](#)

[Transition between inpatient hospital settings and community or care home settings for adults with social care needs \(NG27\)](#)

[Transition between inpatient hospital settings and community or care home settings for adults with social care needs \(QS136\)](#)

[Violence and aggression: short-term management in mental health, health and community settings \(NG10\)](#)

[Vitamin D: supplement use in specific population groups \(PH56\)](#)

[Weight management: lifestyle services for overweight or obese adults \(PH53\)](#)

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APPENDICES

APPENDIX 1

Number	Benchmarking statement	Total votes cast	Outcome (most common response)	Number of votes for outcome	Proportion who voted for outcome
Healthy active ageing (prevention)					
1	Influenza and pneumococcal pneumonia vaccination for people with frailty.	17	Green	11	65%
2	Adequate treatment for 'minor conditions' which may limit independence.	16	Amber	9	56%
3	Support to maintain healthy lifestyle –regular exercise, not smoking, reducing alcohol consumption, healthy eating and preventing obesity.	16	Amber	12	75%
Living well with long-term conditions					
4	Personalised care planning and shared decision-making is a universal offer for all those aged 75 and over with one or more long-term condition.	16	Amber	9	56%
5	Treatment and management of long-term conditions in older people is optimised and there is no discrimination on the basis of age alone.	16	Amber	7	44%
6	The use of assistive technology is part of the menu of options in place for patients to effectively self-manage their long-term condition.	16	Amber	15	94%
Living well with comorbidities					
7	Systematic, targeted case-finding. This includes using risk stratification, electronic case-finding tools and screening within primary and community settings.	16	Blue	6	38%
8	Proactive comprehensive geriatric assessment (CGA) and follow-up. An identified keyworker who acts as a case manager and coordinator of care across the system.	16	Blue	7	44%

Number	Benchmarking statement	Total votes cast	Outcome (most common response)	Number of votes for outcome	Proportion who voted for outcome
9	General practices monitor hospitalisation and avoidable ED attendances regularly and determine whether alternative care pathways might have been more appropriate.	16	Blue	7	44%
10	Carers are offered an independent assessment of their needs and signposted to interventions to support them in their caring role.	16	Amber	11	69%
11	Opportunities to participate in exercise are available to frail older people.	16	Amber	11	69%
12	Frail older people have access to services to prevent falls.	16	Green	8	50%
13	A comprehensive service for those with dementia is available and accessible.	16	Amber	12	75%
14	Services are available to reduce polypharmacy in frail older people.	16	Amber	7	44%
Rapid crisis support					
15	Single point of access available to facilitate access to community services to manage crisis at home with specialist opinion and diagnostics.	16	Red	10	63%
16	A comprehensive geriatric assessment initiated rapidly, within four hours of referral, 8am to 8pm, seven days a week.	16	Red	8	50%
17	Ambulatory emergency pathways with access to multi-disciplinary teams are available with a response time of less than four hours for older people who do not require admission but need ongoing treatment.	16	Amber	10	63%
18	Mental health services contribute with specialist mental health assessments if appropriate.	16	Amber	11	69%
19	An interface or community geriatrician service is available to provide expert clinical opinion, clinical support and supervision to community teams and domiciliary care when needed to housebound patients.	16	Red	10	63%
20	Rapid access ambulatory clinics available in acute and community hospital settings for the provision of rapid access to specialist advice from the multi-disciplinary team.	16	Red	11	69%

Number	Benchmarking statement	Total votes cast	Outcome (most common response)	Number of votes for outcome	Proportion who voted for outcome
21	A personalised care plan including emergency contingency plan, advanced care plan and the facility to allow a natural death order (if clinically appropriate) is in place and can be accessed by the patient and all services involved in their care and support.	16	Amber	11	69%
22	There are shared care protocols with ambulance organisations that can enable older people to remain at home.	16	Amber	10	63%
Acute hospital care					
23	A simple referral system with a single point of access for frail older people.	16	Red	12	75%
24	Expert decision makers are available at the front door of the acute hospital from 8am to 8pm, seven days a week. Specialist assessment should be available within 12 hours of admission, seven days a week.	16	Amber	9	56%
25	An identified Frailty Unit/Service is available with staff trained how to look after frail focusing on rapid assessment, treatment and rapid discharge.	16	Amber	11	69%
26	The presence of one or more frailty syndromes triggers a comprehensive geriatric assessment.	16	Blue	7	44%
27	Sufficient specialty and community hospital beds are available to look after all frail older patients with complex needs and enough relevantly trained staff to deliver high-quality care and assessment for them.	16	Amber	8	50%
28	Hospitals have operational plans to reduce the number of ward moves, especially out of hours with accompanying plans to mitigate their adverse effects on continuity of care, reduction in harm and improved patient experience for frail older people.	16	Blue	6	38%
29	There is adequate education and training for staff in all clinical areas focusing on care and compassion for frail older people.	16	Amber	9	56%

Number	Benchmarking statement	Total votes cast	Outcome (most common response)	Number of votes for outcome	Proportion who voted for outcome
30	Strategies are in place to reduce avoidable unexpected mortality should be in place including physiological warning scores, critical care outreach, regular senior review and adequate access to high dependency beds.	16	Blue	10	63%
31	Older people are not denied potential life-saving treatment such as emergency surgery, stroke thrombolysis or coronary revascularisation on the grounds of age alone.	16	Blue	8	50%
32	Hospitals incorporate organisational learning from safety incidents and near misses into operational policies, education and training and should encourage a culture of open reporting of safety incidents affecting older patients.	16	Amber	9	56%
33	Hospitals make safer care for older people a key priority, and safety strategies must include specific attention to the prevention and treatment of falls, pressure sores, hospital-acquired infection, medication errors and deep vein thrombosis, based on national guidance. However, hospitals also have regard for some of the other potentially preventable harms of hospitalisation for older people. These include malnutrition, delirium and immobility as a result of bed rest.	16	Amber	11	69%
Discharge planning and support					
34	Patient, carers and families are involved in decision making from admission.	16	Amber	9	56%
35	Discharge to an older person's normal residence is possible within 24 hours, seven days a week – unless continued hospital treatment is necessary.	16	Red	11	69%
36	Older people are only discharged from hospital with adequate support and with respect for their preferences.	16	Amber	6	38%
37	Older people being admitted following an urgent care episode have an expected discharge date set within two hours.	16	Red	9	56%

Number	Benchmarking statement	Total votes cast	Outcome (most common response)	Number of votes for outcome	Proportion who voted for outcome
38	There is a hospital based multi-disciplinary team located at the front door of the hospital integrated with the community team focused on the facilitation of discharge.	16	Red	7	44%
39	Care packages to support discharge are available within 24 hours of referral to Adult Care and Support.	16	Red	10	63%
40	Adequate and timely information is shared between services whenever there is a transfer of care between individuals or services.	16	Amber	11	69%
41	When preparing for discharge, older people and carers are offered details of local voluntary sector organisations, other sources of information, practical and emotional support including information on accessing financial support and re-ablement services.	16	Amber	10	63%
42	Voluntary sector services are available to provide a 'welcome home' service for frail older people who live alone 7 days a week.	16	Amber	9	56%
Rehabilitation and re-ablement					
43	There is adequate and flexible provision of step-up and step-down home-based and bed-based rehabilitation and re-ablement services with enough capacity and responsiveness to meet the needs of everyone who might benefit.	16	Red	9	56%
44	Shared assessment frameworks across health and social care lead to a personalised care plan for each individual, where the individual and their carers are key participants in any decision made.	16	Red	9	56%
45	Contracting and commissioning of services is done not on the basis of time periods and tasks, but on the outcomes desired for the person.	16	Amber	10	63%

Number	Benchmarking statement	Total votes cast	Outcome (most common response)	Number of votes for outcome	Proportion who voted for outcome
46	Workforce required for home-based rehabilitation and re-ablement services include an appropriate skill mix including; nurses, therapists, social workers and community psychiatric nurses, voluntary and community groups, led by a senior clinician.	16	Red	10	63%
Nursing and residential care					
47	All older people for whom long-term care is being considered have a comprehensive assessment of need, adequate treatment of medical problems which are precipitating decisions to move, adequate rehabilitation and wherever possible, are not 'placed' directly from acute hospital settings.	16	Amber	8	50%
48	Alternatives to long-term care are fully considered. Telecare/AT options considered and optimised before move to care home.	16	Amber	9	56%
49	Assessments are not a cause of delay in hospital.	16	Red	12	75%
50	When a person is admitted to a care home, primary-care services provide comprehensive geriatric assessment, personalised care planning in partnership with the person and planning for the future. Commissioners need to commission adequate primary care services to ensure this can happen effectively.	16	Red	11	69%
51	Healthcare for care home residents is an actively commissioned service, with clear service specifications linked to quality standards detailed in contracts. The goal should be to provide high-quality, multi-disciplinary and multi-agency healthcare support for older people in long-term care.	16	Blue	8	50%
52	There is adequate clinical training for care home staff; both registered and non-registered workers learning together on-site as part of an overall quality improvement programme.	16	Amber	7	44%
53	When a new resident moves into a care home, there is a prompt transfer of clinical information to the care home.	16	Blue	6	38%

Number	Benchmarking statement	Total votes cast	Outcome (most common response)	Number of votes for outcome	Proportion who voted for outcome
54	Comprehensive geriatric assessment is carried out on admission to long-term care facility, and a personalised care plan put in place aimed at prevention of admission, optimising management of long-term conditions and ensuring the wishes of the resident are at the forefront of any decision made.	16	Red	7	44%
End of life care					
55	There are structured approaches to end of life care in care homes such as the Gold Standards Framework, with advance care plans, advance decisions and adequate choice, control and support towards the end of life.	16	Amber	8	50%
56	Tools are used systematically to identify frail older people at the end of their life.	16	Red	8	50%
57	Advance care planning is not seen as a one-off event; communication with patients and families is a continuous process and should be made available to patients with and without mental capacity, fully involving carers/relatives in best interest decisions.	16	Amber	8	50%
58	Equitable access to specialist palliative care services for frail older people.	16	Amber	12	75%
59	Commissioners should use the BGS Commissioning Guidance: 'High Quality Health Care for Older Care Home Residents' (BGS, 2013) to specify the clinical and service priorities for meeting care home residents' needs.	16	Amber	9	56%