



# Joint Strategic Needs Assessment

## Older People Cambridgeshire 2010

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# 1 Executive summary and headlines

## 1.1 What do we know?

### 1.2 Facts, figures and trends

- ❖ In Cambridgeshire in 2009, there were around 95,500 people aged 65 and over (almost 16% of residents).
- ❖ Huntingdonshire has the greatest number of older residents and the proportion of the population aged 65 and over ranges from 11.8% in Cambridge City to 19.6% in Fenland.
- ❖ In all localities apart from Cambridge City, the number of older people is forecast to rise steadily until at least 2021.
- ❖ People in Cambridgeshire are living longer. Between 1991/93 and 2006/08, life expectancy at birth has increased for both males (to around 78 years of age) and females (to around 82 years of age). Life expectancy at 65 has also increased to more than 17 years for men and to more than 20 years for women.
- ❖ Life expectancy in Cambridgeshire is higher than the national average but life expectancy in older people is lower in the most deprived fifth of the Cambridgeshire residents compared to the rest.
- Between 1981 and 2006, the length of time lived in good health has increased as life expectancy has increased. Healthy life expectancy at birth has increased 4.1 years for males and 3.8 years for females to 68.5 years and 70.5 years respectively.<sup>1</sup>  

People are also living longer in poor health. English males aged 65 can expect to spend 4.4 years in poor health and English females 5.4 years.<sup>2</sup>
- Most older people are in good health but the number of frail older people is increasing.<sup>3</sup>
- ❖ Older people comprise a higher proportion of the population in rural areas than in urban. This proportion is expected to increase.
- ❖ The proportion of older people belonging to a Black and Minority Ethnic Group rose between 2001 and 2007 but remains only 2% of the population.
- The relationship between income and health is strong. Poverty of income is related to being single, a low level of pensions and being out of the labour force.<sup>4</sup> In Cambridgeshire, around a third of older people live alone, and around a fifth claim pension credit which is available to those on low incomes and an indicator of poverty. Nationally, around 3% of people of pensionable age are in full time employment.
- ❖ Around 5% of older people receive disability living allowance, and a higher proportion receives disability living allowance in Fenland than in the rest of Cambridgeshire.
- ❖ Around 12% of older people were providing unpaid care in 2001.
- ❖ Although nearly a third of Cambridgeshire's population of older people are in the least deprived fifth of England, seven small areas are in the most deprived fifth of England – two in Fenland and five in Cambridge.

<sup>1</sup> <http://www.statistics.gov.uk/cci/nugget.asp?id=934>

<sup>2</sup> [http://www.statistics.gov.uk/downloads/theme\\_health/Health-Expectancies-2000-2007\\_submitted.xls](http://www.statistics.gov.uk/downloads/theme_health/Health-Expectancies-2000-2007_submitted.xls)

<sup>3</sup> <http://www.cfes.ac.uk/>

<sup>4</sup> <http://www.scotland.gov.uk/Resource/Doc/156479/0042008.pdf>

- Nationally, only around 3% of over 65s, 18% of over 80s, and 28% of over 90s live in residential care.<sup>5</sup>
- ❖ In 2008, around 4,300 older people in Cambridgeshire were found to have housing support needs. Between 6,000 and 15,000 older people households are thought to be living in fuel poverty.
- ❖ In Cambridgeshire in 2008/09, 6.2% of older people were victims of crime. In 2009/10, there were 119 distraction burglaries involving people aged 65 and older. Serious violent attacks on older people are, however, rare.
- HIV infections in people aged over 50 more than doubled between 2000 and 2007<sup>6</sup>.
- ❖ Cigarette smoking is the largest cause of preventable death. Smoking prevalence is likely to be lower in Cambridgeshire than nationally, but there are estimated to be around 40,000 smokers over the age of 50.
- ❖ Around 30% of older people consider themselves to be physically active.
- Around a third of people aged 65 and older will fall once a year. This rises to approximately half of those aged 85 and older. In Cambridgeshire, in 2008/09, 2,525 hospital admissions were the result of a fall. This is more than expected compared to the East of England, and within Cambridgeshire, it is highest in Cambridge City. Each year, around 20 deaths are associated with a fall.
- ❖ Less than half of all older people in Cambridgeshire are thought to consume a healthy diet and 20% of older people are thought to be obese. Significant numbers are heavy drinkers.
- ❖ The prevalence of health conditions recorded in general practice is lower in Cambridgeshire compared to England, but higher than in PCTs with similar populations.
- Although 40% of older people do not have a long term condition such as diabetes, hypertension, coronary heart disease or asthma, many people live with a long term condition that limits their ability to cope with day to day activities<sup>7</sup>. In Cambridgeshire, 6.4% of people have diabetes, 6.0% cardiovascular disease and 2.5% have chronic obstructive pulmonary disease. By 2020, the prevalence is expected to rise to 7.4%, 6.4% and 2.7% respectively.
- ❖ The number of older people with dementia in Cambridgeshire is expected to double from 7,000 to 14,000 over the next 20 years.
- ❖ The number of older people with depression in Cambridgeshire is expected to increase from 8,600 in 2010 to 14,500 in 2030.
- ❖ The number of older people not able to manage at least one domestic task on their own is expected to almost double in the next 20 years from 40,800 to 74, 500.
- ❖ Most deaths of older people in Cambridgeshire are from circulatory disease and cancer. In the very oldest age groups, the contribution to deaths from cancer is lower. Mortality is falling over time, and the greatest reduction is in deaths from circulatory disease. Historical falls in smoking account for much of this reduction but smoking-attributable deaths remain high, and are highest in Fenland.

### 1.3 Local views

- ❖ 10% of older people consider themselves to be in poor health. Within Cambridgeshire, people in Fenland are more likely to report poor health.

<sup>5</sup> <http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/DontStopMeNow17July08REP.pdf>

<sup>6</sup> <http://journals.lww.com/aidsonline/pages/currenttoc.aspx>

<sup>7</sup> [http://www.dh.gov.uk/dr\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_082067.pdf](http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_082067.pdf)

- ❖ Areas in Cambridgeshire with higher proportions of older people are less likely to have a strong sense of belonging to their neighbourhood.
- ❖ 51% of older residents agree that public services promote the interests of residents and act on the concerns of residents.
- ❖ 88% of older people in Cambridgeshire are satisfied with both their home and neighbourhood. Within Cambridgeshire, older people are most likely to be satisfied with their neighbourhood in South Cambridgeshire (92%) and least likely in Fenland (82%).
- ❖ Fewer than 30% of people felt that residents are given the support they need to live at home as long as they want. Within Cambridgeshire, this ranges from 25% in Cambridge City to just fewer than 30% in South Cambridgeshire.
- ❖ In 2010 Cambridgeshire Older People's Enterprise forum surveyed their members who attended the Annual General Meeting in 2008:
  - Two-thirds reported a long term condition affecting daily life and just under half taking at least four daily medications, but almost all of whom reported being active on a daily basis and half described their health as good.
  - One third reported falling at least once in the last year and less than two-thirds reported having someone to call on in the event of a fall.
- ❖ The Cambridgeshire Older People's Reference Group surveyed 260 community groups in 2008/09 and highlighted:
  - 85% of older people do not access social care services.
  - Most care and support is unpaid and informal.
  - Men are less likely than women to participate in organised groups.
  - People aged 85 and over continue to be involved in community groups.
  - Income, ability to travel, the availability of physical activities and access to information are important concerns.
- ❖ Older people in Cambridgeshire are most concerned about:
  - Income
  - Transport and social inclusion
  - Access to information on services and activities
  - Housing, including help in the home.

Sources: Age UK, Cambridgeshire Older People Reference Group, Cambridgeshire Older People Enterprise, Place Survey 2008, Regional Lifestyle Survey.

#### 1.4 Evidence and best practice

If current patterns of need and care are applied to the projected numbers of older people, current provision of services is unsustainable.<sup>8</sup> This drives two main themes:

1. Prevention of ill health and promotion of good health.

<sup>8</sup>

<http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20100218-underpressure-nationalstudy.pdf>

2. Reconfiguration of services to support people to live in a community setting as long as possible, avoid admission to hospital, and return to a community setting after discharge from hospital.

A whole system approach is needed:

- Work in partnership across agencies providing health and social care and the voluntary sector
- A balance of short and long term goals
- Planning to cope with increasing numbers of older people
- Equal access for older people to mainstream services
- Services tailored to people with coexisting care needs
- Targeting of individuals with greatest capacity to benefit
- Reduction of health inequalities

There is comparatively little evidence of effective preventive services because studies in this area tend to be small scale and not comparable with other studies. It is often not clear quantitatively or qualitatively what elements of a reportedly successful intervention have contributed to its success and can be replicated elsewhere, since many of the interventions are complex. Some benefits of, for example, an improved diet may take a long time to become apparent and disentangling the effects of other factors in this period in order to establish the contribution of diet is difficult. Research evidence in this area may over estimate the benefits of an intervention eg a referral management scheme, by describing the patterns of referral before and after a scheme, and not consider the counterfactual ie what might have happened in any case. There is particularly a shortage of evidence on prevention of poor mental health.

The Wanless Social Care Review<sup>9</sup> commissioned two major research papers and a number of background papers to help in the estimate of future trends and costs. A King's Fund report<sup>10</sup> on the cost effectiveness of preventive services found a strong case for reducing hospitalisation (particularly through falls) and for maintaining independence, although a lack of evidence on how best to achieve these. It found conflicting evidence on the cost effectiveness of intermediate care but stronger evidence to support intermediate care that targets specific groups or illnesses or events eg stroke and falls, strong evidence for secondary stroke prevention, and evidence of cost effectiveness for the primary prevention of stroke through dietary salt reduction and smoking cessation. It highlighted that in order to maximise the effectiveness of any intervention, it is important to target those who will benefit most.

A recent paper<sup>11</sup> from the University of Birmingham also recognises the shortage of strong evidence on preventive services but from the available evidence, identifies ten 'high impact changes': Healthy life styles, vaccination, screening, falls prevention, adaptations/practical support, telecare, intermediate care, re-ablement, partnership working, personalisation.

The Partnerships for Older People Projects (POPPs) initiative was funded by the Department of Health to develop services for older people to promote their health, wellbeing and independence, and prevent or delay their need for higher intensity or institutional care. 29 councils in England were involved as sites for the pilots, which ran from 2006 to 2009. Projects ranged widely and included the provision of low-level services such as lunch clubs and interventions to avoid hospital admissions. An evaluation of the initiative was published

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<sup>9</sup> [http://www.kingsfund.org.uk/publications/securing\\_good.html](http://www.kingsfund.org.uk/publications/securing_good.html)

<sup>10</sup> [http://www.kingsfund.org.uk/publications/appendices\\_to.html](http://www.kingsfund.org.uk/publications/appendices_to.html)

<sup>11</sup> <http://www.hsmc.bham.ac.uk/publications/policy-papers/policy-paper-eight.pdf>



in December 2009.<sup>12</sup> The authors are cautious in their conclusions but broadly positive. They estimate that for every pound spent on POPP services, £1.20 was saved in avoided emergency bed days. However, statistical uncertainty on this estimate ranged from £0.80 to £1.60 and so a clear cost saving was not demonstrated. Several projects found efficiency gains for health care services, with no apparent consequences for social care. The greatest improvements were reported by older people receiving practical help for daily living and being supported to take more exercise. The clearest benefits were demonstrated by projects focussing on people with complex needs. Overall, it appears that there is scope for increased investment in low intensity measures to promote health and wellbeing and avoid higher intensity services. The experience of the pilot sites provides useful information to guide the design of future services but there is no clear evidence of best practice that can be applied to other local areas with confident expectation of success. New projects should therefore be designed within a strong evaluation framework, with clear outcomes, in order to allow disinvestment or revision at an early stage.

Discrimination, participation in meaningful activities, relationships, physical health, and poverty have been found to be particularly important factors influencing the mental health and wellbeing of older people.<sup>13</sup> *Confident Communities, Brighter Futures*<sup>14</sup> by the Department of Health in 2010 identifies the following effective interventions for the promotion of wellbeing specifically among older people: psychosocial interventions, high social support before and during adversity, prevention of social isolation, multi-agency response to prevent elder abuse, walking and physical activity programmes, learning, volunteering. It concluded early intervention, and prevention in high risk groups, to be effective against depression and exercise and anti-hypertensive treatment to be effective in dementia.

Evidence of best practice is stronger for specific conditions and disease areas. The Department of Health has published a suite of prevention package resources<sup>15</sup> to support the commissioning of services that support the health, wellbeing and independence of older people. This includes:

- Prevention of falls and fractures
- Foot care
- Intermediate care
- Hearing
- Telecare
- Accidental injuries
- Planned discharge from hospital and intermediate care

National service frameworks,<sup>16</sup> have been published for

- Older people
- Mental health
- Long term conditions
- Stroke
- Cancer
- COPD
- Diabetes
- Mental health
- Renal services

<sup>12</sup> [http://www.dh.gov.uk/dr\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_111353.pdf](http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111353.pdf)

<sup>13</sup> <http://www.nice.org.uk/nicemedia/live/11671/41268/41268.pdf>

<sup>14</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_114774](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114774)

<sup>15</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh\\_103146](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146)

<sup>16</sup> <http://www.nhs.uk/nhsengland/NSF/pages/Nationalserviceframeworks.aspx>

Guidance has been issued by the National Institute of Clinical and Public Health Effectiveness (NICE) on a wide range of topics.<sup>17</sup> Key areas of relevance to the Older People JSNA are smoking cessation, physical activity, mental wellbeing, and screening for risk of cardiovascular disease.

NICE has recently published Quality Standards<sup>18</sup> on stroke, dementia, and prevention of venous thromboembolism (an important cause of death and morbidity in hospitalised patients) and more are due to follow this year on chronic obstructive pulmonary disease, chronic kidney disease, diabetes, end of life care, alcohol dependence, glaucoma, breast cancer and chronic heart failure.

**Figure 1: Under Pressure. Audit Commission, 2010**



Source: <http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20100218-underpressure-nationalstudy.pdf>

- If care service costs simply increase in line with population change, they could nearly double by 2026
- If current trends in means-testing and self-funding continue, private spending on social care would increase from £5 billion to £23 billion
- Carers over 60 provide care worth twice public spending on care services for older people
- The biggest single financial impact will be on social care spending
- There are big differences in care costs – some councils spend three times more than the average per person on some services
- Small investments in services such as housing and leisure can reduce or delay care costs and improve wellbeing

<sup>17</sup> <http://www.nice.org.uk/Guidance/Topic>

<sup>18</sup> <http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp>

**Figure 2: Preventive Social Care. Is it cost effective? Kings Fund 2006**



- There is little quantified information of the effectiveness of preventive services
- Available cost-effectiveness analyses are often small scale and not comparable with other studies
- It is often not clear quantitatively or qualitatively what element(s) of a reportedly successful service elsewhere have contributed to its success and could be potentially replicated
- “Measuring the effectiveness of community services (eg improved public transport) has seemingly proved too complex”
- Although the benefits are difficult to quantify, low level interventions provided informally, and by all sectors, are highly valued

Source: [http://www.kingsfund.org.uk/publications/appendices\\_to.html](http://www.kingsfund.org.uk/publications/appendices_to.html)

**Figure 3: ‘The billion dollar question’: embedding prevention in older people’s services – 10 ‘high impact’ changes HSMC, 2010**

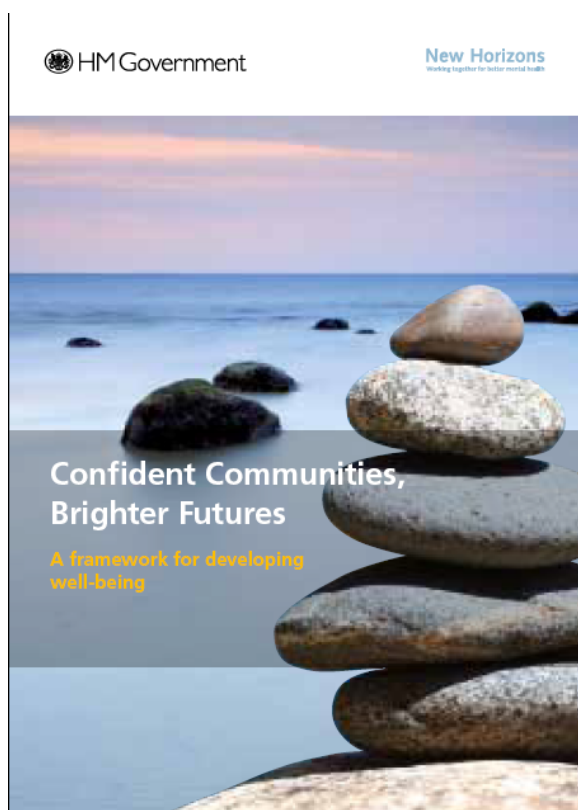


This paper draws on Interlinks, an EU review of prevention and long term care in older people’s services across 14 European countries and *The case of adult social care reform - the wider social and economic benefits*<sup>19</sup> and finds evidence to invest in:

- Healthy life styles
- Vaccination
- Screening
- Falls prevention
- Adaptations/practical support
- Telecare
- Intermediate care
- Re-ablement
- Partnership working
- Personalisation

Source: <http://www.hsmc.bham.ac.uk/publications/policy-papers/policy-paper-eight.pdf>

**Figure 4: Confident Communities, Brighter Futures, Department of Health, 2010**



Source:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_114774](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114774)

- Age-related decline in mental wellbeing should not be viewed as an inevitable part of ageing
- The factors affecting mental health and wellbeing in older people are the same as in the general population
- To promote the wellbeing of older people:
  - psychosocial interventions, high social support before and during adversity, prevention of social isolation, multi-agency response to prevent elder abuse, walking and physical activity programmes, learning, volunteering.
- To reduce prevalence of depression:
  - early intervention
  - target prevention in high risk groups
- For dementia:
  - exercise
  - anti-hypertensive treatment

## 1.5 Current activity and services

- Around 85% of older people do not access social care services.<sup>20</sup>
- Most support is provided informally by networks of family and friends.
- A small number of people require intensive health and social care services. The need for health and social care is not distributed equally among older people.
- ❖ Priority areas of activity in Cambridgeshire:
  - Prevention of ill health and promotion of good health
  - Supporting older people with health and social care needs to live in a community setting
    - Increasing support to carers
    - Extracare housing
    - Assistive technology
    - Re-ablement
    - Falls prevention
  - Prevention and treatment of stroke
  - Prevention and treatment of chronic obstructive pulmonary disease

<sup>20</sup>

<http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditComsmissionReports/NationalStudies/DontStopMeNow17July08REP.pdf>

- Promotion of good mental health and management of poor mental health including dementia
- End of life care

#### **1.6 What is this telling us? Is this section meant to be blank (1.6?)**

#### **1.7 What are the key inequalities?**

- ❖ Although life expectancy at age 65 in Cambridgeshire is higher than the national average, there remains a consistent gap of one to two years between the most deprived 20% of the population and everyone else.
- ❖ Although a third of Cambridgeshire's older people are among the 20% most wealthy of the country, seven small areas of the county include some of the 20% most deprived in which 30-40% older people are in receipt of income-related benefits.
- ❖ While data are routinely collected on the age at which people receive services, measures of health and wellbeing at different ages are less well recorded, which means that the inequalities among older people and inequalities among different age groups may be overlooked.

#### **1.8 What are the key gaps in knowledge and services?**

- ❖ The Strategic Housing Market Assessment team has proposed a specific project to examine the housing needs of older people in Cambridgeshire. This JSNA supports the need for this work.
- ❖ Local access and transport issues have been well researched. These local studies should be reviewed and synthesised to ensure they are considered in the development of new services.
- ❖ The development of new strategies for older people should address how to engage older people in service development, in activities to promote and maintain good health, and how to tackle the challenge of social isolation.

#### **1.9 Is what we are doing working?**

- ❖ Cambridgeshire has recognised the changing housing needs of the older population and invested in Extra care housing to support people to remain living in a community setting. Three new schemes are in development and there are plans for one new scheme per year for the next five years. Each scheme provides health, social care and leisure facilities for the wider community.
- ❖ Cambridgeshire has provided homecare services to help older people to remain living in their own homes.
- ❖ With an increasing plurality of service providers, the need to provide accurate information to support informed decision making is increasing.
- ❖ Despite concerted efforts and success in some areas, inequalities among older people continue to exist. Reduction of inequalities remains a high priority across Cambridgeshire.
- ❖ We should collect more information on the health and wellbeing of the population in different age groups to ensure older people have equal access to preventive programmes and care services.

## 1.10 Recommendations

- ❖ Promote the message that stopping smoking, sensible alcohol consumption, healthy eating and physical activity have health benefits even at older ages.
- ❖ Hold a multiagency conference to agree and take forward the future approach to the development of key services to meet the range of needs of people with dementia in Cambridgeshire.
- ❖ Re-examine the access to and availability of health and social care services (including the third sector), in the light of changes to health and social care.
- ❖ Develop active partnerships with older people in pathway redesign and decision-making for long term conditions using outcome-based measures that reflect patient experience.
- ❖ Comply with the requirements of the national Carers' Strategy as identified by the Joint Carers' strategy for Cambridgeshire.
- ❖ In future needs assessments, explicitly consider the needs of older people as a specific group eg among prisoners, Travellers.

## 2 Introduction

### 2.1 What is a JSNA?

A Joint Strategic Needs Assessment (JSNA) identifies the needs and service requirements that are most relevant and important to a defined population. It brings together existing information of all types and from a range of different sources to summarise the current picture. The data include routine data from national organisations such as the Office of National Statistics, routine health data such as the number of hospital admissions for stroke, routine social care data such as the number of people assessed for community care, local specially commissioned surveys of the general population such as the regional lifestyle survey<sup>21</sup>, local surveys of service users and of citizens such as the Place Survey.<sup>22</sup> Through involving representatives of different stakeholders in the population served and the providers of services such as health and social care, the JSNA provides a comprehensive summary of what is currently known about the needs of a population, and the services it receives.

The Joint Strategic Needs Assessment and evidence of best practice provides a solid basis to inform decisions on how best to provide for the needs of the local population within the national policy framework.

### 2.2 Purpose of this JSNA

This JSNA describes the needs and services of older people in Cambridgeshire and highlights the available evidence and best practice on effective and cost-effective services. Following this, the JSNA will make recommendations to guide commissioning priorities, planning decisions and market development.

The first Cambridgeshire Older People JSNA published in January 2008 emphasised the requirement of service providers to realign their efforts from treating ill health towards an agenda that is about promoting quality of life, independence and wellbeing, addressing ageism and social isolation and recognising older people as valued citizens in society, highlighting the importance of preventative services to enable people to remain independent. Two years' later, prevention rather than cure remains the central theme. The 2010 JSNA builds on the work of the 2008 JSNA, revising and adding to the knowledge base, and concentrates particularly on dementia for which a national strategy was published in 2009.<sup>23</sup>

The JSNA focuses on people living in Cambridgeshire aged 65 and over. The needs of people in this group vary greatly according to age, health, and socio-economic status. As such a diverse group, the needs of Older People are often similar to the needs of the wider population. The JSNA sets out to highlight areas specific to older people and identify groups of special need and inequalities where they exist to underpin the reduction of inequalities through tailored services. It sets out to highlight where data are sparse eg on ethnic group, faith and where data are needed to establish whether what we are doing is working.

Each section makes reference to external reports and to more detailed information and includes publicly accessible web links to these sources where possible. The population of Cambridgeshire as a whole is described in the JSNA Summary 2010.

<sup>21</sup> <http://www.erpho.org.uk/lsr/lsr.aspx>

<sup>22</sup> <http://www.cambridgeshire.gov.uk/business/research/consultations/placesurvey.htm>

<sup>23</sup> Living well with dementia – a national dementia strategy. Department of Health, England, 2009. [http://www.dementia.dh.gov.uk/library/downloads/DH\\_094051.pdf](http://www.dementia.dh.gov.uk/library/downloads/DH_094051.pdf)



## 2.3 Policy context

National policy is currently under review but the broad direction of travel has been set out in July 2010 in the White Paper *Equity and excellence: liberating the NHS*.<sup>24</sup>

- Integration of local NHS services, social care and health improvement
- Emphasis on improving public health, tackling health inequalities and reforming adult social care
- Encouraging prevention
- Increased use of technology
- Increased use of personal health budgets
- Implementation of the ban on age discrimination in NHS services and social care from 2012

The draft structural reform plan<sup>25</sup> for the Department of Health published 12 July 2010 identifies the following areas of relevance to an ageing population:

- Review of hospice funding.
- Promotion of patient-held records.
- A ring-fenced cancer drugs fund.
- Greater access to talking therapies.
- Prioritisation of dementia research.
- Funding reform of social care system.
- Increased roll-out of personal health budgets.
- A re-focused carers' strategy.

The Operating Framework for the NHS in England for 2010/11,<sup>26</sup> published in December 2009, set out the following five priorities:

- Improving cleanliness and reducing healthcare associated infections.
- Improving access through achievement of the 18-week referral to treatment pledge and improving access (including at evenings and weekends) to GP services.
- Keeping adults and children well, improving their health and reducing health inequalities.
  - Emphasis on stroke (more people receiving an early brain scan after hospital admission, greater investigation of transient ischaemic attacks) and cancer (extending the breast and bowel cancer programmes to people at older ages).
- Improving patient experience, staff satisfaction, and engagement.
- Preparing to respond in a state of emergency such as an outbreak of pandemic flu, learning from our experience of swine flu.

In the Revision to the Operating Framework for the NHS in England for 2010/11 published in June 2010, implementation of the National Dementia Strategy was given additional emphasis,<sup>27</sup> and a revised implementation plan for the Strategy was published in September 2010<sup>28</sup>

<sup>24</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117794.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf)  
<sup>25</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117370.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117370.pdf)

<sup>26</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh\\_110159.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_110159.pdf)

<sup>27</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_103136.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103136.pdf)

<sup>28</sup> [http://www.dementia.dh.gov.uk/library/WEB\\_VERSION\\_-\\_FINAL\\_-\\_Refresh\\_Implementation\\_Plan\\_27.pdf](http://www.dementia.dh.gov.uk/library/WEB_VERSION_-_FINAL_-_Refresh_Implementation_Plan_27.pdf)



This emphasises that that while the Strategy should be implemented full, the immediate priority objectives are:

- good-quality early diagnosis and intervention for all
- improved quality of care in general hospitals
- living well with dementia in care homes
- reduced use of antipsychotic medication.

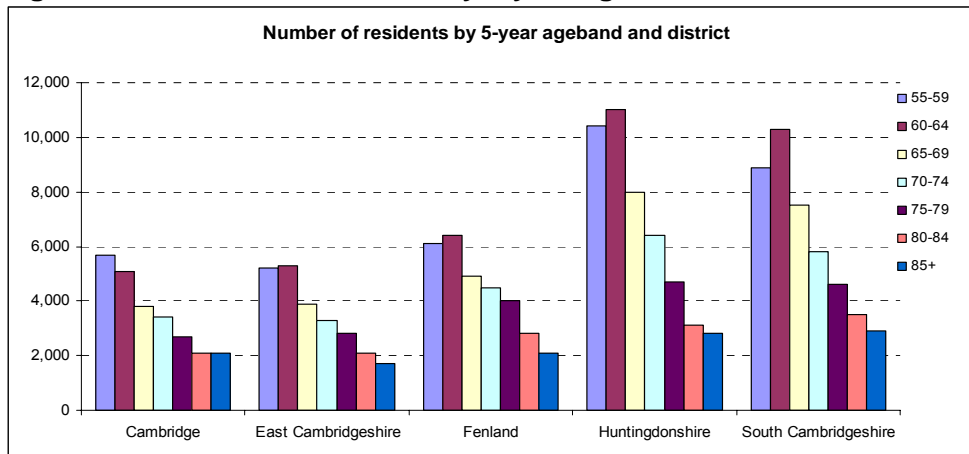
Further details of the developing national policy on dementia are available here <http://www.dementia.dh.gov.uk>.

### 3 Demography

#### 3.1 Current resident population of Cambridgeshire

In Cambridgeshire in 2009, there were 95,500 people aged 65 or over (almost 16% of all residents), 44,000 people aged 75 or over (7% residents), and 11,600 people aged 85 and over (2% residents). Overall, this is similar to the national picture but there is variation within Cambridgeshire (Figure 5, Table 1). The district with the greatest number of older residents is Huntingdonshire. The proportion of the population aged 65 and over ranges from 11.8% in Cambridge to 19.6% in Fenland (Figure 6).

**Figure 5: Number of residents by 5-year age band and district**



Source:

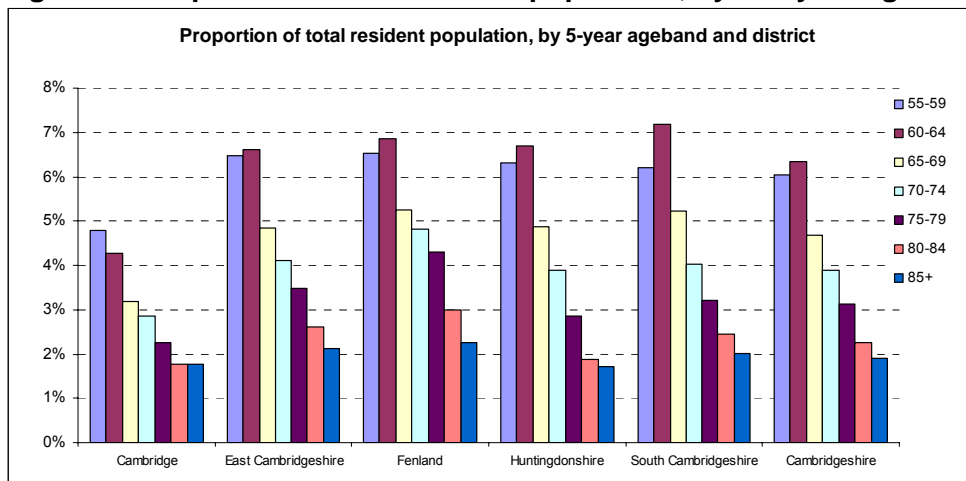
**Table 1**

	55-59	60-64	65-69	70-74	75-79	80-84	85+
Cambridge	5,700	5,100	3,800	3,400	2,700	2,100	2,100
East Cambs	5,200	5,300	3,900	3,300	2,800	2,100	1,700
Fenland	6,100	6,400	4,900	4,500	4,000	2,800	2,100
Huntingdonshire	10,400	11,000	8,000	6,400	4,700	3,100	2,800
South Cambs	8,900	10,300	7,500	5,800	4,600	3,500	2,900
Cambridgeshire	36,300	38,100	28,100	23,400	18,800	13,600	11,500

Source:

Resident population data are collected as part of the national census undertaken every ten years and population estimates for subsequent years are published routinely by the Office of National Statistics [www.statistics.gov.uk](http://www.statistics.gov.uk). Cambridgeshire County Council [www.cambridgeshire.gov.uk](http://www.cambridgeshire.gov.uk) produces annual population estimates for parishes, wards and settlements within Cambridgeshire.

**Figure 6: Proportion of total resident population, by five year age band and district**



Source:

### 3.2 Registered and resident population

NHS Cambridgeshire is responsible for people who are registered with a Cambridgeshire general practitioner and people who are resident within the county boundary but not registered with a GP. The resident and registered populations of Cambridgeshire therefore differ. The registered population is larger than the resident in Cambridge City and in Fenland but in all other areas, the resident population exceeds the registered population due to people being registered with GPs in other PCTs.

For a detailed discussion of the difference between the registered and resident population of Cambridgeshire, see 2008 JSNA Older People.<sup>29</sup>

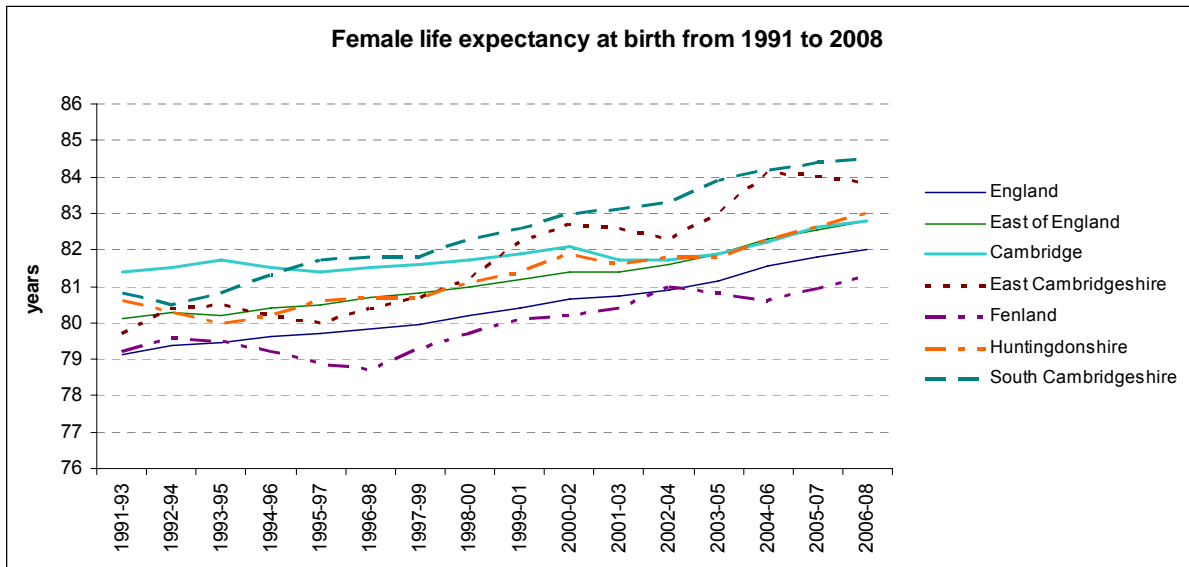
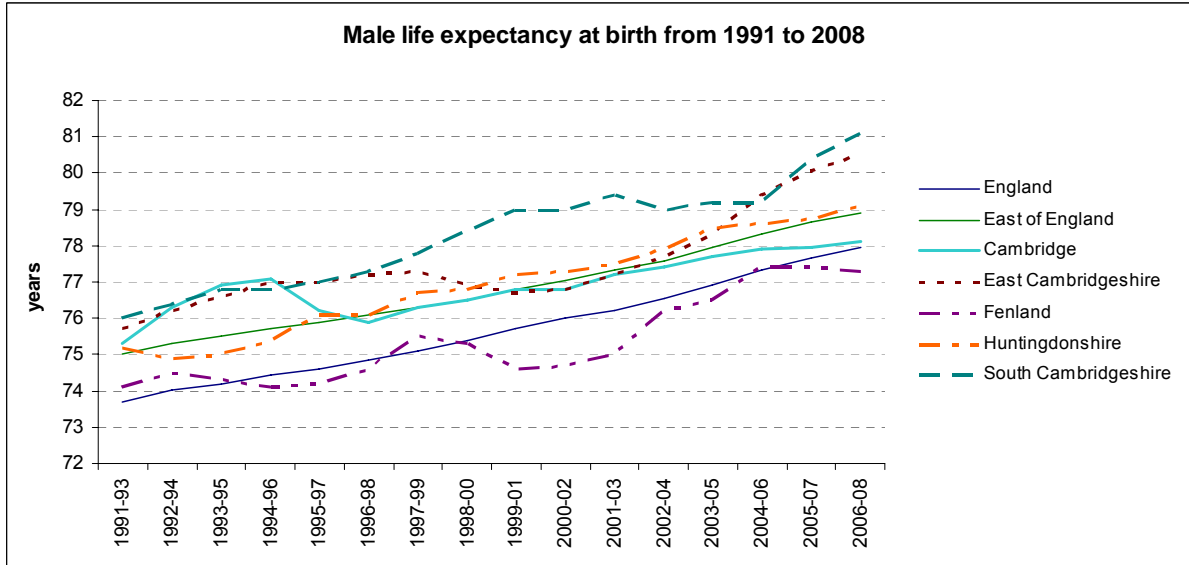
### 3.3 Life expectancy

People in Cambridgeshire are living longer (Figure 7). Between 1991/03 and 2006/08, life expectancy at birth has consistently increased across the county for both males (to around 78 years of age) and females (to around 82 years of age). Increasing life expectancy means that older people are an increasing proportion of our population and this trend is set to continue (Figure 8). Generally, life expectancy in Cambridgeshire is better than the national average. The gender gap has narrowed slightly over time but differences in life expectancy in different parts of the county have remained consistent.

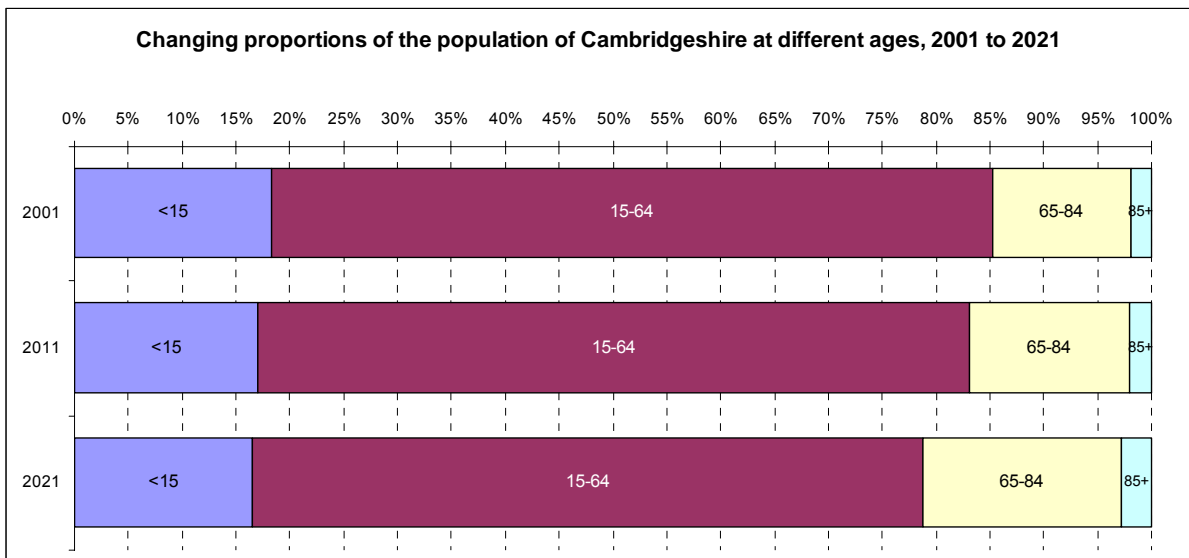
Life expectancy at 65 has also increased (Figure 9) to more than 17 years for men and 20 for women, ie mortality in older people is lower in 2008 than in 1991.

<sup>29</sup> <http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/JSNAs/Older%20Peoples%20JSNA.pdf>

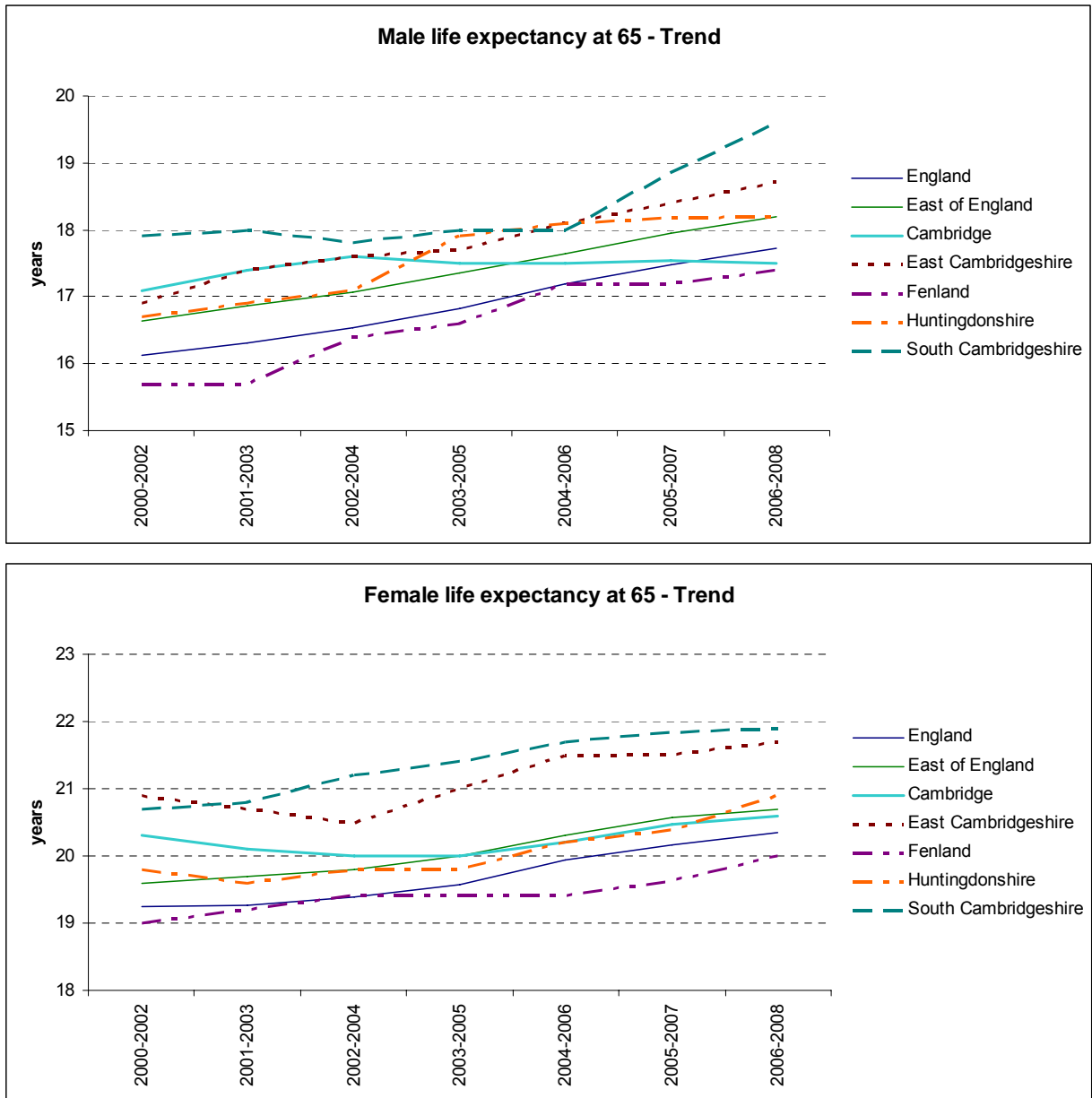
**Figure 7: Male and female life expectancy at birth from 1991-2008**



**Figure 8: Changing proportions of the population of Cambridgeshire at different ages, 2001-2021**



**Figure 9: Male and female life expectancy at 65 - trend**



While the length of time we can expect to live has increased, the period we can expect to live with long term illness and disability has also increased. Periods of life spent in poor health or with a limiting chronic illness or disability have increased by more than two years in the period 1981-2006. The most recent figures<sup>30</sup> indicate that English males aged 65 can expect to spend 4.4 years of their life in poor health; and English females 5.4. In 1981, males at birth could expect to spend 6.4 years of their life in poor health; but this had risen to 8.7 years in 2006. For females these figures were 10.1 and 11 years respectively. Similarly, periods of life with a limiting chronic illness or disability rose from 12.8 years in 1981 to 14.6 years in 2006 for males and from 16.0 to 17.7 years for females.<sup>31</sup>

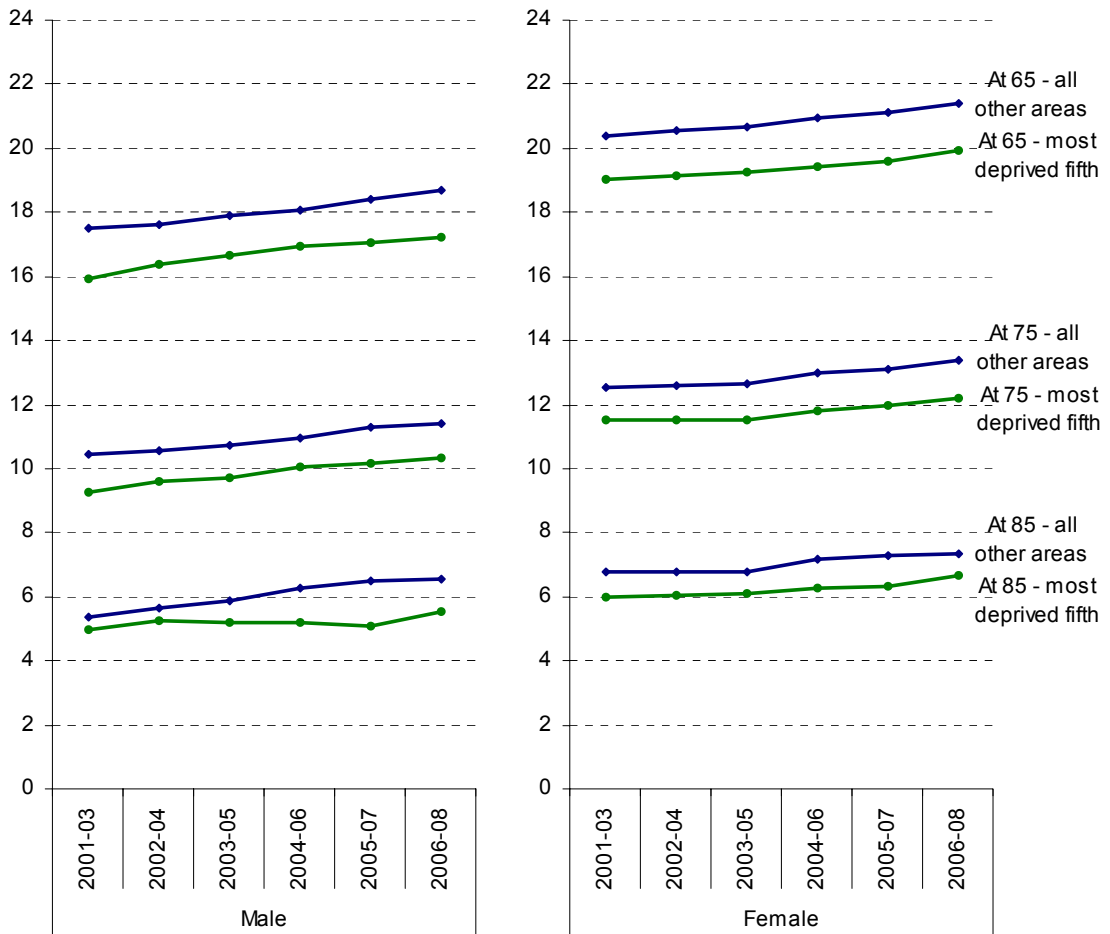
Even excluding the poorest 5% and the richest 5%, however, the gap in life expectancy between those of low and high income is greater than the overall increase in life expectancy over the last 25 years. The less well off die on average six years earlier, and spend 13 years more years living with disability.<sup>32</sup>

<sup>30</sup> [http://www.statistics.gov.uk/downloads/theme\\_health/Health-Expectancies-2000-2007\\_submitted.xls](http://www.statistics.gov.uk/downloads/theme_health/Health-Expectancies-2000-2007_submitted.xls)

<sup>31</sup> <http://www.statistics.gov.uk/cci/nugget.asp?id=934>

<sup>32</sup> <http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf>

**Figure 10: Inequalities in life expectancy (years) at older ages in Cambridgeshire**



Life expectancy data are published by various sources using routine data on age at death. Life expectancy at birth is strongly influenced by rates of infant mortality. Life expectancy cannot be calculated precisely for small areas but Figure 10 shows that despite improvements in health, and in life expectancy, clear differences even within Cambridgeshire between the most deprived residents and everyone else.

### 3.4 Future population change

The following section describes forecasts of the population aged over 65, from a 2005 base through to 2021 (Table 2).

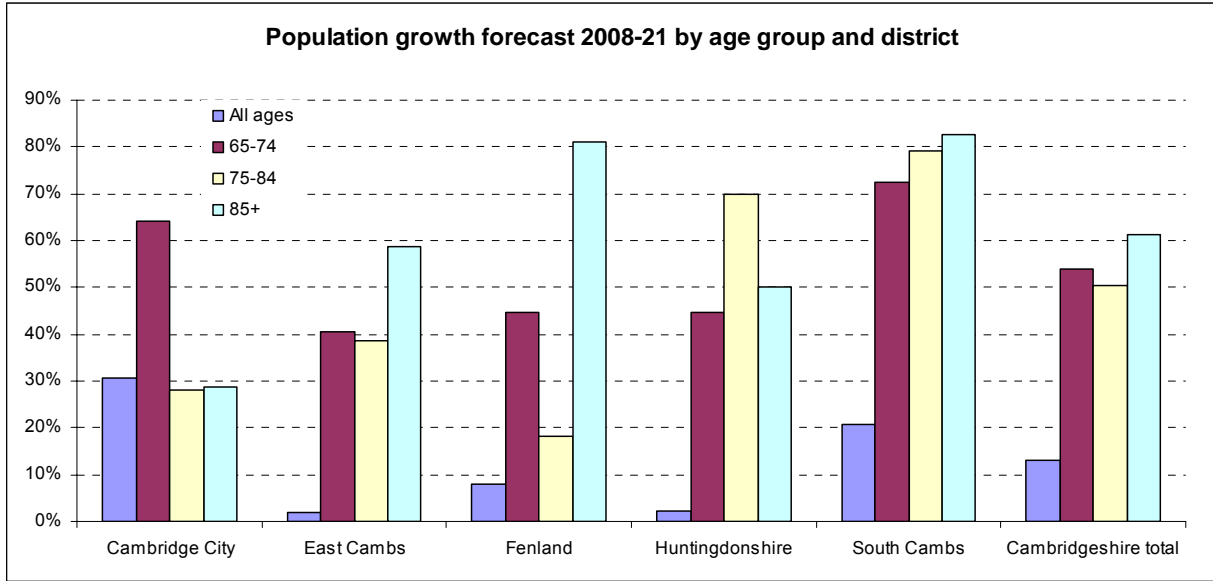
**Table 2: Local authority population forecasts by age, 2006-2021**

		2006	2011	2016	2021	% change
Cambridgeshire County Council	45-64	145,800	162,100	169,700	173,200	19%
	65-74	45,900	56,800	70,800	75,600	65%
	75-84	31,100	33,700	38,500	47,800	54%
	85+	11,100	12,500	14,900	17,400	57%
	Population of all ages	579,000	622,700	653,300	669,400	16%
	Population aged 65+	88,100	103,000	124,200	140,800	60%
% population aged 65+		15%	17%	19%	21%	
Cambridge City Council	45-64	21,400	24,800	27,300	27,300	28%
	65-74	6,600	8,000	10,100	11,400	73%
	75-84	5,100	5,000	5,300	6,400	25%
	85+	2,100	2,200	2,300	2,400	14%
	Total	113,800	131,700	147,700	149,400	31%
	Population aged 65+	13,800	15,200	17,700	20,200	46%
% population aged 65+		12%	12%	12%	14%	
East Cambridgeshire District Council	45-64	20,000	22,800	24,100	24,300	22%
	65-74	6,600	7,800	9,400	10,100	53%
	75-84	4,600	5,000	5,800	6,800	48%
	85+	1,500	1,800	2,100	2,500	67%
	Total	76,400	80,700	82,200	81,300	6%
	Population aged 65+	12,700	14,600	17,300	19,400	53%
% population aged 65+		17%	18%	21%	24%	
Fenland District Council	45-64	23,000	25,600	27,000	27,900	21%
	65-74	9,100	9,900	12,100	13,400	47%
	75-84	6,400	6,800	6,800	7,700	20%
	85+	1,900	2,300	3,100	3,500	84%
	Total	89,800	91,700	95,400	99,700	11%
	Population aged 65+	17,400	19,000	22,000	24,600	41%
% population aged 65+		19%	21%	23%	25%	
Huntingdonshire District Council	45-64	43,700	47,300	47,900	48,000	10%
	65-74	12,500	15,800	19,200	19,300	54%
	75-84	7,500	8,300	10,100	12,900	72%
	85+	2,700	3,100	3,600	4,300	59%
	Total	160,800	168,200	166,000	166,300	3%
	Population aged 65+	22,700	27,200	32,900	36,500	61%
% population aged 65+		14%	16%	20%	22%	
South Cambridgeshire District Council	45-64	37,700	41,600	43,400	45,700	21%
	65-74	11,100	15,300	20,000	21,400	93%
	75-84	7,500	8,600	10,500	14,000	87%
	85+	2,900	3,100	3,800	4,700	62%
	Total	138,200	150,400	162,000	172,700	25%
	Population aged 65+	21,500	27,000	34,300	40,100	87%
% population aged 65+		16%	18%	21%	23%	

Source: <http://www.cambridgeshire.gov.uk/business/research/>

Figure 11 shows the relative population change, by locality, for the total population and the population aged over 65 by age band. The greatest relative population change overall is seen in South Cambridgeshire and Cambridge City. In South Cambridgeshire this growth includes major increases in the population aged over 65. In contrast, Cambridge City shows very slight increases in the populations aged 65 to 74 and 85+, along with a decline in the population aged 75-84. Each locality, apart from Cambridge City, is forecast to show marked population growth among older people. While Huntingdonshire is forecast to show only a 3% rise in the total population, the population aged 85+ is forecast to rise by 59%.

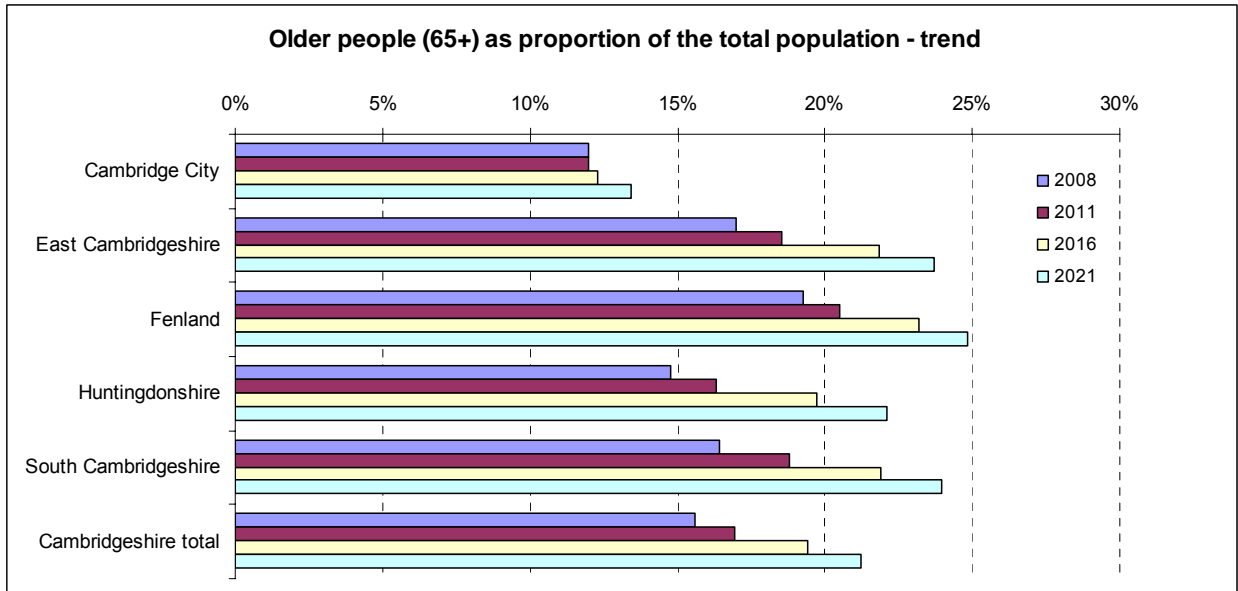
**Figure 11: Population growth forecast 2008-21 by age group and district**



Source: <http://www.cambridgeshire.gov.uk/business/research/>

Figure 12 shows that in all localities apart from Cambridge City, the proportion of the population composed of people aged over 65 is forecast to rise steadily to 2021. This increase is particularly fast in Huntingdonshire. Throughout the forecast period, the population aged over 65 makes up the highest proportion of the total population in East Cambridgeshire and Fenland. In Cambridge City the proportion of the population aged over 65 is forecast to decline to 10% by 2021.

**Figure 12: Older people (65+) as proportion of the total population - trend**



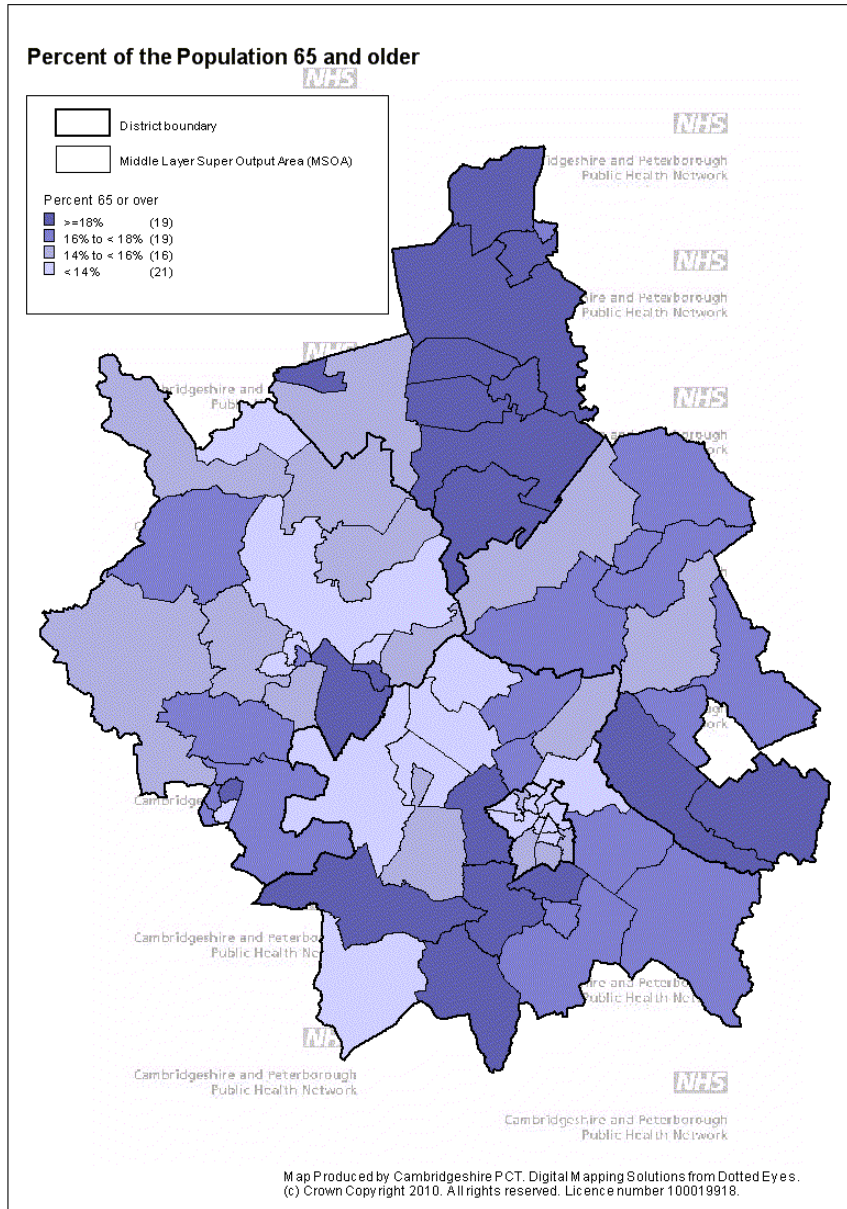
Source: <http://www.cambridgeshire.gov.uk/business/research/>



### 3.5 Area of residence

Figure 13 shows that older people comprise more of the population in rural areas than urban.

**Figure 13: Percent of the population 65 and older**



Cambridgeshire is comprised of five districts – Cambridge, East Cambridgeshire, Fenland, Huntingdonshire, and South Cambridgeshire. These districts can be further subdivided into wards and again into ‘output areas’. Output areas were designed to have similar population sizes and to be as socially homogenous as possible. Urban/rural mixes were avoided where possible and the areas are constrained by obvious boundaries such as major roads. Most output areas consist of about 125 households and we have a total of 1,820 in Cambridgeshire.

These output areas have been classified in attempt to broadly describe the population that lives there (Table 3). Approximately 1% of the population is described as ‘Senior Communities Constrained by Circumstance’.

**Table 3**

Output Area Classification		Number of Output Areas in Cams	% output areas (approximates % population)
Blue Collar Workers	Terraced Blue Collar	17	0.9
	Younger Blue Collar	59	3.2
	Older Blue Collar	142	7.8
City Living	Settled in the City	111	6.1
	Transient Communities	25	1.4
Countryside	Village Life	301	16.5
	Agricultural	112	6.2
	Accessible Countryside	148	8.1
Prospering Suburbs	Prospering Younger Families	124	6.8
	Prospering Older Families	130	7.1
	Prospering Semis	69	3.8
	Thriving Suburbs	68	3.7
Constrained by circumstance	Senior Communities	14	0.8
	Older Workers	92	5.1
	Public Housing	6	0.3
Typical traits	Settled Households	71	3.9
	Least Divergent	169	9.3
	Young Families in Terraced Homes	29	1.6
	Aspiring Households	98	5.4
Multicultural	Asian Communities	32	1.8
	Afro-Caribbean communities	3	0.2
TOTAL		1820	100

Source: <http://www.cambridgeshire.gov.uk/NR/rdonlyres/77541B70-C6A0-4ED1-8945-5BBFB205CF01/0/PlaceSurveyOACAnalysis.pdf>

### 3.6 Ethnicity

The estimates of older people in each ethnic group are described as ‘experimental’ by the Office of National Statistics but they show (Table 4) that the number of Black and Minority Ethnic group (BME) older people is thought to have risen slightly since 2001 while remaining low, comprise only around 2% of the total population.

There is some variation across the county with more older people in Cambridge belonging to a BME group than elsewhere.

**Table 4: Post-working age population (women 60+, men 65+) by ethnic group, numbers and proportion of total population in this age group**

	Cambridgeshire			Cam bridge	East Cambs	Fen land	Hunts	South Cambs	East of England	England
	2001	2004	2007	2007	2007	2007	2007	2007	2007	2007
	White: British	90,900	96,100	102,200	14,400	15,500	20,300	27,500	24,500	1,052,800
White: Irish	1,100	1,400	1,500	300	200	200	500	300	21,800	206,100
White: Other	2,000	2,400	2,800	900	300	300	700	600	22,700	188,700
Mixed	200	200	200	100	-	-	100	-	2,900	28,300
Asian or Asian British	500	600	900	300	100	100	200	200	14,700	208,500
Black or Black British	100	300	500	100	-	100	200	100	8,500	123,800
Chinese or Other Ethnic Group	200	300	500	200	100	-	100	100	3,700	39,100
<b>Total</b>	<b>95,000</b>	<b>101,300</b>	<b>108,600</b>	<b>16,300</b>	<b>16,200</b>	<b>21,000</b>	<b>29,300</b>	<b>25,800</b>	<b>1,127,100</b>	<b>9,644,500</b>

White: British	95.7%	94.9%	94.1%	88.3%	95.7%	96.7%	93.9%	95.0%	93.4%	91.8%
White: Irish	1.2%	1.4%	1.4%	1.8%	1.2%	1.0%	1.7%	1.2%	1.9%	2.1%
White: Other	2.1%	2.4%	2.6%	5.5%	1.9%	1.4%	2.4%	2.3%	2.0%	2.0%
Mixed	0.2%	0.2%	0.2%	0.6%			0.3%		0.3%	0.3%
Asian or Asian British	0.5%	0.6%	0.8%	1.8%	0.6%	0.5%	0.7%	0.8%	1.3%	2.2%
Black or Black British	0.1%	0.3%	0.5%	0.6%		0.5%	0.7%	0.4%	0.8%	1.3%
Chinese or Other Ethnic Group	0.2%	0.3%	0.5%	1.2%	0.6%		0.3%	0.4%	0.3%	0.4%

Source: Resident Population Estimates by Ethnic Group, All Persons, 2001, 2004 and 2007

Ethnic group is not routinely recorded in many health and social care datasets so information relies heavily on the national census, supplemented with ad hoc surveys and research.

### 3.7 Travellers

Cambridgeshire has one of the largest Gypsy and traveller populations in the United Kingdom. A JSNA focusing specifically on travellers will be published in 2010.

Older people from Gypsy and Traveller communities face potentially severe social exclusion and vulnerability in several respects:<sup>33</sup>

- much lower life expectancy than the national average,
- low percentage of Gypsies and Travellers aged over 50 in paid employment,
- low likelihood of entitlement to full pension,
- low levels of literacy,
- lack of awareness of entitlements to state benefits,
- complex issues around accommodation policies and planning permission which make it difficult for older people to settle on authorised sites with other family members or with carers,
- barriers in accessing health and social care services,
- discrimination and negative attitudes towards Gypsy and Traveller communities,
- lack of cultural awareness, sensitivity and appropriate outreach methods by housing, health and social care professionals.

### 3.8 Prison population

There is good evidence that prisoners experience significantly poorer health than the rest of the population. Amongst the national prison population there are very high rates of diagnosed mental health and substance misuse problems, a high prevalence of smoking, and of hepatitis B and C infection secondary to injecting drug use. Older prisoners are less healthy than younger prisoners and less healthy than their contemporaries outside prison.<sup>34</sup> Over half of all older prisoners are reported to suffer from a mental illness, the most common being depression which can emerge as a result of imprisonment. Older prisoners are more likely to be serving longer prison sentences due to the nature of their offences, hence they account for a larger proportion of the prison population than numbers received into prison. Prisoners aged over 60 are the fastest growing age group in prison both because they are more likely to be sentenced to imprisonment than before, and because longer sentences are being imposed.<sup>35</sup> The proportion of people aged 65 and over is projected to increase from 16% of the population in 2006, to 22% by 2031.<sup>36</sup> While health services are reported to have improved since primary care trust became responsible in 2006, in 2008 the Prison Reform Trust found that access to social services inside prison and on release was sometimes poor.<sup>37</sup> Family relationships may suffer because the close family members of older prisoners are often older themselves and find it more difficult to visit prisoners who are often accommodated some distance from home. The National Offender Management Service recognises that the needs of older people are often not met.<sup>38</sup>

Cambridgeshire has two prisons – HMP Whitemoor and HMP Littlehey. In 2010, they had a capacity to hold 993 and 448 men respectively. In the last quarter of 2010/11, both were rated as ‘good’ by the Ministry of Justice.<sup>39</sup> More detailed reports on their performance are published.<sup>40</sup>

A health needs assessment for each Cambridgeshire prison was undertaken in 2008 and will be repeated in 2010 at which there will be the opportunity to look at the varying needs of prisoners in different age groups.

The prison health needs assessments planned for 2010 should examine the particular needs of older people. The Department of Health has produced a toolkit for this purpose.<sup>41</sup>

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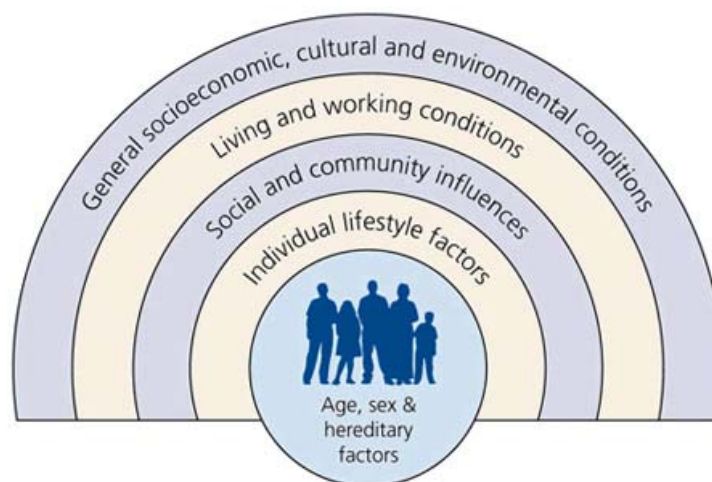
34 <http://ageing.oxfordjournals.org/cgi/reprint/30/5/403>  
 35 <http://www.prisonreformtrust.org.uk/subsection.asp?id=273>  
 36 [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_097135.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_097135.pdf)  
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 39 <http://www.justice.gov.uk/publications/docs/prison-ratings-q4-09-10.pdf>  
 40 <http://noms.justice.gov.uk/noms-regions/east-england/publications/strategy/>  
 41 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079928](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079928)

## 4 Social, economic and environmental context

The social determinants of health have been described as 'the causes of the causes'. They are the social, economic and environmental conditions that influence the health of individuals and populations. They include the conditions of daily life and the structural influences upon them. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances.

Dahlgren and Whitehead (1991) developed a model that showed how health is influenced, either positively or negatively, by a variety of factors (Figure 14).

**Figure 14**



Source:

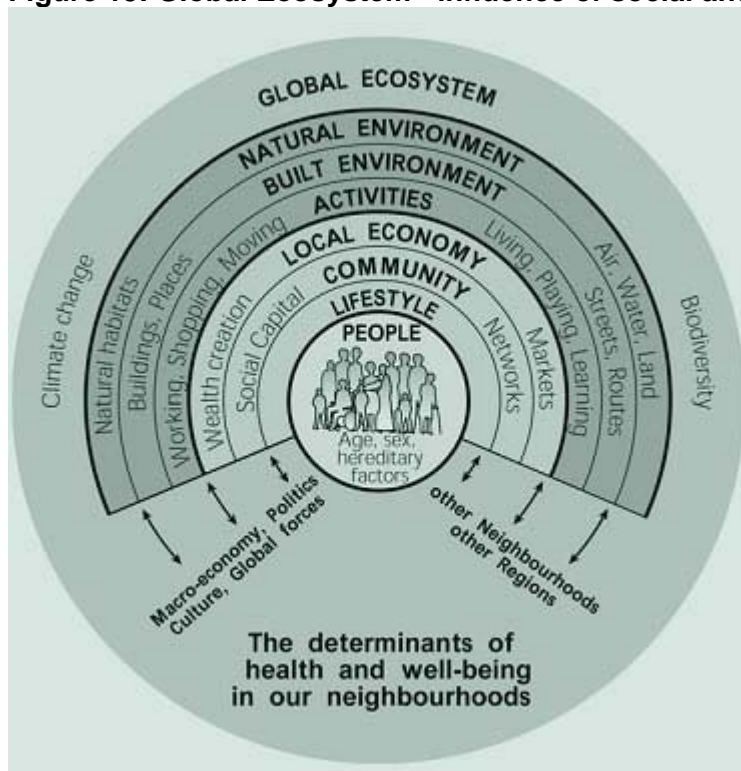
At the centre are age, sex and hereditary factors – genetic or biological and relatively fixed. However, these are nested within the wider determinants of health which arise from social, environmental and economic conditions.

These include household living conditions, conditions within communities and workplaces and healthcare, along with policies and programmes affecting any of these factors.

Such factors can either directly influence our health or can have a bearing on the lifestyle decisions we make and our ability to make such choices.

Barton and Grant (2006) have developed the Dahlgren and Whitehead model to produce the health map for the local human habitat (Figure 15).

**Figure 15: Global Ecosystem - influence of social and environmental factors on health**



The map continues to place people at the centre, but sets them within the global ecosystem which includes:

- natural environment
- built environment
- activities – such as working, shopping, playing and learning
- local economy – includes wealth creation and markets
- community – social capital and networks
- lifestyle.

The health map illustrates why the social determinants are of such relevance to local government. The majority of local government services impact upon or can influence the conditions in which people live and work and, to a certain extent, the life chances of individuals.

Looking at the social determinants of health emphasises the point that health is not just affected by health care and health services (ie the domain of the NHS) but also by the many other factors, many of which can be influenced by the activities of local government. As a planning authority, for example, local government can do a great deal to plan for healthy environments. Not just those which promote physical activity but also promote mental wellbeing by including green space and opportunities to interact with others. Provision of leisure and culture services, and housing, for example, also have the potential to influence health.

A Healthy Communities JSNA is being published in 2010 and many of the aspects it describes influence the health of Older People. The JSNA for Older People 2010 focuses on aspects of relevance to Older People (**see section 'Views of Older People'**): income, housing, access and transport, and access to information.



The relationship between income and health is well established across many measures of health and wellbeing. Income affects access to healthy food, activities, leisure and many other social and environmental activities related to health. Income in retirement may be fixed. Some aspects of housing<sup>42</sup> have been found to have a direct relationship with physical and mental health and wellbeing eg damp, central heating, stairs, access to services; but type of housing is also important with an increasing number of older people requiring the types of housing not currently available eg single occupancy, Extra care. Transport and access to services are important across the population but have particular relevance to older people who are more likely to rely on public transport, to an increased need for health and social services. Access to information is important in order to be able to claim entitlements, to benefit from services and to make informed choices. Increasingly, information and communication use electronic media, which are quick and inexpensive to update, but require computers and computer skills for access.

#### 4.1 Wealth and income

The English Longitudinal Survey of Ageing (ELSA)<sup>43</sup> which repeatedly surveys a sample of people who were aged 50 and over in 2002 points out that reaching pension age does not itself lead to poverty. It found that poverty of income is related to:

- Being single - single individuals are more likely to be in income poverty (less than 60% of the median family income) than people in couples, with women who are divorced, separated or widowed having the highest risk of income poverty
- A low level of pensions - those estimated to have accumulated relatively low levels of state and private pension rights are found to have a much greater risk of being in income poverty.
- Being out of the labour force - those who moved out of the labour force and those whose partner moved out of the labour force between 2002–03 and 2006–07 were more likely to move into income poverty in this period and less likely to move out of it.

Large increases in wealth occurred between 2002/3 and 2006/7. One-in-nine respondents to the ELSA survey in 2006/07 had estates worth more than the Inheritance Tax threshold. This occurred across all income groups but was predominantly the result of higher house prices; only 6% of the 49% increase was from non-housing sources.

##### *Paid employment*

Employment at older ages has been increasing in recent years.<sup>44</sup> In 2006/07, 3.1% of men of retirement age were in full time work and 6.3% were in part time work. By age 80, few were in employment. The proportions for women (aged 60 and over) were similar at 3.6% and 7.7% respectively. Since age at retirement is influenced by income, the proposed increases in the State Pension Age are likely to increase this further. There are many reasons for retirement from paid employment, however. Caring for unwell dependents is discussed below, but grandparents may also reduce or stop paid employment in order to contribute to child care.

##### *Benefits*

The state pension is universal and not means-tested although the amount received depends on the number of qualifying years of an individual's National Insurance contributions and

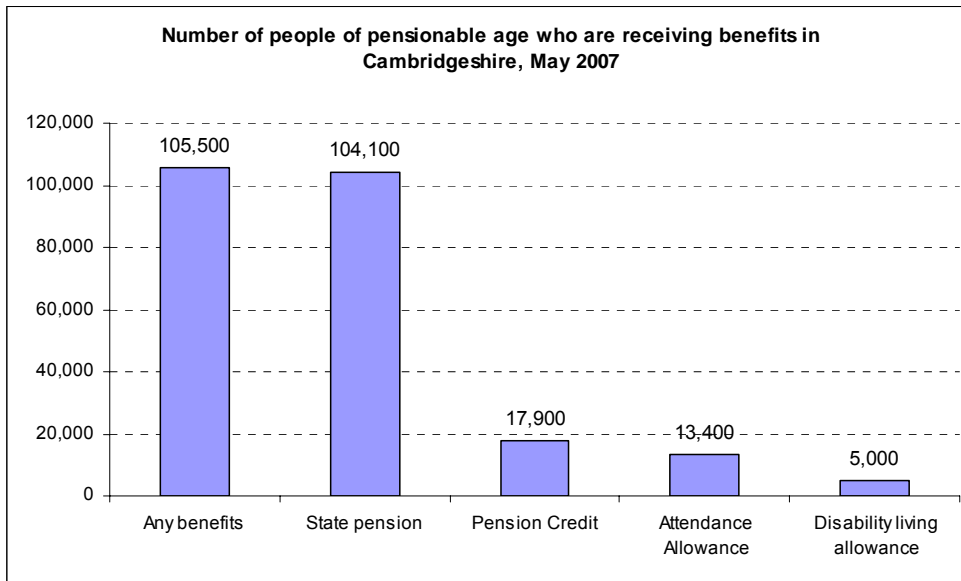
<sup>42</sup> <http://www.scotland.gov.uk/Resource/Doc/156479/0042008.pdf>

<sup>43</sup> <http://www.ifs.org.uk/elsa/>

<sup>44</sup> [http://www.ifs.org.uk/elsa/report08/elsa\\_w3.pdf](http://www.ifs.org.uk/elsa/report08/elsa_w3.pdf)

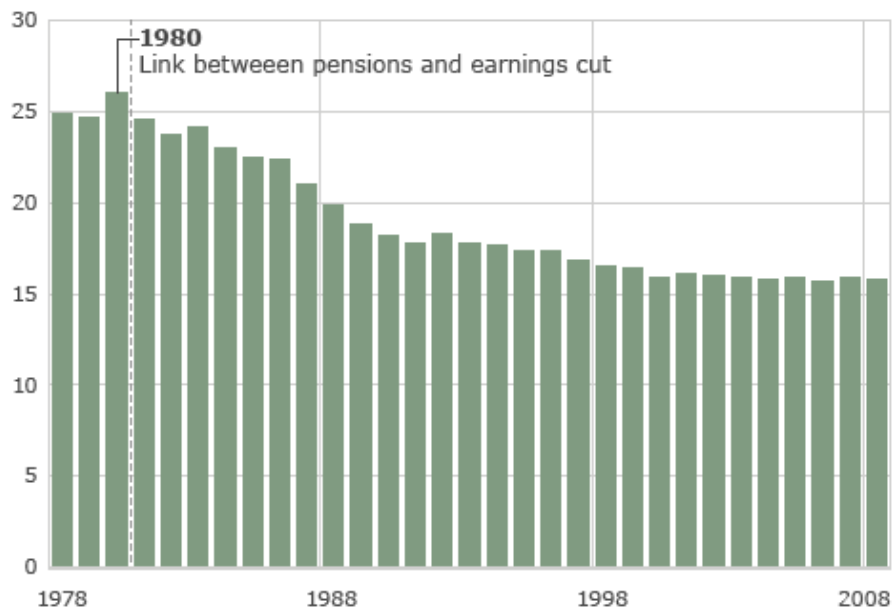
credits. Today, the state pension age for men is 65, but this is expected to rise. From 2010 the state pension age for women begins to increase from 60 until it reaches 65 in 2020. For men and women, the State Pension age will then increase from 65 to 68 between 2024 and 2046. The pension system is complicated. Additional benefits are available to pensioners on very low income, and to people with disabilities or who are carers. Figure 16 shows the number of pensioners in Cambridgeshire in 2007. Just under a fifth are claiming the pension available to those on very low incomes, which is an indicator of the number of pensioners in poverty. In 2008, 29% of pensions in Cambridgeshire were receiving state pension plus at least one other state benefit (incapacity, carer, income-related, disability or bereavement).<sup>45</sup> The ratio of the state pension to average earnings fell between 1980 and 1999 but has remained stable since then (Figure 17). Significant numbers claim attendance and disability living allowance.

**Figure 16: Number of people of pensionable age who are receiving benefits in Cambridgeshire, May 2007**



**Figure 17: How much is a state pension worth?**

% of average earnings



Source: DWP

45



Source: <http://www.bbc.co.uk/news/10406640>

### Attendance Allowance

Attendance Allowance is a benefit for people aged 65 or over who have an illness or disability and need help with personal care. To qualify, people must have needed help with personal care for at least six months. The benefit is paid at two rates, the higher rate for people who need help with personal care throughout the day and during the night, the lower rate - for people who need help with personal care throughout the day or during the night.

Table 5 shows that in 2006, 16% of people aged 65 or over claimed Attendance Allowance. This proportion was highest in East Cambridgeshire and lowest in South Cambridgeshire. All areas appear to be considerably lower than the proportion in England as a whole.

**Table 5: Number of people entitled to Attendance Allowance (AA) by age and percentage of resident population**

Local authority	65-74	75-84	85+	65+	65-74	75-84	85+	65+
England	227,700	771,480	680,100	1,679,280	5%	27%	68%	21%
Cambridge	260	990	1,160	2,410	4%	19%	55%	17%
East Cambridgeshire	280	1,020	950	2,250	4%	22%	63%	18%
Fenland	370	1,350	1,170	2,890	4%	21%	61%	17%
Huntingdonshire	450	1,500	1,470	3,420	4%	20%	55%	15%
South Cambridgeshire	310	1,330	1,500	3,140	3%	18%	52%	15%
Cambridgeshire	1,670	6,190	6,250	14,110	4%	20%	56%	16%

Source: Department of Work and Pensions. Population: CCC Mid 2006 estimates. ONS England mid 2005.

### Disability Living Allowance

Disability Living Allowance (DLA) is a benefit for children and adults who need help with personal care or have walking difficulties because they are mentally or physically disabled. This benefit contributes to the disability-related extra costs of severely disabled people. People who claim these benefits before the age of 65 can continue to receive the allowance after reaching age 65 if they continue to satisfy the entitlement conditions. As with other benefits, payments are made at different levels and for DLA there is a care component and a mobility component depending on the type of disability. Table 6 shows a higher proportion of claimants in Fenland.

**Table 6: Disability Living Allowance claimed by older people in 2009**

	any entitlement		mobility related entitlement	
	number	% of population 65+	number	% of population 65+
Cambridge	900	6.4%	700	5.0%
East Cambridgeshire	400	3.0%		
Fenland	1,400	7.8%	1,300	7.2%
Huntingdonshire	1,100	4.6%	800	3.3%
South Cambridgeshire	700	3.0%	600	2.6%
Cambridgeshire	4,600	5.0%	3,700	4.0%

Source: Department of Work and Pensions <https://www.nomisweb.co.uk/Default.asp>

## Unpaid care

Although a partner's health was not a common reason for full retirement in the ELSA study<sup>46</sup>, it was among a number of reasons for reducing paid hours, and the number of older people providing unpaid care shows both a need in the population for health and social care, and a potential for reduced income.

Definition: "A Carer spends a significant proportion of their life providing unpaid support to family or potentially friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems."<sup>47</sup>

Nationally, three in five people will become a Carer at some point in their lives, with women having a fifty-fifty chance of providing care by the time they are 59, men by the time they are 74.

Each year a third of all Carers will be new to caring. Most people take a considerable time to think of themselves as Carers, with consequent delay in accessing information and services for Carers.

The help that unpaid Carers provide nationally is valued at over 87 billion pounds / year, more than the annual cost of the NHS.<sup>48</sup> In Cambridgeshire this level of unpaid care equates to 60 to 65 million pounds/year.<sup>49</sup>

According to the 2001 Census there were more than 50,000 Unpaid Carers in Cambridgeshire, representing around 5% of the population. 13,000 of these Carers reported they were caring for more than 20 hours per week, and more than 8,000 Carers said they were caring for more than 50 hours per week (Table 7).<sup>50</sup> Unpaid Carers account for around 12% of people aged 65 and over (Table 8) including 500 people aged 85 and over (Table 9).

**Table 7: Number of people (all ages) providing unpaid care because of long term physical or mental ill health or disability or problems relating to old age by hours worked and district.**

Local Authority	Provides unpaid care	% of total population	Of those that provide care		
			1 to 19 hours	20 to 49 hours	50 or more hours
England & Wales	5,194,568	10.2%	3,538,226	571,018	1,085,324
Cambridge	8,399	8.8%	6,409	745	1,245
East Cambridgeshire	7,023	9.7%	5,243	574	1,206
Fenland	8,112	9.9%	5,249	884	1,979
Huntingdonshire	13,729	8.8%	9,992	1,233	2,504
South Cambridgeshire	12,785	10.0%	10,177	957	1,651
Cambridgeshire total	50,048	9.4%	37,070	4,393	8,585

Source: 2001 Census

In November 2009, the Department of Health asked Cambridgeshire County Council to undertake survey of Carers' views. This survey was sent to Carers who had received a Carers Assessment in the past year, using their records from the social care database. This provided an opportunity to identify and profile those carers who receive a Carer's Assessment.

<sup>46</sup> [http://www.ifs.org.uk/elsa/report08/elsa\\_w3.pdf](http://www.ifs.org.uk/elsa/report08/elsa_w3.pdf)

<sup>47</sup> Carers at the heart of 21st-century families and communities "A caring system on your side. A life of your own." DH 2008

<sup>48</sup> Department of Health: Departmental Report 2007, The Stationary Office, May 2007

<sup>49</sup> <http://www.sociology.leeds.ac.uk/assets/files/research/circle/valuing-Carers.pdf>

<sup>50</sup> <http://www.cambridgeshire.gov.uk/business/research/populationresearch/census/Health+and+social+indicators.htm>

From the information held on the adult social care database at November 2009, approximately 70% of this subset of Carers is female, and 30 % male. The peak age band for caring is between 55 and 64. 57% of Carers on the SWIFT database are caring for a spouse or partner, 27% are caring for a parent or parent in law. Carers are themselves vulnerable to poverty, ill health and isolation, as a result of their caring role.<sup>51</sup> Many people continue to manage outside the care system, unaware of what help is available, with the help of families or friends, and only contacting statutory services when they reach crisis point. The prospect of financial assessment and charging for services acts as a barrier to seeking support for some families. Carers who support people who have refused an assessment or services often feel that they are in a particularly isolated position. For this reason the Cambridgeshire County Council Carers Support Team has undertaken responsibility for the completion of Carers Assessments for Carers who care for those who are not receiving services.

Carer's Allowance can be claimed by people who look after a severely disabled person for at least 35 hours per week. The severely disabled person must be getting either the highest or middle rate of Disability Living Allowance care component, or Attendance Allowance, or a Constant Attendance Allowance at the maximum rate under the War Pensions or Industrial Injuries Scheme.

**Table 8: Numbers (rounded) of older people providing unpaid care because of long term physical or mental ill health or disability or problems relating to old age by hours worked and district**

Local Authority	No of people aged 65+ who provide care	% of all aged 65+	Of those that provide care		
			1 to 19 hours	20 to 49 hours	50 or more hours
Cambridge	1,770	12.3%	1,120	170	480
East Cambridgeshire	1,440	12.0%	820	140	480
Fenland	1,680	10.5%	810	190	680
Huntingdonshire	2,270	11.2%	1,290	230	750
South Cambridgeshire	2,340	12.2%	1,500	210	630
<b>Cambridgeshire total</b>	<b>9,490</b>	<b>11.6%</b>	<b>5,530</b>	<b>940</b>	<b>3,020</b>

Source: 2001 Census

**Table 9: Number of older people providing unpaid care because of long term physical or mental ill health or disability or problems relating to old age by hours worked and proportion of that age group who are providing unpaid care: Cambridgeshire**

Cambridgeshire		Number of people who provide care	% of all people	1 to 19 hours	20 to 49 hours	50 or more hours
Men	50-64	8,360	17.0%	6,740	590	1,030
	65-74	2,850	13.8%	1,880	280	690
	75-84	1,510	12.9%	730	170	610
	85+	260	8.4%	90	30	140
Women	50-64	11,120	22.7%	8,550	1,000	1,570
	65-74	3,300	14.7%	2,080	310	910
	75-84	1,360	8.1%	660	130	570
	85+	220	3.1%	100	20	100

Source: 2001 Census

As the population ages, more very aged people will need care. The help that family Carers provide will become even more critical, not only in terms of managing the burgeoning care costs of an aging population but also in building a society where interconnectedness and social cohesion are valued. Those family members who are willing to provide unpaid care

<sup>51</sup>

<http://www.Carersuk.org/Professionals/ResearchLibrary/Healthandcare/1201185222>

should be valued and supported. By 2017 numbers of older people needing care are likely to outstrip the numbers of working age family members currently available to meet that demand.<sup>52</sup>

As increase in the retirement age leads to longer working lives, more people are likely to be combining work and providing unpaid care. Employers are at risk of losing skilled staff members if they do not make appropriate adjustments to support working Carers. This underlines the need to promote employment support for family Carers.<sup>53</sup>

#### *What should we be doing for Carers of Older People?*

Carers repeatedly tell us that their priorities include :

1. Being helped to recognise themselves as Carers, often by their GP in the first instance – in this way accessing information and support for Carers earlier in their caring career.
2. Being helped to look after their own health.
3. Being able to take a break, without worrying about the person they care for.
4. Being consulted and treated with respect by health and social care staff.
5. Being able to access both individual and group support at times of stress.
6. Having a voice, which is listened to by professionals and service planners.
7. Accessing information about who to contact in an emergency, and what help they can expect.
8. Help for Carers of people who fund their own care in being able to access information about community care support options and also access dedicated Carer support in their own right.
9. Support to manage transitions, including when the caring role comes to an end.

There is a small specialist Carer Support Team in Cambridgeshire County Council, working to provide information and support to Carers with a range of caring responsibilities, including Young Carers.

Voluntary organisations like Crossroads Care, Age Concern, Speaking Up and Alzheimer's Society provide individual and group support to Carers and the people they care for, both through independent fund raising and/or on a commissioned basis on behalf of health and social care services.

Commissioned services for Carers in Cambridgeshire include Open Access Carers Breaks, Carers Emergency Planning, Carers' Support Groups and Carers Advocacy, GP Enhanced Services to Carers, and Opportunities after Caring.

In addition, NHS Cambridgeshire started an initiative in April 2010 to provide a Carers Break 'Prescription' Service, with the twin aims of expanding the range of breaks available and to raise Carer Awareness in GP Practices.

An annual Carers Directory is compiled and published by the Carers Support Team. More than 11,000 copies are distributed. 6,000 named Carers receive a Carers Newsletter every other month. This is a much valued service.

The Local Authority's statutory responsibility to inform Carers who provide 'regular and substantial' care of their right to a Carer's assessment has provided a platform for raising Carer awareness. In 2009/10, 2,469 Carers had a Carer's assessment (through their Locality Team/Carers Support Team/Alzheimer's or Age Concern) with outcomes which included:

- One-off advice and information.

<sup>52</sup>

<http://www.Carersuk.org/Professionals/ResearchLibrary/Socialcontract>

<sup>53</sup>

<http://www.employersforCarers.org/Home>

- Carers breaks.
- A Carers grant.
- Other professional support (including Carers emergency planning).

As an outcome of their Carers Assessment in 2009/2010 more than 1600 Carers received an individual Carer's grant – a one-off payment to fund an item or service (eg washing machine, travel costs) - to promote the sustainability of their caring role.

Specific Carers' Issues raised at the Carers Partnership Board or other Carers forums include:

- While more than 2,000 Carers received an individual assessment of their needs, this remains a tiny proportion of the total number of Carers countywide. Reaching Carers who are isolated through geography/disability/language/membership of a minority cultural or social group remains a real challenge.
- Carers who look after someone who receives 'NHS Continuing Care' are not able to take planned breaks, which they can look forward to, as respite is currently commissioned at short notice.
- Long OT waiting lists impact negatively on Carers who are often the people who depend most on mobility and moving and handling equipment. Where Carers do not have the benefit of equipment and adaptations early in their caring role, there may be long term costs to their own health and ability to continue to care.
- The provision of wheelchair services is inconsistent across Cambridgeshire. Carers in some areas have reported problems in access, flexibility and timely response. The Partnership Board has offered to assist with a consultation prior to re-contracting.
- Carers cannot easily access the sort of home based advice and training to help them safely use moving and handling equipment when it is provided.
- The introduction of the Self Directed Support process is a major innovation. Carers' individual circumstances, including the amount of care they are willing and able to provide needs to be properly taken into account in the Resource Allocation System (RAS) used to calculate a Personal Budget. This is an emerging area where there is little evidence available to support best practice, either locally or nationally. While some carers are delighted with the additional flexibility and choice a personal budget offers, others are concerned about potential responsibilities. Carers need to be actively involved in the evaluation and development of local practice.
- Carer recognition and services have made real progress in Cambridgeshire during the past decade. There remains a very clear need for health and social care to work in partnership in supporting and developing this service to achieve the best outcomes for both service users and carers, and in order to maximize the use of increasingly scarce resources.

Continuing focus is required on:

- Incorporating carer awareness training into professional development programmes.
- Developing and promoting Carer-friendly employment practices.
- Continuing and refining information resources for carers in a way which targets hard to reach groups.
- To develop formal and informal groups and channels through which Carers can express their views and give feedback on services, in a way which contributes meaningfully to improving the quality of outcomes.

*Population dependency ratio*

As population structures change, the balance of the population of working age compared to the 'dependent' population may shift. This changes the proportion of people likely to be economically active (and paying taxes) in relation to the proportion of people more likely to be supported by the state.

The population dependency ratio is the ratio of the population aged under 15 and over 65 to the population aged 15-64 years, ie those of 'working age'. This informs workforce planning because less people aged under 65 are available to care for and support older people.

As with much of the UK, the dependency ratio across Cambridgeshire is forecast to fall. The following tables 10 and 11 show the ratio of the working age population to the population aged under 15 or over 65 and the number of people aged 15-64 per person aged over 65. These tables illustrate clearly the significant demographic shift forecast to occur. In the majority of Local Authorities, the number of people aged 15-64 per person aged over 65 is forecast to drop by between 20-40%. The picture in Cambridge City is very different. This is because the number of people aged over 65+ is projected to fall, while the population of working age is projecting to increase substantially. In South Cambridgeshire, the dependency ratio is affected by the expected age structure of the new developments (eg in Northstowe).

**Table 10: Ratio of working age population to those aged 0-14 or over 65**

	2006	2011	2016	2021	% change
Cambridge	2.86	2.98	2.82	2.46	-13.9%
East Cambridgeshire	1.86	1.77	1.59	1.48	-20.3%
Fenland	1.69	1.70	1.62	1.54	-8.9%
Huntingdonshire	2.02	1.98	1.79	1.67	-17.3%
South Cambridgeshire	1.93	1.77	1.56	1.46	-24.3%
Cambridgeshire	2.05	2.01	1.85	1.70	-16.8%

Source:

**Table 11: Number of people aged 15-64 per person aged over 65**

	2006	2011	2016	2021	% change
Cambridge	4.14	4.55	4.46	3.80	-8.1%
East Cambridgeshire	3.26	2.94	2.46	2.09	-35.7%
Fenland	2.69	2.50	2.17	2.02	-24.6%
Huntingdonshire	3.92	3.38	2.70	2.39	-39.0%
South Cambridgeshire	3.52	2.98	2.40	2.10	-40.3%
Cambridgeshire	3.52	3.22	2.74	2.41	-31.6%

Source: Income Deprivation Affecting Older People (IDAOP) Index

This index, IDAOPI 2007 represents the percentage of a SOAs (super output area) population aged 60 and over claiming income support or job seekers allowance or income benefit.<sup>54</sup>

Of the 32,482 SOAs nationally, seven in Cambridgeshire are within the most deprived fifth of the population, two in Fenland and five in Cambridge. In these areas (Table 12), between 30% and 40% of the population aged 60 and over claim income-related benefits. At the other end of the scale, nearly a third of Cambridgeshire’s population is in the least deprived fifth.

**Table 12: Small areas in Cambridgeshire which are among the most deprived 20% in England**

LSOA	in Ward	in District	IDAOPi score (0-1)	Rank of IDAOPi (out of 32,482)
E01018107	Waterlees	Fenland	0.40	2572
E01017979	King's Hedges	Cambridge	0.40	2687
E01017948	Abbey	Cambridge	0.33	5112
E01018103	Staithe	Fenland	0.33	5242
E01017958	Castle	Cambridge	0.32	5388
E01017991	Petersfield	Cambridge	0.31	5912
E01017999	Romsey	Cambridge	0.30	6229

Source:

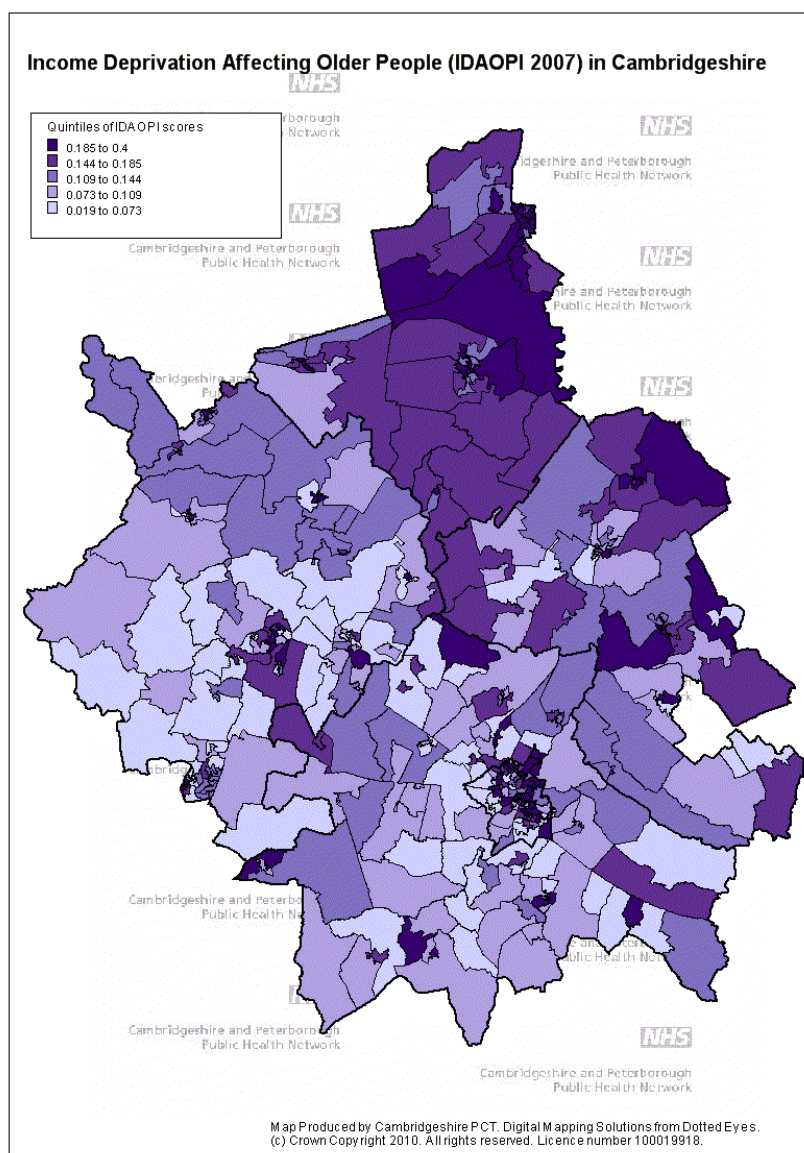
Among the Cambridgeshire population as a whole, parts of Fenland, north east Cambridge, Cambridge City, Huntingdon and St Neots have the greatest areas of deprivation. Among older people, deprivation is more evenly spread geographically (Figure 18).

54

<http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/>



**Figure 18: Deprivation in Cambridgeshire (Cambridgeshire deprivation quintiles). The SOAs shaded darkest represent the most deprived 20% of Cambridgeshire’s SOAs**



## 4.2 Housing

Providing appropriate housing for Cambridgeshire’s ageing population is a significant issue, and work about the aspirations of older people and the need for different housing models is ongoing. Chapter 34 of the Strategic Housing Market Assessment<sup>55</sup> discusses some of the issues around housing for older people, and will be updated in the coming year.

The SHMA project team is planning a significant piece of work researching older people’s housing needs in Cambridgeshire. If that work is carried out it will consider emerging models of housing for older people and aspirations of older people for housing options. The aim would be to inform medium term strategic thinking for older people’s housing in Cambridgeshire.

Older people move less frequently than younger age groups and moves tend to happen because they have to, ie the property they are living in no longer adequately meets their needs. One possible solution to this is the adoption of the life time homes standard – this is a

set of 16 design criteria for new homes to be more user-friendly/ easier to adapt at all stages of life. For further details see <http://www.lifetimehomes.org.uk/>.

Homelessness among older people is described in the Homelessness JSNA 2010

*Household composition*

Table 13 shows the household composition from the most recent national census undertaken in 2001. Around 30% of households in Cambridgeshire included at least one person of pensionable age and around 10% of households consisted of two or more people, all of whom were pensioners. Fenland has a higher proportion of households that include at least one person of pensionable age (36%) than the national average (32%). Both East Cambridgeshire and Fenland Districts have a higher proportion of 'all pensioner' households (11% and 13%) than the national figure (9%).

**Table 13: Households with at least one person of pensionable age and households where two or more people are pensioners (by age), 2001**

	Households			All Pensioners		
	Total number of households (occupied)	At least 1 person of pensionable age	% of all households	2 or more people: All Under 75	2 or more people: All 75 +	% of all households which are all pensioners
Cambridge	42,660	11,930	28%	1,650	1,660	8%
East Cambs	29,780	9,640	32%	1,920	1,370	11%
Fenland	35,190	12,580	36%	2,560	1,880	13%
Huntingdonshire	63,060	16,950	27%	3,250	2,370	9%
South Cambs	52,180	15,520	30%	3,040	2,360	10%
Cambridgeshire	222,870	66,620	30%	12,420	9,640	10%
England and Wales	21,660,475	6,870,720	32%	1,132,500	899,030	9%

Source: 2001 Census, National Statistics, Theme Table T06. Numbers rounded. © Crown Copyright 2003

The highest proportion of one-person pensioner households is in Fenland where over 15% of households consist of one pensioner living alone (data not shown).

*Pensioners living alone*

The living circumstances of older people affect both opportunities for social interaction and the need for additional support from formal and informal services. In 2001, there were around 8,200 households consisting of pensioners living alone in the PCT area (29% of all pensioners, Table 14). There were a further 6,700 households consisting of other pensioner families. The table shows the number of people at the 2001 Census recorded as living alone and the proportion of the population in each age group who were living alone.

**Table 14: Number of people aged 65 and older living alone**

	Number of people living alone (2001 Census)			% of all People		
	60-74 (F) 65-74 (M)	75-84	85+	60-74 (F) 65-74 (M)	75-84	85+
Cambridge	2,510	2,290	1,220	36%	43%	55%
East Cambridgeshire	1,640	1,640	740	25%	40%	49%
Fenland	2,270	2,170	890	26%	39%	49%
Huntingdonshire	3,010	2,710	1,120	27%	38%	47%
South Cambridgeshire	2,500	2,570	1,280	25%	39%	51%
Cambridgeshire	11,930	11,380	5,250	28%	40%	50%
England and Wales	1,398,360	1,225,820	502,160	32%	42%	49%

Source: 2001 Census, National Statistics. Theme Table T06. Numbers rounded.

### Tenure

The tenure of a household is derived from the response to the question asking whether the household owns or rents its accommodation and if rented, from the response to the question asking who is the landlord. Table 15 shows the number of pensioner households by type of tenure for both men and women living alone and two person pensioner households for households where both pensioners are aged under 75, and Table 16 those households where at least one person is aged 75 and over.

**Table 15: Tenure – Single person or two pensioner households, people aged under 75**

	Pensioner households – living alone or two pensioner households								
	Owned outright or with mortgage/loan		Rented from council or other social rented		Private rented		Rent free		Total
Cambridge	2,697	65%	1,237	30%	127	3%	105	3%	4,166
East Cambs	2,634	74%	678	19%	145	4%	98	3%	3,555
Fenland	3,737	77%	735	15%	214	4%	140	3%	4,826
Huntingdonshire	4,824	77%	1,056	17%	282	5%	90	1%	6,252
South Cambs	4,151	75%	1,089	20%	147	3%	146	3%	5,533
Cambridgeshire	18,043	74%	4,795	20%	915	4%	579	3%	24,332
England and Wales		71%		22%		4%		2%	

Source: 2001 Census, National Statistics, Table T06.

Note: Living rent free could include households that are living in other than private rented (including tied accommodation). This category can include people living in council or housing association properties. Sometimes respondents think they live rent free when they do not, ie people on full benefit whose housing benefit is paid directly to their landlord. This category includes people living with family or friends.

**Table 16: Tenure – Single person or two pensioner households, any aged over 75**

	Pensioner households – living alone or two pensioner households								
	Owned outright or with mortgage/loan		Rented from council or other social rented		Private rented		Rent free		Total
Cambridge	2,942	57%	1,749	34%	222	4%	241	5%	5,154
East Cambs	2,265	61%	1,070	29%	146	4%	252	7%	3,733
Fenland	3,298	67%	1,067	22%	239	5%	326	7%	4,930
Huntingdonshire	3,990	65%	1,701	28%	265	4%	221	4%	6,177
South Cambs	3,855	62%	1,758	28%	189	3%	411	7%	6,213
Cambridgeshire	16,350	62%	7,345	28%	1,061	4%	1,451	6%	26,207
England and Wales		63%		28%		5%		5%	

Source: 2001 Census, National Statistics, Table T06

Fenland has the highest proportion of houses that are owned outright (67%) by pensioners living alone. East Cambridgeshire and Huntingdon have more lone pensioners living in 'other social rented' households than that rented from the council.

#### *Supporting People Needs Analysis*

In 2008 Supporting People commissioned a needs analysis of groups with housing support needs in Cambridgeshire, including older people. This model includes estimates for demography, vulnerability and attempts to split need between accommodation based services (mainly sheltered housing) and support only services. It shows that there are around 4,300 older people with housing support needs in Cambridgeshire currently. Over time this is likely to increase because of demographic demands.

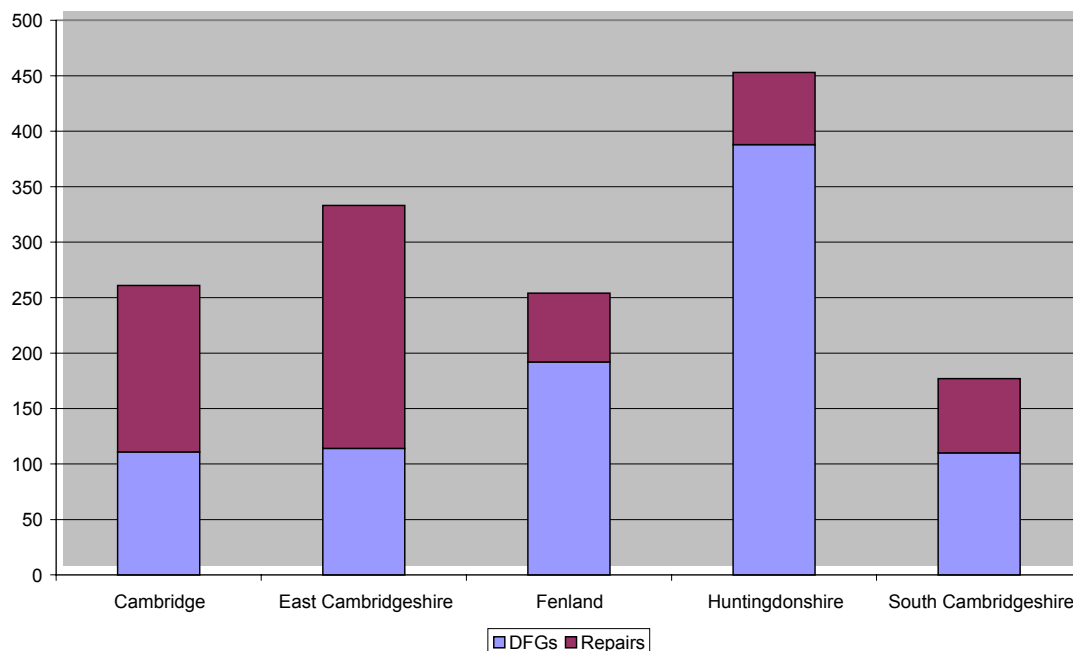
#### *Home improvement agencies*

Home Improvement Agencies (HIAs) help older people, disabled people and people on low incomes and people to repair, improve and adapt their homes. Services provided by HIAs support vulnerable households to maintain independence in their own homes. Works can include:

- Handyperson schemes to do small jobs around the home. In some cases these are provided, in other cases this is a signposting service.
- The provision of assistive technology such as alarm systems.
- Helping with grants and other forms of financial assistance for larger repairs (including Decent Homes) and adaptations.
- Advice on tendering, overseeing works and ensuring they are completed to a good standard.
- Referrals to other agencies such as benefits advisors.

There are currently five HIAs in Cambridgeshire. Fenland HIA service is provided by Care and Repair West Norfolk, East Cambridgeshire has an independent Care and Repair agency. Huntingdonshire, South Cambridgeshire and Cambridge all have in-house agencies.

**Figure 19: Cambridgeshire Home Improvement Agencies' major works processed 2006/07 and 2008/09 by type and district**



Source: Cambridgeshire Supporting People HIA Review, 2008

The Cambridgeshire Supporting People HIA Review of 2008 shows Cambridge City and East Cambridgeshire processed comparatively more repair work and the other three districts processed proportionately more disabled facilities grants between 2006/07 and 2008/09 (Figure 19). When the number of major works processed by HIAs is compared to the number of households in the districts, it shows a high level of activity in East Cambridgeshire (10 households per thousand) and a low level of activity in South Cambridgeshire (three households per thousand). The future funding arrangements for HIA services. A review of the HIA services in Cambridgeshire in 2010, show savings to be made by having one or two HIAs serving the County rather than the five agencies which currently exist.

### *Sheltered and Extra Care housing*

Although there is a growing private market for sheltered housing for older people with some element of support, particularly in the Cambridge City area, the vast majority of provision of sheltered and Extra Care (housing designed to meet the care needs of people in a community setting) in the county remains social rented accommodation provided through Councils and registered social landlords.

A Best Value Review of Sheltered Housing was undertaken between 2003 and 2004 by Cambridgeshire's five district councils, Supporting People, Cambridgeshire County Council, NHS Cambridgeshire and Registered Social Landlords. The Review established key principles for the development of supported housing for older people. In particular it aimed for an equitable provision across the county and an increase of 1079 additional extra care units in Cambridgeshire. Up to July 2010 there have been 425 units developed with a further 167 in development.

Given the length of time that has elapsed since the Best Value review and considering the financial pressures on both capital and revenue budgets the Extra Care Commissioning Strategy Group carried out a scoping exercise to identify areas of high demand yet low supply of extra care housing. The aim of this was to prioritise new schemes to be funded out of the resources available. This process established a high priority for additional schemes in



Huntingdonshire and South Cambridgeshire. Figures 20-23 show examples of maps used in the scoping exercise. Figure 20 shows the provision of residential, sheltered and Extra Care homes plotted against the background of the percentage of people aged 70 and over living in receipt of the disability living allowance.

**Figure 20: Cambridgeshire: Disability Living Allowance**

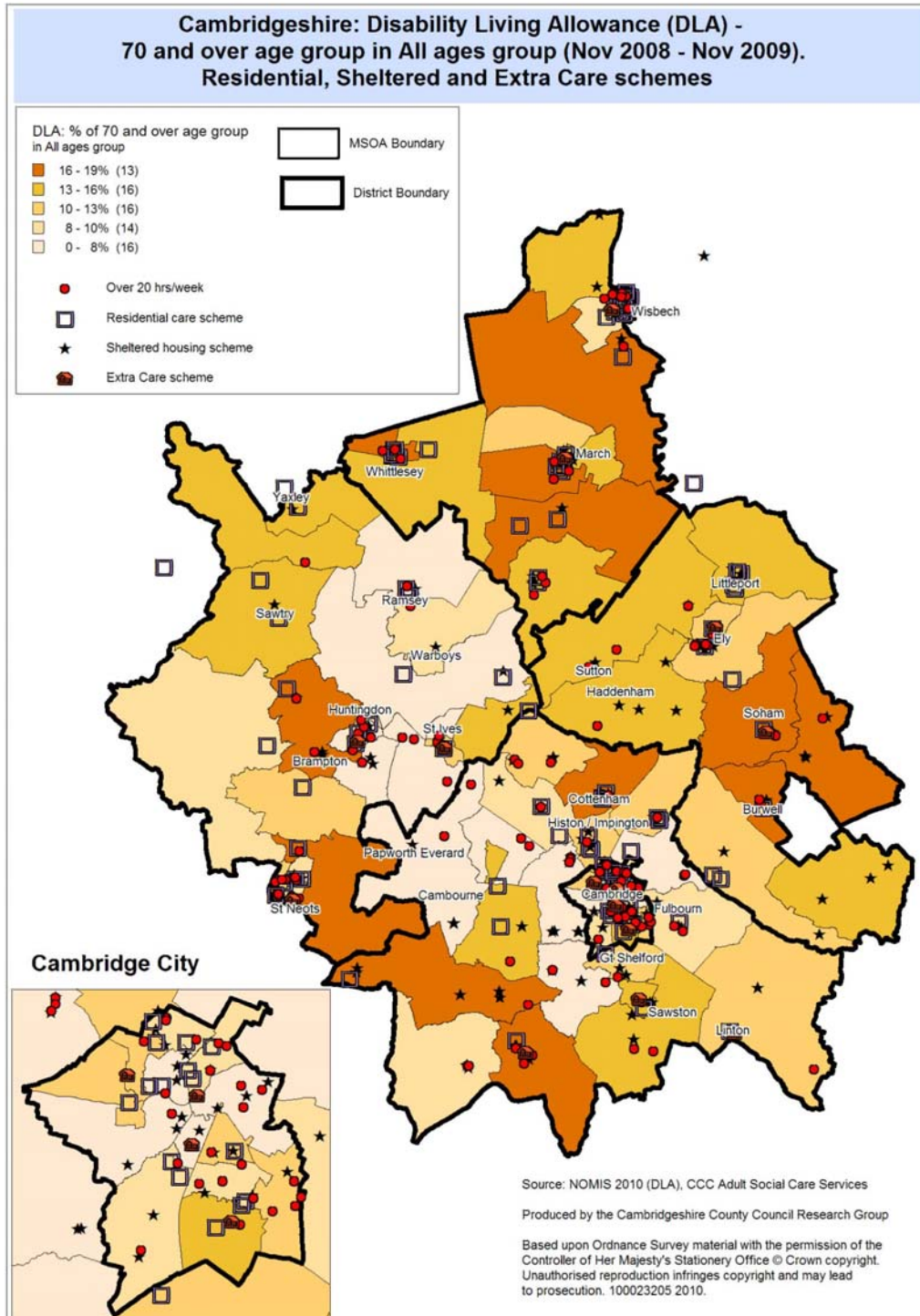


Figure 21 shows the provision of residential, sheltered and Extra Care homes and the proportion of domiciliary care service users in the Middle Super Output Areas (MSOAs), e.g. 1.7-3% of all domiciliary care service users lived in areas marked with the darkest colour (August 2008 – September 2009).

**Figure 21: Cambridgeshire: Domiciliary care service users**

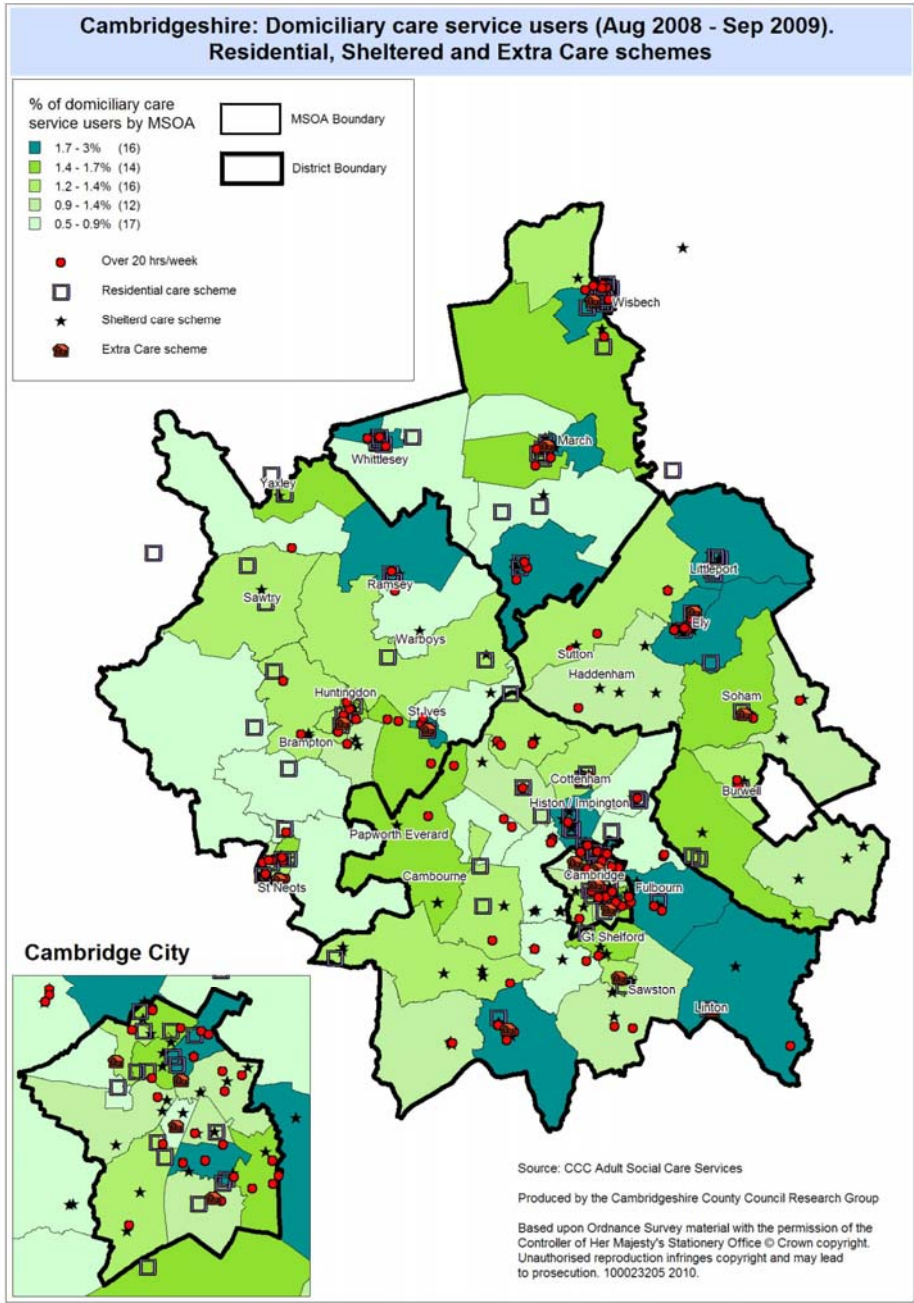


Figure 22 shows the provision of residential, sheltered and Extra Care homes and the proportion of people aged 75+ in all age groups, e.g. areas marked with the darkest colour have 9-13% of people aged 75 and over.

**Figure 22: Cambridgeshire: Proportion of 75+ age group in all age groups**

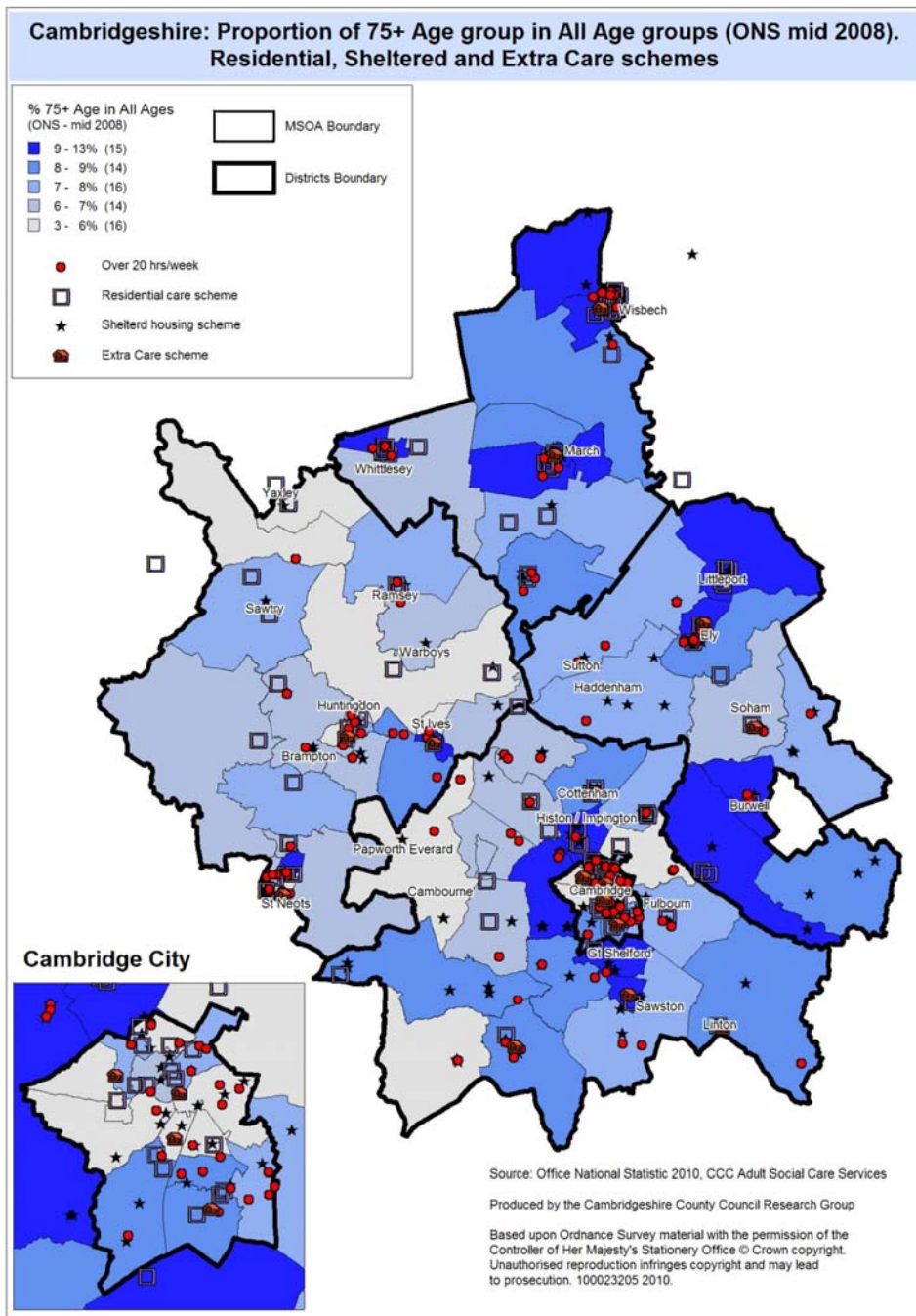
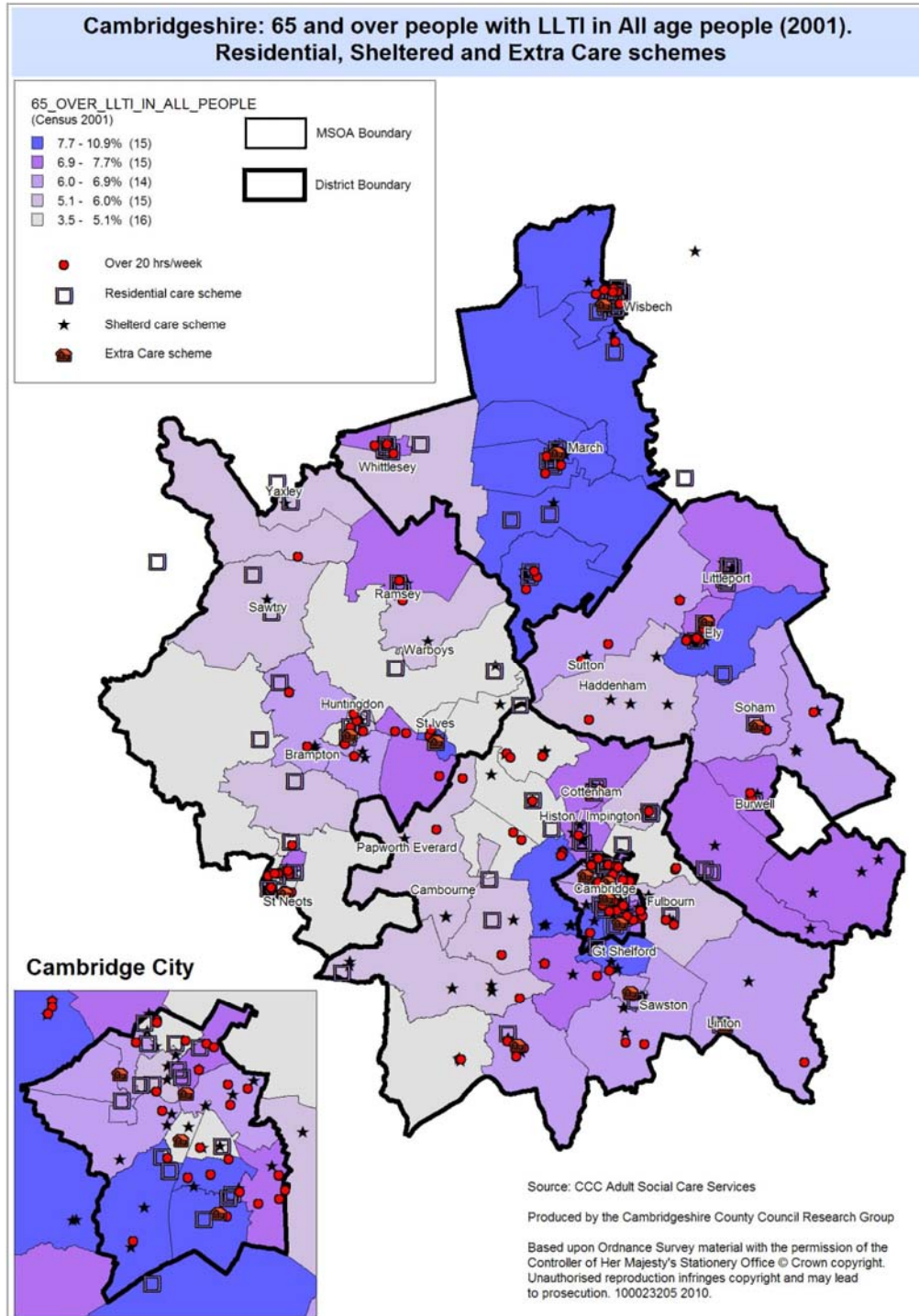




Figure 23 shows the provision of residential, sheltered and Extra Care homes and the proportion of people with limiting long-term illness aged 65+ in all age groups, e.g. areas marked with the darkest colour have around 8-11% of people in this group.

**Figure 23: Cambridgeshire: Proportion of 65+ age people with limiting long-term illness (LLTI)**



An additional exercise to calculate the capacity within the county to develop new schemes established that one new scheme of approximately 40 units could be developed each year for the next ten years, that is until April 2020. These approximately 400 units will replace the need for additional residential care places that are forecast to be required due to population growth in the next ten years. As the cost of social care in extra care schemes is around half

that in residential care this provides a considerable saving as well as providing older people with new homes and helping them maintain their independence. The need for Extra Care housing will be kept under review and the priorities for developments adjusted accordingly.

### *Nursing Homes and Residential care*

Around 3% of over 65s, 18% of over 80s, 28% of over 90s live in residential care.<sup>56</sup>

The distribution of care homes by type across Cambridgeshire used in the Statistical Appendix to the Commissioning Strategy for Older People 2008-11 is given in Table 17.

**Table 17: Nursing and residential care homes by type – Cambridgeshire and districts**

	Residential						Nursing				
	Permanent residential	Permanent EMI	Permanent Dementia	Respite Dementia	Respite Res	Total	Nursing Non EMI	EMI / Dementia	Over 65 Dementia	Over 65 EMI only	Total
Cambridge City	277	3	84	2	10	376	144	50	39	25	258
East Cambridgeshire	135	0	120	2	7	264	86	97	0	0	183
Fenland	233	0	223	2	5	463	220	37	57	0	314
Huntingdonshire	393	0	197	2	13	605	192	0	5	0	197
South Cambridgeshire	313	14	101	4	17	449	135	40	0	0	175
Cambridgeshire	1,351	17	725	12	52	2,157	777	224	101	25	1,127

Source: Cambridgeshire County Council. Commissioning Strategy for Older People – Statistical Appendix

### *Older households and the Decent Homes Standard*

The 2000 Green Paper “Quality and Choice: A Decent Home for All set the target of ensuring that all social rented homes met the decent homes standard by 2010. Further legislation set targets for private sector homes to also meet the standard. According to the government a decent home is one that is “wind and weather tight, warm and has modern facilities”. There are four components of the standard:

- Fitness for habitation. It should be fit for habitation with no Category 1 (serious) hazards under the HHSRS<sup>57</sup> hazard rating system.
- Serious disrepair. Households should be in a good state of repair.
- Modern facilities, especially kitchens and bathrooms
- A reasonable degree of thermal comfort.

District councils produce occasional stock condition reports, detailing the condition and type of housing stock in their districts and estimating the cost of repairs etc. These (as well as details of the HHSRS) are summarised in Chapter 12 of the Strategic Housing Market Assessment. These surveys are all conducted at different times, and are conducted by different consultants using different standards for presentation etc. Some are more recent than others, and so follow different sets of guidance for completion. Because of this comparison is difficult, but the proportion of older people in private housing stock (owner occupied or privately rented) in non-decent stock is summarised in Table 18.

<sup>56</sup>

<http://www.audit-commission.gov.uk/nationalstudies/localgov/dontstopmenow/Pages/Default.aspx>

<sup>57</sup>

The Housing Health and Safety Rating System is a prescribed method of assessing individual hazards. National statistics on the health impact of hazards encountered in the home are used as the basis for assessing individual hazards. It covers 29 hazards in four groups – physiological requirements (damp, mould, excess cold, asbestos, carbon monoxide, radon), psychological requirements (crowding, space, security, lighting, noise), protection against infection (domestic and personal hygiene, food safety, water supply), protection against accidents (falls, electrical hazards, fire, etc.).

**Table 18: Older people in non-decent homes**

Local Authority	Year of report	Findings
Cambridge City	2009	33% of households aged 60-74, 48% of households aged 75-85, 56% of households aged 85+ in non-decent homes
East Cambridgeshire	2008	35% of single pensioners and 29% of two pensioner households live in non-decent homes
Fenland	2008	29% of single pensioners and 22% of two pensioner household live in non-decent homes
Huntingdonshire	2005	20% of households aged 65+ are in non-decent homes
South Cambridgeshire	2004	33% of households aged 65+ are in non-decent homes

Source:

*Overcrowding and under-occupation*

The percentage of pensioners living in overcrowded households varies greatly across the county, with over 6% living in such conditions in Cambridge City (Table 19). Cambridge City also has a higher percentage of pensioners living in overcrowded households than the county average. The national average is 4.4%. An overcrowded household is one in which there are one or more too few rooms<sup>58</sup> than deemed necessary.

**Table 19: Pensioners in overcrowded housing, 2001**

Local Authority	All households with people of pensionable age		% of pensioners living in overcrowded households
	Living in overcrowded households	Households with at least one person of pensionable age	
Cambridge City	774	11,924	6.5%
East Cambridgeshire	232	9,640	2.4%
Fenland	384	12,577	3.1%
Huntingdonshire	475	16,955	2.8%
South Cambridgeshire	261	15,519	1.7%
Cambridgeshire	2,126	66,617	3.2%

Source : Census 2001 © Crown Copyright 2003 – Table T06

Under-occupation is more of an issue for older households – a property that is too large for the household living there is harder and more expensive to maintain and heat as well as limiting housing options for larger households. South Cambridgeshire has the highest proportion of under-occupation followed by Huntingdonshire (Table 20).

<sup>58</sup>

This is based on the occupation standard. The bedroom standard is a more meaningful way of measuring occupation, but no local level is currently available. The 2011 Census will ask about number of bedrooms which will help to calculate overcrowding by age group to the bedroom standard.

**Table 20**

	All households with people of pensionable age		
	With two or more rooms than required by occupancy rating	Households with at least one person of pensionable age	% of pensioners living in under occupying households
Cambridge	7,013	11,924	59%
East Cambridgeshire	5,645	9,640	59%
Fenland	6,710	12,577	53%
Huntingdonshire	10,720	16,955	63%
South Cambridgeshire	9,985	15,519	64%
Cambridgeshire	40,073	66,615	60%

Source: Census 2001 © Crown Copyright 2003 – Table T06

### *Lowest floor level*

The lowest floor level of the accommodation is shown below for pensioner households (whether living alone or two pensioners together). Cambridge City has a higher proportion of pensioners living on the first floor or above than the other Districts or the national average (Table 21).

**Table 21: Lowest floor level of pensioner households**

LAD	Lowest floor level of accommodation					
	Basement or semi-basement	Ground Floor	1st or above	2nd or above	% 1 <sup>st</sup> or above	% 2 <sup>nd</sup> or above
England & Wales	73,902	4,472,332	611,635	196,813	12%	4%
Cambridge	99	7,890	1,345	341	14%	4%
East Cambridgeshire	28	6,975	306	51	4%	1%
Fenland	27	9,297	443	44	5%	0.5%
Huntingdonshire	39	11,514	895	162	7%	1%
South Cambridgeshire	45	11,488	206	13	2%	0.1%
Cambridgeshire	238	47,164	3,195	611	6%	1%

Source: 2001 Census, National Statistics, Table T06

### *Central heating*

A lack of central heating indicates a strong likelihood of difficulty in heating one's home. For older people who often experience chronic illness, this can be particularly problematic as cold homes can cause exacerbation of respiratory and circulatory disease and reduce dexterity making falls more likely.

Table 22 shows the number and proportion of pensioners living alone who did not have central heating at the time of the Census<sup>59</sup>. Most districts have a lower proportion of pensioners living alone without central heating than the national average. Cambridge City and Fenland have figures approaching the national proportion in the older age groups.

<sup>59</sup>

A household's accommodation is classed as having central heating if it has central heating or some or all rooms, whether used or not. Central heating includes gas, oil or solid fuel heating, night storage, warm air and underfloor heating.

Cambridge City has large numbers of pensioners living alone without central heating. In Cambridge City over 600 people aged 65 and over and nearly 200 people aged 85 and over (15% of those aged 85 and over who were living alone) have no central heating. These figures are noticeably higher in the older population than the proportion shown for all occupied households (last column).

**Table 22: Pensioners living alone without central heating by age group and proportion of single pensioner households without central heating**

Local Authority	Pensioners living alone without central heating								% all occupied households
	Number				% of households				
	65-74	75-84	85+	65+	65-74	75-84	85+	65+	
England & Wales	158,419	148,058	103,107	409,584	13%	14%	17%	14%	9%
Cambridge	202	242	198	642	9%	12%	15%	11%	6%
East Cambridgeshire	110	97	76	283	7%	6%	8%	7%	4%
Fenland	194	194	155	543	9%	10%	14%	11%	7%
Huntingdonshire	182	125	107	414	6%	5%	8%	6%	4%
South Cambridgeshire	117	116	102	335	5%	5%	7%	5%	3%
Cambridgeshire	805	774	638	2,217	7%	8%	10%	8%	5%

Source: 2001 Census, National Statistics, Table T06

Table 23 shows the number of households consisting of two people, both pensioners by age group, and as a proportion of households of that type. All LADs have proportionately less households without central heating than the figure for England and Wales.

**Table 23: Two people (all pensioner) households without central heating**

Local Authority	Two or more people, all pensioners			
	All under 75	Any aged over 75	% of same type of households	
			All under 75	Any aged 75+
England & Wales	76,784	84,177	7%	10%
Cambridge	92	141	6%	9%
East Cambridgeshire	76	92	4%	7%
Fenland	146	114	6%	6%
Huntingdonshire	105	100	3%	4%
South Cambridgeshire	75	98	3%	4%
Cambridgeshire	494	545	4%	6%

Source: 2001 Census, National Statistics, Table T06

### *Fuel poverty*

Households are deemed to be fuel poor if they spend more than 10% of their net income on heating. The UK government has a target to effectively end fuel poverty in England by 2016<sup>60</sup>. Fuel poverty is caused by a combination of low incomes, high fuel prices and poor energy efficiency of dwelling stock.

<sup>60</sup> DECC (2009) "The UK Fuel Poverty Strategy: Seventh Annual Progress Report" accessed at [http://www.decc.gov.uk/assets/decc/Statistics/fuelpoverty/1\\_20091021091505\\_e\\_@@\\_UKFuelPovertyStrategy7AnnReport09.pdf](http://www.decc.gov.uk/assets/decc/Statistics/fuelpoverty/1_20091021091505_e_@@_UKFuelPovertyStrategy7AnnReport09.pdf) [July 2010]

**Table 24: Dwelling stock age by district**

	Pre-1919	1919-1944	1944-1964	Post 1964
Cambridge	31%	16%	22%	33%
East Cambridgeshire	18%	9%	15%	58%
Fenland	17%	12%	13%	58%
Huntingdonshire	12%	7%	13%	67%
South Cambridgeshire	17%	7%	22%	55%
England	22%	18%	20%	38%

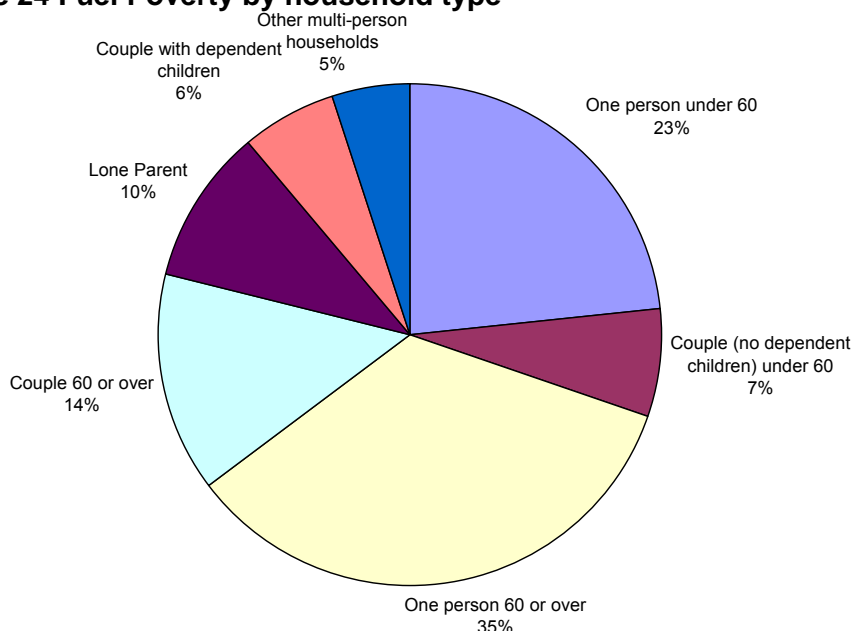
Source: These data are taken from the most recent private sector stock condition surveys for each district. These surveys therefore follow different guidance and different formats, which makes comparison across districts for different subject areas problematic. The dates for the data used in this table are Cambridge (2009), East Cambridgeshire (2010), Fenland (2008), Huntingdonshire (2005), South Cambridgeshire (2004).

Percentages may not equal 100% due to rounding.

Between January 2004 and November 2009, the average dual fuel energy bill increased from £600 to £1,200<sup>61</sup>. And while building standards with regard to energy efficiency are increasingly demanding, there is still a large proportion of older stock (Table 24) which is less efficient than that currently being built, with older homes being most inefficient.

Figure 21 shows how fuel poverty affects different household types. A large proportion of these households (82%), are classed as vulnerable (in receipt of some element of means tested benefit) (DECC, 2009: 9). Older people, particularly those living in single person households are most likely to be affected by fuel poverty. Older owner occupiers who have paid their mortgage in full are likely to be income poor but housing rich. Some of the younger households in fuel poverty, including those with children are less likely to be in this position.

**Figure 24 Fuel Poverty by household type**



61

OFGEM (2009) "Quarterly Price Report" accessed at <http://www.ofgem.gov.uk/MARKETS/RETMKTS/ENSUPPRO/Documents1/Quarterly%20Wholesale%20Retail%20Price%20Report%20November%202009.pdf> [July 2010]

Source: NEA & Energy Action for Scotland (Feb 2010) "Fuel Poverty Progress? The UK perspective" accessed at <http://www.nea.org.uk/assets/Uploads/UK-Fuel-Poverty-Monitor-2010.pdf> [July 2010]  
In recent years, the number of fuel poor households has increased significantly, largely because of increases in energy prices. It is estimated that nationally number of households in fuel poverty more than doubled between 2003 and 2007 (DECC 2009: 7).

Actions to tackle fuel poverty include:

- Energy efficiency grant programmes such as Warm Front. Originally this included the provision of low energy lighting, but this has now been discounted as a fuel poverty measure.
- Improvements to building standards on new build properties.
- Regulatory guidance to energy suppliers and involving them in fuel poverty initiatives as part of their corporate social responsibility.
- Education initiatives such as encouraging people to switch supplier to get the best tariff available.
- Winter Fuel and Cold Weather payments. Winter Fuel Payments are specifically for older households. The standard rate is £200 per household where the oldest person is aged between 60 and 79, and £300 for the 80+ age group.

The most recent local level data on fuel poverty is from the 2003 fuel poverty indicator ([www.fuelpovertyindicator.co.uk](http://www.fuelpovertyindicator.co.uk))<sup>62</sup>. Fuel poverty is more significant in the north of the country than the south and East Anglia, although there are pockets of fuel poverty in the County, with areas in Fenland and Huntingdonshire being particularly highlighted. For Cambridgeshire this showed an estimated 13,154 households in fuel poverty based on full income – 6% of households. If the national trend is consistent in this area, then there may be around 30,700 households in fuel poverty in Cambridgeshire. If the household type split above is applied to these figures, between 6,000 and 15,000 older person households in Cambridgeshire may be living in fuel poverty.

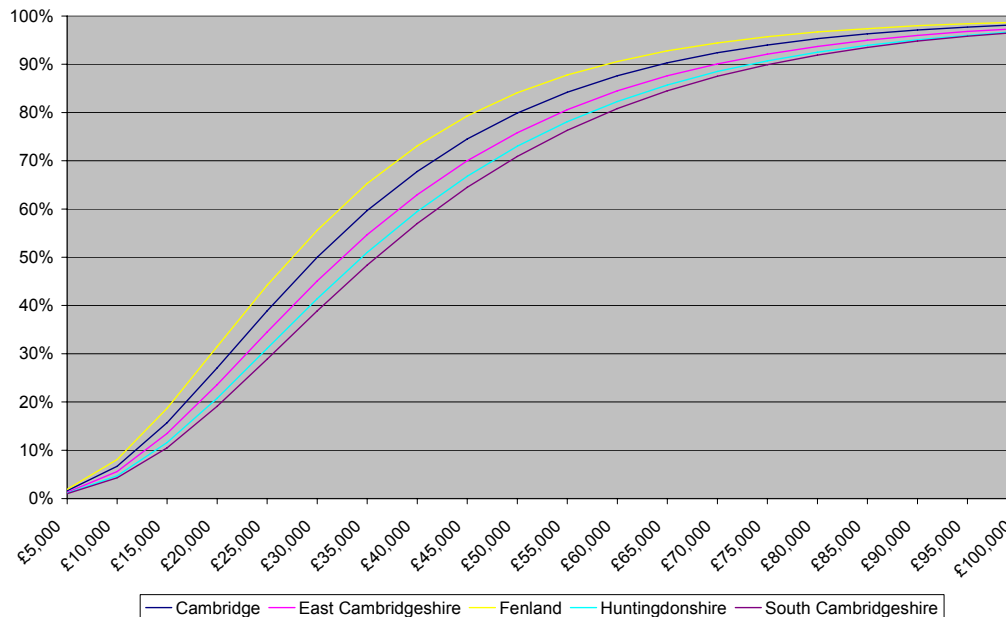
The rest of this section provides some information on factors affecting fuel poverty at a very general district level, namely household income and energy efficiency. Figure 22 shows the income distribution for households in Cambridgeshire. In Cambridgeshire as a whole, 6% of households have a gross income of less than £10,000 per year, but there is variation between the districts. In Fenland 10% of households have a household income of less than £10,000pa, but in South Cambridgeshire it is only 5%.

<sup>62</sup>

A more detailed local picture is available at [http://www.fuelpovertyindicator.co.uk/newfpi.php?mopt=1&pid=fpi\\_areamap&step=4&map=35](http://www.fuelpovertyindicator.co.uk/newfpi.php?mopt=1&pid=fpi_areamap&step=4&map=35)



**Figure 25 Gross household income by district, all households**



Source: CACI, 2009

**Table 25 SAP rating**

	Average SAP rating	% of dwellings with SAP rating below 35
Cambridge	51	12
East Cambridgeshire	50	10
Fenland	53	14
Huntingdonshire	57	5.9
South Cambridgeshire	54	15

Source: HSSA 2008/9, Huntingdonshire District Council

Table 25 shows information on the energy efficiency of private dwellings by district. The SAP rating measures efficiency on a scale of 1 to 100. In 2006, the average SAP rating for England was 49<sup>63</sup>. Huntingdonshire has the least energy efficient dwelling stock and is the only area with a rating below the national average. Between 10 and 15% of dwellings in each district are very inefficient. South Cambridgeshire has the highest average SAP rating, but also the largest proportion of properties with a low SAP rating (less than 35). Data from the most recent English Home Condition Survey show social rented stock<sup>64</sup> to be more efficient than private stock. Private rented stock is less efficient than stock which is owner occupied.

Fuel poverty, where more than 10% of income is spent on heating, is linked to general poverty but also affected by energy prices and energy efficiency. Despite government targets and a range of initiatives to reduce significantly the number of households living in fuel poverty has more than doubled since 2003. Domestic energy prices have also doubled over the same period. Different household types are affected differently by fuel poverty – a large proportion of households who are fuel poor are single older people and older couples. The most recent good quality data (the fuel poverty indicator, 2003) shows a low proportion of households in Cambridgeshire living in fuel poverty compared to other parts of the country, but it also shows small pockets where fuel poverty is a significant issue, mostly in

<sup>63</sup> CLG, 2006 page 134

<sup>64</sup> Ibid, page 137. This is largely due to the previous government emphasis on bring all homes in the social rented sector up to Decent Homes standard. Decent Homes standards includes thermal comfort and “reasonably modern facilities”, both of which increase efficiency.



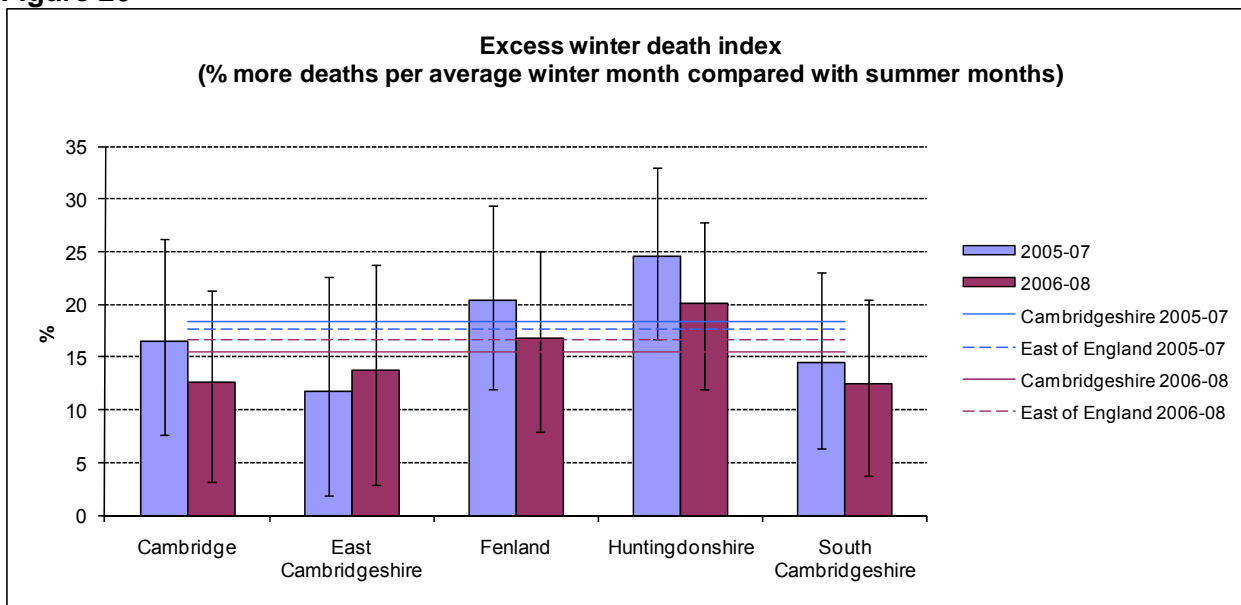
Huntingdonshire and Fenland. More up-to-date district level information on incomes (particularly) and SAP ratings suggests that these areas are still more likely to have a higher proportion of households living in fuel poverty than elsewhere in the County.

*Excess winter deaths*

The excess winter deaths index is calculated as the percentage more deaths per average month during the winter period (December to March) compared to the summer period (August to November and April to July). The main underlying causes of excess winter deaths are ischaemic heart disease, influenza and pneumonia, cardiovascular diseases and chronic lower respiratory diseases. The older population experiences the greatest increase in deaths each winter. Excess winter deaths increased nationally in 2008/09 (Figure 23).

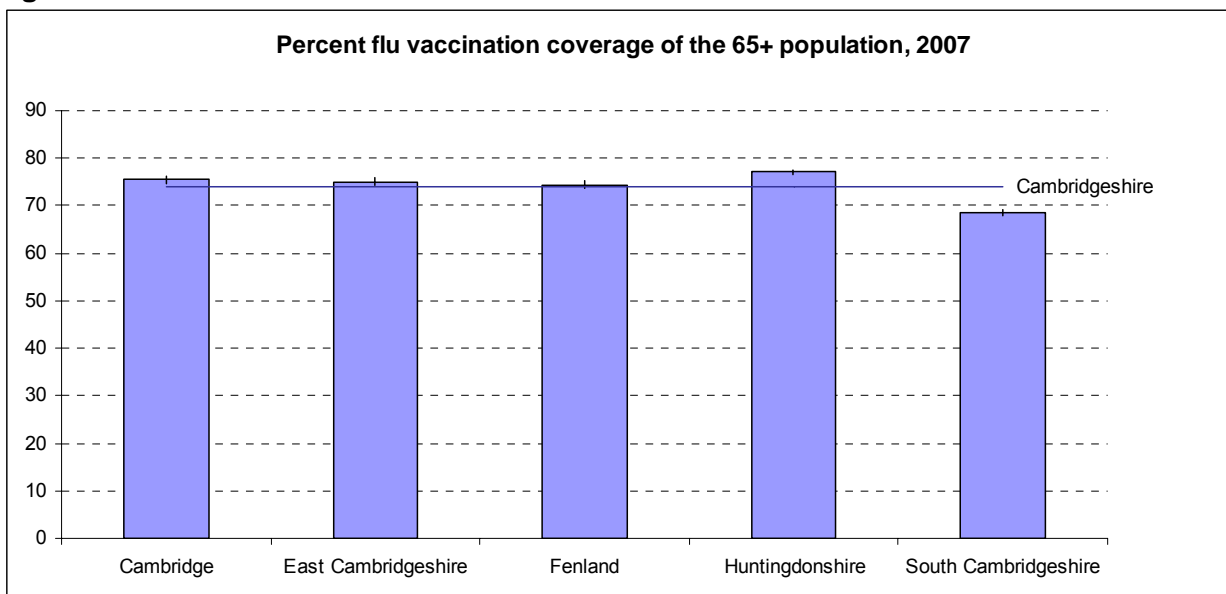
The number of extra deaths occurring in winter varies depending on temperature, the level of disease in the population, and other factors. Increases in deaths from respiratory and circulatory diseases are responsible for most of the excess winter mortality. Influenza is often implicated in winter deaths as it can cause complications such as bronchitis and pneumonia, especially in older people. Although relatively few deaths are attributed to influenza itself, uptake of flu vaccine is important in reducing morbidity as well as mortality (Figure 24). It is important to note that it is not possible to identify the individuals who make up the excess.<sup>65</sup>

**Figure 26**



<sup>65</sup> Further analyses are available in report *Excess Winter Deaths in Cambridgeshire and Peterborough*, CPHN Public Health Intelligence Team (June 2007).

**Figure 27**



### 4.3 Rurality, Transport and Access

#### *Rurality*

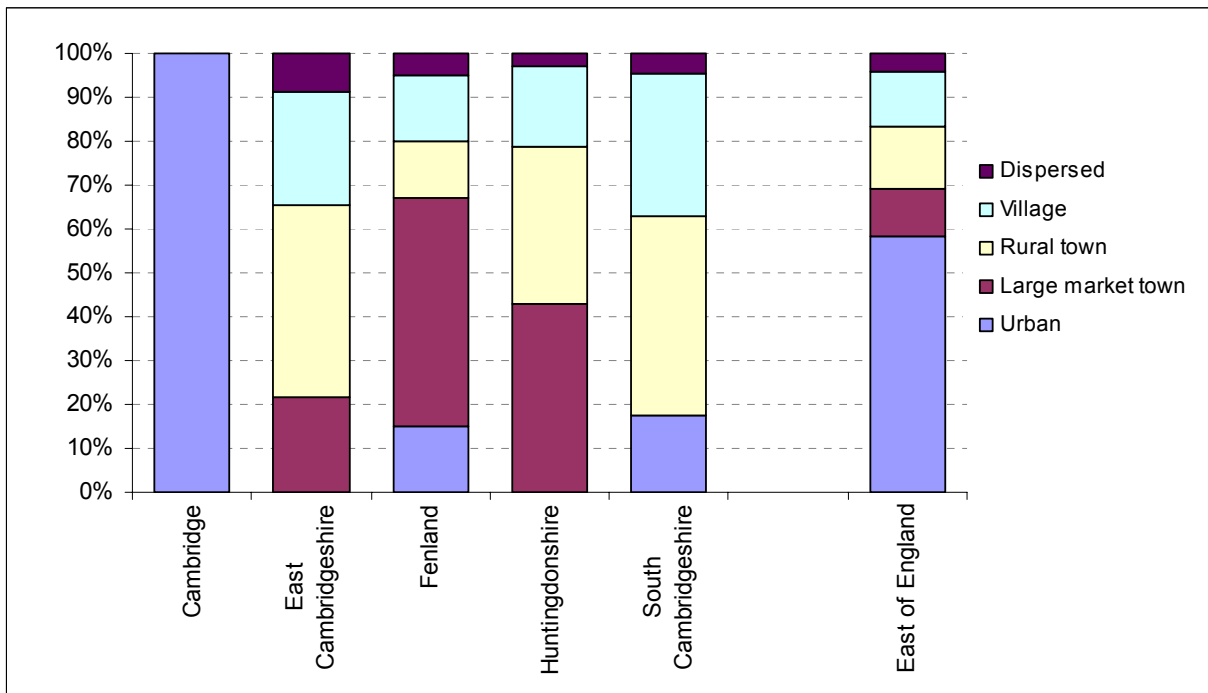
The Commission for Rural Communities' *State of the Countryside 2010* report<sup>66</sup> gives an overview of how issues in England's rural areas have changed over the last ten years. They note:

- Between 2001 and 2008 the population of rural England rose faster than in urban areas
- Whilst over 98% of urban residents have the following services within 4km, for rural residents 80% a GP surgery, 62% a supermarket, 57% an NHS dentist, 67% a pharmacy
- Approximately 5% of rural households were using dial-up internet connections in 2009 compared with 2% in urban areas.
- People in villages and hamlets with the lowest incomes spend an average of £50 per week on travel compared with £32 in rural towns and £28 in urban areas
- 28% of those households not on the mains gas network in villages and hamlets are in fuel poverty compared with 13% who are on the mains gas network. The comparative figures for urban areas are 18% and 12%
- 87% of people living in the most rural districts are satisfied with their area as a place to live compared with 76% living in the most urban authorities.

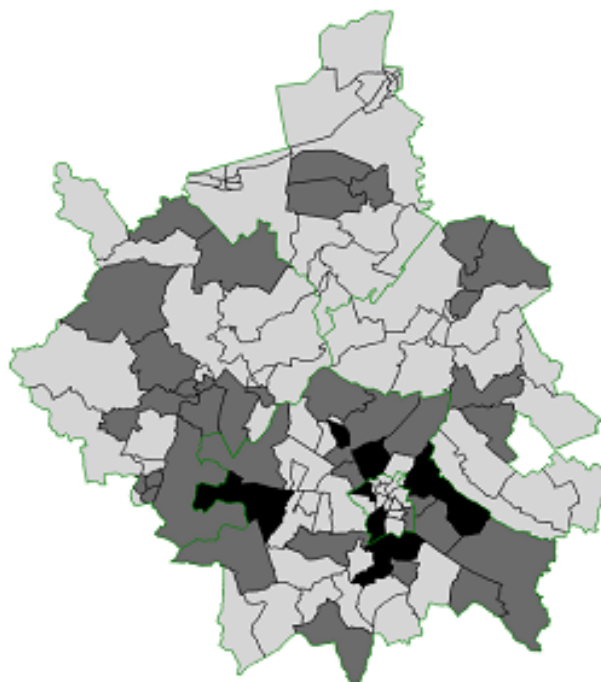
66

<http://ruralcommunities.gov.uk/sotc2010/>

**Figure 28**



**Figure 29**



- 100-400 people
- 401-900 people
- 901-2,100 people

Cambridgeshire is predominantly a rural area. The DEFRA classification<sup>67</sup> (revised in 2009) classifies Cambridge as urban and the other districts as having at least 80% population living in rural areas. Figure 25 shows the distribution of population in each area. Over the period to 2021, it expected that population numbers will decline in many rural wards but grow in the Fens, and the proportion of older people in rural area will increase more than in urban areas. This is due to longer life expectancy in rural areas and migration of younger people to more urban areas. Northstowe is expected to see the biggest increase in people over 65 (2100, Figure 26).

Source: Cambridgeshire County Council Population estimates and forecasts and presentation <http://www.cambridgeshire.gov.uk/business/research/populationresearch/population/>

<sup>67</sup> <http://www.defra.gov.uk/evidence/statistics/rural/documents/rural-defn/laclassifications-techguide0409.pdf>

Routine national data on rurality are available from the Department of Environment, Food and Rural Affairs (DEFRA <http://www.defra.gov.uk/evidence/statistics/rural/>) and Commission for Rural Communities <http://ruralcommunities.gov.uk/>. County information is available through Cambridgeshire County Council Cambridgeshire and ACRE (Action with Communities in Rural England), the community council for Cambridgeshire and Peterborough <http://www.camsacre.org.uk/>.

### *Transport and access*

Transport is important to access services such as banks, pharmacies and general practitioners but also to maintain relationships with friends and family and to participate in social and leisure activities.

The rural population includes many older people for whom access to services and transport may be more difficult. Figure 27 shows a scarcity of pharmacies, for example, in some areas with a comparatively high proportion of residents over 65. Community transport is available in some areas but coverage is not comprehensive since the workforce is largely voluntary. Various surveys such as *The Patient's Journey*<sup>68</sup>, *Community Transport Strategy*,<sup>69</sup> *Unsung Heroes in a Changing Climate*<sup>70</sup> identify continuing gaps in transport provision as a barrier to access.

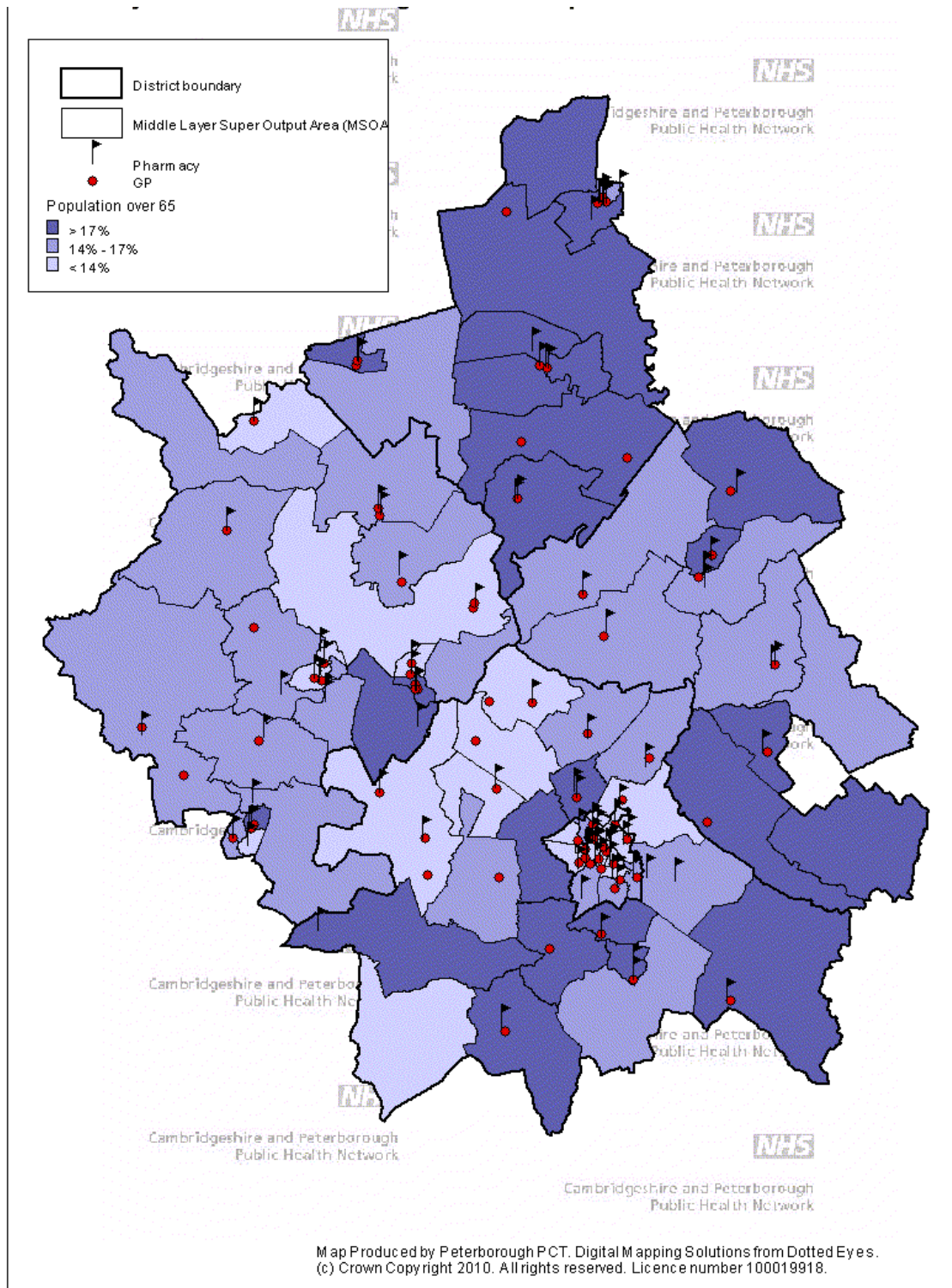
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<sup>68</sup> PPI Forum for Hinchingbrooke Hospital, 2008

<sup>69</sup> South Cambridgeshire District Council, 2010

<sup>70</sup> Cambridgeshire Older People Reference Group, 2010

Figure 30



Consultation on the rural strategy for Cambridgeshire<sup>71</sup> identifies the way in which services are delivered as the barrier to access. In terms of health services, for example, it proposes that NHS Cambridgeshire finds better models of delivery in rural areas, taking services to local places rather than expecting people to travel. This may be more efficient than individuals' travelling independently but is still more expensive than delivering care in urban areas.

71

[http://www.cambsacre.org.uk/downloads/evidencebase\\_090827133021.pdf](http://www.cambsacre.org.uk/downloads/evidencebase_090827133021.pdf)



Comparisons of car ownership across different geographies can be difficult to interpret without reference to local transport infrastructure but census data shows that older people are less likely to have access to a car or van. In 2001, in Cambridgeshire, 43% of pensioner households had no access to a car or van, which rose to 62% among pensioners living alone. Bus services, however, increased in the East of England between 1995/7 and 2007/8 when 84% of households were living within 13 minutes of a bus stop with a service at least once per hour.<sup>72</sup> Nationally, the take up rate of concessionary fare passes among people aged 60 and over increased from 52% in 2002 to 63% in 2006 and 73% in 2008. This reflects changes to the coverage and eligibility of concessionary fare schemes since 2002.

The Department of Transport has published a resource guide for local authorities *Transport Solutions for Older People*<sup>73</sup> and routinely publishes transport data here <http://www.dft.gov.uk/pgr/statistics/> A national Travel Survey is published annually. Consultation on the third local transport plan for Cambridgeshire closed in July 2010.

#### 4.4 Information

Interviews with people aged 76 and over have found important correlations between access to information and access to services; and between access to services and quality of life for older people.<sup>74</sup> Older people have been found to place a higher value on information than other groups in the population.<sup>75</sup> With growing numbers of people using care and support services who do not meet the assessment thresholds for help from public funds, and increasing numbers of people receiving self-directed care, there is an increasing need for information and advice that is accurate and easily accessible. Directgov <http://www.direct.gov.uk/en/index.htm> aims to provide a single point of access to help inform key choices on health and social care needs. However, only in a recent large survey by the King's Fund,<sup>76</sup> only 4% of patients used the NHS Choices website, and 1% used other websites in choose which hospital to attend for treatment. They preferred to rely on:

- Their own past experience (41%)
- Advice from their GP (36%)
- Advice from friends and family (18%).

The Audit Commission has published a series of reports to stimulate debate about how data on public services should best be provided in a form that is acceptable, accessible and useful.<sup>77 78</sup>

According to a 2003 report by the Joseph Rowntree Foundation<sup>79</sup>, older people:

- experienced barriers in accessing information, advice and advocacy in three stages:
  - becoming aware that there was information, advice or advocacy that could help in their situation;
  - gaining access to appropriate and comprehensive information and advice; and
  - receiving practical assistance to act on the information and achieve a solution.

<sup>72</sup> <http://www.dft.gov.uk/pgr/statistics/datatablespublications/personal/>

<sup>73</sup> <http://www.dft.gov.uk/pgr/inclusion/older/transportsolutions.pdf>

<sup>74</sup> <http://coi.gov.uk/documents/commongood/commongood-older-qualresearch.pdf>

<sup>75</sup> Meeting the Information Needs of Older People: A Challenge for Local Governance  
Rose Gilroy . Local Government Studies, 1743-9388, Volume 31, Issue 1, 2005, Pages 39 – 51

<sup>76</sup> [http://www.kingsfund.org.uk/publications/choice\\_at\\_the\\_point.html](http://www.kingsfund.org.uk/publications/choice_at_the_point.html)

<sup>77</sup> [http://www.audit-](http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20100305thetruthisoutthere.pdf)

[commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20100305thetruthisoutthere.pdf](http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20100305thetruthisoutthere.pdf)

<sup>78</sup> <http://www.audit-commission.gov.uk/SiteCollectionDocuments/Downloads/91105nothingbutthetruth.pdf>

<sup>79</sup> <http://www.jrf.org.uk/publications/older-peoples-views-information-advice-and-advocacy>

- welcomed advice that helped relate information to their particular circumstances, and assistance to obtain the services they needed. The volume of information available could be as problematic as an absence of information.
- valued information that was topic-based, rather than the agency-based information that was more frequently offered.
- had diverse approaches to obtaining information. Different modes and styles of information suited people at different times and in relation to different topics. They wanted timely information, often at a point of change or crisis in their lives, and comprehensive information actively offered in their first language at such stages.
- desired continuity of contact, to avoid having to retell their story to new people. A follow-up service was also appreciated, ensuring a solution was achieved, rather than simply being referred on to yet another potential source of information.

A study undertaken in 2005 for the Central Office of Information<sup>80</sup> identified out some of the key features of older people's use of, and preference for, different channels of communication:

- older people have a preference for face-to-face communication, especially informal communication
- they watch more TV per day than any other age group, peaking at around age 70, although they have lowest advertising recall and less interest generally in advertising
- one-quarter of 70-74 year olds reads a daily paper
- older people listen to more radio than other age groups (again peaking around age 70) but are less interested in commercial stations
- Saga is the most popular magazine among older people (18 % of those aged 65-69)
- older people are less likely to throw out printed material of value
- older people expect, and like, official information to be available in hard copy
- older people like telephone helplines, but these are less good for people with certain kinds of impairment and for older people from black and ethnic minorities
- there is still limited access to the Internet among older people but it is growing

People may not benefit from available activities and services through lack of knowledge of what is provided and how to gain access.<sup>81</sup> This may lead to worsening of inequalities if access to information is poorer among people already worse off, and to inefficiencies in service delivery if cost effective services do not reach people who would benefit. Conversely, service providers require information about the needs and wants of users in order to design accessible services.

The information needs of older people are not homogenous. Stage of life, state of health and wellbeing drive information needs. Life events such as moving house, bereavement and adverse health events may prompt changes in information-seeking behaviour but targeting unsought information appropriately requires a multifaceted approach.

Information on opportunities for many activities, on how to follow a healthy lifestyle, on health and social care services, on benefits etc. are available from many different organisations through a variety of channels (websites, newsletters, road shows, group consultations, libraries). However, there is evidence that some older people are reluctant to contact unfamiliar organisations as the first point of call.

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80

<http://coi.gov.uk/documents/commongood/commongood-older-deskcommentary.pdf>

81

<http://campaigns.dwp.gov.uk/asd/asd5/WP47.pdf>

Older people increasingly have access to the internet, but it is estimated that nearly a third of people in the UK will remain digitally excluded by 2015.<sup>82</sup> This proportion is likely to be higher among older people, disabled people, people on a low income, and those with lower poorer health and education.



## 5 Primary prevention – promoting wellbeing

In 2008 the Department of Health published a guide to *Making a strategic shift to Prevention and Early Intervention*.<sup>83</sup> This guide sets out a framework for understanding what is meant by primary prevention and the promotion of wellbeing:

‘Primary prevention is aimed at people who have no particular social care needs or symptoms of illness. The focus is therefore on maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc.’

The World Health Organisation defines healthy ageing as ‘the process of optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life.’<sup>84</sup>

Primary prevention actions to promote healthy ageing are, therefore, grounded in neighbourhoods and communities, affecting community and home life. In Cambridgeshire, these actions are articulated in Sustainable Community Strategies produced by each Local Authority, in Neighbourhood Management Action Plans and in Strategies such as Tackling Health Inequalities in Cambridgeshire.<sup>85</sup> Sustainable Community Strategies can be found on the websites of each Local Authority or hard copies can be requested. These local strategies and plans will be complemented by a new Ageing Well programme recently launched by the Local Government Improvement and Development Agency.<sup>86</sup> Support will be given to local authorities to use their resources effectively to:

- promote wellbeing in later life
- ensure that older people can live independently for longer
- engage older people in civic life
- tackle social isolation by recognising older people's potential

Research into exceptional longevity in men published in 2008 concluded that modifying behaviour in early elderly years, that is stopping smoking, weight management, blood pressure control and regular exercise was not only associated with a longer lifespan, but also with good health and function during older age.<sup>87</sup>

A recent Cambridgeshire Community Study produced by the Cambridgeshire Older Peoples Reference Group found that ‘the promotion of active ageing by public sector organisations is now a more common theme and has had some practical outcomes for older people’. Despite these welcome findings, the study also reminds commissioners and service deliverers that ‘active ageing relates not only to physical exercise but also to social inclusion’.

This section describes what is known about healthy ageing in Cambridgeshire in areas such as feeling safe, sexual health, smoking, obesity, physical activity, falls, diet and nutrition and alcohol. The Prevention Strategy Framework being drafted by Cambridgeshire County Council and its partners will complement this Joint Strategic Needs Assessment. Achieving

<sup>83</sup> Department of Health (2008). *Making a strategic shift to Prevention and Early Intervention*. Leeds. See: <http://www.dhcarenetworks.org.uk/Prevention/type/Resource/?cid=4421>

<sup>84</sup> World Health Organisation (2006). *Healthy Ageing – a Challenge for Europe*. Stockholm. See: <http://www.fhi.se/en/Publications/All-publications-in-english/Healthy-Ageing--a-Challenge-for-Europe/>

<sup>85</sup> NHS Cambridgeshire (2010). *Tackling Health Inequalities in Cambridgeshire*. Cambridge. See: <http://www.cambridgeshirepct.nhs.uk/downloads/Your%20Health/OtherPublicHealthReports/Cambridgeshire%20Health%20Inequalities%20Strategy%202009-2011.pdf>

<sup>86</sup> Local Government Improvement and Development Agency (2010). Ageing Well Programme. See: <http://www.idea.gov.uk/idk/core/page.do?pagelid=20344655>

<sup>87</sup> Yates, L.B. et al (2008) *Exceptional Longevity in Men*. Archives of Internal Medicine Vol. 168 (3): 284-290.

independence for older people through rehabilitation and intermediate care is a strategic priority for Cambridgeshire.<sup>88</sup>

Prevention of future disease and ill health also has the potential to reduce or avoid future health and social costs. While the benefits may not be apparent immediately, investment in preventive services is good value for money. A recent paper<sup>89</sup> points out

- A majority of the most costly health conditions are (at least in part) preventable eg heart disease, diabetes.
- Prevention has the potential to reduce end-of-life care costs.
- Savings from prevention accrue beyond the health sector.

## 5.1 Feeling safe – Crime and Older People

Based on findings from the British Crime Survey for England and Wales, a report was published in 2002 looking at the victimisation of older people, their worry about crime, use of security precautions and confidence in the Police and the Criminal Justice System:

- From 1991 to 1999 the share of incidents of crime of the over 60-year-olds has remained more or less constant (12% to 14%). This compares to a figure of 6.2% of the people aged 65 and older in Cambridgeshire in 2008-09
- Older people's risk of suffering from a household or a personal crime is much lower than for the other age groups. Older people are more likely to report violent incidents of crime and much less likely to be repeatedly victimised than the other age groups
- Older people have similar levels of worry for most crime types to those of other age groups despite their lower levels of victimization
- Older women, are more likely than older men to worry about fear of household or personal crime. Those that perceive their health to be bad or very bad also worry more about crime than those that perceive their health to be fair to very good. This may help to explain why older people have disproportionate levels of fear, given their relatively low levels of victimisation, as they also tend to suffer from worse health than the other age groups
- Older people (aged over 60) and those aged over 30 are more likely to employ security devices at home than those aged under 30. In terms of vehicle security, the young and the old seem to have fewer security devices than the 30- to 59-year-olds. Personal security is more prevalent amongst the youngest age group as they are more likely to carry weapons or to have done a self-defence course
- Older people tend to have a better opinion about most criminal justice system agencies than those aged 30- to 59-years-old. On the other hand, the over 60s are: less likely to think that witnesses are very/fairly well treated by the police but more likely to think that witnesses are very/fairly well treated by the courts than the other age groups; and, more likely to think that court sentences are much too lenient

Between April and December 2008, only 3% of all victims of violent crime were aged over 60 years and on almost all occasions the victim either knew the offender or was a victim of death

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88

<http://www.cambridgeshire.nhs.uk/downloads/Corporate%20documents/WCC%20Panel%20Report%20Cambridgeshire%20Final.pdf>

89

<http://www.preventioninstitute.org/component/jlibrary/article/id-79/127.html>

by dangerous driving. Serious violent attacks on older people by strangers remain very rare within the Cambridgeshire Constabulary area.

During 2009-10 there were 119 distraction burglaries involving people 65 years and over in the Cambridgeshire and Peterborough area. Of the total number of distraction burglaries reported (128) 93% involved people 64 years and over.

Eighty eight Rogue Trader incidents were reported to Cambridgeshire Trading Standards during 2009-10 but this is thought to underestimate the size of the problem.

## 5.2 Fire safety home visits

Fire Safety Checks is a free service offered to any resident in Cambridgeshire. Firefighters or specially trained community safety officers will visit homes to help identify and assess the risks of fire and advise on the best practices to keep homes and families safe; this includes fitting the appropriate number and correct type of smoke alarms.

Table 26 shows the number of visits the Cambridgeshire Fire and Rescue Service made to the homes of people aged 60 and over across Cambridgeshire during 2008-09 and 2009-10. The type of visits ranged from a flyer drop to a Home Fire Safety check. Injuries and fatalities are few (around 12 and 2 pa respectively) but are thought to be largely preventable through the provision of smoke alarms.

**Table 26**

Locality	1/4/2008-31/3/2009	% of population	1/4/2009-31/3/2010	% of population
Cambs City	193	0.16%	195	0.16%
East Cambs	226	0.27%	178	0.21%
Fenland	336	0.37%	282	0.31%
Huntingdon	570	0.35%	309	0.19%
South Cambs	235	0.17%	69	0.05%

Source: Cambridgeshire Fire and Rescue Service

## 5.3 Sexual health

From 2002 onwards there has been an increase in the rates of Sexually Transmitted Infections (STIs) across the country including the East of England.<sup>90</sup> Most recent data from 2008 suggests that there are signs of improvement with some indicators showing that the increases were levelling. Although the prevalence of STIs is well documented there is little evidence relating to the sexual health of the older age groups. There are some indications, however, that a focus on older people is necessary.

The Health Protection Agency has published a review of adults aged 15 and over who were newly diagnosed with HIV between 2000 and 2007<sup>91</sup>. Key findings are:

- HIV infections diagnosed in the over 50s have more than doubled over a period of seven years
- Of those over 50s diagnosed during the review period, half were diagnosed late. This compares with a third in younger adults. During the eight year study period three quarters of deaths among people aged 50 and over occurred within one year of diagnosis, with half of those diagnosed late.

<sup>90</sup> Eastern Regional Public Health Observatory (2006) *HIV and sexually transmitted infections in the East of England*. Issue 16. Cambridge, England.

<sup>91</sup> R. Smith et al. HIV Transmission and high rates of HIV diagnosis among adults aged 50 years and over. *AIDS* 2010, 24:000-000. <http://journals.lww.com/aidsonline/pages/currenttoc.aspx>

- When compared with younger adults with HIV, older people were significantly more likely to have been infected through sex with men. Older heterosexual adults were more likely to be infected within the UK, with evidence of travel abroad among white heterosexual men

In Cambridgeshire there has not been any research with the specific aim of understanding the sexual health of older people. Data from the last quarter of 2008 indicates that there were fifty-one people aged 55 years and over living with HIV of a total of 356.<sup>92</sup>

These indicators, along with increased longevity accompanied with improvements in health and more older people starting new relationships, indicate that a better understanding of the sexual health of older people is required. The current Sexual Health Strategy has a key aim of decreasing health inequalities and decreasing any inequity in access to preventative and treatment services.

Further information regarding the sexual health of older people is required if this objective is to be fully achieved.

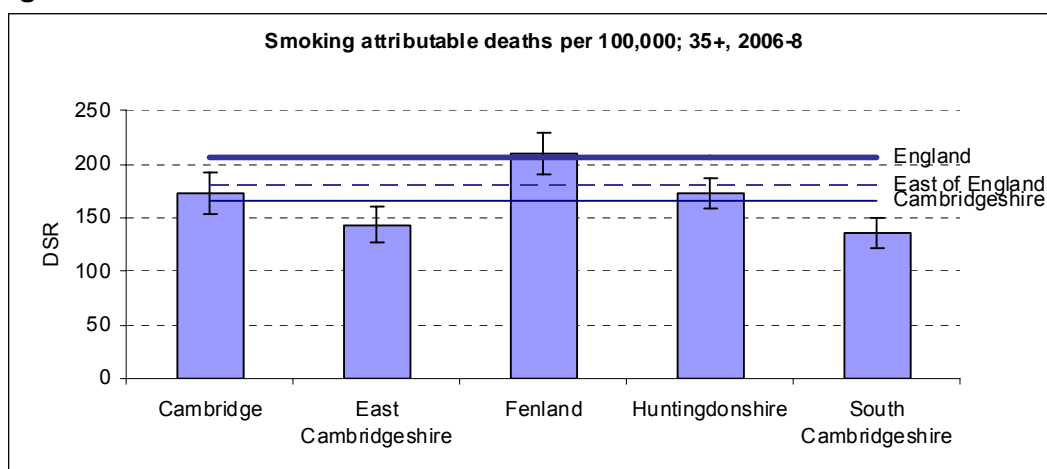
## 5.4 Smoking

Cigarette smoking is implicated in eight of the top fourteen causes of death for people 65 years of age or older. Smoking causes disabling and fatal disease, including lung and other cancers, heart and circulatory diseases, and respiratory diseases such as emphysema. It also accelerates the rate of decline of bone density during ageing. At age 70, smokers have less dense bones and a higher risk of fractures than non-smokers. Female smokers are at greater risk for post-menopausal osteoporosis. Half of long-term smokers die of tobacco-related illnesses, most prematurely, and many suffer from a variety of chronic conditions related to smoking.

Cigarette smoking continues to be the leading preventable cause of death, locally as well as nationally. It is estimated to have killed over 730 people in Cambridgeshire per year.<sup>93</sup> That is an average of 14 deaths per week.

Of the deaths caused by smoking, about 64% were among men and 36% among women (Figure 28). Most were due to the three main diseases caused by smoking – lung cancer, chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD).

**Figure 31**



<sup>92</sup> 4 Source: SOPHID, Health Protection Agency. See [http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/AccessingHIVCare/hivsti\\_soph\\_SophidContacts/](http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/AccessingHIVCare/hivsti_soph_SophidContacts/)

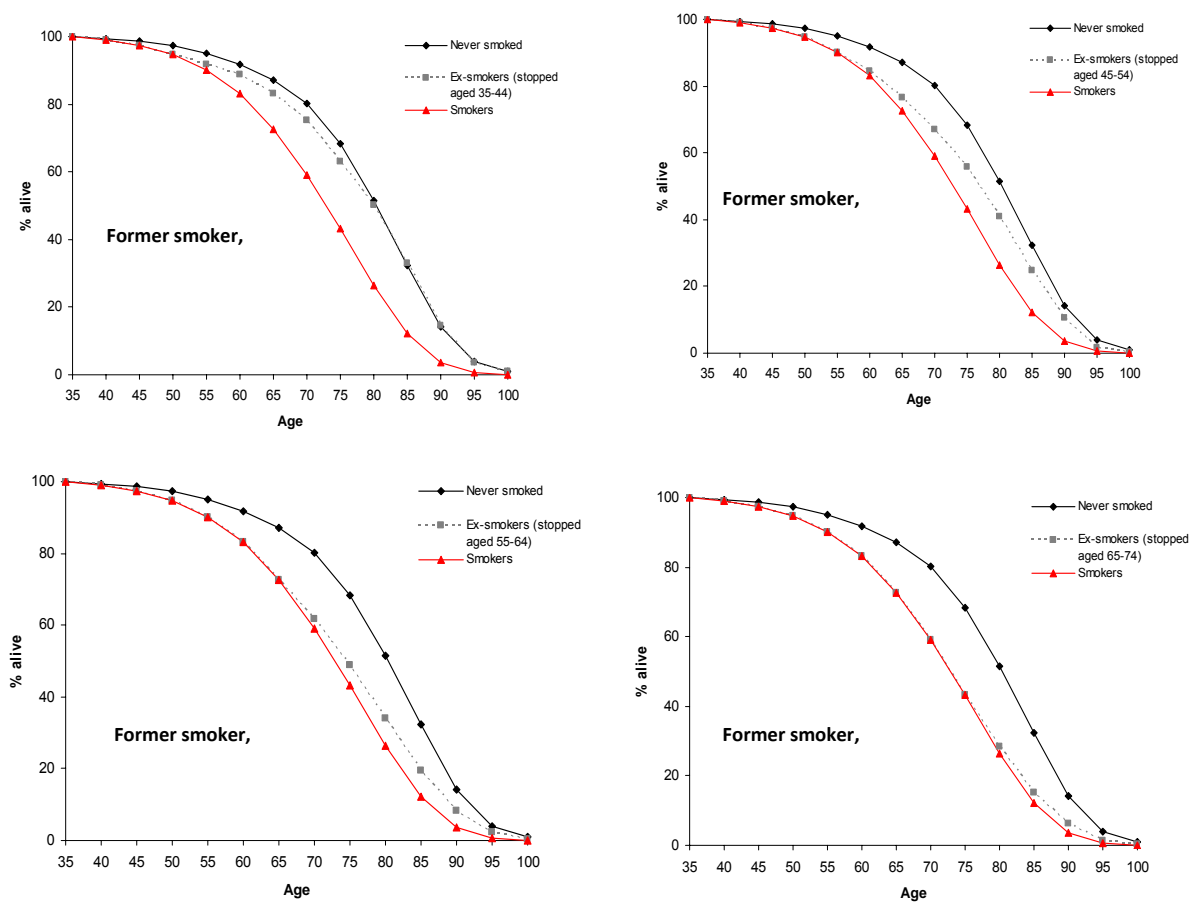
<sup>93</sup> APHO Health profiles 2010, <http://www.apho.org.uk/default.aspx?RID=49802>

The good news is that many of the negative health effects of smoking can be reversed with cessation. Doll *et al* (2004)<sup>94</sup> reported on a 50 year cohort study examining the impact of smoking cessation on survival. The study found that quitting smoking beyond middle age still had a positive effect on total mortality. Overall, the British doctors cohort study found that stopping smoking at age 50 halved the hazards of smoking; cessation at 30 avoided almost all of it. Stopping smoking at age 60, 50, 40, or 30 gains, respectively, about 3, 6, 9, or 10 years of life expectancy. Smokers who quit at 65-74 years of age had age-specific mortality rates beyond 75 years which were lower than smokers who do not quit.

The grey lines in Figure 29 show the benefits in years gained in men who stopped smoking in the previous decade.

**Figure 32**

**Effects on Survival of Stopping Smoking in the Previous Decade for Men**



Doll et al 1994 BMJ ; 309 –901-911

### Smoking prevalence

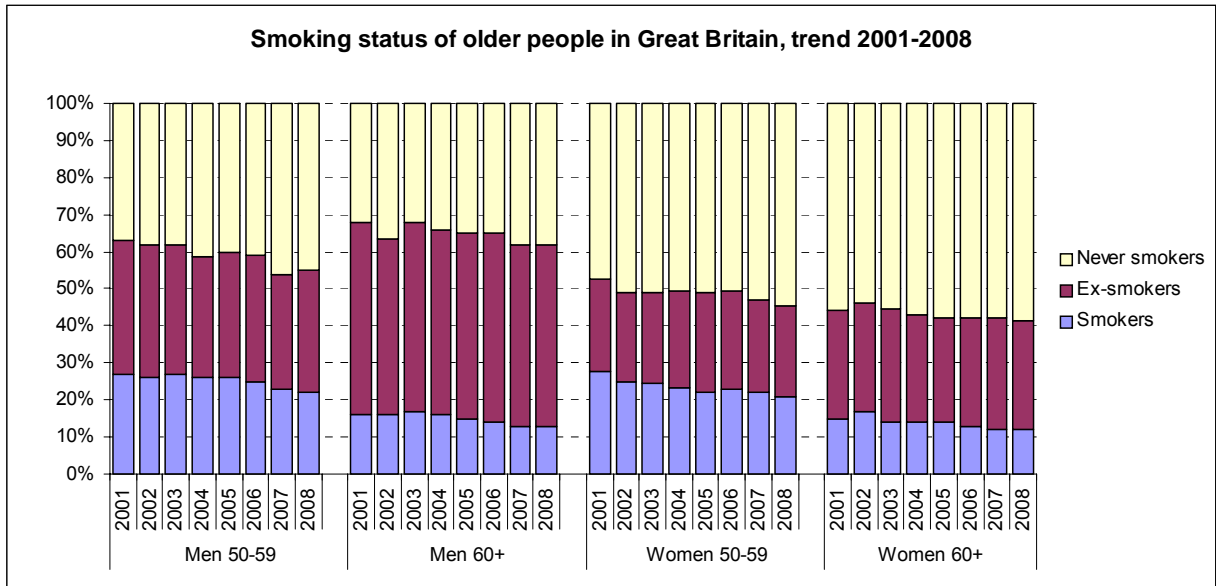
In Britain the highest rates of smoking are in the 20-24 age-group. The prevalence of smoking declines with age, but 17% of men and 14% of women over 60 smoke.<sup>95</sup> The difference between the age groups has historically been smaller and has increased as the result of higher smoking cessation rates amongst older people.

<sup>94</sup> Doll R, Peto R, Boreham J and Sutherland I (2004) Mortality in relation to Smoking, 50 years Observations on Male British Doctors, *British Medical Journal* 328: 1519

<sup>95</sup> ONS, Living in Britain: Results from the 2002 General Household Survey. 2004, TSO: London

Figure 30 shows the smoking status in different age groups in Great Britain. In Cambridgeshire, there are estimated to be 37,360 smokers over the age of 50. The prevalence estimates from the regional survey are imprecise and trends with Cambridgeshire are unclear, but the overall picture suggests that the prevalence in Cambridgeshire as a whole is general lower than the national average (Figure 31).

**Figure 33**

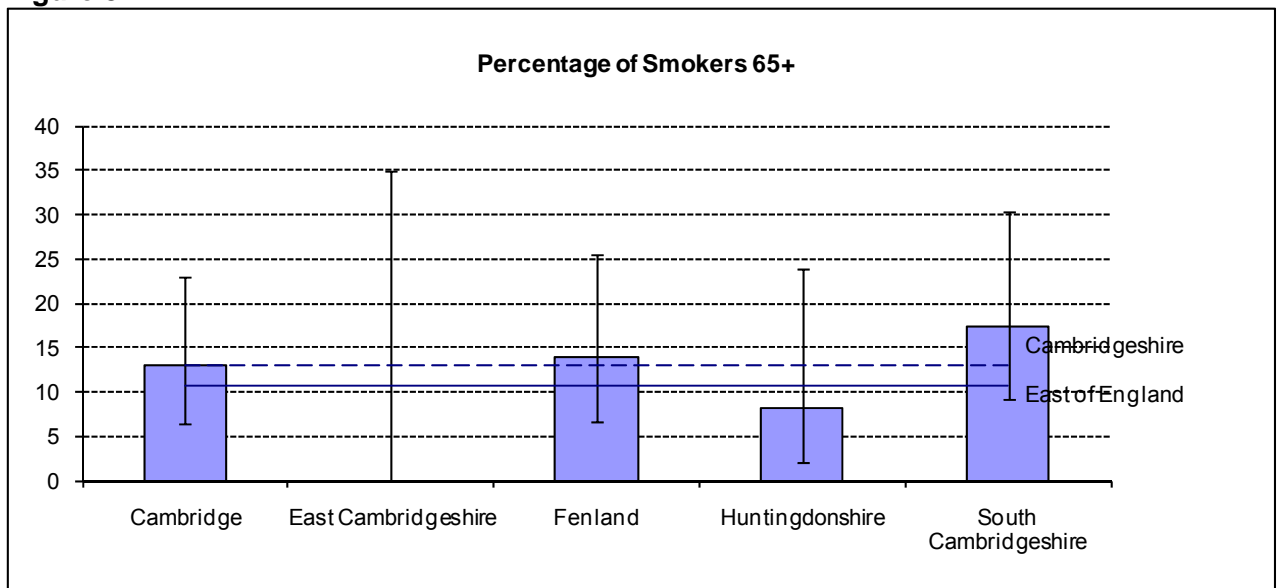


Source: ONS Living in Britain (2002). Prevalence figures from General Household Survey, applied to population figures CCC Research Group (2006).

NICE public health intervention guidance on brief interventions and referral for smoking cessation in primary care and other settings underpins local delivery programmes. The guidance considers whether brief smoking cessation interventions are effective at encouraging individuals to quit smoking.

<http://guidance.nice.org.uk/PHI1/?c=296726>

**Figure 34**



*Smoking cessation activity*

Camquit, the local smoking cessation service, provides evidence-based stop smoking interventions to the population of Cambridgeshire. Services are delivered in General Practice, Pharmacy and various Community Settings. Priority groups for Cambridgeshire include pregnant women and routine and manual workers. Older people are not specifically targeted but people aged 50 and over make up 34% of total service users and people aged over 60 make up nearly 20% of service users (Tables 27a, 27b). People are encouraged to 'set a quit date' and this is recorded and monitored at the four week stage. The quit rate ie percentage of people that have quit at four weeks increases with age.

**Table 27a: Camquit: Smoking cessation activity 2008/09 – 2009/10 by age group**

Age at quit date	People accessing services			Four week quitters		
	Male	Female	Persons	Male	Female	Persons
10-19	341	376	717	70	121	191
20-29	1,024	1,190	2,214	446	511	957
30-39	1,428	1,498	2,926	701	694	1,395
40-49	1,433	1,463	2,896	718	691	1,409
50-59	1,018	1,119	2,137	538	563	1,101
60-69	884	908	1,792	525	501	1,026
70-79	315	284	599	186	150	336
80+	36	32	68	24	18	41
<b>Total</b>	<b>6,479</b>	<b>6,870</b>	<b>13,349</b>	<b>3,208</b>	<b>3,249</b>	<b>6,457</b>

Source:

**Table 27b: Camquit: Smoking cessation activity 2008/09 – 2009/10 by age-group**

AgeAtQuitDate	Quit rates (%)			Proportion of service users		
	Male	Female	Persons	Male	Female	Persons
10-19	21%	32%	27%	2.6%	2.8%	5.4%
20-29	44%	43%	43%	7.7%	8.9%	16.6%
30-39	49%	46%	48%	10.7%	11.2%	21.9%
40-49	50%	47%	49%	10.7%	11.0%	21.7%
50-59	53%	50%	52%	7.6%	8.4%	16.0%
60-69	59%	55%	57%	6.6%	6.8%	13.4%
70-79	59%	53%	56%	2.4%	2.1%	4.5%
80+	67%	56%	60%	0.3%	0.2%	0.5%
<b>Total</b>	<b>50%</b>	<b>47%</b>	<b>48%</b>	<b>48.5%</b>	<b>51.5%</b>	<b>100.0%</b>

Source: CAMQUIT, Cambridgeshire's free Stop Smoking Support Service; Ph 0800 018 4304 or visit [www.camquit.nhs.uk](http://www.camquit.nhs.uk).

NICE public health guidance on smoking cessation services in primary care, pharmacies and local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities also underpins local delivery programmes.

<http://guidance.nice.org.uk/PH10>

**5.5 Physical activity**

For people of all ages, physical activity improves the quality of life in many ways. Physical benefits include improved and increased balance, strength, coordination, flexibility and



endurance. Physical activity has also shown to improve mental health, motor control and cognitive function.

Active lifestyles provide older persons with regular occasions to make new friendships, maintain social networks, and interact with other people of all ages. Improved flexibility, balance, and muscle tone can help prevent falls—a major cause of disability among older people. It has been found that the prevalence of mental illness is lower among people who are physically active.<sup>96</sup>

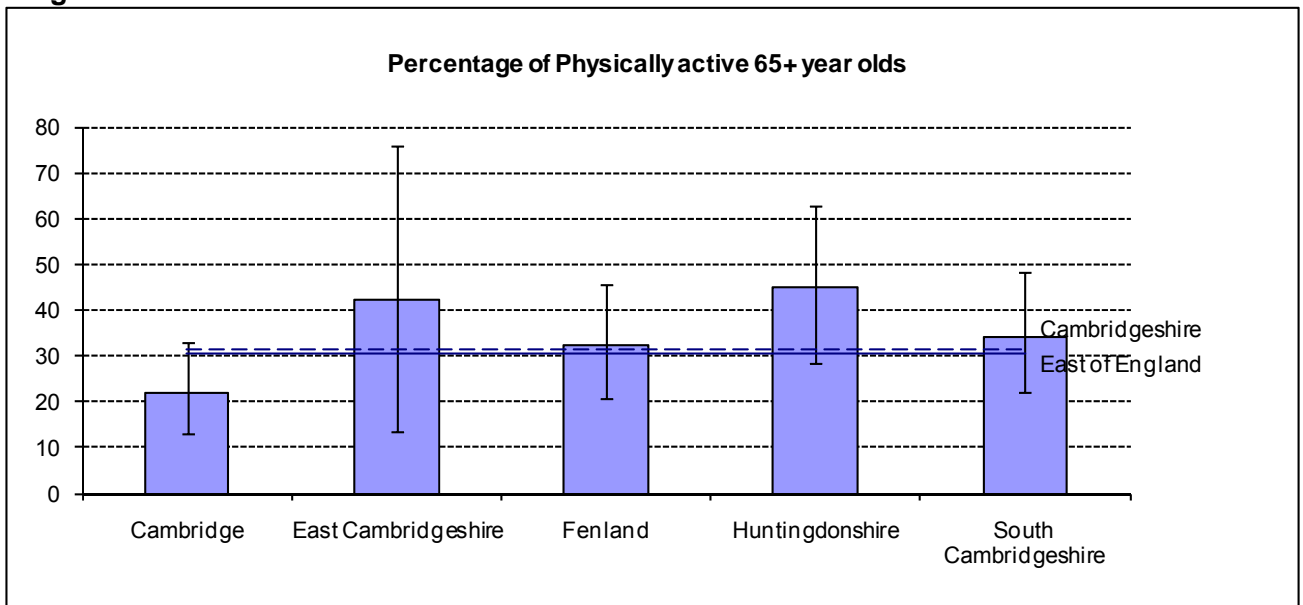
According to the regional lifestyle survey, around 30% older people in Cambridgeshire consider themselves to be physically active (Figure 32).

The NICE physical activity public health intervention guidance covers four common methods used to increase the population's physical activity levels:

- Brief interventions in primary care
- Exercise referral
- Pedometers
- Community based walking and cycling schemes

<http://guidance.nice.org.uk/PHI2/?c=296726>

**Figure 35**



*Active People survey*

The Active People Survey collects data on people aged 55 years and over. National Indicator 8 (NI8) is the percentage of the adult population in a local area which participates in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last four weeks (equivalent to 30 minutes on three or more days a week). This indicator includes recreational and 'sport' walking and cycling. It also includes 'light intensity' activities for people aged 65 and over eg bowls, archery, yoga, pilates, croquet (considered 'moderate intensity' for this age group). The indicator does not include activity

<sup>96</sup>

<http://www.sportscotland.org.uk/ChannelNavigation/Resource+Library/Publications/Older+People+Sport+and+Physical+Activity.htm>



related to travel eg walking to work or physical activity at work, and can be expected to identify lower levels of activity than the regional lifestyle survey.

Figure 33 shows that there has been a slight decrease in the proportion of males aged 55 years and over who participated in at least three days of 30 minutes moderate participation in sport and active recreation in Cambridgeshire within the previous four weeks before the survey.

**Figure 36:** Trend in at least three days a week of 30 minutes moderate participation in sport and active recreation, last four weeks, people aged 55+ years (NI8)

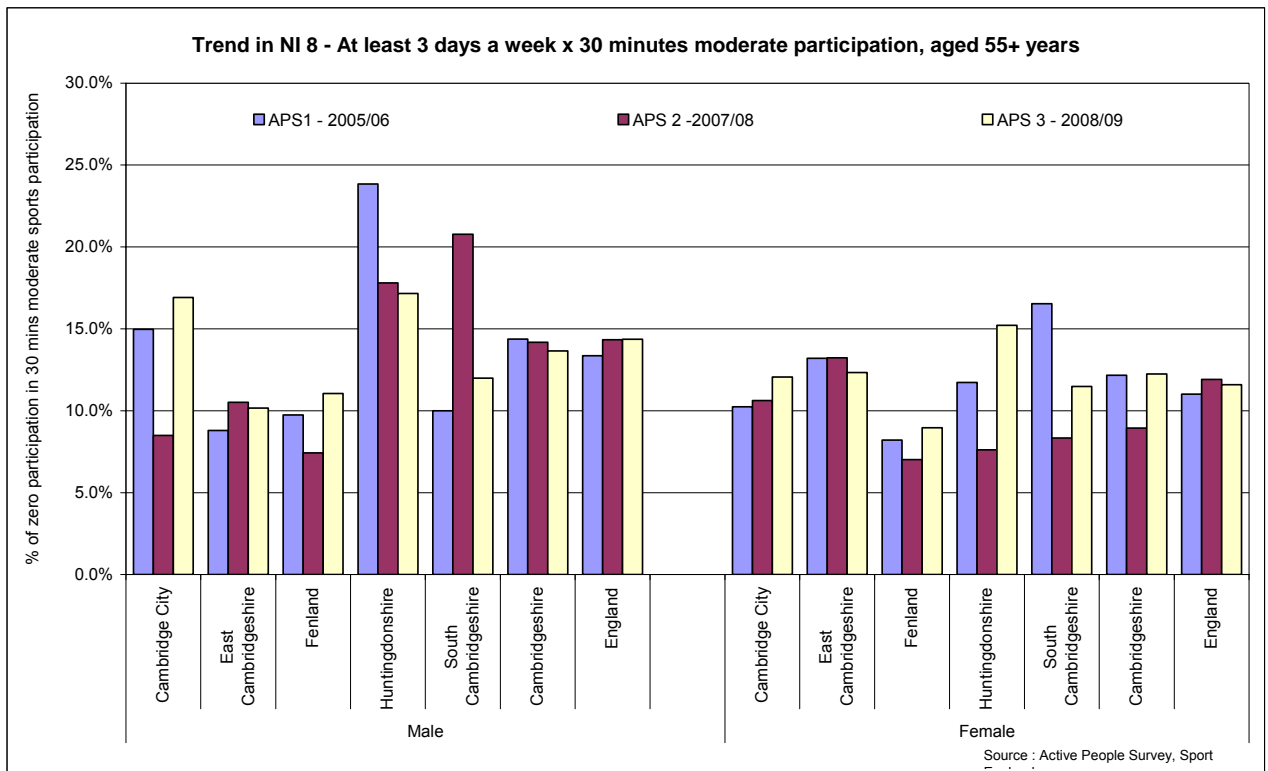
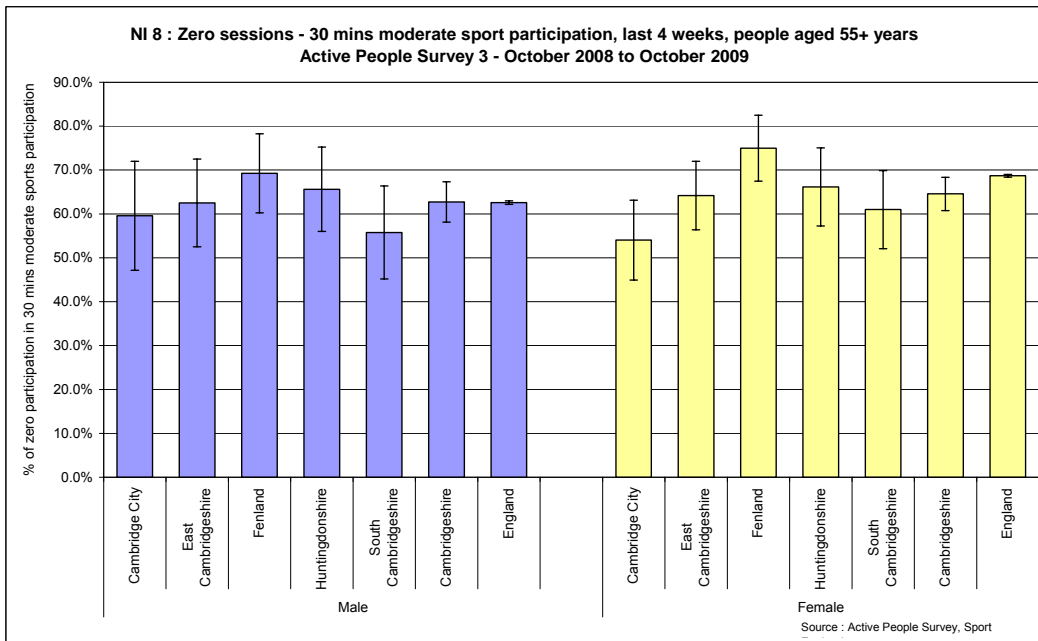


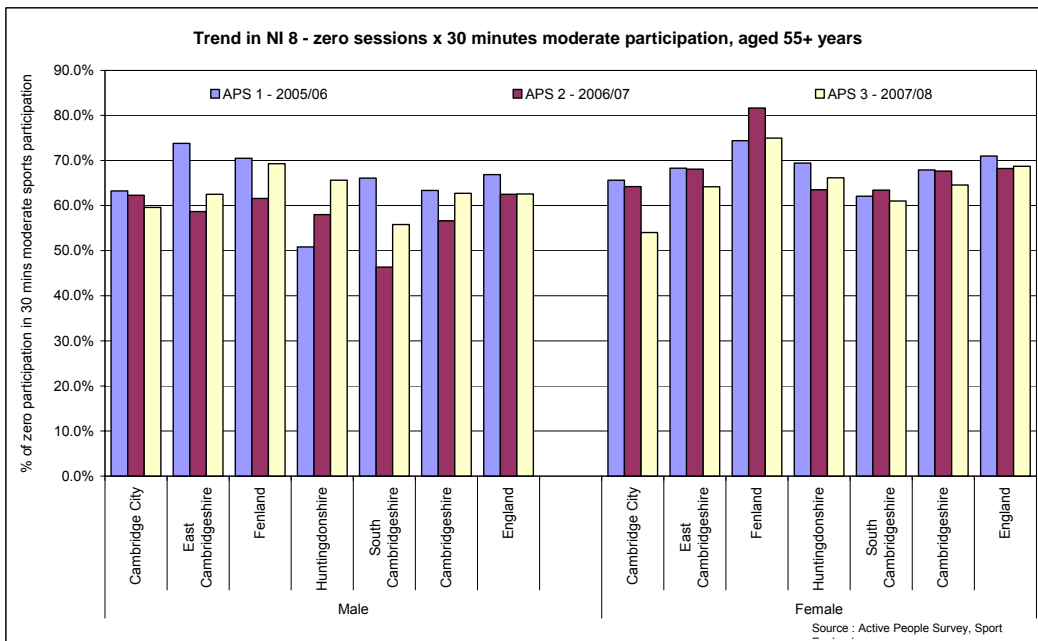
Figure 34 shows that in 2008/09 non-participation in sport and active recreation in people aged 55 years and over was highest in Fenland for both males and females. The pattern for Cambridgeshire differs to the national picture in that non-participation in Cambridgeshire is fairly equal between the sexes, whereas nationally a significantly higher proportion of females do not participate in such activities. The overall proportion for males in Cambridgeshire is similar to the national average whereas the proportion for females is lower.

In general, the number of people in Cambridgeshire with zero days of 30 minutes of moderate participation in sport and active recreation has remained fairly stable for males and has decreased for females (Figure 35). It appears that there has been a large increase in the proportion of males in Huntingdon, whilst there have been decreases in Cambridge City, East Cambridgeshire and South Cambridgeshire. There has been a noticeable decrease in females aged 55 years and over not participating in moderate sport and active recreation in Cambridge City. East Cambridgeshire, Huntingdonshire and South Cambridgeshire have also experienced decreases.

**Figure 37: Zero sessions in participation of 30 minutes moderate participation in sport and active recreation, last 4 weeks, people aged 55+ years (NI8), APS3 – 2008/09**



**Figure 38: Trend in zero sessions in participation of 30 minutes moderate participation in sport and active recreation, last four weeks, people aged 55+ years (NI8), APS3 – 2008/09**



The majority of Local Authorities in Cambridgeshire have specific programmes designed to increase or maintain levels of physical activity in older people. These include Forever Active in Cambridge City, Fitness4Health in South Cambridgeshire, Mature and Active in East Cambridgeshire and Active at 50 and the Right Start programmes in Huntingdonshire. These are complemented by additional programmes such as the Dancing for Better Health and Fun, Health Walks and evidence based falls prevention classes.

It is recommended that District Councils and other delivery partners be asked to ensure physical activity related active ageing programmes are evidence-based and cost effective to safeguard future sustainability.

## 5.6 Falls

A recent review by the East of England Strategic Health Authority (SHA), *Benefits of implementing NICE Falls Prevention guidelines on utilisation of healthcare highlights the morbidity and costs due to falls in the population.*<sup>97</sup> Falls represent the most frequent and serious type of accident in the over 65 age group.

Community studies have estimated that about a third of people aged 65 and over will fall at least once a year.<sup>98</sup> This rises to approximately half of those aged 85 and over. A study of falls among over-90-year-olds in the Cambridge City over-75s Cohort study (CC75C),<sup>99</sup> found 58% of the cohort of 110 people had fallen at least once in the previous year. Between 5% and 10% of community-dwelling older adults who fall each year sustain a serious injury – such as a fracture, head injury or serious laceration.<sup>100</sup> Around 20 deaths each year in Cambridgeshire are associated with a fall.

Common causes for falls among older people are muscle weakness, problems with balance and mobility, poor eyesight, or a combination of these factors.<sup>101</sup> Side effects of medication can be important contributing factors.

It was found that among community-dwelling adults the risk of falls rose by about 30% for patients who used four or more drugs. A wide range of medications frequently used by older patients is known to increase the risk of falls significantly. Particularly sleep aids, antidepressants, antipsychotics, cardiovascular drugs, pain medication and antihistamines can have side effects such as dizziness, drowsiness or confusion which are related to falls.

Especially when new drugs are prescribed it appears to be important to raise awareness with patients and carers about these issues. Maintaining a sufficiently high level of Vitamin D on the other hand seems to have a beneficial effect for fall prevention.<sup>102</sup>

In Cambridgeshire, in 2008/09, there were 2525 admissions where a fall was coded as the reason for hospital admission. The age-standardised rate of admission to hospital for an accidental fall was around 1700 admissions per 100 000 people. This is higher than the East of England, and within Cambridgeshire, highest in Cambridge City (Figure 36). Figure 37 shows the implications of an ageing population on the number of serious falls if these figures are applied to the projected population of older people. The estimated number of total falls is higher (Figure 38), of whom a significant proportion will result in A and E attendance (Figure 39).

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<http://www.erpho.org.uk/Download/Public/15968/1/Impact%20of%20implementing%20NICE%20Falls%20Prevention%20Guidelines%20on%20utilisation%20of%20healthcare.doc>

98 Gillespie LD, Gillespie WJ, Robertson MC, Lamb SE, Cumming RG, Rowe BH. Interventions for preventing falls in elderly people. *Cochrane Database of Systematic Reviews* 2003, Issue 4. Art. No.: CD000340. DOI: 10.1002/14651858.CD000340

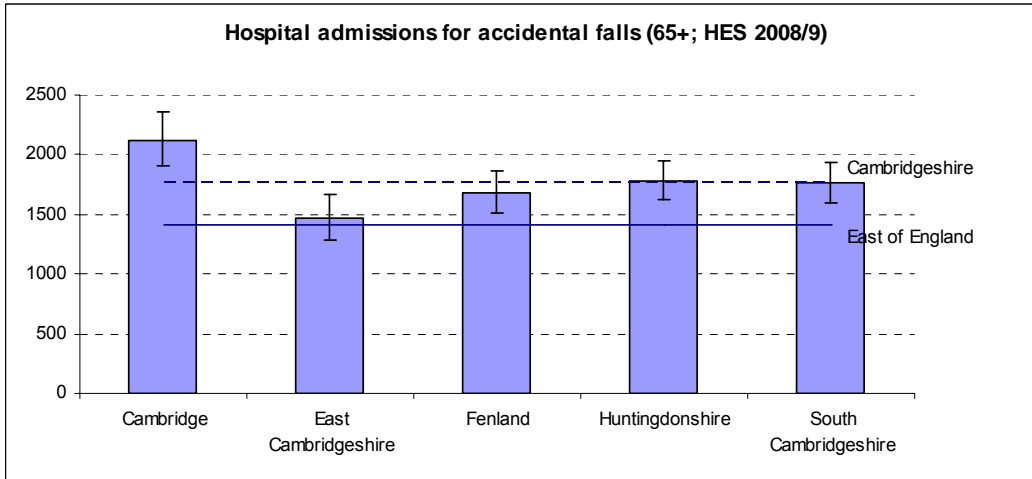
99 <http://www.cc75c.group.cam.ac.uk/pages/internaldocuments/publications/fallsbmc.pdf>

100 Scuffham P et al. Incidence and costs of unintentional falls in older people in the UK. *J Epid. Comm Health* 2003;57:740-744

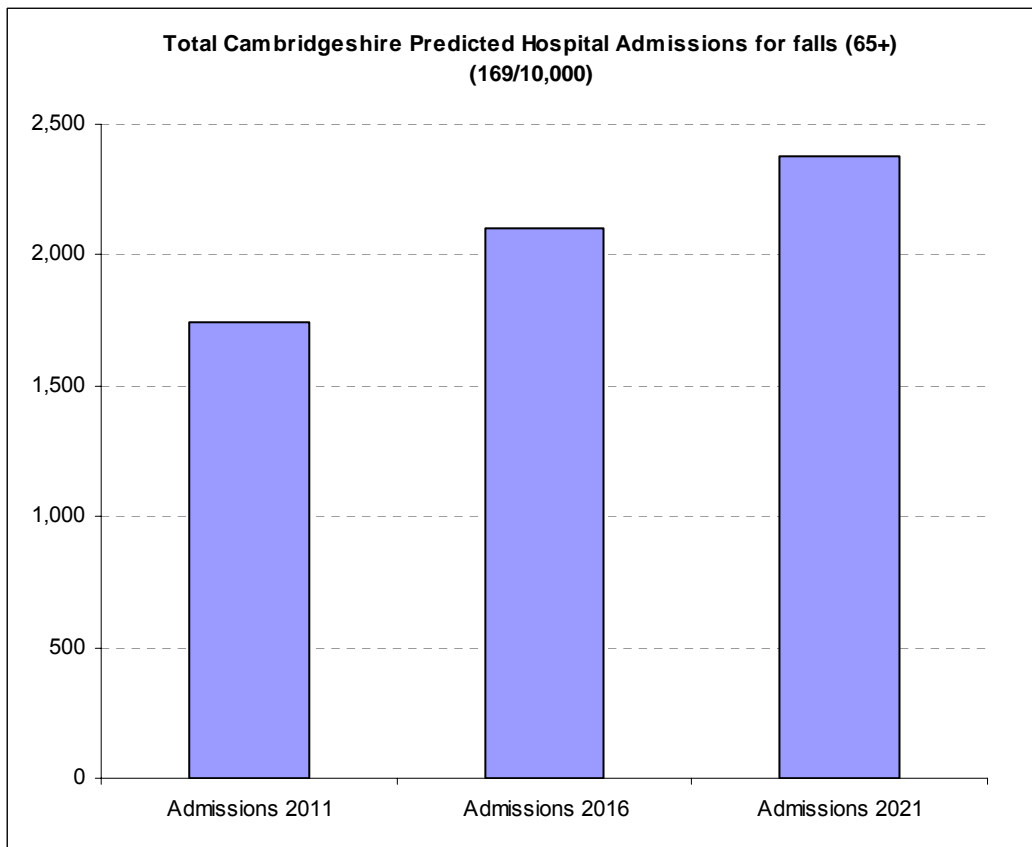
101 <http://www.nhs.uk/conditions/falls/Pages/Introduction.aspx>

102 Stump, AL. Effect of Medication Use on Falls: Balancing Risk, Benefit, and Prevention Strategy, 2009 Wyoming Conference on Aging, 19 May 2009, <http://wdh.state.wy.us/Media.aspx?mediaId=7081>

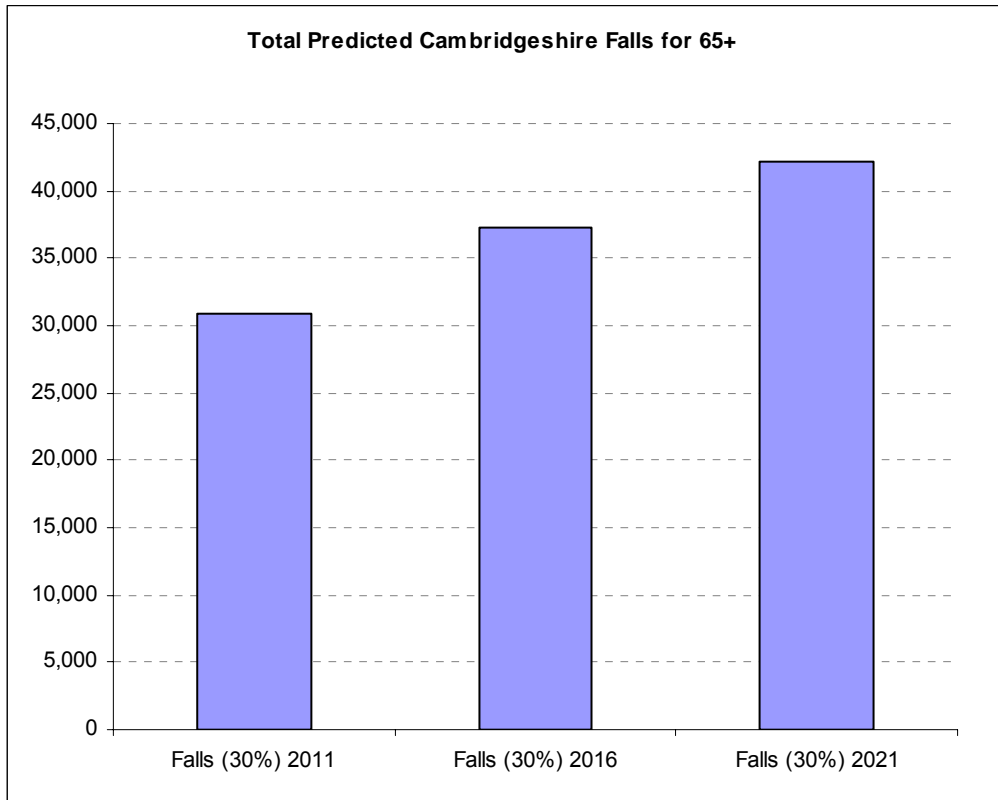
**Figure 39**



**Figure 40**



**Figure 41**



**Figure 42**

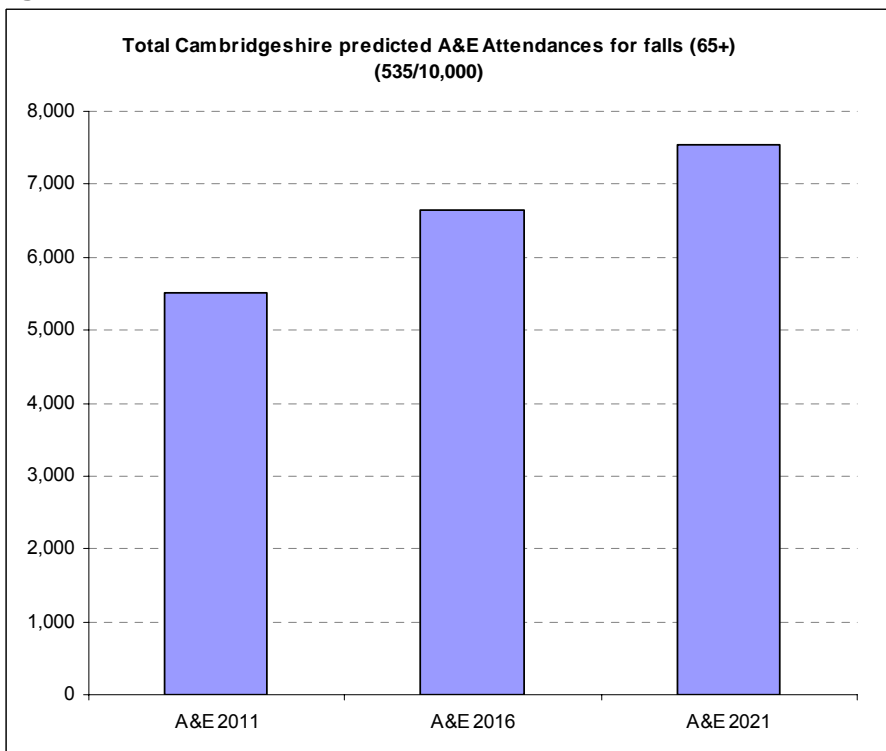


Table 28 show the calculations from the SHA review using local population figures (registered population) and for the local authority areas. An estimate of the costs of NHS and Social Care components for Cambridgeshire PCT is also shown.

**Table 288: Estimated A&E attendance and hospital admission and costs due to fall related injuries in Cambridgeshire PCT, 2007**

Study Estimates		Cambridgeshire	East Cambs and Fenland	Greater Cambridge	Hunts
	Population all ages	584,332	176,293	256,525	151,514
	Population 60+	120,601	41,910	47,393	31,298
	% of population 60+	21%	24%	18%	21%
30%	Expected number of falls in a year	36,180	12,573	14,218	9,389
535 per 10,000	Number likely to attend A&E in a year	6,452	2,242	2,536	1,674
169 per 10,000	Number of hospital admissions in a year	2,038	708	801	529
£810,000 per 10,000	Costs of treating accidental falls (NHS and social care)	£9,768,680	£3,394,710	£3,838,830	£2,535,140

Source: Population: FHS Registration system (Exeter) April 2006. Rates for A&E and hospital admissions from HES data 1999 (Scuffham P et al, 2003).

Similar calculations for Fractured Neck of Femur due to falls based on an incidence of 25 per 250,000 population give an annual number of 579 with an estimated cost of treatment at £12,163<sup>103</sup> a case of around 7.5 million pounds and total annual bed days (based on an average length of stay of 26 days) of over 15,000 bed days. An estimate of the number of people requiring long term care following an admission to hospital for a falls related complication is 483 people (nearly 27% in over 75 year age group and 9% in 70-74 year olds).

NHS Cambridgeshire is leading a multidisciplinary/multi-agency falls prevention and management commissioning project. It aims to develop a falls pathway including early intervention and prevention activity. There is a commitment to move away from acute based secondary care interventions and develop the three levels of prevention and community provision.

The project aims to make the shift towards prevention by increased access to evidence based falls related exercise groups across the county working with both community providers and the District Councils. Opportunities to develop improved case finding of people at risk of osteoporosis in Primary Care will be identified and follow up fracture liaison activity will be integrated into falls management provision. A rapid response service to attend to people who fall in their own home will be developed. This response service will provide rapid response to a person and provide the appropriate social care and functional support including assistive equipment following a fall. The falls response service works closely with the service which started in Cambridgeshire in autumn 2010. The re-ablement service promotes independence and confidence for people who fall and provides secondary prevention activity.

Currently the provision of evidence-based community falls-related exercise opportunities for older people is inequitable across the five Districts of Cambridgeshire. These falls-related exercise opportunities provide both primary, as well as secondary, prevention and act as an exit route to maintain ability and function following rehabilitation.

It is recommended that each District Council works with NHS Cambridgeshire in partnership to identify opportunities for prioritising the provision of evidence-based falls related programmes in Locality Sports Development Business Plans as a contribution to falls

<sup>103</sup>

Costs from Lawrence TM, White CT, Russell W et al. The current hospital costs of treating hip fractures. Injury 2005, 36,88-91.

prevention, long term condition management and the shift towards prevention. The number of recalled falls in the last year has been found to be strongly predictive of subsequent falling, which could be asked of older people to identify those at greatest risk.<sup>104</sup>

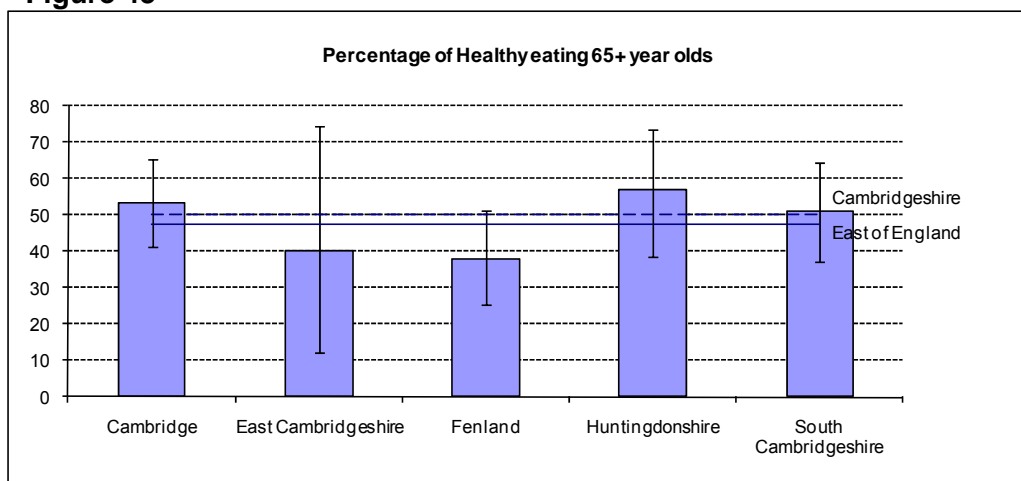
## 5.7 Diet and nutrition

Good nutrition for older people is important to promote good health and wellbeing and to reduce the risk of disease, particularly cardiovascular disease and some cancers. An adequate energy intake is also important to preserve functional capacity by maintaining bone and muscle strength.

Healthy eating messages such as ‘5 a day’ which promotes the importance of eating at least five portions of fruit and vegetables daily to the general public are as important to older people. The EPIC-Norfolk study<sup>105</sup> found among people aged 45-79, an approximately 30% increase in risk of death in people with a low consumption of fruit and vegetables.

The EPIC-Norfolk study found among men and women aged 45-79 (mean age 58), 50% men and 30% women consumed low levels of fruit and vegetables. This supports the findings of the self-reported regional lifestyle survey in which just half the population of older people reported following a healthy diet (Figure 40).

**Figure 43**



On the whole, well older people achieve an adequate nutritional intake but the frail, less well older people are most at risk of malnutrition as they eat and drink much less. Low blood levels of Vitamin C and other nutrients are more prevalent in this group.<sup>106</sup> With ‘care in the community’ there is an increase of frail older people in their own homes dependent on three - four visits a day from community carers for their nutrition and hydration. These are a high risk group for malnutrition.

Work on nutrition in older people has concentrated on the small but vulnerable groups with malnutrition and eating difficulties associated with frailty or the result of other health conditions. However, recent NICE guidance estimates that cutting salt and saturated fat in foods could avoid up to 40 000 deaths each year.<sup>107</sup> A National Action Plan to tackle the issue of older people and nutrition is in progress. The type of issues that are under discussion include:

- Raising awareness of the link between nutrition and good health

<sup>104</sup> <http://www.bmj.com/content/337/bmj.a2227.abstract>

<sup>105</sup> <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0050012>

<sup>106</sup> National Diet and Nutrition Survey (1998)

<sup>107</sup> <http://guidance.nice.org.uk/PH25>



- Nutritional standards
- Streamline guidance
- Prioritisation of nutrition from leaders and managers in both health and social care
- Training for frontline staff and managers
- Clearer focus on inspections

The Cambridgeshire Community Services Dietetic Business Unit has provided a Dietetic service to care homes since 1997 in Cambridge City, South and East Cambridgeshire; Fenland since 2006, and Huntingdonshire 2010. The total numbers of homes served now is 83 with several more due to be built or extended. The population in these homes has become increasingly frail with a high incidence of poor eaters.

The Dietetic Service has implemented the Malnutrition Universal Screening Tool (MUST) in the majority of Care Homes in Cambridge City, South and East Cambridgeshire and Fenland areas. This enables the staff in the care homes to identify those residents needing referral to the Dietician or Dietetic Assistant Practitioner.

In 2010 the Dietetic Business Unit will be rolling out services to Huntingdonshire to ensure an equitable service. They will also be working with the care home staff throughout the county to ensure appropriate prescribing of oral nutritional supplements (ONS; eg fortisip, ensure, Complan) and maximising a “food first” approach. Initial findings suggest that weight gain has been better using a “food first” approach rather than ONS as first line treatment.

Training sessions on ‘Nutrition risk screening’ and ‘Fortifying and enriching food’, ‘Diabetes’, ‘Nutrition and Dementia’ are also provided. Nutrition Link Nurses have also been established within the majority of care homes.

The Service will visit clients in their own home for those requiring it. The number of new referrals for home visits from March to July 2010 was 107.

## 5.8 Obesity

Cambridgeshire published a strategy for the prevention and management of obesity in 2008.<sup>108</sup> Obesity is one of the major public health issues in the developing world. Obese people have an increased risk of dying prematurely and obesity is responsible for more than 9,000 premature deaths per year in England. It increases risk of developing cardiovascular disease, type 2 diabetes, hypertension, dyslipidemia, some cancers, musculo-skeletal problems (leading to the need for hip and knee replacement), and other diseases. Among people aged 35 and over classified as having a raised waist circumference, men are twice as likely and women were four times more likely to develop type 2 diabetes. Obese people are more likely to suffer from a number of psychological problems such as low self-image and confidence, social stigma, reduced mobility and a poorer quality of life. There is a social class gradient with obesity.

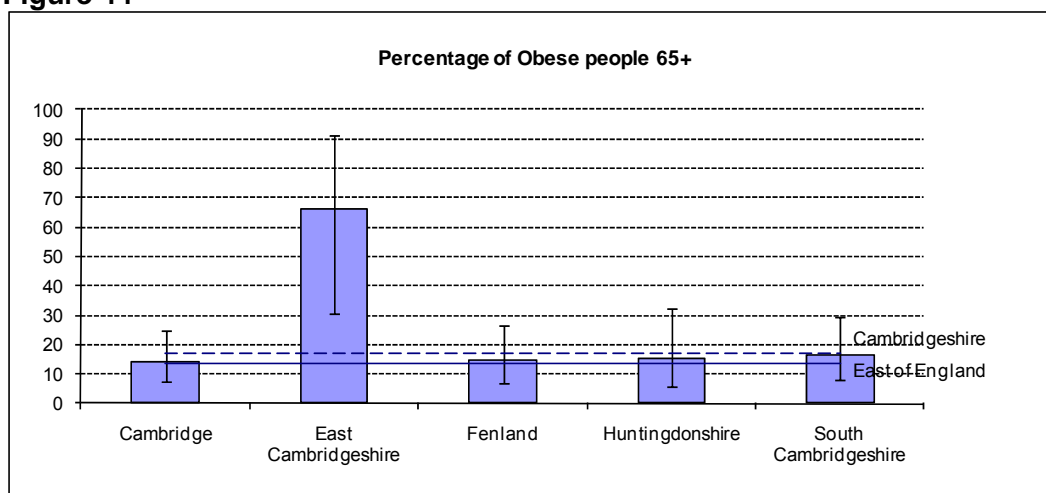
We have limited data on the prevalence of obesity in older adults in Cambridgeshire. There is no routine data collection and special surveys are hampered by lack of agreement in the most appropriate measure to use. The measure of BMI commonly used in adults has been found to have a lower correlation with percentage body fat in the old than in the young, and a weaker association with cardiovascular mortality, than measures of central adiposity such as waist circumference or waist-to-hip ratio. However, some adverse outcomes (eg functional disability) have not been evaluated by waist-to-hip ratio or waist circumference; and others (eg hip fracture incidence in women) have been found to have an association with BMI, but not with waist-to-hip ratio or waist circumference (likely reflecting that generalised, not central,

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obesity is important in their aetiology.<sup>109</sup> The relationship between obesity and disease in older adults does not always mirror the relationship in younger adults, and recommendations for younger adults cannot always be applied to older people. This is an area where further research is needed.

The regional lifestyle survey, estimates that in Cambridgeshire nearly 20% of older adults are obese (Figure 41) but these estimates are imprecise (as shown by the width of the confidence intervals). While this study is based on self-report, the findings are similar to those of the EPIC-Norfolk study of people aged 45-79 (Table 29). It is reasonable to conclude that around 10-15% of the older population in Cambridgeshire are obese but the level of uncertainty highlights the need for more accurate data to better establish need, and to monitor the effect of any interventions.

**Figure 44**



**Table 29**

BMI	Men (n=9,191)	Women (n=11,063)
<25 kg/m <sup>2</sup>	34%	45%
25-<30 kg/m <sup>2</sup>	54%	39%
>=30kg/m <sup>2</sup>	13%	16%

Source:

<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0050012#pmed-0050012-t003>

## 5.9 Oral health

Older people have specific oral health needs as oral health problems increase with age. In particular, age related changes can lead to xerostomia or dry mouth (often drug related), root caries, recurrent decay and decreased manual dexterity can lead to reduced plaque control. Diets high in sugar can lead to an increased risk of dental decay.

Systemic problems can also have an effect on oral health, for example many older people suffer from progressive neurocognitive impairing illnesses (eg Parkinson’s disease, Alzheimer’s disease) and this can cause difficulties in controlling and retaining dentures.<sup>110</sup> It

<sup>109</sup> Cockcroft A, Gooch C, Ellinghouse C, Johnston M, Michie S. Evaluation of a programme of health measurements and advice among hospital staff. *Occup Med (Oxf)* 1994; 44(2):70-76.

<sup>110</sup> Chiapellie F, Bauer J, Spackman S et al. Dental needs of the elderly in the 21<sup>st</sup> century. *Gen Dent* 2002 50(4) 358:63.

is important therefore to consider both the specific treatment needs of older people as well as oral health promotion for all so as to minimise oral health problems in later life. In older people the retention of natural teeth into old age makes a major positive contribution to the maintenance of good oral health related quality of life and there is a clear and consistent relationship between retention of natural teeth and a healthy diet and good nutrition.<sup>111,112</sup>

*Planning for the future of “the heavy metal generation”*

The proportion of people retaining a useful number of natural teeth into retirement age and beyond has increased dramatically during the past 40 years. This improvement has been tracked by the ten-yearly *Dental Health Surveys* carried out by the Office for National Statistics. The improvement means fewer people struggling to manage with complete dentures, so more are able to eat a healthy diet and talk or smile without risk of embarrassment. Keeping teeth longer does, though, bring with it the need to maintain and replace many more fillings, crowns, bridges and partial dentures, which are expensive procedures. For any of the latter, the current cost in to the NHS is about £250, of which paying patients contribute £198.

## 5.10 Alcohol

Even modest alcohol use in old age may be potentially harmful as a contributor to falls, compromised memory, medicine mismanagement, inadequate diet and limitations on independent living.<sup>113</sup> The rate of alcohol related hospital admissions increases with age (Figure 42). The prevalence of self-reported heavy drinking among older people in Cambridgeshire is around 22% (Figure 43) according to the regional lifestyle survey. Variation among the districts of Cambridgeshire is likely but this survey was not designed to estimate precisely the prevalence within districts by age, and the confidence intervals of the prevalence estimate in each district are wide. No older heavy drinkers were sampled in East Cambridgeshire, for example. The EPIC-Norfolk study of people aged 45-79 found (Table 30) 15% of men and 5% of women to drink more than the recommended weekly limits of 21 units for men and 14 units for women. The EPIC cohort tends to be healthier than the general population but it is reasonable to conclude that significant numbers of older people in Cambridgeshire are drinking at hazardous or harmful levels, particularly men.

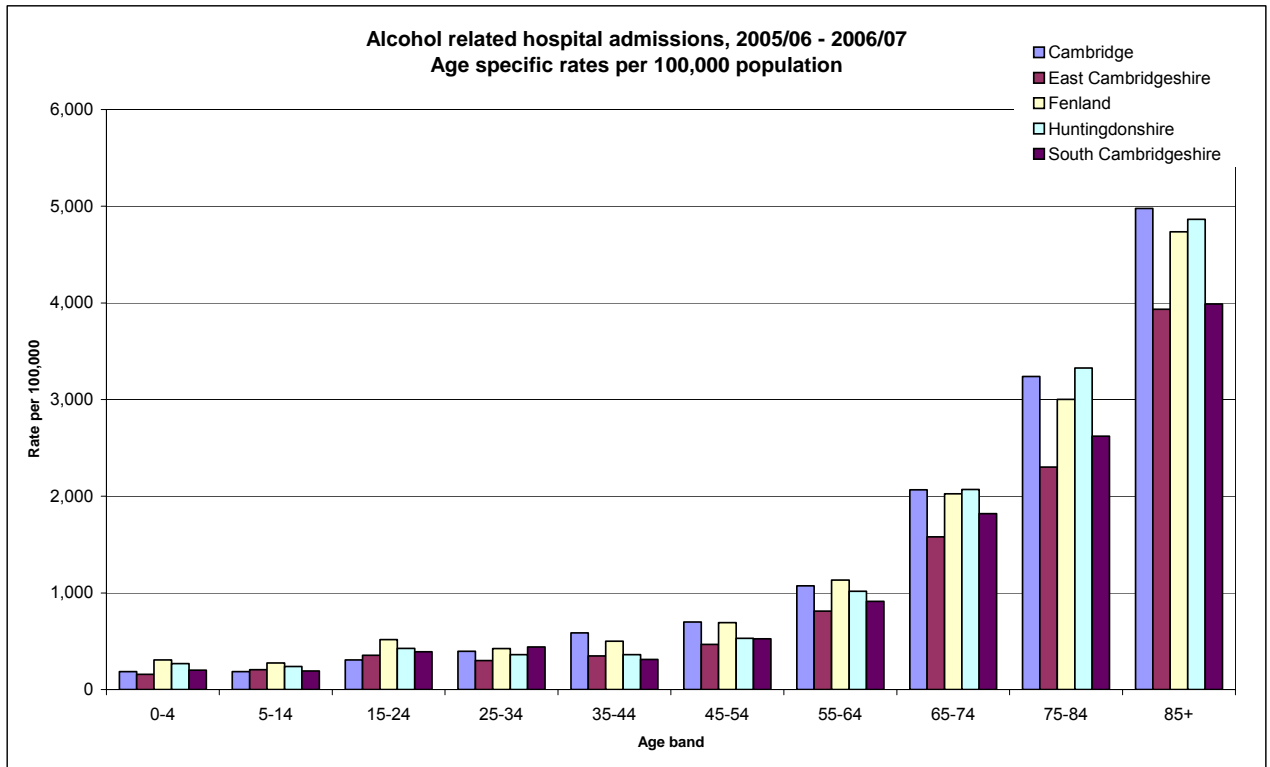
NICE guidance on alcohol dependence and harmful alcohol use is expected in February 2011.

<sup>111</sup> Gerodontology 2005; 22 (Supplement 1) 2:48.

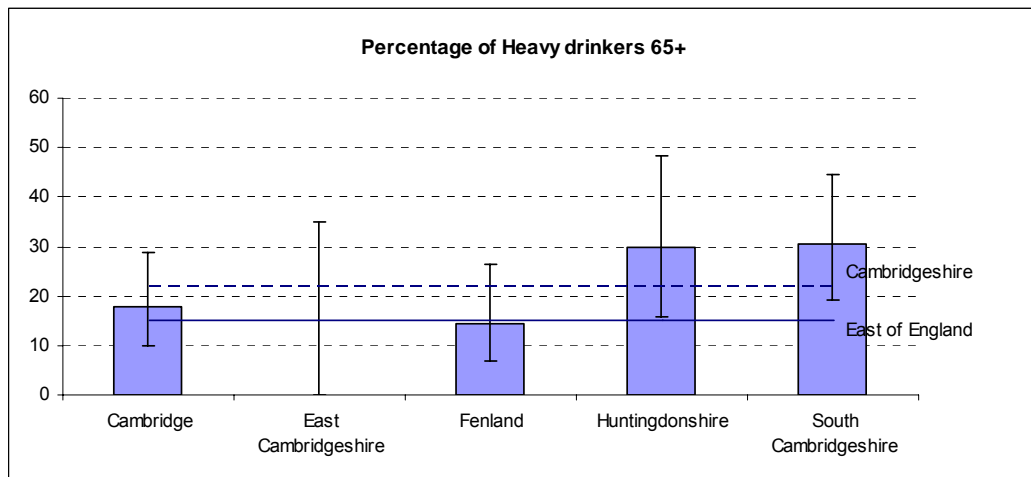
<sup>112</sup> See also: Oral Health Needs Assessment (pending). Amanda Crosse and Jennifer Donaghy. Cambridgeshire and Peterborough Public Health Network.

<sup>113</sup> Older people and alcohol: a report on research in Ayrshire and Arran. [www.3sf.co.uk](http://www.3sf.co.uk)

**Figure 45: Alcohol related hospital admissions**



**Figure 46**



**Table 290**

Weekly alcohol consumption	Men (n=9,191)	Women (n=11,063)
Non drinker	9%	17%
1 to <7 units	42%	59%
7 to <14 units	22%	16%
14 to <21 units	12%	5%
21 + units	15%	1%

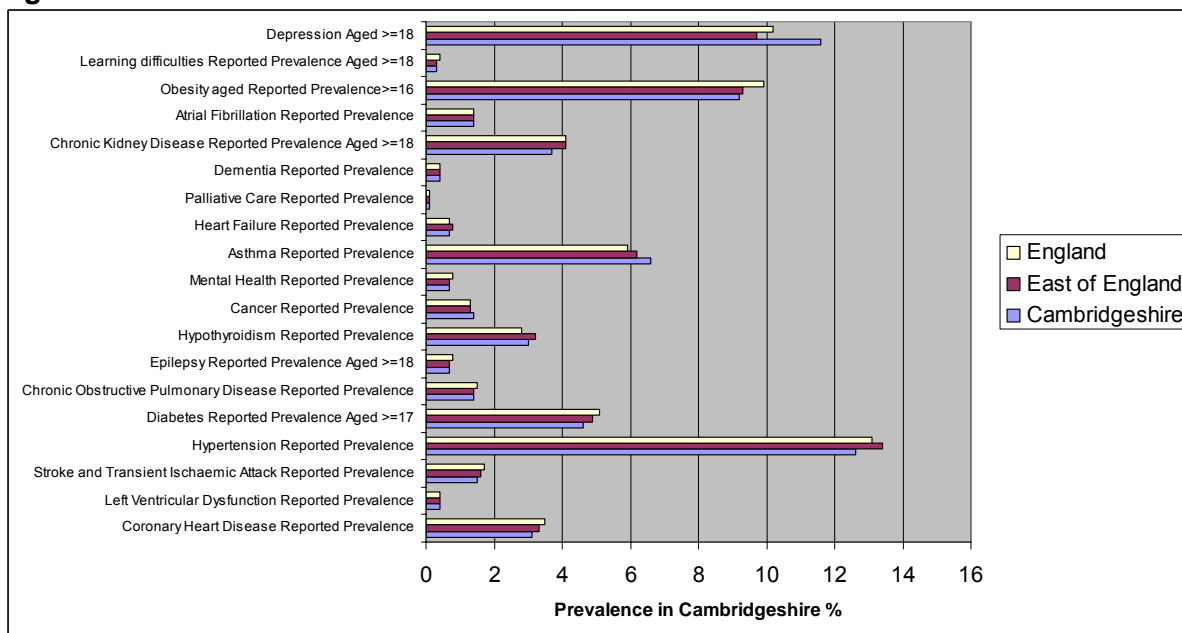
Source:

<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0050012#pmed-0050012-t003>

## 6 Health and wellbeing

The prevalence of health conditions in NHS Cambridgeshire, as recorded by GP practices is generally lower than the national average and the East of England average (Figure 44) but tends to be higher than in the similar counties allocated to the same ONS cluster.

**Figure 47**



Source: <https://www.nhscomparators.nhs.uk/NHSComparators/CommissionerResults.aspx>

Differences among areas may reflect genuine differences in prevalence, or reflect variation in completeness of recording. However, recorded prevalence is generally an underestimate of the burden of disease in the population. Table 31 shows the estimated number people affected with these conditions in Cambridgeshire.

**Table 30**

Condition	Number of Patients Recorded on Cambridgeshire GP Registers	Estimated Total Number of Patients in Cambridgeshire, Modelled by Public Health Observatory
Hypertension (high blood pressure)	77,134	138,910
Depression	56,636	
Asthma	40,506	
Diabetes	22,724	22,274
Coronary heart disease	19,007	23,385
Hypothyroidism	18,541	
Chronic kidney disease	17,946	
Stroke and transient ischaemic attack	9,201	11,154
Cancer	8,579	
Atrial fibrillation	8,492	
Chronic Obstructive Pulmonary Disease	8,357	12,483
Heart failure	4,246	
Severe mental health problem	4,224	
Epilepsy	3,436	
Dementia	2,434	
Learning disabilities	1,608	
Palliative care	572	

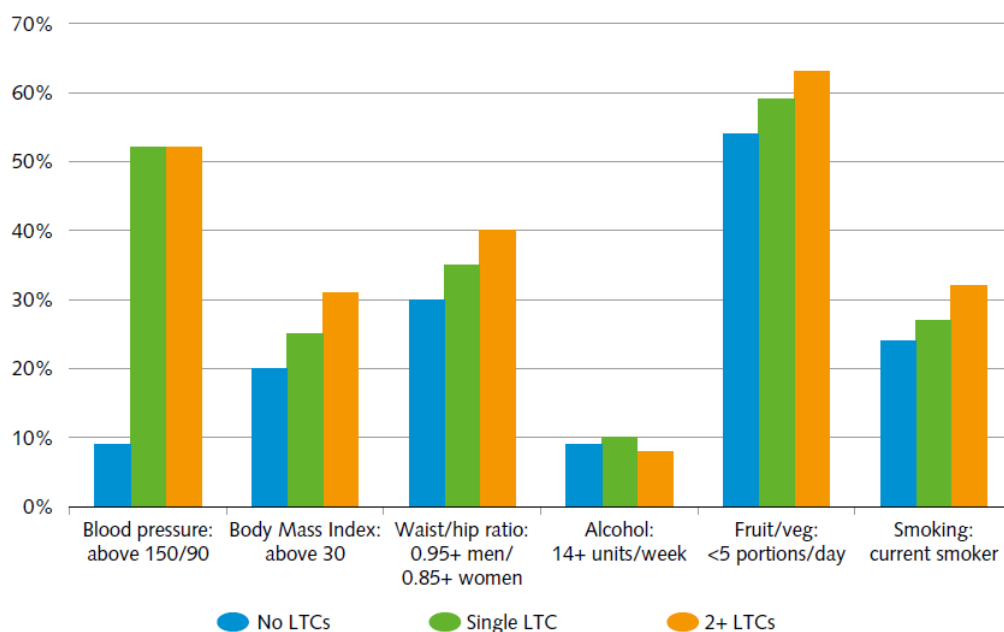
Indicator, Year, Data source: Quality and Outcomes Framework (QOF), 2008/9, Information Centre.

ERPHO has predicted the likely increase in prevalence of some common health conditions in Cambridgeshire to 2015.<sup>114</sup> Prevalence estimates are available at PCT, local authority and practice level and may be given for males and females separately. The estimated prevalence of cardiovascular disease is 6.0%, projected to rise to 6.4% by 2020.

The most common long term conditions (LTCs) are hypertension, asthma, coronary heart disease, and diabetes.<sup>115</sup> LTCs are the main contributors to reduced life expectancy and are to a large degree preventable (see section **Primary prevention – promoting wellbeing**). Age is the single biggest factor associated with having long term condition and 60% of people aged 65 and over are affected, but lifestyle factors such as smoking, excessive alcohol consumption, unhealthy diets and physical inactivity are estimated to cause approximately 50% of Long Term Conditions (Figure 45).

**Figure 48**

**Risk factors and lifestyle choices by number of LTCs**



Source: Health Survey for England 2005 (age-adjusted rates).

Source:

[http://www.dh.gov.uk/dr\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_082067.pdf](http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_082067.pdf)

Many people live with a Long Term Condition that limits their ability to cope with day-to-day activities including physical, psychological and social aspects. For some people, especially older people, their carers and those who have more than one condition, discomfort and stress is an everyday reality. For those living in disadvantaged circumstances or those for whom English is not their first language, the challenges are even greater. And for the most vulnerable, a lack of co-ordinated, personalised care can lead to a significant deterioration in health and often avoidable emergency admissions to hospitals.

The NHS published an Improvement Plan that set out the Government’s priority to improve care by moving away from reactive care based in acute systems, towards a proactive, patient-centred approach. The Government took the lead in setting the national Public Service Agreement target for improving outcomes for people with Long Term Conditions aiming to reduce emergency bed days by through improved care in primary and community settings. This target was significantly overachieved (Figure 46), primarily through reductions

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<http://www.apho.org.uk/resource/view.aspx?RID=48308>

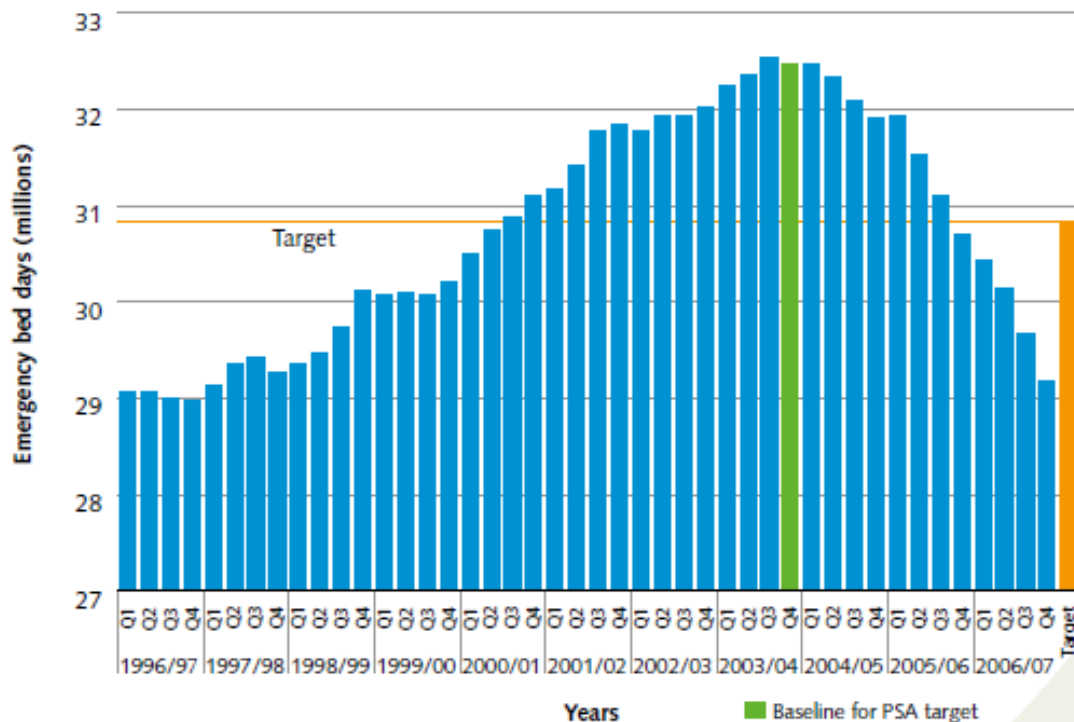
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[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_082067.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_082067.pdf)

in mental health and circulatory bed days but the challenge to maintain this is increased by an ageing population. *High Quality Care for All*<sup>116</sup> sets a target of agreed care plans for all people with Long Term Conditions.

**Figure 49**

### Annual emergency bed days



Source:

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_082067.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_082067.pdf), page 38

The Strategic Plan for NHS Cambridgeshire 2010-2015 highlights key priority areas:

- Focus on three clinical pathways and apply an “industrial scale” approach to service transformation. The priority has been given to Diabetes and Chronic Obstructive Pulmonary Disease along with Stroke Care, where pathway redesign is at an advanced stage. Our pathways can be better, safer and cheaper.
- Pilot the use of the combined model for risk stratification, working with selected GP practices. Targeting interventions to patients according to predictors of high utilisation of hospital services enhances opportunities for savings of long term costs. The combined risk tool identifies those at high risk, particularly those with heart failure. Interventions to improve care coordination or integration are likely to improve quality of care, but are much less likely to reduce costs. The strongest evidence for cost reduction comes for patients with heart failure.
- Continue to review pathways for people with dementia, stroke and dermatological conditions and heart failure.
- Continue with the remainder of clinical pathway reviews and their re-commissioning.

<sup>116</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_085828.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf)



A summary of the health of Older People in Cambridgeshire was published by erpho in 2009.<sup>117</sup> These data can also be viewed as the constituent district authorities.

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<sup>117</sup> <http://www.erpho.org.uk/olderpeopleprofiles/Profile.aspx?parea=12&carearea=PARENTPROFILE>

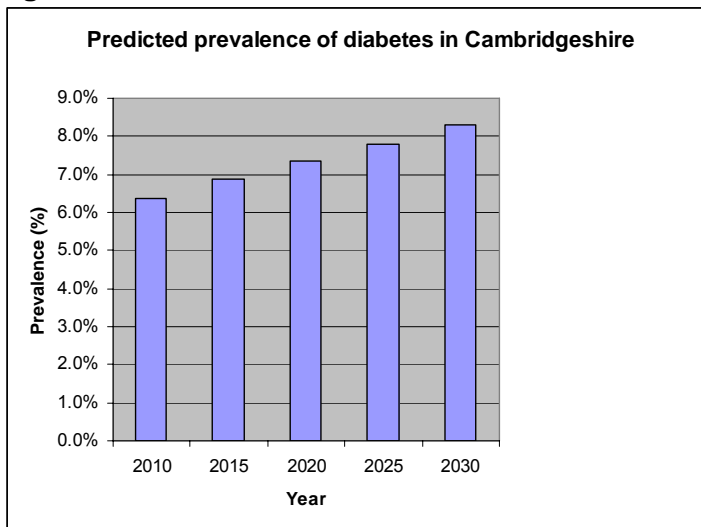
## 6.1 Diabetes

Diabetes is a costly and complex condition. The associated high glucose levels result in slow, silent, progressive damage to proteins in the body which over many years lead to damage to blood vessels, nerves and skin and then to a range of severe complications. High blood pressure and abnormal blood fats can also lead to progressive damage to arteries.

The prevalence of diabetes is estimated to rise to epidemic proportions within the next twenty-five years. It is estimated that there are 2.35 million people with diabetes in England and this is predicted to increase to more than 4 million people by 2025. The estimated prevalence of diabetes is 6.4%, projected to rise to 7.4% by 2020 (Figure 47). The number in Cambridgeshire is expected to rise from 32,000 in 2010 to 53,000 in 2030. East Cambridgeshire and Fenland have the highest prevalence in Cambridgeshire compared to other localities. Huntingdonshire has seen the largest increase whilst Cambridge City and South Cambridgeshire have the lowest prevalence and have seen only a very small increase.

The rise in obesity, social and behavioural changes, consumption of processed food and the decline in physical activity levels (see section **Primary prevention – promoting wellbeing**), are thought to be the main factors involved in the predicted global explosion. The overall cost to those affected and their families is considerable with diabetes increasing the risk of stroke, heart attack, blindness, kidney failure, amputation and other complications.

**Figure 50**

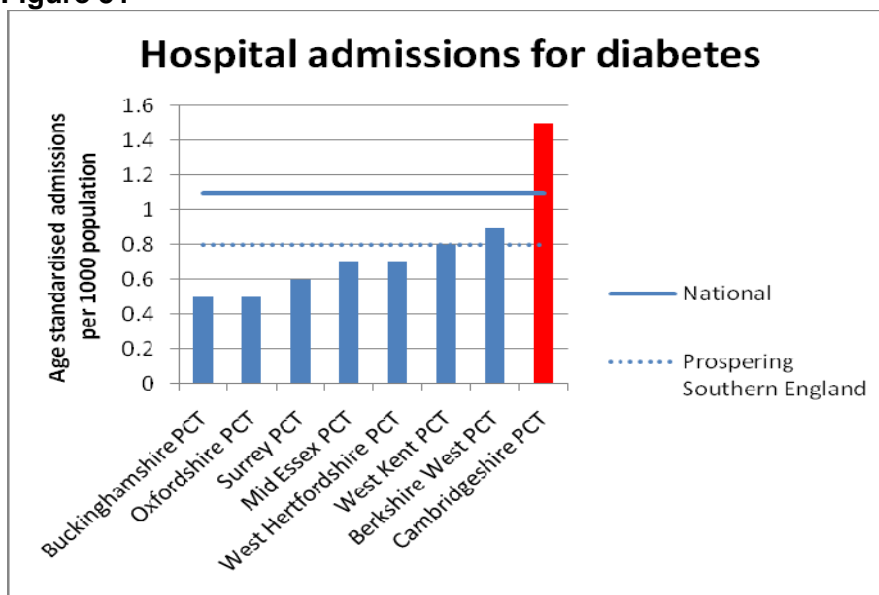


Social services expenditure for those with diabetes who have developed complications is quadruple the expenditure for other groups of people.

The financial cost of diabetes care to the National Health Service is considerable. When the Diabetes National Service Framework Delivery strategy was published in 2003, 5% of all NHS expenditure and 9% of hospital expenditure was accounted for by the condition. Social services expenditure for those with diabetes who have developed complications is quadruple the expenditure for other groups of people. The inpatient costs paid by NHS Cambridgeshire for patients with diabetes have increased from £17,876,028 in 2006/07 to £24,885,551 during 2009/10. These costs are likely to rise over the coming years as the impact of the ageing population and more sedentary lifestyles take their toll.

The number of admissions for diabetes in Cambridgeshire is higher than in similar counties with a similar age distribution (Figure 48) and the national rate.

**Figure 51**



Source: <https://www.nhscomparators.nhs.uk>

NHS Cambridgeshire aims to deliver a person-centred Integrated Community Diabetes Service to the people of Cambridgeshire that will increase uptake of a wide range of interventions to improve the outcomes for individuals diagnosed with diabetes. It is expected that beyond their self management the majority of patients will be managed by their own primary care clinicians for most of the time. In addition, they will have ready and timelier access to more specialised services during periods when they suffer instability of their diabetes.

The East Cambridgeshire and Fenland integrated diabetes care pilot has demonstrated that such a service can deliver:

- improvements in patient care and outcomes
- improved access to specialist diabetes care and brings care closer to home
- improvements in the knowledge of diabetes and its management among primary care and community clinicians
- improvement in glucose control among those with poor glucose control and/or elevated glucose levels -often with weight loss and reduction in medication
- avoidance of diabetes foot associated hospital activity
- reductions in acute hospital costs and/or reductions in the rate of increase of spend at acute hospitals
- reductions in the rate of increase in insulin and ADQ anti-diabetic drugs

## 6.2 Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is a general term which includes the conditions chronic bronchitis and emphysema. It is common. It is estimated that another half million people have the condition but are undiagnosed. COPD becomes more common with increasing age. The average age of diagnosis is around 67 years. It is more common in men than women. It accounts for more time off work than any other illness. A flare-up (exacerbation) of COPD is one of the most common reasons for admission to hospital (one in eight admissions is due to COPD). Emergency admissions are forecast to rise by 1.5% p.a. due to the ageing population alone.

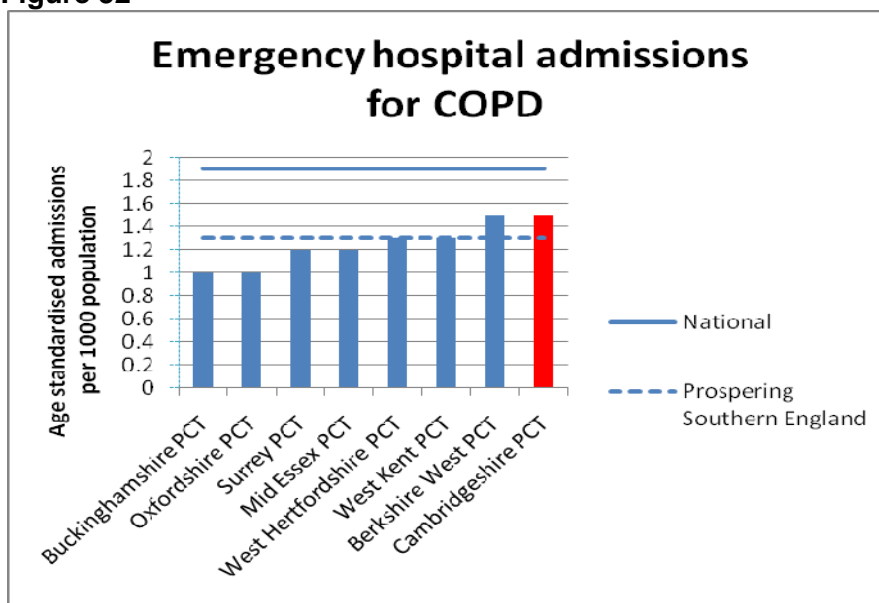
Smoking is the cause in the vast majority of cases. The lining of the airways becomes inflamed and damaged by smoking. About three in 20 people who smoke one packet of cigarettes (20 cigarettes) per day, and one in four 40-per-day smokers, develop COPD if they

continue to smoke. For all smokers, the chance of developing COPD is between one in 10 and one in four.

In Cambridgeshire, the number of emergency admissions for COPD is below the national average, but high compared to similar populations (Figure 49). This is likely to reflect historical differences in smoking.

The estimated prevalence for COPD in Cambridgeshire is currently 2.5% and is projected to increase to 2.7% by 2020. This small increase in percentage points equates to more than 2500 people.

**Figure 52**



The Health Foundation Co-creating Health Initiative is a £5million initiative funded by The Health Foundation which brings together four organisations to form the National CCH Support Team. The aim is to improve outcomes for people living with long term conditions through self management support. The initiative draws on the chronic care model developed by Professor Wagner and his colleagues in Seattle, USA. There are three dimensions to the project: the self management programme for patients, advanced development programmes for clinicians, and a service improvement programme. NHS Cambridgeshire and Cambridge University Hospitals NHS Foundation Trusts are together the national lead for improving outcomes for patients with COPD. They are paired with North Ayrshire, South Ayrshire and East Ayrshire Community Health Partnerships and Ayrshire and Arran NHS Borad. There are three key enablers. The patient and clinicians agree the aims of each. The clinician supports the patient in choosing small and achievable goals. These do not necessarily need to be clinical. This becomes a core part of the patient-clinician interactions.

### 6.3 Stroke and Transient Ischaemic Attack

A stroke means that the blood supply to a part of the brain is suddenly cut off. The brain cells need a constant supply of oxygen from the blood. Soon after the blood supply is cut off, the cells in the affected area of brain become damaged, or die.

The blood supply to the brain comes mainly from four arteries – the right and left carotid arteries, and the right and left vertebrobasilar arteries. These branch into many smaller arteries which supply blood to all areas of the brain. The area of brain affected, and the extent of the damage, depends on which blood vessel is affected.

For example, if blood supply is lost from a main carotid artery, then a large area of the brain is affected which can cause severe symptoms, or death. In contrast, if a small 'branch' artery is affected, then only a small area of brain is damaged which may cause relatively minor symptoms.

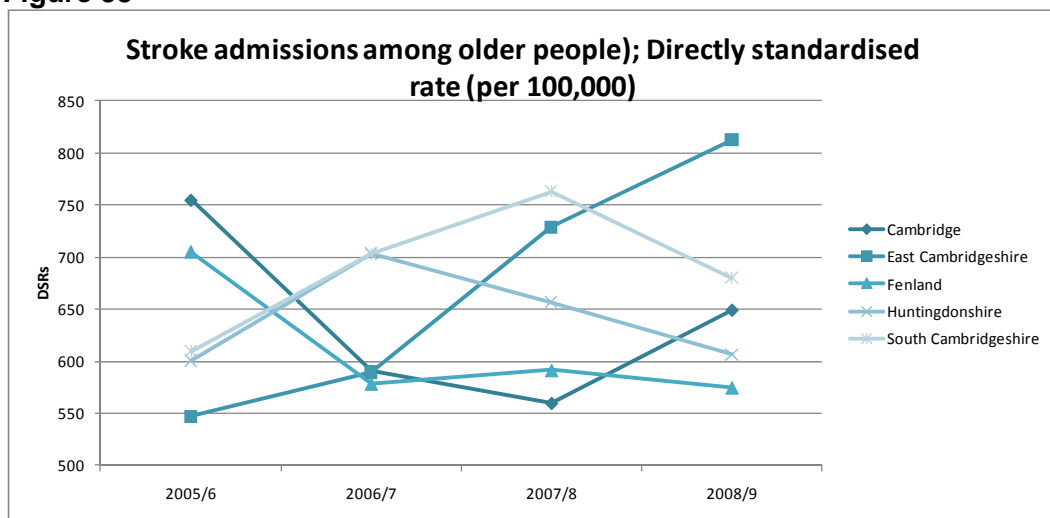
Each year about 110,000 people in the UK have a first stroke, and about 30,000 have a recurrent stroke. It is the third largest cause of death: 11% of deaths are the result of stroke. 20-30% of people who have a stroke die within a month. Stroke is the largest cause of disability in the UK, and the third commonest cause of death (after heart disease and cancer). Most cases occur in people aged over 65. Each year about one in 100 people over the age of 75 have a stroke.

Stroke is the single largest cause of adult disability. About one million people in the UK are living with the effects of stroke, with half of these being dependent on other people for help with everyday activities. A third of people who have a stroke are left with long-term disability. The effects can include aphasia, physical disability, loss of cognitive and communication skills, depression and other mental health problems.

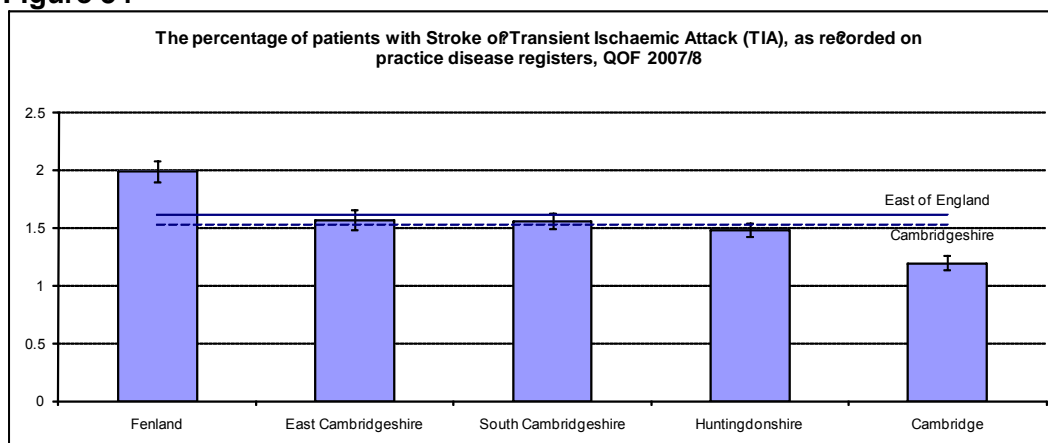
A transient ischaemic attack (TIA) is a set of symptoms similar to a stroke, but which last less than 24 hours. It is due to a temporary lack of blood to a part of the brain. In most cases, a TIA is caused by a tiny blood clot that becomes stuck in a small blood vessel (artery) in the brain. This blocks the blood flow, and a part of the brain is starved of oxygen. The affected part of the brain is without oxygen for just a few minutes, and soon recovers.

Stroke costs the NHS economy about £7billion a year, £2.8 billion in direct costs to the NHS from a high number of hospital admissions (Figure 50), £2.4billion of informal care costs, and £1.8 billion in income lost to productivity and disability. Outcomes in the UK compare poorly internationally despite our services being among the most expensive with comparatively long lengths of stay and high levels of potentially avoidable disability and mortality.

**Figure 53**



In Cambridgeshire, in 2010, the prevalence of stroke was around 2.2% of the population (more than 12,000 people). This is estimated to rise to 2.5% by 2010, 5.9% (40 000) people aged 65-74 and 10.5% (nearly 7000) of the people aged 75 and over. Within Cambridgeshire, the prevalence is highest in Fenland and lowest in Cambridge (Figure 51).

**Figure 54**

Stroke is preventable (see section on prevention). The main risk factors are smoking, high blood pressure, overweight, high cholesterol, a low level of physical activity, poor diet, excessive alcohol consumption, and diabetes.

## 6.4 Mental health and wellbeing

NICE guidance for *Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care* was published in April 2008.<sup>118</sup> The definition of 'mental wellbeing' used was developed by NHS Health Scotland as part of their national programme of work on mental health improvement. This definition includes areas such as life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support.

NICE identifies five key factors that affect the mental health and wellbeing of older people: discrimination (eg by age or culture), participation in meaningful activity, relationships, physical health (including physical capability to undertake everyday tasks) and poverty; and emphasised the links between physical health and mental health, and physical activity and physical health.

Chronic diseases are now the leading cause of death and disability within developed countries. An increasing awareness of how individuals cope with chronic, life-long health problems has required clinicians to develop alternative models of care to those traditionally used for acute medical illnesses. Concepts such as biopsychosocial models of illness, stigma, expert patients, treatment adherence and the recovery model are crucial to the understanding of how patients with chronic illness should be managed. The "recovery model" is a new way of conceptualising the management of chronic illness with treatment moved away from a sole focus on cure, towards broader goals such as reduced symptoms, hope and improved social and occupational functioning. The diagnosis of a life-long medical condition requires an individual to make a number of adjustments, and may contribute to the development of a psychiatric illness. Rates of psychiatric disorders, such as depression and anxiety, are increased at least twofold amongst individuals with chronic medical problems. There is increasing evidence that depression may also be a risk factor in the development of some chronic diseases, especially those related to lifestyle, such as type 2 diabetes and cardiovascular disease and may influence their prognosis. As a result the early detection and management of psychiatric morbidity in those with chronic illness is essential.

The biopsychosocial model shows that to understand and respond to a patient's suffering clinicians must simultaneously consider the biological, psychological and social dimensions of illness.

<sup>118</sup> <http://guidance.nice.org.uk/PH16>

Patients with a chronic illness are experts in their own illness and have a major role in the monitoring and treatment of any relapses. Some patients experience this increased responsibility with difficulty. Despite this, there is some evidence that programmes which enhance patient's participation in their own healthcare result in reduced symptoms, decreased disability and reduced costs.

It has been estimated that as many as 60% of patients with a chronic illness are poorly adherent to treatment. There are multiple factors which may contribute to low levels of treatment adherence. Patients may not have received understandable instructions or may forget when they are meant to take medication. Many chronic illnesses do not have obvious physical symptoms, leading to many patients assuming that they do not need to continue to take their medication. Sometimes patients may have difficulties accepting or believing a diagnosis. Such patients are unlikely to comply with treatments for a disorder they do not acknowledge. Studies have shown that individuals with depression are less likely to comply with suggested treatments for chronic medical problems.

In recent decades a new model of chronic disease management has emerged; the recovery model. The recovery model is based around the concept that people can "recover" from an illness even although the illness is not cured. There is not a fixed definition of what recovery means, but it should include hope, social inclusion, supportive relationships and a return to a quality of life that the individual finds acceptable. Medical management is only part of the personal recovery journey and should not be focused solely on cure, but assist in broader goals such as reduced symptoms with improved social and occupational functioning. This model has been used in the conceptualisation of chronic mental illness, but is equally relevant to the care of those with chronic physical diseases.

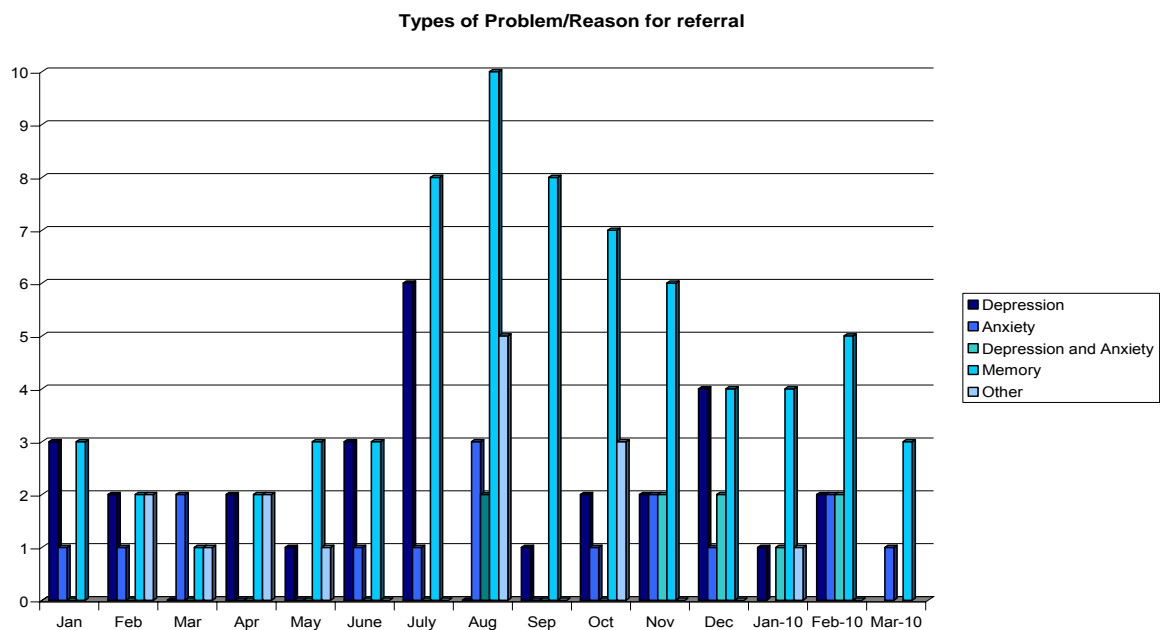
The Healthy Communities JSNA 2010 describes Cambridgeshire in terms of the elements that contribute to a coherent and healthy society that promotes mental (and physical) wellbeing. The mental health of the population of Cambridgeshire is described in the mental health JSNA 2010. Much applies equally across all age groups and it is important to remember that the majority of older people have good mental health. Compared to the general population, however, older people are more at risk of social exclusion for reasons of income (see section **Wealth and Income**, transport (see section **Rurality, Transport and Access**) and disability (see section **Disability**). Older people are more likely to live alone than younger people (see section **Housing/Pensioners living alone** and unsuitable housing may be a contributing factor (see sections **Housing/Older households and the Decent Homes Standard** and **Housing/Lowest floor level**). Older people are also more likely to be in poorer health (see section **Health and wellbeing**). Depression may lead to social exclusion or arise through social exclusion.

Depression and dementia affect proportionally more older people than any other demographic group.

A primary care project for the mental health of older people among three surgeries in St Ives was set up in 2009. This found that the main reason for referral to be memory problems (Figure 52).



**Figure 55**



## 6.5 Depression

Estimates of depression vary because of under diagnosis but around 20 % of people over 65 are thought to have depression. A higher prevalence in older people arises because older people face more events and situations that may trigger depression: physical illness, debilitating physical conditions, bereavement, poverty and isolation. Depression can prevent or delay recovery from other illnesses and injuries. In people aged 75 or over, depression may be associated with a metabolic imbalance resulting from poor diet and sleep, and can suppress immunity, increasing susceptibility to infections.

In *New Horizons. A shared vision for Mental Health*<sup>119</sup> it was reported that although 20% to 40% of older people in the community show symptoms of depression only 4% to 8% will consult their GP about this problem, and that this is particularly true for older men. The report calls for equal access to services across all age groups and points out that research and audit should include older people equally.

Table 32 shows the number of people in 2010 to 2030 predicted to have depression based on a prevalence of 2-4% in people aged 65 and over.

**Table 312: People in Cambridgeshire aged 65 and over predicted to have depression, 2010 to 2030**

	2010	2015	2020	2025	2030
Cambridgeshire	8,605	10,181	11,448	12,846	14,594
Cambridge City	1,197	1,285	1,374	1,481	1,648
East Cambridgeshire	1,296	1,534	1,752	1,972	2,255
Fenland	1,678	2,009	2,293	2,591	2,955
Huntingdonshire	2,312	2,823	3,214	3,618	4,101
South Cambridgeshire	2,078	2,518	2,840	3,197	3,627

Source: Prevalence estimates taken from McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787-1795.

## 6.6 Dementia

Dementia is the second most common mental health problem in older people and 20 % of people over 85, and 5 % over 65, have dementia. Dementia is the name given to a group of diseases that affect the normal working functions of the brain. This can lead to a decline of mental ability, affecting memory, thinking, problem solving, concentration and perception.

- In the 20 years from 2010 to 2030, the expected number of people with dementia in Cambridgeshire is expected to double from 7,000 to more than 14,000
- Dementia is predominantly a disorder of later life but there are least 150 people in Cambridgeshire under 65 with dementia
- The incidence (number of new cases) of dementia and prevalence (number of cases at any one time) increases exponentially with age
- Dementia affects men and women in all social and ethnic groups
- Only around a third of people with dementia are diagnosed and treated
- Dementia is a terminal condition but people can live with it for around 7-12 years

### *Cause*

There are a number of different causes of dementia but the most common cause and the best studied is Alzheimer’s disease (AD) (approximately 60% of all causes). Other causes are vascular dementia (VaD) (20%), dementia with Lewy bodies (DLB) (10%) and frontotemporal dementia (FTD) (2%). These diseases are not mutually exclusive and mixed pathologies are common.

Heavy alcohol consumption is a predisposing factor.<sup>120</sup>

### *Symptoms*

A wide variety of cognitive symptoms occur in dementia, but memory loss is the most common and indeed is a core feature of any dementing illness. Short term memory loss is usually the presenting complaint with patients having difficulty in learning new information, such as names, shopping lists and details of conversations. Later on in the disease remote memories are also affected. Other cognitive deficits include aphasia, apraxia, agnosia and executive deficits. In most dementias, including AD, the onset of memory problems is insidious and gradually progressive. In VaD cognitive changes are classically of sudden onset with a step-wise progression. Neuropsychiatric symptoms are very common in

<sup>120</sup>

Marshall J, Guerrini I, Thomson A(2009) Introduction to This Issue: The Seven Ages of Man (or Woman) *Alcohol & Alcoholism*, 44 (2), 106–107

dementia. A wide variety of symptoms have been described including disorders of thought, perception, affect and behaviour. Mood symptoms including depression and apathy are very common in all dementias. Marked changes in personality, including a decline in social and personal conduct with early emotional blunting, are characteristic features of FTD.

#### *Treatment*

Current treatment options for the cognitive deficits seen in AD include the use of acetylcholinesterase inhibitors that increase the amount of available acetylcholine in the brain in line with NICE guidance. In the UK these treatments are currently available for patients with moderate disease and they appear to temporarily delay cognitive deterioration. These drugs are not recommended for use in other dementia types.

Neuropsychiatric symptoms may be the result of physical problems unrelated to the dementing process. Therefore, adequate note is taken of other illnesses that may be causing pain or an acute-on-chronic confusional state (ie a sudden deterioration in cognitive function in a patient with an established dementia). For these symptoms a non-pharmacological approach may be better to wait for a few weeks to see if symptoms resolve without the use of drugs or ask carers to try simple psychological strategies such as reassuring touch or redirection.

Patients with dementia are at risk of financial and physical abuse (including neglect) and early advice regarding lasting power of attorney, financial aid eg attendance allowance, and local support networks for carers is an essential part of management. Commonly used approaches include the use of a community psychiatric nurse and domiciliary support, day care and respite care. Institutional care is usually reserved for patients with more severe physical or persistent neuropsychiatric symptoms.

In 2007, a comprehensive review of the available research on nonpharmacological interventions for persons with early-stage dementia was conducted.<sup>121</sup> From more than 150 research studies reviewed, evidence of effectiveness was found for physical exercise, cognitive therapy, recreational therapy and dietary modification.

In the management of dementia, a large focus is on helping carers to cope with the increased dependence of patients as the disease progresses or with the emergence of troublesome neuropsychiatric symptoms. Co-existing physical problems complicate management. Despite improved public awareness of dementia, and in particular AD, there is still a large amount of stigma perceived to these diseases, and this can prevent some carers from seeking help. A systematic review<sup>122</sup> of the management of dementia in primary care concluded that caring for people with dementia requires the same systematic approach as the management of other long term conditions. The systematic follow-up of both people with dementia and their carers should be integrated into primary care. Reframing dementia, with an emphasis on abilities retained may allow people with dementia and their families to develop more effective coping strategies; an increase in skill mix within primary care is required to deliver this and may also improve the management of behavioural problems. The potential benefits of person-centred interventions, like advance care planning, and alternative models of service delivery, such as a structured, collaborative care approach which promotes integrated case management within primary care, require further evaluation.

A recent systematic review<sup>123</sup> of the factors associated with risk for and prevention of cognitive decline in later life found little strong evidence of evidence that supported the benefits of selected nutritional factors or cognitive, physical, or other leisure activities was

<sup>121</sup> Burgener SC et al. Effectiveness of community-based nonpharmacological interventions for early stage dementia. *J Geront Nurs* 2009;35 (3):50-7.

<sup>122</sup> Robinson et al. Primary care and dementia: 2. Long-term care at home: psychosocial interventions, information provision a, carer support and case management. *Int J Geriatr Psychiatry* 2010; 25:657-664.

<sup>123</sup> <http://www.annals.org/content/153/3/182.full?sid=1c0de15d-1b21-42c0-ad08-51487c44068b>

limited. Current tobacco use, the apolipoprotein E  $\epsilon$ 4 genotype, and certain medical conditions were associated with increased risk. One RCT found a small, sustained benefit from cognitive training (high quality of evidence) and a small RCT reported that physical exercise helps to maintain cognitive function.

### *Research*

Much of the dementia literature points to the need for further research, and emphasises the importance of distinguishing between different types of dementia and different service needs at each stage of the disease. Led by the Collaboration for Leadership in Applied Health Research and Care Public Health theme in Cambridge, two programmes of systematic reviews have been funded to start in September 2010. The first is a Cochrane Collaboration programme of systematic reviews on dementia diagnostic test accuracy, and the second, funded by the BUPA Foundation, will examine the effects, suitability of available tools, and the harms and benefits of population screening for dementia. In addition, work is ongoing to examine risk factors (which include high blood pressure, elevated blood cholesterol, diabetes and excess weight), the potential for screening for dementia, the consequences of early diagnosis, and the effectiveness of different nonpharmacological therapies. It is thought unlikely that an effective pharmacological therapy will be available in the near future but this continues to be investigated. It is estimated that delaying the onset of Alzheimer's Disease by five years would reduce the prevalence by 50%. Several randomised trials are ongoing.

### *National guidance*

The most recent NICE guidance on dementia was published in 2006<sup>124</sup> and is due for review in November 2011 but NICE has published quality standards for dementia in 2010.<sup>125</sup> Current national policy is not to offer population screening for dementia.<sup>126</sup> Aligned with the goals of the National Dementia Strategy,<sup>127</sup> NICE's quality standards are a set of specific, concise statements designed to act as markers of high-quality, cost-effective patient care, covering treatment and prevention. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with the NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience. Figure 53 shows how the ten NICE quality standards relate to the different stages of dementia. Primary Care Trusts in England are currently working to implement the national Dementia Strategy published in 2009. This points out that "contrary to social misconception, there is a very great deal that can be done to help people with dementia. Services need to be re-engineered so that dementia is diagnosed early and well and so that people with dementia and their family carers can receive the treatment, care and support following diagnosis that will enable them to live as well as possible with dementia."

The strategy has three main strands:

- raising awareness and understanding
- early diagnosis and support
- living well with dementia.

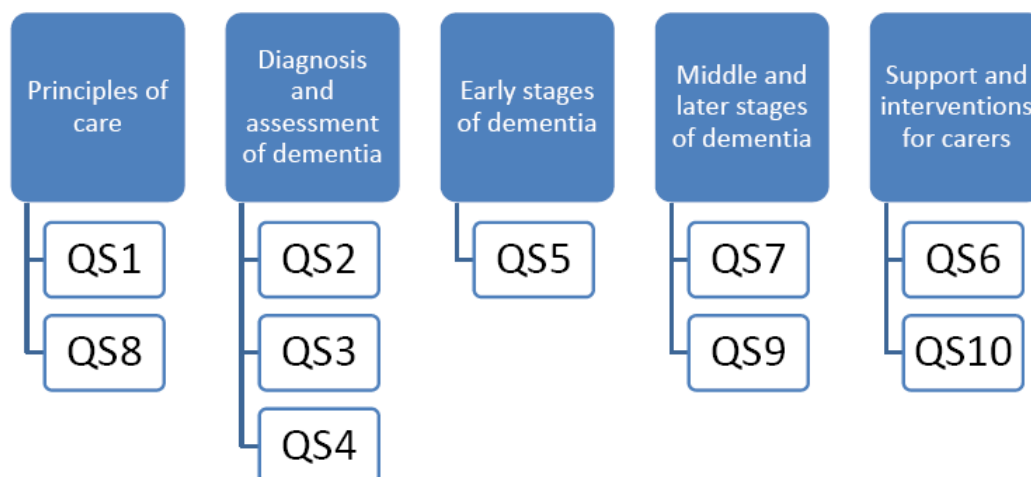
124 <http://www.nice.org.uk/CG42>

125 <http://www.nice.org.uk/aboutnice/qualitystandards/dementia/dementiaqualitystandard.jsp>

126 <http://www.screening.nhs.uk/alzheimers>

127 Living well with dementia – a national dementia strategy. Department of Health, England, 2009. [http://www.dementia.dh.gov.uk/library/downloads/DH\\_094051.pdf](http://www.dementia.dh.gov.uk/library/downloads/DH_094051.pdf)

**Figure 56: NICE Quality standards for dementia**



Number	Quality statements
1	People with dementia receive care from staff appropriately trained in dementia care.
2	People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.
3	People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.
4	People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care coordinator and addresses their individual needs.
5	People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of : <ul style="list-style-type: none"> <li>• advance statements</li> <li>• advance decisions to refuse treatment</li> <li>• Lasting Power of Attorney</li> <li>• Preferred Priorities of Care.</li> </ul>
6	Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.
7	People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in their care plan.
8	People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health.
9	People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs.
10	Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.

Source: <http://www.nice.org.uk/media/7EF/3F/DementiaQualityStandard.pdf>

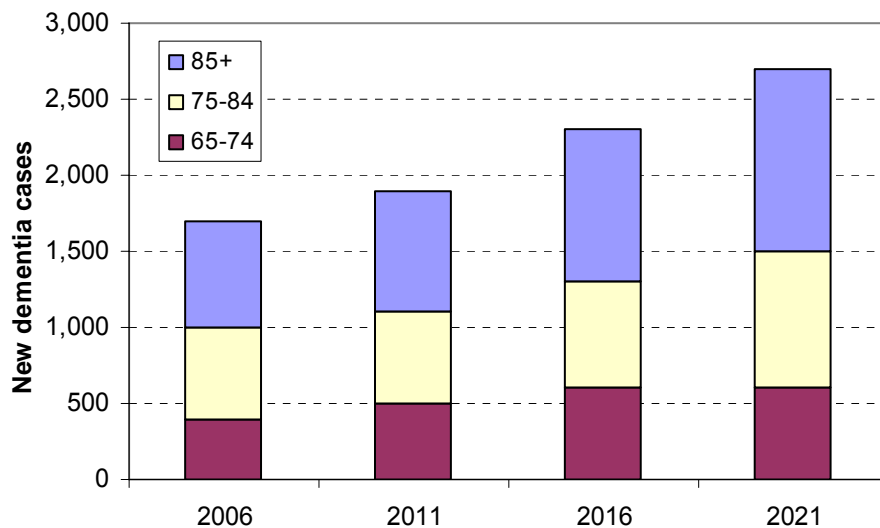
Table 33 shows the incidence of dementia per 1,000 people years increases with age. Figure 54 shows how this translates into number of new cases of dementia forecast to 2021. By 2021, this annual number is forecast to have increased to 2,700. The number of new dementia cases is forecast to increase across all localities by 2021. The smallest increase will be in Cambridge City and the largest in South Cambridgeshire (Table 34).

**Table 33: Dementia incidence (per 1,000 person years)**

Age	Men	Women
65-69	6.9	6.3
70-74	14.5	6.1
75-79	14.2	14.8
80-84	17.0	31.2
85+	58.4	71.7

Source: MRC CFAS study

**Figure 57: Annual number of new dementia cases, in Cambridgeshire, 2006-2021, by age**

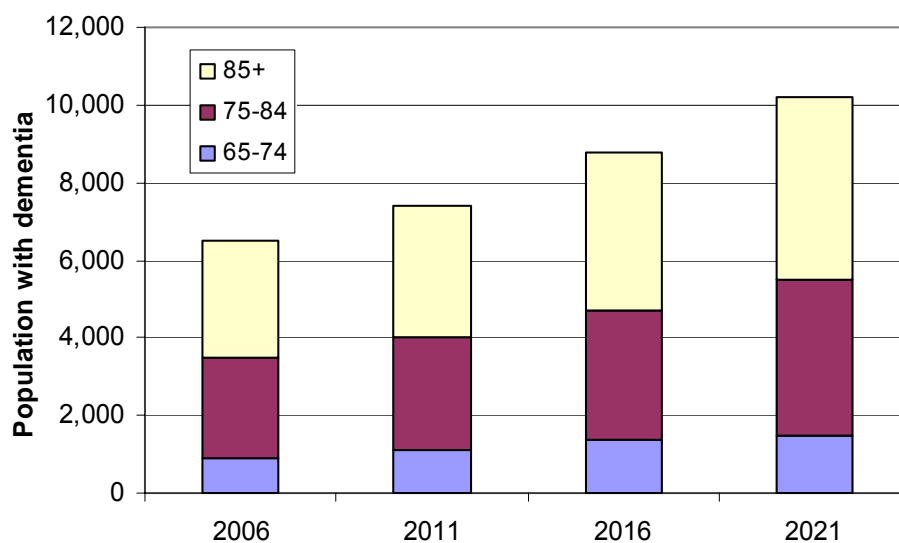


**Table 34: Incidence of dementia per year, by age and local authority**

Area	Age group	2006	2011	2016	2021	% change
Cambridgeshire County Council	65-74	380	470	580	620	64%
	75-84	600	650	740	910	52%
	85+	750	840	1000	1160	55%
	Total with dementia	1720	1950	2310	2690	56%
	% population aged 65+	2.0%	1.9%	1.9%	1.9%	
Cambridge City Council	65-74	50	70	80	90	74%
	75-84	100	100	100	120	25%
	85+	140	150	160	160	14%
	Total with dementia	300	310	340	380	29%
	% population aged 65+	2.1%	2.0%	1.9%	1.9%	
East Cambridgeshire District Council	65-74	50	60	80	80	52%
	75-84	90	90	110	130	45%
	85+	100	120	140	160	64%
	Total with dementia	240	280	330	380	54%
	% population aged 65+	1.9%	1.9%	1.9%	1.9%	
Fenland District Council	65-74	70	80	100	110	47%
	75-84	120	130	130	150	19%
	85+	130	150	210	230	81%
	Total with dementia	320	360	430	490	50%
	% population aged 65+	1.9%	1.9%	2.0%	2.0%	
Huntingdonshire District Council	65-74	100	130	160	160	54%
	75-84	150	160	200	250	72%
	85+	180	210	240	290	58%
	Total with dementia	430	500	590	700	62%
	% population aged 65+	1.9%	1.8%	1.8%	1.9%	
South Cambridgeshire District Council	65-74	90	130	160	170	91%
	75-84	140	160	200	270	85%
	85+	190	210	250	310	61%
	Total with dementia	430	500	620	750	76%
	% population aged 65+	2.0%	1.8%	1.8%	1.9%	

Similarly, the number of people with dementia in Cambridgeshire is expected to rise (Figure 55) (Table 35). In the 20 years from 2010 to 2030, the expected number of people with dementia in Cambridgeshire is expected to double from 7,000 to more than 14,000.

**Figure 58: Estimated and forecasted number of people with dementia, by age, for Cambridgeshire**





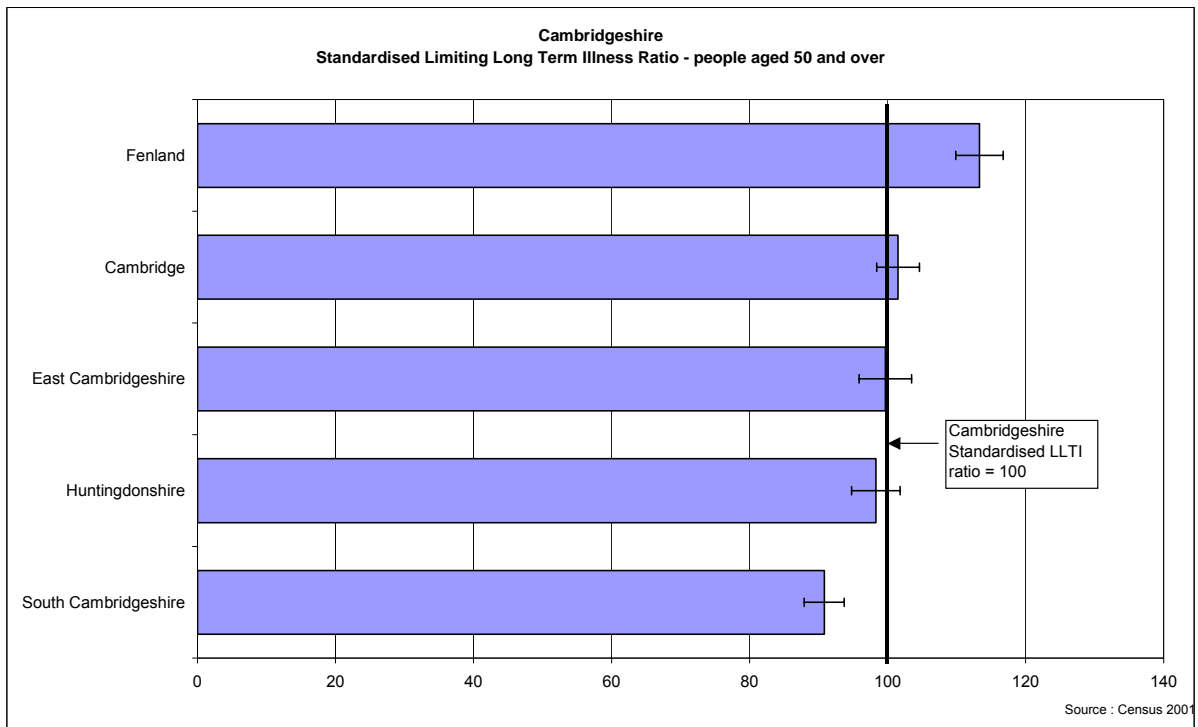
**Table 325:** Estimates of population with dementia (prevalence), by age and local authority

Area	Age group	2006	2011	2016	2021	% change
Cambridgeshire County Council	65-74	890	1,100	1,370	1,460	64%
	75-84	2,650	2,860	3,260	4,050	53%
	85+	3,040	3,420	4,060	4,730	56%
	Total with dementia	6,580	7,380	8,690	10,240	56%
	% population aged 65+	7.5%	7.2%	7.0%	7.3%	
Cambridge City Council	65-74	130	150	200	220	74%
	75-84	440	430	450	550	25%
	85+	580	610	630	660	14%
	Total with dementia	1,140	1,190	1,280	1,430	25%
	% population aged 65+	8.3%	7.8%	7.2%	7.1%	
East Cambridgeshire District Council	65-74	130	150	180	200	52%
	75-84	390	420	480	570	45%
	85+	410	490	570	670	64%
	Total with dementia	930	1,060	1,230	1,440	55%
	% population aged 65+	7.3%	7.3%	7.1%	7.4%	
Fenland District Council	65-74	180	190	230	260	47%
	75-84	540	570	570	650	19%
	85+	520	630	840	950	82%
	Total with dementia	1,240	1,390	1,650	1,850	50%
	% population aged 65+	7.1%	7.3%	7.5%	7.5%	
Huntingdonshire District Council	65-74	240	310	370	370	54%
	75-84	640	710	860	1,100	72%
	85+	740	850	990	1,180	59%
	Total with dementia	1,630	1,870	2,220	2,650	63%
	% population aged 65+	7.2%	6.9%	6.7%	7.3%	
South Cambridgeshire District Council	65-74	220	300	390	410	92%
	75-84	640	730	890	1,180	86%
	85+	790	850	1,030	1,280	61%
	Total with dementia	1,650	1,870	2,310	2,870	75%
	% population aged 65+	7.7%	6.9%	6.7%	7.2%	

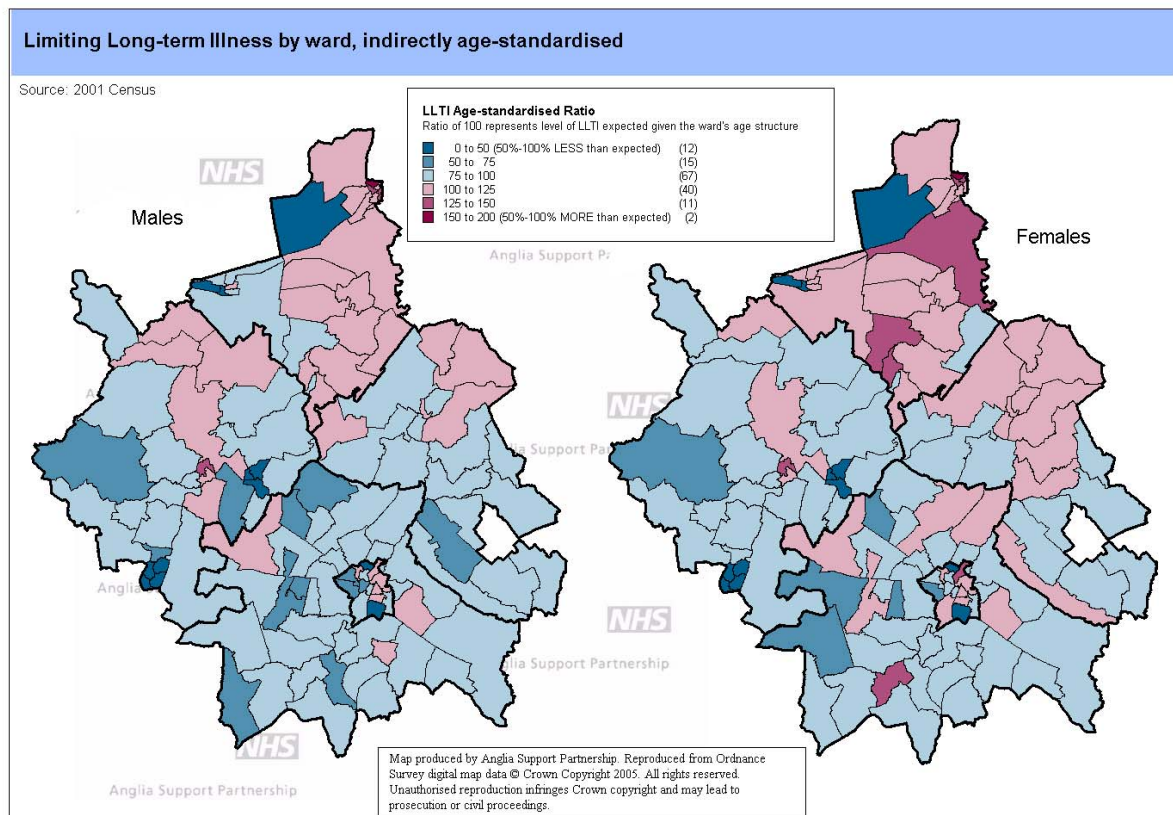
## 6.7 Disability

According to the Census taken in 2001, the percentage of older people in Cambridgeshire with a long term illness or disability was higher than expected in Fenland but lower than expected in South Cambridgeshire (Figure 56). Figure 57 shows greater detail of this North-South gradient. The regional lifestyle survey in 2008 showed that this picture has broadly remained the same. The most common limitation reported by men and women was mobility, followed by the ability to lift, carry or move objects and manual dexterity. The most common condition was musculoskeletal disorders, followed by heart and circulatory problems and respiratory diseases.

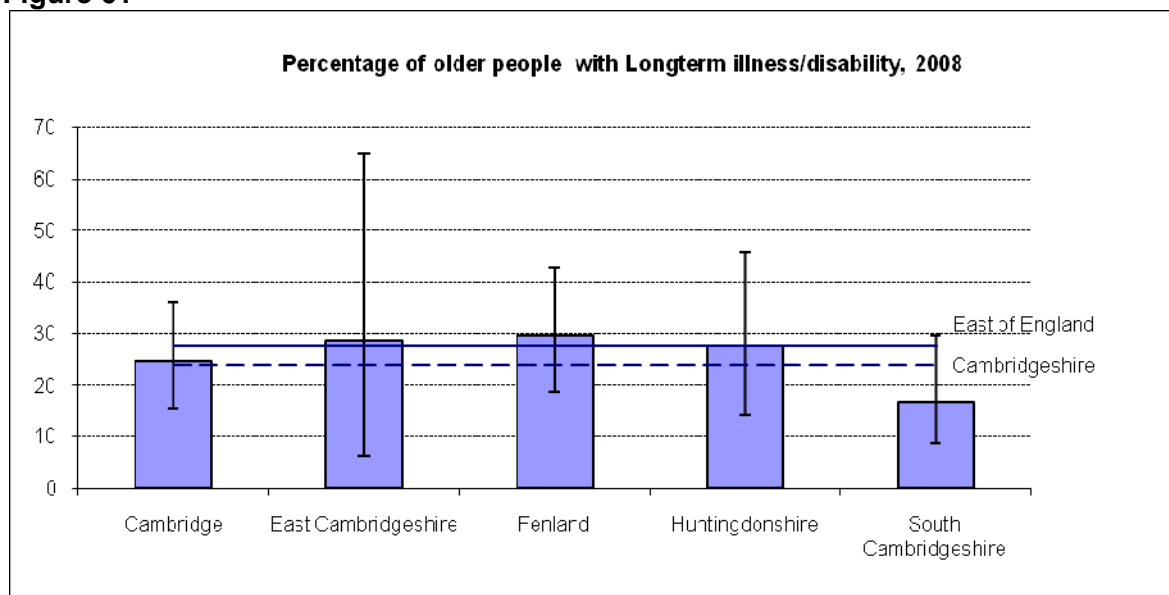
**Figure 59:** Age standardised LLTI ratios for people aged 50 and over



**Figure 60**



**Figure 61**



The Joseph Rowntree Trust found that a third of adults aged 65 to 74 and half of adults aged 75 and over report a limiting long-standing sickness or disability. Both proportions are similar to a decade ago. For those aged 65 to 74 the proportion with a limiting long-standing illness or disability increases as income decreases. The differences in income are less for those 75 and over.<sup>128</sup>

#### *Learning disability*

A JSNA for adults with learning disabilities in Cambridgeshire was published in 2008. It highlights:

- more people with learning disabilities are living longer and facing the additional problems associated with older age
- a third of people with learning difficulties are aged 50 and over
- the proportion of older adults with learning difficulties and dementia is increasing
- Carers of an older person with learning difficulties may require additional support, particularly as they age themselves

People with learning difficulties may be more vulnerable to abuse as they get older (see section **Safeguarding Adults**).

#### *Sensory impairment*

Among older people, hearing loss is very common; over half of people over 60 have impaired hearing. Sight loss, though less common, affects one in 12 people in this age group, and some have both a hearing and sight loss together. As more people survive into older age, the incidence of sight and hearing loss is growing.

The sensory services team works with individuals aged 19 to 119 who have a significant loss of sight, hearing or a dual loss. They work closely with Health colleagues in Audiology and the Eye Clinics, and with both national and local voluntary organisations such as Camtad, RNID, Camsight, RNIB, SENSE and DBUK (Deaf Blind UK). Within the team there are VI Rehabilitation workers who can assist individuals to regain skills in daily living skills and mobility after suffering from sight loss. On the hearing loss side the team provides advice and alerting/communication equipment to minimise risks and to ensure that the individual can be alerted to the smoke alarm, door bell, phone etc. Some people with profound dual loss are assisted with communicator guides.

*Sight loss*

Leading causes of sight loss in the UK are: macular degeneration (AMD), glaucoma and diabetic retinopathy<sup>129</sup> (Bunce & Wormald, 2006). Figures from the NHS (2008) indicate that 153,000 people were registered blind at the time and 156,300 were registered partially sighted. Sight loss is expected to become more prevalent in the future. The main impact of sight loss for visually impaired people is the sight loss itself but other health impacts associated with sight loss include falls, risk of depression, and loss of ability to undertake usual activities of daily living. Visually impaired people are identified as more likely to live alone<sup>130</sup> and have additional disabilities or chronic health conditions.<sup>131</sup>

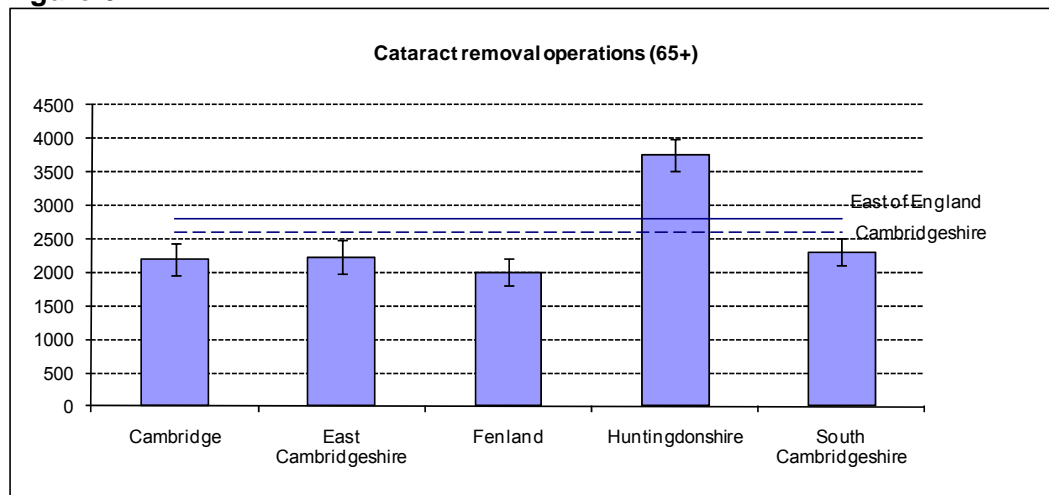
Cambridgeshire County Council maintains a register (Table 36) of individuals who are registered with severe sight loss (blind) and partial sight loss (partially sighted) but this underestimates the total number of people affected since individuals can though choose whether or not they are registered. Cataract operations are more common in Huntingdonshire than the rest of the county (Figure 59).

**Table 36: Visual Impairment registration total in Cambridgeshire in July 2010**

Cambridgeshire	All ages	0-4	5-17	18-49	50-64	65-74-	75+
Blind	2,193	12	39	189	160	146	1,647
Partially sighted	1,512	4	28	158	127	107	1,088
Total	3,705	16	67	347	287	253	2,735

Source:

**Figure 62**



*Hearing loss*

Hearing loss cannot usually be prevented or reversed. There are many causes of deafness but in later life the commonest is presbycusis. This condition affects the inner ear and makes it difficult to hear certain frequencies. This affects people’s ability to hear speech. Fortunately many people with this condition can be helped by hearing aids, which are now

<sup>129</sup> BUNCE, C. & WORMALD, R. (2006). Leading causes of certification for blindness and partial-sightedness in England & Wales  
<sup>130</sup> DOUGLAS, G., CORCORAN, C., & PAVEY, S. (2006). Network 1000 Survey 1: Opinions and circumstances of visually impaired people in Great Britain: report based on over 1000 interviews  
<sup>131</sup> ORR, A.L. (1992). Ageing and Blindness: Toward a System Approach to Service Delivery. In A.L. ORR (ed.), Vision and Ageing: Crossroads for Service delivery (pp. 3-33) New York: AFB Press

both powerful and discreet. Recent advances such as cochlear implants may help a few people who cannot benefit from conventional hearing aids.

Almost nine million people in the UK are deaf or hard of hearing and approaching 6,500,000 of these are over 60.<sup>132</sup>

- 71.1% of over 70-year-olds will have some kind of hearing loss
- 26.7% of over 70-year-olds will have mild hearing loss
- 36.8% of over 70-year-olds will have moderate hearing loss
- 6.3% of over 70-year-olds will have severe hearing loss
- 1.3% of over 70-year-olds will have profound hearing loss

Cambridgeshire County Council also maintains a deaf/hard of hearing register, but is not under a duty to do so and may be less than complete (Table 37).

**Table 337: Deaf/hard of hearing register for Cambridgeshire in July 2010**

Cambridgeshire	All ages	0-4	5-17	18-49	50-64	65-74	75+
Deaf with speech	367	0	13	98	49	34	173
Deaf with speech and blind	13	0	0	2	0	2	9
Deaf without speech	66	0	2	33	15	7	9
Deaf without speech and blind	3	0	1	0	0	0	2
Hard of hearing	1,045	0	2	66	106	125	746
Hard of hearing and blind	13	0	0	0	3	0	10
Total	1,507	0	18	199	173	168	949

Source:

#### *Deafblindness (dual loss)*

For a small minority of people, problems can occur with both of their hearing and vision and this can cause particular difficulties with communication, mobility, isolation and loss of independence.

The everyday challenges depend not only on the degrees of hearing and sight loss, but also on how people came to lose both major senses. People fall into one of four major groups:

- The majority of those with hearing and sight loss have had both sight and hearing throughout most of their lives and usually acquire dual loss in later life.
- Some people who have been hard of hearing or deaf all or most of their lives go on to lose their sight in later life.
- Some people who have been blind or partially sighted all or most of their lives lose their hearing as they get older.
- A very small minority of people have been born with both impaired hearing and sight. Their needs are very complex.

#### *Frailty*

The number of people in the very oldest age groups is important. For the older population, it is useful to consider the population in finer age bands since the impact of morbidity, and the effects of mortality, are quite different within the age groups.

<sup>132</sup> RNID [www.rnid.org.uk/information\\_resources/aboutdeafness/statistics/](http://www.rnid.org.uk/information_resources/aboutdeafness/statistics/)

In 2008, there were estimated to be nearly 8,000 people aged between 85 and 89 years and nearly 4,000 people in Cambridgeshire PCT aged over 90 years.

When planning services for older people, it is not only the absolute number of older people that is of concern, but also the number of people likely to be in need of support. With increasing life expectancy, more people (particularly men) are living to an age where they are more likely to be physically frail or confused, which has significant implications for service planning.

Frailty refers to the number of older people estimated to be frail because of either physical disability, mental disability or both. Frailty estimates are important as they indicate whether the population is becoming more or less frail. Physical frailty is measured using an activity of daily living scale and mental frailty using standard assessment scales.

Forecasting the proportion of people likely to be frail necessitates an understanding of changes to the population and the likelihood of any individual becoming frail. The Medical Research Council's Cognitive Function and Ageing Study<sup>133</sup> (CFAS) provides estimates of the current prevalence of frailty among older people. Applying these rates to the local population provides a forecast of the likely number of frail people in the future. This methodology assumes that the prevalence of frailty will remain constant into the future.

Table 38 shows how the prevalence of frailty varies by age and sex and type of frailty. Among all men aged over 65, 11% are likely to be frail, of whom just over half will be physically frail, just over a quarter will have a cognitive impairment and the remaining 19% will be physically and cognitively frail. Among women, a higher proportion is likely to be physically frail, and a lower proportion to be cognitively impaired. The prevalence of frailty rises with age, such that among women aged over 85, over half would be expected to be frail.

**Table 38: Prevalence of frailty**

Prevalence	65+		65-74		75-84		85+	
	Men	Women	Men	Women	Men	Women	Men	Women
% frail	11%	19%	6%	7%	14%	21%	36%	54%
Frailty:								
Physical only	54%	66%	59%	75%	53%	69%	48%	59%
Cognitive only	27%	16%	28%	18%	29%	15%	22%	16%
Combined	19%	18%	13%	7%	17%	15%	30%	25%

Source: MRC CFAS study

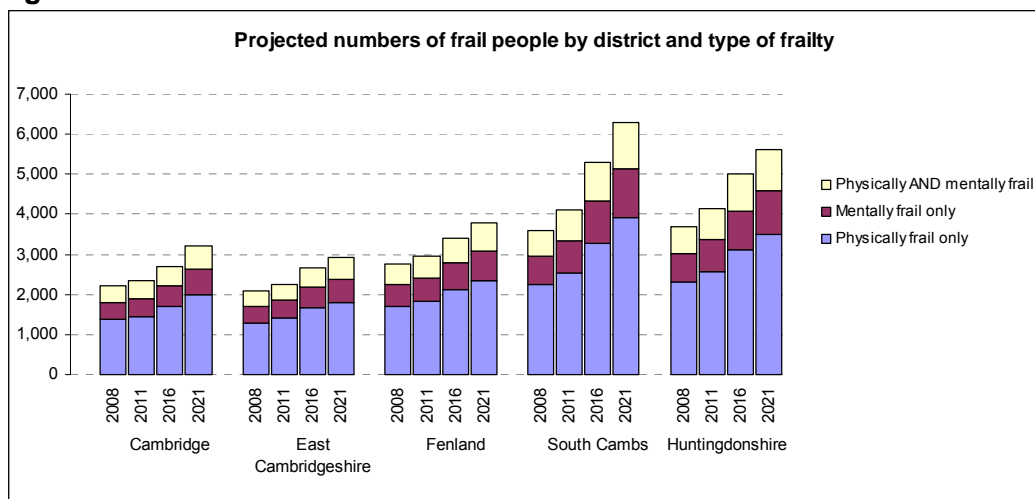
Across Cambridgeshire, the number of physically frail older people is projected to rise by 53% by 2021. The number of cognitively impaired older people is projected to increase by 59% and the number of people who are both physically and cognitively frail is projected to increase to nearly 22,000 in the next 10 years (Table 39). Data by local authority are shown in Figure 60 and Table 40.

**Table 39**

	2008	2011	2016	2021	change 08-21
Physically frail only	8,922	9,807	11,849	13,558	52.0%
Mentally frail only	2,798	3,084	3,748	4,295	53.5%
Physically AND mentally frail	2,628	2,892	3,500	4,007	52.5%
Total	14,348	15,782	19,097	21,861	52.4%

<sup>133</sup> Melzer D. *et al.* Medical Research Council Cognitive Function and Ageing Study (MRC CFAS) and Resource Implications Study (RIS MRC CFAS): Profile of disability in elderly people: estimates from a longitudinal population study. *BMJ* 1999; **318**:1108-1111.

Source:  
**Figure 63**



**Table 40**

	2008	2011	2016	2021	2008	2011	2016	2021	2008	2011	2016	2021
	Males				Females				Person			
<b>Physical only</b>												
Cambridge	346	382	444	520	1,038	1,075	1,245	1,485	1,384	1,457	1,689	2,005
East Cambs	367	395	481	535	919	1,010	1,180	1,279	1,286	1,405	1,660	1,813
Fenland	477	509	616	702	1,238	1,321	1,497	1,641	1,715	1,830	2,112	2,343
Huntingdonshire	650	730	900	1,024	1,651	1,845	2,201	2,465	2,300	2,575	3,101	3,489
South Cambs	627	727	959	1,133	1,610	1,814	2,327	2,774	2,237	2,541	3,286	3,907
Cambridgeshire	2,467	2,742	3,398	3,914	6,455	7,065	8,450	9,644	8,922	9,807	11,849	13,558
<b>Cognitive only</b>												
Cambridge	173	191	222	260	252	261	302	360	425	452	524	620
East Cambs	183	197	240	267	223	245	286	310	406	442	526	577
Fenland	239	254	308	351	300	320	363	398	539	575	671	749
Huntingdonshire	325	365	450	512	400	447	534	598	725	812	983	1,110
South Cambs	314	363	479	567	390	440	564	672	704	803	1,044	1,239
Cambridgeshire	1,233	1,371	1,699	1,957	1,565	1,713	2,049	2,338	2,798	3,084	3,748	4,295
<b>Combined</b>												
Cambridge	122	134	156	183	283	293	339	405	405	428	496	588
East Cambs	129	139	169	188	251	275	322	349	380	414	491	537
Fenland	168	179	217	247	338	360	408	448	505	539	625	694
Huntingdonshire	229	257	317	360	450	503	600	672	679	760	917	1,033
South Cambs	221	256	337	399	439	495	635	756	660	750	972	1,155
Cambridgeshire	868	965	1,196	1,377	1,760	1,927	2,305	2,630	2,628	2,892	3,500	4,007
<b>Frail</b>												
Cambridge	641	707	822	963	1,572	1,629	1,886	2,251	2,213	2,336	2,708	3,214
East Cambs	679	731	890	990	1,392	1,530	1,788	1,937	2,071	2,261	2,678	2,928
Fenland	883	942	1,140	1,300	1,875	2,002	2,268	2,486	2,759	2,944	3,408	3,786
Huntingdonshire	1,203	1,352	1,666	1,896	2,501	2,795	3,336	3,736	3,704	4,147	5,001	5,632
South Cambs	1,162	1,346	1,775	2,099	2,439	2,749	3,526	4,203	3,601	4,094	5,302	6,302
Cambridgeshire	4,568	5,078	6,293	7,248	9,780	10,704	12,804	14,613	14,348	15,782	19,097	21,861

Source

## 6.8 Activities of daily living

The following table estimates the number of people in Cambridgeshire aged 65 and over unable to manage at least one domestic task (“instrumental activities of daily living”) on their own, by age and gender, projected to 2030. Tasks include: household shopping, wash and



dry dishes, clean windows inside, jobs involving climbing steps, use a vacuum cleaner to clean floors, wash clothing by hand, open screw tops, deal with personal affairs, do practical activities. This shows that the number of people aged 65 and over unable to manage at least one domestic task on their own is estimated to almost double in the next 20 years (Table 41).

**Table 41: Number of people unable to manage domestic tasks on their own by age and sex**

	2010	2015	2020	2025	2030
Males aged 65-69 unable to manage at least one domestic task on their own	2,288	2,832	2,576	2,832	3,280
Males aged 70-74 unable to manage at least one domestic task on their own	2,394	2,814	3,507	3,213	3,549
Males aged 75-79 unable to manage at least one domestic task on their own	3,096	3,672	4,392	5,472	5,040
Males aged 80-84 unable to manage at least one domestic task on their own	2,460	2,870	3,526	4,264	5,371
Males aged 85 and over unable to manage at least one domestic task on their own	3,196	4,216	5,508	7,276	9,588
Females aged 65-69 unable to manage at least one domestic task on their own	4,200	5,264	4,928	5,292	6,216
Females aged 70-74 unable to manage at least one domestic task on their own	4,920	5,800	7,280	6,840	7,400
Females aged 75-79 unable to manage at least one domestic task on their own	5,304	5,980	7,072	8,944	8,424
Females aged 80-84 unable to manage at least one domestic task on their own	5,494	5,896	6,834	8,174	10,385
Females aged 85 and over unable to manage at least one domestic task on their own	7,462	8,610	10,004	12,300	15,416
Total population aged 65 and over unable to manage at least one domestic task on their own	40,814	47,954	55,627	64,607	74,669

## 6.9 Self care

The projected number of people aged 65 and over unable to manage at least one self-care activity on their own, by age and gender, projected to 2030. Activities include: bathe, shower or wash all over, dress and undress, wash their face and hands, feed, cut their toenails, take medicines is expected to nearly double in the next 20 years (Table 42).

**Table 42: Number of people unable to manage self-care activities on their own by age and sex**

	2010	2015	2020	2025	2030
Males aged 65-69 unable to manage at least one self-care activity on their own	2,574	3,186	2,898	3,186	3,690
Males aged 70-74 unable to manage at least one self-care activity on their own	2,166	2,546	3,173	2,907	3,211
Males aged 75-79 unable to manage at least one self-care activity on their own	2,494	2,958	3,538	4,408	4,060
Males aged 80-84 unable to manage at least one self-care activity on their own	1,980	2,310	2,838	3,432	4,323
Males aged 85 and over unable to manage at least one self-care activity on their own	2,397	3,162	4,131	5,457	7,191
Females aged 65-69 unable to manage at least one self-care activity on their own	3,150	3,948	3,696	3,969	4,662
Females aged 70-74 unable to manage at least one self-care activity on their own	3,690	4,350	5,460	5,130	5,550
Females aged 75-79 unable to manage at least one self-care activity on their own	3,978	4,485	5,304	6,708	6,318
Females aged 80-84 unable to manage at least one self-care activity on their own	4,346	4,664	5,406	6,466	8,215
Females aged 85 and over unable to manage at least one self-care activity on their own	6,734	7,770	9,028	11,100	13,912
Total population aged 65 and over unable to manage at least one self-care activity on their own	33,509	39,379	45,472	52,763	61,132

Source: [www.poppi.org.uk](http://www.poppi.org.uk)

## 6.10 Mortality

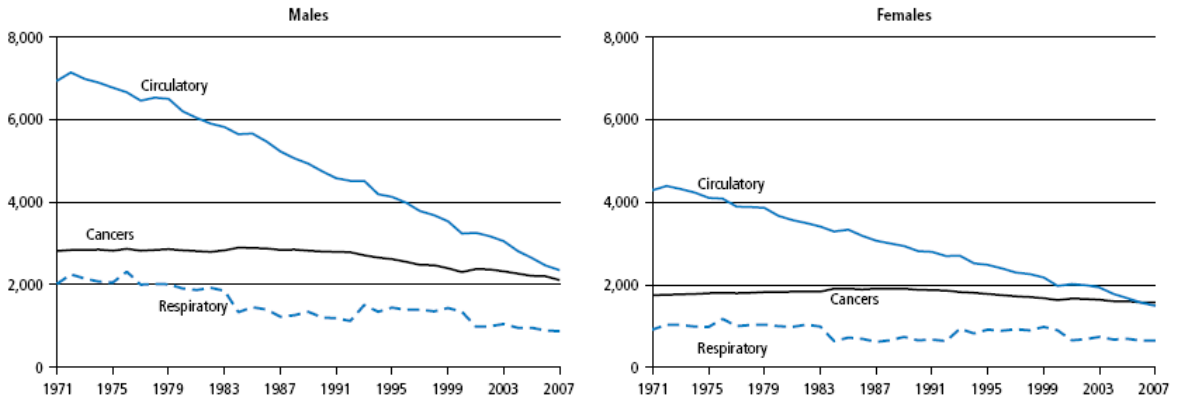
Cause of death is not a good indicator of the burden of disease in a population unless the disease is fatal, but it can be a useful although blunt indicator of differences between populations and show important trends over time in either underlying health or health care. Figure 61 shows a lower age-standardised mortality in females than males, and a general decline in mortality, especially from circulatory disease which comprises mainly coronary heart disease (mainly angina and heart attack) and stroke. In 2006, mortality from circulatory disease fell below mortality from cancer for females. Figure 62 shows a similar picture in Cambridgeshire. Figures 63 and 64 show the contributions of different diseases to death at different ages.

**Figure 64**

**Mortality:<sup>1</sup> by sex and leading cause groups**

United Kingdom<sup>2</sup>

Rates per million population

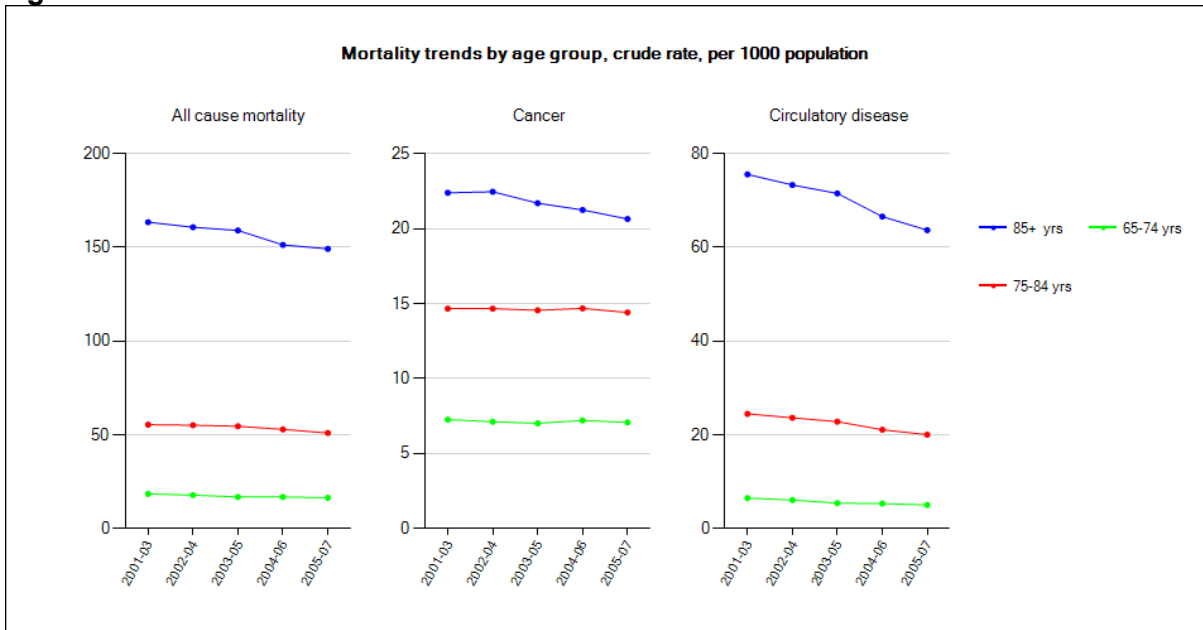


1 Data are for all ages and have been age-standardised using the European standard population. See Appendix, Part 7: Standardised rates, International Classification of Diseases, and European standard population.  
 2 Data for 2000 are for England and Wales only.

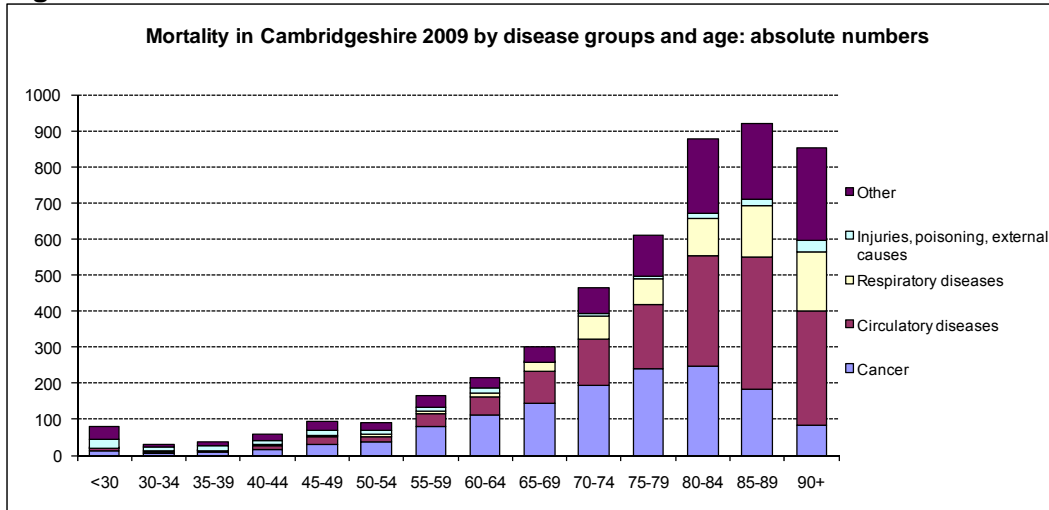
Source: Office for National Statistics

Source: [http://www.statistics.gov.uk/downloads/theme\\_social/Social\\_Trends39/Social\\_Trends\\_39.pdf](http://www.statistics.gov.uk/downloads/theme_social/Social_Trends39/Social_Trends_39.pdf)

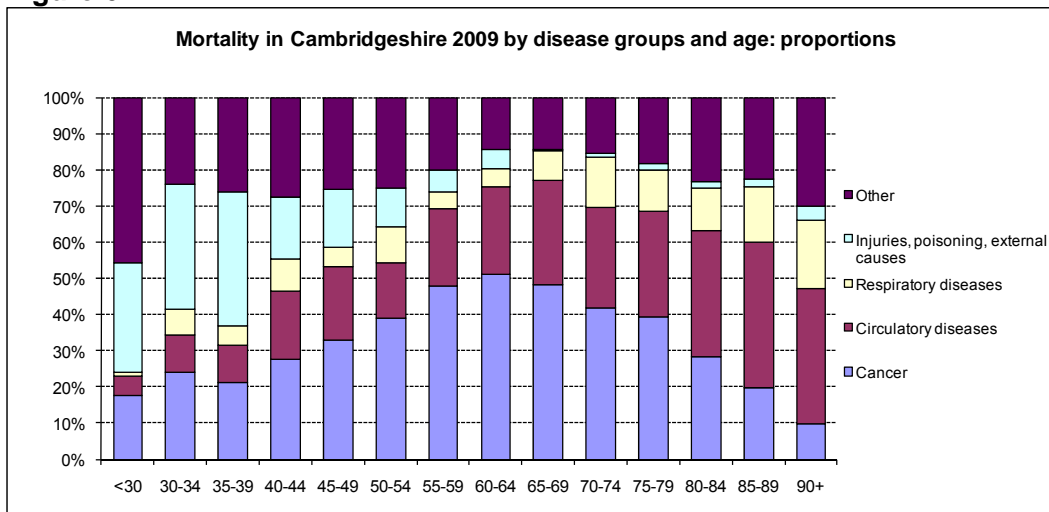
**Figure 65**



**Figure 66**



**Figure 67**

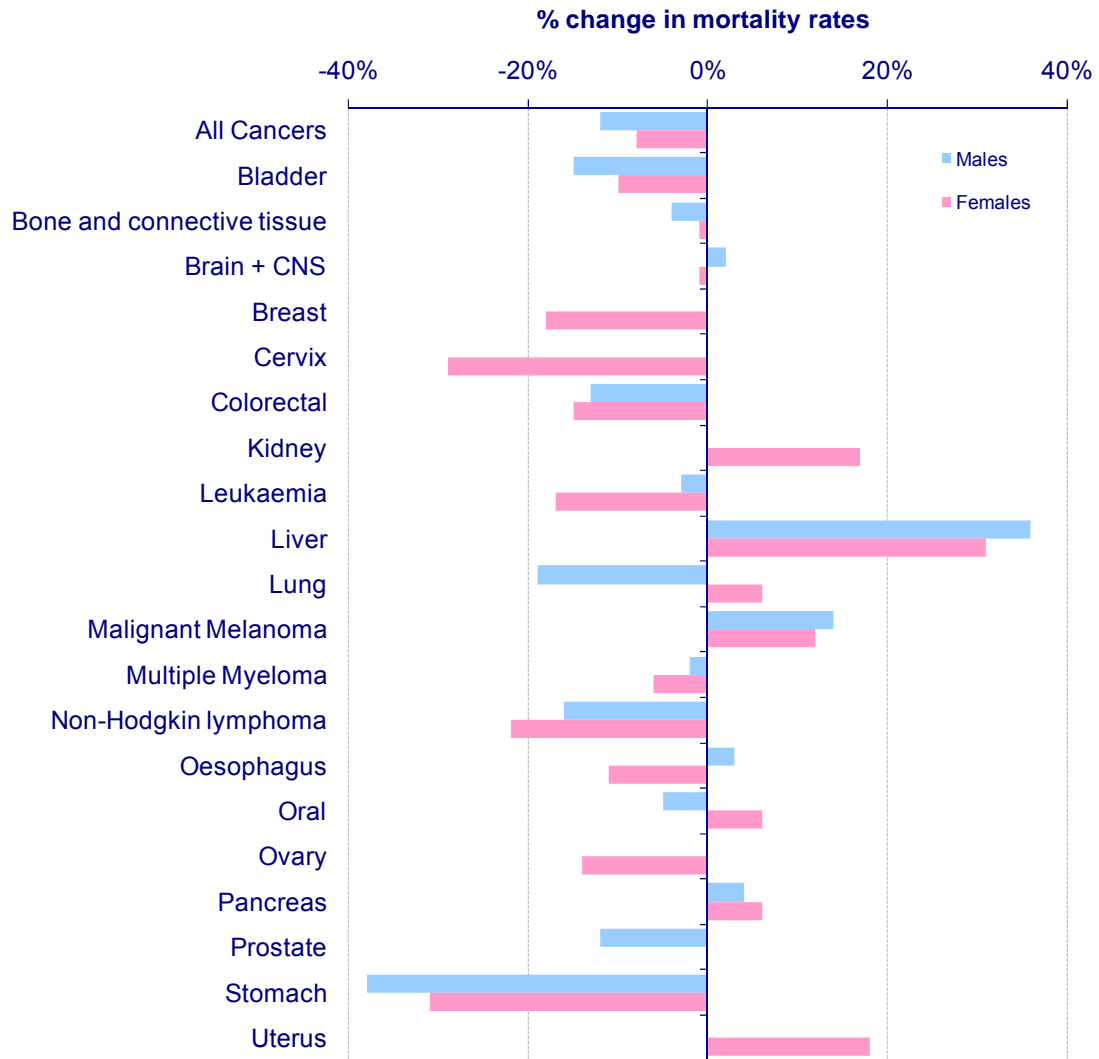


Mortality rates for the majority of cancer types have decreased in the past 10 years (Figure 65). Apart from female lung cancer, all of the four most common causes of cancer death - lung, bowel, breast and prostate cancers - have seen decreases in the last decade, with male lung cancer dropping by almost one fifth (-19%), and female breast cancer by -18%. The largest falls in mortality have been for stomach cancer, more than a third (-35%), and cervical cancer, more than a quarter (-29%), between 1999 and 2008. Since the late 1970s there have been large increases in liver cancer mortality rates, where the rate has more than tripled. The male skin cancer rate has almost tripled since the early 1970s. Other notable cancer mortality increases over the same period include female kidney cancer (+47%), male non-Hodgkin lymphoma by more than a half (+57%), female lung cancer and male oesophageal cancer by almost three-quarters (+74% and +71% respectively). The largest decreases in cancer mortality since 1979 have been seen for testicular cancer, stomach cancer, Hodgkin's lymphoma and cervical cancer, all having decreased by around 65-73%.<sup>134</sup> Historical falls in smoking account for much of the reduction but in Fenland particularly, smoking-attributable deaths remain high.

<sup>134</sup> <http://info.cancerresearchuk.org/cancerstats/mortality/timetrends/#All>

**Figure 68**

**Percentage change in the European age-standardised mortality rates, by sex, major cancers, UK, 1999-2008**



## 7 Health and social care services

Awareness of the need to avoid age discrimination (direct or indirect) is growing in health and social care. Earlier this year, the East of England published a discussion document *What do you expect at your age?*<sup>135</sup> Some groups may be at particular risk. A report from Age Concern (now Age UK) points out that lesbians, gay men and bisexuals may face additional discrimination in older age.<sup>136</sup>

### 7.1 Safeguarding

The Cambridgeshire Adult Safeguarding Board is an inter-agency forum, which promotes the protection of vulnerable adults from abusive behaviour and practice. It achieves this by developing, implementing, monitoring, and evaluating procedures and practice models, which encourage the prevention, detection, and reporting of abuse in all its forms. Its focus is to facilitate effective inter-agency collaboration and cooperation at all levels of safeguarding work by working with all partners and stakeholders to develop a robust response in order to protect vulnerable people from abuse and harm. Another primary aim is to raise awareness amongst all staff, care providers, service users, family carers and residents of Cambridgeshire as to what constitutes abuse, how to respond, and what actions to take to prevent abuse reoccurring.

Adult Safeguarding in Cambridgeshire focuses on five interlocking approaches:

- To decrease the risk of vulnerable people being subjected to abusive or unacceptable practice and behaviour
- Working in partnership with vulnerable people to promote their levels of awareness, assertiveness and empowerment
- Screening out and preventing potential abusers coming into contact with vulnerable people
- Development of policy and best collaborative practice for staff and care providers.
- Training opportunities in order to make sure that all staff members understand their roles and responsibilities in recognising and responding to abusive practice

The emphasis for adult safeguarding within Cambridgeshire is on prevention.

The three year adult safeguarding strategic action plan identifies twelve key areas of work for safeguarding in Cambridgeshire including whole community engagement, partnership working, and engagement of the third sector all essential ingredients in ensuring that we engage at all levels in a meaningful way to ensuring that vulnerable adults are able to live lives how they choose with dignity, respect and free from a fear of abuse.<sup>137</sup>

Of the 777 reports of abuse for 2009/10 (Figure 66), it can be seen that 219 were inconclusive; it is often the inconclusive cases that present the most difficulties, as they need ongoing monitoring.

135

[http://www.eoe.nhs.uk/page.php?page\\_id=1042](http://www.eoe.nhs.uk/page.php?page_id=1042)

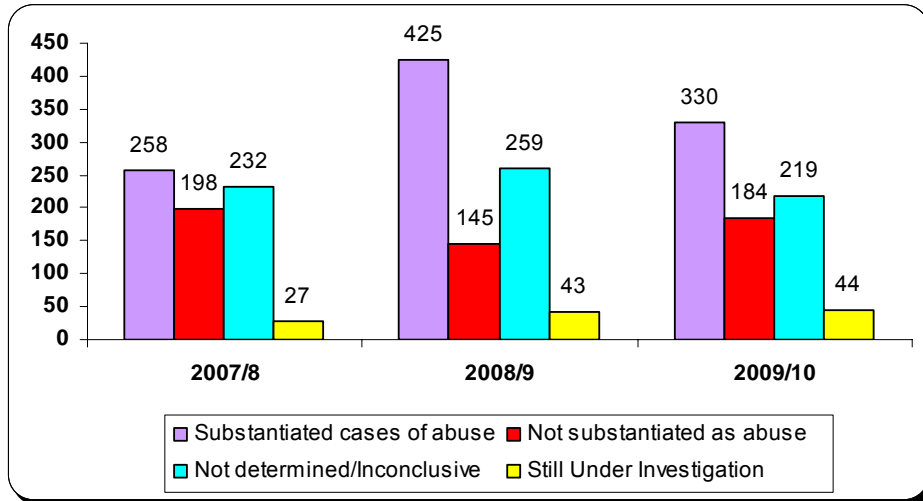
136

[http://www.spectrum-lgbt.org/downloads/OlderLGBT/AgeConcern\\_Issues\\_facing\\_older\\_LGB.pdf](http://www.spectrum-lgbt.org/downloads/OlderLGBT/AgeConcern_Issues_facing_older_LGB.pdf)

137

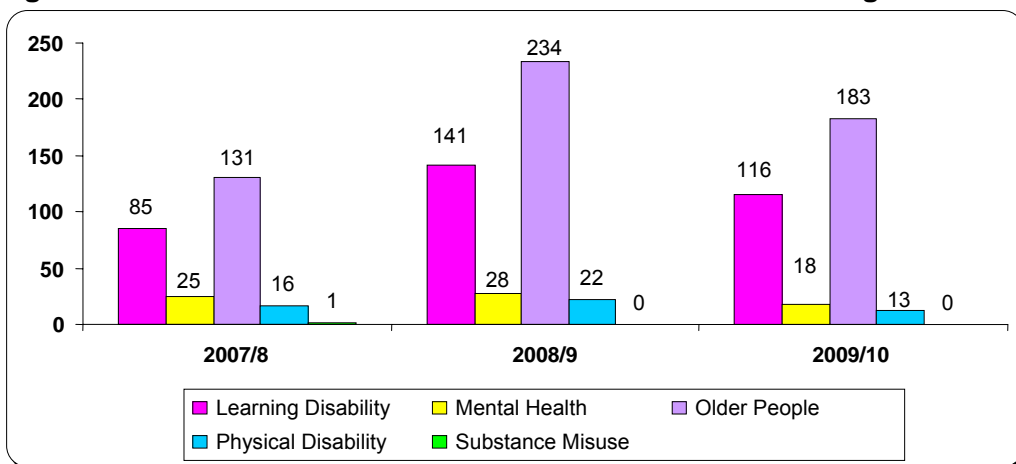
[www.cambridgeshire.gov.uk/social/adultprot/](http://www.cambridgeshire.gov.uk/social/adultprot/)

**Figure 69 Number of cases of abuse reported in Cambridgeshire 2007/8 to 200/10**



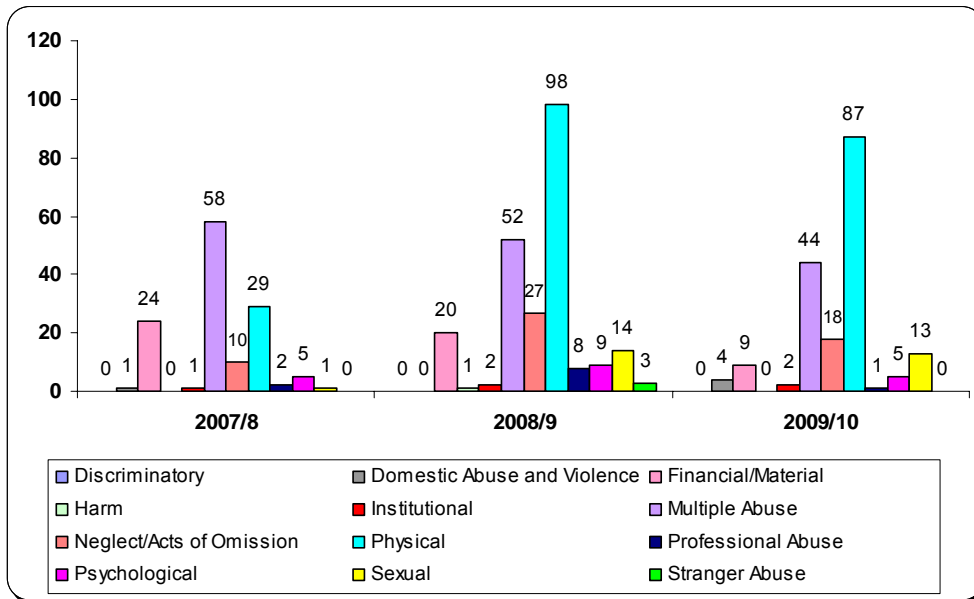
Figures 67 to 69 give more details about the substantiated cases of abuse reported to Cambridgeshire Adult Support Services. Most cases for the period 2007 to 2010 were against older people. *In the period from 2009 to 2010 there were forty four cases where the vulnerable adult had suffered a combination of two or more forms of abuse.* In the period 2009 to 2010 thirty three incidents of abuse occurred in the older person's own home.

**Figure 70 Number of cases of substantiated abuse in Cambridgeshire**

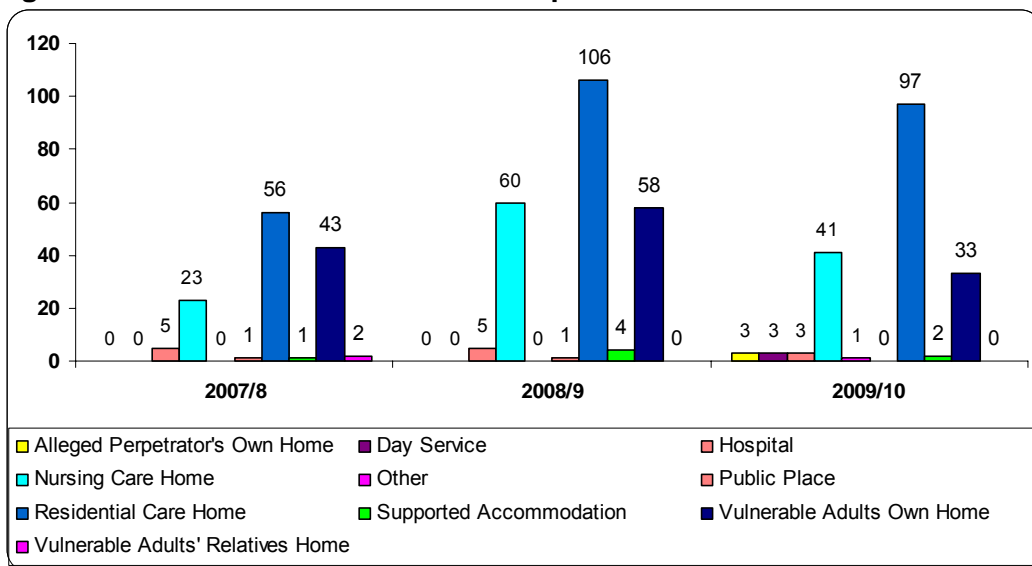




**Figure 71 Type of abuse against older people**



**Figure 69 Location of abuse of an older person**



**7.2 Services for carers**

*Caring about carers*, the national Carers’ Strategy<sup>138</sup> sets out a vision to be achieved by 2018: “Carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals’ needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen.” General practitioners have central role in the Carers’ pathway to identify carers and refer to relevant support services. The Joint Commissioners’ Carers’ Strategy for Cambridgeshire sets out the local plans.<sup>139</sup>

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139

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4049323.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4049323.pdf)  
<http://www.cambridgeshire.gov.uk/NR/rdonlyres/512A25B9-1177-41FB-96C2-7C8E6617398D/0/CarersStrategy20082011WEB.pdf>

Many carers have a need for services that provide support to them in their role as carers (see section **Unpaid Care**). Carers can request an assessment of their needs. The annual Adult Social Service Referrals, Assessments and Packages of Care (RAP) return records the number of carers through the assessment process and the number of carers reviewed in a year. In 2007/08, 42% of carers who received a service were themselves aged 65 or over (Table 43).

**Table 43: Carers receiving services following assessments and reviews by age group of carer, 2007/08**

Age Group of Carer	Services including breaks for the carer and / or carers specific services	Information and advice only
Under 18	133	1
18-64	757	87
65-74	298	30
75+	338	43
All Ages	1,526	161

Source: 2007/08 RAP return, table C2 page 1

### 7.3 Assessments of need for social care

The Referrals, Assessments and Packages of Care (RAP) annual return was developed to provide a coherent set of national statistics on adult community care. Older people make up 71% of all adult social services clients. Each year, in Cambridgeshire, more than 8000 contacts from new clients result in further assessment of need or commissioning of an ongoing service and this number is increasing (Table 44).

**Table 44:**

Description	2005/6	2006/7	2007/8
Contacts from new clients that resulted in further assessment of need or commissioning of ongoing service	8,260	8,346	8,491

Source

In 2007/08 self-referrals, and referrals from family, friends or neighbours made up 35%, down from 57% the previous year, while referrals from health care professionals increased from 31% to 48%. This suggests that efforts to deliver closer working practices between health and social care professionals have been effective.

Most initial assessments for new clients are for people with physical disability, frailty and/or temporary illness and nearly 80% are for people aged 65 or over (Table 45).

**Table 45: Number of completed assessments for new clients by primary client type and age group 2007/08**

Client type	18-64	65-74	75+	All ages
<b>Physical disability, frailty and sensory impairment (total)</b>	<b>775</b>	<b>614</b>	<b>2,407</b>	<b>3,796</b>
Of which : Physical disability, frailty and/or temporary illness	639	509	1,902	3,050
Hearing impairment	45	19	127	191
Visual impairment	22	12	91	125
Dual sensory loss	3	1	13	17
<b>Mental Health (total)</b>	<b>108</b>	<b>55</b>	<b>242</b>	<b>405</b>
Of which : Dementia	10	32	169	211
<b>Vulnerable People (total)</b>	<b>5</b>	<b>4</b>	<b>19</b>	<b>28</b>
<b>Learning Disability (total)</b>	<b>65</b>	<b>3</b>	<b>1</b>	<b>69</b>
<b>Substance Misuse (total)</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>2</b>
<b>Totals</b>	<b>954</b>	<b>677</b>	<b>2,669</b>	<b>4,300</b>

Source: RAP Return 2007/08, table A1 page 1

In 2007/08, more than 72% of completed reviews for existing clients<sup>140</sup> were for people with physical disability, frailty and/or temporary illness. 66% of all reviews were for people aged over 65 years (Table 46).

**Table 46: Number of completed reviews<sup>141</sup> for existing clients by primary client type and age group 2007/08**

Client type	18-64	65-74	75+	All ages
<b>Physical disability, frailty and sensory impairment (total)</b>	<b>1,844</b>	<b>905</b>	<b>5,293</b>	<b>8,042</b>
Of which : Physical disability, frailty and/or temporary illness	1,486	762	3,962	6,210
Hearing impairment	65	30	206	301
Visual impairment	47	19	180	246
Dual sensory loss	10	2	32	44
<b>Mental Health (total)</b>	<b>690</b>	<b>159</b>	<b>766</b>	<b>1,615</b>
Of which : Dementia	17	49	490	556
<b>Vulnerable People (total)</b>	<b>160</b>	<b>58</b>	<b>76</b>	<b>294</b>
<b>Learning Disability (total)</b>	<b>1,113</b>	<b>52</b>	<b>23</b>	<b>1,188</b>
<b>Substance Misuse (total)</b>	<b>7</b>	<b>4</b>	<b>5</b>	<b>16</b>
<b>Totals</b>	<b>3,814</b>	<b>1,178</b>	<b>6,163</b>	<b>11,155</b>

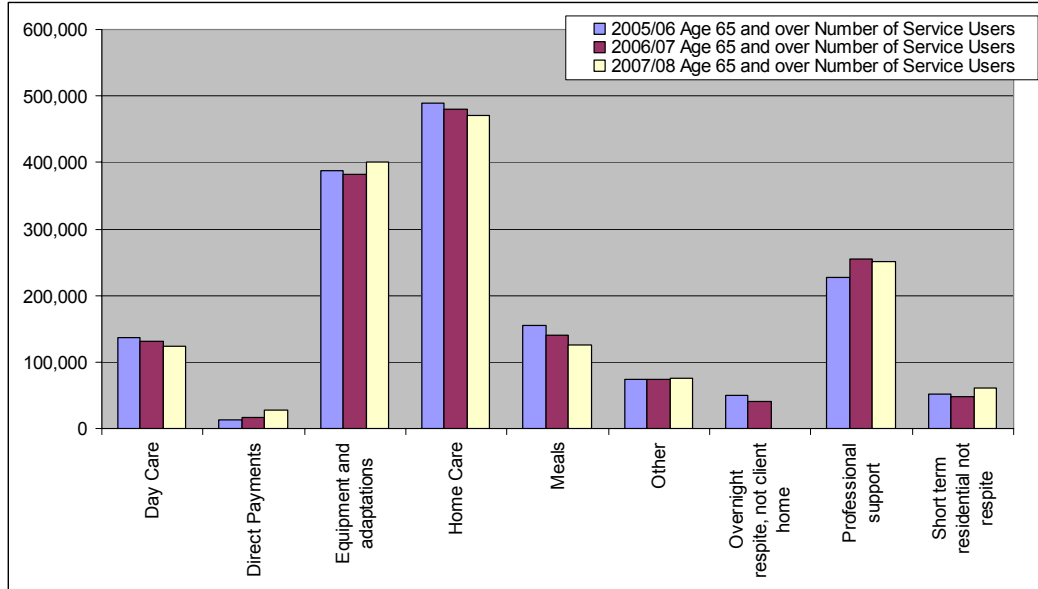
Source: RAP Return 2007/08, table A1, page 2

<sup>141</sup> A 'review' is an examination of an existing client's needs and must include a formal reassessment

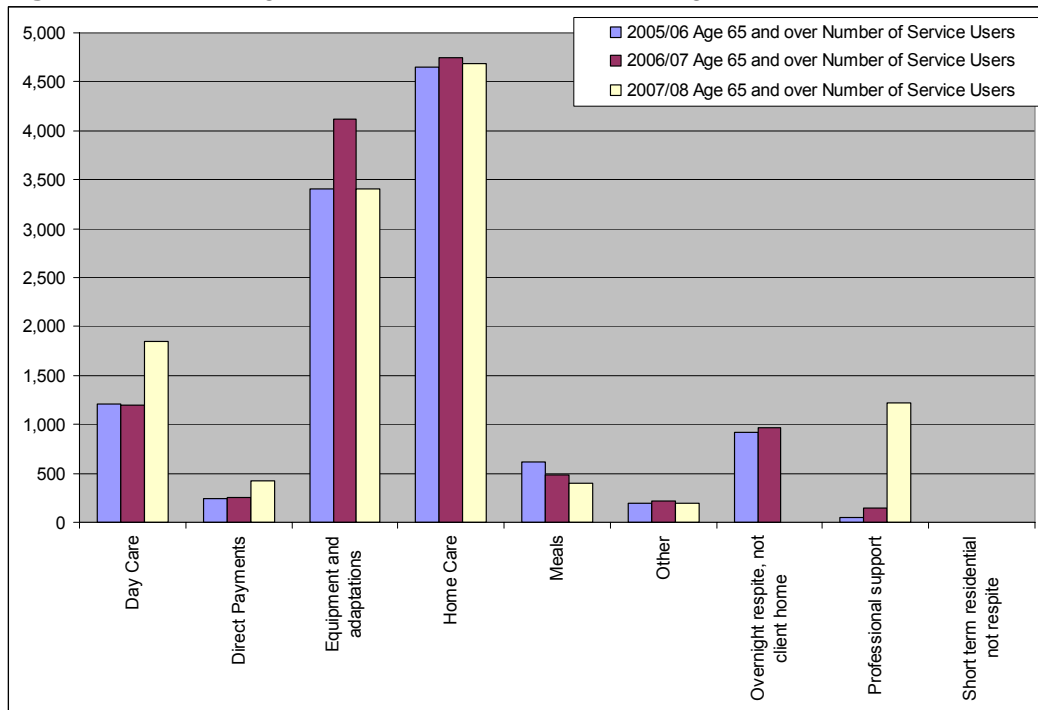
### 7.4 Packages of care and independence

Nationally, and locally, equipment and adaptations and home care are the main services provided to people aged 65 years and over (Figures 70 and 71).

**Figure 70:** England 2005/06 – 2007/08. Categories of care in persons aged 65

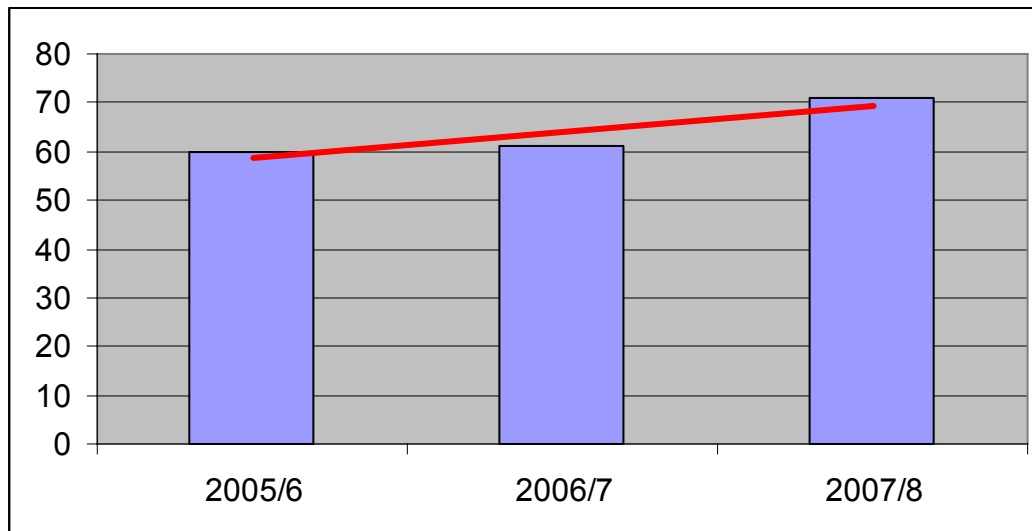


**Figure 71:** Cambridgeshire 2005/06 – 2007/08. Categories of care in persons aged 65



Home care services help people to remain at home or to go home following hospital treatments or after period spent on a temporary basis in a residential home. The provision of home care services by local authorities helps people to live a normal, independent life.

The graph below shows that in Cambridgeshire, the number of older people helped to live at home per 1,000 of the population has increased over the 2005/06, 2006/07 and 2007/08 financial years (Figure 72).

**Figure 72: Cambridgeshire older people helped to live at home per 1,000 county population**

Source: RAP Return 2007/08, table P2S

## 7.5 Assistive technology

Telehealth is the remote monitoring of physiological data eg temperature and blood pressure that can be used by health professionals for diagnosis or disease management. Examples of telehealth devices include blood pressure monitors, pulse oximeters, spirometers, weighing scales and blood glucometers. Telehealth also covers the use of information and communication technology for remote consultation between health professionals or between a health professional and a patient eg providing health advice by telephone, videoconferencing to discuss a diagnosis or capturing and sending images for diagnosis. Examples of telehealth:

- Remote consultation between nurses eg a district nurse seeks advice on a leg ulcer via video from a tissue viability nurse
- Remote interaction between nurses and patients eg a patient seeks advice from NHS 24 , an online and telephone health information and advice service for Scotland, about an episode of breathlessness
- Remote environmental monitoring eg a falls sensor in a patient's home triggers an alert in a control centre
- Remote physiological monitoring eg blood pressure data is send to a cardiology unit for interpretation
- Store-and-forward eg an ultrasound scan is captured and sent for remote interpretation

Telecare uses a combination of alarms, sensors and other equipment, usually in the home environment, to help people live more independently by monitoring for changes and warning the people themselves or raising an alert at a control centre. Examples of telecare devices include personal alarms, fall detectors, temperature extremes sensors, carbon monoxide detectors, flood detectors and gas detectors. Telecare helps older people to remain at home for as long as possible and reduces the need to move to residential or nursing care. It also can avoid unnecessary admissions to hospital and support early discharge. It also provides reassurance for older people and their carers.

The Care Services Improvement Partnership reviewed the available literature in 2008 and found inconsistent evidence of the effectiveness and cost effectiveness of telecare and

telehealth.<sup>142</sup> However, the review concludes that there is sufficient evidence of the potential of telehealth and telecare to improve quality of care, and reduce health care costs to justify expansion of the use of these technologies, and suggests ways of mitigating risks of local implementation. An updated review will be published by the Evidence Adoption Centre <http://www.eac.cpft.nhs.uk/> in 2010. Telecare is part of the Department of Health prevention package for older people resources.<sup>143</sup> The Telecare Learning and Improvement Network supports service provision through the application of telehealth and telecare.<sup>144</sup>

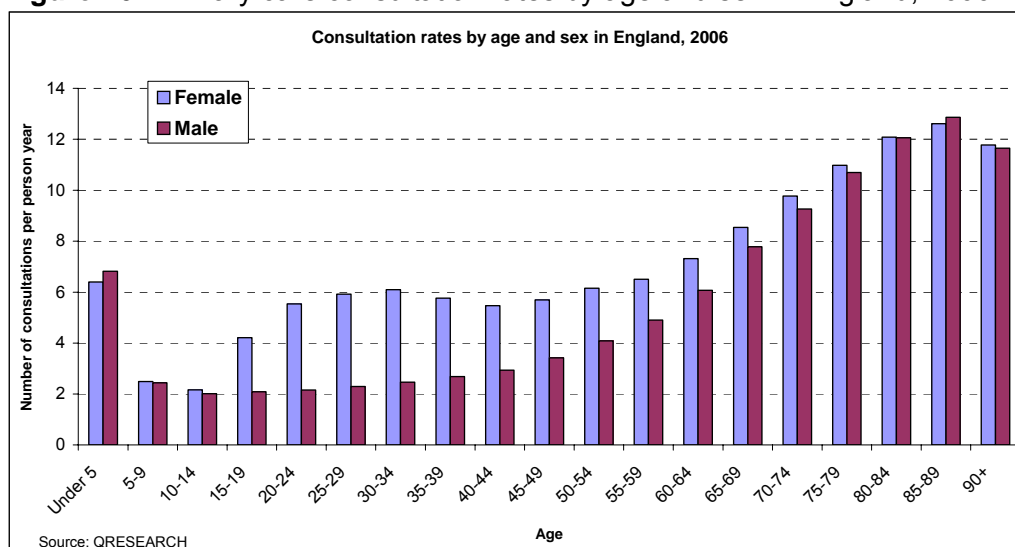
Telecare services in Cambridgeshire are available to anyone in Cambridgeshire who meets the eligibility criteria, but they are predominantly used by older people. Referrals come from a range of sources such as social workers, care managers, occupational therapists, physiotherapists, nurses, GP's, carers and potential service users themselves. The preventive nature of telecare devices means that they are available to a wider group than those in receipt of services ie recipients do not have to meet the stringent criteria required for care services. An evaluation of the effectiveness of the telecare service was carried out between 2007 and 2008. It found nearly 1100 people were given help through telecare in that year and a net saving of nearly £1.7 million through avoiding the cost of unnecessary care and avoiding hospital or residential care home admission.

A strategy is currently under development to build on the successes so far, to give strategic direction for the service and ensure a more robust financial framework for the provision of telecare and telehealth in Cambridgeshire. This strategy will be available on the NHS Cambridgeshire website from November 2010. The future requires commissioners and providers to develop a greater potential range of options, delivering in a more flexible way and exploiting the use of new technology. Community alarms are the vital link in providing remote monitoring and assistance in this.

## 7.6 Primary care

Figure 76 shows age and sex specific consultation rates (all clinicians in primary care) in England in 2006. Consultation rates increase with increasing age and are higher in women than men until the oldest age groups. This pattern is unlikely to have changed since 2006.

**Figure 76:** Primary care consultation rates by age and sex in England, 2006.



Source:

<sup>142</sup> [http://www.dhcarenetworks.org.uk/library/Resources/Telecare/Support\\_materials/Briefing\\_-\\_Telehealth\\_SB\\_Final2.doc](http://www.dhcarenetworks.org.uk/library/Resources/Telecare/Support_materials/Briefing_-_Telehealth_SB_Final2.doc)

<sup>143</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh\\_103146](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146)

<sup>144</sup> <http://www.dhcarenetworks.org.uk/IndependentLivingChoices/Telecare/>

## 7.7 Dental services

Although around a quarter of the population think dental care is expensive, older people have demonstrated an increasing willingness to visit the dentist to have check ups or treatment to keep their teeth. The number of older people who said that they had regular check ups steadily increased up to 1998 (Table 48). The impact of changes to the way NHS dentistry has been reorganised in the past decade may have an effect on this trend when the 2009/10 data are reported.

**Table 48: Dental attendance; percentage of UK population who say they attend for regular dental check ups**

	1978	1988	1998
Age 55 and over	32	45	66
All ages	43	50	59

When people were asked if they now visited a dentist more frequently than 5 years ago, in most adult age groups the proportion going less frequently is similar to the proportion going more frequently. However at age 65-74, 11% reported more frequent attendance, but 20% said they are going less often. A similar picture is seen among those aged 75 and over (26% reported reduced attendance).

The barriers to dental attendance are complex. Major concerns highlighted in national surveys are listed below. The percentage agreeing, in 1998, with the statements listed is shown in brackets:

- I would like to be given an estimate without commitment (50%)
- I would like to know what the dentist is going to do and why (43%)
- I would like to be able to drop into the dentist without an appointment (40%)
- I always feel anxious about going to the dentist (32%)
- I'm nervous of some kinds of dental treatment (31%)
- I would like to pay for my dental treatment in instalments (29%)
- I find NHS dental treatment expensive (28%)
- The worst part of going to the dentist is the waiting (22%)
- It will cost me less in the long run if I only go when I have trouble (19%)
- I don't see any point in going unless I have to (19%)

For the first time in 2010 questions about local dental services have been included on the Department of Health GP patient survey carried out by Ipsos MORI and this will also help inform planning of future dental services.

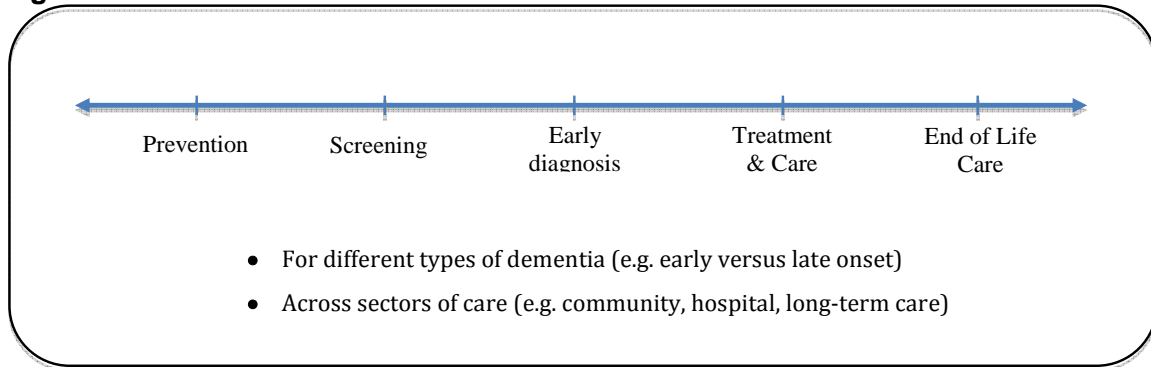
In planning and promoting services it is important to have an understanding of the impact of barriers such as cost and fear, and also what people feel about the organisation of dental services and its long term value to them. Local qualitative research would be useful to inform service design. There are a range of options, from traditional approaches eg questionnaires and street interviews, to including oral health within the structure of a local social marketing exercise. Important themes to explore include those already in use within the national Adult Dental Health Survey. Treatment services need to be sensitive to the mobility problems and increasing frailty encountered by many older people, so that barriers to their accessing care are removed. This may include enhancing current domiciliary services. Getting access to homebound older people to establish their particular needs is an important element of the process.



## 7.8 Mental health services

NHS Cambridgeshire currently commissions from the Cambridgeshire and Peterborough NHS Foundation Trust seven major pathways for people with mental health services including dementia. People are assessed on referral and allocated to the pathway most appropriate to their needs. Individuals' needs vary according to the progression of disease (for each disease subtype) (Figure 74).

**Figure 74**



The seven pathways in Cambridgeshire are:-

1. Community care for functional problems – this pathway is for older people who are experiencing mood or affective disorder, a psychotic disorder or neurosis (ie, a functional illness). They may have a mental illness that needs the use of legislation, is resistant to treatment, presents a risk to the patient or other people and may have one or more social, behavioural or psychological needs (Appendix 1).
2. Community Care for moderate to severe dementia - this pathway is for older people with dementia experiencing moderate to severe dementia and with an MMSE score of less than 25 (Appendix 1)
3. Community Care – diagnosis and stabilisation – this pathway is available for people who are experiencing mild memory problems (Appendix 1).
4. Intermediate Care Pathway – this pathway is for older people experiencing a functional or organic mental illness and be presenting significant challenges to services in preventing deterioration in their mental health and/or be at risk of self harm, harm to others or of admission to older people's mental health in-patient services or a care home. Their complex mental illness may be inter-related to physical health needs, be of an acuity that may present risk, cause distress to themselves and others, require intensive care, treatment and support (daily) for up to six weeks, or be accompanied by one or more behavioural or psychological needs (Appendix 1).
5. In-Patient Treatment Pathway – this pathway is for people experiencing an acute or long-term functional illness or moderate to severe dementia that cannot be safely be managed at home. They may have a mental illness that needs the use of legislation, is resistant to treatment, presents a risk to themselves or other people and have multiple social, behavioural or psychological needs. They are likely to require specialist assessment and treatment within an in-patient setting and a range of ongoing interventions from the multi-disciplinary team, a complex care plan integrated with other statutory agencies, and assessment of their continuing care needs which cannot be carried out in the community (Appendix 1).

6. Young-Onset Dementia Pathway – this pathway is for people under the age of 65 who are experiencing memory problems/mild to severe dementia and have one or more significant social, behavioural or psychological needs. They may require a specialist assessment for the diagnosis of dementia and require a complex care plan integrated with other statutory agencies or a range of specialist older people's mental health interventions (Appendix 1).
7. Day Therapies Pathway – this pathway is for people experiencing an acute or long-term functional illness or moderate to severe dementia. They may be at risk of admission to in-patient services or their treatment may require the use of legislation. They are likely to require specialist assessment and treatment and a range of ongoing interventions from the multi-disciplinary team, including psychotherapeutic group and/or individual therapy and art therapies (Appendix 1).

In addition to these core pathways, NHS Cambridgeshire also commissions services from local voluntary agencies, and in particular the Alzheimer's Society. People accessing these services come from all age groups and typically present alongside their carers with cognitive impairment, or dementia of any form.

These services offer a range of interventions and activities to service users and their carers (see section **Services for Carers**):-

1. Outreach services – these offer information and support for people with dementia and their carers at a person's home or an agreed venue or local drop-in centres.
2. Peer Support groups – these are structured group sessions for people with dementia and/or their carers to discuss the diagnosis of dementia and its consequences in an informal environment in the presence of, and supported by, peers (people with dementia and/or their carers).
3. Outings and events - Outings and events are available to people with dementia who may attend with family, friends or carers. They enable and support social interaction with the specific intention of reducing social isolation and helping people with dementia and their families to feel part of society.
4. Carer information sessions – these offer experiential learning from peers and information sharing around key information services facilitated by dementia support workers.
5. Carers' assessments - these are offered to carers of people with dementia or mild cognitive impairment.

During the past two years Cambridgeshire has been exploring the potential benefits for older people with dementia and other mental health problems of providing more services in primary care and the community generally in order that people may be diagnosed and signposted to effective help at a much earlier stage of their illness (figures 75 and 76). This is in line with external evidence. Primary care mental health teams for adults with mild to moderate mental health problems have been well-received by service users and GPs since they were introduced locally in 2005. There is much evidence that earlier diagnosis improves the quality of life and general experience of dementia for both those affected and their carers. This focus upon raised awareness and earlier diagnosis is also a key objective of the National Dementia Strategy.

Figure 75: Service Plan Flow Chart

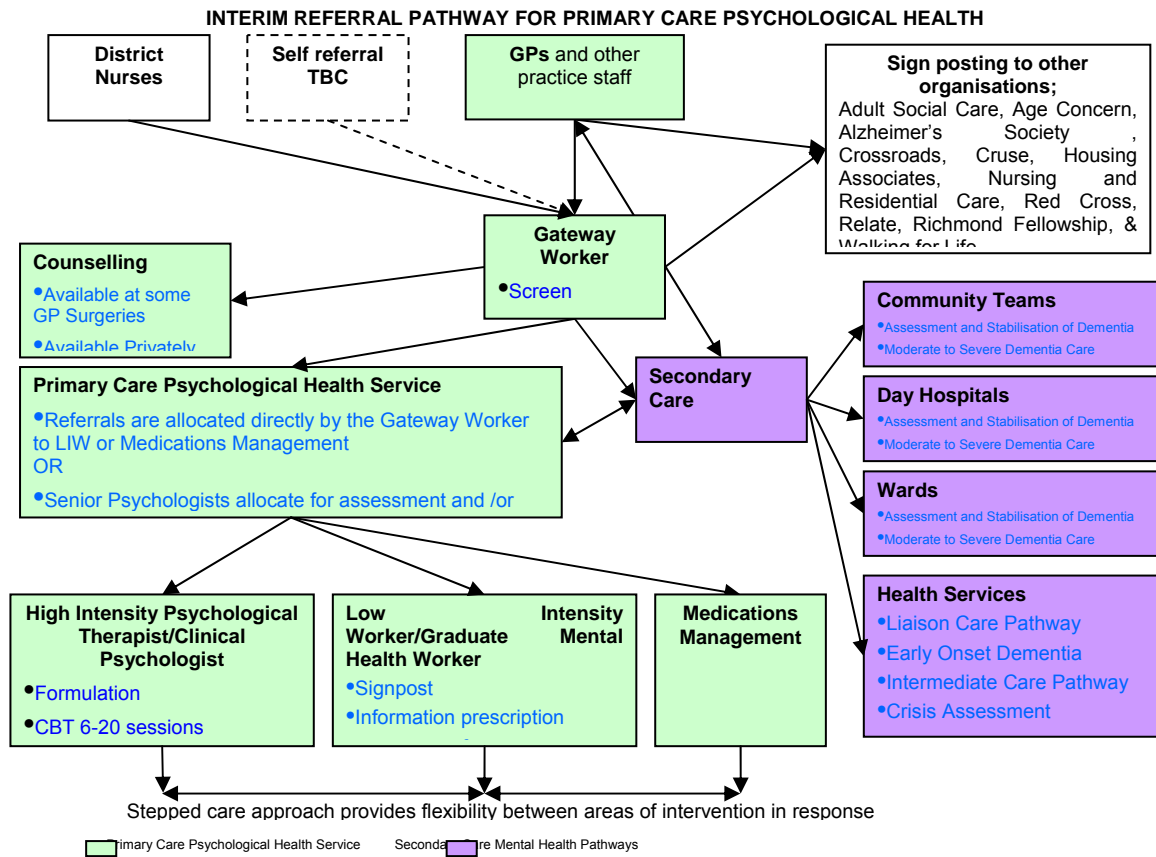
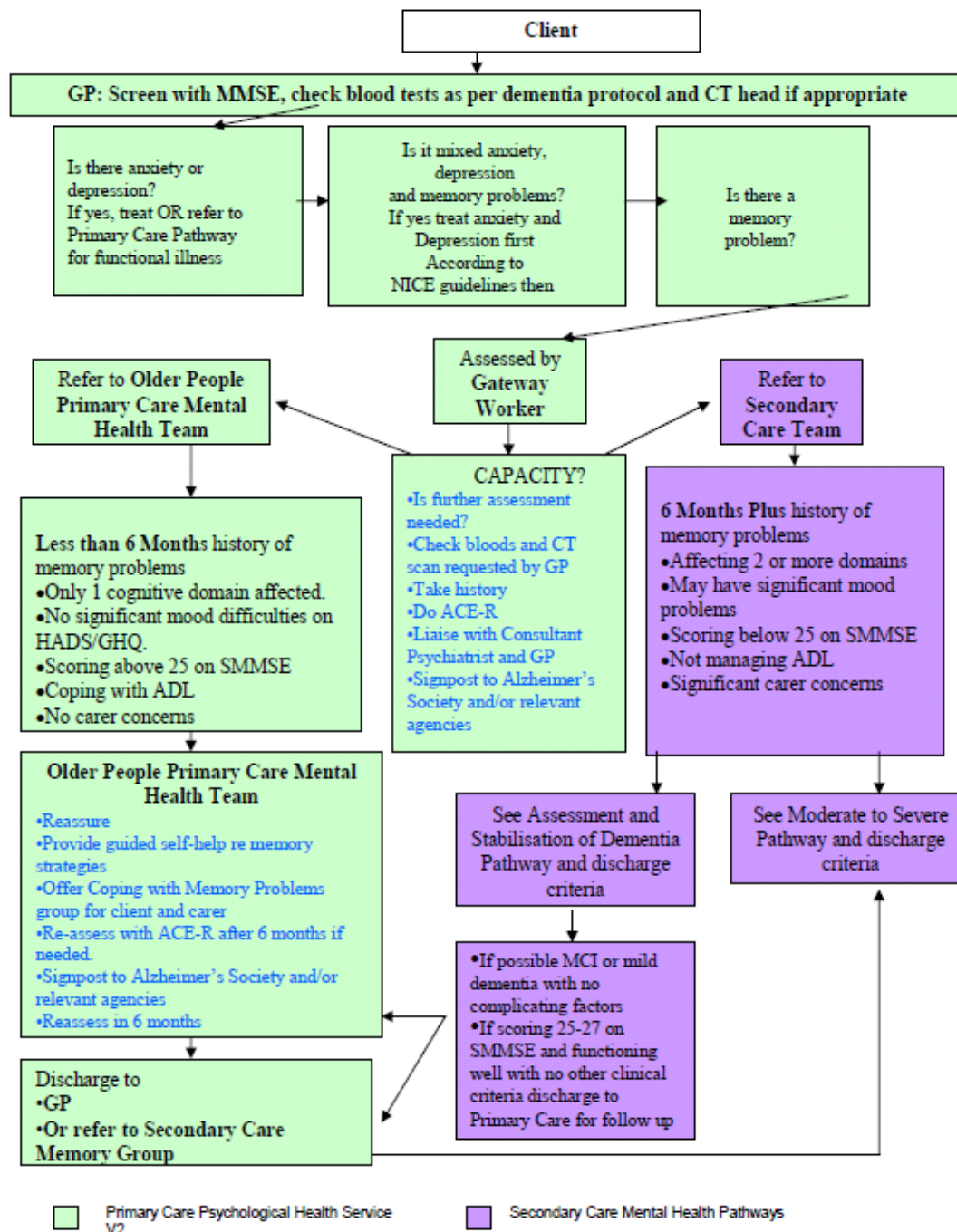


Figure 76



We have been piloting a primary care service model in St. Ives<sup>145</sup> to better explore what such a service for older people might look like, which interventions would be most effective, where it would be best delivered, the preferences of service users, etc. This work has generated much information about what style and type of service works best in meeting the needs of older people with dementia and other mental health problems. The feedback has been extremely positive and we are using this to design future services for this patient group.

Our emerging vision is very much of a new primary care pathway for older people with mental health problems, delivered in partnership by both statutory and voluntary service providers,

145

Burley, C. (2009). Older people Primary Care Project: Third Quarterly Report, October 2009. Cambridgeshire and Peterborough NHS Foundation Trust

and again seeking to raise awareness and ensure earlier diagnosis and access to help. This service would also include new roles such as dementia advisers and peer support workers able to offer practical help to people at a relatively early stage of their illness. Because many people with a mental health problem also have a range of other physical health problems, close working with other community and practice-based health services will also be essential. This new service would be complemented by an expanded range of treatment options available in the community and in specialist day therapy centres. We will be developing and consulting upon proposals to implement such service models during the next few months.

It is recognised that the experience of people with dementia or another mental health problem who enter local hospitals for treatment for physical health problems unrelated to their mental health problems is often poor. This arises mainly from the lack of awareness of hospital staff of dementia, how to recognise the symptoms, and how best to manage the problems faced by people with dementia in the unfamiliar hospital setting. This leads to longer stays in hospital and poorer outcomes from the treatment received. We will also therefore be working with our service providers to implement a number of measures to improve the experience of people with dementia in local hospitals.

#### *Access to services of the Alzheimer's Society*

Throughout Cambridgeshire, more than 1700 people have accessed the services of Alzheimer's Society.. Table 49 shows the number of attendances at specific events. One off contacts are not recorded.

**Table 49: Number of attendances at events hosted by the Alzheimer's society in 2009/10**

	Younger people with dementia	Older people with dementia	People with dementia unknown age	Carers
Social events	47	1174	220	1047
Support groups	63	1977	4	1728

Source:

People and their carers who accessed the service have presented with cognitive impairment, dementia of any form. People using the service are of all age groups. There are currently no waiting lists for services. Services include:

- **Outreach services.**
  - Information and support service for people with dementia and their carers at a person's home or an agreed venue
  - Drop-in services for information, often on weekly basis
  - Information and support service available through Primary care project in St Ives
- **Peer Support groups**
  - structured group sessions for people with dementia and/or their carers to discuss the diagnosis of dementia and its consequences in an informal environment in the presence of, and supported by, peers (people with dementia and/or their carers)
  - lunch groups
  - activities groups
- **Outings and events**
  - Outings and events are available to people with dementia who may attend with family, friends or carers. They enable and support social interaction with the specific intention of reducing social isolation. To help people with dementia and their families feel part of society where they are supported to access social activity.
- **Carer information sessions**

- experiential learning from peers and information sharing around key information services facilitated by dementia support workers
- **Carers assessments**
  - Carers assessments to carers of people with dementia or mild cognitive impairment

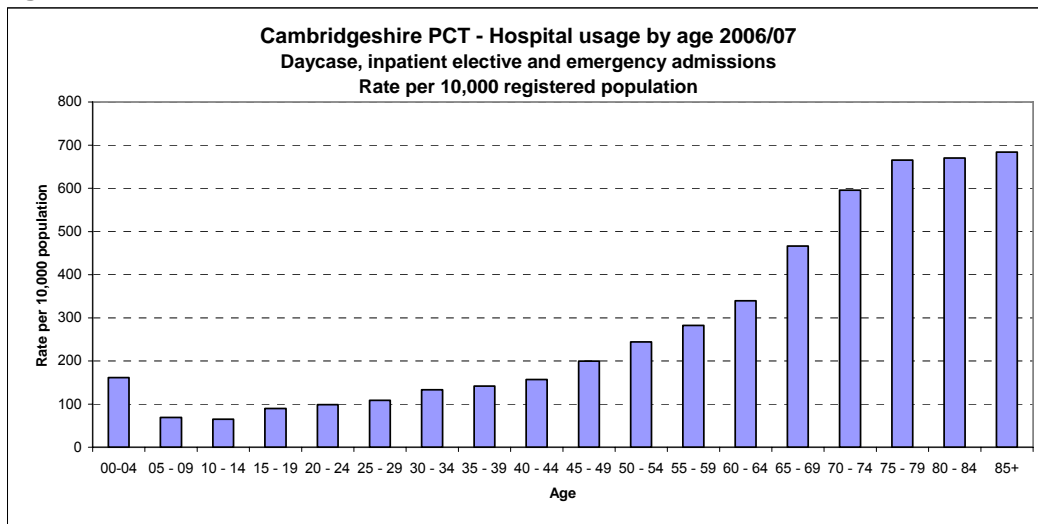
Access to services should be improved across Cambridgeshire for younger people with dementia, travellers, and people from ethnic minority groups. Access to early intervention services is not consistent across the county.

## 7.9 Hospital care

With the exception of the early years, hospital usage increases rapidly with increasing age (Figure 77). The number of elective admissions is significantly higher in the populations of South Cambridgeshire and Huntingdonshire (Figure 78). Variation is lower when day cases are excluded which may indicate differences in the coding of procedures as day cases or outpatient appointments (Figure 79). Variation within Cambridgeshire in emergency admissions is even lower (Figure 80).

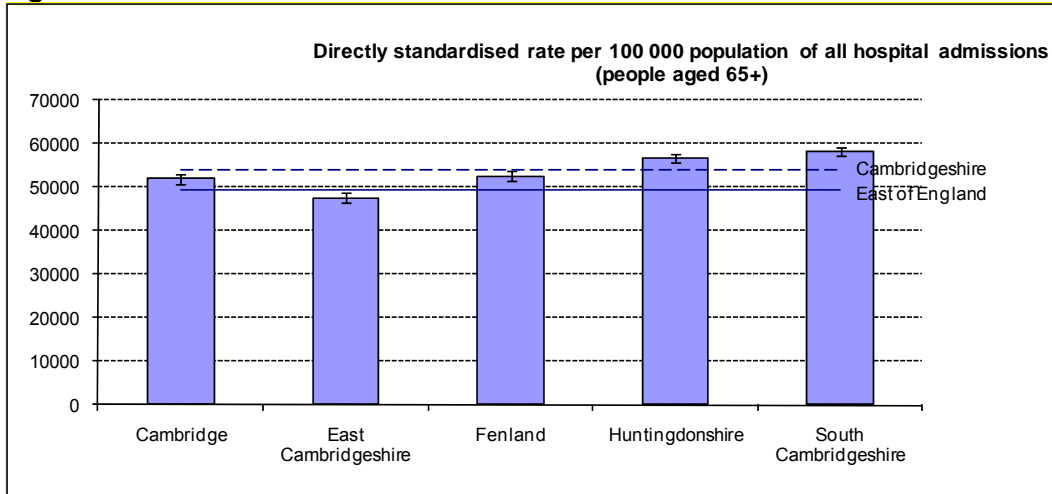
The number of admissions is increasing across Cambridgeshire (Figure 81), and the risk of an emergency admission increases with age (Figure 82). In 2009, 8.5% of the population age 65-74 had at least one non-elective admission to hospital. This rose to 16.6% in the 75-84 age group and to nearly 30% in those aged 85 and older.<sup>146</sup>

**Figure 77:**



<sup>146</sup> <http://www.erpho.org.uk/olderpeopleprofiles/Profile.aspx?pArea=12&cArea=parentprofile&yr=2009&theme=2000032>

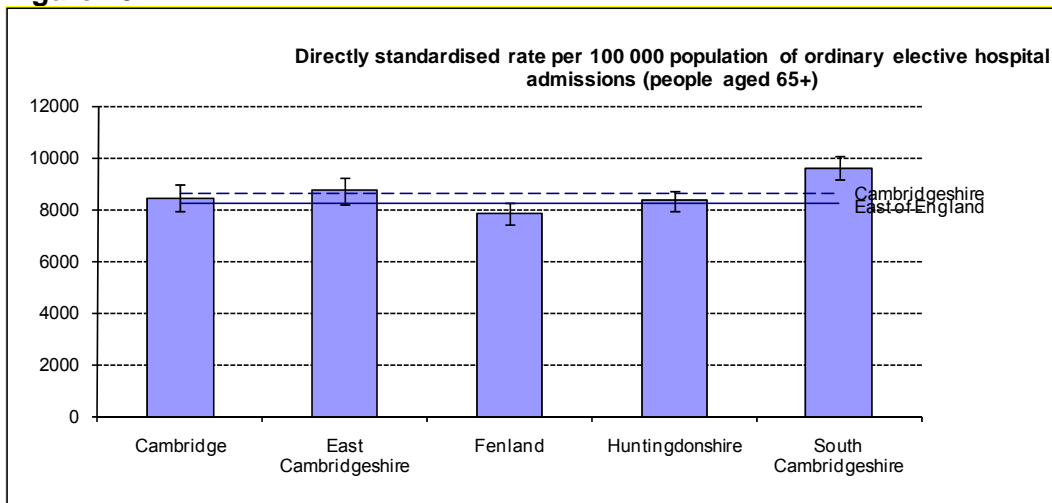
**Figure 78**



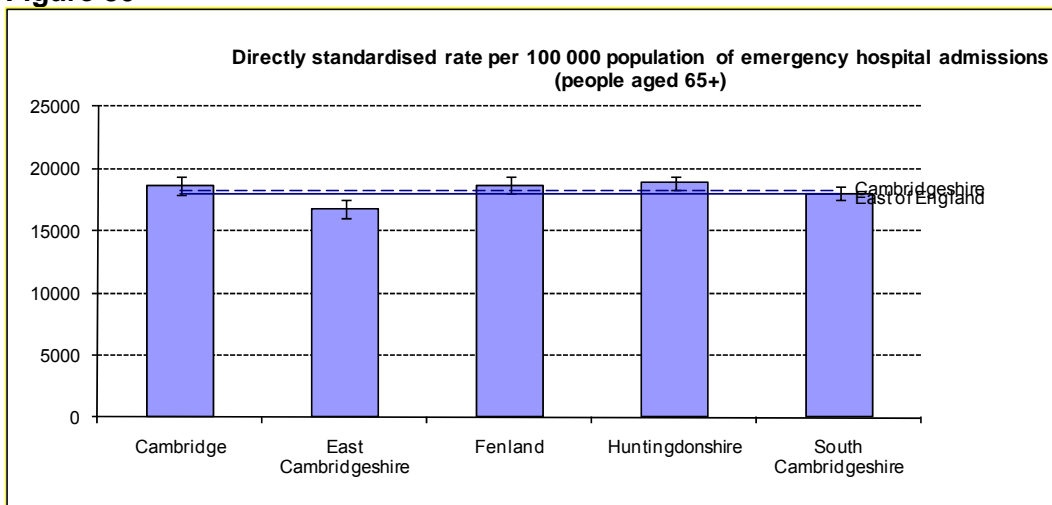
Source: Erpho. Older people's profiles, 2008.

<http://www.erpho.org.uk/olderpeopleprofiles/Profile.aspx?pArea=12&cArea=parentprofile&yr=2009&theme=2000032>

**Figure 79**

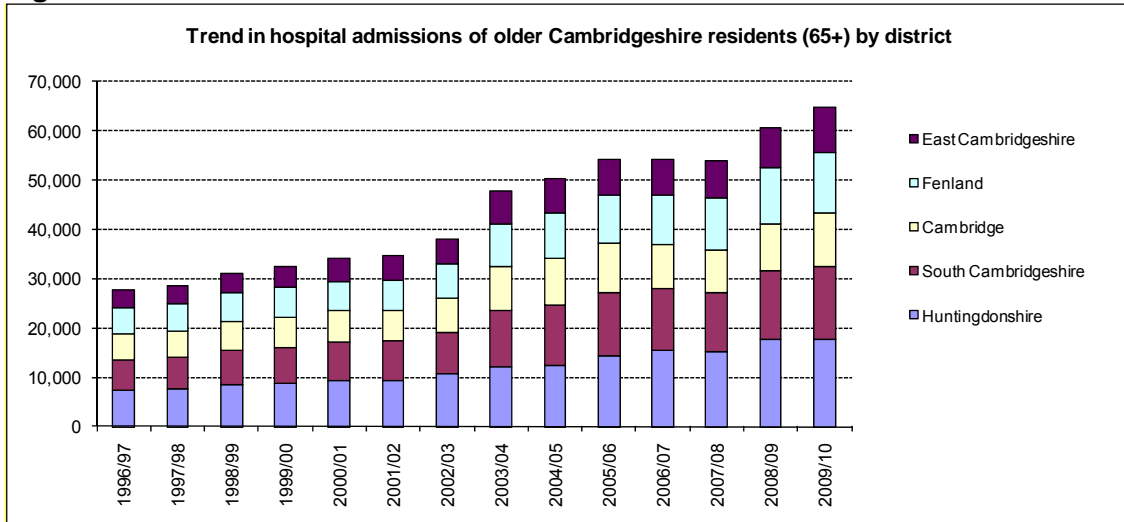


**Figure 80**

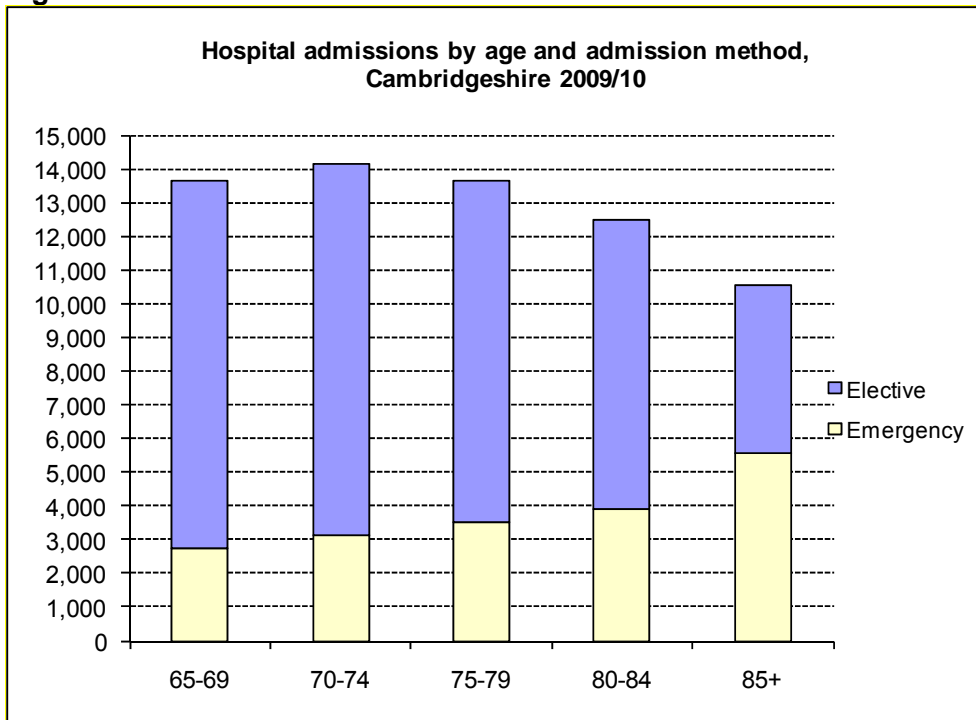




**Figure 81**



**Figure 82**



*Preventing avoidable hospital admissions*

As part of a wider shift to directing resources to the prevention of ill-health and promotion of wellbeing, several local initiatives<sup>147 148</sup> have been established which are expected to lead to a reduction in avoidable<sup>149</sup> admissions to hospital, either directly or indirectly.

Several predictive models are available to identify individuals at greatest risk of admission to hospital. The aim is that by identifying people at high risk, hospital admission can be averted by offering additional support in a community setting. Care at home is preferred by patients, and reduces the costs to the NHS.

147 <http://www.cambridgeshire.gov.uk/NR/rdonlyres/D0594161-C33F-470A-8589-5C05125AFCE4/0/271109ExecutiveSummaryShapingourFutureAFrameworkforActionDraftStrategysmaller.pdf>  
 148 <http://www.cambridgeshire.gov.uk/NR/rdonlyres/19689B53-6EC5-4E18-BFCE-FFE8C5A2DD3C/0/UnderstandingReablementLayout1.pdf>  
 149 <http://www.nejm.org/doi/full/10.1056/NEJMc1001882>

The Evidence Adoption Centre <http://www.eac.cpft.nhs.uk/> has recently reviewed two of the prediction models most commonly used by PCTs in the UK – PARR++ and the Combined Predictive Model. PARR++ uses inpatient data to identify people at greatest risk of re-admission to hospital in the next twelve months. The Combined Predictive Model is an extension of the PARR model that uses accident & emergency, outpatient, social services and GP data in order to be able to identify, in addition, people who are at risk of hospital admission who have not recently been admitted to hospital. Drawing on more datasets, the Combined Predictive Model is slightly better at identifying people most at risk of re-admission, but since age, sex, previous admission and existing clinical conditions are the factors most predictive of future admissions, the models are very similar in their predictions. Software is freely available from the King's Fund to implement PARR ++ but not the Combined Predictive Model.

A large proportion of hospital admissions cannot be prevented or avoided even with the most effective care and case management. For example, most major trauma is generally not preventable or avoidable. A broad range of surgical procedures and medical conditions (heart attacks, treatment of neoplasms, congenital defects) exists for which the need for care is largely driven by factors beyond the control of a care management intervention, at least in the medium term and short term. Accordingly, the PARR case-finding algorithm focuses on a range of “reference” conditions (such as congestive heart disease, chronic obstructive pulmonary disease, diabetes, sickle cell disease) for which timely and effective ambulatory care, case management, or social services have the potential to help to reduce the risks of readmission. These conditions represent just under one third of all emergency medical admissions.

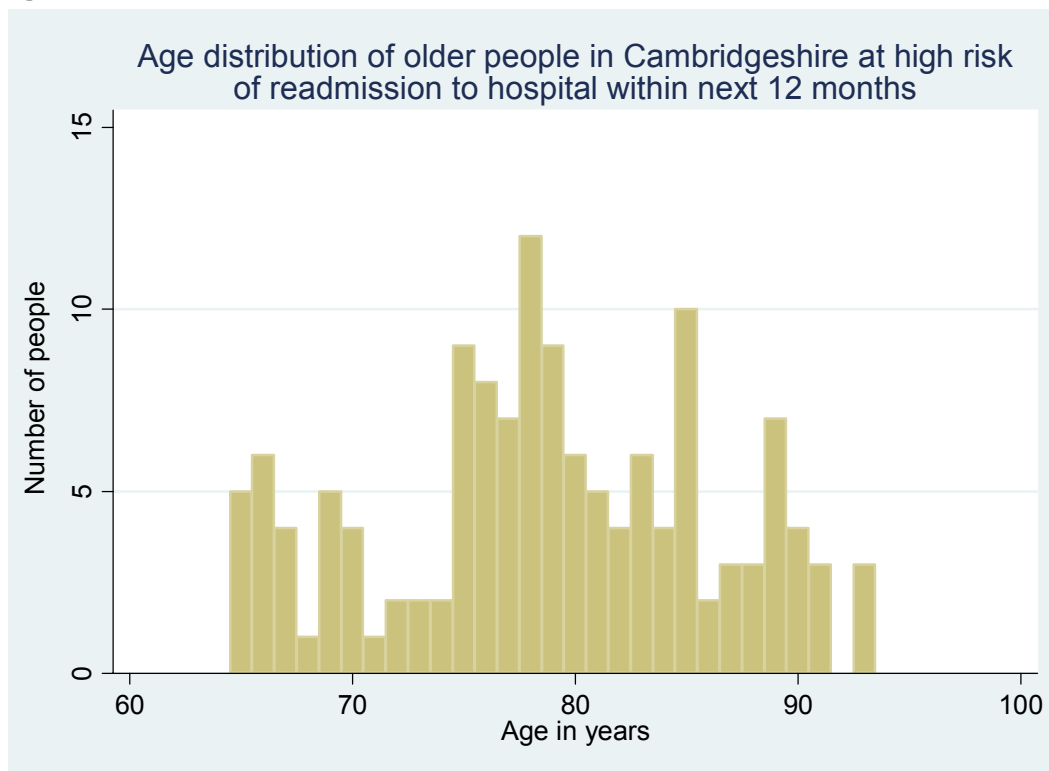
Predictive modelling to identify people at risk in order to intervene and prevent a hospital admission has been used in the United States for some time. However, most research has focussed on the accuracy of different tools in identifying people at risk,<sup>150 151 152</sup> and there is little published evidence of these tools being used in combination with effective interventions to prevent hospital admissions. Trials of different interventions including supported self-management through community matrons, virtual wards, health coaching, support with polypharmacy have reported better quality of care compared to usual care but this has not translated into clear reductions in care costs.<sup>153 154 155 156 157</sup> One explanation is the interventions may be identifying and providing for previously unmet needs. However, there has been comparatively little research in this area.

Using the PARR++ tool, a list of Cambridgeshire patients at greatest risk of admission to hospital in the next 12 months was extracted. The algorithm allocates a risk score to each patient from 0 to 100. Higher scores indicate a higher risk of admission and a risk score of 50 or above is estimated to identify more than 50% of patients who will be admitted in the next 12 months (although a third of people with a score of 50 or above score will not be admitted). A risk score of 70 and above is estimated to identify only 23% people incorrectly as at high risk, but only 18% of people who will be admitted in the next 12 months.

The PARR++ tool identified 279 people in Cambridgeshire with a score of 70 or more, of whom 137 were aged 65 and over. Two-thirds were men, and the average age was 79 years (95% confidence interval from 64 to 93 years, figure 83).

150 <http://www.bmj.com/content/333/7563/327.full?sid=70237c0b-7b4d-4ac1-84ae-8774520f9b5b>  
 151 <http://www.cmaj.ca/cgi/content/full/182/6/551>  
 152 <http://archinte.ama-assn.org/cgi/content/full/168/13/1416>  
 153 <http://www.bmj.com/content/334/7583/31.full>  
 154 <http://jama.ama-assn.org/cgi/content/full/301/6/603>  
 155 <http://biomedgerontology.oxfordjournals.org/content/65A/7/734.abstract>  
 156 <http://www.bmj.com/content/336/7636/130.long>  
 157 <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=1682228>

**Figure 83**



The primary reason for the most recent emergency admission among the people at high risk of readmission was most commonly (40% patients) a respiratory or circulatory problem eg chronic obstructive pulmonary disease, chest pain (table 50), but more than 200 co-existing conditions were recorded which may have contributed (table 51).

The statistics demonstrate the range of reasons for hospital admission, and the large number of co-existing conditions that may predispose one person to require treatment in a hospital setting when another may not. More detailed work is needed to quantify the number of hospital admissions potentially preventable through the use of the PARR tool and additional resources potentially required. The merits of introducing this or a similar tool to Cambridgeshire will be informed by the reports of the pilot programmes expected in 2010/11, and the evaluation of Cambridgeshire Re-ablement Service which was launched in autumn 2010. An evaluation of re-ablement, funded by the Department of Health is expected in 2010.<sup>158 159</sup>

<sup>158</sup> <http://www.york.ac.uk/inst/spru/research/pdf/ReablementOutcomes.pdf>

<sup>159</sup> <http://www.dhcarenetworks.org.uk/library/Resources/CSED/CSEDProduct/benefitsofhra02.pdf>

**Table 50**

Main reason for admission to hospital (grouped into chapters of the International Classification of Diseases)	count
Diseases of the respiratory system	29
Diseases of the circulatory system	26
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	24
Diseases of the digestive system	18
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	7
Neoplasms	6
Diseases of the genitourinary system	5
Injury, poisoning and certain other consequences of external causes	5
Diseases of the nervous system	4
Endocrine, nutritional and metabolic diseases	4
Diseases of the musculoskeletal system and connective tissue	3
Diseases of the skin and subcutaneous tissue	2
Certain infectious and parasitic diseases	2
Diseases of the eye and adnexa	1
Mental and behavioural disorders	1

**Table 51**

Most common ten coexisting conditions in older people at highest risk of admission to hospital in next 12 months	count
Essential (primary) hypertension	50
Non-insulin-depend diabetes mellitus without complication	32
Other forms of chronic ischaemic heart disease	32
Atrial fibrillation and flutter	27
Chronic ischaemic heart disease, unspecified	22
Angina pectoris, unspecified	18
Hypertensive renal disease with renal failure	13
Asthma, unspecified	13
Chronic obstructive pulmonary disease, unspecified	12
Personal history of diseases of the circulatory system	10

## 7.10 End of life

Research indicates that 50-70% of people state they wish to die at home – although this is a complex decision and opinions may change during the course of their illness or according to local factors. An End of Life health needs assessment for Cambridgeshire was published in 2009.<sup>160</sup> It found that NHS Cambridgeshire was the highest performing PCT nationally for deaths at home (excluding deaths in care homes) at 25% in 2006. More up to date statistics on place of death by month are processed quarterly by the Eastern Region Public Health Observatory (ERPHO) for the whole of the East of England region.<sup>161</sup> Table 52 shows a general improvement over time across the county.

<sup>160</sup>  
<sup>161</sup>

<http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/JSNAs/End%20of%20Life%20Health%20Needs%20Assessment.pdf>  
<http://www.erpho.org.uk/viewResource.aspx?id=20884>

**Table 52**

<b>Year of death</b>	<b>% deaths at home in Cambridge City</b>	<b>% deaths at home in East Cambs</b>	<b>% deaths at home in Fenland</b>	<b>% deaths at home in Hunts</b>	<b>% deaths at home in South Cambs</b>
<b>2002</b>	20.7%	24.2%	22.0%	20.0%	25.1%
<b>2003</b>	20.1%	19.7%	20.8%	19.9%	22.5%
<b>2004</b>	22.4%	20.5%	20.0%	21.5%	24.7%
<b>2005</b>	22.2%	25.2%	18.5%	22.7%	23.1%
<b>2006</b>	23.1%	27.3%	21.1%	26.1%	29.7%
<b>2007</b>	24.5%	26.6%	23.6%	25.1%	29.2%
<b>2008</b>	28.0%	27.2%	24.2%	26.7%	28.1%
<b>2009</b>	25.8%	31.6%	23.8%	27.9%	29.4%

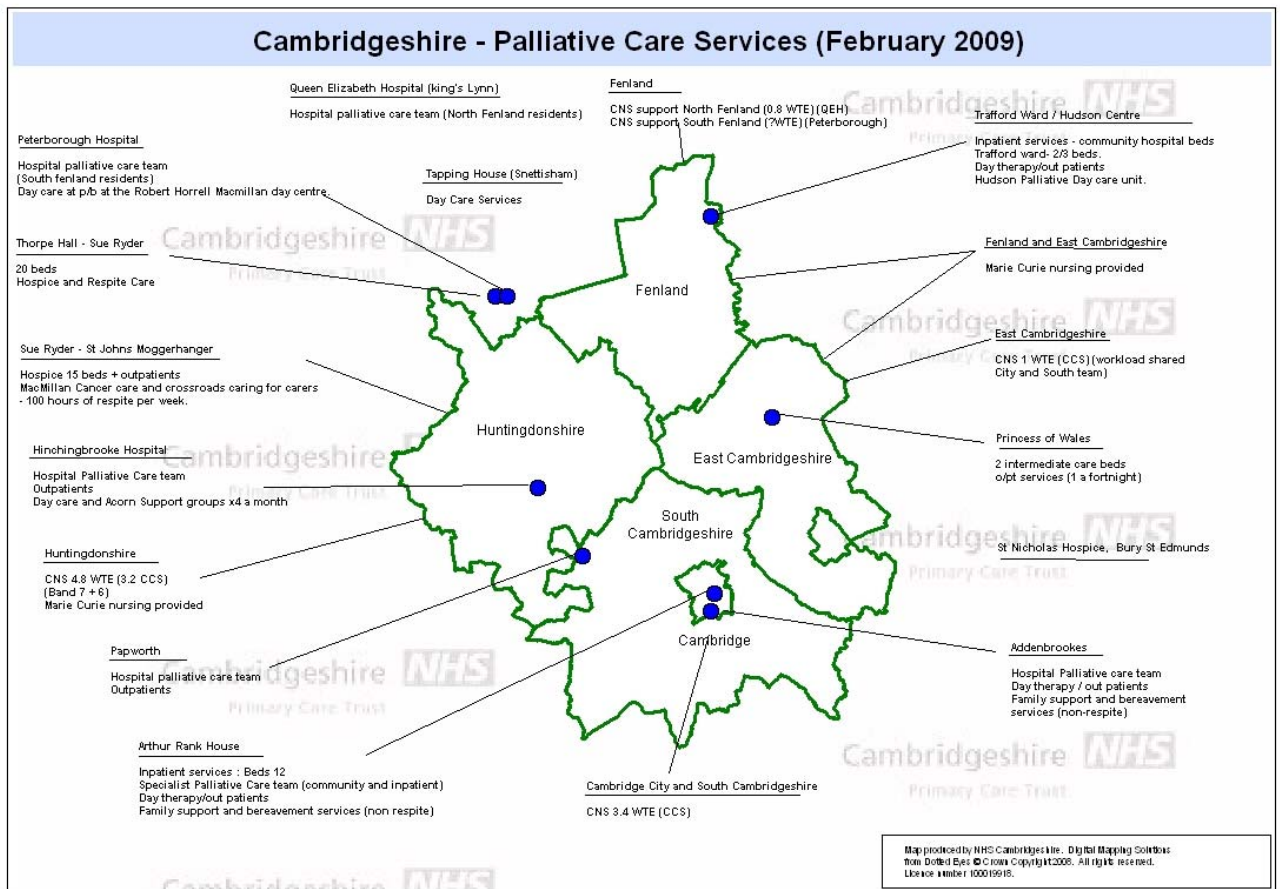
National Indicator 129 for number of deaths recorded as taking place 'at Home' is currently the only official measure for comparing End of Life services. These figures exclude anyone who dies in a care home.

In the short term, the proportion of acute hospital deaths will be measured to take into account that at the end of life a person's preferred place of death may be a care home. In the longer term, success will be measured against patients' recorded preferences for place of care. In a recent audit of 14 Cambridgeshire GP practices only 106 out of 842 patients who had died were on the practice End of Life register, and of those on the register only 5% had their expressed preference for place of death recorded on the GP information system.

Work is ongoing to more firmly establish the processes within GP practices and Community Services for ensuring that the right patients are on End of Life registers, and for discussing and recording patients' PPC with them at the appropriate time. An End of Life Strategy for Cambridgeshire is being developed.

Figure 84 shows that palliative care services are located in each district, but that travel times may be considerable for some residents.

Figure 84



## 8 The Views of Older People

### 8.1 Information in Cambridgeshire

Agencies in Cambridgeshire actively seek the views of residents, service users and patients on specific areas from time to time, and all service providers eg NHS Cambridgeshire and Cambridgeshire County Council encourage feed back from service users and other Cambridgeshire residents. The Cambridgeshire LINK <http://www.cambridgeshirelink.org.uk> was established in 2008 as part of a government initiative for local communities to have a stronger voice in the way their health and social care services are planned and run. It acts as an information portal to seek, receive and collate local concerns on publicly funded services. LINK then acts on these concerns, working with the NHS and local authorities to improve health and social care. In 2009/10, 200 people in Cambridgeshire submitted a comment or feedback form regarding health or social care services to LINK.

A recent information needs analysis undertaken by Cambridgeshire County Council found:

- The section of its website on the subject of disability receives more than 5,000 page views per month and its section on older people receives more than 3,000 page views per month.
- A need for greater clarity over which agency should be contacted for a query.
- A need for better information on community activities.
- Radio Cambridgeshire is a frequently-used information source.
- Local newspapers are frequently used to seek information (particularly free ones) but the small print can be difficult to read.
- The internet is used but guidance would be useful on which sites to visit
- Older people who frequently use the internet are most commonly aged 50-65 years.
- Older people would value a freephone service as a single point of access for queries.

Key findings from agencies contacted as part of the needs analysis who made particular reference to the views of older people are presented below by agency:

#### *Citizens Advice Bureau*<sup>162</sup>

- In 2009/10, 10% clients of the City and South Cambridgeshire branch and 18% of the Fenland branch were aged 65 and over.
- Preferred methods of receiving advice were via the telephone, and face to face.
- Some people experienced visiting CAB offices and outreach sessions.
- Specialist advisors (eg for debt and housing issues) are highly valued.

#### *Age UK*<sup>163</sup>

- The most common enquiries relate to care after discharge from hospital and care assessments.
- The public are confused by multiple sources of information and multiple publications ie help is required to navigate the information available.

#### *Cambridgeshire User Led Organisation*<sup>164</sup>

- Older people funding their own care are a significant group in need of information.
- Local information and knowledge is important.
- Libraries are not often used as sources of information.
- Information is often found by accident.
- Friends and families often have the same information needs as service users.

<sup>162</sup>

<http://www.cambridgecab.org.uk/>

<sup>163</sup>

<http://www.accambs.org/index.cfm>

<sup>164</sup>

<http://www.cambsulo.org.uk/>

- People often do not approach with their main question and need help in clarifying and finding an answer to the underlying issue.
- It is important to consider the needs of people with sensory impairment.
- Local groups reliant on volunteers cannot always meet information needs

*A guide for older people. Useful information and activities, health and wellbeing* has been developed by Cambridgeshire County Council and NHS Cambridgeshire and will be published in 2010.

## 8.2 The census 2001

As a whole, Cambridgeshire has a healthy population. In all districts except Fenland, fewer residents perceive their health to be poorer than average for England. Across the county as a whole, in 2001, 15% of residents reporting having a limiting long-term illness and 7% perceived their health to have been 'not good' in the year prior to the Census (Table 53) compared to 18% and 9% nationally. Table 54 shows the projected number of people aged 65 and over with a limiting long-term illness in Cambridgeshire and its constituent districts.

**Table 53: Percentage** of residents with a limiting long-term illness and percentage with 'not good' health (all ages)

Local authority	% Limiting long term illness	& "not good" health
England	17.9%	9.0%
Cambridgeshire	14.6%	6.6%
South Cambridgeshire	13.3%	5.5%
Huntingdonshire	13.5%	6.0%
Cambridge	13.7%	6.8%
East Cambridgeshire	15.2%	6.8%
Fenland	19.4%	9.1%

Source: 2001 Census National Statistics. © Crown Copyright 2003

**Table 54: Total population aged 65 and over with a limiting long-term illness**

	2010	2015	2020	2025	2030
Cambridge	6,137	6,455	6,962	7,625	8,516
East Cambridgeshire	6,397	7,596	8,738	10,116	11,539
Fenland	8,694	10,340	11,946	13,686	15,714
Huntingdonshire	11,354	13,864	16,077	18,578	21,121
South Cambridgeshire	9,980	12,003	13,779	15,994	18,172
Cambridgeshire	42,516	50,359	57,483	65,993	75,153

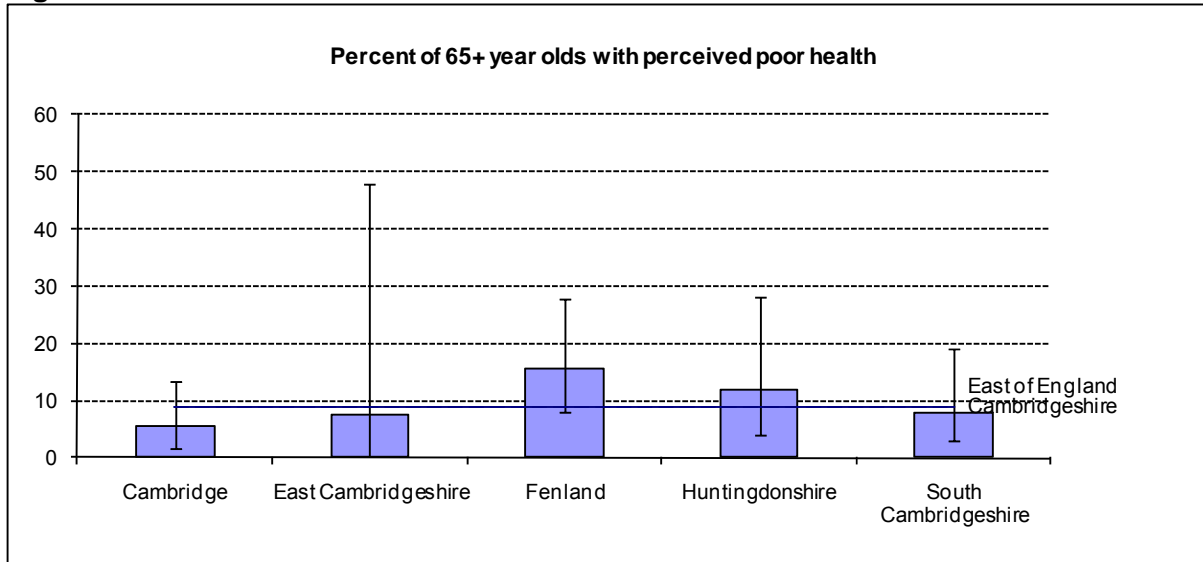
Source: [www.poppi.org.uk](http://www.poppi.org.uk) Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S016 Sex and age by general health and limiting long-term illness. Numbers have been calculated by applying percentages of people with a limiting long-term illness in 2001 to projected population figures.



### 8.3 Regional survey

The regional lifestyle survey undertaken in 2008 found that around 10% of people aged 65 and older considered themselves to be in poor health (Figure 85). This is higher than the figure for all ages reported in the last census but poorer health is associated with increasing age and the vertical bars demonstrate the high level of uncertainty on the estimates from the regional survey.

**Figure 85**



Source: <http://www.erpho.org.uk/viewResource.aspx?id=18584>

### 8.4 Place survey

In Autumn 2008, local authorities across England conducted a postal survey of residents. The 'Place Survey' was designed to capture local peoples' views, experiences and perceptions, to ensure services and solutions reflect local views and preferences. The survey collected information on 18 national indicators for local government. Two are specific to older people. More than 15,300 people were surveyed, and the response rate was around 39% in Cambridgeshire. Thirty-two percent of respondents were aged 65 and over, reflecting a good response to the survey in this age group which was reweighted to contribute 19% of the responses where all ages were combined.

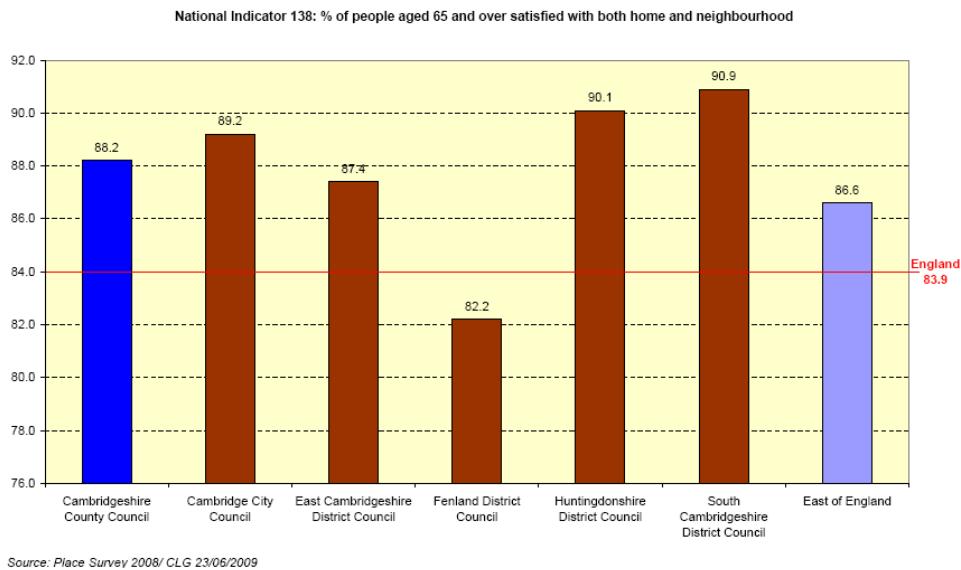
Areas in Cambridgeshire with higher proportions of older residents reported that they are less likely to have a strong sense of belonging to their neighbourhood. The Output Area Classification groups Older Blue Collar (46.7%), Prospering Older Families (43.3%) and Older Workers (51.9%) reported amongst the lowest percentages for those feeling a sense of belonging to their neighbourhood.<sup>165</sup> Fifty-one percent of residents 65 or older agreed that public services promote the interests of residents and act on the concerns of residents.<sup>166</sup> Older residents were more satisfied than other residents with transport information provision (51%) and the local bus services (59%). Half of older residents had used a local bus in the last month compared with 37% average use. Teenagers hanging around in the street was thought to be a problem for 28% of older residents.

<sup>165</sup> <http://www.cambridgeshire.gov.uk/NR/rdonlyres/77541B70-C6A0-4ED1-8945-5BBFB205CF01/0/PlaceSurveyOACAnalysis.pdf>

<sup>166</sup> <http://www.cambridgeshire.gov.uk/NR/rdonlyres/54AC616A-3572-4F77-A162-1B6629829BF0/0/MRUKPlaceSurveyReport.pdf>

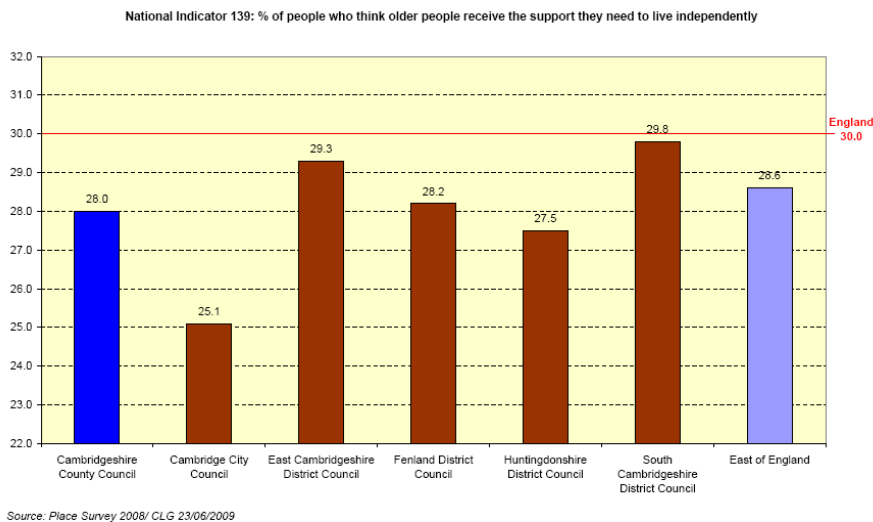
The survey found 88% of people over 65 in Cambridgeshire to be satisfied with both their home and the neighbourhood (Figure 86). This ranged from 82% in Fenland to 91% in south Cambridgeshire, compared with a regional average of 87% and a national average of 84%.

**Figure 86**



Only 30% of respondents nationally felt that older people get the support they need to live at home as long as they want. The regional average, and the percentage in most Cambridgeshire district was slightly lower, at 28 or 29% and only 25% Cambridge residents were satisfied with the level of support (Figure 87).

**Figure 87**



## 8.5 Age UK (Cambridgeshire)

Age Concern recently joined with Help the Aged to form Age UK. The Cambridgeshire branch <http://www.accambs.org/> consulted with older people in the period leading up to the integration of older people's services in Cambridgeshire. They found the following areas to be important:

- Social contact and getting out and about
- Transport
- Feeling safe at home
- Help at home, especially with household chores
- Information and help with form filling
- Simple assessment processes
- Adequate income and dignity and respect

At the Age Concern Cambridgeshire Annual General Meeting, similar concerns were raised (Table 55), but additionally several of which related to income.

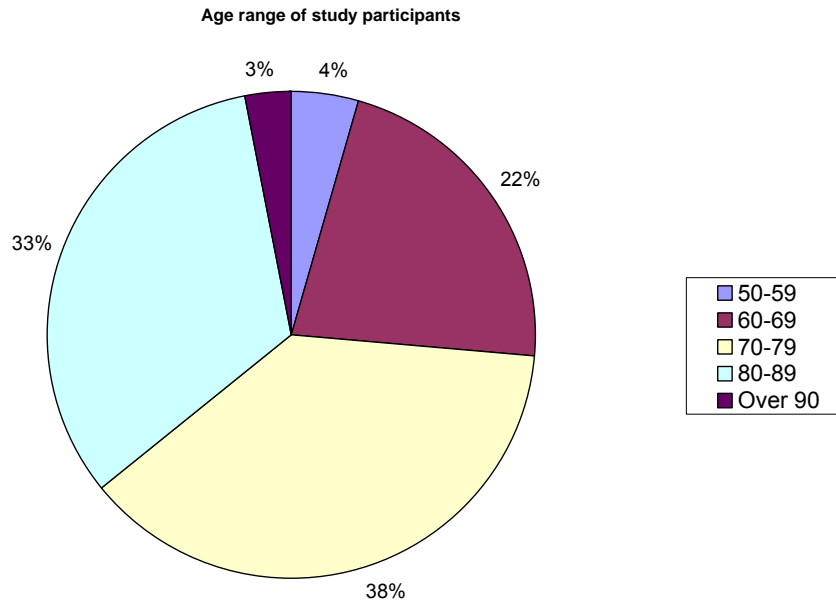
**Table 55**

<b>Issue</b>	<b>number of delegates</b>
Social care (and paying for care)	42
Pensions	35
Transport and bus passes	35
Ban political correctness	30
Support for carers	27
Fuel poverty	16
Attendance allowance	11
Volunteering and community effort	10
Difficulties in accessing information (lack of internet access)	8
Means tested benefits	3

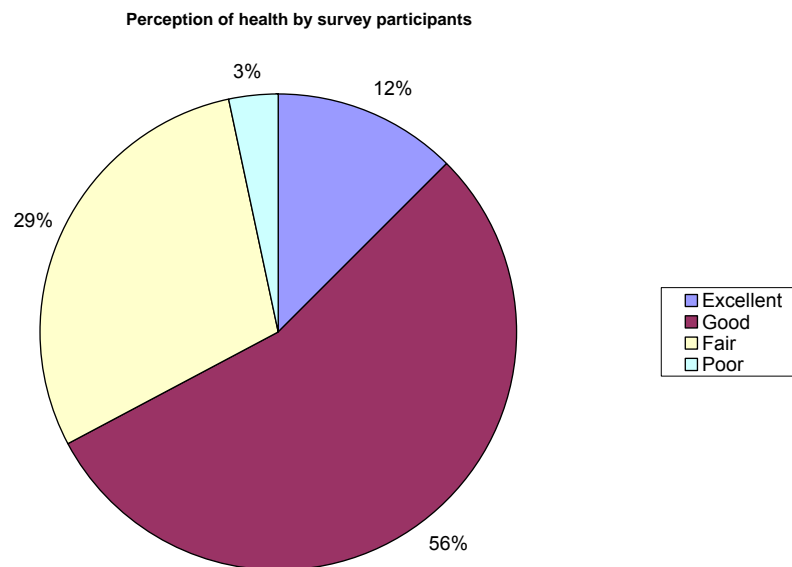
## 8.6 Cambridgeshire Older People Enterprise forum (COPE)

COPE [www.cambridgeshirecope.org](http://www.cambridgeshirecope.org) is one of the largest of over 600 senior citizens' forums in the UK. It is a voluntary organisation that campaigns on behalf of Older People, and its Executive Committee includes representatives from the five Cambridgeshire localities. In a survey undertaken by its research group in 2010 of 561 members who attended the AGM in 2008, most respondents were aged over 70 (Figure 88). Two-thirds reported a long term condition affecting daily life but almost all reported being active on a daily basis and half reported their health as good (Figure 89). Just under half reported taking four or more medications daily. About a third reported falling at least once in the previous year and less than two-thirds reporting having someone to call on in the circumstances of a +fall.

**Figure 88**



**Figure 89**



COPE surveyed local housing needs among its members in its report *COPEing with Housing in and around Cambridge*. Most of the 308 respondents (a 17% response rate) were keen to remain in their current accommodation. Of those planning to move, most were prompted for a need for suitable accommodation (eg smaller, easier to maintain). The report identifies barriers to moving (eg lack of suitable accommodation, need for support with practical tasks associated with moving house) and points out that supporting older people to move into smaller housing, would release larger homes available for families. The report makes recommendations for actions for both COPE eg supporting older people's access to information and government agencies eg providing more suitable housing alternatives.

COPE plans to work with Age UK England to repeat a focus group to look at developments in assistive technology, with a view to testing out new equipment.

## 8.7 Cambridgeshire Older People Reference Group (COPRG)

In 2008/09, the Cambridgeshire Older People Reference Group, a network of representatives of community groups across Cambridgeshire undertook a study of residents' views, and in February 2010 published the report *Unsung heroes in a Changing Climate*.<sup>167</sup> These groups provide networks and are run and supported by volunteers. The Cambridgeshire Voluntary Sector Infrastructure Consortium has estimated there are around 12 000 such groups in Cambridgeshire, possibly many more. Not all are groups are specifically for older people but many are inter-generational.

Key messages from this comprehensive survey of 260 groups include:

- 85% older people do not access social care services
- Most care and support is unpaid and informal
- Men are less likely than women to participate in organised groups
- People aged 85 and over continue to be involved in community groups
- Income, ability to travel, the availability of physical activities and access to information are important concerns

## 8.8 Older People and Village services

An interview survey<sup>168</sup> of 44 older users of village services and 25 key informants undertaken in six villages including in the East of England found that

- Village services such as lunch clubs, befriending and information and advice services actively promote the social inclusion of older people for relatively small cost. They are dependent on the goodwill, commitment and generosity of paid staff and older volunteers.
- Village services are highly valued.
- Most users of village services are female and white. Older men are more reluctant to engage with the services currently on offer
- Loneliness and isolation are strong and recurrent themes in very rural settings
- A lack of transport options and locally available services may exacerbate the social exclusion of older rural residents.

Recommendations from the report include:

- Considerations for funding rural services.
- In rural areas which lack frequent bus services, older people should be provided with mobility vouchers to enable them to purchase transport from other providers
- Service providers must consider the needs of BME groups when establishing, delivering and developing services
- Providers need to find new ways of engaging with older men in rural areas.

<sup>167</sup> <http://eastern.skillsforcare.org.uk/news/news.aspx>

<sup>168</sup> Dwyer, P & Hardill, I 2008, 'Older people and village services: exploring the impact on community based services in rural England', for: *Age Concern, West Midlands, Age Concern East Midlands, Age Concern East of England, Age Concern, England*, London, UK.

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