JSNA – OLDER PEOPLE - HEALTH & SOCIAL CARE

SUE MATTHEWS, CONSULTANT IN PUBLIC HEALTH
Hertfordshire County Council, October 2015

CONTENTS

1 Summary ....................................................................................................................................................................................2
  1.1 Introduction ...........................................................................................................................................................................2
  1.2 Population and demography ..................................................................................................................................................2
  1.3 Health and Social Care activity ................................................................................................................................................2
    1.3.1 Healthcare spend and activity ...........................................................................................................................................2
    1.3.2 Social care spend and activity ............................................................................................................................................3
    1.3.3 Understanding disability and care ......................................................................................................................................4
    1.3.4 Future projections .................................................................................................................................................................4
  1.4 Evidence ....................................................................................................................................................................................5
    1.4.1 Evidence on what drives demand for health and social care ...............................................................................................5
    1.4.2 Interventions and approaches to delay demand on H&SC ...............................................................................................6
  1.5 Discussion ................................................................................................................................................................................6
    1.5.1 What do we want to improve? ...............................................................................................................................................6
    1.5.2 Priorities and next steps .......................................................................................................................................................7
  2 Introduction ................................................................................................................................................................................9
  3 Aims and objectives ....................................................................................................................................................................9
    3.1 Aims ..........................................................................................................................................................................................9
    3.2 Objectives .................................................................................................................................................................................9
  4 Population and demography ........................................................................................................................................................10
    4.1 Demography for older people ................................................................................................................................................10
    4.2 Health status and functional capacity ..................................................................................................................................12
  5 Health and Social Care activity ..................................................................................................................................................14
    5.1 Healthcare spend and activity ................................................................................................................................................14
      5.1.1 Accident and Emergency Attendances .................................................................................................................................17
      5.1.2 Emergency Admissions .......................................................................................................................................................18
    5.2 Social care spend and activity ..................................................................................................................................................22
    5.3 Unpaid care ................................................................................................................................................................................26
    5.4 Understanding disability and care ..........................................................................................................................................27
    5.5 Future projections ....................................................................................................................................................................29
  6 Evidence .....................................................................................................................................................................................30
    6.1 Evidence on what drives demand for health and social care ...............................................................................................30
    6.2 Interventions and approaches to delay demand on H&SC ...............................................................................................31
  7 Discussion ..................................................................................................................................................................................33
    7.1 What do we want to improve? ...............................................................................................................................................33
    7.2 Priorities and next steps ..........................................................................................................................................................36
# 1 Summary

## 1.1 Introduction
We are facing unprecedented reductions in public sector funding: at the same time there is an increase in demand for services both from an increasingly ageing population and through an increase in the expectations of individuals. This report provides an evidence base to inform strategic decisions for adult Health and Social Care (H&SC) in Hertfordshire (both current and future) focusing on the needs of older people and support and identify priority areas for future action.

## 1.2 Population and Demography
- Approximately 16% of Hertfordshire’s population are aged 65 years and over (173,915). It is predicted that this will significantly increase over the next 20 years showing an increase over more than 50% over the next 20 years.
- There are higher concentrations of those aged 65/85 years or more in North Hertfordshire, Dacorum, St Albans, Welwyn Hatfield and Three Rivers.
- 13.1% of Hertfordshire’s older population is considered to be living in poverty. Districts with higher levels of deprivation are in Stevenage, Watford, Broxbourne, Hertsmere and North Hertfordshire.
- Disability-free life expectancy (DFLE) is the average number of years an individual is expected to live free of disability if current patterns of mortality and disability continue to apply. There is a strong correlation with DFLE and levels of deprivation\(^1\).

## 1.3 Health and Social Care Activity

### 1.3.1 Healthcare Spend and Activity
NHS England has published ‘Commissioning for Value - Integrated care pathways’ (2015) which aim to support commissioners to identify priorities that provide the best opportunities to improve healthcare for populations by comparing each Clinical Commissioning Group (CCG) against 10 similar CCGs. These reports highlight the following:

- **60% of patients with 2% highest inpatient spend were over 65 years of age meaning that a significant proportion was in younger age groups.**
- Circulation, cancer, musculoskeletal and gastro intestinal were the top three areas of spend across both CCGs.
- Programmes with the highest inpatient spend for patients aged 75 years and over included: circulation, musculoskeletal and cancer (Herts Valleys CCG) and neurological, vision and respiratory (E&N Herts CCG).
- Key areas for improvement for dementia pathways focus on: reducing the rate of emergency admissions aged 65+ with dementia; percentage of emergency admissions with dementia who stay one night or less; percentage of people with a long term condition who had enough support; rate of delayed transfers of care; percentage aged 65+ who received reablement/rehabilitation services after discharge and the rate of emergency admissions aged 75+ with a stay of <24 hrs.

---

There has been an increase in the number of A&E attendances and emergency admissions for both CCGs over the last 4 years for both 65+ and 75+ year age groups.

- Lower Lea Valley, Stevenage, WelHat and Hertsmere have significantly higher rates of A&E attendance when compared against the CCG average for 65+ and 75+ year age groups.
- While data highlights a clear age trend with an increase in unplanned admissions from the age of 50 years and over, age is not the strongest indicator for increased health and social care demand. Recent research\(^2\) showed that costs and patterns of spend in health and social care were driven more by an individual’s morbidity profile than by their age, in terms of both the number of chronic conditions and specific conditions. However it is however currently not possible to map health and social care activity and spend by morbidity profiles.
- Stevenage, North Herts, WelHat and Watford & Three Rivers have significantly higher rates of unplanned admissions when compared against the CCG average for both 65+ and 75+ year age groups.
- Cardiac, Respiratory and Urinary Tract and male reproductive system HRG chapters accounted for the higher proportion of spells. Falls related admissions also represent a small but significant number of emergency admissions for those aged 65 years and over. The Public Health Outcomes Framework indicator shows higher rates of injuries due to falls for those aged 65 years and over in Watford, Three Rivers and Stevenage.
- Length of stay (LOS) appears to increase when comparing 65+ and 75+ age groups. The most common LOS was 2-5 days with a zero days as the second most frequent. Zero day admissions was highlighted earlier in the Commissioning for Value as an area which requires further review as may be indicative of an inappropriate admission. There were also a significant proportion of patients with a LOS over 15 days. Further review of care coordination within both acute and community provision to delay extended LOS may be of value.

### 1.3.2 Social Care Spend and Activity

Approximately 46% of Hertfordshire County Councils expenditure is on social care, of which 48% is on older people. Breakdown of the Gross Current Expenditure for this client group shows:

- 56% on Nursing and Residential Care
- 33% Day and Domiciliary Care
- 11% Assessment and Care Management

The following trends were noted:

- Watford and Stevenage have the highest rate of older people receiving statutory social care, which mirrors higher levels of deprivation for over 65 years in the county.
- The need for personal care due to limitations in activities of daily living was the most common reasons for receiving social care support.
- 55% of those receiving statutory care receive Home Care (n=4,685) and 28% receive local authority funded Equipment & Adaptations (n=2420). It should be noted that these data only include statutory provision and does not account for the range of non-statutory services commissioned in Hertfordshire.

\(^2\) Centre for Health Economics (2014). The Importance of Multimorbidity in Explaining Utilisation and Costs Across Health and Social Care Settings: Evidence from South Somerset’s Symphony Project. CHE Research Paper 96, University of York. [https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP96_multimorbidity_utilisation_costs_health_social%20care.pdf](https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP96_multimorbidity_utilisation_costs_health_social%20care.pdf)
A review of Home Care services (known as ‘support at home’) showed that those aged 85 years and over make up a greater proportion of those receiving home care packages and nearly 50% of average spend is up to £120 per week, followed by approximately 40% whose average spend is between £120-360 per week. Approximately 60% received home care services for 2.5 years or more (data taken in December 2014).

### 1.3.3 Understanding Disability and Care

A review of national datasets highlighted that in Hertfordshire (for those aged 65 years and over):

- 45% are limited in daily activities by a health problem or disability (77,936)
- 16% of those aged 65 years and over receive attendance allowance, of which 68% are female and 56% receiving the allowance at the higher rate.
- 14% provide unpaid care (23,496) and, of these, 20% receive statutory carers services or information (4,620)
- 6% of older service users are formally supported by local authorities (9,815)

It is estimated that in England, approximately 6.7% of the older population living at home would require some level of care and support (those experiencing difficulties with three or more ‘Activities of Daily Living’). Approximately 12% of this group did not receive any form of care (approximately 70,000 older people in England). The level of unmet need is likely to increase because the percentage of people in receipt of care is dropping and the size of the older population is rising.

### 1.3.4 Future Projections

The Personal Social Services Research Unit estimated that projected future expenditure on social care and continuing health care will vary depending on future life expectancy:

- Office of National Statistics (ONS) low life expectancy projection - older people with moderate or severe disabilities is projected to rise by 30% (social care & Continuing Health Care (CHC) expenditure rising by 35% in real terms 2010-2022).
- ONS high life expectancy projection - older people with moderate or severe disabilities is projected to rise by 34% (expenditure rising by 40% 2010-2022).

If rates of chronic disease continue to rise with recent trends there will be a projected increase of 54% of older people with moderate or severe disabilities and a 56% increase in social care & CHC expenditure (2010-2022).

*Projections will remain largely unchanged if the balance of care shifted such that publicly-funded residential care was replaced by an average of around 20 hours per week of home care.* However, a shift in the balance of care from informal to formal care could significantly increase projected future public expenditure on social care for older people.

---

3 Lower rate - Frequent help or constant supervision during the day, or supervision at night; Higher rate - Help or supervision throughout both day and night, or you're terminally ill. [https://www.gov.uk/attendance-allowance/what-youll-get](https://www.gov.uk/attendance-allowance/what-youll-get)


Implementation of a cap on the amount that an individual pays towards care costs (as per Dilnot Commission) would lead to 25% increase in social care costs in 2022 than if the current means-tested system continued.

1.4 Evidence

1.4.1 Evidence on what drives demand for health and social care

Recent evidence shows that multimorbidity was a stronger indicator than age alone when exploring drivers for increased demand on health and social care. Multimorbidity is defined as the presence of two or more long term conditions (LTC) and is associated with high mortality, reduced functional status, and increased use of both inpatient and ambulatory health care. It is estimated that 42% of patients had one or more morbidities and 23% were multimorbid. Prevalence of multimorbidity increased with age and was present in most aged 65 years or over. However, the absolute number of people with multimorbidity was higher in those younger than 65 years. Onset has been shown to occur 10–15 years earlier in people living in the most deprived areas and the prevalence of both physical and mental health long term conditions (LTC) was 11%, in most deprived area compared to 6% in least deprived. In addition the presence of a mental health LTC increased as the number of physical morbidities increased and was much greater in more deprived people.

The Global Burden of Disease study (2010) report a growing burden of disability, particularly from mental disorders, substance use, musculoskeletal disorders, and falls and recommend that each area deserves an integrated and strategic response. Tobacco, high blood pressure and high body mass index account for around 30% of all disability life adjusted years (DALYs) in the UK. Diet and physical inactivity accounted for 14-3% of UK DALYs in 2010.

The prevalence of obesity-related disabilities among adults is increasing. Obesity is associated with the four most prevalent disabling conditions in the UK: arthritis, back pain, mental health disorders and learning disabilities. Obesity is also a contributory factor to the development of long term conditions such as diabetes and cardiovascular disease. In addition, severe obesity can result in physical and social difficulties which impact on social care.

Social and physical environments also have a significant influence on someone’s health and use of health and social care. For example, poor quality housing can drive increased demand in respect of chronic obstructive pulmonary disorder (COPD); housing with trip hazards can increase the risk of falls and fractures amongst older people.

The Nuffield trust (2013) reported that UTIs were one of the top ambulatory care sensitive conditions (considered preventable) which disproportionately affected older people and was on the increase.

---


There is limited evidence on UTI related emergency admissions for the elderly population. One review\textsuperscript{11} highlighted a number of contributory factors which include the overuse of antibiotics, interpretation of culture results, those using catheters, the incontinent, those receiving antipyretics or analgesics, those who are immunocompromised and the cognitively impaired.

\textbf{1.4.2 INTERVENTIONS AND APPROACHES TO DELAY DEMAND ON H&SC}

The Kings Fund (2015)\textsuperscript{12} identified ten priorities for commissioners to transform the health care system:

1. Active support for self management
2. Primary prevention
3. Secondary prevention
4. Managing ambulatory care sensitive conditions
5. Improving the management of patients with mental and physical needs
6. Care co-ordination through integrated health and social care teams
7. Improving primary care management of end-of-life care
8. Effective medicines management
9. Managing elective activity-referral quality
10. Managing emergency activity: urgent care

The main report also includes evidence of good practice for falls prevention and UTIs.

\textbf{1.5 DISCUSSION}

This report demonstrates a significant challenge for health and social care, both now and in the future. The Kings Fund\textsuperscript{13} identified several common themes across the 10 priorities for health care referred to earlier which include:

- a more systematic and proactive management of chronic disease
- the empowerment of patients
- a population-based approach to commissioning to ensure that we direct resources to the patients with greatest need
- more integrated models of care

\textbf{1.5.1 WHAT DO WE WANT TO IMPROVE?}

Key areas for improvement are summarised below.

1. \textbf{Prevent / delay disability and poor health in population} - shift our focus from frailty to proactively addressing the challenges of multimorbidity.

2. \textbf{Take a systems approach prevention and service provision} - better coordination of services across the wider system adopting a population based approach to both prevention and service provision.

3. \textbf{Greater role of non NHS services to support prevention} - services outside of the NHS, including the voluntary sector, benefits services, police, fire service and wider communities are integral to a systems approach both in terms of their reach to vulnerable people and skills.

1.5.2 PRIORITIES AND NEXT STEPS

Hertfordshire's Health and Wellbeing Board has asked commissioners to work with Public Health to create a strategic approach to prevention. A number of priorities have been identified which will link into and inform this work. These are summarised below:

<table>
<thead>
<tr>
<th>Priority</th>
<th>Progress to date</th>
</tr>
</thead>
</table>
| 1. Better understanding of where we can reduce avoidable demand in the short term | • Hertfordshire hosted an event in June where the CfV data was discussed with CCGs and public health.  
• Further work is currently under discussion with both CCGs and Public Health England. This will be closely aligned with the 'Strategic Shift to Prevention' work led by the Health & Wellbeing Board. |
| a. Further review of priority areas identified in NHS England’s 'Commissioning for Value toolkit' | |
| b. This work may be usefully linked to a locality focus for areas where admission rates are higher and should be linked with the integrated care work. | |
| c. There may also be value in reviewing reasons for emergency UTI admissions to inform service development. | |
| 2. Improve our understanding of multi morbidity within Hertfordshire and develop systems which enable us to proactively identify patients requiring assertive case/self management to reduce the demand on health and social care and delay disability or deterioration from established health conditions or complex social care needs. This work should be fed into plans for integrated care using evidence from Centre for Health Economics research. | • A business case has been developed for a population approach to risk stratification.  
• Risk stratification is closely aligned with the Hertfordshire Self Management Steering Group, led by the Director of Public Health, which will work with the CCGs to embed risk stratification into patient pathways. The Steering Group are also leading a work stream to develop skills among the workforce to support patients with multimorbidity.  
• A JSNA chapter on multimorbidity is currently under development. |

---

https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP96_multimorbidity_utilisation_costs_health_socialcare.pdf
<table>
<thead>
<tr>
<th>Priority</th>
<th>Progress to date</th>
</tr>
</thead>
</table>
| 3. Ensure that a system wide approach to prevention is incorporated into service priorities. | - A prevention strategy for healthy ageing has been developed which includes a range of actions focussed on the social and physical environment (e.g. housing, local community infrastructure) to support older people to live independently for as long as possible. The strategy also includes the implementation of Making Every Contact Count (MECC) targeting older people across the wider workforce where frontline are trained to offer brief prevention advice and support to local residents.  
- Public health are undertaking a Carers Health Needs Assessment which will identify opportunities for prevention and priorities to support commissioners  
- A falls prevention strategy is currently under development. These plans need to be fully integrated with wider service provision. |
2 INTRODUCTION

We are facing unprecedented reductions in public sector funding: at the same time there is an increase in demand for services both from an increasingly ageing population and through an increase in the expectations of individuals.

NHS England (2014) recently published The Five Year Forward View which recognised that “The NHS needs a radical upgrade in prevention if it is to be sustainable”. In addition, The Care Act (2014) recognises that to meet the challenges of the future, the care and support system need to intervene early to support individuals, helps people retain or regain their skills and confidence, and prevents need or delays deterioration wherever possible.

This report will provide an evidence base to inform strategic decisions for adult Health and Social Care (H&SC) in Hertfordshire (both current and future) focusing on the needs of older people and will support future delivery of the requirements of the Care Act outlined above. This chapter aims to provide a high level assessment of where we are now and our direction of travel over the next few years. The chapter will provide the evidence to both support and articulate a prevention approach for Hertfordshire and identify priority areas for future action.

This chapter will summarise key population trends, map against current H&SC activity, and model future need based on population change. Evidence what influences increases demand and interventions to delay the need for health and social care will be summarised to explore priority areas for the future.

3 AIMS AND OBJECTIVES

The aims, objectives of this chapter are summarised below.

3.1 AIMS

1. Review current adult health and social care activity and assess future need in Hertfordshire
2. Summarise what is currently being done to address current and future need and how we can develop this further
3. Identify gaps in the evidence base
4. Propose priorities for action based on these findings

3.2 OBJECTIVES

1. Summarise population demography in Hertfordshire for adults and older people both now and in the future
2. Assess health and social care activity, spend and outcomes and how it is distributed across the system
3. Review the evidence on effectiveness of interventions to delay the need for health and social care
4. Define and identify where inequalities exist and make recommendations for improvement
5. Use this evidence to identify priorities for local decision making
6. Produce recommendations for the Health and Wellbeing Board
4 POPULATION AND DEMOGRAPHY

4.1 DEMOGRAPHY FOR OLDER PEOPLE
Approximately 16% of Hertfordshire's population are aged 65 years and over (173,915). It is predicted that this will significantly increase over the next 20 years showing an increase over more than 50% over the next 20 years (Figure 1).

Figure 1: Projected number and percentage increase of people aged 65 and over in Hertfordshire, 2015 to 2035


Figure 2 and Figure 3 maps variations in population density for those aged 65/85 years or more across Hertfordshire with higher concentrations in parts of North Hertfordshire, Dacorum, St Albans, Welwyn Hatfield and Three Rivers.

Figure 2: Percentage of all Hertfordshire populations aged 65+

Data source: http://atlas.hertslis.org/IAS/dataviews/report/fullpage?viewId=1156&reportId=505&geold=18
Levels of deprivation among older people can also be measured through reviewing the proportion of older people (aged 60 years or over) that are living in pension credit (guarantee) households. 13.1% of Hertfordshire’s older population is considered to be living in poverty, this lower than the England average (18.1%). Levels of deprivation among older people varies considerably across the county. The districts with higher levels of deprivation are in Stevenage (18%), Watford (16%), Broxbourne (15.5%), Hertsmere (14.1%) and North Hertfordshire (13.6%).

Approximately 8% of those aged 65 years and over live alone. There are higher proportions in Broxbourne, Three Rivers and North Herts (Figure 4). Watford (5.4%) and Stevenage (7%) have considerably lower levels of one family households.

**Figure 3: Percentage of all Hertfordshire populations aged 85+**

**Figure 4: Percentage of all Hertfordshire one person households (65+)**
4.2 HEALTH STATUS AND FUNCTIONAL CAPACITY

Disability-free life expectancy (DFLE) is the average number of years an individual is expected to live free of disability if current patterns of mortality and disability continue to apply. Figure 5 highlights DFLE by area and shows a strong correlation with levels of deprivation\(^\text{15}\).

**Figure 5: Disability Free Life Expectancy (1999 – 2003)**

In Hertfordshire 45\% of those aged 65+ are limited in daily activities by a health problem or disability (n=77,936). Figure 6 and Figure 7 map activities of daily living where they are limited a little and a lot.

Recent research\(^{16}\) explored disability and care using data from the Census, Department of Work & Pensions (DWP), Health and Social Care Information Centre (HSCIC) and Wave 6 of the English Longitudinal Study of Ageing. This study highlighted that 6.7% of the older population living at home experienced three or more activities of daily living difficulties, of which 40% lived alone.

5 HEALTH AND SOCIAL CARE ACTIVITY

This section will summarise key points for the following areas:

- health and social care activity, spend and outcomes
- key areas of greatest spend for health and social care and how this is broken down across the health and social care economy

5.1 HEALTHCARE SPEND AND ACTIVITY

NHS England published ‘Commissioning for Value - Integrated care pathways’ (2015) which aim to support commissioners to identify priorities that provide the best opportunities to improve healthcare for populations by comparing each Clinical Commissioning Group (CCG) against 10 similar CCGs. These reports included analysis of 2% of patients with greatest inpatient spend in 2013/14. These data highlighted that 60% of those in this group were aged 65 years or more; meaning that a significant proportion were in younger age groups.

- E&N Hertfordshire CCG – analysis of 2% with greatest inpatient spend made up 16% of total inpatient spend (1497 patients), with an average of 2.8 conditions and 6.2 admissions per year. Circulation, cancer and gastro intestinal were the top three areas of spend.

- Herts Valleys CCG – analysis of 2% with greatest inpatient spend made up 15.9% of total inpatient spend (1530 patients), with an average of 2.91 conditions and 6.7 admissions per year. Circulation, cancer and musculoskeletal were the top three areas of spend.

Figure 8 and 9 show programmes with the highest inpatient spend for patients aged 75 years and over for both CCGs. Herts Valleys CCG shows a number of areas of greater spend when compared to 10 similar CCGs, particularly for circulation, musculoskeletal and cancer (Figure 8). Key areas of higher spend in E&N Hertfordshire CCG include on neurological, vision and respiratory (figure 9).

Figure 8: Inpatient spend for those aged 75 years or more – Herts Valleys CCG

[Graph showing inpatient spend for those aged 75+]

Figures 10 and 11 present benchmarking data for Dementia and long term conditions (LTC) and identify opportunities to reduce spend and improve outcomes. Key areas for improvement for both CCGs focus on:

- the rate of emergency admissions aged 65+ with dementia
- % of emergency admissions with dementia who stay one night or less
- % of people with a long term condition who had enough support
- Rate of delayed transfers of care
- % aged 65+ who received reablement/rehabilitation services after discharge
- Rate of emergency admissions aged 75+ with a stay of <24 hrs
Figure 10: Dementia and long term conditions (secondary care and outcomes) – Herts Valleys CCG


Figure 11: Dementia and long term conditions (secondary care and outcomes) – E&N Hertfordshire CCG

5.1.1 Accident and Emergency Attendances

Figure 12 provides a breakdown of Accident & Emergency (A&E) attendances over the last four years. There has been an increase in the number of A&E attendances for both CCGs over the last 4 years for both 65+ and 75+ year age groups.

**Figure 12: Number of A&E attendances, age 65+ and 75+ years, NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG, 2011/12 to 2014/15**

Data source: SUS via Mede Analytics, Public Health Evidence and Intelligence, June-15

Figure 13 and Figure 14 show the rate of attendances (per 1,000) for both CCGs by CCG locality during 2013-2015. Lower Lea Valley, Stevenage, WelHat and Hertsmere have significantly higher rates of A&E attendance when compared against the CCG average for both 65+ and 75+ year age groups.

**Figure 13: A&E attendances, age 65+, rate per 1,000 population, NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG, by CCG locality, 2013/14 to 2014/15**

Data source: SUS via Mede Analytics, Public Health Evidence and Intelligence, June-15
Figure 14: A&E attendances, age 75+, rate per 1,000 population, NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG, by CCG locality, 2013/14 to 2014/15

Data source: SUS via MedeAnalytics, Public Health Evidence and Intelligence, June-15

5.1.2 Emergency Admissions

Figure 15 shows that there has also been an increase in the number emergency admissions for both CCGs over the last 4 years for both 65+ and 75+ year age groups; particularly during 2014-15.

Figure 15: Number of emergency admissions, age 65+ and 75+ years, NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG, 2011/12 to 2014/15

Data source: SUS via MedeAnalytics, Public Health Evidence and Intelligence, June-15

Figure 16 highlights a gradual increase in unplanned admissions from the age of 50-69 years with a steeper increase from 70 years and over. However, it is important to stress that age is not the strongest indicator for increased health and social care demand. A recent study led by the Centre for Health Economics (South Somerset Symphony project), assessed utilization and costs of care across health and social care settings to identify which groups of people would most benefit from better integrated care.
This study\(^{17}\) found that costs and patterns of spend in health and social care were driven more by an individual's morbidity profile than by their age, in terms of both the number of chronic conditions and specific conditions. Costs are higher the more co-morbidities a person has, and for people from more deprived areas. Patients with asthma and diabetes, hospital costs account for the largest proportion of costs; in contrast, costs for those with dementia occur mostly in social care, mental health care and community care settings. It is however currently not possible to map health and social care activity and spend by morbidity profiles locally so age has been used for the purposes of this report.

**Figure 16: Emergency admissions by 5 year age band, rate per 1,000 population, NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG, 2013/14 to 2014/15**

![Graph showing emergency admissions by age band](image)

Data source: SUS via MedeAnalytics, Public Health Evidence and Intelligence, June-15

Figure 17 and Figure 18 show the rate of admissions (per 1,000) for both CCG localities during 2013-2015. Stevenage, North Herts, WelHat and Watford & Three Rivers have significantly higher rates of unplanned admissions when compared against the CCG average for both 65+ and 75+ year age groups.

**Figure 17: Emergency admissions, age 65+, rate per 1,000 population, NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG, by CCG locality, 2013/14 to 2014/15**

![Graph showing emergency admissions by locality](image)

Note: Numbers on bars represent number of attendances

Figure 18: Emergency admissions, age 75+, rate per 1,000 population, NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG, by CCG locality, 2013/14 to 2014/15

Data source: SUS via MedeAnalytics, Public Health Evidence and Intelligence, June-15

5.1.2.1 Reasons for emergency admissions

Table 1 provides a summary of HRG and primary diagnoses for those aged 65 years and over. Cardiac (E codes), Respiratory (D codes) and Urinary Tract and male reproductive system (L codes) HRG chapters accounted for the higher proportion of spells.

<table>
<thead>
<tr>
<th>HRG</th>
<th>E&amp;N Herts CCG</th>
<th>HV CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>EB01Z - Non-Interventional Acquired Cardiac Conditions</td>
<td>2229 19.5% 1946 16.5%</td>
<td></td>
</tr>
<tr>
<td>DZ11A - Lobar, Atypical or Viral Pneumonia with Major CC</td>
<td>2040 17.8% 2429 20.6%</td>
<td></td>
</tr>
<tr>
<td>LA04D - Kidney or Urinary Tract Infections with length of stay 2 days or more with Major CC</td>
<td>1473 12.9% 1696 14.4%</td>
<td></td>
</tr>
<tr>
<td>AA26A - Muscular, Balance, Cranial or Peripheral Nerve Disorders; Epilepsy; Head Injury with CC</td>
<td>1010 8.8% 1066 9.0%</td>
<td></td>
</tr>
<tr>
<td>WA22V - Other Specified Admissions and Counselling with Major CC</td>
<td>886 7.8%</td>
<td></td>
</tr>
<tr>
<td>AA22A - Non-Transient Stroke or Cerebrovascular Accident, Nervous System Infections or Encephalopathy with CC</td>
<td>865 7.6% 1044 8.8%</td>
<td></td>
</tr>
<tr>
<td>EB07I - Arrhythmia or Conduction Disorders without CC</td>
<td>798 7.0% 947 8.0%</td>
<td></td>
</tr>
<tr>
<td>EB08I - Syncope or Collapse without CC</td>
<td>728 6.4%</td>
<td></td>
</tr>
<tr>
<td>LA04G - Kidney or Urinary Tract Infections with length of stay 1 day or less</td>
<td>713 6.2%</td>
<td></td>
</tr>
<tr>
<td>EZ22A - Unspecified Acute Lower Respiratory Infection with Major CC</td>
<td>687 6.0% 663 5.6%</td>
<td></td>
</tr>
<tr>
<td>HD21B - Soft Tissue Disorders with CC</td>
<td>690 5.8%</td>
<td></td>
</tr>
<tr>
<td>EB03H - Heart Failure or Shock with CC</td>
<td>661 5.6%</td>
<td></td>
</tr>
<tr>
<td>EA36A - Catheter 19 years and over</td>
<td>656 5.6%</td>
<td></td>
</tr>
</tbody>
</table>

Data source: SUS via MedeAnalytics, Public Health Evidence and Intelligence, June-15

Falls represent a small but significant number of emergency admissions for those aged 65 years and over. Figure 19 shows higher rates of injuries due to falls for those aged 65 years and over in Watford, Three Rivers and Stevenage.
Figure 19: Injuries due to falls for those aged 65 years and over (directly standardised rate - 2013-14)

Figure 21: Length of stay

There is an increase in the average length of stay (LOS) for those aged 75+ compared to 65+ age groups (Figure 20). Length of stay varies considerably among those aged 65 years and over.

Figure 21 shows that the most frequent LOS was 2-5 days with a zero days as the second most frequent. Zero day admissions was highlighted earlier in the Commissioning for Value as an area which requires further review as may be indicative of an inappropriate admission. There were also a significant proportion of patients with a LOS over 15 days. Further review of care coordination within both acute and community provision to delay extended LOS may be of value.
5.2 SOCIAL CARE SPEND AND ACTIVITY

Spend for the Health & Community Services in Hertfordshire was £361,609,000 during 2013/14 (£344,918,000 2014/15). Approximately 46% of Hertfordshire County Councils expenditure is on social care, of which 48% is on older people. Breakdown of the Gross Current Expenditure for this client group shows:

- 56% on Nursing and Residential Care
- 33% Day and Domiciliary Care
- 11% Assessment and Care Management

The Audit Commission recently published value for money profiles where they benchmark each local authority against statistical nearest neighbours on key areas of spend for all social care (2012-13). A review of spend for older people highlights that Hertfordshire spent £984.71 per head of 65+ population (2012-13). This compares with highest spend in Oxfordshire (£1025.58) and the lowest in Somerset (£790.31).
**Figure 22: Social care spends (£ per head) for older people including older mentally ill per adult aged 65+ (2012-13)**

**Comparator Local Authorities:**
- Buckinghamshire County Council
- Cambridgeshire County Council
- Essex County Council
- Gloucestershire County Council
- Hampshire County Council
- Kent County Council
- Lancashire County Council
- Northamptonshire County Council
- Oxfordshire County Council
- Somerset County Council
- Staffordshire County Council
- Surrey County Council
- Warwickshire County Council
- West Sussex County Council
- Worcestershire County Council

Taken from: The Audit Commission VFM profiles [http://profiles.audit-commission.gov.uk/_layouts/acwebparts/NativeViewer.aspx?Report=/Profiles/VFM_Standard&EntityID=15108&EntityGroupId=189&GroupId=172&SelectedCategoryId=7437&TopLevelCategoryId=7422&DescriptorId=42183](http://profiles.audit-commission.gov.uk/_layouts/acwebparts/NativeViewer.aspx?Report=/Profiles/VFM_Standard&EntityID=15108&EntityGroupId=189&GroupId=172&SelectedCategoryId=7437&TopLevelCategoryId=7422&DescriptorId=42183)

The HSCIC publish annual data on activity and outcomes for social care. 2013/4 data\(^{18}\) reports that 68% of those aged 65 and over receiving social care services are women. Figure 23 provides a breakdown of the rate of people aged 65+ receiving social services by district. Watford and Stevenage have the highest rate of social care use across all district areas for those aged 65+. The main reason for receiving social care support was personal care needs due to limitations in activities of daily living (Figure 24).

**Figure 23: rate of people aged 65+ receiving social services by district (per 1,000) (2012-14)**

Data source: HCC

---

Figure 24: primary support reason by age (2014)

Figure 24 shows the distribution of primary support reasons by age band for the year 2014. The data is divided into three age bands: 65-75, 75-85, and 85+. The support reasons are categorized into various types such as No reason entered, Social - Carer support, Social - Isolation / Other, Sensory, Learning Disability, Physical - Personal Care, Physical - Access/Mobility, Memory and Cognition, and Mental Health. The graph indicates that the majority of clients in the 65-75 age band receive support for Social - Carer support, while in the 85+ age band, the primary reason is Physical - Access/Mobility.

Data source: HCC

Figure 25 breaks down the numbers of people aged 65 years and over receiving statutory services in Hertfordshire and shows that 55% of those receiving statutory receive Home Care (n=4,685) and 28% receive local authority funded Equipment & Adaptations (n=2420). It should be noted that these data only include statutory provision and do not account for the range of non-statutory services commissioned in Hertfordshire. For example, data in Figure 25 shows that local authority funded meals on wheels makes up 1% of users (n=80), however review of local activity data shows that approximately 111,000 meals are delivered each quarter, alongside approximately 10-11,000 teatime meals and 12,000 lunch club meals each quarter.

Figure 25: numbers receiving statutory funded care aged 65 years and over in Hertfordshire (2011-12)

Data source: Strategic Society (HSCIC)
Home care services (known as ‘support at home’) was reviewed in more detail (data extract October 2014). From April 2015, all support at home services lead providers adopt the Hertfordshire Care Standards. These aim to provide better working conditions to create an environment for the best possible care. Their employees will benefit from:

- a sustainable wage
- good quality mandatory training
- paid sick pay, travel time, travel costs and other necessary expenses such as mobile phones and uniforms

Those aged 85 years and over tend to make up a greater proportion of those receiving home care packages and nearly 50% of average spend is up to £120 per week, followed by approximately 40% whose average spend is between £120-360 per week (figure 26). More intensive home care packages in Stevenage, Welwyn Hatfield, Broxbourne and East Herts (Figure 27).

Figure 26: Homecare packages per week by age band (2012-14)

![Figure 26: Homecare packages per week by age band (2012-14)](image)

Data source: HCC

Figure 27: Homecare cost bands by district (2012)

![Figure 27: Homecare cost bands by district (2012)](image)

Data source: HCC
Service duration was also reviewed. Approximately 60% of those receiving home care for 2.5 years or more when analysing data taken in December 2014 (Figure 28).

**Figure 28: service duration for those receiving social services by age group**

![Service Duration for Clients receiving Social Care Services as of 1st December 2014](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAIgAAAAHCAIAAADtLdJSAAAAA1BMVEX///8AAAdpFHRHAAAAASUVORK5CYGDh8ADPAAAAADAAADjEAAAD/BAQAAAABJRU5ErkJggg==)

Data source: HCC

Hertfordshire County council recently published a Market Position Statement for Older People 2015\(^\text{19}\) which identifies gaps in current service provision and areas for development.

### 5.3 Unpaid Care

The recent research on ageing and disability by the Strategic Society\(^\text{20}\) estimated that 14% of older people in Hertfordshire provide unpaid care (n=23,496) and, of these, 20% receive statutory carers services or information (n=4,620). The study reviewed key datasets for England and estimated the following:

- 5% of the older population provided 50+ hours of unpaid care per week.
- 56% of older carers in England were female, and over 40% were aged between 65 and 70.
- Nearly 50% older carers reported high blood pressure or hypertension, cholesterol and arthritis.
- Approximately 20% of older carers experienced self-care (ADL) difficulties themselves, for example, as many as 13% reported difficulty dressing.
- 17% of older carers providing 50+ hours of care per week received local authority services (2011-2012).
- Approximately 40% of older carers looking after someone for 20 or more hours per week reported that if they wanted a break for a few hours, someone else would have to look after the person they care for. 20% reported that they do not have someone else they could rely on to look after the person, whether at home or elsewhere.

The Adult Social Care Outcomes Framework (ASCOF) published data\(^\text{21}\) on the distribution of statutory support levels for carers looking after people aged 65 years and over. These data show that 23% of carers who were assessed received statutory services and 77% received information only. These data need to be considered in the context of the wider non statutory provision. Hertfordshire County Council commission a range of non-statutory carer services, mainly using the voluntary sector where the main


focus is no preventing breakdown of the caring role and supporting carers. In 2014-15, the budget for preventative carers’ services from the voluntary sector was approximately £2,435,000 and focussed on carer’s breaks, information, general support, development activities and training. There is also a Carers Market Position Statement which summarises Hertfordshire’s future commissioning intentions for services to directly support carers.

**Figure 29: Distribution of support levels for carers looking after people aged 65+ (2013-14)**

8. Percentage distribution of support levels received by carers looking after people aged 65 and over, 2013-14

![Distribution of support levels](chart.png)

Source: RAP table C2. Data for 2013-14 are based on final data.

Comparators are based on the CIPFA Statistical Nearest Neighbours (post April 2009) model with the default variables selected.


Comparators are based on the CIPFA Statistical Nearest Neighbours (post April 2009) model with the default variables selected.

### 5.4 UNDERSTANDING DISABILITY AND CARE

Section 4.2 provided a summary of health status and levels of function. This section will explore the relationship between levels of function and the care system. A review of national datasets highlighted that in Hertfordshire (for those aged 65 years and over) (Figure 30):

- 45% are limited in daily activities by a health problem or disability (77,936)
- 41% are in receipt of some form of benefit (Disability Living Allowance, Attendance Allowance or Pension Credit (62,680)
- 6% of older service users are formally supported by local authorities (9,815)

Those receiving statutory social care therefore represent a small proportion of those that are limited in daily activities and/ or receiving some form of benefit.
Figure 30: benefit and social care data for 65+ (2011-12)


Attendance Allowance is paid to those who need frequent help or constant supervision, and the eligibility criteria for it have marked similarities to those for social care – i.e., the need for support in activities of daily living such as preparing food, eating, washing, dressing, going to the toilet and medicines compliance, and whether someone is a risk to themselves or others. In Hertfordshire approximately 16% of those aged 65 years and over receive attendance allowance, of which 68% are female and 56% receiving the allowance at the higher rate.

The Strategic Society research estimated that in England, approximately 6.7% of the older population living at home would require some level of care and support (those experiencing difficulties with three or more ‘Activities of Daily Living’). They estimated that approximately 12% of this group did not receive any form of care (approximately 70,000 older people in England). The report also highlighted that:

- 17% of the older population with limited day-to-day activities received some form of local authority funded care and support in 2011-12, (care home, day care in the community or adaptations to a person's home).
- 54% of the older population with limited day-to-day activities received disability benefits.
- Approximately 17% of older people received Attendance Allowance (AA), and 10% receive Disability Living Allowance (DLA).

---

23 Lower rate - Frequent help or constant supervision during the day, or supervision at night; Higher rate - Help or supervision throughout both day and night, or you're terminally ill. https://www.gov.uk/attendance-allowance/what-youll-get
• Approximately 25% of those with limited day-to-day activities who lived at home had high blood pressure or hypertension, 45% had high cholesterol, 60% had arthritis, and around half of this group reported severe difficulty walking one quarter of a mile unaided.
• 6.9% of older people who received some form of paid or unpaid care or help at home reported that their overall care and support only sometimes or hardly ever met their needs, i.e. they had unmet need.

It is estimated that the level of unmet need will be increasing because the percentage of people in receipt of care is dropping and the size of the population is rising. In 2010 The Personal Social Services Research Unit (PSSRU) estimated that 800,000 people aged 65 and over in England have unmet care needs. This is considerably higher than Strategic Society estimates and is now thought to be much higher as the number of recipients of social care services has decreased by 335,000, from 1,231,000 in 2005/6 to 896,000 in 2012/13. The number of people aged 65 and over has increased by more than a million people in the same period.

5.5 FUTURE PROJECTIONS

The Personal Social Services Research Unit projected future demand using four key variables: the future numbers of disabled older people, the likely level of demand for long-term care services and disability benefits for older people, the costs associated with meeting this demand and the social care workforce required. They estimated that projected future expenditure on social care and continuing health care will vary depending on future life expectancy:

• Office of National Statistics (ONS) low life expectancy projection - older people with moderate or severe disabilities is projected to rise by 30% (social care & Continuing Health Care (CHC) expenditure rising by 35% in real terms 2010-2022).
• ONS high life expectancy projection - older people with moderate or severe disabilities is projected to rise by 34% (expenditure rising by 40% 2010-2022).

They also report that if rates of chronic disease continue to rise with recent trends there will be a projected increase of 54% of older people with moderate or severe disabilities and a 56% increase in social care & CHC expenditure (2010-2022).

*Projections will remain largely unchanged if the balance of care shifted such that publicly-funded residential care was replaced by an average of around 20 hours per week of home care. However, a shift in the balance of care from informal to formal care could significantly increase projected future public expenditure on social care for older people.*

Implementation of a cap on the amount that an individual pays towards care costs (as per Dilnot Commission) would lead to 25% increase in social care costs in 2022 than if the current means-tested system continued.

---

6 EVIDENCE
This section will explore the following:

- What drives demand for health and social care
- Evidence on how to reduce/delay health and social care demand

6.1 EVIDENCE ON WHAT DRIVES DEMAND FOR HEALTH AND SOCIAL CARE
This section will provide a brief overview of key areas that are known to influence demand for health and social care. There is a strong relationship between age and demand for health and social care. The Kings Fund (2012)\(^{26}\) reviewed emergency bed use among older people and reported that age, deprivation and geographical access are major drivers of emergency bed use.

However, the recent study led by the Centre for Health Economics (South Somerset Symphony project)\(^{27}\) highlighted that multimorbidity was a stronger indicator than age alone. Multimorbidity is defined as the presence of two or more long term conditions (LTC) and is associated with high mortality, reduced functional status, and increased use of both inpatient and ambulatory health care. Multimorbidity will also negatively impact someone’s ability to self manage and can be challenging for clinicians when supporting patients – for example 82% of people with osteoarthritis have at least one other long term condition such as cardiovascular disease, hypertension or depression, which can exacerbate the impact of osteoarthritis\(^{28}\).

A Scottish study used primary care data to review multimorbidity and found that 42% of patients had one or more morbidities and 23% were multimorbid. They reported that the prevalence increased with age and was present in most aged 65 years or over. An important finding however was the absolute number of people with multimorbidity was higher in those younger than 65 years. Deprivation was also a key influence on both onset and prevalence of multimorbidity. Onset occurred 10–15 years earlier in people living in the most deprived areas and the prevalence of both physical and mental health long term conditions (LTC) was 11%, in most deprived area compared to 6% in least deprived. In addition the presence of a mental health LTC increased as the number of physical morbidities increased and was much greater in more deprived people\(^{29}\).

The Global Burden of Disease study (2010)\(^{30}\) report a growing burden of disability, particularly from mental disorders, substance use, musculoskeletal disorders, and falls and recommend that each area deserves an integrated and strategic response. The study found that years lived with disability (YLD) per person by age and sex has not changed substantially from 1990 to 2010 but age-specific mortality has been falling. Therefore the importance of chronic disability is rising. The major causes of YLDs in 2010 were mental and behavioural disorders (including substance abuse and musculoskeletal disorders) and account for more than half of years lived with disability in the UK. Tobacco, high blood pressure and

---

\(^{26}\) Kings Fund (2012). Older people and emergency bed use - Exploring variation
high body mass index account for around 30% of all disability life adjusted years (DALYs) in the UK. Diet and physical inactivity accounted for 14% of UK DALYs in 2010.

The prevalence of obesity-related disabilities among adults is increasing. Obesity is associated with the four most prevalent disabling conditions in the UK: arthritis, back pain, mental health disorders and learning disabilities. In 2013 Public Health England published a report which showed that a third of obese adults have a limiting long term illness or disability compared to a quarter of adults in the general population. Obesity is also a contributory factor to the development of long term conditions such as diabetes and cardiovascular disease. In addition, severe obesity can result in physical and social difficulties which impact on social care.

Social and physical environments also have a significant influence on someone's health and use of health and social care. For example, poor quality housing can drive increased demand in respect of chronic obstructive pulmonary disorder (COPD); housing with trip hazards can increase the potentiality of falls and fractures amongst older people. New accessible housing into which health and care services can be easily delivered reduces the need for acute provision in both health and care services.

Urinary tract infections (UTI) was also identified as a key reason for admissions among older people. The Nuffield trust (2013) reported that UTIs were one of the top ambulatory care sensitive conditions (considered preventable) which disproportionately affected older people and was on the increase. There is limited evidence on UTI related emergency admissions for the elderly population. One review highlighted a number of contributory factors which include the overuse of antibiotics, interpretation of culture results, those using catheters, the incontinent, those receiving antipyretics or analgesics, those who are immunocompromised and the cognitively impaired. A systematic review also found that urgency urinary incontinence is significantly associated with falls in elderly individuals, depression, urinary tract infections, increased body mass index, diabetes and deaths. Another report found that a significant number of continence services are poorly integrated across acute, medical, surgical, primary, care home and community settings. "Although 55-80% of services report themselves as integrated across healthcare settings, only four services across the country fulfil all of the requirements set out in the DH guide "Good Practice in Continence Services". There has been a gradual upward trend in the documentation of the likely cause or type of urinary tract infection. However, a third of people still have no diagnosis written down. The majority of policies regarding the provision of containment products, e.g., pads, include a statement that provision is according to clinical need. However, 66% of primary care sites impose a limit on provision of 4 or less pads per day.

6.2 INTERVENTIONS AND APPROACHES TO DELAY DEMAND ON H&SC
The Kings Fund (2015) identified ten priorities for commissioners to transform the health care system:
   11. Active support for self management

---

32 Institute of Public Care (2011). ADASS Eastern region - Investing in prevention for older people at the health and social care interface
36 Institute of Public Care (2011). ADASS Eastern region - Investing in prevention for older people at the health and social care interface
12. Primary prevention
13. Secondary prevention
14. Managing ambulatory care sensitive conditions
15. Improving the management of patients with mental and physical needs
16. Care co-ordination through integrated health and social care teams
17. Improving primary care management of end-of-life care
18. Effective medicines management
19. Managing elective activity-referral quality
20. Managing emergency activity: urgent care

National Institute for Health and Care Excellence (NICE) guidance shows that identifying those at risk of falls and setting up fracture prevention services for older people can reduce hospital admissions and the need for social care such as admission to a care home. NICE (2013) recommend that older people should be asked routinely whether they have fallen in the past year and that older people who report recurrent falls should be offered a multifactorial falls risk assessment and individualised intervention. Successful intervention programmes include: strength and balance training; home hazard assessment and intervention; vision assessment and referral and medication review with modification/withdrawal.

While it is acknowledged that there is limited evidence on how to reduce UTIs among older people, the following good practice is cited in the literature:

1. Promote prevention messages among patients at risk of UTI (particularly patients with continence problems). This includes:
   a. Maintaining fluid intake
   b. Encouraging complete emptying of the bladder
   c. Personal hygiene
   d. Frequent changing of incontinence pads
   e. Setting reminders or timers for those who are memory impaired to use the bathroom
2. The role of social care and community services to reinforce prevention messages and encourage fluid intake among elderly patients.
3. One of the most important preventive strategies in the elderly is to minimise the use of urinary catheters. Indwelling catheters are a major risk factor for UTI and subsequent sepsis. A review of the appropriateness of catheter use would be beneficial.
4. Review and audit emergency UTI admissions to determine reasons for admission and follow up to inform management.
5. Review of healthcare associated UTIs.

---

DISCUSSION

This report demonstrates a significant challenge for health and social care, both now and in the future. We have an ageing population and NHS data highlights increasing demand on NHS and social services with reductions in budgets.

There is a clear need to change the way we work to make the health and social care systems sustainable for the future. The Kings Fund\textsuperscript{40} identified several common themes across the 10 priorities for health care referred to earlier. These include:

- A more systematic and proactive management of chronic disease to improve health outcomes, reduce inappropriate use of hospitals, and have a significant impact on health inequalities
- The empowerment of patients.
- A population-based approach to commissioning to ensure that we direct resources to the patients with greatest need and redress the ‘inverse care law’. Clinicians involved in CCGs need to shift their focus from the patients that present most frequently in their practice to the wider population that they serve.
- More integrated models of care – from ‘virtual’ integration through shared protocols to integrated teams and in some cases shared budgets and organisational integration,

7.1 WHAT DO WE WANT TO IMPROVE?

Key areas for improvement are summarised below.

1. Better understanding of where we can reduce avoidable demand in the short term

NHS England’s ‘Commissioning for Value’ toolkit has provided some useful insights into areas where both CCGs can reduce spend and improve outcomes. This should be explored further with a particular focus on:

- a. circulation, cancer, respiratory, gastrointestinal and musculoskeletal
- b. Dementia – prevention of emergency admissions, delayed transfers of care, reablement following discharge
- c. Reducing LOS in acute and preventing admissions <1 day

Public Heath England has recently published a report exploring admissions for people with dementia which provides a useful background to commence further review of dementia admissions\textsuperscript{41}. The report notes that improved diagnosis and greater awareness of dementia account for some of the increases in dementia related admissions but also highlights the importance of reducing admissions for those with dementia which can be traumatic and result in significant distress and deterioration of their condition. The review estimates that early intervention can prevent more serious progression for approximately 20% of dementia related admissions (9% were for other diseases of urinary system, 8% for pneumonia and 3% for other acute lower respiratory infections). Reviewers also highlight that 11% of admissions, relate to injuries to head, hip or thigh which indicate that initiatives targeted at people with dementia for slips, trips and falls may be beneficial. Similarly 26% of emergency admissions involving people with dementia were for 1 night or less. Further review indicated that shorter stays in hospital were more likely to be related to ‘symptoms, signs and abnormal clinical and laboratory findings’ and ‘injury,
poisoning and consequences of external causes’ (11% of these related to head injuries). This requires further investigation but indicates that home accident prevention interventions might assist in reducing avoidable admissions. This work can potentially be linked to existing services, such as ‘Herts Healthy Homes’ and dementia services commissioned by health and social care.

2. Prevent / delay disability and poor health in population

NHS England ‘Commissioning for Value’ data and evidence on multimorbidity highlight that a significant proportion of patients experience a range of complex conditions that increase demand for health and social care are younger than 65 years; particularly in deprived areas where onset occurred 10–15 years earlier.

In order to make any impact on delaying future demand for services we need to shift our focus from frailty to proactively addressing the challenges of multimorbidity. This poses a significant challenge as while the evidence is clear that we need to act there is limited evidence on effective interventions to support patients to manage multiple conditions effectively.

3. Take a systems approach prevention and service provision

Considerable progress has been made with Health and Social care integration. Much of the focus for integration has been on those most complex and intensive users of health and social care. This review highlights the need for better coordination of services across the wider system where they are likely to be considerable gains in extend an integrated approach across the whole population and take a systems approach to both prevention and service provision. For example, it is estimated that approximately 25% of the population have two or more long terms conditions yet the NHS is traditionally organised around a single-disease framework by which most health care, medical research, and medical education is configured. This means that individual LTC services can be duplicative and inefficient, and burdensome for patients due to poor coordination and integration and mental health is not consistently core component of LTC pathways. Therefore one priority is to support generalist clinicians to provide personalized continuity of care, especially in deprived areas.

The Kings Fund exemplifies this point in a recent paper highlighting the need to view integrated care as part of a broader shift away from fragmentation, towards an approach focused on improving population health. This requires a move away from accountability for population health that is concentrated in single organisations or within the boundaries of traditional health and care services to a collaborative approach across a range of sectors and wider communities. The Kings Fund note that due to the complex range of influences on population health we need to view this as a “shift in relation to systems rather than organisations. Figure 31 shows how this approach could work at an individual and population level, illustrating how services and prevention approaches can be delivered.
In addition the research led by the Centre for Health Economics\(^4\) concluded that the group of people most appropriate for integrated care arrangements should comprise those with three or more conditions from a set of eight chronic conditions deemed most important by local GPs. The main reasons for selecting this group were:

- This group of patients offered a reasonably high level of predictable cost variation, providing a sufficiently large risk pool for financial management;
- The group incurred costs across all settings, thereby offering the prospect of strengthening links across health, mental health and social care;
- There is an opportunity to reduce inpatient costs, which currently account for 38% of total costs for this group.

4. **Greater role of non NHS services to support prevention**

This review showed that while 45% of those aged 65 years and over were limited in daily activities by a health problem or disability only 6% of those aged 65+ were formally supported by local authority. Non-statutory services therefore play a vital role in terms of providing informal support for older people. If we are to adopt a systems approach to prevention, services outside of the NHS, including the voluntary sector, benefits services, police, fire service and wider communities are integral to this approach both in terms of their reach to vulnerable people and skills.

The promotion of wellbeing and preventing the need for care are key local authority responsibilities. Social care play an important role both in terms of preventing or delaying the need for care and also

https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP96_multimorbidity_utilisation_costs_health_social%20care.pdf
ensuring statutory services embed a preventative approach to maximise independence among its users.
The Care Act (2014) places particular focus on the following areas:

- Promoting wellbeing
- Developing resilience and promoting individual strength
- Developing a local approach to preventative support
- Working with other partners to focus on prevention
- Identifying those who may benefit from preventative support
- Helping people access preventative support
- Assessment of adults’ and carers’ needs

There is also considerable potential to use community services to both identify those at risk and deliver simple prevention messages and healthier lifestyle choices for older people and their carers to support an older person to live more independently. For example, Public Health England\textsuperscript{43} highlight how a partnership approach, working across health, social care and the voluntary section is need to tackle obesity through embedding physical activity and healthy eating support within existing social care pathways and providing a wide range of appropriate physical activity and healthy eating opportunities across a wide range of settings. Another example is ensuring that older people at risk of UTIs maintain adequate fluid intake and encourage complete emptying of the bladder.

This work has already commenced and a prevention strategy focussing on older populations has recently been developed to provide a strategic framework, which aims to support a shift in focus whereby we create an environment, which promotes healthy aging, while at the same time identifying those who might benefit early intervention and support and enable people to remain independent for longer. A joined up approach to prevention will maximise efforts to prevent or delay the progression of chronic disease, promote independence, increase healthy life expectancy, and deliver social, economic and health benefits.

7.2 PRIORITIES AND NEXT STEPS

In response to these growing pressures on health and social care, Hertfordshire's Health and Wellbeing Board has asked commissioners to work with Public Health to create a strategic approach to prevention. The approach is very consistent with many of the priorities identified in The Kings Fund\textsuperscript{44} report and includes the following principles:

- Deliver preventive activities and pathways at all levels, using primary prevention for long and medium term prevention but ensuring a high focus on secondary and tertiary prevention due to current burdens in short and medium term;
- Identify and undertake a series of high impact actions to achieve preventive aims for each track/domain of prevention and seek to reduce variation across the healthcare system for these high impact actions.
- Particular focus on people with established disease. For example, healthy weight, reducing depression and increasing physical activity in people with long term conditions to support improved health, functioning and self management.
- Where evidence is silent or nascent, theory-led innovation with good ongoing monitoring evaluation is needed (an example of this is multimorbidity).


\textsuperscript{44} The Kings Fund (2015). Transforming our health care system: Ten priorities for commissioners. \url{http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf}
Develop pathways that motivate and engage, not just inform and treat. This requires a shift in thinking and culture change where we move away from 'doing to' to 'doing with'.

A number of priorities have been identified which will link into and inform this work. These are summarised below:

<table>
<thead>
<tr>
<th>Priority</th>
<th>Progress to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Better understanding of where we can reduce avoidable demand in the short term</td>
<td>• Hertfordshire hosted an event in June where the CfV data was discussed with CCGs and public health. • Further work is currently under discussion with both CCGs and Public Health England. This will be closely aligned with the 'Strategic Shift to Prevention' work led by the Health &amp; Wellbeing Board,</td>
</tr>
<tr>
<td>a. Further review of priority areas identified in NHS England’s ‘Commissioning for Value toolkit' b. This work may be usefully linked to a locality focus for areas where admission rates are higher and should be linked with the integrated care work. c. There may also be value in reviewing reasons for emergency UTI admissions to inform service development.</td>
<td></td>
</tr>
<tr>
<td>2. Improve our understanding of multi morbidity within Hertfordshire and develop systems which enable us to proactively identify patients requiring assertive case/self management to reduce the demand on health and social care and delay disability or deterioration from established health conditions or complex social care needs. This work should be fed into plans for integrated care using evidence from Centre for Health Economics research.</td>
<td>• A business case has been developed for a population approach to risk stratification. • Risk stratification is closely aligned with the Hertfordshire Self Management Steering Group, led by the Director of Public Health, which will work with the CCGs to embed risk stratification into patient pathways. The Steering Group are also leading a work stream to develop skills among the workforce to support patients with multimorbidity. • A JSNA chapter on multimorbidity is currently under development.</td>
</tr>
</tbody>
</table>

45 Centre for Health Economics (2014). The Importance of Multimorbidity in Explaining Utilisation and Costs Across Health and Social Care Settings: Evidence from South Somerset’s Symphony Project. CHE Research Paper 96, University of York. [https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP96_multimorbidity_utilisation_costs_health_social%20care.pdf](https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP96_multimorbidity_utilisation_costs_health_social%20care.pdf)
<table>
<thead>
<tr>
<th>Priority</th>
<th>Progress to date</th>
</tr>
</thead>
</table>
| 3. Ensure that a system wide approach to prevention is incorporated into service priorities. | • A prevention strategy for healthy ageing has been developed which includes a range of actions focussed on the social and physical environment (e.g. housing, local community infrastructure) to support older people to live independently for as long as possible. The strategy also includes the implementation of Making Every Contact Count (MECC) targeting older people across the wider workforce where frontline are trained to offer brief prevention advice and support to local residents.  
• Public health are undertaking a Carers Health Needs Assessment which will identify opportunities for prevention and priorities to support commissioners  
• A falls prevention strategy is currently under development. These plans need to be fully integrated with wider service provision. |