Index

1
Introduction 6

2
Older people in East Sussex 8
Includes data on: population profiles; income deprivation; proportions of older people from black and minority ethnic groups; percentage of single person households and access to transport.

3
Life expectancy and mortality 22
Contains data on life expectancy by geographical area, all-cause mortality and mortality from specific diseases and conditions, such as cancer, cardio-vascular disease and falls.
What makes older people ill?

Follows up the key areas reviewed in the Older People’s Needs Assessment 2007, namely, stroke, dementia, COPD and falls. Provides additional data on A&E attendance, along with data on the level of illness in relation to mental health, coronary heart disease, cancer and diabetes, as well as outpatient attendances.

Promoting health in old age

Provides information on lifestyles and health promotion campaigns.

Quality counts

Includes information on the latest schemes to improve the quality of health and social care services.

Working together

Outlines how we will work across health and social care to improve the health and wellbeing of the older people of East Sussex.
This is my third annual public health report for NHS Hastings and Rother and NHS East Sussex Downs and Weald and East Sussex County Council (ESCC). I have chosen to focus on older people’s health and wellbeing and emphasise the importance of the quality of services provided for them.

Chapter 2 describes the population, such as the proportions of people aged 65 and over living in different areas of East Sussex. It also provides data on the numbers of older people experiencing poverty in East Sussex and how this impacts on their use of services and the inequalities in health. In East Sussex we have the highest proportion of older people of any county in England and we need to ensure that there is a balance between commissioning services where the greatest concentrations of older people live and also targeting the areas where older people are likely to be in the greatest need, because of social isolation, income deprivation and being aged over 85 years.

Chapter 3 focuses on data concerning life expectancy and mortality of older people. There are technical notes in appendix 1 to help understand how this data is measured and interpreted. There is a variation in life expectancy across East Sussex and work needs to continue to target the Investing in Life programme in areas of lowest life expectancy.

Chapter 4 describes the pattern of illnesses that older people tend to develop such as stroke, dementia, chronic obstructive pulmonary disease (COPD) and the services provided to treat them. Recommendations are made for the local variations in conditions such as COPD, hospital admissions and falls, to be reviewed by Practice Based Commissioning (PBC) clusters to consider alternative service provisions in the community.

Chapter 5 reviews activities for promoting healthy old age and describes work being carried out in East Sussex on areas such as stopping smoking, eating a healthy diet and taking exercise, taking part in screening programmes and having an annual flu jab with the overall benefit of adding years to life and life to years. It’s never too late to improve health by stopping smoking.

Chapter 6 describes the range of quality initiatives that have been taking place and are in development.

Finally, chapter 7 outlines how we work across health and social care in order to improve the health and wellbeing of older people in East Sussex. It is my intention that the findings of this annual public health report will be used to inform the future commissioning of services for older people to better meet their needs.

I would like to acknowledge the hard work and contributions of the public health team in the PCTs and the Adult Social Care team at ESCC for helping to produce this report.

Diana Grice
Director of Public Health
NHS Hastings and Rother
Contributors

Barry Atkins
Ben Banfield
Joanne Bernhaut
Jennifer Broome-Smith
Angela Broomfield
Debbie Charman
Sophie Clark
Rob Cooper
Graham Evans
Steve Hare
Clare Harmer
Rachel Harrington
Joanne Hayward
Beverly Hone
Jennifer Hopkin
Nigel Hussey
Adrian Leah

Cynthia Lyons
Maurice Marchant
Jessie McArthur
Nicky McCrudden
Hannah Messer
Beja Morrison
Kate Naylor
Geraldine O'Shea
Martin Packwood
Se-Yeon Park
Stuart Ramsbottom
Howard Sleeth
Jane Thomas
Richard Watson
Jim White
Lisa Williams
Imran Yunus
Introduction
East Sussex has the highest percentage of people over the age of 85 in any county in England and we expect this number to increase at a fast rate after 2010. The county also has higher than average numbers of all people aged over 65 and this is also expected to increase in the next ten years. Although the black and minority ethnic (BME) population is relatively small we expect the BME elders population to have doubled since the 2001 Census and to do so again in the next ten years. We are improving our data collection and monitoring processes so that we will be able to see if there are significant health inequalities experienced by BME groups in East Sussex.

We have used this information and the views expressed by older people about accessing a range of services — from support with enjoying a healthy and active life to receiving more specialist help when needed — to work with partners in health, housing and social care to develop a Joint Commissioning Strategy for Older People (2007–2010). This strategy details the ambition of East Sussex County Council (ESCC), the NHS in East Sussex and a range of partner organisations in the voluntary and independent sector to work in partnership with older people and carers to improve the experience of people who use their services and to get the most out of available resources.

The strategy describes how health, social care and housing support services will change in the next few years, taking into account national and local priorities and the views of older people and carers. We put together a three year action plan to help us improve services for older people and carers by promoting independence and wellbeing, providing local services and helping people remain in their own homes. 2009/10 is the final year of the current strategy and an action plan and a review will take place shortly in preparation for the development of a new joint commissioning strategy for older people from 2011.

In addition ESCC, the Primary Care Trusts (PCTs) and many partners developed the *Time of our Lives strategy – Improving and promoting quality of later life in East Sussex*. This strategy has been designed to respond directly to what older people have told us about how they can have a healthy and active old age for as long as possible.
Older people in East Sussex
This chapter presents some of the information collated as part of the Joint Strategic Needs Assessment, including population data on the numbers of older people living in East Sussex, projected future trends and data on sub-groups of the population, such as those living in single person households.
East Sussex has the highest percentage of people over the age of 85 of any county in England and this figure is increasing. The county also has higher than average numbers of all people aged over 65 and this figure is also expected to increase over the next ten years.

Table 1: Population aged 65 years or over, East Sussex

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>65–69</th>
<th>70–74</th>
<th>75–79</th>
<th>80–84</th>
<th>85+</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne</td>
<td>4845</td>
<td>4723</td>
<td>4603</td>
<td>3835</td>
<td>4117</td>
<td>22123</td>
</tr>
<tr>
<td>Hastings</td>
<td>3803</td>
<td>3488</td>
<td>2850</td>
<td>2249</td>
<td>2532</td>
<td>14922</td>
</tr>
<tr>
<td>Lewes</td>
<td>5253</td>
<td>4840</td>
<td>4420</td>
<td>3379</td>
<td>3697</td>
<td>21589</td>
</tr>
<tr>
<td>Rother</td>
<td>5868</td>
<td>5577</td>
<td>4874</td>
<td>4129</td>
<td>4216</td>
<td>24664</td>
</tr>
<tr>
<td>Wealden</td>
<td>8242</td>
<td>7282</td>
<td>6348</td>
<td>4691</td>
<td>4769</td>
<td>31332</td>
</tr>
<tr>
<td>East Sussex County</td>
<td>28011</td>
<td>25910</td>
<td>23095</td>
<td>18283</td>
<td>19331</td>
<td>114630</td>
</tr>
</tbody>
</table>

Table 2: Population aged 65 years or over, NHS Hastings and Rother

<table>
<thead>
<tr>
<th>PBC Cluster</th>
<th>65–69</th>
<th>70–74</th>
<th>75–79</th>
<th>80–84</th>
<th>85–89</th>
<th>90+</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexhill Centre</td>
<td>3010</td>
<td>3010</td>
<td>2859</td>
<td>2859</td>
<td>2537</td>
<td>1005</td>
<td>14297</td>
</tr>
<tr>
<td>East Hastings</td>
<td>1597</td>
<td>1359</td>
<td>1037</td>
<td>726</td>
<td>459</td>
<td>225</td>
<td>5403</td>
</tr>
<tr>
<td>St Leonards</td>
<td>2097</td>
<td>1808</td>
<td>1437</td>
<td>1188</td>
<td>898</td>
<td>484</td>
<td>7912</td>
</tr>
<tr>
<td>Rural Rother</td>
<td>2523</td>
<td>2180</td>
<td>1746</td>
<td>1367</td>
<td>834</td>
<td>415</td>
<td>9065</td>
</tr>
<tr>
<td>West Hastings</td>
<td>810</td>
<td>739</td>
<td>592</td>
<td>438</td>
<td>306</td>
<td>164</td>
<td>3049</td>
</tr>
<tr>
<td>NHS Hastings and Rother</td>
<td>10037</td>
<td>9096</td>
<td>7671</td>
<td>6256</td>
<td>4373</td>
<td>2293</td>
<td>39726</td>
</tr>
</tbody>
</table>
The population of NHS Hastings and Rother is 182,000 with nearly 40,000 people aged over 65. There is a wide variation across the PBC clusters*, with less than 15% of people in Lewes aged over 65 in West Hastings and over 31% aged over 65 in Bexhill Centre.

This means that in Bexhill Centre almost one in three people are aged over 65 years of age. In Little Common Surgery in Bexhill Centre over 39% of registered patients are aged over 65.

Figure 1: Percentage of population aged 65 and over

Source: Exeter October 2008 and Mid year population estimates 2007, ONS

* Practice Based Commissioning (PBC) is a government policy which devolves responsibility for commissioning services from Primary Care Trusts (PCTs) to local GP practices. A PBC cluster refers to a group of GP practices working together to provide services for the local population.
There are slightly more women aged over 65 years than men.

In NHS Hastings and Rother, 12.5% of the population are women aged over 65 and 9.3% are men.

The highest proportions of the population aged 65 or over are in these wards: Sackville, Collington, Kewhurst, St Marks, Old Town, St Michaels, Central and Marsham.
In NHS Hastings and Rother, there are over 6,600 residents aged over 85 years (3.7% of the total population). The majority of these (more than 4,600) are women.

The highest proportions of the population aged 85 or over are in these wards: Sackville, Collington, Old Town, Central, St Michaels, Kewhurst, Maze Hill and St Marks.
Between 2001–2016 it is predicted that there will be a 23% increase in the number of people aged over 65 in East Sussex.

Older people who are living on low incomes may be at a higher risk of poor health. Low income is associated with poorer housing and diet, and less access to transport, which can increase social isolation. In particular, this can lead to poorer physical health; older people who report difficulty in managing their income experience earlier onset of disability.

The current financial recession has had a great impact on older people with fixed incomes and has resulted in older people with some savings seeing their incomes fall over the last 18 months.

The Income Deprivation Affecting Older People Index measures the proportion of people aged 60 and over in receipt of benefits and their partners (if also aged over 60).
In NHS Hastings and Rother, 11% of older people are affected by income deprivation. There is a wide variation across the PBC clusters with over one in five older people affected by income deprivation (22%) in West Hastings to just over one in twenty (6%) in Bexhill Centre. Nearly one in three older people registered at Stone Street Surgery (32%) are affected by income deprivation. Over one in five (22%) older people living in Hastings Borough Council are affected by income deprivation compared to over one in ten (12%) in Rother District Council. In Central St Leonards, Tressell, Hollington and Wishing Tree wards, around one in three older people are affected by income deprivation.

Older people who live on their own may be at greater risk of poor mental and physical health. From the 2001 Census over a third of people in East Sussex of pensionable age were living on their own.

In terms of households, just under half of all households with at least one person of pensionable age (47%) are single-occupancy households, with large differences between men and women.

In Hastings 52% households with at least one person of pensionable age are single-occupancy compared to 46% in Rother.

Out of households with at least one older person in them, 73% in Central St Leonards are single-occupancy households, with the lowest ward rate in the county in East Dean where 31% are single-occupancy.

### Table 3: Income deprivation affecting older people by PBC cluster

<table>
<thead>
<tr>
<th>PBC cluster</th>
<th>Percentage older population affected by income deprivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexhill Centre</td>
<td>6%</td>
</tr>
<tr>
<td>East Hastings</td>
<td>15%</td>
</tr>
<tr>
<td>St Leonards</td>
<td>19%</td>
</tr>
<tr>
<td>Rural Rother</td>
<td>7%</td>
</tr>
<tr>
<td>West Hastings</td>
<td>22%</td>
</tr>
<tr>
<td>NHS Hastings and Rother</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: IDAOPI 2007 and Exeter October 2008 population data
East Sussex is a popular retirement area and there are about 6,800 residents, aged 65 or over, in communal establishments (Census 2001). This is about 6% of the population over 65. Just over a fifth of this population are men. There are more women aged 90 years or over in communal establishments than the total of all male communal-establishment residents over the age of 65.

There were around 1,400 people aged over 65 who migrated to Hastings and Rother from mid 2006 to mid 2007 (from elsewhere within the UK).

Recent figures show that across the county there are 306 residential homes and 78 nursing homes, as well as over 8,451 placements in care homes (Source: CSCI).

The ‘old age dependency ratio’ is the ratio of those aged over 65 years to those of current normal working age (16–64 years). For East Sussex this ratio is 0.38 compared to 0.25 for the rest of England. This means that for every ten working age individuals there are almost four residents aged 65 or over.
The ‘oldest old support ratio’ complements the old age dependency ratio. It is an indicator of informal care resources and stands at 8.2 for East Sussex compared to 12.1 for the rest of England. This means that for every dependent over the age of 85, there are potentially around eight ‘informal carers’ aged 50–74. As the potential pool of informal carers is lower, this may, in turn, place a higher demand on formal services.

Almost three-quarters of people aged over 65 in East Sussex live in urban areas with over 10,000 residents, 10% live in other towns and in the fringes, and the remainder live in villages, hamlets and isolated dwellings.

Although there are only a few people from the black and minority ethnic (BME) population in East Sussex, we expect the number aged over 65 to have doubled since the census of 2001 and to do so again in the next ten years. We are improving our service data collection and monitoring processes because we know from national data that there are some health conditions experienced more frequently by BME groups and we want to ensure that the services they need are readily accessible by them. Across East Sussex around 5.2% of older people are from a BME groups. This is lower than both the national percentage of 8.2% and the regional percentage of 6.5%.

* Defined here as persons from a non-White British background
Across NHS Hastings and Rother, Hastings Borough Council has the highest percentage of older people from a BME background, with 5.7%, compared to 4.9% in Rother District Council.

Older people from BME groups may be at greater risk of some physical illness, including diabetes and heart disease. It is important that treatment and health promotion services they need are provided in an accessible and culturally appropriate way.

In addition the PCTs and ESCC have recently commissioned a Comprehensive Needs Assessment for Black and Minority Ethnic Groups and Gypsies and Travellers. Findings from this, including any specific needs for older people, will form part of the Joint Strategic Needs Assessment and inform future commissioning intentions.

**Race for Health**

Race for Health is an NHS-based programme which is being piloted to drive forward improvements in health for people from black and minority ethnic backgrounds. NHS Hastings and Rother joined the programme in 2008 and in March 2009 hosted a peer review to share learning and good practice between PCTs and identify areas of improvement. Action points from the review have been developed into an implementation plan, which will be monitored by the PCTs’ Equality and Diversity Committee.
Key points from chapter 2

— The East Sussex population is older than the national profile with almost 23% of the total population over 65 years of age. This compares with 17% regionally and 16% nationally.

— There is a wide variation in the proportions of older people living in different areas and in their levels of income deprivation.

— Bexhill Centre has the highest proportion of older people in the PCT and they are the least likely to be affected by income deprivation. West Hastings has the lowest proportion of older people in the PCT, though they are likely to experience the greatest income deprivation.

— In NHS Hastings and Rother, 11% of older people are affected by income deprivation.

— 5.2% of older people are from BME backgrounds and this number is expected to have doubled since the census in 2001.

— East Sussex is a popular retirement area and there are a large number of older people living alone and in residential or nursing homes.

— There were around 1,400 people aged over 65 who migrated to Hastings and Rother from mid 2006 to mid 2007 (from elsewhere within the UK).

— The ‘old age dependency ratio’ is the ratio of those aged over 65 years to those of current normal working age (16–64 years). For East Sussex this ratio is 0.38 compared to 0.25 for the rest of England.

— The ‘oldest old support ratio’ complements the old age dependency ratio. It is an indicator of informal care resources and stands at 8.2 for East Sussex compared to 12.1 for the rest of England.
Recommendations from chapter 2

— The demographic information about older people from the Joint Strategic Needs Assessment reports should be regularly updated and monitored and used to ensure effective service planning to meet the needs of older people for the next three to five years.

— The issues of social isolation and rurality need to be tackled in commissioning health and social care services.

— The services commissioned across health and social care should be balanced between locating them in areas of greatest concentration of older people and also targeting those groups of older people who are likely to be in greatest need – socially isolated, income deprived and people aged over 85 years.

— Practice-based commissioning (PBC) clusters and practices with high proportions of older people in greatest need should develop accessible services to improve health and wellbeing as part of their cluster plans.

— The particular needs of older people from BME groups will be further informed by the comprehensive needs assessment work being undertaken. The findings will need to be implemented by the Race for Health programme and the services commissioned.

— The importance of the support provided for older people by their carers is recognised. Services to ensure the wellbeing of carers need further development and this will be informed by the learning from the Carers’ Strategy Demonstrator Site (Carers Support initiative).
Life expectancy and mortality
This chapter presents some life expectancy figures relating to the average number of years that residents in different parts of the county are living beyond the age of 65, and the patterns of death from major diseases including cancer and coronary heart disease in older people in East Sussex.

Some of the tables contain black lines representing the confidence intervals of the information. The confidence intervals show the range of values in which we can be 95% confident that true value lies. Therefore when comparing values, we can only say there is a ‘statistically significant difference’ between the values when the confidence intervals do not overlap. There are technical notes in appendix 1 to help further understand how this data is measured and interpreted.
Life expectancy

Overall life expectancy in East Sussex at the age of 65 years is an additional 18.5 years for men and 21.1 years for women. Both sexes are living more than a year longer than the average life expectancy figure for England.

Life expectancy at age 65

Figures 7 and 8 show PCT and GP practice cluster figures, separately for men and women. East Sussex is used as the standard population for calculating these figures. They were produced from ward level life expectancy data apportioned according to the distribution of populations across wards within each cluster.

It should be noted that ward level rates are shown here only for persons (map in Figure 9) and not by sex. Figures for men and women have not been produced as numbers across many of the age ranges are zero or very small.

Increased longevity is much more desirable if it is accompanied by good health. Healthy life expectancy is defined as the years of good or fairly good perceived health. There is variation within the county with the lowest healthy life expectancy in Hastings (12.2 for men and 14.2 for women) and the highest in Wealden (14.8 for men and 17.0 for women).

All districts have significantly higher healthy life expectancy than England except for Hastings borough where there is no significant difference.

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>12.5</td>
<td>14.5</td>
</tr>
<tr>
<td>South East</td>
<td>13.7</td>
<td>15.8</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>13.4</td>
<td>16.3</td>
</tr>
<tr>
<td>Hastings</td>
<td>12.2</td>
<td>14.2</td>
</tr>
<tr>
<td>Lewes</td>
<td>14.6</td>
<td>16.8</td>
</tr>
<tr>
<td>Rother</td>
<td>13.9</td>
<td>16.4</td>
</tr>
<tr>
<td>Wealden</td>
<td>14.8</td>
<td>17.0</td>
</tr>
</tbody>
</table>

Source: ONS. Data relates to 1999–2003

Investing in Life

In order to reduce death rates and premature death, the PCTs have invested in a health inequalities reduction strategy called Investing in Life. This is a local initiative that is aimed at reducing inequalities in life expectancy across East Sussex by targeting health improvement services at the 20 wards with the lowest life expectancy.

As part of Investing in Life, additional services to help people stop smoking have been offered. GPs are also being encouraged to prescribe medications called statins and aspirin to those eligible, to help prevent heart disease and stokes.

Projects and programmes are in place to promote a healthy diet and exercise which, as part of a comprehensive programme of interventions for reducing heart disease, can markedly reduce the number of early deaths.
Figure 7: Life expectancy at age 65 by district / borough

Source: ONS (deaths 2005–2007)

Figure 8: Life expectancy at age 65 by PBC cluster

Source: ONS (deaths 2005–2007) and Exeter for population data
Disability-Free Life Expectancy

Disability-Free Life Expectancy (DFLE) defines healthy life as years free from limiting long-standing illness. The DFLE, at 65 years of age, is below the England and South East regional average in Hastings borough though not significantly. All other districts have significantly higher disability-free life expectancy than England.

Mortality

Older people experience higher mortality and the increase is significantly higher amongst the oldest age groups, particularly those over 85 (see Figure 12).
Figure 10: Disability-free life expectancy at age 65 – men


Figure 11: Disability-free life expectancy at age 65 – women

All-cause mortality

The directly age-standardised rates (DSR) of mortality from all causes has been consistently lower for both men and women, of all ages, living in East Sussex compared to the rest of England for more than a decade. More specifically, the DSR of mortality from all causes among residents aged 65 years and over is significantly lower than the comparable England rate.

The age-specific death rate for both men and women aged over 65 years living in the NHS Hastings and Rother area is similar to comparable rates for England.

By mapping deaths to PBC clusters according to their population distribution across wards, it is possible to calculate whether mortality at a PBC cluster level is above or below what would be expected if they experienced the same mortality rates as East Sussex as a whole.
Figure 13: Average age-specific mortality rates for all causes for ages 65–74, 2005–2007

Source: Compendium of Clinical and Health Indicators

Figure 14: Average age-specific mortality rates for all causes for ages 75 and over, 2005–2007

Source: Compendium of Clinical and Health Indicators
At PBC cluster level, St Leonards-Lower has a significantly higher mortality rate than East Sussex.

The main causes of death in East Sussex among older people are shown in figures 16 and 17, to the right.

The main causes of death in those aged 65 or over in East Sussex is similar to the national picture, with slight differences seen between men and women.

The main cause of death in both men and women are diseases of the circulatory system (38% and 43% respectively). Cancers are second and cause around a fifth of the deaths in women (21%) and 29% of deaths in men. Respiratory disease is the third most common cause of death.

**Mortality from Circulatory Diseases**

Circulatory disease includes coronary heart disease and stroke is the commonest cause of death in those aged 65 years and over in East Sussex.

**Mortality from coronary heart disease**

The data in Figure 17 from 2005–2007 shows that the DSR for mortality from coronary heart disease in people aged 65–74 living in East Sussex is 223 per 100,000 of the European Standard Population (ESP). This is significantly lower than the DSR for England at 329 per 100,000. This has been the case since 1993.

Source: ONS, CACI ward population estimates and Exeter populations
Figure 16: Causes of death among men aged 65 and over resident in East Sussex, 2005–2007

Source: Vital Statistics 2007, ONS

Figure 17: Causes of death among women aged 65 and over resident in East Sussex, 2005–2007

Source: Vital Statistics 2007, ONS
Figure 18: Directly standardised mortality rates from coronary heart disease (ICD 10 I20–I25) for ages 65–74, 2005–2007

Source: Compendium of Clinical and Health Indicators

Figure 19: Directly standardised mortality rates from stroke (ICD10 I60–I69) for ages 65–74, 2005–2007

Source: Compendium of Clinical and Health Indicators
Mortality from stroke

Mortality from stroke is low in East Sussex compared to the rest of England with small variations across the districts and boroughs. NHS Hastings and Rother has a lower rate than nationally, although not significantly.

Mortality from cancer

Cancer occurs in many forms and has different causes and outcomes.

Around one in five male deaths from cancer in those aged 65 and over in NHS Hastings and Rother is for lung cancer.

Table 5: Five main cancers that cause mortality in men, 2007

<table>
<thead>
<tr>
<th>ICD 10</th>
<th>Cancer of:</th>
<th>No. of deaths</th>
<th>% of cancer deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>C33–C34</td>
<td>Trachea, bronchus and lung</td>
<td>59</td>
<td>24%</td>
</tr>
<tr>
<td>C61</td>
<td>Prostate</td>
<td>46</td>
<td>19%</td>
</tr>
<tr>
<td>C18</td>
<td>Colon</td>
<td>20</td>
<td>8%</td>
</tr>
<tr>
<td>C19–C21</td>
<td>Rectosigmoid junction, rectum and anus</td>
<td>14</td>
<td>6%</td>
</tr>
<tr>
<td>C25</td>
<td>Pancreas</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>All other cancers</td>
<td>95</td>
<td>39%</td>
</tr>
<tr>
<td>C00–C97</td>
<td>Total cancers</td>
<td>245</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Vital statistics, ONS

Table 6: Five main cancers that cause mortality in women, 2007

<table>
<thead>
<tr>
<th>ICD 10</th>
<th>Cancer of:</th>
<th>No. of deaths</th>
<th>% of cancer deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>C33–C34</td>
<td>Trachea, bronchus and lung</td>
<td>37</td>
<td>17%</td>
</tr>
<tr>
<td>C50</td>
<td>Breast</td>
<td>32</td>
<td>14%</td>
</tr>
<tr>
<td>C18</td>
<td>Colon</td>
<td>18</td>
<td>8%</td>
</tr>
<tr>
<td>C56</td>
<td>Ovary</td>
<td>18</td>
<td>8%</td>
</tr>
<tr>
<td>C25</td>
<td>Pancreas</td>
<td>9</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>All other cancers</td>
<td>107</td>
<td>48%</td>
</tr>
<tr>
<td>C00–C97</td>
<td>Total cancers</td>
<td>394</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Vital statistics, ONS
Prostate cancer is the second most common cancer that causes mortality in men (Vital Statistics, 2007 ONS). Breast cancer is the most common cancer that causes mortality in women.

Within NHS Hastings and Rother the DSR of mortality from all cancers in men aged between 65–74 years is higher than the England average, using data from 2005–2007. It is lower than the England average in the case of women of the same age group.

Overall, the mortality from all cancers for people aged 65–74 is lower for those living in East Sussex compared to the England average and has been since 1993. Mortality from cancer is lower in women than men across all districts / boroughs in the county, with significant differences between the sexes in Hastings borough, Rother district and East Sussex county, as well as nationally.

**Mortality from respiratory diseases**

Respiratory diseases include conditions such as asthma, pneumonia, bronchitis, emphysema and chronic obstructive pulmonary disease. Respiratory mortality is associated with social inequalities.

There is a difference in the age distribution for deaths from pneumonia compared to age at death for all other respiratory diseases. Deaths from pneumonia occur more in the elderly population.

For 2005–2007, 69% of pneumonia deaths in East Sussex were in those aged 85 years and over, compared to 41% of deaths for other respiratory diseases.

**Excess winter deaths and excess summer deaths**

Excess mortality related to temperature extremes is an important public health issue, potentially amenable to effective interventions. Up until the summer of 2003, the main public health concern regarding temperature variation was that older people were at risk of increased mortality due to drops in temperature and problems with heating homes and keeping warm.

Local authority and health campaigns that tie in with promotion of the winter flu jab, aim to alert older people to benefits they may be entitled to and give tips on insulation and other heat saving measures.

Since the summer heatwave of 2003, the risks associated with excess heat are now being considered and addressed. The 12 warmest years on record within the past 150 years have been during the past 13 years: 1998 was the warmest, followed by 2005, 2002, 2003, and 2004. The Intergovernmental Panel on Climate Change (IPCC) states that the evidence for global warming is unequivocal and is due to human activity (Costello, 2009).

This means that excess summer deaths will be monitored and community nursing staff and social services leads are provided with information for patients, clients and staff before the start of the summer. A heatwave alert system is in place.

ESCC has developed a Climate Change Strategy to reduce carbon emissions and respond to environmental changes. The PCTs will be key partners in the implementation of this work.
Figure 20: Directly standardised mortality rates from all cancers (ICD10 C00–C99) for ages 65–74, 2005–2007

Source: Compendium of Clinical and Health Indicators

Figure 21: Indirectly standardised mortality ratios from respiratory diseases (excluding pneumonia) for ages 65 and over, 2005–2007, East Sussex = 100

Source: ONS Public Health Mortality Files
Figure 22: Indirectly standardised mortality ratios from pneumonia for ages 65 and over, 2005–2007, East Sussex = 100

<table>
<thead>
<tr>
<th>Location</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne</td>
<td>99</td>
</tr>
<tr>
<td>Hastings</td>
<td>125</td>
</tr>
<tr>
<td>Lewes</td>
<td>63</td>
</tr>
<tr>
<td>Rother</td>
<td>102</td>
</tr>
<tr>
<td>Wealden</td>
<td>99</td>
</tr>
<tr>
<td>NHS HR</td>
<td>110</td>
</tr>
</tbody>
</table>

Figure 23: Excess winter deaths in the South East, 1991–1992, to, 2007–2008

Falls and accidents

Falls and accidents are a comparatively low cause of mortality when seen alongside circulatory diseases and cancer. However, some of them are preventable and there are particular measures that can be taken to prevent falls and accidents in older age groups that are discussed in the next chapter.

Mortality from accidents, which includes falls, is significantly higher than the England rate in Eastbourne district, with higher than national rates in both men and women.

Hip fracture is a common serious injury related to falls in older people. Mortality rates from fractured neck of femur are lower across East Sussex than nationally in the 65–84 years age group.

In those aged 85 years and over, Eastbourne district has the highest mortality rate and is significantly higher than the national average in men (SMR for men is 206, 95% CI 120, 386 with England as the standard).

Figure 24: Indirectly standardised mortality ratios from accidents for ages 65 and over, 2005–2007. England = 100

Source: Compendium of Clinical and Health Indicators
Figure 25: Indirectly Standardised Mortality Ratios from fracture of femur (ICD10 S72) for ages 64–84, 2005–2007. England = 100

Source: Compendium of Clinical and Health Indicators

Figure 26: Indirectly Standardised Mortality Ratios from fracture of femur for ages 85 and over, 2005–2007. England = 100

Source: Compendium of Clinical and Health Indicators
Figure 27: Percentage of people aged 65 and over who died at home

![Bar chart showing percentage of people aged 65 and over who died at home in different areas.]


End of life

An End of Life Care Strategy for East Sussex was completed in December 2008.

The strategy’s aim is that people in East Sussex who have been diagnosed with a life limiting illness should have choices in their end of life care. This will enable people to die at home, rather than in hospital, if that is their wish.

There is a variation across the county in the percentage of people aged 65 and over who died at home. In Hastings borough, 18% of people aged 65 years or over died at home during 2007, compared to 30% in Rother.

End of life care may occur in hospital when the need for additional pain control or nursing care for the dying person becomes difficult to manage in other settings.

However, local hospices are key specialists, with a wealth of expertise and we intend to work more closely with them and other care providers, to ensure that improvements recommended in the strategy are made.
Key points from chapter 3

— The life expectancy in East Sussex at the age of 65 is an additional 18.5 years for men and 21.1 years for women.
— There is variation of life expectancy at 65 within NHS Hastings and Rother, the lowest in St Leonards Lower with 16.3 for men and 18.7 for women, to the highest in Rural Rother at 18.8 for men and 21.7 for women.
— The age-specific death rate for people living in East Sussex is lower than the rest of England except for men and women over 75 living in Hastings. At PBC cluster level, St Leonards Lower has a significantly higher mortality rate than East Sussex.
— The main causes of death in those over 65 years in East Sussex are similar to the national picture – circulatory diseases, cancers and respiratory diseases.
— The death rate from stroke is lower in East Sussex than the national rate.
— Death rates from cancers in men aged 65–74 in NHS Hastings and Rother is higher than England.
— The main cause of cancer death in NHS Hastings and Rother is lung cancer in men and breast cancer in women.
— Death rates for pneumonia and also for all other respiratory diseases in NHS Hastings and Rother are above that for East Sussex, especially in Hastings.
— Older people are at risk of increased mortality due to extremes of temperatures.
— There is a variation across East Sussex of the percentage of people over 65 years who die at home, from 17.7% in Hastings borough to 29.7% in Rother district.
Recommendations from chapter 3

— Ensure the implementation of the Investing in Life programme in the areas of lowest life expectancy.

— Reduce the mortality rate from pneumonia and other respiratory diseases in the Hastings borough by increasing investment in the chronic obstructive pulmonary disease (COPD) local enhanced GP service (see chapter 4) and stop smoking services.

— Ensure implementation of East Sussex Climate Change Strategy to reduce carbon emissions and respond to impacts of environmental change now occurring.

— Ensure implementation of the Joint End of Life Care Strategy and further development of a co-ordinated range of extended-hours services to support people to die at home if they wish at the end of their life, especially in Hastings.

Costello, A et al (2009)
*Managing the health effects of climate change*,
The Lancet and University College London Institute for Global Health Commission

East Sussex End of Life Care Strategy (2008)
NHS Hastings and Rother
NHS East Sussex Downs and Weald
What makes older people ill?
This chapter sets out the key data on illnesses that affect older people in East Sussex.

Adding ‘years to life’ and ‘life to years’ is a key public health goal. It is therefore important to monitor the extent to which older people are experiencing health problems, so that appropriate services can be provided to meet their needs.

As people age they tend to use health and social care services more as the frequency of most illnesses and ill health rises with increasing age. It has been estimated that older people account for 43% of the total NHS budget, occupy 65% of hospital beds and receive 71% of social care packages (Department of Health, 2007).

A health needs assessment was conducted into older people’s health in East Sussex in 2007. This chapter provides an update on issues concerning the disease groups that the needs assessment concentrated on: stroke; dementia; COPD and falls (stroke, respiratory diseases and falls have also been discussed in chapter 3 of this report). It also provides information on hospital usage by older people including: A&E attendances; emergency admissions; mental health; coronary heart disease; cancer; diabetes and outpatient attendances.
Stroke

A stroke is a potentially life-threatening event in which parts of the brain are deprived of oxygen. The most common type of stroke is an ischaemic stroke, which involves a blockage of blood, usually in the form of a blood clot, that supplies oxygen to the brain. The other main type of stroke is a haemorrhagic stroke, which involves bleeding in or around the brain.

---

Findings from Older People’s Needs Assessment, 2007:

It is estimated that there are 1,150 first strokes per year in East Sussex currently, rising to 1,350 by 2016. Over half of these will be aged 80 years or over. It will become more common as the population ages. If we assume that 25% of people die early after a stroke, and 70% of the remainder need rehabilitation, then there are about 607 East Sussex residents suitable for organised stroke care per year. Providing this form of care would save about 20 lives per year and enable about 32 people to be discharged home rather than to institutional care. About 9% will be left with severe residual disability. This equates to around 80 people per year in East Sussex.

Early in 2009 a new East Sussex Stroke Strategy was agreed by the PCT board. It makes a total of 63 recommendations to be implemented over the next three years to improve on the quality of stroke services for people living in East Sussex. These recommendations focus on:

- raising awareness of stroke among the public and professionals
- primary prevention of stroke and transient ischaemic attack (TIA)
- access to advise, advocacy and information
- assessment and treatment of stroke and transient ischaemic attack
- discharge and rehabilitation
- long term care and support
- supporting principles.

Progress against the recommendations will be monitored by an East Sussex Stroke Improvement Board.

Key areas that have been improved recently and which will be developed further in 2009 include: prevention and awareness of the symptoms of stroke; 24 hour access to thrombolysis; the redesign of acute stroke units to ensure direct admission; and specialist assessment and diagnostics.

New services, many developed jointly with Adult Social Care, will also be provided to support people who have had a stroke and their families in the community and all stroke survivors will be offered peer volunteer support on returning home. People who have had a stroke will, in addition, be offered leisure or community centre sessions involving exercise and interactive education.

It is estimated that across NHS Hastings and Rother 6.7% of people aged 65–74 and 11.6% of people aged 75 and over have had a stroke. This is higher than the national estimates of 6.4% and 11.2% respectively.

The estimated rates in Rother District Council are 5.9% and 10.4% respectively, which are lower than the PCT and national estimates.
In NHS Hastings and Rother in 2007/08 there were 3,917 persons of all ages on a primary care stroke register which accounted for 2.2% of all patients registered with GPs. This was higher than the national rate (1.6%) and regional rate (1.7%).

Table 7 shows age-specific emergency hospital admission rates for stroke. Admission rates increase with age, with 18.4 admissions per 1,000 population aged 85 years and over compared to 2.3 in those aged 65–69 in East Sussex.

Emergency hospital admissions ratios for stroke are shown in figures 28 and 29 (East Sussex is the standard -100).

There are around 400 emergency stroke admissions from NHS Hastings and Rother patients a year.

Emergency hospital admissions rates for stroke are significantly higher in Hastings borough than would be expected (if the borough had the same rates as the county). Rother district also has higher admissions than East Sussex, although not significantly.

### National Stroke Sentinel Audit

The National Sentinel Audit of Stroke takes place every two years. The audit measures stroke service organisation and care against the National Clinical Guidelines for Stroke. It enables hospitals and PCTs to compare the quality of their stroke services both nationally and regionally and measures changes in quality of care for stroke patients.

The audit gathers data on a range of indicators to show the quality of care provided, with nine of these indicators identified as being particularly important factors in high quality care. Table 8 shows the percentage of patients receiving optimum treatment or assessment across these nine areas for each of the main hospitals used by East Sussex patients.

<table>
<thead>
<tr>
<th>NHS HR</th>
<th>65–69</th>
<th>70–74</th>
<th>75–79</th>
<th>80–84</th>
<th>85+</th>
<th>Total (65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS HR</td>
<td>2.8</td>
<td>4.7</td>
<td>8.9</td>
<td>13.8</td>
<td>23.5</td>
<td>9.6</td>
</tr>
<tr>
<td>East Sussex</td>
<td>2.3</td>
<td>4.3</td>
<td>7.3</td>
<td>11.3</td>
<td>18.4</td>
<td>7.8</td>
</tr>
</tbody>
</table>

Source: SUS hospital episode extracts 06/07–08/09, Exeter Oct 2008 population figures
Figure 28: Indirectly standardised admission ratios for stroke (ICD10 I60–I69) for ages 65 and over, April 2006–February 2009. East Sussex = 100

Source: SUS hospital episode extracts, CACI 2008 ward population estimates

Figure 29: Indirectly standardised admission ratios for stroke (ICD10 I60–I69) for ages 65 and over, April 2006–February 2009. East Sussex = 100

Source: SUS hospital episode extracts, Exeter Oct 2008 population figures
In 2007, the National Stroke Strategy recommended that everyone with a suspected acute stroke should receive an MRI scan within 24 hours. The low levels achieved at East Sussex Hospitals Trust in 2008 are a concern and they already have taken steps to improve this position. We have agreed that they will achieve a target of 90% in 2009/10 as part of the local Commissioning for Quality and Innovation scheme (CQUIN, discussed in chapter 6) process. It has also been identified as one of the PCT’s World Class Commissioning ten health outcome measures for 2009/10.

In addition the PCTs’ Quality Improvement and Clinical Outcomes Group (QICOG) has selected a number of other indicators of the quality of stroke services which will be monitored by the PCTs:

- the percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months
- the percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less

Table 8: Percentage of patients receiving treatment or assessment, National Sentinel Audit 2008

<table>
<thead>
<tr>
<th>Measure</th>
<th>Royal Sussex County Hospital (BSUH Trust)</th>
<th>Princess Royal Hospital (BSUH Trust)</th>
<th>Conquest Hospital (ESH Trust)</th>
<th>Eastbourne District General Hospital (ESH Trust)</th>
<th>Kent and Sussex Hospital (MTW Trust)</th>
<th>Maidstone Hospital (MTW Trust)</th>
<th>National (all hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swallowing screen within 24 hours</td>
<td>98</td>
<td>88</td>
<td>66</td>
<td>70</td>
<td>69</td>
<td>54</td>
<td>72</td>
</tr>
<tr>
<td>Brain scan within 24 hours</td>
<td>82</td>
<td>72</td>
<td>36</td>
<td>46</td>
<td>80</td>
<td>73</td>
<td>59</td>
</tr>
<tr>
<td>Physio assessment within 72 hours</td>
<td>98</td>
<td>90</td>
<td>90</td>
<td>90</td>
<td>55</td>
<td>78</td>
<td>84</td>
</tr>
<tr>
<td>OT assessment within 4 working days</td>
<td>65</td>
<td>42</td>
<td>63</td>
<td>65</td>
<td>5</td>
<td>64</td>
<td>66</td>
</tr>
<tr>
<td>Weighed</td>
<td>96</td>
<td>73</td>
<td>98</td>
<td>100</td>
<td>70</td>
<td>64</td>
<td>72</td>
</tr>
<tr>
<td>Mood assessed</td>
<td>98</td>
<td>28</td>
<td>74</td>
<td>92</td>
<td>43</td>
<td>71</td>
<td>65</td>
</tr>
<tr>
<td>Rehabilitation goals agreed</td>
<td>100</td>
<td>88</td>
<td>96</td>
<td>81</td>
<td>59</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td>Aspirin within 24 hours</td>
<td>98</td>
<td>97</td>
<td>64</td>
<td>81</td>
<td>86</td>
<td>86</td>
<td>85</td>
</tr>
<tr>
<td>90% of stay on a Specialist Unit</td>
<td>61</td>
<td>60</td>
<td>57</td>
<td>58</td>
<td>48</td>
<td>13</td>
<td>58</td>
</tr>
</tbody>
</table>

Source: SUS hospital episode extracts 06/07–08/09, Exeter Oct 2008 population figures
— the proportion of A&E patients admitted to a stroke unit within a certain time period
— deaths within seven days of admission
— deaths within 30 days of admission
— average length of stay in hospital.

Dementia

People aged over 85 constitute 17% of the total population aged over 65 in East Sussex, but make up 51% of those with dementia.

Findings from the Older People’s Needs Assessment, 2007:

Dementia is a progressive loss of memory and other cognitive functions. It progressively undermines older people’s independence, leading to complex patterns of severe disability in advanced cases. The two main causes of dementia are Alzheimer’s disease and cerebrovascular disease. The cause and risk factors for Alzheimer’s disease are unknown. Vascular dementia is caused by damage to the brain’s blood supply. The frequency of dementia increases with age and the disease is quite common over the age of 80 years.

Most people with dementia live in the community, although, once the disease becomes severe, most move into care. However, there are many people with marked disability due to dementia living in the community. Few interventions used in dementia are informed by research evidence of their effectiveness. One exception is cholinesterase drugs, which have a limited role.

The Department of Health’s Dementia Strategy, published in February 2009, lists 17 objectives where outcomes for local people should be improved and the PCT and ESCC are putting plans in place to implement these.

The data in Table 9 shows the predicted and known numbers of patients with dementia. The known numbers are from the dementia registers as part of the Quality and Outcomes Framework data on GP records (the dementia register is all ages though the majority would be aged over 65).

The predicted numbers are calculated by applying national prevalence estimates to local population data*. All PBC clusters have a much higher predicted number of patients with dementia than can be seen on their QoF registers.

Table 9: Predicted and known patients with dementia

<table>
<thead>
<tr>
<th>PBC Cluster</th>
<th>QOF register</th>
<th>Expected number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexhill Centre</td>
<td>544</td>
<td>1408</td>
</tr>
<tr>
<td>East Hastings</td>
<td>163</td>
<td>418</td>
</tr>
<tr>
<td>St Leonards</td>
<td>295</td>
<td>710</td>
</tr>
<tr>
<td>Rural Rother</td>
<td>180</td>
<td>733</td>
</tr>
<tr>
<td>West Hastings</td>
<td>71</td>
<td>261</td>
</tr>
<tr>
<td>NHS Hastings and Rother</td>
<td>1253</td>
<td>3530</td>
</tr>
</tbody>
</table>

Source: East Sussex JSNA scorecards July 2009

* Doncaster Model
Table 10: Age-specific hospital admission rates where primary diagnosis is dementia. Rates per 1,000 population

<table>
<thead>
<tr>
<th></th>
<th>65–69</th>
<th>70–74</th>
<th>75–79</th>
<th>80–84</th>
<th>85+</th>
<th>Total (65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Sussex</td>
<td>0.1</td>
<td>0.3</td>
<td>0.5</td>
<td>1.6</td>
<td>1.9</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Source: SUS hospital episode extracts 06/07–08/09, Exeter Oct 2008 population figures

Table 10 shows age-specific hospital admission rates for dementia (where dementia is the primary diagnosis). Admission rates increase with age.

**Early intervention services for people with dementia**

As highlighted in the national Dementia Strategy, early recognition and detection of dementia enables patients, their families and clinicians to plan more effectively for the future. Building on an innovative pilot funded by the Department of Health through Adult Social Care, the Memory Assessment Support Team provides an early intervention service for people in Hastings and Rother identified as having issues with memory and cognitive functioning. Referred to the team by a GP, an initial cognitive assessment is carried out and a second feedback session with a clinical psychologist is arranged. The client and carer receive a range of support from the team which can include information, learnt coping strategies, out-reach support and group work opportunities. In 2008/09, 257 people were referred to the service, of whom almost 60% were women. The majority of referrals (around 70%) were for people aged 75 years and over. From October 2009 three dementia advisors will be operating across East Sussex.

This is a partnership between the PCTs, ESCC and the Alzheimer’s Society and this will provide a personalised point of contact providing information support and guidance for individuals diagnosed with Alzheimer’s Disease and their carers throughout their journey through the health and social care system.

The existing Psychiatric Liaison Service, which provides support for inpatients across both District General Hospital sites in East Sussex, will be expanded in the late autumn. This will enable a larger number of those people who have a pre-diagnosis of dementia prior to a hospital stay and those who are identified as a result of a hospital stay to be supported and discharged in the most appropriate manner. The extended team will also provide ongoing formalised training for acute staff so they are better able to deal with the needs of those with Dementia and their carers. The Sussex Partnership NHS Foundation Trust will develop a plan by September 2009 to provide an in-reach service to care homes within East Sussex to help these homes to support and care for those with cognitive impairment, as part of its Commissioning for Quality and Innovation (CQUIN) scheme.
Chronic Obstructive Pulmonary Disease (COPD)

COPD is a respiratory disease caused by damage to the lungs over many years. This is usually caused by smoking, although breathing in other poisonous chemicals (including coal dust) can also cause COPD. The main symptoms of COPD are coughing and getting short of breath. Although there is no cure for COPD, there are treatments that can help to stop it getting worse. People who smoke are provided support to help stop.

In England in 2006, it was estimated that 8.1% of people aged between 65–74 years and 8.9% of those over 75 years had COPD (Eastern Region Public Health Observatory, 2008).

The estimated prevalence in Hastings (7.9% and 8.5%, respectively) was higher than the PCT estimates (of 7.4% and 8.2%).

In NHS Hastings and Rother in 2007/08 there were 2,886 persons of all ages on a primary care COPD register which accounted for 1.6% of all patients registered with GPs. This was higher than the national (1.48%) and regional rates (1.3%).

Emergency respiratory admissions

A&E attendance may result unplanned admission. Here we set out data on respiratory cases. There are just under 3,000 emergency respiratory hospital admissions for East Sussex over one year. At ward level there is an association with older people who are income deprived (using IDApoi, IMD 2007), with 34% of the variation in admission rates at ward level explained by income deprivation affecting older people.

Findings from Older People’s Needs Assessment, 2007:

Estimated prevalence is between 4–10%. Assuming prevalence is at the lower end of the range, it is estimated that there will be approximately 4,500 patients with COPD rising to 5,500 by 2016. Prevalence may be higher in Hastings where there are more areas of severe deprivation and higher prevalence of smoking. This is supported by the higher death rates there. Assuming a prevalence of 6–8% the numbers will be in the region of 900–1200 rising to 1100–1400 by 2016.

Men are more likely to be admitted to hospital with COPD than women. COPD is usually caused by smoking. Smoking prevention and cessation programmes have great potential in preventing the disease. Several interventions are of value in treating COPD, including pulmonary rehabilitation and non-invasive ventilation.

In NHS Hastings and Rother there are six wards that have higher admissions than expected when compared to the East Sussex admission rate for emergency respiratory admissions (Silverhill, Baird, Hollington, Ashdown, Wishing Tree and Ore). With the exception of Ashdown, the other five wards are amongst the wards with the highest levels of income deprivation affecting older people in the county.

There is a variation in emergency respiratory admissions rates across NHS Hastings and Rother PCB clusters. St Leonards and West Hastings have significantly higher admissions than would be expected.
Figure 30: Indirectly standardised emergency admission ratios for respiratory diseases (ICD10 J00–J99) for ages 65 and over, April 2006–February 2009, East Sussex = 100

Source: SUS hospital episode extracts, CACI 2008 ward population estimates

Figure 31: Indirectly standardised emergency admission ratios for respiratory diseases (ICD10 J00–J99) for ages 65 and over, April 2006–February 2009, East Sussex = 100

Source: SUS hospital episode extracts, Exeter Oct 2008 population figures
Services for People with COPD

The aim is to provide integrated specialist services for COPD patients across community, primary and secondary care.

Once people are diagnosed with COPD, they will be given structured education and advice, along with regular reviews, according to individual need.

Plans are made to support patients’ early discharge from hospital if admission is required, arrangements for pulmonary rehabilitation, improved management of home oxygen and education for carers, families and staff in addition to the patients. Social care support will be available and this will include assistive technology such as aids and equipment, and also telecare services. Written management plans detailing individual targets, necessary actions and contact details will be made available with close monitoring of the care that is given.

The specialised service should enable patients to better manage their condition in partnership with health care professionals, thus improving patient care and experience.

Services for COPD have been successfully commissioned in NHS Hastings and Rother through practice based commissioning by our local GPs. A COPD Working Group meets in Hastings and is chaired by a local GP. Currently the focus of the group’s work includes clinical education and audit to ascertain whether the services in place are effective in reducing hospital admissions and improving patient outcomes.

Findings from Older People’s Needs Assessment, 2007:

Falls in older people can cause fractures, especially hip, which in turn lead to increased mortality and have an impact on long-term independence. Even if they do not sustain a fracture, older people who fall may experience a loss of confidence, which impairs their ability to lead full lives.

The risk of falls and fractures can be reduced by adoption of healthy lifestyles. Multidisciplinary falls clinics can identify and reduce risk factors for falls. It is estimated that about 7,600 older people in East Sussex attend Accident & Emergency departments after a fall each year, about a third of whom are admitted. The number of serious falls is expected to rise by about 1.4% per year over the next ten years due to the increasing numbers of older people, and reach about 8,700 in 2016.

The number of admissions to hospital is expected to rise at a similar rate to reach about 3,000 by the same date.

In the over 75s, admission to hospital following a fall often results in discharge to long-term care. It is estimated that about 650 people in East Sussex are discharged to long-term care each year after a fall-related admission. This number set to rise to about 720 in 2016, assuming no change in incidence, and that there are sufficient places in care to accommodate people.
Falls

Falls are a significant cause of poor health and reduced mobility in older people. Nationally, it is estimated that almost one in three (30%) people aged 65 and over, and half of those aged 80 and over have a fall every year.

Falls in older people are much more likely to result in a hospital admission, compared to falls in younger people, and can be used as a measure of more serious falls (with less serious falls occurring though being less likely to result in a hospital admission). The number of serious falls increases with age. People aged 85 years and older are 12 times more likely to have a serious fall resulting in a hospital admission than those aged 65–69 years in East Sussex (68.3 per 1,000 population compared to 5.7).

On average there are around 1,100 emergency hospital admissions a year due to accidents (including falls) in NHS Hastings and Rother. There are no significant differences in admission rates by district/borough. At PBC cluster level, St Leonards cluster has a significantly higher number of emergency hospital admissions due to accidents than would be expected compared to the county as a whole.

The admission rate due to falls in Hastings Borough Council is between 5–27% higher than would be expected if the borough experienced the same admission rate as the rest of the county.

At ward level, Maze Hill has significantly higher hospital admissions due to accidents and falls than the county. Maze Hill also has the highest number of care beds per 1,000 population in East Sussex and the third highest number of residents in communal establishments from the 2001 Census.

Fractures of the neck of femur are more common in the elderly population and may have an impact on their independence levels. Data from both PCTs show that standardised rates for hospital admissions due to this condition are not significantly different across the different areas, even at a local authority level or PBC cluster level, when compared to the county as a whole.

Following admission to hospital for falls and accidents, the majority of older people are able to return to their homes and live independently. Where this is not possible, support is arranged to allow the individual to be safely discharged and to maintain independence as far as possible. However, in some circumstances this is not possible and residential accommodation is required.

Table 11: Age-specific hospital admission rates for falls. Rates per 1,000 population

<table>
<thead>
<tr>
<th></th>
<th>65–69</th>
<th>70–74</th>
<th>75–79</th>
<th>80–84</th>
<th>85+</th>
<th>Total (65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS HR</td>
<td>7.3</td>
<td>11.0</td>
<td>19.7</td>
<td>34.6</td>
<td>70.6</td>
<td>25.5</td>
</tr>
<tr>
<td>East Sussex</td>
<td>5.7</td>
<td>9.6</td>
<td>17.0</td>
<td>31.9</td>
<td>68.3</td>
<td>23.3</td>
</tr>
</tbody>
</table>

Source: SUS hospital episode extracts 06/07–08/09, Exeter Oct 2008 population figures
Hospital Episode Statistics (HES) data for 2008/09 in NHS Hastings and Rother shows that 282 people representing 1.5% of those aged over 65 years who were admitted to hospital were discharged to residential accommodation.

**Falls Prevention Services**

In East Sussex there are primary prevention services which aim to reduce the risk of people falling. There is also a specialist falls prevention service delivering secondary prevention and rehabilitation for those who have had a fall, to help reduce the likelihood of it happening again.

**Primary falls prevention initiatives in East Sussex include:**

- Exercise sessions which include weight bearing and co-ordination activities (see Chapter 5 on physical activity for more details).
- Home safety checks / environmental risk assessment.
- The Stay Active, Keep Well health promotion courses.
- The Supporting People programme, which requires an assessment of each tenant’s support needs, and is providing falls prevention and awareness training to housing support staff.
- Adult Social Care has developed a falls risk assessment to be used for every client in directly provided services. Chair based or other suitable exercise is provided in Adult Social Care day centres.
- ‘Forward from 50’ is a handbook produced to provide advice on a range of issues that may arise for people in East Sussex as they grow older; it aims to influence healthy ageing. One of the twenty-one subject areas specifically relates to falls prevention advice.
- Befriending schemes, which are based in the voluntary sector, offer practical support, advice and information, such as accompanying those who have lost their confidence to go out alone to go shopping or attend exercise sessions, and can help to overcome the practicalities of getting there.
- National Falls Awareness Day is a focus for local awareness raising and information giving events and activities.
- Medication reviews which are available from pharmacists at pharmacies across East Sussex.

**Secondary prevention services and rehabilitation services include a Falls Prevention Team, which is a multi-disciplinary service providing: occupational therapy; physiotherapy; nursing; services of a falls training lead; and administrative support.**

The services focus on both primary and secondary prevention and their objectives are:

- to increase awareness of falls prevention
- to improve service users’ confidence and quality of life
- to reduce emergency admissions for falls and falls-related fractures.

Additional support is provided by the Home from Hospital Service, which provides short-term practical help and support for older people when they are first discharged from hospital. Between April–December 2008, 279 referrals were received. Of these, 99 were recorded as being due to falls; also noted were 53 fractures, 26 hip surgery and 23 referrals for knee surgery.
Accident and emergency attendances

Health and social care services in East Sussex are working to reduce the number of times older people need to have an emergency admission to hospital. Some of these people do not require the acute services provided in hospital. They could have their condition treated more effectively in the community. The services recognise that hospital provision should only be accessed when care cannot be provided in the community and that patients should be treated as close to their home as possible.

Actions taken and plans to reduce unnecessary admissions are discussed in detail in Chapter 7 Working Together.

There are many factors that influence the differences in the older people’s A&E attendance rates by area. These include deprivation, distance from the hospital, availability of alternative services including access to minor injuries units and access to out-of-hours GP services and differences in networks of extended family, close neighbours and friends.

There are minor injury units at Crowborough, Lewes and Uckfield.

Figure 32 shows that older people living within Hastings borough have slightly higher rates for A&E attendance than would be expected.

Hastings Borough Council has significantly higher A&E attendances, with attendances between 15 and 22% higher than would be expected.

At PBC cluster level, the clusters with higher A&E attendance rates than would be expected are: West Hastings (16% higher than would be expected), St Leonards (16% higher than would be expected) and East Hastings (11% higher than would be expected).

The PBC clusters of Bexhill and Rural Rother have A&E attendance rates that are lower than would be expected. The map (figure 34) identifies those wards that have significantly higher A&E attendances than East Sussex.

The Emergency Admissions Services Improvement Group (EASIG) is working to improve the numbers of inappropriate referrals and attendances at A&E and the Medical Admissions Unit (MAU). The urgent care network sets the strategic direction and oversees all work to reduce inappropriate emergency care in acute settings.
Figure 32: Indirectly standardised A&E attendance ratios for ages 65 and over, October 2007–March 2009. East Sussex = 100
(note – excludes Minor Injury Unit attendances)

Source: A&E SUS data, CACI 2008 ward population estimates

Figure 33: Indirectly standardised A&E attendance ratios for ages 65 and over, October 2007–March 2009. East Sussex = 100
(note – excludes Minor Injury Unit attendances)

Source: A&E SUS data, Exeter October 2008 population figures
Figure 34: Standardised A&E Attendance Ratios for over 65s by electoral ward, Oct 2007 to Mar 2009
Figure 35: Age-specific emergency admission rates by age group, East Sussex residents, April 2006–March 2009 (rate per 1,000 population)

Figure 36: Indirectly standardised emergency admission ratios for ages 65 and over, April 2006–March 2009. East Sussex = 100

Source: SUS hospital episode extracts and population mid year estimates 2007, ONS

Source: SUS hospital episode extracts, CACI 2008 ward population estimates
Emergency Hospital Admissions

Emergency hospital admission rates are highest amongst the older population and increase with age (Figure 35). On average there are 1.3 emergency admissions per person aged 85 or over in East Sussex.

East Sussex residents aged 65 or over have around 25,000 emergency hospital admissions a year. Comparing emergency admission rates at a district / borough level to East Sussex county shows that both Lewes and Wealden have significantly lower rates than East Sussex, and Hastings has significantly higher emergency admission rates.

NHS Hastings and Rother patients have around 9,000 emergency hospital admissions a year and significantly higher rates compared to East Sussex.

There is variation across the PBC clusters with East and West Hastings and St Leonards all having significantly higher emergency admission rates when compared to the East Sussex registered population.
Mental health

Mental health services cover a range of conditions including depression, anxiety, compulsive disorders, psychosis and schizophrenia. Services are delivered in the voluntary sector, primary care, emergency settings, the community and within inpatient settings. Here we look at three areas: mental health admissions; suicide and depression.

Dementia has been reviewed previously in this chapter.

Mental health admissions

There are around 450 hospital admissions for mental and behavioural disorders a year for East Sussex residents aged 65 years and over. Due to small numbers it is not possible to see much true variation across the county at a small geographical level. However, although there are wide confidence intervals around the rates, there are two wards that have significantly higher mental health admissions than would be expected when compared to East Sussex. Gensing and Baird have significantly higher admissions.

Hastings borough has significantly higher admissions for mental and behavioural admissions than East Sussex with between 20–84% more admissions than expected. There are no significant differences at PBC cluster level.
Figure 39: Indirectly standardised admission ratios for mental and behavioural disorders (ICD10 F00–F99), April 06–Feb 09. East Sussex = 100

Source: SUS hospital episode extracts, Exeter Oct 2008 population figures

Figure 40: Indirectly standardised admission ratios for mental and behavioural disorders (ICD10 F00–F99), April 06–Feb 09. East Sussex = 100

Source: SUS hospital episode extracts, Exeter Oct 2008 population figures
Suicide

A local suicide audit was completed early in 2009. It included data on suicides and open verdicts. The audit looked at suicides that took place in East Sussex of non-residents, as well as suicides of East Sussex residents.

Note that data for 2008 was incomplete at the time the audit was undertaken.

An age breakdown shows that for East Sussex residents for a five year period, 2004–2008:

Table 12: Number of East Sussex resident suicides, by age, 2004–2008

<table>
<thead>
<tr>
<th>Age</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>60–69</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>70+</td>
<td>24</td>
<td>12</td>
</tr>
</tbody>
</table>

For non-residents, 2004–2008:

Table 13: Number of non-resident suicides 2004–2008, 60 years and over

<table>
<thead>
<tr>
<th>Age</th>
<th>All persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>60+</td>
<td>8</td>
</tr>
</tbody>
</table>

For East Sussex residents there appears to be a small peak in the number of suicides and open verdicts in those aged over 80 years. This may be a reflection of the local make-up of the East Sussex population. For non-residents there are small numbers of suicides above the age of 60 years. The majority of deaths in non-residents were at Beachy Head.

An East Sussex Suicide Prevention Strategy was drawn up in 2008/09. Key actions within this strategy for implementation in 2009 are as follows:

— continue to audit trends
— assess prescribing issues
— support agencies to provide specialist training
— undertake and review risk management planning in areas where there have been more than one suicide
— review pathways from accident and emergency departments for those who have attempted suicide
— continue on-going work in: mental health services, the prison and within the mental well-being planning framework (see chapter 5).

Depression and anxiety

Psychological therapies services for those with depression and anxiety have been commissioned in 2008 and this ‘Improving Access to Psychological Therapies’ (IAPT) programme will considerably expand from April 2010.

The data on prevalence of depression and anxiety, below, is modelled from national data.

This shows that, for men, the rate of depression and anxiety in the community is likely to be equivalent to disease groups such as diabetes. However, rates are significantly higher among women.

The England Adult Psychiatric Morbidity household survey produces age and sex specific prevalence rates for a number of mental health and well-being disorders (see table 14).
### Table 14: Prevalence of common mental disorders experienced in the last week

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevalence from survey (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>65–74</td>
<td>75+</td>
</tr>
<tr>
<td>Mixed anxiety and depressive disorders</td>
<td>3.9</td>
<td>3.8</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>2.9</td>
<td>2.2</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>0.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Suicidal thoughts experienced in past year</td>
<td>1.7</td>
<td>1.8</td>
</tr>
</tbody>
</table>

### Table 15: QOF data estimates of numbers of people aged 65 and over experiencing depression

<table>
<thead>
<tr>
<th>Area</th>
<th>Mixed anxiety and depressive disorder in the past week</th>
<th>Generalised anxiety disorder in the past week</th>
<th>Depressive episode in the past week</th>
<th>Suicidal thoughts in past year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne</td>
<td>1400</td>
<td>600</td>
<td>300</td>
<td>500</td>
</tr>
<tr>
<td>Hastings</td>
<td>900</td>
<td>400</td>
<td>200</td>
<td>300</td>
</tr>
<tr>
<td>Lewes</td>
<td>1300</td>
<td>600</td>
<td>300</td>
<td>500</td>
</tr>
<tr>
<td>Rother</td>
<td>1500</td>
<td>700</td>
<td>300</td>
<td>500</td>
</tr>
<tr>
<td>Wealden</td>
<td>1900</td>
<td>900</td>
<td>400</td>
<td>700</td>
</tr>
<tr>
<td>East Sussex</td>
<td>7000</td>
<td>3400</td>
<td>1500</td>
<td>2500</td>
</tr>
<tr>
<td>NHS ESDW</td>
<td>4600</td>
<td>2200</td>
<td>1000</td>
<td>1600</td>
</tr>
<tr>
<td>NHS HR</td>
<td>2500</td>
<td>1200</td>
<td>500</td>
<td>900</td>
</tr>
</tbody>
</table>

Source: Adult psychiatric morbidity in England 2007: Results of a household survey. The Information Centre Population source: 2007 MYEs

Note: districts and PCT figures may not sum to East Sussex county figures due to rounding
The prevalence derived from the survey can be applied to local population data to estimate the number of people locally that may be affected by the disorders. The survey is households only, but the prevalence rates have been applied to whole population aged over 65 – those in communal establishments are not included in the prevalence rates but are included in the population denominator (so numbers may be an underestimate).

Joint Strategic Needs Assessment Quality and Outcomes Framework scorecard data are also available on depression, however, the data are not age-specific.

**Coronary Heart Disease**

Coronary heart disease (CHD) is an important cause of illness and mortality and results in A&E, inpatient, out-patient and primary care attendances. It develops when the artery supplying blood to the heart becomes partially or wholly blocked. It is often caused by fatty deposits building up on the inside lining of the arteries. This causes symptoms of chest pain, which is temporary and treatable. CHD can result in a heart attack if the blood supply to the heart is stopped for long enough to cause damage.

It is estimated that across NHS Hastings and Rother there are around 16.8% of 65–74 year-olds and around 23% of people aged 75 and over with CHD. These figures are higher than the national estimates of 15.6% and 21.3%, respectively. The rates in Rother District Council (14.3% and 19.9%, respectively) are lower than the PCT and national estimates.

Table 16 shows age-specific hospital admission rates for CHD. The highest rates can be seen in the 75–79 years age group.

**Cancer**

Cancer is a major cause of illness and death in East Sussex.

For men aged over 65 in NHS Hastings and Rother prostate cancer accounts for one in four of all newly registered cancers between 2003 and 2005.

For women aged over 65 the most commonly registered cancer is breast cancer accounting for one in four of all cancers.

In NHS Hastings and Rother between the period of 1997 to 2006, there were a total of just under 7,500 patients placed on the cancer register.

Data from 1985 to 2006 shows that just over 3,200 of the cancer patients aged over 65 registered during this period were alive by the end of 2006.

Between 2003 and 2005, the rate of new cases of cancer in men and women aged 65–74 in NHS Hastings and Rother was lower than the regional and the national rates.
Table 16: Age-specific hospital admission rates for CHD.
Rates per 1,000 registered population

<table>
<thead>
<tr>
<th></th>
<th>65–69</th>
<th>70–74</th>
<th>75–79</th>
<th>80–84</th>
<th>85+</th>
<th>Total (65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS HR</td>
<td>17.6</td>
<td>23.6</td>
<td>25.7</td>
<td>22.0</td>
<td>18.3</td>
<td>21.4</td>
</tr>
<tr>
<td>East Sussex</td>
<td>20.0</td>
<td>23.8</td>
<td>27.0</td>
<td>23.9</td>
<td>25.5</td>
<td>23.8</td>
</tr>
</tbody>
</table>

Source: SUS hospital episode extracts 06/07–08/09, Exeter Oct 2008 population figures

Figure 41: Indirectly standardised admission ratios for coronary heart disease (ICD10 I20–I25) for ages 65 and over, April 2006–February 2009. East Sussex = 100

Source: SUS hospital episode extracts, Exeter Oct 2008 population figures
In people aged 75 years and over, the rate of new cases of cancer among men is lower than the national and regional rate. The rate of new cases of cancer among women aged 75 and over appears to be slightly higher in Hastings than the regional rate, though is lower than the national rate.

NHS Hastings and Rother patients had just under 3,000 hospital admissions for cancer a year. The PCT has a higher rate of hospital admissions for cancer than would be expected (expected admissions if NHS Hastings and Rother had the same admission rate as the East Sussex registered population).

At PBC cluster level there is variation within the PCT with Rural Rother having 20% more admissions than expected and East Hastings 14% higher cancer admissions. The three other clusters do have slightly higher admission rates than East Sussex but not significantly.

Figure 42: Indirectly standardised admission ratios for coronary heart disease (ICD10 I20–I25) for ages 65 and over, April 2006–February 2009. East Sussex = 100

Source: SUS hospital episode extracts, Exeter October 2008 population figures
Table 17: Five main cancers that are registered in men aged over 65, 2003 to 2005

<table>
<thead>
<tr>
<th>Cancer of:</th>
<th>Number</th>
<th>% of total cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate</td>
<td>261</td>
<td>25%</td>
</tr>
<tr>
<td>Trachea, bronchus and lung</td>
<td>181</td>
<td>18%</td>
</tr>
<tr>
<td>Colon</td>
<td>115</td>
<td>11%</td>
</tr>
<tr>
<td>Bladder</td>
<td>63</td>
<td>6%</td>
</tr>
<tr>
<td>Rectosigmoid junction, rectum and anus</td>
<td>40</td>
<td>4%</td>
</tr>
<tr>
<td>All other cancers</td>
<td>369</td>
<td>36%</td>
</tr>
<tr>
<td>**Total cancers *</td>
<td><strong>1,029</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Thames Cancer Registry  
* excluding skin cancers other than malignant melanoma

Table 18: Five main cancers that are registered in women aged over 65, 2003 to 2005

<table>
<thead>
<tr>
<th>Cancer of:</th>
<th>Number</th>
<th>% of total cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>268</td>
<td>25%</td>
</tr>
<tr>
<td>Colon</td>
<td>129</td>
<td>12%</td>
</tr>
<tr>
<td>Trachea, bronchus and lung</td>
<td>110</td>
<td>10%</td>
</tr>
<tr>
<td>Other and unspecified parts of uterus</td>
<td>49</td>
<td>5%</td>
</tr>
<tr>
<td>Pancreas</td>
<td>48</td>
<td>4%</td>
</tr>
<tr>
<td>All other cancers</td>
<td>470</td>
<td>44%</td>
</tr>
<tr>
<td>**Total cancers *</td>
<td><strong>1,074</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Thames Cancer Registry  
* excluding skin cancers other than malignant melanoma
Figure 43: Directly standardised incidence rates from all cancers (ICD 10 C00–C99 excl C44) for ages 65–74, 1993–1995 to 2003–2005

Source: Thames Cancer Registry
Note: axis does not start at zero

Figure 44: Directly standardised incidence rates from all cancers (ICD 10 C00–C99 excl C44) for ages 75 and over, 1993–1995 to 2003–2005

Source: Thames Cancer Registry
Note: axis does not start at zero
Figure 45: Indirectly standardised admission ratios for all cancers (ICD10 C00–C99) for ages 65 and over, April 2006–February 2009. East Sussex = 100

Source: SUS hospital episode extracts, CACI 2008 ward population estimates

Figure 46: Indirectly standardised admission ratios for cancer (ICD10 C00–C99) for ages 65 and over, April 2006–February 2009. East Sussex = 100

Source: SUS hospital episode extracts, Exeter Oct 2008 population figures
Figure 47: Standardised admission ratios for cancer for over 65s by electoral ward, April 2006 to February 2009

Source: SUS hospital episode extracts, Exeter Oct 2008 population figures
Diabetes

Diabetes is a condition where the level of glucose (sugar) in a person’s blood becomes too high. The condition leads to increased need to attend primary care services and outpatient appointments. It results either from an inability to produce insulin or because the individual’s body has become resistant to the insulin produced. About 2.3 million people in the United Kingdom are known to have diabetes and a further 750,000 may have the condition and not know it. Insulin is a hormone which controls the movement of glucose into most of the body’s cells and maintains blood glucose levels within a narrow concentration range.

People may be unaware that they have diabetes. The symptoms include feeling thirsty, tired and needing to urinate more frequently than usual. The sooner diabetes is identified, the quicker people can start treatment and reduce the risk of associated problems including high blood pressure, heart disease, kidney problems and damage to vision.

The Yorkshire and Humber Public Health Observatory have modelled the prevalence of Type 1 and Type 2 diabetes (both diagnosed and undiagnosed) down to small geographical areas for the whole country and for specific age groups (Yorkshire and Humber Public Health Observatory, 2008). These estimates are based on a number of assumptions and have wide confidence intervals around the estimated prevalence, particularly at a ward level.

Locally, under the Quality and Outcome Framework practices report on the number of patients on their diabetes register. The diabetes register under QoF is for patients aged 17 and over and cannot be broken down into specific age groups. The data presented in table 19 relates to those aged 60 and over and is modelled from prevalence estimates derived from the evidence base which incorporates those whose diabetes is undiagnosed. Due to the difference in age groups and whether capturing both diagnosed and undiagnosed, the data in table 19 is not comparable to the local QoF diabetes data. The East Sussex JSNA scorecards use QoF data and therefore provide the picture for the population aged 17 and over. Depending on the age profile of the population, the most relevant diabetes prevalence data should be used to assess the needs of the population.

The estimated prevalence in 2005 of Type 1 and Type 2 diabetes (both diagnosed and undiagnosed) for people aged over 60 was 14.1% in NHS Hastings and Rother compared to 13.7% for England.

There is variation across the wards, with some of the highest rates likely to be in Central St Leonards, Central Ward in Rother, Castle, Gensing Tressell and Ore.
Table 19: The top 20 wards with the highest estimated prevalence of diabetes in population aged 60 and over

<table>
<thead>
<tr>
<th>Ward</th>
<th>District / Borough</th>
<th>Modelled prevalence of diabetes in those aged 60+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central St Leonards</td>
<td>Hastings</td>
<td>16.3%</td>
</tr>
<tr>
<td>Central</td>
<td>Rother</td>
<td>16.1%</td>
</tr>
<tr>
<td>Castle</td>
<td>Hastings</td>
<td>15.7%</td>
</tr>
<tr>
<td>Gensing</td>
<td>Hastings</td>
<td>15.6%</td>
</tr>
<tr>
<td>Maze Hill</td>
<td>Hastings</td>
<td>15.3%</td>
</tr>
<tr>
<td>Upperton</td>
<td>Eastbourne</td>
<td>15.3%</td>
</tr>
<tr>
<td>Devonshire</td>
<td>Eastbourne</td>
<td>15.2%</td>
</tr>
<tr>
<td>Sidley</td>
<td>Rother</td>
<td>15.2%</td>
</tr>
<tr>
<td>Hampden Park</td>
<td>Eastbourne</td>
<td>15.2%</td>
</tr>
<tr>
<td>Tressell</td>
<td>Hastings</td>
<td>15.1%</td>
</tr>
<tr>
<td>Braybrooke</td>
<td>Hastings</td>
<td>15.1%</td>
</tr>
<tr>
<td>Sackville</td>
<td>Rother</td>
<td>15.0%</td>
</tr>
<tr>
<td>Hollington</td>
<td>Hastings</td>
<td>15.0%</td>
</tr>
<tr>
<td>Meads</td>
<td>Eastbourne</td>
<td>14.9%</td>
</tr>
<tr>
<td>Ore</td>
<td>Hastings</td>
<td>14.9%</td>
</tr>
<tr>
<td>Langney</td>
<td>Eastbourne</td>
<td>14.8%</td>
</tr>
<tr>
<td>Wishing Tree</td>
<td>Hastings</td>
<td>14.8%</td>
</tr>
<tr>
<td>St Michaels</td>
<td>Rother</td>
<td>14.6%</td>
</tr>
<tr>
<td>Hailsham East</td>
<td>Wealden</td>
<td>14.6%</td>
</tr>
<tr>
<td>Baird</td>
<td>Hastings</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

Source: Diabetes Prevalence Modeller Phase III, YHPHO May 2008
Pacesetters Programme

The development of diabetes services is a priority for the NHS in East Sussex, especially with regards to the hard-to-reach patient groups, including those disadvantaged because of age.

The Pacesetters Programme is a partnership between local communities, the NHS and the Department of Health, aiming to deliver equality and diversity improvements and innovations in healthcare for diabetes.

The aim of the Pacesetters Diabetes Project is to engage patients and carers in the development of accessible services that will improve health outcomes for older people with diabetes.

Plans will be made to ensure health inequalities experienced by older people with diabetes are minimised and services are designed to be sustainable, accessible, responsive and patient-centred to support patients and carers in managing their condition as effectively as possible.

Outpatients

In the preceding sections we have set out some of the major reasons for outpatient attendance. In East Sussex there are around 53,000 outpatient attendances a year for patients aged over 65, for all diseases.

Across NHS Hastings and Rother, attendance ratios were highest in the St Leonards and East Hastings PBC clusters, although none were significantly higher than for East Sussex as a whole.

Nine of the 37 wards had significantly higher than expected ratios when compared to East Sussex, as highlighted in the map below.

At district / borough level there is little variation in out patient attendance rates.
Table 20: Indirectly standardised outpatient attendance ratios, April 2007 to February 2009

<table>
<thead>
<tr>
<th></th>
<th>Ratio</th>
<th>95% LL</th>
<th>95% UL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wealden</td>
<td>105</td>
<td>103</td>
<td>107</td>
</tr>
<tr>
<td>Hastings</td>
<td>103</td>
<td>100</td>
<td>105</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>99</td>
<td>97</td>
<td>101</td>
</tr>
<tr>
<td>Rother</td>
<td>97</td>
<td>96</td>
<td>99</td>
</tr>
<tr>
<td>Lewes</td>
<td>95</td>
<td>96</td>
<td>99</td>
</tr>
<tr>
<td>St Leonards</td>
<td>103</td>
<td>100</td>
<td>106</td>
</tr>
<tr>
<td>East Hastings</td>
<td>102</td>
<td>98</td>
<td>106</td>
</tr>
<tr>
<td>West Hastings</td>
<td>92</td>
<td>87</td>
<td>97</td>
</tr>
<tr>
<td>Bexhill Centre</td>
<td>91</td>
<td>89</td>
<td>94</td>
</tr>
<tr>
<td>Rural Rother</td>
<td>90</td>
<td>87</td>
<td>93</td>
</tr>
</tbody>
</table>

N.B. 95% LL is the lower limit of the 95% confidence limit and 95% UL is the upper limit of the confidence limit. See appendix 1: Technical Notes for more information on how to interpret this.
Figure 48: Outpatient attendance ratios for persons aged 65+ by electoral ward, April 2007 to February 2009.
Key Points from chapter 4

Stroke:

— Across NHS Hastings and Rother approximately 6.7% of people aged 65–74, and approximately 11.6% of people aged 75 years and over have had a stroke.
— Quality measures for stroke services have been developed and these are:
  - the percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months
  - the percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less
  - the proportion of A&E patients admitted to a stroke unit within a certain time period
  - deaths within seven days of admission
  - deaths within 30 days of admission
  - average length of stay in hospital.

Dementia:

— Data modelling suggests that approximately 6% of men and 10% of women over the age of 65 suffer from dementia in NHS Hastings and Rother.
— Building on an innovative pilot funded by the Department of Health through Adult Social Care, the Memory Assessment Support Team provides an early intervention service for people in Hastings and Rother identified as having issues with memory and cognitive functioning.
Chronic obstructive pulmonary disease (COPD):

— In NHS Hastings and Rother in 2007/08 there were 2,886 persons of all ages on a primary care COPD register which accounted for 1.6% of all patients registered with GPs. This was higher than the national rate (1.48%) and regional rates (1.3%).
— In NHS Hastings and Rother there are six wards that have higher admissions than expected when compared to the East Sussex admission rate for emergency respiratory admissions (Silverhill, Baird, Hollington, Ashdown, Wishing Tree and Ore). With the exception of Ashdown, the other five wards are amongst the wards with the highest levels of income deprivation affecting older people in the county.

Falls:

— Falls in older people are much more likely to result in a hospital admission, compared to falls in other people, and increase with age.
— There are around 1,100 emergency hospital admissions a year due to accidents (including falls) in NHS Hastings and Rother.
— Maze Hill ward has significantly higher hospital admissions due to accidents and falls than the country as a whole.
— Hospital Episode Statistics (HES) data for 2008/09 in NHS Hastings and Rother shows that 282 people representing 1.5% of those aged over 65 years who were admitted to hospital were discharged to residential accommodation.
A&E attendances:

— There is a large variation in A&E attendance rates across the PCT, Hastings Borough Council has significantly higher A&E attendances, with attendances between 15 and 22% higher than would be expected. At PBC cluster level, the clusters with higher A&E attendance rates than would be expected are: West Hastings (16% higher than would be expected), St Leonards (16% higher than would be expected) and East Hastings (11% higher than would be expected). The PBC clusters of Bexhill and Rural Rother have A&E attendance rates that are lower than would be expected.

— There are many factors that influence the differences in the older people’s A&E attendance rates by area. These include deprivation, distance from the hospital, availability of alternative services including access to minor injuries units and access to out-of-hours GP services.

Emergency admissions:

— East Sussex residents over 65 years have approximately 25,000 emergency admissions a year. Hastings borough has significantly higher rates that East Sussex.

— NHS Hastings and Rother patients have around 9,000 emergency hospital admissions a year and significantly higher rates compared to East Sussex. There is variation across the PBC clusters with East and West Hastings and St Leonards all having significantly higher emergency admission rates when compared to the East Sussex registered population.
Mental health:

— There are around 450 hospital admissions for mental and behavioural disorders a year for East Sussex residents aged 65 years and over.

Coronary heart disease (CHD):

— It is estimated that across NHS Hastings and Rother there are around 16.8% of 65–74 year-olds with CHD and around 23% of people aged 75 and over. These figures are higher than the national estimates. The rates in Rother District Council (14.3% and 19.9%, respectively) are lower than the PCT and national estimates.

Cancer:

— In NHS Hastings and Rother, between the period of 1997 to 2006, there were a total of just under 7,500 patients placed on the cancer register

— NHS Hastings and Rother patients had just under 3,000 hospital admissions for cancer a year. The PCT has a higher rate of hospital admissions for cancer than would be expected (expected admissions if NHS Hastings and Rother had the same admission rate as the East Sussex-registered population). At PBC cluster level there is variation within the PCT with Rural Rother having 20% more admissions than expected and East Hastings 14% higher cancer admissions.
Diabetes:

— The estimated prevalence in 2005 of Type 1 and Type 2 diabetes (both diagnosed and undiagnosed) for people aged over 60 was 14.1% in NHS Hastings and Rother compared to 13.7% for England.

— There is variation across the wards, with some of the highest rates likely to be in Central St Leonards, Central Ward in Rother, Castle, Gensing Tressell and Ore.

Outpatients:

— In East Sussex there are 53,000 outpatient attendances a year for patients aged over 65.

— Across NHS Hastings and Rother, attendance ratios were highest in the St Leonards and East Hastings PBC clusters, although none were significantly higher than for East Sussex as a whole.
Recommendations from chapter 4

**Stroke:**

— The quality of stroke service needs to be improved and the PCT has agreed a number of quality indicators which are being monitored.
— The PCTs have agreed with East Sussex Hospital Trust that the percentage of patients receiving brain scan within 48 hours should be 90% by April 2010 as part of the CQUIN programme.

**Dementia:**

— The National Dementia Strategy needs to be implemented in East Sussex.
— There is a need to further develop early intervention services for patients with dementia and their families.

**Chronic obstructive pulmonary disease (COPD):**

— PBC clusters with higher admission rates need to consider developing specialised community based services for patients with COPD.
— The COPD PBC scheme should be further developed to target those areas of deprivation with highest admission rates for COPD. The wards that have higher than expected rates for emergency respiratory admissions are Silverhill, Baird, Hollington, Ashdown, Wishing Tree and Ore
— Smoking cessation services should be targeted in areas of high COPD prevalence and admission rates.
A&E attendance:

— A continued drive towards reducing disproportionately high A&E attendances by developing alternative community based services is required.
— PBC cluster with higher A&E attendance need to consider developing alternative services in the community to prevent these. These are West Hastings, St Leonards and East Hastings.

Emergency admissions:

— PBC clusters with high rates of emergency admissions need to consider developing alternative community based preventative services. These wards are East and West Hastings and St Leonards.

Mental health:

— The Suicide Prevention Strategy should be implemented across the PCT.
— The PCT should ensure Improving Access to Psychological Therapies (IAPT) programme is expanded.
Coronary heart disease:

— The PCT should continue to invest in the Investing in Life Programme to further reduce CHD.

Cancer:

— The PCT should invest in cancer prevention services: smoking cessation, targeting the highest prevalence areas in Hastings.
— The PCT should encourage uptake of early cancer detection services, including cervical, breast and bowel cancer screening.

Diabetes:

— PBC clusters should continue to develop their diabetes registers to enable systematic community based services to be available in areas of high prevalence.
— PBC clusters with estimated higher rates — St Leonards and East Hastings — should investigate this and determine whether alternative services could be developed.
Promoting health in old age
This chapter describes the PCT’s approach to supporting people to improve and maintain their health in old age. It describes how the PCT works with partners to develop and offer health improvement opportunities and initiatives which minimise the impact and reduce the prevalence of the main threats to health described in previous chapters.


This chapter outlines local approaches to delivering *Choosing Health* and ‘Time of our Lives’ for older people across East Sussex. It describes the strategic approach and mechanisms through which partners identify and agree evidenced based initiatives to improve health and provides examples of how these initiatives are being delivered across the county.

The local picture is set within the wider context of national health policy and research. An update on vaccination and screening programmes is also provided. Finally, there is a short section outlining two wider determinants of health – employment and transport.
Strategic Approach


East Sussex County Council, the PCTs and local older people have developed the ‘Time of our Lives’ strategy 2008–2011: Improving and promoting quality of later life in East Sussex. The strategy aims to improve and promote the quality of later life for people in East Sussex. It was produced in consultation with older people and a wide range of voluntary sector organisations. In keeping with the agenda set by older people themselves, it begins thinking about later life from the age of 50 onwards.

There are eight quality of life areas that people felt were important to them and these are:

— Looking forward from 50
— Staying healthy and active
— Continuing to learn and develop and be culturally active
— Playing a part and contributing to community life
— Feeling safe and secure
— Getting out and about – transport and access to services
— Maintaining healthy finances
— Maintaining quality of life for older people who need care and support.

The ‘Time of our Lives’ strategy is overseen by the Promoting a Healthy Old Age Steering Group. A Health Improvement Partnership Group which facilitates better inter-agency working has been established as a sub group of this group.

Older People Health Improvement Partnership Groups in East Sussex

There are two health improvement partnership groups for older people in East Sussex, one covering Hastings and Rother and the other covering the Eastbourne, Lewes and Wealden areas. They aim to identify, develop and deliver practical solutions with regard to health improvement issues for older people. They give particular consideration to: disadvantaged and vulnerable groups, focusing on Choosing Health priorities (healthy eating, physical activity, stopping smoking, accident prevention, mental well-being) and the ‘Time of our Lives’ strategy.

Through these two groups, older people’s issues are fed into the Health Improvement Partnerships at the borough and district council level, which are the wider health improvement planning and delivery vehicles covering the county. These Older People’s Health Improvement Partnerships in turn link into the Promoting a Healthy Old Age Steering Group, ensuring alignment to the Joint Commissioning Strategy for Older People.

Smoking

It is estimated that over one in five people (22%) aged 50–59, and over one in ten people (12%) aged over 60, are currently smokers (Office for National Statistics, 2006).

For people who smoke, stopping smoking is usually the single most important lifestyle change they can make. It is never too late to stop smoking. For people who have smoked all their adult lives, giving up in later life will still have health benefits. For example, five years after giving up smoking the risk of a stroke will be the same as for a non-smoker (Allen, 2008).
People are more likely to stop smoking successfully if they receive help from a health professional than if they try to stop without support and older people who set a date to stop smoking are more likely to succeed than younger people (Health and Social Care Information Centre, 2008).

Older people may be more likely to stop smoking if they are: living with others; don’t drink alcohol; have a shorter smoking history; or, experience a change in health, such as hospital admission for an acute respiratory or cardiac condition (Allen, 2008). Some specific barriers to older people stopping smoking have been identified. These include the belief that the damage has already been done and scepticism about the harm caused by smoking. This may be reinforced when health professionals do not promote the benefits of stopping smoking to older people (Martin and O’Neal, 2009).

The local picture

NHS Stop Smoking Services are available across East Sussex, and offer a variety of options including one-to-one advice, group sessions and drop-in clinics. Support is offered in a range of settings including GP surgeries, pharmacies and community venues. All services offer support, advice and pharmacotherapy, such as nicotine replacement therapy (NRT) for which a prescription charge is payable. NRT and other stop smoking medication is available free of charge to people who are exempt from paying prescription charges.

Obesity

Obesity is increasing in all age groups including older people.

Body mass index is a measure used to assess whether people are underweight, normal, overweight, obese or morbidly obese. It is based on height and weight measurements. Almost half (49%) of men aged 65–74 are overweight and, additionally, nearly one in three (28%) are obese (Health Survey for England, 2007). Among men aged 75 and over, half are overweight (50%) and a further 22% are obese.

Among women aged 65–74, 37% are overweight and, additionally, nearly one in three (29%) are obese. Among women aged 75 and over, 40% are overweight and a further 25% are obese.

If the national rates applied across NHS Hastings and Rother, there would be around 8,400 men aged 65 and over who are overweight and a further 4,300 who are obese. There would be around 9,000 women aged 65 and over who are overweight plus 6,200 women who are obese.

The health dangers of being overweight or obese include the following risks:

— high blood pressure
— high cholesterol
— type 2 diabetes
— heart disease
— stroke
— back pain
— hip and knee pain
— reduced mobility, leading to increased risk of falls
— reduced mobility, leading to lack of social activities
— depression.
Being physically active and eating a healthy diet are the best ways that most older people can reduce their risk of obesity.

Physical Activity

National physical activity guidelines recommend that people undertake moderate intensity activity on a minimum of five days a week for 30 minutes or more.

Only around one in five men aged 65–74 and one in ten men aged 75 and over achieve the national activity guidelines (Health Survey for England, 2006).

Older women appear to be even less physically active than men, with only 16% of women aged 65–74 and 4% aged over 75 achieving the guideline.

Regular activity is important for maintenance of mobility and independent living. Exercises increasing muscle strength are important for activities of daily living such as walking and getting up from a chair. These exercises also reduce the incidence of falls. In addition, exercise has a number of other potential health benefits – it can reduce the complications of immobility such as constipation, pressure sores and deep vein thrombosis and can be as effective as antidepressants in reducing depression. (British Heart Foundation, National Centre Physical Activity and Health, 2007).

Inactivity contributes to a loss of physical function which can impact on the individual’s ability to maintain their independence. For example, 20% of women and 14% of men aged over 50 years do not have the flexibility to wash their own hair comfortably. Among people older than 65 years, 12% cannot manage to walk outside on their own, while 9% cannot manage stairs unaided (BHF National Centre Physical Activity and Health, 2007).

For most older people any activity is better than none at all. The greatest health gains are achieved when a sedentary person becomes a little more active more often. Levels of physical activity should be increased gradually and those who have been sedentary should start with short sessions of light intensity.

The PCTs work in partnership with borough, district and county councils, the voluntary sector and seniors forums to ensure a wide and varied range of physical activity opportunities are available to cater for the differing interests and abilities of older people in community groups, community venues and day centres.

In 2008, Age Concern East Sussex received Big Lottery ‘Fit as a Fiddle’ funding to purchase Nintendo Wii consoles, sports packages and TV screens to pilot the delivery of activity sessions in day centres.

A health promotion handbook ‘Forward from 50 – a guide for later life in East Sussex’ has been produced by ESCC, the PCTs and local older people to provide help and advice for older people to improve their health and wellbeing.
Diet

Diet and nutrition are important aspects of staying healthy. National guidance suggests that people of all ages should eat at least five portions of fruit and vegetables a day. Just over one in three people aged 65–74, and less than one in three people aged over 75, eat the recommended five or more portions of fruit and vegetables per day (Health Survey for England, 2007). A lack of fruit and vegetables in the diet increases the risk of many health conditions including:

- cancers, especially bowel cancer
- constipation due to reduced fibre in the diet
- obesity

Some older people may experience specific barriers to eating healthily such as:

- limited income which can lead to reduced choice
- difficulties with shopping or preparing food
- access to premises selling healthy food, for example, where shops are not within walking distance or where public transport is poor.

To address these barriers and promote healthy eating, the PCTs work with partners to commission a range of support services such as community fruit and vegetable box schemes, ‘cooking for one’ sessions and local ‘market stalls’ in housing schemes.

The NHS Health Check programme

Vascular disease has been recognised as a major threat to health and wellbeing. The Department of Health’s — Putting Prevention First, 2008 — proposed that all 40–74 year-olds in England should be offered a face-to-face assessment of their vascular risk, followed by appropriate management of that risk. All eligible patients will be offered a vascular risk assessment or ‘health check’ every five years.

GPs across East Sussex are already working on developing cardiovascular risk registers, primarily assessing patients with hypertension and those with obesity. Building on this, the risk registers are being extended to include anyone who is at high risk and these will be used to prioritise invitations for the NHS Health Check.

Mental wellbeing

A programme of work to address mental wellbeing is under way for the whole population, including older people, across East Sussex. The PCT’s Choosing Health Improving Mental Wellbeing Health Promotion Action Plan aims to:

- reduce the stigma of mental illness and discrimination
- raise awareness
- reduce inequalities
- promote physical activity
- promote healthy diets
- improve support systems.

For older people specifically, the focus is on:

- those who experience poor life satisfaction
- those who experience a poor sense of involvement
— improvement of early detection of mental illness.

A variety of initiatives to improve mental wellbeing in older people have been commissioned, for example in Rother, research has been commissioned to look at the needs of people living in rural areas who experience mental distress.

To address the particular needs of people from black and minority ethnic communities a new initiative, Race Equality in Mental Health, began in December 2008. A team of four community development workers are focusing on:

— reducing inequalities in black and minority ethnic (BME) patients’ access to, experience of, and outcomes from mental health services
— responding to recommendations made by the inquiry into the death of David Bennett.

The initiative is based on three building blocks:

— more appropriate and responsive services
— community engagement
— better information.

The community development workers are based in Adult Social Care, and are currently working with the PCT and other agencies on a nine-point action plan, which includes:

— increased consultation with BME communities and service users
— improved mental health promotion to BME communities
— investment in and the creation of a BME community peer mental health initiative to improve early identification of people with mental health needs
— creation of culturally competent counselling and emotional support services
— provision of cultural competence training to frontline staff.

**Sexual Health**

Nationally, rates of sexually transmitted infections have increased among those aged over 45 years, with men aged 55–59 more likely to be affected. The World Health Organisation (2009) has also reported that increasing numbers of sexually active people aged over 50 are contracting the HIV virus, making up 8% of new HIV diagnoses in Europe.

Recent national surveys suggest that those aged over 50 do not routinely practice safe sex. More than one in ten of the over 50s say that they had not used a condom despite not knowing their partner’s sexual history.

**The local picture**

Over the six-year period, 2003 to 2008, there were 161 diagnosed sexually transmitted infections (syphilis, gonorrhoea, genital warts, genital herpes or chlamydia) in those aged 50–69 attending East Sussex Genito-Urinary Medicine (GUM) clinics.

Table 21 shows the numbers by infection and year. Note that some data is pooled to prevent disclosure of small numbers.

In 2008 a comprehensive sexual health needs assessment was commissioned by the two East Sussex PCTs. The report indicated that more prevention work could be targeted towards the adult population. While sexually transmitted diseases are not a marked problem for older people in East Sussex, awareness of national trends and risk behaviour should be taken into account in planning campaigns.
Alcohol can be harmful to health and wellbeing if consumed above the recommended daily units. With decreased social activity and lifestyle disruptions, such as retirement, some older people develop problems with alcohol misuse.

Alcohol is known to contribute to a number of medical conditions ranging from liver damage to psychosis. As they get older people may be at greater risk of injury if falling whilst under the influence of alcohol.

The recommended alcohol limits are 21 units a week for men and 14 units a week for women. These should be spread throughout the week with men drinking no more than four units a day and women no more than three. One unit equates to a standard pub measure (25ml) of spirits, half a pint of normal strength beer or lager (3.5% abv), or a small glass of wine (125ml, at 9% abv).

There is evidence that nationally, older people may be consuming more alcohol than previous generations, with surveys suggesting that since 1984 the proportions of men and women aged 45–65 years exceeding the recommended limits has been rising steadily (Institute of Alcohol Studies, 2009). Some reports indicate that one in six older men and one in 15 older women are exceeding the recommended limits for regular consumption (Royal College of Psychiatrists, 2008).

Research suggests that up to 60% of older people admitted to hospital because of confusion, falls at home, recurrent chest infections and heart failure may have unrecognised alcohol problems (Institute of Alcohol Studies, 2009).

The local picture

A recent needs assessment on alcohol services in East Sussex found that there does not appear to be an increasing or significant problem of alcohol dependency among older people, however, this picture will be monitored.
Drugs

Using the England 2007 adult psychiatric morbidity survey it is estimated that in East Sussex there are 200 people aged over 65 who are dependent on cannabis and a further 200 dependent on tranquillisers (The Information Centre, 2009).

Vaccination

Seasonal Flu Vaccination

Everyone aged 65 and over is offered an annual seasonal flu jab, as well as those aged under 65 with chronic health conditions including asthma and diabetes. The national target is for 70% of people aged 65 and over to receive a seasonal flu jab each year.

Across NHS Hastings and Rother, 74.4% of people aged over 65 received the seasonal flu vaccine in 2008/09. This was higher than both the national rate of 74.1% and the South East Coast rate of 72.9%. Bexhill was the PBC cluster with the highest rate (78%) and St Leonards had the lowest rate (69.6%).

Preparations are underway to plan for the autumn and winter of 2009/10 as the course of the swine flu pandemic, underway at the time of writing this report, is predicted to worsen as temperatures fall in the Northern Hemisphere. It is anticipated that a phased vaccination programme against the swine flu strain will take place this winter alongside the seasonal flu vaccination programme.

Pneumococcal Vaccination

Pneumococcal vaccine is offered to everyone aged 65 and over, as a single one-off vaccine. The vaccine protects against the most common type of pneumonia and its associated conditions, including meningitis.

Influenza and pneumonia are major threats to health in older people, particularly in the winter months. The PCTs work with partners to promote and encourage uptake of vaccinations in all eligible groups.

Screening

Bowel cancer screening

By December 2009 East Sussex will be part of the new National Bowel Cancer Screening Programme. As part of a phased programme, screening has already started in parts of West Sussex and Brighton.

All men and women aged between 60 and 69 will be invited to take part, initially being invited over a two-year period.

The first part of the screening test is a self-taken stool sample, called a faecal occult blood test. A testing pack will be posted to those involved to take the sample in their own homes and post back for analysis.

If blood is detected in the sample, a colonoscopy will be offered, which is a way of visualising the colon to look for polyps and evidence of bowel cancer. This is the first national screening programme that involves men.
We will be promoting the service within the community once it is up and running to ensure that as many 60–69 year olds as possible take up the offer of screening. Once the programme is in place, anyone aged 70 or over can request to be sent a test kit.

**Abdominal Aortic Aneurysm Screening (AAA)**

This is another new screening programme which will be available in East Sussex from April 2010. The test is for men aged 65 years. It is a single ultrasound test used to detect any swelling in the main blood vessel in the body.

**Breast Screening**

All women aged between 50 and 70 are invited every three years to have a mammogram to detect breast cancer. The screening is provided in mobile units around the community.

In the next few years, and by 2012, the screening programme will extend to offer tests for those aged between 47 and 73, so that every woman is offered an additional two tests. Currently, a local and national shortage of radiographers is causing around a six month delay to women being invited for screening. A recovery plan is being agreed and it is anticipated that this delay will be rectified by the end of 2009/10.

The national target is that 70% of eligible women should be screened.

In 2007/08, NHS Hastings and Rother had screened 75.3% of eligible women. The PBC cluster with the highest screening rate was Rural Rother with 78.6% of women eligible screened. West Hastings had the lowest rate with 66.9% of women screened.
Cervical Screening

The services in East Sussex are compliant with national policy and so between the age of 25 and 50, women are invited every three years for a cervical screening test. Between 50 and 65, women are invited every 5 years. Over 65, women will be invited only if they have had a recent abnormal test, or if they have not had a test since they were 50 years old.

The national target is to test 80% of women aged 25–65 years.

Table 22: Cervical Screening Coverage 1 April 2008–31 March 2009

<table>
<thead>
<tr>
<th>Age</th>
<th>NHS HR</th>
<th>NHS ESDW</th>
</tr>
</thead>
<tbody>
<tr>
<td>50–54</td>
<td>82.4%</td>
<td>83.5%</td>
</tr>
<tr>
<td>55–59</td>
<td>79.3%</td>
<td>80.3%</td>
</tr>
<tr>
<td>60–64</td>
<td>77.2%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Total 25–64</td>
<td>80.6%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

Across the county we are working with primary care clinicians to improve the uptake of breast and cervical screening. In particular groups who are less likely to access screening services have been targeted through initiatives such as working with community groups, promoting the programmes using posters and leaflets, working with agencies that provide support for people who are homeless or in temporary accommodation, targeting those who are receiving treatment for drug and alcohol misuse; and targeting those who do not speak English.

There is variation between practices and we are encouraging those with the lowest rates to improve their performance by sharing best practice from those that have.

We have developed a Good Practice Guide for Cervical and Breast Cancer screening based on feedback from practices with the highest rates. This will be shared with all GP practices. We are keeping the PCTs’ Professional Executive Committee informed of developments regarding rectifying the current delay in women being invited for breast screening. There is a Cervical Screening Action Plan which includes actions to support practices with the lowest rates to improve their uptake. This will be implemented during 2009/10.
The wider determinants of health

Employment

Increasingly, people aged over 60 years are remaining in paid employment and we will monitor the impact of the recession on this trend. Depending on the quality of jobs, there may be health-related benefits for older people who remain in paid and unpaid employment. These include promotion of good mental health, both through social contact associated with work and through providing a sense of structure to daily living. However, low-paid work with poor benefits may have a negative impact on health through preventing older people spending time with their families and undertaking physical activity.

Across East Sussex 10% of the retirement population are in employment.

In NHS Hastings and Rother there are nearly twice as many people of retirement age in paid employment in Hastings (14%) than in Rother (8%).

Transport

Transport has both a positive and negative impact on the health of older people (Health Development Agency, 2005). Active transport such as cycling improves health by reducing the risk of obesity, coronary heart disease and diabetes. Transport also enables older people to access essential services such as retail facilities, social networks and healthcare settings. The main negative effects are road traffic accidents, respiratory problems due to air pollution, obesity associated with reduced physical activity and noise annoyances (South East Public Health Observatory, 2008).

Local picture

Transport planning locally is lead by ESCC. Close work between the PCTs and ESCC to develop local transport plans and initiatives provides an opportunity to improve health outcomes for older people and access to health services.

For example, because older people have lower levels of car ownership, community transport schemes offer older people alternative transport arrangements, particularly in areas where public transport is limited.

The ESCC’s Cycling Strategy, published in March 2009 contains targets to increase cycling trips throughout East Sussex and it supports objectives in the PCT’s Choosing Health – Prevention of Overweight and Obesity strategy. ESCC is also currently developing a promoting-walking strategy.
Key Points from chapter 5

— Local statutory agencies work together and with wider partners to develop and promote initiatives to improve the health of older people in East Sussex. Older people are supported to engage in this process through Older People’s Forums.

— Measures to improve health such as stopping smoking, eating a healthy diet and taking exercise, drinking alcohol in moderation, practicing safe sex, taking part in screening programmes and having an annual seasonal flu jab and pneumococcal jab are key for the over 50s age group to achieve the overall benefit of adding years to life and life to years.

Smoking:

— It’s never too late to give up smoking. Five years after giving up smoking the risk of a stroke will be the same as a non-smoker.

Obesity:

— Obesity levels are high amongst older people. Nationally, almost half (49%) of men aged 65–74 are overweight and 28% are obese.
Exercise:

— Only around one in five men aged 65–74, and one in ten men aged 75 and over, achieves the national activity guidelines.
— Older women appear even less physically active than men with only 16% of women aged 65–74 achieving the guidelines and 4% aged 75 years and over.
— Inactivity contributes to loss of function and ability to maintain independence.

Diet:

— Just over one in three people aged 65–74, and less than one in three people aged 75 and over, eat the recommended five or more portions of fruit and vegetables per day.

Mental wellbeing:

— There are particular challenges to improve the mental wellbeing of older people:
  — Poor life satisfaction
  — Poor sense of involvement
  — Improve early detection of mental illness

— A Race Equality in Mental Health team has been in place in East Sussex County Council since December 2008.
Sexual health:

— Although sexually transmitted diseases are not a big issue for older people, there is a need to encourage them to practice safe sex.

Alcohol:

— Although nationally older people may be consuming more alcohol than previous generations, the recent needs assessment in East Sussex found that there does not appear to be an increasing or significant problem of alcohol dependency amongst older people.

Vaccination:

— Flu and pneumonia are major threats to older people, especially in the winter months
— Although at PCT level we meet the national target of immunizing 70% of those aged 65 and over for flu, there is variation at PBC cluster level and some practices will not be meeting the target.
Screening:

— For the first time, men will be invited to attend a national screening programme. The national bowel cancer screening programme will be in place by December 2009 and all men and women aged 60–69 years will be invited to take part over a two-year period.

— Uptake of cervical and breast screening is generally above the national targets for women in East Sussex.

Employment:

— 10% of the retirement population are employed in East Sussex.
Recommendations from chapter 5

— Local Partnership arrangements should continue to ensure that agencies work together with older people to improve the health and wellbeing of older people by implementing the ‘Time of our Lives’ strategy.

— It is never too late to promote healthy lifestyles in the over 50s. Physical activity, obesity prevention and stop smoking services are vital for adding years to life and life to years.

— The PCT should ensure that its Choosing Health – Prevention of Overweight and Obesity strategy is implemented in conjunction with East Sussex County Council’s Cycling Strategy and its proposed promoting Walking Strategy.

— The PCT should promote the update of the seasonal flu vaccine and achieve 70% target.

— The PCT should promote the uptake of cancer screening programme by:
  
  – encouraging the new bowel cancer screening programme should be promoted to 60–69 year olds.
  – sharing the Good Practice Guide to Cervical and Breast screening with all GP practices
  – ensuring that the Cervical Screening Action plan is implemented.

— The county council and health services work together and continue to develop local accessibility planning and improved transport access to services and healthcare settings.

— Support the Race Equality Mental Health team’s work programme, in particular their planned input into the delivery of the East Sussex Dementia Strategy.
References


Allen, S. C. (2008) *What determines the ability to stop smoking in old age?* Age and Ageing; 37; 490 – 1

British Heart Foundation, National Centre Physical Activity and Health (2007) Guidelines for the promotion of physical activity with older people, British Heart Foundation, London


Department of Health (2005) *At least Five a Week*, Report of the Chief Medical Officer, Department of Health, London


Institute of Alcohol Studies (2009) *IAS Factsheet – Alcohol and the elderly*, Institute of Alcohol Studies, St Ives


South East Public Health Observatory (2008) *Choosing Health in the South East: Road Transport and Health*, South East Public Health Observatory, Oxford


Quality counts
Last year, along with over 8000 men and women in East Sussex (nearly 3000 in Hastings and Rother), the NHS arrived at its 60th birthday. This was a cause for celebration, but also an opportunity for the NHS to reflect on how to move forward to deliver better healthcare in the future. The last ten years have seen a focus on improving the accessibility of healthcare services. In 2008, Lord Ara Darzi’s *Next Stage Review* made a compelling case that the NHS should now focus on delivering a *high quality* service to *all* people *every* time they use the health service. This means that, as well as being able to access health services quickly and easily, patients should also be confident that they are getting the best possible care and treatment in clean, safe environments delivered by respectful and well-trained staff, leading to the best possible health outcomes.
In East Sussex, the PCT is working with our partners to monitor and improve the quality of health services provided by local GPs and community nurses and by our local hospitals. Monitoring is vital to understand the quality of current services and consider how and where improvements need to be made. The PCT has established a Quality Improvement and Clinical Outcomes Group (QICOG) to take the lead on determining and monitoring key clinical outcomes. The group’s vision is to meet and surpass the expectations of patients for high quality services.

One of the key challenges for QICOG is to ensure that the group can collect and analyse meaningful data from a range of sources to assess whether services are of high quality. To assist with this process, the Department of Health has developed a Commissioning for Quality and Innovation (CQUIN) payment framework. This enables the PCT to link a proportion of the funding allocated to East Sussex Hospitals NHS Trust (ESHT) and Sussex Partnership NHS Foundation Trust (SPT) to the collection of data on clinical outcomes and the achievement of locally agreed quality goals. A similar Quality Performance Scheme has also been drawn up with NHS East Sussex Community Health Services, and all GPs continue to be monitored through the Quality Outcomes Framework (QoF) which assesses GPs on the extent to which they deliver high quality care.

There are a high proportion of older people living in East Sussex, it is particularly important to consider the quality of care provided for conditions more prevalent in old age such as stroke, dementia and heart disease. In East Sussex, people aged 65 and over make up 23% of the population but account for 43% of hospital admissions, so the experience of these patients during hospital stays is an important factor to improve.

Patient reported outcome measures

The NHS Next Stage Review, High Quality Care for All, noted that assessing the quality of care provided is not just a matter of considering measures of clinical improvement or mortality rates; it is just as important to consider the effectiveness of treatment from the patient’s own perspective. Patient reported outcomes measures (PROMS) are measures of a patient’s health status or health-related quality of life, which can be assessed through short, self-completed questionnaires. From April 2009, the Department of Health has stipulated that providers of acute hospital services must administer questionnaires to patients to assess their self-reported health status before and after four specific elective healthcare interventions: hip replacements; knee replacements; groin hernia surgery; and varicose vein surgery. We will report on responses from these surveys in subsequent public health literature.

The Adult Social Care Department also seeks self-reported feedback from service users and carers on a regular basis. For 2008/09, overall satisfaction of ‘older people’s directly provided services’ was reported at 92.5% for respite services and 96.5% for homecare. Emerging themes of less positive feedback included phoneline problems at one establishment, uncertainty over timing of homecare visits and also inconsistency with visiting care staff.
Homecare commissioned by Adult Social Care from the independent sector is also monitored for quality. During the period 1 January 2009–31 March 2009 the Home Care Quality Monitoring Team dealt with a total of 35 incidents relating to the independent sector. This is eight incidents fewer than the previous quarter. Of these 22 calls related to one area of service failure or quality of service, and 13 calls related to two or more areas of service failure or quality. There was one formal complaint.

One particular area continuing to be a focus for improvement for Adult Social Care is the involvement of a carer in the assessment process of a potential service user. In 2008/09 this was reported at nearly 69%. For 2009/10 it is intended this will improve to at least 75%. Operational instructions for staff have been reviewed, updated and relaunched to staff in July 2009.

Clinical audit

The NHS needs to ensure that services provided are clinically audited. This provides important lessons for clinicians that can lead to improvements in the quality of care experienced by patients.

Improving the health of older people was one of the four identified key health priorities for East Sussex PCTs during 2008/09. The other priorities were: improving health and wellbeing and reducing health inequalities; improving the health of children and young people; and developing safer, stronger economic communities.

These four areas were identified via local improvement plans that were formulated following consultation with patients, public and staff, using the Joint Strategic Needs Assessment and agreement with local partners.

It is within this framework that we have worked with experts in other health organisations to audit standards and strategies against services that commonly affect the older population, for example, stroke and falls.

In 2008/09 audits were published on the following areas of relevance to older people across East Sussex:

— Falls audits across East Sussex were commissioned by the Health Improvement Partnership and were undertaken by the Royal College of Physicians. The findings include the need for improvement in: risk assessment using a standardised tool, consistency in frequency and duration of recommended exercise programmes, recording of intervention plans, service provision in care homes, referral from minor injury units and staff training. Work to address these issues is being implemented.

— Audit against the position of the Older Peoples’ National Service Framework undertaken across both trusts. The findings have been used to inform the work outlined in the final chapter of this report.

— Audits against National Stroke Strategy (Conquest Hospital and Eastbourne District General Hospital) were conducted by the Royal College of Physicians.

These are discussed in Chapter 4 of this report.
Relevant NICE guidance – 2008/09

It is the responsibility of the NHS to ensure that new guidance from the National Institute for Health and Clinical Excellence (NICE) is reviewed. NICE guidance helps to ensure that standards of provision are similar across the NHS and mitigates against a so-called ‘postcode lottery’ that is known to be unpopular with patients and the wider public.

NICE generally publishes four types of guidance. These are: clinical guidelines, technology appraisals, public health intervention guidance and interventional procedures. The local NHS has in place mechanisms to ensure that all relevant departments are made aware of the latest guidance that is published on a monthly basis by NICE. We consider the appropriateness of each new piece of guidance against the services that are provided and then implement as applicable.

The following examples of NICE guidance from 2008/9 were identified as most relevant to older people. Implementation, where identified as relevant to local services, has been monitored by the clinical governance team, with regard to:

- type 2 diabetes: the management of diabetes
- the diagnosis and acute management of stroke and transient ischaemic attacks
- early identification and management of chronic kidney disease in adults in primary and secondary care
- rheumatoid arthritis: the management of rheumatoid arthritis in adults
- breast cancer (early & locally advanced): diagnosis and treatment
- advanced breast cancer: diagnosis and treatment
- mental wellbeing and older people
- macular degeneration (age related)
- osteoporosis – primary prevention
- osteoporosis – secondary prevention (including strontium ranelate).

Systems are in place to ensure that all new NICE guidance is disseminated appropriately and, where identified as relevant to services, is implemented both within the PCT and by primary and secondary care providers.

Patient respect and dignity

Delivering high-quality health care is not just about ensuring that treatment is clinically effective; it is also about providing care in a respectful and dignified way. It is about ensuring that patients feel listened to, that staff are friendly and sensitive to patient needs, that patients understand the treatment they are being given and the reasons for it and that patients feel as comfortable as possible whilst in healthcare environments. The Community Services Privacy and Dignity Survey will be reporting in 2009.

Patient Environment Action Teams (PEAT)

The Patient Environment Action Team (PEAT) programme was established in 2000 to inspect every inpatient healthcare facility in England with more than ten beds. PEAT teams, which consist of NHS staff, patients, patient representatives and members of the public, inspect standards across a range of patient services including with regard to food, cleanliness, infection control and patient environment (bathroom areas, décor, lighting, floors and patient access), to give the hospital an overall rating.
Table 23 shows ratings for 2009 for community hospitals in East Sussex. The ratings were either ‘good’ or ‘excellent’ for environment, food, and privacy and dignity.

**Patient Experience Trackers**

Patient Experience Trackers (PET) are handheld electronic devices that can be used to capture patients’ experience of the service they receive. PET devices have been used to assess community services provided by the PCT in a range of wards in different hospitals.

**Mixed-sex accommodation**

The Department of Health has given a clear public commitment to eliminating mixed-sex accommodation for hospital inpatients. As part of its CQUIN scheme with East Sussex Hospitals Trust, the PCT has identified patient experience — including the provision of single sex accommodation — as a key area for quality improvement. A pilot survey has been completed to assess the experience of patients using ESHT services.

**Patient safety**

Patient safety is a key element of the quality agenda. Patients using NHS services should be treated in a clean and safe environment. This means keeping to an absolute minimum the risk of vulnerable, elderly patients contracting healthcare-associated infections, tripping and falling whilst in the hospital, being wrongly administered medication, or becoming malnourished.

**Healthcare-associated infections**

Older people are more susceptible than younger people to healthcare-associated infections, such as methicillin-resistant staphylococcus aureus (MRSA) and *Clostridium difficile*.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Environmental score</th>
<th>Food score</th>
<th>Privacy &amp; dignity score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexhill Hospital</td>
<td>Good</td>
<td>Good</td>
<td>Excellent</td>
</tr>
<tr>
<td>Rye Memorial Care Centre</td>
<td>Good</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td>Lewes Victoria Hospital</td>
<td>Good</td>
<td>Excellent</td>
<td>Good</td>
</tr>
<tr>
<td>Uckfield Hospital</td>
<td>Good</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td>Crowborough War Memorial Hospital</td>
<td>Excellent</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
</tbody>
</table>
In the last year, there were no cases of MRSA in specimens taken from patients in East Sussex community hospitals, and all main acute trusts serving East Sussex residents kept within specified limits for the number of MRSA cases.

In 2008/09, there were a total of 38 cases of MRSA for patients registered with GPs in East Sussex, most of which occurred in the over-65s. All of these cases were picked up in specimens taken from patients in acute hospital settings.

Clostridium difficile

An outbreak of Clostridium difficile strain 027 within the Medical Division at Eastbourne District General Hospital was declared as a serious untoward incident on February 1\textsuperscript{st} 2009 following the analysis of numbers of cases in the previous month. In total, 61 cases were attributed to the 027 outbreak, which was declared over on 14\textsuperscript{th} April 2009. It has been concluded that three patients died directly as a result of Clostridium difficile, and a further ten patients died where Clostridium difficile contributed to their death.

The outbreak led to a decision to convert one of the medical wards, East Dean, into a dedicated isolation facility and this opened on February 13\textsuperscript{th}, 2009. On March 6\textsuperscript{th}, four cases were identified on four different wards and the hospital was then closed to medical admissions until 10\textsuperscript{th} March. Elective surgery ceased temporarily. The hospital reopened to admissions on the 10\textsuperscript{th} March 2009.

Factors contributing to the outbreak included winter pressures, lack of side room capacity, patient movement around the hospital, the frail elderly population, antibiotic usage and norovirus infection.

The SHA, PCT and the Health Protection Agency were fully involved throughout the outbreak, and regular outbreak control team meetings were held daily during the height of the outbreak.

Since the outbreak, there has been a focus in the hospital trust on hand hygiene compliance and antibiotic policy reinforcement. An infection control steering group has also been established to oversee the implementation of recommendations by the Health Protection Unit and to ensure that current practice relating to the control of healthcare-associated infections meets with national standards.

In East Sussex in 2008/09, there were a total of 368 cases of Clostridium difficile, most of which occurred in the over 65s.
Nutrition

Good nutrition is a key element of high-quality care, and it is vitally important to ensure that the nutritional needs of patients in hospitals are met. This is particularly true for vulnerable older people who may be malnourished when they arrive in hospital or become undernourished in hospital because of factors such as: lack of support with eating; limited choice of food; loss of appetite; the side effects of medication; lack of a conducive environment for eating; failure to identify particular nutritional needs; and poor food presentation.

Essence of Care benchmarking is a process for comparing, sharing and developing best practice in order to improve the quality of care. A rolling programme has been established to implement Essence of Care throughout East Sussex, with the initial focus being on nutrition. A small number of patients (usually five) on a number of different community hospital units were asked a series of questions related to mealtimes, food and eating.

The results of the nutrition survey have been used to develop a range of nursing-led actions in community inpatient units. This includes the recent establishment of a clinical nutrition group, which is spearheading policy and practice development, and initiatives by local units, which are all implementing focused improvement activity around nutrition support and training.

Intermediate care

Preventing unnecessary admission to hospital and facilitating timely discharge and effective rehabilitation are two important measures of quality.

In 2008/09, 2,286 people received intermediate care to prevent hospital admission (1,164 in a non-residential setting and 1,122 in a residential setting). This represented an improvement of more than 9% on the previous year’s activity, where 2,097 people received intermediate care to prevent hospital admission.
A further 1,577 people received intermediate care to facilitate timely hospital discharge and effective rehabilitation (783 in a non-residential setting, 794 in a residential setting). This represented an improvement of approximately 11.6% on the previous year’s activity, where 1,413 people received intermediate care to facilitate timely hospital discharge and effective rehabilitation.

Having been assessed against national standards, East Sussex has been found to do comparatively well on keeping people independent and out of hospital (national indicator 125). Improving performance against these indicators is a key requirement of the intermediate care strategy.

**Safeguarding Vulnerable Adults**

East Sussex Adult Social Care Department has lead responsibility for investigating abuse of vulnerable adults. They work closely with a wide range of partners, including Sussex Police, the NHS and independent and voluntary sector service providers, to promote prevention and address incidents when they arise. Abuse can arise from both neglect and intentional harm, and can be a one-off incident or sustained over a long period of time. In all cases sensitivity to the presenting circumstances is maintained and, wherever practical, carers and family members assist with decisions alongside consultation with the victim.
In 2008/09 there were 1,323 referrals for investigation of suspected abuse received by Adult Social Care. The most common type of incident reported was of physical abuse, which accounted for 32% of incidents. Neglect saw the most significant increase, from 120 referrals in the previous year to 274 during 2008/09, and there was also a substantial increase in the reports of suspected financial abuse, from 158 to 239. The most common location of a reported incident of abuse was a care home with the next highest percentage being at the home of the victim. The reasons for such a high percentage from care homes may actually be due to raised staff awareness and ‘safe’ reporting mechanisms and therefore will need further analysis.

Service inspections

Prior to April 2009, the Commission for Social Care Inspection (CSCI) were responsible for inspecting all Adult Social Care Departments in England. East Sussex Adult Social Care Department was inspected in 2008 regarding its service to older people. This inspection focussed on prevention services and safeguarding and the overall outcome found the department to be of a ‘good’ standard.

In April 2009, CSCI merged with the Healthcare Commission and the Mental Health Act Commission to become the Care Quality Commission (CQC) with responsibility for the regulation of health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. The CQC is also responsible for protecting the rights of people detained under the Mental Health Act.
Key points from chapter 6

— Lord Ara Darzi’s *Next Stage Review* made a compelling case that the NHS should focus on delivering a *high-quality* service to *all* people *every* time they use the health service. This is particularly important for older people who are high users of health services.

— In East Sussex, the PCTs are working with our partners to monitor and improve the quality of health services provided by local GPs and community nurses and by our local hospitals. A Quality Improvement and Clinical Outcomes Group has been established to lead on determining and monitoring key clinical outcomes.

— The PCT has worked with experts within other health organisations to audit standards and strategies for services that commonly affect the older population, for example, those concerning stroke and falls.

— A recent inspection by the Patient Environment Action Team has rated East Sussex community hospitals as either ‘good’ or ‘excellent’ for environment, food, and privacy and dignity.

— In the last year, there were no cases of MRSA in East Sussex community hospitals, all acute trusts serving East Sussex residents achieved the reduction targets limits for the number of MRSA cases.
An outbreak of *Clostridium difficile* at Eastbourne District General Hospital was declared as a serious untoward incident on February 1\textsuperscript{st}, 2009. In total, 61 cases were attributed to the outbreak, which was declared over on April 14\textsuperscript{th}, 2009. It has been concluded that three patients died directly as a result of *Clostridium difficile*, and a further ten patients died where it was thought to have contributed to their death.

The outcome of the 2008 CSCI inspection into Adult Social Care’s older people’s services for prevention and safeguarding was ‘good’.

**Recommendations from chapter 6:**

- Quality counts in East Sussex and the PCT should continue to develop the quality improvement work, particularly including the public feedback measures, in its commissioned services.
- The services commissioned by the PCT need to meet infection control standards and reduce healthcare-associated infection. The PCT and East Sussex Hospitals Trust need to ensure that the lessons learned from the Health Protection agency review of the *C.difficile* outbreak are implemented.
Working together
This chapter outlines the joint working arrangements in East Sussex for older people.

In recent years, our joint structures for planning and delivering care and support for older people in East Sussex have developed in line with national policy. The diagram overleaf summarises the various groups and how they link.
At an executive level, the Joint Health & Social Care Executive Group provides strategic direction for joint planning, commissioning, service development and delivery across the whole range of health and adult social care services. Membership of the Joint Health & Social Care Executive Group includes:

- East Sussex County Council – Director of Adult Social Care
- East Sussex Hospitals Trust – Chief Executive
- East Sussex Primary Care Trusts – Chief Executive
- Sussex Partnership Trust – Chief Executive

There are currently six key planning streams that make up the health and social care ‘whole system’:

- services for people with a learning disability
- services for older people
- services for people with mental health problems
- services for carers
- services for people with a physical disability, sensory impairment and/or long-term condition – this work is being described in a new strategy called *Improving Life Chances*
- housing related support including the Supporting People programme funding.

There are ‘partnership boards’ in each of the above service areas. Broadly speaking, each partnership board aims to be as inclusive as possible in terms of stakeholder involvement and also undertakes to co-ordination of issues set out below.
In 2007 East Sussex published its first Joint Commissioning Strategy for Older People and Carers. This strategy detailed the ambition of East Sussex County Council, the NHS in East Sussex and a range of partner organisations in the voluntary and independent sector to work in partnership with older people and carers to improve the experience of people who use our services and to get the most out of available resources.

The strategy describes how health, social care and housing support services will change in the next few years taking into account national and local priorities and the views of older people and carers. We put together a three-year action plan to help us improve services to older people and carers by promoting independence and wellbeing, providing local services and helping people remain in their own homes.

**The Care Pathway**

Locally Adult Social Care has worked in partnership to make sure that we achieved our goals for improving services to older people and carers. We recognised that people would need services at different stages of their life depending on their health, social care and housing needs. To make sure that we are able to respond to these needs we identified different points when care is required and planned how we should change and deliver services at each stage.

We identified these stages and they are shown below. These are when people are:

1. fit and well and growing older
2. experiencing problems that might be preventable
3. in immediate need of help or treatment
4. ready / preparing to go home
5. in need of long-term support.

In addition we recognised that people can experience mental health issues in later life that may or may not be age-related and that these could occur at any of the above stages. We decided we needed to make sure that we planned and improved services to address these issues at each stage. We identified this work as an underpinning pathway called ‘mental health in old age’.

Whilst it is clearer to think in terms of these stages, we also recognised that people may move from one stage to another and back again depending on their needs, and that in some cases it was important to put in services to try to prevent this happening unnecessarily e.g. re-admission to hospital.
What we have achieved so far and our next steps

Summarised below are examples of what groups reporting to the Older People’s Partnership Board have achieved in our first two years of working together and our ‘next steps’:

1. Fit and well and growing older

— The *Time of Our Lives* strategy was published in 2008. This is our three-year plan (2008–2011) to improve and promote the quality of life for people in the later stages of their life in East Sussex.

— The Joint Strategic Needs Assessment (JSNA) Board was established and a programme was agreed to deliver a series of reports which will help us understand wider trends in health and wellbeing across the county for the whole population of East Sussex.

— We used the £3.2 million of funding which the county council was awarded from the Department of Health in 2006, through the ‘Partnerships for Older People Projects’ programme, to provide a range of preventative services.

— Services include:
  - the Navigator Service, where staff visit older people in their homes, advise them about local services and provide grants for exercise and wellbeing activities, carers, transport and handy person services
  - improved access to simple aids and equipment, which help people remain living at home
  - the County Connect service, a service which helps frontline staff from a number of partner agencies who work with older people to make it easier to refer people to each other

Next steps:

— We will continue our work directly with older people through the Older People’s Forums, responding to their priorities in improving older people’s quality of life in East Sussex.

— We will continue to use the information from the new Joint Strategic Needs Assessment reports to ensure we develop services to meet future needs.

— We will continue to work with all our partners to provide, develop and evaluate a wide range of advice and simple services that promote people’s health and wellbeing and support their independence.

2. Experiencing problems that might be preventable

— Health and social care staff have worked together to examine case management practice and process.

— The Joint Information Access Project has completed its review of available information for older people, their carers and staff and will now develop better information which will be available in a range of different ways.

— The East Sussex Stroke Strategy has been developed and supported by significant public and patient involvement.
— The telecare service has been running for two years and now has over 2,000 telecare users.

— Falls services were established across the whole county. These are a team of professionals including occupational therapists, and Physiotherapists who support older people who are at risk of falling by providing advice and treatment.

Next steps:

— We will develop the ‘Improving Life Chances’ Strategy for people with long-term conditions, physical disability or sensory impairment.

— We will continue to improve the ways Adult Social Care and the National Health Service work together.

3. In immediate need of help or treatment

— The Single Telephone Access Number (STAN) has operated to provide advice to GPs on alternative services in the community for their patients so that they do not have to be admitted to hospital.

— An Intermediate Care Strategy has been developed – this brings together a range of short term intensive services to help prevent people having to go into hospital and help people regain their health after they have been in hospital.

— General Practitioners are now working in the Accident and Emergency departments in both Eastbourne and Hastings Hospitals to treat patients who may not need to be admitted.

— We introduced Emergency Care Practitioners – clinically trained paramedics visiting people at home as part of the ambulance service. The paramedics are able to diagnose people’s health issues and provide treatment if appropriate at home.

— We introduced an Enhanced Response Team- a quick responding home care service for people attending Accident and Emergency departments who do not require hospital admission but need care and support to enable them to return home.

Next steps:

— We will reduce Accident and Emergency admissions at the hospitals in Hastings and Eastbourne by providing alternative local health and care services.

— We will provide training and support to staff in residential and nursing homes in East Sussex to reduce the number of people being admitted to hospital from the homes.

— We will improve access to a range of short-term intensive services, such as community beds for those people who do not have to be admitted to hospital.

— We will reduce the time that people have to stay in hospital by continuing to improve the way we work together.
4. Ready or preparing to go home

This includes providing support for people whose immediate need for help or treatment has been addressed in hospital and they are either ready to go home or need further care, support or treatment to recover.

— We are working on improving information to patients on what may happen and the choices regarding a range of other services available when they are ready to leave hospital. This is called the ‘discharge information booklet’.

— We have developed a ‘carers pathway’. This is to support staff within the hospital to identify carers ensuring that opportunities to refer for a carers’ assessment can be highlighted and that carers are supported as individuals and included within the discharge planning process.

— We have improved access for patients so that they can see social care assessors when they need to.

— We have improved joint working with adults and older people’s mental health services, for example, in developing information packs for patients.

— We have agreed to three year’s funding for the ‘Home from Hospital’ and ‘Take Home and Settle’ services. These services are provided by Age Concern and successfully support people once they have been discharged from hospital by providing transport home, help with light housekeeping and shopping.

Next steps:

— We are aiming to improve referral processes between teams to ensure that patients are not unduly delayed within hospital whilst waiting for assessments.

— We will provide further work and training around supporting discharge planning at the earliest point in a patient’s hospital stay.

— We will promote best practice with discharges seven days a week.

5. In need of long-term support

— A review of the way services are provided in our three extra care housing schemes was completed. Extra-care housing is a special housing scheme for older people, which provides on-site 24-hour care and support services to people living in the scheme. We also funded an outreach support service to help people to continue to live independently in the community.

— We have successfully developed a new extra-care scheme called Downlands in Peacehaven, which will provide 41 homes, including 11 homes that can be purchased and eight homes for people with dementia. The scheme will open in September 2009.

— We are in the process of identifying potential providers for The Age Well project, which will provide a range of care services on four sites in East Sussex. This project will provide 180 beds which will meet the needs of people with dementia and provide intermediate care and respite services.
A plan on care services to be provided at the end of someone’s life was produced in June 2008. We have worked together and agreed that the services will now be delivered in a more joined-up way.

We have successfully submitted two initial bids to the Department of Health to obtain funding to pilot work for a two-year period with GP surgeries to support carers and provide flexible respite for carers of people with dementia. We have now progressed to the second stage of the bidding process.

**Next steps:**

- We will consult widely on what housing-related support services are needed to support as many older people as possible regardless of tenure.
- We will review our strategy to improve and deliver services for carers.
- We will implement a co-ordinated range of services to support people at the end of their life.
- We will develop and improve a range of day care and day opportunity services across the county.

**6. Mental health in old age**

- A specification for a specialist dementia home care service was completed and work will commence on identifying interest from potential providers of services in 2009, with an aim for services to be introduced in 2010.
- We successfully reviewed the use of inpatient mental health services, so that they more effectively meet the needs of older people. Changes were made without disruption to the patients.
- The above review enabled funding to be released so that we could continue the provision of the services provided by the Memory Assessment and Support Team (an assessment and signposting service for people with early signs of memory loss) and the Intensive Community Support Service, whose funding was due to end.
- We began discussions on how to improve access to intermediate care services for older people with mental health problems.
- We carried out work to prepare for the publication of the first National Dementia Strategy.

**Next steps:**

- We will increase early identification of older people’s mental health issues in primary care.
- We will increase provision of the services provided by the Memory Assessment and Support Teams.
- We will work with partners to support seamless discharge from hospital back into community settings.
- We will implement intermediate care plans to provide opportunities to reduce hospital stay and actively rehabilitate people back into their communities.
Improving Life Chances

*Improving Life Chances* is the name of the East Sussex joint commissioning strategy for disabled adults with physical and sensory impairments and those with limiting long-term conditions. This strategy is currently being developed. A number of patient and public engagement events were held in 2008/09 to understand what was important to our local population. The outcome of these are being combined with national and regional strategies to develop a joint commissioning strategy between health and adult social care. The strategy is expected to be completed by September 2009.

East Sussex Joint Commissioning Strategy for Carers 2010–2015

East Sussex has a total of 50,993 unpaid carers, representing 10.35% of the total population. Of those caring, approximately 30% have caring responsibilities for more than 20 hours per week and nearly 20% have caring responsibilities for in excess of 50 hours per week. The likelihood of becoming a carer increases with age and the number of older carers is increasing. Currently, one third of all carers are aged over 60. The heaviest caring roles are most often undertaken by older carers, for longer hours per week, at a time when their own health and strength are more vulnerable. More than 80% of carers say caring has damaged their health and more than 50% of older carers have their own long-term illness or disability (Census, 2001). Further information on carers is provided in Chapter 2.

In 2009, the PCTs’ and ESCC’s local Commissioning Strategy for Carers’ Services is being revised in consultation with carers and clinicians. This is in response to the 2008 National Strategy for Carers: Carers at the Heart of 21st Century Families and Communities, which aims to ensure that support for carers, particularly older carers, is prioritised in all health and social care settings.
The PCTs and ESCC have historically commissioned a range of services from the voluntary sector, including a hospital liaison worker, who works with East Sussex Hospitals Trust staff to support carers and outreach workers that support carers in their homes and provide training for primary care staff to raise their awareness of carers’ issues.

The focus of the new local strategy will be on preventative work to avoid carer stress, developing better opportunities for respite care, the provision of information and emotional support for carers, back care advice and to ensure that staff recognise and value the contribution that carers make to the local health economy.

By working across agencies we can achieve the effective interagency communication and integration of care that older people have recommended.

Recommendation:

— The findings of this public health report should be considered by the Older People’s Partnership Board and the working groups reporting to it to inform the refreshed Joint Commissioning Strategy for older people and its future joint work programmes.

Footnote: For more information on the work of the Programme Boards and progress on the Joint Commissioning Strategy for Older People and Carers please contact:

Geraldine O’Shea,
Strategic Commissioning Manager (Older People)
Tel: 01273 482751
Email: geraldine.o’shea@eastsussex.gov.uk
Population definitions

East Sussex residents are defined as those who live in the county of East Sussex, i.e. have an East Sussex postcode. The registered population are those who are registered with a GP practice within the PCT. Some patients living outside East Sussex may register with an East Sussex GP practice, and similarly, some East Sussex residents may register with a GP practice outside the county. GP list data is available via the Exeter database and has been sourced accordingly.

Standard populations used to calculate life expectancy

The district / borough and county figures were produced using England as the standard. The standard population data is only used if, within a small area, there are no deaths in a certain age group. In such situations, the age-specific mortality rate from the standard area is used. The East Sussex population is likely to have experienced lower death rates where such substitution occurs (only likely in younger age groups) than when England rates are used. This explains potential differences between East Sussex figures.

Morbidity and mortality can vary widely by age. An older population will normally experience higher mortality and morbidity than a younger population. To allow meaningful comparisons between areas with different age structures, mortality/morbidity rates are often age standardised. There are two methods – direct and indirect age standardisation.

Directly age-standardised rates (DSR)

Age-specific rates in the population we are interested in (e.g. East Sussex) are applied to a standard population; normally the European standard population is used. This produces a rate for East Sussex that would have occurred if the county had the standard population age structure. This method allows mortality / morbidity rates to be compared across different populations and time, as long as the same standard population is used.
Indirectly age-standardised ratios (often expressed as SMRs)

Age-specific rates of a standard population (e.g. East Sussex) are applied to the population we are interested in (e.g. PBC cluster) to calculate the expected number of events, i.e. the number of events expected in a PBC cluster if they experienced the same age-specific rates as East Sussex. The expected number of events is compared to the number of events observed in the population of interest and expressed as a ratio (observed / expected). A ratio above 100 indicates a higher than expected number of events and a ratio below 100 shows a lower than expected number of events. Indirectly age-standardised rates allow comparison to the standard population only, they cannot be compared across different geographies.

Significant differences in rates

Age-standardised rates (both directly and indirectly standardised) can have 95% confidence limits calculated for them; that is, the range within which we can be 95% confident that the true value lies. To identify (statistically) significant differences in rates for different populations the confidence intervals must not overlap. Note that any graphs for indirectly-standardised rates display the confidence intervals for the populations interested in on the bars (e.g. PBC cluster). The 95% confidence intervals around the standard (e.g. East Sussex = 100) are not displayed so although at first glance there may appear to be significant differences between a cluster and the standard, this may not be the case. Populations identified in the text as significantly different are only where the 95% confidence limits for the standard population and the population interested in do not overlap.