

Older People in Walsall



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The 2001 Annual Report of the Director of Public Health Medicine



Continuing the theme-based tradition of recent annual reports, my report this year explores the issues affecting the health of older people in Walsall. There are about 55,000 residents in Walsall aged 60 and over, and the report focuses on an examination of the health, the interrelated socio-economic conditions, and the services provided for this group of people.

Older people are the main users of health and social care services. The recently published National Service Framework for Older People recognises that services sometimes fail to meet older people's needs, and sets out a series of national standards which are designed to improve services and provide a uniformly high standard of care across the country. The standards cover a wide range of issues including improved intermediate care (to promote faster recovery from illness and to maximise independent living), integrated stroke services, falls prevention and rehabilitation, mental health services for older people, and promoting health and active life in old age. Social services as well as health services are integral components of the National Service Framework.

It is my intention that the report will help inform and facilitate the decision making process for all agencies and individuals involved in improving services and the health of older people in Walsall. In addition, my report provides a broad range of information and analysis, which I hope will be of assistance in designing local action for implementation of the National Service Framework in Walsall.

Dr Sam Ramaiah

Director of Public Health Medicine

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Introduction

About 21% of the population of Walsall are aged 60 or over and this proportion is expected to increase over the next 20 years. The health of older people is a vast subject and is affected by a wide and diverse range of issues, including socio-economic conditions. The report aims to provide an overview of the key issues, although a brief report of this nature cannot claim to be comprehensive.

As in recent Public Health Annual Reports, the small area analysis is presented on the basis of the four Primary Care Group areas as they were configured up to September 2001, and by electoral ward where available. However, it should be noted that the organisation and structure of health services in Walsall are currently in a period of transition, as the four Primary Care Groups merge into two, to be followed by the establishment of one or more Primary Care Trusts by April 2002.

The report is divided into five chapters:

Chapter 1 describes the structure of the older population and life expectancy in Walsall. The wide variation of older people as a proportion of the total population in different parts of Walsall is outlined. Estimates and projections of the proportion of older people from ethnic minorities are also presented. Together with the projected increase in the total older population in Walsall over the next 20 years, this chapter suggests that services will need to adjust to meet the challenges presented by these changes.

Chapter 2 examines some of the socio-economic conditions in which older people live in Walsall. Housing, income levels, crime and transport issues all have a bearing on the health of older people. This points to the need to continue the programme to increase the supply of

housing suitable for older people in Walsall, to ensure older people claim the range of new and higher income entitlements being introduced by Government, to continue development of local programmes to protect older people from criminal activity, and to improve access to public transport for older people.

Chapter 3 considers care and support of older people in the community. Key data on long term illness and disability and issues concerning the maintenance and promotion of good health among older people are examined. The second part of the chapter examines the range of services in place to help older people to live independently in the community. These include home care, sheltered housing, aids and adaptations, and intermediate care. Finally, this chapter reviews residential and nursing care for older people whose needs have become too great for them to continue to live in their own homes, including palliative care for the terminally ill. It is evident that there is a significant number of older people who are in need of support from the statutory agencies and this needs to be taken into consideration as part of the process of implementing the National Service Framework for Older People in Walsall.

Chapter 4 examines hospital admissions of older people in Walsall. These are shown broadly to reflect the pattern of deprivation. Links with community care (such as good sheltered housing or home care) and intermediate care are emphasised as being important elements in reducing emergency admissions of older people, which in Walsall are among the highest in the West Midlands. By contrast, Walsall currently leads the national league table for the least number of people per head of population waiting for elective surgery.

Chapter 5 looks at key data and trends for a range of specific conditions which are more prevalent in older people. These include stroke, coronary heart disease, diabetes, cancers, orthopaedic conditions (and falls), and influenza. It is clear that there remains considerable scope for undertaking preventative activity among older people and this should remain an important priority.





Who Are We?

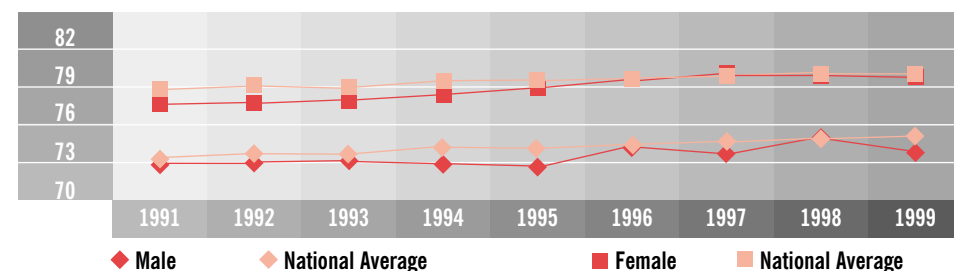
1.1 POPULATION

Walsall is an area of great diversity, in the distribution of young and old, in ethnicity, culture and income. It contains some of the most deprived wards in the country, and others of some affluence. Widely varying mortality rates reflect this diversity within the borough (Director of Public Health, 1999). Figure 1 below sets life expectancy of people in Walsall in a national context. It appears that the position of women overall in Walsall has improved slightly in the last years of the 20th century compared to national life expectancy. Men, however, have been less likely to live as long as the national average in the past 10 years. However, the wide local variation in mortality rates within Walsall would suggest that borough figures for life expectancy may conceal similar variation.

Unlike many other districts, the boundaries of Walsall's Primary Care Groups fit neatly into the boundaries of Electoral Wards, as shown in previous Public Health reports. It is difficult to be precise about the exact number of older people

Figure 1

Life Expectancy in Walsall 1991-1999



Source: Office for National Statistics

who live in Walsall: the last full Census for which results are available was in 1991, and is known to have underestimated certain population groups. Analysis of this year's 2001 census is awaited. In between each census a mid year estimate is made, taking into account births, deaths and migrations. Population estimates by Oxford University have calculated the number of persons aged over 60 for every electoral ward in the country. By this estimate, Walsall has a total of 55,400 persons aged 60 or above (Map 1 page 6). The population of older people as a proportion of total population in each ward ranges from a low of 15% in Blakenall to 30% in Pheasey.

Another source of population data derives from the number of people registered with a GP, held by the Health Authority. The total number of Walsall residents registered with a GP, aged 60 or above, is 51,298, some 7% less than the Oxford estimate. Figure 2 shows the age distribution in the Walsall Primary Care Groups as they were configured up to September 2001. It shows that South and East PCG have a higher population aged 60 and over than West and North PCGs.

The 1999 mid-year estimates for population show that the female population predominates in all age groups over 60 in Walsall and in the 75+ age group the number of women is double that of men (Figure 3). Despite a downward trend in the population as a whole, the older population is expected to increase in the first twenty years of the new century (Figure 4 page 6).

1.2 ETHNIC POPULATION

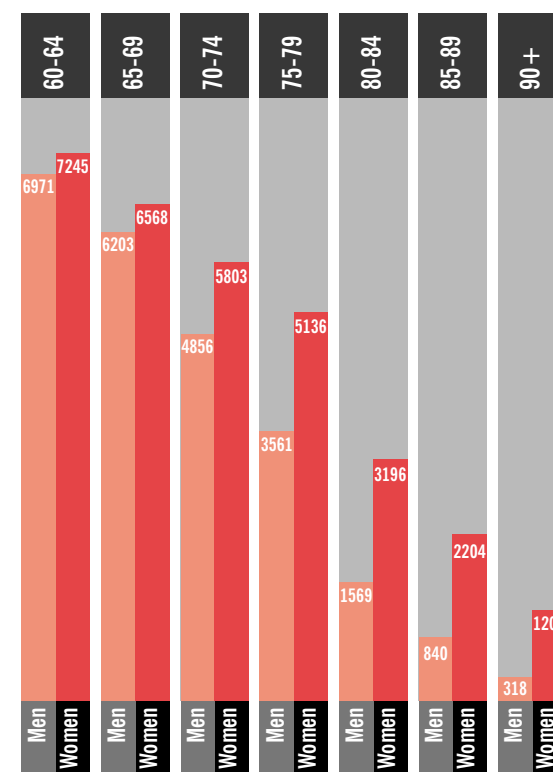
Figures for Walsall's ethnic minority population are estimated. It is hoped that more detailed and reliable figures will emerge with the results of the 2001 Census. What we currently have is contained in the 1999 Annual Report of the Director of Public Health Medicine, with the addition of some general projections of ethnic

minority population in the borough (Table 1 page 6). As that table shows, Walsall's older minority population is expanding. Those who migrated to Walsall as young adults in the 1950s and 1960s are now moving into retirement.

It has been suggested that ethnic minority older people face "multiple hazards" entering old age. Issues of social disadvantage are discussed in detail in the Profile of Poverty and Health in Walsall (Griffiths S., 1999b). National data for mortality show some important differences in the health problems faced by different ethnic groups, some, but not all, arising from social inequality. For example, mortality from coronary heart disease is higher than average for people born in South Asia, and lower for people born in the Caribbean and for men born in West Africa. Mortality ratios for cerebrovascular disease are higher for all migrant groups (except those born in East Africa); and they are lower for lung cancer in migrant groups born in the Caribbean, Asia and Africa. Mortality ratios for accidents are higher among those over the age of 65 who were born in the Indian sub-continent. Diabetes has a higher incidence among South Asians and those of Caribbean origin. Some of these issues are related to lifestyle, for example the

Figure 3

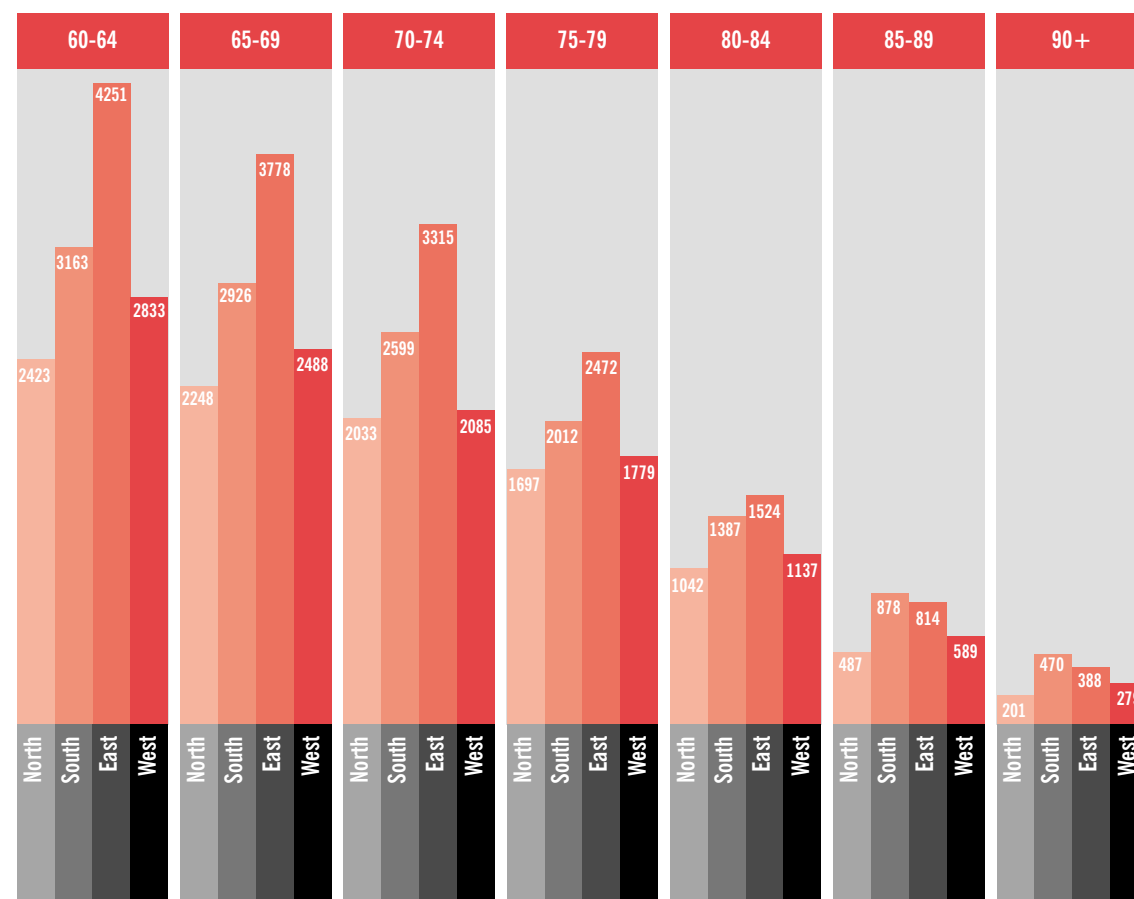
Mid Year Population Estimates for Walsall 1999



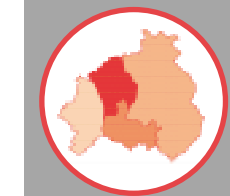
Source: Office for National Statistics

Figure 2

GP Registered Population by Primary Care Group, Older People, Walsall, 2001



Source: Walsall Health Authority

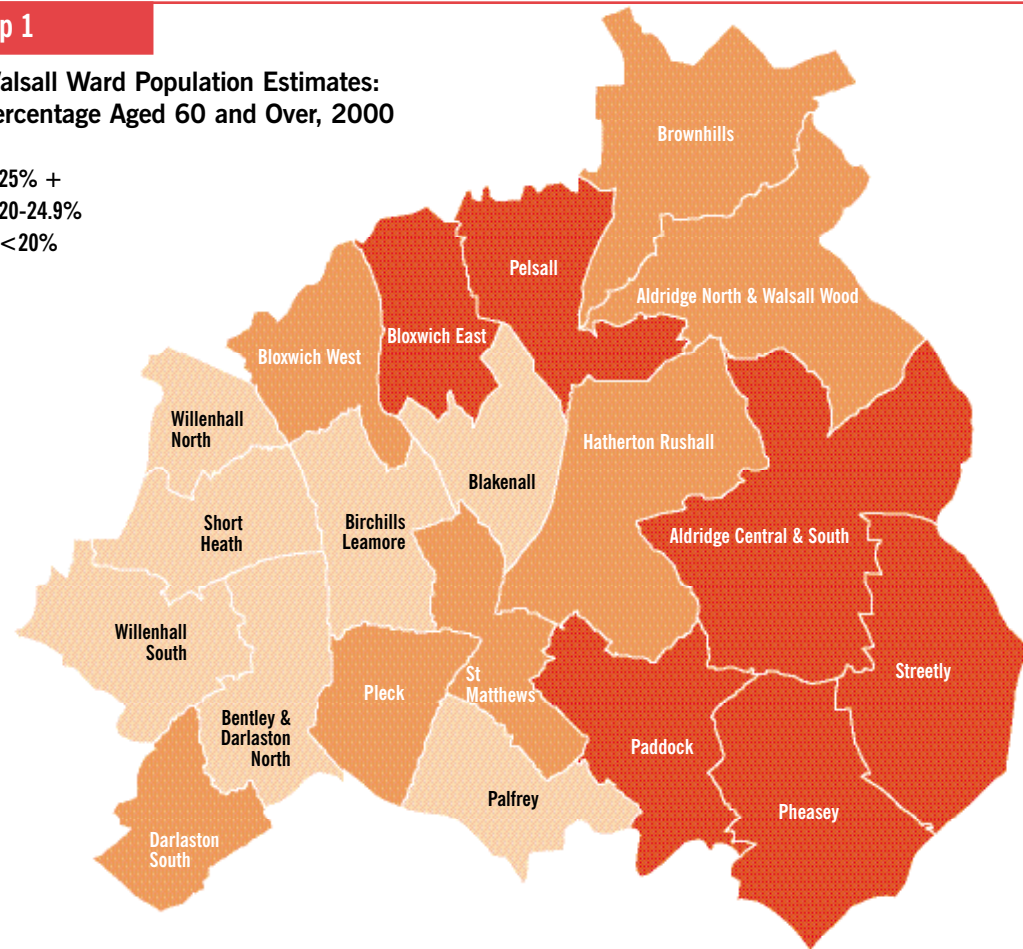




Map 1

Walsall Ward Population Estimates: Percentage Aged 60 and Over, 2000

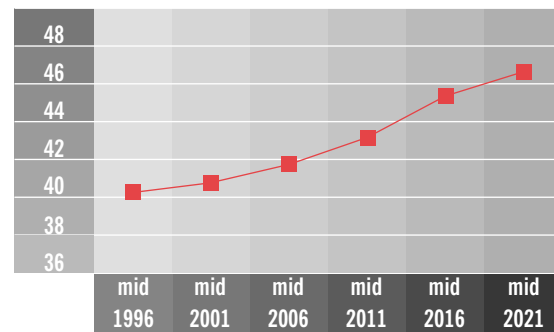
- 25% +
- 20-24.9%
- <20%



Source: Social Disadvantage Research Group, Oxford University

Figure 4

Projected Population for Persons Aged 65 and over in Walsall, 1996 - 2021 (Thousands).



Source: Office for National Statistics

lower level of lung cancer in minority ethnic groups will relate to lower levels of smoking compared to the White communities; others reflect a predisposition. If the numbers of older people in some communities are expected to grow in Walsall over the coming years, health services will need to adjust to meet different challenges, in terms of prevention, early intervention, and care.

Table 1

Walsall's Population Aged 65 and Over by Ethnic Group: Population Projections, %

| | 1996 | 2001 | 2006 |
|-------|------|------|------|
| WHITE | 96.3 | 93 | 91.5 |
| ASIAN | 3 | 6 | 7 |
| BLACK | 0.7 | 1 | 1.5 |

Source: Walsall MBC

Social and Economic Conditions

greatest need. All of these approaches relate to the needs of older people. However, the availability of suitable housing for older people is influenced by major factors of supply and demand: population trends and their match with supply, what is regarded as 'suitable', and the size, nature and quality of the housing stock.

The expected increase in numbers of older people in the borough over the next few years will clearly influence housing demand. Along with this, the rise in numbers of smaller households generally will put pressure on supply: a higher number of single households accounted for all of an increase of 500 in Walsall MBC's Housing List in the year to May 2000. However, the number of older people on the Housing List has only increased marginally. In all, older people account for 1600 of a Housing List numbering nearly 14,000. Two-thirds of the older applicants are couples.

The problem for older people is a major mismatch between expressed housing need and the nature of supply. Walsall has a current stock of over 1,800 bungalows and 2,100 flats and bedsits designed for the older people. However, across much of the borough, demand for what is on offer is low, with the exception of Bloxwich North, where it is high, and Brownhills, Burrowes Street TMC, New Invention and Rushall, where it is classed as 'medium'.

Much of the problem of widespread low demand for this housing for older people arises from its failure to meet modern expectations. Part of this is to do with poor housing conditions, which are associated with a wide range of health problems. Dampness is associated with higher levels of allergic and inflammatory lung diseases, such as asthma, independent of smoking and socio-economic factors. Unmodernised older properties have far higher heating costs than modern or improved homes, adding to the health consequences of low income.

In response to the mismatch described above, and to improve housing conditions, a rolling investment programme has been undertaken to address shortcomings in housing provision for Walsall's older residents.

2.1 HOUSING

This section provides a brief generally overview of housing issues affecting older people in Walsall. Housing that provides support or care for older people who need it, such as sheltered housing or residential care, is discussed in Chapter Three.

Housing tenure is linked profoundly to differences in health. For example, the mortality rate generally among people aged 60-74 who have been living in Council accommodation is 16% higher than the average for that age group; while that of people in owner-occupied accommodation is 13-14% lower than average (Smith J. and Harding S., 1997). Many factors related to income influence this difference; but clearly the quality, availability and nature of the housing itself is important. Walsall MBC's Housing Strategy Statement sets out the ways in which the Council believes that its housing provision can affect health, by:

- Influencing housing location
- Promoting good housing design/layout
- Providing support with improvements/adaptations to property and promoting affordable warmth
- Helping to resolve conflict (e.g. landlord/tenant disputes)
- Providing support to people in stressful housing situations
- Improving community safety
- Working with appropriate agencies to target health services/health promotion in areas of

- Extension, central heating and new windows for one-bedroom bungalows in the Birchills area
- Window replacement to all the remaining older persons' bungalows with metal windows
- Replacement of baths with flat-bottomed showers, in accordance with recommendations of Occupational Health
- Installation of lifts to upper levels of low rise accommodation designated for older people.

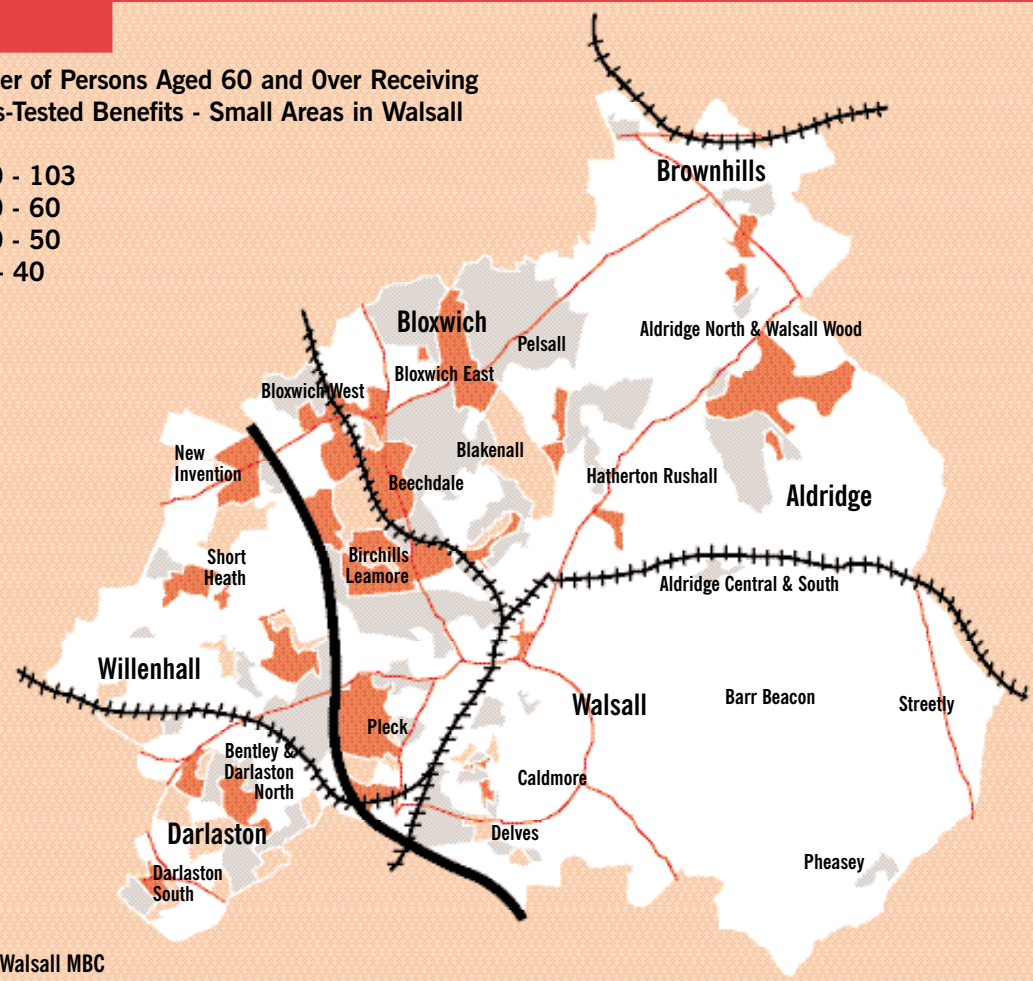




Map 2

Number of Persons Aged 60 and Over Receiving Means-Tested Benefits - Small Areas in Walsall

- 60 - 103
- 50 - 60
- 40 - 50
- 1 - 40



Source: Walsall MBC

2.2 INCOME

Income has a core influence on living conditions and the health associated with them. There is not much direct research on the relationship between income and health in older people, but socio-economic group can be taken to represent income. The biggest differences between socio-economic groups in mortality of those aged 65 and over are found in lung cancer and respiratory disease, coronary heart disease and stroke, all of which show higher rates as disadvantage increases (Acheson, 1998). As for prevention of disability and maintenance of health, respiratory function is lower and blood pressure higher among older people from lower socio-economic groups.

There is much evidence of the distribution of low income in Walsall among older people. In May 1998 there were 10,741 people aged 60 and over receiving Income Support in the borough.

In November 1998, 4,410 single persons aged 60 and over not in receipt of Income Support were getting Housing or Council Tax Benefit on grounds of low income.

2,883 claimants where either the claimant or partner was over pension age, who were not in

receipt of Income Support, were getting Housing or Council Tax Benefit on grounds of low income.

Thus over 18,000 people either of pension age, or claiming with someone of pension age, were claiming means-tested benefits in Walsall in 1998.

Among Income Support recipients aged 60 or over nationally, the average number of people 'dependent' (excluding dependent children) on each claim was 1.164. If we multiply the total number of Income Support claims in Walsall by that figure, and add numbers we have for those dependent on the other means-tested benefits, taking account of partners under 60, we have a reasonable estimate of the number of people aged 60 and over dependent on means-tested benefits in Walsall in 1998: over 21,000.

This suggests that about 12,000, or 22% of the population aged 60 and over in Walsall, are dependent on Income Support; and that 39% are dependent on means-tested benefits, compared to a third nationally.

However, it is estimated that both nationally and in Walsall, if those who are entitled but not claiming are taken into account, half the population aged 60 and over is living at a level to qualify for means-tested benefits (Griffiths, 1999a and 1999b). The increase in the Minimum Income



2.2.1 The Distribution of Older People Receiving Means-Tested Benefits in Walsall

Map 2 above shows small areas (Census enumeration districts) where there are concentrations of older people receiving means-tested benefits. It shows numbers rather than

Guarantee in 2001, and the introduction of the new Pension Credit in 2003 combined with possible higher Housing Benefit levels, will increase this proportion significantly. It will present a challenge both locally and nationally to ensure that older people are claiming and receiving these new and higher entitlements.

Table 2

Persons Aged 60 and Over Receiving Means Tested Benefits - Wards, Walsall November 1998

| WARD | RECEIVING INCOME SUPPORT | | | | | RECEIVING MEANS TESTED BENEFIT (IS/HB) | |
|---------------------------------|--------------------------|--------------|-----------------|---------------|---------------------------|--|--|
| | AGED 60 - 69 | AGED 70 - 79 | AGED 80 OR OVER | TOTAL REC. IS | % OF ALL OCCUPIED H/HOLDS | TOTAL NO. | % RECEIVING MEANS TESTED BENEFIT OF ALL OCCUPIED H/HOLDS |
| ALDRIDGE CENTRAL AND SOUTH | 115 | 118 | 207 | 440 | 8.3 | 682 | 12.9 |
| ALDRIDGE NORTH AND WALSALL WOOD | 105 | 149 | 220 | 474 | 9.1 | 709 | 13.7 |
| BENTLEY AND DARLASTON NORTH | 202 | 241 | 266 | 709 | 13.6 | 1137 | 21.9 |
| BIRCHILLS LEAMORE | 251 | 238 | 202 | 691 | 13.0 | 1125 | 21.2 |
| BLAKENALL | 225 | 193 | 153 | 571 | 12.7 | 940 | 21.0 |
| BLOXWICH EAST | 200 | 258 | 301 | 759 | 16.1 | 1150 | 24.4 |
| BLOXWICH WEST | 263 | 268 | 214 | 745 | 12.0 | 1338 | 21.6 |
| BROWNHILLS | 166 | 163 | 188 | 517 | 10.9 | 807 | 17.0 |
| DARLASTON SOUTH | 213 | 242 | 255 | 710 | 14.2 | 1223 | 24.5 |
| HATHERTON RUSHALL | 150 | 201 | 302 | 653 | 11.8 | 876 | 15.9 |
| PADDOCK | 83 | 75 | 124 | 282 | 5.4 | 327 | 6.3 |
| PALFREY | 265 | 227 | 249 | 741 | 14.7 | 953 | 18.9 |
| PELSALL | 148 | 168 | 226 | 542 | 9.6 | 981 | 17.4 |
| PHEASEY | 73 | 45 | 112 | 230 | 6.4 | 367 | 10.3 |
| PLECK | 194 | 233 | 256 | 683 | 16.5 | 1005 | 24.2 |
| ST. MATTHEW'S | 277 | 233 | 225 | 735 | 14.8 | 782 | 15.8 |
| SHORT HEATH | 118 | 142 | 160 | 420 | 8.9 | 724 | 15.3 |
| STREETLY | 45 | 39 | 100 | 184 | 3.5 | 227 | 4.3 |
| WILLENHALL NORTH | 101 | 123 | 128 | 352 | 7.4 | 672 | 14.1 |
| WILLENHALL SOUTH | 168 | 184 | 231 | 583 | 10.3 | 881 | 15.6 |

Source: Department of Social Security; Strategic and Environmental Planning, with Benefits Service, Walsall MBC; and author's calculations



percentages in order to convey numerical concentrations. Broadly speaking, the distribution of numbers of persons aged 60 and over receiving means-tested benefits corresponds with the pattern of deprivation across the borough (Director of Public Health, 1999).

The second set of figures confirms this interpretation. Table 2 (page 9) shows wards with the totals of persons aged 60 and over receiving means-tested benefits in November 1998, and the percentages of all occupied dwellings these totals represent. They show that in seven wards, over a fifth of all households comprised older people receiving means-tested benefits: Darlaston South, Bloxwich East, Pleck, Bloxwich West, Blakenall, Bentley and Darlaston North, and Birchills Leamore. These are among the borough's most deprived wards overall.

This table also contains a breakdown of the number of Income Support claimants aged 70-79 and over 80, which may be useful in planning services. The highest numbers of over-80s receiving Income Support are in Hatherton Rushall and Bloxwich East.

Table 3 below shows that North PCG has the highest proportion of all households comprising older people receiving means-tested benefits: at more than a fifth.

Table 3

Primary Care Groups: Households Receiving Means Tested Benefits, November 1998

| PCG | TOTAL RECEIVING MEANS-TESTED BENEFITS | % OF ALL OCCUPIED HOUSEHOLDS |
|-------|---------------------------------------|------------------------------|
| NORTH | 4553 | 22.0 |
| SOUTH | 3067 | 15.9 |
| EAST | 4649 | 13.2 |
| WEST | 4637 | 18.3 |

Source: Strategic and Environmental Planning, with Benefits Service, Walsall MBC; and author's calculations.

2.3 CRIME

England and Wales are still among the most crime-prone areas in Western Europe despite the recent decline in recorded crimes. The national Crime Reduction Strategy, local crime reduction partnerships, and drugs strategy all have policies to tackle racially-motivated crime and anti-social behaviour, and to protect witnesses from intimidation.

Older people are a particularly vulnerable group, and when a crime is committed against them it undermines the basic freedom to live one's life free from fear and intimidation. However, the fear of crime is often disproportionately greater than the actual level of crime, particularly among older people and women more generally, so that it is an important factor in itself (Mirrlees-Black et al, 1997).

Several national schemes to overcome such problems have been specifically aimed at older people. These include improved security packages. CCTV schemes have been shown to deter the incidence of crime, help reduce the fear of crime and increase public confidence in communities. As a result of public consultation two projects are being funded by Walsall's Health Action Zone (HAZ). The projects are aimed particularly at the older population and the very young and are currently operational in Caldmore town centre and in the Willenhall / Darlaston area. Early monitoring of these projects indicates that crime levels are falling in both areas. Increased levels of reporting of crime and a higher number of arrests have been reported.

Crime statistics illustrated in this section are recorded by the Police and use Ordnance Survey Grid references based on location of the crime itself, not where the victim lives. They are aggregated by the Police by beat areas which do not conform neatly with ward boundaries in Walsall.

Types of crime are categorised thus:

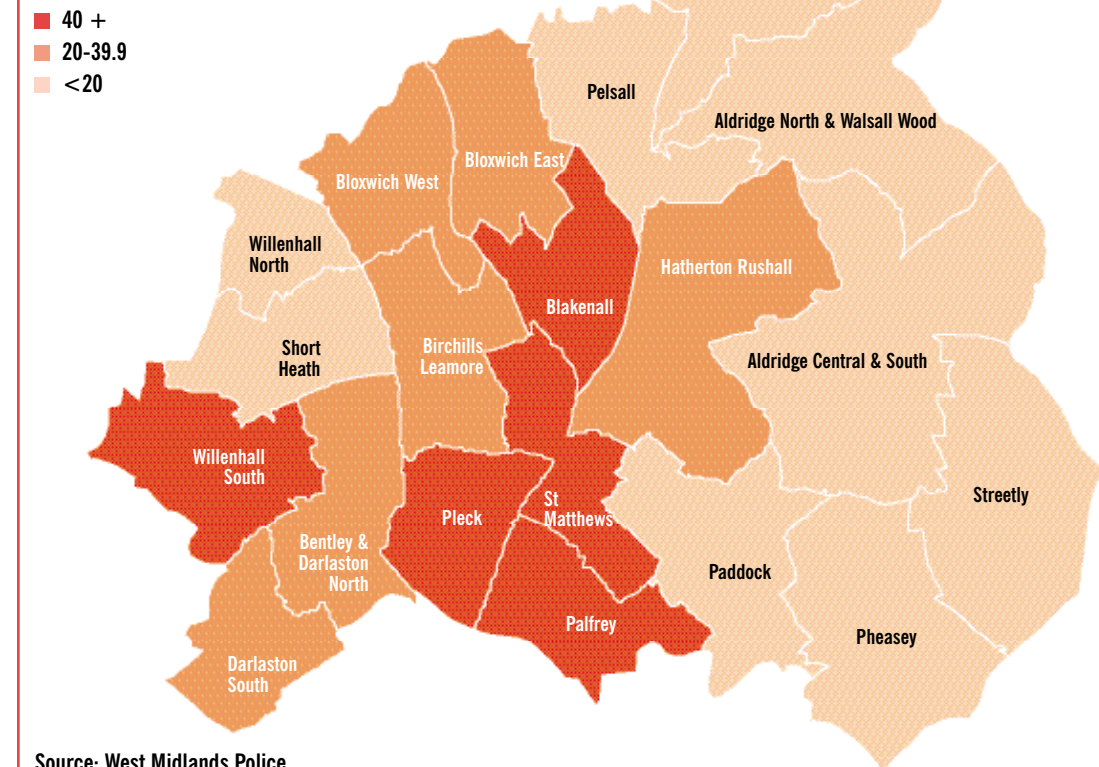
- Criminal damage
- Domestic burglary
- Robbery
- Theft from person
- Vehicle theft
- Other burglary (e.g. shops)

The types of crime most often experienced by Walsall's older population are domestic burglary and criminal damage, which account for nearly 60% of all crimes against those aged 60 and over. Theft of and from vehicles is one of the largest categories of crime recorded by the police nationally. In 1998/99 it accounted for over 1 million crime incidents (21% of all recorded crime). In Walsall vehicle crime among the older population is relatively low, at 15% of all crimes against older people. The majority of these occur in St. Matthews, which includes the town centre. Other types of burglary (for example from shops) account for approximately 15%, theft from the person 10%, and robbery less than 2%.

Three year averages for all types of crime by location are illustrated in Map 3. The highest

Map 3

Crimes Against People Aged 60 and Over In Walsall – Rate Per 1,000 Aged 60 and Over, Three-Year Average, 1998-2001



Source: West Midlands Police

rates are found in St. Matthews, Blakenall, Palfrey and Willenhall South. However, the exceptionally high rate in St. Matthews is distorted by high crime levels in the town centre, particularly for theft from the person. Pheasey and Streetly have the lowest levels of crime against older people. The level in Blakenall is nine times that in Pheasey. Levels generally reflect the distribution of deprivation.

The most common crime against older people is burglary. The highest levels are in Pleck, Palfrey, Blakenall, and St. Matthews. The level in Pleck is nine times that in Pheasey, the lowest.

The second most common is criminal damage. The highest levels are in Blakenall, Pleck, Birchills Leamore, St. Matthews and Willenhall South. The level in Blakenall is eight times that in Pheasey, the lowest

2.4 TRANSPORT

Older people in Walsall have experienced dramatic changes over the last 20-30 years with respect to transport. Road transport has increased rapidly, and this growth is not without its problems.

Road traffic impinges on human health in a number of ways: through the pollutants it releases into the atmosphere, through road traffic accidents, and through impairment of the quality of life because of noise. High traffic volumes give rise to feelings of insecurity, and decrease both walking and the use of other transport (Hine and Russell, 1996; Langlois et al, 1997).

One of the greatest concerns in relation to health is the effect of road traffic on respiratory disease. Many of the gases released from road traffic pose hazards to health. Nitrogen dioxide from vehicle exhausts is an irritant gas which acts to increase the sensitivity of asthma sufferers to attacks of wheeze. Fine particulate matter (PM10 and PM2.5) is also implicated.

Recent research findings suggest that around 2 per cent of adults over the age of 65 have untreated asthma (Dow et al, 2001). In Walsall it is estimated that over 1,400 men and nearly 2,000 women over the age of 65 years are affected by the disease.

During the year 2000, 589 or 90% of respiratory deaths in the older people in Walsall were attributed to respiratory disease of some form. Age specific death rates for asthma in people aged 65-74 years in Walsall are currently



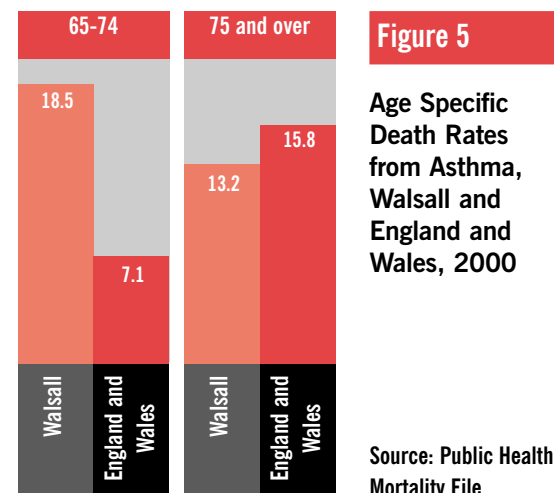


more than double the national average, 18.5 in Walsall compared to 7.1 per 100,000 population nationally. For those aged 75 or more Walsall is below the national average, at 13.2 in Walsall compared to 15.8 per 100,000 population nationally (Figure 5 below).

As roads become busier, the problem of traffic congestion increases: this not only causes inconvenience to road users but increases the risk of injury. Despite the fact that the number of road traffic accidents on the roads are declining in Britain, and Britain now has one of the lowest accident rates in Europe, road traffic accidents remain one of the commonest causes of premature and preventable deaths, and they take a significant toll each year in terms of severe injuries.

Accident and Emergency admissions data from the Manor Hospital for road traffic accidents have shown a three-fold increase during the last 3 years in the older population, from a total of 68 in 1998-99 to 258 by 2000-01. (Figure 6 below). This data must be interpreted with caution, given that not all Walsall residents would necessarily be admitted to the Manor Hospital. However, this does appear to be a very substantial increase over a short time.

Accessible public transport and the independence that comes with driving a car are factors known to be linked to the quality of life in old age. While older people may experience increasing difficulties in continuing to drive and many might like to increase their use of public transport, recent privatisation has meant that the provision of transport has declined (Gilhooly et al). Older people experience poor access to public transport more than other groups in the community (Davis, 1998). This limits their access to goods, services, opportunities and social contacts (Hamilton et al, 1991, Gant and Smith, 1998). This applies particularly to older women and older people who are disabled (Office for National Statistics, 1998; Department of Transport, 1995).

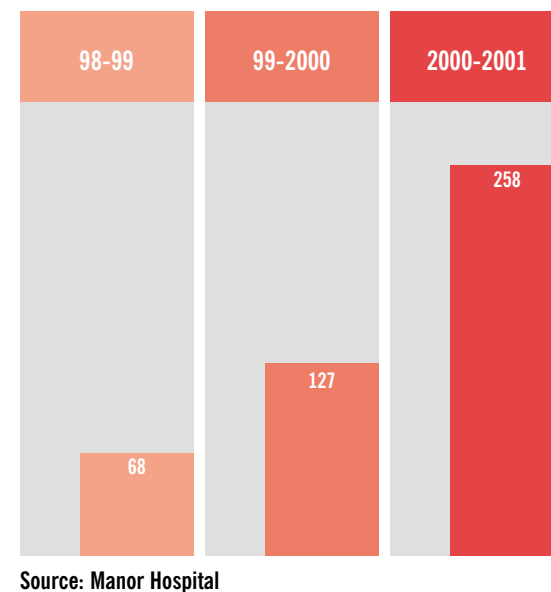


On the other hand, as the Independent Inquiry into Inequalities in Health put it, more opportunity for travel through the availability of affordable and effective public transport should remove a barrier to health-promoting activities. For example better access to community-based leisure facilities should offer increased opportunity to older people to enjoy physical and social activity. Increased exercise is important in preserving muscle tone, which reduces the risk of falling and injury, and reduces the disability caused by osteoarthritis (Acheson, 1998). A recent study of older users of home care services found that accessible and affordable transport was a major concern for them in maintaining and promoting independence (Raynes et al, 2001). A comprehensive survey of the transport needs of older people, with recommendations as to how they might be met, was published by the Government early in 2001 (Atkins, 2001).

Local services available to Walsall residents include :

- Minibus facilities for community groups, offered by Community Services
- Voluntary transport services operated by Darlaston Fellowship for the Disabled offering transport on a voluntary basis to people with a mobility problem
- Ring and Ride, funded by Centro and operated by West Midlands Special Needs Transport Ltd., a registered charity. This is a door-to-door accessible service provided for anyone who finds it difficult or impossible to use ordinary

Figure 6
Road Traffic Accident Admissions to Manor Hospital (All Causes), Age 65 and over, Trend 1998/99 - 2000/2001



bus services. It uses minibuses with lifts, so that people who use wheelchairs, or find steps very difficult, can use the bus. The service is free to concessionary pass holders, with non-pass holders paying fares similar to those charged on other bus services in the area. A review of this service, which emphasises its health benefits, has recently been published (West Midlands Special Needs Transport, 2001). While the service is found to compare favourably with many others, the review emphasises that there is a high level of unmet need.

- All residents in Walsall who are either 65 years of age or over (men) or 60 years of age or older (women) are entitled to a Senior Citizen's Pass. Passes enable free travel on local bus, rail and metro services in the West Midlands at certain off-peak times. The scheme is also operated by Centro on behalf of the Passenger Transport Authority.





Care and Support in the Community

3.1 ILLNESS, DISABILITY, AND PREVENTING ILL HEALTH

This chapter is divided into two sections. The first part summarises some key data on ill health and disability, and some of the main issues concerning maintenance and promotion of good health among older people. The second examines the range of services in place to help older people to live independently in the community.

3.1.1 Long-term illness in Walsall

According to the 1991 Census, Walsall had the 55th highest standardised level of long-term illness out of 366 local authority areas in England. 28% of households in Walsall contained at least one person with a limiting long-term illness or disability.

This is important for the planning of services. Recent analysis has shown that while life expectancy increased between 1981 and 1995, the number of years people could expect to live free of illness or disability did not increase at the same rate. As a result, the number of years men aged 65 could expect to live with a limiting long-standing illness went up, from 5.4 years in 1980 to 6.4 in 1995. The increase for women was from 8.4 to 8.8 years over the same period (Kelly S., Baker A. and Gupta S., 2000).

Numbers will have changed substantially since 1991; but it is possible to apply the 1991

percentages of long-term illness to age band numbers from the 1999 population estimates.

This method produces an estimate (Table 4) that the population aged 60 and over with a long-term illness or disability will have increased by about 3,500 since 1991 to over 23,500. This is very close to an estimate made from the findings of the Walsall Housing Needs Survey (DCA, 2000).

3.1.2 Older people receiving Attendance Allowance

Older people can qualify for Attendance Allowance if they require:

- Frequent attention from another person throughout the day in connection with their bodily functions; or
- Continual supervision throughout the day in order to avoid substantial danger to themselves or others; or
- Prolonged or repeated attention at night in connection with bodily functions; or
- Another person to be awake at night for a prolonged period or at frequent intervals for the purpose of watching over (them) in order to avoid substantial danger to themselves or others'.

Table 4

Projected Numbers with Long-Term Illness or Disability in Walsall in 1999, Using Age-Band Percentages From 1991 Census

| | ESTIMATED % WITH LONG TERM ILLNESS (1991) | ESTIMATED % POPULATION (1999) | ESTIMATED TOTAL POPULATION WITH LONG TERM ILLNESS (1999) |
|--------------|---|-------------------------------|--|
| Women | | | |
| 60-64 | 25.5 | 7,245 | 1,847 |
| 65-74 | 36.2 | 12,371 | 4,478 |
| 75-84 | 54.3 | 8,332 | 4,524 |
| 85+ | 72.5 | 3,405 | 2,469 |
| TOTAL | 42.3 | 31,353 | 13,318 |
| Men | | | |
| 64 | 35.0 | 6,971 | 2,440 |
| 65-74 | 38.9 | 11,509 | 4,477 |
| 75-84 | 50.3 | 5,130 | 2,580 |
| 85+ | 62.1 | 1,158 | 719 |
| TOTAL | 41.1 | 24,768 | 10,216 |
| ALL | 41.8 | 56,121 | 23,534 |

Source: Walsall MBC

A higher rate is paid if both a day and a night condition is met, or if the claimant is terminally ill.

Receipt of Attendance Allowance is therefore evidence of substantial disability or illness. It is not means-tested. There is substantial evidence of underclaiming, so that it cannot be taken as a

Table 5

Recipients of Attendance Allowance by Ward and Percentage of all Occupied Households, May 1998

| WARD | ALL AA RECIPIENTS | HIGHER RATE | LOWER RATE | % OF ALL OCCUPIED HOUSEHOLDS |
|---------------------------------|-------------------|-------------|------------|------------------------------|
| ALDRIDGE CENTRAL AND SOUTH | 327 | 122 | 205 | 6.2 |
| ALDRIDGE NORTH AND WALSALL WOOD | 320 | 119 | 201 | 6.2 |
| BENTLEY AND DARLASTON NORTH | 402 | 166 | 236 | 7.7 |
| BIRCHILLS LEAMORE | 361 | 128 | 233 | 6.8 |
| BLAKENALL | 327 | 163 | 164 | 7.3 |
| BLOXWICH EAST | 520 | 210 | 310 | 11.0 |
| BLOXWICH WEST | 421 | 185 | 236 | 6.8 |
| BROWNHILLS | 313 | 130 | 183 | 6.6 |
| DARLASTON SOUTH | 461 | 224 | 237 | 9.2 |
| HATHERTON RUSHALL | 432 | 170 | 262 | 7.8 |
| PADDOCK | 255 | 103 | 152 | 4.9 |
| PALFREY | 392 | 166 | 226 | 7.8 |
| PELSALL | 384 | 139 | 245 | 6.8 |
| PHEASEY | 192 | 84 | 108 | 5.4 |
| PLECK | 339 | 128 | 211 | 8.2 |
| ST. MATTHEW'S | 379 | 171 | 208 | 7.6 |
| SHORT HEATH | 300 | 108 | 192 | 6.4 |
| STREETLY | 258 | 103 | 155 | 4.9 |
| WILLENHALL NORTH | 234 | 94 | 140 | 4.9 |
| WILLENHALL SOUTH | 343 | 121 | 222 | 6.1 |

Source: Public Health Common Dataset

measure of the extent of severe disability or illness among older people. An increasing number of older people receive Disability Living Allowance, introduced in 1992. If they claimed this benefit before the age of 65, they continue to receive it once they reach that age. If they become disabled after the age of 65, they should claim Attendance Allowance. We do not have a local breakdown of numbers of older people receiving DLA. Table 5 is therefore an underestimate of the numbers of older people receiving benefits for severe disability.

These figures, understated as they are, are striking as a conservative estimate of the extent of severe disability in some of Walsall's wards. For example, the number of older people disabled enough to receive Attendance Allowance in Bloxwich East amounts to more than a tenth of the total number of households.

Households are used here as the denominator because a high proportion of those receiving Attendance Allowance live in small households. In a small number of cases, more than one person in a household will be receiving Attendance Allowance (e.g. a severely disabled couple).

There is a significantly high incidence of older people receiving Attendance Allowance in Bloxwich East, Darlaston South, Pleck, Hatherton Rushall, Palfrey, Bentley and Darlaston North, and St. Matthews.

Though these figures do not fully represent the distribution of severe disability in Walsall, they may help PCGs and Social Services to think about the distribution of need in the borough.

Table 6 shows a particularly high incidence of receipt of Attendance Allowance as a percentage of the number of households in North PCG.

The level of receipt of Attendance Allowance is expected to increase significantly in the coming decade, partly because of an increase in the numbers of older disabled people in their own homes, but also because the Department of

Table 6

Attendance Allowance Recipients by PCG, May 1998

| PCG | ALL AA RECIPIENTS | HIGHER RATE | LOWER RATE | % OF OCCUPIED HOUSEHOLDS |
|-------|-------------------|-------------|------------|--------------------------|
| NORTH | 1629 | 686 | 943 | 7.9 |
| SOUTH | 1365 | 568 | 797 | 7.1 |
| EAST | 2226 | 867 | 1359 | 6.3 |
| WEST | 1740 | 713 | 1027 | 6.9 |
| | 6960 | 2834 | 4126 | 6.9 |

Source: Public Health Common Dataset





Health has issued a consultation paper proposing that financial assessment for capacity to pay charges for non-residential social services should include assessment for eligibility for benefits, and help in claiming them (Department of Health, 2001a).

3.1.3 Prevention of ill health and disability

The new National Service Framework for Older People (Department of Health, 2001b) reinforces the Government's emphasis on the promotion of health, already set out in the National Service Frameworks on Mental Health, Coronary Heart Disease, and Cancers, for example through reducing the incidence of smoking, and extending the availability of Breast Cancer screening to women up to the age of 70 (and continues to make it available to women over 70). It proposes that the NHS and local partners should re-focus on helping and supporting older people to continue to live healthy and fulfilling lives. It stresses the importance of evidence that older people can benefit from:

- Increasing physical activity
- Improved diet and nutrition
- Immunisation and management programmes for influenza.

It establishes milestones from April 2003 for local plans to set in motion programmes to improve levels of health and well-being among older people in these fields:

- Flu immunisation
- Smoking cessation
- Blood pressure management

Flu immunisation is dealt with in Chapter Five below. There are no current available baseline figures for smoking levels either generally or for older people in Walsall; the 1995 West Midlands Lifestyle Survey found that smoking levels in Walsall among adults were lower than the national level. National data suggest that the proportion of men who smoke falls from the age-band of 45-54, and from 25-34 among women, and that the proportion of ex-smokers increases consistently with age (Health Education Authority / ONS, 2000). The findings of Walsall's Smoking Cessation Service, now in its second year, are consistent with that: older people have the highest 'quit rate' of all groups. The benefits of stopping smoking show within hours, and continue to reduce risks such as those of lung cancer and heart disease over a period of years, so the advantages to older people are clear.

The focus on diet emphasises the need to increase consumption of fresh fruit and vegetables and whole grain cereals, and avoiding overweight and underweight. Consumption of fruit and vegetables was mapped by ward in the 1999 Public Health Report, and found low consumption in areas of high deprivation, though areas with high ethnic minority population tended to be an exception to this. The National Service Framework highlights the value of healthy diet in preventing cardiovascular disease, stroke, diabetes and osteoporosis in older people. It draws attention to the need to prioritise dietary standards in residential care, hospital and in meals on wheels.

The Framework also emphasises the finding that a large proportion of people aged over 50 are sedentary, taking less than half an hour of moderate physical activity a week. Adapted exercise can benefit the health of even very frail older people, helping strength, mobility and balance, and reducing the risk of falling (see Chapter Five for more on the latter).

Obesity is a risk factor in many diseases, including coronary heart disease. We do not have recent Walsall data related to age, but men aged 45-64 in the West Midlands had the highest incidence of obesity of all the English Health Regions in 1998. (Source: Public Health Common Data Set 2000).

3.2 SUPPORTING INDEPENDENCE: THE SERVICES AND WHO NEEDS THEM

As they get older, people are likely to need services to maintain, or to regain, their independence and health. These needs are beginning to be seen less in terms of blocks of service, such as hospital admissions, sheltered housing, and residential care; and more in terms of what older people may need at different times to ensure that they are able to live as part of the community: a process which as far as possible has independent living as its purpose.

This means a critical process which puts questions as never before, such as, how many people are kept in hospital longer than need to be because of lack of the right facilities in the community? What are those facilities and how can they work best? Where and why are older people being admitted to hospital, and are there ways of preventing hospital admissions? Finding the answers to these and other questions

demands that we identify some key numbers to guide us; but also that we view a spectrum of services, from home care to hospital care and back, as interlinked. To take just one example, if older people do not receive help to do things they cannot do at home, they are more likely to end up, or remain, in hospital.

That is why this section describes the main areas of service between community support, residential care and hospital as an interconnected process. The Promoting Independence Partnership Grant Report (Walsall Social Services, 2001) summarises the purposes behind this process:

- Promoting independence,
- Addressing the need to avoid unnecessary hospital admissions,
- Improving discharge arrangements, having in place plans to meet emergency pressures, and creating new rehabilitation services,
- Improving reviewing processes for people receiving long term care,
- Improving direct service provision,
- Improving advocacy services for carers and service users.

Below, we identify some of the main building blocks in this enterprise, and some baseline data to measure success.

3.2.1 Home care

About 2,500 older people in Walsall were receiving home care in 2000. More than a quarter of these were receiving substantial home care of more than 11 hours a week. In comparison with the previous two years, numbers appear to be fairly stable. The proportion receiving home care from the independent sector has been growing steadily.

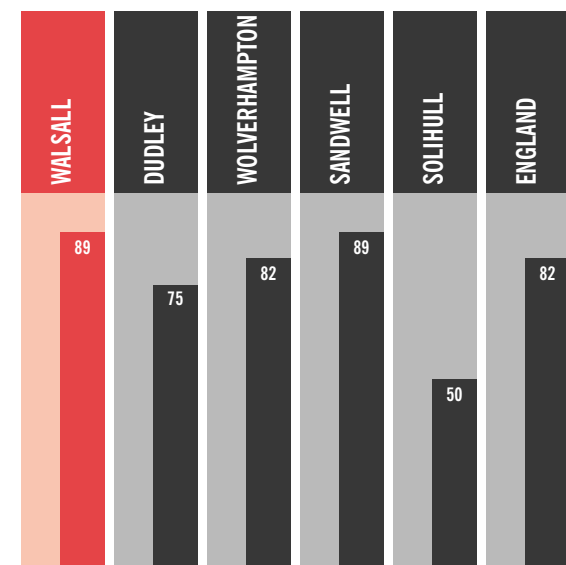
Data for the numbers of recipients of home care are collected by the Department of Health. Figure 7 shows that more older people in Walsall receive home care than the average for England, and that the number served is higher than in many other West Midlands authorities, at 89 per 1000 aged 65 and over compared to an average for England of 82 per 1000.

For intensive home care to people aged 65 and over, Walsall is also providing a service to a higher proportion of the population than the English average.

A user survey carried out in 1999 found that an overwhelming majority found the home care services 'good' or 'excellent', although the approval rating of home care provided by the local authority was higher than for that provided by the independent sector. There were a number of

Figure 7

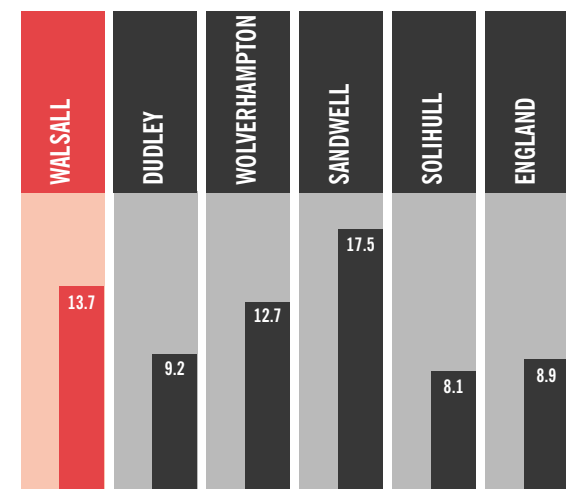
Older People Helped to Live at Home per 1,000 Population 65 and Over, Year Ended March 2000



Source: Department of Health, Social; Services Performance Assessment Framework

Figure 8

Older People Receiving Intensive Home Care Per 1,000 Population 65 and Over, Year Ended March 2000



Source: Department of Health, Social; Services Performance Assessment Framework

significant criticisms of the latter: more than a fifth of users said that carers did not usually stay for the length of time agreed in their care plan, compared to 8% of local authority home carers. A third had made a complaint about their independent sector home carers, compared to 12% of those using local authority home carers. There was an overwhelming view among users that the system of charging for care was fair. The





current charging system will be changed in the future following a Department of Health consultation paper on the subject (Department of Health, 2001a).

3.2.2 Sheltered housing

Sheltered housing and the provision of support related to accommodation will be subject to a new policy and financial regime from April 2003, the Supporting People programme, developed by the Department of Transport, Local Government and the Regions. As well as a greater degree of accountability within a policy framework aiming to ensure higher quality services, the funding of Supporting People will be switched from a number of national channels (predominantly Housing Benefit), to a combined local budget run by the local authority. This should mean that it will be easier to make strategic decisions about meeting need which are consistent with the other initiatives described in this chapter (DETR, 2001). A priority will be to create alternatives to residential care in the form of extra care supported housing, maintaining residents' control over their own lives with their own front door. That way, support can be changed according to need, which may grow or diminish.

Sheltered housing is coordinated and planned in Walsall by the Walsall Housing Partnership, which comprises the Registered Social Landlords active in the borough, and Council representatives from Housing, Social Services, and Planning. On the basis of a household survey carried out in 2000, it is estimated that Walsall is going to need around 1,900 units of sheltered or extra care housing, as well as the adoption of 'lifetime home standards' for new housing, which mean that homes can be adapted to greater needs for support as older people become frailer, rather than creating a need to move away from familiar surroundings. There is also a need to cater for an emerging ethnic minority older population, who may have very different needs from those of the majority community (DCA, 2000).

The local authority changed its approach to sheltered housing in the 1980s by creating a Neighbourhood Community Officer service to replace wardens attached to sheltered accommodation. The aim was that the service would be available to others with similar needs who did not live in purpose-built accommodation. It is based in Neighbourhood Offices, and covers:

- Home visiting to older people (primarily, though not exclusively, those over 75)
- The promotion of group social and welfare activities

- Giving advice on Council services (primarily housing and benefits)
- Liaison with other agencies including health and social services.

This service is now being reviewed, with the aim to bring it into line with the continuum of services, and the new policy developments, described in this chapter.

Walsall MBC is working with Prime Focus Housing Association to develop a 48-unit very sheltered or 'extra care' housing scheme in 2002. Accord Housing Association are planning to convert two existing supported housing schemes to 'extra care' schemes, with the possible addition of a third. However, major reviews of needs and present provision will need to be completed in 2002. In the past, there has been little integration of this sector with the preventative strategies of other parts of the local authority and the health sector. This is expected to change quite radically over the next two years (Director of Health and Regeneration, 2001b).

3.2.3 Aids and Adaptations

Aids and adaptations have recently been defined (Department of Health 2001c) as 'equipment for home nursing usually provided by the NHS, such as pressure relief mattresses and commodes, and equipment for daily living, such as shower chairs and raised toilet seats, usually provided by local authorities. It also includes, but is not limited to:

- Minor adaptations such as grab rails
- Auxiliary equipment for people with sensory impairments such as hearing loops
- Communication aids for people with speech impairments
- Wheelchairs for short-term loan
- Telecare equipment such as falls alarms, gas escape alarms etc.

A recent study of users of local authority home care found that they placed great emphasis on the value of aids and adaptations for their quality of life and independence (Raynes et al, 2001).

In Walsall, there are three main channels of provision:

- The community equipment store, currently operated by Social Services
- The medical equipment loans store, currently

operated by Walsall Community Health Trust, and

- The incontinence service, currently operated by Walsall Community Health Trust.

Both nationally and locally, the provision of aids and adaptations has been a concern for some time, in terms of the quality and efficiency of service, delays, and possible duplication of effort (Griffiths, 1999b).

The NHS Plan has made improvement a priority, seeing aids and adaptations as a crucial link in enabling independent living, and where it is not working, as a bottleneck that undermines hospital service provision by delaying discharge, and deprives people of a return to living in the community when they are ready to do so. The Plan undertook to achieve single integrated community equipment services by 2004, and to increase the number of people benefiting from the service by 50%. This has been reinforced by the National Service Framework for Older People (Department of Health, 2001b), with the following principles:

- Identification of need for equipment to be an integral part of any assessment, treatment or care plan
- Clear accountability with relevant professionals having specified responsibilities for ensuring that older people and their carers know what is available and that they have choice in selection of equipment
- Services to take a preventative approach, recognising that effective equipment provision can maintain independence, slow down deterioration in function, prevent pressure sore damage, and support and protect the health of carers
- Services should be timely and resolve the current long delays.

Walsall Health Authority, Walsall Community Health Trust and Walsall MBC have set up a project team to bring together the three main channels of provision in the borough. A report to the Joint Strategy Group in April 2001 sets out an approach for doing this (Director for Health and Regeneration, 2001). It concludes that it should be straightforward to standardise referral criteria; that there should be a comprehensive catalogue of aids and adaptations to improve access and choice for users; and that the new service should make it a priority to produce regular figures showing waiting times between referral and assessment and between assessment and delivery

and installation of equipment; satisfaction with the assessment process, installation and instruction in use; and improved outcomes for the user in terms of maintaining or improving independence. The merging of services may take place in the Autumn of 2001.

3.2.4 Intermediate care

The aim of Intermediate Care, set out in the National Service Framework for Older People (Department of Health, 2001b), is to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge, and maximise independent living. Thus it fits directly into the context of this chapter.

This aim arises from findings over a number of years that, as a report by the Audit Commission has put it, there has been too little investment in preventative and rehabilitative services, leading to unplanned admissions of older people to hospital and, in turn, premature admission to long term residential care. The Commission recommended breaking into the vicious circle through investment in prevention and rehabilitation (Audit Commission, 1997). A literature review commissioned by the National Beds Inquiry found that for older people, around 20% of bed days were probably inappropriate, and would be unnecessary if the right facilities were in place (Goddard et al, 2000). Older people who are in hospital when they should be receiving community-based services are running unnecessary risks of disruption to their social networks, disorientation, and infections picked up in hospital (Luff et al, 2000).

There are national targets which the National Service Framework sets out; and a Walsall Intermediate Care Strategy is in preparation. It aims to be an inclusive process which involves users and carers.

Winter Pressures work was a prelude to this strategy in 2000/2001, particularly in providing Aided Recovery Beds. This involves keeping people out of hospital and at home, with physiotherapy and other services. In response to need, a dedicated transport service was set up to deliver aids and minor adaptations for installation. This serves the Rapid Response Team (which deals with strokes) and Rehabilitation Occupational Therapists and Physiotherapists. There is also now a District Nursing Team for Aided Recovery Beds which will be developed into a team to deliver 'hospital-like' care at home, e.g. intravenous antibiotics, where otherwise patients would have gone into hospital, or remained there, just for that purpose. In addition, more OTs and





physiotherapists have been appointed, and that funding will continue.

There will be an Older People's Service Development Manager, whose job it will be to forge a marriage between Intermediate Care and Mental Health, as well as making other links. There will be a Community Psychiatric Nurse funded for the Rapid Response Team to carry out assessments, and to make a distinction between mental health problems and temporary confusion resulting from physical problems. Also, there will be new Day Centres to enable older people with mental health problems to be treated without going into hospital.

Intermediate Care has had an emphasis on early discharge, but there will also be a strong emphasis on prevention:

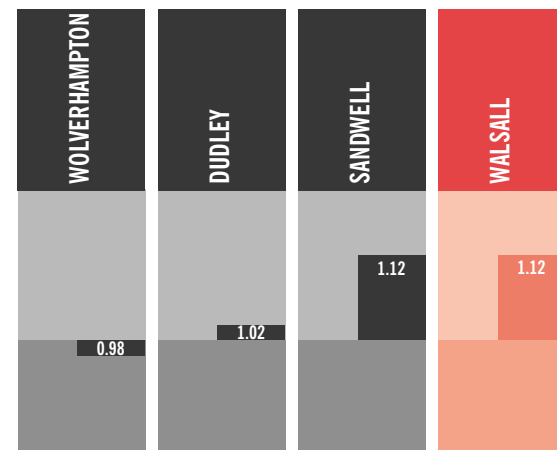
- Keeping people at home rather than admitting them to hospital,
- 5-week rehabilitation programmes at home or in Aided Recovery Beds or in Homeward Bound Beds.

There is funding in 2001/2 for the spot purchase of Aided Recovery Beds in the independent sector to meet patient needs. Patients will be transferred to these beds only if the move will benefit them, (i.e. they will benefit from the recovery programme) not as a holding bed to await long-term placement.

One important indicator for the success of this whole raft of policies, and the part played in them by hospital care, will be the average length of stay by older people in hospital, taking into account their age and case type. At present, the length of

Figure 9

Length of Stay in Hospital, (Adjusted for Age and Case Type), as a proportion of the Expected Length of Stay. Ratio of Observed to Expected (1 = expected length of stay).



Source: NHS High Level Performance Indicators

time before discharge taking these factors into account is 12% longer in Walsall than would be expected. The same excess is shown by Sandwell. Wolverhampton's length of stay figure is marginally lower than would be expected (Figure 9).

Another is the rate for emergency admissions of over-75s. There, Walsall shows a rate lower than the neighbouring areas of Wolverhampton and Sandwell (Figure 10).

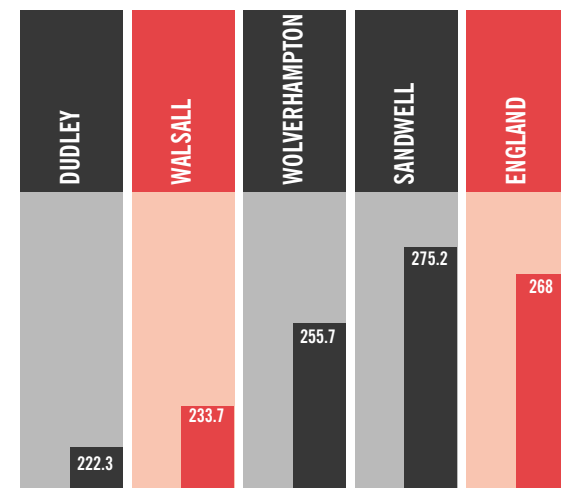
A third aspiration will be to reduce the proportion of older patients readmitted to hospital within a short time of discharge. Figure 11 shows that Walsall has the highest percentage of such readmissions in the Region, so there is much to achieve.

Another part of the preventative emphasis is a successful Falls Programme, which is implemented over 2 PCGs, and will be extended to the whole borough. People who have falls will then be picked up by primary care with a preventative aim as part of a care pathway. The Programme also includes work on other preventative issues such as diet, risk assessments for medication, and home safety.

Stroke is another key preventative area, discussed in Chapter Five on Specific Conditions.

Figure 10

Emergency Admissions of Over-75s, Numbers per 1,000 Population 75 and over, Some West Midlands Districts and England 1998/99



Source: NHS High Level Performance Indicators

3.3 RESIDENTIAL AND NURSING CARE

When their health or social needs become too great for them to continue to live in their own homes, older people may move to live in residential care or nursing homes.

The Health Authority is responsible for the registration and inspection of nursing homes; and Social Services Inspection Units for residential homes. That however will soon change, as the National Care Standards Commission takes responsibility for standards for both, with eight Regional Commissions.

The proportion of people over retirement age in residential or nursing homes in Walsall has fallen

Table 7

Occupied Residential and Nursing Home Places in Walsall, 2001

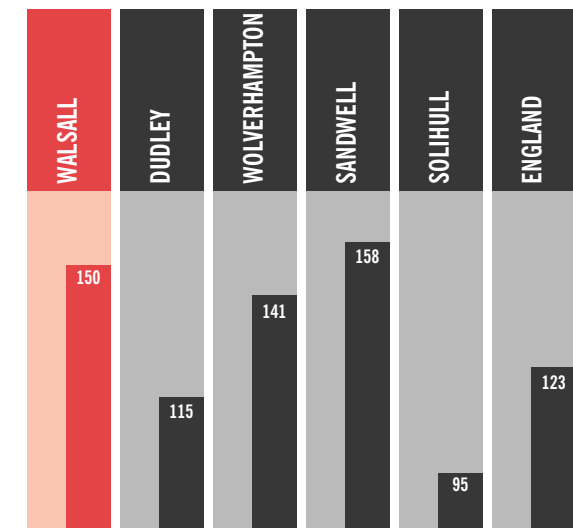
| PLACES OCCUPIED, RUN BY | NO |
|-------------------------------|-------|
| LOCAL AUTHORITY RESIDENTIAL | 358 |
| NURSING HOME | 394 |
| PRIVATE DUAL REGISTERED HOMES | 162 |
| PRIVATE RESIDENTIAL HOMES | 666 |
| REGISTERED SMALL HOMES | 13 |
| TOTAL | 1,593 |

Source: Walsall MBC

since 1991, and is expected to continue to do so. There are currently 1,593 residential or nursing home places occupied by Walsall residents (Table 7). However, as Figure 12 shows, the level is still well above the national and regional average. This suggests that the strategies to encourage independent living described above are particularly needed in Walsall. This aim, and a high vacancy level in residential homes in the borough, has led to a decision to reduce the size of the residential care sector in Walsall, by 100-

Figure 12

Admissions to Supported Residential and Nursing Home Care per 10,000 Population 65 and Over, Year Ending March 2000



Source: Department of Health, Social; Services Performance Assessment Framework

Figure 11

Percentage Re-admissions to Hospital Within 7 Days, Patients Aged 75 and Over, Year Ending March 2000.



Source: NHS Executive West Midlands - Regional Database





150 over the next three years. This will be done by closing one residential home, and by transferring three others to the independent sector. It is expected that the nursing home sector will grow (Director of Health and Regeneration, 2001b).

A Long Term Care Charter for Walsall has been published which sets out minimum standards that can be expected by those in residential care homes and their carers, and where they can go for advice and support if they are not satisfied with services (Walsall NHS and Walsall MBC, 2001).

The financial conditions experienced by people in residential or nursing care are very different from those of people living in their own homes. The payment of fees allows for a 'personal expenses allowance' for the resident of only £16.05, which is far too little for residents without substantial private means to aspire to any kind of independent living. A recent comparison of the quality of life of residents in residential care and 'very sheltered' housing, which offers a comparable level of care but much more independence, found that the majority of 'very sheltered' tenants believed that 'they were enjoying a new lease of life, that their physical and mental health had improved, and that they could do things now which they had not been able to do for some time' (Oldman, 2000). There is currently no sign of the personal expenses allowance being brought into line with the overall Government commitment to encouraging independence; indeed, there are dangers that rigid application of the Government's new Care Standards Act could undermine innovative housing projects by insisting on registration as residential care, with an adverse impact on residents' disposable income.

There are currently some problems in Walsall over the funding of residential and nursing care, and of home care. Social Services budgets have increased by about 2% less than the amount included for inflation in contracts with providers. This may affect the capacity of Social Services to make new placements, which may in turn affect the capacity of hospitals to discharge patients who are ready to move on to residential or nursing homes, or to receive support in their own homes (Walsall MBC Social Services, 2001).

3.4 DELAYED DISCHARGE

The issue of delayed discharge from hospital, resulting in older people who are recovering having to remain in hospital because there is nowhere suitable for them to go, creating a

blockage in the provision of scarce hospital beds, has received much public attention nationally and regionally. There are factors in Walsall, such as the pressure on Social Services funding, that could have an adverse effect. It is very closely monitored, through a Non-acute Register which records and monitors older people who are ready to be discharged from hospital and those who cannot be. In June 2001 there were 39 such patients. Over the winter of 2000/2001 with the help of the Winter Pressures money, the number was reduced to single figures. At present, 24 of the 39 patients have had their needs assessed and are awaiting authorisation from Social Services for a nursing home place. Six are awaiting a residential home placement in similar circumstances. The others are in a range of circumstances, mainly awaiting a suitable place, rather than allocation of funding. Walsall is in a better position than several neighbouring authorities. The best use of Intermediate Care is being made to keep the numbers down, though as stated above, allocations are only made if the patient can genuinely benefit from Intermediate Care.

3.5 PALLIATIVE CARE

The World Health Organisation defines palliative care as, "the active total care of patients whose disease is not responsive to curative treatment. Control of pain or other symptoms and of psychological, social and spiritual problems is paramount.". In other words it means care which gives temporary relief from the symptoms of a disease but does not actually cure the disease. The goal is to achieve the best quality of life for patients and their families.

The draft 'National Plan and Strategic Framework for Palliative Care: 2000-2005' is presently out for public consultation (National Council for Hospice and Specialist Care Services, 2001). Within it are the findings of two Palliative Care surveys commissioned by the Department of Health, to provide an overall picture of the extent of palliative care provision across the country.

96% of all Health Authorities described their palliative care services as not yet adequate. The West Midlands region ranks low on the volume of service provision for inpatient and day care (sixth and fifth out of eight respectively). However, it is top in terms of hospital support, and in the upper half for home care provision (3/8). The availability of services varies widely across the UK. Walsall fares quite well. Day care provision is above the national average of 1,320,

at 1,365 places per 100,000 population. Most districts have care teams in the community and/or in hospitals. Walsall's hospital palliative care support team is also above the national average of 8 nurses, with a rate of 10 per million population. Provision of home palliative care in Walsall is equal to the national rate of 21 nurses per million population. However, for specialist inpatient beds, Walsall is below the national average of 51 beds per million, with a rate of 39.

Palliative care has been traditionally associated with terminal illnesses such as cancer, but is increasingly being provided for patients with AIDS, and neurological disorders such as motor neurone disease and multiple sclerosis. Walsall is above the national average in cancer deaths per 100,000 population both for all ages and in older people (65-74 years).

The number of palliative care referrals of Walsall residents aged 65 years or more show a steady increase from nearly 7 per 1000 population (65+) in 1995 to over 15 per 1000 in the year 2000. (Figure 13). The types of disease with which people are most commonly referred are cancers of the lung, breast or prostate and noninfective disorders of the lymph vessels, which accounts for 12% of the total (Figure 14).

Recent research undertaken by the GP Macmillan Facilitator reported that palliative care in Walsall is "relatively in its infancy, but is being built on a strong foundation" (Poole, 2000). Walsall has a palliative care strategy which is in the process of being updated.

Some sections of the community are said to lose out on specialist care (Higginson, 1999). It has been reported that older patients have limited

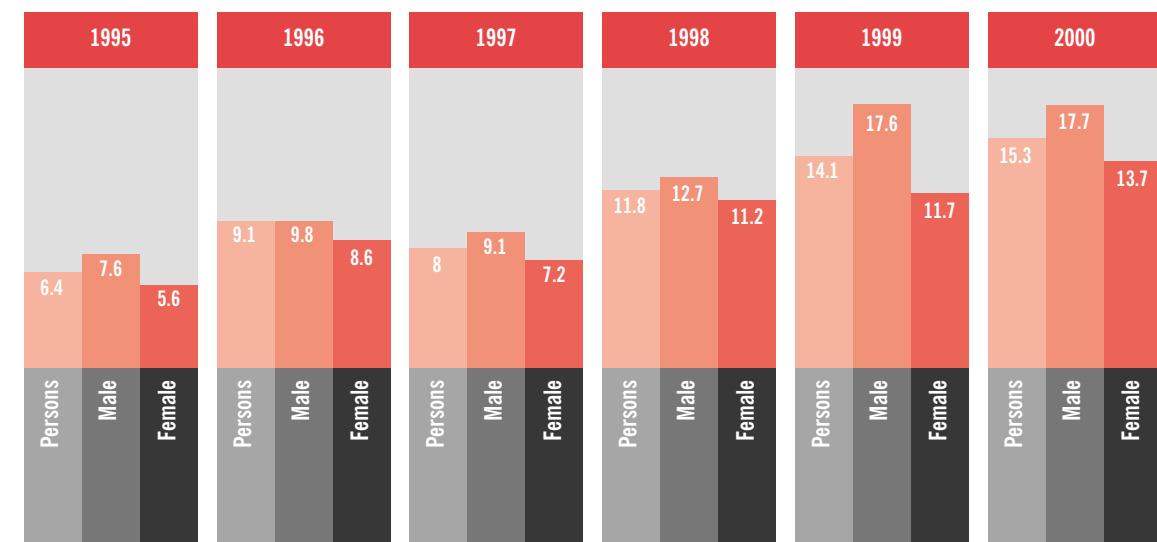
access to palliative care (Ramirez et al, 1998). At present Walsall has no hospice, although the Health Authority, Acute Trust and Community Trust are in the final stages of agreeing a site. It is anticipated that this will open in late 2002. It will provide a focus for palliative care at which the Macmillan team will be based.

The funding of palliative care services differs from that of the rest of the health service. Only about a fifth of inpatient units in the UK are funded exclusively by the NHS. Most are funded by the voluntary sector with some financial support from the health service. Major providers of palliative care include charities such as Macmillan Cancer Relief, Marie Curie Cancer Care and the Sue Ryder Foundation.



Figure 13

Palliative Care Referral Rates Age 65 and Over, Walsall, 1995-2000 (Rate per 1,000 Population).

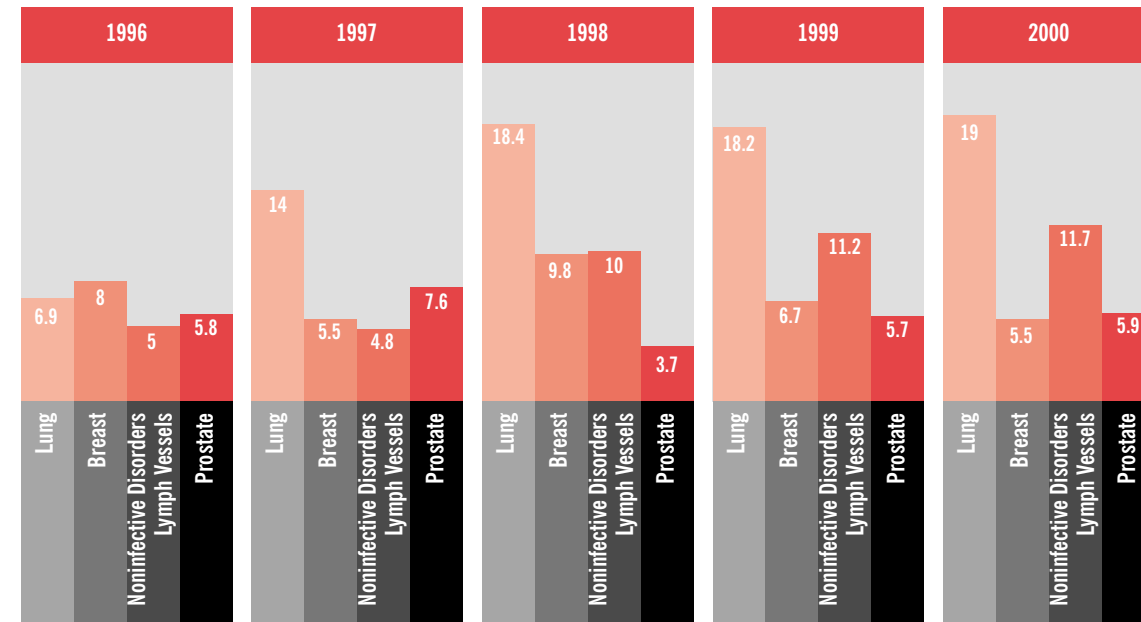


Source: Walsall Community Health Trust



Figure 14

Most Frequent Types of Palliative Care Referrals, Walsall, 1996-2000 (Percentage of All Referrals Aged 65 and Over).



Source: Walsall Community Health Trust

Hospital Admissions and Referrals

chapter into elective and non-elective cases.

- Elective admissions are those that have been arranged in advance, including those on a waiting list, booked or planned. This excludes emergency admissions, maternity admissions or routine transfers from beds elsewhere.
- Non-elective admissions are unplanned, and include emergency admissions and emergency transfers between hospitals.

The overall hospital admission rates for Walsall between 1998 and 2000 in those aged 60 and over are illustrated in Map 4 on page 26. The rates broadly reflect the distribution of deprivation examined in some detail in the last two Public Health Reports. Non-elective admissions particularly tend to be higher in Walsall's more deprived wards.



4.2 LENGTH OF STAY

Over recent years it has been reported that the time patients spend in hospital has reduced as pressure on resources and beds has grown and developments in medical technology have improved recovery times. The average length of stay for geriatric patients in the UK fell by over 60% between 1982 and 1993 (Parker et al, 2000). Of Walsall's older residents admitted to the hospital between 1998 and 2000 the average length of an elective admission was 5.85 days, and that of a non-elective admission 7.03 days. This is shown in more detail in Table 8.

Table 8 Length of Stay in Hospital, Walsall Residents, Patients Aged 60 and over, 1998-2000

| TIME (DAYS) | ELECTIVE ADMISSION % | NON ELECTIVE ADMISSION % |
|-------------|----------------------|--------------------------|
| 0 | 11.1 | 4.0 |
| 1-7 | 65.8 | 63.0 |
| 8-14 | 13.0 | 20.7 |
| 15-21 | 5.1 | 7.1 |
| 22-28 | 2.2 | 2.6 |
| 29-35 | 1.0 | 1.0 |
| 36-42 | 0.6 | 0.6 |
| 43-49 | 0.4 | 0.3 |
| 50-56 | 0.2 | 0.2 |
| 57+ | 0.6 | 0.5 |

Source: Walsall Health Authority

4.1 OVERVIEW

Hospital admissions tell us little in isolation: they are the tip of the iceberg. Levels of admission are influenced by general levels of health in the community which in turn are profoundly determined by the nature of the population, such as the distribution of age and ethnicity; by social circumstances, in particular those influencing the degree of health inequality; and by health behaviour, which is again influenced by all of these factors and others. These determining local conditions are then overlaid by issues of health policy, resources and practice. For example, different primary care physicians have different thresholds at which they seek the help of the specialist. Often this variation is influenced by the provision of other services such as support with housing, or community care. Hospital admissions, and other hospital data, are a pivotal point for understanding what is going on, not only in the hospital, but what conditions out in the community have led to admission. In other words, we can use the data to work back to causes and the fundamental agenda, which is about the promotion of health, its maintenance, and prevention of illness. We then have to work forward: how can we give people who have been in hospital the support to ensure that if possible they do not return?

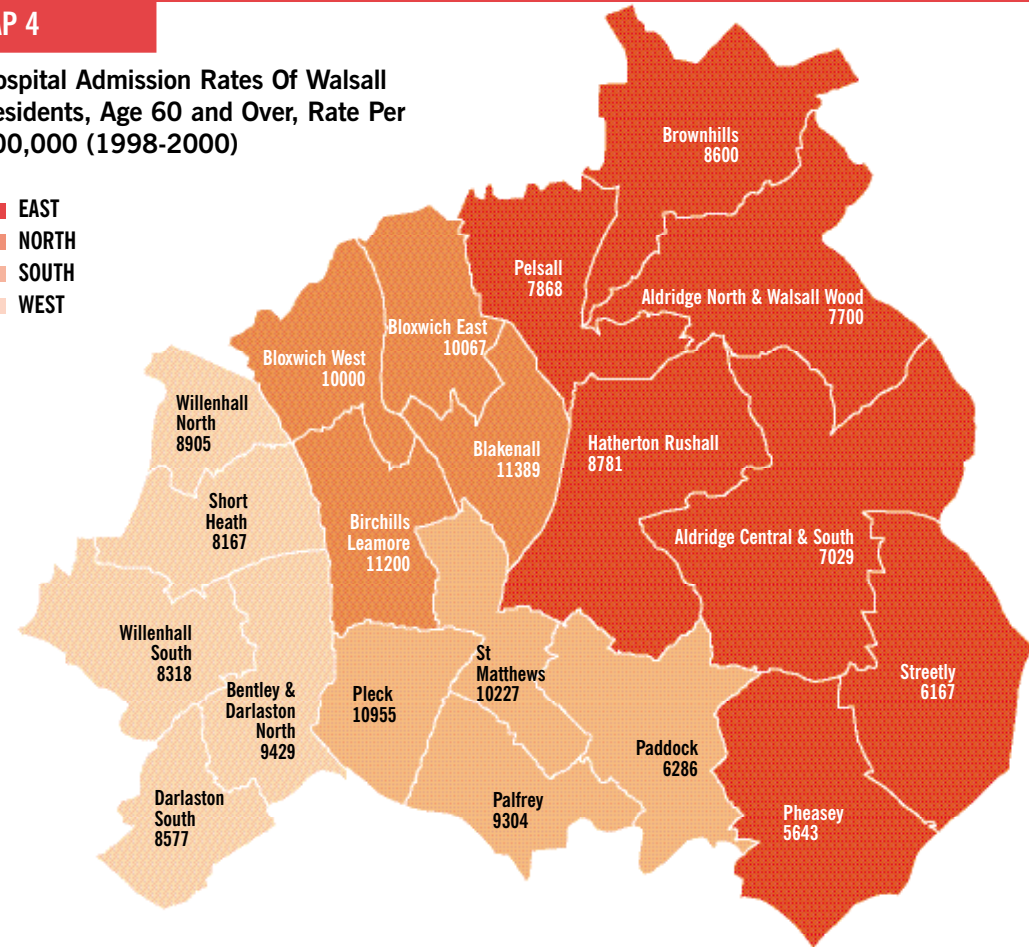
Admissions to hospital are divided in this



MAP 4

Hospital Admission Rates Of Walsall Residents, Age 60 and Over, Rate Per 100,000 (1998-2000)

- EAST
- NORTH
- SOUTH
- WEST



Source: Walsall Health Authority

4.3 EMERGENCY ADMISSIONS

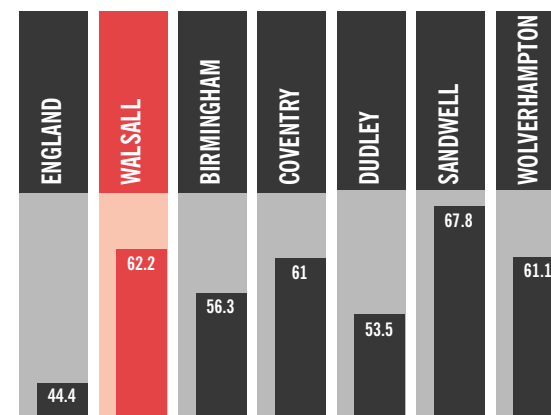
Emergency admissions are subject to many external influences, including levels of infectious disease like influenza and the availability of community support services and access to elective services. Deprivation is a factor in levels of emergency admission: poor health in itself is related to deprivation; but in addition effective use of health services, more positive health behaviour, and access to health care in the community are positively associated with socio-economic well-being.

Some emergency admissions may result from a breakdown of a particular element of primary, community or social care, or from a breakdown in the co-ordination of agencies involved. There is often much that can be done to prevent the patient's condition deteriorating to such an extent that an emergency admission is required, for example timely community care, such as good sheltered housing or home care, to prevent an older person's health deteriorating; or post-operative support to prevent readmission (see previous section on Intermediate Care). As an

important measure of all these factors, Walsall has one of the highest emergency admission rates to hospital among older people in the West Midlands (62.2), second only to Sandwell (67.8) (Figure 15).

Figure 15

Emergency Admissions to Hospital per 1000 People Aged 75 and Over (1998/1999)



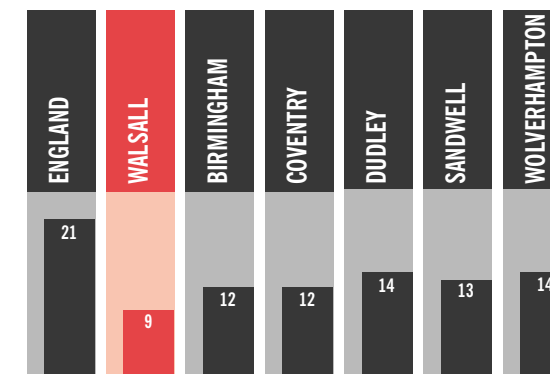
Source: DOH High Level Performance Indicators July 2000

4.4 INPATIENT WAITING LISTS

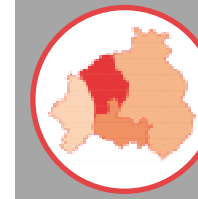
The size of the inpatient waiting list per head of population also demonstrates variations in access to secondary care. Walsall currently leads the national league table for the lowest number of people per 1000 head of population who are waiting for elective surgery, generally suggesting that supply is meeting demand across all ages. Waiting lists per head of population are adjusted to take into account differences that affect the level of need for care, such as the age of the population. As illustrated in Figure 16 Walsall is far ahead of its neighbouring districts.

Figure 16

Inpatient Waiting Lists per 1000 Population



Source: DOH High Level Performance Indicators July 2000





Specific Conditions: Key Date And Trends

5.1 STROKE

Stroke is the third most common cause of death in England and Wales after heart disease and cancer. It can affect anyone at any age including children. However the older you are, the greater the risk. The commonest form of stroke entails blockage of a blood vessel in the brain, which leads to a portion of the brain dying. Those at highest risk include people with hypertension (high blood pressure), those who have transient ischaemic attacks (mini-strokes), heart attacks, or suffer from arteriosclerosis, (narrowing of the blood vessels), diabetes or high blood cholesterol. Lifestyle risk factors include smoking, physical inactivity and obesity, excessive alcohol consumption and illegal drug abuse. See Chapter Three for discussion of health behaviour issues. People of African-Caribbean and South Asian ethnic origin are also at

higher risk. The White Paper "Saving Lives: Our Healthier Nation" includes a national target to reduce the death rate from coronary heart disease, stroke and related conditions in people under 75 by 25% in 2005 and by 40% in 2010. Applying this national target to deaths from stroke in persons aged 65-74 will require Walsall to achieve a 36% and 48% reduction, in stroke deaths in this age group respectively in 2005 and 2010 (20 and 28 fewer deaths in number). This will require the rapid downward trend illustrated in Figure 17 to be maintained over the decade.

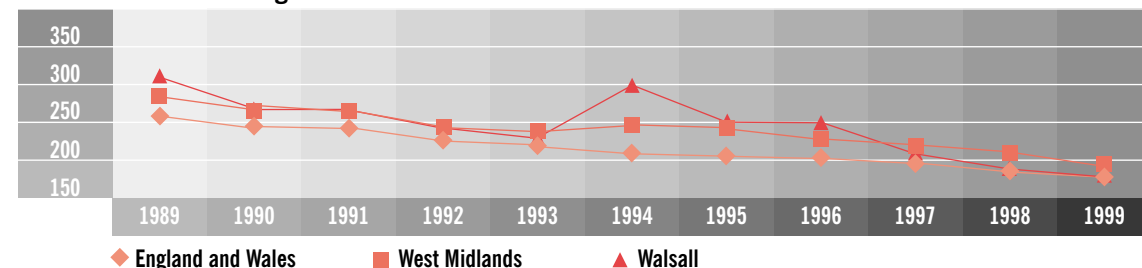
Death rates in people aged 65 to 74 years from strokes have fallen dramatically in Walsall since 1994 from a peak of 298 deaths per 100,000 to 180 deaths per 100,000 in 1999, which is the same as the national rate and below the regional rate of 195.

A substantial decline in the incidence of strokes in Walsall in 2000 takes it 25% below the expected level, and this is thought to be at least partly due to Walsall's preventative strategy. Walsall is at the forefront of modernising stroke services and provides an integrated stroke service jointly operated by the Manor Hospital and Community Health Trust, which has recently been awarded national beacon status. There is a service aimed at TIAs (Transient Ischaemic Attacks, or mini-strokes). Organised stroke care in Walsall consists of a team approach to provide equitable stroke management from the early onset of the disease through to lifelong follow-up. GPs refer at-risk patients early. A Clinical Care Pathway provides consistent information for both patients and carers. The Intermediate Care Strategy (see Chapter Three) will develop further rehabilitation programmes. The number of deaths as a percentage of all those suffering a stroke (Figure 18 opposite) has declined substantially since 1996, which suggests that these programmes are working.

Stroke is the largest single cause of severe disability in the UK. It is therefore a priority to restore function and well-being for stroke patients as far as possible. Studies estimate that between

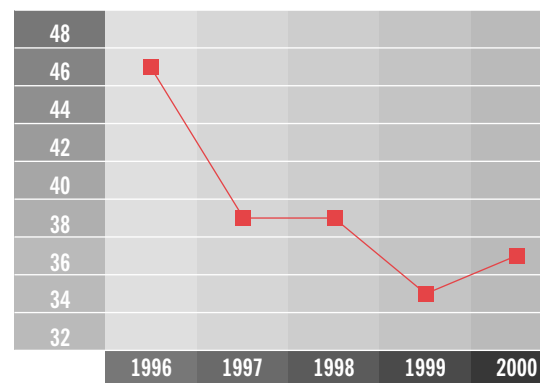
Figure 17

Age Standardised Death Rates for Stroke, in Persons Aged 65-74, Rate per 100,000, Walsall, West Midlands and England and Wales



Source: Public Health Common DataSet 2001

Figure 18 Mortality From Stroke in Walsall: Percentage of all Suffering Stroke, Trends 1996-2000



Source: Walsall Community Health Trust

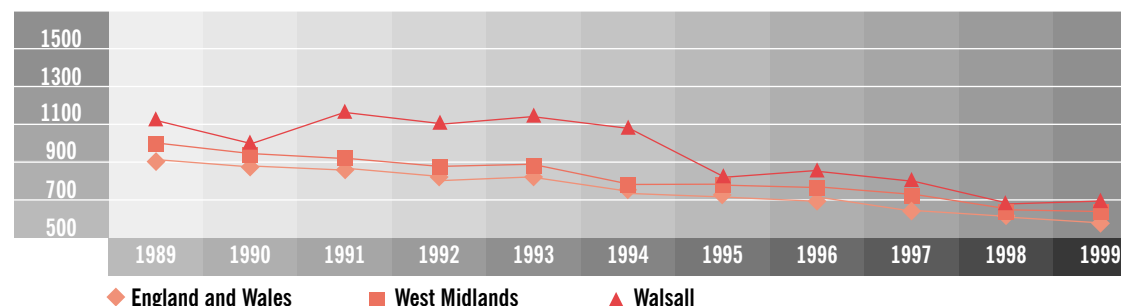
Table 9 Discharge to Usual Place of Residence Within 56 Days of Admission to Hospital with a Stroke (Ages 50 and over) 1998/1999

| | % | CONFIDENCE INTERVAL | NATIONAL RANKING DERIVED FROM PROPORTION OF DISCHARGE |
|---------------|------|---------------------|---|
| ENGLAND | 47.2 | 46.62-47.71 | |
| WEST MIDLANDS | 46.6 | 44.96-48.21 | |
| WALSALL | 47.2 | 39.74-55.55 | 48 |
| BIRMINGHAM | 48.7 | 45.05-52.54 | 37 |
| COVENTRY | 47.8 | 41.96-54.18 | 43 |
| DUDLEY | 38.1 | 32.40-44.45 | 98 |
| SANDWELL | 42.3 | 36.48-48.73 | 88 |
| WOLVERHAMPTON | 53.2 | 45.15-62.33 | 8 |

Source: High Level Performance Indicators July 2000

Figure 19

Age Standardised Death Rates for CHD Aged 65-74 Years, Walsall, West Midlands and England and Wales, 1989-1999



Source: Public Health Common DataSet 2001

50% and 90% of stroke patients are admitted to hospital (Bamford et al, 1986). Not all patients who have a stroke however need to be admitted. One proxy measure of the effectiveness of such care is the number of patients who are able to return to the place where they usually live following a period of rehabilitation. The time estimated to be appropriate for rehabilitation (avoiding an unduly long stay in hospital) for inpatients over 50 years of age is about 8 weeks. Table 9 below illustrates that Walsall is about average for successfully returning patients to their usual place of residence prior to their stroke. It is expected that this position, referring to 1998/99, will improve significantly in the light of the initiatives described above.

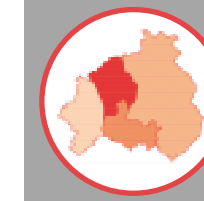
5.2 CORONARY HEART DISEASE (CHD)

Coronary Heart Disease is the single most common cause of premature death in the UK and accounts for approximately 330 deaths per day. Government policy aims to target resources to those in greatest need.

As noted in the previous section, "Saving Lives: Our Healthier Nation" sets a national target to reduce the death rate from CHD, Stroke and related conditions in people under 75 by 25% in 2005 and by 40% in 2010. Applying this national target to deaths from CHD in persons aged 65-74 will require Walsall to achieve a 38% and 50% reduction in CHD deaths in this age group respectively in 2005 and 2010, (74 and 99 fewer deaths). This will require the downward trend illustrated in Figure 19 to be maintained over the decade.

Death rates in people aged 65 to 74 years from CHD have been falling in Walsall. However, in 1999 it is still one of the highest in the West Midlands (700 per 100,000) and is significantly higher than the regional rate of 635 and the national rate of 587.

Research has identified a number of risk factors for CHD, the most important being hypertension, cigarette smoking, high cholesterol levels,





diabetes, obesity, genetics, physical exercise and diet. The prevalence of these risk factors varies with age, gender, ethnicity, socio-economic status and geographical location.

Risk of CHD has been shown to be significantly reduced by improving access to services, and by greater investment in both primary prevention and treatment services. Enabling MOR groups known to be at greater risk to have better access to such services will help reduce inequalities.

Walsall has adopted an integrated approach to developing the National Service Framework for CHD, which identifies priorities for effective prevention, treatment and national standards of care. It also has a local CHD-specific HAZ programme. The HAZ programme aims to join up community, primary and secondary care services by establishing a comprehensive referral scheme from acute hospital services into community programmes. One example of this is the commissioning of Heart Care, the Cardiac Rehabilitation Service, to provide an outreach service in a Community Association used predominantly by South Asian Communities.

Local information for accurately assessing the prevalence of CHD within Walsall is poor, but will improve in time given the development of CHD registers in General Practice. Hospital admissions

data are shown in Table 10. Admissions are shown to be consistently higher in North PCG. Levels of non-elective admissions are a particularly important indicator of the effectiveness of both preventative strategies and access to, and use of, community health services.

However, these figures should not be taken to represent prevalence, since all patients will not necessarily experience hospital inpatient care. The age-specific death rates illustrated in Figure 19 on page 29 are more useful and robust, but again, such death rates are not currently available for PCG or ward. A CHD mortality map for all ages appeared in the 1999 Annual Report of the Director of Public Health Medicine (Director of Public Health, 1999). This is an area where the availability of postcoded data needs to be significantly improved to inform service development for older people.

5.3 DIABETES MELLITUS

Diabetes Mellitus (DM) is a chronic condition that affects the body's ability to control the amount of sugar in the blood. Serious complications of diabetes include: coronary heart disease and stroke, kidney problems, lower limb ulceration and

amputation, and diabetic eye disease and blindness.

The disease is sub-divided into Types 1 and 2. Type 2 is more common in people over 40, and can be treated by diet, tablets, and failing these, insulin. It represents more than 80% of cases of diabetes. Type 1 requires insulin treatment and is more common in children and young adults.

Diabetes affects about 3% of the population. However as many as half of these cases remain undiagnosed. The prevalence of diabetes increases with age, affecting 10% of those aged over 65 years. There is higher prevalence in both Asians and African Caribbeans. More than 25% of South Asians aged 60 and over are affected each year in the UK.

Data from Walsall's chronic disease management registers (99/00) show that there are 2,390 persons over the age of 65 with Type 2 diabetes and 653 with Type 1. Given Walsall's population structure, we should expect 4000 persons with diabetes, with a 10% prevalence in the over 65's. This however does not take account of minority ethnic groups, which would make the expected figure substantially higher.

The National Service Framework (NSF) for diabetes sets standards and defines models to improve the care of people with diabetes. It encompasses the range of diabetes management from prevention through to rehabilitation and continuing care. People with diabetes account for nine per cent of all hospital costs. Complications, which result in high numbers of hospital admissions and longer than average stays, account for most of this spending.

Much work is being done in Walsall but there are gaps in the service. Information systems need to be refined. In particular, the development of a diabetes register will aid the delivery of quality care, for example in terms of identifying patients for annual reviews and eye screening. It should also result in better monitoring and audit.

Services need to be accessible to all groups. There is currently no provision for eye screening in residential homes and for the housebound. The

needs of South Asians and African Caribbeans with higher prevalence, who are often in less contact with health services, must also be addressed.

There is currently one Asian link worker in Walsall, which is hardly adequate given the prevalence of diabetes in the South Asian community.

5.4 CANCERS

There are many types of cancer, each affecting different parts of the body. The most common cancers are: breast, colorectal, lung, prostate, stomach, bladder and ovarian. Effective treatment can improve survival and quality of life. The majority of people who develop cancer are aged 60 and over (Sikora, 1998). Smoking, poor diet and alcohol account for 68% of the risk factor in the western world. Therefore public health education and support for individuals to enable a healthy lifestyle can achieve an enormous positive impact. It is estimated that effective tobacco control could reduce overall cancer incidence by 20% by the year 2020. Similarly dietary change from current high fat, low fibre diets to a wholefood diet rich in vegetables, grains and pulses could result in a further reduction of 20%.

The national target set by Our Healthier Nation is to reduce the cancer death rate in all persons under the age of 75 years by 20% by 2010 (12% by 2005). This includes all types of cancers. To achieve the national target rate, Walsall needs to reduce its cancer deaths by 24% by 2010 (100 fewer deaths in number).

Death rates per 100,000 population in people aged 65 to 74 years from all cancers in Walsall have fluctuated over the past decade (Figure 20). In 1999 the rate in Walsall remained one of the highest in the West Midlands (892), and was significantly higher than the regional rate of 835 and the national rate of 851.

The following sections examine how different cancers affect Walsall people over the age of 64

Table 10

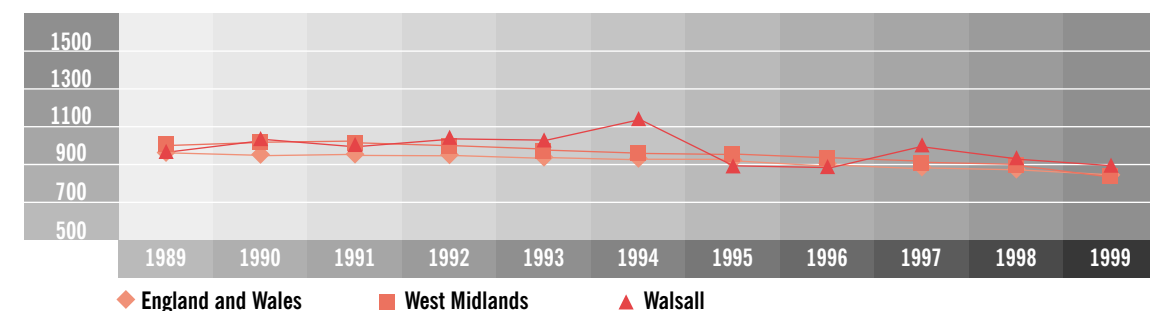
CHD Hospital Admissions by Age: Total & Rates per 1000 Population, Walsall Primary Care Groups, 1998-2000 (Three Years Aggregated).

| | AGE | EAST | NORTH | SOUTH | WEST | TOTAL |
|-------------------------|-------|-------|-------|-------|-------|-------|
| NON ELECTIVE ADMISSIONS | 65-74 | 426 | 497 | 243 | 371 | 1537 |
| | RATE | 60.1 | 116.1 | 44.0 | 81.1 | 71.6 |
| | 75-84 | 377 | 435 | 277 | 340 | 1429 |
| | RATE | 94.3 | 158.8 | 81.5 | 116.5 | 109.5 |
| | 85+ | 156 | 137 | 121 | 102 | 516 |
| | RATE | 129.8 | 199.1 | 89.8 | 117.5 | 125.7 |
| ELECTIVE ADMISSIONS | 65-74 | 108 | 98 | 51 | 60 | 317 |
| | RATE | 15.2 | 22.9 | 9.2 | 13.1 | 14.8 |
| | 75-84 | 33 | 41 | 24 | 26 | 124 |
| | RATE | 8.3 | 15.0 | 7.1 | 8.9 | 9.5 |
| | 85+ | 4 | 8 | 13 | 10 | 35 |
| | RATE | 3.3 | 11.6 | 9.6 | 11.5 | 8.5 |
| DAY CASE ADMISSIONS | 65-74 | 118 | 87 | 47 | 59 | 311 |
| | RATE | 16.6 | 19.9 | 8.5 | 12.9 | 14.5 |
| | 75-84 | 17 | 19 | 7 | 10 | 53 |
| | RATE | 4.3 | 6.9 | 2.1 | 3.4 | 4.1 |
| | 85+ | 1 | 1 | 0 | 0 | 2 |
| | RATE | 0.8 | 1.5 | 0 | 0 | 0.5 |
| ALL ADMISSIONS | 65-74 | 652 | 682 | 341 | 490 | 2165 |
| | RATE | 91.9 | 159.3 | 61.7 | 107.2 | 100.8 |
| | 75-84 | 427 | 495 | 308 | 376 | 1606 |
| | RATE | 106.9 | 180.7 | 90.6 | 129.0 | 123.0 |
| | 85+ | 161 | 146 | 134 | 112 | 553 |
| | RATE | 134.0 | 212.2 | 99.4 | 129.0 | 134.7 |

Source: In-house calculation, Walsall Health Authority

Figure 20

Age Standardised Death Rates for Cancers Aged 65-74 Years, Walsall, West Midlands and England and Wales, 1989-1999



Source: Public Health Common Dataset





years. Analysis is presented by PCG as well as making regional comparisons. The figures may point to some priority areas for PCGs. The data presented have been provided by West Midlands Cancer Intelligence Unit.

5.4.1 Bronchus and lung cancer

Walsall North PCG had the highest rate in 1996/98. This corresponds with the high levels of smoking and of deprivation found by the 1999 Public Health Report. All the PCGs had levels higher than that for the West Midlands; and all the PCGs except North were increasing. East PCG had the highest increase between 1990/92 and 1996/98. (See Figures 21-23).

5.4.2 Cancer of the Colon

North PCG had a far higher rate than that for the West Midlands in 1996/98, and it is rising steeply, while rates for the other PCGs fell between 1990/92 and 96/98. South has an upward trend from 1994/96 (See Figures 24-26).

5.4.3 Cancer of the Bladder

The rates for North and West PCGs are higher than the rate for West Midlands and are rising, though the rate for North has fallen overall since 1990/92. The rates for West and East rose significantly overall between 1990/92 and 1996/98, though that for the East has registered a decline recently. South has a low and steeply falling level (See Figures 27-29).

5.4.4 Cancer of the Prostate (Men)

Rates in all PCGs have risen substantially, particularly in North, East and South, which have rates significantly above that for the West Midlands. There are now as many cases of prostate cancer in Walsall men as there are of breast cancer in women (See Figures 30-32).

5.4.5 Breast cancer (Women)

There have been substantial rises in North and East PCGs, with falls in South and West. Levels in North and East substantially exceed those for the West Midlands, and are increasing. (See Figures 33-35)

5.4.6 Ovarian cancer (Women)

Levels of ovarian cancer are higher than those for the West Midlands in North, East and West PCGs, and are moving in the wrong direction. West has had the biggest rise, though from a low base. The already low level in South PCG has declined further (See Figures 36-38).

Bronchus and Lung Cancer Figures 21-23

Figure 21 Bronchus and Lung Cancer, Trends of Incidence per 100000 People Aged 65 and Over, by Walsall PCGs 1990/92-1996/98

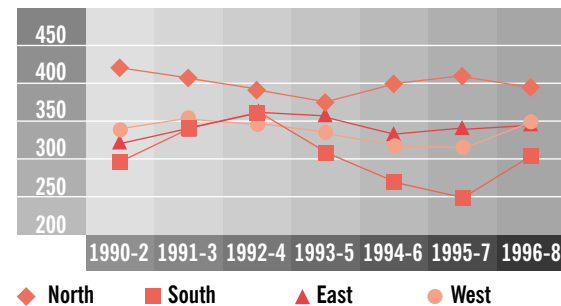


Figure 22 Bronchus and Lung Cancer, Incidence per 100000 People Aged 65 and Over, West Midlands, Walsall and Walsall PCGs 1996/98

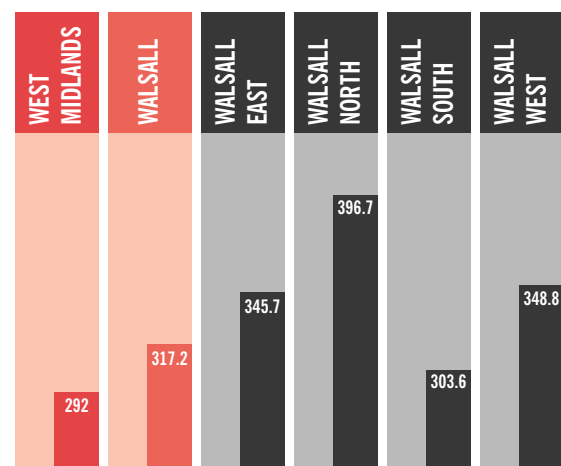
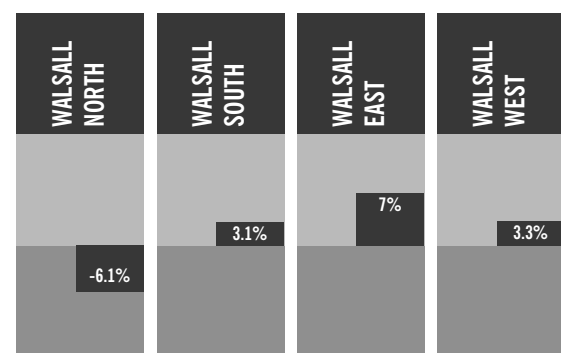


Figure 23 Bronchus and Lung Cancer, Change in Incidence per 100000 People Aged 65 and Over in Walsall PCGs 1990/92-1996/98



Cancer of the Colon Figures 24 - 26

Figure 24 Cancer of the Colon Trends of Incidence per 100000 People Aged 65 and Over, by Walsall PCGs, 1990/92-1996/98

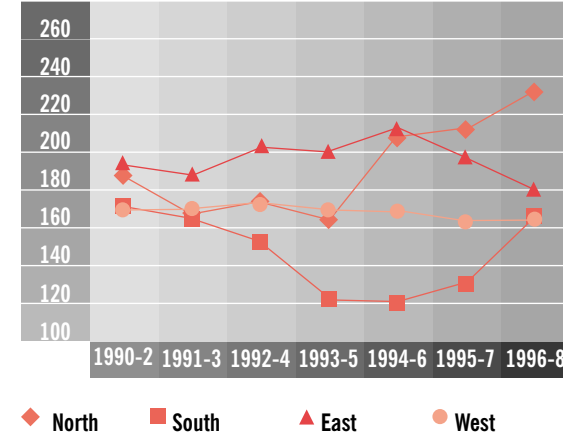


Figure 25 Cancer of the Colon, Incidence per 100000 People Aged 65 and Over, West Midlands, Walsall and Walsall PCGs 1996/98

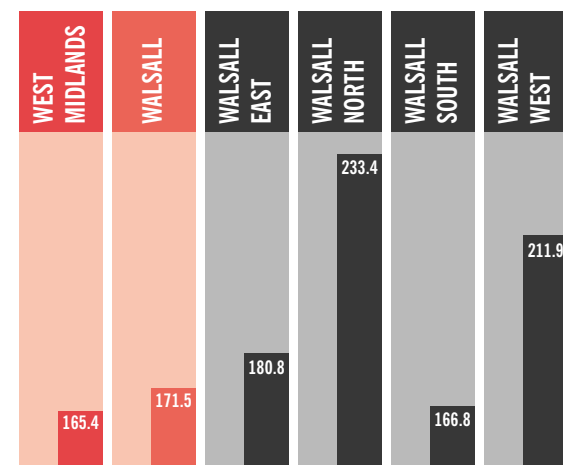
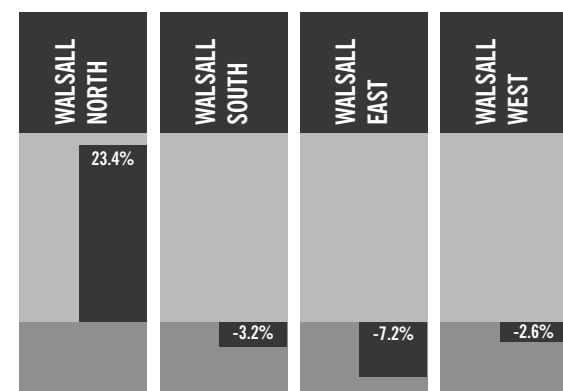


Figure 26 Cancer of the Colon, Change in Incidence per 100000 People Aged 65 and Over in Walsall PCGs 1990/92-1996/98



Cancer of the Bladder Figures 27 - 29

Figure 27 Cancer of the Bladder, Trends of Incidence per 100000 People Aged 65 and Over, by Walsall PCGs, 1990/92-1996/98

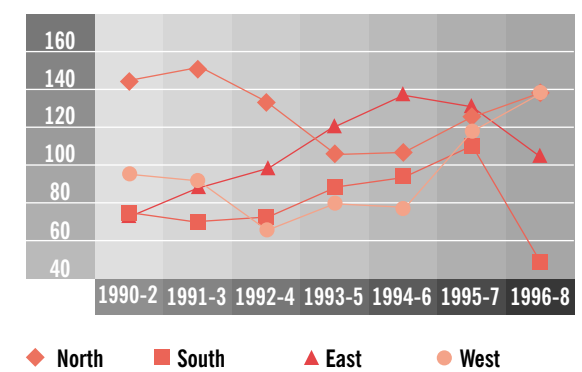


Figure 28 Cancer of the Bladder, Incidence per 100000 People Aged 65 and Over, West Midlands, Walsall and Walsall PCGs 1996/98

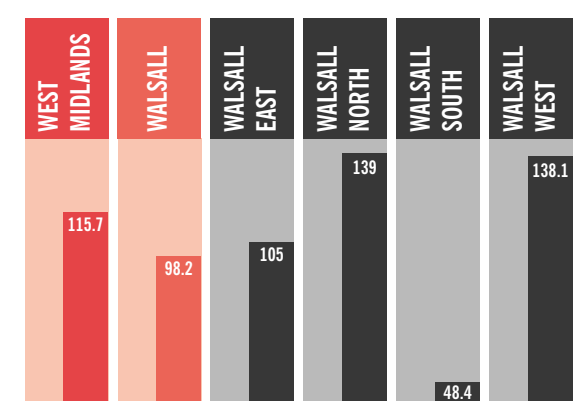
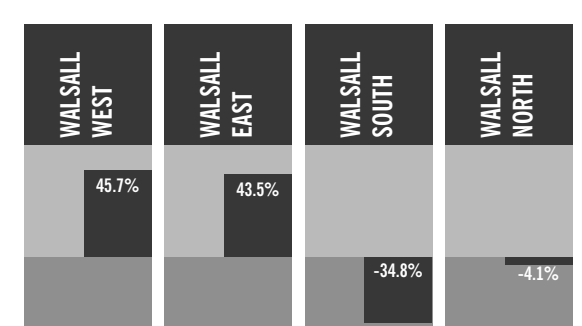


Figure 29 Cancer of the Bladder, Change in Incidence per 100000 People Aged 65 and Over in Walsall PCGs 1990/92-1996/98





Cancer of the Prostate (Men) Figures 30 - 32

Figure 30 Cancer of the Prostate, Trends of Incidence per 100000 Men Aged 65 and Over, by Walsall PCGs, 1990/92-1996/98

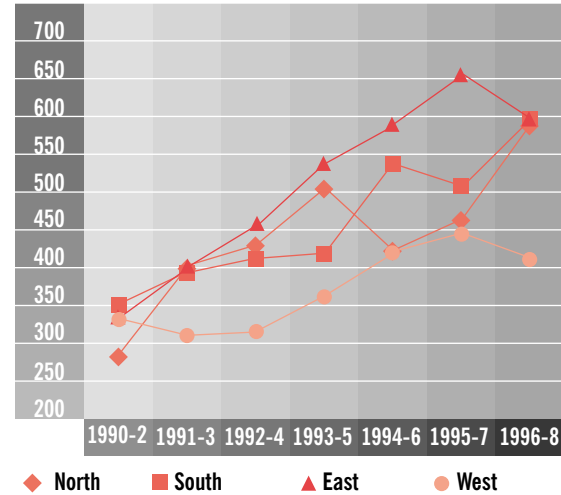


Figure 31 Cancer of the Prostate, Incidence per 100000 Men Aged 65 and Over, West Midlands, Walsall and Walsall PCGs 1996/98

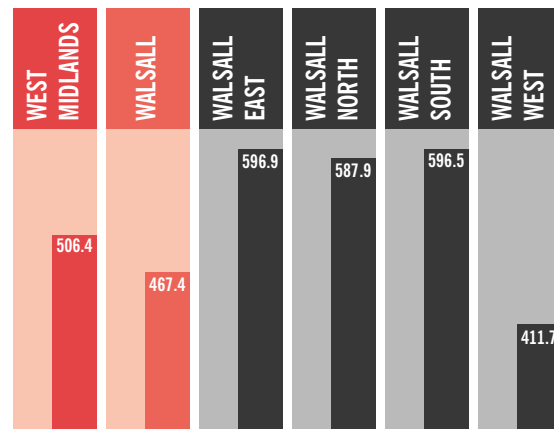
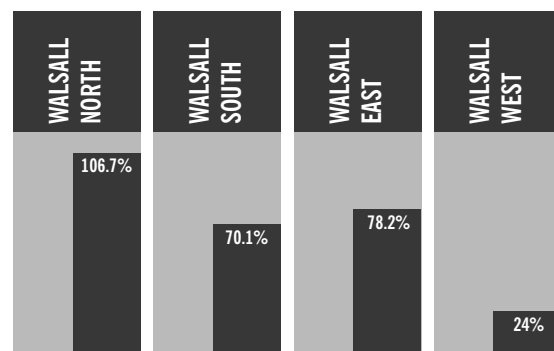


Figure 32 Cancer of the Prostate, Change in Incidence per 100000 Men Aged 65 and Over in Walsall PCGs 1990/92-1996/98



Breast Cancer (Women) Figures 33 - 35

Figure 33 Breast Cancer, Trends of Incidence per 100000 Women Aged 65 and Over, by Walsall PCGs, 1990/92-1996/98

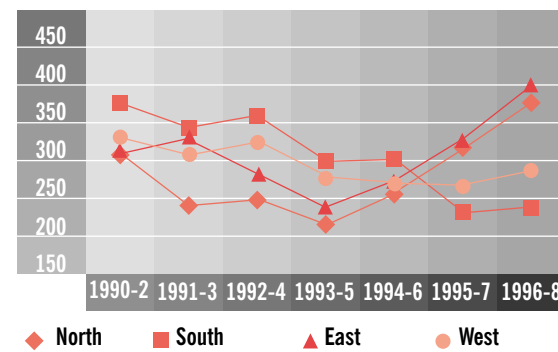


Figure 34 Breast Cancer, Incidence per 100000 Women Aged 65 and Over, West Midlands, Walsall and Walsall PCGs 1996/98

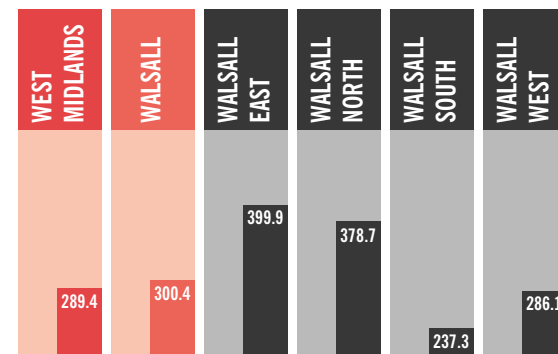
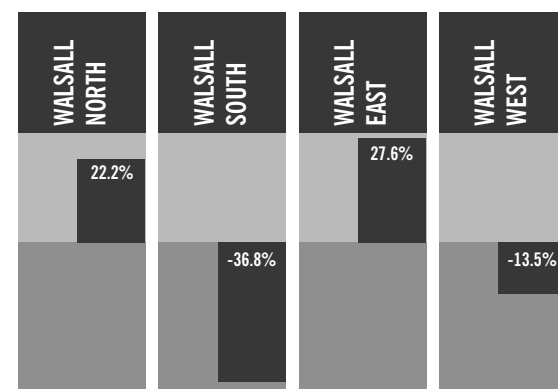


Figure 35 Breast Cancer, Change in Incidence per 100000 Women Aged 65 and Over in Walsall PCGs 1990/92-1996/98



Ovarian Cancer (Women) Figures 36 - 38

Figure 36 Ovarian Cancer, Trends of Incidence per 100000 Women Aged 65 and Over, by Walsall PCGs, 1990/92-1996/98

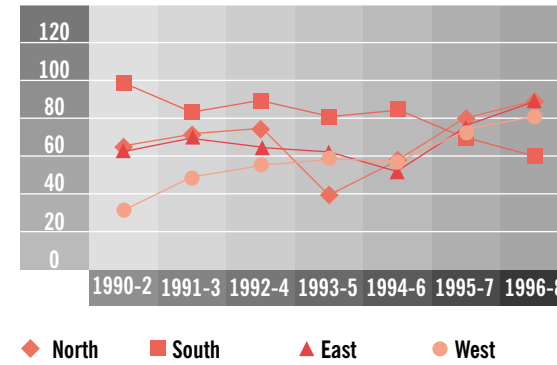


Figure 37 Ovarian Cancer, Incidence per 100000 Women Aged 65 and Over, West Midlands, Walsall and Walsall PCGs 1996/98

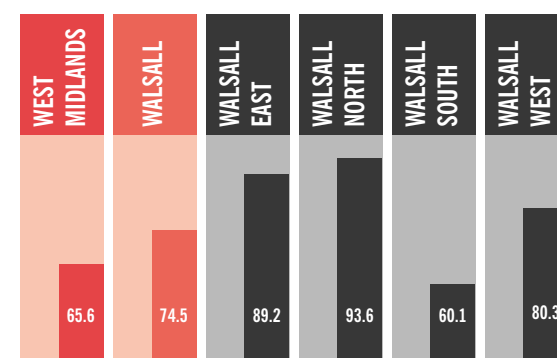
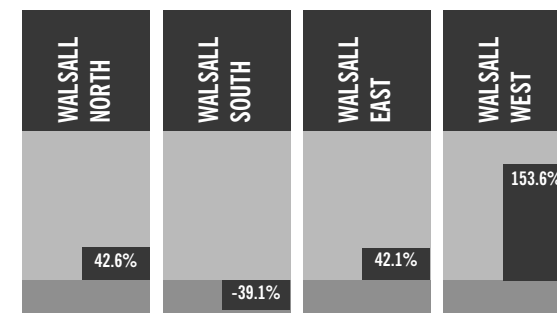


Figure 38 Ovarian Cancer, Change in Incidence per 100000 Women Aged 65 and Over in Walsall PCGs 1990/92-1996/98



5.5 ORTHOPAEDICS



Orthopaedics is the medical speciality devoted to the diagnosis, treatment, rehabilitation and prevention of injuries and diseases to the body's musculoskeletal system. It involves the bones, joints, ligaments, tendons, muscles and nerves.

5.5.1 Arthritis

In older people, arthritis is one of the most common conditions. Arthritis is the general term used to describe a condition where a joint is damaged or painful. The two most common types of arthritis are osteoarthritis and rheumatoid arthritis. Osteoarthritis is most common in old age and is a result of wear and tear in the joints as opposed to an inflammation of the lining of the joint associated with rheumatoid arthritis. There are no data for the incidence of arthritis in Walsall. North PCG appears to have the highest rate of hospital admission for arthritis (Table 11).

5.5.2 Osteoporosis

Osteoporosis is a loss of bone density which often leads to a fracture or break. There are many risk factors for osteoporosis, including:

- Early onset of menopause
- Low dietary calcium
- Alcohol and cigarette use
- Lack of regular exercise

These factors are amenable to simple preventative measures.

In the population aged 65 years and over between 1998 and 2000 there were 249 men and 743 women admitted to hospital for each

Table 11 Number of Hospital Admissions by Age group and Rate Per 1000 Population, 1998-2000: Arthritis

| All Admissions | East | North | South | West | Total |
|----------------|------|-------|-------|------|-------|
| 65-74 | 264 | 182 | 124 | 143 | 713 |
| Rate | 37.2 | 42.5 | 22.4 | 31.3 | 33.2 |
| 75-84 | 134 | 143 | 76 | 104 | 457 |
| Rate | 33.5 | 52.2 | 22.3 | 35.7 | 35.0 |
| 85+ | 21 | 18 | 34 | 18 | 91 |
| Rate | 17.5 | 26.1 | 25.2 | 20.7 | 22.2 |

Source: In-house calculation, Walsall Health Authority



100,000 population. There are no simple treatments for established osteoporosis. Primary preventative approaches focus on reducing the prevalence of osteoporosis. Treatment is aimed at the time of rapid bone loss during the menopause. HRT based on oestrogen, alone or in combination with progesterone, has been shown to retard, stop or even reverse bone loss after the menopause.

5.5.3 Hip Fracture

Hip fractures are most common in older people but can occur at any age (Gillespie, 2001). The reported lifetime risk of a hip fracture of those living in the western world is reported to be approximately 18% in women and 6% in men. Prevalence of hip fracture increases sharply with age. A four-fold increase from 3 per 100 in women aged 65-74 to 12.6 per 100 in women aged 85 years or older has recently been reported. Up to 25% of all older people encountering a fracture are likely to require a higher level of long term care after the event. 20% are likely die within the first year after a fracture.

Non-elective hospital admissions for a fractured femur in Walsall's older population between 1998 and 2000 are shown in Table 12. North PCG generally has the highest rate.

Restoring function and well-being for hip fracture patients is a reflection of successful health care in rehabilitating the patient; but it also requires resources in the community to ensure that older people are helped to regain a degree of independence. Because most hip fractures occur at older ages, patients are often admitted to hospital as emergencies. Table 13 indicates a low percentage of Walsall residents returning home after a fractured hip. However, the strategies described in Chapter Three, particularly the work

Table 12 Number of Non-Elective Hospital Admissions for Fractured Femur and Rate per 1,000 Population, Age-Specific Aggregated Figures for 1998-2000

| All Admissions | East | North | South | West | Total |
|----------------|------|-------|-------|------|-------|
| 65-74 | 24 | 40 | 22 | 18 | 104 |
| Rate | 3.4 | 9.3 | 4.0 | 3.9 | 4.8 |
| 75-84 | 88 | 95 | 54 | 55 | 292 |
| Rate | 22.0 | 34.7 | 15.9 | 18.9 | 22.4 |
| 85+ | 69 | 55 | 61 | 49 | 234 |
| Rate | 57.4 | 79.9 | 45.3 | 56.5 | 57.0 |

Source: In-house calculation, Walsall Health Authority

Table 13 Discharge to Usual Place of Residence Within 28 Days of Admission to Hospital With a Hip Fracture (Ages 65 and over), 1998/99

| | % | CONFIDENCE INTERVAL | NATIONAL RANKING DERIVED FROM PROPORTION OF DISCHARGE |
|---------------|-------|---------------------|---|
| ENGLAND | 47.77 | 47.13 - 48.42 | 0 |
| WEST MIDLANDS | 43.85 | 44.96-48.21 | 0 |
| WALSALL | 36.83 | 28.11 - 47.41 | 93 |
| BIRMINGHAM | 41.82 | 37.68 - 46.29 | 79 |
| COVENTRY | 52.46 | 44.76 - 61.11 | 31 |
| DUDLEY | 29.68 | 23.42 - 37.10 | 98 |
| SANDWELL | 36.12 | 29.39 - 43.94 | 96 |
| WOLVERHAMPTON | 47.18 | 37.84 - 58.13 | 53 |

Source: DOH High Level Performance Indicators July 2000

Table 14 Indirectly Age and Sex Standardised Rates of Deaths in Hospital Within 30 days of Emergency Admission With a Hip Fracture (neck of femur) for Patients Aged 65 and Over (1998-1999)

| | RATE | CONFIDENCE INTERVAL |
|-------------------------------------|------|---------------------|
| ENGLAND | 9070 | 8794 – 9352 |
| WEST MIDLANDS | 8485 | 7673 – 9360 |
| WALSALL HOSPITALS | 4968 | 2139 – 9790 |
| GOOD HOPE HOSPITAL | 7475 | 4351 – 11970 |
| ROYAL SHREWSBURY HOSPITALS | 5573 | 2668 – 10250 |
| MID STAFFORDSHIRE GENERAL HOSPITALS | 6626 | 3619 – 11118 |
| WORCESTER ROYAL INFIRMARY | 9618 | 5951 – 14703 |

Source: DOH High Level Performance Indicators July 2000

on Intermediate Care, should improve Walsall's performance.

Walsall has a good performance to build on in terms of the hospital response to emergency admission with a hip fracture (neck of femur) for patients aged 65 and over. Standardised rates of deaths in hospital within 30 days of admission are shown in Table 14 (1998-1999). Regional comparisons are drawn with other large acute trusts. Walsall proves to have the lowest rate in the region.

Hip fractures are often sustained through a fall. The pattern of incidence is consistent with two main risk factors: increased risk of falling and loss of skeletal strength from osteoporosis. Both of

these are associated with ageing; but the factors influencing risk can be influenced.

5.5.4 Falls

Research suggests that up to one third of the population in the UK aged over 65 has a fall every year, and that half fall at least twice. Women are at greater risk than men. High mortality is associated with both. In 1997, 67% of accidental deaths in females aged over 65 were due to falls.

The Falls Programme in Walsall sponsored by HAZ (Health Action Zone) is subject to national interest (see Chapter Three on Intermediate Care and its context).

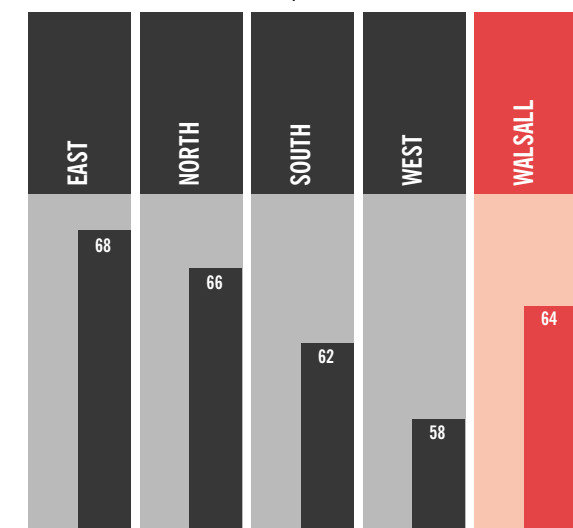
Table 15 shows the falls among people aged 65 and over recorded in 1998-2001 by PCG in Walsall. More than two-thirds of older people's falls were at home, underlining the need for preventative programmes. The highest number of falls recorded were in South PCG.

numbers will be significantly higher. Nearly 30,000 deaths in Britain were attributed to the 1989/90 outbreak.

Large segments of the population are susceptible to influenza every year because immunity is short-lived. Vaccination has been shown to be effective in reducing infection, associated illness, hospitalisation and mortality in older people. Research has indicated that vaccination of people over the age of 60 can halve the risk of influenza infection (Govaert, 1994).

The current age threshold for those able to get a free flu vaccine is 65 years. The Department of Health sets an annual target of immunising at least 60% of the over 65 population. Uptake of vaccine in Walsall during 2000/1 exceeded the national target, reaching 64%. Variation within the four Primary Care Groups is illustrated in Figure 39. Only West PCG fell below the national target.

Figure 39 Vaccine Uptake in Population Aged 65 and over, Walsall's PCGs, 2000/2001



Source: Public Health Department, Walsall Health Authority

5.6 INFLUENZA

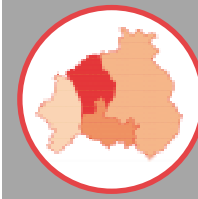
Influenza is a common respiratory illness that is known to affect up to 20 per cent of the population annually (Couch, 1993). Symptoms of influenza include fever, chills, cough, sore throat, runny or stuffy nose, headache, muscle aches, and often extreme fatigue. Its spread is primarily airborne, especially in crowded enclosed spaces. Most people recover completely within 1-2 weeks. However, complications can be especially harmful for older people and other vulnerable groups. Those with underlying chronic conditions such as asthma and bronchitis, chronic heart disease, kidney failure, diabetes mellitus and immunosuppression are at a particularly high risk of illness or death from the disease.

Nationally 3,000 to 4,000 deaths are attributed to the condition. 85% of these are people aged over 65. In an epidemic year the

Table 15 Falls Recorded in Walsall, Persons Age 65 and Over, 1998-2001, by PCG

| Year | East | | North | | South | | West | | Total |
|--------------------------|--------|------|--------|------|--------|-------|--------|------|--------|
| | Female | Male | Female | Male | Female | Male | Female | Male | |
| No. of falls 65 and over | | | | | | | | | |
| 98-99 | 206 | 70 | 177 | 68 | 191 | 77 | 181 | 63 | 1033 |
| 99-00 | 313 | 114 | 241 | 118 | 373 | 140 | 297 | 93 | 1689 |
| 00-01 | 332 | 111 | 245 | 75 | 333 | 137 | 290 | 85 | 1608 |
| 3 yr total | 851 | 295 | 663 | 261 | 897 | 354 | 768 | 241 | 4330 |
| 3 YR AVE. | 283.7 | 98.3 | 221.0 | 87.0 | 299.0 | 118.0 | 256.0 | 80.3 | 1443.3 |

Source: Manor Hospital



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