Needs Assessment to inform Adult Social Care Prevention Strategy for Older people in Gloucestershire

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Gloucestershire COUNTY COUNCIL

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Executive summary

The goal of this needs assessment was to inform the development of a prevention strategy for older people's social care by identifying local needs and making recommendations. While undertaking the assessment, wider gaps, for example in data quality and availability were also identified, and needs relating to services outside adult social care (ASC) were also noted.

There are important differences between biological age (how well your body is ageing and functioning) and chronological age (the number of years since your birth). Indeed, understanding those differences gives insight into societal understanding of ageing and responses to it. For data reasons, the needs assessment generally presents data for those aged over a chronological age of 65 as a key threshold (around retirement age) for increasing health need for many people.

The assessment supports Gloucestershire County Council's efforts to create a sustainable care market, emphasising the importance of prevention over the next five to ten years. The social care focus means that the assessment predominantly highlights needs for secondary and tertiary prevention for older adults who are likely to draw on social care. This is contrasted to needs relating mainly to primary prevention for younger age groups (e.g. 50 plus) or broader structural changes (such as place-based work to support healthier ageing). These latter two elements are equally important to the County Council and are the focus of work led by public health and implemented by the County Council and Integrated Care System more widely.

Gloucestershire’s population is ageing faster than the national average, with about 1 in 5 people aged 65 or older. This creates challenges for the county’s social care system due to rising demand for services. The number of people aged 65-74 is slightly decreasing, while those aged 75-84 are increasing significantly. The overall population of older adults (65+) is projected to rise by 52.5% by 2043, straining health and social care resources. Additionally, the number of working-age people is decreasing, adding financial and social pressure.

The 2021 Census shows that 6.9% of Gloucestershire’s population is from a diverse ethnic community background (excluding white minorities), up from 4.6% previously. This is below the national average of 19.0%. Including white minorities (who often face challenges accessing health and care services), the total is 12.3%, compared to the national average of 26.5%. Most older residents (65+) are white (87.7%), but there are diverse ethnic communities with unique needs that must be considered in service delivery. About 27,000 residents (4.3%) in Gloucestershire don’t speak English as their main language, with Polish, Romanian, and Portuguese being the most common. Gloucester and Cheltenham have the highest numbers of non-English speakers. Older adults (50+) are less proficient in English, with 32.3% lacking proficiency compared to 12% of those under 50.

The Equality and Human Rights Commission report shows that people from diverse ethnic communities (DEC) face ongoing discrimination in health, housing, and education. In Gloucestershire, older DEC individuals are more likely to have disabilities and poor health, live in inadequate housing, and develop dementia earlier, often accessing services later in crisis situations.

The 2021 Census shows that 0.2% of adults aged 65+ reported a different gender identity from birth, with 6.4% not answering. Older individuals may be less likely to disclose their gender identity due to fears of discrimination. Older transgender individuals may face unique challenges in accessing medical care and medications. In the 2021 Census, 0.6% of people aged 65+ in England and Wales identified as bisexual, gay, or lesbian, while 91.3% identified as straight. Younger people are more likely to identify as non-heterosexual due to greater acceptance. Older adults may report lower rates due to past discrimination and legal barriers. They also face unique ageing challenges, such as being less likely to have children, living alone, and relying more on friends for support.

In Gloucestershire, people aged 65 can expect to live longer than the national average. The life expectancy at 65 of women is approximately 21.6 more years, and for men, approximately 19.1 more years. Nationally, the life expectancy at 65 is 20.89 years for women and 18.4 years for men. Both genders have around 12 years of healthy life expectancy at age 65. However, those in less deprived areas live about 3.5 years longer than those in poorer areas. This shows the need for targeted support to improve health outcomes for older adults in deprived areas.

In 2021, 16.8% of Gloucestershire residents were considered disabled, slightly below the national average. By 2030, nearly 37,000 older adults in the county are expected to have significant long-term disabilities, especially those aged 75 and over. Disabilities are more common in deprived areas, highlighting the need to address societal barriers to support healthy ageing. It was projected in 2020 that by 2024, about 12,373 adults in Gloucestershire will have a learning disability, with 2,517 having moderate to severe impairments. For those 65 and older, numbers are expected to rise from 3,113 in 2023 to 4,285 by 2040. People with learning disabilities often have a shorter life expectancy and higher risks of age-related health issues. They also face social and economic challenges, such as providing unpaid care, lacking private transportation, and living in social housing.

The dementia diagnosis rate for those over 65 is 63.2%, below the NHS target of 66.7%. Lifestyle factors like hearing loss, social isolation, smoking, alcohol use, and lack of physical activity impact dementia risk. The 2022 Gloucestershire Dementia Survey found that 58% of respondents hadn’t received information on reducing their dementia risk.

It has been highlighted that it’s never too early or too late for dementia prevention. Early life risks affect cognitive reserve, while midlife and later life risks influence the development of dementia. Addressing these risks, especially in deprived communities, can provide the greatest benefits.

In Gloucestershire, 54% of adults over 65 are living with mild to severe frailty, with nearly a third having at least one emergency admission in the past year. Frailty increases with age and is more common in deprived areas. High emergency admissions among frail older adults highlight the need for better more integrated Adult Social Care support and preventative strategies to manage frailty and reduce Emergency Department visits.

Falls and fall-related injuries are a significant concern for older adults, as they can lead to physical injuries and serious psychological and social consequences, such as loss of mobility, isolation, and dependency. In Gloucestershire, older adults (particularly those over 80) are at high risk. While Gloucestershire’s falls rate is lower than the national average and has been declining over time, the county’s ageing population necessitates a proactive,

preventative approach to reduce falls. Females have higher rates of falls across all age categories, making them an important target group for intervention. Hip fractures are a critical health issue for older adults in Gloucestershire, especially those over 80, with significant impacts on independence, mortality, and long-term care needs. Approximately one-third of individuals with a hip fracture will move to long-term care, and only one in three will regain their prior level of independence. The average age of individuals suffering hip fractures is around 83, with women being disproportionately affected. Despite fluctuations in rates over time, Gloucestershire's rates are consistent with national averages, and the data show no significant long-term improvement.

The 2021 Census shows that 8.9% of Gloucestershire's population are unpaid carers, who support people with care and support needs. Carers face challenges balancing their responsibilities, which can impact their health and finances. Carers range from young people to the elderly, many with their own health needs. The 2021/22 Carers Survey indicates declining satisfaction with services since the 2018/19 survey, less involvement in decision-making, and poor information access. Many carers were not utilising available services, and non-disclosure of care requirements and health conditions raises concerns about unmet needs.

Eye health is vital for overall well-being, especially for older adults. Age-related macular degeneration (AMD) is the leading cause of sight loss in this group. In Gloucestershire, the AMD rate in 2022/23 was 65.7 per 100,000, slightly above some neighbouring regions. The county's sight loss prevalence is 3.8%, higher than the national average. With an ageing population, sight loss is projected to increase by 26% by 2032, emphasizing the need for preventive strategies.

Hearing impairment is a major concern for older adults in Gloucestershire. About 80,000 people have moderate to severe hearing loss, and around 1,760 have profound impairment. It is also a well-recognised risk factor for the development of dementia. Hearing loss increases significantly with age, especially from 75 onwards. Stroud has the highest prevalence, while the Forest of Dean has the lowest.

In 2022/23, 84.8% of Gloucestershire residents aged 65+ received the flu vaccine, making it the third highest among its peers. Shingles vaccination rates have also been strong, with 52.6% of 71-year-olds vaccinated. Disparities exist among minoritised groups and deprived areas, indicating a need for targeted efforts to improve access and awareness. Despite the commendable coverage rates, it is crucial to continue monitoring flu vaccination uptake among older adults in Gloucestershire, particularly since historical data indicates fluctuations that have previously fallen below the 75% target.

Population screening is crucial for early disease detection, especially among older adults. In Gloucestershire, NHS screening programmes show mixed results. Breast and cervical cancer screenings are high, with rates of 71.9% and 77.7% respectively, leading the South West. Bowel cancer screening is also above the national average at 76.3%. However, the Abdominal Aortic Aneurysm (AAA) screening rate is low at 61.6%, below the regional average. This highlights a need for improvement, particularly given the impact of the COVID-19 pandemic on screening services. Although not a screening programme, the NHS Health Check programme is designed to identify individuals aged 40 to 74 who may be at risk of developing serious health conditions, enabling early intervention and management.

Barriers to accessing the NHS Health Check are likely to be particularly high amongst deprived groups could include lack of awareness, logistical challenges in booking appointments, or systemic issues in healthcare provision. Efforts to target outreach and education are essential to improve engagement with this service.

Loneliness and social isolation significantly impact the health and well-being of older adults in Gloucestershire. Around 6,000 older adults report feeling lonely “always” or “often,” with higher rates among those with long-term illnesses or disabilities. Loneliness can harm physical and mental health and in turn increase the risk of chronic illnesses. This can lead to higher use of healthcare services and added pressure to the healthcare system. Major risk factors include poor health, living alone, and socioeconomic status. Addressing these issues is crucial to improving the quality of life for older adults.

Long-term health conditions like diabetes and rheumatoid arthritis are usually diagnosed in people’s late 50s or 60s, while dementia is diagnosed later. In Gloucestershire, about 129,188 people, especially those aged 85 and older, experience multiple long-term conditions (multimorbidity) such as diabetes and heart disease together. These individuals will often face daily living challenges like reduced mobility and mental well-being. Many of these individuals use multiple medications (polypharmacy), which can lead to negative health outcomes. Socioeconomic factors also play a role, with disadvantaged communities developing multiple health conditions earlier. Men in Gloucestershire can expect to live nearly 25 years and women about 31 years with significant health conditions. From a public health perspective, we need to see more work to prevent and delay those conditions arising in the first place, however for Adult Social Care, this highlights need for effective secondary prevention (to delay further decline).

In Gloucestershire, the majority of people in receipt of Adult Social Care are older adults, especially those over 80 needing physical assistance. Learning disabilities and physical support for younger adults are also significant areas of focus for the service.

Most people in receipt of care and support from Adult Social Care are female, white British, single, divorced or widowed; to reside in areas of high multiple deprivation and are more likely than the general population to experience mental health needs.

Many people who have a need for adult social care information contact the front desk of the service every year. As per the Care Act 2014, many of these people are directed to other services or requiring no further action from Adult Social Care. A significant portion of these contacts are from previous or repeat people. Additionally, the 2024 CQC self-assessment completed has identified waiting times for assessments as an area needing sustained improvement.

Fewer people in Gloucestershire need to return to hospital or require ongoing services after reablement support, and fewer are admitted to long-term care compared to other counties. However, Gloucestershire has fewer individuals managing their own support or receiving direct payments for services, placing it in the bottom quartile among peers.

Most people prefer living in their own homes, and GCC supports this through various options, including reablement. Reablement offers up to six weeks of short-term support to help individuals regain independence after illness, hospital stays, residential care, or accidents.

Recommendations

Based on the data outlined in the needs assessment below and considering the aim and objectives of the needs assessment, the following recommendations have been made. These have been grouped as:

- Adult Social Care as a service
- Adult Social Care as a strategic partner to the One Gloucestershire Integrated Care System

Adult Social Care as a service

A culture of prevention

Three strategic recommendations for ASC are derived from the Care Act, SCIE Prevention guidance and the Chief Medical Officer (CMO) 2023 report:

1. Prevention - Develop Ageing-Well and Preventative Care Strategies: ASC should consider ways to continue to build its strengths-based approaches for all residents, encompassing a range of services, facilities and resources that will help avoid the need for care and support developing. As a service, it should consider agreeing a strength-based working definition and language around prevention for its service delivery and strategies

2. Reduce - Targeted Support for the 75-84 Age Group: ASC should target support at individuals at risk of developing needs where support may slow this process or prevent other needs from developing – broadly speaking it is recommended that ASC focus this support on the 75-84 year old age group, recognising that some may reach these thresholds at a younger age than this, particularly in vulnerable groups

3. Delay – Tertiary Prevention for the over 85s: ASC should support people with established complex health conditions to minimise the effects, supporting them to regain skills and to reduce their needs wherever possible. It is recommended that ASC focus this support on those aged over 85, again recognising that some may reach this threshold at younger age, particularly in vulnerable groups

Training and workforce

4. Address Workforce Challenges: ASC has identified its workforce challenges in its Market Position Statement (2024)[1] and should continue to respond to these to support a robust preventative approach.

5. Enhance Support and Accessibility for Diverse Older Adults: To ensure comprehensive and personalised care for older adults in Gloucestershire, ASC should continue existing workstreams to improve the monitoring of older people's characteristics and respond with inclusive practices such as cultural competence for

[1] GCC (2024) Market Position Statement (MPS) for Adult Social Care Services 2024

diverse older adults including those who are disabled, LGBTQ+ individuals, and non-English speakers.

6. Address Unpaid Carers' Needs: The service should ensure that ASC staff are trained and confident to work with unpaid carers to address any barriers to disclosure about their own health to allow for more accurate assessments of carers' needs and to identify tailored support options.

7. Identify loneliness and social isolation: Equip social care staff with the skills to identify key social factors such as signs of loneliness and social isolation during routine assessments. Link those people to sources of support in the community such as community connectors.

Population Health Management and data gaps

8. Review ASC data: Adult Social Care (ASC) should keep checking how it and its partner organisations collect data, so they can fix any problems or missing information. This includes making sure they collect data about important modifiable drivers of need like social isolation, and about people's backgrounds, such as ethnicity, which are often missing from health and care records.

9. Data Tracking and Continuous Improvement: Adult Social Care should ensure it continuously improves how it uses the data that is available to better understand people's journeys through the health and social care system and spot where services are missing or need to be improved – an approach which is often discussed as Population Health Management (or PHM)[2]. This will help make sure resources are used wisely and services work as well as possible to support people in a timelier way.

Improving the service offer and addressing service gaps

10. Earlier intervention at the 'Front Door': Adult Social Care should look at how the first point of contact—like the help desk—can help prevent problems before they get worse. At every step, staff should check for chances to offer early support and put prevention into action. It's important to spot key moments when someone might need help early on, and make sure they get support quickly, so their needs don't become bigger issues later.

11. Co-production of Services and Interventions with Stakeholders: Engage with people with care and support needs, unpaid carers, and local voluntary and charity organisations in co-designing ASC preventative services and interventions, ensuring solutions are responsive to the diverse needs of older adults. Facilitate regular feedback sessions to refine and adapt services over time.

[2] Population Health Management (PHM) explainer by NHS England - NHS England » Population Health Management

12. Promote Self-directed support: Increase awareness and uptake of direct payments by providing targeted advice and simplified processes to empower individuals to manage their own care.

13. Expand step up intermediate intervention services: Consider scaling up ‘step up’ intermediate intervention to prevent admission to hospital or long-term care.

14. Enhance home-care options: Continue to develop home-based support programmes to cater to individual needs, enabling more people to remain in their own homes.

15. Preventative Health and Wellness Programmes: Ensure tailored wellness initiatives for older adults with disabilities, including those with learning disabilities are available. These programmes should encourage physical activity, social engagement, and cognitive engagement, focusing on both physical and mental health maintenance. By doing so, they can reduce the progression of impairments and improve overall well-being.

16. Improve Access to Transportation: ASC to consider how to address barriers to mobility by enhancing transportation options for older adults who are likely to use social care, making it easier for them to attend social events, healthcare appointments, and community activities.

Adult Social Care as a strategic partner to the One Gloucestershire Integrated Care System

Healthy Ageing

17. Community-based health initiatives: ASC should continue to work in partnership with public health and wider healthcare services to support preventative health screening, vaccination, NHS health checks, and healthy lifestyle interventions.

18. ASC as part of holistic neighbourhood-level service: ASC should continue to be actively involved in co-developing multi-disciplinary preventative neighbourhood approach to health and care with wider ICS partners including the NHS and VCSE to support individuals to manage their needs as independently, and as close to home, as possible.

19. Wider determinants of health interventions: ASC should continue to keep its provisions related to social determinants (such as financial hardship, housing quality, and social isolation). While these are not a direct responsibility of ASC, the service should continue to work closely with Districts/Borough Councils and the VCSE to signpost those contacting the service with social needs who may benefit from those partner organisations

Working in strategic partnership

20. Support wider strategic work: ASC should continue to support the wider system in the delivery of system strategies predominantly aimed at older population such as Gloucestershire's Dementia and Frailty Strategies and work around Falls prevention.

21. Needs assessment: ASC should continue to work with public health, to assess need and assess evidence for what works.

Health Needs

22. Oral Health Training in Care Homes: Adult Social Care (ASC) should help care homes make sure residents brush their teeth and look after their mouths every day, and notice when someone might need to see a dentist. ASC should also work with dental professionals so that regular dental check-ups and preventive care happen in the care home. Oral health should be included in care home and community-based contract requirements and checked as part of quality assurance.

23. Integrated hearing health promotion: Consider how to raise awareness of hearing health among social care staff to mitigate the social, physical, cognitive and psychological impacts of hearing loss. ASC should work with Audiology and sensory loss professionals so that regular check-ups and preventative care happen in the care home. This should be included in care home and community-based contracts and checked as part of quality assurance.

24. Post-fracture rehabilitation: ASC should, where possible, support the NHS to strengthen post-fracture rehabilitation and prevention to help older adults maintain independence and reduce long-term care admissions.

Chapter 1: Purpose and methodology

Scope of this needs assessment

A needs assessment is a way of gathering and looking at different types of information to get a clear picture of what people in a community need at a certain time. The results help make suggestions for improving services, planning for the future, solving problems, or seeing how things change over time.

This assessment looks at what older people in Gloucestershire need from social care. It covers things that affect their quality of life, health, and wellbeing. In this report, "older people" usually means anyone aged 65 or over. However, it's important to remember that people age differently—someone's health and abilities might not match their actual age.

Gloucestershire County Council has to create a Market Position Statement (MPS)[3], which is a plan for making sure there are enough care and support services now and in the future. The MPS explains the current challenges, what support will be needed, and how the council plans to meet those needs. It says that prevention is important for older people who might lose independence or struggle because of illness, disability, or other disadvantages.

Taking steps to prevent problems before they happen is a key part of this plan, especially over the next five to ten years. This means focusing on helping people who already have some needs (secondary and tertiary prevention), while also encouraging healthy habits and improving things like housing and income (primary prevention). Adult Social Care works with other organisations on these broader issues, but often only gets involved when older people or their families can't manage on their own anymore. That's why prevention and early support are so important in Adult Social Care's role.

Aims and objectives

The aim of this needs assessment is to collate the available data to inform the development of an ASC Older People's Prevention Strategy. The objectives of the needs assessment are:

- To determine what is known locally about the social care and health needs of Gloucestershire's population aged 65 and over
- To make recommendations to inform the development of a prevention strategy for older people in social care
- To understand gaps in available needs data, and make recommendations to the system to address those gaps

This needs assessment aims to gather comprehensive information, data, and insights about the health, care, and other needs (e.g., financial, social needs) of those aged over 65 in Gloucestershire. Given the large size of this population, a wide range of data has been included. However, the needs assessment will not have captured everything but will provide a foundation for the work it is intended to inform.

[3] GCC (2024) Market Position Statement (MPS) for Adult Social Care Services 2024

Please note, in some cases, more specific needs assessments already exist. Instead of reiterating their specific findings, these reports have been reviewed as part of this work, salient findings drawn into the text, and the source reports with fuller detail included in the references.

Ageing well

As people biologically age at different rates, it is challenging to define a person or group as ‘older’. people biologically age at different rates. However, people aged 65 and over will be defined as ‘older’. for the purpose of this needs assessment which uses statistics to broadly summarise key demographic, care and health need trends.

Chapter 2: The prevention agenda

Prevention Explained

In 2023, the Chief Medical Officer (CMO) for England chose to focus on Healthy Ageing in his statutory annual report[4]. Key among his observations was the importance of prevention when supporting older people as well as the forthcoming challenge from ageing for the country, but particular for rural counties such as Gloucestershire where population ageing is far more rapid.

The CMO report recognises that older people can benefit in the short term as individuals from primary prevention and he notes that that these should be promoted by health and care and other professionals throughout the system. For primary prevention, the report highlights that older people need support in:

- Exercise – strong evidence that being physically active is good for health throughout our lives, with distinct benefits for entering older age in good health and subsequently maintaining good health as long as possible. From a secondary prevention perspective, maintaining exercise can retain mobility and functional independence in older age for those with health and daily living needs.
- Smoking cessation – as early as possible in life but noting that cessation in older age still leads to significant benefits limiting further illness and disability.
- Overweight and obesity – living with overweight or obesity accelerates multiple conditions which reduce independence in older age. These include mechanical problems such as knee arthritis, balance, diabetes, heart failure and stroke as well as several cancers. Weight management services should be available, accessible, and tailored to older adults who require them.
- Limiting alcohol use – the recent Director of Public Health Annual Report (2023)[5] for Gloucestershire, older people are highlighted as a group more likely to drink regularly. Limiting excess alcohol use throughout life is important, but in older age heavier alcohol use is often triggered by common older age life events (e.g. spouse bereavement), is exacerbated by lower tolerance to alcohol and having a role in key health events such as falls and frailty. Alcohol issues in older people can also be under-recognised by professionals as they can be masked by frailty. Alcohol services need to be accessible for older people.
- Community engagement - social isolation and loneliness can exacerbate issues with health and daily living, reducing resilience and independence. Promoting community engagement can mitigate these impacts.
- Screening programmes and vaccination – strong evidence for effectiveness to prevent onset of disease, for example the role of seasonal vaccination programmes such as flu and Covid.

[4] Chief Medical Officer's Annual Report 2023 – Health in an Ageing Society (publishing.service.gov.uk)
[5] Gloucestershire County Council (2023), Director of Public Health Report: Just another drop? The ripple effect of alcohol gcc-dph-annual-report.pdf (gloucestershire.gov.uk)

Secondary and Tertiary Prevention can focus on the following:

- Falls prevention – strong evidence for multifactorial intervention as primary prevention (before a fall) and secondary prevention (following a fall or falls)
- Frailty identification - Smoking cessation in older age has rapidly realised impacts on limiting further disability.
- Mental health – depression and anxiety – strong evidence for preventative role of exercise, and some evidence for interventions promoting social interaction.
- Infection management – robust infection, prevention and control in care homes.

Prevention in ASC

Prevention in the social care context, as defined in the Care Act Statutory Guidance (2016)[6], is about the care and support system actively promoting independence and wellbeing. This means intervening early to support individuals, helping people retain their skills and confidence, and preventing need or delaying deterioration wherever possible.

The Social Care Institute for Excellence (SCIE)[7] in the 'Prevention in Social Care' guidance outlines three approaches to prevention:

Prevent – primary prevention/promoting wellbeing
This approach should be applied to everyone – including those who fund their own care. It will encompass a range of services, facilities and resources that will help avoid the need for care and support developing. It could include information and advice promoting healthy and active lifestyles, and reducing loneliness and isolation.

Reduce – secondary prevention/early intervention
This approach is targeted at individuals at risk of developing needs where support may slow this process or prevent other needs from developing. It could include carer support, falls prevention, housing adaptations or support to manage money.

Delay – tertiary prevention/formal intervention
The third approach is aimed at people with established complex health conditions, to minimise the effects, support them to regain skills and to reduce their needs wherever possible. This could include rehabilitation/reablement services, meeting a person's needs at home, and providing respite care, peer support, emotional support and stress management for carers.

Therefore, prevention is already intrinsic to social care. Identification of need earlier and shifting to earlier intervention will support more prevention as well as addressing existing gaps in service provision. Demand on social care provision can often mean that more cost-effective prevention work can be challenging to prioritise sufficiently.

Prevention and health inequalities

Health inequalities are differences between individuals and across populations that are systematic, avoidable, predictable, and unjust. Health equity is realised when every individual has a fair opportunity to achieve their full health potential.

[6] Department of Health and Social Care (2016) Care and support statutory guidance
[7] Social Care Institute for Excellence (2021) Prevention in social care - SCIE

Work on prevention and health inequalities go hand in hand – if there's inequality there is an opportunity for prevention; if you target one you will impact the other. Therefore, the impact of health inequalities contributes to the need for ASC.

In terms of prevention in social care, inequalities can lead to late and differential access to care through variation in cultural competence, high distances to travel for rural communities, differential quality of care amongst other drivers which can lead to avoidable and unjust early loss of independence, reduced quality of life, and avoidable experience of crisis. These differences result in people who are worst off missing out on life chances, experiencing poorer health and having shorter lives.

Inequalities in what?

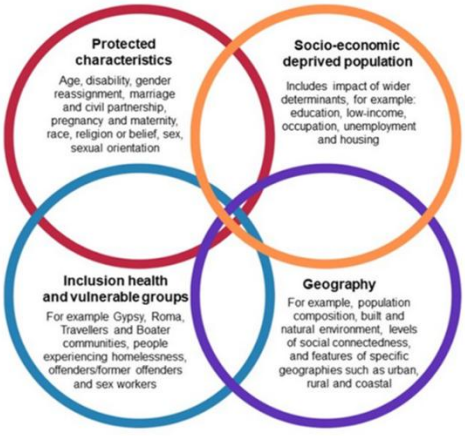
Health inequalities can relate to:

- Health status e.g. healthy life expectancy
- Access to high quality care e.g. access to clinical appointments
- Quality and experience of care e.g. patient satisfaction
- Health and care outcomes e.g. long-term condition management
- Behavioural risks to health e.g. alcohol consumption
- 'Wider (or core) determinants of health' e.g. quality of housing, employment, income, community connectedness and the environment.

Inequalities among whom?

Health inequalities occur between people or groups based on social, geographical, biological, or other factors.

Figure 1: Inequalities between whom? [8]



There is a well-documented tendency for those who most need a service or intervention to be least likely to receive it, thereby widening health inequalities – this phenomenon is known as the 'inverse care law'.

[8] Prevention definitions, produced by the GCC Public Health and Communities team in partnership with ICS colleagues

Chapter 3: The Policy Context

There are many national and local policies, strategies and guidance relevant to this needs assessment and the development of any relevant local strategies.

Some key legislation and policies at the national and local level are listed below but it is acknowledged that this is not exhaustive.

National

- The Care Act (2014)
- Prevention in Social Care (Social Care Institute for Excellence, 2021)
- Chief Medical Officer (2023) Annual Report 2023: Health in an Ageing Society
- NHS Long Term Plan (2019)
- Healthy ageing: consensus statement (2019)
- Framework for Enhanced Health in Care Homes (2020)
- People at the Heart of Care White Paper (2021)
- Health and social care integration: joining up care for people, places and populations (2022)
- The Health and Care Act (2022)
- Next steps to put People at the Heart of Care (2023)
- NHSE Proactive Care Framework (2023)

Local

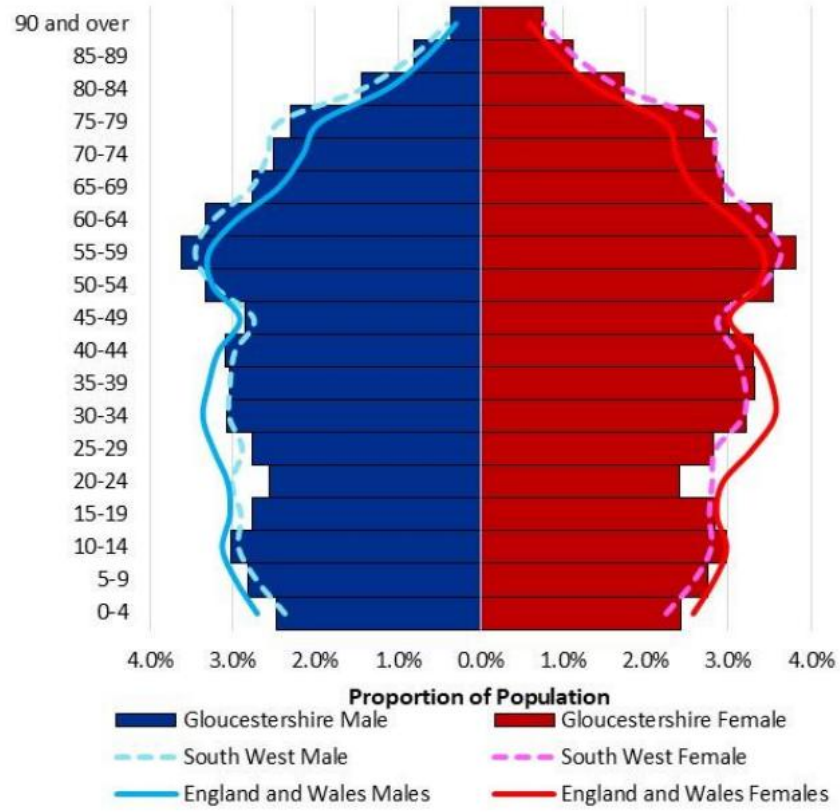
- One Gloucestershire Interim Integrated Care Strategy (2022)/ Integrated Care Strategy
- Market Position Statement (MPS) for ASC Services 2024
- Gloucestershire Health & Wellbeing Strategy 2019-2030
- One Gloucestershire Housing with Care Strategy 2020
- Frailty Strategy for Gloucestershire 2022-2027
- One Gloucestershire Primary Care Strategy 2019-2024
- One Gloucestershire Dementia Strategy 2024-2027
- One Gloucestershire Proactive Care Strategic Plan 2024-2027 (due to be published 2024)
- One Gloucestershire 5 Year Strategy/Forward Plan
- One Gloucestershire End of Life Strategy 2021-2025

Chapter 4: Background to Gloucestershire's population

Gloucestershire is a county in the Southwest region of England. In mid-2023, people aged 16-64 made up the majority (60.42%) of the population, which aligned with the South West region but was slightly less than England at 62.85%. People aged 65 plus accounted for 22% of Gloucestershire's population[9]; this cohort is discussed in more detail below.

Population pyramids (see figure two below) illustrate the age structure of a population as well as the gender balance. In 2023, the overall gender distribution for Gloucestershire was 52.10% female, which is roughly similar to both the South West region and England and Wales. Gloucestershire's population pyramid (figure 2) indicates a slightly higher proportion of males between ages 0-24, which is reversed for ages 25 plus. Gloucestershire and the South West have higher proportions of people aged 55 plus, which indicates a more rapidly ageing population than in England and Wales.

Figure 2: Population by age band and sex, Gloucestershire compared with South West region, and England and Wales, 2023[10]

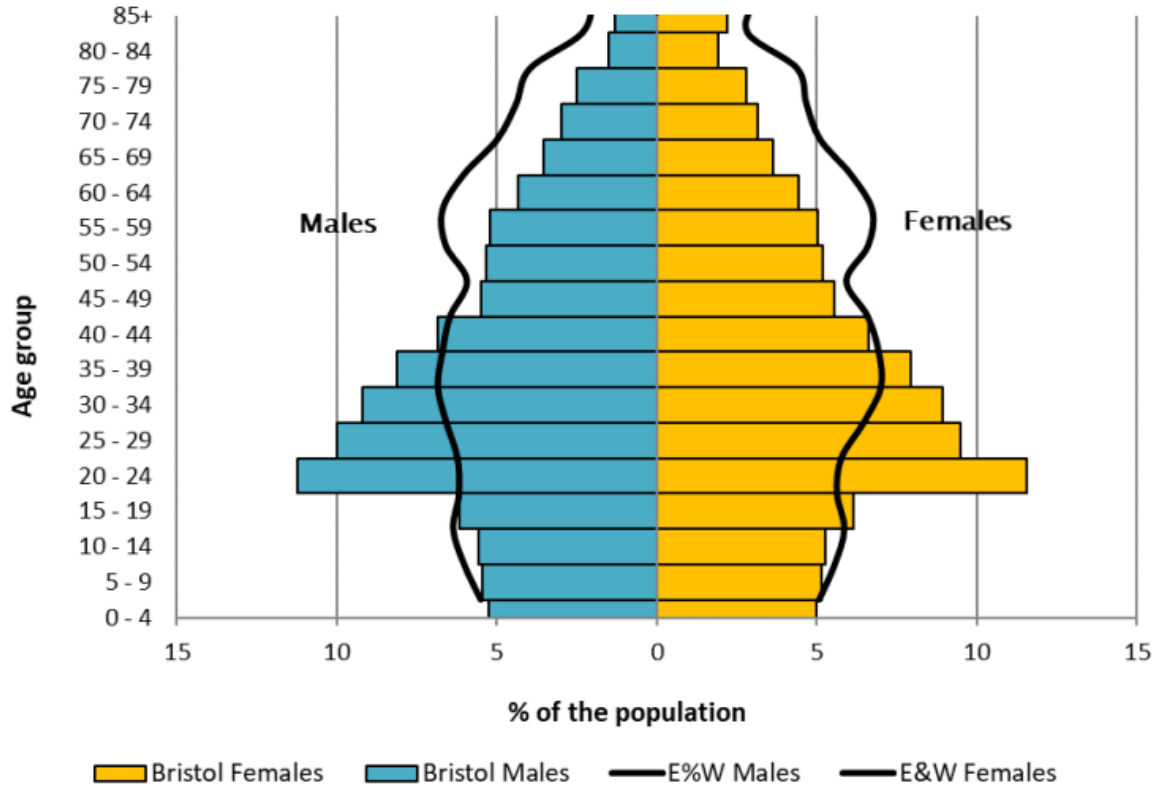


[9] Inform Gloucestershire, Gloucestershire County Council (2023) Current Population of Gloucestershire (Mid-2023 population estimates): An overview mid-2023-report.pdf (gloucestershire.gov.uk) - All data in this report is sourced from the Office for National Statistics Population Estimates, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

[10] Inform Gloucestershire, Gloucestershire County Council (2023) Current Population of Gloucestershire (Mid-2023 population estimates): An overview mid-2023-report.pdf (gloucestershire.gov.uk) - All data in this report is sourced from the Office for National Statistics Population Estimates, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

As a comparison, Bristol's population pyramid (figure 3 below) reflects a younger overall population; the largest age band being 20-24, followed by a steady decrease each band to age 85 plus when there is a slight increase for females.

Figure 3: Population by age band and sex, Bristol, mid-2023[11]



Diverse Ethnic Communities (DEC)

The 2021 Census[12] found that overall, 6.9% of the population in Gloucestershire were from a diverse ethnic community background (excluding white minorities), an increase from the previous Census which detailed 4.6%. This was considerably lower than the national figure of 19.0% of the population that were from a diverse ethnic community background. When including white minorities, the proportion of people in Gloucestershire from a diverse ethnic community rose to 12.3%, less than half of the national average of 26.5%, even though people from white minority backgrounds in Gloucestershire also rose from 3.1% in 2011 to 4.5% in 2021.

The following table (Table 1) shows the breakdown for ethnicity for people aged 65 and over. Although the majority of older people in Gloucestershire identify as 'White: English, Welsh, Scottish, Northern Irish, or British,' it is important to acknowledge that diverse ethnic communities, though smaller in number, have distinct experiences and needs that must be considered when providing services. Despite their smaller representation, older individuals from Black and Minority Ethnic groups require tailored approaches to ensure equitable and effective service delivery.

[11] Bristol City Council (2023) Mid-2023 Population Estimates for Bristol Mid-2023 Population Estimates Note (bristol.gov.uk)
[12] 2021 ONS Census Data cited in equality-profile-2024-refresh.pdf (gloucestershire.gov.uk)

Table 1: Percentage population breakdown by ethnicity aged 65 plus, and percentage of total population, Gloucestershire[13]

	Aged 65 years and over	Total Population
Asian, Asian British or Asian Welsh: Bangladeshi	0.03%	0.24%
Asian, Asian British or Asian Welsh: Chinese	0.14%	0.34%
Asian, Asian British or Asian Welsh: Indian	0.53%	1.28%
Asian, Asian British or Asian Welsh: Other Asian	0.18%	0.73%
Asian, Asian British or Asian Welsh: Pakistani	0.06%	0.27%
Black, Black British, Black Welsh, Caribbean or African: African	0.06%	0.61%
Black, Black British, Black Welsh, Caribbean or African: Caribbean	0.33%	0.41%
Black, Black British, Black Welsh, Caribbean or African: Other Black	0.04%	0.19%
Mixed or Multiple ethnic groups: Other Mixed or Multiple ethnic groups	0.10%	0.51%
Mixed or Multiple ethnic groups: White and Asian	0.09%	0.64%
Mixed or Multiple ethnic groups: White and Black African	0.02%	0.27%
Mixed or Multiple ethnic groups: White and Black Caribbean	0.08%	0.78%
Other ethnic group: Any other ethnic group	0.17%	0.54%
Other ethnic group: Arab	0.02%	0.13%
White: English, Welsh, Scottish, Northern Irish or British	95.55%	87.71%
White: Gypsy or Irish Traveller	0.05%	0.15%
White: Irish	0.99%	0.62%
White: Other White	1.54%	4.46%
White: Roma	0.02%	0.11%
Grand Total	100.00%	100.00%

The Centre for Ageing Better[14] [15]highlights that the diversity of the older population is increasing as people live longer. This growing diversity has the potential to enrich communities and workplaces, but it also brings challenges, such as increased inequality. Discrimination and structural inequality accumulate over a lifetime, leading to significant gaps in wealth and health in later life. As the older population becomes more diverse, it's crucial to address these inequalities to ensure everyone can age well. This includes considering the specific needs of different ethnic groups, those living alone, and

[13] ONS (2021) Office for National Statistics cited in '*Gloucestershire County Council Population Profile 2024: An overview of the population of Gloucestershire by the nine protected characteristics set out in the Equality Act 2010*' (2024) equality-profile-2024-refresh.pdf (gloucestershire.gov.uk)

[14] Centre for Ageing Better (2024) Ageing population | Centre for Ageing Better

[15] Centre for Ageing Better (2023) Our Ageing Population | The State of Ageing 2023-24 | Centre for Ageing Better

older adults without children, who may have less access to informal care and social networks.

Languages spoken in Gloucestershire

According to the 2021 Census, 27,000 people in Gloucestershire (4.3% of the population) did not speak English as their main language. Amongst this group, Polish was the most common language (6,703 people), followed by Romanian (2,796 people) and then Portuguese (1,144 people). An EU language other than Polish was the main language of 10,683 people.

At district level, Gloucester had the highest proportion (8%) of people who did not speak English as their main language, followed by Cheltenham (6.9%). Some 84% of people whose main language was not English could speak English well or very well.

Older people were less likely than younger people to be proficient in English; 32.3% of people aged 50 and over who did not speak English as a main language were not proficient in English, compared with 12.0% of people aged under 50 who did not speak English as a main language.

Based on census data and local reports, it's estimated that over 100 distinct languages are spoken in the county.

Gender identity

Out of the individuals who answered this question in the 2021 Census, 0.2% (244 people) of adults aged 65 and over reported having a different gender identity to the one they were registered with at birth, and 6.4% (8,907 people) did not give an answer. Table two below shows a noticeable trend where younger individuals aged 16-24 are more likely (at 1.1.%) to report a gender identity as being different from the one assigned at birth, although this age range has a higher proportion (6%) of individuals who did not answer this question. A higher percentage in the younger cohort reporting changes in gender identity could be partly due to increased awareness and acceptance in younger generations, as well as access to information and support in this area. Changing social norms over generations may also contribute; older people may not disclose gender identity due to fear of discrimination. As transgender individuals age, they might face challenges in obtaining the medication necessary for their transition[16]. Additionally, transgender individuals may encounter difficulties in accessing medical screenings or care pertinent to their sex assigned at birth[17].

[16] Wright, T., Nicholls, E.J., Rodger, A.J. *et al.* Accessing and utilising gender-affirming healthcare in England and Wales: trans and non-binary people's accounts of navigating gender identity clinics. *BMC Health Serv Res* **21**, 609 (2021). https://doi.org/10.1186/s12913-021-06661-4

[17] Mikulak, M., Ryan, S., Ma, R., Martin, S., Stewart, J., Davidson, S. and Stepney, M., 2021. Health professionals' identified barriers to trans health care: a qualitative interview study. *British Journal of General Practice*, 71(713), pp.e941-e947. DOI: https://doi.org/10.3399/BJGP.2021.0179.

Table 2: Estimated gender identity population breakdown by age bands, and percentage of total population, Gloucestershire[18] [19]

Gender Identity	Aged 16-24 years	Aged 25-34 years	Aged 35-49 years	Aged 50-64 years	Aged 65 years and over	Total Population
Gender identity the same as sex registered at birth	92.9%	94.7%	95.2%	95.2%	93.5%	94.4%
Gender identity not the same as sex registered at birth	1.1%	0.6%	0.4%	0.3%	0.2%	0.4%
Not answered	6.0%	4.7%	4.5%	4.5%	6.4%	5.2%

Sexual orientation

Out of the individuals who answered this question in the 2021 Census, 0.6% (2,997 people) for age 65 and over answered 'other, bisexual, gay or lesbian'; 8.1% did not answer and 91.3% responded they were straight or heterosexual. Further breakdown by age band is displayed in Table 3. Similarly to gender identity, there is a trend where younger individuals are more likely to report a different sexual orientation to being straight or heterosexual. Similar factors outlined for changes in gender identity are relevant here too such as increased social acceptance, greater awareness and education and more supportive communities. But there are some bigger social and legislative changes that may have an impact.

Table 3: Estimated sexual Orientation population breakdown by age bands, and percentage of total population, Gloucestershire[20]

Sexual Orientation	Aged 16-24 years	Aged 25-34 years	Aged 35-44 years	Aged 45-54 years	Aged 55-64 years	Aged 65-74 years	Aged 75 and over	Total Population
All other sexual orientations	0.98%	0.63%	0.31 %	0.19 %	0.12 %	0.06 %	0.03%	0.31%
Bisexual	4.26%	2.48%	1.17 %	0.59 %	0.33 %	0.19 %	0.08%	1.21%
Gay or Lesbian	2.02%	2.33%	1.67 %	1.31 %	0.92 %	0.51 %	0.20%	1.28%

[18] ONS 2021: Sexual orientation and gender identity data combining multiple variables, England and Wales: Census 2021 - Office for National Statistics (ons.gov.uk) data set adjusted for Gloucestershire - Source: Gender identity by age - Office for National Statistics (ons.gov.uk) Note info on quality released by ONS Quality of Census 2021 gender identity data - Office for National Statistics (ons.gov.uk)

[19] Caveat: Please note that the numbers provided are not exact, as the Office for National Statistics (ONS) applies suppressions, and each data download may yield slightly different figures. These variations occur due to the way data is processed and presented. Additionally, it is important to highlight that these statistics are in development and are not accredited official statistics. They are estimates. For more information on the quality and caveats of the data, please refer to the ONS's quality information for Census 2021 on sexual orientation and gender identity here: . Sexual orientation and gender identity quality information for Census 2021 - Office for National Statistics (ons.gov.uk)

[20] ONS, (2021) Sexual orientation by age - Office for National Statistics (ons.gov.uk)

Not answered	9.07%	6.00%	5.51 %	5.55 %	6.20 %	6.78 %	9.60%	6.80%
Straight or Heterosexual	83.67 %	88.57 %	91.3 3%	92.36 %	92.42 %	92.46 %	90.08%	90.40%

In England and Wales, sex between men was decriminalised in 1967[21], and homosexuality was removed from the list of mental illnesses in 1992[22]. Same-sex couples were not permitted to adopt or foster children until 2002, and Section 28 of the Local Government Act 1988, which prohibited the discussion of homosexuality in schools, was only repealed in 2003.

It is important to recognise that the discrimination and criminalisation experienced by individuals now over 65 when they were younger may make them more hesitant to disclose their sexual orientation[23]. Additionally, older lesbian, gay, and bisexual adults are less likely to have children compared to their heterosexual counterparts, may be more likely to live alone, and often rely more on close friends for care and support as they age rather than relatives[24] [25].

People aged 65 plus in Gloucestershire

The largest age group within the 65 plus cohort are people aged 65-74, although this is the only age group to see a decline (albeit marginal at 0.22 percent) between 2022 and 2023, as was the case in 2021 when there was a decline of 1.40 percent. This percentage decline in the 65-74 age group coincides with the South West and England and Wales. The age group with the largest increase (4.60 percent) in Gloucestershire was 75–84-year-olds, which again corresponds with the South West and England and Wales.

For Gloucestershire districts, all districts saw an increase in people aged 75-84 between 2022 to 2023, with Cotswold seeing the highest increase at 5.65 percent. All districts apart from Gloucester and Tewkesbury saw a decrease in the population aged 65-74, and Cheltenham saw a further decrease in people aged 85 plus. Stroud, however, continues to have the largest population of people aged 65 plus, although population numbers roughly balance out across all districts at aged 85 plus (Table 4).

[21] Hubbard, K. A., & Griffiths, D. A. (2019). Sexual offence, diagnosis, and activism: A British history of LGBTIQ psychology. *American Psychologist*, 74(8), 940–953. DOI: 10.1037/amp0000544
[22] Burton, N. (2024). When Homosexuality Stopped Being a Mental Disorder. *Psychology Today*.
[23] Jackson, S. E., Hackett, R. A., Grabovac, I., Smith, L., & Steptoe, A. (2019). Perceived discrimination, health and wellbeing among middle-aged and older lesbian, gay and bisexual people: A prospective study. *PLOS ONE*, 14(5). DOI: 10.1371/journal.pone.0216497
[24] Yang, J., Chu, Y., & Salmon, M. A. (2017). Predicting Perceived Isolation Among Midlife and Older LGBT Adults: The Role of Welcoming Aging Service Providers. *The Gerontologist*, 58(5), 904–912. DOI: 10.1093/geront/gnx092
[25] Bailey, D., Calasanti, T., Crowe, A., di Lorito, C., Hogan, P., & de Vries, B. (2022). Equal but different! Improving care for older LGBT+ adults. *Age and Ageing*, 51(6), afac142. DOI: 10.1093/ageing/afac142

Table 4: Population age breakdowns aged 65 plus, Gloucestershire and its districts, South West, and England and Wales, mid 2022-23[26]

	65-74			75-84			85+		
	2022	2023	% change	2022	2023	% change	2022	2023	% change
Gloucestershire	**72,373**	**72,211**	**-0.22%**	**50,998**	**53,345**	**4.60%**	**19,667**	**19,913**	**1.25%**
Cheltenham	11,308	11,161	-1.30%	8,309	8,734	5.11%	3,801	3,771	-0.79%
Cotswold	12,098	12,018	-0.66%	8,792	9,289	5.65%	3,342	3,364	0.66%
Forest of Dean	11,650	11,531	-1.02%	7,887	8,271	4.87%	2,715	2,767	1.92%
Gloucester	11,588	11,679	0.79%	7,912	8,201	3.65%	3,057	3,102	1.47%
Stroud	14,960	14,939	-0.14%	10,065	10,561	4.93%	3,876	3,938	1.60%
Tewkesbury	10,769	10,883	1.06%	8,033	8,289	3.19%	2,876	2,971	3.30%
South West	**653,628**	**649,424**	**-0.64%**	**465,739**	**486,269**	**4.41%**	**181,709**	**183,184**	**0.81%**
England	**5,483,487**	**5,472,865**	**-0.19%**	**3,721,420**	**3,863,610**	**3.82%**	**1,424,848**	**1,446,612**	**1.53%**
England and Wales	**5,836,722**	**5,824,078**	**-0.22%**	**3,956,751**	**4,108,576**	**3.84%**	**1,509,957**	**1,532,669**	**1.50%**

The workforce population

Whilst the population of Gloucestershire is ageing, the workforce population is reducing, increasing the dependency ratio (a measure that indicates the level of support required by working aged people to the younger and older populations, ages 0-15 and 65 plus). In Gloucestershire in 2021 for example, for every 100 working age people, there were 36 dependents aged over 65 years, higher than England and a narrowing gap to the Southwest[27].

Crucially, the slower increase in the county's healthy working age population could lead to a higher financial burden on this population. Projections suggest this situation will worsen as the population ages[28]; increasing numbers of people with disabilities and long-term conditions, coupled with the high housing costs, will have implications for the workforce. The number of jobs available is expected to exceed the number of working-age people by 2035. If nothing is done to address this issue, by 2039 there will be 79,000 more people over 65 but only 7,000 more people aged 18 to 64.

[26] Inform Gloucestershire, Gloucestershire County Council (2023) Current Population of Gloucestershire (Mid-2023 population estimates): An overview mid-2023-report.pdf (gloucestershire.gov.uk)
[27] Gloucestershire County Council (2021) Current Population of Gloucestershire, current-population-of-gloucestershire-2021.pdf
[28] Government Office for Science (2016), Future of an Aging Population

Chapter 5: ASC and health services

Introduction

This Needs Assessment was a desktop exercise undertaken to inform the development of the Older People's Prevention Strategy published in February 2024. Most data was drawn from publicly available sources.

At the time, the ASC activity data available had not been quality assured for publication of the needs assessment and as a result it was not published. As of August 2025, GCC could collate the quality assured ASC activity data presented here in chapter 5. However, there are still known gaps in the ASC data but there are significant programmes of work underway to address these so that in the future, the analysis of ASC need can be more comprehensive.

Gloucestershire's ASC is guided by a clear vision: "We make the difference that matters." Our Target Operating Model, approved by County Council Cabinet in July 2025, puts prevention, early intervention, and personalisation at the heart of everything we do. This means:

- Focusing on prevention: Helping people retain and regain skills and confidence and intervening early to prevent needs from developing or worsening.
- Personalised, strengths-based support: Working with people to build on their strengths and what matters most to them.
- Co-production: Involving people with lived experience in designing and improving services.
- Equity and health inequalities: Recognising and addressing the impact of social and economic factors on people's health and wellbeing.
- Digital and data-driven transformation: Using technology and better data to improve decision-making, target support, and deliver more responsive, efficient services.

As part of our ongoing transformation programme, Gloucestershire ASC is fundamentally redesigning its systems, processes, and use of data to deliver more effective, person-centred, and preventative support for older people. This work is driven by our commitment to continuous improvement, as reflected in our response to the Care Quality Commission (CQC) inspection findings[29] and our strategic ambition to "make the difference that matters" for Gloucestershire residents.

Our transformation and improvement plan is focused on embedding seamless, data-driven processes that enable better decision-making, more efficient use of resources, and evidencing improved outcomes for individuals. This includes strengthening our approach to prevention, early intervention, and the use of intelligence to understand and respond to changing needs across the county.

[29] GCC (2025) Adult Social Care Improvement: Adult Social Care Improvement | Gloucestershire County Council

This chapter provides an analysis of the contacts received by ASC over the past year and explores the characteristics and needs of individuals drawing on long-term services. It highlights key trends, challenges, and opportunities identified through our data and engagement with people who use services, carers, and professionals. The recommendations at the front of this needs assessment are directly informed by these insights and are designed to address the priorities set out in the Older Persons Prevention Strategy and our wider transformation and improvement plan.

While the chapter primarily focuses on recent data, it also acknowledges the ongoing impact of the COVID-19 pandemic and the evolving landscape of ASC. We recognise that there are still gaps in our data and understanding, particularly in relation to short-term services and outcomes for specific groups. Addressing these gaps is a priority for ASC, and work is underway to improve data quality, integration, and the use of client-level data to generate deeper insights and support more targeted prevention and support.

This needs assessment should be read alongside the Gloucestershire County Council's ASC Prevention Strategy for Older People 2025-2030[30], our new Target Operating Model[31] and the ASC Improvement Plan[32], which together set out our vision for a more resilient, equitable, and person-centred ASC system.

While this chapter generally excludes the period of the COVID-19 pandemic itself (2020–2022) and does not directly address its immediate impact, some analyses do cover the end of that period. Demand for services was notably suppressed during lockdowns, with services restarting at different points, and the pandemic has continued to shape the need, use, and delivery of ASC. The emotional legacy of COVID-19, as highlighted in the Gloucestershire Market Position Statement (2024)[33], includes a significant depletion of people prepared to work in the sector. Many left the profession during this time, and recruitment and retention of staff remain major concerns.

Recent data show an increase in people contacting Gloucestershire County Council about ASC services for support with their care needs, while the overall number of individuals drawing on care services has remained stable. The majority of support is provided to older adults with physical needs, particularly those aged 80 and over and females. Patterns of service use vary by age, sex, marital status, ethnicity, and deprivation, with a notable over-representation of people from more deprived areas. The experience of health inequalities, combined with the means-tested nature of most ASC services, contributes to increased use of ASC in these communities.

Looking forward, the transformation and improvement plan sets out a clear ambition to address these challenges by embedding data-driven and technology-enabled approaches at the heart of our new target operating model. This includes investing in better data quality, integration, and analytics to generate actionable insights, support more targeted prevention, and enable more responsive and equitable services. The use of digital tools and improved

[30] GCC (2025) Adult Social Care Prevention Strategy for Older People 2025-2030

[31] GCC (2025) Appendix One: Adult Social Care Target Operating Model, in Adult Social Care Operating Model and Delegated Functions

[32] GCC (2025) Adult Social Care Improvement: Adult Social Care Improvement | Gloucestershire County Council

[33] GCC (2024) Market Position Statement (MPS) for Adult Social Care Services 2024

information systems will be critical in supporting staff, improving decision-making, and delivering better outcomes for people who draw on care and support.

Overview of ASC

ASC in Gloucestershire exists to help adults e.g., people aged 18 and over live as independently, safely, and healthily as possible, for as long as possible. ASC supports people at different stages of their lives, whether their needs arise suddenly (such as after a hospital stay), develop gradually, or require lifelong support. Our approach is to work with individuals, their families, and carers to understand their unique circumstances and ensure they can access the right support, at the right time, in the right way.

ASC provides support for a diverse range of needs, including learning and physical disabilities, mental health conditions, dementia, autism, and other long-term conditions. Our services are designed to empower people to manage their own needs and achieve the lives they want to live, in line with the Care Act 2014 and national best practice.

Support can include:

- Information, advice, and guidance, including for unpaid carers
- Support to stay connected with friends, family, and community
- Equipment, technology, and home adaptations
- Personal care for daily living (washing, dressing, household tasks)
- Supported living and care homes[34]

ASC is not usually free; means-tested charges apply to almost all care and support arranged or provided by GCC. As a general guide:

- If an individual's capital assets or savings are £23,250 or less, they are likely to pay something towards the total cost of their care.
- If assets are above £23,250, they will not be eligible for financial help from the council until their assets fall below this threshold and will be required to pay for their own care.

Once someone has had an ASC assessment and is found eligible for support, a financial assessment (means test) determines how much they will pay. Most people contribute something towards their care, with the council paying the balance; some people pay the full cost.

Following an assessment of need, if an individual is eligible to receive ASC support, a financial assessment will determine whether and how much they will have to pay towards the cost of care and they will be supported to create a personalised care and support plan. A support plan outlines assessed needs and how they will be met and funded. For the purposes of this chapter, ASC data has been separated into two broad categories as follows[35]:

[34] Gloucestershire Care and Support Guide - https://www.carechoices.co.uk/publication/gloucestershire-care-services-directory/

[35] GCC (2024) Adult Social Care Update Report, Adult Social Care and Communities Scrutiny Committee

1. Short term care which focusses on: time limited care or support which maximises independence and reduces the need for ongoing support

2. Long term care: care and support services provided on an ongoing basis which can range from community support or support in the individual's own home, to accommodation-based services such as extra care, residential or nursing care.

ASC contacts

Every year, many people reach out to GCC's ASC services for information, advice, or support. In 2023, these contacts included professionals such as doctors, nurses, and hospital discharge teams, as well as individuals and families seeking help for themselves or someone they care for.

Here's what the data shows:

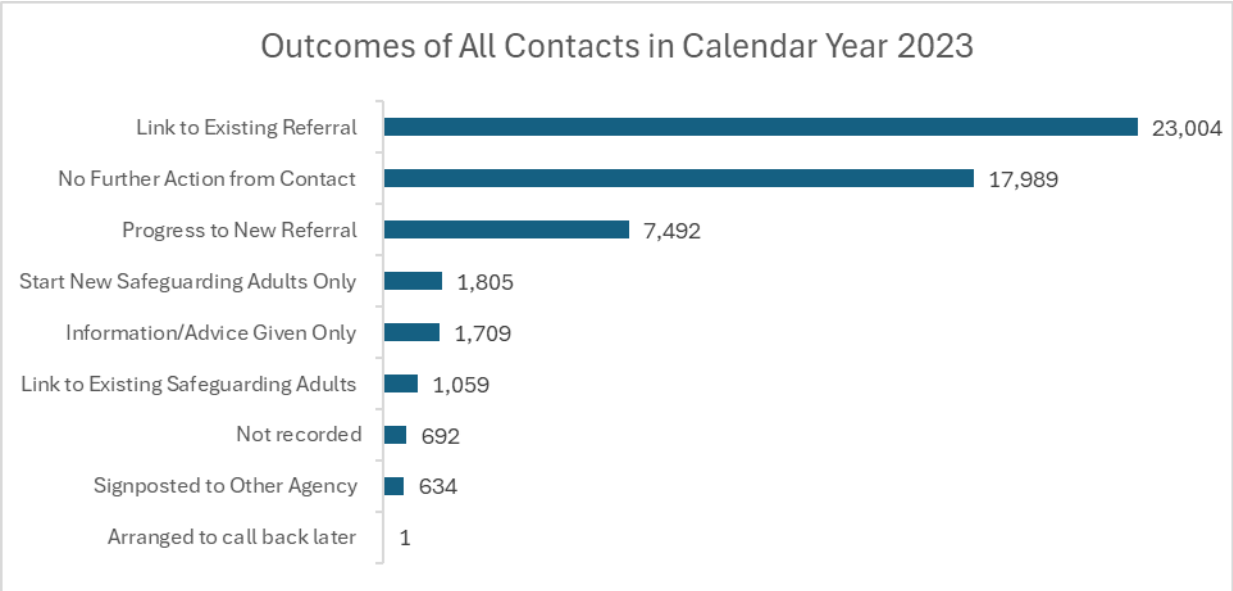
- 41% of contacts came from professionals who were new to the ASC system.
- 24% were from individuals already known to ASC (for example, people who had used services before).
- 19% were from new individuals contacting ASC for the first time.

When people get in touch, their needs and outcomes vary:

- 14% of contacts led to a new referral for support or services.
- 44% were about an existing referral—meaning people were following up on ongoing support.
- 33% of contacts did not require further help at that time and were signposted to further information and support they could source for themselves such as the Your Circle online directory.

The above information helps ASC understand who is reaching out, what kind of support is needed, and how services can be improved to better meet the needs of Gloucestershire's residents. See figure four for a breakdown of outcomes for contacts.

Figure 4: Outcomes of all GCC contacts, calendar year 2023[36]



Between April 2021 and March 2024, GCC's ASC Contact Centre received enquiries from people of all ages.

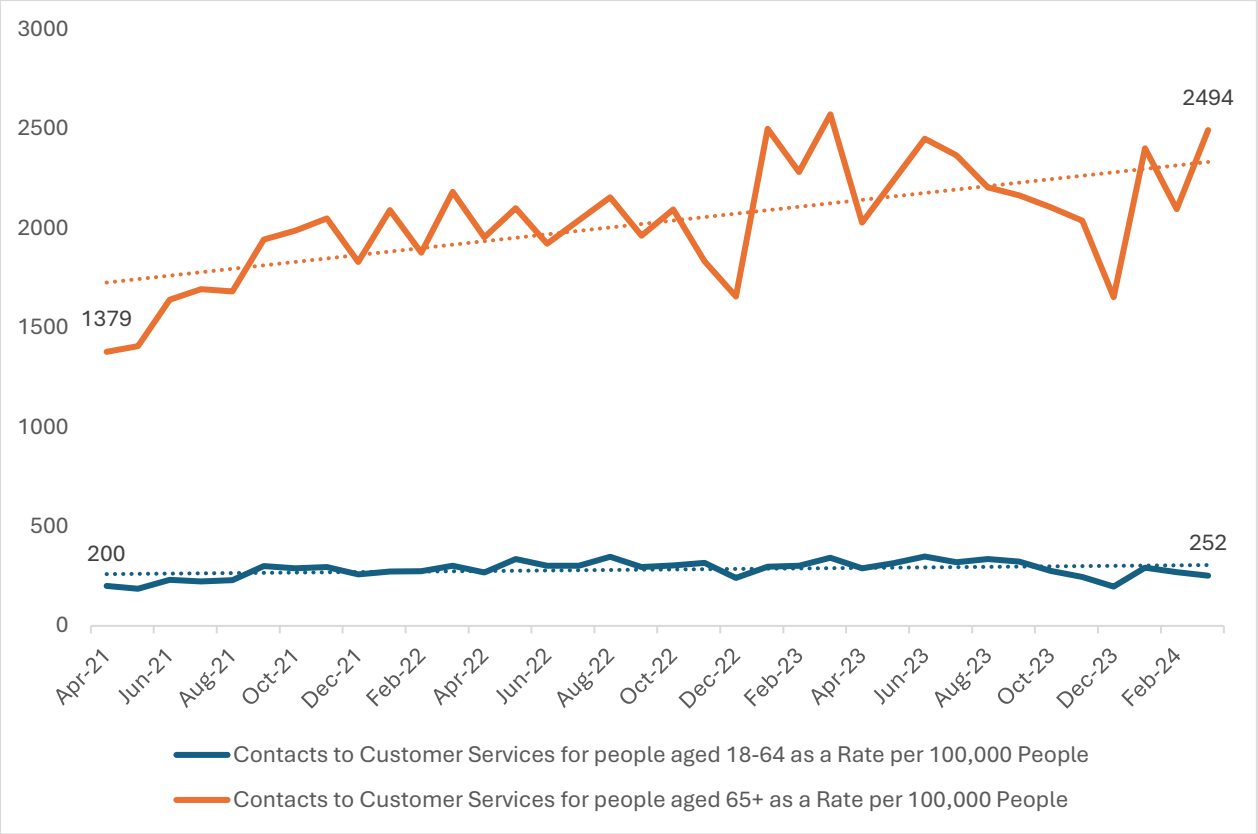
When we look at the data by broad age group in figure five below, we see that people aged 65 and over consistently made more contact than those aged 18 to 64. In fact, the number of contacts from the older age group has generally increased over time, with some noticeable ups and downs, especially from December 2022 onwards.

For adults aged 18 to 64, the number of contacts has also risen gradually, but the changes have been smaller and steadier, with slight drops during the winter months of December 2022 and 2023.These trends help us understand when and how different age groups are reaching out for support, and they highlight the ongoing demand for services among older

[36] Gloucestershire County Council internal data

people in particular. This information is important for planning and improving the way we deliver care and support across Gloucestershire.

Figure 5: Total contacts received by GCC Customer Services Team, 2021 to 2024, as a rate per 100,000 people[37]



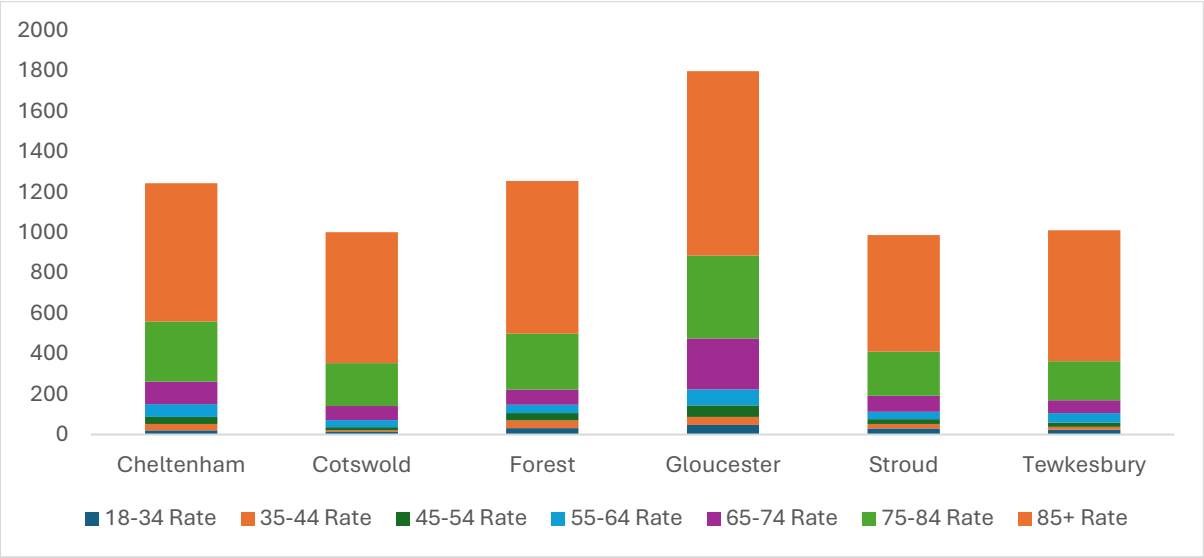
During the pandemic, demand for services was suppressed due to lockdowns and restrictions, but as services reopened and communities adapted, we saw a steady increase in older adults reaching out for support (see figure five). This suggests that many older people are now seeking help that may have been delayed or disrupted during the pandemic period.

Importantly, data shows that the number of contacts rises with age and increases sharply for those aged 85 and over (see figure six below). This highlights the particular needs of those older people in our community who are the most likely to require support as they age. However, it's not just age that shapes demand. Health inequalities such as differences in income, living conditions, and access to services also play a significant role. People living in more deprived areas (such as Gloucester, which consistently shows the highest contact rates across all age bands) are more likely to contact ASC, reflecting both greater need and the impact of means-tested services.

Going forward, we are committed to developing our analysis of the 65+ age group in more detail. By looking more closely at the experiences of the oldest residents and understanding how health inequalities affect demand, we can better plan and target our support, ensuring that everyone in Gloucestershire can live independently, safely, and well as they age.

[37] Gloucestershire County Council internal data; ONS Population Estimates

Figure 6: Total contacts received to GCC Customer Services Team, 2023, as a rate per 1,000 people, by age group and locality[38]



ASC assessments

The improvement work around ASC assessments in Gloucestershire is focused on upgrading our systems, processes, and data management to meet the requirements of the national client level data (CLD) specification[39]. This means we are moving towards collecting and reporting more detailed, individual-level information about people who use ASC services. The aim is to improve the accuracy, visibility, and quality of our data so that we can better understand people's needs, monitor outcomes, and plan services more effectively. This work involves strengthening governance, ensuring referral, assessment, services and review data is recorded consistently, and making our systems more joined-up so that information flows smoothly between teams and partners. The CLD specification sets out what data must be collected and how it should be reported nationally, which helps create a clearer and more comparable picture of ASC across England.

This needs assessment does not include detailed analysis under the client level data specification because the relevant data was not yet available at the time of writing. There are several reasons for this:

- The new systems and processes required for CLD reporting are still being implemented, with the first phase going live in December 2025.
- Some data, especially for short-term services and delegated functions (such as reablement), is not currently held by the council or is managed by external providers, making it difficult to include in the assessment.
- The chapter acknowledges these gaps and notes that improving data quality and integration is a priority, with work underway to address these issues in future reporting and needs assessments.

[38] Gloucestershire County Council internal data; ONS Population Estimates
[39] https://standards.nhs.uk/published-standards/adult-social-care-client-level-data-set

Short-term services

In the short term, we face some challenges with how visible and complete our data is, especially for services that are managed by other organisations on our behalf. For example, some short-term support, like reablement, is delivered by delegated providers, which means we do not always have direct access to all the information we need. Our current systems also have some limitations, making it harder to bring together data from different sources. This can affect how quickly and accurately we can see what support people are getting and where improvements are needed. We are working to address these issues by improving our systems and working more closely with partners, but it will take time to achieve full visibility and integration of all our data.

Open long-term services (OLTS)

ASC in Gloucestershire offers different types of support, depending on people's needs. Some services are short-term, designed to help people regain independence after a setback, while others are long-term, providing ongoing support for those who need it.

This section focuses on people who are receiving open, long-term services, meaning support that is intended to continue for as long as it's needed. The information here is based on records from the council's main ASC finance system (ContrOCC) and covers the years 2019/20 to 2024/25.

It's important to note that these figures do not include some types of care, such as NHS continuing healthcare, services that people pay for themselves (like self-funded nursing care), or support provided by organisations like the Carers Hub and Telecare or loaned equipment, which are recorded separately.

Population figures used in this analysis come from the latest official estimates, so we can understand how many people in Gloucestershire are receiving long-term support compared to the wider community.

By looking at this data, we can see how many people rely on ongoing care, spot trends over time, and make sure services are planned to meet the needs of Gloucestershire's residents.

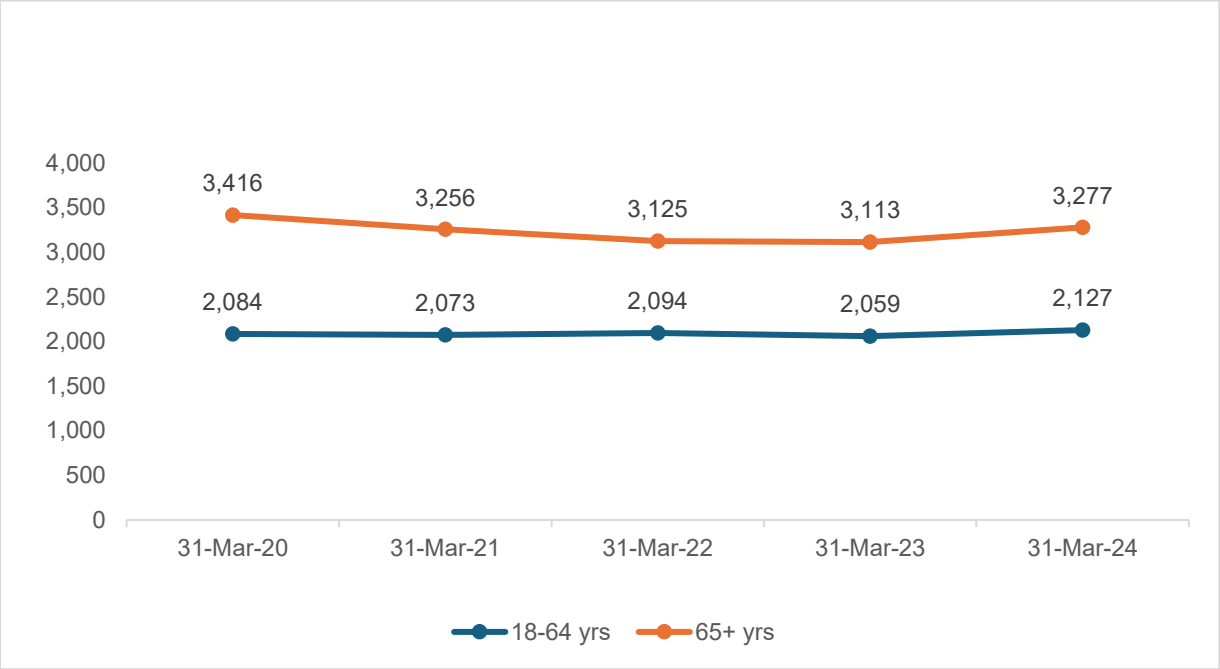
Trends in long-term support

The number of people in Gloucestershire receiving ongoing, long-term support from ASC has changed over recent years (see figure seven below). When we look at the data from 2020 to 2024, we see that people aged 65 and over have consistently made up the largest group receiving this kind of support. However, the number of older adults using long-term services has seen a slight decline during this period.

In contrast, the number of adults aged 18 to 64 receiving long-term support has gradually increased. This means that while older people still make up the majority of those needing ongoing care, there is a growing need for long-term support among younger adults as well.

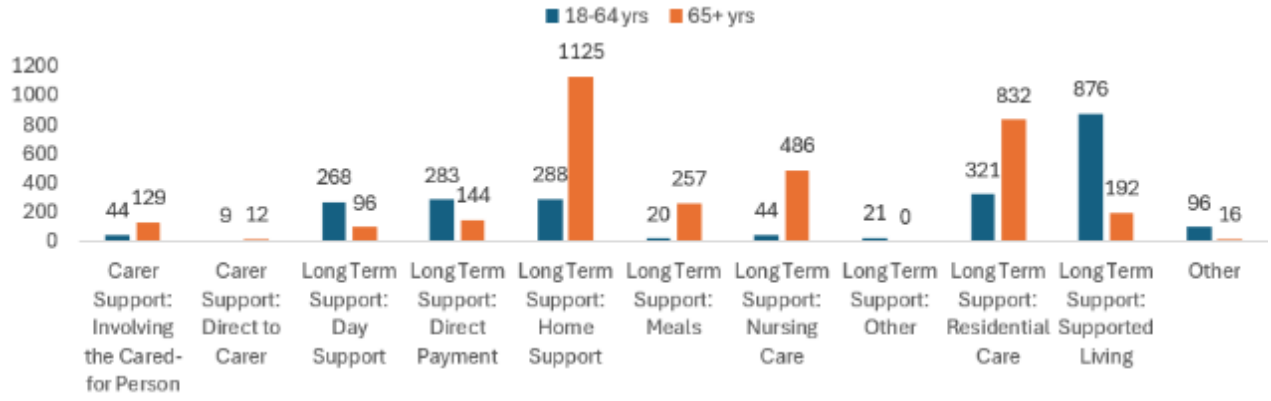
Understanding these trends helps ASC plan and deliver services that meet the changing needs of Gloucestershire's residents, ensuring that support is available for people of all ages who need it.

Figure 7: Number of people with an open long-term service (OLTS) for GCC ASC, 2020 to 2024, by broad age group[40]



When we look at the different types of long-term support provided by ASC in Gloucestershire (figure eight below), we see some clear patterns based on age. Just over half of the service types are used more by people aged 65 and over. Services like home support, meals support, nursing care, and residential care are much more commonly used by older adults compared to younger adults.

Figure 8: Number of people with an OLTS, March 2023, by service type[41]

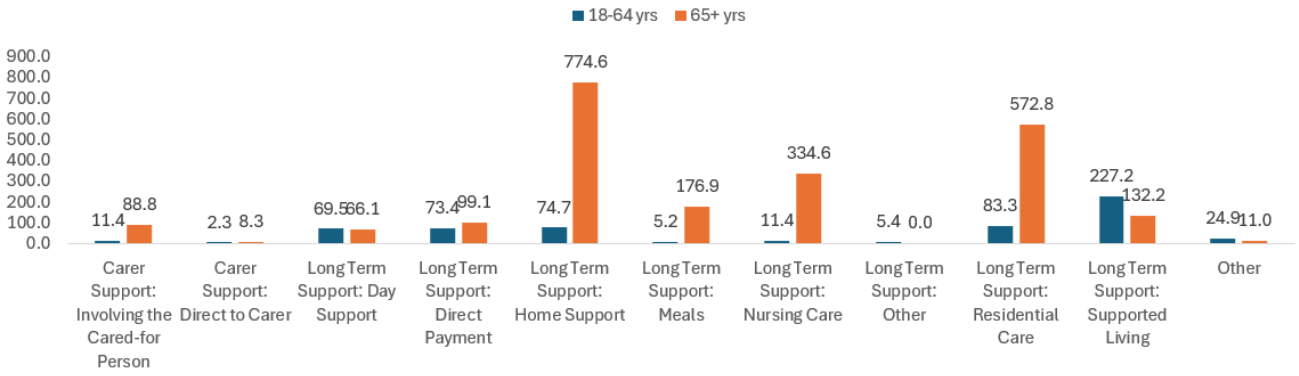


However, when we adjust data to account for the size of each age group in the county (figure nine below), day support and direct payments show similar uptake rates in the 18–64 and 65+ groups. In contrast, home support and residential care have a higher relative uptake amongst older people. This does not imply lower need among older adults. Instead, it points to barriers and market configuration, for example, direct payments appear harder

[40] Gloucestershire County Council internal data
[41] Gloucestershire County Council internal data

for older people to manage as well as possible digital exclusion, and day support capacity/offer for older people may not match younger adults' needs or awareness levels.

Figure 9: People with an OLTS, March 2023, by service[42]



Open long-term service by district

When we look at the number of people receiving ongoing, long-term support from ASC across Gloucestershire's districts (figures ten and 11 below), some clear patterns emerge. Data for 2022–2023 show that people aged 65 and over make up a much higher proportion of those receiving long-term care in almost every district. This difference is even more pronounced when we look at the rate per 10,000 people, reflecting the county's smaller population of older people compared to those aged 18–64.

Gloucester stands out with the highest proportion of people receiving long-term support, both in terms of actual numbers and rates, across all age groups. In contrast, Cotswold and Tewkesbury tend to have the lowest rates, especially among younger adults, although for those aged 65 and over, Cotswold and Tewkesbury are similar by actual numbers.

Why does this matter?

These patterns reflect both the ageing population in Gloucestershire and the way health needs, especially frailty, are distributed across the county. Nationally, the CMO's 2023 report[43] highlights that as people live longer, more are living with frailty, which increases the need for ongoing care and support. In Gloucestershire, about 41.7% of people aged 65+ are living with some level of frailty, and this is expected to rise as the population ages.

[42] Gloucestershire County Council internal data; ONS Population Estimates, 2023 downloaded from NOMIS 21/08/2025 published by ONS 30/07/2025 Population estimates - local authority based by single year of age - Nomis - Official Census and Labour Market Statistics

[43] Chief Medical Officers Annual Report 2023: Health in an Ageing Society, Executive summary and recommendations

Figure 10: Number of people with an OLTS, March 2023, by broad age group and split by Gloucestershire district[44]

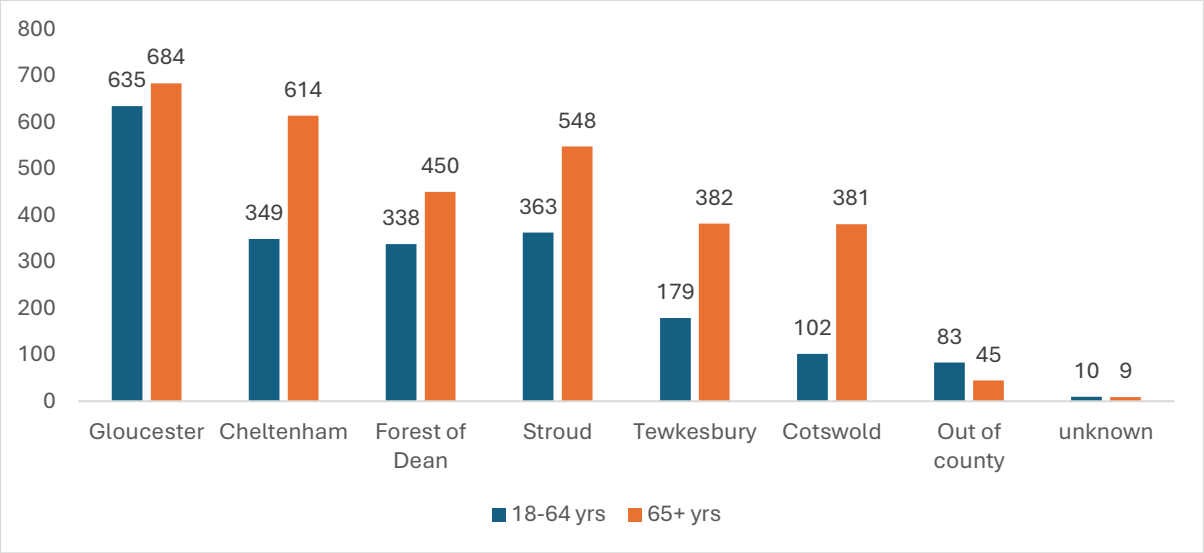
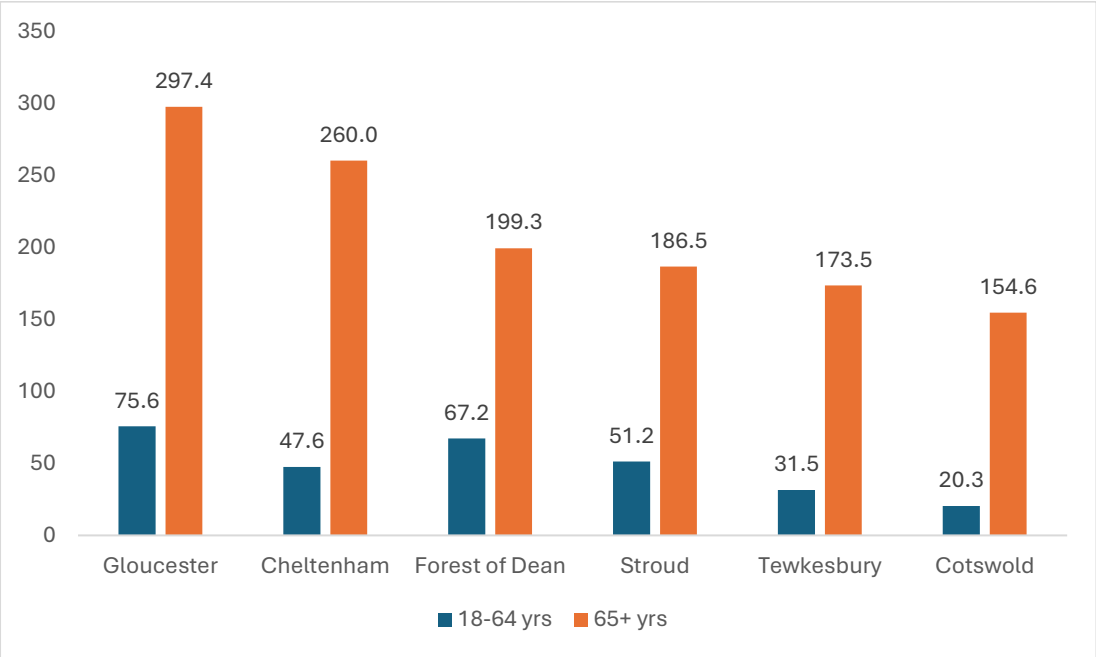


Figure 11: Number of people with an OLTS, March 2023, by broad age group and split by Gloucestershire district, as a rate per 10,000 population[45]



The CMO's report also shows that the need for social care is not evenly spread as rural and semi-rural areas, like much of Gloucestershire, are seeing faster growth in their older populations than cities. This means that planning for care services must consider not just the number of older people, but also where they live and the specific challenges they face, such as transport, access to services, and social isolation.

[44] Gloucestershire County Council internal data

[45] Gloucestershire County Council internal data; ONS Population Estimates, 2023 downloaded from NOMIS 21/08/2025 published by ONS 30/07/2025 Population estimates - local authority based by single year of age - Nomis - Official Census and Labour Market Statistics

National benchmarking data[46] shows that the proportion of older adults (65+) receiving long-term publicly funded care varies widely across England from 2% to nearly 9% of the older population, depending on the area. Gloucestershire's rates are broadly in line with national trends, but the county's faster-than-average growth in the older population means demand is likely to keep rising.

Gloucestershire county's Frailty Strategy[47] emphasises prevention, early identification, and supporting people to live independently for as long as possible, in line with national best practice.

OLTS by primary support reason

For people aged 65 and over, the most common reason for needing support is help with personal care such as washing, dressing, or managing daily activities (see figure 12 below). This reflects the challenges that can come with ageing and the importance of helping older adults maintain their independence and dignity.

For adults aged 18 to 64, the main reason for receiving long-term support is a learning disability (figure 12 below). This means that many younger adults rely on ASC to help them live as independently as possible, whether that's through supported living, help with daily tasks, or other tailored services.

When we look at the overall picture across all support reasons (see figure 13), support with memory and cognition such as dementia care makes up the largest percentage for people aged 65 and over. For those aged 18 to 64, learning disability remains the top reason, followed by support for mental health needs.

[46] Institute for Government (2025) Adult Social Care across England
[47] One Gloucestershire (2025) Frailty Strategy 2022-2027: https://www.nhsglos.nhs.uk/your-health-services/community-and-hospital-care/frailty/

Figure 12: Number of people with an OLTS, March 2023, by primary support reason and broad age group[48]

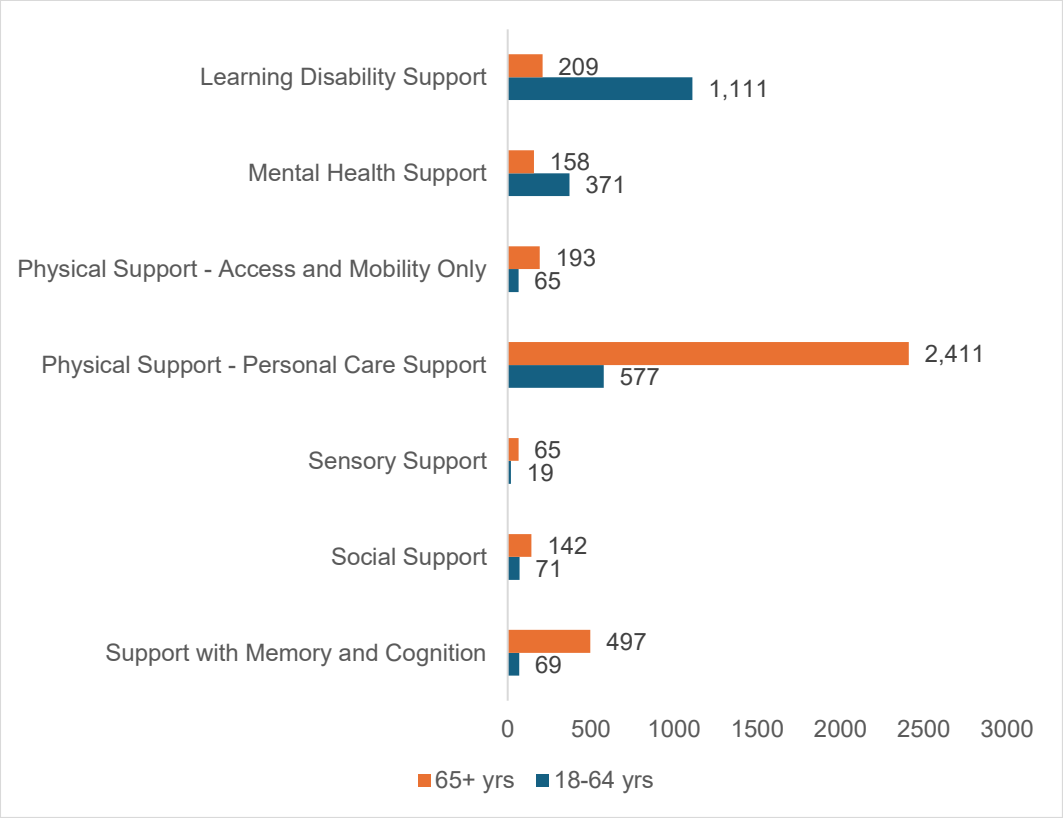
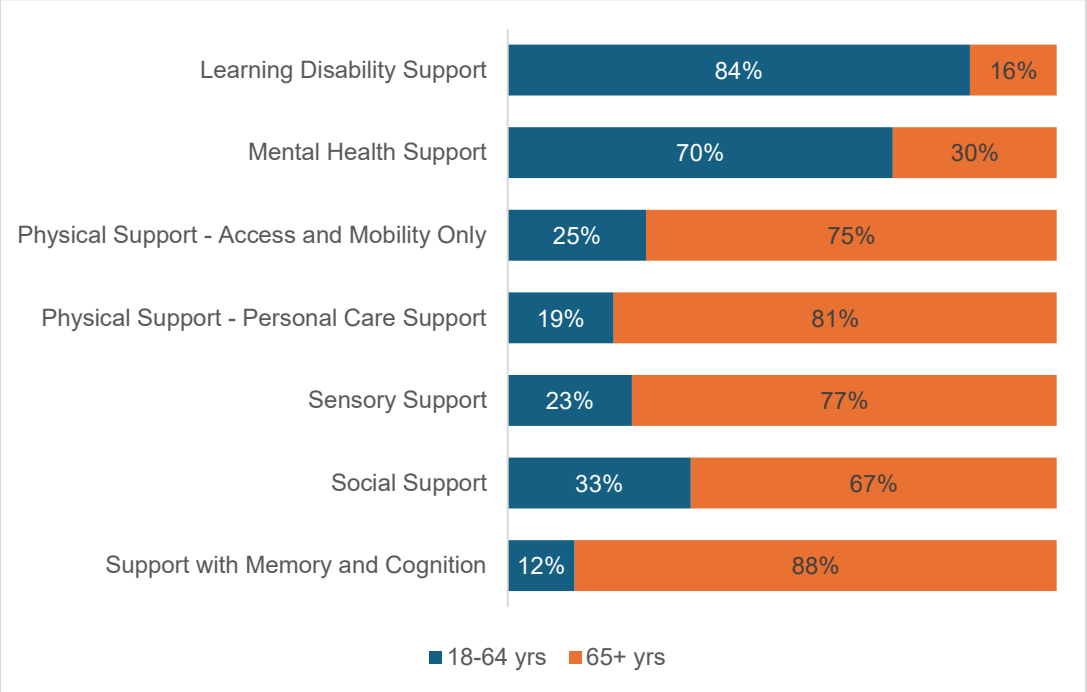


Figure 13: Percentage of people with an OLTS, March 2023, by primary support reason and broad age group[49]



[48] Gloucestershire County Council internal data
[49] Gloucestershire County Council internal data

Who uses long-term support? Age, gender, and national context

When we look at who is receiving ongoing, long-term support from GCC ASC in figure 14 below, some clear patterns emerge around age and gender.

Older women are the largest group:

> Data shows that females aged 65 and over make up the highest proportion (as a rate per 100,000 people) of those accessing ASC services, followed by males in the same age group. For adults aged 18–64, males make up a slightly higher proportion than females.

Trends over time:

> For women aged 65 and over, there was a noticeable decline in the rate of service use from 2020 to 2023, with a slight increase by March 2024. For men in this age group, rates have remained broadly similar to 2020, though there was a dip in 2022. Among adults aged 18–64, rates have stayed stable, especially for females.

How does this compare nationally?

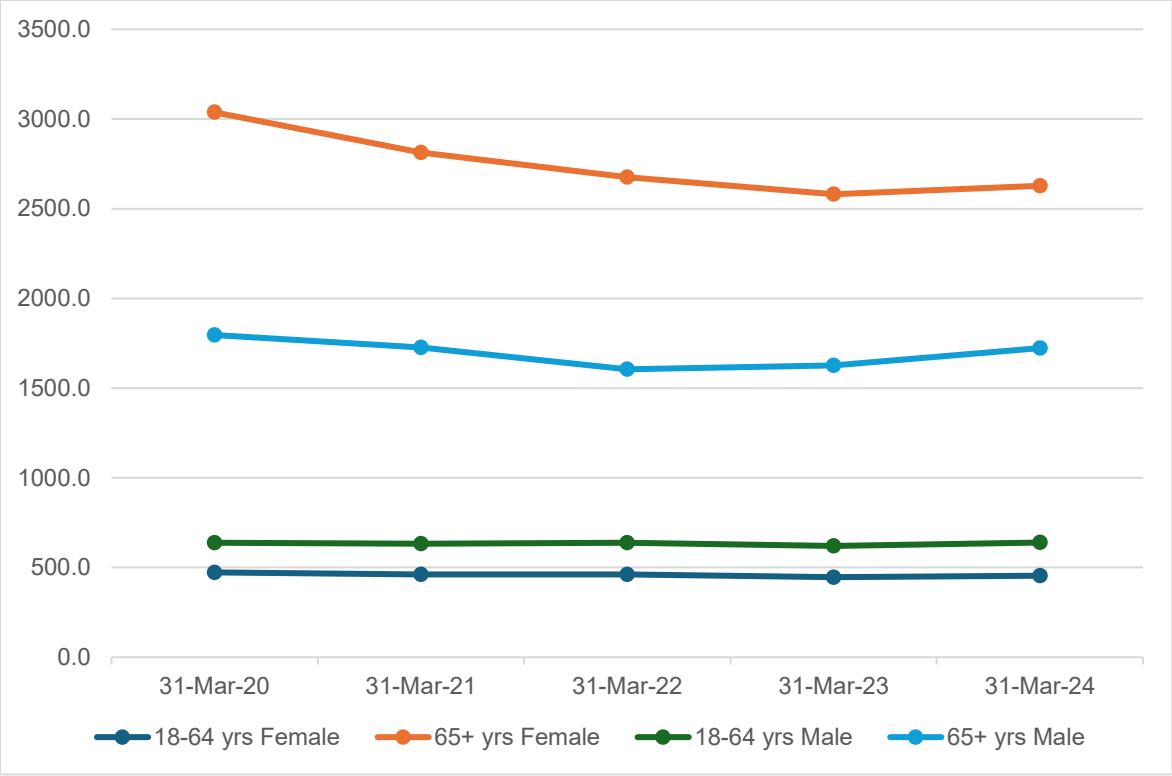
> These patterns are reflected across England. The CMO's 2023 report[50] highlights that women tend to live longer than men and are more likely to need social care support in later life. National benchmarking[51] also shows that the oldest age groups, especially those over 85, are the most likely to use long-term care services, and that women make up the majority of this group due to their longer life expectancy and higher rates of frailty

The CMO report also notes (nationally):

- The number of people aged 85 and over will almost double by 2045, increasing demand for care.
- Frailty and multiple long-term conditions are more common in older women, leading to greater need for support.
- Social inequalities and where people live (urban vs. rural) can affect who needs and accesses care.

[50] Chief Medical Officers Annual Report 2023: Health in an Ageing Society, Executive summary and recommendations
[51] National Institute for Health and Care Research (2024) Frailty: Research shows how to improve care

Figure 14: People with an OLTS, 2020-2024, by broad age group and gender, as a rate per 100,000 population[52]



OLTS for people aged 65+ by gender and age band

When we look more closely at the rate people aged 65 and over who receive ongoing, long-term support from Gloucestershire's ASC, we see that the need for support increases with age (see figure 15 below). This trend is especially noticeable for women: as they get older, a higher proportion of females require long-term care compared to males in the same age groups.

Key Patterns:

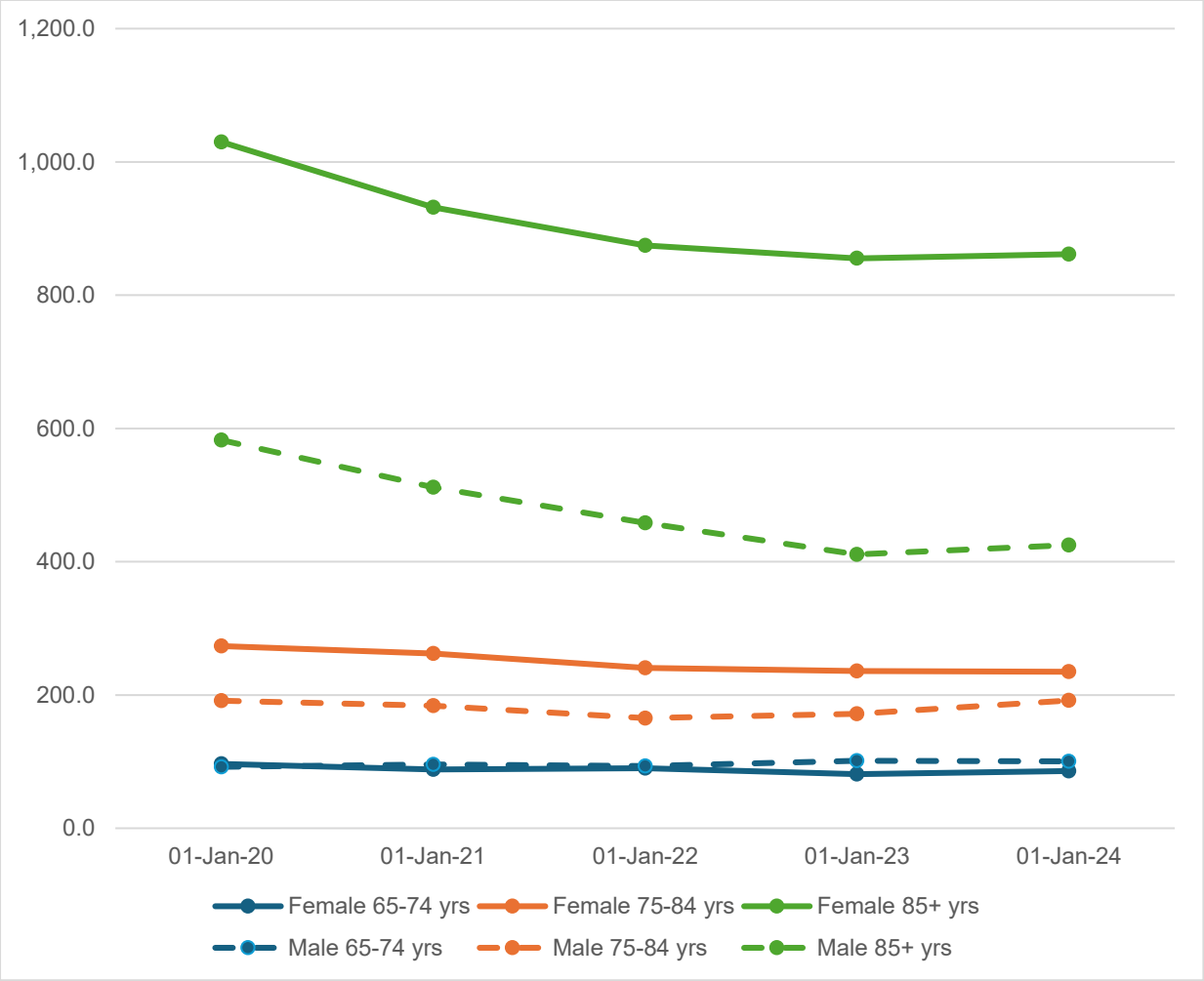
- Age matters: The rate of people receiving long-term support increases significantly with age. Those aged 85 and over have the highest rates of OLTS, followed by the 75–84 group, and then the 65–74 group.
- Gender differences: In every age band, females have higher rates of OLTS than males. This is especially pronounced in the 85+ group, where the gap between females and males is widest.
- Trends over time: For the oldest group (85+), both males and females show a gradual decline in the rate of OLTS from 2020 to 2024. The 75–84 and 65–74 groups remain relatively stable, with only minor fluctuations for both genders

[52] Gloucestershire County Council internal data; ONS Population Estimates, 2020 - 2024 downloaded from NOMIS 21/08/2025 published by ONS 30/07/2025 Population estimates - local authority based by single year of age - Nomis - Official Census and Labour Market Statistics

What does this mean?

- Older age, greater need: The data confirms that as people age, they are more likely to need ongoing social care support. This is consistent with national findings and the CMO's 2023 report, which highlights that frailty and complex health needs become more common with age—especially for women, who tend to live longer and are more likely to require support in later life.
- Gender and longevity: The higher rates for females, particularly in the oldest age group, reflect both longer life expectancy and higher prevalence of frailty among older women, as noted in national benchmarking and the CMO's report.
- Recent decline in the oldest group: The gradual decline in OLTS rates for those aged 85+ between 2020 and 2023 may reflect a combination of factors, such as changes in service delivery, improvements in prevention and community support, or the lasting impact of the COVID-19 pandemic on the oldest population.

Figure 15: Number of people aged 65+ with an OLTS, 2020-2024, by 10-year age range and gender, as a rate per 100,000 population[53]



Understanding who accesses OLTS in Gloucestershire

Our analysis of OLTS in Gloucestershire reveals important patterns about who is receiving ongoing social care support. Data covering financial years 2020 to 2025 and standardised against Census 2021 ethnicity data, show that:

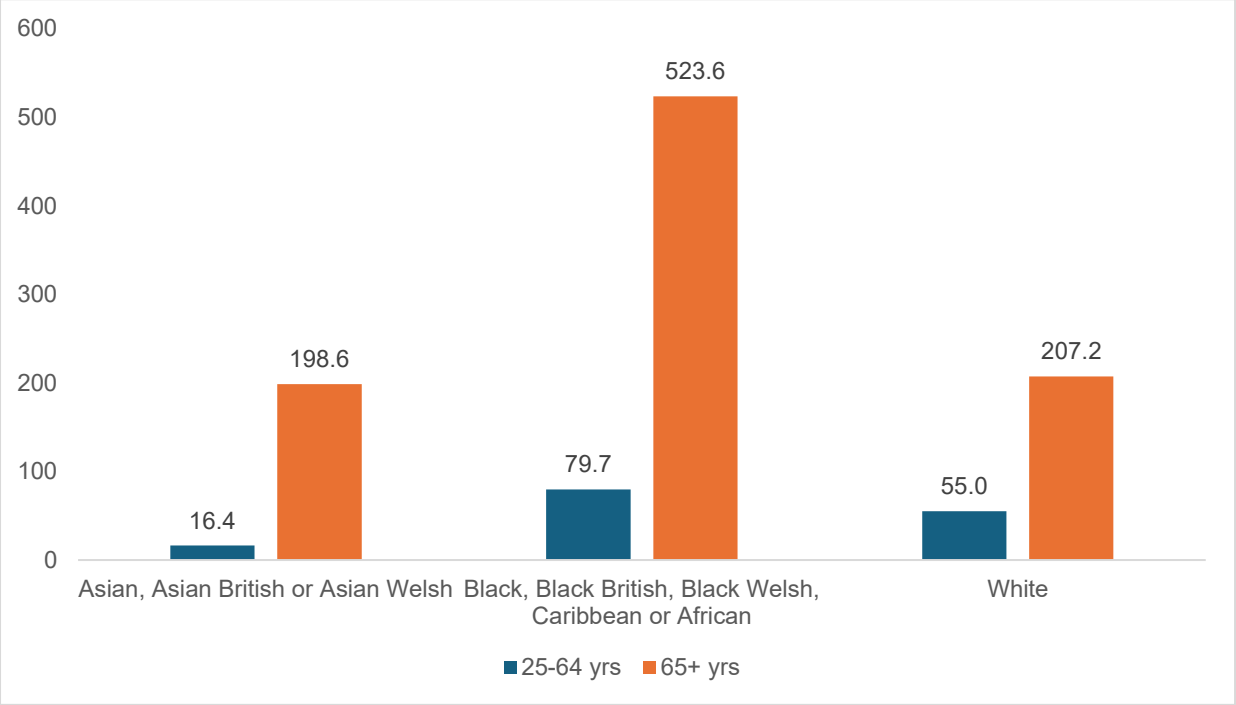
- People who identify as White (all categories) make up most (roughly 89% and above) of those accessing OLTS across all years. This reflects the overall demographic profile of Gloucestershire, where the population is majority White.
- People from Black/Black British, Welsh, Caribbean, or African backgrounds make up a larger proportion of OLTS users than any other ethnic group and this difference is particularly pronounced in the older age group (see figure 16 below).

Figure 16 shows OLTS as a rate per 10,000 people and highlights:

[53] Gloucestershire County Council internal data; ONS Population Estimates, 2020 - 2024 downloaded from NOMIS 21/08/2025 published by ONS 30/07/2025 Population estimates - local authority based by single year of age - Nomis - Official Census and Labour Market Statistics

- Higher rates of OLTS among older adults (65+) across all ethnic groups.
- A marked disparity: While White residents are the largest group in absolute numbers, the rate of OLTS use among older Black/Black British, Welsh, Caribbean, or African residents is much higher than for other groups.

Figure 16: People with an OLTS, 2023, split by broad age group and ethnic group, as a rate per 10,000 Census21 population[54]



Research shows that Black and Hispanic older adults in the UK spend more years with disabilities and are more likely to experience unmet care needs than White counterparts. These groups also tend to rely more on unpaid care from extended family but face greater barriers to accessing formal support. The CMO's[55] report highlights that health inequalities, including those linked to ethnicity and deprivation drive higher demand for social care in some communities.

Understanding demand for OLTS across deprivation levels in Gloucestershire

Our analysis explores how demand for OLTS varies across Gloucestershire's communities, to understand the impact of social and economic factors. Indices of Multiple Deprivation 2019 (IMD) deciles rank areas from the most deprived (decile one) to the least deprived (decile ten) and help us identify where needs are greatest.

- Older adults are much more likely to require OLTS than younger adults, regardless of where they live.

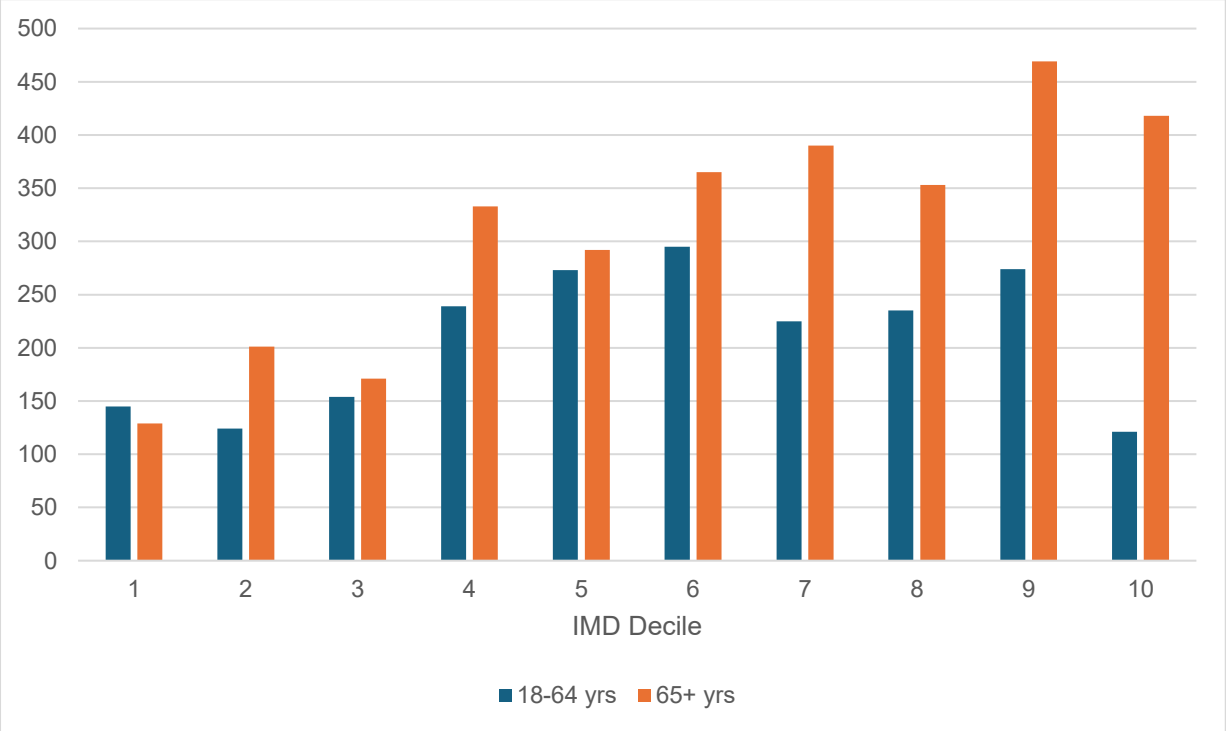
[54] Gloucestershire County Council internal data; Census 2021, downloaded from NOMIS 2021 Census - Census of Population - Data Sources - home - Nomis - Official Census and Labour Market Statistics
[55] Chief Medical Officers Annual Report 2023: Health in an Ageing Society, Executive summary and recommendations

- Deprivation matters: The most deprived areas have the highest rates of OLTS usage (see figure 18), reflecting the greater health and social care needs in these communities.

Figure 17 below shows the actual number of people in two age groups, 18-64 years (blue bars) and 65+ years (orange bars), who have an OLTS and is split by IMD 2019 decile. Data shows:

- That older adults (65+) consistently have higher numbers of OLTS across all deciles.
- There are peaks for the 65+ group in deciles 4, 6, and especially 9, suggesting that some less deprived areas have a larger population of older adults requiring support.

Figure 17: Number of People with an OLTS, 2022, by IMD 2019 Decile and broad age group[56]

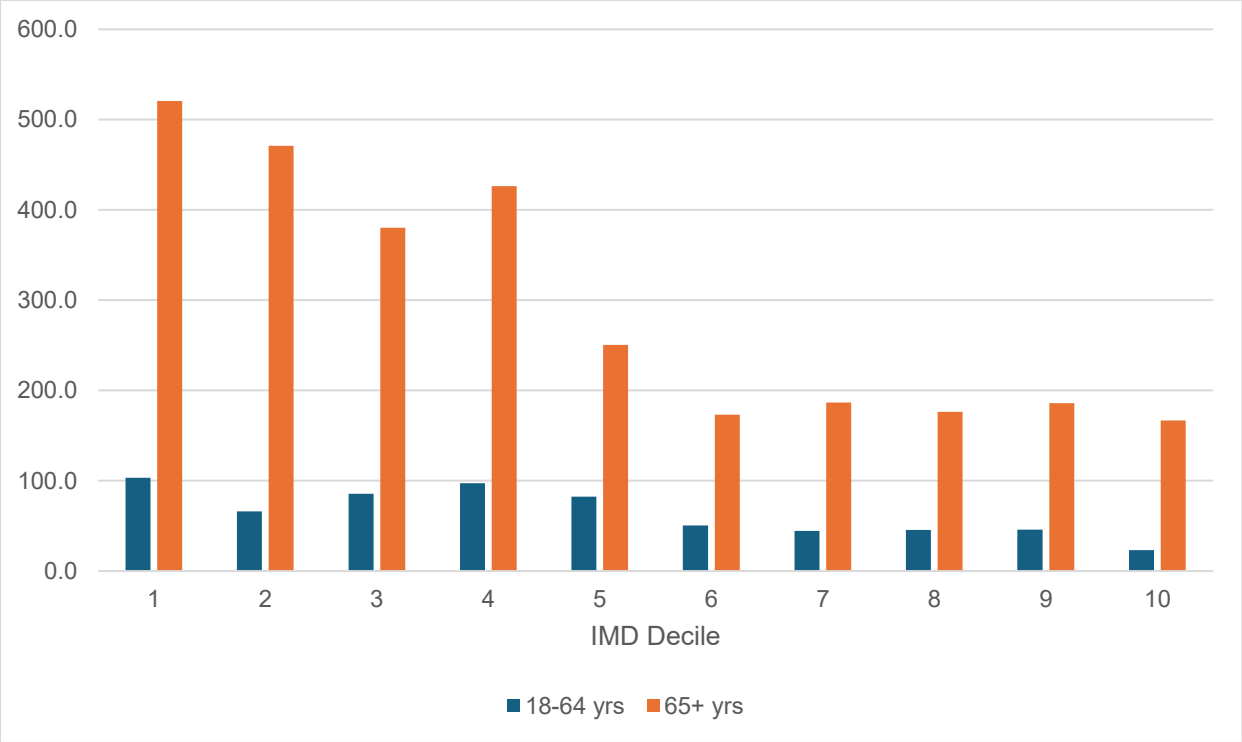


However, figure 18 below shows the rate per 10,000 population, split by two broad age groups as above and IMD 2019 decile. Data now show:

- Older adults (65+) have a much higher rate of OLTS usage across all deprivation levels compared to younger adults (18-64).
- The highest rates are seen in the most deprived areas (lower deciles), with an overall downward trend as deprivation decreases, which is particularly clear for the age 65+ group. However, for younger adults, rates show some increases in the middle deciles, and for older adults fluctuations can be seen in the middle-upper deciles.

[56] Gloucestershire County Council internal data; Indices of Multiple Deprivation 2019, Ministry of Housing, Communities and Local Government

Figure 18: Number of people with an OLTS, 2022, by IMD 2019 Decile and broad age group as a rate per 10,000 population[57]



Understanding demand for OLTS among Older Adults Across Deprivation Levels

Figure 19 below highlights how the need for OLTS varies among older adults in Gloucestershire, when segmented by age (65-74, 75-84, and 85+) and levels of deprivation (where IMD decile one is most deprived).

OLTS demand increases sharply with age:

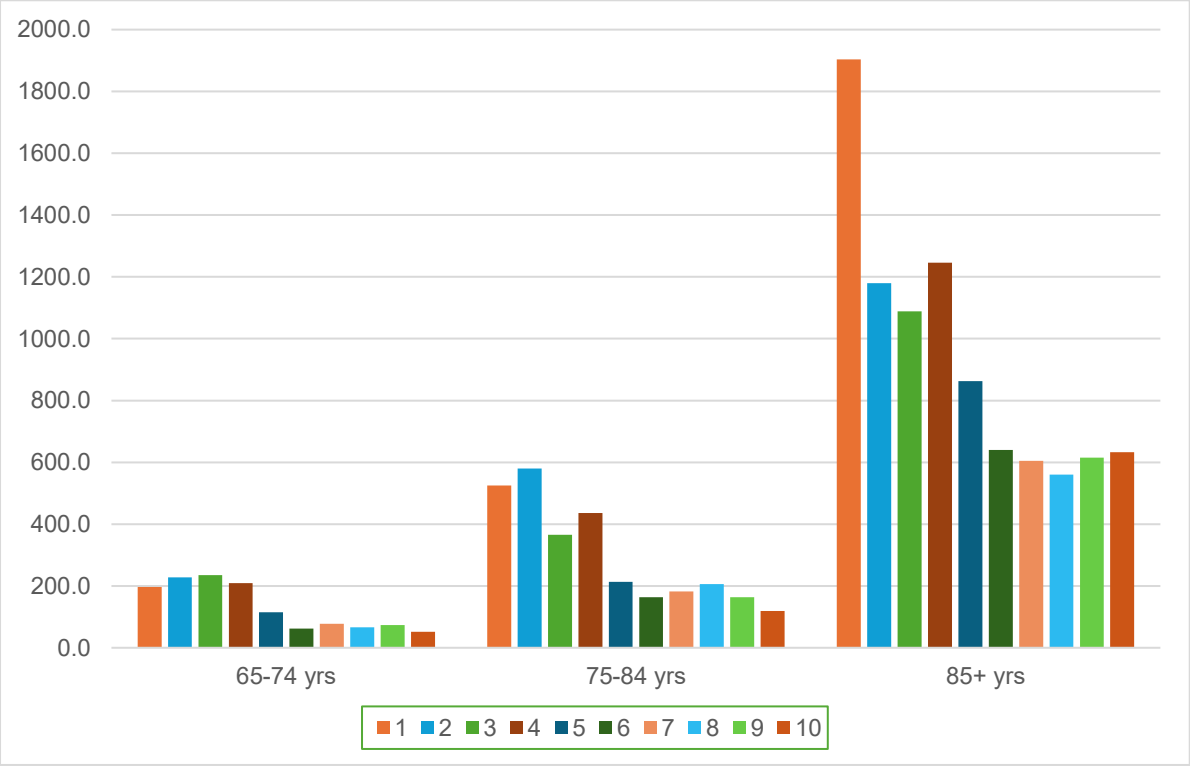
- The 65-74 age group has the lowest rates of OLTS usage across all IMD deciles and an overall downward trend showing lower usage in lesser deprived areas.
- The 75-84 age group sees a noticeable rise in demand, especially in the most deprived areas (the lower deciles).
- The 85+ age group shows a dramatic increase in OLTS demand across all deciles, with the highest rate in the most deprived area (decile one), and elevated rates in other lower deciles (two and three).

Deprivation amplifies demand:

[57] Gloucestershire County Council internal data; Indices of Multiple Deprivation 2019, Ministry of Housing, Communities and Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019; ONS Population Estimates, 2022, downloaded from NOMIS 21/08/2025, published by ONS 30/07/2025 Population estimates - local authority based by single year of age - Nomis - Official Census and Labour Market Statistics

- Across all age bands, the most deprived areas (lower IMD deciles) have the highest rates of older adults accessing OLTS.
- For the oldest group (85+), the gap between the most and least deprived areas is especially pronounced, highlighting the impact of social and economic disadvantage on care needs.

Figure 19: People aged 65+ with an OLTS, 2022, by IMD Decile and 10-year age group, as a rate per 10,000 Population[58]



[58] Gloucestershire County Council internal data; Indices of Multiple Deprivation 2019, Ministry of Housing, Communities and Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019; ONS Population Estimates, 2022, downloaded from NOMIS 21/08/2025, published by ONS 30/07/2025 Population estimates - local authority based by single year of age - Nomis - Official Census and Labour Market Statistics

Chapter 6: Population and workforce projections

County-wide projections

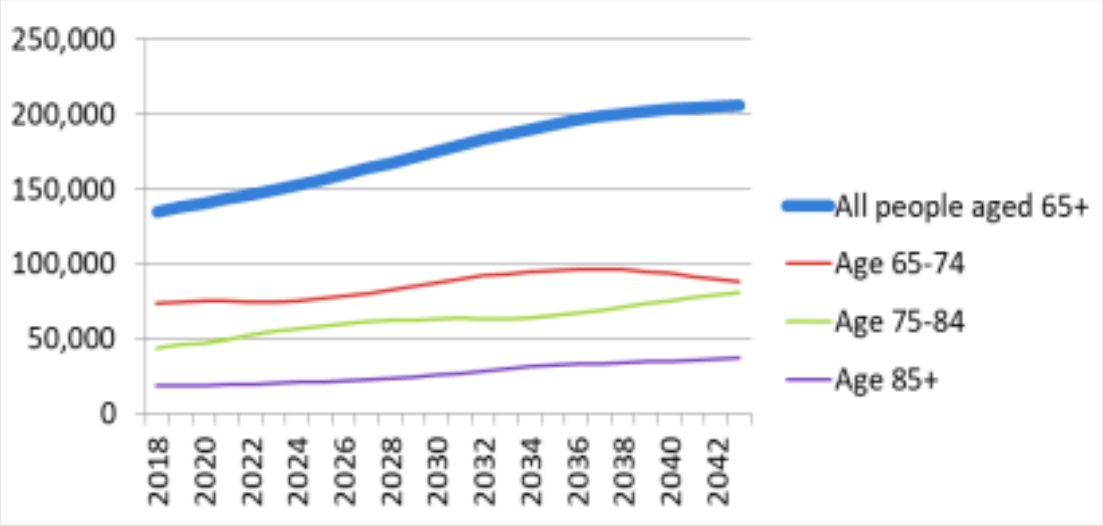
Overall, the 65 plus age group in Gloucestershire is increasing as highlighted above in the population pyramid, a trend being experienced UK-wide that will pose resource challenges as an ageing population has an increased reliance on services such as healthcare.

Gloucestershire's relative affluence leads to many residents living longer and in better health than the England average. This combined with internal migration (people moving to Gloucestershire from other regions in the UK) of older adults is creating a population that is ageing faster than the rest of England. For example, the increase in over-65s in Gloucestershire between 2010 and 2020 was 26.3 percent compared with the Southwest at 24.2 percent, and England at 22.2 percent[59].

Population projections estimate that the population aged 65 plus in Gloucestershire will rise at a faster pace than nationally between 2018 and 2043 (52.5% for Gloucestershire and 43.2% for England), reaching an estimated 205,900 people by 2043 (figure 4). This projected increase equates to an average annual increase of 2,800 people over the stated 25-year period, with the over-75s accounting for most of the increase (2,240 people).

In contrast to older age groups, over the next 20 years Gloucestershire is expected to see minimal change in the number of adults of working age. A stark but relatively consistent drop in the birth rate from 1969 means that this age group has generally stopped growing naturally and any increases are driven by migration into Gloucestershire[60]. While the South West and England experienced increases in their working-age populations by 3.43% and 4.27% respectively, Gloucestershire saw a more modest rise of 3.24% (Figure 3.12).

Figure 4: Population projections aged 65 plus, Gloucestershire, 2018 to 2043[61]



[59] 2021 ONS Census Data cited in equality-profile-2024-refresh.pdf (gloucestershire.gov.uk)

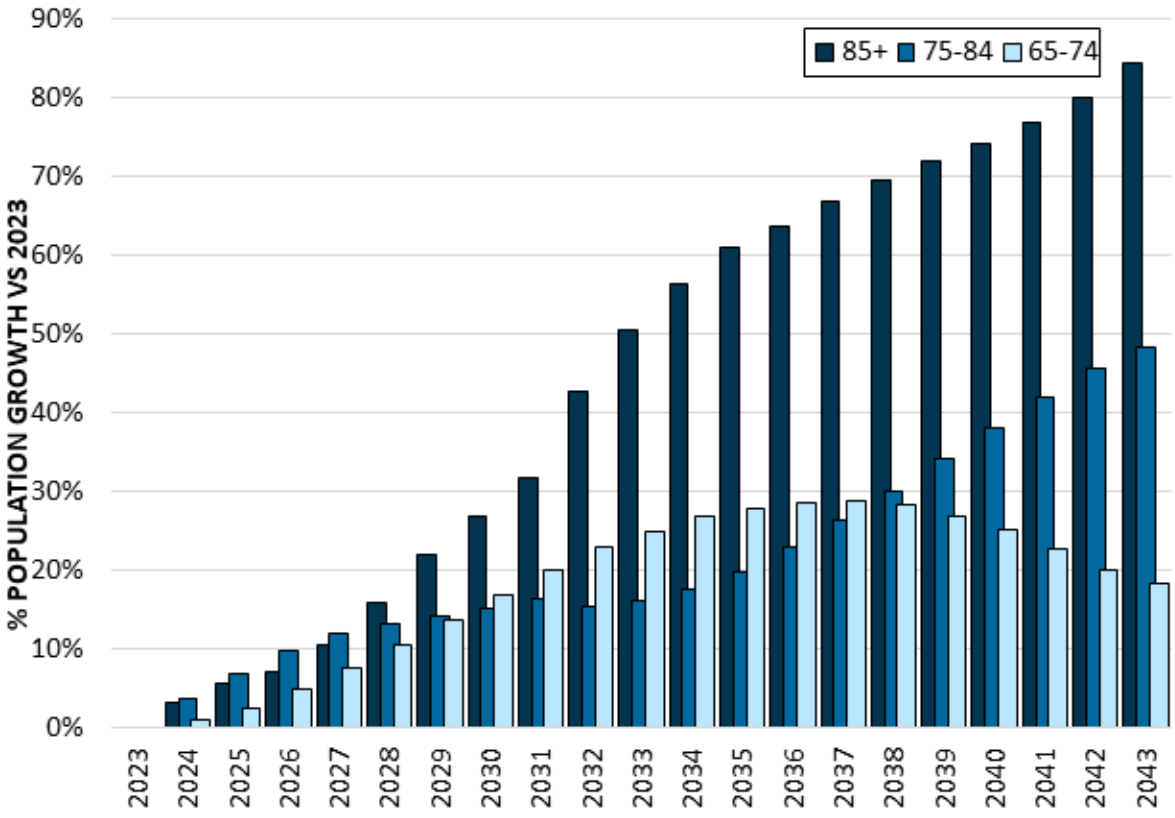
[60] GCC (2024) Market Position Statement (MPS) for Adult Social Care Services 2024

[61] Gloucestershire County Council (2020) 2018-based Population Projections, Office for National Statistics cited in 'Older People in Gloucestershire Prevalence of Needs' (2020), InformGloucestershire Summary (gloucestershire.gov.uk)

The main (predominate) component of Gloucestershire's population change is Internal Migration Inflow[62]. The ageing population will bring increasing numbers of retired people who have experience, resources, and time to contribute to their communities. As these people grow older and frailer, however, they may require more support from health, social care, and safeguarding services.

The rate of population growth will be fastest between 2028 and 2033. Although consistent increases are expected for the next 20 years, they will be most extreme for the next 10 years. Figure 5 below illustrates that while the overall population of older people will increase annually over the next 20 years, the growth rates of different age cohorts will vary significantly. For example, the number of people aged 65–74 is projected to increase to year 2037 before decreasing again. The number of people aged 74-85 is projected to increase every year, however the most extreme period of growth is projected between 2033 and 2043.

Figure 5: Percentage population growth projections, Gloucestershire, by age range from age 65 plus, 2024 to 2043[63]



Population projections estimate that by 2025:

- there will be 155,800 people over 65 years living in the County (21.8% of the total population), rising to 173,300 by 2030 (25.3% of total population).
- 11,249 people will be living with dementia, rising to 12,929 people by 2030.

[62] Gloucestershire County Council (2023) Internal migration in Gloucestershire, mid 2022 estimate Gloucestershire County Council, InformGloucestershire Microsoft Word - Final mid-2022 internal migration report v2

[63] GCC (2024) Market Position Statement (MPS) for Adult Social Care Services 2024

- the number of those over 65 years providing unpaid care for partners, family members or friends will be 22,239, rising to 24,964 by 2030.
- 10,266 men and 22,000 women over the age of 75 will be living alone.

District-level projections

Population projections (Table 5) at district level show Cotswold is to have the greatest increase in people aged 65 plus between 2018 and 2043, rising by 65.1 percent (14,800 people).

Table 5: Population projections aged 65 plus, Gloucestershire and districts, 2018 to 2043[64]

	2018	2030	2043	No. change 2018-2043	% change 2018-2043
Gloucestershire	134,973	175,365	205,865	70,892	52.5%
Cheltenham	22,519	28,374	32,759	10,240	45.5%
Cotswold	22,760	31,074	37,571	14,811	65.1%
Forest	21,034	26,888	30,675	9,641	45.8%
Gloucester	21,570	28,191	32,958	11,388	52.8%
Stroud	26,618	33,704	39,295	12,677	47.6%
Tewkesbury	20,472	27,134	32,607	12,135	59.3%

The future care workforce

Workforce sustainability in the health and social care sector is one of the biggest challenges Gloucestershire will face over the next five to 10 years[70.] 4.9% of the current total workforce work in the care sector[69] but with an expected 29%[69] increase in the number of people requiring care services, a stagnating workforce is likely to aggravate existing challenges such as recruitment, retention, training levels, and quality [69]. With demand per carer expected to increase, stretching the workforce thinner, there is heightened pressure to find solutions including improving prevention.

Over 28,000 people work in health and social care in Gloucestershire with average vacancy rates of 7% to 12%. The average age of the workforce is 43 years but 21% of NHS staff and 25.4% of social care staff are aged over 55. Predictions from Skills for Care[65] identified that Gloucestershire would need an extra 7,900 posts in the over 65s market by 2040 but like in other areas of the country, recruitment is an issue.

In social work and domiciliary care, recruitment is increasingly difficult, and the cost-of-living crisis has aggravated this. Social care workers and providers in rural areas particularly struggle due to poor public transport and fuel costs – staff cannot afford to drive to and from their clients, and the rural nature means fewer clients can be seen due to journey times. What's more, where property prices are highest, the pool of working age adults from which to recruit is more limited than other areas of the county. In 2022, a person earning the

[64] 2018-based Population Projections, Office for National Statistics cited in 'Older People in Gloucestershire Prevalence of Needs' (2020), Gloucestershire County Council, InformGloucestershire Summary (gloucestershire.gov.uk)
[65] Skills for Care website - https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/local-information/My-ICB-area.aspx - accessed 07/03/2025

median salary in Gloucestershire needed 8.9[66] times their income to buy a median-priced home.

Availability of staff restricts providers' ability to take on work, and the overarching market challenges mean this area cannot grow capacity to meet demand. National research suggests other factors such as the perception of social care and pressure on staff to work more hours contribute to workforce shortages.

Error! Reference source not found. below demonstrates that by extrapolating national trends[67] across the different professions that make up the care workforce, significant deficits are expected across all groups.

Figure 6: Projections of required health and social care workers by type, Gloucestershire, 2028 to 2043[68]

Registered Nurses

Year	Expected	Required	Deficit
2028	471	665	200
2033	487	778	297
2038	504	901	405
2043	528	992	472

Direct Care Workers

Year	Expected	Required	Deficit
2028	2,994	3,742	748
2033	3,100	4,386	1,286
2038	3,206	5,120	1,914
2043	3,359	5,643	2,284

Senior Care Workers

Year	Expected	Required	Deficit
2028	482	605	123
2033	500	710	210
2038	516	828	312
2043	541	913	372

Indirect Care Workers

Year	Expected	Required	Deficit
2028	2,107	2,646	539
2033	2,182	3,101	919
2038	2,257	3,619	1,362
2043	2,364	3,988	1,624

Projected demand for ASC services

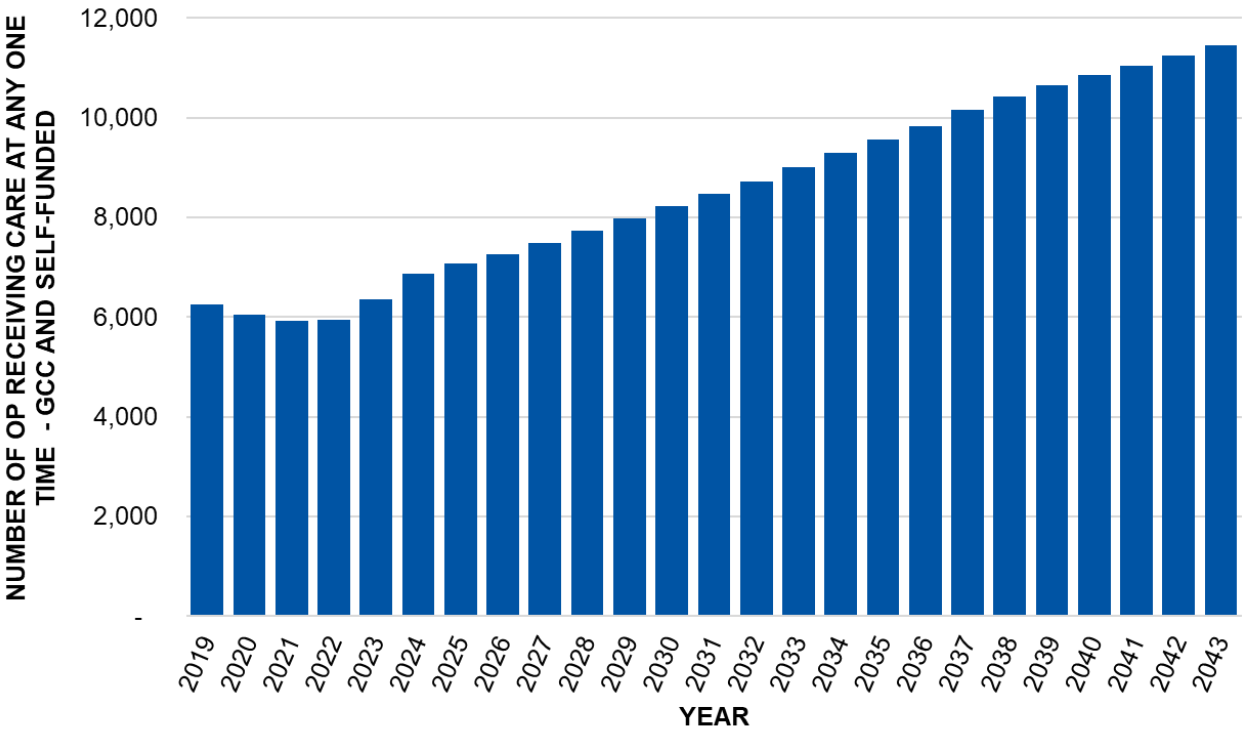
Figure 7 below demonstrates that overall demand for services by older adults will increase by 80% over the next 20 years (this is the combined view across all demand sources). Given the large increase expected in Gloucestershire for the cohort aged 85+, and their high likelihood of requiring care, it is anticipated that the demand for services for older adults will surge over the next 20 years. As the oldest cohorts are most likely to need bedded care, this demographic will likely experience the largest percentage increase in demand.

[66] Inform Gloucestershire, Economic Strategy - Economic Strategy Executive Summary

[67] Skills for Care "The size and structure of the adult social care workforce in England Workforce supply and demand trends 2022/23"
ONS Sub-national population projections 2018-based principal projection

[68] GCC (2024) Market Position Statement (MPS) for Adult Social Care Services 2024

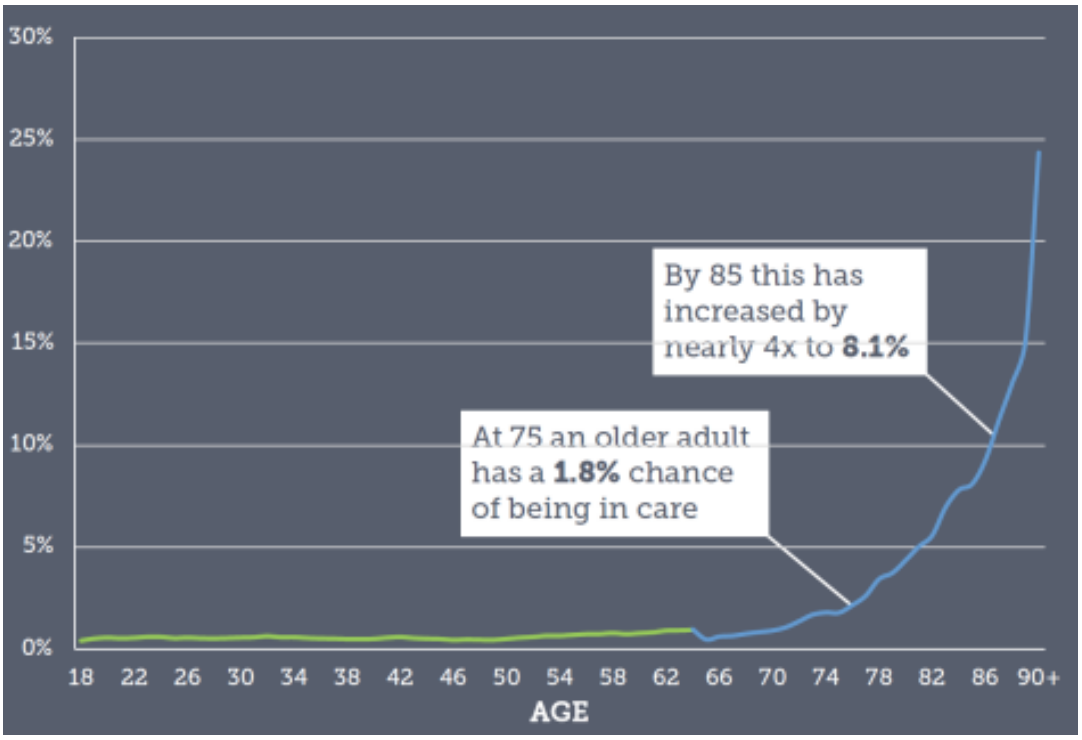
Figure 7: Number of older people (65 and over) receiving (GCC and self-funded) care at any one time, 2019 to 2043[69]



For much of adult life (18-50), people are likely to need some care, however, in later middle age (50-65), the likelihood for care starts to increase. This increase may be driven by a combination of factors including carer breakdown and the natural deterioration of a person's independence. As people reach age 65, the likelihood that they will be in receipt of formal care brokered by the council increases exponentially. More significant, however, is the increase in likelihood for care need for people aged over 75.

[69] GCC (2024) Market Position Statement (MPS) for Adult Social Care Services 2024

Figure 8: Percentage of the adult population receiving council brokered care, by age, Gloucestershire, 2024[70]



The demand for care in Gloucestershire does not just come from those who have services brokered by GCC, there is also a significant private market for older adult care, and placements made into Gloucestershire by other local authorities for adults of working age. Overall, GCC purchases 56% of all care, including 52% of care for older people and 63% of care for adults of working age.

Given the predicted increase in Gloucestershire of people aged 85 plus, and the care requirements of that age group, it is expected there will be a significant increase in demand for older adults' care services over the next 20 years, which will inevitably have an impact on the care workforce.

[70] GCC (2024) Market Position Statement (MPS) for Adult Social Care Services 2024

Chapter 7: Health Inequalities in Gloucestershire

Life Expectancy

Life expectancy is a key measure of health inequalities. The following section uses measures of life expectancy calculated from age 65, rather than from birth, as these figures may be more useful for informing services related to the older population. Life expectancy at 65 is the average number of years a person is expected to live beyond the age of 65. Healthy life expectancy at 65 is an important indicator of how well a population is ageing. Healthy life expectancy is a measure of the average number of years that a person can expect to live in good health, without disability or irreversible limitation of activity.

Gloucestershire County Council has recently published a JSNA section focused on Life Expectancy and Healthy Ageing[71] [72].

In 2020-2022, women aged 65 were on average expected to live a further 21.6 years to about 87 years old and men were expected to live another 19.1 years to approximately 84 years old. When it comes to healthy life expectancy (period 2018-202073) however, there is little difference; men with 12.3 years and women with 12.1. Likewise, the numbers of years for living disability free after 65 are similar; 11.1 for male and 11 for female. For all these indicators, Gloucestershire is above the national average (figure 6[74].

Figure 9: Life expectancy indicators by sex, Gloucestershire and England average, 2018 to 2022[75]

Indicator	Period	Glouc'shire			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Life expectancy at 65 (Male, 1 year range)	2022	–	-	19.2	18.7	16.1		20.5
Life expectancy at 65 (Male, 3 year range)	2020 - 22	–	-	19.1	18.4	15.8		20.3
Life expectancy at 65 (Female, 1 year range)	2022	–	-	21.5	21.2	18.7		23.7
Life expectancy at 65 (Female, 3 year range)	2020 - 22	–	-	21.6	20.9	18.2		23.3
Inequality in life expectancy at 65 (Male)	2018 - 20	–	-	3.6	5.2	12.7		2.2
Inequality in life expectancy at 65 (Female)	2018 - 20	–	-	3.5	4.8	8.6		0.1
Healthy life expectancy at 65 (Male)	2018 - 20	–	-	12.3	10.5	5.9		16.1
Healthy life expectancy at 65 (Female)	2018 - 20	–	-	12.1	11.3	6.9		17.2
Disability-free life expectancy at 65 (Male)	2018 - 20	–	-	11.1	9.8	6.2		14.6
Disability-free life expectancy at 65 (Female)	2018 - 20	–	-	11.0	9.9	6.4		15.5

Notes: Value is in years

Life expectancy at 65 varies across different areas of Gloucestershire, with deprivation being a key factor influencing these differences. The slope index of inequality measures the

[71] Inform Gloucestershire, Gloucestershire County Council (2024) Life Expectancy and Healthy Ageing https://www.gloucestershire.gov.uk/media/2l5dootr/life-expectancy-report-final.pdf

[72] Please note: Since 2020 Healthy Life Expectancy has not been available at local level and is only available at regional and national level. Further detail can be found in the Life Expectancy and Healthy Ageing report: final-life-expectancy-and-healthy-ageing-report-2021-to-2023.pdf

[74] OHID Public Health Profiles, https://fingertips.phe.org.uk

[75] OHID Public Health Profiles, https://fingertips.phe.org.uk

extent to which life expectancy varies with levels of deprivation. This measure indicates that at the age of 65, women living in the least deprived IMD decile (England classification) can expect to live 3.5 years longer than those living in the most deprived decile. For men, the gap is 3.6 years between the least and most deprived areas.

Although Healthy Life Expectancy is still displayed on the OHID Public Health Outcomes Framework there have been issues with data quality and the impact of the COVID 19 pandemic on data which is why it is still displaying for 2018-2020 period.

Discrimination and Inequalities

A recent report by the Equality and Human Rights Commission[76] found that people from Black and Minority Ethnic groups continue to experience discrimination and inequality in education, employment, housing, pay and living standards, health, and the criminal justice system. The 2021 Census showed differences in outcomes in several areas in Gloucestershire:

- Amongst people aged 65 and over, people from Black, Black British, Black Welsh, Caribbean or African backgrounds were more likely than people from other ethnic backgrounds to be disabled under the Equality Act, or be in poor health
- People living in households who are from Ethnic minorities (excluding white minorities) backgrounds were all more likely than people living in households from White: English, Welsh, Scottish, Northern Irish or British, and White: Irish backgrounds to have fewer bedrooms than required
- People from Black, Black British, Black Welsh, Caribbean or African, and Mixed or Multiple ethnic groups were more likely than other ethnic groups to live in social housing
- People from all groups which were not White: English, Welsh, Scottish, Northern Irish or British were more likely to be living in a household without access to a car or van

People from black and minority ethnic backgrounds are reported to be more likely to develop dementia and develop it at a younger age than the white British population overall. People from black and diverse ethnic community backgrounds tend to access dementia services much later, when they are in crisis, or no longer able to cope alone[77].

[76] Equality and Human Rights Commission (2016), Healing a divided Britain: the need for a comprehensive race equality strategy Healing a divided Britain: the need for a comprehensive race equality strategy | EHRC (equalityhumanrights.com)
[77] Dementia Strategy_October23 FINAL.pdf (gloucestershire.gov.uk)

Chapter 8: ASC needs and conditions

This chapter covers important aspects of ASC such as disability, falls, and hip fractures. These topics are crucial for understanding the needs of older adults and ensuring they receive the right support. By addressing these areas, we can improve the quality of life for older people and help them live independently and healthily.

Disability

The World Health Organisation (WHO)[78] defines disability as an umbrella term, covering impairments, activity limitations and participation restrictions. Disability is therefore not just a health problem but a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which they live. This social model of disability makes the distinction between impairment and disability and considers that disability is caused by the way society is organised, rather than a result of a person's impairment. The focus of this approach is improving life experiences of disabled people by removing barriers that restrict people's life choices.

The Equality Act 2010 defines a disability as a physical or mental condition which has a substantial and long-term impact on a person's ability to do normal day to day activities. This is consistent with the Census definition of a limiting long-term health problem. Broadly speaking, physical disabilities (or impairments when using the WHO terminology) can be caused by congenital anomalies or acquired during the life course.

According to 2021 Census data, 16.8% of residents in Gloucestershire are Disabled under the Equality Act, compared to 17.3% for England[79].

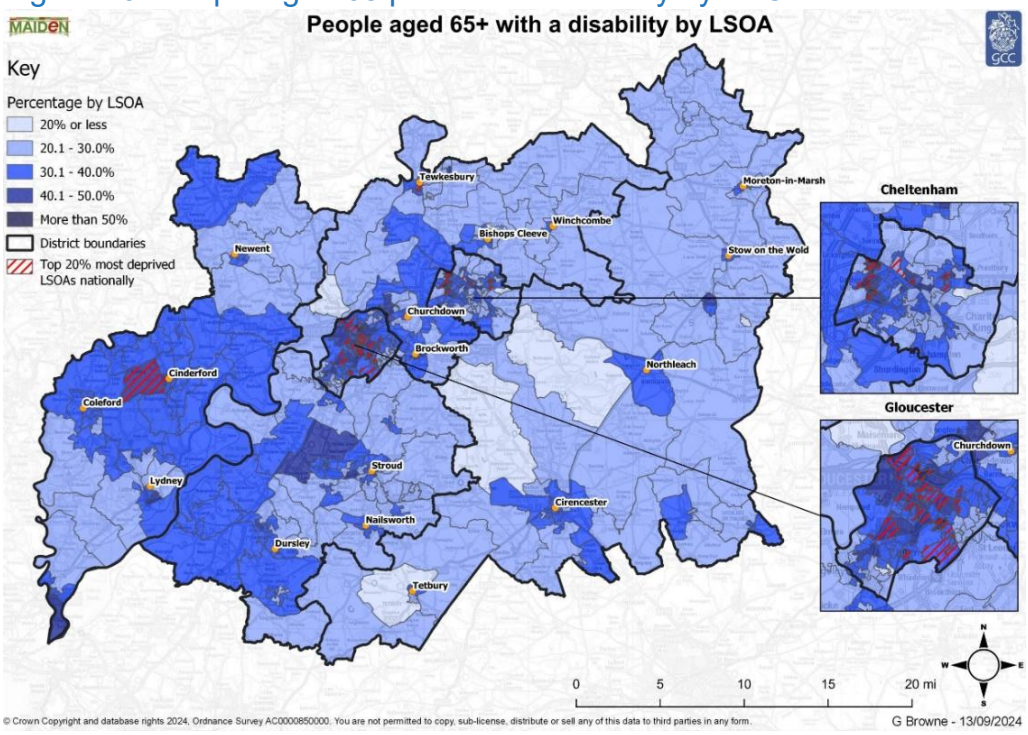
Table 6: People aged 65 plus by disability status, Gloucestershire, and percentage of total Gloucestershire population[80]

	Aged 65 years and over (n)	Aged 65 years and over (%)	Total Populati-on (n)	Total Populati-on (%)
Disabled under the Equality Act: Day-to-day activities limited a little	24973	17.86%	67177	10.41%
Disabled under the Equality Act: Day-to-day activities limited a lot	19386	13.87%	41202	6.39%
Not disabled under the Equality Act: Has long-term physical or mental health condition but day-to-day activities are not limited	13836	9.90%	51411	7.97%
Not disabled under the Equality Act: No long-term physical or mental health conditions	81620	58.38%	485286	75.23%
Grand Total	139815	100%	645076	100%

[78] World Health Organisation (2017) Disability and Health WPR-2017-DNH-005-factsheet-01-disability-eng.pdf (who.int)
[79] ONS Census 2021
[80] ONS Census Data 2021

This data can also be mapped geographically to show where in Gloucestershire residents are reporting disability. Figure 10 below shows people aged 65 and over with a disability by Lower-Level Super Output Area (LSOA).

Figure 10: People aged 65 plus with a disability by LSOA[81]



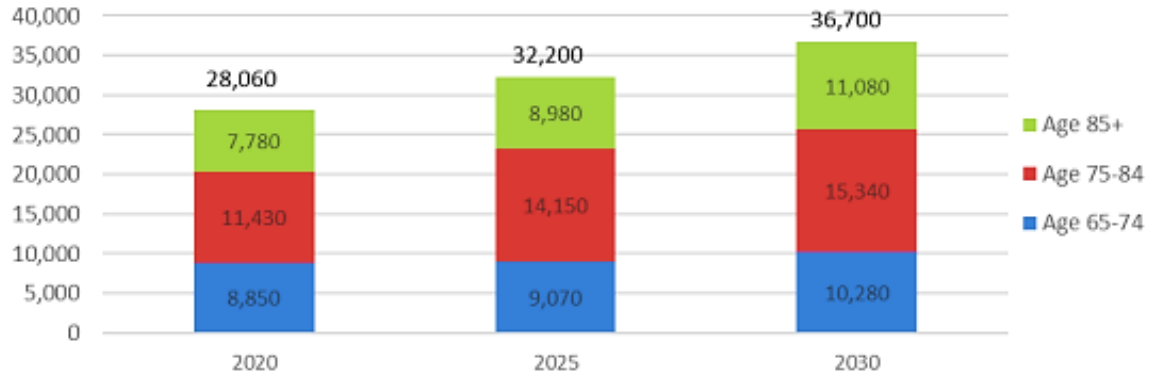
The map also shows the areas included in the top 20% most deprived LSOAs nationally. The majority of these areas have the highest proportion of people aged 65 and over with a disability.

The Projecting Older People Population Information (POPPI) System[82] model forecasted that in 2020, about 28,000 older people in private households would have a long-term illness or disability that limits their day-to-day activities a lot. The model estimated that this number would increase to nearly 37,000 by 2030 (Figure 11). Most of this increase will be in the 75-84, and 85 plus age groups.

[81] ONS Census Data 2021

[82] This system is provided by the Institute of Public Care (IPC) at Oxford Brookes University with supporting funding from Partners in Care and Health.

Figure 11: Projected population aged 65 plus with a limiting long-term illness or disability whose day-to-day activities are limited a lot, Gloucestershire, 2020[83]



Notes: 2016-based projections, numbers rounded

Learning Disabilities

In 2020, estimated projections suggest that by 2024 there would be approximately 12,373 people aged 18+ living with a learning disability in Gloucestershire (see Table 7), equating to 2.3% of the adult population[84] Within this figure, it is estimated that approximately 2,517 will have moderate or severe learning disabilities (equating to 0.5% of the adult population)[85].

Table 7: Estimated number of people with a learning disability by age range, Gloucestershire and districts, 2020[86]

	Total	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Cheltenham	2,232	302	364	370	333	345	254	186	78
Cotswold	1,823	159	204	274	293	343	278	203	70
Forest of Dean	1,698	161	217	237	260	332	260	179	52
Gloucester	2,442	288	428	440	385	393	264	178	66
Stroud	2,304	191	296	361	404	434	323	223	72
Tewkesbury	1,875	145	286	336	295	325	251	176	60
Gloucestershire	**12,373**	**1,247**	**1,795**	**2,015**	**1,964**	**2,175**	**1,632**	**1145**	**400**
England	1,071,395	124,961	187,156	187,066	168,279	169,577	121,822	82,529	30,004

Notes: Figures may not sum due to rounding.

The POPPI model estimated that in 2023 a total of 3,113 adults aged 65 and over had a learning disability and this number is predicted to rise to 4,285 in 2040 (Table 8). The model

[83] POPPI (Projecting Older People Population Information System), 2020. Projected population aged 65 plus with a limiting long-term illness or disability whose day-to-day activities are limited a lot, Gloucestershire. https://www.poppi.org.uk

[84] PANSI (Projecting Adult Needs and Service Information System), 2020. Estimated number of people with a learning disability by age range, Gloucestershire and districts. Available at: http://www.pansi.org.uk/index.php?pageNo=388&areaID=8260&loc=8260

[85] PANSI (Projecting Adult Needs and Service Information System), 2020. Estimated number of people with a learning disability by age range, Gloucestershire and districts. Available at: http://www.pansi.org.uk/index.php?pageNo=388&areaID=8260&loc=8260

[86] PANSI (Projecting Adult Needs and Service Information System), 2020. Estimated number of people with a learning disability by age range, Gloucestershire and districts. Available at: http://www.pansi.org.uk/index.php?pageNo=388&areaID=8260&loc=8260

suggests that the numbers of people with learning disability decrease as people get older, significantly so past aged 75.

Table 8: People aged 65 plus predicted to have a learning disability, by age range, Gloucestershire, 2023 to 2040[87]

	2023	2025	2030	2035	2040
People aged 65-74 predicted to have a learning disability	1,621	1,654	1,885	2,069	2,034
People aged 75-84 predicted to have a learning disability	1,104	1,183	1,275	1,337	1,553
People aged 85 and over predicted to have a learning disability	388	411	497	638	698
Total population aged 65 and over predicted to have a learning disability	**3,113**	**3,247**	**3,657**	**4,043**	**4,285**

Notes: Numbers may not sum due to rounding.

People with a learning disability often experience poorer physical and mental health and may develop conditions associated with ageing, such as hearing loss or dementia, at a younger age compared to the general population[88].

National data on life expectancy for 2018-19 shows that males with a learning disability have a life expectancy at birth of 66 years, 14 years lower than males in the general population. For females with learning disabilities, this difference increases by three years. Females with a learning disability have a life expectancy of 67 years, 17 years lower than for females in the general population[89]. Everyone with a learning disability should be registered from the age of 14 on their GPs learning disability register and receive an annual health check.

When ageing, people with learning disabilities may find it harder to communicate their needs. NICE guidance sets our further recommendations for care and support in this cohort.

The 2021 Census found that people in Gloucestershire reporting a disability under the Equality Act were more likely than people who were not disabled under the Equality Act to be providing unpaid care, to be living in a household without access to a car or van and to be living in social housing.

The risk of developing dementia is around 4-5 times greater for people with a learning disability and onset of dementia is typically at a younger age[90].

[87] POPPI (Projecting Older People Population Information System), 2023. People aged 65 plus predicted to have a learning disability, by age range, Gloucestershire, 2023 to 2040. https://www.poppi.org.uk
[88] NICE (2018). Care and support of people growing older with learning disabilities. www.nice.org.uk. [Online] 2018. https://www.nice.org.uk/guidance/ng96/
[89] NHS Digital (2020) Health and Care of People with Learning Disabilities, Experimental Statistics: 2018 to 2019 [PAS]. digital.nhs.uk. [Online] 2020. https://digital.nhs.uk/data-andinformation/publications/statistical/health-and-care-of-people-with-learningdisabilities/experimental-statistics-2018-to-2019/condition-prevalence#mortality
[90] Dementia Strategy_October23 FINAL.pdf (gloucestershire.gov.uk)

Currently there are 203 adults aged 65 and over supported by Gloucestershire County Council ASC that have a learning disability, of a total 1509 individuals with learning disabilities registered with GCC ASC[91].

Dementia

Dementia is the loss of cognitive functioning, (thinking, remembering and reasoning) to such an extent that it interferes with a person's daily life and activities. Some people with dementia experience alterations in sensory perception (such as hallucinations); some cannot control their emotions, and their personalities may change. Dementia ranges in severity from the mildest stage, when it is just beginning to affect a person's functioning, to the most severe stage when the person will be completely dependent on others for basic activities of living[92].

Dementia is an umbrella term and includes Alzheimer's disease, vascular dementia, mixed dementia, dementia with lewy bodies (DLB) and frontotemporal dementia. It is a syndrome or group of related symptoms associated with a decline of brain functioning.

Dementia is the condition with the highest 'general outcome weight' in the Cambridge Morbidity Score[93]. The general outcome weight is calculated to predict likelihood of death, unplanned hospital admissions, and GP consultations.

A briefing[94] on effective support for people with dementia referenced the Lancet Commission on Dementia's findings on prevalence, intervention, and care, highlighting modifiable risk factors for dementia throughout the life course quoting

"*It is never too early and never too late in the life course for dementia prevention. Early life (younger than 45 years) risks, such as less education, affect cognitive reserve; midlife (45-65 years), and later life (older than 65 years) risk factors influence reserve and triggering of neuropathological developments. Culture, poverty, and inequality are key drivers of the need for change. Individuals who are most deprived need these changes the most and will derive the highest benefit*" (Livingston *et al*., 2020[95], p. 413).

Figure 12 summarises the estimated Population Attributable Fraction (PAF) of dementia worldwide that could be reduced by eliminating risk factors, and the relative contribution of each factor. It is important to note that, in addition to lifestyle factors, social isolation and hearing loss were identified as key areas where efforts to prevent or delay dementia could be effective in keeping people cognitively active. The evidence indicated that the lack of hearing aid use in those with hearing loss was associated with worse cognitive outcomes.

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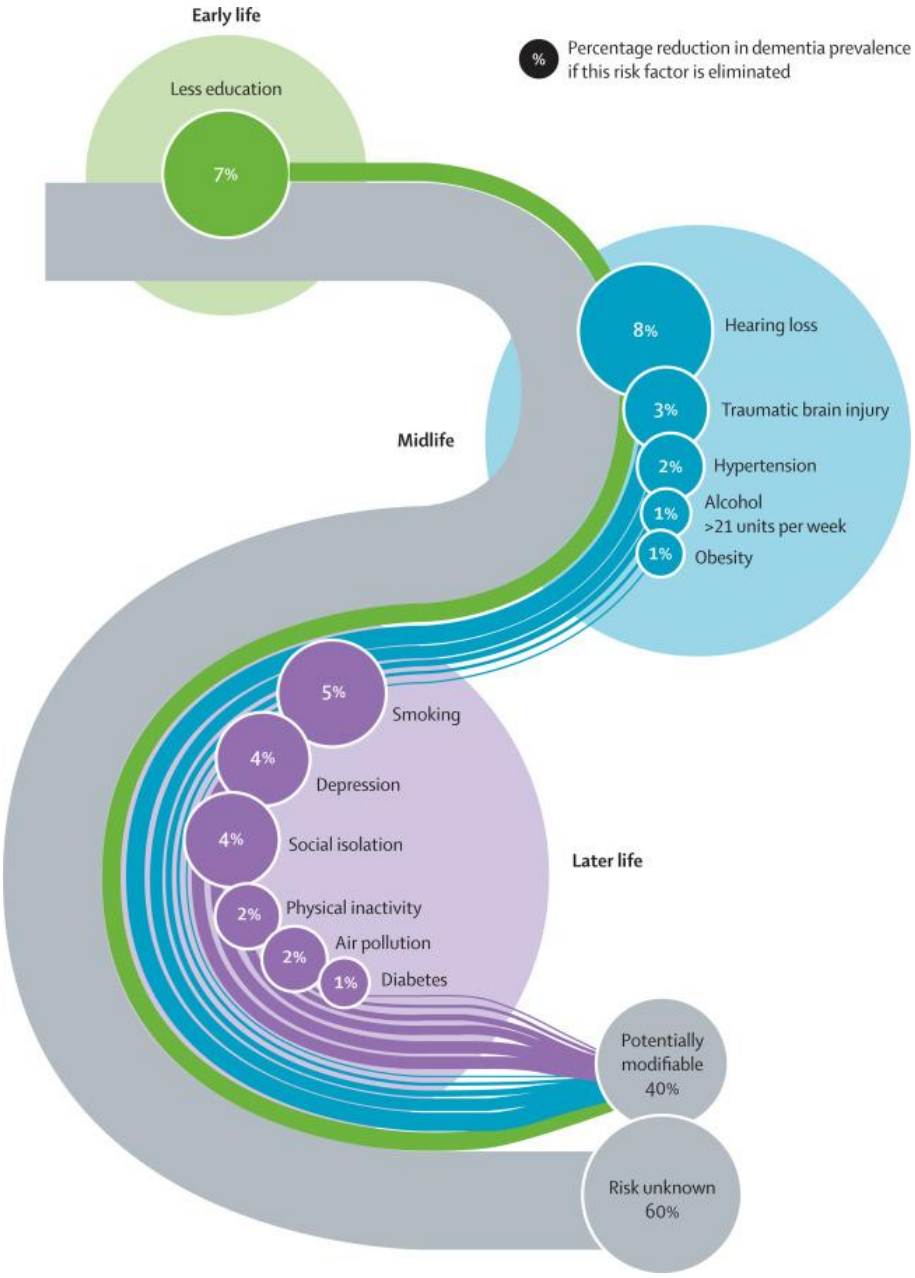
[91] Gloucestershire County Council (2024) Commissioning and Performance data accessed 06/09/24. This figure may be slightly out due to how data is categorised but is an approximate figure.
[92] NIH National Institute on Aging (NIA) July 2021 www.nia.gov/health/what-is-dementia
[93] Development and validation of the Cambridge Multimorbidity Score | CMAJ
[94] Livingston G, Sommerlad A, Orgeta V, Costafreda SG, Huntley J, Ames D, Ballard C, Banerjee S, Burns A, Cohen-Mansfield J, Cooper C, Fox N, Gitlin LN, Howard R, Kales HC, Larson EB, Ritchie K, Rockwood K, Sampson EL, Samus Q, Schneider LS, Selbæk G, Teri L. Dementia prevention, intervention, and care. www.thelancet.com. [Online] 2017. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31363-6/fulltext. 28735855
[95] Livingston G, Huntley J, Sommerlad A, et al. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. The Lancet, 2020

Figure 12: Infographic showing the global PAF of potentially modifiable risk factors for dementia[96]

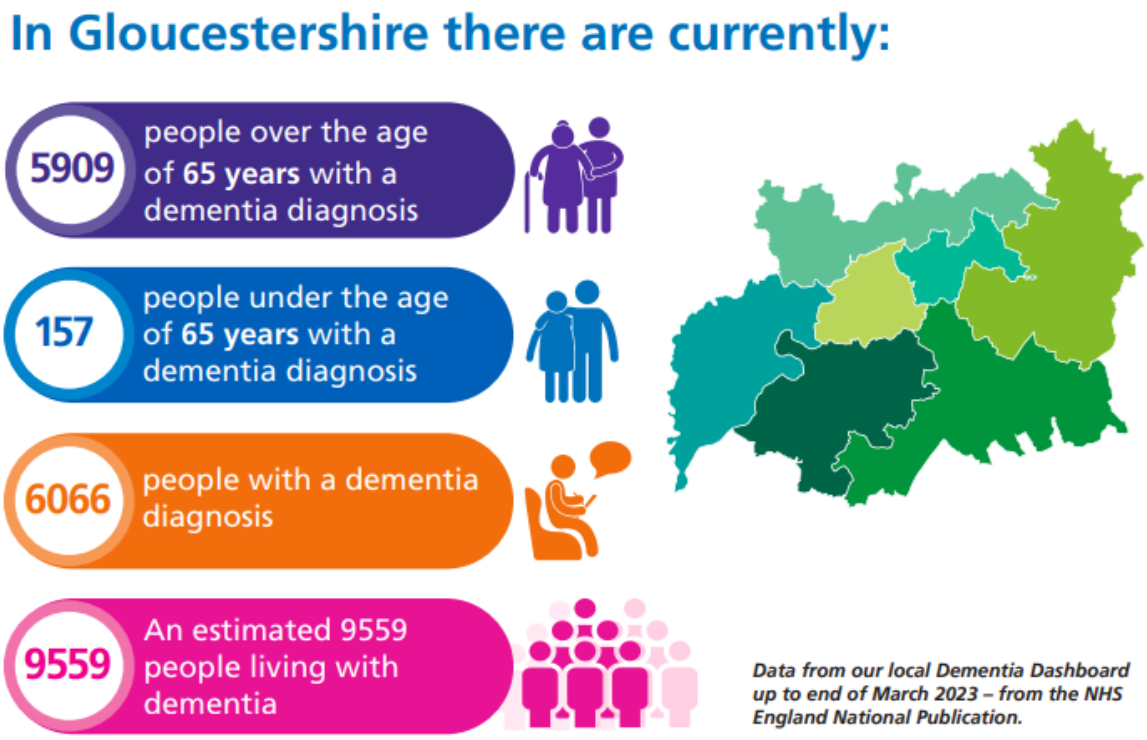


Dementia in Gloucestershire

In Gloucestershire, a needs assessment[97] for dementia was carried out in 2022 and this was used to inform the recently published One Gloucestershire Dementia Strategy 2023-2028[98]. Findings and relevant information from both these key sources are summarised below (Figure 13).

[96] Livingston G, Huntley J, Sommerlad A, et al. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. The Lancet, 2020
[97] 2022 Dementia Needs Assessment V2.pdf (gloucestershire.gov.uk)
[98] Dementia Strategy_October23 FINAL.pdf (gloucestershire.gov.uk)

Figure 13: Infographic detailing dementia in Gloucestershire, to end March 2023[99]



The current dementia diagnosis rate for those over 65 years in Gloucestershire is 65.1%, with the NHS England ambition being 66.7%[100]. All areas saw a drop-in diagnosis rate due to changes in provision during the Covid 19 pandemic. A formal diagnosis is critical as it enables care needs to be assessed and appropriate treatment to be delivered.

Dementia is one of the causes of disability in older people. Estimated projections for 2024 were that approximately 11,000 people in Gloucestershire aged 65+ were living with dementia. The proportion of people with dementia increases with age; people aged 65-69 account for 6.0% of dementia sufferers over 65 in Gloucestershire, which increases to 22.6% for the 80-84 age group. Given Gloucestershire's ageing population, the number of dementia sufferers will increase in the future.

Looking at table 14 below, Gloucestershire is a relatively healthy county compared with the UK average but there is a higher number of residents over the age of 65 and it is known that age is a major risk factor in developing dementia. Health and care professionals should provide support and advice on dementia risk reduction as part of their daily contact with individuals. Using conversation at NHS Health Checks to discuss how prevention in heart health is also protective for dementia risk; Every Contact Counts is a chance to educate and empower people to make positive choices about their own health. Health and care professionals can support the implementation of NHS England's Well Pathway for Dementia and have an impact on an individual and population level. Findings from the 2022 Gloucestershire Dementia Survey indicate that the majority of respondents (58%) had not been given information about reducing their personal risk of developing dementia.

[99] Dementia Strategy_October23 FINAL.pdf (gloucestershire.gov.uk)
[100] Primary Care Dementia Data, September 2024 - NHS England Digital

Table 9: Risk factors for dementia in adults and percentage of risk, Gloucestershire and England, 2022[101]

Risk Factor (for Adults) 2020/2021	Gloucestershire	England
Smokers	12%	14.5%
Age 17+ with diabetes	6.8%	7.1%
Physically inactive	21.4%	23.4%
Obesity	6.7%	6.9%
Hypertension (all ages)	14.3%	13.9%
Admission episodes for alcohol-related conditions	417 per 100,000	456 per 100,000

The Gloucestershire Dementia Needs Assessment[102] carried out in 2022 included a number of recommendations that would be relevant to the development of an ASC Prevention Strategy.

Frailty

The NHS describes frailty as:

"a distinctive state of health related to the ageing process, usually characterised by a complex mix of physical, mental health and social care needs. It is a condition where the body's in-built reserves are eroded, meaning people are vulnerable to sudden changes in their health triggered by seemingly small events, such as a minor infection or a change in medication" (NHS Right care 2016[103]).

People who experience frailty can be at an increased risk of sudden and dramatic changes in their physical and mental well-being, even after seemingly small events such as minor infections and change in medication[104],[105]. The greater the level of frailty, the more impact a small event may have on an individual's health and wellbeing. Frailty can impact at any age; there is however increased risks for older people. Risk factors include BMI, cognitive impairment, loneliness, isolation, hospitalisation, bereavement, depression, living environment, physical activity, disability, nutrition (these include lack of vitamin D, diabetes, metabolic syndrome) sarcopenia, osteoporosis, tobacco and alcohol, polypharmacy, low income, poor self-rated health and a fall in last 12 months[106].

Positive steps can help build resilience and reduce frailty factors. Early identification supported by targeted interventions to build resilience can slow or halt or reduce the progression and impact of frailty.

[101] 2022 Dementia Needs Assessment V2.pdf (gloucestershire.gov.uk)
[102] 2022 Dementia Needs Assessment V2.pdf (gloucestershire.gov.uk)
[103] NHS RightCare. (2016). RightCare Scenario: The variation between standard and optimal pathways. Retrieved from https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/janets-story-frailty-full-narrative.pdf
[104] Turner G, Clegg A. (2014) Best practice guidelines for the management of frailty: A British Geriatrics Society, Age UK and Royal College of General Practitioners report. *Age Ageing*. 2014. https://pubmed.ncbi.nlm.nih.gov/25336440/
[105] https://www.bgs.org.uk/resources/resource-series/fit-for-frailty
[106] https://journals.lww.com/md-journal/Fulltext/2018/01190/Evaluation_of_frailty_and_influencing_factors

Living with frailty brings a number of risks, including:

- Falls
- Delirium
- Mobility and difficulties with activities of daily living
- Delayed transfer of care
- Increase attendance at emergency departments
- Adverse effects from medication
- Increased mortality risk

By identifying and understanding someone's level of frailty, means that plans can be coproduced and the individual empowered, to build resilience that aim to help reduce, halt, or slow frailty.

'Frailty' as a term is often and understood more by health professionals and is not used as frequently or always understood in ASC [107].

Frailty in Gloucestershire

In February 2024, there were 146,000 patients over 65 in Gloucestershire; 78,000 of these have an eFI[108] frailty category of 'Mild', 'Moderate' or 'Severe'. This gives a frailty prevalence of 54%[109].

Of those patients:

- 49,000 are considered to be 'Mildly Frail'
- 21,000 are considered to be 'Moderately Frail'
- 9109 are considered to be 'Severely Frail'

The following analysis illustrates the demography of the current frail population 65+ registered within Gloucestershire using the eFI frailty index. This does not include deceased patients or patients who have moved away and is instead a snapshot of the current frail population within Gloucestershire.

In 2023/2024, 28% of frail patients aged over 65 in Gloucestershire had at least one emergency attendance (as of February 2024) and 30% had at least one emergency admission. Seven percent of frail patients over 65 are living with dementia, while four percent live in a care home. Figure 14 below shows the further breakdown of these patients as per severe, moderate or mild frailty.

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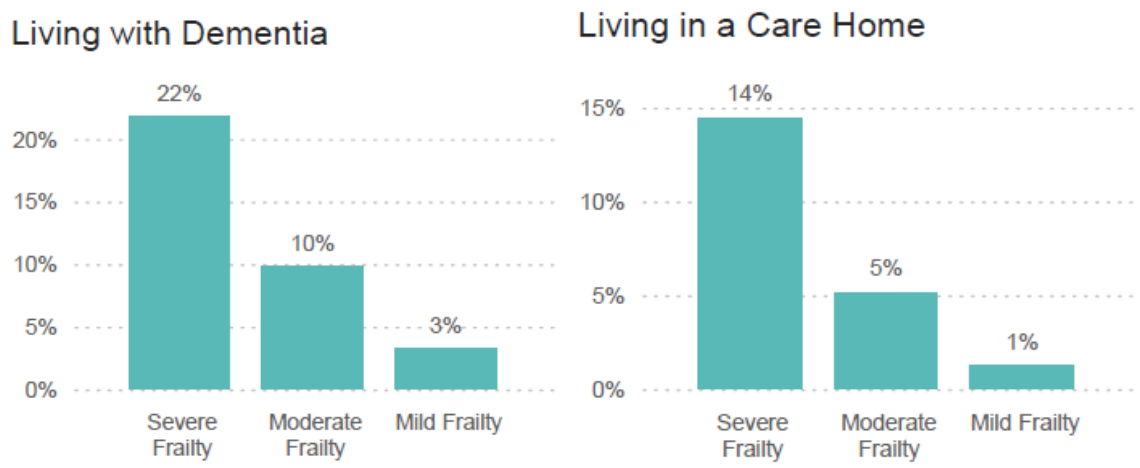
[107] Manthorpe J, Iliffe S, Harris J, Moriarty J, Stevens M. (2018) Frailty and Social Care: Over- or Under-Familiar Terms? *Social Policy and Society*. 2018;17(1):23-33. doi:10.1017/S1474746416000427

[108] Electronic Frailty Index – the eFI is based on 36 physical, mental and social deficits, the presence/ absence of each of these are combined to provide an overall score. The score is then used to classify the population into fit, mild, moderate or severe frailty levels. This isn't a useful measure at individual level

[109] NHS Gloucestershire (2024) Frailty CPG Report. Updated March 2024. Report Reference Number: ICBBI0004.02

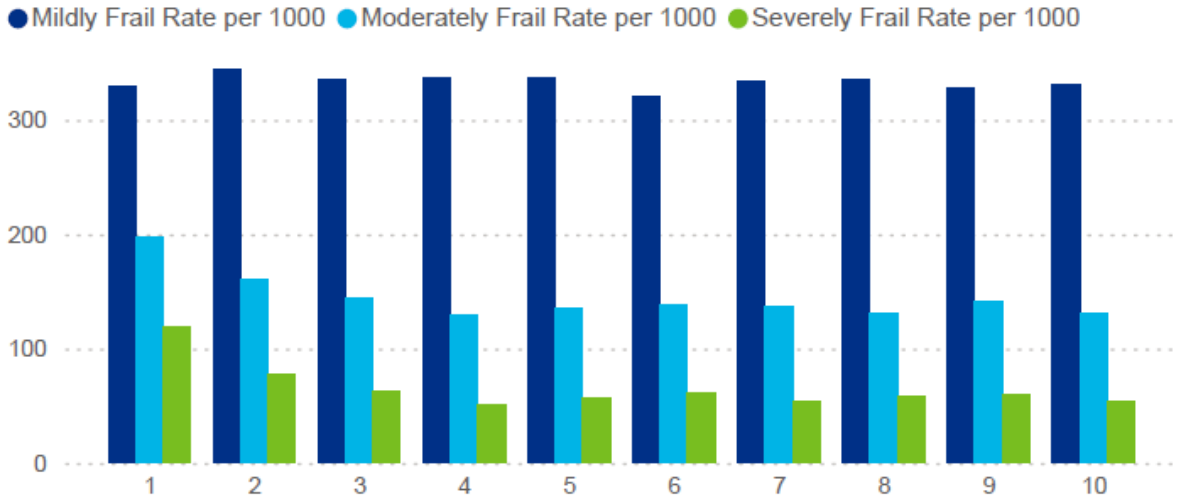
Figure 14: Frail patients living with dementia or living in a care home by level of frailty, shown as a percentage, Gloucestershire, as of February 2024



Source: NHS Gloucestershire (2024) Frailty CPG Report. Updated March 2024[63].

There is a similar distribution of frailty rates across each district in Gloucestershire, however, when the rates are arranged by deprivation decile the top two most deprived deciles experience greater rates (Figure 15).

Figure 15: Frailty prevalence by deprivation decile, Gloucestershire, as of February 2024[110]



In terms of prevention and early intervention, the distribution across age is important. Figure 16 below shows how total frailty increases with age as does the severity of frailty.

[110] NHS Gloucestershire (2024) Frailty CPG Report. Updated March 2024

Figure 16: Frailty prevalence and severity by age range, Gloucestershire, as of February 2024[111]

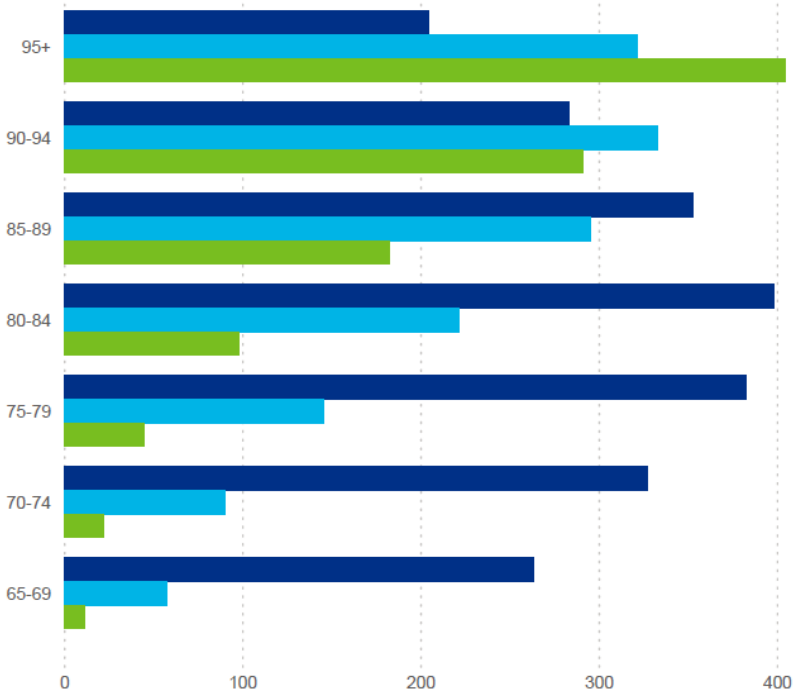
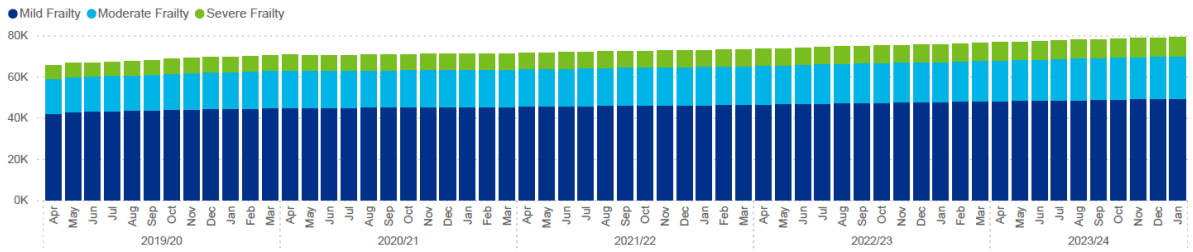


Figure 17 below illustrates how the frail population aged 65+ registered in Gloucestershire has changed over time, it includes patients who are now deceased or have moved away. An overall increase across all levels of frailty is in line with the increasing age of groups affected by frailty in the county.

Figure 17: Frailty prevalence and severity, Gloucestershire, 2019/20 to 2023/24[112]

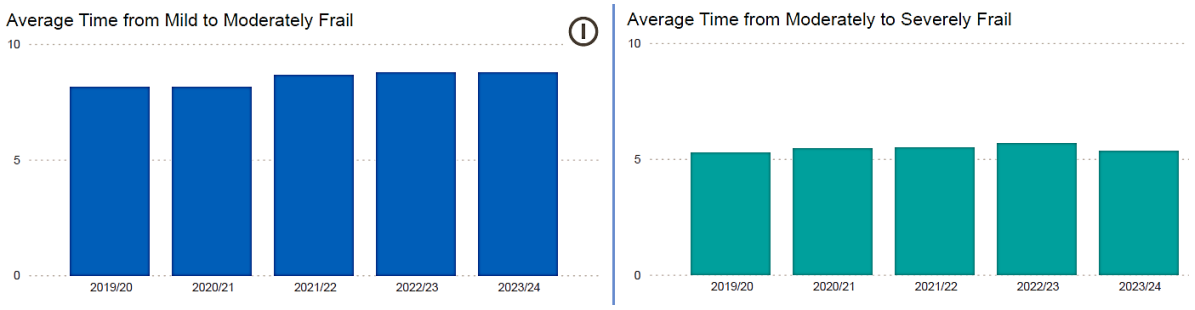


Careful consideration should be given to the time taken for people to move between different stages of frailty. Early identification combined with targeted interventions to build resilience, can slow, reduce, or halt the progression and impact of frailty. Identifying and understanding an individual's level of frailty, along with co-produced plans, enables people to feel empowered and helps build resilience. Figure 18 and Figure 16 below show the average time it takes an individual's level of frailty to go from mild to moderate. In 2021/22 there was a small increase in the average time from mild to moderate frailty, which has

[111] NHS Gloucestershire (2024) Frailty CPG Report. Updated March 2024
[112] NHS Gloucestershire (2024) Frailty CPG Report. Updated March 2024

remained over the past couple of years; this may indicate there are interventions taking place to prevent deterioration.

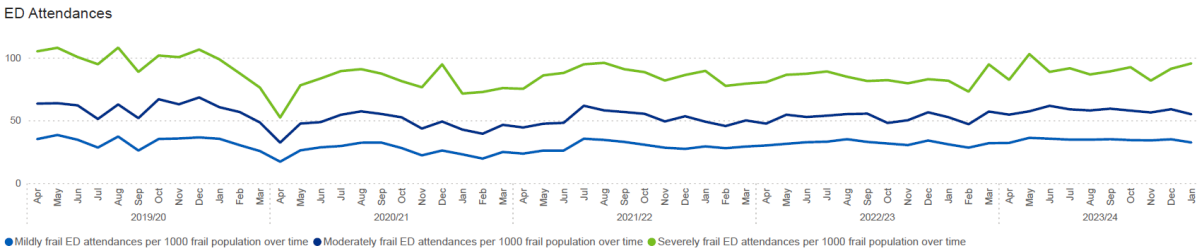
Figure 18 and Figure 19: Average time (years) it takes an individual's frailty to change from mild to moderate, and moderate to severe frailty, Gloucestershire, 2019/20 to 2023/24[113]



Frailty-related emergency department (ED) admissions are a concern for ASC because they often indicate a decline in an individual's health and functional ability, leading to a higher need for ongoing support and care services. These admissions can result in longer hospital stays, increased demand for rehabilitation or long-term care, and greater strain on social care resources. Additionally, frequent hospital visits can reduce the quality of life for frail older adults and may accelerate their dependency on social care, highlighting the need for proactive and preventative measures. There may be opportunities for ASC and partners to intervene before somebody has an incident that ends in an ED admission.

Figure 20 shows the rate of ED attendances per 1000 frail population over time from April 2019 until January 2024. The rate is higher for those who are severely frail and is increasing.

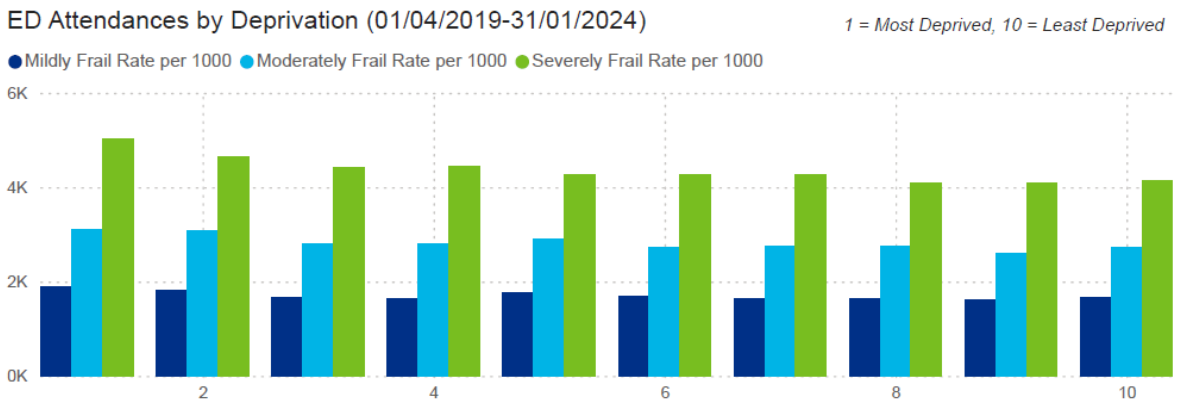
Figure 20: Emergency Department Attendances by Frailty, rate per 1000 frail population over time, as of February 2024[114]



When considering deprivation, frailty-related emergency department admissions become an even greater concern for ASC, and these will often be individuals who are more likely to rely on ASC services. Those from more deprived areas are more likely to have an ED attendance (Figure 21).

[113] NHS Gloucestershire (2024) Frailty CPG Report. Updated March 2024
[114] NHS Gloucestershire (2024) Frailty CPG Report. Updated March 2024

Figure 21: Emergency Department Attendances by Deprivation, rate per 1000, as of February 2024[115]



In 2021 needs assessment[116] was carried out focused on Frailty and Dementia and a number of key themes were identified that would be relevant to the development of an ASC Prevention Strategy.

Falls and Hip Fractures

Falls and fall-related injuries are a common and serious problem for people as they age. As well as the physical impact of the fall such as cuts, bruises and fractures, falls can lead to adverse psychological and social outcomes. Loss of mobility and confidence can cause loneliness, social isolation and loss of independence. Older people who fall and are unable to get back up are at risk of hypothermia and pressure-related injuries.

According to OHID data[117], in Gloucestershire in 2022/23, there were a total of 2,070 emergency hospital admissions due to falls in people aged 65 and over, the majority of which (1,380) were for people aged 80 and over (Figure 22). When compared with its statistical neighbours, Gloucestershire's rate of falls (per 100,000) comes out best. There will, however, be more older people who fall and seek non-emergency care or no care at all. The county's ageing population means a preventative approach to falls reduction is needed, perhaps targeted more at females whose falls rate is considerably higher across all age breakdowns (65 and over, 65 to 79, and 80 plus) than the rate for males.

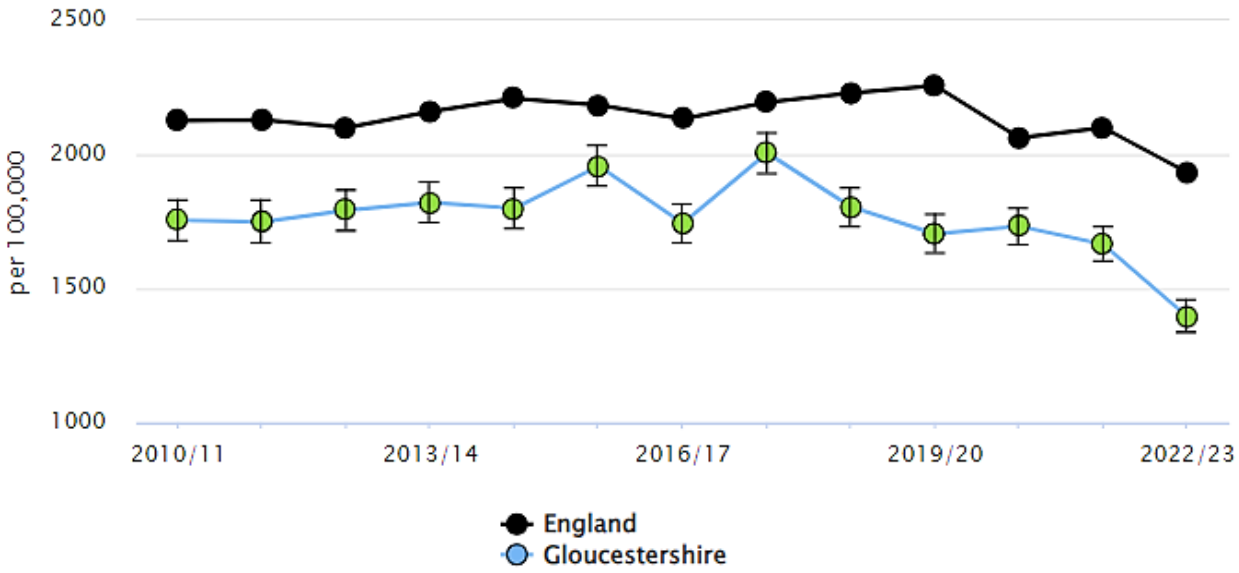
[115] NHS Gloucestershire (2024) Frailty CPG Report. Updated March 2024
[116] One Gloucestershire (2021) Frailty and Dementia Needs Assessment 2021 (not published online)
[117] Fingertips | Department of Health and Social Care (phe.org.uk)

Figure 22: Emergency hospital admissions due to falls in people aged 65 plus, Gloucestershire and statistical neighbours, 2022/23[118]

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	209,989	1,933	1,925	1,941
Neighbours average	↓	-	-	-	-	-
Cheshire East	→	2	2,145	2,248	2,154	2,345
Cheshire West and Chester	↓	7	1,665	2,099	1,999	2,203
West Sussex	↓	8	4,730	2,098	2,038	2,159
Staffordshire	→	9	4,030	2,025	1,963	2,089
Kent	→	11	6,575	1,955	1,908	2,003
Warwickshire	↓	5	2,485	1,913	1,839	1,990
Wiltshire	→	6	2,290	1,907	1,830	1,987
Leicestershire	→	15	2,845	1,867	1,799	1,937
Nottinghamshire	↓	4	3,370	1,865	1,802	1,929
Central Bedfordshire	↓	10	975	1,842	1,728	1,962
Essex	↓	14	5,825	1,766	1,721	1,813
Hampshire	↓	3	5,705	1,708*	1,664	1,753
Worcestershire	↓	1	2,355	1,624	1,558	1,691
Suffolk	↓	12	2,840	1,471	1,417	1,526
Gloucestershire	↓	-	2,070	1,395	1,335	1,456
Buckinghamshire UA	→	13	-	*	-	-

Figure 23 shows that when looking at falls data over time, Gloucestershire consistently has fewer falls per 100,000 than the England average. Across all age brackets, there has been a decline in the falls rate in Gloucestershire since 2010/11, with a steeper decline from 2020/21 (Figure 23, Figure 24, Figure 25).

Figure 23: Emergency hospital admissions due to falls in people aged 65 plus, Gloucestershire and England, 2010/11 to 2022/23[119]



[118] Fingertips | Department of Health and Social Care (phe.org.uk)

[119] Fingertips | Department of Health and Social Care (phe.org.uk)

Figure 24: Emergency hospital admissions due to falls in people aged 65 to 79, Gloucestershire and England, 2010/11 to 2022/23[120]

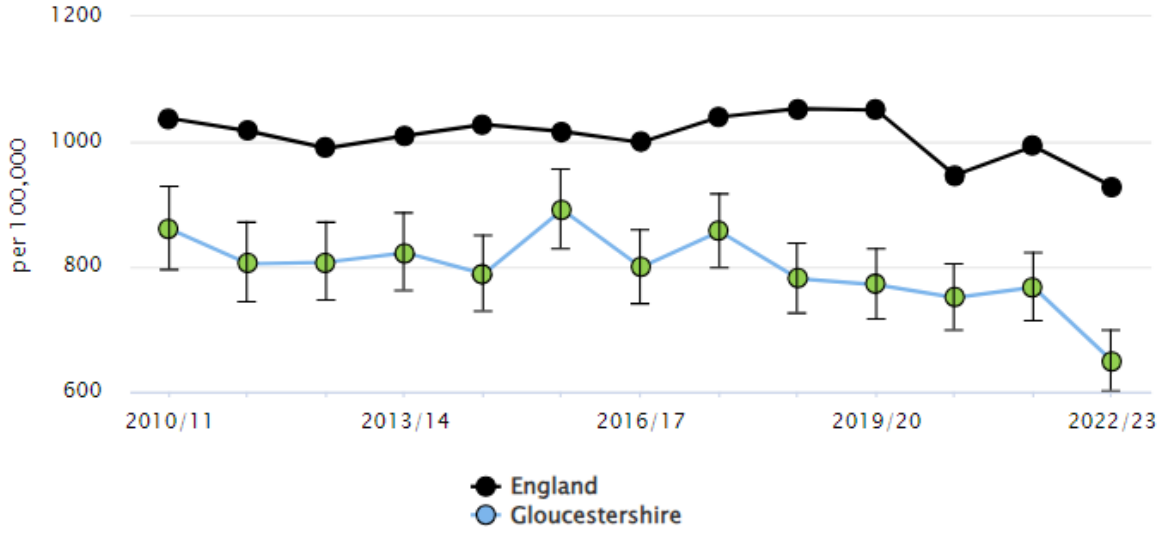
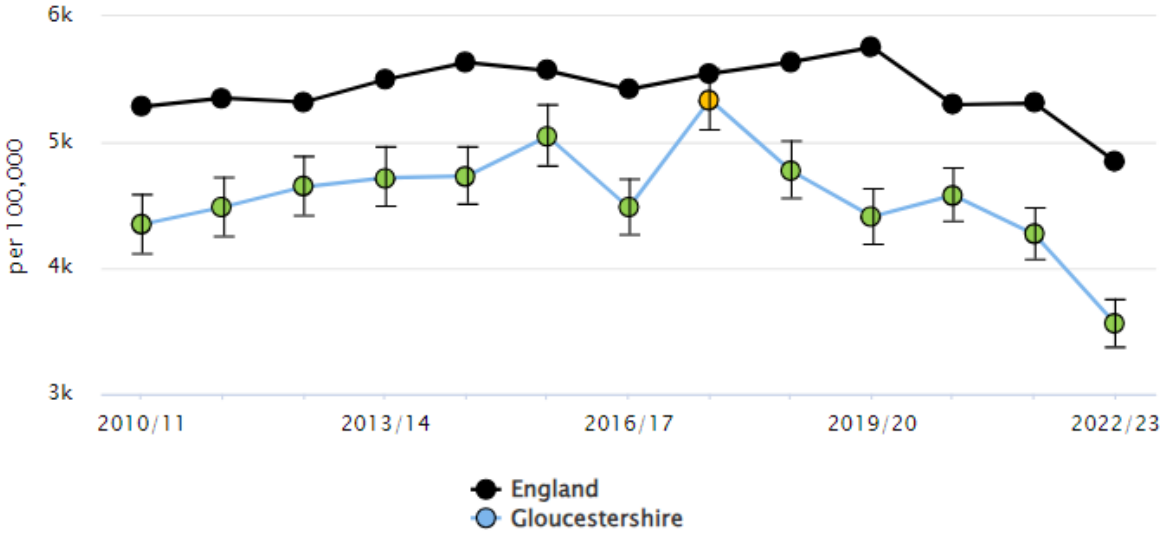


Figure 25: Emergency hospital admissions due to falls in people aged 80 plus, Gloucestershire and England, 2010/11 to 2022/23[121]



Hip fractures

Only one in three people who experience hip fracture return to their former level of independence, and one in three ends up moving to long term care. The average age of a person with hip fracture is about 83 years in the UK, and about 73 percent of cases are women[122]. There is a high prevalence of comorbidity in people with hip fracture, and a high

120 Fingertips | Department of Health and Social Care (phe.org.uk)
121 Fingertips | Department of Health and Social Care (phe.org.uk)
122 Fingertips | Department of Health and Social Care (phe.org.uk)

mortality rate, with about one in ten people suffering a hip fracture dying within one month and about one in three within 12 months[123].

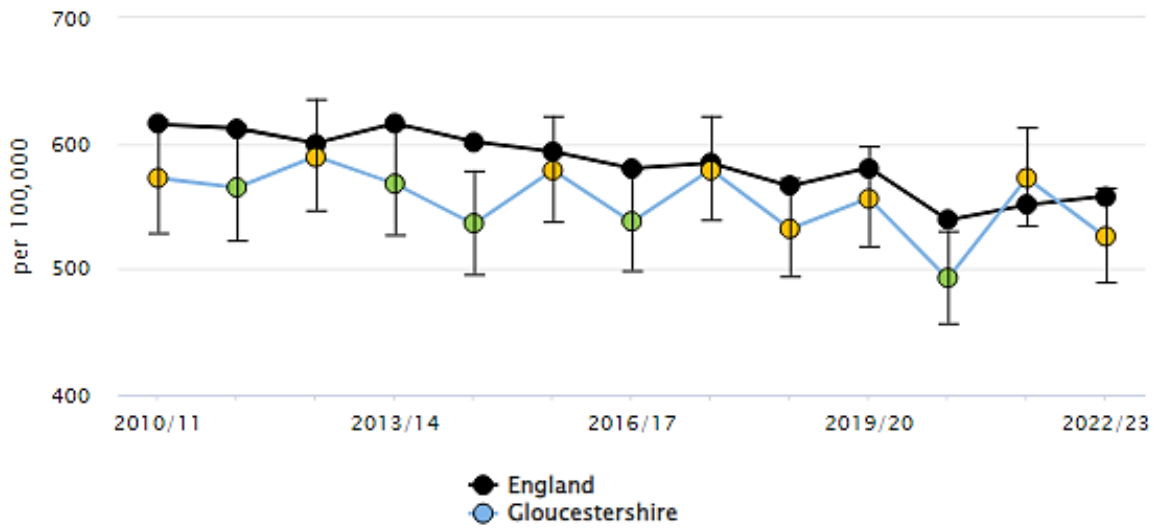
Hip fracture rates for Gloucestershire in people aged 65 plus is detailed below in Figure 26. Gloucestershire's rates across all age groups are average compared to other statistical neighbours, and the sharp increase in age 80 plus can also be seen across all geographical areas. Across all age groups females have a considerably higher rate than males, which aligns with data for the UK.

Figure 26: Hip fractures in people aged 65 plus, rate per 100,000, Gloucestershire and statistical neighbours, 2022/23[124]

Indicator	Period	England	Gloucestershire	1 - Warwickshire	2 - Worcestershire	3 - Suffolk	4 - West Sussex	5 - Somerset Cty	6 - Staffordshire	7 - North Yorkshire Cty	8 - Cambridgeshire	9 - Leicestershire	10 - Essex	11 - Devon	12 - Oxfordshire	13 - Nottinghamshire	14 - Hampshire	15 - Cumbria
Hip fractures in people aged 65 and over	2022/23	558	526	574	622	451	515	-	578	-	589	566	572	534	569	602	468*	-
Hip fractures in people aged 65 to 79	2022/23	243.8	219.5	251.9	257.6	195.2	219.8	-	258.2	-	245.5	231.7	239.4	222.4	240.9	252.8	212.3*	-
Hip fractures in people aged 80 and over	2022/23	1469	1413	1510	1680	1194	1371	-	1506	-	1586	1534	1536	1436	1522	1614	1210*	-

When looking at hip fracture data over time for Gloucestershire, no significant change or improvement has remained, rates have fluctuated since 2010/11. However, there was a decrease between 2021/22 and 2022/23, perhaps resulting from limitations to going outside due to COVID-19 lockdowns.

Figure 27: Hip fractures in people aged 65 plus, rate per 100,000, Gloucestershire and England, 2010/11 to 2022/23[125]



[123] Royal College of Physicians (2013) National Hip Fracture Database http://www.nhfd.co.uk/20/hipfractureR.nsf/luMenuDefinitions/CA920122A244F2ED802579C900553993/$file/NHFD%20Report%202013.pdf?OpenElement

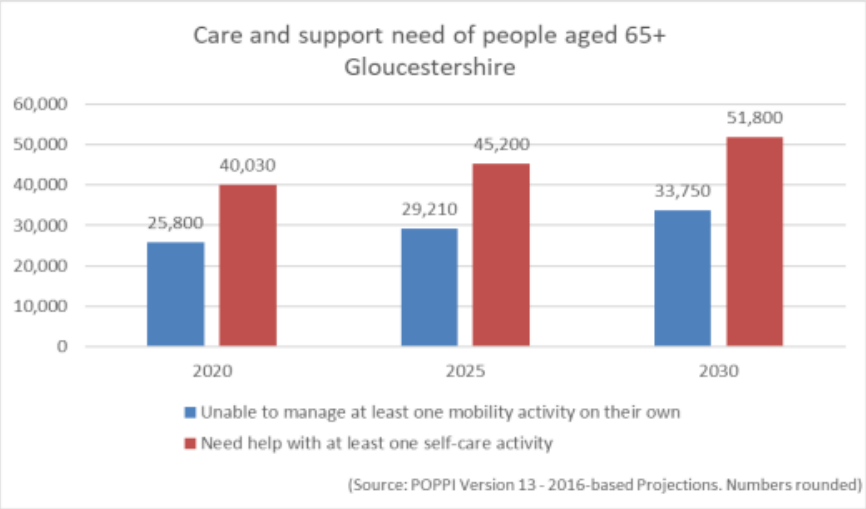
[124] Fingertips | Department of Health and Social Care (phe.org.uk)

[125] Fingertips | Department of Health and Social Care (phe.org.uk)

Chapter 9: Carers

Using results from the Living in Britain Survey, the POPPI model estimated in 2020 that about 25,800 people aged 65 and over in Gloucestershire are unable to manage at least one mobility activity on their own[126]. This number is projected to increase to 33,800 in 2030. It is also estimated that about 40,000 older people are unable to manage at least one self-care activity on their own[127], which is expected to increase to 51,800 in 2030.

Figure 28: Number of people aged 65 plus who need help with self-care, and who are unable to manage at least one mobility activity alone, Gloucestershire, 2020[128]



Notes: Numbers have been rounded

Carers

The NHS defines a carer as “anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support”[129]. The care they give is unpaid. We know that carers often have significant pressures to balance work, school/study, caring responsibilities, childcare and other commitments. Caring can look different for each person and includes but is not limited to: Children and young people supporting parents and siblings, adults supporting spouses and family members with long term conditions, parents supporting children with a disability.

In the 2021 Census, there were 51,862 unpaid carers in Gloucestershire (8.9% of the population, down from 10.5% in the previous Census)[130].

[126] Mobility activities include going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; and getting in and out of bed.
[127] Self-care activities include bathe, show er or w ash all over; dress and undress; get in and out of bed; feed; and take medicines.
[128] Projecting Older People Population Information (POPPI). (2020). Number of people aged 65 plus who need help with self-care, and who are unable to manage at least one mobility activity alone, Gloucestershire. Projecting Older People Population Information System
[129] NHS England. Who is considered a carer? www.england.nhs.uk. [Online] https://www.england.nhs.uk/commissioning/comm-carers/carers/.
[130] ONS 2021 Census

Characteristics of carers

Carers caring for long hours are more likely to experience poor health themselves and are less likely to be economically active. Many carers face very difficult financial situations, often finding their own income affected by due to having to give up work or reduce their hours to provide care or because they use their own income or savings to pay for care or support services, equipment or products for the person they care for.

In 2022/23, Gloucestershire County Council ASC supported almost 4,100 carers. The majority of carers were female (71%); this has remained broadly consistent over time[131].

Just under half (44%) of carers were within the 18-64 years range (typically working-age people), this is similar to prior to the pandemic. Carers aged 65-84 years also made up 44% of those receiving support for their caring responsibilities, while 10% of carers were aged 85 years and over[132].

While the proportion of carers by age remains consistent prior to the pandemic, almost three-fifths of carers retired at the end of 2022/23 (57%). This is an increase from 50% in 2019/20 and could relate to the trend in people taking themselves out of the job market early since the pandemic. A quarter of people cared for another person in addition to working full-time or part-time (26.0%, up from 15.7% prior to the pandemic). 8% of carers were unemployed and 3% reported that they were unable to work due to their caring responsibilities[133].

Most carers were white (93%, white British, white Irish, white other). People from diverse ethnic communities made up 1% or fewer of carers each but equated to just under 200 people representing a wide range of backgrounds.

One-fifth of new carers had a disability or health need of their own (39%). The majority of these were categorised as 'Other' need (32%). This has increased from around 10% over the past three years, impacting visibility of the types of vulnerabilities that our carers may be coping with and which their caring responsibilities may place a strain upon. No carers were recorded as having a mental health condition, down from 9% the previous year[134].

Almost three-fifths of carers chose not to disclose whether they had a physical or mental health condition (57%); this has followed an increasing trend over time.

Almost 80% of carers were married, in a civil partnership, or living with a partner. The marital status for 9.5% of our carers had not been disclosed, and around 12.5% of carers were single, separated, divorced, or widowed.

Almost three-fifths (58%) of carers cared for a spouse/partner of another member of their family. This has followed an increasing trend over time, up from 44% four years ago. Around 17% of carers were supporting a parent with their needs. This has been similar for the last three years but is up from 12% prior to the pandemic. The proportion of carers supporting the needs of their child has fluctuated over time but accounted for one-fifth of caring

[131] Gloucestershire County Council (2023) Adult Social Care Service User Diversity Report 2022/23
[132] ibid
[133] ibid
[134] Gloucestershire County Council (2023) Adult Social Care Service User Diversity Report 2022/23

arrangements in 2022/23 (22%). A small proportion (around 1%) of carers cared for a neighbor or friend and 8% of carers had a child/children who they were responsible for in addition to their caring responsibilities[135].

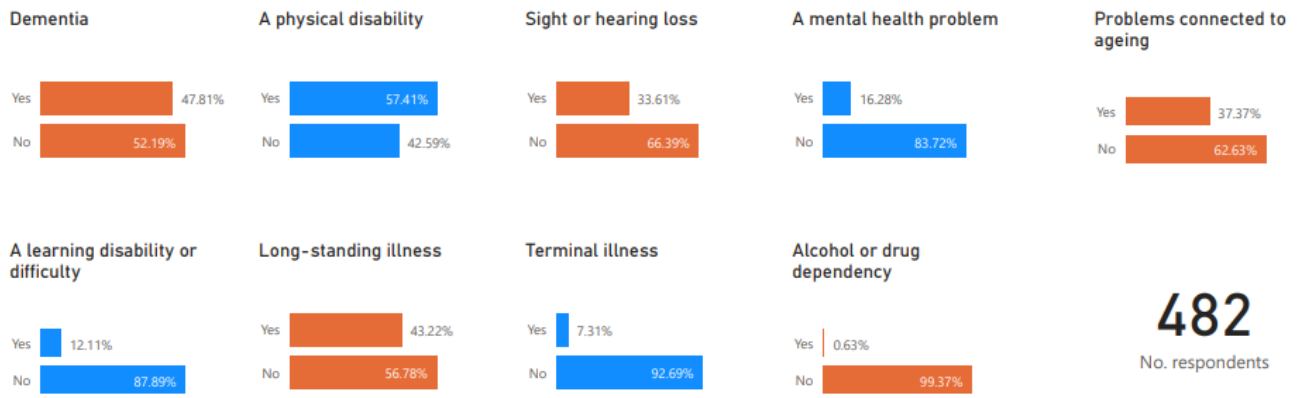
Just over one-third of those cared for had needs relating to memory or cognition (35%, up slightly from 31% prior to the pandemic), while almost 30% of people cared for had a long-term health condition.

In the ASC Service User Diversity Report 2022/23, it is highlighted that it is important to understand the changes in carers reporting physical or mental health conditions) of their own (increase in non-disclosure and conditions categorised as 'other', no disclosures of mental health conditions). The question is asked as to whether ASC staff are having the right conversations with carers to ensure support needs are well-sighted and managed so that carers can maintain their own health while sustaining their caring role.

The carers survey[136] carried out by Gloucestershire County Council in 2021/22 was a postal questionnaire sent out to 852 carers and had a response rate of 56.6% (482 respondents). Of these respondents, 77.18% were age 65 and over and 62.66% were female. In terms of who was being cared for, 78.01% were aged 65 and over.

Carers were asked what the conditions those they care for have. The results are displayed in Figure 29. The majority had a physical disability, followed by dementia and then long-standing illness.

Figure 29: What does the person cared for have? GCC Carer Survey 2021/2022 key findings[137]



Nearly a third of respondents (33.18%) said they hadn't received any support services from ASC in the last 12 months.

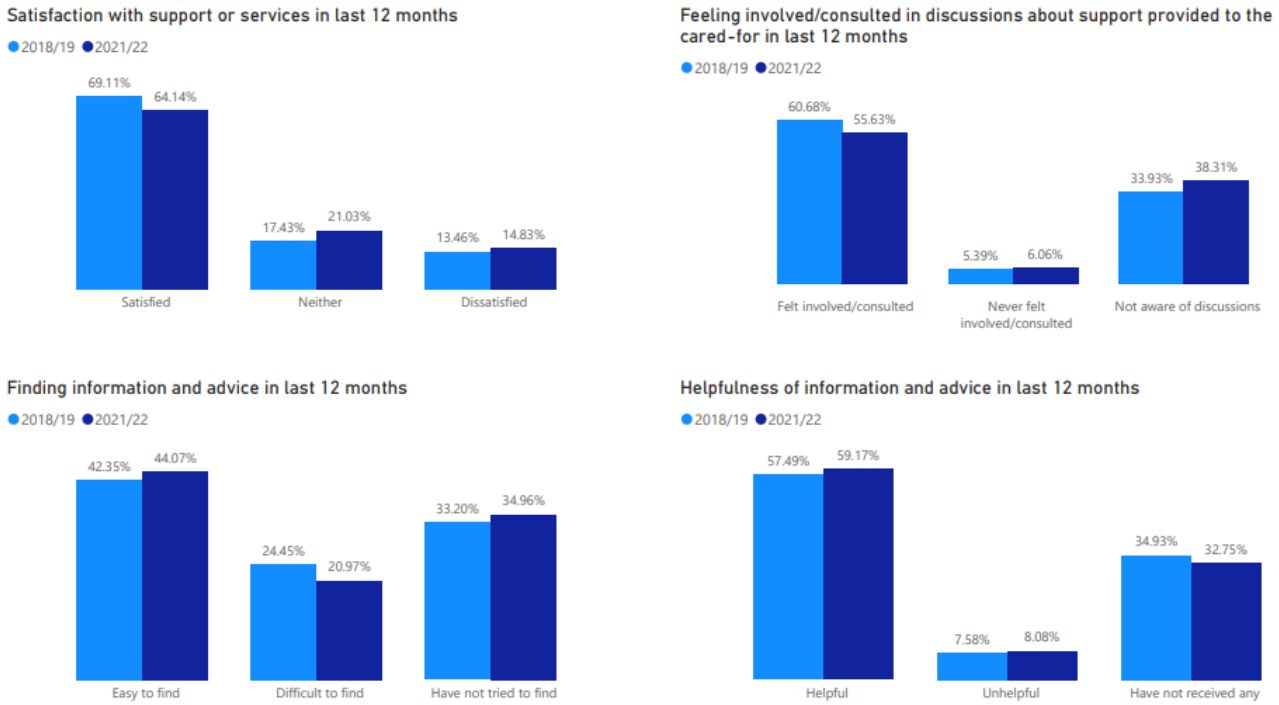
For those who received services in 2021/22, 64.14% were satisfied with the support, a decline from 69.11% in 2018/19. When asked about feeling involved/consulted in discussions about support provided to the cared-for in last 12 months, 55.56% said they felt

[135] Ibid.
[136] Gloucester County Council, (2023) Carers Survey 2021/22 https://www.gloucestershire.gov.uk/media/hicncrwk/carersurvey_202122_findings.pdf
[137] Inform Gloucestershire, Gloucestershire County Council (2022) Survey of Adult Carers 2021/22 Findings carersurvey_202122_findings.pdf (gloucestershire.gov.uk)

involved/consulted (60.68% in 20218/19). Just 6.06% said they never felt involved/consulted and 38.38% said they were not aware of discussions.

For finding information and advice in the last 12 months, 44.07% of carers reported it as easy to find, an increased from 42.35% in 2018/19. However, 20.97% said it was difficult to find and 34.96% had not tried to find information and advice. For those that found the information and advice in the last 12 months, 59.17% had found it helpful; just 8.08% had not found it helpful and 32.75% had not received any (see figure 53).

Figure 30: Experience of support and services, GCC Carer Survey 2021/2022 key findings[138]



Quality of life of carers

Carers were also asked questions regarding the quality of life (see fFigure 31). Only 14.11% of carers felt they were able to do things as they want, a slight decrease from the year before. Just over two thirds (67.37%) said ‘some but not enough’ and 18.65% said none, a slight increase from the previous year. There was a similar pattern for when carers were asked if they felt they had control over daily life; 17.99% said they had as much as they want, 62.13% said they had some but not enough and 19.87% felt they had no control.

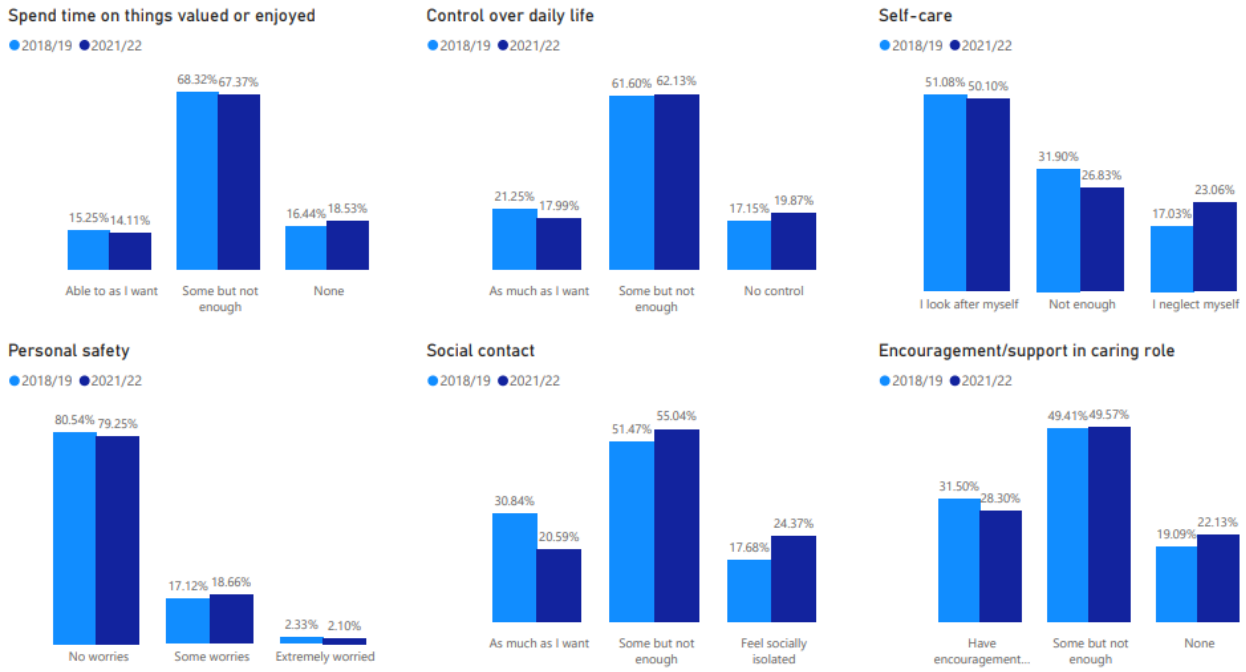
Carers were asked about self-care and over half (50.10%) felt they did look after themselves, but 26.83% answered ‘not enough’ and 23.06% said they neglect themselves; this was an increase from 17.03% in 2018/19.

Just over a fifth (20.59%) of carers had as much social contact as they wanted. This was quite a drop from 2018/19 where 30.84% had as much as they wanted. Over half felt they had some but not enough and 24.37% stated they feel socially isolated. When asked about

[138] Inform Gloucestershire, Gloucestershire County Council (2022) Survey of Adult Carers 2021/22 Findings carersurvey_202122_findings.pdf (gloucestershire.gov.uk)

encouragement/support in their caring role, 28.30% felt they have encouragement and support, down from 31.5% in 2018/19. Just under half of respondents felt they had some but not enough and 22.13% felt they had none and increase from 19.09% in the previous year.

Figure 31: Quality of Life, GCC Carer Survey 2021/2022 key findings[139]



Carer services and support

Respondents were asked about support or services used by the person they care for in the last 12 months (see fFigure 32). The majority of respondents hadn't received any services listed. However, one service was different, and this was equipment or adaptation to their home.

[139] Inform Gloucestershire, Gloucestershire County Council (2022) Survey of Adult Carers 2021/22 Findings carersurvey_202122_findings.pdf (gloucestershire.gov.uk)

Figure 32: Has the person you care for used any of the support or services listed below in the last 12 months? GCC Carer Survey 2021/2022 key findings[140]

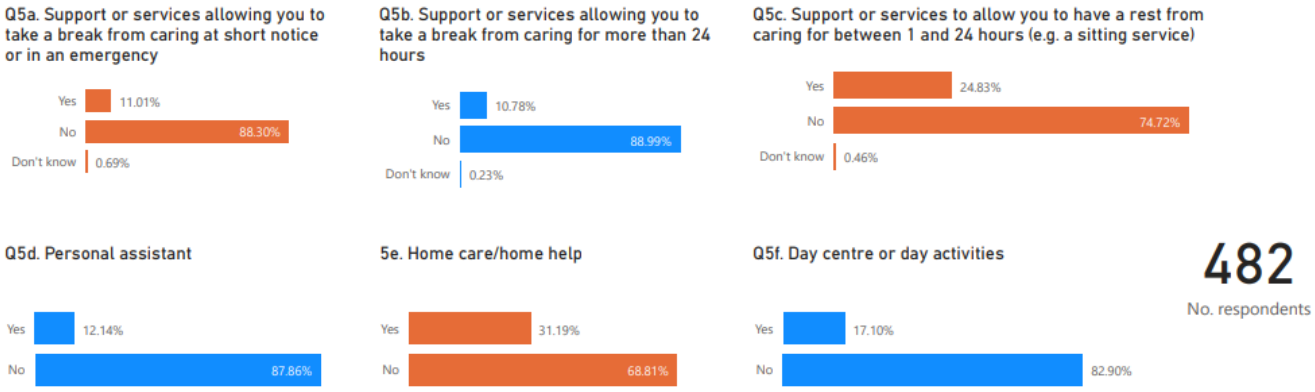
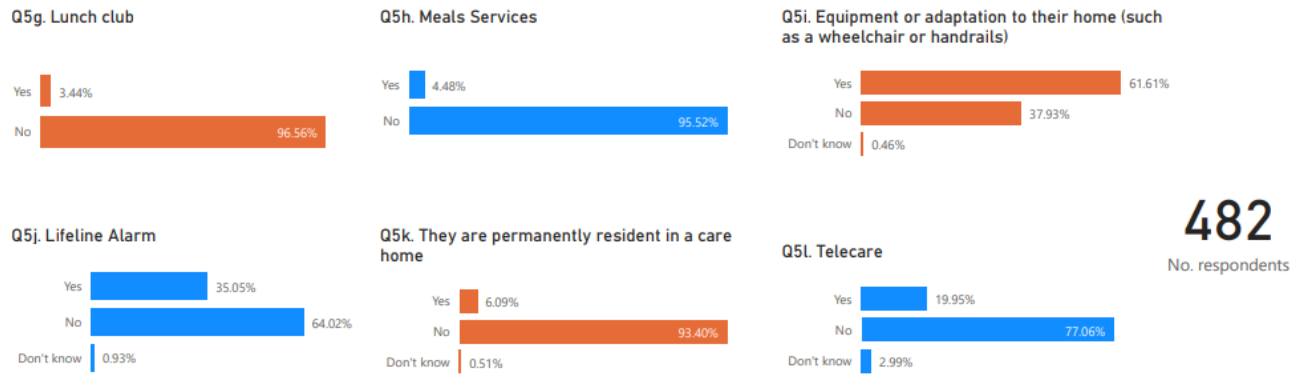


Figure 33: Has the person you care for used any of the support or services listed below in the last 12 months? GCC Carer Survey 2021/2022 key findings[141]

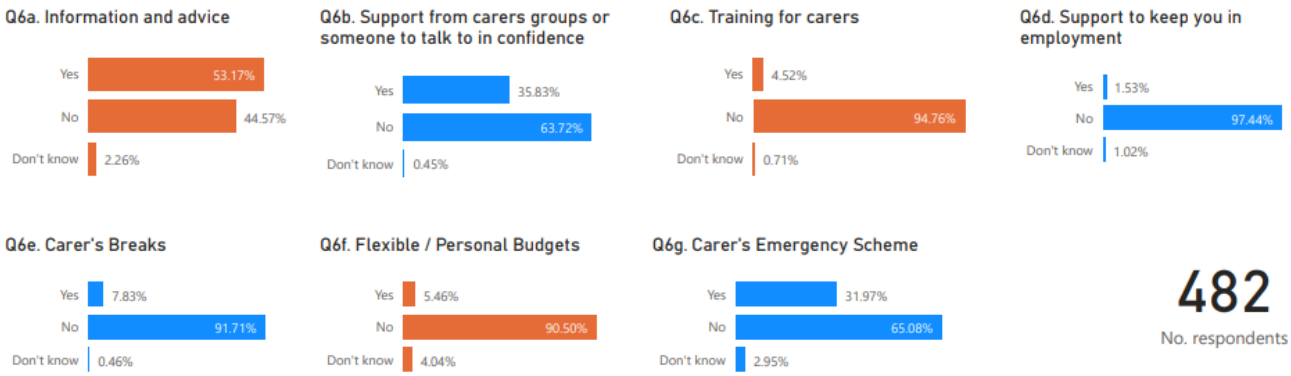


Looking at the results for use of services alongside the finding of information and advice, this could be because carers are not aware of what is available to them and the people they care for.

Carers were also asked about a variety of other support or services available to them that could also be provided by a variety of organisations including voluntary organisations, private agencies or social care (see fFigure 34). Here the results were more diverse. However, most carers were not receiving support or services.

[140] Inform Gloucestershire, Gloucestershire County Council (2022) Survey of Adult Carers 2021/22 Findings carersurvey_202122_findings.pdf (gloucestershire.gov.uk)
[141] Inform Gloucestershire, Gloucestershire County Council (2022) Survey of Adult Carers 2021/22 Findings carersurvey_202122_findings.pdf (gloucestershire.gov.uk)

Figure 34: Have you used any of the support or services listed below, to help you as a carer over the last 12 months? (exc family and friends) GCC Carer Survey 2021/2022 Key findings[142]



Summary of needs of carers

In summary, the 2021/22 Gloucestershire carers survey reveals a decline in satisfaction with support services and involvement in care decisions compared to 2018/19. Challenges persist in accessing helpful information and advice, with many carers feeling socially isolated and lacking sufficient support. Additionally, a significant portion of carers reported struggles with self-care and control over their daily lives, indicating unmet needs in these areas. The data suggests a need for improved support and engagement strategies for carers to enhance their quality of life and care experience.

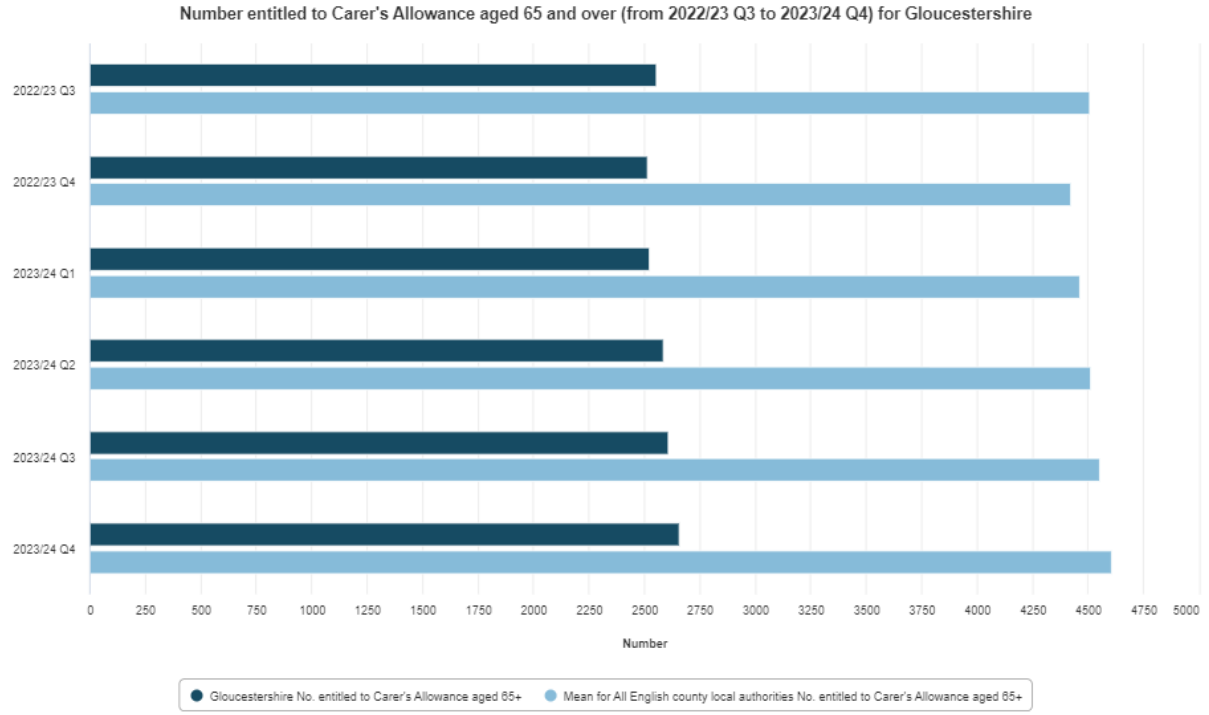
The survey highlights concerning trends in carer satisfaction, involvement, and well-being, underscoring the necessity for targeted interventions to address these gaps. To improve outcomes, a more proactive and supportive approach is needed, focusing on better communication, access to resources, and addressing social isolation among carers. Enhancing the quality of life for carers is essential to ensuring effective and sustainable care for those they support.

Carer's Allowance is the primary welfare benefit designed to assist carers. Many individuals may not identify as carers, but if they support a partner, friend, or relative who would struggle to manage without their help, they qualify as carers. It is not necessary to be related to or live with the person being cared for.

Figure 35 below shows the number entitled to Carer's Allowance aged 65 and over. This is the total count for all entitled cases of Carer's Allowance for people aged 65 and over living in the area. It refers to the age of the carer and not the care recipient. To claim Carer's Allowance, the individual must be aged 16 or over. There is no additional payment for caring for more than one person. If multiple people care for the same individual, only one can claim Carer's Allowance. The amount paid is typically increased annually each April.

[142] Inform Gloucestershire, Gloucestershire County Council (2022) Survey of Adult Carers 2021/22 Findings carersurvey_202122_findings.pdf (gloucestershire.gov.uk)

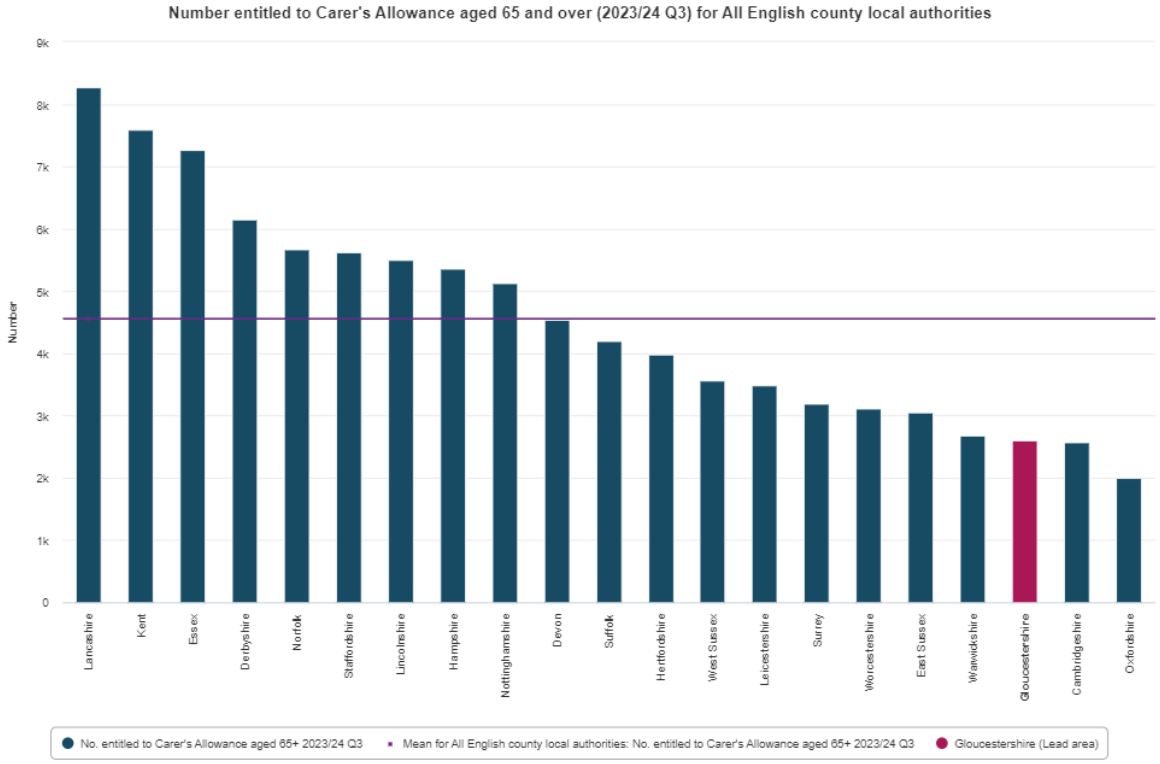
Figure 35: Number entitled to Carer's Allowance aged 65 and over (from 2022/23 Q3 to 2023/24 Q4) for Gloucestershire[143]



[143] Department of Work and Pensions (2024), cited as a source by LG Inform Number entitled to Carer's Allowance aged 65 and over in Gloucestershire | LG Inform (local.gov.uk) accessed 28.05.24

Figure 36 below shows there are a fewer people aged 65 and over that are entitled to carer's allowance compared to similar local authorities.

Figure 36: Number entitled to Carer's Allowance aged 65 and over (2023/24 Q4) for all English county local authorities[144]



Source:
Department for Work and Pensions

[144] Department of Work and Pensions (2024), cited as a source by LG Inform Number entitled to Carer's Allowance aged 65 and over in Gloucestershire | LG Inform (local.gov.uk) accessed 28.05.24

Chapter 10: Screening and immunisation

NHS screening

Population screening is the process of identifying and testing individuals who may have an increased chance of a disease or condition. Most people who are screened appear healthy and will pass through the screening without needing further investigation. Some people, however, will be flagged from the screening and need further tests to investigate whether they have the condition being screened for. Screening helps with early identification and can save lives and reduce someone's chances of developing a serious condition. Screening cannot guarantee that someone will never develop a disease or condition, and as with any diagnostic testing, false positives and negatives can occur[145].

The Covid-19 pandemic impacted on the running of all screening services in England but mainly adult ones[146]. The NHS England screening programme for adults in 2020 to 2021 (latest information) consists of five programmes, three of which are for cancer:

- NHS Abdominal Aortic Aneurysm Screening Programme - offered to males from aged 65 (most at risk cohort), it reduces premature deaths in this cohort from ruptured AAAs by up to 50% through early detection, appropriate follow-on tests and referral for potential treatment[147].
- Diabetic Eye Screening Programme - offered annually to people aged 12 plus who have diabetes. Screening detects diabetic retinopathy, which can cause sight loss if left undiagnosed and untreated[148].
- Bowel cancer screening - targeted at people aged 54 to 74 but is being gradually rolled out to people from age 50[149].
- Breast cancer screening - offered to women aged 50 to 71[150].
- Cervical screening - available to anyone with a cervix aged 25 to 64 in England. Anyone registered as female with their GP will receive an automatic invitation to cervical screening[151].

Abdominal Aortic Aneurysm (AAA) screening programme

Data for the NHS AAA Screening Programme is provided by Gov.UK quarterly and is available both regionally and by local screening service[152]. Latest data, published June 2024, is for quarter three (1st October to 31st December) 2023 and shows the South West region performing top at 73.4 percent for the percentage of eligible men who are tested for AAA, including compared to the England average of 62.6 percent. Gloucester AAA Screening Cohort is towards the bottom across all South West regions at 61.6 percent, compared to Peninsula at 82 percent and Dorset and Wiltshire at 80.2 percent. Across

[145] Population screening explained - GOV.UK (www.gov.uk)
[146] NHS screening programmes in England: 2020 to 2021 - GOV.UK (www.gov.uk)
[147] Abdominal aortic aneurysm screening: programme overview - GOV.UK (www.gov.uk)
[148] NHS diabetic eye screening (DES) programme - GOV.UK (www.gov.uk)
[149] Bowel cancer screening: programme overview - GOV.UK (www.gov.uk)
[150] Breast screening: programme overview - GOV.UK (www.gov.uk)
[151] Cervical screening: programme overview - GOV.UK (www.gov.uk)
[152] NHS population screening programmes: KPI reports 2023 to 2024 - GOV.UK (www.gov.uk)

quarters two and three, Gloucester AAA Screening Cohort meets the acceptable but not the achievable threshold, an improvement from quarter one, meaning that the service is expected to put measures in place for improvement that is both rapid and sustainable.

Cancer screening

Breast cancer screening rates across all ICBs in the South West for 2022/23 are roughly similar, and are higher than the England average, with Gloucestershire ICB producing the highest rate at 71.9 percent of eligible women[153]. There are no data available for previous years.

Figure 37: Breast cancer screening coverage for women aged 53 to 70, past 36 months, South West NHS Regions, 2022/23[154]

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	4,305,230	66.6	66.6	66.7
South West NHS Region	–	498,650	70.6*	70.5	70.7
NHS Gloucestershire Integrated Care Board - QR1	–	58,275	71.9	71.6	72.2
NHS Dorset Integrated Care Board - QVV	–	71,205	71.3	71.0	71.6
NHS Devon Integrated Care Board - QJK	–	112,720	71.3	71.0	71.5
NHS Cornwall and the Isles of Scilly Integrated Care Board - QT6	–	54,875	70.5	70.2	70.8
NHS Somerset Integrated Care Board - QSL	–	52,825	70.1	69.7	70.4
NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board - QOX	–	79,820	70.0	69.7	70.2
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board - QUY	–	68,930	69.2	68.9	69.5

Source: NHS England, Breast Screening Programme

The cervical cancer screening rate for Gloucestershire ICB, 2022/23, is highest across all South West ICBs at 77.7 percent of eligible women (Figure 38). Aside from Cornwall and the Isles of Scilly ICB at 74.4 percent, all other South West ICBs have similar rates of approximately 76 percent. Compared with 2021/22 data, Gloucestershire's cervical cancer screening rate has remained the same, however, the count (number of people screened) has increased by roughly 500 people.

Figure 38: Cervical screening coverage for women aged 50 to 64, past 5.5 years, South West NHS Regions, 2022/23[155]

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	⬇	4,037,949	74.9	74.9	75.0
South West NHS Region	–	427,454	76.4*	76.3	76.5
NHS Gloucestershire Integrated Care Board - QR1	–	50,516	77.7	77.4	78.0
NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board - QOX	–	72,259	76.8	76.5	77.0
NHS Devon Integrated Care Board - QJK	–	93,123	76.5	76.3	76.8
NHS Dorset Integrated Care Board - QVV	–	58,264	76.4	76.1	76.7
NHS Somerset Integrated Care Board - QSL	–	44,728	76.3	76.0	76.7
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board - QUY	–	63,541	76.1	75.9	76.4
NHS Cornwall and the Isles of Scilly Integrated Care Board - QT6	–	45,023	74.4	74.0	74.7

Source: NHS England, Cervical Screening Programme

153 Cancer Services - Data | Fingertips | Department of Health and Social Care (phe.org.uk)
154 Cancer Services - Data | Fingertips | Department of Health and Social Care (phe.org.uk)
155 Cancer Services - Data | Fingertips | Department of Health and Social Care (phe.org.uk)

Overall, the South West region's rates for bowel cancer screening are higher than the England average, with Gloucestershire ICB (at 76.3 percent) marginally lower than Dorset ICB (at 76.4 percent) and Devon ICB (at 76.5 percent). Compared with 2021/22 data, Gloucestershire ICB improved both the number of people screened for bowel cancer by more than 3,000 people and improved (by 2 percent) the percentage of the eligible population screened.

Figure 39: Bowel screening coverage for people aged 60 to 74, South West NHS Regions, 2022/23[156]

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	6,675,930	72.0	72.0	72.0
South West NHS Region	–	797,070	75.6*	75.5	75.7
NHS Devon Integrated Care Board - QJK	–	183,425	76.5	76.3	76.7
NHS Dorset Integrated Care Board - QVV	–	117,785	76.4	76.2	76.7
NHS Gloucestershire Integrated Care Board - QR1	–	90,570	76.3	76.1	76.6
NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board - QOX	–	125,575	76.1	75.9	76.3
NHS Somerset Integrated Care Board - QSL	–	86,900	75.4	75.2	75.7
NHS Cornwall and the Isles of Scilly Integrated Care Board - QT6	–	88,720	74.6	74.4	74.9
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board - QUY	–	104,095	73.2	72.9	73.4

Source: NHS England, Bowel Cancer Screening Programme

NHS Health Checks

The NHS Health Check is a free service in England for individuals aged 40 to 74 without specific pre-existing conditions. Every five years, individuals are invited to attend to assess the risk of developing certain health problems including heart disease, diabetes, kidney disease, and stroke. During the check, healthcare professionals measure height, weight, waist, blood pressure, and cholesterol. They discuss risk reduction strategies and may provide cardiovascular risk scores. The checks are a good opportunity for early intervention in middle age to prevent dementia but also a key touch point for 65–74-year-olds with their doctor to keep them healthy if they are not attending regularly for other reasons. However, it can be a challenge to ensure that people at most risk are accessing the checks. A high uptake up of NHS Health Checks is important to identify early signs of poor health leading to opportunities for early interventions. Local authorities have a legal duty to arrange provision of the NHS Health Check programme to 100% of the eligible population over a five-year period and to achieve continuous improvement in uptake.

Data below demonstrates the progress made by Gloucestershire in offering NHS Health Checks; Gloucestershire has a considerably lower percentage of appointments offered than the mean for all English county level authorities (Figure 40). Figure 41 demonstrates where Gloucestershire compares with other similar local authorities.

156 Cancer Services - Data | Fingertips | Department of Health and Social Care (phe.org.uk)

Figure 40: NHS Health Checks: Appointments offered (annual %) (from 2018/19 to 2023/24) for Gloucestershire[157]

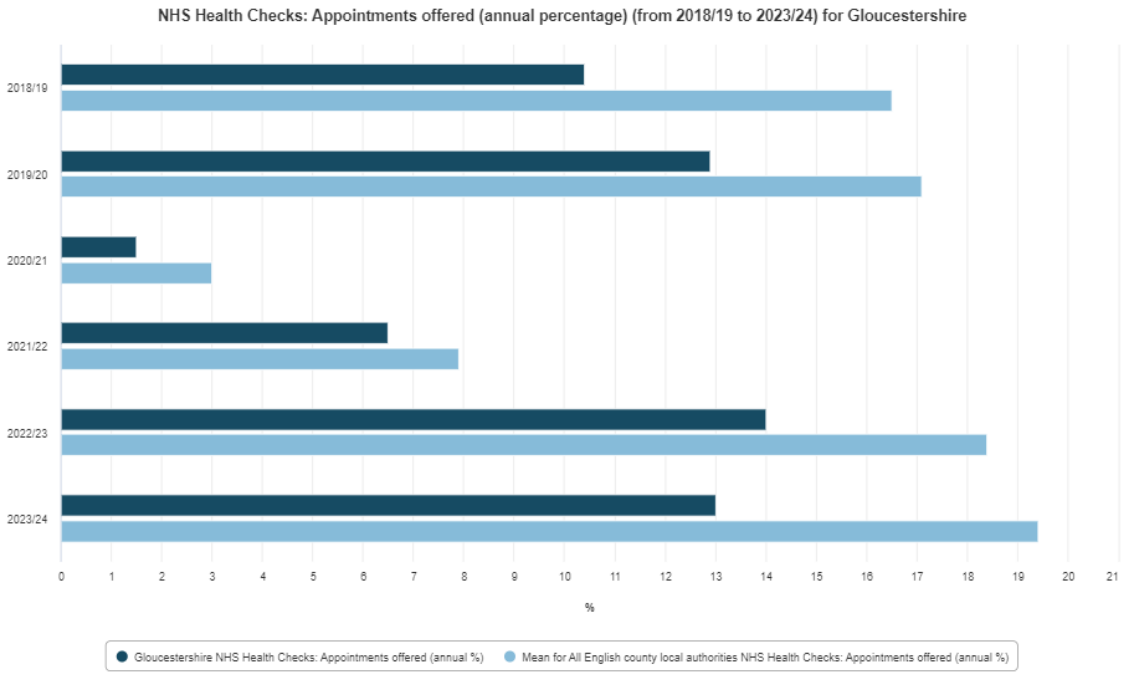
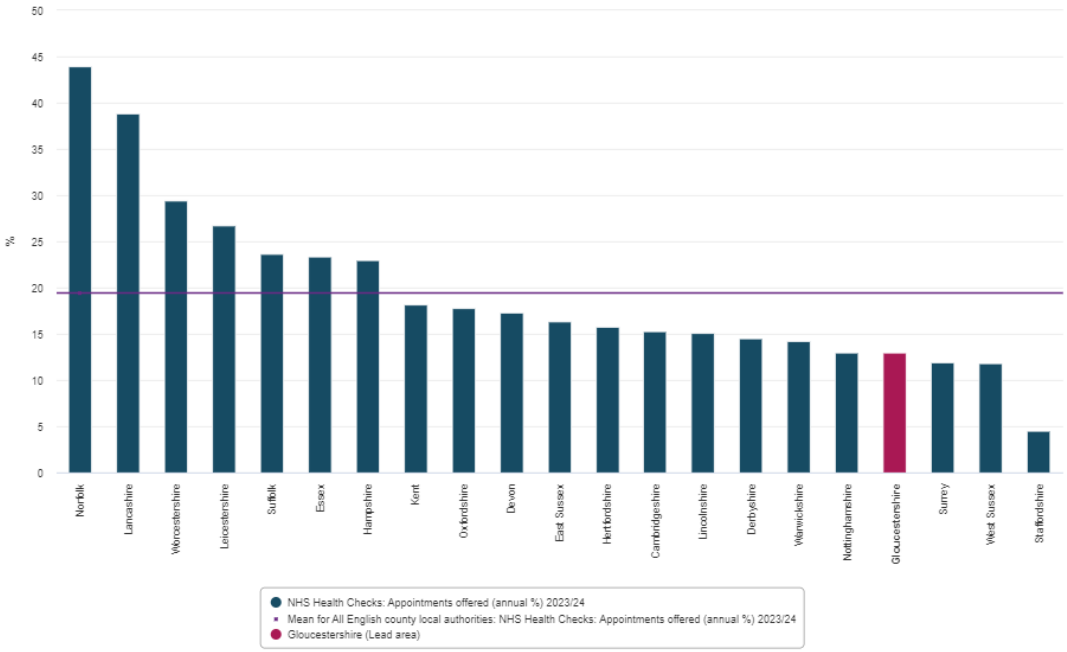


Figure 41: NHS Health Checks: Appointments offered (annual %) (2023/24) for all English county local authorities[158]

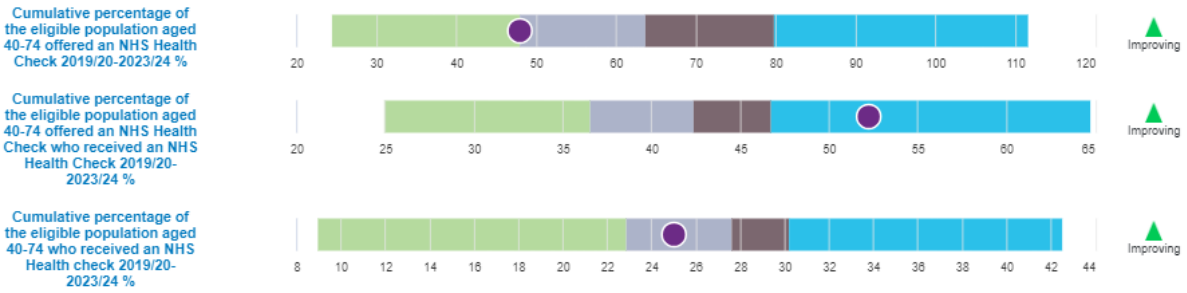


The cumulative percentage of the eligible population offered and receiving an NHS Health Check is a key indicator of the programme's reach and effectiveness. For Gloucestershire this is displayed in Figure 42. Even though the performance is lower than other English

157 NHS Health Checks: Appointments offered (annual percentage) in Gloucestershire | LG Inform
158 NHS Health Checks: Appointments offered (annual percentage) in Gloucestershire | LG Inform

counties, Gloucestershire has been improving and in particular for those being offered and then receiving the check.

Figure 42: NHS Health Checks: Cumulative Percentage of the eligible population aged 40-74 offered and NHS Health check and received an NHS Health Check[159]



Vaccinations

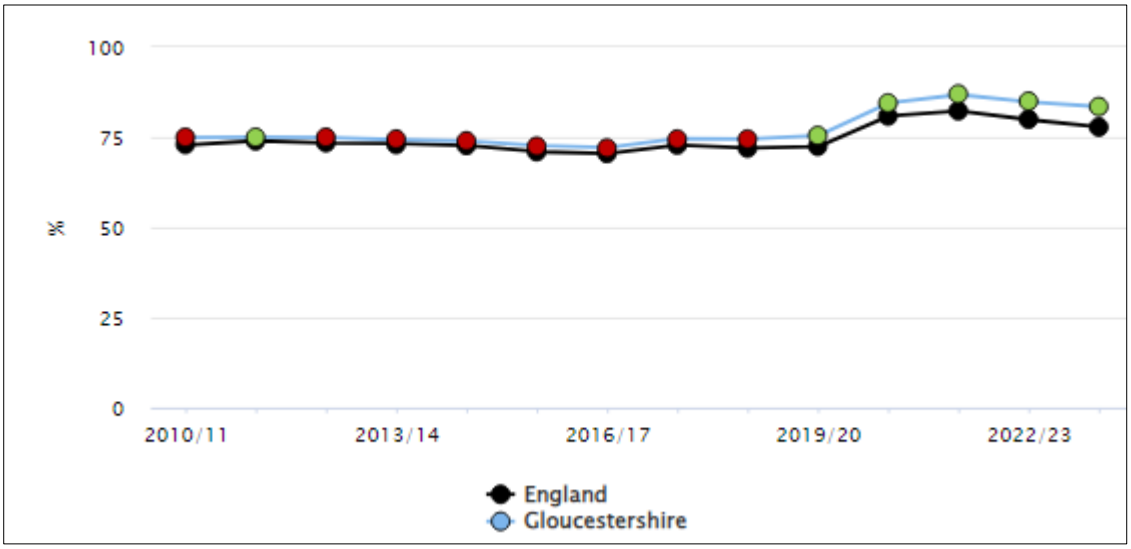
Vaccinations help reduce the transmission and negative health effects of preventable infections, particularly benefiting older adults who are more vulnerable to serious health consequences. Vaccines are most effective when population-wide coverage is high, reducing overall spread. However, ensuring coverage among those most at risk, such as older adults and those with health conditions, is essential, especially in settings like care homes.

Flu

In 2022/23, 84.8 percent of the population of Gloucestershire aged 65 and over received flu vaccinations, making it the third highest against its statistical neighbours with just Hampshire, and Chesire East having marginally more coverage at 85%. Although a small decrease from 2021/22, overall Gloucestershire has seen an upward trend and since 2019/20 the target of 75% coverage has been met (see Figure 43 below). However, this is an area that still needs to be monitored as coverage has previously been below 75%, and the increase can be attributed to the Covid-19 pandemic when promotion of vaccinations was greater.

159 NHS Health Checks: Appointments offered (annual percentage) in Gloucestershire | LG Inform

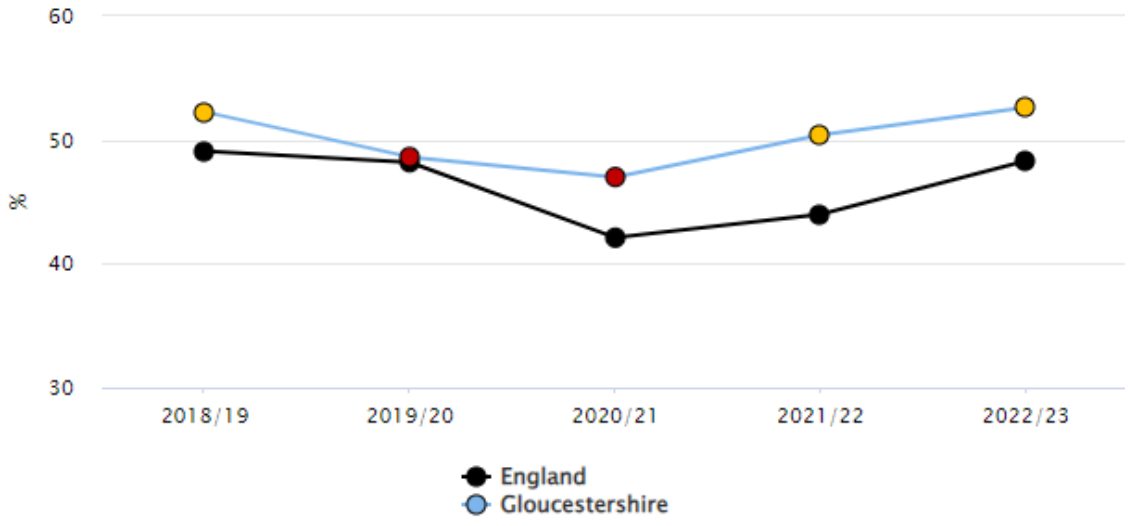
Figure 43: Flu vaccination coverage for people aged 65 plus, Gloucestershire and England, 2010/11 to 2022/23[160]



Shingles

Over the past five-year, shingles vaccination in Gloucestershire have been equal to or higher than the England average (Figure 44). In 2022/23, 52.6 percent of the population of Gloucestershire aged 71 received shingles vaccinations, which is a similar percent to 2018/19 but coverage had seen a decrease in 2020/21, likely due to Covid-19.

Figure 44: Shingles vaccination coverage for people aged 71, Gloucestershire and England, 2010/11 to 2022/23[161]



COVID-19

In December 2020 the first approved vaccination for COVID-19 was administered, which led to a substantial phased vaccination rollout programme across the UK. Added protection from the vaccines is particularly important for older people who are disproportionately

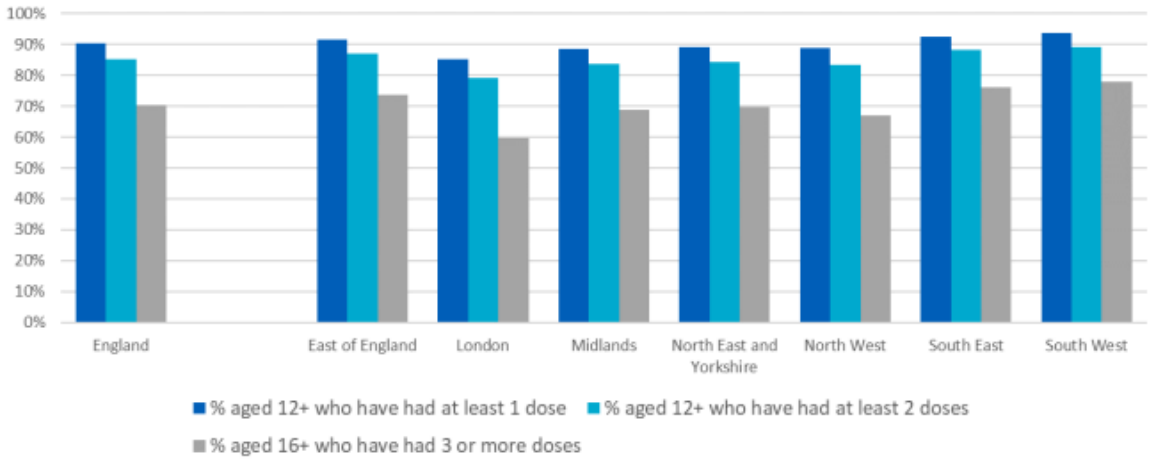
[160] Fingertips | Department of Health and Social Care
[161] Fingertips | Department of Health and Social Care

severely affected by the infection. ONS data[162] as of January 2021, show the death rate due to COVID-19 increases exponentially with age, from 3,231 at age range 60 to 64, to 17,404 at aged 90 plus.

People who are eligible have now been offered four doses of the vaccine, however, according to ONS, across the UK older people were more likely than younger and middle-aged people to take up the offer; 94 percent of people aged 80 plus continued to a fourth vaccination compared with 66.4 percent of people aged 50 to 59[163].

Figure 45 below shows COVID-19 uptake for people aged 12 plus whereby the South West has a marginal higher uptake rate than other regions for the three doses reported.

Figure 45: COVID-9 vaccination uptake rate (percentage) by NHS region of residence, as of 27th March 2022, split by dose amounts[164]



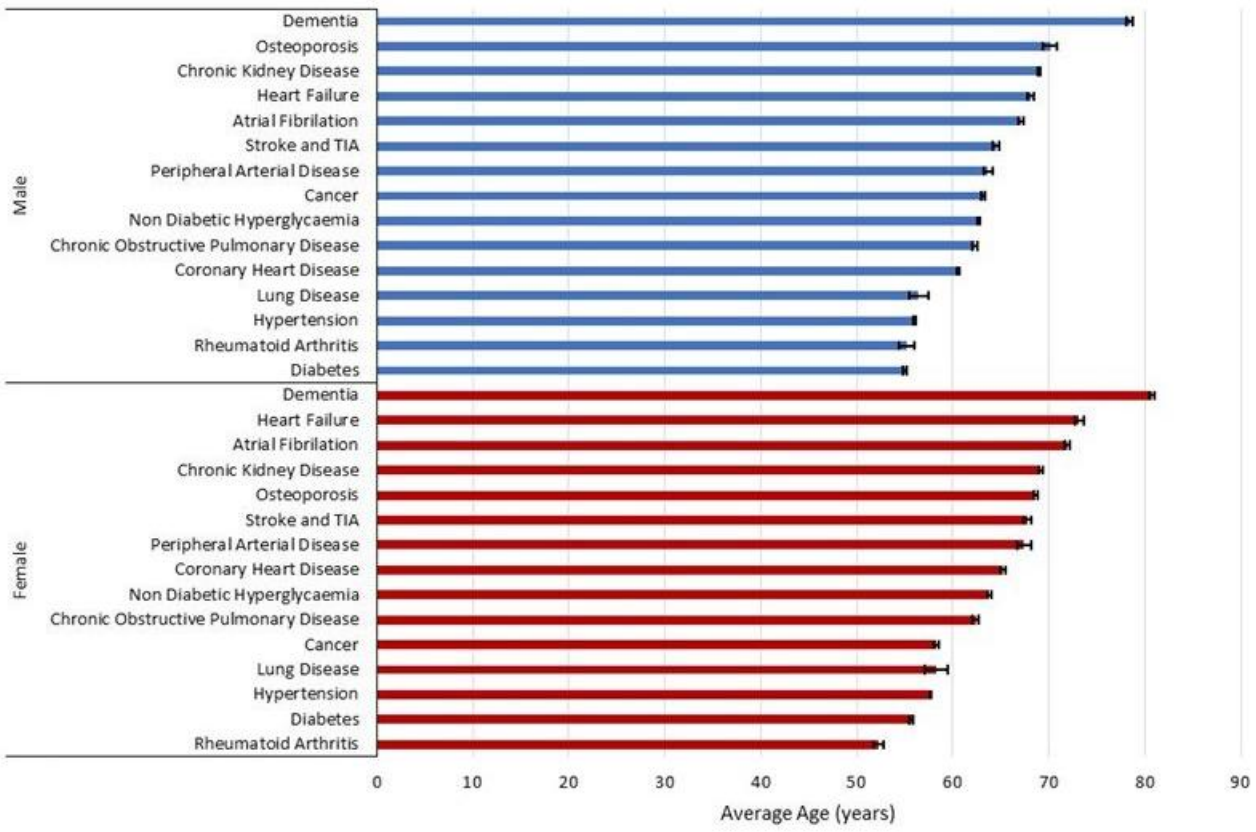
[162] Deaths from COVID-19 by age band - Office for National Statistics (ons.gov.uk)
[163] Coronavirus and vaccination rates in adults by socio-demographic characteristic and occupation, England - Office for National Statistics (ons.gov.uk)
[164] COVID-19-weekly-announced-vaccinations-31-March-2022.pdf (england.nhs.uk)

Chapter 11: Morbidity in Gloucestershire

Diagnosed conditions

Diagnosed conditions and long-term health conditions are those that carry a high risk of mortality or negatively impact a person's daily function or quality of life. Figure 46 shows the average age of first diagnosis of long-term conditions by sex for Gloucestershire. Most diagnosed conditions are diagnosed in the late 50's or 60's. On average diabetes and rheumatoid arthritis are diagnosed at the earliest age. Dementia is diagnosed later than all other conditions.

Figure 46: Average age of first diagnosis of long-term conditions by sex, Gloucestershire[165]



This data highlights the age-related patterns of long-term health conditions in the population. Understanding the average age of first diagnosis helps in targeting early interventions and healthcare planning. Early diagnoses of conditions like diabetes and rheumatoid arthritis suggest opportunities for earlier management, potentially reducing the impact on individuals' quality of life. Conversely, the later diagnosis of dementia underscores the need for focused strategies in older populations to manage this condition effectively as people age.

[165] Gloucestershire ICB, June 2024 in Inform Gloucestershire, Gloucestershire County Council (2024) Life Expectancy and Healthy Ageing https://www.gloucestershire.gov.uk/media/2l5dootr/life-expectancy-report-final.pdf

Multiple long-term conditions (multimorbidity)

When an individual has one or more long-term conditions, it is known as multimorbidity.

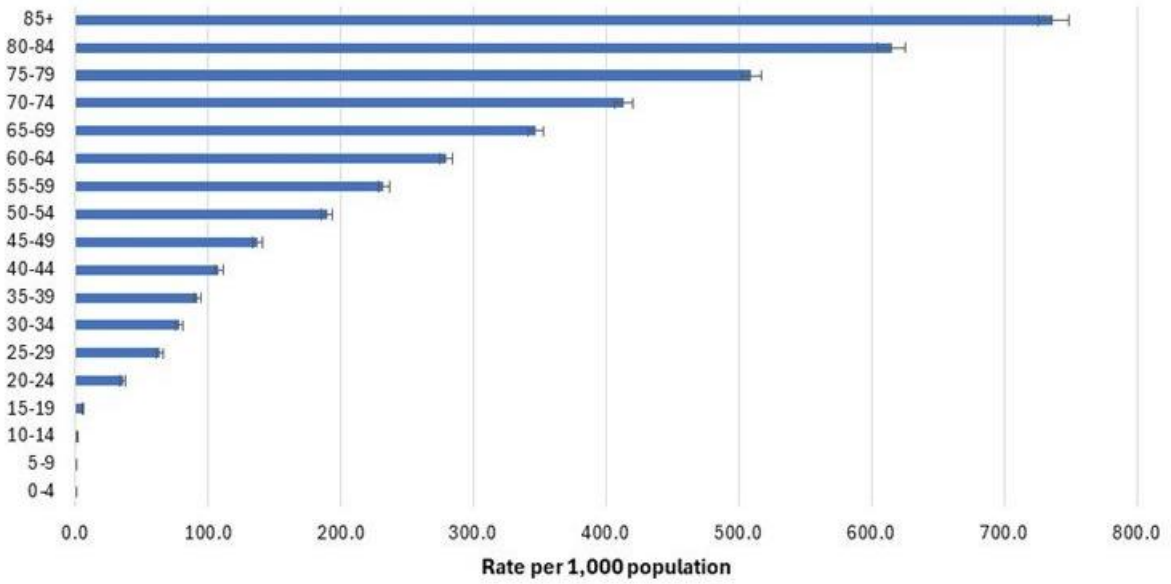
People with multiple conditions are more likely to have poorer health, poorer quality of life and a higher risk of dying than those in the general population. Some combinations of mental and physical diseases are associated with especially poor outcomes.

Despite the diverse conditions and circumstances, they face, individuals with multiple health conditions often experience similar challenges, such as limited mobility, chronic pain, reduced social connections, difficulty working, and decreased mental well-being.

There are approximately 129,188 people in the county with multi-morbidities. This equates to a rate of 186.8 per 1,000 population.

The prevalence of multi-morbidities increases with age. Figure 47 shows the rate of multimorbidities by 5-year age band in Gloucestershire. The rate of multi-morbidity is highest amongst those aged 85+, where it stands at 736.7 per 1,000 population.

Figure 47: Rate of multi-morbidities by 5-year age band, Gloucestershire[166]



One of the most common consequences of having multiple chronic conditions is the long-term use of multiple medications, known as polypharmacy. This practice is linked to various negative health effects, including drug-related complications, adverse reactions, declines in physical and cognitive abilities, increased hospitalisations, and higher mortality rates. However, establishing a direct cause-and-effect relationship is challenging due to the influence of underlying health conditions as a confounding factor (Chen et al., 2020[167]). There is growing evidence that having multiple conditions is a more important driver of

[166] Gloucestershire ICB, June 2024 in Inform Gloucestershire, Gloucestershire County Council (2024) Life Expectancy and Healthy Ageing https://www.gloucestershire.gov.uk/media/2l5dootr/life-expectancy-report-final.pdf

[167] Chen, Y.H., Karimi, M., Rutten-van Mölken, M.P.M.H., 2020. The disease burden of multimorbidity and its interaction with educational level. PloS One 15, e0243275.

costs in the health and social care system than other factors such as age (Kasteridis et al., 2015[168]). Depression was a particularly significant driver of cost and utilisation of care (Soley-Bori et al., 2021[169]).

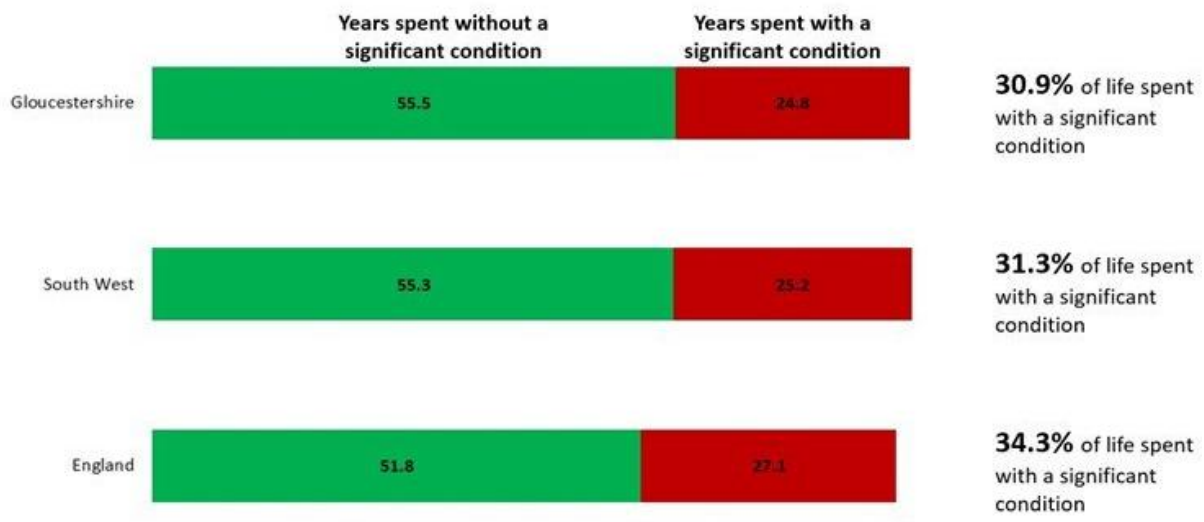
People living in the most disadvantaged communities can expect to have two or more conditions 10 years earlier than those in the least deprived (Stafford et al., 2018[170]).

Time spent with a significant condition

Healthspan aims to provide an objective measure of the amount of time individuals spend in 'good health'. It bases this on the age at which people develop their first significant long-term health condition

In Gloucestershire, the average estimated age at which a male develops their first significant condition is 55.6 years and for females it is 54.3 years (2021-22). A Gloucestershire male could expect to live 24.8 years or 30.9% of their life with a significant condition. A Gloucestershire female could expect to live 30.8 years or 36.2% of their life with a significant condition. Figure 48 shows how Gloucestershire compares to the South West and England.

Figure 48: Time spent with/without a significant condition – Males and Females, Gloucestershire, South West and England (2021-2022)[171]



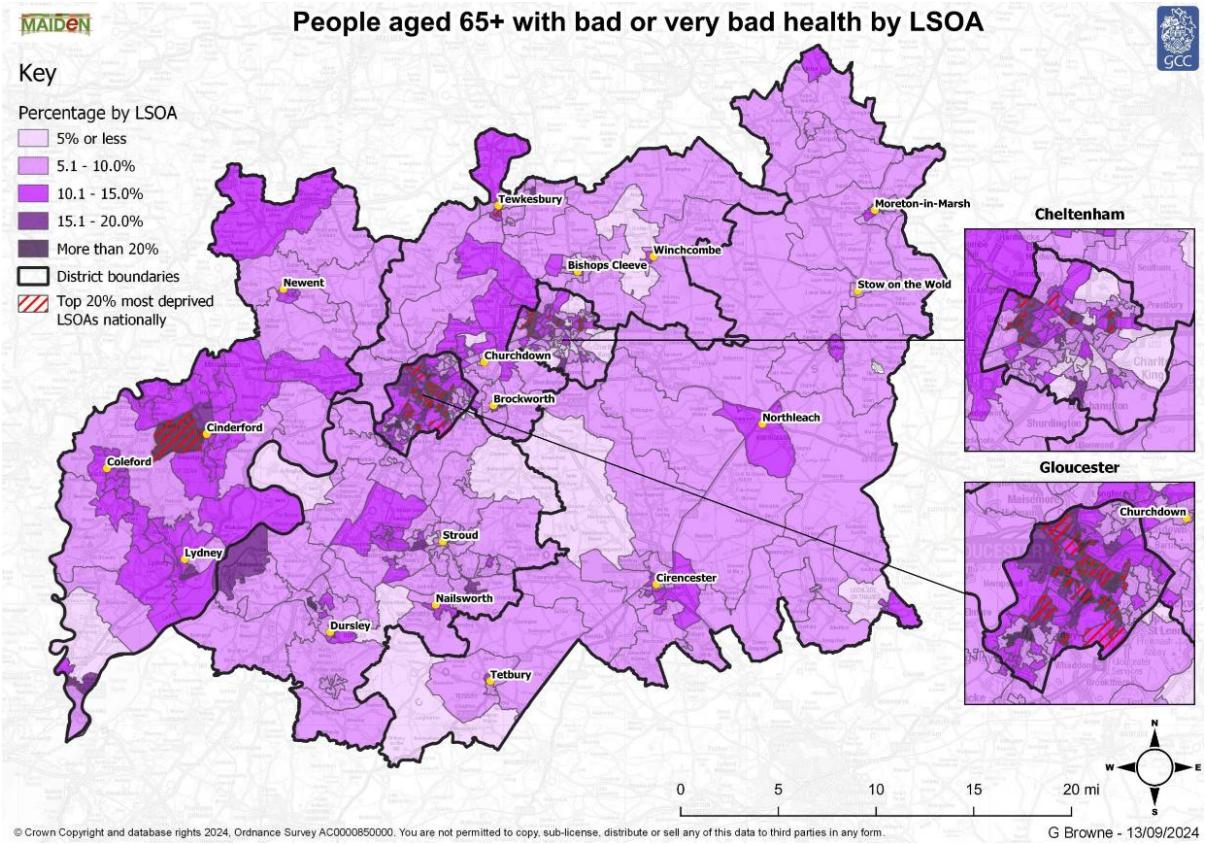
[168] Kasteridis, P., Street, A., Dolman, M., Gallier, L., Hudson, K., Martin, J., Wyer, I., 2015. Who would most benefit from improved integrated care? Implementing an analytical strategy in South Somerset. Int. J. Integr. Care 15.
[169] Soley-Bori, M., Ashworth, M., Bisquera, A., Dodhia, H., Lynch, R., Wang, Y., Fox-Rushby, J., 2021. Impact of multimorbidity on healthcare costs and utilisation: a systematic review of the UK literature. Br. J. Gen. Pract. 71, e39–e46.
[170] Stafford, M., Steventon, A., Thorlby, R., Fisher, R., Turton, C., Deeny, S., 2018. Understanding the health care needs of people with multiple health conditions. Health Foundation.
[171] Healthspan, Outcomes Based Healthcare

Living in poor health

The census captures data on self-reported state of health. Respondents are asked to assess their general health with the question 'How is your health in general?'. The question aims to capture a self-reported measure of overall health status.

For this needs assessment, this data has been broken down to look at people aged 65 and over and then broken down by Lower Layer Super Output Area (LSOA) see Figure 49 below. This figure also highlighted those areas included in the top 20% most deprived nationally.

Figure 49: People aged 65 and over with self-reported bad or very bad health by LSOA[172]



Oral health

Oral diseases, including tooth decay and gum disease, are largely preventable. However, older adults and those living in care homes are at greater risk due to poorer general health and functional limitations. Care home residents experience worse oral health than the general adult population[173]. More can be done locally to follow best practice guidance on oral health in care settings, where residents rely on care staff for personal care assistance.

[172] ONS Census Data 2021

[173] Public Health England (2015) What is Known About the Oral Health of Older People in England and Wales: A review of oral health surveys of older people What_is_known_about_the_oral_health_of_older_people.pdf (publishing.service.gov.uk)

Poor oral health can lead to discomfort and pain, affecting a person's ability to eat, speak, and socialise. It can also cause changes in mood and behaviour, particularly in individuals who cannot articulate their pain or ask for help. Problems with chewing and swallowing can result in poor nutritional uptake[174]. Additionally, there is evidence that poor oral health is associated with an increased risk of cardiovascular disease and a higher risk of aspiration pneumonia in older adults[175].

In 2021, a South West Oral Needs Assessment[176] was published. It describes the oral health profile of people living in the South West of England, summarises currently commissioned dental care services, and identifies potential gaps in service provision. Adults in care homes are recognised as a vulnerable group. Local authorities have statutory commissioning responsibilities to provide oral health promotion programmes aimed at improving the population's oral health and reducing inequalities. Local authorities also commission care homes, providing an opportunity to improve population health by integrating oral health improvement into these settings.

Sight loss and hearing loss

Eye health and vision impact many aspects of life such as education, employment, and overall health. In 2019, the WHO predicted a substantial increase in eye conditions and vision impairment globally, which led to a new resolution at the 2020 World Health Assembly for integrated people centred eye care[177]. A large proportion of people affected by vision impairment live in low and middle-income countries, with young children and older adults being mostly affected by what are largely preventable or treatable issues[178]

The most common cause of registrable sight loss in older people is age-related macular degeneration (AMD). OHID's Public Health Outcomes Framework[179] includes a preventable sight loss indicator; data is based on New Certifications of Visual Impairment (CVI) and includes sight loss due to age related macular degeneration as the main cause, or if no main cause as a contributory cause.

AMD in Gloucestershire for 2022/23 was 65.7 people per 100,000, which is less than ten people per 100,000 more than Suffolk who had the best rate in that period amongst all statistical neighbours.

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[174] Dietrich, T., Webb, I., Stenhouse, L. et al. (2017) Evidence summary: the relationship between oral and cardiovascular disease. Br Dent J 222. [Online] 2017. 381–385 Evidence summary: the relationship between oral and cardiovascular disease | British Dental Journal

[175] Van der Maarel-Wierink, C. D, Vanobbergen J. N, Bronkhorst E. M. (2013) Oral health care and aspiration pneumonia in frail older people: a systematic literature review. Gerodontology 30(1):3-9. [Online] 2013. https://pubmed.ncbi.nlm.nih.gov/22390255/

[176] NHS England and NHS Improvement (2021) Oral Health Needs Assessment and Report: South West of England. [Online] 2021. https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2021/02/South-West-OHNA-Main-Report.pdf

[177] World Health Organisation (2020) 73rd World Health Assembly Decisions (who.int)

[178] The Lancet, (2020) The *Lancet Global Health* Commission on Global Eye Health: vision beyond 2020: The Lancet Global Health Commission on Global Eye Health: vision beyond 2020 - The Lancet Global Health

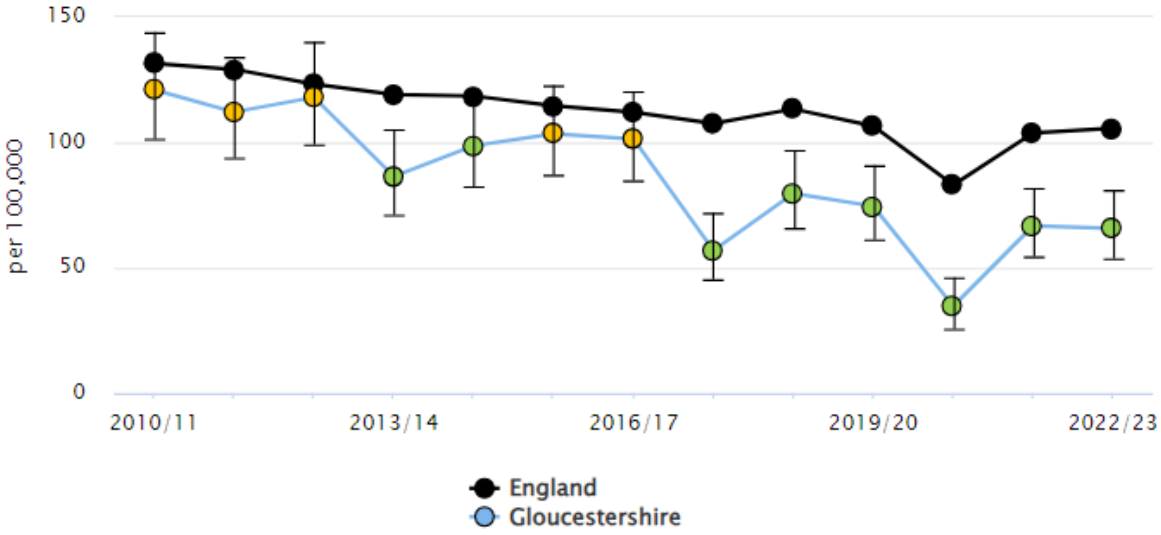
[179] Fingertips | Department of Health and Social Care (phe.org.uk) [accessed Aug 2024]

Figure 50: AMD in people aged 65 plus, rate per 100,000, Gloucestershire and statistical neighbours, 2022/23[180]

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	→	-	11,226	105.6	103.7	107.6
Neighbours average	→	-	-	-	-	-
Leicestershire	→	15	271	178.8	158.1	201.4
Cheshire West and Chester	↑	7	134	172.5	144.5	204.3
Cheshire East	→	2	123	134.6	111.9	160.6
Wiltshire	→	6	141	122.8	103.4	144.9
Worcestershire	↑	1	173	122.6	105.0	142.3
West Sussex	→	8	241	117.1	102.8	132.9
Nottinghamshire	→	4	207	115.7	100.5	132.6
Warwickshire	→	5	145	115.5	97.5	135.9
Hampshire	→	3	354	113.2	101.7	125.6
Essex	↑	14	322	101.8	91.0	113.5
Buckinghamshire UA	→	13	107	100.7	82.5	121.7
Staffordshire	→	9	177	89.3	76.6	103.4
Kent	→	11	282	86.5	76.7	97.2
Central Bedfordshire	→	10	40	73.2	52.3	99.7
Gloucestershire	→	-	94	65.7	53.1	80.4
Suffolk	↓	12	104	56.6	46.3	68.6

Rates of AMD in Gloucestershire have almost halved since 2010/11 (from 121.0 to 65.7 per 100,000), however, data counts provided by Moorfields Eye Hospital have also reduced significantly, particularly for the year 2020/21 due to the COVID pandemic (figure 35).

Figure 51: AMD in people aged 65 plus, rate per 100,000, Gloucestershire and England, 2010/11 to 2022/23[181]



The Royal National Institute of Blind people (RNIB) state that estimated overall prevalence of sight loss in Gloucestershire is 3.8 percent, which is slightly higher than the England average of 3.3 percent. Sight loss includes people who are registered blind or partially sighted; people whose vision does not qualify as blind or partially sighted; people who are awaiting eye treatment or surgery to improve vision; and people whose sight loss could be improved by wearing correctly prescribed glasses or contact lenses. When RNIB data is

[180] Fingertips | Department of Health and Social Care (phe.org.uk) [accessed Aug 2024]
[181] Fingertips | Department of Health and Social Care (phe.org.uk) [accessed Aug 2024]

broken down by age range and represented in (rounded) numbers of people, sight loss estimates from 2022 for Gloucestershire are as follows[182]:

- 4,300 are aged 18 to 64 years
- 4,790 are aged 65 to 74 years
- 7,340 are aged 75 to 84 years
- 7,950 are aged 85 years and over

RNIB project that by 2032, (mild to severe) sight loss prevalence is expected to increase by roughly 26 percent. Although age breakdowns for this data are not provided, it is likely due to Gloucestershire's ageing population that more older people will experience higher levels of sight loss.

Sight loss data is also broken down by registered blind and partially sighted; similar to above, numbers increase rapidly from age 75 (see table 16).

Table 10: Number of people in Gloucestershire registered blind or partially sighted, by age range, 2023[183]

Age band	Registered blind	Registered partially slighted	Total
50-64	135	200	335
65-74	90	150	240
75+	775	1,520	2,295

The Royal National Institute for Deaf People (RNID) state that one in three adults in the UK are either deaf, have hearing loss, or tinnitus; rising to more than half of the population aged 55 plus, and 80 percent of the population aged 70 plus[184].

The RNIB sight loss tool also provides prevalence data on hearing impairment for Gloucestershire, although data is not provided as a percentage of the population. In 2022, they estimated that 80,000 people in the county experienced moderate or severe hearing impairment and 1,760 people a profound hearing impairment[185]. Across Gloucestershire there is a large increase in moderate or severe hearing loss between ages 75 to 84. However, for people who are profoundly hearing impaired, numbers increase at ages 65 to 74, then again more sharply at aged 85 and over. Data broken down by districts indicates that Stroud has the highest prevalence across both indicators and Forest of Dean the lowest, which reflects the greater number of people aged 65 plus in Stroud (Table 11 below).

[182] RNIB Sight Loss Data Tool - statistics on sight loss | RNIB [accessed Aug 24]
[183] RNIB Sight Loss Data Tool - statistics on sight loss | RNIB [accessed Aug 24]
[184] Prevalence of deafness and hearing loss - RNID
[185] RNIB Sight Loss Data Tool - statistics on sight loss | RNIB **Calculation:** Base prevalence rates for hearing impairment, split by age and gender, were taken from POPPI and applied to subnational population projections.

Table 11: Estimated number of people moderately or severely hearing impaired, and profoundly hearing impaired, by age range, Gloucestershire, 2022 [186]

	Estimated number of people moderate or severely hearing impaired - aged 20-64 (2022)	Estimated number of people moderate or severely hearing impaired - aged 65-74 (2022)	Estimated number of people moderate or severely hearing impaired - aged 75-84 (2022)	Estimated number of people moderate or severely hearing impaired - aged 85 and over (2022)	Estimated number of people moderate or severely hearing impaired - Total (2022)	Estimated number of people who are profoundly hearing impaired - aged 20-64 (2022)	Estimated number of people who are profoundly hearing impaired - aged 65-74 (2022)	Estimated number of people who are profoundly hearing impaired - aged 75-84 (2022)	Estimated number of people who are profoundly hearing impaired - aged 85 and over (2022)	Estimated number of people who are profoundly hearing impaired - Total (2022)
United Kingdom	1,650,000	1,280,000	2,810,000	1,480,000	7,220,000	14,800	41,000	28,100	73,800	158,000
England	1,390,000	1,070,000	2,360,000	1,250,000	6,060,000	12,400	34,100	23,600	62,600	133,000
Gloucestershire	17,000	14,200	32,300	16,500	80,000	150	460	320	830	1,760
Cheltenham	2,810	2,230	5,260	3,280	13,600	25	70	55	160	310
Cotswold	2,570	2,410	5,690	2,880	13,600	25	75	55	140	300
Forest of Dean	2,450	2,310	4,970	2,190	11,900	25	75	50	110	250
Gloucester	3,230	2,270	5,080	2,740	13,300	30	75	50	140	290
Stroud	3,370	2,860	6,290	2,970	15,500	30	90	65	150	330
Tewkesbury	2,530	2,170	5,020	2,450	12,200	25	70	50	120	260

Notes: Data has been rounded

[186] RNIB Sight Loss Data Tool - statistics on sight loss | RNIB **Calculation:** Base prevalence rates for hearing impairment, split by age and gender, were taken from POPPI and applied to subnational population projections

Chapter 12: Mortality in the over 65s

Preventable premature mortality

In Gloucestershire in 2022, the rate of preventable premature mortality for individuals under 75 was 132.2 deaths per 100,000. When broken down by sex, a significant difference emerges, with men having more than twice the rate of preventable premature mortality. The rate for men is 181.3 per 100,000, compared to 85.8 per 100,000 for women[187].

Deaths by age and sex

In 2022, there were 7,038 registered deaths in Gloucestershire, resulting in a crude death rate of 10.79 per 1,000 people. This rate was higher than the national average for England but slightly lower than the South West region's average, which had crude death rates of 9.46 and 10.85 per 1,000 population, respectively[188].

The number of deaths generally increases with age, with the highest proportion occurring in the 80+ age group across all areas. In Gloucestershire, 58.9% of deaths were among those aged 80 and over, slightly lower than the South West's 59.9%, but higher than England's 55.3%. In 2022, 49.6% of deaths in Gloucestershire were male and 50.4% female, similar to the national and regional figures. By 2013, more than half of deaths occurred in individuals over 80 (59.3%)[189].

Table 12: Proportion of Registered Deaths (n=7,038) by Sex and Age in Gloucestershire and Districts, 2022[190]

	Male	Female	0-14	15-34	35-64	65-79	80+
Gloucestershire	**49.6%**	**50.4%**	0.5%	0.9%	12.1%	27.6%	58.9%
Cheltenham	46.9%	53.1%	0.4%	0.8%	12.4%	24.3%	62.1%
Cotswold	50.3%	49.7%	0.0%	0.5%	9.3%	25.4%	64.9%
Forest of Dean	51.2%	48.8%	0.5%	1.0%	12.1%	28.5%	57.9%
Gloucester	48.8%	51.2%	0.4%	1.3%	16.5%	28.7%	53.0%
Stroud	51.2%	48.8%	0.5%	0.8%	10.5%	29.8%	58.5%
Tewkesbury	49.4%	50.6%	0.5%	1.0%	10.9%	29.0%	58.6%
South West	**50.7%**	**49.3%**	0.4%	0.9%	11.4%	27.5%	59.9%
England	**50.6%**	**49.4%**	0.6%	1.2%	13.7%	29.3%	55.3%
England & Wales	**50.6%**	**49.4%**	0.6%	1.2%	13.7%	29.4%	55.2%

When comparing by sex, 67.3% of female deaths occurred in the 80 and above age group, while for males, it was 50.3%. Conversely, the 65-79 age group accounts for a larger share

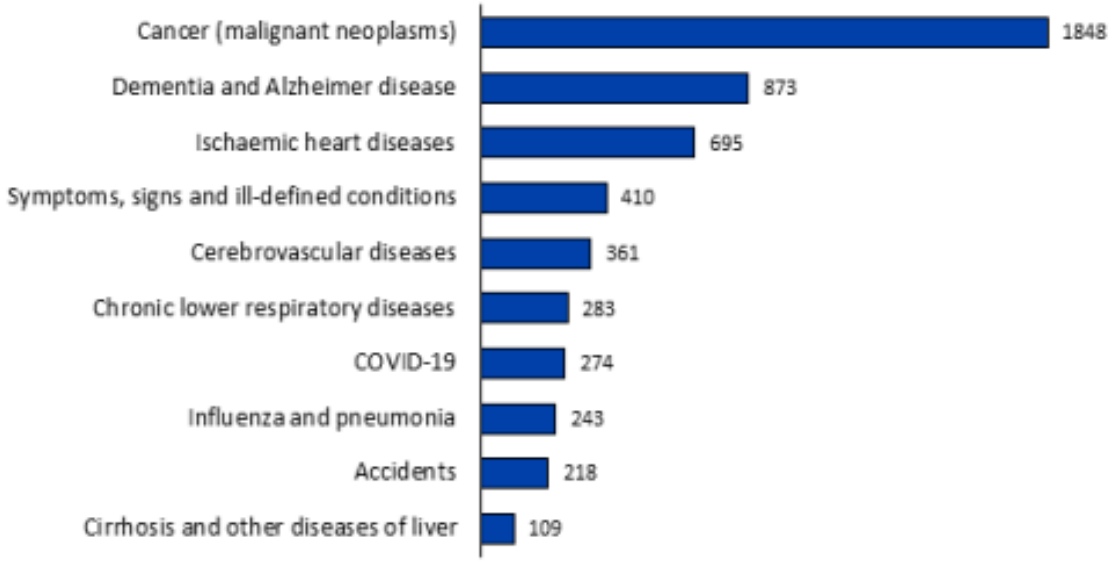
[187] OHID Public Health Profiles Public health profiles - OHID (phe.org.uk)
[188] NOMIS (Office for National Statistics), Mortality Statistics - underlying cause, sex and age used in mortality-trends-report-2022.pdf (gloucestershire.gov.uk)
[189] ibid
[190] NOMIS (Office for National Statistics), Mortality Statistics - underlying cause, sex and age used in mortality-trends-report-2022.pdf (gloucestershire.gov.uk)

of male deaths (32.9%) compared to female deaths (22.8%). This pattern continues in younger age groups, where males consistently have a higher proportion of deaths than females[191].

Leading causes of death in Gloucestershire

In 2022, the top three causes of death among the 47 leading causes identified in Gloucestershire were Cancer (malignant neoplasms) with 1,848 deaths (26.3%), Dementia and Alzheimer's disease with 873 deaths (12.4%), and Ischaemic heart diseases with 695 deaths (9.9%). These causes were also the primary contributors to mortality in both England and the South West region.

Figure 52: Main 10 causes of death in Gloucestershire, 2022[192]



Cancer (neoplasms) was the leading cause of death for both males and females in Gloucestershire. Dementia and Alzheimer's were the second highest cause of death in women, leading to 15.8% of female deaths, whilst Ischaemic heart diseases were the second highest cause of deaths in men, accounting for 12.9% of male deaths.

[191] NOMIS (Office for National Statistics), Mortality Statistics - underlying cause, sex and age used in mortality-trends-report-2022.pdf (gloucestershire.gov.uk)
[192] NOMIS (Office for National Statistics), Mortality Statistics - underlying cause, sex and age used in mortality-trends-report-2022.pdf (gloucestershire.gov.uk)

Chapter 13: Adapting to an ageing population – wider determinants of health

It's clear from the 2023 CMO's report[193] that a large proportion of people migrate away from cities before they reach older age. The result is that urban areas largely maintain their current demographic, ageing only slowly, but - importantly for Gloucestershire - rural and semi-rural areas will age much faster. Alongside this, we know our older population will spend a higher proportion of their time in homes than at other time in their life.

The importance of accessible housing design cannot be overstated - impacting individuals with disabilities and health challenges, but also the wider systems in society including ASC and the NHS. The future of Gloucestershire's housing stock needs to reflect the changing needs of housing over a life course, ensuring that mix and tenure of housing provision will provide high standards of affordable, accessible dwellings, and that accessibility to the local facilities is a primary consideration. Homes for older people need to be located where they can easily and safely access the everyday shops and services that they need, preferably by active transport (walking or cycling) to help maintain their physical health. This infrastructure should meet the needs of all users including older people and those with sensory and physical impairments.

In the ever-changing climate and environment that surrounds us, generous, accessible, good quality green and blue infrastructure is the catalyst for promotion of health, wellbeing, and quality of life. Our climate is changing and extremes in temperatures, for prolonged periods, are impacting the health of our population. The greatest driver of both heat and cold-related deaths in the UK is the vulnerability of older adults to extreme temperatures. Protecting older adults during cold and hot weather periods, including considering the social determinants of vulnerability, is a key lever for minimising health risks. While cold-related health risks will continue, heat-related health risks will increase, potentially substantially. Temperatures that may cause inconvenience for most healthy adults can pose a significant health risk to individuals with chronic health conditions and older adults. Considered planning and place making can ensure the inclusion of cool spaces in the wider environment to offer welcome relief during sustained hot weather. Easy access to nearby shaded areas, with cover, benches/tables and where available, water features, can provide refuge when homes are retaining heat.

With the UK population spending on average, over 95% of their time in indoor environments and 66% of their time in their own homes the design of current homes and the homes of future developments become a crucial enabler to good health, particularly amongst our older adult population. Indoor air quality is affected by various factors, including the ambient air or environment, urban planning and layout, indoor sources, ventilation, and occupant behaviours and activities.

Air pollutants generated from indoor sources, can trigger or exacerbate asthma, irritation, and other respiratory or cardiovascular conditions. Various studies have found associations between respiratory health outcomes and markers of dampness or moisture in buildings

[193] Chief Medical Officer's Annual Report 2023 – Health in an Ageing Society: Executive summary and recommendations

such as visible mould, mould odour, or moisture in the walls[194]. Again, our aging population with pre-existing conditions affecting the respiratory or immune systems, have the potential to be impacted the most.

Older people are particularly vulnerable to social isolation and/or loneliness due to loss of friends, family, mobility, health or income and this is harmful to health. Loneliness and isolation increase the risk of high blood pressure, being more prone to depression, and leads to an increased chance of developing clinical dementia. Those who are lonely are also more likely to visit their GP, have a higher use of medication, use Accident and Emergency services, draw on ASC, and have early admission to residential or nursing care The 2022 Director of Public Health Annual Report for Gloucestershire; No person is an island; Social connections in Gloucestershire[195] highlights both the power of social connections but also the challenges, many of which are experienced by those living in rural areas across Gloucestershire. Crucially, it sharpens a focus on the work being done to tackle social isolation and the responsibility we all share in supporting those most in need. Using national studies, it was calculated that around 6,000 older people in Gloucestershire feel lonely always or often. This also underlines the importance of considering how communities create opportunities for social connections across the life course.

It is crucial that we continue to work towards narrowing the digital divide in Gloucestershire (the gap in society between people who have full access to digital technologies and those who do not) and the impact of this exclusion to specific groups including disabled people, older people, those on low incomes, people with mental health challenges and those living in rural areas where internet connectivity is poor. The benefits of digital inclusion include wider social and economic inclusion and emotional resilience including maintaining a secure social network, engaging in cultural life, pursuing interests and hobbies and developing skills and confidence for employment.

Addressing the wider determinants of health for our aging population requires a systems approach to demonstrate how decision making and interplay between areas such as housing, transport, climate and planning, can have a significant impact on health outcomes. If decision making in these areas prioritise public health considerations, there are significant benefits for people's healthy life expectancy.

While the importance of accessible housing design, climate resilience, social connectivity, and digital inclusion for Gloucestershire's aging population is evident, this needs assessment has not delved into these areas in detail. Further comprehensive analysis is required to fully understand and address these critical factors impacting the health and wellbeing of older adults in the region.

[194] HECC report 2023. Chapter 5: Impact of climate change policies on indoor environmental quality and health in UK housing (publishing.service.gov.uk)

[195] Item 4 - Annual Public Health Report 2022-23.pdf (gloucestershire.gov.uk)glostext.gloucestershire.gov.uk/documents/s88074/Item 4 - Annual Public Health Report 2022-23.pdf

Glossary of Terms

Term	Definition
Abdominal Aortic Aneurysm (AAA)	A swelling or bulge in the aorta detected through NHS screening, usually for men aged 65.
Adult Social Care (ASC)	Support provided by local authorities to help adults live as independently, safely, and healthily as possible.
Ageing Well	An approach focused on independence, healthy lifestyles, prevention, and adapting environments for older adults.
Carer (Unpaid Carer)	Someone who provides unpaid support to a person who would struggle to manage without their help.
Care Act 2014	Law outlining local authority duties including prevention, assessment, eligibility, and support for carers.
Cancer Screening	NHS programmes that detect early signs of cancer before symptoms appear.
Chief Medical Officer (CMO)	The UK government's most senior medical adviser.
Community-based Support	Local services and groups that help people stay independent, connected, and well.
Dementia	A group of symptoms affecting memory, thinking, and daily functioning, including Alzheimer's and vascular dementia.
Deprivation / IMD	A measure showing how disadvantaged an area is based on income, employment, health, education, housing, and crime.
Direct Payments	Money provided so individuals can arrange and manage their own care and support.
Disability	A physical or mental impairment with long-term impact on daily activities.
Electronic Frailty Index (eFI)	A tool identifying levels of frailty using health records.
Equipment and Assistive Technology	Items that help people carry out daily activities more independently and safely.
Falls Prevention	Actions that reduce the risk of falling, such as exercise, home adaptations, and medication reviews.
Frailty	A condition where reduced physical or mental reserves increase vulnerability to health changes.
Healthy Life Expectancy	Years a person can expect to live in good health.
Integrated Care System (ICS)	Partnerships across NHS, councils, and the voluntary sector to improve population health.
Learning Disability	A lifelong condition affecting understanding, learning, and independence.
Long-Term Support (LTS) / OLTS	Ongoing ASC services for people with long-term or permanent support needs.
Market Position Statement (MPS)	A document outlining current and future local care needs and market conditions.
Mental Health Support	Support for people whose mental health conditions impact daily life.
Multimorbidity	Having two or more long-term health conditions at the same time.
NHS Health Check	A free check for adults aged 40–74 assessing risk of serious conditions.
Oral Health	The health of the mouth, teeth, and gums, important for nutrition, communication, and wellbeing.

Physical Support (Personal Care)	Help with washing, dressing, eating, toileting, and mobility.
Population Health Management (PHM)	Using data to understand health needs and target support effectively.
Prevention	Actions that prevent, reduce, or delay care needs—primary, secondary, and tertiary prevention.
Reablement	Short-term support to regain independence after illness or injury.
Screening	Testing people without symptoms to detect early signs of disease.
Self-Funding	People who pay the full cost of their care because they exceed the financial threshold.
Short-Term Support	Short interventions aimed at improving independence.
Sight Loss	Reduction in vision that cannot be fully corrected with glasses or lenses.
Social Isolation / Loneliness	Limited social contact or feeling disconnected, linked to poorer health.
Statistical Neighbours	Local areas with similar characteristics used for comparison.
Strengths-Based Practice	An approach focusing on individual abilities and community resources before formal services.
Unpaid Carer Support	Support provided to people caring for others without payment.