APPENDIX 3: HEALTH NEEDS ANALYSIS

Moray Health Needs Analysis

2010 - 2011

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Introduction

A key part of the development of the Joint Commissioning Strategy for partners required analysis of the health and wellbeing needs of the older population to determine the potential demand both now and in the future. This included an examination of the social/economic factors that can impact on the health and wellbeing of older people in Moray.

Based on a systematic method of collecting national and local data and prioritising local health needs, this document provides a thorough review of health issues facing our older population (65 years and over) and identifies key challenges for partners in improving the health and wellbeing of older people in Moray.

It advocates the necessity for health and wellbeing to be a shared goal of partners and informs the priorities of the Joint Commissioning Strategy.

A: THE OLDER POPULATION IN MORAY

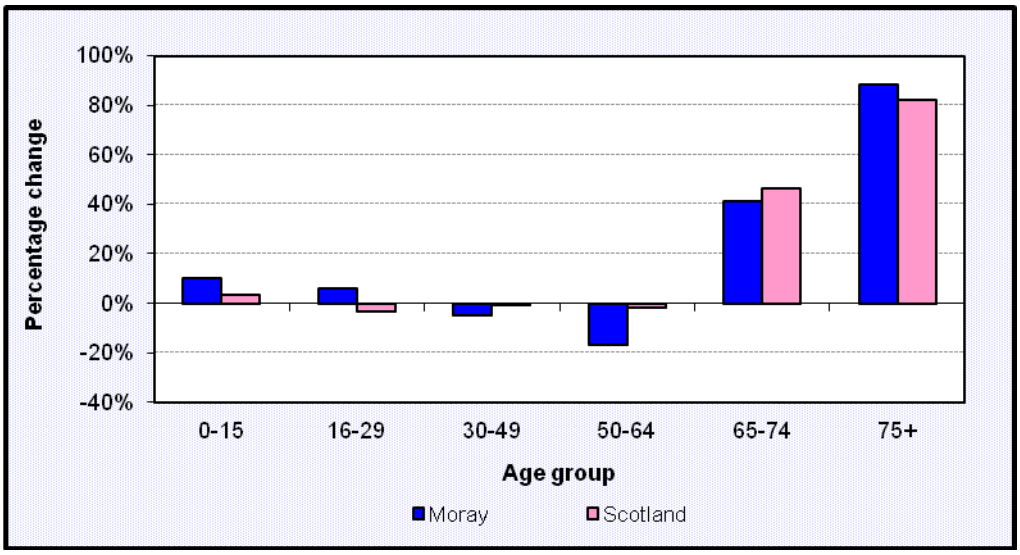
1 Overview of current population

By 2035 the population of Moray is projected to be 96,367, an increase of 9.9% compared to the population in 2010. The population of Scotland is projected to increase by 10.2% between 2010 and 2035.

Over the 25 year period, the group projected to experience the greatest increase in Moray is the 75+ age group. This is the same as for Scotland as a whole. The Moray increase is expected to be higher than the national rate at 88%.

The population aged under 16 in Moray is projected to increase by 10.2% over the same period.

Figure 1: Percentage change in population in Moray and Scotland, 2010-2035 (2010-based projections), GRO estimate



Further breakdown into locality area GP statistics from the Information Service Division[1] show that there are 89,395 people registered with a GP practice in Moray across the four locality areas.

The Elgin Lossiemouth locality is the largest population area, with a working age population close to the national average although slightly under at 65.6%, while the percentage of people over 75 is lower than the national average at 7.5%.

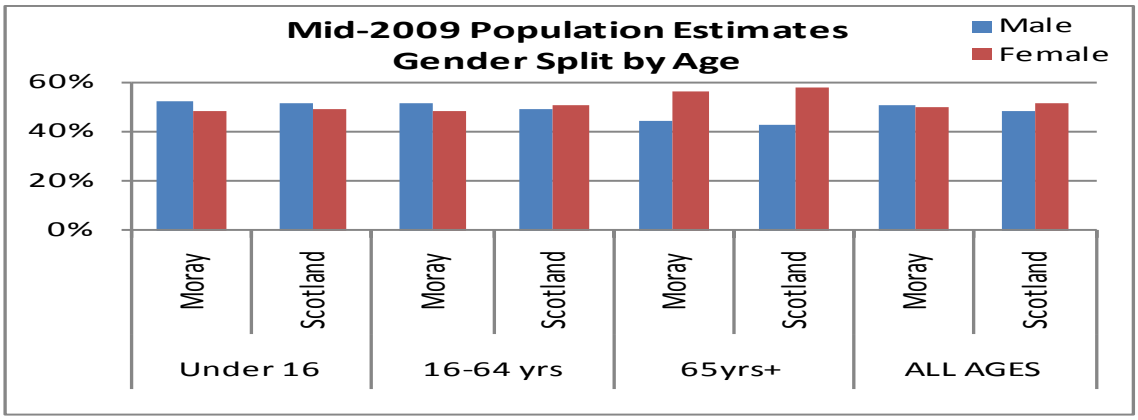
The other three locality areas have a slightly lower percentage of people of working age than the national average, with Buckie/Cullen locality having the smallest at 63.1% and the highest percentage of people over 75 at 10.4%.

Table 1: Population per locality area

Area	Total population	% working age	% aged 75 and over
Scottish average		65.7%	7.7%
Moray	89,395	64.7%	8.5%
Speyside/Keith	15,894	64.1%	9.1%
Buckie/Cullen/Fochabers	18,631	63.1%	10.4%
Elgin/Lossiemouth	39,740	65.6%	7.5%
Forres	15,130	64.9%	8.3%

The overall gender split in Moray shows very slightly more males than females – 50.3% to 49.7%, the reverse of the split nationally where 51.6% of the population is female and 48.4% is male. An age breakdown shows that in the 65 years+ age group there are considerably more females than males in both Moray and nationally, reflecting the higher life expectancy of females.

Figure 2: Mid-2009 population estimates, gender split by age



SUMMARY

Currently the population in Moray shows a higher proportion of older people compared to the Scottish average, with particularly high proportions in the Buckie locality and the most rural locality of Speyside. In contrast, the Elgin locality with the largest population has a lower than national average proportion of older people.

There are lower proportions of people of working age compared to the Scottish average, particularly in the Buckie/Cullen/Fochabers area.

There are slightly more males in Moray than females in contrast to Scotland which is likely due to the number of Ministry of Defence personnel. However, within the over 65 age group, there are considerably more females than males in both Moray and nationally which reflects the higher life expectancy of females.

2 Demographic change

2.1 Recent population change

The population of Moray has grown by 5% between 1981 and 2009, compared with a 0.8% rise nationally. The broad age structure for Moray and Scotland in 1981 and in the most recent mid-year population estimated in 2009 is as follows:

Table 2: Age breakdown of population

Age (years)	MORAY		SCOTLAND	
	1981	**2009**	**1981**	**2009**
Under 16	24%	18%	23%	18%
Working age	59%	60%	60%	63%
Pensionable age +	17%	22%	17%	20%

The figures suggest that although Scotland as a whole has an aging population, the proportion of older people in Moray has increased at a faster rate than nationally.

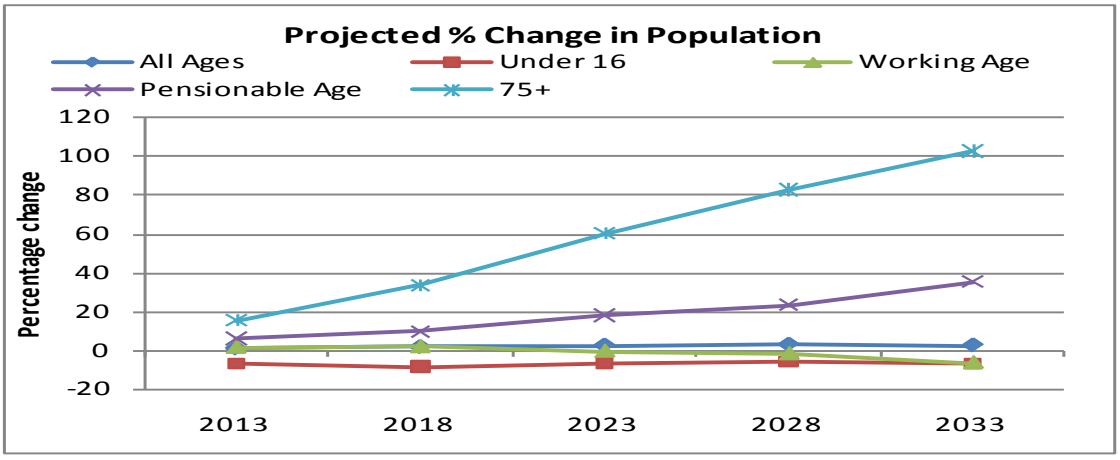
Between 1981 and 2009 the proportion of under 16s age group has fallen by 6% in Moray compared with a 5% fall nationally, while the proportion of people of working age shows a rise of 1% in Moray compared with 3% nationally and the proportion of people of pensionable age has increased by 5% in Moray compared with a 3% rise nationally[2].

2.2 Projected population change

Between 2008 (most recent population projections) and 2033, Moray's population is projected to increase by just 3% to about 90,400, compared with a 7% rise nationally.

The number of over 65s in Moray is projected to increase by 36% to around 25,730 compared with a 31% rise nationally, while the numbers of people of working age and under 16s are projected to decrease by 6% each to about 50,000 and 14,710 respectively. This compares with a projected Scotland-wide fall among under 16s of 2%, while the number of people of working age is projected to rise by 2%.

Figure 2: Projected % Change in Population



2.3 Older population

Between 2008 and 2033, the number of people in Moray aged 75 years and over is projected to rise by 103% and will then account for more than half (53%) of the pensionable age group. Nationally this age group is projected to grow by 84% and will then account for 51% of the pensionable age population.

Further analysis of projections for the next 20 year period, to inform the Joint Commissioning Strategy, was undertaken to see the extent of need. Table 3 shows a continual increase across the over 65 age group until 2030, with a significant increase (140.5%) in the over 85s. This older age group is predicted to have higher, more complex levels of need and is most likely to require specialist accommodation and support services.

Table 3: Moray population projections

Age	2011	2014	2020	2030	% change by		
					2014	2020	2030
50-64	18,380	18,720	19,776	16,147	1.8%	+7.6%	-12%
65-74	9,153	10,121	11,076	12,257	10.6%	21%	34%
75-84	5,842	6,274	7,149	9,032	7.4%	22.4%	54.6%
85+	1,613	1,818	2,442	3,880	12.7%	51.4%	140.5%

The 50-64 age group shows a projected increase (7.6%) by 2020, however by 2025 this age group starts to gradually decrease and by 2030 has reduced by 12%. This will have an impact on the availability of carers.

When the percentage change above is applied to the population at locality level using GP practice population data, a clearer picture of the number of older people and age structures in each locality over the next two decades emerges.

Table 4: Older population projections by locality

Locality	Age	2011	2014	2020	2030
Speyside/Keith	**65-74**	1781	1970	2137	2386
	75-84	1113	1231	1362	1720
	85+	349	393	528	839
Buckie/Cullen/Fochabers	**65-74**	2118	2342	2562	2932
	75-84	1461	1569	1788	2259
	85+	486	548	786	1168
Elgin/ Lossiemouth	**65-74**	3644	4030	4409	4883
	75-84	2250	2416	2754	3478
	85+	729	822	1104	1753
Forres	**65-74**	1593	1762	1927	2135
	75-84	914	982	1119	1413
	85+	345	389	522	830

3 Minority groups within the older population

3.1 Black/minority ethnics

The 2001 Census data indicates the population of BME (Black /Minority Ethnics) groups in Moray is very small (0.86%). It is, however, somewhat out of date and can be assumed to provide a conservative figure for the BME population.

There are varied ethnic groups and languages dispersed in small numbers throughout the overall population in Moray. Migrants can experience problems accessing employment, housing, training, health and social care services because of language difficulties and knowing their rights. The most commonly asked for translation languages in Moray are Polish, Portuguese and Mandarin/Cantonese – this has been the case for the last three years. It should be acknowledged that this data is in relation to the whole population and not age specific.

3.2 Gypsy/traveller

Across Grampian, the gypsy/traveller population is fairly evenly spread across all three authorities, ranging between 56 households in Aberdeen City, 50 in Aberdeenshire and 47 in Moray. Based on current trends identified in the household survey, a potential growth of up to 50 households is possible in the resident Grampian gypsy/traveller population over the next five years.

There is evidence to suggest that gypsies/travellers in England have significantly lower life expectancies than the settled population due to a number of factors, including greater prevalence of smoking, poor access to healthcare, low literacy levels, exposure to the outdoors and poorer quality housing.[3]

3.3 Learning disability

In 2009 there was a 9% increase in the numbers of adults with a diagnosed learning disability in Scotland compared to 2008 and a 53% increase since 2003. In Moray there has been a 4% fall in the number of adults known to have a learning disability, reducing from 449 (2008) to 430 (2009) during this period.

There has been a corresponding increase nationally in the number of people with a learning disability, rising by 0.8 to 6.5 known people per 1,000 population compared to a drop of 0.3 to 6.0 per 1,000 in Moray. Moray is ranked 18th out of the 32 local authorities in Scotland for the number of adults known to have a learning disability per 1,000 of the population.

TABLE 5: Adults known to have a learning disability in 2009

Age	MALES				FEMALES				Overall total	Adults known per 1,000 population
	16-20	21-64	65+	Total	16-20	21-64	65+	Total		
Moray	30	203	14	247	15	151	17	183	430	6.0

Of the 430 adults in Moray known to have a learning disability, there is a slightly higher percentage of males at 57%, while the largest proportion (82%) are aged between 21 and 64. The age and gender groupings of Moray generally reflect that of the national picture, although there is a slightly higher proportion nationally of adults aged 65 and over with a learning disability (10%) compared to 7% in Moray.

With 354 adults in the 21-64 in 2009, it is clear this client group will have specific care and support needs and accommodation needs as they age. [4]
There are currently 61 adults with autism in Moray known to services. In 2005 the Scottish Government used a prevalence figure of 90/10,000 and on that basis

produced distribution data for age groups in local authority areas. A ratio of 4:1 was used as the distribution of the condition between male and female.

This would give a Moray figure of 781 which underlines that there are many more undiagnosed adults in the population. This includes 363 adults in the 30-65 age group and 118 aged 65+. This client group will require care and support coping with this lifelong condition as they grow older.

3.4 Visual impairment

In October 2010 there were 394 people registered blind or partially sighted in Moray. This represents 4.5 per 1,000 of the Moray population against a national average of 6.6 per 1,000 population. Compared to other Scottish local authorities Moray has the seventh lowest proportion of people registered blind or partially sighted per 1,000 population.[5]

74% of people registered blind or partially sighted are aged 65 and over and 26% are under 65, which is in line with the overall Scottish distribution. Further breakdown shows that a higher percentage of females (59%) have a physical and/or sensory disability than males (41%).

3.5 Informal carers

Older people themselves have a critical role to play in enabling other older people to stay out of the formal care system, to remain in their home safely, independently and with dignity. They provide far more informal care than they receive. It is estimated in Scotland that just over 3,000 people over 65 years receive more than 20 hours of paid care a week while over 40,000 people over 65 years provide more than 20 hours unpaid care a week.[6]

There are an estimated 657,000 unpaid informal carers in Scotland[7] providing care for children, adults and older people with care needs.18% of carers are aged 70 and

over and 19% are aged 60-69. 70% of carers have been caring for over five years and 25% care for 50 hours or more a week.

As unpaid informal carers get older they take on more responsibility. It is much more likely that a cared-for person will be admitted to hospital as their carer's own health deteriorates.

The number of unpaid carers quoted in Moray has varied from 6,835 (Census 2001) to 11,628 which is the equivalent of 13% of the population (Scottish Household Survey 2007-08[8]). The 2009 Carers Scotland/Leeds University report 'A Weight off my mind' estimates the number in Moray as 7,162.

Carers Scotland estimates that with the ageing population, the number of unpaid informal carers in Scotland will increase by one million by 2037.

4 The geography of Moray

Moray stretches from the Moray Firth central coast at its northern edge to the Cairngorm mountain area in the south, covering approximately 2,238 square kilometres of predominantly rural landscape, with most people (57%) living in the five main towns of Elgin, Lossiemouth, Buckie, Forres and Keith.[9]

Other smaller communities are scattered throughout Moray (e.g. Aberlour, Dufftown, Fochabers, Cullen and Tomintoul) in remote and rural locations.

27% of Moray is covered in woodland; the average population density is low at 39 people per square kilometre compared with 67 people nationally.

CONCLUSION

The projected growth in the older population will create significant additional demand on health, care and support services, and available housing. This is

particularly relevant in the over 85 age group which is most likely to have the highest level of need.

The changing demographic is likely to impact in each locality, particularly with regards to the availability of the workforce within the health and social care sector to meet the increasing needs of older people. Current services are not sustainable for the future.

As the older population continues to increase, so will the numbers of older unpaid carers. Unpaid carers are a large provider of care, providing more care than the formal care system, and it is essential there is help to support, sustain and grow this capacity as any loss of care provision will have an impact on health and social care.

There is a need to plan for older people within minority groups e.g. learning disability, and/or autism, migrants and their specific needs as they grow older.

The rural nature of some parts of Moray makes access to services more challenging. Current service models will not be sustainable.

B: DETERMINANTS OF HEALTH

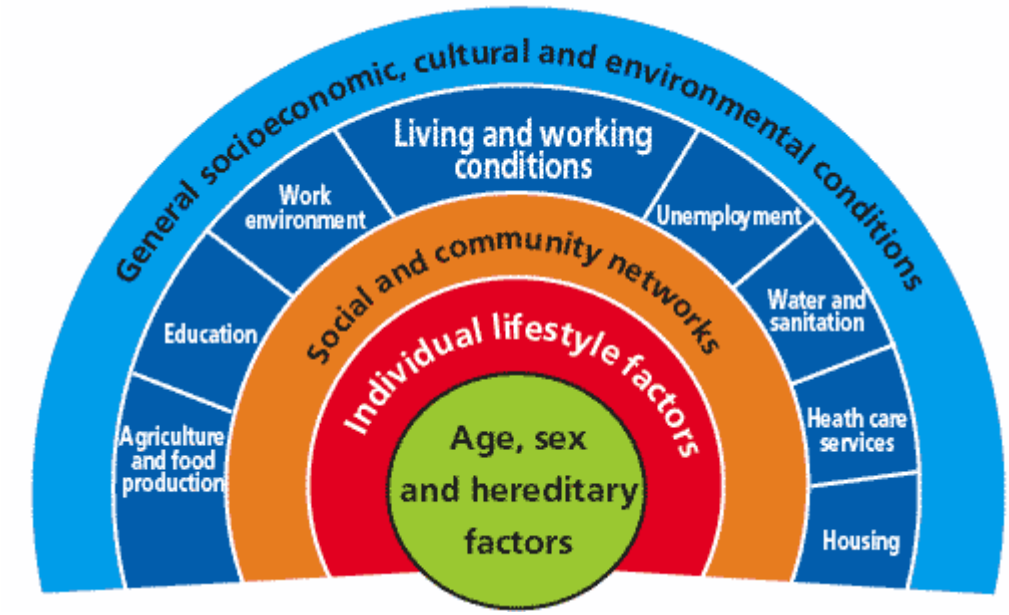
1 Overview

Many factors combine together to affect the health of individuals and communities. The conditions of daily life that include the social, economic and environmental conditions under which people live will impact upon and determine the health status of individuals and populations.

The World Health Organisation describes the social determinants of health as 'the circumstances in which people are born, grow up, live, work and age, and the

systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.'

Figure 4: Dahlgren and Whitehead 1991 model of the social determinants of health



This multifactor approach differentiates between individual and social factors.

Age, sex and genetic make-up influence people's health potential but are fixed. Factors in the surrounding layers of the model which can potentially be modified to achieve a positive impact on individual and population health, include:

- individual lifestyle choices such as smoking, diet and physical activity have the potential to promote or damage health
- interactions with family, friends and social activities and networks within communities can sustain people's health
- wider influences on health such as living and working conditions; access to transport, essential goods and services; and the overall economic, cultural and environmental conditions prevalent in society as a whole.

The evidence on the social determinants for older people's health highlights a wide range of socio-economic and environmental factors that are associated with health related quality of life and negative health outcomes. These factors include income, area deprivation, social class, the loss of a spouse or partner, housing tenure, family

relationships, ageism, bereavement, social activities and social networks, neighbourhood safety and access to services. These factors particularly impact upon the emotional health and wellbeing of older people.

2 Economic factors

2.1 Economy

Moray ranks above the Scotland average on all education and economic indicators. The percentage of the population who are income deprived is 11.2% (Scotland 15.1%) and 3.1% of the working age population are claiming Jobseeker's Allowance (Scotland 4.4%).

The Moray Economic Strategy (draft 2011) identifies that the Moray economy does have its weaknesses, such as high reliance on government-funded jobs. The demography and economy of Moray are heavily influenced by the two air bases, RAF Kinloss and RAF Lossiemouth. In addition Moray has its own local authority and a major hospital, contributing to a high proportion of public sector employment.

Recent concerns over the long-term future of RAF bases in the area - which contribute £156.5 million (including civilian expenditure) a year to the Moray economy, of which £76.6 million is retained and spent locally - have been rationalised. RAF Kinloss closed as an operational air base but has since converted to an Army base. RAF Lossiemouth will remain as Scotland's only RAF station.

Moray must also contend with a perceived remoteness in terms of the strategic road and rail network and how this impact on key markets. Higher than average levels of economic activity, employment, self employment and low unemployment mask the effects of out migration.

2.2 Deprivation

Overall, Moray is one of the least deprived areas in Scotland, as defined by the Scottish Index of Multiple Deprivation (SIMD), having no data zones in the 15% most

deprived in Scotland and just two in the 20% most deprived areas, both of which are in Elgin. This represents just 1.7% of Moray's data zones, the lowest in Scotland with the exception of the three island groups.

However, the rural nature of Moray means that 27.6% of its data zones are within the 15% most access deprived in Scotland due to the financial cost, time and inconvenience of travelling to basic services.

Although categorised as one of the least deprived local authority areas in Scotland, the median gross weekly wage in Moray is the lowest in Scotland at £388.40, compared with £461.80 nationally. The SIMD states that 9.3% of Moray is income deprived, which accounts for 8,169 residents. However, the level of income deprivation in Moray varies greatly across the area, from 1.5% in Kinloss to 22.7% in one area of Buckie [10].

2.3 Welfare benefits

Figures from the Department of Work and Pensions (2010) estimated 16,900 older people were receiving a state pension in Moray. The gender split was 10,000 female and 6,900 male.

The percentage of adults claiming Incapacity Benefit or the highest rate of Disability Living Allowance was significantly lower than Scotland.

There were approximately 430 Disability Living Allowance (DLA) claimants aged under 16, 2,500 of working age and 1,350 of pensionable age at August 2010 (latest published figures). There has been an increase of 8% in the number of claimants in the under 16s and working age groups since August 2006, and an increase of 24% in the number of claimants of pensionable age. The proportion of male claimants reduces with age group, accounting for about 66% of the under 16s, 55% of working age claimants and 33% of claimants of pensionable age.

There were a total of 670 claimants of Carers Allowance at August 2010, 630 of whom were of working age, 40 being of pensionable age. There was an increase of 8% since August 2006, predominantly in the number of working age claimants. 80% of working age claimants were female while virtually all pensionable aged claimants were female.

The number of Attendance Allowance claimants has remained fairly steady over the last five years at around 2,220. The majority of claimants (about 70%) are female and the proportion increases with age. As at August 2010, 50% of claimants aged 65-69 years were female, rising to 78% of claimants aged 90 years and over.

2.4 People experiencing fuel poverty

"A household is in fuel poverty if it would be required to spend more than 10% of its income (including Housing Benefit or Income Support for Mortgage Interest) on all household fuel use. 'Extreme fuel poverty' can be defined as a household having to spend more than 20% of its income on fuel." (Scottish Fuel Poverty Statement, 2002).

Statistics for fuel poverty are obtained from the Scottish House Condition Survey. Three years worth of data are combined to obtain statistically reliable local authority analyses.

Between 2003 and 2006, the number and proportion of households living in fuel poverty has increased in both Moray and nationally. Additionally, the proportion of households in fuel poverty in Moray was higher than nationally until 2007/09 when the national proportion rose above that in Moray.

A breakdown of households in fuel poverty by household type suggests that about 15% of family households, 60% of pensioner households and 20% of other household types are in fuel poverty.

The proportion of Moray households in extreme fuel poverty remains higher than nationally at 13% compared with 8%.

CONCLUSION

Whilst planning for effective services to meet the needs of older people in Moray, it must be recognised that there are many factors which have an influence on physical and mental health and wellbeing. These include accessibility to and the ability to take part in meaningful community activities and maintain good quality relationships.

There is a need to strengthen the capacity of the community to improve health and wellbeing particularly for older people who find themselves socially isolated.

There are increasing numbers of older people who have a disability or who are carers, particularly among the female population, with increasing numbers of carers in the working age group

Economic factors also have an influence on health and wellbeing.

There is a need for older people to have access to regular benefit checks in order to prevent any impact on health due to fuel poverty, including a focus on male carers.

3 Housing and social care

3.1 Older people and housing

The Scottish Government has found that the vast majority of older people (nearly 90%) live in mainstream housing, and given current rates of house building this is unlikely to change significantly.

Well over half of older people in Scotland own their own home and most would prefer to remain in that sector. The great majority of sheltered housing, and nearly all of housing with care/very sheltered housing, is provided by the social rented sector. Although the majority of older people live in mainstream housing, some 6% currently live in sheltered housing of some form[11].

The Scottish Government also identified that for older people, the factors encouraging them to leave rural areas are: a lack of suitable accommodation; limited support to stay in one's own home; a lack of local care services; poor availability and accessibility of local shops and services; and feelings of social and geographical isolation. The factors encouraging older people to move into rural areas are: an appreciation of the local environment; ease of access to this; the availability of appropriate, affordable housing; and the perceived strong sense of community available in some rural areas."[12]

In Moray, 36.3% of older people with intensive care needs are cared for at home rather than in care homes or geriatric long-stay hospital beds (Scotland 31.7%). The percentage of older people receiving free personal care at home is 4.8% (Scotland 5.3%). The percentage of adults claiming incapacity benefit or severe disability allowance is significantly lower than Scotland

The recently completed Moray Housing Needs and Demand Assessment (2010) states that the total number of dwellings in Moray in 2008 was 41,649, a rise of 6% since 2003 which was slightly higher than the national rise of 5%.

In Moray, and nationally, approximately 64% of the population lives in owner-occupied accommodation. However, Moray has a smaller proportion of people living in social rented accommodation at 20% (Scotland 24%), but a higher percentage renting privately at11% (Scotland 6%).

A smaller proportion of Moray's population lives in lone parent families – 8% compared with 13% nationally, and a slightly smaller proportion of people living alone at 12% compared with 14%. An equivalent proportion of people aged 65 years and over live on their own in both Moray and Scotland as a whole at 5.7%[13].

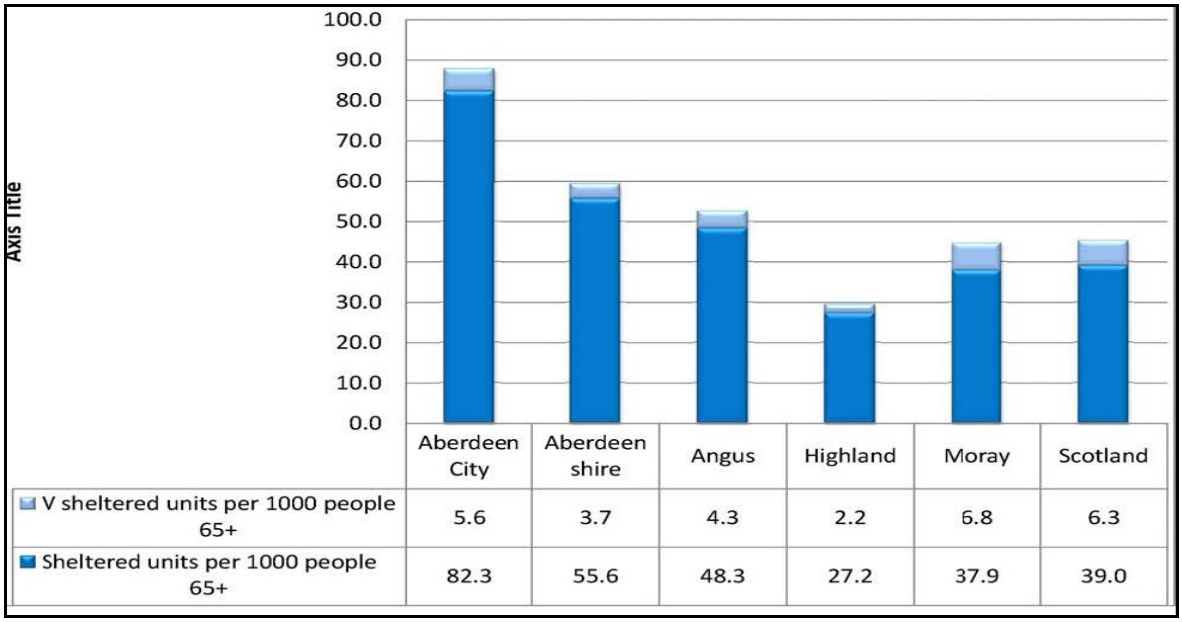
There are no data zones in Moray that are within the 15% most housing deprived in Scotland. However, four of Moray's data zones (3.4% of the total) are within the 20% most housing deprived in Scotland: two in Elgin, one in Forres and one in Lossiemouth [14].

Care home provision in Moray has increased by 9.2% between 2000 and 2009. This change differs from that of neighbouring local authorities and the Scottish average which have all reduced. Yet at 39 places per 1,000 population, Moray remains lower than the national average (45 places).

The figure below shows the provision of sheltered and very sheltered housing for older people. Moray is amongst the local authorities in Scotland with the lowest provision of sheltered units per 1,000 people[15].

In Moray, 36.3% of older people with intensive care needs are cared for at home, rather than in care homes or geriatric long-stay hospital beds (Scotland 31.7%). The percentage of older people receiving free personal care at home is 4.8% (Scotland 5.3%).

Figure 5: Provision of social housing for older people: number of houses per 1000 population aged 65+, 2010



	Aberdeen City	Aberdeen shire	Angus	Highland	Moray	Scotland
V sheltered units per 1000 people 65+	5.6	3.7	4.3	2.2	6.8	6.3
Sheltered units per 1000 people 65+	82.3	55.6	48.3	27.2	37.9	39.0

When broken down further to locality areas and compared to population figures, the distribution of sheltered and extra care housing across housing market areas is disproportionate to the older population. The housing market areas with least provision are Keith and Speyside.

3.2 Future sheltered and extra care housing provision

The Moray Housing Market Partnership has attempted to estimate how many new units of sheltered/ very sheltered/ extra care housing will be required to meet the needs of the projected increasing older population in Moray. To maintain the same ratio of provision in 2018 as in 2010, 759 new units of sheltered or extra care housing will be required, i.e. there will be 95 newly forming households in need of sheltered/ very sheltered housing each year.

SUMMARY

Older people have repeatedly expressed their desire to remain living in their own homes for as long as possible. This will require partnership working to ensure that whether they live in mainstream or specialist housing, they have homes which are safe, secure and, if necessary, adapted to meet their needs.

As well as meeting needs, housing must meet the changing aspirations of older people in terms of location, neighbour, space and facilities.

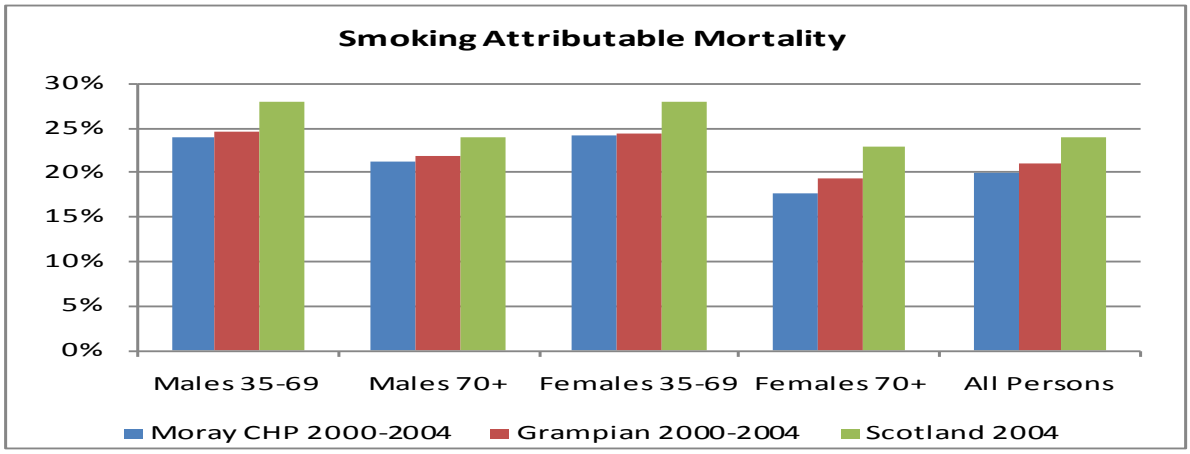
New build will not be able to keep pace with demand. Moray is already amongst the local authorities in Scotland with the lowest provision of sheltered units per 1,000 people. There will be a need to increase the provision of flexible housing support options that are needs led.

4 Lifestyle Choices

Smoking

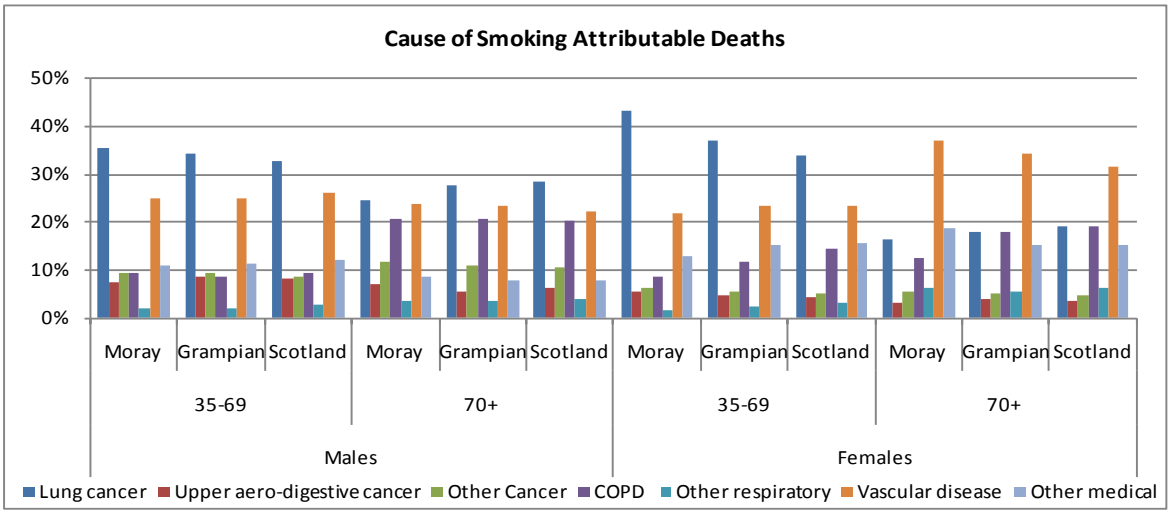
The ScotPHO Health and Wellbeing Profile 2010 for Moray suggest that 23% of the adult population smoke, 3% lower than the national figure. The level of smoking in adults over 64 years reduces quite considerably, with the proportion of those aged 75 years and over smoking being less than half the proportion aged 55-64 years.

Figure 6: Smoking attributable mortality in Moray, Grampian and Scotland



The figures indicate that a smaller proportion of deaths in Moray are attributable to smoking compared to those for the whole of Grampian and nationally. However, about 20% of all deaths are attributable to smoking, increasing to nearly 25% of deaths of 35-69 year olds.

Figure 7: Cause of smoking attributable deaths in Moray, Grampian and Scotland



Deaths from lung cancer in woman aged 35-69 and men in the same age group were higher than the Grampian and Scottish percentages. In the older female age group, the rate of deaths from vascular disease was higher than the Grampian and Scottish levels.

Causes of smoking attributable deaths in the 70+ males was similar in Moray, Grampian and Scotland, with upper aero-digestive cancer being slightly higher than the comparators.

Smoking is one of the biggest avoidable causes of morbidity and mortality, with smoking related disease and illness placing considerable burden upon local health and social care services. Whilst older people are more likely to quit smoking, older smokers are at greater risk from smoking related disease and illness because they have smoked longer, tend to be heavier smokers and are less likely than younger smokers to heed health warnings.

4.1 Alcohol

In Moray there have been 223 deaths from alcohol related conditions in the last five years, giving a death rate not significantly different to Scotland whilst the proportion of the population hospitalised with alcohol conditions is significantly worse (higher) than average.

Alcohol misuse is a major public health problem in all age groups. Consumption of alcohol generally tends to reduce with increasing age, with older adults consuming less alcohol than younger and middle aged people[16].

In Grampian the exact number of older people engaging in 'problematic drinking' is not available. Even if the prevalence of problem drinking in the elderly remains constant, it can be expected that the absolute numbers of elderly people who misuse alcohol will increase in line with the projected increase in the population of those aged 65 years and over[17].

A recent study of alcohol misuse in the elderly in Grampian[18] describes how older people are at increased risk of alcohol related problems than their younger counterparts. This is because the normal ageing process is accompanied by certain physiological changes in the body that lead to decrease tolerance and poorer ability to metabolise alcohol at a given level of use as one grows older. These physiological changes include: a decrease in body water; an increase in body fat; a decrease in blood flow to the liver; and inefficient liver enzymes.

In addition, the increased likelihood that elderly people would use medications that may interact adversely with alcohol also contributes to the higher risk of negative health effect for a given level of use. Furthermore, alcohol misuse in the elderly may also aggravate underlying medical conditions such as heart failure and hypertension[19 20]. Thus it is possible that the recommended daily allowance set for the general population may in fact represent excessive intake and greater risk for older people.

Available evidence suggests that about 11% of all accident and emergency attendances are alcohol related[21].

In 2009/2010, a total of 315 individuals in Moray were admitted to hospital 529 times due to alcohol related general medical problems (Table 6). Of these, 56 patients (18%) were aged 65 years and over. Lower percentages of alcohol related admissions in over 65s were observed in Aberdeen City (13%), Aberdeenshire (17%).

Table 6: Alcohol related hospital admission episodes (main or secondary diagnosis) in Grampian by age group and community health partnership (CHP) 2009/2010[22]

Area	Episodes	Number of patients		
		0-64 yrs	65 yrs and over	Total
Aberdeen City CHP	2588	1154	169	1323
Aberdeenshire CHP	1144	581	117	698
Moray CHP	529	259	56	315
Non-Grampian Practice	120	91	7	98
Total	4381	2085	349	2434

In 2009/2010, a total of 238 individuals in Moray were admitted 392 times due to alcohol related mental and behavioural disorders (including electives, emergencies, transfers).

Of these 45 patients (19%) were aged 65 years and over. Lower percentages in the age group were observed in Aberdeen City (13.4%), Aberdeenshire (17%).

Table 7: Alcohol related admission episodes due to alcohol related mental & behavioural disorders in Grampian by age group and CHP 2009/2010[23]

Area	Episodes	Number of patients		
		0-64 yrs	65 yrs and over	Total
Aberdeen City CHP	2021	907	140	1047
Aberdeenshire CHP	876	452	93	545
Moray CHP	392	193	45	238
Non-Grampian Practice	90	68	7	75
Total	3379	1620	285	1905

Alcohol misuse remains a significant health problem in older people because factors associated with ageing puts older people at particular risk from harm and the recommended sensible drinking levels may in fact be harmful in this population group.

SUMMARY

The prevalence of alcohol use disorders in elderly people in Grampian will increase in line with the projected increase in the ageing population. There is a need to provide more care and support for elderly people who may develop late onset alcohol

problems. This requires partnership work across a range of agencies including health, social services and the voluntary sector.

4.2 Diet, levels of exercise and obesity

Obesity can reduce people's overall quality of life. It creates a strain on health services and leads to premature death due to its association with serious chronic conditions such as Type 2 diabetes, hypertension and hyperlipidaemia, which are all major risk factors for cardiovascular disease. The two major lifestyle factors associated with the growth of obesity are physical inactivity and poor diet.

Nationally there has been a steady upward trend in the prevalence of overweight and obesity among both sexes aged 16-64 since 1995. Obesity prevalence increases with age for both sexes, from 11.0% of men and 15.5% of women aged 16-24, before peaking among men aged 55-64 (37.5%) and women aged 65-74 (35.4%).

Differences between men and women are more pronounced at ages 16-34 years and 75 years and over for both general and central measures of obesity.
Lower prevalence of obesity in older age groups may be partly a selection effect due to higher mortality among obese people at younger ages.[24]

There are no figures at local level for older people and obesity. However it is acknowledged that older people who are overweight are at significantly increased risk of developing problems with mobility and carrying out everyday tasks, and will therefore have higher care needs.[25]

SUMMARY

Individual lifestyle choices and behaviours are influenced, and even to a larger extent constrained, by the wider socio-economic and environmental conditions of daily life. Actions which focus on lifestyles factors in isolation will be insufficient to address health inequalities and the social determinants of older people's health. Progress on health determinants therefore demands a whole systems approach involving actions across a wide range of policy areas.

These issues are often too complex for any single organisation to resolve and require integrated policy and actions on the part of a broad range of partner agencies. Increasing numbers of older people and higher levels of overweight and obesity will lead to a greater burden of disability and ill health. Good nutrition can help to combat chronic disease whereas poor diet and nutrition increases complications of disease and delays recovery from illness.

C: HEALTH AND WELLBEING IN MORAY

1 Overview

General health in Moray is reported as being slightly better than nationally with nearly 93% of Moray's population reporting good or fairly good health and just 7% reporting not good health. This compares with 90% and 10% respectively for Scotland.

The percentage of the population that has a limiting long-term illness is approximately 3% lower in Moray than nationally, at 17% of the population compared with 20%[26].

An estimated 26.0% of adults smoke (Scotland 25.0%). There have been 223 deaths from alcohol conditions in the last five years, giving a death rate not significantly different to Scotland, whilst the proportion of the population hospitalised with alcohol conditions is significantly worse (higher) than average.

The CHSCP has an incidence of cancer the third lowest of any CHP. For chronic obstructive pulmonary disease (COPD) patients, cerebrovascular disease patients, patients hospitalised as an emergency, and patients aged 65 years and over with multiple hospitalisations, the proportions of the population hospitalised are significantly lower than the Scotland average.

The proportions of the population hospitalised with coronary heart disease, and with asthma, are significantly worse (higher) than average.

1.1 Life expectancy

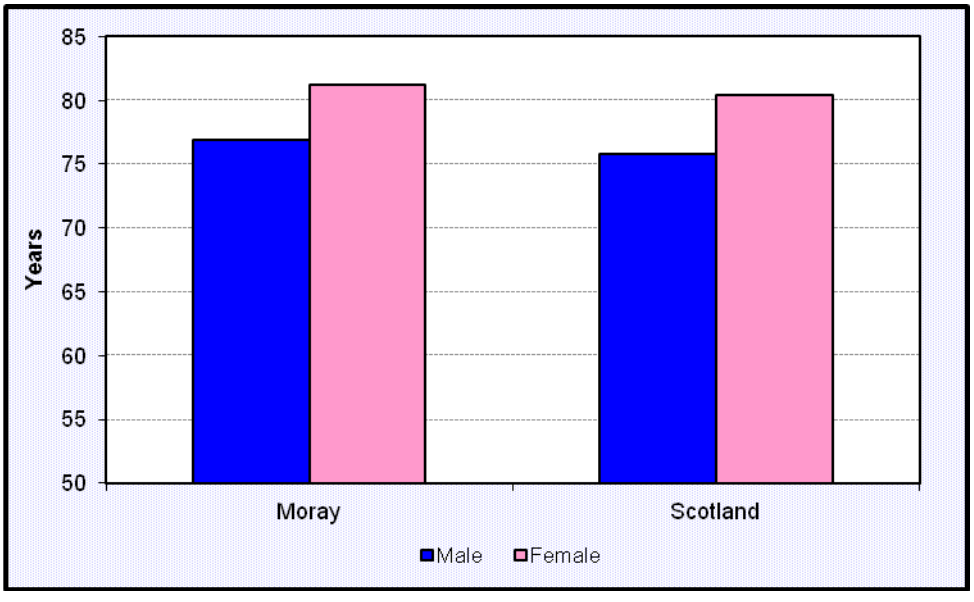
Between 1997 and 2009 there has been an improvement in life expectancy at birth for males and females both nationally and in Moray, and the percentage improvement is greater for males than females. This suggests the gap in life expectancy between the genders is reducing.

Life expectancy at birth in Moray is greater for both males and females than the national average and female life expectancy is greater than for males, a trend apparent across all areas of Scotland.

Female life expectancy at birth (81.3 years) is greater than male life expectancy (76.9 years), and both were greater than the Scottish average. Male life expectancy at birth in Moray is improving more rapidly than female life expectancy.

In Moray female life expectancy at age 65 (19.9 years) is greater than male life expectancy at age 65 (17.7 years).

Figure 8: Life expectancy at birth – GRO Scotland 2009



1.2 Healthy life expectancy

The most recent data for Healthy Life Expectancy (HLE) at a local authority level is for the period 1999-2003 based on five years of data on deaths and populations, and a single year of data for self-assessed health (SAH) from the Scotland Census for 2001[27].

It showed men in Moray had a life expectancy of 74.2 years and a healthy life expectancy of 69.1 years, giving 5.1 years in 'not good' health. This was a shorter period than the Scottish average of 7 years, with life expectancy being 73.3 years (lower than the Moray figure) and healthy life expectancy of 66.3 years.

Women in Moray had a life expectancy of 79.7 years and a healthy life expectancy of 73.4 years – a difference of 6.3 years in 'not good' health. For Scotland as a whole the figure was 8.5 years, the difference between life expectancy of 78.7 years and healthy life expectancy of 70.2 years.

The larger gap between Moray and Scotland in healthy life expectancy than life expectancy means that Scotland's population as a whole can expect more years of 'not good' health than Moray's population. Females will also have slightly longer in 'not good' health than males both in Moray and nationally.

Male and female life expectancies in Moray are both significantly better than the Scotland average.

1.3 Mortality

All-cause mortality (all ages) and the mortality rate from coronary heart disease (under-75s) are significantly better than the Scotland average. Mortality rates from cancer and cerebrovascular disease (under-75s) are not significantly different to Scotland.

The causes of mortality in this age group are reflected in the most frequent causes of mortality below[28]. The majority of deaths occur in this age group. In a study carried out by NHS Grampian Health Intelligence of the 5317 deaths in Grampian in 2008, 81% were in those aged 65 years and over with 62% of deaths in those 75 years and over. Deaths due to pneumonia, cerebrovascular disease and dementia are increasingly common in this age group.[29]

Figure 10: Cause of death in males, Moray, 2011

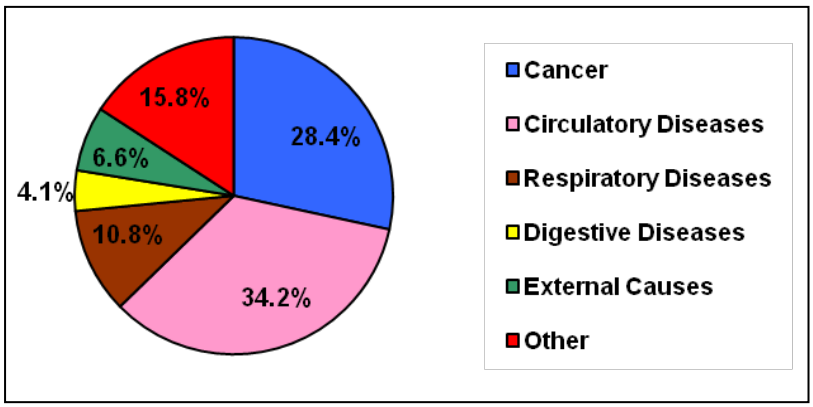
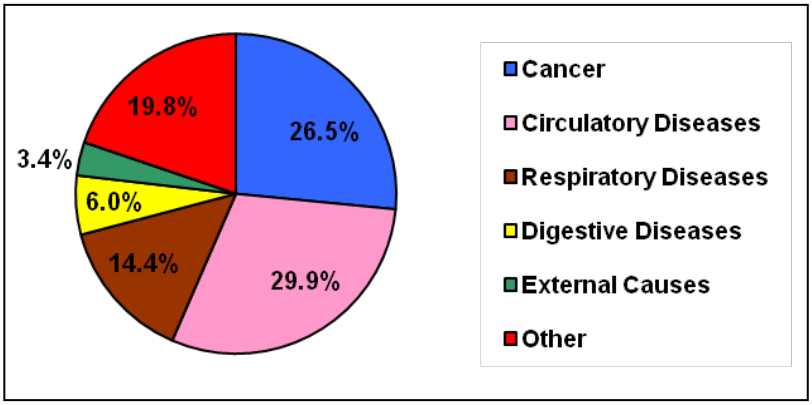


Figure 11: Cause of death in females, Moray, 2011



2 Long Term Conditions

2.1 Chronic diseases

Long term conditions, or chronic diseases as they tended to be referred to, are conditions that last a year or longer, impact on a person's life, and may require ongoing care and support. Common long term conditions in the elderly include dementia, diabetes, some mental health problems, heart disease, chronic pain, arthritis, chronic obstructive pulmonary disease (COPD).

The national action plan for improving health and wellbeing of people with long term conditions in Scotland(2009) states that around 2 million people in Scotland have at least one long term condition, with one in four adults over 16 reporting some form of long term illness, health problem or disability.

Long term conditions become more common with age 19% of adults aged 16-24 had a long-term condition, rising steadily with age to 69% of those aged 75 and over. By the age of 65, nearly two thirds of people will have developed a long term condition.The association with age was stronger for limiting conditions than for non-limiting ones. For example, 9% of men and 12% of women aged 16-24 had a limiting long-term condition, which increased to 58% of men and 55% of women aged 75 and over. Older people are also more likely to have more than one long term condition: 27% of people aged 75-84 have two or more such conditions.

The human costs and the economic burden of long term conditions for health and social care are profound. 60% of all deaths are attributable to long term conditions and they account for 80% of all GP consultations. People with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionately longer and account for over 60% of hospital bed days used. Most people who need long term residential care have complex needs from multiple long term conditions.

There are clear links between long term conditions, deprivation, lifestyle factors and the wider determinants of health. People living with a long term condition are likely to be more disadvantaged across a range of social indicators, including employment, educational opportunities, home ownership and income. Someone living in a disadvantaged area is more than twice as likely to have a long term condition as someone living in an affluent area and is more likely to be admitted to hospital because of their condition.

People living with long term conditions are also more likely to experience psychological problems. Around one in three people with heart failure and diabetes and one in five people with coronary heart disease and chronic pain will experience depression. Prolonged stress alters immunity, making illness more likely and recovery more difficult, especially for those who are already unwell.

2.1.1 Diabetes

Diabetes is an important cause of disability and is associated with increased risk of other key diseases, including coronary heart disease, cerebrovascular disease and renal failure. For example, the Scottish Diabetes Survey(2008) found that 9.5% of diabetes patients had had and survived a myocardial infarction. Whilst the disease itself can be prevented, good diabetic control, management of risk factors for associated disease, and early detection of complications such as diabetic eye disease is important in reducing disability and mortality.

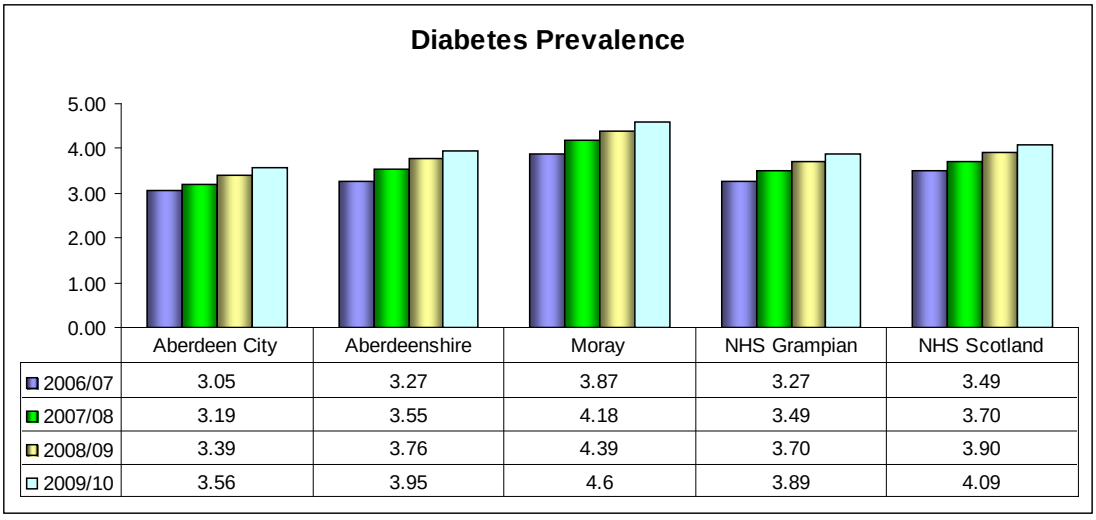
Prevalence in Scotland is increasing rapidly as in many other countries. Although this is influenced by increased awareness of the disease, more complete recording, and an increasingly elderly population, poor diet and low physical activity are also contributing with overweight and obesity key risk factors. The Scottish Diabetes Survey found that 33% of patients with a recorded BMI were overweight, with 50% of patients obese. Prevalence of diabetes also rises with deprivation. The odds of having type 2 diabetes is 77% higher among the most deprived compared with the most affluent.

The most recent Scottish Diabetes Survey (2011) estimated that around 4.7% of the Scottish population had a diagnosis of diabetes at the end of 2010. A prevalence of 4.37% of the population was found in Grampian. These estimates are somewhat higher than the QOF prevalence figures but both show prevalence in Grampian to be below that of Scotland. A clear majority of disease, 88%, was attributable to type 2 diabetes.

QOF data shows that the prevalence of diabetes rose in all areas over the four years (2006/7 to 2009/10) and in figures published on a practice basis, the Moray figure for 2010/11 was 4.85 per 100, up again on previous years and up by almost one whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 3.99 to 5.84 (Tomintoul and Cullen).
According to the National Statistics Release (2009/10 figures), in Moray there were 101 'episodes of care' related to diabetes of which 14 (13.86%) were attributed to those aged 65+ (the proportion of 65+ was over 10% less than the national percentage) with 10 new patient incidents.

There were 475 bed days attributed to diabetes with 128 (26.95%) attributed to those aged 65+ (the proportion of 65+ was over 20% less than the national percentage). The rate in Moray remains the highest of the three Community Health Partnerships in Grampian at 4.6% compared with 4% in Aberdeenshire and 3.6% in Aberdeen City. The prevalence in Moray is also higher than the national rate of 4.1%.

Figure 11: Diabetes prevalence



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	3.05	3.27	3.87	3.27	3.49
2007/08	3.19	3.55	4.18	3.49	3.70
2008/09	3.39	3.76	4.39	3.70	3.90
2009/10	3.56	3.95	4.6	3.89	4.09

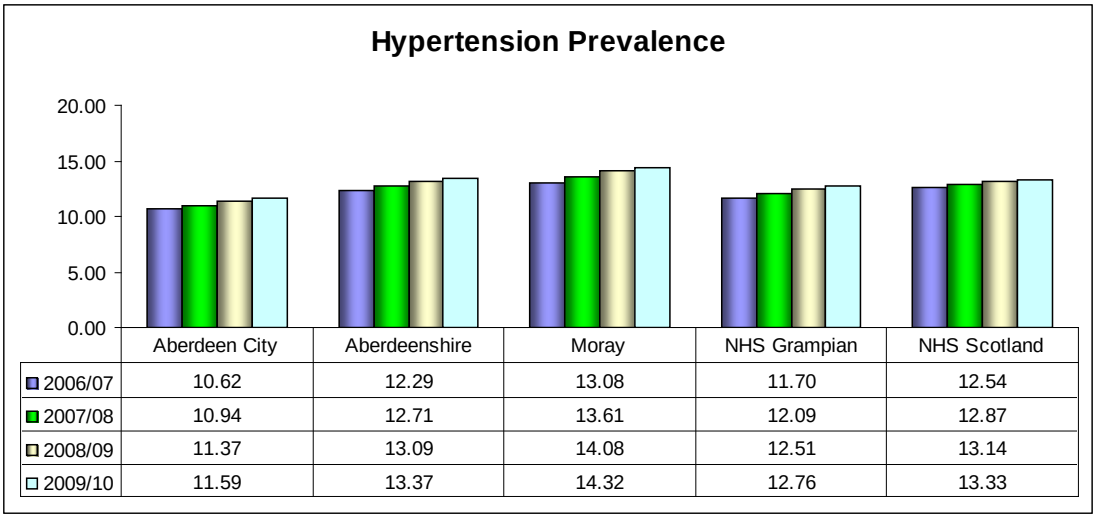
2.1.2 Hypertension

Hypertension is characterised by elevated systolic and diastolic blood pressure and is a major risk factor for cardiovascular, cerebrovascular and renal disease. In 2009, around three in ten men and women in Scotland had raised blood pressure. The prevalence of raised blood pressure increases with age.

Prevalence of hypertension rose in all areas over the four years and in figures published on a practice basis the Moray figure for 2010/11 was 14.70 per 100, up again on previous years and up by 0.9 of a whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 10.66 to 20.76 (Glenlivet and Fochabers).

According to the National Statistics Release (2009/10 figures), in Moray there were 23 'episodes of care' related to hypertension of which 10 (43.48%) were attributed to those aged 65+ (the proportion of 65+ was over 2% more than the national percentage) with 4 new patient incidents. There were 189 bed days attributed to hypertension with 158 (83.60%) attributed to those aged 65+ (the proportion of 65+ was almost 18% more than the national percentage).

Figure 12: Hypertension prevalence



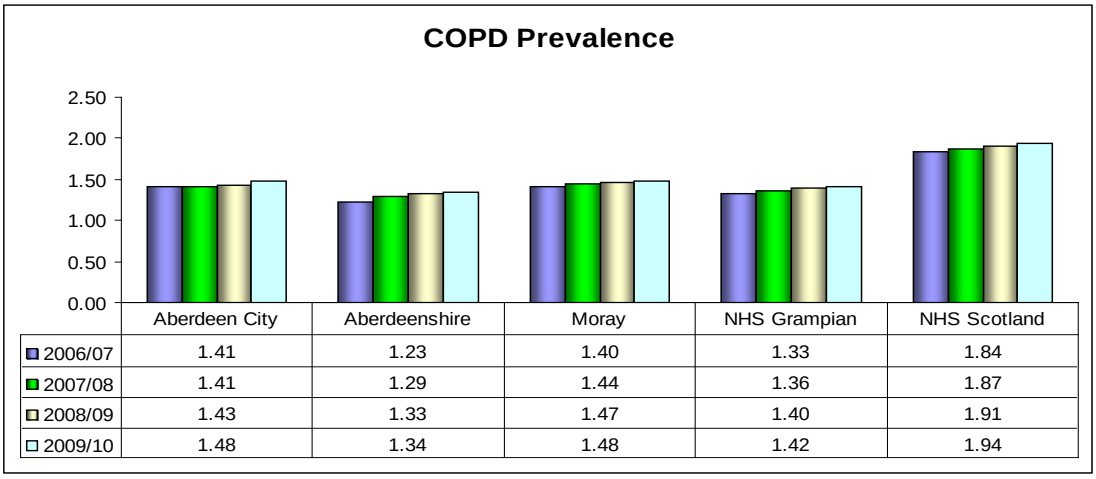
	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	10.62	12.29	13.08	11.70	12.54
2007/08	10.94	12.71	13.61	12.09	12.87
2008/09	11.37	13.09	14.08	12.51	13.14
2009/10	11.59	13.37	14.32	12.76	13.33

2.1.3 Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a progressive disease that affects breathing but also causes weight loss, nutritional disturbances and muscle problems. It produces chronic and limiting breathing problems but is also associated with acute exacerbations often related to the increased rate of respiratory infection associated with this disease. Some of these acute exacerbations will require hospitalisation. COPD is also frequently associated with and can contribute to numerous co-existing diseases such as heart disease. It is an important cause of morbidity and mortality in Scotland.

The most significant risk factor for COPD is cigarette smoking. Despite lower rates of smoking the prevalence of COPD and deaths from COPD are continuing to rise, particularly in women, as the rate of COPD may only fall many years after declines in smoking rates. Today's young and middle age smokers are at high risk of developing COPD in later life unless they can be helped to stop smoking.

Figure 13: COPD prevalence



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	1.41	1.23	1.40	1.33	1.84
2007/08	1.41	1.29	1.44	1.36	1.87
2008/09	1.43	1.33	1.47	1.40	1.91
2009/10	1.48	1.34	1.48	1.42	1.94

Prevalence of Chronic Obstructive Pulmonary Disease (COPD) rose in all areas over the four years and in figures published on a practice basis the Moray figure for 2010/11 was 1.53 per 100, up again on previous years and up by 0.13 of a whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 0.68 to 2.73 (Rothes and Fochabers).

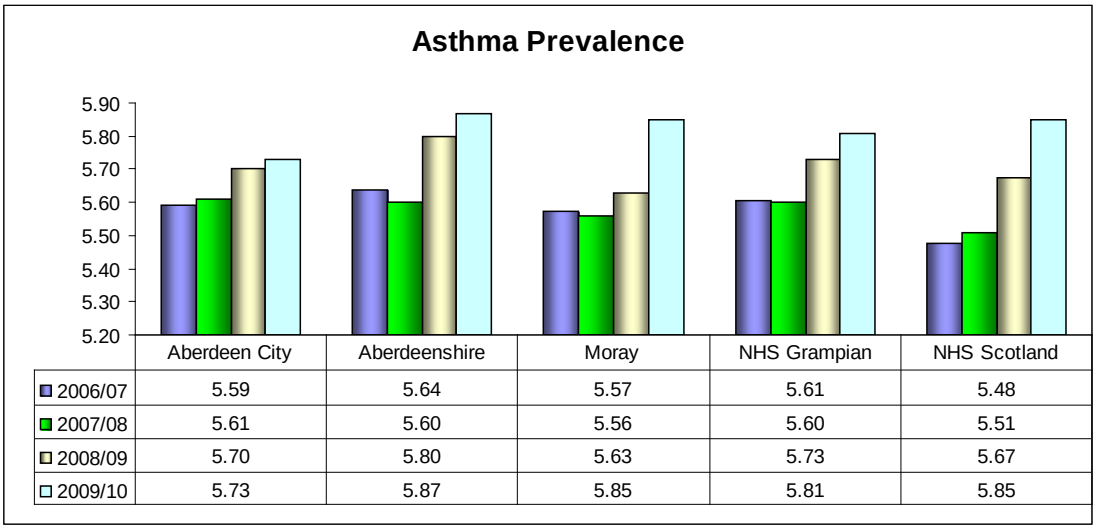
It produces a significant burden on secondary care. According to the National Statistics Release (2009/10 figures), in Moray there were 347 'episodes of care' related to COPD of which 260 (74.93%) were attributed to those aged 65+ (the proportion of 65+ was 2.7% more than the national percentage) with 52 new patient incidents. There were 1753 bed days attributed to COPD with 1486 (84.77%) attributed to those aged 65+ (the proportion of 65+ was 4.59% more than the national percentage).

2.1.4 Asthma

Prevalence of asthma in 2008/09 and 2009/10 rose in all areas and in figures published on a practice basis the Moray figure for 2010/11 was 5.81 per 100, down slightly on the previous year and up by 0.24 of a whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 3.08 to 7.27 (Tomintoul and Fochabers).

According to the National Statistics Release (2009/10 figures), in Moray there were 132 'episodes of care' related to asthma of which 21 (15.91%) were attributed to those aged 65+ (the proportion of 65+ was 3.5% more than the national percentage) with 6 new patient incidents. There were 309 bed days attributed to asthma with 102 (33.01%) attributed to those aged 65+ (the proportion of 65+ was 6.93% more than the national percentage).

Figure 14: Asthma prevalence



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	5.59	5.64	5.57	5.61	5.48
2007/08	5.61	5.60	5.56	5.60	5.51
2008/09	5.70	5.80	5.63	5.73	5.67
2009/10	5.73	5.87	5.85	5.81	5.85

2.1.5 Coronary heart disease

Coronary heart disease encompasses a spectrum of illness from patients with occasional episodes of chest pain or shortness of breath, to those presenting with an acute myocardial infarction. It also includes a group of patients with chronic debilitating symptoms significantly impacting on quality of life. Alongside aiming to prevent coronary heart disease from developing, steps can be taken at each stage to reduce symptoms, reduce the risk of progression and death, and improve the quality of life of patients. In Scotland it remains one of the leading causes of death. About 16% of premature deaths in Scotland in 2007 were as a result of coronary heart disease. [30]

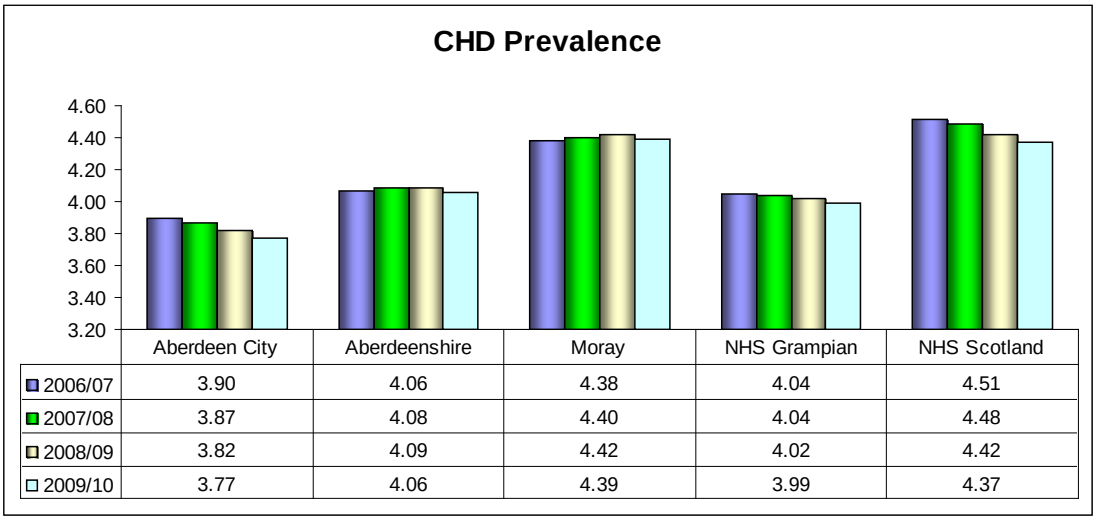
Main risk factors are behavioural. As with many of the diseases which are currently of concern in our population, smoking, obesity, lack of physical activity and poor diet play a role in the risk of coronary heart disease. Other health conditions which can be treated or prevented in many cases such as high blood cholesterol, high blood pressure and type 2 diabetes mellitus are also strong risk factors. [31]

Although the incident rate of CHD is falling, the prevalence is much higher. The crude prevalence of CHD per 100 population is closely related to age and it is highest in those aged 65 years and over. SMR1 data suggests that the crude prevalence rate of CHD per 100 population in Grampian is about 3.15 per 100 compared with the Scottish rate of 3.51 per 100 population. Corresponding estimates for Aberdeen City, Aberdeenshire and Moray CHP areas are 3.14, 3.03 and 3.50 per 100 population respectively. QOF data suggest that around 4.04 per 100 registered population in Grampian have coronary heart disease, below the Scottish figure of 4.48 per 100 registered.

Prevalence of Coronary Heart Disease (CHD) fell in all areas in 2008/09 and in figures published on a practice basis the Moray figure for 2010/11 was 4.42 per 100 - up on previous years - and up by 0.04 of a whole person per hundred in 5 years, influenced by both new cases and increasing number of people living with the disease. This is still likely to be an underestimate of the true prevalence of disease. It is estimated that around 8.2% of men and 6.5% of women are living with coronary

heart disease in Scotland[32]. By practice, the raw prevalence rates ranged from 2.63 to 5.80 (Glenlivet and Tomintoul).

Figure 15: Coronary heart disease prevalence



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	3.90	4.06	4.38	4.04	4.51
2007/08	3.87	4.08	4.40	4.04	4.48
2008/09	3.82	4.09	4.42	4.02	4.42
2009/10	3.77	4.06	4.39	3.99	4.37

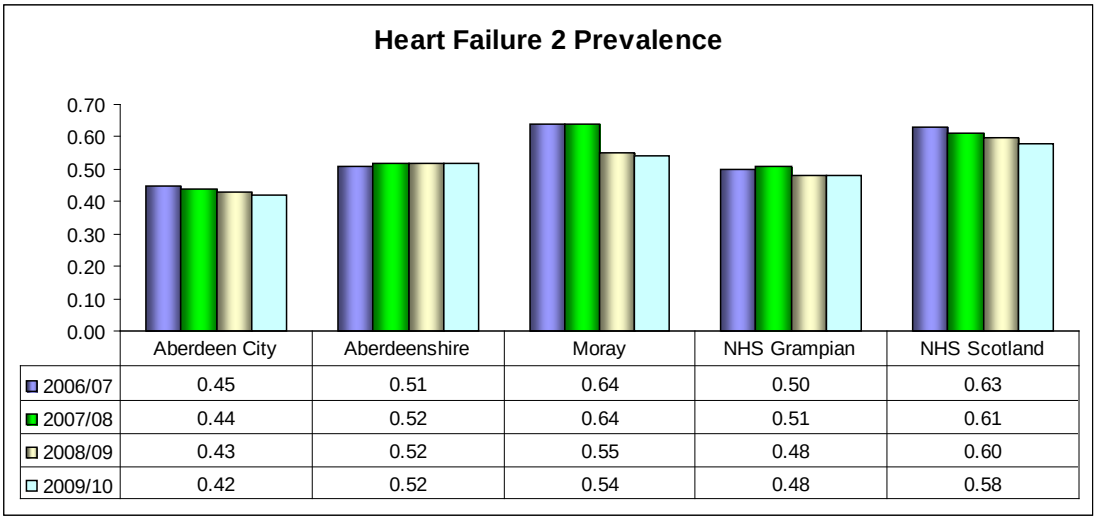
2.1.6 Heart Failure

Heart failure occurs when cardiac output sufficient to meet the demands of the body is compromised.

Prevalence of heart failure fell in all areas over the four years and in figures published on a practice basis the Moray figure for 2010/11 was 0.86 per 100, down again on previous years and down by 0.2 of a whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 0.36 to 1.5 (Ardach and Seafield).

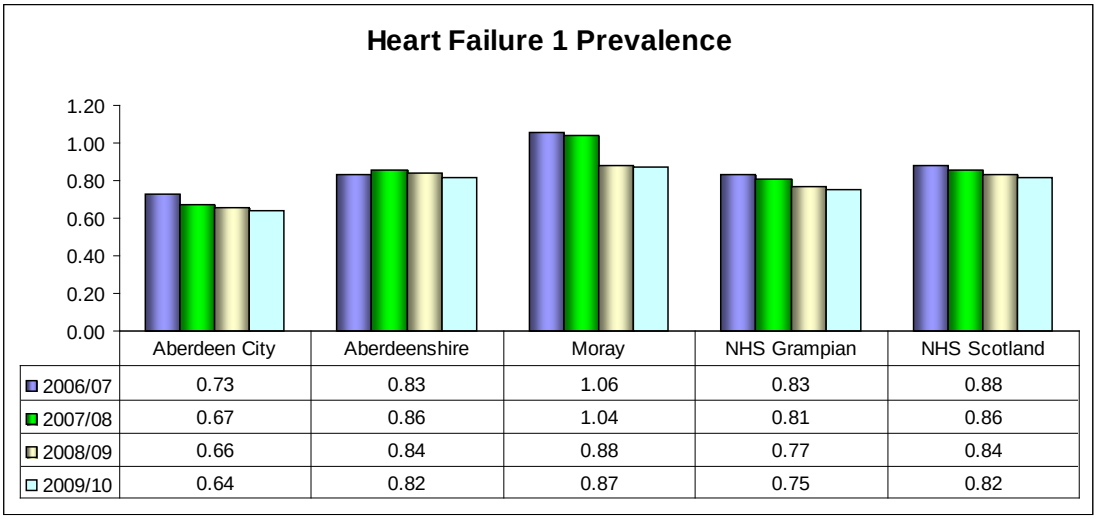
According to the National Statistics Release (2009/10 figures), in Moray there were 156 ‘episodes of care’ related to heart failure of which 129 (82.69%) were attributed to those aged 65+ (the proportion of 65+ was 3.46% lower than the national percentage) with 71 new patient incidents. There were 1433 bed days attributed to heart failure with 1276 (89.04%) attributed to those aged 65+ (the proportion of 65+ was 1.86% lower than the national percentage).

Figure 16: Heart failure 2 prevalence (confirmed by an echocardiogram of specialist assessment)



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	0.45	0.51	0.64	0.50	0.63
2007/08	0.44	0.52	0.64	0.51	0.61
2008/09	0.43	0.52	0.55	0.48	0.60
2009/10	0.42	0.52	0.54	0.48	0.58

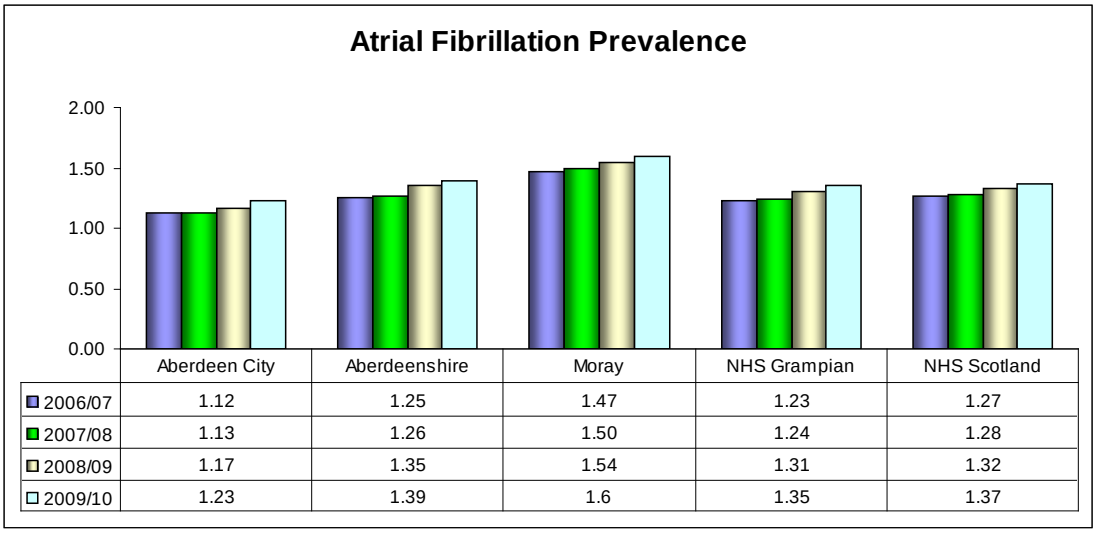
Figure 17: Heart failure 1 prevalence (patients diagnoses with heart failure)



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	0.73	0.83	1.06	0.83	0.88
2007/08	0.67	0.86	1.04	0.81	0.86
2008/09	0.66	0.84	0.88	0.77	0.84
2009/10	0.64	0.82	0.87	0.75	0.82

Prevalence of atrial fibrillation rose in all areas over the four years and in figures published on a practice basis the Moray figure for 2010/11 was 1.65 per 100, up again on previous years and up by 0.18 of a whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 0.97 to 2.68 (Glenlivet and Cullen).

Figure 18: Atrial fibrillation prevalence



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	1.12	1.25	1.47	1.23	1.27
2007/08	1.13	1.26	1.50	1.24	1.28
2008/09	1.17	1.35	1.54	1.31	1.32
2009/10	1.23	1.39	1.6	1.35	1.37

2.2 Seasonal influenza

Although influenza is generally a mild illness, some patients develop serious complication such as pneumonia. Whilst these complications can occur in any age the elderly, very young and those with chronic health problems are most at risk.

76.3% of the 65 and over age group in Scotland in 2008/09 took up the offer of the seasonal influenza vaccine, in excess of targets. Uptake in Grampian is at a similar level. The uptake in those at risk in the under 65 age group is estimated to be around 48.5%, below the target of 60%[33].

SUMMARY

The prevalence of long term conditions will increase with the ageing population and will increase the burden on health and social care in the community setting and the use of emergency beds if not managed well in the community.

There are clear links between long term conditions, deprivation, lifestyle factors and the wider determinants of health.

Public health messages are important for preventing long term conditions and

those which are not prevented need to be managed in the community through increased self care and support.

Prevention, care and support and support for carers will be key.

There will be a need for providing care and support for older people with long term conditions and those with complex needs who have more than one long term condition.

There will be a need to provide more palliative and terminal care.

3 Mental Health

3.1 Overview

Mental health problems in later life are relatively common. The Department of Health estimates that perhaps 40% of older people seeing their general practitioner (GP), 50% of older people in general hospitals and 60% of care home residents have a mental health problem.

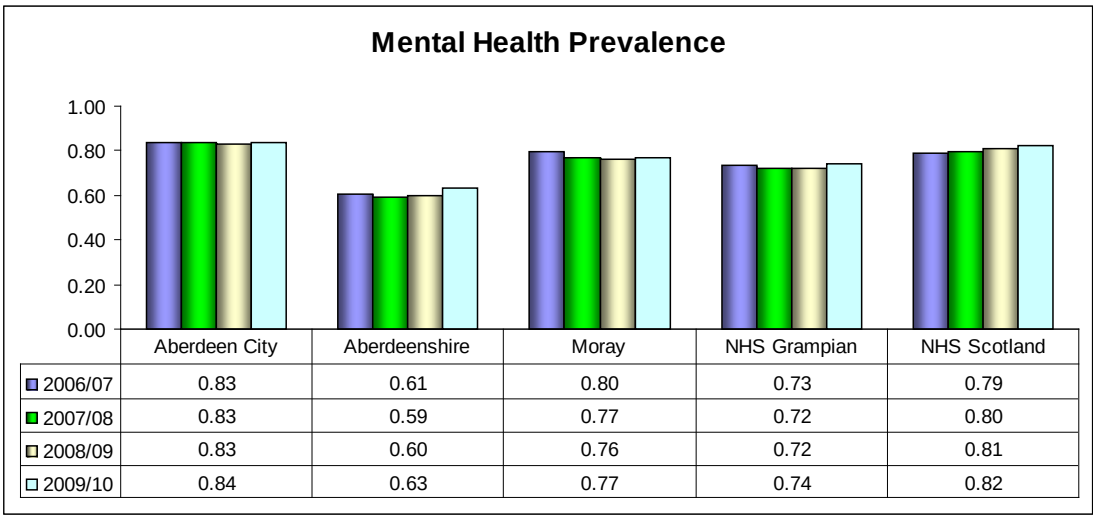
Older people with mental health problems are more likely to end up in institutional care, they recover less well from physical problems and illness, and they are more vulnerable to abuse. 'The presence of a mental health problem is a strong and independent predictor of poor outcomes such as increased mortality, length of stay, institutionalisation and resource use' (National Institute for Mental Health England, 2005).

People living with long term conditions are also more likely to experience psychological problems. Around one in three people with heart failure and diabetes and one in five people with coronary heart disease and chronic pain will experience depression. Prolonged stress alters immunity, making illness more likely and recovery more difficult, especially for those who are already unwell[34].

3.2 Prevalence of mental illnesses

Prevalence of mental illness rose in all areas over 2008/09 and 2009/10 and in figures published on a practice basis the Moray figure for 2010/11 was 0.81 per 100, up again on previous 2 years and up by 0.01 of a whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 0.43 to 1.12 (Rothes and Elgin Community).

Figure 19: Mental health prevalence



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	0.83	0.61	0.80	0.73	0.79
2007/08	0.83	0.59	0.77	0.72	0.80
2008/09	0.83	0.60	0.76	0.72	0.81
2009/10	0.84	0.63	0.77	0.74	0.82

In 2007/08, there were a total of 23,377 psychiatric admissions in Scotland. Of these, 1733 were in Grampian. Table 8 below shows the corresponding figures for the community health partnership areas during the same period[35].

Table 8: Admissions to mental illness specialities in Grampian hospitals by type of admission 2007/2008

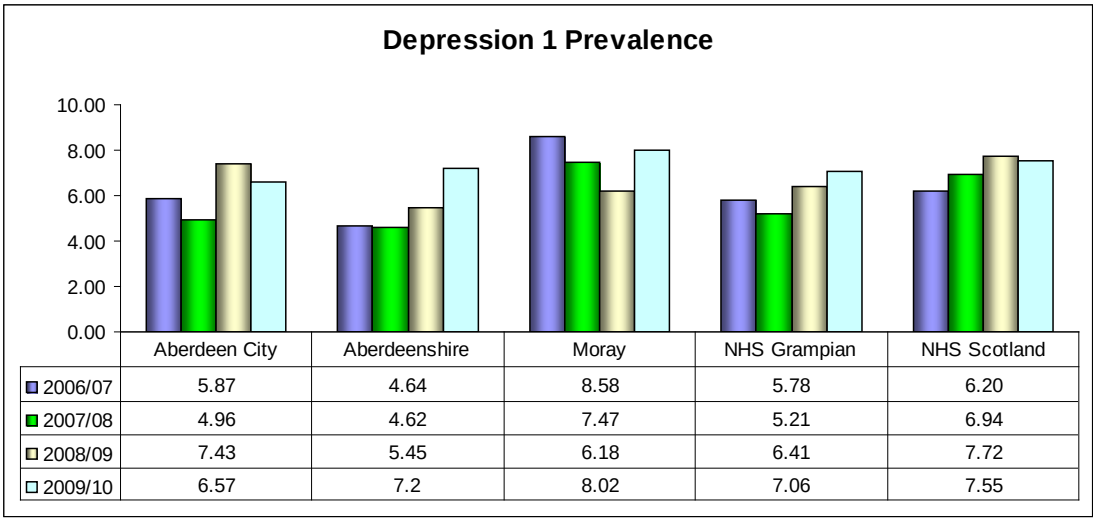
	Total	1st admission	Readmission	transfer	others/not known
Aberdeen City	**819**	226	512	76	5
Aberdeenshire	**638**	244	345	47	2
Moray	**298**	91	178	27	2
Grampian	**1 755**	561	1 035	150	9
Scotland	**23 377**	**6 930**	**13 542**	**2 252**	**653**

3.3 Depression

Depression is the most common mental health problem in later life. In Scotland, around 10% of people aged 75 and over have a depressive disorder. Of these, more than 30% have severe depression. In 2010, approximately 71,000 people had dementia in Scotland. Around 97% of these were aged 65 and over. The number of people with depression is expected to rise to 127,000 by 2031[1].

Prevalence of Depression 1 varied in all areas over the four years with Moray and Aberdeenshire rising over 2009/10 and Aberdeen City falling. In figures published on a practice basis the Moray figure for 2010/11 was 8.25 per 100, up again on previous years but down by 0.33 of a whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 6.37 to 10.04 (Glenlivet and Cullen).

Figure 20: Depression 1 prevalence (patients with diabetes and/or CHD who have been diagnosed)

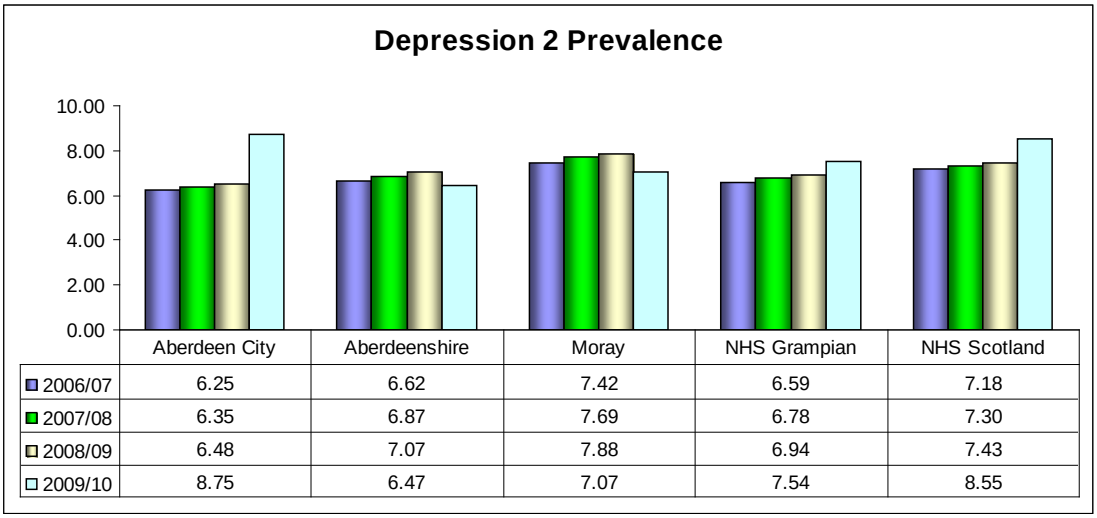


	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	5.87	4.64	8.58	5.78	6.20
2007/08	4.96	4.62	7.47	5.21	6.94
2008/09	7.43	5.45	6.18	6.41	7.72
2009/10	6.57	7.2	8.02	7.06	7.55

Prevalence of Depression 2 fell in Aberdeenshire and Moray in 2009 and in figures published on a practice basis the Moray figure for 2010/11 was 7.89 per 100, up on the previous year and up by 0.47 of a whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 0.98 to 15.10 (Dufftown and Forres).

[1] British Geriatrics Society Scotland

Figure 21: Depression 2 prevalence



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	6.25	6.62	7.42	6.59	7.18
2007/08	6.35	6.87	7.69	6.78	7.30
2008/09	6.48	7.07	7.88	6.94	7.43
2009/10	8.75	6.47	7.07	7.54	8.55

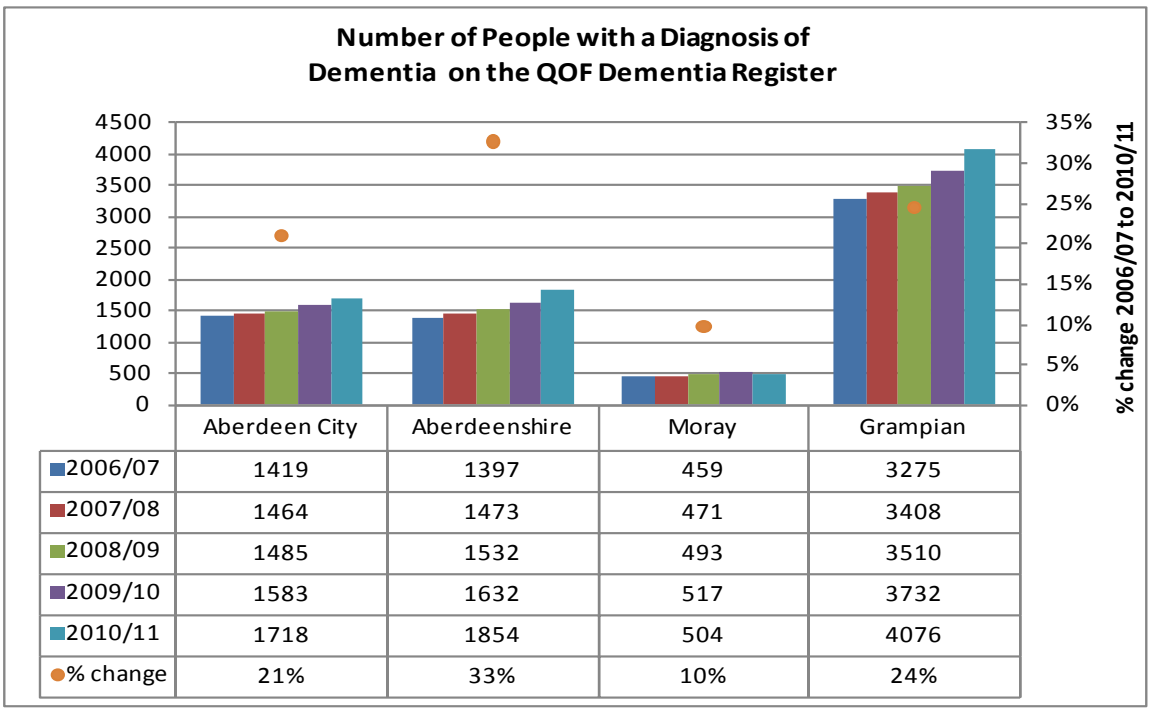
3.3.1 Dementia

There are approximately 71,000 people with dementia in Scotland, around 2,300 of who are under the age of 65. As our population ages, the number of people with dementia will increase and it is expected that the number will double over the next 25 years. Prevalence of dementia increases with age; around 1.5% of the 65 to 69-year-old population are affected, increasing to about one in three of the 90-plus age groups.

Dementia is a key health issue facing Moray in the coming decades. As our population ages there is a projected 50% increase in the number of sufferers. Dementia is a major cause of disability in people aged 60 and over. It contributes 11.2% of all years lived with disability, which is more than stroke (9%), musculoskeletal disorders (9.8%), cardiovascular disease (5%) and all forms of cancer (2.4%).

In Moray there were 504 people on the QOF dementia register in 2010/11, representing a 10% increase from 2006/7. This compares with 21% and 33% in Aberdeen City and Aberdeenshire respectively.

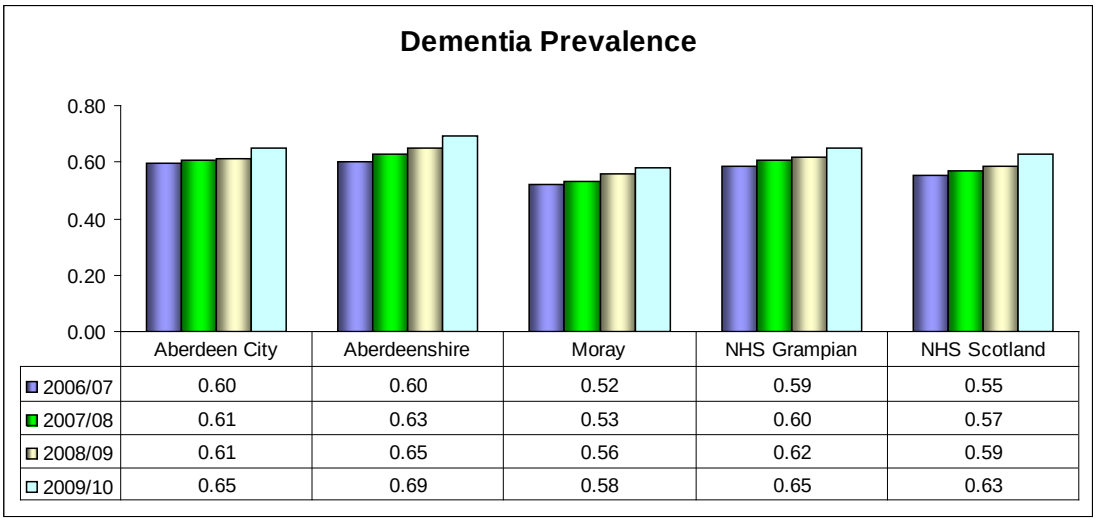
Figure 22: Number of people with a diagnosis of dementia on the QOF dementia register



	Aberdeen City	Aberdeenshire	Moray	Grampian
2006/07	1419	1397	459	3275
2007/08	1464	1473	471	3408
2008/09	1485	1532	493	3510
2009/10	1583	1632	517	3732
2010/11	1718	1854	504	4076
% change	21%	33%	10%	24%

Prevalence of dementia rose in all areas over the four years and in figures published on a practice basis the Moray figure for 2010/11 was 0.68 per 100, up again on previous years and up by 0.16 of a whole person per hundred in 5 years. By practice, the raw prevalence rates ranged from 0.40 to 1.30 (Glenlivet and Fochabers).

Figure 23: Dementia prevalence



	Aberdeen City	Aberdeenshire	Moray	NHS Grampian	NHS Scotland
2006/07	0.60	0.60	0.52	0.59	0.55
2007/08	0.61	0.63	0.53	0.60	0.57
2008/09	0.61	0.65	0.56	0.62	0.59
2009/10	0.65	0.69	0.58	0.65	0.63

CONCLUSION

A significant rise in the older population and in related mental health problems is predicted in the next 10-15 years. Addressing the wider determinants of health is essential in order to address mental wellbeing in later life.

Dementia is most common in older people, with prevalence rising sharply in people over 65 years. It is one of the main causes of disability in later life. As the numbers of older people rise, so will the numbers of people with dementia. It is recognised that current levels of diagnosis are low.
Early diagnosis of dementia and support to enable people to live well with the condition are the keys to delaying admission to long term care and to help people remain independent for longer.

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Table of tables and figures