

Ageing Well in Hampshire



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Foreword

I am delighted to introduce my first report as Director of Public Health for Hampshire.

The Director of Public Health's annual report is one of the ways in which I can highlight specific issues for the health and wellbeing of the people of Hampshire and make recommendations for improvement, to a wide range of organisations.

This report focuses on the health of the older population of Hampshire.

People are living longer and our older population is increasing in number. This is a real success for improvements in public health, health and social care and something we should celebrate. Unfortunately in the UK we too often use language that suggests as people age they 'inevitably' become a burden, rather than an asset to our communities. This is of course far from the truth and fails to recognise the huge contribution to our society that older people make.

Many people remain healthy and independent as they age with the majority of older people reporting that their health is good. However, older people are not a homogenous group and a significant minority spend too many years in poor health. Also health inequalities persist into old age.

This report looks at some of the areas where there is a significant burden of disease and where we have good evidence of what we need to do to prevent disease and to keep people as healthy as possible. This means that our residents will be healthier as they age and more likely to remain active and independent in their own homes.



Dr Sallie Bacon

Introduction

People are living longer and our older population is increasing. This is a real success for improvements in public health and social care and something to celebrate.

Modern medical and other technological advances have transformed our lives, and many people are staying healthy, happy and independent well into old age.

Unfortunately in the UK national conversations have all too often focused on equating growing old with poor health – the ‘demographic time bomb’. We have used language that suggests that as people age they ‘inevitably’ become a burden, rather than an asset to our communities. This ignores the huge variety of ways in which older people continue to make valuable contributions to society through supporting the younger generation – practically, financially and through their knowledge and wisdom, volunteering and engaging with their community and with local and national political issues.

Happiness ratings are highest in 65 to 79 year olds, according to Office for National Statistics research, while those aged 45 to 59 reported the lowest levels of life satisfaction, with men on average less satisfied than women.

It is certainly true that growing older isn’t without its challenges. As we grow older we tend to develop more health problems, live with multiple long term health conditions (LTCs), develop dementia or poor mobility and become frail, but this isn’t inevitable. Frailty is a distinctive health state related to the ageing process where the body loses its in built reserves. It defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care and so it impacts on the ability to live independently and on quality of life. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years.

Older people are more likely to report poor health; around two thirds report that their health is good, although in the 80 plus age group just over one in ten describe their health as poor¹. About 2 in 3 people over



60 have a long term condition, but most people don’t report that the conditions are life limiting. However, it is not just ‘medical’ conditions that can impact on health and wellbeing; more recently we have recognised the negative impact of social isolation and loneliness on the health and wellbeing of older people and the significant costs to health and social care².

Older people are not a homogenous group. The consequences of ageing vary so that some people will become frail at a relatively young age and some will still be fully active and independent well into their 90s and beyond.

1 The Dynamics of Ageing – Evidence from the English Longitudinal Study of Ageing 2002 – 15 Wave 7.

2 House JS, Landis KR, Umberson D. Social relationships and health. *Science*. 1988. 241: 540-545.

Despite the general health and wealth in Hampshire, health inequalities persist into older age. Life expectancy for men living in the poorest areas of Hampshire is almost 7 years less than for those in the most affluent areas, the gap for women is almost 5 years and the gap is widening. Despite increasing life expectancy, healthy life expectancy isn't keeping up. This means the time people live in poor health is almost 14 years for men and 17 years for women and over recent years the time lived in poor health has increased.

Older people in deprived populations are likely to develop health problems 10-15 years earlier than their wealthier neighbours. They are more likely to have more than one long term condition and there is evidence that it is the number of conditions that drives use of health and care services, rather than the specific disease, highlighting the need for prevention and management of multi morbidity.

If we can identify the factors that influence the way we age, those that keep us healthy as well as those that lead to poor health and identify people at increased risk we can take action to improve health. We know that much of the poor health in older people is related to unhealthy lifestyles and so is potentially preventable.

It is important that we enter older age as healthy as we can possibly be. How long we stay healthy depends on our social, economic and physical environment as well as our individual characteristics and behaviours. We can influence some of these factors, for example whether we smoke, what we eat, how much alcohol we drink and how much physical activity we do. Some factors we can't change, such as our age, sex, genes and family history. It's never too late to take action to promote health in later life.

However good we are at prevention it is inevitable that some older people will still become unwell and this has obvious implications for health and care services; older people will still become ill, however good we are at prevention. Complex planning is required to ensure that the economic, social and health needs of older people can be met. We know that our health and care system is struggling to deliver the care that older people need. Managing frailty is a key issue for our current health and social care services and radical changes in the way that we deliver care are needed or needs will remain unmet and cost pressures will rise inexorably.

But it is not just costs to health and care services if people's health deteriorates. There is an impact on family and friends who want to care for their loved ones. As our population is ageing so is the population of people who will be their carers. If the health of carers breaks down the impact on our services will rise still further.

We know that what matters to older people in terms of wellbeing and quality of life is the ability to maintain their independence, stay in their own home and remain socially engaged³



What matters to older people in terms of wellbeing and quality of life?

“The ability to remain at home in clean, warm, affordable accommodation; to remain socially engaged; to continue with activities that give their life meaning; to contribute to their family or community; to feel safe and to maintain independence, choice, control, personal appearance and dignity; to be free from discrimination; and to feel they are not a ‘burden’ to their own families and that they can continue their own role as caregivers.”



3 <http://www.phoutcomes.info/>

In Hampshire we are living longer and our population is ageing

In 2016 an 85 year old Hampshire male can expect to live 11 months longer and a Hampshire female 10 months longer compared to ten years ago.

There are 280,600 people aged 65 and older in Hampshire and this is projected to increase by 34,000 over the next five years. The number of people aged 85 and over is likely to increase by 21% to almost 50,000.

We need to ensure that we can support people to age in better health and increase our efforts to reduce health inequalities in older people.

In this report I have looked at some of the ways in which we can work together to enable our residents to be socially, physically and mentally active for as long as possible so that they live for longer in good health, avoiding the need to be reliant on health and social care and can age well.



What is Ageing Well?

More than half of the illness among older people aged 60 years and over is potentially avoidable through changes to lifestyle



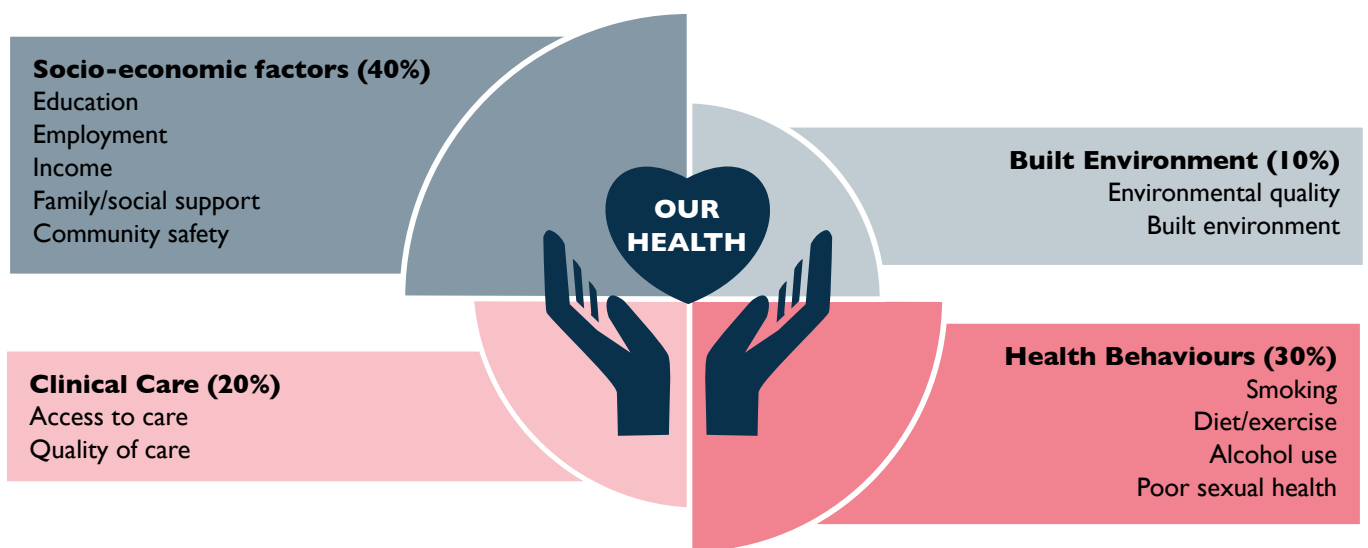
A community that has people that are ‘ageing well’ has significant benefits. Identifying opportunities to reduce the risk of people becoming ill or developing increasing health and social care needs has a benefit for both our communities and our services. There is strong evidence that making positive changes to the way we live, adopting healthy lifestyles at any age, including in older age, can make a real difference to future health. Many adults 65 and over spend, on average, over 10 hours each day sitting or lying down and they pay a high price for being inactive. There are significant health benefits for people who become physically active relatively late in life⁴ including a reduced risk of falls, obesity and heart disease. A healthy diet, being active, stopping smoking and protecting the eyes from bright sunlight can reduce the risk of Age-related Macular Degeneration (AMD) in the eye. AMD is a leading cause of loss of vision in older people⁵ and is due to damage to the macula of the retina.

The World Health Organisation estimates that more than half of the illness among people aged over 60 years is related to five risk factors. Obesity, lack of exercise, smoking, heavy alcohol use and low consumption of fruit and vegetables, accounts for as much as a 14 year difference in life expectancy and this is potentially avoidable through lifestyle changes^{2 6}.

How can we stay healthy as we get older?

Our health at any age is influenced by a number of factors, some we can change ourselves, some we can change with help from others and some we can’t change. Our age, genetic background, gender, ethnicity, whether or not we have a job, how much money we have, the type of house we live in, the lifestyle we follow and the healthcare we receive all affect our health.

What contributes to our health?



4 Physical Activity Benefits <http://bjsm.bmj.com/content/early/2013/10/28/bjsports-2013-092993.abstract>

5 <https://www.ncbi.nlm.nih.gov/pubmed/21149749?dopt=Abstract>

6 <http://www.phoutcomes.info/>

In other words our health is influenced by how we live, the places where we live and the communities we live in – the wider determinants of health.

Collectively we can change our environment to help make healthy choices easier, for example by having a transport infrastructure that encourages active travel, by ensuring access to affordable, healthy food, decent homes and safe neighbourhoods.⁷

Healthy People

We are not bystanders in the creation of our health. Our chances of good health are largely shaped by the lifestyles we lead. But our lifestyles are, in turn, shaped by our circumstances. Being in good health is a complicated balance between the choices we make, genetic factors that can increase (or decrease) our risk of poorer health and the environment that influences those choices.

Healthy Places

Healthy people need healthy environments. This means we need to take every opportunity to ensure that the places that matter the most to us: for example our schools, our workplaces, our homes and our streets, are designed to help to create good health.

Healthy Communities

Communities create and protect our health by connecting us as individuals and by promoting certain ways of living. Communities have many strengths that can be tapped to enhance people's health. Within communities there are skills, knowledge and commitment that can be used to improve the health and wellbeing of local people. The health of our communities is more than the sum of the health of each individual.

Supporting older people to remain socially engaged and connected will keep people healthier for longer. This means they will continue to be an asset to their communities.



⁷ Based on the PHE policy direction: Healthy People, Healthy Places 2013

Hampshire's older population: What we know

We are all living longer and this includes people with long term conditions and complex needs.

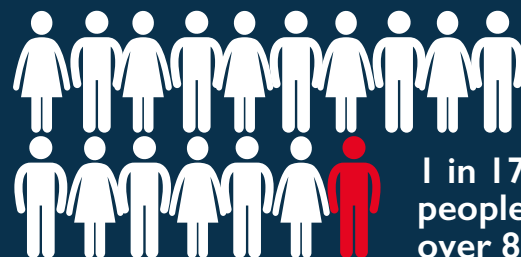
- We are becoming more diverse. In the 10 years between the 2001 and 2011 Census ethnic diversity increased from 5% to 8%.
- In Hampshire, 20.9% of the population is aged 65 and over⁸ (compared to 18.6% regionally and 17.6% nationally). This means there are over 280,600 people who are over 65 years old and this is projected to increase to over 320,800 people by 2021.
- New Forest has the highest number of older residents with over a quarter of the population aged 65 and over compared to just 14% of Rushmoor's total population
- Population forecasts suggest that our total population will grow by 6% between now and 2021⁹.
- Over the next 5 years, up to 2021, the number of 65-74 year olds will increase by 8% to 162,413, the 75-84 year olds will increase by 20% to 107,173 and the over 85 year olds will increase by 26% to 51,291. This is reflective of the 'baby boomer' generation ageing¹⁰.
- Over the past few years the proportion of the population of older people receiving long term social services has been 1% of the 65-74 year olds, 3% of the 75-84 years olds and 13% of our over 85 year olds. While that may suggest that 87% of the over 85 years don't require social care support, it also suggests that if there are no changes to how we live by 2021 there will be an additional 6,000 older people requiring social care support, just by virtue of the increase in our population.
- The ratio of people of state pension age is increasing compared to working age population⁶.
- Based on current figures, a boy born in Hampshire could expect to live on average for 81.1 years, and girl, 84.3 years, a gap of 3.2 years⁶.
- The gap between the number of years men and women can expect to spend in 'good' health shows that women are living longer in poorer health. Men and women are expected to live 67.2 years of their life in 'good' health. For men this is 83% of their expected 81.1 years. On the other hand for women as they live longer (84.3 years) they spend about 3 years longer in poorer health³.
- There are significant inequalities across the county. In terms of life expectancy, for men there is a 6.5 years gap between those in the most deprived and least deprived areas of Hampshire; for women the gap is 4.9 years. The lowest life expectancy for men and women is in Gosport.



1 in 5 people are over 65 years



1 in 10 people are over 75 years



1 in 17 people are over 80 years

⁸ HCC 2015 based small area population forecasts for districts

⁹ Hampshire JSNA 2015 <http://www3.hants.gov.uk/jsna>

¹⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/578665/Baby_boomers_v4.pdf

Our challenge in understanding our population

While national information/intelligence on lifestyles is helpful, we do need more local intelligence to help us understand how to change the environment in a way that will encourage the take up of healthy lifestyles (at any age) and to ensure our older population have access to the support they need to stay healthy.

We need a better understanding of the impact of living longer, and what this will mean for service planning; for people who have long term conditions or complex needs such as people with HIV; people affected by substance misuse; people with learning disabilities; and also carers, veterans and people who are isolated either from social contact or who are living in isolated areas.

By **2030** for every
2 people of
working age there will be
1 person of
pensionable age



Healthy life expectancy is the proportion of life spent in good health.

On average, Hampshire females live over three years longer than Hampshire males but these three years are likely to be spent in poor health.

How can we support people to age well?

The most important action we can take to achieve a healthy older age is to adopt healthy behaviours throughout our lives. If we think about good health as being like a piggy bank – you start with some ‘good health’ inherited from your parents and as you live your life the things you do can either be added to or taken away from what is in your piggy bank. As you get older the more you have in your piggy bank, the more likely you are to be able to cope with any illness you may develop.

As was highlighted in the Director of Public Health’s last Annual report¹¹, even a few minor lifestyle changes could mean that more people spend far more of their life in good health and avoid the need to access health

and social care. Small changes focusing on healthy eating and being a healthy weight, keeping well hydrated, being more physically active, improving muscle strength, not smoking (or stopping smoking), not drinking more than the recommended levels of alcohol and protecting your emotional and mental health can make a big difference and protect us from the risk of certain diseases and ill health.

For this report I have focused on some of the areas where there is a significant burden of disease and where there is evidence that taking appropriate action can have an impact in helping people to remain independent, reducing reliance on health and social care and improving outcomes.

	Falls and Fractures	Sight Loss	Keeping Healthy - at and in the Home	Dementia	Social Isolation
Scale	In 2014/15 there were 5,800 people over 65 years admitted to hospital with a fall related injury	In 2014/15 there were an estimated 788 new preventable sight loss certifications. Estimated prevalence of 53,000 living with sight loss; 7,000 who are blind (all ages)	Over the past 5 years there have been an average of 600 excess winter deaths per year due to preventable causes	12,224 people were recorded as having dementia in 2014/15 (0.87%) – set to increase with increasing age	Estimated 27,400 people aged 65 and over are lonely or isolated
Impact	Risk of falls increases with age, socio-economic conditions and poorer health. Impacts on mobility and independence especially if there is hip fracture. Human cost includes distress, pain, loss of confidence, independence and mortality.	Older people with sight loss are more likely to have additional health conditions or disabilities and are more likely to become socially isolated	Increased mortality is linked to fuel poverty and colder living conditions making older people particularly susceptible to infection, stroke and heart attacks (due to increased blood pressure) due to cold putting pressure on health and care services	Degenerative disease, needs and costs increase over time	Social isolation and loneliness are associated with an increased risk of cardiovascular disease, cognitive deterioration and overall mortality
Costs	Hospitalisation and social care for hip fractures (caused by falling) estimated at £50 million pa for Hampshire (NICE estimates)	Estimated costs of £133 million direct and indirect costs for conditions of the eye to health, social care and for disability benefits (all ages). Costs will also reflect service increases due to isolation and loneliness	Costs associated with additional morbidity are difficult to estimate but are likely to be in excess of £1.5million in hospital admissions alone	Analysis suggests the average annual costs for people with dementia is £12,000, of which social care costs are a third (£3,900)	Estimate increase in service usage due to loneliness results in a cost to the public sector of £12,000 per person over 15 years; 40% of which occurs in the first five years

11 <http://documents.hants.gov.uk/public-health/annual-report/2015-09-21PublicHealthAnnualReport.pdf>

Falls and Fractures

Injuries from falls are the most common and costliest event for older people. The consequences of falling can be minor, but with increased frailty and osteoporosis (a condition where there is thinning of the bones) the consequences can be significant resulting in fractures, particularly hip fractures. Falls are the leading cause of ambulance call-outs to the homes of people over 65³. It has been estimated that around 1 in 3 people over 65, and 1 in 2 over 80, fall each year. In Hampshire this equates to approximately 95,000 people over 65 years falling each year, of which 40,900 are over 80 years old. Falling is often a turning point and older people recovering from a fall frequently require more continuing care from both health and social services. Falls are estimated to cost the NHS more than £2.3 billion per year, having an impact on quality of life, health and healthcare costs.¹²

The return on investment from preventing falls is high;¹³ between £2.60 and £7.00 saved for every £1 invested, depending on the initiative and setting.



Why are 'falls' a problem?

- Falls are the leading cause of ambulance call outs to the homes of people aged over 65
- One in three people over 65 years and half of over 80 year olds fall at least once a year
- Half of those with hip fractures never regain their mobility
- Predictions suggest that with an ageing population there will be a 16% increase in falls

How can we prevent people falling?

- Falls prevention has a good return on investment, improving quality of life and reducing health and social care costs.
- Adopting a life course approach to musculoskeletal health and reducing the risk of osteoporosis by being physically active and having good nutrition, including calcium and vitamin D
- The key prevention initiatives are:
 1. Adaptations for the home including telecare
 2. Exercise programmes to improve balance and strength
- Tailored exercise interventions have beneficial effects for balance, wellbeing, mobility, cognition and bone fragility

¹² <https://www.nice.org.uk/guidance/cg161/chapter/introduction>

¹³ NICE Guidance – Falls in Older People. <https://www.nice.org.uk/guidance/qs86>

What are we doing?

For older people who have fallen or who are at risk of falling, local NHS services provide 12 weeks of an evidence based exercise programme. The programmes are generally delivered in groups with participants attending once a week for an hour. However, the evidence indicates that to deliver the best return on investment 50 hours of exercise is the minimum that should be provided over 6 to 12 months. The Council provides a falls co-ordination service for the delivery of exercise classes. There are three types of exercise classes; 'Steady and Strong', 'Otago' and 'Better Balance for Life'. 'Steady and Strong' classes are the most advanced in terms of the movements. 'Otago' classes, involve gentler, chair based exercise. 'Better Balance for Life' is aimed at the more frail elderly who are not able to undertake the 'Steady and Strong' or 'Otago' classes.

The 12 week approach was developed with the idea that once participants had attended for the initial 12 weeks they would be sign-posted to attend local 'Steady and Strong', 'Otago' or 'Better Balance for Life' sessions delivered by a trained instructor to make up the 50 hours needed. These classes are fee paying. However, we know that the level of take up of these local classes is not enough to impact the number of falls. There is considerable drop off in the numbers attending classes. The main reasons are thought to be increasing frailty, the cost of classes, transport issues and lack of availability of a local class. To get a better understanding of the barriers to continuing with exercise classes we have commissioned some research to understand the issues in more detail. We will use this information to help us to co-design a programme to make it easier for people to continue with the exercise that they need to reduce their risk of falling and consequent poor health outcomes. This piece of insight research is part of a wider review of falls prevention services across health and social care linked to the Sustainability and Transformation Plan for Hampshire.

Technology has a huge part to play in reducing the risk from falls. 'Telecare' is the use of personal alarms and environmental sensors to monitor people's support needs, to allow them to remain safe and independent in their own homes. Argenti, a consortium led by PA Consulting, has been commissioned by the Council to provide telecare services across Hampshire. These are starting to have a positive impact on reducing the risk of falling.

What are the challenges for falls prevention that we need to address?

The Global Burden of Disease Study 2015¹⁴ reported that disorders of muscles, bones and joints (musculoskeletal disorders) are the single biggest cause of disability in the UK, at 31.3% of the population. Having poor bone health and weak muscles can significantly impact on health and increase the risk of falling and the severity of injury. Lifestyle factors can contribute to the prevalence of musculoskeletal conditions. Preventive measures are vitally important at both an individual and a community level. The most important are good nutrition, maintaining a healthy weight and being physically active, especially load-bearing exercise. Excess alcohol and smoking are also important modifiable risk factors.

How do we promote good bone and joint health as we age? The important elements are ensuring people remain active throughout their lives and have good nutrition including calcium and vitamin D. The workplace has a huge 'good practice' role to play in supporting people to remain active, to help address back pain which is one of the most common reasons for sickness absences at work and can lead to poor bone and muscle health.

Case Study

Ms A, has physical disabilities and chronic fatigue syndrome and is at high risk of falling. She has been injured and admitted to hospital on a number of occasions.

The solution: Argenti installed a MyAmie pendant, a falls detector and a PIR (passive infrared) sensor linked to a lifeline to ensure 24 hour support was available.

The outcome: The service has allowed Ms A to live more independently and be less reliant on family and paid carers.

The benefit: 24 hour support, reassurance and reduced anxiety for Ms. A and her family and a saving of £550 per month through a reduction in the need for domiciliary care.



¹⁴ [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)31743-3/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31743-3/fulltext)

Sight Loss

Sight loss is one of the leading causes of disability in older people. Older people with poor eyesight are more likely to have additional health conditions or disabilities and are more likely to become socially isolated. Sight loss can also have a profound effect on access to services. For example it is not uncommon for people with sight loss to receive information in formats that they cannot read, consequently missing essential access to services.

A significant proportion of blindness, particularly in older age is preventable. The effective use of treatment and rehabilitation services to improve people's immediate environment or their ability to take on day to day tasks can help maintain independence and improve quality of life.

Research¹⁵ suggests that half of cases of blindness and serious sight loss could be prevented if detected and treated in time. The five leading causes of preventable blindness and partial sight loss in the UK are: age-related macular degeneration (AMD) for which smoking is a significant risk, diabetic retinopathy¹⁶ which is a complication of diabetes, glaucoma, which in itself cannot be prevented but early detection and treatment prevents sight loss, cataracts, which if left untreated cause loss of vision and refractive error which if uncorrected causes visual loss.

In Hampshire the crude rate of sight loss due to AMD and diabetic retinopathy is significantly higher compared to the average in the rest of the country (158.8 cases per 100,000 in Hampshire compared to 118.1 for England in 2014/15 for AMD and 4.4 per 100,000 in Hampshire compared to 3.2 for England in 2014/15 for diabetic retinopathy). The reason for this is not clear and it may be due to differences in recording. The figures are based on self-certification.

The research¹⁴ implies that the take-up of sight tests nationally is generally lower than would be expected. This is particularly the case within areas of social deprivation. Low take-up of sight tests can lead to late detection of preventable conditions and increased sight loss due to late intervention. Risk of sight loss is heavily influenced by health inequalities, including ethnicity, deprivation and age and sight loss can increase the risk of depression, falls and hip fractures, loss of independence and living in poverty.

Can we prevent sight loss?

- Much sight loss is preventable. Effective use of treatment and rehabilitation services can improve quality of life and independence
- Half of the causes of blindness and serious sight loss could be prevented if detected and treated in time
- Risk of sight loss is associated with health inequalities
- Age related macular degeneration rates are higher in Hampshire than England; smoking and obesity (poor diet) are a significant factor

What can we do?

- Risk of sight loss is associated with health inequalities – increase eye sight test uptake in more deprived areas
- Smoking and obesity are significant risk factors for sight loss and therefore helping people to give up smoking and lose weight at any age would reduce the risk of AMD and other preventable eye conditions that impact on independence

¹⁵ Access Economics (2009), Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK adult population. RNIB

¹⁶ Diabetic Retinopathy is when high blood sugar levels cause damage to the retina. If left untreated it can lead to blindness. The projected increase in cases of diabetes makes early diagnosis and treatment of the condition a significant priority

What are we doing?

For individuals who have been identified with vision impairment, the Council services emphasis has been on early intervention to provide support to develop 'independent living skills'. These skills are designed to improve independence and include: day to day living skills to support household activities such as financial control and cooking; skills to support going out safely, using long canes and building confidence in using public transport; future proofing skills so that if the person has a condition which is likely to get worse over time they develop strategies for dealing with this. There are also new initiatives being developed to support people with vision impairment to be able to take any medication they may need safely. It is recognised that new technology will increasingly form part of the support for people with vision impairment and that they will need to develop skills in using this technology.

What are the challenges for sight loss that we need to address?

As people become more frail, or disabilities deteriorate, they often become less able to do day to day tasks which impacts on their independence. Adapting people's environment can make a big difference to independence and increasingly the use of technology can improve this. Our challenge is how we adapt housing and use technology more effectively to support people to live independently with a disability such as sight loss.

Case Study

Living in the rural part of the Test Valley Mrs. I's husband recently passed away. Her serious visual impairment meant that she was no longer able to drive and the poor rural public transport meant she found it difficult to visit her family.

Using her Breezie (a tablet specially modified for use by older people) with a special magnifying glass has enabled her to contact her family through email and send photos to her daughter. The Breezie has also helped her shop online, so that she doesn't have to rely on others to do it for her. "This means an awful lot to me", she says. "I am less isolated and able to look after myself".



Healthy Homes

People need healthy places to live healthy lives. The physical environments where people are born, live, grow, work and age have significant effects on mental and physical health and wellbeing. Planning, transport, housing, the built and natural environment and health services all influence our health and wellbeing.¹⁷ There is strong evidence that mental ill health, cardiovascular disease, respiratory disease, excess seasonal deaths and accidental injuries are heavily influenced by social determinants.

Older people are particularly at risk of dying during winter months compared to the rest of the population. Excess Winter Deaths (EWD) is the measure used to describe how many more people die during winter months than at other times of the year.

The UK has one of the highest Excess Winter Death (EWD) rates in Europe despite having relatively milder winters. This is because we tend to take fewer precautions in cold weather (such as wearing warmer protective clothing) compared to people living in countries with cold winters. Countries with milder winters also tend to have fewer homes with cavity wall insulation and double

glazing, which makes them harder to keep warm during the winter. There are various physiological effects of cold weather, which may lead to death in vulnerable people especially older people. In older people a one degree lowering of living room temperature is associated with a rise of 1.3 mmHg blood pressure; this increases the risk of strokes and heart attacks. Fuel poverty (i.e. the ability of households to heat their homes) also disproportionately affects older households, and those living in rural districts. Although the rate of EWD and fuel poverty is lower in Hampshire compared to England it is still higher than European countries.

People over 85 years are more likely to have an underlying health condition that may make them more vulnerable to a winter death. By virtue of age they are more likely to be frail. Respiratory and circulatory diseases each account for around one third of EWDs. The level of circulating influenza can be also a major explanatory factor. A lower resistance to respiratory infections and the increased level of influenza circulating in the population in winter can lead to life-threatening complications in vulnerable groups, such as bronchitis or pneumonia.



¹⁷ Marmot Fair Society Healthy Lives (2010) <http://www.instituteoftheequity.org/projects/fair-society-healthy-lives-the-marmot-review>

What are the issues for how we live?

- In England, a relatively sharp increase in deaths occurs when the outdoor temp falls to around 6°C⁶
- Older people are more at risk of dying during the winter because underlying health conditions make them more vulnerable as does living alone and not having adequate social services support⁶
- Influenza and pneumonia are the most common underlying cause of excess winter deaths, accounting for 64% of all excess winter deaths in Hampshire⁷
- Fuel poverty disproportionately affects older households and rural areas and is higher in privately rented homes

What can we do to prevent poor living conditions?

- Essential that new housing stock reflects the needs of the local ageing population⁵
- Effective promotion and uptake of the Winter Flu Vaccinations Programme should continue to target those populations at greater risk
- Evidence indicates that changes in home heating, insulation and temperature can have a beneficial effect on illnesses from a range of causes
- Effective long term condition management to improve the outcomes for people living with cardio-vascular and respiratory conditions
- Working with planners to ensure we build healthy homes and healthy environments



What are we doing in Hampshire to support better living conditions?

Both the built and natural environment play a key role in improving physical and mental health, reducing segregation and isolation, and preventing long-term illness, such as obesity and associated diseases.

Key factors that can influence specific health issues at a local level are as follows:

- **Mental health and wellbeing:** housing density and escape (overcrowding; access to green spaces and opportunities for physical activity, social facilities, places to stop and chat; community facilities such as libraries); safe highway network; housing design (the look of the development); housing quality (e.g. damp, noise; fear of crime (feeling unsafe to go out))
- **Obesity and cardiovascular disease:** air quality, total volume of traffic and local congestion; safe highway environment; opportunities for active travel and recreational exercise outdoors; damp homes; overcrowding
- **Excess seasonal mortality:** ensuring buildings are sufficiently insulated and designed to not trap excess heat in summer
- **Accidental injuries:** traffic calming, pedestrian-friendly environments

In Hampshire, the new development in Whitehill and Bordon has been awarded 'Healthy New Town' status. This is an NHS England programme, supported by Public Health England, which aims to design towns with health and wellbeing at their heart.

The aim is to influence the design of the town to ensure that healthy choices are easier to make to help prevent illness, encourage healthy lifestyle choices and enable people to remain independent to a much later age than at present.

Local NHS organisations, public health organisations, local government, voluntary sector partners and developers are all working in partnership.

Public Health are working closely with Strategic Planning in the Council and the District planning teams to consider how health concerns can best be addressed through planning. A planning position statement has been developed¹⁸ that sets out how Hampshire County Council and partners can deliver the County Council's statutory public health responsibilities and District Councils' duties to deliver relevant elements of the National Planning Policy Framework through the planning system.

Reducing the risks of excess winter deaths for older people: keeping warm and vaccination

Two of the biggest preventable risks of early death in older people over the winter months are low body temperature or hypothermia and respiratory infections, such as pneumonia and influenza (flu). Ensuring that people can keep warm and that they are protected against the pneumococcal and influenza viruses through vaccination can make a difference.



¹⁸ Public Health in Hampshire Planning Position Statement - <https://www.hants.gov.uk/socialcareandhealth/publichealth>

Case Study

keeping warm, tackling fuel poverty

'Hitting the Cold Spots'¹⁹ is an initiative that provides support to improve heating and warmth in the home as well as identifying funding for repairs and replacements to existing heating systems where necessary and providing advice on available benefits for those in need.

The initiative is supported by a broad range of both statutory and voluntary sector partners with their own wide networks of contacts that can help identify the most vulnerable in our community. All eleven District Councils are active partners in the initiative which has added to its successes.

Mrs. D lives alone in a park home in rural Winchester. She has previously had a double transplant and has lowered immunity. Therefore she finds it difficult to control her body temperature. Her heating system is not very effective so she struggles to stay warm in winter. Due to her condition Mrs. D can only work limited hours and relies on benefits. Hitting the Cold Spots has leveraged £1,360 from external sources towards the cost of work to upgrade her heating.

Case study

flu vaccination

Since 2000, GPs have routinely given flu and pneumococcal vaccinations to people over 65 years. The main benefit of the flu vaccination is that it can prevent or reduce the severity of complications associated with flu. The pneumococcal vaccination is given as a one off vaccination but the flu vaccination is given annually. This is because the flu virus can mutate and a vaccine that is effective one year may not be effective the following year. The annual programme for flu has two elements. The first element is vaccination of those at risk (that includes all those over 65 years, people under 65 years with certain long term conditions or who care for someone who would be at risk if their carer got ill). The second element, introduced in 2014, is the vaccination of young children (all children aged 2 to 8 years), not only because they could be at risk of flu but because young children are very good at spreading viruses. In Hampshire in 2015/16 the uptake of flu vaccine for those over the age of 65 years was 73.1% which although above the England average, is still below the target of 75%. The vaccination rates in 2-4 year olds in 2015/16 was 41.5%, higher than the national and regional averages but less than the target of more than 65%. For both elements we need to increase uptake to reduce the risk of disease especially to the frail elderly.

What are the challenges?

Adapting people's environment can make a big difference to future health and well being and independence. Living in poor quality housing, particularly unsafe, cold, damp, noisy or overcrowded homes, has both direct and indirect health impacts. Badly managed homes or homes in poor physical condition put older people at risk of deteriorating health. Influencing planning and housing design for an ageing population is critical to improving

health and wellbeing. The use of technology can support some of what is needed and our challenge is how we adapt housing and use technology more effectively.

A key issue for Hampshire County Council, working with the Districts, is how to improve the availability of housing that supports an ageing population alongside improving the quality of the private rented sector, reducing levels of overcrowding and fuel poverty; meeting demand for social housing and provision of a suitable mix of housing tenure.

¹⁹ Hitting the cold spots - <https://www.hants.gov.uk/socialcareandhealth/adultsocialcare/coldspots>

Dementia

Dementia is more likely to affect older people. Prevalence is increasing and the rate is higher in Hampshire than England. It has a significant impact on individuals and families and it often complicates multiple co-morbidities or frailty.

Dementia presents major challenges for health and social services and remains a misunderstood and stigmatised disease. It is a syndrome, a term for a group of diseases and conditions that are characterised by the decline and eventual loss of awareness such as memory, thinking and reasoning and often by changes in personality and mood.

Old age is the largest risk factor for dementia and prevalence (that is the number of people who have the condition) doubles every decade after the age of 65. Some 68% of all people with dementia are aged over 80 and most will also have other illness or long term conditions that result in physical impairment. These co-morbidities often go undiagnosed and/or untreated. Alzheimer's disease (AD) is reported to account for the majority of dementias (54%), vascular dementia (16%) and mixed or other dementias accounting for the remainder²⁰.

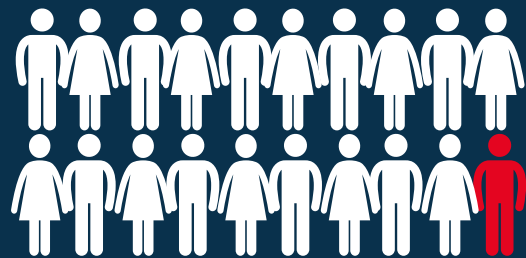
Dementia is a leading cause of disability in people aged over 65. Dementia is a progressive disease, and the prognosis after diagnosis is not good. Most people die within five to eight years of diagnosis. Women with dementia outnumber men by two to one. It is

estimated that 63.5% of people with dementia live in the community, of whom two thirds are supported by carers and one third live alone. Approximately 36.5% live in care homes. Social services data have identified that a key issue for demand for services is the break-down of carer support. Supporting carers is critical but what we do needs to be based on evidence of what works.

In Hampshire, in 2014/15 the recorded prevalence of dementia was 0.88% (4.22% of the over 65 year olds) which is above national and regional recorded prevalence. This equates to 11,918 people.



Dementia isn't exclusively a disease of old age. Early onset dementia refers to dementias that occur before the age of 65. In contrast to dementias in older people, dementias in younger people often present with other features other than memory decline. Early onset dementias are less common than dementias in people over 65 years of age, and younger people are more likely to have rarer forms of dementia. The distribution of dementias in younger people is 31% Alzheimer's disease, 15% vascular dementia, 13% frontotemporal dementia and 12% alcohol-related dementia²¹. There is also an increased incidence of the Alzheimer type of early onset dementia in people with Down's Syndrome which can significantly impact on the need for care²².



1 in 20 people over 65 years have dementia

20 Lobo A, Launer IJ, Fratiglioni L, et al. Prevalence of dementia and major subtypes in Europe: a collaborative study of population-based cohorts. *Neurologic diseases in the elderly research group. Neurology* 2000;54(11 suppl 5):S4-9.

21 *Advances in psychiatric treatment* (2009), vol. 15, 380-388 doi: 10.1192/apt.bp.107.004572

22 Lai, F, and Williams, R. S. (1989) A prospective study of Alzheimer disease in Down syndrome. *Archives of Neurology*.46,849-853

The increases in prevalence are significant but so far have been less than predicted. This may reflect that we have yet to see the ‘baby boomer’ generation reaching the age when most dementia is diagnosed. As dementia is a degenerative disease, the needs of an individual for health and social care will change over time with the greatest need coming towards the end of life.

There is growing evidence that certain dementias are preventable, particularly vascular dementia. Preventing people from developing dementia through supporting healthy lifestyles and reducing vascular disease is key. However, once diagnosed the focus should be on supporting people to remain independent and active with the best possible quality of life for as long as possible. In the final phase of the condition we need to focus on ensuring good end of life care.

What are the issues for living with dementia?

- Over two thirds of people with dementia are aged over 60 years. Most people die within 5 to 8 years of diagnosis
- 64% of people with dementia live in the community, two thirds are supported by a carer, one third live alone
- Dementia can be associated with other long terms conditions such as heart disease, and diabetes. As people get older if these conditions are not managed well complications can lead to them having multiple LTCs including dementia. These complications are potentially avoidable.



Can we prevent long term conditions such as dementia and/or prevent the conditions from getting worse?

Interventions that improve memory function and reduce the risk of disease or slow the deterioration of disease include:

- Being mentally and physically active
- Eating a balanced diet
- Having good networks of family and friends
- The way we live our lives impacts on health. Stopping smoking, eating healthily, drinking sensibly, and being active (mind and body) at any age can all help improve health and how we feel day to day and prevent the development of long term conditions, including dementia in older age.

What are we doing in Hampshire?

Hampshire County Council has been leading a programme to improve awareness of what dementia is and how those who have been diagnosed might be feeling – the Dementia Friendly Initiative. People across the County are working to promote the need for understanding, clear communication, patience and support for those with dementia and their families. Ultimately, the aim is to forge a community spirit in which people with dementia will be able to live independently for longer, with help and support when they need it.

The programme has included the creation of:

- The Hampshire Dementia Action Alliance
- Dementia Ambassadors
- Dementia Friendly High Streets
- Awareness raising initiatives
- Peer support groups
- Dementia Action Group

The Supportive Communities Programme is working with the voluntary sector developing community and voluntary sector partnerships to support people with dementia. One of the areas of focus for community grants is for people with dementia and their carers.

Vascular dementia is due to reduced blood flow to the brain. Things that increase the chance of developing vascular dementia in later life include: high blood pressure, smoking, high cholesterol, diabetes, being overweight or obese, atrial fibrillation, physical inactivity and excessive alcohol consumption. Reducing the prevalence and/or reducing the impact of these risk factors will help to reduce the incidence of dementia. The Council is working to achieve this by commissioning services such as: the NHS Health Check programme, that helps to identify risk factors for diabetes, vascular disease and dementia; weight management services that can help people achieve a healthy weight and the Stop Smoking Service (Quit4life) that helps people quit smoking.

As people with dementia comprise an ever-growing proportion of people using health services and accounts for about a quarter of people who access acute health services, it is essential that health environments are tailored to their needs. There is increasing evidence that the environment of care in hospitals can have

a significant and detrimental effect on patients with cognitive problems and dementia, leading to additional distress and confusion. The Kings Fund has been running the Developing Supportive Design for People with Dementia programme on behalf of the Department of Health since 2003. The programme has identified what works to improve the environment for people with dementia. It is often small things such as clear signage, light and airy rooms and good handrails that make a big difference. Supportive design should be founded on an understanding of the impact of physical environment on people with dementia and strong partnership working with them, their carers and care staff.



What are the challenges for Dementia?

Dementia is not an inevitable consequence of growing old. However, while there is growing evidence about what we can do to reduce the risk for future generations, it is likely that over the next 5-10 years there will be an increase in the number of people who develop dementia. Dementia gets worse over time but there is growing evidence that the rate of deterioration can be slowed. Keeping physically and mentally active, adopting a healthy lifestyle, maintaining social connections, adapting living conditions to make it easier to keep people with dementia safe and ensuring that their carers have access to support are all vitally important.

The challenge is to ensure that people can access the right support at the right time in their communities. The Council has started to redesign its services for older people using a strengths-based approach but there is more to do to fully understand what support is available in the community and where there are gaps so that we can work with communities to develop the resources that are needed.

Case study

the effectiveness of awareness raising sessions as part of the Dementia Friendly Initiative

Drivers from Wiltshire Farm Foods (deliverers of meals on wheels) were one of the first groups to attend one of the initiative's awareness sessions. A few weeks later the Local Area Coordinator received feedback about the experience of one of the drivers.

A driver was delivering meals to a client's house where the family told him 'mum won't stay in her room – she says there's someone in there'. They had looked under the bed, behind the curtains and tried every way they could think of how to show her no one was in there, but with no success. The driver, feeling he might be able to use the knowledge learnt at the awareness session, asked if he could look and the family agreed. The driver looked in the room and remembered about possible perception problems for people with dementia. He saw a dressing gown on the back of the door and took it down, following which the woman was happy to go into her room.



Social Isolation and Loneliness

Social relationships are vital for the maintenance of good health and wellbeing²⁴. Social isolation and loneliness are associated with poor mental and physical health and increased mortality²⁵. While social isolation and loneliness are closely linked they are different. It is possible to be socially isolated and not feel lonely, or to feel lonely when not socially isolated. Both are independently linked to poorer health²⁶.

Social isolation and loneliness can affect people of any age and younger age groups are frequently neglected in discussions around social isolation and loneliness. However many of the risk factors such as bereavement and poor physical health are more common in the elderly, making this group particularly vulnerable.

In 2016 we did a more comprehensive review (needs assessment) of social isolation and loneliness, why it is important, who might be affected, how can we identify those at risk and what works to prevent or alleviate isolation or loneliness. This report²⁷ found

- Social isolation and loneliness are associated with poor mental and physical health, and increased mortality
- The impact on health is as significant as well known risk factors such as smoking, high blood pressure and physical inactivity
- Certain groups are particularly at risk of becoming isolated and lonely including, but not limited to, the older population
- Social isolation and loneliness represent a health inequality, with deprived communities being most affected
- Social isolation and loneliness have a large financial cost on adult social and health care services
- There is good evidence on what can be done to prevent and reduce social isolation and loneliness
- The cost of delivering programmes to prevent and reduce isolation and loneliness can be significantly less than doing nothing
- Some risk groups in Hampshire remain underserved in terms of programmes and interventions, and more should be done to support them

Who is affected by isolation and loneliness and what are the impacts?

- Older people, especially older women, are more vulnerable to social isolation and loneliness
- The factors that may make people more likely to be isolated or lonely include bereavement, pensioners living alone, being aged over 70 years, being an older carer and living in deprivation
- Loneliness contributes to poorer mental health and problems such as anxiety and depression.
- Social isolation in older people is associated with increased risk of early death
- Social isolation and loneliness are predicted to be higher in urban areas and those of greater deprivation



What can we do?

- Identify people at risk of social isolation and loneliness to effectively target services
- Older people undertaking voluntary work is associated with improved wellbeing and quality of life (reducing loneliness and isolation) and builds community resilience
- Individual interventions (e.g. Community navigators, befriending services) and group based activities (e.g. day centres) are effective both in cost and positive outcomes

24 Steptoe A, Shankar A, Demakakos P, Wardle J. Social isolation, loneliness, and all-cause mortality in older men and women. PNAS. 2013; 110(15): 5797-5801.

25 Cornwell EY, Waite LJ. Measuring social isolation among older adults using multiple indicators from the NSHAP study. Journal of Gerontology: Social Sciences. 2009; 64B (S1): i38-i46.

26 Holwredra TJ, Deeg DJ, Beekman AT, van Tilburg TG, Stek ML, Jonker C, Schoevers RA. Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL). J Neurol Neurosurg Psychiatry. 2014; 85(2): 135-42.

27 Social isolation and loneliness in Hampshire: a health needs assessment - <http://www3.hants.gov.uk/healthandwellbeing/public-health/jsna.htm>

What are we doing in Hampshire to tackle social isolation and loneliness?

There are a large number of services and initiatives that are aimed at reducing social isolation and loneliness across Hampshire which have been highlighted in the report.²⁷ Many of these represent partnerships between the voluntary and public sector and, in addition to work to prevent isolation and loneliness, many provide opportunities for community members to get involved in volunteering, the benefits of which are far reaching.

Finding out what services and initiatives are available in a particular community can present a real challenge. ‘Connect to Support’ is an online information and advice guide being developed by the Council, which contains a directory of local services and support including community and local voluntary sector initiatives.

However, many of the smaller voluntary organisations which provide an invaluable service for their community are often missed in such initiatives because of their small size. There is an opportunity to enhance the information in the directory by undertaking a more detailed map of the initiatives in local areas that would support people who are or could become socially isolated or lonely.

We are also starting to investigate how to unlock the potential of technology to support more isolated people, particularly those in rural areas to stay connected.

What are the challenges for social isolation and loneliness?

There are interventions that have been shown to be cost-effective but these need to be targeted and implemented in a sustainable way and at scale. We clearly need to identify what already exists in local communities, the strengths and the gaps and to work with partners to understand how we can best meet the needs in the community.

Thinking about and identifying people who are isolated or lonely needs to be ‘business as usual’. The challenge for public sector workers is to recognise social isolation and loneliness and know how to use community resources to connect their patients/clients with organisations who can help. The challenge for the voluntary sector is to be able to identify and engage with local people to increase volunteering that will support the isolated and lonely.

The built environment and surroundings play an important part as well. Good urban design including creating and maintaining spaces that encourage social interaction and good public transport access to services are all important. Developing such an enabling environment will require commitment and close partnership working.

Case study

We are working with the providers of our telecare services, Argenti, to see whether technology can be used to tackle social isolation in older people in rural areas by connecting users with each other and to relevant services.

Two devices (Breezie Tablets and Speakset) are being tested and users are being supported to use the technology by volunteers from the library service and the community. The devices can be used to communicate with friends/family/clinicians, to access online materials and social groups, as well as access online shopping and library services.

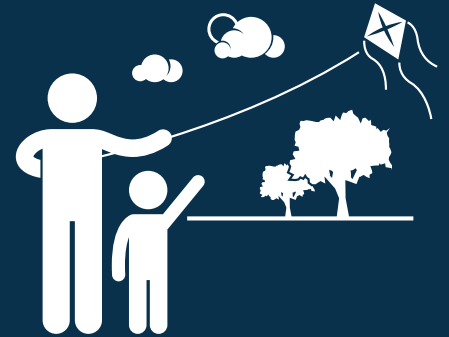
Mrs. H has been caring for her husband for 20

years since he had a stroke. In recent years her health has suffered and her husband has had to move into a care home. Mrs. H has lived in a small Hampshire village for 33 years but because the area is very rural she is very cut off from friends, family and wider society. Visiting her husband is a real struggle as Mrs. H can no longer drive.

“I’m lonely here, all tucked away. I can’t get out. I want to be involved; I recently had to give up running a club for disabled people that I had been running for years”.

“This device can help me to connect with people and see what is going on. It will be good for me as I’m a sociable person”.

How can we increase healthy life expectancy?

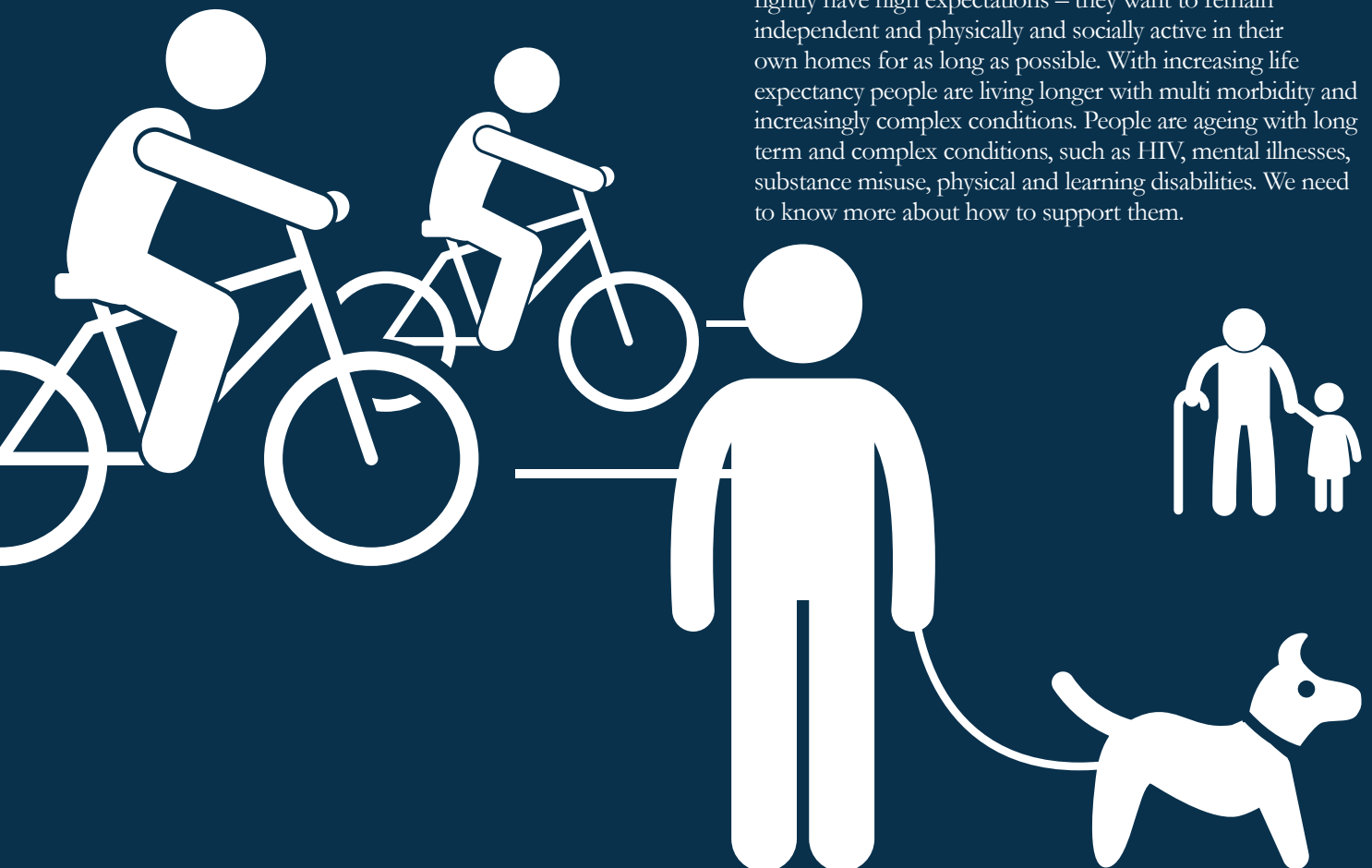


What matters to older people in terms of wellbeing and quality of life?

The ability to remain at home in clean, warm, affordable accommodation; to remain socially engaged; to continue with activities that give their life meaning; to contribute to their family or community; to feel safe and to maintain independence, choice, control, personal appearance and dignity; to be free from discrimination; and to feel they are not a 'burden' to their own families and that they can continue their own role as caregivers.⁵

Living longer in good health, that is, increasing healthy life expectancy, is something we should strive for. I believe it is attainable through the collaborative and co-ordinated efforts of all of us to make sure that the places and the communities we live in promote health and enable people to make healthy choices. But it isn't an easy task and we shouldn't underestimate the challenges that we face.

People are living longer, society is changing and people rightly have high expectations – they want to remain independent and physically and socially active in their own homes for as long as possible. With increasing life expectancy people are living longer with multi morbidity and increasingly complex conditions. People are ageing with long term and complex conditions, such as HIV, mental illnesses, substance misuse, physical and learning disabilities. We need to know more about how to support them.



We know that we face increasing risks from antimicrobial resistance, so that conditions that were previously readily treated could become more complicated in future years.

This is at a time when the resources available for the public sector are reducing year on year and we have to make difficult choices and do things differently. Keeping people healthy and preventing illness has never been more important.

We already know there are initiatives that could make a difference. However, these are often only implemented in small areas and not in a systematic way – this means that they don't have a significant impact on the health of the whole population and that we aren't making the best use of our reducing resources. They are always often not evaluated in a way that helps us understand how they are working or why they don't work! We need to start thinking big – prevention at scale.

We have seen that more than half of the illness in people aged 65 and older could be preventable through changes to lifestyle. While there is increasing evidence for interventions that either prevent the onset of poor health or reduce the rate of deterioration of long term conditions, for example staying physically active for as long as possible and sensible drinking, implementing these at scale remains a challenge.

If we are to reach our goal then we must implement initiatives consistently. However, we also need to be bold and innovative – testing out new ways of working, for example, engaging older people as volunteers, as we know this has health benefits, using community navigators to support people to gain confidence and independence and looking at how we can support people to develop and use their social networks.

- We need to continue our work with younger adults (40-64 year olds) so that people are entering older age as healthy as they can be
- We need to listen to the voices of our older citizens and strengthen our links with community groups and voluntary organisations
- Identify opportunities where we can help to reduce the risk of people becoming ill or having increased health and/or social needs and do this consistently
- Work with the voluntary sector in developing networks and resilience in local communities to ensure there is support to help people locally

Recommendations

Over the next two to five years, working in partnership with colleagues across the Council and with external partners, including the NHS and the voluntary sector, to help our population to age well and have a positive older life we need to:

- Ensure that older people are supported to have a healthy lifestyle and improve their access to lifestyle services where appropriate
- Adopt a life course approach to promoting good bone and joint health, support older people to remain physically strong to reduce their chances of falling and ensure that we have a comprehensive evidence based falls prevention programme
- Promote healthy lifestyle choices that will reduce the risks of sight loss
- Improve the availability of housing that supports an ageing population
- Prevent the development and/or deterioration of long term conditions, such as dementia
- Support people who may be socially isolated or lonely to get connected with families, friends and their community
- Continue to work with planners to promote healthy environments and ensure that we build healthy homes
- Identify priority actions to reduce social isolation for people providing unpaid care
- Continue to build dementia friendly communities through raising awareness and improving access for people with dementia to the built and natural environment



