DPH report 2015/16
Part One:
Ageing in Worcestershire

Introduction

One of Worcestershire's extraordinary assets is its older people. We should celebrate longevity and the contribution older people make to our communities through volunteering, informal caring, economic contributions and local leadership. Many older people are living active and vibrant lives and are well connected with other people in their communities. People's length of life is longer than at any time in our history.

However, the experience of being old is not the same for everyone and is not always positive. There is considerable variation in the age-related changes that occur. This variation is often due to existing inequalities and differences in socio-economic factors, lifestyles and living conditions. The number of years of life is not the same as the number of years spent in good health. In Worcestershire, people may live long, but the length of time spent living in poor health can also be long.

This need not be inevitable. We can do far more to increase the chances of a healthy old age, so that more people can live in good health until they die. People in Worcestershire are, on average, healthier than they are elsewhere in the country. To increase the chances of all older people living a good quality of life, we need to strengthen our positive focus on the preventative approach, and to promote healthy ageing for everyone.

Our challenge is how best to do this. A recent report from the World Health Organisation finds: 'Some of the most important barriers to developing good public policy on ageing are pervasive misconceptions, negative attitudes and assumptions about older people. Although there is substantial evidence about the many contributions that older people make to their societies, they are frequently stereotyped as dependent, frail, out of touch, or a burden. These ageist attitudes limit older people's freedom to live the lives they choose and our capacity to capitalise on the great human capacity that older people represent.'

We all, as individuals, and in our communities and organisations, have a part to play in creating a better future for the older members of our community. I hope that this year's report will draw attention to the issue of a healthy old age in Worcestershire, and be a call to action for all of us in creating that future.

Section 1: Being Older in Worcestershire.

1.1 It is well known that Worcestershire has a relatively high proportion of older people, compared with the rest of the UK. In 2014 the proportion of older people aged 65 or over in Worcestershire was 21.2% compared to 17.3% nationally.

1.2 This picture varies across the County with the highest proportion in Malvern Hills (26.6%), and the lowest proportions in Worcester (16%) and Redditch (16.2%).

1.3 These percentages translate into large numbers. There are now 125,600 people over 65 living in Worcestershire, and 17,000 who are over 85.

1.4 The experience of being old is not only defined by age. Our experience is defined crucially by our general health and well-being, and there is a difference between the number of years lived, and the number of years that are lived in generally good health. The key quantitative measures for these are life expectancy and healthy life expectancy.

1.5 It is also important to recognise that Worcestershire is a varied area and people in different areas experience different health outcomes as was examined in the previous Annual Report on health inequalities.

1.6 The table below shows life expectancy (LE) and healthy life expectancy (HLE) broken down by areas of deprivation in 2011 (the latest year we can calculate these at this level). We can see that both figures are higher in the least deprived areas and lowest in the most deprived, however the gap between the most deprived and least deprived was bigger (around 15 years) for healthy life expectancy than for life expectancy (about 6 years). This also means that the most deprived are not only living shorter lives, but they are spending a higher number of these years in poor health (23 compared to 15 in the least deprived).

Life Expectancy and Healthy Life Expectancy at Birth by IMD Decile, Worcestershire, 2011

IMD Decile	Both Sexes			Males			Females		
	LE	HLE	Poor Health	LE	HLE	Poor Health	LE	HLE	Poor Health
1 (most deprived)	79.0	55.7	23.3	76.9	54.9	22.0	80.9	56.5	24.5
2	79.9	59.8	20.1	78.2	58.6	19.5	81.5	61.1	20.4
3	81.8	62.4	19.4	78.4	60.9	17.5	85.2	63.9	21.3
4	81.1	64.5	16.6	78.3	64.0	14.3	84.0	65.0	18.9
5	81.0	67.2	13.8	79.6	66.4	13.2	82.4	68.1	14.3
6	82.3	67.1	15.2	81.4	65.9	15.5	83.4	68.4	15.0
7	83.3	67.7	15.6	82.4	66.9	15.5	84.1	68.4	15.7
8	83.7	68.7	15.0	83.0	68.2	14.8	85.0	69.1	15.9
9	84.0	69.6	14.4	82.1	69.2	13.0	85.7	69.9	15.7
10 (least deprived	85.2	70.6	14.6	83.8	70.3	13.5	86.4	70.8	15.6

1.7 There is no significant gender difference in terms of the life expectancy or healthy life expectancy gaps between the most and least deprived. However, both life expectancy

and healthy life expectancy at birth are higher for women than for men in all deprivation groups.

1.8 Looking only at older ages though, at 65, women in Worcestershire can expect the gap between life expectancy and healthy life expectancy to be 9.7 years (compared with 9.8 years in England.) For men, the gap is 7.4 years in Worcestershire (and 8.2 years in England.)

1.9 By 75 years of age these gaps are 6.8 years for women and 4.8 years for men in Worcestershire (and 7.2 and 5.7 years in England,) and by 85 they are 5.5 and 2.9 years in Worcestershire (and 4.2 and 3.5 years in England.) Thus, for women, the experience of being very old in Worcestershire becomes worse, compared with the rest of England, as they get older.

Life expectancy and healthy life expectancy, Worcestershire and England, 2011-13

Worcestershire

Males	@ Birth	@65	@75	@85
LE	79.8	84.0	86.7	91.1
HLE	66.0	76.6	81.9	88.2
Difference	13.8	7.4	4.8	2.9
% in Poor Health	17.3%	38.8%	41.0%	47.3%

Females	@ Birth	@65	@75	@85
LE	83.5	86.3	88.3	92.1
HLE	66.4	76.6	81.5	86.6
Difference	17.1	9.7	6.8	5.5
% in Poor Health	20.5%	45.4%	51.4%	76.8%

England

Males	@ Birth	@65	@75	@85
LE	79.4	83.7	86.5	91.3
HLE	63.3	75.5	80.8	87.8
Difference	16.1	8.2	5.7	3.5
% in Poor Health	20.3%	43.9%	49.6%	55.6%

Females	@ Birth	@65	@75	@85
LE	83.1	86.1	88.3	92.1
HLE	63.9	76.3	81.1	87.9
Difference	19.2	9.8	7.2	4.2
% in Poor Health	23.1%	46.4%	54.1%	59.2%

1.10 Poor health in older age is associated with a number of health conditions. Prevention, or successful early management of these, can significantly impact on the experience of being older. Although measures of the rates of ill-health may be low compared with England averages, it should be noted that the numbers are relatively high in Worcestershire, because a higher proportion of our population is over 65 years of age.

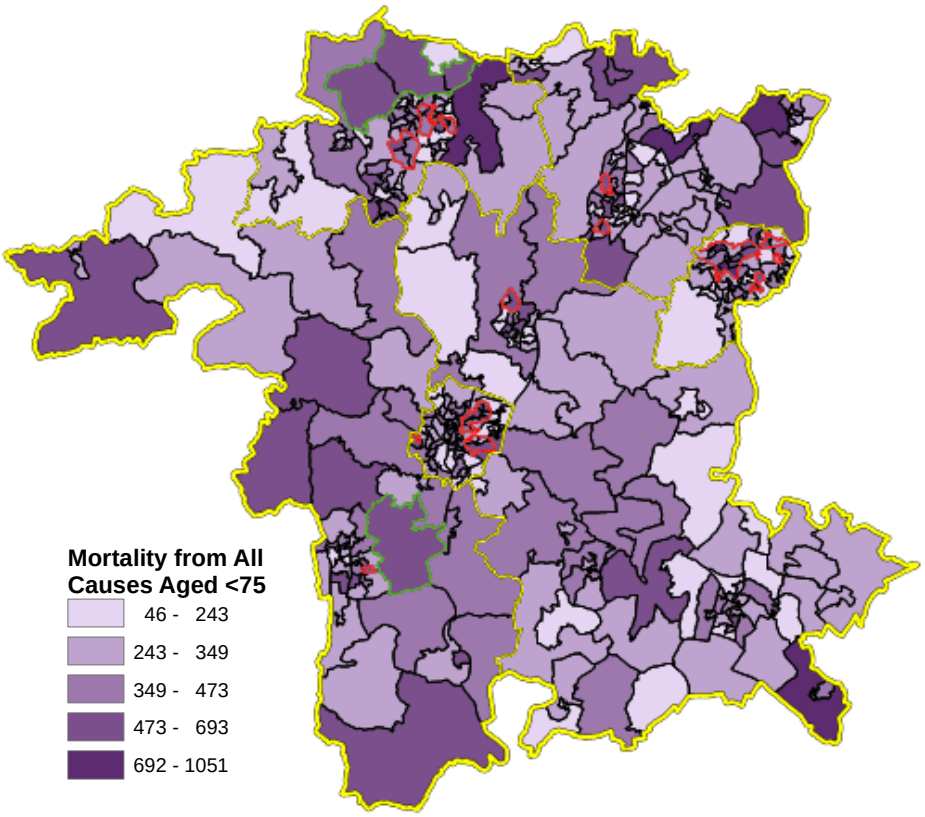
1.11 Many older people live lives which are adversely affected by:

- **Hearing impairment** – 52,200 people aged 65+ in Worcestershire are estimated to suffer from moderate to severe hearing loss
- **Vision impairment** – There are estimated to be 10,900 over 65s in Worcestershire with moderate to severe sight loss
- **Falls** – there are around 2,200 falls in Worcestershire that result in injury requiring a hospital admission. Nearly 1,000 people are participating in Postural Stability Instruction at 44 classes across the county.
- **Hip fractures** – There were 740 hip fractures in people aged 65+ in Worcestershire in 2014/15
- **Stroke** – 2,900 people were living following a stroke whilst 440 people aged 65+ died from Strokes in Worcestershire in 2015

- **Dementia** – There are an estimated 8,600 people over the age of 65 in Worcestershire living with dementia
- **Diabetes** – Just under 16,000 people aged 65+ have diabetes in Worcestershire
- **COPD** – About 8,300 people in Worcestershire over the age of 65 suffer with chronic obstructive pulmonary disease (COPD)
- **CHD** – About 4,400 over 65s in Worcestershire have coronary heart disease
- **Fuel poverty** - Worcestershire has one of the highest rates of fuel poverty in the country with around 14,800 people (11.8% of the population aged 65+) in fuel poverty.

1.12 As was discussed in detail in last year's DPH report, inequalities and social disadvantage have a significant impact on health and well-being. About 25% of people aged over 65 in Worcestershire live in areas classed in the most deprived fifth in the country. This is slightly higher than for the rest of the population (about 24%). Furthermore there are many older people living in poverty and isolation within rural areas that would not be reflected in these figures. In last year's report we identified health hotspot areas with significantly poorer health outcomes.

All Cause mortality <75 and Health Hotspots



1.13 The differences brought by social deprivation impact on healthy life-expectancy as well as on simple life expectancy. In Worcestershire, as set out in Table 1 above, at the age of 65 years the gap between life expectancy and healthy life expectancy is on average about 8 years. These are the years spent in poorer health. However, as set out below, the number of years spent in poorer health for those living in the most deprived areas is nearly double – at about 15 years.

1.14 Lifestyle factors have a significant impact on health and well-being and all the conditions listed above are more likely to develop if people drink too much alcohol, smoke, are physically inactive, and eat too much of foods that are high in sugar, fat and salt.

1.15 Our population is fatter and drinks more alcohol than ever before, and this is evident in older age too. Some unhealthy behaviours get more marked in old age, in particular sedentary or inactive lifestyles. In fact it is estimated that over 85% of older adults do not do enough physical activity to keep themselves healthy and in Worcestershire this means over 100,000 people aged 65+ are not doing enough exercise. In those aged 75+, just 6.6% do enough exercise in Worcestershire. Although the prevalence of the other major lifestyle risk factors is lower in older people there are still an estimated 13,800 smokers aged 65+ and 22,600 who drink more than safe levels (binge drinking) and still over 36,000 obese older people, with all the associated health problems and risks of further problems.

1.16 As was noted in last year's Annual Report, unhealthy lifestyles are linked to social deprivation. This is one of the main explanations for the increased number of years that people from poorer areas live in poor health, compared with people from more affluent areas. Smoking, drinking too much, not taking enough exercise, and eating too much of the high fat, salt and sugar foods are all higher in more disadvantaged areas.

1.17 Older people are invited to a number of screening and immunisation programmes, with variable uptake. All of these are built on a strong national evidence base of health protection, and compliance with the programmes will reduce health risk in old age significantly. In general, our uptake rates are good compared with national averages, but these could be improved.

1.18 Screening for breast cancer is offered to women aged between 53 and 70, about 70,000 women in Worcestershire. The local uptake is good at just below 80%, meaning nearly 56,000 women are screened per year. Bowel cancer screening is offered to those aged 60-74. Uptake rates for Worcestershire are higher than average at 62%, meaning 62,000 people are screened each year in the County.

1.19 The flu vaccination programme is offered to all those aged 65+. In Worcestershire in 2014/15 74% were vaccinated – just under the national target of 75% - this equates to 92,000 people across the County. The other routine vaccination programme for older people is the pneumococcal vaccine (PPV). Here rates in Worcestershire are above the target set, with about 90,000 people vaccinated, 73% of those eligible.

1.20 However, again, comparisons with the national average can be misleading. Our ambition should be that 100% of older people take up the screening and vaccination programmes that are available to them, in order to have the best possible chance of a healthy old age.

1.21 Many physical health conditions are linked inextricably with mental health and well-being. Dementia is perhaps the best known of the mental health conditions associated with old age, and about 8,600 people in Worcestershire are estimated to be living with dementia. An alliance of dementia and older people's organisations has run effective national and local campaigns on dementia awareness. This has resulted in over 10,000 people in Worcestershire being trained as Dementia Friends, and the first dementia friendly towns being created.

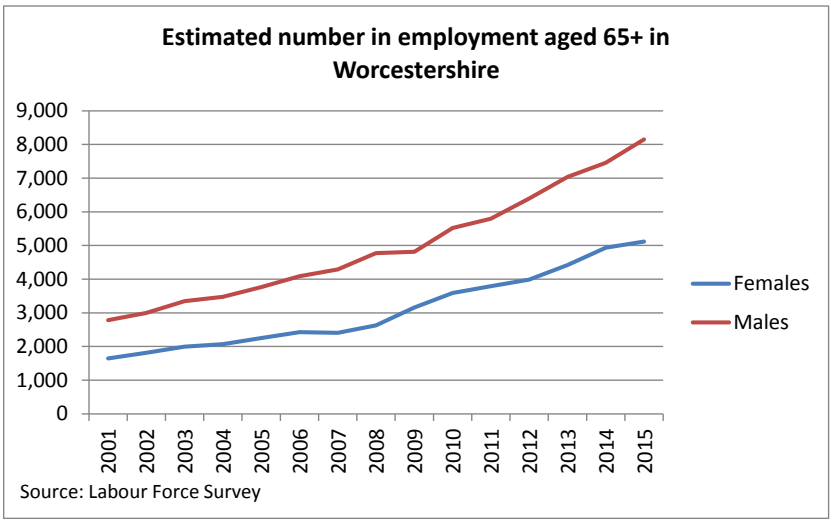
1.22 Other mental health conditions increase with age too. 10,800 people aged 65+ are estimated to suffer with depression in the County. Nationally, depression prevalence is about 1 in 4 of the over 65 population, compared with 1 in 14 for dementia.

1.23 There are strong links between social deprivation and mental ill-health. Mental health emergency admissions rise with increased deprivation in Worcestershire. Those aged over 75 years who live in the 20% most deprived areas have a hospital admission rate for a mental health emergency over a third (35%) higher than do those living in the 20% least deprived areas.

1.24 Important influences on mental well-being are social connectedness, and social capital. Many people who live busy and social lives find that as they age they lose contact with friends and family through illness, bereavement, retirement, and re-location. Many old people are socially isolated, and many lose the social capital that they have built up during their earlier lives. Around 45,000 older people in Worcestershire live alone and although many of these will be well connected and do not consider themselves to be lonely there are nearly 16,000 people aged 65+ who do feel lonely. Compared to people who don't feel lonely, people who are lonely are:

- 2½ times as likely to go into care
- Visit their GP nearly twice as often
- Visit A&E 63% more often
- Have 28% more emergency admissions.

1.25 To balance the picture of an increasingly isolated old age, it should be noted that an increasing number of older people are remaining in employment after the official retirement age. Nationally 7.6% of women and 14.0% of men aged 65+ were in employment in 2015 up from 3.2% and 7.3% in 2001. In Worcestershire this equates to over 13,000 people aged 65+ in employment.



1.26 Older people contribute to society and the economy in other important ways, thereby retaining social capital. For example, national surveys have shown that around 39% of people aged 65-74 and 3% of those aged 75+ volunteer at least once a month. In Worcestershire this equates to about 28,700 people aged 65+.

1.27 Furthermore surveys have found 15% of all children aged 0 to 14 received grandparental childcare in 2010/11, equating to 14,100 children in Worcestershire and this is likely to have increased as the general trend is upward. 28% of families where both parents work use grandparental childcare and one in five (19%) grandmothers provide at least 10 hours a week of childcare.

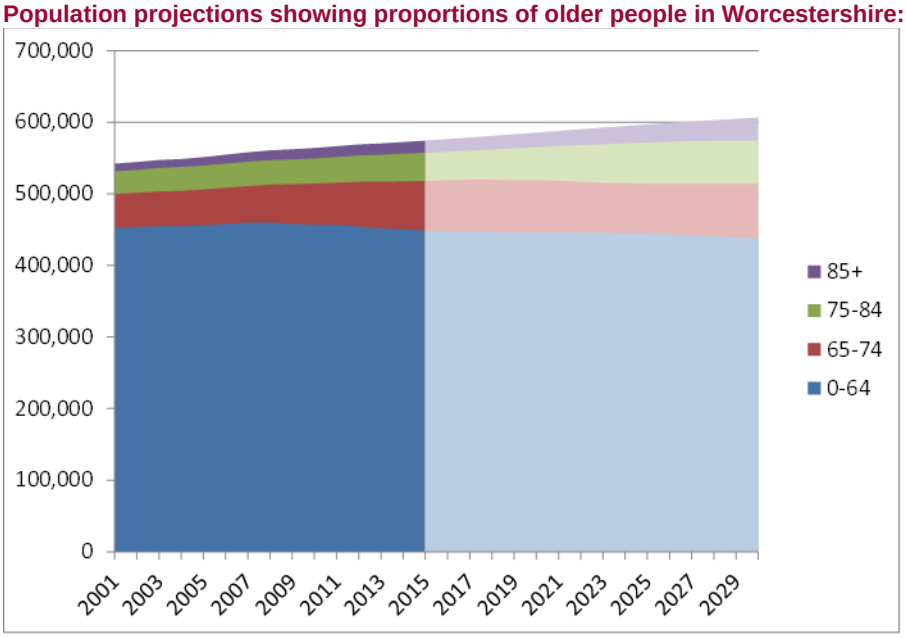
1.28 Older people will often carry leadership roles, contributing much on the basis of their lived experience. For example, 22% of local authority councillors in England in 2013 and 4% of MPs at the 2015 election. were aged 70 or over.

Section 2: Being Older in the future

2.1 There is now a body of evidence dealing with the likely future consequences if current trends in ageing continue. It has become commonplace to paint an alarming picture of our future. Population projections usually describe increased numbers of frail and dependent older people whose needs will stretch the resources of the health and social care system to breaking point.

2.2 In Worcestershire, by 2030, the number of people aged 65+ will increase by over 40,000 to 168,800. It is in the oldest age groups that the rise is most significant, with those aged 75+ going up by 65% to 92,800 and 85+ nearly doubling to 32,200. This will mean that, by 2030, 28% of the population of the County will be aged 65+, 15% will be 75+ and 5.3% aged 85+ (compared to 22%, 10% and 3% in 2015).

Population projections showing proportions of older people in Worcestershire:



2.3 Some further calculation on projected population trends gives the likely future detail of this older population. If things continue as they are, key numbers will include:

- A further 1,500 people will suffer hearing impairment and 7,900 visual impairment by 2030
- Falls will increase such that 2,500 will require hospital admission simply due to the increasing number of at risk older people
- Stroke mortality is projected to continue to fall, but the numbers living following stroke is likely to increase and could be over 4,000 by 2030
- The number of people living with dementia is projected to increase by more than ⅔ to 14,500 by 2030
- The number of older people with diabetes will continue to increase and is projected to be 20,900 by 2030
- The numbers with COPD and CHD will increase to 11,300 and 5,900 respectively simply due to the increasing numbers of older people

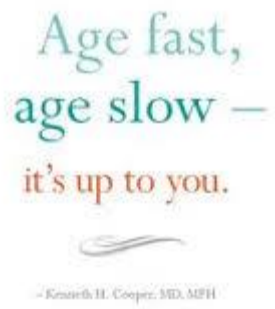
2.4 These increases in poor health outcomes are continuations of existing and in many cases long-standing trends and are driven by underlying lifestyle and socio-economic factors. For example if current trends persist by 2030 we could see:

- 64,300 people aged 65 and over living alone in Worcestershire

- Over 24,000 people aged 65+ providing unpaid care
- 6,800 living in care homes and
- Nearly 20,000 over 65s in fuel poverty

In addition if we project forward lifestyles along with the population growth we could see in the over 65s 18,600 smokers, over 30,000 binge drinkers 48,900 obese people and not far off 150,000 who don't do enough physical activity to keep themselves healthy.

2.5 It is clear that, in the current policy and economic climate, these numbers will create demands on current health and social services which cannot be met, with consequences that are unclear.

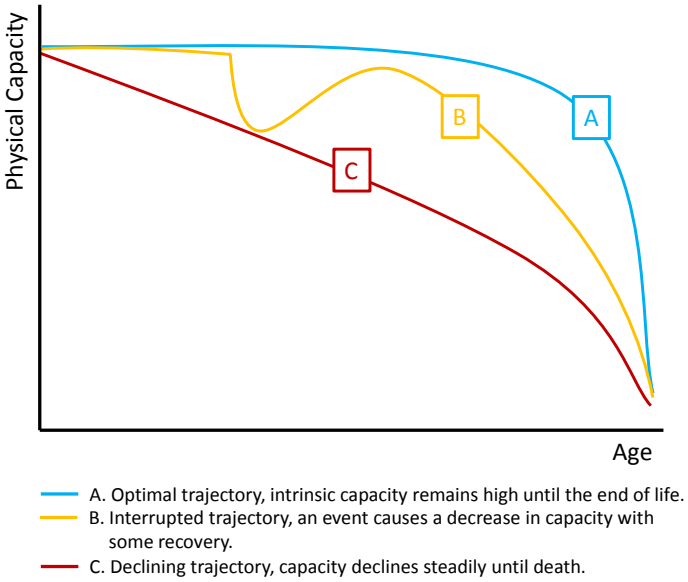


Section 3: Being older in the future – an alternative vision

"Only around 20% to 30% of what we think of as 'ageing' is biological; the rest is 'decay' or 'deterioration', which can be actively managed or prevented."

Public Health England

3.1 The future can be different. Our key focus must be to reduce the gap between life expectancy and healthy life expectancy. The World Health Organisation describes three different scenarios of ageing with an optimal and achievable one of intrinsic capacity remaining high right until the end of life.



3.2 It is right to have the highest aspirations. These are achievable. If we simply achieved what the best in the country are achieving now, then we could see some dramatic differences in our older population by 2030. For example in comparison to the projections in the previous section by matching the current best rates in the country we could have:

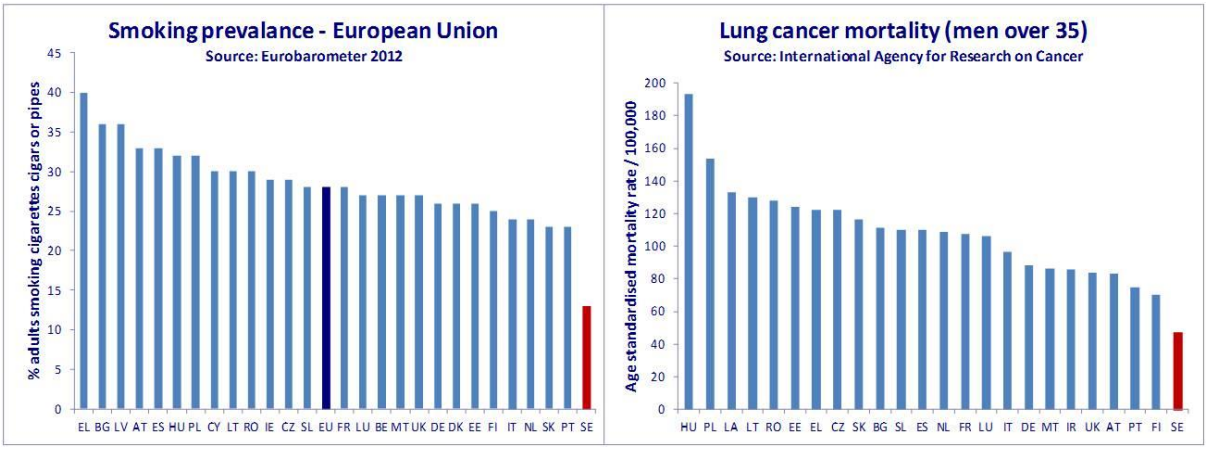
- 12,700 fewer people with long-term illnesses that limit their daily activities
- 1,500 fewer people with COPD, 2,600 fewer with diabetes, 3,700 fewer with CHD and 1,100 fewer with Stroke
- reduced the rise in dementia such that numbers are only a few hundred higher by 2030 instead of nearly 6,000 higher
- Have 6,000 fewer people who consider themselves lonely
- Reduced the number living in fuel poverty instead of seeing it increase, such that the number is 9,500 in 2030 instead of the projected 19,900
- Over 5,000 fewer older smokers and binge drinkers and more than 6,000 fewer obese older people as well as increasing physical activity such that more than 50,000 more older people are doing an adequate amount of exercise.

3.3 We can also learn from other cultures. For example in Okinawan Japanese there is the highest fraction of centenarians in the world (18.5 per 100,000 population). In this culture they eat fewer calories, with children eating 60% of the amount of calories recommended in the UK and adults just 80% of our recommended calories. The result of this is that compared to Americans they:

- Are 75% more likely to retain cognitive ability
- Get 80% fewer breast and prostate cancers
- Get 50% fewer ovarian and colon cancers
- Have 20% fewer hip fractures
- Have 80% fewer heart attacks

3.4 We can also learn from other, more similar, cultures.

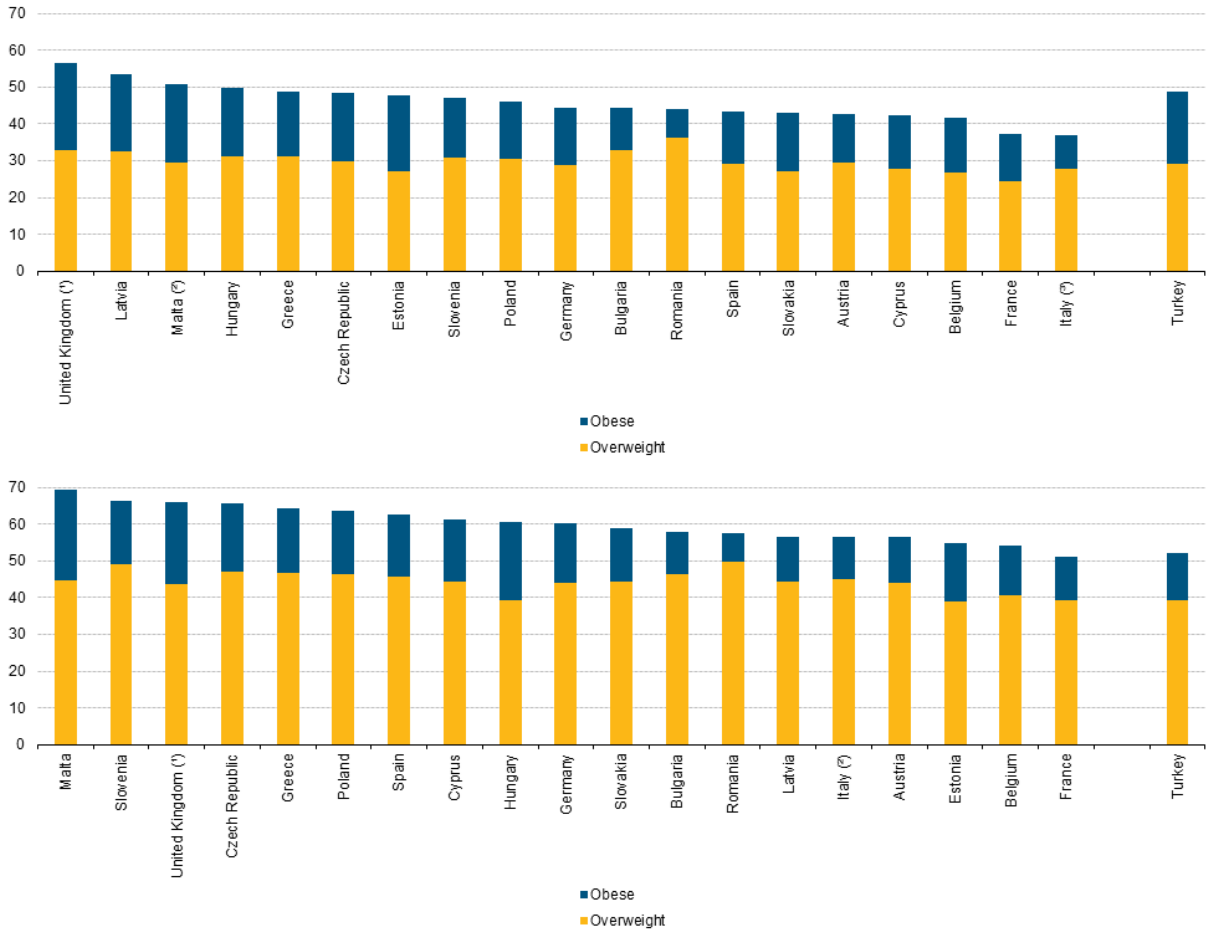
- For example over the whole of Sweden just 11% of the adult population smokes compared to 18% in Worcestershire. [Special Eurobarometer 429: Attitudes of Europeans Towards Tobacco and Electronic Cigarettes. 2015]



- In the Netherlands 44% of adults engage in physical activity outside of sport compared to just 14% in the UK. [British Heart Foundation: Physical Activity Statistics 2015]
- In the UK 44% of adults never do any moderate physical activity. In the EU, the Netherlands has the lowest proportion with 14%. [British Heart Foundation: Physical Activity Statistics 2015]
- In 2008 England had the highest proportion of women who are obese in the EU at 23.9%, whereas in France just 12.7% of women were obese. [Eurostat Overweight & Obesity – BMI Statistics 2008]

	Frequency of adults doing moderate physical activity			adults doing activity outside sport
	Never	1-3 days	4-7 days	
Denmark	23%	39%	38%	32%
Finland	23%	42%	34%	28%
France	46%	30%	23%	17%
Germany	26%	33%	39%	18%
The Netherlands	14%	33%	53%	44%
Sweden	24%	41%	35%	30%
United Kingdom	44%	31%	24%	14%
EU	44%	30%	25%	15%

- In 2010 UK alcohol consumption per capita age 15+ was 10.3 litres compared to just 6.1 litres in Italy. [WHO (2014) Global Information System on Alcohol and Health]
- Mortality from chronic liver disease and cirrhosis in the UK increased steadily over the 2 decades from 1990 to 2010. In contrast the rate across states that were EU members prior to 2004 has decreased such that the UK is now above average. The rate in the Netherlands which was about the same as the UK rate in 1990 has declined and is now less than half the UK rate. [Mladovsky, P., Allin, S., Masseria, C et al (2009) Health in the European Union: trends and analysis. Observatory Studies Series No. 19]



(1) England only. Source: Health survey for England, 2009.
(2) Source: Aspects of daily living survey, 2009.
Source: Eurostat (online data code: hlth_ehis_de1)

3.5 And we can learn too from inspirational individuals. This is the story of one woman in Worcestershire:

Case Study – How it can be if we look after ourselves

"Mrs A is 66. She has a very active lifestyle which has been motivated by the fact that her mother had dementia and she is keen to be as proactive as possible to keep herself fit and enjoy her health for as long as possible.

She is a member of a number of sporting activities and regularly plays tennis and climbs. She has also taken up kayaking in the last two years. Mrs A is a proactive member of the U3A being involved in her local cycling group.

Her enjoyment of these activities is reflected in her holidays, her most recent one entailing a 60k bike ride every day!

Mrs A eats healthy and has made a conscious decision to do so ensuring that her diet does contain a good balance of foods. However, she does have a reputation for making very good homemade ice cream and trifle!

Mrs A plays bridge a number of times a week and she feels this helps her to keep mentally as well as physically active. She also has a grandson and this helps her to keep active too!"

Section 4: Taking action to achieve the best future for older people

4.1 Our key ambition in bringing about a different future for older people should be to narrow the gap between life expectancy and healthy life expectancy. To do this, we need a coordinated and different approach to ageing. There are already many specific initiatives and pathways in place across the County to treat and improve the lives of frail and older people. Health and social care are working better together and in more integrated ways. However, we do not yet have a single narrative across the system as to what will work best to bring about an increase in healthy life expectancy, as opposed to life expectancy alone. This section of the report draws out some key areas of work which focus on a change at population level, based on local and national evidence.

4.2 The Worcestershire Joint Health and Well-being Strategy includes a renewed emphasis on prevention. It calls for action over the long term to address the wider influences on health and well-being, as well as more immediate action to make sure that prevention is included in system thinking on health.

4.3 The Joint Health and Well-being Strategy sets out five approaches to prevention: creating a health promoting environment; encouraging and enabling people to take responsibility for themselves, their families and their communities; providing clear information and advice; commissioning prevention services; and gate-keeping services in a professional, systematic and evidenced way. The actions set out here, to achieve the best possible future for older people, sit within this strategic prevention framework.

4.4 **Creating healthy places**. Worcestershire has a great opportunity to design heathy ageing into its development plans. Over the next 20 years, there will be a significant increase in housing, and continued developments of our infrastructure and planned environment. These create chances to drive healthy lifestyles which are consistent with a healthy old age.

4.5 Key changes to the built environment, which will support healthier populations and healthier old age include:

- new infrastructure development for cycling and walking. It should be noted that creation of cycle paths and walkways will not in themselves bring about behaviour change. Training, education, and support are all needed to make sure that these opportunities are open to all;
- redesigning existing infrastructure to cope with an older population, so that we are not excluded from the built environment as we age. For example, increasing the time at light controlled pedestrian crossings means that those with slower walking speeds can cross the road safely;
- creation of more green spaces. Although Worcestershire has a relatively high amount of green space, the population is below the national average in terms of using it for exercise and recreational purposes. Although nationally, utilisation for exercise and recreational purposed has increased, in Worcestershire it has declined in the last four years;
- creation of more sports space and leisure facilities. Again, for this to prompt behaviour change, attention needs to be paid to motivating people who are inactive to make changes in their lives, and making it easier for them to make use of facilities;
- improving housing insulation to reduce extremes of heat. Fuel poverty is higher than the average in Worcestershire, and this will have a role in excess winter deaths which are linked to the harshness of the winter. The number of excess winter deaths have

varied between 183 and 400 in the 13 years which are listed in the part two of this Report.

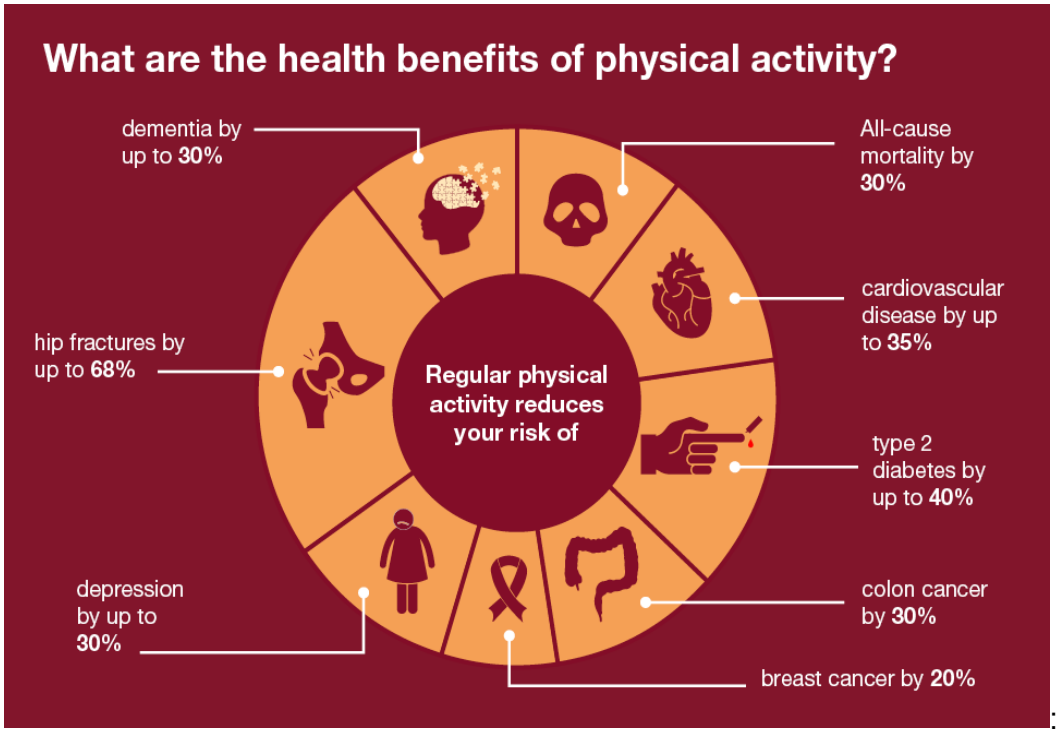
- increasing housing development which promotes social interaction. There is evidence that a healthy old age is more likely where housing design is mixed so that generations can easily meet each other, and so that people can stay within an areas known to them as they age and their housing requirements change;
- making sure that new housing is designed for a healthy old age, with particular attention paid to aids and adaptation to assist older people, and to the use of internal space to allow for the use of such aids;
- making sure there is a good balance of private and communal facilities. This will create the opportunities for social interaction and for local services which can be easily reached by those with mobility problems;
- making sure that new places are digitally enabled. As the digital revolution continues, public access to the internet and ever-faster broadband speeds will bring about social change. It is important that no one is left behand in this digital revolution and access to the internet can bring real improvements to peoples' lives as they age, enabling better access to services, information, and people.
- extending smoke free public areas. Although smoking rates are declining, it is important to maintain a focus on the health benefits of clean air, and to look for new places (such as playgrounds) to extend a smoking ban and ensure that new generations do not start to smoke;
- reducing fast food outlets so as to promote home prepared food, and food that is lower in fat, salt and sugar;
- limiting the availability of alcohol through licensing and through promoting alcohol free activities, so as to reduce the opportunities for drinking to excess.

4.6 **Helping people to help themselves.** As set out in Section 3 of this report, the chances of a healthy old age are significantly increased by following healthy lifestyles. The four main lifestyles factors which are associated with a healthy old age are: not smoking; not drinking too much alcohol; being physically active; and eating a healthy diet with only limited amounts of foods that are high in fat, salt and sugar.

4.7 It is never too late to make changes to lifestyle. The main four lifestyle factors will bring health improvements in a short space of time for the individual, however old. The health benefits of smoking, for example start to be noticed very soon after quitting, from blood pressure and pulse rate returning to normal in less than an hour, through blood circulation to teeth and gums returning to normal in 10-14 days to heart attack risk, lung function and circulation beginning to improve within 3 months, such that walking becomes easier and chronic coughs usually disappear. After just 1 year the risk of coronary heart disease, heart attack and stroke has dropped to less than half that of a smoker and whilst some benefits take longer, after 15 years the risk of stroke, heart disease, diabetes and some cancers is down to that of a non-smoker and after 20 years even the risk of lung cancer has returned to that of a non-smoker.

4.8 Increasing physical activity is particularly important for older people where a decline in muscle mass can reduce daily activities such as climbing stairs and managing to use a toilet. Increasing physical activity has an almost immediate impact of various aspects of personal health such as improved mood, better sleep and self-esteem as well as the improved physical condition that comes with continued exercise over an extended period.

4.9 Achieving the Chief Medical Officer's recommendations of 150 minutes of exercise a week will bring significant improvement to a sedentary population, bringing the risk reductions below, many of which impact significantly on the chances of healthy old age



4.10 In addition to following these four healthy behaviours, the chances of a healthy old age are significantly increased by a high level of social connectedness. Social isolation and loneliness increase the risk of dementia, increase inactivity, and shorten length of healthy life. Tackling this not only requires people to make new connections at a time when they may feel particularly vulnerable (such as following bereavement), but also requires people to recognise when a pattern of spending time alone is becoming chronic loneliness which is hard to change.

4.11 Key actions to help older people to help themselves to healthier old age include:

- Training all front line staff across the health and social care system to have motivational conversations about lifestyles with older people and their carers, helping older people to identify how they can make changes and live healthier lives;
- Building a 'public health army' of people in the County who are aware of key healthy lifestyle issues; able to have motivational conversations; and knowledgeable about digital and local assets. These should include staff outside the health and social care system, as well as residents;
- Scaling up a single approach to social prescribing across the health and social care system so that older people and their carers can become aware of organisations that support healthy lifestyles as well as be enabled to join social organisations to reduce loneliness, and are encouraged in a systematic way to link to them;
- Creating county wide campaigns, based on the principles of social marketing, to encourage healthy lifestyles. Social marketing techniques and methods should support delivery of campaigns to those older people we have traditionally failed to reach;
- Increasing the uptake of health walks by older people; by those older people who live in deprived areas; and by those older people who are already experiencing health challenges;

- Building integrated on-line information about healthy lifestyles, self-care and available services. Maximising the role of digital information in health improvement requires a scaled up approach to public access to the internet, including developments such as digital cafes and training for volunteers to support older people who are digitally excluded, through lack of education or opportunity;
- Supporting workplaces to be health promoting environments so that employees in middle and older age are encouraged and supported to live healthier lifestyles, and so that carers' in paid work have their particular needs met.

4.12 **Developing prevention services which will increase the chances of a healthy old age.** Whilst living in a healthy place and following healthy lifestyles will increase the chances of a healthy old age, there will continue to be people who face challenges which are best overcome by tailored services. In order to reduce the length of time spent in ill-health in old age there are a number of areas for action and focus. These include:

- Falls prevention services. The risk of falls increases steadily with age. Falls-related injury in old age is more likely to be severe and to lead to longer-lasting ill health and hospitalisation than it is in youth. Yet most falls are preventable. Environmental hazards account for between a quarter and a half of all falls, and other factors include muscle weakness, gait and balance disturbance, a history of falls, and multiple medication. Falls prevention programmes, such as Postural Stability Instruction, can raise awareness of risk factors, strengthen muscles, and improve balance for those at highest risk of falling, including those who have experienced previous falls.
- Tailored physical activity initiatives. Physical activity is one of the strongest predictors of healthy ageing and people tend to become even less active as they age. Tailored exercise programmes for older people, including walking in volunteer led groups, can bring about real change.
- Vaccination programmes. As set out in section 3, uptake of older people's programmes is far from the 100% required to bring benefits to everyone, and more needs to be done to understand and overcome variation across the County. It is also important to make sure that staff and carers who work with older people are immunised against influenza on an annual basis, to reduce the chance of transmission to the vulnerable older people in their care.
- A generic lifestyle change service for those older people who find it hardest to change, including on-line resources (supported where necessary), education, goal-setting, and mutual aid.
- Initiatives to tackle social isolation for people who are chronically isolated. Across the County, several different approaches are in place, and there is a need to evaluate these rigorously and systematise an effective approach.
- NHS Health checks. These offer 5 yearly checks to everyone between the ages of 40 and 74 years, excluding those already on a disease register, with the aim of identifying and reducing the risk of cardio-vascular disease and diabetes. Uptake in the County is relatively low, and varies between areas, genders, and ages. Increasing uptake significantly, and targeting efforts to increase uptake on the disadvantaged areas, would have an important impact on the avoidable disease burden.

Case Study – It's never too late to change

"Sandra was referred through the Citizen Advice community buddies team that is based at the York Street surgery practice in Kidderminster. Her plan stated that she was depressed, had low mood and was diabetic. Sandra had difficulty getting out of her house because of her arthritic hip. She also uses sticks to help her walk.

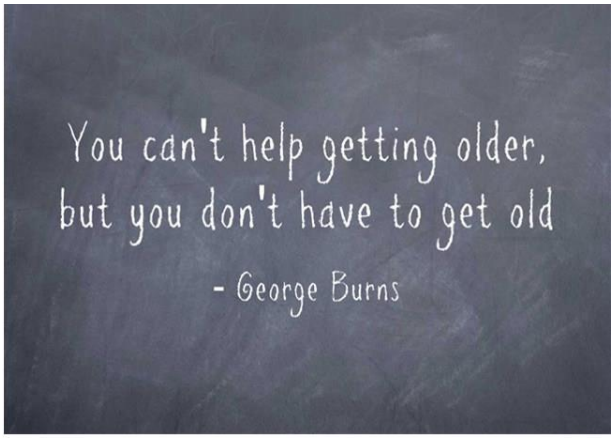
During the first meeting with the volunteer, Sandra cried quite a lot and spoke of her depression and loneliness. She also shared about her serious hip pain that affected her mobility, as well as other medical conditions.

The volunteer spoke to Sandra about visiting her regularly and also about the opportunities for her to get involved at the Simply Limitless Health and Wellbeing Centre in Kidderminster. Sandra quickly took up the offer of going along to an exercise class at the centre that was followed by tea, teacakes and community singing. Sandra quickly started to come twice a week.

Initially Sandra felt unable to do more than sit on a chair with minimal involvement in the exercise activity. However she now does everything including step work and is using weights. She has improved her strength, mobility and balance. Her conversation is now less about her ailments. She now enjoys conversation and laughter with her new friends.

Sandra's family are glad she is reconnecting with society. Monday to Fridays are now far busier for her. She has recently started a CBT class. Sandra now looks so much better as she takes care of her appearance when coming out. She is a far more positive person. She is self-motivated, less depressed and considerably more active. Sandra stopped baking when her husband died seven years now she is talking about cooking and she has started to bake again for her family.

The volunteer has spoken of the privilege in working with Sandra and is excited to see how the Reconnections programme has transformed Sandra's life."



Section 5: Conclusions and recommendations

5.1 An ageing population should be a good news story – it comes about because we are better at reducing ill-health, identifying health problems early and treating them effectively. However, it is clear from the data presented in this report and the data appendix that current trends in population ageing and health outcomes present a serious challenge. Healthy life expectancy is not the same as life expectancy and ever increasing numbers of people will live in unhealthy old age, unless there are significant changes.

5.2 This is bad news for the quality of people's lives, especially for those who live in deprived areas. It is also bad news for the sustainability of our local health and social care services, which cannot be funded to the level of likely demand. To change this, we must work together to re-shape the lives and health behaviours of people in Worcestershire so that healthy life expectancy is the same as life expectancy.

5.3 This report has highlighted areas for improvement. Worcestershire does not always compare well with the best areas in Country and, where we are at national average level, we may mask our worst problems. In particular, social deprivation continues to define people's chances of a healthy old age. But we know from national evidence that it is possible to make changes which will result in reduced demand for services as well as improving people's lives.

5.4 It is also clear that most of what we see as the natural consequences of ageing are not inevitable and are to some extent reversible. It is never too early to consider the consequences of lifestyle choices on our future health and wellbeing as making the right choices can lead to a far better old age in which we can remain active both physically and mentally for much longer. Equally however it is never too late to benefit from making changes to improve our lifestyle, with the chance to reverse or delay some of the physical consequences of lifestyles and improve mental wellbeing in older age.

5.5 Although much of the responsibility for this rests with individuals, we know that the decisions to be healthy are not made in isolation from the culture and environment they live in. Therefore creating an environment in which making the healthy choice is the easy option is essential if we are going to change the future for older people living in Worcestershire.

5.6 The key recommendations of this report link back to the fuller summary of actions which were presented in section 4 above. There are five:

5.7 **Recommendation one:** that planners, elected members and health and social care leaders in Worcestershire commit to giving a higher priority to reducing the gap between life expectancy and health life expectancy during this next planning period.

5.8 **Recommendation two:** that planners and decision makers give more focus to the health impact of the planned environment, and especially in increasing the chances of a healthy old age.

5.9 **Recommendation three:** that health and social care leaders give more focus to helping people to help themselves, specifically by scaling up training to create a public health army; by building inclusive digital assets; and by systematising social prescribing.

5.10 **Recommendation four:** that health and social care leaders increase the availability of evidence based programmes such as lifestyle change; falls prevention; and physical activity, tailoring and focussing services on those who have the greatest need.

5.11 **Recommendation five:** that there be a shift of attitude, so that the fact of increased numbers of older people in Worcestershire is seen as a good news story, and growing older in Worcestershire is associated with long, healthy living, rather than an inevitable decline into dependency and ill-health. Older people should be seen as an asset in our County, and investment leading to an improvement in the quality of life for older people should be understood as an investment bringing real gain to us all.

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