



Ageing well in Medway: the health and wellbeing of Medway's older population

The Annual Public Health Report of
the Director of Public Health

2013/14

Electoral wards in Medway

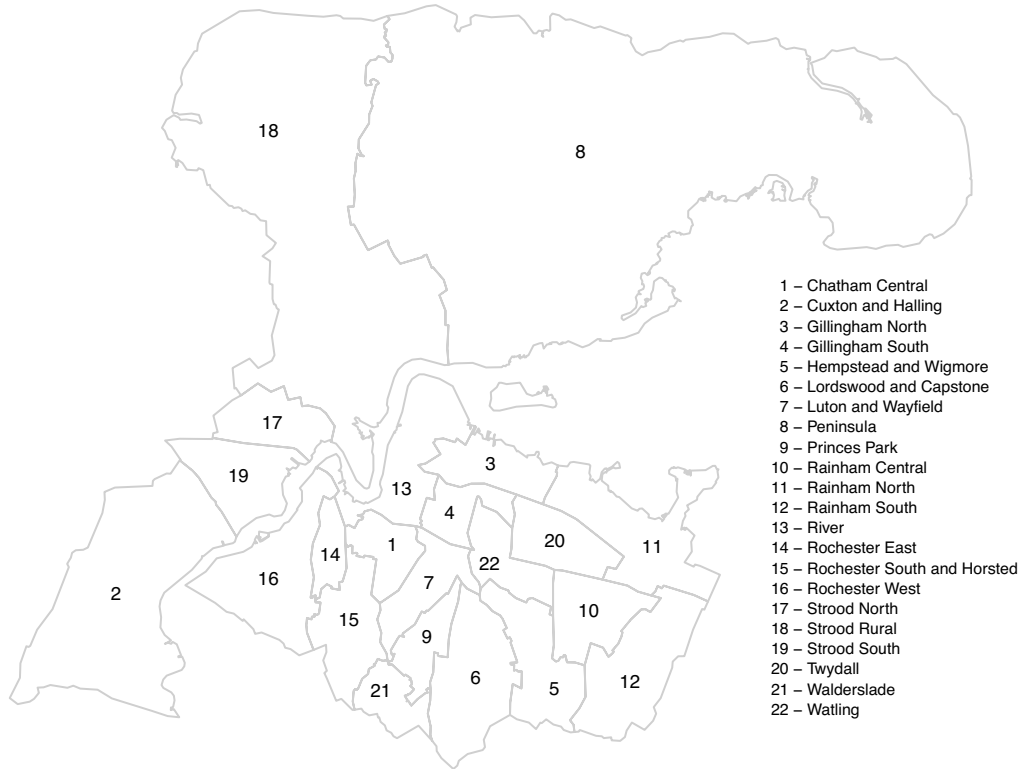


Table of contents

Foreword	iv
List of figures	v
List of tables	vi
Acknowledgements	
Chapter 1: Introduction	
Background	2
Overview of Medway's older population	4
Morbidity and mortality	7
Lifestyle	13
Chapter 2: Social isolation	18
Chapter 3: Falls	28
Chapter 4: Dementia	38
Chapter 5: The living environment	48

Foreword



This year's Annual Public Health Report focuses on the health of older people. Over the last century there has been a marked increase in life expectancy in the UK, which resulted initially from reductions in mortality from infectious diseases and, more recently, from reductions in mortality from degenerative diseases such as cardiovascular disease. These are great public health achievements brought about by better living conditions, immunisation, healthier lifestyles and better treatment. This would not be such a great achievement, however, if enjoyment of a longer life is marred by a longer time spent in ill health with fatal or non-fatal degenerative diseases.

Although the population is living longer and in better health, there are new trends emerging that will impact on population health. For example, we know that social isolation increases the risk of ill health and death. Surveys have shown an increasing prevalence of social isolation in people aged over 65, with many relying on the TV or a pet as the main source of companionship.¹ The full impact of the increasing prevalence of obesity has yet to be seen but it is likely to affect both life expectancy and healthy life expectancy.

Our challenge is to add life to years through preventing disease, effective treatment of disease and minimising the impact of disease on independence and quality of life. To do this we will need to ensure that older people feel respected and supported in their local community, enjoy good health and social care, have resilience to cope with life's challenges and live in environments that help them to maintain their independence and health and wellbeing. This is occurring at a time of financial austerity in the public sector, which has brought a focus on the importance of prevention and early intervention along with the design of integrated services to meet needs more efficiently and the development of the capacity of communities to support themselves. I hope that this report will help Medway Council and its partners rise to this challenge.

A handwritten signature in black ink that reads "Alison Barnett".

Dr Alison Barnett
Director of Public Health
Medway Council

*1. TNS Survey. Over a million older people in the UK regularly feel lonely. Age UK.
<http://www.ageuk.org.uk/latest-press/over-1-million-older-people-in-uk-feel-lonely/>*

List of figures

Chapter 1: Introduction

Figure 1:	The wider determinants of health	3
Figure 2:	Population pyramid: Medway and England, 2013	4
Figure 3:	Projected changes in Medway's older population, 2012–2037	5
Figure 4:	Income Deprivation Affecting Older People 2010 local quintiles for Medway	6
Figure 5:	Female life expectancy at 65 years, Medway and England, 2000/02–2010/12	7
Figure 6:	Male life expectancy at 65 years, Medway and England, 2000/02–2010/12	7
Figure 7:	Life expectancy at 65 years by Medway ward, all persons, 2009–2013	8
Figure 8:	Number of long term conditions recorded in Medway resident patients admitted to hospital as an emergency by deprivation quintile, 2013–14	11
Figure 9:	Mortality from all causes by age and sex, Medway, 2004 and 2013	12
Figure 10:	Mortality from main causes by age, Medway, 2004 and 2013	12

Chapter 2: Social Isolation

Figure 1:	Proportion of households in which a single person aged 65 years and over is living alone	22
Figure 2:	Relative social isolation per household of persons aged 65 years and over	22

Chapter 3: Falls

Figure 1:	Falls-related hospital admission rate (all falls) for Medway residents by age and gender, 2012	30
-----------	--	----

Chapter 4: Dementia

Figure 1:	Causes of dementia	40
Figure 2:	Estimated prevalence of dementia in Medway in people aged 65 years and over, 2012	41
Figure 3:	Trends in estimated number of people aged 65 years and above living in Medway with dementia, 2012–2037	42

Chapter 5: The Living Environment

Figure 1:	Proportion of Medway's population aged 60 years and above in receipt of the guaranteed part of Pension Credit by Medway ward, February 2010	53
-----------	---	----

List of tables

Chapter 1: Introduction

Table 1:	Medway residents aged 65 and over by age and ethnic group, 2011	5
Table 2:	Disability-free life expectancy and life expectancy at age 65, England and Medway: 2009–2011	8
Table 3:	Estimated numbers of people aged 65+ living in Medway with common LTCs, current and projected to 2030	10
Table 4:	Self-reported smoking status, males and females aged 65–74 years in England in the years 1993, 2003 and 2012	13

Chapter 2: Social Isolation

Table 1a:	One-to-one interventions to address social isolation	23
Table 1b:	Group interventions to address social isolation	24
Table 1c:	Wider community engagement activities to address social isolation	24

Chapter 3: Falls

Table 1:	Contributing factors to falls in the elderly	32
Table 2:	Place of occurrence of falls resulting in a hospital admission, Medway population aged 65 years and above, 2009/10–2013/14	32
Table 3:	Compliance with NICE guidance: examples of current falls services in Medway	34

Chapter 4: Dementia

Table 1:	Dementia severity in Medway by age group in those aged 65 years and above, 2012	42
----------	---	----

Chapter 5: The Living Environment

Table 1:	The effect of indoor temperatures on health	51
----------	---	----

Acknowledgements

This report has been produced by the Public Health Directorate with support from colleagues in Medway Council, Medway NHS Foundation Trust, Kent County Council, Kent Police and groups from Medway's Community and Voluntary Sector.

Thanks are also due to Taiye Aro, Julian Barlow, Laura Bottle, Rachel Britt, Mark Chambers, Steve Gill, Mark Goodman, Matt Gough, Caroline Hardingham, Rachael Horner, Phil Lewis, Kaz Macklin, Luci Napleton, Arron Nicholls, John Norley, Su Ormes, Lance Phillips, Christine Potts, Emily Silcock, Dr Sanjay Suman, Dr David Whiting, Dr Kirstin Williamson and Samantha Wood.

I would particularly like to thank Dr Saloni Zaveri and Colin Thompson for leading the production of this report.

1 Introduction



1 Introduction

Background

Medway has an extraordinary asset: its older people. In a society that very much values youth, we often define the elderly population in terms of their problems, needs and costs but there is a growing body of evidence that, far from being a burden, older people contribute more resources to society than they consume and play an invaluable role through volunteering, active involvement in the community, local leadership, informal caring and economic contributions. The voluntary work of the UK's older people in caring and family maintenance alone has been valued at over £50 billion per year.¹

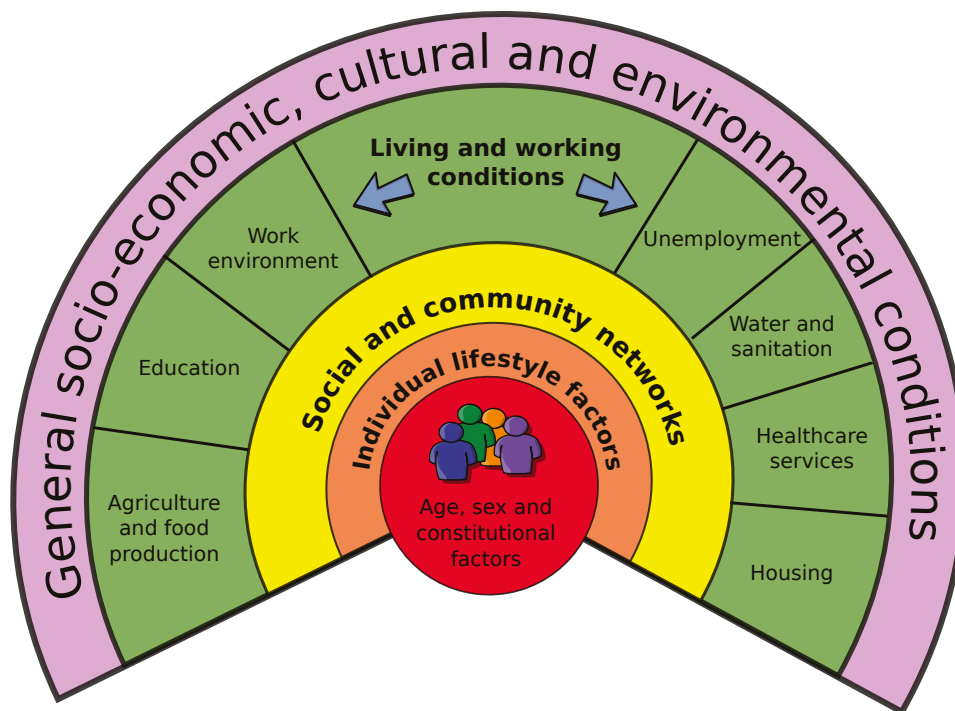
The population of Medway, like the UK as a whole, is ageing. This is due to increasing life expectancy and changes in the age structure of the population due, in particular, to the large number of people born during the 1960s "Baby Boom". Medway currently has a younger age profile than nationally (see "Overview of Medway's older population") but population projections suggest that the number of people aged 65 years or above will increase over the period 2012–2037 from 39,100 to 69,800 and the number of people over 85 years will more than double over the same time period from 4,500 to 12,200.

The increase in life expectancy is a great public health achievement and, although our population is ageing rapidly, it is not inevitable that old age will lead to a progressive decline into ill health and dependence. Indeed, over several decades the proportion of older people who report limitations on activities of daily living has consistently decreased, with a concurrent increase in disability-free life expectancy over time. Recent evidence suggests that morbidity (illness) is being "compressed" into the period just before death, in particular the 18 months at the end of a person's life. This has led to the suggestion that it is dying, rather than being old, that leads to high costs and increased burden on health and care services.²

Evidence is also emerging to suggest that the main driver for spending on health care is advancement in medical knowledge and healthcare technology. Whilst it is true that increased longevity means that more people will live long enough to take advantage of medical advances (for example, hip replacements), thereby increasing healthcare costs; preventative treatments (for example, blood pressure and cholesterol lowering medication) are likely to enable people with long term conditions to remain well, disability free and productive well into their older years thus delaying major health and social care costs and sustaining for longer the vital contributions to society that older people can make.²

Whilst biological factors such as ageing and gender play an important role in determining our health outcomes, figure 1 shows that there are many wider factors relating to the conditions within which we live and work that can influence our health.

Figure 1: The wider determinants of health



Source: Dahlgren and Whitehead 1991

Improving health outcomes for older people requires addressing these wider determinants of health as well as ensuring the effectiveness of our health and social care services. All of us as members of society have a major role in ensuring that our older population, who make such a vital contribution to society, are supported to preserve their dignity and capacity and enjoy good health and independence for as long as possible

This report focuses on the health of our older population and has been structured to look at the following four key issues affecting older people's health and wellbeing:

1. Social isolation. Estimates suggest that around one in 10 older people experience chronic loneliness, with people living in deprived areas experiencing much higher rates. Maintaining strong social networks and being part of a community has far reaching benefits for physical and mental health and wellbeing in later life.
2. Falls. Each year one in three people over 65 and almost one in two people over 85 experience one or more falls, many of which are preventable. Falls can have serious implications for the health, wellbeing and independence of older people and the related costs to health and social care are substantial.
3. Dementia. Dementia is an increasingly important public health problem. The main risk factor for the development of dementia is age and it is becoming the main cause of disability in older people. Dementia has significant impact on family, carers, society, health and social services.
4. The living environment. There is a substantial body of evidence which links our living environments, for example the quality of our housing conditions, to our health outcomes.

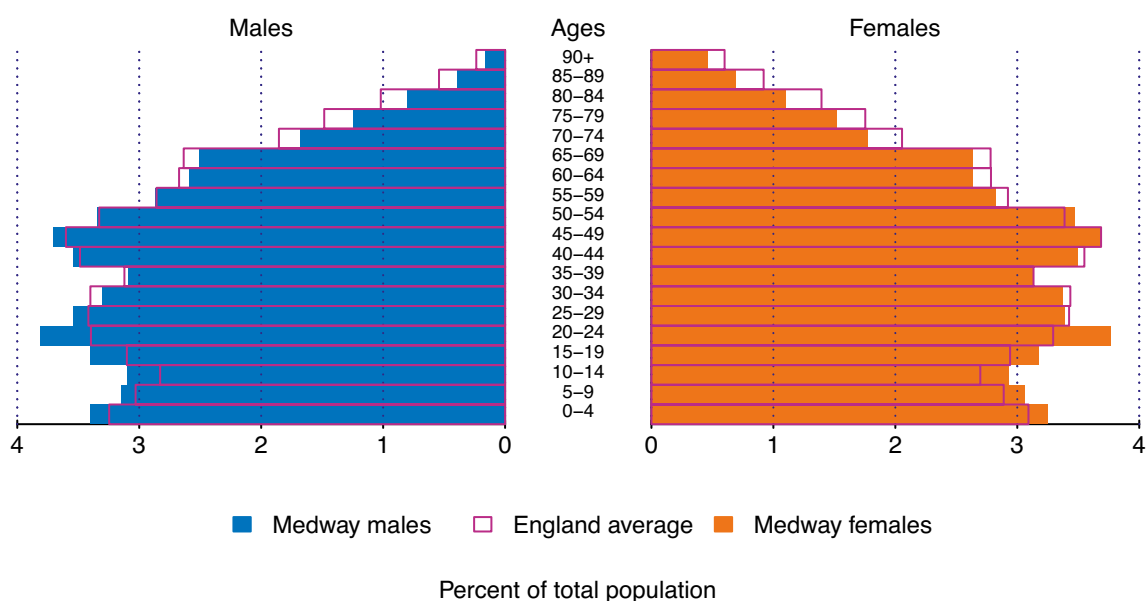
Overview of Medway's older population

Medway's population is younger than the population of England overall. Compared to the England average, Medway has a smaller proportion of people over the age of 65 years (figure 2).

According to Office for National Statistics (ONS) population estimates for mid-2013, approximately 40,600 people over the age of 65 years currently live in Medway, of whom approximately 4,600 are over 85 years old. There are differences in the age distributions of Medway's wards. Rainham Central, Hempstead & Wigmore and Rainham North have the largest proportions of older people with one fifth or more of their population aged 65 years and above.

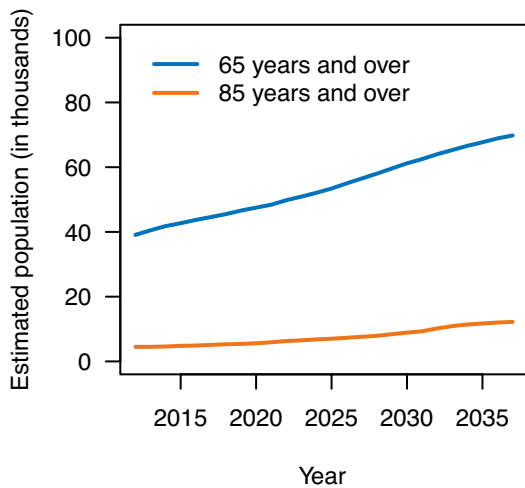
The population profile in Medway is changing over time, with an increasing proportion of older people. Population size at a future date can be estimated through population projections, whereby assumptions are made about levels of fertility and mortality and about how many people will move into or out of an area before that date. The net population increase or decrease over the period is added to the "baseline" population to project future population. Projections from 2012 to 2037 suggest that the number of people aged 65 years or over will increase from 39,100 to 69,800 and the number of people over 85 years will more than double from 4,500 to 12,200³ (figure 3).

Figure 2: Population pyramid: Medway and England & Wales, 2013



Source: Mid-year estimates 2013, Office for National Statistics (ONS)

Figure 3: Projected changes in Medway’s older population, 2012- 2037



Source: ONS, 2012-based subnational population projections

Ethnicity

Table 1 shows that, amongst Medway’s population who are aged 65 years and over, 96 percent are of white ethnicity. Since the proportion of black and ethnic minority groups within Medway’s population is increasing, the percentage of older people represented in these groups would be expected to increase over time.

Table 1: Medway residents aged 65 and over by age and ethnicity, 2011

Age (years)	White	Mixed/ Multiple Ethnic Ethnic Group	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other Ethnic Group
65-74	19,717	125	617	139	54
75-84	11,524	66	289	50	17
85+	4,323	23	53	7	1
Total Population aged 65+	35,564	214	959	196	72

Source: Projecting Older People Population Information System (POPPi). Figures are taken from the Census 2011, ONS, May 2013

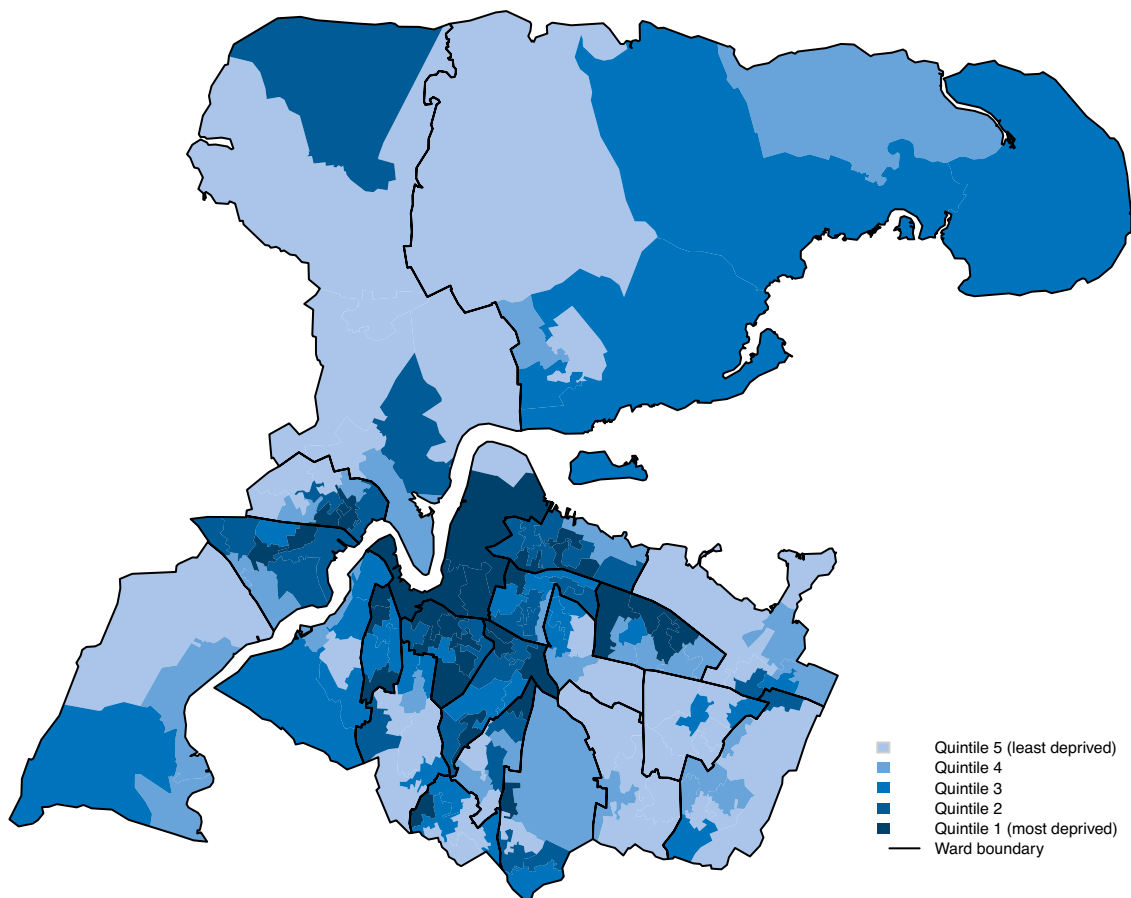
Living arrangements of Medway's older people

Medway has fewer than the national average of one-person households where the resident is aged over 65 years, but there are still nearly 15,000 people aged over 65 living alone in Medway, 67 percent of whom are female. This number is projected to rise to over 22,000 by 2030.⁴

994 people in Medway over the age of 65 years (two percent) currently live in a care home with or without nursing care. Although this proportion is low compared with the local authorities in England which are most similar to Medway,⁵ the figure is projected to rise to 1,736 by 2030.⁶

A considerable proportion (13 percent) of Medway's over 65s currently provide unpaid care (look after, give help or support because of long-term physical or mental ill health or disability, or problems related to old age) to a partner, family member or other person.⁷ This care may be provided within or outside of the person's own household.

Figure 4: Income Deprivation Affecting Older People 2010 local quintiles for Medway



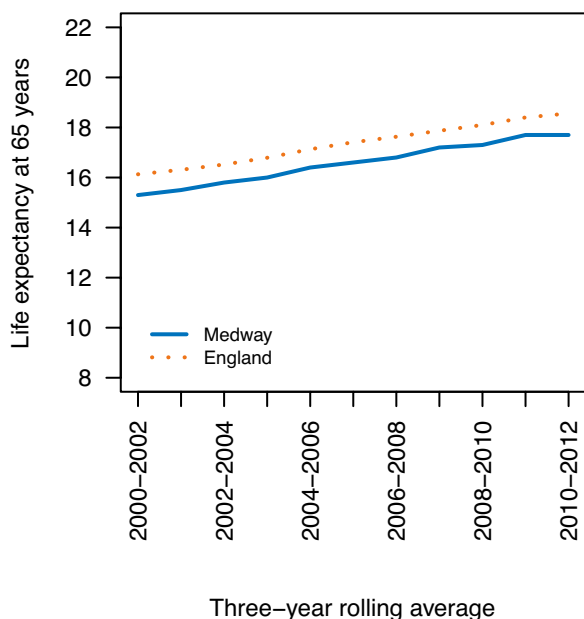
Note: please refer to map of electoral wards on inside front cover

Deprivation

Levels of deprivation among older people are included in the 2010 Indices of Deprivation as a supplementary index: Income Deprivation Affecting Older People Index (IDAOP). This index takes into account adults aged 60 years and above living on income support or income-based jobseekers allowance or pension credit families. The index calculates a percentage representing older people suffering from income deprivation in each area. Figure 4 shows the levels of income deprivation amongst older people across Medway.

Of Medway's lower layer super output areas (LSOAs), 12 percent (19/164) fall within the most deprived quintile nationally. Chatham Central, Luton and Wayfield, River and Gillingham North are the wards in Medway with the largest number of LSOAs falling within the most deprived national quintile.

Figure 5: Female life expectancy at 65 years, Medway and England, 2000/02–2010/12



Source: ONS

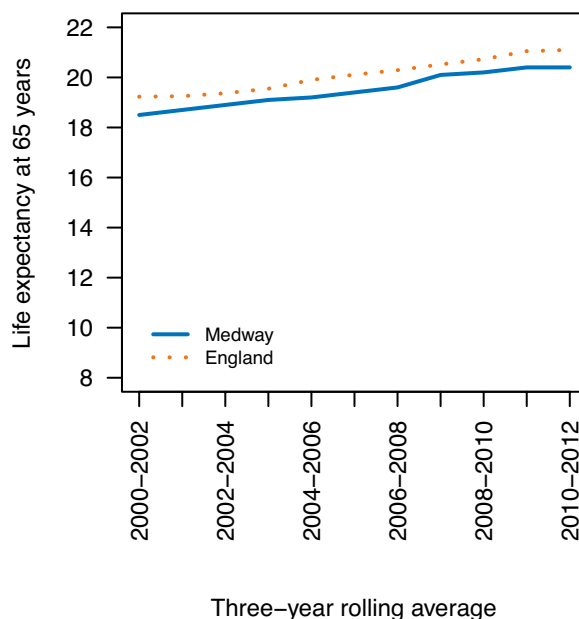
Morbidity and mortality

Life expectancy

The increase in the proportion of older people that we are seeing in our population is due to consistently improving life expectancy for men and women and the ageing of the large “Baby Boomer” generation. When today's 65-year-olds were born in the UK in 1949, life expectancy at birth for males and females was only 66 years and 70 years respectively. Life expectancy at birth today in the UK is 79 years and 83 years respectively (ONS).

In Medway today, life expectancy at 65 years of age is almost 18 years for men and more than 20 years for women. Although Medway's life expectancy at 65 years is slightly lower than the average for England, which is almost 19 years for men and just over 21 years for women, there has been considerable improvement over the past decade both nationally and locally (figures 5 and 6).

Figure 6: Male life expectancy at 65 years, Medway and England, 2000/02–2010/12



Source: ONS

Table 2: Disability-free life expectancy and life expectancy at age 65 (England and Medway): 2009-2011

Area	Sex	Life expectancy	Disability- free life expectancy
England	Males	18.4	10.5
	Females	21.0	11.2
Medway	Males	17.7	10.0
	Females	20.4	10.6

Source: ONS

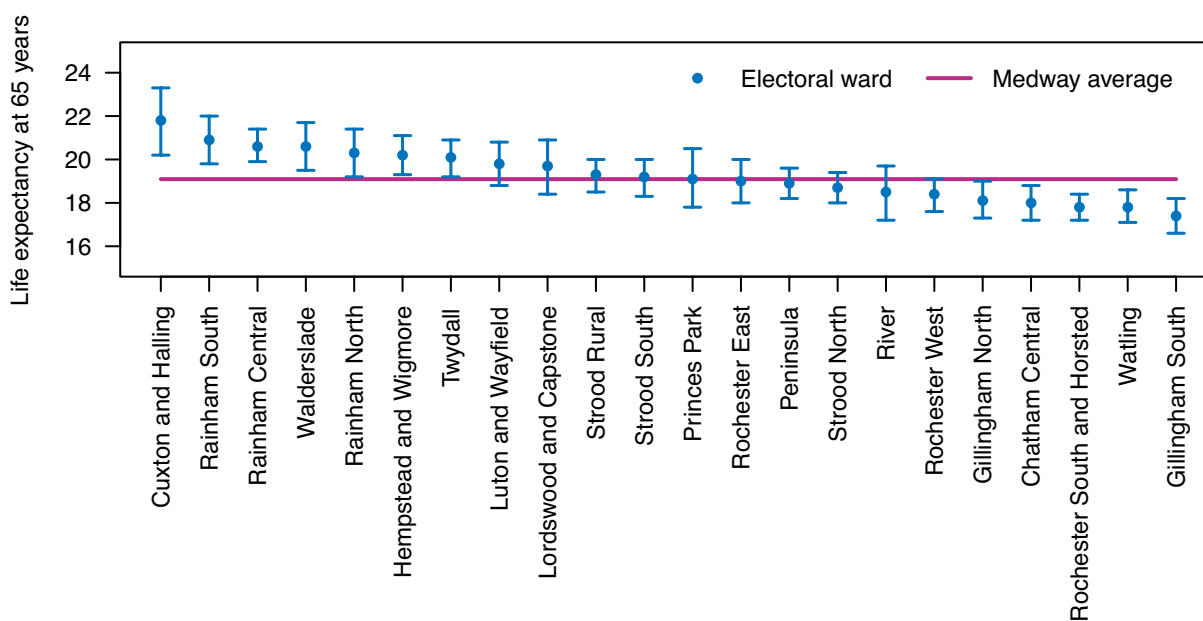
It is important that, as well as living longer, older people live those extra years in good health. The latest data show that, at age 65, men and women in Medway have a healthy, disability-free life expectancy of just over ten years (table 2).

Although table 2 shows that the average disability-free life expectancy for England is higher

for both men and women compared to Medway, the differences are not statistically significant.

Figure 7 illustrates that there are differences in life expectancy between Medway’s wards.

Figure 7: Life expectancy at 65 years by Medway ward, all persons, 2009–2013



Source: PMCD, ONS Population Estimates, SEPHO, KMPHO

The difference between the ward with the highest life expectancy at 65 years and the lowest is 4.4 years. Differences are also seen in life expectancy between men and women in Medway, with the average gap in life expectancy at 65 years being 2.6 years.

Health conditions affecting older people

Long term conditions (LTCs) are chronic diseases for which there is currently no cure and which are managed with drugs and other treatments.

LTCs are more prevalent in older people:

58 percent of people aged over 60 have at least one LTC compared with 14 percent under the age of 40 years.

The increase in numbers of older people in the population has led to a rise in the prevalence of LTCs. Although this will inevitably have an impact on the need for health and social care,⁸ the older population are now living long enough to take advantage of medical technologies and treatment which may reduce the life-limiting nature of LTCs.

Limitation of daily activities

Calculations based on Census data estimate that 9,578 people over the age of 65 years in Medway have a limiting long term illness (LLTI) which significantly limits their day-to-day activities.

This figure is projected to rise to 14,894 by 2030.⁹

An estimated 39 percent of Medway's population aged over 65 years are currently unable to manage at least one domestic task on their own (for example, household shopping, washing dishes, using a vacuum cleaner, opening screw tops, dealing with personal affairs) and an estimated 32 percent of Medway's over 65s are unable to manage at least one self-care activity (for example, bathe, shower or wash all over, dress and undress, wash their face and hands, feed, cut their toenails, take medicines).¹⁰

The burden of long-term conditions in the older population

Long-term conditions (LTCs) place a huge burden on health and care resources. Those with LTCs are much more likely to attend their GP and to use secondary care (e.g. inpatient) services.¹¹

The elderly are significantly more likely to be affected by LTCs and as our population ages, inevitably the incidence and prevalence of these conditions will increase.

Table 3 shows the estimated numbers of Medway's older population who are currently living with common LTCs and how these numbers are projected to rise in the future.

Table 3: Estimated numbers of people aged 65 years and above living in Medway with common LTCs, current and projected to 2030

Disease	Estimated numbers of people aged 65 years and above (2014)	Projected numbers of people aged 65 years and above (2030)
Depression ⁱ	3,586	5,246
Cardiovascular disease ⁱⁱ	13,200	19,400
Respiratory disease ^{iii,iv}	7,100	10,300
Diabetes ^v	5,200	7,600
Arthritis ^{vi}	16,700	24,500
Dementia ^{vii}	2,600	4,600

Source:

i: Projecting Older People Population Information System (POPPI). Taken from McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787–1795

ii: Public Health England CVD prevalence estimates Dec 2011

iii: Public Health England COPD prevalence estimates Dec 2011

iv: Health Survey for England - 2010, Respiratory health

v: Health Survey for England - 2006, CVD and risk factors for adults, obesity and risk factors for children [NS]

vi: Health Survey for England - 2005, Health of Older People

vii: Dementia UK: The Full Report 2007; Alzheimer's Society

Detailed descriptions of these chronic diseases within Medway's population are available in Medway's Joint Strategic Needs Assessment: <http://www.medwayjsna.info/>

Multiple morbidities

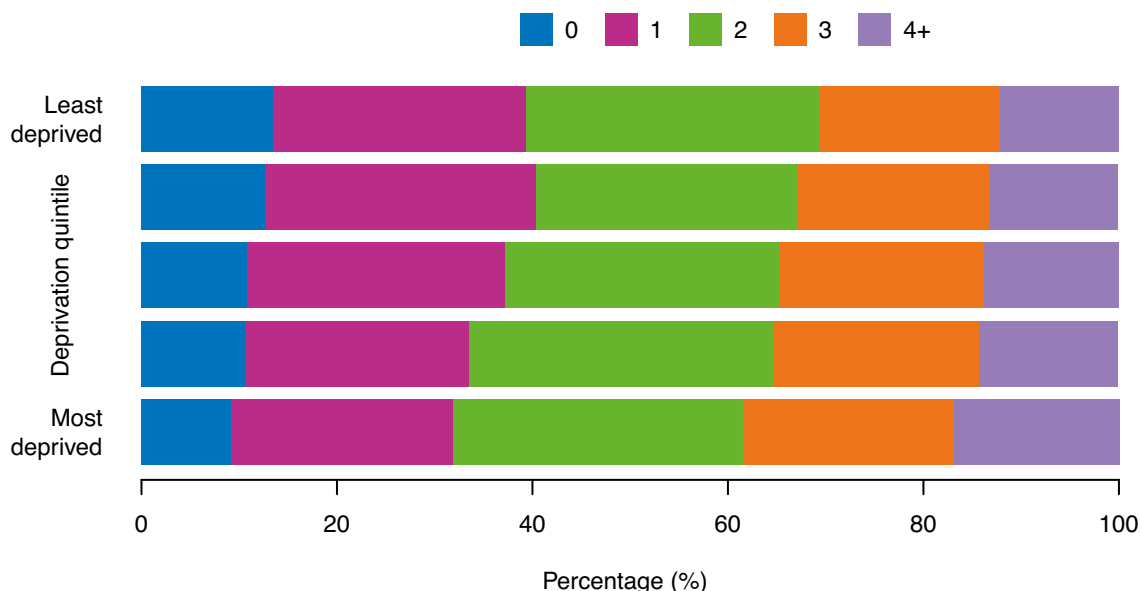
Many older people live with more than one LTC, which can increase the complexity of the management and care required by the individual. There is evidence that the number of people with multiple LTCs (multi-morbidity) is rising: it is predicted that the number of people in England with three or more LTCs will rise from 1.9 million in 2008 to 2.9 million in 2018.⁸ There will be an increasing need to prevent and manage multi-morbidities rather than focusing on single diseases.

Multi-morbidity is more common among deprived populations.¹² People with the most deprived backgrounds have a 60 percent higher prevalence than those with the most affluent backgrounds.⁸

Figure 8 shows that the likelihood of multi-morbidities amongst older people who are admitted to hospital increases with the level of deprivation in Medway.

The analysis reflected in figure 8 is based on emergency hospital admissions for Medway residents and the number of LTCs recorded for each patient. There is a very highly significant association for Medway between the level of deprivation in a patient's area of residence and the existence of four or more LTCs.

Figure 8: Number of long term conditions recorded in Medway resident patients admitted to hospital as an emergency by deprivation quintile, 2013–14



Source: Secondary Uses Service admitted patient care (accessed via KMHIS data warehouse). Note: The number of LTCs recorded for each patient was calculated by examining the primary diagnosis and first 12 secondary diagnoses for the hospital admission. The list of conditions is as follows: hepatitis, cancer, anaemia, dementia, bi-polar or schizophrenia, depression, anxiety, epilepsy, hypertension, ischaemic heart disease, atrial fibrillation, stroke, diabetes, chronic heart failure, bronchitis, chronic obstructive pulmonary disease, asthma, bronchiectasis, pulmonary oedema). Each patient was categorised by the number of conditions recorded. The deprivation quintile is based on the lower super output area in which the patient lives. This was matched to a quintile relative to Medway.

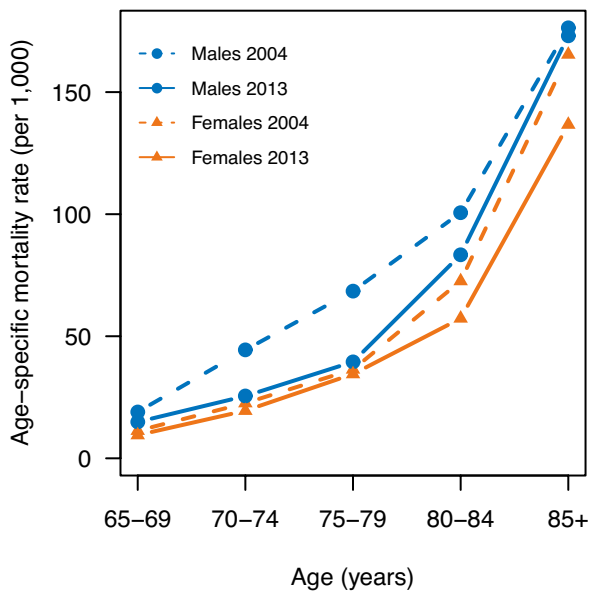
Mortality

Figure 9 shows how overall mortality rates in Medway in both men and women aged over 65 years have changed in the last decade. Rates are lower now, compared to ten years ago, for men and women in all older age groups but most striking is the reduction in the mortality rate for men aged below 80-84 years.

The major LTCs which lead to death in Medway's older people are circulatory disease (this includes heart disease and stroke), cancer and respiratory disease. Figure 10 indicates that the drop in overall

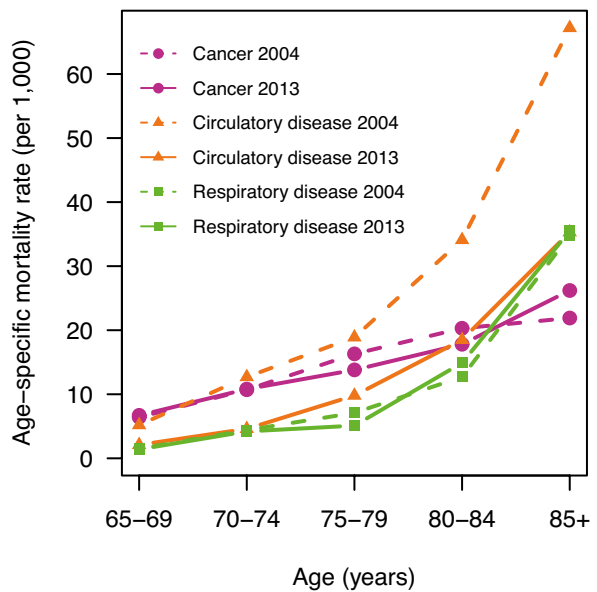
mortality in older people between 2004–2013 is attributable largely to a drop in deaths from circulatory disease. This decline in deaths from circulatory disease over the last decade has also occurred nationally, with evidence indicating that the main contributory factors are advances in the field of medicine and improvements in public health, for example, a decline in smoking prevalence and reductions in dietary salt intake resulting in reduced risk of developing cardiovascular disease.^{13,14}

Figure 9: Mortality from all causes by age and sex, Medway, 2004 and 2013



Source: Primary Care Mortality Database, Mid-year population estimates (ONS). Note: All deaths have been counted where deceased is aged 65 years and over and a resident within Medway UA.

Figure 10: Mortality from main causes by age, Medway, 2004 and 2013



Source: Primary Care Mortality Database, Mid-year population estimates (ONS). Note: Only deaths where underlying cause is in ICD-10 chapters for Malignant neoplasms (C00-C97), Circulatory disease (I00-I99) and Respiratory disease (J00-J99) have been counted. Deceased aged 65 years and over and a resident within Medway UA.

Lifestyle

Lifestyle factors play a major role in the prevention and management of LTCs affecting older people and are largely modifiable. Healthier lifestyle patterns can delay the onset of LTCs, reduce premature deaths and have a considerable positive impact on wellbeing and quality of life in our older population.

Smoking

Data from the Health Survey for England show that the prevalence of smoking in England's adult population has declined over the past two decades in both males and females. Table 4 shows how smoking prevalence has changed over time for those aged 65–74 years.

Table 4: Self-reported smoking status, males and females aged 65–74 years in England in the years 1993, 2003 and 2012

Lifestyle factor	Prevalence in females aged 65-74 years (%)			Prevalence in males aged 65-74 (%)		
	1993	2003	2012	1993	2003	2012
Smoking	18	15	11	20	13	12

Source: Health Survey for England

The smoking prevalence across all adults in Medway is significantly higher than the England average and has increased from 21.9 percent in 2010 to 25.6 percent in 2012, although the difference between 2010 and 2012 is not significant. Smoking prevalence amongst Medway's routine and manual workers is over 34 percent. Although this is higher than the England average for this group of 29.7 percent, the difference is not statistically significant.

Local data from Medway's Stop Smoking Service indicate that, although the numbers of people aged 60 years and above accessing the service are lower than for younger age groups, the highest success rate with respect to quitting smoking is seen amongst the over 60s.

Diet and physical activity

There is strong evidence that overweight and obesity are related to certain cancers. Survey data have shown that two thirds of adults in Medway are either overweight or obese. Although higher, this figure is not significantly different to the England average.¹⁵

Poor diet and lack of physical activity are risk factors for obesity. Studies have found that regular physical activity protects against the development of breast, colonic and endometrial cancer. Consumption of fruit and vegetables is associated with reductions in mortality from cardiovascular disease and cancer whilst over a fifth of bowel cancers in the UK are estimated to be associated with red and processed meat consumption.^{16,17}

Medway is worse than the national average for healthy eating, with a significantly lower proportion of adults eating five or more portions of fruit or vegetables per day than nationally.

Alcohol consumption

Consumption of alcohol has been shown to be associated with a number of cancers, including cancer of the mouth, throat, oesophagus, liver, breast and colon.¹⁸ Older people are likely to be more sensitive to the potential adverse effects on the body of regular, frequent drinking, even if only moderate amounts are consumed at any one time.¹⁹ The reasons for this include physiological changes in the body related to ageing and the potential interactions of alcohol with prescribed medications, which can cause adverse effects on the body.

There is evidence that older people in the UK today may consume alcohol more heavily than previous generations and that, although older people still drink little relative to younger adults, older drinkers consume alcohol more frequently than other age groups. Data from the 2011 General Lifestyle Survey (GLF), a national survey conducted by the

Office for National Statistics to collect data about households, families and people, show that those aged 65 years and above were more likely than any other age group to have drunk alcohol on every day of the week prior to the survey.²⁰ Data from the National Treatment Agency also show an upward trend in new cases of treatment for alcohol misuse among older people in England over the last decade.²¹

The Medway Alcohol Insights project was undertaken in 2014 with the aim of providing a greater understanding of attitudes towards alcohol and associated patterns of behaviour. A total of 1,067 people responded to an online survey, 103 of whom were aged 65 years and over (68 male, 35 female and 95 described their ethnicity as White British). The group of older people surveyed was typically characterised by regularly drinking a modest amount of wine at home and, to a lesser extent, in pubs and restaurants. Of the respondents, the older group tended to drink most frequently of all the age groups, with 48 percent drinking at least three or four times per week and 13 percent drinking every day. Despite this, the surveyed older people appear to have a high level of awareness of the dangers of drinking too much alcohol: this is reflected by the fact that 83 percent of this group believed that moderating alcohol consumption contributed to a healthy lifestyle and 76 percent reported conforming to this. This sample of Medway's older people appear to be fairly comfortable with their current level of drinking, with 76 percent of those surveyed not intending to change their drinking habits over the next six months.

Recommendations

- Interventions to prevent and limit the effects of chronic disease should continue to be prioritised.
- Older people should be actively encouraged and empowered to manage their long term conditions in order to reduce the risk of complications and poor outcomes.
- It is important to ensure that health improvement interventions and programmes give adequate consideration to the needs of the older population.

References

1. WRVS, 2011. Valuing the socio-economic contribution of older people in the UK.
2. Commission on the Future of Health and Social Care in England, 2014. A new settlement for health and social care.
3. Office for National Statistics. 2012 based Subnational Population Projections.
4. Institute of Public Care and Oxford Brookes University (2010). Projecting Older People Population Information System. Figures are taken from the General Household Survey 2007, Percentage of men and women living alone by age, Office for National Statistics. Available from: <http://www.poppi.org.uk>.
5. CIPFA nearest neighbour model, updated April 2009. Available from: <http://www.cipfastats.net/resources/nearestneighbours/profile.asp?view=select&dataset=england>.
6. Institute of Public Care and Oxford Brookes University (2010). Projecting Older People Population Information System. Figures are taken from Office for National Statistics 2011 Census, Communal establishment management and type by sex by age, reference DC4210EWL. Available from: <http://www.poppi.org.uk>.
7. Institute of Public Care and Oxford Brookes University (2010). Projecting Older People Population Information System. Figures are taken from the Census 2011 reference CT0224 - Sex by age by provision of unpaid care by general health. Available from: <http://www.poppi.org.uk>.
8. Department of Health, 2012. Long Term Conditions Compendium of Information: 3rd Ed.
9. Office for National Statistics. 2001 Census, Long term health problem or disability by health by sex by age.
10. POPPI. Figures are taken from Living in Britain Survey (2001), table 35. Available from: <http://www.poppi.org.uk>.
11. Department of Health, 2004. Improving chronic disease management.
12. Kings Fund. Long term conditions and multi morbidity. Available from: <http://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/long-term-conditions-multi-morbidity>.

13. Bajekal M, Scholes S, Love H, Hawkins N, O'Flaherty M, et al (2012) Analysing Recent Socioeconomic Trends in Coronary Heart Disease Mortality in England, 2000–2007: A Population Modelling Study. *PLoS Med* 9(6): e1001237. doi:10.1371/journal.pmed.1001237.
14. Mills E J, Rachlis B, Wu P, Devereaux P J, Arora P, Perri D (2008). Primary prevention of cardiovascular mortality and events with statin treatments: a network meta-analysis involving more than 65,000 patients. *Journal of the American College of Cardiology*, 52(22):1769-1781.
15. Sport England Local Sport Profile. Medway- Health Profile. Available from: <http://www.sportengland.org/our-work/local-work/local-government/local-sport-profile>.
16. Parkin DM, Boyd L (2011). Cancers attributable to dietary factors in the UK in 2010. *British Journal of Cancer* 105, S19–S23. doi:10.1038/bjc.2011.477 www.bjcancer.com Published online 6 December 2011.
17. Oyinlola, O. et al. Fruit and vegetable consumption and all-cause, cancer and CVD mortality: analysis of Health Survey for England data. *J Epidemiol Community Health* doi:10.1136/jech-2013-203500.
18. Baan R, Straif K, Grosse Y, Secretan B, El Ghissassi F, Bouvard V, Altieri A, Coglianò V (2007). Carcinogenicity of alcoholic beverages. *Lancet Oncol* 8: 292–293.
19. Institute of Alcohol Studies. IAS factsheet: Older people and alcohol. Updated May 2013. Available from: <http://www.ias.org.uk/uploads/pdf/Factsheets/Alcohol%20and%20older%20people%20FS%20May%202013.pdf>.
20. General Lifestyle Survey (GLF) 2011, Office for National Statistics. Also Office for National Statistics: Opinions and Lifestyle Survey 2012. "Drinking habits amongst adults", 2012. Published December 2013.
21. National Treatment Agency for Substance Misuse, Oct 2012. Alcohol statistics from the national drug treatment monitoring system, 1st April 2011- 31st March 2012.

2 Social Isolation

Social Isolation

Estimates suggest that around one in 10 older people experience chronic loneliness, with people living in deprived areas experiencing much higher rates. Maintaining strong social networks and being part of a community has far reaching benefits for physical and mental health and wellbeing in later life.



2 Social Isolation

Social isolation occurs when a person has little or no social interaction with other people and society. It differs from loneliness which is concerned with negative feelings that an individual may have due to a lack or loss of meaningful social relationships.

Social isolation can affect anyone, although certain groups in the population are at increased risk. This chapter focuses on social isolation in the older population.

The impact of social isolation

Social isolation can have a considerable negative impact on health and well-being. It is associated with a range of negative health outcomes including increased risk of dementia, high blood pressure, stress levels, poorer immunity and death.¹

Research has shown that people with strong social relationships have a 50 percent increased likelihood of survival than those with weaker social relationships. This difference in survival is comparable with well-established risk factors for mortality such as smoking, obesity and physical inactivity.¹

Who is at risk?

Older people are significantly more likely to suffer from social isolation with contributing factors being loss of friends and family, loss of mobility, deterioration in physical health or loss of income, but other population groups are also at risk including carers, refugees and those with mental health problems.²

It is estimated that, across the UK population aged 65 and over, 12 percent feel socially isolated.³ If this approximation was applied to Medway this would result in an estimate of 4,698 people over 65 years old being socially isolated.

There are limited data available that robustly measure social isolation in older people. Figure 1 shows the proportion of Medway households in which a single person aged 65 years and older is living alone.

The data show that wards that have the highest proportions of people over 65 years old living alone include parts of Peninsula, Strood Rural, Strood South, Rainham North, Rochester West and Twydall wards.

A limitation of using single older-person households as a proxy for social isolation is that it does not take account of people's individual circumstances in terms of health, mood, mobility and engagement with social networks. For example, an older person may live alone but may have a thriving social network of family, friends and relatives. To address this, a composite index from consumer data has been developed using a range of factors which can lead to social isolation. The factors include:

- being widowed;
- having a perception that little can be done to change life;
- rarely/never meeting friends or relatives (who are not living with individual);

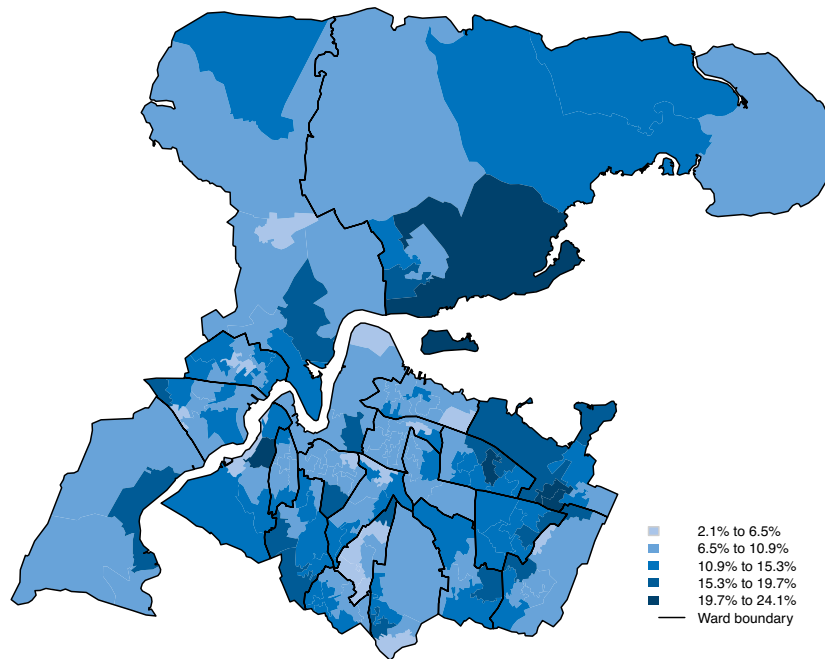
- never talking to neighbours or talking to neighbours less than once a month;
- being visually impaired;
- being hard of hearing;
- having anxiety or depression;
- a one person household: aged 65 and over;
- being a lone parent with dependent/non-dependent children;
- people in the household not having English as the main language;
- a household without private transport;
- being an unpaid carer within the household.

Figure 2 shows the estimated proportion of households in Medway who are likely to be socially isolated according to this composite index. Areas estimated to have the highest proportion of households that contain socially isolated people aged 65 years or above include parts of Chatham Central, Peninsula, Princes Park, Rainham South, River, Rochester East, Rochester South and Horsted, Rochester West, Strood Rural, Strood South, Twydall and Walderslade.

There are some similarities between the areas highlighted in figures 1 and 2, but there are also differences. For example, there are similarities in the relatively high proportion of people over 65 years old living alone and overall estimated isolation in parts of Cuxton and Halling, Rainham North and Peninsula wards. Other parts of Rainham North show that there is a difference though, with a relatively high proportion of people over 65 years old living alone with low estimates of social isolation. Parts of River and Chatham Central wards also have considerable differences, with low levels of people over 65 years old living alone and relatively high estimates of isolation.

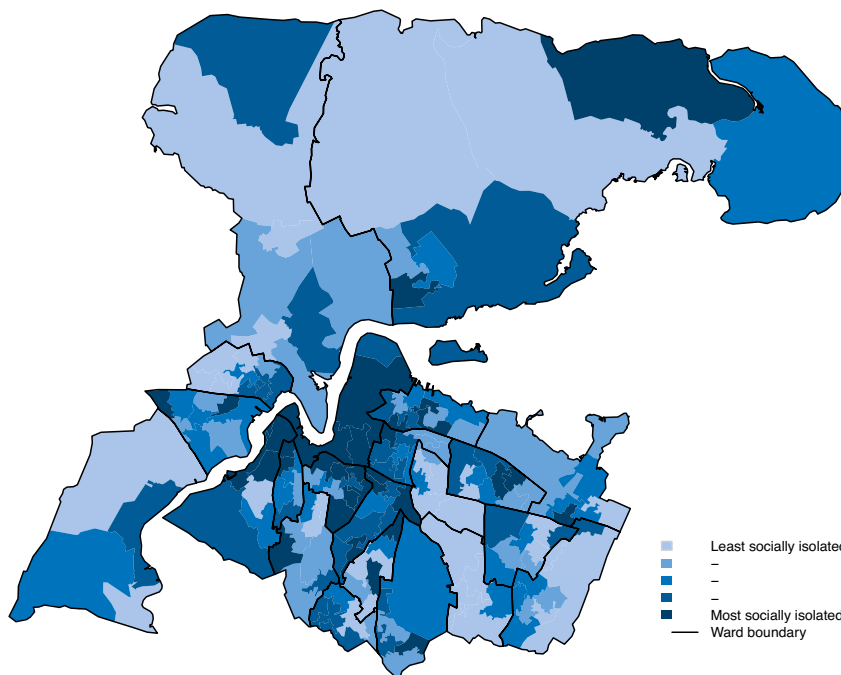
Possible reasons for the difference may be due to the social infrastructure in that area. Parts of River and Chatham central wards have relatively high levels of deprivation and a high proportion of privately rented housing, and consequently may result in a greater likelihood of population churn that involves people moving in and out of households at a relatively higher rate than usual. This impacts on the social infrastructure and may make it more difficult to make long-term social connections and increase the risk of social isolation.

Figure 1: Proportion of households in which a single person aged 65 years and over is living alone



Source: Table QS113EW, Census 2011, ONS. Please refer to map of electoral wards on inside front cover.

Figure 2: Relative social isolation per household of persons aged 65 years and over



Source: Medway Public Health Intelligence team. Analysis based on MOSAIC Public Sector social segmentation, Experian Ltd. Please refer to map of electoral wards in Medway on inside front cover.

What works?

Reducing social isolation can decrease the demand for health and social care services and there are a number of interventions that can have a positive impact on reducing social isolation. The quality of the relationships in the interventions is a vital component.

Interventions that tackle social isolation can be split into three broad groups: one to one interventions, group interventions and wider community engagement. These are described in tables 1a, b and c.

Table 1a: One-to-one interventions to address social isolation

ONE TO ONE			
Type of intervention	Description	Positives	Potential issues
Befriending	Introduces the client to one or more individuals, whose main aim is to provide the client with additional social support	<p>Compared with usual care or no treatment, befriending appears to have a modest but significant effect on depressive symptoms in the short and long term</p> <p>Can be relatively inexpensive</p> <p>May also involve provision of transport and the completion of small errands</p>	<p>Often involves volunteers who can be difficult to recruit</p> <p>The intervention may only be short-term and individual may become isolated when befriending concludes</p>
Mentoring	A relationship between someone offering support (often a volunteer) and the individual, based on meeting an agreed objective (e.g. to stop smoking)	Individuals have reported an improvement in self esteem, increased social interaction and engagement in other community activities	<p>If a social relationship is achieved, this is usually incidental to the original goal and hence can be withdrawn once the goal has been achieved</p> <p>Evidence presents a mixed picture in terms of impact on loneliness and social isolation</p> <p>There is often a shortage of skilled mentors</p>
Community 'Navigators' or 'Connectors'	Usually volunteers from within the local community who can provide links to 'hard-to-reach' or vulnerable people	<p>Can act as an interface between the community and public services, helping individuals to find appropriate interventions</p> <p>Can offer practical options for re-engaging with local neighbourhood</p> <p>Some evidence to suggest that people became less lonely and socially isolated following such contact</p> <p>Can help to build overall well-being and resilience within the wider community</p>	<p>Identification of 'connectors'</p> <p>A lack of appropriate support options may lead to an unfair amount of responsibility resting with the connector</p>

Table 1b: Group interventions to address social isolation

GROUP			
Type of intervention	Description	Positives	Potential issues
Day centre-type services e.g. lunch clubs	Day support, activity and personal care for a wide range of vulnerable people according to individual need	Can prevent social isolation and the feeling of loneliness	Cannot be relied upon for longer-term solutions unless self-sustainable for funding
Social group schemes e.g. self-help groups and special interest groups	Groups set up to meet the needs of the population to whom the intervention is addressed	Some evidence that these can lead to reductions in loneliness and re-engagement with the wider community Like-minded individuals with common aims/goals Can be highly structured to achieve specific aims or more 'organic', developing activities dependent on the interests of the group members	Restricted to those pursuing a particular line of support or interest Evidence presents a mixed picture in terms of impact on loneliness and social isolation Some evidence to suggest lower usage of health services after intervention

Table 1c: Wider community engagement activities to address social isolation

WIDER COMMUNITY ENGAGEMENT			
Type of intervention	Description	Positives	Potential issues
Community activities e.g. libraries, museums	Programmes that support individuals to increase their participation in existing activities	Some evidence that well-managed schemes can 'reverse the deteriorating effects of social isolation and loneliness'	Often involves volunteers which can be difficult to recruit Generally short-term
Volunteering schemes	Programmes that support individuals to give their time, skills, and resources to help other individuals/causes	Volunteers themselves can increase their health and wellbeing	
Neighbourhood 'committees'	Groups that encourage members of the community to work jointly with leaders of local services to develop the local community	Can increase individuals' self-esteem, feelings of worth and social networks Can help to identify other vulnerable community members and reach out to them	Meetings often held during 'unsociable' hours Require individuals to make the first contact/approach

Source: Adapted from SCIE Research Briefing 39: preventing loneliness and social isolation: interventions and outcomes (2011)

Cost effectiveness of tackling social isolation

There is limited evidence on the cost-effectiveness of interventions to reduce social isolation.

One economic analysis has demonstrated a positive cost impact of befriending interventions.⁴ It found that a typical service for befriending would cost around £80 per older person within the first year and provides about £35 in 'savings' due to the reduced future need for treatment and support for mental health needs. One study has found that supportive closed groups can be cost-effective and found that there was a saving of €62 per person due to a reduction of hospital bed days, physician visits and outpatient appointments.⁵

Examples of projects that are tackling social isolation in Medway

Medway men's health group

This weekly group, based at the Sunlight Centre, Gillingham, was established in November 2013 and is supported and facilitated by Rethink, a national charity which provides expert advice and information to everyone affected by mental health problems. The group's focus is to reduce social isolation in men and provide an environment in which they can discuss their problems and receive peer support and health promotion information. There are opportunities for the men to have one-to-one sessions with Rethink Community Development Workers to discuss specific issues. Members of Medway Council's Health Improvement Team have frequently provided support to improve lifestyles (e.g. stop smoking, more exercise, healthy walks etc).

Evaluation of the group has shown that attendance is good: over 20 men usually attend. Men reported feeling that they were in a comfortable environment with a warm approach. The attendees also reported that they felt the group to be crucial in reducing isolation. Specific comments by group

attendees included:

- "we don't have politics, racism or religion in our group: the only religion is hope";
- "Medway Men's Health Project broke my depression".

Flexicare housing

This programme aims to accommodate a growing population of older people through an innovative and flexible approach to maintaining independent living. The emphasis is on a shift away from residential care towards alternatives which enable older people to live as independently as possible.

Medway's Flexi-care Housing Scheme is a model of supported accommodation available to older people aged 55 and over including those with sensory needs, mental disorders including dementia, short- or long-term illnesses, and those who require end of life care. The scheme is designed to offer a safe, private and secure environment as an alternative to residential care, ensuring people are able to retain the independence of having their own home whilst 24 hour care and support staff are available on-site. Independent living skills are preserved or rebuilt through support, making independent living possible for people with a range of abilities.

Bellerophon House in Rochester is an example of a purpose-built scheme promoting independent living with care packages tailored to individual needs. Bellerophon house has 41 self-contained one and two bedroom flats with a community alarm which is enabled with telecare and telehealth. The scheme also benefits from a restaurant, hairdresser, communal lounge/hobby room, gardens and good public transport links. Care is available 24 hours a day and seven days a week.

Hands & Gillingham Volunteer Centre – community friendship scheme

The Hands & Gillingham Volunteer Centre offer a befriending scheme to provide support and information to the community and to develop the involvement of other voluntary and statutory organisations. It is offered primarily to elderly or disabled people who are at risk of becoming isolated due to difficulty leaving the house.

Suitable befrienders are matched to clients and visit them at home. During the visit they can discuss everyday issues, enjoy a game of cards or encourage the client to contact old friends again. Befrienders are also able to take clients out to local amenities, such as the park or shops, providing the opportunity to meet others. Regular contact between the client and befriender can establish a strong bond and encourage participation in community activities to encourage independence.

Energise Dance Nourish Art (EDNA)

EDNA was a pilot project designed to explore the health and well-being benefits of dance and arts activities for older people in Medway and Gravesham. Two groups of people aged over 50 years took part in a 12 week programme between August and November 2013 led by two facilitators (professional artist and dancer). The dance and arts sessions were delivered in outreach community settings in areas where there was little uptake of arts activities. Outcomes from the project showed significant improvements in balance, posture and shoulder mobility over the course of the study. Self-reported health-related quality of life for the participants also improved, with notable improvements to psychological wellbeing. Participant feedback was positive, with reported physical, psychological and social benefits.

Case Study: Medway Men's Health Project

Mr Z, a 62-year-old African-Caribbean male who has lived in the UK for 22 years (seven years in Medway), has a diagnosis of schizophrenia. He lost both parents several years ago and was unemployed. The combination of family bereavement, socio-economic pressures and a lack of support available to him triggered severe depression and anxiety, resulting in the need for hospital admission.

In Mr Z's words:

“When I first came to the group, I was somewhat low. I was not too friendly or wanting to open up to others, I had much more negative feelings overlapping through life. I am now a lot stronger and resilient. I got encouragement from Steve (co-ordinator of the group) and this has lifted me. I sometimes feel slightly ill, sometimes depressed but it doesn't

last long. Talking to Steve and the group gives me strength and energy, it helps break isolation. I don't go out partying and I like the group because the group gives me strength. I like what goes on, Tai Chi, confidence building, stress reduction, music, cards and healthy eating. It is a very positive group. The group makes me feel useful, positive and helps me to do more positive things in my life. I now do charity work with the food bank and the homeless. I also have an allotment and that helps with my wellbeing.”

When asked about how he sees his future, Mr Z states;

“I want to be a counsellor, help people. Help young people 18–30 and want to help all races. I'm happier now. I feel uplifted because of being part of this group.”

Recommendations

- Individuals within local communities should be encouraged to take responsibility for identifying, 'reaching out' and supporting potentially isolated people within their own area. In order to achieve this, statutory, voluntary and community organisations need to work in partnership to build greater community capacity and better social outcomes for at risk populations.
- Interventions that have an evidence base of being effective to reduce social isolation, such as befriending programmes, should be commissioned on a greater scale to increase the current levels of provision.
- Frontline health and social care staff should receive training and information in order to increase their awareness of the risks of social isolation and enable them to connect people to activities or organisations that can help. This approach could be built in to care pathways for a range of different conditions.
- There should be an emphasis to support people to engage with the wide range of opportunities (e.g. leisure facilities, drama groups) in Medway which would address social isolation. A greater understanding of people's behaviour in terms of what would make them utilise facilities is needed. This could be undertaken via action research.
- Public awareness should be raised around potential opportunities in Medway to help reduce social isolation. The role of a community navigator or connector could be considered for this function.

References

1. Holt-Lunstead, J. et al. (2010) 'Social relationships and mortality risk: a meta-analytic review', *PLoS Medicine*, vol 7, no 7, doi:10.1371/journal.pmed. 1000316.
2. Social Care Institute for Excellence, 2011 Research Briefing 39. Preventing Loneliness and Social Isolation: Interventions and Outcomes. <http://www.scie.org.uk/publications/briefings/files/briefing39.pdf> (Accessed 07/07/2014).
3. Greaves, C.J. and Farbus, L. (2006) 'Effects of creative and social activity on the health and well-being of socially isolated older people: outcomes from a multi-method observational study', *The Journal of the Royal Society for the Promotion of Health*, vol 126, no 3, pp 133–142.
4. Knapp, M. et al. (2010) Building community capacity: making an economic case, PSSRU Discussion Paper 2772, London: PSSRU.
5. Pitkala, K.H. et al. (2009) 'Effects of psychosocial group rehabilitation on health, use of health care services, and mortality of older persons suffering from loneliness: a randomised, controlled trial', *Journal of Gerontology: Medical Sciences*, vol 64A, no 7, pp 792–800.

3 Falls

Falls

Each year one in three people over 65 and almost one in two people over 85 experience one or more falls, many of which are preventable. Falls can have serious implications for the health, wellbeing and independence of older people and the related costs to health and social care are substantial.



3 Falls

A fall is defined as 'an event whereby an individual comes to rest on the ground or another lower level with or without the loss of consciousness'.

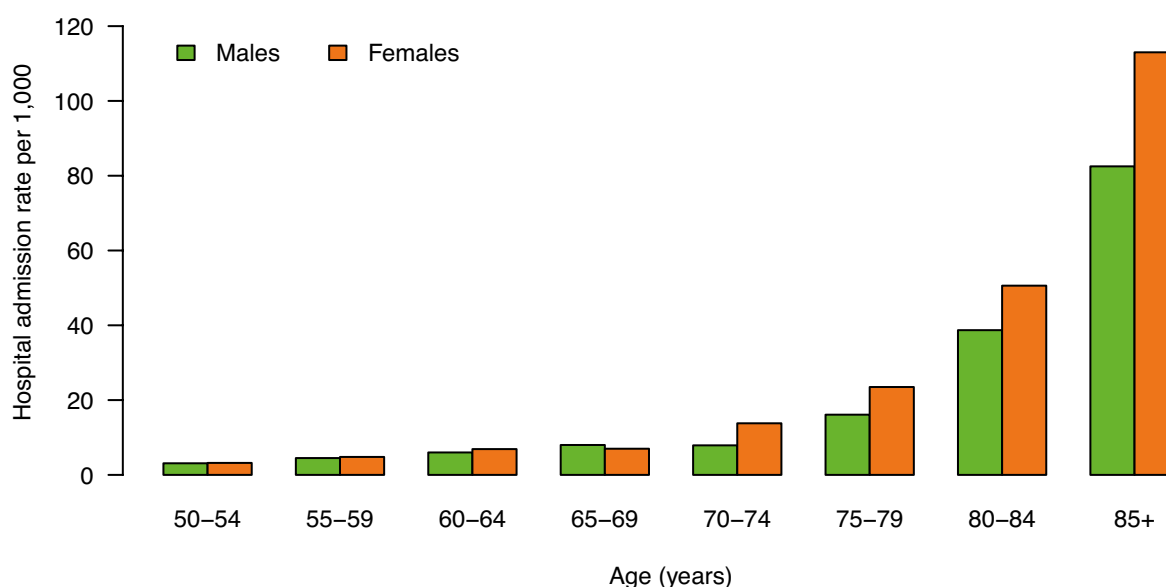
(American Geriatric Society, 2001).

The impact of falls

Falls are an increasingly significant public health issue nationally due to the increasing number of elderly people in the UK population. Obtaining accurate data on falls is problematic, as most falls are not reported and do not lead to hospital attendance. Even for those falls which do result in a hospital attendance, the coding of falls in hospital data can be imprecise. These factors lead to difficulties in estimating the exact incidence of falls in the population. We do know that older people have the highest incidence of falls and the greatest susceptibility to injury.

The incidence rises sharply after the age of 65 years: nationally one in three people aged over 65 fall at least once a year.¹ This increases to about 50 percent in the over-75s as they become frailer and develop comorbidities.² Figure 1 illustrates this finding for Medway: a particularly rapid acceleration in the hospital admissions rate for falls in 2012 occurred from age 70–74 years onwards, with the rate for females aged over 85 years reaching almost 12 percent.

Figure 1: Falls-related hospital admission rate (all falls) for Medway residents by age and gender, 2012



Source: Secondary Uses Service via KMHIS data warehouse and ONS

The consequences of falls are wide ranging, from physical injury, such as fractures, to psychological harm such as loss of confidence and the ability to live independently. Falls are the commonest cause of death from injury in the over-65s and many falls result in fractures and/or head injuries. Even 'minor' falls can be very debilitating: individuals can lose confidence and become nervous about falling again, which means that they may become unwilling to move about, leading to dependence and social isolation.

Older people who fall are also likely to fall again, with a large proportion of recurrent fallers subsequently needing long-term care at home or in a residential facility. One of the most serious consequences of a fall is hip fracture and half of people suffering a hip fracture will never return to their previous level of independence.³

Data from Medway NHS Foundation Trust show that of the total number of Accident & Emergency (A&E) attendances for falls in people aged 65 and over registered with a General Practice in Medway in 2013/14, 37 percent resulted in hospital admission. Whilst attendances to the A&E Department at Medway NHS Foundation Trust for falls in older people have risen steadily over the last four years, falls-related hospital admissions in older people have declined over the same time period. A contributory factor to the fall in admissions may be the establishment of a multi-disciplinary approach to falls management in Medway with the aim of preventing hospital admissions and linking secondary care services with community falls services, in order that patients who have suffered falls can be managed effectively in the community.

The predicted growth in the older population over the next few decades has, without doubt, cost implications on social care and independent living.

The UK spends at least £1.7 billion annually on treatment related to falls.⁴ In 2001 the combined NHS and social care costs for a single hip fracture in the UK were estimated to be £20,000 with an estimated total of more than £1.73 billion per year for all UK hip fractures.

Medway's population aged over 65 years is expected to increase substantially over the next two decades (see "Overview of Medway's older population on page 4). Developing effective interventions to prevent falls becomes increasingly important to ensure that our older population remains independent and well for as long as possible and to reduce the impact on our health and social services.

Who is at risk?

Identifying risk factors is crucial in preventing falls in the elderly population. The main risk factors for falls become more common with age. These are shown in table 1.

Table 1: Contributing factors to falls in the elderly

Risk category	Examples
Risks relating to the surrounding environment	Poor lighting, especially on stairs Steep stairs Loose carpet Wet, slippery or uneven floors Obstacles/ clutter Unsafe or absent equipment, such as handrails
Risks relating to the individual	Previous falls Changes in the body caused by ageing Certain medical conditions (e.g. diabetes, depression, stroke) Being less physically active Side-effects of or combinations of several medications, e.g., sedatives and hypnotics

Risks relating to the individual can result in changes in an individual which may limit mobility and further increase the risk of falls. Previous falls, for example, can lead to a fear of falling and loss of confidence. The process of ageing can lead to muscle weakness, slowed reactions and difficulty moving around, all of which may be compounded by the presence of certain medical conditions such as stroke and arthritis.

Many of these risk factors become more common with age. Multiple factors, many of which are modifiable, can combine to cause falls. Identifying and modifying risk factors is therefore vital to falls prevention.

59 percent of falls amongst Medway residents aged 65 years and above which required hospital admission in 2013/14 occurred at home. 13 percent occurred within a residential institution,

Table 2: Place of occurrence of falls resulting in a hospital admission, Medway population aged 65 years and above, 2009/10–2013/14

Place of occurrence	2009/10	2010/11	2011/12	2012/13	2013/14
Home	491	542	606	533	548
Residential institution	154	151	124	107	119
School, other institution and public administrative area	25	25	39	40	43
Street and highway	74	43	54	53	32
Trade and service area	15	28	24	19	19
Industrial and construction area	1	0	0	0	1
Sports and athletics area	2	2	2	1	1
Other specified places	21	25	9	6	28
Unspecified place	456	461	463	168	137
Total	1239	1277	1321	927	928

Source: Secondary Uses Service. NB: Place of occurrence derived from fourth character of falls ICD-10 code (W00-W19).

making this an important setting for falls prevention work. Table 2 gives a breakdown of place of occurrence of falls over the last five years in Medway.

It may be that some groups of older people in our population are affected by falls more than others. Nationally, there is evidence that the hospital admission rate for falls in older people is higher amongst older people from more deprived backgrounds.⁵

This could be because some of the risk factors for falls, such as poor housing and certain long term medical conditions, are more prevalent amongst people in more deprived areas. It is possible that a fall that occurs in an individual with multiple co-morbidities or a poor living environment/social support network is more likely to lead to admission to hospital.

Improved collection of information about whether some communities are affected by falls and the consequences of falls more than others would be valuable in helping to prevent falls in the population.

What works?

The National Institute for Health and Care Excellence (NICE) provided updated guidance, based on the best available evidence, on the prevention of falls in older people in June 2013.⁶ The key recommendations from NICE are outlined in table 3 and are based on the following principles:

1. Case/risk identification
2. Multifactorial falls risk assessment
3. Multifactorial interventions

What are we doing in Medway?

We are very concerned in Medway about the number of falls suffered by our residents and the impact that falls may have on their lives.

Reducing falls and falls-related harm is a priority within Medway's Joint Health and Wellbeing Strategy and Medway Clinical Commissioning Group's Commissioning Plan, thus ensuring that all key partners from a wide range of agencies across Medway will work effectively together on the falls agenda. Our strategic objectives focus on preventing falls in those who may be vulnerable, but have not yet had a fall; on reducing the risk of further falls in those who have fallen already; and on supporting our older population to live as independently and well as possible.

Examples of work underway in Medway across the latest recommendations from NICE are shown in table 3.

Table 3: Compliance with NICE guidance: examples of current falls services in Medway

Recommendation 1: Case/risk identification	
<ul style="list-style-type: none"> Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the falls. 	<ul style="list-style-type: none"> Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.
Fast Access Falls Clinic (Medway NHS Foundation Trust)	
<p>The clinic aims to achieve significant improvements in acute care of falls patients, to provide rapid access for complex patients to be reviewed and to prevent avoidable emergency re-admissions to hospital. Key elements of the service include:</p> <ul style="list-style-type: none"> The use of a risk assessment tool in A&E to identify fallers A triage process in place in A&E to refer patients to the most appropriate service – their GP, the Community Falls Service (Medway Community Healthcare) or the Fast Access Falls Clinic (Medway Foundation Trust) 	<ul style="list-style-type: none"> For patients referred to the Fast Access Falls Clinic, a comprehensive medical review is undertaken on appropriate patients to reduce the risk of recurrent falling and prevent further A&E attendance and emergency admissions. Once seen within the fast track clinic, a patient may be referred by the Consultant Geriatrician to Medway’s Community Falls Service if required.
Recommendation 2: Multifactorial falls risk assessment	
<ul style="list-style-type: none"> Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial 	<p>falls risk assessment. This risk assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service.</p>
Fast Access Falls Clinic (Medway NHS Foundation Trust)	
(See above)	
Medway Community Falls Service (Medway Community Healthcare)	
<p>The Community Falls Service is provided by a multi-professional team that can take referrals from any health professional as well as self-referrals. The aim of the service is to provide a comprehensive assessment and treatment to those who fall or who are at high risk of falling in order to prevent falls and falls-related injury; and to help those who have fallen to regain independence and confidence.</p>	<p>Each patient is triaged and assessed according to clinical need and a personalised treatment plan is agreed with the patient. Patients can be seen in either their own home or in a clinical setting according to their individual circumstances. Complex cases are referred to a Consultant Geriatrician with a special interest in falls.</p>

Recommendation 3: Multifactorial interventions

- All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention;
- NICE recommends that the following components of multifactorial interventions are effective:
 - strength and balance training;
 - home hazard and safety intervention;
 - vision assessment and referral;
 - medication review with modification/withdrawal.
- Following treatment for a fall-related injury, older people should be offered a multidisciplinary assessment to identify and address future risk and individualised intervention aimed at promoting independence and improving physical and psychological function.

Fracture Liaison Service (Medway NHS Foundation Trust)

The Fracture Liaison Service is led by a dedicated Nurse Specialist, working under the guidance of a Specialist Consultant. The service aims to identify all patients over the age of 50 years presenting with a new fragility fracture and to offer the opportunity to

have Bone Density Measurement (DXA) if considered at risk and a bone health assessment. An individual management plan is then produced for implementation in primary care.

Medway Community Falls Service

(See above)

Medway Rapid Response Team

Jointly funded by Medway Community Healthcare and Medway Council, the Rapid Response Team consists of two teams, the Admission Avoidance (hospital-based) team and the community-based team. As part of their wider role, the teams assist patients who have fallen or

are at risk of falls and help to assemble an individualised care package that may involve integrated working with other health and social care professionals or provision of nursing care and rehabilitation/equipment from occupational therapists and physiotherapists.

Exercise Referral Programmes

There are a number of exercise programmes in Medway which promote strength and balance in those at risk of falls or those who have already fallen. These include

the Exercise Referral Scheme (Medway Council Public Health Directorate) and Medway Community Falls Service's tailored exercise programme.

Falls prevention and management training for care homes

This current pilot project is a collaboration between Public Health and the Medway College of Social Care. The project aims for a consistent approach

across Medway care homes to falls prevention and management, leading to a reduction in falls and falls related injury in care home settings.

What more can we do?

Older people who have fallen may need support from more than one organisation or service. There are considerable opportunities for agencies to work in partnership to reduce the risk of falls and minimise falls related harm for our older people, and whilst good progress is being made, we now need to ensure that all stakeholders and agencies who could be involved in falls prevention

or management for older people (including the statutory, community and voluntary sector and, most importantly, individuals and their families) are fully engaged and involved in driving progress. The prioritisation of falls within the strategic objectives of Medway's key health and social care organisations is an important step towards ensuring that this happens.

Case Study: An 80 year old lady with falls and wrist fracture

Mrs Y is an 80-year-old lady who was assessed in Medway NHS Foundation Trust's falls and syncope clinic in March 2013. This appointment had resulted from Mrs Y's attendance to Medway's A&E Department in February 2013 on two occasions.

On the first occasion, Mrs Y had been in the kitchen at the time and could not remember how she had fallen. According to her family, she had not lost consciousness on this occasion. This initial fall resulted in a fracture of Mrs Y's wrist, which was treated in fracture clinic with a plaster cast.

A day after the first event, Mrs Y was brought back to A&E having suddenly passed out in the armchair at home for a brief period of time. A structured falls assessment tool was used in A&E to assess her and she was referred to the falls and syncope clinic, where she was seen by the lead Consultant Geriatrician for falls.

Risk factors identified in the clinic for predicting future falls and fractures included low blood pressure and unsteadiness when standing or walking. A detailed review of Mrs Y's regular medication identified responsible medications for her low blood pressure (Furosemide and Ramipril) and these were subsequently stopped. Mrs Y's mobility had declined in the last few

months and she had become more unsteady. She did have a walking stick but because of the wrist fracture she was finding it difficult to hold on to it. Mrs Y was referred to the community falls team who taught her exercises to improve her balance, gait and muscle strength.

This resulted in a much steadier gait and she gained confidence. Follow up in fracture clinic in late March of 2013 revealed that the wrist fracture had healed nicely.

Mrs Y was also assessed by Medway NHS Foundation Trust's Fracture Liaison Service, through which an osteoporosis screen with DEXA scan (to assess bone density and risk of fractures) was arranged for her. This scan confirmed that Mrs Y had osteoporosis. She received an appointment in the consultant-led metabolic bone clinic in May 2013. The lead consultant detected both osteoporosis and vitamin D deficiency and commenced appropriate treatment for conditions in order to minimise her future risk of fractures.

To date Mrs Y has not had any further falls or fractures and remains well and independent in her own home. This case illustrates how joined up multidisciplinary and multiagency assessment and management of falls and fractures can effectively identify and treat important risk factors.

Recommendations

- A strong evidence base on prevention and the projected increases in the burden of falls and falls-related injury mean that falls and falls prevention should be an ongoing priority issue for commissioners and providers.
- A Medway falls strategy should be developed and implemented as a framework for consideration of the whole falls care pathway by commissioners.
- Effective falls prevention schemes can be implemented at little cost with the involvement of professionals working in health, social care and in the community. The majority of falls in Medway occur in the home or in residential care settings, highlighting the need to examine the existing provision of home safety information in the community and the need for a better understanding of falls prevention activities within care settings. All care homes should have falls prevention strategies in place, the objectives of which should include more robust recording and reporting of data on falls.
- Falls prevention should also consider the wider environment, for example, through partnership working with town planners to ensure that the risk of falls to older people is taken into account and through systematic approaches to the reduction of environmental hazards in the home.

References

1. Todd C, Skelton D (2004). What are the main risk factors for falls among older people and what are the most effective interventions to prevent these falls? Copenhagen, WHO Regional Office for Europe.
2. Rubenstein LZ (2006). Falls in older people: epidemiology, risk factors and strategies for prevention. *Age Ageing*; 35 Suppl 2: ii37-ii41.
3. National Institute for Health and Care Excellence, 2012. Commissioning Guide 46: Management of hip fracture in adults.
4. McKay C, Anderson KE (2010). How to manage falls in community dwelling older adults: a review of the evidence. *Postgrad Med J*; 86: 299-306.
5. West J, Hippisley-Cox J et al (2004). Do rates of hospital admission for falls and hip fractures in elderly people vary by socio-economic status? *Public Health* 118, 576–581.
6. National Institute for Health and Care Excellence, 2013. Clinical Guidance 161. Falls: assessment and prevention of falls in older people.

4 Dementia

Dementia

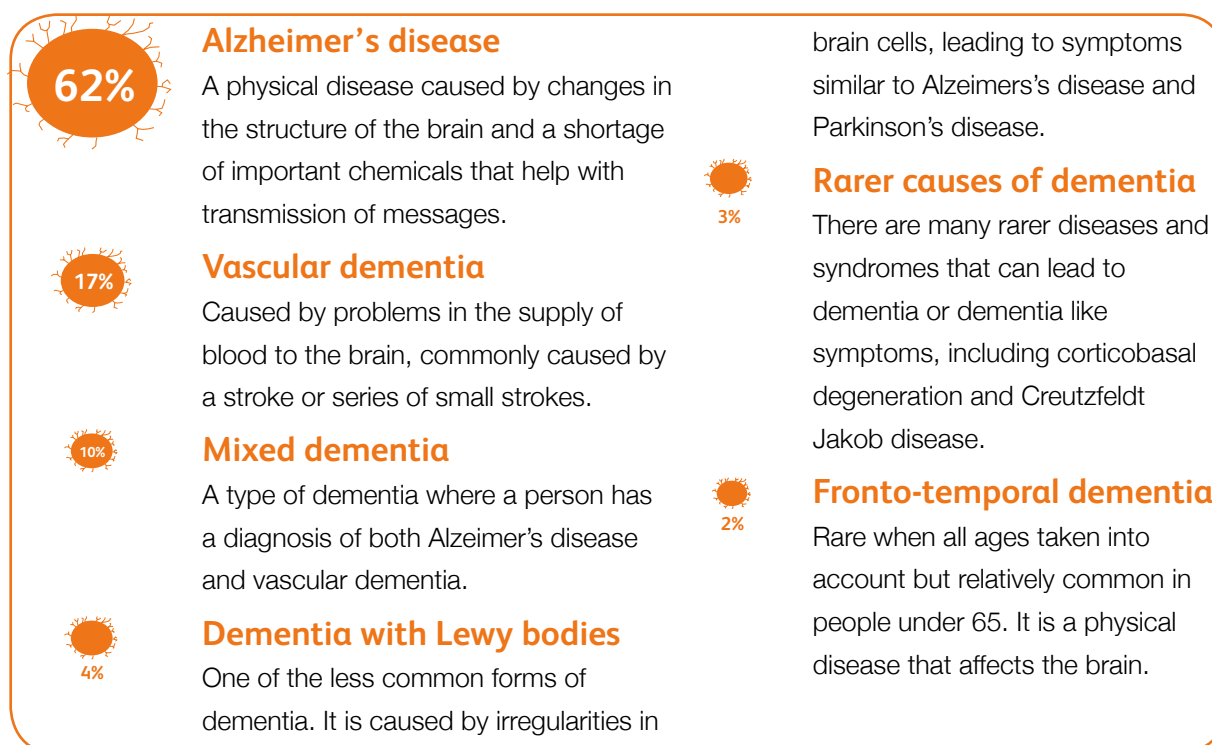
Dementia is an increasingly important public health problem. The main risk factor for the development of dementia is age and it is becoming the main cause of disability in older people. Dementia has significant impact on family, carers, society, health and social services.



4 Dementia

Dementia is not a disease but a collection of symptoms resulting from damage to the brain caused by a number of diseases or conditions that affect memory, thinking, reasoning, communication skills, behaviour and ability to perform everyday activities. The main types of dementia are illustrated in figure 1.

Figure 1: Causes of dementia



Source: Alzheimer's Society, 2013. *Dementia 2013 Infographic*

Common symptoms:

- memory loss, especially for recent events;
- increasing difficulties in planning or organising tasks and activities;
- confusion in unfamiliar environments;
- communication problems, for example, difficulty finding the right words;
- difficulty with numbers, for example, when handling money in shops;
- personality/ mood changes, for example, depression.

The impact of dementia

Dementia can have a considerable impact on those affected and their carers: with the growing number of sufferers and increasing related costs, dementia presents a significant public health problem. Dementia is estimated to cost the UK economy £23 billion per year:¹ this is more than cancer and heart disease combined. The average care costs for each individual with dementia are £29,746 per year which results in an estimate of £39,621,672 per year for the Medway population who are known to have received a diagnosis.

In March 2012 the Prime Minister raised the profile of dementia by setting the Dementia Challenge:

to deliver major improvements in dementia care and research by 2015. Within the Challenge a commitment to the development of dementia friendly communities across the UK was made. A national Dementia Action Alliance was created in 2012 with the subsequent establishment of a number of regional alliances which consist of organisations and individuals committed to making a positive difference to the quality of life for people with dementia and their carers. Local Dementia Action Alliances can undertake a range of actions to improve the lives of people with dementia and carers. Such actions may include:

- dementia awareness training for staff;
- building dementia training into customer service or induction training;
- appointing a dementia ambassador for local organisations.

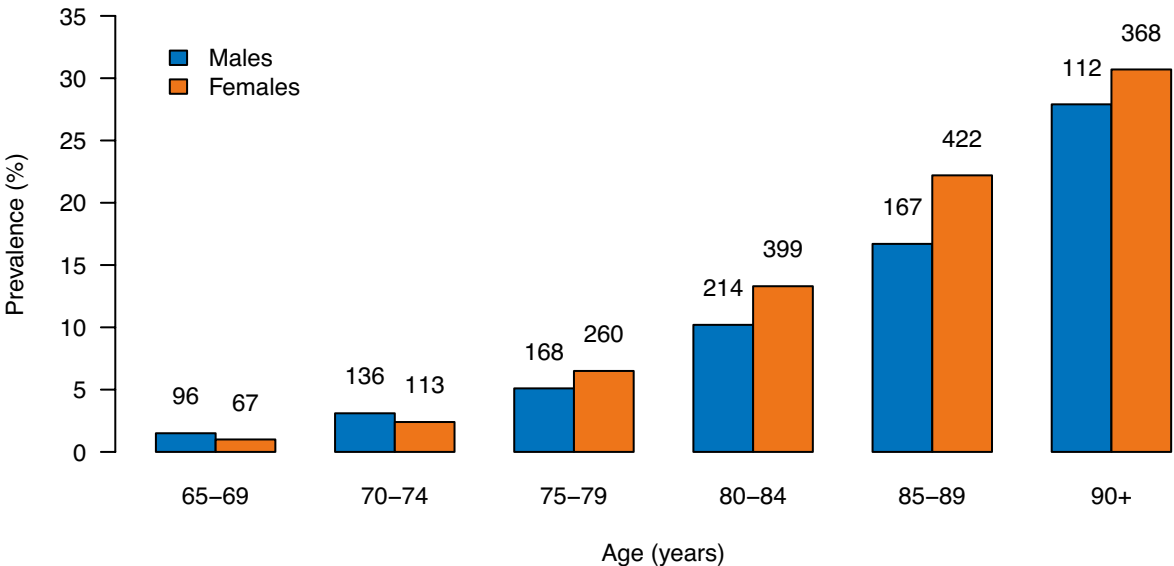
Who is at risk?

In Medway in 2012 there were an estimated 2,587 people living with dementia, 2,523 of whom were over 65 years old. The expected

number of people with dementia for Medway Clinical Commissioning Group’s (CCG) registered population is estimated to be 2,783. According to the Quality and Outcomes Framework for 2012/13, only 1,332 patients in Medway were recorded in primary care as having dementia. The diagnosis rate of dementia for the Medway CCG population is 48 percent which is higher than the Kent and Medway average of 43 percent and the South of England average of 46 percent. This under-diagnosis may be in part explained by the fact that over half of individuals with dementia have mild symptoms which may mean that dementia is undiagnosed until the symptoms worsen.

Multiple factors, including age, genetics, medical history and lifestyle can combine to lead to the onset of dementia but the main risk factor is ageing: over 95 percent of people with dementia are over 65 years old. Figure 2 shows the profile for age and gender for the estimated prevalence of dementia for Medway. There is a notable increase in the estimated prevalence with age. Figure 2 also shows that for all age groups over 75 years old, the prevalence of dementia is considerably higher for women compared to men.

Figure 2: Estimated prevalence of Dementia in Medway in people aged 65 years and over, 2012



Notes: Age-sex prevalence estimates have been taken from Dementia UK 2007 report produced for the Alzheimer’s society by King’s College London and the London School of Economics.¹ The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia in 2012. These numbers are shown above the bars.

Table 1: Dementia severity in Medway by age group in those aged 65 years and above, 2012

Age (years)	Mild		Moderate		Severe	
	Number	Percentage	Number	Percentage	Number	Percentage
65-69	101	62	52	32	10	6
70-74	157	63	75	30	17	7
75-79	244	57	133	31	51	12
80-84	349	57	196	32	67	11
85-89	318	54	194	33	77	13
90+	226	47	158	33	91	19

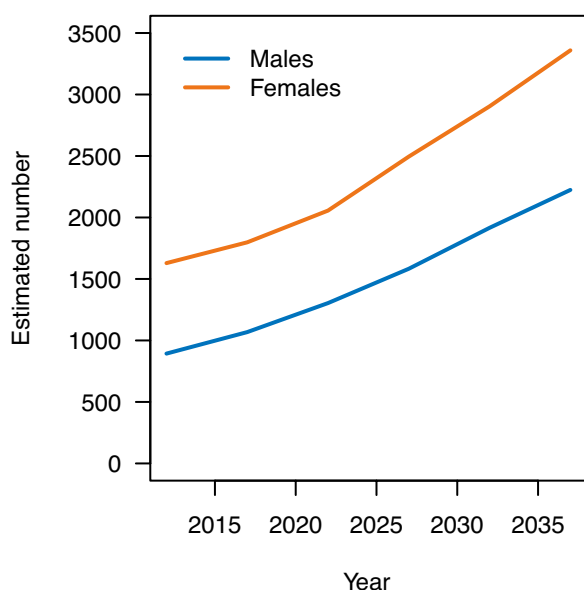
Source: Estimates calculated from Dementia UK 2007 report produced for the Alzheimer's society by King's College London and the London School of Economics¹

The severity of dementia is normally classified as mild, moderate or severe. At any one time about 55 percent of the population who have dementia will have mild dementia, 32 percent moderate dementia and 13 percent severe dementia.¹ This is reflected in table 1 which shows the estimated prevalence of dementia severity by age group for Medway's older population.

in the ageing population and the inevitable related growth in numbers of people living with dementia. Between 2012 and 2037 the number of older people living in Medway with dementia is expected to increase from just over 2,500 to 5,600 (figure 3).

A significant challenge with respect to the provision of dementia care is the predicted future increase

Figure 3: Trends in estimated number of people aged 65 years and above living in Medway with Dementia, 2012–2037



Source: Estimates calculated from Institute of Public Care and Oxford Brookes University (2010) Projecting Older People Population Information System.⁵

Risk factors for vascular dementia are the same as those that increase the risk of cardiovascular disease (for example, smoking, lack of physical activity and poor diet). Other risk factors include having a learning disability and chronic alcohol misuse.

People with a learning disability are at greater risk of developing dementia at a younger age, particularly those with Down's syndrome.

As people with learning disabilities are living longer there is an increasing need for awareness and early detection of the condition. A study of people with Down's syndrome found the following prevalence of Alzheimer's disease³:

- 30–39 years: one in 50;
- 40–49 years: one in 10;
- 50–59 years: one in 3;
- 60–69 years: more than half.

What works?

Obtaining an early diagnosis of dementia enables individuals and their carers to benefit from timely treatment, support and the ability to prepare for the future at an early stage of the condition. This might include making legal and financial arrangements, changes to living arrangements and finding out about aids and services that will enhance quality of life for people with dementia and their family and friends. Early diagnosis can allow the individual to have an active role in decision-making and planning for the future while families can find out more about the disease and learn effective methods of communication. There is evidence that the currently available medications for Alzheimer's disease may be more beneficial if given early in the disease process⁴. These medications, whilst not suitable for all individuals and not a curative measure, can help to maintain daily function and quality of life as well as stabilise cognitive decline in some people.

The National Institute for Health and Care Excellence (NICE) recommends that people with dementia should have a named person who supports them to develop a care plan and acts as a single point of contact across all organisations. NICE also recommends that staffing should be consistent and stable and that a familiar environment with minimisation of relocation can help people retain independence.⁴

Carers play a crucial role in supporting people with dementia and helping people maintain independence. Nationally it has been estimated that carers for people with dementia save the UK £8bn a year.¹ However, caring can also impact on the health and wellbeing of the carer. Recognising the value of carers and providing appropriate support is vital.

Current service provision

Current services to support people living with dementia are wide and varied but are not always visible or consistent across different areas in Medway. Medway Council and Medway Clinical Commissioning Group (CCG) are working together to develop a dementia strategy which will aim to achieve the following outcomes:

- people with dementia are able to 'live well' and feel empowered to have high aspirations, confidence and know they can contribute;
- ensure commissioning processes are evidence-based and reflect current need;
- a clear partnership commissioning strategy upon which intelligent and responsive services are created, maintained and developed to ensure an enhanced quality of life for people living with dementia and their carers;
- a dementia pathway that will provide timely interventions that focus on early diagnosis, reducing admissions to hospital and mental health units and averts crises;

- improved quality of care for patients in acute hospitals and supported early discharge;
- high quality care for adults with dementia at the end of their lives.

Memory Assessment Service

Kent and Medway NHS and Social Care Partnership Trust (KMPT) takes referrals from GPs where there are symptoms suggestive of dementia and support people through an assessment process with both pre- and post-diagnostic counselling as part of their memory assessment service. This support is provided through a multi-disciplinary team which includes Admiral Nurses, who are mental health nurses specialising in dementia care. KMPT provide ongoing support and guidance with the aim of working in a shared care approach with a person's GP.

Residential nursing care

In Medway, there are twelve independent sector nursing homes registered with the Care Quality Commission and most of these will support older people many of whom are likely to have varying degrees of dementia. However, there are few dedicated nursing homes providing care to people with complex and often challenging needs arising from their dementia. A pilot scheme will provide these homes with additional support through a multi-disciplinary team in the form of the Integrated Care Home Model. The aim of this scheme is to support homes to achieve a high standard of care and reduction in the need to use secondary care services.

Medway Community Healthcare (MCH) provide community based services and run Darland House a specialist residential facility providing nursing care to older people with mental health needs which are predominantly associated with dementia. Darland House offers people with complex needs an opportunity for careful assessment and for care plans to be developed that will help people live with needs that are often felt as very challenging to less specialist facilities.

Dementia Support Service

MCH also provide a Dementia Support Service with a multidisciplinary team lead by an Admiral Nurse which responds to and works to prevent crises that might occur in people's homes where the main support for a person with dementia is being provided by a carer. It is the aim of the service to avoid, where possible and appropriate, an admission to hospital or care home. A move away from a familiar setting can be a highly traumatic experience that may exacerbate a decline in the person's wellbeing.

MCH are also overseeing a scheme that employs two Carer Support Coordinators from Carers First, with one being based with the Dementia Support Service in the community and the other based with the Integrated Discharge Team at Medway Maritime Hospital. This scheme provides support to carers to reduce the risk of crisis leading to avoidable hospital admissions or to support an earliest possible discharge.

Dementia Friends

Medway Council and NHS organisations in Medway are supporting the national Dementia Friends initiative- a scheme led by the Alzheimer's Society and Public Health England to deliver free dementia awareness sessions to the public in order to improve their understanding of dementia and create an environment where people with dementia feel understood and included in their community.

2,258 people have become Dementia Friends in Medway since May 2014, with a range of activities planned to increase the numbers of people signing up to receive a session.

To find out about local dementia information sessions and the Dementia Friend campaign go to: www.dementiafriends.org.uk

Voluntary Sector led services

Medway Voluntary Action (MVA) has been commissioned by Medway Council to achieve the following outcomes in the local area:

- building the capacity of the Voluntary and Community Sector (VCS);
- co-ordination, networking and engagement amongst Medway's VCS organisations;
- encouragement and development of volunteering across the VCS, private and public sector;
- representation of the diverse views of the VCS at local strategic and planning meetings;
- provision of information, support and training.

The role of the voluntary sector in developing communities that are resilient and aware is crucial to improving opportunities for people living with dementia and their families.

Dementia cafés run by voluntary sector organisations provide opportunities for people with dementia and their carers to come together in an informal setting for mutual support and guidance. Organisations such as the Alzheimer's Society, Age UK and the Sunlight Development Trust provide valuable support by telephone and face-to-face.

Bernard Unit, Medway NHS Foundation Trust

Medway NHS Foundation Trust have made dementia the focus of much work in the last year and opened the Bernard Unit to support people with dementia whilst they receive treatment as inpatients for a range of conditions that would previously have seen people in various different parts of the hospital. The unit has a dedicated doctor, occupational therapist and nurses to ensure patients receive tailored care. The Trust has also adopted the Butterfly scheme, which allows people with memory impairments to consent to a dementia friendly person centred approach to their care. This operates throughout the hospital and it allows people whose memory is permanently affected by dementia to make this clear to hospital staff and provides staff with a simple, practical strategy for meeting their needs. The patients receive more effective and specific personalised care, reducing their stress levels and increasing their safety and well-being. In addition to these initiatives dementia awareness training for staff working in the hospital has also been prioritised.

Primary Care

The central role of GPs is recognised in the Dementia Strategy and initiatives are being developed to develop a greater understanding and awareness of the importance of early diagnosis, treatment and providing patients and carers with meaningful information about care and support services that are available through the NHS, adult social care and the independent sector.

Case Study: Living with dementia

Mr B, a retired professional, and his wife have lived in Medway for many years. During retirement they have enjoyed time with their children and old friends. On one occasion a friend, who had developed awareness around dementia through his experience with a family member, asked Mr B if he had noticed anything unusual about his wife's memory. Mr B had thought that his wife's forgetfulness was nothing extraordinary or worrying.

Mr B discussed the issue with his wife and, through their GP, a referral was made to the local memory assessment service for a series of tests. A brain scan at the local hospital, together with the results of the test and Mr B's description of changes in his wife over time led to a diagnosis of vascular dementia with Alzheimer's disease.

Mr and Mrs B were both offered counselling and support in the form of a ten week programme where each separately learnt about the likely progression of the disease and how to manage this in their lives with the aim of living as well as possible with dementia. Mrs B was a member of her local Women's Institute and the group were committed to continuing her involvement 'come what may'. It was this support and commitment of her close circle of friends that allowed Mrs B to maintain her independence for as long as possible. At that time both Mr and Mrs B were able to look forward to the regular visits of the local Admiral Nurse. Having someone come to the home and talk to them both about how the disease was affecting their lives was very valuable, and increasingly so to Mr B who was now his wife's main carer, a position that occupied his life totally.

As the disease began to impact increasingly on Mrs B's abilities, a place at a local day

centre was arranged with the support of Adult Social Care staff. Further decline in Mrs B's health resulted in hallucinations that made her too anxious to leave her house. The disease progressed to the point where more help was required and further support was subsequently arranged by Adult Social Care, with paid carers now visiting once a day to help in the morning and provide occasional respite.

Over time, Mrs B became increasingly frail and confused. Successive falls led to hospital admission and a general decline in Mrs B's physical health. At that time services were not always understanding of the special needs of people living with dementia and Mr B set about challenging services to recognise the person behind the dementia and convincing people to become part of a campaign to increase awareness and improve services.

As Mrs B's health deteriorated Mr B was offered a final course of counselling and support that prepared him for his wife's end of life. Through discussion with other family members, the difficult decision was made to move Mrs B to a nursing home for 24 hour nursing care and support. The nursing home supported Mrs B's involvement in activities of daily living and encouraged her to help keep the house looking tidy. Mrs B's dementia gradually progressed until she finally deteriorated and sadly passed away.

Mr and Mrs B's story is one experienced by an increasing number of people and Mr B continues to live with the effects of dementia. Through the journey that they both faced there were times when the services, care and support received were outstanding, but at other times were moments of great anxiety and anger at the lack of understanding that was shown toward a person with dementia.

Mr B challenged services throughout his wife's illness and continues to do so now.

The challenge of dementia is one faced by an increasing number of people and one which needs to be recognised by whole

communities. It is through the actions of individuals and the ability of communities to listen and respond that the quality of life of those living with dementia will be improved.

Recommendations

- Public awareness about dementia and its effect on people's lives should be the focus of attention within Medway's communities. A local Dementia Action Alliance should be created with the aim of establishing Medway as a dementia friendly community.
- The role of the GP is central to meeting people's needs and there should be a continued development of understanding of the importance of early diagnosis, treatment through medication, and the care and support that is available through social care services including those provided by the independent sector.
- The role and importance of the 'carer' should be incorporated into the Dementia Strategy and supported by the commissioning options prioritised for implementation. A focus of attention will need to be given to ensuring that services are available to avoid and manage crises that might lead to avoidable hospital or care home admissions.
- Clear dementia care pathways should be established, supported by practitioner and patient information in easy to read formats.
- Preventative interventions to reduce vascular dementia should be prioritised and promoted. For example, maintaining a healthy lifestyle that consists of not smoking, maintaining a healthy weight and being physically active.

References

1. Emiliano DA, Banerjee PS, Dhanasiri S, et al. Dementia UK: The Full Report 2007; Alzheimer's Society. <http://alzheimers.org.uk/site/scripts/download.php?fileID=2SheffieldDementiaInformationPack> (2013) http://www.sheffield.ac.uk/polopoly_fs/1.207026!/fileSheffieldDementiaInformationPack.pdf.
2. Alzheimer's Society (2011). Factsheet: Learning disabilities and dementia 2011.
3. Alzheimer's Society (2011). Factsheet: Drug treatments for Alzheimer's Disease.
4. NICE guidelines CG42 (2013) Dementia: Supporting people with dementia and their carers in health and social care.
5. Institute of Public Care and Oxford Brookes University (2010). Projecting Older People Population Information System.

5 The Living Environment

The Living Environment

There is a substantial body of evidence which links our living environments, for example the quality of our housing conditions, to our health outcomes.



5 The Living Environment

The quality of housing and our living environment has a significant impact on our health. Accessible, well designed housing and neighbourhoods can enhance health and wellbeing and prevent the onset of poor health, just as poor housing and a negative environment can worsen and even cause ill health.

It is predicted that the largest growth in households over the next three decades will be older households (those containing no-one below the age of 55 years). Housing is a particularly important factor influencing the physical and mental health and wellbeing of older people, and contributes to many preventable diseases and injuries.

Links have been identified between housing and major long-term conditions such as heart disease, stroke, mental illness, respiratory disease and arthritis. Older people spend a large proportion of their time at home and are more vulnerable to cold and damp related problems. The risk of falls- a major cause of morbidity, emergency hospital admission and loss of independence in older people- is also affected significantly by the living environment, both internal and external. Relevant key factors affecting mental health are financial pressures, fuel poverty and housing insecurity.

This chapter explores the impact of the physical environment, particularly housing, on the health and wellbeing of our older population.

The impact of the living environment

The relationships between housing, the neighbourhood, environment and health are complex and it is therefore difficult to look at the impact of any one factor in isolation.

The internal living environment

Factors relating to the internal living environment that may impact adversely on the health of older people include poor air quality, excessive heat, cold, damp, causes of slips, trips and falls, noise, dust and fires.¹ As we age, we may become less able to maintain our properties, change light bulbs or curtains, tidy away wires or fix down carpets, all of which can be hazards as well as potentially contributing to levels of depression and anxiety.

Older people are frequently managing on a low income. Age UK has estimated that one in four pensioners are struggling financially.² This puts them at greater risk of not being able to heat their own homes. In addition to the increased risk of major long term conditions, cold homes may exacerbate arthritic symptoms (resulting in even poorer mobility and a higher risk of falls), increase the level of minor illnesses such as colds and flu, and impact negatively on mental health. Cold homes also contribute to excess winter deaths (from, for example, heart disease, stroke and respiratory conditions).³

Table 1: The effect of indoor temperatures on health

Indoor temperature	Effect
18°C (65°F)	Recommended minimum indoor temperature in winter. No health risks although occupants may feel cold ¹
Under 16°C (61°F)	May diminish resistance to respiratory diseases
9-12°C (48-54°F)	May increase blood pressure and risk of cardiovascular disease
5°C (41°F)	Poses a risk of hypothermia

Source: Adapted from Public Health England (2014). *Minimum home temperature thresholds for health in winter- a systematic literature review* and Department of Health, 2011. *Cold Weather Plan for England- making the case: why cold weather planning is essential to health and wellbeing.*

Fuel poverty is defined as the situation where a household needs to spend more than 10 percent of its income on fuel to maintain an adequate level of warmth and to meet its other energy needs (i.e. lighting, appliances etc.). An adequate level of warmth is usually defined as 21 degrees celsius for the main living area and 18 degrees for other occupied rooms. The key elements in determining whether a household is fuel poor or not are:

- income;
- fuel prices;
- fuel consumption (which is dependent on the lifestyle of the household and the dwelling characteristics).

In 2012, Medway had a lower percentage of fuel poor households compared to the Kent and England averages, with 8.7 percent (9,214) households being classified as fuel poor in Medway.⁴

There is, however, a high representation of older people amongst those living in poor energy efficient homes, who are therefore at greater risk of fuel poverty. Older, less energy efficient housing is more expensive to heat and difficult to insulate and protect against draught and damp.

The energy efficiency rating is a measure of the overall efficiency of a home: the higher the rating the more energy efficient the home is. Housing with a poor or very poor energy rating may place inhabitants at risk of excess cold. A Stock Condition Survey undertaken in Medway in 2007 found that 55.9 percent of “very poor” energy efficient dwellings were households where the head was over 60 years old. In the “poor” category, 40 percent of households had a head over 60 years old. Together, this came to a total of 3,798 households in either poor or very poor energy efficiency housing where the head of the household was over 60 years old.

The housing health and safety rating system (HHSRS) is a risk-based evaluation tool introduced under the Housing Act 2004 to help local authorities, during inspections, assess for, identify and protect against potential risks and hazards to health and safety from any deficiencies identified in dwellings. The system applies to all residential properties in England and Wales, irrespective of their ownership or occupation.

An inspection by Housing Services at Medway Council can be instigated in a number of ways, for example; through direct contact from tenants with concerns; through complaints from members of the public about a property; or through routine inspection of properties prior to client placement.

1. Heating homes to at least 18°C in winter poses minimal risk to the health of a sedentary person, wearing suitable clothing. During daytime, this minimum home temperature is particularly important for people aged 65 years and above, or for people with pre-existing medical conditions. Having temperatures slightly above this threshold may be beneficial for health. Maintaining the 18°C threshold overnight may be beneficial to protect the health of those aged 65 years and above or those with pre-existing medical conditions: they should continue to also use sufficient bedding, clothing, thermal blankets or heating aids as appropriate.

Social housing should meet a minimum standard of decency (the Decent Homes Standard), which sets out that homes should:

- be free of health and safety hazards;
- be in a reasonable state of repair;
- have reasonably modern kitchens, bathrooms and boilers;
- be reasonably insulated.

Hazards are categorised as Category 1, where the council has a duty to take action, or Category 2, where the council may take action.

Housing-related support and the services provided by Housing Associations help to tackle health inequalities. The use of the HHSRS enables the identification of, for example, those homes with poor energy efficiency, following which the council can take supportive action such as alerting of private landlords and assistance with grant applications for heating system upgrades. These preventative services, discussed in the “practical support” section of this chapter, can mean that people are less likely to need acute health services or may be discharged home earlier from hospital.

The external living environment

Evidence also indicates that elements of the surrounding external environment are a significant factor in the physical and mental health of older people.

Poor community-based services and difficulty in accessing services, shops or leisure activities can all increase the risk of social isolation and mental health issues.^{1,5} Older people are more likely to have mobility, vision or hearing problems so find it harder to get to the shops, access their GP or chemist, provide food and cook for themselves. Additionally, lack of facilities such as public toilets and benches on which to rest potentially prevent a substantial proportion of older people from going

out.⁶ Many older people are also less likely to be able to find out about services they are entitled to or that could assist them.

High levels of neighbourhood crime or fear of crime, vandalism, anti-social behaviour and harassment can destabilise feelings of safety and security for many older people. This is felt even more acutely for those with dementia.

All of the above factors serve to increase an older person’s sense of isolation and loneliness and so may impact negatively on their physical and mental health.

Who is at risk?

The majority (82 percent) of Medway’s older population live in privately owned housing and the needs of an ageing population present specific challenges. The projected increase in numbers of older people with support needs due to long term conditions is likely to mean people will need assistance in order to remain in their own homes. Adaptations and mobility aids help people live independently for longer yet few owner-occupier homes nationally have been adapted to meet people’s needs.⁷

Certain groups of older people are particularly vulnerable to the impacts of negative housing conditions, for example, older people living alone, living as private tenants and living in poverty. The current economic situation — notably lower incomes, reduced value of assets/savings and higher cost of living — is likely to increase the risk of a negative living environment.

Medway has fewer than the national average one-person households where the resident is aged over 65 years. Whilst there has been a decrease since 2001, there are still nearly 15,000 people aged over 65 — 67 percent of whom are female — living on their own in Medway. This number is projected to rise to over 22,000 by 2030.⁸ As discussed in

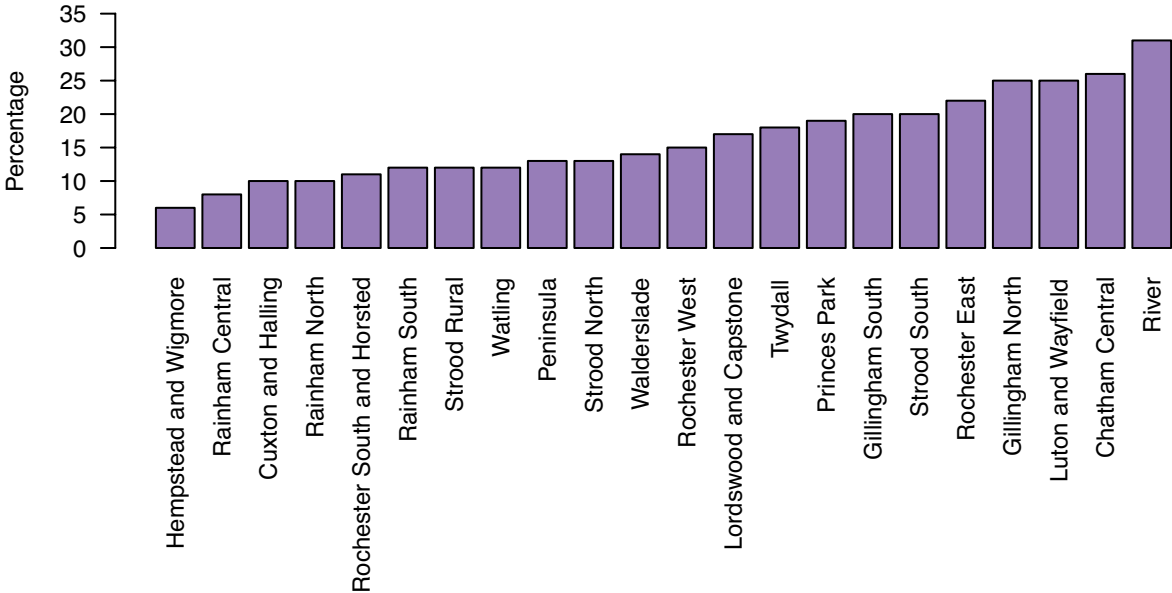
chapter 2 (social isolation), the Medway wards that currently have the highest proportions of people over 65 years old living alone include parts of Peninsula, Strood Rural, Strood South, Rainham North, Rochester West and Twydall wards.

The private rented sector has the highest proportion of homes with poor energy efficiency levels, and private rented dwellings have been found to be more likely than other tenures to experience damp problems as they are more likely to be older stock.⁹ Most recent data from Housing Services at Medway Council indicates that around 20 percent of properties within the private rented sector do not meet minimum standards, the majority due to excess cold. There are additional

potential detriments to health for older people who live in rented accommodation: they are less likely to have access to amenities which may benefit health, such as gardens and may be more likely to worry over finding the rent.¹

Deprivation amongst Medway’s older population is discussed in chapter 1. As shown in figure 4, chapter 1, levels of income deprivation amongst older people vary across Medway’s wards. The wards with the highest levels of income deprivation affecting older people are Chatham Central, Luton and Wayfield, Gillingham North and River. The proportion of the older population receiving guaranteed pension credit in 2010 was accordingly also highest for these wards (figure 1).

Figure 1: Proportion of Medway’s population aged 60 years and above in receipt of the guaranteed part of Pension Credit by Medway ward, February 2010



Source: The Poverty Site. www.poverty.org.uk/maps/wards%20data.xls

Evidence shows that fear of crime can be associated with poorer quality of life, limited mobility, depression and poor self-reported health status. The World Health Organisation SAGE study¹⁰ found that older people who reported fear of crime in their neighbourhood were less likely to leave their homes to visit friends and relatives, resulting in reduced social networking outside the home and a higher risk of social isolation.

Data obtained from Kent Police over the last three years indicate that, of all types of crime, people aged 65 years and above in Medway are most vulnerable to theft and criminal damage offences. The Medway wards with the highest rate of crimes (all crimes) where the victim was aged 65 years or above for the period April 2011–March 2014 were River (crime rate 52.8 per 1,000) followed by Gillingham South (47 per 1,000) and Gillingham North (34.7 per 1,000). The average crime rate where the victim was aged over 65 years for this period for Medway overall was 22.3 per 1,000. Recent information from surveys of crime victims undertaken by Kent Police show that feedback is positive with regard to how the crime victims are dealt with and with their perceptions of the Police and local issues.

Recent Medway's Citizens' Panel survey data have shown that 85 percent of respondents felt safe when outside in their area during the day, while nine percent felt unsafe. 95 percent of respondents living in Lordswood and Capstone, Rainham North and Rochester West reported feeling safe during the day. Medway wards where the highest proportion of surveyed residents felt unsafe during the day were Luton and Wayfield, (33 percent) Gillingham North (18.5 percent) and Chatham Central (17.4 percent).

The potential impact of the living environment on older people's health

Excess winter deaths

There are more deaths in the winter period than in the rest of the year (adjusted for the length of the period), and older people account for the majority of the excess deaths. The majority of these deaths have been shown to have respiratory disease as the underlying cause, symptoms of which are exacerbated in colder weather and by cold, damp conditions at home.¹¹

The excess winter deaths ratio is a measure of the difference in numbers of deaths occurring in the winter months (December–March) in an area, compared to the level of deaths in the other months of the year. This statistic is a percentage, showing how much higher (or in some cases, lower) the death rate is in the winter.

The excess winter deaths ratio for 2010–2012 was 14.6 for Medway, which is lower than the ratio of 17 for Kent and Medway overall for the same time period. The total number of excess deaths in the winter months over this period for Medway was 284.

Falls related hospital admissions and A&E attendances in the elderly

As discussed in chapter 3 (Falls), the incidence of falls rises steeply after the age of 65 years. The consequences of falls in older people can be serious. Half of people suffering a hip fracture never return to their previous level of independence, and experiencing falls is a strong predictor of needing placement in a nursing or care home in the future.¹²

Local data show that 59 percent of falls amongst Medway residents aged 65 years and above which required hospital admission in 2013/14 occurred at the patient's home, making the internal living environment a critical setting for falls prevention measures.

Social isolation & loneliness

Chapter 2 (social isolation) discusses the potential negative health effects of being socially isolated and estimates that 4,698 people over the age of 65 years living in Medway may be socially isolated.

What works?

The environments in which people are born, live, work and age have been found to have significant impacts on physical and mental health and wellbeing⁵ and it is recognised that there is a need for policies and programmes relating to planning, transport, housing, environmental and health systems to be developed collaboratively in order for health inequalities to be reduced.

Improvements to housing conditions can lead to overall improvements in general health and wellbeing, respiratory health and mental health: this positive impact is most likely when improvements to housing are targeted at people with poor health and poor existing housing conditions, notably inadequate warmth.¹³

Research has also highlighted the importance of the external living environment to older people's health and wellbeing. Social participation and support, neighbourhood facilities and a sense of security all have a major impact on quality of life in older age. Access to good and convenient public transport has also been found to be important to older people's quality of life, their sense of freedom and independence.¹⁴

A small body of evidence indicates that the use of Assistive Technology (for example, telecare), when integrated with other components of a care package, may lead to reductions in older people's need for personal assistance at home, thereby potentially promoting independent living. This supports a growing consensus amongst health and social care professionals that telecare has benefits to individuals and carers and to health and social care organisations.¹⁵

What are we doing in Medway?

Strategic actions

Medway's Health and Wellbeing Board has prioritised social isolation and falls within its Joint Health and Wellbeing Strategy, both with clear objectives relating to the living environment. Key partners in the delivery of health and social care services and Public Health will work in collaboration on the delivery of action plans to tackle social isolation and falls in Medway.

Locally, Medway Council is in the process of updating its Housing Strategy, with promoting choice and independence being key themes within the new strategy.

Medway's Housing Strategy 2011–14 was designed around three themes:

- bridging the gap — working to create a pathway into suitable housing and home ownership by increasing choice;
- early prevention — providing suitable, appropriate and timely housing advice to help people make the right housing choice;
- health and housing — Improving health through quality housing and places.

Good progress has been made across the themes over the life of the strategy. Notable progress relating to the housing of older people in Medway including:

- 187 fully wheelchair compliant homes have been delivered;
- over 400 households have had major adaptations undertaken within their home through the Home Adaptations Service;
- over 10,000 households have been assisted through the HomeSafe scheme (provides minor works, safety and security checks);

- over 11,000 households have been assisted to undertake repairs, adaptations and improvements to their home;
- 163 Extra Care units have been delivered and another 103 have been planned to meet identified need;
- work with the Institute of Public Care and Adult Social Care to undertake housing needs analysis on a range of client groups including those with dementia and learning disabilities;
- priority is given, through the allocations policy, to those people whose housing conditions have a detrimental impact on their health to ensure that their housing needs are appropriately met. A floating support service provides housing related support services across all tenures. Floating support services can help people claim benefits, manage debts and budgeting, find appropriate support groups, signpost to other agencies and develop life skills.

Practical support

Practical support relating to housing and the living environment in Medway includes:

Older person's accommodation

In keeping with national and local priorities to promote choice and independence for the older population, Housing Services at Medway Council are working to develop alternatives to residential care. By improving the housing offer in Medway, people can be empowered to make choices about the type of accommodation they would like to accept. Sheltered housing is self-contained housing which is built to mobility standards sometimes with a scheme manager on site and communal facilities such as a lounge area. This option is an example of housing which promotes independent living whilst still providing a safe, supported living environment.

For those who decide not to live independently, a choice of specialist housing is available in Medway. Extra care housing schemes enable people to self-care for longer but with access to care and other services on-site as needed. There are three existing extra care schemes in Medway, with a further two under development.

Home Improvement Agency

Home Improvement Agency (HIA) has worked in partnership with Medway Council for a number of years to support householders who need care or support to remain independent in their own homes. HIA can help with small repairs in the home to major adaptations and advice on, for example, central heating and energy efficiency measures, repairs to doors and windows and improvements to safety and security in the home.

HIA also provides the Homesafe scheme that provides essential repairs and maintenance which may be considered too minor for general contractors to undertake. These repairs include securing loose carpets, installation of grab rails and minor carpentry or plumbing work.

Medway Council Occupational Therapy service

Medway Council's team of occupational therapists and rehabilitation co-ordinators provide assistance to people in their own homes if they are registered (or eligible to be registered) as having a permanent or substantial physical disability.

The team carry out assessments and offer support to help people with disabilities to be as independent as possible in their own homes, for example, giving advice or providing equipment and adapting the home if necessary.

Medway Council housing advice services

Medway offers a range of assistance to reduce the number of households living in substandard and non-decent housing. Advice and information is offered which aims to:

- assess the housing needs of an individual and advise on ways to ensure that housing needs are met, either through floating support, advising on alternative accommodation options or signposting to other agencies;
- improve non-decent homes occupied by vulnerable households in order that the minimum standards are achieved;
- encourage landlords to invest in their homes to achieve the minimum standards;
- improve the take-up of sustainable energy measures.

Disabled Facilities Grants

When all other options have been explored to meet the housing needs of a person with a disability, a Disabled Facilities Grant may be used to help improve the existing home. The grants are means tested and can cover works that help to reduce hazards that might lead to falls in the homes such as the provision of stair lifts, replacing baths with level access showers, ramps and safer access.

Raising standards in the private rented sector

The role of the private rented sector in housing provision is increasing in Medway. Housing services in Medway Council aim to maximise the full potential of this sector as a flexible, well-functioning element of the housing market. Households that have traditionally been placed within social housing are increasingly housed in private rented accommodation. A minority of landlords provide unacceptably poor homes and management practices. Housing services work to professionalise the private rented sector and take enforcement action where appropriate.

Assistive Technology

Medway Council hosts a Control Centre which provides, amongst other services, telecare services.

Telecare is a type of Assistive Technology (AT) which aims to enable independent living for older people. 24-hour instant response to alerts received from telecare sensors, including Lifeline. Every sensor is programmed to a small telecare unit linked to the telephone line. On activation of the unit, a trained operator can talk to an individual through a speaker unit in the home to assess the situation and implement the appropriate response, e.g. contacting a family member, neighbour, doctor, mobile warden, emergency services or mobile response team.

Some of the benefits of Telecare for older people include:

- helps individuals maintain independence;
- increases safety and confidence;
- supports carers alongside traditional healthcare, social care and housing initiatives;
- helps the shift from traditional models of residential care to supporting people at home;
- reduces pressure on the NHS and social services.

Case Study: Maintaining independence at home

Mrs E is an 85 year old lady who lives alone in Medway. Mrs E's poor mobility and unsteadiness mean that she needs lifting and assistance to bath or shower herself. Since her carers are unable to do this for her due to restrictions on manual handling, Mrs E had been unable to have a bath or shower for over two years, causing her considerable distress.

Following a referral from Medway Council's Occupational Therapy Team to Home Improvement Agency (HIA), an HIA caseworker arranged for a joint visit and assessment to take place. A Grants Officer and Occupational Therapist from Medway Council, a Surveyor and the HIA caseworker visited Mrs E in her home. The assessment included a detailed financial review and a home fire safety and heating system check as well as reviewing the need for any home adaptations.

The need for bathroom adaptations to meet Mrs E's accessibility needs was identified, as well as

her entitlement to Council Tax Relief. Detailed specifications were drawn up for the bathroom works and a Disabled Facilities Grant application was sent to Medway Council for approval.

Mrs E was awarded Council Tax benefit and a full grant for the adaptation works which included general bathroom refurbishment, creation of a flush floor shower area with modern shower unit and shower seat, and replacement of the floor covering to create a level floor surface and reduce the risk of trips and falls. In addition, Mrs E's heating system was upgraded to improve her home's energy efficiency.

In addition to her improved financial situation, Mrs E can now shower herself alone. With her dignity and self-confidence restored, she now enjoys renewed independence in her own home.

Recommendations

- Promotion of an integrated approach across housing, health, public health and social care to maximise the potential for housing to improve and maintain health.
- Housing strategies should consider the impact of the ageing population on need for housing, suitability of housing stock, systems in place for adapting/improving housing, integrating consideration of housing across health and social care systems.
- Continue to develop the way properties are appropriately allocated according to need by Housing Services at Medway Council, through both the use of occupational therapist assessments of individual need and by ensuring that the housing application system enables people to apply for the most appropriate housing to meet their needs.
- Development of a pathway for healthcare professionals to identify and refer older people who are vulnerable to being cold or at risk of health problems due to cold temperatures to appropriate agencies for further support. This support should include advice on grant benefits and practical advice on controlling temperatures indoors.
- Planning and policing strategies to enhance perceived and actual neighbourhood safety should be implemented more widely.

References

1. Housing Corporation and Housing Learning and Improvement Network, 2008. Good housing and good health? A review and recommendations for housing and health practitioners.
2. Older people tracker survey for Age UK, UK TNS, 2014– fieldwork.
3. UCL Institute of Health Equity, 2011. The Health Impacts of Cold Homes and Fuel Poverty.
4. Department of Energy & Climate Change. Sub-regional Fuel Poverty England 2012.
5. UCL Institute of Health Equity, 2010. Fair Society Healthy Lives. Strategic review of health inequalities in England post-2010.
6. Help the Aged, 2007. Nowhere to Go: Public Provision in the UK.
7. Adams S, Ellison M (2009). Time to Adapt- Home Adaptations for Older People: The increase in need and future of state provision.
8. Institute of Public Care and Oxford Brookes University (2010). Projecting Older People Population Information System. Figures are taken from the General Household Survey 2007, table 3.4: Percentage of men and women living alone by age, Office for National Statistics.
9. Department for Communities and Local Government. English Housing Survey 2011/12.
10. WHO Study on global AGEing and Adult Health (SAGE). Geneva, World Health Organization.
11. The Poverty Site. UK: Excess winter deaths. Available from: <http://www.poverty.org.uk/67/index.shtml>.
12. Tinetti ME, Christianna S Williams M (1997). Falls, injuries due to falls, and the risk of admission to a nursing home *New England Journal of Medicine*; 337 (18): 1279-1284.
13. Thomson H, Thomas S, Sellstrom E, Petticrew M. Housing improvements for health and associated socio-economic outcomes. *Cochrane Database of Systematic Reviews* 2013, Issue 2. Art. No.: CD008657. DOI: 10.1002/14651858.CD008657.pub2.
14. Economic and Social Research Council evidence briefing, 2011. Independence crucial to wellbeing in older age.
15. Social Care Institute for Excellence, 2008. Research Briefing 28: Assistive technology and older people.

Medway Council

Gun Wharf
Dock Road
Chatham
Kent ME4 4TR

Tel: 01634 306 000

Email: info@medway.gov.uk

