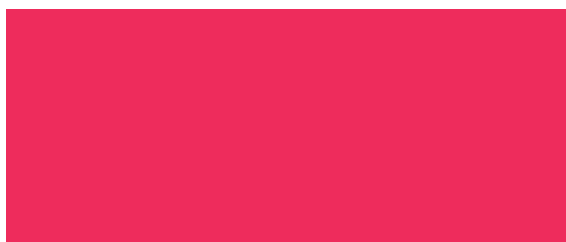


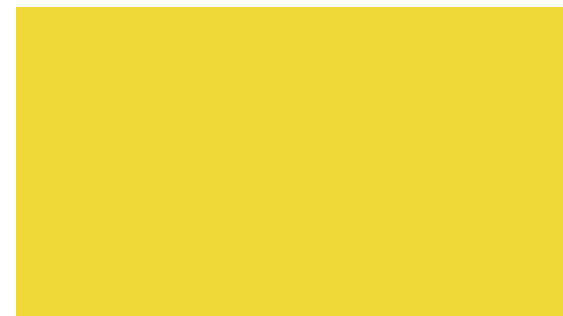


# Age Old Questions

Calderdale Public Health  
Annual Report 2017/18



Calderdale  
Council



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**Paul Butcher**  
Director of  
Public Health

**In this year’s report I have focussed on healthy ageing and our changing demographics in Calderdale. I explore its implications for the future of our health and social care system. I make a number of recommendations on how organisations, communities and individuals, need to respond more effectively to the changing age profile in Calderdale.**

I have sought to challenge a number of assumptions and generalisations about ageing. I have proposed an ageing well framework to help the NHS, the local authority, businesses and the voluntary and community sector, to support how we adapt to the increasing number of older people in our area.

We need to support the development of age friendly communities, built around suitable homes and neighbourhoods, which are designed to encourage physical activity, be safe and bring people of all ages together. So people both contribute and are able to receive support from their community, as well as supporting people in later life, to take up opportunities to contribute their skills, knowledge and experience through whatever form that fits.

This clearly aligns with Calderdale Vision 2024. A place that is kind, resilient, talented, enterprising and distinctive. Voluntary activities, formal civic roles and small acts of neighbourliness all contribute significantly to well being and social connections in later life.

Ageing populations are a public health success story. Longer lives are a benefit to society in many ways, including financially, socially and culturally, because older people have skills, knowledge and experience that benefit the wider population. There is an opportunity to utilise this increased longevity as a resource. We must challenge ageism and a view that retirement is about ‘sitting more and moving less’. However, the opportunities available to each of us as we age will be dependent on one important characteristic - our health.

As life expectancy rises, we must promote the concept of productive healthy ageing, which involves:

- **improved health and wellbeing**
- **increased independence and resilience to adversity**
- **the ability to be financially secure through work**

- to retirement and build resources**
- **engagement in social and volunteering activities**
  - **being socially connected with enhanced friendships and support**
  - **enjoying life in good health**
  - **intergenerational connections and contact**

As the NHS reaches 70 years old itself, many commentators have talked about the costs brought about by an ageing population. This widespread belief needs challenging. Costs are brought about due to ill health not age per se. As a whole system which includes public, private and third sector organisations, we need to continue our efforts to promote good health throughout our ages, if we want sustainable and effective health and social care for our future generations.

The report does not cover all aspects of ageing, rather it highlights some of the key issues for us to address, Namely our responses to an ageing population, recent local trends in life expectancy and the main reasons for ill health in older age. The report contains a number of positive projects. It contains a number of recommendations, aimed at policy makers and leaders in Calderdale.

These are three key dimensions of a good later life:

- **health**
- **financial security**
- **social connections**

These are consistent regardless of gender, ethnicity or other socio-demographic characteristics. These dimensions are interrelated and all influence each other. They also have an impact on the extent to which people feel happy, satisfied with their lives, and that their life has meaning and they are in control. Interestingly, a recent study<sup>1</sup> revealed the significance of strong social connections and how they help some people to overcome disadvantages, such as poor health or a lack of financial security.

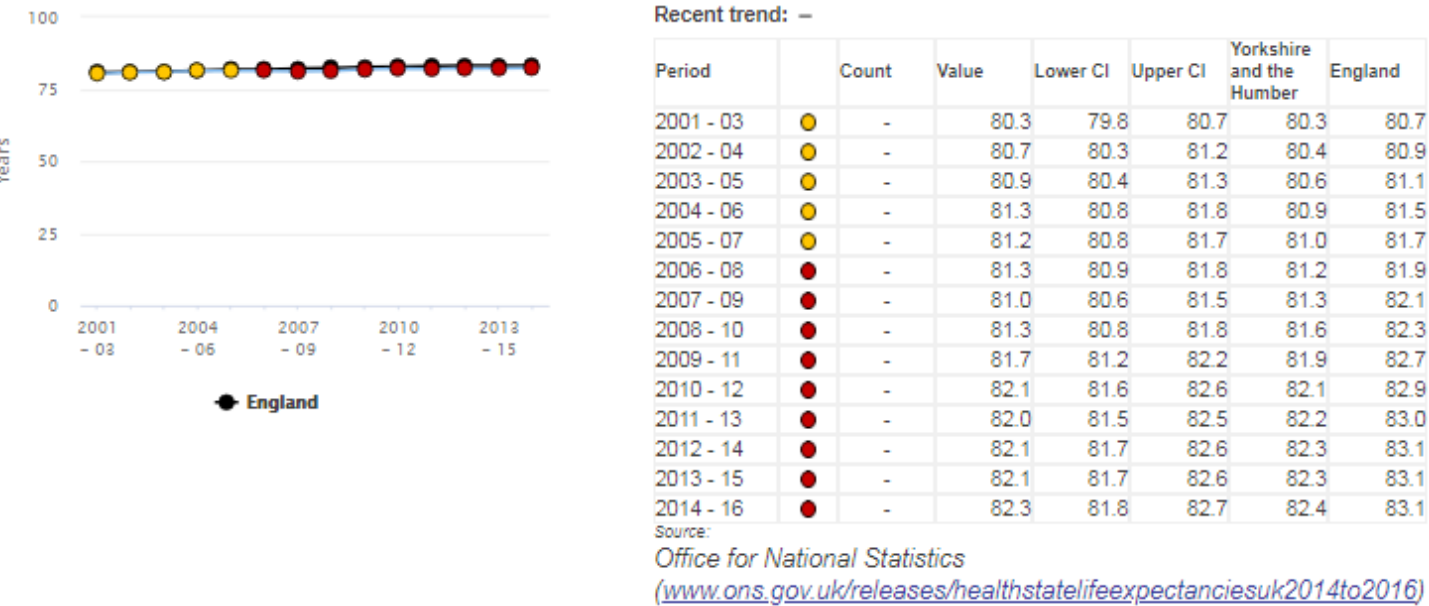
The bottom line is frailty and poor health isn’t inevitable as we get older. It’s the same public health messages as repeated ad infinitum: move more! don’t smoke! and reduce obesity!

I urge all involved to commit to a vision for Calderdale residents, in that they should live long and healthy lives, enjoying an active, fulfilling and independent retirement - in which the ageing process becomes a positive rather than a negative experience.

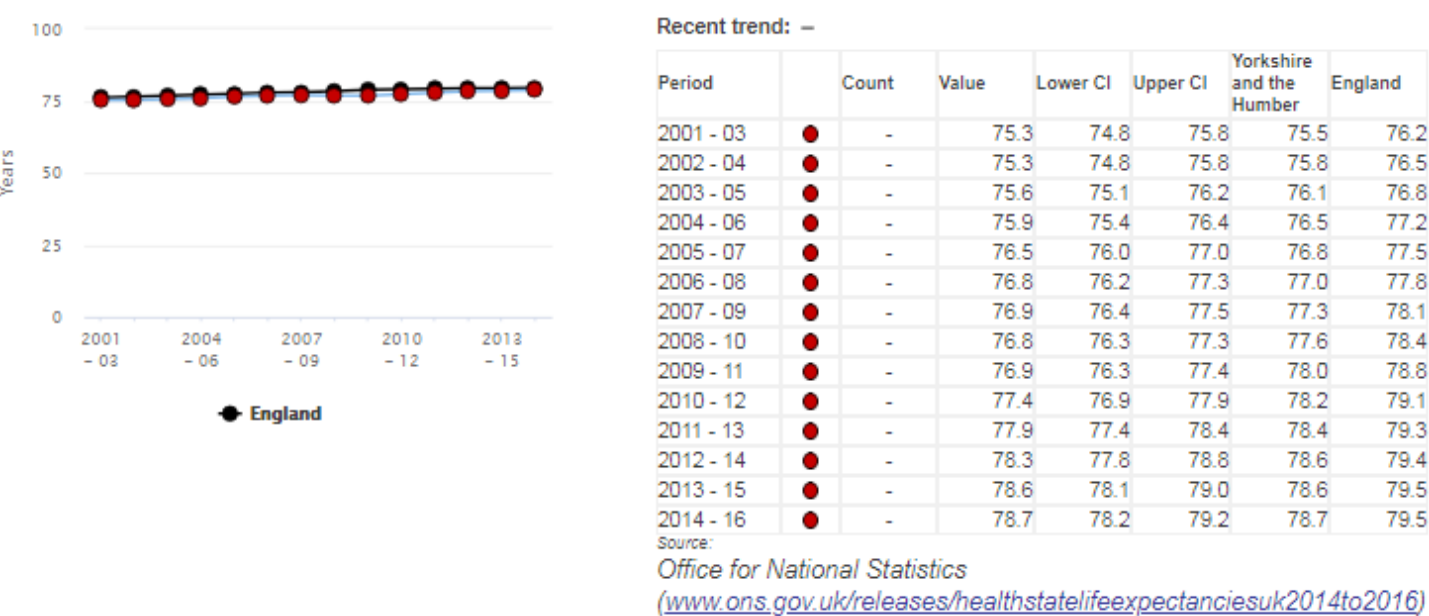
# Life Expectancy

For a number of years, life expectancy at birth in Calderdale has been significantly lower than in England, for both males and females, but has tended to increase over time both locally and nationally.

## Life expectancy at birth in Calderdale: Females

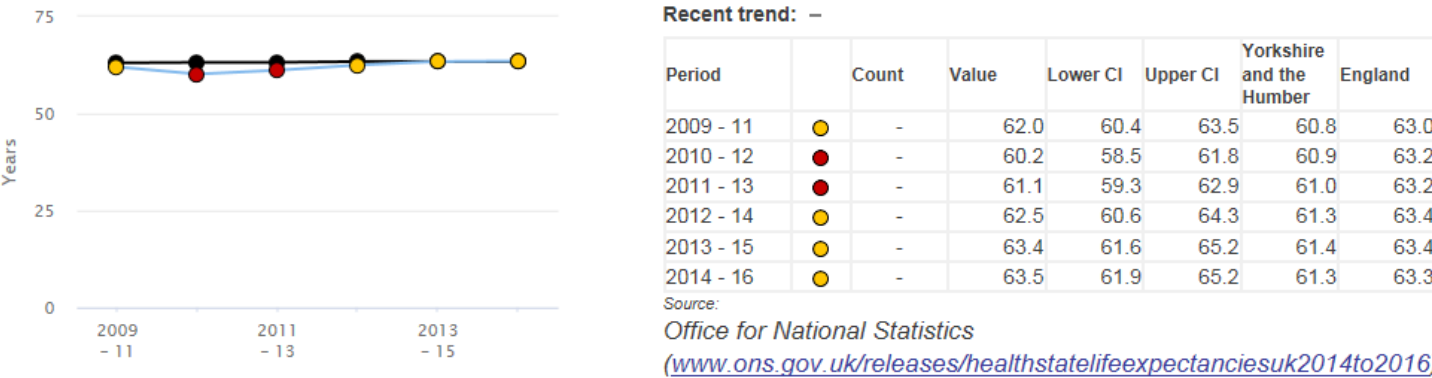


## Life expectancy at birth in Calderdale: Males

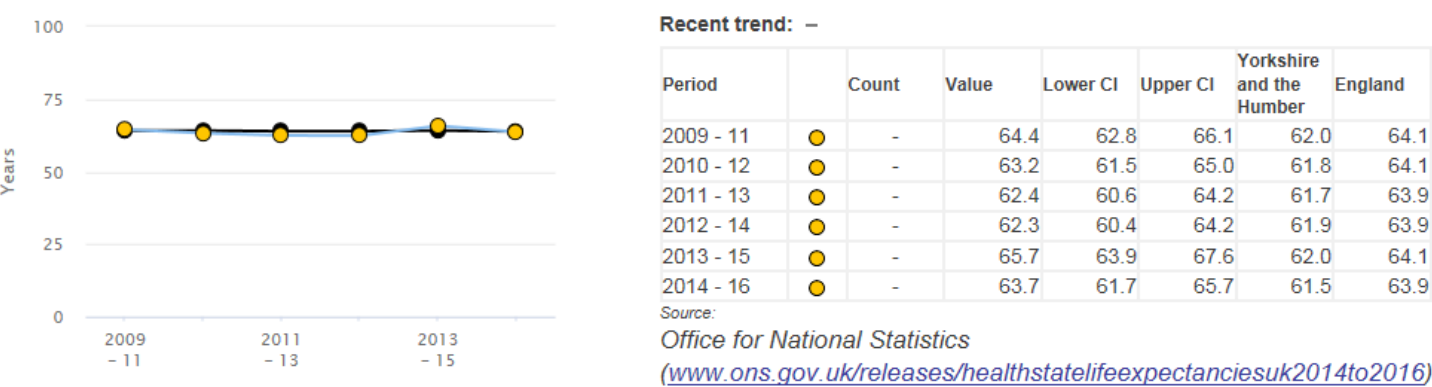


A boy born in Calderdale today will live to around 79 years old, of which almost 64 years will be in good health. A baby girl can be expected to live until around 82 years old, of which again almost 64 years will be in good health. Whilst men and women in Calderdale are living longer, they do not live as long as the English average and a higher proportion of their lives are in slightly poorer health, compared to the England average.

## Healthy life expectancy at birth: Males



## Healthy life expectancy at birth: Females



Life expectancy at 65 for men was 18 years in 2014-16. Of this, 10.3 years was free of disability. For women it was 20.7 years with 12.5yrs free of disability. (ONS)<sup>2</sup> Please see graphs on page 10.

Whilst Calderdale life expectancy is increasing, the picture for our wards is mixed. Whilst there are no statistically significant changes in life expectancy, inequalities appear to have increased.

The arrows in the table overleaf show where there has been a consistent upward or downward trend over the three-year aggregated time periods (2012-14, 2013-15 and 2014-16). If there is no consistent trend no arrows are shown.

The gap between our most and least deprived wards, has increased for both men and women to almost 11 years. In 2004-06 the gap was 7.7 years for men and 7.6 years for women.



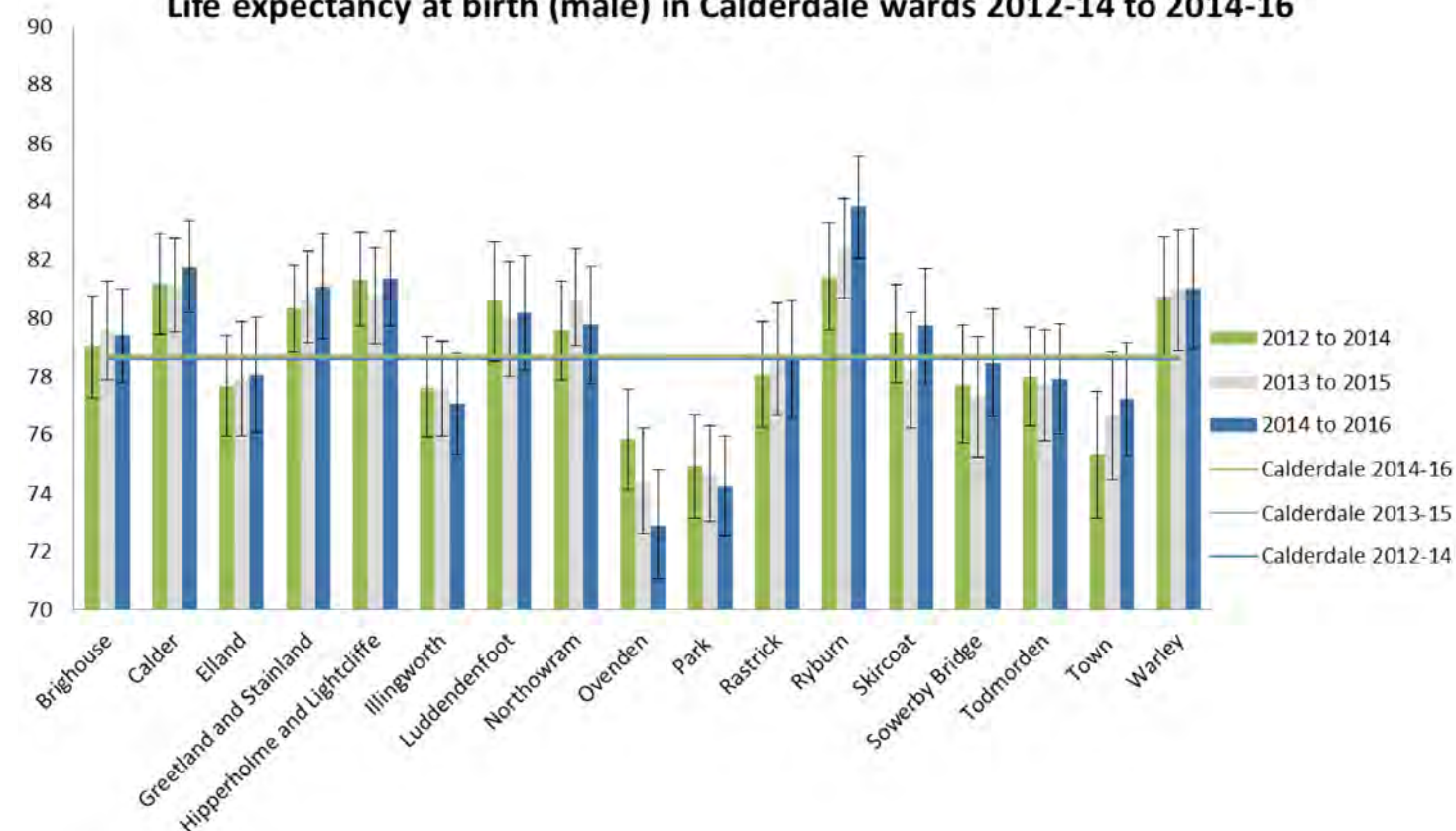


### Ward level figures for life expectancy 2014-16: Males

	Life Expectancy at Birth (years)	Lower Confidence Interval	Upper Confidence Interval	Trend
Brighouse	79.40	77.82	80.99	
Calder Valley	81.74	80.18	83.31	
Elland	78.04	76.06	80.03	↑
Greetland and Stainland	81.08	79.26	82.91	↑
Hipperholme and Lightcliffe	81.35	79.72	82.99	
Illingworth	77.05	75.31	78.79	↓
Luddendenfoot	80.17	78.21	82.14	
Northowram	79.77	77.78	81.77	
Ovenden	72.90	71.03	74.78	↓
Park	74.23	72.52	75.94	↓
Rastrick	78.54	76.51	80.58	
Ryburn	83.80	82.05	85.55	↑
Skircoat	79.72	77.77	81.68	
Sowerby Bridge	78.45	76.59	80.31	
Todmorden	77.90	76.03	79.77	
Town	77.23	75.29	79.17	↑
Warley	81.01	78.97	83.04	↑
Calderdale	78.70	78.20	79.20	↑

For males in Ovenden, there has been a reduction of almost 3 years since 2012/14. Park has shown a small reduction of 0.67 years and Illingworth a small reduction of 0.57 years.

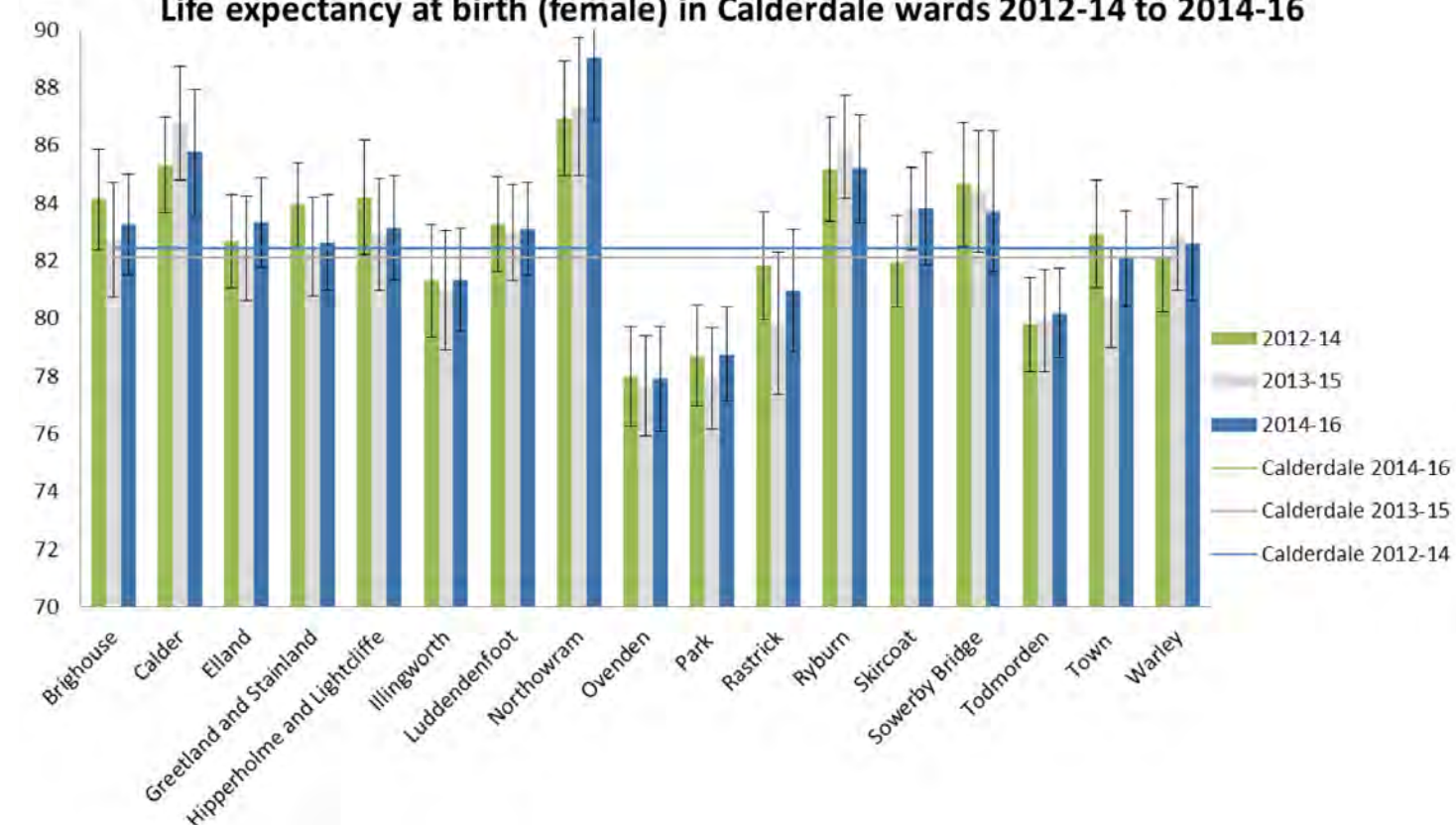
### Life expectancy at birth (male) in Calderdale wards 2012-14 to 2014-16



### Ward level figures for life expectancy 2014-16: Females

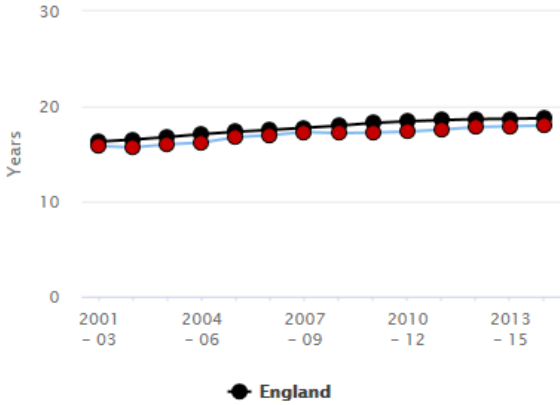
	Life Expectancy at Birth (years)	Lower Confidence Interval	Upper Confidence Interval	Trend
Brighouse	83.26	81.54	84.98	
Calder Valley	85.75	83.56	87.95	
Elland	83.34	81.79	84.89	
Greetland and Stainland	82.63	80.98	84.28	
Hipperholme and Lightcliffe	83.14	81.33	84.95	
Illingworth	81.34	79.54	83.14	
Luddendenfoot	83.13	81.52	84.73	
Northowram	89.03	86.83	91.23	↑
Ovenden	77.91	76.09	79.72	
Park	78.76	77.12	80.40	
Rastrick	80.97	78.85	83.09	
Ryburn	85.20	83.32	87.08	
Skircoat	83.82	81.87	85.76	
Sowerby Bridge	83.72	81.61	85.84	
Todmorden	80.18	78.63	81.73	↑
Town	82.07	80.41	83.72	
Warley	82.59	80.62	84.56	
Calderdale	82.10	81.70	82.60	

### Life expectancy at birth (female) in Calderdale wards 2012-14 to 2014-16





Life expectancy at 65 (Male)

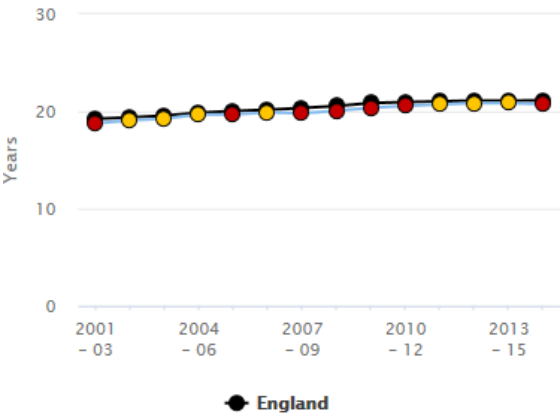


Recent trend:

Period		Count	Value	Lower CI	Upper CI	Yorkshire and the Humber	England
2001 - 03		-	15.8	15.5	16.1	15.9	16.3
2002 - 04		-	15.7	15.3	16.0	16.1	16.5
2003 - 05		-	16.0	15.7	16.3	16.4	16.8
2004 - 06		-	16.2	15.8	16.5	16.7	17.1
2005 - 07		-	16.8	16.4	17.1	16.9	17.3
2006 - 08		-	17.0	16.6	17.3	17.1	17.5
2007 - 09		-	17.3	16.9	17.6	17.3	17.7
2008 - 10		-	17.2	16.8	17.5	17.4	18.0
2009 - 11		-	17.2	16.9	17.6	17.7	18.2
2010 - 12		-	17.3	17.0	17.7	17.9	18.4
2011 - 13		-	17.5	17.2	17.9	17.9	18.5
2012 - 14		-	17.8	17.5	18.1	18.1	18.6
2013 - 15		-	17.9	17.6	18.2	18.1	18.7
2014 - 16		-	18.0	17.7	18.3	18.2	18.8

Source: <https://www.ons.gov.uk/releases/healthstatelifeexpectanciesuk2014to2016>

Life expectancy at 65 (Female)



Recent trend:

Period		Count	Value	Lower CI	Upper CI	Yorkshire and the Humber	England
2001 - 03		-	18.8	18.4	19.1	18.9	19.2
2002 - 04		-	19.1	18.8	19.4	19.0	19.4
2003 - 05		-	19.2	18.9	19.6	19.2	19.6
2004 - 06		-	19.7	19.3	20.0	19.5	19.9
2005 - 07		-	19.7	19.3	20.0	19.6	20.0
2006 - 08		-	19.9	19.5	20.2	19.7	20.2
2007 - 09		-	19.8	19.5	20.1	19.8	20.3
2008 - 10		-	20.1	19.7	20.4	20.1	20.5
2009 - 11		-	20.4	20.0	20.7	20.3	20.9
2010 - 12		-	20.6	20.2	20.9	20.4	20.9
2011 - 13		-	20.7	20.4	21.0	20.4	21.0
2012 - 14		-	20.8	20.5	21.2	20.5	21.1
2013 - 15		-	20.8	20.5	21.2	20.5	21.1
2014 - 16		-	20.7	20.4	21.0	20.6	21.1

Source: <https://www.ons.gov.uk/releases/healthstatelifeexpectanciesuk2014to2016>

The main causes of death in older people

Among older adults (65 and older), cardiovascular diseases (chronic ischaemic heart disease, heart failure and stroke) are the most common cause of death and account for 32% of deaths. Cancer is the second most common cause of death (25% of deaths)<sup>3</sup>. Respiratory conditions accounted for 14% of deaths, whilst dementia accounted for 12% of deaths.

The proportion of deaths attributable to flu or pneumonia in the 65 years and over population was 6%, rising to 7% in the over 80 years population.

In our residents over the age of 80, the proportion of deaths attributable to circulatory diseases rises to 34%, followed by cancer (19%) and respiratory diseases (16%). An increasing proportion of deaths are as a result of multiple organ failure and frailty associated with old age.

Recommendation

NHS and local authority partners further investigate fall in life expectancy for men in Ovenden

Changing Demographics in Calderdale

Ageing populations is a worldwide phenomenon, and one which can bring challenges, such as increasing demand on health and social care services, long-term care and funding, if our health through the years is not optimal. Calderdale is no different and is experiencing these same pressures.

But the good news is we are now living longer than ever before, and the underlying causes of this significant change include improved living conditions and advances in health and social services, in terms of prevention, treatment and care.



Age distribution of the UK population, 1976 to 2046 (projected)

	0 to 15 years (%)	16 to 64 years (%)	Aged 65 and over (%)	UK population
1976	24.5	61.2	14.2	56,216,121
1986	20.5	64.1	15.4	56,683,835
1996	20.7	63.5	15.9	58,164,374
2006	19.2	64.9	15.9	60,827,067
2016	18.9	63.1	18.0	65,648,054
2026	18.8	60.7	20.5	69,843,515
2036	18.0	58.2	23.9	73,360,907
2046	17.7	57.7	24.7	76,342,235

Source: Office for National Statistics

Who is older in Calderdale?

There is no clear definition as to what defines an ‘older adult’; in research studies, age ranges vary widely. Traditionally, retirement at 65 was equated with old age but as there is no longer an official retirement age, older age may vary depending on the inequalities people face.

The Mental Health Foundation defines ‘later life’ as starting at 50 years and although acknowledging that many people at this age do not consider themselves ‘old’, they take this approach due to several critical factors. Many people will begin to experience physical decline or deterioration in their 50s, and many begin to seriously plan for their retirement, take early retirement or find it difficult to secure employment. It’s important therefore to recognise that whilst we focus on the over 65s generally in this report, decline in physical and mental wellbeing can start much earlier.

There are approximately 38,000 people aged 65 or over in Calderdale (18% of our population); this is still less than the number of people aged 0-16 approximately which is 43,500. However, it is estimated that by 2024 the number of people aged 65 and over will be 44,500 which is an increase of 17% in a relatively

short time period. Overall, this is an increase of 27.3% in the older population, compared to 2005.

By 2024 there will be a rise of 25% in number of people aged 75 and over from 16,300 to 21,800 and the number of people aged over 85 will have gone up from 4,800 to 5,900, an increase of 23%.

54% of the population aged 65 or over are women – rising to 61% among the 80 and over population.

57% of the population growth in Calderdale over the past decade has been due to an increase in over 65 year olds. Between 2006 and 2016 the overall population increased by 13,500 and over 65s have increased by 7716.

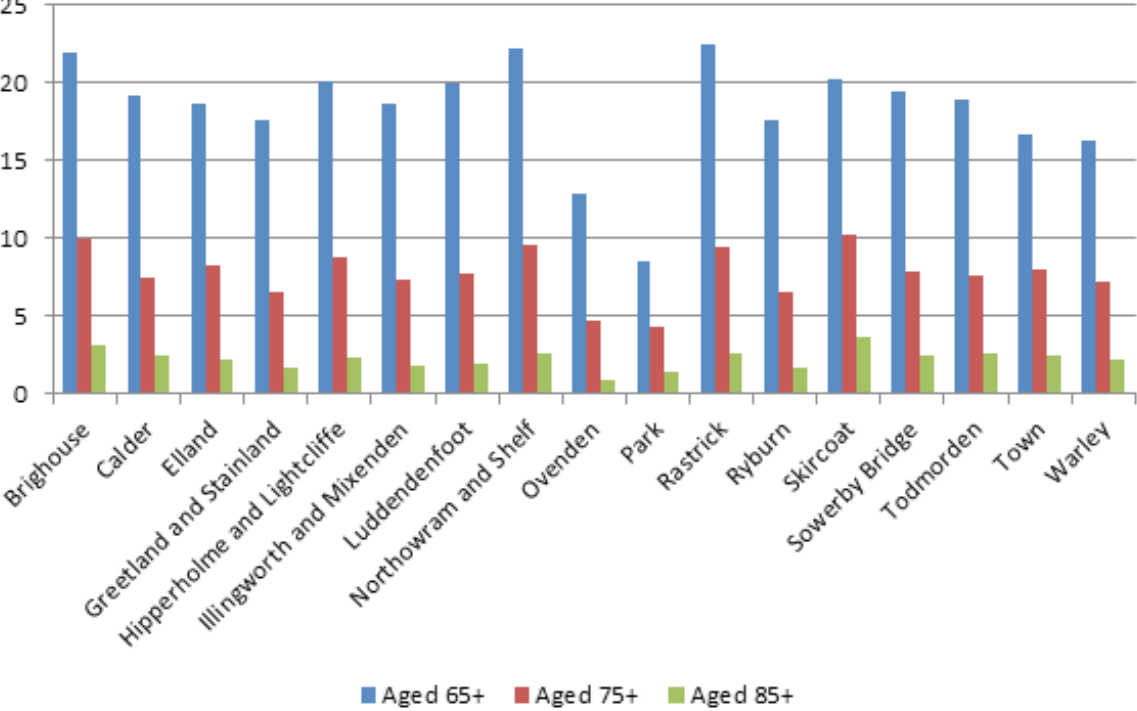
The population is ageing, we are all familiar with the challenges of meeting the needs of the growing number of older people here in Calderdale, and we all work tirelessly to ensure the right care and support services are in place when older people need them. While this reactive approach is indeed vital to helping those in need of our support, the increasing demand suggests that this approach will be unsustainable in the long-term. As a result of the ageing population, the old age dependency ratio (OADR) is increasing.

The OADR is the number of people over 65 years old for every 1,000 people aged between 16 and 64 years old. In mid-2016 the UK’s OADR was 285. It is a useful measure to understand how the balance in the population will change, particularly when planning for the needs of the different age groups.

The OADR in Calderdale in 2006 was 238, which increased to 289 in 2016 and is projected to increase further to 354 in 2026 and further still in 2036, up to 443.

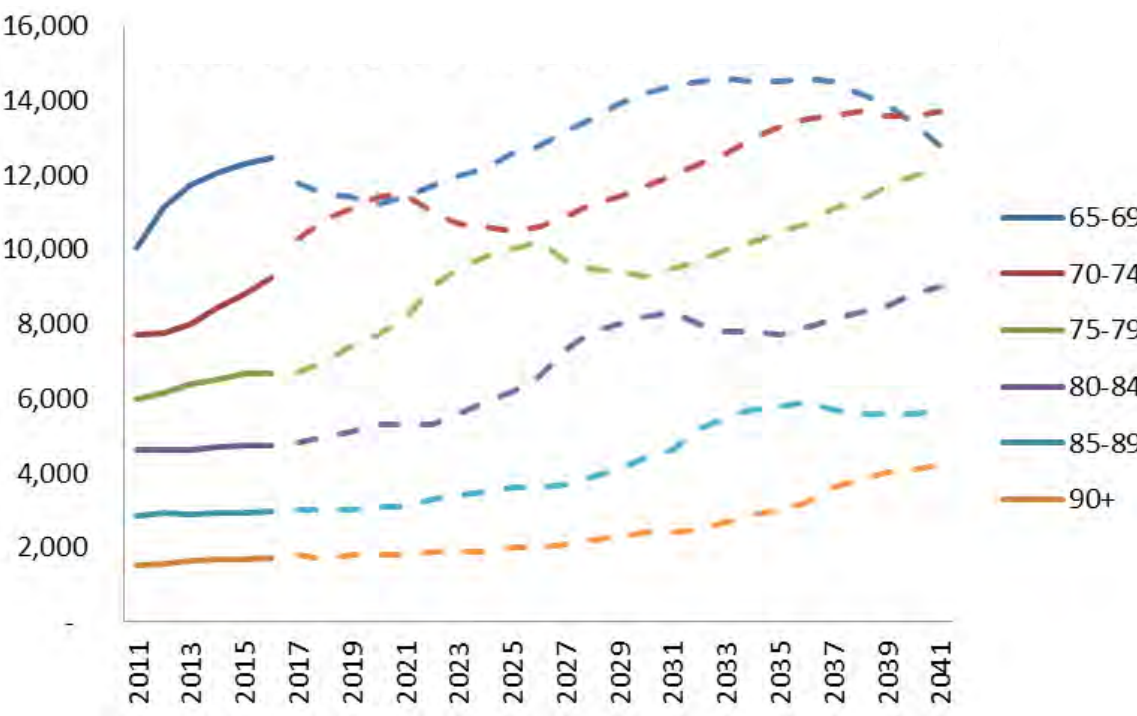
Immigration in the UK has been higher than emigration since the early 1990s. In 2015, levels of immigration (631,000) were more than double those of emigration (298,000). The highest immigration levels to date were seen in 2014 with 632,000 people coming to the UK. Rises in immigration have tended to coincide with the expansion of the EU, allowing more people to freely migrate to the UK. Immigration has fallen with provisional data for the year ending 2016 showing immigration dropped to 588,000, while emigration increased to 339,000. Immigration generally occurs in younger people rather than over 65s, so can balance out to some extent an ageing existing resident population. If immigration levels fall this will therefore increase the proportion of our over 65s population to a small extent.

Percentage of older people by ward



As can be seen, the distribution of people aged over 65 is fairly even, apart from in Ovenden and particularly Park ward.

Calderdale population (65+): estimated and projected



The graph highlights substantial increases in all Calderdale populations aged over 65 over the next 20 years.

Overall there is expected to be an increase of 20,000 in those aged 65+ between 2017 and 2037.



## Older People as Assets

Seeing older people as assets to be valued and part of the solution for sustainable development will be crucial to Calderdale, as our communities grow older. This report recommends using an evidence-based framework for healthy ageing across the life-course - the World Health Organisation's (WHO) Life-Course Approach to Healthy and Active Ageing - which offers a long-term, sustainable framework for maximising opportunities to embrace and embed all the positive aspects of ageing.

The framework provides a spectrum for reviewing the current situation in Calderdale, as well as exploring the latent potential of our older residents. When they are engaged as an asset, our older people can be enabled to remain independent, active and in good health - whilst continuing to make a positive contribution to their communities, our economy and society as a whole.

Older people participate in society in many ways, for example through voluntary work, unpaid care and employment. This is estimated to contribute between £40bn and £61bn a year to the UK economy<sup>4</sup>.

### Case study

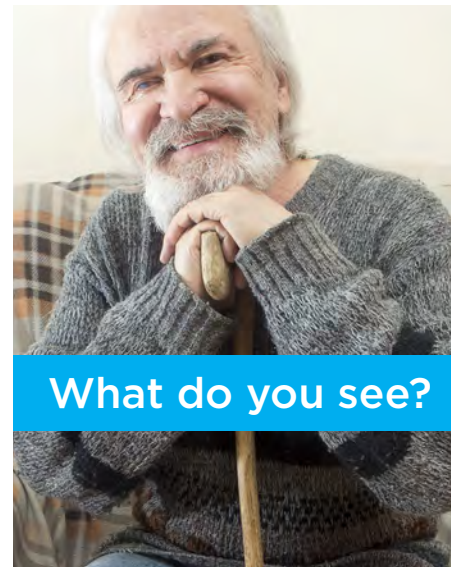
Molly and Bill (Making Our Lives Lively and Being Involved in Local Life) is a partnership between VAC, Calderdale Clinical Commissioning Group and Calderdale Council and supported by a National Lottery Awards for All grant and the Abraham Ormerod Trust. It is a project that works with volunteers and 6 residential and intermediate care settings were part of the pilot, where creative activities are provided by a mixture of paid providers from the voluntary and private sector and volunteers. The aim is to stimulate and engage residents, utilise lost skills, maintain and improve current capabilities and develop social skills and confidence. Volunteers are recruited, trained and supported to deliver a range of activities that are matched to the needs of the residents and the settings.

Activities include:

- **Beat it Music sessions**
- **Memory making - reminiscence sessions**
- **Chair based circle dancing**
- **Cookery**
- **Family History**

Between May and September 2017, 255 volunteering hours were accumulated at a value of £2,155. They led 25 volunteer activities and in total the project delivered 134 creative activities over 185 hours with 963 people attending.

"A very capable volunteer started volunteering at Norton House. Initially she supported the circle dance sessions and spent time getting to know residents who don't socialise in the wider group very much. She didn't feel able to lead an activity. After 4 months of volunteering, she felt more confident and wanted to share some of her skills and interests with residents. With the support of the Molly and Bill Coordinator and after chatting to residents and staff, she devised and delivered 3 sessions - a bingo session with bingo lingo, helping residents make bird feeders to hang outside their rooms, and potting indoor flowering plants with residents to bring colour to their rooms as autumn approaches."



### Implications

As highlighted by many commentators, there will continue to be major changes in how our population is comprised. We can frame how we see this challenge in a number of ways, either positively, for example increasing number of people who have years of life experience and resources or negatively, for example by reinforcing ageism.

Some of the most important barriers to developing good public policy on ageing, are pervasive misconceptions, negative attitudes and assumptions about older people. Although there is substantial evidence about the many contributions that older people make to their

societies, they are frequently stereotyped as dependent, frail, out of touch, or a burden. These ageist attitudes limit older people's freedom to live the lives they choose and our capacity to capitalise on the great human capacity that older people represent.

Older age is characterised by great diversity. A large proportion of the diversity in capacity and circumstance observed in older age, is the result of the cumulative impact of advantage and disadvantage across people's lives. The physical and social environments in which we live, are powerful influences on Healthy Ageing.

### Ageism harms the public's health<sup>5</sup>

- Negative attitudes about age can begin to form among children as young as six years old.
- These attitudes can be generated and reinforced in a number of ways, including:
  - negatively framed headlines in the media;
  - pressure from the beauty industry to use "anti-ageing" products;
  - lack of regular contact between older and younger generations;
  - age-based prejudice in the workplace.

As a result, ageist attitudes solidify as we grow older, into a set of stereotypes about older people and the ageing process, which can be hard to unseat.

- Ageist attitudes harm older people, as they lead to direct age-based discrimination - which can promote social exclusion, impact on mental health, and affect wider determinants of health like employment.
- Ageist attitudes also harm individuals who, as they grow older, begin to apply negative age stereotypes to themselves. Previous research has shown that those with more negative attitudes to ageing live on average 7.5 years less than those with more positive attitudes to ageing.

- There is now a growing body of research, evidencing the real-life consequences that negative attitudes to ageing have on individual health outcomes, such as memory loss, physical function, and even the risk of developing dementia. This provides a compelling case for a public health campaign and policy interventions aimed at deconstructing societal drivers of ageism.



Inequalities in Older Age

A good life in older age shouldn't be dependent on where we live or how much money we have, but is something we should expect for everyone. Yet, for too many people, the experience of later life is difficult and challenging and, as a society, we are a long way off this aspiration. We should not take the view that it's just a part of growing older. There are actions we can take now to make changes and ensure a good later life for all. Failure to address inequalities risks a future where an even smaller group of people experience a good later life.

“Amongst people aged between 46 and 65 years old, those in the highest 20% income bracket have a household income about three times greater than the bottom 20%. For people aged between 66 and 85 the difference is more than double.”<sup>6</sup>

However, there are inequalities in people's health experience as they age as highlighted in Public Health England's Health profile for England.

Nor should gender, race, disability or sexuality determine the quality of our later life.

Older people living in disadvantaged areas have less access to services than those living in more affluent communities

People living in the most disadvantaged areas are also much less likely to receive treatment than those in the least deprived areas\*

\*Source: Guimaraes, M. & Allen, S. (2011). Health care for older persons in England and the United States: A context of systems and values.

Older adults who are most well-off have higher walking speeds

A person aged 71 with the most wealth has an average walking speed of 0.91 metres per second compared to 0.75 metres per second for someone with the least wealth\*

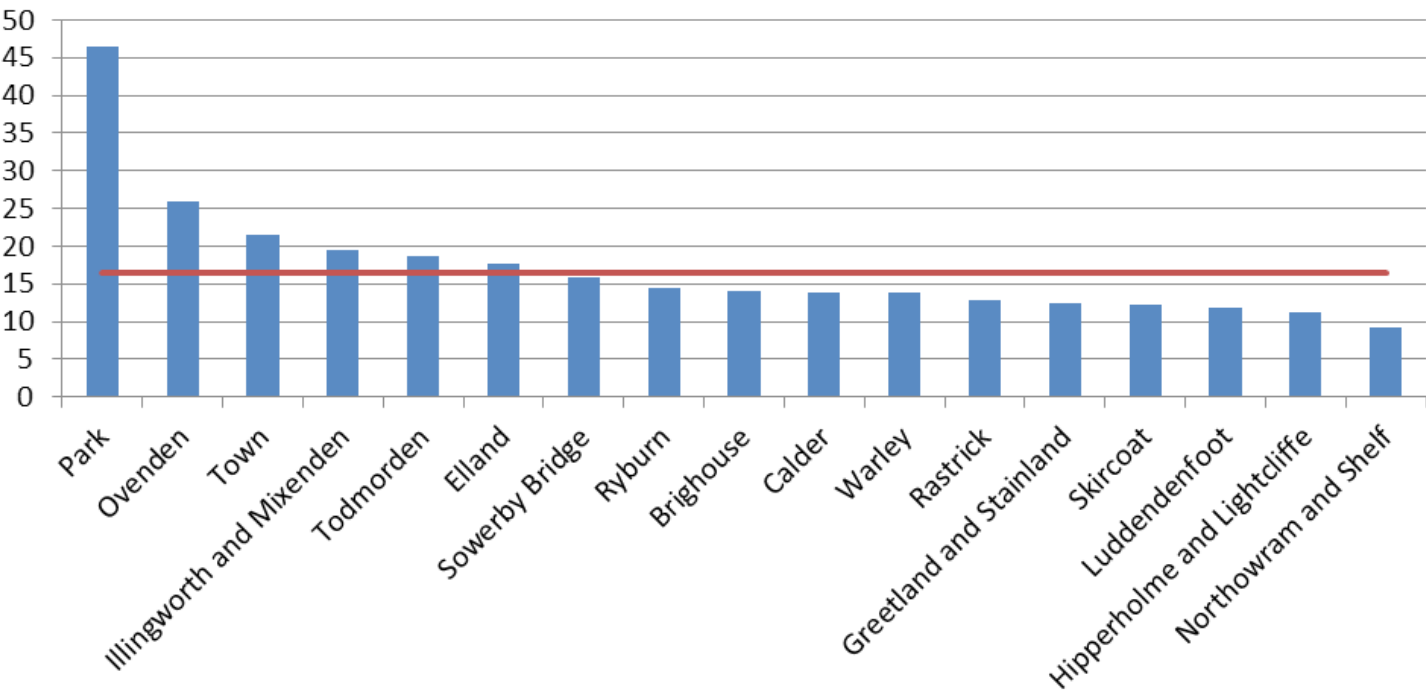
\*Source: Zanotto, P., Sacker, A. & Head, J. (2015). Relationship between wealth and age trajectories of walking speed among older adults: evidence from the English Longitudinal Study of Ageing.

Older women are at greater risk of not receiving the full state pension

Only 36% of women aged 65 to 69 years received the full state pension in 2014 with most receiving over 50% but less than 100% of its value\*

\*Source: Women and pensions (2015).

Percentage aged 60+ who are income deprived



Despite much lower numbers of people who are aged over 65 in Park, almost 50% are classified as income deprived. The number who are income deprived is almost double that of the next ward.

2.3% aged 65+ are Asian. This is different to our ethnicity groupings across all ages which shows that 8.3% are from a Asian or Asian British background.

Recommendations

Assess whether access to benefits can be maximised across the community with particular emphasis given to those areas in which income deprivation is higher than the rest of Calderdale.

Demographic changes and health and care costs

There is concern that the demographic pressures of population ageing will lead to an unprecedented rise in public expenditure, to levels unsustainable under current financing arrangements. Getting older is associated with increased healthcare costs.

The population is living longer. This is good news in that most people are experiencing more years of life, but it also means that there are more people with single and multiple Long Term Conditions (LTCs). LTC's include illnesses such as heart disease, Chronic Obstructive Pulmonary Disease (COPD), diabetes, dementia, hearing and vision impairment, and cancer.

LTCs are important because there is scope to prevent some of them, by modifying lifestyles and behaviours and promoting healthy living. They also contribute to inequalities, by affecting an individual's ability to earn.

Based on the four chronic conditions of diabetes, chronic heart disease, stroke and cancer, for 2015/16 Calderdale has around 38,850 patients on NHS GP Practice registers. Applying the fact that between 40-80% of the big four diseases can be prevented to the 2015/16 local GP Practice register statistics above, there are in the region of 20,000 people in Calderdale, many of whom are over 65, for whom their condition was likely to have been preventable.

The challenge we have now is that some 40% of people over 65 have some form of long term health problem or disability in Calderdale. Even if we managed to keep this percentage the same as now, we have seen increases from 14,120 in 2011 to 16,231 in 2015 and projected forward, we will reach 19,954 by 2025.

People with LTCs tend to need more health and social care, and family members and friends may need to take on a carer role to support a person with a LTC. Individuals are more commonly found to have multiple LTCs rather than just one. This is an important issue, because the effective management of individuals with multiple co-existing conditions, is more complicated.

Getting older is also associated with having more than one health condition at the same time (often referred to as multi-morbidity) and consequently complex healthcare needs. A recent study found<sup>7</sup>:

• **Total per person annual healthcare costs increased from age 80-84 years (£3,588) to 85-95 years (£4,018) before reaching a maximum in the 90-94 age group (£4,115) and then declining after that (£3,931 for 95-99 years, £2,867 for 100 years +). Secondary care costs were highest in the 90-94 age**

**group (£2,737), and primary care in 95-99 year-olds (£676).**

• **Although women were more likely than men to use healthcare services, there were no differences between healthcare costs overall between men and women.**

• **The likelihood of using healthcare services did not change with age, except for people aged over 100 who were less likely to incur healthcare costs than 80-84 year-olds.**

• **As the number of multi-morbidities in each individual increased, so did the likelihood of increased healthcare costs.**

• **Proximity to death was the strongest predictor of incurring high healthcare costs. However, the cost of end-of-life care decreased with increasing age. Healthcare costs in the last 12 months of life were £10,027 for people aged 80-84 years compared with £7,021 for people aged over 100 years.**

Professor Andrew Street<sup>8</sup> estimated from work in one outer London borough that one of the crucial financial drivers behind social and NHS costs is multi- morbidity. This is a key reason for investment in improved primary care, prevention, case management and integrated/co-ordinated care.

In 2014 there were 15.4 million people with at least one long term condition. People with long term conditions consume 70% of the NHS budget and about the same percentage of social care budget.

The total number of people with long term conditions is expected to stay the same (with rising obesity that will change over a longer time frame) but the number with three or more conditions rises from 1.9 million to 2.9 million by 2018. It is increasing multi-morbidity that is driving costs not age or demographics per se.



Patient Type	Cost to the NHS	Approx % of population
Healthy patient	£288 per year	64%
1 long term condition	£783 per year	19.8%
2 long term condition	£1521 per year	11% with 2 to 3 LTC
3 long term condition	£2599 per year	11% with 2 to 3 LTC
5 long term condition	£5512 per year	3.7% with 4 to 6 LTC
6 long term condition	£8083 per year	3.7% with 4 to 6 LTC

Admissions Data

- There are 26 unplanned hospital admissions every day for people over 65
- Following discharge from hospital, around 16% of patients over 65 do not return to their normal place of residence
- During 2016/17 over 65s made up around 34% of all emergency admissions, 64% of unplanned hospital bed days and 51% of costs despite making up only 18% of the population



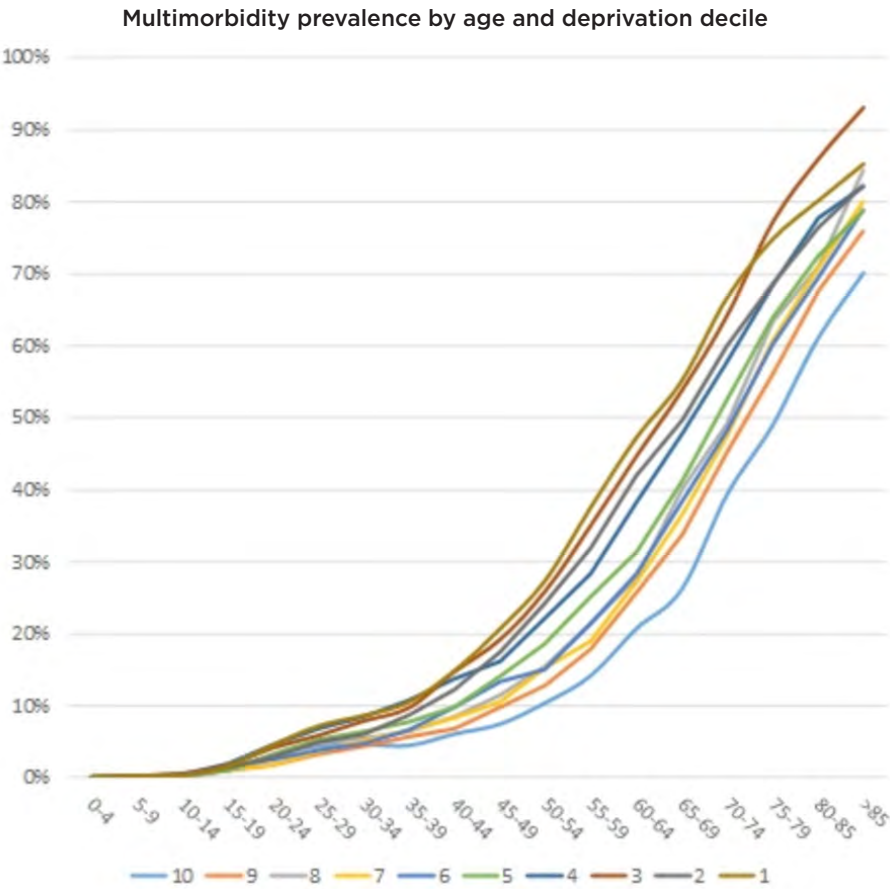
Implications

Ageing on its own does not drive healthcare costs. Instead, the increasing number of health conditions and age-related impairments, along with the proximity to death, are more strongly linked to healthcare costs than age alone.

Multi-morbidity and nearing the end of life, appear to be the main drivers of costs in the 80+ population, rather than age.

For healthcare delivery, this suggests a shift away from predicting healthcare costs based on age alone; we need to ensure investment is in improved primary care, prevention, case management and integrated/co-ordinated NHS and social care.

The likelihood that people will need medical care, and its cost, might be measured by the number of different conditions at one time, frequency of contact with the health service, proximity to death, and socioeconomic status.



We need to change traditional services, which are often organised around single conditions.

Better integration of NHS and social care, with improvements to information sharing across services, may help. This is likely to require long-term strategy and investment.

All the evidence points to the need to invest in preventative approaches across the life course.

**Recommendation**

Support NHS and social care service developments which ensure that multi morbidity is more effectively managed.

Social prescribing

Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being. Social Prescribing helps people with long-term health conditions to access a wide variety of services and activities provided by voluntary organisations and community groups. It relies on bringing together health, social care and voluntary sector professionals, who work together in a co-ordinated way to plan care for people with long-term health conditions.

Social prescribing is an opportunity to implement a sustained structural change to how a person moves between health and social care professionals and around their community. To fully address the social determinants of health, social prescribing schemes view a person not as a ‘condition’ or disability, but quite simply as a person.

An evaluation by Sheffield Hallam University’s Centre for Regional Economic and Social Research found that as a result of social prescribing within Rotherham<sup>9</sup>:

- non-elective inpatient episodes reduced by 7%
- non-elective inpatient spells reduced by 11%
- Accident and Emergency attendances reduced by 17%.

82% of service users, regardless of age or gender, also reported a positive change in their well-being within four months of being issued with a social prescription.

**Recommendations**

Develop the “Taking Control” self-management programmes by supporting the VCS to help provide this

Develop the Staying Well approach within localities as part of a wider development of social prescribing

Older People and mental health

Depression affects around 22% of men and 28% of women aged 65 years and over, yet it is estimated that 85% of older people with depression receive no help at all from the NHS.

In 2014 it was estimated that the total cost of dementia in the UK was £26.3 billion, with an average cost of £32,250 per person<sup>10</sup>.

It is estimated that up to 40% of older adults living in a care home experience depression, and it often remains undetected. It is estimated that up to 60% of older adults who have had a stroke may experience depression, as well as up to 40% of those with coronary heart disease, cancer, Parkinson’s, and Alzheimer’s disease.

Social Inclusion, not Isolation

30% of the public believe “being lonely is just something that happens when people get old”<sup>11</sup>

Changing social attitudes can encourage the participation of older people in society and promotes social Inclusion. Older people are particularly vulnerable to social isolation and loneliness, due to loss of friends and family, mobility or

income. Social isolation and loneliness have a negative impact on an individual’s health and wellbeing.

The proportion of lone pensioner households in Calderdale is slightly higher than the England average. Across Calderdale 11,210 pensioners live alone.



Ward 2016	Number living alone	Pensioners living alone (%)
Brighouse	771	35.6
Calder	678	38
Elland	690	35.1
Greetland and Stainland	502	31.2
Hipperholme and Lightcliffe	616	29.6
Illingworth and Mixenden	632	32.3
Luddendenfoot	627	34.4
Northowram and Shelf	696	31.1
Ovenden	559	38.5
Park	509	38.1
Rastrick	645	29.7
Ryburn	578	34.7
Skircoat	793	34.6
Sowerby Bridge	735	36.8
Todmorden	659	33.8
Town	814	42
Warley	706	34.6

Case study

In 2014 a new project, ‘Staying Well’, was designed to explore the impact of bespoke, community-based interventions for lonely and isolated older people. The programme aimed to consider how a range of interventions could impact positively on the health and wellbeing of individuals; also how it could affect demand on primary care services. It was established from an emerging evidence base around the health consequences of social isolation and loneliness, e.g. that lacking social networks is as damaging to health as smoking 15 cigarettes a day. Considered a ground-breaking approach at the time, it was enthusiastically supported by the Council, CCG and the voluntary sector as a key initiative in tackling physical and mental health.

Four Staying Well workers were located in four voluntary sector community hubs, working closely with the Council’s neighbourhood workers. The Staying Well workers carried out face-to-face ‘holistic’ and ‘asset-based’ visits with older people to ascertain their needs, wants and skills. Workers facilitated attendance at a range of community and

local activities, sometimes attending with older people. As a response to ‘grass roots’ pressures to improve community capacity and cohesion, an important focus of the project was to create more connected communities. Integral to this was the use of ‘micro-commissioning’ budgets. Each Staying Well ‘hub’ was given a devolved fund of £50,000 to build community capacity, strengthening existing local provision and developing new and innovative activities. Each hub approached this differently, some undertaking a grants based approach whilst others used the funding to provide facilities for use by local groups. The independent evaluation conducted by Lincoln University concluded that “the micro-commissioning exercise was particularly effective.”

The Staying Well pilot saw some really good community-led commissioning and it was partly due the success of this model, that the Community Foundation for Calderdale asked Staying Well to develop micro-commissioning across Calderdale for their Isolation Fund.

The Staying Well partners developed a plan to distribute equally £50,000 micro- commissioning money across the 17 wards of Calderdale, meeting 2 key objects, namely, sustainable community solutions to address or prevent isolation and increased capacity in communities to direct local development and take decisions on local funding.

More broadly, the relationships built through Staying Well have reaped benefits in other areas. For example, one of the community hubs has become involved in Calderdale’s suicide prevention group. Similarly, a programme around “Taking Control of Pain” that had been run by the local acute trust in the hospital is now being delivered in the community, in a collaboration between the acute trust, a voluntary sector support organisation (VAC) and a new service staffed by social workers, based in the local market, providing accessible, face-to-face information and support “to stay healthy, independent and in control of your life for as long as possible.”



## Case study

In late 2016, Calderdale West Yorkshire Fire & Rescue Service contacted the Staying Well project to talk about how they might be able to help them pilot a new initiative about the way they conducted home fire safety checks. They were looking to add value to their existing home fire safety checks, and also make sure that limited resources were targeted more effectively.

In Calderdale, the Fire Service visit approximately 2000 homes a year, in the past this was conducted without any referral criteria. Following a public consultation, the fire service moved to a triage system where home visits were only undertaken for people who had vulnerabilities – frailty, ill health, etc. This was rebranded as a Safe and Well visit and the scope of the visit expanded to include looking at other risks, in addition to fire safety, including risk of falls and social isolation.

The Todmorden Fire Station was selected to lead a pilot, as whilst this is a retained station, it is not staffed 24/7; consequently all members of the crew are required to live within 5 minutes of the station. This also meant that they are known and trusted members of the community and already had a track record of working with community

groups and had strong links, e.g. to the Dementia Friendly Todmorden group.

Through the Safe & Well visits, the Fire Service were able to engage with people who were more vulnerable and identify where they might benefit from some additional support, such as advice and signposting to other services such as Staying Well, Social Services, Falls prevention services and other support and advice. Often they were able to identify people who were not already known to statutory services and offer a referral to organisations and groups, that could help people improve their quality of life.

This proved to be a very fruitful relationship and was subsequently augmented by linking people who attended the Daisy's Café, run by Dementia Friendly Todmorden, into the Safe & Well visits so opening conversations about how people could access additional support to improve their quality of life. This has culminated in Dementia Friendly Todmorden being successful in applying for funding to provide aids and equipment to people identified via the Safe & Well visits from the micro commissioning grants managed by Staying Well from the Community Foundation for Calderdale Todmorden Mental Health Commission funds. The equipment, such as easy grip cutlery and thermal plates

and bowls, are available at the Daisy's Café for people to try, and if they think that the equipment would be beneficial they are referred to the Fire Service for a Safe and Well visit.

This enables the Fire Service to visit a person at home, provide advice and signposting to other services and groups as appropriate and, thanks to the micro commissioning funding to Dementia Friendly Todmorden, provide the equipment for the individual to enable them to live more independently and improve their quality of life. The service is often able to engage with people who would otherwise not be aware of what was available to help them and would be reluctant to involve formal statutory agencies.

As a result of the relationship between the Fire Service, Dementia Friendly Todmorden and Staying Well this initiative has resulted in vulnerable older people in the community being able to remain more independent and resilient, become more connected to their community and, through proactive preventative measures, reduce the need for more costly interventions by statutory health and social care services and reduce emergency hospital admissions.

## Dementia

Dementia is not a specific disease. It's an overall term that describes a group of symptoms associated with a decline in memory or other thinking skills, severe enough to reduce a person's ability to perform everyday activities. Alzheimer's disease accounts for 60 to 80 percent of cases.

Today, nearly 50 million people worldwide have dementia, with this figure projected to increase to 75 million by 2030 and to 132 million by 2050. Dementia causes not only disability and dependency for individuals affected by the condition, but can also have a profoundly detrimental effect on family and other carers, who are at high risk of developing depression and anxiety disorders.<sup>12</sup>

With no disease-modifying treatments for dementia currently available, health-care systems are in danger of becoming overwhelmed by the future costs of caring for people with dementia. Around 850,000 people are living with dementia in the UK and this figure is set to rise to over 2 million by 2050. According to a survey by Alzheimer's Research UK<sup>13</sup>, dementia is the most feared health condition for people over the age of 55 – more than any other life threatening disease, including cancer and diabetes.

It also presents a considerable health and social care challenge globally.

Public Health England's Dementia Intelligence Network (DIN) has published new data on the dementia profile, which suggests the recorded prevalence of dementia in the over 65 population has shown a small but significant increase from 4.29% in April 2017 to 4.33% in September 2017. There has been a marked increase in the number of cases during the last few years, which is in part due to increased awareness and better diagnosis, as well as increasing numbers of older people.

The numbers are strikingly large and for each and every person with a diagnosis of dementia, the impact is enormous for not only themselves, but also the people who share their lives.

Although the symptoms of dementia generally occur in later life, the underlying brain pathology develops many years earlier. As outlined in the Lancet Commission, dementia is likely to be a clinically silent disorder that begins at mid-life (about age 40-65 years) and only in the terminal stage manifests as symptoms of dementia.

This hypothesis suggests a window of opportunity to intervene by addressing dementia risk factors in middle age.

Evidence<sup>14</sup> suggest that if we adopt a life-course approach, there are nine potentially modifiable risk factors at different stages of life, that if eliminated, might prevent more than a third of cases of dementia: low educational level in childhood, hearing loss, hypertension, obesity, smoking, depression, physical inactivity, social isolation, and diabetes. Diagnosis is often delayed due to the mistaken belief that dementia is a natural consequence of ageing, or because of an individual's reluctance to seek help about their memory problems.

Although therapies to modify the course of dementia are not currently available, much can be done to manage its manifestations—for example, pharmacological treatments have clinically important effects on cognition, and psychological, environmental, and social interventions can help to alleviate behavioural and psychiatric symptoms.

Public health strategies targeting the main lifestyle, clinical, and social risk factors could reduce the incidence of dementia or substantially delay its onset. Naturally, prevention of all potentially modifiable cases of dementia will not be feasible, but pushing back the age of dementia onset would bring enormous benefits. Estimates<sup>15</sup> suggest that even a delay in onset of 1 year could prevent more than 9 million cases of dementia by 2050 and delaying onset by 5 years could halve the prevalence of dementia globally.

Despite decades of research, there is currently no cure for dementia. However, it is now widely accepted that there are steps that can be taken to lower the risk of developing dementia.

A healthy lifestyle may help lower the risk of dementia and this entails:

- **keeping physically active**
- **maintaining social engagement**
- **reducing smoking**
- **management of hearing loss, depression, diabetes and obesity**
- **active treatment of hypertension in middle aged (45-65 years) and older people (over 65 years)**

Age is a leading risk factor, as it often comes with changes such as weakening of the body's natural repair systems. However, dementia is not an inevitable part of ageing.

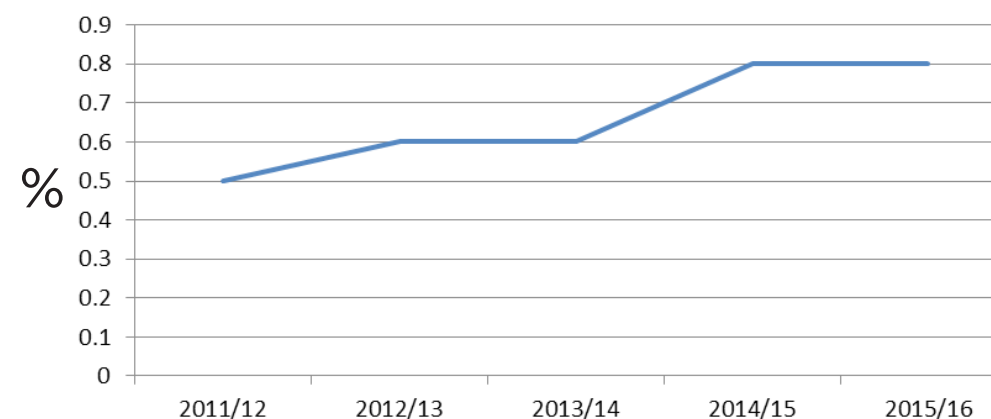
In the same way that we cannot control age as a risk factor, we also cannot control whether we are genetically predisposed to developing dementia – although very few dementias are hereditary. This is also the case for ethnicity, as there

is evidence to suggest that people of certain ethnicities, including South Asian, African and African-Caribbean populations, are at higher risk compared to white European populations.

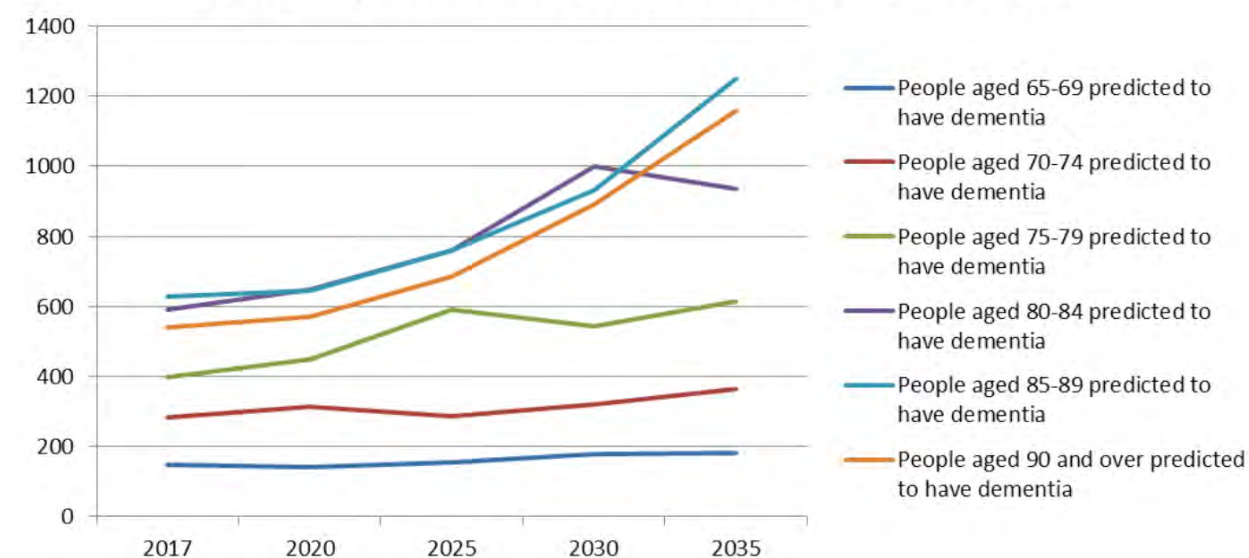
Smoking is one of the biggest lifestyle risk factors for dementia. It doubles the risk of dementia by increasing the risk of cardiovascular disease, diabetes and stroke, narrowing the blood vessels in the heart and brain, and causing oxidative stress which damages the brain. Therefore, one of the easiest ways to prevent dementia, and the other conditions smoking can lead to, is to quit smoking.

In Calderdale there has been a steady increase in the percentage of people diagnosed with dementia and increasing numbers of hospital admissions. The indications are that dementia cases will increase to over 4500 within less than 20 years from a baseline of approximately 2500 now. This will have profound impacts on health and social care costs and emphasises the importance of effective public health interventions now.

## Dementia Prevalence - All Ages



## People predicted to have dementia Calderdale



### Recommendation

Develop a campaign to increase public awareness of the steps that can be taken to reduce risk of dementia



Falls

Falling over can happen to anyone, but for older people the risk is particularly high and the consequences potentially severe, including distress, pain, injury, loss of confidence, loss of independence and mortality. Falls are a common and serious health issue for older people, with around a third of all people aged 65 and over falling each year, increasing to half of those aged 80 and over. In around 5% of cases a fall leads to fracture and

hospitalisation, which is costly for health services and the wider economy. There are around 255,000 falls-related emergency hospital admissions in England, among patients aged 65 and over each year, and it is estimated that fragility fractures cost the UK around £4.4 billion, of which 25% is for social care<sup>16</sup>.

Therefore preventing falls is important for the health and wellbeing of older people and those that care for them, as well as the future of our NHS and social care services. As can be seen in the table below, emergency hospital admissions vary greatly across Calderdale. Park, Todmorden, Ovenden and Rastrick have significantly higher rates of admission. Park ward is particularly high.

Fortunately, there are a whole host of things that can be done to help prevent falls and fractures. One example is engaging in regular physical activity, to develop and maintain strength and balance. However new research carried out by IPSOS Mori for the Centre for Ageing<sup>17</sup> Better shows that more than 40 per cent of over 70s don't realise how important good strength and balance is to reduce falls, and that people of all ages are confused about what activities help with improving their strength and balance. Poor muscle strength increases the risk of a fall by 76% in older adults. So raising awareness about what individuals can do to reduce the risk of falling is important, but we must also ensure that appropriate and effective services are in place.



Ward 2016	Emergency hospital admissions for hip fracture in 65+ standardised admission ratio	LCL - Lower confidence limit	UCL - Upper confidence limit
Park	206.4	167	251.8
Todmorden	146.3	118.6	177
Ovenden	137.3	102.2	178.9
Rastrick	126.7	100.3	156.3
Northowram and Shelf	104.5	82	130.5
Town	100.8	77.1	128.1
Illingworth and Mixenden	100.4	75	130.7
Skircoat	95.5	75.4	118.8
Luddendenfoot	83.8	60.8	111.5
Ryburn	83.6	58.3	113.6
Elland	82.9	61.6	107.3
Sowerby Bridge	80.9	60.2	106
Greetland and Stainland	79.5	56.3	108.2
Calder	73.1	52.7	98.5
Hipperholme and Lightcliffe	73	54	95.9
Brighouse	72.1	53.7	93.5
Warley	64.4	46.2	86.7

### Recommendations

Investigate reasons why Park ward has such high levels of admissions for hip fractures.

Ensure home hazard assessment and improvement programmes are in place across the borough.

Ensure that local approaches to improve housing address falls prevention.

Demonstrate actions taken to reduce risk in high-risk health and residential care environments.

Substance misuse

The proportion of older people with substance misuse continues to rise more rapidly than can be explained by the rise in the proportion of older people in the UK.

The “baby boomer” population born between 1946-1964 (now aged between 53 and 71 years old) is at highest risk of rising substance misuse in the older population.

The misuse of illicit drugs such as cannabis and amphetamines, prescription painkillers such as morphine and buprenorphine, as well as gabapentinoid drugs is now recognised as a growing public health problem.

Substance misuse in older people is associated with reduced life expectancy and accelerated ageing, which is further compounded by socio-economic deprivation.

Death rates in older people with substance misuse are higher than in the general older population.

Deaths related to poisoning from substances in older people have more than doubled over the past decade.

Recent revision of lower risk drinking guidelines for all age groups may still be too high for some older people, especially for those who have accompanying physical and mental issues and who are receiving medication.

Older people with mental disorders such as depression, anxiety, and personality disorder have higher rates of substance misuse than those without mental disorders.

Psychosocial factors such as social isolation, financial problems, retirement, life events, pain and insomnia have strong associations with alcohol misuse<sup>18</sup>.

- We will strive to;
- Have better informed policy and practice about preventing alcohol dependency in later life.
  - Improved health and well-being for people age 50 and over, who are at risk of developing substance misuse problems.
  - Ensure the delivery of more effective services to prevent alcohol dependency amongst the ageing population.

**Recommendation**

Focus Alcohol Awareness week and Dry January on older adults and the ‘baby boomer’ generation, to help people make healthier choices about alcohol as they age.

Excess winter deaths

Every year in England and Wales an average of 24,000 extra deaths occur in the months December to March than in other four-month periods of the year. Those known to be most vulnerable are older people aged 85 and over and those with chronic health conditions such as chronic renal disease, coronary heart disease, diabetes and chronic obstructive pulmonary disease (COPD). ONS shows that over the winter of 2016-17 there were 31,800 excess winter deaths in England and Wales’ among the over 65s, from cold-related illness such as heart attacks and strokes (compared to 20,800 the previous year)<sup>19</sup>. One third of all the excess winter deaths reported were caused by respiratory diseases. Trends will be carefully monitored over the next few years to show if this was a one off, or part of a pattern of increasing seasonal mortality. Calderdale data shows our excess seasonal mortality to be in line with the Yorkshire and Humber average. It is clear that some of this death is preventable, as excess death rates in England are higher than many equivalent countries.

**Recommendation**

Improve information sharing between health, social care and the third sector as a way of identifying vulnerable individuals who have poorly heated homes.

Period	Count	Index	Lower CI	Upper CI	Yorkshire and the Humber	England
Aug 2006 - Jul 2009	124	21.8	10.8	33.8	25.2	26
Aug 2007 - Jul 2010	128	22.7	11.6	35	25.5	26.5
Aug 2008 - Jul 2011	117	20.1	9.4	32	25.4	26.1
Aug 2009 - Jul 2012	144	24.4	13.4	36.4	21.9	22.6
Aug 2010 - Jul 2013	152	24.7	13.9	36.4	24.5	24.1
Aug 2011 - Jul 2014	132	20.9	10.5	32.2	22.7	22.3
Aug 2012 - Jul 2015	146	22.4	12	33.6	28.4	28.2
Aug 2013 - Jul 2016	144	22.1	11.8	33.3	24.2	24.6

Excess winter deaths index = (excess winter deaths / average non-winter deaths) x 100



## A good death

We don't like talking about death. It can be uncomfortable for the person who is dying, for their family and friends and for health professionals. However it's something that will happen to all of us at some point, and we would all want to have as good a death as possible.

What a good death looks like will be different for everyone, but there are some common themes that are important for everyone – be they someone who is terminally ill, their family or health professionals working with them.

An evidence review undertaken in 2016 suggests the most important factors to people at the end of life are that their preferences for the dying process are taken into account and that they are pain free. If we were in a position to do so, we would all want to be able to influence where we die, how it might happen, when it might happen and who would be there to support us.

We would also want to have our financial affairs in order and have given consideration to our funeral. We would all want to die during our sleep if at all possible, without suffering and with our symptoms and pain controlled.

When we reach the end of our life, we would all want the opportunity to say goodbye to our friends and loved ones, to feel that we lived our life well and to feel an acceptance of impending death. We would all want to avoid prolonging life unnecessarily, but at the same be sure that all the options had been explored and we had been involved in, and had some control over, the treatment options wherever possible. We would all want to maintain independence and be respected as an individual. We would all want support from our family, whilst not being a burden to them, and we would all want to feel our family had accepted and was prepared for our death.

What the above demonstrates is the importance of involving individuals in their end of life care as much as possible, and adapting their care accordingly. We should all have a clear end of life plan in place with our families, carers and friends.

This means we need to talk more about what a good death means to those we most care about, so they can represent our views if we are not able to do so ourselves. Writing down what we want to happen when we approach end of life should be something we all do when we are healthy, even if we might want to change things later on. The NHS website [www.nhs.uk/conditions/end-of-life-care/advance-statement/](http://www.nhs.uk/conditions/end-of-life-care/advance-statement/) is a really helpful place to start.

Equally, it demonstrates the importance of health care professionals working with individuals and their nearest and dearest to co-produce a good death at end of life. That means seeking explicit views and acting on them in a timely way to deliver personalised care that is person centred.

## Recommendations

All adults in Calderdale should have an 'advance statement' in place, setting out their preferences, wishes, beliefs and values regarding their end of life care. This should be promoted by all health care professionals.

Health Care Professionals should routinely ask for an individual's 'advance statement', and centre end of life care around that statement.





## A Framework for Healthy Ageing

The World Health Organisation (WHO) 'Life-Course Approach to Healthy and Active Ageing'<sup>20</sup> provides four themes: Healthy Behaviours and Lifestyles; Age friendly environment & community supporting health; Encouraging social inclusion & positive mental health, independence & productivity; and, Quality integrated services and preventative interventions, all of which cover a broad range of issues.

The concept of an 'age-friendly city/area' is not new; it was developed by the WHO and refers to a city (or community) that enables and encourages people to age well according to their needs, desires and capacities.

WHO identifies eight domains of an age-friendly community based on extensive research with older people and care givers across 33 cities worldwide. Each domain is characterised by a set of age-friendly features.<sup>11</sup>

The eight domains are:

- **Outdoor spaces and buildings:** A sufficient number of clean, pleasant and accessible public areas with adequate facilities (for example seating and toilets).

- **Transport:** Accessible, reliable, affordable and frequent public transport that has good coverage across city areas.
- **Housing:** Sufficient, affordable and adaptable housing (and home maintenance and support services) available to rent or buy in safe and convenient locations.
- **Social participation:** Conveniently located, accessible, well-lit venues that are easily reached by public transport.
- **Respect and social inclusion:** Regular consultation by public, voluntary and commercial services to ensure that services and products suit varying needs and preferences.
- **Civic participation and employment:** A range of flexible paid opportunities and options for older volunteers.
- **Communication and information:** A basic, regular, accessible and effective communication system across different formats.
- **Community support and health:** Adequate range of free or subsidised health and community support services (including home

care services) that are conveniently located and accessible.

### Recommendation

Adopt World Health Organisation's 'Life-course Approach to Healthy and Active Ageing'

In a growing elderly population, healthy ageing is becoming a crucial factor to reduce the burden of disease and disability and related healthcare costs. Emerging evidence<sup>21</sup> suggests that regular physical activity is among the most important lifestyle factors for maintenance of good health at older ages. Across developed regions of the world, inactivity ranks alongside tobacco, alcohol and obesity as a leading cause of reduced healthy life expectancy.

Sustained physical activity in older age is associated with improved overall health. Significant health benefits are seen among participants who become physically active relatively late in life<sup>22</sup>.

### Recommendation

Develop focused physical activity programmes with and for the over 50s as part of the Active Calderdale strategy

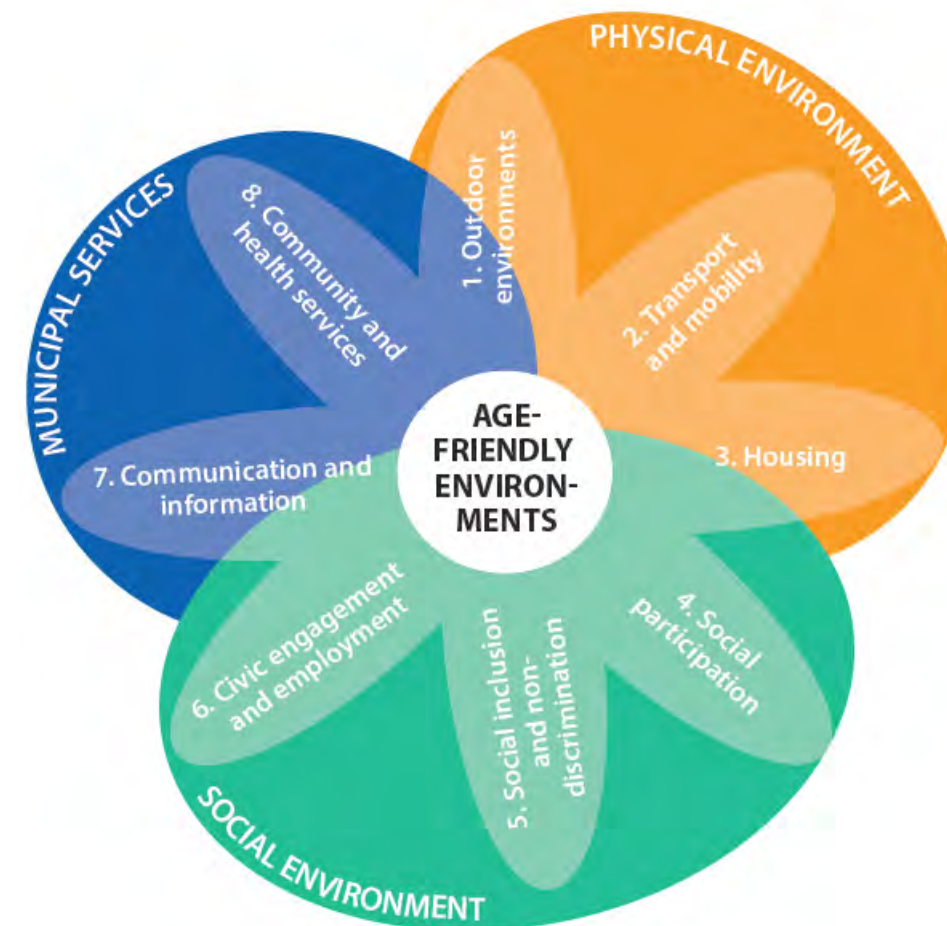
## Age-Friendly environments

Age-friendly environments are one of the most important public health responses to population ageing. Age-friendly environments aim to encourage active and healthy ageing by optimizing health, stimulating inclusion and enabling well-being in older age.

The World Health Organisation's Global Healthy Ageing Strategy talks not of age, but rather 'functional ability', which is a combination of intrinsic ability (our physical and mental abilities) and environmental factors (transport, housing, relationships). We need to transform environments into supportive and inclusive places where older people can live, work and enjoy their surroundings; making it inclusive for older people also makes it inclusive for all.

WHO have identified three dimensions through which environments can be inclusive and supportive of older people with varying capacities: physical environments, social environments and municipal services.

With the right policies and services, partners and local communities can support a positive approach to healthy ageing. Whether people in older age experience ill health, disability, dependence or loneliness depends not only on their functional capacities but also to a large extent on the physical and social environment in which they live. Supportive environments help people with diverse capacities maintain their ability to do the things that are important to them.





Healthy Streets

The risk of becoming socially excluded increases with age and impairment, as does the proportion of people excluded from essential shops and services. Geographic mobility reduces with age, and so local neighbourhood conditions will have a greater impact on older people as they feel bound to reduce the distance they travel from their home. Conditions of pavements can also act as a barrier to older people being

socially connected, remaining physically active and accessing essential goods and services, such as health care, healthier food, advice and advocacy. This can exacerbate existing health, economic and environmental problems that older people may have, such as poor housing, poverty and social isolation. Healthy Streets™ is an evidence-based approach for creating fairer, sustainable, attractive urban

spaces. Healthy streets can be considered an asset that promotes and improves the health of local residents and the wider local community. They feature good quality design and furniture, providing accessible, safe communal spaces that can be used to create healthier, safer and more cohesive local communities.<sup>23</sup>

**Recommendation**

Promote the vision of people friendly streets and work towards embedding the Healthy Streets approach in Calderdale to ensure that it becomes an integral part of future transport and planning policy.



Intergenerational work through food

**Two thirds of the public have no friends with an age gap of 30 years or more**

**25% of 18-34 year olds believe it is “normal for older people to be unhappy and depressed”**

Food is something that we all have in common and as the Incredible Edibles’ say ‘if you eat you’re in’ so using food as a way of bringing people together to learn from and connect with each other can have a powerful effect. Evidence shows that intergenerational activities that bring older people and children together to take part in meaningful activity both breaks down barriers and prejudices, and enhances wellbeing. What could be more meaningful than growing, preparing and sharing food?<sup>24,25,26</sup>

We have been delivering intergenerational projects in partnership with the Better Care team whose aim is to use the power of good food to improve the health and wellbeing of older people and bring communities together to reduce loneliness. By bringing children into a care home setting to grow and make food with residents, relationships form and develop over time as the children return to tend the growing plants.







**Year 10 girl - Halifax Academy** “Gordon showed me how to dig, cutting squares in the grass, I held a worm! and he showed me which were weeds to pull out and not the flowers, he knew a lot, can we come here again?”.

**Year 4 boy - Beech Hill Primary school** “The lady told me what shapes to make my bread and we were both laughing cause I made funny shapes. Then I made pizza, Eileen sprinkled the cheese on top and I got her to try some, she’d never had pizza before, and I’d never made bread!”

**Mavis, resident - Summerfield House Care Home** “It was wonderful having the children here and watching them plant stuff in the garden, I will go to bed with a happy heart”.

**Dudley, resident - Summerfield House Care Home** “The little lad, he helped me knead the dough because I’ve a bit of arthritis, but I helped him with which way to plait it, we were a good team, we’ve worked up an appetite”.

**Carol (Summerfield Resident) with Sarah (8 year old Beechill Primary):**

**Carol** – I told her how we used to pick rhubarb from’t allotment and sit on’t doorstep dipping it in a bag of sugar cause it were that sour!”

**Sarah** – Carol, we could plant some rhubarb in the garden and eat it together, and it’s alright if we have a bit of sugar on it cause rhubarb is one of our five a day!”.

**Carol** – can we plant a chilli plant with those cute little chillis on as well, I could keep it in my room and we could make a curry”

#### Intergenerational work video links

Intergenerational cooking & Growing Mytholm Meadows Sheltered Housing

Full length - [youtu.be/h8UG\\_WE0OwM](https://youtu.be/h8UG_WE0OwM)

Social Media version - [youtu.be/qdvAZzlvTFQ](https://youtu.be/qdvAZzlvTFQ)

Summerfield House Care Home

Intergenerational Tea Party - [youtube.com/watch?v=Ed9duCbBG\\_U](https://youtube.com/watch?v=Ed9duCbBG_U)

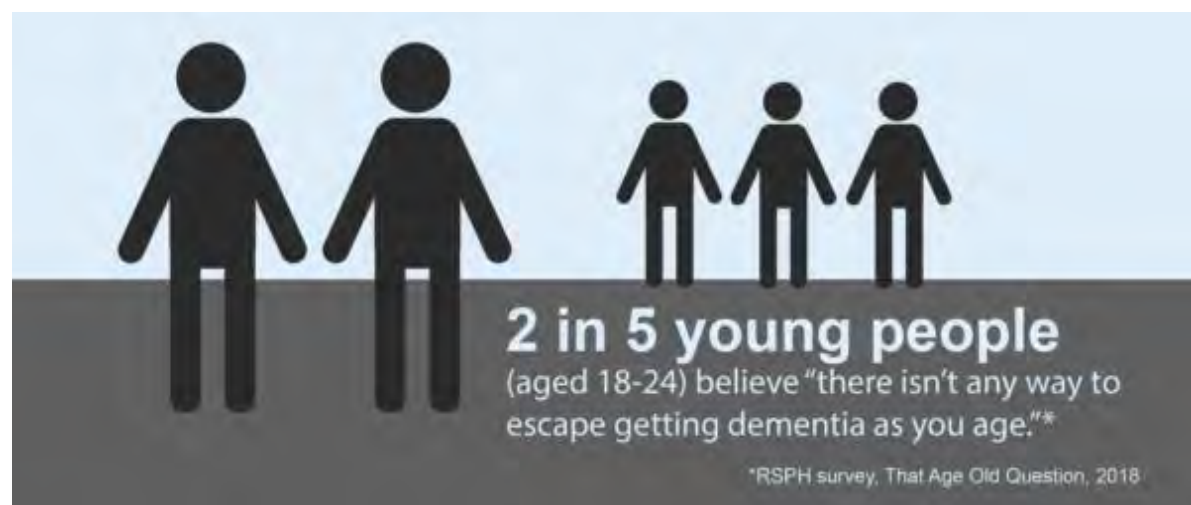
Intergenerational growing and cooking activities - [youtube.com/watch?v=sDV7n20M24Y](https://youtube.com/watch?v=sDV7n20M24Y)

Care Home Big Community Lunch - Includes interviews with Holly Lynch, Police Community Support Officer etc.

Big Lunch (2 minute film) [youtube.com/watch?v=nd1N9qNaLDA](https://youtube.com/watch?v=nd1N9qNaLDA)

Big Lunch (short social media version) [youtu.be/BczkviBzFeQ](https://youtu.be/BczkviBzFeQ)





## Recommendations

NHS and local authority partners further investigate fall in life expectancy for men in Ovenden.

Assess whether access to benefits can be maximised across the community with particular emphasis given to those areas in which income deprivation is higher than the rest of Calderdale.

Support NHS and social care service developments which ensure that multi morbidity is more effectively managed.

Develop the "Taking Control" self-management programmes by supporting the VCS to help provide this.

Develop the Staying Well approach within localities as part of a wider development of social prescribing.

Develop a campaign to increase public awareness of the steps that can be taken to reduce risk of dementia.

Investigate reasons why Park ward has such high levels of admissions for hip fractures.

Ensure home hazard assessment and improvement programmes are in place across the borough.

Ensure that local approaches to improve housing address falls prevention.

Demonstrate actions taken to reduce risk in high-risk health and residential care environments.

Focus Alcohol Awareness week and Dry January on older adults and the 'baby boomer' generation to help people make healthier choices about alcohol as they age.

Improve information sharing between health, social care and the third sector as a way of identifying vulnerable individuals who have poorly heated homes.

All adults in Calderdale should have an 'advance statement' in place, setting out their preferences, wishes, beliefs and values regarding their end of life care. This should be promoted by all health care professionals.

Health Care Professionals should routinely ask for an individual's 'advance statement', and centre end of life care around that statement.

Adopt World Health Organisation's 'Life-course Approach to Healthy and Active Ageing.

Develop focused physical activity programmes with and for the over 50s as part of the Active Calderdale strategy

Promote the vision of people friendly streets and work towards embedding the Healthy Streets approach in Calderdale to ensure that it becomes an integral part of future transport and planning policy.

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