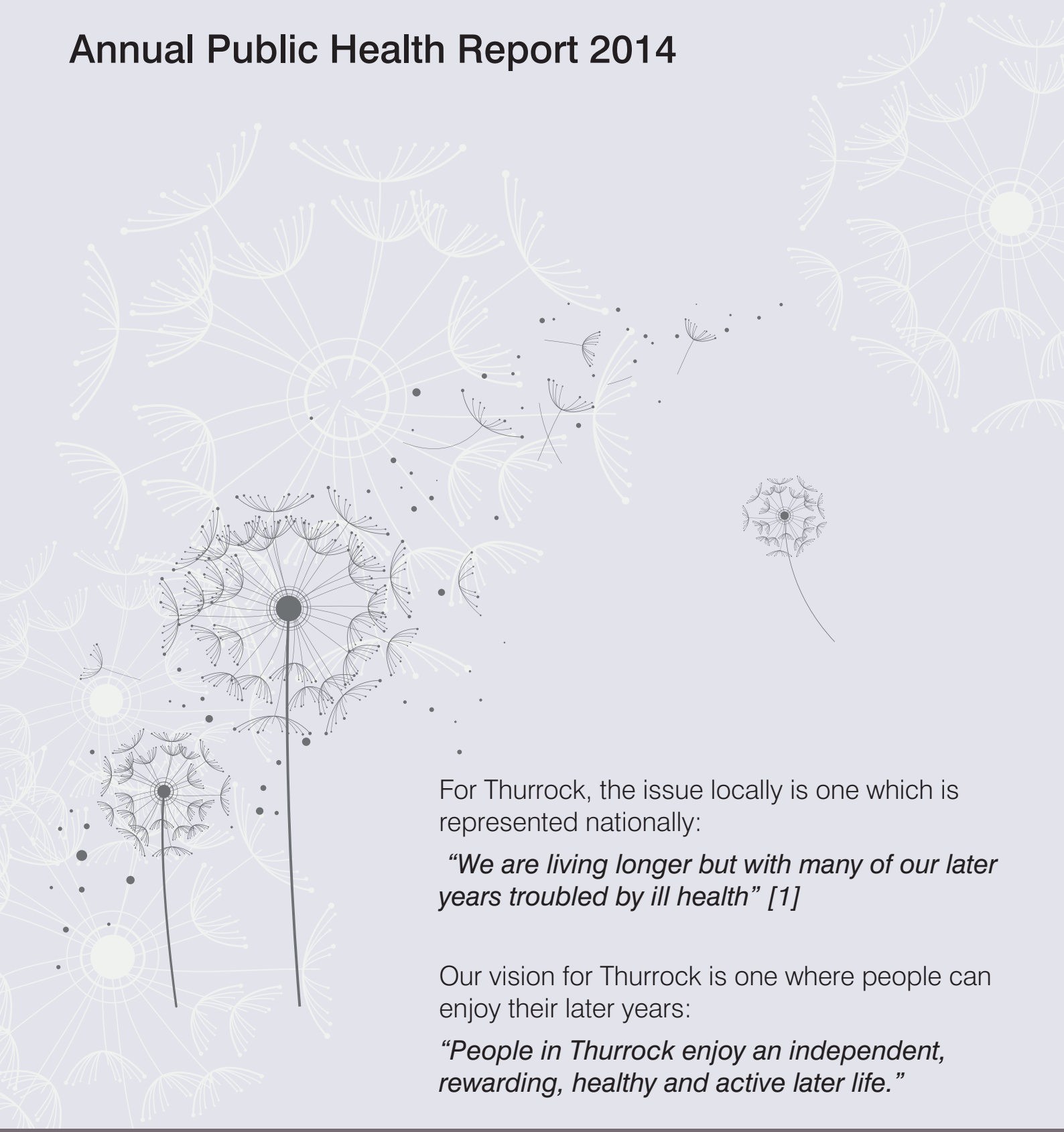
Ageing Well

Opportunities of a healthy later life in Thurrock

Annual Public Health Report 2014



For Thurrock, the issue locally is one which is represented nationally:

"We are living longer but with many of our later years troubled by ill health" [1]

Our vision for Thurrock is one where people can enjoy their later years:

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Foreword

The purpose of the Annual Public Health Report is to provide an important record of the health of the local population, highlighting major issues and problems and making recommendations to address them. This year I have chosen to focus on the health and wellbeing of older people in Thurrock.

Both nationally and locally we are seeing a shift in the age structure of the population, with significant increases in the proportion of the population aged over 65.

Ill health and the need for health and social care services is greater in old age and particularly in the over 80's, where we expect to see the largest relative growth in population size in the next twenty years. In addition to meeting this growing demand we are faced with the challenge of a reduction in the growth of public funding for these services over the coming years.

The health and well-being of older people is influenced by an interplay of the determinants of health – such as poverty and housing, genetic factors and lifestyle behaviours. This makes it vitally important for agencies and communities to work together to ensure that older people have active, independent and fulfilling lives for as long as possible.

To achieve this we need to have a positive approach to ageing, whilst recognising that at times people will need extra help and support, particularly in their later years. There needs to be a key focus on prevention and helping people to make healthy lifestyle choices throughout the life course and during older age.

In such times of austerity, it is vitally important that we spend our collective resources wisely. Protecting the health of older people through immunisation, the prevention of falls and fractures and managing long term conditions well in the community, will help to achieve better outcomes and individual experience, as well as realising savings.

I hope that you find my report interesting and I would welcome your feedback, comments and suggestions.

Dr Andrea Atherton
Director of Public Health, Thurrock Council

Executive summary

The 2014 Annual Public Health Report for Thurrock focuses on the key health and wellbeing issues for those people aged 65 years and over.

The proportion of people aged 65 and over currently living in Thurrock is lower than the average for England (13.6% compared to 17.3% respectively). However, the number of older people in Thurrock is expected to grow sharply in the coming years, particularly those aged 85 years and over. This will have significant implications for health and social care services.

Addressing the issues impacting on older people is a complex undertaking. A wide range of factors, including quality of housing, poverty and fuel poverty can greatly affect the health of older people. Thurrock has the 10th highest level of older people living in poverty in the East of England

Locally there are various housing options for older people including sheltered housing, extra care housing and the HAPPI housing scheme. The Well Homes project, a joint initiative between public health and the private sector housing team in the Council offers private sector residents a 'well homes visit' which provides advice on a wide variety of issues.

Older people living in cold homes are at greater risk from heart disease and stroke and have reduced resistance to respiratory infections and poor mental health. In addition to local housing initiatives the messages of the national 'Keep Warm, Keep Well' campaign have been promoted locally. Excess winter deaths in all age groups in Thurrock have fallen since 2007.

Healthy lifestyle choices during the ages of 40-60 years can have a marked impact on health in later years. It is never too late to make lifestyle changes and older people, particularly those with long term chronic health conditions, need to be supported to address negative lifestyle behaviours. For example stopping smoking results in health benefits for the individual at any age.

There are well evidenced benefits associated with being physically active, however, less than 40% of people aged 65 and over meet the recommended physical activity guidelines. Diet also affects key aspects of health in old age. The proportion of people who are overweight or obese tends to increase with age. An estimated 26.4% of people aged over 65 in Thurrock are obese, which is similar to the national average. Being obese is not the only issue for older people. Research suggests 1 in 10 of people aged over 65 are malnourished or at risk of malnutrition.

Older people often consume alcohol above recommended levels. Excessive alcohol consumption can have a significant impact on the physical and mental health of older people, increasing risks related to injurious falls and also a number of clinical conditions. The NHS Health Check programme for people aged 40-74 now incorporates questions on alcohol intake.

There is greater recognition of the impact that loneliness and social isolation has on the quality of life in older age as well as its contribution to premature death.

Thurrock's Health and Wellbeing Strategy has been awarded 'gold standard' accreditation by the 'Campaign to End Loneliness' for the inclusion of actions and targets to address loneliness. The Local Area Co-ordinators have an important role in helping the more vulnerable members of the community, such as the frail elderly to engage more with other members of the community.

Depression in later life can be triggered by a variety of factors, including social isolation. The local voluntary sector plays an important part in supporting positive mental health and well-being, with community mental health services in place for those with greater mental health difficulties.

Flu vaccination is a safe and effective way to protect older people and reduce avoidable illness, hospitalisation and excess seasonal deaths. Only 69.2% of people aged 65 and over living in Thurrock received flu vaccine in 2013, which is below the England average (73.2%) and below the World Health Organisation target of 75%.

Dementia is one of the major health and social care issues of our time. Currently around 815,827 people in the UK have dementia and this number is set to increase by 40% in the next 12 years. It is more common in people aged over 65 and prevalence roughly doubles from this age onwards. In Thurrock currently less than half (41.89%) of the estimated number of people with dementia have received a formal diagnosis. Early detection allows for more effective planning of treatment and appropriate support for the person and their family.

There are a range of local initiatives being delivered to increase awareness of dementia and provide support to those with a diagnosis of dementia as well as their carers. These include the roll out of the Dementia Friends initiative and plans for a local Dementia Action Alliance, will which help to facilitate earlier diagnosis and support from local services.

Although life expectancy has been increasing, people are not necessarily living longer in good health. Disability-free life expectancy at 65 years is significantly lower for males and females in Thurrock compared to the England average. Conditions including urinary tract infection, chronic obstructive pulmonary disease and pneumonia are the leading causes of emergency hospital admissions in people aged 65 and over in Thurrock.

Falls and fall-related injuries are a common and serious problem for older people. It is estimated that 30% of people aged over 65 years and 50% of people over 80 have a fall at least once a year. Hip fracture is the most common injury related to falls and can lead to loss of mobility and independence. In 2013-14, there were 91 emergency admissions of people aged 65 in Thurrock with a hip fracture, at a cost of over half a million pounds. The local falls service includes a community falls clinic a falls group programme, which helps to reduce the risk of falls and reablement services.

Thurrock Council and the local NHS work closely in a number of areas linked to reducing admissions for the over 65, this includes the Rapid Response and Assessment Service. In partnership with Thurrock Clinical Commissioning Group, Thurrock Council also has an integrated Joint Reablement Team with the NHS community service provider. This team provides support for people to regain skills or

mobility after a period of illness or hospital admission, and supported 531 people in 2013/14.

Long term conditions (LTC) are more prevalent in older people, 58% of people aged over 65 have an LTC compared to 14% of people under 40. Most long term conditions are multifactorial, however, there is a strong link between unhealthy lifestyle behaviours and some of the most prevalent and disabling long term conditions.

The NHS Health Check programme, which aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia, is delivered in GP practices and community outreach events.

A wide range of initiatives are available to provide help and support to patients with the management of their long term conditions, with an increasing focus on supporting people to self- care.

In the 2011 Census, 6.5 million people in the UK identified themselves as carers, compared with 5.8 million people in 2001. Of the carers in Thurrock aged 65 and over, 45% report providing a minimum of 50 hours of unpaid care per week. The demands of being a carer can have a negative impact on their quality of life, including their physical and mental health. Older carers in Thurrock report a significantly better quality of life compared to the national average. The Council and local voluntary sector provide a range of services to support carers with their caring responsibilities.

Summary of Recommendations

- Raise awareness of frontline health and social care staff, the voluntary sector and local area co-ordinators of the importance of wider determinants on the health of older people, to facilitate early intervention and referral to appropriate services for help and support in claiming welfare and housing benefits to which they are entitled

- Raise awareness with Thurrock residents and frontline services of the link between poor housing and poor health so that older people are referred to appropriate housing services in Thurrock

- Promote partnership working and utilise the community network to ensure that hazards in the home are identified

- Encourage and support people in later life to quit smoking

- That the Tobacco Control Strategy for Thurrock includes actions to support older people as a target group

- Ensure information about age-appropriate lifestyle activities is accessible to communities

- Work with communities to identify and remove barriers to lifestyle services

- To cascade 'Making Every Contact Count' awareness training, which includes brief alcohol interventions to staff in the NHS, Council, Local Area Co-ordinators, community groups and other relevant local organisations

- To promote alcohol-related public health campaigns such as 'Dry January'

- Work in partnership with Thurrock Adult Community College (TACC) and the University of the Third Age (U3A) to deliver messages around a healthy and active retirement

- Develop a peer mentor programme in partnership with existing agencies such as Thurrock Age Concern, local colleges, Cariads and faith groups

- Local Area Coordinators to work alongside vulnerable individuals within the community and increase the number of referrals to lifestyle and other preventative programmes

- Work with commissioners within Thurrock Clinical Commissioning Group and adult social care to jointly improve identification of depression in older people and access to psychological therapies

- Encourage and support people aged 65 and over to have their annual flu jab

- Promote and engage frontline health and social care staff in the take-up of the flu jab

- The Thurrock Health & Wellbeing Board should review the local work being undertaken to increase the proportion of people who receive an earlier diagnosis of dementia

- The Thurrock Health and Wellbeing Board should consider the specific needs of carers of people with dementia

- Develop a training programme for health and social care staff to identify dementia symptoms to ensure timely referral to specialist dementia services, including memory clinics, to facilitate formal diagnosis

- Further work is done to promote dementia friends training within the Council, with external partners and the community

- Review current provision related to falls prevention and develop a comprehensive cost-effective falls prevention programme focused on early detection, management and treatment of risk factors that lead to falls in the elderly

- Work with our wider health and social care partners and our communities to support self- care of long term conditions

- Work is undertaken with health and social care to raise awareness of services to support end of life care, including greater use of end of life registers and supporting patients around choices such as preferred place of death

- Continue to support carers to access services offered by statutory and voluntary organisations

- Health and well-being services are promoted to carers through the Carers Information and Advice Service

Chapter 1 A Profile of Older People in Thurrock

Key Messages

- People aged 65 and over represent 13.6% of the total population in Thurrock compared to the national average of 17.4%
- The population of older people is set to increase dramatically over the next 23 years, particularly those aged 85 years and over
- The proportion of older people from a black, Asian and minority ethnic group is set to increase

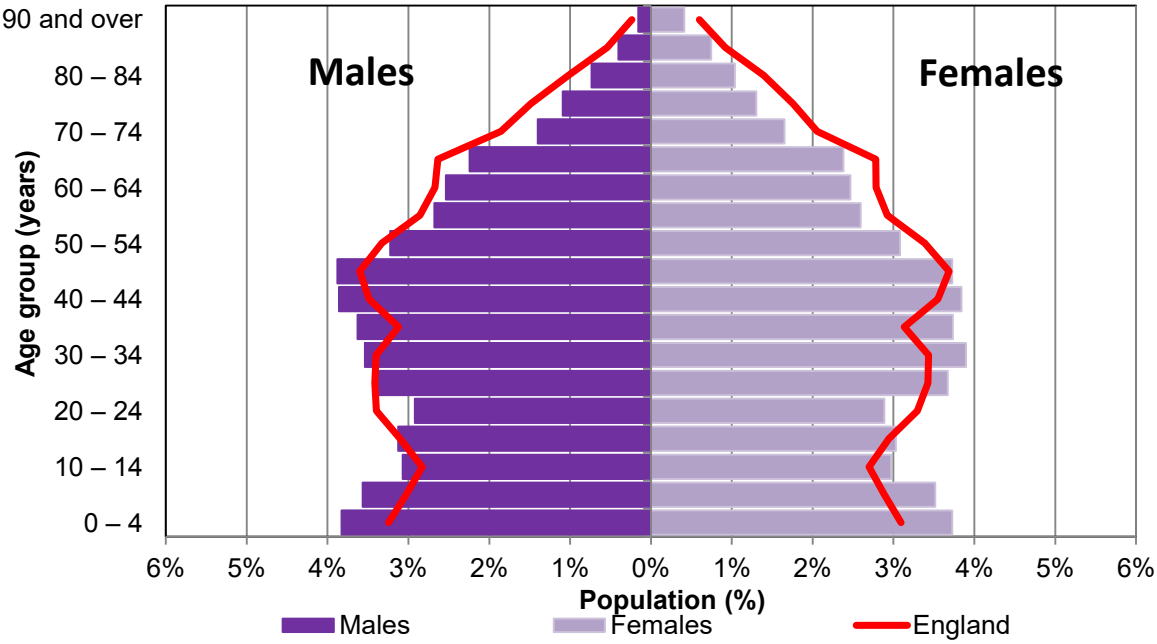
Introduction

Although there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. Most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person. This definition has been adopted for the purpose of this report. However, it is recognised that this age cut off point is arbitrary and cannot reliably predict a person's health and level of function.

The Current Population

The latest figures indicate that there are 21,815 people aged 65 and over in Thurrock. Of these 9,468 are aged 75 and over and 2,762 are aged 85 and over. The 65 and over age group represents 13.6% of the total population, which is lower than the regional average of 18.7% and the national average of 17.3%. Figure 1 shows the population of older people within Thurrock is lower than the national average, with proportionately more females than males in those aged over 70.

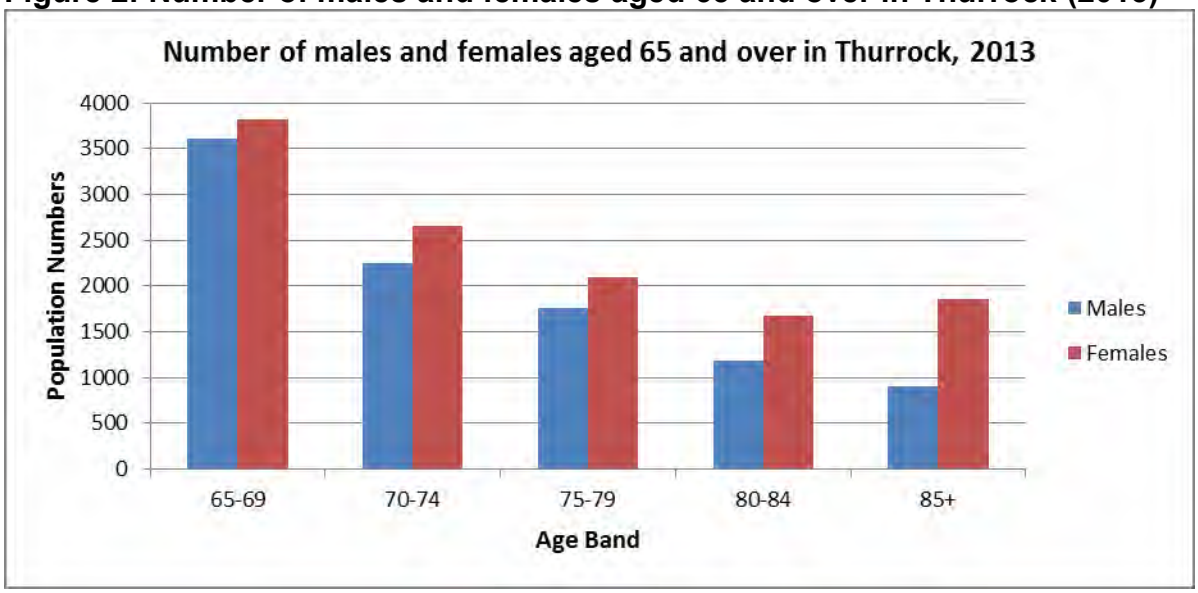
Figure 1: Population Structure of Thurrock, all ages (2013)



Source: ONS, Population Mid-Year Estimates 2013

Around 52% of the Thurrock population in the 65 -69 year age group are female. As females live longer than males, the difference between numbers of females and males becomes more apparent in the older age bands. In Thurrock there is more than double the number of females than males in the 85 and over age group (1859 females compared to 903 males). Figure 2 shows the breakdown of males and females aged 65 and over in Thurrock.

Figure 2: Number of males and females aged 65 and over in Thurrock (2013)



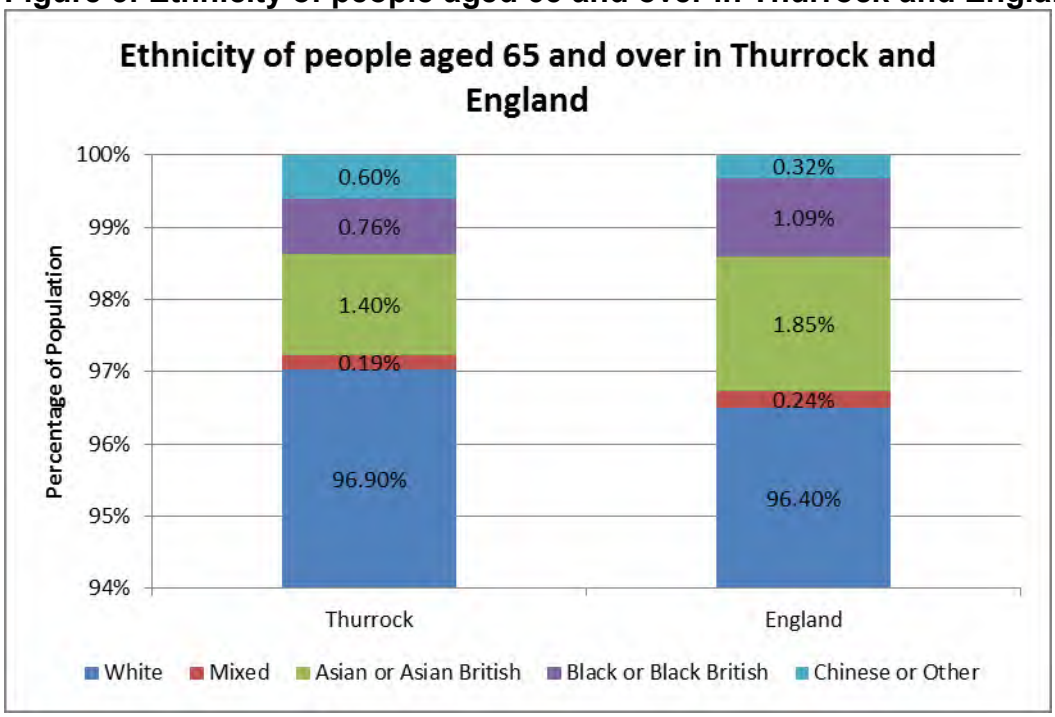
Source: ONS, Population Estimates 2013

Ethnicity

Only 2.7% of people aged 65 and over in Thurrock are from a black, Asian and minority ethnic (BAME) group, which is lower than the national average of 4.7% (Figure 3). However, as ethnic diversity in younger age groups in Thurrock has increased over the last decade at a faster rate than the national average (2014 school census data shows the proportion of pupils from a BAME group is 28.9%), the proportion of older people from a BAME group in Thurrock is set to increase.

Local health and social care services should recognise the greater prevalence of some illnesses among specific groups of people, for example increased rates of hypertension and stroke among African-Caribbeans and of diabetes among South Asians. This will become increasingly significant as these populations continue to age.

Figure 3: Ethnicity of people aged 65 and over in Thurrock and England, 2011

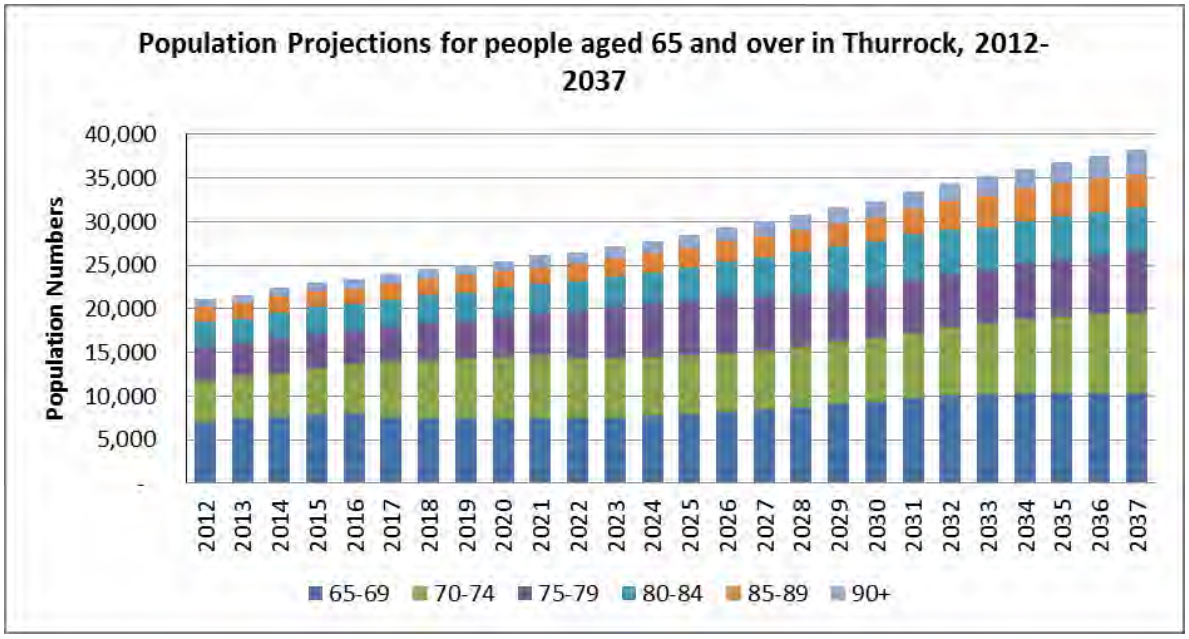


Source: POPPI (calculated using ONS statistics, 2011)

Population Change

In Thurrock, the population aged 65 and over is expected to increase by 17,100 by 2037 (Figure 4), which is an increase of 81% from 2012, this compares to 65% nationally. There are particularly noticeable increases in the number people aged 85-89 years and those aged 90 and over.

Figure 4: Population projections for people aged 65 and over in Thurrock, 2012- 2037

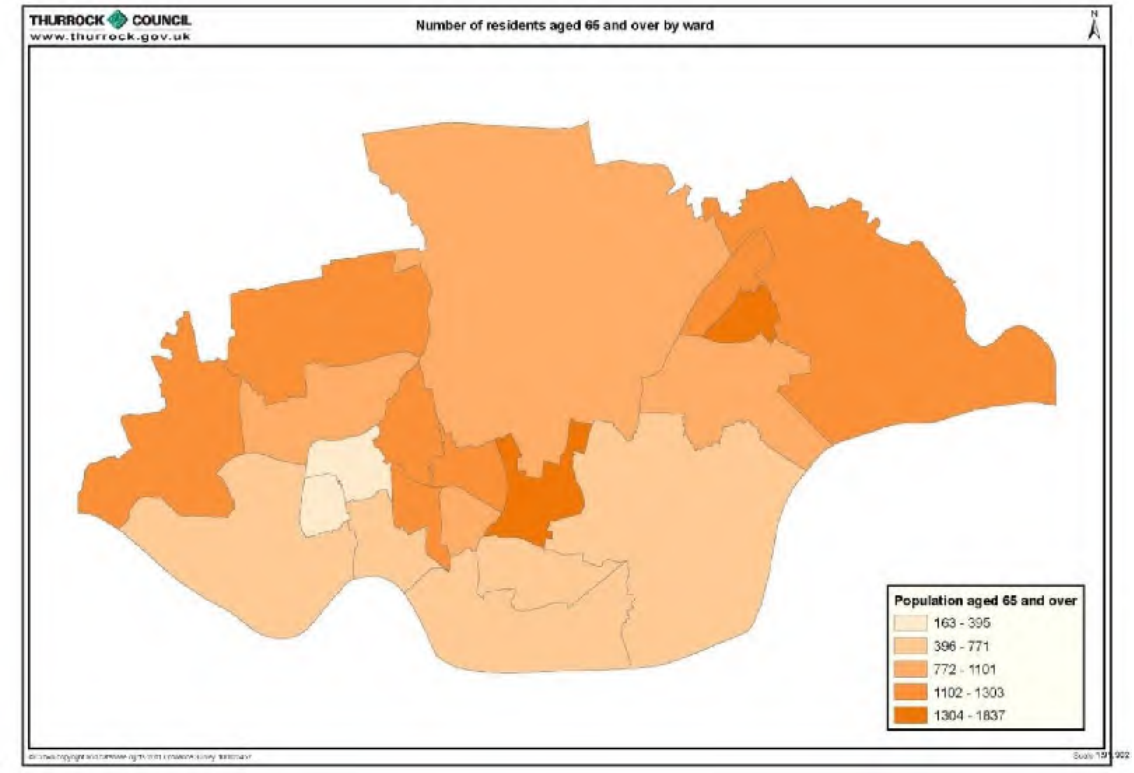


Source: ONS, Subnational Population Projections 2012

The Location of Older People in Thurrock

Figure 5 shows the distribution of where people aged 65 and over live in Thurrock. Chadwell St. Mary, Corringham and Fobbing wards have the highest number of residents aged 65 and over, with 1837 in each ward. South Chafford has the lowest number with just 163 residents aged 65 years and over.

Figure 5: Number of residents aged 65 and over by ward in Thurrock



Source: ONS, 2011

Household characteristics

The living circumstances of older people affect both opportunities for social interaction and the need for additional support from formal and informal services.

Evidence suggests that older people who live alone are more likely to report fair or poor health, social isolation, difficulties in the basic activities of daily living, lower mood and lower levels of physical activity, which has implications for the potential level of support that may be required from external agencies.

In Thurrock it is estimated that 20% of men and 30% of women aged 65-74, and 34% of men and 61% of women aged over 75 years live alone. Table 1 provides a breakdown of the predicted number of those aged 65 and over living alone over the next 16 years.

Table 1: Predicted number of people aged 65 and over living alone in Thurrock, by age and gender (2014-2030)

	2014	2015	2020	2025	2030
Males aged 65-74 predicted to live alone	1,220	1,260	1,400	1,420	1,620
Males aged 75 and over predicted to live alone	1,326	1,394	1,598	2,074	2,380
Females aged 65-74 predicted to live alone	1,980	2,070	2,250	2,250	2,580
Females aged 75 and over predicted to live alone	3,477	3,477	3,843	4,758	5,429
All persons aged 65-74 predicted to live alone	3,200	3,330	3,650	3,670	4,200
All persons aged 75 and over predicted to live alone	4,803	4,871	5,441	6,832	7,809

Source: POPPI – based on 2007 figures

Chapter 2 Ageing Well

Healthy ageing may be considered as 'the promotion of healthy living and the prevention and management of illness and disability associated with ageing' [2]. It is often used interchangeably with other such terms 'active ageing', 'successful ageing' and 'positive ageing'.

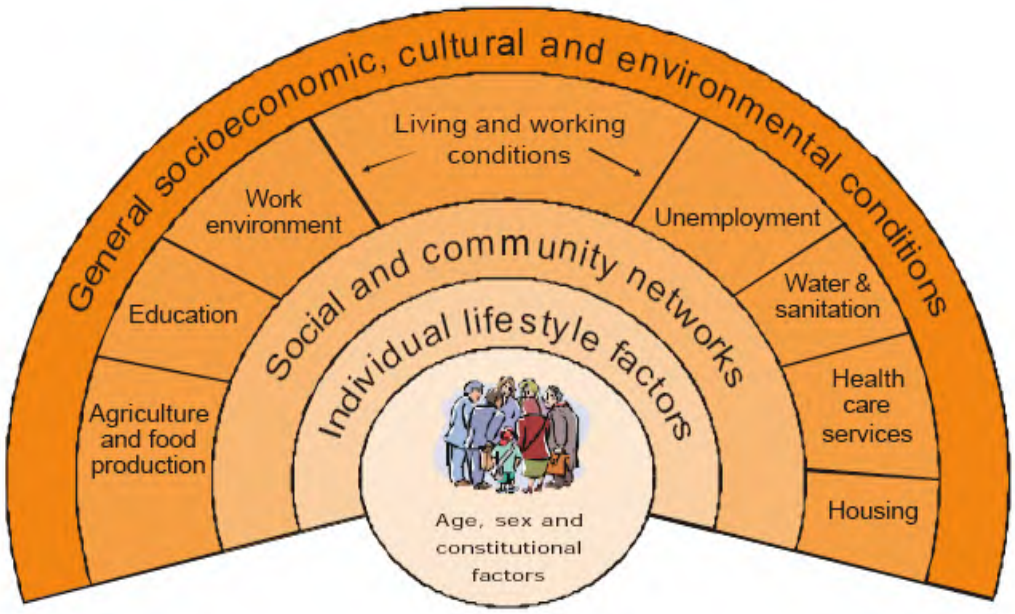
The ageing process itself is caused by a gradual build-up of subtle faults in the cells and organs of our bodies, with genes influencing cellular repair. However, evidence suggests that genetic factors only account for 25% of human longevity and much can be gained from targeting the non-genetic factors that impact on the ageing process such as nutrition, lifestyle and factors such as poverty, housing, transport and employment, often referred to as the wider determinants of health.

2.1 Healthy, Supportive and Safe Environments

Determinants of Health

A wide range of factors beyond health and social care have a major effect on the health and well-being of older people. These factors include poverty, housing, the environment, transport and employment, and are referred to as the wider determinants of health. Figure 1 shows the complex interrelationship of all the issues that impact on the health and well-being of a population. This complexity highlights the need to work collaboratively across different agencies and communities to ensure that older people have active, independent and fulfilling lives for as long as possible.

Figure 1: The Determinants of Health



Source: Dahlgren G and Whitehead M, 1991.

Poverty and Deprivation

Key Messages

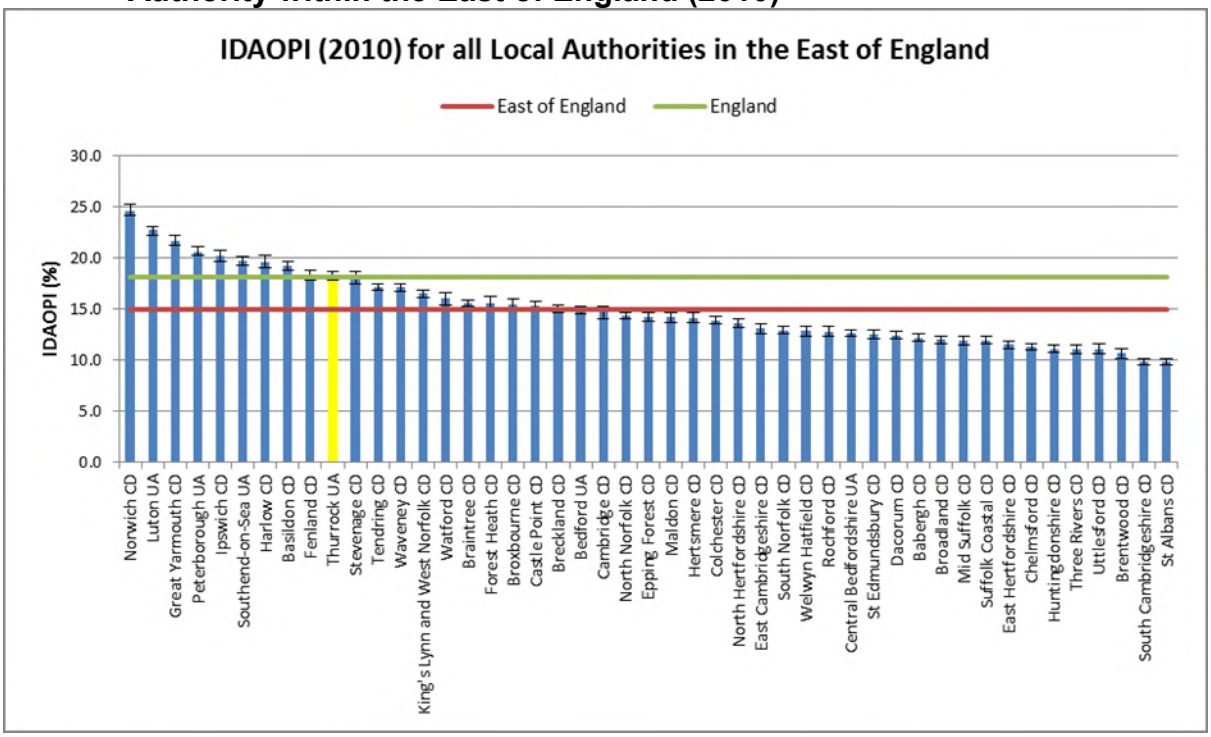
- Thurrock has the 10th highest level of older people living in poverty in the East of England
- This has the potential to impact on the health and well-being of older people in Thurrock

"Not having enough money can lead to an inability to buy a healthy diet, adequate accommodation, heating, and to not have enough money to participate in society." [3].

The current difficult financial climate and increasing costs have become key issues for many older people. Having an adequate income is essential if older people are to maintain an appropriate standard of living to maintain their health and wellbeing.

The Income Deprivation Affecting Older People Index (IDAOPI), a subset of the Index of Multiple Deprivation 2010, is a measure of older people living in poverty. The score for this Index gives the proportion of adults age 60 or over living in income deprived households (i.e. someone in the family is claiming Income Support or income based Jobseeker's Allowance or Pension Credit [Guarantee]).

Figure 2: Income Deprivation Affecting Older People Index (IDAOPI) by Local Authority within the East of England (2010)

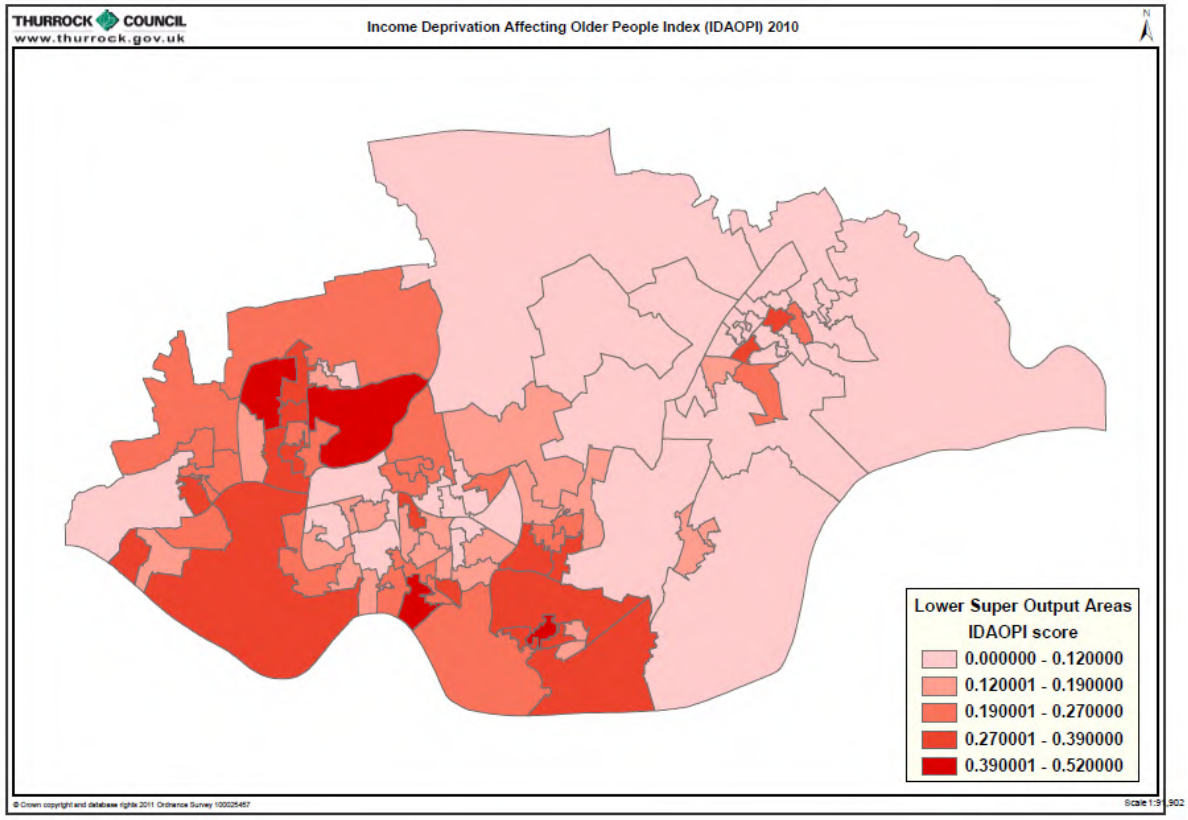


Source: APHO

At a local authority level there are significant differences between levels of income deprivation in older people, with Thurrock having the 10th highest level within the East of England (Figure 2).

The level of income deprivation among older people varies within Thurrock, with areas in Belhus and Ockendon having the highest levels (Figure 3).

Figure 3: Income Deprivation Affecting Older People Index (IDAOPI) by Lower Super Output Area in Thurrock, 2010



Source: Department for Communities and Local Government, Indices of Deprivation 2010

Local Action

Advice and information services are provided by the Thurrock Citizen's Advice Bureau. Residents can access this service in a number of venues or by phone to obtain practical help and advice, including financial and debt relief services, housing advice, and benefits advice. These services help increase incomes in low-income households and contribute to increased standards of living. In 2013/14 the Thurrock Citizen's Advice Bureau (CAB) supported 5,640 residents with a total of 11,552 issues [4], 21% were aged between 50 and 64 years and 8% were aged 65 years and over. During 2013/14, the top advice issues were welfare and benefits (31% of advice in Thurrock) and debt (21% of advice in Thurrock) (CAB, 2014 [4]).

Adult social care undertakes assessments of financial eligibility for care and support and will signpost to the CAB if there are any financial issues identified.

In Thurrock the Local Area Coordinators help to identify and signpost older people to appropriate services. The latest evaluation of this service highlighted that to date 20 individuals have been supported to access benefits that they were entitled to. Nine of these

individuals received additional income, which helped them live more comfortably or pay off debt. Examples included applying for and accessing pensions that they may be entitled to or supporting individuals to reclaim funds from TV licences that had been incorrectly paid, and helping and supporting individuals to make appeals [5]. This will impact on well-being through reduction of stress relating to financial challenges.

Housing and Well-homes

Key Messages:

- A large proportion of older people in Thurrock own their own home
- Good quality housing can protect and promote health, whilst poor quality housing can contribute to or exacerbate poor health

There is a wealth of evidence linking housing and health [6]. There are aspects of poor housing that are known to impact on health. These are likely to affect older people to a greater extent as they spend more time at home and may be unable to afford heating or ongoing repairs.

Health problems may be caused by a number of hazards within the home:

- Excessive cold
  Older people living in cold homes are at a greater risk from heart disease and stroke, reduced resistance to respiratory infections, poor mental health and are also at risk from hypothermia. Cold housing can also cause an exacerbation of arthritic symptoms. This then impacts on strength and dexterity, which both decrease as temperatures drop, increasing the risk of falls and other non-intentional injuries in the elderly [7]. The particular issue of fuel poverty is considered in the next section.

- Damp and mould growth
  Key factors contributing towards damp and mould include cold housing due to poor construction, along with poor ventilation and inefficient heating within homes. Those living in damp mouldy homes are more likely to experience health problems such as respiratory infection, allergic rhinitis and asthma [6].

- Quality of housing
  Poor housing conditions such as poor lighting, unsafe stairs or lack of stair handrails, electrical hazards and disrepair can all increase the risk of accidents and injuries within the home, with older people being particularly at risk. The majority of injuries to people aged 75 and older occur at home.

Housing services can play a vital role in ensuring that an older person's home is fit to provide a safe environment and to maximise independence [8].

Good quality housing can protect and promote health. The health and wellbeing of older people can be improved by:

- Adequate heating and ventilation
- Basic safety checks and minor repairs
- Adaptation of existing homes to facilitate independent living at home

Table 1 shows that in Thurrock, the proportion of householders owning their home is highest for those aged 65-74, with 74.8% owning their home. The proportion of older people renting their home is highest in the 85 and over age group.

Table 1: Proportion of Thurrock population aged 65 and over by age and tenure

	People aged 65-74	**People aged 75-84**	**People aged 85 and over**
Owned	74.8%	72.6%	62.07%
Rented from council	19.3%	21.95%	31.38%
Other social rented	1.29%	0.95%	1.32%
Private rented or living rent free	4.61%	4.51%	5.24%

Source: POPPI – based on 2011 figures

Local Action

There is much local action on supporting older people to live independently and promoting their health and well-being in their own homes.

Development of HAPPI (Housing our Ageing Population: Panel for Innovation) housing scheme concentrates on the development of more homes that can be flexible to the changing needs of older people can support people to maintain better health and independence. Thurrock Council, a stock-holding authority, is using its housing revenue account (HRA) settlement to develop new housing options for older people, alongside appraisals of existing stock. New developments, such as South Ockendon, are bespoke models built to HAPPI design standards with high levels of energy efficiency. A second HAPPI housing scheme is being considered for Tilbury.

Thurrock Council is also **working with private housing developers** to engage them with the opportunities for bespoke developments for older people in the borough.

Sheltered Housing - There are 29 complexes in Thurrock which allow older people to live independently in their own property, with the support of a sheltered housing officer. In addition to making regular contact with residents as required, the sheltered housing officer liaises with health workers and social services to meet specific needs. They also deal with day to day issues of home maintenance and repairs and help to arrange social activities for residents.

Extra Care Housing - Thurrock Council owns two extra care housing schemes, with a third scheme managed by a housing association. All three provide extra care to meet the needs of older people and help them to stay in their own home for as long as possible.

Specialist Advice and Support -Thurrock Council works in partnership with Papworth Trust Home Solutions to provide specialist advice and support to repair, improve or adapt the homes of disabled and older people. The services offered include:

- handy person scheme
- home safety check
- gardening
- decorating
- Home from Hospital
- benefit entitlement
- housing options advice
- case management
- architectural/technical services
- Hospital Prevention Service providing adaptations such as grab rails and stair rails to assist with hospital discharge or help prevent admission to hospital

Well Homes - the Well Homes project is a new project through the Papworth Trust, which has been implemented since May 2014. Public health are working jointly with Thurrock Council's housing team to offer private sector residents in Tilbury Riverside, Thurrock Park, Grays Riverside, West Thurrock and South Stifford a 'well homes visit' which advises tenants on:

- Improvements to the home
- Energy efficiency grants for boiler replacements/repairs, loft and cavity wall insulation
- Raising health and safety issues with landlords
- Financial assistance to owner occupiers to carry out repairs in their home
- Reduced cost gas safety checks and boiler services
- Reduced cost electrical safety checks
- Handyman and gardening services

The **Oven Cleaning Project** - A safeguarding adults and fire prevention initiative in partnership with Fire Service. This is a service that helps to prevent kitchen fires, the biggest cause of fires in the over 65 age group in Thurrock. A person is referred for a free oven cleaning when they are too frail to be able to do it themselves and there is a noticeable build-up of grease and food that could present a hazard. The fire service receives the referrals. General advice and fire safety is also given to any resident that qualifies for this support. To date there have been 50 ovens cleaned.

Fuel Poverty

Key Messages:

- Nationally the proportion of households where older people reside which are fuel poor has fallen; however, the fuel poverty gap has increased for this group
- Older people living in cold homes are at a greater risk of heart disease, stroke, falls and poor mental health and well-being
- Fuel poverty can contribute to excess winter deaths, particularly In older people

Older people can be more susceptible to fuel poverty as they are likely to spend more time in their home and therefore need to heat it for longer, but may be unable to do so due to their low income.

Through the Energy Act 2013, there is now a new legal framework to monitor fuel poverty in England using the Low Income High Costs Indicator (LIHC). A household is considered to be fuel poor if:

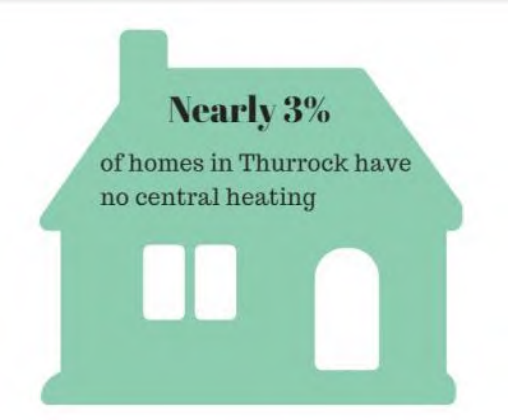
- they have required fuel costs that are above average (the national median level)
- were they to spend that amount, they would be left with a residual income below the official poverty line.

Under this indicator, overall there are around 2.4 million households and 1.14 million older people in England living in fuel poverty [9].

The key elements in determining whether a household is fuel poor are:

- Income
- Fuel bills
- Energy consumption (dependent on dwelling characteristics and the lifestyle of house holders).

Nationally the proportion of households which are fuel poor has fallen between 2003 and 2012, from 12% to 8% in households where the oldest person is aged 60-74 and from 15% to 7% in households where the oldest person is aged 75 or more.



However, the average fuel poverty gap increased from £241 to £504 in households where the oldest occupant is 60-74year and £261 to £557 where the oldest occupant is 75 years and older [10]. This increase in the fuel poverty gap is the result of rising fuel prices.

The health implications of living in cold homes have been described earlier, and range from cardiovascular and respiratory disease to depression, at an estimated cost to the NHS of £1.36bn a year.

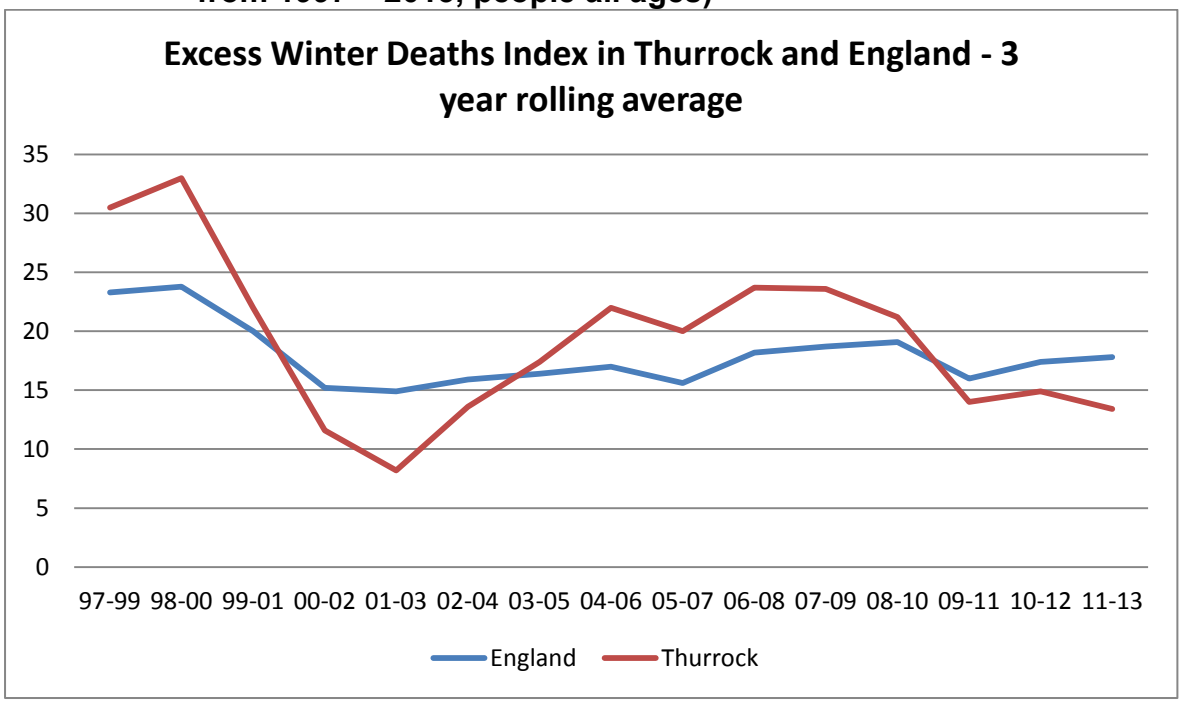
Fuel poverty can also contribute to excess winter deaths in all age groups, but the proportion of excess deaths is greater in older age groups.

Excess Winter Deaths (EWD) are defined as the difference between the number of extra deaths that occur in the winter months (December-March) compared to the average number of deaths in non-winter months (August-November and April-July).

In the winter of 2012/13, there were 31,100 ‘excess winter deaths’ (EWD) in England and Wales, the majority of which occurred in people aged 65 and over [11]. The majority of deaths were from complications associated with respiratory infections (41%) and dementia (29%).

In 2012/13, there were 70 more deaths in Thurrock (people of all ages) attributable to cold, than would normally be expected. This figure is not statistically different to that for England or other comparator local authorities. Figure 4 provides an overview of EWD for Thurrock during the period 1997-2013 for people of all ages.

Figure 4: Excess Winter Deaths in Thurrock and England (3 year rolling average from 1997 – 2013, people all ages)



Source: ONS

Local Action

The Cold Weather Plan for England (CWP) aims to prevent avoidable harm to health by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately. The CWP also aims to reduce pressure on the health and social care system during winter through improved anticipatory actions with vulnerable people [12]. In Thurrock, local implementation of the cold weather plan has been overseen by relevant departments across the Council and Thurrock Clinical Commissioning Group (CCG).

Local action also includes the promotion of the Keep Warm, Keep Well initiative. This government campaign provides messages to the public to help protect health, especially over the winter period:

Keep Warm Keep Well – Key Messages

1. Get your free flu jab if you are aged 65 or over, pregnant, have certain medical conditions, live in a residential or nursing home or are the main carer for an older or disabled person
2. Keep warm - by setting your heating to the right temperature (18-21 c or 65-70f), you can keep your home warm and your bills as low as possible
3. Look after yourself and check on older neighbours or relatives to make sure they are safe, warm and well. Layer your clothing and wear shoes with a good grip if you go outside
4. Food is a vital source of energy, which helps to keep your body warm. Try to make sure that you have hot meals and drinks regularly throughout the day and keep active in the home if you can
5. Get financial support - there are grants, benefits and sources of advice available to make your home more energy efficient, improve your heating or help with the bills. It's worthwhile claiming all the benefits you are entitled to before the winter sets in
6. Have your heating including your boiler and cooking appliances checked – carbon monoxide is a killer.

Recommendations:

- Raise awareness of frontline health and social care staff, the voluntary sector and local area co-ordinators of the importance of wider determinants on the health of older people, to facilitate early intervention and referral to appropriate services for help and support in claiming welfare and housing benefits to which they are entitled

- Raise awareness with Thurrock residents and frontline services of the link between poor housing and poor health so that older people are referred to appropriate housing services in Thurrock

- Promote partnership working and utilise the community network to ensure that hazards in the home are identified

2.2 Promoting Healthy Ageing

To ensure the health and wellbeing of the growing numbers and proportion of older people there needs to be greater focus on health promotion and disease prevention in old age.

The five main risk factors contributing to early death and reduced quality of life are:

- smoking tobacco
- having high blood pressure
- being overweight or obese
- lack of physical activity
- excessive alcohol consumption

[13]

Nationally and locally there has been considerable effort to address these risk factors, through topic based strategies e.g. tobacco control, obesity and alcohol. Tobacco control and obesity prevention have been identified as local priorities.

The evidence suggests that it is especially important to take action to address these risk factors in middle age i.e. from 40-60 year, as the lifestyle choices made at this time can have a marked impact on health in later years. At age 65, men in the UK can expect to live on average another 10.1 years in good health. Women can expect to live 11.6 years in good health. For both sexes, this constitutes 56.8% of their expected remaining life span [14] [15].

Public Health is working with a number of departments in the Council (including transport, education, housing and social care) in identifying joint projects and working practices that reflect their current preventative strategies.

Public Health is also working with the voluntary and community sector in using an Asset Based Community Development (ABCD) approach to identify community based strengths and assets that can be utilised to deliver preventative health outcomes by communities at a local level. Public Health, working with the Thurrock Council for Voluntary Services (CVS) has developed a funding stream that encourages local community and voluntary groups to identify health promoting activities within their own communities and bid for funding to achieve these.

Smoking

Key Messages:

- Smoking remains the single greatest preventable cause of ill health, premature death and health inequalities
- Approximately 16% of people aged over 50 in Thurrock smoke
- As people age they are more likely to attempt to stop smoking and be more likely to quit. It is never too late for older people to stop smoking and gain health benefits

Smoking remains the single greatest preventable cause of ill health, premature death and health inequalities. Smoking accounts for one third of all deaths from respiratory disease and over one quarter of all deaths from cancer and about one seventh of deaths from cardiovascular disease (CVD) [16]. On average a smoker loses 10 years of life as a result of their habit [17].

Smoking reduces the general health and quality of life of those who continue to smoke. It is associated with over 50 different diseases and conditions and is responsible for many chronic disease conditions that affect older people, including: respiratory disease such as chronic obstructive pulmonary disease, coronary heart disease and stroke, lung and other cancers, eye disease (macular degeneration), osteoporosis and increased risk of fractures.

Smoking prevalence has been declining nationally and locally due to a range of interventions such as:

- legislation on smoke free places
- free NHS Stop Smoking Services
- widely available and effective medication
- health warning labels on packaging
- national and local campaigns and social marketing

Currently 1 in 5 adults in Thurrock are smokers [18]. Smoking rates decline with age, mainly due to more deaths and illness in smokers resulting in fewer older smokers being left alive.

According to GP practice records, 16% of people aged over 50 in Thurrock are smokers. However, there is considerable variation in recorded smoking status ranging from around 2% to 27%.

People are more likely to quit when they attempt to stop smoking at an older age. It is never too late for older people to stop smoking and gain health benefits. Quitting reduces the risk of serious illness, and if a person already has a smoking related disease, stopping can slow the progression of the disease. Long-term smokers who quit before the age of 50 will halve their risk of dying from smoking related illness [17]. Even quitting at the age of 60 will add on average three years to the ex-smoker's life [17].

In 2013, a total of 2372 people in Thurrock set a quit date using the Thurrock Local Stop Smoking Services and 1145 (48%) successfully quit. Of these 333 were aged 60 or over and 189 (58%) successfully quit.

Local Action

The Public Health team is in the process of producing a tobacco control strategy for Thurrock that will cover prevention, enforcement and treatment. This will outline our priorities and actions to achieve a coordinated reduction in prevalence of smoking within Thurrock in all age groups.

Thurrock Council Public Health Team commissions a Local Stop Smoking Service (LSSS) from North East London NHS Foundation Trust (Vitality), local GP practices and community pharmacies. The service offers behavioural support and smoking cessation aids such as nicotine replacement therapy.

In addition to the LSSS, work has been ongoing to support the reduction of prevalence in smoking locally, including:

- Local promotion of national health campaigns such as Stoptober.
- Working with Action on Smoking and Health (ASH) and the Chartered Institute of Environmental Health (CIEH) to update the Council's smoke free policy for staff
- Establishing a multi-agency smoke free work stream that will evolve into a Tobacco Control Alliance in 2015, which will oversee the delivery of the Tobacco Control Strategy

The Stoptober Campaign 2014

- **22** locations were visited stimulating an estimated **25,000** visual hits.
- The Stoptober team estimated speaking to over **1000** residents throughout September.
- Over **200** people were tested using the CO (carbon monoxide) monitor.

Stoptober 2014 resulted in 857 estimated sign ups

There are also plans to redesign the LSSS during 2015 to have a strong focus on prevention, enforcement of tobacco legislation and to support the reduction in prevalence of smoking in all age groups.

Recommendations:

- Encourage and support people in later life to quit smoking
- That the Tobacco Control Strategy for Thurrock includes actions to support older people as a target group

Healthy Eating and Obesity

Key messages:

- Eating a healthy diet can significantly reduce the risk of many chronic diseases and premature mortality
- 26.4% of people aged 65 an over in Thurrock are obese, which is similar to the national average

Nutrition plays an important role in healthy ageing. It is estimated that around 70,000 avoidable deaths in the UK are caused by diets that do not match current guidelines [19]. Increasing the consumption of fruit and vegetables to at least five portions a day can significantly reduce the risk of many chronic diseases.

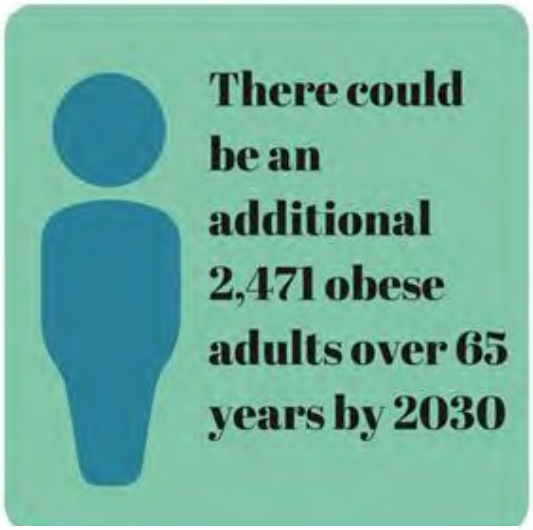
Nutritional guidelines for fat, carbohydrate and fibre are the same for older people as for adults of working age. However, low dietary intake is not uncommon among healthy older adults. **Malnutrition**, defined as 'state of nutrition in which a deficiency, excess or imbalance of energy, protein, and other nutrients causes measurable adverse effects on tissue and body form (body shape, size, and composition), body function and clinical outcomes'. Nationally 1 in 10 people aged over 65 are malnourished or at risk of malnutrition [20].

There are multiple risk factors for malnutrition, including:

- Poverty - leading to inability to access and afford good food
- Mobility - poor mobility, disability, and poor transport links can all lead to difficulties accessing local shops
- Functional constraints – inability to prepare food, poor dental health, difficulty using food containers
- Psychological factors – social isolation, dementia, depression and bereavement can all lead to reduced food intake

The numbers of people who are **overweight or obese** have increased dramatically in all age groups over the last two decades. Overweight and obesity are most commonly assessed through the Body Mass index (BMI). This is calculated by dividing a person's weight in kilograms by their height in metres squared (kg/m^2) An individual is considered to be 'overweight' if their BMI is 25-30, and obese if 30 or above. As well as reducing life expectancy by 8-10 years, obesity is associated with an increased risk of many serious diseases including heart disease and stroke, type 2 diabetes, hypertension, musculoskeletal issues and some cancers (breast and bowel).

Nationally, the proportion of people who are overweight or obese tends to increase with age. It is estimated that there are approximately 5,910 adults aged over 65 in Thurrock (approximately 26.4% of the over 65 population) who are obese in 2014 (POPPI data). This is a similar proportion to the national average of 26.1%. This number is set to increase with the projected rise in population.



Source: POPPI

The prevalence of some long-term conditions associated with obesity (such as diabetes) is high in Thurrock. An increase in the number of obese older adults is likely to further increase demand on primary and secondary care services in the future.

Local Action

There are a range of initiatives in place locally to support older people in Thurrock to lose weight and maintain a healthy weight.

The Council's Social Care department can arrange meals for those people who meet the relevant criteria. For those requiring assistance with personal care and meal preparation, the Joint Reablement Team support adults discharged from hospital for up to six weeks, and support in the longer term is provided by a variety of home care agencies.

A variety of healthy eating initiatives take place within the local sheltered housing complexes, and the new extra care facility Elizabeth Garden has a community café to enable non-residents to access nutritional meals.

Other opportunities exist within the borough to facilitate older residents to eat healthy meals and combat social isolation. A Diners Club has recently been established in Purfleet and provides affordable food and entertainment in a local public house on Monday and Tuesday lunchtimes. This enables elderly residents to come together and share a meal whilst enjoying some entertainment.

The Thurrock Healthy Weight Strategy was developed in partnership with the Council, Thurrock Clinical Commissioning Group (CCG) and the community and voluntary sector. This strategy was produced to ensure that the local population receives the most appropriate support to address weight management issues.

The Public Health team commissions an adult weight management programme for adults of all ages with a BMI of 28 and above, which focuses on healthy eating, behaviour change and advantages of physical activity.

Making Every Contact Count (MECC) is a fundamental approach to encourage and support people to adopt healthier lifestyle, which includes weight management. This is a project that uses the everyday contact people have with frontline staff, to deliver brief lifestyle interventions and signpost them to services that can help them modify their behaviour and manage any existing long term condition better. Work is underway to ensure that frontline staff are trained in MECC. The NHS Future Forum has been directive in its advice in the role of the NHS in the public's health "Every healthcare professional should "make every contact count": use every contact with

an individual to maintain or improve their mental and physical health and wellbeing where possible, whatever their specialty or the purpose of the contact" [21].

It is recognised that supporting residents to maintain a healthy weight requires a joint approach from a range of organisations.

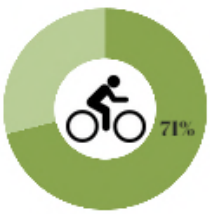
Physical Activity

The most substantial body of evidence for achieving healthy active ageing relates to the beneficial effects of regular exercise. Increased physical activity is associated with a reduced incidence of coronary heart disease, hypertension, type 2 diabetes, colon cancer, depression and anxiety. In addition, increased physical activity increases bone mineral content and reduces the risk of osteoporotic fractures. It also plays an important role in helping to maintain a healthy body weight.

The latest physical activity guidelines were published in 2011 by the four UK Chief Medical Officers, and include specific physical activity guidelines for those aged 65 and over [22]. The key messages are:

- Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.
- Older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
- For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.
- Older adults should also undertake physical activity to improve muscle strength on at least two days a week.
- Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.
- All older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

of those aged 65 years and over meet the recommended physical activity guidelines



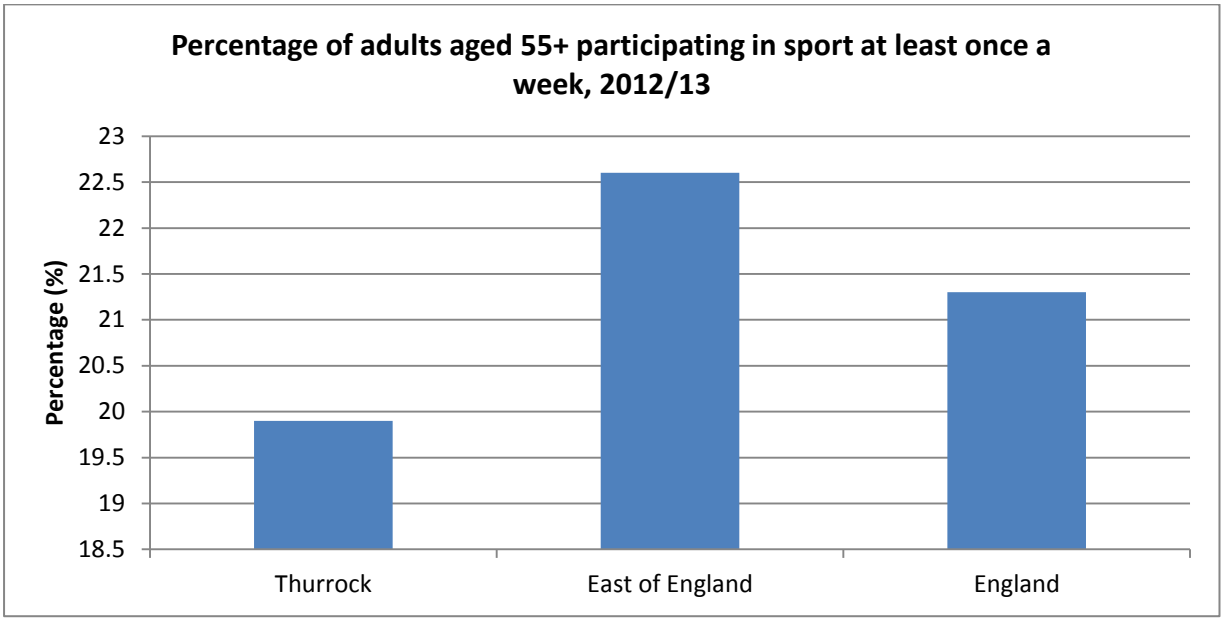
of those aged 16-18 years meet the recommended physical activity guidelines

In later life, the most popular forms of physical activity include active transportation, (such as walking to the shops), group based activities, (such as dance and movement classes, tai chi) and activities of daily living (such as climbing stairs, gardening and household activities). Regular walking is the predominant activity undertaken by older adults.
Participation in physical activity decreases with age: fewer than 40% of those aged 65 and above meet the

recommended physical activity guidelines, compared with 71% of 16-18 year olds (Active People's Survey, 2012/13).

The latest Active People's Survey data shows that Thurrock has a lower proportion of adults aged 55 years and over who are participating in sport at least once a week than the regional and national average (Figure 5).

Figure 5: Percentage of adults aged 55 and over participating in sport at least once a week

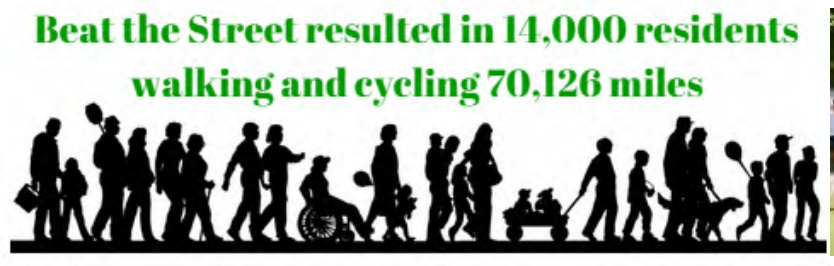


Source: Active People's Survey

Local Action

Strong partnerships have been made with the local county sports partnership – Active Essex. A Physical Activity Connector has been jointly appointed between Active Essex and Thurrock Council to strengthen links between existing physical activity groups in Thurrock and identify future funding bids. A community database of physical activity opportunities within the borough has been developed and can be accessed by all residents to source suitable activities.

Those adults who are currently inactive and have a BMI of 28 or above with no comorbidities, can access a Sport England funded project 'Active Sport 4 Life. This offers the opportunity to participate in a sporting opportunity for 12 weeks. There is also a Tilbury-based physical activity project involving mainly younger people but some intergenerational work is undertaken. An exercise on referral scheme is being piloted in partnership with Impulse Leisure.



Active travel is promoted for all age groups, with the Council's Transport Team working with local residents to develop cycling skills and promote active ways of travel. Alongside this, a successful project called **Beat the Street** was run during the summer of 2014 which aimed to increase walking and cycling in all residents of Thurrock.

Following the success of Beat the Street, the **Thurrock World 100** project is being developed to keep people walking. The project will enable participation in an exciting arts based walking project that will inspire hundreds of local participants to get involved. Thurrock World 100 will be a sustainable programme of physical activity across the borough.

Funding opportunities have also been made available to local community and voluntary groups to support them to run health promoting activities within their local areas.

Recommendations:

- Ensure information about age-appropriate lifestyle activities is accessible to communities
- Work with communities to identify and remove barriers to lifestyle services

Alcohol

Key Messages:

- Alcohol misuse in older people is a serious and growing public health challenge in England
- Alcohol problems in older people are often overlooked and undertreated

Although the average consumption of alcohol tends to decrease with age, there is evidence that the proportion of older people drinking more than the recommended amount is rising [23].

Problem drinking is defined as drinking above the recommended medical guidelines [24] which currently state that:

- Men should not regularly drink more than 3 to 4 units of alcohol a day.
- Women should not regularly drink more than 2 to 3 units of alcohol a day.

'Regularly' means drinking these amounts every day or most days of the week.

However, older people tend to have higher blood alcohol levels than younger people on drinking the same amount of alcohol. This difference is attributable to a lower

body mass: water ratio and less efficient alcohol metabolism in older people. Recent evidence suggests that the upper 'safe limit' for older people is 1.5 units per day or 11 units per week for both men and women [23].

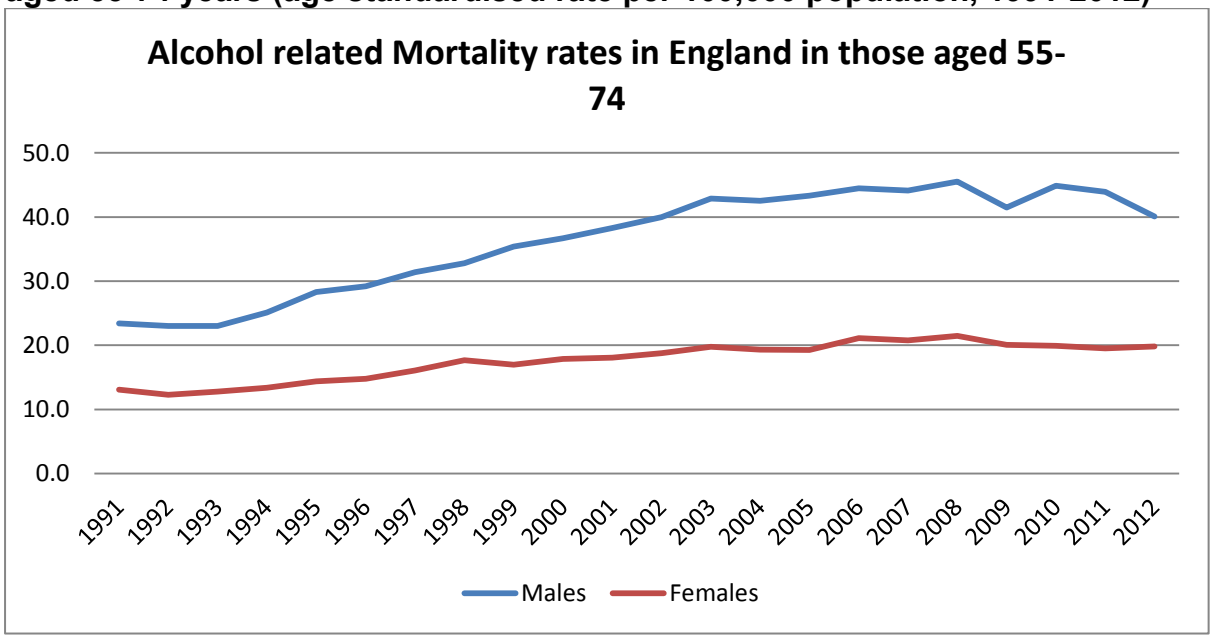
Alcohol misuse in older people can be linked to, or exacerbate, a number of physical, mental, social and practical problems such as:

- cardiovascular disease and stroke
- liver disease
- cancers
- malnutrition/ weight gain
- loss of sense of balance, possibility of falls and accidents
- blackouts or fits
- high blood pressure

Alcohol misuse in older people is often overlooked and undertreated. This is due to a number of factors including reluctance of older patients and their relatives to accurately disclose their alcohol intake. Family members and health professionals may regard the presenting issues, such as falls and confusion to be merely signs of ageing.

The Royal College of Psychiatrists have highlighted particular risk factors for alcohol misuse in older age which includes homelessness, bereavement, retirement and depression [23] [25].

Figure 6: Alcohol related mortality rates in England, in males and females aged 55-74 years (age standardised rate per 100,000 population, 1991-2012)

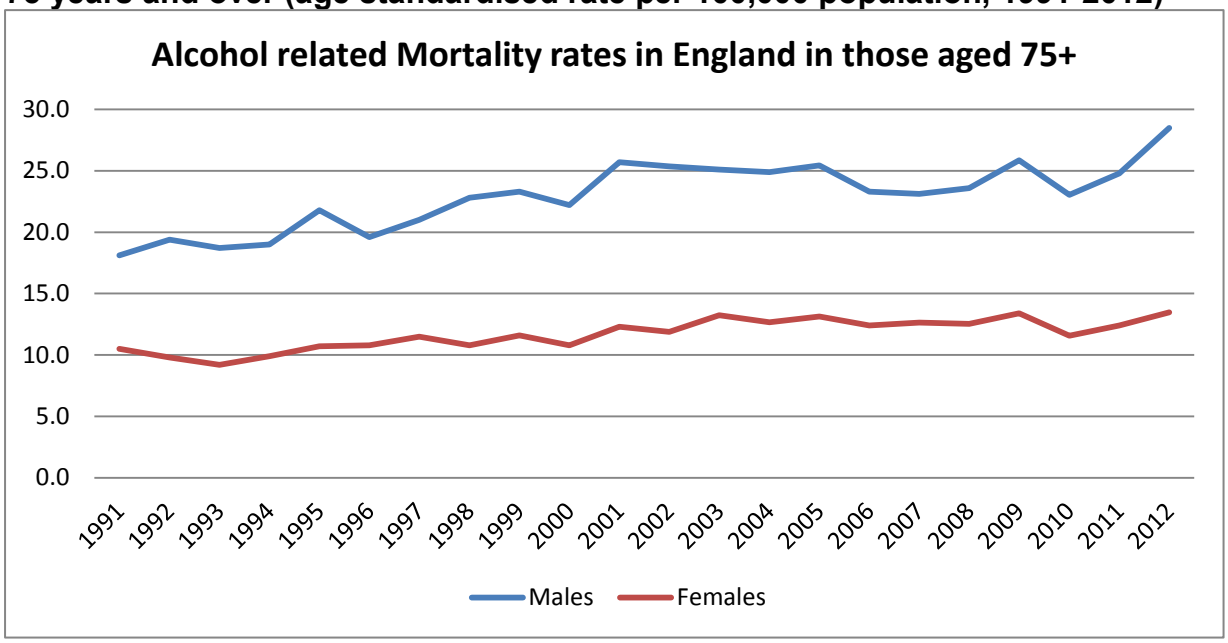


Source: Office for National Statistics 2014

Figure 6 shows that the alcohol related mortality rate in England has been increasing in those aged 55-74 years, particularly for men. This increasing trend in alcohol

related mortality rates is also observed in males and females aged 75 years and over (Figure 7), although the rates are lower compared to those aged 55-74.

Figure 7: Alcohol related mortality rates in England, in males and females aged 75 years and over (age standardised rate per 100,000 population, 1991-2012)



Source: Office for National Statistics 2014

Thurrock has a lower rate of alcohol related hospital admissions (461 per 100,000 population, 2012/13 data) compared to the England and East of England average. There may be a number of reasons for this low figure, including the under reporting and under recording of alcohol-related illness and injury. A new identification and reporting system has recently been introduced at Basildon & Thurrock University Hospital NHS Foundation Trust (BTUH) to capture accurate data on patients presenting with an alcohol related condition.

Nationally those aged 65 and over form a small proportion of those in alcohol treatment – 4% of women and 3% of men [26] . However, an estimated 1.4 million people in this age group currently exceed recommended drinking limits [25], indicating that this is a hidden problem that is not recognised generally.

In partnership with Essex County Council and BTUH, Thurrock Council works with an Alcohol Liaison Service based within the hospital. A key role of the Alcohol Liaison Service is to train health professionals, raise the profile of alcohol attributable illness and injury, and to ensure that these patients are identified and receive the appropriate management. During a 12 month period (September 2014 to September 2014) 10% of patients seen by the Alcohol Liaison Service were aged 65 years and over.

A growing body of evidence suggests that older drinkers are just as likely to benefit from intervention as younger drinkers but embarrassment, shame and the cultural inappropriateness of some mixed-age addiction services can deter older people from seeking alcohol treatment. Lack of transportation and mobility problems may prevent older people from attending services [25].

Local Action

Public Health in collaboration with the Drug and Alcohol Action Team (DAAT) commission a community drug and alcohol service for all age groups. The over 18 service is called KCA Visions and is provided by KCA. There is a prescribing service within this provision including residential detoxification and rehabilitation where applicable.

As a part of the General Medical Services Contract 2014/15, NHS England commissions a Directed Enhanced Service for an alcohol related risk reduction scheme. This scheme requires general practices to case find newly-registered patients aged 16 or over who are drinking at increased or higher levels. Once identified as at risk, patients receive simple brief advice and where identified as alcohol dependent are considered for referral to specialist services. Under this enhanced service, these patients are also assessed for anxiety and depression and are provided with treatment and advice as appropriate.

Local Area Coordinators, adult social workers and sheltered housing officers are have undertaken brief and opportunistic advice (BOA) training delivered by Alcohol Concern. Public Health and the DAAT coordinated this successful multi-agency event and staff from KCA Visions and the Alcohol Liaison Service at BTUH also attended to appraise attendees of the local services and referral pathways.

Recommendations:

- To cascade ‘Making Every Contact Count’ (MECC) awareness training, which includes brief alcohol interventions to staff in the NHS, Council, Local Area Co-ordinators, community groups and other relevant local organisations
- To promote alcohol-related public health campaigns such as ‘Dry January’

Mental health and social interaction in later life

Key Messages:

- Social networks and social contact increase levels of wellbeing in older people
- Social isolation increases the risk of premature death

- Depression is the most common mental health problem in older people

Although mental health problems are not uncommon in older people, they are not an inevitable part of getting older.

The demand for mental health services is likely to increase [27] whilst there is also pressure on public spending to make budget savings. A focus on preventative mental health may prove more cost effective, particularly during a period of economic downturn where the rates of depression tend to increase, along with suicide, attempted suicide and other types of mental illnesses.
Two key areas of focus for older people are the growing issue of loneliness and social isolation and the impact of depression on quality of life in older age.

Loneliness

"Loneliness can escalate to people becoming more isolated, leading to mental health problems and depression and that has a physical impact as well. There's a risk of people losing their independence as result of all of that..." [28]

The LGA guide, Combating Loneliness, describes loneliness as "a subjective state - a response to people's perceptions and feelings about their social connections – rather than an objective state" [29].

Marmot noted that: *"Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill."* [30]

This effect on premature death is comparable with the well-established risk factors of smoking and alcohol abuse [31] [32].

Key risk factors for loneliness include being in later older age (over 80 years), on a low income, in poor physical or mental health [33], and living alone or in isolated rural areas or deprived urban communities [34].

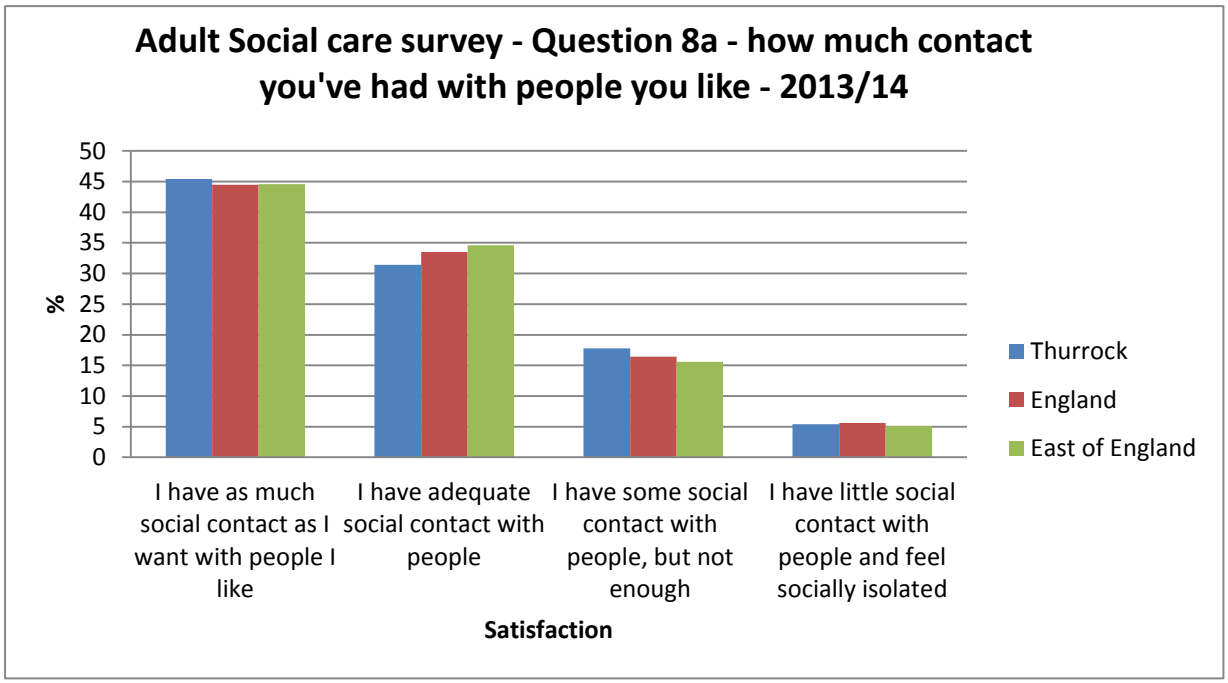
Research has shown that poor mental health and sensory impairments are associated with smaller and less satisfying support networks, as well as lower levels of contact with social networks. Loneliness increases the risk of cognitive decline and dementia, while frequent emotional support and social activity reduce the risk of cognitive decline [31].

Social networks can be important tools in building people's resilience and increasing social contact can increase the levels of wellbeing of older people [35] [36].

The 2013/14 Adult Social Care Survey identified those users of adult social care services in Thurrock are fairly satisfied with their social contact. However, nearly

18% feel that they do not have enough social contact and over 5% feel socially isolated.

Figure 8: Adult Social Care Survey. Response to question on how much social contact adult social care users have had in 2013/14.



Source: HSCIC Personal Social Services Adult Social Care Survey 2013/14

There is some evidence to support mentoring and befriending models although more research is required [37].

Local Action

Thurrock Council's Health and Wellbeing Strategy has been awarded 'gold standard' accreditation by the 'Campaign to End Loneliness', on account of the measurable actions and targets to address loneliness included in the strategy. Thurrock is one of only eight councils in the country to receive this accreditation.

Thurrock Council commission Age UK Essex to provide a home befriending service which provides one-to-one telephone and home based befriending and coffee mornings. Age UK Essex also provide an 'Active Lives' service. This is a volunteer led programme where for a time limited period (approx. 12 weeks) a volunteer helps people aged over 60 on a 1-2-1 basis to access the community, helping them to regain independence and/or confidence by supporting them to attend clubs, visit shops, restart a hobby etc. This intervention is being used with people with no mobility issues but who have become lonely and lost confidence, often after the death of a loved one, when caring responsibilities end or after an illness.

Community Hubs - A co-production between the community, council and partners, Community Hubs are places for services and offer help and support to communities on a variety of issues. Hubs are in place or in progress in Aveley and Uplands, Ockenden and Belhus, Corringham and Stanford, Chadwell St Mary and Tilbury Riverside.

Alongside the Community Hubs, Community Organisers and Community Builders, work in local communities, Community Organisers bring people together, build networks and support people to tackle the local issues which are important to them. Community Builders make connections across communities and organisations.

Local Area Coordinators (LACs) are provided by Thurrock Council and help people who are vulnerable through age, frailty, disability or mental health issues to find their own local solutions, and use a strength-based approach on hopes, aspirations and needs. The 14-month evaluation report for the project has shown that to date more than 46 individuals over the age of 60 have been helped to engage more with other local people [5]. The LACs help with connecting people and communities, an example of this work includes developing a lunchtime club for socialising and healthy eating in partnership with a local public house in Purfleet.

The Public Health Grant is providing seed funding for local activities to enable communities to come together and support one another, leading to improved health and well-being. One example is the community garden in Chadwell. This aims to bring all sections of the community together to achieve a community space for activity and play.

Depression

Depression is a disorder of mood characterised by low mood and feelings of sadness, loss of interest or enjoyment, poor memory and concentration, poor appetite and weight loss, tiredness and feelings of guilt. When severe, sufferers may be unable to cope with everyday life and they may have suicidal thoughts or impulses.

"Depression is the most common mental health problem in older people. Some 25% of older people in the community have symptoms of depression that may require intervention." [27]

The rate of depression is higher for those older people living in a care [38]. Older people with physical ill health, and socially isolated older people are at higher risk [39].

Depression in later life may be triggered by a variety of factors such as bereavement and loss, life changes such as unemployment or retirement, and social isolation. Older people can also become depressed because of increasing illness or frailty or following a stroke or fall.

Early recognition and prompt treatment of depression can reduce distressing symptoms and help to prevent more serious consequences including physical illness, self- neglect, self- harm or suicide.

There are a number of actions an individual may take to help them cope with depression. Asking for help is key, but only one in six older people with depression discuss this with their general practitioner and less than half of these receive adequate treatment [40]. Keeping active, eating healthily and moderating alcohol

intake are also important and can help to improve mood. Enhancing social interaction through hobbies and interests and visiting friends and family can all help to improve mood and assist recovery.

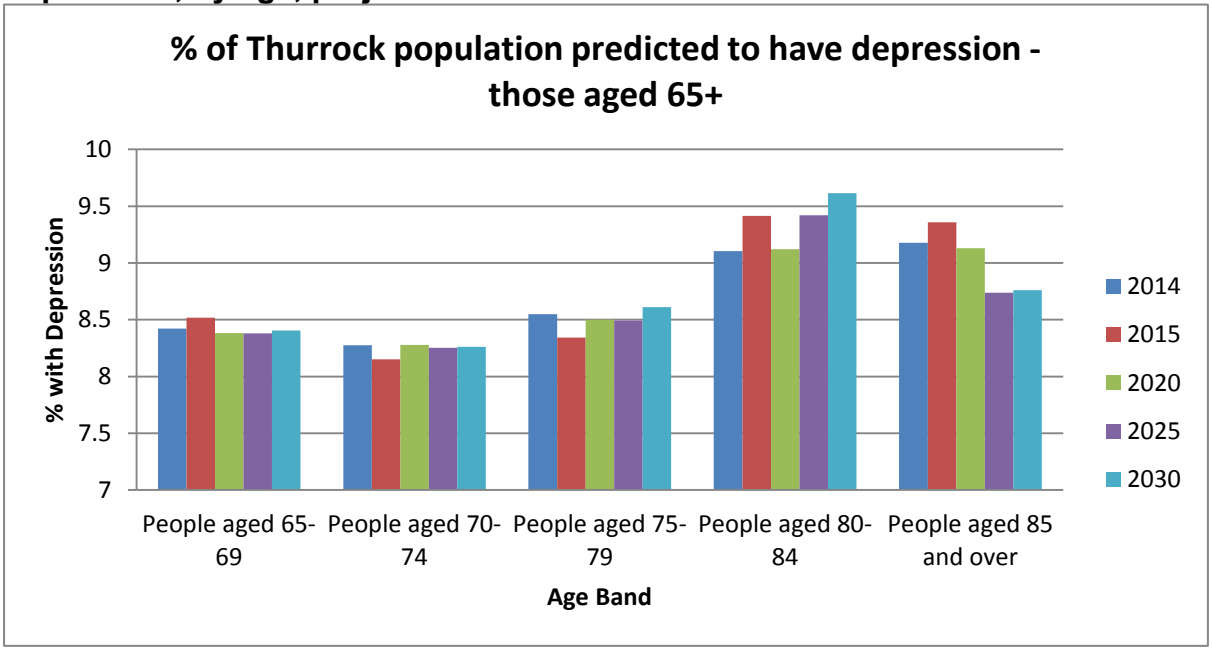
Untreated depression can have a detrimental impact on quality of life in older people, but in addition to this it can increase need for other services, including residential care [27].

Treatment for depression includes antidepressant medication and talking therapies such as psychotherapy and cognitive behavioural therapy in the community. The DH [17] report that older people can respond very well to psychological and medical treatments.

Referral to specialist services is required if treatment has failed to make any improvement. Admission to hospital may be required for a small number of older people who are very unwell with their depression e.g. unable to eat or drink or has attempted suicide.

Figure 9 shows the proportion of older people aged 65 and over predicted to have depression from 2014 to 2030.The predictions show that depression is likely to be highest in the 80-84 age group.

Figure 9: Percentage of People aged 65 and over predicted to have depression, by age, projected to 2030.



Source: POPPI (2013)

Local Action

Improving Access to Psychological Therapies (IAPT) – There are a range of interventions available under the umbrella 'Therapy for You' including psychological interventions such as cognitive behavioural therapy (CBT), counselling and group therapy. They also offer guided self-help through bibliotherapy (book prescription

scheme) and online CBT programmes such as Beating the Blues, Fear Fighter and The Mood Gym.

Public Health within the Council has funded an **exercise referral scheme** for emotional well-being which is being delivered by Impulse Leisure from January 2015. The programme is available to people of all ages and requires a referral by a professional for a well-being assessment.

Public Health has recently commissioned the Thurrock CVS to administer a **preventative mental health grant funding programme** in Thurrock. The aim is to provide funding for community-led initiatives that will improve mental health promotion and mental illness prevention within local communities. Three key areas have been identified for preventative mental health, including: dementia, suicide prevention and depression.

The **voluntary sector** plays an important part in supporting positive mental health and well-being locally. Thurrock MIND offers a range of services to promote positive mental well-being and relief from emotional distress through a range of community services including: befriending, counselling, stepping stones (support with returning to work), Community Bridge Building (one-to-one support in the community) and the Well-being Centre. The Well-being Centre supports adults diagnosed with mental health difficulties to be empowered to take responsibility for themselves by working in a recovery-focused model.

For people with mental health difficulties there are **Community Mental Health services** available. Thurrock Council in partnership with the Alzheimer's Society and South Essex Partnership University NHS Foundation Trust (SEPT), offer advice, information, social activities, short-term intermediate care and assessments and help to access appropriate social and health services. There is an **Older Peoples Community Mental Health Team**, provided by SEPT. This is available to support older people requiring specialist mental health services and provides assessment, care planning, coordination and monitoring, rehabilitation, occupational therapy and domiciliary support.

Recommendations:

- Work in partnership with Thurrock Adult Community College (TACC) and the University of the Third Age (U3A) to deliver messages around a healthy and active retirement
- Develop a peer mentor programme in partnership with existing agencies such as Thurrock Age Concern, local colleges, Cariads and faith groups
- Local Area Coordinators to work alongside vulnerable individuals within the community and increase the number of referrals to lifestyle and other preventative programmes
- Work with commissioners within Thurrock Clinical Commissioning Group and adult social care to jointly improve identification of depression in older people and access to psychological therapies

2.4 Protecting health in later life

Health protection seeks to prevent or reduce the harm caused by infectious diseases and minimise the health impact from environmental hazards [41].

As well as major programmes such as the national immunisation programmes and the provision of health services to treat infectious diseases, health protection involves planning and emergency preparedness, surveillance and response to incidents and outbreaks.

From 1 April 2013, the responsibility for health protection at a local level transferred from Primary Care Trusts and the Health Protection Agency, to Public Health England. Local authorities have maintained their responsibility for aspects of health protection. In addition unitary and upper tier local authorities have a new health protection duty to ensure that threats to health are understood and properly addressed.

The NHS England (Essex Area Team) Screening and Immunisation Team is responsible for commissioning the screening and immunisation programmes covered by the Section 7a agreement of the NHS Act 2006 (amended by the Health and Social Care Act 2012).

For older people, the key areas of focus for protecting health and well-being are seasonal influenza and the uptake of relevant age-related screening programmes.

Seasonal Influenza

Influenza or 'flu' is an acute respiratory illness associated with infection by the influenza virus. Symptoms frequently include fever chills, headache, cough, sore throat, aching muscles and joints and fatigue.

The incubation period, i.e. the period between infection and the appearance of symptoms, is about two to three days. Adults are usually considered to be infectious once symptoms appear and for 3-5 days afterwards.

The flu virus is highly contagious and is easily passed from person-to-person when an infected person coughs or sneezes. Transmission can also occur by touching a surface contaminated with respiratory secretions and then putting the fingers in the mouth or nose or near the eyes. The flu virus can live on a hard surface for up to 24 hours and a soft surface for around 20 minutes.

The Influenza Immunisation Programme

The aim of the influenza immunisation programme is to protect those who are at a higher risk of serious illness or death should they develop influenza. It also helps to reduce transmission of the infection,

The seasonal flu vaccine is offered free on the NHS to the following at-risk groups:

- People aged 65 years or over
- All pregnant women

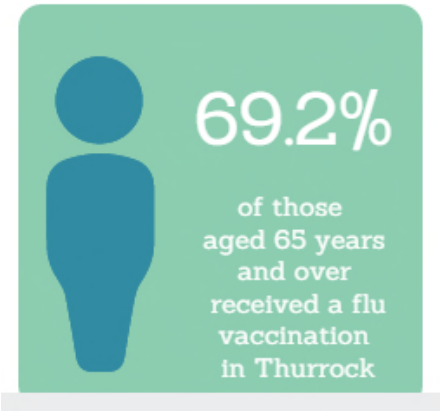
- People with a serious medical condition such as:
  - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
  - chronic heart disease, such as heart failure
  - chronic kidney disease
  - chronic liver disease
  - chronic neurological disease, e.g. Parkinson's disease or motor neurone disease
  - diabetes
  - splenic dysfunction
  - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
- People living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality (excluding prisons, young offender institutions, or university halls of residence)
- People who are in receipt of a carer's allowance, or those who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill

As a part of occupational health, all front line health and social care workers should also be offered flu vaccination.

In 2012, the national Joint Committee on Vaccination and Immunisation (JCVI) recommended that the programme should be extended to all children aged two to 16 years. In addition to providing direct protection from flu for the children who are vaccinated, once fully implemented this will help to interrupt transmission of influenza reducing the spread to unvaccinated children and adults.

Local Statistics

For the 2013/14 season NHS England, Public Health England and the Department of Health set the target for uptake of seasonal influenza vaccine at 75% for those over 65 years of age and 75% for those under 65 years and in risk groups.



NHS England Essex Local Area Team achieved coverage in the over 65 age group in Thurrock of 69.2% (England 73.2%). Uptake in those under 65 years in high risk groups however was 45.2% (England 52.3 %). Vaccine uptake by frontline healthcare workers reached 65.8% in Basildon & Thurrock University Hospitals NHS Foundation Trust (2013-14). The overall uptake for frontline healthcare workers – all trusts in England was 54.8% [42].

In Thurrock, uptake of flu vaccination by those aged over 65 years varies considerably by GP practice from 58-80% (2013/14).

Local Action

The 2014/15 Flu Plan for England [43] contains a good practice guide for GPs to assist them with increasing uptake of flu vaccine in high risk groups locally. This focuses on up-to-date practice registers of high risk individuals, robust call and recall systems and efficient data collection. The NHS England Essex Area Team undertook a flu immunisation pilot with a number of community pharmacists, which evaluated positively. Consideration will continue to be given to improving access arrangements.

Shingles

Shingles is an infection of a nerve and the area of skin around it. It is caused by the herpes varicella-zoster virus, which also causes chickenpox.

The affected area may be very painful and intense itching is common. The rash typically lasts between two and four weeks. Following the rash, persistent pain at the site, known as post herpetic neuralgia (PHN), can develop and is seen more frequently in older people. PHN typically lasts from three to six months, but can persist for longer.

The incidence of shingles in England and Wales is estimated to be around 790 to 880 cases per 100,000 people per year for those aged 70 to 79 years. The risk and severity of shingles increases with age however, the estimated effectiveness of the vaccine decreases with age. The shingles vaccination programme commenced in September 2013, for people aged 70 years in addition to a catch-up programme for people aged 79 years.

Public Health England has published shingles vaccine coverage in England by age cohort and Clinical Commissioning Group (CCG) for the year 1 September 2013 to 31 August 2014. This shows that for NHS Thurrock CCG, 57.2% of the routine 70 year cohort have been vaccinated (compared to 61.8% in England) and 55.2% of those in the 79 year old catch up cohort (compared to 59.6% in England). 100% of practices in Thurrock are reporting annual data (compared to 89.9% in England) [44].

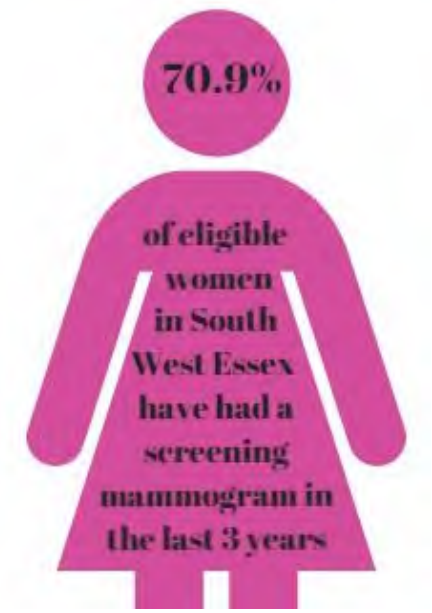
Screening

Alongside leading a healthy lifestyle, participation in screening is an important aspect of maintaining older people's health. There are national screening programmes for breast cancer, bowel cancer and abdominal aortic aneurysm.

The Breast Cancer Screening Programme

The incidence of breast cancer increases with age, with eighty percent of cases occurring in postmenopausal women. It is the 2nd most common cause of cancer death among women in the UK, accounting for 15% of female deaths from cancer [45].

The NHS Breast Screening Programme provides free breast screening every three years for all women aged 50-70 and over using mammography. A mammogram can detect small changes in breast tissue which may indicate cancers which are too small to be felt either by the woman herself or by a doctor. Women aged over 70 may also self-refer to the programme. From 2010 the Breast Screening programme began phasing in an extension of the age range of women eligible for breast screening to those aged 47 to 73, this is due to be completed by 2016.



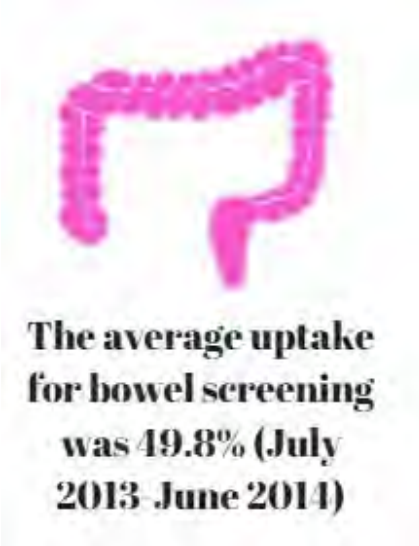
The South Essex Breast Screening Service which covers Thurrock is provided by Southend University Hospital NHS Foundation Trust. This service has a static unit as well as three mobile units which are sited in different areas of the district during the screening round. The service intends to commence age extension in January 2016.

The latest figure (2013/14) for breast screening coverage (proportion of eligible women who have had a screening mammogram in the last 3 years) for women in South West Essex was 70.9%. There has been ongoing work with the breast screening service and their commissioner to increase coverage.

The Bowel Cancer Screening Programme

About one in 20 people in the UK will develop bowel cancer during their lifetime and it is the third most common cancer in the UK [46]; 95% of bowel cancer cases occur in people aged 50 and over.

Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective. Bowel cancer screening can also detect pre-cancerous polyps which may become malignant over time. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.



Polyps and bowel cancers sometimes bleed and the bowel cancer screening programme uses the faecal occult blood test (FOBT) which detects tiny amounts of blood which cannot normally be seen in bowel motions. The FOBT test does not diagnose cancer, but the results indicate whether further investigation (usually a colonoscopy to directly visualise the large bowel) is needed.

Bowel cancer screening is offered to men and women aged between 60 and 74. They receive an invitation in the post followed by a screening test kit. Those with an

abnormal result are offered an initial appointment to discuss the result and decide on the next steps. This is followed by a colonoscopy if required.

The local bowel screening programme is provided by Basildon & Thurrock University Hospitals NHS Foundation Trust.

Uptake of bowel cancer screening has varied from between 45.3% to 56.8% during the year July 2013 to June 2014; the national standard is 55.8%. The Programme is preparing a health promotion plan to target wards with low uptake.

Abdominal Aortic Aneurysm Screening (AAA)

Abdominal aortic aneurysms are formed when the major blood vessel (the aorta) in the body weakens and expands. Large abdominal aortic aneurysms can be very dangerous because they can rupture – if this occurs the outcome is very likely to be fatal.

Men are six times more likely to have this type of aneurysm than women. The chance of having an aneurysm increases with age. The risk also increases if a person:

- smokes
- has high blood pressure
- has a brother, sister or parent that has, or has had, an abdominal aortic aneurysm.

Around 5,000 people, mostly men aged 65 and over, die every year from ruptured AAA. The screening programme should eventually prevent up to half of these deaths through early detection, appropriate monitoring and treatment, usually surgery.

All men in England whose 65th birthday falls on or after 1 April 2013 will automatically be invited for screening. Older men who have not previously been screened can arrange an appointment by contacting their local screening service.

The local AAA screening programme which covers Thurrock is provided by Southend University Hospital NHS Foundation Trust. Screening commenced in August 2013.

For 2013/14, the Essex-wide programme screened a total of 4,679 men of 5,713 invited, an uptake of 82.5%. (This compares to a national average of 81.5%) Of self-referrals, 100% were screened. Four clinics are run in the Thurrock area, at Langdon Hills, Corringham, Grays and Tilbury.

Recommendations:

- Encourage and support people aged 65 and over to have their annual flu jab
- Promote and engage frontline health and social care staff in the take-up of the flu jabs

Chapter 3 In Focus - Dementia in Thurrock

Key messages:

- Dementia is a term used to describe a collection of symptoms, including memory loss, mood changes and problems with communication and reasoning.
- In 2013 there were an estimated 1469 people in Thurrock with dementia
- In 2013 the overall diagnosis rate for dementia in Thurrock was 41.89%

Introduction

Dementia is one of the major health and social care issues of our time. Around 815,827 people in the UK have dementia and this number is set to increase by 40% in the next 12 years [47]. The total cost of dementia to society in the UK is currently £26.3 billion.

It is estimated that one in three people will care for a person with dementia in their lifetime.

Currently only 48% of people with dementia in England have a formal diagnosis or have contact with specialist services.

In recognition of the severe detrimental health and financial impacts of dementia, the Department of Health published a national Dementia Strategy [48]. The key principles of this strategy are:

- Improved public and professional awareness of dementia
- Earlier diagnosis and intervention
- A higher quality of care for people with dementia from diagnosis to end of life.

A follow up report to the Dementia Strategy [49] highlighted that there has been some major progress. This has particularly been in the area of identifying and assessing people with dementia as well as a reduction in the prescription of antipsychotic medication. However, there are still challenges in supporting people with dementia to feel part of their community and making it easier for them to access services. There are also concerns that society in general needs to adapt to deal with the growing number of people with dementia.

What is dementia?

Dementia is a term used to describe a collection of symptoms. These include memory loss, mood changes and problems with communication and reasoning, and a gradual loss of skills needed to carry out daily activities.

Dementia can affect people of any age, but is more common in people aged over 65. Dementia is progressive, which means the symptoms will gradually get worse and the condition is currently incurable. However, medicines and other interventions can lessen symptoms and people may live with their dementia for a further 7-12 years after diagnosis.

There are many diseases that result in dementia. The most common types of dementia are:

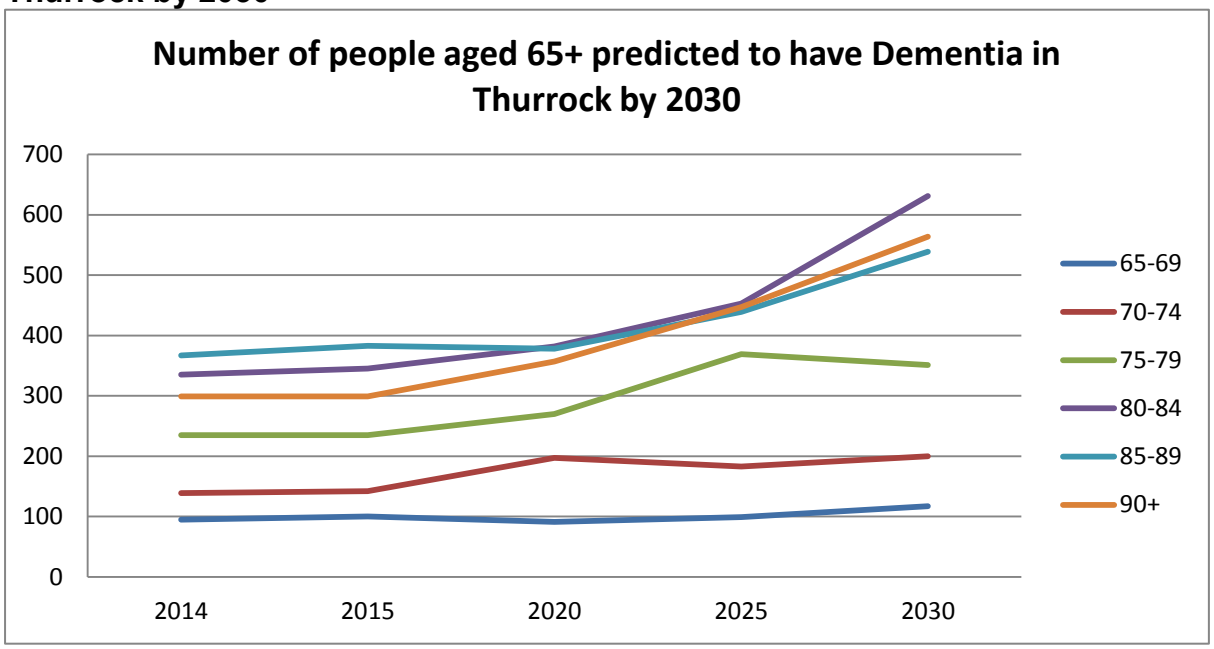
- Alzheimer's disease, which is the most common cause of dementia and accounts for around 62% of cases in England. Brain cells are surrounded by an abnormal protein resulting in their damage and loss.
- Vascular dementia. This results from damage or loss of brain cells due to a reduced or loss of the oxygen supply to the brain because of narrowing or blockage of blood vessels. Vascular dementia accounts for around 17% of cases.
- Mixed dementia**.** This is when someone has more than one type of dementia, and a mixture of symptoms. These account for 10% of total cases.
- Dementia with Lewy bodies – This type of dementia accounts for around 4% of cases. It involves tiny abnormal structures (Lewy bodies) developing inside brain cells.

The symptoms of these types of dementia are often different in the early stages but become more similar in the later stages as more of the brain becomes affected.

People with learning disabilities have an increased risk of developing dementia than other people and usually develop the condition at a younger age. This is particularly true of people with Down's syndrome, one in three of whom will develop dementia in their 50s.

If the prevalence of dementia remains the same, the number of people with dementia in the UK is forecast to increase to 1,142,677 by 2025 and 2,092,945 by 2051, an increase of 40% over the next 12 years and of 157% over the next 38 years [47]. Latest estimates suggest that there are **1469 people in Thurrock with dementia** in 2014 and **1503** predicted in 2015 [47].

Figure 1: Number of people aged 65 and over predicted to have Dementia in Thurrock by 2030



Source: POPPI

Figure 1 shows that the number of people in Thurrock predicted to have dementia by 2030 is highest in those aged 80 and over.

Dementia can affect people of any age, but is more common in people aged over 65, and prevalence roughly doubles from this age onwards. Table 1.0 shows the population prevalence of late onset dementia.

Table 1.0 UK estimated percentage of UK population with late onset dementia by gender and age

Age Group	Females (%)	Males (%)	Overall Prevalence of Dementia in Population (males and females)
60-64	0.9	0.9	0.9
65-69	1.8	1.5	1.7
70-74	3.0	3.1	3.0
75-79	6.6	5.3	6.0
80-84	11.7	10.3	11.1
85-89	20.2	15.1	18.3
90-94	33.0	22.6	29.9
95 and over	44.2	28.8	41.1

Source; Knapp et al, 2014 (1)

People from all ethnic groups are affected by dementia. It is estimated that there are nearly 25,000 people living with dementia from black, Asian and minority ethnic groups in the UK. This is expected to rise significantly as the BAME population ages to nearly 50,000 by 2026 and over 172,000 by 2051 [50].

The cost of dementia

The overall economic impact of dementia in the UK is estimated to be £26.3 billion. This includes:

- £4.3 billion spent of healthcare costs, of which around £85 million is spent on diagnosis.
- £10.3 billion is spent on social care for people with dementia (£4.5 billion publicly funded and £5.8 billion privately funded
- The cost of unpaid care for people with dementia in the UK is £11.6 billion,

The total number of unpaid hours of care provided to people with dementia in the UK is £1.34 billion. Around £111 million is spent on other dementia costs.

Prevention

Risk factors for developing dementia are well documented [51] [52]. Established risk factors that are (or are potentially) modifiable/ preventable include:

- Hypertension
- Excessive alcohol consumption
- Smoking
- Obesity
- Diabetes
- Head injury

Up to 30% of dementia cases have a vascular component (i.e. vascular dementia or mixed dementia) and the effects of vascular dementia can be minimised or prevented altogether through a healthy lifestyle.

Early intervention

Currently only about one-third of people with dementia receive a formal diagnosis at any time in their illness [53]. When a diagnosis is made, it is often too late for those suffering from the illness to make choices.

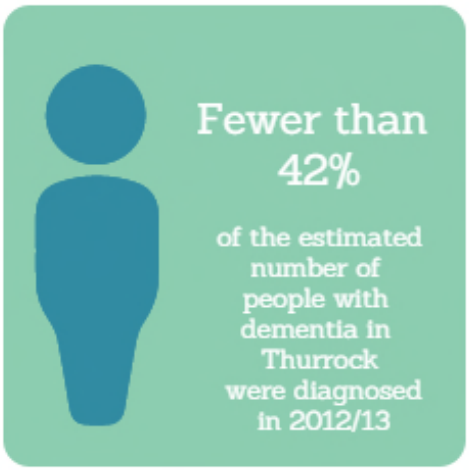
Diagnosis is not an end in itself, but a gateway to making informed personal life choices. It should provide access to a full range of treatment, including medical and psycho-social interventions, and importantly, post-diagnosis support and services. There is also strong evidence that early diagnosis and intervention can help to delay or prevent unnecessary admissions into care homes by up to 22% [54].

Diagnosis

The timely diagnosis of dementia is very important. It is the key to helping people with dementia, their families and carers get the support they need, to plan for the future and to make informed choices about how they would like to be cared for.

More needs to be done to increase the number of people with dementia being properly diagnosed. Currently less than half of the estimated number of people with dementia in England receive a formal diagnosis or have contact with specialist

dementia services. While there has been a slight increase nationally in the diagnosis rate from 46% in 2011/12 to 48% in 2012/13, the diagnosis rate varies across the country from 39% in the worst performing areas to 75% in the best.
In Thurrock this figure was 41.89% in 2012/13 [55]. Similar to the national picture, there is a wide variation in the dementia diagnosis among GP Practices in Thurrock.



The GP disease registers for dementia in 2012/13 indicates that 715 people have been identified with Dementia in Thurrock.

Currently around half of people diagnosed with dementia are in the early stages of the condition, which provides a greater opportunity for planning for the future and increased efficacy of anti-dementia drugs.

Living with dementia

Once someone has received a diagnosis of dementia there will be a range of different types of support they and their families will need. Depending on how advanced their dementia is they may need health and care support straight away. Everyone will need support, advice and help to understand what it means to have dementia, what they can do to live as well as possible with the condition and to enable them to plan for the future.

Post-diagnosis help and support includes:
- information about available services and sources of support
- a dementia adviser to facilitate access to care and advice
- peer support to provide practical and emotional support to reduce isolation and promote self-care.

Helping communities to become dementia-friendly is an important part of what we as a society can do to help support people after they have been diagnosed with dementia.

Supporting carers

The majority of people with dementia are cared for at home by a relative or friend. The average age of unpaid family carers is between 60 and 65 years, and many are much older. Given the nature of dementia, and the effect it can have, such as changes in personality and mood, carers of people with dementia can experience stress over many years of caring.

Most family carers want to be able to support the person they are caring for at home, but they sometimes need more assistance in terms of information and advice on caring for someone with dementia while also looking after their own health.

Supporting carers must become an integral part of the care and support package for people with dementia. When carers are well supported, they can provide better care for the person with dementia, leading to better outcomes for all.

The Dementia Action Alliance launched a 'Carers Call to Action' in 2013 [56] setting out goals to bring about real change for carers. It calls for a society where carers of people with dementia:

- have recognition of the unique experience of caring for someone with dementia
- are recognised as essential partners in care – valuing their knowledge and the support they provide to enable the person with dementia to live well
- have access to expertise in dementia care for personalised information, advice, support and co-ordination of care for the person with dementia

The Dementia Action Alliance is approaching Health and Wellbeing Boards in England to sign up this shared vision for carers of people with dementia.

End of life care

One in three people over the age of 65 will die with dementia [57] and dementia is now one of the top five underlying causes of death. Early conversations with people with dementia are important so that plans can be made well in advance about their future care, including palliative and end of life care. All too often emotional decisions are made in a crisis when the wishes of the person with dementia, including for example where they want to die, cannot be taken into account.

Every person with dementia should receive excellent care at the end of their life and be treated with dignity and respect. More health and care professionals need to be aware of the possible alternatives to hospitalisation and having 'planning ahead' conversations with people with dementia and their families. This will allow more choice and control over their care, an improved experience and their needs and wishes respected.

Dementia Friendly Communities

People with dementia want to live in communities that give them choice and control over their lives and provide services and support designed around their needs. They also want to feel valued, understood and part of family and community life.

However, nearly half of UK adults acknowledge that public understanding of dementia is limited, and 73 % of them do not believe society is geared up to deal with the condition [57].

In response to these challenges, the Alzheimer's Society set up the 'Dementia Friendly Communities' programme in 2013 [58]. This programme sets out criteria that communities who wish to be recognised as working to become dementia friendly are expected to achieve, such as involving people with dementia, raising awareness of dementia and setting achievable goals.

In addition to Dementia Friendly Communities, the Alzheimer's Society also launched the Dementia Friends initiative, to help to change how the public thinks and feels about dementia and understand how to help people with the condition.

Dementia Friends training allows people to have the confidence to engage with people who have dementia and provides them with the skills to interact in a way that is both useful and welcome. Dementia Friends is being implemented by a network of Dementia Friends Champions who deliver short information sessions through networks of friends, workplaces and communities. The ambition is to have one million Dementia Friends by 2015.

Establishment of Dementia Action Alliances

A national Dementia Action Alliance (DAA) was established in 2010, to act as a catalyst for national action and collaboration on dementia. Since its inception it has co-ordinated action on cross cutting issues affecting people with dementia and has ensured members have committed to action plans around improving the lives of people with dementia.

Local dementia action alliances have the potential to be similarly transformative in their communities, bringing together organisations and individuals committed to taking action to support people with dementia and their carers.

Local Action

The Council has pledged its support for Thurrock to become a Dementia Friendly Community. A significant proportion of the staff who work for the Council also live in Thurrock and this provides a unique opportunity for them to be the catalyst for local change around raising awareness of dementia in the wider community.

There has been top level support for Dementia Friends training, with senior officers receiving the training as well as supporting its roll out more widely in the Council. All Members agreed a motion for Thurrock Council to work towards 'Dementia Friendly' status, and have attended Dementia Friends information sessions.

During 2014, the Council worked jointly with the Alzheimer's Society to deliver Dementia Friends sessions to all Council staff and the wider community. There are also plans to build a local Dementia Action Alliance.

The local Neighbourhood Watch have been introduced to individuals that could provide dementia friends training, thus providing existing community support networks with the tools they need to continue and better support vulnerable individuals within the communities they live.

The Council offer a range of services to help people live independently at home, including personal care services, domestic help and day care services. Residential care is also available for people with significant need who qualify.

GPs play a vital role in not only timely diagnosis of dementia but also in ensuring that well-planned and co-ordinated community services are in place to help the person once they have been diagnosed.

National initiatives to support an earlier diagnosis of dementia include:

- The introduction of a memory test as part of the assessment of NHS Health Checks in those aged 65 -74 will help to identify those people requiring further assessment in the local Memory clinic.
- Supporting people to recognise the signs and symptoms of dementia. A nationwide campaign was launched in 2012 to raise dementia awareness by encouraging people to visit their doctor if they were worried or if they wanted more information, to visit NHS Choices. The campaign reached over 27 million people.
- Supporting GPs to identify people with dementia through the use of enhanced services in which GPs ask people in certain at risk groups about their memory, for example, those with cardiovascular risk factors, people with long term neurological conditions and people with learning disabilities.

The Alzheimer's Society in Thurrock offer a range of services and activities including a Memory Group, support group for men, keep fit for younger people with dementia, information provision and awareness events, community support service, the carer information and support programme (CrISP), and one-to-one dementia support.

The Council also commissions POhWER to deliver Independent Mental Capacity Advocacy, Deprivation of Liberty Safeguards, Paid Relevant Persons Representative Advocacy Services and Community Advocacy. POhWER hold regular drop in services at the South Ockendon Centre, Corringham Library, Grays Library, Tilbury Library. POhWER has a free one-to-one advocacy service for people with dementia.

Recommendations:

- The Thurrock Health & Wellbeing Board should review the local work being undertaken to increase the proportion of people who receive an earlier diagnosis of dementia
- The Thurrock Health and Wellbeing Board should consider the specific needs of carers of people with dementia
- Develop a training programme for health and social care staff to identify dementia symptoms to ensure timely referral to specialist dementia services, including memory clinics, to facilitate formal diagnosis
- Further work is done to promote dementia friends training within the Council, with external partners and the community

Chapter 4 Maintaining Independence and Self-care

Introduction

The challenge being faced in Thurrock is one which is being faced nationally. A growing population of older people placing an increasing demand on health and social care services. While providing excellent quality services remains an important aim, preventing ill-health, maintaining independence and self-care have all become a significant focus of work to help people in Thurrock have a better quality of life in old age.

This means working in partnership with communities and statutory, voluntary and private sectors to shift resources towards preventative well-being services and community solutions to meet needs and support individuals to remain independent [59].

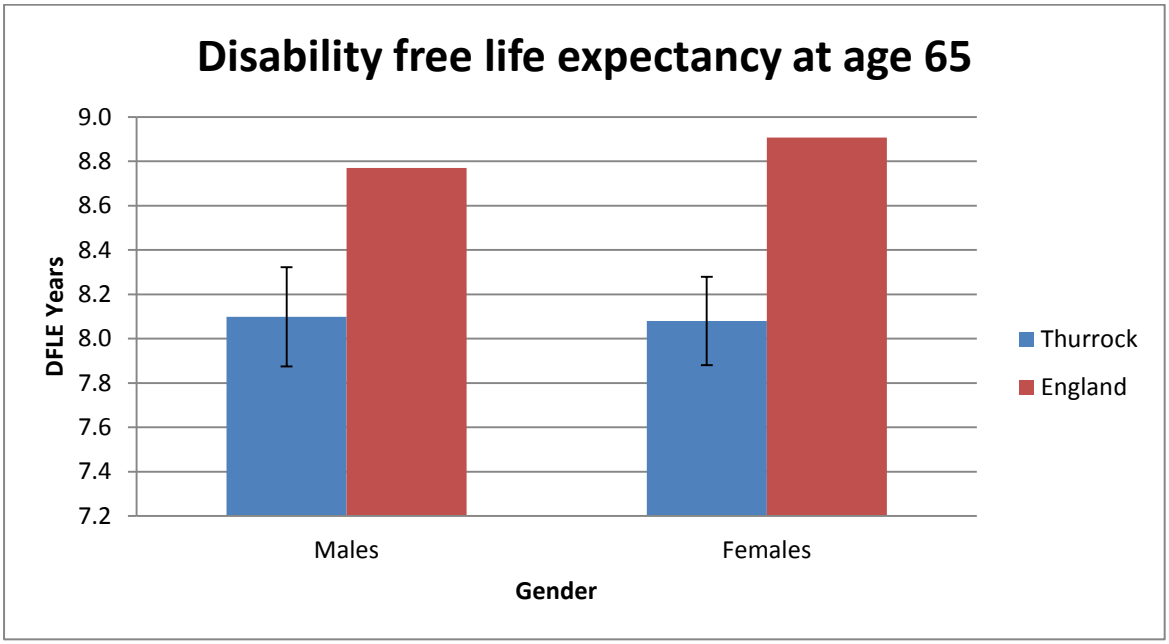
Prevention is embodied by the Care Act, approved by Parliament in May 2014. The Act establishes new duties and responsibilities on councils. The key changes include:

- New duty to provide clear information and advice to help people understand what help they can get
- New duty to promote a principle of well-being
- Stronger emphasis on prevention and focusing on people's own strengths and capabilities, and those, that may exist in the communities and networks around them to support people to live as independently as possible
- Increased rights for carers
- New minimum eligibility threshold that will determine whether people can access support from the council
- Reforms to the way in which people pay for care and an introduction of a cap on care costs

The Government has also introduced the Better Care Fund. The purpose of the fund is to use existing pooled money shared between the Council and Health (Thurrock NHS Clinical Commissioning Group (CCG)) to support integration between social care and health services to provide people with better, more holistic care and support. This fund is to help with the new duty in the Care Act 2014.

Nationally life expectancy has been increasing; however, people are not necessarily living longer in good health. This is a particular issue locally, Figure 1 highlights that disability-free life expectancy at 65 years is significantly lower for males and females in Thurrock compared to England.

Figure 1: Disability-free life expectancy at age 65 years



Source: ONS

Understanding the factors determining people's use of health and social care services can help to inform the care and support provided to people to help them live well for longer.

4.1 Hospital Admissions

Key Messages

- The main reasons for emergency hospital admissions and readmissions for people aged 65 years and over in Thurrock are urinary tract infections and respiratory problems - chronic obstructive pulmonary disease and pneumonia

Emergency admissions are unpredictable and happen at short notice [60]. Emergency admissions may represent a life event which may change the health and social care needs of an individual, and may highlight that a condition or illness had not been previously identified or not managed.

Emergency Hospital Admissions

Table 1 provides a summary of the top 5 reasons for emergency admissions of people aged 65 and over in Thurrock, and their associated costs for 2013-14. Urinary tract infection caused the highest number of emergency

For people aged 65 years and over

In 2013/14:

There were 4,935 emergency admissions

The total cost of emergency admissions was £15,527,498

admissions and had the highest associated cost.

Although there were only 91 emergency admissions from fractured neck of femur in 2013/14, they accounted for the third highest level of expenditure (£559,821) for emergency admissions in older people.

Table 1: Thurrock Emergency Hospital Admission by Primary Diagnosis and Cost, People aged 65 years and over, 2013-14

Thurrock Emergency Admissions Summary by Volume		
Primary Diagnosis	**Volume**	**Cost**
Urinary tract infection, site not specified	278	£956,195
Chronic obstructive pulmonary disease with acute lower respiratory infection	190	£509,296
Lobar pneumonia, unspecified	164	£582,336
Pneumonia, unspecified	128	£445,637
Unspecified acute lower respiratory infection	120	£320,028

Source: SUS data

Emergency Re-admissions

Emergency re-admission data shows a similar picture, with urinary tract infection being the primary cause of emergency re-admission (Table 2).

For people aged 65 years and over

In 2013/14:

There were 1,175 emergency readmissions

The total cost of emergency readmissions was £3,581,989

Table 2: Thurrock Emergency Re-Admissions, by Primary Diagnosis and Cost, People aged 65 years and over, 2013-14

Thurrock Emergency Re-Admissions Summary by Volume		
Primary Diagnosis	**Volume**	**Cost**
Urinary tract infection, site not specified	57	£195,388
Chronic obstructive pulmonary disease with acute lower respiratory infection	54	£171,454
Congestive heart failure	48	£169,194
Pneumonia, unspecified	34	£107,136
Lobar pneumonia, unspecified	30	£100,846

Source: SUS data

Urinary Tract Infection

A recent review [61] highlighted that urinary tract infections (UTIs) are one of the top ambulatory care sensitive conditions (considered preventable) which disproportionately affect older people. The prevalence of UTI increases with age and this increase is seen in both sexes [62]. It is estimated that 10% of men and 20% of women over the age of 65 years have asymptomatic bacteriuria [62].

It is particularly important to promote prevention messages among patients at risk of UTI, particularly patients with continence problems. These messages include maintaining fluid intake and hygiene.

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, and emphysema. It is one of the most common respiratory diseases in the UK and the main cause of COPD is smoking [63].
Local tobacco control profiles for Thurrock show that smoking attributable mortality and smoking attributable hospital admissions are significantly worse than the England average (all ages) [64]. Stopping smoking is the single most effective way to reduce the risk of getting COPD [63].

Pneumonia

Pneumonia is inflammation of the tissue in one or both of the lungs, usually caused by an infection [65]. The most common form of pneumonia is caused by the bacteria Streptococcus pneumonia, also known as pneumococcal pneumonia.
Good hygiene and a healthy lifestyle can help to prevent pneumonia and smoking can increase the chances of infection [65]. People at high risk of pneumonia should be encouraged to have the pneumococcal (pneumo) jab and an annual flu jab.

Falls

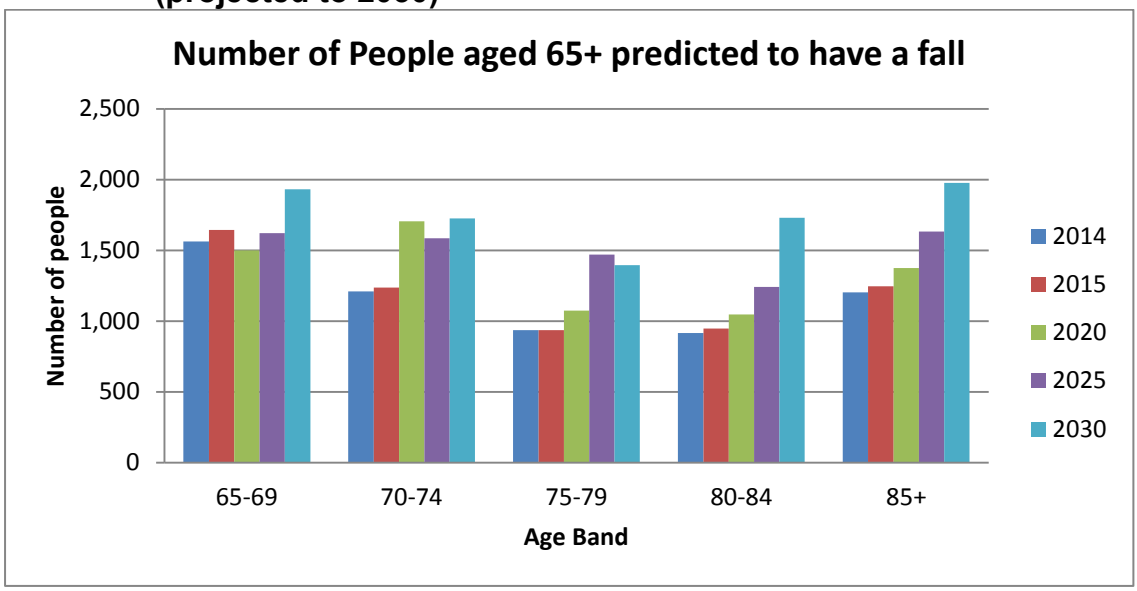
Hip fracture is the most common injury related to falls in older people and is a major cause of disability and the leading cause of mortality due to injury in older people aged 75 and over. NICE [66] report that 30% of people aged over 65 and 50% of people aged over 80 have a fall at least once a year.

Hip fractures in the elderly can lead to loss of mobility and loss of independence. For many older people it is the event that forces them to leave their homes and move into residential care. Half of those with a hip fracture never regain their former level of function and one in five dies within three months [67]. Mortality after hip fracture is high, around 30% at one year.

The annual cost to the UK Government from falls in those aged 60+ is £1 billion with the average cost of a single hip fracture estimated at £30,000. This is five times the average cost of a major housing adaptation (£6,000) and 100 times the cost of fitting hand and grab rails to prevent falls. [68].

With the predicted increase in the number of older people in the population, there is likely to be an increase in the numbers of older people who have a fall (Figure 2).

Figure 2: People aged 65 and over predicted have a fall, by age and gender, (projected to 2030)



Source: POPPI, version 9.0

It is estimated [69] that a falls prevention strategy could reduce the number of falls by 15 – 30%. NICE have issued a clinical guideline [66] on the assessment and prevention of falls in older people which recommends:

- 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 fall/s and considered for their ability to benefit from interventions to improve strength and balance.

- 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 falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service.

- All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention.

- In successful multifactorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):
    - strength and balance training
    - home hazard assessment and intervention
    - vision assessment and referral
    - medication review with modification/withdrawal

There is strong evidence that [70] that regular exercise may be one way of preventing falls and falls-related fractures. Participation in a weekly group exercise programme with ancillary home exercises has been shown to improve balance and reduce the rate of falling in at-risk older people living in the community. Exercise

interventions should be acceptable to older people and sustainable in the long-term. GPs are in an ideal position to identify and support those who would derive the greatest benefit from the programmes [71].

Age UK have put together 8 Top Tips to help support older people to reduce their chance of a fall:

1. Exercise regularly – focusing on activities that challenge your balance, such as gardening or dancing
2. Ask about your medicines – certain medicines can make you feel faint or affect your balance
3. Check your eyes and hearing – problems with either could affect your balance and coordination
4. Visit your GP – if you have had a fall or are worried about falling, a
5. Vitamin D for vitality – it's essential for keeping your bones strong and the best source is sunshine
6. Count your calcium – a balanced diet rich in calcium helps to keep bones strong too, so make milk and dairy foods part of your diet
7. Check for home hazards – make sure your home is hazard free and well lit to prevent tripping
8. Look after your feet – problems with your feet can affect your balance and be sure to wear well fitted shoes and slippers.GP can help to put your mind at rest

Local Action

COPD & Pneumonia

NHS Thurrock CCG jointly worked with NHS Basildon and Brentwood CCG on a **respiratory review,** with a focus on chronic obstructive pulmonary disease (COPD) services provided within primary, community and secondary care. This identified some gaps within the existing service provision and the CCG are now working with the providers in delivering services in line with best practice guidelines.

COPD winter planning - As part of winter planning initiatives, NHS Thurrock CCG in collaboration with NHS Basildon and Brentwood CCG and the community COPD team have implemented a new model of care provision for COPD patients. Each patient seen by the COPD team receives:

- An offer of smoking cessation support services if a smoker
- Review by nurse specialist
- Offer of referral for pulmonary rehabilitation
- Review of the their COPD medication
- Review of their rescue pack/plan
- Pneumonia or flu vaccine
- Spirometry review
- Referral for oxygen assessment if relevant [72]

COPD Nurses now form a part of the Rapid Response and Assessment Service.

Falls

NELFT provide a **falls clinic** which operates from Thurrock Day Hospital. The patient is assessed for various risk factors relating to falls including cardiovascular, neurological and cognitive examination, medication review, vision assessment, osteoporosis risk assessment, strength, balance and mobility assessment, functional assessment and home hazards.

A **Falls Group Programme** operates within Thurrock and Brentwood Day hospitals. This once weekly, ten-week programme includes education and exercises to help improve an individual's strength and balance to reduce the risk of falls.

Public Health commission a **pilot exercise referral scheme** which includes a referral pathway for older people. Activities include chair based exercise, swimming, and strength and mobility based exercise programmes. The focus of the programme is the reduction of falls.

Under the Better Care Fund programme there has been further development of a **comprehensive falls prevention programme** that provides multidisciplinary assessment, a programme of falls risk reduction (including exercise programmes, adaptations, prescribing interventions etc.) and on-going follow up. This will target patients that have experienced falls to reduce risk of recurrence, in addition to those identified as at risk by primary care and acute and community services.

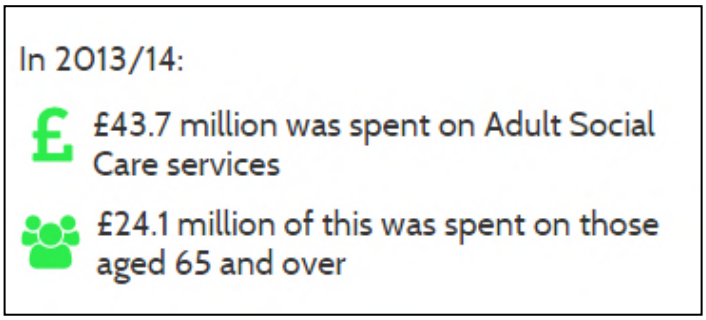
The **Well Homes project** which works with private sector housing, includes the identification and rectification of trip hazards.

4.2 Use of Social Care

Key Messages:

- **5% of older people receive reablement services after leaving hospital (excluding NHS reablement)**
- **Nearly 90% of older people are at home 91 days after leaving hospital into reablement**
- **Referrals to adult social care from secondary care are increasing**

The use of social care differs according to the presence of certain long-term conditions. For example people with mental health problems, falls and injury, stroke, diabetes and asthma tend to use local-authority funded social care more; those with cancer appear to use relatively less [73].



The Adult Social Care Outcomes Framework looks at how social care is performing across the country. Overall, Thurrock has similar or better outcomes in comparison to England, Eastern region, and similar local authorities.

Source: [59]

The number of permanent admissions to residential and nursing care homes can be used as a measure of the effectiveness of care and support in delaying dependency on care and support services. Reablement or rehabilitation services seek to support people, in order to minimise their need for on-going support and to maximise their independence [74].

Supporting people to achieve and maintain independence at home through effective discharge from hospital into reablement services is a priority for Thurrock. Overall, Thurrock performs well with 89.9% of people discharged into these services still at home 91 days after their intervention.

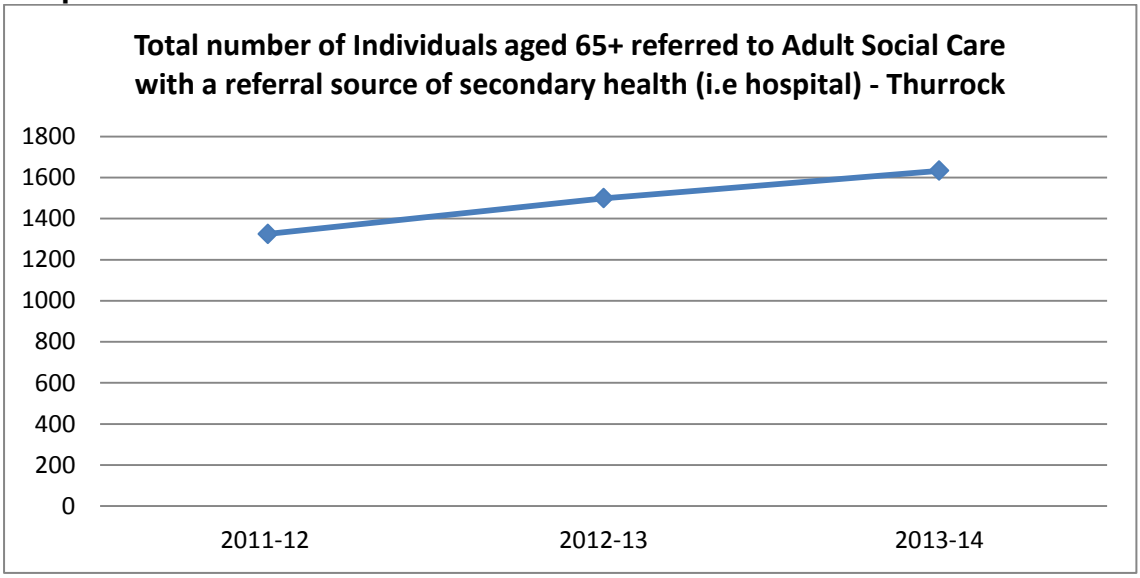
Table 3: Adult Social Care Outcomes Framework indicators relating to supporting people to maintain independence.

Permanent admissions to care homes in people aged 65 years and over	623.4 per 100,000
Older people who are at home 91 days after leaving hospital into reablement	89.9%
Older people receiving reablement services after leaving hospital (Social Care only, excludes NHS reablement)	5%

Source: HSCIC, 2014

A recent review looking at older people with complex needs highlighted that important service-level design elements of care for older people with chronic and multiple conditions include holistic care assessments, care planning, a single point of entry, and care co-ordination. Successful models also demonstrated effective working with individuals and informal carers to support self-management. Personal contact with a named care co-ordinator and/or case manager was also shown to be more effective than remote monitoring or telephone-based support [8].

Figure 3: Referrals of patients aged 65 years and over to social care from hospital.



Source: Thurrock Council Referrals to Social Care

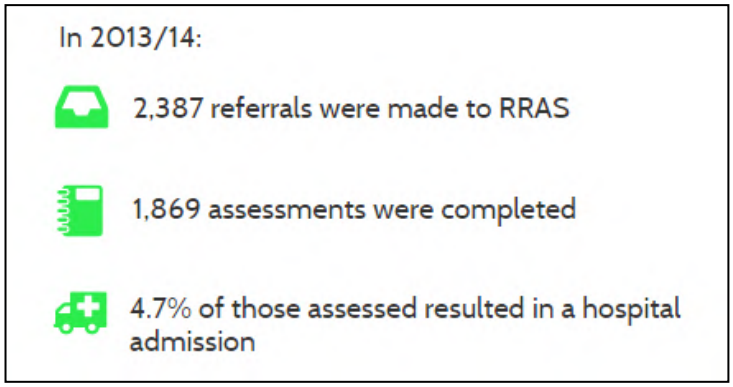
Figure 3 shows that there has been a steady rise over the last three years in those aged 65 and over being referred to adult social care from a secondary health source i.e. hospital. There were an additional 300 referrals in 2013/14 compared to 2011/12, which equates to a 23% increase.

Local Action

Under the **Better Care Fund** the Council and Thurrock Clinical Commissioning Group (CCG) have established a Whole System Redesign Project Group as part of their Health and Social Care Transformation Programme. Guided by data and intelligence and patient and service user experience, the Group is reviewing how and what requires redesign, with the focus on reducing hospital and residential home admission for adults aged 65 and over.

Thurrock's strategy to ensure people age well focuses on solutions – recognising that a service response is not the only response. Our ageing well strategy is known as **Building Positive Futures** and has a number of strands:

- Create the homes and neighbourhoods that support independence;
- Create the communities that support health and wellbeing; and
- Creating the social care and health infrastructure to manage demand.



The Council and NHS already work closely in a number of areas linked to reducing admissions for the over 65s. This includes the **Rapid Response and Assessment Service** – an integrated service between adult social care and the NHS community health

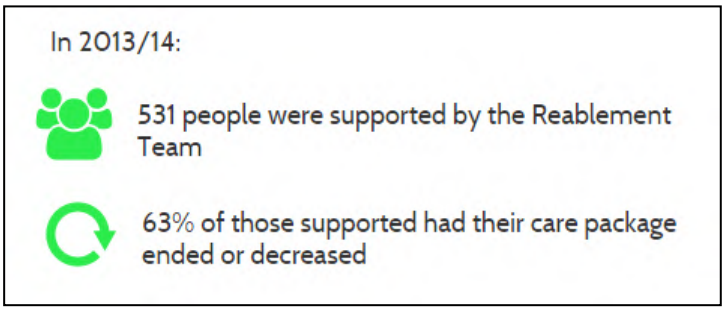
provider aimed at identifying individuals who are at risk of hospital admission and preventing that admission. The service relies heavily on GPs recognising those at risk and linking in to the service.

The Council, in partnership with Thurrock CCG, also has an integrated **Joint Reablement Team** with the NHS community service provider aimed at preventing readmission to hospital through the provision of a 6 week support for people to regain skills or mobility after a period of illness or hospital admission.

Telecare and **assistive technology** services are designed to enable independence for disabled and older people. In Thurrock, Careline is an emergency home alarm system that runs 24 hours a day, 365 days of the year. It is available for all tenants in Thurrock who are elderly, disabled, vulnerable or suffering from a chronic sickness.

The Council also provides i**nterim beds** in a Council-run care home in Corringham, which is a short-term service to help people regain their independence after an illness or hospital admission. Interim extra care flats are also available. In 2013/14 30% of people were able to return home from interim beds.

Under the **Better Care Fund** a number of projects, including a joint frailty model to enhance services for people with complex needs (including dementia and frailty) are currently being developed [59].



4.3 Long term conditions

Key Messages:

- **58% of people aged over 60 have a long term condition**
- **People with long term conditions are the most intensive users of health and social care services**
- **The NHS Health Check presents an opportunity in mid-life for checking risk of disease and offering action which could prevent ill health, or risk factors from getting worse, particularly in older age.**

A long term condition is a condition that cannot presently be cured, but can be controlled by medication and /or other treatments and therapies [75]. There is no definitive list of long term conditions (LTCs) and the term can refer to a wide range of conditions including chronic obstructive pulmonary disease (COPD), diabetes, asthma, coronary heart disease (CHD), hypertension, neurological conditions, musculo-skeletal conditions and arthritis.

It is estimated that 15.4 million people in England (over a quarter of the population) live with a long term condition [76]. This figure is predicted to increase by nearly 17% to 18 million by 2025 [76].

"People with long-term conditions now account for about 50 per cent of all GP appointments, 64 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days." [76] [75]

In total around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs [75].

Long term conditions are more prevalent in older people. Approximately 14% of people aged under 40 have an LTC, compared with 58% of people aged over 60 [75]. The population of people aged 65 or over is set to increase and services will be put under pressure by the growing population of older people with an LTC. Services will need to radically change if they are to meet their clients' needs effectively. There will also be increased pressure on informal carers, many of whom are older and in poor health themselves.

Long term conditions are also more prevalent in more deprived groups. People in the poorest social class have a 60% higher prevalence than those in the richest social class, and 30% greater severity of disease [75].

In addition, an increasing number of people have what is termed 'multi-morbidity' i.e. two or more long term conditions, which makes the delivery of their care more complex [77]. Although the prevalence of multi-morbidity increases with age, more than half of all people with multiple long term conditions are younger than 65 years [77]. Care for people with multi-morbidity can be complex and become fragmented, as they will often see a number of different specialists to manage their individual long term conditions.

Some combinations of conditions are more common than others, in particular physical and mental health co-morbidity is very common. Many people with physical long -term conditions also experience mental health problems such as anxiety and depression. People with mental health problems are also more likely to have poor physical health.

The prevalence of long term conditions can be derived from a number of sources. A key source of information that can be used to assess local prevalence is the Quality and Outcomes Framework (QOF). This is a major part of the General Practice (GP) contract to secure better health outcomes by early, systematic and sustained monitoring and treatment of people with risk factors and long term conditions.

Data on various health conditions is collected from specific GP disease registers and entered onto a national IT system, known as QMAS. The number of people on GP disease registers in Thurrock is shown in Table 4.

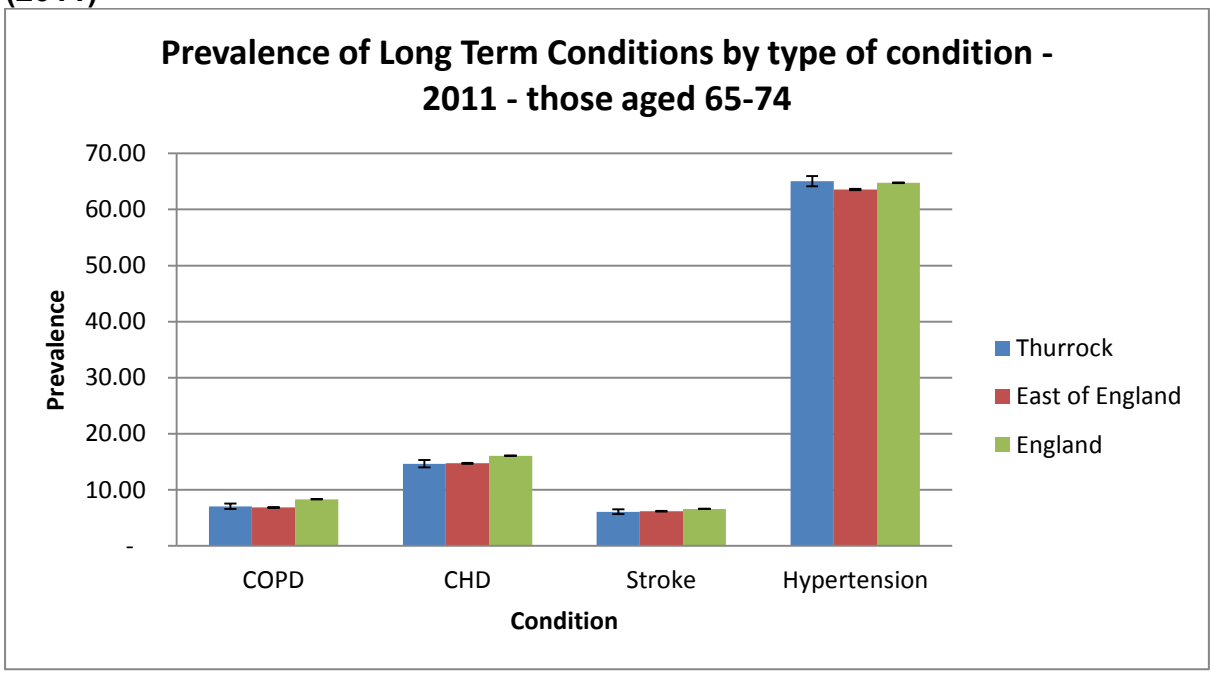
Table 4: Number of people on GP disease registers in Thurrock with a long term condition in 2013/14 (People aged 16 and over)

LTC	Thurrock		Midlands & East of England	England
	Register Size	Prevalence %		
COPD	2989	1.8	1.77	1.78
Obesity	14691	11.3	9.86	9.42
Cancer	2762	1.66	2.17	2.1
CKD	5304	4.22	4.21	4
Diabetes	7901	6.18	6.53	6.21
Dementia	715	0.43	0.62	0.62
Depression	9339	7.42	6.8	6.52
Mental Health	1119	0.67	0.8	0.86
CHD	4497	2.71	3.36	3.29
CVD	5362	3.23	2.89	2.81
HF	1103	0.66	0.75	0.71
STIA	2469	1.49	1.75	1.72

Source: Quality and Outcomes Framework (QoF)

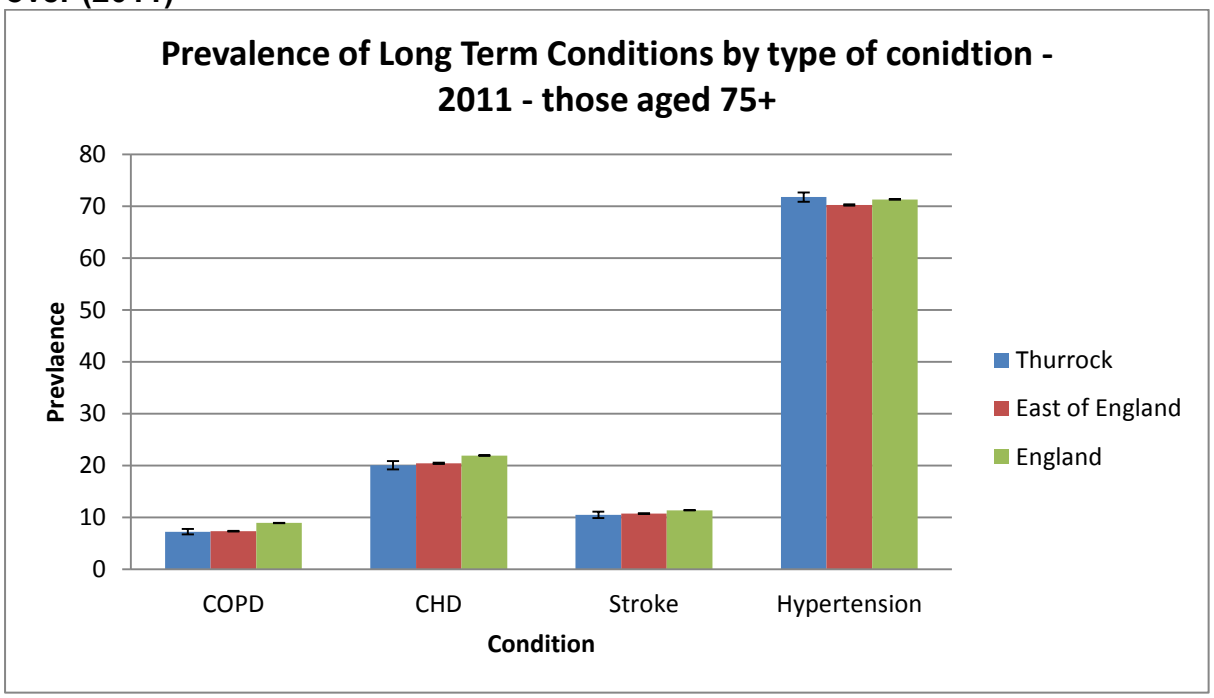
Modelled estimates of long term conditions based on local demographics for those aged 65-74 years (Figure 4) and those aged 75 years and over (Figure 5) indicate that the prevalence of these diseases is not significantly different to the national average.

Figure 4: Modelled Prevalence of Long-Term Conditions in people aged 65-74 (2011)



Source: ERPHO

Figure 5: Modelled Prevalence of Long-Term Conditions in people aged 75 and over (2011)



Source: ERPHO

As with all complex health issues there is no simple solution to the challenge of long-term conditions, but there is a growing consensus that better outcomes can be achieved by a whole system approach with a combination of:

- "upstream action" to reduce risk factors such as smoking, high blood pressure , physical inactivity, poor diet, obesity, poor mental health and alcohol
- improved access to preventative health care and to early diagnosis
- a shift from "giving care" to a system of self-management , reablement and independence
- development of an integrated model of care delivery

The new public health, health and social care system was established in 2013, with a focus on improving outcomes. In the same year, the Secretary of State for Health set out a challenge for the public health, health and social care system in his document, *Living Well for Longer: A Call to Action to Reduce Avoidable Premature Mortality* [19]. The challenge was to:

- to reduce the rate of premature avoidable deaths, and
- to improve quality of life by prevention, early diagnosis and treatment [19]

The Kings Fund [78] report that less than one in four people over 75 self-report receiving any support or advice in preventing further falls or progression of osteoarthritis or in managing their own diabetes, despite a growing focus on supported self-management for people with long-term conditions.

The Government has given local authorities new statutory duties to improve public health with protected resources through a ring-fenced budget. The local authority

and its partners on the Thurrock Health and Well-being Board have assessed need and agreed priorities for action, which are set out in a series of ambitions in its Health and Well-being Strategy.

The new responsibilities for local authorities are complemented by a shift in focus in the NHS from treating ill-health to improving health through prevention and early intervention. Thurrock CCG has developed a 5-year system plan on how this will be achieved by investing in community and primary care services and moving from reactive to proactive disease management.

Prevention of long term conditions - lifestyle behaviours

Most long-term conditions are multifactorial i.e. they do not have a single cause, but result from a complex interplay of genetic, environmental and lifestyle factors across the life-course.

There is a strong link between unhealthy lifestyle behaviours such as smoking, inactivity, poor diet, and alcohol intake, and some of the most prevalent and disabling LTCs:

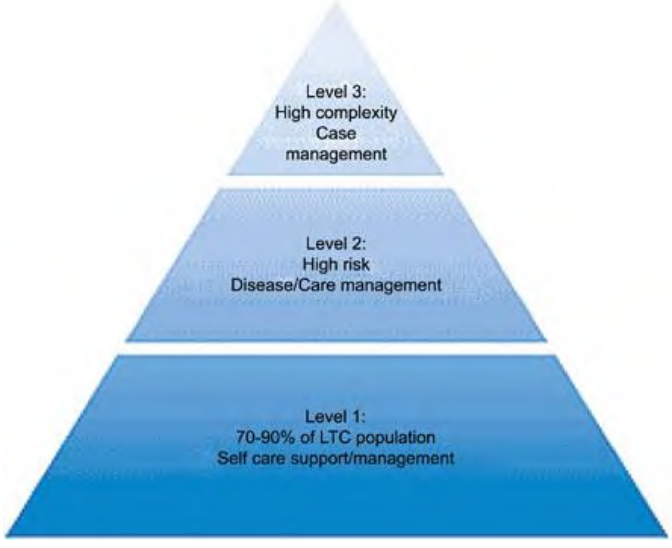
- vascular disease such as coronary heart disease, diabetes, chronic kidney disease
- some cancers e.g. lung and bowel
- respiratory disease such as chronic obstructive pulmonary disease (COPD)

By modifying behaviour i.e. making changes in lifestyle, or by active management with drug treatment or other therapies, some LTCs may be prevented or their impact on health reduced.

Risk prediction and stratification

There is a strong evidence base for what works to improve outcomes in people with LTCs and this has been developed into a generic model to assist clinicians in planning care, commissioners planning services, and local health and social care partnerships in identifying levels of need in the population [79].

Figure 6 The NHS and Social Care Long-Term Conditions Model



Source: Department of Health

The model stratifies the population using a risk prediction approach to help commissioners quantify levels of need and then design services to provide appropriate levels of care and support. Figure 6 shows that approximately 5% of people in a population have complex needs, around 25% have a moderate level of need, and around 70% have a low level of need.

Building on this approach it is important to identify individuals in the population that have complex needs, as this group will be at particular risk of acute episodes of illness, and will be more likely to require higher levels of primary care and/or hospital admission. Proactive and anticipatory strategies can be put in place for these individuals to help them retain their independence and avoid hospital admission, and if a period in hospital is needed, to ensure timely rehabilitation and reablement after a period of illness.

Similarly identifying and engaging with those people with long-term conditions who have moderate or low levels of need, gives the opportunity to promote prevention services, self-management and self-care skills, national and local support groups and access to high quality information on their long term condition.

Local Action

Early Diagnosis and Early Intervention

The **NHS Health Check programme** aims to help prevent coronary heart disease, stroke, diabetes, chronic kidney disease, and certain types of dementia.

Everyone between the ages of 40-74, who has not been previously diagnosed with one of these conditions or has certain risk factors [80] are invited (once every five years) to have a check to assess their risk of vascular disease and given support and advice to help reduce or manage that risk.

The programme is an important part of ensuring that individuals stay healthy for longer by identifying any potential underlying conditions. Vascular disease accounts for about 66,000 deaths each year in people aged under 75 years. With age, the risk of developing these diseases increases.

All of these diseases are also linked by a common set of risk factors, some of which we cannot change, such as age, gender, ethnicity and family history. However, many of the risk factors are things that we can change, including being overweight, our diet and physical activity levels, smoking, blood pressure and cholesterol [81].

The evidence suggests that it is especially important to take action to address these risk factors in middle age i.e. from 40-60 years, as the lifestyle choices made at this time can have a marked impact on health in later years. For example by maintaining a healthy weight, taking regular physical activity and by managing blood pressure and cholesterol from age middle age onwards an individual can reduce their risk of cardiovascular disease and cancer, but can also reduce their risk of developing dementia by up to 20% [82].

As well as reducing risk of chronic disease, improving lifestyle can also impact on other aspects of health in old age including functional ability, mobility, general wellbeing and overall quality of life. [83]

Following on from the health check, participants will be referred to their GP if required and informed about how they can make important lifestyle changes to reduce their risk of developing life-altering disease.

In 2013/14, over 5,900 people in Thurrock received a health check of which 13.9% were aged 65 or over.

Local Action

A borough wide program of NHS health checks is undertaken by Vitality (commissioned by Thurrock Council Public Health with North East London Foundation Trust) through GP practices and outreach events.

Workplace health checks are also promoted and supported through local businesses. This includes Thurrock Council as a large employer of people who reside in Thurrock.

Signposting and referral is provided following the health check to the relevant service e.g. Stop Smoking Service, exercise on referral, and weight management programmes. GPs are notified of any clinical outcomes which might need further investigation (e.g. high blood pressure or cholesterol).

Blood Pressure Programme - High blood pressure affects around 30% of adults in England, over five million are undiagnosed and around 40% of those in treatment are not well 'controlled' i.e. <140/90mmHg. A new area of work being developed by Public Health England is a Blood Pressure Programme with a systematic approach to preventing, detecting and better managing hypertension.

Primary Care Management of Long Term Conditions

General practice has changed dramatically over the last decade and patients who would have previously needed hospital referral and follow up are now managed in primary care. The maintenance of disease registers of patients with a range of long term conditions play a key role within these primary care long term condition management services. These registers enable the primary care team to improve the quality of care offered by ensuring the regular, systematic monitoring of people with long term conditions.

As a part of the Better Care Fund new ways of working between primary care, public health and social care are being explored to prevent emergency admissions in those aged 65 years and over. This will also look at closer working with care homes.

Community Based Care and Resources

Thurrock Clinical Commissioning Group and Thurrock Council commission an integrated health and social care **Rapid Response and Assessment Service**. This service is discussed in more detail in the Social Care Use section.

Primary Care Multi-Disciplinary Team (MDT) meetings are established across GP practices in Thurrock to discuss and review patients identified as vulnerable and at risk of admission to hospital. The meetings include Primary Care, Community, Mental Health and Social Care providers to create a personalised care plan that responds to the patient's circumstances and conditions [72].

Integrated Community Geriatrician - Utilising the expertise of Consultant Geriatricians within a community setting, Community Geriatrician-led MDT reviews (escalation of primary care MDT reviews and enhanced community hospital bed criteria *and* Care Home MDT reviews help to improve health outcomes for patients in residential and nursing homes.

Community matrons and **condition specific services** are provided by NELFT within the Thurrock area.

Community matrons manage people with long term conditions who have complex clinical problems and/or social needs, and those at risk of re-admission to hospital. The majority of patients accessing the service are aged 65 and over.

Condition specific services offered in the community include a COPD team, Diabetes Specialist Nursing, Heart Failure service and a Stroke Hub team.

There is increasing interest in using **assistive technology** to help provide care and support for older people and those with LTCs.

The Department of Health has estimated that at least three million people with long-term conditions could benefit from telehealth and telecare. The DH funded a randomised control trial of telehealth and telecare focused on three conditions: diabetes, COPD and coronary heart disease. The trial showed that if used well across a whole system, technology can reduce the need for hospital admissions for people with LTCs, and the amount of time they spend in A&E.

Telehealth is electronic equipment used to read a person's vital health signs including pulse, weight, respiration and blood oxygen levels. These measures are then automatically transmitted to a clinician or monitoring centre, where staff can observe the person's health status without the person having to leave home. Staff examine the readings every day to check whether a person's condition is getting worse and whether action should be taken to help them [84].

The use of telehealth locally has contributed to a reduction in acute admissions [85].

Complex Social Work team also support people with long-term and complex conditions, working with health to ensure needs are met.

Self-care

The **Prevention and Early Intervention Scheme**, as a part of the Better Care Fund, aims to provide an integrated response to a number of successful existing and developing initiatives that result in a cohesive prevention and early intervention offer spanning the community, public health and social care system [85].
This model will also interface with the risk stratification of Thurrock residents, encompassing physiological and social indicators, to ensure targeted promotion and uptake is facilitated.

As part of Thurrock's vision for **Building Positive Futures,** from June 2013 Local Area Coordinators (LAC) have been introduced to Thurrock. Their role has since been developed to discuss with individuals their general health and wellbeing, and to promote public health initiatives to help people stay well.

Another aspect of LAC has been to build more inclusive communities that are great places to grow old in. The LACs has worked within the community to support them in various ways, including, setting up groups that are aimed at the over 65 age group and linking them with small sparks funding and providing assistance where possible.

Feelings of loneliness can turn to depression, and some older people may stop looking after themselves properly. We are actively working with our communities to identify what types of wellbeing activities could be delivered in their communities. Activities being identified are gardening clubs, walking clubs, tai chi, yoga, allotment and gardening clubs, gentle exercise and chair based exercise. Some of these services will be developed in local communities this year.

4.4 End of Life Care

The General Medical Council [86] define that people are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent, i.e. expected within a few hours or days, and those with:

- advanced, progressive, incurable conditions
- general frailty and coexisting conditions that mean they are expected to die within 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- life-threatening acute conditions caused by sudden catastrophic events. [86]

End of Life Care Profiles published by Public Health England, look at both the place of death and the causes of death to specific age groups at local levels, and calculate the proportion of deaths attributable to cancer, cardiovascular disease, respiratory conditions or other causes. In 2014, the Thurrock CCG End of Life Care profile [87] highlights that a significantly higher proportion of deaths occur in hospital and a significantly lower proportion of deaths occur in a care home or a hospice.

The profile shows that the proportion of deaths attributable to cancer was significantly higher than the England average. Deaths from cardiovascular disease (CVD) and respiratory disease are similar to the England average. However, Thurrock has a statistically higher proportion of deaths due to CVD in males aged over 65 years and for respiratory conditions in males aged 85 and over.

The provision of end of life care is becoming increasingly complex, with people living longer and the incidence of frailty and multiple conditions in older people rising. Information on peoples' wishes is often not captured or shared and a lack of services to support them at home may lead to unplanned and unwanted admissions to hospital.

Dignity at the end of life is a subjective concept. However, there are certain fundamental principles that are deemed essential to the maintenance of a dying patient's dignity, e.g. holistic assessment and care, privacy, symptom control, provision of choice and psychological and spiritual support.

End of life registers support healthcare staff in working with patients to put plans in plans for their care at the end of life. The registers can also record preferences such as place of death for those patients approaching end of life.

Around 1% of patients per GP practice die each year [88]. The National End of Life Strategy [89] encourages GPs to identify this cohort of patients and ensure they are included on a palliative care register, and to predict how many people may still need to be identified within their practice population as approaching end of life.

Local Action

The **One Response Support, Assessment & Advice Service** (provided by NELFT) was launched in November 2014 with the aim of coordinating palliative and end of life care services across South West Essex. Patients, carers and other family members as well as professionals will have one number to ring to address new and existing problems.

The end of life care service offers a range of services to support both individuals nearing the end of their lives and the people that are important to them. The end of life care team also provides education, information and support for health and social care providers.

The **Community Macmillan palliative care** team offers specialist palliative care assessment, advice, support and symptom management for those in our community with life limiting illness and complex needs.

The **Macmillan specialist occupational therapy** team offers specialist assessment for people affected by life limiting illness who need occupational therapy support. The team liaise with other professionals to ensure that people have access to appropriate resources at the end of life. This may include accessing specialist equipment.

Recommendations:

- Review current provision related to falls prevention and develop a comprehensive cost-effective falls prevention programme in Thurrock focused on early detection, management and treatment of risk factors that lead to falls in the elderly
- Work with our wider health and social care partners and our communities to support self- care of long term conditions
- Work is undertaken with health and social care to raise awareness of services to support end of life care, including greater use of end of life registers and supporting patients around choices such as preferred place of death

Chapter 5 Carers

Key Messages:

- 45% of carers aged 65 and over are providing a minimum of 50 hours of unpaid care per week.
- In Thurrock, around 300 carers aged 65 and over have been identified.
- Caring responsibilities can have a negative impact on the health and well-being of carers
- Older carers in Thurrock report a significantly better quality of life compared to the national average

Introduction

"A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support." [90]

In the 2011 Census 6.5 million people in the UK identified themselves as a carer, compared to 5.8 million people in 2001. It is estimated that 3 in 5 people will become carers at some point in their lives.

The majority of carers are of working age and the peak age for caring is 50-64. However, the number of carers over the age of 65 is increasing more rapidly than the general carer population. Whilst the number of carers nationally has risen by 11% since 2001, the number of older carers rose by 35%.

The duties, whether recognised as caring or not, can include a wide variety of activities. The Carers UK State of Caring Survey 2014 showed that:

- 93% provide practical help such as preparing meals, doing laundry or shopping.
- 87% provide emotional support, motivation or keeping an eye on someone either in person or by phone.
- 85% arrange or co-ordinate care services or medical appointments.
- 83% manage paperwork or financial matters for the person they care for.
- 71% provide personal care like help with washing, dressing, eating or using the toilet
- 57% assist the person they care for with their mobility – getting in and out of bed, moving around or getting out of the house.

[91]

Under the Care Act 2014 carers are placed on an equal footing to the person they are caring for and that they are entitled to an assessment, information and advice and where required support and services [92].

One of the biggest issues is identifying carers, as many carers may not identify themselves as one, and therefore may not have an understanding about what support is available to them or the people they are caring for.

Data from the Care and Information Advice Service (Cariads) in Thurrock confirms that there are approximately 300 carers over 65 known to them at the moment, which represents 25% of the carers identified in Thurrock.

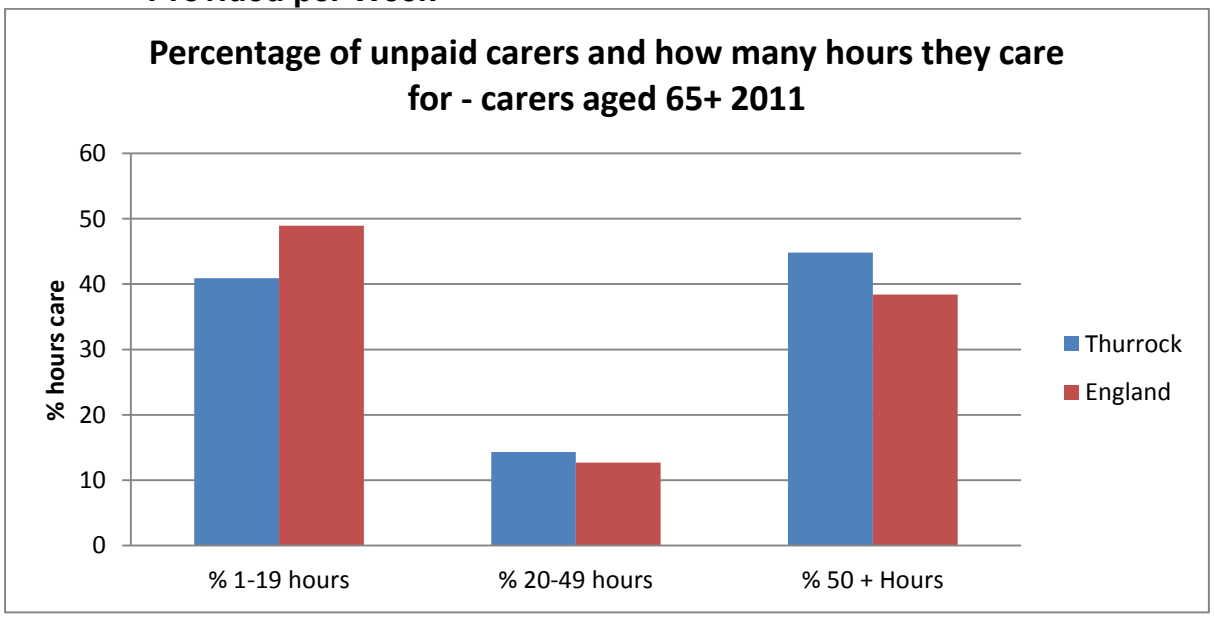
Although for many the experience of providing care can be rewarding, the consequences of caring can have detrimental effects on physical and mental health [93].

The Carers UK (2014) Carers Manifesto reported that:

- Full-time carers are more than twice as likely to be in bad health as non-carers
- 80% of carers say caring has had a negative impact on their health
- Half of carers say they have experienced depression after taking on a caring role
- 61% of carers say they are at breaking point

[94]

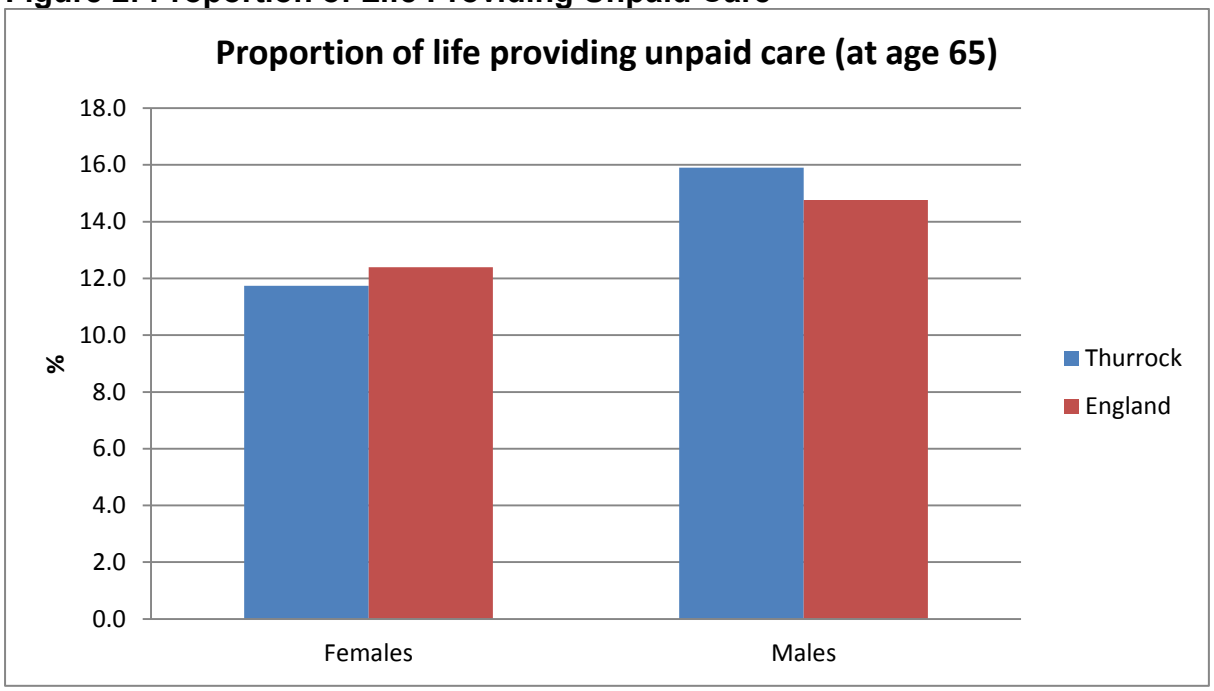
Figure 1: Unpaid Carers Aged 65+ years and Number of Hours of Care Provided per Week



Source: ONS

Figure 1 shows that of those carers aged 65+ that provide some level of unpaid care, just over 40% provide between 1-19 hours of unpaid care and around 45% provide 50+ hours of unpaid care. Almost half of unpaid carers in Thurrock aged 65+ are providing 50+ hours of care, which is higher than the England average.

Figure 2: Proportion of Life Providing Unpaid Care



Source: ONS

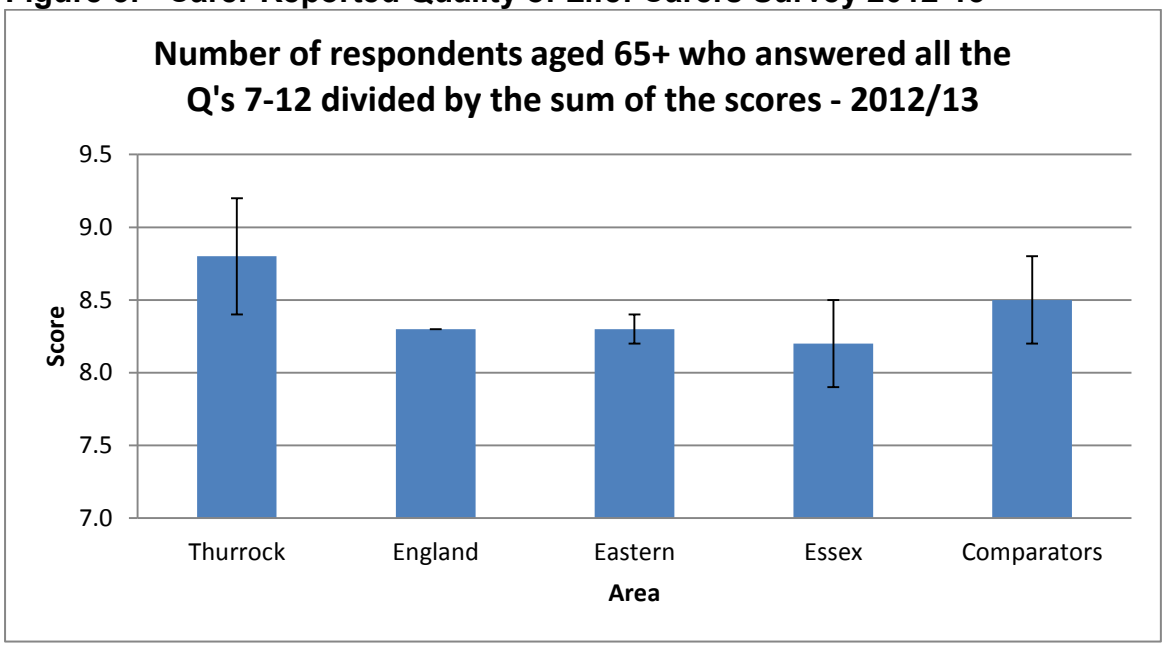
Figure 2 shows the proportion of life that is expected to be spent on unpaid care at age 65. It can be seen that in females the percentage (11.7%) is slightly lower than that of England overall (12.4%) but for males in Thurrock it is slightly higher (15.9%) than the England average (14.8%). In Thurrock, it is estimated that females at the age of 65 will spend 2.4 years providing unpaid care and males 2.9 years.

Supporting carers has the following benefit for health and social care systems:

- Delayed admission to residential care
- Delayed uptake of social care
- Reduced hospital admissions
- Carer is able to remain in employment / reduction in likelihood of reduced working hours
- Savings from improving carer (physical and mental) health and subsequent reductions in their use of health and social care systems

Figure 3 shows the results from the Carers Survey 2012-13 [95] for the Adult Social Care Outcomes Framework indicator on the Carer reported quality of life. This shows that Thurrock residents aged over 65 who are carers report a significantly better quality of life compared to the national average.

Figure 3: Carer Reported Quality of Life: Carers Survey 2012-13



Source: HSCIC, 2013

Local Action

The Care Act 2014 ensures that local authorities identify carers early on and are well-informed about what support is available to them through information and advice.

The Thurrock Carer Strategy 2012-2017 and sets out how carers will be supported to maintain their own health and well-being through a range of health-promoting schemes, including therapy and training sessions, group and individual support.

Thurrock Council commissions Carers Information and Advice Services (Cariads), a dedicated information and advice service for carers. Three voluntary sector providers are commissioned to provide the service - MIND, Independent Living and Thurrock Lifestyle Solutions.

The service supports access to day care for older people, care home respite beds and a sitting service, all designed to give the carer a break and/or allow carers to look after their own needs (for example health appointments or short breaks). The service also provides counselling support and access to a number of support groups such as the all Carer Support Group, the Mental Health Support Group and the Art and Craft Group.

Of the 300 carers aged over 65 identified by the service, around 1% has accessed support groups, nearly 7% over 60 have accessed counselling services and a high number have accessed training, particularly dementia awareness and power of attorney.

People who are in receipt of a carer's allowance, or those who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill are

eligible for a free flu jab under the Influenza Immunisation Programme. Carers' taking up their flu jab is an important factor in protecting the health of the people they are caring for during the winter period.

Recommendations:

- Continue to support carers to access services offered by statutory and voluntary organisations
- Health and well-being services are promoted to carers through the Carers Information and Advice Service

Appendix 1 Update on Recommendations of 2013 Annual Public Health Report

Recommendation	Update
Work with Thurrock schools to commission evidence-based interventions to improve children and young people's health, for example healthy eating and physical activity programmes.	A number of projects and initiatives have been commissioned to increase healthy lifestyle behaviours in children and young people, including 'Beat the Street' to increase physical activity and work with the School Food Trust on healthy eating. A new model of school nursing will be offered in schools in 2015 to enhance support for emotional wellbeing and children's weight management
Undertake a value for money exercise for tobacco and weight management public health programmes in 2013/14	A benchmarking exercise with CIPFA comparator authorities was undertaken on children's and adult weight management, which has led to a new community commissioning model for these services in 2015/16. Work has been undertaken with the current provider of stop smoking services to look at developing a more prevention focused model. Further work will be undertaken in this area in 2015/16.
Produce a new Joint Strategic Needs Assessments (JSNA) to include Assets working through the JSNA Delivery Group	A new format for the JSNA refresh has been agreed, to include information on assets. A JSNA chapter on local demography and a Children and Young People's JSNA have been produced in 2014/15.
Review seasonal mortality rates in Thurrock and produce recommendations on reducing excess deaths	The current data confirms that excess winter deaths have fallen in Thurrock. There are mechanisms to inform vulnerable groups about Met Office weather warnings. A cold weather action plan and heatwave plan have been produced.
Continue to work with all directorates within the council to embed public health principles.	Members of the Public Health Team are linked to each directorate in the Council and attend their key senior management team meetings. The Public Health Strategy Board has been established with cross departmental members, this Board reports into the Health and Wellbeing Board
Develop a Healthy Weight Strategy in 2014	A Thurrock Healthy Weight Strategy has been completed.
Develop a Tobacco Control Strategy in 2014	A draft Thurrock Tobacco Control Strategy has been developed and will be completed in 2015.

Recommendation	Update
Develop a Public Health Responsibility Deal for Thurrock Council and across local businesses.	A Public Health Responsibility Deal is in place for Thurrock Council, with a key focus on workplace health. Further work will be undertaken to develop a Thurrock Public Health Responsibility Deal for local businesses.
Review the needs of the local population in recognition re changing demography of Thurrock and need to look at health needs within the BME community	The demography chapter of the JSNA has been completed, which identifies the local population characteristics. The health needs of each group will be considered in each particular JSNA topic area.
Undertake health impact audits for the new regeneration projects in Thurrock.	Public health has provided input into proposed housing developments in Thurrock. Regeneration projects requiring an environmental permit are reviewed by Public Health England and the local public health team. The team have produced a Health Impact Assessment process for key planning and regeneration proposals which feeds into the work of the new Planning and Advisory Board.
Work with NHS England (Essex Area Team) to prepare for the smooth transition of the 0-5 service in 2014 into Local Authority, and work with key stakeholders to develop a comprehensive 0-19 service.	The public health team have been working closely with the NHS England Essex Area Team on the transfer of commissioning responsibility of 0-5 service from 1st October 2015. Further work is required to look at the development of a 0-19 service.
Support Thurrock Clinical Commissioning Group as public health specialists as agreed within the Memorandum of Understanding	There has been limited progress with this recommendation due to the inability to recruit key public health staff. An interim appointment has been made to lead this work.

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