Older People in the Bradford District 2014

Annual Report of the Director of Public Health

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Foreword

Welcome to the Annual Report of the Director of Public Health.

This is the first report which has been produced since the public health department moved from the NHS to the local authority. This has meant that public health has faced enormous organisational changes, at the same time as we witness significant changes in our population. These changes present us with great opportunities to continue to improve the health and wellbeing of the population of Bradford – because if we are to do so, different organisations will need to work together in a coordinated and integrated way.

One of the most interesting Public Health issues of our time is that people are living longer, and the number of older people amongst our population is increasing. These changes will have a deep and lasting effect on how we in Bradford, with a traditionally younger population than other areas, provide services to our population. For this reason, this year's report is focussed on older people.

The report has two aims:

On the one hand it is to help us to understand how the demand for health services and social care is likely to change as the older population grows.
On the other, the report aims to communicate what we can do now to help people to live healthily and well into older age. The most important message running through the report is that it is never too late to make changes to a healthier lifestyle.

I hope you find it an interesting read. If you have any comments, queries or suggestions please get in touch. You can do so by calling the public health directorate team on 01274 432333 or emailing jonnie.dance@bradford.gov.uk.

Cllr Amir Hussain
Portfolio Holder
City of Bradford MDC

Dr Anita Parkin
Director of Public Health
City of Bradford MDC

Part One

Older people in Bradford

Definition

There is no single definition of how old a person needs to be before they are classed as an older adult, because it depends heavily on the topic area. In this section, the demographics of the population are described using the groups over 60s, for those coming up to retirement age and above, and over 75s.

The growth in the number and proportion of older adults in the Bradford district is unprecedented. It is anticipated that by 2035 there will be nearly 108,000 Bradfordians aged 65 or older, 40% more than in 2010.

The rapid aging of the population is being driven by two realities: people in Bradford are living longer than in previous decades and, given the post-World War II baby boom, there are proportionately more older adults than in previous generations. Many people in the district are now living into their 70s, 80s, and beyond. The leading edge of the baby boomers reached age 65 in 2011, launching an unparalleled phenomenon in the growth in numbers of older people. By 2030, more than 1 in 5 Bradford residents will be over 65.

Demographics

Current population

We estimate that there are just over 75,000 people aged 65 or over living in the Bradford district. This is 13.4%, just over one in eight, of the total population. Across England and Wales as a whole, older people make up a greater proportion of the population, with over 65s accounting for around 16.6% of the population, or one in six. Within Bradford these figures vary greatly. In the City ward, over 65s account for fewer than 6% of the population; in Ilkley, to the north of the district, for more than 25%. Figure 2 shows the variation across the district.

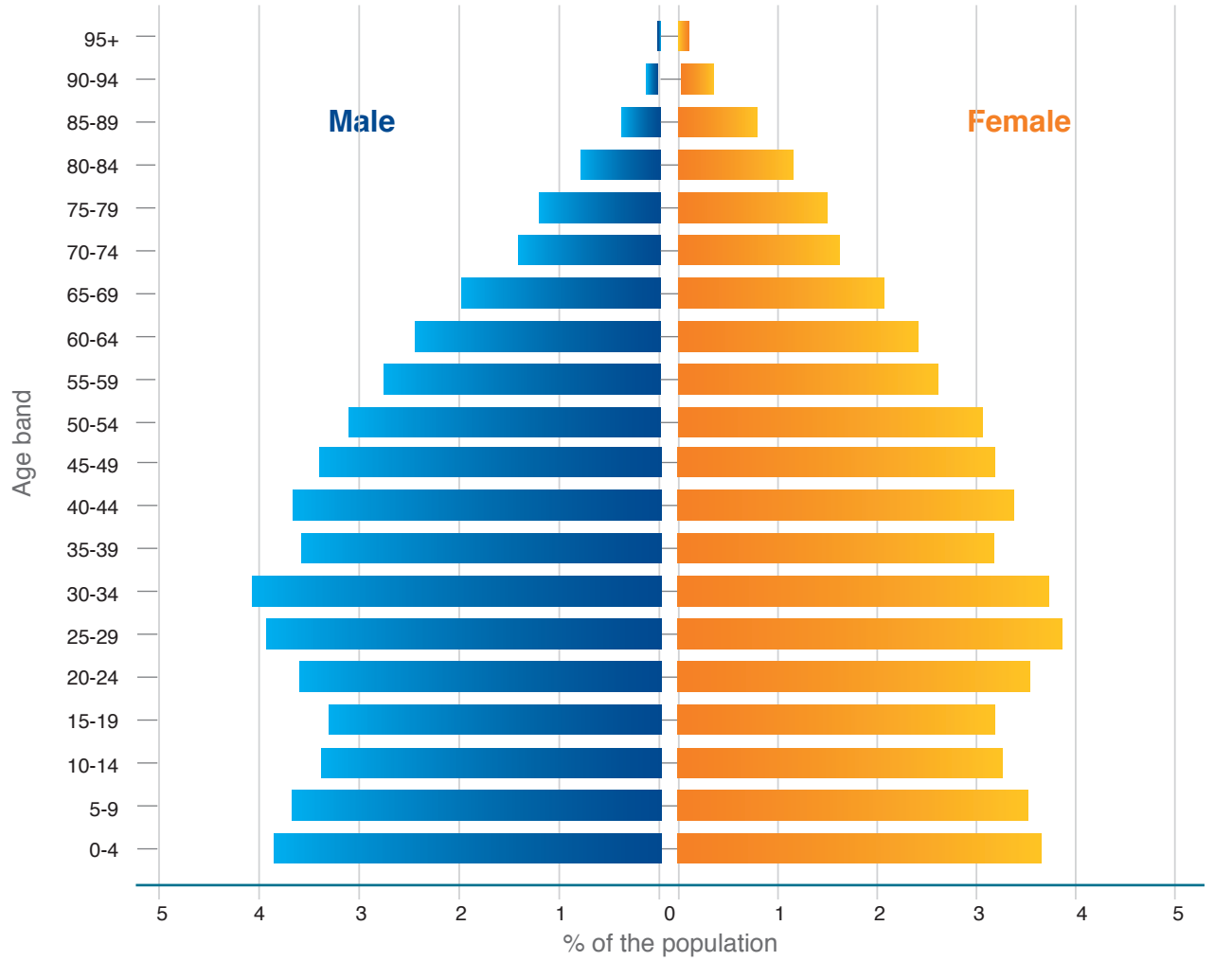
In the over 65s – both in Bradford and nationally – women outnumber men by a ratio of roughly 5 to 4.

We also know that almost a third of people aged 65 and over live alone in Bradford. The figure is higher for females at 39% compared to males at 24%.

We will continue to see significant increases in racial and ethnic diversity along with the dramatic aging of the population during the next several decades. Young people in Bradford currently reflect diversity more than their older counterparts - it is currently estimated that 9% of the over 65 population is of South Asian origin compared to 30% in the under 65s population.

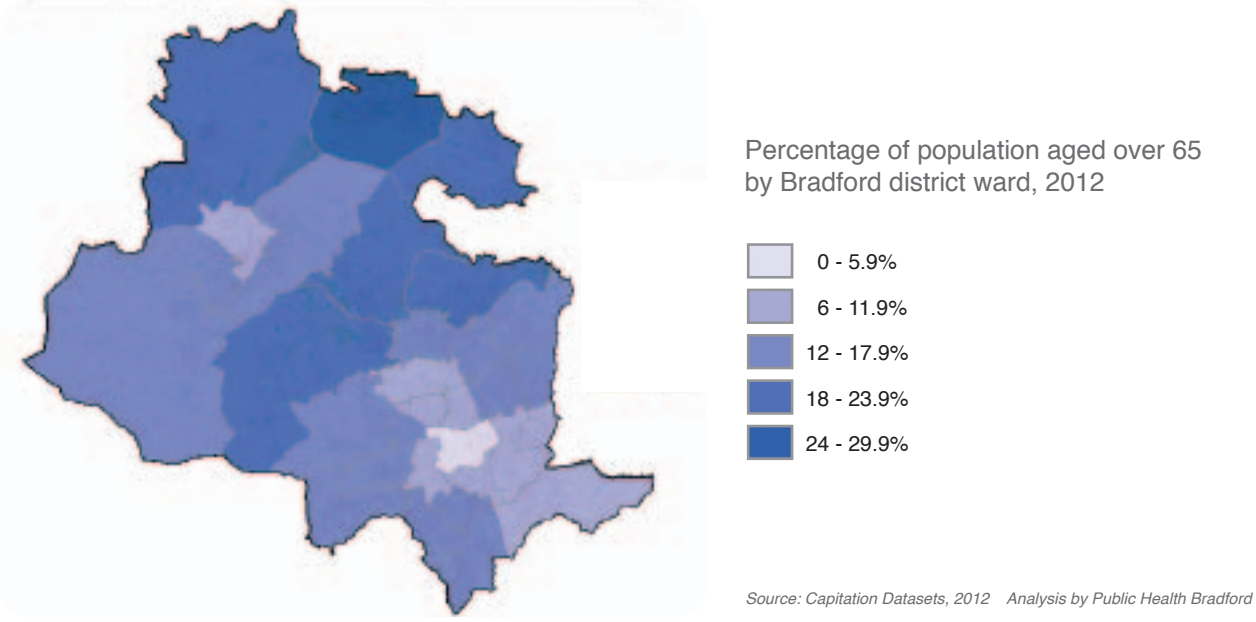
As the diverse population grows older, the population of older adults will change. In 2010, 80% of adults aged 65 years or older in the district were white. By 2030, it is estimated the figure will be around 71% of the population, whilst those from South Asian background will make up 12%.

Figure 1: The age and sex of the population of Bradford district



Source: Capitation Datasets, 2012 Analysis by Public Health Bradford

Figure 2: The distribution of older people across Bradford district



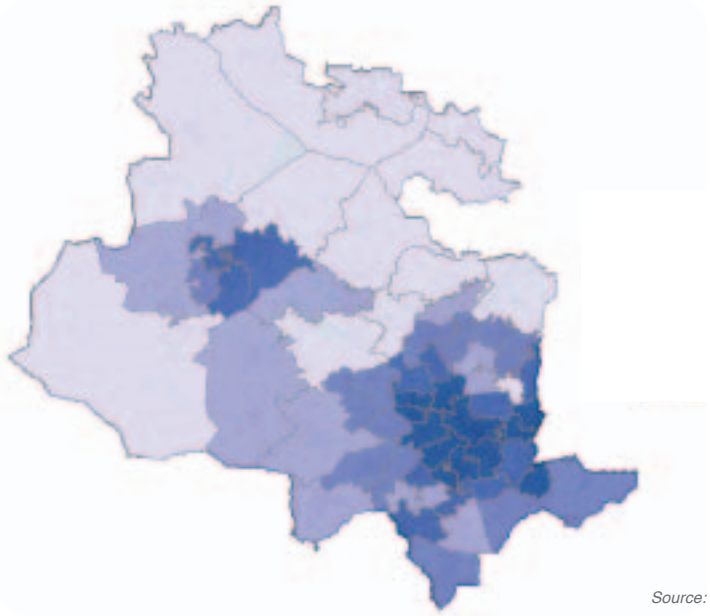
Source: Capitation Datasets, 2012 Analysis by Public Health Bradford

Deprivation

Bradford has a reputation for having a wide gap between the least and most deprived parts of the district; the Indices of Multiple Deprivation (IMD) (2010) suggested the gap was wider in Bradford than in any other Local Authority area.

One of the population groups affected most by deprivation is older people, and in addition to IMD, Communities and Local Government (CLG) also produce figures which compare the proportions of older people affected by income deprivation. Figure 3 below illustrates the large difference between the more affluent areas to the district's north and the more deprived areas to the south and west of the district, and near Keighley's town centre.

Figure 3: How income deprivation affects older people across the Bradford district



Income Deprivation Affecting Older People Index (IDAOPI) by Bradford MSOA, 2010

IDAOPI, 2010

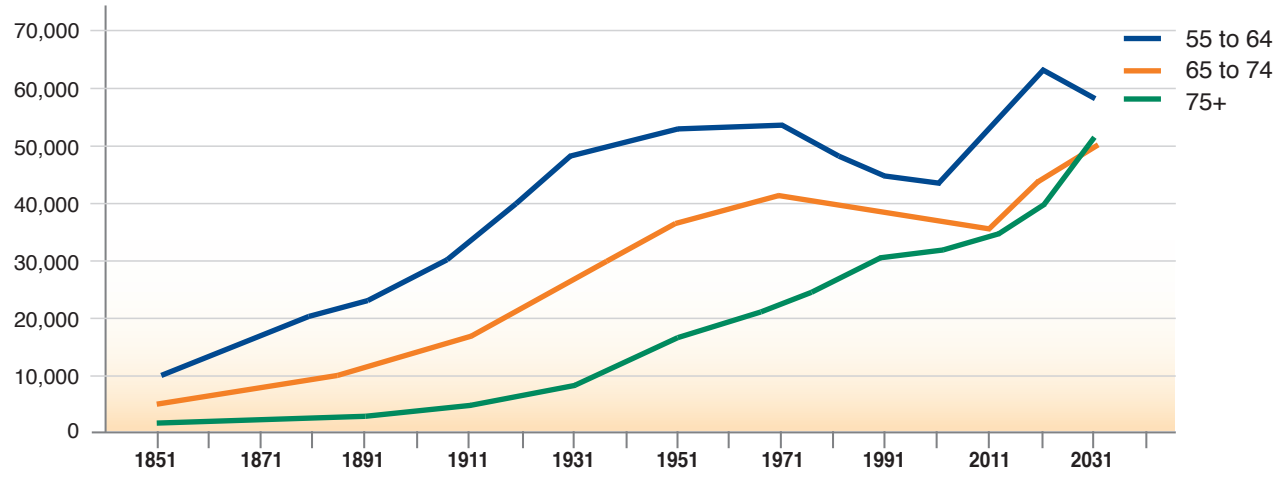
- 0 - 5.9%
- 6 - 11.9%
- 12 - 17.9%
- 18 - 23.9%
- 24 - 29.9%

Source: Communities and Local Government, 2011 Analysis by Public Health Bradford

Future population

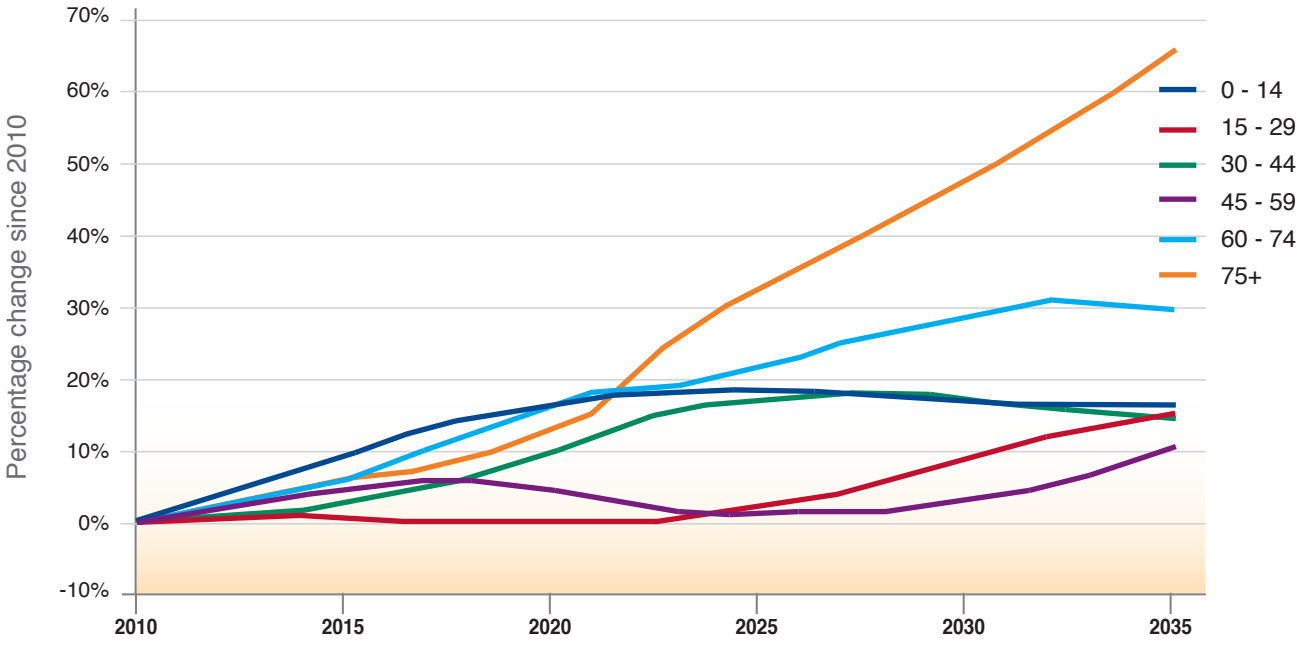
The over 75 population in Bradford has been consistently growing over time and is expected to increase rapidly over the next 20 years. Figure 4 and Figure 5 illustrate the growth in the older population.

Figure 4: The growth in the number of people in Bradford district, since 1851



Sources: Census data from 1851, 1881, 1891, 1911, 1931, 1951, 1971, 1981, 1991, 2001 from Vision of Britain; 2011 census data from ONS; 2021 and 2031 population estimates from 2010-based subnational population projections, ONS.

Figure 5: The projected growth in the proportions of older people in different age bands

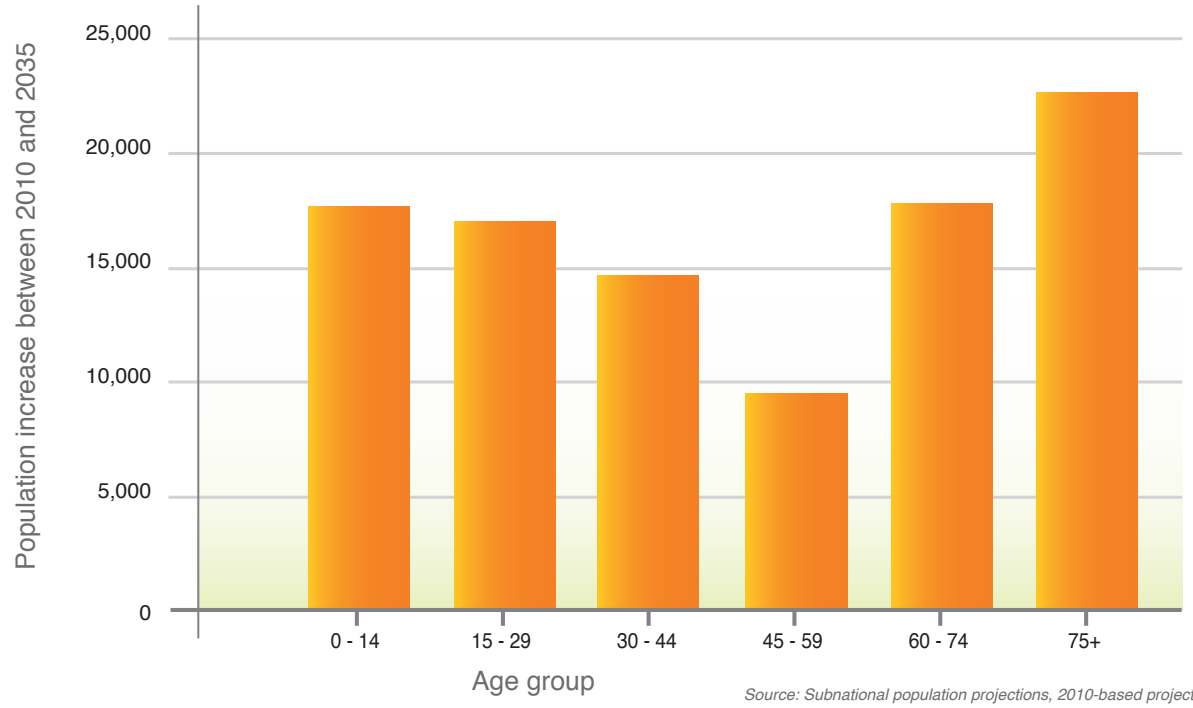


Source: Subnational population projections, 2010-based projections, ONS *Analysis by Public Health Bradford*

Figure 4 and Figure 5 show slightly different things; Figure 4 illustrates the long-term increase in the numbers of older people; Figure 5 demonstrates the projected growth of the population relative to the population in 2010.

The rise in the population of those over 75 years of age is predicted to be greater than for any other age group. Figure 6, on the next page, shows what these percentages mean in terms of actual numbers of people.

Figure 6: The projected growth in the number of people in different age bands

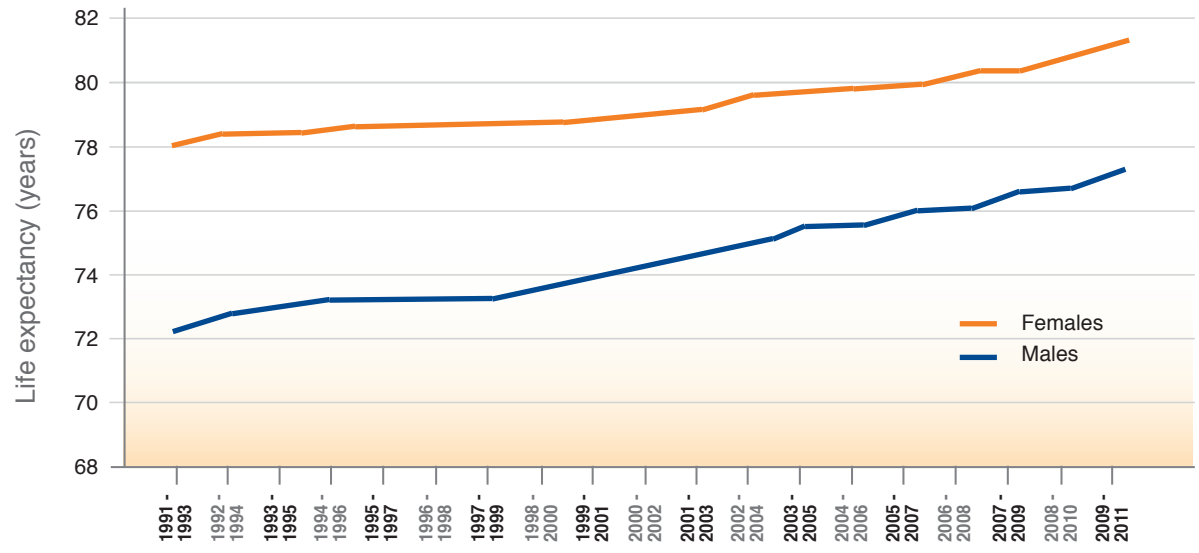


Source: Subnational population projections, 2010-based projections, ONS

Life expectancy

Figure 7 shows that life expectancies for babies born today are increasing. In the future, people will live longer lives. The graph also shows that the gap between male and female life expectancy is getting smaller.

Figure 7: Increases in life expectancy, 1991-2011



Source: ONS life expectancies Analysis by Public Health Bradford

Mortality

Causes of death differ between those who die in older age and those who die prematurely.

Across all age groups, the biggest causes of death in Bradford are cancers and heart diseases. In the 65 and over population, cancers account for between one in four and one in five deaths. In both the 65 and over population and the 75 and over population, approximately 20% of deaths are attributable to heart diseases.

Beyond these two principal causes, there are a number of causes which affect older populations more, as the table in Figure 8 shows. For example, cerebrovascular diseases, which include strokes and vascular dementia, cause about 10% of deaths in the older population compared to only 3% in the under 65 population.

Figure 8: Top ten causes of death in the older population (in comparison to under 65s)

Cause of death		Up to 65	65 and over	75 and over
Cancer		1,340 (30.5%)	4,169 (23.9%)	2,816 (20.3%)
Heart Disease	Coronary heart diseases	639 (14.5%)	2,757 (15.8%)	2,133 (15.4%)
	Other forms of heart disease	119 (2.7%)	785 (4.5%)	676 (4.9%)
Cerebrovascular diseases		139 (3.2%)	1,820 (10.4%)	1,549 (11.2%)
Chronic lower respiratory diseases		183 (4.2%)	1,254 (7.2%)	957 (6.9%)
Organic, including symptomatic, mental disorders		8 (0.2%)	1,034 (5.9%)	978 (7.0%)
Influenza and pneumonia		117 (2.7%)	991 (5.7%)	880 (6.3%)
General symptoms and signs		<5 (<0.2%)	863 (4.9%)	863 (6.2%)
Diseases of arteries, arterioles and capillaries		22 (0.5%)	352 (2.0%)	294 (2.1%)
Other degenerative diseases of the nervous system		38 (0.9%)	333 (1.9%)	283 (2.0%)
Grand Total		**4,399**	**17,450**	**13,885**

NB: Grand Total includes all deaths, including those attributable to causes other than the 10 most common causes.
Source: ONS mortality data, 2007-2011 Analysis by Public Health Bradford

Part Two

What makes older people ill?

Understanding the impact that age has upon people's health

Chronic conditions

During the twentieth century, effective public health strategies and advances in medical treatment contributed to a dramatic increase in average life expectancy in the United Kingdom. The 30-year gain in life expectancy had never before been seen within the span of a century. Many of the diseases that claimed our ancestors, including tuberculosis, diarrhoea and enteritis, and syphilis, are no longer the threats they once were. Although they may still present significant health challenges, these diseases are no longer the leading causes of death in adults.

The burden of chronic diseases encompasses a broader spectrum of negative health consequences than death alone. People living with one or more chronic diseases often experience diminished quality of life, generally reflected by a long period of decline and disability associated with their disease. Chronic diseases can affect a person's ability to perform important and essential activities, both inside and outside the home. Initially, they may have trouble with the instrumental activities of daily living (IADLs), such as managing money, shopping, preparing meals, and taking medications as prescribed. As functional ability, physical, mental, or both further declines, people may lose the ability to perform more basic activities, called activities of daily living (ADLs), such as taking care of personal hygiene, feeding themselves, getting dressed and going to the toilet. The inability to perform daily activities can restrict people's interest in life and their ability to enjoy the company of family and friends. The inability to get 'out and about' or even move freely around the home significantly restricts their ability to do the things that bring enjoyment and meaning to life. Loss of the ability to care for oneself safely and appropriately means further loss of independence and can often lead to the need for care in a nursing or residential home.

The need for caregiving for older adults by formal, professional caregivers or by family members and the need for long-term care services and supports, will increase sharply during the next few decades.

Death and decline associated with most chronic diseases are often preventable or can be delayed. Multiple opportunities exist to promote and preserve the health of older adults. The challenge is to apply what we already know about reducing the risk of chronic disease to a greater proportion of the population. Although the risk of developing chronic diseases increases as a person ages, the root causes often begin early in life. Practising healthy behaviours from a young age can substantially reduce a person's risk of developing chronic diseases and associated disabilities; being screened for certain conditions can increase the chances of those conditions being detected early and better managed. Research shows that people who do not use tobacco, who get regular physical activity, and who eat a healthy diet significantly reduce their risk of developing heart disease, cancer, diabetes and other chronic conditions.

Unfortunately, current data on health-related behaviours among people aged 55-64 years do not indicate a positive future for the health of older individuals. If a meaningful reduction in chronic diseases among older adults is to occur, then the whole population – adults, adolescents and children – need to pursue healthier behaviours and make full use of recommended preventive services.

Communities can play a pivotal role by making healthy choices easier and making changes to policies, systems, and environments that help people of all ages take charge of their health.

For some chronic conditions, we have good information on prevalence from the Quality and Outcomes Framework (QOF). This also gives us the ability to track trends in disease prevalence over time. A limitation of using QOF data is that it only tells us about diagnosed disease. It tells us nothing about patients who have diseases that have not yet been diagnosed, which may not be well managed and which are at an increased risk of developing complications.

Coronary heart disease

Coronary heart disease (CHD) is the UK's most common cause of death and, in Bradford, one in five people aged 65 and over die from the condition. Having heart disease puts people at greater risk of having heart attacks and heart failure. In Bradford, this condition affects almost 19,000 people diagnosed on the CHD register held by GP practices. Of these, only 5% are aged under-50; so this condition predominantly affects the older population with almost 70% of affected people over the age of 65.

Age group	No. of people	% of people
up to 50	892	4.7%
50-65	5218	27.5%
over 65	12873	67.8%
Grand Total	18983	100%

Stroke

A stroke is a serious medical condition that occurs when part of the blood supply to the brain is cut off. Although it is possible to recover to a good quality of life after stroke, many people are left impaired, including having difficulty walking and speaking. People who have suffered from stroke are at risk from having more strokes in the future. In Bradford, over 9,000 people are on the stroke register kept by GP practices and, of these people, 95% of people are over the age of 50 with 73% being over 65.

Age group	No. of people	% of people
up to 50	455	4.9%
50-65	2038	21.8%
over 65	6834	73.3%
Grand Total	9327	100%

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have difficulties breathing due to the narrowing of their airways. The most common cause of COPD is smoking, which accounts for approximately 80% of cases. Women are more susceptible than men, as women's lung function worsens at lower levels of smoking. In Bradford, over 11,000 people have been diagnosed with COPD. The overwhelming majority of people with it are over the age of 50, and more than 60% of those affected are over 65.

Age group	No. of people	% of people
up to 50	663	5.8%
50-65	3731	32.9%
over 65	6955	61.3%
Grand Total	11349	100%

Diabetes

Diabetes is a condition where the levels of glucose in the body are too high because the body cannot use it properly. Diabetes can lead to a range of complications which can affect a wide variety of parts of the body including eyes, feet, kidneys, nerves and the heart. People are being diagnosed with diabetes at a younger age so are living into old age with a greater risk of developing other conditions as well as diabetes. Also, as more people are also being diagnosed later in life, so we become aware of a greater prevalence of diabetes amongst older people.

Age group	No. of people	% of people
up to 50	6505	19.1%
50-65	12395	36.4%
over 65	15163	44.5%
Grand Total	34063	100%

Cancer

Cancer is a broad group of diseases that involve unregulated cell growth that result in tumours which invade nearby parts of the body. Cancer is the most common cause of death and the age distribution of people living with cancer is different to other chronic conditions. Over 50% of people living with cancer are over age 65 and just under 15% of people affected are under the age of 50.

Age group	No. of people	% of people
up to 50	1,234	14.2%
50-65	2,559	29.6%
over 65	4,865	56.2%
Grand Total	8,658	100%

Co-morbidity

Increasingly it is recognised that many older people do not have a single chronic condition, but may be affected by many conditions at the same time. The term that has developed to describe this is "co-morbidity". A prominent study published in the Lancet in 2012 found that the majority of people with a chronic condition also have other conditions at the same time; for example, 97% of people with heart failure had at least one other condition. The study also found that 13% of people with coronary heart disease (CHD) also have chronic obstructive pulmonary disease (COPD). Although this research has not been replicated in Bradford, there is no reason to suspect that the findings do not apply locally.

Naturally, as people get older it becomes considerably more likely that they will be diagnosed with more than one condition.

There is a need to ensure prevention is a key part of the approach. Smoking, increased alcohol intake and being overweight all increase the risk of having one or more of these conditions. Almost two-thirds of cardiovascular diseases can be attributed to the combination of diet and physical inactivity. This emphasises how important it is to have a healthy lifestyle.

A large burden of disease is related to high blood pressure (hypertension), which exceeds the risks of alcohol and high body-mass index. It is estimated that only a third of men with hypertension have their condition under control. Data from examination surveys in England and Scotland confirm that existing approaches have not adequately identified and treated hypertension.

The prevalence of various forms of liver disease has increased markedly in the past 20 years, underscoring the need for a robust and sustained response to reduce illness associated with excess alcohol consumption.

There is increasing evidence that, even in old age, there are substantial benefits in stopping smoking, increasing physical activity or changing diet. As the old adage suggests – it is never too late.

In addition to focusing effort on prevention, there are people with chronic conditions that need care now. The response to co-morbidities brings into focus the difficult balance between health care, social care and a broader response. We need to understand how to better support people with co-morbidities across the whole spectrum of care; from taking good care of themselves through to highly specialised support. Primary care is central to providing this support but needs to be supplemented by timely support from specialists.

The patterns of future long term conditions are predictable and will be a result of population growth, current lifestyle and other risks. Factors affecting future patterns in chronic conditions include:

- **Risk factors for disease and how they change over time in a population** - this includes lifestyles and broader social, economic and environmental influences and risks.
- **Incident disease** - this is the rate at which people in a population develop disease for the first time.
- **People living longer** - we have seen significantly improved life expectancy in the last 20 years. This is a reflection of improved social

and economic circumstances and improved health care. Thus over time there will be a greater absolute number of people living in a district.

- **Demographic change** - we can see that over time there will be a shift in the proportion of older people, which is likely to mean a higher prevalence of certain conditions in the population.

Some of the future burden of chronic conditions is preventable but needs sustained effort now, with both individual and population focused public health interventions.

Social and environmental factors are very important both in terms of preventing the development of chronic conditions and improving the ability of older people to cope with them.

The future will see a greater number of older people with more chronic conditions, often with many chronic conditions at once. In addition, it is possible that there will be an increasing number of older people living alone or with a more limited informal support network than now. It is important to consider both the medical and the social aspects of health and well being, and the interventions that follow. There is increasing anecdotal and research evidence that many of those contacting the NHS are raising social issues. The challenge for the future is partnership working across a wide range of agencies to equip frontline clinicians to be able to effectively respond.

Mental Health

Before the Second World War, people deemed 'mentally defective' might have expected a long stay in a Victorian asylum, hidden away from the rest of society. The creation of the National Health Service saw the beginnings of a more open-minded approach. Progress was slow, with mental health in-patient numbers peaking at about 140,000 in 1954. The 1942 Beveridge Report, which laid the foundations for the Welfare State, implied that older people were not a priority, apart from vital needs.

Even over the last thirty years, it has been widely acknowledged that the mental health and wellbeing of older people has been neglected across the spectrum of promotion, prevention and treatment services. Direct and indirect age discrimination has been evident through reductions in service and investment for older people's mental health.

Although there is a considerable way to go, this trend is beginning to be addressed, most noticeably in the acknowledgement of the need for strategies and approaches that promote the overall quality of life of older people and their engagement in the community.

The likelihood that older people would come to be major users of psychiatric services was first identified during the Second World War, and since then many social and demographic changes have influenced the mental health and wellbeing of older people in the UK, with a direct effect on levels of mental illness. One notable trend since the 1950s is the increasing proportion of older people living alone in the UK, particularly as a result of the rising divorce rate. This has resulted in increasing social isolation amongst this demographic.

Though many older people lead happy, well-balanced and independent lives, the transition into later life can be affected by many different variables, including physical health, financial security, societal attitudes, geographical location, access to support and services and responsibility for their care. Despite better health and increases in wealth over the last 50 years, there is evidence that many older people are becoming increasingly dissatisfied, lonelier and more depressed, and many live with low levels of life satisfaction and wellbeing. 40% of older people attending GP surgeries, and 60% of those living in residential institutions have been reported to have 'poor mental health'. Worryingly, it has been estimated that more than one million older people in the UK have been diagnosed with depression and that there are still greater numbers of undiagnosed depression in the elderly.

Isolation remains a particular risk factor for older people from minority ethnic groups and those in rural areas. This trend is a concern in Bradford and Airedale where there are large rural areas, particularly to the West of the District. Although the absolute numbers of ethnic elders may be relatively small, there is a greater concentration of pensioners from ethnic minorities in deprived inner-city areas.

In 2008, NICE published national Public Health guidance directed at NHS primary care and professionals who have a role in promoting Mental Wellbeing and Older People. The guidance complements and supports NICE guidance on supporting people with dementia, their carers in health and social care, and on managing depression in primary and secondary care. Meanwhile, the Government has stated its concern that older people have poor access to mental health services and have identified Health and Wellbeing Boards as the key for mandating local action to address this. The Public Health Outcomes Framework includes indicators relating to both older people's perception of community safety and health-related quality of life for older people.

Locally in Bradford:

- **Mental Health Needs Assessment –** In 2011, the Public Health team at NHS Airedale, Bradford and Leeds published a Mental Health Needs Assessment for Bradford and Airedale. The main purpose of the report was to help in the development of plans for the prevention and treatment of mental illness in both Primary and Secondary care settings. It outlines the patterns of mental illness across the Bradford District, with additional activity data supplementing population level statistics.
- **Great Places To Grow Old** – Bradford's housing strategy for the over 50s sets out a vision for the future of housing and the coordinated strategy to help individuals and organisations work together to achieve it. The over 50s age category was chosen as a point at which many people's circumstances start to change in ways which affect their future, not because it marks the start of 'old age'. A key aim is to help older people remain healthy, active and independent.
- **Priority 7 of the Joint Health and Wellbeing Strategy (JHWS)** – The seventh priority in Bradford's emerging is to "Improve the mental health of people in Bradford District". In making this a priority, the key stakeholders across the district have made a clear commitment to improving the mental health of the whole population. The JHWS is supported by a Health Inequalities Action Plan (HIAP) which will ensure that these priorities are delivered in such a way that the greatest resources are allocated to the most vulnerable groups – such as older people.

The growing number of older people in Bradford presents a formidable challenge to all care sectors, particularly health and social care. At a time of significant pressure on health and social care budgets, there remains the danger that mental health in older people may be seen as a lesser priority in comparison to 'big ticket' healthcare priorities. A decline in mental wellbeing need not be viewed as a natural and inevitable part of ageing, provided that there is access to high quality integrated services.

Dementia

The term dementia describes a range of conditions caused by physical and chemical changes to the brain, which lead to a decline in memory, communication, reasoning and the ability to carry out routine tasks of living. The most well known of these is Alzheimer's disease. Dementia can occur at any age; however, it is far more common in the elderly. One in six people over 80 and one in 14 people over 65 will have a form of dementia. As the numbers of elderly people in the population continues to grow, so will the number of people with dementia.

"Senile dementia" was considered a normal part of aging and treated as such. It was not until the 1950s that scientists began to study the biological structure of plaques in the brain that Alois Alzheimer had noticed in the early 1900s. In the 1960s, researchers connected these plaques in the brain to dementia and recognized Alzheimer's disease as a distinct disease. Even so, it was not until the 1980s that diagnostic criteria were first outlined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Since then, the diagnosis of dementia has improved considerably, particularly with the use of diagnostic brain scanning, and several other types of dementia have been discovered alongside Alzheimer's Disease.

The perception of dementia has also changed with increased awareness of the disease and the tools that are available to diagnose and manage the disease. Increasingly, early diagnosis and management of dementia is being seen as a priority and the role of carers is recognised and supported.

Only 40-50% of people with dementia have actually received a diagnosis. This means that for every patient diagnosed and who enters treatment, there is another who is not accessing care.

Two-thirds of people with dementia live in their own homes or with family. This includes many who live alone. The remaining one-third live in care homes. There are estimated to be 670,000 people in the UK acting as primary carers for people with dementia. In the UK, 80% or more of care home residents have dementia or significant memory problems. At any one time, up to a quarter of hospital beds are occupied by people with dementia.

It has been recognised that many patients with dementia are being inappropriately prescribed antipsychotic medication which is primarily designed for use in schizophrenia. The first governmental warning in the UK about prescribing antipsychotic medication in dementia came as a safety briefing in 2004, alerting clinicians to the risks of stroke with two of the atypical antipsychotics. Meanwhile, evidence in America pointed not only to increased risk of stroke, but also sedation, urine infections, Parkinsonism and cognitive deterioration. It was these concerns that led the Department of Health to commission a report from Professor Sube Banerjee on the use of antipsychotics in dementia.

A National Dementia Strategy was published in 2009 and set new standards for dementia care. This was followed by the Prime Minister's Dementia Challenge in 2012 which set out three dementia challenge champion groups, each focusing on one of the main areas for action: driving improvements in health and care, creating dementia friendly communities and improving dementia research. A variety of NICE Guidance on dementia has been published including Technology Appraisals mandating access to new dementia medicines.

The National Dementia Commissioning for Quality and Innovation (CQUIN) was introduced in October 2012. It charges acute trusts with putting a system

into place to identify people over the age of 75 with a likely diagnosis of dementia, directing them to appropriate follow-up for diagnosis and, if necessary, treatment. In line with the National CQUIN 2013/14, Bradford Teaching Hospitals NHS Foundation Trust is continuing to screen all acute admissions over the age of 75 for dementia.

In 2011, a Bradford audit of the use of antipsychotic medication for people with dementia was published. This has since been updated and has demonstrated that prescribing rates are falling. A working group has now been established to oversee the implementation of the recommendations from the Banerjee Report, and work is being carried out with local care homes to manage the transition, as recommended in NICE guidance, from prescribing medication to behavioural management.

Memory Assessment and Treatment Services (MATS) are being piloted and developed alongside Acute Care Home Liaison Services (ACHL). The three Clinical Commissioning Groups are completing a review of the two services and this will include local stakeholder views to support the formulation of a future service model.

A network of 21 Wellbeing Cafés located within communities and neighbourhoods have been set up across the Bradford District. The cafés support older people with early memory loss or low mood, and their carers, by bringing people together in social settings.

The Alzheimer's Society has launched a new monthly evening café aimed at younger people with Dementia and those whose carers work during the day.

The A&E care liaison team (part of Bradford District Care Trust) provides specialist support in care settings where additional input and expertise is needed in managing patients with dementia in Bradford Royal Infirmary (BRI), St Luke's, the Bradford community hospitals and Airedale General Hospital.

The Local Authority and the Joseph Rowntree Foundation jointly funded the Bradford Dementia Friendly Community Project (BDFCP) with the Alzheimer's Society which formally started in April 2013. It helps organisations to be more accessible and more inclusive to those living with dementia. The pilot phase of the project included organisations such as the Co-operative Retail Group, Church of England, Bradford Diocese, Bolton Road Gurdwara, Council For Mosques and Lloyds TSB.

The Local Authority is currently carrying out a detailed Health Needs Assessment of Dementia across the District. This work is being carried out in partnership with key local stakeholders and is led by the Dementia Strategy Group.

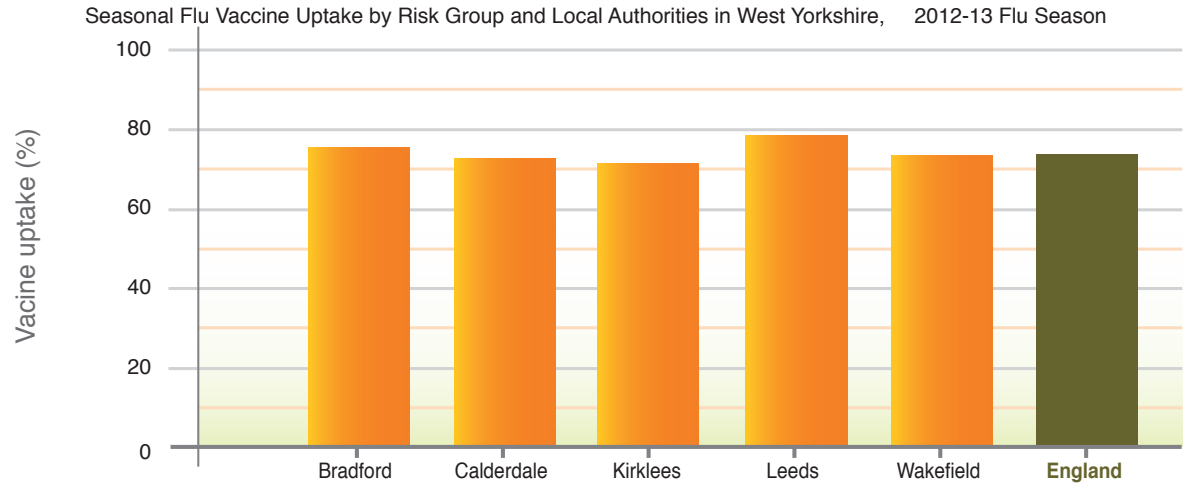
The Alzheimer's Society continue to receive grant funding to provide support to carers of people with dementia which help both the carer and the person with dementia to maintain their independence, improve their sense of wellbeing and take more control of their lives.

It is estimated that by 2021 there will be over 1 million people living with dementia in the UK because the size of the population is growing and people are living longer.

Pneumonia and Flu

Influenza, or flu, is an acute viral illness which affects the respiratory tract including the lungs and airways. Symptoms include fever, chills, aching all over, headache and extreme tiredness. It is very infectious and contagious, and can spread very quickly amongst people who are in close contact with each other through droplets coughed or sneezed out into the air, or through touching

Figure 9: Flu vaccination uptake by over 65s (2012-13 Flu Season) in local authority areas



Source: ImmForm, Public Health England, Aug 2013

surfaces where the flu virus has settled. There are many different strains of flu and the virus is constantly evolving.

Flu can affect large numbers of people at the same time and past pandemics have resulted in many people becoming ill or dying from the disease. In the last one hundred years, pandemics have occurred in 1918, 1957, 1968 and most recently in 2009. Most, but not all cases of flu, tend to be seen in the winter months and it is seen as a seasonal problem.

In general, those affected by flu are unwell for between two and seven days, but it can affect some people much more severely and can lead to severe illness or even death. One of the populations most at risk of contracting flu are people over 65 years of age. Vaccinations to protect against flu were first recommended by the government in the 1960s for those most at risk, and in 2000 the vaccination became available for all those aged 65 and over.

The seasonal flu programme is developed each year to minimise the impact of flu through effective monitoring, prevention and treatment; including vaccinating with the seasonal flu vaccine before the virus starts to circulate.

Campaigns are undertaken nationally and locally each year to improve uptake of the flu vaccine for those most at risk. The Department of Health sets targets for the uptake of flu vaccine in at risk groups and for over-65s. In 2012-13, uptake in the Bradford area was just over the target rate of 75% for over-65s. This compares favourably with other areas in West Yorkshire and with the national figure of 73.3%.

Pneumococcal disease is the umbrella term used to describe infections caused by a specific bacterium. The organism can cause localised infections in the ear and the sinuses, but can also cause more widespread infections including pneumonia, bloodstream infections and meningitis. As with flu, pneumococcal infections are seen most frequently in the winter months. Those most at risk include the very young, the elderly and those with impaired immunity. Immunisation against pneumococcal infection was extended to all those over 65 years of age in 2003.

Uptake of pneumococcal vacation in the Bradford area is high at over 72% in 2011-12 in the over 65 age group, which compares favourably with other areas in West Yorkshire. (Source PHE 2013)

Vaccination and immunisation programmes, like the programmes to protect against flu and pneumococcal disease, are essential to the health and wellbeing of our communities. They are key to protecting individuals and the population against diseases that can kill or cause long-term ill health. Even in areas where uptake rates are good, there are groups of the population that are either un-immunised or not completely immunised and at risk from vaccine preventable diseases. Bradford district has an immunisation strategy and action plan to protect the local population from vaccine preventable disease, including flu and pneumococcal vaccine programmes. The aim is to increase vaccination uptake across the district and continuing to reach or supersede the targets set by the Department of Health (DoH) to protect as many people as possible. This work is led by the Immunisation team based within NHS England in close collaboration with GP practices, School Nursing services and Bradford Council's Public Health department.

Accidents

Older people, especially the frail elderly, are one of the groups of our population most vulnerable to accidents, particularly in and around the home. Accidents are a common cause of hospitalisation and loss of independence in older people. There are a wide number of causes of accidental injury which include falls, fires, scalds, burns and poisoning incidents. This section focuses on the most common cause of accidental injury: falls.

Although most falls do not result in serious injury, the consequences of falling, or not being able to get up from a fall, can be significant. These can include loss of confidence, impaired mobility - which may lead to social isolation and loneliness - an increase in dependency and disability and, in extreme cases, hypothermia.

Hospital admission rates due to falls for those aged 65 and over in Bradford district are not significantly different from the national average. However, there are always improvements that can be made to services or to prevent avoidable loss of health and independence.

Bradford Council's Public Health department has published a comprehensive analysis of falls and bone health. It is estimated that approximately 25,000 falls occur per year. About three quarters of falls among people aged 65 or more result in arm, leg or shoulder injuries.

Epidemiology of falls, fracture and osteoporosis in Bradford district

	No. per year
At risk population: older people aged 65+	71,220
Estimated number of falls	25,449
A&E presentations	6,452
Ambulance call outs	3,696
Hospital admissions	1,246
GP contacts	498

Over 6,000 attend A&E each year after a fall and approximately 20% have an injury serious enough to be admitted to hospital. Many of those not admitted will need to attend a fracture clinic. It is estimated that 5% of all falls will result in a fracture, which equates to about 1250 fractures in the Bradford district each year.

Osteoporosis is a progressive bone disease characterised by a decrease in bone mass and density. Having osteoporosis increases the chance a fracture will occur should a fall happen. It is important to understand this condition and have a system in place to identify and manage osteoporosis as well as trying to reduce falls. It is estimated that approximately 30,000 people in Bradford have osteoporosis and new indicators in the quality outcomes framework should help contribute to understanding how this condition affects Bradford's population.

Fracture of the neck of the femur (or hip fracture) is the most serious form of fracture that commonly occurs. Each year about 450 people suffer a hip fracture in Bradford which can cause issues over the loss of independence and increases in the risk of death. The rate of hip fracture in Bradford is not high comparative to other local authority areas, and is stable over time. This reflects our young population, a sustained effort to improve fracture prevention and the early identification and treatment of osteoporosis.

The National Institute for Health and Care Excellence (NICE) has published guidance on how to reduce falls and fractures resulting from falls. Fully implementing the NICE recommendations might not be possible within the resources currently available, so decisions need to be made locally about what can be achieved.

The analysis undertaken in Bradford in 2010 recommended that the health and social care services in Bradford agree a common approach to the processes and systems for managing and reducing the risk of falls, and a single approach to ensuring that those who have fallen get the best quality care to reduce subsequent loss of independence.

In Bradford, there are a number of different approaches to assessing risk of falling, intervening to reduce this risk and managing those that have fallen so that they maintain their health and independence. There is ongoing debate about whether the approach to managing falls as a population health issue is one for a generalist approach (ie part of everybody's job) or requires specialists (dedicated falls clinics). Both approaches have their own merits and disadvantages. There are a number of different tools and processes for screening for fallers. Many recommend that all those at risk are treated as "fallers" unless proven otherwise.

Significant progress has been made over the last few years in the early identification and treatment of osteoporosis in Bradford. There is now a

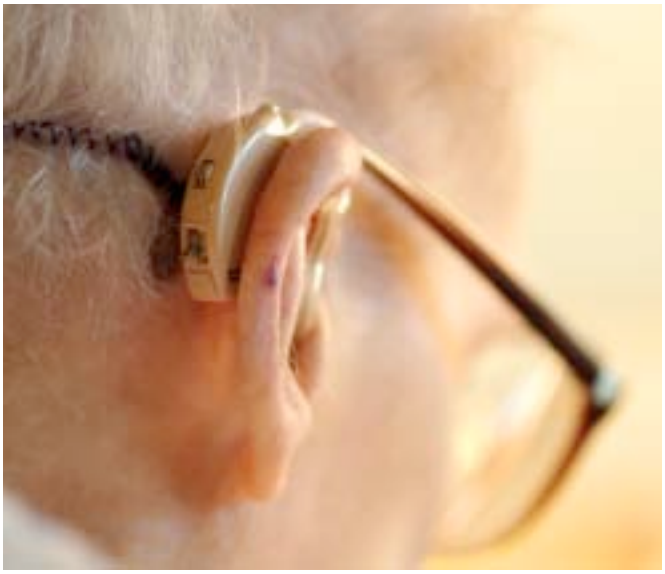
single pathway in place across the whole district within primary and secondary care which has standardised the approach across general practice. This is in line with the recommendation from the 2010 analysis that there was a renewed campaign to identify those who have high risk of fracture and ensure they are offered treatment for osteoporosis where needed.

Some aspects of risk assessment may need further attention; for example, people on multiple medicines or the need to ensure a sight test for those at risk.

There is also scope to work more systematically in both care homes and nursing homes to identify those at high risk and put in place preventive interventions. In residential homes this can be organised through district nursing but it is less clear how changes can be made in nursing homes.

There may also be some scope to work more effectively with ambulance services to reduce the demand on ambulance services. Currently those who have fallen but have no apparent injury will be referred for immediate Intermediate Care response, but if there is any minor injury an ambulance will be called. It may be possible to work with Yorkshire Ambulance Service to introduce further means of risk assessing people who have fallen and sustained a minor injury to reduce call out to those that do not need an ambulance.

There is still work to do to enable a systematic approach to identify undiagnosed osteoporosis. This will involve working with those parts of hospitals that see patients that have had a fracture (principally orthopaedic and radiology) and ensuring they are recommending risk assessments for osteoporosis to be carried out by GPs. It will also involve working with GPs to promote risk assessments on their patients.



Sight and hearing loss

In the years following the Second World War, blind, deaf and deafblind people tended to be cared for in institutions. There were benefits in providing specialised care, but it often meant that people's other needs were not fully understood. For example, clinicians believed that the incidence of mental health issues was low amongst deaf people and blind people; now, it seems that people with sensory loss did not have the opportunity to be diagnosed and treated.

In the decades that have followed, there has been an increased emphasis on caring for older people and people with disabilities in the 'community' – wherever possible, allowing individuals to live in their own home rather than in care, and to remain at home instead of going into care in later life. This has meant that many people experiencing sight or hearing loss have more of a say in how they live.

Since the Second World War, life expectancy has increased, and so have age-related conditions. It is accepted that some of the population will experience hearing loss and/or sight loss as an inevitable consequence of aging. Because there are more older people, there are more people who experience hearing loss, eye problems such as cataracts, glaucoma, macular degeneration and have difficulty reading.

Exposure to noise in earlier life is likely to hasten and worsen hearing loss, and people reaching retirement age now are more likely to have worked in noisy, unregulated environments than today's working population.

The Department of Health says people are deafblind 'if their combined sight and hearing impairment cause difficulties with communication, access to information and mobility'. In the UK, there are an estimated 356,000 people with combined visual and hearing impairment in the UK. The majority – around 62% – are aged 70 or over, and most have developed hearing and sight loss in later life. Estimates suggest the overall number of deafblind people will increase markedly by 2030, and that most of this increase is attributable to the increasing number of older people. Around half of older people who live with hearing and/or sight loss have additional disabilities or long term health conditions.

When someone begins to lose their sight or hearing, particularly in later life, this can lead to a number of other serious problems, such as isolation, boredom, stress, depression and withdrawal. They can also find it harder to carry out healthy behaviours like taking exercise, eating a healthy diet, maintaining social contacts, getting to a GP and hospital appointments, collecting prescriptions, and reading the labels on medication. Sensory loss is also seen as the cause of falls and subsequent injuries. Those encountering sensory loss in later life find it harder to join supportive peer groups or develop new important communication skills, such as learning sign language and learning braille.

A great deal of support is available from organisations nationally and locally. All agencies promote the idea that, with some aids and adjustments, many people who have sight loss or hearing loss can continue to lead their normal lives – and to live healthily and actively.

It is now considered that sometimes hearing loss and, to an even greater degree, sight loss is preventable, with smoking, diet and lifestyle all considered to play a part in the likelihood of an individual losing one or both senses. Work which successfully promotes healthier lifestyles is therefore likely to help to prevent sensory loss in later life.

The NHS provides people over 60 with free of charge eye examinations every other year, and those over 70 can have a free of charge test annually. Older people who are unable to leave their homes to have the test can have the eye

test at home. Some organisations are concerned that too few people take advantage of these free tests – and that failure to do so may lead to more significant problems later, both for the individual and the population as a whole.

The NHS provides advice on how individuals can get their hearing checked if they have concerns. Some preliminary tests can be done by the individual in their own home, quickly, painlessly and free of charge. The NHS provides follow-up checks for those who remain concerned. More information on hearing tests can be found at the NHS Choices website.

Sometimes, individuals experiencing sensory loss cannot get the support they need because they, and those around them, have difficulty in recognising the changes that are happening. Sometimes this is because the individual and friends and family are unwilling to accept that their hearing or sight is deteriorating; sometimes it is because the deterioration is so gradual that the changes go unnoticed, or the changes accepted as an inevitable part of getting older. In other instances, individuals think that nothing can be done to improve their situation. As health professionals and others become more aware of depression and dementia, it is possible that problems with sensory loss may be misattributed to other conditions.

If hearing or sight loss means that the individual cannot communicate as well as before, it is difficult for those around them,families, friends, social services, health professional, to find out the individual's needs and preferences, to discuss their options or keep them informed. Not supporting people with these needs is likely to lead to higher costs later on for the NHS, for local authorities and for older people themselves.

Part Three

Lifestyle

How your lifestyle now can prepare you better for older age

Nutrition

Post war rationing of food was still in place until 1954, and brought stability to people's diets and their nutritional and general health at this time. Local shops provided the majority of a family's needs and food was, in general, home cooked from raw ingredients and eaten together as an intergenerational family.

The arrival of supermarkets in the 1960s and 1970s brought about a change in how people shopped, cooked and ate their food. Certain foods were cheaper and there was more variety and choice. Convenient 'ready meals' began to be sold as lifestyles changed, and time spent preparing cooking and eating food was reduced.

The changing nature of the population and the popularity of other food cultures, have also added to changes in people's eating habits. The rapid boom in take away shops and fast food outlets and the overall increase in the availability of food has resulted in an environment and culture where food can be purchased at any time of the day and is often eaten on the move.

As today's older population have lived through these many changes, their choices about how, when, what and why they eat may be different to other age groups within the population.

There are a number of barriers which hinder some older people living in the community in meeting their nutritional requirements. These include: issues around social isolation; grief, depression and other mental health factors; chronic illness and disability; the impact of medication associated with any conditions; food safety issues, access to food; and a lack of nutritional knowledge or education.

Poverty and/or budgeting skills may also be barriers to healthy eating.

Between 1993 and 2007 the prevalence of obesity in adults who took part in the Health Survey for England rose from 15% to 24% while the prevalence of overweight and underweight stayed constant. The increase in obesity in adults was greatest in the age range 65-74, especially in women.

The Caroline Walker Trust (1995) stated that many older people in residential care accommodation are undernourished, either through previous poverty, social isolation, personal or psychological problems, or due to the effects on appetite of illness or medication.

While the concerns about rising levels of overweight and obesity in the adult population are very real, eating less and unintentional weight loss are also common issues in older people. Surveys of admissions to hospital and to care homes consistently find that underweight older people form a much higher proportion than those who are overweight. Studies have shown that the relative risk of death is consistently higher in people who are underweight, than in those who are overweight and in older people.

The World Health Organisation (2013) has produced guidance on nutrition for the older person suggesting increasing fruit and vegetables by up to two servings per day could reduce the risk of cardiovascular disease. Reduction in salt and saturated fat could reduce blood pressure and blood lipid profiles.

Bradford's Food Strategy (2012) highlights the aims and objectives around all aspects of food, from production to consumption for all populations across the Bradford District including the older population.

Bradford Council provides food in the home to vulnerable and older adults via a private organisation - Appetito - which takes hot food to the door of the customer and serves it, if necessary, to the customer. This organisation also delivers to sheltered housing and luncheon clubs in the community. The meals are nutritionally sound and can be tailored to the needs of the individual in relation to their health requirements such as diabetes.

Many older people attend local community centres to access luncheon clubs and 'cook and eat' sessions. The 'cook and eat' programmes allow for the customers to participate in a group setting to cook a meal and then eat it together after.

Good nutrition plays a vital role in the wellbeing and health of older people and helps delay and reduce the risk of developing disease. Generally, the nutritional requirements of the older adults are the same as those for the rest of the adult population. Access to nutritious food is essential for older people to maintain their health.

Increasingly, dementia and mental health are affecting older people's ability to feed. As the numbers of people with dementia increases, it will be a challenge to ensure adequate nutrition for this group in the future.

Aside from ensuring that vulnerable older people are eating, there needs to be a system in place to ensure that all benefit from a nutritional and well-balanced diet.

Physical activity

Historically, the majority of people were fairly active in their daily life. Bradford was based on an industry of textiles and mills and working in these conditions was physically demanding. People walked to and from work and, at the end of the day, had a family and home to attend to with shopping, cooking, cleaning and general household activities. Recreationally, people were active with the city parks being used as meeting places for communities and families. Children in particular tended to be very physically active in their leisure time.

Because of these factors, the population at large tended to be a healthier weight up until the 1970s and 80s.

Since then, advancements in technologies such as home labour saving devices, car travel and the reduction in manual labour has diminished activity levels in people of all ages.

The increase in chronic conditions such as dementia, heart disease and some cancers can be attributable, in part, to lower physical activity levels.

As people age there is a natural decline in their functionality which is compounded and exacerbated by a low physical activity level. Barriers to participation in physical activity as an older adult can include: reduced mobility and functionality; access to services; social isolation and fear of personal safety.

As age increases, people's participation in physical activity decreases. The decline in participation is more pronounced among minority ethnic groups, lower socio-economic backgrounds and those who have lower levels of educational attainment. Older women tend to be less active than older men.

There is known to be a significant drop in physical activity for both males and females in participation rates between the ages of 65 and 75. After 75 years of age participation rates across England drop to fewer than 10%, with women over 75 being the least active.

The Chief Medical Officer released the first ever guidelines for physical activity in older adults in 2011. These include the recommendations that older adults aim to be active daily and minimise the amount of time spent being sedentary (sitting), and where possible to undertake two and a half hours of moderate intensity activity per week, which includes activities to maintain muscular strength. Older adults at risk of falls should incorporate physical activity to improve balance and co ordination on at least two days a week.

In Bradford there are various initiatives to support physical activity in the older person.

The Bradford Encouraging Exercising People (BEEP) scheme, based in the council, takes referrals from patients who are inactive and have a medical condition. The aim of the scheme is to identify what type of physical activity would be most suitable for them to undertake.

There are services for the frail elderly and those with long term medical conditions, aimed at prevention and rehabilitation. There are chair based exercise classes for those who have limited mobility and are at risk of falls, and cardiac and pulmonary rehabilitation classes are also available.

Bradford Council's leisure department provides activities aimed specifically at the older adult with their over 50s keep fit programmes. This provision will be rebranded in the near future to include access for all those who would like to use leisure facilities as a first step back to fitness and physical activity participation. In the meantime, some nursing and residential homes include physical activity opportunities within their settings.

Many older adults make use of their local community and healthy living centres where they can access a variety of physical activity opportunities.

There is a growing body of evidence suggesting physical activity plays an important part in preventing diseases and conditions which are the primary cause of loss of function and independence in later life. People who remain active throughout their life reduce the risk of developing long term medical conditions such as heart disease, some cancers and diabetes.

Participation in regular physical activity also supports people to remain independent and maintain their ability to participate in daily living activities. Even in less active older adults, the uptake of low to moderate intensity activities will reduce the rate of an age related decline in functionality.

If participation rates in physical activity by older people remain at the same levels there is a real risk that an increasing number of older people will not have the quality of life that they would want in their later years. This will have an impact not only on themselves and their families but also a rise in health and care costs.

Tobacco

Smoking has increased dramatically since the first half of the 20th century and, by the First World War, smoking was regarded as the norm for most men. At the same time, it was frowned upon for women to smoke, but as women's rights became more aligned with those of men it became much more socially acceptable. In 1948, it was estimated that 65% of men and 40% of women smoked. During this 1950s peak, Sir Richard Doll established the first links between smoking and lung cancer and since this discovery there has been a steady decline in the number of adults who smoke. Although it is hard to establish a reliable figure, most estimates suggest that around 20% of the adult UK population smokes.

Smoking is the most preventable cause of death and ill health in Bradford and is responsible for more sickness, disability, injury and death than any other single factor. Older smokers are at greater risk from smoking related ill health because they have smoked longer. Smoking is the most significant factor underlying the variation in health outcomes and life expectancy between the wealthiest and poorest in our communities.

Smoking is responsible for a lot of poor health in older age including: lung cancer, respiratory disease, coronary heart disease, many other cancers, increased risk of eye disease, hip fractures, susceptibility to infection, dementia and cognitive decline. Smoking harms nearly every organ in the body and reduces the general health of those who continue to smoke. Although declining, the number of smokers in Bradford is still too high, especially when compared to the lowest rates of smokers in the UK and worldwide.

Men aged 65 and above who smoke are twice as likely to die from a stroke; and women smokers are about one and a half times more likely to die from a stroke than their non smoking counterparts. The risk of dying from a heart attack is 60% higher for smokers than non smokers aged 65 or above.

Cigarette smokers have a greater chance of developing all forms of dementia including Alzheimer's disease compared to non-smokers. Smokers also have two to three times the risk of developing cataracts, the leading cause of blindness and loss of vision.

Smoking reduces a person's life expectancy by an average of 13 to 15 years - eliminating retirement years for many smokers.

The move away from the Department of Health using four-week quit rates as a measure of the Stop Smoking Service's effectiveness has allowed the local service to focus more clearly on measures that will reduce the prevalence of smoking in Bradford. This focus includes helping older smokers to quit.

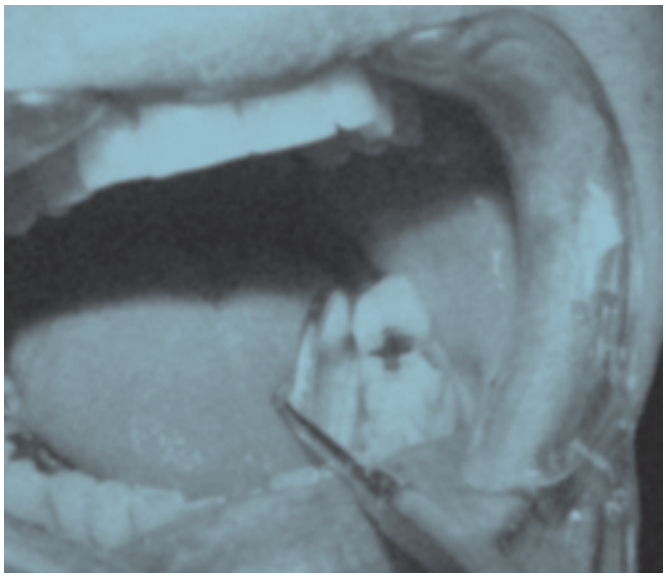
- Quitting smoking has proven health benefits, even at a late age. When an older person quits smoking, circulation improves immediately and the lungs begin to repair damage. In one year, the added risk of heart disease is cut almost in half, and risk of stroke, lung disease, and cancer diminish. Among smokers who quit at age 65, men gained 1.4 to 2.0 years of life and women gained 2.7 to 3.4 years.
- Just cutting down on cigarettes, but not quitting entirely, does not reduce mortality risks from tobacco-related diseases.

- A study found that middle-aged smokers and former smokers with mild or moderate COPD breathed more easily after quitting. After one year the women who quit smoking had 2 times more improvement in lung function compared with the men who quit.
- Many older adults say they do not quit smoking because doing so offers no benefit at an advanced age. There is strong evidence that smoking cessation, even late in life, not only adds years to life, but also improves quality of life. Similar to this belief, most obstacles brought up by older adults for not quitting are based on incorrect information, such as the potential health risks from cessation aids like nicotine replacement therapy.

As people age, they are also more likely to attempt to stop smoking and are more likely to succeed. Quitting smoking by the age of 50 will halve the risk of dying from tobacco related disease and lead to immediate improvements in health. It is never too late to stop smoking, even in older age.

Benefits continue for years, and those who no longer smoke report feeling physically better, and having more stamina, energy and improved self-esteem. There are also personal financial savings which can improve quality of life.

Older smokers are at greater risk from smoking because they have smoked longer (an average of 40 years), tend to be heavier smokers, and are more likely to suffer from smoking-related illnesses. They are also significantly less likely than younger smokers to believe that smoking harms their health. Smoking rates will continue to decline with age, and a significant factor in this rate is smoking related death and illness, with the greatest proportion of the burden of disease due to smoking affecting those aged between 55 and 75.



Oral health

The oral health of adults nationally, and in Bradford, has significantly improved over the last 60 years. The custom prevalent in the early part of the 20th century for young women to have all their teeth removed and replaced by false teeth as a 21st birthday present to prevent dental bills in future would now be deemed an unnecessary precaution.

Before the 1970s toothpaste contained only mild antiseptics and was of little therapeutic value. Many people would have lived with painful tooth decay and missing teeth. The addition of fluoride within toothpaste made it a highly effective method of preventing and arresting tooth decay. Because of the introduction of fluoride in toothpaste, there has been a substantial decline in dental decay, despite the increase in sugars in our diet.

Many people still suffer the pain and discomfort of oral diseases which are largely preventable and remain a major public health problem.

Periodontal disease is characterised by the inflammation of the gums and loss of the tissues supporting the teeth, which can cause pocketing, a gap between the gum line and the tooth. In 2009, 42% of adults in Yorkshire and the Humber who have some natural teeth had evidence of pocketing of 4mm or more; 10% were affected by pocketing of over 6mm and 2% have severe pocketing of 9mm

or more. Each of these figures is roughly in line with the national level.

The most recent Adult Dental Health Survey found that nationally only 6% of adults were edentulous (without any natural teeth). Locally, this figure is slightly higher at 7%. In the older population, 15% of people aged 65 and over had no natural teeth in 2009 compared to 78% in 1978.

There has been substantial investment in NHS dental service provision in recent years which has yielded an increase in dental access. Between 2006 and 2011, the proportion of adults who attended a dental practice in Bradford and district increased from 53.6% to 55.9%. These figures are higher than the average for England (52.3%), and approach the average for the region.

Whilst adults now retain their teeth for longer, those aged 45-65 years who were born before the introduction of fluoride toothpaste have had high levels of disease treated by fillings and other restorations in the past (the 'heavy metal generation'). They will now require complex care and maintenance into older age. This will include the treatment of tooth decay (in the crown and roots of teeth) and periodontal disease.

Oral cancer cases are increasingly being seen in younger age groups with a steady rise in incidence in younger females. This increase has been attributed to excessive alcohol consumption and smoking, and may have a long-term impact upon oral health into old age. In the UK, 87% of oral cancers occur in people aged 50 or over.

Since the introduction of dentistry to the NHS, there has been a focus of treatment of disease. Recently the focus has shifted to improving health outcomes, and the delivery of dentistry is moving towards prevention rather than 'care and repair' of teeth. Dental teams including therapists, hygienists and extended duty dental nurses are now trained to give preventive advice to their patients to improve health outcomes rather than focussing on treatment alone. National documents such as 'Choosing Better Oral Health' and 'Delivering Better Oral Health' provide the evidence base for advice and treatment to ensure prevention of oral disease is at the fore of modern dentistry.

Sexual health

Since the end of the Second World War, sexual health and sexuality has undergone a significant transformation. Changes in legislation and in social demographics have ensured that the current population aged over 50 has witnessed rapid changes affecting their sexual health. These include the Sexual Offences Act 1967 - which decriminalised homosexual acts between men aged over 21; the increased rate of divorce; cohabiting couples; and birth control methods, such as the introduction of the oral contraceptive pill in the 1970s.

Society at large tends to make the assumption that sexuality and sexual health is a health issue which is exclusive to young people. The focus on sexual health in recent years has been teenage conceptions and Chlamydia infections in the under 25 population. The over 50s have found their specific sexual health needs side-lined. Access to clinical services and education has focussed on

young people – whereas, until recently, discussions about sex, relationships and sexual health services have remained taboo in older populations. Whilst teenage conceptions and Chlamydia infections in younger people reduce, there has been an increase in sexually transmitted infections (STIs) in the over 50s nationally.

Although older people do not generally have to consider their contraceptive needs as part of sexual activity, they will still need to take into account the risk of sexually transmitted infections (STIs), particularly when embarking on new relationships. This population will not have had comprehensive sex and relationships education either in school or in the home and this is leading to an increase in STIs in the over 50 population. The over 50s are the fastest growing group of people with the human immunodeficiency virus (HIV) in the UK and research by the Terrence Higgins Trust and Age UK has shown that this group has specific needs including reporting poorer general health than their peers, being worse off financially and having specific emotional needs. In addition to the increase in STIs, some older people experience sexual ill health as a result of other health conditions. For example erectile dysfunction can be a symptom of conditions including diabetes, multiple sclerosis, Parkinson's disease and coronary heart disease. These conditions can in turn contribute to mental and emotional ill-health. The menopause, as well as conditions such as diabetes, can affect libido and also trigger sexual health problems in women, making sexual intercourse difficult or painful.

Limited data is available locally, and national sources have been used to predict trends, although some descriptive research has been undertaken in the district. Questionnaires and focus groups have started to give a better picture of need locally and will form the basis of future sexual health work. Initial findings show a need to increase staff training to raise awareness of the sexual health needs of older people and to make health promotional materials more accessible for older people.

Evidence suggests that older people are happy to talk to their GPs, but may not necessarily raise sexual health issues. Training is therefore being developed for primary care providers and older people's services to instigate conversations, to talk more openly with service users about sexual health and where necessary to make older people aware of sexual health services.

The Sexual Health Needs Assessment carried out in Bradford in 2011 noted "STIs in older adults must not be forgotten – there is a need to develop appropriate service access informed by robust information and support."

Future generations are currently being prepared for good lifelong sexual health by comprehensive sex and relationships education in schools, informal settings and the home and also are increasingly aware of community based clinical sexual health services.

Since HIV was first identified over 30 years ago, tens of millions of people across the world have died of HIV related causes, often at a young age. With the development of new drugs since the mid-1990s, long term survival rates have been transformed. There are now a growing number of older people living with HIV.

One in five adults treated for HIV in the UK in 2011 was aged 50 or over compared with just one in nine in 2002, according to Health Protection Agency figures. Many have been living with the virus for years, but there are also increasing numbers who are acquiring it in later life. Anecdotal local evidence suggests that older age groups are more likely to be diagnosed at an advanced stage of the disease.

Alcohol

The post-war 'baby boomer' generation consume greater volumes of alcohol than previous generations, and with that increased consumption there has been a significant cultural shift, with attitudes becoming generally more favourable towards alcohol. The combination of demographic and cultural changes have been accompanied by improvements in average disposable incomes and the buying power of many older people, and there has been a steady increase in the amount of alcohol consumed by older age groups in recent years.

An estimated 1.4 million people aged 65 and over currently exceed recommended drinking limits in the UK whilst people currently aged 46-65 consume more alcohol than any previous generation.

As individuals become older, they often experience multiple losses: loss of family, friends and health, as well as changes in role such as retirement or becoming a caregiver for an elderly partner or relative. Additional stresses, like chronic pain, insomnia and multiple crises like poor health and financial problems may result in an overwhelming situation in which alcohol misuse may begin or increase. Alcohol use disorders are common among elderly people and are associated with notable health problems. Additionally, in elderly people they are often under detected and misdiagnosed as screening instruments and diagnostic criteria are geared towards younger people.

Media attention and public health research about alcohol use also tend to focus on younger age groups. In the UK, 3% of men and 0.6% of women aged 65-74 are diagnosed as being alcohol dependent.

A particular concern is the effect that alcohol is having on older people with mental illness. Hospital admissions in England for mental and behavioural disorders in people aged 60 and over associated with alcohol use outnumber those with alcohol related liver disease. Furthermore, the number of people between the ages of 60 and 74 admitted to hospitals for these reasons has risen by over 50% more than in the 15-59 age group over the past 10 years.

In Bradford District, alcohol dependency within the older population has become more prominent. Treatment services report rising numbers of older people accessing services, with a reported increase in older carers. A small group of older people with alcohol dependency issues have been identified through the Total Place project which aims to improve integrated services across the district to support elderly people back into independence when they leave hospital or other care.

Nationally, the government has published its Alcohol Strategy which addresses many of the key issues affecting alcohol consumption across age groups. A number of alcohol guidelines which directly affect older people have been published by NICE and there is a growing focus on alcohol and older people in scientific literature and amongst health and social care professionals.

There is some debate about whether alcohol limits should be moderated for elderly people. There are three main reasons for this:

- The elderly are more likely to have co-morbidities that may be exacerbated by alcohol, even if they are undiagnosed.
- The elderly are more likely to be taking prescription medication that may interact with alcohol to their detriment causing, for example, falls or confusion.
- There is a drop in lean body mass and total body water with age meaning a 'standard drink' can give rise to higher blood alcohol content in the elderly.

Locally, partnerships are firmly committed to providing evidence-based identification, prevention and management of alcohol problems for all ages. Primary Care based alcohol workers are being introduced across the District and Alcohol Clinical Nurse Specialists are working in A&E Departments. Local 'third sector' partners have developed initiatives to raise awareness and work is now under way to better understand the extent and nature of drinking in our older people.

Alongside the broader issues of the rising older population and prioritising diagnosis and access to care for older people, there are a number of issues which are specific challenges to this group of patients and the people who look after them.

Social isolation and cuts to social support may add significantly to the stresses of daily life for older people and this may in turn lead to further increases in the use of alcohol.

Older people are more likely to have other illnesses which may complicate the recognition, diagnosis and management of alcohol abuse, particularly where there is co-existing mental illness – and in general, for a variety of reasons, older people may be less likely to recognise that they have a drinking problem.

There is therefore a pressing need to introduce programmes to raise awareness of these issues amongst older people, their carers and the professionals who work with them.

Part Four

Older people at home

Supporting older people to live healthily and well

Housing

Housing has long been recognised as an important influence on health and wellbeing. Much of Bradford's elderly population used to live in houses built before the Second World War, which were lacking in amenities which are now considered basic. Older people's general tendency to prefer not to move meant that these properties were still occupied extensively by older people into the 1970s and 1980s. In the years following the Second World War, however, several new housing estates were built and large Victorian houses were either adapted into collections of flats, or into houses which hosted larger families. This led to improvements in housing stock, as basic changes such as indoor bathrooms and toilets, double glazing and central heating became more commonplace. Over time, these more modern properties have become increasingly occupied by older people – but even so, there are still significant parts of the population who live in properties built before the war.

The elderly population often choose to stay in the homes they have lived in for many years – either because they want to, because they do not want the turmoil of moving or because they are not aware of the alternatives. This creates challenges for health and social care services as family housing is often not designed specifically for the needs of elderly people and care services have to be provided over a geographically diverse area.

Much of Bradford's current housing was built before 1919 when houses were not built with modern amenities. Over 40% of housing in the private sector being classed as non-decent in the most recent stock condition survey (2007). The Housing Health and Safety Ratings System assessed that 25% of private sector housing in Bradford was found to have the most serious failures, largely due to the risk of falls on steep stairs and excessive cold from poor insulation. Poor housing quality leads to a higher risk of accidents, as well as a greater likelihood of illness related to issues such as low temperatures, damp, mould and poor hygiene. Older people are naturally more vulnerable to all of these issues.

Good housing can enable older people to live healthy, independent lives and reduces the pressure on working families to care for older relatives. It can also prevent costs to the NHS and social care. For some older people, a move to a smaller, more accessible and manageable home can also free up much-needed local family housing.

Fuel poverty is increasing in Bradford; 22% of households are considered to be in fuel poverty, up from 16% in 2007. When asked, 21% of households agreed that they struggled to find the money to pay for heating and hot water. There is particular concern that older people may be at greater risk of fuel poverty.

The Development Plan for Bradford, which is being prepared by the Council's Planning Service, promotes a Housing Quality policy. One of the requirements of the policy is that all new homes should be designed to be accessible and easily adaptable to support the changing needs of families and individuals over their lifetime, including people with disabilities.

Whilst caring for people in their own homes is often more favourable than hospital admission or residential care, it is important to give older people options that enable them to remain independent longer and be less reliant on health and care services. This could be by adapting existing accommodation by removing physical barriers such as steps, or by reducing the risks of falling in the home. Older people should have the option of moving to more appropriate housing which is safer and cheaper to heat as well as being more accessible to local services such as GPs and bus routes. This includes high quality specialist self-contained accommodation for older people, often referred to as retirement housing.

The focus on fuel poverty in the district has been to help people in crisis over winter through the

Warm Homes, Healthy People programme and to adapt homes to ensure they are more energy efficient through the Affordable Warmth strategy. The programme ran over the winters of 2011/12 and 2012/13 providing crisis support to people to help keep them warm and healthy over the winter period. This ranges from the provision of clothing and food parcels to emergency utilities provision to home energy checks and the subsequent adaptation of homes to increase their energy efficiency. In 2013/14 the programme was partly funded by the Clinical Commissioning Groups (CCGs) in Bradford. This has not been seen elsewhere in the country and highlights the local understanding that fuel poverty can have a negative impact on the health of the population.

Affordable warmth operates year round and takes a more preventive approach, working with national energy firms. In the future, this is likely to focus particularly on the Green Deal whose aim is to help households to become as energy efficient as energy efficient as possible, whilst at the same time helping people to get on the best energy tariffs to suit their situation.

With a growing elderly population in the district, changes to benefits payments, the growing cost of utilities and an increasing number of people reaching retirement without adequate pension provision, fuel poverty is likely to become an increasing problem.

Social care

Unlike the other topics in this report, social care is difficult to define. The white paper Our Health, Our Care, Our Say (2006) described social care as "the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships".

Using this defintion, social care includes a wide range of services, provided in a variety of different ways to many different people – including the older population. Most social care is provided by friends and relatives on a voluntary basis; the remainder is provided by the private sector and the Local Authority.

From the Local Authority perspective, social care includes adult day care, adult residential care, domiciliary (home) care, housing support and equipment and adaptations to people's homes that make their daily lives easier.

Social care is an evolving and developing concept; there has been a recent move away from the concept of social care as an individual receiving care towards a more shared approach of being supported.

Before the Second World War the only publicly-funded social care for older people was through the Poor Law. This law sought to ensure people receiving aid were not better off than the poorest worker. As a consequence, a lot of social work involved financial matters - checking eligibility and the state of an individual's finances - rather than the kind of activities we might associate with social work now. The profession was largely viewed as a policing function, and was held in very low esteem.

This began to change with the National Assistance Act 1948, which separated services for older people into two categories: In the first category were services for those who were 'sick' and 'in need of hospital care'; in the second, those needing 'care and attention'. Furthermore, the Act required local authorities to provide residential accommodation for older people "in need of care and attention not otherwise available to them".

When the NHS was established in 1948, the service was free at the point of delivery for health care for those 'in need of hospital care'. However, local authorities could levy charges for services considered to be 'care and attention'. From this early stage, the state paid for services for people who were eligible but unable to afford charges.

Throughout the 1950s and early 1960s, social work moved from being seen as auxiliary to other professions to becoming an important profession in its own right. As it did so, the older people and their vulnerability began to assume a higher profile.

These decades also saw the development of community care – the basic concept that people with social care needs were supported to live at home, rather than cared for in institutions. The closure of large geriatric wards led to an increase in smaller, private care homes. Throughout the 1970s, community care continued to develop and more emphasis on preventing disability and promote independence.

Entitlements to free care changed in the 1980s to promote private sector provision and to move responsibility for care towards families, individuals and voluntary organisations. Long stays in

hospitals became less common and this practice increased the workload of social care providers.

The white paper Caring for People (1989) and the National Health Service and Community Care Act in 1990 split the role of health authorities and local authorities and changed their internal structure. From this point, local authorities took on the responsibility for assessing the needs of the local population and for commissioning services. This changed their role from providers of care to commissioners of care, whose role was to purchase services from independent providers.

In the early 21st century, the government introduced Fair Access to Care Services (FACS) which produced a framework for all Councils to establish and operate agreed criteria for eligibility of services. FACS introduced four levels of need: low, moderate, critical and substantial. Councils were advised to prioritise those with greatest immediate and longer-term need. There was increased use of charges and greater selectivity in state funded social care. This is in line with the expectation that people pay towards the cost of their care.

Policy on safeguarding adults has evolved sporadically since the 1980s often in response to different approaches from Councils. While criminal law covers the deliberate harm of adults by other adults, the question of capacity to act as witness or provide testament as a victim could make prosecution difficult. A key driver in developing policy for safeguarding adults was the 1998 Human Rights Act which set a framework to encourage high standards and working between agencies to protect adults. There is recognition that 'at risk' groups are very diverse, as are the circumstances under which abuse happens. There is an important distinction between putting people at risk and enabling people to make their own choices and take reasonable risks. The Government 'No Secrets' guidance provides the framework for a strategy for agencies to work together to safeguard adults.

The National Services Framework (NSF) for older people was introduced in England in 2001. The NSF raised the profile of services for older people and emphasised joint working as the most effective way of providing care. This has led to the emergence of a whole systems approach to social care. There had also been a recognition of 'winter pressures' affecting older people who had been experiencing longer hospital stays, and particularly whose discharge from hospital had been delayed, leading to poor health outcomes for older people.

Current policy in social care aims to put individuals at the centre of decision making about their own care. This is known as personalisation and aims to give choice and control to every person who receives support over how and when care is provided. The FACS system defines the levels of need and local authorities determine the level they will apply. Individuals requiring social care support receive a needs assessment to determine their eligibility then, if eligible, a personal budget is allocated. People can choose to manage their own budget or ask a third party, including the local authority, to manage it on their behalf. Personalisation can mean that care and support are tailored to fit the individual, and may be important in providing cost effective solutions for the future.

Intermediate care is a network of health and social care services, strengthening work between health services and local authorities. These have been developed to provide rehabilitation and enablement services outside hospital for older people with complex needs. In order to ensure individuals retain their independence where possible, it is important to ensure older people are admitted to hospital only when necessary and that they are discharged from hospital as soon as it is appropriate. With this approach, quick access to medical care should be made available if needed.

National frameworks and institutions have been developed to promote consistency, set minimum standards and play a role in disseminating information about both good and harmful practice. Increasingly, there is acknowledgement that older people can play an important part in improving the quality of services.

Bradford has benefited from a strong Older People's Strategic Partnership which has pioneered a range of programmes. Bradford Council invests in Wellbeing Cafes and activities for older people, as well as developing a district wide crisis response service for older people.

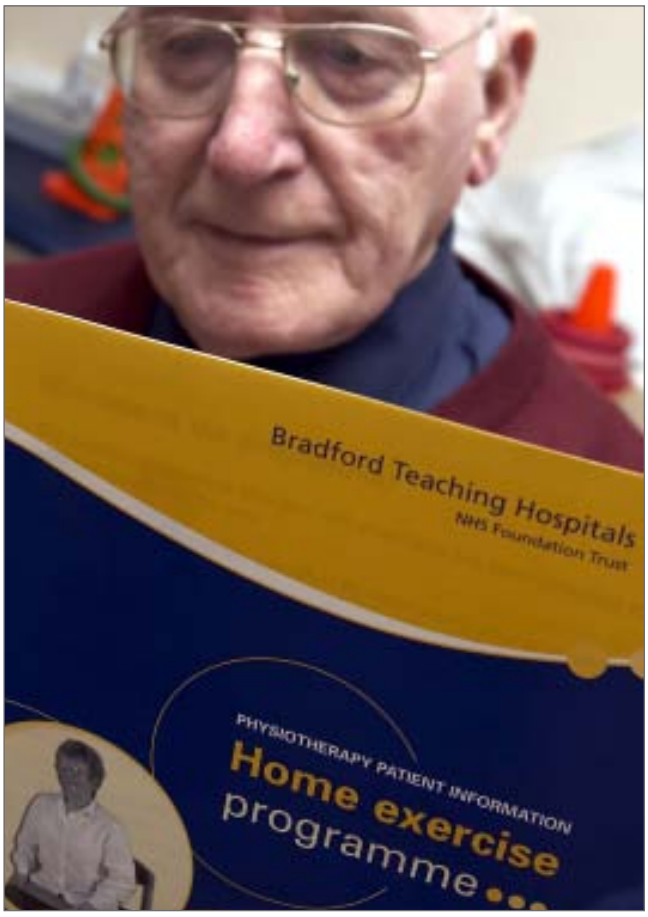
In Bradford District, the Integrated Care for Adults Programme has been planning and testing new ways of working between health and social care to deliver a more coordinated approach across community services. Multi-disciplinary teams have been piloted in four GP practice areas in Bradford and across the whole of the Airedale, Wharfedale and Craven Clinical Commissioning Group. The programme also supports a range of initiatives to enable people to make decisions about everyday life that support them with multiple conditions, and to take responsibility for their own "self-care".

A review of housing related support for older people in 2011 led to the commissioning of community based support teams, and the development of "Not over the Hill Yet", and "Feel Good" groups through

a new Community Integration project. A Mutual Support Network for older people's groups has been developed in each postcode area in Bradford. More recently, the Joseph Rowntree Foundation has begun a study of loneliness in Bradford focusing on issues in two specific communities, and attempting to ensure that the community at large does more to make itself aware of loneliness.

"Great Places to Grow Old" is a new programme set up jointly between housing, social care and the NHS to improve services for older people. This programme recognises the importance of health, housing and social care services working together to provide flexible support that enables people to stay independent and well for as long as possible. The programme will create new integrated services to enable older people to stay well through crises and will provide more specialist housing and other innovative approaches to allow people to remain independent for as long as possible. It will also work with the independent sector to improve the quality and choice of residential and nursing care, particularly for people with Dementia.

The projected growth in the older population and the reduction of budgets in adult social care are expected to put pressure on services. It will be important to create different ways of delivering care and support. There is already a financial imperative to be more effective, avoid unnecessary care, and be more efficient.



For local community based care to succeed, different agencies must work together in a coordinated and integrated way.

Areas of development for the future include:

- Promoting people's independence and wellbeing to enable them to keep optimal levels of health, wellbeing and independence.
- Ensuring that everyone has a responsibility to contribute to, prevent, postpone and minimise people's need for formal care and support.
- Ensuring that people are in control of their own care and support services.

There is a major challenge across all health and social care providers for the future to deliver a truly integrated system of health and care.

Carers

It is only since 1986 that Government legislation has begun to recognise the needs of carers and several acts have been passed that establish carers' rights (Carers and Disabled Children Act 2000, Carers Equal Opportunities Act 2004). The first national carers' strategy was published as recently as 1999 and subsequent updates have provided an additional £400 million investment over four years to provide carers, with additional support. There is now a recognised national Carers Week in the UK every year.

In Britain it is estimated 1 in 10 is a carer at any one time. There are around 51,000 carers identified in the district with around 16,500 carers aged 50-64 years and 8,500 over 65 years of age. This is likely to be an underestimation as many carers do not recognise themselves as carers and these figures, taken from the census, are dependent on self-identification. The number of carers in the district continues to rise and the most recent figures show 9.8% of the total population are carers.

In total, 28% of all carers in the district who provide 50 hours or more of care per week, are over 65 years old. This means a high proportion of full time carers are older people themselves. However, most carers fall into the 25 to 49 year age band. We know that carers providing high levels of care are twice as likely to report poor health compared to those who do not have any caring responsibility.

The following tables show the numbers of carers in different age groups, the number of hours of unpaid care provided and also the general health of carers.

Older people can be carers for older relatives and friends, but also have an important role in providing childcare for families who have young children. Young carers (those under the age of 18) were first identified as a group requiring specific support during the early 1990s and they are often supporting older family members. Since that time there has been a development of research, policy and legislation in this area. There are around 5,000 young carers identified across the district.

Figure 10: Numbers of carers in different age groups in Bradford district, by hours worked

	All carers	0 to 24 hrs	25 - 49 hrs	50 - 64 hrs	65+ hrs
1 to 19 hours unpaid care a week	30,889	3,595	12,410	10,793	4,091
20 to 49 hours unpaid care a week	7,734	854	3,641	2,216	1,023
50 or more hours unpaid care a week	12,291	633	4,786	3,434	3,438
Provides unpaid care: Total	**50,914**	**5,082**	**20,837**	**16,443**	**8,552**

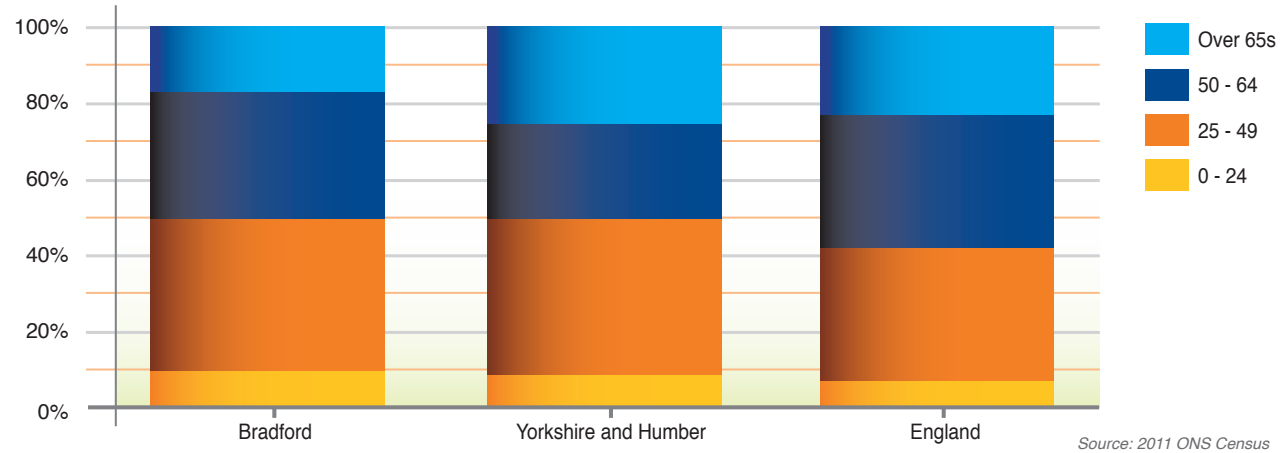
Source: 2011 ONS Census, Strategic Support CBMDC

Figure 11: The health of carers in Bradford district, by numbers of hours worked

	All carers	Very good or good health	Fair health	Bad or very bad health
Provides 1 to 19 hours unpaid care a week	30,889	24,460	5,127	1,302
Provides 20 to 49 hours unpaid care a week	7,734	5,293	1,805	636
Provides 50 or more hours unpaid care a week	12,291	7,130	3,699	1,462
Provides unpaid care: Total	50,914	36,883	10,631	3,400

Source: 2011 ONS Census, Strategic Support CBMDC

Figure 12: Proportion by age of carer of unpaid care



Source: 2011 ONS Census

The Local Authority and the NHS developed a joint carers' strategy which aims to improve support in line with the priorities in the national strategy by:

- Supporting carers to identify themselves at an early stage
- Enabling carers to fulfil their educational and employment potential
- Personalising support for carers and the people they care for
- Supporting carers to be healthy

The aims for commissioning services are to:

- Reach carers using a range of methods
- Support carers to have up-to-date and accessible information
- Signpost carers to relevant services whether they are carer specific or related to the person they care for
- Support carers emotionally and practically
- Support carers to plan for emergencies
- Support more carers to have breaks form caring
- Support carers to access training to help them in this role
- Provide carers with a cash payment to improve their own health and wellbeing

In a changing society, where people are living longer, many are developing long term conditions. Most people wish to remain independent and have control over their lives and caring roles are becoming increasingly common. More people, often at the peak of their careers, may need to give up work or reduce working hours to care for an ill or disabled loved one. Some may end up in debt, forced to depend on the benefits system and face financial hardship into their retirement. The combination of childcare and eldercare – particularly from a distance – can significantly add to workplace stress and absence. Support is key from employers and other agencies during such times.

Health and social care systems are becoming increasingly reliant on unpaid carers as people live longer and there are more people with chronic illnesses. As more pressure is felt on all services and resources, more carers are potentially at risk of poor health and wellbeing. This could result in possible carer breakdown and an increased demand on statutory provision to meet the gap in services.

The needs of all carers should be at the centre of family policy both now and in the future and all carers need to receive the recognition and support they deserve and require. Local services provided by the Council, Health and the Voluntary and Community Sector are key to supporting carers and ensuring they can be as healthy as possible.

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