Halton Joint Strategic Needs Assessment 2015/16

Older People:

Lifestyles and prevention of ill health

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Description	The document constitutes chapter 4 of the 2015/16 Older People's JSNA for Halton. It describes the policy context, estimated prevalence, risk factors and sub-groups of need, current service provision and national best practice in relation lifestyles and key prevention interventions, including vaccinations and falls amongst Halton's over 65 age population.
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Related documents	

Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.

List of Abbreviations

A&E	Accident and Emergency (hospital department)
BAPEN	British Association for Parenteral and Enteral Nutrition
BMI	Body Mass Index
CCG	Clinical Commissioning Group
CSU	Commissioning Support Unit
DSR	Directly age Standardised Rate
GP	General Practitioner
Halton OPEN	Halton Older People's Empowerment Network
HSCIC	Health and Social Care Information Centre
ICD-10	International Classification of Diseases, version 10
JSNA	Joint Strategic Needs Assessment
LJMU	Liverpool John Moores University
MLS	Merseyside Lifestyles Survey
MUST	Malnutrition Universal Screening Tool
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
ONS	Office for National Statistics
PCMD	Primary Care Mortality Database
PHE	Public Health England
POPPI	Projecting Older People Population Information system
SSLL	Sure Start to Later Life
STIs	Sexually Transmitted Infections
SUS	Secondary User System (hospital admissions database)
TIIG	Trauma and Injuries Intelligence Group
WHO	World Health Organization

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Overall, older people have healthier lifestyles than younger adults. Data from the 2012/13 Merseyside Lifestyle Survey (MLS) shows that older people, i.e. those aged 65 and over are:

- Less likely to smoke (17% compared to 30% of all adults aged 18+)
- Eat more portions of fruit and vegetables than the average with the 18-24 age group eating the least
- A lower percentage drink alcohol and of those that do only 4% drink to harmful levels, with older men are more likely to do so than older women
- 1 in 5 drink skimmed milk most regularly
- They are least likely to add salt to food at the table

However, there are some areas were older people's health related behaviour is not as good as younger adults:

- Older people do not undertake moderate or vigorous exercise to the same extent as younger adults
- They spend more time per day sitting and less walking
- Those aged 45-64 are most likely to be overweight and obese. Although the percentages are lower for those aged 65 and over the percentage of older people who are overweight or obese is higher than the borough average

Sexual relationships remain inportant for older people. Yet many find it difficult to talk to their partner or a health professional about sex. Levels of sexually transmitted infections (STIs) are lower in the 65+ age group than in any other age group and this has been consistently so over time. Halton rates are lower than the England average.

Screening and vaccinations

Cancer screening levels in Halton are lower than the national targets; uptake of bowel screening is 48.8% compared to the target of 60% with breast screening uptake being much closer to target at 69.8% compared to the target of 70%. No practice in Halton achieves the bowel screening target, with uptake ranging from 39% to 56%. For breast screening 5 practices reach the target, with uptake ranging from 57.6% to 78.5%. For both these screening programmes Beaconsfield practice has the highest uptake rate.

Influenza vaccinaton is offered annually to all those over the age of 65. Halton uptake is higher than England at 73.8% but falls just short of the 75% target. Practice uptake varies from 67.2% to 79.4%, with 7 practices achieving uptake above target. More Halton older people receive the pneumococcal vaccination than England, 70.8% compared to 68.9% but the local rate is lower than across Merseyside which overall sees a 70.8% uptake. The newest vaccination programme for older people was introduced from September 2013 and is for shingles. Uptake amongst the eligible population varies greatly from 18.2% to 76.9%, with the average uptake being 47.8%. Offered to

people at age 70 there is also a catch up programme. Again less than half those eligible take this up, just 46.8% with practice level variation of 15.6% to 80.6%.

Falls

There is no local or national falls register. Using national research, the estimated prevalence of falls amongst those aged 65+ is 3,266 women and 2,154 men (2015 figures). Assuming the underlying prevalence remains static, given the projected increase in older people, this is likely to rise to approximately 4,915 women and 3,375 men by 2030. In a survey of people aged 55+ across Cheshire & Merseyside, 36% of Halton residents stated they have ever had a fall, the third highest across Cheshire & Merseyside, behing Liverpool and Knowsley. The pattern seen across Cheshire & Merseyside suggests deprivation may be a factor.

There were 8,243 attendances at A&E departments between April 2012 and March 2015. At least 23% of these were due to falls. This percentage may be higher as Warrington hospital does not code falls as a primary injury type. Whiston does and here 47% of the injuries seen in those aged 65 and over were due to falls. Applying this higher rate would suggest as many as 3,874 attendances during the 3-year peiod were due to falls, or nearly 1,300 per year.

The rate of hospital admissions due to falls in the over 65s is statistically significantly higher in Halton than the national average, although the rates have fallen between 2010/11 and 2013/14. Halton's rate for 2013/14 was the highest of its statistical neighbours group, statistically higher than every local authority in the group apart from Salford. Rates rise substantialy from aged 75+ and are highest in the 85+ age group for both men and women, with rates highest for women. Rates also vary by electoral ward and GP practice, lowest in Daresbury ward and Windmill Hill practice and highest in Broadheath ward and Hough Green practice. Only a small proportion of falls result in fractured neck of femur (hip fracture). Rates in Halton are statistically higher than comparators.

Unlike admissions, the mortality rate due to falls in the over 65s is relatively low in Halton compared to its statistical neighbours group. It is only the 5th highest (out of 18 local authorities in the group) for ages 65-74 and 6th highest for those aged 75+.

1. Introduction

Primary prevention can be defined as: universal services that are aimed at people who have no or no particular health or social care needs or symptoms of illness (but including those who are at risk of needing social care support).[1]

The emphasis of primary prevention is therefore 'preventing the preventable' forms of ill health. A focus on health promotion within ageing populations is identified as a key high impact change in a recent policy paper on embedding prevention in older people's services.[2] The paper draws from European research to outline the benefits for both individuals and societies, specifically that:

- Health is a basic right of (older) people
- Health is one of the most important predictors of life satisfaction in old age
- Health is a prerequisite for an independent life in old age
- Health is vital to maintaining an acceptable quality of life in older individuals and ensuring the continued contributions of older people to society
- Health is a determinant of economic growth and competitiveness (for example, decreasing early retirement of older workers
- A healthy population reduces health-care spending and lowers the burden on the health-care system.

The underlying principle to primary prevention is that modification of risk factors in later life is still beneficial for health. This chapter of the older people's JSNA examines the the main lifestyle behaviours as well as other preventative mesaures such as vaccinations and falls prevention.

The work of Professor Fries and his team at Stanford University, has developed the 'Compression of morbidity' hypothesis which describes an emphasis on delaying the age of onset of chronic illness relative to the age at death and therefore squeezing most of the morbidity experienced in life into a shorter period: in other words a long life with a shorter period of lifetime disability. While there is debate about this theory and the academic perspective on ageing is being refined, there is a particularly helpful de-lineation of the forms of prevention in postponing morbidity and the following definitions are used:[3]

- **"Primordial" Prevention** prevents the risk factor (not the illness) from developing. For instance, decreasing the number of teenagers who start smoking or preventing childhood obesity represents primordial prevention.
- **Primary Prevention** decreases risk factor prevalence, as by stopping smoking, promoting exercise, reducing weight and reducing hypertension and cholesterol levels.
- **Secondary Prevention** is aimed at preventing progression of disease, as in decreasing second heart attacks, congestive heart failure, or complications of diabetes.
- **Tertiary Prevention** aims at a reduction of morbid states that have already occurred, as with replacement of faulty hips, failed kidneys or livers, or use of a scooter for locomotion. Tertiary Prevention can reduce morbidity but often does not eliminate it.

This definition of primary prevention and the comparison to other forms of prevention is useful for considering a focus on primary prevention in older people. There are many nonmodifiable risk factors that contribute to ill health including age, gender, and familial history. Older adults may already be living with a range of forms of disease and disability, including long term conditions, but

by modifying other risk factors they may experience benefits for their health, and this work is part of primary prevention. Chronic degenerative disease and ill health are not inevitable concomitants of ageing and an emphasis on modifying risk factors ought to be continued throughout the lifecourse.

Chronic disease in older age groups reflects an accumulation of exposures to risk factors throughout the lifecourse, and it is in the older age groups that most chronic diseases will become apparent.[4] Further, there is secular patterning of behaviours: lifestyle habits may be set down as a child and as an adult that are resistant to later change.

There are many positive health behaviours demonstrated within the population of older adults: evidence from the Lifecourse Tracker national survey demonstrated that adults aged 55 years and over were less likely than the all-adult average to report all of the core negative health behaviours that were measured.[5] There is an unanswered question, in terms of interpreting, whether that reflects the behaviour of a healthier generation, or positive health changes that have been made in middle and later years.

2. Policy Context

Since the National Service Framework for Older People was published in 2001[6] with the inclusion of standards on health promotion and falls prevention, there have been a range of national public health strategies

The World Health Organisation (WHO) has been highlighting the increasing numbers of older people globally and has championed an approach emphasising active ageing, with thorough consideration of health throughout the lifecourse,[7] in contrast to traditional geriatric paradigms. This 'lifecourse' approach recognises the impact of earlier exposures, continued choices and behaviours, and the opportunities for intervention, change and ongoing support at all life transition points.

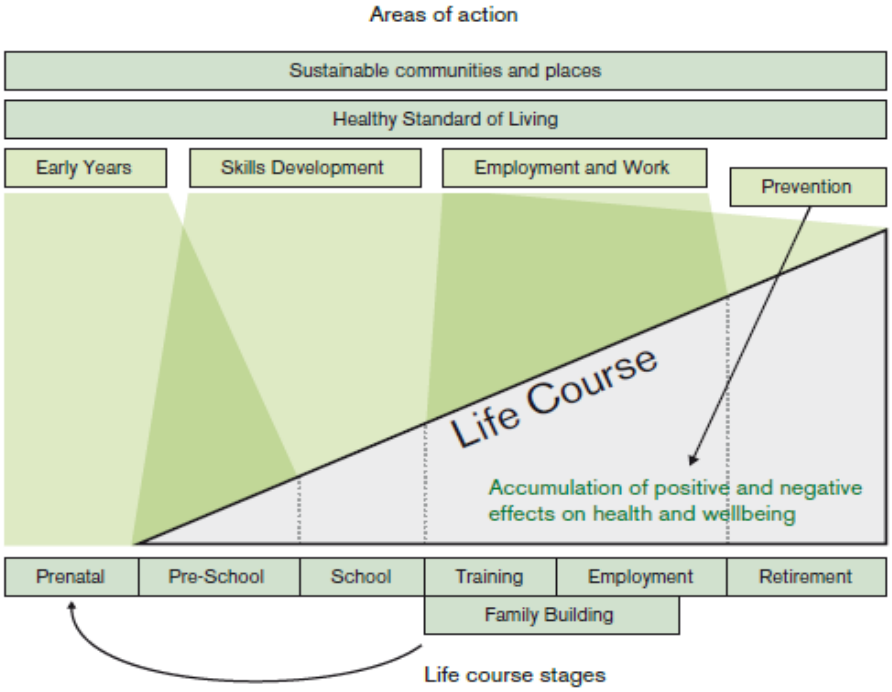
Table 1: A lifecourse approach to healthy and active ageing (WHO)

Promoting good health and healthy behaviours at all ages to prevent or delay the development of chronic disease. Being physically active, eating a healthy diet, avoiding the harmful use of alcohol and not smoking or using tobacco products, can all reduce the risk of chronic disease in older age. These behaviours need to start in early life and continue into older age.
Minimizing the consequences of chronic disease through early detection and quality care (primary, long-term and palliative care). While we can reduce the risk of chronic disease through a healthy lifestyle, many people will still develop health problems in older age. We need to detect metabolic changes such as high blood pressure, high blood sugar and high cholesterol early and manage them effectively. But we also need to address the needs of people who already have chronic disease, care for those who can no longer look after themselves and ensure that everyone can die with dignity.
Creating physical and social environments that foster the health and participation of older people. Social determinants not only influence the health behaviours of people across the lifecourse, they are also an important factor in whether older people can continue to participate. It is, therefore, important to create physical and social environments that are 'age-friendly' and foster the health and participation of older people.
Reinventing ageing – changing social attitudes to encourage the participation of older people. Many current attitudes to ageing were developed during the 20th century when there were far fewer older people and when social patterns were very different. These patterns of thinking can limit our capacity to identify the real challenges, and to seize the opportunities, of population ageing in the 21st century. We need to develop new models of ageing that will help us create the future society in which we want to live.

The Marmot Review[8] of Health Inequalities also advocated action across the lifecourse within 6 policy objectives, demonstrating that disadvantage starts before birth and accumulates throughout life:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Figure 1: Marmot Review framework for action



In response to the Marmot Review the Government produced its national public health strategy *Healthy Lives, Healthy People.*[9] In it there was an emphasis on action by local government, local communities and individuals. In relation to Ageing Well it highlights:

- The ageing population and the challenge this presents for health and care systems geared to treating short-term illness
- That decline is not an inevitable part of ageing. Public health will have a major leadership role in prevention, promoting active ageing and tackling inequalities
- Local government's new role in public health presents an opportunity to address this challenge. Public health will be better integrated with areas such as social care, transport, leisure, planning and housing, keeping people connected, active, independent and in their own homes
- The need for strong partnerships between communities, business and the voluntary sector will help address a range of health challenges such as depression and winter deaths
- The need to create an environment that supports people in making healthy choices, and that makes these choices easier, in particular housing that supports older people to remain healthy and both NHS and social services that provide prevention and reablement services to help older people remain independent
- It recognises that carers also play a vital role in supporting people to stay at home
- The need to continue to change social norms and attitudes. Ageist attitudes and practices have a detrimental effect on older people, both directly and through their take-up of services

3. Level of need in the population

3.1 Lifestyles

Between September 2012 and January 2013 over 13,000 interviews with Merseyside residents were conducted asking them about their general health, physical activity levels, smoking and drinking habits, and diet. In Halton, there were over 1,200 participants in the survey with 24% of these aged over 65 years. The general characteristics of the 289 Halton older people who took part in the Mersyside Lifestyles Survey (MLS) were:

- There were equal numbers of females (145) and males (144)
- Over half (54%) were married or cohabiting (mostly married) whilst more than a third (34%) were widowed
- Two-thirds owned their properties, and 3 out of 10 were social renters
- Nearly half (48%) had a long term illness, disability or health problem
- Nearly 2 out of 3 (67%) were overweight or obese

3.1.1. Physical Activity

The benefits of being active daily helps to maintain cognitive function, reduces cardiovascular risk, helps to maintain the ability to carry out daily living activities, improves mood and self-esteem, and reduces the risk of falls.[2]

In separate survey of residents aged 55 and over, conducted by Liverpool John Moores University (LJMU) found that 58% of those surveyed stated that they were physically active. This was one of the lower levels of activity, the same as Liverpool with only Knowsley having a lower level. However, this survey did not ask any further questions about levels of activity so it is not possible to determine what people's understanding of physical activity was and how this may have affected their response. The MSL asked questions about the amount, frequency and type of activity and so was able to determine levels of both vigarous and moderate activity. It found that only 4% of older people that were surveyed participated in vigorous intensity physical activity for at least 10 minutes continuously compared with a Halton average of 19%. For moderate intensity physical activity, that could include brisk walking, dancing, or swimming, 30% of older people undertook such activities for at least 10 minutes continuously, compared to the Halton average of 36%.Understandably older people with a limiting long term illness were less likely to undertake moderate activity than those who did not have a long-term illness (16% compared with 25%), and smokers were also less likely to exercise than ex-smokers (23% compared with 37%).

41.5% of older people (65+) said they spent over 30 minutes on a typical day walking or cycling. Conversely 97.1% of older people (65+) said on a typical day they spend over an hour reclining or sitting.

3.2.2. Smoking

Smoking prevalence decreases with age and older smokers who decide to give up have been shown to be more successful at quitting than younger people. Older people can expect a range of benefits if they stop smoking, many of which can be seen quite quickly, and include:

- being able to breathe easier
- any existing heart or lung problems are less likely to become serious
- being less likely to have a stroke or heart and lung problems
- being able to recover from an operation more quickly
- living longer

Almost a fifth (17%) of older people who participated in the MLS were current smokers compared with a borough prevalence rate of 30%. 63% of older people stated that they had ever smoked, higher than the Halton average of 53%. This is indicative of a time when smoking was much more prevalent in the adult population with the low current smoking rate suggestive of high levels of successful quitting. The LJMU survey also asked if people were smokers. It found that 17% of older respondents in Halton (ie those aged 55 and over) were current smokers, the same as the rate across Merseyside as a whole. If these prevalence rates were applied to the Halton population this would equate to 3,572 older smokers.

3.1.3. Alcohol Consumption

Although the majority of older people across the country drink alcohol within recommended guidelines and do not harm their health, there are dangers in consuming alcohol for certain groups of older people:

- alcohol can add to the effect of some medications e.g. painkillers or sleeping tablets
- alcohol can reduce the effects of some medications e.g. warfarin, which thins the blood and can increase the risk of bleeding or develop blood clots
- balance deteriorates with age and even a small amount of alcohol can increase the risk of falls

Nationally, about a third of older people with drinking problems develop them for the first time in later life.[10]Bereavement, physical ill-health, difficulty getting around and social isolation can lead to boredom and depression, so it can be tempting to use alcohol to make these difficulties more bearable. It can then become part of daily routines and difficult to give up. There may be less pressure to give up drinking than for a younger person, fewer family responsibilities, and no pressure to go to work each day.

Over half (59%) of older people in Halton drink alcohol (lower than the borough average of 67%), and the vast majority do so within recommended guidelines (96%). Only 4% drink at hazardous or harmful levels, much lower than for older people nationally. If this prevalence was applied to Halton's 65+ population, this would equate to 12,398 older people drinking alcohol and 496 drinking at hazardous or harmful levels. Older men were more likely than older women to drink at hazardous levels with owner occupiers more likely to drink at these levels than social renters. This is a similar pattern to the Halton population as a whole and probably reflects the financial circumstances of social renters (tend to have less disposable income) rather than, or at least as much as, lifestyle choices.

3.1.4. Body Mass Index and Healthy Eating

Findings from the MLS showed that both overweight and obesity increase with age, with levels being highest in the 45 to 65 age group then reducing in the 65+ age group. 1% of older people surveyed were underweight which was lower than the borough average of 2%. A fifth (20%) were classified as obese which again was lower than the Halton average (28%). Older people with a limiting long-term illness were more likely to be obese (25% compared with 15% without a long-term illness).

Whilst physical activity levels were lower in this age group, the survey showed that older residents tend to eat more fruit and vegetables than their younger counterparts, with those aged 65+ consuming 4.3 portions compared to 3.5 portions among 18-24 year olds. Older people eat significantly more fruit. Those aged 55 and over eat an average of 2.1 portions of fruit a day compared to 18-24 year olds, who eat an average of 1.6 portion a day. Younger people (aged 18-44) are significantly more likely to drink whole milk (18%), whilst those over 65 were the most likely to drink skimmed milk with one in five (18%) drinking this milk the most regularly. The over 65s were also most likely to rarely or never add salt at the table with 58% stating this compared to just 43% of 18-24 year olds.

A mixed pattern was seen for questions relating to fat/oil intake. Younger people in Halton, specifically those aged 18-34, are significantly more likely to say that they do not use fat at all in their cooking (18%), with over 65s are the most likely to use butter or lard like fat for cooking with seven per cent stating they use these compared to just two per cent of 35-44 year olds and one per cent of 18-24 year olds. However, those over the age of 65 were more likely to use cholesterol lowering spreads (13% compared to 3% of those aged 18-44).

Older people were much less likely to eat 'fast foods', from both major chains and non-chain, just 15% of all those over the age of 55, compared to half (50%) of 18-24 year olders and 41% of 25-34 year olds.

This is also true when looking at 'at least once a week consumption, with 35% of 18-24 year olds and 29% of 25-35 year olds have 'fast food' from major chains at least once a week, compared to 5% of those aged 55 and over. When considering take-away means from non-chain restaurants, 33% of those aged 18-34 have at least one a week compared to 13% of those age 55 and over.

3.1.5. Sexual Health

The Natsal-3 survey showed that people aged 50 were at an older age when they first had sex than younger generations. They note that education on sexual health was also limited or non-existant for many of todays 50+ generation, especially those aged 65+.

An Age UK online poll of over 2,000 people revealed that many people over 65 spoke openly about attitudes to sex and ageing, revealing a desire to remain sexually active – but a lack of understanding about where to go for advice.

The charity says it commissioned the poll to highlight the role of sex and sexual health in later life, helping to dispel some of the stereotypes and taboos around older people and sexual relationships.

With nearly a quarter (24%) of those polled stating that age hasn't affected their sex lives, the survey shows that sex remains important, regardless of age. Almost two thirds (62%) said that they are

currently enjoying a fulfilling sex life. One in eight (12%) said they would like to try new things with their partner and just under one in five (18%) wanted to be more sexually active. Some 8% were keen to embark on a new sexual relationship.

Despite this desire for a fulfilling sex life in later life, the survey revealed that many of the older generation find it difficult to talk to partners or health workers about sex. Over a quarter (28%) feel they can't talk to their partner, with women finding it harder to disclose their feelings than men. Reasons behind the silence included embarrassment and not knowing how to initiate the conversation.

While clinicians have been aware of a rise in the number of Sexually Transmitted Infections (STIs) among over 45s for some years, 69% in the survey revealed that they had never sought any type of sexual health advice. The findings also revealed:

- Three quarters (76%) of over-65s do not currently seek sexual health advice
- Just one in seven (14%) have sought sexual advice in the last 20 years
- Almost half (46%) feel they don't need any sexual health advice, rising to 54% of women

The poll found that the most likely source of sexual health information is a nurse or doctor, with 17% of those polled turning to their healthcare professional for help.

In the European study 23% of men and 32% of women reported some sexual dysfunction, most commonly ejaculation problems (11%) and erectile dysfunction (8%) in men and lack of sexual interest (18%), inability to reach orgasm (13%) and lubrication difficulties (11%) in women.[11]

Although sexually transmitted disease does occur in older people the rates are significantly lower than for all other age groups and Halton rates are also lower than those for England as a whole.

Figure 2: Trend in rates of all new STIs in Halton residents, by age group

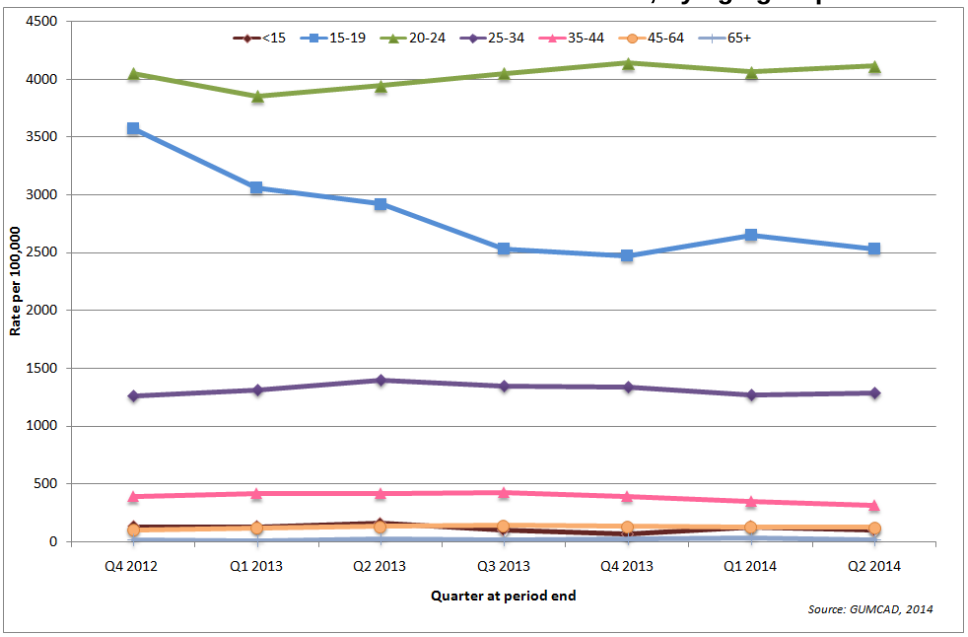
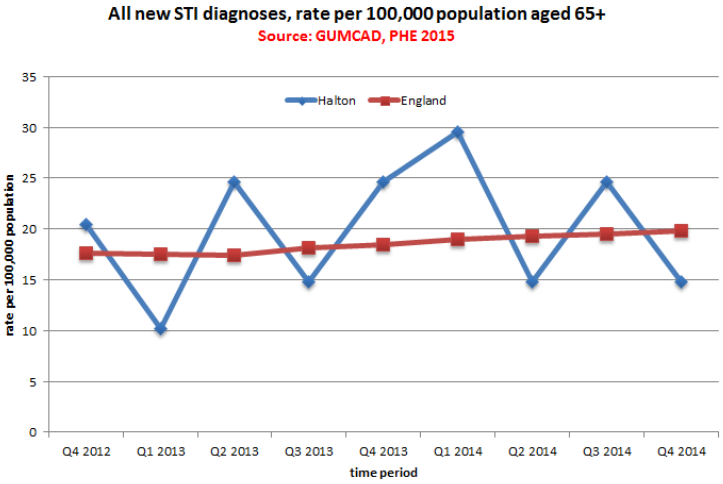


Figure 3: Rate of new STIs amongst those aged 65+, Q4 2012/13 to Q4 2013/4



3.2 Screening and Vaccination

There are numerous health tests that are offered by the NHS to older people including screening for cancers, diabetes, aortic aneurysms, cholesterol, anaemia, thyroid, respiratory system, bone disease, kidney disease, glaucoma, as well as a general health check.

3.2.1. Cancer Screening

There are three cancer screening programmes delivered by the NHS; bowel, breast, and cervical. They are coordinated by the national office of the NHS Cancer Screening Programmes which is part of Public Health England.

Screening for bowel cancer (the third most common cancer in the UK) reduces deaths in the screened population by 16%. Screening can also detect polyps which may develop into cancers over time. These can be easily removed, reducing the risk of bowel cancer developing. Screening is offered to men and women aged 60-75 years in the form of a faecal occult blood testing kit in the post. After this age bowel cancer screening can be requested, but people aren't invited automatically.

Almost a third of breast cancers are detected through screening which is offered to all women aged 47-73 years. The screening involves a mammogram of each breast which can detect small changes in breast tissue and may indicate cancers which are too small to be felt by hand.[12]

Locally NHS England is responsible for administering the screening programmes.

Table 2: Cancer screening uptake by GP practice

GP Name	Bowel	Breast
Appleton Village	54.3%	70.1%
Beaconsfield	56.0%	78.5%
Brookvale	42.2%	68.4%
Castlefields	50.4%	68.2%
Grove House	46.7%	70.9%
Heath Road	46.3%	66.9%
Hough Green	44.9%	68.7%
Murdishaw	44.9%	69.5%
Newtown	39.1%	58.0%
Oaks Place	45.9%	57.6%
Peelhouse	48.6%	74.6%
The Beeches	45.6%	65.8%
Tower House	53.5%	73.5%
Upton Rocks	54.9%	68.7%
Weaver Vale	47.4%	67.7%
West Bank	51.3%	59.4%
Windmill Hill	39.0%	64.1%
Halton CCG	48.8%	69.8%
Merseyside		
England		
National Target	60.0%	70.0%

3.2.1.1. Bowel Cancer Screening

In 2013/14, only 48.8% of Halton's 60-74 year olds who were sent the bowel screening kit adequately completed it, which was significantly below the national target of 60%. For all but two practices there was an increase in uptake compared to the previous year.

There was a wide degree of variance at the GP practice level ranging from 39% to 56%. Of those with an adequate screen during 2013/14 approximately 96 patients are identified as having a definitive abnormal test result, suggesting that bowel cancer screening can be an effective tool for preventing and/or detecting early symptoms of cancer.

3.2.1.2. Breast Cancer Screening

In 2012/13, Halton had a breast screening uptake rate of 69.8% fractionally below the national target of 70%. However only six practices performed at or above this target. There was less variation at the GP practice level ranging from 58% to 78.5%.

3.2.2. Vaccination

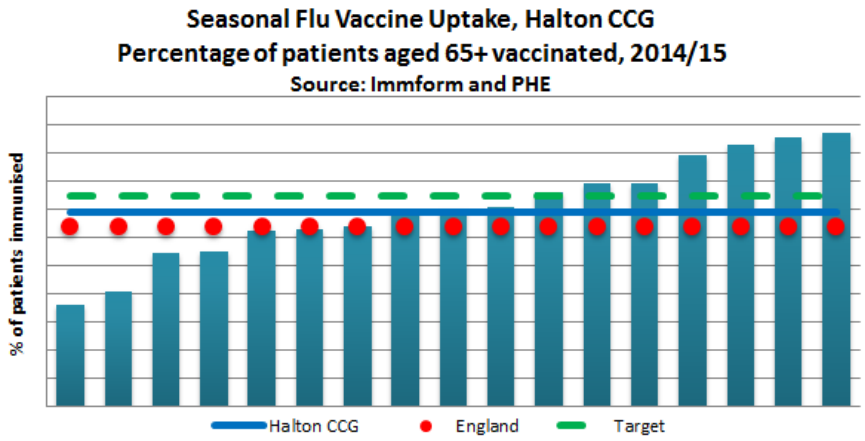
Influenza ('flu') and Pneumonia account for the largest proportion of emergency hospital admissions in England each year (13%), at a cost of £286m. Many of these cases could have been prevented by vaccination.[13]

3.2.2.1. Flu Vaccination

Flu vaccination by injection, commonly known as the "flu jab" is available every year on the NHS to all over 65 year olds to protect people from the risk of flu and its complications. Those who are aged over 65 are at a much greater risk from experiencing complications relating to flu, such as pneumonia. This is why flu vaccination is strongly recommended, and available free of charge via their GPs each winter. It takes up to two weeks for a person to develop a full immune response to the vaccine, hence why, ideally, a person should get it at the beginning of winter (October/November) before flu levels start to increase. However, it is still useful to get the vaccination at any time during the winter months.[14]

For 2014/15, some 73.8% of older people in Halton had the seasonal flu vaccination which was lower than the national target of 75%. However this still leaves a significant proportion of the local at risk population unvaccinated. There is also a wide variation in uptake of the vaccine among general practices registered populations, ranging from 67.2% to 79.4%. 7 of Halton CCGs 17 practices had uptake rates above the national target and over half above the national average uptake rate.

Figure 4: Influenza vaccination uptake amongst 65+ year olds, practice level, 2014/15[i]



3.2.2.2. Pneumococcal Vaccination

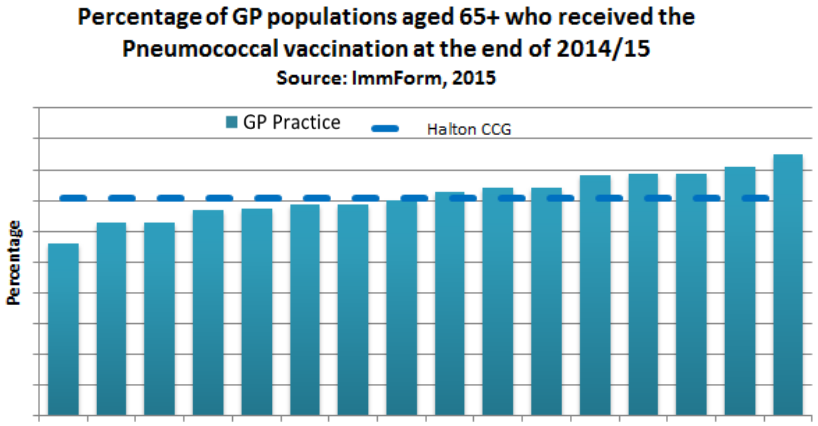
The Pneumococcal vaccine protects against one of the most serious forms of pneumonia, Streptococcus Pneumoniae. This accounts for approximately 50% of all cases of community acquired pneumonia (the others being viral causes such as Influenza and the Respiratory Syncytial Virus). Pneumococcal vaccination is believed to be 50-70% effective at preventing virtually all (96%) of the types of pneumococcal bacteria that cause serious disease in the UK.[15] Observational studies also show that vaccination can reduce 50-70% of hospitalisations for invasive pneumococcal disease.[16]

[i] *GP level figures for vaccinations and immunisations can no longer be presented in a public forum, unless they are already published nationally. As a result the figures for flu uptake have been GP-anonymised.*

The vaccine itself is offered to all those aged over 65, and is only required as a one off vaccination, rather than the annual flu vaccination.[17] Data for Halton shows that 70.8% of the eligible population have been vaccinated, however data was not available for Tower House practice, therefore this figure may not be a true indication of uptake. However, it is broadly comparable with the England and Merseyside Area Team coverage levels of 68.9% and 71.7% respectively.

A recent Cochrane review of the efficacy of pneumococcal vaccination suggests that there is strong evidence that the vaccine is effective in preventing invasive pneumococcal disease.[18] It is recommended that a review be carried out locally to look at how increasing uptake may impact on the health of the local population.

Figure 5: Pneumococcal vaccination uptake 2014/15, practice level



3.2.2.3. Shingles

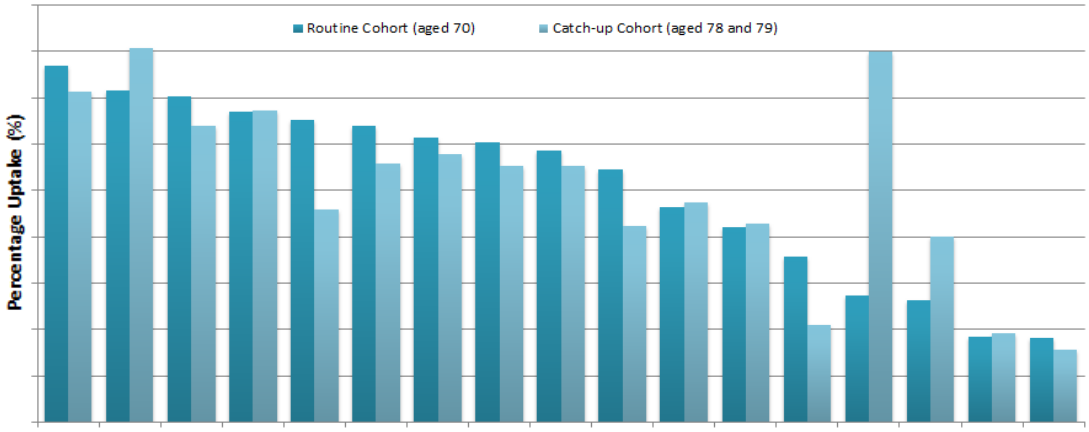
Shingles is an infection of a nerve and the area of skin around it. It is caused by the herpes varicella-zoster virus, which also causes chickenpox. Following chickenpox infection, the virus can lie dormant in the nervous tissue but may reappear following reactivation as shingles. It is possible to have shingles more than once.[19]

The shingles vaccination programme started in September 2013 for 70 year olds with a catch up at 78-79. Data for Halton shows that since this time the routine vaccination (70 year olds) uptake rate has varied substantially at practice level, from 18.2% to 76.9%, with the CCG average being 47.8%. The catch up programme uptake has similar levels of variation between 15.6% to 80.6%, with the CCG average of 46.8%.

Figure 6: Shingles vaccination uptake since 2013, practice level

Shingles vaccine uptake for routine cohort (aged 70) and catch-up cohorts (aged 78 or 79) since 2013, by Halton GP Practice, 2014/15

Source: Immform



3.3. Falls and unintentional Injuries

3.3.1. National Policy Context

Falls and falls related injuries are a common and serious problem for older people.Falls can have a significant physical and psychological impact amongst older people, as they can often cause injury and/or loss of confidence. These in turn can cause people to become withdrawn and feel they have lost their independence.[20]

There are a number of common health conditions that can increase the likelihood of having a fall:

- Chronic health conditions such as coronary heart disease, dementia and low blood pressure
- Poor vision
- Muscle weakness
- Osteoporosis

The Royal Society for the Prevention of Accidents (ROSPA) estimates that one in three people aged 65 years and over experience a fall at least once a year – rising to one in two among 80 year-olds and older.[21] Approximately 5% of older people in the community who fall in a given year experience a fracture or require hospitalisation.

Incidence rates for falls in nursing homes and hospitals are two to three times greater than in the community and complication rates are also considerably higher. The key issue of concern is not simply the high incidence of falls in older people – but rather the combination of a high incidence and a high susceptibility to injury.[22]

Standard 6 of the National Service Framework for Older People stated that the NHS in partnership with councils had to take action "to prevent falls and reduce resultant fractures or other injuries in their populations of older people." It further advised that people who had fallen receive effective treatment and rehabilitation and receive advice through a specialised falls service.

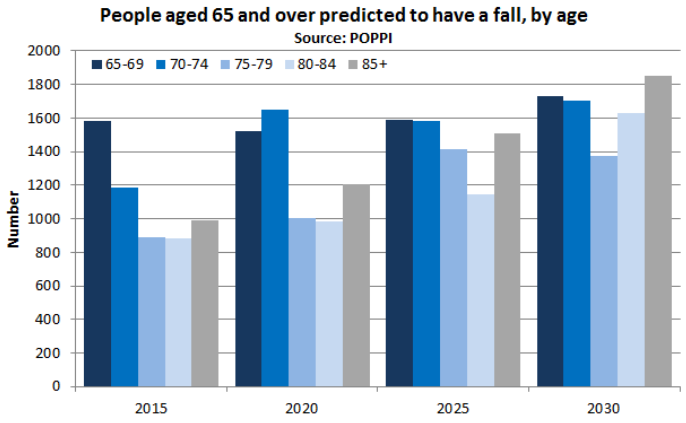
3.3.2. Falls Prevalence

Not all falls result in a visit to an Accident and Emergency (A&E) department and even fewer result in an admission to hospital. Many more older people will fall at home than official statistics indicate. Yet, it is likley that at some point continued falls will result in A&E or even admissions being necessary.

It is helpful for primary and secondary prevention action to be able to estimate the total number of falls happening, irrespective of immediate outcome. Using national research applied to Halton's population it is estimated that 3,266 females and 2,154 males in the borough are likely to have a fall in 2015. Predicted increasing population size for those aged 65 and over means this number is also likely to rise if the current prevalence remains the same, to 4915 females and 3,375 males by 2030.

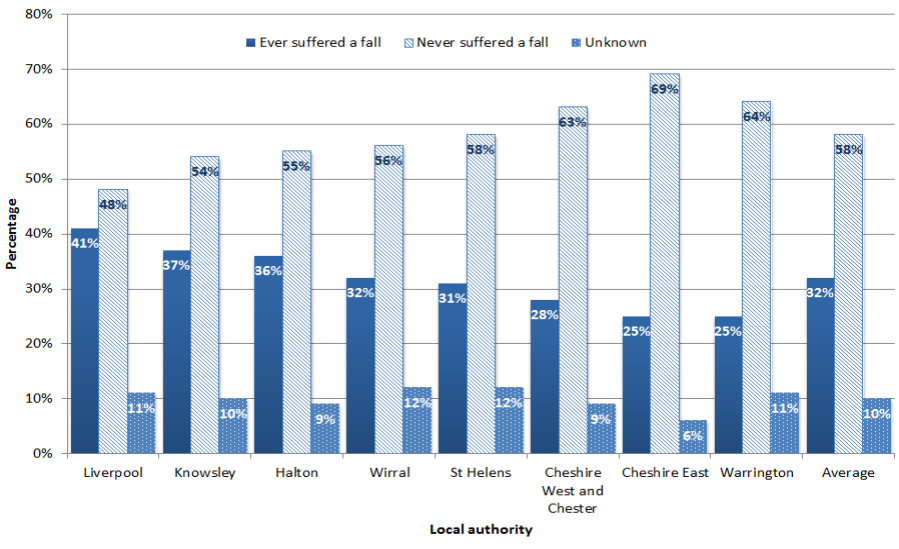
This shows a shift from the majority being in the 65-69 and 70-74 populations to the majority being in the much older populations, albeit with numbers increasing across all age bands.

Figure 7: Estimated prevalence of falls 2015 to 2013



The 2014 LJMU survey of older people showed that over a third of respondents said they had ever had a fall, the third highest across Cheshire & Merseyside.

Figure 8: respondents who had ever suffered a fall, by local authority



3.3.3. A&E Attendances due to injuries

A special data sharing agreeing between all accident and emergency departments across the North West and the Trauma and Injury Intelligence Group (TIIG) at the Centre for Public Health, LJMU, means it is possible to provide analysis of the demographics and injury types presenting to A&E. Analysis of data April 20102 to March 2015 showed:[23]

- Between April 2012 and March 2015 there were 58,776 injury attendances made by Halton residents to Accident & Emergency Departments (A&Es) across Merseyside and Cheshire; of which **8,243** were made by people aged 65 years and over. People aged 65 and over represent **14%** of total injury attendances to EDs while representing 16% of the total population
- Of attendees aged 65 years or over, 60% were female and 40% were male; where ethnicity was known, 98% of attendees were white
- Across all A&Es combined, 72% of attendances were classified as other injuries, 23% were falls, 3% were road traffic collisions, 1% were assaults and sports injuries, while less than one percent were for burns and scalds and deliberate self-harm
- Females were more likely than males to attend an A&E for falls (25% of total injuries compared to 23%). People aged 85 years and over were also more likely to attend an A&E for falls compared to people aged 65 to 74 and 75 to 84 (37% compared to 23% and 15% respectively)
- The time of day with the most attendances was between 10:00 and 11:59 (14%); the busiest day of the week was Monday (16% of attendances); and, the month with the highest average daily attendances was July (29 per day)
- People aged 65 years and over were more likely to arrive at the A&Es by ambulance, be referred to an A&E by the emergency services and be admitted into hospital than the average for all age groups combined. Older people were also more likely than other age groups to report their home as the injury location
- Rates of injury attendances were found to correlate with deprivation, with increasing attendances found to be associated with increasing levels of deprivation
- Rates of falls were also correlated with deprivation but inconsistent categorisation of falls between A&Es prevented more robust analysis

Whilst 23% of all injuries in those aged 65 and over were classified as falls, it must be noted this may be an underrepresentation of the level of injury presentations due to falls. This is because Warrington Hospital, which accounts for 49% of all injury attendances by Halton residents aged 65 and over, does not categorise falls as a primary injury group. Data from Whiston (Hospital, which does have a seperate classification for falls, shows it accounts 47% of injuries amongst those aged 65 and over. This lack of classification at Warrington is also likley to impact on the mapping work in the TIIG report, which does higher rates of falls injuries in Runcorn compared to Widnes. However, the rate of all injury attendances is also highest in Widnes.

Table 3: Injury attendances by Halton residents aged 65 and over, by injury group, 2012/13 to 2014/15

Injury group	2012/13	2013/14	2014/15	Total	Percentage
Assault	30	22	11	63	*0.8%*
Burns ands scalds	12	7	8	27	*0.3%*
Deliberate self-harm	12	9	7	28	*0.3%*
Falls	439	621	832	1892	*23.0%*
Other	2374	2159	1425	5958	*72.3%*
Road traffic collision	114	67	42	223	*2.7%*
Sports injury	33	11	8	52	*0.6%*
Total	3014	2896	2333	8243	*100%*

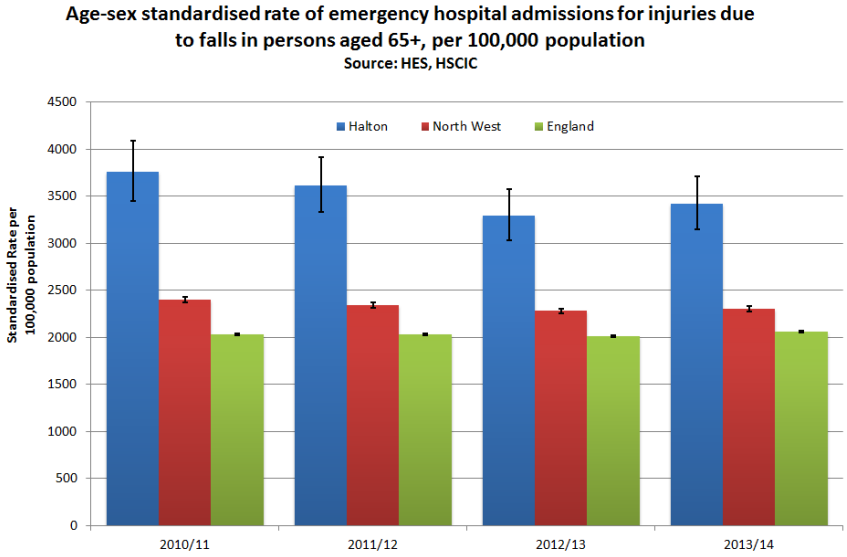
Source: TIIG 2015

This shows that whilst injury attendances overall have reduced over this three-year period, injuries due to falls are the only category where numbers have increased; this is a 47% increase during this fairly short period of time. Whilst improvements in coding may account for this in part, it is more likely a reflection of greater numbers in this age group, mirroring the predicted number of falls estimates by POPPI.

3.3.4. Hospital Admissions

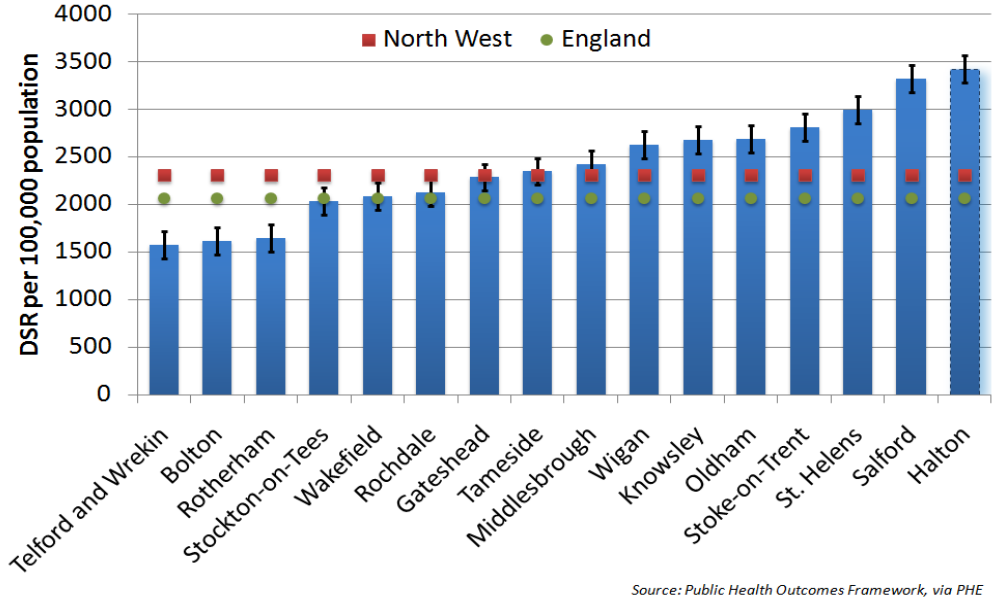
Halton has some of the highest hospital admission rates for falls in the country and has done for several years. This is why the Health and Wellbeing Board chose it as one of their five priorities, in recognition of the harm it can do to the individual both immediately and in the longer term as well as the impact it has on local health and social care resources.

Figure 9: Hospital admission rates, Halton and comparators



Halton has and continues to have rates that are statistically significantly higher than both the regional and England rates. Not only that but when looking at admissions due to injuries from falls within the borough's statistical neighbours group, not only is the Halton rate the highest but the difference is statistically significantly higher than all but Salford and St Helens.

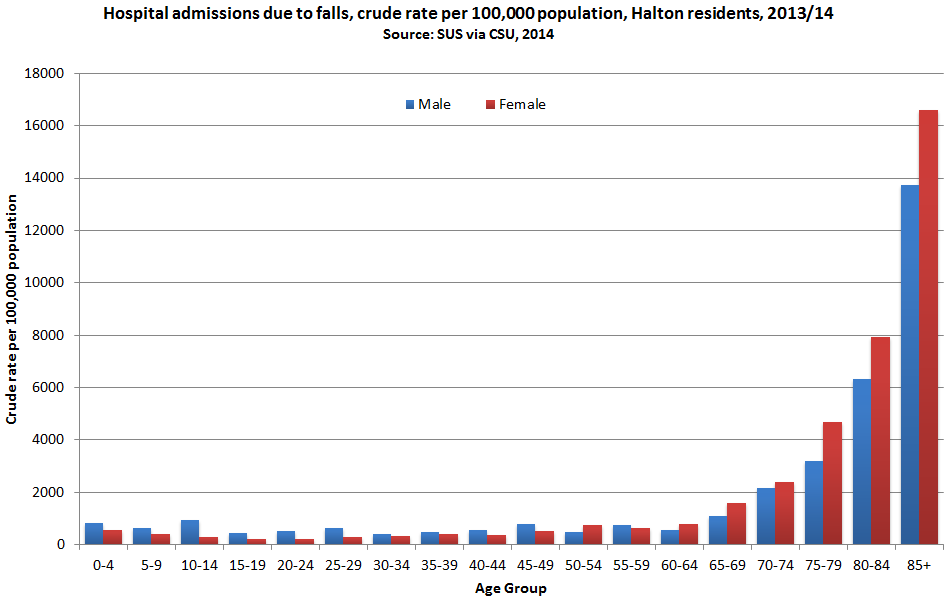
Figure 10: Injuries due to falls in people aged 65 and over, hospital admissions rates, Halton and its statistical neighbours, 2013/14



Source: Public Health Outcomes Framework, via PHE

In 2013/2014 there were 1,441 admissions recorded as a fall (ICD-10 W0* -W1*) among Halton residents with over half of these being amongst those aged 65 and over with this proportion being greater for females than males (308 out of 632 admissions for males and 565 out of 809 for females). Figure 7 shows the crude rate per 100,000 population which demonstrates why falls is seen as a particular issue amongst those aged 65 and over, with the rates being substantially higher in this age group and increasing across each 5-year age band.

Figure 11: Hospital admissions due to falls, by age and gender, crude rate per 100,000 population



In terms of numbers and percentages females aged 85 and over make up the large single number per any age/gender group with 85 and overs generally making up over a quarter of all admissions,

with this rising to nearly 1 in 3 amongst women. The majority are emergency admissions, 577 out of 616 for males and 794 out of 845 for females.

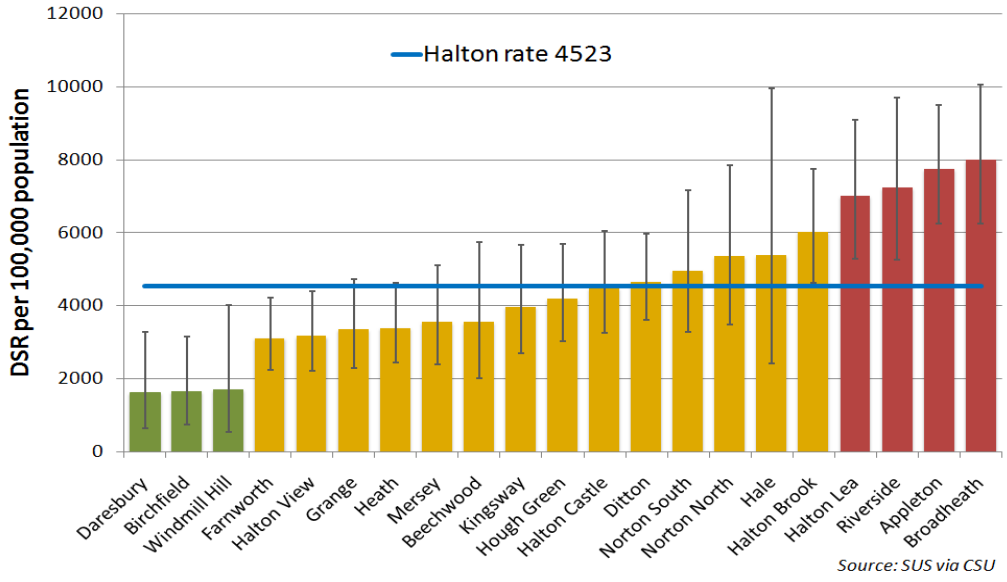
Table 4: Number and percentage of admissions due to falls, by age and gender, 2014/15

Age Group	Male		Female		Persons	
	Number	Percentage	Number	Percentage	Number	Percentage
0-4	34	5.5%	47	5.6%	81	5.5%
5-9	15	2.4%	31	3.7%	46	3.1%
10-14	20	3.2%	30	3.6%	50	3.4%
15-19	4	0.6%	14	1.7%	18	1.2%
20-24	11	1.8%	15	1.8%	26	1.8%
25-29	14	2.3%	11	1.3%	25	1.7%
30-34	10	1.6%	14	1.7%	24	1.6%
35-39	12	1.9%	12	1.4%	24	1.6%
40-44	20	3.2%	28	3.3%	48	3.3%
45-49	25	4.1%	16	1.9%	41	2.8%
50-54	23	3.7%	30	3.6%	53	3.6%
55-59	25	4.1%	38	4.5%	64	4.4%
60-64	35	5.7%	32	3.8%	67	4.6%
65-69	48	7.8%	58	6.9%	106	7.3%
70-74	38	6.2%	53	6.3%	91	6.2%
75-79	63	10.2%	99	11.7%	162	11.1%
80-84	65	10.6%	117	13.8%	182	12.4%
85-89	87	14.1%	117	13.8%	204	14.0%
90+	67	10.9%	83	9.8%	150	10.3%
65+	368	59.7%	527	62.4%	895	61.2%
All Ages	616		845		1462	

Source: SUS data via CSU

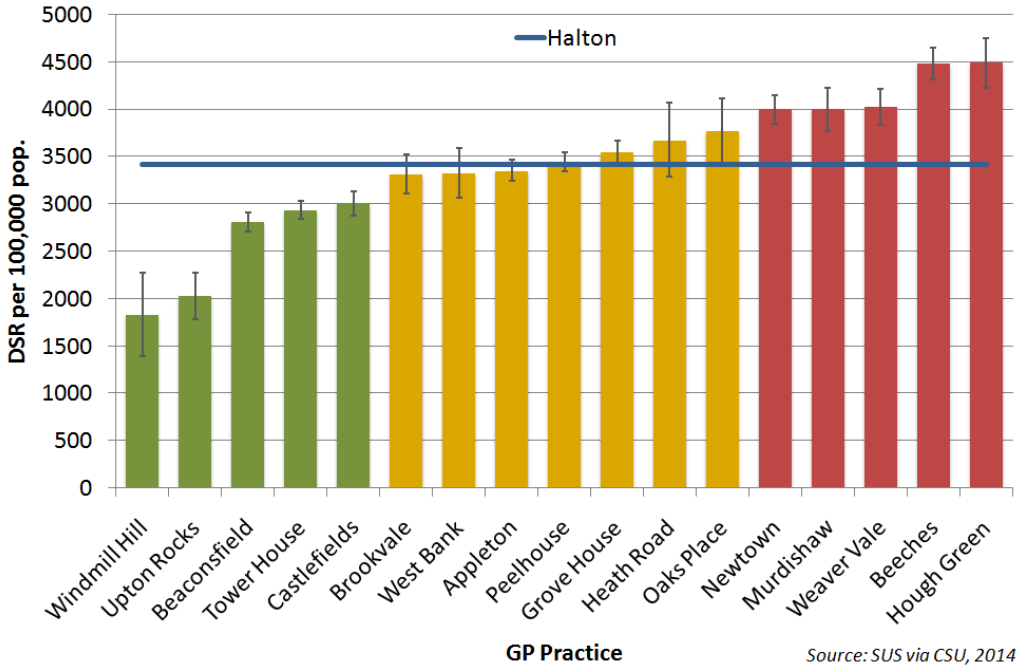
Figure 12 shows there is a marked variation in the admission rate for falls across the borough, with figures for 2014/15 showing that the crude rate in Broadheath ward was more than four and a half times that in Daresbury. Four wards have rates that are statistically significantly higher than the Halton average (as indicated by the red bars in Figure 12) and three had rates statistically lower (green bars).

Figure 12: Directly Standardised Rate (DSR) of emergency hospital admissions due to falls in Halton residents aged 65+, per 100,000 population, ward rate 2014/15



At a GP practice level a similar level of variation can be seen, with five practices statistically higher than the Halton rate (coloured red in Figure 13) and five statistically lower (coloured green). There does not appear to be a relationship with deprivation but more of a reflection on the relative age structure of the practice population.

Figure 13: Directly Standardised Rate (DSR) of admissions due to injuries from falls, by Halton residents aged 50+, also registered with Halton GP Practice, 2012/13 - 2013/14

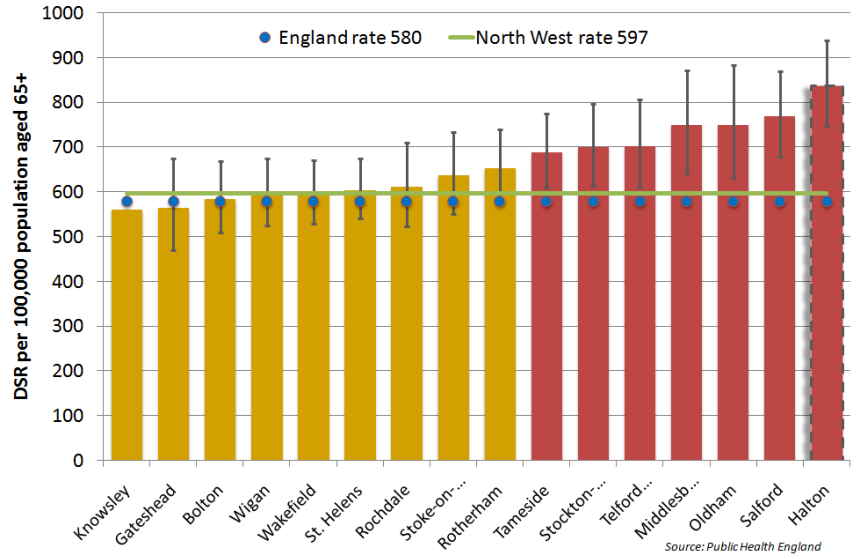


For some people, the injury sustained during a fall will be of such magnitutude that it results in a fracture. The most common fracture amongst older people in a hip fracture. Known as fragility fractures, these are fractures that result from forces that would not ordinarily result in a fracture, otherwise known as 'low-level trauma. Reduced bone density from conditions such as osteoporosis is a key risk factor for fragility fractures, with post-menopausal women most at risk.

Targeting those at risk of poor bone health in primary and secondary care may be an effective way to reduce the risks of those people going on to experience falls in the future. There are a number of lifestyle factors which increase the risk of developing osteoporosis; diet, lifestyle, alcohol intake and smoking. Regular weight bearing exercise, a well-balanced diet and keeping alcohol consumption with the recommended limits all contribute to lowering the risk of developing osteoporosis. Healthy bones need a diet which incorporates a wide range of minerals and vitamins in particular calcium and Vitamin D.[24]

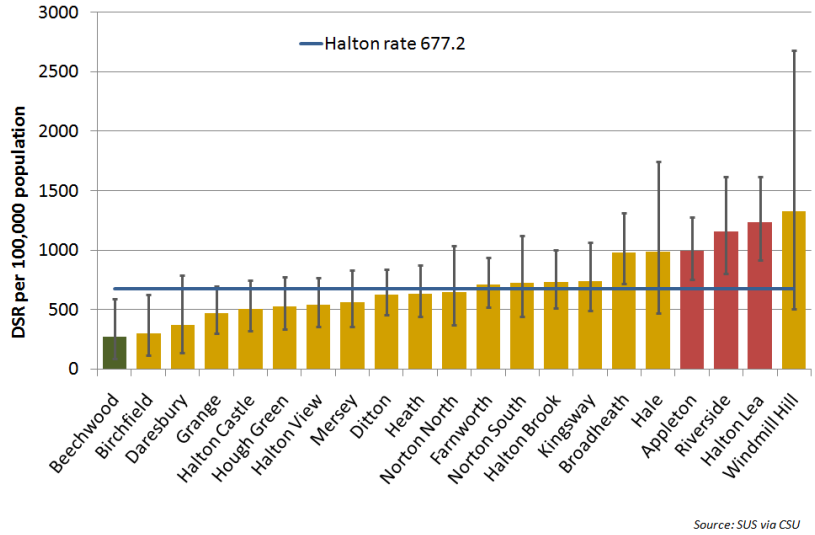
Rates are much lower for this severity of injury but again Figure 14 shows that Halton has the highest rate of its comparator group and is statistically higher than England and the North West rates. In 2013/14 it had the highest rate in the counrty at 838 per 100,000 population aged 65+.

Figure 14: Hospital admissions due to hip fracture, Directly Age Standardised Rate (DSR) per 100,000 population aged 65+, Halton and comparator group, 2013/14



The same type of geographical variation as with admissions due to falls, can be seen for hip fractures.

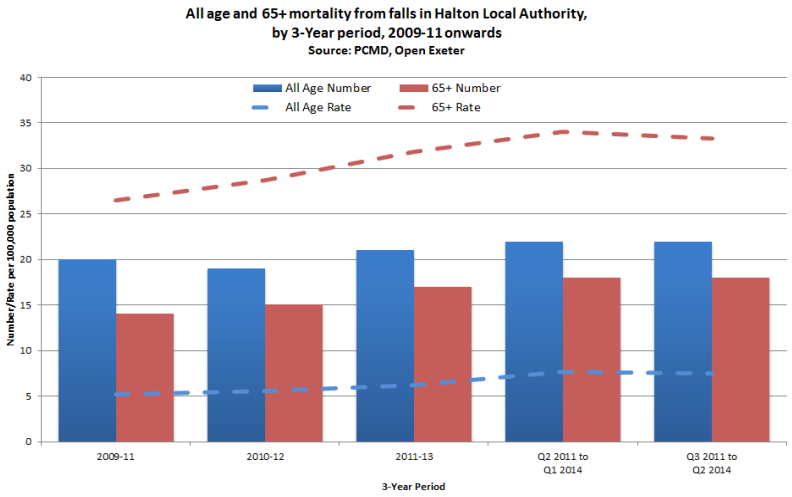
Figure 15: Emergency admissions due to hip (neck of femur) fracture (S72.0, S72.1 and S72.2), 65+, 2010/11 - 2014/15



3.3.4. Mortality

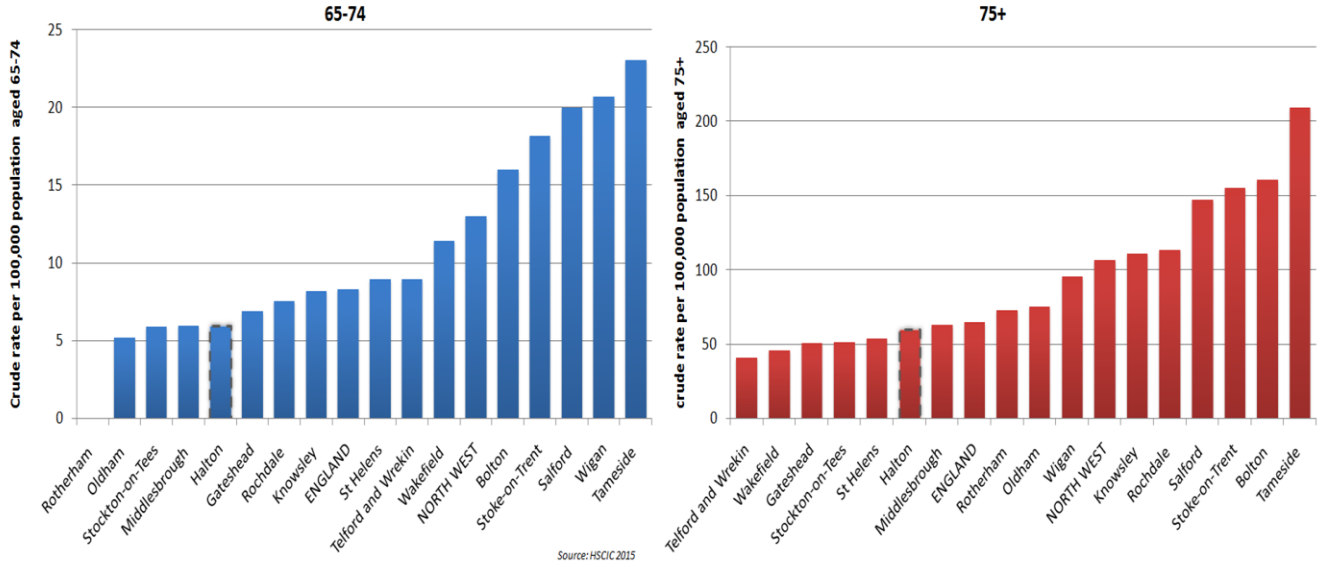
As with admissions, the majority of deaths due to falls are amongst the 65+ population, with the mortality rate for 65+ being nearly four and a half times that of the all age rate.

Figure 16: Halton mortality rate due to falls



In contrast to hospital admissions, Halton has fairly low mortality rates due to falls among its comparator group, with levels for both 65-74 and 75 and overs being lower than the England and North West rates.

Figure 17: Mortality from accidental falls (ICD10 W00-W19), crude rate per 100,000 population, Halton and comparators, pooled 2011-2013



3.3.6. National Institute of Clinical Excellence (NICE) Guidance

NICE has published a suite of guidance in relation to falls prevention and risk assessment, including identifying those at risk of fragility fractures. This includes a 2013 update on their original guidance published in 2004. There is clear evidence outlined within the NICE guidance about what works and

what doesn't in relation to falls prevention. Much of the NICE guidance for falls in a community setting were unchanged 2004 to 2013 and included:

- Case/risk identification: Older people reporting a previous fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve balance and mobility

- Falls risk assessment: Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a falls risk assessment. This should be carried out by healthcare professionals with appropriate skills and experience, normally within the setting of a specialised falls service. Falls risk assessments can include: assessment of gait, balance and mobility and muscle weakness; assessment of osteoporosis risk; assessment of visual impairment; assessment of home hazards; cardiovascular examination; and, medication review

- Multifactorial interventions: All older people with recurrent falls, or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. Common components of such interventions include: strength and balance training; home hazard assessment and intervention; vision assessment and referral; medication review with modification/withdrawal

3.4 Oral Health

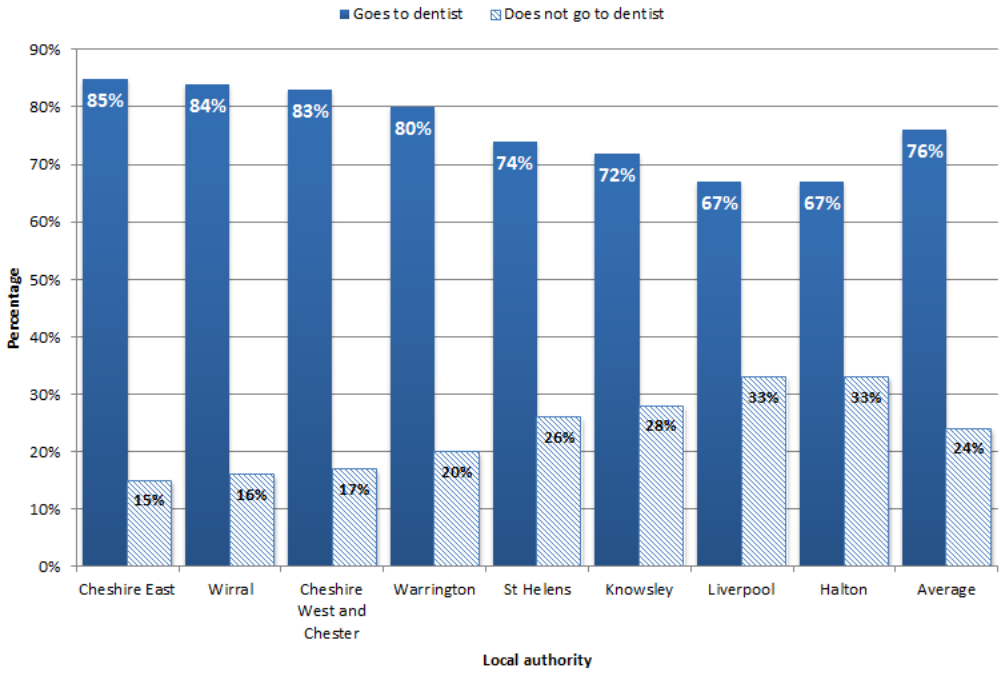
In 2012/13, Public Health England carried out a survey that sought to find out the oral health policies, practices, and problems of three different services for older people in the North West.

Some of the main findings showed:

- Access to treatment services was an issue with people having problems travelling to and climbing stairs to dental surgeries
- Difficulties in obtaining domiciliary care and emergency care were mentioned as a widespread concern
- There was a clear demand for training by professionals and provision of leaflets and guidance

The 2014 LJMU telephone survey of older people across Cheshire and Merseyside found that, of all the local authorities survey, Halton had the joint lowest proportion of respondents across Cheshire who attended a dentist (67%), with rates more similar to Merseyside local authorities. This probably reflects levels of deprivation in Halton which are more similar to Merseyside than Cheshire.

Figure 18: Attendance at dentists, 2014 LJMU survey findings



There is no routine local epidemiological or service use data available specifically for older people.

3.5. Malnutrition and Dehydration

3.5.1. Malnutrition

Malnutrition is measured as a Body Mass Index (BMI) lower than 18.5kg/m^2 or unintentional 10% weight loss. NICE[25] identified malnutrition as the sixth largest source for potential NHS savings. The annual health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient spells, more primary care consultations and the greater long-term care needs of malnourished individuals.

About two thirds of cases of malnutrition are not recognised; the impacts are increased burden of disease and treatment costs. Based on the NICE costing template[26] applied to the 2011 Census population aged 15 and over, it is estimated that 5,287 older residents are at risk of malnutrition or are malnourished. Social networks have a preventive role, as interest groups and shopping clubs support motivation and the means for good nutrition.

Regular screening for malnutrition is recommended by NICE; early intervention screening and appropriate treatment is cost-effective. Those at risk should have a 'food first' approach, including dietary advice to optimise their intake, and support with practicalities. NICE estimates that the overall resource impact of increased screening, early intervention and appropriate treatment could lead to a saving of £71,800 per 100,000 people.

Awareness of malnutrition needs to be improved by both healthcare workers and the wider public. Efforts to prevent malnutrition should be integrated with other care to prevent ill-health, and between healthcare workers, carers, social workers, and the voluntary sector.

The majority of individuals at risk of malnutrition live in the community; preventative resources include domicilliary care, community navigators, lunch clubs, day care centres, shopping services and the support offered by voluntary organisations. Lack of awareness of the problem and services or support available can hinder engagement and access to support. This might be improved by raising awareness amongst older adults, their families and GPs about the services available in the community.

NICE has recommended the use of BAPEN's[ii] interactive e-learning resource on nutritional screening using the 'Malnutrition Universal Screening Tool' ('MUST') for staff working in hospitals, primary care and care homes to aid implementation on the new NICE Quality Standards for Nutritional Support of Adults: http://guidance.nice.org.uk/QS24. This tool is being rolled out in Halton, as part of collaboration between Halton Borough Council and Halton Dieticians.

3.5.2. Dehydration

Research into dehydration among older people has shown that around 30% of older people at A&E have dehydration related illnesses.[27] Preventing dehydration could therefore help to reduce avoidable emergency admissions. Tackling dehydration can prevent other illnesses, including constipation, urinary tract infections, gallstones and heart disease.

Identifying those at risk and raising awareness is key to prevention, therefore locally, we need to establish if work is being done to identify those at risk and raise awareness in the general population. Evidence has shown that rapid weight loss is a good indicator of dehydration.

ii) BAPEN is the British Association for Parenteral and Enteral Nutrition

4. Service provision

Stop smoking

Halton Stop Smoking Service is a small team made up of 4 whole time equivalent staff adopting a hub and spoke approach to delivering tobacco control and cessation in Halton. The service offers 19 sessions per week in 14 venues including 2 evening sessions and more recently a Saturday morning session in Widnes Market to allow 'out of hours' access. The venues are in community and clinical settings across the borough ranging from GP practices to Widnes Urgent Care Centre and Walk in Centre, Community Centres, Children Centres, Widnes Library and Runcorn Halton Direct Link. The cessation sessions offer clients 12 weeks of support via a choice of one to one appointments or 'drop in' depending on the clients preference. Home visits are also available on request for 'Housebound' clients.

Texting and telephone counselling are also available as forms of support with clients consent. The team are National Centre for Smoking Cessation trained and follow NICE and National Stop Smoking Service Guidelines to deliver a comprehensive service which includes behavioural and pharmacotherapy support. Nicotine replacement therapy-based pharmacotherapy support is delivered via a voucher scheme which allows clients easier and speedier access to NRT products. Champix is also offered via a GP prescription.

As well as delivering cessation support directly to clients the service offers Very Brief Advice and Intermediate Cessation training to a range of staff groups in order to increase referrals and maximise access to smoking cessation for the Halton population. These include:

- GP Practise staff
- Pharmacies
- Leisure Centre staff
- Citizens Advice Bureau
- Mental Health staff
- Substance Misuse Service (alcohol/substance use)
- Respiratory Health staff
- Hospital staff
- Dentists
- Opticians

Recently adopting a hub and spoke approach has allowed the team to target groups with the highest smoking prevalence and as such each Specialist has been allocated an area to lead on:

- Smoking and pregnancy
- Mental Health
- Substance Misuse
- Routine & Manual Workers (via their workplaces)
- Secondary Care
- Chronic Obstructive Pulmonary Disease

Exercise on Referral

Exercise Referral is a 6 month programme to increase physical activity levels and improve a person's lifestyle. It is available for anyone over the age of 16. Additionally, it caters for special populations such as patients with cardiac history, pulmonary disease, post stroke and cancer. It offers one-to-one support, rehabilitation group exercise sessions and access to exercise facilities such as the gym, swimming and so on.

Halton residents can access the service through their GP practice or physiotherapist. It is based upon the National Quality Assurance Framework from the Department of Health. Referral must be from a registered clinician.

The service supports the individual to have improved disease management, lower blood pressure, increased physical activity levels, increased fitness, lower blood glucose, lower cholesterol levels, as well as improved self-esteem & mental well-being and improved quality of life.

Physiological measures are taken (height, weight, BMI, blood presure) at an initial sign-up and are compared to follow up points at 6 weeks, 12, weeks and 24 weeks.

Feedback and evaluation forms are completed with each individual and case studies are done regularly

The service has many established links with community services to increase or maintain new healthier lifestyle such as Sports Development, Wellbeing Enterprises and Places for People Leisure.

Fresh Start Weight Management

Weight Management is a 6 month to 2 year programme offering support to help people lose weight for adults 18 years old or more. People are offered one-to-one and group support to help them eat a healthier diet and lose weight. Appointments and groups are offered mornings, afternoons, and evenings each week. There are over 10 venues available across Widnes and Runcorn.

Halton Residents can access the service through their GP practice or physiotherapist or by self-referring to the Health Improvement Team.

The service not only measures weight loss (reduced BMI) and increased levels of physical activity but also the impacts this can have on a person's overall health and wellbeing. This includes:

- Lower blood pressure
- Improved quality of life
- Improved self-esteem & mental well-being

Physiological measures are taken (height, weight, BMI, blood pressure) at an initial sign-up and are compared to follow up points at 6 weeks, 12, weeks, 24 weeks , 1 year & 2 year. Feedback and evaluation forms are completed at every course and case studies are done regularly.

Clients/patients will be referred back to their GP or Nurse if required. People who fail to complete a course are offered other opportunities to attend another course or are offered one-to-one support.

NHS Health Checks

Health Improvement works with partners within primary care to deliver the NHS Health Check programme. The NHS Health Check is aimed at adults in England aged 40 to 74 who are not on a GP disease register. It provides a cardiovascualr check and works out the individuals risk of developing diseases such as coronary heart disease,type 2 diabetes, stroke, kidney disease and some forms of dementia.

Halton residents can access the Free NHS Health Check through their GP practice or by contacting the Health Improvement Team. If increased risk is identified this is fed back to the person's GP and approporaite investigations and support can be made at an early stage of disease, before obvious systems have manifested or the person has an acute hospital episode as a result of a condition not being diagnosed and managed.

Intergenerational Programme

In June 2015, the Health Improvement Team piloted an intergenerational project within a secondary school which aimed to provide the opportunity for older and young people to come together through positive activities. The participants steered the project, with the support of the Health Improvement Team and school staff. The activity of focus for the pilot emerged as a radio station. The learning from this pilot is to be utilised in order to expand this project to other settings involving different people and the use of varying activities guided by the participants themselves. The pilot was run during the school day, at times to suit all participants and was delivered over a period of two months.

The recruitment of participants was achieved through:

- Recruitment of younger people: approaching the school, as part of their Healthy Schools Award, to select a small group of young people to be involved in the project.
- Recruitment of older people: contact was made with existing social groups and older people accessing existing health services.

The project received a good response, which led to the formation of a group of approximately 20 individuals. The aim of the project was to increase the participation of older and younger people within their communities through positive activities

Expected outcomes included:

- To help to break down the barriers between the generations
- To build an active community
- To promote mutual understanding within the groups
- To increase in the well-being of individuals
- To reduce feelings of isolation
- To reduce fear of crime and risky behaviour
- To improve self-esteem and confidence

These are measured using a variety of methods including:

- Baseline attitudinal questionnaire which is administered at the beginning of the project and again at the end of the project to measure any attitudinal change as a result of the project
- Photos / video footage taken throughout the project
- Case studies generated by those involved in the project

Sure Start to Later Life

Sure Start to Later Life (SSLL) is a free, personal and confidential information service providing low level intervention and prevention for the overs 55's which aims to help people to live a happy independent life. It includes answering requests for information on a wide range of things from activities, to local services, to information on benefits and more.

The team help with information on what is going on locally so people can take an active part in the community and provide them with the opportunity to make positive choices to improve their health, well-being and maybe even their social life.

SSLL also have two projects - the DayTrippers group and the Grangeway Get Together. Both help people get out and about, get active, maybe make new friends and in some cases, reacquaint with old friends**.**

In addition SSLL have a volunteer service supporting people in their own homes. This may be simply having a cup of tea and chat, or if people want to get out and about and need a little support then our volunteers can help with that too. IT volunteers support people to use an iPad, laptop, new phone and so on, working at the individuals pace in their own home where they can feel relaxed and comfortable learning a new skill or building on one they already have.

Office hours are 9-5 Monday to Friday but the DayTrippers group is active Saturdays and Sundays. Volunteer support may also be at the weekends.

Halton Residents can access the service via Referrals to the team via other teams,GP's, other agencies, self-referrals, family referrals, in person to the office, via one of the direct link shops or by phoning HBC contact centre.

Falls Prevention

Falls Prevention is a programme of exercise and education designed to improve someone's strength, balance, co-ordination and confidence. This program is appropriate if someone has had one or more falls, if they have a fear of falling, or if they have osteoporosis. Classes are held in both Widnes and in Runcorn. Transport is available to clients at the entry level class (level 1).

Referal to the programme is via a person's GP to the Health Imrovement Team. An initial assessment determines which of the 3 levels of provision is most appropriate for the individual, based on a falls assessment which grades a person's balance, strength and flexibility.

The programme aims to help :-

- Strengthen muscles and bones
- Improve Balance and Coordination
- Reduce the risk of falling
- Increase confidence and mobility
- A person carry out everyday tasks more easily- like getting out of a chair

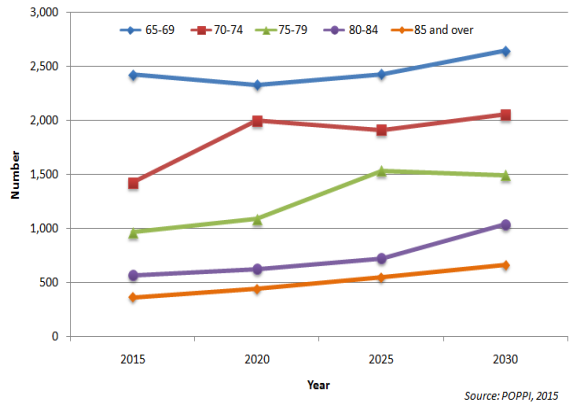
Clients are assessed at 12 weeks and 24 weeks to see what improvements have been and to progress the client through the Levels 1-3. Clients are referred to SSLL if appropriate, to the Falls Practitioner Nurse to arrange physiotherapy, podiatry etc, or their GP if there are any concerns.

6. Projected levels of need

Population projections detailed in chapter 2 of the older people's JSNA indicate that the 65 and over population will continue to increase. Assuming current known prevalence rates remain then population projections can be applied to current rates to predict future numbers. The Projecting Older People Population Information system (POPPI) has applied age-specific prevalence of obesity and falls to ONS population projections. In doing this it predicts:

- The number of obese older people will increase from an estimated 2,412 males and 3,345 females in 2015 to 3,276 and 4,629 respectively by 2030
- The number of older people who experience a fall will increase from an estimated 2,172 males and 3,355 females in 2015 to 3,3,75 and 4,915 respectively by 2030

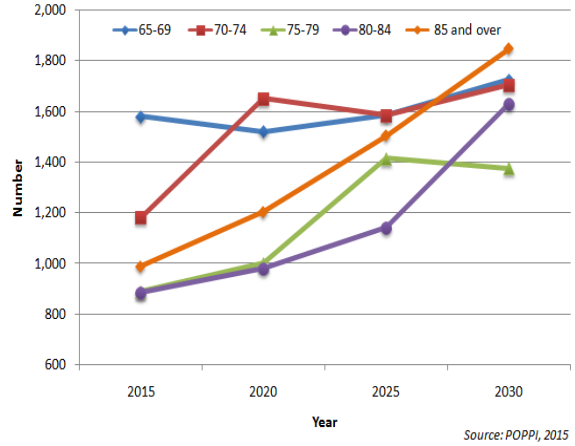
Figure 19: Predicted number of Halton residents aged 65 and over who will be obese, 2015 to 2030, persons trend and by gender



	2015	2020	2025	2030
Males aged 65-69	1,140	1,080	1,110	1,230
Males aged 70-74	648	918	864	918
Males aged 75-79	357	420	609	567
Males aged 80-84	187	221	272	391
Males aged 85+	80	100	130	170
Total Males aged 65+	2,412	2,739	2,985	3,276
	2015	2020	2025	2030
Females aged 65-69	1,287	1,254	1,320	1,419
Females aged 70-74	780	1,080	1,050	1,140
Females aged 75-79	609	667	928	928
Females aged 80-84	384	408	456	648
Females aged 85+	285	342	418	494
Total Females aged 65+	3,345	3,751	4,172	4,629

Source: POPPI, 2015

Figure 20: Predicted number of Halton residents aged 65 and over who will experience a fall, 2015 to 2030, persons trend and by gender



	2015	2020	2025	2030
Males aged 65-69	684	648	666	738
Males aged 70-74	480	680	640	680
Males aged 75-79	323	380	551	513
Males aged 80-84	341	403	496	713
Males aged 85+	344	430	559	731
Total Males aged 65+	2,172	2,541	2,912	3,375
	2015	2020	2025	2030
Females aged 65-69	897	874	920	989
Females aged 70-74	702	972	945	1,026
Females aged 75-79	567	621	864	864
Females aged 80-84	544	578	646	918
Females aged 85+	645	774	946	1,118
Total Females aged 65+	3,355	3,819	4,321	4,915

Source: POPPI, 2015

7. User views

There has been no local qualitative research with older people around lifestyles and prevention. However, Halton OPEN's survey clearly shows keeping healthy is a prime concern for older people, enabling them to remain independent and to maintain social contact.

Falls Prevention Exercise Classes

Halton Health Improvement Team deliver a postural stability falls prevention exercise programme which has three distinct levels of provision based on need. Each level is assessed on completion and the later stages include support and guidance about how to get up off the floor in the event of a fall. The classes are for older people who have had a fall, have a fear of falling or a family history of osteoporosis.

The majority of the people who attend the classes are referred by a health professional and many report an improvement in flexibility as a result of the exercises. There is also evidence that the classes increase levels of confidence and therefore enable attendees to access a wider variety of activities as they feel more able take a bus or get out and about in their community.

The following comments are a small selection of the type of feedback received following a consultation in January 2016;

"I am able to walk up and downstairs easier, pick things up off the floor and get up off the floor without help"

"I have improved my flexibility"

"It has built my confidence; I can get down onto the floor slowly and get back up"

"I have gained confidence; I can now walk to the shops"

"I enjoy all the exercises and the social time".

"I know that if I have a fall, I can get up again"

"Balance slightly better, the classes helped me after my hip operation".

"It has helped me get back to being independent again and I have enjoyed meeting likeminded people"

As an added benefit, the classes also offer a much needed social resource and people who attend often form friendships which go beyond the structure of the classes. There is time allotted at the end of each session for participants to have a cup of tea and a chat.

Attendees reported improvements in everyday activities such as getting up out of a chair, doing jobs around the house, getting out of bed and getting washed/dressed.

8. Best practice interventions

There is a wide range of national guidanceon tobacco control and obesity which consider population level and invidual level interventions. These are detailed in the 2015 Tobacco and Healthy Weight JSNA chapters and so are not duplicated here. Below is a list of older people specific guidance

NICE Pathways

Diet
Falls in older people
Lifestyle weight management services for overweight or obese adults
Nutrition support in adults
Obesity
Obesity: working with local communities
Physical activity
Smoking
Smoking cessation in secondary care
Stroke
Walking and cycling

NICE guidelines

Falls in older people: assessing risk and prevention (CG161) June 2013
Workplace health:management practices (NG13) June 2015

NICE quality standard
Falls in older people (QS86) March 2015

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