Office for Health Improvement & Disparities

State of Healthy Ageing in the North West 2022

A resource to support local Health Needs Assessments

March 2022

This report provides an overview of healthy ageing and a look at how we're doing in the North West

Prior to 2020, the North West regional team of the Office for Health Improvement and Disparities (OHID), formerly Public Health England (PHE), had little focus on the healthy ageing agenda due to capacity. However, COVID-19 has highlighted the **need to push this agenda** within the region.

This report provides a comprehensive **overview of healthy ageing** and begins to look at **how we are doing** in the North West, with examples of great work already taking place in our region.

This precedes the establishment of a **North West Healthy Ageing Network** that aims to:

- bring together key players across the region
- identify and share best practice
- make the North West the best place in England to grow old

This report is **recommended for** Public Health and other local authority teams, elected members, Integrated Care Systems, Voluntary and Community sector and other partners in the North West with an interest in this area.

It should be read **in conjunction** with existing PHE/OHID data packs, including:

- Productive Healthy Ageing Profile
- COVID-19 Health Inequalities Monitoring for England (CHIME) tool
- Wider impacts of COVID-19 on health monitoring tool
- Excess mortality in English Regions
- NW State of the Region report

Aims and objectives

The North West region is experiencing an ageing population. As people age they tend to put a greater demand on health and care services. Additionally COVID-19 has had a disproportionate impact on older people and highlighted the **need to focus on this agenda** within the region.

This report therefore aims to:

- shine a **spotlight** on healthy ageing in the North West
- **highlight** wider impacts of COVID-19 on older people (with a more comprehensive review to follow)
- **engage** with elected members, Public Health teams and wider local authorities, and start a regional discussion on healthy ageing to identify and share examples of good practice
- **support** Local Authority Public Health teams who are currently undertaking or planning to undertake or refresh their JSNAs/healthy ageing strategies
- **explore** more integrated ways of working with our ICS, NHSE/I and ADASS partners

How to use this report

- This report contains **6 sections**
- You can **access each section and topic directly** from the contents and section header pages by clicking on the hyperlinks
- The report is intended to give a **brief overview** of topics that are **specific** to healthy ageing; it does not provide detail about issues that affect all ages
- Page titles **summarise** the information on each page for those who need quick access to specific topics
- **Hyperlinks** throughout take you to more information that is available online
- Specific **recommendations** are dotted throughout the report, and general recommendations are listed at the end (N.B. some local areas may already have these recommendations in hand) → do a search for “Recommendation” to quickly find the specific recommendations
- All **images** depict older people in non-stereotypical ways

Contents

1. Context

- Impact of COVID-19 on older people
- Policy context

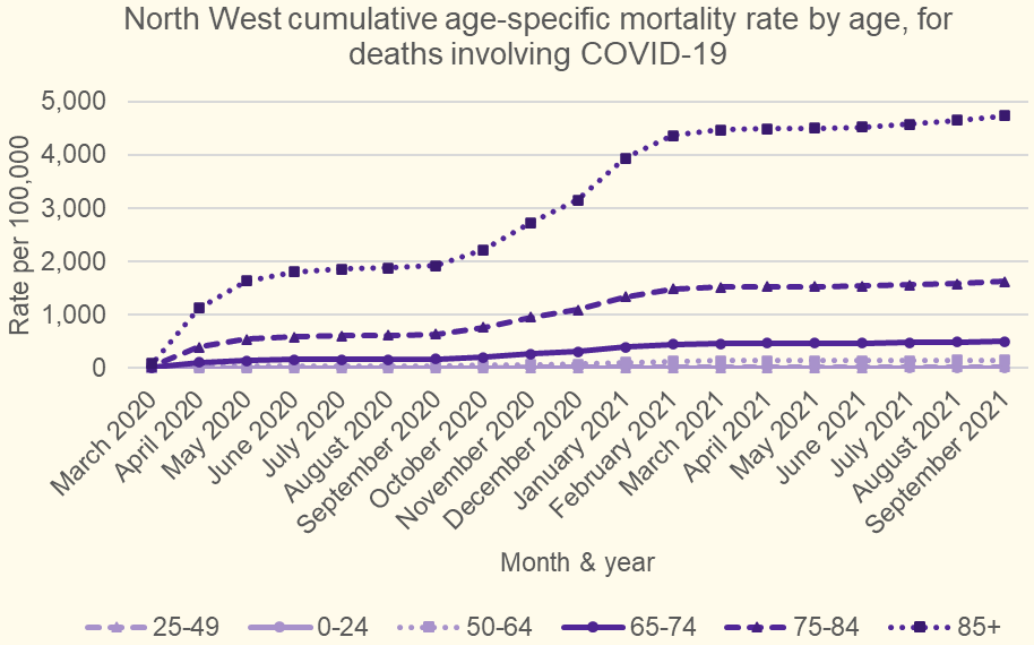
COVID-19 has had a disproportionate direct impact on older people

In January 2020, COVID-19 reached the UK, and by 23rd March the country went into lockdown. Stay at home and self-isolation orders were imposed by the Government, **over 70s were advised to 'shield'**, and all non-essential contact and travel was banned.

The pandemic placed **huge pressures** on healthcare services, particularly around critical and emergency care, and routine and preventative services were suspended.

Whilst the pandemic has had an impact on all population groups, **mortality and hospitalisation rates** have been much higher in older age groups due to physiological changes that come with ageing and pre-existing health conditions. These rates have been even **higher in the North West**.

The pandemic has also highlighted the inequalities around how people age, and **exposed the flaws and shortcomings** of various systems, including health, long-term care and support, social protection, finance, and information-sharing.



Data source: OHID CHIME tool

The pandemic has highlighted the inequalities around how people age

This report includes the results of a **rapid review of evidence** investigating the impact of COVID-19 on older people in England and across the UK. Each section contains the **high level findings** of this review.

In summary, the findings identify **negative physical and mental health impacts** of COVID-19 and its restrictions, particularly for those with **pre-existing long-term** conditions and older people in **minority groups** (deprived, disabled, LGBT+, and ethnic minority groups).

This is due to delayed or cancelled **diagnosis, treatment and care** for many, as well as increased physical inactivity, the adoption of **unhealthy coping strategies** and the magnified effects of **poor quality housing**.

The review also found that, for older people, the pandemic has increased the **digital divide**, the **burden of caring** for loved ones, and reduced **household income** for some, affecting their retirement plans.

But the review also highlights that the negative indirect impacts of COVID-19 are **not universal**, and that some older people have identified **positive aspects of lockdowns**.

These findings were less frequent as the pandemic persisted. But, they highlight how the pandemic has **exacerbated existing inequalities** in older age, with pandemic restrictions increasing isolation and feelings of loneliness for some, and limiting access to healthcare, groceries, medication, and other essentials.

The review also identifies initial findings that the risk of **long-COVID** increases with age, and that those who have had COVID-19 are more likely to have been at risk of **malnutrition**.

The **full results** of our rapid literature review will follow in a separate resource, alongside examples of how local areas have supported older people through the pandemic.

There is no universal definition of an ‘older person’

Generally, someone **over the age of 65** might be considered an older person.

However, it is not easy to apply a strict definition because people can **biologically age at different rates**, e.g. some 80-year-olds have better **physical and mental capacity** than some 30-year-olds.

Instead of simple age, **‘frailty’** has a bigger impact on the likelihood of requiring care and support (NHS England).

Images courtesy of:

Centre for Ageing Better

Action today for all our tomorrows

The older population is growing, but increased demand on health and social care is not inevitable

The ageing population is **growing faster** than in the past, and already, there are more than one billion people aged 60+ in the world. This demographic transition will have an impact on almost all aspects of society.

ONS currently estimates there to be **10.5 million people aged 65+ in England** (18.5% of the total population). But, the older population is growing faster than the younger, largely driven by improvements in life expectancy, as well as a decrease in fertility and people having children later in life. By 2040, the older population is likely to **increase by 38%** (ONS, 2020).

A new report by the Centre for Ageing Better has also found that people in the UK in their 50s and 60s today – the tail end of the post-war baby boom – face greater challenges than those who were the same age in 2002, with inequality skyrocketing and financial pressures worsening.

While the current focus on the best start in life rightly prioritises prevention, we also need to focus on the **full life-course approach** and the things we can do to help people live productive and healthy lives all the way through older age.

Older populations tend to put a greater **demand on health and care services**, and later life is still synonymous with ill-health (Centre for Ageing Better, 2020), resulting in 'inevitable' cognitive and physical decline. But it doesn't have to be this way, and often isn't.

We need to **fight against the stereotypes** people have about older people, and support everyone to achieve healthy productive ageing.

Ageist attitudes continue and this needs to be challenged

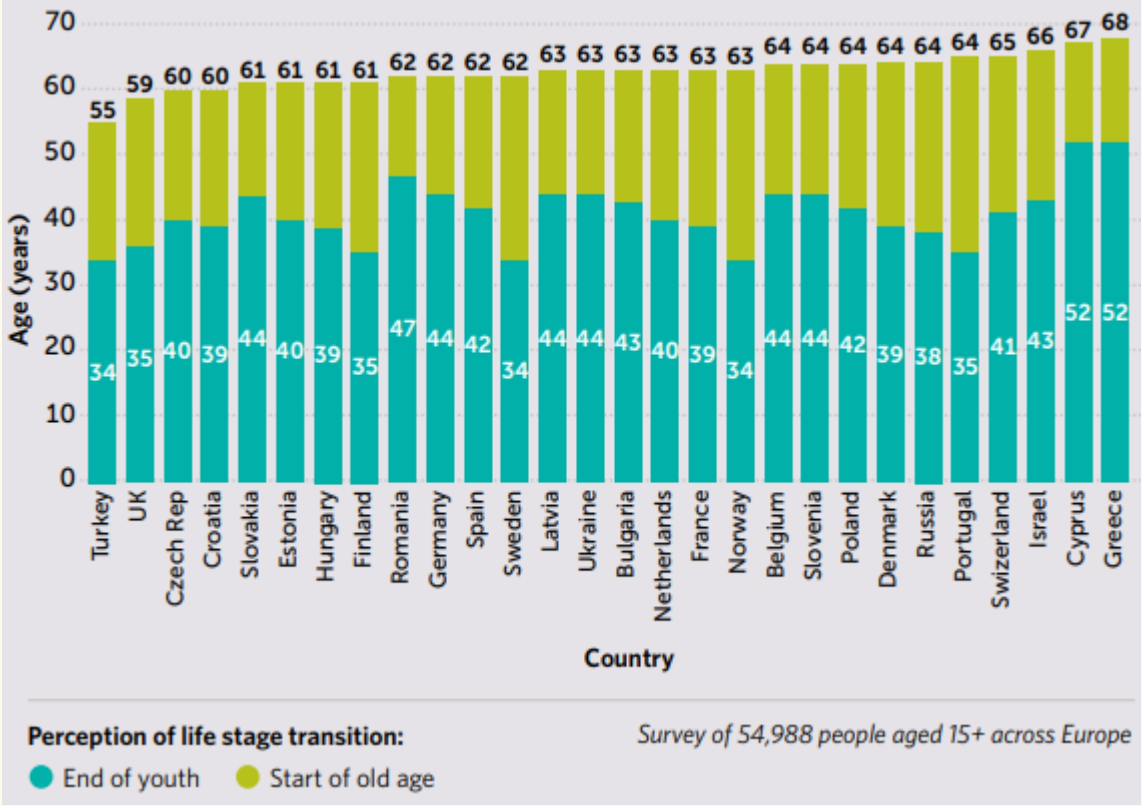
Recommendation:
Challenge negative language and imagery of older people and shift conversation to celebrate successes and benefits of an ageing population

In the UK, people's perceptions of when we transition out of youth and into old age are much lower than in other European countries. **We believe that old age starts at 59**, but those aged 59 are quite different from those aged 90 (Government Office for Science, 2016).

This **can result in ageism**, characterised by feelings of pity in which older people are patronised, ignored or their concerns dismissed. This has **broad and far-reaching negative consequences**. Not only can it have a negative impact on physical and mental health, it can also influence whether older patients receive treatment, as well as the duration, frequency and appropriateness of treatment (Centre for Ageing Better, 2020).

To support productive healthy ageing, it is important to understand the characteristics of the older local population and, **embed this understanding** into strategies and commissioned services.

Perceptions of youth and old age across Europe



Source: Government Office for Science, 2016

2021-30 is the UN Decade of Healthy Ageing

UN Decade of Healthy Ageing 2021-30

A **global collaboration** that brings together diverse sectors and stakeholders including governments, civil society, international organizations, professionals, academic institutions, the media and the private sector to improve the lives of older people, their families and communities

With the impact of COVID-19, the Decade of Healthy Ageing is an opportunity for **concerted, sustained focus, investment and action** to foster healthy ageing, to tackle factors that impact older people's health status and contribute to their increased susceptibility to serious illnesses

Fundamental shifts will be required not only in the actions we take but in how we think about age and ageing

The collaboration focuses on **4 action areas** that are strongly interconnected:

- changing **how we think, feel and act** towards ageing;
- **developing communities** in ways that foster the abilities of older people;
- delivering **person centred integrated care** and primary health services responsive to older people; and
- providing older people who need it with **access to long-term care**.

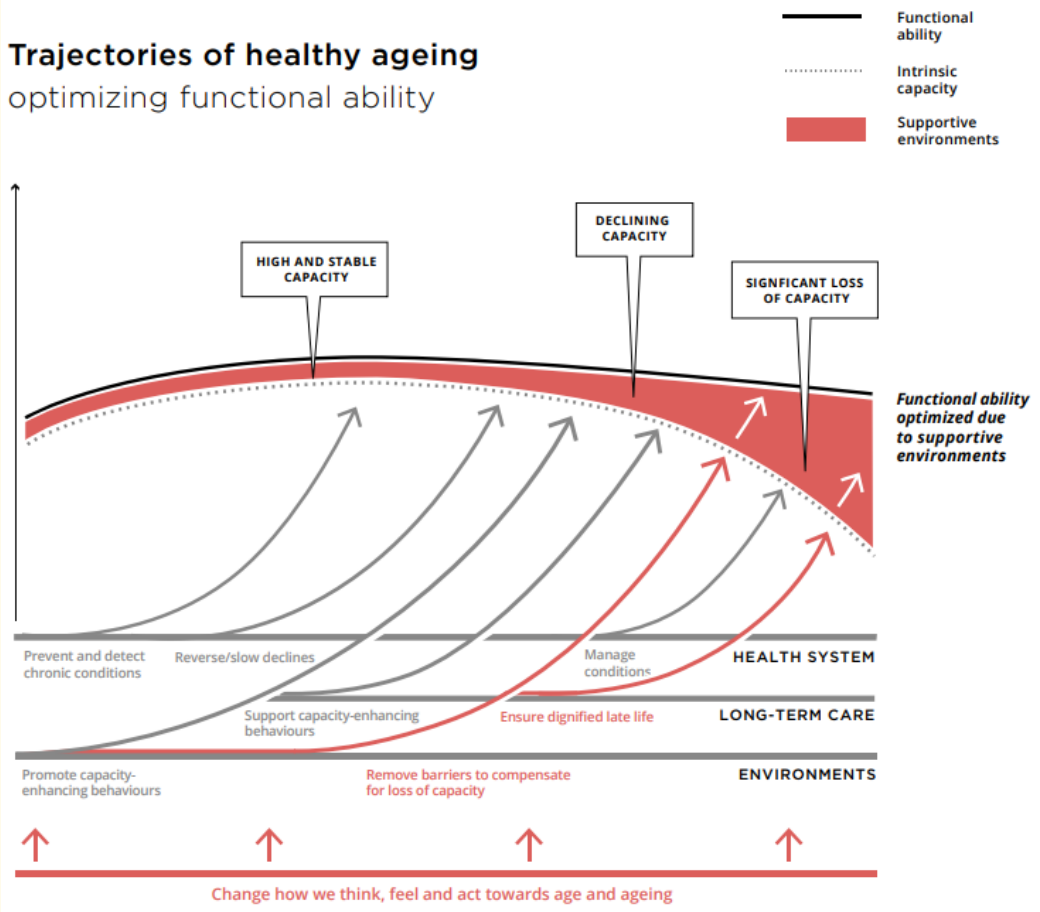
‘Healthy ageing’ is about maintaining functional ability

Everybody can experience healthy ageing. **Being free of disease or infirmity is not a requirement**.

WHO defines healthy ageing as “the process of **developing and maintaining the functional ability*** that enables wellbeing in older age”. Functional ability combines the intrinsic capacity of an individual, the environment they live in, and how they interact with that environment. Healthy ageing is therefore influenced by multiple factors **throughout the life course**.

*Functional ability refers to people’s ability to: 1) meet their basic needs to ensure an adequate standard of living; 2) learn, grow and make decisions; 3) be mobile; 4) build and maintain relationships; and 5) contribute to society.

Almost all determinants of healthy ageing can be improved by the continued implementation of **Health in All Policies** across the life course. Actions that dismantle discrimination and level up socioeconomic conditions are likely to **uplift the trajectory** of healthy ageing for everyone.



Source: WHO Decade of Healthy Ageing Baseline Report

England pledges to uphold 5 commitments to healthy ageing

In 2019 Public Health England and the Centre for Ageing Better facilitated an initiative to develop a healthy ageing consensus statement. This sets out a **shared vision** for making England the best place in the world to grow old, and aims to **demonstrate our leadership** as we enter the Decade of Healthy Ageing.

As of September 2021, only seven organisations based in the North West had signed up as co-signatories to the statement.

Policy paper overview: Healthy ageing: consensus statement - GOV.UK

Signatories pledge to uphold **five commitments**, and to challenge and support others to do the same, and to promote collaborative action to achieve the vision:

1. Putting **prevention first** and ensuring timely access to services and support when needed
2. Removing **barriers and** creating more **opportunities** for older adults to contribute to society
3. Ensuring good **homes and communities**
4. Narrowing **inequalities**
5. Challenging ageist and negative **language, culture and practices**

Recommendation:
Sign up to the Healthy Ageing Consensus Statement to demonstrate commitment to Healthy Ageing and use the framework for Age-friendly Covid-19 recovery plans

Healthy ageing is built in to a range of policy areas in England

Department for Business, Energy and Industrial Strategy Industrial Strategy (2018)

- Including the 'Grand Challenge on Ageing'*

Department for Work and Pensions
Fuller Working Lives (2017)

- Older people enabled to work for longer

Department for Health and Social Care
Dementia 2020 challenge (2015)

- Including raising awareness of risk reduction

Department for Digital, Culture, Media and Sport
Loneliness strategy (2018)

- Addressing loneliness across the life course

National Health Service
NHS Long Term Plan (2019)

- A renewed focus on prevention for a 'thriving' older age, including use of data and technology to prevent illness

Department for Environment, Food and Rural Affairs
25 Year Environment Plan (2018)

- High quality, accessible, natural spaces close to where people live and work

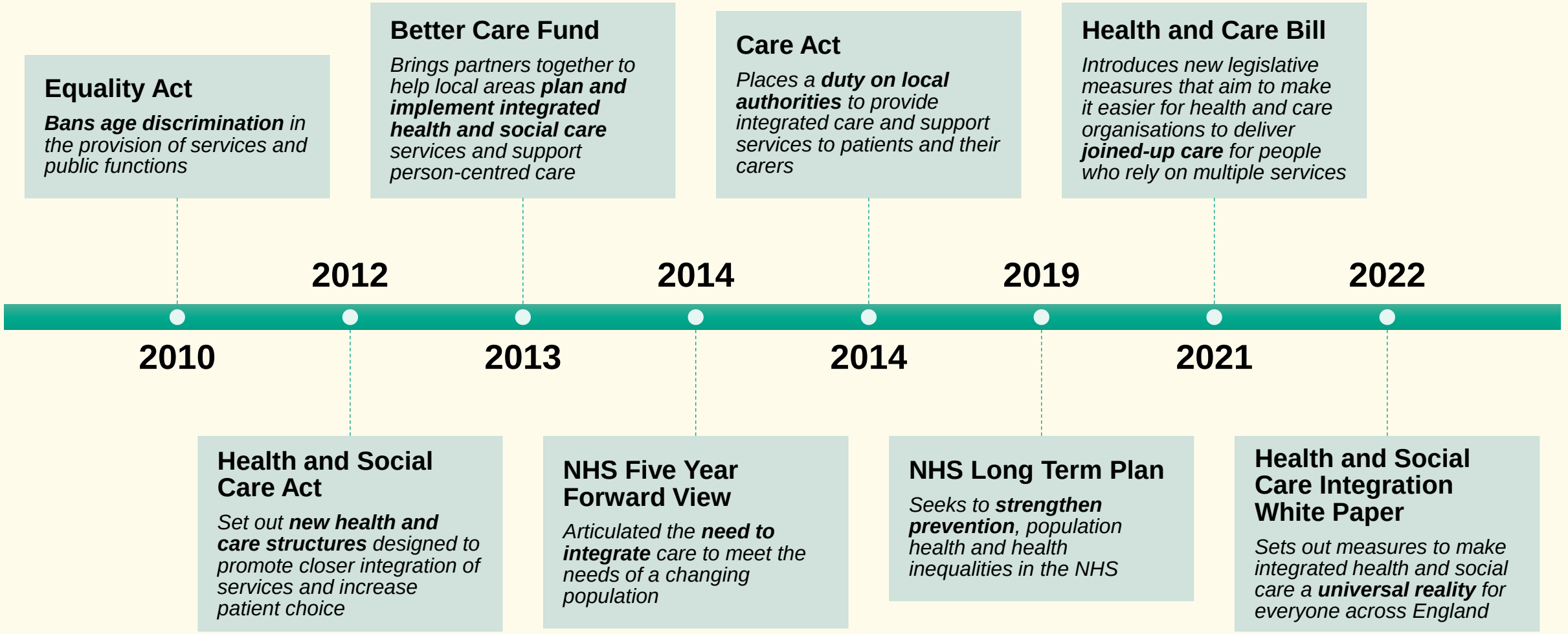
* The government has outlined a mission to "Ensure that people can enjoy **at least 5 extra healthy, independent years of life by 2035**, while narrowing the gap between the experience of the richest and poorest"

There is a range of NICE guidance, pathways and quality standards specific to older people

Guidance	Pathway	Quality standard
NG189 **Safeguarding** adults in care homes	**Safeguarding** adults in care homes	
NG96 Care and support of people growing older with **learning disabilities**	Care and support of people growing older with **learning disabilities**	QS187 **Learning disability**: care and support of people growing older
NG13 **Workplace** health: management practices	**Workplace** health: policy and management practices	
NH32 Older people: **independence** and mental **wellbeing**	Mental **wellbeing** and **independence** in older people	QS137 Mental **wellbeing** and **independence** for older people QS50 Mental **wellbeing** of older people in care homes
NG22 Older people with social care needs and **multiple long-term conditions**	Social care for older people with **multiple long-term conditions**	QS132 Social care for older people with **multiple long-term conditions**
NG21 **Home care**: delivering personal care and practical support to older people living in their own homes	**Home care** for older people	QS123 **Home care** for older people
NG6 Excess winter deaths and illness, and the health risks associated with **cold homes**	Excess winter deaths and illness associated with **cold homes**	
CG161 **Falls** in older people: assessing risk and prevention	Preventing **falls** in older people	QS86 **Falls** in older people
PH16 **Mental wellbeing** in over 65s: occupational therapy and physical activity interventions		
		QS184 **Dementia**

Source: NICE; There are also 2 guidance documents on age-related macular degeneration (IPG565 and IPG339)

The legislative landscape is building to enable joined up care for those with multiple needs



The North West is making good progress on healthy ageing, but we want to make it the best region in England to age

There is already **a lot of good work going on** in the North West around healthy ageing, with 11 local authorities and both combined authorities part of the UK age-friendly network.

But we want to make the North West the best region in England to age. This **requires co-ordination** of the various elements of healthy ageing at a local level, including age-friendly principles embedded into all commissioned services. We recognise that budgets have been squeezed in recent years, but it is **important that healthy ageing is prioritised**.

While many local authorities have elements of healthy ageing included in their JSNAs, we would like to see this happen **consistently across the region**. Also the impact of the **wider determinants on healthy ageing** need to be made clearer.

Local examples of healthy ageing research and good practice are included in appendix one of the report, but these are not exhaustive.

The next step in further developing the North West healthy ageing agenda is to **establish a healthy ageing network** to meet and discuss healthy ageing, and further identify and share examples of good practice across the region.

2. Population

- Age and sex
- Ethnicity
- Sexual orientation
- Disability
- Deprivation
- Intersectionality

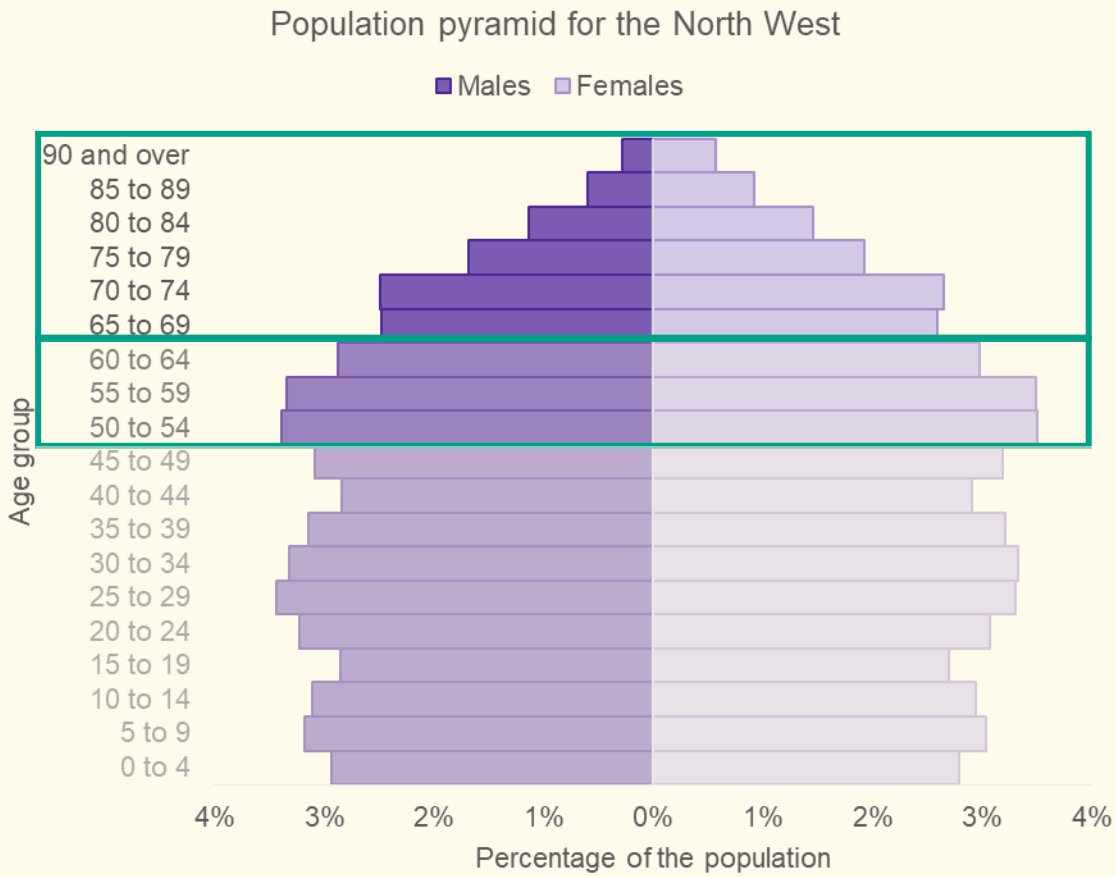
Older people make up a fifth of the North West population

Older people aged 65+ currently make up a fifth of the North West population (19%), totalling nearly **1.4m people**.

People aged 50 to 64 total **another 1.4m**. This group will be preparing for retirement, if they haven't already retired, and will move into the older age group over the next 15 years.

As a result, it is projected that, by 2040, the older population in the North West is likely to **increase by 36%** to 1.8m people. The **oldest cohorts** are projected to increase most:

- those aged 85-89 will have **more than doubled**
- those aged 90+ will have **increased by 93%**

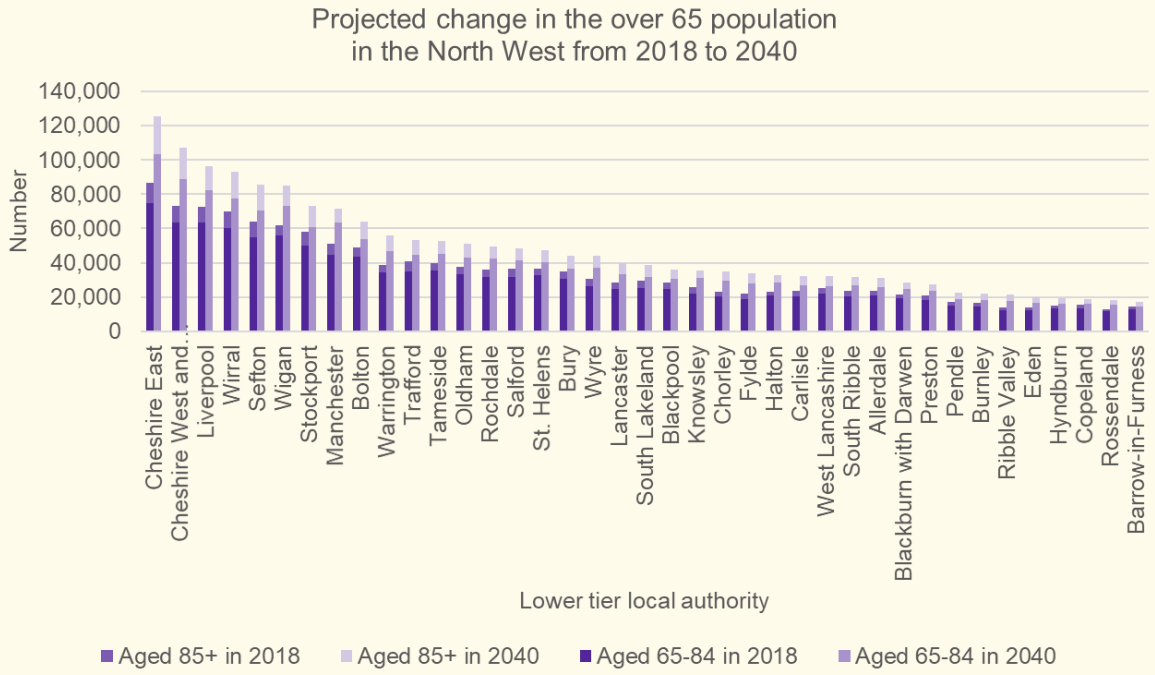


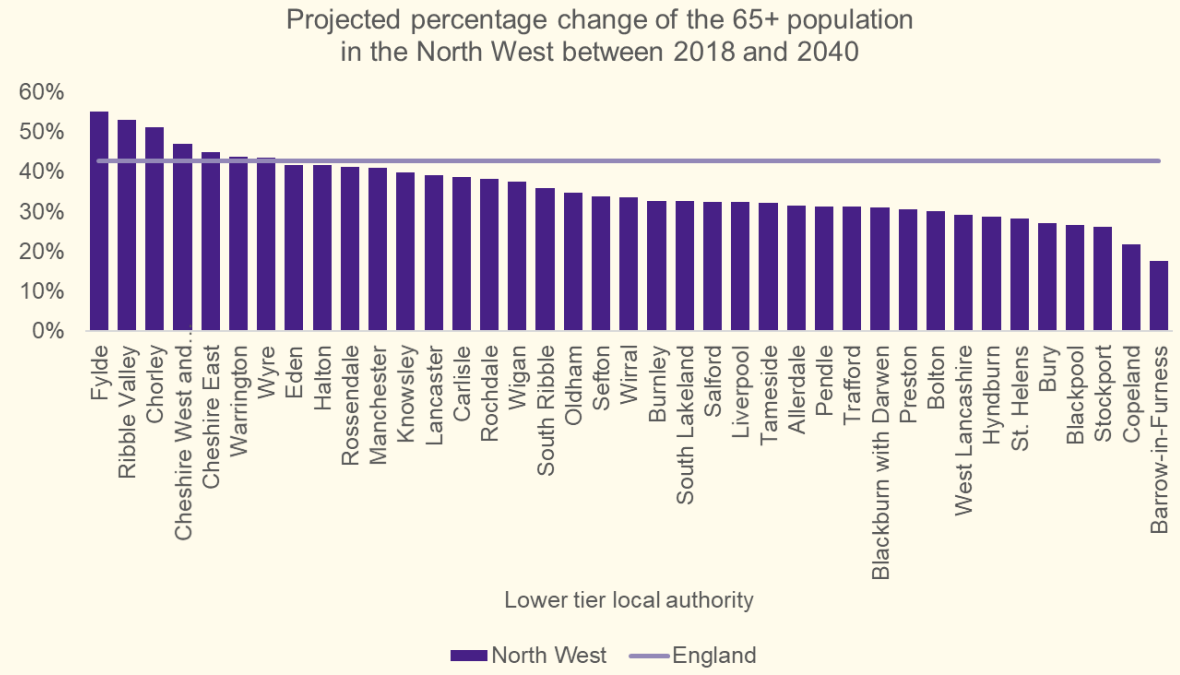
Data source: ONS [Mid-2020 population estimates]

The growth rate of those aged 65+ varies across the region

Between 2018 and 2040, the predicted rate of growth in the over 65 population is **lower in the North West** than in England. However, this **varies greatly** across the region. Six local areas are set to see greater growth than England:

- Fylde (55%)
- Ribble Valley (53%)
- Chorley (51%)
- Cheshire West and Chester (47%)
- Cheshire East (45%)
- Warrington (44%)





Data source: ONS [2018 based population projections]

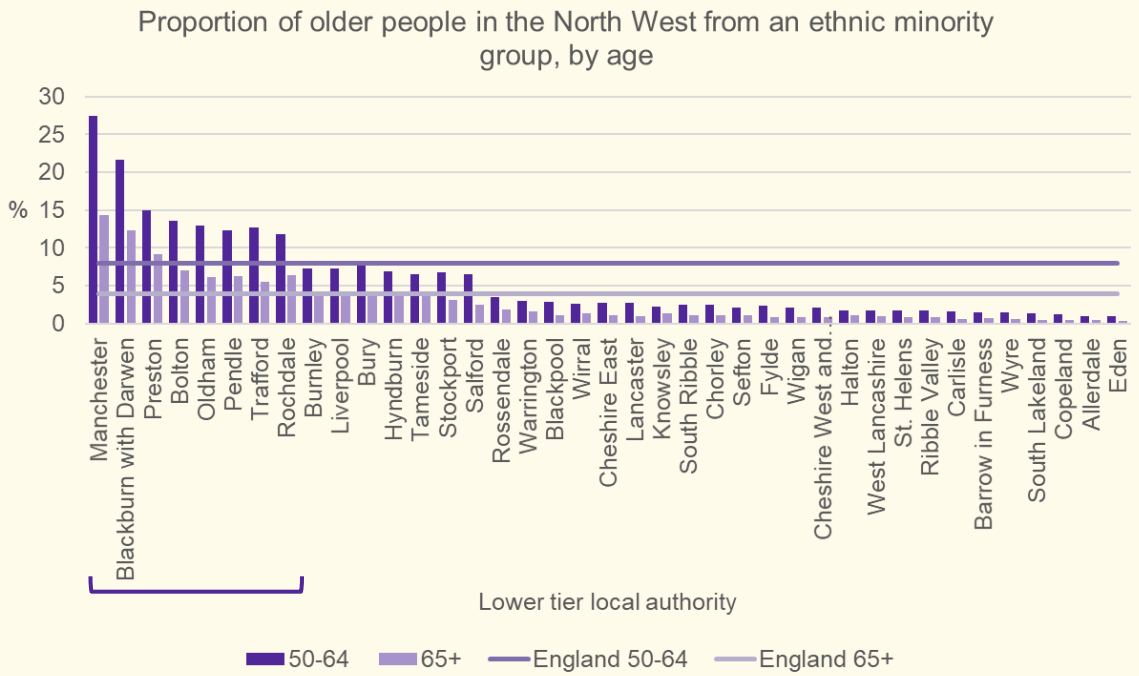
There are small pockets of older ethnic minority groups in the North West

Within the North West region the older ethnic minority population varies with **small pockets** across the majority of the region.

However, eight North West local authorities (marked on the chart) have larger older ethnic minority populations than the England average, particularly **Manchester** and **Blackburn with Darwen**:

- 27.4% aged 50-64, and 14.3% aged 65+ in Manchester
- 21.6% aged 50-64, and 12.4% aged 65+ in Blackburn and Darwen

At the other end of the spectrum, Eden, Allerdale, Copeland, and South Lakeland have the lowest percentage of ethnic minority groups at less than 2% of their 50+ population.



Data source: ONS [Population denominators by broad ethnic group (2019)]

N.B. These are neither National Statistics nor standard published experimental statistics and have not been produced using methods which have undergone formal Quality Assurance. They have been produced specifically for use as part of the Race Disparity Audit, following discussion with the Race Disparity Unit of their specific requirements and time-frame.

Ethnic inequalities in health status grow after the age of 30

Ethnic minorities face challenges due to an **accumulation of disadvantages** built up over the life course. The health status of different ethnic groups **diverge at around the age of 30**, continuing into old age (Centre for Ageing Better, 2021).

The disadvantages span across a large number of areas in life with recent research finding that older ethnic minorities are more likely to be **deprived** or have a lower income and/or savings, and are less likely to **own their home** outright (Centre for Ageing Better, 2020).

Older ethnic minorities are more likely to experience **language barriers** than their younger counterparts. They are also less likely to **access services** due to structural issues such as cultural inappropriateness, long standing mistrust of authorities, and experiences of racism, discrimination and stigma.

The **health inequalities** that exist within ethnic minorities have been **exacerbated** during the COVID-19 pandemic, with all ethnic minority groups at an **increased risk of mortality** due to COVID-19. However, those of black African and black Caribbean descent are at greatest risk (PHE, 2020).

The **disproportionate impact** on older ethnic minorities arose from factors including:

- a greater likelihood of family members being in **key worker roles**
- a greater likelihood of living in **overcrowded households** with a higher rate of transmission
- a greater risk of becoming seriously ill or dying due to a complex combination of **historic social, economic and health inequalities**

Older LGBT+ adults have poorer self-rated health and are less likely to access services

The Annual Population Survey (ONS, 2019) showed that **2.2% of people in the North West** identify as lesbian, gay or bisexual (LGB), compared to England at 2.7%. And whilst people aged 16-24 were the most likely to identify as LGB, the proportion of people aged 65+ identifying as such has increased (from 0.7% in 2018 to 1.0% in 2019).

Research shows that older LGBT+ people are especially **vulnerable to loneliness**, particularly if living in rural or coastal areas. This is because they are more likely to be single, live alone, and have less contact with relatives.

Other research also shows that older LGBT men and women have **poorer self-rated health** and are more likely to have other conditions that impact their health and wellbeing. They also have **worse outcomes** in relation to physical health, loneliness, social isolation, mental health, and experiences of violence (ILC, 2019).

Experiences of **stigma, discrimination and abuse** over the years also mean that over 80% of older LGBT+ people do not trust professionals to understand their culture or lifestyle (Age UK). As a consequence, the LGBT+ community are less **likely to engage with local services**.

There is limited data available about **older trans people**, but we know they face a unique set of challenges in navigating health and other services.

In the **2021 Census** the ONS included a question around gender identity and sexual orientation **for the first time**. Initial data is due to be published in March/April 2022.

This will be useful to inform policy and service planning and provision.

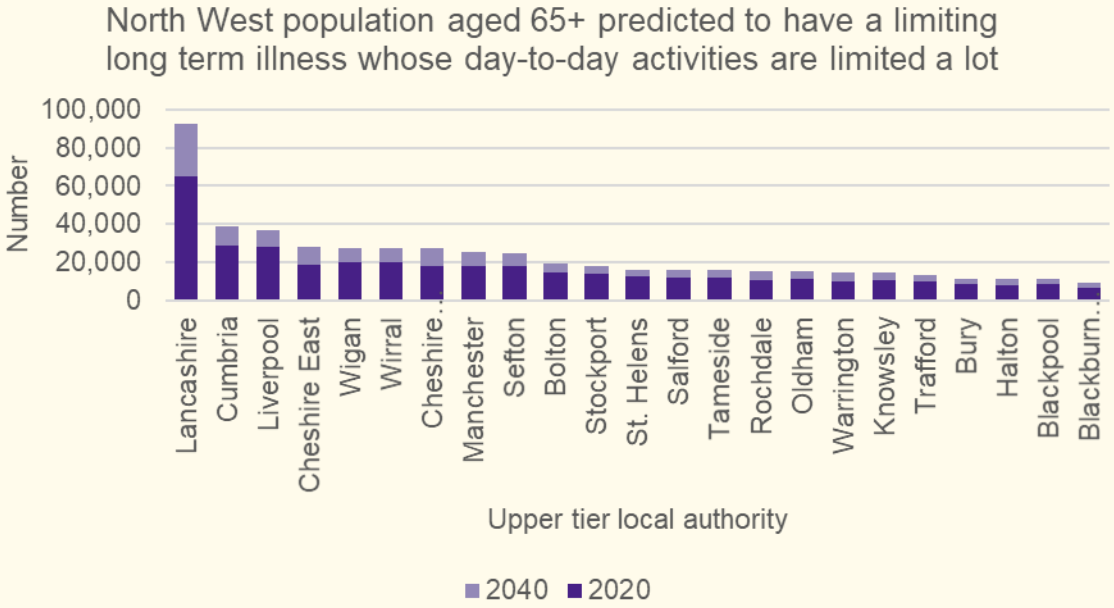
Over a quarter of older people in the North West are severely limited in their day-to-day activities

According to the Equality Act 2010, a disability is a **physical or mental impairment** that has a 'substantial' and 'long-term' negative effect on someone's ability to do **normal daily activities**.

In the North West, 53% of older people aged 65+ are estimated to have a long-term illness whose day-to-day activities are limited at least a little. **28% are limited a lot** in their day-to-day activities, totalling over 385,000 people. This figure is **projected to rise** to nearly 530,000 older people in the North West by 2040.

People with disabilities are likely to have **poorer health and wellbeing**, and face **barriers to accessing services**, as well as good quality education, employment, pay and housing. They are also more likely to be socially isolated and/or **lonely**, and vulnerable to crime.

People with disabilities are therefore most likely to have **social care needs**, particularly in older age.



Data source: POPPI

Adults with learning disabilities develop age-specific conditions earlier in life

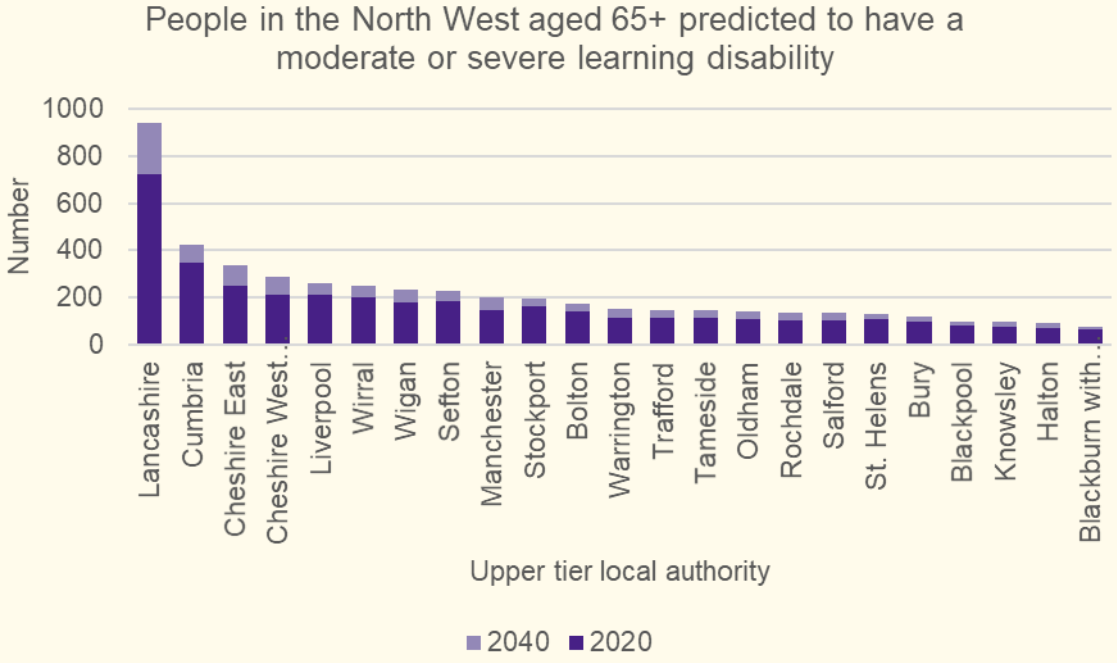
The older population with a moderate or severe learning disability is **also growing**. Currently estimated at nearly 4,000 older people in the North West (0.3%), this figure is predicted to rise by 28%, to nearly 5,000 older people, by 2040 (POPPI).

This group have very specific care needs as they will often develop conditions associated with **ageing at a younger age**, particularly dementia and sensory impairment.

However, this group is **less likely to access healthcare** generally and may find it difficult to express their needs and be heard, particularly if they are living independently or with family. Symptoms for dementia can also be **hard to distinguish** from those associated with learning disabilities.

Older people with learning disabilities should therefore have **health checks annually** to identify any issues early. Services should be accessible to them and their carers, and any communication clear (NICE guideline 96).

The National Development Team for Inclusion have produced a **toolkit to support health and social care commissioners** develop services for older people with learning disabilities.



Data source: POPPI

Up to a third of older people in the North West are living in poverty, which is the root cause of inequality

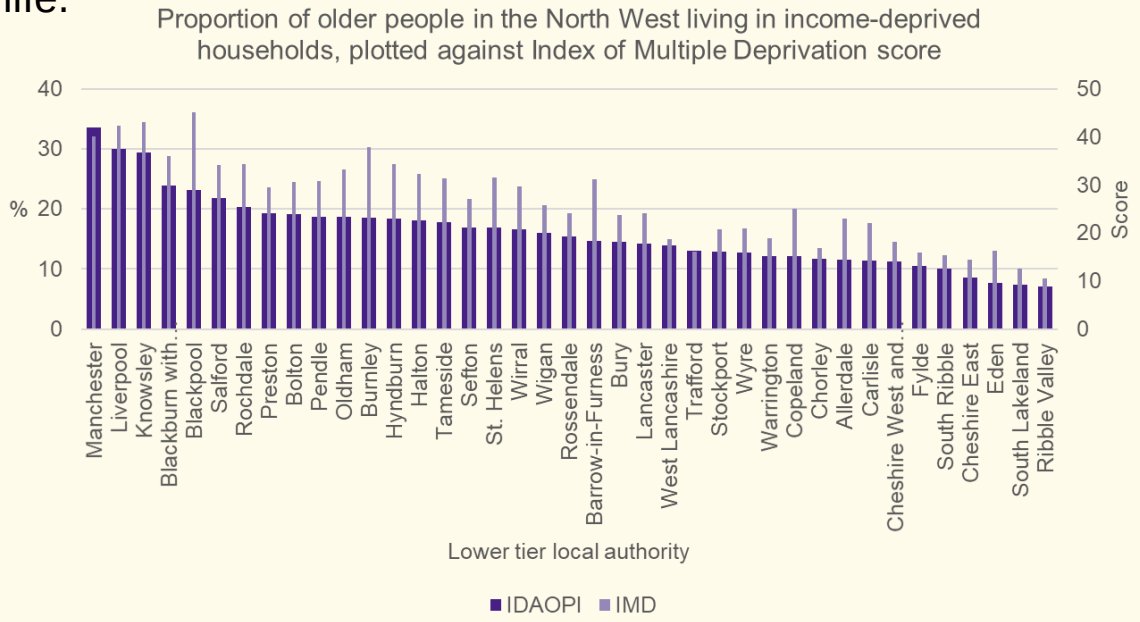
According to the 2019 Index of Multiple Deprivation (IMD) rankings, **4 of the 5 most deprived local authorities** in the country are in the North West, including:

- Liverpool, which has the **largest number** (31) of LSOAs* in the most deprived 1% nationally
- Blackpool, which has the **highest proportion** (23%) of its LSOAs in the most deprived 1% nationally

The **Income Deprivation Affecting Older People Index** (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation. Of the 20 local authority districts with the highest proportions of older people living in income deprived households, 4 are in the North West:

- Manchester (33.6%)
- Liverpool (30.0%)
- Knowsley (29.4%)
- Blackburn with Darwen (23.8%)

Deprivation has a huge impact on health. It is **the root cause** of most, if not all inequalities throughout the life-course. As a result, those living in the most deprived areas have the worst health outcomes, creating a **cumulative impact** for those who experience deprivation throughout life.



Data source: OHID [Productive Healthy Ageing Profile]

* LSOA: lower super output area

Individual factors interact to influence our level of vulnerability to poor health

It is important to recognise that individual factors such as age, gender, ethnicity, sexual orientation, disability and deprivation do not exist in isolation. They **interact** with one another to **influence our vulnerability** to poor health.

And evidence shows that our state of vulnerability is **neither a constant nor a given**. While some factors are fixed (i.e. ethnicity), others are fluid (i.e. age, deprivation, geography, employment), altering our state of vulnerability at any point in time. And while we may have one or more **risk factors**, we may also have **protective factors** that attenuate risk, for example a strong social network.

It is, therefore, **not a given that older people are vulnerable**, nor that those from an ethnic minority have poorer health. It is how individual factors co-exist that influence vulnerability. **This emerging concept is referred to as 'intersectionality'.**

Recommendation:
Engage communities to understand how individual factors intersect to affect health in your local area

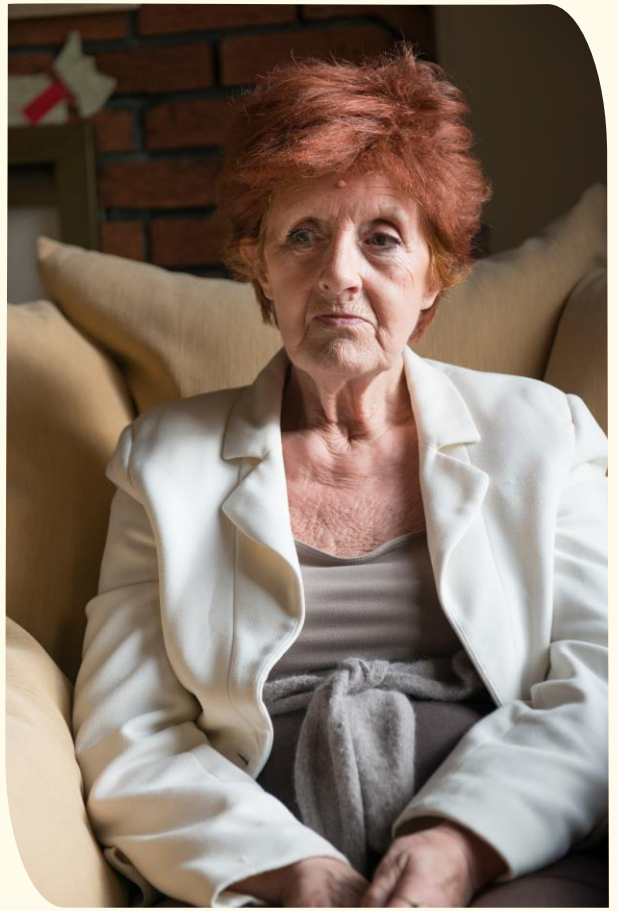
COVID-19 has had a disproportionate impact on older people, especially those in vulnerable groups

COVID-19 has exacerbated existing inequalities. It has had a **direct impact** on those whose health is most vulnerable, with older people, ethnic minority groups and the most deprived affected most.

The **indirect impacts** of lockdowns and social distancing have also been stronger on older people, ethnic minorities, people with disabilities, and the LGBT+ community.

Our rapid review of evidence* shows that all of these groups have suffered **poorer physical and mental health and wellbeing**. Some have also felt **unable to access** healthcare, groceries, medication and other essentials, leading to a feeling of being a burden on others.

In addition, older people, particularly those with a disability and the LGBT+ community, who were already more likely to be socially isolated before COVID, have experienced increased **isolation and feelings of loneliness**.



*Rapid review to be published at a later date

3. Wider determinants of health

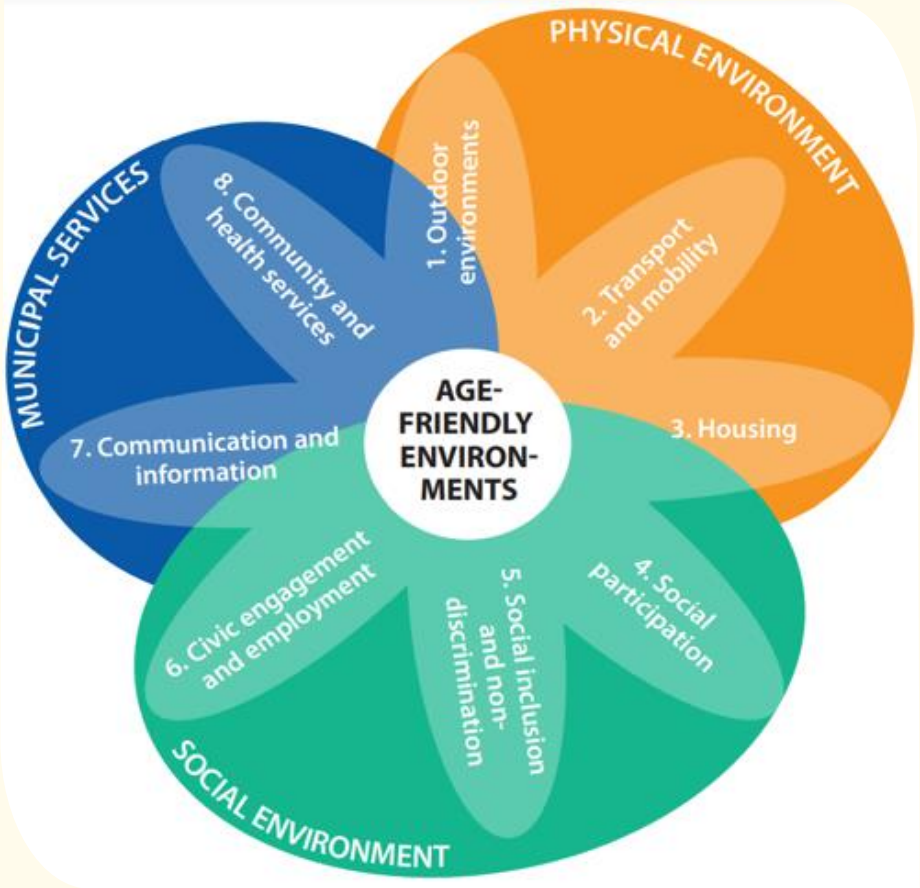
- Connectivity
  - Travel
  - Geography
  - Technology
  - Communities
- Loneliness and social isolation
- Housing
- Employment and retirement

There are 8 domains to an age-friendly environment and the North West is off to a good start

1. **Outdoor spaces and buildings**: accessibility, safety and cleanliness
2. **Transportation**: infrastructure, equipment and service
3. **Housing**: affordability, design and layout, maintenance provisions, and community integration
4. **Social participation**: information about what's on, where, when and how to get there
5. **Respect and social inclusion**: education about ageing, intergenerational activities and respectful and inclusive services
6. **Civic participation and employment:** accessible and flexible paid or unpaid work
7. **Communication and information:** plain language, oral and print communication, and easier to use technology
8. **Community support and health services**: effective and accessible services

Greater Manchester Combined Authority, Liverpool City Region Combined Authority and 11 North West local authorities are already **Age-friendly Communities**

Recommendation:
Follow the 4 steps to becoming an Age-friendly Community:
1. Engage and understand
2. Plan
3. Act and implement
4. Evaluate



Source: World Health Organisation, 2018

The AHAH index indicates that the North West is conducive to good health, but it excludes key elements of connectivity

How conducive an area is to good health, relative to other areas, is measured using the Access to Healthy Assets and Hazards (AHAH) index. It is comprised of **four domains**:

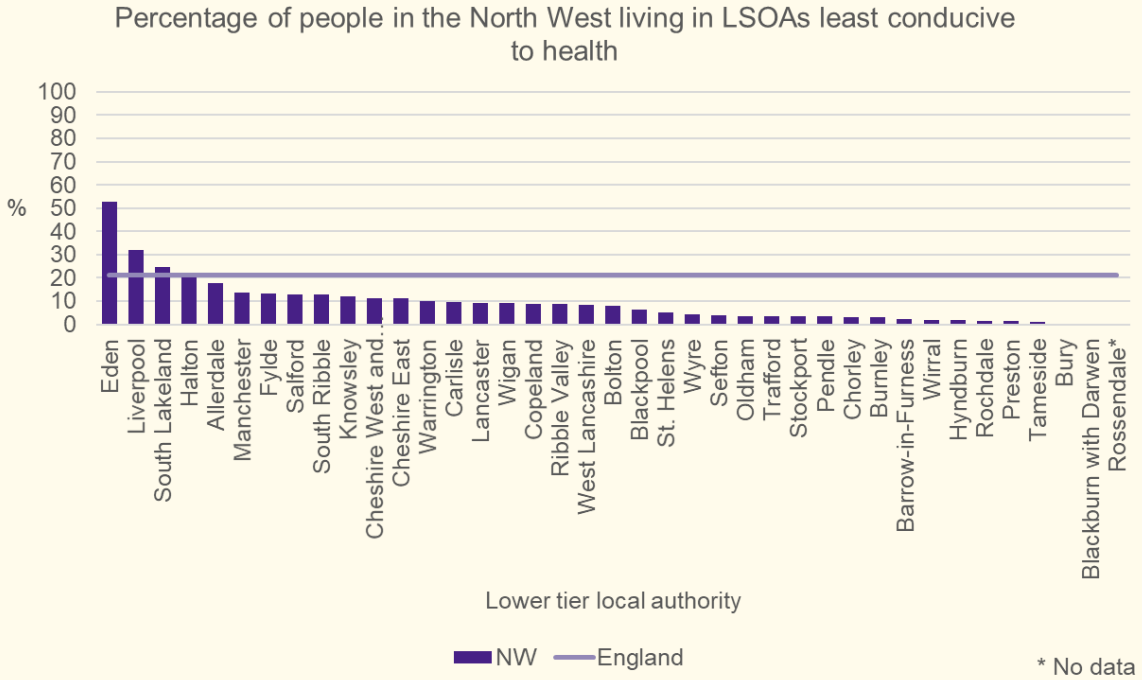
- access to health demoting retail services
- access to health services
- the physical environment
- air pollution

The percentage of people in North West local authorities who live in LSOAs least conducive to health is **generally low**, but basic regression indicates that the AHAH index is **not associated with deprivation**. Only three North West local authorities have a higher than average proportion of people living in less conducive areas:

- 52.7% of people in Eden
- 32% of people in Liverpool
- 24.7% of people in South Lakeland

Older people confined to these areas during COVID restrictions may have suffered **worse impacts** of lockdown.

It is important to note that the **data quality** of the AHAH index is not perfect and, while it provides a summary of **specific indicators**, it does not include access to transport and digital services.



Data source: OHID Productive Healthy Ageing Profile

Connectivity, in the broadest sense, is important in supporting and enabling healthy ageing

Further to the AHAH index, connectivity – the ability to access **services**, **travel** easily, use **technology**, and **socialise** – will be particularly important as the population ages.

Levels of connectivity can determine work, education, health and care outcomes, and **barriers** to physical and virtual connectivity create issues for individuals and society.

Public transport is a particular issue. And as we get older, we are more likely to cite 'health' as our reason for not taking public transport, highlighting the need for more **accessible services**.

However, in every age group the proportion of people who don't use public transport because it's either **unavailable, unreliable, infrequent or inconvenient** has increased. This is especially in rural areas where the average minimum journey time by public transport or walking is 29 minutes – approximately twice as long as in urban areas.

During the COVID-19 pandemic, many older people, especially those shielding, have **avoided public transport**. For those without a car, this has restricted their ability to get out and about and remain independent. Some have even felt a burden to others.

Digital and social connectivity are explored later in this report.

Recommendation: Support people to remain connected as they age with good transport links, green spaces, services, and facilities close to homes

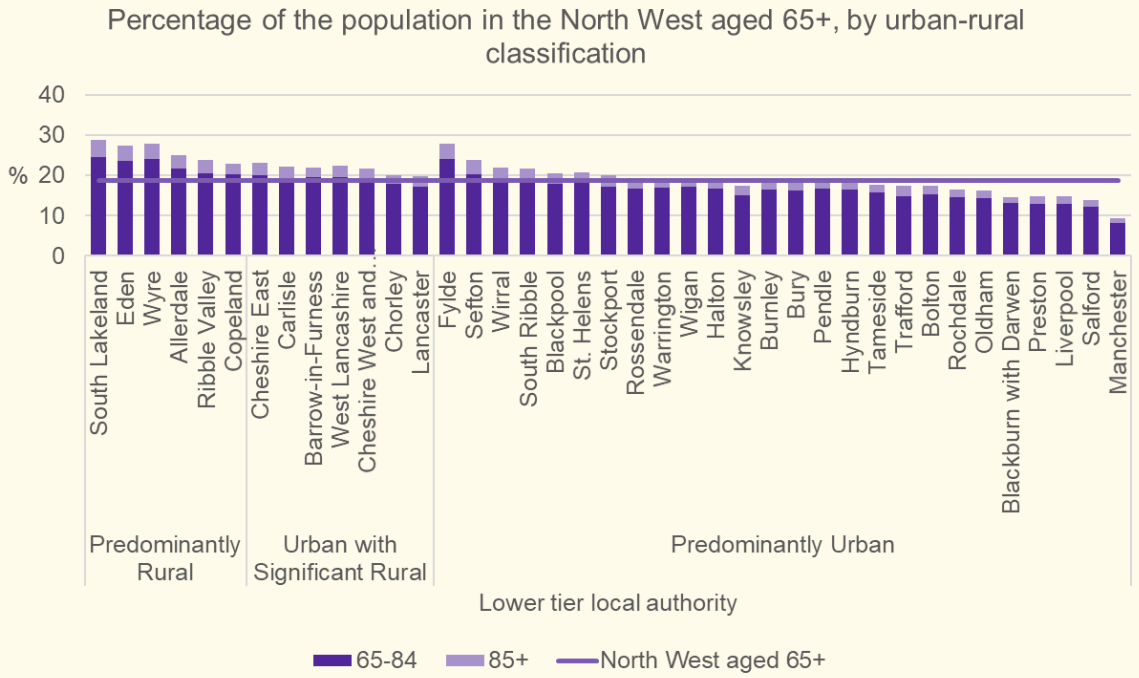
Older people tend to live in more rural areas that are less well connected

Rural areas in the North West are most likely to have the highest proportion of older people. In five local authority areas in the North West, **at least one in four** people are aged over 65:

- South Lakeland (29%) – predominantly rural (N.B. 7th highest proportion of 65+ in the country)
- Wyre (28%) – predominantly rural
- Fylde (28%) – N.B. predominantly urban
- Eden (27%) – predominantly rural
- Allerdale (25%) – predominantly rural

Manchester has one of the lowest proportions of older people in the country, with **less than one in 10** aged 65+.

Sadly, as rural areas are generally **less well connected**, they and coastal areas tend to have larger health inequalities than urban areas.



Data source: ONS Mid-2020 population estimates

Rural and coastal areas have larger health inequalities, but they also have sources of resilience

A PHE report, published before the 2021 CMO report, investigated health inequalities in ageing in rural and coastal areas. It found that, while **mortality is lower** in rural areas, older people in rural and coastal areas are more likely to have **poorer physical and mental health**.

The main **drivers of inequalities** in ageing in these areas are thought to be:

- social exclusion and isolation
- access to, and awareness of health and other community services
- financial difficulties (e.g. fuel poverty and housing issues)
- lack of transport and distance from services
- low levels of physical activity and mobility
- existing poor health (the healthiest populations are those of working age moving out of rural areas)

But there are also a number of **strengths, assets and sources of resilience** in coastal and rural areas, which can support healthy ageing **if available**:

- community networks and services
- family support and informal care
- environmental factors, including less crime, more green space, access to a car or other transport, home visits, sitting/ befriending services

Recommendation:
Map these drivers, strengths and assets in your local rural areas to identify areas for action

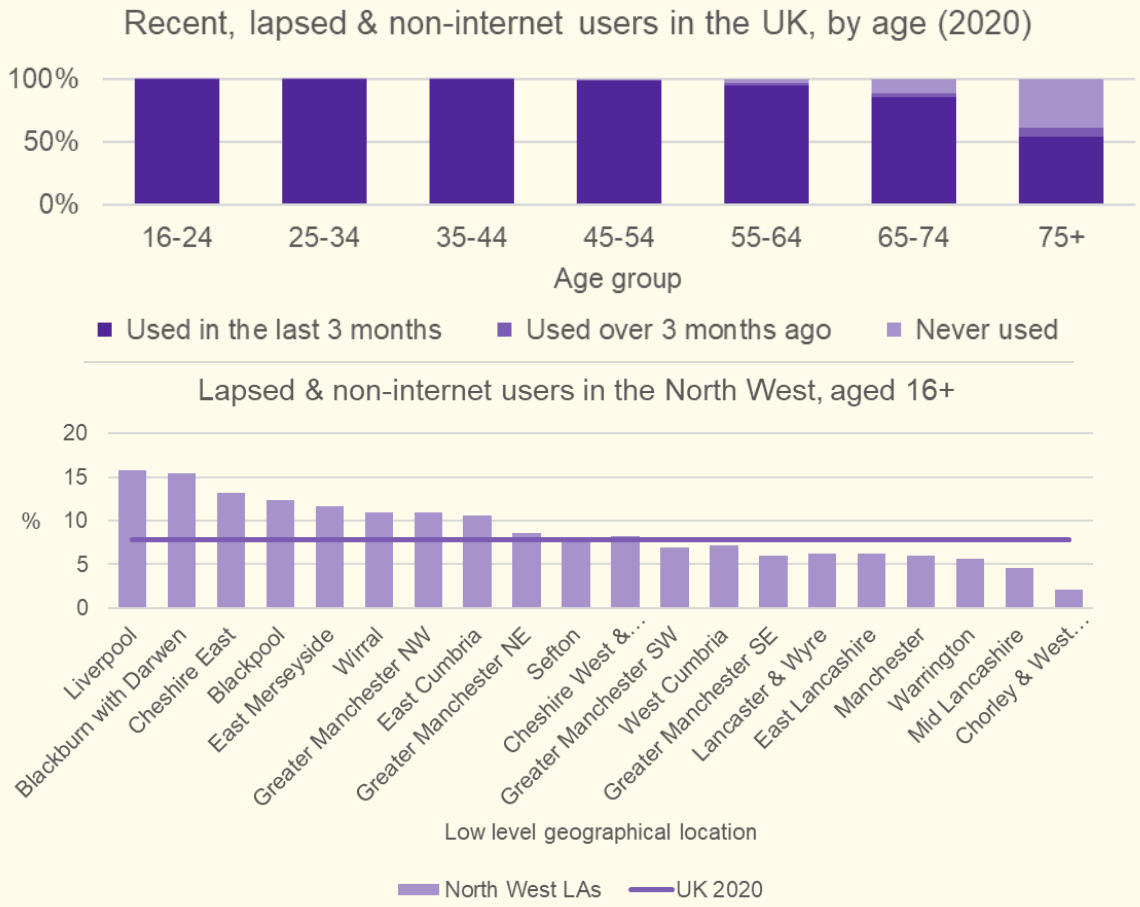
A large proportion of older people have still never used the internet

Beyond the ability to physically travel, new technologies and digital tools have an **increasingly important effect** on a person's ability to interact with the world around them.

The proportion of older people who **use the internet** regularly has grown rapidly in recent years, but still 11% of people in the UK aged 65-74, and 39% of those aged 75+ have never used the internet.

North West usage is not broken down by age, but nine areas in the region have **higher levels of internet non-usage** than the UK. We can therefore assume that the proportion of North West older people who are digitally excluded is higher than the figures quoted above.

Within the older age groups, **women** are less likely to use the internet, and 45% of the 75+ who are **disabled** have never used the internet. Across all ages, data also show that **Bangladeshi, White and Pakistani** ethnic groups are less likely to have used the internet at all.



Data source: ONS Internet users (2020)

Barriers remain in getting older people online, despite the rise in internet use during COVID-19

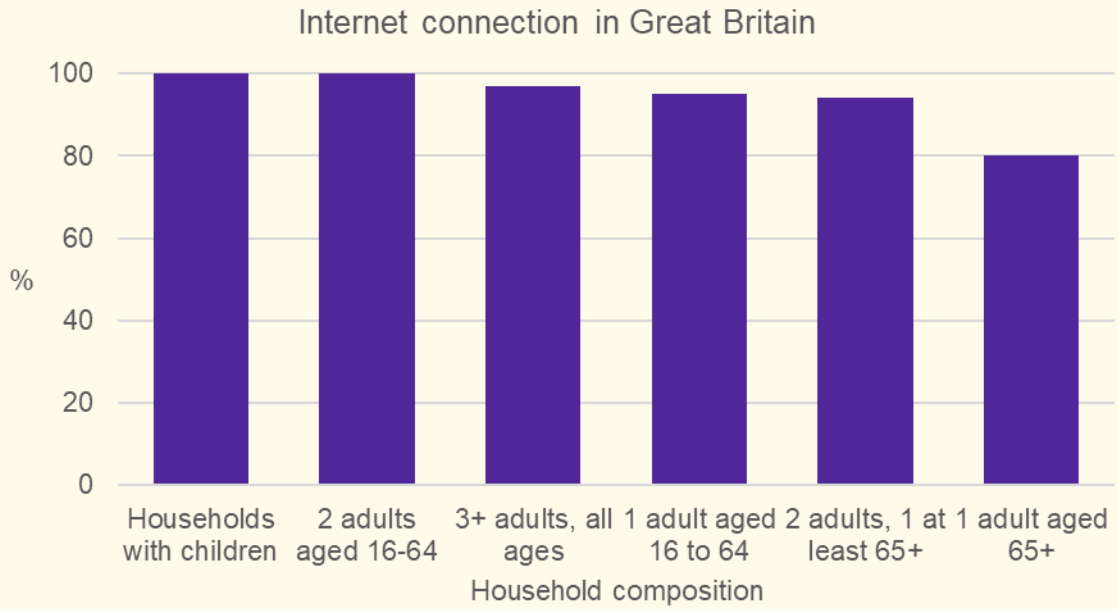
The various lockdowns during the COVID-19 pandemic have **increased the need for services to go digital**, creating a greater urgency to getting people online.

However, our rapid review of evidence* shows that this does not appear to have encouraged many previous internet non-users online. And a large proportion of older people are **still not interested in using the internet** more.

But older people who did use the internet before the first lockdown have **increased their use** of digital devices and social media since the pandemic began. They identified the internet as an important resource during this time in helping them to stay connected.

And encouragingly, some older internet non-users do want to use the internet more frequently and for more tasks, but poor **IT skills**, lack of **trust** in the internet, and poor/no **access to equipment** and/or broadband inhibit this desire (Age UK, 2021).

ONS data show that, while 100% of some household types have **internet access**, up to 20% of households with older people do not, most of which are **single person households**. This indicates that people who live alone are less likely to be connected to the outside world.



Data source: ONS Internet access (2020)

*Rapid review to be published at a later date

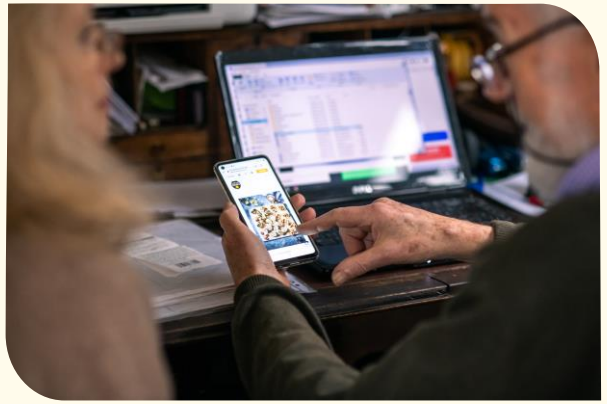
Older people are more susceptible to scams and fraud, which have risen during COVID-19

Whilst going online has many benefits, it also increases the risk of being a victim to **scams and fraud**.

Anyone can become a victim of fraud, however **older people are more susceptible**, particularly those who are lonely or socially isolated with no family or network around them. Additionally older people who are scammed in their own home are 2.5 times **more likely to end up in permanent residential care**.

According to Age UK:

- 43% of people aged 65+ have been targeted by scammers
- only 11% of older people who've been targeted by a scam report it to the police
- only 3% of older people who've been targeted by a scam report it to Action Fraud



Research by Citizens Advice suggests that, while older people do experience online fraud, scams experienced by people aged 65+ are **more likely to occur through phone calls** and less likely to occur by email or online, compared to younger people.

However, online scams are becoming **increasingly common and more sophisticated**. Awareness needs to be raised about all types of scams, and older adults must be supported to **protect their personal information**. There are many resources (online and in paper form) that provide advice and tips on online safety and security.

Scams have been prolific during the COVID-19 pandemic, many targeting older people. And while many types of crime decreased during this time, total crime increased by 12%, driven mainly by a 43% **rise in fraud and computer misuse** (ONS Crime in England and Wales).

The move towards digital can actually reduce independence and autonomy

Internet is not the only issue for older people. Wider **digital and technical exclusion** is another big issue. Aside from many services now only being available online, many household items and instructions are now digital, alienating a large proportion of the older population.

Digital **white goods and heating controls**, and paying for parking charges by phone are just some of this difficulties that face older people. This **reduces their independence and autonomy**, limits their mobility, and affects their health and wellbeing. Fear of, and inability to use technology can **induce anxiety**, and result in over- or under-heating homes and unwittingly paying for services that they don't understand.

It is **increasingly difficult** to purchase appliances which aren't digital, and more and more services and goods are only available online. This has a major impact on day-to-day life and is not just limited to older people.

There is currently a **gap around support** for those struggling with technology and digital devices, especially around the support that goes into older people's homes.

More work is needed to explore this issue, both locally and more broadly. Local areas should **engage their communities** to ask them what support they need to get online and be able to use the internet, and how this support should be delivered.

Recommendation:
Support older people to develop the skills to get online and use digital appliances while maintaining paper communication

Older people make up 63% of unpaid carers and who have unmet care needs themselves

Connectivity is also about **social connections** and, encouragingly, as age increases, people are more likely to volunteer regularly and feel they belong to their neighbourhood.

Recommendation: Support older adults to volunteer, mentor and peer support

Volunteering has a wide range of health and wellbeing benefits, giving people a sense of worthwhile. Alongside unpaid work, this emphasises the contributions that older people can make to society. But, people in their 50s and 60s with **long-term illnesses** are less likely to feel a sense of belonging, and those in **more deprived** areas are less likely to volunteer.

A number of older people are also **informal carers**, some of whom would not describe themselves as volunteers. The recent State of Caring report found that an estimated 63% of unpaid carers in the UK are aged 55+. The recipients are largely **older parents, spouses and partners**. But, unpaid care does not yield the benefits of volunteering.

An estimated 34% of unpaid carers are also in **full or part-time paid work**, meaning they get no respite time.

In addition, unpaid carers often experience **poor physical and mental health**, as well as having a variety of **unmet care needs** themselves. These can include financial issues that cause anxiety and stress, with the average carer fronting over £114 a month of their own income to support those they care for.

While COVID restrictions stopped some older people from providing care to others during the pandemic, many had to **increase the level of care they provided**. Those aged 80+ were least likely to stop or reduce care.

Some older adults actually became new carers during the pandemic. And nearly half a million people – around 600 every day – have had to **give up work** to care for others over the past two years.

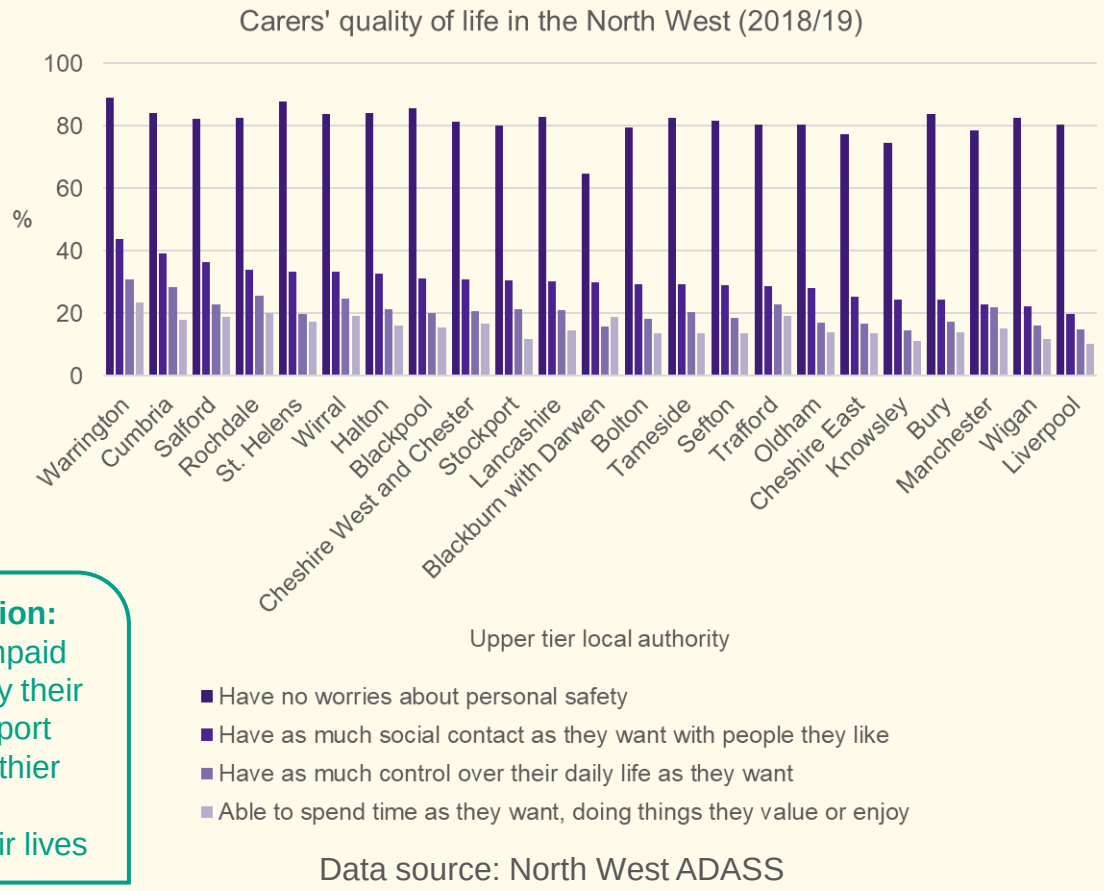
Caring should be considered a social determinant of health

A PHE review explored the consequences of being an unpaid carer of older people, and found mounting evidence that unpaid caring should be considered a **social determinant of health**. However, there is a lack of clear and robust evidence about how best to support people caring for older populations.

Data from the Survey of Adult Carers 2018/19 shows that, while many carers in the North West have no worries about their personal safety, few feel they have **control over their lives** or are able to spend their time as they want with people they like.

Many **unpaid carers** of older people are friends or family members, and this is an important resource for people in need. However, in recent years there has been a steep decline, for every age group, in the proportion of people who report that they 'definitely' have **someone to rely on**.

Recommendation:
Engage local unpaid carers to identify their needs, and support them to be healthier and have more control over their lives



Data source: North West ADASS

Ageing without children increases the need for formal care, and we should plan accordingly

There have been **huge social changes** in recent decades, including:

- changes in household size and structure
- people living far away from family members
- increasing numbers of older 'out' LGBT+ people

There are a number of older people who have not had children either through **choice, infertility or circumstance**, including the LGBT+ community. Others have children who have **predeceased** them, have care needs of their own, or are **unwilling** to offer help and support because they are estranged or have no contact.

The increased mobility and migration of people today also results in some families **living far away** from their older relatives, and being unable to offer help or support. All these older people are ageing without children.

Ageing without children can leave people **without support and help** at a time when they need it most, meaning they are:

- 25% more likely to **go into a care home**
- a third more likely to **be carers** for their own parents

Today, 20% of people aged 50+, and 10% of people aged 60+ have no children. But there is **predicted to be an 80% increase** in the number of single, childless older people needing care by 2032.

Work is ongoing to **raise awareness and understanding** of the issues affecting people ageing without children, and to advocate the inclusion of this **group in mainstream discussion** on ageing. Preparation and planning for this will be key to managing the increased care needs of the next decade.

Recommendation:
Engage those ageing without children in your local area when planning future service provision

Up to 40% of older people in the North West live alone, and up to a third of people feel lonely

Regardless of whether or not they have children, many older people **live alone**. Data from the 2011 Census* show that this applies to over a third of residents in 15 North West local authorities. This can lead to **social isolation**, especially if people don't leave the house very much.

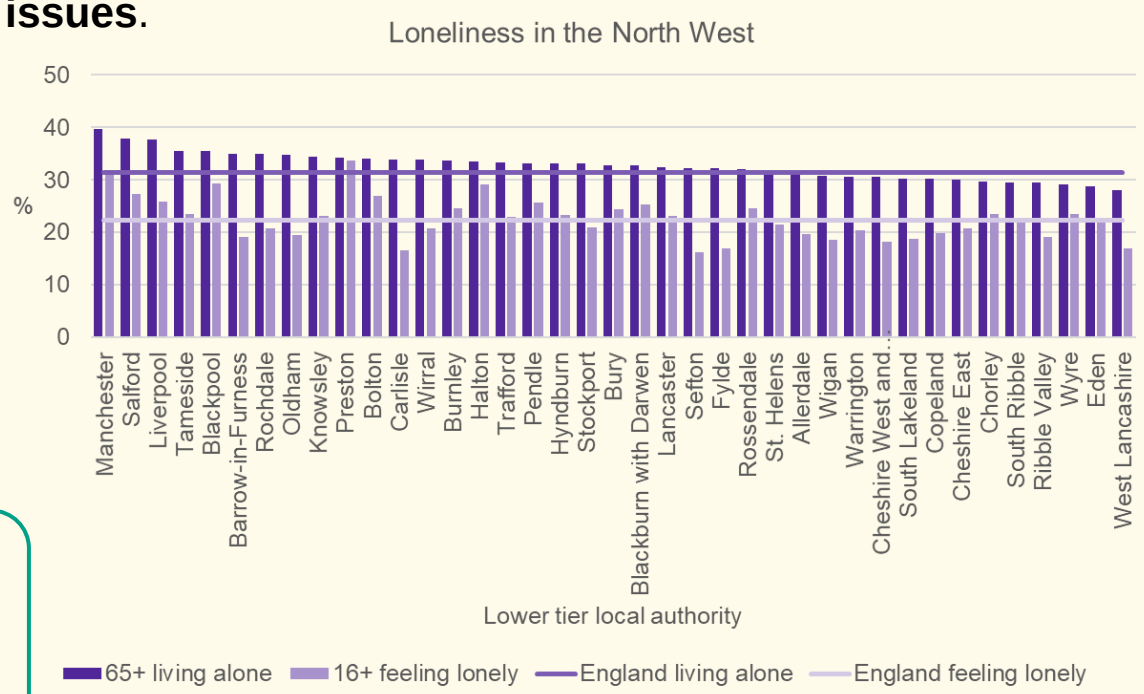
Areas in the North West with the **highest proportions** of older people living alone tend to be in more urban areas:

- Manchester: 39.7%
- Salford: 37.9%
- Liverpool: 37.6%
- Tameside: 35.5%
- Blackpool: 35.4%

Up to a third of people of all ages in the North West feel lonely often or some of the time. Older people are likely to be more vulnerable to loneliness **following illness or loss** of mobility, job and income, or a spouse, family or friends. Those who are LGBT+ or have a disability are particularly vulnerable to loneliness.

*Census 2021 data will provide updated local figures.

Research has found that the over-50s are over five times more likely to be lonely if they are **widowed**, nearly four times more likely to be lonely if they are in **poor health**, and more than twice as likely to be lonely if they have **money issues**.



Data source: OHID Productive Healthy Ageing Profile

COVID-19 restrictions have increased social isolation, loneliness and abuse in older people

Evidence shows that **loneliness in older people has increased** during the COVID pandemic, despite current rhetoric about impacting younger age groups more. Even before COVID, younger age groups reported feeling lonely more often, but this doesn't mean it's not an issue for older people.

During the pandemic many older people had regular contact with family and friends, either by phone, videocall, or written contact, but they have still felt that **social distancing regulations** made them experience less social contact and support, and more loneliness. Many older people have also **lost partners, relatives and friends** during this time and have not been able to say goodbye or attend funerals.

The rise in loneliness during the pandemic was **steeper for older people with multimorbidity**, and women and those who are most deprived felt more lonely than others.

As might be expected, loneliness was much more common in **high-risk isolating groups**. However, this was regardless of whether or not they had a partner, highlighting that loneliness does not only occur in those who are socially isolated.

Social isolation also makes older people more **susceptible to abuse**, which can be physical, emotional, financial, neglect, or any combination of these. During COVID-19 lockdowns there has been great concern about the rise in domestic abuse, but **elder abuse is a hidden issue** which has never been widely talked about, even before the pandemic.

Recommendation:
Ensure opportunities are available to remain engaged with creative, learning and cultural activities as people age

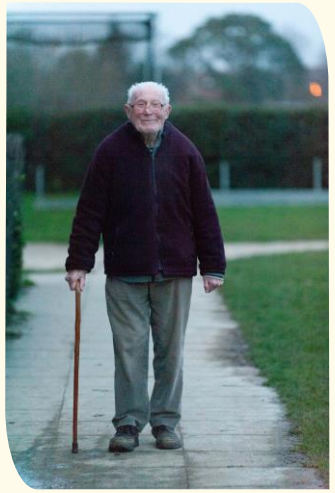
We should build new models of living in later life to prevent the negative impacts of loneliness

Loneliness and social isolation are **not the same**. People can be isolated without feeling lonely, or be surrounded by others and still feel lonely (Age UK).

But, both loneliness and social isolation can have a **serious impact on older people's physical and mental health and wellbeing**, increasing the likelihood of early death by 26%. And research has found that people aged 65+ who live alone are 50% more likely to go to A&E than those who live with someone else. They are also at increased risk of being admitted to hospital as an inpatient.

Some older people are more likely to be socially isolated & lonely than others, including disabled & LGBT+ people. And, as our population ages, older generations are becoming more diverse and traditional family structures less common. Building **new models of living in later life** is becoming ever more important to ensure that people stay connected as they age.

For some, this might mean co-housing, or specialist LGBT+ retirement housing. For others, it simply means **finding ways to be more connected** to communities, which provide invaluable support networks, as well as keeping us active and making us feel valued as we age.



Recommendation:
Ensure diverse housing options meet the needs of older people across all tenures

Recommendation:
Adopt a range of community centred approaches that encourage community participation from people of all ages

Around a third of homes need work to make them suitable for healthy ageing

There are 4.3 million **non-decent homes** in England, of which, almost half are lived in by someone over the age of 55. Poor housing such as this creates hazards that cost the NHS an estimated **£2.5 billion per year** (across all ages).

The cost to the NHS of poor housing is **over three quarters of the cost of alcohol abuse** and 2.5 times the cost of physical inactivity.

Most older people aged 65+ **own their own home**, with more than 90% living in mainstream housing. However, the number of over 55s living in **private rented accommodation** has more than doubled since 2003 – a trend that is set to continue – and one in five of these homes is classified as non-decent.

The **levels of satisfaction** of private renters with their accommodation and local area are lowest in the North West. Private renters in our region also have **higher average costs** (£10,569) to make their homes decent.

Recommendation:
Help people remain healthy, active and independent by improving the quality of local housing and future proofing new housing making them accessible and adaptable

Recommendation:
Support low income owner occupiers to access funds to repair and improve their home

Some **Travellers** move into 'bricks and mortar' as they age. However, there is a growing number of older people who have previously lived in bricks and mortar accommodation, who **now live on boats**. This poses new challenges that this group has not previously had to consider.

Housing is an important factor in keeping people independent. However, around a third of people aged 50+ say their **home needs work** to make it suitable as they get older, particularly those who are struggling to get by financially. Additionally, more than half of people aged 50+ who move home **don't downsize**.

At least 9% of households in North West local authorities experience fuel poverty

Nearly half a million homes lived in by someone aged 55+ are **excessively cold**, risking poor health outcomes, and contributing to excess deaths in winter. Fixing this alone could save the NHS over £300m. It could also save people from falling into **fuel poverty**, which is distinct from general poverty.

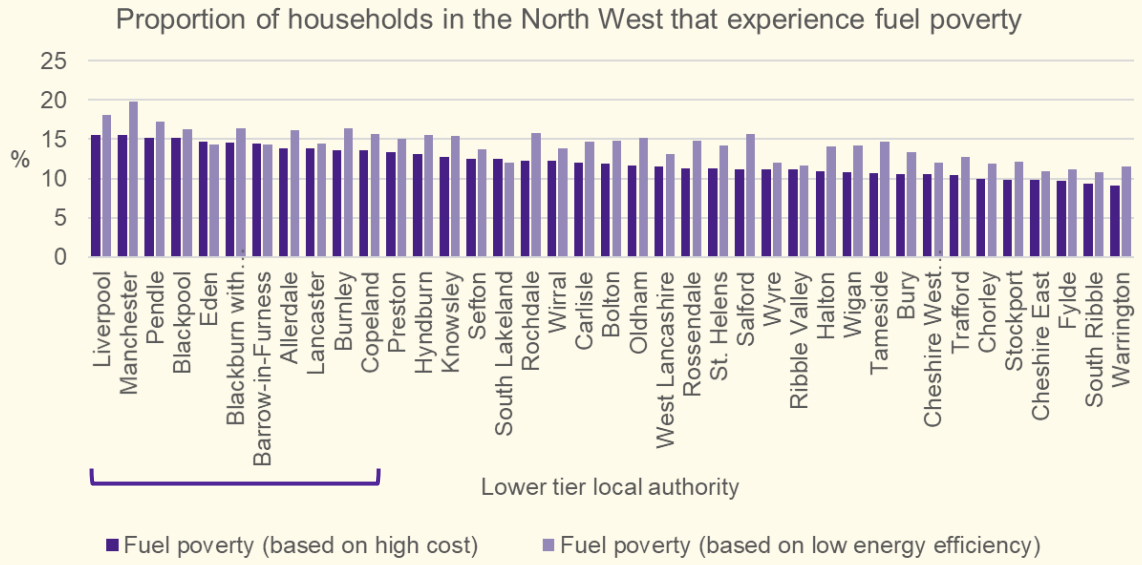
Not all poor households are fuel poor, and some households that wouldn't normally be considered poor **could be pushed into fuel poverty** if they have high energy costs.

A household is considered to be fuel poor if they have required fuel costs that would leave them with a **residual income below the official poverty line**.

The **drivers of fuel poverty** are considered to be low income, poor energy efficiency, and high energy prices. The **North West** performs worse when considering **high energy prices** rather than low energy efficiency to calculate fuel poverty. Manchester and Liverpool have two of the highest fuel poverty rates in the country.

When considering **high energy costs**, 11 out of the 20 most fuel poor local authorities in the country are in the North West (marked on chart).

When considering **low energy efficiency**, Manchester and Liverpool are two of the most fuel poor local authorities in the country.



Data source: OHID Productive Healthy Ageing Profile

COVID-19 lockdowns have magnified the existing effects of poor-quality housing

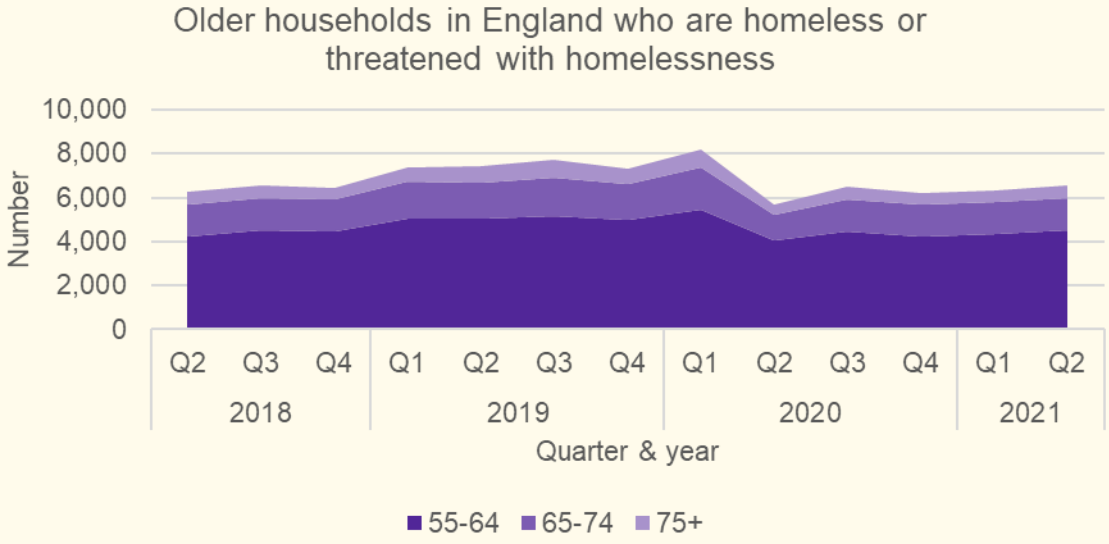
The association between older people and poor housing conditions is well-established. But the impact of COVID-19 and the reduced access to health and social care on older people's health has created a **critical situation**.

Living in a non-decent home during this time is associated with **worse health**, and overcrowding with **worse mental health**. Together, these create a much larger effect on health (Care and Repair England, 2021).

Organisations providing specialised support to older homeowners have also been particularly concerned about the **under-reporting of repairs** and the impact this is having on already poor living standards and unsafe environments.

The number of older households who are **homeless** or threatened with homelessness dropped from record highs early on in the pandemic. However they are now **back on the rise**, making up 9% of all homeless households. People experiencing homelessness suffer from **early ageing** and significantly more premature mortality.

As the NHS and Social Care face ever more pressures, an important housing contribution that can help to reduce these crisis demands is **immediate, targeted (and resourced) action** to make the homes of disadvantaged older people safer, healthier places to age well and, where care is needed, good places to be looked after.



Data source: DLUHC Live tables on homelessness

People aged 50+ are likely to be long-term unemployed or earn less

The **employment rate** of people aged 50-64 has increased over time, reaching 73% before the COVID-19 pandemic. By the time they are 65, **nearly half of men and a third of women** are still in employment. Those who work **part-time** are three times more likely to be women than men.

The **menopause** can have a real and lasting impact on women's working lives. This continues to be an issue that is **largely ignored** by employers, but a survey found that 1 in 4 consider leaving work due to severe symptoms, which can include fatigue and 'brain fog'.

Health is the leading reason for the 50+ to be out of work, and the **disability employment gap** is especially large for older workers. However, **caring responsibilities** and a lack of skills or training are other contributors. The result is that the 50+ who are unemployed are twice as likely as the youngest adults to be long-term employed.

Workers aged 50+ are the least likely to receive 'off the job' training, and 40% of 55-64 year olds have undertaken **no formal training or education** since leaving school. This impacts their ability to keep up to date with new skills and gain further employment.

Finances are a key part of **planning for retirement**. However, the Department for Work and Pensions (DWP) has estimated that 38% of the working age population (12 million people) are not saving enough and are facing an **inadequate retirement income**.

While this will also be linked to regular spending, **median weekly earnings** typically peak in people's 40s and begin to decline in their 50s and 60s, particularly for full-time workers. Additionally, the **gender pay gap** is largest for women in their 50s, who are more likely to be working part-time.

The COVID-19 pandemic means some older people will have a lower retirement income

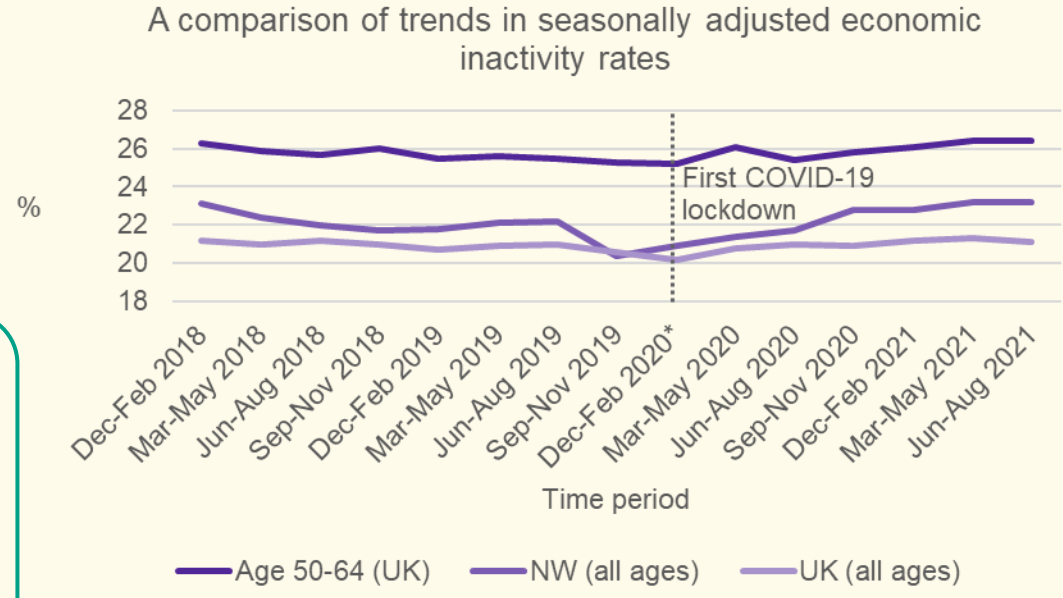
Deprivation has been further impacted upon by the COVID-19 pandemic in 2020-21. Since the COVID-19 pandemic began, **economic inactivity** has increased by 11% in the North West, more than double the rise in the UK overall (4%). The national trend in those aged 50-64 is similar to the UK, and was sitting at 26.4% in June-August 2021. However, it is likely that this figure is higher in the North West.

Our rapid review of evidence* has shown that most retirees and those on a fixed income have been economically unaffected during COVID-19. However, some older workers have **lost their jobs** because of the pandemic, and many have experienced a lower household income. As a result, nearly half of older workers expect a **lower retirement income**, and some will retire later than planned.

Recommendation: Identify older people locally who are out of work and help them develop the skills they need to get back into work if they wish

*Rapid review to be published at a later date

Employment rates are now back on the rise again as **job vacancies** reach record levels. There are job sectors with staff shortages that may be **open to older workers** who want to return and have the right skills, or are willing to re-train – the best opportunities may be in health, social work and social care, teaching, IT and construction.



Data source: OHID WICH monitoring tool

We should support older people to lead fuller and longer working lives

The proportion of the working age population aged between 50 and the state pension age will increase to 34% in 2050. Therefore, **encouraging older people to remain in work**, even if part-time, will help society to support growing numbers of dependents, while providing individuals with the financial and mental resources needed for longer periods of retirement.

A 1% increase in the number of people aged 50-64 in work would increase GDP by around **£5.7 billion per year**.

The ageing population **presents opportunities** to individuals and society. However, as with any major demographic change, it **also presents challenges**, and ignoring these could undermine the potential benefits of living longer.

The Centre for Ageing Better has published an **evaluation of flexible working arrangements** for the over 50s.

According to the Government Office for Science (2016), **priority areas** include:

- supporting the ageing population to lead **fuller and longer working lives**
- **adaptations** to the workplace
- ensuring individuals **re-skill** throughout their life time
- addressing falling participation in **lifelong education and training**, as well as barriers to later in life learning
- specific focus on **technological and financial skills** through life

Recommendation:
Work with local employers to develop age-friendly policies that enable the recruitment and retention of older people in work

4. Health and wellbeing

- Life and health expectancies
- General health:
  - Falls
  - Dementia
  - Sensory impairment
- General health:
  - Multi-morbidity
  - Health behaviours
  - Sexual health
  - Mental health

Older people in the North West live only up to 60% of their lives in good health

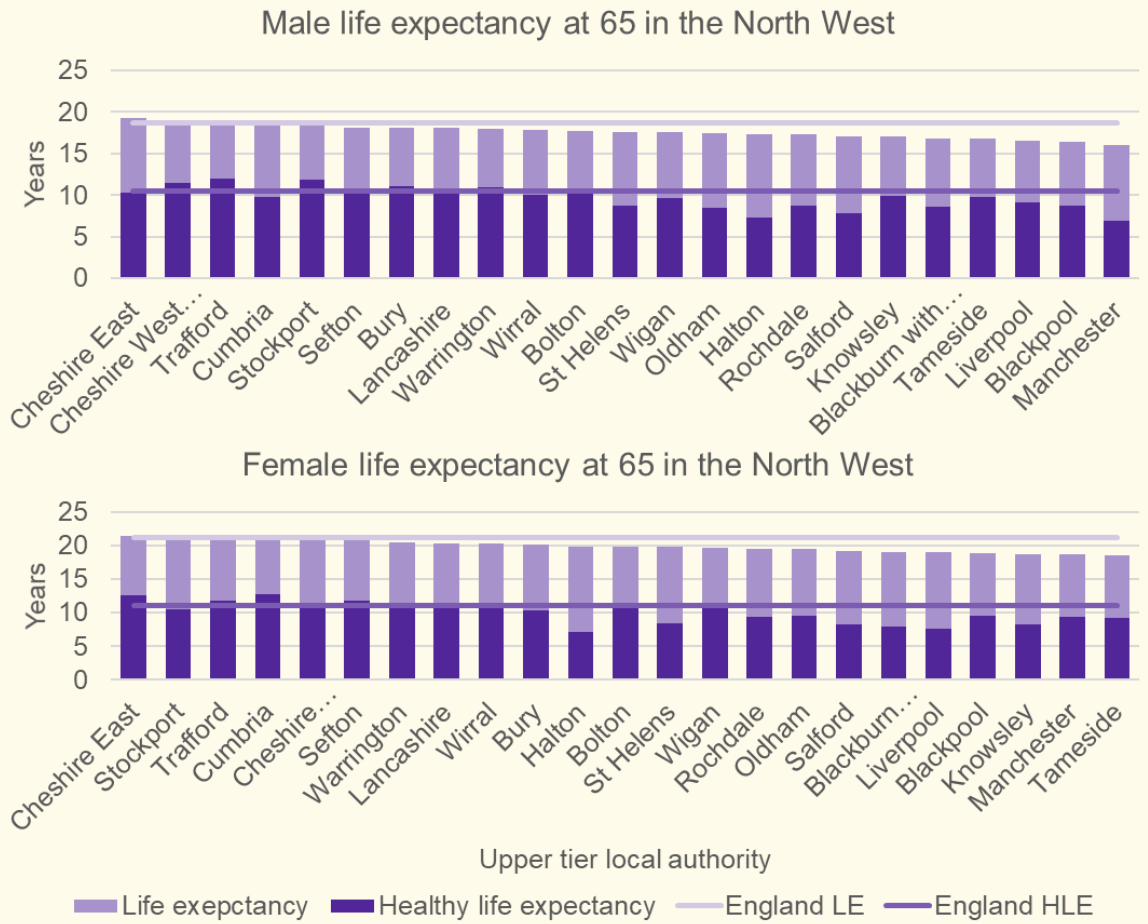
Life expectancy (LE) in the UK has **increased over the last 40 years**, primarily because of **improvements in mortality** at older ages driven by advances in **health care**, and improvements in **living and working conditions** (ONS, 2021). However, progress on LE has stalled and we are living a longer proportion of our lives with disability.

Life and healthy life expectancies (HLE) in the North West are some of the **lowest in the country**; only three North West local authorities have LEs above England in both men and women:

- Cheshire East (19.3 and 21.4 years respectively)
- Trafford (18.9 and 21.4 years)
- Cumbria (18.9 and 21.2 years)

No North West local authorities have a HLE above the England average for both males and females, and the **percentage of life lived in good health** after 65 ranges:

- from 42% (Halton) to 63% (Trafford and Stockport) in men
- from 36% (Halton) to 60% (Cumbria) in women



Data source: OHID Productive Healthy Ageing Profile

There are social and ethnic inequalities in life expectancy which vary within local areas

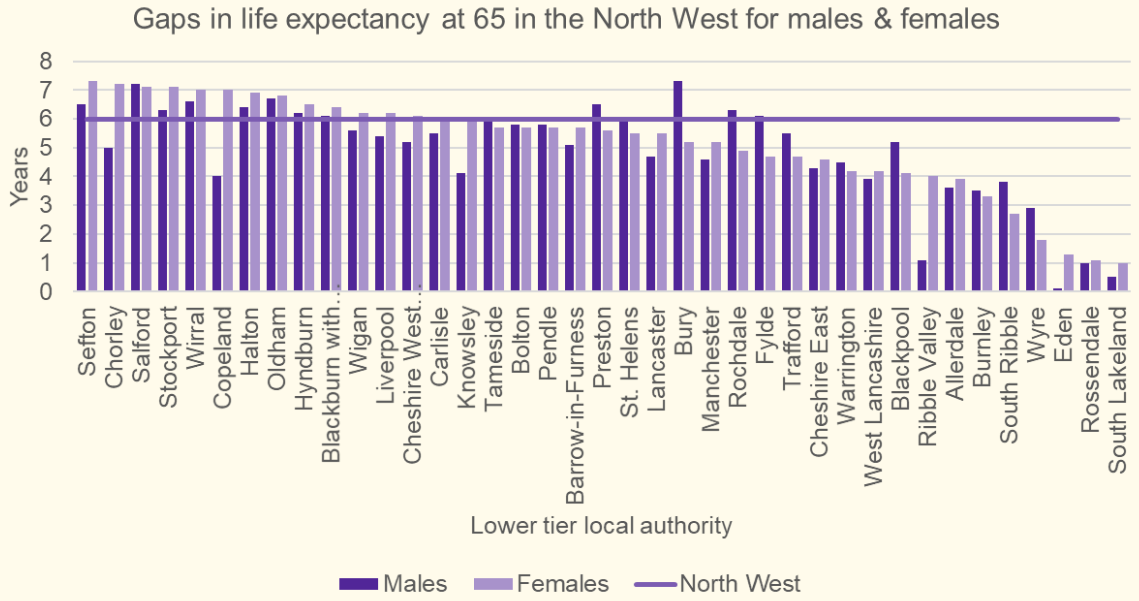
Life expectancy for people living in more affluent areas is significantly higher than for those living in deprived areas, resulting in some large gaps in life expectancy at 65. This **gap is higher in the North West** than in England (6.0 and 6.2 years for men and women in the North West, compared to 4.9 and 4.7 years in England).

Eight North West areas have **higher inequality** in life expectancy at 65 than the North West in both men and women:

- Salford
- Oldham
- Wirral
- Sefton
- Halton
- Stockport
- Hyndburn
- Blackburn with Darwen

Pre-COVID-19 experimental ONS data indicate that people from a **white or mixed** ethnic background have a **lower life expectancy** than other ethnic groups; men and women from a black African background live 3.8 and 5.9 more years, respectively, than those from a white background.

These experimental statistics **cannot be confirmed** in mortality statistics because ethnicity is not currently recorded at death registration. However, following the disproportionate impact of COVID-19 on ethnic minority communities, work is underway to make this mandatory (Kings Fund, 2021).



Data source: OHID Productive Healthy Ageing Profile

The leading cause of death is shifting from ischaemic heart disease to dementia and Alzheimer's disease

Approximately **half a million people die** in England each year, two-thirds of whom are aged 75+. Of deaths in this age group, a third were amongst people aged 90+ in 2017.

Ischaemic heart disease (IHD) has long been the leading cause of death in England. However IHD deaths have been steadily decreasing since 2001, and dementia and Alzheimer's disease is becoming the new leading cause of death.

In those aged 75+, ONS analysis shows that **dementia** was a contributory or underlying cause in a quarter of deaths in England in 2017. But **cancer and liver disease** deaths have also risen in this age group, while deaths from chronic heart disease and stroke have fallen.

In the North West, mortality rates in the 65+ from **cardiovascular disease, respiratory disease and cancer** are significantly higher than England. These deaths are avoidable through healthier behaviours.

They are also contributors to **underlying causes** of death:

- **respiratory disease** contributes to a significantly higher proportion of underlying causes of mortality in all ages in the North West
- **cardiovascular disease** contributes to a significantly higher proportion of underlying causes of mortality in 65-74s
- **cancer** contributes to a significantly lower proportion of underlying causes in 65-84s

Data show that there are **inequalities** in mortality by deprivation and ethnicity:

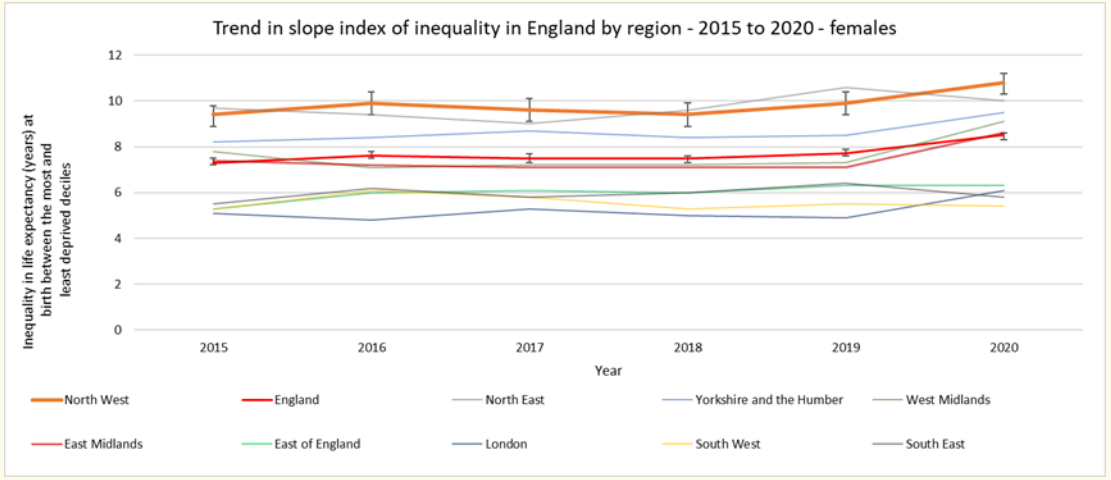
- people from **more deprived areas** die at younger ages
- ischaemic heart disease mortality is highest in the **Bangladeshi, Pakistani and Indian groups**
- people from a **white ethnic background** are more likely to die of cancer than their Black or Asian counterparts

The North West had the highest COVID mortality rate in England and inequalities are persisting

COVID-19 caused a **drop in life expectancy** across the country in 2020 as age-standardised mortality rates (ASMRs) in England **increased significantly**. These rates were significantly higher than every year back to 2010 in males and 2009 in females.

The North West had the **highest mortality rate** in England for deaths due to COVID-19 in 2020: 176 deaths per 100,000 people. **Excess deaths** in the North West were highest in those aged 75-84, but the ratio of registered to expected deaths was highest in those aged 50-64. More information is available here.

Early 2021 data shows a **small lift** back towards pre-pandemic levels. However, **inequalities** in life expectancy in the North West appear to be persisting, albeit at a smaller increase than in some other regions of the country (WICH).



Data source: OHID Wider Impacts of COVID-19 on Health

Independence is important in older age, but health related quality of life is lower in the North West

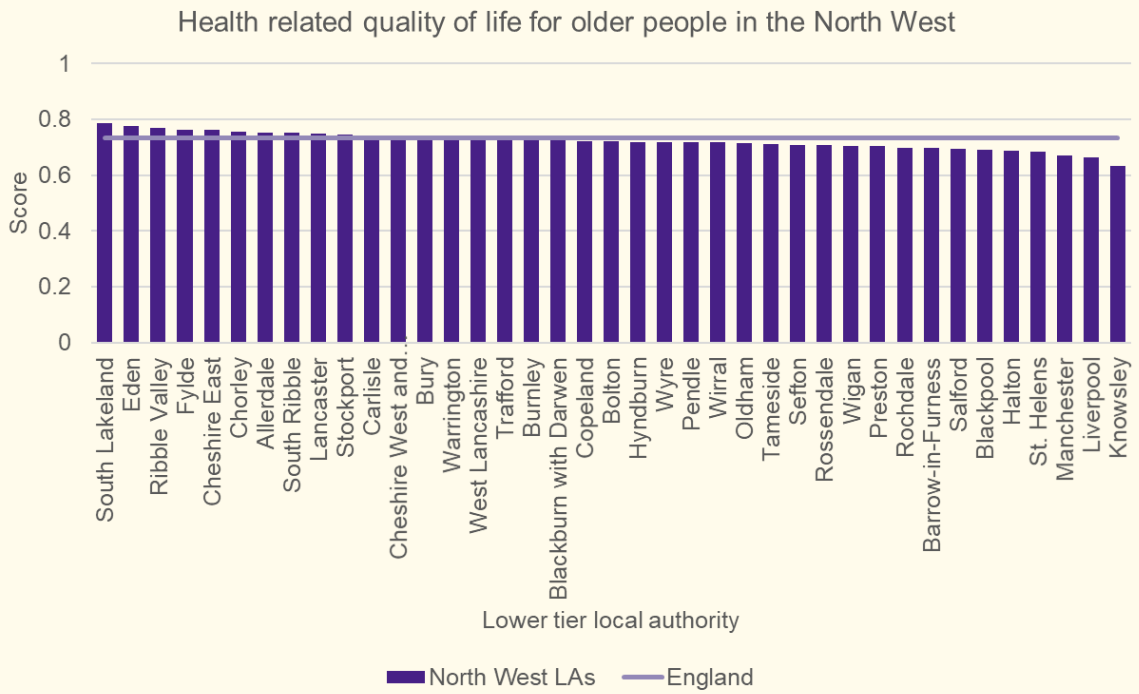
Health-related quality of life (HRQoL) for older people gives an indication of how healthily they are ageing and how independent they are.

It is measured using the **EQ-5D scale**, which is also widely used to calculate quality-adjusted life years (QALYs) in NICE economic evaluations. This measure ranges from 0 (bad) to 1 (good). It asks respondents to describe their health status using **five dimensions**:

- Mobility
- Self-care
- Usual activities
- Pain / discomfort
- Anxiety / depression

But HRQoL in the North West is **significantly worse than England**, varying across the region. The North West local authorities with the lowest HRQoL are:

- Knowsley (0.634)
- Liverpool (0.663)
- Manchester (0.672)
- St. Helens (0.685)



Data source: OHID [Productive Healthy Ageing Profile]

Falls are the number one reason for older adults going into long term care

Falls are a large contributor to **loss of independence** in older age with potentially devastating consequences. They are a **common cause of injury**, which can sometimes be fatal.

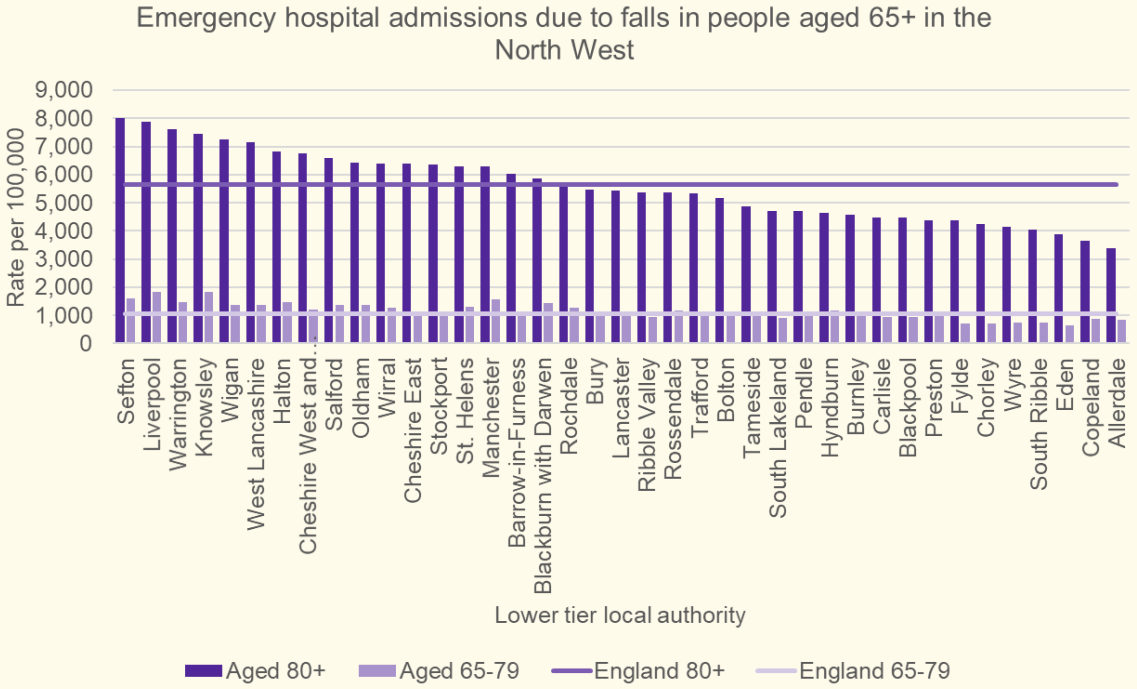
Around one in three adults aged 65+, and half of those aged 80+, fall at least once a year. This **costs the NHS** over £2bn a year and over 4 million bed days. The impact on the individual can be wide-ranging, causing pain, injury, distress, **loss of confidence** and a greater risk of death.

A first fall can set in motion a **downward spiral** of fear of falling which, in turn, can lead to more inactivity, loss of strength and a greater risk of further falls. For this reason, falls are the **leading precipitating factor** for older adults going into long term care.

The North West has **particularly high** levels of emergency hospital admissions due to falls in people aged 65+, with wide variation between local areas.

The North West's **highest falls rates** occur in:

- Liverpool
- Knowsley
- Sefton
- Warrington



Data source: OHID [Productive Healthy Ageing Profile]

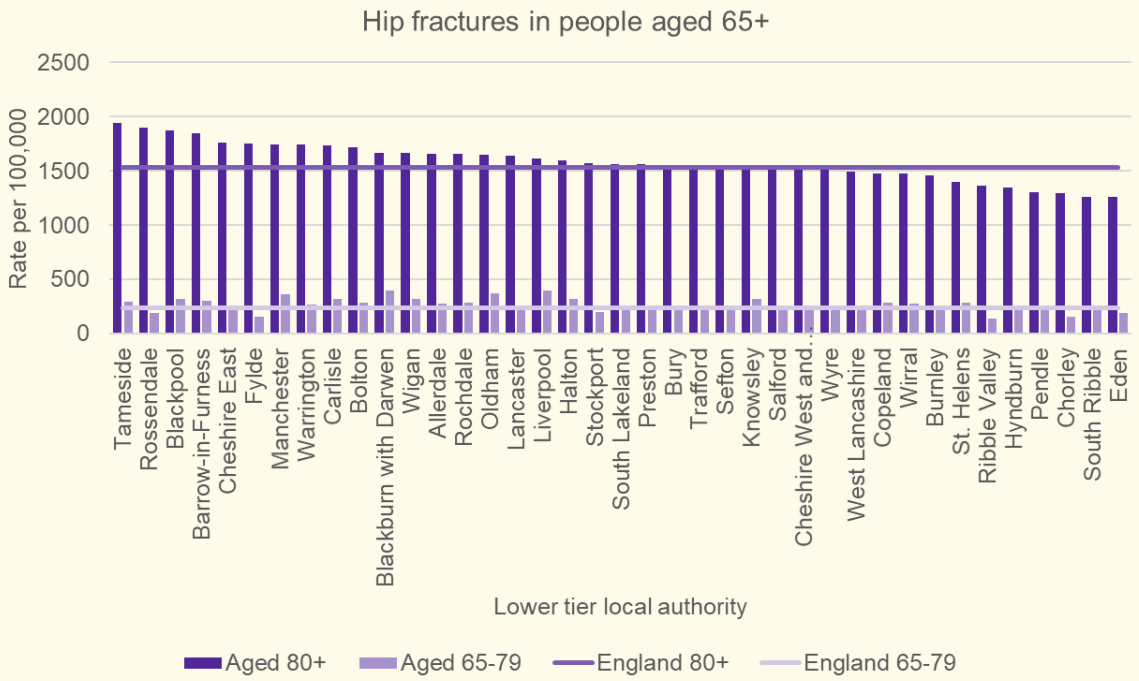
Hip fractures make it difficult to retain independence and can be life-threatening

Hip fractures are a common outcome of falls, though they are not always directly related. Hip fractures are also caused by other factors, primarily **low bone mineral density**, which can lead to osteoporosis.

The average age of a person with a hip fracture is about 83 years, and about 73% of fractures occur in women. Only one in three hip fracture sufferers return to their **former levels of independence**.

In the North West, **emergency hospital admissions** for hip fractures are significantly higher than the England average, leading to frailty, a loss of independence and an increased risk of mortality – around one in 10 people with a hip fracture die within one month and around one in three within 12 months.

Sadly, osteoporosis is often only **diagnosed** when a fall or sudden impact causes a bone to break.



Data source: OHID [Productive Healthy Ageing Profile]

Osteoporosis is most common in post-menopausal women, but there are ways to reduce the risk

Post-menopausal women are by far the most common sufferers of osteoporosis, due to the **rapid bone loss** in the first few years after the menopause. This is due to the **reduction in oestrogen** levels that occur during the menopause. Oestrogen is important for maintaining bone density.

The menopause is a **natural part of ageing** in which women's hormone levels change. But whether a woman develops osteoporosis after menopause depends on the **strength of her bones** before the menopause, her **age at menopause** (younger age increases the risk), and the **rate of bone loss**.

Hormone replacement therapy can protect women experiencing premature menopause against osteoporosis, but there are risks and benefits to this treatment.

But osteoporosis **does not have to be a part of ageing**, for anyone. Those at risk of developing osteoporosis, including peri-menopausal women, should take steps to help keep their bones healthy:

- taking **regular exercise** to keep bones as strong as possible
- **healthy eating** – including foods rich in calcium and vitamin D
- taking a daily supplement containing 10 micrograms of **vitamin D**
- making **lifestyle changes** – such as giving up smoking and reducing alcohol consumption

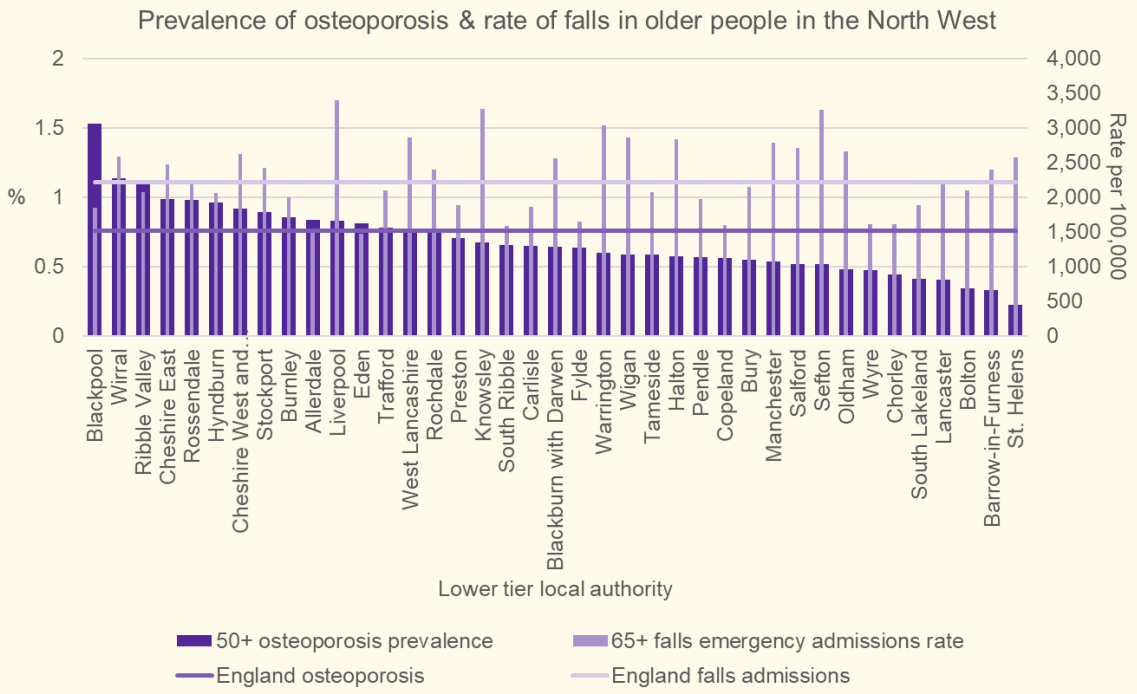
Diagnosing osteoporosis is important in preventing future falls and may need to be improved

Osteoporosis is **difficult to diagnose** before a fragility fracture occurs, generally in the hip, spine or wrist. However, this is an important step in preventing future falls and fractures.

In the North West 0.7% of the over 50s have been **diagnosed with osteoporosis**, but this varies considerably across the region and does not tally with emergency admissions for hip fractures.

Some North West local authorities have **particularly low osteoporosis prevalence** when compared to hip fractures. Effective diagnosis may need to be mapped against the NICE quality standard for osteoporosis, which states that adults who have had a fragility fracture or a history of falls **should have an assessment** of their fracture risk:

- St. Helens (0.2%)
- Barrow-in-Furness (0.3%)
- Bolton (0.3%)
- Lancaster (0.4%)
- South Lakeland (0.4%)



Recommendation:
Use local data to review the proportion of adults aged 50+ with a history of falls who have had an assessment of their fracture risk

Data source: OHID
Productive Healthy Ageing Profile

Falls are not a ‘normal’ part of ageing, and they can be prevented by strength and balance exercises

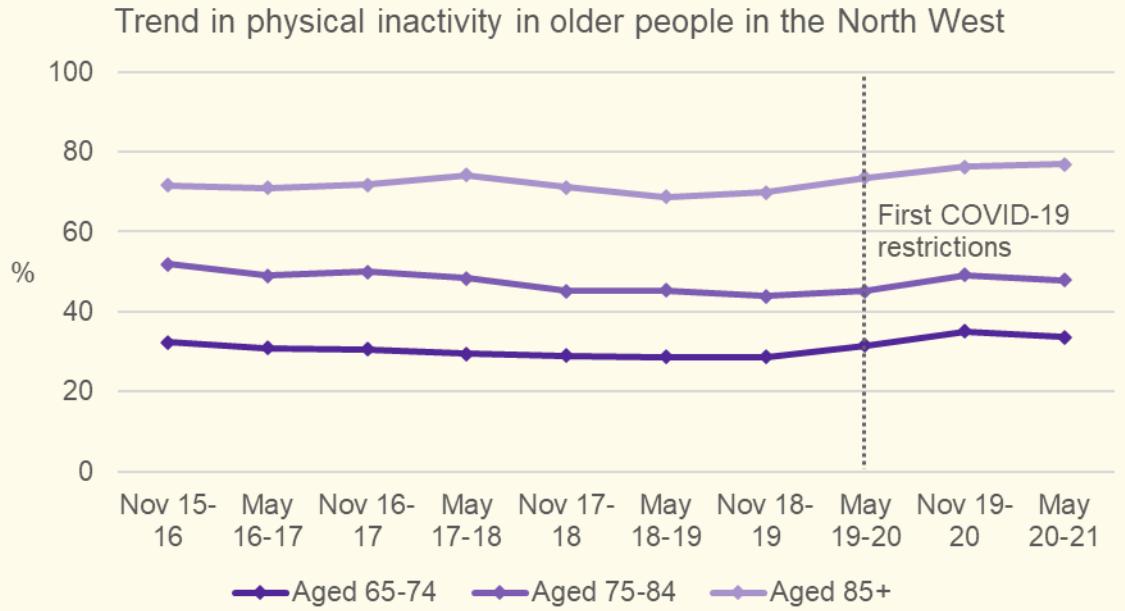
Whilst declines in muscle mass and bone density start to occur from around 50 years of age, falls are not a natural part of the ageing process and are **preventable**.

Reasons for older people falling include muscle weakness, poor balance, effects of medication, sensory impairment, and environmental and home hazards. All of these can be addressed to help older people stay independent.

Physical activity, particularly strength, balance and flexibility exercises, is one essential element in preventing falls. According to UK Chief Medical Officers' Physical Activity Guidelines (2019), older adults should aim to accumulate **150 minutes per week** of moderate intensity aerobic activity, building up gradually from current levels.

However, the proportion of people who are **physically active** decreases with age, and older people in the poorest neighbourhoods are much more likely to be physically inactive than people in the wealthiest.

Before the COVID-19 pandemic, **physical inactivity levels were falling**, with fewer than half of people aged 75+ in the North West inactive*. Since COVID-19 however, physical inactivity has risen again to higher levels than 2015/16.



Data source: Sport England Active Lives

*Inactive is less than 30 minutes of moderate activity per week

COVID-19 has increased deconditioning and inequalities, and strategies are needed to address this

Our rapid review of evidence* shows that the impact of COVID-19 on physical activity has been seen across all ages. **Inequalities have also widened**, with larger rises in physical inactivity seen in those in more deprived areas and those from Chinese, Asian and 'other' ethnic backgrounds.

During the pandemic, many older people, especially those shielding and from ethnic minority groups, have been reluctant to go out for fear of catching COVID-19. They have instead stayed home for long periods. While this has reduced the number of falls occurring, it has also led to higher levels of physical inactivity and **deconditioning**.

Deconditioning is the **physical, psychological and functional decline** that occurs as a result of prolonged inactivity and associated loss of muscle strength.

If this issue goes unaddressed, **falls are projected to increase** considerably, costing the health and social care system £211m over 2.5 years (PHE, 2021).

As normal life resumes, it is essential that **recovery plans** include strategies to address deconditioning and falls prevention. Whole population approaches, as well as targeted interventions, should include **strength and balance exercises** such as FaME and Otago.

But physical activity is not only important in preventing falls. It also has an important role in wider health and wellbeing, **physically, mentally and socially**. Our rapid review* indicated that older people who were more physically active during the pandemic were also less socially isolated.

Health and social care services should therefore ensure a **joined up approach** with an emphasis on early intervention.

Recommendation: Distribute the 'Active at Home' booklet to older people most affected in your local area

Recommendation: Target evidence-based strength and balance programmes at an individual level to those most affected by the pandemic

*Rapid review be published at a later date

Dementia takes many different forms and can have a huge impact on individuals, their carers and the economy

Dementia is another key reason for loss of independence in older age, associated with an **ongoing decline of brain functioning**.

Dementia is not a disease itself, but a collection of symptoms that result from damage to the brain **caused by different diseases**, such as Alzheimer's disease or vascular dementia. These are the two most common types of dementia, but there are many others.

Symptoms **vary** according to the part of the brain that is damaged. They may include memory loss, mood swings, confusion, and difficulty concentrating or following a conversation. It **affects a person's mental abilities**, and can interfere with daily living.

The symptoms of dementia **usually become worse** over time and, in later stages, people will usually need help from friends or relatives. In some cases they will need **constant care and attention**, in the community or in a care home.

An estimated one in three people will **care for a person with dementia** in their lifetime. This can be challenging and have a huge impact on carers' lives, including reducing working hours or leaving work altogether.

This contributes to the huge economic cost associated with dementia, estimated at **£29.5 billion a year** (LSE, 2019). This is more than the cost of cancer, heart disease and stroke combined, and **looks set to triple** by 2040.

The risk of dementia increases with age, but it is **not a natural part of ageing**. And while there is no certain way to prevent all types of dementia, there is good evidence that a **healthy lifestyle** can help reduce the risk of developing dementia in older age. NHS Health Checks encourage this.

A healthy lifestyle can also **prevent cardiovascular diseases**, such as stroke and heart attacks, which are themselves risk factors for Alzheimer's disease and vascular dementia.

Poorly managed dementia has severe consequences, but these are avoidable

It is important to **catch dementia early**, to slow its progression and maintain mental function longer. And with **treatment and support**, many people with dementia can lead active, fulfilled lives.

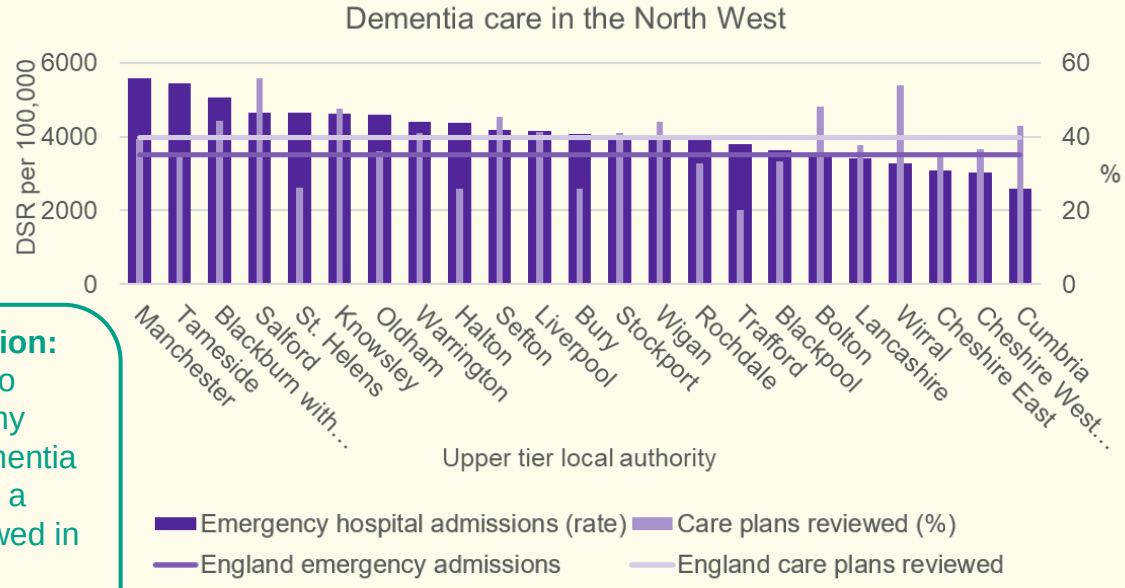
However, poorly managed dementia can lead to **emergency hospital admissions** for avoidable illnesses and injuries. This unfamiliar environment can trigger distress, confusion and delirium for someone with dementia, contributing to a **decline in functioning** and a reduced ability to return home to independent living.

In the North West, emergency hospital admissions for dementia in those aged 65+ are **significantly worse** than England. Only five North West local authorities have lower rates than England:

- Cumbria: 2,591
- Cheshire West and Chester: 3,019
- Cheshire East: 3,071
- Wirral: 3,267
- Lancashire: 3,423

Recommendation: Use local data to review how many emergency dementia admissions had a care plan reviewed in the previous 12 months

The support needs of dementia patients and their carers should be reviewed regularly, helping to prevent avoidable outcomes such as these. However, the proportion of **dementia care plans** that are reviewed every 12 months in the North West varies greatly, from just 20% in Trafford to 56% in Salford.



Data source: OHID Productive Healthy Ageing Profile

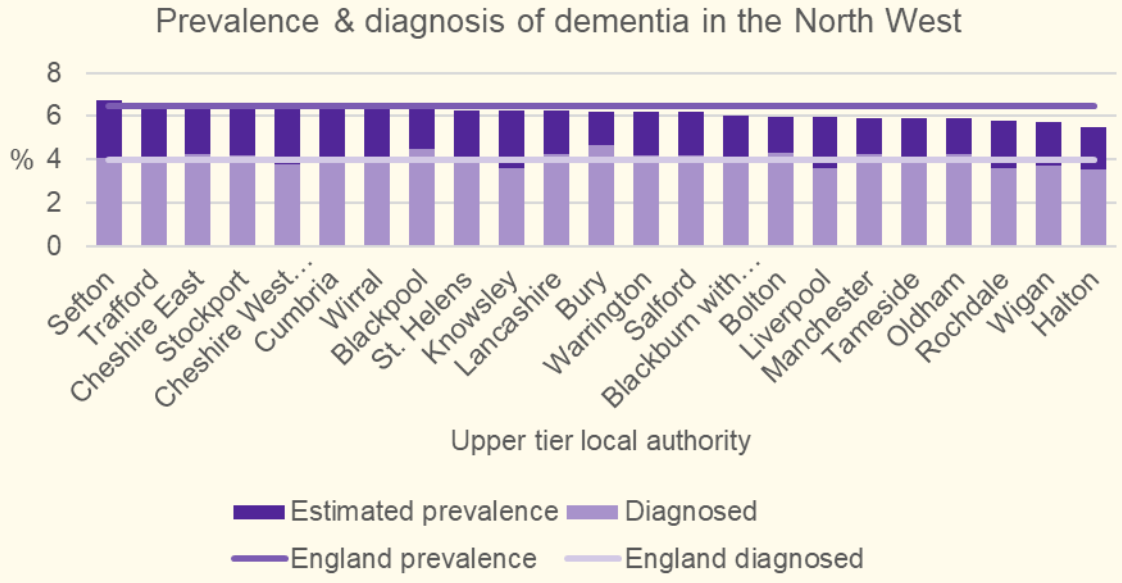
It is important to catch dementia early, but it can be difficult to recognise due to its slow decline

There are an estimated 748,000 older people with dementia in England at a prevalence rate of 7.2% (LSE, 2019). However, the prevalence of dementia diagnoses is only 3.97% meaning that **nearly half of all dementia cases go unidentified**.

By 2040 the estimated number of people with dementia is **set to increase** by 81% in England to 1.35 million older people. This will have a huge impact on individuals and society if cases are not identified. It is therefore essential that we **strive to identify** all dementia cases as early as possible.

The **recorded prevalence** of dementia in the North West is significantly higher than in England (4.04% compared to 3.97%), despite a similar diagnosis rate. As we are no better at diagnosing dementia, this suggests that dementia is a larger issue in the North West. However, **more needs to be done** to identify dementia in the region.

Dementia can be **difficult to recognise** due to the slow decline that it causes. It requires awareness and personal acknowledgement, as well as that of those close to someone with dementia. NICE provides guidance on **initial assessment** of dementia in non-specialist settings and NHS Health Checks provide advice to reduce risk.



Data source: OHID Productive Healthy Ageing Profile

COVID-19 has prevented many dementia diagnoses and jeopardised dementia care

COVID-19 and the consequent reduced access to health and social care has **disproportionately affected** people suffering from dementia.

Dementia diagnosis rates and memory clinic referrals have dropped, meaning that cases have not been identified, and **needs have gone unmet**. This decline has continued into 2021.

Our rapid review of evidence* also shows that there were **higher variations in social support usage** compared to pre-pandemic levels. This has presented huge challenges to people with dementia and their carers, resulting in **worse quality of life and increased anxiety** in those affected by dementia. This also risks cognitive decline.

Challenges faced during the pandemic include issues with **medicines management**, which are difficult for people with dementia even at the best of times. This is a group that is more likely to experience co-morbidities.

Compared to other older people, those with dementia living in the community **rely on support** from family, friends and primary healthcare professionals to ensure they are on the right medication and that they adhere to it. Community-dwelling older people with dementia should be considered a **priority for medication review**.

Health Checks are also an important opportunity to assess and advise on dementia risk.

Recommendation:
Prioritise medication review for people with dementia living in the community, particularly those living alone

Recommendation:
Ensure NHS Health Checks are being used effectively to raise awareness of dementia

*Rapid review to be published at a later date

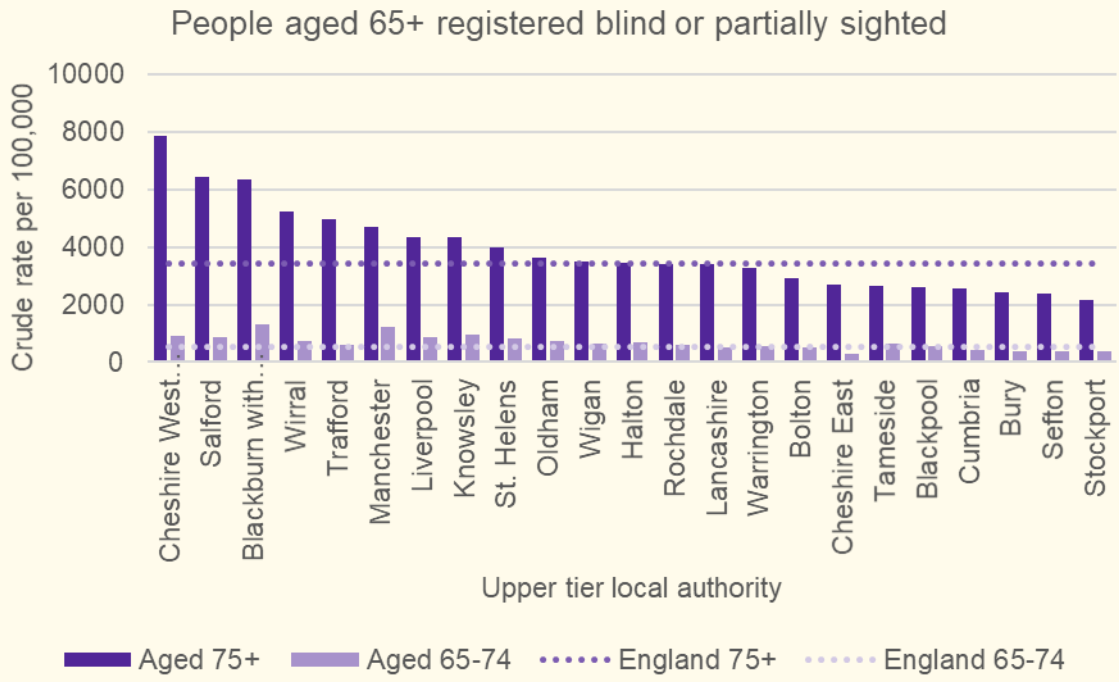
Sensory impairment can be debilitating, and is a barrier to accessing services

Sensory impairment is another issue that can reduce independence in older age. While **not limited to or expected in older age**, it is common at this point in life. Most commonly, sensory impairment refers to sight or hearing loss, or deafblindness (dual sensory impairment).

Loss of hearing and/or sight **can be debilitating**, with a wide range of negative impacts on health and wellbeing, increasing the risk of depression, falls and hip fractures, loss of independence, withdrawal from society and cognitive decline. They are also a barrier to accessing services and **may be overlooked** in health and social care.

A **significantly higher rate** of older people in the North West are registered blind or partially sighted than in England (3,743 per 100,000 aged 75+). However, there is **huge variation** across the North West, ranging from 7,850 per 100,000 in Cheshire West and Chester to 2,163 per 100,000 in Stockport.

Research by the Royal National Institute for Blind People (RNIB) suggests that 50% of cases of blindness and serious sight loss **could be prevented**.



Data source: OHID [Productive Healthy Ageing Profile]

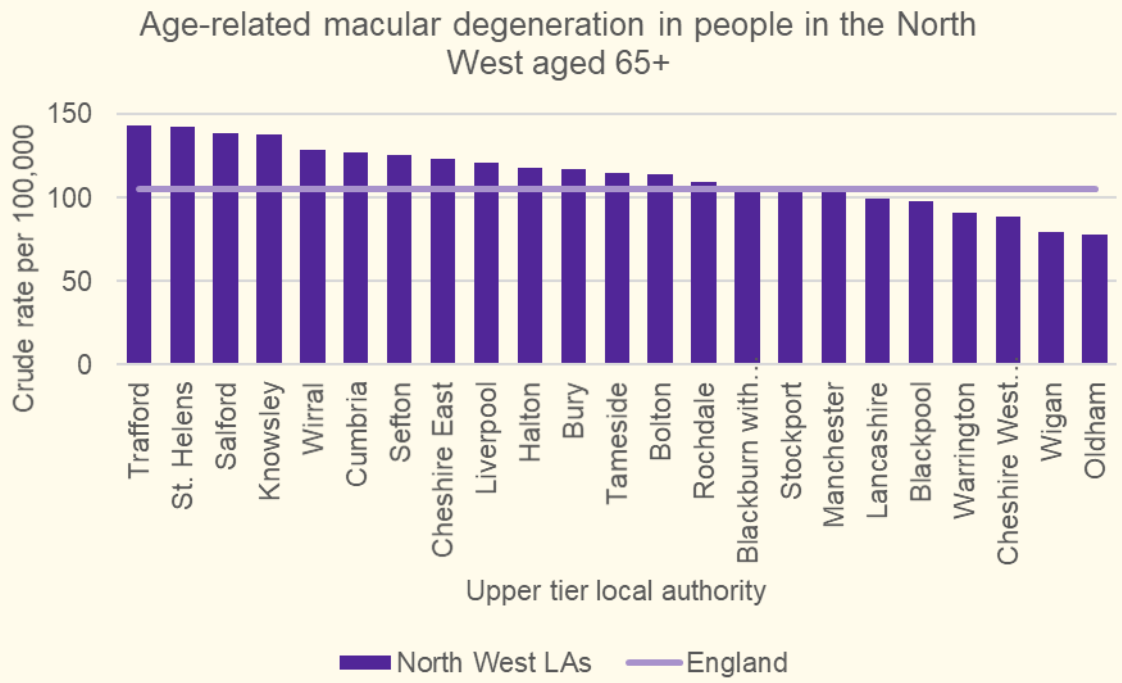
Two significant causes of sight loss are significantly higher in the North West

Age-related macular degeneration (AMD) is by far the **most common cause** of sight loss among older people in the UK, followed by glaucoma and diabetic retinopathy.

AMD predominantly affects the **central vision**, which is used for reading, and recognising faces. Glaucoma affects **peripheral vision** following damage to the optic nerve. And diabetic retinopathy follows **retinal damage** caused by poorly managed diabetes.

AMD and glaucoma are **significantly higher** in the North West than England. And while these conditions may not be preventable, sight loss as a result can be, through early diagnosis and treatment.

In the North West 111.7 per 100,000 people aged 65+ were **certified as having a visual impairment** in 2019/20 due to AMD, and 14.3 per 100,000 due to glaucoma. 2.9 per 100,000 were certified as having a visual impairment due to diabetic retinopathy.



Data source: OHID [Productive Healthy Ageing Profile]

There are social and ethnic inequalities in sight loss, but regular eye tests allow early detection and intervention

The risk of sight loss is **heavily influenced by health inequalities**. Data show that those in the poorest fifth of the population have an almost 80% higher risk of developing severe visual impairment than those from the wealthiest fifth (RNIB, 2015).

Research also shows **ethnic inequalities** in eye health. AMD is higher in people from a white background, and diabetic eye disease is higher in people from black and Asian backgrounds. The risk of glaucoma is also higher for people from a black background (RNIB, 2014).

This may be related to a **lower uptake of sight tests** in these groups, which would allow early detection and intervention. NHS advice is to have a **regular eye test** at least every two years, however many people do not visit an optician until they notice that something is wrong.

For adults with diabetes, annual **diabetic eye screening** is offered to prevent retinopathy. However, the uptake of this screening in the North West is significantly worse than in England, at 79.0% compared to 82.6%. This has been declining since 2015/16.

To reduce the risk of sight loss, **NHS advice** for older people is to:

- have regular eye tests
- wear the correct glasses
- eat well
- wear sunglasses
- quit smoking
- stay a healthy weight
- use good lighting
- exercise
- sleep well

Recommendation:
Promote regular eye tests and diabetic eye screening locally to prevent sight loss

Hearing loss is more likely as we age, but hearing technology can reduce the negative impacts

Hearing loss **cannot always be prevented**. Sometimes it is just a part of getting older. However, there is strong evidence that **hearing technology**, including hearing aids and cochlear implants, enables people with hearing loss to stay socially active, reduces the risk of depression, and may even reduce the risk of dementia.

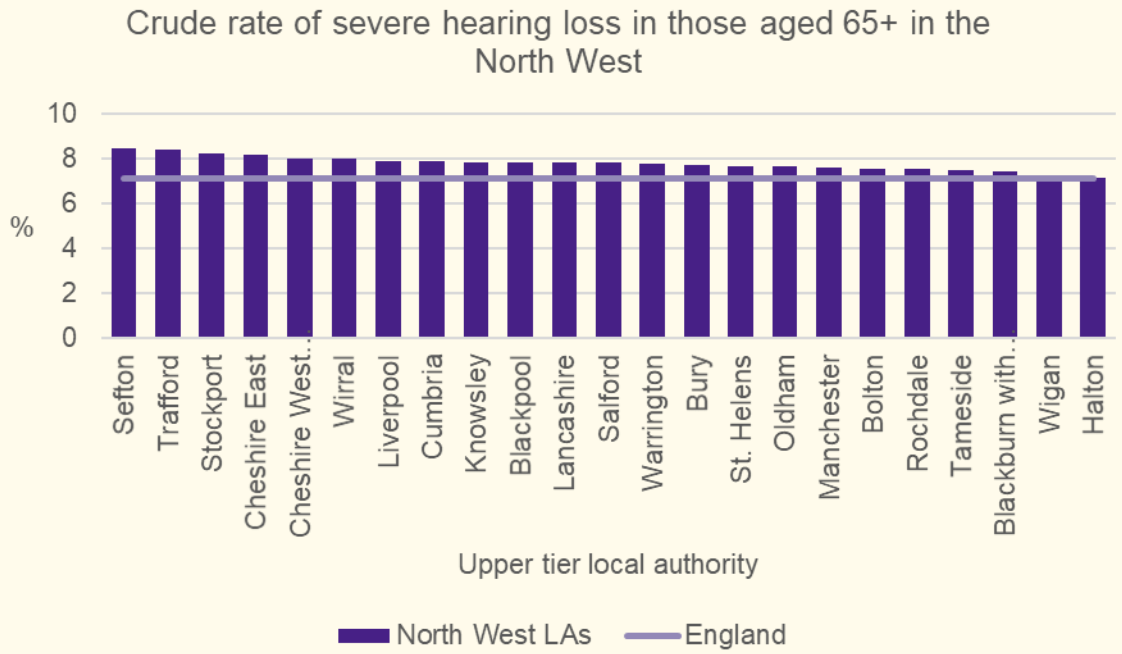
In the UK, hearing loss affects 42% of people aged 50+ and 71% of people aged 70+*. In the North West, it affects **62% of people aged 65+**.

8% of the 65+ in the North West suffer with **severe hearing loss** – a similar proportion to England. However, this proportion is higher in:

- Sefton (8.4%)
- Trafford (8.4%)
- Stockport (8.2%)
- Cheshire East (8.1%)

*Lower tier local authority prevalence figures can be found on the NHS England website.

NHS England has developed a **guide for commissioners and providers** to support hearing loss and healthy ageing.



Data source: POPPI

Hearing loss is the leading cause of years lived with disability and stops some people from working

While hearing loss is not limited to older age, age-related hearing loss is the single biggest cause and the **leading cause of years lived with disability** for those aged over 70 (RNID, 2015).

It can also lead to people retiring early and a loss of income, **costing the UK economy** £25bn a year in lost productivity and unemployment.

Hearing tests can identify any issues and ensure early intervention. However, there is, on average a **10 year delay** in people aged 55-74 seeking help for hearing loss. In addition, only a third of adults with self-reported hearing loss have their hearing tested.

Ear wax is normal but an excessive build-up can lead to ear ache, hearing problems or affect how hearing aids work. Clearing wax and whisper tests are simple but effective interventions.

Although not age-related, hearing loss due to exposure to loud noises can be prevented throughout the life-course.

Our rapid review of evidence* **did not uncover any information** about the impact of COVID on age-related hearing loss.

However, given other information from the rapid review, it is **likely that older people put off going for a hearing test** or adjusting/repairing their hearing aids during the pandemic. If this is true, this will have delayed diagnosis and therefore intervention.

Recommendation:
Encourage older people in your local area to seek help for hearing loss

*Rapid review to be published at a later date

Two thirds of older people are predicted to have multi-morbidity by 2035, affecting those in deprived areas more

As previously mentioned, people are living a **longer portion of their lives in poorer health**. This is largely due to long-term conditions and the increasing numbers of people with multi-morbidity.

Long-term conditions are more prevalent in older people, and NIHR research found that 54% of people aged 65+ in 2015 had at least two long-term conditions. It also predicted that, by 2035:

- the proportion of older people with **at least two conditions** will rise to 67.8%
- the number of older people with **at least four conditions** will double, with those aged 75+ contributing most
- most people over 65 will be affected by **arthritis**, followed by high blood pressure, respiratory disease, cancer and diabetes
- **cancer** will increase most, doubling from 12.6% in 2015

In addition, the contribution of **mental illness** to multi-morbidity increases with the number of diseases or impairments. And the pattern seen in 2015 is expected to change little by 2035:

- 4.1% of people with at least two conditions, and
- 34.1% of people with at least four conditions had mental ill-health

This impact is likely to be larger in the most deprived areas, where healthy life expectancy is lower, and women and men aged 50+ are twice as likely to have **type 2 diabetes and/or respiratory illness**.

Multi-morbidity, particularly if poorly managed, leads to **greater complexity in care**, higher risk of hospital admissions and re-admissions, longer hospital stays, and lower quality of life. This reduces independence in older age, and increases reliance on health and social care.

Multi-morbidity in younger ages has the potential to burden health and care services, but not if conditions are well-managed

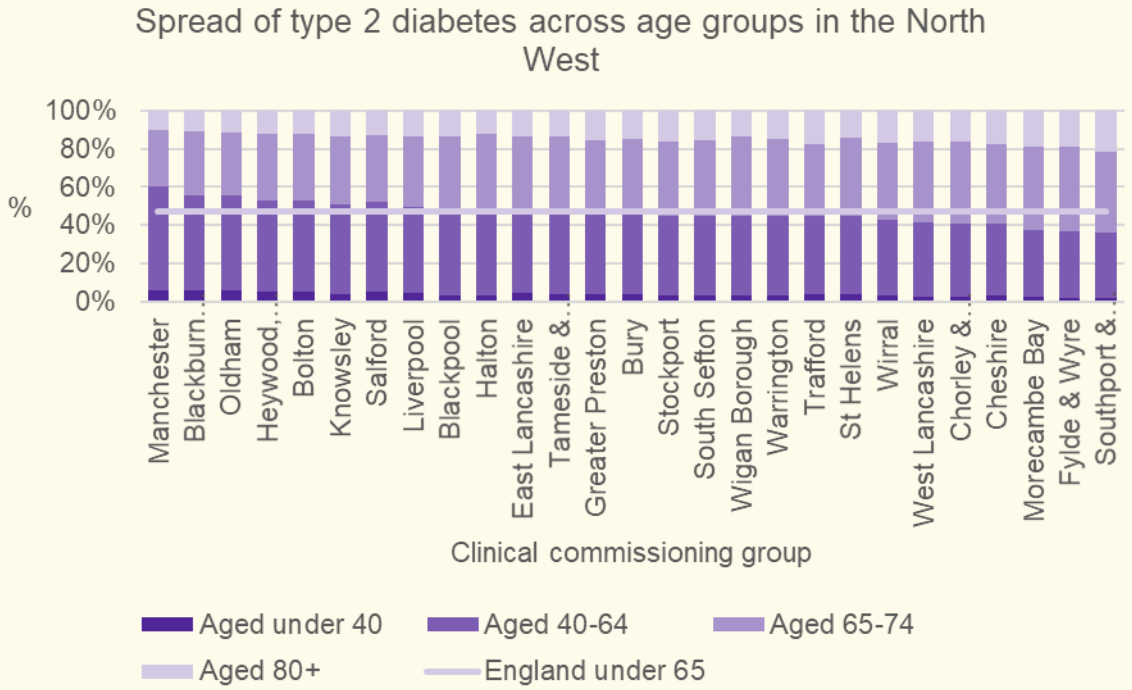
This increased reliance on services is particularly an issue in the knowledge that there is a **growing number of younger people** with multi-morbidity, particularly related to obesity.

In the North West, this is demonstrated by the **prevalence of type 2 diabetes**. Here, the proportion of diabetes cases in those aged 40-64 is larger than the England average in over half of the region's CCG areas. This is particularly true in Manchester, Oldham, and Blackburn with Darwen, where **people aged 40-64** make up over 49% of type 2 diabetes cases.

This could put a huge burden on health and social care as they age, but this doesn't have to be the case. If long-term conditions are **well-managed**, these people can live long, healthy and independent lives.

Recommendation: Consider the inclusion of mental health and wellbeing in regular medication reviews

In older adults, there is an **increased risk of self-harm and suicide** for those with long-term conditions, particularly dementia, cancer, neurological disorders, COPD, liver disease, arthritis and pain.



Data source: OHID Productive Healthy Ageing Profile

Smoking, poor diet and alcohol use are high in the North West, and have increased in some older people during COVID-19

Health behaviours are key to both preventing and managing long-term conditions. But in the North West, smoking rates, physical inactivity, diet and obesity are all **significantly worse** than the England average.

Smoking and diet are the **top behavioural risk factors** for years lost to disability in people aged 50-69. And, the COVID-19 pandemic has led to some older people adopting **unhealthy coping strategies**, including comfort eating, drinking to excess and smoking more (Age UK, 2021).

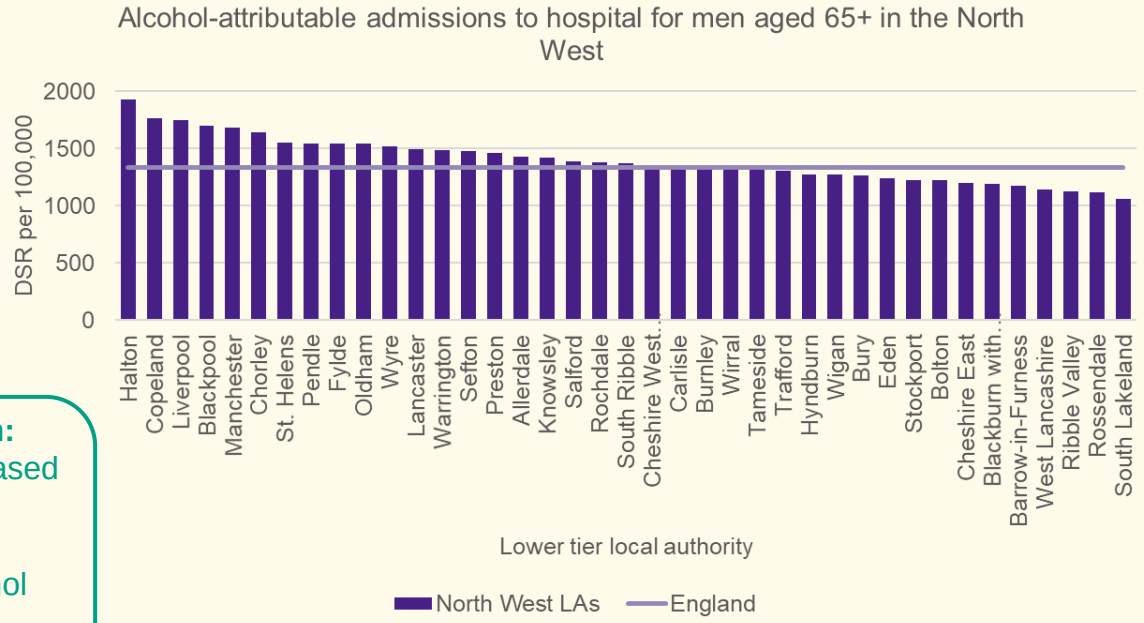
And while the majority of older people are lower risk drinkers, age-related factors can lead to **increased drinking**, which is a particular concern in men:

- social isolation and loneliness
- life transitions such as retirement and bereavement
- medication use
- dementia
- frailty

Alcohol misuse is frequently under-recognised as a **risk factor for suicide** in older adults.

Recommendation: Target evidence-based smoking cessation interventions and treatment for alcohol dependence at an individual level

In the North West, **hospital admissions for alcohol-related conditions** in men aged 65+ are significantly worse than England, while admissions in women are significantly better. Rates are particularly high in Halton, at 1,930 per 100,000 men aged 65+.



Data source: OHID Productive Healthy Ageing Profile

Increasing numbers of older people are in alcohol treatment, and services should be designed with older adults in mind

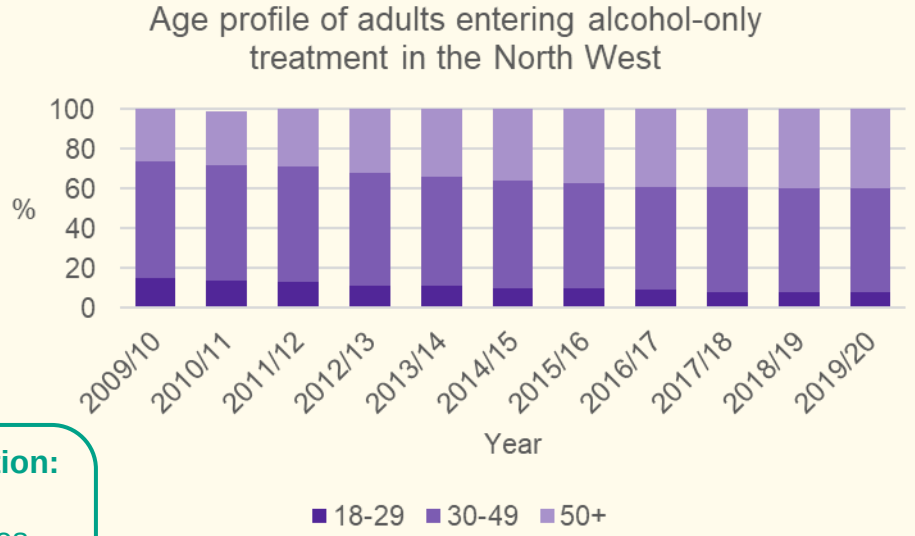
Research suggests that being a **higher risk drinker** after the age of 50 is associated with being male, younger, and identifying as LGBT+, along with living alone, not having a partner, being widowed, and having a chronic illness or disability.

The same research also suggests that older adults tend to have a **lack of understanding and knowledge** about units and recommended alcohol guidelines. And the proportion of people in alcohol treatment who are older is also increasing, indicating a **rise in older higher risk drinkers**.

While this might indicate better engagement in services, research suggests that a quarter of people aged 50+ wouldn't know where to go for help, and **wouldn't tell anyone** if they needed it.

Data also shows that older adults have **consumed more alcohol** since the pandemic began. This may lead to an increased need for support in this age group.

In addition, research has identified a lack of appreciation in **primary and acute services** about the relationship between alcohol-related harm and age. It also found that **treatment and service provision** are often not designed with the needs of older people in mind.



Data source: National Drug Treatment Monitoring System

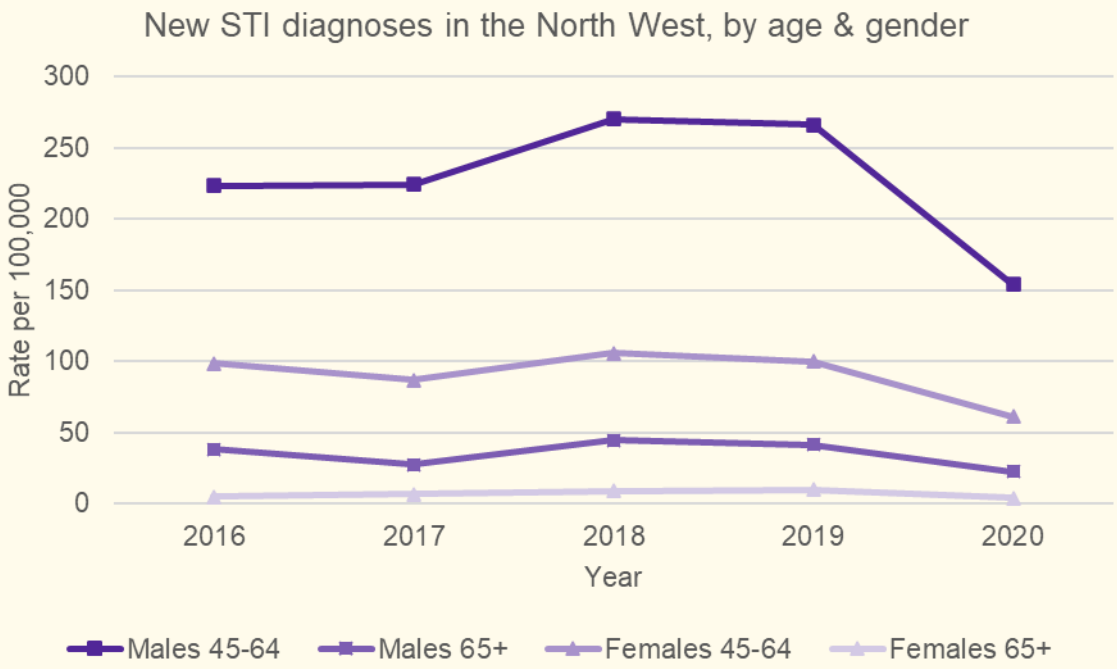
Recommendation: Ensure local alcohol strategies specifically identify the needs of older adults

Before the COVID-19 pandemic, sexually transmitted infections were rising in older people

It is important for local areas to consider sexual health as part of healthy ageing. Data show that, while sexual activity decreases with age, 60% of men and 37% of women aged 65+, and at least 25% of men and 10% of women aged 85+ are **still sexually active**.

Before the COVID-19 pandemic, the rate of **new sexually transmitted infections** (STIs) in North West residents aged 65+ was rising. But, the rate for people aged 65+ is still much lower than rates for those in other age groups (24.4 per 100,000 in 2019, compared to 2,347 in 15-19s, 3,929 in 20-24s, and 1,708 in 25-34s in 2019. However, rates for all age groups declined in 2020 when the pandemic hit.

The rise in STIs could be due to a number of factors, including an increase in the number of older people having **condomless sex** with new or casual partners, increased partner turnover, and **concurrent and overlapping relationships** among older people.



Data source: PHE STIs: annual data tables

Recommendation:
Develop and target clear and relevant information about sexual health including STI prevention to older people locally

Longer life expectancy is creating new issues in sexual health that require a change in how services are provided

Evidence is also emerging that increased sexual activity in older people is associated with higher **subjective well-being**.

However, **sexual difficulties** increase with age. Older people often feel unable to talk to health professionals about it, due to misconceptions, a lack of awareness and understanding, and embarrassment in the health and care workforce.

The **taboo topic** of sex in older age needs to normalised. Sexual health strategies and services should consider the specific needs of older people.

Recommendation:
Ensure local sexual health and HIV strategies specifically identify the needs of older adults

There are also increasing numbers of **people with HIV** living into older age. While increasing the life expectancy of people with HIV is a great success, it brings with it its own set of new challenges in public health, social care and wellbeing.

The Terrence Higgins Trust published a report into the **first generation growing older with HIV** in 2017. This found that:

- over half of people living with HIV aged 50+ are living on or below the poverty line
- a quarter would have no one to support them if they needed help with daily tasks
- a third are socially isolated and 82% experience moderate to high levels of loneliness

COVID-19 has had an uneven and potentially lasting impact on older people's physical and mental health and wellbeing

Our rapid review of evidence* shows that, in general, the COVID-19 pandemic and its restrictions have had a **negative impact on older people's physical and mental health and wellbeing**. Many of these impacts have already been mentioned in this report, but more detail is available from a report published by Age UK.

The impacts have **not been evenly spread** - those with pre-existing health or care needs, carers and those on low incomes have reported a more significant adverse impact on their health and wellbeing.

But the impacts are **not universally bad**. Some research shows little impact on some older people, particularly those who didn't adhere as strictly to COVID guidance. Some older people with certain personality traits and higher cognitive ability even identified **positive aspects of lockdown**.

*Rapid review to be published at a later date

However, some people, regardless of individual factors, have been **living in significant pain** thanks to reduced physical activity and the postponement of elective surgeries, such as hip and knee replacements.

Our rapid review* has also found strong evidence that the risk of **long COVID** increases with age (Whitaker et al., 2021). Some older people have reported continued COVID-19 symptoms, which is causing depression, low mood and anger.

Finally, older people who have had COVID-19 are more likely to have been at **risk of malnutrition** during lockdowns, especially if they live alone. Malnutrition can lead to sarcopenia, and is an added risk, not just for general health, but also for deconditioning and falls.

Recommendation: Ensure that local strength and balance programmes give thought to malnutrition and sarcopenia

Older people are more likely to respond to mental health treatments but many are undiagnosed

Mental health problems in older people are common, but **often more apparent in settings** such as hospitals and care homes; depression affects 4 in 10 care home residents, and psychotic symptoms, like delusions and hallucinations, are seen in 1 in 10 nursing home residents.

Depression is the most common mental health condition in older people. It is associated with:

- personal suffering
- high level of physical health problems, including frailty
- social isolation
- risk of suicide
- increased health and social care costs

Recommendation:
Primary care services should conduct depression screening when these risk factors are present in older people

Concentrating on depression can also help to **identify and address** anxiety that is another common mental disorder in older people. But, if resistant to treatment, there is likely **underlying dementia**.

Depression and other mental health conditions in older people often go **undiagnosed and untreated**. However, older people with mental health problems are likely to respond to treatments as well as or better than younger people.

In fact, a greater proportion of older people (42%) **complete treatment** than their working age counterparts (37%) after being referred to Improving Access to Psychological Therapies (IAPT) services.

Additionally, older people achieve **good outcomes** from IAPT treatment, sometimes better than people under 65. Planners and commissioners should ensure the **full range of services** for mental health problems are available for older people.

Recommendation:
Ensure local mental health strategies specifically identify the needs of older adults

Depression and anxiety in older people are similar to England, but IAPT outcomes need improving in some areas

10.9 per 100,000 people aged 65+ are estimated to have a **common mental health disorder** (depression or anxiety) in the North West, similar to England. The areas with the highest rates per 100,000 are:

- Manchester (13.8)
- Liverpool (13.4)
- Knowsley (13.2)
- Blackpool (12.9)

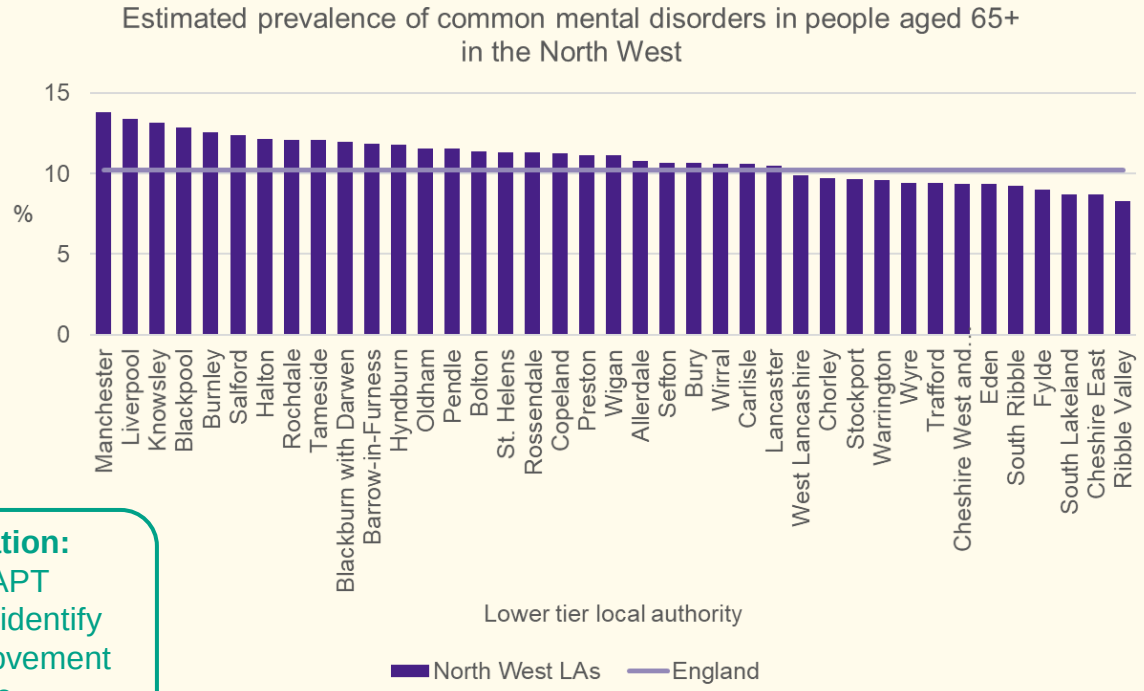
Rates are likely to be **higher in more deprived areas**, where women and men aged 50+ are up to five times more likely to have depression.

IAPT is available across the North West. Referrals of older people in the region are relatively high, but outcomes are varied:

- 50% in Stockport and Halton, and 100% in Oldham and Chorley and South Ribble see reliable improvement
- 0% in Halton, and 83% in Trafford move into recovery

Recommendation: Review local IAPT outcomes and identify areas for improvement for older people

More effective identification and long-term management of older people with depression and a history of self-harm will improve the **prevention of suicide** in this group, by both mental health services and primary care.



Data source: OHID Productive Healthy Ageing Profile

COVID-19 restrictions have taken away usual coping strategies from older people - worsening their mental health and resilience

Our rapid review of evidence* shows that the COVID-19 pandemic has **increased depression and anxiety** in some older people. Carers, and those who have been bereaved or shielding have been particularly hard hit. This has continued for some and is leaving them fearful for the future, with some still not leaving the house.

But, while some older adults have experienced challenges during the pandemic, **many have been resilient**. They have put into practice activities and behaviours that help to protect their mental health, using their time to reflect or organise end-of-life affairs.

However, more recent evidence suggests that, as the pandemic has continued, some older people who felt they managed during the first wave have **started to struggle**.

In addition, some older people living with pre-existing mental health conditions have experienced a **worsening of symptoms** and have increased their medication. This is because the pandemic has robbed them of their usual coping strategies (socialising, physical activity and hobbies).

Lastly, low mood, depression and reduced resilience have resulted in some older people **neglecting themselves**, ranging from no longer cleaning the house or taking care of their appearance, to not getting dressed, eating, or managing their medication and health conditions.

Recommendation:
Fully utilise all approaches including social prescribing to ensure older people are connected

*Rapid review to be published at a later date

5. Health and social care

- Social care
- Prevention and early intervention
- Dental care
- Palliative care
- Barriers to accessing services
- The future of health and social care

Social care is important in helping older people stay independent, but costs to individuals can be steep

Adult social care covers a **wide range of activities** to help people live independently, and stay well and safe. It is for people who are older, or who are living with disability or physical or mental illness.

Social care includes **short- and long-term support** which may take place in people's own homes, day centres, care homes, or nursing homes. It also provides 'reablement' services, aids and adaptations for people's homes, information and advice, and support for family carers.

Expenditure on adult social care is increasing, and total expenditure has now returned to 2010/11 levels. However, gross current expenditure and per capita expenditure are **still lower than before austerity**.

Social care spending is allocated based on need, and **local authorities** are responsible for assessing this need. But, while care for those eligible is organised and purchased by local authorities, services are mostly delivered by **independent providers and voluntary sector** organisations.

However, the social care means test threshold has not kept pace with inflation. This means that **fewer people are eligible** for publicly funded social care, and must contribute towards the cost from their income.

Self-funding care **costs individuals** a huge amount of money, with the Dilnot Commission estimating that:

- 50% of people aged 65+ will spend up to £20,000 on care costs in their lifetime; and
- 10% will face costs of more than £100,000

The government's **social care reform** aims to address this issue.

Permanent residential and care home admissions are high in the North West, but the number of beds is falling

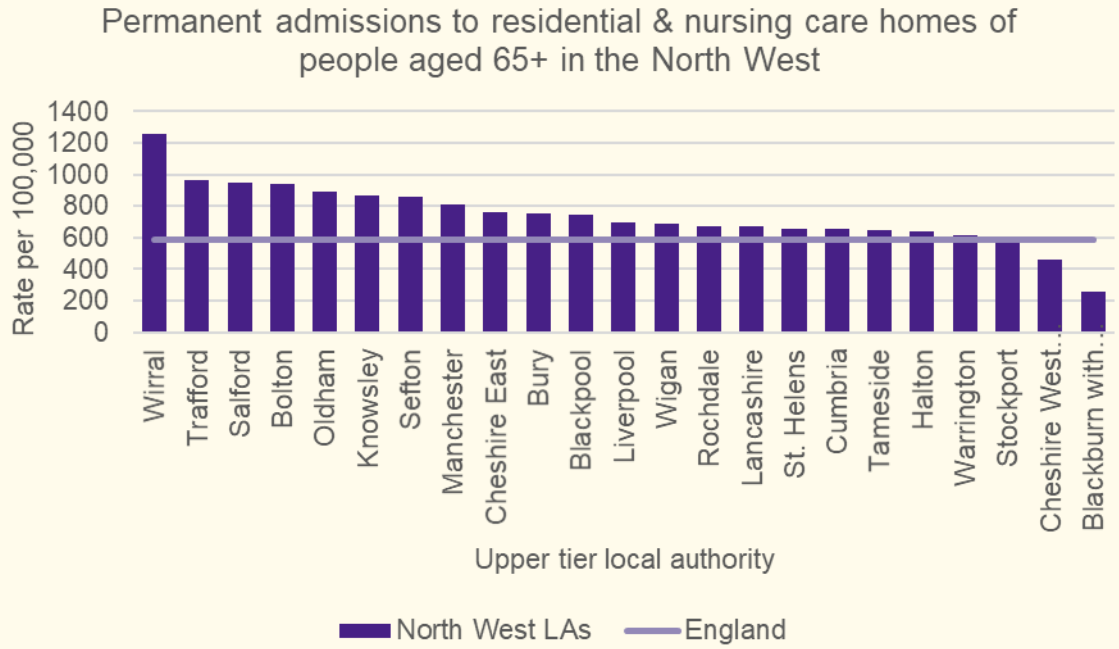
While care homes are the most considerable care costs, **residential care costs** in the North West are the lowest of all regions in the UK (Age UK). It is preferable, both to individuals and the social care system, to keep people in their own homes where possible.

Older people with **learning disabilities** are likely to be placed in older people's residential services at a much younger age than the general population. However, this may not meet their preferences or needs, especially in relation to communication, support and activities. Their **specific needs** should be considered at this time.

Permanent admissions of people aged 65+ to residential and nursing care homes is significantly higher in the North West than England. And only two local authorities are significantly lower:

- Blackburn with Darwen (257 per 100,000)
- Cheshire West and Chester (462 per 100,000)

These data show that fewer older people in the North West remain independent in older age. But **permanent admissions are falling** in some areas, and the total number of residential home beds in the North West is also falling.



Data source: OHID Productive Healthy Ageing Profile

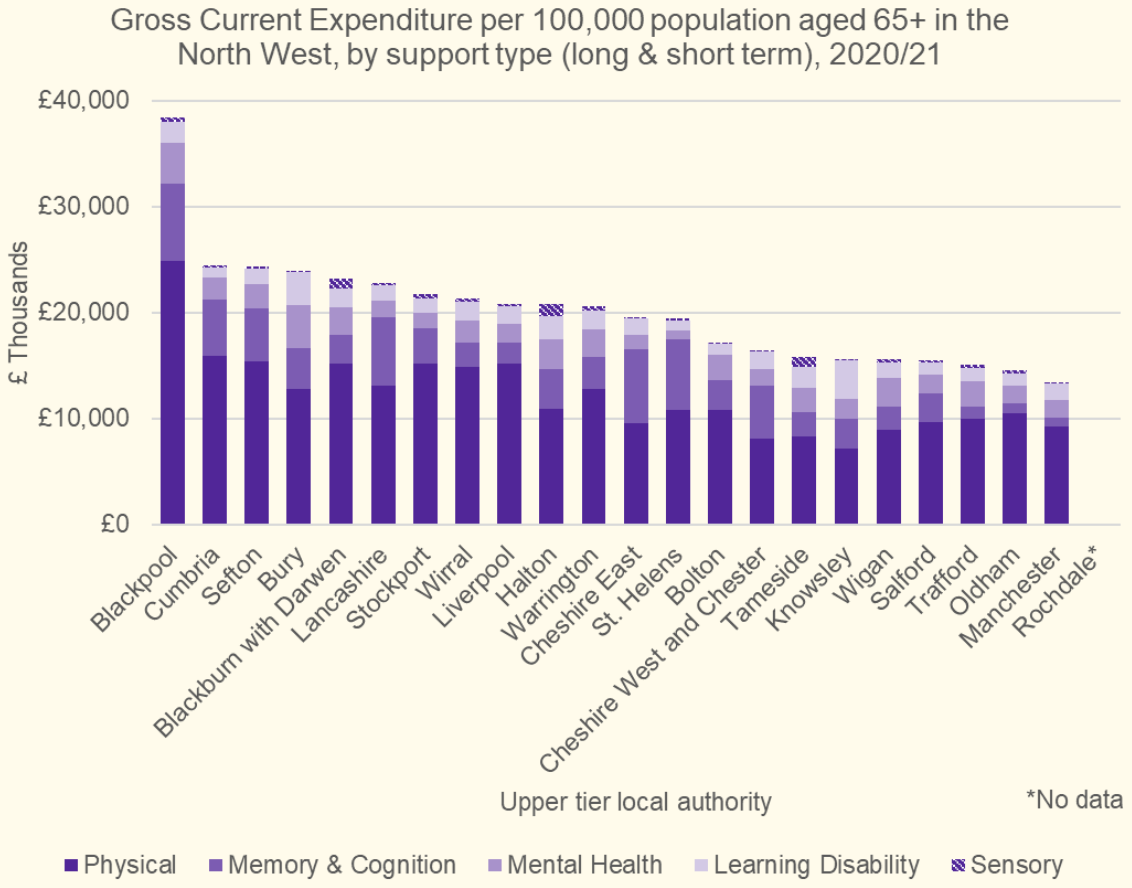
Millions of pounds are spent on social care every year, with local authorities prioritising different types of support

Requests for social care support in England are growing in all age groups, but there is a **shift in care for older people**, with long-term care falling and short-term care rising.

In 2020/21, the North West spent £440.8m on social care for older people. This is just under half of the total spend on adult social care. But, local authorities decide their own spending for social care, resulting in **great variety across the region**. Blackpool is an outlier, spending £38.4m.

Most of the spend on older people is for physical support, followed by support with memory and cognition. But some areas are outliers for **spending on different types of support**:

- Blackburn with Darwen, Halton and Tameside for sensory support
- Blackpool for physical support
- Bury for mental health support
- Bury and Knowsley for learning disability support



Data source: North West ADASS

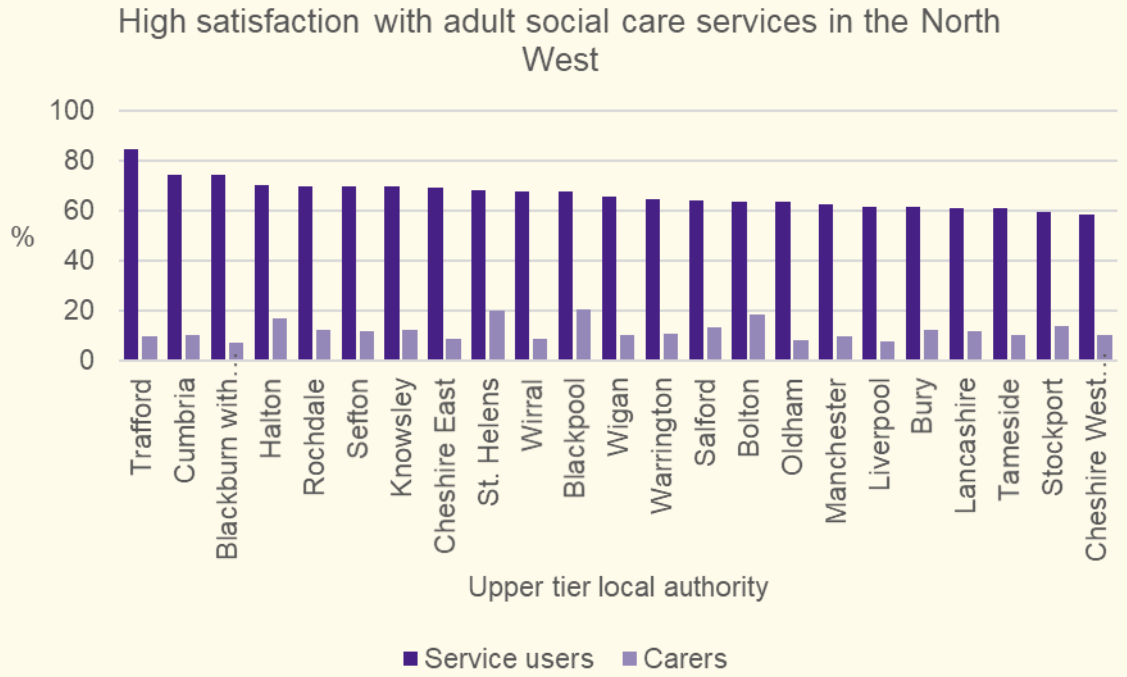
Service users are fairly satisfied with social care services, but carers need better support

The percentage of care services rated ‘outstanding’ or ‘good’ has continued to increase in England. And, **service user satisfaction** with care and support is fairly high the North West, ranging from 59% of users in Cheshire West to 85% in Trafford.

Carer satisfaction however, is very low, despite a greater proportion of carers in England receiving support from their local authority. Less than 20% of carers (a much smaller proportion than England) are satisfied with services in the North West. In Blackburn with Darwen, as few as 7.4% of carers are satisfied with services.

Low carer satisfaction may be the result of an increasing amount of **support being limited** to information, advice and signposting.

Recommendation:
Ensure timely access to high quality health, care and rehabilitation services, and personalised support and adaptations to help older people stay independent



Data source: North West ADASS

Recommendation:
Explore the needs of carers locally and identify better ways to support them

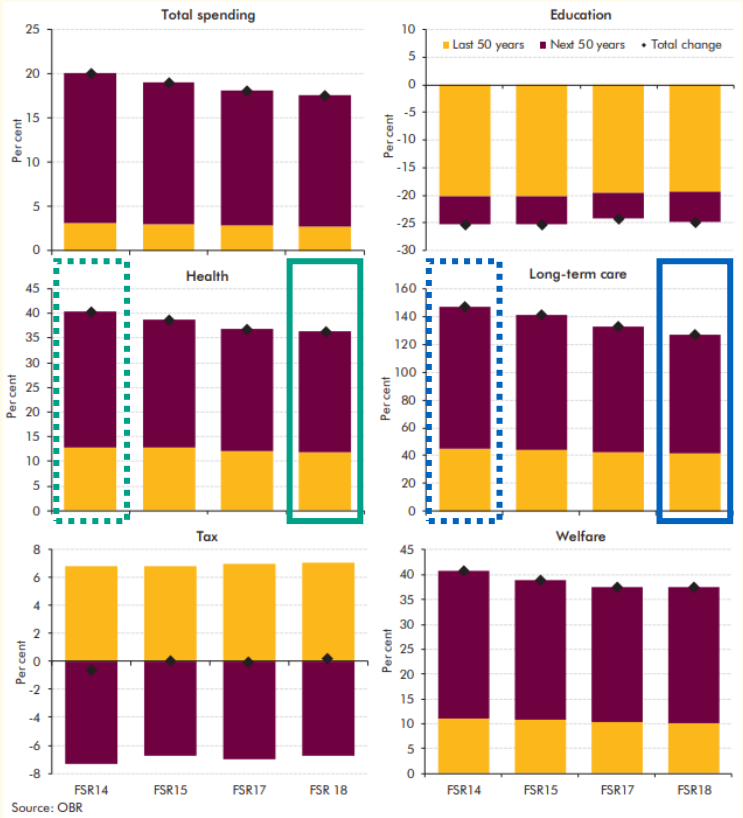
Long-term care spending is projected to increase more than any other public spend

The Office for Budget Responsibility (OBR) predicts that the ageing population is likely to be a **bigger challenge in the future** (purple bars) than in the past (yellow bars), putting greater pressures on public spending than in previous decades.

These predictions are recalculated every year or two in a new FSR* (x-axis). They assume that **spending rises to accommodate** the ageing population with no change to existing government policy. However, they **do not include other pressures**, such as technological advances in healthcare and the prevalence of chronic conditions.

These pressures were greatest in 2014 (marked by the dotted boxes).

Projected financial implications of age-related demographic changes between 1967 and 2067



Source: OBR

*Fiscal Sustainability Report 2018

In 2018, OBR projections indicated that age-related pressures between 1967 and 2067 will **increase health spending** by 36% (marked by the green box), with just over two-thirds yet to occur (purple bar).

Age-related pressures are projected to increase **long-term care spending** significantly more than any other item of public spending (marked by the blue box), with per capita spending **roughly doubling** over the next 50 years (purple bar).

This is a smaller component of public spending than healthcare, but has **large implications** for social care, especially as it does not consider the impact of ageing with a disability.

It is possible to have a long-term condition without having social care needs, but this requires early diagnosis and intervention

The increasing years living with long term conditions is **set to increase demands** on health and social care that will continue to 2035 (APPG for Longevity, 2020). By this point, there will be approximately 16 million cases of dementia, arthritis, type 2 diabetes and cancers in people aged 65+ (twice as many as in 2015).

However, as the Health Foundation recently noted, the prevalence of these conditions may be increasing because diagnostic practices are improving – more research is needed on this. And it is **possible to have a long-term condition without having social care needs**.

This is demonstrated by the fact that a third of those with **no limitations to daily activities** have at least two long-term conditions. And the proportion of people with multiple long-term conditions and no social care needs rose between 2006 and 2018.

There are some conditions which result in **complex needs**, namely later stage neurological conditions. Dementia is by far the most prevalent of these conditions. But, increasing early diagnosis and intervention can limit the number of people reaching this level of need.

For this reason, it is **difficult to predict future demand** for social care services. It is largely dependent on our ability to identify and treat poor health early. This requires a co-ordinated approach to understanding needs using evidence and joined-up datasets. Integrated Care Systems will be uniquely placed to lead this work.

Recommendation:
Develop local projections of how demographic changes will impact demand, informed by the latest, best available data and evidence

Uptake of preventative and early interventions is generally low in the North West

Prevention and early interventions are essential tools to enable healthy ageing and prevent high health and care expenditure. Many older people are eligible for these*.

This includes **screening** for abdominal aortic aneurysm (AAA), breast cancer, cervical cancer, and bowel cancer. The North West coverage of all these screening programmes is **significantly lower** than England.

Consequently, the proportion of **cancers diagnosed early** in the North West are also **significantly lower**. In addition, both screening coverage and early cancer diagnoses decrease as deprivation increases.

Older people, who are considered a vulnerable group, are also offered three vaccinations. Since COVID-19, all local authorities in the North West, except for Manchester, have seen a **significantly higher 65+ uptake of the flu vaccine** than England. This is a dramatic change from pre-COVID.

The uptake of the **PPV vaccine**, which prevents pneumococcal disease however, is similar to England, and the uptake of the **shingles vaccine** is significantly worse. Excess winter deaths in the North West are similar to England, but without these vaccines older people are more susceptible to severe disease and fatality.

*__Screening__: Abdominal aortic aneurysm (men aged 65-74); Breast cancer (women aged 53-70); Cervical cancer (women aged 50-64); Bowel cancer (all aged 60-74); Diabetic eye screening (all aged 12+ with diabetes)
__Vaccines__: Flu and PPV (all aged 65+); Shingles (all aged 71)

Many people in the North West have received an NHS Health Check, but uptake is low and COVID-19 has halted these checks

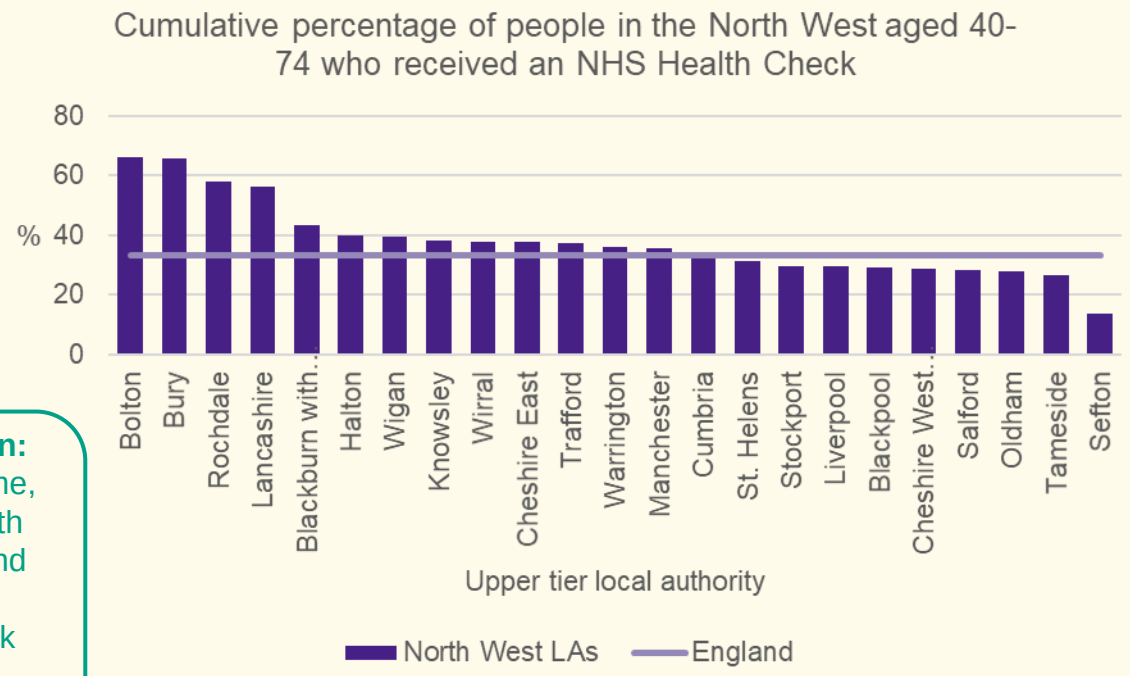
Adults in England aged 40-74 are also eligible for an **NHS Health Check**. As we get older, we have a higher risk of developing **stroke, kidney disease, heart disease, type 2 diabetes and dementia**. An NHS Health Check is a health check-up designed to spot early signs of these conditions and helps find ways to lower this risk.

Currently, the number of eligible people in the North West who have received an NHS Health Check is much **higher than the England average**, but performance varies across the region. The uptake rate may be lower, depending on age, ethnicity, gender and deprivation.

NHS Health Checks were **halted during the COVID-19 pandemic**, but we know that people with pre-existing CVD, diabetes, obesity, high blood pressure and certain population groups experience worse outcomes; relating to socio-economic, behavioural and clinical risk factors.

Recommendation: As services resume, ensure NHS Health Checks identify and prioritise eligible people most at risk of poor health

As **preventative services resume**, NHS Health Checks should be targeted at those most at risk to identify risks early and prevent long-term conditions in older age and align with other preventative programmes.



Data source: OHID Productive Healthy Ageing Profile

Older people are keeping their teeth for longer, but their oral health needs are increasingly complex

Preventative dental care is also important in preventing poor health. Care homes have a key role in this. Although there are no data specific to older people, the proportion of people in the North West successfully obtaining a **dental appointment** is similar to England.

Over the past 40 years, standards of adult oral health have **improved significantly**. As a consequence, more people are retaining at least some of their natural teeth into old age.

The 2009 Adult Dental Health Survey shows that **85% of 65–74** year olds, and **67% of the 75+** in England now retain some of their natural teeth, compared to just 22% in 1978

This is clearly good news, but one of the consequences is that the oral health needs of older people are changing and becoming **increasingly complex**, as many older people now require ongoing regular **maintenance of heavily restored teeth**, creating new challenges for dentists.

Maintaining good oral health can also become more difficult in old age – long-term conditions such as arthritis and Parkinson's disease can **reduce dexterity**, and dementia can make people resistant to care.

On top of this, many medicines reduce the amount of saliva produced and leave people with a **dry mouth**, reducing the protective, anti-microbial effect of saliva, and increasing the risk of tooth decay and oral infections.

Poor oral health can also make it **difficult to speak and eat**, making people more reluctant to socialise and more at risk of malnutrition. Older people with poor oral health are also more susceptible to pneumonia (BGS, 2017).

In 2005 the British Society of Gerodontology found that this will have a long-term impact on dentistry, **increasing demand** among older people. NICE has produced a quick guide to improving oral health for adults in care homes.

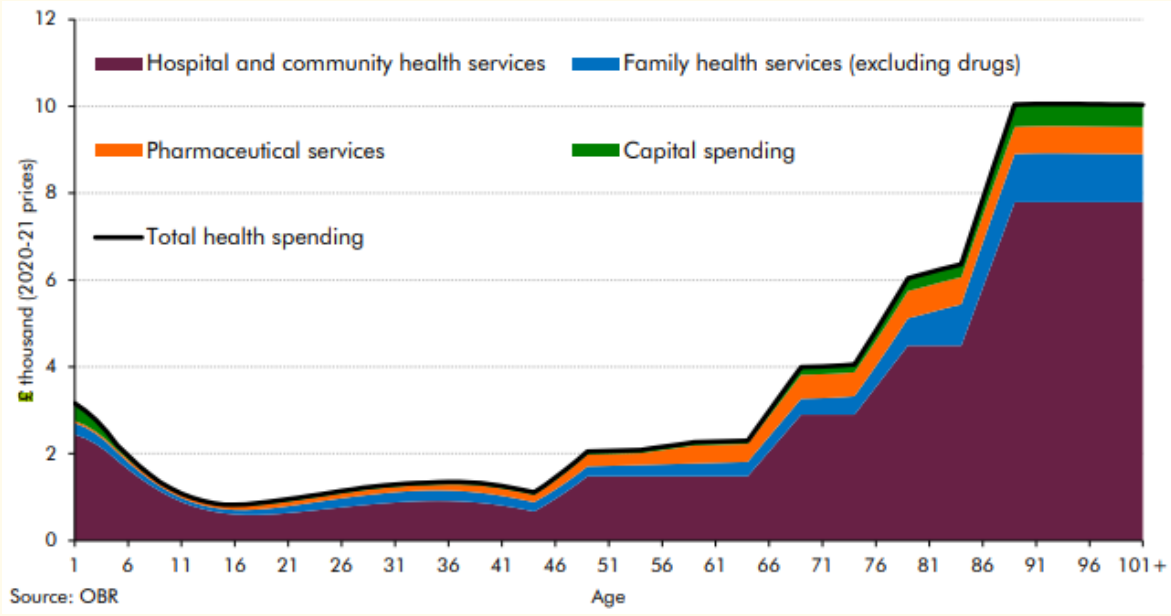
While social care costs are driven by poor health, higher health care costs in older age are driven mostly by end-of-life

This chart from the Office for Budget Responsibility (OBR) shows that **healthcare costs increase with age**. This is partly due to the increase in multi-morbidity.

However, evidence suggests that another reason for higher health spending in older age is that mortality rates are higher. Therefore, a higher proportion of those cohorts will be subject to the much higher **costs associated with the final months of life**.

This raises the issue of **palliative care** for patients who are nearing the end of their lives. Research indicates that most people would prefer to die at home, but hospital was still the most likely place of death in England in 2019. The economic case for moving palliative care into home or community settings is, however, unclear.

Representative profile for health spending, by age



Source: OBR (2016) Fiscal sustainability analytical paper: Fiscal sustainability and public spending on health

Palliative care is on the rise, but many more individuals could be referred to benefit from this support

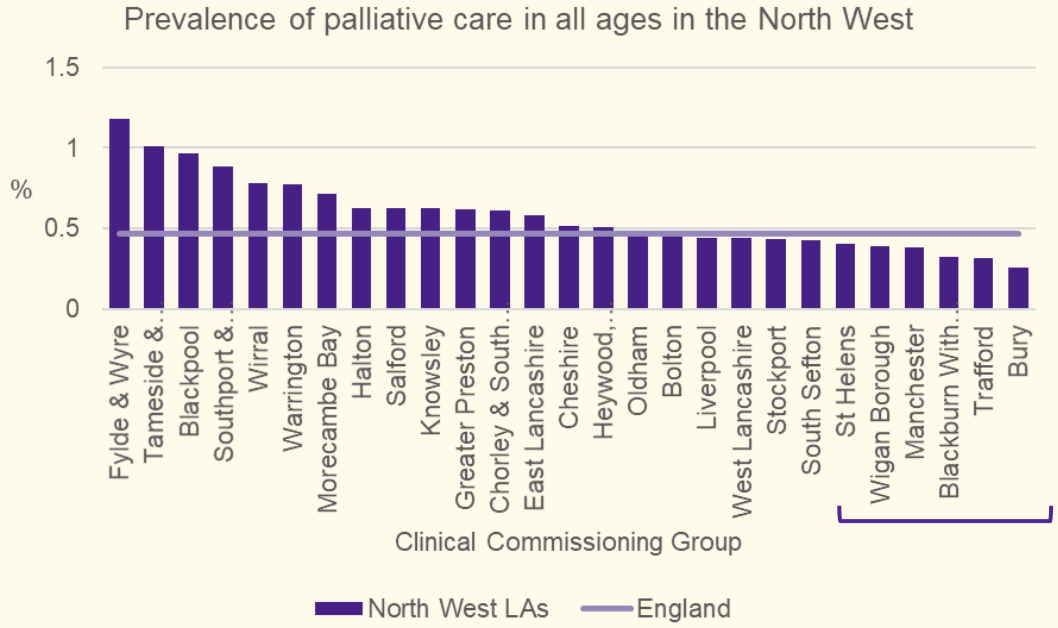
About 1% of the population in the UK **die each year** (over half a million), with an average of 20 deaths per GP per year. But only a twelfth of patients have a sudden death.

There are **considerable benefits** of identifying patients in need of palliative care. It allows people to die comfortably, with dignity and without pain. It also allows both patients and families to receive the best health and social care, and avoid crises by prioritising them and anticipating need.

Palliative care rates are **on the rise** across the country, indicating an increasing awareness and practice of supporting people at the end of their lives.

The same applies in the North West, where 0.6% of people (significantly more than England) were **identified** as needing palliative care or support in 2020/21. Only six North West CCGs have a prevalence of palliative care significantly lower than England (marked on the chart).

But despite the rise in palliative care, recent data show that slightly less than 50% of all people dying in England are receiving palliative care and support. This suggests that **many more individuals could benefit** from a referral to palliative care.



Data source: [OHID Productive Healthy Ageing Profile]

Barriers to health and care for older people are linked to individual circumstances and health and care workforce training

As already mentioned, older people who are LGBT+, from an ethnic minority background (including Gypsy, Roma and Travellers), and/or disabled (physical or learning) face **barriers to accessing health and social care** services.

Their concerns generally centre around a **lack of understanding of their needs**, leading to discrimination, and a lack of culturally appropriate care. This highlights the need for effective **training of the health and care workforce** to ensure that all older people feel comfortable accessing services.

Older people living with **frailty** also face barriers to accessing health and care. Sometimes this may come down to the simple fact that an individual does not see themselves as frail. They therefore find it **hard to engage** with health or social care professionals who treat them as such. This links back to **social attitudes** surrounding ageing.

Some older people may also face **financial barriers** to social care. This is likely to happen if they are on the cusp of eligibility but their request for support is denied. These people are **most at risk** of poor health and lack of independence.

Some may also face **geographical barriers**, particularly in rural areas, which are more likely to have:

- **workforce** challenges, service providers moving out of area, and differences in types of treatment
- increased costs for equitable outcomes because of **remoteness** and limited economies of scale
- seasonality and weather affecting recreational activities and **environmental conditions** specific to coastal areas

Older **prisoners on release** also face barriers to care for their complex health and social care needs, as social care and GP registration can be difficult to arrange on release.

There has been unequal access to services during COVID-19, led by the move to digital

Health and social care changed during COVID-19, creating many opportunities to improve care. However, our rapid evidence review shows that the sudden and dramatic increase in the use of **tele- and video-consultations** has alienated some older people, particularly those without family and friends to help get them online.

GPs have also recognised the challenges of **conducting effective consultations remotely**, with concerns that remote consultations increase the risk of misdiagnosis, delayed care, missing early signs of disease deterioration, and the inability to monitor and update medications.

Some older people had no problems **accessing** health, social/council, pharmacy, voluntary or dental services during the pandemic. Mental health staff felt that patients in rural areas could be accessed more easily.

However, some older people have **avoided booking appointments** with their GP during the pandemic, for fear of being called into the surgery and catching COVID-19. As a result, there have been **fewer referrals** to many specialist services during lockdowns, including for cancer and mental health.

In addition, older people are most likely to have had medical appointments and planned **procedures** delayed or cancelled. Many **clinical trials** have been interrupted, removing vital treatment for older patients with cancer and other life-threatening conditions.

As a result, many older people have faced increased **frailty, pain and mobility issues**, as well as **anxiety and cognitive decline**.

The government has set out plans to address the health and care issues brought about by COVID-19

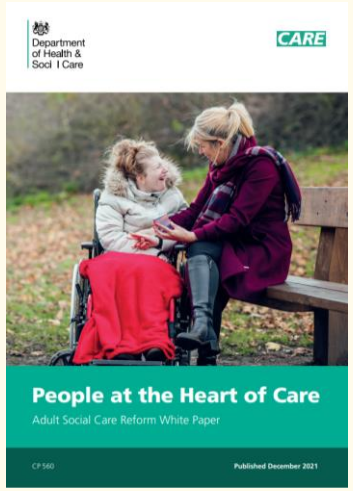
Following the significant disruption to health and social care provision during the COVID-19 pandemic, the Government has published a new **plan for health and social care**: Build Back Better. This includes a reform of adult social care, and involves:

- tackling the electives backlog
- putting the NHS back on a sustainable footing
- increasing the focus on prevention
- capping adult social care costs
- providing financial assistance to people without substantial assets

Government has committed £5.4 billion for **adult social care reform** over the next three years. And at the Autumn Spending Review 2021, it was confirmed that £1.7 billion of this funding would be for **major improvements** across the adult social care system.

On 1st December 2021, the government published a **white paper**, setting out how some of this money will be spent to begin to transform the adult social care system in England, such as **new investments** in:

- housing and home adaptations
- technology and digitisation
- workforce training and wellbeing support
- support for unpaid carers, and improved information and advice
- innovation and improvement



6. Call to action

- Recommendations
- Next steps

General recommendations for action by local areas

Continue providing **strategic leadership** to co-ordinate joined-up action on healthy ageing locally

Consider collaborating with partners and demonstrating commitment to healthy ageing by signing up as a co-signatory to the **PHE Healthy Ageing Consensus statement**

Ensure all interfacing key strategies have a **healthy ageing focus**, using Health economic assessment tool (HEAT) and Environmental Impact Assessment (EIA)

Develop a **JSNA** and co-produce a **healthy ageing strategy** to support the inclusion of older people in all plans, policies and services, if there is not one already

Embed **prevention and early intervention** for older people into any new **local strategies and services** and ensure they specifically consider the needs of older people

Develop strong and effective collaboration with key partners to ensure a **joined-up approach** to health and social care for older people

Explore with partners key **mitigating actions** highlighted by the rapid review of evidence* and WICH monitoring tool

We recognise that different local areas will be progressing at different rates, and these and the following recommendations are intended to be a checklist for inclusion in JSNAs and/or healthy ageing strategies to help prioritise healthy ageing in local areas

*High level results of the rapid review are available in this report, but the full results will be published at a later date

Topic	Slide No.	Topic-based recommendations (as highlighted throughout the report)
Communities	28	Engage communities to understand **how individual factors intersect** to affect health in your local area
Communities	31	Follow the 4 steps to becoming an **Age-friendly Community**: Engage and understand, Plan, Act and implement and Evaluate
Connectedness	33	Support people to **remain connected** as they age with good transport links, green spaces, services, and facilities close to homes
Rural areas	35	Map the drivers, strengths and assets in your local **rural areas** to identify areas for action
Digital literacy	39	Support older people to develop the **skills to get online** and use **digital appliances** while maintaining paper communication
Connectedness	40	Support older adults to **volunteer, mentor and peer support**
Carers	41	Engage local **unpaid carers** to identify their needs, and support them to be healthier and have more control over their lives
Services	42	Engage those **ageing without children** in your local area when planning future service provision
Loneliness & Social Isolation	44	Ensure opportunities are available to remain engaged with **creative, learning and cultural activities** as people age
Loneliness & Social Isolation	45	Ensure **diverse housing options** meet the needs of older people across all tenures
Loneliness & Social Isolation	45	Adopt a range of community centred approaches that encourage **community participation** from people of all ages
Housing	46	Help people remain healthy, active and independent by improving the quality of **local housing** and future proofing new housing making them accessible and adaptable
Housing	46	Support **low income owner occupiers** to access funds to repair and improve their home

Topic	Slide No.	Topic-based recommendations (as highlighted throughout the report)
Work	50	Identify older people locally who are out of work and help them develop the skills they need to **get back into work** if they wish
Work	51	Work with local employers to develop age-friendly policies that enable the **recruitment and retention of older people** in work
Falls prevention	61	Use local data to review the proportion of adults aged 50+ with a history of falls who have had an **assessment of their fracture risk**
Falls Prevention	63	Target evidence-based **strength and balance programmes** at an individual level to those most affected by the pandemic
Comms	63	Distribute the **'Active at Home'** booklet to older people most affected in your local area
Dementia	65	Use local data to review how many emergency dementia admissions had a **care plan reviewed** in the previous 12 months
Dementia	67	Prioritise **medication review for people with dementia** living in the community, particularly those living alone
Dementia/NHS health checks	67	Ensure NHS Health Checks are being used effectively to **raise awareness of dementia**
Sensory impairment	70	Promote **regular eye tests** and diabetic eye screening locally to prevent sight loss
Sensory impairment	72	Encourage older people in your local area to seek help for **hearing loss**
Mental Health	74	Consider the inclusion of mental health and wellbeing in **regular medication reviews**
Alcohol/ Tobacco	75	Target evidence-based **smoking cessation** interventions and treatment for **alcohol dependence** at an individual level
Alcohol	76	Ensure **local alcohol strategies** specifically identify the needs of older adults

Topic	Slide No.	Topic-based recommendations (as highlighted throughout the report)
Sexual health	77	Develop and target clear and relevant **information about sexual health** including STI prevention to older people locally
Sexual health	78	Ensure **local sexual health and HIV strategies** specifically identify the needs of older adults
Malnutrition	79	Ensure that local strength and balance programmes give thought to **malnutrition and sarcopenia**
Mental Health	80	MH Primary care services should conduct **depression screening** when these risk factors are present in older people
Mental Health	80	Ensure **local mental health strategies** specifically identify the needs of older adults
Mental Health	81	Review **local IAPT outcomes** and identify areas for improvement for older people
Mental health/ Connectedness	82	Fully utilise all approaches including **social prescribing** to ensure older people are connected
Access to Services	87	Ensure timely access to high quality **health, care and rehabilitation services**, and personalised support and adaptations to help older people stay independent
Carers	87	Explore the **needs of carers** locally and identify better ways to support them
Data	89	Develop **local projections** of how demographic changes will impact demand, informed by the latest, best available data and evidence
NHS Health Checks	91	As services resume, ensure **NHS Health Checks** identify and prioritise eligible people most at risk of poor health

Next Steps for OHID North West

Organise a North West healthy ageing **webinar** to further engage local areas and help identify what they can do and achieve

Establish a **NW healthy ageing steering group** to advise on local gaps and priorities, examples of best practice and development of supplementary resources

Establish a **cross-sector network** of partners (PH / NHSE/I / ADASS / VCSE etc.) to provide system leadership on healthy ageing in the North West

Consult on and develop a series of North West topic-based **webinars** including continued professional development (CPD) sessions

Consult on establishing a regional or sub-regional **Falls Prevention and Deconditioning collaborative**

Develop a **Community of practice database** (CoPD) of healthy ageing good practice across the North West

Offer support to local authorities, ICSs and other partners for one-to-one discussions

Appendix 1: Examples of local good practice

Local Area	Topic	Case Study Details	Contact
Cheshire	Physical activity; Falls prevention; Dementia; Social Isolation	**Walkeez** Walkeez project - YouTube	Roger Elliot roger.elliott@activecheshire.org
Merseyside	Physical Activity; Mental Health; Social Isolation and loneliness	**Bowl for Health** https://merseysidesport.com/bowlforhealth/	Danny Woodworth d.woodworth@merseysidesport.com
Cheshire East	Digital inclusion	**Cheshire East Digital Inclusion Taskgroup (CEDIT)**	Guy Kilminster Guy.Kilminster@cheshireeast.gov.uk
Cheshire East	Health Inequalities	**Tartan Rug** Ward profile tartan rug Nov17 CE produced 18-08-23 (cheshireeast.gov.uk)	Guy Kilminster Guy.Kilminster@cheshireeast.gov.uk
Cheshire East	Adult Social Care; Services	**Adults Quarterly Scorecard** Appendix 1 - Adults Scorecard Q4 2021-22.pdf (cheshireeast.gov.uk)	Guy Kilminster Guy.Kilminster@cheshireeast.gov.uk
Cheshire	Digital Inclusion; Social inclusion and loneliness	**Connect All - Digital Inclusion** Connect All	Dale Maskell dale.maskell@ageukcheshire.org.uk
Salford	Digital Inclusion; Mental health; Social inclusion and loneliness	**Tech and Tea** Example of impact	Bernadette Elder bernadette@inspiringcommunitiestogether.co.uk
Salford	Loneliness, social isolation,	**Age Friendly Salford programme** https://youtu.be/5mAWMIrnmnw	Bernadette Elder bernadette@inspiringcommunitiestogether.co.uk
Greater Manchester	Falls Prevention	**GM Falls Collaborative** ARC GM | Greater Manchester Falls Prevention Delivering Integration and Reconditioning (nihr.ac.uk)	Jane Mcdermott j.mcdermott@manchester.ac.uk
Greater Manchester	Physical Activity	**GM Active Ageing Programme** https://www.gmmoving.co.uk/media/3889/gm-active-ageing-evaluation-summary.pdf	Beth Mitchell beth@greatersport.co.uk

Local Area	Topic	Case Study Details	Contact
Greater Manchester	Food and Nutrition	**The Greater Manchester Nutrition and Hydration programme (GMNH)** nutrition-and-hydration-programme-final-report-4th-june-2020.pdf (ageuk.org.uk)	Carmel Berke CarmelBerke@ageuksalford.org.uk
Greater Manchester	Social Isolation, Communities, Connectedness	**Culture Champions** https://greatplacegm.co.uk/creative-ageing/	Julie McCarthy Julie.McCarthy@greatermanchester-ca.gov.uk
Greater Manchester	Oral Health; Mouth Care; Learning difficulties; Care Homes	**Mouth care to reduce the risk of aspiration pneumonia**	Helen Parsley Helen.Parsley@phe.gov.uk
Cheshire & Merseyside	Oral Health; Mouth Care; Dementia; Care Homes	**Mouth Care Assessment and Treatment in Care Homes**	Helen Parsley Helen.Parsley@phe.gov.uk
Greater Manchester	Falls Prevention; Digital literacy; Hospital discharge	**The KOKU Digital Programme to prevent falls** KOKU_Summary.pdf	Emma Stanmore emma.stanmore@manchester.ac.uk
North West	Dementia; Carers; Social Isolation	**Greater Moments App** Evaluation of Greater Moments App Report.pdf	Gary Lovatt Gary@socialsense.co.uk

Appendix 2: Tools and resources

- Recommended reading list
- Resources
- Tools

Recommended healthy ageing reading list

- PHE's consensus on healthy ageing sets out **shared commitments** on healthy ageing
- The WHO's Baseline Report for the Decade of Healthy Ageing 2021-2030
- Centre for Ageing Better's The State of Ageing in 2020: an online, interactive report capturing a **snapshot of how people in the UK are ageing** today, while looking at past trends and our prospects if action isn't taken
- The NHS Long term plan sets out a **10-year vision** for the Health Service – search for the term 'older people' to find relevant sections:
  - Identifying and supporting unpaid carers (1.19)
  - Social care funding (1.57)
  - Slowing the development of frailty (2.2)
  - Improving the response to pneumonia (3.87)
  - Funding to scale successful volunteering programmes (4.54)
- Centre for Ageing Better: Living longer evidence cards
- Age UK reports and publications: Reports and briefings | Age UK

Healthy ageing resources

- UN Decade of Healthy Ageing - The Platform is a space where all relevant knowledge can be **accessed, shared and interacted with** in one place
- Adding extra years to life and extra life to those years sets out a **local government guide** to healthy ageing
- Centre for Ageing Better publications, including freely available **reports and infographics**, on employment, housing, health and communities
- Return on Investment (ROI) tool for **falls prevention programmes** in older people in the community
- Covid-19 Mental Health and Wellbeing Recovery Action Plan identifies **key commitments for 2021 to 2022**, building on the actions taken to date
- National Falls Prevention Coordination Group: progress report outlines when COVID-19 had a major impact on both older people and falls services in England
- PHE Campaigns Resource Centre and Coronavirus Resource Centre have everything you need to deliver **award-winning marketing campaigns** on a local level
- English Longitudinal Study of Ageing (ELSA) collects **data from people aged over 50** to understand all aspects of ageing in England

OHID Local Knowledge and Intelligence Service (LKIS) tools

- The OHID Public Health Profiles are a **source of indicators** across a range of health and wellbeing themes that has been designed to support JSNA and commissioning
- The Productive Healthy Ageing Profile provides data and further information on a wide range of topics relevant to **our health as we age**
- The Wider Impacts of COVID-19 on Health (WICH) monitoring tool is designed to allow users to explore the **indirect effects of the COVID-19 pandemic** on the population's health and wellbeing
- WICH Intel packs help places understand **potential negative and positive impacts** on their populations and inform where interventions could be considered

Free library of positive and realistic images of people aged 50+ available from Centre for Ageing Better

Centre for Ageing Better

Action today for all our tomorrows

Authors and contributors

Authors: Sophie Baird and Tasneem Choudhri

Contributors: Val Upton, Cameron Hill, Katherine Valentine

Acknowledgements: A special thanks to Fiona Reynolds, Greg Barbosa and Michael Molloy for their steer and guidance on this resource.