Office for Health Improvement & Disparities

State of Healthy Ageing in Yorkshire and the Humber 2023

A resource to support local Health Needs Assessments

February 2023

This report provides an overview of healthy ageing and a look at how we're doing in Yorkshire and the Humber (Y&H)

The population is ageing with the number of people aged 65 and over in Y&H predicted to grow by around third between 2020 and 2040 (ONS, 2020; ONS, 2021)*. These changing demographics will result in new challenges for the health and care system and so it is important to understand the specific needs of the older population. This will enable appropriate actions to improve health as people age, reduce inequalities and to make Y&H a great place in which to grow old.

This report provides a comprehensive **overview of healthy ageing.** It begins to look at **how we are doing** in Y&H, with examples of great work already taking place in our region.

Work on healthy ageing in Y&H is underpinned by the **Age Well, Live Well Network**, established in 2021 to improve the lives and experience of older adults, promote healthy ageing and address the wider determinants of health in later life, and by the **Healthy Ageing Community of Improvement** bringing together the public health leads for older adults from local authorities across the region.

This report is **recommended for** public health and other local authority teams, elected members, integrated care boards (ICBs), NHS providers, voluntary and community sector and other partners in Yorkshire and Humber with an interest in this area.

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

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

* Based on latest subnational projections available by ONS, from 2018 mid year population estimates, compared to 2020 mid year estimates by ONS. Projections based on Census 2021 estimates were not available at the time of writing.

Aims and objectives

People are living longer lives with fewer children which means the population in the UK and in the Y&H region is ageing. 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** across the system in Y&H.

This report therefore aims to:

- shine a **spotlight** on healthy ageing in the Y&H
- **highlight** wider impacts of COVID-19 on older people
- **engage** elected members, public health teams, other local authority teams, NHS and voluntary sector partners in a regional discussion on healthy ageing to identify and share examples of good practice
- **support** Local authority public health teams who are developing or refreshing their joint strategic needs assessments (JSNAs) or healthy ageing strategies
- **explore** more integrated ways of working with our integrated care boards (ICBs), NHS England (NHSE) 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

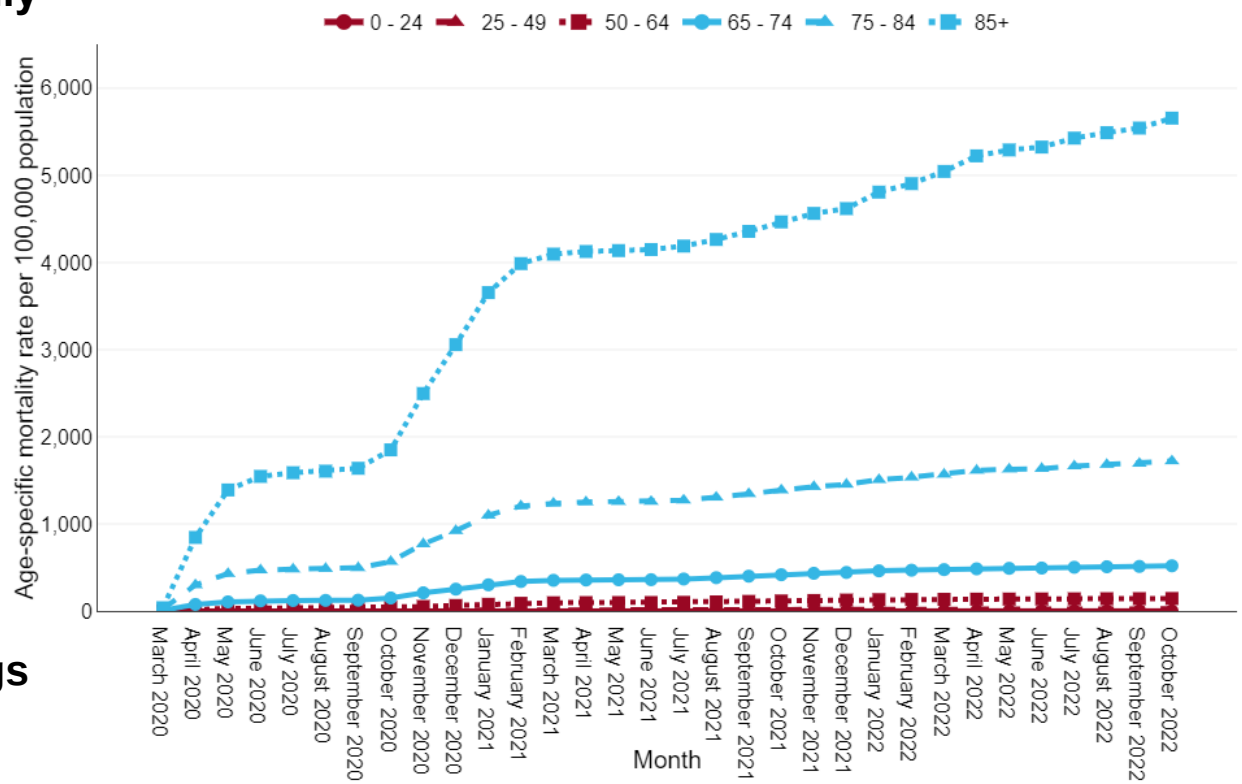
COVID-19 has had a disproportionate direct impact on older people

In January 2020, COVID-19 reached the UK, and by 23rd March the country went into lockdown. As part of stay at home and self-isolation guidance by the government, **over 70s were identified as 'clinically vulnerable'***, 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, COVID-related **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. Mortality rates involving COVID-19 in ages 75 and over have been significantly higher in **Yorkshire and Humber compared to the England average****. 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.

Yorkshire and Humber cumulative age-specific mortality rate by age, for deaths involving COVID-19



*The clinically vulnerable included all those aged 70+ regardless of medical conditions, a classification distinct from the 'clinically extremely vulnerable' who were advised to shield and take particular care to minimise contact with anyone outside their household. ** Accurate as at Jan 2023. Source: OHID CHIME tool, cumulative death rates involving COVID.

Data source: OHID. CHIME tool Jan 2023

The pandemic has highlighted the inequalities around how people age

This report includes the results of a **rapid review of evidence** originally undertaken by OHID North West. It investigates 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 the OHID North West rapid review** are published in a separate resource.

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 this demographic transition will have an impact on almost all aspects of society.

ONS Census 2021 estimates there to be **10.4 million people aged 65+ in England**, **18.4%** of the total population (ONS. 2022). But the older population continues to grow, driven by improvements in life expectancy, as well as a decrease in fertility and people having children later in life. **The age group 65+ is projected to grow to around 24% of the total population by 2043** (ONS, 2022)*.

A 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** about older people, and support everyone to achieve healthy productive ageing.

* ONS Principal projections accurate as at January 2023, 24% refers to England population projections in 2043. National population projections which will based on Census 2021 data, were not available at the time of writing. ONS principal projection is based on assumptions considered to best reflect recent patterns of fertility, life expectancy and migration

Ageist attitudes continue and this needs to be challenged

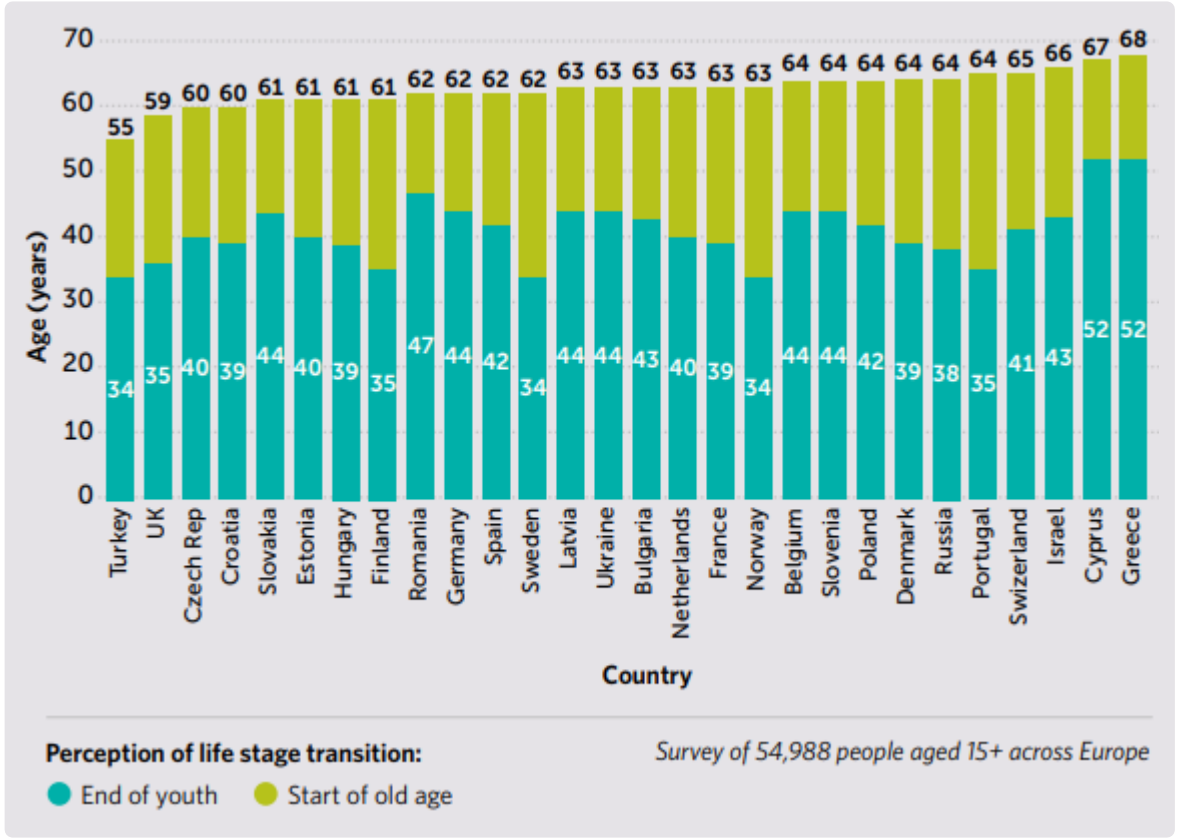
Recommendation:
Challenge negative language and imagery of older people and shift conversation to celebrate successes and benefits of an ageing population

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 is 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;
- providing older people who need it with **access to long-term care**.

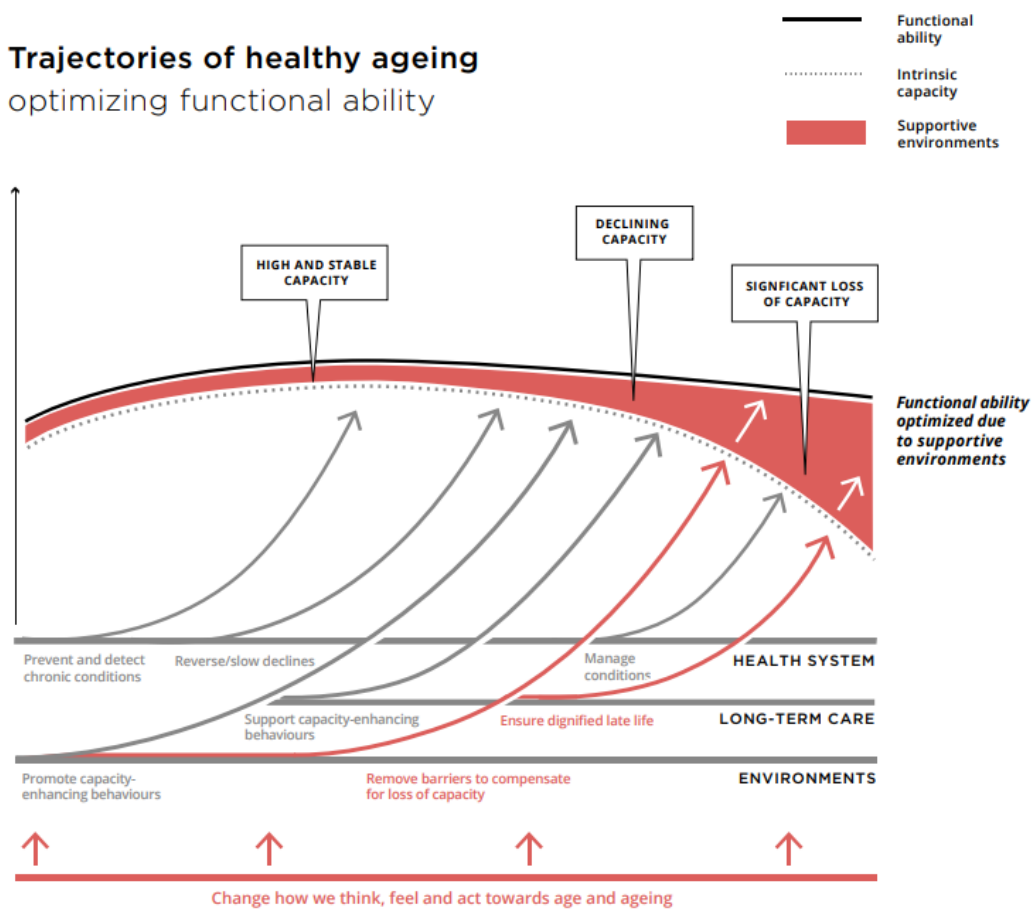
‘Healthy ageing’ is about maintaining functional ability

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.



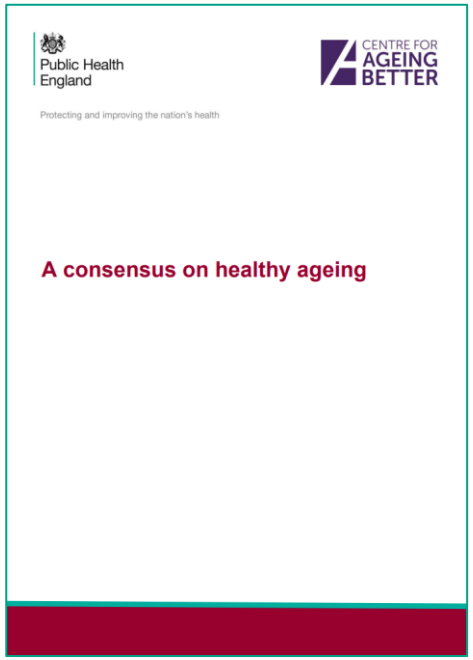
Source: WHO. Decade of Healthy Ageing Baseline Report. 2021

England pledges 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 entered the Decade of Healthy Ageing.

Organisations in Y&H can use the consensus statement as a framework for taking action on healthy ageing.

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



Signatories pledged to champion **five commitments**, 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**

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

People at the Heart of Care (2021)

Personalised care to enhance quality of life and independence

* 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"

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

Department for Levelling Up, Housing and Communities

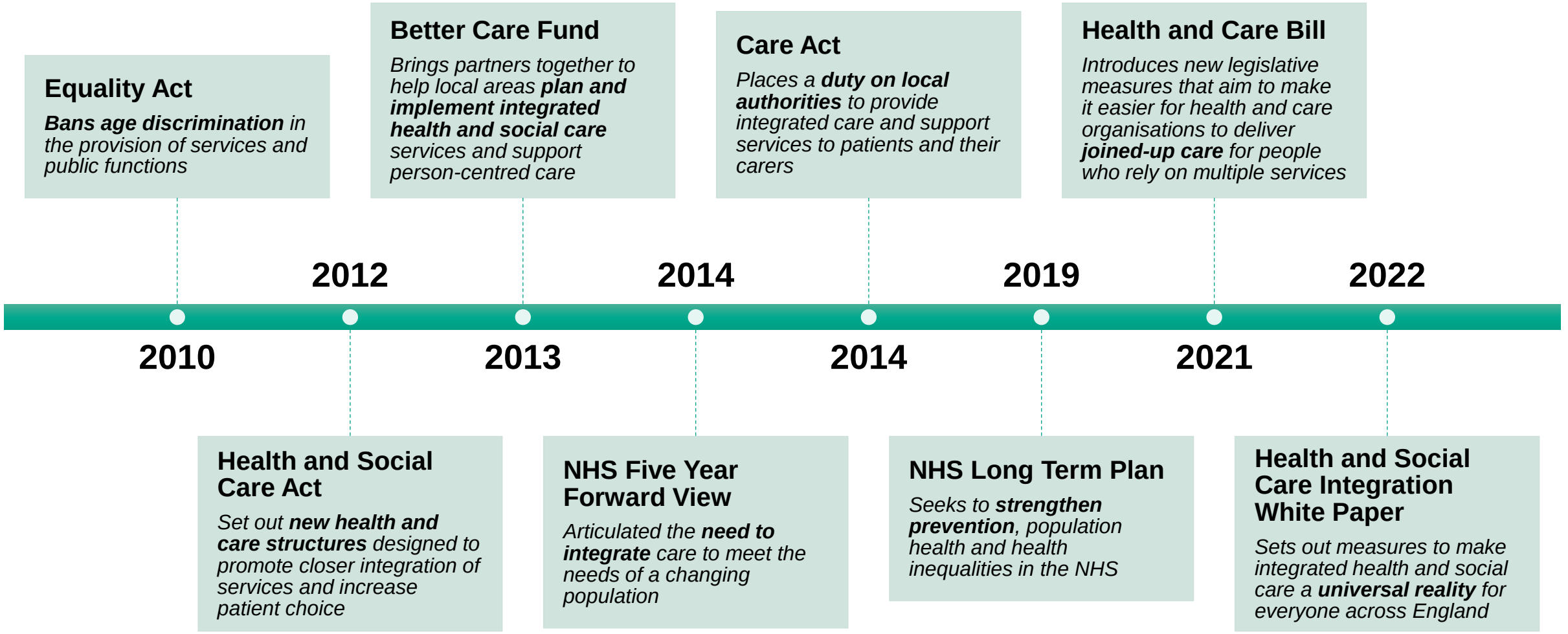
Levelling Up the United Kingdom (2022) Task force to look at better choice, quality and security of housing for older people

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



Yorkshire and the Humber 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 Y&H around healthy ageing, with all 15 local authorities engaged in the healthy ageing community of improvement and seven local authorities part of the UK age-friendly network.

But we want to make Y&H 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** needs 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 recent establishment of the **Age Well, Live Well network** to collaborate across the system is a key mechanism for driving progress on the healthy ageing agenda.

2. Population

Age and sex

Ethnicity

Sexual orientation

Disability

Deprivation

Intersectionality

Age structure in the region between Census 2011 and 2021

Census 2021 estimates show that older people **aged 65+ make up nearly a fifth** of the Yorkshire and Humber population (19.0%), totalling over **1.04m people**.

Age group **50 to 64 make up another 1.08m people (19.7%** ONS, 2022). This group will be preparing for retirement, if not already retired, and will move into the older age group over the next 15 years.

These population pyramids show the population of males and females in each five-year age group at the time of the 2011 Census and 2021.

The **largest age group** in Yorkshire and the Humber in 2011 was those aged 40 to 44 years. More recently, in 2021, the largest age group in the region was made of people aged 50 to 54 years, as shown in the population pyramids below (highlighted in dark blue).

The age and sex distribution of the population of Yorkshire and the Humber in 2011 and 2021

From: Population change, Census 2021 – ONS

Older people make up nearly a fifth of the region's population but this varies by local authority

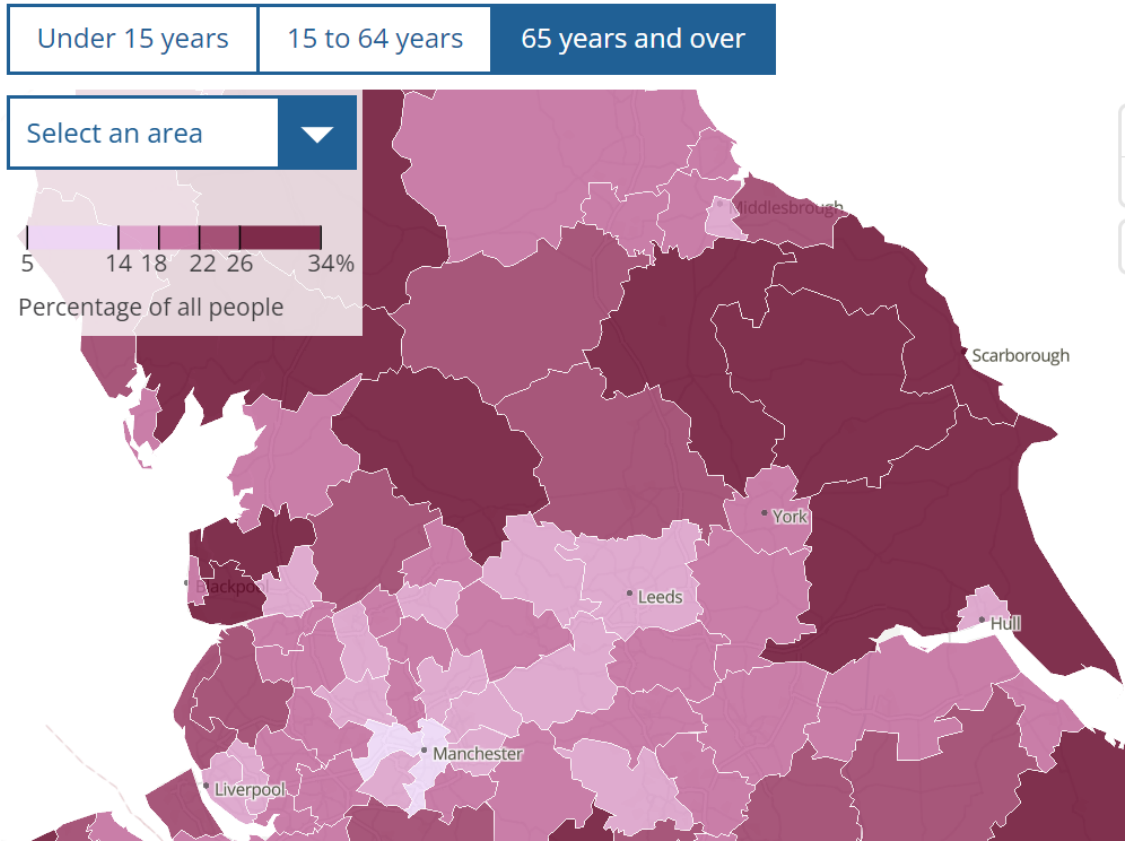
As shown on the map by ONS, the proportion of the population aged 65+ varies by local authority. In Yorkshire and the Humber region, five local authorities already have over 26% of the population in the 65+ age group.

ONS data predicts* that between 2020 mid year population estimates and 2040 projections, the older population in Yorkshire and Humber is set to **increase by 34%**, to around **1.4m** people. The **oldest cohorts** are projected to increase most:

- those aged 85-89 will have increased by 55%
- those aged 90+ will have increased by 89%

*As projections based on Census 2021 data is planned to be published later in 2023, the projections used in this section are the latest ONS 2018 based projections available at regional and LA level. The baseline is the ONS 2020 mid-year estimates available at the time of writing. There are also methodological changes planned including 'Prospective new method for setting mortality assumptions for national population projections'

The proportion of ages 65 and, 2021, local authorities in Yorkshire and the Humber

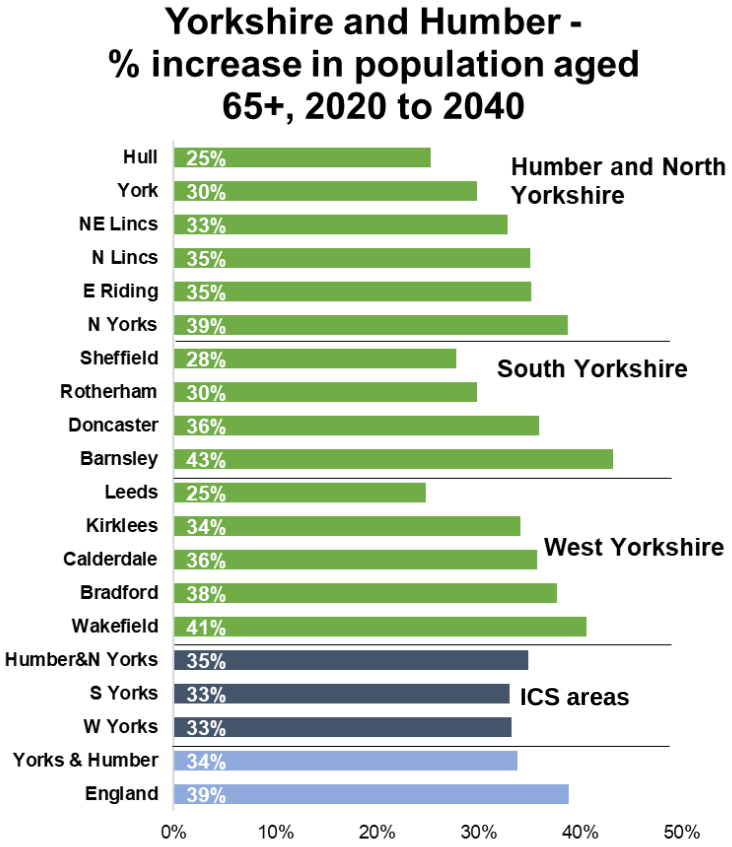


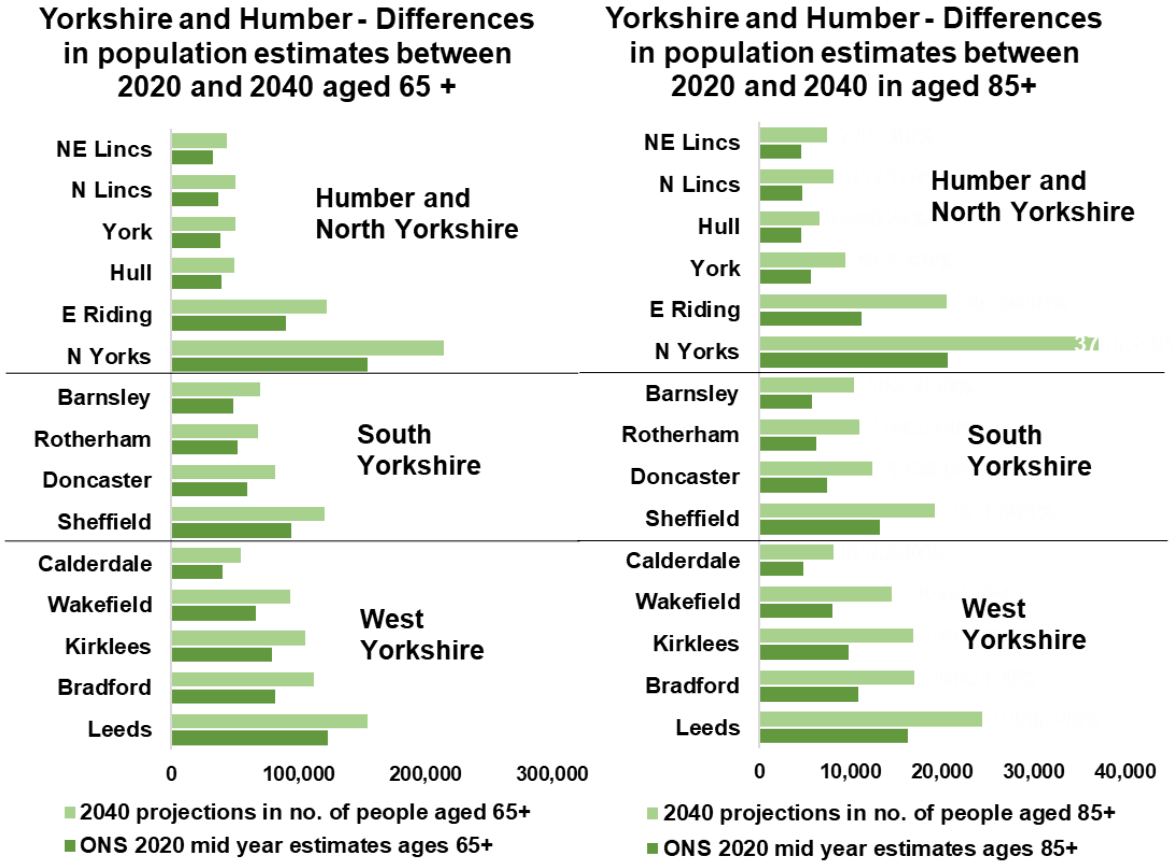
Source: Population and household estimates, England and Wales - ONS

The projected growth of those aged 65+ and 85+ by local authority

Between 2020* and 2040, the over 65 population in the Yorkshire and Humber region is predicted to grow by around **34%.** However, this **varies greatly** across the region.

According to these estimates, three local areas are set to see **greater growth** than other areas: **North Yorkshire, Barnsley and Wakefield**.



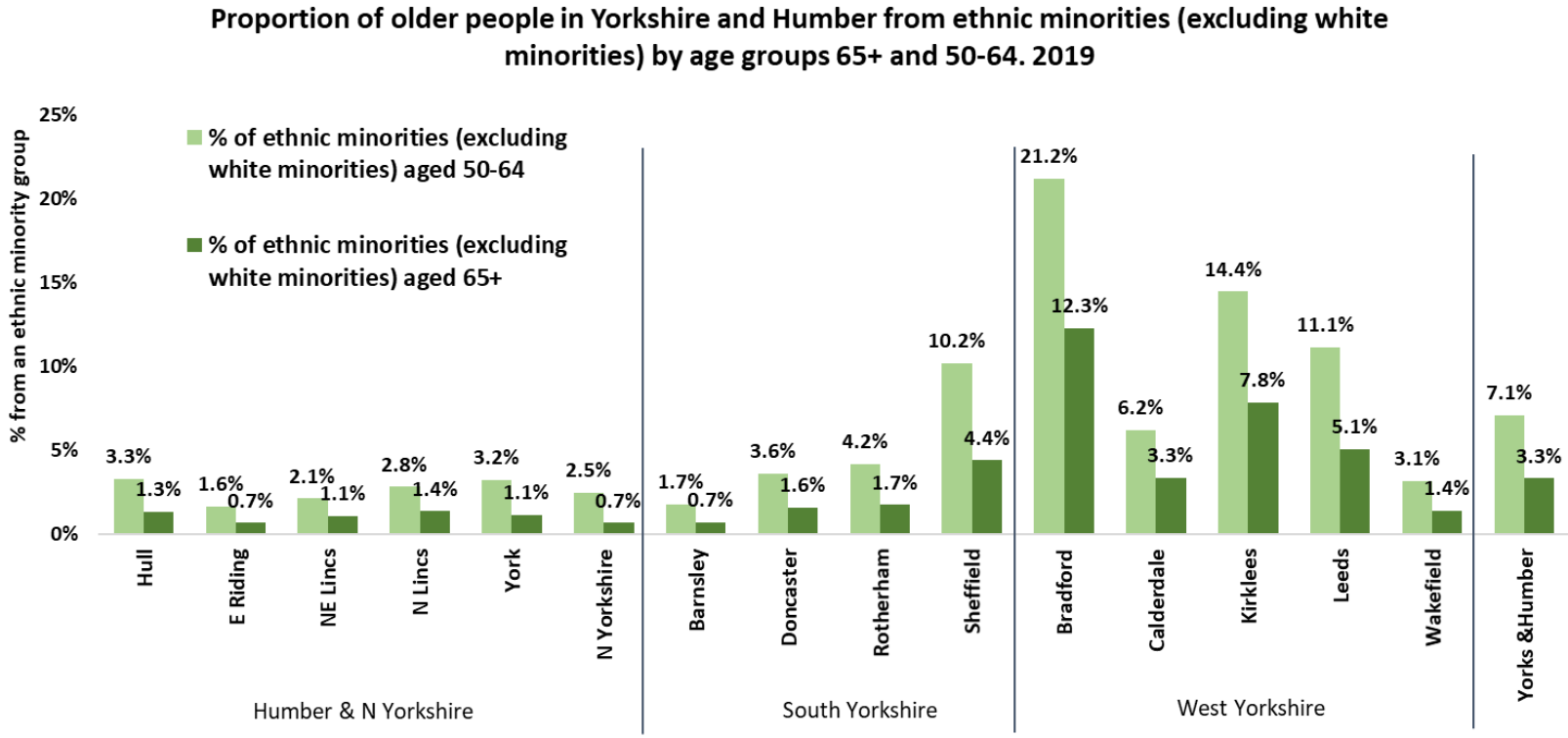


Data source: ONS. *ONS 2020 mid-year estimates and 2018 based population projections 2020. **NB.** Projections are not forecasts and, because of the inherent uncertainty of demographic behaviour, or COVID-19 impact long term, migration etc. any set of projections will inevitably differ from actual future outcomes to a greater or lesser extent. As such, the subnational population projections should be used as a starting point and supplemented with local information for planning purposes. ** ICS estimates are totals of the local authorities estimates.

There are small pockets of older ethnic minority groups in Yorkshire and Humber

The proportion of older ethnic minority population (excluding white minorities) varies across the region. The latest available data shows also large differences between ages 65+ and the age group 50-64, in 2019. (ONS. 2020)

Census 2021 data suggests some areas have seen significant changes in their ethnicity breakdowns since the 2011 Census, but that data broken down by age was not available at the time of writing. Nevertheless, the chart and data from 2019 gives an indication of the variation by local authority areas and older age groups.



Data source: ONS Population denominators by broad ethnic group (2020)

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. At the time of writing, Census 2021 data on ethnicity by age was not available

Ethnic inequalities in self-reported 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 self-reported 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. Research by the Centre for Ageing Better (2020) found that people from black, Asian and ethnic minority groups aged 50-70 are more likely to live in **deprived neighbourhoods**, be in low paid jobs and/or with **less access to other sources of income**, such as pension savings and assets and are **less likely to own their home** than their white counterparts. Some ethnic minority groups are more likely to experience **language barriers** than their younger counterparts. Other barriers in accessing services are 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 Census 2021 estimates show **3.07% of people in Y&H** identifying as gay or lesbian, bisexual, or other sexual orientation, compared to England at 3.2% (ONS, 2022). The proportion of the population aged 16+ who reported that their gender identity was different from their sex in Y & H was 0.53%, similar compared to England at 0.55% (ONS, 2023).

Findings from the Annual Population Survey (ONS, 2019) indicate that whilst people aged 16-24 were the most likely to identify as LGB, the proportion of people aged 65+ identifying as such increased between 2018 to 2019.

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 Loneliness and social isolation were not universal experiences among older LGBT people, but the risk increased where resources for them to meet and socialise with other members of the community were not available or accessible (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**.

LGBT+ people broadly considered larger urban areas safer than smaller towns and rural areas and older LGBT+ people reported travelling from rural and coastal areas to nearby cities or larger towns to access specialist services (Age UK). 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.

Older LGBT+ people face inequalities that may be reduced through tailored care and support

- Older LGBT+ people value peer-led support and services, including around caring responsibilities and dementia.
- Older LGBT+ people with dementia may face challenges such as being unsure who they have come out to and may express new identities and orientations as the condition progresses. Specialist support to cater for their particular needs including tailored support around planning for later life and end of life may reduce the inequalities they face (Age UK).
- Differences in the social networks of older LGBT+ people (such as not having children or being alienated from family members) can lead to a greater need for formal care (ILC, 2019).
- Many services are heteronormative, which assumes everybody is heterosexual and expects everybody to have lives that are the same as heterosexuals. This can result in inequalities in access to and the delivery of health and care services.

A webinar exploring **health inequalities for older LGBT+ people** was held in Y&H in 2021
North Yorkshire County Council participated in a test and learn project to implement findings of the Age UK/PHE report on **ageing in coastal and rural communities and the factors underlying inequalities for older LGBT+ people**.

In the **2021 Census** the ONS included a question around gender identity and sexual orientation **for the first time providing** useful data, including at local authority level, to inform policy and service planning and provision.

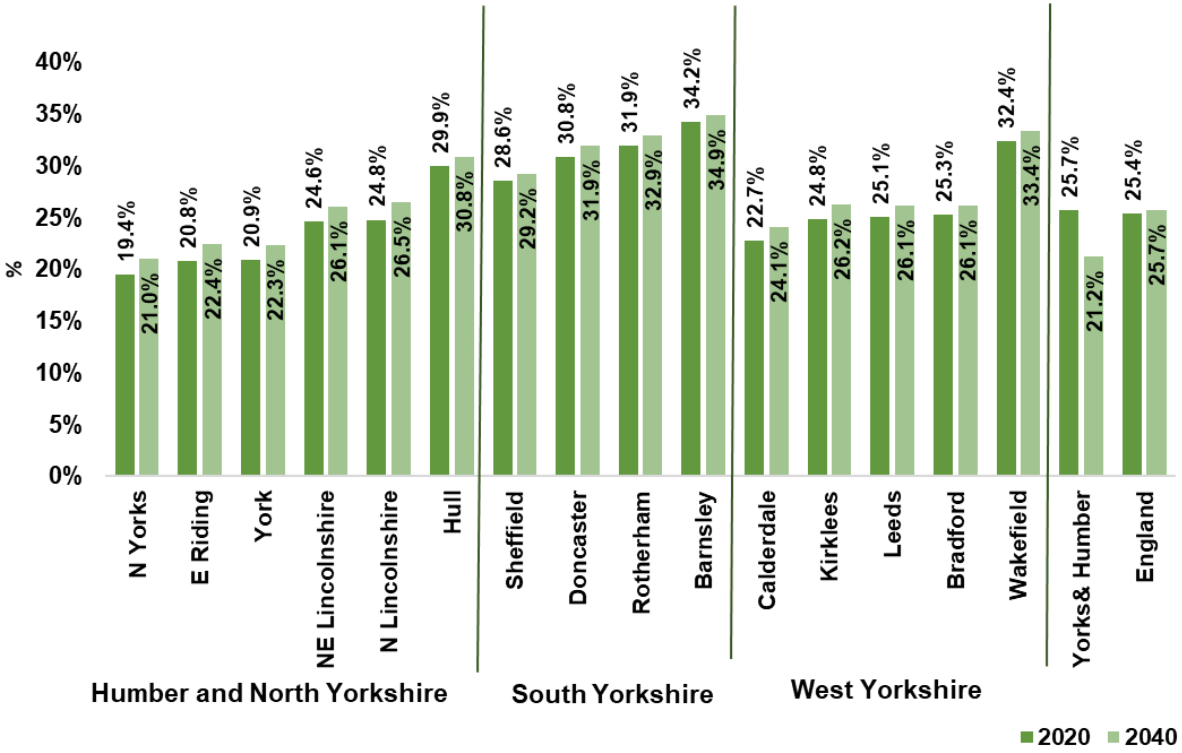
Over a quarter of older people in Yorkshire and the Humber are severely limited in their day-to-day activities

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 2020, Yorkshire and Humber, 52% of older people aged 65+ are estimated to have a long-term illness whose day-to-day activities are limited at least a little. **26% are limited a lot** in their day-to-day activities, totalling about 270,000 people. With population growth, this figure is **projected to rise** to nearly 380,000 older people in region 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.

Percentage of people aged 65+ projected to have a limiting long term illness whose day to day activities are limited a lot.
Yorkshire and the Humber. 2020 values and 2040 projection



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**. In 2020 that was estimated at nearly 3,000 older people in Yorkshire and Humber (0.3%), and projected to rise, with the population growth, by 22%, to nearly around 3,800 older people, by 2040 (POPPI. 2022)

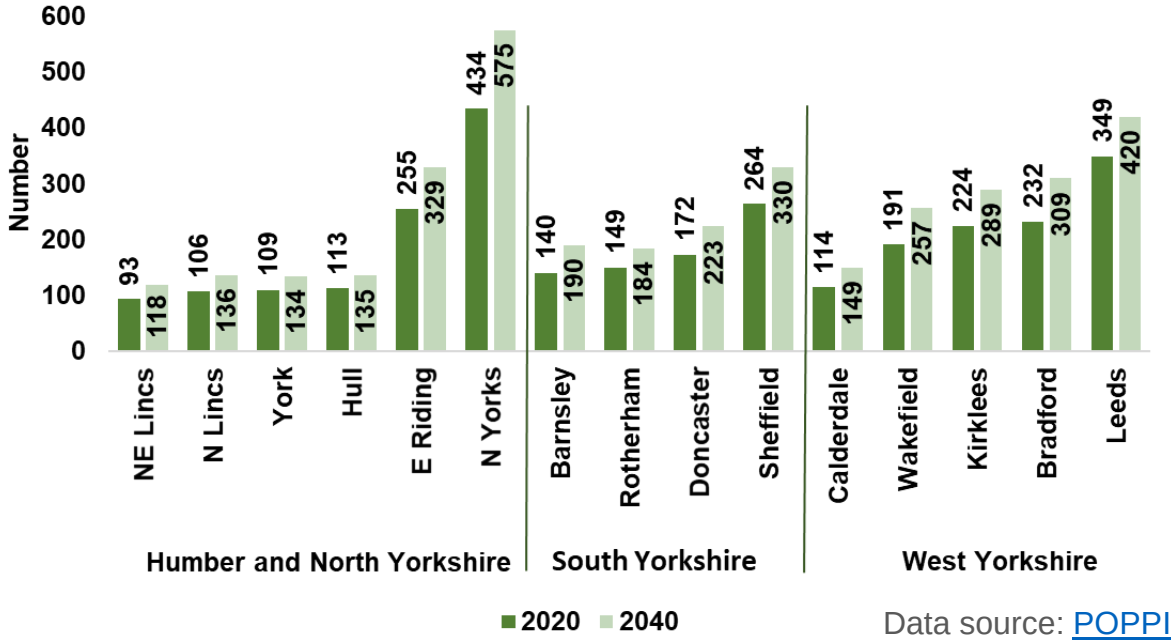
This group have very specific care needs as they will often develop conditions associated with **ageing at a younger age**, particularly dementia and sensory impairment.

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.

Number of people aged 65+ predicted to have a moderate or severe learning disability. Yorkshire and the Humber. 2020 values and 2040 projection



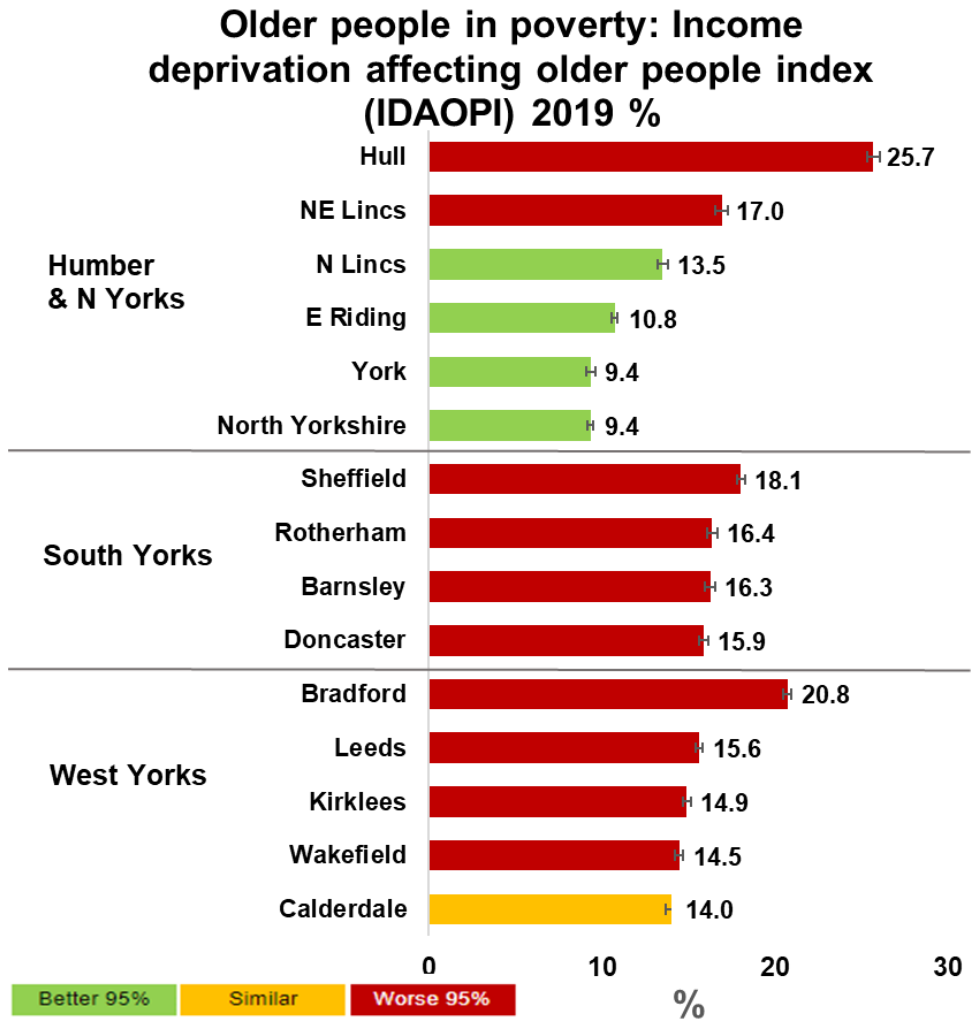
Data source: POPPI

Up to a quarter of older people in Yorkshire and Humber are living in income deprivation

Area level deprivation is significantly associated with health outcomes and a major factor in health inequalities. Those living in the most deprived areas are more likely to have worst health outcomes, creating a **cumulative impact throughout life course**. According to the 2019 Index of Multiple Deprivation (IMD) rankings, **2 of the 12 most deprived local authorities in the country** are in **Yorkshire and Humber**, Kingston upon Hull and Bradford.

Part of the IMD 2019, the **Income Deprivation Affecting Older People Index** (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation.

As shown on the chart, the highest proportion of older people living in income deprived households in Y & H local authorities are **Hull, Bradford, Sheffield and North East Lincolnshire**. The local authority areas with smallest proportion of older people in poverty, and significantly better than the England average, are York and North Yorkshire, East Riding and North Lincolnshire.



Data source: OHID Productive Healthy Ageing Profile. 2022

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 concept is referred to as 'intersectionality'.

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

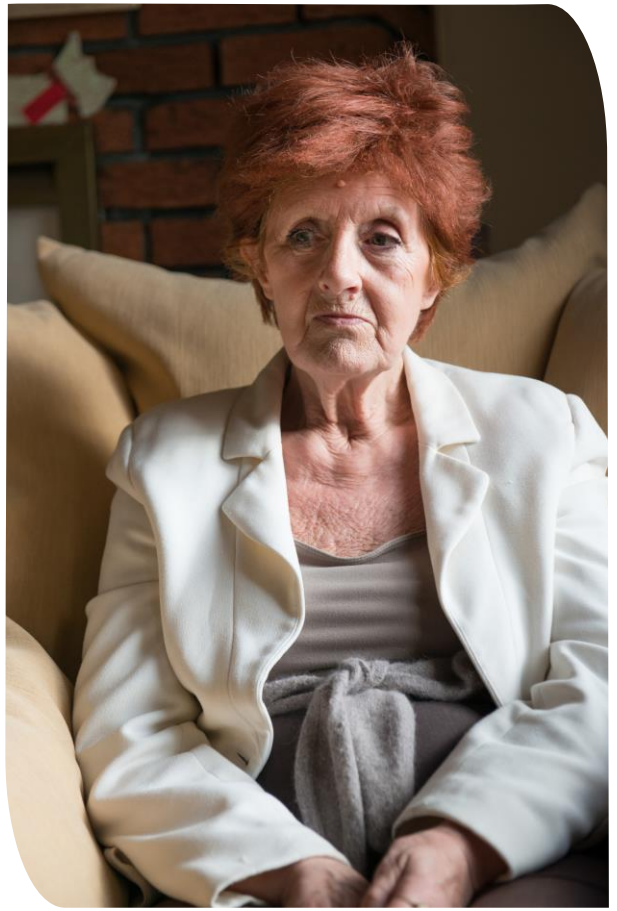
COVID-19 has had a disproportionate impact on older people, especially those in vulnerable groups

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.

The 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

Loneliness and social isolation

Housing

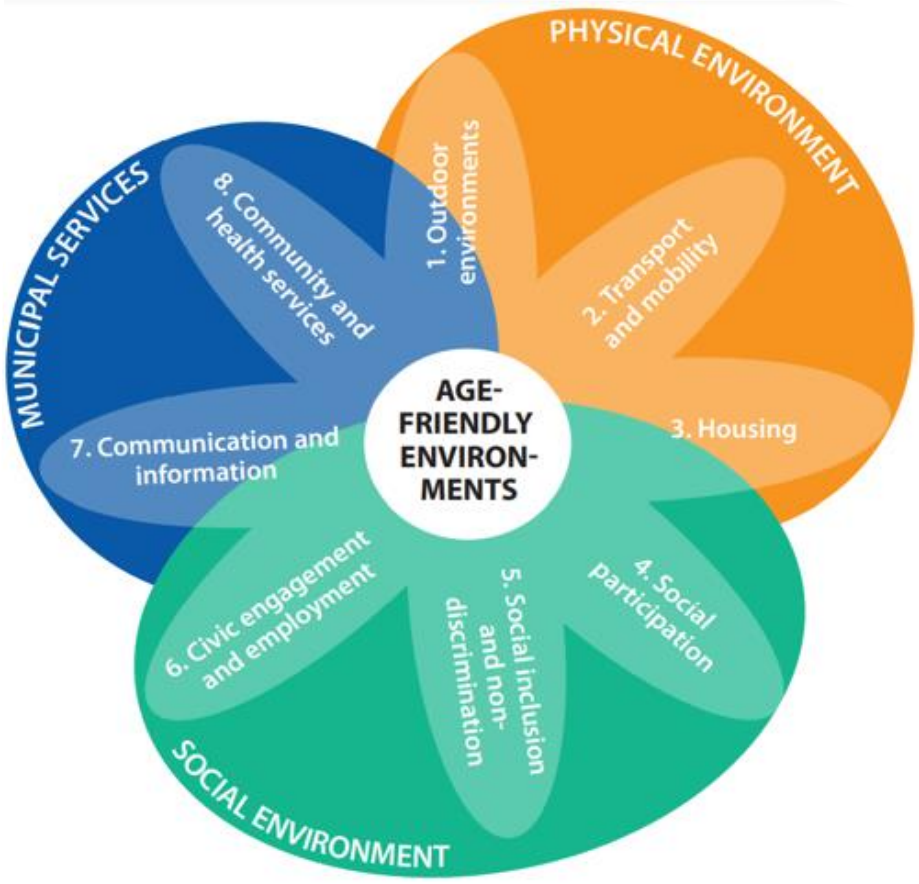
Employment and retirement

There are 8 domains to an age-friendly environment and Yorkshire and Humber is making good progress

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

Seven areas in Y&H are already members of the network of **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



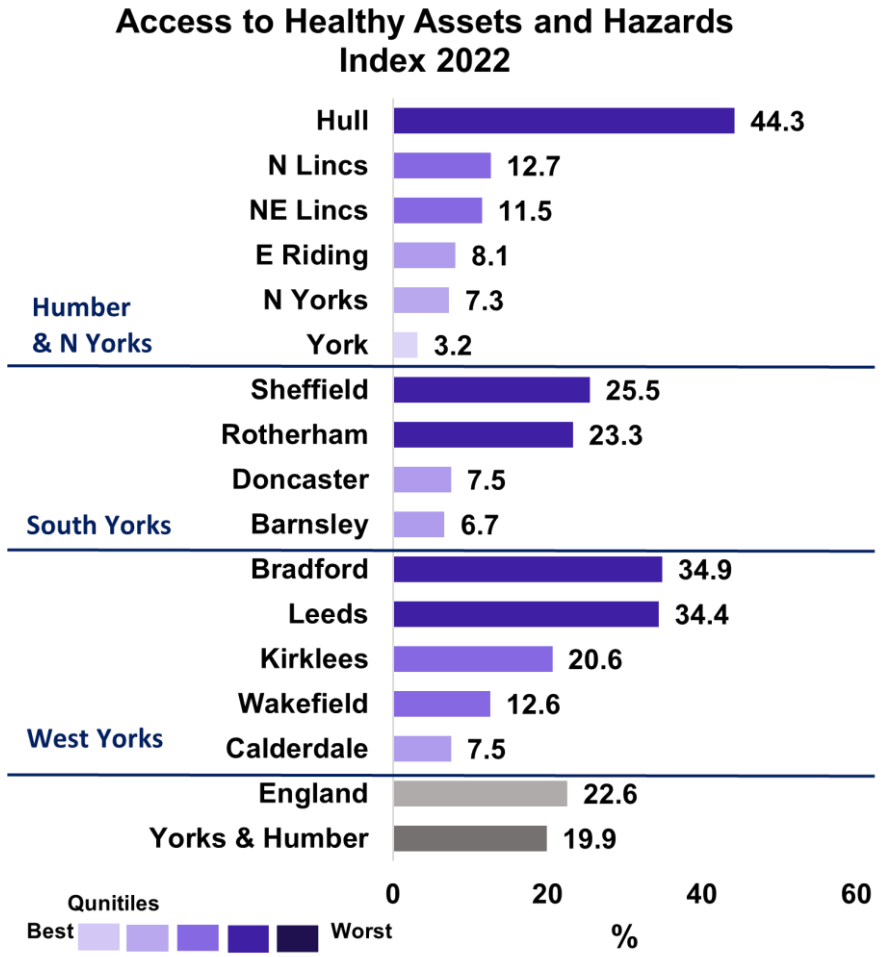
Source: World Health Organisation, 2018

The AHAH index indicates that Y&H is conducive to good health, but it excludes key elements of connectivity

The Access to Healthy Assets and Hazards (AHAH) index provides information on how conducive an area is to good health, relative to other areas. It comprises four domains:

1. **access to retail services** (e.g. fast food outlets, gambling outlets, pubs)
2. **access to health services** (e.g. GP surgeries, A&E hospitals, pharmacies, leisure centres)
3. **the physical environment** (e.g. access to green spaces)
4. **air pollution** (NO2 level, PM10 level, SO2 level).

Overall, Y&H as a region is a place conducive to good health: the percentage of **people in Yorkshire and Humber who live in neighbourhoods *least conducive to health* is lower than the England average (19.9%)***. Areas that have the highest proportion of people living in areas *not conducive to health*, are: Kingston upon Hull, Bradford, Leeds, Sheffield and Rotherham. Older people confined to these areas during COVID restrictions may have suffered worse impacts of lockdown.



Data source: OHID Productive Healthy Ageing Profile

* It should be noted that basic regression analysis indicates that the AHAH index is **not associated with deprivation***. It is important to note the caveats around data quality of the AHAH index and, while it provides a summary of specific indicators, it does not include access to transport and digital services.

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.

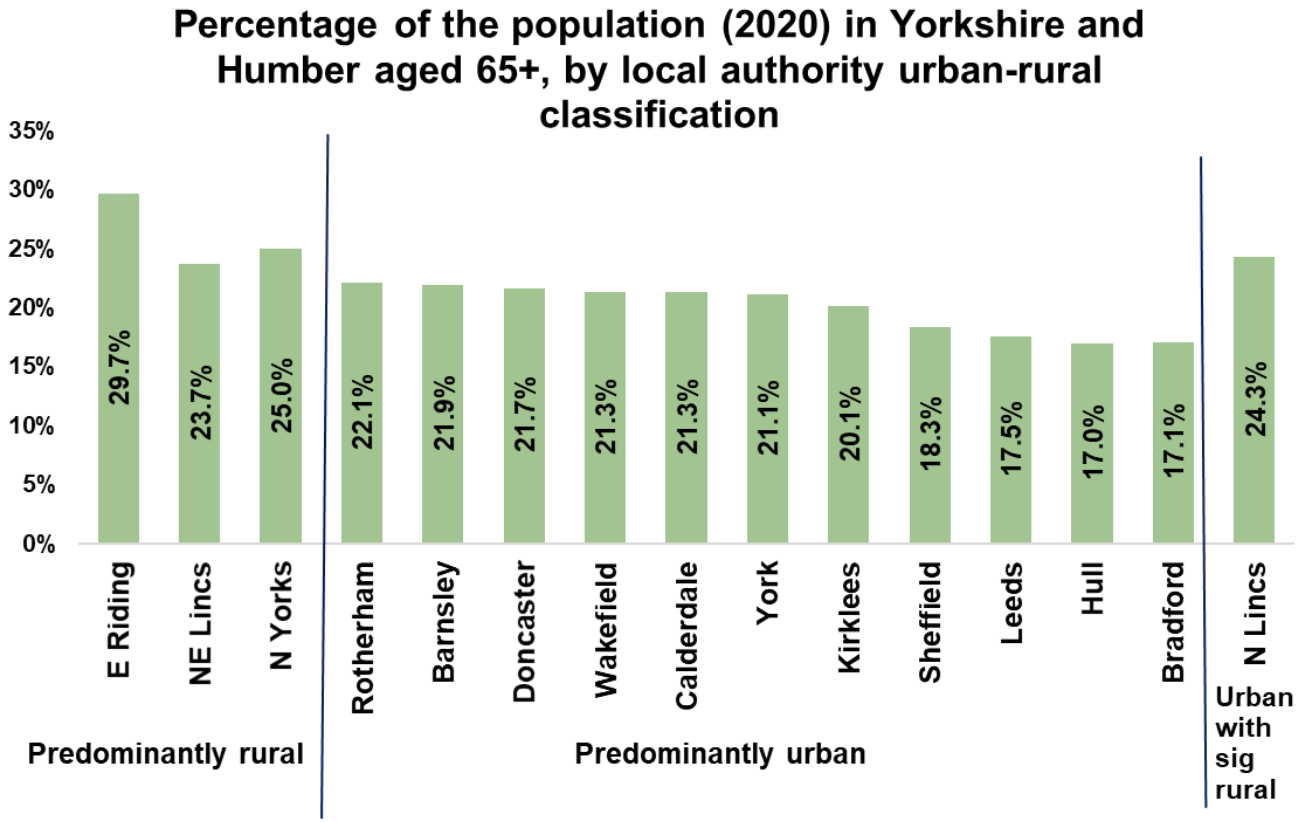
Recommendation: Support people to remain connected as they age with good transport links, green spaces, services, and facilities close to homes

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

Rural areas are more likely to have the higher proportion of older people than in the predominantly urban areas. As shown on the chart, in Y & H the four local authority areas with the highest proportion of ages 65 and over were:

- East Riding – predominantly rural
- North Yorkshire – predominantly rural
- North Lincolnshire – urban with significant rural areas
- North East Lincolnshire – predominantly rural

Sheffield, Leeds, Hull and Bradford have the lowest proportions of older people in the region, with **fewer than one in five** aged 65+. Rural and coastal communities are generally **less well connected** than urban areas and can have large health inequalities (CMO Annual Report 2021).



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

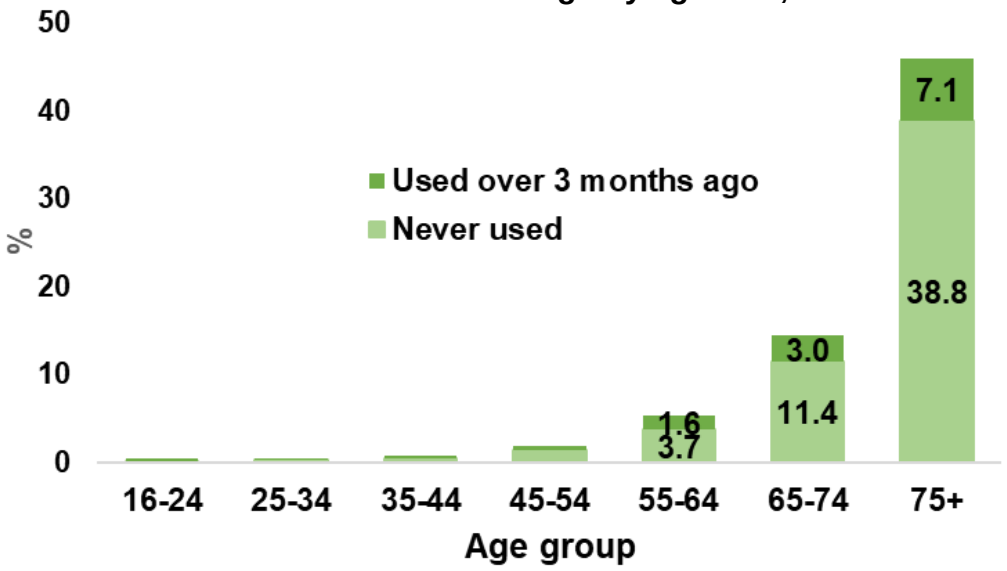
Beyond the ability to physically travel, new technologies and digital tools have an **increasingly important effect** on a person's ability to interact with the world around them.

The proportion of older people who **use the internet** regularly has grown rapidly in recent years, but still in 2020, 11% of people in the UK aged 65-74, and 39% of those aged 75+ have never used the internet, the age disparities clearly shown in the top chart on the right.

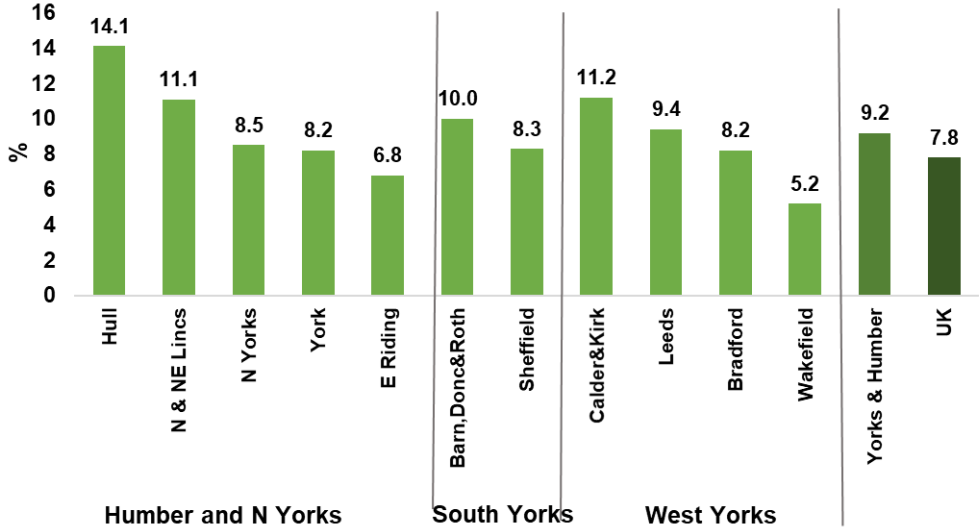
Y&H usage is not broken down by age, but four areas in the region have **higher levels of internet non-usage** than the UK. We can therefore assume that the proportion of Yorkshire and Humber older people who are digitally excluded is higher than the figures quoted above.

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.

Percentage of people (16+) who have never used the internet or used 3 months ago by age. UK, 2020



Percentage of people (16+) who have not used the internet within 3 months or more. Yorkshire and Humber, 2020



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.

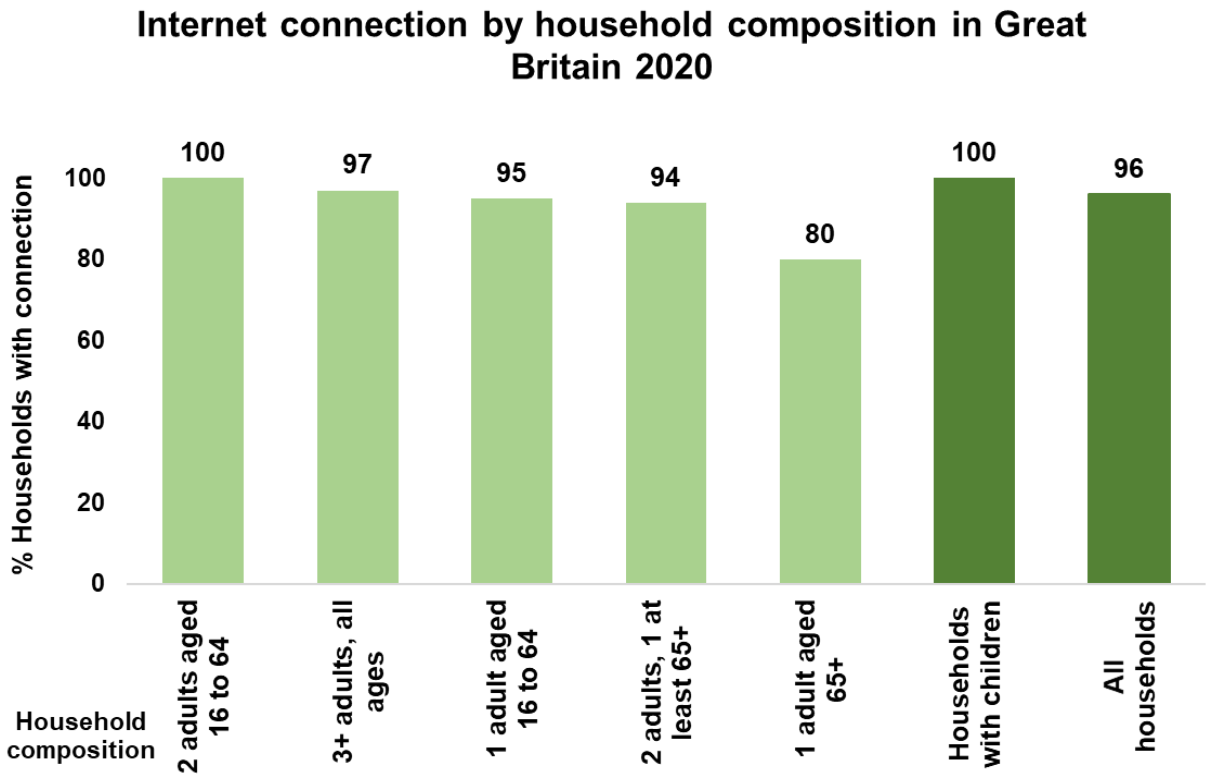
However, our rapid review of evidence* shows that this does not appear to have encouraged many previous internet non-users online. And a large proportion of older people are **still not interested in using the internet** more.

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).

*Rapid review accompanies this report

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)

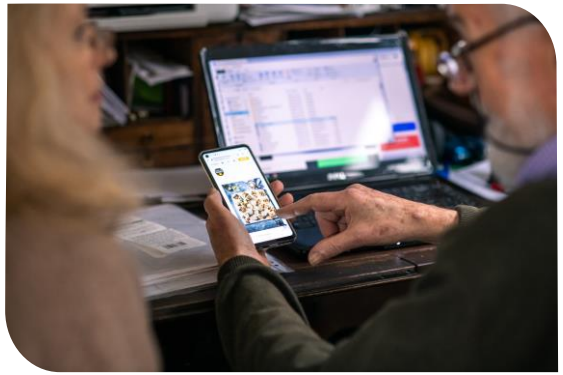
Older people are more susceptible to scams and fraud, which have risen during COVID-19

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, scams experienced by **people aged 55+ are more likely to occur through phone calls** and less likely to occur by email or online, compared to younger people. Survey data also suggests that adults aged 65+ were less likely to be a victim of fraud than all other age groups, except for adults aged 18 to 24 years (ONS, 2022).

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 access 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 may 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 provide peer support

Volunteering has a wide range of health and wellbeing benefits, giving people a sense that life is 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.

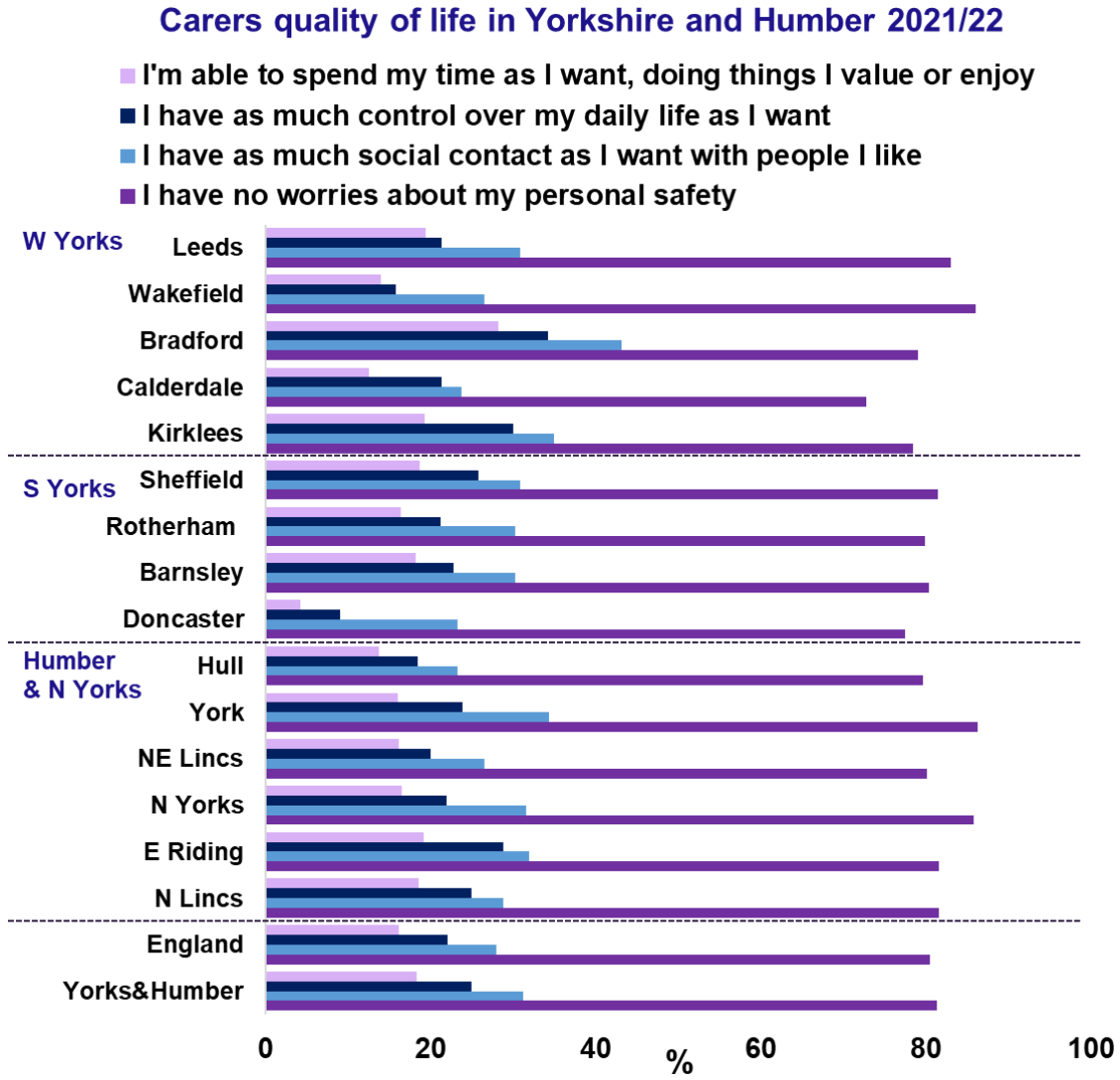
Caring should be considered a social determinant of health

A PHE review (2021) 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 2021/22 shows that, while many carers in Yorkshire and Humber 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: Personal Social Services Survey of Adult Carers in England

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

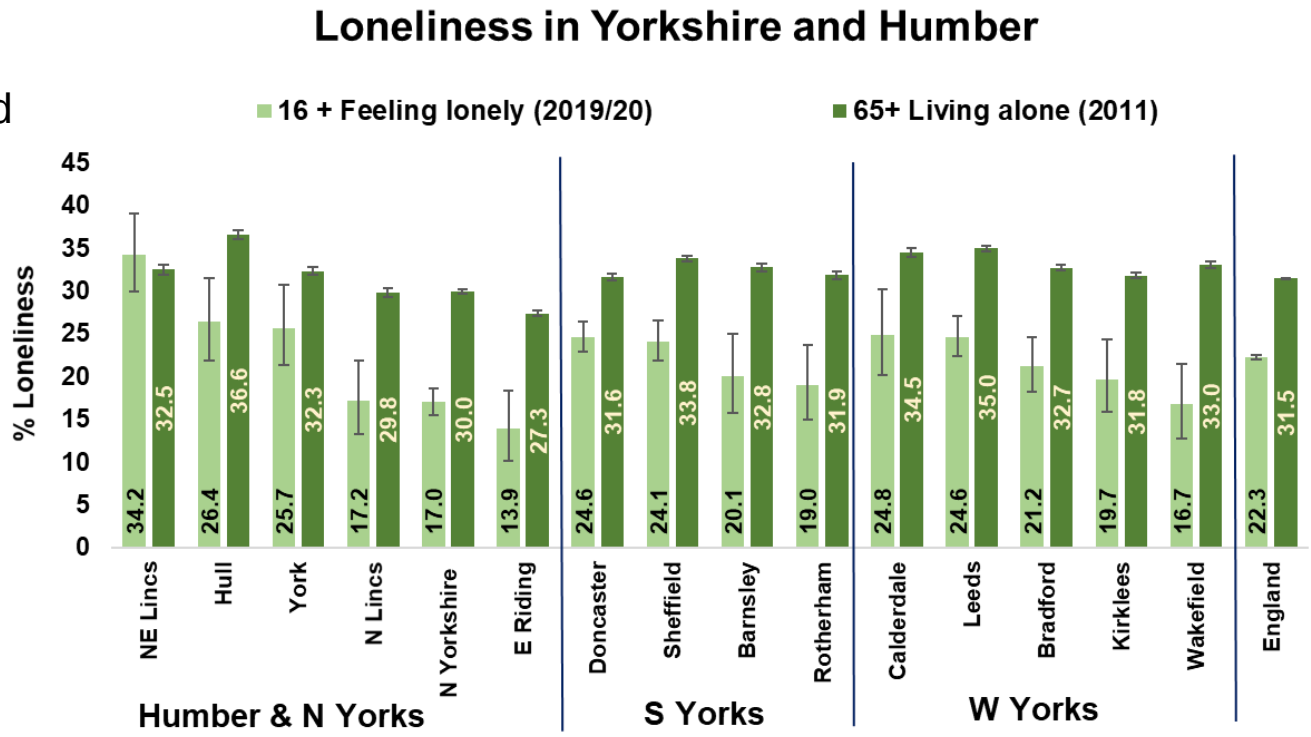
A third of older people in Yorkshire and Humber live alone, and over a fifth of people feel lonely

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

Up to a third of people of all ages in Yorkshire and the Humber 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.

Research by Age UK 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**.

*Census 2021 data will provide updated local figures, not available at the time of writing.



Data source: OHID. Productive Healthy Ageing Profile. 2022

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 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

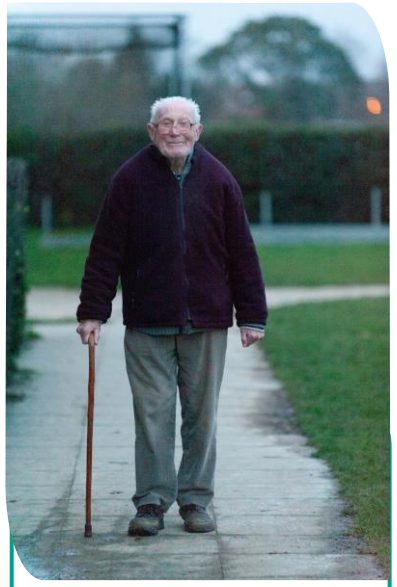
Loneliness and social isolation are **not the same**. People can be isolated without feeling lonely, or be surrounded by others and still feel lonely (Age UK).

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 and lonely than others, including disabled and 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 some **£1.4billion per year** (across all ages).

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** with repairs and maintenance varied by region, ranging highest (80%) in Yorkshire and the Humber.

Around 160,000 people in England live in park homes/mobile homes, 68% of whom are aged 60+. Whilst they can provide affordable housing an often offer a quiet retirement community, residents often find them very expensive to heat in the winter.

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

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

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**.

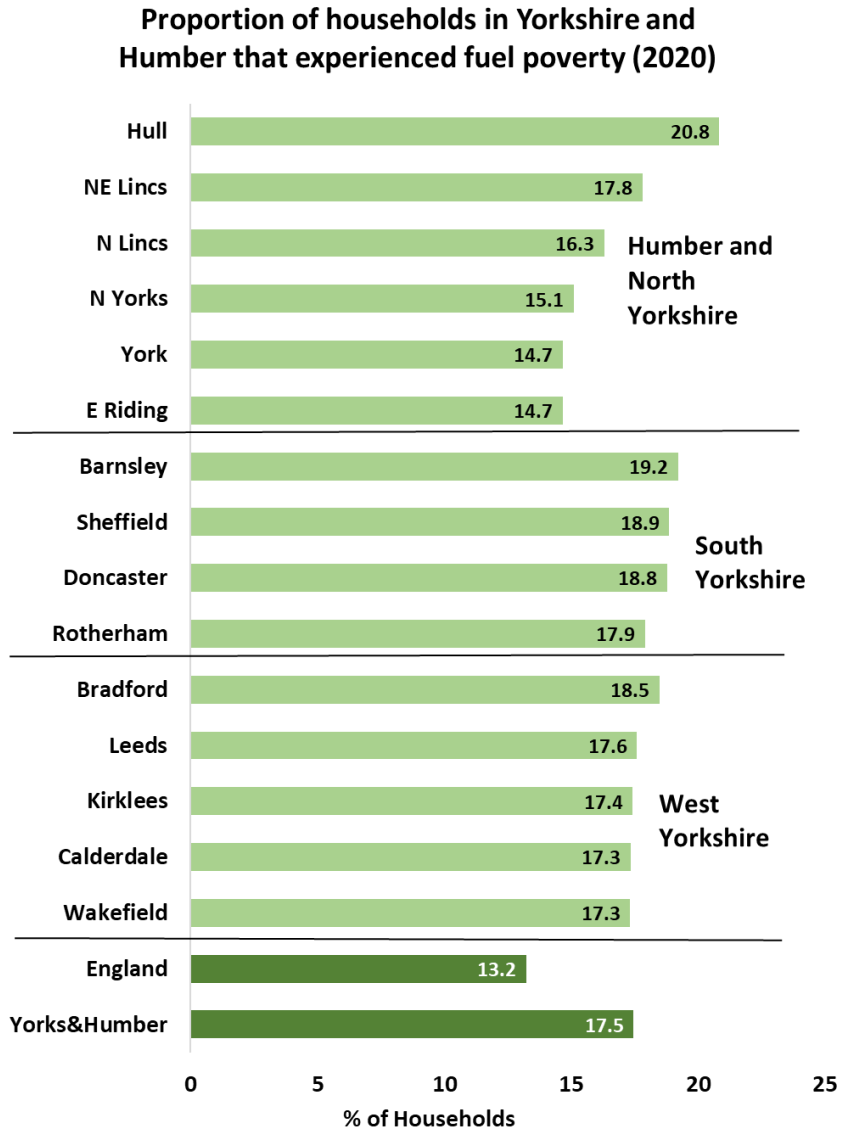
A Homes and Health webinar series examined some of the inequalities facing older adults

Estimated 18% of households in the region experienced fuel poverty in 2020

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.

The **drivers of fuel poverty** are considered to be low income, poor energy efficiency and high energy prices. In 2020, Yorkshire and Humber were estimated to have around 18% of households in fuel poverty. Hull, Barnsley, Sheffield, Doncaster and Bradford ranked highest in the estimated proportion of people in fuel poverty in 2020. The latest fuel crisis and rising prices are likely to have exacerbated the situation.

A household is considered to be fuel poor if they are living in a property with a fuel poverty energy efficiency rating of band D or below and when they spend the required amount to heat their home, they are left with a residual income below the official poverty line.



Fuel poverty (low income, low energy efficiency methodology)
Data source: OHID Productive Healthy Ageing Profile

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

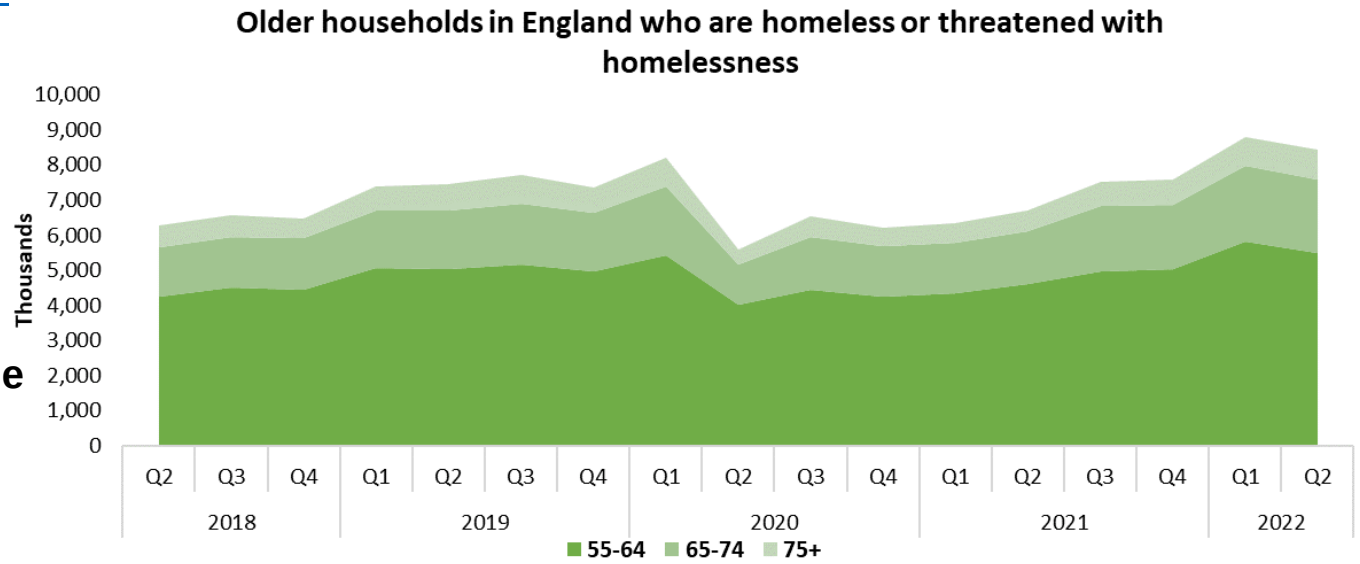
The association between older people and poor housing conditions is well-established. But the impact of COVID-19 and the reduced access to health and social care on older people's health has created a **critical situation**.

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** are highest in the **55 to 64 age group.** Overall numbers dropped from highs early on in the pandemic. However they are now **back on the rise and even higher than during the pandemic**, making up **12%** 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.



Source: Live Tables on Homelessness

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

The **employment rate** of people aged 50-64 has decreased from 73% at the time of the COVID-19 pandemic to 71% in 2020/21 (Fingertips). 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 (Centre for Ageing Better).

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 four consider leaving work due to severe symptoms, which can include fatigue and 'brain fog' (Centre for Ageing Better).

Health is the leading reason for the 50+ to be out of work, and the **disability employment gap** is especially large for older workers (ONS). 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 (ONS).

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 (Centre for Ageing Better). This impacts their ability to keep up to date with new skills and gain further employment.

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 (Centre for Ageing Better).

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 from 26% in 2012 to 34% in 2050 (Government Office for Science, 2016).Though the pandemic impacted on this and economic activity rates in the over 50s has decreased since.

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**. (HM Treasury, 2018)

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 **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

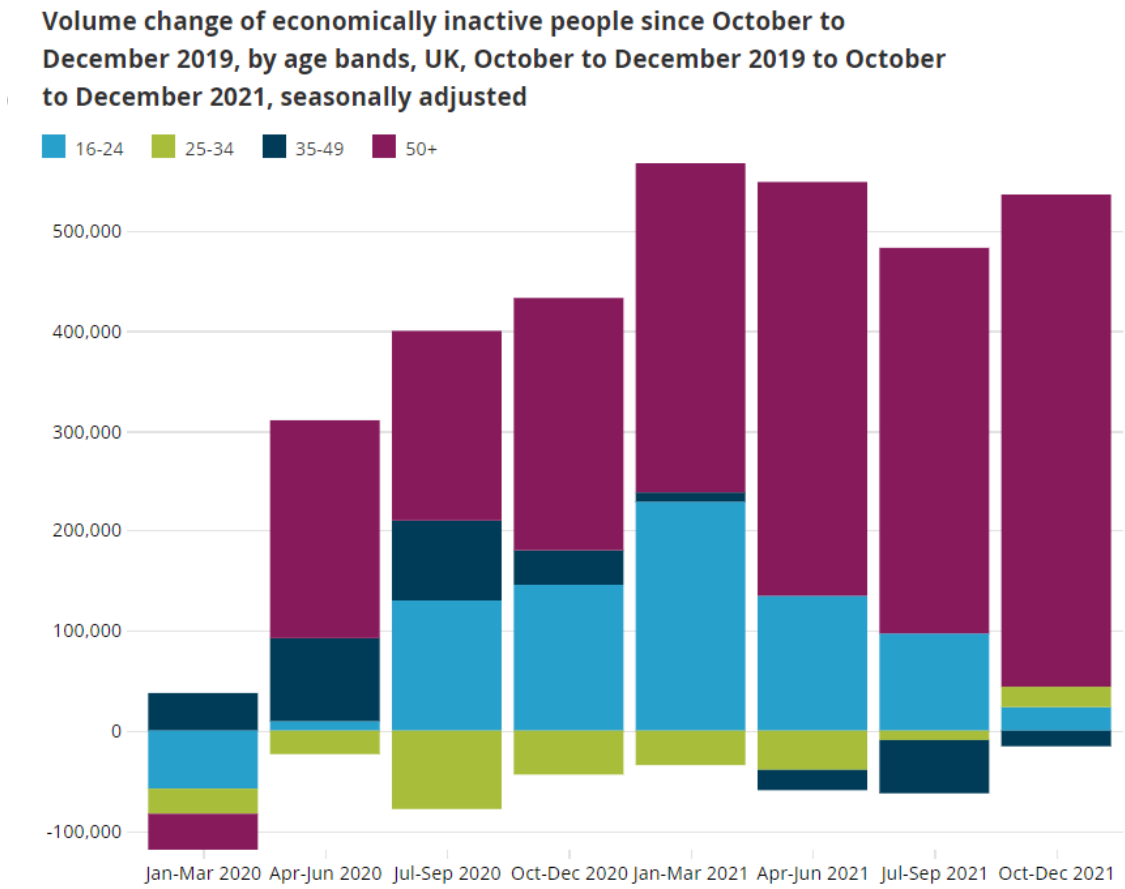
Recommendation:
Work with local employers to develop age-friendly policies that enable the recruitment and retention of older people in work

The COVID-19 pandemic increased economic inactivity for those aged 50+

Since the start of the Covid-19 pandemic more people aged 50 years and over moved out of work than any other age group, reversing the trend of reducing economic inactivity over the previous 10 years.

Almost half report retirement as the reason for leaving work, with people in professional occupations most likely to leave the workforce. Those leaving professional occupations were more likely to report that their savings had increased since the start of the pandemic and therefore may be better able to afford to retire.

Whilst retirement is the key driver, health, caring and change in lifestyle are also factors in decisions to stop working. Those who would like to return to the workforce are looking for more flexible working arrangements: working hours, the ability to work from home and to fit work around other responsibilities such as caring. Women were more likely to state they left their job to look after the home or for caring responsibilities.



Data source: ONS Labour Force Survey

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

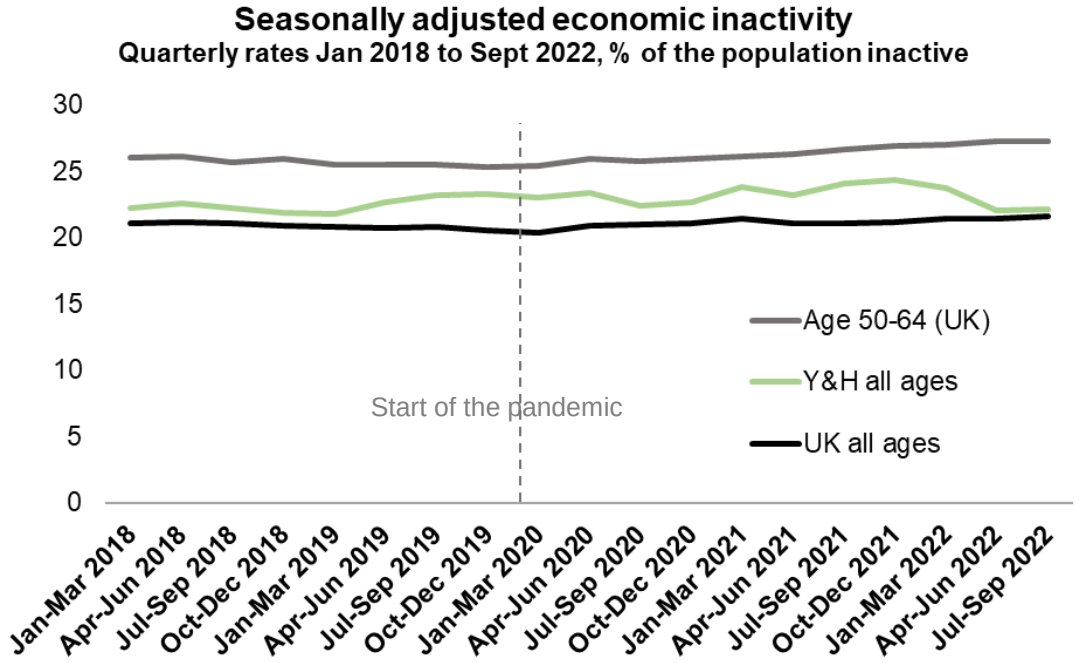
Deprivation has been further impacted upon by the COVID-19 pandemic in 2020-21. Since the COVID-19 pandemic began, Yorkshire and Humber, like other regions, experienced an fluctuations in economic inactivity, highest at 24.1% Oct – Dec 2021, but more recently the quarterly rates have has returned to pre-pandemic levels, as shown in the trend chart. The national trend in those aged 50-64 is similar to the UK, and was sitting at 26.6% in July-September 2021. However, this figure is less in Yorkshire and Humber.

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.

*Rapid review accompanies this report

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

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, Jan 2023

Pensioner poverty rates are rising, with more single pensioners in poverty than pensioner couples

Joseph Rowntree Foundation's 2022 UK Poverty report finds that pensioner poverty rates are rising, and rising faster for older females than for males. They attribute this difference to longer lives, less complete National Insurance contribution history and more gaps in employment history.

The state pension is the main source of income for 35% of retired adults, and women and single pensioners being more likely to rely on it. Pension credit tops up weekly income and opens up entitlement to additional benefits that provide financial stability to those in later life. However there is **poor awareness and poor take-up of pension credit**, with only 63% of those eligible receiving the benefit.

Increases in the age of eligibility for state pension may be widening inequalities. The proportion of 65-year-olds still in employment **increased more in the most deprived areas** than the least, possibly due to being unable to fund an early retirement through private pension savings.

Issues such as the gender and ethnicity pay gaps, which persists into retirement, auto-enrolment pensions and pension flexibilities also contribute to some groups at greater risk of pension poverty now, or when they reach state pension age:

- Women
- Black, Asian and minority ethnic people
- Generation X (born between 1965 and 1980)
- Single person households
- Carers
- Private renters
- Low paid workers
- Self-employed

4. Health and wellbeing

Life and health expectancies

General health:

- Falls
- Dementia
- Sensory impairment
- Multi-morbidity
- Health behaviours
- Sexual health
- Mental health

Older people in Yorkshire and Humber live only up to 54% of their lives in good health

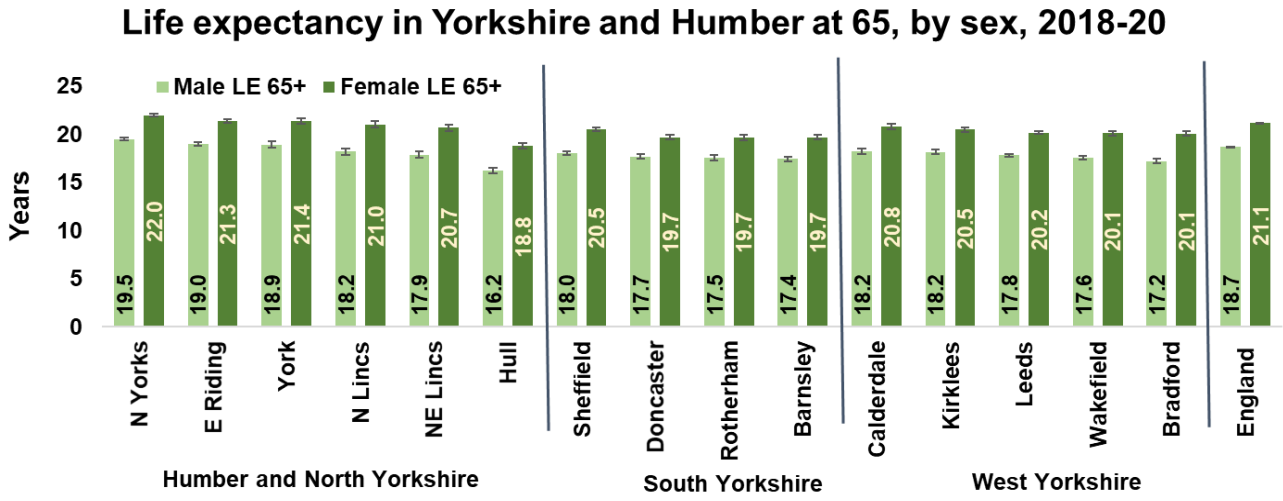
Life expectancy in the UK has **increased over the last 40 years**, primarily because of **improvements in mortality** at older ages driven by advances in **health care**, and improvements in **living and working conditions** (ONS, 2021). However, progress has stalled in the last decade and we are living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

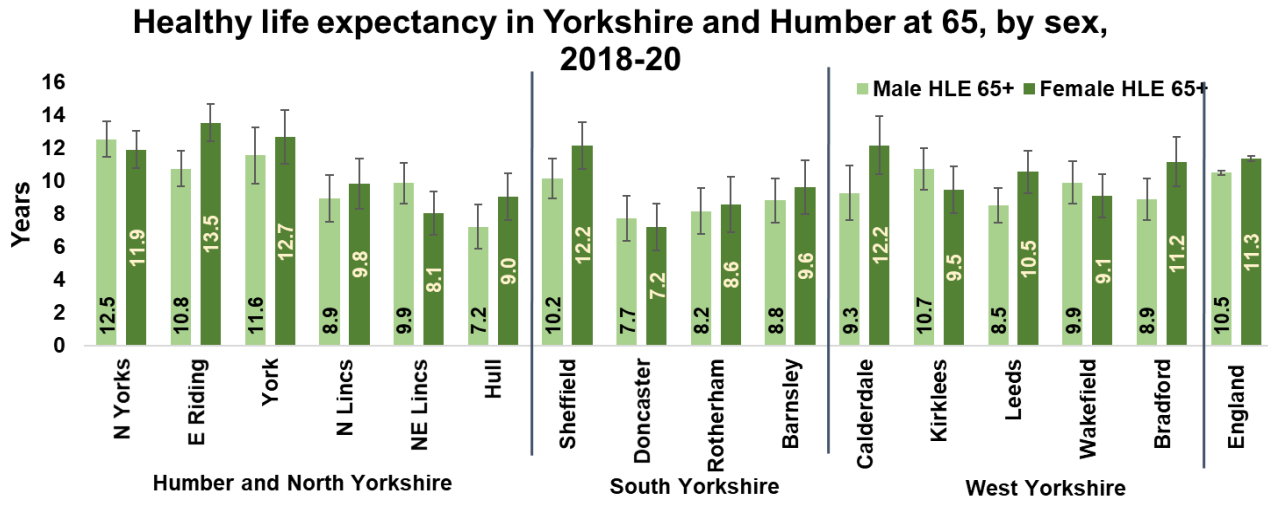
Life expectancy and healthy life expectancy in the region are some of the **lowest in the country**; in 2018-20 only three local authorities in Y&H had an average life expectancy at the age of 65 above or at England level, in both men and women:

- North Yorkshire (19.5 and 22.0 years respectively)
- East Riding of Yorkshire(19.0 and 21.3 years respectively)
- York (18.9 and 21.4 years respectively)

Three local authorities in Y&H had a healthy life expectancy above the England average **for both males and females**:

- North Yorkshire (12.5 and 11.9 years respectively)
- York (11.6 and 12.7)
- East Riding of Yorkshire (10.7 and 13.5)





Data source: OHID Productive Healthy Ageing Profile. 2022

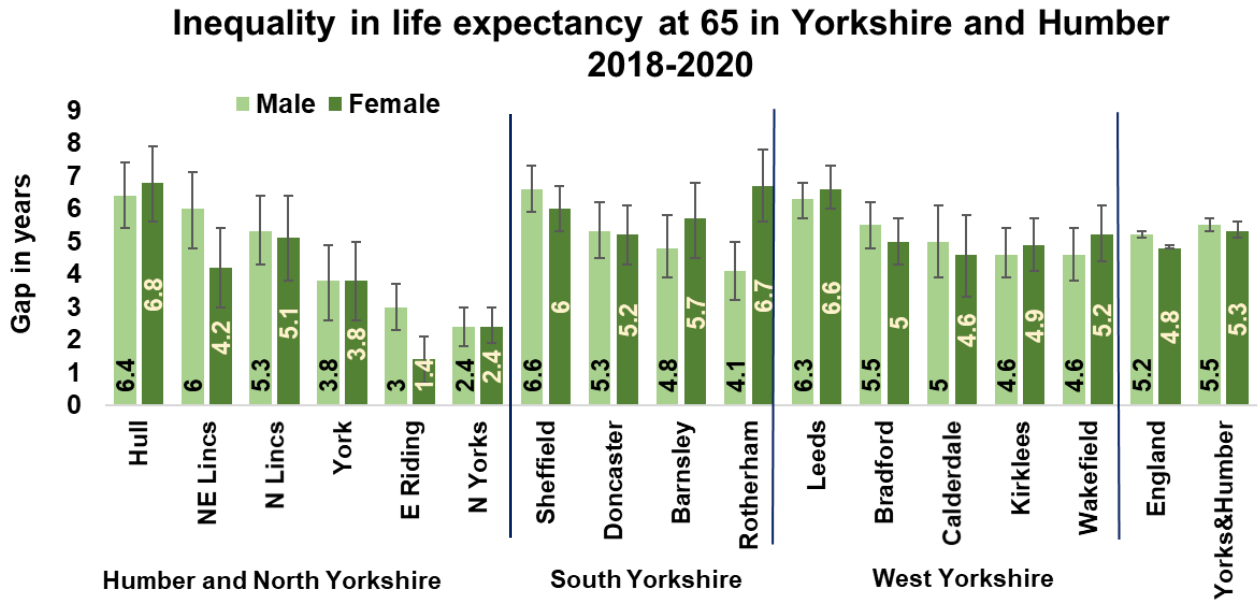
There are social and ethnic inequalities in life expectancy which vary within local areas

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 Yorkshire and Humber** than in England (5.5 and 5.3 years for men and women in Y&H, compared to 5.2 and 4.8 years in England).

Six local authorities in Y&H have **higher inequality** in life expectancy at 65 than the England average, in both men and women: Bradford, Doncaster, Hull, Leeds, North Lincs and Sheffield. In Rotherham there is a much larger gap in life expectancy in women than men.

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 has been underway to make this mandatory (Kings Fund, 2021).



Data source: OHID Productive Healthy Ageing Profile. 2022

Leading causes of death

Ischaemic heart disease (IHD) has long been the leading cause of death in England and has been steadily decreasing since 2001, with dementia and Alzheimer's disease taking over as the leading cause of death before the COVID-19 pandemic.

As shown in the charts, in 2020, the leading cause of death in Y&H in both females and males in the 65-79 age group was **COVID-19, followed by lung cancer and heart disease**. In the younger age group, in females aged 50 to 64, the leading cause of death was **lung cancer, followed by breast cancer and heart disease.** Whereas in **males aged 50-64, heart disease** remained the leading cause, **COVID-19** was the main cause in both 65 to 79 and 80+ age groups in males.

Mortality rates **vary by ethnicity and deprivation**. The cumulative death rate in the region for all ages and causes, since the start of the pandemic until October 2022, was highest in Asian and Asian British groups (3,265 per 100,000), followed by any other ethnic groups (3,114) and white or white British groups (2,754). The rate was lowest in mixed / multiple ethnic groups (1,819). In the same period, the difference in the cumulative death rate between the most and least deprived neighbourhoods was over two fold (4,189 and 2,079 per 100,000 population)*.

Source: *ONS mortality data and population estimates via OHID CHIME tool. Accurate as at January 2023.

Leading cause of death for Females by age group (ranked by number deaths descending), Yorkshire and The Humber, 2020

	1	2	3	4	5
All ages	Dementia and Alzheimer's disease	COVID-19	Heart Disease	Stroke	Lung cancer
80+	Dementia and Alzheimer's disease	COVID-19	Heart Disease	Stroke	Influenza and Pneumonia
Aged 65 to 79	COVID-19	Lung cancer	Heart Disease	Chronic lower respiratory diseases	Dementia and Alzheimer's disease
Aged 50 to 64	Lung cancer	Breast cancer	Heart Disease	COVID-19	Liver Disease

Leading cause of death for Males by age group (ranked by number deaths descending), Yorkshire and The Humber, 2020

	1	2	3	4	5
All ages	COVID-19	Heart Disease	Dementia and Alzheimer's disease	Lung Cancer	Chronic lower respiratory diseases
80+	COVID-19	Dementia and Alzheimer's disease	Heart Disease	Stroke	Chronic lower respiratory diseases
Aged 65 to 79	COVID-19	Heart Disease	Lung Cancer	Chronic lower respiratory diseases	Dementia and Alzheimer's disease
Aged 50 to 64	Heart Disease	COVID-19	Lung Cancer	Liver Disease	Chronic lower respiratory diseases

Key: Cancers | Circulatory | COVID-19 | External | Other | Respiratory

Source: Regional profiles 2021. Yorkshire and the Humber. 2022

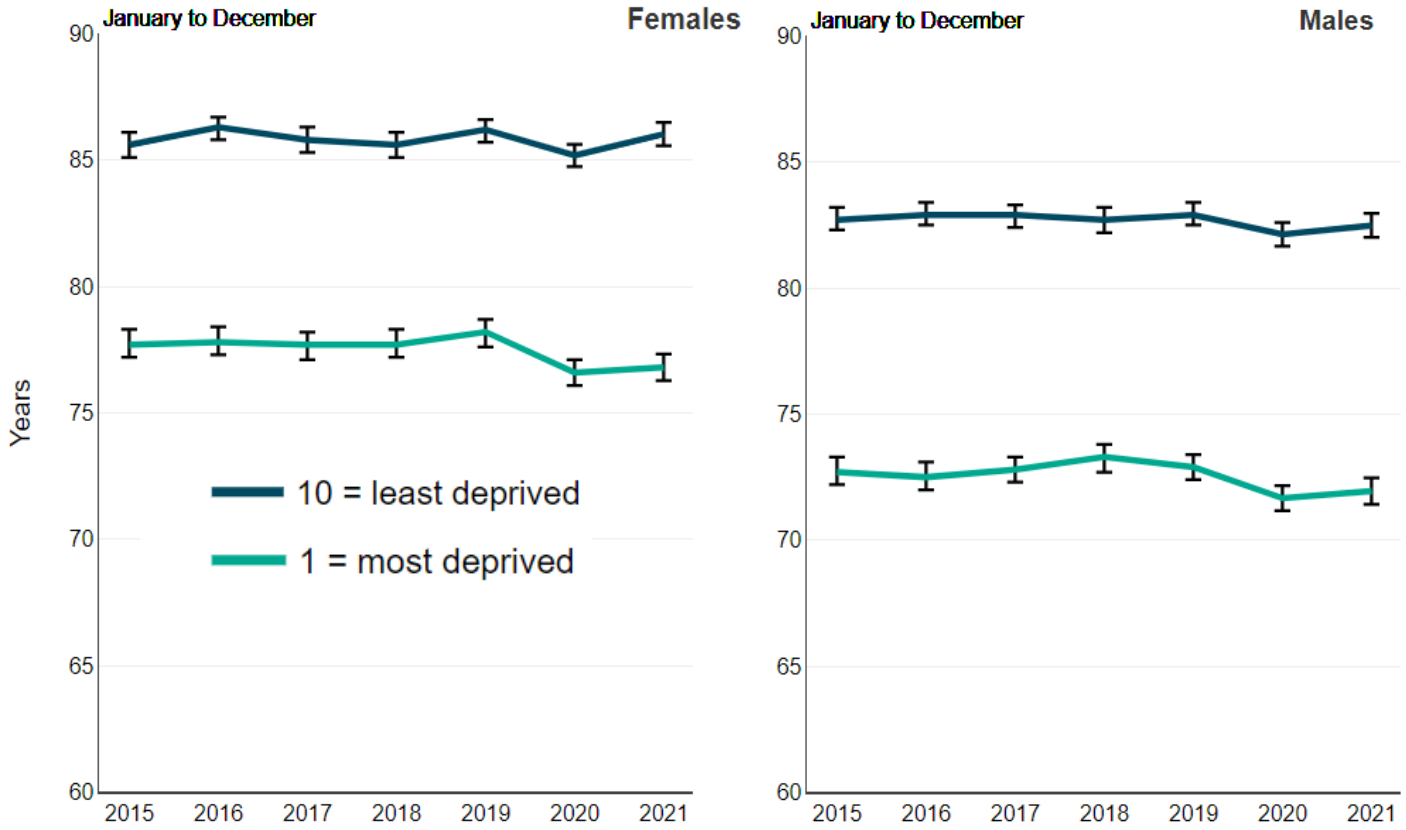
Yorkshire and Humber had a high COVID mortality rate and inequalities are persisting

COVID-19 caused a **drop in life expectancy** across the country as age-standardised mortality rates in England increased. Compared with 2019, in 2020 the mortality rate for all persons was 14% higher, and in 2021 it was 10% higher.*

The Y&H region similarly had a **higher mortality** rates in 2020 compared to previous years due to COVID-19. The *number* of **excess deaths** by 30 December 2022 in Y&H compared to pre-pandemic period were **highest in those aged 75+,** but the *ratio* of registered to expected deaths was highest in those aged 25-49.

Inequalities in life expectancy by deprivation has increased since 2019, as shown in the widening gap between the least and most deprived deciles in the charts for trends in the region, both in females and males.

Trend in life expectancy at birth by deprivation decile. Yorkshire and the Humber



* OHID. WICH tool accurate as at 23 Jan 2023

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 Yorkshire and Humber.

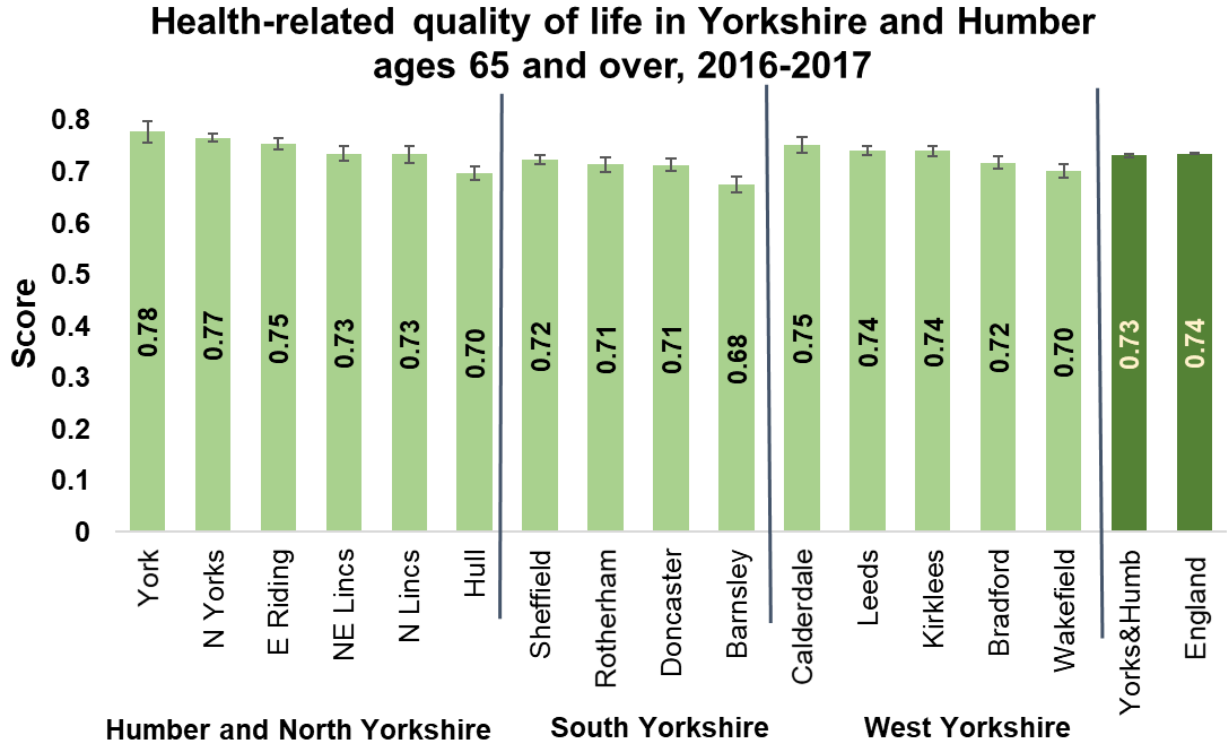
Health-related quality of life (HRQoL) for older people gives an indication of how healthily they are ageing and how independent they are.

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

HRQoL in Yorkshire and Humber is **significantly worse than England**, varying across the region. The Y&H local authorities with the lowest HRQoL are:

- Barnsley (0.68)
- Kingston upon Hull (0.70)
- Wakefield (0.70)
- Doncaster (0.71)



Data source: OHID Productive Healthy Ageing Profile

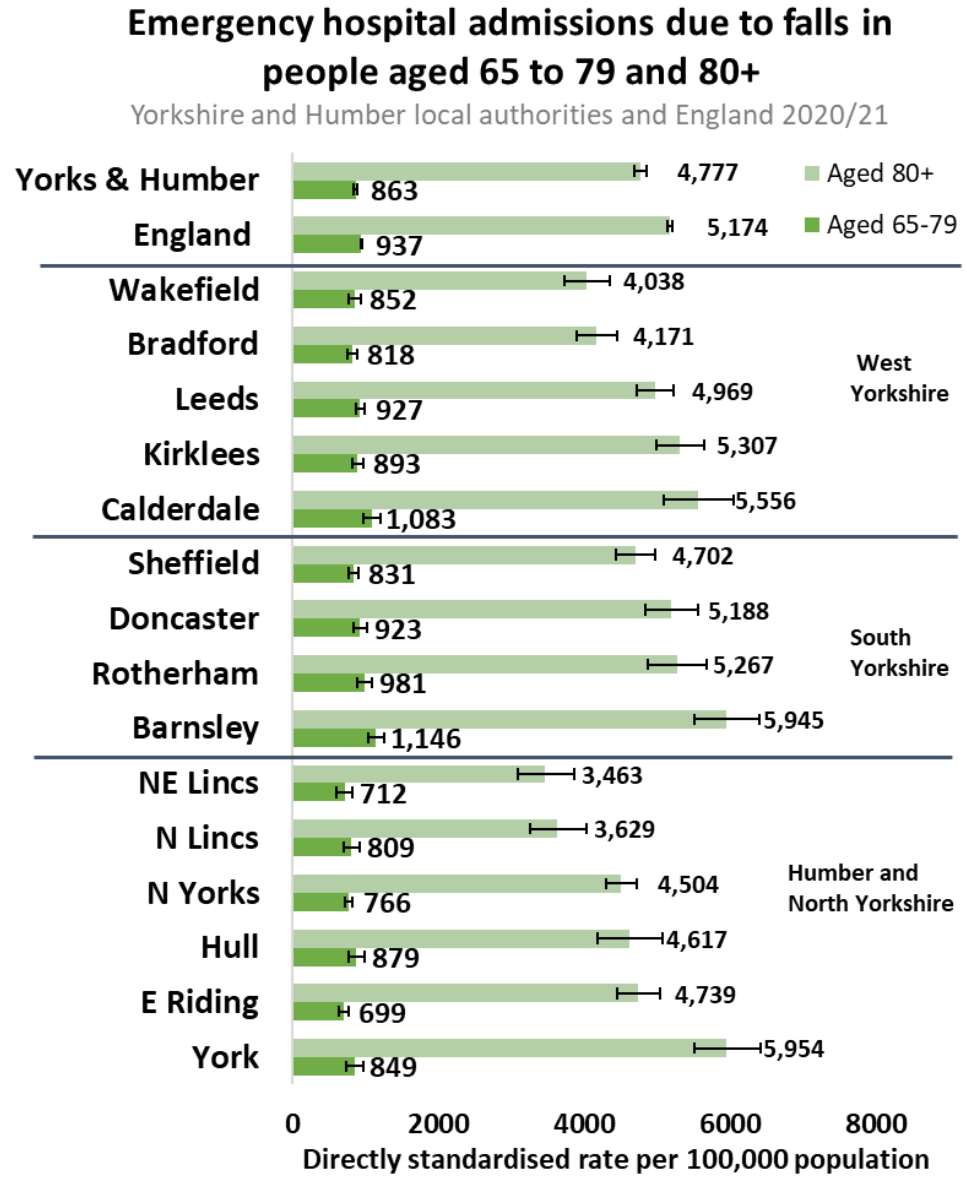
Falls are the number one reason for older adults going into long term care

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. A study from 2011 showed the costs to the NHS at over £2bn a year with 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 levels of emergency hospital admissions due to falls in people aged 65-79 and ages 80 and over in the region is significantly better than England average, however there is wide variation between local areas as shown on the chart.



Data source: OHID. Productive Healthy Ageing Profile. 2022

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

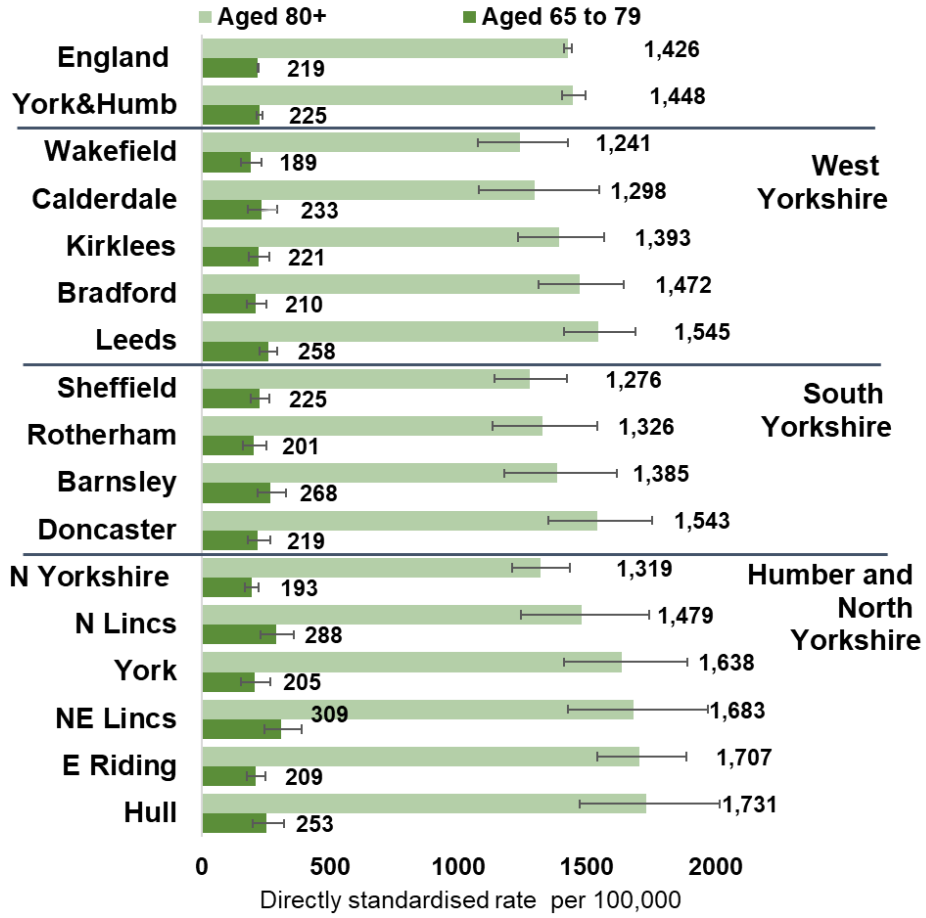
Hip fractures are a common outcome of falls, though they are not always directly related. Hip fractures are also caused by other factors, primarily **low bone mineral density**, which can lead to osteoporosis.

The average age of a person with a hip fracture is 84 years for men and 83 for women, and only one in three people experiencing a hip fracture returns to their **former levels of independence**.

In 2020/21, 72% of hip fractures in people aged 65 and over in Y&H were women. Six of the region's local authorities had rates of emergency hospital admissions for hip fractures that were significantly higher than the England average, in the five years leading up to 2020/2021. This can lead 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.

Hip fractures in people ages 65 to 79, and 80 + Yorkshire and Humber local authorities 2020/21



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 most likely to develop 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:

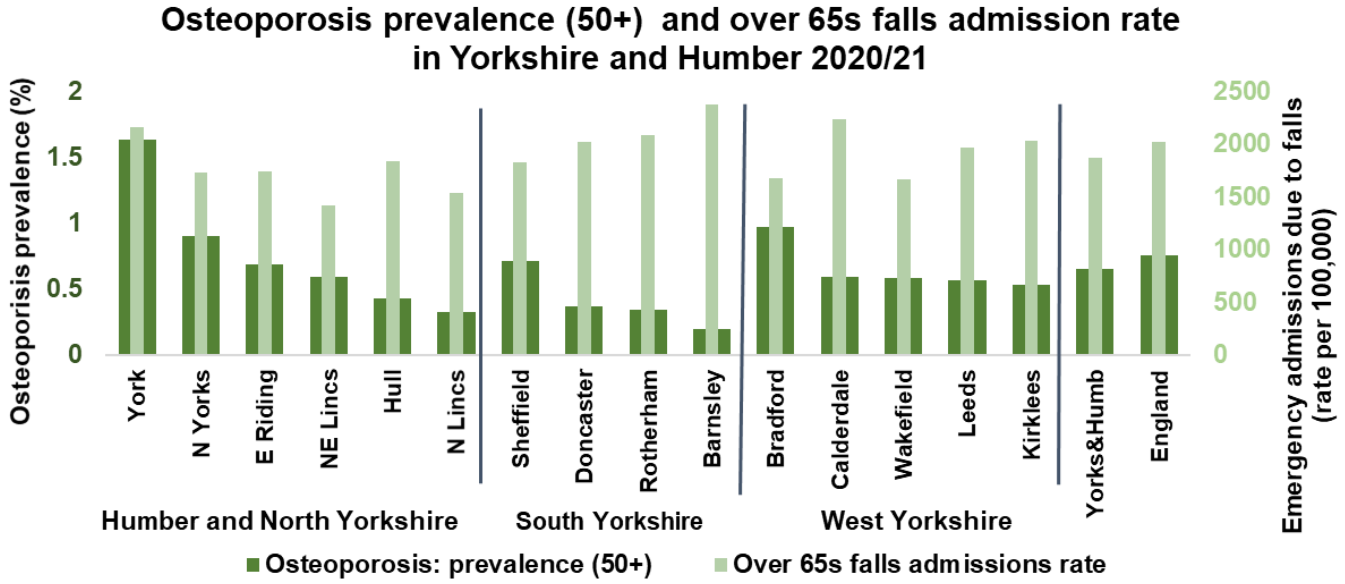
- taking **regular exercise** to keep bones as strong as possible
- **healthy eating** – including foods rich in calcium and vitamin D
- taking a daily supplement containing 10 micrograms of **vitamin D**
- making **behaviour changes** – such as giving up smoking and reducing alcohol consumption

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 Yorkshire & the Humber 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 Y&H 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. Barnsley (0.2%), North Lincolnshire (0.3%), Rotherham (0.3%), Doncaster (0.4%), Kingston upon Hull (0.4%) had a low osteoporosis prevalence when compared to hip fractures in 2020/21

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

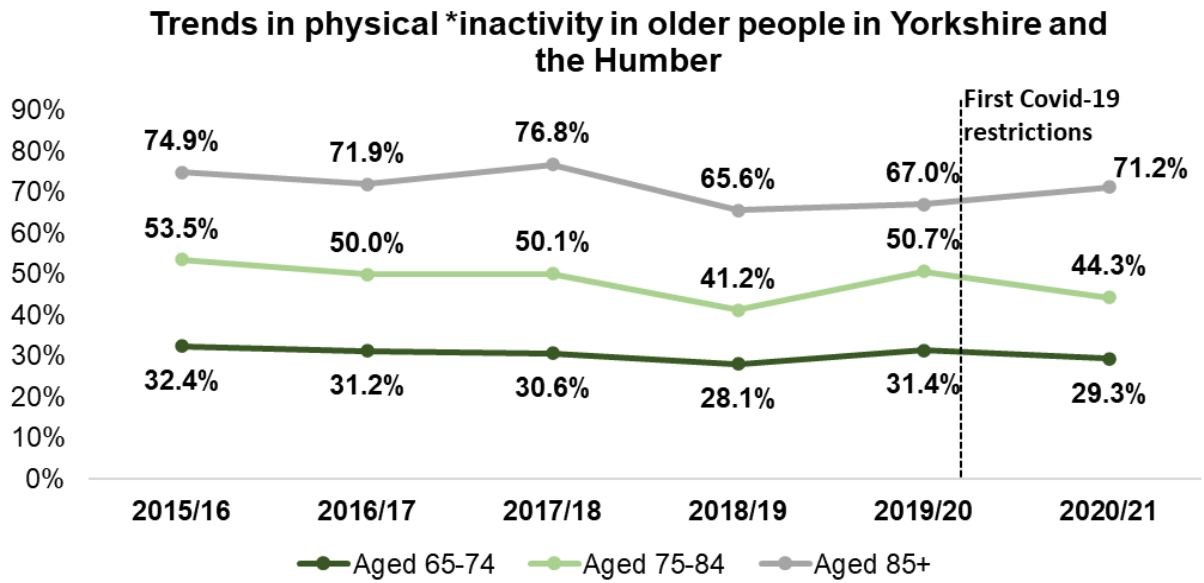
Falls are not a ‘normal’ part of ageing, and they can be prevented by strength and balance exercises

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, and activity to improve strength, balance and flexibility at least twice each week.

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.



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

Data source: Sport England Active Lives

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

The 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.

Y&H's **Falls and Deconditioning Network** facilitates collaborative action across health and social care, including undertaking a clinical audit of NICE Quality Standards on falls prevention.

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.

There are many risk factors for dementia, some of which can be modified

The risk of dementia increases with age, but it is not an inevitable part of ageing. There are several known risk factors for Alzheimer's disease and vascular dementia, the main ones being age and genetic factors. The older a person is the more likely they are to be dealing with other health conditions that can increase dementia risk.

Women are more likely than men to be living with dementia, though the reasons for this difference are unclear. Differences are also seen between ethnic groups, with people from **black African, black Caribbean and South Asian** groups having a higher risk than white ethnic groups; these differences may be related to social determinants rather than be intrinsically linked to ethnicity itself.

There are a number of health conditions that can increase a person's risk of dementia including cardiovascular disease, hearing loss, traumatic brain injury and depression. Exposure to particulate air pollution can also increase dementia risk.

While there is no certain way to prevent all types of dementia, there is good evidence that **healthy behaviours can help reduce the risk of developing dementia in older age**. Stopping smoking, eating a healthy diet, keeping physically active and drinking alcohol only in moderation in mid-life can also prevent cardiovascular diseases, such as stroke and heart attacks.

Regular mental and social activity can also be beneficial. Although there are no studies to date showing that brain training prevents dementia evidence does suggest it may help older adults in managing their daily tasks better.

Regular social interaction with others not only provides opportunities for active listening and communication, engages your mind, processes information and develops thinking skills, which can help people increase their cognitive reserve.

Poorly managed dementia has severe consequences, but these are avoidable

With **treatment and support** many people with dementia can lead active, fulfilled lives.

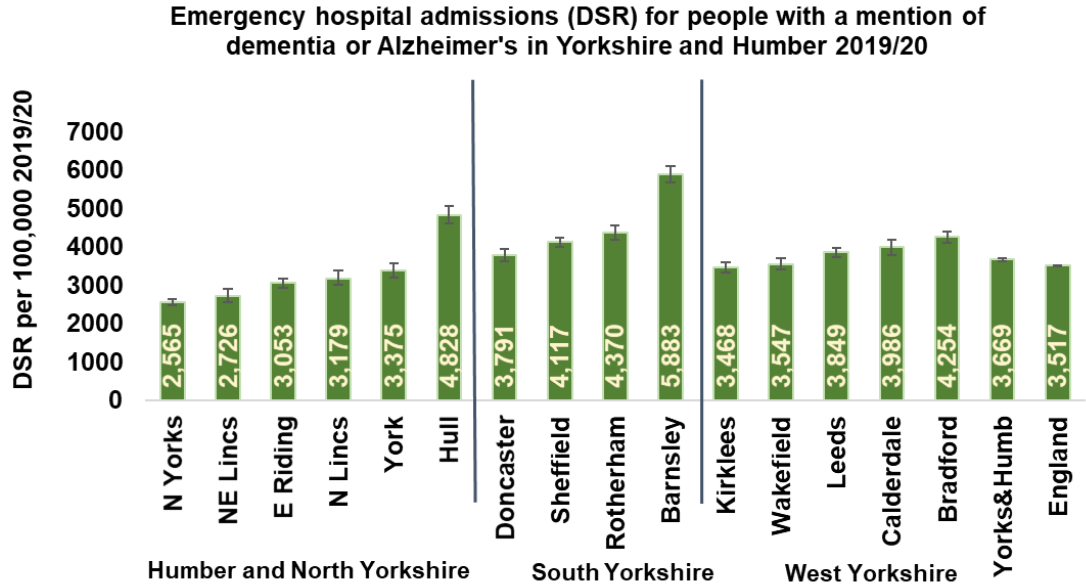
However, poorly managed dementia can lead to **emergency hospital admissions** for avoidable illnesses and injuries. This unfamiliar environment can trigger distress, confusion and delirium for someone with dementia, contributing to a **decline in functioning** and a reduced ability to return home to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

In Y&H, emergency hospital admissions for dementia in those aged 65+ are **significantly worse** than England. In 2019/20, only four Y&H local authorities have significantly lower rates per 100,000 than England at.

- North Lincolnshire 3,179
- East Riding 3,053
- North East Lincolnshire 2,726
- North Yorkshire 2,565

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 has nearly halved in the region **between 2019/20 and 2020/21 from 75% to 40%,** this is probably due to the impact of the pandemic on disruption of services.



Data source: OHID Productive Healthy Ageing Profile

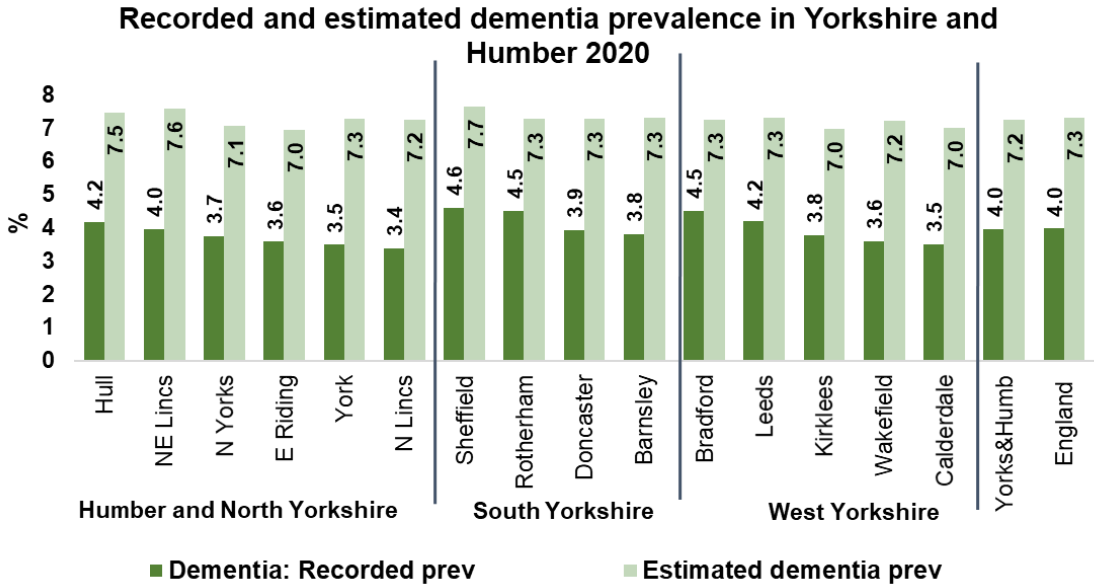
It is important to diagnose dementia early, but it can be difficult to recognise due to its slow decline

There were an estimated 748,000 older people with dementia in England in 2019, suggesting a prevalence rate of 7.2% (LSE, 2019). However, the prevalence of diagnosed dementia was only 4.0% 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 Y&H is similar to England (3.96% compared to 3.97%) with a similar estimated diagnosis rate (63.1% compared to 62.0%). **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 and LSE

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 dropped, meaning that cases have not been identified, and **needs have gone unmet**. This decline has continued into 2021.

The 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 **worsened 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**.

The NHS Health Check is also an important opportunity to advise on dementia risk reduction.

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 accompanies this report

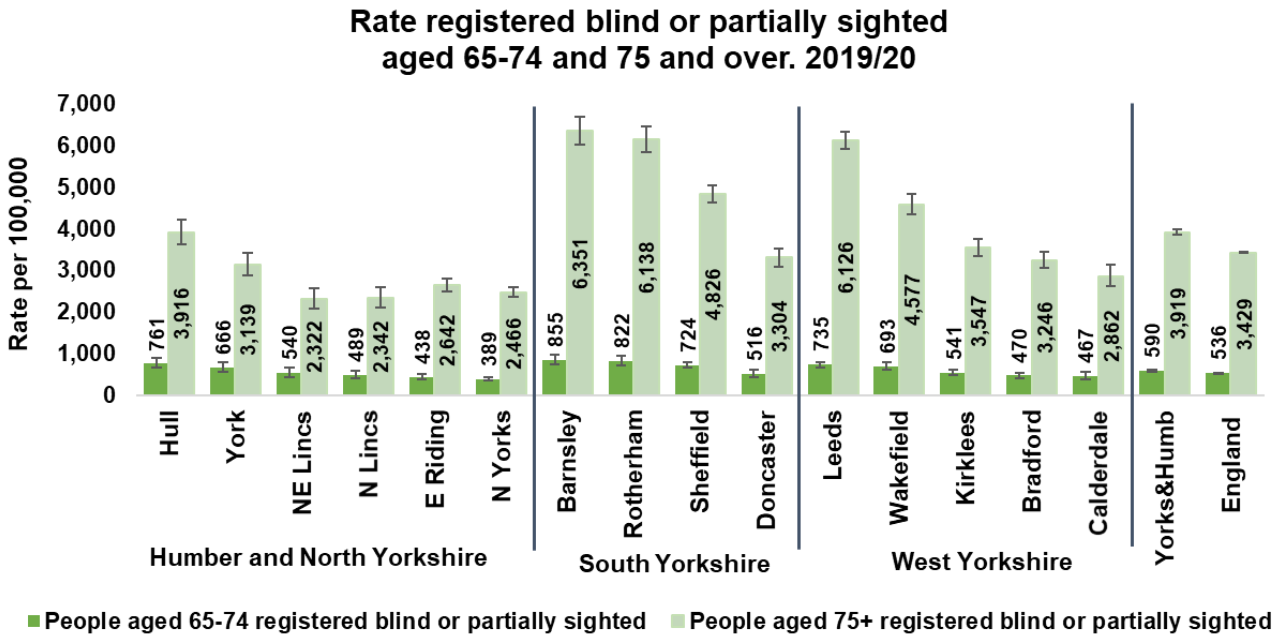
Sensory impairment can be debilitating, and is a barrier to accessing services

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. Sensory impairment is also a barrier to accessing services and **may be overlooked** in health and social care.

In 2019/2020, Y&H had significantly higher rates than England of people aged 75 years and over who were registered blind or partially sighted. There was also **wide variation** within the region, ranging from 6,351 per 100,000 in Barnsley to 2,322 per 100,000 in North East Lincolnshire, as shown in the chart.

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

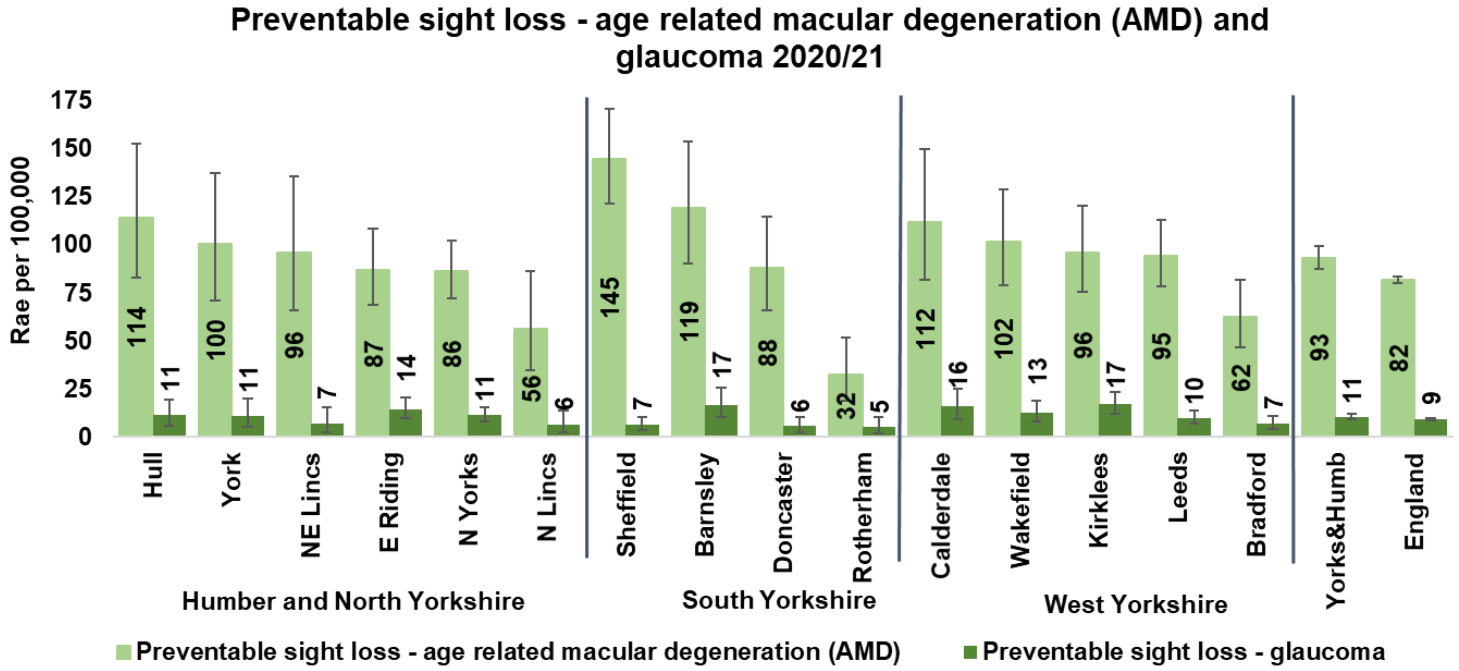
Two major causes of sight loss are significantly higher in Yorkshire and the Humber than in England

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 controlled diabetes.

AMD and glaucoma are **significantly higher** in Yorkshire and the Humber than England. And while these conditions may not be preventable, the resulting sight loss can be through early diagnosis and treatment.

As shown in the chart, in Y&H 93 per 100,000 people aged 65+ were certified as having a visual impairment in 2020/21 due to AMD, and 11 per 100,000 due to glaucoma. 1.5 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. Uptake of this screening in Y&H was significantly better than in England, at 85.5% compared to 82.6% in 2018/19, where the latest data is available. The uptake had 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

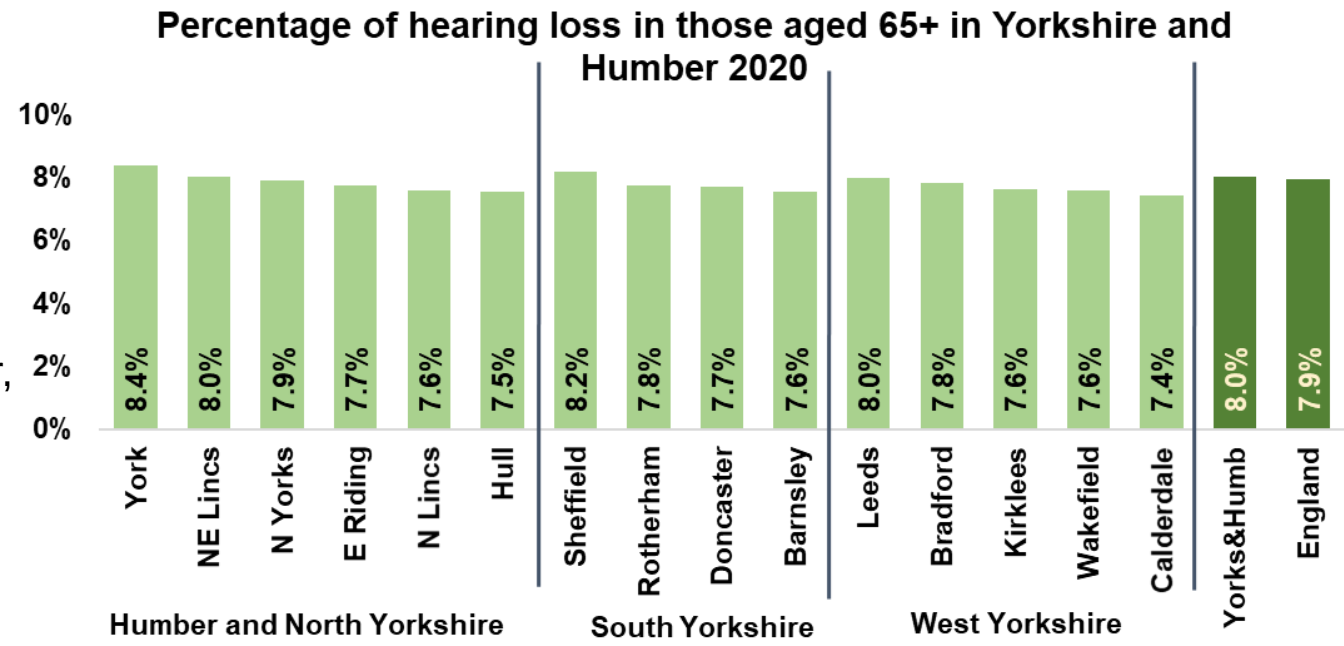
Hearing loss is more likely as we age, but hearing technology can reduce the negative impacts

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 more than 40% of people aged 50+ and more than 70% of people aged 70+*. RNID In Yorkshire and the Humber, it affects **61% of people aged 65+** and 8% of our 65+ population have **severe hearing loss** – a similar proportion to England. However, this proportion is higher in:

- York (8.4%)
- NE Lincolnshire (8.0%)
- Sheffield (8.2%)
- Leeds (8.0%)

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



Data source: POPPI

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

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. Simple hearing screening apps such as the World Health Organization hearWHO tool, can identify hearing impairments to enable early treatment.

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

The 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 accompanies this report.

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

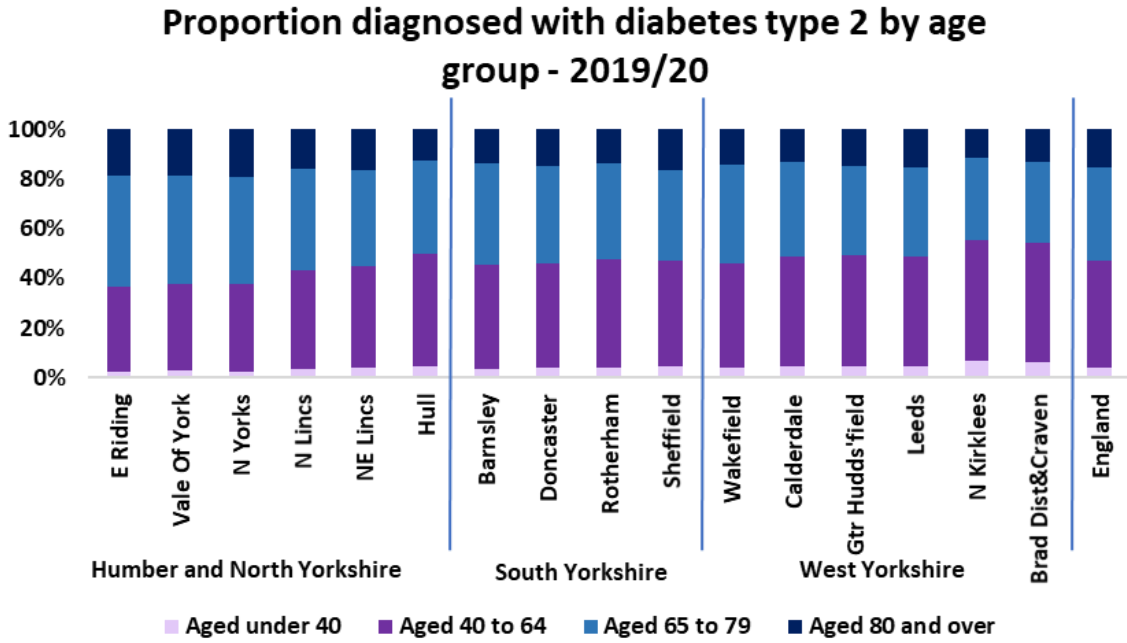
This increased reliance on services is particularly an issue in the knowledge that there is a **growing number of younger people** with multi-morbidity, particularly related to obesity.

In 2019/20, the proportion of people **diagnosed with type 2 diabetes** nationally who were aged 40-64 was 43.1%. Across the Yorkshire and Humber region this measure ranged from 34% (East Riding of Yorkshire CCG) to 48% (Bradford and Craven CCG).

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**, people can live long, healthy and independent lives.

Recommendation: Encourage 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. 2022]

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

Health behaviours are key to preventing and managing long-term conditions. But in Yorkshire and Humber, smoking rates, physical inactivity and obesity are all **significantly higher** 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).

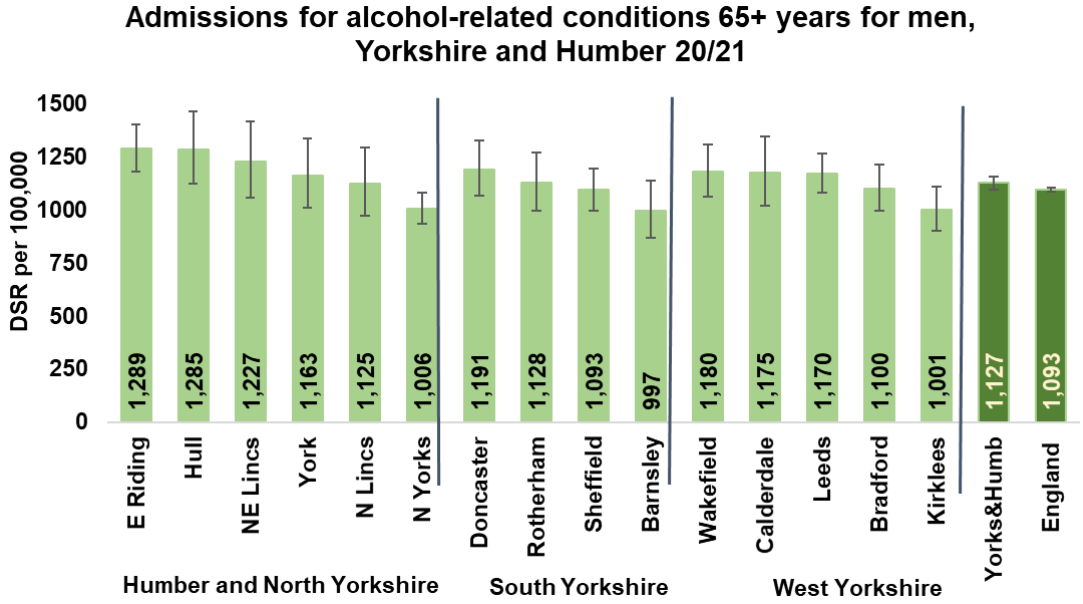
And while the majority of older people are lower risk drinkers, age-related factors can lead to **increased drinking**, which is a particular concern in men:

- 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

2020/2021 data shows that the region's **hospital admissions for alcohol-related conditions** in men and women aged 65+ are significantly worse than the England average. Rates are particularly high in East Riding of Yorkshire, at 1,289 per 100,000 men aged 65+ and in Barnsley at 471 per 100,000 women 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.

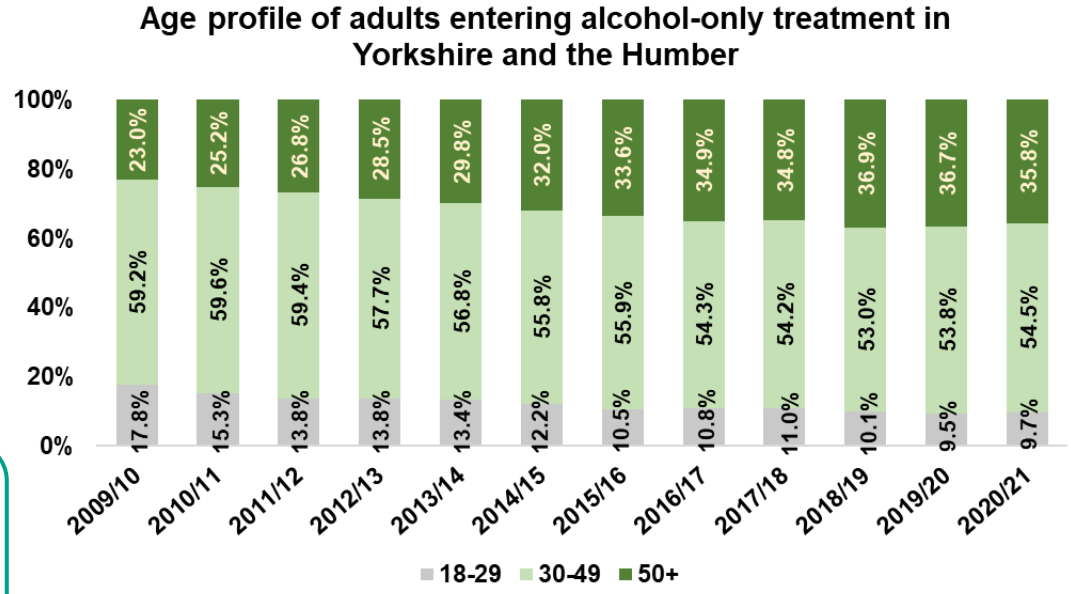
The same research also suggests that older adults tend to have a **lack of understanding and knowledge** about units and recommended alcohol guidelines. And the proportion of people in alcohol treatment who are older is also increasing, indicating a **rise in older higher risk drinkers**.

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.

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

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.



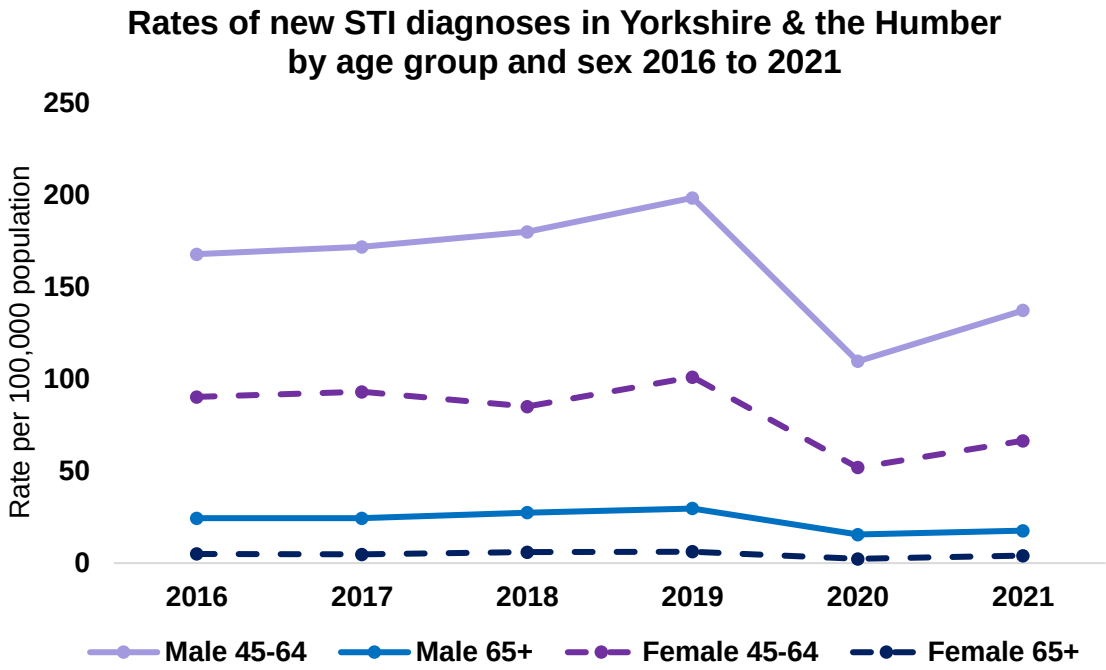
Data source: National Drug Treatment Monitoring System

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 84.5% of men and 59.9% of women aged 60-69, and 31.1% of men and 14.2% of women aged 80+ are **still sexually active** (Lee et al, 2016).

Before the COVID-19 pandemic, the rate of **new sexually transmitted infections** (STIs) in people aged 65+ was rising. However, rates for all age groups declined in 2020 when the pandemic hit. The rate for people aged 65+ is still much lower than rates for those in other age groups. National data for 2019 recorded 26.5 per 100,000 new STI diagnoses for the 65+ age group, compared to 2311 in 15-19s, 4224 in 20-24s, and 2014 in 25-34s in 2019.

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: UKHSA STIs: annual data tables 2021 data available at the time of writing

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.

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

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

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

The 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, but further 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 accompanies this report

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.

The 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 may be **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 rates in older people are similar to England, but IAPT outcomes need improving in some areas

10.7% of people aged 65+ are estimated to have a **common mental health disorder** (depression or anxiety) in Yorkshire and the Humber, similar to England. The areas with the highest rates, as shown in the chart are **Kingston upon Hull, Doncaster, Barnsley and Rotherham.**

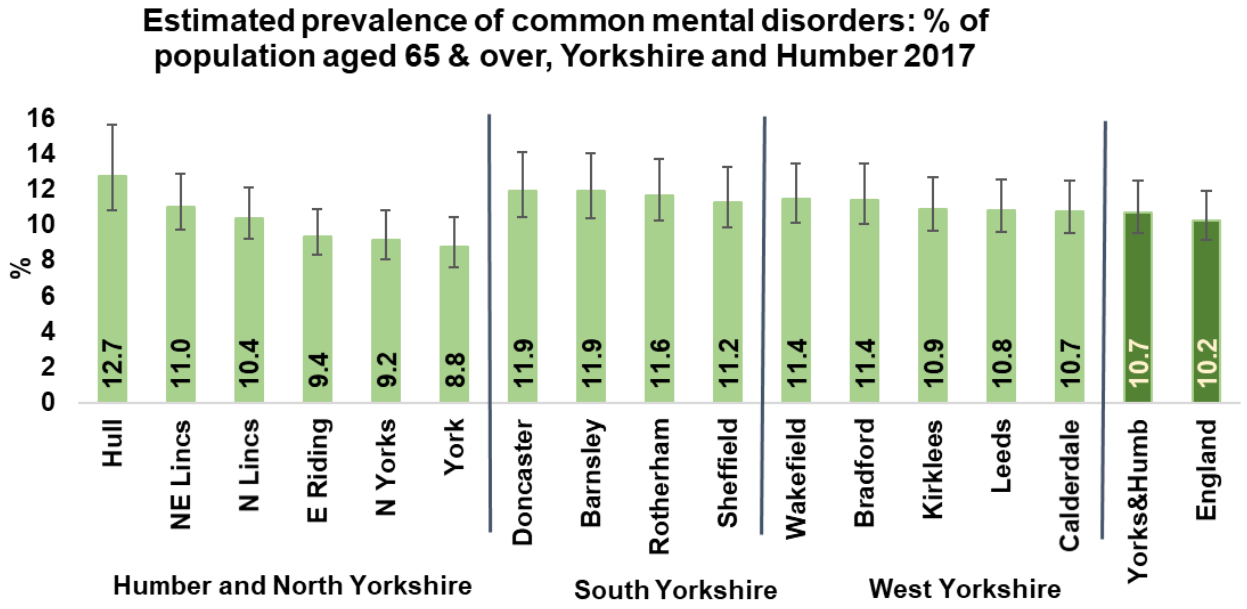
Rates are likely to be **higher in more deprived areas**, where women and men aged 50+ are up to five times more likely to have depression.

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

- 50% in Barnsley, and 88.2% in Doncaster see reliable improvement
- 44% in Leeds, and 81% in Hull 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.



Source: Public health profiles - OHID (phe.org.uk)

Serious mental illness occurs in later life but may present differently

Older adults may also experience severe mental illness, usually a longstanding condition that developed at a younger age. It is uncommon to develop new onset severe mental illness such as bipolar affective disorder or psychotic disorder in later life.

Older adults with pre-existing bipolar disorder have different symptoms to those with late-onset disease. Schizophrenia developed after the age of 65 is more common among women and often presents with a different symptom profile to when developed at a younger age. Whilst only a small percentage of older adults will experience these serious mental illnesses, **as a result of the ageing population the absolute number of people with serious mental illness will increase** and comprise a larger proportion of all people with these diagnoses in the future.

Eating disorders also occur in later life but are often unrecognised. Triggers for disordered eating in older age include life transitions, loss and trauma, bereavement and the onset or worsening of other health symptoms.

Suicide rates fall as people age, but then rise again in later old age, particularly in men. Self-harm is less common in later life but older adults who self-harm have increased suicidal intent and should be considered at high risk of suicide. Risk factors for suicide and self-harm in later life include:

- Psychiatric illness, particularly depression
- Deterioration of physical health that impairs independence
- Pain, particularly for older men
- Stressful life events such as loss, breakdown of relationships and serious financial problems
- Social connectedness and the perception of being a burden to others

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

The 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 accompanies this report

5. 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. However, the King's Fund note that taking account of the increased adult population spending per head in 202/21 is actually **lower than in 2010/11.**

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 Yorkshire and the Humber, but the number of beds is falling

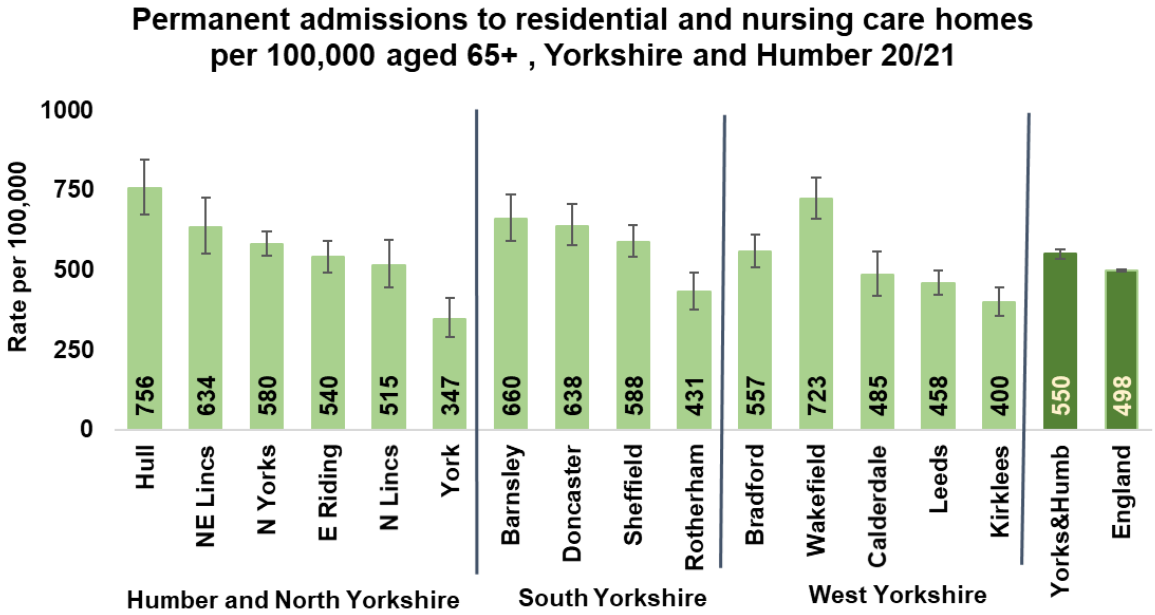
While care homes are the most considerable care costs, **residential care costs** in Yorkshire and Humber are the 3rd lowest of all regions in the UK (Age UK). It is preferable, both to individuals and the social care system, to keep people in their own homes where possible.

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 worse in the Y&H than England. And only two local authorities are significantly lower:

- Kirklees (400 per 100,000)
- York (347 per 100,000)

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



Data source: Public health profiles - OHID (phe.org.uk)

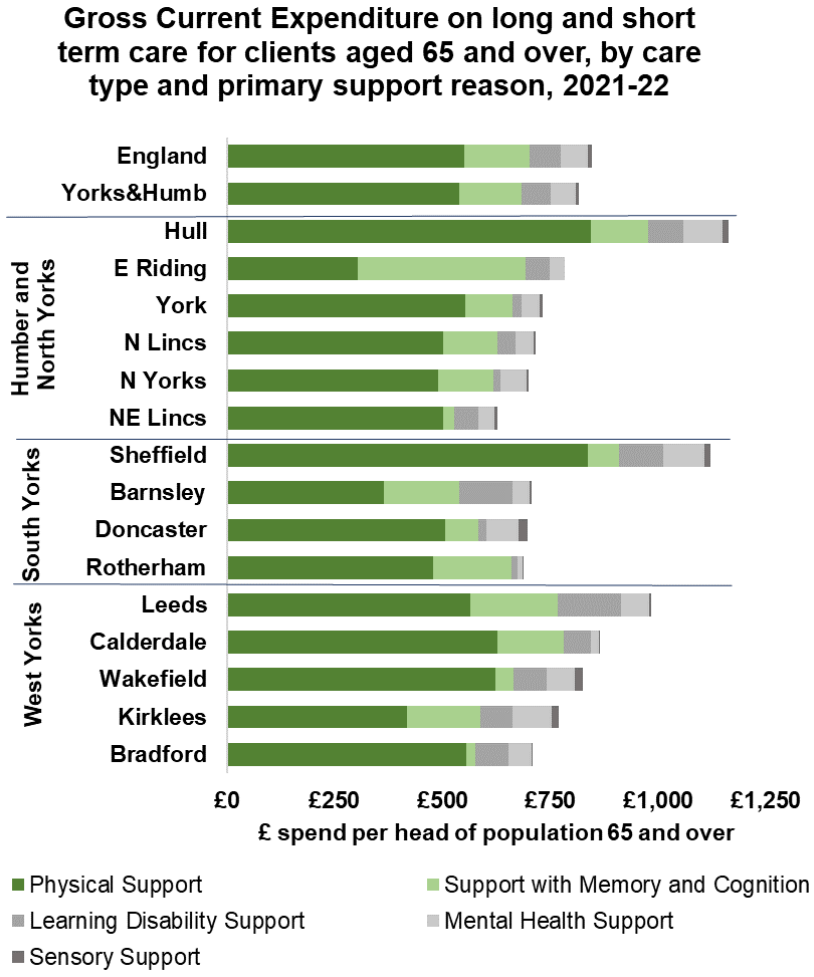
Millions of pounds are spent on social care every year, with local authorities prioritising different types of support

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 2021/22, Yorkshire and the Humber spent **£2158m** on social care for adults. **£856m** of this was on long and short term care for the elderly. This is **40% 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**. **Hull and Sheffield spend the highest amount per head of population over 65.**

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**:

- East Riding for support with memory and cognition
- Sheffield and Hull for physical support
- Hull, Sheffield and Kirklees for mental health support
- Leeds and Barnsley for learning disability support



Adult Social Care Activity and Finance Report, England, 2021-22 - NDRS (digital.nhs.uk)

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

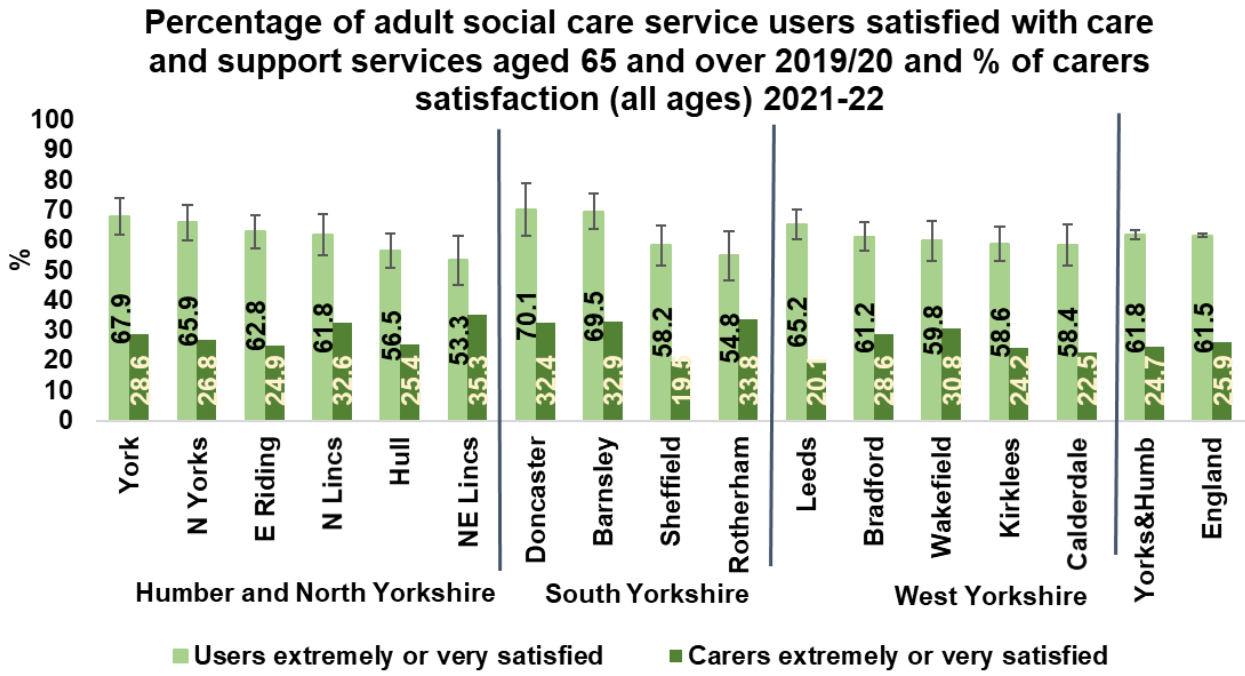
The percentage of care services rated ‘outstanding’ or ‘good’ has continued to increase in England. **Service user satisfaction** with care and support ranges from 53.3% of users in North East Lincolnshire to 70.1% in Doncaster.

Carer satisfaction however, is very low, despite a greater proportion of carers in England receiving support from their local authority. Less than 25% of carers are satisfied with services in Yorkshire and Humber. In Sheffield only 19.5% 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

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



Data source: Productive Healthy Ageing profile and PSS Survey of Adult Carers 2021-22

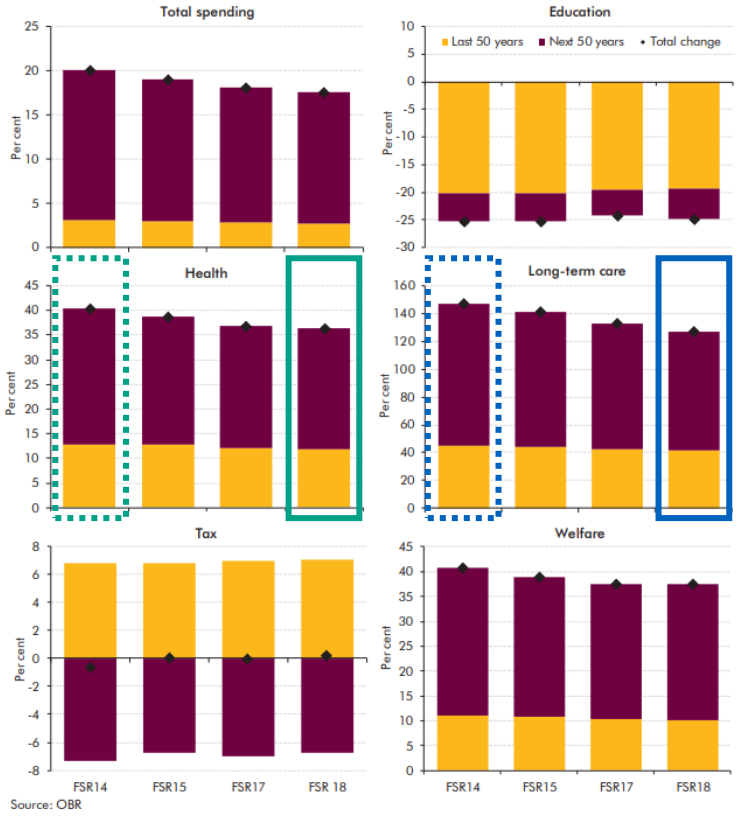
Long-term care spending is projected to increase more than any other public spend

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

Many people in Yorkshire and Humber have received an NHS Health Check, but uptake is low and COVID-19 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 identify risk factors for these conditions, advise and refer to services that provide support to address these risks.

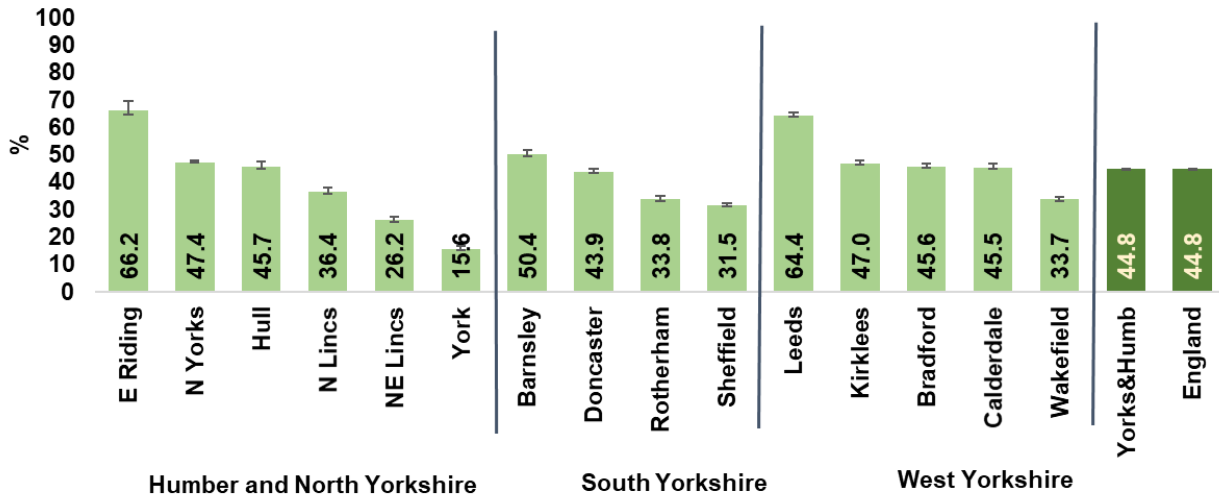
Recommendation:
As services resume, ensure NHS Health Checks identify and prioritise eligible people most at risk of poor health

Currently, the number of eligible people in the Y&H who have received an NHS Health Check is the same as the England average and 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.

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.

Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check 2017/18 to 2021/22



Data source: OHID Productive Healthy Ageing Profile

Uptake of preventative and early interventions is generally low in Yorkshire and Humber.

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.

In 2021/22 cancer screening rates were significantly better than England average across North East and Yorkshire ICBs across all screening programmes, apart from breast cancer screening in West Yorkshire ICB at 59% compared to the England average of 62%, and similar to England average for cervical screening in younger age groups. Nevertheless, emergency hospital admissions with cancer were lower than England average only in West Yorkshire ICB during the same period.

Older people, who are considered a vulnerable group, are also offered three vaccination programmes. Since COVID-19, all local authorities in the Y&H met the benchmarking goal of **75% uptake of the flu vaccine.**

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 Y&H 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)

Good oral health is essential for good general health, especially as people age

Maintaining **good oral health** can become more difficult in old age - long term conditions such as arthritis and Parkinson's disease can reduce dexterity for mouthcare, and dementia can make people resistant to care. Many medicines cause a dry mouth, increasing the risk of tooth decay and oral infections.

Older adults with poor oral health are also more susceptible to pneumonia; those with diabetes are a greater risk of gum disease and oral infections can affect control of blood glucose; and there are associations between coronary heart disease, stroke, peripheral vascular disease and oral health.

Poor oral health can also make it difficult to speak, smile and eat, and pain can affect behaviour, making people more reluctant to socialise and more at risk of malnutrition and dehydration. Although function and absence of pain are key, maintaining appearance, dignity and self-respect are also important to older people.

Successive surveys of adult dental health in England since the late 1960s have identified a clear trend of people keeping their natural teeth for longer as age cohorts with improved oral health progressively make up more of the population. In 1978 around 80% of adults aged 65 and over in England were edentulous (had no natural teeth); by 2009 this had fallen to less than a third.

> The 2009 Adult Dental Health Survey shows 26% of those aged 85 and over had 21 or more natural teeth, the number that will allow most people to eat in comfort without the need for a partial denture

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.

Residents of care homes are most likely to experience tooth decay

Although the overall proportion of adults in the North East and Yorkshire accessing dental care remains higher than England, many older people, particularly those living in care homes or receiving homecare, struggle to access dental care.

Those with natural teeth living in care homes experience the highest prevalence of untreated tooth decay . A survey of mildly dependent older people living in supported housing in Rotherham found that 27% had an open pulp, ulceration, fistula or abscess, indicative of pain and infection.

Care homes (and domiciliary care providers) have a key role in supporting mouthcare to prevent tooth decay and gum disease, and ensuring residents have regular dental visits. NICE has provided guidance, quality standards and a quick guide to improving oral health for adults in care homes.

Despite this, a CQC report on oral health in care homes found:

- Most had no policy to promote and protect oral health
- Nearly half were not providing any staff training on oral healthcare
- 73% of residents' care plans did not cover, or only partially covered oral health. Homes for people with dementia were least likely to have oral health plans in place.

In response PHE produced a toolkit to support improvements in oral health, and oral health is also included in the NHS Enhanced Health in Care Homes framework.

The **Keeping Care Homes Smiling** project in Rotherham provided training for care home staff to enable them to better support oral health in their residents.

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

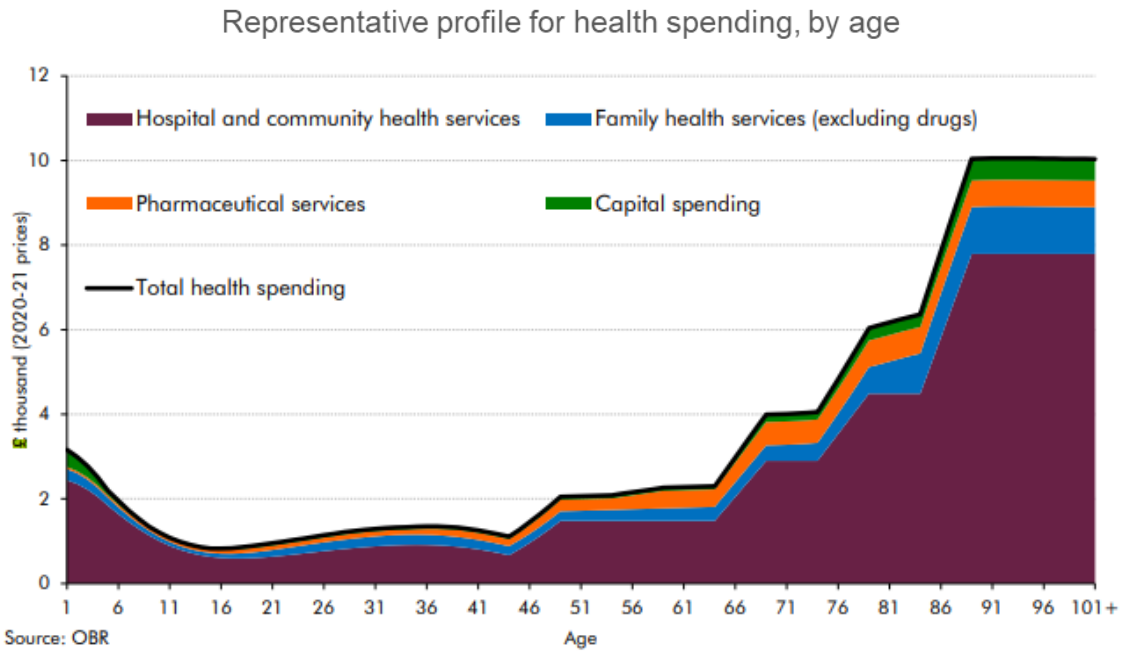
This chart from the Office for Budget Responsibility (OBR) shows that **healthcare costs increase with age**. This is partly due to the increase in multi-morbidity.

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.

It is important to understand the palliative and end of life care needs of the local population in order to ensure services are sufficient and appropriate.

To support this OHID has worked with NHS colleagues to develop a needs assessment toolkit for palliative and end of life care available on the NHS Futures website.



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

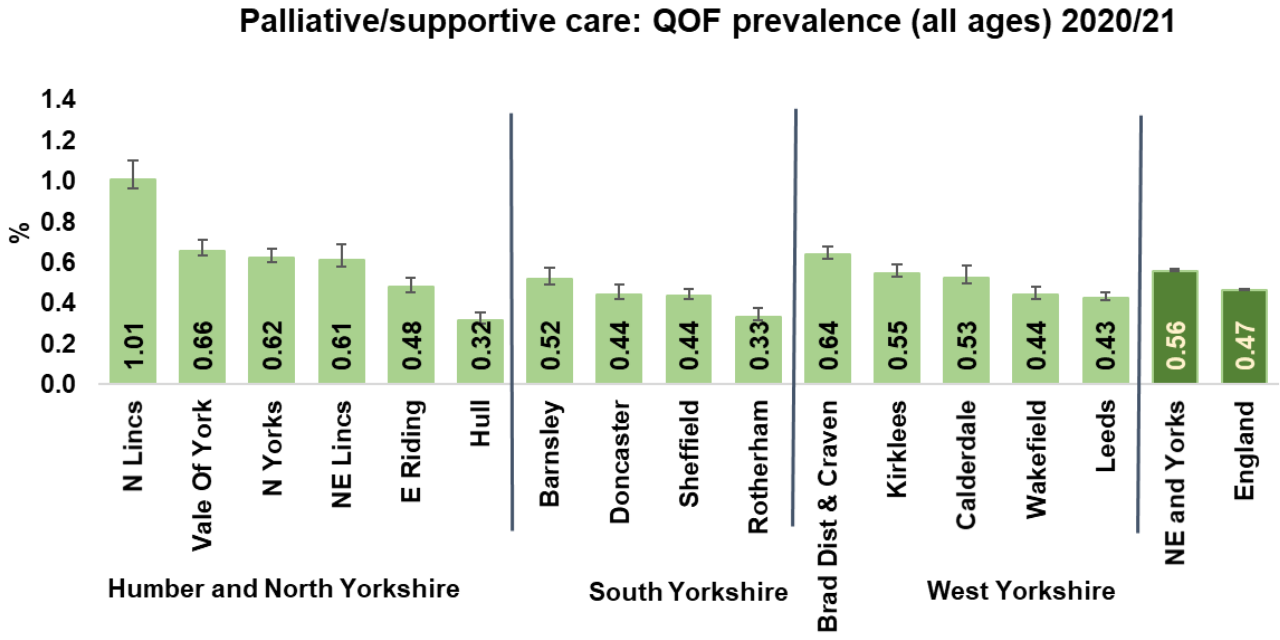
About 1% of the population in the UK **die each year** (over half a million), with an average of 20 deaths per GP per year. But only a twelfth of patients have a sudden death.

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 Yorkshire and the Humber, where 0.6% of people (significantly more than England) were **identified** as needing palliative care or support in 2020/21. Four Y&H CCGs have a prevalence of palliative care significantly lower than England.

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 those with a physical or learning disability face **barriers to accessing health and social care** services.

These 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**.

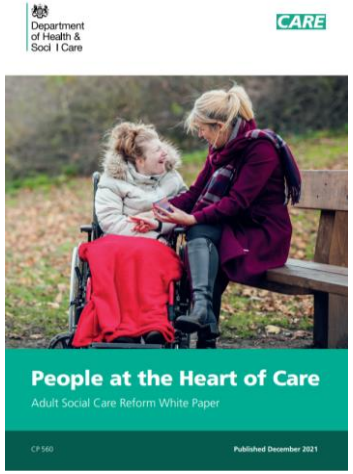
The government has set out plans to address the health and care issues brought about by COVID-19

Following the significant disruption to health and social care provision during the COVID-19 pandemic, the Government 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

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



In November 2022 the Government announced details of the £500 million Adult Social Care Discharge Fund to enable the discharge of patients from hospital to the best place for their ongoing care. This was followed by an additional £200 million to fund community care stays of up to 4 weeks.

6. Call to action

General recommendations for action by local areas

The following recommendations are directed towards different organisations operating in the health and care system:

- **Integrated Care System** (ICS): partnerships bringing together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. They were introduced in 2016 as informal partnerships, but in July 2022 were formalised as legal entities with statutory powers and responsibilities. ICSs have two components:
  - **Integrated Care Boards** (ICB): holds responsibility for planning and funding most NHS services in the area, including those previously planned by clinical commissioning groups (CCGs)
  - **Integrated Care Partnerships** (ICP): statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector, NHS organisations and others to develop a health and care strategy for the area.
- **Combined Authority**: a legal body that enables a group of two or more local authorities (councils) to collaborate and take collective decisions across council boundaries. Powers and resources can be devolved from national government to combines authorities.
- **Office for Health Improvement and Disparities** (OHID): part of the Department of Health and Social Care bringing together expert advice, analysis and evidence with policy development and implementation to shape and drive health improvement and equalities priorities for government.
- **Association of Directors of Public Health** (ADPH): membership body for Directors of Public Health in the UK. The Yorkshire and Humber ADPH network supports the delivery of better public health outcomes through leadership, influence, public health development, collaboration and collective advocacy.
- **Association of Directors of Adult Social Services** (ADASS): membership body for Directors of Adult Social Care promoting higher standards of social care services and the independent voice of adult social care. The ADASS Yorkshire and Humber network's improvement approach is based on collaboration and innovation through regional networks of social care professionals.

General recommendations for action by local areas

	Action at region/system/place	Action by
Continue providing strategic leadership to co-ordinate joined-up action on healthy ageing locally	Region	OHID/NHSE/ADPH/ ADASS
Develop strong and effective collaboration with key partners to ensure a joined-up approach to health and social care for older people	Region, System and Place	All
Challenge negative language and imagery of older people and shift conversation to celebrate successes and benefits of an ageing population	Region, System and Place	All
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	System and Place	Local authorities, Integrated Care Boards
Ensure all interfacing key strategies have a healthy ageing focus, using Health economic assessment tool (HEAT) and Environmental Impact Assessment (EIA)	System and place	Local authorities, Integrated Care Boards
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	Place	Local authorities

Topic specific recommendations	Action at region/system/place	Action by
Engage with older adult communities to understand **how individual factors intersect** to affect health in your local area	Place	Local authorities and place-based teams in Integrated Care Boards
Follow the 4 steps to becoming an **Age-friendly Community**: Engage and understand, Plan, Act and implement, and Evaluate	Place	Local authorities and partners
Support people to **remain connected** as they age with good transport links, green spaces, services, and facilities close to homes	Place and System	Local authorities, combined authorities
Map the drivers, strengths and assets in your local **rural areas** to identify areas for action	Place	Local authorities and place-based teams in Integrated Care Boards
Support older people to develop the **skills to get online** and use **digital appliances** while maintaining paper communication	Place	Local authorities and VCS organisations
Support older adults to **volunteer, mentor and peer support**	Place	Local authorities, NHS organisations, private sector businesses and VCS organisations
Engage local **unpaid carers** to identify their needs, and support them to be healthier and have more control over their lives	Place	Local authorities and place-based teams in Integrated Care Boards
Engage those **ageing without children** in your local area when planning future service provision	Place	Local authorities and place-based teams in Integrated Care Boards
Ensure opportunities are available to remain engaged with **creative, learning and cultural activities** as people age	Place	Local authorities, NHS organisations, private sector businesses and VCS organisations

Topic specific recommendations	Action at region/system/place	Action by
Ensure **diverse housing options** meet the needs of older people across all tenures	Place and System	Local authorities, combined authorities, housing associations
Adopt a range of community centred approaches that encourage **community participation** from people of all ages	Place	Local authorities, NHS organisations and VCS organisations
Help people remain healthy, active and independent by improving the quality of **local housing** and future proofing new housing making them accessible and adaptable	Place and System	Local authorities, combined authorities, housing associations
Support **low income owner occupiers** to access funds to repair and improve their home	Place	Local authorities and VCS organisations
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	Place and System	Local authorities, combined authorities, Local Enterprise Partnerships and all employers
Work with local employers to develop age-friendly policies that enable the **recruitment and retention of older people** in work	Place and System	Local authorities, combined authorities and Local Enterprise Partnerships
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**	System	Integrated Care Boards
Target evidence-based **strength and balance programmes** at an individual level to those most affected by the pandemic	Place	Local authorities, NHS providers and place-based teams in Integrated Care Boards
Distribute the **Active at Home** booklet to older people most affected in your local area	Place	Local authorities, NHS providers, place-based teams in Integrated Care Boards and VCS organisations
Use local data to review how many emergency dementia admissions had a **care plan reviewed** in the previous 12 months	System	Integrated Care Boards

Topic specific recommendations	Action at region/system/place	Action by
Prioritise **medication review for people with dementia** living in the community, particularly those living alone	System	Integrated Care Boards
Ensure NHS Health Checks are being used effectively to **raise awareness of dementia**	Place	Local authorities
Promote **regular eye tests** and **diabetic eye screening** locally to prevent sight loss	System	Integrated Care Boards
Encourage older people in your local area to seek help for **hearing loss**	System	Integrated Care Boards
Encourage the inclusion of mental health and wellbeing in **regular medication reviews**	System	Integrated Care Boards
Target evidence-based **smoking cessation** interventions and treatment for **alcohol dependence** at an individual level	Place	Local authorities and place-based teams in Integrated Care Boards
Ensure **local alcohol strategies** specifically identify the needs of older adults	Place	Local authorities and place-based teams in Integrated Care Boards
Develop and target clear and relevant **information about sexual health** including STI prevention to older people locally	Place	Local authorities and place-based teams in Integrated Care Boards
Ensure **local sexual health and HIV strategies** specifically identify the needs of older adults	Place	Local authorities and place-based teams in Integrated Care Boards
Ensure that local strength and balance programmes give thought to **malnutrition and sarcopenia**	Place	Local authorities and place-based teams in Integrated Care Boards

Topic specific recommendations	Action at region/system/place	Action by
MH Primary care services should conduct **depression screening** when these risk factors are present in older people	System	Integrated Care Boards
Ensure **local mental health strategies** specifically identify the needs of older adults	Place	Local authorities and place-based teams in Integrated Care Boards
Review **local IAPT outcomes** and identify areas for improvement for older people	System	Integrated Care Boards
Fully utilise all approaches including **social prescribing** to ensure older people are connected	Place and System	Local authorities, NHS providers and Integrated Care Boards
Ensure timely access to high quality **health, care and rehabilitation services**, and personalised support and adaptations to help older people stay independent	Place and System	Local authorities, NHS providers and Integrated Care Boards
Explore the **needs of carers** locally and identify better ways to support them	Place	Local authorities and place-based teams in Integrated Care Boards
Develop **local projections** of how demographic changes will impact demand, informed by the latest, best available data and evidence	Place	Local authorities
As services resume, ensure **NHS Health Checks** identify and prioritise eligible people most at risk of poor health	Place	Local authorities

We recognise that different local areas will be progressing at different rates, and these and these recommendations are intended to be a reviewed against existing action and for inclusion in JSNAs and relevant strategies to help prioritise healthy ageing in local areas

Next Steps for Yorkshire and Humber

OHID will continue offering support to systems and places in Y&H to **develop healthy ageing strategies**

Promote the Age Well, Live Well Network, a **cross-sector network** of partners (ADPH/ADASS/NHSE/VCSE) providing system leadership on healthy ageing in Yorkshire and Humber and encourage additional partners to engage with the work programme.

In consultation with the Y&H Healthy Ageing Community of Improvement, develop a series of topic-based **webinars** including continued professional development (CPD) sessions

Build upon the success of the virtual **Falls in Social Care Conference and the falls and deconditioning network** to develop a cross-sector work programme to reduce the impact of falls on maintaining independence.

Appendix 1:
Examples of local good practice

Local Area	Topic	Case Study Details	Contact
North Yorkshire	Physical activity in care settings	Care home and supported living summer Olympics. https://www.valeofyorkccg.nhs.uk/about-us/partners-in-care/post-covid-inter-care-home-and-supported-living-summer-olympics/?preview=1	sam.varo@nhs.net
Barnsley	Mouthcare assessments in care homes	Implementing best practice – creation of oral health pilot pack	Hannah Rowley hannahrowley@barnsley.gov.uk
Barnsley	ECHO oral health training	Roll out of ECHO training around Oral Health ensuring all staff and new starters in adult social care can access oral health training.	Hannah Rowley hannahrowley@barnsley.gov.uk
Hull	Social isolation and loneliness	Forever Young, Hull Libraries. The sessions are not currently advertised on the library website. Leaflets are available in the library, in local notice boards and is promoted by word of mouth and social media. www.hcandl.co.uk	Hull Libraries library.link@hcandl.co.uk 01482 331 254
East Riding of Yorkshire	Co-produced Dementia Peer Support	A Good Life with Dementia course and the East Riders Group https://intel-hub.eastriding.gov.uk/jsna-needs-assessments-and-intelligence-documents/#dementia	Damian Murphy, Innovations in Dementia damian@myid.org.uk

Detailed case studies for some of the practice examples are described in an accompanying publication.

Local Area	Topic	Case Study Details	Contact
East Riding of Yorkshire	Oral Health Improvement	Improving Oral Health care in residential homes, through recruiting, training and supporting Oral Health Champions City Health Care Partnership (chcpcic.org.uk)	City Health Care Partnership Oral Health Team chcp.oralhealth@nhs.net
East Riding of Yorkshire	Sexual Health	Workplace Health Learning Opportunities Understanding the Menopause – General Awareness session Understanding the Menopause - Briefing for Managers	Sarah Oliver Sarah.Oliver@eastriding.gov.uk
East Riding of Yorkshire	Mental Health	Healthy Minds in East Riding Online resource providing mental health information for all, including details of a range of activities which contribute to Healthy Ageing for example Men in Sheds, Healthy Walking, Mental Health Chat Healthy Minds (eastridinghealthandwellbeing.co.uk)	Adam Gibson Adam.Gibson@eastriding.gov.uk
East Riding of Yorkshire	Isolation and Loneliness	Social Prescribing Linking residents with local community groups and services that offer support and advice Social Prescribing (eastriding.gov.uk)	NHS Humber TFT hnf-tr.socialprescribing@nhs.net
East Riding of Yorkshire	Health Behaviours	Exercise on referral Long covid rehabilitation Escape Pain Health Checks https://www.eastridingleisure.co.uk/health/	East Riding Leisure leisure.health@eastriding.gov.uk

Local Area	Topic	Case Study Details	Contact
East Riding of Yorkshire	Health Behaviours	Health Trainers https://www.nhs-health-trainers.co.uk/	NHS Humber TFT ryan.nicholls@nhs.net
East Riding of Yorkshire	Health Behaviours	Quit smoking | Xyla Health & Wellbeing (xylahealthandwellbeing.com)	
East Riding of Yorkshire	Isolation and Loneliness Health Behaviours	Libraries Health Offer • Reducing Loneliness and Isolation with groups and activities including Cuppa and a Chorus, Book Groups, Reminiscence sessions and Chatter and Natter groups. • Health promotion: Reading Well collections available in every Library across the authority and some e books. • Boditrax: body composition machines available in 5 branches, delivered alongside a 'healthy chat' to signpost people to other council services which may help with any concerns. https://www.eastridinglibraries.co.uk/more-than-books/health-zone/	lama.admin@eastriding.gov.uk
Hull & East Riding	Social isolation, Loneliness, Communities, Connectedness, Falls prevention, Dementia, Sensory impairments, physical and mental health, Social care, Prevention and early intervention	Older People's Partnership Hull and East Riding www.olderpeoplespartnership.org.uk	info@olderpeoplespartnership.org.uk OPPG phone -01482 425450 Champlin118@gmail.com

Local Area	Topic	Case Study Details	Contact
Bradford	Intergenerational Work	https://thelinkingnetwork.org.uk/what-we-do/intergenerational-linking/	linda.cowie@thelinkingnetwork.org.uk
Bradford	Connecting Older Adults	https://www.carersresource.org/worth-connecting/	CWhiley@carersresource.org
Leeds	Falls	Dance On programme - 10 weekly dance sessions for people over 55yrs across Leeds. https://yorkshiredance.com/project/dance-on/	Robina Ahmed, Advanced Health Improvement Specialist (Older People) 0113 3786507 Robina.Ahmed@leeds.gov.uk Adie Nivison, Projects Manager (Older People), Yorkshire Dance: adienivison@yorkshiredance.com
Leeds	Falls, Housing	Home Plus Leeds Service offering holistic support focused on interventions that improve independence, safety and health within the home. Home Plus - Care & Repair (care-repair-leeds.org.uk)	Robina Ahmed, Advanced Health Improvement Specialist (Older People) 0113 3786507 Robina.Ahmed@leeds.gov.uk Sharon Brookes sharon.Brooks@care-repair-leeds.org.uk
Leeds	Prevention and early intervention, social isolation, and loneliness	Supporting Wellbeing and Independence for Frailty (SWIFt) – service offering a person centred, targeted, wraparound support to older people living with frailty who are at risk of social isolation and loneliness.	Robina Ahmed, Advanced Health Improvement Specialist (Older People) 0113 3786507 Robina.Ahmed@leeds.gov.uk
Leeds	End of Life/Palliative Care	Leeds Dying Matters Programme – programme of work to change the culture around discussing death and dying by opening a debate about death, dying, bereavement and making plans	Hannah McGurk, Health Improvement Specialist (Older People) 0113 378 6055 Hannah.McGurk@leeds.gov.uk
Rotherham	Oral Health	Keeping Care Homes Smiling Project	S.robertson5@nhs.net

Appendix 2: Tools and resources

Recommended reading list

Resources

Tools

Recommended healthy ageing reading list

- OHID and the Centre for Ageing Better'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 2022: 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
- 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

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