



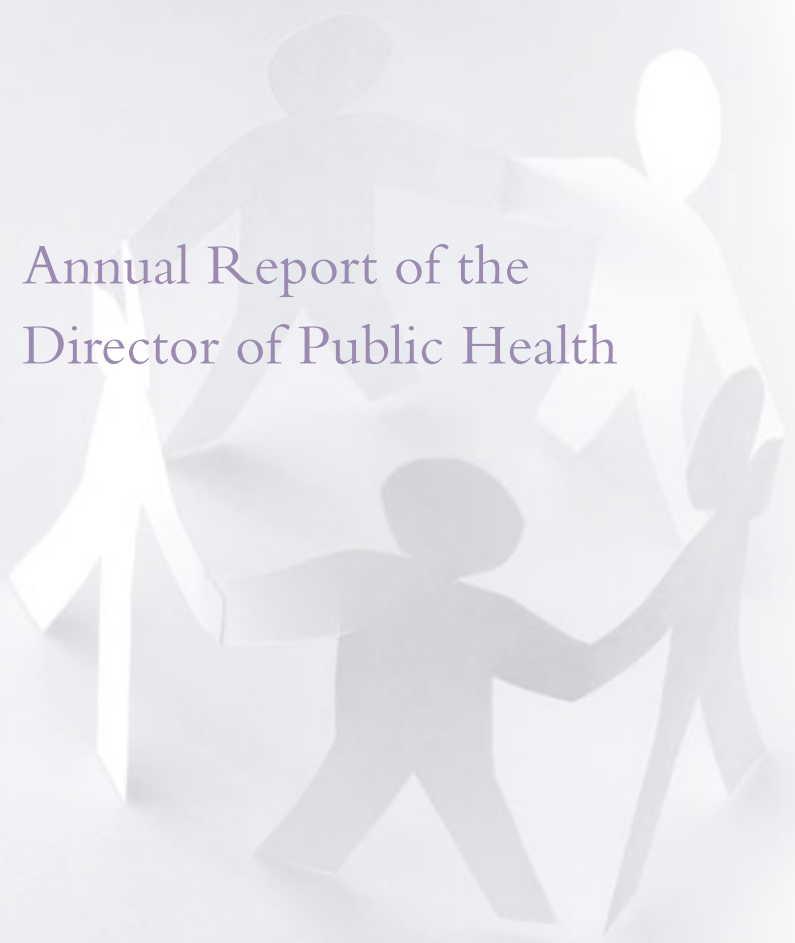
PUBLIC HEALTH

HOUSING

HEALTH AND WELLBEING IN THE OLDER POPULATION

2011

Annual Report of the
Director of Public Health



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Foreword

The population of Somerset is relatively healthy in terms of life expectancy and ill health when compared to the national rates. However, there are some health issues and inequalities in health which are important in Somerset and these are best tackled through a partnership approach - they cannot be solved by the health service alone.

Last year's Annual Public Health Report focused on some key health issues affecting the population. They were important because of the overall impact they have on premature deaths, numbers of people with the condition and diseases that result in high levels of GP consultations and hospital admissions.

The report this year takes a look at what public health is, and highlights two areas where partnership working will be essential, both now and in the future, to deliver the best outcomes for Somerset residents, with the resources available. These two areas, housing and the very elderly, were selected for in depth analysis as part of the overall refresh of the Somerset Joint Strategic Needs Assessment (JSNA).

The JSNA, which is updated every year, identifies priorities for health and wellbeing across Somerset. The full JSNA is available as an e-tool for the first time and can be found at the SINE website: www.sine.org.uk/jsna.

The new Health and Social Care Bill, currently going through parliament, will provide upper tier local authorities with a duty to improve population health and wellbeing, moving the lead for public health back to local authorities, from where it originated. Local authorities will establish statutory Health and Wellbeing Boards and lead on commissioning a range of services such as sexual health, smoking cessation, health checks and obesity prevention.

A new body called Public Health England will be set up and its responsibilities will include:

- allocating budgets to local government and rewarding progress against the public health outcomes framework
- providing public health advice, evidence, data and expertise
- delivering expert health protection support and national preparedness
- commissioning or providing national level health improvement services, for example, behaviour change campaigns
- commissioning some public health services such as vaccine purchasing and screening services from the NHS, for example, via the NHS Commissioning Board.

I hope you find the report interesting and informative.

Dr Caroline Gamlin
Joint Director of Public Health
NHS Somerset and Somerset County Council

Public Health

What is public health? The Faculty of Public Health defines public health as ‘the science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society’.

However, what does this really mean? The essential difference between the clinical and public health roles of healthcare professionals can be illustrated by the image of people rescuing someone who has had a fall while walking along a cliff. The clinical role focuses on rescuing and treating those who have fallen, whereas the public health role aims to go upstream to find out why people are falling. However, the public health role does not stop with understanding the problem; it also aims to try and prevent the event from happening in the first place.

There are a number of possible actions that may be considered in preventing the event illustrated in Figure 1. One option is to put up effective barriers to stop people falling; in the pictures, one can see a fence being erected but it is probably not effective because it is not being erected in the appropriate place. Another option is to provide information to the right people, at the right time, to prevent risky behaviour near the cliff. This may involve putting up appropriate signage. Yet another option is to prevent people from walking near the cliff. This may be by enforcing a no entry zone. It is also necessary to make sure that, if the emergency occurs, the people performing the rescue are well trained and at the right place to save as many lives as possible, effectively and efficiently.

Healthcare professionals usually focus on treating individual patients – rescuing and treating the people who have fallen down the cliff. However for many people, the ability to obtain and follow medical advice is limited by circumstances outside their control. They may not be able to access healthcare, not understand the advice because of educational or cultural barriers, or find it difficult to follow because of their social or environmental circumstances. Understanding these wider social determinants of health is therefore necessary to provide appropriate health services that are both sensitive and effective. Examples of methods that can be used to address such issues include legislation (e.g. seat belts) and economic policy (e.g. taxes on tobacco). There are also specific

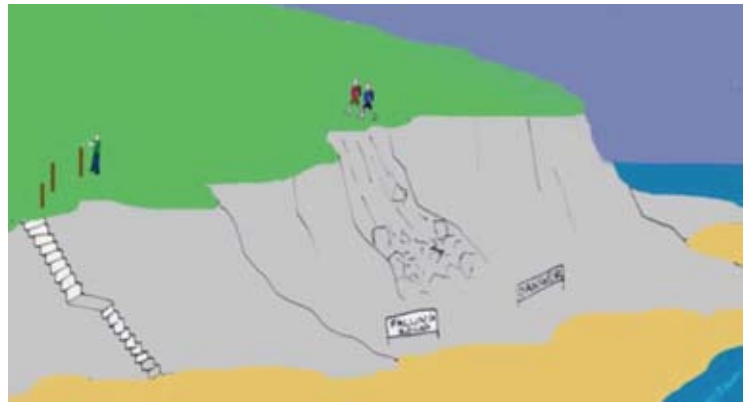


Figure 1 - Understanding public health

prevention programmes (e.g. immunisation and screening) or wider initiatives (e.g. housing improvements and transport) that have an impact on health. These actions involve collaborative working with a range of people and communities across many sectors.

It is important to realise that there can be tensions between the approach of treating individual patients and the approach of dealing with the health of the population generally. Overall, improvement in the health of a population may not translate into a benefit for every individual within it. Conversely, doing what is best for the individual patient may not necessarily benefit the wider population as others could potentially be excluded from getting help. With growing economic pressures and the rising cost of healthcare, it is necessary to focus resources on areas of greatest need and where interventions can be the most effective.

In summary, public health seeks to identify and quantify health problems in the population generally, introduce appropriate evidence-based and cost-effective interventions to improve outcomes, and then evaluate them to ensure they have been effective.

A brief history of public health

Much of the improvement in life expectancy and wellbeing achieved over the last 175 years has been due not to medical advances in treatments, but to the prevention of disease and ill health before it causes harm.

The following sets out a few key milestones in the 19th and 20th centuries which have contributed towards achieving those improved outcomes in population health.

1842 - Edwin Chadwick's report "*The Sanitary Conditions of the Labouring Population*" is published. This argued that disease was directly related to poor living conditions.

1848 - First Public Health Act passed, which caused a Board of Health to be set up and gave towns the right to appoint a Medical Officer of Health.

1853 - Vaccination against smallpox was made compulsory.

1854 - Dr. John Snow isolated the source of a London cholera outbreak to water from the Broad Street pump.

1854 - Improvements in hospital hygiene introduced thanks to Florence Nightingale.

1875 - Public Health Act enforced laws about slum clearance, provision of sewers and clean water and removal of nuisances.

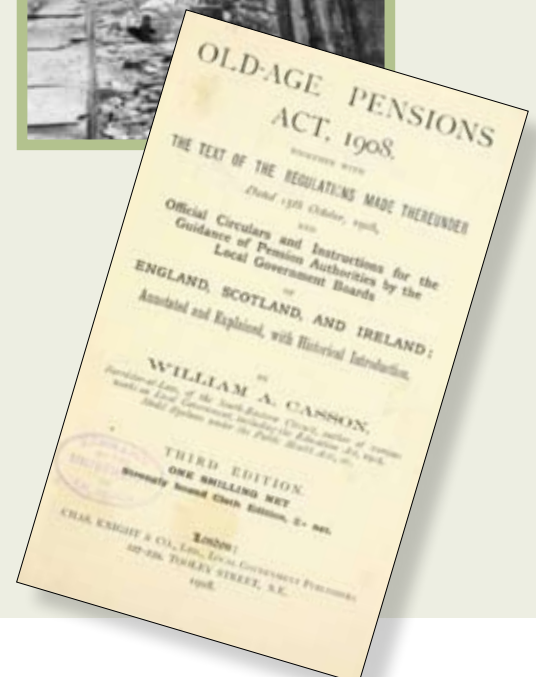
The Boer War revealed that half of the population were unfit for military service. The Government accepted that it had to pass laws to improve the situation of the poor.

1906 - Local councils provided free school meals for poor children.

1907 - School medical examinations were introduced.

1908 - Old age pensions were introduced.

1911 - National Insurance was introduced.



Public health achievements in the 20th century

- control of infectious diseases
- decline in deaths from coronary heart disease and stroke
- recognition of tobacco use as a health hazard
- motor vehicle safety
- fluoridation of drinking water in some areas
- safer workplaces
- safer and healthier foods
- healthier mothers and babies
- family planning.



Public health in the 21st century

Disease patterns are changing. We are living longer but with significant inequalities in life expectancy and ill health.

Unresolved challenges:

- lifestyle
- circulatory diseases, respiratory disease and cancer
- mental ill health
- long term conditions
- new threats (e.g. climate change, drug resistance) and persistent old ones.

Public Health is subdivided into three key areas of practice:

- health improvement
- health services
- health protection.

Health Improvement

Health improvement functions are aimed at tackling the wider determinants of health such as:

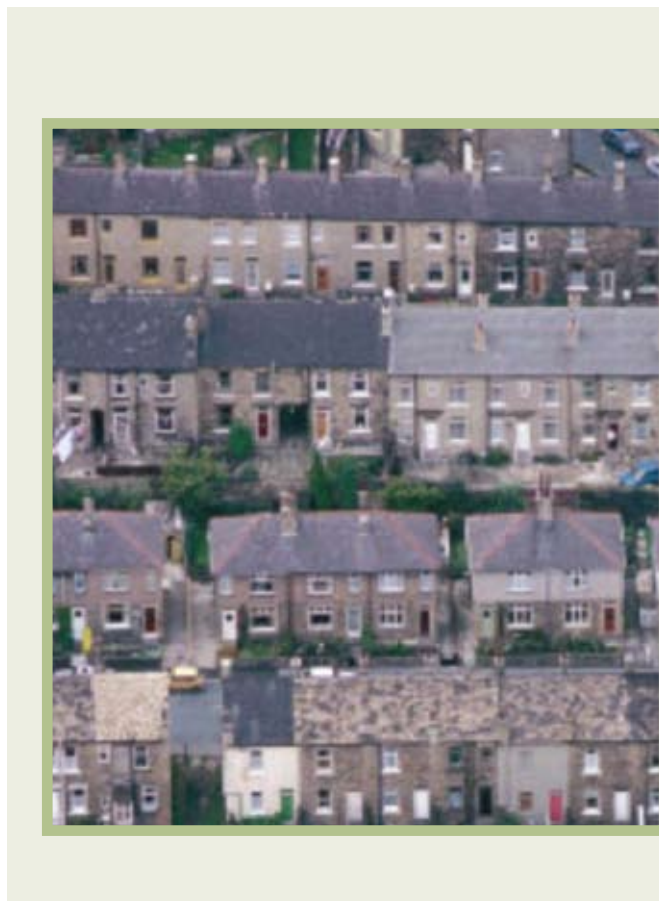
- health inequalities
- education
- housing
- employment
- family/community
- lifestyles
- surveillance and monitoring of specific diseases and risk factors.

Health inequalities can be defined as differences in the health status of one group of people compared with another. These groups of people are commonly defined by age, sex, ethnicity, geography, social class, income and education. It is known that factors such as age, gender and ethnic origin are associated with differences in health status. However, there is evidence to suggest that many of the factors responsible for inequalities in health are related to social and economic inequalities in society. Deprivation indices (usually related to geographical area) and socioeconomic status (usually related to occupation) are commonly used to highlight differences in health status between groups.

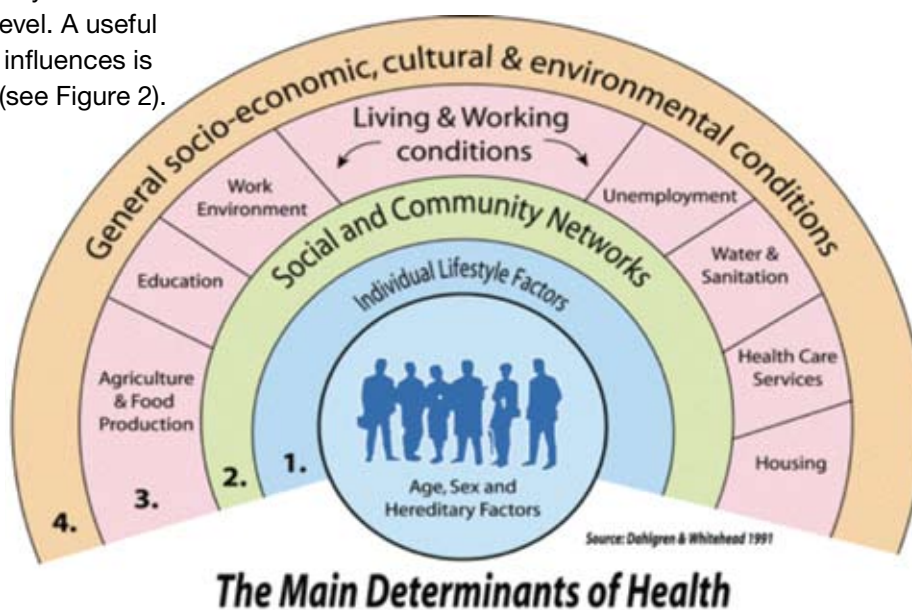
Globally, inequalities in health have been closely related to material deprivation where the burden of disease is often greatest in the poor. While absolute material poverty is relatively rare in a developed country such as the UK, there are still large inequalities in health between different groups which are related to income differentials between them. Currently, life expectancy at birth between different electoral wards in the UK differs by over 10 years in both men and women. Not only do poorer people die sooner, they also spend more time living with a disability. Again, there is a gradient across the range with these patterns being seen in terms of education, housing, and other measures of social and economic status. Some of these factors are interrelated – for example, lack of education is associated with poor employment opportunities and consequently lower incomes.

From a public health perspective, the fact that avoidable inequalities exist between population groups is unfair and unacceptable in a developed society. However, tackling health inequalities is complex and requires coordinated action across sectors and agencies with multiple actions directed at various aspects to reduce the gap between different population groups and places.

An individual's health is determined by a range of factors. Some of these can be modified at an individual level while others can only be modified at a collective or environmental level. A useful framework for considering these influences is provided by the Rainbow Model (see Figure 2).



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The Main Determinants of Health

Figure 2 - Rainbow Model (Dahlgren and Whitehead, 1991)

In England, the importance given to tackling inequalities was demonstrated in 2003 by the Department of Health's strategy, *"Tackling Health Inequalities: A Programme for Action."* The strategy identified four themes which would reduce inequalities in the longer term:

- supporting families, mothers and children
- engaging communities and individuals
- preventing illness and providing effective treatment and care
- addressing the underlying determinants of health.

The strategy also marked the setting of a national public service agreement (PSA) target to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth by 2010.

More recently, the Marmot Review (2010) identified the most effective evidence-based strategies for reducing health inequalities from 2010 onwards.



The Marmot review suggested that actions focussing on the most disadvantaged would not be sufficient. To reduce the steepness of the health inequalities gradient, action must be universal but with a scale and intensity that is proportional to the level of disadvantage (known as 'proportional universalism').

The population of Somerset is relatively healthy in terms of disease and death rates when compared to the national average. Life expectancy at birth is greater than the national average for both men and women. Over the past decade, death rates from all causes have decreased and rates of death from coronary heart disease and cancer are lower than national averages. However, there are differences within Somerset – for example, life expectancy and mortality from coronary heart disease is higher in the more deprived groups in Somerset compared to the more affluent groups. Within Somerset, there are a range of initiatives being undertaken to tackle inequalities, based on the recommendations of the Marmot Review.

Health Service Improvement

Health service improvement is aimed at planning and modifying services to meet the needs of the population, ensuring appropriate evidence-based and cost-effective interventions are in place, and services are evaluated in a rigorous manner.

It includes:

- clinical effectiveness
- efficiency
- service planning
- audit and evaluation
- clinical governance
- equity.

A good example of where public health supports this work is on cancer screening. There are three national cancer screening programmes operating within the NHS:

Cervical screening

The NHS Cervical Screening Programme invites women aged 25 to 50 for screening every three years and those aged 50 to 64 every five years. Women aged 65 and over are taken out of the call/recall system unless they need ongoing surveillance or follow up or have never had a test, in which case they are entitled to one. Somerset has higher uptake figures than both the South West and England as a whole, although it has fallen during recent years.

Overall, the proportion of women aged 25-64 screened within the last five years in Somerset is 81.6% compared to 78.9% nationally. However, a recently undertaken health equity audit across Somerset identified a number of inequalities in terms of uptake. Lower uptake was observed in deprived practices, younger women, ethnic minority groups and women with learning disability. Visits have since taken place to raise awareness of these inequalities and to promote good practice across all GP surgeries.

Breast screening

The NHS Breast Screening Programme provides free breast screening every three years for all women in the UK aged 50 and over. Across Somerset, women aged 50-70 are routinely invited for a mammogram every three years. This programme is currently being extended to include those age 47-49 and 71-73, whilst women over this age are able to opt into the programme and request a mammogram. The percentage of women aged 53-70 being screened for breast cancer within the last three years is just over 82% which is higher than both the South West and England figures.

A breast screening health equity audit across Somerset also identified lower uptake in deprived GP practices and a limited awareness from



practices in terms of when the breast screening van was visiting their area. Work is on-going to tackle these inequalities and to ensure the screening service meets future needs.

Bowel screening

The NHS Bowel Screening Programme is co-ordinated regionally and offers screening every two years to all men and women aged 60 to 74 across Somerset. People over 74 can request a screening kit and opt into the programme. As with the cervical and breast screening programmes, Somerset performs well in terms of uptake for bowel screening. Between November 2009 and October 2010, 63.5% of those invited across Somerset were screened compared to 56.3% nationally.

Similar inequalities were identified around deprivation whilst there is also a much lower uptake for men than women. During early 2011, an extensive regional media campaign took place to promote awareness of the signs and symptoms of bowel cancer and raise awareness of the screening programme. It is likely that such campaigns will be repeated in the coming months and local campaigns will need to be targeted to ensure inequalities are addressed.

Health Protection

Health protection functions are aimed at providing better protection against infectious diseases and other dangers to health including chemical hazards, poisons and radiation. Health protection issues can have an immediate impact on health and wellbeing. Some examples of issues that public health is involved with include:

- immunisations
- infectious diseases
- chemicals and poisons
- radiation
- emergency response
- environmental health hazards.



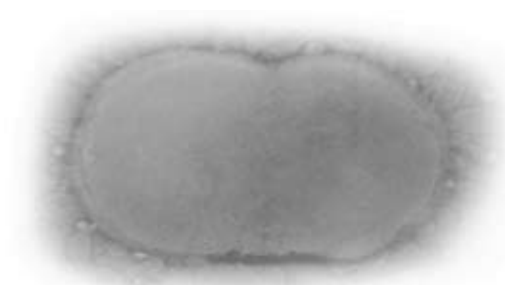
Meningitis and Meningococcal disease

Meningitis is the inflammation of the linings of the brain and spinal cord, while septicaemia is the blood poisoning form of the disease. They may be caused by a variety of different organisms, including bacteria, viruses and fungi. When caused by the meningococcus bacteria (*Neisseria meningitidis*), these two conditions are known as meningococcal disease (see Figure 3).

The bacteria is found naturally in the back of the throat or nose (approximately 10% of the general public can carry the organism) and will only occasionally cause disease. Infection is not easily spread; it is transmitted from person to person by inhaling respiratory secretions from the mouth and throat or by direct contact (kissing). Close, prolonged contact is usually required to transmit the bacteria.

In the past, most disease in the UK was caused by groups B and C. However, cases caused by group C have dramatically reduced since routine vaccination was introduced. There is currently no vaccine for group B.

When a case of suspected meningococcal disease is notified, the role of public health is to offer advice and information to all contacts of the suspected case. Close contacts (i.e. household or similar) are additionally offered antibiotics as prophylaxis. While antibiotic prophylaxis can play a role in preventing disease, its main purpose in this situation is for public health reasons, i.e. to get rid of throat carriage and therefore prevent people from passing the infection to others. In Somerset there were 31 cases of meningococcal disease in 2010/11.



© Meningitis Research Foundation

Figure 3 - Meningococcus bacteria

Seasonal Influenza, Avian Influenza and Pandemic Influenza

Seasonal influenza or 'flu' occurs every year in winter. The flu virus is highly contagious and is easily passed on from person to person. Certain groups have a greater risk of being infected with the flu virus (see Figure 4). These include the young, the elderly and individuals whose respiratory, cardiac or immune systems make them more vulnerable to flu and more likely to suffer severe illness. Routine vaccination offers the best protection and people who are at high risk of infection are offered vaccination each year. The virus undergoes constant minor genetic change and different subtypes circulate each winter. The composition of the vaccine therefore changes every year and is based on recommendations from the World Health Organisation.

Rarely, the virus can undergo significant genetic change resulting in a pandemic (i.e. an epidemic that affects a large geographical area). The main underlying factor is the exposure of a population with no or little resistance to a new strain of the flu virus which can be easily transmitted from person to person. Since the alteration undergone by the virus is considerable, there will not be a vaccine available initially.

In the light of avian influenza outbreaks across the world, there is on-going concern regarding the creation of a new human influenza virus to which the population would have little immunity. These concerns have led to heightened influenza surveillance both internationally and throughout the UK. Locally, plans have been drawn up to deal with a potential pandemic in Somerset. This preparation and the collaborative working involved proved useful in dealing with the swine flu pandemic in 2009/10.

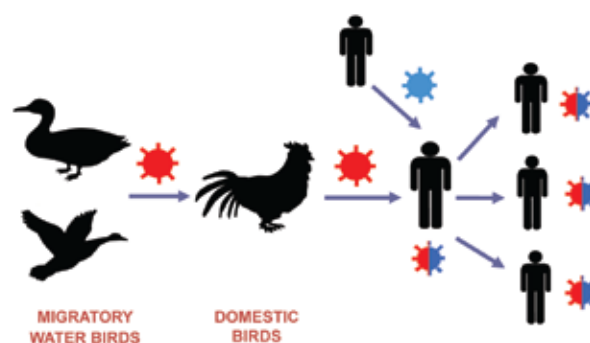
At present, avian influenza remains essentially a disease of birds. To date, affected human beings have had close contact with an infected bird and there is no evidence yet to suggest that the infection can be spread easily from person to person (see Figure 5).



Figure 4 - The flu virus

Emergency Response

Public health specialists contribute to multi-agency planning arrangements across Somerset. Plans are in place to protect the health of the population in the event of a major incident, whether deliberate (e.g. bio-terrorism) or natural (e.g. flooding). Public health staff provide an emergency response to chemical, biological, radiological and nuclear incidents requiring health advice and operates an on call service 24 hours a day, 365 days a year.



Source: Respiratory Diseases Department
Health Protection Agency
Centre for Infections, London

Figure 5 - From Birds to Humans followed by re-assortment in Humans

Measles and MMR

The MMR vaccine remains the safest and most effective way of protecting against mumps, measles and rubella. However, following inaccurate media coverage there was a sharp drop in the uptake of the vaccine and the level of protection became insufficient to prevent measles, a dangerous disease with significant complications. There are currently outbreaks of measles across Europe due to low vaccine uptake and we have had confirmed cases in Somerset during 2009 and 2010.

The main priority is to ensure a high uptake of the childhood MMR vaccine. A considerable amount of work over the past few years has seen a steady increase in the uptake of the vaccine; this has risen from 80% in 2005 to about 90% currently. MMR is also offered at the same time as the school leaver immunisations (usually in Year 10) to those who have received no MMR or only one dose.

While the upward trend is encouraging, it is essential that the work to improve uptake to a level sufficient to prevent outbreaks of measles (around 95%) is continued (see Figure 6).

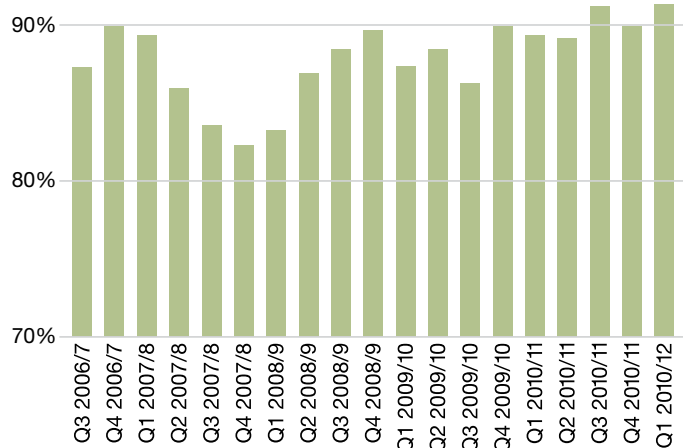


Figure 6 - Trends in MMR vaccine uptake within Somerset

‘Healthy lives, healthy people: our strategy for public health in England’

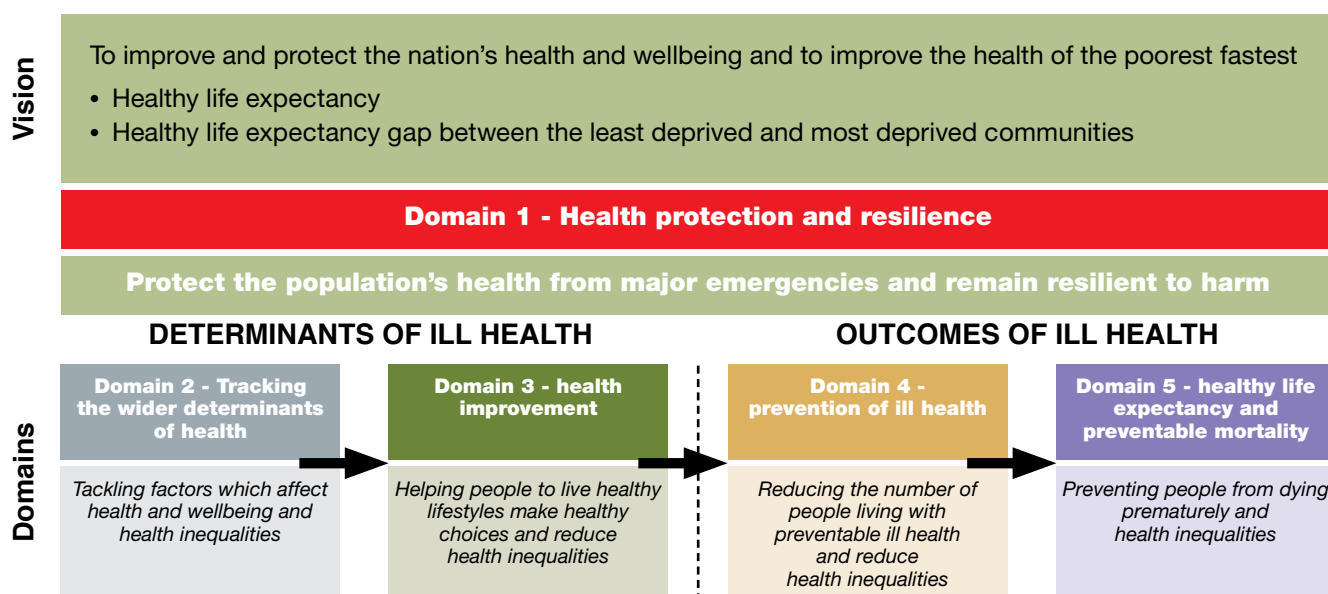
“*Healthy Lives, Healthy People: Our strategy for public health in England*” (November 2010) outlines the proposed shift in approach to tackling the public health challenges in England. The paper responds to Professor Sir Michael Marmot’s “*Fair Society, Healthy Lives*” report and adopts the proposed life course approach to tackling the wider social determinants of health (see Figure 7 over). The paper proposes a new approach to:

- protect the population from health threats
- empower local leadership and encourage wide responsibility across society to improve everyone’s health and wellbeing
- focus on key outcomes with transparency of accountability through a new public health outcomes framework
- reflect the government’s core values of freedom, fairness and responsibility by strengthening self esteem, confidence and personal responsibility
- positively promoting healthy lifestyles
- adapting the environment to make healthy choices easier
- balance the freedom of individuals and organisations with the need to avoid harm to others using a ladder of interventions to determine the least intrusive approach necessary to achieve the desired effect and aiming to make voluntary approaches work before resorting to regulation.

The approach is intended to be:

- **responsive** - owned by communities and shaped by their needs
- **resourced** - ring fenced public health budget
- **rigorous** - professionally led, evidence based, efficient and effective
- **resilient** - strengthening protection against current and future health threats.

Figure 7 - The five domains for Public Health



The new Health and Social Care bill, currently going through Parliament, sets out new arrangements for public health, with the formation of Public Health England, a new body which will be an Executive Agency of the Department of Health. Their responsibilities will include:

- allocating a ring-fenced budget to local government and rewarding progress against the public health outcomes framework
- providing public health advice, evidence, data and expertise to the Secretary of State and public health system
- delivering expert health protection support and national preparedness
- commissioning or providing national level health improvement services, e.g. behaviour change campaigns
- commissioning some public health services such as vaccination and screening services from the NHS.

Local authorities will take on public health responsibilities which will include:

- a duty to improve population health and wellbeing
- the development of integrated and joined up commissioning plans across the NHS, social care, public health and other local partners
- a requirement to develop a Statutory Health and Wellbeing Board, a Joint Strategic Needs Assessment and pharmaceutical needs assessments
- a statutory health protection duty, including the requirement to maintain a robust and resilient on-call rota for major incidents and infectious disease outbreaks
- the employment of the Director of Public Health.

In addition, Local Authorities will commission the following public health services

- Accidental injury prevention
- Alcohol and drug misuse
- Breastfeeding, healthy eating
- Children (5-19 years only)
- Community safety
- Dental public health
- Excess deaths in winter or summer
- Health at work
- Health protection local level
- Immunisation (HPV & teen booster)
- Intelligence at local level
- Mental wellbeing
- NHS Health Checks
- Interventions to tackle obesity
- Physical activity
- Preventing and reducing birth defects
- Prevention and early presentation of cancer
- Sexual health services (apart from contraceptive services which are via NHS Commissioning Board)
- Social exclusion
- Tobacco Control.

There are two further examples of ongoing work in Somerset which are summarised on the following pages. Both areas have been reviewed in detail as part of the Joint Strategic Needs Assessment in 2011.

Housing

Housing plays a key role in the health and wellbeing of a population. In Somerset, social housing eligibility is changing and there is a need to support people to ensure that lack of housing or poor housing does not increase their need for health or social care.

Health and wellbeing in the older population

Somerset has one of the highest proportions of older people in the United Kingdom. The proportion of older people is projected to increase significantly in the future. This has implications for health and social care provision to support and promote health and wellbeing in an older and ageing older population.



Housing

Housing provision cuts across many other themes relating to health and wellbeing, from giving people a good start in life to dealing with mid-life emergencies and caring for the older sector of the population. This section identifies the key issues surrounding housing in Somerset and the many ways in which housing relates to the health and wellbeing of its residents.

It focuses on several key themes:

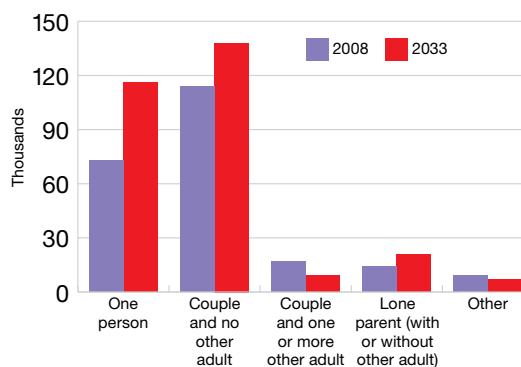
- the size of the housing market
- affordable housing
- social housing
- housing vulnerable people
- views of residents and organisations
- housing strategy - what is being done nationally and locally?
- on-going work.

14

The number of households in Somerset is projected to increase by 65,000 (29%) to 291,000 by 2033. Most of this growth will be for older people and single-person households (see Figures 8 and 9). Current construction programmes will fall well short of meeting this growth in demand, especially for affordable housing.

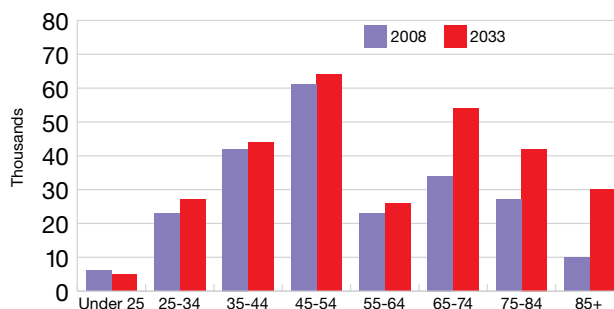
Demand for social housing is rising steadily. At the end of June 2011, there were more than 21,000 households on the waiting list. All district councils have been increasing provision of affordable homes in the private sector and the construction of new market housing has been maintained in some areas. However, the housing market remains weak, with increasing pressure on the rental market from people in need, whether they are facing homelessness, moving for employment or care, looking for more bedroom space, downsizing or many other reasons (see Figures 9 and 10).

Figure 8 - Projected Change in Household Types, Somerset



Source: ONS/Department for Communities and Local Government (DCLG)

Figure 9 - Projected Change in Households by Age, Somerset



Source: ONS/Department for Communities and Local Government (DCLG)

Figure 10 - Trends in Additional Affordable Dwellings provided by Local Authority



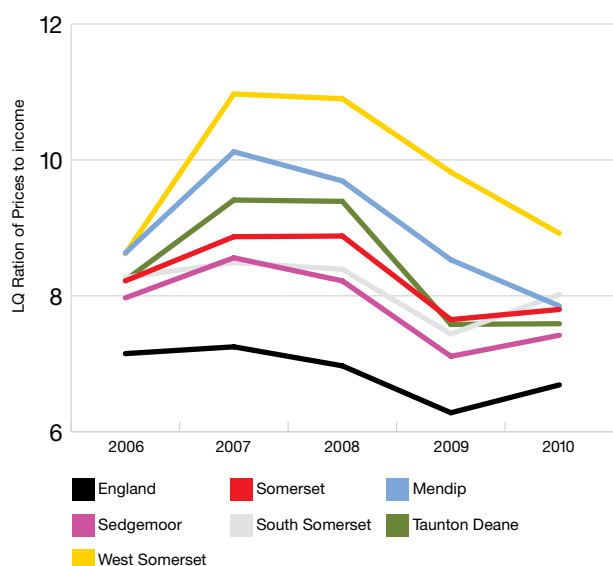
(P) denotes Provisional figures - Source: Homes & Communities Agency/Local Authorities

The ratio of house price to earnings is greater in all Somerset's districts than the national average. It is particularly high in the West Somerset area where, even in an economic downturn, house prices at the market entry levels are almost nine times the average earnings figure. This makes it almost impossible for young people to get onto the property ladder or move into the area for employment (see Figure 11).

At present, there is a net emigration of young adults from Somerset and, if this situation continues, there will not be enough people of working age to meet the needs of predicted growth in employment opportunities in Somerset over the next twenty years.

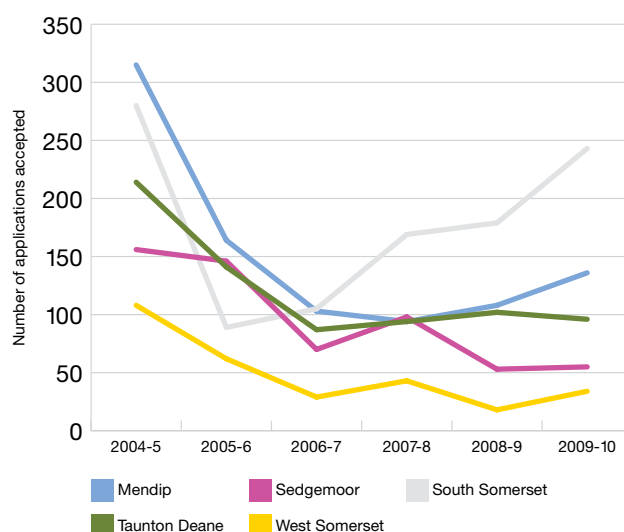
In recent years, supported by the Somerset Homelessness Prevention Strategy, the number of homelessness applications in Somerset has declined, in line with the England average. However, in 2009-10, there was an increase in applications and acceptances (see Figure 12).

Figure 11 - Trends in Affordability Ratio by District, County and Nation



Source: ONS Annual Survey of Hours and Earnings (ASHE) and Land Registry

Figure 12 - Trends in Homelessness Applications Accepted by District



Source: Local authorities' returns to DCLG

Stress caused by actual or fear of homelessness does affect people's health and wellbeing, both physically and mentally. Quality of housing is another important issue. A substantial proportion of private homes in Somerset fail to meet the Decent Homes Standard, although much is being done to improve accommodation. A large number of areas within the county also experience fuel poverty, which transcends income deprivation. A household is said to be in fuel poverty if it needs to spend more than 10% of its income on fuel to maintain a satisfactory heating regime (usually 21°C for the main living area, and 18°C for other occupied rooms). It is often the older, larger, under-occupied homes in rural communities that require a greater proportion of income to heat adequately. Cold, damp housing conditions impact on health, morbidity and mortality, especially amongst older people. It also indirectly affects physical and emotional wellbeing amongst all age groups.

Supported housing is a vital service to help vulnerable groups, such as the elderly, those with dementia or learning disabilities and people with problems related to substance and alcohol misuse. Somerset County Council and its partners have long adopted a policy of floating support which improves outcomes by promoting independent living wherever possible and reduces the need for residential care. This has the effect of benefiting the lives of individuals and being a more cost-effective model.

The borough and district councils in Somerset have statutory responsibilities for housing and in 2010 a Strategic Housing Vision for Somerset was agreed with their partners, which addresses the key issues identified in the Joint Strategic Needs Assessment. It involves a joined-up approach in which the three strands of housing, health and social care all pull together.

Multi-agency thematic groups covering older people, young people, those with learning disabilities and the socially excluded have produced recommendations for the way forward in the current economic climate. The approach harnesses health, housing, care, support and the voluntary sector so that vulnerable people are able to draw on the services they need to meet their individual needs and help them to move on. The challenge is to commission services across the whole system which provide people with the information they need to make choices and exercise control through their individual pathway.

Housing

Key points

- housing plays a key role in the health and wellbeing of a population
- cold, damp housing conditions impact on health, morbidity and mortality, especially amongst older people, but also indirectly affect physical and emotional wellbeing amongst all age groups
- the number of households in Somerset is projected to increase by 65,000 (29%) to 291,000 by 2033; most of this growth will be for older people and single person households
- the ratio of house price to earnings is greater in all Somerset Districts than the National average (it is nine times higher in West Somerset).

Recommendations

- implement the recommendations of the multi-agency thematic groups for housing outlined in Section 6 of the Joint Strategic Needs Assessment (JSNA) for Somerset 2011
- continue measures to tackle fuel poverty.

Health and wellbeing in the older population

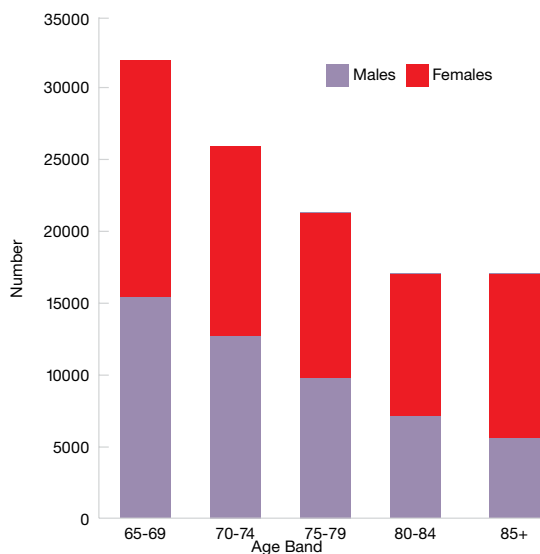
In comparison with many other areas, Somerset has a relatively old population. In addition, we are witnessing a rise in the very elderly (those aged 85 years and over) and this is expected to rise dramatically over the next 25-30 years. It is therefore essential that there is a focus on the health and wellbeing in the older population to identify key issues so that service providers and those planning for services understand the needs of this group.

Demography

People aged 65 years and over make up over 20% of Somerset's population. This is greater than the South West regional proportion (which has the highest proportion in the country). This distribution is not uniform across Somerset. West Somerset has the highest proportion of people aged 65 and over compared to the rest of Somerset. Of Somerset's 65 and over population, 55% is female; this figure rises to 67% in the 85 and over age group because females live longer than males (see Figure 13).

In 2010, 17,076 people in Somerset were aged 85 and over, equating to 3% of its population. Within Somerset, South Somerset has the largest number of people aged 85 years or older, whilst West Somerset has the highest proportion of 85 and over relative to the whole population.

Figure 13 - Somerset's 65 and over population by age and gender breakdown, 2010



Source: Office for National Statistics

More than two-thirds of those aged 85 years and over live in a home they own, although this age group also accounts for the largest portion of those living in care or residential homes – 3,126 out of the total of 4,751. About a third of all those aged 85 years and over are living on low incomes and claim pension tax credit.

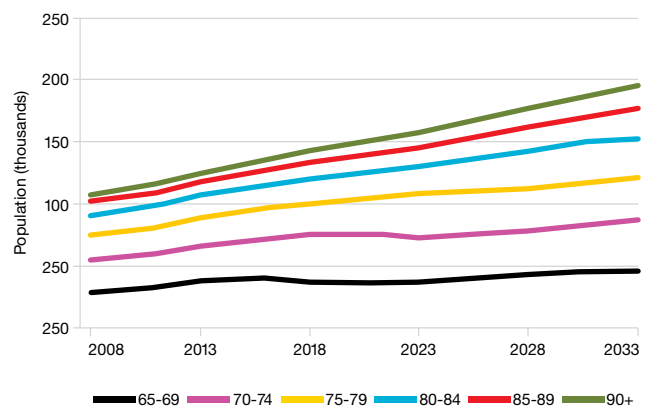
In 2033 Somerset's population is projected to be 619,400, an increase of 18% from 2008. The largest increase is projected to be in Somerset's older population, in particular those aged 90 years and over, which will increase by 267% from 5,100 in 2008 to 18,700 in 2033 (see Figure 14).

In the 65 years and over population, 16% are economically active, which is twice the national average. With the phasing out of the default retirement age of 65 years, this is set to rise.

The Office of National Statistics' (ONS) 2009 mid-year population estimates by ethnic group indicate that 96% of Somerset's older population is White British. The largest ethnic group after White British is White Other accounting for 1800 people, or approximately 1% of Somerset's older population. This is followed by White Irish which accounts for 1300 people. Numbers of older people in the remaining ethnic groups is relatively low.

Somerset saw a net inflow of older people in 2010. In total, 2,400 people aged 65 years and over moved here from outside of the county. Of these, 700 moved into South Somerset.

Figure 14 - Somerset older people population projections for 2008 to 2033, by age.



Source: Office for National Statistics

The projected increases in the older population also have significant implications for carers as they become older themselves. There are issues with accurate estimates of the numbers as many of them do not identify themselves as carers but solely as a family member. Older people in households may be both carers and cared for and an event such as hospital illness means a solution has to be found for both. Independence is valued by this group and to address their future needs, issues such as raising awareness of their entitlements and ensuring they are accessed are important.

Health Status

The average life expectancy at age 65 for people in Somerset is similar to that in the region and better than the national average. There is little difference in life expectancy between levels of deprivation once someone has reached the age of 85. Amongst the very elderly, circulatory diseases remain the single largest cause of death. Men are most likely to die in hospital and more likely than women to die at home. Women are more likely than men to die in a care or nursing home. The Excessive Winter Deaths

Index (EWDI) is higher for women than for men and older women appear to have the highest rate of excess winter deaths.

Figure 15 below shows the crude prevalence (i.e. not age or sex standardised) of certain conditions within Somerset for those aged 85 and over (MIQUEST). The figure also shows the proportion of recorded number of cases to that expected, based on models. A proportion of less than 100% is less than expected and a proportion greater than 100% is more than expected. This may suggest that conditions are being underdiagnosed or overdiagnosed, assuming the models are very accurate estimates (see Figure 15).

A comparison with the expected numbers of cases amongst this group suggests that some conditions are ‘overdiagnosed’, with more observed cases than the model predicts, and some being ‘underdiagnosed’. Some of this could be because of issues with the models being used in the prediction and the age profile of Somerset. The underdiagnosis could also reflect ‘unmet’ need and could suggest a need for efforts to increase

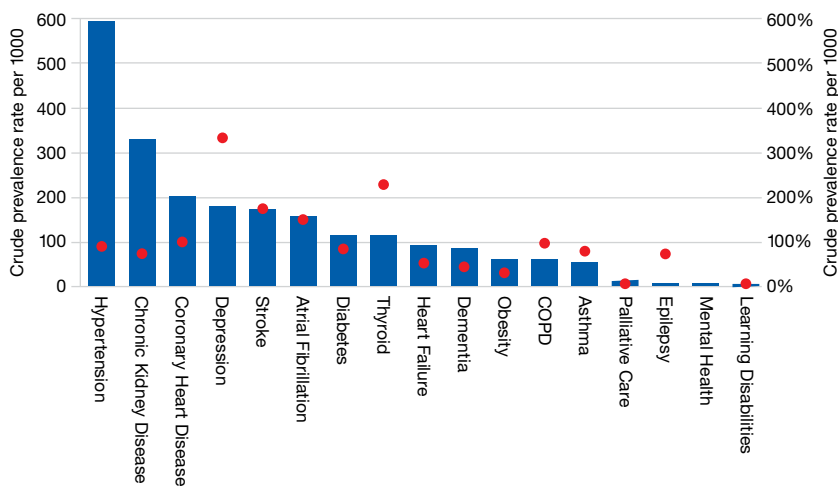


Figure 15 - Crude prevalence (85+) and the proportion of recorded cases to expected cases

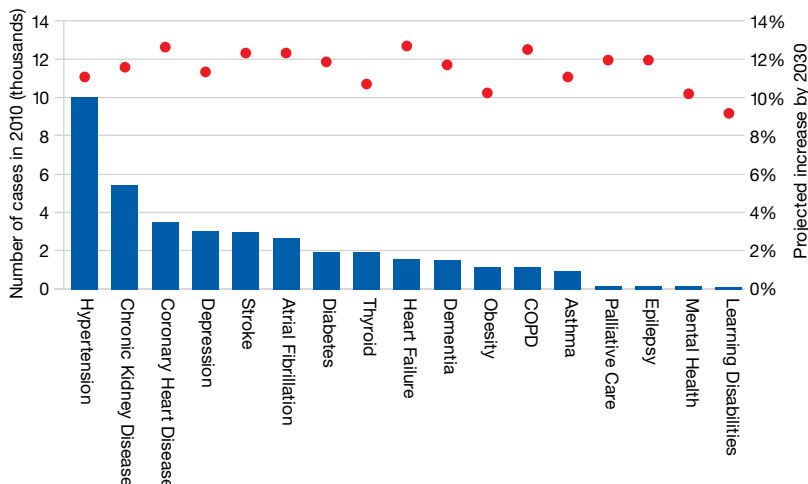
Source: Based on models in NHS Comparators

■ Crude prevalence
● Recorded/Expected

Figure 16 - Number of cases in 2010 and projected increase in cases by 2030 (85+)

Source: Based on models in NHS Comparators

■ Number of cases registered in 2010
● Projected increase by 2030 based on population demographic change



the number of cases diagnosed. Depression and thyroid disease are the most obvious examples of this.

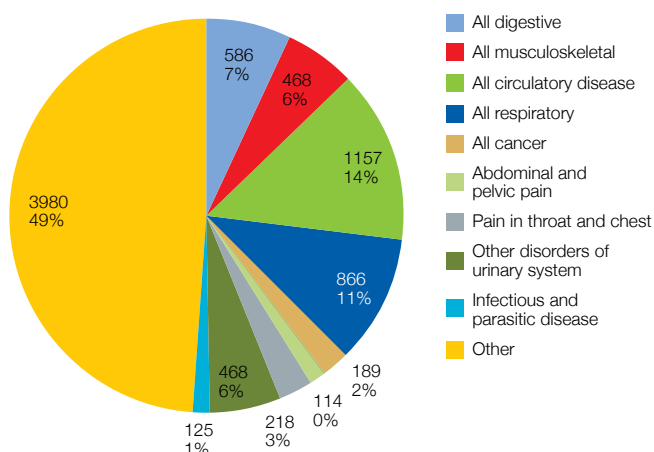
Figure 16 shows the number of cases of certain conditions in 2010 and their projected increase as a percentage by 2030.

Amongst those in the very elderly group (aged 85 years and over) circulatory disease and cancer account for a significant proportion of the burden of disease. Projected estimates suggest that the number of those over 85 years with limiting long term illness will increase by almost 15% by 2015. A similar figure is expected for those aged over 85 years living in a care home (with or without nursing care). There are increases predicted for diabetes, obesity, heart attacks, stroke and COPD as well as conditions such as falls, dementia, depression, visual and auditory impairments. The projections, based solely on demographic change, suggest the numbers for most conditions will double by 2030. However, these increases do not make any assumptions about the effects of changes in factors affecting health and wellbeing, such as weight and physical activity or changes in the completeness of case finding or new treatments.

During 2010/11 there were 14,333 admissions to hospital amongst those aged 85 years and over – a substantial proportion, when considered alongside the total number of admissions of 17,076. More than a half of these (8,172) in the over 85s were emergency admissions.

The growing population of those aged 85 years and

Figure 17 - Number of emergency admissions by cause, for those aged 85 and over, 2010/11 (8,172 admissions)



Source: NHS Secondary Uses Service

over is likely to place very heavy demands on all types of hospital activity in the future. Projections show that there will probably be considerable increases in most conditions which would increase in an ageing population. Admissions (both non-emergency and emergency) for respiratory, 'other disorders of urinary system' and infectious diseases are set to rise at a slightly higher rate than other cases, whilst musculoskeletal and circulatory diseases show marked rises in respect of emergency admissions (see Figure 17).

There are also a number of proactive initiatives aimed at older people to support the maintenance of good health including screening and health checks, promoting 'active living' and falls prevention – these initiatives will assume increasing importance as the population ages.

Health and Wellbeing in the Older Population

Key points

- there are 17,076 people aged 85 and over in Somerset
 - of these, 67% are female
 - two-thirds live in a home they own
 - one-third live on low incomes and claim pension tax credits
 - 3,126 live in a care home/residential care
- in 2010/11 those aged 85 and over accounted for 14,333 admissions to hospital, of which 8,172 were emergencies
- the 90+ population will increase from 5,100 (2008) to 18,700 (2033).

Recommendations

- improve information about services, volunteering, job opportunities and ways to improve health
- further commissioning of joint health and social care approaches such as the "reablement pilot"
- maintain the Active Living Network
- continue work to reduce falls and improve bone health
- improve detection and management of dementia
- greater use of 'telecare' technology to support older people in their own homes
- increase choice at the end of life for all adults, irrespective of the condition they are suffering from, to live and die in a place of their choice.

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