Public health responses to an ageing society
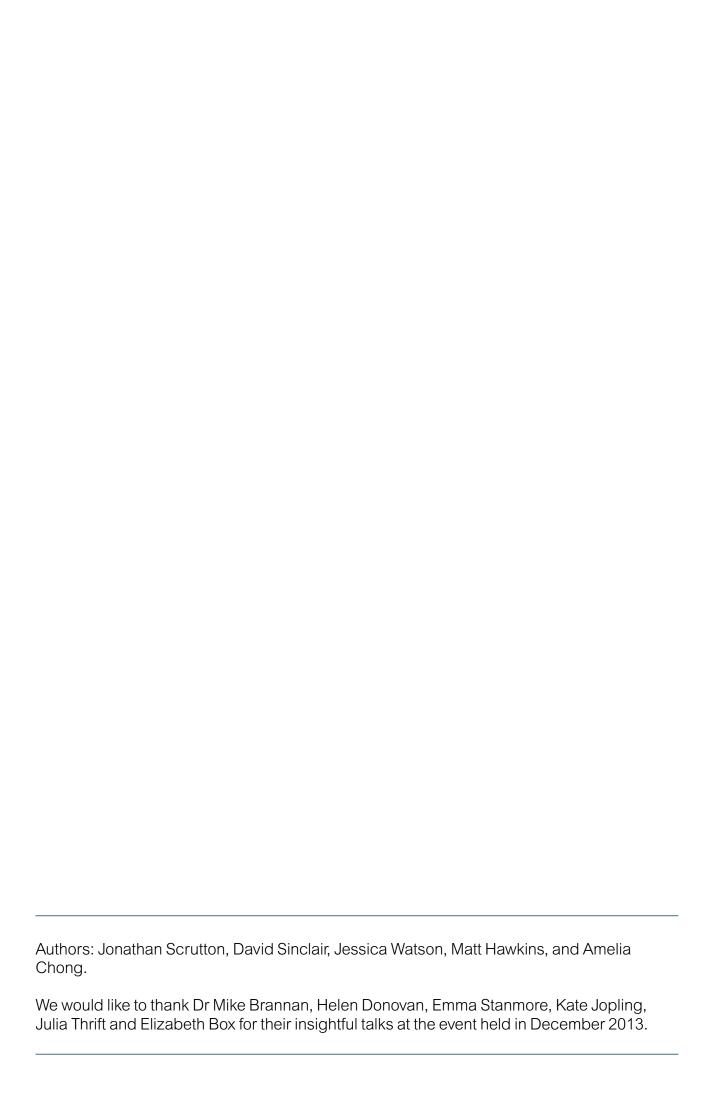
opportunities and challenges

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Public health responses to an ageing society

This think-piece explores the extent to which England's public health structures are able to respond to our ageing population after the radical reforms introduced by the Health and Social Care Act. In December last year, ILC-UK hosted an event which explored this topic. We brought together representatives of local government with a series of experts who highlighted how the changes may affect key areas of public health. This paper builds on these themes by outlining the opportunities and challenges offered by the public health structures to our ageing society, highlighting examples of both good practice and potential pitfalls.

Summary

The localism enshrined into the Health and Social Care Act creates an opportunity to tackle the challenges presented by our rapidly ageing population at a grassroots level. Some localities are embracing this opportunity by taking a life course approach to health, commissioning services that both encourage healthy ageing and improve the health of the current old.

But local authorities have gained these additional powers at a time when they are struggling under the weight of funding cuts; face significant public service responsibilities; and when they need to step up to the challenge of responding to an ageing population.

Localism has the benefits that local health priorities can be addressed by targeted initiatives, and innovative strategies can be developed that encourage more integrated working between departments.

But it also has the potential to worsen the effects of the 'postcode lottery', where the quality and availability of NHS services older people can expect are defined by where they live. And the introduction of a system that pays on results has resulted in councils focussing on short-term solutions rather than long term health initiatives.

Local authorities may also not have the expertise to deliver effective policies in an area as complex and fast-changing as public health, while transferring public health responsibilities to a democratically elected body will further politicise the sector.

While the Health and Social Care Act aimed to create a holistic approach to care, it will take some time for policy-makers to build up a rich bank of evidence on how to deliver a public health programme that interacts with transport, environmental policy and so on.

If public health structures are to overcome these challenges to addressing the issues surrounding our ageing society it is vital that they first make the most of the opportunities the Act has created.

Opportunities

- Local Authorities know their residents best.

- Local Authorities are strategically placed to deal with today's public health concerns.

- The move could encourage innovation.

- The public want these changes.

Challenges

- Privatisation may lead to a focus on short-term solutions.

- Localisation may worsen the effects of the 'postcode lottery'.

- The changes may politicise public health.

- Localisation may shrink the size, budget and capabilities of the NHS.

- The squeezing of local budgets may mean public health is not prioritised.

- Local Authorities may lack the expertise to deliver public health.

Recommendations

- Local health strategies should prioritise long-term health initiatives over short-term target hitting. For example, Ageing Well strategies could usefully focus on increasing physical activity earlier in life to ensure people have an active, healthy old age.

- Health and Wellbeing Boards should make use of local authority's links into communities to maximise the potential of public health impact and to ensure that the voices of older residents are heard, and incorporated into health strategies.

- Local authorities should commission services which address the underlying causes of non-communicable diseases, such as poor diet and insufficient physical activity.

- Local authorities and Clinical Commissioning Groups should recognise the importance of environmental factors in tackling non-communicable diseases

- The NHS Commissioning Board should monitor healthcare commissioning to support consistency of quality across the country and help reduce differences in healthy life expectancies.

- Government should ensure that local authorities' public health budgets continue to meet the needs of local citizens after the 2 year ring fenced period.

- Recognising the long term return on investment in public health, five year budgets should be developed. Evaluations of impact should be considered over a similar length period rather than over the short term.

- Government needs to adopt a life course approach to public health as good health in old age requires early intervention – from pre-conception through to preparing for older age.

- Government should ensure that data protection and organisational security do not discourage information sharing between departments and stunt integrated working.

- Joint Health and Wellbeing Strategies should incorporate plans for action on: Smoking cessation, physical activity, nutrition, road safety, housing, loneliness, falls and immunisation.

Introduction

Public Health and The Health and Social Care Act (2012)

Responsibility for delivering public health policies moved from the National Health Service to local authorities.

Each local authority now has a **Director of Public Health**, as well as a Health and Wellbeing Board.

Each **Health and Wellbeing Board** aims to improve the health and wellbeing of their locality by undertaking a **Joint Strategic Needs Assessment (JSNA).** They use this to develop a **Joint Health and Wellbeing Strategy (JHWS)** prioritising the key health needs of the area.

Clinical Commissioning Groups (CCGs) commission health services in line with the priorities set out in their corresponding Board's Health and Wellbeing Strategy.

The Health and Social Care Act, introduced in March 2012, has been described as the greatest reorganisation of the National Health Service in England to date[1]. The overarching changes introduced in the field of public health has moved responsibility for delivering public health policies from the National Health Service to local authorities. Each local authority now has a Director of Public Health, as well as a Health and Wellbeing Board. Each Board is made up of a local elected council member, the directors of public health, adult social services, and children's services and representatives of the local Healthwatch organisation and clinical commissioning group/s. The aim of the Board is to improve the health and wellbeing of their locality by undertaking a Joint Strategic Needs Assessment (JSNA) analysing the health of the local population, and using this assessment to develop a Joint Health and Wellbeing Strategy (JHWS) prioritising the key health needs of the area. Newly formed Clinical Commissioning Groups (CCGs), made-up of GPs from local General Practices, are in charge of commissioning health services and have an obligation to commission in line with the priorities set out in their corresponding Board's Health and Wellbeing Strategy.

These changes have come about at a time when the UK is facing the huge challenge of a rapidly ageing population. Longer life expectancies now mean that by 2020, people aged 50 and over will comprise almost a third (32%) of the working age population and almost half (48%) of the adult population[2]. This rise in life expectancy has not been uniform across the country, and stark differences in both life expectancy and healthy life expectancy exist across geographic areas[3]. Simultaneously, there are fewer people to support every retired individual as a result of longer lives and a low birth rate.

These changes pose huge challenges to the health and social care system. With more people living longer the conditions associated with old age, along with their associated costs, are set to increase dramatically. For example, there are currently over 800,000 people estimated to have dementia in the UK[4], with a financial cost of £26 billion per annum[5]. The number of cases is projected to exceed 1.7 million by 2051[6].

Preventative strategies will need to be developed which ensure older people are healthy and independent for as long as possible. This will involve taking a life course approach to public health, as good health in old age requires early intervention – from improving nutrition during childhood to ensuring that people are suitably vaccinated.

However, the sheer scale of the financial and logistical challenges these demographic changes pose to the health service, combined with the infancy of the new public health structures, has left uncertainty over their ability to cope.

Opportunities and challenges

The new system created by the Health and Social Care Act creates opportunities to tackle the issues presented by our rapidly ageing population at a grassroots level. However, if the public health structures are going to make the most of these opportunities, there are a number of challenges which they must first overcome.

Opportunities

1. Local Authorities know their residents best

Endowing local authorities with power over public health means that decisions over resident health are being made closest to the people they affect. It creates an opportunity to fully consult local people during every stage of the process. The JSNAs, by charting the health needs of each locality, should result in each Health and Wellbeing Strategy prioritising the health issues most effecting each area, ensuring that money and services are streamlined to where they are needed most. This creates an opportunity to both tackle the dominant health issues effecting the current old, while simultaneously addressing the health issues which will affect the health of the future old, such as obesity.

Local authorities should already have the experience necessary to make this process effective, having built practical, supportive relationships with their local community and having undertaken a range of community engagement programmes.

> The **Partnership with Older People Projects** (POPPs)[7] conducted between 2006 and 2009 in 29 local authorities across England, engaged older people in the development and piloting of new, 'low level' local services aimed at promoting older people's independence and quality of life[8].

Health and Wellbeing Boards are in a good position to use this experience and links with the local community to ensure that the voices of older residents are heard, and the issues effecting them are addressed in local health strategies.

2. Local Authorities are strategically placed to deal with today's public health concerns

The rise in life expectancy over the last century has led to a huge increase in the diseases associated with later life - non-communicable, often chronic disease such as cancer, diabetes, and dementias. For example, there are currently 766,000 people with dementia in the UK and that number is set to grow to 1.32 million by 2040[9].

The risk factors for these diseases are predominately linked to people's lifestyles earlier in life, with major factors being smoking, poor diet, insufficient physical activity and alcohol use. Local authorities are well-placed to respond to these health challenges as they already have responsibility for the wider services which influence public health – including quality of public transport, availability of green and open spaces, education and employment[10].

Take weight as an example. The number of people who are overweight is expected to rise by 10% in the next decade which, if left unaddressed, will lead to an increase in the cases of dementia, diabetes and heart disease. Local authorities are able to provide an environment where they can address this issue holistically by commissioning services that tackle the underlying causes of obesity; for example by providing green spaces to encourage people to exercise. Health and Wellbeing Boards, with their broad membership of councillors, health professionals and lay members, can enhance this process by collating resources and ideas from different departments, encouraging integrated working and avoiding doubling-up efforts on particular health issues.

3. The move could encourage innovation

As the European Commission report on Public Sector administration notes: local governments are generally seen as being the fount of innovation in governance. This is largely because local governments deal with smaller populations and because they operate closer to the population they govern and further away from the centre where a more generalist approach is needed[11].

The Health and Social Care Act, by devolving power to local authorities, increases the likelihood of innovation to improve local health outcomes. Successes in this area have already been seen. Dudley Council, working in partnership with NHS Dudley, have developed an innovative, integrated approach to the diagnosis, care and support offered to people with dementia, their carers and families; achieved through the development of three dementia gateways located across the borough[12].

4. The public want these changes

Research by Populus found that 58% of the public believe public health should be the responsibility of local authorities and 76% of local authority workers welcome these changes[13]. This might not seem like an overwhelming argument in favour of reform but it is important that the public appear to have given these changes their backing.

The success of a public health message very often lies in its ability to persuade and inform and that in turn depends on the trust and respect that the public give to the orator of the message. If local authorities – which do benefit from being democratically elected and close to their local communities – are deemed by the public to speak with authority on public health issues their message might have more penetrable value. This could be of significant value when initiating public health campaigns which can facilitate healthy ageing.

Challenges

5. Privatisation may lead to a focus on short-term solutions

Critics of the Health and Social Care Act have voiced concerns that the reforms have continued the gradual privatisation of a once entirely public and national health service[14]. The introduction of commissioning through competitive tendering and the opening up of NHS contracts to the voluntary sector are seen as gradually moving the provision of services away from the NHS and over to private providers. This will see patients gradually have to pay for more of the services that were once provided for free.

The apparent privatisation introduced by the Act may actually impinge on the ability of local authorities to offer a preventative approach to healthcare – even though this is one of the theoretical benefits of devolving public health to the local level. Preventative policies by their very nature bring financial rewards and health improvements in the long-term, but the injection of further competition into the NHS could encourage a culture of short-termism and of target-hitting. For example the Government have already agreed to reward, through an incentive payment, local authorities that succeed in improving on elements of the Public Health Outcomes Framework[15].

6. Localisation may worsen the effects of the 'postcode lottery'

The changes brought in by the Health and Social Care Act could also worsen the effects of the 'postcode lottery', where the quality and availability of NHS services a person can expect are defined by where they live. While this process was started in the 1990s, largely as a result of GPs receiving a fixed budget from which to pay for primary care, drugs, and non-urgent hospital treatments, the Act has increased the level of rationing within the NHS, and in turn the 'lottery's' potential effects. Researchers from the Medical Technology Group, investigating knee and hip replacement waiting times – a major issue effecting many older people - found that patients are waiting up to a month longer for operations depending on the area they live in[16].

7. The changes may politicise public health

The differences in health and social care that older people receive based upon their geographic location could be further exacerbated by the politicisation of public health inherent in transferring public health responsibilities to a democratically elected body. What will older people's services under a Conservative local authority look like compared to, for example, a Labour one? Will healthcare priorities come to be shaped by the political colour of local administrations – to the benefit of some and the detriment of others? Drugs policy, for instance, is an area on which there can be widely differing approaches dependent on one's political background and it might take more than examples of specific policy successes or failures in this area to change the philosophical basis of an authority's approach to this type of issue. Another possible challenge arises when one considers that elected officials, being elected for a fixed term, may have a tendency to favour short-term solutions when in fact many of our public health problems require longer term investment. Faced with an upcoming election, politicians may invest in 'quick wins' to aid their re-election, rather than prioritising those problems, such as improving nutrition across the lifecourse, that bring about benefits in the long term.

8. Localisation may shrink the size, budget and capabilities of the NHS

The transfer of public health responsibility from the NHS to local authorities has raised fears that the Conservative Party's commitment to ring-fence NHS spending is being broken. Although local authority's public health budgets have been guaranteed for the next 2 years, beyond that there is no stipulation that government funds will continue to match their needs. Neither has a guarantee been made that the services transferred to local authorities will be offered as free services as has always been the case in the past.

There are also fears that taking health responsibilities away from a body specifically concerned with health – the NHS – and giving those responsibilities to an authority with competing concerns – local councils – will ultimately see health as a policy issue becoming side-tracked and funds earmarked for health policies being diverted into other projects. This risks a potential breakdown of health and social care in many areas as England's rapidly ageing population puts an increasing strain on an underfunded system.

Additionally, while funding has been guaranteed for the next two years many commentators have concerns over how that funding is being calculated. Initial funding levels have been based on historic spending, meaning that areas like Waltham Forest in London, which was characterised by a very low-level of spending by the Primary Care Trust, will have to wait a long time before it can compete with neighbouring health services. On the other hand, local councils such as Hackney, which benefitted from having a high-spending PCT, will now feel the pressure to use their funding efficiently and quickly expand the services they offer or risk a drop in funding in two years-time[17].

This approach to funding risks exacerbating the health inequalities already found between different geographical areas. Local Authorities receiving low levels of funding may find it hard to implement the holistic strategies that the Health and Social Care Act's restructuring aimed to generate, and which could help increase healthy ageing in our communities. It also encourages short-termism to the cost of preventative strategies.

9. The squeezing of local budgets may mean public health is not prioritised

All of these new responsibilities and expectations could not have come at a more pressured time for local authorities. Councils are facing a 28% reduction in resources over the current spending period. Changes to the manner in which health spending is allocated will see the most deprived 20% of councils receive £8 less per head of population[18]. These cuts have already severely affected services catering to older people, with spending on social care for older people falling by 15 per cent in real terms from £10.6 billion to £9.8 billion between

2009/10 and 2012/13 and home and day care spending by councils falling by 23 per cent (or £538 million) over the same period[19]. The increased rationing of health and social care in response to these cuts means that it is highly likely that older people's health and wellbeing is being affected negatively, but there is not adequate data to properly assess the impact, leaving the NHS and Government blind to the consequences[20].

10. Local Authorities may lack the expertise to deliver public health

One of the most commonly cited fears regarding the shake-up of public health in England has been that local authorities do not have the expertise to deliver effective policies in an area as complex and fast-changing as public health. The appointment of one Director of Public Health may simply fail to offer the breadth and depth of skills and knowledge needed to understand and deliver a public health programme.

Health and Wellbeing Boards include a Director of Child Services and a Director of Adult Social Services – but these posts are not necessarily filled by health professionals. The prime representative/s of health professionals on the HWBs are the seat/s filled by the CCG member/s. However, their influence is limited as they are one of several board members, there is no requirement on HWBs to follow the advice of the CCG member/s and they are not necessarily able to offer expert advice on the delivery of a public health programme as that is not their area of specialism. Health and Wellbeing Boards do have the option of bringing on non-statuary Board members who have expertise in specific areas, which creates the opportunity for creating an older people's champion to ensure that older people's health and social care issues are adequately addressed. However, research by the King's Fund found that many of the Boards they analysed had not brought on any non-statuary members[21].

Implications for our ageing society

The new system created by the Health and Social Care Act creates an opportunity to tackle the challenges presented by our rapidly ageing population at a grassroots level. The key health issues of each locality can be addressed by targeted initiatives, and innovative strategies can be developed that encourage more integrated working between departments.

There is already evidence that some localities are embracing this opportunity by taking a life course approach to health – for example, Newcastle West Clinical Commissioning Group has developed an Ageing Well Strategy in conjunction with Newcastle Council that focusses on the 'mature life cycle' ('preparing for active old age', 'active old age', 'vulnerable old age' and 'dependent old age'). The strategy includes initiatives such as health checks aimed at identifying risk factors including obesity, physical inactivity and poor diet in those aged 40–74[22]. This approach is particularly encouraging as life-course strategies for public health have traditionally focussed on children and working-age adults rather than older people[23].

The Government has also developed structures aiming to help local authorities make the most of the changes by supporting them to improve their services for older people. The Department for Work and Pensions launched the Ageing Well programme in July 2010 with the aim of providing a better quality of life for older people through local services that are designed to meet their needs. It is hoped that the Programme will help local authorities to use their resources effectively to promote well-being in later life, ensuring that older people can live independently for longer, are engaged in civic life, and their potential is recognised so as to help tackle social isolation[24].

However, local authorities are finding that there are barriers which prevent them from making the most of the opportunities. For example, a major benefit of the new system is the way it encourages more integrated working between departments. Information sharing is key to this, with services such as extra care for older people theoretically being able to benefit from combining health and local authority data. However, Councils are finding that they are unable to exchange data for these important issues due to data protection or organisation 'security'. This even applies to non-patient specific information between the NHS and local authorities[25].

The introduction of a system that pays on result has also led many local authorities to a focus on short-term solutions rather than long term health initiatives. Local health strategies need to ensure that their strategies include long term targets, as preventative policies are absolutely critical in addressing the ongoing health and financial challenges of our ageing population – for example the average NHS spending on retired households is already nearly double that for non-retired households[26], and this is only set to rise if local authorities do not address the factors effecting people's unhealthy lifestyle choices earlier in life, for example around nutrition and exercise.

Devolving responsibility to the local level has also increased the risk of stark differences between the healthcare available in different regions, and the resulting impact on life expectancy and healthy life expectancy, as the funds made available for care now vary and the priorities differ depending on the interests of the local community, the philosophy of the council, and the knowledge of the Director of Public Health. It is therefore vital that the NHS Commissioning Board take an active role in ensuring that services are commissioned in ways that support consistency of quality across the country, monitoring whether commissioners across the NHS implement agreed national standards, and addressing inequalities in access to healthcare provision[27].

While the new system creates opportunities for engaging with older people as local authorities decide on how to design and deliver their health and social care services, there is a very real risk that the voices of certain groups of older people are not being heard. For example, affluent retirees in good health may be well-placed to contribute to the engagement process

while others, for example, those who do not speak English as their first language, may get overlooked[28]. This could be exacerbated by the system now paying on results, as providers may target 'quick wins', those people already engaged with health providers, rather than those who are harder to reach, such as older people from some minority ethnic groups[29].

While the closeness of local authorities to their communities has clear benefits for getting health messages across; at a time of financial constraints and short-term target hitting, public health campaigns may lose funding since it will be hard to make steadfast financial justifications for investing in them. This is worrying, as research has shown that these campaigns are instrumental in tackling major age related health issues, for example reducing the burden of infectious disease in old age by initiating public health literacy campaigns that take a life-course approach to vaccination[30].

As the 2010 Marmot Review highlighted, understanding the important interaction between public health and social and physical environments is only a very recent development. While it is imperative that the health and social care system takes a holistic approach to care, it will take some time for policy-makers to build up a rich bank of evidence and good-practice examples on how to deliver a public health programme addressing the needs of our ageing society that interacts with public transport, environmental policy and so on. It might not be best to trial the new approach to public health on councils already suffering under the weight of funding cuts, and huge public service duties, and at a time when our ageing society its presenting huge financial and logistical challenges.

Case study: **Smoking cessation**

> **Good practice**: Haringey Council found that people living in the east of the borough were more likely to smoke than those in the west. The same was true for certain ethnic groups, lone parents and people with mental health problems. By harnessing this local knowledge, the council plans to strengthen the 'stop smoking' service to target groups at risk'[31].

According to the World Health Organisation (WHO), tobacco is 'one of the biggest public health threats the world has ever faced'[32]. It will kill up to half of its users and in the United Kingdom (UK), smoking (including second-hand smoke) is the single biggest risk factor for disease[33]. Recently, the focus has been on introducing plain packaging to discourage youth smokers, but we must not forget the 13 million people[34] who have already succumbed to the habit.

The short- and long-term benefits of quitting are well documented. For example, within the first year carbon monoxide levels in the blood return to normal, circulation improves and shortness of breath decreases. After ten years, the risk of lung cancer is halved. Most importantly, age is no barrier: even at 60 years old one can expect to gain three years of life expectancy[35].

One advantage of NHS reform is that local authorities can target stop smoking services- such as physician advice, quit lines (telephone counselling) and nicotine replacement therapy (NRT) – to where they are most needed. For example, following their Joint Strategic Needs Assessment (JSNA), Haringey Council found that people living in the east of the borough were more likely to smoke than those in the west. The same is true for certain ethnic groups, lone parents and people with mental health problems. By harnessing this local knowledge, the council plans to 'strengthen the stop smoking service to target groups at risk'[36].

Another advantage is increased opportunity for partnership working. Again using Haringey Council as an example, in 2011 they formed a multi-agency Tobacco Control Alliance (TCA) with Enfield. One objective in their latest strategy is to collaborate with voluntary sector organisations such as Age UK and in doing so, promote the stop smoking service to the over 50s[37]. It is now up to the Health and Wellbeing Board- whose members come from a variety of backgrounds- to continue this good work.

Finally, the Local Government Declaration on Tobacco Control deserves a special mention. Created by Newcastle City Council in 2013, it commits local authorities to reducing the number of smokers in their community and now has 31 signatories[38]. Such enthusiasm suggests that tobacco control- including smoking cessation- is a priority that is here to stay.

Case study: **Physical activity**

Good practice: Haringey Council: they plan to expand exercise prescriptions but also want to develop walking routes in Tottenham and invest in Smarter Travel options and the Biking Borough programme[39]

The Department of Health recommends that those aged 65 or over should complete 150 minutes of moderate intensity exercise or 75 minutes of vigorous intensity exercise per week. They should also undertake activities designed to improve muscle strength on at least two days[40].

However, the British Heart Foundation says that, according to self-reported activity levels, only 16 percent of men and 12 percent of women aged over 65 meet these targets. The story presented when activity levels are objectively measured is even worse, with the figures being just 5 percent and 0 percent respectively[41]. This leaves older adults at an increased risk of coronary heart disease, stroke, diabetes, breast and colon cancer, depression and falls[42].

EXTEND, supported by Coventry City Council incorporates low impact recreational movement to music[43]

While physical activity programmes provide one solution, the built environment is becoming increasingly important. For example, Nagel *et al.*[44] found that older people walked for a greater amount of time each week when traffic volume was low and there were retail outlets and green space nearby. Another, recently launched project, aims to explore the impact of the built environment on objectively measured health outcomes (including cardiovascular events, respiratory problems and depression) across the life course[45].

It follows that in 2008, the National Institute for Health and Care Excellence (NICE) published guidance relating to physical activity and the environment. Their recommendations included reallocating road space, charging road users, introducing traffic calming schemes and maintaining public spaces to a high standard. They also emphasised the need to 'involve all local communities and experts at all stages of development to ensure that the potential for physical activity is maximised'[46]: this is where the new NHS structure comes into its own.

By bringing together a wide range of actors- especially those from the transport and environmental sectors- Health and Wellbeing Boards (HWBs) can tackle physical inactivity in a far more holistic way than under the old system. Take Haringey Council: they plan to expand exercise prescriptions but also want to develop walking routes in Tottenham and invest in Smarter Travel options and the Biking Borough programme[47]. In fact, the London Mayor's Office recently selected Haringey for an e-bike trial, which will commence in 2014[48].

So while the relationship between the built environment and health is not fully understood, local authorities are well-placed to take advantage of it. This could benefit not only physical activity, but also social links and mental health[49].

Case study: **Nutrition**

Good practice: Hampshire County Council's nutrition strategy provides one example of good practice, and takes its overarching principle from the International Longevity Centre UK (ILC-UK): 'Good nutrition is not just about food and meals, but about people, warmth and social inclusion[50].' To this end, they have identified eight priorities to provide sustainable, county wide assistance for older people. These include the creation of a community meals service, work with transport schemes and development of voluntary sector partnerships, to find imaginative opportunities for social eating[51].

The term malnutrition refers to both under and over nutrition, yet it is the latter that gets far more attention. In fact, under nutrition has been referred to as a 'Cinderella' subject, which has not been adopted by public health'[52].

It is an important issue though: one million people aged over 65 in the United Kingdom are malnourished and 93 percent of them live in the community (as opposed to residential care or hospital)[53]. Symptoms include tiredness, increased susceptibility to infections, difficulty keeping warm and depression[54].

So far, few Joint Strategic Needs Assessments (JSNAs) mention malnutrition. But when you consider its causes - such as dementia, social isolation and reduced mobility[55] - there is a clear opportunity for local authorities to identify those at risk and improve access to food.

For one, Health and Wellbeing Boards (HWBs) must include representatives from the local clinical commissioning group (CCG) and adult social services[56]. This will allow greater promotion of malnutrition to GPs and social workers, putting the issue at the forefront of their minds and ensuring that they recognise undernourished adults in the community. The British Association for Parenteral and Enteral Nutrition (BAPEN) have developed a screening tool for this purpose[57].

An alternative approach is to address the underlying causes of malnutrition by, for example, establishing a community food project. These can include lunch clubs, shopping activities, transport provision, social activities and/or cooking classes. According to Age UK, older people become less isolated and regain control of their diet. However, they may also experience difficultly attending[58]. This is where HWBs can help, by working closely with the transport sector.

Hampshire County Council's nutrition strategy provides one example of good practice, and takes its overarching principle from the International Longevity Centre UK (ILC-UK): 'Good nutrition is not just about food and meals, but about people, warmth and social inclusion[59].' To this end, they have identified eight priorities to provide sustainable, county wide assistance for older people. These include the creation of a community meals service, work with transport schemes and development of voluntary sector partnerships, to find imaginative opportunities for social eating[60].

In addition, Age UK has recently launched a project- with government backing- to raise awareness of malnutrition among professionals and the elderly alike[61]. With recognition of the issue growing, it is now up to local authorities take action.

Case study: **Road safety**

Good practice: In Leicestershire, a commissioning panel set up by the local authority to investigate sport and physical activity brought together members of the Public Health and the Travel Choice and Access teams. The commission established dialogue between the two departments on a common issue, and has resulted in both departments working more closely together, and putting funding towards each other's projects – for example, the highways department funded cycling equipment and training to support obesity prevention programmes[62].

Older people are a group particularly vulnerable to the effects of poor road safety. In the UK, older people represent 22.8% of the population and 19% of all trips and miles walked, yet account for 43.6% of all pedestrians killed[63]. Effectively addressing road safety involves tackling a wide range of areas including quality and upkeep of road infrastructure, speed limits and road user training. Motor traffic volume is also a key issue, with an increase of 1000 vehicles a day on a road being associated with a 6% increase in pedestrian injuries, a 5% increase in cyclist injuries, and a 7% increase in vehicle occupant injuries[64].

A safer road environment not only results in accident reduction, but can also benefit other areas of health – for example, people are encouraged to be more physically active by undertaking 'active travel' rather than driving to their destination. In contrast, poor road safety not only impacts on the levels of physical exercise people undertake, it can also lead to less social contact – studies have found that people who live on streets with high volumes of motorised traffic go out less and so have fewer friends and acquaintances[65]. A lack of social contact can have devastating effects on health, with people who have no social contact being between two and four times more likely to die prematurely than those who have the most social contact[66]. This is a serious issue effecting older people as they are already at a greater risk of social isolation with 12% of over 65s reporting that they feel isolated[67].

Health and Wellbeing Boards are particularly well placed to tackle the health ramifications of poor road safety as they can create integrated working between health and transport services. For example, they can identify joint health and transport funding of road safety schemes that have predictable benefits for other areas of health, or identify how the priorities from the JSNA could be met through joint working[68].

Despite the opportunities for integrated working between transport and health services created by the JSNAs, a review conducted by RoSPA found that exactly half of the JSNAs they surveyed did not have a road safety section[69]. Road safety activities were also seen solely as a way to prevent injury, even though the JSNA gives considerable scope to exploring the links between road safety and wider health[70].

An example of good practice can be found in Leicestershire, where a commissioning panel set up by the local authority to investigate sport and physical activity brought together members of the Public Health and the Travel Choice and Access teams. The commission established dialogue between the two departments on a common issue, and has resulted in both departments working more closely together, and putting funding towards each other's projects – for example, the highways department funded cycling equipment and training to support obesity prevention programmes[71].

Case study: **Housing**

Good practice: Bristol's comprehensive JSNA resulted in the link between housing and health within the older population being identified and addressed[72]. Key to this was work carried out by Bristol's Private Rented Sector team. The team cross referenced data on housing hazards in Bristol with local authority statistics and PCT health profiles. Key health problems of relevance to housing were identified which were then fed into and addressed in the JSNA, including low cost or free loft and cavity wall insulation for vulnerable persons in all parts of the city and subsidised loans for homeowners to enable them to improve their properties to meet the Decent Homes Standard.

Older people are at an increased risk of the health ramifications of poor housing- research has shown that 51% of the care home population have moved there after hospitalisation because a return to home is not practical, and 15% are admitted because of serious housing problems[73]. Older people are also twice as likely to be unable to afford fuel in winter, while at the same time being more vulnerable to cold weather[74]. The economic advantages of older people staying in their own homes longer are significant, with adaptations to support an older person to remain at home for just one year potentially saving £28,000 on long-term care costs[75].

Housing, while intimately linked with health, has been neglected in many Health and Wellbeing Strategies, which have instead focussed on NHS services, despite their capacity to address the broader determinants of health. For this to change, Health and Wellbeing Boards should ensure that their JSNAs bring together all relevant information about population needs, including housing, in order to provide a framework for integrating social care, public health and the NHS in response to those needs[76]. Encouragingly, a survey of local authority areas carried out by the Kings Fund identifies a clear desire from many Boards to improve their JSNAs in this way[77].

Bristol provide one example of good practice where their comprehensive JSNA resulted in the link between housing and health within the older population being identified and addressed[78]. Key to this was work carried out by Bristol's Private Rented Sector team. The team cross referenced data on housing hazards in Bristol with local authority statistics and PCT health profiles. Key health problems of relevance to housing were identified which were then fed into and addressed in the JSNA, including low cost or free loft and cavity wall insulation for vulnerable persons in all parts of the city and subsidised loans for homeowners to enable them to improve their properties to meet the Decent Homes Standard.

Health and Wellbeing Boards are well placed to identify and tackle the health ramifications of housing due to their statutory obligation to create more integrated working, in this case between housing, social care and health. They are also well positioned to measure the progress made from a housing perspective and to be able to identify appropriate action when initiatives are not working. For example, linking the data on hospital admissions and residential care to the impact of inappropriate or poor housing on the health of the older population and, in turn, the potential demand for well-designed older people housing and housing related services[79].

Case study: **Loneliness**

> **Good practice**: Hampshire Health and Wellbeing Board outlines in its JSNA how it plans to track and tackle loneliness, with a clear set of recommendations for action, including prioritising the resourcing and development of the existing community based network of activities and opportunities that help to prevent or alleviate loneliness in old age[80].

Loneliness is associated with poor mental, physical and emotional health, including increased rates of cardiovascular disease, hypertension, cognitive decline and dementia[81]. Positive and supportive relationships with close family members contribute significantly to older people's wellbeing, but they are the least likely group to have these networks, especially when over 75[82].

A report published by the Campaign to End Loneliness found that 49% of Health and Wellbeing Board Strategies did not include any reference to loneliness and/or isolation, and only 10 contained measurable actions or targets on loneliness[83]. The lack of engagement by local authorities with this important subject was further highlighted by Freedom of Information (FOI) requests by UNISON, which showed that lonely and vulnerable older people were receiving minimal person-to-person contact during care visits, with 73 per cent of LAs commissioning visits lasting just a quarter of an hour[84].

When Boards do engage with this topic their focus on needs-led, evidence-based interventions can have a positive impact. For example, Hampshire Health and Wellbeing Board outlines in its JSNA how it plans to track and tackle loneliness, with a clear set of recommendations for action, including prioritising the resourcing and development of the existing community based network of activities and opportunities that help to prevent or alleviate loneliness in old age[85].

Effective interventions to combat older people's isolation and exclusion often combine public services action with volunteering and greater involvement by families and communities[86]. Health and Wellbeing Boards are well placed to create this type of intervention due to their focus on creating more integration between different departments, and the engagement channels they have into the local community.

Case study: **Falls**

Good practice: In Milton Keynes, the Council and Clinical Commissioning Group joined with their Public Health colleagues to create a Falls Prevention Strategy. As well as proposing new initiatives, this strategy brings together all the work currently being conducted across both health and social care on falls. The planning and delivery of the strategy will be implemented by the 'Milton Keynes Falls Prevention Strategy and Implementation group', which is made up of representatives of the public, independent and voluntary organisations, GPs, specialist clinicians, social care providers and commissioners, and Public Health[87].

Falls and fractures in people aged 65 and over account for 4 million hospital bed days each year in England, cost the NHS around three quarter of a billion pounds, and are the leading cause of accident-related mortality in older people[88]. After a fall, an older person has a 50 per cent probability of having their mobility seriously impaired and a 10 per cent probability of dying within a year[89]. Falls not only result in physical injury, they can also lead to a loss of confidence, increased isolation and the reduction of independence, with around 1 in 10 older people who fall becoming afraid to leave their homes in case they fall again[90].

Evidence shows that specific programmes for improving strength and balance can reduce the risk of falls by as much as 55 per cent[91]. If all over-65s followed a tailored exercise programme, we would prevent 7,000 unnecessary deaths a year – 19 a day – from hip fractures alone[92].

The new health structure provides an opportunity for local government, the NHS and social care services to work more closely together to reduce the number of falls amongst older people. More integrated working between these organisations could lead to people at risk of falling being identified earlier, and the referral to falling prevention services increasing. Patient's NHS numbers could be used as a way for tracking and assessment, which if implemented could cut falls by 30%[93].

An example of good practice can be seen in Milton Keynes, where the Council and Clinical Commissioning Group joined with their Public Health colleagues to create a Falls Prevention Strategy. As well as proposing new initiatives, this strategy brings together all the work currently being conducted across both health and social care on falls. The planning and delivery of the strategy will be implemented by the 'Milton Keynes Falls Prevention Strategy and Implementation group', which is made up of representatives of the public, independent and voluntary organisations, GPs, specialist clinicians, social care providers and commissioners, and Public Health[94].

Older people's fear of falling is not only based on health problems but also on the poor design or maintenance of the outdoor environment. Cracked, uneven paving and slippery paving; obstructions; steps and slopes being common causes of falls[95]. Local authorities are well-placed to respond to these issues as they already have responsibility for the wider services in their area, including pavements and public transport.

Case study: **Immunisation**

Good practice: Brighton and Hove's JSNA highlighted that the uptake of the seasonal flu vaccine amongst people aged 65 and over was 69.8%, lower than both the national average and national target for this age group. The JSNA also highlighted that older people living in the most deprived area of the city were less likely to get vaccinated. Based upon these findings, four recommendations were made to help inform future local health priorities:

1. Primary care needs to increase uptake in people aged 65 years or over to ensure that the target of 75% coverage is met.

2. GP practices should ensure accurate uptake records are kept, at risk patients are identified and timely invitations are sent for vaccination appointments.

3. Primary care needs to ensure that immunisation appointments are accessible to all who require them and that patients are provided with up to date information on the need to be immunised.

4. Further work should be done on opportunistic vaccination and developing outreach services for hard to reach groups[96].

Vaccination has been a hugely successful in reducing the likelihood of early mortality, however around 600 people still die each year in the UK from a complication of seasonal flu[97]. This can rise to 13,000 during an epidemic[98]. Older adults are particularly susceptible as their immune systems have weakened with age.

Despite the NHS reforms aiming to move responsibility for public health to local bodies, England's vaccination programme continues to be administered nationally, with responsibility shared between the Department of Health, Public Health England and NHS England[99].

However, local authorities have been tasked with supporting, reviewing and challenging the delivery of immunisation programmes[100]. This includes being proactive in ensuring there is sufficient uptake and monitoring of immunisation across all the age groups[101]. For example, when addressing flu vaccinations, local authorities, through their Director of Public Health, have responsibility for:

- Providing appropriate challenge to local arrangements to ensure access to flu vaccination and to improve its uptake by eligible population.

- Scrutinising and challenging the arrangements of NHS England, PHE and local authority employers of frontline social care staff and other providers of health and social care.

- Providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of flu infection[102].

As a result, Joint Strategic Needs Assessments will play an important role in maintaining standards in vaccinations, as they are the main document which informs the decisions of Health and wellbeing Boards. JSNAs should cover communicable diseases in sufficient detail to notify Boards of any issues surrounding local vaccination and screening arrangements. Boards can then make informed decisions on how to improve access and uptake.

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4. Further work should be done on opportunistic vaccination and developing outreach services for hard to reach groups[103].

Another group which have a poor track record in the uptake of vaccinations are health and social care workers- in 2012, just 45.6% were vaccinated against flu[104], and the levels of vaccination varied significantly by NHS Trust. Without vaccinations, healthcare workers risk spreading infection to the people they are looking after. For older people this can be terminal. Research has shown that increasing vaccine uptake amongst healthcare workers would significantly reduce both mortality and morbidity amongst older adults[105].

Local authorities could play a key role in improving uptake amongst this group by initiating targeted advertising campaigns. Similar schemes have been run by Community Health NHS Trusts and have been shown to be extremely effective. For example, Liverpool's Community Health NHS Trust launched a campaign based upon a series of 'spoof' 1950's style images featuring real Trust employees. These were accompanied by comic captions about why they didn't want to have a flu jab. Developed with support from a creative agency, the 2012 campaign resulted in uptake amongst health staff rising from just 47.7% the previous winter to 71.6%[106].

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