



Improving the health and wellbeing of people in mid-life and beyond: making the case for local authorities

‘My local leisure centre now offers low-cost day courses for the over 50s, so I enjoy salsa and exercise classes for the first time ever’

Why promote the health and wellbeing of those in mid-life and older people?

The numbers game: the changing age balance of the population means that there are more people aged over 60 than there are children. In 2001, 21% of the population were aged over 60 and 40% were over 50. Service providers should view older people as citizens in their communities, using a range of services, rather than merely as consumers of health and social care. They are also a key group for building sustainable communities through local alliances.

The changing demographics will lead to a **skills shortage** in the workplace unless people are enabled and encouraged to continue working. For example, one in five nurses are aged over 50, and are eligible for early retirement at 55; in some regions one in four family doctors are due to retire in the next five to ten years (Meadows, 2002).

The **cost of personal social services** for adults is expected to rise from £10 billion to £11 billion as a result of the impact of demography and health status changes. The Wanless Report, *Securing our Future Health: Taking a Long-Term View* (Wanless, 2002), makes the case to the Treasury for investing in public health services in order to reduce health and social care costs in the future. It is vital to intervene to improve the health and wellbeing of those in mid-life and older people, to ensure a healthier and more independent old age.

Inequalities in health and wellbeing are widening, and the gap in life expectancy is large and continues to grow. The mortality rate for working-age men in the early 1970s was almost twice as high for unskilled compared with professional groups; by the 1990s it was almost three times higher. To reduce this gap, public services must pay attention to the wider determinants of inequality rooted in the economic, social and environmental wellbeing of local populations. To make an impact on people in later life, those in mid-life should be targeted (Department of Health, 2003).

Tackling Health Inequalities – A Programme for Action states that tackling health inequalities is a priority for local government (Department of Health, 2003: 39). The report also stresses the importance of working with people aged over 50 as a key group, in order to make speedy progress in raising life expectancy.

Valuing the contribution and experience of people as they grow older is important, and challenges the ageist assumption that promoting the health and wellbeing of older people wastes resources. **Health and wellbeing is a fundamental right** throughout life, and shows real benefits in terms of quality of life and independence.

How can local authorities promote the health and wellbeing of older citizens?

Power to improve economic, social and environmental wellbeing

Local authorities have a range of powers and incentives that may be used to forward this agenda with other partners.



'Local councils have been given powers to use their community leadership role to improve the economic, social and environmental wellbeing of their local populations, and promote community wellbeing'
(Local Government Act, 2000)

Comprehensive performance assessment (CPA). Introduced by the Office of the Deputy Prime Minister, CPA assesses the performance of local authorities in relation to their strategic role and their commissioning and service provision. The CPA process is being refreshed in 2005, and will strengthen the focus on local authorities' relationships with key organisations and their communities. One area under consideration is a broader approach to the wellbeing of older people.

Community strategy. The Local Government Act (2000) gives councils powers to improve the economic, social and environmental wellbeing of their local populations, and a duty to produce a community strategy that sets out how this will happen. The guidance provided to local authorities refers explicitly to health improvement.

Community strategies that promote economic, social and environmental wellbeing are encouraged through

Best Value: 'A community strategy developed in collaboration with the local strategic partnership for improving the economic, social and environmental wellbeing in a way that is sustainable' (Indicator 1, Corporate Health; odpm 2003). Best Value indicators are used not only in the Best Value process, but also in CPA and Beacon Council Assessments.

Health scrutiny legislation in the Health and Social Care Act (2001). This places a duty on the NHS to assist with the scrutiny function of local authorities, encouraging councils to build on their community leadership role in promoting health and wellbeing. The key role of members of overview and scrutiny committees is to consider whether the health needs of the local population are being met, and how far services are tackling health inequalities.

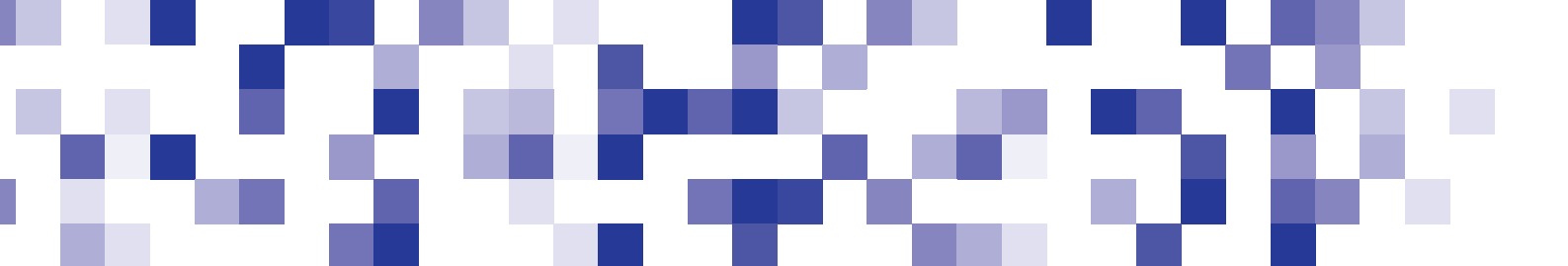
Shared priorities. Promoting healthier communities and narrowing health inequalities is one of seven shared priorities agreed between central and local government.

Democratic process. Local authorities are accountable through the democratic process, which enables them to respond more sensitively to the needs and wishes of their local community. Elected members are the representatives of their local areas, and with 42% of the current electorate over 50 years old, community strategies need to reflect the needs of the older people in the local population.

Community plans are produced through local strategic partnerships with a joint approach to strategic planning and delivery. Councils also involve the government offices for the regions in the development of their community strategies.

Councils provide local populations with a wide range of services that have a major impact on their quality of life. Some functions, such as environmental health, are directly health-related; others, such as housing, benefits work, leisure provision, community safety and the promotion of citizenship, make a significant contribution to health. **Older people are the major users of public services** and, as their numbers grow, services will need to be tailored to their needs.

The National Service Framework for Older People (Department of Health, 2001) recognises that promotion of health and active ageing requires the NHS to work with organisations whose services are connected to the wider determinants of health and quality of life: 'To improve the health and wellbeing of older people through a co-ordinated programme of action led by the NHS with support from councils' (standard 8). The standard is also a tool for local



authorities to use in promoting independence, equality and inclusion, and provides a useful framework for the development of quality-of-life strategies for older people.

Local public service agreements (PSAs)¹ and health inequalities. The government's programme for tackling health inequalities emphasises the need to work with people over 50. Tackling health inequalities is a priority for local government, and the national health inequalities target is included in the list of local PSAs' national targets. This means local authorities are able to set local PSA targets to deliver specific improvements in performance on tackling health inequalities.

The Supporting People Programme (www.spkweb.org.uk) has been implemented by all local authorities from April 2003, with older people forming the largest client group for services provided under this programme. This new way of funding housing-related support services illustrates how local authority services can work to improve the quality of life of older citizens.

Local authorities have to carry out **accessibility planning in transport** for access to jobs and services for disadvantaged groups. People over 50 are considered by the government to be a vulnerable group, and many are still working, or wish to work.

The Beacon Council Scheme Round 5 (2004) includes the theme 'Services for older people', and provides an opportunity for local authorities to demonstrate they are taking a strategic approach to developing services that reflect both national priorities and the priorities of older people locally. Innovation and performance in developing services that promote independence, choice and citizenship could be demonstrated (www.odpm.gov.uk).

Case study – Manchester

Manchester City Council's Community Strategy 2002–12 includes three indicators focusing on the theme of tracking health inequalities, and the council has developed a local PSA around life expectancy:

'By 2004, to reduce the gap in life expectancy between Manchester and the England average to 6.2 years for men and 4.3 for women, from an expected gap of 6.6 years and 4.6 years respectively'.

The council is also leading the development of a 'Valuing Older Adults' strategy, which cuts across all the themes of Manchester's Local Strategic Partnership. For more information, contact David Regan, Director, Joint Health Unit: d.regan@notes.manchester.gov.uk

What it feels like

'I've been on the walking project. Now I don't take a bus if I can walk. I feel more confident, it took me a long time to get confidence to walk because the accident, my accident, was a simple fall. It's to walk on your own without falling but I've now got that back so I now enjoy walking again... I've just basically changed the way I eat and I walk a lot more. When I had the accident I sort of stopped and now I have started again.'

Participant in Southwark Active, www.southwarkactive.co.uk

Southwark Active is a community-based project to improve the physical and mental health of people in the age range 50–65 living and working in north Southwark

¹ A local PSA is an agreement between an individual local authority and the government. It sets out the authority's commitment to deliver specific improvements in performance, and the government's commitment to reward these improvements. It also sets out what the government will do to help the authority achieve improved performance.



Example of cost benefits

In 2000–01 in England, expenditure on personal social services was £5.9 billion. A 1% reduction in the number of people in local authority-supported homes, achieved through improving health and wellbeing, would save each local authority approximately £1 million a week.

(Local Authority Personal Social Services Expenditure 2000–01; National Statistics, 2003)

Common barriers to involving local authorities – and some solutions

Barriers	Solutions
Lack of indicators and performance targets	<p>Check out the library of local performance indicators provided by the Audit Commission and the Improvement and Development Agency (IDeA) (www.local-pi-library.gov.uk); work is in progress to develop indicators on quality of life and transport for older people</p> <p>Adopt a local PSA target for increasing life expectancy by promoting health and wellbeing with the over-50s</p> <p><i>Tackling Health Inequalities – A Programme for Action</i> (Department of Health, 2003) details suggested actions for local authorities</p>
Confusion on who should lead in promoting health and active ageing in the National Service Framework for Older People (Department of Health, 2001) – seen as NHS responsibility, but local authorities know their services are key to this agenda	It is a shared agenda – work through local strategic partnerships to allow planning and shared budgets, adopting a whole-system approach
The duty on local authorities to provide social and community care services dominates the budget and makes it difficult to promote health and wellbeing	<p>Intervening in mid-life reduces the burden of caring that falls to local authorities</p> <p>Engage the support of the elected member who has taken on the role of ‘older people’s champion’</p>
Lack of funding	<p>Service modernisation is about doing things more efficiently – reconfigure within existing limits to improve delivery</p> <p>Use Beacon Status or the Supporting People Programme to showcase ideas and gain local support for funding; link to local PSA life expectancy targets</p>

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Improving the health and wellbeing of people in mid-life and beyond: making the case for the voluntary and community sector

'I have now started to exercise regularly, keeping me physically fit and helping me to be clearer about personal goals'

Why promote the health and wellbeing of those in mid-life and older people?

The numbers game: the changing age balance of the population means that there are more people aged over 60 than there are children. In 2001, 21% of the population were aged over 60 and 40% were over 50. Service providers should view older people as citizens in their communities, with rights and obligations, rather than merely as consumers of health and social care.

The changing demographics will lead to a **skills shortage** in the workplace unless people are enabled and encouraged to continue working. For example, one in five nurses are aged over 50, and are eligible for early retirement at 55; in some regions one in four family doctors are due to retire in the next five to 10 years (Meadows, 2002).

To reduce spiralling costs in public services: older people comprise 75% of users of the NHS, and spending on personal social services for adults is expected to rise over the next 20 years from £10 to £11 billion as a result of the impact of demography and health status changes. The Wanless Report, *Securing our Future Health: Taking a Long-Term View* (Wanless, 2002), makes the case to the Treasury for investing in public health services in order to reduce health and social care costs in the future. It therefore makes sense to improve the health and wellbeing of those in mid-life and older people to enable a healthier and more independent old age.

Inequalities in health and wellbeing are widening, and the gap in life expectancy is large and continues to grow. The mortality rate for working-age men in the early 1970s was almost twice as high for unskilled compared with professional groups; by the 1990s it was almost three times higher. To reduce this gap in the next decade will require health improvement approaches to be directed at people in mid-life and older age (Department of Health, 2003).

Valuing the contribution and experience of people as they grow older is important, and challenges the ageist assumption that promoting the health and wellbeing of older people wastes resources. **Health and wellbeing is a fundamental right** throughout life, and shows real benefits in terms of quality of life and independence.

'Active ageing is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age'
(World Health Organization, 2002)



How to build on the strengths of the voluntary and community sector?

The voluntary and community sector has a different understanding of local communities because of the nature of the work they undertake. They are often perceived in an **advocacy role**, and are able to develop a greater understanding of the community's needs. In Norfolk, for example, there are 700 clubs and groups serving older people on the database of Age Concern Norfolk. It is worth remembering that the majority of older people do not receive statutory services, except through their local general practice.

It is because of this difference in service provision, which is less about health and social care and more about improving the quality of life for local people, that the sector is particularly well placed to be **an essential partner** in the delivery of health improvement initiatives. The voluntary sector can provide services that complement and add value to such initiatives within the statutory sector.

However, there is **unrealised potential** in the voluntary sector, which can be developed by involving the sector more fully in the public health and inequalities agenda.

The voluntary and community sector is closer to, and able to more readily access, local communities – thereby assisting statutory partners in finding effective ways of engaging with older people, and building their own relationships with local citizens. One mechanism they use is through **facilitating local forums**. There are over 650 senior citizen forums across the UK which enable older people and their organisations to come together at local level to share their views, develop their agendas, and influence local services and decision makers. Help the Aged's 'Speaking Up For Our Age' programme is designed to support the development of such forums, and build capacity among older people.

The Compact, launched in 1998 by the Prime Minister, has emphasised and legitimised the partnership between the sectors. The Compact focuses on building local relationships between the voluntary and statutory sectors as a means of stimulating good practice and promoting respect between them (www.thecomcompact.org.uk).

The case for involving the voluntary sector was further enhanced through a Treasury **cross-cutting review** (HM Treasury, 2002) which spoke of the unique potential for the voluntary and community sector to reach marginalised groups and to enable more participation. The value-added factor of the sector was also highlighted.

Following this review, a consultation document has been produced on **the 'futurebuilders' fund** (HM Treasury/ Compact, 2003). This is a three-year investment fund of £125 million which will provide resources for the voluntary and community sector to become more involved in public service delivery. The fund is due to be launched in September 2003. For more information see www.hm-treasury.gov.uk/ and click on 'futurebuilders'.

The government has set a target of a **5% increase in voluntary sector involvement in public service delivery** by 2005, which should be linked to the statutory sector's strategic planning mechanisms. However, not all voluntary agencies provide, or wish to provide, statutory services for public sector agencies.

Older people themselves make a significant contribution to the voluntary and community sector through their **involvement in volunteering** activities. In one year, the National Survey of Volunteering found that people aged over 55 give 1.5 billion hours of their time as volunteers (Davis Smith, 1998).



Case study – North Staffordshire

In North Staffordshire the primary care trust has funded a voluntary sector organisation to develop a strategic approach to health improvement for older people, focusing on developing trained community volunteers working in local settings. The programme has a number of elements, including:

- Trained volunteers delivering exercise programmes in local settings
- Developing work on smoking cessation
- Looking at the impact of food and nutrition on general health
- Developing a network of trained lay health advisers to make advice, information and guidance available to the most disadvantaged groups

Strategically, the programme links to the health improvement targets around preventing falls, promoting mental health, reducing cardiac disease, and healthy workplace initiatives. It supports implementation of the National Service Frameworks for older people, coronary heart disease, diabetes and mental health. The Department of Health's strategy to reduce health inequalities specifically mentions working with lay health workers (Department of Health, 2003: 5.37).

For details contact the Director at the Beth Johnson Foundation: 01782 844036, alan@bjf.org.uk

What it feels like

'I am female, 53 years old, and have lived in Hackney most of my life. During my working life I have worked as a machinist, a telephonist, a carer and in catering. I have had some ongoing health problems – back pain, which resulted in surgery and high blood pressure. These problems had a big effect on my wellbeing which is why I joined AgeWell¹. I found out about the project through Hackney Carers Association, which produces a news sheet one or two times a month. Since joining the project I have started doing yoga. I have also become a volunteer befriender. I feel much better informed on many issues due to being a member of the focus group, and think the project has provided me with opportunities to explore different avenues. The focus group has provided a good support network and friendships that we all hope will continue after the project finishes. I feel that the AgeWell project has allowed me to have a voice. I now have a stronger feeling of self worth that I will continue to develop. I also feel that I have more choices in my life. This has been highlighted through my work as a befriender of a frail elderly person.'

Volunteer at Age Concern Hackney (Tel: 020 7249 7149)

¹ Agewell was a project to enable people in mid-life to plan and think about their future health needs.





Examples of cost benefits

- The economic value of formal volunteering has been calculated to be in the region of £40 billion per year.
- The estimated economic value of volunteering for health and social services is £7 billion.
- Every pound invested in the voluntary sector turns into £7 by tapping other sources of charitable funding and the contribution of volunteer time and skills (www.ivr.org.uk).
- Six out of 10 adult volunteers say volunteering gives them an opportunity to learn new skills.
- There is increasing evidence demonstrating the positive impact of voluntary activity on health and wellbeing, for both clients and volunteers. For example, a study by the Active Community Unit looking at older people volunteering to benefit their local community (Ellis, 2003) found that 85% of the volunteers did not feel downhearted or depressed.

Common barriers to voluntary and community sector involvement – and some solutions

Barriers	Solutions
Short-term funding creating uncertainty and a barrier to adopting a strategic approach	Greater involvement of the voluntary and community sector in local planning and delivery processes, eg in local delivery plans and community plans, will enable funding streams to be built in
Statutory sector does not always value the voluntary sector contribution	Voluntary sector to use Compact and the 5% government target set for public sector organisations, to strengthen their case
Lack of capacity to deliver because of a potentially diminishing pool of volunteers	Thinking about the changing nature and role of volunteering. Seeking to understand the characteristics and motivations of the large cohort of people entering mid-life, and exploring new ways of involving them in volunteering

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Improving the health and wellbeing of people in mid-life and beyond: making the case for the National Health Service

'I found the health check made me look at my lifestyle and has made me try to do something about it'

Why promote the health and wellbeing of those in mid-life and older people?

The changing age balance of the population means that there are more people aged over 60 than there are children. In 2001, 21% of the population were aged over 60 and 40% were over 50. Mid-life and older people will be a growing group of health service users, and they will expect it to be responsive to their needs.

'The health and wellbeing of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.'

Standard 8 of the National Service Framework for Older People (Department of Health, 2001: 107)

To reduce spiralling costs in the health service. Older people comprise 75% of users of the NHS, and there are concerns that this group will place an increasing burden on the service. The cost of an in-patient stay is estimated at £447.20 per patient per day, and the average stay is between 5 and 16 days, making a total cost of £3,577.76. The NHS already has challenging targets to reduce hospital admissions and the length of patient stay, and health-promoting activities can help to reduce this burden. The Wanless Report, *Securing our Future Health: Taking a Long-Term View* (Wanless, 2002), makes the case to the Treasury for investing in public health services in order to reduce health and social care costs in the future.

The changing demographics will lead to a **skills shortage** in the workplace unless people are enabled and encouraged to continue working. For example, one in five nurses are aged over 50, and are eligible for early retirement at 55; in some regions one in four family doctors are due to retire in the next 5 to 10 years (Meadows, 2002). This report from the King's Fund recommends that the NHS should have a proactive occupational health service to prevent retirement on grounds of ill health.

Inequalities in health and wellbeing are widening, and the gap in life expectancy is large and continues to grow. The mortality rate for working-age men in the early 1970s was almost twice as high for unskilled compared with professional groups; by the 1990s it was almost three times higher. To reach the targets in the next decade will require health improvement and prevention approaches to be directed at people in their 50s.

Valuing the contribution and experience of people as they grow older is important, and challenges the ageist assumption that promoting the health and wellbeing of older people wastes resources. **Health and wellbeing is a fundamental right** throughout life, and shows real benefits in terms of quality of life and independence.



How can the NHS improve the health and wellbeing of mid-life and older people?

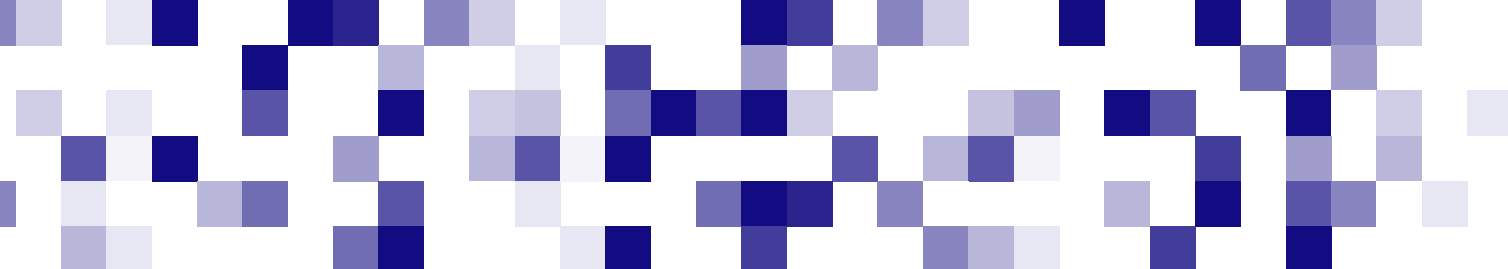
Through local delivery plans. Primary care trusts (PCTs) are performance-managed by strategic health authorities, which are accountable to the Department of Health, against their local delivery plans. These are three-year plans based on the Department of Health's *Priorities and Planning Framework 2003–06* (Department of Health, 2002a) which identifies national priorities and targets that organisations need to build into their local plans. One of the priority groups is older people. An emphasis on prevention and health improvement will directly contribute to meeting the targets for emergency hospital admission and waiting lists in the future, as older people are major consumers of services.

Health inequalities target. In the *Priorities and Planning Framework* (Department of Health, 2002a) there is a health inequalities target directly relating to older people – 'to achieve the target of 70% uptake in influenza immunisation in people aged 65 years and over, targeting populations in the 20% of areas with the lowest life expectancy'. This offers the opportunity to engage older people in wider discussions about improving their health in other ways besides flu injections.

Local leadership in driving forward the **health inequalities agenda**. PCTs are responsible for leading and supporting partnerships, and influencing partners to support improvements in narrowing health inequalities. *Tackling Health Inequalities: A Programme for Action* (Department of Health, 2003) requires that, by 2010, life expectancy should have been raised more quickly in the most disadvantaged areas. It identifies one of the key interventions as 'Targeting the over 50s – among whom the greatest short-term impact on life expectancy will be made'.

For the population as a whole, achieving the **NHS targets** within the disease-focused *Priorities and Planning Framework* and the *National Service Frameworks* for reduction in coronary heart disease, strokes, diabetes and cancer can be assisted if services also focus on those in mid-life and older people.

The implementation of the **National Service Framework for Older People** (Department of Health, 2001) is to be reviewed in 2004, jointly by the Commission for Health Audit and Inspection, the Social Services Inspectorate and the Audit Commission. This will include the effective implementation of standard 8, because planning for delivery should address all the national milestones of this framework. The first milestone in standard 8, for April 2003, states that 'local plans should have included a programme to promote healthy ageing and to prevent disease in older people'. The review will examine how this has been taken forward at local level.



In *Shifting the Balance of Power* (Department of Health 2002b), PCTs were given responsibilities to improve the health of their local communities through **partnership working** and membership of the local strategic partnership. The public health function has been strengthened through the appointment of a director of public health in each PCT, and health improvement plans must recognise the diversity of local needs. This change in the relationship of the NHS to its local population gives an opportunity for the health and wellbeing needs of the older population to be articulated more clearly. PCTs are performance-managed by strategic health authorities. The National Primary and Care Trust Development Programme (www.natpact.nhs.uk) has developed organisational competences for PCTs, which include public health.

Case study – Osteoporosis Dorset

Osteoporosis Dorset, in partnership with GP practices in South and East Dorset PCT, has piloted a health check with women aged 56–65 to improve health, with particular reference to osteoporotic fractures, cardiovascular and cerebrovascular disease and diabetes. All eligible women on the GPs' lists were invited to attend a health check, which was accompanied by a self-completion questionnaire. A 45 minute individual check with a trained technician included a heel ultrasound scan, urinalysis, blood pressure and body mass index measurements, as well as an opportunity to discuss issues of concern. Anyone identified as a lifestyle risk was offered a lifestyle workshop, and those with high risk were also referred to the GP. All women were given the opportunity to attend a health fair.

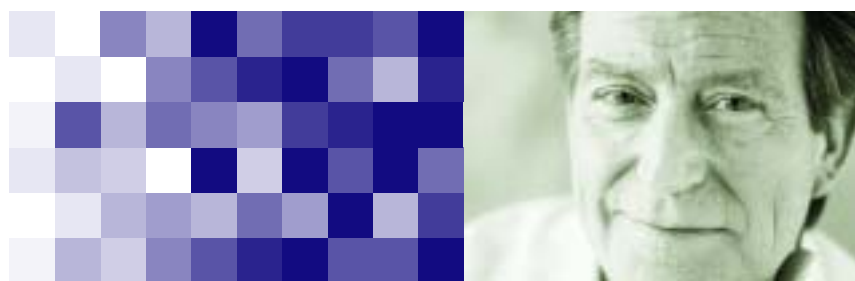
In the 18 months of the pilot, 1,146 women were eligible to participate and 975 (85%) attended. The pilot concluded that osteoporosis and fracture risk assessment was a draw to attendance. Further integration with existing local services was seen as beneficial to maximising the role of health checks as a feeder service, and as increasing efficiency.

For further information contact: Carol Jones, Osteoporosis Dorset, osteodorset@dial.pipex.com

What it feels like

'Following my health check, my blood pressure was high. I returned to the surgery and after a few tests it was discovered that my cholesterol level was very high at 8.5. With dieting, it is now down to 6.5, and my blood pressure is all right. I am most grateful.'

Participant in Osteoporosis Dorset pilot project, www.osteodorset.org.uk





Examples of cost benefits

- An older people's project which promotes healthy eating and shopping on the Internet was estimated to save the NHS £309,000 in reduced hospital admissions and length of stay, over the three-year pilot phase (www.it2eat.org.uk).
- The National Osteoporosis Society estimates that a strategy to prevent fractures would cost the same as managing 15 of the 104 hip fractures that occur in a population of 100,000 each year. It is estimated that each hip fracture costs the NHS £17,000 a year. Therefore there would be an annual saving of just over £1.5 million (www.helptheaged.org.uk/AdviceInfo).

Common barriers to NHS involvement – and some solutions

Barriers	Solutions
The NHS is reactive to older people, concentrating on treating illness and disease	Proactive planning with older people as partners will identify their health and wellbeing needs
No specific resources allocated to improving health and wellbeing	Use existing services, but 'bend the mainstream' and reconfigure to account for this age group
Is it the responsibility of the NHS?	Partly, as PCTs have been given the responsibility and mechanisms to improve the health of their local population
There are no performance targets specifically attached to promoting older people's health	Can be used as a lever to support disease and access targets by directing attention to people over 50. Examples of targets: substantially reduce mortality rates from the major killer diseases by at least 40% in people aged under 75 by March 2010; reduce the maximum wait for an outpatient appointment to 3 months and the maximum inpatient treatment to 6 months by the end of 2005

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