Croydon joint strategic needs assessment 2010/11

Living well in later life

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Key findings

In 2009, there were 101,000 people (29.4% of the population) aged over 50 and 44,400 people (12.9% of the population) aged 65 or over living in Croydon. The number of people aged 65 and over will rise to 48,900 by 2015 and 52,400 by 2020. In 2009, 6,200 people were aged over 85. This number will rise to 7,200 by 2015 and 8,400 by 2020. This is the group that is most likely to need healthcare and social care support. Ethnicity can be an important additional risk factor for certain conditions which affect people in later life. Croydon has an ethnically diverse ageing population.

Smoking is a risk factor for many chronic diseases associated with ageing. Many people with chronic diseases, for example stroke and hypertension, continue to smoke. Around 17% of men in their 50s with hypertension continue to smoke, although it tends to be White British and White Irish men who do so.

Having high blood pressure (hypertension) is a risk factor for various types of heart disease and stroke. The prevalence of hypertension increases with age and is highest in the 80 to 84 year age group in Croydon. Black and Mixed populations have the highest recorded prevalence of hypertension at GP practices at all ages, and have earlier onset than White British and other ethnic groups. Hypertension rates are higher in the more deprived wards of Croydon. This may be because a higher proportion of people from Black and Asian ethnic groups live in these areas.

Influenza causes substantial ill health in older people, including hospitalisation. The Department of Health target for uptake of seasonal flu immunisation in those over 65 is 70%. In 2008/09, Croydon achieved 68.7% uptake, compared with 72.5% for London and 74.1% for England.

The number of Croydon patients with osteoarthritis starts to increase from age 50 and it typically affects more Asian and Black women and people from Mixed ethnic groups. Local GP data shows a social class gradient which demonstrates a small association between increased deprivation and increased rates of diagnosed arthritis. Arthritis is the most common reason for a visit to the GP for pain management. A diagnosis of chronic pain was highest in the 60 to 64 age group, with women far more likely than men to visit the GP for chronic pain.

In Croydon, there were 4,272 (1.1%) patients registered with stroke in GP practices in 2008/09. Onset of strokes in men tends to be earlier (60s) than women (70s). If national prevalence figures are applied to Croydon, then the prevalence rate is estimated at 2% which indicates that there may be some unmet need. Local data demonstrates a significant difference in the rate of strokes in Black men compared with White British men.

Chronic obstructive pulmonary disease (COPD) commonly starts at around 40 years of age. In 2008/09, 3,089 (0.8%) patients were registered with chronic obstructive pulmonary disease in Croydon GP practices. However, if national prevalence figures are applied to Croydon then the prevalence rate is estimated at 4%. This indicates there may be significant unmet need in terms of the numbers of people not yet diagnosed or receiving support. COPD is associated with smoking in nine out of 10 cases and in Croydon, White British and White Irish males are most at risk.

There are high numbers of people with diabetes in Croydon and research suggests a link between vascular diseases such as diabetes and dementia.

In Croydon, patients' visits to their GPs for prostate cancer begin in the mid 50s and men from Black ethnic groups are the most affected. Numbers are low, with around 250 men visiting their GP for prostate cancer in Croydon in 2009. The incidence (new cases) of prostate cancer is high in Croydon, compared with London and England and mortality rates are also high. This may be because patients are not accessing services when the disease is in its early stages and more treatable or because they are not being diagnosed.

Croydon has more people recorded with a learning disability than expected and this difference is greater than any other London primary care trust. This reflects previous patterns of placing people in residential care in the borough. People with learning disability have complex health and social care needs and their life expectancy is increasing because of better care. As they and their parents or carers age, this population will increasingly need support.

GP data shows 1,336 people registered with dementia in 2009/10, compared with estimated prevalence figures of 3,052, indicating there may be a large number of persons with dementia in Croydon who are not diagnosed or in receipt of services.

Among Black and minority ethnic groups in the UK 6.1% of cases of dementia are early onset, compared with only 2.2% for the UK population as a whole, reflecting the younger age profile of Black and minority ethnic communities. Age is the most important risk factor for dementia.

In 2009/10, the majority of carers receiving services in Croydon were parent carers but the second largest group were those caring for older relatives. In 2009, most carers in receipt of a service were between 16 and 64, however there were also many carers aged over 65 and more than 2,000 aged over 75. Given increasing life expectancy and increasing numbers of older people, this is a trend set to continue. Adequate support and information for carers helps them to manage the impact of caring on their lives. The percentage of carers being supported with services, advice and information in Croydon is 12.7%, significantly below the London average (24.6%) and the England average (26.4%).

Ending employment, increasing ill health, bereavement or a drop in income can all be factors which lead older people to becoming socially isolated. Projects such as local exchange trading schemes or time banks bring people into contact with one another through trading skills and can build local communities, as can volunteering. The over 45 age group is more likely to volunteer than those under 45 locally.

Recommendations

1 Implement the older people's strategy, emphasising work on prevention and taking a broad approach to wellbeing (including financial planning, maintaining health and volunteering).

2 Carry out a community asset mapping exercise in a geographically based area, such as inner north Croydon, to understand current social networks. Following on from this, consider the piloting of community development models to reduce isolation and increase volunteering.

3 Build on the forthcoming evaluations of local telehealth and telecare projects to increase their usability, efficiency and acceptability if they prove effective.

4 Work with local businesses to pilot vocational rehabilitation schemes and work with *Croydon Adult Learning and Training* and others to develop education opportunities for the over 50s.[1]

5 Consider different approaches to help people manage pain for common conditions such as osteoarthritis, for example, through more use of pharmacies or other community services.

6 Further investigate the apparently high incidence of prostate cancer in Croydon and develop appropriate strategies to reduce this, such as helping people recognise early signs and symptoms.

7 Improve the prevention and early management of dementia and training for carers and staff.

8 Develop new ways of supporting carers. This includes support for older people who are carers and those who care for older people.

9 Improve the uptake of the flu vaccination in Croydon for people in risk groups of all ages and people aged 65 and over.

1 www.nesta.org.uk – see the *Age Unlimiting and Third Age Entrepreneurs* work streams

Introduction

The UK population is ageing. By 2030, a quarter of the population will be over 65 based on the current trend.[2] Older people are an asset to any society, a wealth of resource and experience.

Ageing does not conform to a chronological, uniform rate.[3] For many, good physical functioning will continue for many years and will be an important component of having a healthy later life. For others, physical functioning may decline rapidly with age. Accepting this fact, and making the necessary adjustments to their lifestyle, will help to ensure a positive mental attitude and a decent quality of life. Whilst average life expectancy will increase, years in good health are not expected to increase at the same rate, which has implications for service delivery. By encouraging people to stay healthy for longer, the need for care may be delayed.

There is a relationship between enjoying a healthy later life and educational attainment, the type and nature of employment, income, adequate housing and whether or not one has a disability. But successful ageing is also about how individuals experience ageing themselves and their social network. Those who have a social network are more likely to remain healthy and active.

This chapter describes the patterns of the most common types of illness and disability amongst people as they age, the patterns of mental health and ill health and the social and economic issues that face people from older middle age. The data presented pays particular attention to ethnic and social class difference, where available, in order to reflect the great diversity of the borough and the differential impact of ageing on different communities. The chapter looks at how Croydon compares with similar populations and London and England averages where available. It also describes services targeted at this age group.

Croydon's population and life expectancy

In 2009, there were 101,000 people (29.4% of the population) aged over 50 and 44,400 people (12.9% of the population) aged 65 or over living in Croydon.[4] The number of people aged 65 and over will rise to 48,900 by 2015 and 52,400 by 2020.[5] In 2009, 6,200 people were aged over 85[6] and this number will rise to 7,200 by 2015 and 8,400 by 2020.[7] This is the group that is most likely to need healthcare and social care support.

Figure 1 shows that there is an expected increase in the 50 to 75 age group in the next 10 to 20 years. This means conditions related to ageing such as circulatory and respiratory diseases and musculoskeletal disorders are likely to account for a larger proportion of the health burden. Furthermore as medical intervention improves, people will live longer with chronic conditions. This will increase the number of people requiring care for associated disabilities and end of life care. There will also be greater pressure on social care services to provide residential care.

2 Office for National Statistics population projections. 2009

3 Scales J, Scase R. Fit and fifty. Swindon: Economic and Social Research Council; 2000.

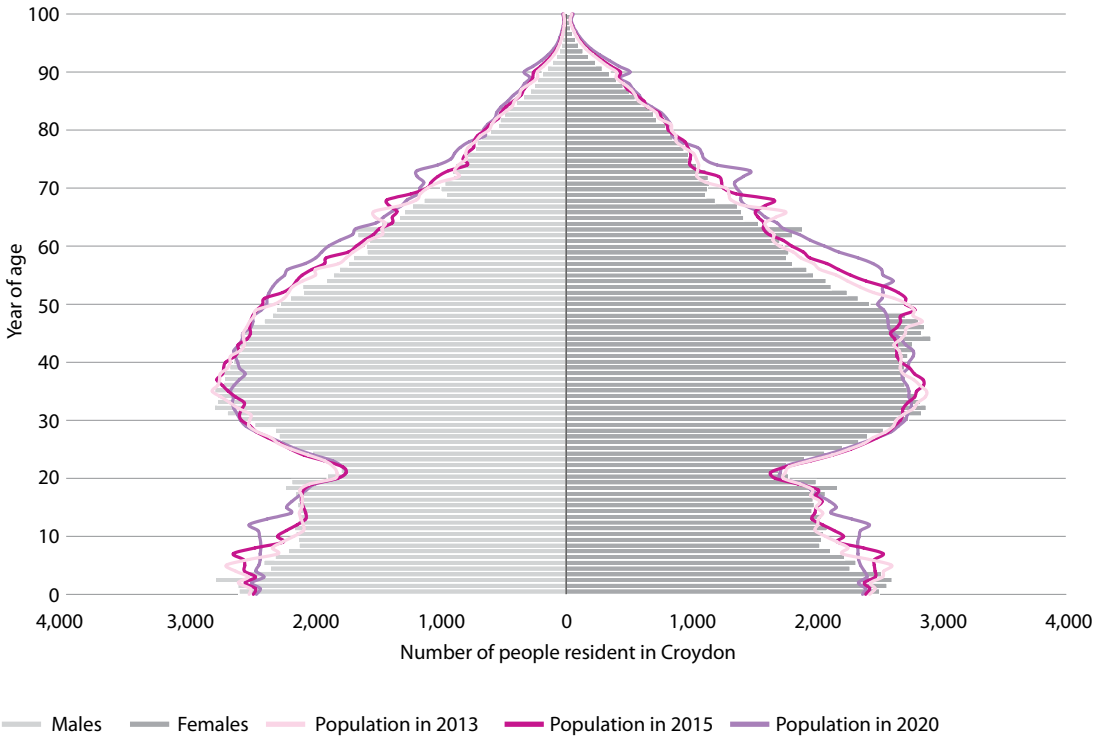
4 Office for National Statistics mid 2009 population estimates

5 Office for National Statistics 2008 based subnational population projections

6 Office for National Statistics mid 2009 population estimates

7 Office for National Statistics 2008 based subnational population projections

Figure 1 | population projections, Croydon 2010, 2013, 2015 and 2020



Source: Greater London Authority Population Projections – 2009 Round for London Plan

At 41%, the proportion of the population from Black and minority ethnic groups in Croydon is similar to the London average (42%).[8] The majority of young people aged 0 to14 years in Croydon are from Black and minority ethnic groups, but those aged 50 and over are mostly of White ethnicity. However, older age groups are likely to see significant increases in the Black and minority ethnic population in the future. In 2010, the estimated percentage of Croydon's population aged over 50 from Black and minority ethnic groups was 26.4%. This is estimated to increase to 32.1% in 2015 and 27.1% in 2020.[9]

Croydon's male life expectancy (78.9 years) and female life expectancy (82.2 years) are above the England average, although closer to the England average for women (82 years) than men (77.9 years).[10] Healthy life expectancy at age 65 is 13.3 years for males and 14.8 years for females, significantly above the England average for both males and females.[11]

Figure 2 shows that a greater percentage of people aged between 50 and 70 live in the south and east of the borough.

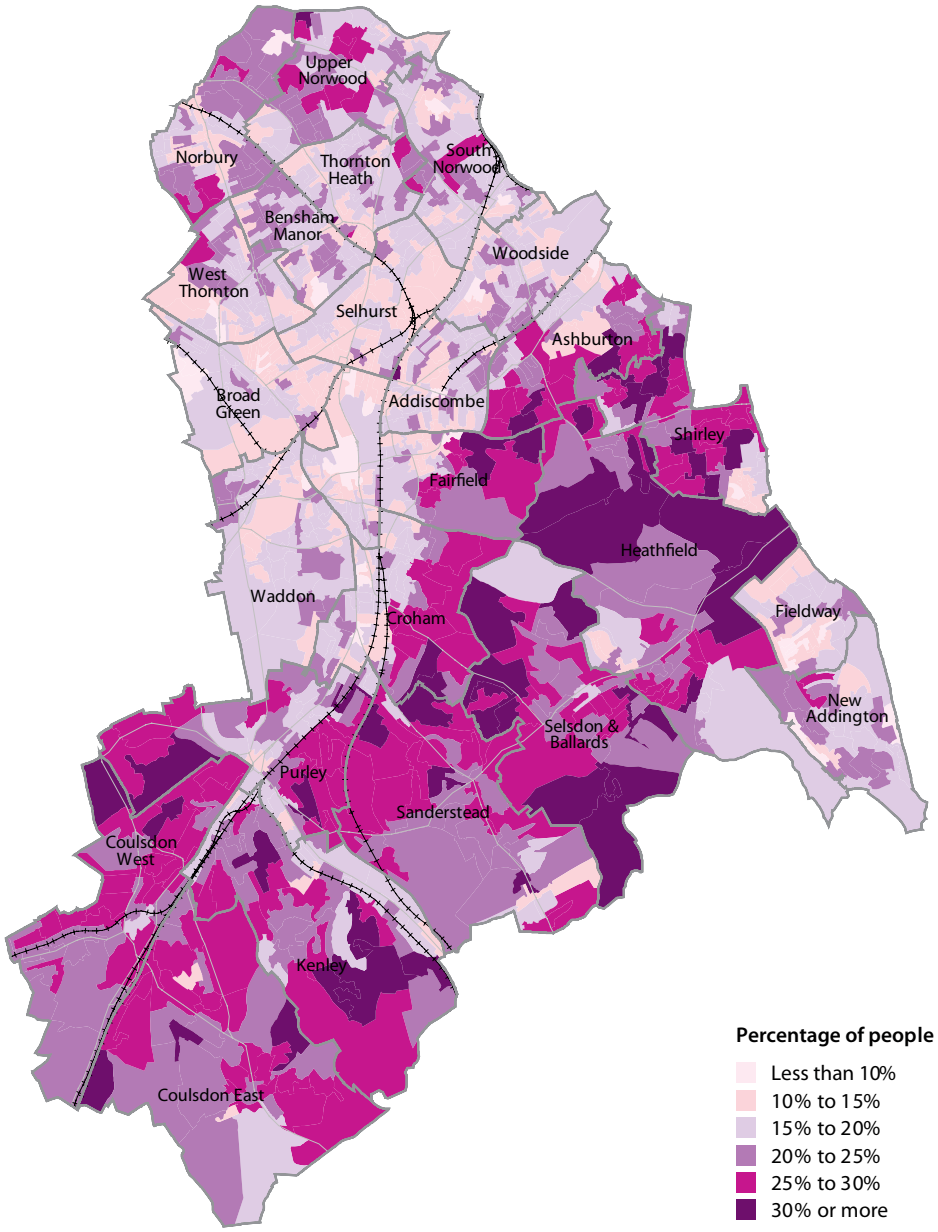
8 Greater London Authority Ethnic group population projections – 2008 Round for *London Plan*

9 Greater London Authority Ethnic group population projections – 2008 Round for *London Plan*

10 Compendium of clinical and health indicators. Life expectancy at birth. 2006-2008,

11 Office for National Statistics. Healthy life expectancy at age 65. 2001.

Figure 2 | geographical distribution of people aged 50 to 70 years, Croydon 2010



Source: Data from Croydon general practices, 31 March 2010

Risk factors and ageing

There are certain non modifiable risk factors which increase our risk of getting certain diseases as we age. These include our gender, ethnicity and genetic make up. For example, rates of stroke in Black men are higher than for White British men.[12]

Onset of disease cannot be completely avoided, being part of the ageing process, but healthy behaviours can address those risk factors which are modifiable. This can help to delay the onset of certain conditions and may lessen their impact. In order to maintain or improve our health as we get older, most of us need to maintain a healthy weight, normal blood pressure and normal levels of cholesterol, all of which tend to be negatively affected by the ageing process.

12 Data from Croydon general practices, 31 December 2009

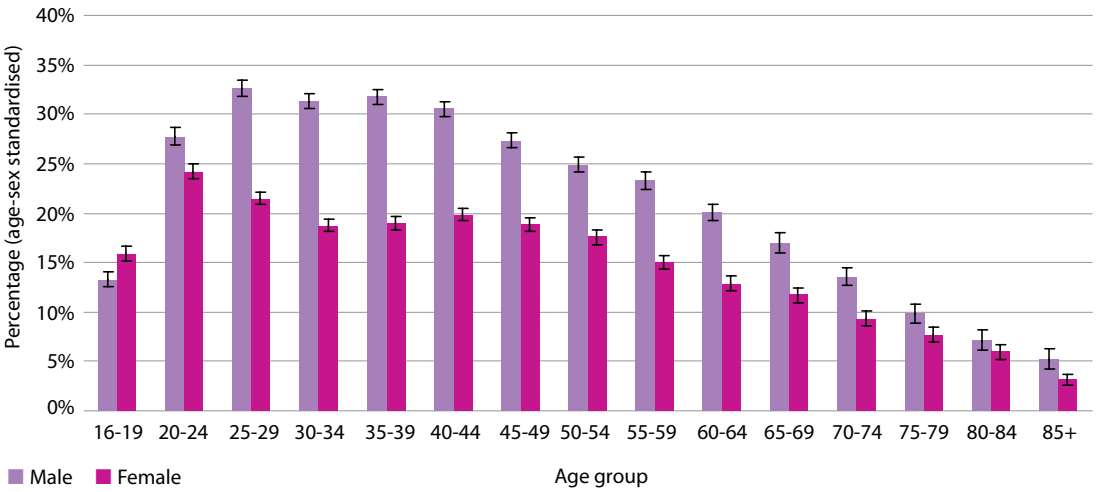
Modifiable risk factors associated with poor health throughout life are smoking, poor diet, excess alcohol and lack of exercise. Poor mental health can also impact on physical health and can be amenable to intervention. With any of these, the earlier the changes are made, the earlier the benefit. However, the benefits of modifying behaviour can be seen even at older ages. For example, once someone gives up smoking, carbon monoxide levels in the blood reduce after just one hour, after one year lung function improves, after five years cervical cancer risk declines to that of non smokers and after ten years, the risk reduction of coronary heart disease compares with that of non smokers.[13]

Other ways of improving health in later life include participation in national screening programmes, such as cancer screening or diabetic retinopathy, immunisations such as for influenza and newer initiatives like the recently introduced five yearly cardio vascular health checks for 40 to 70 year olds.

Smoking

GP recorded smoking prevalence (those who have ever smoked) gives the most accurate estimate of the rate of smoking in Croydon. In March 2010, this was just under 22%. In Croydon, as in the rest of the UK, the highest rates of smoking tend to be in the 20 to 44 age groups. However, there are still many smokers in their 50s, particularly men (figure 3).

Figure 3 | GP recorded smoking prevalence ages 16 and over by age and sex, Croydon 2010



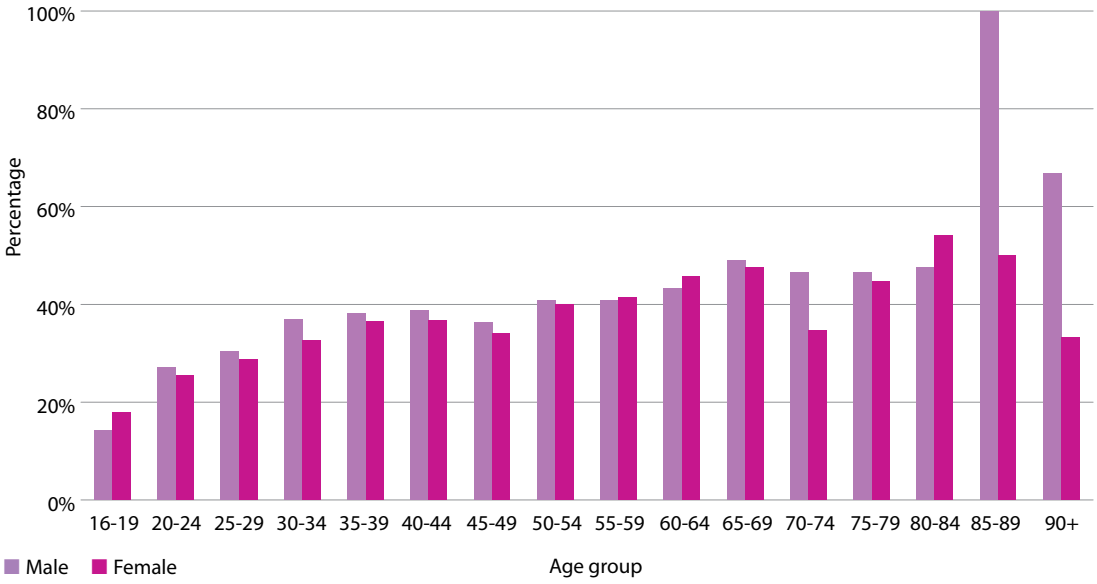
Source: Data from Croydon general practices, 31 March 2010

Men are more likely to smoke than women. Over a third of men smoke until the age of 44 and a fifth of women smoke until the age of 49. Rates continue to decline into old age. Lowest prevalence (below 10%) is reported for both men and women in the over 75 age group.

Use of Croydon Stop Smoking Service gives one indication of whether current provision of services can reach the older smoker. There is no policy guidance targeting this group. As most long term smokers are smoking by age 18, smoking is a seriously entrenched habit and addiction by the 40s, although people may have added incentive to give up as health deteriorates. Figure 4 indicates that older smokers have had more success at quitting than younger users of the local Stop Smoking Service, with men being slightly more successful quitters than women.

13 Brunnhuber K, Cummings KM, Feit S, Sherman S, Woodcock J. Putting evidence into practice: smoking cessation. Minneapolis, MN: United Health Foundation; 2007.

Figure 4 | quit rate for Stop Smoking Service clients by age and sex, Croydon 2004-08

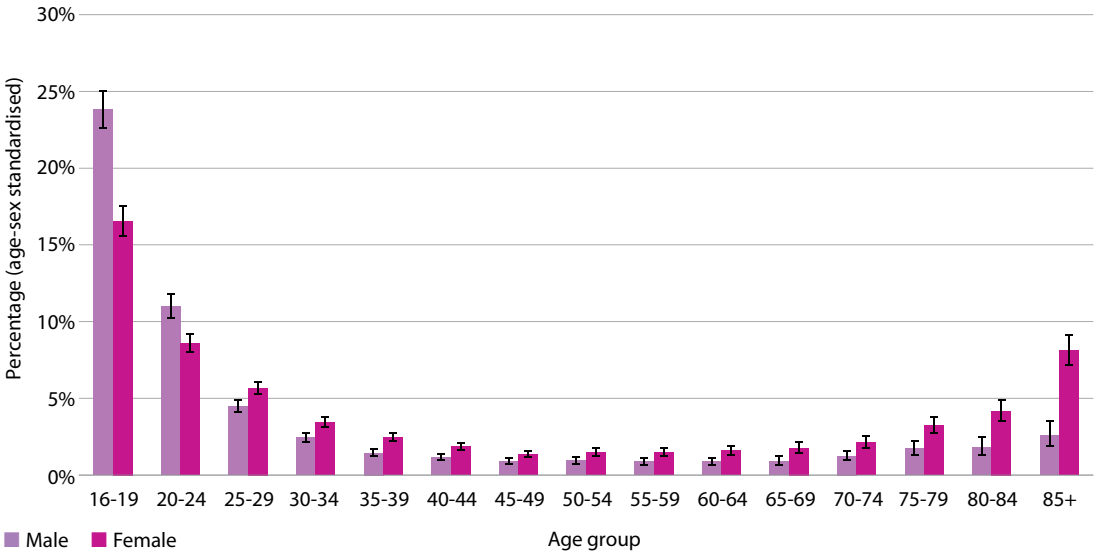


Source: Croydon Stop Smoking Service, April 2004 to December 2008

Diet and exercise

Whilst being overweight is a problem for many age groups in Croydon and nationally, malnutrition and underweight is a key issue for the over 65 population, with an estimated 10% of this age group malnourished nationally.[14] Figure 5 shows that in Croydon, underweight is more prevalent in very young age groups but also in those aged over 79, particularly females. Local GP data indicates that underweight may be a problem for those of Asian ethnicity, although the data is not age specific.[15]

Figure 5 | GP recorded underweight (BMI<18.5) prevalence (ever recorded), ages 16 and over by age and sex, Croydon 2009



Source: Data from Croydon general practices, 31 December 2009

14 Department of Health, Nutrition Summit stakeholder group. Improving nutritional care: A joint action plan from the Department of Health and Nutrition Summit stakeholders. Department of Health; 2007 [cited 2011 15 February]; Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079931.

15 Data from Croydon general practices, 31 December 2009

Alcohol

In 2005, 3.1% of deaths in England (14,882 people) and 500,000 hospital admissions were attributable to alcohol. Men are more at risk of death from alcohol than women. The highest number of deaths is in the 75 and over age group, although young people are affected too. Liver cirrhosis, cancers of the oesophagus and breast and hypertensive diseases are the principal causes of alcohol related deaths in the over 35 population.[16]

GP data in Croydon shows that 0.6% of the population are dependent on alcohol, with the White Irish community most affected.[17] Age of onset of alcohol dependence is the early 20s for all ethnicities, with a peak in the 55 to 59 age group for both men and women. The annual patient survey, sent to 10% of GP registered patients, captures other patterns of alcohol use. This shows more regular drinking in more affluent areas and heavier drinking in more deprived areas, giving us a clearer picture of those drinking frequently and those drinking more than the recommended daily units.

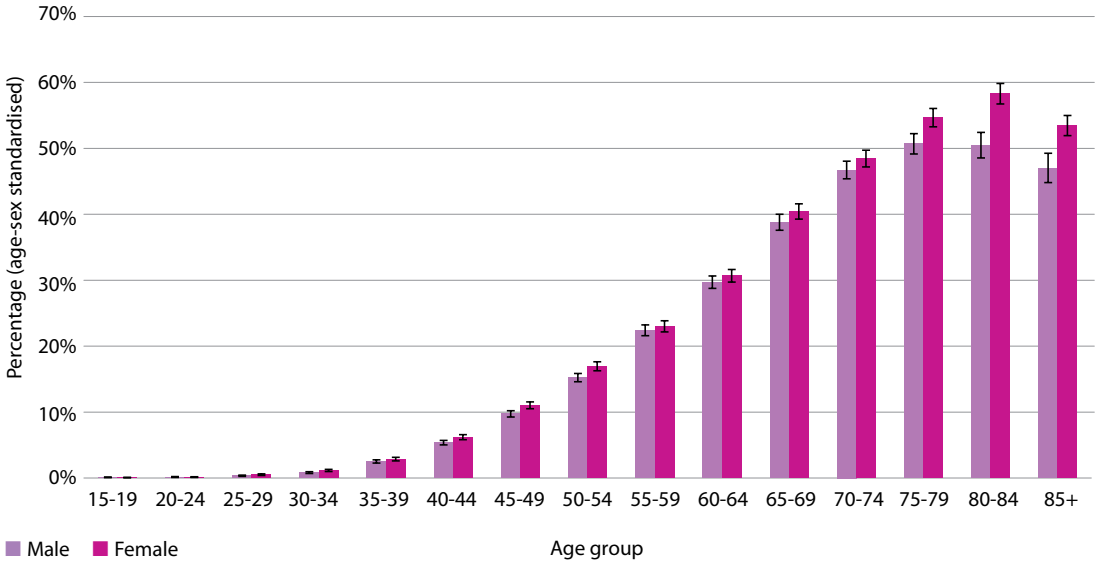
Blood pressure

Having high blood pressure (hypertension) is a risk factor for various types of heart disease and stroke. It can also be an outcome of uncontrolled or poorly managed diabetes, overweight and obesity. The prevalence of hypertension increases with age and is highest in the 80 to 84 year age group (figure 6). It is extremely important to control it through good diet, regular exercise and where indicated an antihypertensive drug.

Figure 7 shows that in Croydon, Black and Mixed ethnicity populations have the highest recorded prevalence of hypertension at GP practices at all ages and have earlier onset than White British and other ethnic groups. The condition also affects women slightly more across all ages.

Hypertension rates are higher in the more deprived wards of Croydon, which may be because a higher proportion of people from Black and Asian ethnic groups live in these areas. Around 17% of men in their 50s with hypertension continue to smoke although it tends to be White British and White Irish men who do so, with rates of smoking amongst Black and Asian people with hypertension dropping with age. Smoking with established hypertension increases the risk of heart disease and stroke.

Figure 6 | GP recorded hypertension prevalence by age and sex, Croydon 2009

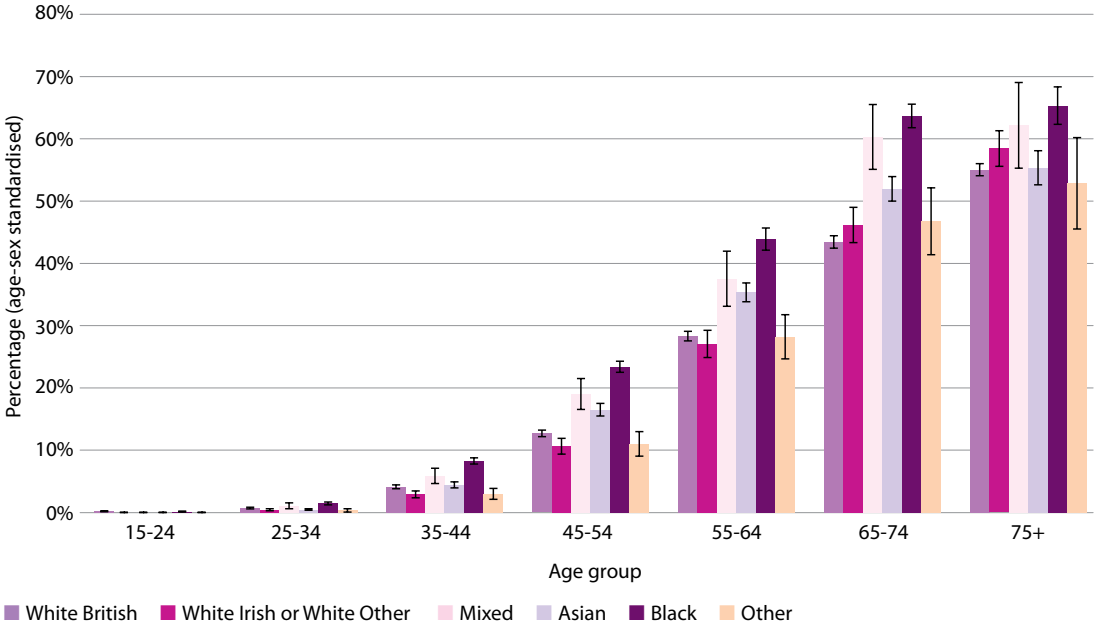


Source: Data from Croydon general practices, 31 December 2009

16 North West Public Health Observatory. Local alcohol profiles for England: 2009. Centre for Public Health, John Moores University

17 American Psychiatric Association Committee on Nomenclature. Diagnostic and statistical manual of mental disorders : DSM-IV. 4th ed. Washington, D.C.: American Psychiatric Association; 1994.

Figure 7 | GP recorded hypertension prevalence by ethnic group and age, Croydon 2009



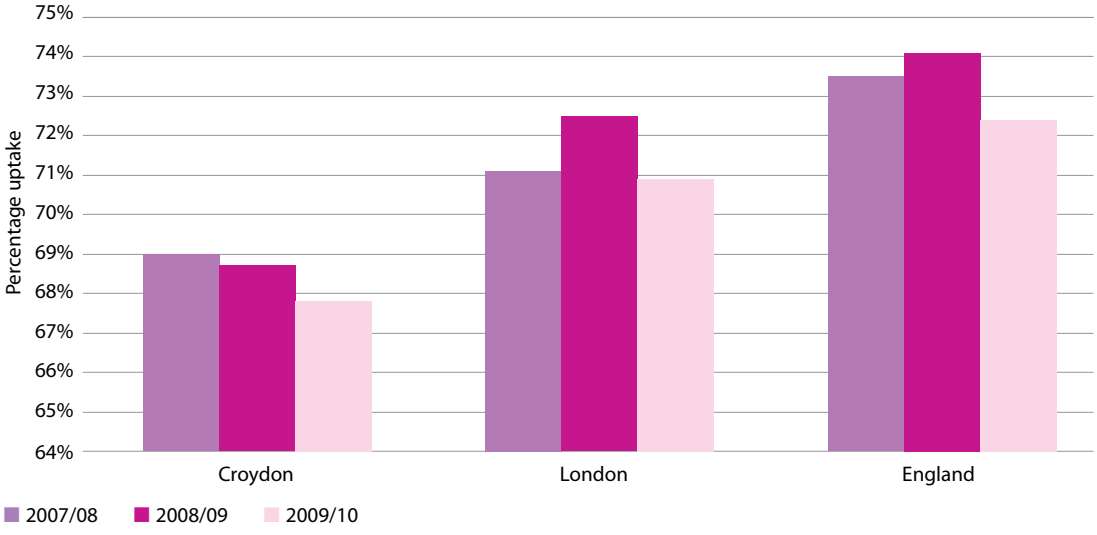
Source: Data from Croydon general practices, 31 December 2009

Immunisations

One of the aspects of ageing is a progressive deterioration in immunity which contributes to increased illness and deaths from infection.[18] It has been recognised for some time that influenza causes substantial ill health in older people, including hospitalisation. People in risk groups of all ages and those over 65 are offered an annual seasonal flu vaccination, which has a valuable role in reducing the illness and death associated with influenza infection in the older population.

The Department of Health target for uptake of seasonal flu immunisation in the over 65 age group is 70%. Croydon has narrowly missed this target for the last two years, achieving an uptake of 68.7% in 2008/09, compared with 72.5% for London and 74.1% for England (figure 8).[19] There is opportunity to encourage uptake of the vaccination.

Figure 8 | uptake of seasonal flu vaccination, Croydon, London and England, 2007/08 to 2009/10



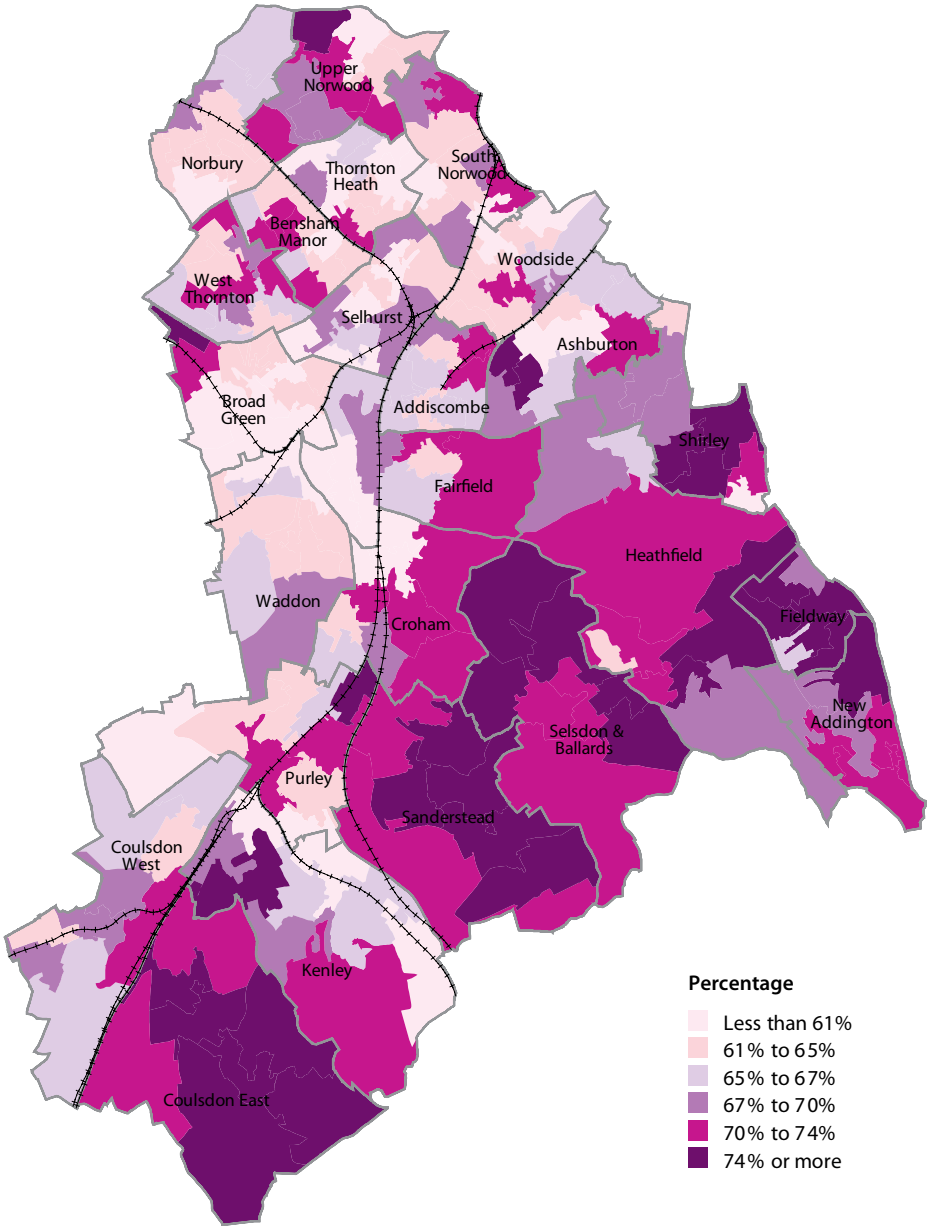
Source: Influenza vaccine uptake. Health Protection Agency, Department of Health

18 Williams M. Influenza vaccination in older people: where's the proof? Prescriber. 2010; 21(10):8-13.

19 Percentage of people aged 65 and over immunised against influenza. 2008/2009. Information Centre for Health and Social Care. May 2010.

There is a significant difference in uptake of vaccine between some of the most advantaged and some of the most disadvantaged areas in Croydon, however this is not a consistent pattern with uptake being higher in Fieldway and New Addington (figure 9).

Figure 9 | flu vaccine uptake for patients aged 65 and over in the last 15 months, Croydon lower super output areas, 2010

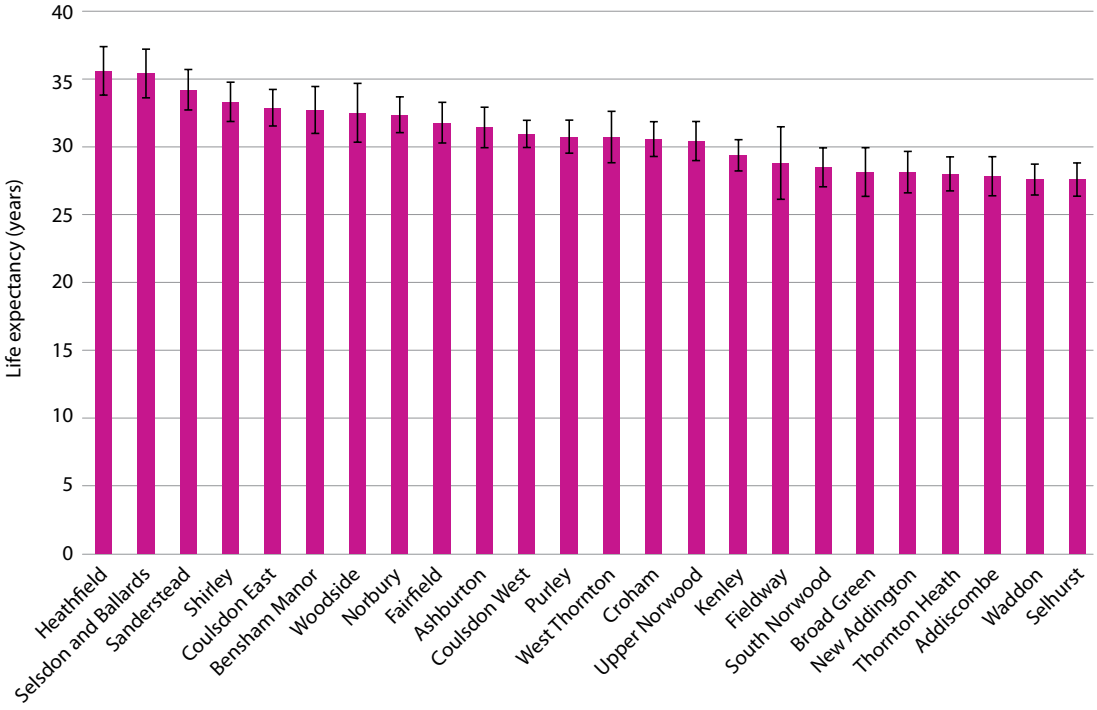


Source: Data from Croydon general practices, 31 March 2010

Deprivation and life expectancy

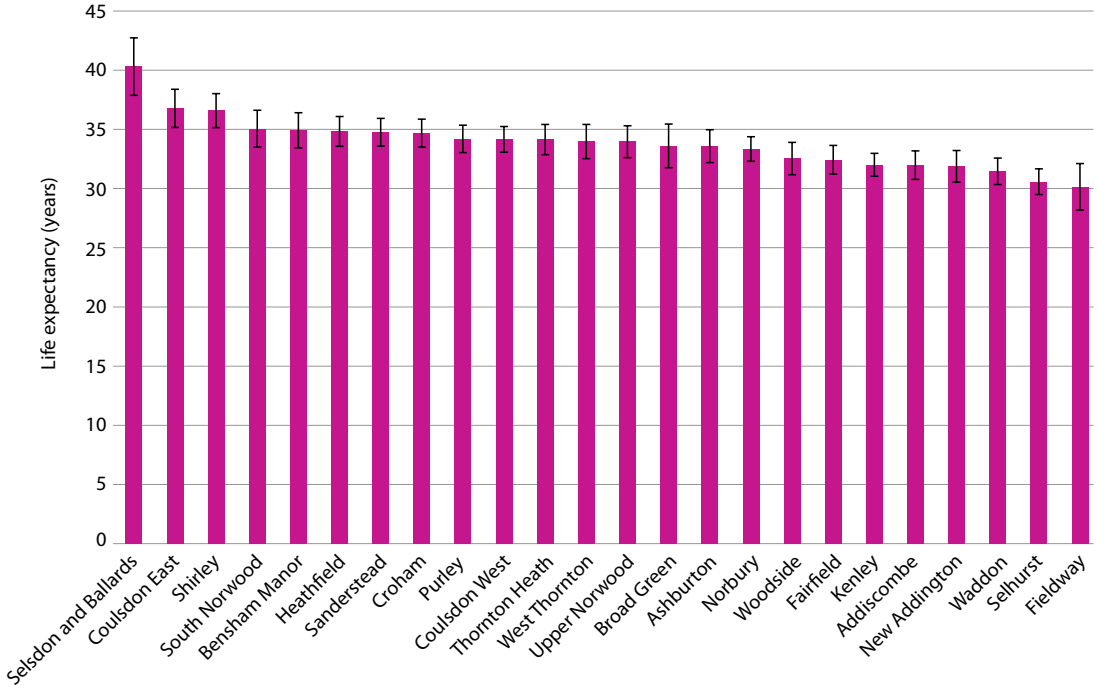
Figures 10 and 11 show the life expectancy at 50 years old for both males and females in Croydon by electoral ward. There is a significant gap of around 10 years between wards in terms of life expectancy for both men and women. This gap between wards is associated with the varied deprivation levels in different parts of the borough.

Figure 10 | male life expectancy at 50 by electoral ward, Croydon 2005-2009



Source: Death registrations data, Office for National Statistics

Figure 11 | female life expectancy at 50 by electoral ward, Croydon 2005-2009



Source: Death registrations data, Office for National Statistics

Common conditions in later life

The following section describes the most common conditions that affect us as we age and looks at whom they affect most in Croydon, using GP, hospital and social care data where available. Some of these conditions affect people at a younger age and some tend to have later onset. Onset of disease cannot be completely avoided, being part of the ageing process, but healthy behaviours can address the modifiable risk factors, help delay onset and may lessen their impact.

For many people the effects of conditions associated with ageing are tolerated and self managed to some extent. Some diseases, such as arthritis and diabetes, are largely managed in primary care and others mainly within hospital settings. Hospital data reflects not only the pattern of disease in an area but also hospital admission policies and community and primary care policies and practice.

GP data can give us an indication of whether a disease is well managed or controlled, as there are indicators for many aspects of disease management, for example when the patient was last reviewed, as well as specific measurements such as blood pressure or medication history for many diseases. Applying estimates of prevalence of a disease or disability from national figures to the Croydon population is a way of estimating unmet need. These estimates indicate that there is some unmet need in Croydon, particularly in undiagnosed chronic obstructive pulmonary disease and hypertension (table 1). Applying for, but not meeting the criteria for social care, also gives an indication of possible unmet support needs.

Table 1 | numbers, prevalence and estimated prevalence of various conditions associated with ageing, Croydon 2008/09

Condition	Number of patients on GP Register	Croydon GP recorded prevalence	Age group	Estimated prevalence
Coronary heart disease	8725	2.3%	All age	4.5%
Chronic obstructive pulmonary disease	3089	0.8%	All age	4.0%
Stroke and transient ischaemic attack	4272	1.1%	All age	2.0%
Diabetes	15940	5.4%	17+	5.6%
Chronic kidney disease	8403	2.9%	18+	7.6% (2007)
Hyper tension	44281	11.7%	All age	29.0%
Obesity	30671	8.1%	16+	10.1%

Source: Croydon general practice data 2009. Assocation of Public Health Observatories

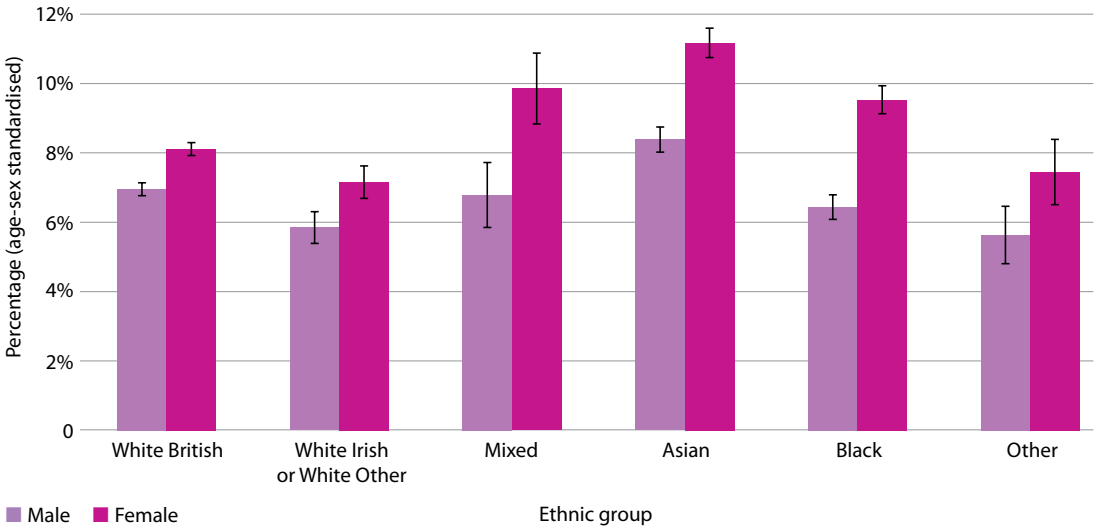
Arthritis

Arthritis is an inflammatory disease that affects the joints. Osteoarthritis is by far the most common disease associated with ageing in the UK.[20] Rheumatoid arthritis, which typically has an earlier onset, is less common. GP records of Croydon patients with arthritis show that people as young as ten have a diagnosis but the numbers start to grow from age 50 upwards. In Croydon, arthritis typically affects more Asian and Black women and people from Mixed ethnic groups (figure 12). Local GP data shows a social class gradient which demonstrates a small association between increased deprivation and increased rates of diagnosed arthritis.[21]

20 www.nhs.uk/conditions/arthritis accessed 23 December 2010

21 Date from Croydon general practices, December 2009

Figure 12 | GP recorded arthritis prevalence by ethnic group and sex, Croydon 2009



Source: Data from Croydon general practices, 31 December 2009

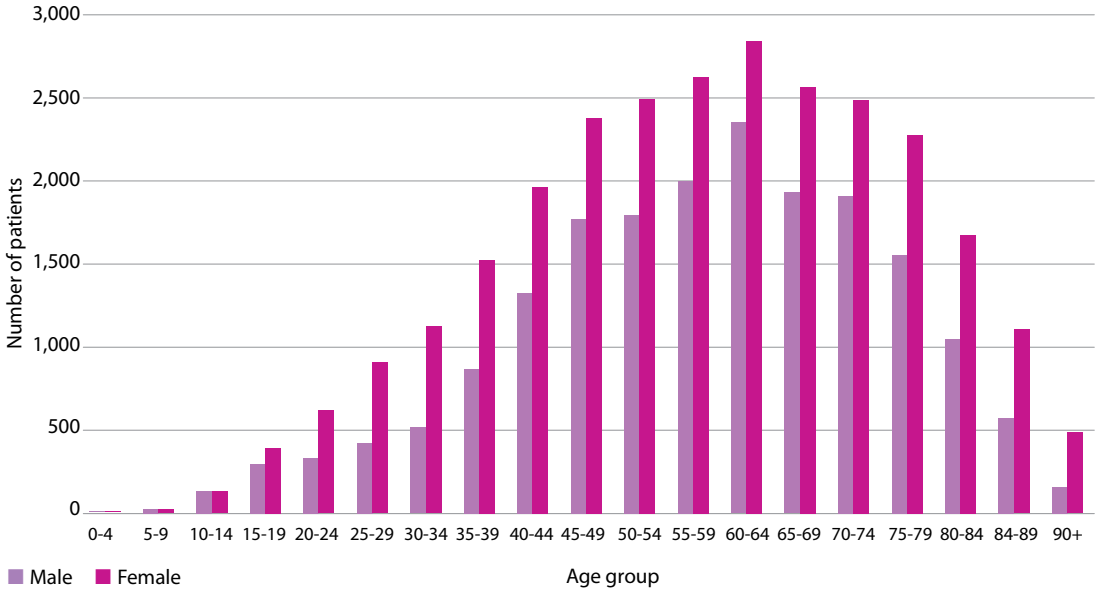
Arthritis affects our ability to carry out tasks of daily living, is painful, and affects prescribing patterns and the demand for visits to the GP. Arthritis is mainly managed in primary care. Table 2 shows that arthritis is the most common reason for a visit to the GP for pain management and figure 13 indicates that a diagnosis of chronic pain was highest in the 60 to 64 age group and that women are far more likely than men to visit the GP for chronic pain.

Table 2 | prevalence of chronic pain conditions, Croydon GP registered patients, 2009

Condition	Number of patients visiting GPs in last year	Percentage in last year	Number of patients visiting GPs ever recorded	Percentage ever recorded
Arthritis (includes rheumatoid arthritis and osteoarthritis)	4470	1.2%	26935	7.2%
Rheumatoid arthritis	233	0.1%	1424	0.4%
Osteoarthritis	3341	0.9%	18545	5.0%
Peripheral neuropathy (incl diabetic neuropathy and neuropathic pain)	1835	0.5%	11103	3.0%
Diabetic neuropathy	26	0.0%	245	0.1%
Neuropathic pain	124	0.0%	427	0.1%
Neuralgia	1645	0.4%	9991	2.7%
Fibromyalgia	54	0.0%	325	0.1%
Migraine or chronic headaches	1380	0.4%	9420	2.5%
Chronic pain	318	0.1%	1265	0.3%

Source: Data from Croydon general practices, 31 March 2009

Figure 13 | patients with a diagnosis of chronic pain in the last year by age and sex, Croydon 2009



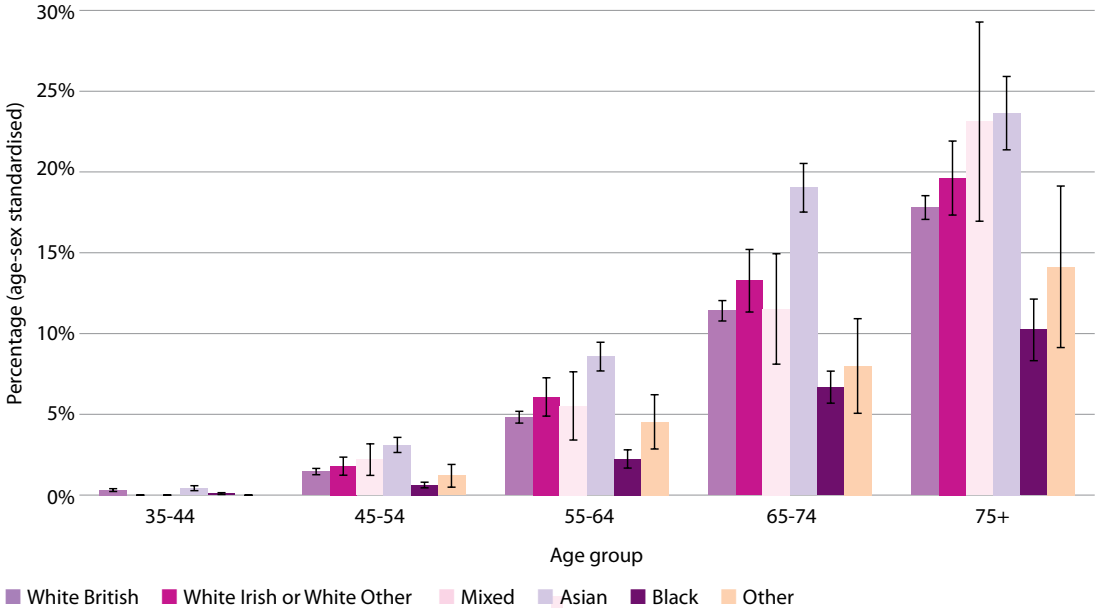
Source: Data from Croydon general practices, 31 March 2009

Coronary heart disease

There were 8,725 patients (2.3%) registered with coronary heart disease in GP practices in Croydon in 2008/09.[22] The estimated prevalence for coronary heart disease in Croydon based on national figures is 4.5%, which may indicate unmet need.[23]

The prevalence of coronary heart disease in Croydon increases with age and is highest in the 75 and over age group (figure 14). Onset is typically in the 50s although some younger people are affected. Asian ethnic groups have the highest rates of coronary heart disease and onset is also at a younger age in this group.

Figure 14 | GP recorded prevalence of coronary heart disease by ethnic group and age, Croydon 2009



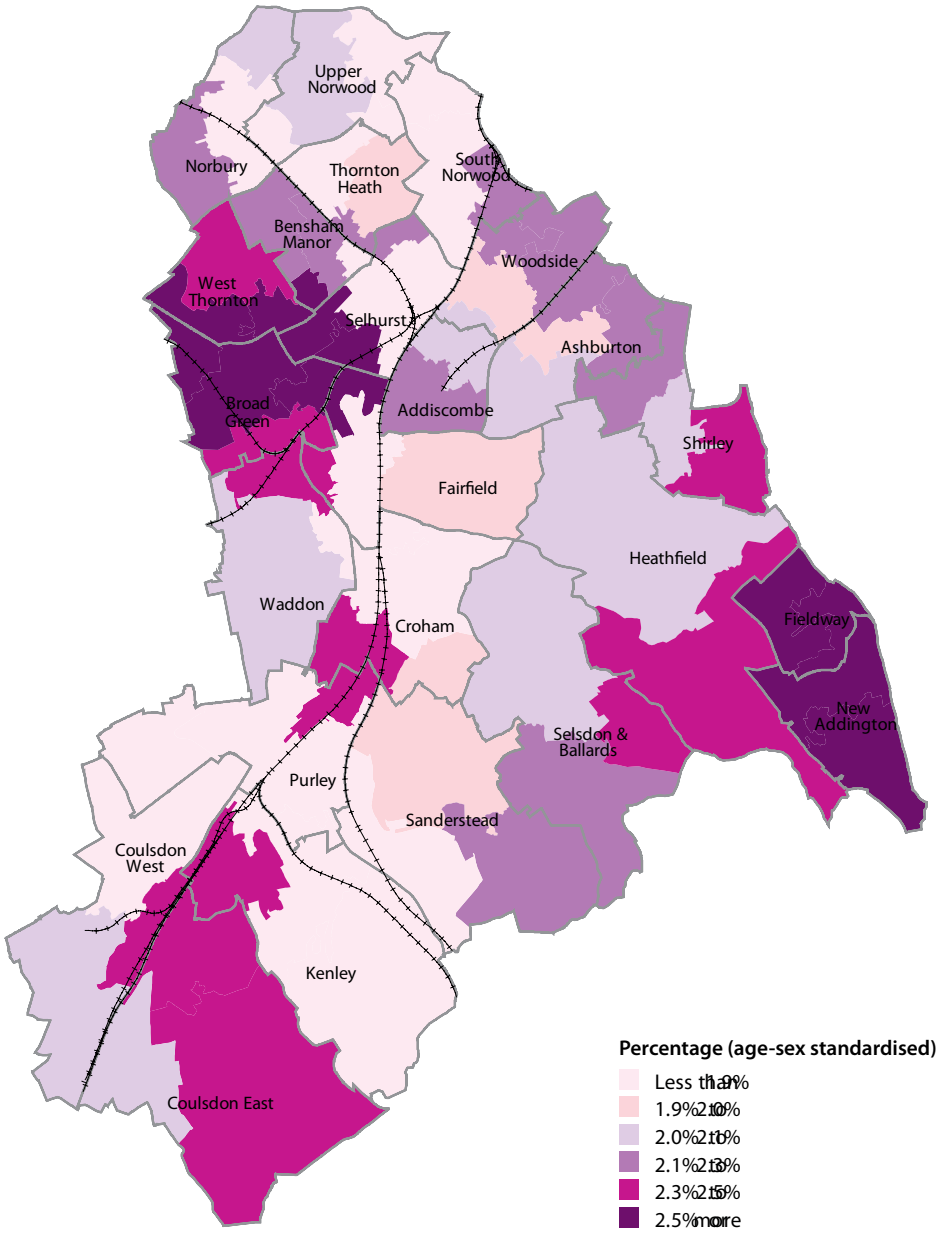
Source: Data from Croydon general practices, 31 December 2009

22 Data from Croydon general practices, 2009

23 Association of Public Health Observatories' estimates 2009

There is a higher recorded prevalence in the most deprived areas in Croydon (figure 15). The risk of coronary heart disease can be reduced by making lifestyle changes such as not smoking, eating well and taking exercise. These risk factors are more strongly associated with people living in poorer areas and therefore targeting prevention initiatives in more deprived areas has an impact on healthier ageing for these people.

Figure 15 | GP recorded prevalence of coronary heart disease, Croydon middle super output areas, 2010



Source: Data from Croydon general practices, 31 March 2010

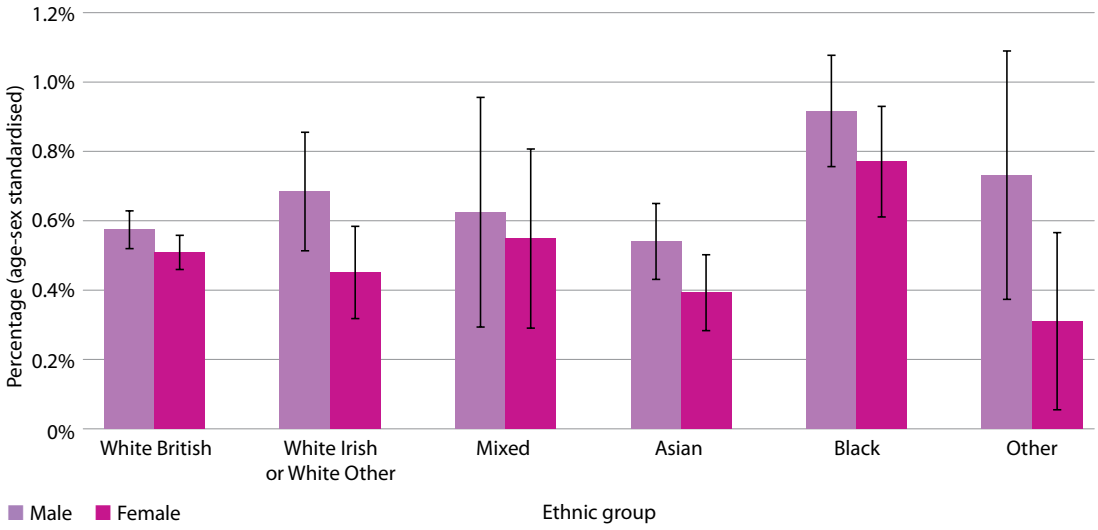
Stroke

Stroke is the third most common cause of death in England but is also a cause of great disability.[24] Hypertension is a key risk factor for strokes. In Croydon, there were 4,272 (1.1%) patients registered with stroke in GP practices in 2008/09. Onset of strokes in men tends to be earlier (60s) than women (70s), although in Croydon people are registered with stroke from age 40 and above. If national prevalence figures are applied to Croydon then the prevalence rate is estimated at 2%, which indicates that there may be some unmet need. Prompt access to a specialist stroke unit has been shown to improve longer term outcomes. Local stroke services have recently been reorganised to implement best practice guidelines.

Anyone over 18 with a stroke is referred to the Croydon Health Services stroke coordinator for their reablement support, which includes neuro rehabilitation, speech and language therapy, occupational therapy and other services as needed. These are delivered at home, at work and in the community.

Local data, in line with data for the UK, demonstrates a significant difference in the rate of strokes in Black men compared with White British men (figure 16).

Figure 16 | GP recorded stroke prevalence by ethnic group and sex, Croydon 2009



Source: Data from Croydon general practices, 31 December 2009

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) affects lung function and commonly starts at around 40 years of age, from whence there is a large rise in the number of cases year on year. In 2008/09, 3,089 (0.8%) patients were registered with COPD in Croydon GP practices. However, if national prevalence figures are applied to Croydon then the prevalence rate is estimated at 4%. This indicates there may be significant unmet need in terms of the numbers of people not yet diagnosed or receiving support.

COPD is associated with smoking in nine out of 10 cases and because of smoking, it is increasingly associated with poorer members of society, impacting on their life expectancy.[25] In Croydon, White British and White Irish males are most at risk. The impact of reducing smoking and reducing onset of COPD would have a marked impact on health inequality, healthy ageing and on the gender gap in life expectancy in Croydon. A local strategy for tackling this condition has been developed and is currently being implemented. This includes the development of services such as a specialist clinic in the community to help avoid hospital admissions and the use of spriometry (the measurement of lung function) in primary care.

24 www.dh.gov.uk/en/Healthcare/Longtermconditions

25 Data from Croydon general practices, 2009

Diabetes

Diabetes is a progressive long term condition caused when the body has problems producing or using insulin, resulting in high levels of glucose in the blood. The risk of developing diabetes increases with age. It usually occurs after the age of 40, although in South Asian and African Caribbean people it can appear after the age of 25.

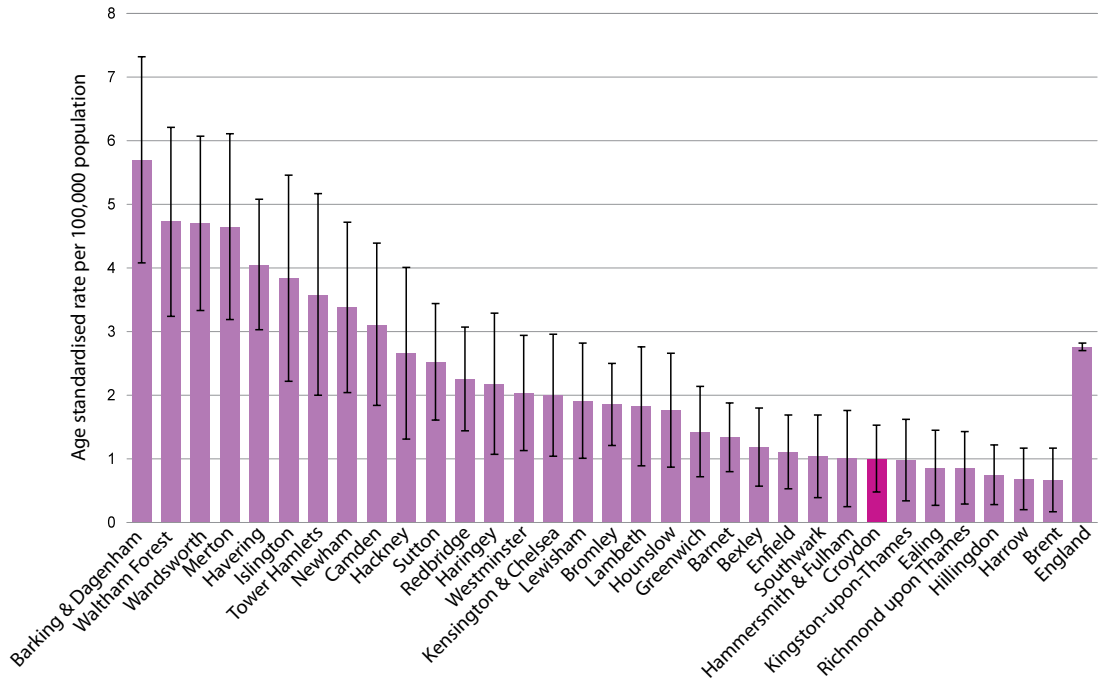
In 2008/09, 15,940 (5%) patients were registered with diabetes in Croydon GP practices. There has been an increase in the prevalence of type 2 diabetes in recent years.[26] The management of diabetes centres around normalising blood glucose (HbA1c) to between 6.5% and 7%, however there are increased difficulties with controlling blood glucose with age.[27] Damage to the blood vessels in the body caused by high blood glucose levels can result in a range of complications including eye and foot problems, cardiovascular disease, kidney disease, nerve damage and sexual dysfunction.[28] These can have a big impact on the ability to live a healthy and independent later life.

Osteoporosis

Osteoporosis is a reduction in the density of the bone, making bone more vulnerable to fracture. It typically affects older, particularly post menopausal women but it can affect men and its onset tends to be from age 40 plus. There are just under 3,000 people with osteoporosis recorded by GPs in the NHS Croydon area and 10% are men. Whilst there is a genetic component of this disease and a European and Asian predisposition toward it, ensuring a calcium rich diet, reducing excess protein and doing strengthening exercise, help to reduce the risk of onset.

Osteoporosis increases the risk of a poor outcome from a fall, because a fractured wrist, spine or hip will lead to hospital treatment or admission. Croydon compares favourably with other London boroughs and with the England average with regard to people dying as a result of fracturing the femur (thigh) bone (figure 17).

Figure 17 | mortality from fracture of the femur, London boroughs 2006-2008



Source: Compendium of clinical and health indicators

26 Quality and Outcomes Framework, 2010

27 Senior diabetes specialist nurse, personal communication, 11November 2010

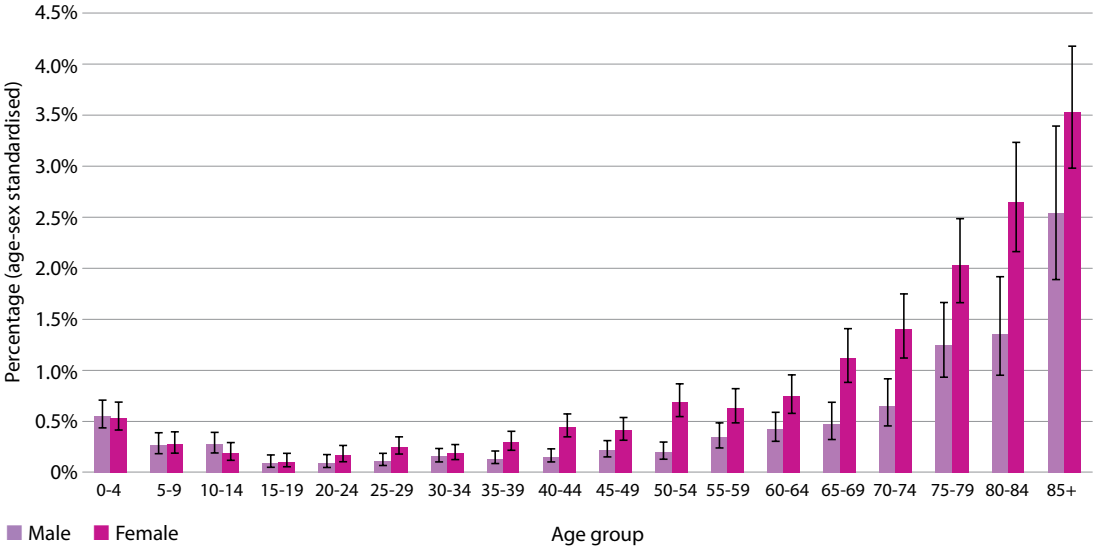
28 Diabetes UK. Diabetes in the UK 2010: key statistics on diabetes. 2010; Available from: www.diabetes.org.uk/Professionals/Publications-reports-and-resources/Reports-statistics-and-case-studies/Reports/Diabetes-in-the-UK-2010/.

Falls

Figure 18 shows that those aged over 75 visit the GP most frequently due to falls, however the problem increases significantly from age 50 onwards. Almost throughout the life span, women visit the doctor for falls more than men.

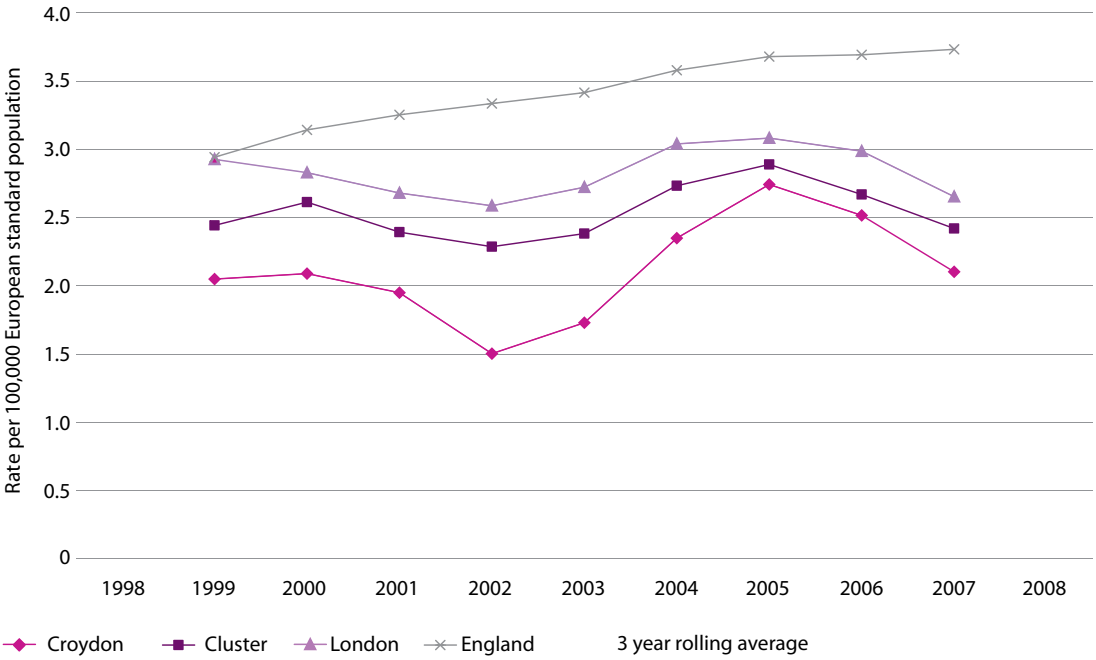
In terms of mortality from falls, Croydon is lower than the outer London Suburbs cluster and low compared with London and England (figure 19).

Figure 18 | GP visits for falls, percentage of patients by age and sex, Croydon 2009



Source: Data from Croydon general practices, 30 September 2009

Figure 19 | mortality from accidental falls, 3 year rolling average, 1998 to 2008



Source: Compendium of clinical and health indicators

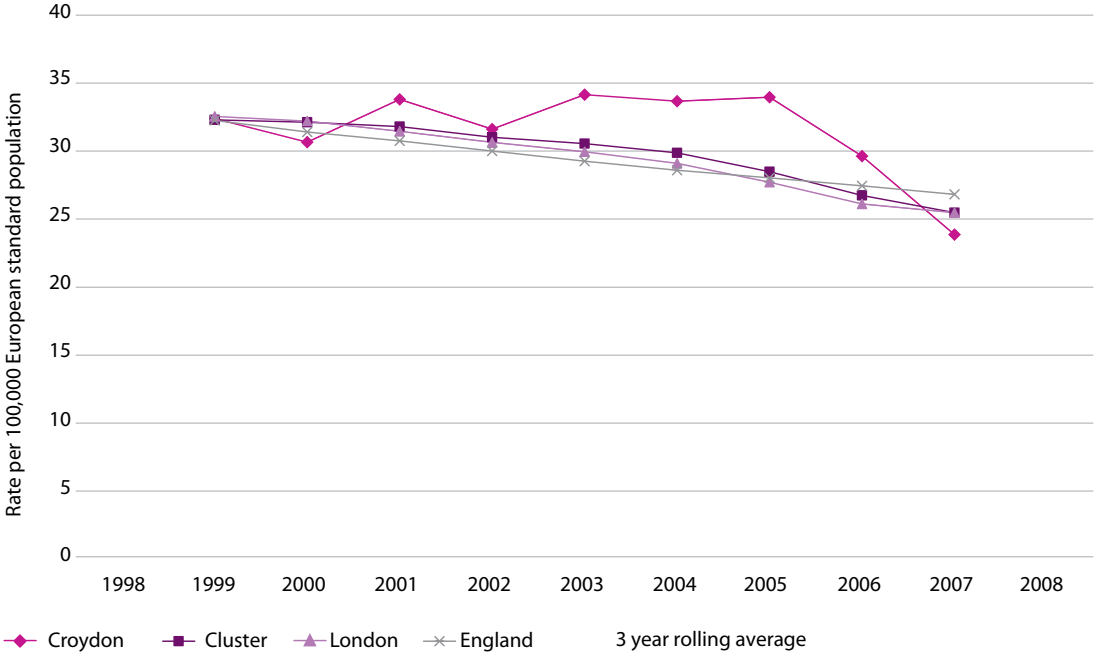
The causes of falls are multiple; they may be related to certain medical conditions, to medication being taken or may even be the result of poor layout in the home. Strength and balance training is important to help people maintain stability and flexibility as they age. In Croydon, a falls prevention coordinator works to help people stay in their homes, assessing and addressing the risk of falls.

Breast cancer

Breast cancer is the most common cancer in women in the UK. Breast cancer affects women in Croydon from age 35 and upwards, with most cases presenting in women in their mid 60s. Breast screening is a method of detecting breast cancer at a very early stage. The national screening programme calls women aged 47 to 73 for screening every three years. Uptake in Croydon, whilst improving, has always been below the 70% target and it tends to be women in the most advantaged areas that attend their appointment.[29]

Figure 20 shows that mortality from breast cancer has reduced over the last 12 years across England, London and Croydon. The mortality rate in Croydon is 23 per 100,000 women, compared with 27 per 100,000 in England. There is no significant difference in mortality between Croydon wards.

Figure 20 | mortality from breast cancer in women, all ages, 1998-2008



Source: Compendium of clinical and health indicators

Bowel cancer

About 17,000 people died from bowel cancer in the UK in 2007 and it is the second most common cause of death from cancer in the UK.[30] Bowel cancer largely affects people age 60 and over. In Croydon, cases have been found in men from the age of 40 and women from the age of 50.[31]

The national bowel cancer screening programme was introduced in Croydon in July 2007. The screening programme has been offered to men and women aged 60 to 69 but will be extended to the age of 75 by 2012. Approximately 48% of the Croydon population offered a screen have taken up the offer during the first screening round. The national minimum standard for cost effectiveness of the programme is 60%, with no area yet achieving this. National results indicate that screening is proving very effective in early detection of polyps and cancers, identifying the disease at an earlier and more treatable stage. Continuous efforts will need to be made to increase the uptake of this service.

29 Exeter (extracted using M-Connect), 31 March 2008

30 Office for National Statistics 2008.

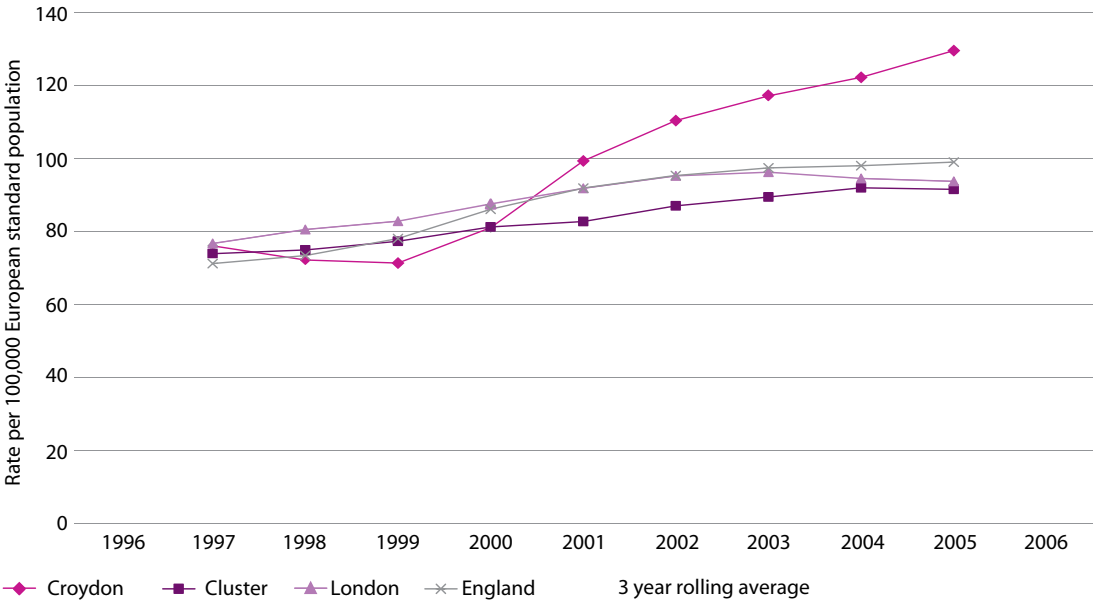
31 Data from Croydon general practices, March 2010

Prostate cancer

Nationally, prostate cancer tends to affect men from age 50 and upwards. Data for Croydon shows visits to GPs for prostate cancer begin in the mid 50s.[32] Men from Black ethnic groups are the most affected nationally and locally.[33] Numbers are low, with around 250 men visiting the GP for prostate cancer in Croydon in 2009.

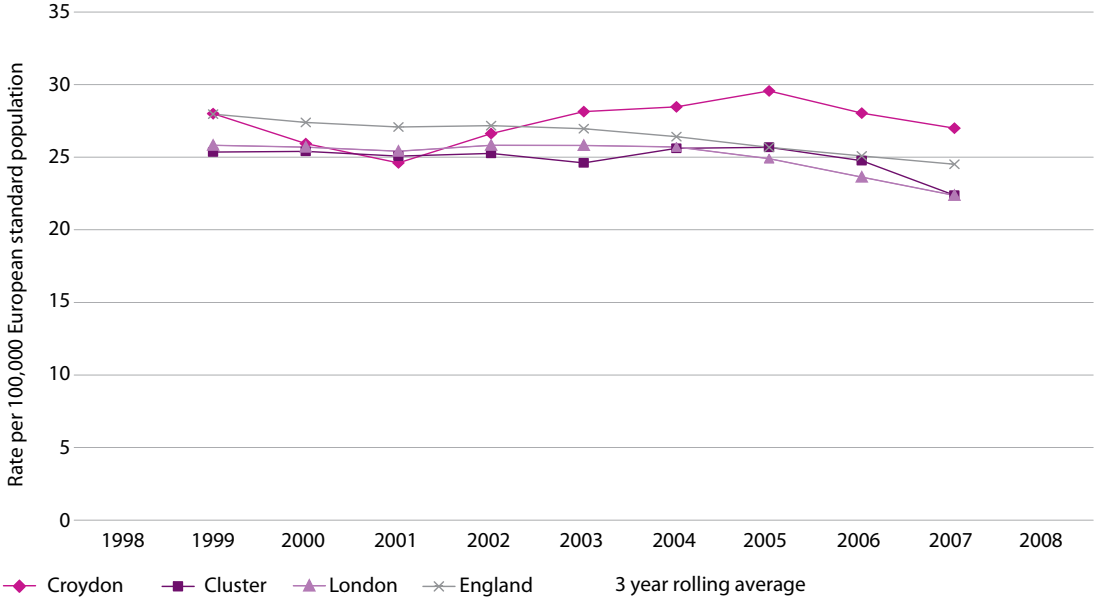
Figure 21 shows that the incidence (new cases) of prostate cancer are higher in Croydon compared with London and England. Mortality rates are also high (figure 22). This may be because patients are not accessing services when the disease is in its early stages and is more treatable or because they are not being diagnosed and warrants further investigation.

Figure 21 | incidence of prostate cancer, three year rolling average, Croydon, London Suburbs cluster, London and England, 1996-2006



Source: Compendium of clinical and health indicators

Figure 22 | mortality from prostate cancer, three year rolling average, Croydon, London Suburbs cluster, London and England, 1998-2008



Source: Compendium of clinical and health indicators

32 Data from Croydon general practices, 30 September 2009

33 Data from Croydon general practices, 30 September 2009

There is no screening programme for prostate cancer, but rather a risk management programme that aims to inform men who are concerned about prostate cancer of the advantages and disadvantages of a prostate specific antigen (PSA) test and treatment for prostate cancer. Because of the high incidence and high mortality rates, a health promotion early awareness campaign would be of value.

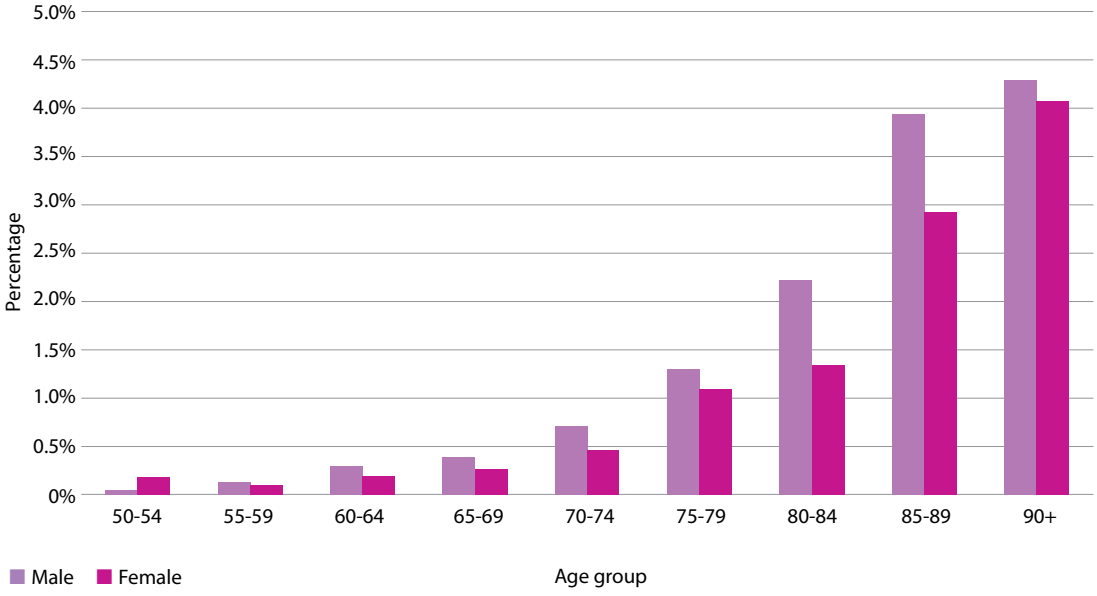
Incontinence

In the 2001 health survey for England, 7% of men and 13% of women reported having some bladder problems nationally. Both the prevalence and frequency of bladder problems increases with advancing age. Only 2% of men and 7% of women aged 16 to 24 suffered bladder problems, compared with 33% of those aged 85 and over of either sex. Under the age of 65, bladder problems were significantly higher among women than men, with similar rates thereafter for both sexes.[34]

National data showed a small increase in overall prevalence and frequency of bladder problems between 1995 and 2001. Over the same period, there has been a large and significant increase in the percentage of men with bladder problems in England consulting one or more health professionals. It is possible that the large increase in men consulting with bladder problems is related to a greater public awareness of the risk of prostate cancer.

Figure 23 shows that the percentage of people having contact with continence services in Croydon increased dramatically in those aged over 85 and that more men used the services than women in all groups aged 55 and over.

Figure 23 | percentage of people having contact with continence services, Croydon 2009/10



Source: Contacts with continence services from Epex; ONS mid 2009 population estimates

34 Health Survey for England 2001

Disabilities and sensory impairment in later life

Physical disability

The Health Survey for England 2001 focused on disability.[35] Eighteen per cent of people aged 16 and over in England reported having at least one disability and 5% reported having a serious disability. The prevalence and severity of disability increased steadily with age, so that the average age of adults without a disability was 44 years and for those with one or more disabilities it was 62 years.

Up to the age of 55, the proportions reporting at least one disability were similar for men and women. Between the ages of 55 and 74, disability prevalence was slightly higher for men but did not reach statistical significance. From age 75 onwards, this gender difference was reversed, with rates for women aged 75 to 84 being significantly higher than for men (51% versus 43%). The type of physical disability experienced included the ability to walk 200 metres, climb 12 stairs without resting and retrieve things from the floor.

Inability to perform self care tasks or activities of daily living without help is widely used in social surveys as a measure of physical dependency. Six per cent of men and 7% of women had a personal care disability, with 1% unable to perform any of six tasks associated with activities of daily living without help. The proportions needing help with washing, feeding and getting to or using the toilet were small (1%).

Overall, just over half (55%) of men and women with any disability had one disability, a third had two disabilities and about a tenth had three or more disabilities. There is a steady increase with age in the prevalence of multiple disabilities.

The number of people who receive disability related and other services from the council is one way to estimate the number of people who have disabilities that impact on their way of life. Because of thresholds for assessment and provision of services, the number in receipt of services is a small sample of those with a disability and should not be interpreted as a very accurate reflection of need. In addition to this, there are also disabled people aided through the voluntary sector and others who are wholly cared for by the health service. Current data from the council shows that around 6,800 people aged 65 or over say they need support with mobility tasks, 66,000 people over the age of 60 have a freedom travel pass, 11,000 are blue badge holders and 6,500 are current wheelchair users.[36] In 2009/10, the council supported 6,783 people aged 65 and over. Of these, about 5,900 were helped to live independently and 880 were supported in residential and nursing placements. In addition, a further 275 people aged 65 and over received direct payments.[37]

Learning disability

Due to increasing awareness of health problems associated with learning disabilities, and improved care, people with learning disabilities have a longer life expectancy than previously.[38] This population will require additional support as they age, perhaps have to care for parents and as they live independently of the care system.

GPs now keep a record of their patients with learning disability (figure 24). This helps with regular review of medical and health care needs. Croydon has a recorded learning disability prevalence of 0.4% on GP registers, with an estimated national prevalence of 2%.[39] There is therefore some under recording of learning disability in primary care. Previous patterns of commissioning residential care in the borough may mean that there are higher than expected numbers of people with learning disability who will need support as they age and it is therefore important to improve recording in primary care.

35 Health Survey for England 2001

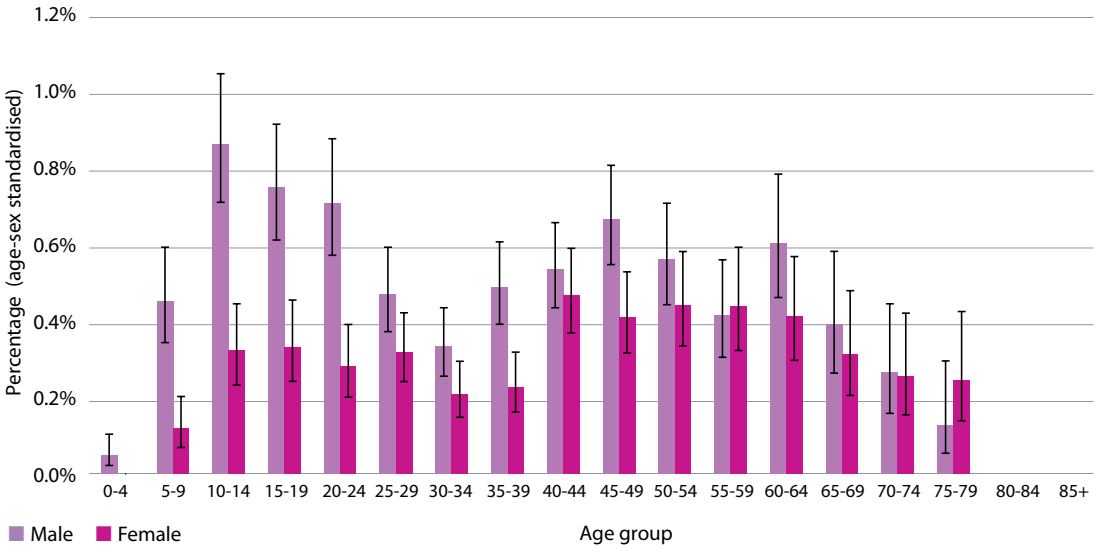
36 Croydon Council, department of adult services and housing

37 Croydon Council, department of adult services and housing service plan 2009/10.

38 Foundation for People with Learning Disabilities www.learningdisabilities.org.uk

39 British Institute of Learning Disabilities. Factsheet – learning disabilities. Kidderminster: British Institute of Learning Disabilities; undated; Available from: www.bild.org.uk/docs/05faqs/Factsheet%20Learning%20Disabilities.pdf.

Figure 24 | GP recorded prevalence of learning disability by age and sex, Croydon 2009



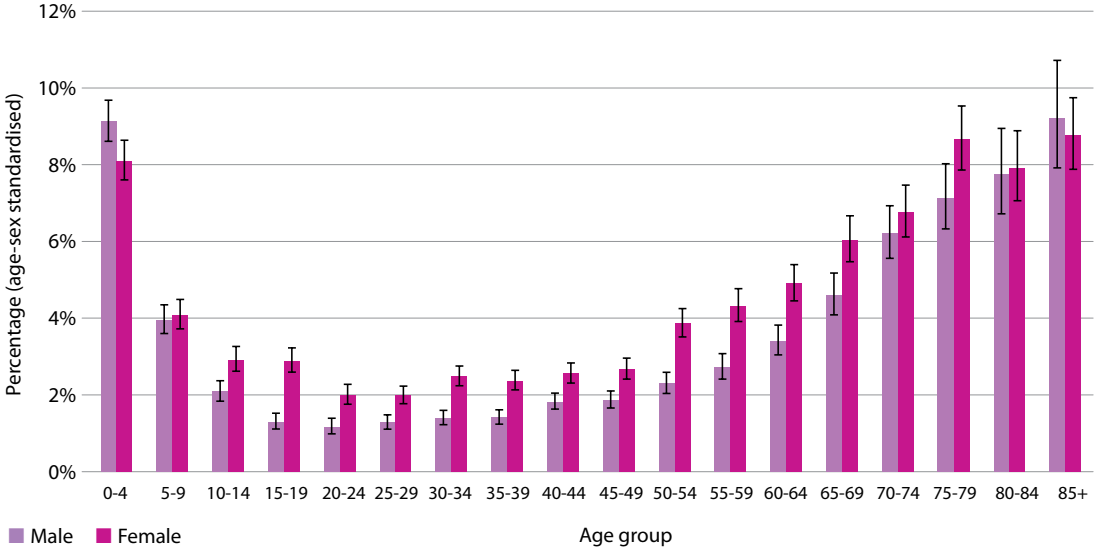
Source: Data from Croydon general practices, December 2009

Sensory impairment

As may be expected, the number of recorded visits to the GP for eye health increases with age (figure 25). There is also a gender difference, with more females visiting the GP than males in most of the age groups.

There are several eye related problems that are more common amongst people as they age. Glaucoma is an eye disease that damages the optic nerve and impairs vision. Nationally, it occurs in 1% to 2% of White people aged over 40 years, rising to 5% at 70 years.[40] Glaucoma is more prevalent, presents at a younger age, is more difficult to control and is the main irreversible cause of blindness in Black populations, especially those of West African origin. Glaucoma related blindness is responsible for 8% of new blind registrations in the UK.[41] The pattern of GP visits for glaucoma in Croydon mirrors the UK picture in terms of age (figure 26). Because people with glaucoma experience no symptoms or pain, regular eye checks are important.

Figure 25 | percentage of patients visiting GPs for diseases of the eye by age group, Croydon 2009

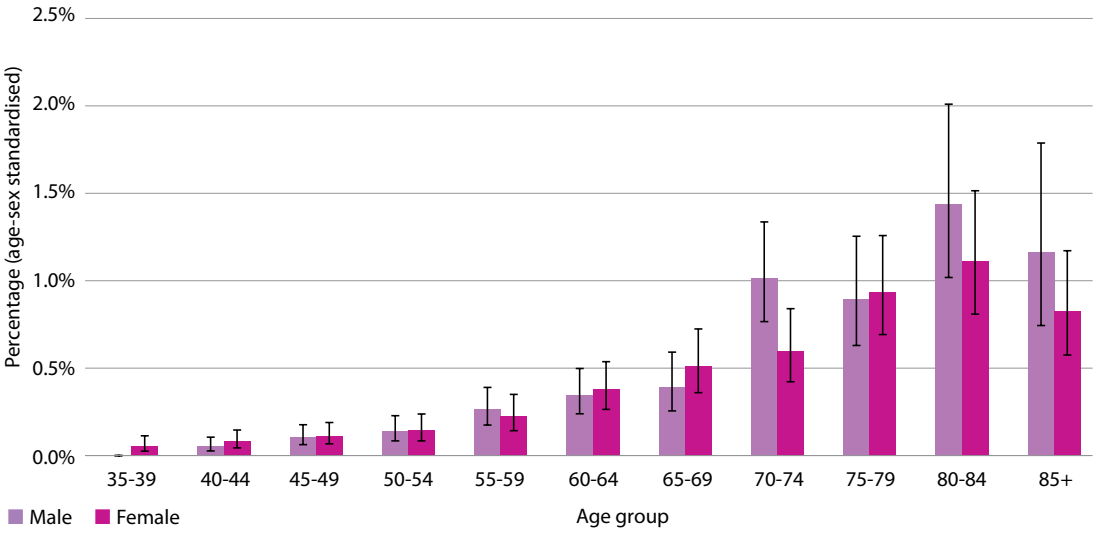


Source: Data from Croydon general practices, 30 September 2009

40 Royal National Institute for the Blind. Glaucoma. [cited 2011 15 February]; Available from: www.rnib.org.uk/eyehealth/eyeconditions/eyeconditionsdn/Pages/glaucoma.aspx.

41 ibid.

Figure 26 | percentage of patients visiting GPs for glaucoma by age group, Croydon 2009

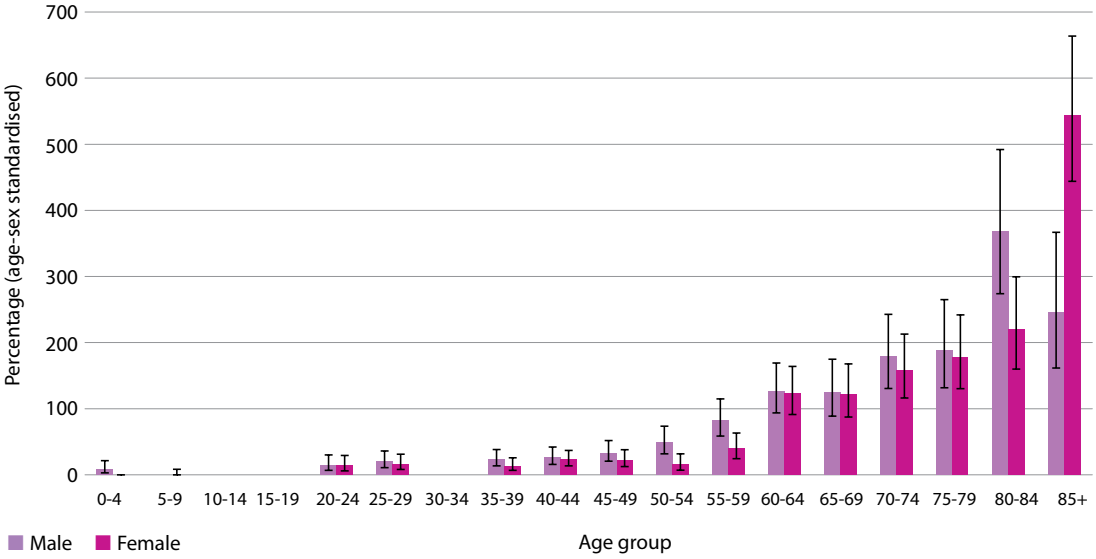


Source: Data from Croydon general practices, 30 September 2009

Macular degeneration, also known as age related macular degeneration, is the leading cause of vision impairment in those aged 65 and above. Age related macular degeneration can be part of the body's natural ageing process or it can be inherited. It is caused by damage to the macula, the small part of the retina that gives sharp, straight on vision. It may cause blurred, distorted vision, often with large blank spots in the central area of sight. Very rarely does the disease cause total loss of sight but the partial loss of sight can be disabling and lead to a loss of independence in later life.

Figure 27 shows that hospital admission rates for eye disorders increase with age. This may be related to better case finding or reflect the availability of new treatments provided by the NHS over the last few years.

Figure 27 | hospital admissions for eye disorders by age and sex, Croydon 2004/05 to 2008/09

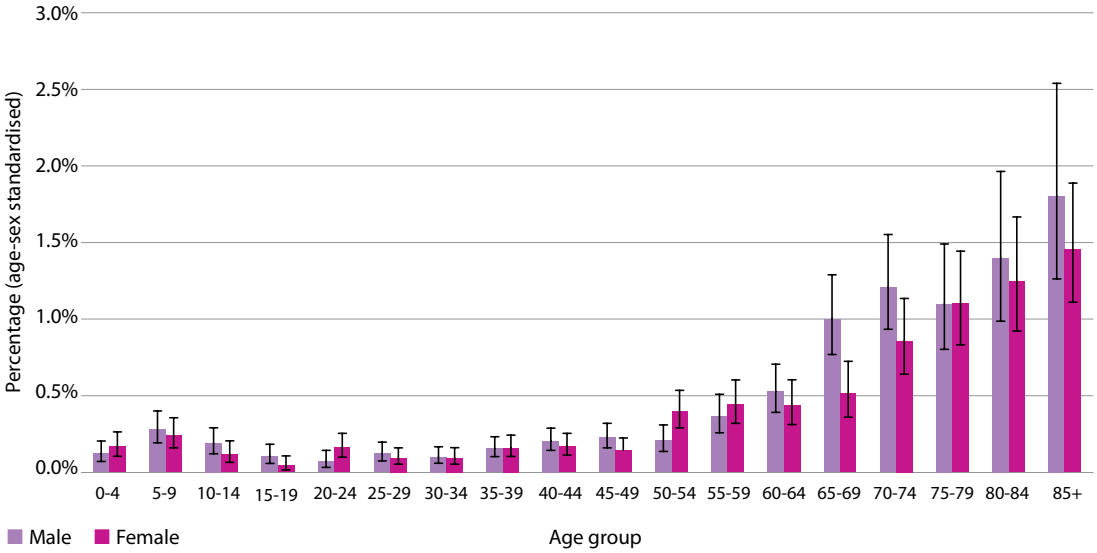


Source: Secondary Uses Service

Hearing loss affects over half of people over 60 years old nationally, making it the second most common disability in older people.[42] The degree of disability varies greatly, as does people's response to coping with the hearing loss. In Croydon, the percentage of patients visiting the GP for hearing loss increases with age (figure 28).

Although the main cause of hearing loss is ageing, there are other factors to consider. Some people may have a genetic predisposition, while diet and lifestyle may also have a role to play. Exposure to noise in earlier life will hasten the onset of noticeable hearing loss and a history of middle ear disease may also contribute. Other aggravating factors include medication frequently prescribed in later life (such as diuretics) and osteoporosis. Research has shown that hearing deterioration tends to halt at around the age of 70.[43]

Figure 28 | percentage of patients visiting GPs for hearing loss by age and sex, Croydon 2009



Source: Data from Croydon general practices, September 2009

Mental health and well being in later life

Maintaining mental health is as important as maintaining physical health. Fears about the future, declining physical health, employment status, feeling part of a community or neighbourhood and a changing role in the family can impact on mental health as people age. Positive attitude, aspiration, and feeling good about the future is important at any age.

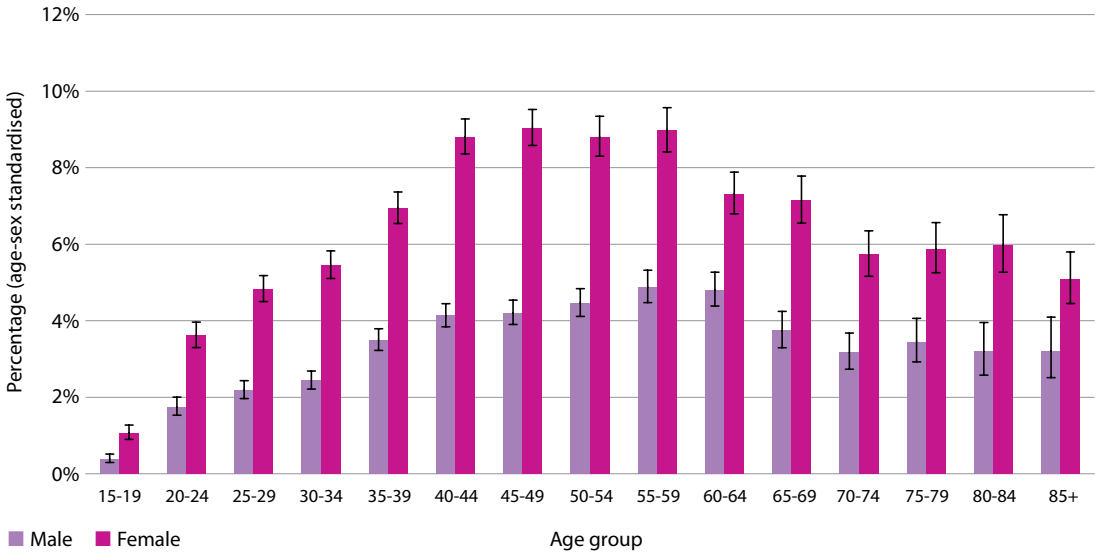
Depression

Local GP data shows a significant gender difference in recorded prevalence of depression (figure 29). There is also a different pattern in age, with a peak between 45 and 59 for women and late 50s to early 60s for men. Whilst this may reflect a different pattern of use of GP services between men and women, it may also reflect the impact of life events occurring at different times for men and women.

42 Royal National Institute for the Deaf www.rnid.org.uk/information_resources/aboutdeafness/statistics

43 Deafness Research UK. Age-related hearing loss. www.deafnessresearch.org.uk/

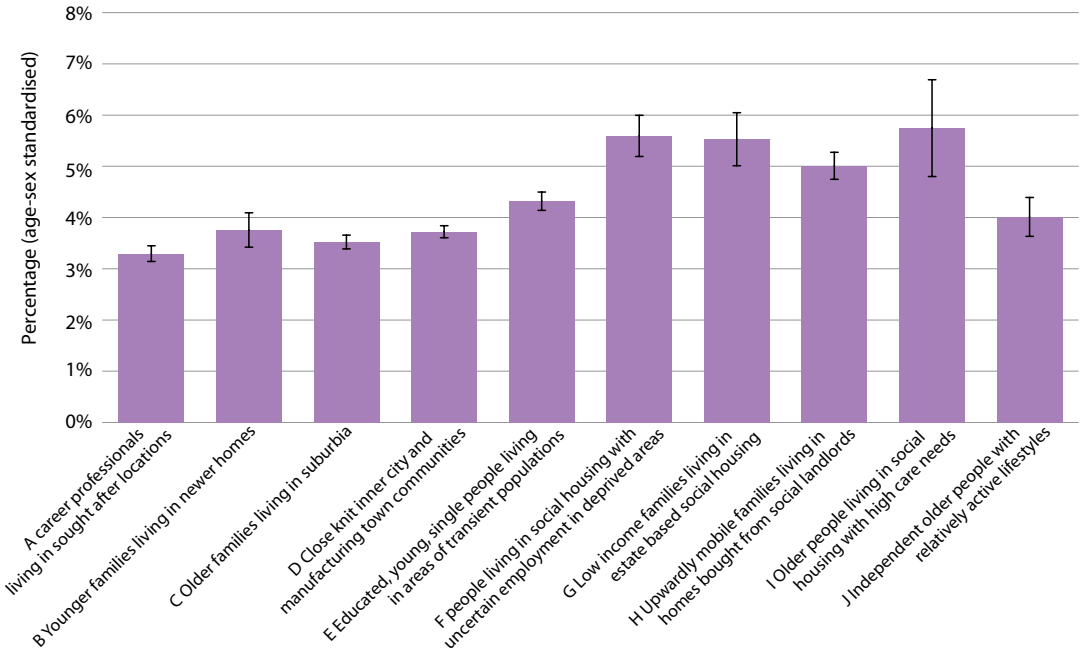
Figure 29 | GP recorded depression prevalence by age and sex, Croydon 2009



Source: Data from Croydon general practices, 31 December 2009

The Mosaic classification tool divides the UK population into 69 types and 15 groups. It uses 440 different pieces of information about people's lives from a range of public and private sector datasets to build a comprehensive picture of the common characteristics of people living in an area. Figure 30 shows depression prevalence by Mosaic group. Older people living in social housing suffer most recorded depression, with wealthier older people appearing not so likely to present to the GP with depression. This helps give an indication of where to target services and interventions.

Figure 30 | GP recorded depression prevalence by Mosaic group, Croydon 2009



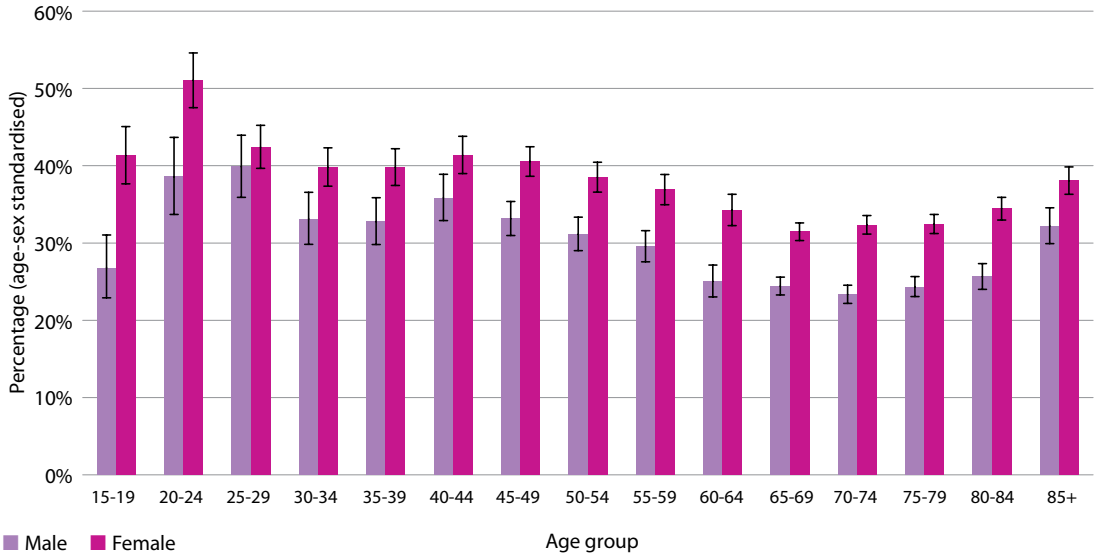
Source: Data from Croydon general practices, 31 December 2009

In Croydon, White British, White Irish people and women from mixed ethnic backgrounds have the highest rates of GP recorded depression.[44]

44 Data from Croydon general practices, 31 December 2009

There is a contrast between GP recorded depression and self reported depression recorded in the 2002 to 2008 local patient surveys. Figure 31 shows a more even spread of self reported depression throughout the age groups and the difference between men and women is less pronounced. Self reported depression is also more evenly spread among the ethnic groups than that recorded by GPs but there is a stronger association with lower socio economic status.[45]

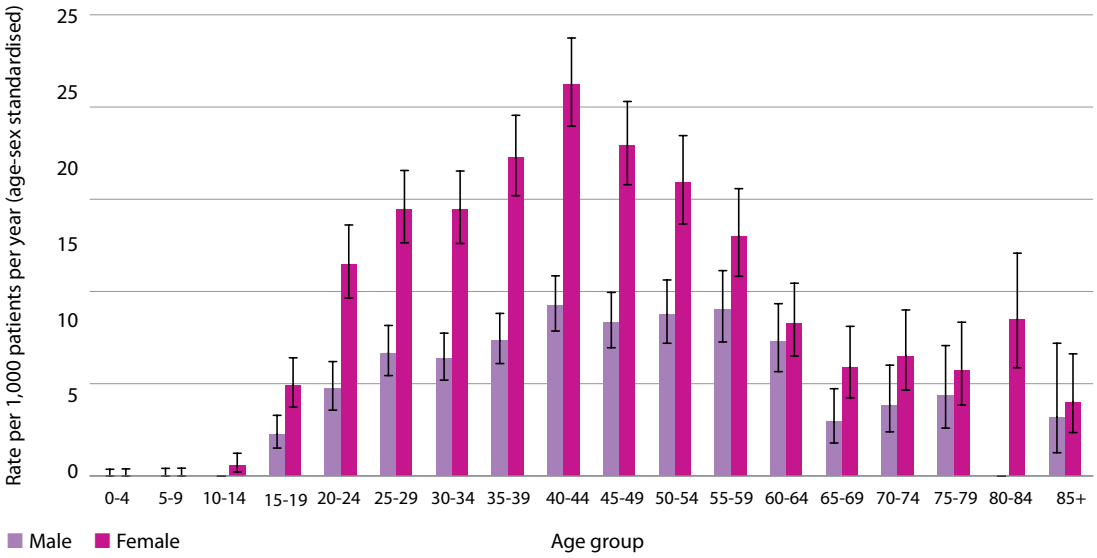
Figure 31 | percentage of people with self reported depression by age and sex, Croydon 2002-2008



Source: Croydon patient surveys, 2002-2008

GP visits for mood disorders (mania, bipolar disorder, and some depressions) follow a similar pattern of gender, ethnicity and age, although the gender difference is even more pronounced, with females visiting much more often than males (figure 32).

Figure 32 | GP visits for mood (affective) disorders by age and sex, Croydon 2009

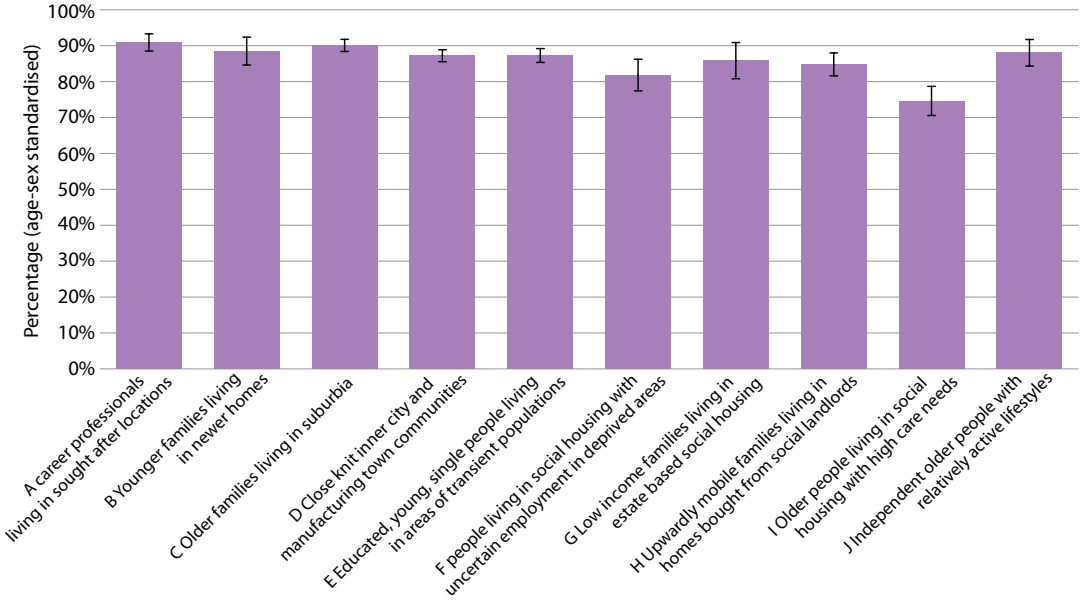


Source: Data from Croydon general practices, visits per 1,000 patients in the last year, 30 September 2009

A high percentage of people in most of the Mosaic groups in Croydon appear satisfied with their life. The one group who appear significantly less satisfied are older people living in social housing with high care needs (figure 33).

45 Croydon patient surveys, 2002-2008

Figure 33 | percentage of people neutral or satisfied with their life as a whole by Mosaic group, Croydon 2002-2008



Source: Croydon patient surveys, 2002-2008

Dementia

The term 'dementia' is used to describe the symptoms that occur when the brain is affected by specific diseases and conditions. Symptoms of dementia include loss of memory, confusion and problems with speech and understanding.[46]

Nationally, the prevalence of early onset dementia is higher in men than in women for those aged 50–65, while late onset dementia is marginally more prevalent in women than in men. This pattern is true of Croydon, as more men than women in their 60s have recorded dementia, and more women than men have a recorded case of dementia from age 75 and upwards. Alzheimer's disease is a type of dementia which particularly affects older people.

GP data shows 1,336 people registered with dementia in 2009/10, compared with estimated prevalence figures of 3,052, indicating there may be a large number of persons with dementia in Croydon who are not diagnosed or in receipt of services.[47]

Among Black and minority ethnic groups in the UK, 6.1% of cases are early onset compared with only 2.2% for the UK population as a whole, reflecting the younger age profile of Black and minority ethnic communities. Dementia amongst Black and minority ethnic communities in the UK is under researched; there is likely to be much misdiagnosis at present and standardised assessment tools may not be culturally specific enough to provide accurate diagnosis.[48] In addition, whilst acquiring a second language is thought to delay onset of dementia, the loss of a second language that is used on a daily basis due to dementia is an added consideration for an ageing minority population in Croydon.

Age is the most important risk factor for dementia. Other risk factors include heart disease, stroke, hypertension, obesity and diabetes, which increase the risk of both vascular dementia and Alzheimer's disease. Rising rates of diabetes and an ageing population of diabetics in Croydon has implications for increased numbers of people with dementia in the future, above and beyond the numbers one would expect for an ageing population. Depression has also been shown to increase risk, as has past head injury which can double the risk in men. Recently, nicotine has been shown to increase the risk and bring forward age of onset (with a genetic interactive effect).[49]

46 Alzheimers Society www.alzheimers.org.uk (cited 2010 21 December)

47 NHS Employers, BMA General Practitioners Committee. Quality and outcomes framework guidance for GMS contract 2009/10: delivering investment in general practice. London: NHS Employers; 2009.

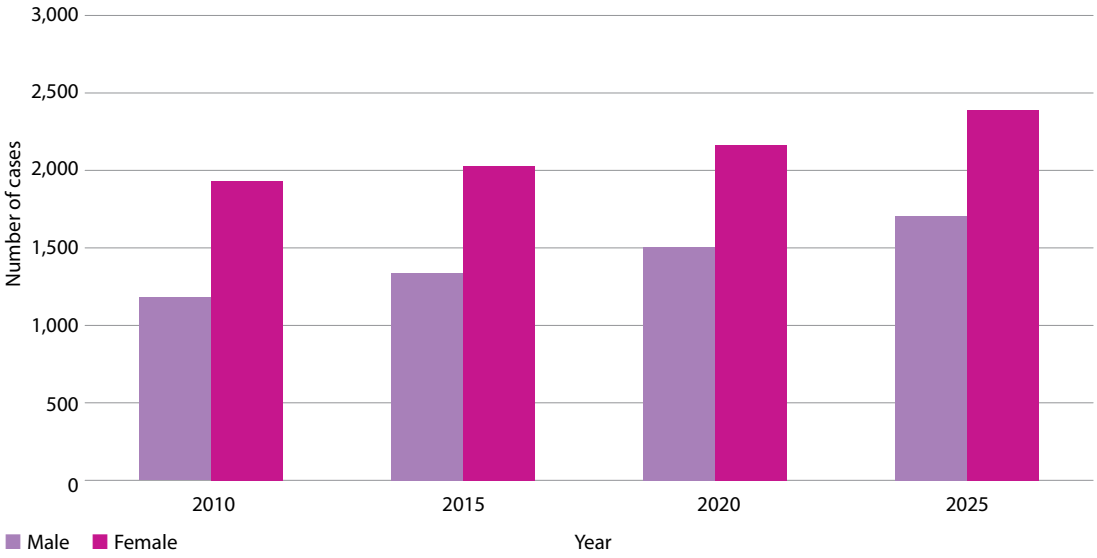
48 Lane P, Hearsum S. The mental health and well being of black and minority ethnic elders: a foundational report on the research literature and a mapping of national resources: CSIP West Midlands; 2007. Available from: www.nmhdu.org.uk/silo/files/bme-report.pdf.

49 Ritchie K, Carriere I, Ritchie CW, Berr C, Artero S, Ancelin ML. Designing prevention programmes to reduce incidence of dementia: prospective cohort study of modifiable risk factors. BMJ. 2010;341:c3885.

In a recent study, 7% of cases were attributable to genetics and 18% to a low reading score. [50] A higher reading test score demonstrates an important protective factor. Participation in cognitively stimulating activities and an active socially integrated lifestyle have been shown to delay onset of dementia. High consumption of fish and vegetables, moderate consumption of alcohol and consumption of caffeine are all possible preventive factors. In the aforementioned study, eliminating depression and diabetes and increasing fruit and vegetable consumption would have led to a 20.7% reduction in incidence of dementia, with 10% of this result attributable to depression.[51] Interventions should be targeted at those most at risk from modifiable risk factors.

The World Alzheimer Report 2010 estimates the future costs associated with an ageing population worldwide.[52] With an estimated 0.5% of the world's population currently living with dementia, the report estimates that by 2030, costs will increase by 85% from today's baseline. Figure 34 shows the estimated future numbers of people with dementia in Croydon is increasing. Evidence based interventions, including care giver support and training and respite care, should be routinely provided but are not, even in high income countries. The report notes that affordable social and health care packages must be urgently developed to meet escalating costs and need.

Figure 34 | estimated future numbers with dementia, Croydon 2008-2025



Source: Mental Health Observatories: mental health brief No 3, May 2008

Social factors and later life

This section looks at different areas of life that impact on us as we grow older. Moving into later life is often a time of transition in terms of changing responsibilities for caring, changing economic and social circumstances and living with conditions or disabilities.

The way we feel about ourselves is affected by our changing circumstances in life, meaningful occupations, social participation and life events. For some, ageing can mean their circumstances change negatively. They may find they are living in poverty and deteriorating health can lead to increased isolation. This can lead to rising costs for health and social care support. For others, ageing will not bring such negative changes in their circumstances. The diversity of people in older age groups and the different areas where support might be needed should be given consideration in planning services.

50 ibid.

51 ibid.

52 Wimo A, Prince M. World Alzheimer Report 2010: the global economic impact of dementia. London: Alzheimers Disease International; 2010.

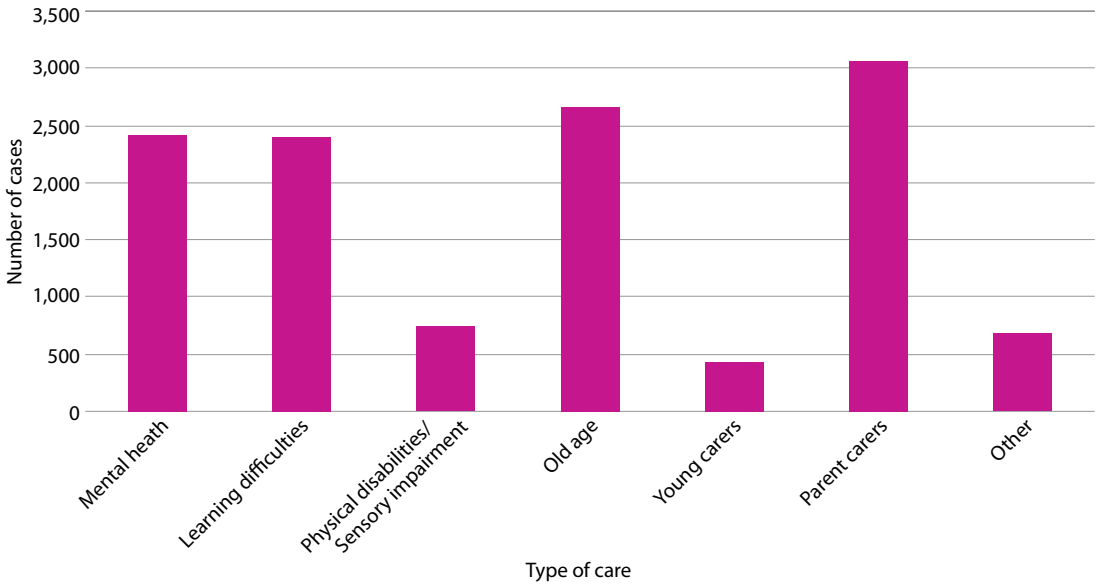
Caring

Caring can be continuous throughout life for a partner or child with a disability but it is also frequently part of the ageing process, as parents begin to need care. This may or may not be combined with looking after children. The vast majority of people caring for relatives do so themselves without recourse to state services. Almost three million people aged 50+ provide unpaid care in the UK and 5% of those aged 85 plus also provide unpaid care.[53]

Caring at any age, whether of children, a partner or relatives impacts on an individual's ability to have a job and to pursue interests including education and social activities. Having some sort of support through the state sector, voluntary sector or a social circle enables a carer to maintain their own physical resilience and good mental health. An unwell ageing population will be an increased burden on carers, increase the number of carers and impact on demand for services.

State support for carers is provided both directly from the council and via the voluntary sector and includes respite care, advice and information on benefits, and help with household tasks. In order to access state funded carers' services, a person will need to be in receipt of services elsewhere, on a carer's allowance or the person they care for in receipt of disability living allowance. If they are assessed as being at a critical and substantial level of need, then they will be entitled to statutory provision. Figure 35 shows that the majority of carers receiving services in Croydon are parent carers, but the second largest group are those caring for older relatives.

Figure 35 | numbers in receipt of state funded carers services (voluntary sector and council provision) by carer type, Croydon 2009/10



Source: Croydon Council department of adult services and housing

In 2009, most carers in receipt of a service were between 16 and 64, however there were also many carers aged over 65 and more than 2,000 aged over 75.[54] Given increasing life expectancy and increasing numbers of older people, this is a trend set to continue.

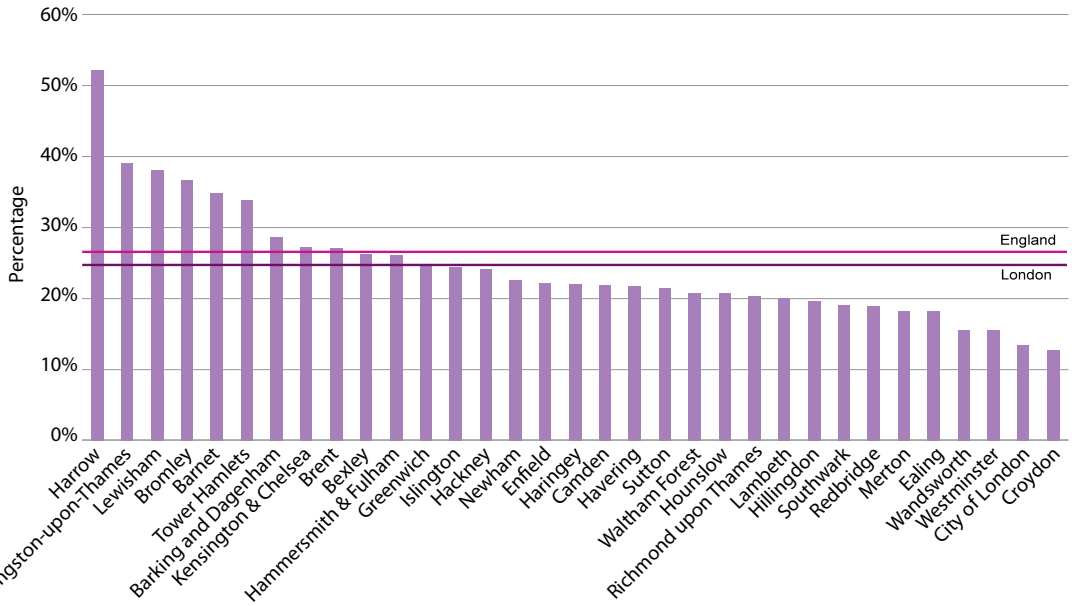
Adequate support and information for carers helps them to manage the impact of caring on their lives. The percentage of carers being supported with services, advice and information in Croydon is 12.7%, significantly below the London average (24.6%) and the England average (26.4%) (figure 36).[55]

53 Soule A, Baab P, Evandrou M, Balchin S, Zealey L. Focus on older people. Norwich: The Stationery Office; 2005.

54 Croydon Council department of adult services and housing, 2010.

55 Percentage of carers receiving needs assessment or review and a specific carer's service or advice and information (NI 135) 2009/10. Information Centre for Health and Social Care.

Figure 36 | percentage of carers receiving needs assessment or review and a specific carer's service, or advice and information in Croydon compared with London boroughs, London and England, 2009/10



Source: National Indicator 135, floor targets interactive website (www.fti.communities.gov.uk)

Employment and financial planning

Nationally about 9% of people over retirement age still work. Many stay in work for financial reasons and many because they enjoy working. Due to the increasing retirement age, people entering their 50s in the next few years will have to work longer than those retiring now to receive their pension. Although welcome for some, others may not feel well enough to continue to work and some may not be able to afford to give up work. Maintaining physical fitness and mental wellbeing in order to continue to work will become increasingly important. There are many factors which improve effective working for older workers and enable them to work longer. These include adequate training, work scheduling and flexible working to avoid overwork, reduction in the manual handling components of jobs and proactive occupational health services.

In 2007, only one in ten non working men aged between 50 and 65 were unemployed, the others were economically inactive, for example retired, sick or caring for others. Of those not seeking work, approximately half were in receipt of sickness or disability benefit (over one million people) and nearly half a million, mainly women, were full time carers. Individuals in this age group are more likely to experience low self esteem, ill health and poverty. Thirty seven per cent of 55 to 64 year olds say they have a limiting long term illness. Depression, social exclusion, and marital problems are also more common in this age group. Most of those not working have been out of employment for long periods, many having previously been in long standing jobs. Involvement in other activities (such as charitable work) is also declining in this age group.[56]

More than two million older people in the UK live below the poverty line and measures to assist these groups include a minimum pension guarantee, pension credit, winter fuel payment and other benefits for over 75s. More people rely on benefits over the age of 65 (a third of 55-64 year olds). Conversely, 69% of 65 to 74 year olds own their home outright, and 80% of the private wealth in the UK is owned by over 65s.[57] Twelve million people, half the UK workforce, are not saving for a pension and only 47% of men and 38% of women contribute to a private pension scheme.[58] Financial planning for later life needs to start at an earlier age and people need advice on complex longer term investments, for example pensions tied to care packages.

56 Black C. Working for a healthier tomorrow: Dame Carol Black's review of the health of Britain's working age population. London: The Stationery Office; 2008.

57 Harris M. Preparing for ageing: research summary. London: NESTA; 2009.

58 ibid.

There is financial and welfare benefits advice available to older people in Croydon. Croydon Age UK provides an outreach money and debt advice service. The Partnership for Older People service and Croydon welfare benefit team both offer welfare benefit advice and www.croydoncrunch.com includes information about unemployment, available benefits and managing money, targeted at older people. Croydon Credit Union is an ethical savings and loans cooperative regulated by the Financial Services Authority. It helps people of all ages borrow affordably and promotes saving.

Fuel poverty

Fuel poverty occurs when a household has to spend more than 10% of its income on domestic fuel to maintain a reasonable level of warmth. Fuel poverty impacts on the ability of an individual to spend their income in other ways, including transport, leisure and food, and therefore has an impact on both physical and mental health.

Fuel poverty in England has risen from 5.9% (1.2 million) of households in 2003 to 13.2% (2.8 million) of households in 2007. In 2007, one in five households with at least one person aged 60 or over were in fuel poverty, a quarter of all fuel poor households had at least one occupant aged 75 or over and just over half of all fuel poor households had an occupant who is aged 60 or over.[59] Although there is no data for Croydon, the England data suggests that those over 60 and single people under 60 are the most likely to be in fuel poverty locally.

As well as the winter fuel payments made by the Government for those over 60 in times of prolonged cold weather, there are schemes in Croydon which help vulnerable and low income residents overcome fuel poverty. These include cavity wall insulation, the Coldbusters grant scheme for energy efficient heating and insulation measures and the Houseproud scheme which enables people to take out a loan against their house to carry out improvements, including insulation measures.

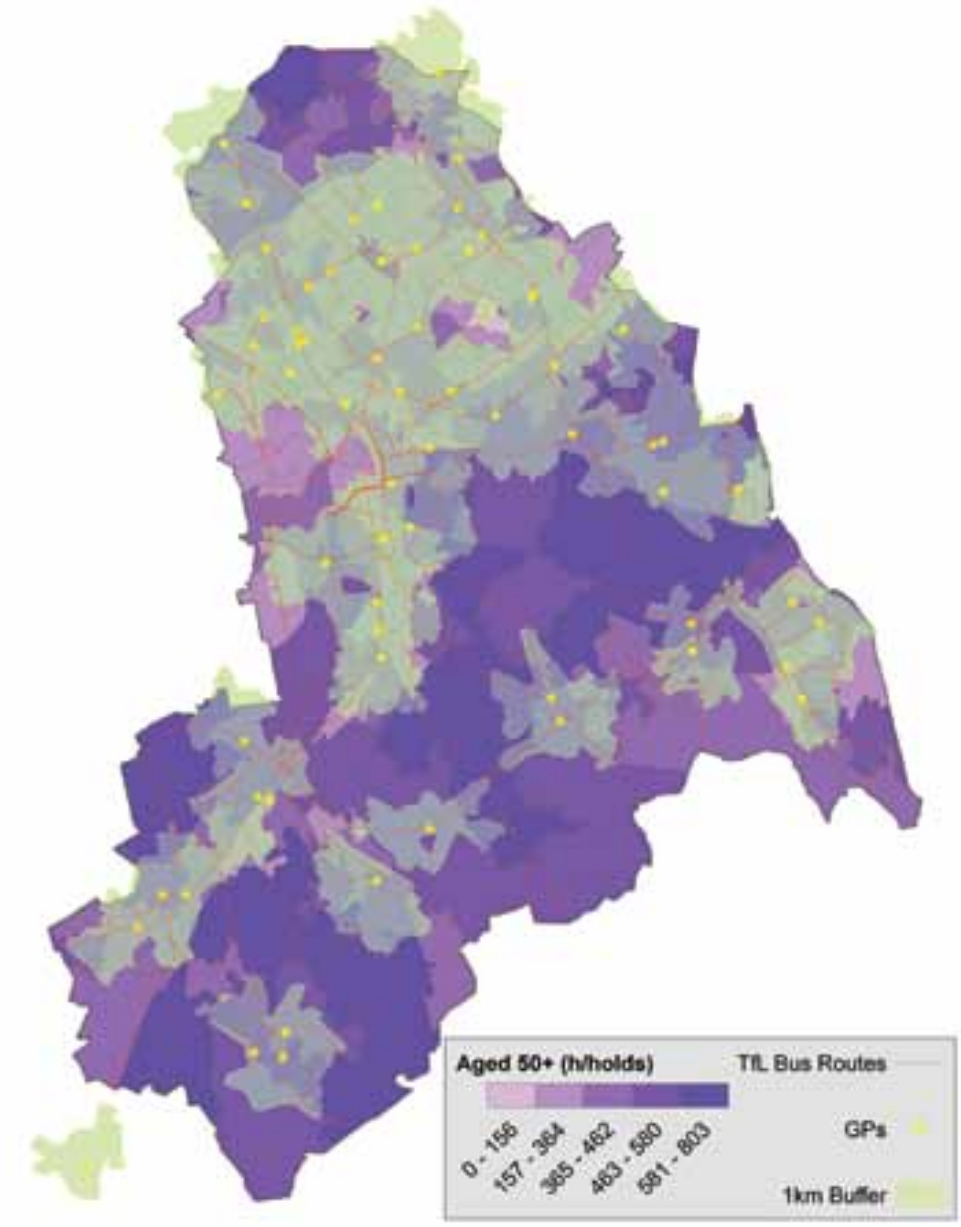
Access to services

Easy access to health and other services is essential in maintaining independence and health in later life. Figure 37 shows that whilst there are areas where the over 50 population is not within a kilometre of a GP's premises, there are accessible bus routes. Comparisons with households who do not own a car show that there are some areas where there are higher numbers of over 50s and no accessible bus route (figures 37 and 38). The 2009 needs assessment of 55 to 65 year olds commissioned by Croydon Council showed that the car is the preferred mode of transport for accessing services.[60]

59 Office for National Statistics 2010

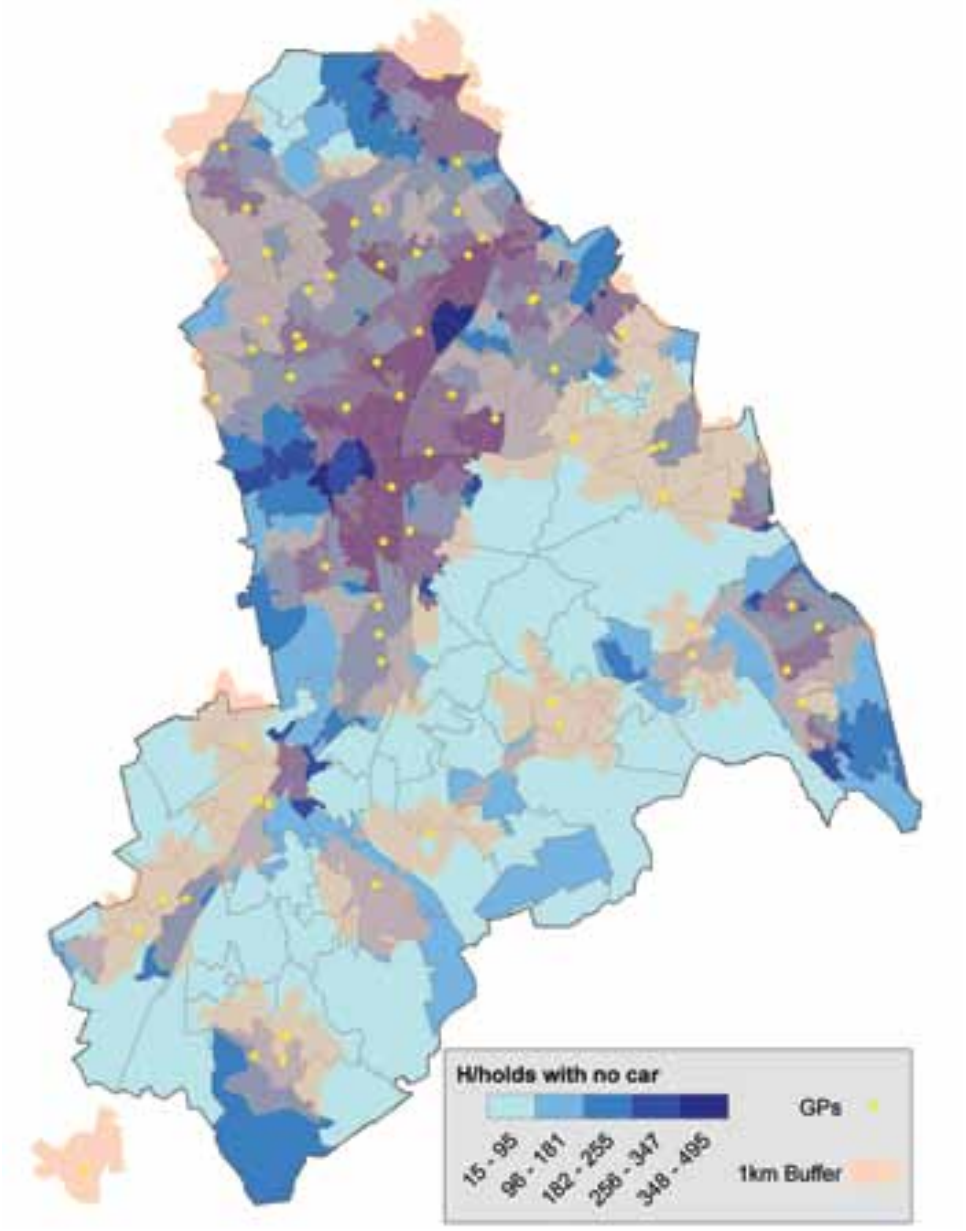
60 Methods Consulting. *Needs assessment for older people in Croydon*. September 2009. Available from the Healthy Croydon Support Unit, 020 8760 5773

Figure 37 | households aged over 50 and distance from GP and bus routes, Croydon 2010



Source: Croydon Council

Figure 38 | households aged over 50 with no car and distance from GPs, Croydon 2010



Source: Croydon Council

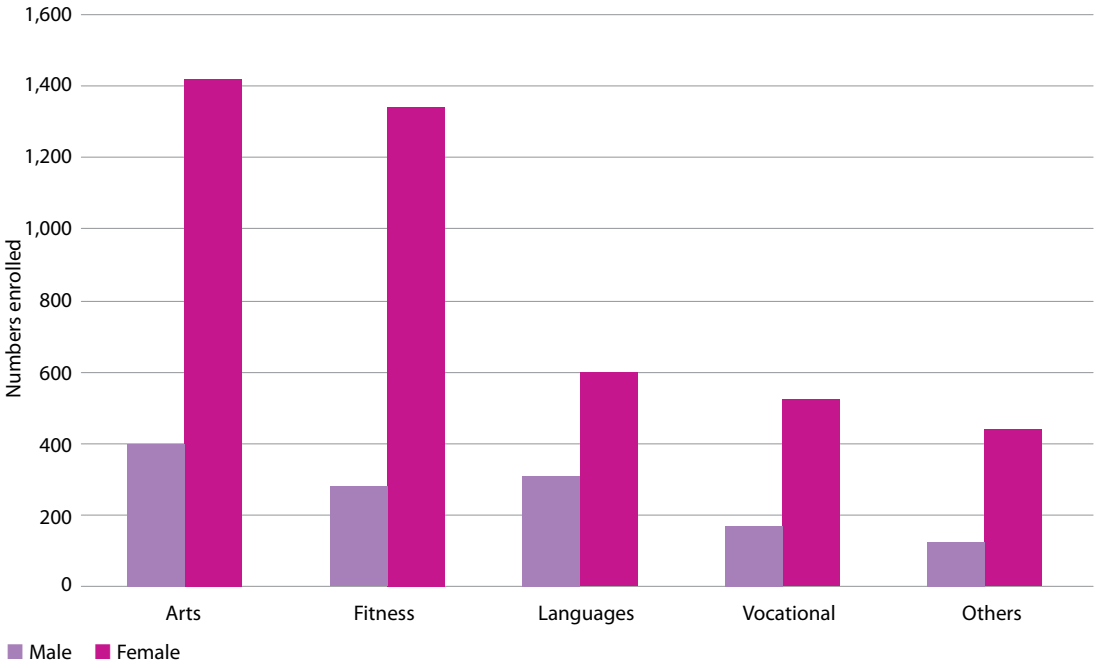
Leisure and education

Involvement in a range of leisure pursuits has potential to contribute to living well in later life by helping to maintain mental and physical wellbeing and avoiding isolation. Older people make use of a range of leisure activities and services in Croydon. These are provided by the council, voluntary and private sectors and include activities ranging from bingo to walking groups.

Local adult education data for 2009 shows a wide range of ages over 50 taking courses in Croydon, with more women than men taking courses.[61] Figure 39 shows that those over 50 take a mix of courses, with the greatest number taking a variety of arts courses, for example painting and furniture upholstery. Fitness classes include dancing, yoga, tai chi and pilates. Languages are taken at all levels and include British sign language and lip speaking courses and community interpreting. The majority of people taking vocational courses leading to certificates and other qualifications tend to be at the younger end of the over 50s age spectrum, although there are people in their 80s learning information technology and how to use their computer.

61 Croydon Adult Learning and Training (CALAT), Croydon Council 2009/10.

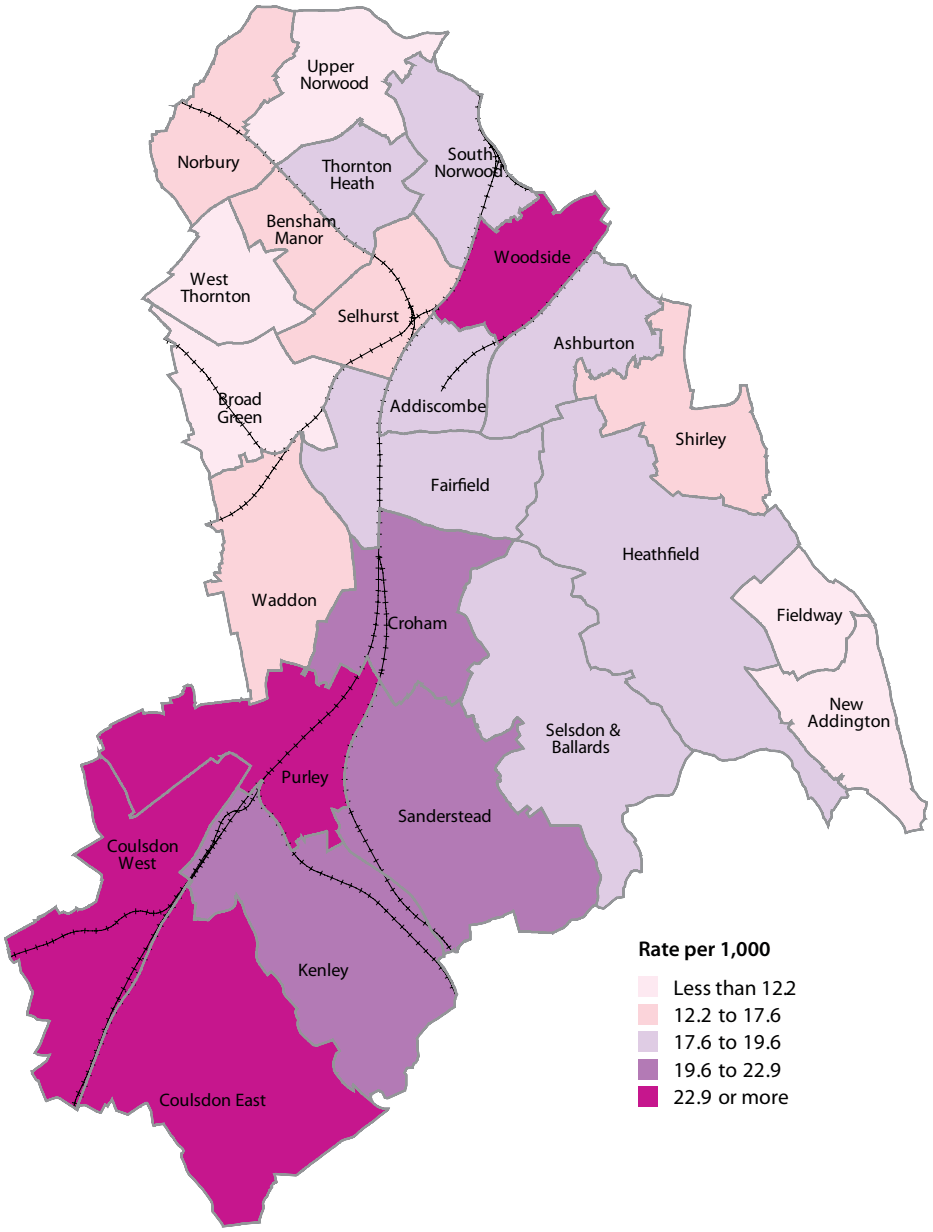
Figure 39 | numbers of adult education courses taken by over 50s, Croydon 2009/10



Source Croydon Council, 2009/10

Figure 40 shows that in 2009/10, residents in more affluent areas of the borough were more likely to sign up for adult education classes. This map does not account for location of education venues which will also influence take up of courses.

Figure 40 | education rates per 1,000 population in over 50s, Croydon 2009/10



Source: CALAT – Croydon Council 2010

Community

A needs assessment for older people undertaken for Croydon Council in 2009 indicates that 66% of people aged 55 to 64 think people from different backgrounds get on well in Croydon, although people in the north of the borough are less likely to agree with this and feel less safe on the streets than those living in the south.[62] There is a relationship between this, dissatisfaction with the area as a place to live and with anxiety about the impact of immigration on the area. The survey also suggests that the transient nature of tenants in private rented accommodation in the north of the borough has led to less pride in the neighbourhood and a reduction in social cohesion and community spirit.

62 Methods Consulting. Needs assessment for older people in Croydon. September 2009. Available from the Healthy Croydon Support Unit, 020 8760 5773.

Social isolation

Leaving employment, increasing ill health, bereavement or a drop in income can all be factors which lead older people to become socially isolated. Projects such as local exchange trading schemes or time banks bring people into contact with one another and can build local communities, as can volunteering. Elsewhere in London, Southwark Circle helps to reduce social isolation by offering a range of practical help (e.g. hanging up the curtains), meet ups, educational opportunities, reliable recommendations for example for a plumber, advice on technology and finance and opportunities to help others. Members pay a fee related to what they receive and related to their income. Age UK and others provide similar schemes in Croydon.

There is a positive association between time spent volunteering and a range of indicators, such as a sense of belonging, satisfaction with the area, feeling safe and being satisfied with the local council and public services.[63] The over 45 age group is more likely to volunteer than those under 45 locally.[64] Croydon Voluntary Action acts as a broker for volunteers, referring them on to over 600 local voluntary sector groups. Figures show that less than 1% of the volunteers who are referred on to other organisations are over 50 and very few over 50s enquire about volunteering via their website.[65] These figures do not include the older people who offer their time direct to many other organisations.

The digital economy

Studies show that both digital choice (choosing to participate) and digital exclusion (factors beyond a person's control that limit their access to and use of information technologies) impact on the ability to participate in the digital economy. What makes an older person disadvantaged in general constitutes a disadvantage digitally (age, health, income, education level, social isolation).[66] This indicates the need for targeted education and training for older adults, easy navigation web design and the preservation of alternate ways of providing information.

Digital services for older adults range from care alarms and food shopping on the web, to fridges that indicate they are low on food and toilets that signal if they have not been used. Digital technology can be used to monitor long term conditions routinely, for example blood sugar measurement or blood pressure uploaded daily to a web monitoring centre, with trigger points raising the alarm. Studies have shown that strength and balance training programmes delivered by a web link to a person's home have also proved successful in control trials.[67] Having access to the internet and social networking sites may have a positive impact on emotional wellbeing, promote cognitive functioning and increase participation in online political activity for older adults, however it may also indicate an increased detachment from their neighbourhood.

63 Croydon Council. Place Survey, 2008

64 ibid

65 Data provided by Croydon Voluntary Action. 2009/10

66 Helsper EJ. The ageing internet: digital choice and exclusion among the elderly. Working with Older People. 2009;13(4):28-33.

67 Nyman SR, Yardley L. Website based tailored advice to promote strength and balance training: An experimental evaluation. Journal of Aging and Physical Activity. 2009;17(2):210-22.

Community services for older adults

There are many services available to help older adults, some of which are outlined below. Many are jointly funded by the NHS and social care and some are commissioned from the voluntary sector.

Social and nursing care, including palliative care, are available to support older people at home. This includes falls prevention and rehabilitation after falls. Adaptive technology and aids in people's homes are offered through CARELINE, the Aztec Centre and the joint equipment service.

The safeguarding adults team and care home support team help vulnerable people at risk of neglect or abuse and improve quality in care homes. The Health Visitors for Older People Service provides an intermediate care service to prevent unnecessary admissions to hospital or help facilitate early discharge.

The Croydon Memory Service provides early assessment, treatment and care for people aged over 65 who have memory problems that may be associated with dementia. Croydon Alzheimer's Society also offer a range of peer support services for people with dementia and their carers and the Aztec Centre has a telecare dementia service for people with severe dementia.

The Partnerships for Older People (POP) service provides information, advice and support to older people in their neighbourhood, helping them to live independently with appropriate support when they need it. The POP service is targeted at the over 55 population and tries to reach people who do not access services. Most services are offered direct from a mobile unit and advice is offered about other services. The aim is to prevent people allowing a condition to deteriorate to the point of needing intensive support or treatment. A 2009 evaluation found that the service was cost effective and well liked by service users, but it recommended encouraging uptake in those aged 50 to 70, who were less likely to access the service.

The Department of Health has funded the development of the telehealth project which enables people with chronic obstructive pulmonary disease and heart failure to be remotely monitored and support services alerted if they need additional care. The Telecare in Homes for the Future project will help people in care homes who are at high risk of hospital admission with personalised care plans, information and education.

The Positive Ageing project from Age UK Croydon offers a variety of services for those aged 50 to 90. They include support to eat well, manage weight, increase physical activity, falls prevention, advice on housing options and using arts and crafts to promote mental wellbeing. Some groups are coproduced by service users, set up initially by the service and then run by members, including dining clubs and healthy eating clubs in sheltered housing.

Over 50 council supported lunch clubs, including the Neighbourhood Care Association lunch clubs, cater for those over 60, although some groups attract those aged 50 plus. These services provide befriending, advocacy, education, training and carers respite.

Policy and best practice

Guidance on best practice to meet older people's needs and services is contained in the National Service Framework for Older People (2001). This set out plans to eradicate age discrimination and to support person centred care with newly integrated services. It stressed the importance of care at home or in care settings. Stroke prevention was emphasised alongside active life, falls prevention and integrated mental health services for older people.

Opportunity Age (2005) from the Department of Work and Pensions highlights the valuable contribution older people make to the economy and community, which can only be fully realised if they have work opportunities and a healthy income, good health in later life, independence and wellbeing.

Putting People First (2007) is a national concordat which stresses the importance of improving access to universal services, strengthening communities, focusing on prevention and ensuring that people have greater choice and control.

The National Dementia Strategy (2009) sets standards for local health and social care partnerships in providing services for people with dementia. The strategy is based on work begun in Croydon.

Croydon's Older People's Strategy (2010 - 2013) aims to help older people to enjoy an ordinary, independent life with the minimum appropriate support when it is needed. It is set out under seven themes:

1 **Improving the quality of life**
2 **Independence, choice and control**
3 **Improving health**
4 **Making a positive contribution**
5 **Equality and freedom from discrimination:**
6 **Dignity and respect**
7 **Promoting economic wellbeing**

There is also a local strategy for physical disability in development.

The Social Care Institute for Excellence develops and promotes good practice in social care services and publishes standards with which providers of social care must comply.

NICE guidance

Guidance from the National Institute for Health and Clinical Excellence (NICE) relevant to health care management of older people:

NICE PH16, *Mental well being and older people*. October 2008

NICE CG21, *Falls*. November 2004

NICE CG42, *Dementia: supporting people with dementia and their carers in health and social care*. November 2006

NICE CG103, *Delirium: diagnosis, prevention and management*. July 2010

NICE CG101, *Chronic obstructive pulmonary disease (update)*. June 2010

NICE CG91, *Depression with a chronic physical health problem*. October 2009

NICE PH15, *Identifying and supporting those most at risk of dying prematurely*. September 2008 (targets those in low income groups/smokers at early risk of heart disease)

NICE also produce quality standards which could apply to adults in later life, for example stroke, dementia and depression. The NICE clinical working group monitors implementation of the guidelines and standards for the Croydon health economy.

Expenditure

Croydon Council set a 2010/11 budget of £30.9 million and expected a further £11.3 million in income for older people's social care. The total council planned expenditure for older people's social care was £42.2 million. The Homes for the Future programme is the council's programme to modernise residential and day care services for older people in Croydon. It is funded through a £39 million private finance initiative source.

While the NHS spends a significant part of its budget on healthcare for older people (especially people 75+), spending is not allocated by age group. It is therefore not possible to give a figure for NHS spending on older people in Croydon. Nearly 40% of the total NHS budget is spent on healthcare for older people.[68] Expenditure on older people will include a large proportion of NHS spending on continuing and palliative care and also includes a significant percentage of the money spent on hospital, primary and community healthcare services. NHS Croydon set a budget of £11.4 million for continuing care, most of which is spent on nursing and palliative care for older people.

NHS and council expenditure for dementia treatment and care is paid for principally from the mental health budgets for both organisations. Conditions such as Alzheimer's disease usually occur in people over 65.

68 Banks J, Breeze E, Lessof C, Nazroo J, editors. Retirement, health and relationships of the older population in England: the 2004 English Longitudinal Study of Ageing (Wave 2). London: Institute for Fiscal Studies; 2006.