



# Healthy transitions; Growing old in North Yorkshire

**Director of Public Health annual report 2017**

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# Introduction

A girl born in the UK in 1917 could expect to live for 57 years given the death rates at the time. Her twin brother could expect to live for 51 years. One hundred years later, girls could expect to live for 84 years and boys for 80<sup>1</sup>. The fact that life expectancy has been increasing steadily over the last century should be celebrated as the triumph of public health – “the science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society.”<sup>2</sup> Why then is the reference to an “ageing population” so often seen in negative terms?

In this my fifth annual report, I focus on the older population in North Yorkshire (NY). In previous reports we discussed the importance of community and starting well in life for the continued health and wellbeing of our residents. Last year we highlighted the importance of maintaining the health of the working age population and ensuring the benefits of “good” work are available to as many of this age group as possible. This year we examine why the achievement of longer lifespans must be matched by societal changes in our attitudes and response to the elderly.

For example, it is sometimes asserted that the pressure on health and social care is due to an ageing population. However, Hospital Episodes Statistics for England in 2014-15 indicate that people aged 15-64 years account for 48% of hospital admissions, 59% of Accident and Emergency attendances and 56% of outpatient appointments<sup>3</sup>. The percentages for people over 65 years are 41%, 20% and 35%<sup>3</sup>, respectively. The picture is more complex, of course, but this data suggests that other explanations are needed.

When the National Health Service (NHS) was established in 1948, the pattern of illness was different. Life expectancy has increased by some 15 years since then and people are living with conditions that would have proved fatal 70 years ago. Only about 200 people lived to be 100. Now that number exceeds 13,000. We take for granted that this prolonging of lifespan will increase.

However, the ancient Greeks understood the enchantment of long life and illustrated this in the myth of Tithonus whose lover asked that he be made immortal but forgot to ask for him to stop ageing. There is a wider context in which we live and it seems that as we make advances against premature death and disease, we are not keeping pace with the needs of the large numbers who achieve unprecedented lifespans.

A report focused on the public health of ageing must look critically at the societal aims of prevention and ask what we seek to prevent. The pursuit of ever increasing lifespans can come at the expense of quality of life, both from an individual and societal perspective, if we do not understand our motivations. Accepting that life has a beginning, middle and end and is lived in a specific social context may help us focus as much on the quality of life as the length of life. The notion of a “good life” may once again inform the aims of public health.

This report is structured around three transitions that many of our older residents will experience at different ages and in different ways. The first is moving from work into retirement. In addition to planning for economic security and optimising our health, we should consider our future social health. If all our friends are of similar age, what happens as we get older and they

pass on? This indicates that the prevention strategy against social isolation and loneliness in later life should include being intentional about forming social networks with younger people during this transition.

The second transition is increasingly topical. It concerns the move from independent living to needing support and care. This transition is not the result of a failure of medical science or preventative medicine. It is, I believe, a natural and biological progression. Improvements in the delivery of health and social care will help but are not the complete answer. A more radical rethinking of how we embrace frail older people as integral to our societies and communities is needed. The fact that someone needs care does not reduce their importance as a member of the community or diminish the contributions they still make.

The final transition is preparing for the end of life. There is a sense in which ageing itself is a terminal condition – the official cause of death is merely the mechanism. Living with the end in mind, rather than being morbid, can be liberating for older people and their families who can help prepare each other for this final stage of life.



As always I hope this report is a spark for conversation and action. I look forward to hearing from you and working with you to implement the recommendations I am making this year.

**Dr Lincoln Sargeant**  
**September 2017**

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## Councillors' Foreword

We welcome this report from our Director of Public Health. It is important that in North Yorkshire we value the contribution of older people in our communities. We recognise that there are a significant number of carers and volunteers doing tremendous work but their contribution is often less visible. Supporting them in what they do is vital for all health and social care organisations.

It is great news that improvements in public health, health and social care have led to increased life expectancy, but we now need to ensure those extra years are of the best possible quality. All organisations across North Yorkshire need to consider how they contribute to this. We need to maximise those wider determinants that have greatest potential for benefit around economic wellbeing, housing, transport and planning. We can build resilience to prevent social isolation and loneliness by enabling people to live in age-friendly communities.

We also need to ensure people can get the right care when they need it. We must strive to ensure that care is compassionate, effective and safe. This includes providing end of life care; the last thing we do for one another. In North Yorkshire our public health outcomes are generally better than the national average. As more of us live into older age it is vital that we plan services to meet the needs of older people.

We look forward to supporting this annual report and work to tackle the challenges described in it.



**Councillor David Chance**  
Executive Member for  
Stronger Communities



**Councillor Caroline Dickinson**  
Executive Member for Public  
Health and Prevention



**Councillor Michael Harrison**  
Executive Member for Adult Social  
Care & Health Integration



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# Foreword

All too often media reports, and even the way that we talk in public services, can present negative images of ageing and older people. Terms such as ‘frailty’, ‘demographic time-bomb’ and the like are used, with connotations that somehow ageing is entirely negative or a burden on society. The truth is quite the opposite: more older people are healthier and more active for longer than they have ever been; they are making a vital contribution to society as paid workers, volunteers, and carers for multiple generations. In many ways, they are the glue of our communities. On a wider scale, I am always very conscious that the current, amazing generation of older people are the people who fought for our liberty and who created many of the things that we most treasure about our way of life.

I am always regularly reminded of these achievements by my great aunt Elizabeth (pictured with me at a Rural Arts event in Stokesley) who was born in the early months of the First World War and has lived through the most incredible century of change – and who is busy using her tablet to keep in touch with friends and family.

So, whilst we clearly need to give thought, care and attention to how we prevent and address ill-health, improve care and enable more people to have more control over their lives (and their deaths), we also need to balance those imperatives with recognition of what older people do for the rest of us.

We also need to challenge ourselves more about what we mean by old age. It is not simply about chronology. In this country, we still talk about 65 as being the onset of old age, yet the pension age is rising above that and most people do not experience the significant health impacts of ageing until their late 70s or early 80s.

If we are to improve people’s experience of ageing, and reflect the norms of how younger generations live now, then public services will need to adjust to these expectations. An important consideration is about making one’s own decisions, planning ahead and having choice and control. One simple thing we could all do – and public services could encourage more people to do – is to make a will and set up Lasting Power of Attorney arrangements, not only for personal finances but also for health and welfare decisions.

Two-thirds of adults in Britain have not yet made a will<sup>4</sup>. We know that increasing numbers each year apply for a Lasting Power of Attorney with 547,021 applications received in 2015/16; up 33.7% from the previous year but we need to ensure people make their wishes clear in good time<sup>5</sup>. As this report recognises we all need to plan for our old age to be as healthy and financially secure as possible, and let those around us know our wishes for the future. Some of the key challenges such as delayed transfers from hospital and social care (DTOCs) and Deprivation of Liberty safeguards (DoLS) faced by service users can be informed if we know what matters to each individual<sup>6</sup>.

Making these arrangements is part of a more open discussion about living – and dying. This report talks about integrating health and social care: the starting point for that has to be the individual, what’s going on in their lives and in the community and how we can harness that to maintain health and to lessen the impact of illness and disability.

This Director of Public Health Annual Report is designed to spark debate, to share practical ideas and, ultimately, to challenge how we think about our own and other people’s ageing.



**Richard Webb**  
Corporate Director Health and Adult Services

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# Demography of older people in North Yorkshire



# Characteristics of older people in North Yorkshire

**It is estimated\* that 140,000 people living in North Yorkshire are aged 65 and over.**

Older people make up 23.3% of the total North Yorkshire population, compared to 17.7% across England in 2015.

There has been an increase of 30,000 older people (27.6% ) since 2005 in North Yorkshire whilst the overall population has grown by only 19,500 (3.4%) for the same period. In England, the 65 and over population has grown by 20.6%. In 2005 this age group represented 16.0% of the total population (overall population growth of 8.6% in England).

Two thirds of the population growth in North Yorkshire over the last ten years has been as a result of increased numbers of people aged 65 and over.

The increase is due to three key factors:

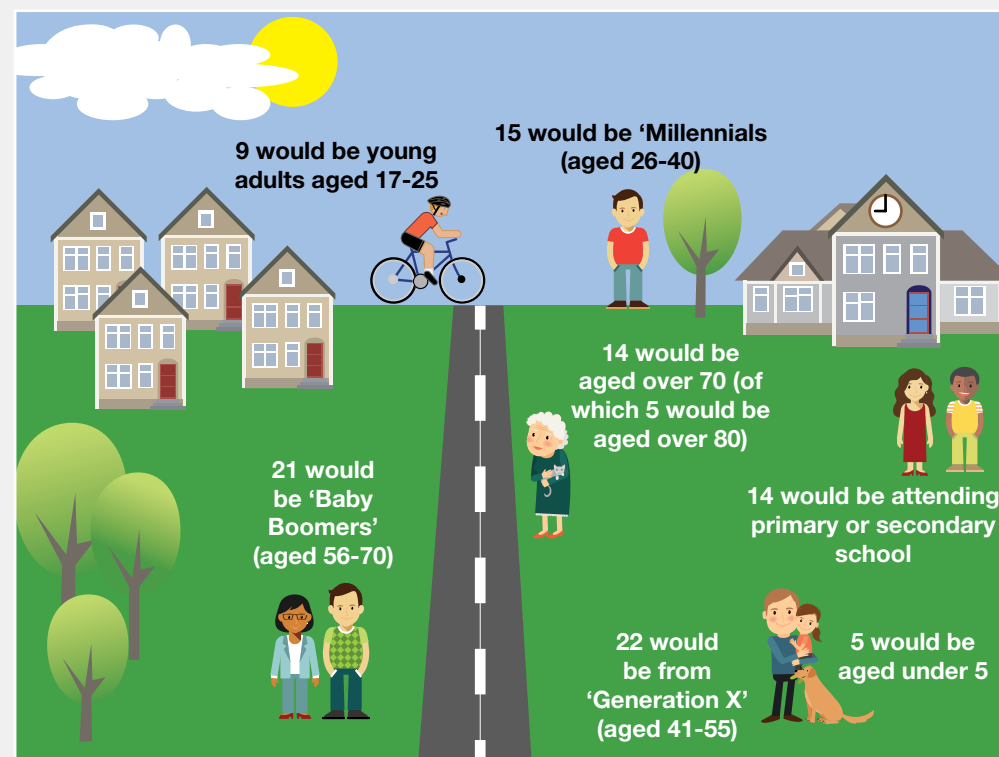
- Baby boomers (born between 1940 and 1964) population ageing now. Baby boomers account for 97% of the increase.
- People migrating to North Yorkshire when they are aged between 50 and 64 accounting for 2% (2480)
- Those migrating to North Yorkshire in older age accounting for around 1% (970)

In 2015 there were:

- More people aged 65 and over in North Yorkshire than people aged under 20 (130,000)
- As many people aged 75 and over (63,700) as there were children aged under ten (63,300)
- More women living in older age than men. 54% of the population aged 65 or over were women and 61% among the 80 and over

Source: ONS-mid year Population estimates, 2015

**If North Yorkshire was a village with 100 people...**

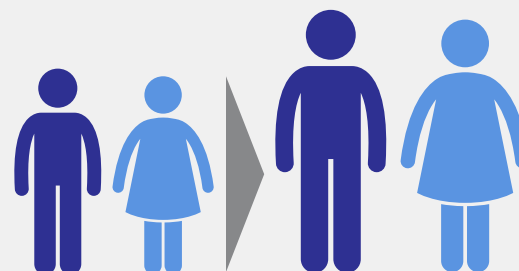


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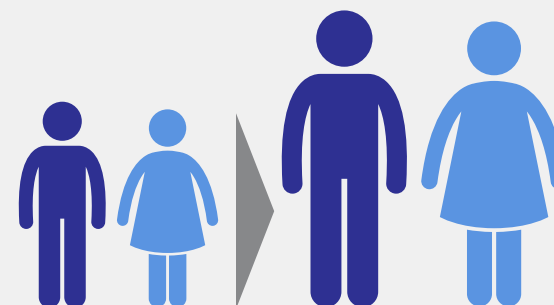
## Future trends

Office of National Statistics (ONS) projections indicate<sup>7</sup>:

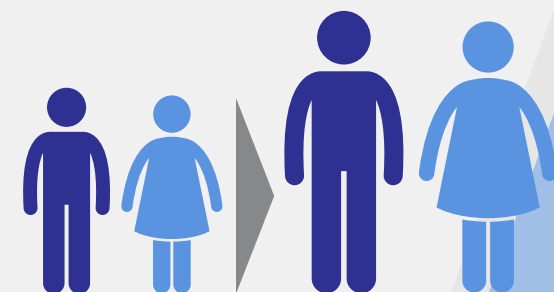
**The 65 and over population in North Yorkshire will rise to over 169,000 (27.6%) by 2025.**



This is predicted to be driven by growing numbers of people aged over 70, with **the largest increase expected in the 75-79 age group increase of 44% (from 26,360 in 2015 to 37,800 in 2025).**



**The proportion of the population aged over 80 is estimated to rise from 6% (37,000) in 2015 to 8% (51,000) by 2025.**





## Where do older people live in North Yorkshire?

The largest number of people aged 65 and over is in Harrogate District (34,503, 25% of all people aged 65 and over in the county). The fewest are in Richmondshire (10,227, 7.4% aged 65 and over in North Yorkshire)<sup>8</sup>.

The highest proportion of the population aged 65 and over is in Ryedale (25.9%), Scarborough (25.8%), Craven (25.7% of population) and Harrogate (22.4%). The lowest proportion are in Selby (19.4%) and Richmondshire (19.9%)<sup>8</sup>. The map indicates over 65 population density and size variance among the districts within North Yorkshire.

### Older people are more likely to live in rural areas.

42.7% of people aged 65 and over live in sparsely populated/dispersed areas, compared to 39.7% of the North Yorkshire population as a whole<sup>8</sup>. The remainder live in towns/urban settings, compared to 60.3% of the overall population. 8.3% of the 65 and over population live in villages or dispersed dwellings in sparsely populated areas (under 11,000 people). At Lower Layer Super Output Area (LSOA) level, rural areas of Craven, Hambleton and Ryedale can be highlighted as having a high proportion of residents aged 65 and over. There are a total of 34 LSOA across North Yorkshire where the proportion of residents aged 65 and over is at least 33%<sup>8</sup>.

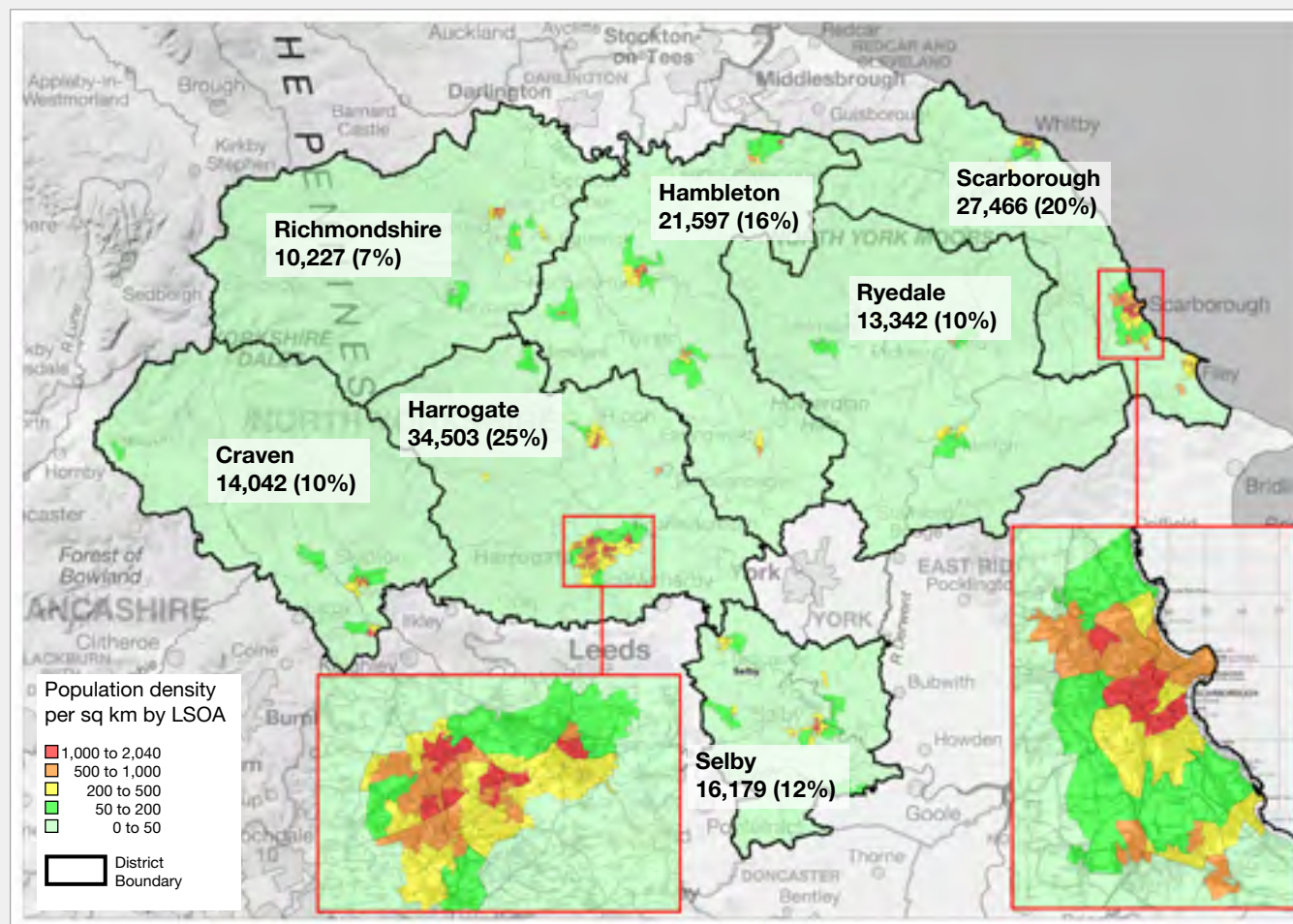
The 2011 Census showed that almost one in three (37,000) people aged 65 and over were recorded as living in a one person household.

### Report recommendations

## North Yorkshire population aged 65 and over

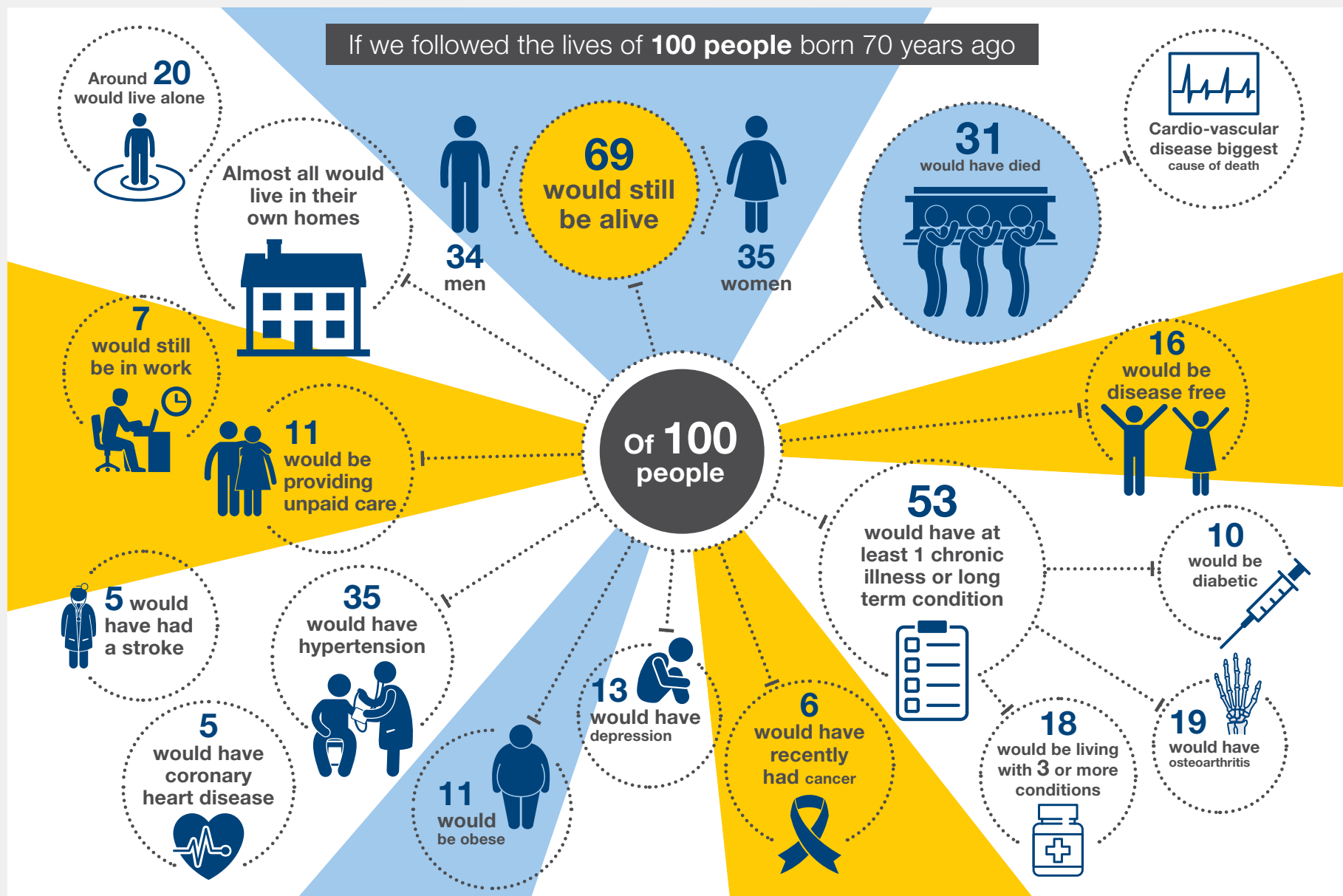
### Lower Layer Super Output Area (LSOA) population density per sq km

Source: ONS Mid-2015 LSOA Population Estimate, DEFRA 2011 Rural Urban Classification



A LSOA is a Geographical area. LSOAs are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales. A typical LSOA represents population size between 1000-3000 or between 400 and 1200 households.





## Life expectancy in 2012-2014

Generally North Yorkshire's population live longer and enjoy healthier older age compared to the average for England. The data suggests that typically a boy born in North Yorkshire today will live to around 80 years of age, of which 66 years will be in good health, but the final 14 years will be lived in poor/declining health, compared to 16 years nationally.

A baby girl can be expected to live until around 84 years of age, of which almost 67 years will be in good health, suggesting the final 17 years will be in poorer/declining health, compared to 19 years nationally.

This indicates that whilst men and women in North Yorkshire live longer, they also live longer in good health and spend fewer years (and a lower proportion of their lives) in poorer health. Of 150 upper tier local authorities North Yorkshire is ranked:

- 45th for female and 43rd for male LE at 65 years
- 21st for female and 73rd for male disability free life expectancy (DFLE)
- When ranked by proportion of disability-free life 19th for female and 82nd for male

However, from 2011-13 onwards DFLE in men has fallen from 11 years to 10.3 years in 2012-14, with expected years with disability at 65 increasing from 7.4 years in 2006-08 and 8.9 years in 2012-14. It will be important to monitor these trends over time.

### Life expectancy 2012-14

Source: ONS, 2015

	NY Female	Eng Female	NY Male	Eng Male
Life expectancy at birth	84.0	83.3	80.3	79.5
Healthy life expectancy at birth	66.7	64.0	65.5	63.4
Life expectancy at 65 (LE)	21.7	21.2	19.3	18.8
Disability free life expectancy at 65 (DFLE)	12.5	10.9	10.3	10.3
Proportion of life with a disability at 65	42.6%	48.7%	46.4%	44.9%
Expected years with a disability	9.3	10.3	8.9	8.4

## Life expectancy in 2012-2014

In Scarborough and Selby districts life expectancy at birth is lower than the County figure. In all districts, except Scarborough and Selby, male life expectancy at 65 is greater than the County figure (see data). Among females, life expectancy at 65 is highest in Craven, Hambleton, Harrogate and Ryedale, and lower in Richmondshire, Scarborough and Selby.

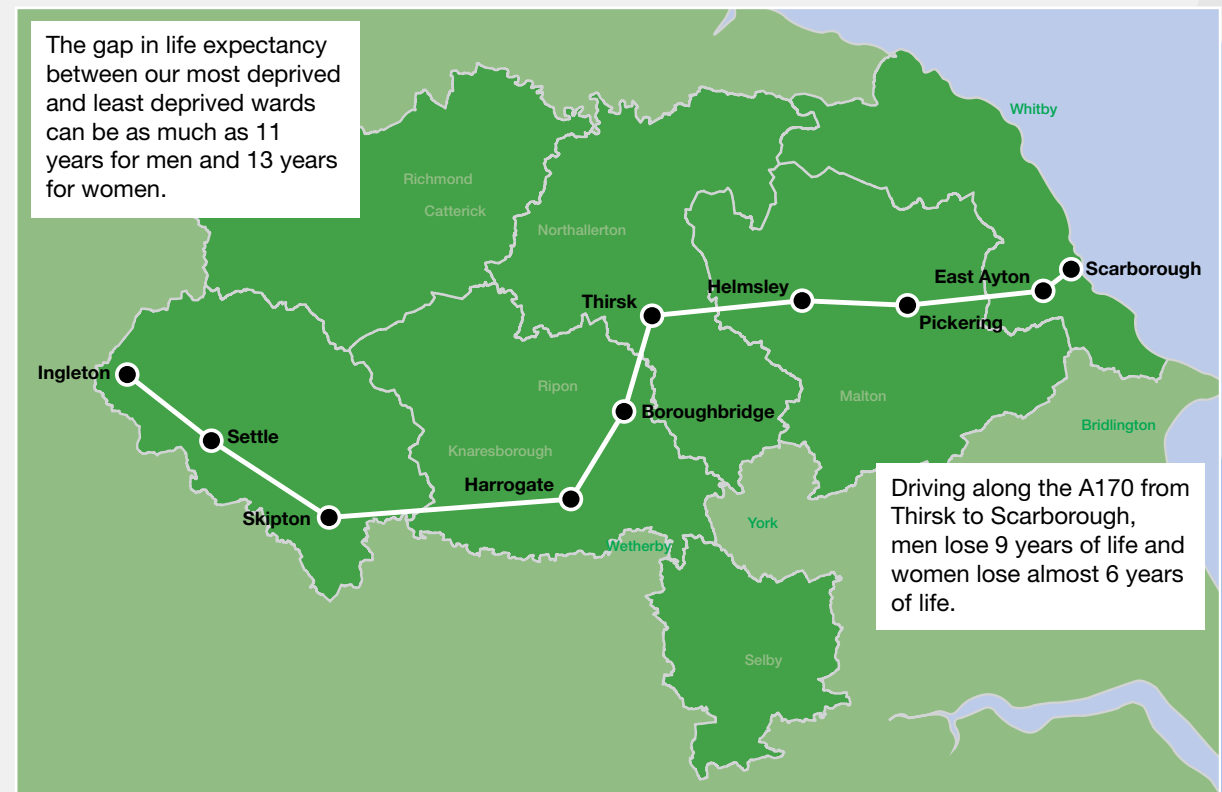
The gap between men and women in terms of healthy life expectancy has narrowed slightly between 2009-11 and 2012-14 (from 2.0 years to 1.2 years).

Life expectancy at 65 has not appreciably narrowed between 2000-02 to 2012-14, although life expectancies have improved for both men and women.

### Life expectancy at birth - a journey across North Yorkshire

Source: 2008-12 life expectancy by ward

Click on the locations to reveal life expectancy



# Older people's quality of life

The health related quality of life for older people indicator highlights that older people in North Yorkshire enjoy the best health related quality of life within the region and above the average for England. The health related quality of life for NY's residents is significantly better than national and regional averages, however, it does vary across the County.

The health related quality of life indicator provides a greater focus on preventing ill health, preserving independence and promoting well-being in older people.

Health status is derived from responses to the GP Patient's Survey, which asks respondents to describe their health status using the five dimensions of the EuroQuol 5D (EQ-5D) survey instrument:

- Mobility
- Self-care
- Usual activities
- Pain/discomfort
- Anxiety/depression

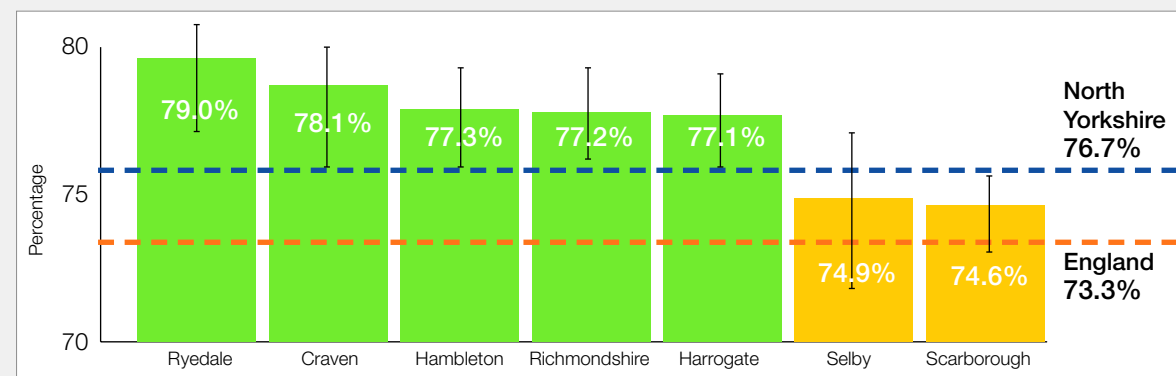
Among all districts, Ryedale has seen good improvement and scored highest within the County, whereas Scarborough scored lowest for quality of life. However health related quality of life is either similar or better than the national average for all North Yorkshire districts.

[Report recommendations](#)

[Older People's Health and Wellbeing Profile - North Yorkshire](#)

## Health related quality of life for older people: 2015/16

Source: GP Patient Survey, 2016



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## Causes of poor health and death

Many older people will be living with one or multiple long term conditions. Some of these illnesses would have been fatal in the past, now people needing long term support from health and social care services. The risk of developing these increases with age.

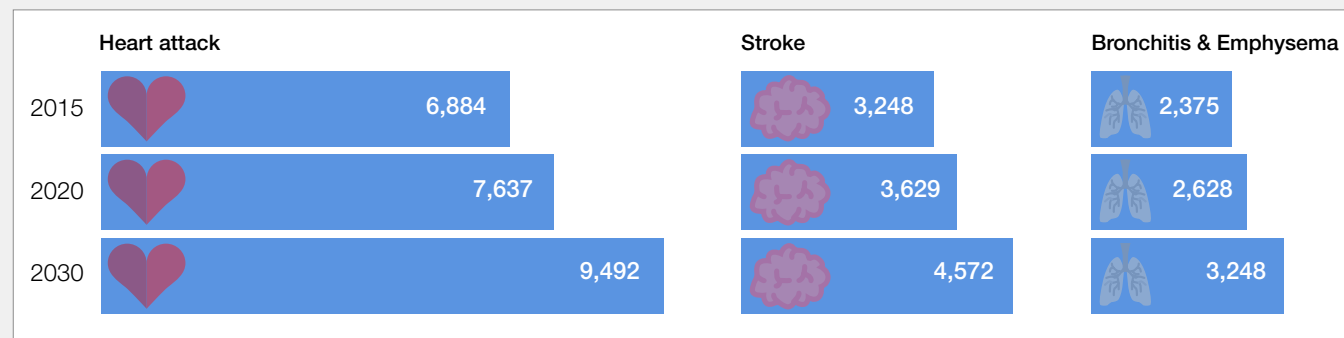
The limited data available suggests increasing rates of some of the most common long term conditions (heart attack, stroke, bronchitis and emphysema) over time for older people in North Yorkshire.

[Local data](#) estimates increasing numbers of people living with long term conditions following heart attacks, strokes and emphysema/bronchitis over the next two decades.

[Report recommendations](#)

### Number of people in North Yorkshire estimated to be living with long term health conditions as a result of heart attack, stroke or bronchitis and emphysema (2015 to 2030)

Source: Projecting Older Peoples Population Information (POPPI), accessed Feb 2017





## What kills us as we age?

From age of 40 onwards, overall mortality rate increases by at least 40% for every five years of additional age, and the all-cause mortality rate for those aged 90 and above is ten times higher than among those aged 45-50 in North Yorkshire.

Among older adults (65 and older), circulatory diseases are the most common cause of death and account for 32% of deaths<sup>9</sup>. Cancer is the second most common cause of death (25% of deaths). Respiratory conditions accounted for 14% of deaths, whilst **dementia** accounted for 12% of deaths<sup>9</sup>.

In our very old (80 and over) residents, the proportion of deaths attributable to circulatory disease rises to 34%, followed by cancer (19%) and respiratory diseases (16%)<sup>9</sup>.

The proportion of deaths in the 65 and over population caused by dementia/Alzheimer's disease was 12% in the period 2013-15, rising to 15% in those aged 80 and over.

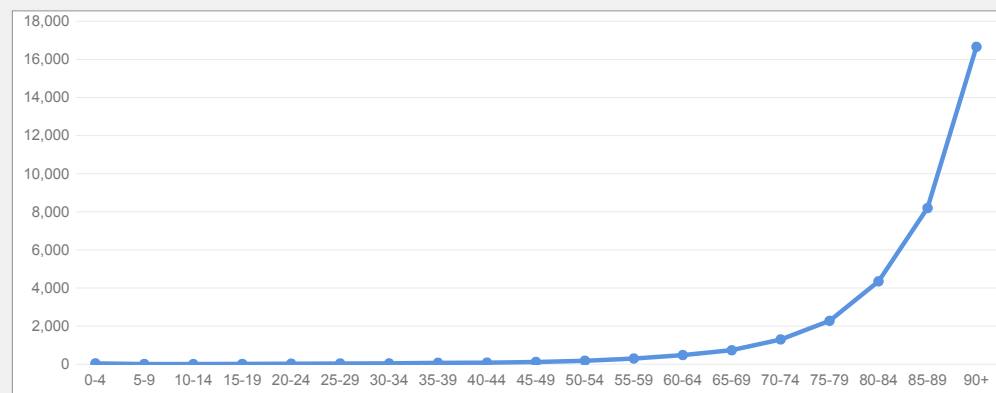
The proportion of deaths attributable to flu or pneumonia in the 65 and over population was 6%, rising to 7% in the 80 and over population<sup>9</sup>.

### Report recommendations

(Mortality data 2013-16; based on death certification and coding)

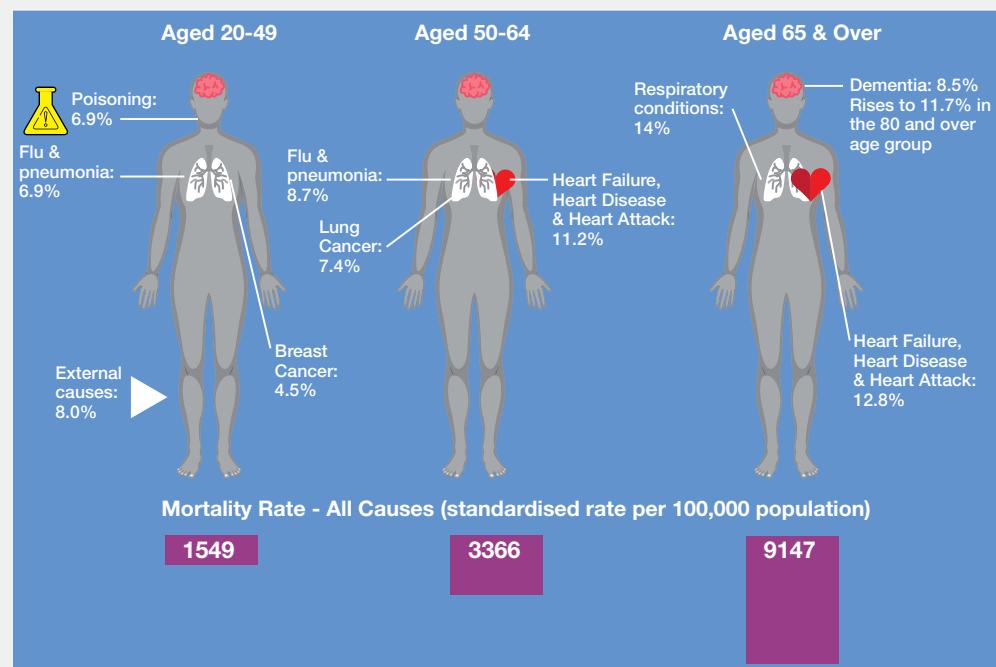
## Age Specific Mortality - Crude rate per 100k (all causes) - 3 year average 2014-2016

Source: Primary Care Mortality data, 2016



## Most common causes of death by age group 2013-16

Source: Primary Care Mortality data, 2016



## Older people as carers

There are around 65,000 people in North Yorkshire across all age groups who identify themselves as providing unpaid care, which is more than one in ten people<sup>10</sup>. This is higher than the average both nationally and through the Yorkshire and Humber region. In reality there are likely to be many more people providing unpaid care who either do not recognise themselves as a carer or do not wish to be recognised as a carer.

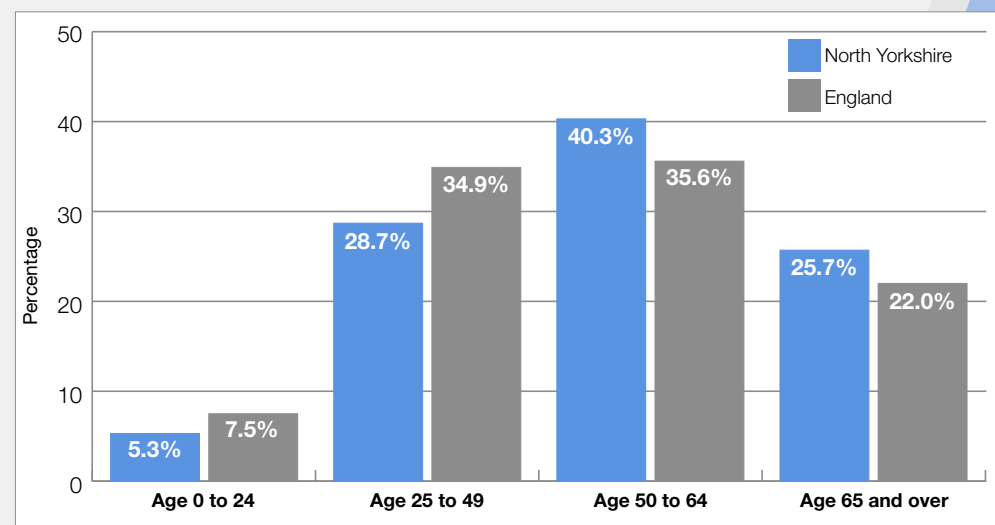
The number of people providing unpaid care has increased by almost 15% (8,250 people) since the 2001 Census compared with a 2.3% increase in the County's overall population figure<sup>10</sup>.

North Yorkshire has a higher number of older carers than the average for England with 57.6% being aged 65 and over<sup>10</sup>. Older carers often provide long hours of care and support, but can be at additional risk of doing this to the detriment of their own health and wellbeing. Older carers can also need additional support with more demanding and physical tasks. They can also be "sandwich" carers or "dual" carers who have a caring role for more than one person, often of different generations.

Projecting Older Peoples Population Information (POPPI) estimates that around 14% of the 65 and over population in North Yorkshire are providing unpaid care. This increases to 16% in the 65-74 age group, and drops to 12% in the 75 and over age group. Data suggests that a significantly higher proportion of the 75 and over age group (5.6%) provide over 50 hours of unpaid care compared to the 65-74 age group (4.1%)<sup>11</sup>.

### Unpaid carers - age profile

Source: Census, 2011



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## Economic activity in older people – working beyond state retirement age

In 2016, ONS highlighted that across England the proportion of people aged 65 and over who work has almost doubled between 1992 and 2016, from 5.5% to 10.4%<sup>10</sup>. In North Yorkshire, this would equate to around 14,500 people – equivalent to a town the size of Selby.

If the increasing trends in both population size and the proportion of older people in work (excluding impact of increases to the state pension age) continue, by 2040 we could expect to see almost 45,000 people aged over 65 in work, almost treble the number anticipated to be in work today.

There are many reasons driving this increase:

- The enjoyment of the work they do and desire to remain physically and mentally active, as well as maintaining key social connections outside of the home and family.
- A new challenge or pace of work
- For some working beyond state pension age is simply to make ends meet

Respondents of a survey by Portus Consulting in 2015 showed that a third of those surveyed believed they would not be able to retire at 65, 74% of those surveyed feared they wouldn't have enough money to stop working<sup>12</sup>.

These findings are supported by Department for Work and Pensions (DWP) data examining economic activity in older individuals. This illustrates that from 2005 there has been a steady increase in the proportion of people aged between 65-74 in employment. The increase has been most pronounced in men aged 65 to 69, rising from around 19% in 2005 to around 26% in 2015<sup>13</sup>.

Additional data from DWP highlights that among men in employment beyond the age of 65, the proportion engaged in full-time work has increased from around 3% in 1995 to around 5% in 2015<sup>13</sup>. However, part-time working remains more common in both men and women aged 65 and over. In the 65-74 age group, there has been a pronounced decrease in economic inactivity over the last 20 years, indicating an increased proportion of individuals working beyond state pension age<sup>13</sup>. The largest decreases in economic inactivity have been observed in women aged 65-69 (from 92.6% in 1995 to 83.1% in 2015) and men aged 65-69 (from 84.5% in 1995 to 73.5% in 2015)<sup>13</sup>. Changes to state pension ages in the coming years will undoubtedly exacerbate this trend.

### Report recommendations

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# Transition 1: From working life to healthy retirement



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## Transition 1: From working life to healthy retirement

In this section we examine how people can stay healthy during the transition from working age to retirement. This includes emotional wellbeing and physical health as well as financial planning for older age. Key challenges such as being a carer and living with long term conditions are examined, along with opportunities to stay connected by volunteering and lifelong learning.

Many people dream about what they will do when they stop working. Some plan to spend time with loved ones, seeing children and grandchildren grow up. Others want to travel the world. Some look forward to spending more time on hobbies like cycling, gardening or walking the dog.

To a great extent, having a healthy retirement depends on the lifestyle choices and behaviours in the years prior to retirement. Choices earlier in life can leave an irreversible health legacy. However, positive behaviour change at any age can realise significant benefits to health outcomes.

It is important to remember that older people make a huge contribution to communities across North Yorkshire by volunteering, being carers and actively participating in society.

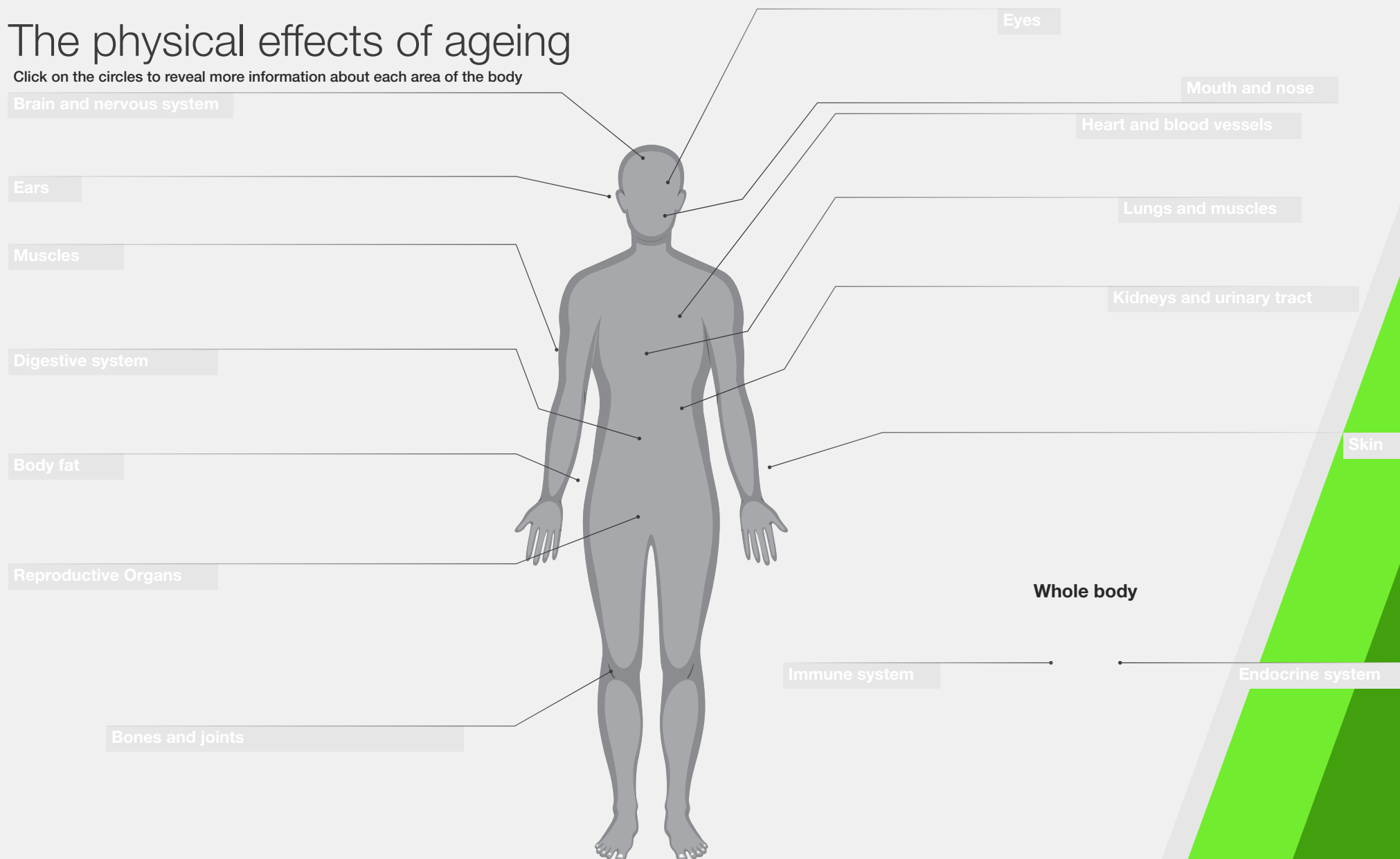
Individuals and their employers have a key role in planning comprehensively for retirement and noted in my recommendations.

[Report recommendations](#)



# The physical effects of ageing

Click on the circles to reveal more information about each area of the body



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# Good mental health

Good mental health and emotional wellbeing are important in older age. Many factors can affect [older people's mental health](#). These include being a carer, ill health, living alone, retirement, bereavement, money worries, loss of independence, for example:

- giving up driving or losing mobility
- moving house, including moving to a new area or moving into a care home
- loss of daily routine and social contact after retirement

As we age, events or changes in our situation may make us more vulnerable to low mood, depression and anxiety. Sometimes, there might not be an obvious cause at all.

Evidence suggests that a small improvement in wellbeing can help to decrease some mental health problems and also help people to flourish resulting in 'five ways to wellbeing': a set of evidence based actions to improve personal wellbeing:

- Connect with the people around you
- Be active
- Take notice
- Keep learning
- Give

For more information: [Five ways to wellbeing](#)

Dementia, depression and memory loss aren't inevitable in older age. However one in four over 65s live with depression and 40% of 85 and over have debilitating depression<sup>14</sup>. As we age, it is important to maintain a sense of purpose and self-worth, to keep interests out of work and in to retirement<sup>15</sup>.

[Ageing Better](#) has shown that those with a more positive attitude to retirement live, on average, 4.9 years longer than those with negative attitudes. Staying connected and having a sense of purpose are vital in maintaining emotional wellbeing, so opportunities like volunteering and learning are explored in this report.

For more information:

[How to look after your mental health in later life](#)

[Ageing Better](#)

[Loneliness and Isolation Evidence Review](#)

[Hidden in plain sight: the unmet mental health needs of older people](#)

[Hope, Control and Choice North Yorkshire's Mental Health Strategy 2015-20](#)

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## Staying connected

As we get older opportunities to connect with other people on a day to day basis may reduce. Retirement from work frequently reduces the number of people we meet on a daily basis. Grown up children may have moved away from home and health and mobility issues may reduce the opportunities for us to get out and meet people.

Staying socially connected to others is crucial to our health and wellbeing. It can<sup>16</sup>:

- Help alleviate feelings of being lonely and isolated
- Maintains social activity and befriending
- Provide an opportunity to participate in social and cultural activity

Use of digital technology such as text, email, skype, facetime and whatsapp are widely used across the population, but many older people rarely use it. Around a third of older people have never used the Internet.

It is important not only to maintain connections when moving from work into retirement, but also to make new connections, establish new interests. Men are particularly at risk of becoming socially isolated and organisations such as Men's Sheds provide opportunities to take part in new interests or share skills with others.

Maintaining family contacts is important and older people need not be a burden to their family. In fact many older people are carers or provide valuable and much needed support to children, grandchildren or other family members.

Older people can and do make a huge contribution to society through volunteering. Data from the 2008-9 Citizenship Survey found that 30% of those aged 65-74 and 20% of those aged over 75 do some formal volunteering<sup>17</sup>.

## Case Study

### Memory Lane Lunches

Memory Lane Lunches are run by Revival North Yorkshire CIC and take place every month. Each lunch has an average of 25 people attending. It is an opportunity for people to catch up and to create new friendships. Many of the participants are elderly people, housebound and living alone and in their 80s and 90s. Since May 2016, 52 people have attended and are supported by 20 volunteers.

The project provides transport and a meal delivery service. The lunches aim to reduce loneliness and isolation, and associated health risks, for elderly people living in the remote area of the North Yorkshire Moors. The lunches have encouraged examples of an informal good neighbours support network which include: a young volunteer who visits an elderly and isolated man each week and volunteers providing transport, and making contact with new beneficiaries on a regular basis.

There is now an added value Hot Seat guest who will be able to provide useful advice and guidance at the lunches, these include; Age Concern, Making Space (Dementia Support), Danby Surgery Team – Administrator – Flu Jab appointments, Community Nurse, Carers Coordinator, Danby Health Food Shop, Living Well and the CQC Health Network Group.

Memory Lane Lunches are being recognised by the Danby Surgery as of benefit to the health and wellbeing of our elderly population. Revival was asked to be part of the Surgery's recent CQC inspection and Doctors are now, with consent, referring patients to Memory Lane Lunches.

We are currently working with the Community Nurse from Danby Surgery and Making Space to ensure elderly people and their carers' are receiving the correct entitlements to allow them to remain supported at home for as long as possible.

For more information:  
<http://www.revivalnorthyorkshire.com>



The lunches are all themed with decorations, old photographs and props. This is in order to stimulate discussion and encourage reminiscing about the past – this is particularly important for those with dementia.

**“Enjoy the occasion to have company and chat to friends and enjoy a very good meal.”**

**“These monthly lunches are wonderful. They keep people in touch with one another. Keep up the good work.”**

**“We have had a lovely meal and sing song together in our village hall. Heard lots of good tips about keeping warm in winter, reminisced together and cheered up the lonely ones. More please!”**

**“It’s been grand – meal was lovely!”**

## Lifelong learning

You are never too old to learn and as older people may spend up to a third of their lives in retirement, it is becoming increasingly important to support them to continue their personal development and so contribute to society. Retirement is also a good time to start learning, doing something you always wanted to do but never had the time for.

Learning can help older people maintain good physical and mental health, as well as living active and independent lives. Taking part in learning helps develop and maintain social networks and avoids isolation. There is the opportunity to meet people and befriend, participate in social events, trips and get-togethers. It is an excellent way to meet people who have the same interests; passing on knowledge.

The National Institute of Adult Continuing Education (NIACE) 2012 Adult Participation in Learning Survey shows that only 16% of those aged 65-74 and 7% of those aged 75+ regard themselves as learners; 14% of those aged 65-74 and 7% of those aged 75+ plan to take up learning in the future.

### Case Study

#### Keep Learning: Sleights Area Mens (SAMs)

The local Men's Shed, hosted in Littlebeck is now nine months old with 18 regular members. Tuesdays and Thursdays are Shed days. The record is 13 attendees on one day; this is split between SAMs Place at the Chapel and the Whittaker Annex, provided by a local resident. As time has passed, people of good-will have provided materials, equipment, facilities and cake. The atmosphere within the Shed is delightfully casual, with banter that the men miss from their working days.

During the summer period they welcomed over 150 Coast to Coasters from all over the world. Despite its title, SAMs has involved a few women from time to time – it's called living dangerously! With all the activity, SAMs is a good place for men who are/have been isolated. There is sensitivity amongst the regulars, born of personal experiences, in welcoming newcomers in individual ways.

***"We also undertake "random acts of kindness", responding to requests when we can, renovating a dovecot, making small crosses and walking sticks, bird boxes, and presently replacing the fence to Sleights' Parish water pump."***

You can view the website [www.sleight-area-mens-shed.org.uk](http://www.sleight-area-mens-shed.org.uk). On the website there is a link to a short video that was made last year and shows how important the creations on the Men's Shed has been to some of the attendees in helping to give hope, purpose and laughter back into their lives.

### Case Study

#### Keep Learning: The University of the third age (U3A)

U3A is a self-help organisation for people no longer in full time employment providing educational, creative and leisure opportunities in a friendly environment. It consists of local U3As all over the UK, which are charities in their own right and are run entirely by volunteers.

Local U3As are learning co-operatives which draw upon the knowledge, experience and skills of their own members to organise and provide interest groups in accordance with the wishes of the membership. A U3A is a learning co-operative of older people, which enables members to share many educational, creative and leisure activities.

Activities are organised mainly in small groups that meet regularly, often in each other's homes. Members, through sharing their knowledge, skills and experience, learn from each other.

The link to the Yorkshire and Humber area is U3A. There is a U3A in many towns and larger settlements, offering a range of opportunities to learn and socialise with like minded people. There is even a U3A for people who are isolated either geographically, through illness or through personal commitments. Virtual U3A.



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# Making healthier choices

## [The 2015 report of the Chief Medical Officer for England](#)

focussed on baby boomers. This group has experienced extraordinary change over their lifetimes, with life expectancy rising, major improvements to healthcare including screening, immunisation and cancer care.

At the same time, one in three of this generation is currently obese. There are many opportunities for those in this age group to help themselves. If they choose to, the choices they make every day will have a positive impact on how they age, embracing the opportunities to be healthier, getting and staying fit and by doing so improving the chances of an enjoyable and happier older age. Many organisations contribute to these choices; for example, employers offering good quality jobs provide many beneficial health effects. Likewise, effective screening and immunisation programmes which aid early identification and treatment improve outcomes.

For more information:

[One You](#)

## Being physically active

Physical activity at any age is important to maintain good health. However the level and duration of the activity varies with age. Older adults need to do two types of physical activity each week: aerobic and strength exercises. Many adults over the age of 65 spend more than ten hours a day sitting or lying down. Sedentary behaviour is now considered an independent risk factor for ill health. The advice for older people is to break up long periods of sitting with light activity.

Adults aged 65 or older who are generally fit and mobile should try to do at least 150 minutes of moderate aerobic activity, such as cycling or walking, every week, although any amount of activity is beneficial.

Older adults at risk of falls, or with poor balance, should also do exercises to improve balance and co-ordination such as strength exercises on two or more days a week that work all the major muscles (legs, hips, back, abdomen, chest, shoulders and arms). You don't need to join a gym to be physically active, you just need to move. If you have mobility issues, you can even exercise sitting down.

Physical activity has a protective role in slowing cognitive decline. People who are active have a lower risk of heart disease, stroke, type 2 diabetes, some cancers, depression and dementia. If you keep moving, it helps to stay pain-free, reduces risk of mental illness and assists with independence.

There are plenty of ideas for how to get physically active on the NHS Choices website

[Why we should sit less](#)

[Physical activity guidelines for older adults](#)

[Exercises for older people](#)

[Importance of exercise as you get older](#)

[Interpreting physical activity guidelines for older adults](#)

## Physical activity benefits for adults and older adults

- BENEFITS HEALTH**
- IMPROVES SLEEP**
- MAINTAINS HEALTHY WEIGHT**
- MANAGES STRESS**
- IMPROVES QUALITY OF LIFE**

REDUCES YOUR CHANCE OF	Type II Diabetes	<b>-40%</b>
	Cardiovascular Disease	<b>-35%</b>
	Falls, Depression and Dementia	<b>-30%</b>
	Joint and Back Pain	<b>-25%</b>
	Cancers (Colon and Breast)	<b>-20%</b>

## What should you do?

For a healthy heart and mind

To keep your muscles, bones and joints strong

To reduce your chance of falls

**Be Active**

**Sit Less**

**Build Strength**

**Improve Balance**

VIGOROUS

MODERATE



RUN



WALK



TV



GYM



DANCE



SPORT



CYCLE



SOFA



YOGA



TAI CHI



STAIRS



SWIM



COMPUTER



CARRY BAGS



BOWLS

MINUTES PER WEEK

**75 OR 150**

VIGOROUS INTENSITY  
(BREATHING FAST  
DIFFICULTY TALKING)

MODERATE INTENSITY  
(INCREASED BREATHING  
ABLE TO TALK)

**OR A COMBINATION OF BOTH**

**BREAK UP SITTING TIME**

**2**

DAYS PER WEEK

Something is better than nothing.

Start small and build up gradually:  
just 10 minutes at a time provides benefit.

**MAKE A START TODAY: it's never too late!**

UK Chief Medical Officers' Guidelines 2011 **Start Active, Stay Active:** <http://bit.ly/startactive>

## Eating well

One in ten older people are suffering from or are at risk of malnutrition. 65.1% of adults (2013-15) in North Yorkshire are overweight or obese (England)<sup>18</sup>. Obesity levels vary across the districts by 5.9% with 62.7% for Harrogate residents and 68.6% for Selby residents<sup>19</sup>.

As we age, our energy needs reduce due to a lowered metabolic rate and less physical activity. Generally speaking, normal healthy eating guidelines still apply as we get older. The [Eatwell Guide](#) gives recommendations for eating healthily and achieving a balanced diet.

Weight gain particularly overweight in older adults should be a concern. The International Journal of Obesity reported that one in four older people were obese. This matters because it increases risk of type 2 diabetes and other cardiovascular conditions, some cancers as well as musculoskeletal and mobility problems.

In contrast some older people lose their appetite as part of the aging process. Those suffering from dementia or frailty are at particular risk of poor diet due to missed meals and poor eating habits leading to weight loss. Weight loss without any underlying medical condition should be investigated.

Supplements such as calcium, vitamin D and some micro nutrients are needed to protect against fall and fracture risk. GPs and pharmacists can identify drug/nutrient interactions which can occur with some prescription medicines.

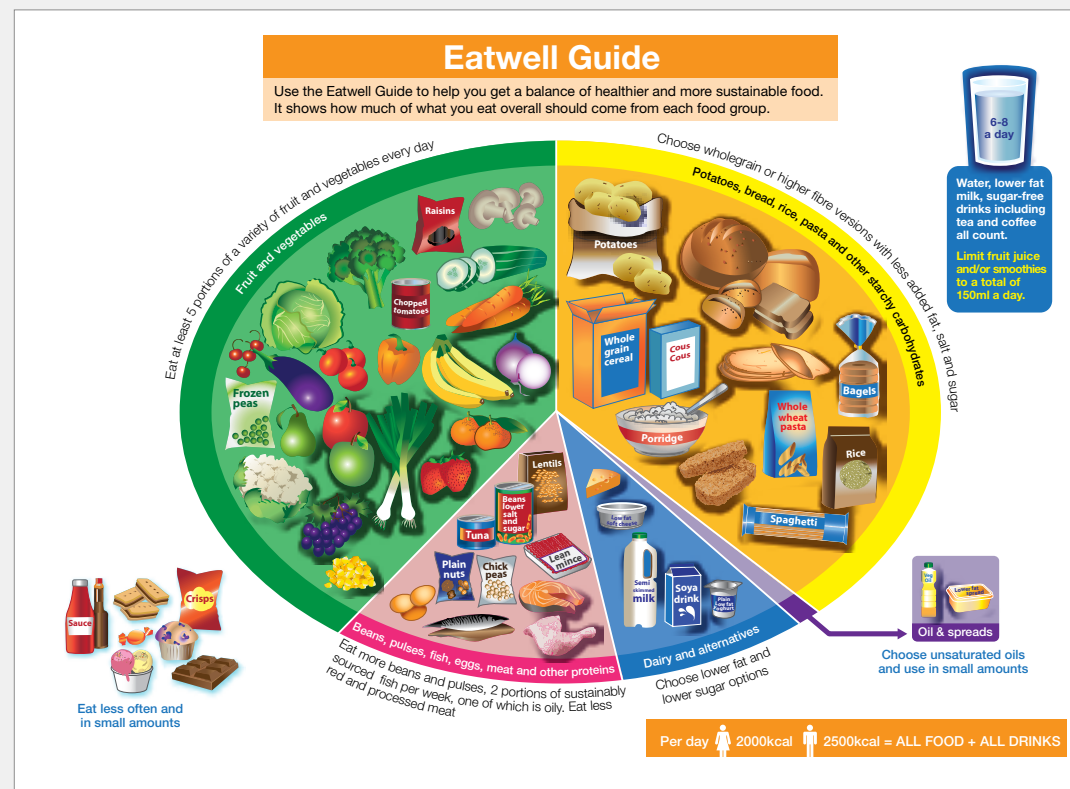
Fluid intake and adequate hydration is important at all ages. Many older people will limit fluid intake to reduce the number of visits to the toilet, particularly when they have incontinence or mobility issues. This can be counter productive as it can lead to dehydration and genitourinary infection (GUI). The advice is to have at least eight drinks a day, around 2.0 litres of fluid.

Good oral hygiene is essential as we grow older. Fifty per cent of over 75s rely on dentures and it is important that we keep our adult teeth for as long as we can. There is also evidence that poor oral hygiene can affect physical health including heart disease, stroke, diabetes and respiratory diseases such as pneumonia.

For more information:

[Oral Health Foundation](#)

## Eatwell Guide



## Smoking

Smoking remains the single biggest cause of premature and preventable death in North Yorkshire. Smoking prevalence in adults is 13.1% across North Yorkshire<sup>20</sup>. [Tobacco](#) is linked to more than 200 diseases and is the primary cause of lung cancer and Chronic Obstructive Pulmonary Disease (COPD), almost half of smoking related diseases are cancers. Smoking prevalence in the over 65s is lower than any other age group at 8.8% in 2015 across the UK, local data is not available<sup>20</sup>. As people get older they are more likely to have quit – partly reflecting that they had more time to do so.

Current and ex-smokers who require care in later life as a result of smoking related illnesses cost society an additional £14.6 million each year in North Yorkshire. The social care costs of smoking to North Yorkshire County Council (NYCC) are approximately £8,358,951 a year, and this is considered an underestimate<sup>21</sup>.

There is good evidence to show that stopping smoking can provide an increased quality and quantity of life in older adults by adding both 'years to life' and 'life to years'. Increasing evidence demonstrates that mortality is reduced among those who stop between 65-75 years and that the benefits of stopping smoking are almost immediate for some conditions. Smoking cessation in older adults can be challenging. Many smokers in this age group have smoked for several years and are strongly addicted to both nicotine and the habit<sup>22</sup>.

North Yorkshire has a FREE local Stop Smoking Service and is available for smokers of any age who wish to access support to quit. Visit [Smokefree Life North Yorkshire](#) or call 01609 663023 or text QUIT to 66777 for more information.

[The North Yorkshire Tobacco Control Strategy](#) has five priorities for tobacco control across North Yorkshire with a vision to inspire a smokefree generation.



[WWW.BREATHE2025.CO.UK](http://WWW.BREATHE2025.CO.UK)

### Case Study:

**Pat** is a 78-year-old great grandmother still working as a carer for the elderly. At a recent health-check at her GP surgery she was advised that a diagnosis of chronic lung disease was likely, having smoked 40-a-day for over 40 years. This spurred Pat on to contact the specialist stop smoking service. Pat admitted stopping was hard and that it took a while. She used patches and an inhalator to reduce the cravings and gradually cut down before stopping completely. The advisor saw Pat 12 times over a period of nearly five months. When Pat did stop smoking, her health improved quite quickly and she was delighted to lose her smoker's cough and be able to walk much further without having to stop to catch her breath. She does not know exactly how much money she has saved but has started to treat her family – and bought herself a £60 new handbag.

## Alcohol

Alcohol is broken down more slowly as we age and our sensitivity to the effects of alcohol increases the older we are. There is also evidence that the safe drinking levels for older people are up to half those of younger adults.

Problem drinking in older people can often be missed or misdiagnosed as a physical or mental health condition. 20% of older men are drinking at levels that are harmful to their health. The figure for women is 10%, but the rate is increasing more rapidly<sup>23</sup>.

An estimated one in three older people have drinking problems, with females being higher than males. Amongst 50-60 year olds, men are drinking approximately four to five units a week **less** than 20 years earlier. Women are drinking approximately two units a week **more** than 20 years earlier<sup>23</sup>.

For many of these, the problems have started in later life usually as a result of a trigger event such as bereavement, loneliness, isolation, retirement, divorce, unhappiness or depression. All are contributory factors.

Problem drinking has health impacts at any age, but in older age the negative aspects are more pronounced. For example taking alcohol with prescription medicines can cause an interaction affecting their efficacy. There is also an increased risk of trips and falls.



### Case study:

#### Alcohol Identification and Brief Advice (IBA)

IBA has been found to be one of the most straight forward and cost-effective approaches to reducing risky but non-dependent drinking at an individual level. It involves screening, using a validated tool, followed by a short structured conversation aimed at changing drinking behaviours. The conversation (intervention) usually lasts no longer than five to ten minutes and is aimed at motivating at-risk drinkers to reduce their alcohol use, or to offer referrals to treatment for dependent drinkers.

NYCC have commissioned Drugtrain to deliver free IBA training for front line non-alcohol specialist staff to enable them to offer effective support and advice to patients to raise awareness of the harmful effects of excessive drinking and to recognise sensible limits. To date over 900 front line staff have been trained including pharmacists, GPs and social workers.

Being able to raise the issue of alcohol use can be difficult so NYCC also provide resources such as rethink your drink scratch cards, information leaflets and alcohol unit wheels to help trained front line staff initiate those conversations about drinking levels.

(Health and social care professionals can book on to a training course by going to [www.drugtrain.org.uk](http://www.drugtrain.org.uk) and clicking the 'book now' button or by contacting Drugtrain directly on 01226 738321 or [admin@drugtrain.org.uk](mailto:admin@drugtrain.org.uk)).

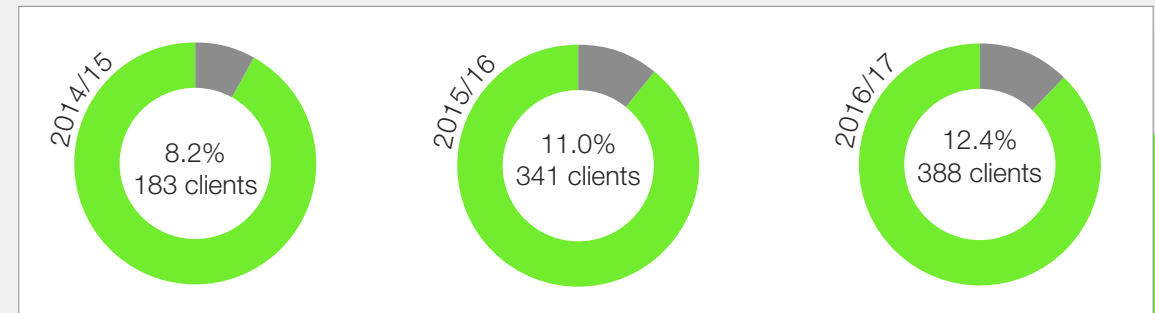
## Substance misuse

The Royal College of Psychiatrists report entitled '[Our Invisible Addicts](#)' notes that substance misuse amongst older people is a growing concern<sup>24</sup>. Evidence suggests that there has been a marked increase in illicit substance misuse in the over 40s in England<sup>25</sup>. Public Health England suggests that this is largely the result of a cohort of heroin users with cumulative and complex health and social needs, who began using heroin in the 1980s. This is the only age group where increasing numbers are engaging with substance misuse services, against a backdrop of reducing numbers engaging from all other age groups. Physical health complaints and prescribed medication regimes (intentional and inadvertent misuse) are highlighted as other important factors in substance misuse in older people<sup>25</sup>.

Older people who misuse substances are more at risk of early mortality than younger people. Physiological changes associated with ageing mean that older people are at increased risk of adverse effects from substance misuse, and chances of overdose are higher. Older people who misuse substances are also at increased risk of physical and mental co-morbidities.

Increasing numbers of over 55s have accessed North Yorkshire Horizons each year since it opened in 2014. The majority are male, in line with overall engagement. However, there has been a greater increase in women engaging with the service since 2014 (122% increase vs 106%) than men. Furthermore, there is a higher proportion of over 55 year old women engaged than over 55 year old men.

**Percentage of clients accessed North Yorkshire Horizons (aged 55+)**  
Source: North Yorkshire Horizons





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## Sex and relationships

Research has demonstrated that sexual activity in older people is as important to their quality of life as in younger adults. Positive sexuality and intimacy throughout the life course is linked to higher levels of happiness and wellbeing - irrespective of age<sup>26</sup>.

Whilst sexual function may be impaired by a combination of age and long term conditions, the fact remains that a healthy sex life into older age brings significant mental and physical benefits.

Alongside the obvious benefits however, there are risks. Rates of sexually transmitted infections (STIs) in older people has increased significantly in recent years. This amongst other things is a consequence of people leading longer, healthier lives and divorce and separation becoming more common, particularly later in life and providing an increased opportunity to form new, second relationships.

Many of the safe sex lessons heeded in teenage years are easily forgotten as couples form stable relationships and raise their families. But practicing safe sex and contraception are as important to older people as they are to younger people.

The CMO report in 2015 noted the increase in the proportion of new diagnoses of human immunodeficiency virus (HIV) in 50–70 year-olds; from 9% (626/7,366) of total new diagnoses in 2005 to 16% (901/5,559) in 2014<sup>27</sup>. The report recognises that “as treatment has advanced, the initial high rates of premature mortality seen with the disease have decreased and we are now seeing an ageing population of people with HIV. The proportion of people aged 50–70 years living with HIV has doubled over the past decade, with population projections indicating that more than half of people accessing HIV care will be over 50 years of age by 2028 (over double the proportion in 2013). The level of co-morbidity (related to age, treatment or other factors) in these patients is likely to increase.”<sup>27</sup>

YorSexualHealth provides a range of sexual health services across North Yorkshire – in 2016/17 there were 417 attendances at sexual health clinics by people aged over 55. In the last 12 months to 30 September 2016 there were new cases of sexually transmitted infections diagnosed in those aged 65 and above including chlamydia, herpes and genital warts, (GUMCAD data)<sup>28</sup>. This indicates that older people are still at risk of contracting STIs.



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# Making best use of health care in older age

With improvements in health and social care many more older people are living longer. Many of these are living with one or more long term conditions such as back pain, diabetes, hypertension, COPD or arthritis. Most long term conditions are more prevalent among older age groups; for example, the [prevalence](#) of diabetes rises steadily among men and women until their early eighties, peaking at 22% for men and 17% for women<sup>29</sup>. This has important implications for self care as management regimes become more complicated and demanding.

NICE have produced a guideline [Multimorbidity: clinical assessment and management](#) which covers optimising care for adults with multimorbidity (multiple long term conditions) by reducing treatment burden (polypharmacy and multiple appointments) and unplanned care. It aims to improve quality of life by promoting shared decisions based on what is important to each person in terms of treatments, health priorities, lifestyle and goals. The guideline sets out which people are most likely to benefit from an approach to care that takes account of multimorbidity, how they can be identified and what the care involves.

## Stay well: screening and care

A number of national screening programmes exist to identify people at risk of specific health problems:

- Abdominal aortic aneurysm
- Bowel screening
- Breast screening
- Cervical screening
- Diabetic Eye screening
- NHS Health Check

These programmes enable earlier diagnosis and earlier treatment where appropriate and in some cases information to help manage a long term condition.

For more information:

[NHS screening](#)

[NHS Health Check](#)

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## Cancer survivorship in older age

Although more people are being diagnosed with cancer, more are surviving a cancer diagnosis due to earlier detection and improved treatments. Cancer is moving from a disease where mortality was often the norm to one where more people can expect to live healthy and active lives for many years once their treatment is over. However, we know that one in three cancer survivors experience moderate to severe unmet needs at the end of treatment.

### Case study:

#### Recovery Package

Through the National Cancer Survivorship Initiative (NCSI) established in 2008, the concept of living with and beyond cancer and more recently the recovery package, the emphasis is moving away from acute episodic care towards an holistic, personalised approach that is coordinated and integrated. With this in mind the York Teaching Hospitals NHS Foundation Trust is developing and implementing the elements of the recovery package including stratified care pathways to enable individualised follow up care, either through supported self management with rapid access back into the specialist team should this be needed or continued face to face follow up with health care professionals.

### Case study:

#### Macmillan Active After Cancer project

Cancer and its treatments can cause physical changes, and dealing with these is often stressful. Being more physically active can help with some of the side effects experienced during and after cancer treatment, such as fatigue, stress, anxiety, weight gain and there's also some evidence that it may help reduce the risk of certain cancers coming back. This programme is grant funded until April 2018. Active After Cancer is a partnership between Inspiring Healthy Lifestyles and Macmillan Cancer Support.

Participants can be referred by a GP or specialist care/hospital unit or self refer into the program. They work with a specialist activity instructor at Selby Leisure Centre and Tadcaster Leisure Centre to support them to find safe and effective ways of becoming more active. In this, participants are provided with a range of individually tailored support, from supervised sessions, to a wide range of group activities and classes where there is an opportunity to meet other people who have had similar experiences. Activities include walking football sessions, specific swim sessions based on programme cards (Swimfit), health walk programmes inclusive of North Yorkshire Discoveries on your doorstep project as well as facility based fitness classes. To date 75 people have been through the project.

For more information:

[RCGP Consequences of cancer toolkit](#)

## Exercise on referral

### Case Study:

As more people live into older age with more long term conditions support for self care becomes increasingly important. Selby Wellbeing Team coordinate the GP referral to exercise programme providing tailored physical activity sessions to support patients experiencing a variety of medical conditions, including cardiac and stroke recovery, arthritis, mental health conditions, recovery from hip and knee replacement as well as cancer. The programme aims to create a sustained healthy lifestyle beyond the initial intervention by linking to the leisure centres and health walk programme.

This 12 week scheme allows participants to use fitness suites and studio facilities at Selby Leisure Centre and Tadcaster Leisure Centre under supervised sessions led by qualified fitness staff. Participants can also choose to take part in other activities such as walking football sessions, specific swim sessions based on programme cards (Swimfit), health walk programmes inclusive of NY Public Health Pathways to Health project as well as facility based fitness classes.

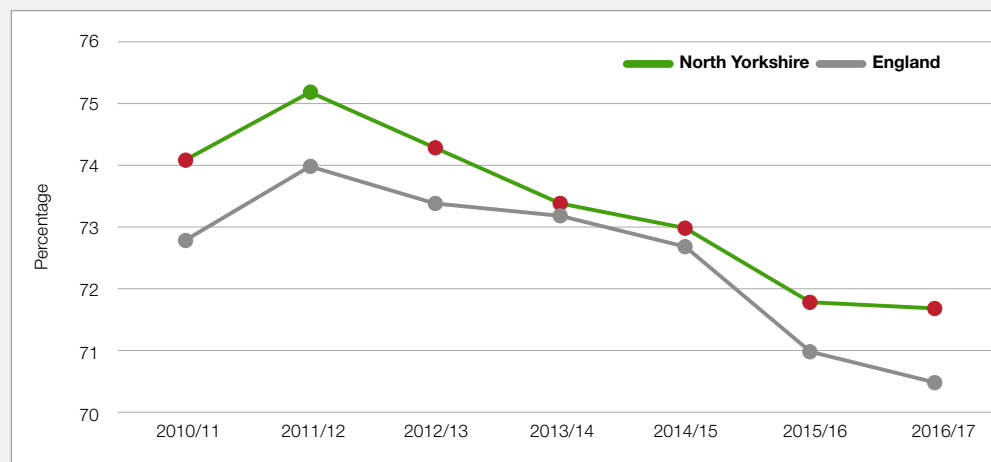
In the year 2016/2017 the exercise referral programme exceeded targets by engaging with 336 participants with a 72% completion rate of the 12 week program. 19% of participants converting to full leisure centre memberships following the initial introduction programme, guaranteeing sustained activity.

## Flu vaccinations

As the previous section noted, the proportion of deaths attributable to flu or pneumonia in the 65 and over population was 6%, rising to 7% in the over 80 population. The high proportion of deaths in the 65 and over population caused by influenza/pneumonia highlights the importance of winter health promotion and the role the annual flu vaccine can play in health protection. Anyone 65 and over and those with certain health conditions are eligible for a free seasonal flu jab, which can reduce the chances of catching flu and associated complications. In 2015/16 just 71.8% of those eligible 65 and over took up flu vaccination from their GP. (Excludes uptake at pharmacies)

### Population vaccination coverage - Flu (aged 65 and over)

Source: gov.uk, seasonal flu vaccine uptake statistics, 2016



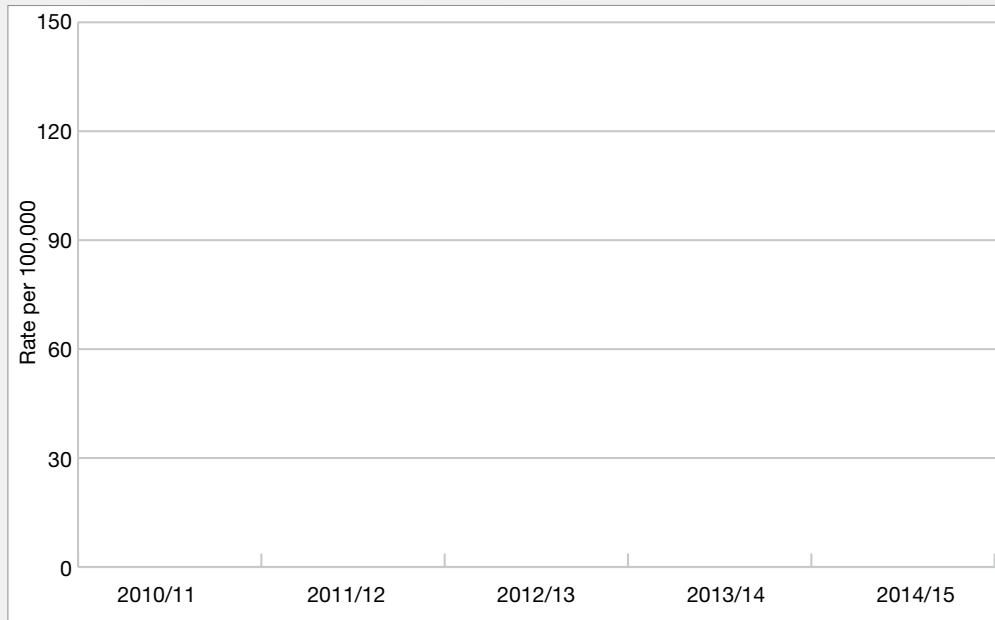
## Sight and hearing loss

Sight and hearing deteriorates slowly with age and often can be imperceptible. Whilst age and genetic factors play a part; lifestyle choices like smoking, alcohol or substance use, and inactivity all contribute to preventing sight loss. Regular eyesight checks (free for those 60 and over) can detect glaucoma, cataracts and age related macular degeneration.

Hearing tests can identify any reduction in hearing capacity and identify any need for hearing aids. [Data predicts](#) increasing numbers of people living with sight and hearing loss in North Yorkshire.

### Preventable sight loss

Source: PHE, accessed May 17



Click on the buttons below to reveal the trends

Age Related Macular Degeneration (AMD) (aged 65+) - [England](#) [North Yorkshire](#)

Preventable Sight Loss Certifications (all ages) - [England](#) [North Yorkshire](#)

Glaucoma (aged 40+) - [England](#) [North Yorkshire](#)

Diabetic Eye Disease (aged 12+ yrs) - [England](#) [North Yorkshire](#)

For more information:

[Sight loss in older people](#)

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# Volunteering

“An activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives.”

Volunteering Compact and Code of Good Practice, Home Office, London, 2005

Last year more than 21 million people in the UK formally volunteered at least once a year contributing an estimated £24bn to the UK economy<sup>30</sup>. Last year almost half of 55-74 year olds in the UK volunteered, contributing 1.4 billion hours to causes. At both a local and national level, volunteering is increasingly regarded as a key mechanism by which communities can be strengthened and made more resilient and by which society can flourish. A growing ageing population and tough financial circumstances mean that local communities will need to provide more of the support that they need. It is in this context that volunteering, particularly amongst older and retired people will become ever more critical.

There is a strong tradition of volunteering throughout North Yorkshire, with individuals who are engaged with their communities at a grassroots level. More than 5,000 voluntary and community sector organisations in the County are supported by an estimated 139,000 volunteers.

Increasingly research is showing that volunteering actually has significant personal benefits, particularly for health and wellbeing, and that these benefits are more pronounced in older volunteers than younger ones<sup>31</sup>. These benefits include better physical and mental health as well as connecting to others with a sense of purpose. It follows that we need to challenge some of those conventional perceptions about older and retired people as simply users of services and instead recognise that they can offer communities significant resources, with a wealth of untapped assets and skills nurtured through a lifetime of work which can be mobilised to the benefit of others, and themselves.

For more information:

## Volunteering Opportunities

Community First Yorkshire

<http://communityfirstyorkshire.org.uk/volunteering>

## Where volunteering begins





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## Supporting older volunteers

There are a number of things that organisations can do to help encourage and retain older volunteers. In their report 'Older People as Volunteers – Evidence Review' Age UK (2011) highlights a number of potential barriers to volunteering as well as good practice; how to recruit, support and retain volunteers. Some considerations are summarised below:

### Barriers

1. **Policies and practices of organisations** - policies and practices of your organisation are sub-consciously or overtly ageist, for instance: a bias towards recruiting younger volunteers or stereotyping suitable activities for older volunteers.
2. **A lack of knowledge** - both about the roles and responsibilities that organisations offer, but also about where to go for information.
3. **The location and transport available** - where the volunteering opportunities are and how to access them can be significant barriers to older people, especially in rural communities. People over 65 are less likely to own a car than other age groups and more dependent on public or community transport.

### Retention

1. **Feeling appreciated** - that a volunteer feels they are doing something worthwhile and that they are respected and acknowledged for their contribution. Organisations working with volunteers to foster and apply their skills and to offer them the opportunity to make a real difference. Studies also show that health benefits are more pronounced in those older volunteers who are in positions that require specialised skills and/or that contributed to public safety than those who worked in generalist roles, such as administrative support.
2. **Training** - appropriate training, particularly on the job training can enhance a volunteer's knowledge, skills and confidence. The language and delivery of training is particularly important to help overcome a 'too old to learn' mentality or back to school nature of classroom learning.
3. **Managing the relationship between paid staff and volunteers** - paid staff are essential to create a welcoming environment and can be important in the roles and responsibilities of volunteers. However, staff can feel threatened by volunteers, particularly younger staff and older volunteers and similarly older people can feel unwanted and undervalued.

# Carers

Being an unpaid carer is a role that can affect many people during the course of their life. Whether caring for family members or friends, carers play a vital role in maintaining the health and wellbeing of those who need help. Three in five people will be a carer at some point and almost everyone will know family members, friends and colleagues who are currently carers.

As described in our earlier section many older people are carers and this is predicted to increase. It is vital that carers are supported both in undertaking this role but also in maintaining their own health and wellbeing.

## NYCC Carers Strategy 2017-2022 - Supporting the health and wellbeing of unpaid carers in North Yorkshire

In summer 2016, NYCC asked members of the public to tell us what they thought the big issues affecting unpaid carers were. Carers do not see themselves as carers but as lifelong partners, sons, daughters, siblings, neighbours and friends. People do not resent being carers, but the commitment and social isolation can be overwhelming at times.

Engagement with carers identified a number of themes to focus on in the carers' strategy:

- Identifying carers
- Advice and information
- Giving carers a break
- Carer health and wellbeing
- Financial wellbeing
- Carers being more involved in care

## Case Study

### A Little Bit of Help from Scarborough and Ryedale Carers Resource

Mr Batley contacted Carers Resource saying he was struggling to maintain his garden now that he was caring for his wife who had mobility problems, following an accident. He was willing and able to continue caring for his wife but was feeling stressed as the weeds grew in what was once his pride and joy.

We sent him a list of local gardeners, together with our information pack. He was added to our mailing list and so keeps up to date with carers issues via our newsletter, 'Focus Carer'. He also periodically rings our helpline for specific pieces of information and advice. His latest enquiry was related to applying for a Blue Badge for his wife whose mobility problems had deteriorated recently. We were able to advise him on the eligibility and how to apply. During the discussion it became evident that Mrs Batley's mobility issues were affecting her ability to move around the home and we agreed to make a referral to Health & Adult Services for a needs assessment relating to this. They were provided with equipment in the home that aided daily living for both of them. Mr Batley also reported that his back pain had reduced significantly since using the new equipment to transfer his wife.

***The carers resource involvement helped the couple maintain their independence at home and prevent further health problems for the carer***

Further Information about services available and contact details available at [www.northyorks.gov.uk/carers](http://www.northyorks.gov.uk/carers)

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• Carers' Resource (Adult Carers Only) - Harrogate and Craven Districts</li><li>• Hambleton &amp; Richmondshire Carers Centre - Hambleton and Richmondshire Districts</li><li>• Scarborough &amp; Ryedale Carers Resource - Ryedale and Scarborough Districts</li><li>• Carers Count (Adult Carers Only) - Selby District</li></ul> | <p>National Information</p> <ul style="list-style-type: none"><li>• <a href="#">National Carers Strategy</a></li><li>• <a href="#">Carers UK</a></li><li>• <a href="#">Carers Resource</a></li><li>• <a href="#">Care Act</a></li></ul> |
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# Financial planning and economic wellbeing

At £320 billion a year, the so called 'grey pound' is vital to the UK economy and it is estimated that people aged over 50 years account for almost 48% of all UK consumer spending in 2012, up from 41% in 2003<sup>32</sup>.

Many children born in the post war years until the 1960s, the baby boomers, have indexed linked final salary pensions. New pension freedoms also allow significant value to be released from pensions as cash. Recent improvements to state pensions including the 'triple lock increases' have led to pensioners now typically having higher incomes than non-pensioners<sup>33</sup>. Home ownership in this group is also high and with rising property values, many older people have a significant cash asset, their home. ONS figures show that average pensioner income increased by an estimated 50% in real terms between 1995 and 2011, and more than one in 10 pensioners have total wealth of £1m or more, helped by spiralling property prices.

However, these figures conceal considerable variations between rich and poor, with the richest quarter of pensioners earning three to four times more than the bottom quartile. More than one in seven will retire with no pension other than what they get from the state. Women are particularly hard-hit, retiring

on 47% less on average than men, according to research from [pension firm LV](#). Older pensioners (especially those aged 85+), single people living alone, private tenants and Asian pensioners are also at particular risk. These statistics highlight the importance of planning for economic wellbeing in older age.

## Staying in work

Data on older people's incomes at local level is limited. Locally the ratio of working age adults to pensioners is reducing from 3.9:1 in 2000 to a projected 2.1:1 in 2025. It is unlikely that these ratios will be sustainable, suggesting that the recent rises in state pension age are likely to continue, to reflect the progressive increase in the older population.

## Poverty

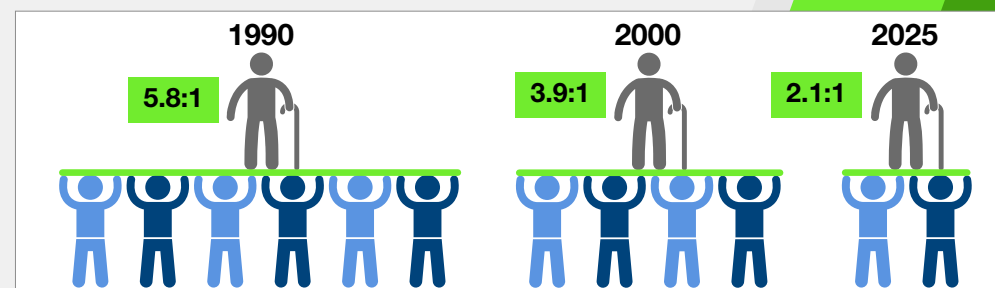
Nationally Age UK (2016) report that one in seven pensioners live in poverty, defined as having incomes of less than 60% of median income after housing costs. A further 1.2 million pensioners have incomes just above the poverty line (more than 60% but less than 70% of median income)<sup>34</sup>. Low income in retirement is often linked to earlier low pay, or time out of employment, for example due to caring responsibilities, disability or unemployment.

In North Yorkshire 11% of people aged 60 and over are living in [income deprivation](#). Harrogate has significantly more (16.3%) than both County (11.1%) and national

average (16.2%) whereas there are significantly fewer in Richmondshire (9.1%)<sup>35</sup>. It is worth noting that for 2014/15 DWP estimated that only 60% of eligible pensioners claimed the benefit so this is likely to be an underestimate of income deprivation. ([Income related benefits](#)).

In North Yorkshire in 2015/16 there were 135,240 people aged 65 and over in receipt of winter fuel payments (estimated uptake 96.3%). This is similar uptake to national levels. ([Winter fuel payment recipient and household figures](#).) Older people are one of the priority groups in [North Yorkshire's Winter Health Strategy 2015- 2020](#). This strategy describes outcomes to support those at risk. Fuel poverty vulnerability maps and information are available at: [Yorkshire Energy Doctor](#).

## Ratio of workers to pensioners



# Financial planning and economic wellbeing

## Planning for economic wellbeing

Too many people delay planning for old age. Making decisions about the future early enough can mean people can share their wishes with loved ones and put protection in place to ensure they get what they want.

There can be advantages in doing this well before retirement for many people.

### Lasting power of attorney

Lasting power of attorney (LPA) An LPA is a legal document that lets the 'donor' choose trusted people ('attorneys') to make financial decisions or health and care decisions on their behalf. There are two types of LPA:

- LPA for financial decisions
- LPA for health and welfare decisions

For more information:

[Age UK: Power of attorney](#)

[Age UK: Making a will](#)

## Making a will

Many people don't like to think about making a will but it is the only way to let people decide what happens to their money, property and possessions after their death.

### Help to access entitlements

In North Yorkshire approximately 75% of the six thousand annual financial assessments for mainstream social care recipients are aged 60 and over. In 2016/17 NYCC's income maximisation team received 2,394 referrals, from which 1,908 new benefits were claimed. In all, weekly amounts increased by over £4,000,000.

The following case studies illustrate outcomes from the income maximisation team at NYCC:

## Case Study

**"I visited Mr and Mrs L when I received a referral from the sensory team.** Mr L is registered as sight impaired. I discussed an Attendance Allowance upgrade with Mr L but he identified that he did not meet the criteria as he did not need night time care. However on speaking to the family it transpired that Mrs L suffered with memory loss. I completed an Attendance Allowance application for her which was awarded at the standard rate. I then re-visited the couple and completed a pension credit application by phone and also applied for carers premiums for both online. Mr and Mrs L were already in receipt of council tax benefit.

***Their income therefore increased by £228.98 per week."***

## Case Study

**"Mrs P is a 90 year old lady who lives on her own in her own home.** She used to live with her sister who sadly passed away. She was referred after coming out of hospital but unfortunately the appointment was delayed due to her being readmitted. Initially she was very concerned about my visit and cancelled several visits. However after several calls to discuss things with Mrs P and her niece she eventually agreed to a visit. I visited and spent a little time explaining the benefits to Mrs P who was struggling to maintain her home and put her at ease. I claimed Attendance Allowance for her which was awarded at higher rate. I then claimed the Severe Disability Premium for her to increase her pension credits. Mrs P now has someone visiting her daily and has a cleaner who is maintaining her home. She is also now able to pay for workmen to do jobs around the bungalow that had been worrying her.

***Her income increased by £144.15 per week."***



## Transition 2: From healthy retirement to increasing need for support

This section describes the transition from independent healthy living to needing more care and support over time. **Five case studies** illustrate the trigger points that affect older people's lives, the services that provide support and some of the outcomes. These include early prevention by the Living Well team, falls prevention activities in the NHS, supported housing provision and services provided by the voluntary sector.

Over time most older people will need more support. The rate at which this happens is affected by many factors.

Support may come from a number of sources including:

- Family members
- Friends
- Voluntary and community groups such as Age UK and faith communities
- Adult social care providers including local authority and private provision
- NHS including GPs and health centres, community health services, acute hospitals and mental health services
- Technology

Fundamentally this support must meet individual's needs whilst maintaining their independence and dignity.

In this section we tell the stories of five different older people, the difficulties that they have, but also their strengths and the services that provide them with support.

The stories and pictures are of fictional older people but the experiences are real; based on the stories of real people living in North Yorkshire.

As you read the case studies click on the tabs at the bottom of the page to see the support available.



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## Transition 3: End of life



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# Overview

End of life care focuses on people who are considered to be in their last year of life. This covers a wide range of people, from those with advanced, incurable conditions to those with life-threatening injuries from a sudden catastrophic event. End of life care includes the palliative management of pain and other symptoms, and also the provision of psychological, social, spiritual and practical support.

In 2015 there were 6352 deaths in North Yorkshire across all age groups (1.05% of the total County population)<sup>36</sup>. Of these, 50.8% (3121) died in their usual place of residence. The main causes of death in North Yorkshire continue to be cardiovascular disease, cancer and respiratory diseases.

NY has committed to improving care for people at the end of life. 'Dying Well' is one of the five key themes for the Joint Health & Wellbeing Strategy 2015-20, focusing on increased training for staff and enabling more people to die in the place that they choose.

The North Yorkshire [Joint Strategic Needs Assessment \(JSNA\)](#) includes a report on end of life care, which highlights areas of good practice and areas for improvement.

This section focuses on the key issues faced by individuals, communities and service providers/commissioners around end of life care in North Yorkshire. It also looks at some of the local ways in which these issues are being addressed, and what more needs to be done to ensure good quality end of life care is provided for everyone.

## Why Dying Matters



## VOICES survey

The [National Survey of Bereaved People \(VOICES\)](#) looks at the quality of care delivered in the last three months of life for adults who died in England. In 2015 the survey found that<sup>43</sup>:

- **Three out of four bereaved people (75%) rated the overall quality of end of life care for their relative as outstanding, excellent or good; one out of ten (10%) rated care as poor**
- **Seven out of ten people (69%) rated hospital care as outstanding, excellent or good which is significantly lower compared with care homes (82%), hospice care (79%) or care at home (79%)**
- **Ratings of fair or poor quality of care are significantly higher for those living in the most deprived areas (29%) compared with the least deprived areas (22%)**
- **One out of three (33%) reported that the hospital services did not work well together with GP and other services outside the hospital**
- **Almost three out of four (74%) respondents felt hospital was the right place for the patient to die, despite only 3% of all respondents stating patients wanted to die in hospital**

For more information:

[Ambitions for Palliative and End of Life Care](#)

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## Where are people dying?

In North Yorkshire in 2015, 41.5% (2634) of people died in hospital, 26.1% (1658) died in care homes, 24.2% (1537) died at home, 6.1% (388) died in hospices and 2.13% (135) died in other places<sup>37</sup>. For just over half of these individuals (50.8%), death occurred in their usual place of residence<sup>37</sup>.

Compared to the national average (2015)<sup>38</sup>:

- More people in North Yorkshire are dying in their usual place of residence across all causes and age groups
- Fewer people are dying in hospital across all age groups
- More people are dying in care homes, particularly those aged 75 plus
- More people are dying at home, particularly those aged 65-74yrs
- More people aged 0-64 are dying in hospices

End of life care has previously focused on enabling people to die at home rather than in hospitals, after national research found that the majority of people would prefer to die at home. However, current good practice now shows that the focus should be on achieving patient preferences as it is recognised that dying at home is not desirable for everyone.

It has also been recognised that people change their preferences around place of death at different stages of illness, particularly when symptoms worsen in the last few days of life; people who may previously have wished to die at home sometimes decide they would rather die in a place where they have better access to treatments such as pain management.

Planning for end of life is therefore very important – individuals need to consider what matters to them at the end of their life and discuss this with loved ones and those involved in their care. Similarly, all staff need to be trained to the right level to ensure that people experience a good quality death across all available settings.

### Report recommendations

## Gold Line video (Bea)



## Case Study

### St Catherine's Hospice – community hospice services

Hospice at Home – a nursing service run by the hospice in partnership with Marie Curie to provide a 'hands on' support service to Scarborough and Filey patients in the final stages of a life-limiting illness. The service provides 24/7 access to clinical expertise, and enables patients to remain in their homes at the end of life.

St Catherine's also runs three Day Hospices in Scarborough, Whitby and Ryedale that provide specialist care, treatment, advice and rehabilitation for palliative patients.

St Catherine's community specialist palliative care nurses also provide community support to GPs, district nurses and palliative patients and families in their own homes.

For more information:

[Public Health England \(PHE\) End of Life Care Profile](#)

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## Impact of causes of death on end of life care

The top three causes of death in the UK are cancer, cardiovascular disease and respiratory diseases.

[link to section in demography](#)

Despite growing awareness of inequalities between cancer and non-cancer patients, people dying of cancer are more likely to receive substantial end of life care compared to those with other diseases (for example better access to hospice care). End of life issues are more commonly associated with cancer and so form a natural part of cancer care pathways. However, despite other conditions (such as heart or liver failure) often having a worse prognosis than some cancers, end of life care is not often addressed as part of routine care pathways for these patients.

People are increasingly dying of, or with, significant co-morbidities such as dementia. These co-morbidities often require complex management, and can further complicate provision of effective end of life care. Towards the end of life the focus often shifts from preventing complications to symptom management.

There are also non-medical considerations regarding long-term conditions. For example, failure to discuss advance care planning early on with people with dementia can lead to legal and ethical issues surrounding individual's wishes once they are judged to no longer have mental capacity to make decisions for themselves.

## Playing Dead



### Then and now

Having the majority of people dying from cancer and heart disease is a relatively new phenomenon. In the mid-nineteenth century more than 50% of deaths were caused by infectious diseases such as tuberculosis and measles, with children particularly affected. At the beginning of the twentieth century over 60% of people died before the age of 60; however, by the end of the century this had decreased to just 12%.

Medical and societal advancements during the last 150 years have meant that the number of deaths from infectious diseases has significantly decreased. Improvements in sanitation, along with the introduction of more effective therapies such as antibiotics and vaccination, have made once-common diseases increasingly preventable and curable. Life expectancy has therefore increased, which has led to more people dying of diseases of old age such as cancer and heart disease.

However, although this is the case in the UK, in other countries around the globe the pattern of dying is very different. Many developing countries still have large numbers of deaths from infectious diseases, particularly diarrhoeal diseases and AIDS. More detail on causes of death at global, national and regional level can be found through the Global Burden of Disease study.

For more information:

[Public Health England \(PHE\) End of Life Care Profile](#)  
[WHO Global Health Observatory](#)

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## Impact of an ageing population

Currently just over 1% of the population die every year. However, with the UK's ageing population the number of deaths in England and Wales is expected to rise by 17% from 2012 to 2030<sup>39</sup>. People are living longer and with more comorbidities, providing challenges across both health and social care in terms of maintaining good quality service provision to all.

As previously described in this report the population of North Yorkshire continues to grow and age. This will have numerous effects on local communities, including the need for more, and more complex, end of life care.

Older people, particularly those with [dementia](#), are at risk of not receiving sufficient good quality end of life care. They often have multiple health problems requiring complex care, and lower levels of social support. The Care Quality Commission (CQC) has identified particular challenges facing dementia patients at the end of life,

Elderly people are also more likely to have multiple hospital admissions during the last year of life. This is both costly for health services and often unnecessary for individuals, who either may not wish for or may not benefit from secondary care interventions. Providing community-based models of care will help to keep people in their own home for longer and reduce unnecessary hospital admissions.

Public Health England (PHE) has recently released a tool for commissioners highlighting the estimated return on investment associated with interventions that assist in shifting end of life care out of secondary services. This also includes an overview of existing literature on cost-effective interventions, which taken together promote a cost-effective approach to commissioning in end of life care.

## Dying Matters poem (elderly)



## CQC Inequalities Report

The CQC report '[A different ending: addressing inequalities in end of life care](#)' (May 2016) identified ten groups of people at risk of receiving poorer quality end of life care. These were:

- People with conditions other than cancer
- Older people
- People with dementia
- People from black and minority ethnic (BME) groups
- Lesbian, gay, bisexual and transgender people
- People with a learning disability
- People with a mental health condition
- People who are homeless
- People who are in secure or detained settings
- Gypsies and travellers

The report found that commissioners and services taking an equality-led approach responding to individual needs provided a better level of care. Recommendations to achieve this included improving staff training, increasing collaboration between commissioners and providers and a focus on individual patient-centred care.

For more information:

[Dementia strategy](#)



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# Improving the quality of End of Life care

## Co-ordination

Many people from many different organisations and sectors are involved in end of life care. Sharing information is vital to ensure that care is delivered smoothly, and to avoid gaps, delays and possible duplication between services. Unfortunately, not all services use the same data recording systems so most patient records are not visible across all relevant organisations. This leads to frustration where patients and carers find themselves repeating information multiple times, which can result in miscommunication and delays in care. Having a means of effectively sharing end of life care information between organisations would improve the quality of care received<sup>40</sup>.

There is need for greater communication between commissioners and providers of end of life care across North Yorkshire. There are many examples of good end of life care services in different areas across the County, which could be learned from and implemented more widely where appropriate.

North Yorkshire has recognised this need and is currently developing a multi-agency forum for end of life care, which will bring together experts from different areas to share knowledge and develop connections to improve end of life experiences for North Yorkshire residents.

## Gold Line video



## Case Study

### Gold Line

The [Gold Line](#) is a 24/7 phone service staffed by senior nurses at Airedale Hospital, available to people in Airedale, Wharfedale, Craven and Bradford who are on the Gold Standards Framework. It is currently also available to palliative patients living in care homes across Hambleton, Richmondshire and Whitby. The nurses provide direct advice and support, and can also arrange admissions and home visits as required through their links to other services. As well as a telephone line, some patients are also provided with iPads to enable face-to-face communication via a video link. The service is available to care homes as well as individuals. The Gold Line nurses can access patients' records, and so can provide coordinated practical support as well as emotional support.

The Gold Line currently works with nearly 1200 people at the end of life, and answers more than 500 phone calls a month. The service has made a positive impact on the number of people at the end of life attending A&E, being admitted to hospital and requiring extra home visits from GPs/community nurses. In 2014/15, only 13% of people registered with the Gold Line died in hospital (compared to the national figure of 58%).



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## Communication

Throughout most of history, exposure to death has been commonplace. However, as death in the UK has become increasingly medicalised and sanitised over the last 100 years it has become an increasingly taboo topic for conversation.

There is a growing popular movement to encourage discussions around death and dying, with recent events including local death cafes (see case study), twitter conversation hashtags, 'Dying Matters' awareness week and even a festival (Pushing Up Daisies, Todmorden). Inspiration has been taken from other cultures where death has never been viewed as unmentionable, such as in Mexico where the Day of the Dead (Día De Los Muertos) is an important public holiday.

However, there is still a long way to go before discussing death is seen as socially acceptable to everyone. Although having open discussions is recognised as vitally important to providing effective end of life care, research suggests that both patients and medical professionals are reluctant to approach discussions around death unless the other brings it up first.

Communication therefore needs to improve across a range of relationships in end of life care. This includes:

- Between healthcare staff and patients
- Between dying individuals and their families
- Between different teams of healthcare staff

There also need to be better documentation of any formal discussions, and encouragement to complete important documents such as advance care plans and advance directives as early as possible.

## Dying Matters – I Didn't Want That



### Case Study

#### Death cafe

Several locations in North Yorkshire have joined the global 'Death Café movement, putting on regular, open-invite events for people to discuss end of life issues. Death Cafés began in 2011, and have quickly become a social franchise centred on people (often strangers) gathering in community locations to 'eat cake, drink tea and discuss death'. Death Cafes involve group-directed discussion of death with no agenda, objectives or themes.

For more information:

[Death café website](#)

**Advance Care Plans**

- [Information for patients](#)
- [Guidance for staff](#)

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## Training

Many people are involved in delivering end of life care. Some people are specialists in palliative care; however, the majority are non-specialists, which includes health and social care staff but also family/carers, legal advisors and members of the spiritual community.

Many individuals currently feel unable to cope with the end of life care issues they are presented with, which they often put down to a lack of training. This is a key cause of people being admitted to hospital during the end of life phase, particularly as clinical symptoms worsen. As well as focusing on health and social care staff, it is important to up-skill voluntary carers in order to increase the amount of support they can provide, particularly in a home/community setting.

A recent audit of North Yorkshire care home records found that many people were being admitted, particularly from hospital, without having any discussions around end of life care or future wishes. Appropriate training is required to increase staff confidence around end of life care, which should include the ability to identify people who may be approaching the end of life and how to initiate discussions on dying with those people.

Outcomes in end of life care currently focus around place of death, with deaths at home (or in a person's usual place of residence) seen as preferable to dying in hospital. However, for some people dying in hospital remains appropriate. It is therefore important to ensure that wherever people are dying they are receiving the same level of high-quality care. This requires people across all care settings having access to the right standard of training to meet their needs.

The recently-released [national framework on end of life care training](#) sets out the core knowledge and skills needed for individuals involved in all levels of end of life care, set out into three distinct tiers. This includes health and social care employers/employees, patients, carers, the community, public and educational organisations which train students who will subsequently be employed in the health and social care workforce.

## Kate's Story



### Case Study

#### Carers' Resource Family Link Workers project

Carers' Resource received funding from Morrisons Supermarket to provide two family link workers based at Manorlands Hospice who could provide one to one support for carers of people with terminal illnesses. Support is tailored to the individual's needs, and can include emotional support, information, guidance and signposting to other services. Over 170 families and staff have been supported by the scheme.

For more information:

[NICE Quality Standard](#)

[Y&H care homes guidance](#)

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## Communities

There has been a national focus on providing community-centred care across both end of life care and health and social care more widely. As well as improving patient-reported quality of care, end of life care pathways that allow more people to die at home rather than in hospital have been found to be more cost-effective.

Effective community care is particularly important in North Yorkshire, where a significant proportion of the population live in rural areas away from specialist palliative care centres. Outreach services such as hospice at home are vital to ensure all people receive the same quality of end of life care, regardless of where in the County they live.

**End of life care**, particularly bereavement, fits into the wider community focus on social isolation and loss. Both dying individuals and their carers experience loneliness and isolation as a result of coping with illness and following a death. National end of life and palliative care guidelines emphasise the development of 'compassionate communities', where it is acknowledged that finding solutions to problems such as social isolation, carer fatigue and stigma is not the sole responsibility of health professionals but requires a whole-community approach. Central to this has been the adoption of Compassionate City/Community Charters, which provide a basic set of principles that can be taken up by individuals, communities and organisations to demonstrate their commitment to improving end of life care. One example is the **Dying Well Community Charter** developed by the National Council of Palliative Care, which has already been implemented at key locations across the country. North Yorkshire is currently developing its own version, evolving from discussions with community stakeholders at the North Yorkshire Wider Partnership Conference in October 2016.

### Case Study

#### Herriot Hospice Homecare

**Herriot Hospice Homecare** provides care to residents of Hambleton and Richmondshire in their own homes. They are part of the wider Community Palliative Care Team, working with local hospitals, doctors, nurses and social services.

Services provided include befriending for people living alone or who need support whilst undergoing treatment, respite sitting to relieve carers for a few hours, a patient grant service to relieve financial crises (both patients and carers), a driving service to take people to/from hospital appointments, bereavement counselling (for adults and children), and at-home therapy services (including aromatherapy, reflexology, acupuncture, chiropody and nail technician/hairdressing).

For more information:

[Guidance for Community Development in End of Life Care](#)

[North Yorkshire Forum for Voluntary Organisations](#)

[National Council for Palliative Care: Dying Matters](#)

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## Holistic Care

At the end of life people often have significant medical problems that need to be addressed, particularly regarding pain. However, focusing on medical needs can cause other important needs to be overlooked. Good end of life care should involve treating individuals and their families as holistically as possible, including support with social, spiritual, legal and financial issues as well as both practical and emotional support.

In order to achieve this, healthcare services need to be better integrated with non-healthcare services. This could be as simple as referring to the local chaplaincy service, or providing information on who to talk to about making a will. Providing support around bereavement care is also important, particularly for carers and relatives.

Often consideration of these extra needs is what makes the biggest difference to dying people and their families. Many people report that their biggest fears involve simple, non-medical issues, such as how they will get their shopping or who will look after their dog once they have died. Assistance with these everyday problems is therefore key to making sure that people are dying well.

## Dying Matters – Amy Logan



### Case Study

#### The Sunflower Centre

[The Sunflower Centre](#) is the new day centre for St Leonard's Hospice, York. It provides a range of wellbeing services to dying people and their families from York and Vale of York. It aims to provide holistic care, with support for emotional and spiritual issues as well as physical symptoms. Some of the services are available via referral only, but they have weekly drop ins and fortnightly drop in bereavement sessions available to anyone affected by terminal illness (both patients and carers).

As well as art therapy and diversional therapies (such as painting, creative writing or mindfulness) patients and carers also have access to free complementary therapies such as aromatherapy, Reiki and reflexology. Sessions are also available on managing symptoms such as anxiety, breathlessness and living with the risk of falls. The overall aim of the Sunflower Centre is 'to enable patients to achieve the things that are important to them and to keep control of their lives and illness as much as possible'.

For more information:

[Age UK](#)

[Marie Curie end of life guide](#)

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## Bereavement

End of life care is not just about supporting the dying individual. It should also include support for their carers, both before and after the death. One important part of this is bereavement (and pre-bereavement) care.

Bereavement is a difficult time, and is experienced differently by all people. The loss of a friend or relative can affect individuals in different ways: the period of grief may last for different lengths of time, and grief itself may be expressed differently between people.

Not everyone will need formal support for each death that they experience. However, support should be available for all people who need it, whether as a one-off conversation or for those who need a more extended period of support.

In North Yorkshire bereavement support is provided free of charge by the local hospices. Other voluntary sector organisations such as [Cruse](#) Bereavement Care and Samaritans offer bereavement support.

Practical support is also needed following a death as well as emotional support. Further information on registering a death and the national 'Tell us once' service can be found on the NYCC website.

### NHS Choices video – Bereavement: life after being a carer



### Case Study

#### Just 'B'

[Just 'B'](#) is a service provided by St Michael's Hospice that offers bereavement support to those living in the Harrogate district. It is available for children, young people and adults, and covers all forms of bereavement. Services offered include telephone support, face to face support, group support and remembrance services. Just 'B' also offer written and verbal advice on pre- and post-bereavement, and can provide input from a psychologist where appropriate.

The Just 'B' team can be contacted on:  
Tel: 01423 856 790  
Email: [info@justb.org.uk](mailto:info@justb.org.uk)

For more information:

[St Leonard's bereavement care and bereavement drop-in service](#)

[St Catherine's Bereavement Support Service](#)  
(individual, group and telephone support)

[NYCC: 'after a death'](#)

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## Key actions to improve end of life care

### Key actions for individuals:

- To engage in and encourage communication around death and end of life care

When problems are talked about it is much easier to address them successfully. If we can normalise talking about death before people reach the dying stage it will be easier for people to have crucial conversations with carers and healthcare staff when they are most needed.

Communication should include written communication of individuals' wishes as well as verbal communication; for example the completion of advance care plans and advance directives. It should also include discussing individuals' wishes beyond just those associated with medical treatment, covering all holistic needs of individuals and their families.

### Key actions for systems leaders:

- To facilitate the setting up of a multi-agency forum on end of life care covering the whole of North Yorkshire to provide strategic leadership and direction

Membership of the forum should include commissioners, providers, voluntary sector and patient/carer representatives. The forum will enable communication, co-ordination and training needs to be met, along with setting and monitoring of appropriate outcomes for end of life care.

## Dying Well in North Yorkshire

The [North Yorkshire Joint Health & Wellbeing Strategy 2015-2020](#) states that by 2020 you can expect to see:

- A greater range of support options for people in their last years of life
- More people receiving support for themselves and their families at the end of life
- More people dying at home or in the place that they choose
- Greater numbers of trained staff and carers with deeper understanding about the range of issues in end of life care
- Adoption of new and emerging best practice and principles around end of life care ([Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020](#))
- End of life care being planned in an effective and sensitively appropriate way, and for staff to be adequately trained

### Links

[End of Life Care Joint Strategic Needs Assessment \(JSNA\) full report](#)  
[Scrutiny of Health: In-depth Scrutiny of End of Life Care in the County](#)

## Last laugh video





# Services in North Yorkshire

## Specialist palliative care services

The following local hospital trusts provide specialist palliative care services:

- Airedale NHS Foundation Trust
- Harrogate & District NHS Foundation Trust
- York Teaching Hospitals NHS Foundation Trust
- South Tees Hospital NHS Foundation Trust

All provide inpatient and some community services. Most services are limited to daytime hours Monday-Friday.

For further details of individual services, please see North Yorkshire EoLC JSNA Appendix B.

## Telephone helplines

Gold Line is a 24/7 palliative care phonenumber covering end of life patients in Craven, and in care homes in Hambleton, Richmondshire and Whitby. Further information can be found on page 48.

PalCall is an out of hours phonenumber for palliative patients and their carers registered with St Catherine's Hospice

## Care homes

Information on care homes providing palliative and end of life care can be found at [www.carehome.co.uk](http://www.carehome.co.uk).

## Hospices serving North Yorkshire

Source: Hospice UK, 2016



# Services in North Yorkshire

## Hospices

The nearest children's hospice is [Martin House](#) in Boston Spa (West Yorkshire). It provides services for North, East and West Yorkshire. Children must be between 0-19 years on first referral.

- Martin House Children's Hospice, Grove Road, Boston Spa, Wetherby, LS23 6TX. 01937 845045

The nearest hospice for Craven residents is [Sue Ryder - Manorlands Hospice](#) in Oxenhope (West Yorkshire). It provides services for Craven, Airedale, Wharfedale and parts of Bradford.

- Hebden Road, Oxenhope, Keighley, West Yorkshire. 01535 642308

The nearest hospice for Bentham is [St John's Hospice](#) in Lancaster. It provides services for North Lancashire, South Cumbria and Craven.

- Slyne Road, Lancaster, Lancashire. 01524 382538

[Butterwick Hospice Care](#) in the North East (Stockton/Bishop Auckland) also covers North Yorkshire. This includes hospice care for both over 18s and under 18s.

- Butterwick Hospice Care, Middlefield Road, Stockton on Tees, TS19 8XN. 01642 607742
- Butterwick Hospice Care, Woodhouse Lane, Bishop Auckland, DL14 6JU. 01388 603003
- Butterwick House Hospice, Middlefield Road, Stockton on Tees, TS19 8XN. 01642 607748

[St Theresa's Hospice](#) in Darlington also covers North Yorkshire, providing hospice at home, day therapy, inpatient care and family support and bereavement services.

- 8 Skinnergate, Darlington DL3 7NJ. 01325 240040

## Hospice care provision in North Yorkshire for adults

Source: NYCC, 2016

Hospice	Contact	Area covered	Inpatient	Outpatient	Day care	H@Home
<a href="#">Herriot Hospice Homecare</a>	18 Omega Business Village, Thurston Road, Northallerton, North Yorkshire 01609 777413	Hambleton and Richmondshire	No	No	No	Yes
<a href="#">Saint Michael's Hospice</a>	Crimple House, Hornbeam Park Avenue, Harrogate, North Yorkshire 01423 879687	Harrogate and District	Yes	No	Yes	Yes (Pilot)
<a href="#">St Catherine's Hospice</a>	Throxenby Lane, Scarborough, North Yorkshire 01723 351421	Scarborough, Whitby, Ryedale and parts of East Yorkshire	Yes	Yes	Yes	Yes
<a href="#">St Catherine's Ryedale Day Hospice</a>	Malton Community Hospital, Middlecave Road, Malton, North Yorkshire 01947 821049		No	No	Yes	Yes
<a href="#">St Catherine's Whitby Day Hospice</a>	5 Mulgrave Crescent, Whitby, North Yorkshire 01947 821049		No	No	Yes	Yes
<a href="#">St Leonard's Hospice</a>	185 Tadcaster Road, York, Yorkshire 01904 708553	York, Vale of York	Yes	Yes	Yes	Yes

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Recommendations  
2016 Report update  
References  
Acknowledgements

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# Director of Public Health 2017 annual report recommendations

**The aspiration is that older people should be recognised as active citizens, not passive recipients of services.**

## 1. Age-friendly communities

As people get older it is important that they live in environments that help them to maintain control over their lives and make a positive contribution to their communities.

*Policies, plans and services should promote healthy ageing by ensuring the contribution and needs of older people are considered, barriers to full participation and inclusion are reduced, and older people feel safe and supported to make choices about their lives.*

## 2. Comprehensive retirement planning

Financial security, physical and mental health, and caring commitments are some of the factors that influence the work decisions of people as they get older. Many older people can expect a long period of their lives to be spent “in retirement” and wish to contribute through formal and informal work opportunities after retirement age.

*Employers should facilitate workers to plan comprehensively for retirement including financial planning, ill health prevention, mental and emotional resilience, and social connectedness.*

*Employers should consider options that allow workers to manage their transition to retirement and allow “retired” people to maintain formal and informal links with the workplace.*

## 3. Identifying and managing frailty

Older people may experience physical and mental decline as they age especially when they have one or more long term conditions. However, frailty is not the only factor that influences their ability to function. Social support, health and care services and environmental factors are also important.

Health and social care practitioners should develop holistic assessments that focus on functional ability rather than physical or mental frailty. This includes sharing data with appropriate consent between services that take account of the full circumstances of the individual; including resources available to help them cope with physical and mental deficits.

*Information should be made available to older people and their carers to help them to identify the factors (physical, mental and social) that predict loss of functioning so plans can be made to manage should these arise.*

*Health and social care practitioners should develop holistic assessments that focus on functional ability rather than physical or mental frailty. This includes data sharing with appropriate consent between all services dealing with the individual’s wellbeing that take full account of their circumstances including the resources available to help them cope with reduced physical and mental capacity.*

## 4. End of life planning

Being able to plan with family and friends about the last stages of life ensures that older people remain in control of the choices that affect them and those they love through the end of their life. This means that they should have access to a wide range of information to plan their end of life wishes.

*Services providing end of life care should to be better coordinated across the County, particularly with regards to sharing patient information and examples of good practice.*

*Health and social care practitioners should facilitate discussions with older people and their carers on end of life planning and support them to access information to inform their planning.*

*All staff involved in end of life care should receive the appropriate level of training to enable them to provide the best possible quality of care in all locations.*

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# Update on North Yorkshire Director of Public Health annual report 2016

## Implementing the DPH annual report 2016 - The health of the working age population

The 2016 DPH annual report “Good work - good for you, good for business: The health and wellbeing of the working age population” has helped to raise the profile of the ‘Live Well’ theme of the North Yorkshire Health and Wellbeing Strategy in demonstrating for partners how to turn evidence into action.

The report has been presented to groups with responsibility for developing ‘healthy’ strategies for the County such as the Local Enterprise Partnership Board and Directors of Development meeting to promote

- ‘Health’ as an outcome of economic development, and that
- ‘Health sells’ the County as a special place for everyone to live, work and visit.

The new growth strategy for North Yorkshire will be launched in November 2018. The strategy aims to deliver growth that is inclusive and sustainable from an economic, social and environmental perspective.

**1. Long-term inclusive economic growth** that recognises the value of well-paid secure employment as a way out of poverty and towards better health and provides quality skills and education, as well as affordable housing.

**2. Inclusive social growth** involves growing a healthy workforce drawing on the value of a skilled workforce to improve productivity.

**3. Sustainable environmental growth** that values our natural environment as a [health asset](#).

### Recommendation 1: Create healthy workplaces

The Health and Wellbeing Board (HWBB) have supported the ambition to deliver a Workplace Wellbeing Charter (WWC) across North Yorkshire and work is ongoing on implementing this in our large rural County with a very diverse economy and predominance of small business. As one of the largest employers, NYCC established a Workplace Wellbeing group which leads and co-ordinates healthy workplace interventions. NYCC signed up to the Mindful Employer charter and is using its values and principles to improve employee wellbeing. It is also working towards excellence in achievement of the WWC.

### Recommendation 2: Build healthy workforces

NYCC are supporting other employers to build healthy workforces by cascading Making Every Contact Count (MECC) training among their employees. This approach seeks to equip people with the knowledge, skills and confidence to make everyday interactions matter and provides brief evidence based advice on key lifestyle issues including mental health so that people can have ‘healthy conversations’. National evidence suggests the impact of the MECC approach is widespread and has positive outcomes for organizations in creating healthy workforces.

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# References

1. BBC (2017). Sharp rise for intestate will queries. [online]. Available at: <http://www.bbc.co.uk/news/uk-36325871> [Accessed 4 Oct. 2017].
2. Faculty of Public Health (2017). FPH: What is public health [online] Available at: [http://www.fph.org.uk/what\\_is\\_public\\_health](http://www.fph.org.uk/what_is_public_health) [Accessed 4 Oct. 2017].
3. GOV (2017). Dashboard - Lasting Power of Attorney registrations [online]. Available at: <https://www.gov.uk/performance/lasting-power-of-attorney/volumetrics> [Accessed 4 Oct. 2017].
4. GOV (2017). Making a will [online]. Available at: <https://www.gov.uk/make-will> [Accessed 4 Oct. 2017].
5. NHS (2017). Find data - NHS Digital. [online] Available at: <http://content.digital.nhs.uk/catalogue/PUB19883> [Accessed 4 Oct. 2017].
6. Office for National Statistics (2017). National life tables, UK - Office for National Statistics. [online]. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2014to2016> [Accessed 4 Oct. 2017].
7. Office for National Statistics (2017). Five facts about...older people at work [online]. Available at: <http://visual.ons.gov.uk/five-facts-about-older-people-at-work/> [Accessed 8 Aug. 2017].
8. North Yorkshire County Council (2016). Population estimates - Data North Yorkshire. [online]. Available at: <http://hub.datanorthyorkshire.org/dataset/population-estimates> [Accessed 8 Aug. 2017].
9. NOMIS (2017). Nomis - Official Labour Market Statistics. [online]. Available at: <http://www.nomisweb.co.uk/> [Accessed 8 Aug. 2017].
10. North Yorkshire County Council (2016). The Carer's Strategy - Evidence Review. [online] Available at: <http://hub.datanorthyorkshire.org/dataset/7b028291-2b78-4439-907c-c6d380aab92d/resource/c2bfb4d7-6a56-4dbd-a1dd-12057c24ab9d/download/carers-strategy-evidence-review-2016.pdf> [Accessed 6 Oct. 2017].
11. Projecting Older People Population Information System (2017). Projecting Older People Population Information System. [online]. Available at: <http://www.poppi.org.uk/> [Accessed 8 Aug. 2017].
12. Rodionova, Z. (2017). The chart that shows UK workers can't afford to retire at 65. [online]. Available at: <http://www.independent.co.uk/news/business/news/pensions-two-thirds-of-uk-workers-expect-to-work-past-65-because-they-can-t-afford-to-retire-a6757451.html> [Accessed 8 Aug. 2017].
13. Department for Work and Pensions (2016). Economic Labour Market Status of Individuals Aged 50 and Over Since 1984. [online]. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/546643/economic-labour-market-status-of-individuals-aged-50-and-over-since-1984.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/546643/economic-labour-market-status-of-individuals-aged-50-and-over-since-1984.pdf) [Accessed 8 Aug. 2017].
14. Mental Health Foundation (2016). Mental health statistics: older people. [online]. Available at: <https://www.mentalhealth.org.uk/statistics/mental-health-statistics-older-people> [Accessed 26 Jul. 2017].
15. LAKRA, D., NG, R. and LEVY, B. (2012). Increased longevity from viewing retirement positively. Ageing and Society, 32(08), pp.1418-1427.
16. Age UK (2011). Technology and Older People Evidence Review. [online]. Available at: [http://www.ageuk.org.uk/documents/en-gb/for-professionals/computers-and-technology/evidence\\_review\\_technology.pdf?dtrk=true](http://www.ageuk.org.uk/documents/en-gb/for-professionals/computers-and-technology/evidence_review_technology.pdf?dtrk=true) [Accessed 26 Jul. 2017].
17. Royal Voluntary Service (2017). Older people and volunteering. [online] Royal Voluntary Service. Available at: <https://www.royalvoluntaryservice.org.uk/our-impact/what-we-think/older-people-and-volunteering-policy> [Accessed 4 Oct. 2017].
18. Malnutrition Task Force (2017). About | Malnutrition Task Force. [online]. Available at: <http://www.malnutritiontaskforce.org.uk/about/> [Accessed 14 Aug. 2017].



## References cont.

19. North Yorkshire County Council (2016). Healthy Weight, Healthy Lives: Tackling overweight and obesity in North Yorkshire 2016 – 2026. [online]. Available at: [https://www.northyorks.gov.uk/sites/default/files/fileroot/About%20the%20council/Consultations/Healthy%20weight%20healthy%20lives/Healthy\\_weight\\_healthy\\_lives\\_-\\_strategy\\_summary.pdf](https://www.northyorks.gov.uk/sites/default/files/fileroot/About%20the%20council/Consultations/Healthy%20weight%20healthy%20lives/Healthy_weight_healthy_lives_-_strategy_summary.pdf) [Accessed 26 Jul. 2017].
20. Office for National Statistics (2015). Adult smoking habits in the UK - Office for National Statistics. [online]. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2015#smoking-data-for-the-uk-from-the-annual-population-survey-2010-to-2015-adults-aged-18-years-and-above> [Accessed 14 Aug. 2017].
21. Action on Smoking and Health (2017). Cost of smoking to social care | Action on Smoking and Health. [online]. Available at: <http://ash.org.uk/localtoolkit/cost-of-social-care/> [Accessed 26 Jul. 2017].
22. North Yorkshire Partnerships (2015). Tobacco control | North Yorkshire Partnerships. [online]. Available at: <http://asvt-nywebsite:1402/sites/default/files/Partnership%20files/Health%20and%20wellbeing/Winter%20health/Tobacco%20control%20strategy.pdf> [Accessed 26 Jul. 2017].
23. North Yorkshire Partnership (2014). North Yorkshire Joint Alcohol Strategy 2014-2019. [online]. Available at: <http://www.nypartnerships.org.uk/sites/default/files/Partnership%20files/Health%20and%20wellbeing/Public%20health/Alcohol%20strategy.pdf> [Accessed 4 Oct. 2017].
24. Royal College of Psychiatrists (2011). Our invisible addicts. [online]. Available at: <http://www.rcpsych.ac.uk/files/pdfversion/CR165.pdf> [Accessed 14 Aug. 2017].
25. Public Health England (2017). An evidence review of the outcomes that can be expected of drug misuse treatment in England. [online]. Available at: <http://www.nta.nhs.uk/uploads/phe-evidence-review-of-drug-treatment-outcomes.pdf> [Accessed 26 Jul. 2017].
26. The University of Sheffield (2017). Sexual health in older people should not be overlooked, says study - News releases - News - The University of Sheffield. [online]. Available at: <https://www.sheffield.ac.uk/news/nr/sheffield-sexual-health-older-people-1.681543> [Accessed 26 Jul. 2017].
27. Davies, S. (2015). Annual Report of the Chief Medical Officer 2015 On the State of the Public's Health Baby Boomers: Fit for the Future. [online]. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/578665/Baby\\_boomers\\_v4.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/578665/Baby_boomers_v4.pdf) [Accessed 26 Jul. 2017].
28. GOV (2015) GUMCADv2 [online]. Available at: <https://www.gov.uk/guidance/genitourinary-medicine-clinic-activity-dataset-gumcadv2> [Accessed 4 Oct. 2017].
29. Age UK (2015). Briefing: The Health and Care of Older People in England 2015. [online] Available at: <http://www.cpa.org.uk/cpa/docs/AgeUK-Briefing-TheHealthandCareofOlderPeopleinEngland-2015.pdf> [Accessed 14 Aug. 2017].
30. Foster, R. (2013). Household Satellite Accounts - Valuing Voluntary Activity in the UK. [online]. Available at: [http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766\\_345918.pdf](http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_345918.pdf) [Accessed 20 Jan. 2017].
31. Casiday, R., Kinsman, E., Fisher, C. and Bambra, C. (2008). Volunteering and Health: What Impact Does it Really Have? Summary. Lampeter. [online]. Available at: [https://www.researchgate.net/profile/Rachel\\_Casiday/publication/228628782\\_Volunteering\\_and\\_Health\\_What\\_Impact\\_Does\\_It\\_Really\\_Have/links/56339fab08aeb786b7013877.pdf](https://www.researchgate.net/profile/Rachel_Casiday/publication/228628782_Volunteering_and_Health_What_Impact_Does_It_Really_Have/links/56339fab08aeb786b7013877.pdf) [Accessed 31 Jul. 2017].
32. West, M. (2017). Baby boomers helped lift Britain out of recession. [online]. Available at: <http://www.thisismoney.co.uk/money/news/article-2553921/Baby-boomers-helped-lift-Britain-recession-grey-pound-accounts-50-consumer-spending.html> [Accessed 5 Oct. 2017].

---

## References cont.

33. Resolution Foundation (2017). Recent retirees drive pensioner incomes above those of working families - Resolution Foundation. [online] Available at: <http://www.resolutionfoundation.org/media/press-releases/recent-retirees-drive-pensioner-incomes-above-those-of-working-families/> [Accessed 26 Jul. 2017].
34. Age UK (2016). Pensioner poverty and financial disadvantage | Age UK. [online]. Available at: <http://www.ageuk.org.uk/professional-resources-home/policy/money-matters/poverty-and-inequality/> [Accessed 14 Aug. 2017].
35. Public Health England (2017). Public Health Profiles. [online]. Available at: <https://fingertips.phe.org.uk/profile/end-of-life> [Accessed 28 Jul. 2017].
36. Health and Wellbeing Board (2015). Joint Health and Wellbeing Strategy 2015 - 2020. [online]. Available at: <http://asvtnywebsite:1402/sites/default/files/Partnership%20files/Health%20and%20wellbeing/jhwbs.pdf> [Accessed 21 Aug. 2017].
37. VOICES (2015). National Survey of Bereaved People VOICES: England 2015. Quality of care delivered in the last 3 months of life for adults who died in England. [online]. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/england2015> [Accessed 28 Jul. 2017].
38. Public Health England (2017). Public Health Profiles End of Life. [online]. Available at: <https://fingertips.phe.org.uk/profile/end-of-life> [Accessed 28 Jul. 2017].
39. Dementia Strategy North Yorkshire [https://www.northyorks.gov.uk/sites/default/files/fileroot/About%20the%20council/Consultations/Dementia%20strategy/Bring\\_me\\_sunshine\\_summary.pdf](https://www.northyorks.gov.uk/sites/default/files/fileroot/About%20the%20council/Consultations/Dementia%20strategy/Bring_me_sunshine_summary.pdf)
40. World Health Organization (2014). Global atlas of palliative care at the end of life. [online] Available at: <http://www.who.int/cancer/publications/palliative-care-atlas/en/> [Accessed 28 Jul. 2017].

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