



Committee and date
Shadow Health & Wellbeing
Board
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Item No
11
Public

AGEING WELL PROGRAMME – HEALTH AND WELLBEING BOARD

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Summary

This report provides information on Shropshire Health and Wellbeing Board's engagement with the Local Government Group's (LGG) Ageing Well Programme. It gives an update on progress against the project plan and sets out how outstanding elements of the project will be undertaken in the period to February 2012. It identifies a number of areas for further consideration by the Board and others and proposes a meeting of relevant senior personnel in early January 2012 to take this forward.

Recommendations

- A. That members of the Shadow Health & Wellbeing Board note the report and provide comment and feedback to the Local Government Group Associate on the Ageing Well project as a whole.
- B. That up to three Board members are nominated to represent the Shadow Health and Wellbeing Board at the meeting in early January (Part 3 of the project) to consider how best to embed the findings from Parts 1 and 2 into the ongoing work of the Board.

Report

Background

1. Shropshire Council has been awarded a place on the Local Government Group Ageing Well, Health and Wellbeing Programme. It is one of 17 areas from across the country that is currently working with the programme. The goal is to 'embed an ageing dimension into the development of the Health and Well-being Board and secure effective engagement of older people'.

2. As an Ageing Well Development Area, the Council receives 5 days consultancy support and £2000 to secure effective engagement of older people in health and wellbeing planning work (particularly those voices not usually heard). LGA Associate, Merron Simpson, is currently working with the Council, the Shadow Health and Wellbeing Board and partners such as Age UK to deliver an agreed project by February 2012 (this date has been moved back from January).
3. A full Project Plan is provided in Appendix 1. It consists of four parts:
 - i. Part 1: Evidence gathering – drawing together relevant evidence to support strategic decision-making;
 - ii. Part 2: Engagement and communication with older people to expand the local evidence and establish preferred engagement style;
 - iii. Part 3: A meeting with relevant senior officers to consider how best to embed the findings from parts 1 and 2 into the developing commissioning framework;
 - iv. Part 4: Learning from the project (required by LGG).

Progress against project plan and outstanding elements

4. The project status relating to each of these parts is provided in paragraphs 5 - 10.
5. **Part 1:** An interim report has been prepared that draws together evidence from national sources relating to two lines of inquiry:
 - a. what is most valued by older people in their efforts to live active/healthy lives; and
 - b. the cost-savings that could be made to more acute health and care services.

These two lines of inquiry have been chosen because they are particularly relevant to public sector organisations taking forward public service reforms at a time of considerable financial pressure. The interim report, which is work-in-progress, is attached in Appendix 2.
6. Work is ongoing on the report both to expand the national evidence and to build in local evidence along the same two lines of inquiry. Sources of local evidence including work being carried out by the Design Team, Live Life Your Way programme, Supporting People Team as well as others. The final report will include a number of recommendations to the Shadow Health and Wellbeing Board and partners
7. **Part 2:** A workshop with between 5 and 10 older people will take place on 15 December. The LGG Associate is working closely with Shropshire Council and Age UK on the content of the workshop and to ensure good attendance at the event. The aims of the workshop are:

- a. to expand local information relating to the first of the two lines of inquiry; to find out what is most valued by older people in their efforts to live healthy/active lives;
 - b. to equip older people with skills to enable them to play a stronger role in representing older people to the Health and Wellbeing Board on an ongoing basis.
8. **Part 3:** A meeting is being planned for early January 2012 to enable several members of the Shadow Health and Wellbeing Board together with other relevant senior officers and partners to consider how best to embed the findings from Parts 1 and 2 into the ongoing work of the Health and Wellbeing Board.
9. This will include discussions relating to:
- a. How the evidence gathered in Parts 1 and 2 might best be used to inform commissioning decisions. Account will be taken of the changing Joint Strategic Needs Assessment (JSNA), the developing Joint Health and Wellbeing Strategy (JHWS), and the recent JSNA peer challenge undertaken on behalf of Shropshire Council by Local Government Improvement and Development. The Health and Wellbeing Board received a separated paper on this matter on 27 July 2011;
 - b. How meaningful ongoing engagement of older people might be achieved through the emerging Stakeholder Alliance and potentially through other routes.
10. **Part 4:** Towards the end of the project, the learning will be captured in two ways. First, a case study will be written up by officers of Shropshire Council and published in a Local Government Group publication. Second, two officers will attend an action learning event run by the Local Government Group, with the LGG Associate. This will take place on 21 February 2012.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)

Human Rights Act Appraisal

The recommendations contained in this report are compatible with the provisions of the Human Rights act 1998

Environmental Appraisal

Risk Management Appraisal

Community / Consultations Appraisal

Cabinet Member

Councillor Ann Hartley

Shadow Health & Wellbeing Board, 9^h Dec 2011 : PROPOSALS FOR SHROPSHIRE SHADOW HEALTH AND WELLBEING BOARD

Councillor Cecilia Motley

Local Member

All

Appendices

Appendix A – Project Plan

Appendix B – Interim report of Part 1

Project Plan

Ageing Well: Health and Well-being Board Programme Shropshire Council

Introduction

Shropshire Council has signed up to the LGG Ageing Well Health and Wellbeing Programme. The goal is to 'embed an ageing dimension in to the development of the Health and Well-being Board and secure effective engagement of older people'. The work must be concluded by mid January 2012. This means that the Council has:

- 5 days consultancy support, ½ a day must be used to facilitate learning
- £2000 to secure effective engagement of older people in HWB planning work (particularly those voices not usually heard).

This project plan sets out a proposal for work to be carried out on behalf of Shropshire Council, for sign-off by the Shadow Health and Wellbeing Board.

Short description of project	The project has 4 elements – research, engagement and communications, support for Shadow Health and Wellbeing Board (HWB), and learning. Taken together, and as long as they continue to influence the HWB, agencies and partners beyond the life of the project, they will focus attention on evidenced valued and cost-effective activities that help older people to live active and healthy lives and will inform strategic re-design of services in an ongoing way – enhancing Shropshire's overall offer to support health and wellbeing of older people.
Timescale of project	Key milestones: <ul style="list-style-type: none"> • End Nov '11 – Part 1 • Before Christmas '11 – Part 2 • To fit with HW Board timetable – Part 3 • Mid Jan '12 – Part 4
	Completion date of whole project: <ul style="list-style-type: none"> • Mid Jan 2012

Name of LGG Adviser(s) delivering project	Merron Simpson
Name of responsible person in Shropshire Council	Val Beint, Corporate Director, Health & Care, Shropshire Council
Others also responsible	Ruth Houghton, Service Manager, Service Development , Assessment and Eligibility Team Jackie Taylor, Partnership Board Facilitator, Service Development, Assessment and Eligibility Team
Costs (borne by LGG)	Funded consultancy, up to 5 days Up to £2000 engagement funding

Objectives

The overall objective is to enhance the health and wellbeing of older people in Shropshire, by embedding an ageing dimension into the work of the Health and Wellbeing Board.

The four objectives of the project are:

1. ***To provide useful information to underpin commissioning decisions by identifying those activities that (i) are most valued by older people in their efforts to live healthy/active lives and that (ii) deliver cost-savings to acute health and care services – from existing national and local sources of evidence***
2. ***To provide useful feedback from older people, to underpin commissioning, by engaging older people living in Shropshire and developing effective ongoing communication between them and the Health and Wellbeing Board***
3. ***To communicate this information effectively to the Health and Wellbeing Board, enabling the Board to make best use of the information to commission in a way that will support the health and wellbeing of older people in Shropshire.***
4. ***To learn from the overall project. This 4th part is required by LGG as a condition of participating in the programme.***

Methodology

The project consists of four distinct parts:

Part 1: Desk-top research

- **Activity 1:** Draw up a list of existing papers/publications/research reports, from both national and local sources that hold information on (i) what is most valued by older people in their efforts to live active/healthy lives (ii) the presence, accessibility and usage of those services that older people value the most, in Shropshire and (iii) cost-savings to more acute health and care services
- **Activity 2:** Review these papers/publications/reports, drawing out information demonstrating the value, accessibility, usage and cost-effectiveness of these data
- **Activity 3:** Prepare a short fact-based paper listing those activities that add most value and provide greatest cost-effectiveness, and recommend how this information might be used in shaping relevant strategies and activities of partners.

Part 2: Engagement and communication

- **Activity 1:** Run a session with a wide range of older people. The purpose of this will be (i) to find out what they find most helpful in their efforts to live healthy/active lives – building from the evidence gathered in part 1 and (ii) to explore with older people what channels and mechanisms will enable them to engage with the Health and Wellbeing Board on an ongoing basis – including through the Stakeholder Alliance and through the Older People's Partnership Board (OPPBB).
- **Activity 2:** Depending on the outcome of activity 1, identify between 5 and 25 older people living in Shropshire from a mix of backgrounds and invite them to take part in a separate workshop to (i) further explore ways in which they may personally facilitate engagement between Shropshire's older people and the Health and Wellbeing Board on an ongoing basis and (ii) to learn how to have meaningful conversations with others and to provide an interface with the Health and Wellbeing Board. This is very much in line with ambitions for the Older People's Assembly which is in the process of being formed.
- **Activity 3:** Prepare a written report from both events, to be tabled at a Shadow Health and Wellbeing Board meeting, containing recommendations for the Board and others for promoting engagement with older people in Shropshire.

Part 3: Facilitate a session with the Shadow Health and Wellbeing Board and the Older People's Partnership Board

- **Activity 1:** Discussions with Val Beint and others on the Health and Wellbeing Board and the Older People's Partnership Board about how a session to (i) explore the findings of the research and of the engagement and consultation and (ii) consider how best to embed these into the work of the Board, would work best.
- **Activity 2:** Prepare for and facilitate a session with the Health and Wellbeing Board and Older People's Partnership Board together.

Part 4: Learning from the project (required by LGG)

- **Activity 1:** An action learning meeting will be held with relevant personnel from relevant agencies and partners across Shropshire to learn from the project as a whole.
- **Activity 2:** The whole project will be written up in a case study.

The work undertaken in this programme is designed to inform the Health and Wellbeing Board in its commissioning capacity about how best to support older people to live healthy and active lives. It is also designed to have longevity, and to leave a legacy beyond the completion of the project. The extent to which it does this, and therefore the long-term impact it has, will depend on how the Health and Wellbeing Board, together with Shropshire's agencies and partners, (i) incorporate the outcomes of the different elements within relevant strategies, (ii) allow the learning to influence their decision-making and delivery activities (iii) continue and develop the processes that have been initiated. These matters will be explored further in Part 4 of the project.

Personnel

Merron Simpson will work on all elements of this project and additional support will be secured from relevant individuals within Shropshire Council and other organisations (eg. Age UK, Senior Citizens Forum etc).

Officer support is sought to enhance the research, engaging in the learning element and also to provide effective administrative support such as setting up meetings and workshops, liaising with relevant internal and external people etc.

Part of project	Personnel	Anticipated no. of days
Project planning, including meeting and preparation of project plan	Merron Simpson	1
Part 1: Desk-top research	Merron Simpson	2
	Council employee	2
Part 2: Engagement and communication	Merron Simpson	4 (funded from the £2000)
Part 3: Facilitate session with HWB and OPPB on older people	Merron Simpson	1
Part 4: Learning from the project	Merron Simpson	1
	Council employee	1

Timescale

- Part 1, all 3 activities, will take place and be completed during November 2011
- Part 2, all activities, will take place in December.

- Part 3 will be timed to suit the Health and Wellbeing Board (a paper will go to 9 Dec meeting)
- Part 4 will take place in 2nd week of January

Cost

This is for details how the project fund (the £2000 for engagement) will be spent.

Details of engagement activity and listed costs	£
• Activity 1: Run a session with a wide range of older people – including preparation	£500
• Activity 2: Run a workshop with a smaller group, with training – including preparation	£750
• Activity 3: Prepare written report from both events and present at a HWB meeting	£750
Total	£2000

Agreement

Merron Simpson will, on behalf of the Ageing Well Programme, deliver this project for Val Beint in accordance with the project plan above.

Signature

...../.....

For [client [name](#)]

Signature

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Ageing Well: Shropshire

Research into value and cost-effectiveness

Interim paper

1. Introduction

Shropshire Council is an Ageing Well Development Area. The Council is working with Merron Simpson, an associate consultant of the Local Government Association, to enhance the health and wellbeing of older people in Shropshire by embedding an ageing dimension into the work of the emerging Health and Wellbeing Board. A project plan has been agreed and can be found as an appendix to this paper.

This interim research report relates to the first of four parts that make up the project, and is work in progress. Its purpose is to provide a platform for further consultation with older people and to inform the Health and Wellbeing Board by providing it with useful information on which to develop public health strategies and base commissioning decisions. It is intended that this information will be incorporated into the JSNA and used, in part, as a basis for commissioning decisions. A recent LGA Peer Challenge suggested that the JSNA needs to change and evolve to meet the new demands arising from the health reforms and to achieve a better balance between quantitative and qualitative data. This paper is intended to support this evolution.

Government expenditure on crisis interventions for older people is significant (47% of NHS budget in 2005)¹. Yet recent work carried out by AgeUK found that there is a growing gap between what older people want and need to live in the community, and what councils are providing. To help ensure both that Shropshire responds well to these insights, and because of the pressure on council funds, this research will focus specifically on two types of evidence:

1. Evidence of **activities that older people value the most**, accessibility and usage in Shropshire, and how these activities contribute to their health and wellbeing
2. Evidence of **activities that save money** by reducing the burden on more acute health and care services. It will also look at evidence of activities that improve older people's quality of life, even where cost-savings are not evidenced.

¹ ODPM presentation, 2005

The interim report distils information from national publications and papers. It presents some of the background evidence relating to older people's health and wellbeing, some feedback from various published consultations that have already been carried out with older people (not in Shropshire) and some evidence from evaluation of various programmes. This national evidence provides a broad analysis that may or may not apply to the situation in Shropshire. It is intended to build in local evidence that will be used to corroborate or otherwise the national information. Looking at local reports will provide some idea of what is already in place and where there are mismatches between older people's aspirations and what is available to them.

The information distilled through this process will be used in workshops with older people to further increase its usefulness.

2. Background information

2.1 Impact of ageing population on health and care services

The statistics in the bullet points below have been collected from various national sources. They are presented in this paper to illustrate both the scale and shape of the issue and to point to areas in which the Health and Wellbeing Board might want to focus its attention.

- Overall, the state spends around £140 billion on older people in England. Of this, the NHS represents around 35% and social care around 6% (the remainder is made up from pensions and benefits).
- Already 60% of all hospital beds are occupied by people aged 65 and over, 40% of whom have a dementia.
- Numbers of people aged 80 and over will increase from 2.3 million to 4.4 million by twenty years time

In its response to the Department of Health consultation *Healthy Lives Healthy People*, Age UK raised a number of wider issues which might impact on the health and well-being of this age group including; working well, housing services, crime and access to local amenities. They said, "*public health professionals should remember that it is never too late to benefit from healthy living as well as address specific health problems that are particularly prevalent in older populations*". Some new measures in the Health and Social Care Bill are designed to place a larger focus on the wider determinants of health as a route to better health and quality of life.

2.2 Experience of self-funders

While clinical/acute health remains essentially free at the point of delivery, financial support for both social care and lower level categories of support is dependent on income. Further to this, 'eligible groups' have so far received the most help accessing relevant care and support services.

Average pensioner incomes have risen faster than average earnings since the mid-1990s, increasing by 44 per cent in real terms between 1994/95 and 2008/09. This suggests that the current population of older people has greater wealth than previous

generations and that more people are in a position to pay for care and support services than in the past. This also means that more of the commissioning power is in the hands of older people – and they will only pay for services that they value.

Research also suggests that self-funders are often worse off than those who are eligible for social care. This is partly because they have difficulties navigating their way through the system without help² and partly because those who are in the lower bands of eligibility (borderline and non-eligible) are unable to get help with housework, gardening etc– it is these simple tasks that are becoming increasingly difficult to access. They struggle to continue doing it for themselves and risk injuring themselves when they try. Self-funders are, therefore, at greater risk of being fast-tracked into residential care without fully exploring other options.

2.3 The ageing process

The graphs in figures 1 and 2 below help to illustrate the current position (nationally) and should help to inform potential goals for the Health and Wellbeing Board.

The solid line in figure1 shows the trajectory that the Health and Wellbeing of older people (as a group) takes as they get older and the small-dashed line shows the impact of current interventions – essentially the same shape, but with slightly better health and wellbeing for longer, increasing the dying age.

The large-dashed line shows the trajectory that would ideally be taken. People's health and wellbeing would be much greater for much longer – which would have advantages both in terms of increasing people's quality of life and in terms of reducing costs of acute health and social care.

Figure 1

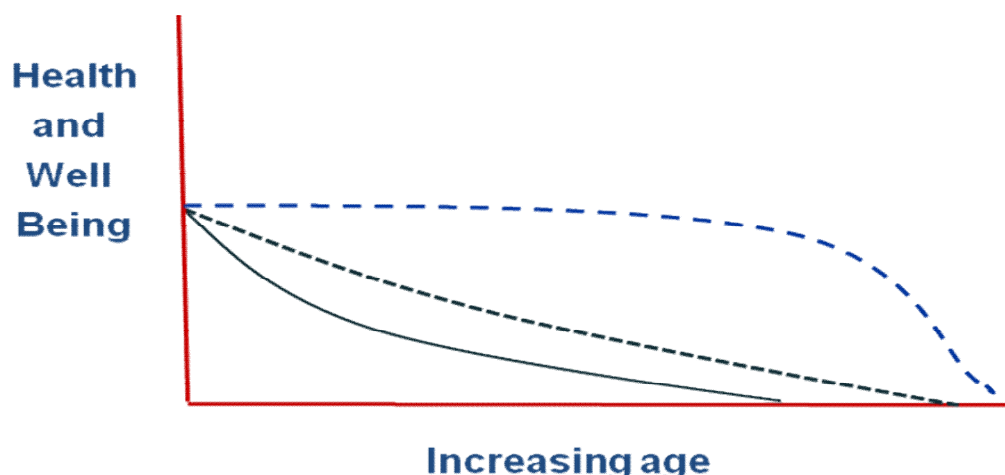
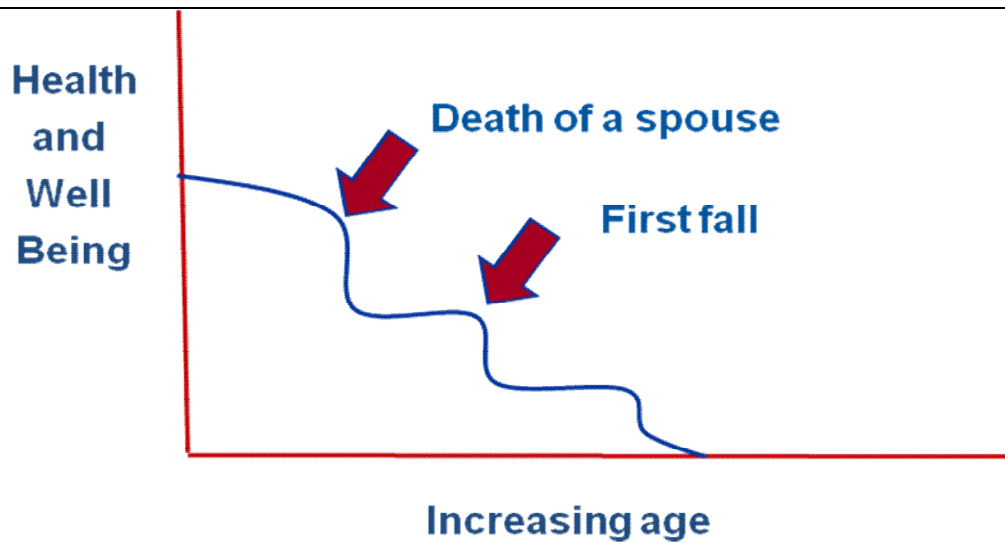


Figure 2 shows the profile that most individuals go through, with decline dropping suddenly following major life events that often accompany the ageing process.

² Lost to the system: Commission for Social Care Inspection
The State of Social Care in England 2006-7



2.4 The economic benefits of reducing dependency³

As well as looking specifically at savings to health services, there are other savings to be made by reducing or delaying dependency:

- Reducing age-specific dependency rates by 1% per year would reduce public expenditure by £940m per year by 2031
- Reducing the rate of institutionalisation by 1% per year could save £3.8bn
- where it is appropriate, postponing entry into residential care for one year saves an average of £28,080 per person⁴
- A one year delay in providing an adaptation to an older person costs up to £4,000 in extra home care hours⁵
- Low-intensity support – emotional, social, practical and housing support - has direct and tangible benefits. Services users feel the services have added something to their lives, particularly in helping them to approach life in a more positive way.

Summary: what this background information means for HWB

- Because the NHS is already over-burdened by demand from older people, and because the number of older people will increase, it is essential that the NHS, Public Health and Health and Wellbeing Boards collectively seek radically different, less expensive solutions to improving the health and wellbeing of this age-group. This means concentrating to a greater extent on reducing the impact of those issues that cause people to move more quickly towards frailty
- Increasing wealth of older people means that more of them are in a position to fund their care and support themselves. However, the current systems for

³ Making Life Better for Older People: An economic case for preventative services and activities, Social Exclusion Unit, ODPM 2006

Low Intensity Support Services: a systematic literature review. JRF 2000

⁴ Heywood et al (2007), **Better outcomes, lower costs**

⁵ Care and Repair England (2010), **Home adaptations for disabled people**

providing this care and support are geared heavily towards those who are eligible – either for adult social care or for supporting people funds. There are insufficient mechanisms in place to assist self-payers to either know what is available or navigate the system.

- Keeping people healthier and independent (or interdependent) for longer – and out of acute health and care services – means focusing spend and activity on measures that delay their demise. It also means targeting different interventions at key points along the pathway where evidence suggests they are likely to prove most successful.
- It is not possible for any one sector to achieve the goal independently. It will require coordinated approach across health, care, support, housing and neighbourhoods – and a purposeful focus on preventative interventions – to create a context and an environment that helps older individuals and communities to maintain or improve their independence (or interdependence) and wellbeing.

3. What do older people value most?

Older people themselves are a very rich source of information about what sort of services, if available and accessible, would help them to live healthier and more active lives. This section draws on existing evidence in nationally available publications – from a variety of recent consultations with older people – into what older people most value.

Recent work carried out by AgeUK found that there is a growing gap between what older people want and need, and what councils are providing⁶. Often, those services that are described as ‘low level’ by professionals are also seen as low need, low value and low priority (the FACS eligibility criteria also pushes resources towards high-end critical/substantial care). However, these low level services are the very services that are of high value to older people.

Key drivers of quality of life for older people include⁷

- To have expectations in life
- A sense of optimism
- Good health and physical functioning
- Engagement in social activities and a sense of being supported
- Living in a community with good community facilities and services
- Feeling safe
- Retaining a sense of control and independence

In relation to their home and living environment, older people say they want:

- Low maintenance property
- Security
- Good access to facilities and transport

⁶ Practical support at home; evidence review, AgeUK

⁷ *Adding quality to quantity. Older people's views on quality of life and its enhancement (Bowling, Kennelly)*

- Good neighbourhood
- Attractive accommodation that's fit for purpose
- To stay in their own property and not to go into residential care.

These are explored under 2 headings below:

- Maintaining independence in their living arrangements (4.1)
- Maintaining interdependence in their social arrangements (4.2)

3.1 Maintaining independence in their living arrangements⁸

Most older people want to remain in their own homes for as long as is practically possible, and this is in line with the government's ambitions to reduce the use of residential care and the high costs associated with it.

Table 1 sets out the variety of support services that older people say they would find most helpful in helping them to maintain their independence. These are gathered from various consultation exercises.

Consultation	That bit of help	Learning to listen	Manchester focus groups	Oxfordshire review - rural
Task				
Housework	√		√	
Gardening	√	√	√	√
Repairs and maintenance	√	√		
Security	√			
Laundry	√		√	
Opportunities for social inclusion	√			
Transport		√		√
Nail cutting				√
Meals on wheels				√
Shopping			√	
Errands			√	

These are explored further below

- **Practical support – housework, shopping, gardening etc**

Timely and effective practical support can:

- help older people to live independently for longer
- reduce risk-taking – which can lead to falls
- help older people to maintain their self-esteem – having a clean and tidy house and garden, rather than a dirty or untidy one can be good for mental health

⁸ Practical support at homes: evidence review, AgeUK

However, there is little evidence of schemes dedicated to providing housework help to older people and consequently there is a high unmet demand among older people for help with housework and other practical support. The main issues for those in need of practical support are:

- Cost
- Reliability
- Knowing about what is on offer locally – availability of information

- **Transport**

A lack of transport and poor health are cited as the main reasons why people aged over 75 don't attend more cultural events.

- **Home repairs, security and adaptations**

Handy-person services that attend to home safety and security, minor aids and adaptations and small repairs are highly valued⁹:

- 94% of customers find handyperson services very useful, 6% find them quite useful
- For minor adaptations eg. grab rails, ramps, louder bells etc, 77% state that the adaptation has produced a good health outcome
- For major adaptations eg. toilet, bathing/heating adaptations, satisfaction is very high (no stats provided)

Trafford Care and Repair Handy Help costs individuals £10/hour + materials cost:

- 94% said Handy Help meets their needs
- 54% said they wouldn't have carried out the repair without the service
- 50% said the work made them feel safer in their own home
- 72% said the work improved their quality of life
- 99% said they would use the service again or recommend it

"It's about changing a light bulb – so the older person doesn't go on to have a fall and end up in hospital ... so we're talking about low-level service"¹⁰.

Home adaptations are also generally successful in meeting the needs identified and are widely appreciated by those who benefit.

- **Warden services**

A recent review of older people's (neighbourhood/community) warden services demonstrated that they are valued and that they have allowed many older residents to maintain independence¹¹. Specifically, they have:

- Reduced social isolation
- Had a positive effect on wellbeing
- Reduced poverty among some of the most vulnerable communities
- Improved home safety and security

⁹ Practical support at home

¹⁰ Tyson, 2009

¹¹ Going the extra mile, Age UK

- Increased awareness and knowledge of welfare entitlements

3.2 Maintaining interdependence in their social arrangements

Isolation and loneliness is now widely understood to have a debilitating effect on health and wellbeing¹². Older people articulate their dislike of being isolated in a variety of ways, but not necessarily directly. For example:

- Older people value the relationships with their support staff as much as they value the help with the task. For this reason, they value familiarity and tend to want to see the same person on each occasion, especially for care services.
- They say that they do not just want 'services', they want to be involved with people and activities in their local neighbourhoods and communities.

Some facts relating to isolation and loneliness¹³:

- Loneliness is strongly allied to perceived poor quality of life
- 7% of older people were often lonely and 31% were sometimes lonely
- 11-17% were socially isolated in 2001
- Rates have remained relatively stable in the previous 50 years
- Both loneliness and isolation appear to increase with age and among those with long-term health problems
- There is a strong connection between low contact with family members and loneliness
- Intergenerational contact is probably more effective in combating loneliness than contact with other older people, although both have proven successful.
- Having friends is a more important factor in warding off loneliness than frequent contact with these friends
- Some groups disproportionately affected – lower socio-economic groups, widowed, physically isolated, people who have recently stopped driving, those with a sensory impairment, the very old.
- The loss of a service which has had success as alleviating loneliness is worse than never having had the service at all (same does for patchy/unreliable services).

Schemes/activities to address older people's loneliness have proved to be more effective when:

- They are undertaken in conjunction with delivery of other services (rather than as a 'befriending service' in their own right)
- They are tailored to the needs of a specific group or area
- Older people are involved in planning, developing, delivering and assessing them
- Older people who are ready and willing to contribute to community life are enabled to do so

¹² Loneliness and isolation: Evidence Review, Age UK

¹³ Facts taken from (i) Growing older project – in which isolation and loneliness was one of 25 themes and (ii) ELSA project

Summary: what 'knowing what older people want' means for the HWB

- The range of 'low level' support services that help older people to meet their changing needs in their efforts to live independently should be expanded.
- The business models and providers will depend on the levels of professionalism required. For example, shopping and laundry services that don't require high skills levels might be best provided by others within the community while works to properties would be best provided by professionals (which could be a community-based business)
- Some older people could contribute to running community services voluntarily or at low cost, both for their own age group and for other age groups (such as creche's and mentoring young people). They have a range of capabilities, a desire to be involved with people and activities in their neighbourhoods, a need for social interaction and a desire to have expectations and a sense of optimism.
- Some services that are currently provided as one-to-one services might be best provided in a group setting, increasing the opportunity for social contact.
- Services aimed at befriending older people, to reduce social isolation, must be combined with other services, and older people must be involved in the design of these services.

4. Evidence of cost-effectiveness of 'preventative services'

4.1 What are preventative services?

Preventative services are those that:

- prevent or delay the need for more costly intensive services or
- promote the quality of life of older people and engagement with the community

They result in two forms of cost-savings:

1. Reduced spending on intensive health services and
2. Increased contribution to society (family and civic)
 - Over 65's contribute around 850million hours of informal care. Increasing this by 10% would be valued at £400m at minimum wage rates
 - Volunteering amongst those aged 65-74 is higher than amongst any other age group. Increasing over-65s volunteer hours by 10% would be worth over £500m (valuing volunteering hours at the minimum wage)

4.2 The evidence for cost-savings

While some preventative services clearly reduce the costs of acute health and care, the evidence for this and assessments of the size of the cost-savings is patchy. Different projects/services have different types of impact, and it is easier to find a correlation between an activity and the cost-saving in some instances than in others. The correlations are assessed and described in different terms in different evaluations.

Despite the information being imperfect, where it does exist evidence of cost-savings should be taken into account in the design of services.

4.3 Evidence of cost-savings of various 'preventative services'

Preventative service	Nature of saving
Grab rails	A fall at home that leads to a hip fracture costs the state £28,665 on average – over 100 times the cost of installing hand and grab rails ¹⁴
Hospital discharge service	A hospital discharge service that enables older people to return to a safe and suitable home environment saves over £100 per day – the amount charged to local authorities when patients 'block beds' ¹⁵
Home adaptations	10% of recipients of <i>Disabled Facility Grants</i> were kept out of residential care as a direct result of adaptations
Various interventions to reduce falls (including the use of protective slippers)	Interventions by a local Healthy Communities Collaborative reduced falls in pilot areas by 32% in the first year, and 37% in the second
Telecare	<p>Telecare Development Programme (TDP)</p> <p>Over 29,000 people began using a telecare service over the period 2006–2010 that they were unlikely to have received without TDP funding. More than 2,000 people are known to have been diagnosed with dementia. TDP partnerships saved around:</p> <ul style="list-style-type: none"> • 346,000 care home bed days (against an expected 188,000); • 65,000 hospital bed days through facilitated discharges and unplanned admissions avoided (against an expected 80,000); • 35,000 nights of sleepover/wakened night care (against an expected 55,000); • 411,000 home check visits savings (against an expected 615,000) <p>The overall financial value of gross benefits was judged to be fairly close to expectations.</p>
Rapid Response Adaptations (RRAP) to homes – in Wales (15,473 clients)	<ul style="list-style-type: none"> • Hospital Discharge – net cost saving = £1,798,000 • Hospital Prevention – net cost saving = £3,720,000 • Accident Prevention – net cost saving = £9,491,000
Care and Repair,	

¹⁴ Laing and Buisson (2008), *Care of Elderly People: UK market survey 2008*

¹⁵ University of Birmingham (2010), *The billion dollar question: embedding prevention in older people's services – 10 high impact changes*

Cymru	
<p>For all Care & Repair services</p> <p>Care and Repair, Cymru</p>	<p>Net cost-saving of £26.37million</p> <p>Based on the following (conservative) assumptions:</p> <ul style="list-style-type: none"> • That 2.5% of all clients would have been taken into residential care if the service hadn't been provided • Weekly cost of residential care of £450
<p>Tai Chi as part of falls prevention – a partnership between the primary care trust and Rochdale Borough Council)</p> <p>Willamson <i>et al.</i>, 2009)</p> <p>www.rochdale.gov.uk/</p>	<p>11 older people attended Tai Chi classes. They identified improvements in balance and mobility that allowed them to carry out activities of daily living, such as washing and ironing, more easily. This led to increased confidence and ability to pursue more leisure activities and travel on public transport. Classes were also relaxing and enjoyable.</p> <p>The total cost of health and social care services used by the group (of 11 people) reduced by £1,535.60 over three months – from £4,029.20 to £2,493.60.</p> <p>The bulk of this is accounted for by A&E visits (including calling an emergency ambulance with paramedic unit). Physiotherapy sessions have remained relatively constant as have visits to the GP.</p>
<p>Supporting older people with mental health problems</p>	<p>Involves co-ordinating three services to provide 24-hour support. People are referred during crisis or on hospital discharge.</p> <p>People are assessed on how they are coping when at home alone through a telecare system (Just Checking). Other forms of telecare, such as safe walking technology, are installed to manage specific risks. The service includes a Roving Night Team, with staff available between 11pm and 7am.</p> <p>Set up in 2008, the whole service cost £400,000 in its first year and now costs £300,000 a year. It saves an estimated £1.5m–£1.7m a year by reducing admissions to residential and nursing care homes. As of March 2010, the council was funding 175 placements a month.</p>
<p>Supporting People</p>	<p>Research identified £668m of benefits from Supporting People expenditure on older people of £308m.30 This represents £2.20 of benefits for every £1 spent (not including benefits from improvements in health or quality of life, participation in the community or the reduced burden on carers)</p>

<p>Coordinating services for the frail elderly</p>	<p>Following a holistic assessment of their needs, arrangements are made for individuals to access support from voluntary sector organisations or local community capacity. A study of sample users by the POPP national evaluation found:</p> <ul style="list-style-type: none"> • visits to A&E fell by 60% • hospital overnight stays were reduced by 48% • visits to practice nurses reduced by 25% • GP appointments fell by 10%
<p>Bleep and monitoring in the home</p>	<p>Bournemouth 'bleep' service and access to equipment to monitor movement and falls are available via Housing Landlord Services. An ongoing pilot in Dorset projects net savings in the region of £847,000 and 250 service users assessed in the first 12 months.</p>
<p>A Total Place approach to older people</p>	<p>Bournemouth, Dorset and Poole (BDP) pilot tests how a whole-area approach to public services, focusing on services to older people, can provide better services at less cost, avoiding duplication and more tailored to local needs. Dorset POPP identified cost savings of over £1m through Housing Options for Older People case workers and Dorset Blind Association case workers, reducing by sixty the need for care home placements and home care packages.</p>

4.4 Evidence of increased quality of life, but not costed in £'s

<p>Social Networks</p>	<p>Research in California found that individuals with more social ties had lower mortality rates over a nine year period.</p> <p>Loneliness and isolation makes people vulnerable</p>
<p>Physical Activity</p>	<p>Physical activity –and particularly training to improve strength, balance and coordination –has been found to be highly effective in reducing the incidence of falls.</p> <p>It also improves mental health and reduces incidence of depression</p>
<p>Neighbourhood wardens¹⁶</p>	<p>A survey showed that 93 per cent of people in later life were pleased with the work that the wardens are doing in their community.</p>

¹⁶ Age UK: Going the Extra Mile

	<p>The role of a specialist warden works most effectively when the following key elements are in place:</p> <ul style="list-style-type: none">• Wardens provide direct and face-to-face contact with no time limitation.• Wardens provide one point of contact for a variety of issues.• Wardens have the skills, experience and personal attributes.• Wardens are local and approachable.• Wardens involve people in later life in the development of services. <p>Between 2005 and 2010, wardens working in 7 areas:</p> <ul style="list-style-type: none">• made 39,773 home visits to people in later life• made 10,487 referrals on to agencies <p>Between 2008 and 2010, the wardens:</p> <ul style="list-style-type: none">• delivered 731 events and activities, attended by people in later life 9,475 times.• dealt with 884 environmentally related enquiries, making 3,383 referrals to street environment managers.
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4.5 Tackling fuel poverty

Warm Front (a national scheme) installs insulation and heating improvements to make homes more energy efficient. It is targeted at people living in private accommodation who are on certain income-related benefits and living in properties that are poorly insulated and/or do not have a working central heating system. There are 1.9 million vulnerable households living in fuel poverty in private accommodation in 2006. Only 5% of private homes are top rated for energy performance compared with 21% of social rented homes and 2.1m private sector homes are a health hazard because of excess cold. Older people are more likely to experience fuel poverty than other age groups with those over 75 most likely¹⁷

A NAO analysis found the scheme to be poorly targeted – 57% of vulnerable households in fuel poverty do not claim the relevant benefits to qualify for the Scheme, yet nearly 75 per cent of households who would qualify were not necessarily in fuel poverty. In some instances, local authorities also provide funding to undertake works that have similar aims. CERT is also poorly targeted.

The NAO analysis concentrated on savings to households. It found that work done under the Scheme reduces a household's energy bill by approximately £300 a year.

The Warm Front scheme reduced the chances of excess winter deaths by 10% for recipients

¹⁷ **Local Authority Private Sector Housing Services: Delivering Housing, Health and Social Care Priorities, Helping Vulnerable People and Local Communities, CIEH, January 2011**

Summary – evidence of cost-savings

- There is significant and growing evidence of the potential for investment in a wide range of ‘prevention activities’ to reduce costs of acute health and care services.
- While it is difficult to provide direct comparisons of cost-savings across different types of clients and activities, this evidence provides pointers to where the Health and Wellbeing Board, and partners, might look to make savings.
- Considered together with information on what older people value, this evidence should assist the Board as it develops its commissioning priorities.

5. Recommendations and potential models

This section will be developed for the final report.