APPENDIX A

Ageing Well: Health and Well-being Board Programme

Shropshire Council

Final Report

Embedding an Ageing Dimension

1. Introduction

This is the final report from the strand of the Local Government Association Ageing Well Health and Well-being Board (HWB) Programme, the aim of which is to support Shropshire to "embed an ageing dimension in to the development of the Health and Well-being Board and secure effective engagement of older people".

The project has four parts:

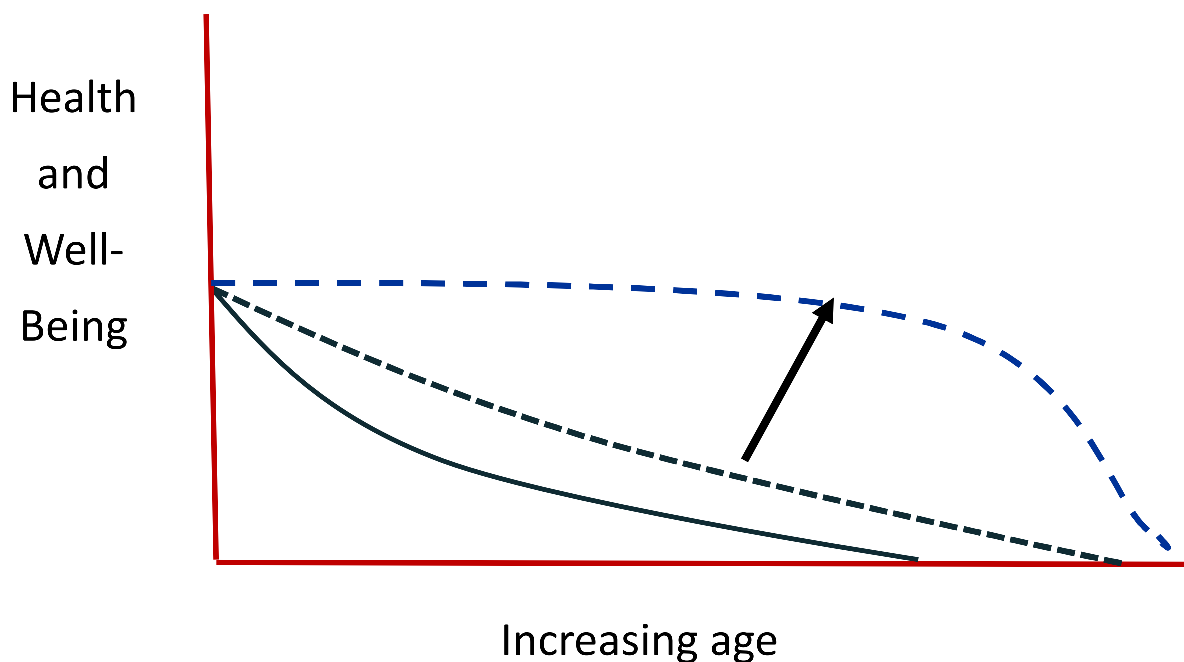
1. Desk-top research: to identify valued outcomes and cost-savings at national and local levels
2. Engagement and training: to support development of constructive communication between Shropshire's older people and the HWB
3. Meeting with key members of the HWB: to reflect on the project at an interim stage, agree directions and further steps
4. Learning from the project: action learning took place on 21 February 2012.

A full project plan is available from Jackie Taylor. Also, the Local Government Association (LGA) is preparing a report on the lessons learned through the Ageing Well Programme across the country.

2. About the project

The project plan was worked up with Shropshire Council and key members of the Health and Well-being Board. Some important points about the project are:

- The overall challenge for local authorities and health services could be described as 'adding life to years'. This means changing the shape of the line of the graph so that people are experiencing better health and general well-being, and therefore better quality of life, for longer and that their ultimate demise is shorter. This aim has been borne in mind throughout the project.



- The LGA associate has worked alongside Shropshire HWB, Shropshire Council and key partner agencies such as Age UK and Senior Citizens Forum to explore systems that the Health and Well-being board might adopt in the long-term – systems for (i) gathering and interpreting evidence efficiently, (ii) engaging and understanding older people well and (iii) using the information well to achieve outcomes. There have been several areas in which the Associate was able to work with individuals to create conditions for existing programmes to flourish and to build on existing thinking to take steps forward. Also, relationships between the Council and Shropshire's older people have become less strained as a result of the project.

- The project has strongly embraced a social model of health and well-being and a focus on the wider determinants of health, rather than focusing on a medical model which tends to focus on specific illnesses and preventing them. The reason for this is that recent research by Age UK found that that there is a growing gap between what older people want and need to live in the community, and what councils are providing - 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[1]. Also, the integration of NHS and Council functions within the HWB provides new opportunities for better integrating commissioning

[1] Practical support at home; evidence review, AgeUK

across clinical health, social care, council functions, other agencies and community-based groups.

3. Observations and reflections from the project

As the LGA Associate has been working on the project, she has made a number of observations and reflections which were discussed at an interim meeting held on 13 January 2012. They have helped to shape the recommendations to the Health and Well-being Board. An update of these reflections and observations (following that meeting) has been collated and can be found at ***Appendix 1***.

4. Outputs from the project

The following papers have been produced which together provide a record of the detailed aspects of the project:

- Research to draw together national evidence about (i) the value of different interventions to older people and (ii) the cost-effectiveness of different activities (***Appendix 2***)
- Notes from an engagement event held on 15 Dec 2011, which comes with its own appendix, (***Appendix 3***)
- Note of an interim meeting with key members of the HWB held on 13 January 2012 (***Appendix 4***)
- Note of a 2nd engagement event held on 26 January 2012, which comes with its own appendix, (***Appendix 5***)
- A note for the Joint Strategic Needs Assessment group – Steps from evidence to action (***Appendix 6***)

5. Core message and progress made

The current level of service provision for older people is unsustainable because the resources available are diminishing while the number of older people is on a long-term upwards trend. Shropshire understands that continuing with the existing model of service provision will inevitably lead to deterioration of services and is taking steps to change both the way it engages older people and its model of service provision.

The Ageing Well project has provided a vehicle for both the Health and Well-being Board and Shropshire's older people through several representative groups, to consider together how best to change the model of service provision so that it better meets the needs of older people and delivers greater well-being for less money.

Notable achievements since the start of the programme in November:

- Improved relations between older people and the Health and Well-being Board

- Older people have helped to shape emerging ‘networked’ arrangements for engagement with the Board through the Stakeholder Alliance, and this has enriched the processes substantially

- The principle that older people should be recognised as (i) people with valuable knowledge that is useful in shaping services and (ii) potential partners in service delivery with energy and expertise to offer – not just consumers of services – has been accepted

- The HWB has made the decision to draw up a strategy for older people, as an element of the Joint Health and Well-being Strategy

- Recognition of the wide range of existing services for older people, and often run by older people as volunteers, have been brought to the fore e.g. the Mayfair Centre, CoCo Project

- A recognition that these existing community-led and largely community-run services make a very large impact and should be built on in the future particularly to deliver ‘low level, high value’ services

- The HWB has agreed to co-produce more services with older people, building on local assets, once priorities, geographies and parameters have been identified through JSNA

- There is a recognition that evidence gathered in the JSNA needs to drive commissioning decisions and partner activity although precisely how this is done has not yet been worked through – the Ageing Well associate made some suggestions for achieving this.

6. Recommendations to the Health and Well-being Board

The following recommendations to the Health and Well-being Board follow on from the significant progress already made during the period that the Ageing Well Project has been running.

- Continue to work with Shropshire Older People’s Assembly to develop and shape its role in representing all older people across the County – including by articulating what ‘good and broad’ representation looks like and encourage SOPA to achieve that aim.

- Consider how the Older People's Partnership Board can add value now that new arrangements are firming up, identifying any changes to their role that might improve their impact, and making those changes.

- Incorporate evidence gathered during the project into the JSNA – including evidence from:
  - the desk-top research – see Appendix 2
  - the issues raised by the Senior Citizen's Forum at the meeting held on 15 Dec 11 – see Appendix 3

- Develop the Older People's element of the Joint Health and Well-being Strategy casting older people in three roles:
  - A knowledge bank – by co-producing with older people
  - Deliverers of services – to the wider community, not just to older people
  - Consumers of services – where necessary

- Revisit/update the Millenium Map including by putting out a general invite for all community groups/individuals to send in a summary of the service they run or asset they hold. Make sure this is drawn into the Joint Strategic Needs/Asset Assessment

- Create the conditions for existing community-based services to develop to address the issues and goals identified in the Older People's Strategy and JHWS (as long as it has been co-produced with older people)

- Consider further how the relationship between evidence and actions might be improved (through the JSNA, JHWS, commissioning), and how this might be fed back, so that older people can see what happens to the information gathered through various consultations.

Appendix 1: Some reflections and observations from the project

- *Relationships*

There has been a view that there are some difficulties with the relationship between older people's representatives and the Council, and this was evident in discussions with older people who attended the event on 15 December. The Ageing Well Project has provided an opportunity for the council to demonstrate its commitment to addressing issues relating to the ageing population. It has also provided an opportunity for older people to raise their concerns and for them to shape a new 'network' model of engagement. It seems to have improved relations significantly.

- *Consistent messages about what older people most value*

The desk-top research (see Appendix 2) found that there is a significant degree of consistency between different studies at both national and local level to identify the 'services' or activities that older people most value (or would most value if they were available) to help them to live healthy and active lives.

- *Existing activities for/by older people*

It is clear that there is a lot already happening for and by older people in Shropshire, mainly run by voluntary groups. Older people are themselves engaged in a wide range of mainly voluntary activities and many that aren't would like to be – as evidenced at the engagement meetings. All of this suggests a high level of motivation among older people to be involved in making things happen and provides a good platform on which to build.

- *Roles of older people*

Older people feel that they are most often cast in the role of 'consumer of services' by the Council and medical professions. However, they feel that they play at least four roles and that their value in the other three roles is not recognised nor drawn on sufficiently. The other roles are:

    - A knowledge bank
    - Partners in delivery
    - Carers of children (grandparents) and other frail or infirm people (e.g. spouses)

- *Style of engagement*

Older people's issues are currently voiced mainly as 'issues', 'views', 'opinions' of older people by their representatives who expect a place in decision-making. Given developments in social networking – both on- and off-line – this model may no longer be the only, nor the most appropriate, model for engaging older people in the future. The Council appears to want to move to a more networked model which engages more people in discussions about service design. However, older people are less

well networked online than younger people so there is a need to develop off-line methods for them.

- *Using evidence to inform and develop the JSNA / JHWS / Commissioning process*

The research element of the project (Part 1) poses the question as to whether ‘lines of enquiry’ might provide an efficient means of marshalling information in a way that provides pointers about what actions to take. Conversations following this research have identified four potential lines of inquiry that might assist in using the information well:

(i) What older people value most in their efforts to live healthy and active lives
(ii) What older people don’t value (and therefore what could be stopped)
(iii) Activities that are cost-effective and that offer cost-savings to acute health and care
(iv) Assets that might be drawn on to achieve outcomes

A separate note that develops the thinking about how evidence is collected and used to achieve a better connection between data and action – see appendix 6.

Appendix 2:

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 well-being of older people in Shropshire by embedding an ageing dimension into the work of the emerging Health and Well-being 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 Well-being 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 takes up 47% of NHS budget. 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**, taken from both national and locally available sources, and how these activities contribute to their health and well-being.

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.

The interim report distils information from national publications and papers. It presents some of the background evidence relating to older people's health and well-being, 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 Well-being 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 help[2] 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

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

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 Well-being Board.

The solid line in Figure1 shows the trajectory that the health and well-being 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 well-being for longer, increasing the dying age.

The large-dashed line shows the trajectory that would ideally be taken. People's health and well-being 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

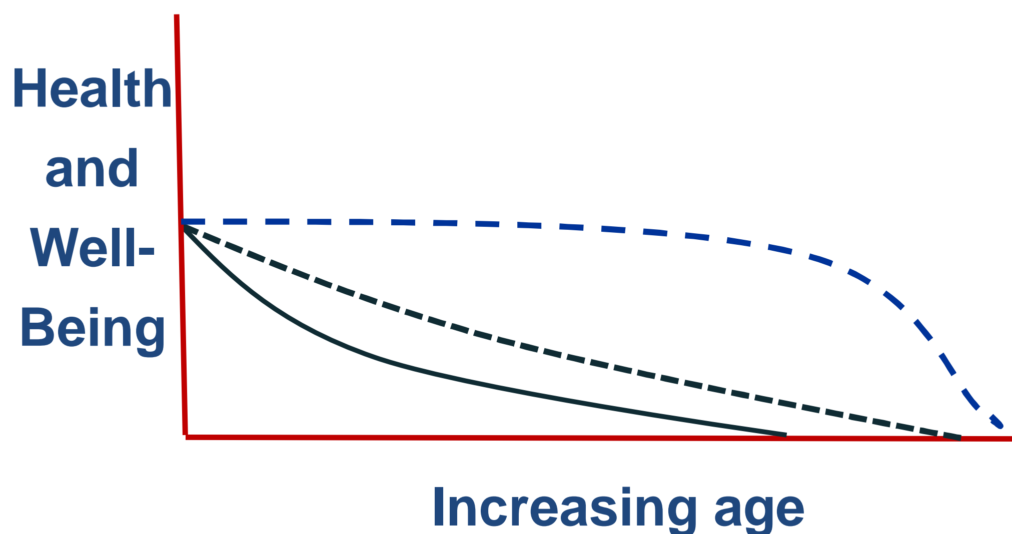
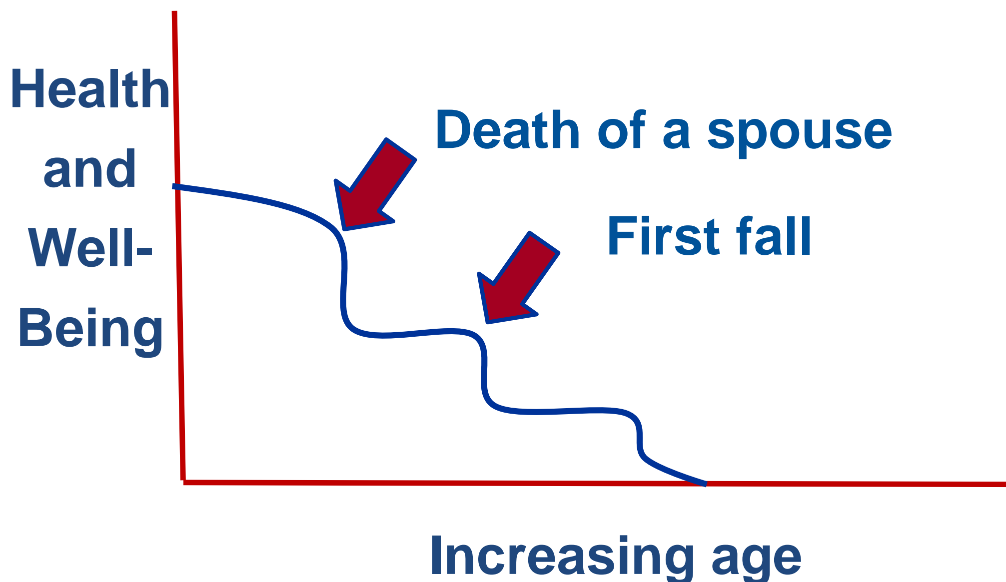


Figure 2 shows the profile that most individuals go through, with decline dropping suddenly following major life events that often accompany the ageing process.



2.4 The economic benefits of reducing dependency[3]

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 person[4]
- A one year delay in providing an adaptation to an older person costs up to £4,000 in extra home care hours[5]
- 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 Well-being Boards collectively seek radically different, less expensive solutions to improving the health and well-being 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 providing this care and support are geared heavily towards those who are eligible – either for adult social care or

[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), H***ome adaptations for disabled people***

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 a 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 well-being.

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 providing[6]. 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 include[7]

- 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.

3.1 Evidence relating to Shropshire

- ***Live Life Your Way***

This consultation around the future of social care in Shropshire was carried out over a three month period from July to September 2011 and led to the development of a new strategy for adult social care in Shropshire. Of those that took part in the consultation, 27% were over 65 years of age. Various events were held including some discussion groups in day centres which involved older people.

[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)*

Thinking about their care, support, independence and choice, people were asked for their feedback on how social care feels to them now and what it could look like in the future. Although feedback was very broad and wide-ranging, some of the issues that are seen as important for older people were transport, loneliness, and help with practical tasks at home.

- ***Design Team Bid work***

Shropshire Council is in the process of responding to the Design Council Business Challenge which is looking for great business ideas that help older adults feel more connected to their friends, families and the wider world. SC is looking to develop a sustainable service that unlocks capabilities in people to stay connected with friends, family and their community. Shropshire Council talked with 80 people from older people, to social workers, and club organisers, carried out 25 in-depth interviews with older people about what keeping connected means to them, and how they do it. Using visual methods older people talked about where they had lived their lives, who they socialised with and the pattern in their days. The findings were analysed looking at the barriers that people face and what motivates them to overcome them.

In terms of what keeping connected means, interviewees talked about:

- Being with a partner
- Being able to get out of the house
- Being in touch with similar people
- Keeping in touch with family and fulfilling a family duty
- Being involved and volunteering in the community
- Helping others
- Having a busy life and feeling valued
- Self development
- Staying healthy

Some of the barriers to keeping connected included:

- Health and mobility issues
- Transport
- Having played a caring role
- Lack of confidence

- ***Supporting People Focus Group***

Shropshire Supporting People carried out some focus group work in January – March 2011 over a series of nine sessions. 48 people over 55 were involved in this work - 18 older service users currently in receipt of a Supporting People service and 28 older non-service users who do not currently receive a Supporting People service. Respondents were asked for their views on a range of subjects relating to the support they receive / may need in the future. These included questions around:

- Your Home
- Your Money
- Day to Day Life
- Quality of Life
- Meeting People

People were also asked about how support should be organised and people's individual goals.

Key messages:

- support to manage the home, help with safety and security and having a warm home was seen as very important by the majority of older participants. Older people also added that being able to access affordable help with maintaining the garden would be useful. They also reported the importance of adequate heating systems in supported housing, as well as security arrangements and the freedom and space to keep pets (which are often restricted).
- Older people said that help with home safety and security was very important;
- Many people said that they would have a much better quality of life if they could get to different places more easily and affordably, or if facilities were provided in their local area;
- When asked about making a contribution, almost half the people said they would like to be able to make a contribution to their community, with 46% of those saying they would like to get involved in voluntary or community groups;
- having a social life was very important to people, and that receiving help with maintaining social contacts can be crucial.

In addition, the Supporting People Peer Review Team carry out individual interviews with users of Supporting People Services in Shropshire in order to review the quality of services received. Key themes that come up repeatedly as areas of concern are loneliness and financial concerns, particularly around fuel costs.

3.2 National level evidence

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

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

i. Maintaining independence in their living arrangements (4.1)
ii. Maintaining interdependence in their social arrangements (4.2)

Maintaining independence in their living arrangements[8]

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.

[8] Practical support at homes: evidence review, AgeUK

The table below 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

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 heath 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 valued [9] :

- 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 independence[11]. Specifically, they have:

- Reduced social isolation
- Had a positive effect on Well-being
- Reduced poverty among some of the most vulnerable communities
- Improved home safety and security
- Increased awareness and knowledge of welfare entitlements

Maintaining interdependence in their social arrangements

Isolation and loneliness is now widely understood to have a debilitating effect on health and well-being[12]. 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.

[9] Practical support at home
[10] Tyson, 2009
[11] Going the extra mile, Age UK
[12] Loneliness and isolation: Evidence Review, Age UK

- 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 loneliness[13]:

- 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

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 creches 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.

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

- 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 What causes the expense?

Accidents in the home	Home accidents, particularly falls, burns and scalds in the over 65's age group cost the health service around £3bn a year and increase dependence on council and other services
Housing in poor repair and an inability to carry out improvement or repairs	Just £35,000 can provide help with minor adaptations for 200 older people – it costs approximately the same amount for one older person to live in a care home for a year. (See Good Practice Example, page 16)[14]
Unsuitable housing – at different stages of the ageing process	

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

Malnutrition	Whilst malnutrition among older people in hospitals and care homes has been well documented, there has been less research among those living in their own homes. It is estimated that up to 40% of people are malnourished or at risk of malnutrition on admission to hospital and research suggests people at risk become caught in a cycle which perpetuates illness and increases the long term risk of ill health and infection (BAPEN, 2007).

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

- ***Local evidence: Compassionate Communities Projects in Shropshire (CoCo)***

The aims of the CoCo projects in Shropshire are to work in partnership with communities in developing their own supportive networks to address loneliness amongst those who are frail and vulnerable, to keep these people connected to their communities and usefully bring together the skills and experience of people in the community with the support available from agencies. Severn Hospice provides 2 days' training to volunteers from the community and then monthly support and education sessions. The model of CoCo is that the medical practice identify a frail and vulnerable person and refer to the CoCo volunteers, the needs of the client are then matched with the skills of one of the volunteers, the type of support and frequency of contact is agreed between the volunteer and the client, support is then reviewed at regular intervals.

Church Stretton, Clun and Cleobury Mortimer have established CoCo projects and 6 other areas are in discussion about developing a project in their area. In the Church Stretton area, evaluation of the project showed a significant reduction in:

- Number of home visits required to the person from the GP and number of calls to the GP surgery;
- Number of calls to Shropdoc and visits from Shropdoc;
- Number of A&E visits and number of hospital emergency admissions.

National evidence

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[15]
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'[16]

[15] Laing and Buisson (2008), ***Care of Elderly People: UK market survey 2008***
[16] University of Birmingham (2010), ***The billion dollar question: embedding prevention in older people's services – 10 high impact changes***

Home adaptations	10% of recipients of *Disabled Facility Grants* 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	Telecare Development Programme (TDP) 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: • 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) The overall financial value of gross benefits was judged to be fairly close to expectations.
Rapid Response Adaptations (RRAP) to homes – in Wales (15,473 clients) Care and Repair, Cymru	• Hospital Discharge – net cost saving = £1,798,000 • Hospital Prevention – net cost saving = £3,720,000 • Accident Prevention – net cost saving = £9,491,000
For all Care & Repair services Care and Repair, Cymru	Net cost-saving of £26.37million Based on the following (conservative) assumptions: • 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
Tai Chi as part of falls prevention – a partnership between the primary care trust and Rochdale Borough Council) Willamson *et al.,* 2009) www.rochdale.gov.uk/	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. 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. 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.

Supporting older people with mental health problems	Involves co-ordinating three services to provide 24-hour support. People are referred during crisis or on hospital discharge. 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. 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.
Supporting People	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)
Coordinating services for the frail elderly	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: • 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%
Bleep and monitoring in the home	Bournemouth 'bleep' service and access to equipment to monitor movement and falls are available via Housing Landlord Services. An on-going pilot in Dorset projects net savings in the region of £847,000 and 250 service users assessed in the first 12 months.
A Total Place approach to older people	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.

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

Social Networks	Research in California found that individuals with more social ties had lower mortality rates over a nine year period. Loneliness and isolation makes people vulnerable

Physical Activity	Physical activity –and particularly training to improve strength, balance and coordination –has been found to be highly effective in reducing the incidence of falls. It also improves mental health and reduces incidence of depression
Neighbourhood wardens[17]	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. The role of a specialist warden works most effectively when the following key elements are in place: • 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. Between 2005 and 2010, wardens working in 7 areas: • made 39,773 home visits to people in later life • made 10,487 referrals on to agencies Between 2008 and 2010, the wardens: • 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.

[17] Age uK: Going the Extra Mile

Appendix 3:

Local Government Association Ageing Well Programme

Shaping Shropshire – for long and active lives

15 December 2012

Trinity Centre

Present:

Richard Chanter	Patient Participation Group (PPG), Shropshire Patient Group, Shropshire Age UK
Mike Seale	Shropshire Senior Citizens Forum (SSCF)
Chris Grundy	SSCF
Christine Meason	PPG, SSCF, Shropshire LINk
David Beechey	Shropshire Older People's Assembly, Shropshire LINk, Association of Local Councils
Pam Wingett	Shropshire Older People's Assembly (SOPA)
John Dodson	SSCF, SOPA
Heather Osbourne	CEO Age UK Shropshire
Merron Simpson	LGA Consultant
Jackie Taylor	Facilitator Partnership Boards, Shropshire Council (morning session)
Carolyn Healy	Shropshire Partnership Coordinator (afternoon session)

Introduction

Heather gave a brief introduction to the workshop, explaining that the aim of the day was to develop some thinking with a small group of older people with a view to opening up the conversation to a bigger group later on.

Background

Merron gave some background to the Ageing Well Programme, the agenda for the workshop and the Shropshire Ageing Well Project.

Key points:

- Shropshire is one of 17 Councils that are Ageing Well Development Areas. This workshop is one of 4 parts of the engagement element of the Shropshire Ageing Well Project.
- The workshop is about understanding the current context, issues and relationship with the Health & Well-being Board (HWB), appreciating and building on what is already in Shropshire, testing out a method for gaining insight into what's important to older people and the style of communication that will be most useful in shaping a relationship with the HWB
- The Older People's Assembly stands out as a key group that needs to be part of the Shropshire Ageing Well project and have an ongoing productive relationship with the HWB.
- Participants voiced their concerns that many in Shropshire OPA feel that the council has gone backwards in its engagement and consultation with older people – from a time several years ago when there was a lot of dialogue, clear routes and structures for influence and when Shropshire had Beacon Status for services to older people to the current situation where many of these routes and opportunities for influence have been removed, are being changed or are unclear.
- It was noted that to some extent statutory guidance has affected some of the ways the council engages.
- Also, Merron made the point that the last 18 months has been a period of huge change and turmoil for councils. It is important to acknowledge that Shropshire Council approached the Local Government Association to get onto the Ageing Well Programme which is an opportunity to help to shape future engagement. The HWB do want to engage, and are developing structures, but it is not yet clear how this will look. Whilst the HWB do not see older people as a more important group than other groups, they *do* recognise the demographic of an ageing population as a crucial issue that needs action.

Other key points raised either by Merron or by participants:

- Years have been added to life and life expectancy has been raised. The challenge now is around how we **add life to years**.
- Older people are ...
    - Consumers of services
    - Partners in delivery
    - A knowledge bank
    - Also grandparents and carers
- Loneliness is often an issue and older people can often be afraid to ask for help
- Are older people being asked about what **they want** and what is important to them?
- More **intergenerational work** would be beneficial and is often more beneficial that work that brings older people together with other older people.
- Doctors need experience in working with older people to prevent **over-prescribing**
- **Health visitors** can be used effectively to identify gaps.

- Using successful processes from other schemes to develop better support for older people eg: in Sure Start Programme the GP notifies the Sure Start team about birth of baby – could this not be done when a person reached 65?

Part 1: Adding Life to Years – stories using Appreciative Interviews

The group was introduced to the method of 'Appreciative Interviews' which aims to get to the essence of what we each value as older people. Participants were asked to do an exercise in pairs to explore the question:

What does 'adding life to years' mean to you?

They were asked to think back to a particular situation (as an older person) when they felt most energised and alive. They were asked to relate that story to their partner to tell them what it was about it that made them feel good and what they most valued about it and particularly about their contribution to it. Then they were asked, if they had one wish for the future to make more of these exceptional experiences, what would it be?

Each person wrote on 3 post-it notes:

1. Their **story**
2. What they **valued** about it
3. What their **wish** for the future would be

They wrote the following:

Story	**Value**	**Wishes**
A walk on my own in a group of strangers, in Madeira, discovering new surroundings	• Socially stimulating, meeting new people • Mentally stimulating – new environment, surroundings • Physically stimulating – 8 mile walk	• To have more opportunity to do it again • To encourage others to do the same, wherever they can be
Went on holiday to Wiltshire and Bath with some and grandchildren. Went to carol service and loved seeing granddaughter smiling and looking up at me	Going on long walks with grandchildren and decorating the Xmas tree Family decorating tree while I was there and their excitement of Christmas. Wanted to do ..... I was there	That my grandchildren lived nearer
Walking over Lawley, Caer Caradoc – 4 hours	Being outside, whether invigorating, achieving length of walk	Longer days in winter, putting time aside to do things I love doing
Joining in with a group of young people celebrating the successful opening of a new business enterprise	Being fully accepted into the group despite the age disparity, then as confidence was established being asked	Being in a position to encourage more young people to move forward in the way that this group was

	for ideas and 'hints' for moving the business forward	obviously determined to do
Took in a friend of a friend who was down on his luck	Feeling good, appreciated, felt that I had achieved something	Give confidence and enable trust from my family and to continue to support people in need
Walking up to Rodney's Pillar one lovely autumn Saturday with Chalkie, who had some real problems	• Winning his confidence • Meaningful conversation • Fellowship between strangers • Energised feeling	The opportunity to do it again – helping a stranger. I was better at prioritising my time for others
Problems of early retirement and finding an outlet where knowledge can be used	To believe that you can use your knowledge to help people	To continue to believe that your efforts are listened to and used

We discussed their experiences and explored the essence of them. Following the meeting, Merron undertook some further interpretation into what 'adding life to years' means to this particular group of people.

Some strong themes about how to 'add life to years' coming through:

- Connection with other people
- Contact with and support of young people
- Using knowledge, skills, experience to achieve something tangible
- Being listened to
- Feeling accepted, valued and trusted
- Helping other people
- Physical activity

Some observations about the exercise

- Every person in the group participated well in the exercise – no one felt it was too silly
- During the exercise, people focused on things that are working, rather than focusing in on 'issues' or 'problems' or things that need to be fixed. This in itself is energising
- People said they had felt they had been listened to, and that they had been heard
- They felt it was a useful exercise to unlock people's stories

Some thoughts about how Shropshire Council could use this

1. The themes they came up with about what 'adding life to years' means to them, were not at all related to 'services' but to a way of life. The next question is how to help people to maintain this way of life for longer and to delay the onset of frailty (since the participants of this workshop are not in the 'frail' category), and to reduce the burden on health and care services. The answers to this question are not likely to be found in 'more services' but in support to older people to

organise, shape and run a variety of different types of activities and in assisting with access to them (especially transport).

2. These older people have a great deal to offer in terms of providing both informal and specialised support to others – this energy and passion could be harnessed to achieve a wide variety of the Council's objectives. By their own admission, they feel this sort of contribution would help to keep them fit and active for longer.
3. The exercise itself could be used as a vehicle for consultation with others – it could be particularly useful for people who are likely to get to meetings or who don't find it easy to bring their thoughts together to communicate in front of others, because it is based on 'story-telling' and interpretation by the listener.

Part 2: The key issues, currently (and how they might be addressed through a strategy)

John Dodson provided a comprehensive list of what the Senior Citizen's Forum considers the key issues to be. These are attached as an appendix to this note.

Heather Osborne also provided some thoughts on what Age UK understands the key issues to be [Heather to prepare a note for appendix].

One person said that the people who need the most help are also those that are harder to contact.

The group said that they didn't expect all of these issues to be sorted out – they understand the limitations. However, they felt that there is currently no Older People's Strategy for these issues to be picked up and through which priorities could be decided and settled upon.

Doing a deal

Merron suggested that older people might want to be seen as part of the solution, rather than always as consumers of services. They might be able to do this by doing a 'deal' with the HWB. Loosely, this means that:

- Older people would become partners in delivery of various services that support better health and Well-being (among people of all ages), identifying the terms and support that would be needed, in return for
- Agreed action on agreed priorities for older people.

This idea went down quite well with those present. It could be achieved through the JHWS or through a separate strategy for older people that forms a significant part of the JHWS.

Part 3: What assets do we currently have?

The group did some brainstorming on what the assets are that could be built on. In some instances, gaps in the services were identified. The list below is not a comprehensive list.

- 1000's of older volunteers
- 1300 voluntary organisations
- Town and parish councils (relatively untapped resource) – their work is not sufficiently recognised nor taken into consideration.
- Broad Places – specialising in broadband provision, IT and training
- Over 60s
- Senior Citizen's Forum
- Village Halls
- Befriending Groups
- Age UK – wide range of services
- Mayfair Centre, Church Stretton and Beech Tree
- Walking for Health
- Ring and Ride – Shropshire Link (although there are gaps in services)
- Community car/bus services – fully booked most of the time
- Shropshire Patient's Group
- Voluntary Sector Assembly
- U3A
- A4U (disability health facility)
- Sheltered housing schemes
- Other local Age Concern and OPWCS
- Voluntary Service organisations eg. Lions, Rotary, SSAFA

This demonstrates the richness and strength of voluntary and self-organised work going on in Shropshire, which could be build on and further developed.

Part 4: Informing the work of the Health and Well-being Board

The emerging Stakeholder Alliance and JSNA-related activities

New engagement arrangements are being developed. Two analogies were presented about where we are currently in relation to these new arrangements:

1. 'Wet concrete' – nothing is yet firmed up, so there is a potential to shape arrangements
2. 'Getting back on track' – the group had been describing a picture of arrangements having fallen off the track, and the challenge being how to get back on track.

Carolyn Healy attended and talked about the ideas and thinking taking place in relation to the developing Stakeholder Alliance as the main vehicle for

communications with the HWB. She also gave some feedback from the Stakeholder Alliance event that took place on 1 December.

She said that:

- this is not about duplicating Healthwatch – other bodies may be able to represent better
- there is likely to be a face-to-face element to engagement, and an e-comms element using facilities such as Facebook and Twitter which people can use if they want to
- it will inform the JSNA, prioritisation etc
- it will be done with people, not for people
- they are working towards a dynamic system for developing strategies / action plans

The group suggested that the existing mechanisms were not being well used and that this will only work if there are good relationships with people/organisations. There could be more than one channel – in particular the Partnership Boards and the emerging Healthwatch could provide 2 channels and there may be more. The group feels that the Stakeholder Alliance could grow/morph out of existing arrangements like the Partnership Boards.

A robust means of establishing priorities

One person suggested that, when identifying priorities, the process to go through should be:

1. someone put forward a priority
2. have a Q and A on it
3. that person has to make a case
4. others rate it

This system is could be used when making collective decisions and is a good way of developing a course of action in a robust manner.

Describing desired communications

The group settled on some words they would use to describe the type of communications they want to see emerging. These are:

- Connectivity
- Openness
- Transparency
- Communication – 2-way, iterative, with feedback (if not, they would like to know why not)
- Accountability
- Honesty

- Fairness
- Co-production – i.e. older people playing a part in designing, shaping, running services
- Influence

Merron suggested that it might be possible to knit these into a set of principles that partners agree to. However, the group felt that this would not be sufficiently measurable and therefore may not be effective.

Stories as a vehicle for consultation

Merron suggested that older people could play bigger roles in representing each other i.e. tasking people to contact others and (i) help to connect them to relevant services and (ii) find out what their issues are and to feed these back to the HWB – this could be a function of the Stakeholder Alliance.

An existing project, The Cocoa Project, Mayfair, was seen to be a vehicle that could be supported and expanded to do these things. The group thought this to be, essentially, a good idea.

Use of evidence and the developing JSNA

Merron suggested to the group that different types of evidence might be incorporated into the JSNA – to develop the link between evidence and actions. She suggested 3 steps:

- ***Step 1: Draw together 'static information'***

'Static information' is the type of evidence that is already collected and that is currently typically found in the JSNA. It is largely quantitative and interpreting it provides a broad picture of the place – the demography, issues, needs, how it compares with other places etc. This type of data is useful for **identifying broad priorities** for action, but it does not help to identify the best actions to take. On its own, it will not provide commissioners with sufficient information on which to make good commissioning decisions.

- ***Step 2: Identify important lines of inquiry that provide 'directional information'***

Identifying important lines of inquiry relating to a broad goal, and collecting evidence relating to these lines of inquiry, provides a short-cut towards identifying which courses of action to take. In the Ageing Well Project, the broad goal is to enhance the health and Well-being of older people in Shropshire and a number of important lines of inquiry have been identified. These are:

(i) evidence of activities that older people value the most in their efforts to live healthy and active lives
(ii) evidence of activities that are cost-effective because they reduce the burden on more acute health and care services
(iii) evidence of activities that older people value the least – and that might be stopped

(iv) evidence of existing assets that could be employed in achieving the overall goal

This is a different type of evidence from that gathered in step 1 as it provides significant pointers towards particular courses of action and away from others, and it helps to shape the actions. It can be quantitative and qualitative.

- ***Step 3: Co-production***

'Co-production' is a process through which those who will use services help to design and shape them. It recognises citizens as knowledgeable about the character of the locality and the specific needs of the people who the service is designed for, and capable of employing this information to shape services that are highly likely to be well used – if well facilitated. It is the point at which this very local evidence and action come together and enables services to be moulded around those who are going to use them.

This type of information is provided directly by service users and is mostly qualitative.

The group understood the three types of evidence and felt they have a lot to offer to Step 2 – helping to provide the directional evidence and Step 3 – co-producing services with the Council and other partners. They feel that quite a lot of this goes on anyway, among partners.

Summary

- There is an understanding that communications in the future will be more networked and less bilateral – ie. taking place between many individuals rather than 2 or 3 organisations that represent 'older people'
- There was agreement that inviting people to tell their personal stories can lead to a deeper understanding of the issues and potential solutions that are different those that professionals usually come up with, and more fitting.
- Older people want to be part of the solution – they want to be recognised as active partners in delivery
- The HWB should adopt a principle of building on and supporting development of voluntary and community 'services' already in place when considering what to commission and support.
- The group would like an Older People's Strategy (possibly part of the JHWS). They would like to co-produce it with others, and would like to explore the idea of doing a deal.
- More thoughts needs to be given to how the OP Partnership Board will morph into the Stakeholder Forum and how engagement and representation will happen
- Embedding any new arrangements will depend on the way the JSNA / JHWS / Commissioning arrangements shape up – the usefulness of the 3 types of information outlined (static, directional, co-production) in making the link from evidence to actions, should be considered.

Appendix: SASCF Current Key Issues

1. **Social Care. *80% of elderly people have depression.***
a. Carers and the cared for. Continuing concern about identification of carers, provision if the carer is ill or needs respite – avoiding the carer becoming the cared for.
b. Home care in various forms to help as far as possible to avoid anxiety and give a feeling of coping and well-being.
c. Meals on Wheels type service which should still be in place for those who cannot prepare their own meals and certainly cannot get out to go to a lunch club or other such venues.
d. Preventative care in various forms to maintain or help stimulate both physical and mental well-being.
e. Day centre provision, closures and more expensive alternatives?
f. Reduction in residential care. Enhancement of home care to cope?

2. **Health Care. *Many elderly feel they are a burden to the services.***
a. Difficulty in accessing to services.
b. Institutional ageism in NHS (See CQC report on hospital inspections) which includes vulnerability to unacceptable care in hospitals and homes. Nursing is a vocation and requires empathy which should be a natural ability not one requiring training.
c. Ability of GP's to identify depression and early stages of Dementia and Alzheimer’s plus treatment programmes.
d. Single assessment on arrival in hospital to ensure appropriate provisions are either in place or planned prior to discharge. Being sent home without adequate provisions does occur only too often. Also causes bed blocking while appropriate arrangements are made.
e. Extra care provision either post hospitalisation or due to serious changes in a person’s condition needs careful monitoring.
f. Electronic home care monitoring must not be a substitute for appropriate home visits.

3. **Housing provision. *The current economic climate will increase demand.***
a. Current availability of sheltered and extra care housing. Is demand out striping availability?
b. Downsizing/availability of affordable or appropriate rented housing. Many are now stuck in their own properties because they cannot afford to move. Being property rich but financially poor is a real problem.
c. Housing related support through the Supporting People services is vital both to those in sheltered housing, housing association properties and property owners.

4. **Transport. *Many cannot afford to retain their own transport.***
a. Totally inadequate rural transport services. An issue that impacts on those with medical appointments, those wanting access services and activities chosen as part of their Personalised Budget or those simply wanting to socialise and avoid isolation.
b. This issue has to be resolved because it is always highlighted at all consultations on whatever subject.

5. General.

a. Peer group interviews amongst housing association residents and home owners found that the greatest concern was about isolation and fuel poverty.
b. 'Concepts' are very interesting but on too many occasions there is no 'nuts and bolts' information about what is being offered either as a reduced, alternative or new service. For this reason many elderly are worried and suspicious about 'changes'.
c. Better communication is vital.
d. Questionable NHS/Social Services liaison and working together.
e. No Older Peoples Commissioner or Champion?
f. Services that are piloted in Shrewsbury are not necessarily appropriate for rural areas – cost are much higher for a start.
g. An up dated Older Peoples Strategy is needed contributed to be both SASCF and the Council as was the case with the first Strategy penned nearly 10 years ago.

6. What Senior Citizens can offer.
a. Use of skills acquired over a 40 year working life.
b. Intergenerational activity that can draw from skills.

JD 14.12.2011

Appendix 4:

Ageing Well Health and Well-being Programme

Shropshire Council

Note of meeting held on 13 Jan 2012

Those present:
Cllr Anne Hartley
Val Beint
Rod Thomson
Heather Osborne
Carolyn Healy
Jackie Taylor
Merron Simpson

General

Merron explained the background to the project and then facilitated a discussion based on the Interim Note prepared and sent round to participants on 3 Jan.

The notes below summarise the conclusions that were drawn.

At the end of the meeting, Merron agreed to put together a draft agenda for the 2nd engagement event that will take place on 26 Jan. Those present agreed to provide Merron with comments on that agenda to help shape the event.

Focus and scope of the HWB

The group confirmed that the scope of the HWB is broad – 'Well-being' in its widest sense. Its understanding of 'integration' goes well beyond the process of integrating health and social care, and it is concerned to integrate across council functions and to include the range of activities that might be undertaken by partners to improve the health and well-being of the population. The focus will be on outcomes and the process of integration will follow and will depend on what's required to achieve the outcomes. That said, the integration of health and care is a primary consideration as required by the latest Future Forum report (published in Jan).

A new Older People's Strategy

The group felt that it is very important to prepare a new strategy for older people and that this should be a part of the Joint Health and Well-being Strategy and fully integrated with other elements (offering cross-generational possibilities e.g. schools offering meals for older people). It was agreed that older people would be recognised as (i) a knowledge bank, (ii) partners in delivery (iii) consumers of services and (iv) carers of children and disabled people. Also:

- The strategy will be co-produced with Shropshire's older people, drawing on their ***knowledge***
- It will be short and focused
- It should be steered by the priorities emerging from the JSNA. The Council may need to, or wish to place some other parameters on its content (such as VFM etc).
- It will not only focus on what the Council will do, but will:
  - Embrace partner agencies' commitment and contribution to health and well-being
  - Recognise, encourage and develop older people's contribution to health and Well-being across generations – as ***partners in delivery***
  - Recognise older people's ***contribution as carers*** of partners, parents, friends and others
  - Incorporate older people's needs and means of addressing them – as ***consumers***
  - *Consider what **assets** are available to support its delivery*
- There would be a broad scope in terms of (i) setting outcomes relating to the priorities and (ii) the nature of activities to achieve the outcomes.

The shift to networking as a model for engagement

The Council does want to shift the way it interacts with the community, from a representative approach to a more networked approach that supports better flows of information. It is developing its approach along the following lines (including through the Stakeholder Alliance):

- There will be both on-line and off-line networking opportunities
- Existing networks will be used as much as possible
- Both formal networking opportunities and informal ones that anyone can set up and the Council will take notice of the weight of support
- Requiring organisations to do some of the interpretation themselves
- The kind of methods mentioned include:
  - Newsletter
  - Inviting people to comment on particular issues
  - Existing groups working on specific issues
  - Expert networks – with people being invited to get engaged in particular issues
  - Patient forums

It is recognised that the Council has to be smart in working in this way – because of capacity issues. It also needs to be smart about how it extracts the information and uses it to support actions on the ground.

The group agreed to write this up as a developing 'vision for engagement' for the HWB (and indeed the Council) and to develop it further with input from the various

sections of the population. The current representative groups – including Age UK, the Senior Citizen's Forum, Older People's Assembly and Older People's Partnership Board – could be invited to consider how they will support its development and make an offer of support for a new 'network' approach to engagement.

Reaching 'hard to reach' groups of older people

The Group agreed that Appreciative Interviews might be a good way of reaching those people who can't attend meetings or who aren't confident in presenting their views in front of others. Precisely how this would be done would need further thought – probably not appointing 'HWB engagement associates' but developed through the Cocoa Project or similar project and sharing the results with GP consortia and others. It was agreed to do some work on this at the event on 26 January.

Co-production

It was agreed that, once priorities, geographies, parameters etc have been agreed, it would be appropriate to 'co-produce' solutions with older people on a frequent basis – this is a means of responding to nuances within diverse groups of people and to shaping a service of intervention to a specific situation. However the HWB needs to be clear with people about what co-production is, how they are doing it and why, and what is expected of people. This is more about the Council 'creating the conditions' for the range of partners to contribute to solutions – rather than about the Council saying what it will do.

Asset-mapping

It was agreed not to do a comprehensive asset-mapping exercise, but to explore what assets are available when exploring how to address a particular issue in a particular location i.e. for it to become a way of working rather than a one-off exercise.

Appendix 5:

Local Government Association Ageing Well Programme

Shaping Shropshire – for long and active lives

26 January 2012

Guildhall, Frankwell

Those present

Val Beint	Corporate Director, Health and Care, Shropshire Council
Cllr Ann Hartley	Chair of Shropshire Shadow Health and Well-being Board
Merron Simpson	Local Government Association
Heather Osborne	Age UK, Shropshire, Telford & Wrekin
Jackie Taylor	Shropshire Council
Mike Seale	Shropshire Association of Senior Citizens Forums
Bridget Mollekin	Shropshire Association of Senior Citizens Forums
Allan Bush	Wem & Whitchurch, Senior Citizens Forum
Ray Twiss	Wem & Whitchurch Senior Citizens Forum
Betty Bateman	Wem & Whitchurch Senior Citizens Forum
Cllr Peggy Mullock	Shropshire Council
Margaret Lewis	Age UK
Gaynor Evans	Age UK
Tricia Maddox	
Christine Norris	
Pat McLaughlin	Association of Local Councils, Shropshire, Telford & Wrekin
Anne Wignall	Age UK Shropshire, Telford & Wrekin
Miranda Ashwell	Shropshire County PCT Public Health
Olivia Matthews	Market Drayton Senior Citizens Forum
Eric Davis	Market Drayton Senior Citizens Forum
Christine Grundy	Market Drayton Senior Citizens Forum
Christine Murison	Market Drayton Senior Citizens Forum
Tom Lederer	Shrewsbury Senior Citizens Forum
Ann Wilde	Shrewsbury Senior Citizens Forum
Dice Buchanan	Mayfair Centre
Daphne Simmonds	Community Council of Shropshire
Roland Brown	Shropshire Housing Support Group
Alan Shermer	Shropshire Housing Support Group
Nadia Shermer	Shropshire Housing Support Group
Pat Stevens	Shropshire Housing Support Group

Introduction

Val Beint, Corporate Director of Health and Care thanked delegates for attending and introduced the event. She explained the background to the Shadow Health and Well-being Board being set up and how the Council is progressing with establishing its engagement methods and ways of working.

Heather Osborne, Chief Executive of Age UK also welcomed delegates. She explained the background to the setting up of the Older People's Assembly and how it is shaping up as the principle route for influencing the Health and Well-being Board.

Part 1: Doing things differently

Merron Simpson (Associate with Local Government Group) introduced herself and explained that Shropshire Council approached the Ageing Well Programme to be part of the Health & Well-being strand of work. This indicates that Shropshire Council recognises the importance of planning ahead for an ageing population.

Merron provided some background to Shropshire's plans to 'do things differently', explaining:

1. *Why is it necessary to change?* – because the population is ageing, older people are expecting more from life, public money to support services is diminishing and the creation of the new Health and Well-being Board provides a new opportunity to establish more integrated patterns of working. The challenge is to 'add years to life' i.e. to support older people in enhancing their quality of life into old age.
2. *How will things be different?* – Merron explained that the 'how' has not yet been firmed up and that the Health and Well-being Board are at the 'wet concrete' stage – they want older people to help them shape the arrangements. Feedback from the 15 Dec meeting suggests that older people want opportunities to connect with other people, especially young people, to use their knowledge and skills, to help other people, to be listened to and valued and physical activity. They want openness, transparency and honesty in communications and they want to co-produce strategies and services with the Board. The Board intends to develop more networked ways of working and to build on assets and activities already taking place within communities.
3. *How can you be involved?* – Merron thanked people for attending the session (part of being involved) and suggested some other ways in which people can be involved on a regular basis ... and that these opportunities might grow and develop over time.

See full presentation for further information.

Part 2: Informing the work of the Health and Well-being Board

Carolyn Healy explained how the Stakeholder Alliance is shaping up through the process of consultation. The key messages that came out of the Stakeholder Event that took place on 1 December 2011 were:

- No single method of engagement will meet all needs
- People do not have time for more meetings
- Existing networks of stakeholders should be used to gather views and information
- A virtual forum will provide an opportunity for more people to contribute and have their say
- Opportunities to meet face to face are still very valuable
- Physical meetings of different stakeholders should be allowed to develop naturally, not imposed from above
- Initial meetings should be focus group type events based on emerging priorities

So far, the proposal is to

- Create a virtual network
- Hold focus group workshops on key themes/priorities
- Produce a regular newsletter

Carolyn pointed out that developing the Stakeholder Alliance and methods of engagement would take time. They felt that it is important to make a start and to review and refine how it works later on, rather than agonise over the precise format, which would cause delays. This means that it will not be perfect initially, but that it would develop over time.

Group discussion

Delegates were asked to discuss three questions in groups of 5-6 people. The precise wording of the questions and actual feedback made from the flip-charts is attached as an appendix. Below is a summary/interpretation of what people said and suggested during this session.

- **Having confidence in being heard**

Partners in planning: People want decision-makers to recognise them as partners in the strategic/action/commissioning planning process – they are inviting decision-makers to draw on their knowledge and expertise to prevent wheels from being reinvented.

Consistent, timely involvement: People want to see their input making a difference as a matter of course, when things are going well as well as when there is a particular issue to address, or problem to solve. They want to see a more timely approach, so they are asked about issues when they are current (more wet concrete opportunities) not when decisions have already been made.

Transparency and feedback: People want to know and be able to see what has happened to a point they made or an idea they had. They want to see action, to have explanations for decisions/actions and to understand where the decision to do or not to do something has been made and by whom. Suggestions for making this happen are (i) to have a clear point of contact, an individual who is responsible for giving feedback and (ii) to map their input, so that they can see their representations taking effect.

- **Methods of communication**

Two-way information: the methods of communication that are fashioned need to be capable of transmitting information in both directions – from older people to decision-makers and from decision-makers to older people.

Reaching into 'hard-to-reach' groups: it is important that people who are unable to leave their homes, for example, can still have their voice heard.

Timing is important: if using a network of organisations to collect and disseminate information, then the timing of this needs to fit timelines for group meetings – a suggestion was made to use the COMPACT guidelines.

Suggestions for communication methods include:

- A dedicated website and virtual network – well publicised
- Good reporting in local press
- Talking newspaper
- Newsletter – simple in style
- Local Radio Stations – Shropshire, Severn
- Distribution system through existing organisations/networks – churches (good at reaching housebound people), libraries, mobile services, parish magazines etc
- Develop a network of older people's representatives
- Provides routes of access to information – through both formal and informal arrangements e.g. trusted buddy, triage system
- Use local market stall
- Develop the Mayfair Centre or similar, so that every community in Shropshire has one.

- **Representation through the Older People's Assembly (OPA)**

The OPA is seen as a key mediator on behalf of Shropshire's older people.

In terms of *style*, people felt the OPA needs to be positive, strong and energetic. In terms of *reach,* it needs to be inclusive seeking the views of 'hidden people' as well as others. In terms of *operations*, it needs to have a method for 'gathering voices' and sufficient time to turn around a consultation (disseminate, collect, feedback) eg. 12 weeks.

Part 3: Getting close to 'hard-to-reach' older people

Paul Cronin introduced the background to what motivated the setting up of the Compassionate Communities Project (CoCo Project) from the Mayfair Centre in Church Stretton. The project grew out of concerns about social isolation and vulnerable people and a recognition that by working with the community frail and vulnerable people could be assisted to re-engage. Paul and a local GP, Sal Riding, took this idea and worked with others through the Maysi (Mayfair Supporting Independence) Project to develop the CoCo Project. As well as improved outcomes for the people supported, evaluations have shown promising wider changes such as a reduced number of home visits required to the person from the GP, reduced number of calls to the GP surgery, reduced number of calls to Shropdoc and visits from Shropdoc.

Dice Buchanan (Project Coordinator) explained how the CoCo project works and what role the community volunteers play in enabling and empowering isolated vulnerable people in the Church Stretton area to re-connect. Currently, the project supports 47 people and has 50 active supporters.

Heather Osborne mentioned a number of other projects that are being run by Age UK, the Red Cross, WRVS etc. that already play a role in reaching 'hard to reach' people.

A short discussion followed to explore

- How might these schemes be developed to provide a channel of information between 'hard-to-reach' older people and the Health and Well-being Board?
- Are there other organisations that you think could provide a similar channel?
- What else would you like to see in place to ensure that the voices of hard-to-reach people are heard?

Delegates could see the value in the Mayfair Centre, the CoCo project and other existing local projects and they could see the potential for expanding and developing this type of work. The following points were made:

- There is a need to map existing services/organisations that could be a route and not reinvent
- Mayfair is bottom-up, which is a very good thing about it – it can be very responsive
- Libraries, good neighbour schemes also mentioned as routes
- Build it around the community – very different way of working
- Start with the Millenium Map, and refresh / build from there
- Long-standing problems – are still there

- Seeing the results – is very important
- Services can be connected to make more of them

Summary and close

Cllr Ann Hartley concluded by reaffirming the Board's commitment to addressing the issues explored throughout the session. While the financial circumstances are difficult and the logistical task is also a very difficult one, the Board is taking opportunities and steps to be responsive to older people, to co-produce and to create the conditions for them to live healthy and active lives. She thanked delegates for attending and closed the meeting.

Appendix: Delegate responses to three questions relating to Informing the work of the Health and Well-being Board

1. **What would make you have confidence that your voice is being heard?**

    - Being given a straight answer ... feedback
    - Clear point of contact (e.g. coordinator of Alliance) so they can pin someone down for a response
    - Understanding where decisions are made ... HWB? Other body?
    - Make sure there isn't just a health focus – other factors are important to Well-being
    - HWB being more open – clearer service user representation
    - Knowledge that suggestions have been acted upon
    - Consultation needs to be genuine, meaningful, accurate – bottom up
    - Timing needs to be good – consultation at the correct stage ie. when questions are being asked / problem is being looked at
    - Demonstrate that consultation has been representative – mapped / transparent
    - Ongoing dialogue – that leads to a recognised outcome. Not 'box-ticking'
    - If we saw a positive response to our questions, suggestions, queries – don't always get a positive response
    - Explanations for decisions and actions

- We want to be involved and informed when things are going well – we feel that older people are only consulted in times of difficult decisions – lip service

- An answer to questions should always be given

- Wheel is always being reinvented – seek our expertise!!

- See action – not large documents to go in a cupboard

2. **Are there other ways you would like to communicate – in addition to a virtual network, focus groups, regular newsletter?**

    - Website
    - Better reporting in local press (eg. Bridgnorth Journal etc.)
    - Newsletter
    - Timelines of information being distributed – needs to fit timelines for group meetings (use the COMPACT guidelines)
    - Too much data protection, preventing organisations from sharing information
    - Every community should have a Mayfair
    - Provides routes of access to information – through both formal and informal arrangements
    - Trusted buddy
    - Triage system
    - Newsletter – not glossy but simple. No jargon. Use existing organisations/networks to distribute. Use of articles in existing organisations – full diversity. Talking newspaper
    - Radio – local radio, regular
    - Whole community – parish, churches – good at reaching housebound people
    - Virtual network – need to publicise it.
    - Don't assume everyone can use email – not accessible for a lot of older people (don't rule it out, but it's not for all)
    - Radio – Shropshire, Severn
    - Needs to be 2-way – getting information back in
    - Into parish magazines, papers etc.
    - Develop network of older people's representations
    - Use local market stall
    - Library services including mobile services
    - Think about resources needed to move quickly

3. **How would you expect the Older People's Assembly and other groups to represent you?**

    - SOPA needs time to disseminate information and collect feedback to be able to represent its members
    - SOPA needs to speak with a positive voice
    - SOPA needs a method (well-communicated) to gather voices – feedback.
    - Need proactive approach to seek views of 'hidden' people i.e. in care homes, day centres etc.
    - Vigorously!!!

Appendix 6:

Note for Shropshire on JSNA from the Ageing Well Programme

Steps from evidence to actions

Merron Simpson – 21 Dec 2011

1. Introduction

The aim of the Ageing Well Programme is to 'embed an ageing dimension into the work of the Health and Well-being Board'. While this is focused on the issue of an ageing population, and therefore on the needs and ambitions of older people, the task of 'embedding' requires some thought about what it is being embedded into i.ei the wider work of the HWB.

A key element of that wider work involves the evolution of the JSNA, the JHWS, and how these relate to commissioning and to the activities of partner agencies working locally. The purpose of this note is to provide the HWB with some thoughts about the purpose of different types of evidence and the use to which it might be put – using information and findings from the Ageing Well project in informing this.

2. Current issues with the JSNA

First, national reports suggest that the main deficit with the JSNA to date is that in most local authorities it fails to provide a sufficiently strong steer to commissioners and to partner agencies, so that the actions taken and the impact they make do not necessarily bear a strong relationship to the evidence base. The steps linking the evidence with action are not usually clearly spelled out or widely understood.

Second, the JSNA will need to increase in scope, once public health is transferred to the local authority. It will need to include not only clinical health and care, but also considerations about transport, education, housing, neighbourhoods etc. There is a danger that it will become even bigger and more unwieldy, and that there will be an even greater focus on the data, rather than on understanding the steps between the evidence and actions.

There is a need for some 80:20 thinking here – to identify the 20% of evidence (of different types) and to use it to inform action in such a way that it will achieve 80% of the potential impact.

3. Developing steps between evidence and actions

I am suggesting that it is possible to identify three steps that will help to turn evidence into action – particularly in relation to community services (possibly less so in relation to medical/clinical services). Currently, most JSNAs do not go far beyond step 1 and it is after this point when the connection between evidence and actions (commissioning and partner activity) is lost.

- ***Step 1: Draw together 'static information'***

'Static information' is the type of evidence that is already collected and that is currently typically found in the JSNA. It is largely quantitative and interpreting it provides a broad picture of the place – the demography, issues, needs, how it compares with other places etc. This type of data is useful for **identifying broad priorities** for action, but it does not help to identify the best actions to take. On its own, it will not provide commissioners with sufficient information on which to make good commissioning decisions.

- ***Step 2: Identify important lines of inquiry that provide 'directional information'***

Identifying important lines of inquiry relating to a broad goal, and collecting evidence relating to these lines of inquiry, provides a short-cut towards identifying which courses of action to take. In the Ageing Well Project, the goal is to enhance the health and Well-being of older people in Shropshire and four important lines of inquiry have been identified. These are:

(v) evidence of activities that older people value and use the most in their efforts to live healthy and active lives

(vi) evidence of activities that are cost-effective because they reduce the burden on more acute health and care services (the more robust this evidence the better, although lack of a robust evidence base should not stop experimentation and evaluation)

(vii) evidence of activities that older people value and use the least – and that might be stopped or reworked so that they are valued and used more

(viii) evidence of existing assets that could be employed in achieving the overall goal

This is a different type of evidence from that gathered in step 1 as it provides significant pointers towards particular courses of action and away from others, and it helps to shape the actions. It can be quantitative and qualitative. It is reasonable to use some national evidence in step 2, but some locally gathered information (e.g. through a survey) is also helpful.

- ***Step 3: Co-production***

'Co-production' is a process through which those who will use services help to design and shape them. It recognises citizens as knowledgeable about the character of the locality and the specific needs of the people who the service is designed for, and capable of employing this information to shape services that are highly likely to be well used – if well facilitated. It is the point at which this very local evidence and action come together and enables services to be moulded around those who are going to use them.

This type of information is provided directly by service users and is mostly qualitative.

Step 1: Static Information

Provides a current picture of the place/people

Informs decisions about broad priorities

Mainly quantitative

- Demographics
- Statistics
- Trends
- Forecasts
- Comparisons

Step 2: Directional Information

Provides more pointers about what to actually do

Lines of inquiry – helps to shape actions

Quantitative & qualitative

- What do people value/use most to keep fit, active?
- What don't they value/use?
- What is cost-effective?
- What assets are there that could be employed / employed differently?

Step 3: Co-production (evidence meets action-planning)

Local information from users themselves

Users shape services drawing on their knowledge

Mainly qualitative

- What Benefit are we aiming for?
- What actions/services will achieve the Benefit?
- How will people use it?
- Who will do it and how?
- How might the community be involved?

4. Using the three steps

The three steps will help to systematically cover the ground between evidence and actions by focusing in on and pinning down:

- the issues
- the geographies
- the broad priorities
- the parameters (cost-effectiveness, use of existing assets etc)
- the benefits to communities (outcomes)
- the actions that are most likely to achieve the benefits

There is likely to be some iteration between the steps, which is expected and reasonable as the strategy process develops.