POPULATION ASSESSMENT BRIEFING DOCUMENT: OLDER PEOPLE

1. Introduction

Through the Understanding Our Communities project, public services are gaining a better understanding of the good things about communities, what matters to people and how their experiences and what they have to offer can help us to plan and provide services.

The Social Services and Well-being (Wales) Act has been put in place to make sure that public services are doing all that they can to support people using care and support services to have their say and get involved in managing their own well-being. The Act means that public services will need to make sure that the right support is available for the people who need it at the right time and in the right way.

Under this Act, public services must carry out and publish a Population Assessment, which looks at:

- the needs for care and support, and the support needs of carers;
- the extent to which those needs are not being met;
- the range and level of services needed to meet those needs; and
- how services are delivered through the medium of Welsh.

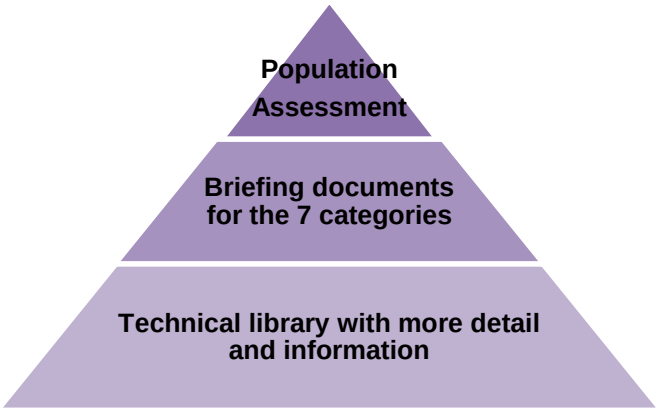
In Cwm Taf, we have been collecting lots of information for the Assessment, from the people making policy and commissioning decisions about services, the people delivering services and the people receiving services. In order to look at all of this information in an organised way, we used the seven 'themes' of the Act;

- Carers;
- Children and young people;
- Learning disability;
- Mental Health;
- Older people;
- Physical disability and sensory impairment; and
- Violence against women, domestic abuse and sexual violence.

We then spent some time, talking with these people about the headlines that emerged under this theme and really thinking about how they affect people and what we as public services can do to meet the needs of people using our services, in the best possible way, now and in the future.

A summary of the headlines relating to older people are contained in this document. The document shows how the older people's headlines fit into the 'bigger picture' and the key messages which relate to *all* themes and what we currently do and/or could do to deal with these headlines.

The overall Population Assessment report contains the headline information across all themes.



The triangle shows the different parts of our work which taken together make up Cwm Taf's Assessment Report. Each level of this Assessment is supported by a more detailed level of data and information. The Assessment Report has been put together like this so that each reader can explore the information we have collected and analysed in as much or as little detail as they would like and can follow up any particular areas of interest. All of the information gathered throughout the project to inform the headlines in this briefing document is also available in an online library.

2. Older people

There is no agreed definition of older or old people and people differ widely in what they consider to be old. Members of each age band are a very diverse group and age is a very unreliable indicator of state of health or mental or physical capacity of any individual.

However, it is also true that the probability of suffering a wide range of health problems and limitations of function increases with increasing age. Any grouping

into age band is arbitrary but in order to plan services it is helpful to consider the needs of the different age groups within the population.

In 2001 policy from the United Kingdom in the form of the National Service Framework for Older People broadly categorized three bands for older people whilst also identifying the associated goals for health and social care. They are as follows:

- Entering old age: People from 50 to the official retirement age who have completed their career. They are supposed active and independent and many remain so into late old age. The goals for health and social care policy for this group would be to promote and extend healthy active lives.
- Transitional phase: A group in transition between healthy, active life and frailty, often occurring in the seventh or eighth decades, but can occur at any stage. The goals of health and social care policy for this group would be to identify emerging problems pre-crisis, ensuring effective responses that prevents crisis and reduce long-term dependency.
- Frail older people: A vulnerable group due to health problems e.g. stroke or dementia, social care needs or a combination of both. Frailty is often experienced in late old age, so services should be designed with this in mind. The goals of health and social care policy should be to anticipate and respond to problems, recognising the complex interaction of physical, mental and social care factors that can compromise independence and quality of life.

As the population ages, the health and well-being of older people and the provision of services to meet their needs becomes increasingly important.

With improved living conditions and better health care throughout life, life expectancy continues to increase. This, combined with declining birth rates has created a shift in the age structure of our population, with increases in the proportion of the population aged over 65. The critical issue is whether people will spend these extra years in good physical and mental health, or in illness, distress and with loss of independence.

3. The current position in Cwm Taf

The number of older people that live in our communities in Cwm Taf is growing. We have achieved real improvements in the effectiveness of our medical and public health services and, as a result, people are living longer healthier lives. In the next 15 years, we expect our population of people over the age of 65 years to grow by 30% and those over the age of 80 years to grow by 70%.

The services we commission to support our older citizens and their carers are often already stretched. It has been estimated that if these services simply increase to keep pace with demographic change, this will result in a near doubling of care costs by 2026. We know that we have to adopt a new approach to use our resources as wisely as possible.

We also know that we must improve the experience of our older citizens as they come to require the support and care that we provide. As large public bodies, we are complex organisations. We have each developed systems to assess people's need for support and to arrange and provide it. These systems are often complex and hard for people to navigate. Our services can operate alongside each other in a way that can make people feel as if they are "being given the run-around". We are committed to improving the way we work together to place our older citizens at the very centre of the services they receive.

The Social Services and Well-being (Wales) Act (2014) sets out a challenge for us to fundamentally reshape the way individuals, families and communities are supported by our statutory organisations. In responding to the Act, we must make a radical change in our "offer" to individuals, families and communities; supporting them to take responsibility for their own health and well-being. We must shift our emphasis from reactive long term (often institutional) services to an approach which promotes choice, dignity and independence, focusing on the strengths of individuals and their social and community networks.

The starting point is to emphasise the key role of families and communities in offering support and care to their members. All our citizens are surrounded by a network of family, friends and neighbours that influence their quality of life. They in turn contribute to the community in which they live. This is perhaps especially true for our older community members.

Our role is to complement these networks by supporting people to continue to live fulfilled lives as they grow older, and when they need it, to help them tackle life problems (e.g. ill-health, bereavement, becoming socially isolated). This is important not only for the individuals concerned, but for the resilience, well-being and development of our communities as a whole. It is our intention to support older people who have become isolated to reconnect with their communities.

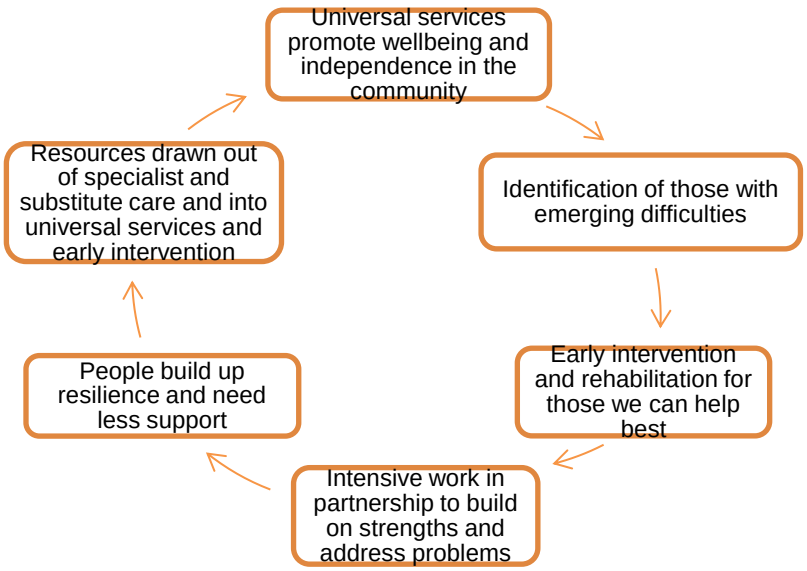
To do this we need to make the right services available at the right time, and ensure that they are efficient and well co-ordinated. By doing so we can support people as soon as they need it, help them to remain happily within their family and community, and for some, avoid expensive and disruptive specialist and substitute care. By doing this successfully over time we can also take some resources out of specialist and substitute care and into better community and universal services.

Together, we have adopted a common vision statement for integrated health and social care services for older people:

"Supporting people to live independent, healthy and fulfilled lives".

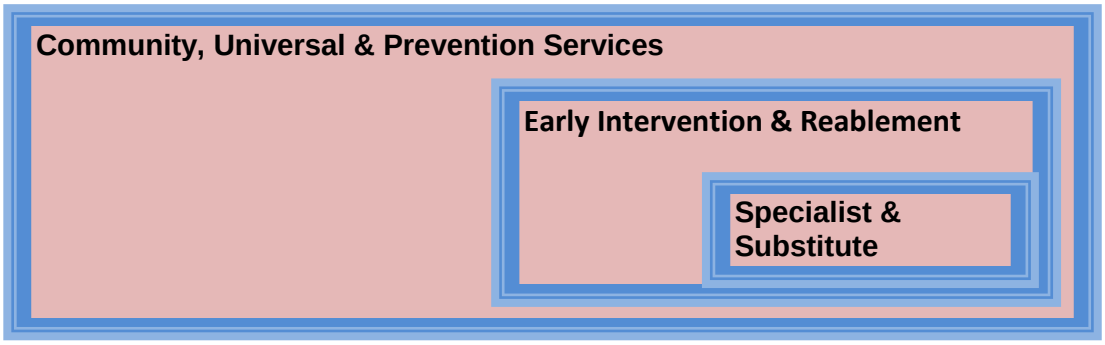
This will be achieved by providing health and social care services that are:

- Integrated, joined up and seamless.
- Focused on prevention, self-management and reablement.
- Responsive and locally delivered in the right place, at the right time and by the right person.
- Safe, sustainable and cost effective.



We will achieve this by building an integrated, co-ordinated approach to health and social care services (where they overlap) comprising 3 inter-related levels:

- Community, Universal and Prevention Services.
- Early Intervention and Reablement Services.
- Specialist and Substitute Services.



The aim is to be sure that we focus our attention on making a difference. We need to be able to see that the support that we offer has improved the health and well-being of our citizens.

For that reason, we need to be clear what "outcomes" we are seeking so our joint commissioning statement sets these out as shown in the table below:

This is what good looks like for older people in Cwm Taf:

- Older people live longer, healthier and happier lives.
- Older people live life to the full and are enabled to maintain their independence for as long as possible.
- Older people who become ill, frail or vulnerable receive the care and support they need at the right time in the right place.
- All individuals and communities recognise the need to take more responsibility for their own health and well-being and are supported to do this.
- That people are treated with dignity and respect and treat others the same.
- That people are heard and listened to.
- That people know and understand what care, support and opportunities are available and use these to help them achieve their well-being.
- That people get the right care and support, as early as possible.

4. Headlines

Undertaking this assessment has given us an opportunity to revisit and build on what we know about older people and during the engagement phase of the assessment we asked older people, staff and the third sector to identify what was important to them - the key themes from that conversation are set out in the table below:

Summary of key and most commonly recorded themes from the engagement with the public, staff and the third sector in Cwm Taf (2015/16):

<u>People have told us that older people:</u>

- Value their independence,
- Value the ability to live in their own home,
- Expect to be treated with dignity and respect,
- Value continuity of care from health and social services,
- Expect health and social care to work together to co-ordinate their care,
- Want help when they need it,
- Value health promotion messages (stroke awareness, eye health and hearing tests),
- Need easy access to good quality information and advice,
- Want to be recognised and valued by professionals if they are a carer,
- Experience loneliness and isolation particularly at night,
- Value social networks,
- Value day centres and public amenities such as libraries as a meeting place,
- Value public transport,
- Lose their confidence following bereavement, illness or frailty etc,
- Want to feel connected to their community,
- Want to be safe,
- Want more housing/accommodation options.

Older People need and value supportive communities and family networks

- Loneliness and isolation

44.5% people aged 75 and over live alone in Cwm Taf.

We know from research that social isolation affects 7-17% of older adults, and is becoming more prevalent. We also know that older people can spend between 70 and 90 % of their time in their home.

Social isolation is associated with an elevated risk of mortality, higher rates of emergency admissions, re-hospitalisation and earlier entry into care homes.

A warm, secure, accessible environment that meets their needs is crucial. The older population is diverse and there will never be a 'one size fits all' solution but a range of more adaptable and specialised housing will be needed and this is identified in the joint commissioning statement.

Housing should however be considered in the context of the wider neighbourhood.

Interventions that improve people's homes are less likely to be effective without similar improvements in the surrounding environment. Connectivity will be increasingly crucial to the health and well-being of the ageing population and should be considered in a holistic way which includes physical mobility, transport, the built environment and technology.

Local discussion with third sector groups and the public has emphasised a need to develop community capacity and resilience across the region to support the need for low level services, close to where people live, that create opportunities to connect with other people and improve quality of life by offering purpose and social interaction.

Some areas in the region already have strong networks of support in place but this is not a consistent picture.

There is evidence in some English Local Authorities that low level community run activities can have a significant impact on supporting vulnerable groups, which is reflected in lower demand for statutory services.

This success appears to be at its strongest where Local Authorities are actively supporting communities to build their capacity in response to their specific local needs.

More locally initiatives such as the Community Co-ordinators have demonstrated success in identifying the community networks of informal support and helping older people to connect with them.

- Carers

During 2001 in Rhondda Cynon Taf, there were 29,640 carers and in Merthyr, 7,427 carers. Giving a Cwm Taf combined total of 37,067 carers.

Of those carers that we know about, a total of 11,752 carers provide over 50 hours of care per week. This has increased by 9% in Merthyr Tydfil and 7% in Rhondda Cynon Taf since the 2001 Census.

Whilst the detail regarding the needs for carers is set out in another section of this population assessment it is important to consider here that between 2001 and 2011 the number of carers who are over 65 has grown by more than 30%.

In this context the aims of the Cwm Taf Carers Strategy below have significant meaning for older people:

- To identify carers of all ages and recognise their contributions.
- To provide up to date, relevant and timely information, advice & assistance to carers of all ages.
- To provide support, services & training to meet the needs of carers of all ages.
- To give carers of all ages a voice, with more choice & control over their lives.
- To work together to make the most of our resources for the benefit of carers of all ages.

In addition to the commitments made in the Carers Strategy we see a key role for ourselves in nurturing supportive communities and family networks. The availability of easily accessible universal services together with general and targeted health and well-being initiatives is the foundation of our service model.

The key components of our role in supporting strong communities through universal and preventative services are as follows:

- Supportive Communities – Building Community Capacity and Resilience.
- Information advice and support.
- Health and Well-being.

- Housing Related Support.

Older People value their independence and want to live in their own home. They also expect Health and Social Care to work together to co-ordinate their care

In Cwm Taf the adult resident population in 2013 was 231,670. There were over 53,000 people over 65 and over 23,000 people over 75.

Current projections see a rise in the total adult population of Cwm Taf to 237,930 by the year 2030. This represents an increase of 2.7%. However, this figure masks a disproportionate increase in the older population. Overall, the population under 55 will decrease by c.14,000 (10%) but we expect the number of older people to grow much more rapidly.

By 2030, the number of people over 65 years will increase by 30.4% and people over 80 years by71.3%.

National policy has focussed on service improvement, co-ordination between national and local government and greater integration of social care, health services and other agencies in Wales, notably the third sector. There is increasing emphasis on individuals and communities being at the centre of decision-making about their care and on providing care and support at home where possible.

Meeting the needs of an increasingly ageing population will be a key challenge for the Cwm Taf Partnership. In the current economic climate, the relative (and absolute) increase in people who are economically dependent and, in some cases, care-dependent, will also pose particular challenges to communities.

We are all familiar with levels of deprivation in our communities. Cwm Taf UHB is the most deprived in Wales with 34% of the population living in some of the most deprived areas of Wales.

This has implications for health and well-being given the association between deprivation and ill-health, which manifest in shorter life expectancy.

There is also a gradient in life expectancy across Cwm Taf with higher levels of deprivation in valley communities, compared to the less deprived areas along the M4 corridor. A man born in the most deprived areas of Cwm Taf can expect to live 5 years less than if he were born in the least deprived areas.

We also observe this gradient in healthy life expectancy - defined as the number of years lived in good health and Disability-Free Life Expectancy. This means that a

man born into one of our most deprived communities can expect to live 23 years of his already shortened life with a disability or limiting long term illness.

Without improvements in healthy life expectancy it is anticipated that health and care costs will increase as the population ages.

Good physical health has a significant beneficial impact on health and well-being in older age, the ability to be physically active improves muscle strength and emotional health whilst reducing risk of falls and isolation.

The World Health Organisation identifies that older people are at most risk of disease as they age and that the following are notable areas that increase those risks:

- Smoking,
- Alcohol,
- Poor oral health,
- Poor nutrition,
- Medication (compliance and review),
- Adherence to therapy/treatment,
- Psychological factors (depression/cognitive function),
- Hearing loss,
- Vision loss,
- Access within the physical environment.

Whilst in general people today are more aware that the above are important factors in preserving health and well-being in the UK, it should be noted that for those aged 65 and over, lower socio-economic status is associated with more physical, psychological, cognitive and overall ill-health.

Continuing with traditional models of service is not an option. There are considerable challenges that, if not managed creatively, will see resources increasingly targeted at those in greatest need. Restricting the number of people receiving support, to those with the highest needs, may result in a short term reduction in demand, but without adequate preventative strategies, we will not secure the sustainability that can deliver long term financial and workforce capacity, to guarantee better outcomes for people.

It is clear from the research and changes to policy across the UK that preventative and early interventions are considered to be the most effective way of supporting older people in the long term particularly where health and social care work together in an integrated way.

Of note with regards to preventative approaches and integration of health and social care has been the development of intermediate care services which are predominantly targeted at older people and aimed at:

- Helping people avoid going into hospital unnecessarily;
- Helping people be as independent as possible after a stay in hospital; and
- Preventing people from having to move into a residential home until they really need to.

Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes and can be provided by a variety of different professionals and care staff. NAIC Audits in England have demonstrated that four service models (crisis response; home based; bed based; and reablement) deliver good outcomes for people in terms of a) likelihood of returning home, b) improvement in activities of daily living and c) achievement of person specific goals.

Further evidence from the Social Care Institute for Excellence also identifies the benefits of reablement in particular with regards to restoring people's ability to perform usual activities and improving their perceived quality of life.

For those who have needs which cannot be met purely by community, universal and preventative support, we will offer time-limited and goal orientated services to help them address their difficulties, by supporting them to recover and regain their independence preventing the need for specialist or substitute care. We will ensure a "whole system" approach where older people and their support networks will experience a single integrated care pathway.

The key components of our role in supporting strong communities through early intervention and reablement services are as follows:

- Single Point of Access.
- Integrated Assessment Process.
- Reablement Service.

- Integrated community health and social care services (@home service).

Older People want to be treated with dignity and respect and value continuity of care from health and social care services

The co-occurrence of two or more chronic diseases in an individual is considered inevitable with age and 'frailty' in particular can create a situation whereby minor incidents trigger a major change in health.

Research literature concludes that person centred and integrated care is essential to support older people effectively, recommending in particular a pro-active and preventative approach across health and social care as most effective particularly where older 'frail' people are concerned.

There are however people who suffer with more complex physical, mental and social care factors usually associated with older old age and frailty and for these people the focus of the Cwm Taf Partnership will be around the quality of care available and the value added towards achieving the well-being outcomes of the person and their carers.

Therefore, specialist or substitute services would only be provided when it has been determined that the person is not able to regain their independence and their needs can only be met through interventions by public sector services. The provision of services at this level would be in response to a holistic assessment that takes into account people's needs and wishes. They will be centred on promoting choice and control, and will work with people to improve their quality of life in ways that work for them. We will ensure that people have access to good quality information and advice to help them make informed choices.

The key components of our role in commissioning and/or providing high quality specialist and substitute services are:

- Equipment and adaptations service.
- Telecare.
- Long Term Domiciliary Care.
- A range of supportive accommodation including extra care housing and residential and nursing home provision.

5. Links to other headlines and common themes

There are a number of issues addressed elsewhere in the Population Assessment that affect older people. Likewise; the things which affect older people do not stand alone. The same things are likely to affect other people who use care and support services.

Of note:

- Dementia (see also mental health briefing document).

We expect dementia to be an issue of increasing significance for older people in the future and predict that the number of people over 65 with dementia will increase from 3,463 to 5,325 (a 53.7% increase) and for those over 75 from 2,903 to 4,676 (a 61% increase).

Dementia is the most costly of all chronic illnesses and increasing age is the greatest risk. There is evidence to suggest that cost-effective drug and non-drug interventions can delay the onset of dementia and also reduce disability once dementia is diagnosed amongst these interventions would be the emerging technologies which have the potential to change care in the home and community. Capitalising on the opportunities this offers however will mean addressing barriers and being sensitive to public concerns around privacy.

Many older people with dementia will access the older people's service model along with other older people but often people with dementia need specialist interventions (such as dementia reablement or EMI nursing or residential care).

The quality of specialist and substitute care for this vulnerable service user group is of particular importance and the training needs of the workforce to effectively help and care for people with dementia is identified as a priority for the social care workforce development partnership in Cwm Taf.

- Sensory impairment (see also the Physical Disability and Sensory Impairment briefing document).

During the engagement process for the Population Assessment the impact of a sensory impairment on the health and well-being of older people was identified.

Older people and third sector groups identified the importance of raising awareness through health promotion activity around the benefit of eye and hearing tests to identify health conditions early on and also to maximise the use of technology to

assist people in adapting to their impairment (i.e. use of glasses, hearing aids, simple aids and some adaptations to the home etc.).

Staff and older people also identified that sensory impairments contributed to falls, loss of confidence, loneliness and isolation and exacerbated some conditions such as dementia.

Sensory impairment was not specifically addressed during the development of the Cwm Taf Joint Commissioning Statement and whilst there are specialist services responding to people's sensory needs this area will require further work in the future particularly with regards to staff training and development.

There is no accurate means of identifying the numbers of people living with sensory impairments in the region as the sensory impairment register maintained by social care only reflects a small proportion of people affected - further work is therefore required in this area.

- Community Resilience.

Local discussion with third sector groups and the public has emphasised a need to develop community capacity and resilience across the region to support the need for low level services, close to where people live, that create opportunities to connect with other people and improve quality of life by offering purpose and social interaction.

Some areas in the region already have strong networks of support in place but this is not a consistent picture.

There is evidence in some English Local Authorities that low level community run activities can have a significant impact on supporting vulnerable groups, which is reflected in lower demand for statutory services.

Older people in particular identified this as they are prone to suffering with loneliness and isolation and reducing social networks as they age - however this is not an exclusive issue for older people and improved local activities and social groups can offer advantages to all vulnerable groups.

6. References

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