

Healthy Leeds



Older Better

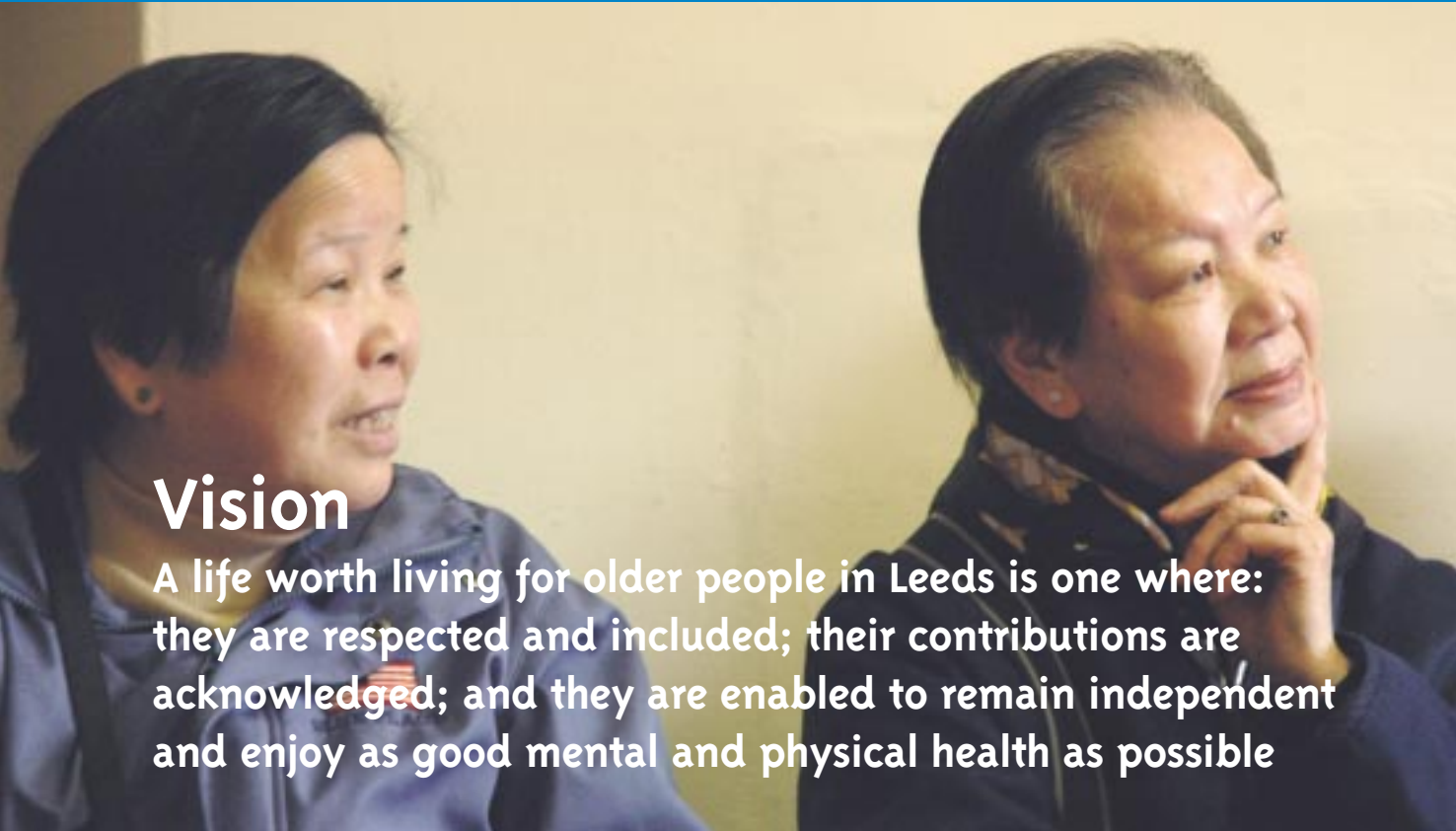
A strategy to promote a healthy and active life for older people in Leeds 2006–2011

The Older Better strategy was developed by the multi-agency Healthy and Active Life Group for Older People. A draft was consulted on between January and March 2006. Comments were received from a number of individuals and organisations. Formal endorsement was secured from a range of organisations including Leeds Older People's Modernisation Team and Older People's Reference Group, The Leeds Initiative Healthy Leeds Partnership, Leeds Older People's Forum, the Leeds PCT Directors of Public Health and Leeds City Council lead councillors for older people. The strategy was launched in May 2006 at Leeds Town Hall.

Membership of the Healthy and Active Life Group for Older People, May 2006

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Vision

A life worth living for older people in Leeds is one where: they are respected and included; their contributions are acknowledged; and they are enabled to remain independent and enjoy as good mental and physical health as possible

Aim: The aim of the Older Better strategy is to promote a healthy and active life for older people in Leeds, by providing leadership to influence policy and practice, and supporting partners to deliver coordinated action, to enable the strategy aspirations to be met.

Aspirations: By 2011, all older people in Leeds will:

- Have access to comfortable and secure homes
- Have an adequate income
- Live in safe neighbourhoods
- Be able to get out and about
- Have the opportunity to develop and maintain friendships
- Have access to learning and leisure
- Be able to keep active and healthy
- Have access to good relevant information
- Be actively involved in planning and decision making that affects them
- Not be discriminated against on the grounds of their age

The Older Better strategy is based on the following action based principles:

- **Reduce health inequalities:** Health inequalities are unacceptable and all work should aim to reduce the health gap. The Northern and Yorkshire Public Health Observatory has identified three factors which intersect causing health inequalities among older people:
 - i) social and economic factors (poverty, housing, gender, ethnicity, isolation)
 - ii) issues of access (transport, information, technology, mobility, safety, discrimination and ageism in service provision)
 - iii) issues of power (public involvement, decision making and ageism)
- **Promote active citizenship:** Older people should be regarded as active citizens, not passive recipients of services. Older people are making a positive contribution to society. Interdependence rather than dependence is an important principle for older people.
- **Involve older people at all levels:** Older people want to play their part in the wider society and in planning for their own futures. Social and economic planners, commissioners and providers of services all need to engage with older people including those currently most excluded (see appendix one).

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Foreword

At the start of the new millennium life expectancy at age sixty-five in England had risen to sixteen years for men and nineteen years for women. This differed by social class; with those from the most deprived backgrounds having a lower life expectancy (twelve years for men and sixteen years for women).

Over the last thirty years the improvement in life expectancy has been greater in men from higher social backgrounds than those from a lower social background (4.1 compared to 1.7 increased years of life expectancy).

Similarly Healthy Life Expectancy (expected years of life in good or fairly good health) at age sixty-five has increased to twelve years for men and fourteen years for women. However, life expectancy is currently increasing faster than healthy life expectancy, in other words there is an increase in years spent in poor health.

The overall improvement in the figures is a testament to all the hard work that has gone into improving health and wellbeing in this country, but clearly there is more to do.

The figure on page 8 shows that health and wellbeing result from the complex interaction of a range of factors of which access to health and social care is only one element. It is obvious that no agency, professional or individual can influence this alone; it will require everyone working in partnership to bring healthy life expectancy into line with overall life expectancy.

This strategy provides the script for a joined up approach to ensure all older people in Leeds have access to healthy living opportunities. The strategy focuses on promoting a healthy and active life and preventing ill health and allowing older people to shape and direct this process. It is in all our interests to ensure that we live longer and are healthier when we do; don't just read the strategy, help to make it happen.

Dr Jon Fear
Director of Public Health
Leeds West Primary Care Trust



Introduction

The UK population is ageing, and Leeds is following the national trend. Since the 1930s the number of people aged over sixty-five has more than doubled. One fifth of the population in Leeds is now aged sixty or over (Leeds Initiative Area Statistics, 2004). This demographic shift impacts on all aspects of our society.

There are two main issues for the agenda to promote healthy and active life in older age. Firstly, the need to recognise older people's contribution as active citizens. Older people play an increasingly important role in voluntary work, sharing experience and knowledge, grand-parenting, as carers and through participation in the workplace. Older people also play a vital part in sustaining local communities, as is beginning to be recognised. These contributions to society need to be acknowledged supported and built on.

Secondly, to support health and wellbeing it is essential to create a climate which promotes good health and maintains independence, including making preventative services and resources available. Promoting health, preventing ill health and maintaining independence and quality of life are what older people want. These play a part in increasing healthy life expectancy, in turn reducing demand for high cost intensive health and social care services. This argument is supported by a wide range of thinkers. (The Nuffield Institute, ADSS, Local Government Association, Audit Commission, Better Government for Older People and the Joseph Rowntree Foundation, 2005.)



Purpose of the Older Better strategy

A strategic joined up approach is needed to ensure all older people in Leeds have access to healthy living opportunities. Older Better focuses on promoting a healthy and active life and preventing ill health. It is not focused on planning and providing intensive specialist health and social care services. Older Better targets one hundred percent of older people in Leeds (illustrated as level one and two below), as well as the fifteen percent of older people who are in regular contact with care services at any one time. The range of organisations and individuals who can deliver action at level one and two is vast; from community safety staff, the pension service and transport staff to older people themselves. These levels are illustrated below:



Key to levels:

Level 1	Citizenship, inclusion, engagement, active ageing
Level 2	Prevention of illness, promotion of health
Level 3	Minimum intervention
Level 4	Community based long term care
Level 5	Intensive time limited interventions and intermediate care
Level 6	Hospital

The Older People's National Service Framework (NSF) is the Department of Health's plan to improve services for older people. It is divided into eight standards. Standard eight sets out the agenda to promote a healthy and active life. Stakeholder conferences have been held in Leeds, London and Bristol, providing an opportunity for older people to comment on standard eight. (Commission for Social Care Inspection, Audit Commission and Healthcare Commission, 2003). Older people were very enthusiastic about the potential offered by the standard, however there was a strong sense that activity in this area is often fragmented and inadequately coordinated leading to risk of duplication, gaps and poor use of resources. The challenge is to develop a local strategic approach that:

- Allows communities to address the whole range of issues that make most difference to older people's wellbeing
- Provides a vehicle for streamlining access arrangements for older people
- Coordinates fragmented pieces of work
- Encourages better use of resources
- Raises the profile of older people's issues
- Increases awareness of the services and opportunities that are available and
- Stimulates new partnerships.

This was confirmed in a review of work in Leeds in 2004. A Joint Review was conducted into the progress of Leeds partners in delivering the NSF for Older People with a focus on standard eight. The review concluded:

- Communication and agreement of priorities for maximising healthy and active life has not yet resulted in coordination and a whole systems approach. There is no agreed strategy across Leeds to improve health and to tackle health inequalities.
- Within Leeds there is a range of services to support older people's independence and wellbeing, but they are not consistent across the city. This causes concern for older people.
- There are a number of methods of engaging with older people in Leeds. The arrangements within the local Primary Care Trust (PCT) areas and the Modernisation Team are developing well, but at present these are focused on improving and developing core health and social care services. Services that have an important role in promoting wellbeing, such as education and leisure are not yet fully included. (Commission for Social Care Inspection, Audit Commission and Healthcare Commission, 2004)

Older Better aims to set out a local strategic approach through providing:

- A brief history of the local background to this work
- Clear information about older people's health needs
- Examples of evidence of interventions effective in improving older people's health and wellbeing
- A summary of the national and local policy context for work to increase a healthy and active life for older people
- Agreement from key partners on strategic direction and a vision for the future
- Clear implementation plans



Local historical background

Older Better builds on the shift from the tradition of developing specialist health and social care services for older people in Leeds to a move towards recognising the value and importance of health promotion and illness prevention work targeting the broader determinants of health.

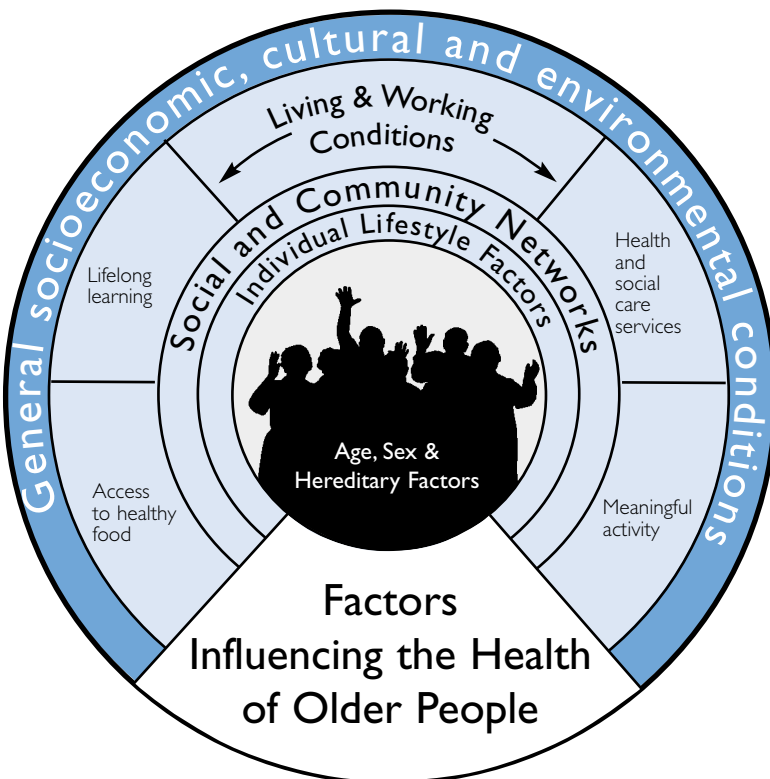
- In 1997 one vision, "When I Grow Old in Leeds", was written, describing how older people's services could look in 2006. The vision set out ideas for excellent and imaginative care for older people however this did not include preventative services targeting one hundred percent of the older population. (Belfield, 1997)
- Also in 1997, Leeds City Council and Leeds Health Authority published a commissioning framework for older people's services. Again, the vision focused on what happened when older people needed health and social care services and did not include preventative work, although the vision did call for "a positive view of old age".
- The National Service Framework for Older People was published in 2001. Standard eight of the NSF is titled The promotion of healthy and active life in older age. Its aim is to extend the healthy life expectancy of older people. The Standard called on the NHS and local partners to re-focus on helping and supporting older people to live healthy and fulfilling lives. This led to the development of a partnership group in Leeds to take forward the Standard 8 agenda.
- In 2003, a Strategic Framework for Older People's Services was published by Leeds Social Services Department and the Five Leeds Primary Care Trusts (PCTs), updating the 1997 commissioning framework. Importantly a new service model was included, this was divided into four tiers. Tier one included health promotion and preventative services.
- There is currently a multi agency steering group for Leeds, called the Healthy and Active Life for Older People Group, which is accountable to the Leeds Initiative Healthy Leeds Partnership and Leeds Older People's Modernisation Team (this is illustrated on page 20). There are two members of staff employed to take forward this agenda. A Health Promotion Coordinator for Older People employed by the Leeds Primary Care Trust and a Project Manager for Healthy and Active Life employed by Social Services. To date work has been coordinated through a multi agency action plan. This is the first Older Better Strategy to promote a healthy and active life for older people in Leeds.

Underpinning definitions and principles

Older Better is based on the World Health Organisation definition of health:

“health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948)

In the context of this strategy health is used to refer to the health of individuals within healthy communities and environments. Health also is understood to be a resource for every day living to enable healthy ageing. This can be seen below in the diagram which illustrates how broader determinants can influence the health of individual and groups of older people.



(Adapted from Dahlgren and Whitehead, 1991)

Older Better defines what it means by active. The term active is used to acknowledge older people as active citizens, and to refer to making active choices, being involved and maintaining independence as well as maximising physical, mental and social activity.

The strategy is based on the following action based principles:

- **Reduce health inequalities:** Health inequalities are unacceptable and all work should aim to reduce the health gap. The Northern and Yorkshire Public Health Observatory has identified three factors which intersect causing health inequalities among older people:
 - i) social and economic factors (poverty, housing, gender, ethnicity, isolation)
 - ii) issues of access (transport, information, technology, mobility, safety, discrimination and ageism in service provision)
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- **Involve older people at all levels:** Older people want to play their part in the wider society and in planning for their own futures. Social and economic planners, commissioners and providers of services all need to engage with older people including those currently most excluded (see appendix one).



Older people in Leeds

The Older Better strategy recognises that the term older people is not precise, and can encompass people over a fifty year span with very different experiences, attitudes, expectations and needs. Increasing healthy life expectancy is shifting definitions of age, while health inequalities have a clear impact on the chronological age when physical ageing occurs. It can be useful to group older people within three life-stages, although it is recognised that many older people's lives do not conform to these categories:

Mid-life: 50–65 years

3rd age: 66–79 years

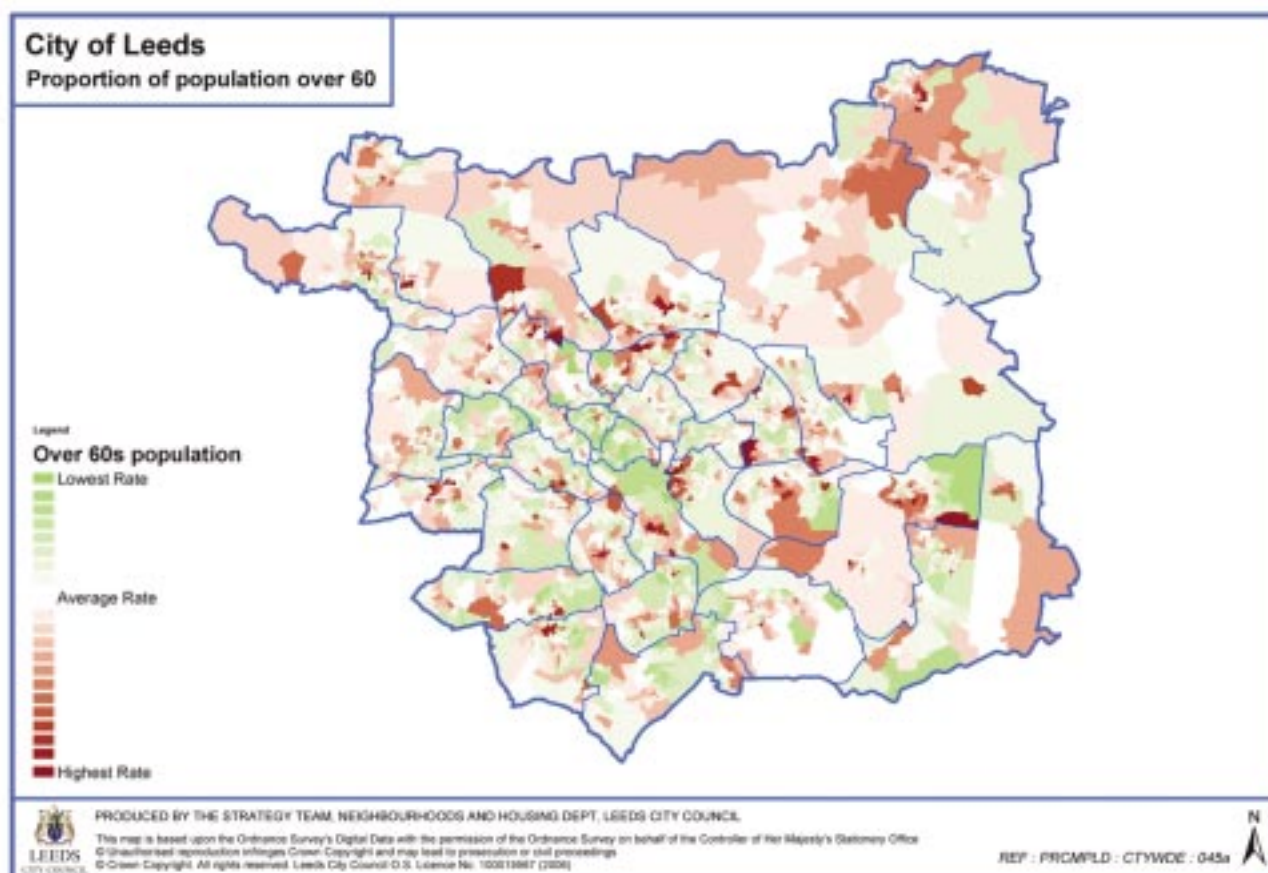
4th age: 80 years plus

The action plan targets people within these groups, as appropriate. Most information and statistics about older people are collated for people aged sixty plus. Leeds has a total population of 715,402. Of these nearly 143,000 (20%) are sixty or over. Opposite are statistics for each geographical wedge of Leeds:

Wedge	No. people over 60 years old	% of population
East	32,646	21
NorthEast	26,614	22
North West	31,913	18
South	28,687	19
West	22,946	20
Total	142,824	100

(Leeds Initiative Area Statistics, April 2004)

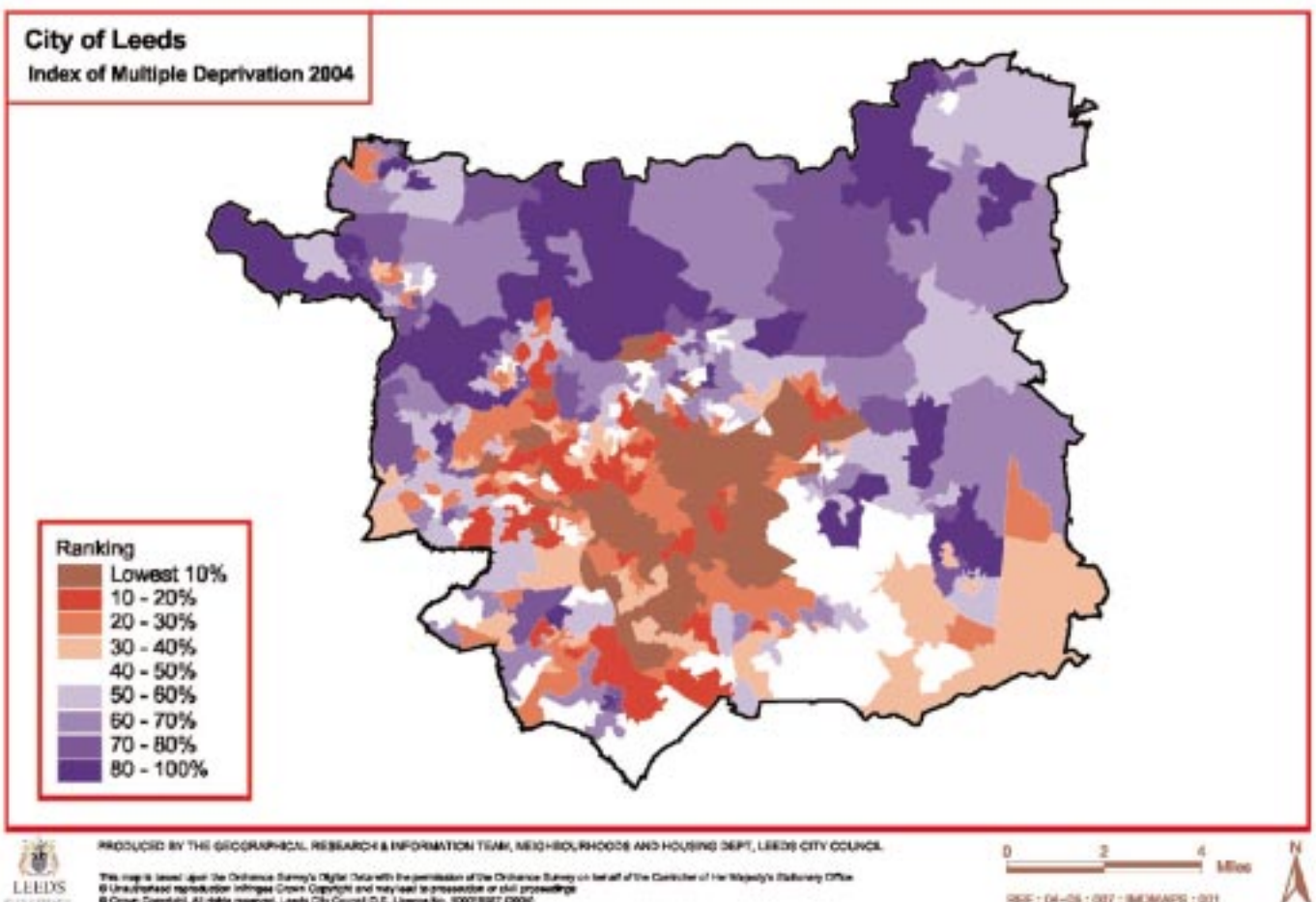
The older population is distributed throughout Leeds. The map below shows the areas where a higher proportion of people aged over sixty live. These areas are marked on the map below as dark red areas.



Deprivation can be measured by the Index of Multiple Deprivation (IoD) which is used to compare different areas. A number of indicators are used to create the IoD, these are grouped into seven domains:

- income
- employment
- health deprivation and disability
- education, skills and training
- barriers to housing and services
- living environment
- crime

There are two additional domains which measure income deprivation affecting children and income deprivation affecting older people. The map below illustrates deprivation levels in Leeds. The dark red areas highlight areas facing the greatest deprivation and the dark blue areas illustrate areas facing least deprivation.



Statistics collected as part of the Index of Multiple Deprivation show that in Leeds there are seven wards in which older people face particularly low levels of income. These wards are ranked below in order of older people's deprivation. The number of older people aged sixty and over is also recorded.

Wards in Leeds where the most deprived older people live	Older people's deprivation ranking ¹	Number of people aged 60 and over living in ward ²
1 City and Hunslet	91.7	3170
2 Gipton and Harehills	87.5	3640
3 Hyde Park and Woodhouse	76.9	2093
4 Chapel Allerton	76.9	3947
5 Headingley	71.4	1586
6 Burmantofts and Richmond Hill	68.8	4446
7 Middleton Park	58.8	4787

Sources: ¹2004 IoD, ²Population from the 2001 Census Area Statistics for 2004 wards

This information enables work to be targeted at areas where older people face the greatest need, and in turn help to reduce health inequalities. Over the next twenty years, the growth of the older population in Yorkshire and Humber will be dominated by people in their sixties. By 2011 they will total 580,000, an increase of 111,000 over the decade. (Sheffield Institute for Studies on Ageing, 2002)

Older people contribute extensively to the life of this city, as paid workers, members of local communities, volunteers and carers. Around six in ten people over seventy years old are caring for someone in their own home. Research into the economic value of older people's contributions in the Yorkshire and Humber Region has been carried out by Age Concern. The value was calculated to be over £1.7 billion.

Economic contribution of people aged 50+ in Yorkshire and the Humber 2001	
Employment	£14,724 million
Caring	£1,741 million
Grandparenting	£427 million
Volunteering	£426 million
Total	£17,318 million

(Meadows, 2004)

Most older people in Leeds live with at least one other person, but inevitably this changes as people age, and fifty-nine percent of women in West Yorkshire in their eighties live alone. 4,139 older people in Leeds (about three percent of the total) live in residential or nursing homes. As elsewhere in the country, older people in Leeds are served by a wide range of statutory and voluntary organisations. Leeds Older People's Forum, made up of voluntary organisations, has one hundred and seventeen members. Unique to Leeds are the Neighbourhood Network Schemes, forty in all, which are community based, locally managed voluntary organisations supporting older people to live independently, and with an improved quality of life.

There are many groups of older people who are more likely to face greater social exclusion and disadvantage. Information can be found in appendix one on:

- Older women
- Older gypsies and travellers
- Older people from other black and minority ethnic groups
- Older people living in poverty
- Lesbian, gay and bisexual older people
- Older carers
- Older prisoners
- Older people with learning disabilities
- Older asylum seekers and refugees
- Homeless older people
- Older people in care homes
- Older disabled people
- Older people with mental health problems



Older people's health and wellbeing needs

This section provides a summary of older people's health needs focusing on those which fit into levels one and two of older people's services as illustrated on page 6.

Older people in Leeds have shared their thoughts on needs a number of times through the following events:

- Five Years On, a consultation event held with older people to inform the Older Better strategy, November 2005
- West Leeds Older People's Health Needs Assessment, 2005
- Leeds Pilot Review of the Implementation of the National Service Framework for Older People, 2004
- The development and production of the video, Leeds: a better city for Older People, 2003
- Commission for Health Care Inspection, Audit Commission and Social Services Inspection stakeholder conferences, 2003
- The Leeds Initiative consultation event with older people, 2002
- Older People Active Citizens event, 2002

A summary of needs identified by older people who attended the above events in Leeds, follows:

An adequate income: The need to secure an adequate income and address pensioner poverty.

Preventative services: The need to redefine the way public services are delivered to older people by shifting away from dependency and deficit towards independence and wellbeing. The need for preventative strategies to focus on the wide range of issues which are most important to older people rather than single issues.

Access to transport: The need for easier, safe, accessible and cheap or free travel, better transport in the evening to all parts of the city, better transport information, buddying schemes, police, waiting rooms for women, improved infrastructure, encouragement for older people to remain active, travel and not become isolated.

To be treated without prejudice: The need to treat people with dignity and to treat everyone as an individual and challenge negative stereotypes of older people. To use education to challenge misconceptions of age, to breakdown stigma and cultural barriers and build

up older people's confidence to express their views. Health services taking a positive view of older people. To challenge ageism which is a real issue of this decade.

Access to lifelong learning: The need to increase lifelong learning opportunities. Access to the right courses in the right place and in the day time. Courses need to be affordable. University prospectuses should reflect that older people are students too. The need for GPs to prescribe a further education course as well as medicine.

To feel included: The need to know your neighbours and have friendships. There is a need to enable older people to be active.

Access to information: The need to get information out to where people are, have a central index for all information, use clear and understandable language. The need for organisations to share information better, get information about services to older people and carers, especially in hospital. Health information needs to be available in different languages.

To feel safe and secure in a healthy environment: There is a need for well maintained neighbourhoods that look cared for. A need for people to be able to walk the streets without fear of crime. There is a need to improve street lighting. The need for the town centre to feel safe in the evening. Need for more police visible on the streets. Need for access to green open spaces. Need for public toilets and benches in town. Need for comfortable secure homes.

To be effectively consulted and involved: There is a need for more honest consultation, lobbying of government, involvement of older people, a need to be genuinely asked what older people want, need to get older people's voices heard. A need for decision makers to listen and tell the truth. GPs and health care professionals need to listen and give time and go out to older people rather than inviting them in. Older people need to be represented on local forums and relevant bodies meetings need to be timed better.

To be able to keep healthy and active: Older people need to keep active mentally and physically. Older people need healthy eating, physical activity and healthy heart programmes and lots of activities.

The needs identified are endorsed by findings published in national literature. The figure opposite illustrates issues which older people have stated relate to their health needs, and some solutions to meet these needs. Full references are included in appendix two.

These are shown as elements which promote older people's health and are required more, and elements that demote older people's health which should be challenged and if unavoidable, ameliorated.

Needs and issues can be viewed on an individual, community or policy level, however action to address them is often needed on all three levels.



Older peoples health needs and issues		
Promoting		Demoting
good diet and nutrition employment physical health mental health physical activity	Individual level	alcohol (if misused) drugs (if misused) smoking bereavement loss of intimacy caring for a partner or relative loneliness
citizenship - being involved affordable warmth independence interdependence leisure lifelong learning meaningful activity physical environment safety and security	Community level	loss of function
accessible services housing information insurance banking services pensions retirement shopping, cleaning and gardening services	Policy level	disabling barriers ageism poverty and low income retirement social isolation

In summary, the needs identified by older people in Leeds and nationally, can be condensed into the priority areas below:

- Access to comfortable and secure homes
- An adequate income
- Safe neighbourhoods
- Ability to get out and about
- Friendships
- Access to learning and leisure
- Able to keep active and healthy
- Access to good relevant information
- Involvement in planning and decision making
- Freedom from age discrimination



Evidence of effective interventions

There is a body of evidence to show public health and health promotion action targeting older people works. Public health and health promotion strategies improve health and wellbeing, delay or prevent disease, disability and in turn reduce the need for specialist health and social care services in later life. These can be measured in cost benefit terms:

- Although people aged 65 and over make up only 16% of the population, they occupy almost two thirds of general and acute hospital beds. The NHS spent around £16 billion on people over the age of 65 in 2003/2004, accounting for 43% of the total NHS budget. In the same year social services spent around £7 billion, which was 44% of the social services budget.
- With timely identification and treatment of depression, up to half a million older people may not withdraw from work and claim incapacity benefit, saving £1.1 billion a year.
- A 1% reduction in dependency and morbidity could reduce publicly funded care costs by as much as £6 billion by 2030.
- By reducing falls by a third, more than £175 million a year of public money could be saved.
- The 2.6 million economically inactive people between the ages of 50 and 65 cost the economy £16 billion per year.

(Walters et al 1999, Godfrey 1999, mentality 2004, Health Development Agency 2003 & 2004, Help the Aged 2004, Victor and Howse 2000, Godfrey et al 2004, Davis Smith and Gay 2005, Healthcare Commission, 2006)

More research is needed into the effects of interventions and the short, medium and long term impacts. (See appendix three for a summary of effective interventions).



National context

Older people are a high priority in national policy. National policy is moving from perceiving the ageing population as a demographic time bomb and disaster to prepare for; to recognising a growing section of the population who make a big contribution to society and need to be enabled to maximise potential for greater contributions. The main strategies are described below.

The National Service Framework for Older People

The National Service Framework (NSF) for Older People was published in 2001. Standard eight of the NSF is titled the promotion of healthy and active life in older age. Its aim is to extend the healthy life expectancy of older people. Standard eight called on the NHS and local partners to re-focus on helping and supporting older people to live healthy and fulfilling lives.

Opportunity Age

Opportunity Age is the national strategy on ageing, published by the Department for Workforce and Pensions (DWP) in 2005. The DWP are the lead department for older people and chair the cross cabinet subcommittee on older people. Opportunity Age contains three priorities for action: to achieve higher employment rates and greater employment flexibility for people over fifty; to enable older people to play a full and active role in society with an adequate income and decent housing and to allow older people to keep independence and control even if constrained by health problems. Local action is needed to support delivery on these issues.

A Sure Start to Later Life: ending inequalities for older people

The Social Exclusion Unit has identified older people as a priority group. Social exclusion is defined as a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdowns. An interim report was published in 2005 and documents older people's current experiences of social exclusion. This was followed by the publication in 2006 of A Sure Start to Later Life: ending inequalities for older people, which includes plans for delivering action to tackle social exclusion through a Link Age Plus project. Link Age Plus aims to provide a single place older people can get information about a wide range of projects which aim to improve their health, wellbeing and quality of life. Leeds has been successful in becoming a pilot site for the project and will be developing local work to deliver the national model illustrated below. (Further information on page 36)





Choosing Health

Choosing Health: making healthier choices easier is the government's public health white paper and was published in 2004. Choosing Health is based on three core principles: supporting informed choice (creating the right environment and providing adequate information); personalisation (building information, support and services around people's lives, and ensuring that people from all social backgrounds have equal access to these) and working together (making sure that private, public, and voluntary sector organisations, local communities and the media all contribute to making good health everybody's business). Emphasis is placed on providing individuals with information in order to make healthy choices. However, there is a large body of evidence to show that information alone does not change behaviour; this traditional health education approach was abandoned by most public health professionals over twenty years ago. The wider determinants of health set out on page 8 remind us that each organisation cannot do this alone and must actively involve a whole range of organisations to succeed. There needs to be effective partnership working locally to ensure effective public health work is delivered locally. A delivery plan for Choosing Health was published in 2005. Choosing Health requires local action to deliver physical activity programmes, health education (alcohol, smoking, obesity, osteoporosis and exercise) to people in midlife, falls and fractures prevention, an increase in pension credit uptake and reduction in fuel poverty.

Our Health, Our Care, Our Say

Our Health, Our Care, Our Say: a new direction for community services, is the NHS white paper published in 2006 sets out plans for health and social care. It builds on the social care green paper, Independence, Wellbeing and Choice which was published by the Department of Health in 2005. There are four main goals: providing better prevention services and earlier intervention; more choice for patients; more work on reducing inequalities and improving access to community services and more support for people with long term needs.

More detailed information about work required locally to deliver for older people on these agendas is included in appendix four.

There are many other national plans and strategies which relate to the older people's healthy and active life agenda, the following are some of the key documents:

- A New Ambition for Old Age, Department of Health, 2006
- Better Health in Old Age, Department of Health, 2004
- Tackling Health Inequalities: A Programme for Action, Department of Health, 2003
- Game Plan: a strategy for delivering the Government's sport and physical activity objectives, The Prime Ministers Strategy Unit, 2002
- The National Service Frameworks for Diabetes (2002), Coronary Heart Disease (2000) and Mental Health (1999), Department of Health.



Local context

The diagram below illustrates the partnership context for Older Better. The strategy sits under both Healthy Leeds Partnership, which is ultimately accountable to the Leeds Initiative Board, and the Older People's Modernisation Team which is accountable to the NHS Modernisation Executive.

The Leeds Initiative Board is responsible for overseeing the development and delivery of the Vision for Leeds which is Leeds' community strategy 2004 – 2020. The Healthy Leeds partnership, one of eight strategy groups, acts as the over-arching city-wide strategic partnership for health improvement and health inequalities. Members of the partnership include representatives from primary care, Leeds City Council, Leeds Teaching Hospitals Trust, Leeds Mental Health Trust, the voluntary sector, staff associations, universities, service users and carers.

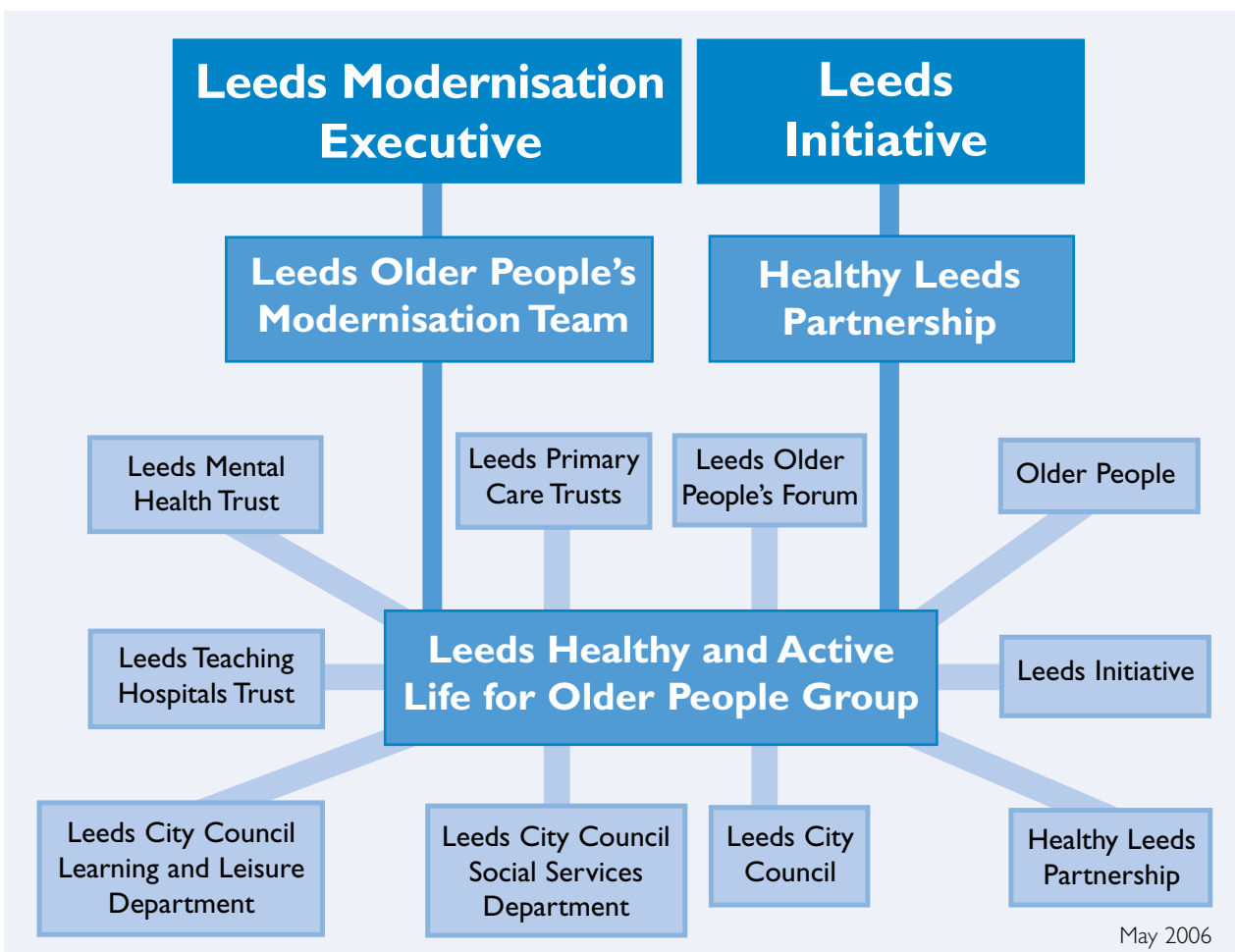
The Modernisation Executive is a partnership of Leeds NHS Chief Executives and Leeds City Council Social Services. A number of modernisation teams sit

below the Modernisation Executive, including The Older People's Modernisation Team. The Older People's Modernisation Team is a high level partnership which sets the framework for delivering older people's work in Leeds.

The Leeds Healthy and Active Life for Older People Group is a subgroup of the Older People's Modernisation Team and reports to the Healthy Leeds Partnership. The Group and its members are illustrated within this structure.

The diagram does not show the full complexity of the political and organisational context within which the Healthy and Active Life Group operates. The structure is accurate at the time of publishing, however there are large scale changes underway in the public sector and there may be changes to the reporting mechanisms.

Significant developments will be reported as part of the annual reporting on progress of Older Better's implementation.



Vision, aim and aspirations

A vision, aim and set of aspirations have been set out to guide the delivery of the Older Better strategy. To ensure older people lead the direction of the strategy, a consultation day was held in November 2005 to develop an overarching vision. Five men and fourteen women attended the day, from a broad range of backgrounds in terms of ethnicity, life experience, religion and age (pictured below). The group was asked to think of one word that is central to the vision of the strategy. There was consensus on key words and concepts to encapsulate the vision of how life should be for older people in 2011. In addition, eight priority areas for action, as defined by older people in "That Bit of Help" research conducted by the Joseph Rowntree Foundation, were discussed. Delegates agreed these were the correct areas to focus on and added two more around being involved and combating age discrimination.



The vision, aim and aspirations are as follows:

Vision: A life worth living for older people in Leeds is one where: they are respected and included; their contributions are acknowledged; and they are enabled to remain independent and enjoy as good mental and physical health as possible.

Aim: The aim of the strategy is to promote a healthy and active life for older people in Leeds, by providing leadership to influence policy and practice, and supporting partners to deliver coordinated action to enable the strategy aspirations to be met.

Aspirations: By 2011, all older people in Leeds will:

- Have access to comfortable and secure homes
- Have an adequate income
- Live in safe neighbourhoods
- Be able to get out and about
- Have the opportunity to develop and maintain friendships
- Have access to learning and leisure
- Be able to keep active and healthy
- Have access to good relevant information
- Be actively involved in planning and decision making that affects them
- Not be discriminated against on the grounds of their age



Implementation

The task of promoting a healthy and active life for older people is extremely broad. It requires strong leadership and ownership from a range of organisations and individuals. Both the task and resources will develop over time. Therefore Older Better will be delivered in three ways: through annual work plans, through seeking out and taking advantage of new opportunities and by influencing colleagues to incorporate action to deliver the strategy in their own plans. Priorities will be set annually.

The following will be delivered in year one:

Older Better work plan 2006–07

The work plan will be led by the Health Promotion Coordinator for Older People and the Project Manager for Healthy and Active Life, and delivered with a wide range of partners. Aspirations prioritised for action for year one are:

- Ensuring an adequate income by reducing pensioner poverty
- Keeping active and healthy by increasing physical activity opportunities
- Safer neighbourhoods through intergenerational work
- Increasing the ability to get out and about by improving access to transport

The work plan sets out citywide multi-agency activity to guide focused work on the areas above and includes clear objectives, targets and outcome measurements.

New opportunities 2006–07

The following are major opportunities in year one:

- The new Local Area Agreement structure with a section on Healthy Communities and Older People
- The Leeds Link Age Plus pilot project
- The information strand of the Partnerships for Older People Project

Partners involved in leading these projects have committed to working towards delivering specific strategy aspirations.

Local Area Agreement: Healthy Communities and Older People

The Local Area Agreement (LAA) is a new three year contract between central and local government aiming to deliver national and local priorities, provide scope to join and or pool funding and deliver better outcomes for local people. LAAs are divided into four sections called blocks. One of the blocks focuses on Healthier Communities and Older People. Within the four blocks, the council and its partners will negotiate and agree with central government a range of outcomes for inclusion in the LAA, along with indicators, targets and baselines for each. These are based on discussions and agreements with local partners about priorities for improvement locally, incorporating and integrating local public service agreements. The Healthier Communities and Older People block of the Local Area Agreement used the Older Better strategy to guide their priority setting and will work towards delivering the following aspirations:

- Have an adequate income
- Are able to get out and about
- Are able to keep active and healthy
- Are actively involved in planning and decision making that affects them.

The Leeds Link Age Plus pilot project

Link Age Plus is an initiative devised by the Department for Work and Pensions to tackle exclusion faced by older people and to implement integrated approaches to promoting older people's health, wellbeing and independence. Leeds has been chosen as a pilot site. The Leeds Link Age Plus programme has a budget of one million pounds over two years starting in 2006. This work builds on participation by Leeds in the original Link Age initiative which led to the integration of the visiting services of Leeds Benefits Agency and The Pension Service. The Leeds Link Age Plus project will develop:

- A single accessible gateway to a wide range of services and information promoting health, independence, wellbeing and quality of life work.
- Capacity building within the innovative voluntary sector for older people in Leeds, to support the development of preventative services and to promote the contribution of older people and active ageing.
- Further work on streamlined assessment.

The Link Age Plus pilot will work towards delivering the following aspirations:

- Have access to comfortable and secure homes
- Have an adequate income
- Live in safe neighbourhoods
- Are able to get out and about
- Have the opportunity to develop and maintain friendships
- Have access to learning and leisure
- Are able to keep active and healthy
- Have access to good relevant information
- Are actively involved in planning and decision making that affects them.

Partnerships for Older People Project: Information strand

The Partnerships for Older People Project (POPPs) in Leeds is a programme of work to improve mental health services for older people in Leeds. Four million pounds will be invested over the next two years with a focus on prevention on an invest to save basis. That means if money spent on preventative services is proved to reduce the need for more acute services then mainstream money will be refocused after the additional funding runs out to pay for preventative services using money that has been saved. The programme represents a shift from reaction to prevention, reducing inappropriate admissions into hospital or residential and nursing care and avoiding unnecessarily extended stays in hospital. There is a focus on the early identification of mental health issues and on support services which allow older people with mental health problems to remain in their own homes. The Leeds POPPs programme is made up of a number of projects, one of which is an information strand. The information strand of the POPPs will work towards delivering the following aspiration:

- Have access to good relevant information
- Are actively involved in planning and decision making that affects them.

Influencing colleagues to deliver 2006–07

During year one, we will work with a wide variety of organisations to support the implementation of Older Better. These will include: The Leeds Initiative, Leeds City Council, Leeds Primary Care Trust, the five Leeds District Strategic Partnerships, Leeds Older People's Forum, Leeds Mental Health Trust and Leeds Teaching Hospitals Trust.

Targets in the action plans will be measured and progress will be reported on annually. The first report will be published by the Healthy and Active Life Group in May 2007.



The implementation of Older Better will be overseen by the Healthy and Active Life for Older People Group. The group will be responsible for ensuring the strategy's principles are embedded in implementation plans including targeting disadvantaged groups of older people. Accountability will be to Leeds Initiative through the Healthy Leeds Partnership and the Modernisation Executive through Leeds Older People's Modernisation Team.



Appendix 1: Disadvantaged older people

There are many sections of the older population who face greater disadvantage. This section highlights issues faced by some of them:

Older women

Most women continue to contribute their skills and experience for the benefit of us all as they grow older. This may be as a volunteer (women are more likely than men to be involved in voluntary activity), a worker, a carer (14.4% of women in Leeds are carers compared to 10.7% of men) or a grandmother. Many older women lead fulfilling lives with the resources and good health to make the most of it. However, for some, old age is a time of poor health, low income and loneliness.

There are slightly more women than men in Leeds and women have a longer life expectancy. In surviving men, older women tend to suffer worse health, lower incomes and poor housing (often living alone). At the oldest ages, when problems become more acute, women overwhelmingly outnumber men. Older women living alone are more likely than other groups to experience poverty. Many more women pensioners than men are claiming housing benefit or council tax benefit. 39.8% of all housing benefit claimants in Leeds are pensioners – 7,592 men over 65 and 14,162 women over 60. 68.8% of council tax benefit claimants are pensioners – 3,615 men and 5,762 women.

Gender affects older people's experiences as service users e.g. women are more likely to report access problems due to transport issues. Women carers are less likely than men to be economically active and to spend more hours per week caring. The major cause of death in women over 45 is Coronary Heart Disease (CHD), the major cause of disability in women over 45 is from disorders of the bones and joints, cancer is a particular fear for older women (not least breast cancer), depression in women over 45 is twice that of men, isolation and loneliness are issues for older women – particularly very old women.

Women from Pakistani, Bangladeshi and other Asian groups in Leeds have particularly high rates of limiting long term illness, health problems or disabilities. There are differences in the health status of men and women and the ways they use the NHS and they have different health care needs. Gender is a major determinant of health and health care needs

and the social implications of gender need to receive attention. Research has shown this in a range of areas e.g. CHD, where women can experience symptoms uncommon in men and may be less visible. Also with regard to rehabilitation programmes e.g. physical exercise – studies show that women feel less able than men to participate in organised exercise in a mixed setting.

All services, strategies, plans and policies need to ask what the impact is on women and data needs to show whether women's and men's experiences of services or areas of policy are different. Adequate income, preventive and gender sensitive healthcare, access to social networks and good quality accommodation will help older women to be stronger, more active and independent. (Sinclair, 2006; Percy-Smith, 2003; Doyal, 2005)

Older gypsies and travellers

The life expectancy of the Gypsy and Traveller communities in Leeds is about 50 years, compared with a Leeds average of 78.2 years. While almost 20% of the general population is over 60 years, less than 2.5% of Gypsies and Travellers are in that category. There are 1,071 Gypsies and Travellers in Leeds. 58% live in private or social housing, the balance live on their own their land or blind eye sites and on the council owned Cottingley Springs site. 42 families live on the roadside and are subject to continual evictions. (Baker, 2005) The single action that would have the biggest impact increasing older gypsy and traveller health would be to have sites they could move to where they would not be moved on.

Older people from other black and minority ethnic groups

In Leeds as elsewhere the population of older people from black and ethnic minority communities is rising. At present there are estimated to be 9,167 people aged 60 and over from around twelve different communities - the majority from Indian, Pakistani, Irish and Caribbean communities. Research by the Joseph Rowntree Foundation has shown that black and minority ethnic older people are more likely to face a greater level of poverty, live in poorer quality housing, and have poorer access to benefits and pensions than 'white' older people (Butt & O'Neil, 2004). Myths about minority ethnic

communities need challenging: there is not necessarily an extended family which 'looks after its own'. Specific barriers highlighted through consultations with BME elders that prevent ethnic minority older people achieving a good quality of life include: language, inadequate access to culturally specific services, financial difficulties, lack of training for staff on specific needs and racism (Sleight, 2005). Faith, like culture, is often a source of strength to individuals and communities; however it can also attract hostility and discrimination.

Older people living in poverty

Poverty is one of the most significant factors leading to social exclusion and isolation. Leeds has been described as a "two speed city" and many pensioners find themselves in the poorest group. A recent Help the Aged report identified Hunslet in South Leeds as the 9th worst ward for pensioner poverty in England and Wales, with more than 84% of those over 75 living on income-related benefits. Leeds as a whole has 41% of this age group falling into this category. One in five older people are living in poverty. (Age Concern, 2006). Nationally 2 million older people are living below the poverty line. (Joseph Rowntree Foundation, 2004). Nearly half the population of older people (44%) are living in accommodation that is not in decent repair or thermally efficient. (Help the Aged, 2005). Every winter between 20,000 and 50,000 older people die as a result of the cold. (Wright, 2004).

Lesbian, gay and bisexual older people

5-7% of the population is estimated to be lesbian, gay or bisexual. This means that every fifteenth older person is a lesbian or a gay man. Lesbians, gay men and bisexuals are just as numerous in older age groups, but they have on the whole been less visible. When compared to their heterosexual counterparts therefore, older lesbians, gay men and bisexuals are twice as likely to live alone and four times as likely to have no children to call upon in times of need.

Older lesbians, gay men and bisexuals are five times less likely to access services for older people than is the case in the general older population, because they fear discrimination, homophobia, ignorance and that they will have to hide their sexuality. Older lesbians and gay men have particular issues. Many have remained invisible because organisations have failed to investigate their needs. They can face discrimination caused by lack of legal recognition of their relationships, in terms of pensions, tenancy rights and next of kin arrangements. Lesbians and gay men with

partners have experienced difficulties when in hospital, for example, where the rights of same-sex partners have not been acknowledged. Housing is another area where same-sex couples have not enjoyed the same rights as heterosexual couples. This is often combined with the loneliness, ill-health and financial issues that all older people can face. (Source: http://www.ageconcern.org.uk/AgeConcern/about_4435.htm accessed September 2005.)

Older carers

In the general carer population there are 70,446 people who described themselves as a carer in the 2001 census. This figure represents 9.8% of the population of Leeds, below the national average which is 11%. Of these, 14,369 (20.4%) were providing 50+ hrs of care per week; 7,631 (10.8%) provide 10-49hrs per week; and 48,446 (68.7%) provide between up to 19 hours of care per week. In terms of older carers, the likelihood of being a carer rises with age and peaks at the 45-60 age group – probably boosted by people caring for elderly parents. 25% of all women aged 50-59 are providing unpaid care. 21% of all carers are over pension age – approx 14,790 in Leeds. Although at younger ages women outnumber men as carers, by the age of 75, men outnumber women as carers, and the majority will be caring for their lifetime partner.

It is estimated that in Leeds, there are about 400 carers of adult sons or daughters with learning disabilities – these people will have been caring for most of their adult lives, up to 50yrs. These carers are particularly likely to have had their own health affected by their caring role, and to have lower income than their peers. They will suffer side effects of long-term stress and musculo-skeletal damage from lifting carrying and moving the person they have been caring for. There are also a significant number of older carers caring for an adult son or daughter experiencing mental illness, sometimes severe.

Carers generally have lower incomes than others in the community due to their career having been interrupted or having to reduce their working hours. As a result, they will have not been able to build up savings or good income from work pensions and will be over-represented in lower income groups. Older carers, particularly where they are co-resident with the person they care for, are likely to be socially isolated, particularly if they do not have other family to assist them with caring. Accessing community activities and facilities for themselves and the person they care for may be more difficult if they are no

longer able to drive, thus further increasing social isolation for both parties. It may require particular effort to identify these carers and make them aware of services which may assist them. As they may have their own health needs, it will be particularly important to provide care services to the person they are caring for and to provide short breaks and respite opportunities. (Maguire, 2006)

Older prisoners

The number of male prisoners aged 60 and over in England and Wales has more than trebled in ten years, from 442 in 1992 to 1,359 in 2002. This compared to a one and a half times increase for those aged 18 – 59, making those aged 60 and over the fastest growing population. (HMCIP, 2004) Currently 1.5% of prisoners in HMP Leeds are over 65 (18 prisoners in January 2006). Issues include poor mobility (stairs and landings) incontinence, age related illness that health care staff aren't fully trained in and being less able to defend themselves in a hostile environment.

People with learning disabilities

There are 17,000 people with learning disabilities in Leeds. People with learning disabilities are living longer than they used to because of better health and social care. They are either living with their families, in residential homes or in their own homes. Older people with learning disabilities need the same kind of support as younger people, but they often receive less help. Older people with Down's Syndrome are more likely to develop dementia. Some projects are helping family carers and services to find the best ways of supporting people with dementia. Many older people with learning disabilities have very limited social networks and few opportunities to use ordinary leisure provision in the community. This is in marked contrast to the experiences of many non-disabled people who, as they grow older, take up new hobbies and other leisure pursuits. People with learning disabilities need support to share these opportunities.

Refugees and asylum seekers

Statistics relating to asylum seekers and refugees generally are poor. However it was known that in November 2004, of the 2703 asylum seekers in Leeds only 8 were over the age of 65. This does reflect nationally as within Leeds numbers of older people who are asylum seekers and refugees are very low. It is therefore important to recognise that when looking at disadvantage, being an older person alongside being an asylum seeker or refugee, means

that you are within an exceptionally small minority within the community of Leeds.

By being more likely to be living in poverty and being from a black and minority ethnic group, the health issues that asylum seekers and refugees are likely to face are often complex. Often these people will have a greater likelihood of poor health, sexual and mental health problems and infectious diseases. This is often due to the effects of potential experiences they have had in their country of origin and here in the UK. People may have experienced many traumatic events i.e. war; imprisonment, famine, torture, rape, female genital mutilation and loss of loved ones. They are likely also to have experienced very basic health care and have originated from a country where life expectancy may be a lot lower than here in the UK or where disease prevalence is higher i.e. HIV or TB.

It is not unusual when people come to the UK to claim asylum or to settle as a refugee that they then face further issues that impact on their health i.e. isolation, no support or family, cultural issues, racism, poor housing, destitution, sleeping rough, poor access to health care and no access to certain health care (if asylum is refused). This is all further impacted by communication difficulties with language barriers as most people will experience. (Greer, 2006)

Homeless older people

Many older people who become homeless, previously lived settled and stable lives. The popular view of homelessness amongst older people, is that they have been homeless for many years and lived an itinerant lifestyle. Whilst there are people for whom this is true, evidence indicates that for many older people, homelessness comes as a result of life events, which are likely to occur in later life (Crane et al, 2004). Such events include bereavement - the loss of a partner or loved ones and related social support networks or failing health (physical and mental) which may lead to the loss of previous good habits e.g. rent payment and household management. Older people who may have been successful, reliable and productive citizens when they were younger may find themselves in debt, misusing alcohol or drugs, being antisocial or generally unable to cope with running a home as their health and social circumstances degenerate.

It is important this is recognised when designing support and care services for older people e.g. offering flexible support to people in their own homes and timely intervention when problems are just starting. Floating support which is not tied to

tenure or type of accommodation is vital in preventing homelessness amongst older people.

Older homeless people will often find themselves defined as socially excluded and there may be elements of their lifestyle that conflicts with more traditional ways of living. In such cases offering someone accommodation in a sheltered scheme where neighbours live closely with each other may not be an option yet without housing support the individual may fail once more in their ability to manage their home.

For those individuals for whom homelessness and an unsettled lifestyle perhaps accompanied by long term alcoholism or other problems, it may be that resettlement is not an option. It is important then that suitable supported residential accommodation is available which allows older people to live safely but within an environment, which can understand and support their particular needs. (McLaney, 2006)

Older people in care homes

There are over 4,500 older care home residents in Leeds. Most residents suffer multiple mental and physical illnesses and disabilities. More than 70% of residents have some degree of dementia and about 40% suffer from depression (Department of Health, 2005). Therefore, most residents share the disadvantages of both older disabled people and older people with mental health problems. Nevertheless, residents want to retain as much independence as possible and to be socially included (Nurock and Livingston, 2002). The required staffing levels in homes (National Minimum Standards 2000) are only sufficient to meet the needs of residents for personal and basic nursing care. However, homes have difficulty in recruiting and retaining staff and must often employ agency staff to meet these requirements.

Shortcomings in the management of medicines have recently been revealed (Commission for Social Care Inspection 2006) and the need for better-trained staff in general has been acknowledged by the announcement of a new registration and training scheme for all care home workers. The way in which homes are traditionally designed and run does not assist residents in retaining their independence and individuality. Residents' rooms are usually furnished by the home and have limited space for personal possessions. They are expected to spend most of the day in the public rooms and have little opportunity to pursue their own interests. In general, opportunities for activity, either physical or

mental, are limited. Very few homes in Leeds cater for the cultural needs of black and minority ethnic elders. Few residents have frequent visits from relatives and friends and few form close friendships with other residents. Consequently, many are lonely. Loneliness and lack of activity exacerbate depression among residents (Chesters, 2006).

Older disabled people

This strategy is based on the social model of disability. The social model is a way of thinking about disability that shows that many of disabled people's problems are not caused by their impairments or medical conditions, but by the way society is organised. An impairment is an injury, illness or inherited condition that causes a loss or difference in the way someone's body or mind works.

Disability is caused by barriers in society, because many things have been set up without taking account of people who have impairments. Clearly, many older people have impairments, indeed the vast majority of disabled people are older people. Therefore applying a social model approach is logical and beneficial. We need to also work to remove disabling barriers. Disabling barriers include: prejudice and stereotypes; inaccessible buildings; inflexible ways of organising things; inaccessible information; inaccessible transport and beliefs about the way people should look or behave. (Ward, 2006)

Older people with mental health problems

Mental health problems present a significant risk in old age. The prevalence of depression in older people is between 10-15%, for Leeds meaning that currently up to 15,500 people are affected. Within care homes this percentage is much higher at between 30-40% (approximately 1,700 people in Leeds) and a number of these people will have a co-existing dementia. The prevalence of schizophrenia in old age is the same as in the general population at 1-2%; for Leeds this means approximately 2,200 people.

While there has been considerable progress in the range and choice of treatments available to younger adults, older people continue to receive medication and attendance at day centres (where their mental health needs are unlikely to be understood or met) as their primary treatment.

Dementia is a condition that particularly affects older people, with prevalence rising from 5 % of the population aged 65-75 years to 20% of people aged 80 years and over. In Leeds this equates to

approximately 6,000 older people. Under detection and poor responses within primary care mean that long delays occur between recognition, help seeking and referral for assessment and diagnosis take place.

In 2004-05, 400 older people with a primary diagnosis of dementia and 1400 other older people with co-existing dementia and physical health problems arrived as emergency admissions at the general hospital Accident and Emergency departments as a first point of contact. This means that many people with dementia are admitted to hospital when a social crisis has occurred. Once in

hospital, they are at high risk of losing skills, having long delays in their care and there is an increased likelihood of moving on to long-term care.

Research has concluded that GP's and primary care staff lack knowledge, skills and confidence in early detection and management of uncomplicated mental health problems in old age. Under-detection, late detection or lack of acknowledgement of mental health problems in older people can result in poor outcomes for treatment of other physical health and/or social problems. (Thornton, 2006)





Appendix 2: Older people's health and wellbeing needs: full references

- **Accessible services** (Lewis et al 1999, Godfrey and Randall 2003)
- **Ageism** (Fee et al 1999, Johnson 2005, Help the Aged 2002 & 2004, Joseph Rowntree Foundation 2004, Age Concern 2005)
- **Alcohol** (Fee et al 1999)
- **Bereavement and loss of intimacy** (Fee et al 1999, Godfrey and Randall 2003, Owen and Bell 2004)
- **Caring for a partner or relative** (Fee et al 1999)
- **Citizenship - being involved in planning, regeneration and neighbourhood renewal** (Godfrey and Randall 2003, Riseborough and Jenkins 2004, Help the Aged 2002 & 2004, Roche 2003)
- **Diet and nutrition** (Fee et al 1999)
- **Disability and loss of function** (Godfrey and Randall 2003)
- **Disadvantaged groups of older people e.g. Being an immigrant particularly for South Asian older people** (Fee et al 1999, Sikh Elders (Miller 2003) and effect of early life experiences (including cruelty, deprivation and inadequate diet) (Fee et al 1999)
- **Drugs** (Fee et al 1999)
- **Employment** (Johnson 2005, Age Concern 2005, Help the Aged 2002 & 2004, Roche 2003, Owen and Bell 2004)
- **Falls** (Lord 2001)
- **Fuel Poverty** (Help the Aged 2004)
- **Health – physical and mental** (Godfrey and Randall 2003, Help the Aged 2004, Killoran 1997, Roche 2003, Bowling and Kennelly 2003, Godfrey 2004, Manthorpe 2005, The Audit Commission, 2000, Third Sector Fist, 2005) Significantly high rates of cancer deaths in older men in Leeds aged 65 – 74 (Department of Health, 2001)
- **Housing** (Fee et al 1999, Lewis et al 1999, Joseph Rowntree Foundation 2004, Bowling and Kennelly 2003, Owen and Bell 2004)
- **Independence, interdependence and control** (Bowling and Kennelly 2003, Godfrey et al 2004, Owen and Bell 2004)
- **Information** (Joseph Rowntree Foundation 2004, Godfrey et al 2004)
- **Insurance and access to some banking services** (Help the Aged 2004)
- **Leisure** (Lewis et al 1999)
- **Lifelong learning** (Lewis et al 1999, Johnson 2005, Help the Aged 2002 & 2004, Owen and Bell 2004)
- **Meaningful activity** (Godfrey et al 2004)
- **Pensions** (Johnson 2005, Help the Aged 2004)
- **Physical environment** (Godfrey and Randall 2003, Fee et al 1999, Lewis et al 1999, Joseph Rowntree Foundation 2004, Godfrey et al 2004)
- **Poverty and low income** (Fee et al 1999, Help the Aged 2002, 2003 & 2004, Joseph Rowntree Foundation 2004, Roche 2003, Bowling and Kennelly 2003, Godfrey et al 2004, Owen and Bell 2004)
- **Retirement** (Fee et al 1999, Godfrey and Randall, 2003, Owen and Bell 2004)
- **Safety and security** (Fee et al 1999, Lewis et al 1999, Joseph Rowntree Foundation 2004, Roche 2003)
- **Shopping, cleaning, gardening – daily hassles** (Lewis et al 1999, Godfrey et al 2004)
- **Smoking** (Fee et al 1999)
- **Social isolation and loneliness** (Fee et al 1999, Cattán 2002, Godfrey and Randall 2003, Lewis et al 1999, Bowling and Kennelly 2003, Godfrey et al 2004, Owen and Bell 2004)
- **Transport** (Fee et al 1999, Lewis et al 1999, Help the Aged 2002 & 2004, Joseph Rowntree Foundation 2004, Owen and Bell 2004)

Appendix 3: Effective interventions: summary of evidence

- **Reducing social inequalities in health:** systematically targeting the most disadvantaged older people, ensuring material wellbeing of all older people, maximising benefit uptake.
- **An integrated approach to health promotion:** strategic plan of reinforcing actions.
- **Physical activity:** prevention of frailty, reducing falls, reducing blood pressure, preventing coronary heart disease and stroke, promoting mental health.
- **Injury prevention:** physical activity to prevent falls, assessment of injury risks, multi sector interventions for injury prevention, reducing road traffic accidents, preventing violent abuse of older people.
- **Interdependence:** being part of a community where people care about and look out for each other; not being a burden, maintaining reciprocal relationships.
- **Healthy eating:** target eating assistance to older people most in need of support, include checks on diet, establish nutrition policies designed to improve affordability of healthy food.
- **Healthy living:** reduce tobacco and alcohol related harm, regular health checks (including medication reviews and screening).
- **Better mental health:** targeting social isolation and loneliness, reduce economic hardship, physical and mental activity, learning on prescription, books on prescription.
- **Housing:** location, design, living arrangements, care provision, familiar social networks, well maintained house.
- **Meaningful activity:** Maintain or creating social networks, keeping active, keeping a routine, volunteering in retirement. Although people aged 65 and over make up only 16% of the population, they occupy almost two thirds of general and acute hospital beds. The NHS spent around £16 billion on people over the age of 65 in 2003/2004, accounting for 43% of the total NHS budget. In the same year social services spent around £7 billion, which was 44% of their social services budget. Health promoting activities can help to reduce this burden. Invest to save and cost-benefit arguments:
 - With timely identification and treatment of depression, up to half a million older people may not withdraw from work and claim incapacity benefit, saving £1.1 billion a year.
 - A 1% reduction in dependency and morbidity could reduce publicly funded care costs by as much as £6 billion by 2030.
 - By reducing falls by a third, more than £175 million a year of public money could be saved.
 - The 2.6 million economically inactive people between the ages of 50 and 65 cost the economy £16 billion per year.

(Walters et al 1999, Godfrey 1999, mentality 2004, Health Development Agency 2003 & 2004, Help the Aged 2004, Victor and Howse 2000, Godfrey et al 2004, Davis Smith and Gay 2005)



Appendix 4: Summary of local action required to deliver national policy

This appendix highlights local action needed to implement The National Service Framework for Older People, Opportunity Age, A Sure Start to Later Life, Choosing Health and Our Health, Our Care, Our Say.

The National Service Framework for Older People, 2001, Department of Health

The NSF for older people is a ten year strategy which set new national standards and service models of care across health and social services for all older people, whether they live at home, in residential care or are being looked after in hospital. It is divided into eight standards. Standard eight focuses on the promotion of healthy and active life in older age. The aim of this standard is to extend the healthy life expectancy of older people. The targets are as follows:

By April 2004 HImPs, SaFFs and other relevant local plans should have included a programme to promote healthy ageing and to prevent disease in older people. They should reflect complementary programmes to prevent cancer and CHD and to promote mental health, as well as the continuation of flu immunisation. Plans should also include action specific to older people, utilising the range of local resources, including those within regeneration programmes and reflecting wider partnership working.

By April 2004, local health systems should be able to demonstrate year on year improvements in measures of health and well being among older people:

- flu immunisation
- smoking cessation
- blood pressure management

Opportunity Age, Department of Work and Pensions, 2005

The document sets out three proposals as priority areas for action:

- To achieve higher employment rates and greater flexibility for over 65s
- To enable older people to play a full and active role in society with an adequate income and decent housing
- To allow us all to keep independence and control over our lives as we grow older.

Areas of work highlighted are:

Employment

- An ambition of an 80% overall employment rate, including a million more older workers
- Age equality in employment law in 2006, supported by CEHR
- An improved Age Positive campaign to help change employer attitudes
- New pension rules to give incentives to stay in work
- Better information and guidance so people can re-skill and plan for later careers and retirement
- Extending learning opportunities for older people so they can stay in work
- Reform of incapacity benefit, helping people back into work
- Support for unemployed people to find jobs and re-skill

Active ageing

- Establishing a new Commission for Equality and Human Rights to root out age discrimination.
- New ways of giving local authorities incentives to involve older people in local decision making.
- New crime reduction programmes, including a £12 million initiative to improve home security for low-income pensioners in England and Wales and record numbers of police and Community Support Officers patrolling our streets.
- Legislation planned for 2007 to require new homes to be built to Lifetime Home Standards. Also an Office of the Deputy Prime Minister (OPDM) Public Service Agreement target to increase the proportion of older people living in decent accommodation.
- All local authorities in England and Wales asked to develop five-year transport plans which identify the accessibility issues affecting the ageing population and their priorities for addressing them.
- On top of existing legislation requiring local authorities to meet half of local bus fares for people over 60, from 2006, free off peak local area

bus travel will be extended to them and disabled people in England. And free bus services will be extended in Scotland.

- Greater access to learning including the removal of the age cap for higher education fee loans from 2006.
- A range of measures to ensure that older people can enjoy leisure activities, including modernising local amenities such as public libraries.
- Measures to encourage volunteering including a new Home Office funded national coordinating body (Volunteering in the Third Age) to provide a focal point for older volunteering.
- Promoting healthy living among older people through proposals in the recent White Paper in public health to encourage physical activity.

Independence and control

- Giving older people the support they need to remain in their own home for as long as possible in warmth and comfort.
- Gathering the evidence about longer term impact of shifting resources from high level to lower level care support.
- Creating The Pension Service to provide an organisation dedicated to tackling pensioner poverty.
- People entering hospital to keep full entitlement to their State Pension, Incapacity Benefit, Severe Disablement Allowance and Income Support for the duration of their stay.
- A Link Age project which is delivering one stop services so older people only have to give information once, and an integrated visiting service so that people who need it can have a full, personal, overall check up of their needs and entitlements.
- Promoting health among older people.
- Developing a fully integrated service pilot Link Age Plus which goes beyond the initial Link Age service.
- Taking steps to ensure that, where people do end up going into residential care, they receive high-quality service.
- Tackling the specific disadvantages that black and ethnic minority elders can experience.
- Building on its interim report Excluded Older People The Social Exclusion Unit will publish an agreed plan of government action in Winter 2005/06.

A Sure Start to Later Life: Ending inequalities for older people, Office of the Deputy Prime Minister, 2006

This document describes the issues of social exclusion for older people and focuses on the areas of: material poverty, health and care, social isolation and loneliness, housing, crime, transport, basic services and attitudes towards ageing. The document lists characteristics of older people which makes them more likely to be excluded. These include: older people on low income, that live alone, are depressed, are aged 80 and above, live in rented accommodation, have no private transport, are in poor physical health, have no children alive and no telephone.

The report outlines thirty actions the government is taking to reduce social exclusion for older people at a national level. It also describes how local action will be delivered through the Link Age Plus Model. Link Age Plus aims to provide a single place older people can get information about a wide range of projects which aim to improve their health, wellbeing and quality of life. Leeds has been successful in becoming a pilot site for the project and will be developing local work to deliver the national model illustrated below:



Delivering Choosing Health: making healthier choices easier, Department of Health, 2005

Older people have been identified as a priority area.

Big wins are:

- Local physical activity programmes
- Tackling social isolation
- Communication and education targeted at people in midlife
- Preventing falls and fractures

There are links with Public Service Agreements:

- Improving the quality of life and independence of older people
- Supporting older people to live in their own homes
- Increasing benefit uptake
- Improving awareness of retirement provision
- Eliminating fuel poverty



Our Health, Our Care, Our Say: a new direction for community services, Department of Health, 2006

Our Health, Our Care, Our Say includes four main goals: providing better prevention services and earlier intervention; more choice for patients; more work on reducing inequalities and improving access to community services and more support for people with long term needs. In terms of prevention and enabling health independence and wellbeing, there is a commitment to:

- Developing NHS life checks
- Better support for mental and emotional well-being
- Improving commissioning and joint working through defining and strengthening the roles of Directors of Public Health and Directors of Adult Social Services
- Better partnership working in local areas
- Stronger local commissioning to shift towards prevention and early support.

In terms of older people, the aims for promoting health and wellbeing in older age are:

- To promote higher levels of physical activity in the older population
- To reduce barriers to increased levels of physical activity, mental wellbeing and social engagement of excluded groups of older people
- To continue to increase uptake of evidence based disease prevention programmes among older people.

Links are made with Choosing Health and the National Service Framework for Older People and their vision for promoting health, independence and wellbeing for older people.



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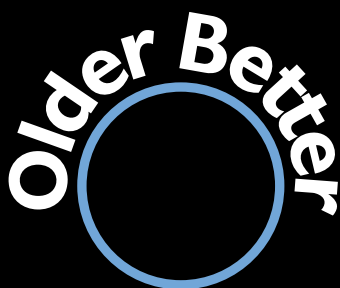
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