Older People Topic Summary
Cumbria JSNA
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Contents

EXECUTIVE SUMMARY 4
1 Key Issues & Gaps 4
2 Recommendations for Consideration for Commissioners: 5
PART 1: INTRODUCTION, OVERVIEW AND KEY CHALLENGES 6
3 Introduction 6
4 Policy Context 7
4.1 National Policy Context 7
4.2 Local policy context 8
5 Population overview 9
5.1 Demographic structure 9
5.2 Life Expectancy 12
5.3 Lifestyles and Health 13
6 Falls 14
7 Long Term Health Conditions 17
PART 2: AGE FRIENDLY COMMUNITIES 24
8 Outdoor spaces and Buildings 24
9 Transportation 27
10 Housing 32
10.1 Older households, Residential Care, Homelessness 32
10.2 Fuel Poverty 35
10.3 Excess Winter Deaths 37
9 Social Participation 40
10 Respect and social inclusion 43
10.1 Social Isolation 43
10.2 Loneliness 46
11 Civil participation and Employment 50
12 Communication and Information 53
13 Community Support and Health Services 56
13.1 Health and Social Care Services 56
13.2 Reablement 60
13.3 Assistive Technology 63
13.4 Carers 64
13.5 Screening Services 69
13.6 Immunisations 70

13.7 End of Life Care 72
PART 3: SPECIFIC POPULATION GROUPS 74
14 Vulnerable Groups 74
14.1 Older People with Learning Difficulties 74
14.2 Gypsy and Irish Travellers 75
14.3 Ethnic minorities 76
14.4 Lesbian, Gay, Bisexual and Transgender Older People 76
15 Geographical differences in need 78
15.1 Allerdale 78
15.2 Barrow-in-Furness 79
15.3 Carlisle 80
15.4 Copeland 81
15.5 Eden 82
15.6 South Lakeland 83
16 User views 84
17 Links to Data Sources 86
18 References 86

EXECUTIVE SUMMARY

1 Key Issues & Gaps

The Cumbrian population is 'super-ageing'. This means that the population of Cumbria is ageing faster than the rest of the UK population and the number of people of working age is reducing. By 2020, nearly 25% of the Cumbrian population will be aged over 65. As people grow older, their health needs become more complex with physical and mental health needs impacting on each other. As an example, there are an estimated 7,721 people living with dementia in Cumbria, with around 1,800 being diagnosed each year. As our population ages this number is expected to rise substantially to 12,410 by 2030. NWAS (North West Ambulance Service) data indicates that falls comprise approximately 88% of all injuries serious enough to warrant an ambulance call out for people aged 50 years and over.

Among older people there are inequalities in terms of deprivation and health outcomes, life expectancy and general health, and it is often the poorest older adults who suffer the greatest disadvantage.

The rurality of Cumbria is a significant factor for older people. Anecdotal evidence from Age UK across Cumbria suggests that access to health and social care services remains a real issue. This is mainly due to access - transport availability; variable clinic locations across Cumbria; challenges to get appointments with GPs; and routine appointments not fitting with bus timetables. Within Cumbria the challenges faced by our communities to ageing well vary between the rural and built environment. Connectivity to services in rural areas is a challenge. In Cumbria, 84 communities (LSOAs) rank amongst the 10% most deprived in England in relation to geographical barriers to services. Standards that may be achievable in an urban area may be difficult in a rural area and vice versa. Internet usage for older people in Cumbria cannot be quantified, but as the age profile in Cumbria is older than the UK it would suggest that internet usage will be lower than the national average.

Communities are a key asset in Cumbria. There are more than 56,000 residents across Cumbria providing unpaid care to either family members, friends, neighbours or others because of long-term physical or mental ill-health / disability or problems relating to old age. There are greater proportions of carers in Cumbria compared to the rest of England (Provision of unpaid care, Source: Census, 2011). A survey in 2009 indicates there are approximately 50,000 volunteers providing support through registered charities across Cumbria, providing on average 1 hour 25 minutes per week. There are reported divisions in communities such as incomers verses those born in an area, rich verses poor, and urban verses rural. Ethnic minority and gay community involvement is also often challenged. There also appears to be some gaps in long term strategies for ongoing issues e.g. volunteer car schemes.

Cumbria Emergency Departments (and Royal Lancaster Infirmary) do not currently categorise falls, which compromise the main injury group among older people, particularly those aged 65 years and over. While it is assumed that the majority of 'other injuries' are falls, especially among older age groups, it would be useful for the purposes of prevention and treatment to distinguish between falls and other accidents, and therefore to consider mechanisms to enable the further categorisation of unintentional injuries to include falls.

2 Recommendations for Consideration for Commissioners:

- Commissioners need to consider barriers to ageing well for older people, this is across various arenas and includes access to services.
- With Cumbria's super-ageing population commissioners should ensure future assets and commissioned services are sustainable.
- Identify risk groups in the older population in Cumbria and prioritise prevention.

PART 1: INTRODUCTION, OVERVIEW AND KEY CHALLENGES

3. Introduction

The population of the UK is ageing as a result of increased life expectancy and demographic trends. People are living longer and there are far more people reaching old age. This section of the joint strategic needs assessment (JSNA) focuses on older people. This chapter may cover topics covered in other chapters, though not in as much detail.

Cumbria has a 'super-ageing' population. This means that there is an increase in the number of people in the older age groups, and a decrease in the number in the younger age groups. By 2020, over a quarter of the Cumbrian population will be aged over 65. This is a greater proportion than the average for the country. At the same time, more younger people with disabilities are surviving into adulthood and old age, and more people are living for longer with complex needs, frailty, long term conditions and/or dementia (Source: Draft Commissioning Strategy for Care and Support delivered by Adult Social Care 2015-2020).

Some residents within Cumbria are extremely isolated, which presents a challenge for individuals and the services trying to help them. There is high demand on public services like health and social care, which means it is a key priority for all services to plan effectively to ensure the needs of older people can be met in the future. Reducing resource across all services presents massive challenges. If we can design and execute effective interventions to prevent or delay the onset of chronic disease and increase healthy life expectancy, there will be social, economic and health dividends for us all. (The Case for Healthy Ageing: Why it needs to be made, Taken from Healthy Ageing Evidence Review).

The World Health Organization's (WHO's) Active Ageing – A Policy Framework (2002) points out that despite the best efforts in health promotion and disease prevention, people are at increasing risk of developing diseases as they age. Ageing can be thought of as an accumulation of changes over the life course that increases frailty (Healthy Ageing Evidence Review).

Healthy ageing is a concept promoted by WHO that considers the ability of people of all ages to live a healthy, safe and socially inclusive lifestyle. It recognises the factors beyond health and social care that have a major effect on health and well-being, and the contribution that must be made by all sectors with an influence on the determinants of health. It also embraces a life course approach to health that recognises the impact that early life experiences have on the way in which population groups age. Healthy ageing may be considered as the promotion of healthy living and the prevention and management of illness and disability associated with ageing, (Healthy Ageing Evidence Review, Age UK, 2011). In seeking ways of addressing healthy ageing the WHO has set out an "Age Friendly Communities" policy framework based around eight key themes, as follows:

- the built environment;
- transport;
- housing;
- social participation;
- respect and social inclusion;
- civic participation and employment;
- communication and information; and

- community support and health services.

This section of the JSNA is therefore built mainly around these eight themes, with an additional summary of the overall demographic picture in Cumbria and consideration of the needs of key population groups.

4 Policy Context

Achieving the goal of healthy ageing has been part of national government policy for many years, and some significant improvements have been made. However this is a highly complex and multi-faceted area of work and many policy aspirations remain to be realised.

4.1 National Policy Context

4.1.1 Early national standards

The National Service Framework (NSF) for Older People (March 2001) set an aim of extending the healthy life expectancy of older people, with a national standard that 'the health and well-being of older people is promoted through a coordinated programme of action led by the NHS with support from councils'. The National Service Framework (NSF) includes the evidence base for a wide range of health promotion activities for older people with the strongest evidence found for increased physical activity, improved diet and nutrition, and immunisation programmes for influenza.

4.1.2 White papers and reviews

In 2004, Choosing Health placed the emphasis on enabling individuals to make healthy choices and removing barriers for particular communities, including older people. The strongest message was that, with the exception of children and young people, the role of government was to enable healthy lifestyles, rather than to intervene. In 2006, Our Health, Our Care, Our Say repeated the aims for promoting health and well-being in old age as: higher levels of physical activity; reducing barriers; and increasing uptake of evidence-based disease-prevention programmes. Lord Darzi's NHS Review in 2009 emphasised that building an NHS for the future demands a focus on helping people to stay healthy as well as treating them when they are sick. It committed to offering health checks to everyone aged between 40 and 74 over a two-year period (High Quality Care for All, 2008). The Review stressed the importance of investment in prevention in the context of the economic downturn.

4.1.3 5 Year Forward View

The five year forward view published in October 2014 by NHS England highlights issues within the current health care systems and a plan of how to overcome these issues. It sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that wellbeing can be promoted and ill-health prevented.

4.1.4 The Care Act 2014

The Care Act 2014 is the most significant change in social care law for 60 years. It applies to England and replaces a host of out-of-date and often confusing care laws. The legislation sets out how people's care and support needs should be met and introduces the right to an assessment for anyone, including carers and self-funders, in need of support. The changes aim to enable people to have more control over their own lives. Support should be less about firefighting and more about prevention, with the ultimate goal of helping people stay independent.

4.1.5 Better Care Fund

The £3.8bn Better Care Fund (BCF) was announced by the Government in June 2013, to support the delivery of more integrated health and social care. The BCF is a single pooled budget to support health and social care services to work closer together in local areas. It brings together NHS and Local Government resources that are already committed to existing core activity (not new money), and also provides an opportunity to improve services.

In 2015 a joint commissioning board has formally been established as a working group of the health and wellbeing board. This joined-up approach is designed to strengthen health and care in Cumbria for patients and service users.

4.2 Local policy context

4.2.1 Success Regime

The Success Regime is part of the Five Year Forward View and provides national support for the most challenged health areas. This additional support will be used to deliver the programme to achieve short-term improvements against quality, performance and financial targets, support longer-term transformation and the development of appropriate new care models, and to develop leadership capacity and capability across the health system. In Cumbria it is Building on the Together for a Healthier Future programme.

4.2.2 The Better Care Together Strategy

'Vanguard' communities have been selected by the NHS New Care Models Programme, to help deliver the NHS Five Year Forward View. Better Care Together made a successful application to be a Vanguard community.

Better Care Together is designed to provide high quality joined-up healthcare to communities in South Cumbria and North Lancashire. Providing high quality joined-up healthcare means that patients get the right interventions, in the right places, at the right times, by the right people. Chances of success are improved greatly through working together with colleagues and partner organisations. The Health and Social Care organisations that deliver services across the bay have united under the banner of "Better Care Together" to co-design high quality adult, children's and mental health services, that will be safe affordable and fit for the future,.

4.2.3 Draft Commissioning Strategy for Care and Support delivered by Adult Social Care 2015-2020

This draft commissioning strategy sets out high level proposals for how Cumbria County Council proposes to shift the balance of care to meet the growing needs of local people with reduced levels of funding. It sets out the challenges that the Council faces in delivering adult social care in the next five years.

It has been produced as the basis for wider engagement about how the Council, partners, providers of social care, community groups and local people can work together to ensure they look after the growing number of older and vulnerable people with a reducing budget..

4.2.4 Ageing Well Working Group

The Cumbria Ageing Well Working Group is a multi-agency partnership, which meets every 2 months and whose role includes providing the Health & Wellbeing Board with an expert group on ageing and promoting coordination between stakeholders to embed an ageing well approach across Cumbria.

The Group is working towards an overall strategic approach to ageing well and has agreed to focus on the strategic set of 8 themes with international evidence, as set out in the WHO *'Age Friendly Environments'* programme.

5 Population overview

5.1 Demographic structure

There are more people aged 65 year or older in the UK than ever before. Owing to the post-war baby boom of 1946/47, the number of people who reached state retirement age in 2012 increased by 169,000 to 726,069 (ONS, 2015). The number of people turning or aged 65 is expected to initially decline after 2012 before increasing steadily until 2030 when there are projected to be over 800,000 people turning or aged 65; future cohorts are not expected to return to pre-2012 levels for at least the next 25 years (Department for Work and Pensions, 2010).

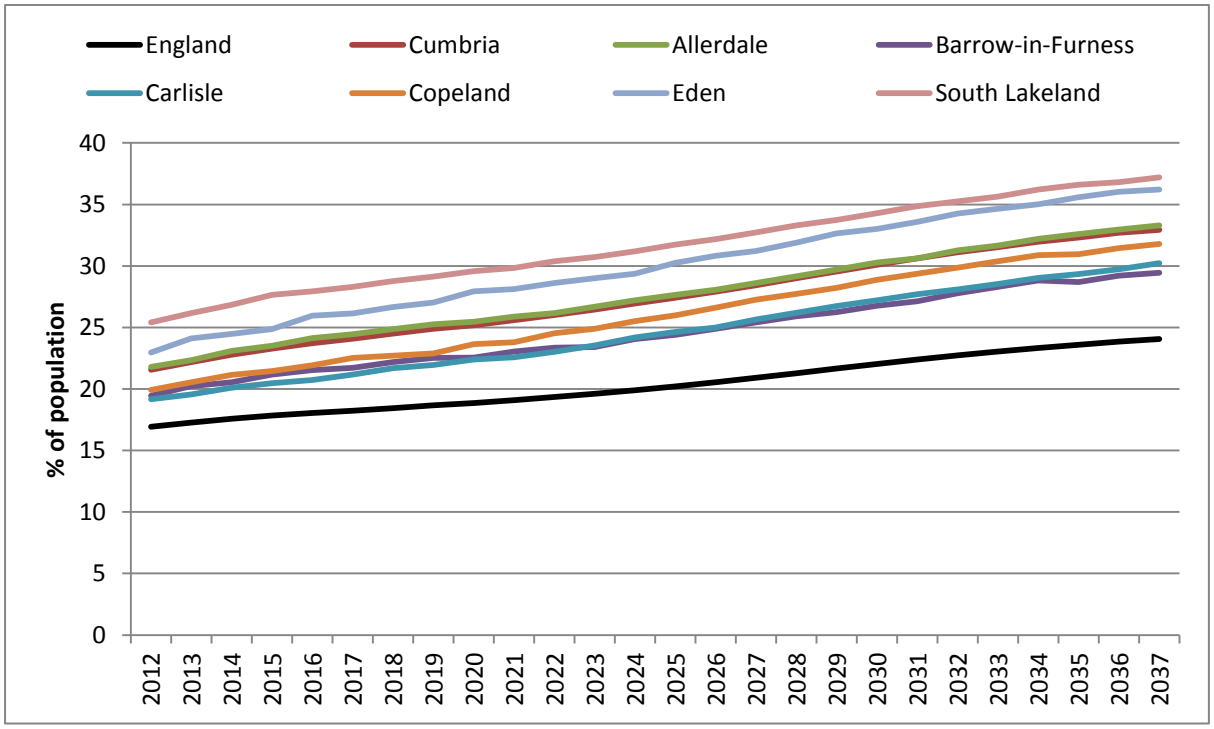
Cumbria has an older population profile than England & Wales, with lower proportions of residents in younger age groups and higher proportions of residents in older age groups. All of Cumbria's districts have older age profiles than the national average, with Allerdale, Eden and South Lakeland having the smallest proportions of younger residents and the greatest proportions of older residents. However, it is important to note that age profiles in some of Cumbria's wards vary considerably from the county and district averages. For example, proportions of residents aged 0-15 years range from 8.5% in Grange North ward to 22.9% in Kendal Kirkland ward, while proportions of residents aged 16-64 range from 43.7% in Grange South ward to 72.4% in Castle ward and proportions of residents aged 65+ range from 12.4% in Penrith West ward to 46.9% in Grange South ward.

Cumbria's population is ageing rapidly, particularly in rural areas. Since 2003, the number of residents aged over 65 has increased by over 20%, a faster increase than the national average of 17%. In addition the number of young people aged 14 and under has decreased

in Cumbria over the last decade by 9.0% compared to an increase of 4% in England and Wales.

Numbers of residents aged 65+ in Cumbria and England are projected to increase year on year to 2037. By 2017, numbers of residents aged 65+ in Cumbria will increase by 12,300 persons (+11.4%) (England +11.6%); and the proportion of residents aged 65+ will increase to 24.1% across Cumbria, the 6th greatest proportion of all counties (England 18.2%). All Cumbrian districts will have greater proportions of residents aged 65+ than the national average.

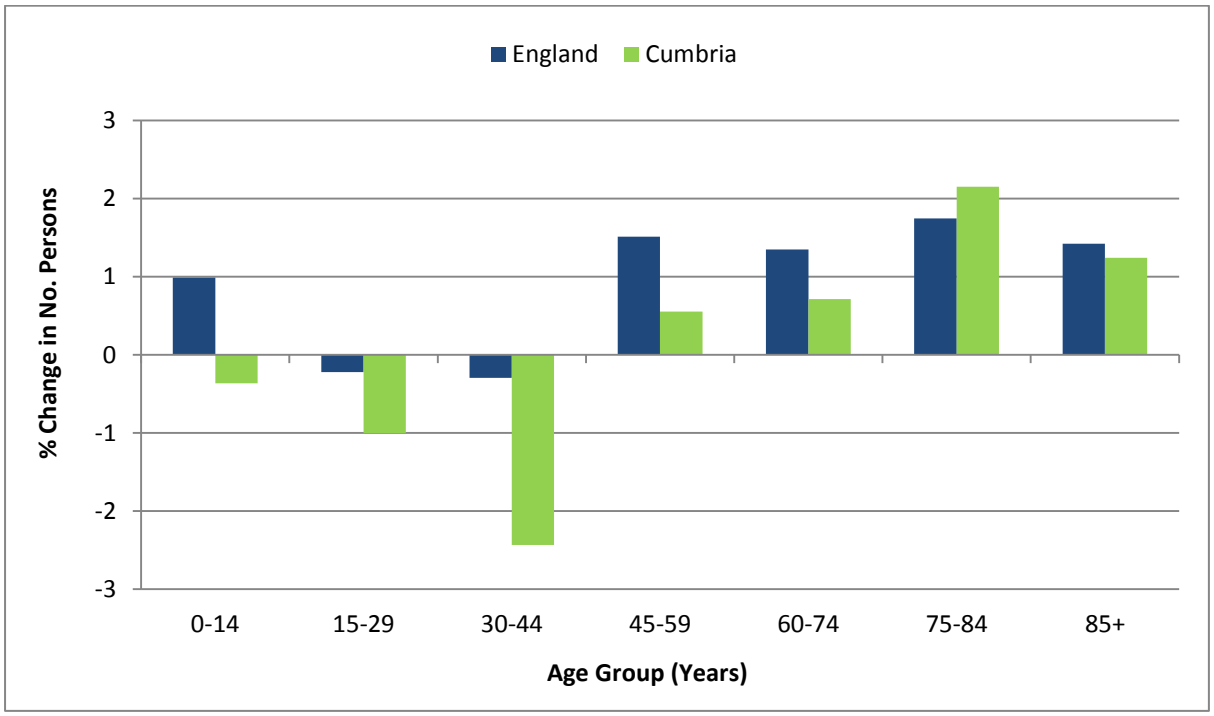
Figure 1: projection of proportion of residents aged 65 years or over by county, district and England; 2012 – 2037



Source: 2012 based Sub-National Population Projections, Office for National Statistics

The most recent population estimates (mid-2013) show that in Cumbria numbers of residents in each of the four oldest age groups (45-85+ years) have increased (see Figure 2). The county's increases in residents aged 45-59, 60-74 and 85+ years were less pronounced than the national average, however Cumbria's increase in 75-84 year olds was more pronounced than the national increase.

Figure 2: Mid-2012 to Mid-2013: % change in no. persons by age group, Cumbria and England



Source: Mid-2013 Population Estimates, Office for National Statistics

According to the mid-2013 census, the population of the United Kingdom (UK) was 64.1 million, of which 22.8 million were people aged 50 years and over (ONS, 2015). Cumbria is the second largest county in England but is the second least densely populated. In 2013, the population of Cumbria was just under half a million (498,070) but the proportion of people aged 50 years and over was 43.5%, which was substantially higher than the proportions for both the North West (36.2%) and the UK (35.5%), as displayed in table 1 (Mid-2013 population estimates, ONS, 2015).

Table 1: Proportion of people aged 50 years and over for Cumbria and by region and country

Area	**Over 50 population**	**Total population**	**Proportion of population over 50 (%)**
Cumbria	216,633	498,070	43.5
North-West	2,570,970	7,103,260	36.2
England	18,976,687	53,865,817	35.2
England and Wales	20,168,428	56,948,229	35.4
United Kingdom	22,773,508	64,105,654	35.5

Table 2 displays the LAs of Cumbria by age group and population proportions. The most populated LA is Carlisle, followed by South Lakeland and Allerdale; the LAs with the highest proportions of people aged 50 years or more are South Lakeland and Eden (48.5% and 46.2% respectively).

Table 2: Cumbria residents aged 50 years and over by Local Authority and age group, with total population and proportion of total population (Mid-2013 population estimates, ONS, 2015).

Local Authority	50-59	60-69	70-79	80-89	90+	Over 50 population	Total population	Proportion of population over 50
Allerdale	13,801	13,686	9,171	4,611	907	42,176	96,208	43.8
Barrow in Furness	9,265	8,708	5,983	2,739	612	27,307	67,831	40.3
Carlisle	15,139	13,270	8,921	4,802	1,016	43,148	107,949	40.0
Copeland	10,478	9,326	6,207	2,977	534	29,522	70,019	42.2
Eden	7,767	7,947	5,234	2,762	579	24,289	52,607	46.2
South Lakeland	15,308	16,356	10,917	6,266	1,344	50,191	103,456	48.5
Total	71,758	69,293	46,433	24,157	4,992	216,633	498,070	43.5

(TIGG Cumbria Injuries in Older People Report May 2015)

The GP registered population as of July 2014 showed 43% of Cumbria CCG population was aged over 50 years, similar proportion to ONS figures.

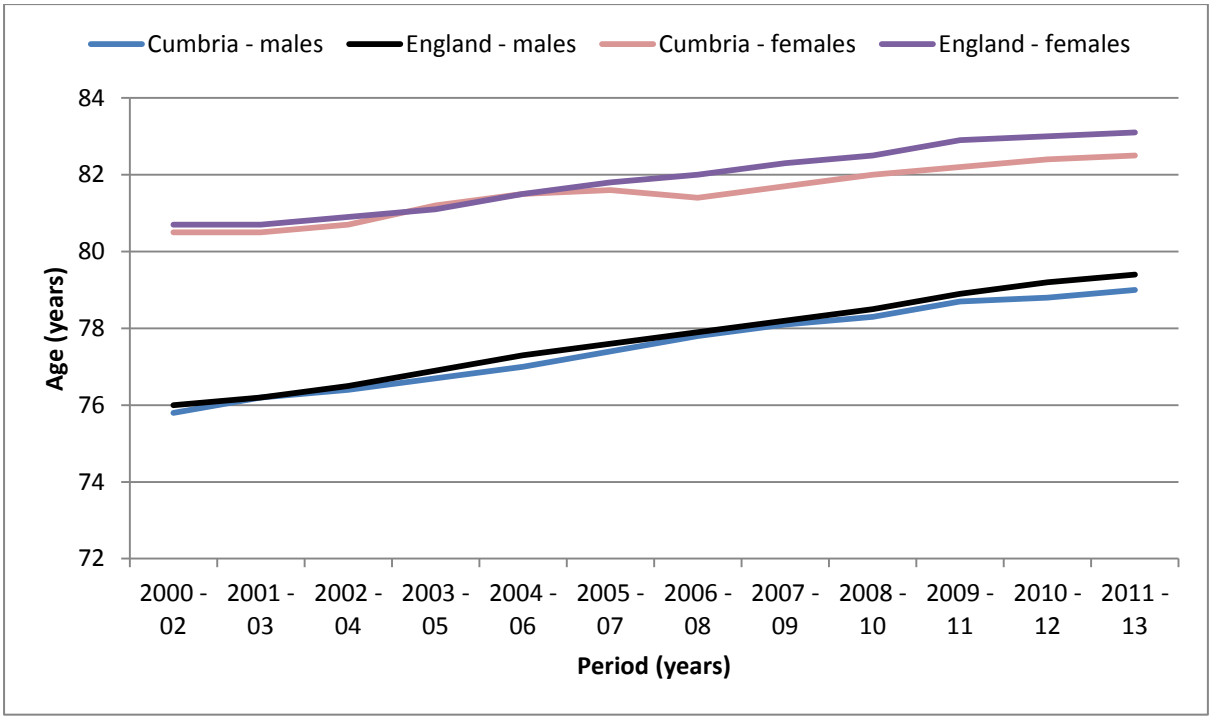
5.2 Life Expectancy

Cumbria's overall performance in a range of health and wellbeing indicators disguises significant inequalities in health outcomes. Life expectancy for both males and females is slightly below the England average. In Cumbria the life expectancy (from birth) for a male is 79.0 years compared to 79.4 for England; the life expectancy for a female is 82.5 years compared to 83.1 for England. There is variation across the districts: for example males living in Barrow-in-Furness can expect to live to 76.9 years, compared to 80.8 years for those living in South Lakeland. Furthermore, the difference in life expectancy between the most and least deprived areas in Cumbria is 9.5 years for males and 7.3 years for females.

Healthy life expectancy is a measure of the average number of years a person would expect to live in good health. The average healthy life expectancy for a male living in Cumbria is 62.7 years compared to England at 63.3 years; for females it is 63.6 years, similar to England at 63.9 years. In addition to this, data on life expectancy at age 65 is available - for males it is similar to England at 18.7 years; however, although the number of years is greater for females at 20.8 years it is below the England average of 21.1 years.

Life expectancy is increasing and it is likely that the number of people living with long term conditions is likely to increase also, however, in order to reduce this risk it is key to improve health outcomes and improve quality of life.

Figure 3: Life Expectancy at birth of males and females: Cumbria and England



Source: Public Health Outcomes Framework, Public Health England

5.3 Lifestyles and Health

People who find it difficult to have a healthy lifestyle are more likely to develop long term conditions. The role of lifestyle factors, such as physical activity, nutrition and diet, smoking, alcohol and drugs play a significant part in influencing a person's health and wellbeing. Eating a healthy diet, doing regular exercise, not smoking and not drinking too much alcohol can help you stay well and enjoy a long life (Source: NHS Choices).

The Healthy Living and Lifestyles Chapter of the JSNA cover these in greater detail and can be found at http://www.cumbriaobservatory.org.uk/health/JSNA/2015/homepage.asp.

6 Falls

6.1.1 Introduction

Unintentional injuries, particularly falls, are the most frequent type of injury suffered among older people in the UK. Falls comprise the majority of injuries among older people (DoH, 2001) and can cause bone fractures, head traumas and can increase the risk of early death (NCIPC, 2014). Every five hours in England an older person dies as a result of a fall and fall-related injuries are the leading cause of death among older people (DoH, 2009). Falls and the result of falls and fear of falling are significant cost pressures with health and social care. It is essential that people have prevention services alongside post falls awareness.

6.1.2 Who is at risk and why

Groups at elevated risk of falls, or adverse consequences of them, are elderly people (aged 75 years or older), inactive people, and people living in relative isolation. People who have existing health problems are also at elevated risk of suffering unintentional injuries and resulting adverse consequences. Falls can precipitate admission to long-term care and people aged 65 and over spend four million days in hospital each year as a result of falls and fractures (Royal College of Physicians, 2011). Falls can also result in hypothermia, pressure-related injuries and infection (DoH, 2001). The consequences of falls are not just physical; the fear of subsequent falls can severely limit daily activities, patients may also experience social isolation and depression due to loss of mobility and an increase in dependency (DoH, 2001).

6.1.3 What is the level of need and gaps / what does local data tell us

Cumbria consistently has a rate of persons injured due to falls aged 65 and over significantly lower than England: in 2013/14 the rate was 1,695 per 100,000 in Cumbria compared to 2,064 per 100,000 in England. This equates to 1932 emergency admissions in Cumbria for falls admissions in 2013/14. (Source: PHOF)

North West Ambulance Service (NWAS) data indicates that falls comprise approximately 88% of all injuries serious enough to warrant an ambulance call out for people aged 50 years and over.

In a Local Authority with a population of just over 100,000, such as Carlisle, there would normally (using England rates) be approximately 5,600 falls among older people each year. Approximately 800 of those will attend an Emergency Department (ED), and 400 will sustain a fracture, of which just under one third will be a fracture of the hip (DoH, 2009). In terms of the economic costs, falls alone cost the National Health Service (NHS) in England £1.8billion a year and the direct cost of a hip fracture is estimated to be £10,000 before the cost of social care (DoH, 2009). Effective falls prevention services could facilitate direct savings to LAs such as Carlisle, South Lakeland and Allerdale of just under £90,000 over five years.

Between April 2011 and March 2014, there were 36,849 total attendances to Cumbria Emergency Departments (EDs) by people aged 50 years and over; of these 33,820 (92%) were Cumbria residents. The highest number of injury attendances of people aged 50 years

and over was to Cumberland Infirmary (17,324) followed by West Cumberland Hospital (10,764) and Furness General Hospital (4,453).

Twenty nine percent (9,797) of all injury attendances were made by people aged 50-59 years, of which 51% (5, 017) were male. Older age groups were comprised of increasing proportions of females; 59% of attendees aged 70-79 years, 65% of attendees aged 80-89 years and 73% of attendees aged 90 years or over. Females accounted for 57% (19,190) and males accounted for 43% (14,630) of injury attendances of people aged 50 years and over to Cumbria EDs between April 2011 and March 2014.

The majority (92%) of injury attendances were recorded as 'other injury' however falls were not categorised at Cumbria EDs and are likely to compromise a substantial proportion of this injury group. Four percent of injury attendances were for road traffic collisions, 2% were for deliberate self-harm and 1% were for assaults and sports injuries.

In terms of incident location, 65% of injuries (21,954) occurred in the home, 24% (7,950) occurred in 'other' locations, 8% (2,762) occurred in a public place and 3% (1,115) occurred at a place of work.

Cumbria EDs (and Royal Lancaster Infirmary) do not currently categorise falls, which compromise the main injury group among older people, particularly those aged 65 years and over. While it is assumed that the majority of 'other injuries' are falls, especially among older age groups, it would be useful for the purpose of prevention and treatment to distinguish between falls and other accidents therefore, consider mechanisms to enable the further categorisation of unintentional injuries to include falls.

6.1.4 Current Services and Assets including projections

- slipper exchanges
- falls prevention events
- Postural stability courses run in west Cumbria
- Numerous exercise, sitting exercise , Tai chi, Pilates and similar community based groups

6.1.5 Evidence of what works

NICE clinical guideline *CG161 Falls: assessment and prevention of falls in older people* offers evidence-based advice on preventing falls in older people. All people aged 65 or older are covered by all guideline recommendations. People aged 50 to 64 who are admitted to hospital and are judged by a clinician to be at higher risk of falling because of an underlying condition are also covered by the guideline recommendations about assessing and preventing falls in older people during a hospital stay.

Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service.

This assessment should be part of an individualised, multifactorial intervention. Multifactorial should include:

- Identification of falls history
- Assessment of gait, balance and mobility, and muscle weakness
- Assessment of osteoporosis risk
- Assessment of the older person's perceived functional ability and fear relating to falling
- Assessment of visual impairment
- Assessment of cognitive impairment and neurological examination
- Assessment of urinary incontinence
- Assessment home hazards
- Cardiovascular examination and medication review

Following the assessment the most effective intervention is a multifactorial one carried out by a suitably trained professional. In successful multifactorial intervention programmes the following specific components are common:

- Strength and balance training
- Home hazard assessment and referral
- Medication review with modification/withdrawal
- Education and information, either written or oral

A Cochrane review (2012) of interventions for preventing falls in older people living in the community (Gillespie et al, 2012) concluded that multifactorial interventions assess an individual's risk of falling, and then carry out treatment or arrange referrals to reduce the identified risks. Overall, current evidence shows that this type of intervention reduces the number of falls in older people living in the community but not the number of people falling during follow-up. These are complex interventions, and their effectiveness may be dependent on factors yet to be determined.

Interventions to improve home safety appear to be effective, especially in people at higher risk of falling and when carried out by occupational therapists. An anti-slip shoe device worn in icy conditions can also reduce falls.

Taking vitamin D supplements does not appear to reduce falls in most community-dwelling older people, but may do so in those who have lower vitamin D levels in the blood before treatment.

A Cochrane review (Cameron et al, 2010) of interventions for preventing falls in older people in nursing facilities and hospitals concluded that there is evidence that multifactorial interventions reduce falls and risk of falling in hospitals may do so in nursing care facilities. Vitamin D supplementation is effective in reducing the rate of falls in nursing care facilities. Exercise in subacute hospital settings appears effective but its effectiveness in nursing care facilities remains uncertain.

A Cochrane review (Turner et al, 2011) determined that there is insufficient evidence to determine whether interventions focussed on modifying environment home hazards reduce injuries.

7 Long Term Health Conditions

7.1.1 Introduction

A Long Term Condition is defined as a condition that cannot, be cured, but can be controlled by medication and other therapies. Examples of long term conditions are diabetes, dementia, depression, heart disease and chronic obstructive pulmonary disease. The good news is that these conditions can often be prevented.

7.1.2 Who is at risk and why

Everyone is at risk of developing a long term condition. Research shows that very few people have just one condition and as age increases so does the likelihood of additional conditions that affect the ability to age well and live life independently. As the number of people over 65 continue to increase and particularly those aged over 85, the need to understand how to live well with not only the main long term condition but also the impact of other related conditions (often referred to as comorbidities) greatens. People with comorbidities disproportionately live in deprived areas, where physical environments are less conducive to community engagement and residents have access to fewer resources of all kinds (Naylor et al., 2012).

One of the consequences of chronic conditions can be mental health problems, which further deteriorate health outcomes and reduce quality of life (Naylor et al, 2012). There's an assumption that mental health problems are a 'normal' aspect of ageing but most older people don't develop mental health problems, and they can be helped if they do. While a significant number of people do develop dementia or depression in old age, they aren't an inevitable part of getting older. More older people are affected by depression in later life than any other age group, this is because older people are much more vulnerable to factors that lead to depression, such as: being widowed or divorced, being retired/unemployed, physical disability or illness, loneliness and isolation.

Diabetes is a common life-long health condition. There are 3.3 million people diagnosed with diabetes in the UK and an estimated 590,000 people who have the condition, but don't know it. Contributing factors for diabetes include - the ageing population, levels of overweight, obesity and physical inactivity that are above the national average and consumption of fruit and vegetables that are below the national average.

Dementia is characterised by progressive deterioration of mental faculties ending in severe incapacity. A person may live with dementia for several years, initially with mild dementia and progressing to severe. Dementia usually affects older people and becomes more common with age. About 6 in 100 of those over the age of 65 will develop some degree of dementia, increasing to about 20 in 100 over the age of 85. Dementia can develop in younger people but is less common, affecting about 1 in 1,000 people under the age of 65, (Cumbria County Council, 2012-14).

There is increasing evidence that lifestyle behaviour may also have a role to play in the prevention of Alzheimer's disease. Recent research (Norton S, Mathews F, Barnes D, Yaffe K, Brayne C Potential for primary prevention of Alzheimer's Disease- an analysis of population based data, 2014) suggests that potentially one third of cases of the disease could be attributable to modifiable risk factors including physical activity, smoking,

hypertension, obesity and diabetes, followed by depression (NICE guidelines [NG16] Published date: October 2015).

Nationally, the number of people living with sight loss is projected to increase, it is therefore important to consider the needs of people with (or at risk of) sight loss when planning services provision.

7.1.3 What is the level of need and gaps / what does local data tell us

An estimated four million people in the UK (34% of people aged 65-74 and 48% of those aged 75+) have a limited longstanding illness. This equates to 40% of all people aged 65+ in England (Life in the UK factsheet, Age UK, 2013). In Cumbria 19.8% of residents have a long term health problem or disability; this is above the England average of 17.2%. Levels are greater than the national average in all Cumbrian districts, with the greatest levels being in Barrow-in-Furness where almost 1 in 4 people (24%) have a long-term health problem or disability. 36.5% of Cumbrian residents aged 50+ years have a long-term health problem or disability, in line with the national average; this increases to 46.2% in Barrow-in-Furness and 39.4% in Copeland. Just over half of all residents aged 65+ years have a long-term health problem, just under the national average. In Barrow-in-Furness this increases to 61.4%. There are more females than males who have a long-term health problem or disability, 20.9% compared to 18.7% it is the same picture for older people, 52.8% of females aged 65+ compared to 48.7% of males. An area (lower super output area) within the Harbour ward in Copeland has the greatest proportion of residents who have a health problem or disability at 38.1%; in Allerdale it is an area within the Moss Bay ward; in Barrow-in-Furness it is an area within the Hindpool ward; in Carlisle it is in an area within the Morton ward; in Eden Penrith Pategill; and in South Lakeland in Grange. *Source to be confirmed*

The NHS Health Check is a sophisticated check of a person's heart health. Aimed at adults in England aged 40 to 74, it checks their vascular or circulatory health and works out their risk of developing some of the most disabling – but preventable – illnesses. Crucially, the NHS Health Check will assess a person's risk of developing these health problems and can detect potential problems before they do real damage and give personalised advice on how to reduce it. It offers advice and support in order to enable people to make lifestyle changes that can reduce their risk of developing disease. In 2014-15, 40,040 people in Cumbria were offered an NHS Health Check. At 23.5% of the eligible population this was higher than the national achievement of 19.7% or the North of England achievement of 17.9%. In the same year, 16,700 people in Cumbria received a health check. At 10.0% of the eligible population, this was higher than the national achievement of 9.6% or the North of England achievement of 8.8% (NHS Health Check Website, Public Health England, June 2015).

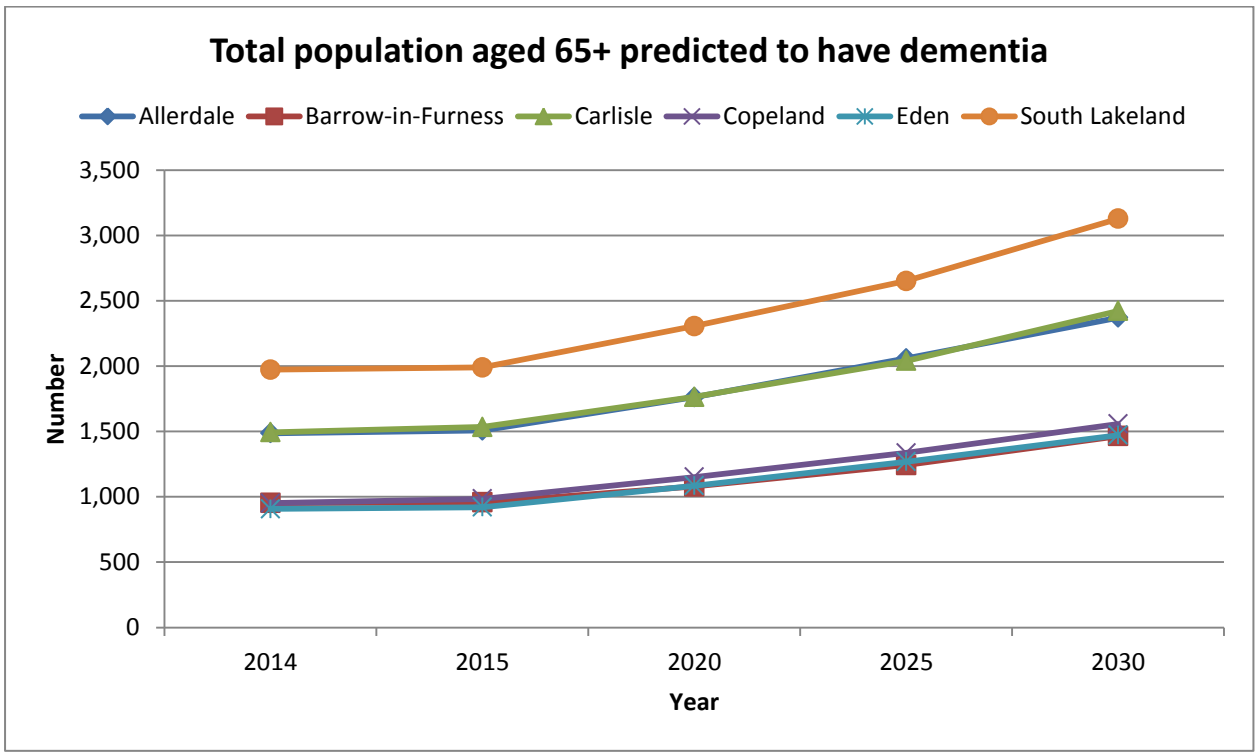
Of the 16,700 people in Cumbria receiving a health check in 2014-15, around 3.5% (584 people) were diagnosed with Hypertension and 0.4% (67 people) were diagnosed with Chronic Kidney Disease (CKD). Around 36% of those who received a health check required additional screening to check if they were at risk of Type 2 Diabetes. Of these, around 7% (381 people) were subsequently diagnosed with Type 2 Diabetes and a further 27% (1,345 people) were diagnosed with Non-Diabetic Hyperglycaemia, a condition which can develop into Diabetes (Local PRIMIS data, extracted from GP systems, September 2015).

The National Cardiovascular Intelligence Network records the prevalence of Type 2 Diabetes in Cumbria at 6.6%, higher than the national average. However, because of under-reporting,

the actual prevalence is estimated at around 7.6%, suggesting that around 31,000 people in Cumbria may have Type 2 Diabetes (Cardiovascular Disease Profile: Diabetes. PHE/NCVIN, March 2015). NHS England estimate that a further 12.3% of the population in Cumbria (aged 16+) may have non-diabetic hyperglycaemia, amounting to around 51,000 people (NHS Diabetes Prevention Programme (NHS DPP) Non Diabetic-Hyperglycaemia. NHS England/NCVIN August 2015). This places Cumbria within the worst decile in the country.

There are an estimated 7,721 people living with dementia in Cumbria with around 1,800 being diagnosed each year and this number is expected to rise substantially as our population ages, to 12,410 in 2030. Although the population of Cumbria is expected to decrease slightly over the next 25 years, the number of people over the age of 65 is expected to increase by 50%.

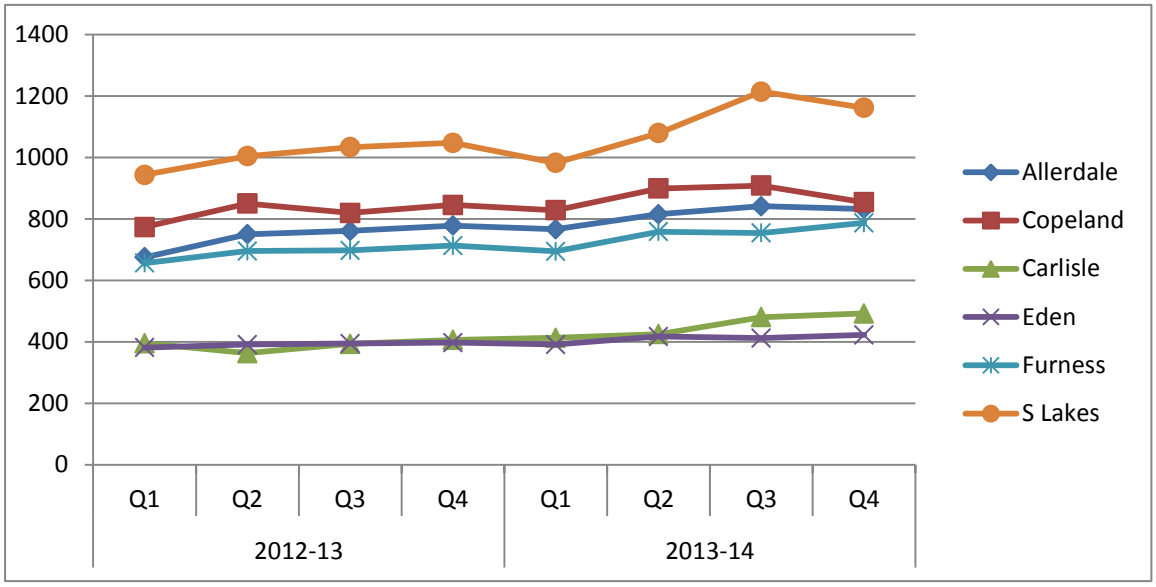
Figure 4: Total population aged 65+ predicted to have dementia, 2014 – 2030, by district



Source: Projecting Older People Population Information System (POPPI)

Throughout 2013/14, 4,548 people resident in Cumbria were registered on the Dementia Quality and Outcomes Framework Register, the greatest proportion of those (1 in 4 people) live in South Lakeland (1,161). 12% of those registered with dementia had received anti-psychotic drugs; while a rate of 0.92 per 1,000 of those aged 65 years+ had a non-elective hospital spell with a diagnosis of dementia (any diagnosis); this rate is more than doubled in South Lakeland. The average hospital stay is 23.1 days; this number almost trebles for residents in Eden (61 days). Throughout 2014/15 In North Cumbria University Hospitals NHS Trust, there were 1,052 patients aged 75 and over admitted as an emergency for more than 72 hours and of those more than half (683, 65%) were identified as potentially having dementia (Source: Dementia Data Collection, NHS England).

Figure 5: The number of people on dementia registers in Cumbria, 2012-14



Almost two million people in the UK are living with sight loss that has a significant impact on their daily lives. In Cumbria there are an estimated 17,760 people living with sight loss, of those 2,150 are living with severe sight loss (blindness). The estimated prevalence of sight loss in Cumbria is 3.6%, compared to 2.9% in the UK. By 2020, the number of people living with sight loss in Cumbria is projected to increase to 21,660; while the number of people with severe sight loss are projected to increase to 2,710. The older you are the more likely you are to be living with sight loss and are more likely to have other health conditions or disabilities. Nationally, 1 in 5 people aged 75+ are living with sight loss compared to 1 in 2 aged 90+. In Cumbria, 13,995 people living with sight loss are aged 65+, of those 26% are aged 65-74 years; 36% are aged 75-84 years; and 39% are aged 85+. 1,260 (0.6% of the total 50+ population) people in Cumbria aged 50+ are registered blind, while 1,525 (0.7%) are registered partially sighted. (Source: Royal National Institute of Blind People; Sight Loss Data Tool http://www.rnib.org.uk/knowledge-and-research-hub-key-information-and-statistics/sight-loss-data-tool). In 2012/13 the rate of admissions for over 65s cataract surgery was 4094.6 per 100,000 population for Cumbria CCG which is in the highest quintile of rates for all CCGS in England (Source: NHS atlas of variation 2015).

In Cumbria in 2015 there estimated to be 49,346 people aged 65 years and over with a moderate, severe or profound hearing impairment. This is predicted to increase to almost 71,000 in 2030, with the majority (32,719) aged 75-84 years. (Source: POPPI). In February 2015 there were 110 people aged 50 and over that were claiming disability living allowance due to deafness. (Source: ONS Crown Copyright Reserved [from Nomis on 26 October 2015).

Some people have dual sensory loss – both hearing loss and sight loss, but there are no figures available to show the numbers of people in Cumbria with dual sensory loss.

7.1.4 Current services and assets including projections

The **NHS Health Check** programme was introduced nationally in 2009 and has been in place in Cumbria since April 2012. There are 79 GP practices and 25 pharmacies in Cumbria providing Health Checks. There is a clear pathway from health checks into Stop Smoking Services in pharmacies and one for weight management referrals.

NHS England recently announced its intention to roll out a **national Diabetes Prevention Programme** (Consultation Guide: National Procurement for the Provision of Behavioural Interventions for People with Non-Diabetic Hyperglycaemia). This will target those identified with symptoms of non-diabetic hyperglycaemia and will focus on three outcomes: - weight loss; achievement of UK dietary recommendations, and; achievement of the UK Chief Medical Officer's physical activity recommendations. Programmes will be systematic and comprised of a series of sessions carried out over a minimum of nine months, and will incorporate behaviour change, goal setting and family/peer support: see https://www.gov.uk/government/publications/diabetes-prevention-programmes-evidence-review and http://www.england.nhs.uk/ourwork/qual-clin-lead/action-for-diabetes/diabetes-prevention/ for further information. Cumbria County Council has submitted an expression of interest to be included in the first wave of the national roll out and, if successful, will work with Cumbria CCG to develop pathways to identify and refer eligible people in to the programme. The programme itself will be commissioned by NHS England.

Fit for the Future is a programme designed to help a person lead a more active and healthy lifestyle and fulfilling life. A Fit for the Future Support worker will visit a person at home to discuss their needs and issues which are important to them and help them to identify areas of their life where they would like support, such as socialising, eating more healthily, physical exercise. They will be given support to explore local opportunities and their support worker will agree with them a plan of action and set achievable goals. Ongoing support and encouragement will be given to the client to help them follow their plan and they will link the client up to other service to meet any additional needs they may have. This is a free service for anyone age 55 + living in the Workington and Maryport areas. The service is for those with long tem health conditions (e.g. diabetes, high blood pressure, COPD) and those who want a more socially included and active later life. A person can refer themselves or be referred by a family member or friend (with their permission). They can also be referred by a GP, Health or Social worker.

Peer Support Groups – Age UK South Lakeland provide a series of dementia peer support groups in Kendal, Milnthorpe and Ambleside. The purpose is to provide information, advice and coping strategies and to promote self-care, independence, wellbeing and choice for people with dementia and their carers. Funding for these groups has now come to an end and next year we aim to support Alzheimer's Society, Dignity in Dementia and South Lakeland Carers in their work.

Dementia Awareness - Age UK deliver dementia awareness training sessions to groups as diverse as local councillors, residents and staff at sheltered housing schemes, local retailers and also to three groups of young people participating in the National Citizens Scheme.

Cumbria Deaf vision provides services, advice and support for people who are deaf in Cumbria.

Services for people with Sight Loss - Barrow Blind Society, Carlisle Blind Society, Eden Sight Support, Sight Advice South Lakes and West Cumbria Society for the Blind all work together as Cumbria Societies for the Blind to provide services, advice and support to people with sight loss in Cumbria. They provide resource centres, support groups and activities. They also provide a specialist dual sensory support group in each district of the county for people with both hearing and sight loss (this is funded by the County Council). They provide visual awareness training courses; and they provide sensory awareness training courses (in conjunction with DeafVision).

7.1.5 Evidence of what works

Research suggests that early diagnosis and intervention is important in increasing the quality of life and life expectancy of people with dementia, and that general practice plays a pivotal role in this (Kings Fund, 2010, GP Inquiry Paper: Managing People With Long Term Conditions).

Health Checks is a mandated programme developed by Public Health England (PHE) and based on existing evidence of preventing cardiovascular disease. For more information on evidence base see - www.healthcheck.nhs.uk.

The NHS Diabetic Eye Screening Programme aims to reduce the risk of sight loss by early detection and treatment (if needed) of diabetic retinopathy and maculopathy. The NHS Diabetic Eye Screening Programme is coordinated and led nationally as part of Public Health England. Screening is delivered locally by NHS England and private providers in line with national quality standards and protocols. All patients in the GP diabetic register aged 12 and over should be enrolled in their local eye screening programme. The local service organises the call and recall process, screening and surveillance clinics results letters and hospital referrals.

7.1.6 Case study

Growing evidence from worldwide research shows that dance really can help people with dementia, helping to improve concentration and responsiveness as well as overall mobility, and can enable people to express themselves more fully.

Dance can help people living with dementia lead more active, independent and fulfilled lives. The Dancing Recall ‘Making Connections’ programme offers specialised community dance classes that are safe, structured and great fun. Activities are designed to foster greater control and ease of movement, stimulate positive memories and a sense of belonging. A wide range of colourful equipment is used, alongside story and song to create a sense of familiarity and place. All these elements together create a joyful experience for everyone involved. The aim is to help those affected by dementia and their caregivers to lead more fulfilling and active lives. Classes take place across all six districts in Cumbria.

The programme refers to the latest NICE guidelines on health and social care and combines key clinical principles of neuro-physiotherapy with best practice in community dance. The programme also offers support and training for healthcare providers, care workers and dance practitioners.

The programme offers a highly cost effective, innovative solution to the huge challenge placed on the health and care services to offer stimulating physical and mental activity to the vast numbers of people now living with dementia. The sessions have limited funding. Dancing Recall ‘Making Connections’ programme won an NHS North West Award for integrated working last year.

PART 2: AGE FRIENDLY COMMUNITIES

8 Outdoor spaces and Buildings

8.1.1 Introduction

A healthy community is a good place to grow up and grow old in (Source: National Planning Policy Framework). The built environment is important to healthy ageing. We need to recognise that there are increasing numbers of older persons living alone, who may be less mobile. Older people who live in an unsafe environment or areas with multiple physical barriers are less likely to get out and therefore more prone to isolation, depression, reduced fitness and increased mobility problems. Hazards in the physical environment can lead to debilitating and painful injuries among older people. Injuries from falls, fires and traffic collisions are most common (Source: Healthy Ageing Evidence Review Age UK).

Older residents may wish to downsize within their existing community where they have an established informal networks of support but have to relocate because of the lack of suitable housing or are forced to move to an unfamiliar area to access services.

One of the key factors often over looked in maintaining health and wellbeing is that of feeling safe in your home and your community. Not feeling safe leads to depression, isolation and sometimes lack of money and the ability to heat and eat.

8.1.2 Who is at risk and why

The outside environment and public buildings have a major impact on the mobility, independence and quality of life of older people and affect their ability to “age in place”. The built environment should connect older people to services, activities, and other people (Source: Healthy Ageing Evidence Review Age UK) in order to do so account should be taken of what the barriers to connectivity are.

Within Cumbria the challenges faced by our communities to age well vary between the rural and built environment. Connectivity to services in rural areas is a challenge. In rural areas older residents, particularly those who have lived in an area for some time, rely initially on informal community networks but it is suggested that these informal networks are weakening – eroded by an influx of residents who were unfamiliar with the ‘rural community’ way of life, or by the loss of communal meeting spaces (Source: DEFRA 2013 Rural Ageing Research Summary Report of Findings).

8.1.3 What is the level of need and gaps / what does local data tell us

Essential features for age friendly communities, outdoor spaces and buildings include

- public areas which are clean and pleasant;
- green spaces and outdoor seating are sufficient in number, well-maintained and safe;
- pavements are well-maintained, free of obstructions and reserved for pedestrians;

- pavements are slip resistant, are wide enough for wheelchairs and have dropped curbs to road level;
- pedestrian crossings are sufficient in number and safe for people with different levels and types of disability, with non-slip markings, visual and audio cues and adequate crossing times;
- cycle routes are segregated from pedestrian walkways;
- outdoor safety is promoted by good street lighting, police patrols and community education;
- services which are situated together and are accessible;
- special customer services are arranged; buildings are well-signed outside and inside, with sufficient seating and toilets, accessible elevators, ramps, railings and stairs and slip resistant floors; sufficient public toilets that are accessible, clean and well maintained (Source: Checklist of Essential Features of Age- Friendly Cities).

Dementia friendly communities replicates the above with more specific requirements around signage, lighting, flooring, toilet design, availability and design of seating and navigation landmarks (Source: Local Government Association: Innovations in Dementia "Developing dementia friendly communities – Learning and Guidance for Local Authorities").

Standards that may be achievable in an urban area may be difficult in a rural area and vice versa. The challenge is identifying how the built environment is excluding rather than who it is including.

Current local data gap – Where are the dementia friendly communities in Cumbria?

8.1.4 Current Services and Assets including projections

Public areas which are clean and pleasant – Cumbria is known for its stunning environment and within its towns are well maintained parks. Parks can be developed to be a playground for all and green gyms can be set up in open spaces. Vulcans Park in Workington has an outdoor gym and a run for life jogging trail.

Street cleaning is done by the local authorities. Allerdale has a "spot the grot" campaign allowing members of the public to report via smart phones, litter problems.

Cumbria has very good air quality with few designated air quality management areas these being restricted to small areas within Carlisle, Penrith and Kendal. *(Check Copeland?)*

Cycle Routes - Cycling is growing in popularity. Cycling can be preferred to other forms of exercise as it is easier on joints. The Cumbria cycling map identifies family-friendly traffic free routes, which are the quieter roads, the National Cycle Network and where you can go mountain biking.

There are numerous bike hire companies and electric bikes for hire, predominantly in the National Park, but also in towns such as Maryport.

Services are situated together and are accessible - Cumbria has many good well-resourced community buildings. It is recognised that in rural areas community buildings are important and are underused. Good access to community buildings is important in the community they serve such as safe travel routes, parking.

Cumbria County Council is looking at developing locally based hubs which would provide access to core services and create opportunities for social interaction (Source: CCC Annual Public Health Report 2014).

Public Toilets - Public toilets have traditionally been provided by local authorities, however as there is no legal requirement for them to do so, some toilets have been closed or taken over by other organisations. Within Eden and South Lakeland businesses or community groups have agreed to members of the public using their facilities when they are open, with no need to make a purchase.

Planning decisions - Local planning authorities should ensure that health and wellbeing, and health infrastructure are considered in local and neighbourhood plans and in planning decision making. Public health organisations, health service organisations, commissioners and providers, and local communities should use this guidance to help them work effectively with local planning authorities in order to promote healthy communities and support appropriate health infrastructure (Source: Planning Practice Guidance).

In Eden a volunteer group supported by the District Council called “Helping to improve access for all” looks at planning applications and advises.

- Handypersons schemes
- Rogue traders e.g. CAB campaign, trading standards campaign, door stickers

8.1.5 Evidence of what works

A Guide: Global Age Friendly Cities, 2007 (WHO) is a guide to help towns and cities see themselves from the perspective of older people in order to identify where and how they can become more age friendly. In terms of Outdoor spaces and buildings the following changes ought to be made (WHO, 2007):

1. Pleasant and clean environment
2. Importance of green space
3. Somewhere to rest
4. Age-friendly pavements
5. Safe pedestrian crossings Accessibility
6. A secure environment
7. Walkways and cycle paths
8. Age-friendly buildings
9. Adequate public toilets
10. Older customers

For more detail:
http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf

8.1.6 User views

How safe do people feel (over 50s Cumbria and districts)? Cumbria Constabulary have just completed a Public Consultation Survey – *awaiting results for inclusion*

Anti-social behaviour victim ages (over 50s Cumbria and districts). It is known that historically most ASB victims (those who report) are aged 18-30years. *Requested from Cumbria Constabulary*

9 Transportation

9.1.1 Introduction

Transport should be easy for everyone to use. The top objectives of the older and disabled national concessionary fares policy were to reduce social exclusion in older people and ensure that bus travel in particular remains within the means of those on limited incomes and of those with mobility difficulties. Making sure that access to buses, coaches, trains and taxis is hassle-free for all will reduce the number of car journeys and therefore help to reduce carbon emissions.

9.1.2 Who is at risk & why

In Cumbria transport is a major issue as there are a number of barriers facing older people including the limited public transport infrastructure; the relative isolation of many of our rural communities; and the low population numbers to support sustainable services. The most dominant factor affecting transport use is health status rather than age. For many older people driving or travelling as a passenger can be a helping hand to maintaining independence and preventing isolation. Accessible and affordable public transport is a key factor influencing active ageing. Cumbria has a large land mass which is overwhelmingly rural; 54% of Cumbria's residents live in rural areas compared to 18% across England & Wales. Allerdale and Eden have the greatest proportions of residents living in rural areas (72% and 71% respectively), while Carlisle has the smallest proportion, although at 27% this is still greater than the national average. The vast majority (98%) of the most deprived LSOAs in England are in urban areas but there are also pockets of deprivation across rural areas. Cumbria is not as deprived as other counties within the North West of England but, owing to the dispersed nature of the population, the true level of deprivation of residents in rural areas can be difficult to define by traditional methods. The geographical barriers to services score was produced by the Department for Communities and Local Government (DCLG) in order to consider the physical proximity of local services to communities. In Cumbria 84 communities rank amongst the 10% most deprived in England in relation to geographical barriers to services. Furthermore, 44 communities in Cumbria rank within the 3% most deprived in the country for geographical barriers to services, with areas of Crummock, Seascale, Lyne and Skelton wards ranking in the top 25 most deprived out of 32,482 areas.

9.1.3 What is the level of need and gaps / what does local data tell us

NoW cards are transport smart card issued to residents across the county and are available to older people of pensionable age as concessionary travel (free travel). As at March 2015, Cumbria County Council had issued a total of 92,776 NoW cards to residents aged 60+, accounting for around 63% of Cumbria's total 60+ population. The greatest number of NoW cards issued was in the district of South Lakeland, however, levels of take-up were greatest in the districts of Barrow-in-Furness (70%) and Carlisle (68%).

Nationally, around 31.8 million people in England hold a full driving licence, of those around 83% of adults are aged 50-59years; 81% are aged 60-69years; and 62% are aged 70+. Males are more likely to hold a licence than females: 89% of males aged 50-59 years compared to 78% of females; and 80% of males aged 70+ compared to 47% of females.

Numbers of driving licence holders are increasing and have been over the last 10 years (The National Travel Survey).

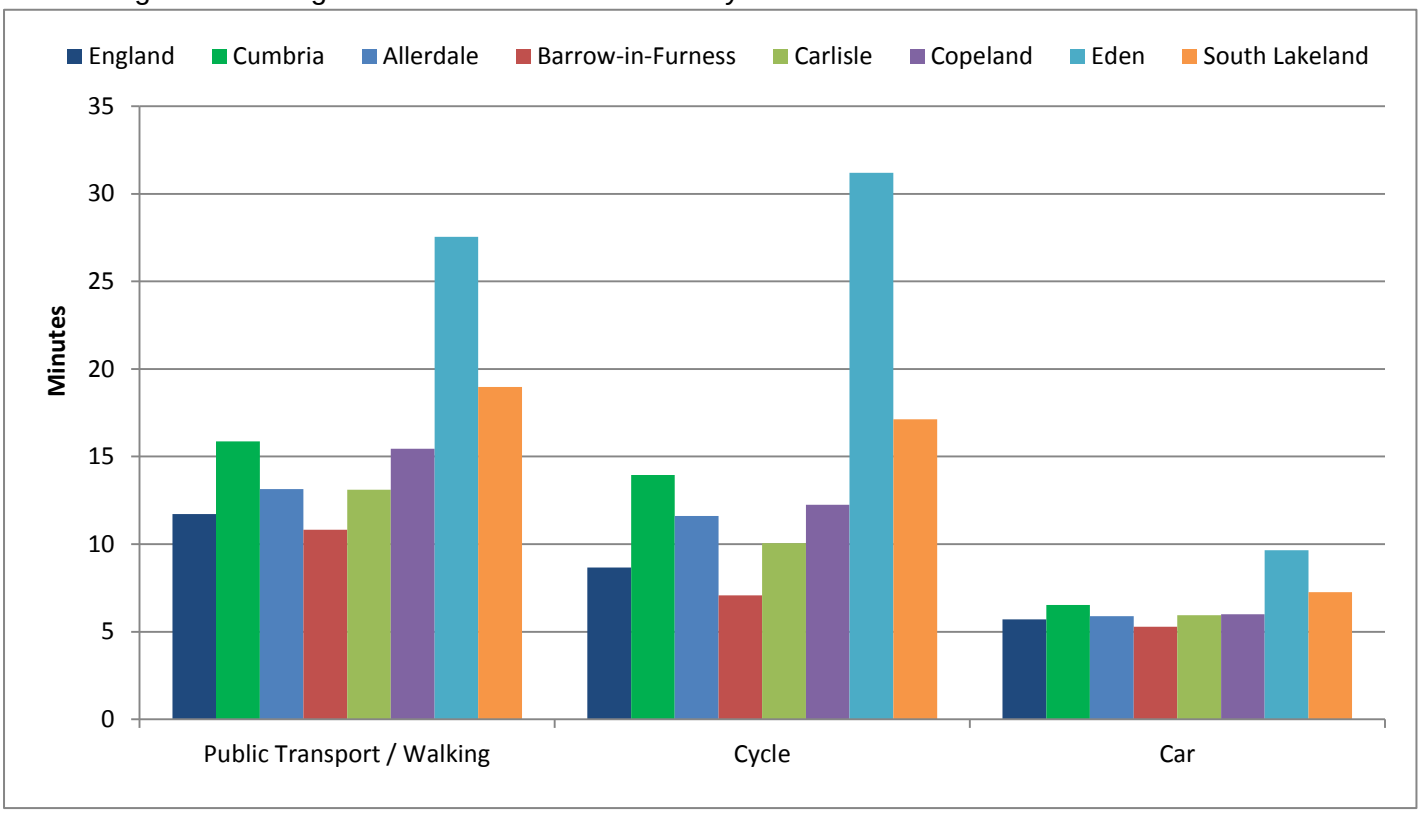
More than 169,000 Cumbrian residents aged 50+ have access to a car or van, equating to around 82% of all 50+ residents; while more than 36,000 residents do not. Proportions of residents with no access is greater in urban areas, perhaps where public transport is more readily available, in particular in Barrow-in-Furness where 1 in 4 (25%) residents do not have access to a car or van. In Eden this falls to 11% where it is likely that those in rural areas would have to have access to a car or van in order to get around and access services. Around 46% of 50+ residents in Eden have access to more than 2 cars or vans, almost double the proportion of residents in Barrow-in-Furness.

More 50+ females than males (almost double) do not have access to a car or van: 23,612 females compared to 12,862 males, reflecting the national picture. There are slightly fewer residents aged 50+ with access to a car or van than there are of those aged 18-49 years, 82% compared to 86%.

There are not enough volunteer car schemes and those that are available struggle to meet the need.

The graph below plots the average minimum travel time to reach a range of key local services (employment centres, primary schools, secondary schools, further education institutions, GPs, hospitals, food stores and town centres), by three modes of transport, for England, Cumbria and districts.

Figure 6: Average Minimum Travel Times to Key Local Services:



Source: Department for Transport (DfT), Accessibility Statistics, 2013.

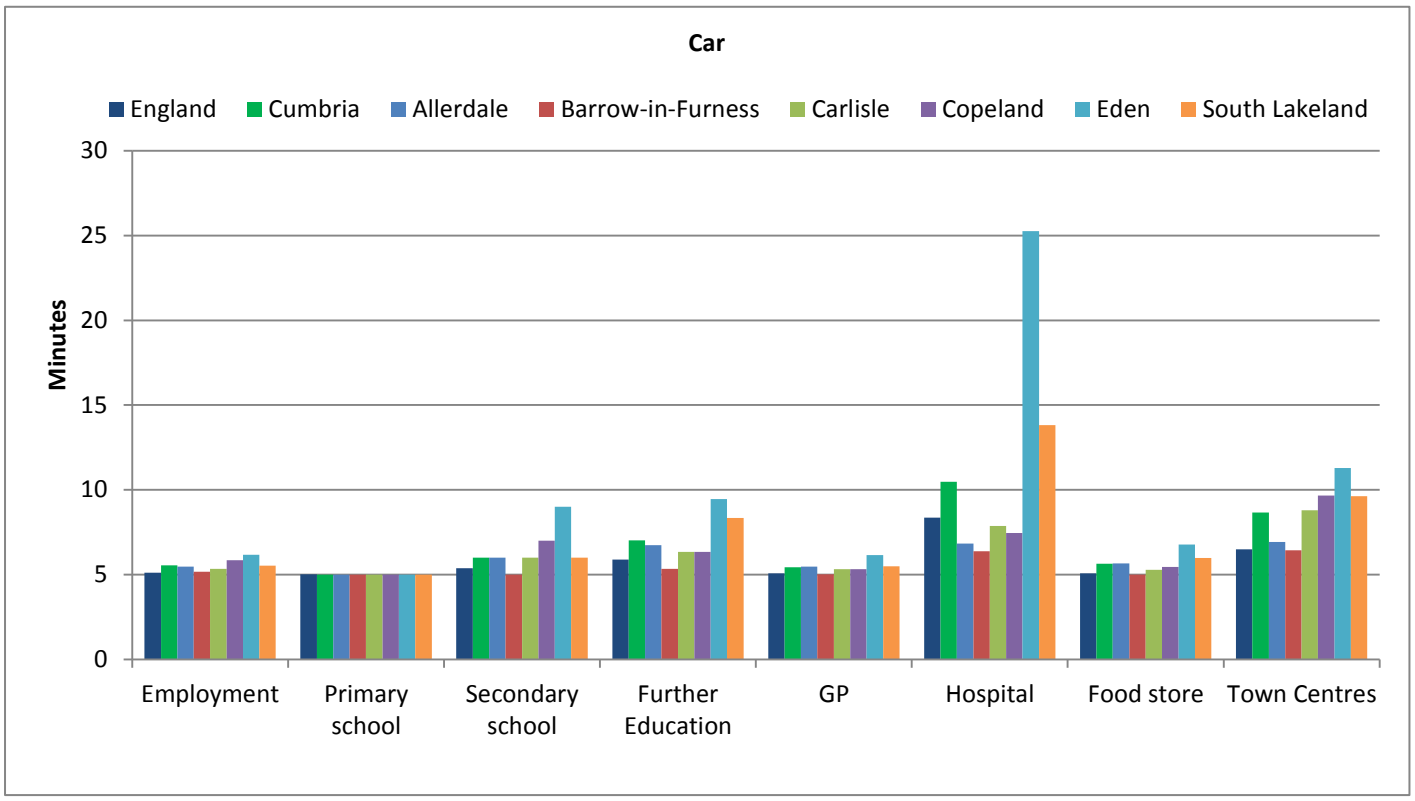
In Cumbria the average minimum travel time to reach key local services is 16 minutes by public transport / walking, 14 minutes by cycle and 7 minutes by car. This is longer than the national averages of 12 minutes by public transport / walking, 9 minutes by cycle and 6 minutes by car, suggesting that key services are less accessible in Cumbria than they are nationally.

Cumbria's districts varied considerably in the accessibility of key services. Of Cumbria's districts, Eden had the longest average travel times to key services; 28 minutes by public transport / walking, 31 minutes by cycle and 10 minutes by car (the 2nd longest times for each mode out of all Local Authorities (LAs) in England). Inversely, Barrow-in-Furness had the shortest average travel times (11 minutes by public transport / walking, 7 minutes by cycle and 5 minutes by car).

As 54% of Cumbria's residents live in rural areas compared to just 18% of the population nationally, it is perhaps reasonable to expect that the county's access times will be longer than the England average. When compared to LAs with similar population densities, average travel times in Allerdale, Barrow-in-Furness, Carlisle and Copeland appear to be relatively short, while South Lakeland's average travel times seem comparable. However, Eden's average travel times stand out as being longer than similarly sparsely populated LAs.

Perhaps due to Cumbria's rural nature, figures suggest there is a dependence on car travel in Cumbria. 79% of Cumbria's households have access to at least one car or van compared to the national average of 74%. Furthermore, the greatest proportion of Cumbria's working residents (45%) travel to work by private vehicle; higher than the national average of 41%.

Figure 7: Average minimum travel times to each type of key local service by car.



Source: Department for Transport (DfT), 2013 Accessibility Statistics

In Eden and South Lakeland, hospitals accounted for by far the longest average journey times, while in all other districts town centres accounted for the longest average journey times. There is a great deal of variation within districts in relation to average journey times to key services.

9.1.4 Current Services and Assets including projections

Free local bus travel is a lifeline for many older and disabled people, who use it to get to their GP or hospital appointments, to go shopping and visit friends. However, in our rural county a complete public transport service seems impossible to achieve, therefore we need local solutions supported at local, County and national level within a mixed economy of public, private, community and personal provision.

Northern Fells Rural project - Was one of HRH The Prince of Wales' three Rural Revival Initiative Projects, running from 1999 to 2002. The aims were to: identify unmet health and social need; map existing services; pilot ways to improve services by 'filling gaps'; and evaluate the project. The Project has a **Flexible Minibus Service** for people of any age without transport. 24 voluntary drivers are organised into a rota by the two employed Transport Co-ordinators who work 5 hours a week each, taking bookings and maintaining the minibus. More information: https://www.northernfellsgroup.org.uk/

Western Dales Bus is a community bus service, run by volunteers and covering 10 parishes in Sedbergh and Kirkby Lonsdale Local Area Partnership. It provides a mini-bus service at weekends on routes which are not commercially viable and the bus is also available for private hire by charities and community groups. The bus service links Dent and Dent Station with the service centres of Sedbergh and Kendal. Work to support this bus route started in 2011 when Cumbria County Council withdrew their subsidy to the existing Saturday service. Dent Parish Council agreed to replace the subsidy themselves to keep the service going and raised £8,400 from a range of grants and donations. This continued the service for a year while they considered how to sustain it longer term, which they have now achieved. More information: www.dentdale.com/CommunityBus.htm

9.1.5 Evidence of what works

The World Health Organization Global Age Friendly Cities Guide 2007 provides the evidence base having identified a number of key findings with regards to transportation for age friendly communities:

- Affordability - Public transportation costs are consistent, clearly displayed and affordable.
- Reliability - Public transportation is reliable and frequent, including at night and on weekends and holidays.
- Availability - All areas and services are accessible by public transport, with good connections and well-marked routes and vehicles.
- Accessibility - for older people specialized transportation is available for disabled people.

- Roads are well-maintained, with covered drains and good lighting and are free of obstructions that block drivers' vision, traffic signs and intersections are visible and well-placed.

For more detail:

http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf

9.1.6 User views

Many people in rural areas see transport as the number one issue to enable rural people to access services which are concentrated in small towns and urban areas (ACT,2015).

10 Housing

10.1 Older households, Residential Care, Homelessness

10.1.1 Introduction

A safe and warm home that is in good repair is essential and often makes the difference between older people being able to remain active and independent or becoming isolated and falling into ill health. A home that is not safe and unsuitable can be a hazard, making older people liable to trips and falls. These and other hazards in the home can significantly impact on their health and life expectancy, as well as lead to unplanned hospital admissions and admissions to residential care. There has been a significant reduction in the public funds available to help owner occupiers and landlords maintain and renovate their properties and the downturn in the economy since the financial crisis has reduced disposable income making it more difficult for people to maintain their homes.

Older people who continue to live in their family home (of all tenures) are likely to be under occupying and may also struggle to heat their home during winter months. Older people living in homes in the owner occupied sector, who are asset rich and cash poor, may struggle to finance the necessary adaptations to make their homes more suitable to their needs and to help reduce the risk of falls. Those living on their own are more likely to be socially isolated, as a result of limited interaction.

Nationally a third of owner occupiers are over 65 and 93% of those own their home outright. Nearly two-thirds (60%) of the projected increase in the number of households from 2008 to 2033 will be headed by someone aged 65 or over. 35% of the homes occupied by older people (60+) in England fail the decent homes standard (approx. 2.7 million homes). Over 65s are estimated to spend an average 80% of their time in the home; 12% of older people feel trapped in their own home.

10.1.2 Who is at risk & why

As people get older, their housing needs often change. Some people need support to be able to continue living in their own home, which may mean their homes need to be adapted. Other older people become unable to care for themselves or be cared for at home and the only option for them is residential or nursing care homes. There is a link between appropriate housing and access to community and social services in influencing the independence and quality of life of older people.

A study in 2004 identified the main reasons for becoming homeless for the first time in old age. The key reasons from this research were:

- The death of a spouse or carer. Some people abandon accommodation after the death of a spouse. This can be due to distress and depression and/or difficulty coping with household tasks, such as paying the rent and bills.
- Physical and mental health problems. Some people have to stop working because of ill health and subsequently experience financial problems. For others, ill health leads to family and marital problems and relationship breakdown.

- Rent arrears due to Housing Benefit claims or payment problems. Some people become homeless after being evicted for rent arrears, and others leave their accommodation because they cannot afford the rent. In many cases rent arrears are due to problems with Housing Benefit claims.
- Alcohol problems that contribute to relationship breakdown. Heavy drinking is associated with relationship breakdown, which can lead to homelessness.
  (Source: Crane, M, et al, Building homelessness prevention practice: combining research evidence and professional knowledge, Sheffield Institute for Studies on Ageing, University of Sheffield, 2004).

10.1.3 What is the level of need and gaps / what does local data tell us

There are more than 205,700 households across the county with residents aged 50+ years, accounting for 42% of all households in Cumbria. There is a greater proportion of 50+ households in Cumbria then there is in England reflecting the county's older population. Of those households almost 1 in 4 are people living alone. There is a greater proportion of older households in South Lakeland, accounting for almost half of all households (47.2%). There are more female single person households than there are male - this is more apparent in the districts of Barrow-in-Furness and Carlisle. There are just over 8,200 cohabiting couple households aged 50+ in Cumbria, accounting for 4% of all 50+ households, reflecting the national picture and across all districts in the county.

In Cumbria, greater proportions of older people (50+) own or have shared ownership of their property compared to the rest of England, 82% in Cumbria compared to 78% in England. Residents living in Eden and South Lakeland have the greatest proportions of residents who own their property outright at 77%, while Carlisle has the lowest at 71%. Carlisle has the greatest proportion of residents who own or have shared ownership of their property at 29% (Source: Census 2011, Office for National Statistics).

There are 32,398 one person aged 65+ households in Cumbria, accounting for 14.6% of all households. There is a greater proportion of 65+ one person households in Cumbria than in England reflecting the county's older population. South Lakeland has the greatest proportion of 65+ one person households at 16.3%, above both county and national averages. More than half (53.6%) of one person 65+ households are in rural areas across the county; in Allerdale this increases to 71.9%. The wards with the greatest proportions are Grange North and Windermere Applethwaite & Troutbeck in South Lakeland; Christchurch and Silloth in Allerdale; Hawcoat and Walney North in Barrow-in-Furness; Morton and Stanwix Urban in Carlisle; Harbour and Haverigg in Copeland; Appleby and Penrith Pategill in Eden.

Fewer older people rent their property in Cumbria, 18% compared to the rest of England 22%. Allerdale has the greatest proportion of older residents who rent their property at 21%, followed by Copeland at 20%. In Copeland, 73% of older residents rent their property through social housing, while in Eden 62% rent privately or live rent free.

There are around 2,500 people in Cumbria who are in residential and nursing care, 86.4% of those are aged 65+ years; while almost half (49.7%) are aged 85+ years. The greatest proportion of residents aged 65+ who are in residential/nursing care are resident in the districts of Allerdale (20.1%) and Carlisle (20.1%). There is a lower proportion of older people in residential/nursing care in Eden (9.5%).

New admissions to residential and nursing care are increasing and rates are above national levels. Around 93% of new admissions are people aged 65+; while almost half (48.1%) of those are aged 85+. Rates of new admissions are greater in Allerdale and Furness, they are lowest in Carlisle (Accommodation – Residential/Nursing Care (Source: Adult Social Care, District Activity Profile, September 2015).

Homelessness in older adults is not quantifiable in Cumbria currently. Statutory homeless acceptances are not available by age in Cumbria due to the low number and it is acknowledged these figures would be considered to underestimate the true figure due to the statutory acceptance criteria.

10.1.4 Current Services and Assets including projections

Home Improvement Agencies (HIAs) Home Improvement Agencies such as Homelife Carlisle and Age UK West Cumbria provide Handyperson Services and access to help with repairs and adaptations as well as Housing Options advice. These services help older people remain safe and warm at home. They also give access to grants for repairs to heating and energy efficiency measures such as draught proofing. They also help with income maximisation which can make repairs and adequate heating affordable. Currently also both HIAs have Hospital Discharge Workers removing the Housing barriers to discharge but the funding is running out.

Extra Care Housing (ECH) - Cumbria County Council has developed an Extra Care Housing (ECH) Strategy that is compatible with the Cumbria Housing Plan and Investment Strategy 2011-2015. The aim of the County Council ECH Strategy is to enable people in Cumbria to plan for their future and realise their aspirations to live independently. It will complement and support the work of our colleagues in Housing who share this aim. The ECH strategy identifies demand for ECH for older people to be 1800 units (apartments) by 2019 – currently Cumbria has approximately 377 units available for social rent. Cumbria currently has 12 ECH schemes supported by CCC (i.e. provision of care services on site.) CCC is currently working with Registered Housing Providers to develop a further 5 affordable rent ECH schemes due 2015 – 2016 and one mixed tenure scheme in 2015, adding a further 196 units to the current figure.

Health and Social Care Coordinators - This project has been commissioned by the Carlisle Locality Clinical Commissioning Group and is based in Homelife Carlisle, a Home Improvement Agency provided by Carlisle City Council. The project is short term for six months with the possibility of extension should further funding become available. The project is designed to reconnect frail elderly people, at risk of hospital admissions and/or a high level of GP/Health intervention, with their communities overcoming those obstacles/issues which put them at high risk. Patients will be referred from GP and District Nurse Teams. The project also works closely with Hospital Discharge Teams to help remove barriers to discharge where housing issues are key. The team consists of a Team Leader and 5 Health and Social Care Coordinators who work across Carlisle District. The project will also closely link to the Healthy City programme and the Community Assets Working Group, which is attended by many of the third sector and other partners who the project will be working with.

10.1.5 Evidence of what works

A Guide: Global Age Friendly Cities, 2007 (WHO) is a guide to help towns and cities see themselves from the perspective of older people in order to identify where and how they can become more age friendly. In terms of Housing the following ought to be in place (WHO, 2007):

1. Affordability: affordable housing is available for all older people
2. Essential services: essential services are provided that are affordable to all
3. Design:

- Housing is made of appropriate materials and well structured
- There is sufficient space to enable older people to move around freely
- Housing is appropriately equipped to meet environmental conditions
- Housing is adapted for older people, with even surfaces, passages wide enough for wheelchairs appropriately designed bathrooms, toilets and kitchens.

4. Modifications:

- Housing is modified for older people as needed
- Housing modifications are affordable
- Equipment for housing modifications is readily available
- Financial assistance is provided for home modifications
- There is good understanding of how housing can be modified to meet the needs for older people

5. Maintenance

- Maintenance services are affordable for older people
- There are appropriately qualified and reliable service providers to undertake maintenance work
- Public housing, rented accommodation and common areas are well-maintained

For more details:
http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf

10.2 Fuel Poverty

10.2.1 Introduction

Fuel poverty in England is measured using the Low Income High Costs (LIHC) indicator. Under the Low Income High Costs definition, a household is considered to be fuel poor if:

- They have required fuel costs that are above average (the national median level)
- Were they to spend that amount, they would be left with a residential income below the official poverty line.

Unlike the previous indicator measuring fuel poverty (the 10% indicator), the Low Income High Costs definition is a relative measure as it compares households to the national median bill and income – thereby ensuring the contemporary trends are reflected in both these measures.

10.2.2 Who is at risk and why

There is no one significant driver or cause of fuel poverty and many fuel poor households have quite different characteristics. Fuel poverty is evident in households with low incomes where there are high levels of deprivation; equally, some areas are relatively affluent with good levels of household income and low levels of deprivation.

Contributing factors to fuel poverty include the age and condition of a property and levels of income. Unemployed households tend to be fuel poor; lone parent households are more likely to be fuel poor; while single elderly households are least likely.

10.2.3 What is the level of need and gaps / what does local data tell us

In Cumbria there are an estimated 24,682 households in fuel poverty, 10.9% of all households, this is above the national average of 10.4%. The districts of Barrow-in-Furness and Eden have the greatest levels of fuel poverty reflecting low income levels in Barrow-in-Furness, and older properties in Eden.

Areas with the greatest levels of fuel poverty across the county are not areas with the greatest proportions of older people. The greatest levels of fuel poverty fall within the wards of Barrow Island, Central and Hindpool in Barrow-in-Furness; while the greatest levels of older people are within the wards of Grange, Arnside & Beetham and Lakes Ambleside in South Lakeland (Sub-Regional Fuel Poverty Estimates produced by the Department of Energy & Climate Change (DECC), 2013).

10.2.4 Current Services and Assets including projections

Since 2001, the Government has had a legal duty to set out policies that will, as far as possible, cut out fuel poverty. Energy suppliers recognise their responsibilities, especially to the elderly and those on key benefits, and with this in mind suppliers have worked closely with social services, citizens' advice bureaux and charitable groups such as Age UK and Macmillan to consider the best way to help vulnerable customers. A variety of schemes and measures have been introduced. Between January 2013 and March 2015, energy suppliers were expected to spend around £1.3 billion a year on energy efficiency measures via the Energy Company Obligation (ECO). A large part of this money was made available to suppliers' most vulnerable customers, to help them reduce their bills, heat their homes and keep warm (Source: Energy UK 2015).

Warm Homes Fund - Allerdale Borough Council, Carlisle City Council, Eden District Council and South Lakeland District Council were successful in their application to the warm Homes Fund and have received £1,140,000 in government funding to tackle fuel poverty and keep bills low for local people living in homes not connected to the gas grid. The result is that people living in fuel poor households will have central heating installed for the first time. Once installed, central heating can help households save up to £1,000 a year as well as keeping their homes warm more effectively.

Select Energy UK members also fund the **Home Heat Helpline** (0800 33 66 99), a free, not-for-profit phone line set up to help energy customers who are struggling to pay their energy bills and keep warm. It was launched by the Energy Retail Association (now Energy UK) in October 2005 after research revealed that 75% of the most vulnerable customers were not aware of the assistance available from energy suppliers, and only a third would consider

approaching their energy supplier. Since it began, the Home Heat Helpline has received over 300,000 calls from across Britain (Source: Energy UK, 2015).

Cumbria Community Foundation's Winter Warmth Appeal raises funds to help older people across the county stay protected from the cold weather. The Winter Warmth Appeal is now in its sixth year and last year raised £107,000. 900 people benefited from the warm generosity of others. This year the charity hopes to raise even more money to help Cumbria's most vulnerable. The cost of fuel is rising and there are many old, rural homes in Cumbria which cost more to keep warm. It's becoming increasingly harder for people to afford to heat their homes, especially for those that no longer have a steady income. This is why the Winter Warmth Appeal has never been more important. Cumbria Community Foundation is also running The Big Sleep again on Saturday 30 January 2016. The fundraising event challenges people to raise sponsorship and sleep out under the stars in the freezing cold behind The Low Wood Bay Hotel, Windermere.

10.2.5 Evidence of what works

NICE NG6 Excess winter deaths and illnesses associated with cold homes (2015)

This guideline makes recommendations on how to reduce the risk of death and ill health associated with living in a cold home. The aim is to help:

- Reduce preventable excess winter death rates.
- Improve health and wellbeing among vulnerable groups.
- Reduce pressure on health and social care services.
- Reduce fuel poverty and the risk of fuel debt or being disconnected from gas and electricity supplies
- Improve the energy efficiency of homes.

Improving the temperature in homes by improving energy efficiency may also help reduce unnecessary fuel consumption.

10.3 Excess Winter Deaths

10.3.1 Introduction

Excess winter deaths (EWDs) are considered preventable and it is important to protect those who are most vulnerable during cold winter months. Research shows that mortality during winter (December to March) increases more in England and Wales compared to other European countries with colder climates, suggesting that many deaths could be prevented (Source: Office for National Statistics; Excess Winter Deaths Atlas, Public Health England; Public Health Outcomes Framework).

10.3.2 Who is at risk & why

EWD affects all ages but is known to increase with age with the elderly being the most susceptible; therefore areas with a greater older population are more likely to have greater EWD. EWD can be attributed to most main causes of death however circulatory and

respiratory diseases contribute to most EWD - around 70% across England (Source: Office for National Statistics; Excess Winter Deaths Atlas, Public Health England; Public Health Outcomes Framework). In a bad winter, more than 300 people die in Cumbria due to the effects of the cold weather and the elderly are among the most vulnerable (Source: PHOF).

A wide range of people are vulnerable to the cold. This includes:

- people with cardiovascular conditions
- people with respiratory conditions (in particular, chronic obstructive pulmonary disease and childhood asthma)
- people with mental health conditions
- people with disabilities
- older people (65 and older)
- households with young children (from new-born to school age)
- pregnant women
- people on a low income.

The health problems associated with cold homes are experienced during 'normal' winter temperatures, not just during extremely cold weather. Year-round action by many sectors is needed to combat these problems. This includes:

- prioritising which homes are tackled first
- shaping and influencing the decisions about how homes are improved
- developing the research agenda

10.3.3 What is the level of need and gaps / what does local data tell us

During the period 2010-2013 there were 775 EWD throughout Cumbria, an index of 15 which was below the England index of 17.4. Across Cumbria, EWD are highest in the districts of Carlisle and South Lakeland, despite this, levels are similar to or below England across all districts in the county.

Rates of deaths (all ages) from respiratory disease are below the England average in Cumbria however there are communities, particularly in the West and in Barrow (the wards of Mirehouse, Sandwith, Central) where rates are significantly higher. Under 75 years mortality rates from respiratory disease are an issue in Barrow-in-Furness with rates above national levels; this is reflected in the district of Carlisle also, making those living in these areas vulnerable.

Deaths caused by circulatory diseases (all ages) are also an issue in communities across the county, in Barrow-in-Furness, in particular in the wards of Low Furness and Central, rates are higher than the national average; this is reflected in the wards of Castle and Belle Vue in Carlisle. Deaths (under 75 years) from circulatory disease are a particular issue in Barrow and Copeland, where rates are above the national average; in some communities (Central in Barrow; Clifton in Allerdale; Castle in Carlisle) rates are significantly higher than England.

The greatest proportion of older people (65+ years) and therefore those who are most vulnerable are in the south of the county in South Lakeland, particularly communities in the

areas of Grange and Arnside & Beetham. Across the districts, the greatest proportion of older people communities fall within the wards of Silloth, Keswick, and St. John's in Allerdale; Hawcoat, Walney North and Dalton South in Barrow-in-Furness; Morton, Wetheral and Belah in Carlisle; Gosforth, Harbour and Seascale in Copeland; Appleby, Eamont, and Kirby Stephen in Eden (Source: Office for National Statistics; Excess Winter Deaths Atlas, Public Health England; Public Health Outcomes Framework).

10.3.4 Current Services and Assets including projections:

The Cold Weather Plan for England provides information on the health effects of cold weather and sets out actions to be taken by the NHS, social care and other agencies. Various national policies are in place to help prevent EWD for example winter fuel payments, warm home discount schemes, green deal project and the flu vaccination programme. In addition to this local communities are encouraged to help and support those most vulnerable by checking on them during severe weather.

10.3.5 Evidence of what works:

NICE guideline *NG6 Excess winter deaths and illnesses associated with cold homes* (2015) makes recommendations on how to reduce the risk of death and ill health associated with living in a cold home. The aim is to help:

- Reduce preventable excess winter death rates.
- Improve health and wellbeing among vulnerable groups.
- Reduce pressure on health and social care services.
- Reduce 'fuel poverty' and the risk of fuel debt or being disconnected from gas and electricity supplies
- Improve the energy efficiency of homes.

9 Social Participation

9.1.1 Introduction:

Social participation and social support are strongly connected to good health and well-being throughout life.

Wherever you live in Cumbria you will be part of a community; urban, rural, estate, residential home, prison, school, work place. Participating in leisure, social, cultural, and spiritual activities in the community, as well as with the family, allows older people to continue to exercise their competence, and to enjoy supportive and caring relationships. It also fosters social integration which is key to staying informed and reducing isolation

Research has shown that feeling useful can be key to enjoying later life. For some people this is about supporting their family, supporting the community, representing the community of interest and for others it is utilising skills in new and exciting ways like volunteering.

9.1.2 Who is at risk and why

There are currently one million older people who are socially isolated in the UK; this number is projected to increase 2.2 million in the next 15 years (IPPR, 2008). Among older people, owing to the discrepancy in life expectancy, there are more females living alone than males, particularly among older people (Age UK, 2010). Social isolation may result in mental health problems, such as depression and anxiety, and reduced levels of physical activity, both of which can lead to elevated risks of suffering injuries and poorer outcomes when injuries are incurred. Social isolation may be physical, where individuals are sedentary within their homes, and in terms of community engagement; individuals who participate more within their communities are at lower risk of suffering unintentional injury but are also better engaged with healthcare services (Vellas et al., 1997).

People can be very isolated in rural areas as there are more limited opportunities for interaction. Participation is often hindered by access to transport and therefore facilities, affordability and limitations of the range of activities on offer and awareness of activities and events in their community Transport is a key factor in socialisation as interaction is easier when there are social activities close to home.

Connecting older people back to their communities and activities is a crucial part of any ageing well strategy.

9.1.3 What is the level of need and gaps / what does local data tell us

These data relate to returns from a survey undertaken by Cumbria CVS in Spring 2009. The survey was sent out to all registered charities in Cumbria, with a response rate of 21% (500 returns). The results from the survey show that there are approximately 50,000 volunteers providing support through registered charities across Cumbria, providing on average 1 hour 25 minutes per week (may not be 50,000 individuals but person may volunteer at more than one organisation. Volunteers who are resident in Barrow and Carlisle provide more volunteering time/hours than those in the rest of the county. Volunteers in Copeland provide the fewest hours/time. Around 55% of volunteers are female and 45% are male. Volunteers who provided information about their age 68% of those were aged 50+ years. Allerdale

district has the greatest proportion of older volunteers accounting for 73% (Source: Cumbria Third Sector Census, 2009).

9.1.4 Current Services and Assets including projections:

Community Exchanges like the Crossthwaite Exchange - Regular community-led events that bring people together, provide services and information and reduce social isolation. Exchanges can be an opportunity to provide basic services and should be relatively easy to sustain and make self-financing.

Good Neighbour Schemes being developed in various parts of the County through NCI partners and other schemes, encouraging informal community neighbourly acts such as putting out the bins, offering lifts, collecting or ordering shopping locally and on-line.

Neighbourhood Care Independence Programme (NCI) uses an Asset Based Community Development (ABCD) approach to provide low level support to vulnerable and older people in Cumbria through partnerships of over 30 third sector organisations working together. The key aim is to enable people to retain their independence for as long as possible through a range of interventions that can be preventative or rehabilitative. Support can include Befriending Services, Hospital Aftercare, small aids and adaptations (including hearing aids) handyperson services and volunteer led activity. In 18 months NCIP had helped 29,689 people (almost 20,000 being over 65) and with 23,103 instances of NCIP clients participating in social inclusion activities.

Community Neighbours is a volunteer befriending project targeted at the frail elderly, run by Carlisle City Council. Community Neighbours provides a range of opportunities designed to improve quality of life, reduce isolation and loneliness and keep older people independent and active for as long as possible in the communities they helped create. The scheme has 68 Volunteers and 51 Live Partnerships.

Age UK South Lakeland's Village Agent Programme using part-time paid staff embedded in communities close to where they live. Village Agents work with the local community to support existing and develop new activities to meet the needs of the area including lunch clubs, job clubs, social groups, exercise classes, swimming and walking groups, IT groups, Men U Can Cook, reading groups and craft clubs. Diverse intergenerational activities including working with the police and local teenagers to renovate benches and regular school lunch clubs also form part of the programme. Village Agents organise one off events to cascade information out to the community and invite partners to attend. Over 100 volunteers are involved. Over 1400 people a month attend an activity supported by a Village Agent and in 2013/14 Village Agents undertook 557 full benefit checks resulting in over £1.1 million of additional benefit income plus 1700 people being referred to Community Officers for more complex support resulting in a further £2.19 million of additional benefit income.

Lunch Clubs - The network of lunch clubs continues to grow both in popularity and size, there are now 38 lunch clubs meeting monthly across the district. As with Men in Sheds, this is yet another example of the power of volunteering. Over 1000 older people benefit from this service every month, yet the organisational support required to maintain this activity considering the size of the service offer is very small. The lunch clubs provide a much needed social opportunity for many clients plus the opportunity to learn what's new and make contact with Age UK if they need support.

9.1.5 Evidence of what works

A study led by the Rotman Research Institute at Baycrest Health Sciences 2014 takes a broad-brush look at all the available peer-reviewed evidence regarding the psychosocial health benefits of formal volunteering for older adults. Key findings:

- Volunteering is associated with reductions in symptoms of depression, better overall health, fewer functional limitations, and greater longevity.
- Health benefits may depend on a moderate level of volunteering. There appears to be a tipping point after which greater benefits no longer accrue. The "sweet spot" appears to be at about 100 annual hours, or 2-3 hours per week
- More vulnerable older people (i.e. those with chronic health conditions) may benefit the most from volunteering
- Feeling appreciated or needed as a volunteer appears to amplify the relationship between volunteering and psychosocial wellbeing.

Database searches identified 113 papers on volunteering benefits in older adults, of which 73 were included. Data from descriptive, cross-sectional, and prospective cohort studies, along with 1 randomized controlled trial, most consistently reveal that volunteering is associated with reduced symptoms of depression, better self-reported health, fewer functional limitations, and lower mortality. The extant evidence provides the basis for a model proposing that volunteering increases social, physical, and cognitive activity (to varying degrees depending on characteristics of the volunteer placement) which, through biological and psychological mechanisms, leads to improved functioning; we further propose that these volunteering-related functional improvements should be associated with reduced dementia risk (Source: Baycrest Centre for Geriatric Care. "Evidence mounting that older adults who volunteer are happier, healthier." Science Daily, 29 August 2014).

9.1.6 User views

Mr W is 78 years old and lives alone in Brampton following the death of his wife. He was originally from Yorkshire but moved to Cumbria for work and is now retired. After attending the NCI Volunteer Information day he decided to volunteer with Carlisle Eden Mind as a Moving on Support Volunteer, offering friendship and support to a lady in her 50's. W received training. Initially just one-to-one, they now meet up with two other befrienders and befriendee's. W also volunteers with the Carlisle Carers with their lunches for carers and is going to be an Ambassador for the charity. W feels now he has a sense of purpose in life and this has improved his health and well-being. He has encouraged and supported his befriendee and over a period of 4 months he supported his befriendee to stop smoking, which was amazing to see. They are now both aiming for the befriendee to increase their confidence and self-esteem so that they too can become a befriender and to help others. W said, "It is very rewarding, satisfying and a pleasure to help others and thoroughly recommends volunteering to others. Often people think volunteering is about helping a charity but in fact volunteering also helps volunteers themselves. It's about helping you to get a sense of routine in your life, meeting others, and offering friendship support and encouragement to others, whilst also helping yourself", (Source: Neighbourhood Care Independence (NCI) Programme, 2015).

10 Respect and social inclusion

10.1 Social Isolation

10.1.1 Introduction

A socially inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity. Social exclusion is the process of being shut out from the social, economic, political and cultural systems which contribute to the integration of a person into the community. Loneliness and social isolation are very different: social isolation is the physical act of not seeing any one day in day out.

10.1.2 Who is at risk and why

Older people report experiencing conflicting types of behaviour and attitudes towards them; On one hand, many feel they are often respected, recognised and included while on the other, they experience lack of consideration in the community, in services and in the family.

Giving older people a voice and ensuring that they are able to fully be part of their communities is important not only for them but for the health of their neighbourhoods.

Social isolation and loneliness can affect an individual at different stages of life. Certain individuals or groups may be more vulnerable to social isolation than others, particularly those with physical disabilities or poor mental health. There are many factors which contribute to social isolation (and loneliness) including: age; low levels of education; poor or lack of employment; low levels of income; ethnicity; gender; living alone; loss of spouse/partner; poverty and deprivation; and geographical barriers. It is important to recognise that it is not only single person households which face social isolation, families who find it hard to access services can become or feel just as isolated. There are links between health and social inequality and social isolation (Source: Public Health England: Local Action on health inequalities; Reducing social isolation across the life course).

10.1.3 What is the level of need and gaps / what does local data tell us

Isolation, loneliness and poor social relations are major factors contributing to the exclusion of older people. It is estimated that social isolation affects about 1 million older people and has a severe impact on people's quality of life in older age (Age UK "Loneliness and Isolation Evidence Review").

Geographical Barriers included in Transport and Access (p.20)

Long-term health/disabilities included in Long-term Health Conditions (p.68)

Loss of spouse/partner widowed included in Loneliness (p.40)

Overall deprivation: Cumbria has 29 communities that rank within the 10% most deprived of areas in England, with 8.5% of the county's population living in the 29 communities. Furthermore, twelve communities rank within the 3% most deprived nationally, with 3.6% of the county's population living within these twelve communities. These communities are located in the wards of Central; Hindpool; Barrow Island and Ormsgill in Barrow; Sandwith in Copeland; Upperby and Belle Vue in Carlisle; Ewanrigg and Moss Bay in Allerdale.

Health Deprivation and Disability: The Health Deprivation and Disability domain within the Indices of Deprivation measures the risk of premature death and the impairment of quality of life through poor physical or mental health. It measures morbidity, disability and premature mortality. There are 55 communities across the county which rank amongst the 10% most deprived in England, with 17 of these communities falling within the 3% most deprived in the country. These communities fall within the wards of Hindpool, Central, Newbarns, Ormsgill, Barrow Island and Walney North in Barrow; Harbour and Sandwith in Copeland; Moss Bay in Allerdale; and Upperby and Morton in Carlisle.

Income Deprivation Affecting Older People Index (IDAOPI): The Income Deprivation Affecting Older People Index is a supplementary index which represents the proportion of people aged 60 and over living in income deprived households. It considers a range of benefits including income based benefits; working tax credits; and pension credits. There are 8 communities that rank within the 10% most deprived of areas in England, these include areas that fall within the wards of Moss Bay in Allerdale; Hindpool, Newbarns, Ormsgill and Walney North in Barrow; Belle Vue and Upperby in Carlisle; and Sandwith in Copeland.

Adult Social Care Users Survey – social contact: The '% of adult social care users who have as much social contact as they would like' indicator is included in both the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework. Throughout 2014-15, in Cumbria, 48.2% of people who use adult social care services reported that they had as much social contact as they would like, this is greater than the England average of 44.8%. 43.2% of adult carers reported they have as much social contact at they would like, this is also greater than the national average of 38.5%.

10.1.4 Current Services and Assets including projections

Older People's Forums are a way of older people engaging with topics that are of interest and importance. The OPFs provide routes to engagement but also encourage mutual respect between individuals for the positive contributions they make

Community Asset Based Development approaches are a way of increasing the involvement of older people in local activities. Carlisle Community Assets group is a sub group of Carlisle's Healthy City programme. The group connects statutory bodies with third sector organisations and community groups sharing and publicising activities and events. They have recently started a Facebook Group page to share the activities and events wider.

Village Support Team (VST) meetings are held in each area and comprise of the Village agent, Volunteers linked to the project (e.g. Lunch Club Co-ordinators, Exercise Class Leaders, Bridge Builders, Welfare Benefit Volunteers, General Social Group Leaders, etc.) and invited representatives from local groups such as WI. The idea is that the VST helps to direct the work of the Village Agent programme for example several VSTs have raised concerned about the number of people living with dementia in their communities and so the VAs and volunteers have been offered training in dementia awareness and new partnerships forged with Dignity in Dementia and Dementia Adventure. Over the next year the aim is to make more of our community based activities suitable for those with moderate dementia to attend.

Combatting social isolation in older men – Age UK (West Cumbria) Men in Workshops

In 2012, Age UK (West Cumbria) started its first Men in Workshops initiative in Millom. The project aimed to reduce social isolation in older men (traditionally a harder-to-reach demographic). Using a shared interest, in this instance woodworking and furniture repair, the group brought isolated men together in a social setting that was familiar.

The scheme has been gradually implemented across West Cumbria, with five groups running currently in Millom, Cockermouth, Workington, Whitehaven, Distington and Kirkbride offering a variety of activities including furniture renovation, bicycle repair and production of products such as garden planters and bird-boxes.

The scheme is supported by Cumbria Mental Health who regards the Men in Workshops scheme as invaluable for improving the social and mental wellbeing of older men suffering from dementia. A Community Psychiatric Nurse regularly accompanies clients to the groups, to enable them to socialise with other men from the community.

The group members report an improvement in positive wellbeing, with increased confidence and self-esteem. Members also learn new skills, with finished products providing income to ensure sustainability of the groups, in addition to projects to The groups have themselves help communities both local (installing bird-boxes in local parkland) and further afield (sending refurbished bicycles to Gambia).

Older communities supporting each other - Age UK Peer Support groups

Peer Support groups have been ran by Age UK since November 2013, with 4 groups running in the Allerdale & Copeland areas. The groups provide an opportunity in the community to support people to reduce social isolation, build confidence, find friendship and a place to discuss, concerns, health problems and fear of losing independence. Additionally, the service is a valuable intervention and prevention activity, mitigating potential future health and wellbeing issues.

Attendees to the groups provide knowledge, experience, and help to one another, whilst being supported by Age UK staff and volunteers.

The groups are held weekly in residential housing establishments, but are open to all members of the older community, and may be used as a drop-in or as respite time for carers. Additionally, referrals to the group are taken from a variety of sources including Adult Social Care, in addition to signposting to relevant services and activities throughout the Third Sector that would be of benefit to the client.

10.1.5 Evidence of what works

The World Health Organisation Global Age Friendly Cities Guide 2007 provides the evidence base having identified a number of key findings with regards to Respect and Social Inclusion for age friendly communities:

1. Older people are regularly consulted by public, voluntary and commercial services on how to serve them better.
2. Services and products to suit varying needs and preferences are provided by public and commercial services.
3. Service staff have helpful and courteous staff trained to respond to older people

4. Older people are visible in the media, and are depicted positively and without stereotyping.
5. Community-wide settings, activities and events attract all generations by accommodating age-specific needs and preferences.
6. Schools provide opportunities to learn about ageing and older people, and involve older people in school activities.
7. Older people are recognized by the community for their past as well as their present contributions.
8. Older people who are less well-off have good access to public, voluntary and private services.

10.1.6 User Views

Mrs Volunteer 3 visits Mrs Client D (75) - Client D was referred to the project by Hospital at Home. She was recovering from an operation on her leg & was upset at losing her mobility, resulting in loss of independence. She was full of praise for Hospital at Home & would recommend it to anyone. She said "being reduced to sitting in a chair was like a living death". A volunteer has really cheered her up, helping her get out to go shopping & finally start going for short walks. They have even been to Brampton to see a concert. The volunteer is Turkish & wants to improve her English. Client D used to teach English to the Vietnamese boat children in the 70s& is helping her with this; it's a fantastic reciprocal partnership.

"NCI will result in lasting change – we've opened up our centre to people who wouldn't otherwise have used it – everything will become self-sustaining through volunteers and contributions. We've already generated lots of extra volunteer hours…..not that they think of themselves as volunteers, they're just people sharing their passions and hobbies."

"I now feel confident that support is out there for me". A recently bereaved gentleman in his 90s referred to Age UK by hospital rehabilitation team, who received help with finances, housework and re-joining community activities.

(Source: Neighbourhood Care Independence (NCI) Programme, 2015)

10.2 Loneliness

10.2.1 Introduction

Loneliness is a complex and usually unpleasant emotional response to isolation or lack of companionship. Loneliness typically includes anxious feelings about a lack of connectedness or communality with other beings, both in the present and extending into the future.

Loneliness is a deeply personal experience – unique to every individual; a problem with different causes and different consequences for each and every one of us. And that makes addressing loneliness complex. Most of us will experience loneliness at some point in our lives, but for many it will be transitory. Sadly though, for a growing number of older people loneliness defines and devastates their lives.

10.2.2 Who is at risk and why

Three and a half million people aged 65 years or over live alone in England and Wales, (ONS, 2014). Living alone is linked with increased chance of mortality. The subjective feeling of loneliness increases risk of death by 26%, according to the new study in the journal Perspectives on Psychological Science (Source: http://time.com/3747784/loneliness-mortality/#3747784/loneliness-mortality/). Social isolation or lacking social connection and living alone were found to be even more devastating on a person's health than feeling lonely, respectively increasing mortality by 29% and 32%.

Levels of loneliness in the UK have remained relatively consistent over recent decades – with around 10 per cent of those over 65 experiencing chronic loneliness at any given time. However as the population of older people has grown, the absolute number of individuals experiencing loneliness often, or all of the time has increased – leaving more older people experiencing this distressing daily grind.

Over recent years there has been growing public attention to loneliness in our communities and this has been accompanied by a shift in our understanding of its impact – and in particular its implications for mental and physical health. We now know that, for example:

• The effect of loneliness and isolation can be as harmful to health as smoking 15 cigarettes a day, and is more damaging than obesity.

• Lonely individuals are at higher risk of the onset of disability.

• Loneliness puts individuals at greater risk of cognitive decline, and one study concluded that lonely people have a 64 per cent increased chance of developing clinical dementia.

10.2.3 What is the level of need and gaps/what does local data tell us

In Cumbria, there are 29,862 widows or surviving partners of same sex civil partnerships, accounting for 13.4% of all households; this is above the England average of 11.3%. In South Lakeland this increases to 14.1% reflecting the older population. 97.4% of widows or surviving partners are aged 50+ years while 84.4% are aged 65+ years. The ward with the greatest proportion of widows or surviving partners is Penrith Pategill in Eden at 16.1%; followed by the ward of Grange North in South Lakeland at 15.9%. In Allerdale the ward of Silloth has the greatest proportion at 13.3%; in Barrow-in-Furness it is the ward of Hawcoat at 12.8%; in Carlisle it is the Morton ward at 11.6%; and in Copeland it is the Harbour ward at 10.5%.

There are more than 71,700 one person households in Cumbria, equating to 14.6% of all households across the county. Barrow-in-Furness has the greatest proportion of one person households at 15.8%; followed by the district of Carlisle at 15.5%. There is significant variation in communities across the county rural wards such as Grange North and Windermere Applethwaite & Troutbeck in South Lakeland; Appleby and Alston Moor in Eden; where more than a third of all households are one person households.

10.2.4 Evidence of what works

Loneliness is a complex, and often time-consuming, issue to address. However it is an issue that must be addressed due to the far reaching and devastating impacts that it has on those who experience it on a daily basis.

There is a body of research on how strategies and specific services should be designed. Mima Cattan (2002) (AgeUK) comes to the conclusion that older people need to be involved in the planning, development and delivery of activities if they are to target loneliness effectively.

In addition, she finds that:

- much of the provision is inadequate
- and unsuccessful at targeting loneliness
- and isolation
- practical, flexible and low-level assistance
- is often most effective
- individually tailored solutions can yield the
- best results
- flexible transport is key to many schemes.

The design of services needs to be informed by the complexity and inter-relationship of the causes of loneliness (Age UK, Loneliness and Isolation Evidence Review).

10.2.5 Current services and assets including projections

The **Campaign to End Loneliness** inspires thousands of people and organisations to do more to tackle loneliness in older age. It is a network of national, regional and local organisations and people working together through community action, good practice, research and policy to create the right conditions to reduce loneliness in later life. It was launched in 2011, and is led by five partner organisations: Age UK Oxfordshire, Independent Age, Manchester City Council, Royal Voluntary Service and Sense, and work alongside more than 2,000 supporters, all tackling loneliness in older age. This work is funded by the Calouste Gulbenkian Foundation, the Tudor Trust and the Esmée Fairbairn Foundation. (Source: Promising approaches to reducing loneliness and isolation in later life, Kate Jopling, January 2015).

Age UK Barrow & District RespectAbility programme is a free service offering clients the opportunity to engage in a variety of ventures that offer vulnerable adults opportunities to participate in a number of activities that are intended to re-engage those who have become isolated, with very limited social interaction, for whatever reason, learn new skills or further develop existing skills and provide for improvements to their physical and mental health as well as reducing call being made on health and care services. Clients are vulnerable adults over the age of 50 living in the borough of Barrow-in-Furness. There is particular focus on those people with life limiting illness (including dementia), carers and those cared for over 50 hours per week and isolated older men. Personal care is not provided but there are support workers involved to assist clients in being involved in activities and all sessions are run by volunteers.

Clients can participate in a variety of ventures that may be of interest or value to them including:

- beginner level IT courses (how to use the internet, e-bay Skype etc.)
- cooking for one +1
- light exercise,
- craft sessions
- reminiscence sessions.

The concept is that if people who are somewhat isolated can re-engage socially there will be health benefits for them, improving their quality of life and many benefits beyond those. We would also hope this will reduce the emergency encounters with health services for those benefiting from RespectAbility as well as improving their general health and well-being. Our objective is to provide opportunities to maximise their own potential, re-empowering them where possible and providing them with positive choices that could improve the quality of their lives.

Age UK SL - Men in Sheds programme is for men aged 50+. It offers a workshop space and companionship, get together with likeminded people every week and work side by side on a variety of different projects like renovating furniture to be sold in our shops; working with other organisations on new items for use in the community; or making something for themselves or family/friends. You don't need to have practical experience – there are lots of shed members with skills they'll enjoy sharing with you. You can learn new skills through free training courses. What you do need is a willingness to get involved and to put some of your free time to practical use. The workshop is based in the Age UK South Lakeland furniture warehouse in Kendal. Members can come along on Mondays, Tuesdays, Wednesdays and Fridays. We also have regular meetings and occasional social trips. The Men in Sheds Group has continued to grow during the year and provides a friendly workshop-based experience for men aged over 50 from Kendal and the surrounding area offering a great deal of enjoyment, fellowship and learning. The group is led by local older men, who not only manage their own project, but provide an open, inclusive and safe environment for those who wish to participate but who are less able. The Men in Sheds project, with the support of a very well organised volunteer team, continues to provide excellent engagement opportunities for older men in the Kendal area. This project provided social engagement for 81 older men during the year.

Age UK West Active Communities project - is jointly funded by Home Group, Copeland Community Fund and Age UK, and is aimed at people living in South Whitehaven and Cleator Moor who are age 50 and over. There are 2 project workers based locally and work in partnership with home group and there aim is to encourage people to become more active in their local communities by supporting them in volunteering roles, or by encouraging then to take part in community activities.

They can help local residents to set up new activities and will support existing local groups with promotion, accessing funding, finding venues and with recruiting new group members. They support campaigns and local events and help people to access information and advice on matters such as financial help, independent living and many other services.

Age UK West Active for Life project- funded by the Big Lottery provides support to those over 50 in Wigton, North Allerdale and Egremont and Mid Copeland in Becoming Active, Boosting Confidence, Enhancing Learning, healthy living, information and advice.

11 Civil participation and Employment

11.1.1 Introduction

Work is good for your health. We live in changing times; the structure of our society is changing, more people are living longer and can expect many more years of healthy life, but despite this, too many people are leaving work prematurely.

One of the key factors in maintaining good health is having enough money to be able to heat and eat but also to be able to make personal choice. This is particularly important as one progresses at each step from retirement to needing personal care support.

Lifelong learning has always been essential to maintain a sense of 'not getting left behind', ability to find new interests, keep in touch and ability to maximise income.

11.1.2 Who is at risk & why

Many people will need to work longer to stay financially independent and fund their retirement, as the default retirement age (formerly 65) has been phased out - most people can now work for as long as they want to as retirement age is when an employee chooses to retire. In the UK of the 2.9m not in work, only about 1m considered themselves retired. Disability (Source: DWP), health conditions and caring for a relative are all reasons that people give up work.

11.1.3 What is the level of need and gaps / what does local data tell us

The UK has now reached a point where there are more people over State Pension age than children. By 2020, the Office for National Statistics (ONS) predicts that people over 50 will compromise almost a third (32%) of the working age population and almost half (48%) the adult population (The Older Workers Statistical Information Booklet, DWP, December 2013).

33.4% of people in work in Cumbria are aged 50+; this is 1/3 of the Cumbrian workforce. In Cumbria just over 40% of people aged over 50 years could be working (Economically active), which in 2013 was slightly lower than the UK percentage. There are variations across the county, in 2013 Eden (47.9%) and South Lakeland (45.8%) both have a high number of people who could but aren't working in comparison to Barrow (29.6%) and Copeland (29.7%) The number of people who are working (the Employment Rate) In Cumbria in 2013, was 40% of people over 50 were working which is slightly higher than the UK overall, after a dip in 2011, this has been increasing. In 2013 Eden (47.1%) and South Lakeland (45.4%) both have a high number of people who are working in comparison to Barrow (29.6%) and Copeland (29.7%).

There are more than 3,300 adult learners aged 50 years accessing around 6,000 Adult Education courses across the county. Just over half of older adult students are aged 50-64 years, while the rest are aged 65+ years. The type of courses accessed include community learning; courses which provide a recognised qualification (i.e. GCSE) and non-funded courses. The greatest proportion of courses being accessed are community learning courses with the greatest proportion of over 50 students being resident in South Lakeland (approximately 40%), (Source: Adult education attendees by age - over 50s Cumbria and districts).

Key changes to the Welfare Reform system will be implemented 2015-2017. The changes which will have the biggest impact on the 50+ age group will be the introduction of Universal Credit which will be established across Great Britain with new claims to legacy benefits closed from 2016 - with mitigation to follow thereafter with the majority of the remaining legacy caseload moving to Universal Credit 2016-17.

There will be a new State Pension (implemented from April 2016) with an increase in the age of entitlement across the board for those born after 1952 and the increase to the state pension age requiring individuals to work longer.

The 50+ age group may potentially be impacted by the “under occupancy” charge and the consequential loss of housing benefit if the composition of the household changes for example through adult children leaving home.

11.1.4 Current Services and Assets including projections

There are a number of initiatives running at local level in Cumbria specifically designed for claimants who are 50+.

Focus at 50+ - Work & Skills courses running with Learn Direct in Carlisle, Workington & Whitehaven. The courses are aimed at individuals who require CV refresh, IT upskilling, job search etc.

In Barrow there is a specific 2 day course for claimants age 50+ called ‘Upskilling Workshop”. This course looks at a claimant’s needs and is tailored specifically to the individual. It also looks at the positives of being 50+ and focusses on the skills that this workforce has.

Job Club in Kendal -This successful group runs at The Gateway Centre in Kendal and supports older people seeking to re-join the workforce. The support provided is tailored to the needs of each individual and varies from practical help such as putting together a CV to emotional support, mentoring and enabling people to have confidence to attend interviews. The club has close links with the Men in Sheds project and also with our IT courses. This service has supported 47 older people during this year.

The Job Centre network in Cumbria has access to many training providers who deliver skills conditionality support and would be suitable for those who are 50+. They will work with providers to tailor courses to individual need where appropriate.

National DWP Initiatives for 50+:

Employer Toolkit - a practical resource offering guidance for managers of older workers. DWP coordinated development of the toolkit with the input of employers across various business sectors.

Employers for Carers is a service for employers to help retain the 1 in 7 people in the workplace who are caring for a family member. They promote the business benefits of supporting carers and provide advice and support on carer friendly policy and practice. Employers for Carers aims to help businesses remain competitive with a healthy and productive workforce.

No Desire to Retire - Promotion through the Job Centre network of No Desire To Retire which is a community all about people and skills dedicated to creating work opportunities for the over 50's and is free to use for both employees and employers. It is not a job board but aims to connect people over the age of 50 who are seeking work, with businesses or households looking to hire mature staff for: Full time employment, Part time work, Seasonal work, a few casual hours a week and/or Volunteering.

No Desire To Retire supports employers looking for staff by providing a free to use database of people who are over the age of 50 listing their skills, experience and location and allowing the employer to contact the individual via a secure gateway. No Desire to Retire has pledged to support Job Centres by providing awareness material and support where required.

- Retirement courses
- Benefits advice
- Health and social care hubs
- CAB
- Advice on downsizing
- Pension advice
- Assessments for support e.g. money health checks
- Adult education provided locally and WEA courses
- Access to library services e.g. book clubs, book net schemes, book exchanges in community buildings.
- University of the Third Age in Cumbria.

11.1.5 Evidence of what works

The Department of Work and Pensions document "Fuller Working Lives – Background Evidence" provides an evidence base for how working longer can benefit individuals, businesses, society and the economy. The "Fuller Working Lives – A Framework for Action" sets out the priorities for action to help people have fuller working lives. This is not simply about people working after State Pension age, though some individuals may want to and this may be right for them. Instead it is about people leaving the labour market involuntarily in their 50s and early 60s. This can be catastrophic for an individual's retirement finances and can also negatively affect their wider health and wellbeing.

11.1.6 Case study

Tom was 62; he lost his job because the cleaning contract he was working on was awarded to a "lower bidder". Tom had been in employment for most of his working life and had been confident he would find other work quickly. However he remained unemployed for several months, eventually he made contact with the job club – he had no computer skills and wanted help to update his CV and print out some copies – assistance which is not available through the Job Centre. Tom was helped to amend his CV and given advice as to how to approach local employers. The other members of the club were delighted when Tom came back within an hour sporting a big smile, to say that he had taken his new CV to Booths and had been offered and accepted a job.

12 Communication and Information

12.1.1 Introduction

Information and communication technologies especially computers and the internet are both welcomed and useful tools appreciated by some older people but also criticised as instruments of social exclusion by many older people because they are unable to use computers or the internet.

The impact of technology on loneliness among older people has been hotly disputed, with some arguing that the increasing use of technology has exacerbated the exclusion of older people, and others pointing to the vital role that technology can play in enabling older people to maintain (and, to a lesser extent, develop) their social connections (Source: Promising Approaches to Reducing Loneliness and Isolation in later life, Age UK, January 2015).

Some older people have made a choice not to use the internet. Attention should be focused on helping those who have expressed an interest in learning, rather than trying to persuade those who do not wish to learn.

12.1.2 Who is at risk and why

Office of National Statistics figures show that since 2006, the proportion of people aged 65 and over using a computer daily has increased from less than 10% to more than 40%. But of the 6.4 million people in the UK who have never used the internet, more than 80% are 55 or older. This highlights how use of internet/computer to provide infrmation or service is a particular risk to older people. (http://www.ons.gov.uk/ons/rel/rdit2/internet-access---households-and-individuals/2014/index.html)

Age-friendly design can help to increase take-up of digital technology, but still 61% of people aged 75 and over have never used the internet. The most common reason that people give for not being on line is that they are not interested in the internet. However there are also other barriers such as costs, and a lack of knowledge and confidence.

Those in rural areas with limited access to the internet may have reduced access to online information or service if it was wanted.

Not having access to the Internet for whatever reason means people are more reliant on other people for information.

12.1.3 What is the level of need and gaps / what does local data tell us

Reducing digital exclusion can help address many wider equality, social, health and wellbeing issues such as isolation, 81% of people over 55 say being online makes them feel part of modern society and less lonely (Source: Govt Digital Inclusion Strategy, 2014).

A BBC survey conducted in September 2013 reported that of the 11 million people in the UK who do not have basic online skills 69% were aged over 55.

Nationally there are now more than 44 million internet users in the UK, 86% of people who have used the internet in the last 3 months. There are significant differences between younger people and older people, and between males and females. 99% of young adults (aged 16-34years) use the internet however this begins to fall as the age groups get older:

71% of those aged 55-64 years use this internet compared to just 33% of those aged 75+ years.

Men are more likely to be internet users than women and these gender differences are more pronounced within the older age groups: 40.7% of men aged 75+ having recently used the Internet compared with just 27.3% of women aged 75+. Adults with a disability and adults with lower earnings are less likely to have used the Internet.

In Cumbria, 86.5% of adults are estimated to have used the Internet recently, similar to the rest of the UK; 1.1% had used the internet 3 months ago; while 11.9% reported they had never used the internet. Unfortunately there are no age breakdowns for Cumbria but what we do know is that the age profile of the county is older than the UK which would suggest that internet usage could be lower than the national average. Furthermore, the age profile of Cumbria's districts and wards vary considerably suggesting that levels of internet usage may also vary widely across communities.

South Lakeland and Eden have the greatest proportions of residents aged 75+, suggesting internet usage in these areas is likely to be low. Across Cumbria's wards, Grange North and Grange South in South Lakeland have the greatest proportion of residents aged 75+ while Sandwith in Copeland has the lowest (Source: Labour Force Survey (Q1, January-March 2015), Office for National Statistics).

58.9% of respondents to a survey carried out by Age UK South Lakeland in June 2015 reported that they believe the role of a Village Agent should include providing information and advice. Other evidence from Age UK in Cumbria shows that having accessed information from the internet many older people then require assistance in understanding the information and this often leads onto the need for further advice

12.1.4 Current Services and Assets including projections:

IT Courses - Locally run IT courses providing a basic introduction to computers and information on how to use the internet are provided by organisations such as The Library Service, Age UK and others. These courses remain very popular particularly when they are run in rural locations using venues such as the local primary school or Sheltered Housing Complex.

IT Club Model/Digipals - Clubs will meet in a local café, at a Health & Wellbeing Hub or a local Village Hall. People take their own laptops, tablets or smart phone along and over a cup of coffee learn how to get the most out of their own equipment. These clubs are also an opportunity for social engagement and intergenerational work.

Barclays Digital Eagles - A well-publicised initiative but currently only available in a small number of branches in Cumbria.

Ageing Well Digital Exchange - The Ageing Well Digital Exchange was set up in 2011 with the remit to look at how to improve older people's access to the internet / social networks. The project will provide a platform to increase funding to support older people. The programme was to be delivered by younger people who would mentor and support older people in their own homes. It is aligned to Cumbria's Broadband initiative 'Connecting Cumbria'. To date this initiative has had limited success and adds weight to the experience of Age UK in Cumbria that smaller, local initiatives aimed at the specific requirements of a neighbourhood are most likely to be successful. However it is acknowledged that for some

older people a mentor who will help them with their own equipment in their own home is needed. Age UK South Lakeland are currently bidding for funding to allow them to set up a Friends Exchange which will include one to one IT support from volunteers. This initiative will be linked to Village Agents and so will be locally based and also include local Telephone Support Groups, an older persons chatroom as well as face to face visiting.

Helpline and First Contact Support - Although many older people are comfortable accessing information from the internet or using complex menu driven telephone contact centres older people say that there remains a need for local, knowledgeable, telephone and face to face information and support services. In addition trained first contact staff are able to gently probe and find out the reason why someone is asking to be sent, for example, a cleaners list and on many occasions this has resulted in a client receiving a full holistic assessment and accessing services and social activities.

Social Diaries and Gateway eHub - Local online social diaries such as those provided by Age UK West Cumbria and the Gateway Collaborative in South Lakeland are extremely well used. For example last year the Gateway eHub website received 37,746 visits and 142,706 page views. However these resources are only valuable if they are kept up to date and relevant. It must also be possible to provide the information in hard copy.

12.1.5 Evidence of what works

There is little direct and credible evidence of the impact of interventions designed to address digital exclusion (Green et al, 2013 Age UK Digital Inclusion Review). Evaluated interventions are few and far between and even fewer evaluations provide robust and useable results (Green et al, 2013 Age UK Digital Inclusion Review).

12.1.6 User views

"Until I received support from my village agent I was unaware of what, as a disabled person, I was entitled to. Her advice and help have benefited me greatly."

"A village agent helped me complete a complex application form to access a benefit. Couldn't have done it without him".

(Source: Age UK South Lakeland Annual Report, 2014/15)

13 Community Support and Health Services

13.1 Health and Social Care Services

13.1.1 Introduction

Statutory services provided by health, social care and local government, Department of Work and Pensions (DWP) and similar are essential to promoting health and wellbeing in later life. Good quality information, advice and access to health, care and support services are vital. Community based support is integral to maintaining health and independence within the community.

Ageing Well in later life requires understanding and planning during working life and should be part of the wider health promotion understanding including finance, location and personal responsibility e.g. screening, healthy lifestyles and community involvement. Key local and community-based services and facilities, such as buses and community transport, public toilets, pavements, public seating, outdoor areas, libraries, leisure facilities, and community and day centres, are essential to the maintenance of older people's health, wealth, independence and wellbeing. These services should be seen as essential community assets that enable individuals to maintain their health, wealth and wellbeing.

Older people have critical events in their lives, such as surgery, infections, mental health issues or acquired ageing issues such as hearing and sight loss. It is important that they are given every opportunity to regain the mobility and independence prior to the event through access to rehabilitation.

Almost half of the NHS drug bill is spent on medicines for older people. However, as many as 50 per cent of older people may not take their medicines as prescribed. Such non-compliance clearly has cost implications, as well as raising clinical concerns; poor medicines management can undermine the effectiveness of treatments and can have negative side effects such as increasing the risk of falls and delirium.

13.1.2 Who is at risk and why

Older people are one of the most vulnerable groups for health and social care. Having well located, easily accessible health and care services is fundamentally important for older people.

In 2013 The Kings Fund reported that estimates suggest that from 1995 to 2010 the number of patients taking ten or more medicines trebled, reflecting a large increase in the number of people with complex, or several, long-term conditions – largely driven by an ageing and increasingly frail population, but also by increasing use of multiple interventions.

The adult dental survey of 2009 displays how oral health can be an issue in older adults. There are now more people with any teeth than there were in 1978, and those who have teeth are likely to have more.

13.1.3 What is the level of need and gaps / what does local data tell us

Equipment Provision

Equipment provision is on a number of levels but all important to contributing to community health and wellbeing. Equipment not only maintains life style, it maintains independence and importantly enables both formal and informal carers to maintain someone at home. Throughout the year (Oct 14 – Sep 2015) there were more than 11,400 deliveries of occupational therapy equipment across the county. The rate of equipment deliveries is greater in Carlisle than any other district in Cumbria; while Eden has the lowest equipment delivery rate. In Cumbria, 92% of equipment deliveries are delivered within 7 days (excluding valid exclusions i.e. where a patient/client has not been able to take delivery which is beyond the control of the provider); across the district this ranges from 89% in the district of Carlisle to 95% in South Lakes.

Medicine Use Reviews

From Jan-Dec 2014 77.68% of pharmacies in Cumbria were conducting Medicine Use Reviews (MURs) compared to 81.9% nationally. There were 2.81 MURs per 1000 items dispensed compared to 3.26 per 1000 in England.

Oral health

The 2009 dental survey indicated 1% or less of adults in England above 55 years could be described as having excellent oral health compared to 23% of 16-24 year olds.

To provide a snapshot of whether supply meets demand the NHS atlas of variation provides a measure and the Cumbria, Northumberland, Tyne and Wear team recently report 96.3% of patients had succeeded in gaining access to NHS dentistry services after requesting an appointment in the last two years (January-March 2014).

13.1.4 Current Services and Assets including projections

GPs look after the health of people in their local community and deal with a whole range of health problems. They also provide health education, offer advice, run clinics, give vaccinations and carry out simple surgical operations in their surgeries.

Dentists provide preventive and restorative treatments for problems affecting the mouth and teeth and gums. They provide advice and instruction on taking care of teeth and gums and on diet choices that affect oral health and can diagnose health issues such as oral cancer.

Day care provided in purpose built day centres, residential homes and community centres is a traditional service offered by Adult Social Care (and others) for many years. This kind of day service remains popular for some people, particularly those with greatest needs, such as those with dementia or challenging behaviour.

Day opportunities are designed around a person's individual interests and preferences. Adult Social Care introduced personal budgets and direct payments which give more choice and more say about how a person's needs are met and is becoming increasingly popular amongst older people.

.As an alternative to day care, some people have chosen to:

- join social groups and lunch clubs
- go shopping
- visit cafes and restaurants
- pursue leisure, arts and crafts activities
- train to learn new skills
- explore volunteering or employment opportunities

These activities enable a person to retain or build good links with their local community.

The Compass Project - owes its development to Age UK South Lakelands delivery of prevention services and latterly social prescribing in South Lakeland. Compass is not an intervention or a service; it is an operational framework that allows them to work in a much more structured way, thus ensuring the maintenance of service standards whilst making sure their clients get a truly holistic service. As the number of clients increases and the resources to satisfy that need decreases, their challenge is to work in the most efficient way possible whilst maintaining the consistency and quality of their services. We also need to ensure we can identify those clients most at risk of decline into crisis and provide the most appropriate interventions to remove or reduce that risk. Compass provides a standardised model of service delivery and risk stratification whilst maintaining that important and valued client-centred approach. Increased client numbers inevitably means the increased possibility of missing something potentially vital; Compass provides the framework to help make sure we don't.

The Community Health & Wellbeing programme delivered by ACTion with Communities in Cumbria, in partnership with Cumbria Community Foundation, offers development support and grants for community-led projects that improve health and wellbeing of local people across Eden district and in the Keswick area, which will:.

- Increase community participation and connection
- Increase skills and understanding for health and wellbeing and resilience
- Reduce isolation and need to travel
- More people undertaking healthy activity
- Reduce reliance on core services and traditional providers
- Direct provision of outreach health services such as health checks and vaccinations
- Add value to existing community projects through active health-related activities.
- It is known that people who are active and involved in communities, and who feel able to access informal and formal support, are both happier and healthier.

The Community Health and Wellbeing programme is funded by Cumbria County Council Adult Social Care and Cumbria Clinical Commissioning Group for 2 years. Cumbria Community Foundation are managing the £300,000 fund, offering grants of usually between £500 and £10,000.

Care Navigator – South Lakes Age UK are working in partnership with Cumbria Clinical Commissioning Group on an 18 month pilot across South Cumbria to trial different models of delivering the Care Navigator role. The role is a non-clinical post based in GP surgeries supporting patients to better manage their health through better engagement with statutory and voluntary services. The Care Navigator is based in Grange Health Centre and works

across 4 Health Practices using the Compass operational framework to assess the patients' needs and develop a support plan. The pilot started in January 2014 but early signs are that the Compass operational framework is achieving some positive successes.

The e hub and Gateway (www.gatewayehub.org.uk) - Age UK South Lakeland was the original founder of the Gateway Group; during the year 2014 – 2015, the number of registered Gateway partners has increased to 26 members. These members are charity and statutory sector partners who share South Lakeland as their area of benefit. The eHub is essentially a website providing members with the ability to share information about their services; events etc. but most importantly, make client referrals between registered charities safely and securely. This facility alone has increased the joint working between the Gateway members significantly. What it also ensures is that we are not duplicating each other's service offer, also that we work efficiently and cost effectively to ensure a seamless joined up service for all our client groups.

ICES - is the jointly funded service between Cumbria County Council - Adult Social Care and Cumbria Clinical Commissioning Group which provides occupational therapy equipment. A reduction in hospital /care beds in Cumbria across all services means that there is an increased need for equipment at home to support and enable people to live independently; there are several key measures (local and national) regarding this area in the Better Care Fund.

Out of Hospital Model of Care – A range of services developed around the patient and his/her general practice through "Primary Care Communities" to provide a better and more cost effective and time efficient service for clients.

- Acute Hospitals
- Community Hospitals
- Adult social care provision from numerous health professionals including OT's, social workers etc.

Pharmacies in England can be commissioned by NHS England to provide a Medicine Use review (MUR). The intention of this service is to improve patient knowledge, adherence and use of their medicines by:

- establishing the patient's actual use, understanding and experience of taking their medicines
- identifying, discussing and resolving poor or ineffective use of their medicines
- identifying side effects and drug interactions that may affect adherence
- improving the clinical and cost effectiveness of prescribed medicines and reducing medicine wastage.

MURs are targeted at patients taking a high-risk medicine; patients recently discharged from hospital with changes made to their medicines while they were in hospital; patients with respiratory conditions; and patients with cardiovascular risk factors. It is expected these patients will derive the most benefit from it.

Dentists – The Care Quality Commission (CQC) in November 2015 had 76 dental service providers registered in Cumbria. In 2003 the British Dental Association created the Oral Healthcare for Older People – 2020 Vision. It was anticipated demand would increase and the combination of greater numbers of older people with more teeth needing restoration would mean more complex work for the dental team.

13.1.5 Evidence of what works

The Care Act 2014 sets out a requirement for councils with adult social services responsibilities to provide oversight of the care market, to work with providers to develop high quality services, to assure capacity to meet local needs and ensure people who use services are safe. This applies to the whole population, not just support for the people who access services through councils.

The Department of Health recommendations that all patients on regular or repeat medication have a review at least once every 12–15 months. Reviews can be undertaken by GP's and pharmacists, This can establish that the most effective medicines have been prescribed and whether there have been side effects. Older people should be encouraged to ask for a medicine review at regular intervals.

13.1.6 User views

Concerns raised by older people, caregivers and service providers are the availability of sufficient good quality appropriate and accessible care and support required. The increasing ageing population will continue to challenge capacity to support older peoples care and wellbeing in the future. The ability to age well and maintain good health and independence to the end of ones days is a priority for individuals as well as the health and social care economy. There are a number of important factors that require ownership by individuals their communities as well as the agencies that support them. Older people tell Age UK's across Cumbria that access to health and social care services remains a real issue. This is mainly due to access, transport availability, clinics being held anywhere in Cumbria, challenges to get appointments with GPs and routine appointments not fitting with bus timetables.

13.2 Reablement

13.2.1 Introduction

Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services. Reablement provides services for people with poor physical or mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living which aims to help people 'do things for themselves', rather than 'having things done for them', working with individuals with support needs to rebuild their confidence, independence and support the development of regaining daily living skills and promote community access and integration. This may be required following an acute medical episode or to reverse or halt a gradual decline in functioning in the community. Reablement is time-limited and often involves providing intensive support to people.

13.2.2 Who is at risk and why

Reablement has the potential to help many different people, including older people; people with a physical or sensory disability; people with a learning disability; people with mental health difficulties; people with dementia; people being discharged from hospital; people at risk of needing to go into a hospital or care home; or people living in sheltered housing, extra

care or a care home. Many reablement services are targeted at specific groups, such as those aged over 65. Some reablement services are specialist ones, delivered by staff with special training and expertise, working exclusively with people with dementia for example (Reablement: A Guide for Frontline Staff, DOH et al, 2010).

13.2.3 What is the level of need and gaps / what does local data tell us

The proportion of older people (65 and over) who were still at home 91 days after discharge from Hospital into reablement/rehabilitation services' measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.

Throughout 2014-15, only 1.9% of older people (aged 65 and over) in Cumbria were offered reablement services following discharge from hospital, this is below both the England average of 3.1% and Cumbria's Comparator Group of 2.6%.

85% of older people (aged 65 and over) were still at home 91 days after discharge from hospital into reablement/rehabilitation services; this is greater than both the England average of 82.1% and Cumbria's Comparator Group of 83.3%. (Source: Adult Social Care Outcomes Framework).

Year	The number of people aged 65 plus supported to live independently through receiving community based services and/or reablement in Cumbria
2011/12	6944
2012/13	6855
2013/14	7029

(Source: Referrals, Assessments and Packages of Care Return Reablement Figures (CCC, ASC)

Adult Social Care aims to further reduce admissions to residential care (against pop growth), via prevention strategy that includes reablement, Neighbourhood Care Independence Project and personal budgets.

Year	**No of Permanent admissions of 65+ people admitted to residential care**	**65+ Cumbria population**	**ASCOF2a permanent admissions of older people to residential care per 100000 population**
2010/11	711	101,440	700.9
2011/12	693	103,565	669.1
2012/13	721	107,560	670.3
2013/14	656	110,430	594.0

(Source: Permanent Admissions from ASC-CAR Return Population Figures from NASCIS)

Disabled Facilities Grants

District Councils provide Disabled facilities grants if you're disabled and need to make changes to your home, for example to: widen doors and install ramps, improve access to rooms and facilities – e.g. stair lifts or a downstairs bathroom, provide a heating system suitable for your needs

Year	Number of DFGs in Cumbria
2013/14	590
2014/15* (estimate)	637

If the estimate for 2014/15 is correct there is an 8% increase in DFGs from the previous year. There is work being done to improve delivery and consistency of DFGs throughout the County. One of the major challenges for housing is to continue to plan and deliver a strategy that meets the needs of our ageing population. Housing is a key determinant of health, and the need for suitable accessible accommodation and adapted properties will become more evident as health and mobility issues increase with the age profile.

13.2.4 Evidence of what works

To support the Better Care Fund, NHS England have published an evidence based planning document which includes details of the evidence base for intermediate care services, including rehabilitation and reablement. Document can be found here: https://www.england.nhs.uk/wp-content/uploads/2014/09/3-ev-based-plans.pdf

This suggests the evidence base highlights the following techniques:

- Commissioning for outcomes instead of periods and tasks
- Workforce led by a senior clinician with specific reablement services and skills
- Adequate provision for rehabilitation and reablement outside acute hospitals, based on demographic characteristics of the local population

A Department of Health funded review showed that home care reablement is almost certainly cost-effective and improves outcomes for users. The study showed that in the first year of setting up a service, set-up costs cancel out savings. http://www.york.ac.uk/inst/spru/pubs/rworks/2011-01Jan.pdf

13.3 Assistive Technology

13.3.1 Introduction

Assistive technology is the name given to a wide range of technology which helps people to be as independent as possible. The use of digital technologies in health and social care (including telemedicine, telehealth, telecare, e-health, online and remote consultations) is becoming increasingly important as services plan for ageing populations, greater prevalence of long term conditions and the needs of dispersed rural communities.

Staying connected with people and receiving information about events and activities in their local communities is vital for active ageing, but some older people are difficult to reach due to social isolation.

13.3.2 What is the level of need and gaps / what does local data tell us

Telecare and community alarms are available through Adult Social Care and also privately through five different local providers around the county, 2495 alarms and 395 telecare were provided in Cumbria during 2013/14.

13.3.3 Current Services and Assets including projections:

Telecare and assistive technologies - aassistive technology is the name given to a wide range of technology which helps people to be as independent as possible. Telecare is a flexible, telephone-based, alarm system which helps you live independently in your own home for as long as possible. Telecare is based around a pendant worn around the neck or wrist. This provides access to a 24-hour monitoring service offering an instant response at the touch of a button from anywhere in your home or garden. Telecare can be linked to a series of alarms or sensors in key parts of your home offering an immediate early warning if something is wrong. For example, telecare can have sensors to detect:

- Falls - if you are at risk of falling or having seizures
- Leaving a bed or chair - if you are at risk of falling
- Smoke - for fire risk
- Carbon monoxide - particularly if you have gas fired equipment
- Temperature extremes - to detect heat which might be a fire risk, or cold if hypothermia is a risk
- Flood - if a tap in a sink or bath has been left on

The technology has been available for some time (and indeed uses technical services already developed for secure online banking, retail and other activities), but barriers to adoption within healthcare persist. Adoption processes based on evidence based medicine have proved ineffectual and do not effectively address professional skills needs, organisational issues and are hard to assess financially.

(Source:http://www.cumbria.ac.uk/Courses/SubjectAreas/HealthWellbeing/Cachet/TelehealthAndTechnologyAdoption.aspx).

Health & Social Care - The possibilities of providing health and social care services using Information Technology are many and Cumbria as a sparsely populated rural county should embrace this technology and encourage initiatives such as the Physiodom pilot being run by Cybermoor in Alston.

13.4 Carers

13.4.1 Introduction

Increasing numbers of people will require at some point formal support on either short of long term arrangements. Carers are often categorised as unpaid and/or paid. Unpaid carers are usually caring for a spouse, relative or friend who is ill, frail or disabled. Many retired older people now also have a major role as carer/s for grandchildren also providing financial support to their own children. Informal caring is increasingly important, carers are a precious resource and need to be looked after and provided with a range of services.

Many people might not recognise themselves as being a carer. For many people being a carer is like having another job on top of a paid job and on top of their family commitments hobbies and interests, which can often create problems.

Formal support from paid carers needs to be affordable, accessible but above all delivered by competent and well trained health and social care workers.

13.4.2 Who is at risk and why

More than 56,000 residents across Cumbria provide unpaid care to either family members, friends, neighbours or others because of either a long-term physical or mental ill-health / disability or problems relating to old age; there are greater proportions of carers in Cumbria compared to the rest of England (Provision of unpaid care , Source: Census, 2011).

Cumbria County Council's Directorate of Health and Care Services provide care and support for adults aged 18 years and older. Services include support for adults and older people with physical or mental health needs; learning disabilities; sensory impairment; substance misuse issues; as well as providing support for those who care for others. There is a range of support available to people including support in the community, support at home or accommodation based support (Service users and Carers registered with Adult Social Care, source: Adult Social Care).

13.4.3 What is the level of need and gaps / what does local data tell us:

The South of the county, both Barrow-in-Furness and South Lakeland, has the greatest proportion of carers. More than half of carers (around 58%) in Cumbria are female, reflecting the national picture. And 1 in 3 carers in Cumbria are aged between 50-64 years. The general age profile of carers in the county compared to the rest of England is older with greater proportions of those aged 50+ and fewer proportions of younger carers, reflecting the older age profile of Cumbria (Provision of unpaid care , Source: Census, 2011).

The greatest proportion of people providing care in the county are living in Barrow-in-Furness, perhaps reflecting the needs of the population. 60% of those carers are aged 50+, however, in South Lakeland this increases to 70% reflecting the older age profile of the district (Source: Provision of unpaid care, Census, 2011).

Most carers in Cumbria (around 64%) provide on average 1 to 19 hours of care per week; yet 1 in 4 carers (around 23.5%) provide 50 or more hours. Numbers of those providing unpaid care are increasing, particularly in the districts of Carlisle and Eden, which may have implications on services provided by local authorities and partners in terms of support needed by both the carer and the person(s) they are caring for. Cumbria's population is

ageing and at a faster rate than England, and people are living for longer both of which may have a significant impact on the numbers of people providing care in the future(Source: Provision of unpaid care, Census, 2011).

There are more than 12,000 people in receipt of Adult Social Care services across Cumbria, around 75% of those are aged 65 years and over. The greatest number of service users are aged 65+ and are resident in the north of the county around the district of Carlisle, however, the greatest proportion are in the south of the county. 76% of service users are using the service because of a physical disability; this increases to 87% in the south. There are approximately 7,500 carers in contact with Adult Social Care, and around one third of those are in receipt of support. Most carers are aged between 18-64years, yet 1 in 3 are aged between 65-84 years, and around 1 in 10 are aged 85+ years (Source: Service users and Carers registered with Adult Social Care, Adult Social Care).

Figure 8: Map showing the proportion of residents aged 50-64 years providing unpaid care for either family members, friends, neighbours or others

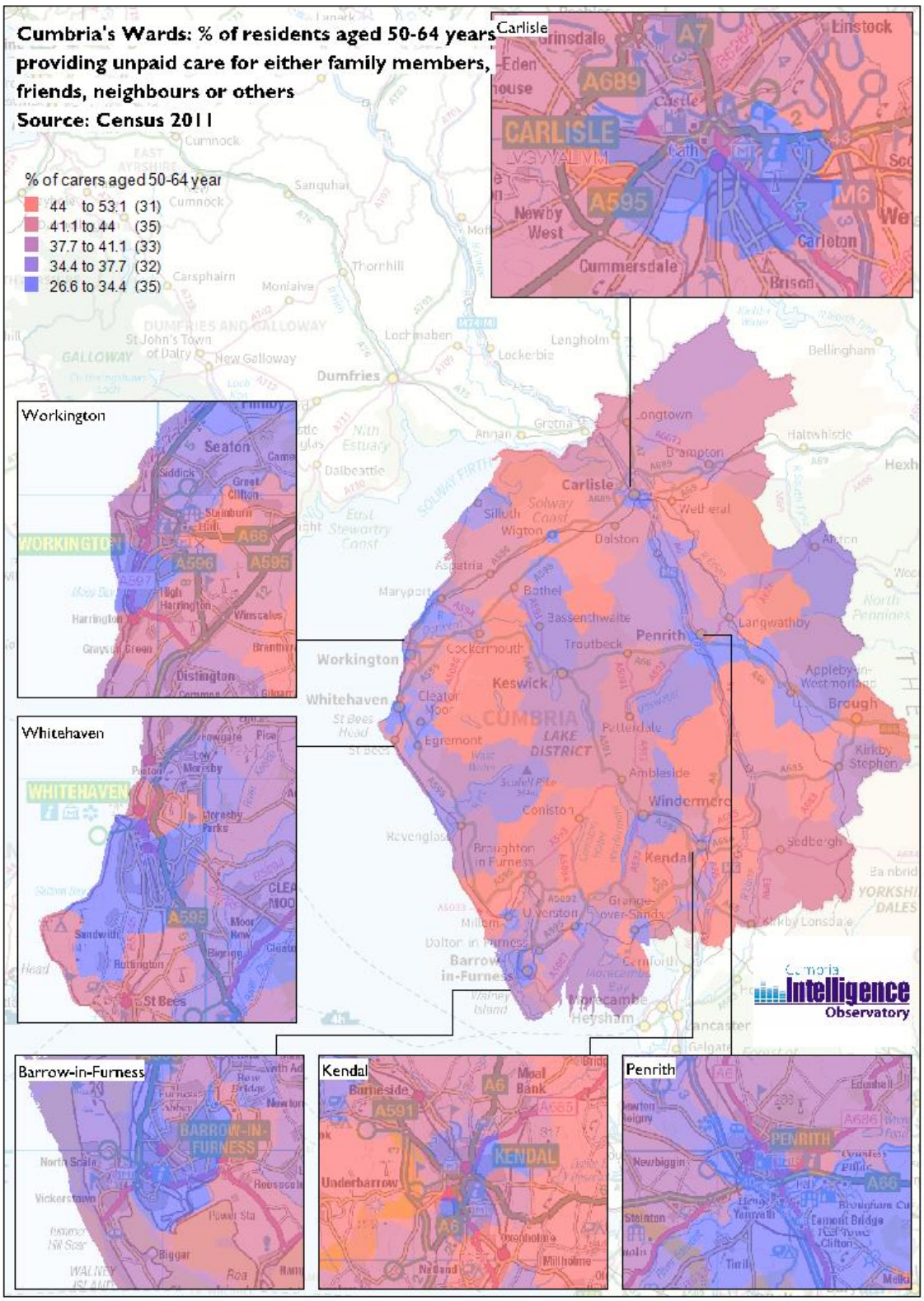
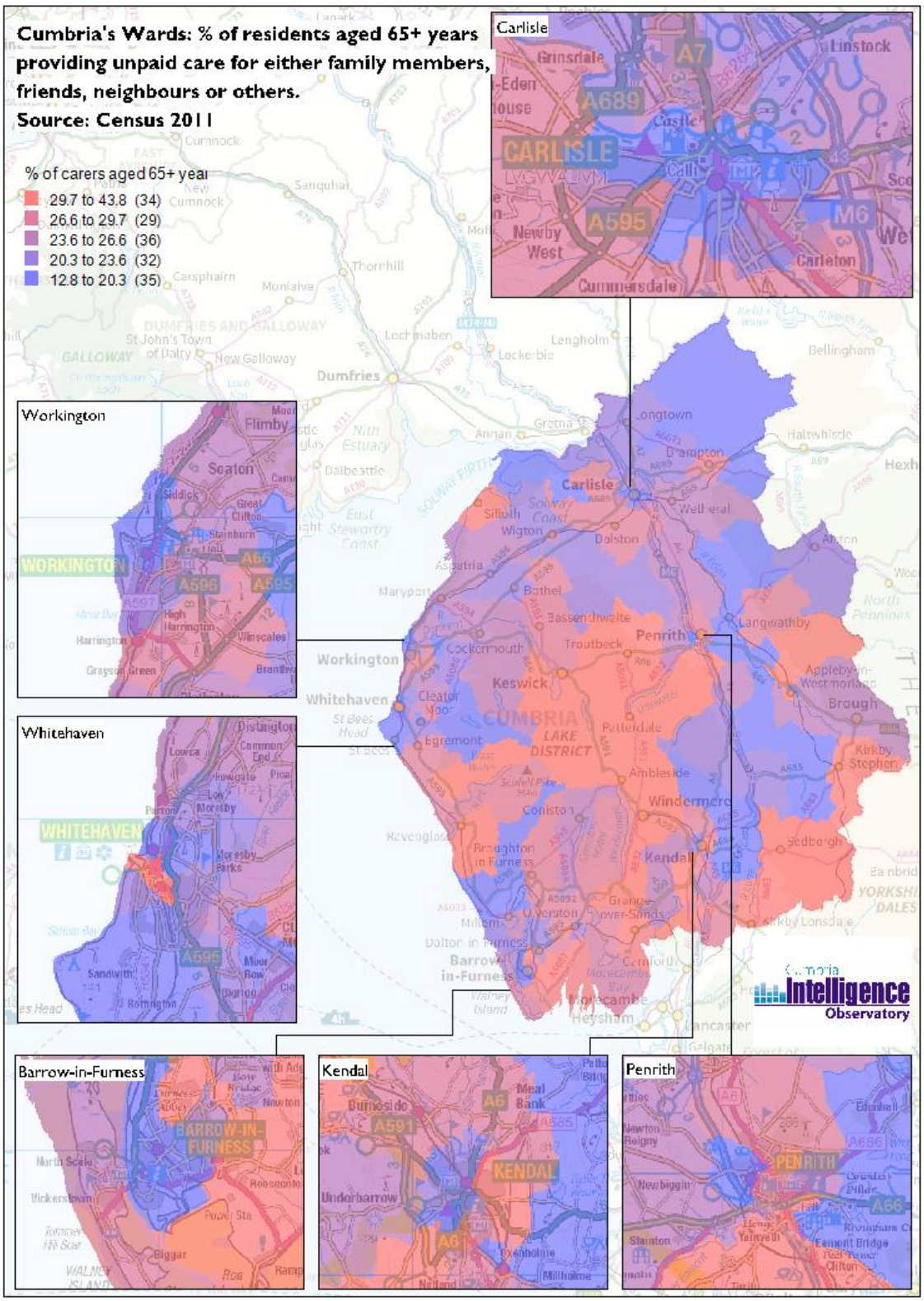


Figure 9: Map showing the proportion of residents aged 65+ years providing unpaid care for either family members, friends, neighbours or others



13.4.4 Current Services and Assets including projections

Supporting Unpaid Carers in Employment – There are two Employment Liaison Officers based at South Lakes Carers covering the whole of Cumbria and offer guidance for employers in Cumbria.

- Carers directory
- Advice hubs
- Specific support groups for carers e.g. carers support groups, carers associations, peer support groups organised by Age UK, condition specific support groups e.g. cancer.

Cumbria County Council works with individuals, families and communities to promote independence in the home, reducing the need for formal services and ensuring everyone can be as independent as possible. The Council has a commitment to join up the commissioning and delivery of services with the NHS wherever this will add value.

13.4.5 Evidence of what works

The NHS Five Year Forward View commits the NHS to find new ways to support carers, to build on the new rights created by the Care Act and to help the most vulnerable carers – the approximately 225,000 young carers and the 110,000 carers who are themselves aged over 85. Whilst commissioners and practitioners cannot solve all of the challenges faced by carers, much more could be done to support them and help ensure that they receive the recognition and support that they need and deserve from the NHS (Source: Principles and resources to support effective commissioning for adult and young carers, NHS England, December 2014).

Commissioning for Carers: Principles and resources to support effective commissioning for adult and young carers is a practical tool and part of a suite of products that will help commissioners to deliver what carers say is important to them in ways that have been shown to work effectively and efficiently in practice. The Principles are based on the latest research, case-studies and best-practice and are the vital and common ingredients to deliver better outcomes for carers, patients, commissioners, practitioners and local communities. They are:

1. Think Carer, Think Family; Make Every Contact Count
2. Support what works for carers, share and learn from others
3. Right care, right time, right place for carers
4. Measure what matters to carers
5. Support for carers depends on partnership working
6. Leadership for carers at all levels
7. Train staff to identify and support carers
8. Prioritise carer's health and wellbeing
9. Invest in carers to sustain and save
10. Support carers to access local resources

The Commissioning for Carers Principles form part of NHS England's Commitments to Carers, published on 7 May 2014, and the RCGP Supporting Carers in General Practice Programme, to help in identifying, supporting and recognising the vital roles that carers play to support them to provide better care and to stay well themselves. This report noted that the improving support for carers was a journey and the Commitments represented a first step in this journey.

13.4.6 User views

Adult Social Care Users Survey – social contact, the '% of adult social care users who have as much social contact as they would like' indicator is included in both the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework. Throughout 2014-15, in Cumbria, 48.2% of people who use adult social care services reported that they had as much social contact as they would like, this is greater than the England average of 44.8%. 43.2% of adult carers reported they have as much social contact at they would like, this is also greater than the national average of 38.5%.

13.5 Screening Services

13.5.1 Introduction

Screening is the process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.

13.5.2 Who is at risk and why

Nationally, cancer cases are increasing. 280,000 people were diagnosed with cancer in England in 2013/14 and this is expected to reach more than 300,000 by 2020, and more than 360,000 by 2030. One in two people will develop cancer at some point in their lives. With survival rates increasing, more and more people are living with cancer (Source: Independent Cancer Taskforce: "Achieving World Class Cancer Outcomes – A Strategy for England, 2015 – 2020").

From the age of 50 years prostate cancer is the most common cancer in males, while breast cancer is the most common cancer in females. (Source: ONS, July 2015).

13.5.3 What does local data tell us

Bowel cancer screening coverage in Cumbria is above national and regional levels. Throughout 2013-14, Cumbria CCG exceeded the bowel screening coverage standard of 60% for residents aged 60-69 years and 60-74 years with average coverage levels of 64.3% and 64.5% respectively. All GP practices across the county met the screening coverage standard. **Uptake levels of bowel screening** in Cumbria are above national and regional levels. Throughout 2013-14, Cumbria CCG exceeded the bowel screening uptake standard (50 – 56%) for those aged 60-69 years and 60-74 years with an average of 62.8% and 62.5% respectively. All GP practices across the county met uptake targets for those aged

60-69 years with levels ranging between 50.0% to 71.6%. For those aged 60-74 years most GP practices met uptake targets with levels ranging between 49.6% to 70.7%, with just two practices falling just below the target (Bowel screening coverage and uptake, 60-69 years and 60-74 years, Source: NHS England).

Breast cancer is the most common cancer in the UK. Women between the ages of 50 and 70 are invited for regular breast screening (every three years) under the national NHS Breast Screening Programme (NHSBSP). Screening is intended to reduce mortality by detecting breast cancer at an early stage when there is a better chance of successful treatment and therefore survival. Women over the age of 70 are eligible for breast screening but are not automatically invited. In England, a trial is taking place by extending breast screening so that women aged 47 to 50 and 70 to 73 are now also invited. (Source: NHS England). A full roll-out to women aged 47-49 and 71-73 is expected to be completed after 2016. Compared to the rest of England, **breast cancer screening uptake** throughout the county (Cumbria CCG) is above national levels. Throughout 2013-14, the average screening uptake for those aged 50-70 years in Cumbria was 78.3%, meeting the 70% - 80% standard range and above the national average of 73.2%. Not all GP practices are meeting the 80% standard with average screening uptake rates ranging between 32.4% to 93.3% across all Cumbria practices. In terms of trends, over the past 3 years screening uptake levels across Cumbria CCG have remained relatively stable and have met target standards (Source: HSCIC; and Cancer Research UK).

Breast screening coverage levels provide the proportion of eligible women (aged 53-70) whom have been adequately screened within the previous 3 years on 31st March. As at 31st March 2014, 50,944 eligible women had been screened accounting for a coverage rate of 81.8%, above both national and regional coverage levels of 75.9% and 73.4% respectively. Coverage rates in Cumbria over the last 3 years have been good and relatively stable and have remained above national and regional levels. Levels of breast cancer screening coverage in all of Cumbria's districts are above national and regional levels (Source: PHOF). Despite this, not all GP practices are meeting the standard with average screening coverage rates ranging between 62.5% to 85.6%.

13.6 Immunisations

13.6.1 Introduction Seasonal flu (influenza)

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Immunisation is one of the most effective healthcare interventions available and by increasing flu vaccination uptake it can help to prevent illness and ease winter pressure on primary care services and hospital admissions.

13.6.2 Who is at risk and why

Seasonal flu (influenza) is a highly infectious viral illness spread by droplet infection. The flu vaccination is offered to people who are at greater risk of severe illness if they catch flu, in particular those with chronic respiratory/heart/kidney/liver/neurological disease or with diabetes and Immunosuppression and also older people and specifically people in long stay residential homes and those who are carers.

13.6.3 What does local data tell us

The national ambition is to achieve 75% uptake in those aged 65 years and over. During the period 1 September 2014 to 31 January 2015, 75.3% of Cumbria's population aged 65 and over had received the seasonal flu (influenza) vaccination, above the national average in England of 72.7%. The 75% target has been met and exceeded in Cumbria over the past 3 years (Source: PHOF).

13.6.4 Current services and assets including projections

NHS England is responsible for commissioning the flu programme and GPs continue to play a key role in providing the vaccination. Flu vaccination is usually carried out between October and January.

13.6.5 Introduction Shingles Vaccine (Herpes Zoster)

Shingles, also known as herpes zoster, is an infection of a nerve and the skin around it, which causes pain and a rash along a band of skin by the affected nerve. It is caused by the same virus which causes chickenpox. Throughout England, as part of the national routine programme the shingles vaccine is offered to patients aged 70 years; 78 years; and 79 years. The programme aims to reduce the incidence and severity of shingles by boosting individuals' pre-existing varicella zoster virus immunity.

13.6.6 Who is at risk and why

Older people are particularly at risk of shingles thought to be caused by having lowered immunity (protection against infections and diseases). It is estimated that the vaccination programme will prevent nearly 40% of the 30,000 cases seen each year in the over 70 age group.

13.6.7 What does local data tell us

In Cumbria (CCG) 93.8% of GP practices are reporting their shingles vaccine coverage, slightly below the national average of 95.8%. Between September 2014 and May 2015 55.5% of those aged 70 years had been vaccinated, above the national average of 52.8%. 54.8% of those aged 78 years, and 58.1% of those aged 79 years, had also been vaccinated, both above the national averages of 52.5% and 53.8% respectively.

Provisional cumulative estimates of shingles vaccine coverage, England and Cumbria, September 2014 to May 2015

CCG	Percentage of GP practices reporting	Percentage of age cohort vaccinated to end November		
		Routine 70 years	Catch-up 79 years	Catch-up 78 years
Cumbria	93.8	55.5%	58.1%	54.8%
England	95.8	52.8%	53.8%	52.5%

Source: Public Health England, 2015

13.6.8 Current services and assets including projections

From September 2013 Shingles vaccination will be introduced for people aged 70 years. There will also be a catch up programme for those aged 71 to 79 years. This is a live vaccine, given as a single dose and can be given safely at the same time as the 'flu vaccine.

13.7 End of Life Care

13.7.1 Introduction

The Department of Health (2008) suggests that, for many, a good death would involve being treated as an individual, with dignity and respect, without pain and other symptoms, in familiar surroundings and in the company of close family and friends. The UK ranks first in the 2015 Quality of Death Index, a measure of the quality of palliative care in 80 countries around the world (The Economist Intelligence Unit). Its ranking is due to comprehensive national policies, the extensive integration of palliative care into the NHS, a strong hospice movement, and deep community engagement on the issue.

13.7.2 Who is at risk and why

In Cumbria most deaths have an underlying cause of circulatory disease whereas in the North West and nationally the highest proportion of deaths are due to cancer. In Cumbria circulatory disease accounts for 29.5% of deaths compared to 27.7% in England: this is the second highest proportion in the North West region. Respiratory disease accounts for 13.9% of deaths and cancer accounts for 28%. The age group with the largest proportion of circulatory disease caused deaths is 85 years and over, with 34.6% of deaths compared to 30.8% nationally. Eden district has the highest proportion of circulatory deaths for this older age group and 40.5% of deaths of people aged 85 are from circulatory disease which is significantly higher than England (Source: End of life care profiles – National end of life intelligence network). As a proxy indicator for quality of end of life care the place of death trends and variations can be monitored. With the right support, 73% of people with cancer would prefer to die at home, yet only 27% actually do (Macmillan).

13.7.3 What is the level of need and gaps / what does local data tell us

Nationally and in Cumbria, for people aged 0 to 64 years, there is a clear increasing trend of dying at home. For older age groups place of death is more variable, most recent data available (2013) shows all age groups in Cumbria have a proportion higher than England dying at home and the proportion decreases with increasing age. For 65 to 74 year olds in Cumbria 32% died at home in 2013 (England 30.2%), for 75 to 84 year olds 23.5% died at home (England 22.6%) and for those aged 85 and over 15.8% died at home (England 14.8%), (Source: End of life care profiles – National end of life intelligence network).

13.7.4 Evidence of what works

The Government's 2008 End of Life Care Strategy (DoH, 2008) recommends a care pathway approach both for commissioning services and for delivery of integrated care for individuals. It recommended that the care pathway involve the following steps:

- Identification of people approaching the end of life and initiating discussions about preferences for end of life care;
- Care planning; assessing needs and preferences, agreeing a care plan to reflect these and reviewing these regularly;
- Coordination of care
- Delivery of high quality services in all locations;
- Management of the last day of life;
- Care after death; and
- Support for carers, both during a person's illness and after their death

A Cochrane review (Shepherd, S et al, 2011) concludes that there is evidence to support the use of end of life home-care programmes for increasing the number of patients who will die at home.

NICE CMG42 Guide for commissioners on end of life care for adults (2011)

13.7.5 Current services and assets including projections:

Compassion in dying My Life, My Decision. Working in co-operation with Compassion in Dying we provide the support and information to help people understand their choices and plan ahead for their future treatment and care. We support clients to make a Lasting Power of Attorney for Health and Welfare, Advanced Decisions and Advanced Statements. This service has supported over 40 older people In SL during the course of the year.

Deciding Right: Your Life, your Choice is about what would happen to a person if they became too poorly to speak for themselves. Deciding Right is a framework across Cumbria which encourages health and social care professionals to talk to people they are providing care for about the options available to them and help them to think about making decisions in advance.

PART 3: SPECIFIC POPULATION GROUPS

14 Vulnerable Groups

14.1 Older People with Learning Difficulties

14.1.1 Introduction

People with learning disabilities are living longer so the number of older people with learning disabilities is growing. They are a diverse group and future generations of older people with learning disabilities will have more complex need, they and their families do not always get the right support and their needs are in danger of being misunderstood, overlooked, or poorly met (Source: Kerr 2007) and can face specific challenges and disadvantages as they age.

14.1.2 Who is at risk and why

Most people with learning disabilities live with their parents and these families are growing older together, but often now they are outliving their parents and main carers. (Source: BILD Factsheet: Older people with a learning disability).

People with learning disabilities face many disadvantages in relation to health (Emerson and Baines 2010, Department of Health 2001). However, better social conditions and access to medicines like antibiotics have meant that more people are surviving beyond childhood and adulthood into older age. For example, people with Down's syndrome have seen a dramatic rise in their life expectancy from seven years in the 1930's to their late 50's today (Holland et al 1998).

Older people with learning disabilities need to be supported to age well, to understand their age related needs, and to remain active and healthy for as long as they can. It is important to listen to what older people with learning disabilities and their families say is important to them. Many services are not well prepared to support older people with learning disabilities and their families; these include services for people with a learning disability, older people, carers and health care. Better information, joint training and planning are needed to meet people's needs at a local and national level (Source: BILD Factsheet: Older people with a learning disability).

14.1.3 What is the level of need and gaps/what does local data tell us

There are an estimated 2,350 people aged 65+ in Cumbria who have a learning disability. More than half of those (57%) are aged between 65-74 years. Numbers of older people with a learning disability are forecast to increase mainly due to the projected increase in the total number of older people across the county. By 2020, the number of ASC service users aged over 65 with a Learning Disability is projected to increase (by 8.4%) from 157 to 170. By 2030 it is projected to increase (by 24.8%) to 196. Numbers of those aged 65+ accessing adult social care services because of a learning disability are low in Cumbria at around 160 people (Source: POPPI; Older people with a learning disability, Cumbria Adult Social Care).

14.1.4 Current services and assets including projections

There is an increasing trend in people with Learning Disabilities who are over 65 and who will have a high chance of frailty and of early onset dementia.

The local market features eleven local and national providers, currently delivering a range of supported living from 24hr to minimal packages.

At present approximately 42% of all learning disability service users (843 people) use learning disability day services. Of the 843 people that use day services in Cumbria, 510 of them attend the 19 day services provided by Cumbria Care (County Council services), 275 people use services purchased from independent organisations, while 58 attend both. (source: Draft ASC commissioning strategy)

High-level services are currently commissioned through the eight providers on the Council's commissioning framework.

14.1.5 Evidence of what works

The Draft Commissioning Strategy for Care and Support delivered by Adult Social Care 2015- 2020 provides an evidence base. Learning Disability stakeholders held an Open Space event called 'Improving the lives of Adults with Learning Disabilities in Cumbria' in September 2014. Key priorities as voted by the attendees were:

- Having choice of where we live and with who, and who supports us
- Specialised Learning Disability social work teams
- Focus on reducing hate crime
- More education opportunities
- Access to appropriate health care services
- Housing: how to make it better and more available
- How to help people with a Learning Disability have healthier diet and exercise
- More work opportunities.

14.2 Gypsy and Irish Travellers

Friends, Families and Travellers (FFT) reported in 2015 that a range of evidence shows that Gypsies and Travellers are more likely to develop certain conditions, less likely to access certain services and more likely to have a poorer experience of health services due to direct or indirect discrimination.

The 2011 Census analysis found that in England and Wales, of any ethnic group, Gypsy or Irish Travellers had: the lowest proportion of people rating their general health as 'good' or 'very good' of any ethnic group; the highest proportions of people providing unpaid care; and the highest proportion of people with no qualifications. The 2011 Census also reported that Gypsy and Irish Travellers tend to have younger age profile: with only 5.9% aged 65+ nationally compared to 16.4% across the overall national population. Additionally FFT (2015) report that studies have shown that Gypsies and Travellers are more likely to: be affected by a long-term condition; have higher levels of stress, anxiety and depression; and have higher numbers of smokers. The 2011 Census reported that 315 Cumbrian residents (0.1%)

identified their ethnic group as Gypsy or Irish Traveller; the same as the national average (0.1%). Of the above 315 Cumbrian Gypsy or Irish Traveller residents, just 24 were aged 65+ years; this equates to less than 0.001% of the county's 65+ population, but is similar to the national proportion. In line with national trends, self-reported general health was worse and the age profile was much younger amongst Gypsy and Irish Traveller residents in Cumbria when compared to other ethnic groups.

Of Cumbria's districts, Carlisle had the greatest number of Gypsy or Irish Traveller residents (196 persons, 0.2% of the district's total population), this was followed by Barrow-in-Furness (39 persons, 0.1%) and South Lakeland (36 persons, less than 0.1%). The county's remaining three districts had less than 15 Gypsy or Irish Traveller residents each. Of Carlisle's 196 Gypsy or Irish Traveller residents, 14 were aged 65+ years (0.001% of the district's 65+ population). All other districts in the county had less than five Gypsy or Irish Traveller residents aged 65+ years.

Across Cumbria's wards, Carlisle's Castle ward had the greatest number of Gypsy or Irish Traveller residents (20 persons), while Lyne ward in Carlisle had the greatest proportion (0.5% of the overall population). However, it is important to note that 2011 Census data only includes respondents who chose to identify with the Gypsy or Irish Traveller ethnic group and FFT report that community estimates suggest that 2011 Census data may have undercounted by a ratio of 1:5 due to unwillingness to ascribe due to fear of discrimination and barriers to completing the census such as low literacy levels and enforced mobility.

The DCLG conducts a biannual count of Gypsy and Traveller caravans on council sites, private sites, caravans on Gypsies' own land (with or without planning permission) and unauthorised sites (tolerated or not tolerated). As this dataset counts caravans rather than people it can only be used to provide estimates of the Gypsy Traveller population living in caravans. The January 2015 count reported that there were a total of 201 traveller caravans across Cumbria, with Carlisle having the greatest number amongst the county's districts (149 caravans), followed by Eden (22 caravans), and Barrow-in-Furness (21 caravans), the remaining districts had less than 10 caravans each.

14.3 Ethnic minorities

Numbers of Black & Minority Ethnic groups are relatively low in Cumbria with just over 17,700 people (3.5% of the total population). Of those, 579 people (0.1%) are of Black/African/Caribbean/Black British ethnicity. In addition to this, 314 people (0.1%) are of 'mixed white and black African' ethnicity. Across Cumbria's districts the greatest proportion of residents of mixed/black/African/Caribbean ethnicity are in South Lakeland (274 residents, 0.3% of the total population) followed by Carlisle (238 residents, 0.2% of the total population).

14.4 Lesbian, Gay, Bisexual and Transgender Older People

Experts argue that while some older LGBT people may wish to develop connections with other LGBT people, others would prefer to receive mainstream provision that was sensitive to their needs. Surveys suggest loneliness can be particularly acute among older lesbian and gay people, and the limited evidence available suggests that these groups experience problems in accessing mainstream provision, and lack confidence that these services will meet their needs. It is clear that more research will be needed to understand how best to

meet the needs of LGBT people as they age, (Source: Promising Approaches to Reducing Loneliness and Isolation in later life, Age UK, January 2015).

Currently there is no robust data relating to numbers of the LGBT population in Cumbria. Nationally, it is estimated at around 5 – 7% of the total population, for Cumbria this would equate to 24,895 to 34,853 residents. Research carried out by the LGBT Foundation reports that the lack of a visible scene locally means the LGB&T population is less accessible to public bodies and LGB&T people are isolated in Cumbria. It is important for services to reach out to these groups by providing support and by making services accessible.

15 Geographical differences in need

15.1 Allerdale

Living longer: Life expectancy in Allerdale is 78.9 years for males and 81.7 years for female. Life expectancy is 6.6 years lower for men and 8.1 years lower for women in the most deprived areas of Allerdale than in the least deprived areas.

There were 7,283 injury attendances for people aged 50 years and over; which was a crude rate of 17,268 per 100,000 population. Of total attendees, 57% were females, 97% were for unintentional injuries and 32% were admitted to hospital. Of unintentional injuries, 92% of attendances were classed as other injury, the vast majority of which were likely to be falls (TIIG Cumbria - Injuries in Older People Report August 2015).

	Allerdale	Cumbria	England
Hip fractures in those aged 65+ per 100,000 population (13/14)	616	587	580
Excess Winter Deaths Index (3 year, 2010-13)	14.7	15.0	17.4
Injuries due to falls per 100,000 (13/14)	1588	1695	2064

Source: PHOF

The table below shows future health projections for **Allerdale**, which will obviously have an impact on services/service provision for older people (Source: POPPI)**:**

ALLERDALE	2014	2015	2020	2025	2030
Unable to manage at least one mobility activity on their own	3,952	4,021	4,546	5,126	5,772
Dementia	1,486	1,507	1,762	2,058	2,371
Long standing health condition caused by heart attack	1,093	1,107	1,213	1,330	1,448
Falls	5,827	5,913	6,565	7,240	8,061
Severe depression	599	614	664	752	818
Longstanding Health condition caused by stroke	515	521	578	642	700
Admitted to hospital as a result of falls	446	458	521	610	666

For more information see:

http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/6164/4156583024.pdf and www.cumbria.gov.uk

15.2 Barrow-in-Furness

Living longer: Life expectancy in Barrow is 76.9 years for males and 81.6 years for females. Life expectancy is 13.0 years lower for men and 8.4 years lower for women in the most deprived areas of Barrow-in-Furness than in the least deprived areas.

There were 3,071 injury attendances for people aged 50 years and over; which was a crude rate of 11,246 per 100,000 population. Of total attendees, 53% were female, 97% were for unintentional injuries and 27% were admitted to hospital. Of unintentional injuries, 85% of attendances were classed as other injury, a substantial proportion of which were likely to be falls (TIIG Cumbria - Injuries in Older People Report August 2015).

	Barrow – In - Furness	**Cumbria**	**England**
Hip fractures in those aged 65+ per 100,000 population (13/14)	467	587	580
Excess Winter Deaths Index (3 year, 2010-13)	12.2	15.0	17.4
Injuries due to falls per 100,000 (13/14)	1854	1695	2064

Source: PHOF

The table below shows future health projections for **Barrow-in-Furness**, which will obviously have an impact on services/service provision for older people (Source:POPPI)**:**

BARROW	2014	2015	2020	2025	2030
Unable to manage at least one mobility activity on their own	2,481	2,486	2,729	3,143	3,473
Dementia	952	957	1,079	1,242	1,464
Long standing health condition caused by heart attack	693	696	752	814	886
Falls	3,694	3,692	4,064	4,457	4,902
Severe depression	380	385	413	459	498
Longstanding Health condition caused by stroke	326	329	360	394	428
Admitted to hospital as a result of falls	280	285	323	371	398

For more information see:

http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/6164/4156583513.pdf and www.cumbria.gov.uk

15.3 Carlisle

Living longer: Life expectancy in Carlisle is 78.9 years for males and 82 years for females. Life expectancy is 10.1 years lower for men and 7.1 years lower for women in the most deprived areas of Carlisle than in the least deprived areas.

There were 11,701 injury attendances for people aged 50 years and over; which was a crude rate of 27,118 per 100,000 population. Of total attendees, 57% were female, 96% were for unintentional injuries and 31% were admitted to hospital. Of unintentional injuries, 93% of attendances were classed as other injury, the vast majority of which were likely to be falls. (TIIG Cumbria - Injuries in Older People Report August 2015).

	Carlisle	Cumbria	England
Hip fractures in those aged 65+ per 100,000 population (13/14)	701	587	580
Excess Winter Deaths Index (3 year, 2010-13)	19.2	15.0	17.4
Injuries due to falls per 100,000 (13/14)	1923	1695	2064

Source: PHOF

The rate of hip fractures in those aged 65 years and over in Carlisle is significantly higher than England in 13/14 and although this is the first year it is significantly higher than England the rate has increased in 12/13 as well as 13/14. The higher rates are seen in males and equate to 46 admissions for males over 65 years in 2013/14.

The table below shows future health projections for **Carlisle,** which will obviously have an impact on services/service provision for older people (Source:POPPI)**:**

CARLISLE	2014	2015	2020	2025	2030
Unable to manage at least one mobility activity on their own	3,923	4,011	4,462	5,074	5,842
Dementia	1,494	1,534	1,764	2,040	2,422
Long standing health condition caused by heart attack	1,050	1,079	1,178	1,320	1,479
Falls	5,704	5,852	6,434	7,208	8,222
Severe depression	591	605	663	750	834
Longstanding Health condition caused by stroke	495	510	561	636	715
Admitted to hospital as a result of falls	448	458	519	599	671

For more information see:

http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/6164/4156583631.pdf and www.cumbria.gov.uk

15.4 Copeland

Living longer: Life expectancy in Copeland is 77.7 years for males and 81.3 years for females. Life expectancy is 12.4 years lower for men and 6.4 years lower for women in the most deprived areas of Copeland than in the least deprived areas.

There were 6,546 injury attendances for people aged 50 years and over; which was a crude rate of 22,173 per 100,000 population. Of total attendees, 57% were female, 97% were for unintentional injuries and 21% were admitted to hospital. Of unintentional injuries, 92% of attendances were classed as other injury, the vast majority of which were likely to be falls. (TIIG Cumbria - Injuries in Older People Report August 2015).

	Copeland	Cumbria	England
Hip fractures in those aged 65+ per 100,000 population (13/14)	519	587	580
Excess Winter Deaths Index (3 year, 2010-13)	14.8	15.0	17.4
Injuries due to falls per 100,000 (13/14)	1615	1695	2064

The table below shows future health projections for **Copeland,** which will obviously have an impact on services/service provision for older people (Source:POPPI)**:**

COPELAND	2014	2015	2020	2025	2030
Unable to manage at least one mobility activity on their own	2,560	2,599	2,946	3,353	3,798
Dementia	951	984	1,151	1,336	1,557
Long standing health condition caused by heart attack	726	740	810	897	982
Falls	3,807	3,880	4,297	4,810	5,388
Severe depression	400	409	445	501	549
Longstanding Health condition caused by stroke	341	350	385	433	474
Admitted to hospital as a result of falls	297	305	346	397	436

For more information see:

http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/6164/41858162916.pdf and www.cumbria.gov.uk

15.5 Eden

Living longer: Life expectancy in Eden is 80.6 years for males and 84.6 years for females. Life expectancy is not significantly different for people in the most deprived areas of Eden than in the least deprived areas.

There were 2,831 injury attendances for people aged 50 years and over; which was a crude rate of 11,656 per 100,000 population. Of total attendees, 57% were female, 98% were for unintentional injuries and 54% were admitted to hospital. Of unintentional injuries, 94% of attendances were classed as other injury, the vast majority of which were likely to be falls. (TIIG Cumbria - Injuries in Older People Report August 2015).

	Eden	Cumbria	England
Hip fractures in those aged 65+ per 100,000 population (13/14)	531	587	580
Excess Winter Deaths Index (3 year, 2010-13)	5.3	15.0	17.4
Injuries due to falls per 100,000 (13/14)	2040	1695	2064

The table below shows future health projections for **Eden,** which will obviously have an impact on services/service provision for older people (Source:POPPI)**:**

EDEN	2014	2015	2020	2025	2030
Unable to manage at least one mobility activity on their own	2,308	2,407	2,700	3,121	3,602
Dementia	907	921	1,085	1,268	1,472
Long standing health condition caused by heart attack	636	655	723	803	889
Falls	3,388	3,500	3,892	4,385	4,971
Severe depression	352	361	400	455	500
Longstanding Health condition caused by stroke	300	308	345	388	430
Admitted to hospital as a result of falls	262	271	313	370	407

For more information see:

http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/6164/41858163759.pdf and www.cumbria.gov.uk

15.6 South Lakeland

Living longer: Life expectancy in South Lakeland is 80.8 years for males and 83.9 years for females. Life expectancy is 6.0 years lower for men and 5.6 years lower for women in the most deprived areas of South Lakeland than in the least deprived areas.

There were 2,388 injury attendances for people aged 50 years and over; which was a crude rate of 4,758 per 100,000 population. Of total attendees, 57% were female, 98% were for unintentional injuries and 43% were admitted to hospital. Of unintentional injuries, 88 % of attendances were classed as other injury, the vast majority of which were likely to be falls. (TIIG Cumbria - Injuries in Older People Report August 2015).

	South Lakeland	Cumbria	England
Hip fractures in those aged 65+ per 100,000 population (13/14)	581	587	580
Excess Winter Deaths Index (3 year, 2010-13)	17.7	15.0	17.4
Injuries due to falls per 100,000 (13/14)	1648	1695	2064

The table below shows future health projections for **South Lakeland,** which will obviously have an impact on services/service provision for older people (Source:POPPI)**:**

SOUTH LAKELAND	2014	2015	2020	2025	2030
Unable to manage at least one mobility activity on their own	5,127	5,195	5,838	6,476	7,359
Dementia	1,972	1,990	2,305	2,651	3,127
Long standing health condition caused by heart attack	1,370	1,393	1,516	1,642	1,790
Falls	7,414	7,530	8,298	9,028	10,121
Severe depression	760	778	837	943	1,022
Longstanding Health condition caused by stroke	647	658	725	797	870
Admitted to hospital as a result of falls	574	585	666	777	841

For more information see; **http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/6164/4156584113.pdf** and www.cumbria.gov.uk

16 User views

Several of the areas referred to within the topic do not have local user or stakeholder information available and national information is referred to:

16.1.1 Older people learning disability

Ward, C (2012) Joseph Rowntree Foundation: Perspectives on ageing with a learning disability

Whilst older parents celebrate the fact that their sons and daughters have survived beyond expectations and enjoyed a full life, worries about what will happen when they are no longer able to care are often overwhelming. Older families have consistently said they want:

• to be known to services before a crisis and have emergency plans in place;

• to feel confident that they have passed on all the information that people may need to support their relative in the future;

• support to make plans for the future and to stay together for as long as they want;

• positive partnerships between families, care workers and services;

• clear, up-to-date information, and support to make good use of it;

• to make their own decisions without feeling rushed into making changes or judged for the way they have cared; and

• to know that the person with a learning disability will be happy, safe and helped to speak up when older family carers are no longer able to support them.

16.1.2 End of Life Care

National Survey of Bereaved People (VOICES), 2014

- 3 out of 4 bereaved people (75%) rate the overall quality of end of life care for their relative as outstanding, excellent or good; 1 out of 10 (10%) rated care as poor.
- 7 out of 10 bereaved people (69%) whose relative or friend died in a hospital, rated care as outstanding, excellent or good. This is significantly lower than outstanding, excellent or good ratings of care for those who died in a hospice (83%), care home (82%) or at home (79%).
- Ratings of fair or poor quality of care are significantly higher for those living in the most deprived areas (30%) compared to the least deprived areas (21%).
- 1 out of 3 (33%) reported that the hospital services did not work well together with GP and other services outside the hospital.
- 3 out of 4 bereaved people (75%) agreed that the patient's nutritional needs were met in the last 2 days of life, 1 out of 8 (13%) responded that the patient did not have enough support to eat or receive nutrition.
- More than 5 out of 6 bereaved people (86%) understood the information provided by health care professionals, but 1 out of 6 (16%) disagreed they had time to ask questions with health care professionals.

- 7 out of 10 (73%) respondents felt hospital was the right place for the patient to die, despite only 3% of all respondents stating patients wanted to die in hospital.

Areas without local user views, national information to be added

- *Long term conditions*
- *Immunisation*
- *Screening*
- *Reablement*
- *Fuel poverty*
- *Excess winter death*
- *Transport and access*
- *Loneliness*

17 Links to Data Sources

NHS Choices - http://www.nhs.uk/pages/home.aspx

Office for National Statistics (ONS) - http://www.ons.gov.uk/ons/index.html

Public Health Outcomes Framework (PHOF) - http://www.phoutcomes.info/

NHS Health Check Website - http://www.healthcheck.nhs.uk/

NHS England - https://www.england.nhs.uk/

Public Health England - https://www.gov.uk/government/organisations/public-health-england

Cumbria County Council - www.cumbria.gov.uk

Cumbria Observatory - http://www.cumbriaobservatory.org.uk

Department for Transport (DfT), Accessibility Statistics - https://www.gov.uk/government/statistics/accessibility-statistics-2013

Cumbria Third Sector Census - http://cumbriacvs.org.uk/wp-content/uploads/2014/05/Cumbria-Third-Sector-Census-Volunteer-factsheet-2009.pdf

Nomis https://www.nomisweb.co.uk/

18 References

Global Age-friendly Cities: A Guide, World Health Organisation, 2007

Draft Healthy Living and Lifestyles Chapter Cumbria JSNA, 2015

Draft Commissioning Strategy for Care and Support delivered by Adult Social Care 2015-2020

Healthy Ageing Evidence Review, Age UK

The better care together strategy the future for health and care services in Morecambe Bay, Better Care Together Team, February 2015

Commissioning for Carers: Principles and resources to support effective commissioning for adult and young carers, December 2014

Cumbria Injuries in Older People Report, TIGG, August 2015

Principles and resources to support effective commissioning for adult and young carers, NHS England, December 2014

The Government's 2008 End of Life Care Strategy, DoH, 2008

District Activity Profile, Adult Social Care, September 2015

Promising Approaches to Reducing Loneliness and Isolation in later life, Age UK, January 2015

NICE CG161 Falls: assessment and prevention of falls in older people

NICE NG6 Excess winter deaths and illnesses associated with cold homes, 2015

NICE CMG42 Guide for commissioners on end of life care for adults, 2011

Cochrane reviews

Fuller Working Lives – Background Evidence, Department of Work, 2014

Fuller Working Lives – A Framework for Action, Department of Work, 2014