Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 18 September 2013

Subject: Promoting social inclusion of older people through the age-friendly city programme

Report of: Liz Bruce, Strategic Director, Families, Health and Wellbeing
David Regan, Director of Public Health

Summary

This report sets out the city's plans for promoting social inclusion of older people through the World Health Organisation's age-friendly city methodology, and its connections with the Health and Wellbeing strategy.

The report also describes a number of new initiatives being taken across the city linked to the urban ageing agenda.

Recommendations

The Board is asked to

(1) Note and approve the approach set out in this report.

(2) To consider strengthening clinical representation from the Health and Well-being Board on the Age-friendly Manchester senior strategy group.

(3) To receive a further report from the Manchester Institute for Collaborative Research into Ageing on its five year development plan.

Board Priority(s) Addressed:

Enabling older people to keep well and live independently in their community

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to four years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

- Manchester Ageing Strategy 2010-2020
- Age-friendly Manchester Development Plan 2013/15

1 Introduction

1.1 This report sets out the city's plans for promoting social inclusion of older people through the World Health Organisation's age-friendly city (AFC) methodology, and its connections with the Health and Wellbeing strategy.

1.2 Section two describes the background and rationale for the AFC approach: section three sets out four Manchester AFC development themes and relevant key actions, and: section three highlights a number of new projects which promote AFC objectives.

2 Creating an age-friendly city and health and wellbeing: links and dependencies

2.1 The Age-Friendly city concept was developed in 2006/7 by the World Health Organisation (WHO) by an international research programme that involved cities in 33 countries. It is now an internationally recognised platform to enable and facilitate good quality-of-life for older people and prepare urban areas for ageing populations. The WHO Global Network which was launched in 2010 has grown from ten members (of which Manchester was an initial member) to over 150 cities and national programmes in just three years.

2.2 The WHO defines an AFC through eight separate but interrelated 'domains', outdoor spaces and buildings, housing, transportation, social participation, respect and social inclusion, civic participation and employment, communication and information and community and health services. Each one of these eight domains, is characterised by its own particular set of age-friendly features.

2.3 There are clear links between the AFC approach and priority eight of the Health and Wellbeing Strategy (HWBS), in particular the objective to reduce loneliness and social isolation. For example research evidence describes how people who are lonely have a lower quality of life than those who are not lonely. Moreover, lonely people die earlier and those experiencing chronic loneliness poses the greatest risk of premature death and increased mortality.

A recent review of the existing evidence suggests that the health risks associated with poor or inadequate social relationships are comparable to those of smoking and alcoholism, and higher than those associated with obesity and physical inactivity. Further loneliness is linked to a wide range of physical and mental health conditions. Loneliness also predicts Increased blood pressure and heightens the subsequent risk of cardiovascular disease, heart attacks and strokes: Is linked to a range of psycho-social problems, including sadness and low self-esteem, whilst, mental health conditions, such as dementia, depression, anxiety, and poor cognition are more prevalent amongst people who are lonely. Lonely people are more likely to use medications and consume alcohol than those who are not lonely.

2.4 Loneliness has broader impacts that affect families, friends and neighbours, communities, and society as a whole and an account of these

impacts are attached in Appendix 2.Accordingly the link between isolation/loneliness and other forms of exclusion demands strategies designed to address these issues are multi-agency and multi-dimensional in nature.

2.5 The dividend to successfully implementing the AFM programme is significant, and goes beyond the direct improvements in older people's lives. The programme can reduce demand on public and community services; promote neighbourhoods to become more stable and sustainable; and further enhance the city's reputation as a place of excellence in connection with ageing policy, research and implementation which will continue to attract resources to the city. Lastly there is potential of an 'economic advantage' to those international cities, and in our case, city-region, that can respond positively to an ageing population.

2.6 Improving community health and support services is one of the eight WHO domains, placing the Living Longer, Living Better (LLLB) programme at the heart of creating an age-friendly Manchester. By the same token city agencies acting together to improve the quality of life of older people through the AFM programme can reduce the demand of the health and social care system and therefore contribute to the strategic objectives of LLLB.

2.7 The AFM programme has worked closely with the Valuing Young People programme, in particular in designing opportunities for intergenerational projects, and sharing learning between the initiatives.

3 AFM Development Plan

3.1 In Manchester, the AFC concept builds on the city's own long-standing citizenship approach to ageing: shifting the focus of attention away from the traditional care models around provision of ageing services (working for older patients or 'consumers') to developing programmes that are led by older people as active citizens. The AFM Development Plan 2013-15 is based around four themes as follows: Age-friendly Neighbourhoods; Knowledge and Innovation; Age-friendly Services; and Involvement and Communication.

Age-Friendly City neighbourhoods

3.2 In an AFC, neighbourhoods have a particularly important role to play: providing basic services for older people (within easy reach); offering networks of social support as well as providing older people with opportunities to take part in and give back to the community in which they live. Neighbourhoods also provide an important sense of community and place too (particularly within the context of unsettling urban change). As people start to spend more of their time in neighbourhoods in older age, there is a growing reliance on those structures that exist at a neighbourhood level and a growing attachment to local neighbourhoods too.

3.3 The AFM programme will build on Valuing Older People's (VOP) locality approach and its extensive neighbourhood networks to create a series of age-

friendly neighbourhoods initiatives across the city. Key actions include: Increasing volunteering opportunities for older people, using the volunteer-led approach developed by the Retired and Senior Volunteer Programme; further developing the AFM small grants programme; supporting local initiatives that promote social participation and tackle loneliness and isolation; and, further developing, with local regeneration teams, the VOP/Age-friendly networks and a range of local-based projects.

Knowledge and Innovation

3.4 A key element of Manchester's age-friendly programme is its commitment to support and develop 'age-friendly' knowledge and innovation. This means devising age-friendly policies, programmes and strategies that are based on evidence and the latest academic research. It means promoting new research on ageing and age-friendly environments across the city, and making sure that that knowledge is shared to audiences across Manchester – and further afield.

3.5 AFM has established strategic partnerships with two of the UK's leading ageing research groups, at Manchester and Keele Universities. These partnerships have led to substantial investment in a range of groundbreaking research and community projects that have secured Manchester's reputation as the city for researchers from a wide range of policy, governmental and research bodies. Other ongoing partnerships exist, with Edinburgh, Leeds and Manchester Metropolitan universities.

3.6 AFM is also developing a Research and Evaluation Framework for Age-Friendly Cities that represents the most comprehensive example in the UK of an evidence-based foundation for an urban ageing strategy – and evaluate work on ageing. Overseen by a small steering group, which includes local and national experts, the Framework builds on inputs in from the WHO international indicator pilot project of which Manchester has been a first wave member.

3.7 AFM is also helping to develop a number of Age-Friendly Demonstrator Pilots across the City. These pilots test out new forms of Age-Friendly work in a variety of different contexts from community-based urban design, to collaborations on economy and ageing with leading policymakers. The Old Moat AFC project led by Southway Housing has seen social researchers working with architects, urban designers and local partners to produce a breakthrough piece of work.

Age-Friendly Services

3.8 'Age-Friendly Services' is all about encouraging and supporting services across the city to become more age-friendly and making sure that older people form an integral part of the strategies of services across the city (from libraries to leisure to the fire service to transport). For Age-Friendly Manchester, this means working with service providers to help shape and adapt their services to ensure that that as service providers they understand and are sensitive to the particular needs of older residents across the city; (ii)

that they are providing the best possible service to older residents across the city – and, most importantly, (iii) that as service providers they commit to providing services that are inclusive, available and accessible to older people.

3.9 Practically, this programme of work involves supporting services to better understand both the principles of age-friendliness as well as the particular context of ageing in Manchester. Two externally evaluated examples are:

- Age-friendly workforce: 75 front line staff, from a broad range of organisations, have graduated from the VOP ageing studies programme. An eight module course co-designed and delivered with Keele University, has now been adopted by three other local authority areas.
- The VOP cultural programme: has attracted £500k to the city in new services for older people and led to 100 residents becoming community cultural champions.

3.10 While the current climate of austerity and cuts to services challenges the ambition of the age-friendly programme to create age-friendly services across the city the impact of these cuts heightens the urgent need to ensure that these services understand and commit to the needs of older residents who are particularly exposed to the loss of services that they have grown to rely upon.

Involvement and communication

3.11 Over the last ten years, Manchester has built up a strong community engagement base through VOP– working closely with older residents to actively shape the work of its older people's programme as well as cultivating a broader culture of participation and involvement across the city, inspiring older people to feel involved and part of the city in which they live.

3.12 That commitment to involve and empower older people across the city continues through the AFM programme: making sure that older residents are able to shape its AFC strategy through the VOP Board and Forums as well as communicating the work of both the programme and broader opportunities available to older people across the city through a communications strategy that commits to challenging negative perceptions around ageing and older people.

3.13 Involvement in the AFC programme also involves engaging others: professionals, academics, the private sector and the voluntary and community sector – broadening the platform of interest and commitment to the AFC agenda – and, in the process, sharing knowledge, know-how and expertise on how the city might be made more age-friendly.

AFM Governance

3.14 A senior strategy group drawing on a wide range of agencies has been established for Age-friendly Manchester and been charged with promoting innovation, investment and informed decision-making. The senior group is chaired by Councillor Sue Murphy, the Council's Deputy Leader. The group's

membership is attached as appendix 2. An annual statement of progress will be submitted to the Health and Well Being Board.

3.15 Clinical representation either directly from, or nominated by, the Health and Well-being Board on the Age-friendly Manchester senior strategy group would strengthen links between the two groups. Moreover, it would give add the city's health services unique voice to the AFM programme.

4 AFM: promoting innovation, investment and informed decision-making

4.1 Central to the next phase of AFM is working in partnership to attract resources and expertise to the city to support age-friendly programmes in a coordinated and strategic approach. Below are four new initiatives that the city is taking.

GM-wide working and Ageing Centre of Excellence

4.2 Manchester is part of a GM-wide bid to the Big Lottery's "Ageing Better" £70m fund aimed at reducing social isolation amongst older people. The GM bid, which is being coordinated by AGMA, has been successful in reaching the last 30, out of 150 local authorities that were invited to take part. Manchester is working with the other authorities to appoint a local third sector agency to lead the next stage of the process, which will see 15 areas benefit from a six year investment. The Big Lottery Fund already funds ageing projects run by the Retired and Senior Volunteering Programme (based with VOP), Healthy Ardwick, and Levenshulme Inspire.

4.3 An additional £50m has been allocated by the Big Lottery to develop a national Centre of Excellence into ageing. Members of the VOP team have met with colleagues from the Big Lottery, setting out the type of research-policy-practice model that it is felt would be most effective. We have been invited to follow-up this meeting with further proposals.

4.4 The GM Public Health team has established a group to pool experience and capacity around the region, which Public Health Manchester is taking part in.

Manchester Institute for Collaborative Research in Ageing (MICRA)

4.5 Launched in April 2010 MICRA was established as a network promoting interdisciplinary and innovative research on all aspects of ageing across the University of Manchester. Two years on, MICRA has established itself as the University's vehicle for generating research on ageing and has achieved significant results Membership approaching 700, close to half from the University of Manchester (about 150 academics from all four faculties and around 140 students) plus NHS, local government, NGOs, practitioners, members of the public, the private sector and other universities; Steering committee of leading academics encompassing fourteen disciplines, key NGO stakeholder representatives, Manchester City Council and older people themselves

4.6 The Council has worked closely with MICRA, with the VOP team and Board sitting on its Steering group. Manchester agencies have also endorsed a number of successful funding bids, including, a two-year programme based on the experience of the Belgian Ageing Study – an acclaimed national programme - to work in three Manchester neighbourhoods. The new programme arose from the collaboration of the Valuing Older People team; the University of Manchester; and the Manchester School of Architecture. The programme will be supported by Prof. Chris Phillipson and Dr. Tine Buffel who have received funding to support this project from the European Commission.

CCG loneliness and isolation programme

4.7 Macc is coordinating a new CCG-funded programme aimed at reducing loneliness and social isolation amongst older people in the city. A total of £550,000 has been set aside by South, Central and North Manchester Clinical Commissioning Groups (CCGs) to provide grants to Voluntary and Community Sector Organisations (VCSOs) to reduce the isolation and loneliness of older people . The Grant Programme is governed by a Programme Board made up of representatives from CCGs and other stakeholders. It is intended that the Grant Programme presents opportunities for learning by all participants at every stage. Each of the larger projects will be partnered with a nominated representative from the appropriate CCG.

OECD programme

4.8 Manchester has been invited to take part in a research study being carried out by the Organisation for Economic Co-operation and Development (OECD), to form part of a new report on urban development in ageing societies. The new OECD report, "Sustainable Urban Development Policies in Ageing Societies", will give policy tools and recommendations for the development of urban communities, looking at population ageing trends, the challenges and opportunities of ageing societies, a range of case studies and an assessment of current urban city policy. Manchester's case study will be showcased in the report as one of four cities from across the globe, alongside Lisbon (Portugal), Milan (Italy) and Toyama (Japan).

Recommendations

The Board is asked to:

(1) Note and approve the approach set out in this report.

(2) To consider strengthening clinical representation from the Health and Well-being Board on the Age-friendly Manchester senior strategy group.

(3) To receive a further report from the Manchester Institute for Collaborative Research into Ageing on its five year development plan.

Appendix 1: Social isolation, loneliness and social exclusion

This information is based on a review of research conducted by Professor Thomas Scharf, formally at Keele University and now Director, Irish Centre for Social Gerontology, NUI, Galway

1 Social isolation and loneliness: defining the terms

1.1 The terms loneliness and social isolation are often used interchangeably. While there are clear links between isolation and loneliness, it is useful to treat them as being distinctive. It is possible for people to be isolated but not lonely and vice-versa.

1.2 *Social isolation* refers to an individual's lack of contacts or ties with other people. In this sense, it is an objective measure. If someone does not regularly meet with, or speak to, family members, friends, neighbours or other people, then they are socially isolated.

1.3 *Loneliness* is a subjective and negative experience – it is felt by individuals based on perceptions of their personal social relationships. One of the most commonly used definitions describes loneliness as being 'the unpleasant experience that occurs when a person's network of social relations is deficient in some important way, either quantitatively or qualitatively' (Perlman and Peplau). As a consequence, while some people may have many social contacts and still feel lonely, others may have very few contacts and not experience loneliness.

2 Impacts of loneliness on individuals in later life

2.1 Loneliness is experienced by individuals as a negative feeling. A growing body of research evidence shows that people who are lonely are affected in a number of ways by such negative feelings. While some of the impacts of loneliness are perhaps predictable, others may be more surprising.

2.2 *Loneliness reduces quality of life*: people who are lonely have a lower quality of life than those who are not lonely.

2.3 *Lonely people die earlier*: people of all ages who report that they are often lonely are more likely to die than people who are not lonely. While chronic loneliness poses the greatest risk of premature death, situational loneliness is also associated with increased mortality. A recent review of the existing evidence suggests that the health risks associated with poor or inadequate social relationships are comparable to those of smoking and alcoholism, and higher than those associated with obesity and physical inactivity.

2.4 *Loneliness is linked to a wide range of physical and mental health conditions*: people who are lonely are more likely to have physical health problems, ranging from conditions affecting the immune system to sleep. Loneliness:

- Predicts increased blood pressure and heightens the subsequent risk of cardiovascular disease, heart attacks and strokes, and
- Is linked to a range of psycho-social problems, including sadness and low self-esteem, whilst
- Mental health conditions, such as dementia, depression, anxiety, and poor cognition are more prevalent amongst people who are lonely.
- Lonely people are more likely to use medications and consume alcohol than those who are not lonely.

3 Broader social and economic impact of loneliness in later life

3.1 Loneliness is an issue for individuals, seriously diminishing the quality of their later lives. Equally, loneliness has broader impacts that affect families, friends and neighbours, communities, and society as a whole.

3.2 *Impacts on families, friends and neighbours*: while severe loneliness affects a relatively small proportion of older people, having a spouse or partner, a family member, a friend or a neighbour who is very lonely means that the impact of loneliness is likely to be felt much more widely. Providing support to someone who is lonely – especially when loneliness is an enduring condition – can cause stress and anxiety. In some cases, people providing such support might also withdraw from their own social relationships, increasing their own potential for isolation and loneliness. Recent research highlights the ‘contagious’ effects of loneliness, with loneliness spreading from person to person in a social network, and reducing the ties of these people to others in the network.

3.3 *Impacts on communities*: a range of community-based interventions, provided by local authorities and by community and voluntary groups, are designed to respond to older people’s isolation and loneliness. Befriending and peer-support schemes, social clubs and day centres, and a variety of mental health initiatives seek to improve older people’s social contacts and enhance individuals’ engagement in their local communities. There is growing evidence that points to the cost-effectiveness of such interventions. Moreover, the existence of these schemes emphasises the supportive nature of local communities. There are nevertheless economic and social costs associated with these types of interventions that are borne by communities.

3.4 *Impacts on society as a whole*: the effects of overlooking loneliness are felt across society as a whole, but may be difficult to identify. Both social and economic costs arise from a failure to address people’s feelings of loneliness. For example, lonely people are more likely to be in contact with their general practitioners, to be admitted to hospital as emergency cases, and to enter long-stay nursing care. The economic costs that are associated with increased use of health and social care services are picked up by society as a whole.

4 Loneliness in cities and urban neighbourhoods

4.1 There is relatively little reliable evidence relating to differences in the prevalence of loneliness across different geographic areas. In particular,

researchers are unsure about whether older people who live a city such as Manchester are more likely to be lonely than those who live in other cities or in suburban or rural communities.

4.2 However, some British studies suggest that loneliness rates tend to be higher amongst older people who live in socially disadvantaged urban communities. While around seven per cent of older people in the UK as a whole are often or always lonely, a study in the London Borough of Hackney reported a loneliness rate of 16 per cent; a 2002 study of deprived neighbourhoods of three English cities, including parts of Manchester, also identified 16 per cent of older people as being severely lonely.

4.3 Closer examination of geographic data suggests that even within socially disadvantaged urban communities rates of loneliness amongst older people vary considerably. Scharf and de Jong Gierveld (2008) report lower loneliness scores in deprived communities in London and Liverpool than in similar communities in Manchester.

4.4 There are at least three reasons why loneliness rates may be higher in some types of urban community.

- First, older people might be adversely affected by changes in the physical fabric of cities. This relates, for example, to the ways in which urban spaces are increasingly developed to meet the needs of affluent, younger consumers. The physical characteristics of some urban areas may no longer be conducive to maintaining the types of social relationships that can protect older people from isolation and loneliness or facilitate good mental health.

- Second, older people's social well-being is prone to changes in population composition. While some urban areas display relatively little population change, others experience high rates of population turnover. The loss of family members, friends and neighbours – either through out-migration or death – has implications for the maintenance of the stable social relationships that are often highly valued by older people and which can protect against the risks of isolation and loneliness.

- Third, older people are affected by changes linked to a broad array of social issues within urban neighbourhoods. For example, they may become vulnerable as a result of a changing service, or as a consequence of their perceived vulnerability to crime and a resultant fear of crime.

5 Social exclusion: the relationship between loneliness in later life and other forms of disadvantage

5.1 One reason why it is important to address older people's loneliness is that loneliness is often associated with other forms of disadvantage that affect people as they age. In this context, loneliness can be regarded as a key element of social exclusion.. In their conceptualisation of social exclusion, Scharf and colleagues (2005) highlight five different dimensions of exclusion:

- Exclusion from material resources, identifying the central role played by income and material security in determining individuals' ability to participate in society;
- Exclusion from social relations, reflecting the importance attributed to the ability to engage in meaningful relationships with others;
- Exclusion from civic activities, recognising the need for individuals to be able to engage in wider aspects of civil society and in decision-making processes which may in turn influence their own lives;
- Exclusion from basic services, drawing upon the key role played by access to services in and beyond the home in terms of individuals' ability to manage everyday life;
- Neighbourhood exclusion, reflecting the contribution made by the immediate residential setting to an individual's sense of self and, potentially, their quality of life.

5.2 Loneliness reflects an individual's exclusion from social relations. It also forms a component of a set of interlocking forms of disadvantage that can reduce the quality of people's lives as they age. Evidence suggests that exclusion from social relations is closely related to exclusion from material resources, exclusion from basic services, and neighbourhood exclusion. In a survey of people aged 60 and over living in disadvantaged urban communities in England, of respondents who were excluded from social relations 43 per cent were also excluded from material resources, 34 per cent from basic services, and 28 per cent from the neighbourhood (Scharf et al., 2004). Loneliness is thus associated with having a low income, having reduced access to key services, and negative perceptions of the neighbourhood immediately surrounding the home.

Appendix 2: membership of the Age-friendly Manchester Senior Steering group.

Councillor Sue Murphy	Manchester City Council
Councillor Sue Cooley	Manchester City Council
Councillor Daniel Gillard	Manchester City Council
Prof Chris Phillipson	Manchester University
Paul Bason	Manchester Met University
Dave Carter	Manchester Digital Development Agency
David Regan	Director, Public Health Manchester
Kate Torkington	VOP Board member
Zoe Robertson	MCC - Children's and Commissioning
Paul Beardmore	MCC - Director, Manchester Housing
Karen Mitchell	Southway Housing Regeneration
Nick Gomm	Manchester Clinical Commissioning Groups
Eamonn O'Rourke	MCC Cultural and Community Services
Stuart Murray	Transport for Greater Manchester
Evelyn Asante-Mensah	Black Health Agency
Paul Martin	Lesbian and Gay Foundation
Esme Ward	Manchester Museum and Whitworth Art Gallery
Elaine Morrison	MCC - Valuing Young People group