Appendix A

Somerset: Our County

Joint Strategic Needs Assessment

Summary 2017
Ageing Well

DRAFT

Somerset Health and Wellbeing Board

DRAFT

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INTRODUCTION

Welcome to Somerset's Joint Strategic Needs Assessment (JSNA) summary for 2017.

Since 2008, when the JSNA came into being through the Health and Social Care Act, this needs assessment has been a 'must do' for all county councils in England and is the responsibility of our Health and Wellbeing Board.

Our objective is to examine the health, wellbeing and social care needs of the whole Somerset population. The JSNA's main purpose has always been to inform commissioners and provide them with accessible information to help them develop and improve services. A large needs assessment like this, therefore, brings together a lot of data and statistics and looks at what we can expect in the future and what we can learn from the past.

There are many, many factors that influence how well we are, both mentally and physically, which is why we collect information on housing, transport, employment, education, hospital admissions, environment, employment - and much more. This gives us a rounded picture of need and helps commissioners (not only in the local authority but in the district councils and the NHS) in their decision-making.

There is often a specific focus to a JSNA and ours this year is 'ageing well'. The public health agenda is very much about prevention; how can we prevent or mitigate ill health and how can we help future generations to maintain good health and wellbeing throughout their lives. It might be a 'slow fix' but it is an intention that brings huge benefits.

This summary is complemented by an interesting qualitative enquiry looking at some Somerset people's experience of ageing. His work has mainly taken the form of discussion groups and interviews; these add depth to our facts and figures and we've included quotes and observations in this summary. During these discussions there was often a lot of empathy expressed towards younger people in Somerset and a real desire to encourage and support younger generations to stay healthy and well, learning the lessons from the past.

My personal thanks go to the many people who help put the JSNA together and the Health and Wellbeing Board for its continued direction and support. We hope you will explore the Somerset Intelligence website which hosts the JSNA and all the information that supports it www.somersetintelligence.co.uk

Christine Lawrence

Chair of Somerset Health and Wellbeing Board

Trudi Grant

Director of Public Health

EXECUTIVE SUMMARY AND IMPLICATIONS FOR COMMISSIONERS

Most of us aspire to health and wellbeing throughout life but in reality many of us do not achieve this. As we explore in this JSNA, many people in Somerset live a long life but not necessarily a healthy one throughout, often people experience health problems as they get older which hinder the way we are able to live our lives and how independent we remain.

Being aware of how we remain healthy and well throughout life and knowing about aging and how to prepare for it is a responsibility of all of us. Moving into older age should be a positive and celebrated part of life. It should be the time when a lifetime of experience, learning and hard work come to fruition. It's often the time of our lives when we know ourselves best of all.

The points below summarise the findings from both the data and qualitative information that has informed this JSNA. These points have been written to inform how services should be developed and delivered in the future.

Remaining healthy

- **Prevention first and foremost** - Nearly half the burden of disease for older people can be attributed to conditions that can be prevented or delayed by changes in lifestyle. The 'usual suspects' - not smoking, drinking responsibility, maintaining good social contacts, eating well and exercising – contribute strongly to ageing well.
- **Dementia** is the condition most associated with getting older. This risk, too, can be reduced by a healthier lifestyle earlier in life.
- There is **no 'safe age'** before unhealthy activities begin to have an effect, nor an age after which improvements do not help.
- Many older aged people are keen to engage with younger people on matters relating to health and wellbeing, they are keen for young people to **learn from what has already past**. Many services and communities would benefit from utilising and supporting this natural resource.
- The importance of maintaining **social and intergenerational contact** is clear and needs a far greater emphasis in the future.
- **Inequalities in health are very evident**, with a small number of poorer older people having a disproportionate burden of disease and so increased cost to health and care. A far greater focus on reducing inequalities will improve lives and save public money.

Remaining independent

- **Staying independent**, preferably in one's own home, is important to older people, there is a great deal of emphasis on more self-help and short-term assistance to regain independence.

- Formal health and care exist within a wider context of the immediate and extended family, and the voluntary and community sector. **The contribution and needs of family carers** in particular needs greater recognition.
- **Good transport** helps independence and social contact in town and the countryside, affordable and sustainable transport solutions are important to keeping older people healthy and well.
- Design and local planning policy has a significant impact on health and independence, particularly for older people seeking appropriate housing solutions without having to move out of their community and away from their social support. **Housing policy** should take health and wellbeing impact into account.

Remaining active and included in community life

- **Social contact** is an essential part of sustaining health and wellbeing.
- Volunteering is of benefit to the community and to the volunteer.
- Rewarding and valued **work** is good for health. Employers should recognise the contribution to be made by older workers, including people past current state pension age.
- Supporting **stronger communities** through village agents, town and parish councils and voluntary groups such as Men's Sheds provides a cost effective way to health and wellbeing across all ages.
- Maintaining social contact into older age can create a **support network** that helps people stay independent in their own homes.

MAIN SUMMARY - BACKGROUND AND CONTEXT

This JSNA, with its focus on 'ageing well', addresses some of the most pressing issues for individuals and public sector bodies in Somerset. Better healthcare over recent decades has led to an increase in life expectancy. This success story, combined with inward migration during middle age, means that the county's population is getting older on average.

'Ageing well' can mean many things, but maintaining good health, social contacts and personal independence are high in almost everyone's priorities. Encouraging people to age well is also of high importance for health and social care services. Healthy, connected and independent people typically delay reaching the stage when they need state-funded support for longer and reduce the pressure on services.

The JSNA concentrates in particular on matters that can be directly influenced through local policy. Issues such as state pension, national retirement age and genetic influence are largely outside of the scope of local action and therefore have not been considered in detail here.

Aging well is an issue that impacts on all of us. It is not a question of simply balancing wellbeing against cost to the public sector; we should expect that a county where more people age well should give benefits to all, whether it's a vibrant third sector, a more thriving economy or greater opportunity to maintain traditional skills and knowledge. This report looks at what it means to age well, what can be done by individuals in middle age and beyond to achieve it, and how Somerset can pull together to improve the life experiences of older people.

The United Nations describes population ageing as 'one of the most significant social transformations of the twenty-first century'[i] and its consequences are unsurprisingly wide ranging. A wealth of information on the social circumstances in Somerset is available on the Somerset Intelligence website (www.somersetintelligence.org.uk/jsna , links to relevant individual pages are also shown throughout this summary. All the webpages relating to ageing well are collected in a single document at (www.somersetintelligence.org.uk/jsna/ageingwell2017.pdf). The web site *is the JSNA*. This document is a summary of its implications.

Definitions and Scope

We have taken 65 as the start of old age – matching state pension age for many. There are 125,000 people aged over 65 in Somerset (http://www.somersetintelligence.org.uk/population-estimates-and-projections/). We have not set an upper age limit, but accept that beyond 85 many people may find activities limited by ill health. Ageing well is also inevitably linked to good quality end of life; this important issue has not been explored it in detail here but is the subject selected for the 2017 Annual Public Health Report in order to complement this JSNA[ii].

Demography – general overview

Somerset covers 3,452 square kilometres (1,333 square miles). The county comprises:-

- Five Districts (Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset)
- 54 County Electoral Divisions
- 138 District electoral wards
- 330 Parishes (excluding Taunton, which is ‘unparished’) and 276 parish or town councils

An estimated 545,390 people live in Somerset (June 2015[iii]) and currently the population is rising by more than 3,000 per year. It is estimated that 48% of the population live in a rural area.

Somerset attracts people of working age, who get older, and people who move on retirement. One in five of the resident population is now aged over 65 with West Somerset having the highest percentage of people over 65 at 33% of the population.

Figure 1- Map of Somerset and districts (Ordnance survey)

SECTION I: REMAINING HEALTHY

Just as life expectancy is the most comprehensive summary measure of population health, so healthy and disability-free life expectancy, calculated on the basis of surveys, summarises how much of life is spent in good health. Figure 2 shows that, excepting a slight fall in the last years' data[iv], life expectancy has shown a steady rise, this has not been matched by an increase in healthy life, meaning that a longer length of time, and a longer proportion of life, is being spent, in poor health. This is not only bad news for the population, but for providers of health and care services. Ageing, *per se*, is not putting pressure on services, but an increasing number of people living with long term conditions *is*.

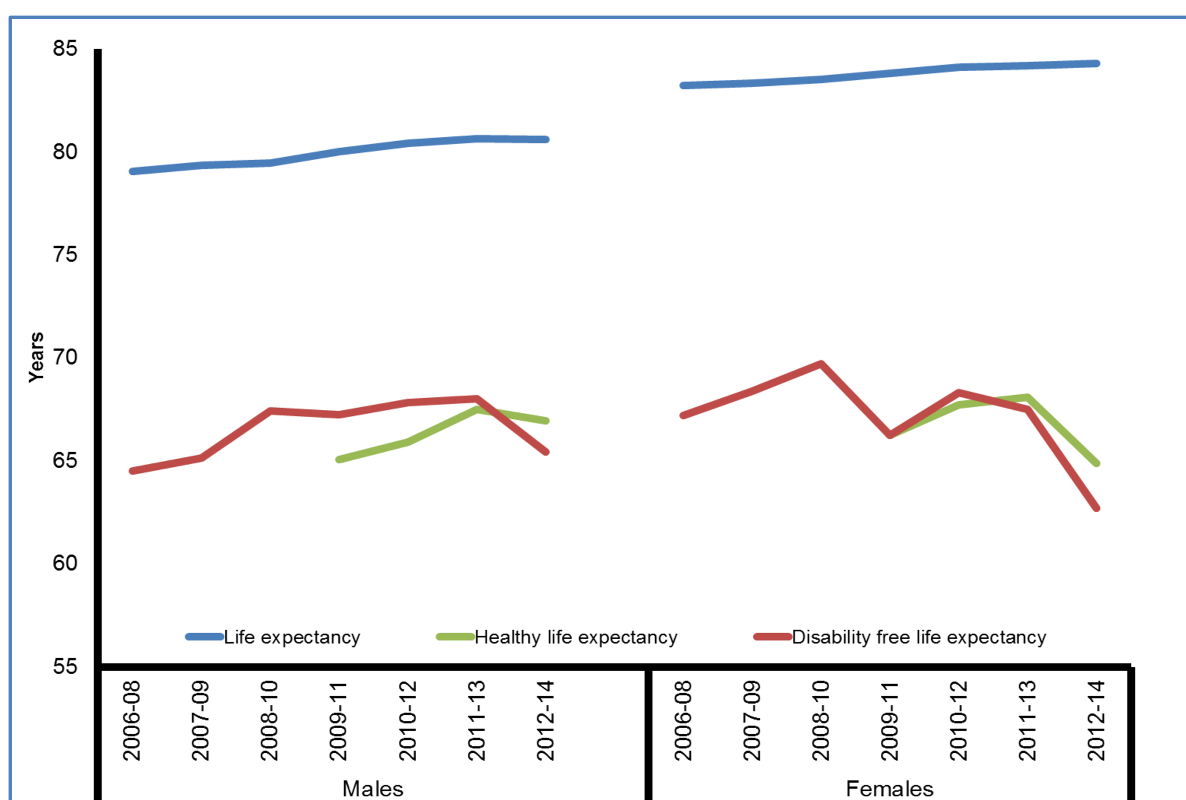


Figure 1 - Life expectancy and healthy life expectancy, Somerset

Figure 3 following shows how the proportion of people who describe their health as 'good' or 'very good' declines with age. This is not unexpected. What is more interesting however is looking at the best and worst areas nationally. Hart in Hampshire does best on this measure in England, they show little variation before people are in their late 30s and 40s. Tower Hamlets in East London which does worst nationally on this measure shows half of all people aged 60 and above say that their health is not good – a level that is only reached in people aged over 80 for Hart. Somerset shows a healthier pattern than the England average, but is still some way behind the best.

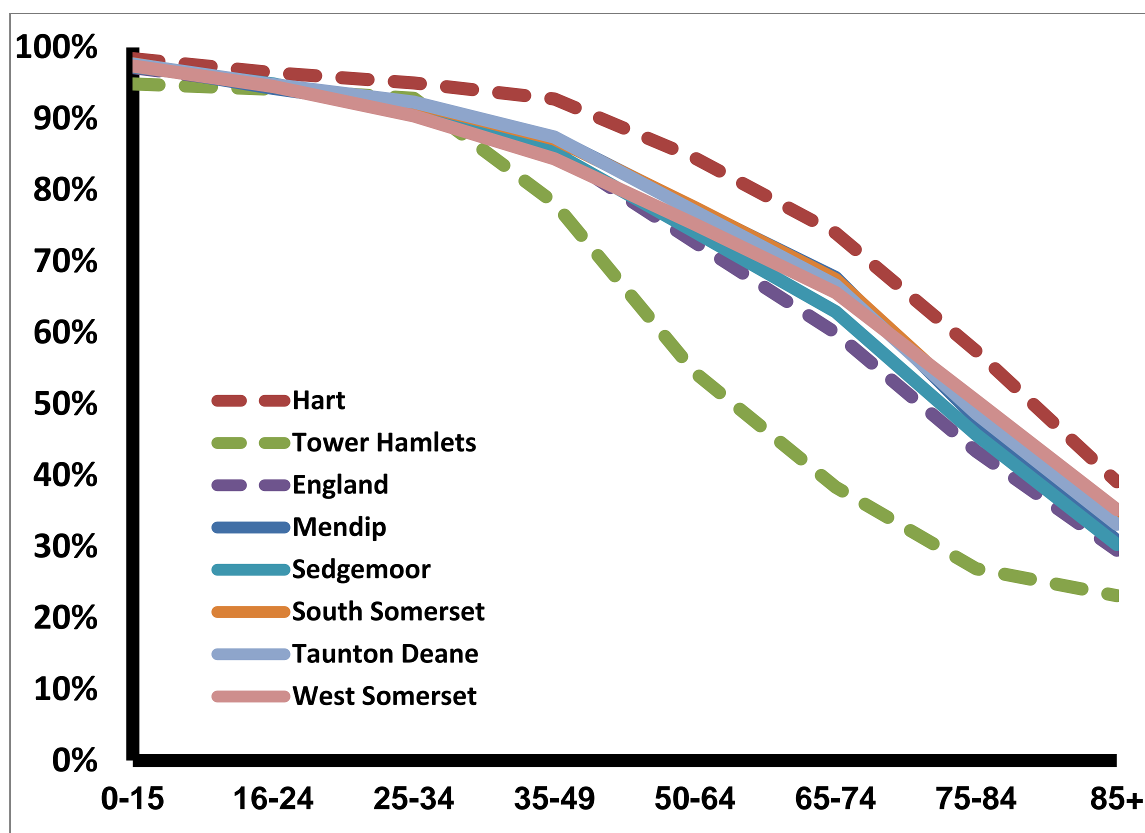


Figure 2 - Self reported health (2011 census)

Looking within Somerset, we are able to use census data to compare how ill people are with how well that they feel. Figure 4 below shows the proportion of people with long term conditions, plotted against the proportion of people saying their health is good or very good, for LSOAs in Somerset. Unsurprisingly, there is a strong relationship. But, it is not a perfect relationship and clearly some communities have more people with long term conditions, but *feeling* well, and some have the reverse.

Areas labelled in black are those where more people are able to age well; they seem generally more prosperous than those in red, where self-reported health is worse than the 'actual' health might suggest. The higher social capital of prosperous neighbourhoods is reflected in a better feeling of health as well.

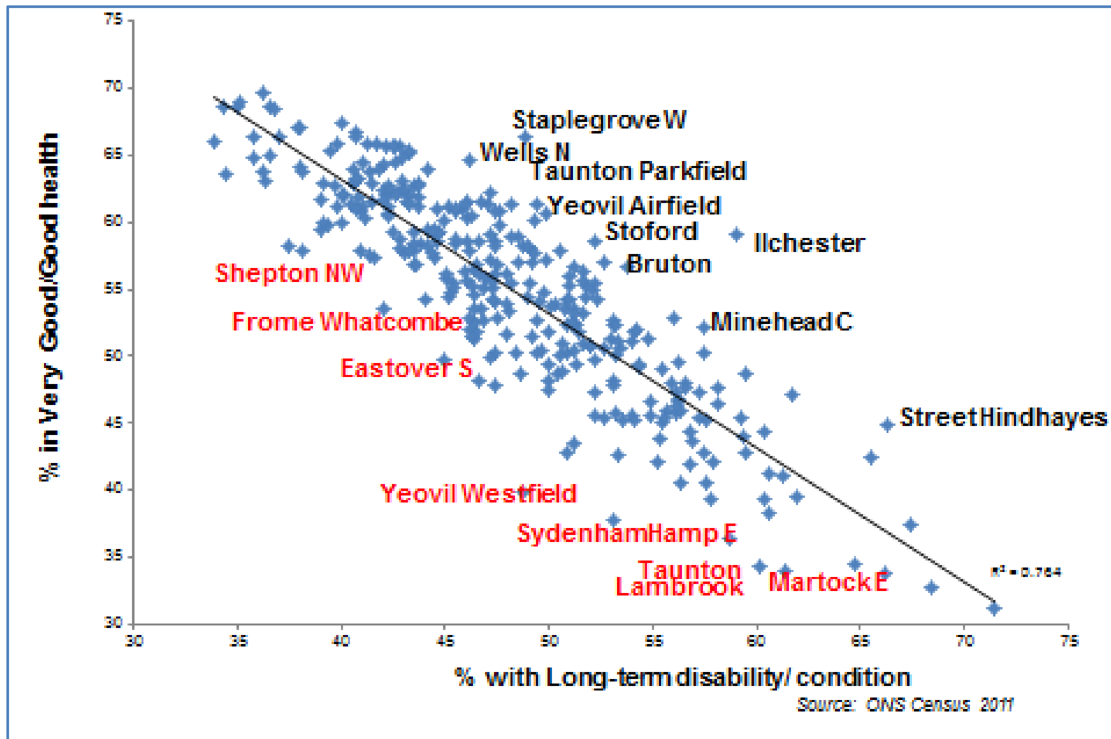


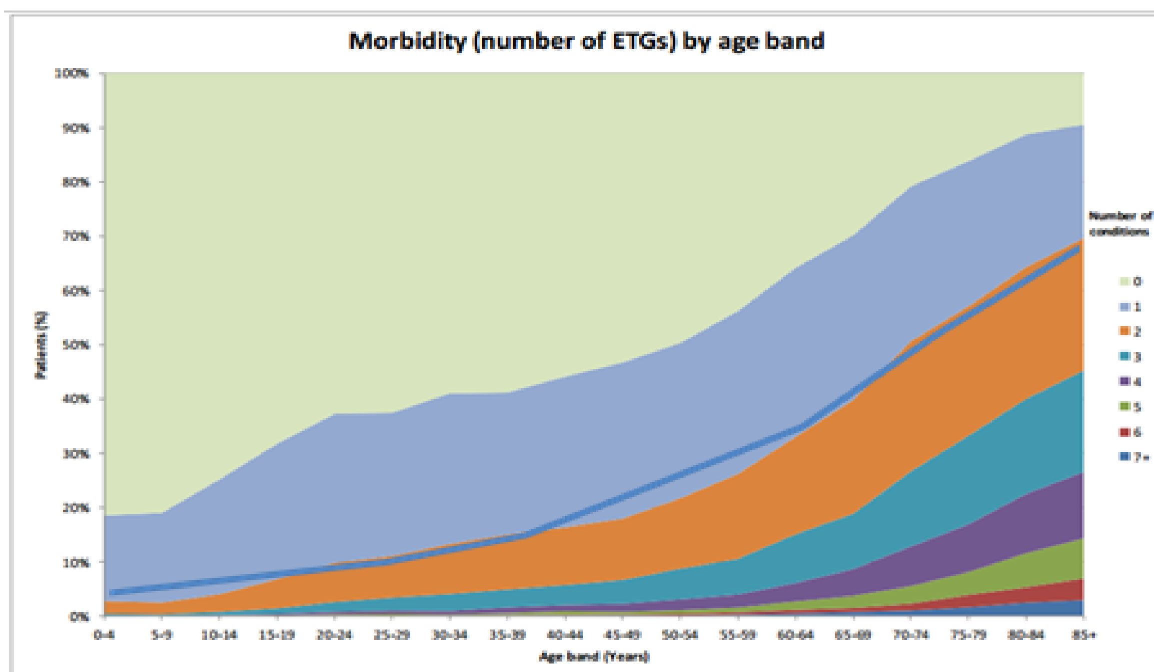
Figure 4 - Age 65+ Good health vs long-term condition

There needs to be a far greater focus on improving the health and wellbeing of those people who are the worst off in our society. Tackling the inequalities associated with ageing well can improve people's lives and makes financial sense for health and social care services.

Figure 5 following shows how more than 80% of under 5s have no long term conditions; by 90 this falls to less than 10%. Figure 5 also shows a close association between the line showing people's perception of whether their health is good/very good and two long term conditions in the Symphony dataset[v]. The Symphony Dataset identifies the following eight priority long term conditions for their prevalence and seriousness:

- Depression
- Cancer
- Diabetes
- Coronary Heart Disease (CHD)
- Stroke
- Chronic Obstructive Pulmonary Disease (COPD)
- Dementia
- Chronic Kidney Disease (CKD)

This could suggest that one to two of these long term conditions can be sufficiently managed and during younger age. It could however reflect the type of long term conditions that are predominant at different ages.



Somerset percentage reporting health as neither good nor very good

Figure 5 - Long term conditions and ageing well (Somerset)

Long-term conditions and multi-morbidity

To explore this a little further, some of the long term conditions, such as mild asthma, which represents a high proportion of long term conditions in young people, are generally easily-treated and have little broader impact on quality of life or susceptibility to other illness.

Other long term conditions can be more restricting and more limiting on health, especially for people who have more than one. Two or more conditions which occur together are called co-morbidities; having more than two conditions is often termed 'multimorbidity'. This can be more debilitating than just having two problems at the same time: for instance, someone with diabetes may find it harder to manage their medication if they also have dementia, and such patients may be described as having 'complex' needs.

Discussion group snapshot

We asked: What motivates you to keep well?

Somerset people said:

- *Having grandchildren and wanting to watch them grow up*
- *Observing other people who are not ageing well*
- *Making a physical effort to do things – walking, swimming, but more free activities would help*

Using the dataset it is possible to see whether the distribution of the various conditions is random or whether there are factors connecting them causing a clustering of conditions. Table 1 (Symphony) below compares the 'observed' and 'expected' values (if it were just random) of conditions.. Most people – more than we would expect if it were random - have no long term conditions (LTCs). We have fewer than we would expect with just one, but we have *many* more people than we would expect with three or more. If it were simply random, we would expect that about 700 people in the county would have three or more LTCs, whereas the true number is over 5,600. This finding demonstrates that multimorbidity is closely linked to inequality. The clustering of conditions is likely to be the result of common risk factors such as smoking, poor diet and exercise, excessive alcohol, social isolation – all associated with deprivation – causing disproportionate ill health in a small group of people.

Table 1 - Observed and Expected Numbers with Long Term Conditions

Number of conditions out of 8	Observed (number of people)	Expected (number of people) given overall prevalences	Obs/Exp
0	447,727	429,243	1.0
1	79,909	110,708	0.7
2	19,187	11,799	1.6
3	4,519	671	6.7
4	953	22	43.5
5 or more	149	0.4	356.8

Depression is the most commonly occurring sole condition (and also that the observed number of people with a lone diagnosis of depression is close to what would be expected by chance). Chronic Kidney Disease is the least common and it occurs with other conditions much more often than would be expected by chance.

All conditions occur alone less often than would be predicted by chance.

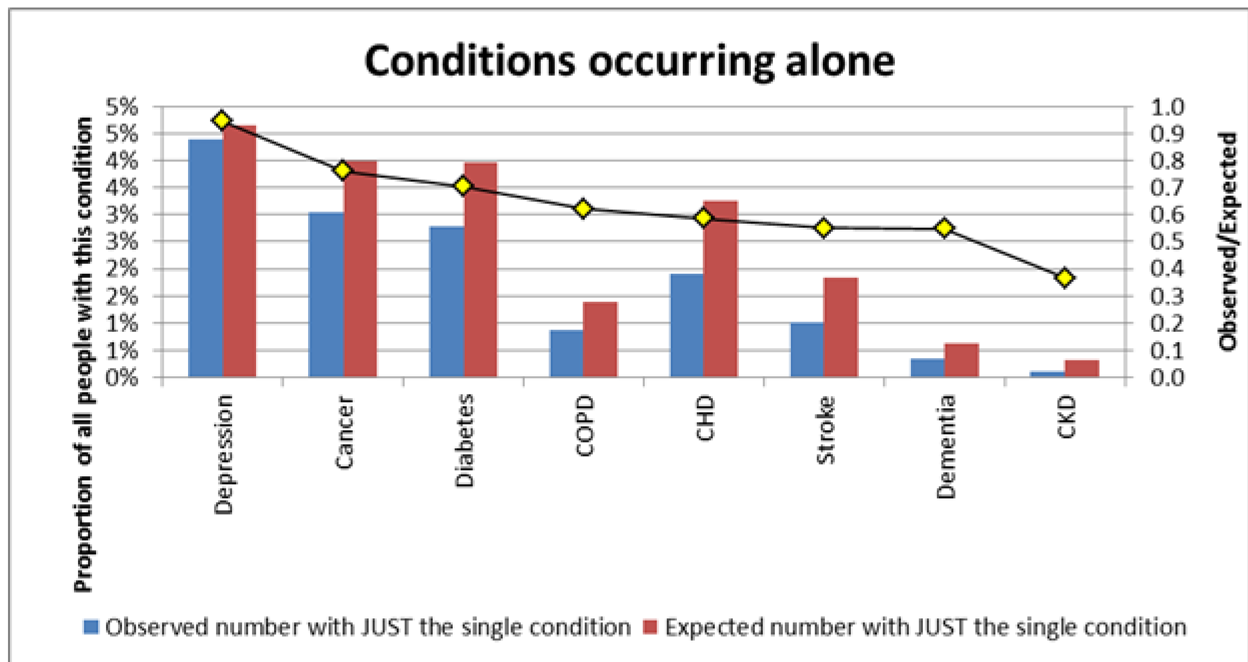


Figure 6 - Long Term Conditions Occurring Alone

It is also possible to look at combinations of the conditions to see which are observed more often than expected by chance. The graph below (Figure 7) looks at people in whom the two conditions listed on the horizontal axis occur together (some of those people will have other conditions as well).

All combinations occur more often than would be expected by chance. Depression occurs in the combinations on the left of the chart and where the observed value is getting more similar to the expected value, which fits with the observation above that depression appears almost to occur independently of other conditions. There are almost nine times more people with both dementia and stroke diagnosed than expected. Indeed groups of vascular conditions tend to show the greater excesses of observed numbers compared to expected numbers.

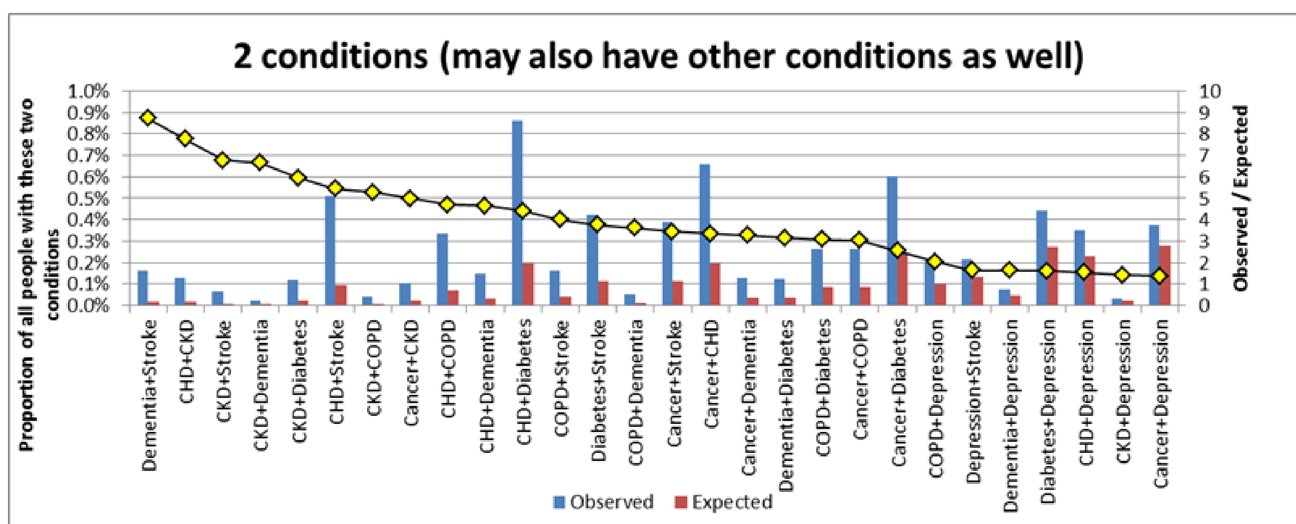


Figure 7 - Prevalence of Two Long Term Conditions Occurring Together

In summary, the Symphony dataset shows that there is evidence that some LTCs cluster together. It is likely that predominant diseases that cluster together do so as a result of common lifestyle risk factors which are strongly linked with people who live in areas of higher deprivation.

In relation to demand on services, people with many conditions – 'multimorbidity' – tend to require *much* more expensive health and social care than those with fewer because the conditions and their treatment affect each other and make the individuals health status more complex. The dataset shows that the healthiest 78% of the population require only 35% of expenditure – about £300 each. The 4% with three or more conditions require approximately 50% of expenditure –about £10,000 each per year.

Ageing is inevitable, but 45% of the associated ill-health burden is preventable[vi].

The evidence is clear, prevention of LTCs (particularly multimorbidities) is key to improving lives in older age **and** reducing costs to the taxpayer. Keeping 100 people in the '78%' rather than the '4%' for one year would save Somerset health and care system £1m.

Inequality in Multimorbidity

Patterns of multimorbidity show the strong relationship between social and economic disadvantage and ill health. Long term conditions are disproportionately found together, and found more in the most deprived communities. As an *additional* effect, people with multiple long term conditions (rather than simply older people) are disproportionately expensive for health and care.

Projections of Multimorbidity

If current trends continue we will see multimorbidity rise steadily. Using the rates for all Somerset registered patients and the ONS 2014-based population projections for Somerset residents gives the following projections over the next 20 years. The

number with three or more of the eight conditions is projected to increase by over 60% from 5,900 to 9,600 and the number with five or more to increase by nearly 70% from 160 to 270.

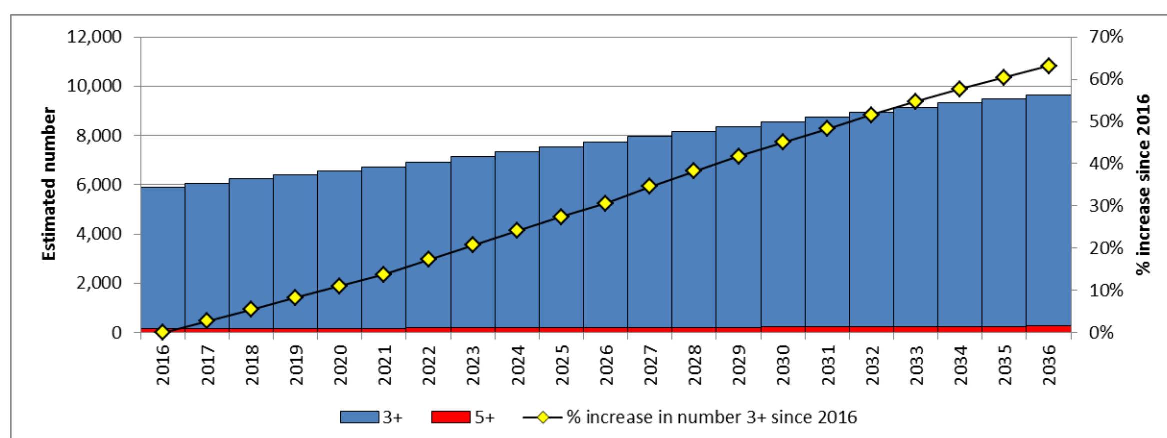


Figure 3 - Projections of Numbers with 3+ and 5+ Long Term Conditions

The estimated increases can only be a rough guide as the population projections are themselves modelled. However, the impact of multimorbidity on wellbeing, and health and social care resources, is such that the increases demonstrated here need to be taken into consideration in planning services.

Cause of death

Understanding the burden of disease also requires studying the causes of death. (Analysis here is of *underlying* cause of death; the immediate cause of death may often be flu or pneumonia that only proves fatal because of the underlying condition.) Figure 9 below shows cause of death for those dying before and after 80.There is a larger number of male deaths than female under 80, and the pattern is reversed for those over 80, reflecting lower male life expectancy.

Secondly, the proportion of deaths from flu and pneumonia is much lower for the over 80s, probably because many by that age have acquired an underlying condition[vii]. Thirdly, and most interesting, the largest increase in cause of deaths is dementia and Alzheimer's, especially for women. To an extent this reflects medicines and lifestyle improvements in reducing the incidence of the major killers – cancer and heart disease. In 2013-15 nearly a fifth of emergency admissions (5,000 out of 26,000) for people over 85 were for someone with dementia.

The rise in dementia, for which there is currently no cure, poses considerable challenges for the health and care system, and the families of those affected.

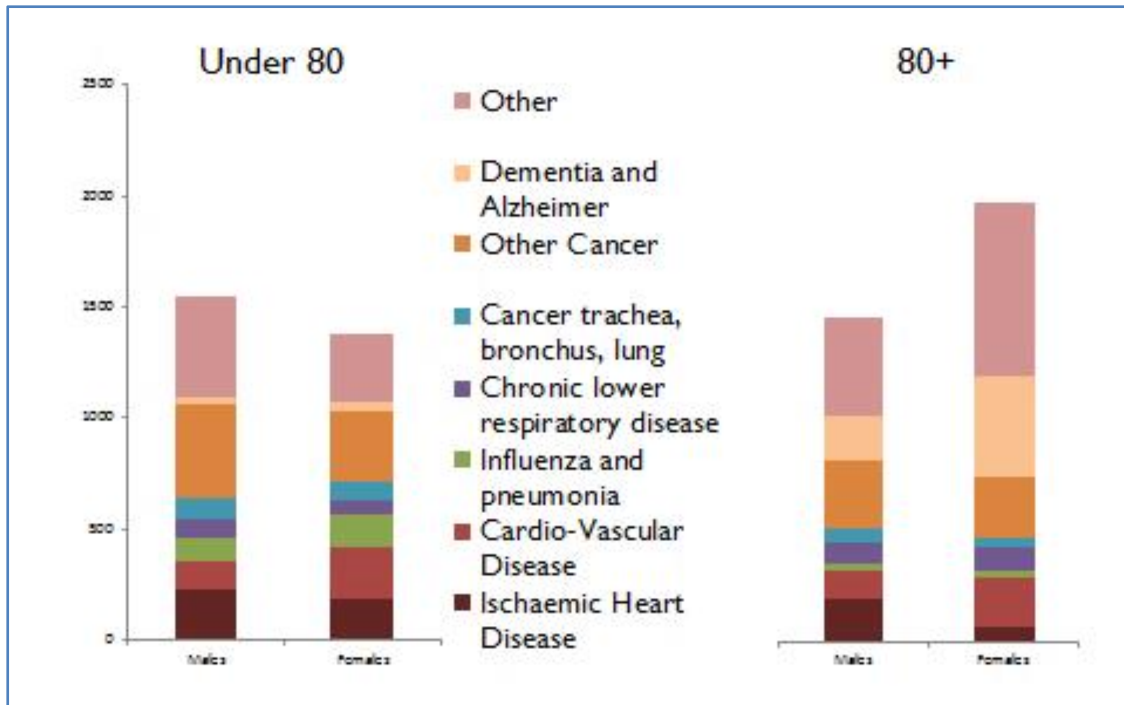


Figure 9 - Cause of death, Somerset 2015

There were over 2000 deaths from dementia and Alzheimer's disease in Somerset care and nursing homes in 2015, with a notably small proportion at home. The recent rise in dementia shown in Figure 10 demonstrates the scale of the challenge.

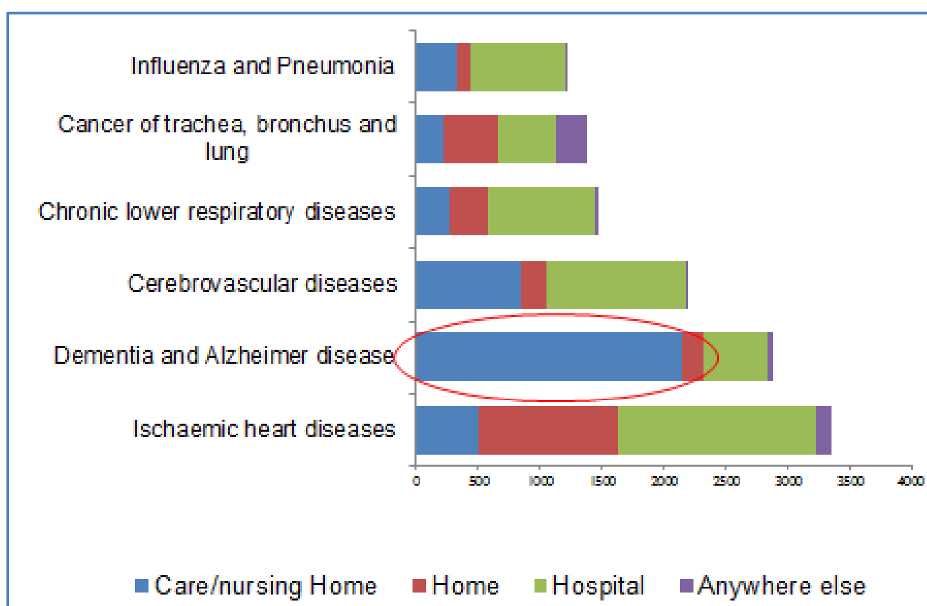


Figure 10 - Place of Death, Somerset

The slight fall in the *proportion* with the condition in 2016 may reflect a genuine reduction, perhaps related to healthier lifestyles at younger ages; this has to be offset by the rise in the absolute *number* from population growth and ageing, and the

possibility that the condition is under-recorded in the county. The number of people with dementia is projected to double by 2035 to approximately 18,000 people.

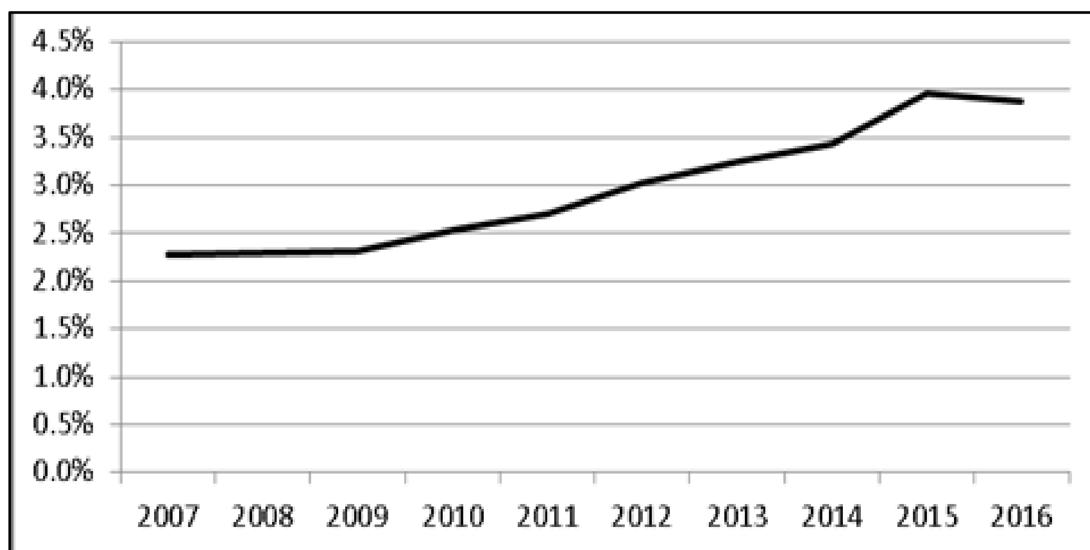


Figure 11 - Dementia recorded prevalence 65+, Somerset registered population

Lifestyles and prevention

In broad terms, the lifestyle factors that have the greatest contribution to make in preventing or delaying the greatest burden of disease are clearly understood, with good diet, exercise, not smoking, drinking responsibly and having good social contact being beneficial for heart disease, stroke, cancer, lung disease, Type II diabetes and dementia, amongst others. Of these, diet was by far the most frequently raised in the discussion groups. Some focus group members referred back to the good habits that begun in their childhood rationing.

Discussion group snapshot

Diet

- *No junk food, cook your own*
- *During the war we had a limited diet, but wholesome. Food was from the land, you knew what was in it*
- *Eating smaller, healthier meals – 'but I am terrible sometimes, I binge*

It is perhaps interesting that smoking and alcohol were not raised specifically during the qualitative work although the discussion of lifestyle would suggest that members of the discussion groups were not unaware of their effects.

Screening, too, has a role in prevention, with health checks a way of identifying conditions early. Nationally, the uptake of bowel screening amongst 50-70 year olds is less than 70%, and less than 50% in men aged 60-64, even though this is the second most common form of cancer in the whole population [xii].

Physical activity

The importance of physical activity was raised in a case study from the Quantocks.

CASE STUDY FROM THE COMMUNITY COUNCIL FOR SOMERSET

At a Village Agent Knowledge Café the village agents were introduced to ‘Zing’; a bag of sports games that is loaned to Village Halls with the aim of getting a group together to try different fun social games whilst helping people to become fitter and more active.

Once the group is hopefully established after about eight weeks, if the group wishes to continue then Zing help them to apply for funding for their own bag. A Village Agent introduced the village of Timberscombe to Zing and they trialed the group for eight weeks. It proved to be a big success and now the group meets weekly having received funding to purchase their own bag and members of the group report that they feel healthier and look forward to meeting up with the friends and having fun.

Summary

Ageing does not *have* to be associated with diminished health, and lifestyle improvements throughout life can delay the onset of illness. Healthy people also tend to show ‘compressed morbidity’, with a much higher proportion of life spent in good health. This is good for us all, and good for health and care service provision.

Social inequality means that a small number of people, experience a disproportionate burden of disease and an even more disproportionate impact on cost. Enabling more people to age well will be a ‘win-win’ for people and the economy.

SECTION II: REMAINING INDEPENDENT

Living an independent life or having a sense of independence emerged strongly in the discussion groups and conversations. For the majority, being independent meant being able to get out and about, meet others and participate in their local community without having to feel over-reliant on other people.

Social contact emerged as the most important aspects of ageing well. Others included being able to live in your own home, having access to public transport, receiving the appropriate type and quality of social care. Because of its prevalence and impact, dementia care is a significant element of maintaining independence in older life.

Care

Figure 12 shows that the bulk of unpaid care in Somerset is provided by those over the age of 50. Importantly, nearly half of carers over the age of 65 provide care for more than 20 hours per week. It is likely that people over 65 years are predominantly providing care for spouses; many 50-64 year olds provide care for their ageing parents. Whilst providing some care for others can be beneficial to health and wellbeing, giving a sense of purpose, high intensity caring has been shown to have a detrimental effect on wellbeing[viii].

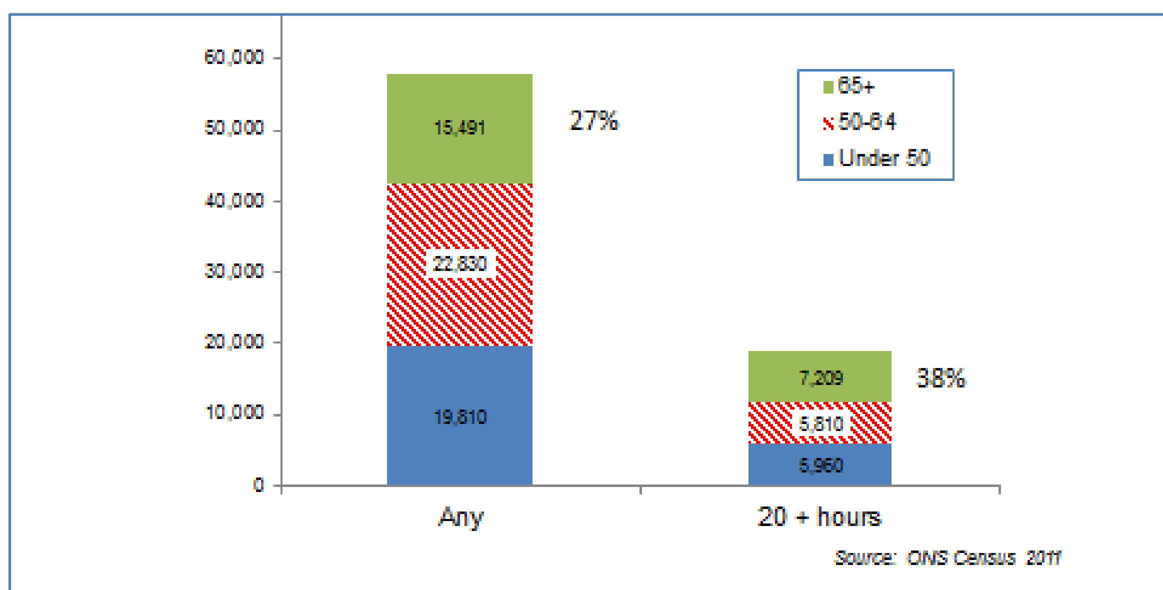


Figure 12 - Providing unpaid care in Somerset

Unsurprisingly, carers' needs were strongly stated during the qualitative work for this JSNA. People commented that families were often more dispersed than in the past and children were unable to give the support that they might have done formerly. Others pointed out how, in some groups such as the Chinese community, caring for elderly people was given particular respect.

Discussion group snapshot

Carers

- *My husband has to stay well to look after me. But [his caring responsibility] puts his health at risk.*
- *Look after the carer or you will have to look after two people.*
- *Increased stress with caring for someone with dementia – makes you defensive all the time – there's no let-up….you become run down, getting ill…..*

We were interested to ask about the attitudes older people experience and whether attitudes towards older people promoted independence or not. Some people in the discussion groups had experienced being 'talked down to' and were extremely resentful of it. There was a feeling that in some circumstances receiving direct support had left them feeling less capable of looking after themselves and more dependent.

Discussion group snapshot

Attitudes to older people

- *Too much being done 'for you' – a bit of help, yes, but more encouragement is needed*
- *Negative expectations of being old from family and well-meaning friends*
- *Being treated like you don't matter – it's degrading*

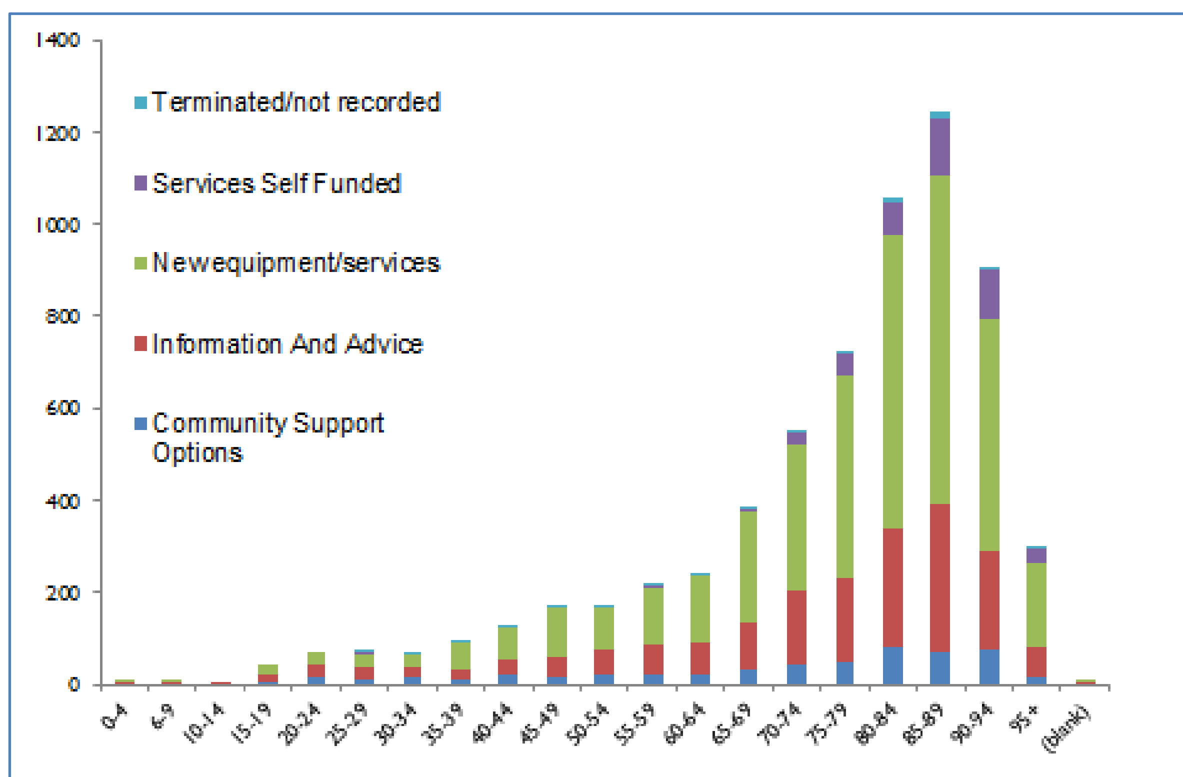


Figure 13 - Social Care Assessment Outcome

Outcomes of adult social care assessments provide a useful insight into how older people are supported. Figure 13 shows the outcomes of assessments done in response to a change in need. The most frequent support is the provision of new equipment or services. For all age groups, only a small proportion of assessments result in support provided by the community. This possibly reflects the complex needs explained above as a result of multimorbidity but it could also suggest a paternalistic approach by services. Interestingly, this is counter to what people want for themselves and their overriding preference to live independently and without undue reliance on others.

An example of how support from the community can work (prompted by the local GP) is can be drawn from Martock, in South Somerset.

Case study from 'Our Place', Martock:

Grace, 80 – Martock

Grace who is 80 had a fall and spent time in hospital. Before, the fall she was highly independent. Afterwards, she was fearful of going out and had become isolated and lonely. The GP asked the seniors' support coordinator to arrange a volunteer befriender, to visit Grace once or twice a week. They started with a walk in the garden, slowly progressing to the local shops. She is now confidently back walking to the shops, and has resumed her social life.

This example of community support is encouraging and shows how GP services, working closely with their communities, can provide the right solutions which may not be medical at all. This simple form of support provided social contact for the befriender as much as it did for Grace. Above all, it helped Grace regain her independence and back to being able to look after herself[ix].

Discussion group snapshot

Promoting independence

- *"I'm here to help you get dressed; but what can* ***you*** *do?" (An attitude of a paid carer, commended by participants.)*

Social care has a strong emphasis on promoting independence to its service users, particularly through 'reablement' – the provision of intensive advice and support for a relatively short time and equipment if necessary – to bring people back to a state of independence.

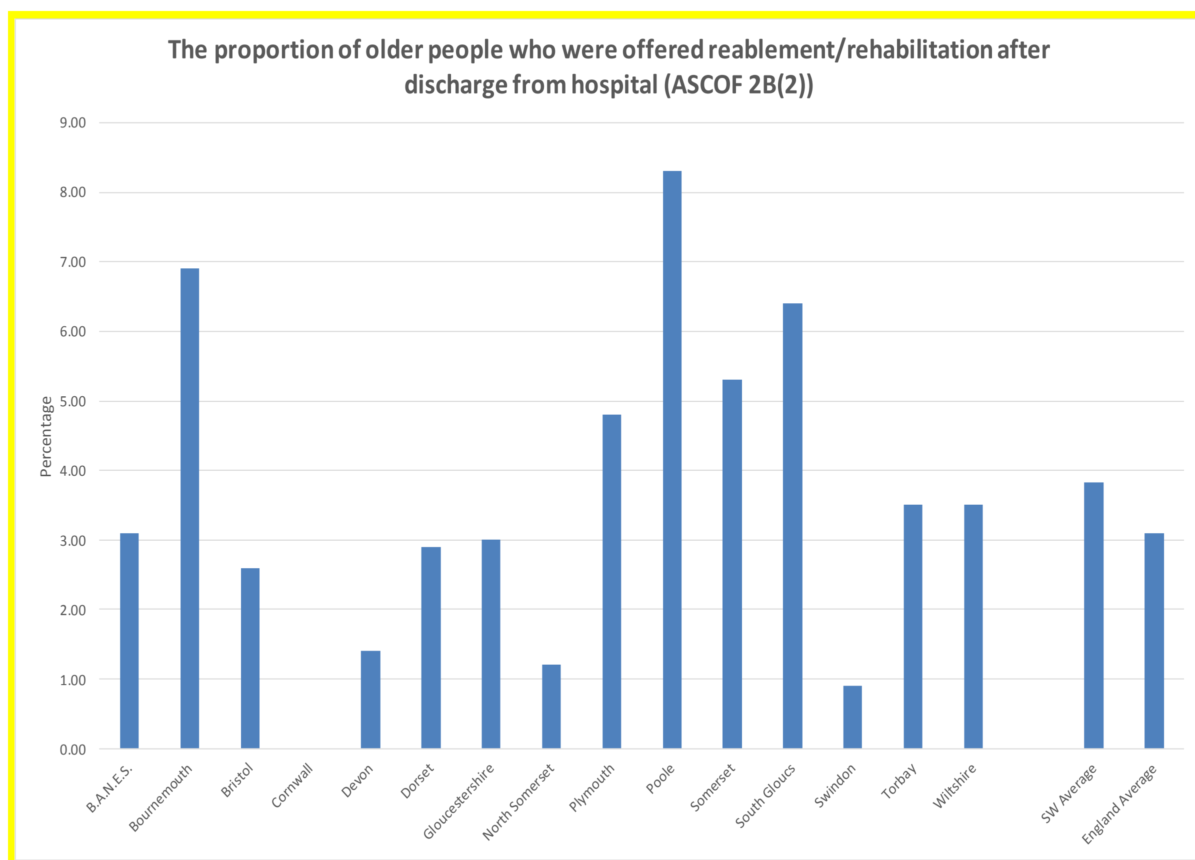


Figure 14 above shows that Somerset is one of the highest in the South West for reablement following discharge from hospital. In principle, this would appear positive, however Figure 15 following compares the outcomes of reablement in Somerset with the rest of the South West. The numbers entering into reablement is extremely high compared to other areas, but interestingly, there is a disproportionate number of people who require ongoing support following the reablement period,

This suggests that reablement wasn't appropriate for some of these individuals in the first place. Similarly, there is a very high proportion of people who needed no support following reablement.

This could also reflect that some of these individuals did not need reablement, they may have regained independence without it. Ensuring and adhering to a suitable referral criteria for reablement is important in maintaining its effectiveness to improve outcomes and the cost effectiveness of the service.

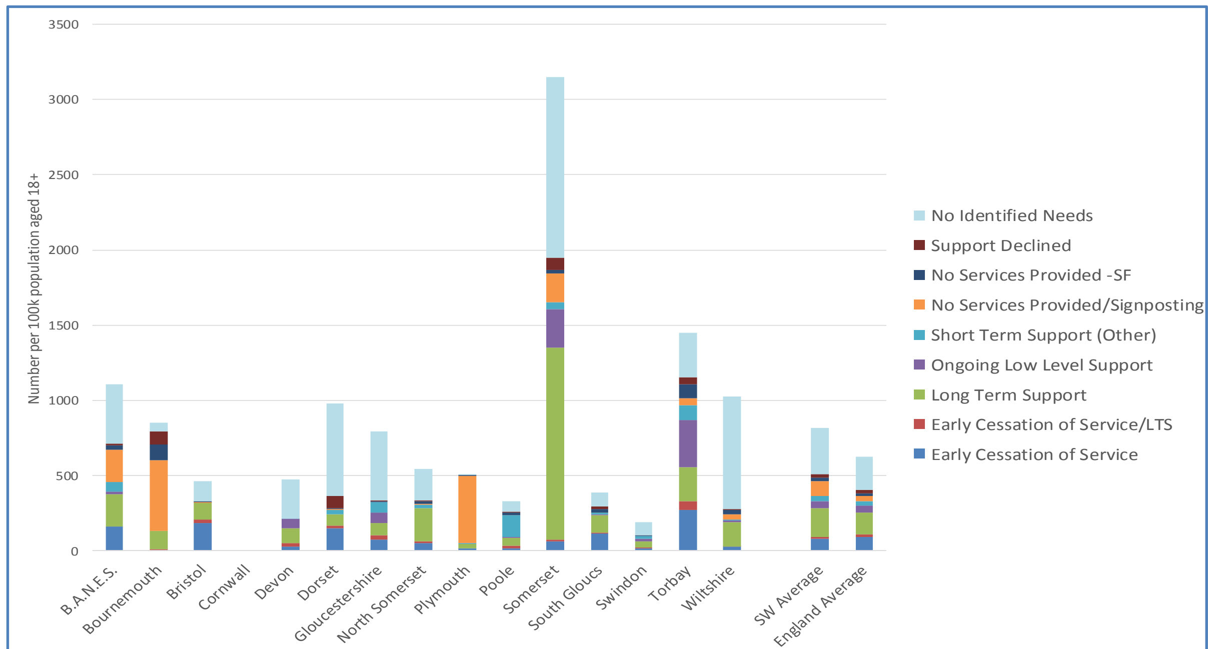


Figure 15 - New and existing customers receiving reablement 2014/15, showing sequels

Figure 16 shows that the number of people in Somerset over 65 receiving long term support is somewhat higher than the regional average. What is notable, though, is that more than half are receiving 'traditional' commissioned support with managed personal budgets and direct payments (both of which give the service user far more control over what services are provided and how) being lower than any other local authority.

It may be argued that this pattern does not encourage independence amongst service users, or people taking responsibility for their health and wellbeing. In thinking about 'ageing well', it is likely that people who are more in control of their support would be more likely to rate their health and wellbeing as 'Good'.

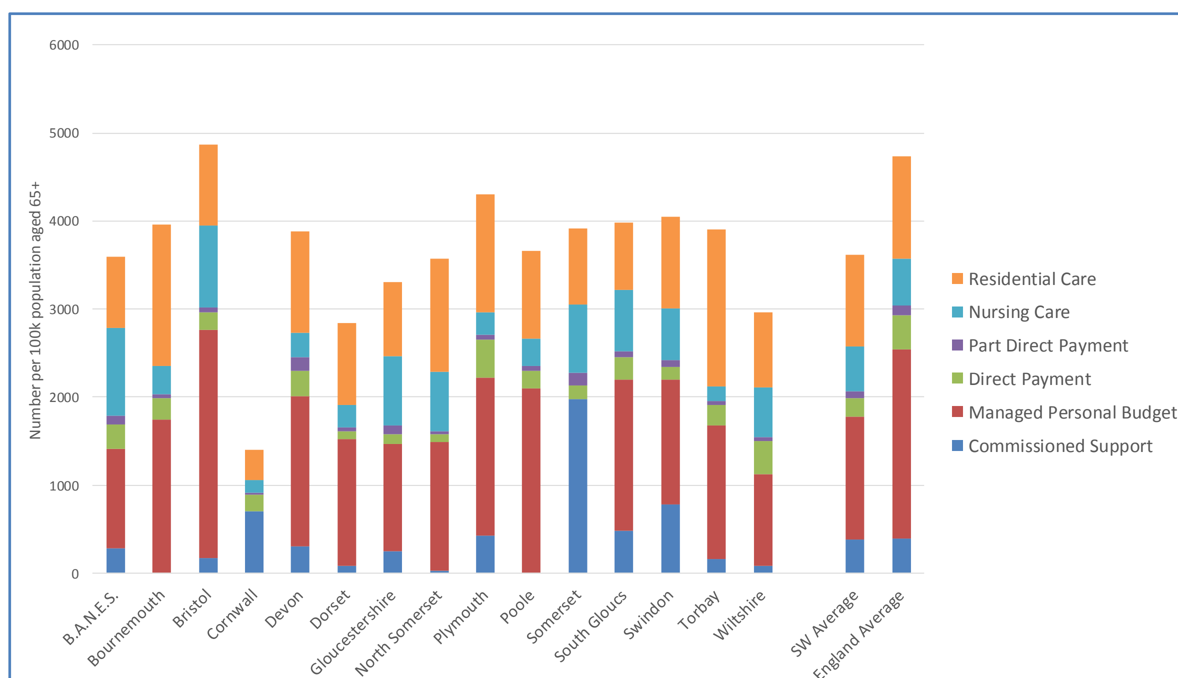


Figure 16 - Number of people aged 65+ receiving long-term support at year end 2014/15 by service type

Within the discussion groups there was a strong desire to take responsibility and 'be treated like adults'. Some people expressed criticism of the attitudes of some care workers not engaging with them or being patronising. They also expressed concern regarding the short length of time they were able to spend with service users being a barrier to providing 'useful' support to help develop independence.

Housing

A major part of independence is the desire to stay in one's own home and this was expressed strongly in the discussion groups. With a rising population of elderly people, it is important to consider whether the current and planned stock of housing is adequate for the population needs.

A quarter of Somerset's households include no one younger than 65. Figure 17 below shows the change in 'heads of household' projected for Somerset to 2039. This shows that almost all increase in demand for housing will come from households in which the oldest person is 65 or above.

On the basis of current provision, the draft Somerset Housing Market Assessment suggests that 300-400 more supported care home places, and 200 residential care places are needed over that period. That, of course, assumes that there is no change in how services are provided. The approach put forward through this JSNA and expressed within the discussion groups, suggests that a different way ahead, in which people are helped to stay at home, with integrated support from statutory, family and community supporters, may be much better received and more effective.

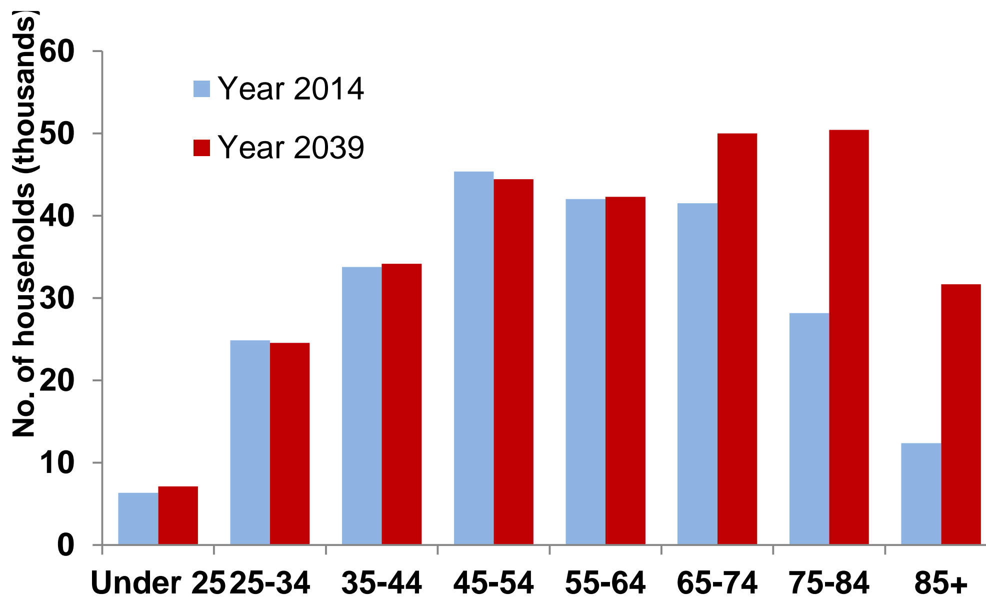


Figure 17 - 'Heads of household' by age

Figure 18 following shows the reasons given by people over 65 for looking for new social housing. Although this source only covers those in housing need, these are many of the people for whom 'ageing well' is particularly difficult and the findings accord closely with national surveys of all house moves. The answers given reinforce the importance of maintaining good health in order to stay at home as we age. It also emphasises families as a cornerstone of support for each other.

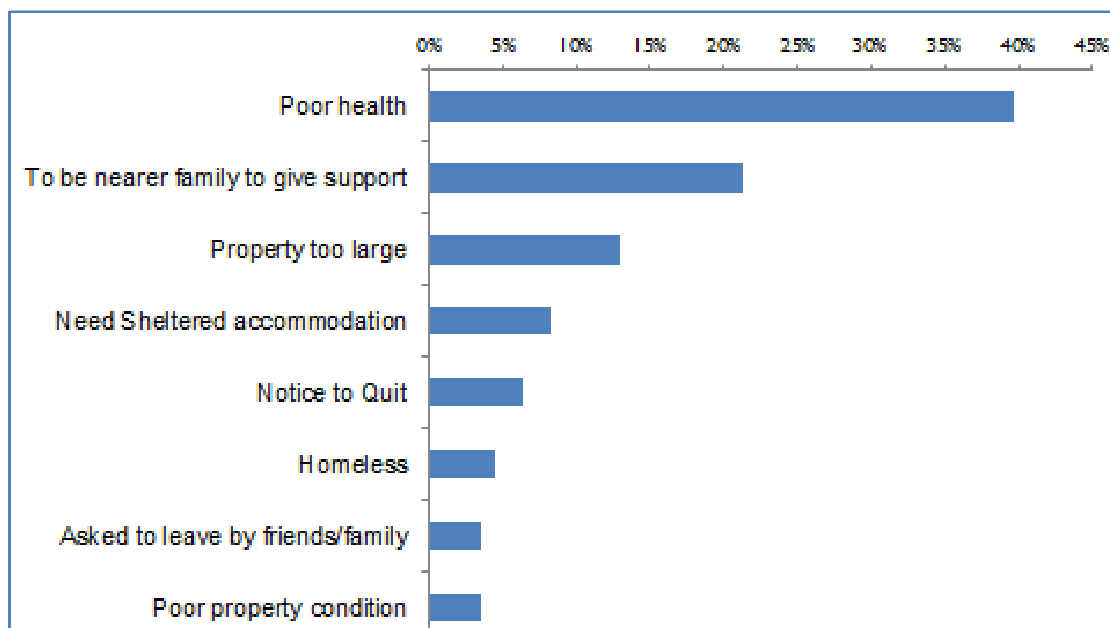


Figure 18 – Homefinder – reasons for moving

Discussion group snapshot

Housing

- *More could be done to keep people in their homes…like the new hospital at home*
- *More community and health support to keep people at home*

The 10% or so (in Figure 18) who wanted to move because their dwelling was too large, raise the question of whether older people 'under-occupy' houses while younger families are overcrowded. Unfortunately we do not have the data sources to answer that question adequately, but we did find resentment amongst older people who felt 'blamed' for the housing crisis (and the crisis in health and social care) and under pressure to 'downsize'.

Transport

http://www.somersetintelligence.org.uk/transport-older-people/

According to information on our Somerset Intelligence website, older women are particularly affected by a lack of transport, especially if they outlive their partner as they are less likely to drive a car. In Somerset, the female to male ratio of non-car ownership for the 65+ age group is around 3:1 across all three rural-urban classifications, with rural towns marginally the higher ratio and urban the lowest (see table 2 following)

While older people (and those of other ages, too) are less likely to have access to private transport if they live in towns, there are nevertheless around 2,700 women and 900 men aged 65 or over living in rural villages with no access to car or van, which can often contribute to increased social isolation and poorer wellbeing.

	Female 65+ No car	Male 65+ No car	% Female 65+ No car	% Male 65+ No car
Rural village and dispersed	2,679	903	15.2%	5.6%
Rural town and fringe	3,547	1,070	28.0%	10.4%
Urban city and town	9,886	3,389	35.0%	15.3%

Table 2 - Older people (aged 65+) with no car, by Rural-Urban classification % based on those living in a residential household, not communal establishments
Source: ONS Census 2011

This is not a study of transport, but perhaps inevitably in a rural county, this issue was raised by many involved in the engagement work to support the JSNA. More surprising was the importance given to it by people living in urban areas. Across the board, a lack of accessible transport was an issue that came up repeatedly.

Discussion group snapshot

Transport

- *No transportation in Priorswood in the evenings*
- *Very difficult to get to Musgrove on the bus, for example from Street and Bridgwater*

Section III: REMAINING ACTIVE AND INCLUDED IN COMMUNITY LIFE

Figure 19: Service Users' Engagement Group (Social Care)

There is a wealth of evidence that social contact supports and sustains wellbeing.

The qualitative work highlighted just how important socialisation is to ageing well and the opportunities it brings to share in activities and conversations, to share knowledge and experience and often to 'lighten the load'. Many activities are low cost – such as coffee mornings, book groups, walking groups and require goodwill and commitment to keep them going. Without this, and the input from statutory and voluntary organisations to support facilities and activities, many people would face increased mental and physical ill health.

Inevitably our strength and abilities decline with age. Accepting the physical restrictions that come as we get older means we need to accept support from other people. This acceptance can contribute to safety and security and highlights the importance of company and social contact.

Social contact and loneliness

http://www.somersetintelligence.org.uk/social-isolation.html

Being lonely is as harmful as smoking 15 cigarettes a day. Being older is itself a risk factor for loneliness, and having no car, being single (through bereavement), having poor health, low internet and Facebook use, as well as low income, can all be associated with ageing. Figure 20 below maps loneliness risk factors at the LSOA level. This shows that the greatest risk of loneliness is in poorer urban areas.

Rural areas have particular problems of transport, although, as noted before, discussion groups in urban areas also demonstrated its importance.

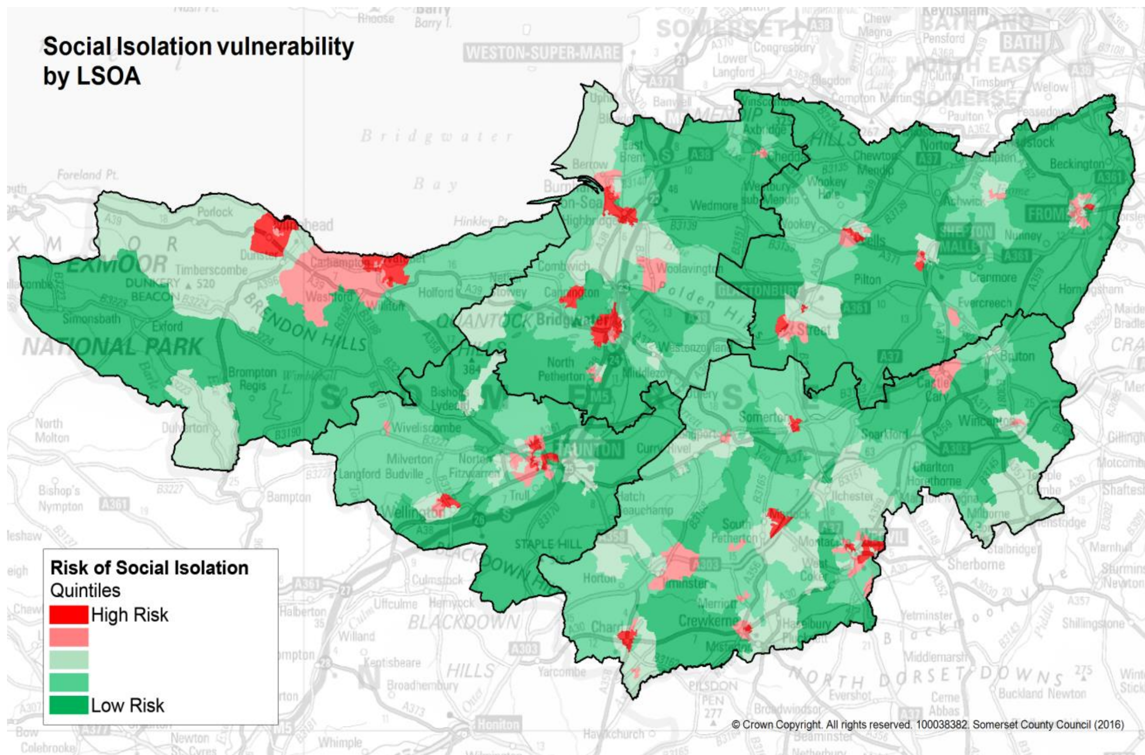


Figure 20 - Risk of social isolation (all ages)

We know isolation and loneliness are bad for health; and social contact and having a purpose are good for it. The term 'social capital' is often used to describe the value associated with a supportive community.

Older people to whom we spoke gave many examples of the importance of social contact and community support to their wellbeing, including a sense of purpose and the pleasure of still learning.

Discussion group snapshot

What helps people to age well?

- *Church work – active in community; drama groups and social singing*
- *Just having somewhere to meet and chat with people*
- *Having the courage to think 'If I don't do it now…'*
- *Coming to the Men's Shed*

In a previous JSNA, talking to younger people who lived rurally, social contact was just as important and social isolation a reality for many of them, particularly digitally.

Discussion group snapshot

What helps people to age well?

- *Community support or asking for help through support networks – feeling you can* ***do*** *that*
- *Laughter, sharing common interests, walking with other people*
- *Having the basics in place: heat, light, food, transport, companionship….and hugs*

Work and Income

We have already seen how being wealthy – having financial capital – usually makes it easier to age well[x]. Figure 21 following shows a graph of the numbers of people over 65s and under 18s in low-income households (as calculated in the Index of Multiple Deprivation) in each Lower Super Output Area[xi] in Somerset. This helps understand how interventions might be focused to encourage healthy ageing.

The distribution of poorer children shows a distinct concentration in a small number of urban areas, and a great dispersal of very small numbers across the rest of the county. The distribution of poorer older people however is very different, with large numbers in rural towns and urban areas particularly, but showing a much more even pattern than for children. It is also important to note the significant numbers with approximately 20,000 people over the age of 65 living in income-deprived households.

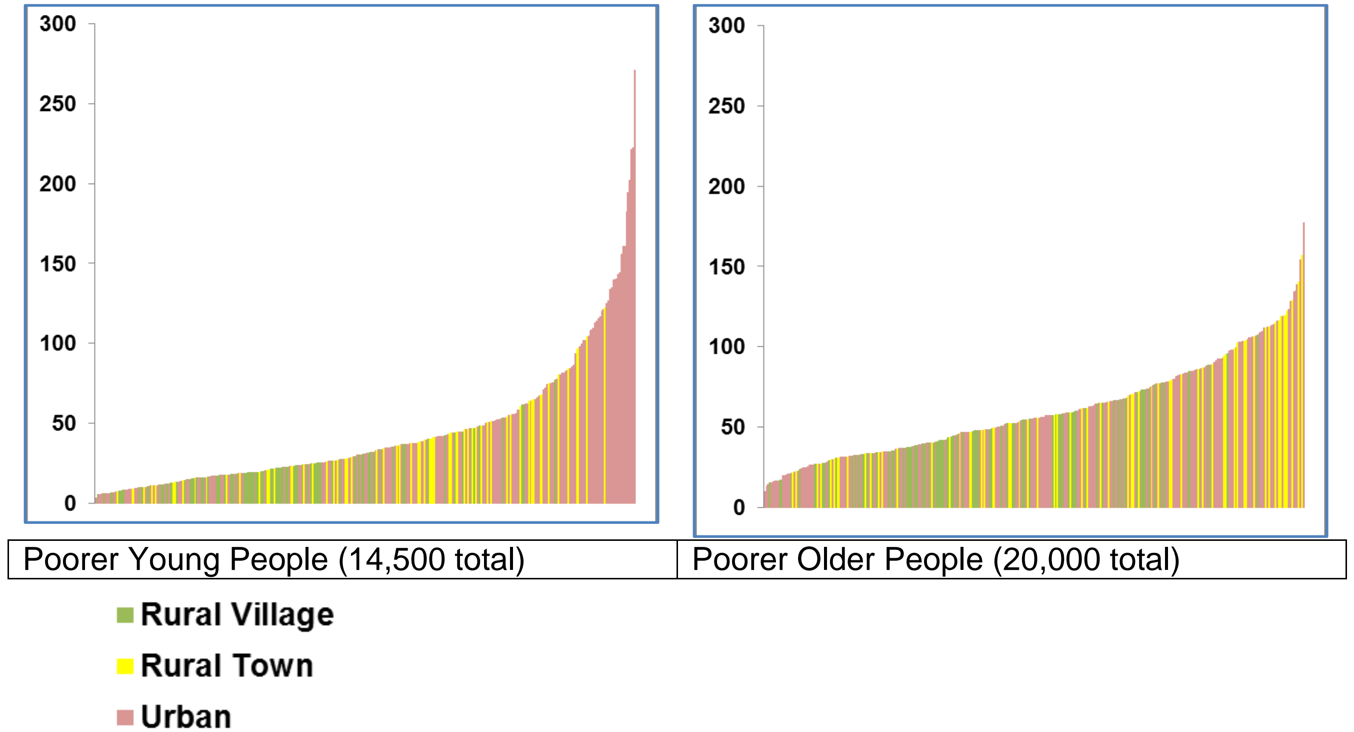


Figure 21 - Numbers of poorer children and older people by LSOA

In a 2016 report on the health people aged between 50 and 70, the Chief Medical Officer for England said that ‘staying in work, volunteering or joining a community group can make sure people stay physically and mentally active for longer. The health benefits of this cannot be overestimated’[xii].

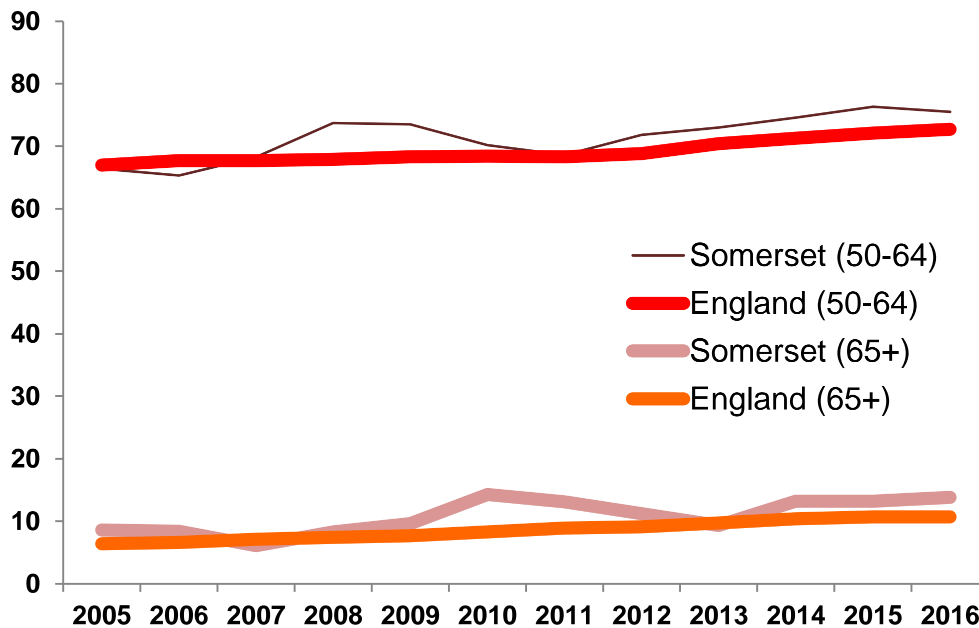


Figure 22 – Economic Activity rates – Somerset and England

Figure 22 above hows that economic activity rates have risen slowly for people in later working age and past male retirement age, and that Somerset has higher rates of both than the England average. However, there is a dramatic fall in economic activity at retirement age.

Whilst an obvious point, this 'cliff edge' represents a major change in lifestyle that can see some people losing social contact and 'purpose' in life. As we have seen, both of these can lead to a decline in wellbeing. Whilst much of this is dependent on national rather than local policies, there is a message for Somerset employers to treat older workers positively in recruitment and retention and, as for all ages, to promote 'good' work that has a health benefit.

Discussion group snapshot

The value of work

- *Being independent and keeping working*
- *Not being stuck at home on your own and isolated*
- *I'm still working, that gets me up in the morning,*

Volunteering

There's good evidence that volunteering brings benefits to both the person volunteering and the people and organisations they support [xiii]

Benefits can include:

- Quality of life.
- Ability to cope with ill health
- A healthier lifestyle
- Improved family relationships.
- Meeting new people. ...
- Improved self-esteem and sense of purpose. ...
- Increased self-esteem and confidence. ...
- Better social interaction, integration and support.

Somerset Community Foundation – 'Active and In Touch' was set up in 2011 in response to the number of people in and around Frome who were known to be suffering from social isolation and loneliness. The group has a network of volunteers who reach out to people and befriend them.

Case study

An older lady who resides in a village just outside Frome was referred to the 'Active and In Touch' group after a spell in hospital. She has lived alone since her husband passed away, and her remaining family live on the other side of the world. She was no longer able to drive, lacking in confidence and felt trapped in her home, with the only social interaction coming from infrequent visits from a neighbour.

Having spent Christmas 2015 alone and feeling very low, this person was first visited by 'Active and In Touch' in January 2016. Just three months later she is visited each week by her one-to-one befriender who takes her shopping, visits at the weekend, invites this person for lunch and has taken her to an antiques fair. The same volunteer has also introduced this person to Skype to help her stay in better contact with her children, grandchildren and great-grandchildren.

Another volunteer has been taking this person to hospital visits in Bath, which previously had been a source of great anxiety for her and a frightening experience on her own. She has been introduced to a support group for those who have lost their partners and is being connected with a hobby group in Frome, as she is interested in crafts.

The level of volunteer support this lady has received from 'Active and In Touch' has transformed her life completely, and she has made many new friends as well. She is now looking to move into Frome so that she can enjoy even more opportunities to interact with others, and she says "I feel as though they have opened up my life again…I am thrilled".

CONCLUSION

Growing older in Somerset is a privilege that many people in in early 1900's never experienced. It is potentially the time of life when we know ourselves and our communities the best we ever have. It can be a time of life when we are able to indulge interests to a greater extent as well as enjoy the fruits of our labours. All this relies on aging well though, preferably in good health with those we love around us.

The longer we live as a population, arguably the harder we have to work at achieving ageing well. Through this work we have heard from some older people about their experiences during the Second World War and rationing and how this influenced their health and wellbeing. We have also heard about the lifestyles some have led and how these have, in many cases, better equipped them for life now - such as growing vegetables, cooking and sustaining a certain level of personal resilience.

One of the main benefits of being able to maintain good health is the continuation of personal independence. This is also dependent on factors such as transport and community support. Although unquestionably people felt the need for health and social care when they were ill, many also wanted to be supported to 'get back to normality', rather than have a long term reliance on carers.

Social contact was a strong theme that ran through much of what we found. This was both a benefit to be gained from health, independence and mobility, and something that helped in maintaining good physical and mental health. For many people, retirement could mean a loss of both social connections and income, and managing this transition is an important part of ageing well.

Some people, of course, fall ill regardless of their income or lifestyle. Whilst this report has shown ways in which ageing can be positive, it should not be forgotten that there is more ill-health associated with age, and one requirement of ageing well is the provision of efficient and effective health and care services. People in deprived communities tend to have greater needs than the better off.

The Somerset population is ageing; adopting a holistic approach to health and wellbeing can lead to a healthier, more content and socially active county.

In summary, the older population of Somerset is a great asset and should be supported in a way that promotes healthy living and provides opportunities for people to continue contributing to society.

Endnotes

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[i] http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf
[ii] End of life care is the subject of the 2017 Somerset Annual Public Health report, see http://www.somerset.gov.uk/organisation/departments/public-health/
[iii] Office of National Statistics (ONS)
[iv] This has been observed in other nations; see http://www.bbc.co.uk/news/world-us-canada-38247385
[v] The Symphony project in South Somerset aims to improve health and wellbeing of the population in response to the findings from integrating data about health and social care, giving a more holistic understanding of the cost of different ways in which an individual is treated (http://www.symphonyhealthcare.co.uk.gridhosted.co.uk/about-symphony/)
[vi] https://www.gov.uk/government/news/health-of-the-baby-boomer-generation
[vii] Flu jabs for the elderly may also contribute.
[viii] Age UK's Index
of Wellbeing in
Later Life http://www.ageuk.org.uk/professional-resources-home/research/reports/health-wellbeing/wellbeing-research/ 2017.
[ix] Whilst there is anecdotal evidence for the value of community support, it is worth noting that analysis of hospital admission rates by the Nuffield Trust did not show evidence of reduction in numbers http://www.nuffieldtrust.org.uk/publications/harnessing-social-action-support-older-people
[x] See also https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/571471/changing_risk_cognitive_health_report.pdf
[xi] LSOAs are census-based areas with about 1500 inhabitants.
[xii] https://www.gov.uk/government/publications/cmo-annual-report-2015-health-of-the-baby-boomer-generation ; for the value of volunteering see also https://16881-presscdn-0-15-pagely.netdna-ssl.com/wp-content/uploads/2016/12/Evidence-Review-Community-Contributions.pdf
[xiii] NHS Choices website